NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

ANCILLARY PACK - BOARD OF DIRECTORS

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7 August 2025

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AGENDA

BOARD OF DIRECTORS PART I ANCILLARY PACK

Items:
9.2 - Quality Account
9.3 - Annual Safeguarding Report
9.4 - Maternity and Neonatal Safety Report
10.2 - Guardian of Safe Working Report
10.3 - Social Value Strategy
13.1 - AHP Safe Staffing Report

9.2 - QUALITY ACCOUNT

REFERENCES

Only PDFs are attached

9.2 - Quality Account - Ancillary paper Final 2024.25.pdf

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Quality Account 2024/2025

Excellent care with compassion

Always Safety First

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Quality Account 2024-25

PART 1 – Chief Executive's Statement

1.1 Chief Executive's Statement

I am delighted to present the 2024-25 Quality Account for Lancashire Teaching Hospitals NHS Foundation Trust. This report provides a comprehensive overview of the quality of services provided at Lancashire Teaching Hospitals NHS Foundation Trust for the period 1st April 2024 to 31st March 2025.

We continue to be immensely proud to serve the people of Preston, Chorley, and the surrounding Central Lancashire footprint, as well as the wider population of Lancashire and South Cumbria. Our commitment to delivering high-quality, compassionate care to patients and their families remains unwavering.

Safety and quality remain at the heart of everything we do at the Trust. The clinical outcomes and experiences of our patients drive every decision we make. Building on the excellent work of our clinical teams, we aim to further enhance the quality of services we provide. This focus on quality is a key motivator for our teams and helps us attract and retain the high-calibre colleagues who deliver our services.

During 2024–25, we transitioned from Our Big Plan and operated under the Single Improvement Plan (SIP) 2024–27, ensuring a balanced approach to safety, quality, experience, workforce, operational effectiveness, finance, and strategy across both local and specialist services.

Our teams have continued to deliver exceptional care during challenging times, and I would like to extend my heartfelt thanks to all staff both clinical and non-clinical who work tirelessly to provide excellent care to our patients. Your dedication does not go unnoticed.

We have seen significant and wide-ranging improvements across many areas of care this year. Elective care services have made strong progress, with more patients receiving timely treatment and a reduction in long waits. Cancer services have also seen sustained improvement, with better access and faster diagnosis contributing to improved outcomes. Medication safety has been a particular area of success, with a notable reduction in reported incidents and a continued focus on learning and prevention. Importantly, the proportion of medication incidents resulting in harm remains below the national average, reflecting the strength of our safety culture.

Mortality rates have remained within expected ranges across all categories, including adult, child, neonatal, and stillbirths. We have also seen a reduction in pressure ulcers, particularly those causing severe harm or associated with medical devices. Complaints have decreased, while compliments

have increased demonstrating growing confidence in the care and experience we provide. Patient feedback, particularly in maternity and cancer services, continues to be consistently positive.

Alongside these successes, we have delivered a number of major service developments, including the introduction of pioneering surgical techniques, the expansion of maternal medicine services, and the opening of new diagnostic and assessment units. These developments not only enhance our capacity and capability but also demonstrate our commitment to innovation and excellence.

While we are proud of these achievements, we recognise that urgent care pathways remain a significant challenge. We are working hard to improve patient flow, reduce delays, and enhance the overall experience for those who need our services most urgently. Diagnostic performance has also been a focus, and while we have made progress, we know there is more to do. Balancing these priorities while maintaining our focus on safety and quality remains our top priority.

To support our improvement journey, we have refreshed our **Board Assurance Framework (BAF)**. This now reflects the principal risks facing the organisation and aligns closely with our strategic priorities. These include improving patient experience in urgent and emergency care and inpatient services, reducing *Clostridioides difficile* infection rates, and enhancing colleague experience. We recognise the strong connection between staff wellbeing, patient outcomes, and operational performance

This year, we have further embedded the national Patient Safety Incident Response Framework (PSIRF), fostering a culture of learning and transparency. When things do not go as planned, we are committed to recognising and responding in ways that ensure affected individuals have their experiences heard and that meaningful improvements are made.

The Board of Directors remains dedicated to ensuring the capability and capacity within the organisation to deliver high-quality services. Our commitment to continuous improvement is equipping colleagues with the skills and confidence to lead change at every level of the organisation.

We continue to work in partnership with local entities to develop collaborative leadership at the Place level within Central Lancashire and with the Integrated Care Board, Lancashire and South Cumbria NHS Foundation Trust, Lancashire County Council, and third sector partners including Derian House and St. Catherine's Hospice. We believe that working with organisations equally committed to the quality agenda benefits all parties and ensures that organisational boundaries do not hinder service improvements for our patients.

This report details our performance, and with the support of the Trust's Executive Directors, I am pleased to confirm that, to the best of my knowledge, the Quality Account 2024–25 complies with national requirements, accurately reflects our performance, and contains precise information.

Professor Silas Nichols

Chief Executive Officer

PART 2 – Priorities for Improvement

2.1 Strategic Overview

2.1.1 Transition from 'Our Big Plan' to the 'Single Improvement Plan" (SIP)

During 2024-25, the Trust transitioned from 'Our Big Plan' to the 'Single Improvement Plan' (SIP). This transition marks an evolution in our strategic approach. The SIP is designed to be more streamlined and focused, ensuring that all efforts are aligned with our core mission of providing excellent care with compassion. This strategic shift emphasises the importance of continuous improvement, collaboration, and patient-centred care.

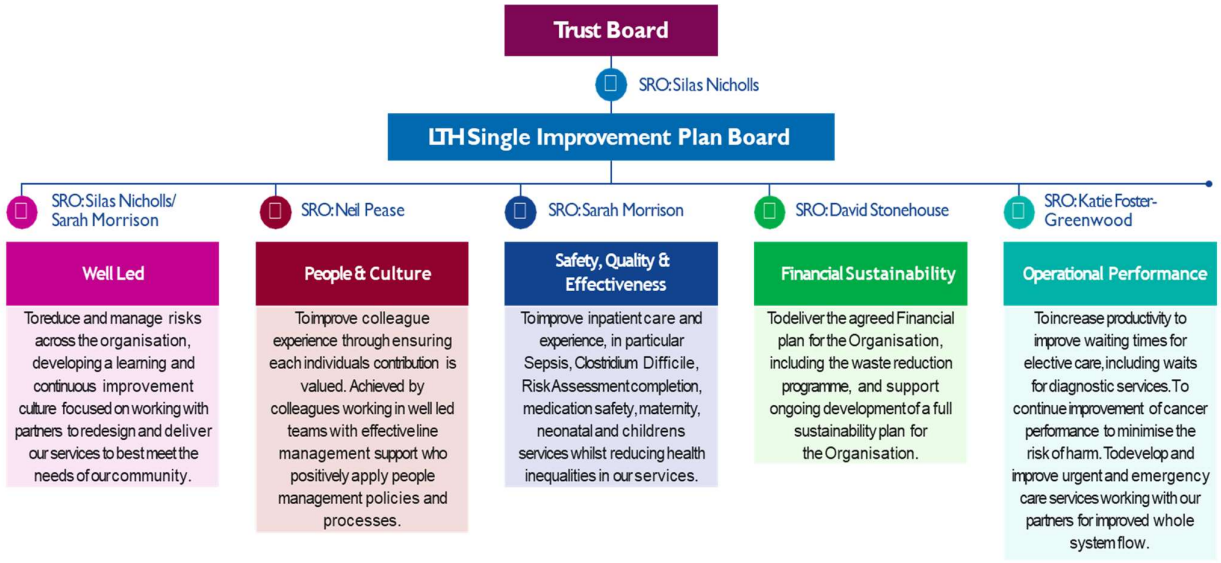
2.1.2 Integration of various sub-strategies

The SIP integrates commitments from various sub-strategies including the Clinical Strategy, Patient Experience and Involvement Strategy, and Continuous Improvement Strategy. By fostering a culture of excellence, we aim to improve outcomes, enhance patient experiences, and ensure a safe and caring environment for both patients and staff.

2.1.3 Mapping of ambitions to portfolios

The four ambitions previously contained in the Our Big Plan have been mapped through to five distinct portfolios with clearly defined responsibilities as outlined below.

Figure 1 SIP portfolios and ambitions



2.2 Use of Symbols in the Quality Account 2024–25

To support clarity, consistency, and transparency, the Quality Account 2024–25 incorporates a set of visual symbols.

2.2.1 Symbols aligned to the SIP

These symbols are used throughout the document to provide a quick and accessible reference to the Trust's five strategic portfolios defined in the SIP. These symbols are shown below.

Figure 2 Symbols aligned to the SIP

Well Led | **People & Culture** | **Safety, Quality Effectiveness** | **Financial Sustainability** | **Operational Performance**

2.2.2 Measuring success

The following symbols are also used throughout the document to represent levels of achievement against different indicators.

Table 1 The symbols used to represent levels of achievement

Symbol	Meaning
	**Sustained or Improved Performance** The Trust continues to perform well in this area and/or has demonstrated measurable improvement.
	**Mixed Performance** The Trust is achieving well in some aspects, but further development is required in others.
	**Under Target with Active Improvement Plans in place** The Trust is not currently meeting its target in this area; however, improvement projects are in place to address the challenges.

These symbols provide a simple, consistent way to interpret performance data, helping stakeholders understand how the Trust is progressing against its priorities while reinforcing its commitment to continuous improvement.

2.3 Key Achievements from 2024-25

In 2024–25, the Trust made significant progress across its five strategic portfolios, delivering measurable improvements in leadership, culture, safety, financial sustainability, and operational performance. These achievements reflect the impact of focused improvement efforts and collaborative working across the organisation.

This section outlines the key outcomes delivered under each portfolio, demonstrating how the Trust is translating strategic intent into meaningful improvements, enhancing care, strengthening systems, and laying the groundwork for long-term transformation.

2.3.1 Well Led

The Well Led portfolio focused on strengthening governance, leadership, and strategic planning across the Trust. Key achievements include:

- **Enhanced Governance and Monitoring**: The governance structure for monitoring SIP delivery was strengthened, ensuring clear communication and alignment with corporate objectives. This included regular reviews and updates to governance processes to ensure they remain effective and responsive to the Trust's needs.
- **Leadership Development**: Significant progress was made in leadership development, with the implementation of a Board development programme and senior leadership training. This included tailored training sessions, workshops, and mentoring aimed at enhancing leadership skills across all levels of the organisation.
- **Accountability Framework**: The Executive team worked with the wider senior leadership team to update the Accountability Framework in line the new draft NHS England Accountability and Assessment Framework, The Framework was approved at Board in October 2024 and implemented from December 2024, providing a clear structure for accountability and performance management.

2.3.2 People & Culture

The People & Culture programme aimed to create a positive organisational culture and improve colleague engagement. Key achievements include:

- **Team Engagement and Development Tool (TED):** The TED tool was embedded across the Trust, supporting improvements in team satisfaction and engagement. This tool facilitated regular feedback and development discussions, helping teams to identify and address areas for improvement.
- **Leadership Behaviours and Training**: Continued delivery of leadership training and appraisal rate improvements, along with the development of a cultural assessment tool and a culture dashboard. These initiatives aimed to foster a positive organisational culture and improve colleague engagement.

- **Agency spend:** Medical and Nurse agency spend has been managed below the cap percentage, demonstrating a commitment to improving financial management and resource allocation.

2.3.3 Safety & Quality

The Safety & Quality programme focused on enhancing patient safety and clinical effectiveness. Key achievements include:

- **Maternity and Neonatal Improvement and The Patient Safety Incident Response Framework (PSIRF)**: Significant progress was made in the Maternity and Neonatal Improvement programme, including the implementation of the PSIRF. This framework provided a structured approach to managing and learning from patient safety incidents.
- **Clinical Effectiveness**: The Clinical Effectiveness Programme drove improvements in medical staffing, outpatient transformation, and the development of a clinical strategy. These efforts aimed to enhance clinical outcomes and patient care.
- **Clostridioides difficile (C.difficile):** The National cleaning standards frequency of cleaning is now visible and monitored through the safety and quality dashboard and the business case for implementation of the national cleaning standards was approved in March 2025, demonstrating a commitment to high standards of cleanliness and infection prevention and control.
- **Health inequalities**: The Board of Directors approved in February 2025 the Trusts first Health Improvement plan designed to reduce health inequalities. The plan has been developed through an extensive consultation exercise to ensure appropriate engagement with key internal and external stakeholders including: Patient experience groups and forums, Colleagues within the organisation and Trust Board, Voluntary, community, faith and social enterprise partner organisations, Primary Care health inequality clinical leads, Integrated Care Board population health colleagues, Public health consultant colleagues from our provider collaborative network, Director of Public Health, Wellbeing and Communities at Lancashire County Council.

  The plan reflects the shared ambition of our partners who are equally crucial to its success. The Director of Public Health, Wellbeing and Communities at Lancashire County Council has been influential in steering our approach to this work and has shared generously his expertise and knowledge, ensuring what is produced aligns to the priorities of both the Integrated Care Partnership, Integrated Care Board and Lancashire County Council.

  The plan sets out the foundations for building health inequalities reduction into core business and progress will be reported to the safety and Quality committee on a twice annual basis.

The Table below gives a summary of Key Performance Indicators aligned to the Safety and Quality Programme of work overseen by the Trust Safety and Quality Committee.

Table 2 Summary of Key Performance Indicator comparable data

Supporting Standards	2023-24	2024-25	Current Period	Comparison
Staffing Fill Rate Registered Nurse	98.4	100.9	% - Cumulative to end Mar 2025	Improved

Staffing Fill Rate Health Care Assistant	101.0	102.2	% - Cumulative to end Mar 2025	Improved
Staffing Fill Rate Registered Midwife	92.4	94.7	% - Cumulative to end Mar 2025	Improved
Staffing Fill Rate Maternity Support Worker	91.9	90.0	% - Cumulative to end Mar 2025	Maintained
Complaints per 1000 bed days	1.3	1.2	Rate - Cumulative to end Mar 2025	Improved
STAR Accreditation all trust (Silver and Above)	92	83	% - Cumulative to end Mar 2025	Deteriorated
Pressure Ulcers per 1000 bed days (Category 2 and above)	2.9	2.6	Rate - Cumulative to end Mar 2025	Improved
MRSA	1	0	Cumulative to end Mar 2025	Improved
C.difficile Infections	203	192	Cumulative to end Mar 2025	Improved
Maintain compliance with 10 Clinical Negligence Scheme for Trusts Safety actions	100	100	% - Cumulative to end Mar 2025	Maintained
Perinatal - Number of Stillbirths	11.0	11.0	Cumulative to end Mar 2025	Maintained
Hospital Standardised Mortality Ratio (56 Basket – Adult)	76.2	75.9	Dec 23- Nov 24 compared to Dec 22 - Nov 23	Within the expected range
Standardised Mortality Rate (All Diagnoses – Adult)	77.4	74.6	Dec 23- Nov 24 compared to Dec 22 - Nov 23	Within the expected range
Standardised Mortality Rate (Child <1 day -17 Years) (All Diagnoses)	59.2	89.9	Dec 23- Nov 24 compared to Dec 22 - Nov 23	Within the expected range
Standardised Mortality Rate (Neonatal <1 day -28 days) (All Diagnoses)	70.3	93.5	Dec 23- Nov 24 compared to Dec 22 - Nov 23	Within the expected range
Compliance with 60 minute ambulance turnaround time target - actual	2025.0	3206.0	Cumulative to end Mar 2025	Deteriorated
Maximum wait of 12 hours as Total Time in Department	9.6	10.2	% - Cumulative to end Mar 2025	Deteriorated
Bed occupancy to 92%	97.3	94.8	% - Cumulative to end Mar 2025	Improved
Reduce not meeting criteria to reside to 5%	9.0	11.6	% - Cumulative to end Mar 2025	Deteriorated

Additional Key Performance Indicators related to Operational Performance including the Accident and Emergency 4 hour Standard, Cancer Waiting Times and Referral to Treatment Times can be found in Section 2.14.5

2.3.4 Financial Sustainability

The Financial Sustainability programme aimed to achieve financial recovery and stability. Key achievements include:

- **Financial Recovery Programme (FRP):** A comprehensive FRP was implemented, identifying and developing delivery teams to achieve significant savings. This included detailed financial planning and monitoring to ensure the Trust remained on track to meet its financial targets.
- **Compliance with Grip and Control Checklists**: Initial actions have been implemented and are reported regularly to the Integrated Care Board (ICB) through the Investigation and Intervention Oversight Program and the Trusts Finance and Performance Committee. This ensured ongoing compliance with financial regulations and standards.
- **Deficit position**: The Trusts revenue deficit at the end of year was within the forecast agreed with the regional Improvement and Assurance Group (IAG).

Following a recommendation from the North West NHS England (NHSE) regional team, it was agreed that the Trust would be placed into NHS Oversight Framework (NOF) segment 4 from February 2025, enabling access to the National Recovery Support Programme (RSP).

Additionally, the North West Regional Support Group determined that the Trust's current Undertakings should be revised in the form of a Variation to Enforcement Undertakings to reflect the Trust's current financial position and to emphasise the actions required to improve this position. NHS England also issued a Notice of Intent to impose an Additional Licence Condition under Section 111 of the Health and Social Care Act 2012, introducing further governance arrangements. Existing Quality Undertakings remain unchanged.

2.3.5 Operational Performance

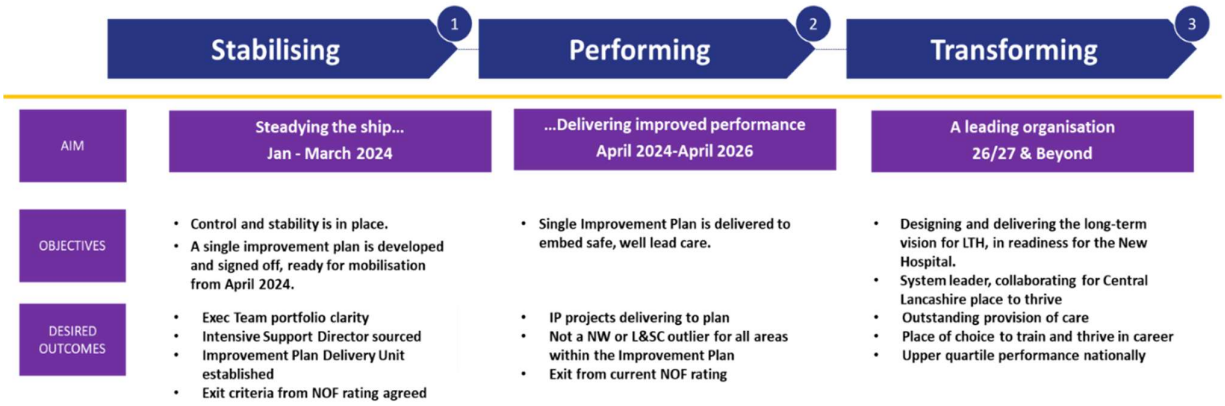
The Operational Performance programme focused on improving service delivery and patient outcomes. Key achievements include:

- **Long waiters**: The Trust has seen a reduction in the number of patients waiting over 52 weeks for treatment. Starting the year with 2,948 patients waiting over 52 weeks, this number has been significantly reduced by approximately 50% at the end of March 2025. This improvement was achieved through targeted initiatives to streamline patient pathways and reduce waiting times.
- **Cancer Waiting Times**: The Trust has seen a reduction in the number of patients waiting over 62 days for cancer treatment, the Faster Diagnosis Standard (FDS) is now achieving trajectory, reflecting improvements in patient pathways and more timely interventions.
- **Ambulance Handover times**: Whilst performance against standards remains challenged, significant improvements have been noted in March with a >10% improvement in patients handed over within 60 minutes. This was achieved through process improvements and better coordination with ambulance services.

2.3.6 Forward plan for 2025-26

The achievements of the SIP in 2024-25 reflect our commitment and focus on key performance metrics, financial sustainability, and operational efficiency. These lay a solid foundation from which to continue our improvement journey, transforming and sustaining improvement as illustrated below.

Figure 3 Forward Plan 2025-26/ building on the achievements



We look forward to building on these achievements in the coming year as we develop our new 10-year strategy (2025-35).

2.4 Continuous Improvement

The main focus for the Continuous Improvement team in 2024-25 has been to support the delivery of the SIP and in the latter part of the year this has included supporting the delivery of the Trust's FRP. As part of this work the team has worked with colleagues to design and test a new systematic approach to improvement, taking the learning from Leeds Teaching Hospitals. The Continuous Improvement team, in collaboration with divisions and corporate teams, has developed the 'Lancashire Improvement Method,' a holistic approach to organisational change set to launch fully in April 2025. Key highlights include the delivery of Rapid Improvement Workshops to identify and deliver savings opportunities.

This summary highlights several achievements from across the year, including the Always Safety First (ASF) programme's adoption of the PSIRF and the continued focus to build improvement capacity and capability, training a further 272 members of staff in Continuous Improvement methods (in alignment with the Trust Capacity & Capability dosing formula for Continuous Improvement).

The Microsystem Coaching Academy has delivered improvements in clinic utilisation, referral processes, and risk assessment compliance, with notable reductions in missed critical medications and pressure ulcers from participating teams. This programme was short-listed for the Health Service Journal (HSJ) Patient Safety Congress for the category of 'Education and Training' along with a participating team in the year's cohort winning the 'Effective use of Quality Improvement Methods' poster abstract submission.

The Trust has participated in a number of national improvement programmes including the HandsFirst2 improvement collaborative, the Acute Thrombolysis in Stroke Care (TASC) collaborative

which led to improvements in thrombolysis rates and the NHS England Race & Health Observatory (RHO) Collaborative which led to a reduction in post-partum haemorrhage rates among black and ethnic minority women and birthing people.

The Continuous Improvement team has also had abstracts accepted for presentation at the Institute for Healthcare Improvement (IHI) & British Medical Journal's (BMJ) Annual Quality Forum 2025, showcasing their work on the RHO project and the Theory of Constraints digital system to improve patient flow.

In response to financial pressures and the urgent need to reduce variable pay spend, the Continuous Improvement team developed and implemented Rapid Process Improvement Weeks across divisions. These workshops brought together colleagues to facilitate rapid problem-solving, idea generation and plans to deliver improvements against the quadruple aim, improving care whilst delivering improved value for money. A direct output was the development of the Daily Management System (DMS), a vital tool designed to reduce variable pay without compromising safety. The DMS integrates real-time data from Health Roster and budget systems, empowering budget holders and leadership teams to make informed daily decisions. It highlights critical staffing issues, tracks variable pay expenditure and offers forecasting opportunities to predict future needs. This system ensures staffing levels meet minimum safety requirements and helps avoid unnecessary additional pay, contributing to a sustainable and affordable model of care.

2.5 Always Safety First (ASF)

The Trust's commitment to patient safety continues to be driven by its three-year improvement strategy, ASF, our organisational response to the national Patient Safety Strategy. Since its launch on World Patient Safety Day in September 2022, ASF has become a cornerstone of our safety culture, embedding learning, visibility, and continuous improvement across all levels of the organisation.

In 2024–25, the Trust made significant progress in delivering the ASF strategy.

- A major milestone was the implementation of the PSIRF. This included a comprehensive training plan, identification of local priorities, and strengthened oversight of learning. Importantly, health inequalities were embedded into the terms of reference for patient safety incident investigations, ensuring a more inclusive and equitable approach to safety.
- To support the delivery of the ASF strategy, the Trust made a significant investment in developing improvement capability across the workforce. Safety training remained a key priority, with Level 1 training for Board members and senior leaders maintained, and the introduction of Level 2 training showing steady uptake across the organisation. In addition,
    - over 1,000 colleagues completed the ASF e-learning module,
    - 615 staff undertook Continuous Improvement Basics,
    - 94 colleagues were trained through the Flow Coaching Academy,
    - 132 participants completed the Micro-Coaching Academy,

  with evaluation demonstrating positive safety outcomes and reinforcing the value of this training.
- To further strengthen safety culture and leadership visibility, Leadership Patient Safety Visits were introduced. These monthly visits, based on Safety I (learning from what goes wrong) and Safety II (learning from what goes well) principles, are conducted by senior nursing, midwifery, allied

health profession (AHP), and clinical governance leadership teams. The themes of the visits are informed by insight and intelligence from the ASF programme, and learning is triangulated from both areas requiring improvement and those demonstrating good practice.

- The Trust also began developing its approach to Safety II, with a dedicated working group led by Continuous Improvement clinical fellows. This work aims to complement traditional safety approaches by learning from what goes well in everyday practice.
- Patient involvement in safety governance was further enhanced through the recruitment of three Patient Safety Partners (PSPs), who commenced in post in November 2023. Their early contributions have been positive, and their role will be formally evaluated in terms of outcome measures. Recruitment of additional patient safety volunteers is also underway to support this work.
- The Trust also introduced Martha's Rule (Call for Concern), empowering patients and families to escalate concerns about care.
- The Trust also launched its Learning Disability Plan, supported by the rollout of mandatory Oliver McGowan Level 1 training for all staff, further strengthening inclusive and person-centred care.
- In maternity and neonatal services, a Maternity Neonatal Voices Partnership Lead was appointed in 2023 to ensure that the voices of women and families are heard and embedded in service design and delivery. The Trust also successfully delivered all ten Year 5 Clinical Negligence Scheme for Trusts (CNST) safety actions, demonstrating continued compliance with national safety standards.
- In 2024, the Trust welcomed a site visit from its Magnet twin partner, Hackensack University Medical Centre in the United States. The learning from this visit has influenced a range of projects, including the development of the trust's Proud Rewards and the concept of Shared Decision-Making Councils, which are currently being developed.
- The ASF programme also supported themed analysis to identify improvement priorities for Year 3. These include deteriorating patients, reducing violence and aggression, Emergency Department (ED) exit block and patient flow, rapid tranquilisation, mental health safety, C. difficile infection reduction, and pressure ulcer reduction.
- To support real-time safety monitoring, the ED safety surveillance system was completed, rolled out, and embedded. Safety surveillance systems are now in place across all adult inpatient acute and general wards, enabling the identification of organisational safety risks as they emerge. The Trust also launched a Deteriorating Patient Dashboard, enabling the Critical Care Outreach Team to proactively review patients at risk of deterioration.
- Additionally, a Critical Care Delivery Group was established to improve outcomes for patients in critical and enhanced care environments, with a focus on achieving compliance with perioperative care standards.
- The impact of these efforts is evident in medicines safety, where the Trust recorded a low rate of harm, just 4% of incidents involving medicines, compared to the national benchmark of 12% reported in the Model Hospital. Medicines safety metrics have also been incorporated into the SIP to ensure continued oversight.
- Venous thromboembolism (VTE) risk assessment compliance improved and was sustained above 90% throughout the year. A recent dip in performance was attributed to the inclusion of community healthcare hub data, which is being addressed.
- Focused work on falls and pressure ulcers has led to a reduction in incidents over the course of the strategy, although further progress is needed to meet target reductions.
- The National Staff Survey showed an improvement in safety scores, reflecting the positive impact of the Trust's safety culture initiatives.

Despite these achievements, the Trust recognises that further progress is needed in a number of areas. While reductions in pressure ulcers and falls were observed, the targets set were not fully met. Similarly, the C.difficile infection rate remains above the desired level. All three areas have been subject to improvement plans and will continue to be a focus in 2025–26.

2.6 Risk Management

In parallel with the Trust's focus on safety culture through the ASF strategy, robust risk management remains a cornerstone of our governance framework. Throughout 2024-25, the Trust has continued to strengthen its approach to identifying, assessing, and mitigating risks at all levels of the organisation. This section outlines the progress made in enhancing risk maturity, embedding a consistent approach to risk management, and aligning our risk appetite with strategic objectives.

2.6.1 Risk Management and Risk Maturity

The Trust's risk management arrangements are underpinned by a clear governance structure and a commitment to transparency and accountability. The Board Assurance Framework (BAF) and Risk Register have been regularly scrutinised through internal and external reviews and are embedded within the Trust's governance processes.

Policies, procedures, and supporting documentation are readily accessible to all staff via the intranet, ensuring consistency in approach. The Trust's organisational management structure and Risk Management Policy reflect a strong commitment to quality governance. Risk management is supported by a central risk management team and a centralised health and safety team, working alongside divisional governance and risk teams, each led by a Lead Clinical Governance and Risk Manager.

2.6.2 Risk Management Strategy

As part of its commitment to continuous improvement and excellence in governance, the Trust introduced its Risk Management Strategy 2024–27 in February 2024. This strategy provides a structured and forward-looking framework to enhance risk management capability across the organisation. In its first year, the Trust has made strong progress in embedding the strategy, with several key developments:

- Implementation of the Risk Management Group, which commenced in March 2024. The Group supported enriched discussion regarding risk management, risk themes and trends and has become the conduit for wider discussion regarding risk escalation and collaborative response.
- Risk Management training rolled out in the form of workshops. Positive feedback received from those attending the sessions.
- Risk Management reports to Risk Management Group, Committees of the Board and Board have been re-designed. Improved reporting has allowed for clearer, more focused discussion on risk at the relevant meetings, enabling oversight of risk progress more easily and improved understanding of the Trust Risk Profile against Strategy.
- Reduction in long standing risks (risks active for 5 years or more) has been reduced by 49, which exceeded the strategy target of 15% (circa 13).

- Reduction of operational high scoring risks by 21 high risks, which exceeded the Year 1 goal by 6.
- Completion of an Annual Risk Maturity Assessment across all Divisions in the Trust. The Assessment saw improvements in the measured characteristics across the Trust, although there was variation across individual Divisions and Corporate Departments. Action plans to improve maturity are in progress.

2.6.3 Risk Management Policy & Board Assurance Framework (BAF)

Each division has governance arrangements in place including a systematic process for assessing and identifying risk in line with the policy. Risk assessments are undertaken, and this information is utilised to populate the relevant divisional risk register via our online system. Risks are continually re-assessed and upon implementation of mitigating actions, where it is considered that the mitigation provides a tolerable level of risk in line with the Trust's risk appetite, the risk can be considered controlled. The responsibility for the management and control of a particular risk rests with the division / department concerned.

The Risk Management Group oversees Risk Management arrangements within the Trust, and this is chaired by the Chief Executive. The group has a cycle of business, and this includes consideration of Divisional / Departmental reports on a cyclical basis to allow oversight, monitoring and escalation of risk areas. The Risk Management Group is able to escalate operational risks of concern to the appropriate Committee of the Board for further consideration when required and the Committee in turn is able to choose to escalate an operational risk of concern to the Board of Directors for oversight.

The Trust has in place a BAF, which is designed to provide a structure and process to enable the Trust to identify those strategic and operational risks that may compromise the achievement of the Trust's high level strategic objectives. In December 2024, the BAF was revised. Previously, the BAF was made up from a Strategic Risk Register, which included risks that may threaten the delivery of the strategic objectives over the life of the strategy, and the Operational Risk Register, which included risks that sit on the divisional and corporate risk registers and may affect and relate to the day-to-day running of the organisation or the internal functioning and delivery and are managed at the appropriate level within the organisation.

In December 2024, the Board agreed to a revised BAF which signalled a change to a Principal Risk approach. Principal Risks are risks to the delivery of the Trust's corporate objectives, which are considered most likely to materialise, and those which are likely to have the greatest adverse impact on delivery. Corporate objectives are set annually by the Board of Directors and any risks to delivery have the potential to affect the ability to deliver the overall strategic objectives of the Trust. In the same way as the previous BAF, it is still possible to escalate operational risks of concern to the Board if required. Principal risks and any operational high risks of concern form the revised BAF.

Responsibility for reviewing and updating the strategic and principal risks and providing assurance to the Board on the controls and mitigations in place is retained by the relevant Executive Director. The BAF is also presented in full to the Audit Committee at each meeting once approved by the Board.

All operational risks are categorised in line with the Trust strategic objectives that they predominantly impact upon. Any higher scoring operational 15+ risks are also presented to Committees of the Board

to which the strategic objectives are aligned.

At the end of 2024-25, the risk profile of the Trust shows improvement with 489 overall risks in March 2024 compared to 418 in March 2025 and 85 high risks in March 2024 compared to 72 in March 2025. High risk themes continue to be reflective of the following:

- Financial challenges.
- Physical environment/estate being suboptimal.
- Increasing demand.
- Use of escalation areas.
- Suboptimal capacity to meet targets/manage backlogs.
- Staffing challenges.

There is a continued focus on risk maturity, and this is being achieved through the continued embedding of risk management within the Trust.

2.6.4 Risk Appetite

The Trust's Risk Appetite Statement and tolerance levels were reviewed and discussed at a workshop with the Board of Directors in May 2024, and approved at the Board of Directors in June 2024, with no changes from the previous year.

In December 2024, the Board of Directors approved a revised BAF, which was linked to Strategic and Corporate Objectives. As a result, the Risk Appetite and tolerances were reviewed, and an updated Risk Appetite Statement was approved by the Board of Directors in December 2024.

The Risk Appetite Statement outlines the level of risk that the Trust is prepared to accept, after balancing the potential opportunities and threats a situation presents. The risk tolerance levels outline 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.

The Trusts strategic objectives described below are in line with the Trusts 'Our Big Plan' and in 2025-26 they will reflect the Trusts' Transition to the SIP.

Table 3 The Risk Appetite Statement set by the Board up until 5th December 2024 was:

Providing safe and effective care for patients is paramount and so we have a low tolerance of risks which would adversely affect the quality and safety of clinical care. However, to **Consistently Provide Excellent Care**, we recognise that, in pursuit of this overriding objective, we may need to take other types of risk which impact on different organisational aims. Overall, our risk appetite in relation to consistently providing excellent care is cautious – we prefer safe delivery options with a low degree of residual risk, and we work to regulatory standards. We have an open appetite for those risks which we need to take in pursuit of our commitment to create a **Great Place to Work.** By being open to risk, we mean that we are willing to consider all potential delivery options which provide an acceptable level of reward to our organisation, its staff

and those who it serves. We tolerate some risk in relation to this aim when making changes intended to benefit patients and services. However, in
recognising the need for a strong and committed workforce this tolerance does not extend to risks which compromise the safety of staff members or undermine our trust values.

We also have an open appetite for risk in relation to our strategic ambition to **Deliver Value for Money** and our strategic aim to **offer a range of high-quality specialist services to patients in Lancashire and South Cumbria,** maintaining and strengthening our position as the leading tertiary care provider in the local system, where we can demonstrate quality improvements and economic benefits. However, we will not compromise patient safety whilst innovating in service delivery. We are also committed to work within our statutory financial duties, regulatory undertakings, and our own financial procedures which exist to ensure probity and economy in the trust's use of public funds.

We seek to be **Fit for the Future** through our commitment to working with partner organisations in the local health and social care system to make current services sustainable and develop new ones. We also seek to lead in **driving health innovation through world class Education, Training & Research** by employing innovative approaches in the way we provide services. In pursuit of these aims, we will, where necessary, seek risk - meaning that we are eager to be innovative and seek options offering higher rewards and benefits, recognising the inherent business risks.

Table 4 The revised Risk Appetite Statement adopted by the Board from the 5th December 2024 is:

Providing safe and effective care for patients is paramount and so we have a low tolerance of risks which would adversely affect the quality and safety of clinical care. However, to **deliver excellent care for Patients,** our **Performance** needs to support the delivery of **timely, effective care** and we recognise that, in pursuit of these overriding objectives, we may need to take other types of risk which impact on different organisational objectives. Overall, our risk appetite in relation to **Patients** and **Performance** is cautious – we prefer safe delivery options with a low degree of residual risk, and we work to regulatory standards.

We have an open appetite for those risks which we need to take in pursuit of our commitment to being **a Great Place to Work for our People.** By being open to risk, we mean that we are willing to consider all potential delivery options which provide an acceptable level of reward to our organisation, its staff and those who it serves. We tolerate some risk in relation to this aim when making changes intended to benefit patients and services. However, in recognising the need for a strong and committed workforce with the right skills and knowledge, this tolerance does not extend to risks which compromise the safety of our **People** or undermine our Trust values.

We also have an open appetite for risk in relation to our strategic objective in relation to **Productivity, to Deliver Value for Money**. However, we are also committed to work within our statutory financial duties, regulatory undertakings, and our own financial procedures which exist to ensure probity and economy in the Trust's use of public funds.

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

2.6.5 Risk Tolerance

In addition, the Trust's risk tolerance levels were also updated to outline 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.

Table 5 The Risk Tolerance levels as agreed by the Trust Board and in place until 5th December 2024:

Strategic Risks		Risk Tolerance	Rationale
Risks to delivery of Strategic Aim of providing outstanding and sustainable healthcare to our local communities	Risk to delivery of Strategic Ambition: Consistently Deliver Excellent Care	1-6	We are not willing to tolerate moderate (or worse) harm, however there will always remain a small possibility of adverse outcomes despite the full range of safety measures being put in place.
	Risk to delivery of Strategic Ambition: A Great Place to Work	4-8	Whilst recognising that the need to meet unprecedented demand for services and to make significant changes will impact on our workforce, the safety and wellbeing of staff is a priority, and we are guided by our shared values.
	Risk to delivery of Strategic Ambition: Deliver Value for Money	8-12	Acute Trusts face considerable financial and operational changes which are heavily influenced by external factors outside of our direct control. Transformational changes needed to meet this challenge inevitably carry a degree of risk.
	Risk to delivery of Strategic Ambition: Fit for the Future	8-12	To transform our services, develop our infrastructure and mature system leadership arrangements we will need to consider all possible solutions to drive innovation and therefore tolerate some degree of risk.
Risk to delivery of Strategic Aim to drive health innovation through world class		9-12	We recognise that investments in education, training and research can take time to generate the expected benefits for

Education, Training & Research		the Trust, and that new ways of working have a higher inherent risk than established methods.
Risk to delivery of Strategic Aim to offer a range of high-quality specialist services to patients in Lancashire and South Cumbria	6-9	We are willing to take risks where there are clear opportunities to streamline and modernise services whilst maintaining and strengthening our position as the leading tertiary care provider in the local system.

Table 6 The updated Risk Tolerance levels as agreed by the Trust Board and in place from 5th December 2024

Strategic Objectives (the 5 Ps)	**Risk Tolerance**	**Rationale**
Patients Deliver excellent care	1-6	We are not willing to tolerate moderate (or worse) harm, however there will always remain a small possibility of adverse outcomes despite the fullest range of safety measures being put in place.
Performance Deliver timely, effective care		
People To be a great place to work	4-8	Whilst recognising that the need to meet unprecedented demand for services and to make significant changes will impact on our workforce, the safety and wellbeing of staff is a priority, and we are guided by our shared values.
Productivity Deliver value for money	8-12	Acute trusts face considerable financial and operational changes which are heavily influenced by external factors outside of our direct control. Transformational changes needed to meet this challenge inevitably carry a degree of risk.
Partnership To be fit for the future	8-12	To transform our services, develop our infrastructure and mature system leadership arrangements we will need to consider all possible solutions to drive innovation and therefore tolerate some degree of risk.

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2.6.6 Our principal risks and issues

The Trust continues to identify potential risks to achieving its strategic aims and ambitions as part of established organisational governance processes. The BAF is used to identify the principal risks to the Trust alongside actions being taken to mitigate them. This enables the Board of Directors to evaluate whether there are the appropriate controls in place to operate in a manner that is effective in driving the delivery of the Trust's strategic objectives.

In this financial year, a review of the BAF was undertaken following a request from the Chair and Chief Executive.

The Trust previously used a strategic risk approach, which had been in place since 2020 and aligned risks to the long-term strategic aims and ambitions of the organisation. Whilst this approach had served the Trust well, the broad nature of these risks had made it challenging to measure or demonstrate tangible progress in some areas. Feedback from the wider Board supported the request from the Chair and Chief Executive to review the approach.

The review compared the Trust's approach to guidance available from NHS Providers, the BAFs at other NHS organisations, and the Government's Orange Book guidance on the concept of risk management. The review also included a survey of the Board of Directors and considered additional feedback gathered during Committee meetings of the Board, Board of Directors' meetings, and separately through discussions with Executive and Non-Executive Directors.

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

Following the Board training day, a revised BAF was developed and discussed at a Board Workshop in November 2024 and subsequently adopted by the Board of Directors in December 2024.

Between 1st April 2024 to 5th December 2024, there were six strategic risks as shown in Table 7:

Table 7 Strategic risk summary

Risk		Risk ID	Risk Summary
Risk to delivery of Strategic Aim to drive health innovation through world class Education, Training & Research.		860	There is a risk that we are unable to deliver world class education, training and research due to challenges in effectively implementing high quality, appropriately funded and well-marketed education, training and research opportunities due to a range of internal and external constraints. This impacts on our ability to develop our reputation as a provider of choice sustaining our position in the market, supporting business growth and retaining our status as a teaching hospital.
Risk to delivery of the Trust's Strategic Aim of Providing a Range of the Highest Standard of Specialised Service		859	There is a risk to the Trust's ability to continue delivering its strategic aim of providing high quality specialist services due to integration and reconfiguration of specialist services across the ICS. This may impact on our reputation as a specialist services provider and commissioning decisions leading to a loss of services from the Trust portfolio and further unintended consequences affecting staff and patients
Risks to delivery of Strategic Aim of providing outstanding and sustainable healthcare to our local communities	Risk to delivery of Strategic Ambitions.. Consistently Delivering Excellent Care	855	There is a risk that we are unable to deliver the Trust's strategic aim of offering excellent health care and treatment to our local communities, as well as the strategic objective of consistently delivering excellent care due to: a) Availability of staff b) High Occupancy levels c) Fluctuating ability to consistently meet the constitutional and specialty standards and d) Availability of some services across the system e) Existing health inequalities across the system This may, result in adverse patient outcomes and experiences.
	Risk to delivery of Strategic Ambitions.. Great Place to Work	856	There is a risk to the delivery of the Trust's Strategic ambition to be a great place to work due to the inability to offer a good working environment; inability to treat staff fairly and equitably; poor leadership; inability to support staff development. This could lead to staff losing confidence in the Trust as an employer and result in poor staff satisfaction levels, impacting on the organisations reputation and culture subsequently affecting the ability to attract and retain staff, causing key workforce shortages, increasing the use of temporary staffing and poor patient care.
	Risk to delivery of Strategic Ambitions.. Deliver Value for Money	857	There is a risk that we are unable to deliver the Trust's strategic objective 'deliver value for money' due to the inability of the Trust to transform given the range of internal and external constraints (relating to complex models of care, workforce transformation, planning processes, capital resources and dealing with high levels of backlog maintenance) which could result in a failure to move toward segment 2 of SOF and less than a 'good' rating from the use of resources of inspection.
	Risk to delivery of Strategic Ambitions.. Fit For the Future	858	There is a risk to the delivery of the Trust's Strategic Objective to be fit for the future due to the challenges of effectively implementing and developing Place and System (i.e. Integrated Care System and Provider Collaborative) level working we fail to deliver integrated, pathways and services which may result in Lancashire Teaching Hospitals no longer being fit for purpose and our healthcare system becoming unsustainable.

In June 2024, the Board of Directors agreed to control the Strategic Risk to delivery of the Trust's Strategic Aim of Providing a Range of the Highest Standard of Specialised Service as the score had remained at 8 for a sustained period of time and this was in line with the Trust's agreed Risk tolerance level.

The BAF was revised in December 2024 and the Board of Directors agreed to control the previous Strategic Risks. During the review, 16 new Principal Risks were identified, which were considered risks to the delivery of the Trust's Corporate Objectives.

Table 8 Principal Risks identified following the BAF review

Ref	Principal Risk	Exec Lead	5Ps	Reporting Committee	Risk Appetite	Risk Tolerance	Score at 31.03.25
PR1 (24/25)	Patient experience within the urgent and emergency care pathway	CNO	Patients	SQC	Cautious	1-6	15
PR2 (24/25)	Higher than trajectory rates of clostridioides difficile (C.*difficile*) Infection	CNO	Patients	SQC	Cautious	1-6	20
PR3 (24/25)	People experiencing Health inequalities	CNO	Patients	SQC	Cautious	1-6	12
PR4 (24/25)	Timely access to planned and cancer care	COO	Performance	FPC	Cautious	1-6	16
PR5 (24/25)	Timely access to urgent and emergency care	COO	Performance	FPC	Cautious	1-6	20
PR6 (24/25)	Reliance on temporary medical workforce	CMO	People	WFC	Open	4-8	16
PR7 (24/25)	Experience of under-represented staff groups	CPO	People	WFC	Open	4-8	12
PR8 (24/25)	Sub-optimal experience of Resident Doctors	CPO	People	ETR	Open	4-8	12
PR9 (24/25)	Failure to effectively manage staff absence and achieve Trust and National target rates	CPO	People	WFC	Open	4-8	12
PR10 (24/25)	Compliance with Core Skills Training & Appraisals	CPO	People	ETR	Open	4-8	12
PR11 (24/25)	Failure to meet the financial plan 2024-25	CFO	Productivity	FPC	Open	8-12	20
PR12 (24/25)	Cash consequences of the Trust's underlying financial position	CFO	Productivity	FPC	Open	8-12	12
PR13 (24/25)	Ability to access required Capital	CFO	Productivity	FPC	Open	8-12	16
PR14 (24/25)	Readiness for the New Hospital Programme	CFO	Partnership	NHP	Seek	8-12	4

Ref	Principal Risk	Exec Lead	5Ps	Reporting Committee	Risk Appetite	Risk Tolerance	Score at 31.03.25
PR15 (24/25)	Research capacity and capability to enable progress towards University Hospital status	DIRI & CMO	Partnership	ETR	Seek	8-12	12
PR16 (24/25)	Implementing the long term strategy for the Trust	DIRI & CMO	Partnership	FPC	Seek	8-12	12

All risks that make up the BAF are subject to review by the respective lead Executive Director and are aligned to the Corporate Objectives and the underpinning enabling strategies to ensure correlation between the risks and Strategic Objectives. These are robustly monitored by the Board and Committees of the Board to ensure that the Board is informed about the Principal Risks faced by the Trust.

Principal Risk 14 was controlled at the Board of Directors meeting in February 2025 as following the government announcement of the delay in the New Hospitals Programme (NHP) for Royal Preston Hospital, on 20th January 2025, the NHP Assurance Committee met as planned on 21st January 2025 and discussed Principal Risk 14 related to 'Readiness for the New Hospital Programme'. It was agreed that this risk had reduced and could be considered reasonably controlled. The delayed timescales meant there was limited risk to the delivery of the Corporate Objective 'to develop and deliver our plans for the New Hospital Programme'.

2.6.7 Operational High Risks escalated to Board:

During 2024-25, there were four operational high risks escalated to the Board within the BAF. These were:

- **Impact of exit block on patient safety** which had been escalated to the Board via the Safety and Quality Committee since December 2020 and demonstrated a risk with long lengths of stay in the ED and high ambulance handover times. To mitigate this risk a series of actions had been undertaken including implementing virtual wards, frailty, therapy pathway improvements and the continued use of Finney House Community Healthcare Hub. Monthly safety forums were also in place to identify further opportunities to improve flow and reduce long waits in the ED. As part of the transition to the new BAF, it was agreed that this operational high risk of concern would be de-escalated on the basis that the Board will retain oversight of this risk through:
    - Principal Risk 1 – Patient experience within the urgent and emergency care pathway.
    - Principal Risk 5 - Timely access to urgent and emergency care.

- **Elective restoration following the Covid-19 pandemic** which had been escalated to the Board via the Safety and Quality Committee since June 2021. Whilst patients have continued to wait for a significant amount of time to receive non-urgent surgery, progress was made in this financial year. As part of the transition to the new BAF, it was agreed that the updated operational high risk of concern would be formally adopted as Principal Risk 4 - Timely access to planned and cancer care.

- **The impact of strikes on patient safety** following announcement of the national pay award and the probability of ongoing strikes which had been escalated to Board via the Safety and Quality Committee since October 2022. The Board agreed to de-escalate this risk from Board oversight in April 2024 as despite continued industrial action, the Trust plans proved robust in response.

- **Increased cases of C.difficile Infection** which had been escalated to Board via the Safety and Quality Committee since April 2024 as the Trust continued to see higher than planned rates of C.difficile infection. As part of the transition to the new BAF, it was agreed that the updated operational high risk of concern would be formally adopted as Principal Risk 2 - Higher than trajectory rates of C.difficile Infection.

As at the end of 2024-25, there are no operational high risks of concern escalated to the Board of Directors in the BAF.

During the year, the Internal Audit review of the Trust's assurance framework and supporting processes noted:

- The BAF is structured to meet NHS requirements.
- The governance and assurance structure was defined, and it aligns to the NHS England's well-led assurance framework.
- There was clear ownership of the AF by the Board and Audit Committee, which seemed to have robust processes to identify emerging risks and capture them within the AF.
- The organisation considers risk appetite regularly and the risk appetite is used to inform the management of the BAF.
- The BAF is visibly used by the organisation.
- The BAF clearly reflects the risks discussed by the Board.

2.7 Statements of Assurance from the Board

This section of the Quality Account is presented with the narrative which is mandated in the Quality Account regulations which refers to Lancashire Teaching Hospitals NHS Foundation Trust or the Trust.

During 2024-25 the Lancashire Teaching Hospitals NHS Foundation Trust provided and/or sub-contracted 46 relevant health services.

The Lancashire Teaching Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 46 relevant health services.

The income generated by the relevant health services reviewed in 2024-25 represents 100% of the total income generated from the provision of relevant health services by the Lancashire Teaching Hospitals NHS Foundation Trust for 2024-25.

2.8 Participation in Clinical Audits

During 2024-25, 62 national clinical audits including four national confidential enquiries covered relevant health services that Lancashire Teaching Hospitals NHS Foundation Trust provides.

During that period Lancashire Teaching Hospitals NHS Foundation Trust participated in 97% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in. The Trust did not participate in 2 national audits: National Diabetes Footcare Audit, due to pressures in the services and inability to find the relevant staff to support the audit, and in 1 National Ophthalmology Database (NOD) Audit due to system requirements.

The national clinical audits and national confidential enquiries in which Lancashire Teaching Hospitals NHS Foundation Trust was eligible to participate during 2024-25 are as follows (see table 9).

Table 9 National Audit and Confidential Enquiries – Eligible for Participation[1]

NATIONAL CLINICAL AUDITS AND CONFIDENTIAL ENQUIRIES			
	National Programme Name	**Audit Title**	**Trust Participation**
1	The British Association of Urological Surgeons (BAUS) Data & Audit Programme	BAUS Penile Fracture Audit	Yes
2	BAUS Data & Audit Programme	BAUS I-DUNC	Yes
3	BAUS Data & Audit Programme	Environmental Lessons Learned and applied to the bladder cancer care pathway audit (ELLA)	Yes
4	Breast and Cosmetic Implant Registry	As per the national audit name	Yes
5	Case Mix Programme (CMP)	Intensive Care National Audit a Research Centre (ICNARC)	Yes
6	Emergency Medicine Quality Improvement Programme (QIPs)	Mental Health Self Harm	Yes
7	Quality Improvement Programme (QIPs)	Care of Older People	Yes
8	QIPs	Time Critical Medications	Yes
9	Epilepsy 12 - National Audit of Seizures and Epilepsies for Children and Young People (CYP)	Epilepsy 12	Yes
10	Falls and Fragility Fracture Audit Programme (FFFAP)	National Audit of Inpatient Falls	Yes

NATIONAL CLINICAL AUDITS AND CONFIDENTIAL ENQUIRIES			
	National Programme Name	**Audit Title**	**Trust Participation**
11	FFFAP	National Hip Fracture Database	Yes
12	Learning Disability Mortality Review Programme (LeDeR)	As per the national audit name	Yes
13	Maternal, Newborn and Infant Clinical Outcome Review Programme	Mothers and Babies: Reducing Risks through Audits and Confidential Enquiries across the UK (MBRRACE UK) Saving Lives, Improving Mothers' Care Surveillance & Morbidity	Yes
14	Maternal, Newborn and Infant Clinical Outcome Review Programme	MBRRACE UK Perinatal Mortality & Surveillance	Yes
15	Maternal, Newborn and Infant Clinical Outcome Review Programme	National Perinatal Mortality Review Tool (PMRT)	Yes
16	Medical and Surgical Clinical Outcome Review Programme (NCEPOD)	Acute Limb Ischaemia	Yes
17	NCEPOD	Blood Sodium Study	Yes
18	NCEPOD	Managing acute illness people with learning disability	Yes
19	NCEPOD	Emergency (non-elective) procedures in children and young people	Yes
20	National Adult Diabetes Audit (NDA)	National Diabetes Core Audit	Yes
21	NDA	National Diabetes Foot Care Audit	No
22	NDA	National Diabetes Inpatient Safety Audit (NDISA)	Yes
23	NDA	National Pregnancy in Diabetes Audit (NPID)	Yes
24	National Audit of Cardiac Rehabilitation	As per the national audit name	Yes
25	National Audit of Care at the End of Life (NACEL)	As per the national audit name	Yes
26	National Cancer Audit Collaborating Centre (NATCAN)	National Audit of Metastatic Breast Cancer (NAoMe)	Yes
27	NATCAN	National Audit of Primary Breast Cancer (NAoPri)	Yes
28	NATCAN	National Bowel Cancer Audit (NBOCA)	Yes
29	NATCAN	National Kidney Cancer Audit (NKCA)	Yes
30	NATCAN	National Lung Cancer Audit (NLCA)	Yes

NATIONAL CLINICAL AUDITS AND CONFIDENTIAL ENQUIRIES			
	National Programme Name	**Audit Title**	**Trust Participation**
31	NATCAN	National Non-Hodgkin Lymphoma Audit (NNHLA)	Yes
32	NATCAN	National Oesophago-Gastric Cancer Audit (NOGCA)	Yes
33	NATCAN	National Ovarian Cancer Audit (NOCA)	Yes
34	NATCAN	National Pancreatic Cancer Audit (NPaCA)	Yes
35	NATCAN	National Prostate Cancer Audit (NPCA)	Yes
36	National Cardiac Arrest Audit (NCAA)	As per the national audit name	Yes
37	National Cardiac Audit Programme (NCAP)	National Heart Failure Audit (NHFA)	Yes
38	NCAP	National Audit of Cardiac Rhythm Management (CRM)	Yes
39	NCAP	Myocardial Ischaemia National Audit Project (MINAP)	Yes
40	National Child Mortality Database (NCMD)	As per the national audit name	Yes
41	National Comparative Audit of Blood Transfusion	National Comparative Audit of NICE Quality Standard QS138	Yes
42	National Emergency Laparotomy Audit (NELA)	As per the national audit name	Yes
43	National Joint Registry	As per the national audit name	Yes
44	National Major Trauma Registry	As per the national audit name	Yes
45	National Maternity and Perinatal Audit (NMPA)	As per the national audit name	Yes
46	National Neonatal Audit Programme (NNAP)	As per the national audit name	Yes
47	National Ophthalmology Database (NOD)	Cataract Audit	No
48	National Paediatric Diabetes Audit (NPDA)	As per the national audit name	Yes
49	National Respiratory Audit Programme (NRAP)	Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	Yes
50	NRAP	Adult Asthma Secondary Care	Yes

NATIONAL CLINICAL AUDITS AND CONFIDENTIAL ENQUIRIES			
	National Programme Name	**Audit Title**	**Trust Participation**
51	NRAP	Paediatric Asthma Secondary Care	Yes
52	National Vascular Registry (NVR)	As per the national audit name	Yes
53	Perioperative Quality Improvement Programme	As per the national audit name	Yes
54	Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS)	Oncology & Reconstruction	Yes
55	QOMS	Trauma	Yes
56	QOMS	Orthognathic Surgery	Yes
57	QOMS	Non-melanoma skin cancers	Yes
58	QOMS	Oral and Dentoalveolar Surgery	Yes
59	Sentinel Stroke National Audit Programme (SSNAP)	As per the national audit name	Yes
60	Serious Hazards of Transfusion (SHOT): UK National Hemovigilance Scheme	As per the national audit name	Yes
61	Society for Acute Medicine Benchmarking Audit (SAMBA)	As per the national audit name	Yes
62	UK Cystic Fibrosis Registry	As per the national audit name	Yes
63	UK Renal Registry Chronic Kidney Disease Audit	As per the national audit name	Yes
64	UK Renal Registry National Acute Kidney Injury Audit	As per the national audit name	Yes

[1] List of national clinical audits as per specification provided by the Department of Health (DH) cited on the HQIP (Healthcare Quality Improvement Partnership) website

https://www.hqip.org.uk/wp-content/uploads/2024/05/20240513_NHSE-QA-List-202425_FINALv2.pdf

There were 22 reports published for the national clinical audits in 2024-25. The reports were reviewed and, where identified, Lancashire Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided. Below are selected examples of actions taken by Lancashire Teaching Hospitals NHS Foundation Trust to improve the quality of healthcare delivery.

Table 10 National Audits and Confidential Enquiries – Intended Actions

Title of Audit	Actions
MBRRACE-UK: Perinatal Mortality Surveillance (2022) Births	• All 2022 cases of stillbirth and neonatal death were reviewed and underwent a PMRT review. • Themes and trends were identified to inform learning and improvement.
National Bowel Cancer Audit (NBOCA)	• Investigate why the Trust's Abdomino perineal excision of rectum (APER) /Hartmann's procedure rate exceeds the national average. • Consider prospective case reviews in MDT meetings. • Explore options to expand theatre capacity.
National Joint Registry (NJR)	• Improve the consent-taking process at Royal Preston Hospital. • Address quality issues in NJR form completion. • Continue annual audits of revision rates and outcomes.
National Ovarian Cancer Audit (NOCA)	• Collaborate with the Cancer Alliance to improve early recognition of ovarian cancer. • Implement a 'pause and check' process in MDT summaries. • Ensure data completeness is reviewed quarterly by MDT chairs.
National Pancreatic Cancer Audit (NPaCA)	• Include Pancreatic Enzyme Replacement Therapy (PERT) prescribing in treatment summaries. • Ensure real-time documentation of Tumor, Node, Metastasis (TNM) staging during MDT discussions.
National Perinatal Mortality Review Tool	• Train staff in using PMRT Parent Engagement materials. • Review submitted data and develop local actions as needed. • Ensure adequate administrative support for PMRT review teams.
National Vascular Registry	• Expand Hot Clinic services and evaluate vascular lab support at Royal Preston Hospital. • Explore additional angioplasty capacity at Blackpool Victoria Hospital. • Address referral delays from non-arterial centres through engagement events. • Weekly meetings now held by the newly appointed Urgent Pathways Coordinator. • Maintain 24/7 endovascular service, contributing to above-average Abdominal Aortic Aneurysm (AAA survival rates.
NPDA National Paediatric Diabetes Audit	• Conduct monthly data quality reviews. • Robust Insulin Dose Adjustments with emphasis on self-management and increase use of technology and pump • Use MDT meetings to tailor care for patients with high HbA1c.
Perioperative Quality Improvement Programme (PQIP)	• Review outcomes for patients with Surgical Outcome Risk Tool (SORT) scores of 1–5% to assess the impact of ward versus High Dependency Unit (HDU) admission.
SAMBA 2024 (Society for Acute Medicine Benchmarking Audit)	• Ensure ED medical patients are included in the 2025 audit sample. • Introduce a third morning consultant at Chorley Hospital to expedite patient reviews.
The National Hip Fracture Database (NHFD)	• Implement an updated ED fractured femur pathway. • Audit the Standard Operating Procedure (SOP) for transferring patients to orthopaedic theatres. • Continue telephone follow-ups and expand

Title of Audit	Actions
	bisphosphonate prescribing. • Sustain or improve 72-hour orthogeriatrician review rates.

All actions are monitored in the Trust's Audit Management and Tracking (AMaT) system.

2.8.1 Local Clinical Audits and Resulting Actions (2024–25)

In 2024–25, the provider reviewed the reports of 221 local clinical audits. Below are selected examples of actions taken by Lancashire Teaching Hospitals NHS Foundation Trust to improve the quality of healthcare delivery.

All actions are monitored through the Trust's Audit Management and Tracking (AMaT) system.

Table 11 Local Clinical Audits and Resulting Actions

Audit title	Actions completed
Discharge Summaries from the Surgical Ambulatory Care Unit (SACU) being sent to General Practitioners (GPs) within 24 hours (Upper Gastrointestinal Surgery)	• Prioritised time for writing discharge summaries to ensure they are sent to GPs within 24 hours. • One hour of protected time allocated daily (2–3pm) for an Advanced Care Practitioner (ACP); if incomplete, the twilight Foundation Year 1 doctor (FY1) continues the task. • Other ACPs to handle nursing queries, referrals, and clerking to avoid distractions.
Suitability of patients listed for Laser Peripheral Iridotomy (YAG PI) as per Royal College Guidelines (Ophthalmology)	• Patient listing aligned with National Institute for Health and Care Excellence (NICE) and Royal College of Ophthalmologists guidelines. • Counselling at listing with clear explanation of side effects; patient information leaflet provided. • Patients booked into face-to-face clinics; one eye listed at a time unless acute glaucoma is present.
Evaluation of referrals to Paediatric Dentistry during January - June 2024 (Dental Specialties)	• Urgent booking slots and direct booking access for clerical staff introduced.
Peri-operative stroke pathway (Anaesthetics)	• New pathway developed in collaboration with the Stroke Team; displayed in Anaesthetics and Theatre Recovery areas at Preston and Chorley.
Reducing unnecessary post-operative bloods for Colorectal inpatients (Colorectal Surgery)	• Protocol implemented to reduce unnecessary post-operative blood tests.
Venous Thromboembolism (VTE) assessment and prescription in Trauma and Orthopaedics	• VTE assessment emphasised in teaching sessions. • Ward teams reminded to complete assessments. • Audit presented in May 2024; re-audit scheduled to assess improvement.

Audit title	Actions completed
Service Review of the Virtual Medical Retina Diagnostic Clinic (Ophthalmology)	• Appointment letters revised to include more detailed patient information.
Cancellation of elective endovascular procedures (Neurosurgery)	• Formal policy introduced for same-day cancellations. • Process formalised with greater clinician involvement in prioritisation.
Propofol infusion rates in critical care patients sedated for more than 48 hours (Critical Care)	• Switched to weight-based dosing (max 4 mg/kg/hr). • Consultant must document rationale for exceeding safe dose. • Awareness raised about Propofol Infusion Syndrome • Regular monitoring of lipid profile, creatine kinase (CK), and electrocardiogram (ECG).
Post-Operative X-Rays for Total Hip Replacements and Hemiarthroplasties of the Hip (Orthopaedics)	• Educational posters created and displayed in key areas. • Teaching sessions delivered to junior Orthopaedic staff.
Quality of Antimicrobial Reviews (Pathology)	• Ward round proforma redesigned to ensure real-time completion with senior clinician input.
Adherence to Open Fracture British Orthopaedics Association Standards for Trauma and Orthopaedics (BOAST) Antibiotic Guidelines (Orthopaedics)	• ED guidelines updated in Harris Flex, the Trust Electronic Patient Record. • Communication campaign launched with updated posters and app details (“Tap on the Bugs”). • Posters displayed in Resus, Theatres, and staff areas.
Effectiveness of chest x-rays in detecting Soft Tissue Sarcoma Metastasis (Plastic Surgery)	• Findings suggested limited impact on life expectancy; further review of follow-up protocols recommended.
Assessing the Inpatient Lack of Capacity pathway (Radiology)	• Reduced delays by assigning a Radiographer daily. • Revised referral process to eliminate need for Part 2 form. • Magnetic Resonance Imaging (MRI) safety queries addressed earlier.
Hyperacusis & Misophonia in Auditory Processing Disorder audit (CNPaeds)	• Findings incorporated into patient information leaflet. • Poster presented at British Society of Audiology scientific meeting. • Manuscript submitted to international journal of Paediatric Otorhinolaryngology.
Mental Health Screening for Epilepsy Patients (Paediatrics)	• To highlight the importance of the mental health screening and documentation during the clinic visit. Mental health screening assessment tool has been added to Harris Flex.
Re-Audit of Handover of Care Between Shift Changes – Preston Birth Centre (Obstetrics)	• Monthly audits initiated and tracked in the AMAT system, with midwife involvement. • Audit results shared and discussed at team meetings.

Audit title	Actions completed
Evaluation of Inpatient Pain Psychology Service (Psychology)	• Skills-based training developed for the pain management team to support patients in distress and manage complex conversations. • Encouraged a MDT approach for chronic pain patients. • Exploring system improvements to track patient length of stay.
Local Safety Standards for Invasive Procedures (LocSSIPs) audit on Invasive neonatal procedures (Neonates)	• LocSSIP form updated to include line removal and Datix incident reporting; integrated into the Electronic Patient Records (EPR) system. • Trainee education included in induction; form completion required even in emergencies.
Local Anaesthetic Surgical Checklist (Plastic Surgery)	• New Local Anaesthetic (LA) checklist implemented in the OPERA system. • Checklist approved by the Trust's Change Board and now in routine use.
Use of Peak Flow Measurements in Asthma Exacerbations (Emergency Department)	• Posters placed in all triage areas. • Increased availability of peak flow meters in assessment areas. • Staff reminded where to document peak flow readings in Harris Flex.
Mastectomy rate at Central Lancashire Breast Unit (Breast Surgery)	• Ensured appropriate counselling for breast-conserving surgery in early breast cancer cases. • Oncoplastic planning used to avoid unnecessary mastectomies. • MDT to assess response to neoadjuvant chemotherapy and consider response-adapted treatment.
Use of Blood Products in Day Case Gynaecology Surgery (Gynaecology)	• Removed procedures not requiring transfusion from guidelines; Group and Save bloods no longer required. • Discussed changes with the Blood Transfusion Team. • Follow-up audit scheduled six months post-implementation to assess outcomes.
Computed Tomography (CT) External Therapy Standards (Core Therapies)	• Clinical lead to develop a proforma for inpatient and outpatient burns assessment. • Proforma to be digitalised and used as a prompt for comprehensive documentation.

2.9 Clinical Research

2.9.1 Participation in Clinical Research

In 2024–25, the Centre for Health Research & Innovation focused on streamlining its research portfolio and increasing participation in commercially funded studies, in alignment with national guidance and performance targets.

Over the year, 1,684 patients were recruited across 84 research studies, covering a broad spectrum of therapeutic areas and research methodologies. These included both early-phase experimental commercial studies and qualitative academic research, conducted in collaboration with university partners.

Key participation figures include:

- 596 patients recruited into National Institute for Health and Care Research (NIHR) portfolio studies.
- 61 patients recruited into commercially funded studies.
- Between 15 and 25 commercial studies were open to recruitment at any given time
- The commercial research portfolio now represents 23% of total studies, up from 13% the previous year.

2.9.2 Trust Achievements in Research

- Continued NIHR funding for the Lancashire Clinical Research Facility (LCRF), alongside a new NIHR Regional Research Development Network strategic award supporting diagnostics and imaging for commercial trials.
- Implementation of the NIHR Manchester Biomedical Research Centre (BRC), with the Trust as a partner. This includes:
    - £750,000 core funding (2022–2027) via the LCRF.
    - Seven embedded studies currently active at the Trust.
    - Progression into year 3 of a joint PhD colorectal fellowship with The University of Manchester.
    - £16,000 capital investment in new equipment to support respiratory trials.
- A new partnership agreement signed with a leading biotechnology pharmaceutical company, valued at £428,528 over two years, to establish a hub-and-spoke network across Lancashire and South Cumbria, expanding access to innovative cancer trials.
- Successful bid for £200,000 of NIHR capital funding for ophthalmology and respiratory equipment.
- The Trust's Research & Innovation (R&I) team has received the Gold Safety Triangulation Accreditation Review (STAR) award for safety and quality five consecutive times.

2.9.3 Research Governance

The Trust reviewed and granted local confirmation of capacity and capability for 53 new research studies opened during the year.

2.9.4 Workforce

- Dr Phillippa Olive, Senior Research Midwife, commenced her NIHR Senior Leadership Programme. This is one of only approximately 30 places across England.
- Several Registrars participated in the NIHR Associate Principal Investigator (API) scheme, contributing significantly to clinical research and progressing toward independent investigator roles.
- The Research Access Team was nominated for the Our People's Awards and the PROUD Team Award.
- The LCRF hosted the first API training day in November 2024.
- The Trust hosted the inaugural Red Rose Research (3Rs) event on behalf of the Integrated Care System (ICS) at Preston North End Football Club, attended by 125 delegates.
- Dr Pierre Martin-Hirsch was appointed Cancer Prevention and Early Detection (PED) Co-Theme Lead at NIHR Manchester BRC.
- Dr Omi Parikh was awarded the title of Honorary Clinical Professor at the University of Central Lancashire (UCLan).
- Dr WingYin Leung received the Pre-Application Support Fellowship, with Dr Beng So as academic supervisor. The project will test a Chronic Kidney Disease (CKD) algorithm to assess CKD prevalence in the community.
- The NHS England Research Toolkit for Matrons and Health Leaders was successfully launched, led by Nichola Verstraelen, Senior Research Programme Manager.

2.9.5 Studies, Trials & Research

In 2024–25, Lancashire Teaching Hospitals NHS Foundation Trust achieved several significant milestones in clinical research, including being the first UK site to recruit research participants into the following high-profile studies:

- BO44157 – A clinical trial investigating treatments for advanced or metastatic urothelial cancer.
- Flotilla (Pfizer) – A continued access study for the cancer therapies Encorafenib and Binimetinib.
- EvoPAR – A research study focused on breast and prostate cancer.
- ARGX-117-2202 (Empasiprubart) – A clinical trial exploring treatments for kidney transplant complications, multifocal motor neuropathy, and dermatomyositis.
- BNT327-01 – A safety and efficacy study targeting small cell lung cancer and triple-negative breast cancer.
- MK5684-01a – A clinical trial evaluating the safety and efficacy of a new treatment for prostate cancer.

These achievements reflect the Trust's growing role in early-phase and complex oncology research, offering patients access to cutting-edge therapies.

Additional highlights:

- Initial results from the Firefighter Study, funded by the Fire Brigades Union and led by Professor Anna Stec, were published nationally in The Guardian. The study was supported by R&I staff over the past two years.
- A Trust publication on the benefits of the API Scheme is available here: https://www.lancsteachinghospitals.nhs.uk/news/article/754

2.10 Registration with the Care Quality Commission

Lancashire Teaching Hospitals NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and it is currently registered to provide the following services:

- Diagnostic and screening procedures
- Maternity and midwifery services.
- Surgical procedures.
- Assessment or medical treatment for persons detained under the Mental Health Act 1983.
- Termination of pregnancies.
- Treatment of disease, disorder, or injury.
- Management of supply of blood and blood derived products.

The Chief Nursing Officer (CNO) is the Nominated Individual with CQC for Lancashire Teaching Hospitals NHS Foundation Trust. The Trust is fully compliant with the registration requirements of CQC.

2.10.1 CQC Finney House

Finney House Community Healthcare Hub provides out of hospital community-based care to medically fit patients. The service has 96 beds over three floors with 32 rooms per floor, and single room facilities. The top floor of Finney house provides nursing care and accommodation to residents.

The Trust is registered with the CQC at Finney House Community Healthcare Hub to provide:

- Accommodation for persons who require nursing or personal care.
- Treatment of disease, disorder or injury.

The Chief Nursing Officer also serves as the Registered Manager for Finney House. Finney House Community Healthcare Hub is fully compliant with the registration requirements of CQC.

2.10.2 Trust Inspections 2024-25

There were no inspections of the Trust in 2024-25 by the CQC. The Trust continues to hold engagement meetings with CQC as part of the required monitoring arrangements.

2.10.3 Inspection 2023-24

Between May and July 2023, the CQC conducted an unannounced inspection as part of its ongoing assessment of safety and quality. The inspection covered:

- Urgent and emergency care at Royal Preston Hospital and Chorley and South Ribble Hospital
- Medicine and surgery at Royal Preston Hospital
- A focused inspection of maternity services as part of the national maternity inspection programme
- The well-led domain across the Trust

The inspection report, published in November 2023, confirmed that the Trust's overall rating remained "Requires Improvement." The domain ratings were as follows:

- Safe: Requires Improvement
- Effective: Requires Improvement
- Caring: Good
- Responsive: Requires Improvement
- Well-led: Requires Improvement

Specific service ratings included:

- Surgery at Royal Preston Hospital: Good
- Urgent and emergency care and maternity at Chorley: Good
- Urgent and emergency care, medicine, and maternity at Preston: Requires Improvement.
- Figure 3 provides a visual summary of the Trust-wide CQC ratings across all domains.

Figure 4 CQC Trust wide rating

2.10.4 CQC Inspection Outcomes and Quality Improvement Plan

Following the Care Quality Commission (CQC) inspection in 2023–24, the Trust was recognised for making progress in performance. However, the CQC also identified areas requiring further improvement, particularly in relation to bed pressures, patient flow, and the delivery of the financial plan. In response, Lancashire Teaching Hospitals NHS Foundation Trust developed a CQC Quality Improvement Plan (QIP) to address the recommendations. This plan has been overseen through the SIP during 2024–25 and continues to be reported to the Board of Directors.

At the end of March 2025, of the 54 'Must Do's' and 'Should Do's' included in the 2023-24 CQC QIP, there are 48 (89%) recommendations assessed as 'Green' i.e., delivered, 3 (6%) as 'Amber-Green' i.e. ongoing and progress made, and 3 (6%) as 'Amber-Red' i.e. not currently delivered and risks with delivery. There are nil currently assessed as 'Red' i.e. not expected to deliver at any point in time.

2.10.5 Recognition of Good Practice

The report also highlighted several areas of good practice recognising improvements and positive changes the Trust had made to drive its safety and improvement culture as follows:

- The Trust had processes to escalate relevant risks and identified actions to reduce their impact.
- The Trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed

with all relevant stakeholders.

- Most staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The Trust supported staff to develop their skills and take on more senior roles.
- Leaders operated effective governance processes, throughout the services and with partner organisations. Staff were clear about their roles and accountabilities. External assurance continued to develop governance processes throughout the Trust and with partner organisations.
- The service collected reliable data and analysed it.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- The Trust had a good understanding of quality improvement methods and the skills to use them.

2.11 Quality of Data 

2.11.1 Information Governance

The Trust maintains a clear focus on data quality. Performance information is triangulated with other known information to identify weaknesses and areas requiring further investigation. Where necessary, targeted reviews are conducted to ensure data integrity.

The Digital and Health Informatics Directorate continue to safeguard the Trust's data and services with monitoring through the NHS England (NHSE) Data Security and Protection Toolkit (DSPT) Regional Health Information and Management Systems Society Infrastructure Adoption Model assessments have also been undertaken, with recommendations assessed and added to the Cyber Security action plan and monitored through the Cyber Security Committee.

The Trust has a high risk (scoring 20) related to the potential for a cyber-attack. The risk is reviewed and updated monthly as controls are continuously improved. All eligible Windows servers and workstations have been onboarded to enhanced national threat detection and monitoring systems. Cyber recovery solutions have been procured to protect critical server backups and over 11,000 staff members have been onboarded to multi-factor authentication, thus protecting Trust email and applications.

2.11.2 Data Quality

It is widely recognised that high-quality data is fundamental to identifying areas for improvement and demonstrating the impact of changes on the quality of care provided.

Lancashire Teaching Hospitals NHS Foundation Trust reports on data quality through submission of a bi-annual Data Quality Assurance Report to the Trust Board providing a summary of Data Quality Team activities and an update in relation to Data Quality Risks and compliance in relation to the National Data Quality Assurance Dashboard and Maturity Index.

Lancashire Teaching Hospitals NHS Foundation Trust submitted records during 2024-25 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the latest published data, which included the patient's valid NHS number, was:

- 100% for admitted patient care.
- 100% for outpatient care.
- 99.5% for accident and emergency care.

The percentage of records in the published data, which included the patient's valid General Medical Practice code, was:

- 99.9% for admitted patient care.
- 99.6% for outpatient care.
- 99.6% for accident and emergency care.

All data set types are either consistent with or show an improvement compared to 2023-24, and all are above the national average for 2024-25.

As part of its annual assessment, the Trust reviews and updates its compliance with the DSPT to ensure alignment with best practice. For 2023–24, the Trust achieved a status of 'Standards Met', with the Toolkit Audit providing substantial assurance for both the self-assessment and National Data Guardian standards. The 2024–25 submission is scheduled for June 2025.

In 2024–25, the Trust underwent an internal Information Governance clinical coding quality assurance audit. Results indicate a high level of coding quality and completeness as follows with a slight deterioration across secondary diagnosis and procedures:

- Primary Diagnosis 91.5%.
- Secondary Diagnosis 88.06%.
- Primary Procedure 91.97%.
- Secondary Procedure 85.98%.

In terms of the NHS Digital Data Quality Maturity Index, the Trust scored the following for the latest position available, above the national average in all datasets and overall showing an improvement compared to the 2023-24 position. See table below for NHS Digital Data Quality.

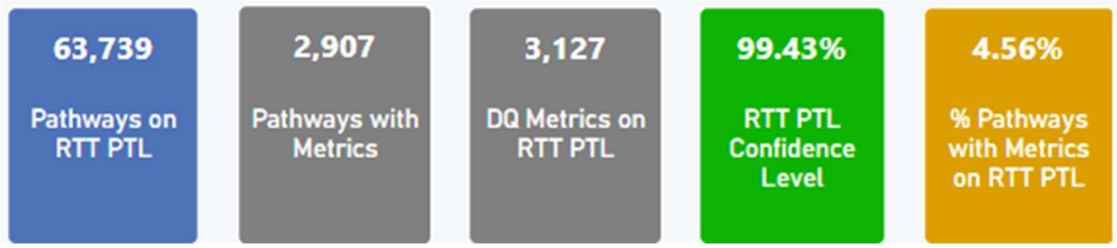
Table 12 NHS Digital Data Quality

	Overall	Emergency Care Dataset	Admitted Patient Care Dataset	Out-Patient Dataset
National Average	87.7	85.5	95.4	95.9
Lancashire Teaching	92.7	86.7	99.5	98.8

Data source NHS Data Quality Maturity Index

The National Waiting List Minimum dataset data quality confidence level of 99.43% for the Trust is above the national threshold of 95%. Compliance is detailed below and shows a consistent level in the number of records with a data quality query compared to the previous year:

Figure 5 National Waiting List Data



LUNA National Data Quality Solution

Whilst the figures for data quality are above the national average the Trust remains committed to continued improvements and supporting actions are referenced below.

- Further development of an extended suite of validation reports to increase validation and assurance of the quality of data on the main Patient Administration System (PAS).
- Interactive workshops to ensure engagement with clinical and support staff regarding the importance of good data quality and individual responsibility.
- Engaged with external audit partners to improve the quality and depth of clinically coded data and overall data completeness.
- Implementation of the corporate rolling audit programme including audit of data collection and completeness at reception points.

2.12 Information Governance

2.12.1 Confidentiality and Information Security

Lancashire Teaching Hospitals NHS Foundation Trust is committed to maintaining the confidentiality and security of information relating to patients, staff, and the organisation. This is achieved through a comprehensive suite of governance and control policies, all of which are aligned with current legislation and subject to regular review.

The Trust is registered with the Information Commissioner's Office (ICO) as a data controller, which carries a legal duty to maintain confidentiality and to share personal information lawfully when necessary.

As personal information is increasingly stored within secure digital systems, the Trust recognises the potential for data breaches. In response, it maintains a robust reporting and investigation process in line with statutory, regulatory, and best practice requirements. All incidents involving personal data breaches are managed through the Trust's risk and control framework, with serious incidents reported to the Department of Health and Social Care and the ICO, where appropriate.

For the reporting period 2024–25, the Trust did not experience any externally reportable data breaches. Of the two incidents reported in the previous year, the ICO confirmed that no further action was required.

2.12.2 Data Security and Protection Toolkit (DSPT)

The Trust conducts an annual review of its compliance with the Data Security and Protection Toolkit (DSPT) to ensure alignment with statutory obligations. In September 2024, the DSPT adopted the National Cyber Security Centre's Cyber Assessment Framework (CAF) as the basis for cyber security and information governance assurance.

The 2024–25 DSPT includes expanded requirements compared to the previous year and is structured around 47 contributing outcomes, each supported by indicators of good practice. These outcomes are assessed as:

- Not Achieved
- Partially Achieved
- Achieved

To meet the 'Standards Met' status, the Trust must achieve the expected level for each outcome as defined by NHS England. The Trust achieved 'Standards Met' for the 2023–24 DSPT and has submitted its baseline assessment for 2024–25, with the final submission due by 30 June 2025. The Trust has established a dedicated information risk framework with Information Asset Owners (IAO) throughout the organisation. This is well embedded and identifies information asset owner responsibilities for ensuring information assets are handled and managed appropriately. There are robust and effective systems, procedures, and practices to identify, manage and control information risks.

2.12.3 Information Risk Management

The Trust has implemented a well-established information risk framework, supported by Information Asset Owners (IAOs) across the organisation. This framework ensures that information assets are appropriately managed and that associated risks are identified and controlled.

Key components include:

- Training and awareness programmes for staff
- Incident management processes for immediate reporting and investigation of actual or suspected breaches
- Compliance with the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018 (DPA 2018)

2.12.4 Governance Structure

While the Board of Directors holds ultimate responsibility for information governance, operational oversight is delegated to the Information Governance Records Committee, which reports to the Finance and Performance Committee. The committee is chaired by the Chief Medical Officer (CMO), who also serves as the Caldicott Guardian.

The Trust's Senior Information Risk Owner (SIRO) is the Director of Corporate Affairs. The SIRO/IAO Working Group plays a key role in:

- Identifying and reviewing local information risks
- Escalating risks where appropriate

- Ensuring decisions are made in accordance with Trust policies

This governance structure ensures that information is protected and that confidentiality, integrity, and availability are maintained when information is shared.

2.12.5 Information Governance Management Framework

The development of the Trust's Information Governance Management Framework is informed by:

- Results from the annual DSPT assessment
- Feedback from the MIAA DSPT audit
- Participation in the Information Governance Assurance Framework

Together with the Trust's Information Governance Policy, this framework supports continuous improvement and ensures that statutory requirements, standards, and best practices are embedded across the organisation.

2.13 Adult Mortality Reviews

2.13.1 Overview of Mortality Governance

Lancashire Teaching Hospitals NHS Foundation Trust has robust governance arrangements in place to monitor, review, report, and learn from patient deaths. Since 2017–18, the Trust has implemented the nationally recommended Mortality Review (MR) process, based on the Royal College of Physicians' Structured Judgement Review (SJR) model. This approach has been embedded in practice for the past seven years and is used to review adult inpatient and Emergency Department (ED) deaths.

Deaths involving neonates and children are reviewed through separate, nationally defined processes. These are reported in the Mortality Surveillance and Learning from Neonatal, Child and Adult Deaths section of this Quality Account.

Further scrutiny of all deaths is also provided by the Medical Examiner Service, as detailed in Part 3 – Review of Quality Performance: Effective Care.

2.13.2 Structured Judgement Reviews (SJRs)

In 2024–25, the Trust recorded 1,773 patient deaths, distributed across the year as follows:

- Q1: 402 deaths
- Q2: 383 deaths
- Q3: 488 deaths
- Q4: 500 deaths

Source: Trust Data Warehouse

By 31 March 2025, the Trust had completed 947 Structured Judgement Reviews (SJRs) and initiated 21 Learning Responses under the PSIRF. One additional case was referred to an external agency for review. These figures exclude neonatal and child deaths.

Of the 21 PSIRF Learning Responses:

- 9 have been completed (including 1 Patient Safety Incident Investigation [PSII], 3 After Action Reviews [AAR], 1 SWARM, and 4 local management reviews).

- 13 were referred to the Coroner, with 4 inquests concluded and 9 pending.

The number of deaths reviewed or investigated per quarter was:

- Q1: 228 SJRs + 3 PSII + 4 PSIRF Learning Responses
- Q2: 238 SJRs + 1 PSII + 1 Maternity and Newborn Safety Investigation (MNSI) + 7 PSIRF Learning Responses
- Q3: 282 SJRs + 1 PSIRF Learning Responses
- Q4: 199 SJRs + 1 PSII + 3 PSIRF Learning Responses

Source: Trust Mortality Review Database & Datix

2.13.3 Deaths Due to Problems in Care

Of the nine completed PSIRF Learning Responses, one death was judged to be more likely than not due to problems in care. This case involved a delayed blood transfusion and occurred on 5 February 2024 (outside the reporting period) but was reported on 29 May 2024 (within the reporting period). The Coroner concluded that the death could have been prevented with timely intervention.

For the nine cases awaiting inquest, it is not yet possible to determine whether problems in care contributed to the deaths.

It is noted that the PSIRF, which the Trust implemented from November 2023, advises that avoidability of death should not form part of the terms of reference for PSII investigations, with that being the remit of HM Coroner.

2.13.4 Learning from Structured Judgement Reviews

The Trust continues to embed learning from deaths into its governance processes. In 2022–23, the mortality review proforma was updated to capture both positive and negative learning. Learning is regularly shared through:

- Divisional Safety and Quality Meetings
- Specialty Governance Meetings
- Mortality and End of Life Care Committee

Key themes are extracted from the electronic SJR tool within the AMAT system and reported to relevant committees.

Positive Themes Identified (2024–25)

- Excellent record keeping
- Good communication with the family
- Early involvement of the palliative care team
- Regular senior reviews
- Timely escalation of the patient.

Areas for Improvement (2024–25)

- Delayed recognition of end of life.
- Importance of handovers – (e.g., unclear nil-by-mouth status, escalation of high National Early Warning Score [NEWS])
- Lack of early discussions and documentation of ceilings of care and Do Not Attempt Cardiopulmonary Resuscitation [DNACPR] decisions

- Abnormal lab results not followed up.
- Incomplete documentation.

2.14 Reporting Core Indicators

2.14.1 Overview

Lancashire Teaching Hospitals NHS Foundation Trust measures its performance against a range of patient safety, access, and experience indicators as outlined in the NHS compliance framework and the acute services contract.
Throughout 2024–25, the NHS continued to face significant challenges in meeting its constitutional standards. System-wide pressures including increased demand, capacity shortfalls, and operational disruptions contributed to extended waiting times across both Urgent and Emergency Care (UEC) and planned elective services.

2.14.2 Operational Pressures and System Challenges

Within Lancashire Teaching Hospitals, performance was impacted by several key factors:

- High bed occupancy, leading to care being delivered in non-designated bed spaces
- Increased length of stay and a rise in patients who do not meet the criteria to reside (NMCTR)
- Industrial action, which disrupted service delivery
- Diagnostic backlogs, which negatively affected overall diagnostic performance
- Despite these challenges, the Trust received targeted support from NHS England to improve performance in Referral to Treatment (RTT), cancer, and diagnostic services. As a result of sustained improvements, the Trust was able to step down from enhanced monitoring in the final quarter of 2024–25.

2.14.3 System-Wide Transformation Initiatives

The Trust played a leading role in delivering key transformation programmes across the local health system, including:

- Establishing a Community Healthcare Hub at Finney House, providing health-led community bed capacity
- Expanding Virtual Wards, including implementation of point-of-care testing and increased utilisation
- Collaborating with Lancashire & South Cumbria NHS Foundation Trust (LSCFT) to develop a single point of access for community and hospital avoidance services, integrating:
    - 2-hour Crisis Response
    - Virtual Ward
    - Same Day Emergency Care
    - Wider community services

These initiatives aim to support patients to remain safely at home and reduce avoidable hospital admissions.

2.14.4 Performance Highlights and Areas for Improvement

In 2024–25, the Trust made measurable progress across several core performance indicators compared to 2023–24. However, challenges remain in two key areas: Urgent and Emergency Care (UEC) and Diagnostics.

Urgent and Emergency Care (UEC)

The Trust's performance has fallen below its objectives in relation to a range of measures across UEC notably in the 4-hour standard for Accident and Emergency which has deteriorated slightly to 69.8% compared to 70.4% in 2023-24; ED length of stay over 12 hours increased from 9.6% in 2023/24 to 10.2% 2024-25 and ambulance handover delays over 60 minutes have increased to 3,206 compared with 2,025 in 2023-24.

To address these pressures, the Trust implemented several key initiatives:

- Established an Acute Assessment Unit to reduce ED wait times ahead of expanded Medical Assessment Unit capacity.
- Expanded the Virtual Ward to include Frailty, Respiratory, and Acute Medicine, with successful deployment of remote monitoring.
- Enhanced internal escalation measures, including a site pressure score and strengthened hospital flow management protocols.
- Expanded Same Day Emergency Care (SDEC) pathways and admission avoidance therapy.
- Introduced revised ward and board round standards and launched the Continuous Flow initiative to improve discharge planning and patient throughput.

Elective

The Trust began 2024–25 under significant pressure due to the residual impact of industrial action and elective backlog recovery. Despite this, substantial progress was made:

- Eliminated 78-week waits for elective care, down from 181 cases in 2023–24 to zero in 2024–25.
- Reduced 65-week waits from 1531 cases in 2023-24 to 19 in 2024-25.
- Reduced 52-week waits from 4944 cases in 2023-24 to 1505 in 2024-25.

These improvements reflect the Trust's commitment to restoring elective services and improving patient access.

Diagnostics

Diagnostic performance remained a challenge throughout the year. Performance against the Diagnostic access standard (DM01) has remained significantly under trajectory despite incremental improvement in Q3 & Q4 achieving 8.4% improvement in DM01 performance from September 2024 to February 2025. Contributing factors included a backlog of patients requiring a diagnostic test in addition to increased demand, workforce shortages with the availability of appropriately trained staff, and equipment and space constraints. To address these challenges, the diagnostic services developed a comprehensive workforce strategy aimed at attracting and retaining specialised

diagnostic staff. This has been supported by the implementation of several targeted training programmes, designed to build internal capability and ensure a sustainable diagnostic workforce for the future.

In addition, the following key initiatives were also implemented:

- Automated validation processes, reducing waiting lists by approximately 4%.
- Established a diagnostic performance meeting focused on backlog reduction.
- Formed a diagnostic improvement group to drive capacity optimisation and transformation.
- Implemented a revised access policy to better manage demand.
- Refined clinical triage in Echocardiography, achieving a 5% rejection rate in line with national standards.

Cancer Services

In 2024–25, the Trust made significant progress in improving cancer performance, building on the foundations laid in the previous year. Focused efforts to streamline pathways, reduce backlogs, and enhance early diagnosis have led to measurable improvements in both access and patient experience.

Key achievements include:

- Exceeded the 28-day Faster Diagnosis Standard, achieving 81.2% in March 2025 and 77.8% for the full year. This means more patients received timely confirmation of a cancer or non-cancer diagnosis, improving reassurance and enabling earlier treatment planning.
- Improved 62-day cancer treatment performance from 56% in 2023–24 to 62% in 2024–25, reflecting faster access to first definitive treatment for patients diagnosed with cancer.
- Streamlined colorectal pathways, increasing Faster Diagnosis Standard compliance from 36.5% in January 2024 to 73% in March 2025.
- Increased gynaecology pathway productivity, enabling faster triage.
- Implemented a post-menstrual bleed pathway, improving early access to diagnostics and allowing timely redirection to appropriate non-cancer pathways, improving overall patient experience.
- Excelled in the National Cancer Patient Experience Survey, maintaining a 9/10 score in the National Cancer Patient Experience Survey for the third consecutive year, with no scores below the national average.
- Enhanced digital triage for suspected skin cancer via local image capture hubs, , reducing the need for multiple hospital visits and expediting diagnosis.
- Delivered 24 community events to raise cancer awareness and reduce health inequalities by supporting earlier diagnosis and improving access.

2.14.5 Summary of Performance against Core Indicators

Table 13 Core Standards 2024-25

Indicator	2023-24	2024-25	Current Period	Comparison
A&E - 4 hour standard	70.4	69.8	% - Cumulative to end Mar 2025	Deteriorated
Cancer - 2 week rule (All Referrals)	83.5	87.1	% - Cumulative to end Mar 2025	Improved
Cancer - 2 week rule - Referrals with breast symptoms	91.0	76.3	% - Cumulative to end Mar 2025	Deteriorated
Cancer - 31 day target	84.4	89.4	% - Cumulative to end Mar 2025	Improved
Cancer - 31 Day Target - Subsequent treatment – Surgery	58.2	66.3	% - Cumulative to end Mar 2025	Improved
Cancer - 31 Day Target - Subsequent treatment – Drug	98.4	98.3	% - Cumulative to end Mar 2025	Deteriorated
Cancer - 31 Day Target - Subsequent treatment -Radiotherapy	87.1	93.7	% - Cumulative to end Mar 2025	Improved
Cancer - 62 day Target	56.0	62.7	% - Cumulative to end Mar 2025	Improved
Cancer - 62 Day Target - Referrals from NSS (Summary)	29.9	36.0	% - Cumulative to end Mar 2025	Improved
28 day faster diagnosis standard – compliance	71.5	77.8	% - Cumulative to end Mar 2025	Improved
MRSA	1	0	Cumulative to end Mar 2025	Improved
C.difficile Infections	203	192	Cumulative to end Mar 2025	Improved
18 weeks - Referral to Treatment - % of Incomplete Pathways < 18 Weeks	55.0	56.4	% - Cumulative to end Mar 2025	Improved
18 weeks - Referral to Treatment - Number of Incomplete Pathways > 104 Weeks	0.0	0.0	End Mar 2025 census position	Maintained
18 weeks - Referral to Treatment - Number of Incomplete Pathways > 78 Weeks	11.0	0.0	End Mar 2025 census position	Improved
18 weeks - Referral to Treatment - Number of Incomplete Pathways > 65 Weeks	312.0	19.0	End Mar 2025 census position	Improved
18 weeks - Referral to Treatment - Number of Incomplete Pathways > 52 Weeks	2918.0	1372.0	End Mar 2025 census position	Improved

Indicator	2023-24	2024-25	Current Period	Comparison
% of patients waiting over 6 weeks for a diagnostic test	45.6	49.9	% - Cumulative to end Mar 2025	Deteriorated

2.14.6 NHS Digital Data availability

All data presented in the following performance indicator tables is sourced from NHS Digital, in accordance with the requirements for Quality Accounts. The data reflects the most current reporting period available for each indicator and is benchmarked against Acute (non-specialist) NHS Trusts.

Indicator	Table Reference	Reporting Period
Summary Hospital-level Mortality Indicator (SHMI)	Table 14	2023-24.
Emergency Readmissions within 30 Days of Discharge	Table 15	2023-24.
Venous Thromboembolism (VTE) Risk Assessment	Table 16	2020-21 (remains paused since COVID-19).
Clostridioides difficile (C. difficile) Infection	Table 17	2023-24.
Patient Safety Incidents	Table 18	2023-24.

Table 14 Summary Hospital-Level Mortality Indicator (SMHI) * most current data

Summary Hospital- Level Mortality Indicator (SMHI)	December 2018- Nov-19	December 2019- Nov-20	December 2020- Nov-21	December 2021- Nov-22	December 2022- Nov-23 *	December 2023- Nov-24 *
	Trust = 0.9702	**Trust = 0.9671**	**Trust = 0.9593**	**Trust = 0.9641**	**Trust = 0.9169**	**Trust = 0.92**
(a) the value and banding of the summary hospital- level mortality indicator ('SHMI') for the Trust for the reporting period	England average = 1.0	England average = 1.0	England average = 1.0	England average = 1.0	England average = 1.0	England average = 1.0
	Low = 0.69	Low = 0.69	Low = 0.71	Low = 0.71	Low = 0.71	Low = 0.87
	High = 1.19	High = 1.18	High = 1.19	High = 1.22	High = 1.25	High = 1.15
	Banding = 2	Banding = 2	Banding = 2	Banding = 2	Banding = 2	Banding = 2
(b) the percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period	**Trust = 53%**	**Trust = 52%**	**Trust = 51%**	**Trust = 55%**	**Trust = 55%**	**Trust = 61%**
	England = 36%	England = 36%	England = 39%	England = 40%	England = 42%	England = 44%
	High = 59%	High = 59%	High = 64%	High = 66%	High = 66%	High = 66%
	Low = 11%	Low = 8%	Low = 11%	Low = 13%	Low = 16%	Low = 17%

Lancashire Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- NHS Digital categorises NHS Trusts into bands 'higher than expected' (banding=1), 'as expected' (banding=2) or 'lower than expected' (banding=3). The trust remains in band 2 which is within the expected range. The SHMI for the most current data available (Dec 2023 – Nov 2024) is 0.92 which is consistent with the previous 12-month period but still below the 1.0 average.
- The SHMI data does not include COVID-19 data because the statistical model was not designed for this kind of pandemic activity and if the data were to be included it would affect the accuracy.

Table 15 Readmissions within 30 days of Discharge * most current data							
Percentage of patients aged:0 to 15 & 16 or over Readmitted to a hospital which forms part of the Trust within 30 days of being discharged from the Trust during the reporting period	**April 2017-Mar 18**	**April 2018-Mar-19**	**April 2019-Mar-20**	**April 2020-Mar-21**	**April 2021-Mar-22**	**April 2022-Mar-23***	**April 2023-Mar-24***
0-15 years	**Trust = 15.2 (A1)**	**Trust = 15.8 (A1)**	**Trust = 13.5 (A5)**	**Trust = 12.0 (W)**	**Trust = 12.5 (W)**	**Trust = 13.7 (A5)**	**Trust = 13.9 (A5)**
	England = 11.9	England = 12.5	England = 12.5	England = 11.9	England = 12.5	England = 12.8	England = 13.2
	High = 17.0	High = 19.3	High = 18.5	High = 12.1	High = 12.6	High = 12.9	High = 13.3
	Low = 1.7	Low = 2.0	Low = 2.4	Low = 11.9	Low = 12.5	Low = 12.8	Low = 13.0
16 years – 74 years	**Trust = 10.9 (B1)**	**Trust = 12.0 (B1)**	**Trust = 11.8 (B1)**	**Trust = 12.4 (B1)**	**Trust = 10.4 (B1)**	**Trust = 12.7 (B1)**	**Trust = 12.4 (B1)**
	England = 12.4	England = 13.0	England = 13.1	England = 14.5	England = 13.4	England = 13.3	England = 13.9
	High = 21.0	High = 21.8	High = 19.5	High = 14.5	High = 13.4	High = 13.3	High = 14.0
	Low = 2.2	Low = 1.2	Low = 3.2	Low = 14.4	Low = 13.4	Low = 13.3	Low = 13.9
75 years +	**Trust = 16.9 (B1)**	**Trust = 17.8 (W)**	**Trust = 17.6 (B5)**	**Trust = 19.5 (W)**	**Trust = 16.6 (B1)**	**Trust = 17.0 (W)**	**Trust = 19.9 (A1)**
	England = 18.4	England = 18.7	England = 18.6	England = 19.6	England = 18.0	England = 17.2	England = 17.9
	High = 22.5	High = 29.4	High = 31.9	High = 19.7	High = 18.0	High = 17.3	High = 18.0
	Low = 6.7	Low = 6.1	Low = 8.6	Low = 19.4	Low = 17.9	Low = 17.1	Low = 17.8
2024 -2025 not yet released by NHS Digital. As such data is presented 12 months in arrears.							

Table 15 Readmissions within 30 days of Discharge * most current data
Banding key:
B1 = Significantly lower than the national average at the 99.8% level
B5 = Significantly lower than the national average at the 95% level but not at the 99.8% level
W = National average lies within expected variation (95% confidence interval)
A5 = Significantly higher than the national average at the 95% level but not at the 99.8% level
A1 = Significantly higher than the national average at the 99.8% level.
Lancashire Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:
• The NHS Digital readmissions data is now categorised into 0-15 years, 16- 74 years, and 75+ years.
• The banding has been presented to indicate the Trust performance.
• The 0-15 and 75+ year's readmissions rates are higher than the England average and shows a deterioration from the last reported figure.
• The Trust re-admissions rate for patients 16-74 is lower than the England average and shows improvement from the last reported figure.

Table 16 Venous Thromboembolism (VTE) Risk Assessment * most current data			
	Q4 2018 -2019	**Q3 2019 -2020 ***	**Q4 2020-2021**
Percentage of patients who were admitted to hospital and who were risk assessed for Venous thromboembolism (VTE) during the reporting period	**Trust = 95.7%**	**Trust = 97.0%**	NHS Digital VTE data collection and publication paused in March 2020.
	England = 95.7% High = 100% Low = 74%	England=95.3% High = 100% Low = 71%	No data for from 2021 onwards
NHS Digital VTE data collection and publication was paused to release NHS capacity to support the response to COVID-19. The Trust's VTE risk assessment compliance data continues in 2023 - 24 to be collated and reported to Safety and Quality Committee in an assurance report.			

Table 17 *Clostridioides Difficile (C. difficile)* Infection * most current data

	2019-20	2020-21	2021-22	2022-23	2023-24*
The rate per 100000 bed days of cases of *C. Difficile* infection reported within the Trust amongst patients aged 2 or over during the reporting period	**Trust = 62.9**	**Trust = 74.5**	**Trust = 71.4**	**Trust = 86.8**	**Trust = 94.8**
	High = 142.8	High = 140.5	High = 138.4	High = 133.6	High = 131.2
	Low = 0	Low = 0	Low = 0	Low = 0	Low = 0

Lancashire Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

The prevention of C. *difficile* infection remains a key priority for our organisation. In the year 2023-24, the national objective set by NHSE for the Trust was to have no more than 122 hospital associated cases. The Trust exceeded the national objective with an increase in hospital associated cases during 2023-24 in comparison to previous years with a total of 203 cases. This was a 3.6% increase from 2022/2023 which had a total of 196 hospital associated cases.

For further information refer to the Infection Prevention and Control section of this Quality Account for comprehensive data on Clostridioides Difficile (C. difficile) Infection.

Table 18 Patient Safety Incidents * most current data

The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that results in severe harm or death
* Comparative data for England all Trusts has not been available nationally since April 2021 to date.

	Oct 2018-Mar 2019	Oct 2019-Mar 2020	April 2020 - Mar 2021	April 2021 - Mar 2022	April 2022-Mar 2023	April 2023-Mar 2024	April 2024-Mar 2025
(i) Rate of Patient Safety Incidents per 1000 Bed days	**Trust Number = 7250 Trust Rate = 52.4**	**Trust Number = 7766 Trust Rate = 51.8**	**Trust Number = 14428 Trust Rate = 68.9**	**Trust Number = 19773 Trust Rate = 67.8**	**Trust Number = 20626 Trust Rate = 66.1**	**Trust Number = 26920 Trust Rate = 81.3**	**Trust Number = 26928 Trust Rate = 83.8**
	England – 45.2 All *Trusts Rate High= 95.9 All *Trusts Low = 16.9	England – 49.6 All *Trusts Rate High= 110.2 All *Trusts Low = 15.7	England – 57.3 All *Trusts Rate High = 118.7 All *Trusts Low = 27.2	No longer produced in the same way to compare.			

The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that results in severe harm or death
* Comparative data for England all Trusts has not been available nationally since April 2021 to date.

	Severe harm or death	Severe harm or death	Severe harm or death	Severe harm or death	Severe harm or death	Severe harm or death	Severe harm or death
(ii) % of Above Patient Safety Incidents = **Severe/Death Rate = per 1000 Bed Days**	**Trust Number = 60 Trust Rate = 0.43 % of all incidents = 0.83%**	**Trust Number = 49 Trust Rate = 0.33 % of all incidents = 0.63%**	**Trust Number =88 Trust Rate = 0.42 % of all incidents = 0.61%**	**Trust Number = 80 Trust Rate = 0.27. % of all incidents = 0.40%**	**Trust Number = 110 Trust Rate = 0.35 % of all incidents = 0.53%**	**Trust Number = 107 Trust Rate = 0.32 % of all incidents = 0.39%**	**Trust Number = 65 Trust Rate =0.20 % of all incidents = 0.24%**
	England – 0.32% All *Trusts Highest % = 1.82% All *Trusts Lowest % = 0%	England – 0.30% All *Trusts Highest % = 1.29% All *Trusts Lowest % = 0%	England – 0.44% All *Trusts Highest % = 2.80 % All *Trusts Lowest % = 0.03%	No longer produced in the same way to compare.			

Table 18 Patient Safety Incidents * most current data
The Lancashire Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: The Trust continues to provide education regarding the reporting of incidents and near misses, the importance of doing so and the outcome of the learning gleaned from incident reporting. The Trust has seen a rise in incident reporting with regards to service delivery and the management of waiting times for example, reporting of delayed admission to inpatient areas due to bed availability, incidents where a patient is placed into a non-designated or boarded bed space, treatment or surgery being delayed or not available and incidents linked to gaps in Thrombectomy service provision. Thrombectomy is a life-saving treatment for people who suffer a certain type of stroke. It works best when delivered quickly and can greatly improve recovery and outcomes for patients. Since October 2021, our Trust has been providing this specialist service for people across Lancashire and South Cumbria. While the national goal is to offer this treatment 24 hours a day, 7 days a week, like many areas across the country, we've faced challenges in recruiting the specialist staff needed to run the service around the clock. Despite these challenges, the Trust has made significant progress. In 2025, service hours were extended to operate seven days a week, with further improvements made to increase availability into the evening. These enhancements have already improved access for patients and reflect the Trust's ongoing commitment to developing a fully 24/7 thrombectomy service in the future. There has also been an increase in the number of incidents reported relating to maternity/neonatal triggers, violence and aggression and restraint of patients/public by security staff at times of violence and aggression. Trust staff are proactively encouraged to report near misses and no harm incidents to enable increased opportunity to identify themes and trends before harm occurs to patients. Incident dashboards and an automated interactive Governance Dashboard continue to be utilised across the Trust for embedded incident analysis. The Trust continues to use the ASF Learning and Improvement Group to respond to learning from incidents.

2.15 Patient experience performance indicator

2.15.1 Adult Inpatient Survey 2023

The Care Quality Commission (CQC) published the results of the Adult Inpatient Survey 2023, which have been disseminated across Lancashire Teaching Hospitals NHS Foundation Trust. In addition to internal review, the Trust has engaged with patient forums and community groups to further explore the findings and gather broader feedback.

The 2023 survey builds on the previous results from 2022 and provides valuable insights into patients' experiences of care. The survey captures feedback on key aspects such as:

- Being treated with kindness, respect, and dignity
- Overall quality of care
- Patient satisfaction, with overall ratings consistently above 7 out of 10

Table 19 Adult inpatient survey Questions 47- 50

Overall Adult Inpatient Survey 2023

		Historical				
		2019	2020	2021	2022	2023
Q47	Treated with kindness and compassion	-	-	-	-	96%
Q48	Treated with respect and dignity overall	97%	98%	97%	98%	97%
Q49	Rated overall experience as 7/10 or more	83%	80%	80%	81%	76%
Q50	Asked to give views on quality of care during stay	8%	11%	8%	12%	35%

2.15.2 Commitment to Continuous Improvement

The Trust recognises the importance of listening to patient feedback and taking prompt action to address concerns. In response to the 2023 survey findings, the Trust is developing targeted improvement plans focused on the following key themes:

- Enhancing communication with patients
- Improving discharge arrangements and the information provided at discharge
- Promoting restful environments, including enabling sleep and reducing overnight patient moves
- Improving meal choices and access to snacks outside of meal times
- Supporting patients who require assistance with eating
- Increasing patient involvement in decisions about their care

To support these efforts, the Trust is developing performance metrics to monitor progress in real time. These metrics will enable the organisation to track improvements ahead of the next survey cycle and ensure that patient experience remains a central focus of care delivery.

2.16 Staff experience performance indicator

Each year, NHS staff across the country take part in the NHS Staff Survey, which helps organisations understand how their teams feel about their workplace and the care they help deliver. Since 2021, the survey has been aligned with the NHS People Promise, a national commitment to making the NHS a better place to work.

One of the key questions in the survey asks staff:

"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation."

This question serves as a meaningful measure of staff trust in the quality and safety of care delivered.

At Lancashire Teaching Hospitals NHS Foundation Trust, the percentage of staff who agreed with this statement has declined over the past four years:

Table 20 Staff Recommendation as a Provider of Care

Q25d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation. (%)	2021	2022	2023	2024
	Trust = 62	Trust = 60	Trust = 58.3	Trust = 52.2

This downward trend indicates a growing concern among staff regarding the standard of care, and the Trust recognises the importance of addressing this issue. In response, a programme of work is underway to better understand the factors contributing to this decline. This includes engaging with staff through feedback sessions, reviewing internal data, and aligning improvement actions with the NHS People Promise.

The Trust remains committed to creating a supportive and empowering environment for its workforce. By strengthening staff engagement and wellbeing, the organisation aims to restore confidence in the care it provides ensuring that both staff and patients feel assured of the quality and safety of services.

2.17 Freedom to Speak Up

At Lancashire Teaching Hospitals NHS Foundation Trust, we are committed to delivering the highest standards of care to our patients while fostering a supportive and empowering environment for our staff.

A cornerstone of our promise to excellence is our robust Freedom to Speak Up (FTSU) offer. This is designed to ensure that every member of our team feels confident and supported in raising concerns about patient care, safety, or any aspect of their working environment.

By promoting a culture of openness and transparency, we empower our staff to speak up without fear of retribution, knowing that their voices will be heard and valued.

The importance of a quality Freedom to Speak Up offer cannot be overstated. It is essential for:

- **Enhancing Patient Safety**: When staff feel safe to report issues, we can address potential risks promptly, preventing harm and improving patient outcomes.
- **Fostering a Positive Work Environment**: Encouraging open communication helps build trust and collaboration among team members, leading to higher job satisfaction and retention.
- **Driving Continuous Improvement:** Feedback from staff is invaluable in identifying areas for improvement and implementing effective solutions, ensuring we continually evolve and enhance our services.

We are committed to nurturing a culture where speaking up is not only encouraged but celebrated. Together, we will continue to uphold the values of integrity, compassion, and excellence that define Lancashire Teaching Hospitals.

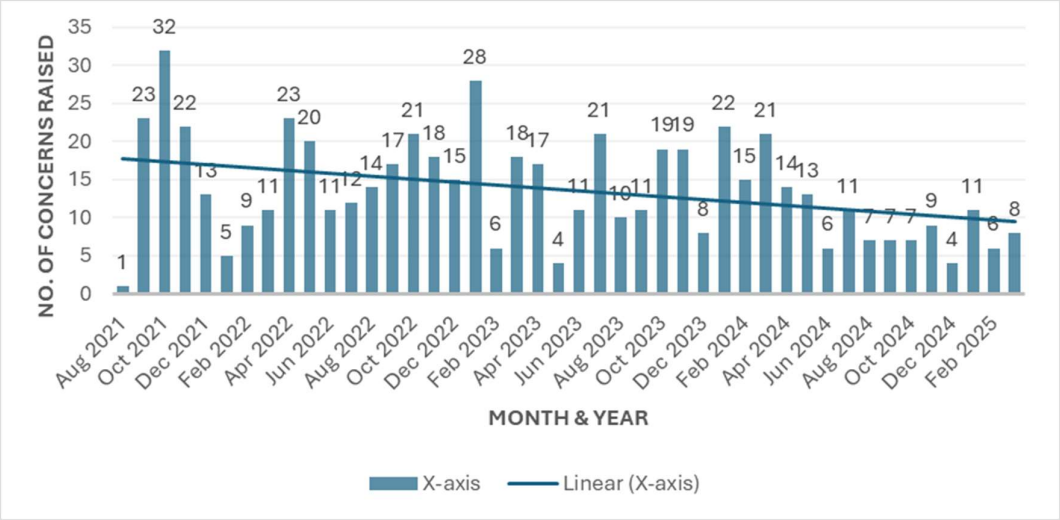
2.17.1 Service Delivery

Our FTSU service is designed to create a safe and supportive environment where staff can raise concerns confidently and without fear of retribution.
Here is how we deliver this vital service and support our colleagues

- **FTSU Guardian:** We have an appointed, dedicated FTSU Guardian who acts as an impartial and confidential advisor. They are available to listen to concerns, provide guidance, and ensure that issues are addressed appropriately.
- **Accessible Reporting Channels:** Staff can raise concerns through various channels, including direct contact with FTSU Guardians, email, phone, or through our online reporting system. This ensures that everyone has a convenient and comfortable way to speak up.
- **Training and Awareness:** We conduct regular training sessions and awareness campaigns to educate staff about the importance of speaking up and the support available to them. This helps to foster a culture of openness and transparency.
- **FTSU Champions**: We have a group of available FTSU Champions who work within our teams and services and are there as a source of support for colleagues who may be experiencing difficulties in their day-to-day working environment.
- **Confidentiality and Protection:** We prioritise the confidentiality of those who raise concerns and provide protection against any form of retaliation. Our policies ensure that all reports are handled appropriately.
- **Support and Follow-Up**: Once a concern is raised, our FTSU Guardians work closely with the relevant departments to resolve the issue. We also provide ongoing support to the staff member who raised the concern, keeping them informed throughout the process.
- **Board-Level Oversight:** Our Board of Directors actively oversees the FTSU service, ensuring that it remains effective and responsive. They are committed to creating an environment where all staff feel valued and heard.

By delivering our FTSU service through these comprehensive measures, we ensure that our colleagues are supported in raising concerns, ultimately contributing to a safer and more positive workplace for everyone.

Figure 6 Activity: Number of Concerns Raised Through the FTSU Pathway



The chart above details the number of concerns that have been raised with the FTSU Service since August 2021, which totals 600 (an average 13.6 per month). This represents the period where the Trust moved to the DATIX system for the accurate recording, monitoring and reporting of FTSU cases. The trendline indicates a steady reduction in the average number of concerns that have been reported during this period. In the period of April 2024 – March 2025, a total of 103 concerns were raised, an average of 8.6 per month. This represents a reduction of 36.8% per month. When compared to regional and national reporting trends, this sits conversely as there is largely an increase in reporting across these areas. There may be the presence of both positive and negative factors influencing the reporting rates, including:

- **Improved Workplace Culture**: If the overall workplace culture has improved, staff might feel that issues are being addressed more effectively through regular channels, reducing the need to use the FTSU service.
- **Fear of Retaliation:** Despite efforts to protect staff, some may still fear retaliation or negative consequences for speaking up, which can deter them from using the service.
- **Lack of Awareness:** There might be insufficient awareness or understanding of the FTSU service and its benefits among staff, leading to fewer reports.
- **Perceived Ineffectiveness**: If staff feel that previous concerns raised through the FTSU service were not adequately addressed, they might lose confidence in the system and be less likely to report issues.
- **Changes in Reporting Channels**: Enhancements to wider reporting processes and the introduction of new systems might temporarily reduce the number of reports as staff adjust to the changes or feel their concerns have been adequately dealt with elsewhere.
- **Workload and Stress**: Increased workload and stress can lead to staff feeling overwhelmed and less likely to take the time to report concerns.

Results from our most recent Staff Survey (2024) suggest that colleagues' perceptions around speaking up have become more negative overall:

- 58.5% of colleagues would feel safe to speak up about anything this concerns me in this

organisation (reduced from 62.8% in 2023).

- 44.2% of colleagues feel the organisation would address any concerns they raise (reduced from 50.1% in 2023).

Table 21 FTSU Themes of Concerns

	Overall Concerns %	Last 12 months %	Change (+/-) *
Adverse impact on Health and well being	48.1%	41.7%	-7.1%
Bullying and harassment – peer	9.3%	12.6%	+3.3%
Bullying and harassment-manager	12.3%	5.8%	-6.5%
Car Parking	5.5%	5.8%	+0.3%
Change in working conditions	7.2%	8.7%	+1.5%
Discrimination – age	0.2%	1%	+0.8%
Discrimination – disability	3.2%	5.8%	+2.6%
Discrimination – gender	0.8%	1%	+0.2%
Discrimination – race	2.5%	6.8%	+4.3%
Discrimination - sexuality	0.3%	0%	-0.3%
Environmental concern	4.7%	4.9%	+0.2%
Fraud/dishonesty	2.5%	2.9%	+0.4%
Lack of involvement/consultation	6%	13.6%	+7.6%
Lack of response from manager	17.8%	22.3%	-4.5%
Patient safety risk	22.3%	16.5%	-5.8%
Poor attitude and behaviour – manager	19.5%	18.4%	-1.1%
Poor attitude and behaviour – peer	14.3%	27.1%	+12.8%
Poor communication	9.7%	15.5%	+5.8%
Poor leadership	13.3%	22.3%	+9%
Professional concerns	20.3%	26.2%	+5.9%
Public safety risk	1%	0%	-1%
Transport	0.7%	1.9%	+1.2%
Unfair treatment/bias/breach of policy	28.2%	36.8%	+8.6%
Unsafe practice – individual	3.2%	1.9%	-1.3%
Unsafe practice – infection control	1.5%	1%	-0.5%
Unsafe practice – non-clinical	1.2%	2.9%	+1.7%
Unsafe practice – patient flow/bed management	1.3%	3.9%	+2.6%
Unsafe practice - Workwear compliance	0.5%	0%	-0.5%
Unsafe practice- clinical	5.3%	7.8%	+2.5%
Unsafe staffing levels	7%	3.9%	-3.1%

	Overall Concerns %	Last 12 months %	Change (+/-) *
Unwanted, inappropriate and/or harmful sexual behaviours (*Note – this was a new category added in 2024)	*	5.8%	*
Worker safety risk	12.3%	17.5%	+5.2%

Within this table the "+/-" symbol is employed to indicate changes in the volume of concerns reported across various categories.

- A "+" denotes an increase in the number of reports.
- A "–" denotes a decrease in the number of reports.

It is important to note that these changes do not inherently signify positive or negative developments. For instance, an increase in reports of bullying may indicate either a deterioration of the issue or an increased willingness among individuals to report concerns. Conversely, a decrease in reports may reflect actual improvements or alternatively, a reluctance or lack of safety in reporting.

The primary objective of monitoring these fluctuations is to gain deeper insight into emerging trends and to ensure that organisational responses are appropriately aligned to support all stakeholders.

Over the past year, we have observed notable shifts in the themes of concern reported through our FTSU service. These changes reflect evolving dynamics within our workplace and highlight areas where we need to focus our efforts to ensure a supportive and safe environment for all staff:

- **Adverse Impact on Health and Well-being**: Reports of concerns related to health and well-being have decreased from 48.1% to 41.7% (-7.1%). This reduction suggests improvements in workplace conditions and support systems, although continued vigilance is necessary to maintain and further enhance staff well-being.
- **Bullying and Harassment:** There has been a mixed trend in bullying and harassment reports. Peer-related bullying and harassment have increased from 9.3% to 12.6% (+3.3%), indicating a need for stronger peer support and conflict resolution mechanisms. Conversely, manager-related bullying and harassment have significantly decreased from 12.3% to 5.8% (-6.5%), suggesting progress in managerial conduct and leadership training.
- **Discrimination:** Reports of discrimination have shown varied changes. Discrimination based on race has notably increased from 2.5% to 6.8% (+4.3%), highlighting need for targeted interventions and diversity training. Discrimination based on disability has also risen from 3.2% to 5.8% (+2.6%), while age and gender discrimination have seen smaller increases. These trends underscore the importance of fostering an inclusive and equitable workplace.
- **Communication and Leadership:** Concerns about poor communication have risen from 9.7% to 15.5% (+5.8%), and poor leadership reports have increased from 13.3% to 22.3% (+9%). These changes indicate a need for enhanced communication strategies and leadership development programs to ensure clear, effective, and supportive interactions across all levels of the organisation.
- **Professional and Safety Concerns:** Reports of professional concerns have increased from 20.3% to 26.2% (+5.9%), reflecting ongoing challenges in professional conduct and standards. Patient safety risk concerns have decreased from 22.3% to 16.5% (-5.8%), suggesting improvements in patient care practices, although continued focus on safety protocols is essential.
- **Unfair Treatment and Bias:** Reports of unfair treatment, bias, and breach of policy have risen from 28.2% to 36.8% (+8.6%). This significant increase calls for continued review of policies and practices to ensure fairness and equity in all aspects of employment.

- **Worker Safety:** Concerns about worker safety have increased from 12.3% to 17.5% (+5.2%), indicating a need for enhanced safety measures and support systems to protect staff from harm.
- **New Category - Unwanted Sexual Behaviours:** The introduction of this new category in 2024 has resulted in 5.8% of reports, highlighting the importance of addressing and preventing inappropriate and harmful sexual behaviours in the workplace.

2.17.2 Key Priorities

In 2023-24, we reviewed and aligned our Freedom to Speak Up policies with national guidance, recruited champions, and established a network to support staff, especially from under-represented groups. We promoted speaking up, enhanced data use for identifying concerns, and strengthened contributions to Divisional Improvement Forums. Our Guardian actively participated in national and regional meetings, raised awareness during staff induction, and offered anonymity options for reporting concerns.

For 2024-25, we aimed to increase the Guardian's visibility, strengthen relationships with the Board and management teams, and contributed more to training resources, particularly in leadership development, to foster a culture of speaking up as a standard practice. Key areas for focus included:

- **Rebrand and Refresh**: New posters have been designed, approved, and distributed. The intranet page has been updated with new branding and additional information, pending further updates. Awareness sessions have been delivered to leaders, with more outreach planned. The video is in development, expected to be completed by May 2025. An online form for raising concerns is now fully operational.
- **FTSU Champion Support:** A new distribution list and database of contacts have been established, with training planned for May/June 2025. A new role description has been developed and communicated. Quarterly network meetings, triangulation of intelligence, resource packs, and staff survey outreach are underway. Representation across divisions is being reviewed, with further outreach planned based on staff survey data.
- **Policy & Processes**: A draft policy is being developed for comments in April 2025. Whistleblowing definitions and protecting staff from detriment have been included in the new policy. Strategic alignment with the cultural programme of work is in progress.

We will further focus on delivering these initiatives over the next 12 months to ensure continuous improvement and support for our staff.

PART 3 - Review of Quality Performance

3.1 Review of Quality Performance - Patient Safety

The Trust considers the safety of patients to be a key organisational priority. To ensure the organisation is a safe place for care and treatment, the Trust monitors performance against certain factors and continually aims to reduce and eliminate patient harm wherever possible.

In 2021, the Trust responded to the NHS National Patient Safety Strategy with Lancashire Teaching Hospitals' Always Safety First programme. During 2024-25, this programme has continued to be led by the CNO and CMO and supported by the Governance, Nursing and Continuous Improvement teams. The programme encourages staff to always consider safety across the organisation and has also included opportunities for lay representatives from the community to share their ideas.

This section of the Quality Account presents indicators relating to patient safety, clinical effectiveness and patient experience as outlined below.

In 2025, the strategy concluded, and plans have been developed to refresh and develop a 2025-2028 Always Safety First Learning Strategy. This action is also part of our Single Improvement Plan. The strategy will provide a structured approach that sets out how we will continuously improve patient safety through learning from incidents, near misses, and other sources of insight. It will also outline the vision, priorities, and actions needed to create a culture of safety, learning, and improvement across services.

Key areas of focus within the programme are as follows:

Table 22 Key areas of focus within the ASF programme

Patient Safety	Clinical Effectiveness	Patient Experience
• PSIRF • The Trust STAR programme. • Falls Prevention. • Safeguarding Adults. • Safeguarding Children. • Maternity Safeguarding and Safety. • Incident Management and Never Events. • Duty of Candour. • Becoming a Learning Organisation • VTE improvement work.	• The Getting it Right First Time (GIRFT) programme. • Tissue Viability – Pressure Ulcer Incidence and Prevention. • Nutrition for Effective Patient Care. • Medication Incident Monitoring. • Infection Prevention and Control. • C Difficile • Methicillin-resistant Staphylococcus Aureus	• Complaints and Concerns & Compliments. • The Parliamentary Health Service Ombudsman (PHSO) • Friends and Family Test (FFT) & Care Opinion • National Survey Results

• Safe Discharge improvement plan.	(MRSA). • Influenza and SARS coronavirus-2 (SARS-CoV-2) – COVID-19. • Mortality Surveillance and Learning from Neonatal, Child and Adult Deaths • Medical Examiner Service.	

3.1.1 The Patient Safety Incident Response Framework (PSIRF)

In line with the National Patient Safety Strategy, the Trust began its transition from the Serious Incident Framework to the Patient Safety Incident Response Framework (PSIRF) on 6 November 2023. PSIRF represents a significant shift in how the NHS responds to patient safety incidents, defined as "unintended or unexpected incidents which could have or did lead to harm for one or more patients receiving healthcare."

A key principle of PSIRF is the emphasis on learning. While some incidents qualify for a Patient Safety Incident Investigation (PSII) based on national or local priorities, others may be more appropriately addressed through alternative learning responses such as 'Being Open' conversations, After Action Reviews (AARs), or audits. The decision to undertake a PSII is based on the potential for system-level learning, although certain incident types, such as Never Events mandate a PSII under national guidance.

The Trust's PSIRF Policy and Patient Safety Incident Response Plan were developed and approved by the Board of Directors and endorsed by the ICB in October 2023. Implementation was delivered in two phases:

- **Phase 1** was implemented on 6th November 2023 and included implementation of patient safety incident investigations (PSIIs) for any patient safety events that met National and Local priorities.
- **Phase 2** was implemented on 25th March 2024, which included implementation of all learning responses.

In November 2024, both the PSIRF Policy and Response Plan were reviewed to ensure they remained current and aligned with the Trust's strategic direction. These documents are publicly available on the Trust's website.

Throughout 2024–25, the Trust has continued to embed PSIRF through a strengthened governance structure. This includes a two-tier triage system comprising a weekly incident triage meeting and a weekly executive-led oversight meeting. Learning from these processes is triangulated through the monthly Always Safety First Learning and Improvement Group, ensuring timely review, escalation, and shared learning from patient safety events.

To support national alignment and improve data quality, the Trust transitioned its incident reporting system Datix to align with the new national Learning From Patient Safety Events (LFPSE) platform, which will eventually replace the Strategic Executive Information System (StEIS). The Trust is also preparing to upgrade to LFPSE version 6.0, enhancing analytical capabilities and aligning with national standards.

Embedding Organisational Learning

A strong culture of learning has been central to the Trust's PSIRF implementation. Throughout the year, the Trust hosted a series of Community of Practice events, themed around insights from incident reviews. Topics have included infection prevention and control, listening to patients, leadership and safety culture, and care for patients with learning disabilities and autism.

Monthly leadership safety visits also provided real-time insights from clinical areas, focusing on key safety themes such as:

- Recognition and escalation of deteriorating patients
- Safety in areas with boarded beds
- Pressure ulcer prevention and the Purpose T tool
- Reasonable adjustments for patients with dementia, learning disabilities, and autism
- Venous Thromboembolism (VTE) risk assessments, fluid balance management, and World Health Organisation (WHO) surgical safety checklist compliance

Learning is shared widely through learning bulletins, clinical reference groups, and weekly leadership forums, with key messages translated into practical actions for teams. The STAR quality assurance programme is also updated biannually to reflect learning from incidents and highlight areas of positive practice that improve outcomes for both patients and staff.

Patient and Staff Engagement

The Trust remains committed to placing patients, families, and carers at the centre of its safety and learning processes. In 2024–25, a new Being Open Policy was launched, incorporating Duty of Candour and PSIRF engagement principles. The Trust also appointed three Patient Safety Partners (PSPs) in November 2023, who play a vital role in embedding patient perspectives into safety planning, risk identification, and improvement initiatives.

Recognising the emotional impact of safety events, the Trust is looking at ways to strengthen its staff debrief training and support, ensuring colleagues feel heard, supported, and valued throughout the incident response process. As part of this, the Trust is also encouraging greater use of SWARM reviews which are rapid, team-based debriefs conducted immediately after an incident to promote timely learning and empower frontline teams.

Looking Ahead: Priorities for 2025–26

In 2025–26, the Trust will carry out a full review of its PSIRF implementation to assess how effectively incidents are being responded to and whether learning is being translated into meaningful improvement. This will include a review of the current local priorities to ensure they remain relevant and aligned with the Trust's safety goals. The current local PSIRF priorities are:

- Delayed recognition of a deteriorating patient, due to gaps in monitoring (including all pregnant women).

- Delayed, missed or incorrect cancer diagnosis.
- Prescribing or administration error or near miss of anticoagulation medication.
- Adverse Discharge due to gaps in communication or misinformation.
- Delay in responding to a critical pathology finding.

Planned areas of focus for the year ahead include:

- Reviewing and updating local priorities.
- Enhancing Datix functionality to support better analysis of themes and trends.
- Strengthening systems for tracking safety actions and learning responses.
- Developing in-house training to build PSIRF capability.
- Launching post-incident engagement surveys to gather feedback from patients and families.

3.1.2 Safety Triangulation Accreditation Review (STAR)

The STAR Quality Assurance Framework is the organisation's audit, assurance, and accreditation system. STAR is reported as part of the accountability framework into Divisional Improvement Forums, in Safety and Quality Committee and the Board. Out of 123 registered clinical areas, 83% have achieved silver or above, and 71% have achieved gold stars.

As of 31st March 2025, there are no red star ratings, there are 21 amber ratings, and 102 green ratings, resulting in 21 bronze, 15 silver, and 87 gold stars.

Despite a decrease in silver and above ratings from 92% to 83%, this still exceeds the target of 75%. A new threshold for green ratings was introduced in July 2024, requiring all mandated critical standards to be met for progression to silver/gold. This change has led to a reduction in silver stars or above, but 20 areas have progressed to gold in the past year, with 3 more awaiting approval. The monthly STAR review provides insights into safety activities at the ward/department level.

The monthly STAR review assesses fundamentals of safety providing insight into activity at ward/department level on a monthly basis.

Figure 7 STAR Accreditation Trust-wide Compliance by Month

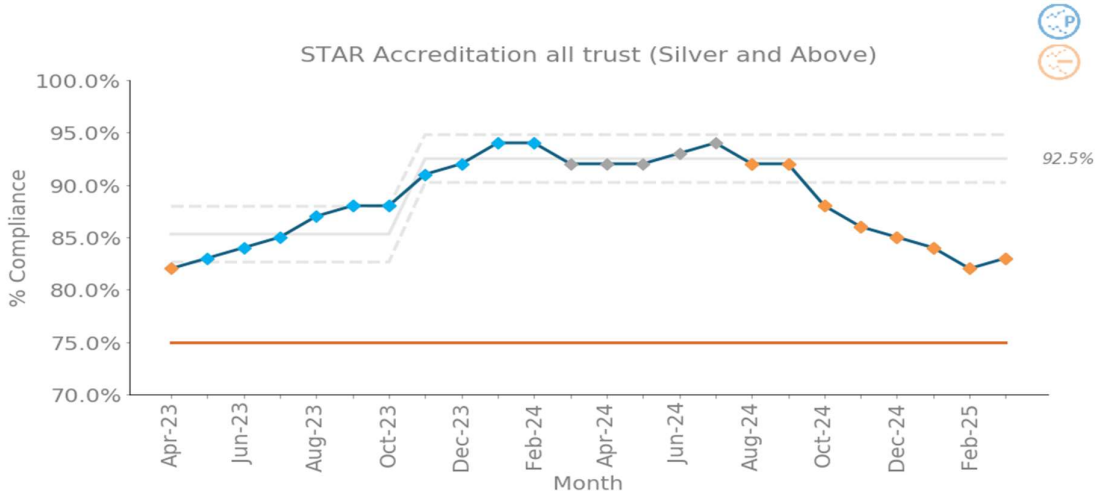
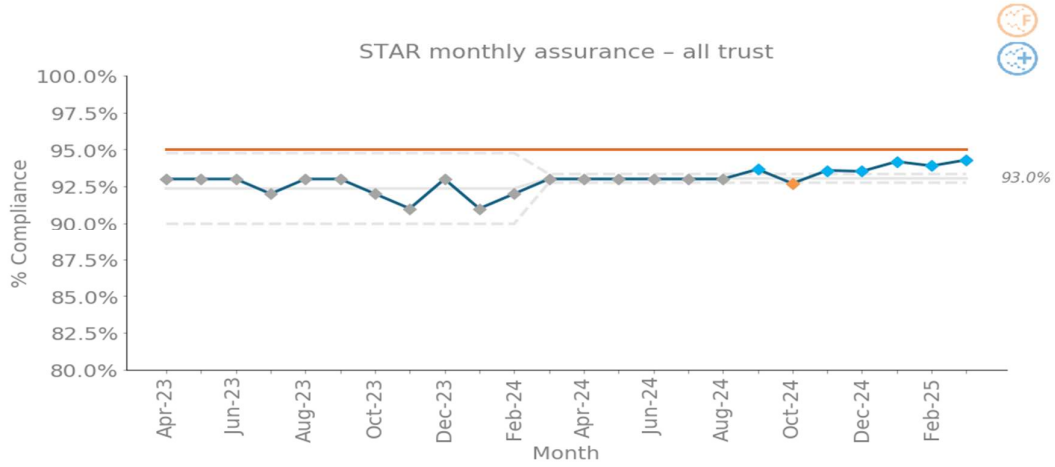


Figure 8 STAR Monthly Review Trust-wide Compliance by Month



3.1.3 Falls Prevention

Falls prevention continues to be one of our key priorities for improvement. 'Our Big Plan' target for 2023-24 aimed for a 5% annual reduction in falls. From 2024 onwards, falls prevention will be integrated into the SIP.

Throughout this reporting period, the Trust has continued to utilise the Falls Prevention Big Room,

employing continuous improvement methodologies developed through the Flow Coaching Academy. This initiative has been combined with the Deconditioning Prevention Big Room to drive team improvements.

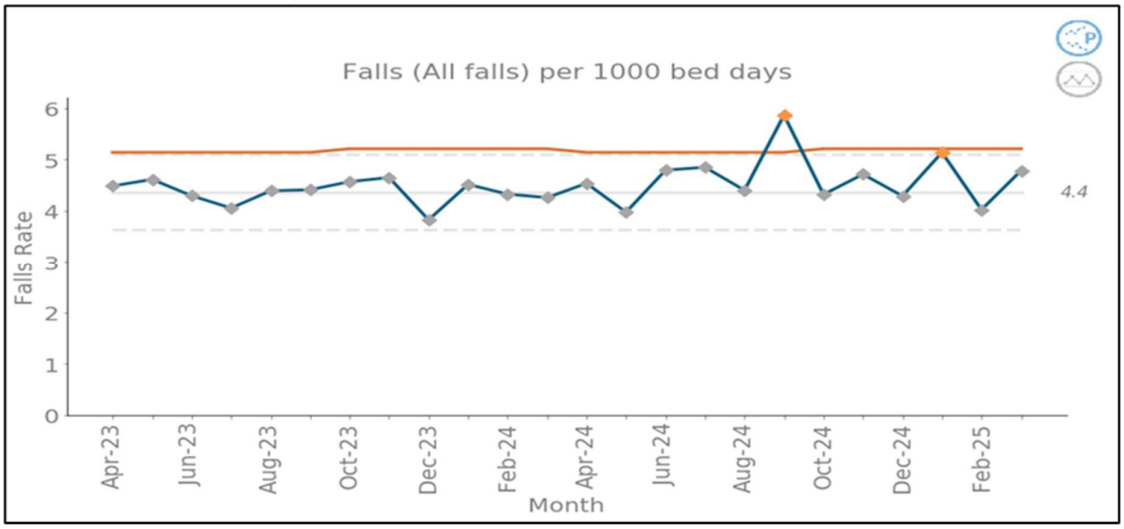
A Trust wide falls prevention improvement action plan is in place and is discussed during harm free care meetings. In February 2025, the Trust initiated work to enhance intentional rounding and levels of care, both of which are expected to contribute positively to reducing falls.

Figure 9 Falls Data 2024–25

- **Total inpatient falls** (excluding Community Healthcare Hub, Finney House Residential, and non-fall events such as faints, collapses, and seizures):
    - **2024–25:** 1,504 falls
    - **2023–24:** 1,443 falls
    - **Change:** Increase of **4.23%**
- **Falls resulting in major harm or above (severe harm or death):**
    - **2024–25:** 12 incidents (9 severe harm, 3 deaths)
    - **2023–24:** 17 incidents
    - **Change: Reduction** in high-harm falls

While the total number of falls has increased, it is important to note that this occurred alongside a rise in patient numbers and hospital occupancy. Therefore, the Trust uses falls per 1,000 bed days as a more accurate measure of performance. This metric provides a more stable and contextualised view of falls trends, as illustrated in Figure 10.

Figure 10 Inpatient falls per 1000 bed days (excluding assisted falls, faints, collapses, seizures, not including Community Healthcare Hub)



Source: LTHTR Datix data

3.1.3.1 Falls in the Community Healthcare Hub and Finney House Residential (2024–25)

During 2024–25, a total of 168 falls were reported across the Community Healthcare Hub and Finney House Residential, excluding assisted falls, faints, collapses, and seizures. This represents a reduction from 177 falls in the previous year. Of these, 2 falls resulted in severe or above harm.

These were reported as:

- Buttercup - 70 falls (includes 1 with severe harm)
- Meadow - 82 falls (includes 1with moderate harm and one with severe harm)
- Orchard (residential) - 16 falls (none resulted in severe harm)

The Community Healthcare Hub supports a high proportion of frail patients who are medically optimised but require further assessment, support, or rehabilitation prior to discharge. The rehabilitation process inherently involves a balance of risk, as patients work toward regaining independence.

A thematic review of falls in this setting has been completed, and a Falls Prevention Action Plan has been developed specifically for the Community Healthcare Hub. However, following a commissioning decision by the ICB, the Community Healthcare Hub is scheduled for closure in May 2025.

3.1.3.2 Falls Risk Management and Governance

Active risks related to increased inpatient falls and harm from falls are currently recorded on the risk registers for the following areas:

- Division of Surgery
- Division of Medicine
- ED
- Royal Preston Hospital
- Neurology
- Community Healthcare Hub

Falls prevention remains a standing agenda item in the ASF divisional meetings, Harm-Free Care meetings, and the ASF Learning and Improvement Group.

The Trust continues to prioritise falls prevention as a key component of the ASF Strategy, reinforcing its commitment to patient safety and continuous improvement.

3.1.4 Safeguarding (including Maternity, Children and Adults)

3.1.4.1 Lancashire Safeguarding Adult Board and Children's Safeguarding Assurance Partnership

In accordance with statutory requirements, the Trust maintains several key safeguarding positions. These include a Head of Safeguarding, Named Doctor for Safeguarding Adults, Named Doctor for Safeguarding Children, Named Nurses for both adults and children, and a Named Midwife. Additionally, the Trust employs a Lead for the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), who also oversees Dementia, as well as a Lead for Mental Health, Learning Disabilities, and Autism. This ensures that the safeguarding and vulnerable people agenda benefits from senior leadership in nursing, midwifery, and social work, providing strategic direction across all portfolio areas.

The safeguarding team comprises specialist roles, some of which are employed directly by the Trust, while others have been externally funded during 2024-25. These externally funded positions will continue into 2025-26.

3.1.4.2 Safeguarding Activity

The Safeguarding team hold a duty function to ensure a responsive all age service, with referrals of enquires into the team from Lancashire Teaching Hospitals NHS Foundation Trust, multi-agency partners, patients, families and carers. The diverse nature of the Safeguarding Team at the Trust encourages multi-professional and multi-agency working both within and outside of the Trust, and complex cases are worked between a number of colleagues including Safeguarding Leads/Practitioners, Domestic Violence Advisors, The Trust Mental Health, Learning Disability or High Intensity User (HIU) Practitioner, Police, North West Ambulance Service (NWAS), Social Care and commissioned mental health services.

The safeguarding team have ensured partnership and system working across Lancashire and South Cumbria. The Trust has been compliant with the requirements of the NHSE Safeguarding Accountability and Assurance Framework (2019) and met compliance with the NHSE updated framework (2024). The Trust is embedded into the local Children's Safeguarding Assurance Partnership (CSAP) and Lancashire Safeguarding Adults Board (LSAB), engaging in the process of multi-agency audit, learning into action and ensuring clear processes to safeguard our children, young people and adults.

The Safeguarding Team continue to attend multi-agency/ICB external meetings to support the safeguarding agenda for example, the Learning from Lives and Deaths – People with a learning Disability and Autistic People (LeDeR) Steering Group, Mental health Multi-agency Oversight Group, CSAP Performance, Assurance and Improvement Group, Lancashire Contextual Safeguarding Operational Group, LSAB Learning and Development Group, Pan-Lancashire Child Death Overview Panel, PREVENT forum along with additional sub-groups or task and finish groups.

Continuous improvement methodology has driven the approach and delivery of the safeguarding agenda and evidence of sustainability is obtained by robust audit activity, demonstrating lessons learnt, and ensuring improvements are embedded in practice. The safeguarding team attend a number of 'Big Rooms' led by continuous improvement, for example – the mental health big room, de-conditioning, nutrition and the violence and aggression big room.

The safeguarding team have embedded PSIRF to ensure learning including attendance to Learning Response review meetings and into the development/completion of PSII reports. Governance is ensured through divisional safeguarding meetings and escalation / assurance into the Safeguarding Board.

The upskilling of our staff has continued to be a priority for 2024-25 with each workstream providing training either face to face or via e-learning modules. Training compliance for Safeguarding Adults and Children is aligned with the Intercollegiate Document standards.

The 2024 CSAP Pan-Lancashire Section 11 Audit self-assessment rated the Trust as fully compliant across all key lines of enquiry, with the exception of training. The training domain was assessed as partially compliant due to the incomplete embedding of Trauma-Informed Practice.

To address this, the 2025–26 workplan includes full implementation of Trauma-Informed training. Notably, six members of the Safeguarding Team have completed the Train the Trainer programme, positioning the Trust to embed this approach more widely and sustainably.

3.1.4.3 Externally commissioned services

The Safeguarding Team benefits from three externally funded specialist roles that enhance support for patients and staff:

Table 23 Safeguarding Teams externally funded specialist roles

ED Navigator • Funded by: Violence Reduction Network • Commissioned until: 31 March 2026	• From April 2024 to March 2025, the ED Navigator received 233 referrals. Each referral is reviewed to ensure it meets criteria, followed by direct patient contact to offer support. • The ED Navigator has established and chairs the Lancashire ED Navigator Forum, which now includes services from Leeds, Huddersfield, Sheffield, and Rochdale, reflecting the growing regional interest in this model. • Two face-to-face conferences were organised using VRN funding, both of which were well-attended and received positive feedback.
Health Independent Sexual Violence Advisor (HISVA) • Funded by: Office of the Police and Crime Commissioner • Commissioned until: 31 March 2027	• Since starting in November 2023, the HISVA has received 135 referrals (April 2024 – March 2025), supporting patients aged 16+ following disclosures of current or historical sexual abuse. • The HISVA also supports Trust staff, contributing significantly to the Sexual Safety in the Workplace Charter. This has encouraged more staff to report inappropriate sexualised behaviour, which is addressed through the managing allegations process, promoting a safer and more respectful workplace culture.

Health Independent Domestic Violence Advisor (HIDVA) • Funded by: Office of the Police and Crime Commissioner • Commissioned until: 31 March 2026	• In the same reporting period, the HIDVA received 354 referrals, with a significant number involving Trust staff. Referrals often come from line managers, Occupational Health, or direct contact. • The HIDVA frequently provides long-term support, particularly for staff who view the workplace as a safe space.

3.1.4.4 Maternity Safeguarding Activity

Referrals to the Enhanced Support Midwifery Team (ESMT) have remained consistently high, with a slight decrease from 1,526 in 2023–24 to 1,497 in 2024–25. The team attended 197 strategy discussions during this period, representing a 23% increase from the 159 attended the previous year. Referrals involving 16-year-olds remained static at 13 cases. Mental health-related referrals decreased slightly from 671 to 639. However, there was a notable increase in cases of Female Genital Mutilation (FGM), rising from 40 to 53. A report on FGM activity has been submitted to the Safeguarding Board, and the ICB is currently reviewing this data in the context of Lancashire and South Cumbria.

3.1.4.4.1 Key Activities and Achievements

- The ESMT supported a Trust-wide awareness campaign, collaborating with the Reproductive Trauma Service (RTS) to promote understanding and access to maternal mental health support.
- The team also delivered two full days of safeguarding simulation training to third-year midwifery students at the UCLan. These sessions included a simulated postnatal home visit in forensic houses, designed to reflect real-life safeguarding concerns such as drug misuse, domestic abuse, mental health issues, neglect, unsafe sleeping environments, ICON (coping with crying babies), and unsafe home conditions.
- The Named Midwife for Safeguarding chairs the ICON Subgroup. In collaboration with the Blackburn with Darwen, Blackpool, and Lancashire Child Death Overview Panel (CDOP), the subgroup launched a digital media campaign titled “Hush Little Baby.” This campaign, delivered through ICON and Bauer Media, targeted adults across Lancashire and ran for six weeks starting on 12 August 2024, coinciding with ICON Week (23–27 September 2024).
- In partnership with NHS Charities, the ESMT successfully secured funding for a fixed-term contract to recruit two Young Person’s Midwives (supporting individuals aged 19 and under) and a Maternity Support Worker. These roles are expected to enhance continuity of care for young parents.
- The Named Nurse for Safeguarding Children and the Named Midwife are active members of the Safer Sleep Subgroup. During Safer Sleep Week 2025 (10–16 March), which is part of the Lullaby Trust’s national awareness campaign, the subgroup led a Pan-Lancashire initiative to promote safer sleep practices. This included professional and public engagement, as well as the launch of a new Professionals Toolkit and an eLearning package developed with support from the Trusts Blended Learning Team.
- The ESMT has received positive feedback from staff regarding the training delivered in collaboration with the corporate team during monthly Public Health Study Days. These sessions included contributions from colleagues in Learning Disability and Autism services and the HIDVA and were informed by learning from Child Safeguarding Practice Reviews (CSPR) and Domestic

Homicide Reviews (DHR). Future training will also cover the MCA and Deprivation of Liberty Safeguards (DoLS).

- Families have also shared positive feedback about the care they received from the ESMT. One particularly touching message was shared by the CDOP Chair, who relayed feedback from a family following the birth of twins. The family praised the Trust's safer sleep and ICON messaging, noting that staff were diligent in ensuring accurate advice was given. They also described the staff on the Neonatal Intensive Care Unit (NICU) as "superheroes," highlighting the compassionate and knowledgeable care provided.

3.1.4.5 Children and Young People

3.1.4.5.1 Summary of Safeguarding Activities

- Over the past 12 months, there have been many changes and improvements in relation to multi-agency working and collaboration. This is particularly evident in relation to close working and sharing of information and guidance with other acute Trusts as well as the ICB, Social Care and LSCFT. Relationship meetings with the Multi-Agency Safeguarding Hub (MASH), Duty and Assessment Team have assisted in sharing learning and discussion of challenging areas and cases. Close working with other acute Trusts and LSCFT has resulted in the production of a Neglect Tool which will be launched this year.
- Over the year, there has been increased joint working with the Sexual Assault Forensic Examination Centre (SAFE) Centre and attendance at Strategy Meetings for children where sexual abuse may have occurred. This has been vital for strengthening the links between SAFE Centre, Safeguarding and Paediatrics for the benefit of our children and young people and for enhancing the mutual support and knowledge of colleagues. Highlighting and working to improve our response to children at risk of sexual harm has been a large part of our work over the past year and this will continue.
- Safeguarding supervision has continued to be embedded across paediatric areas with a focus on social care referrals and thresholds, but with a focus upon case specific supervision.
- The Child Death Policy was updated this year. The primary updates related to the role of the Medical Examiner within neonatal and child deaths. Due to changes in process with neonatal deaths under 28 weeks old, a CDOP Failsafe Meeting has been developed which has improved links and information- sharing between Safeguarding, ESMT, Governance and the Bereavement Team. A process has been embedded to review the National Child Mortality Database (NCMD) thematic reports within the Mortality Meetings.
- There has been on-going work with Gynaecology, Safeguarding and the ESMT over this year. Work has been completed and the Paediatric-Gynaecology SOP updated as has the 'Was Not Brought (WNB)/Did Not Attend (DNA)' flowchart for termination of pregnancy. The Termination of Pregnancy proforma for Children and Young people has also been updated.
- The WNB Policy has been updated. Changes have included a section for dentistry, updates regarding the safeguarding process and trauma-informed practice and reasonable adjustments.
- There has been positive work in relation to Initial Health Assessments (IHAs) with our Child in Care Nurse at LTH and Doctors in developing ways to mitigate missed appointments and was not brought with a range of proactive strategies to encourage attendance. ICB Initial Health Assessment (IHA) Audit was completed with the Children in Care Nurse at the Trust to identify

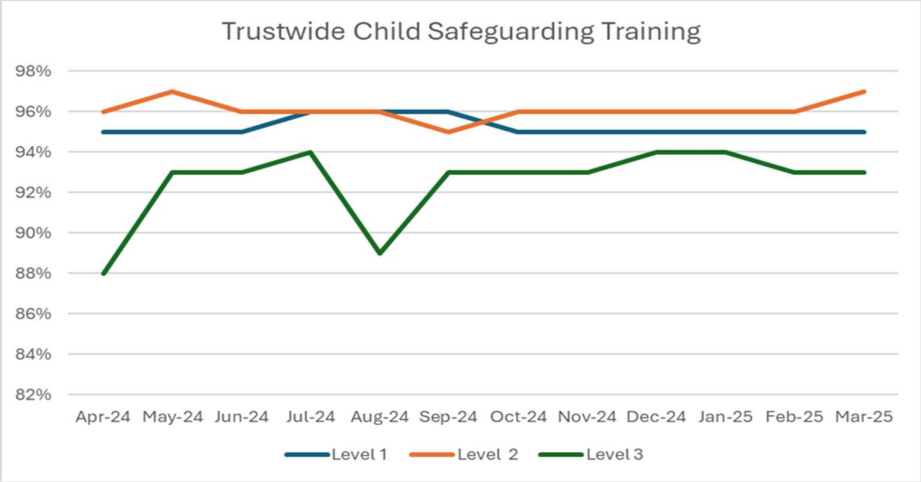
quality of data collected and advice given in IHAs. Initial feedback received and actions are now in place. Work will continue over the following year.

- The escalation pathway in regard to Children's Social Care has been successfully utilised over the past year, with three formal escalations in the past few months which have been resolved at Level one.
- The Safeguarding team have continued to support and be heavily involved in children and young people with complex social and health needs including where there are concerns in relation to fabricated and induced illness/perplexing presentations, medical neglect and our children in care where there may have been placement breakdown. The Children's Safeguarding Team have been commended for their proactive approach with complex children in care in our area and facilitating MDT, where there is high chance of ED attendance and complex support needs.

3.1.4.5.2 Child Safeguarding Training

Figure 11 shows Trust wide annual child safeguarding training levels 1 to 3. The training packages and training needs analysis are in accordance with the requirements of the Royal College of Nursing (RCN) Safeguarding Children and Young People: Roles and Competencies for Health Care Staff (2019). Child safeguarding training across Levels 1 and 2 has remained 95% and above, with level 3 training at 93% and above with decreases in April 2024 and August 2024 to below 90%.

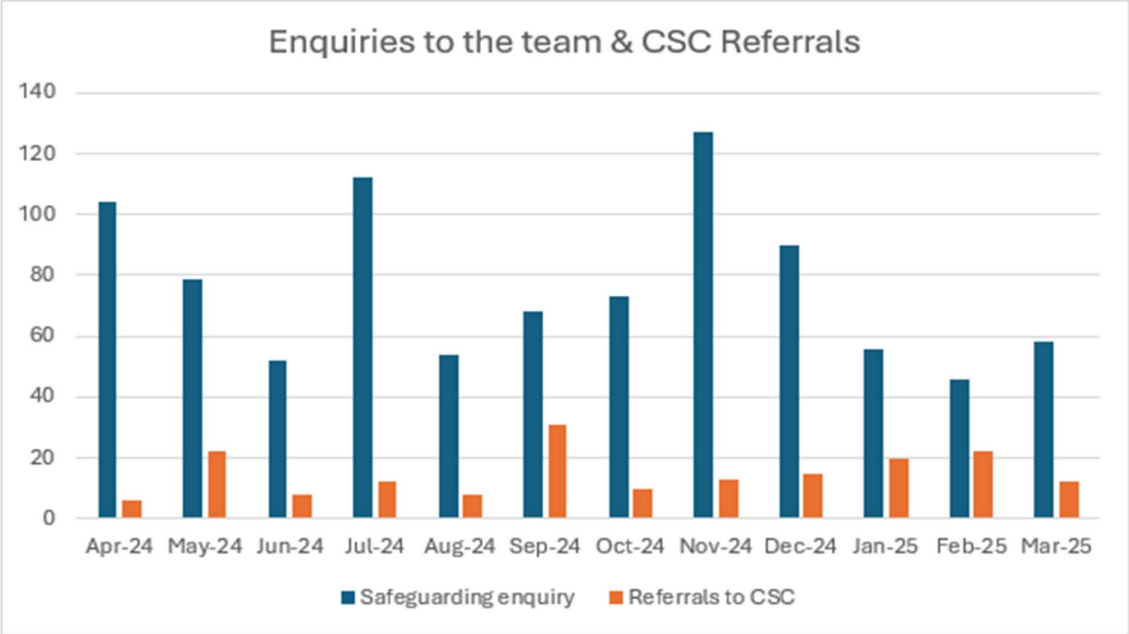
Figure 11 Child Safeguarding Training Mandatory Compliance



Source: LTHTR Datix data

3.1.4.5.3 Social care referrals

Figure 12 Referrals into the Trust Child safeguarding and Children's Social Care (CSC)



Source: LTHTR Datix data

3.1.4.5.4 Children's Social Care Referrals

Referrals to CSC have decreased in comparison to the previous year. In comparison to the previous year (183 referrals in 2022-23, 242 in 2023-24 and 179 in 2024-25). Work has been completed in recent months with Paediatric ED to ensure referrals are made and paediatric liaison and referrals sent to the safeguarding team for review. This has resulted in 22 referrals for the past 4 months from Paediatric ED, as opposed to 8 for the previous 8 months. The annual decline in children social care referrals is not deemed to be as a result of lack of safeguarding and identification but as a result of the number of children who are already open to children social care and multi-agency working.

3.1.4.5.5 Child Deaths

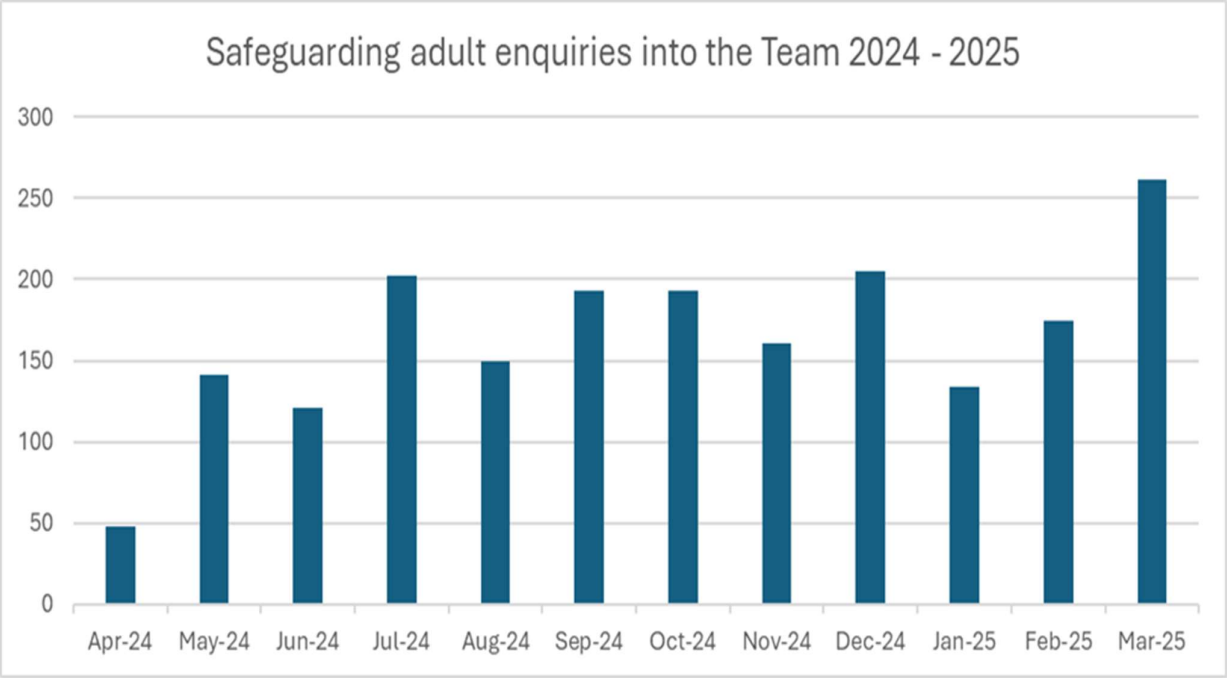
There has been a total of 34 child deaths between April 2024 and March 2025. This is an increase from the 28 in the previous year. Of these, 12 were classified as unexpected, while 21 were expected, and 1, following an uncomplicated pregnancy and birth, the newborn baby was diagnosed with a serious cardiac condition a few hours after birth which unrelated to the care provided and was transferred to another Trust for specialist treatment, where sadly they passed away. Of these expected deaths, 14 were neonatal deaths within the Trust, and several other expected deaths were in relation to neonatal babies known to us but who died at another Trust or Derian House. Unexpected deaths over this year have included Sudden Unexplained Death in Childhood (SUDC), two children who have completed suicide, one child who died of an overdose, and three children and young people who been the victim of significant trauma. The Child Mortality Review Meetings continue to be chaired by the Named Doctor for Children's Safeguarding. These meetings are now formally recorded, with actions monitored through the Women's and Children's Governance structure to ensure accountability and follow-up. The Safeguarding Team remains fully integrated into both internal investigations and

external multi-agency learning processes, including CSPRs. This collaborative approach ensures that learning from each case informs ongoing improvements in care and safeguarding practice.

3.1.4.6 Safeguarding Adult Activity

Referrals and enquiries are received through a variety of channels, including telephone, email, the Trust's Incident Reporting System, Datix, and a newly developed electronic in-patient referral system integrated within the electronic patient notes. Each enquiry is reviewed and responded to by the safeguarding duty practitioner, who either provides direct support or signposts the individual to the most appropriate service.

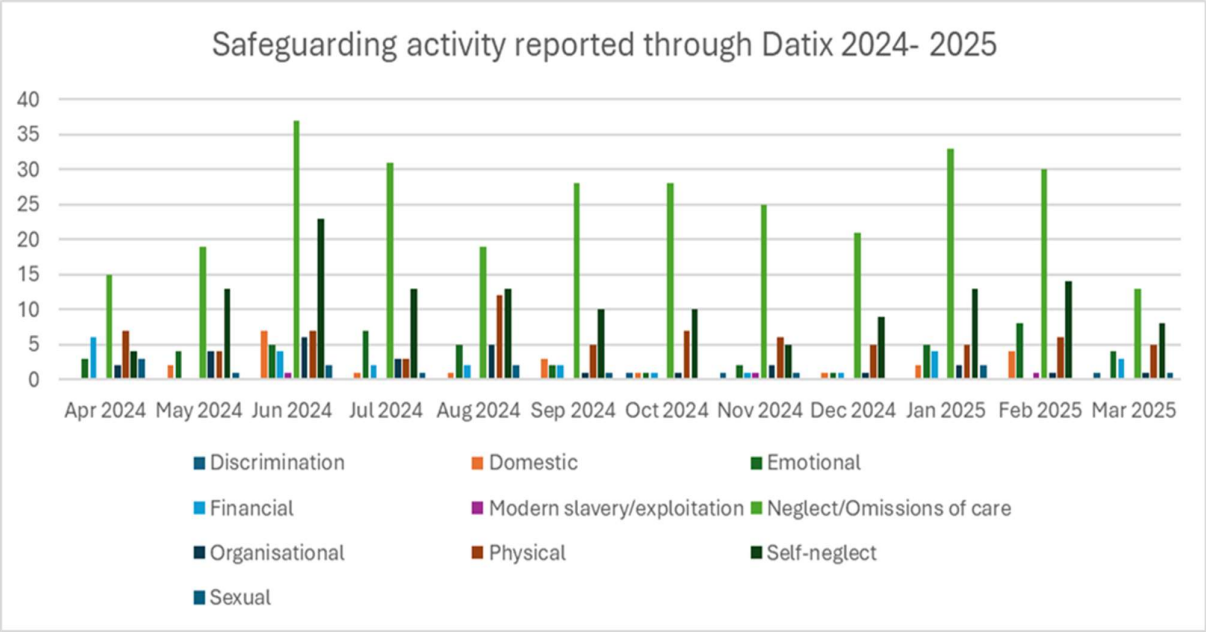
Figure 13 Safeguarding Adult enquiries



Source: LTHTR Datix data

Figure 14 below shows a summary of safeguarding concerns that have been reported through the Datix system from April 2024- March 2025. The most common themes are neglect, omissions of care and self-neglect. A large number of these concerns are identified on admission to hospital, early identification of safeguarding concerns allows discharge plans to be considered in a timely manner and reducing the risk of an increase in hospital stay.

Figure 14 Safeguarding activity reported through Datix



Source: LTHTR Datix data

3.1.4.6.1 Section 42 enquiries

A Section 42 enquiry, under the Care Act 2014, is a formal process initiated by a Local Authority when they suspect an adult in their area has needs for care and support, is experiencing or at risk of abuse or neglect, and is unable to protect themselves. The purpose of the enquiry is to determine if action is needed to prevent or stop the abuse or neglect, and if so, what action and by whom.

The Trust has a robust process that is followed upon receipt of a Section 42 notification from the Local Authority. The Adult Safeguarding Practitioners instigate an internal investigation and act as the link between the Trust and the Local Authority. While the majority of enquiries are responded to within the expected timeframes, there are occasions where additional internal or external investigations are necessary. In such cases, responses may fall outside the timescales outlined in the Care Act.

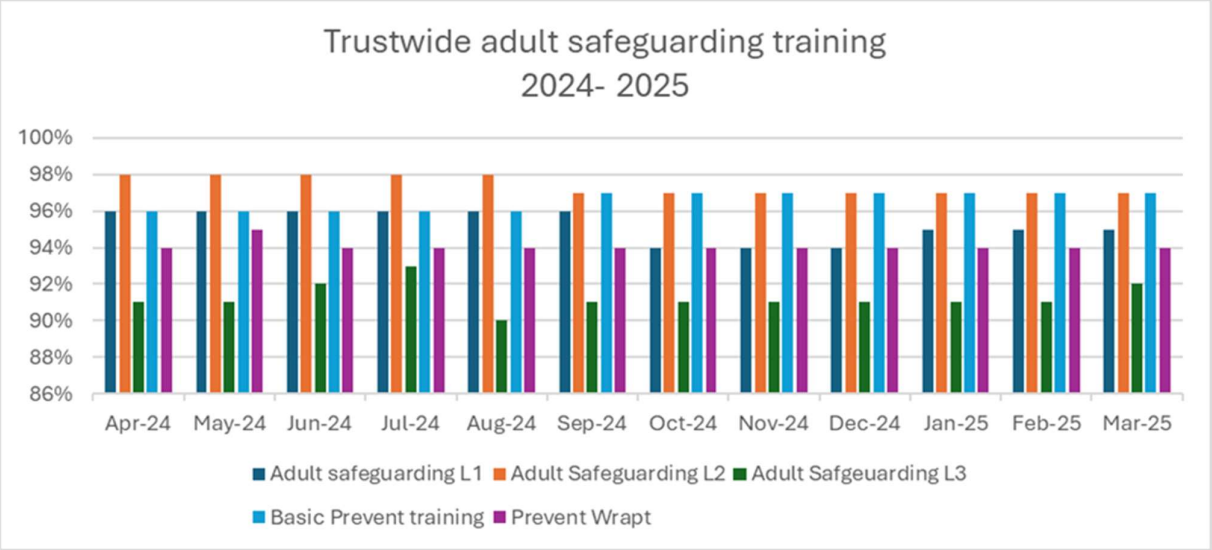
On completion of the internal investigation, an outcome is determined, either substantiated, unsubstantiated or partially substantiated, by the Trust. The outcome and the investigation, including any learning identified is sent to the allocated Social Worker at the Local Authority. However, delays in receiving final outcomes from the Local Authority continue to impact the Trust's ability to close cases within the Datix system. To address this, a link Social Worker from Lancashire County Council has been identified, and efforts are underway to strengthen collaboration and improve the timeliness of outcomes.

3.1.4.6.2 Adult safeguarding training & PREVENT

Figure 15 below shows the figures for safeguarding adults and PREVENT training compliance over the previous 12 months. The training matrix identifies colleague training requirements in accordance with the intercollegiate document. As seen below, training is consistently over 90% compliance in all areas. Training figures are reported by each division in the monthly safeguarding meetings and feed

into the Safeguarding Board. Any drops in compliance are discussed at Divisional Safeguarding meetings and action plans formed after identifying areas of concern. The PREVENT training compliance has consistently been above 90% throughout the year. The Trust submits PREVENT data around training, referrals, and attendance at meetings with multi-agency partners, this information is submitted quarterly to NHS Digital and feeds into national data sets. The Trust has submitted three referrals to PREVENT in the previous twelve months.

Figure 15 Adult safeguarding and PREVENT training



Source: LTHTR Datix data

3.1.4.6.3 Managing Allegations Persons in Position of Trust (PiPoT)

Over the past 12 months, the Deputy CNO has held the role of Named Person in Position of Trust (PiPOT) for the organisation. Plans are in place to transition this responsibility to the Head of Safeguarding in the near future.

The Safeguarding Team plays a key role in supporting both the workforce and Divisional Teams in managing allegations against staff where there is a potential risk to patients, colleagues, or the reputation of the Trust. This includes ensuring that all internal and external processes are followed and facilitating liaison with external agencies such as the Police, CSC, the Local Authority Designated Officer (LADO), and Adult Social Care.

The Managing Allegations Policy has recently been revised to incorporate learning from the Lucy Letby case and recommendations from the MIAA report. These updates aim to strengthen the consistency and robustness of the Trust's approach to managing allegations.

To support this, the Safeguarding Team conducts a monthly audit of managing allegations cases recorded in the Datix system. The audit focuses on monitoring compliance with documentation standards, particularly the timely uploading and updating of relevant records. This process was introduced following MIAA's identification of documentation gaps within Datix.

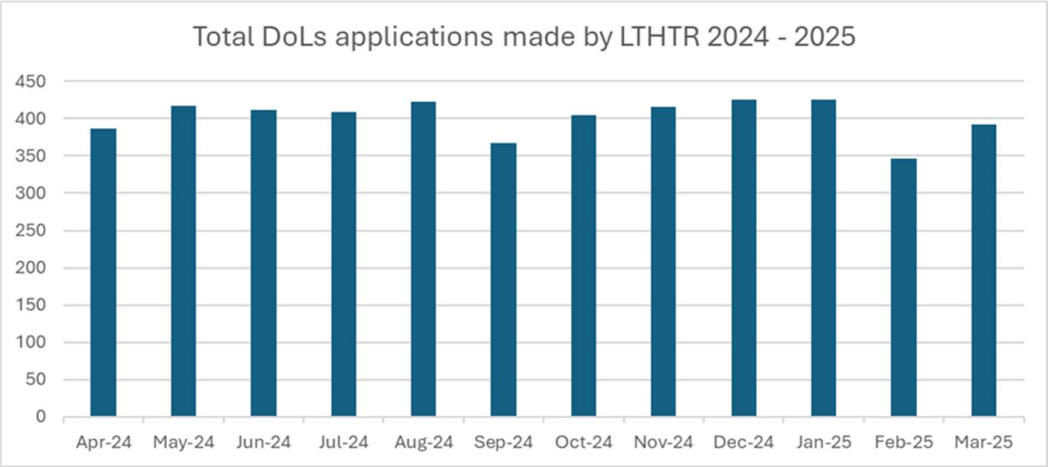
The audit findings have shown month-on-month improvements in compliance, reflecting the effectiveness of the revised processes. As a result, the audit will now move to a bi-annual schedule.

3.1.4.6.4 Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) Trust wide and DoLS Activity

The Trust continues to use the electronic MCA/DoLS pathway as successfully achieved through the previous MCA/DoLS ASF project for the patient's journey during admission/attendance as per the requirements of the Mental Capacity Act (2005). The system design implemented captures cognitive assessment, best interest decision making, least restrictive practice and deprivation of liberty.

Figure 16 highlights the number of DoLS applications by the Trust for 2024-25.

Figure 16 Total DoLS applications 2024-25



Source: LTHTR Datix data

From April 2024 to March 2025 there was a total of 4,823 DoLS applications made by the Trust. This is similar to the number of applications made in the year 2023-24, however an increase of 41% from the year 2022-23.

3.1.4.6.5 Safeguarding Supervision

The Safeguarding Supervision policy has been reviewed as a result of an MIAA which has driven further clarity around roles and the implementation of safeguarding supervision. A quarterly report is provided to the safeguarding board.

3.1.4.6.6 Mental Health, Learning Disabilities, Autism and Dementia

The Mental Health, Learning Disability, Autism, and Dementia Team continues to play a vital role in supporting some of the most vulnerable patients accessing care within the Trust. Embedded within the Safeguarding Team, the service is responsible for driving continuous improvement, enhancing staff knowledge and skills, ensuring compliance with statutory frameworks including the Mental Health Act, MCA and Children's Act and promoting a positive patient experience.

The team includes a HIU Lead and also holds the role of Special Educational Needs and Disabilities (SEND) Champion for the Trust.

A key focus over the past year has been the implementation of the Safeguarding SIP, aimed at improving the experience of patients with mental health needs, learning disabilities, and/or autism. This has included a strong emphasis on reducing the use of restraint and restrictive practices, and on building staff capability through:

- **Training Initiatives**: These include simulation-based learning (e.g., the Dementia Bus), the development and rollout of Tier 2 dementia training, trauma-informed care training, and a new mental health awareness course developed in partnership with Maudsley Hospital, launching in May 2025. The course will focus on de-escalation techniques and one-to-one care. Compliance with the Trust's Learning Disability and Neurodiversity e-learning remains high, supported by Champion events involving individuals with lived experience.
- **Patient and Family Engagement**: Resources have been developed to support patient debriefs and collaborative reviews with families and carers, helping to identify both helpful and unhelpful approaches to care.
- **Data and Governance:** Live dashboards have been developed using Datix to monitor incidents and trends in rapid tranquilisation, physical restraint, and self-harm. These dashboards allow for disaggregation of data for patients with learning disabilities or autism. A revised Rapid Tranquilisation Policy has been implemented, supported by ward-specific checklists and audits to ensure MCA compliance and evidence of de-escalation.
- **Feedback Mechanisms**: Bespoke feedback tools have been introduced, including a Children's Emotional Health Family FFT and a tailored FFT for the Emergency Department.
- **Governance and Assurance:** Audit findings related to rapid tranquilisation and restraint are reviewed monthly at Divisional Safeguarding meetings and escalated to the Safeguarding Board. Prescribing compliance is also reported to the Medicines Management Governance Group.
- **Security Process Review:** Trauma-informed training has been introduced for the security team, who now report directly into the Safeguarding Board.

Broader initiatives have also included:

- **Hospital Passports:** Developed in collaboration with autistic community groups and the Autism Partnership Board, these passports focus on sensory needs, communication preferences, and reasonable adjustments.
- **SEND Improvement Group:** A monthly forum with divisional representation continues to respond to findings from the SEND CQC and Ofsted inspection.
- **Collaboration with Martha's Rule:** The team works closely with the lead for the Trust's "Call for Concern" initiative, attending the Learning Disability and Autism Partnership Boards to improve communication and physical health assessments.
- **Training Compliance and Future Planning:** Trust-wide compliance with Learning Disability and Neurodiversity e-learning stands at 98%. A training needs analysis is underway, and the team is actively engaged with ICB and NHSE to implement the Oliver McGowan training in the coming year.
- **Autism Plan 2024:** Launched as part of the Safeguarding SIP, the plan outlines a comprehensive approach to improving care for autistic individuals.
- **Audit and Reporting:** Audits have been conducted on the completion of the Trust's Mental Health Risk Tool and mandated e-learning, with findings reported to the Safeguarding Board.

- **Reasonable Adjustment Needs Tool:** The team continues to develop this tool to ensure personalised care planning and accessibility for all patients requiring adjustments.

3.1.5 Incidents

Trust staff are proactively encouraged to report all incidents including near misses and no harm to enable increased opportunity to identify themes and trends before harm occurs to patients. Our incident data with associated levels of harm from incidents reported in 2024-25 is presented in table 22 below.

The percentage of incidents with a harm level of moderate and above is 2.5%, which is a decrease from 3% in last year's quality account. The Trust continues to respond with actions and learning in order to reduce incidents across all levels of harm.

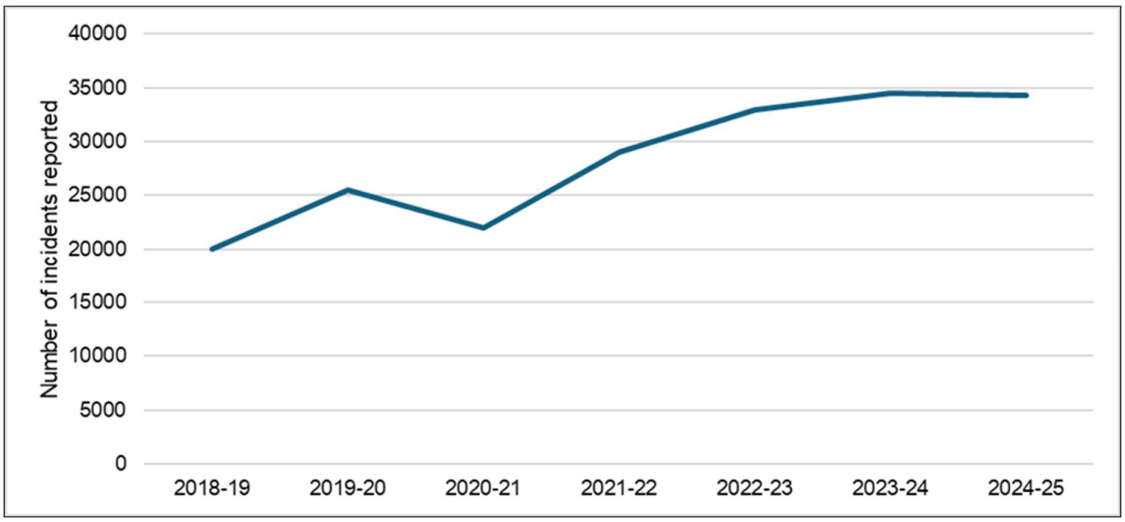
Table 24 Level of Harm Related to Incidents 2024-25

Trust Attributable Level of Harm	Number of Incidents Reported
No Harm	24,919
Low Harm	8,464
Moderate Harm	788
Severe Harm	53
Death	22
Total	34,246

Source: LTHTR Datix data

The Trust's incident reporting has over successive years continued to improve, with the reporting levels plateauing between 2023-24 and 2024-25, which is demonstrated in figure 17 below.

Figure 17 Incidents Reported 2018-19 to 2024-25



Trust staff are proactively encouraged to report all incidents including near misses and no harm to enable increased opportunity to identify themes and trends before harm occurs to patients.

Data as of 2nd April 2025 and subject to change as investigations progress and DOC processes proceed.

3.1.6 Never Events

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. They can lead to serious adverse outcomes and can damage patients' confidence and Trust. All Never Events are subject to consideration for a PSII (under the new PSIRF framework that was implemented within the Trust from 6th November 2023) and reported to the local ICB, as well as nationally, to incident reporting systems where learning can be shared across the country. All three never event investigations for those reported in the period April 2024 to March 2025 have been completed, with two of them having ongoing action plans and one with a completed action plan.

The Trust has an ASF work stream to review actions from all Never Events both for compliance with initial target completion dates and for quality of evidence. Never Events have been added to our 'Learning to Improve' programme to ensure that actions and learning are embedded over time and participation in a regional learning event has taken place to share learning across organisations.

Table 25 Never events incidence April 2024 to March 2025

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.

3.1.7 Duty of Candour

Duty of Candour is a regulation that has been applicable to health service organisations since November 2014 in response to the Francis report (2013) which stated that “any patient harmed by the provision of health care service is informed of the fact and an appropriate remedy offered regardless of whether a complaint has been made or a question asked” (Francis 2013).

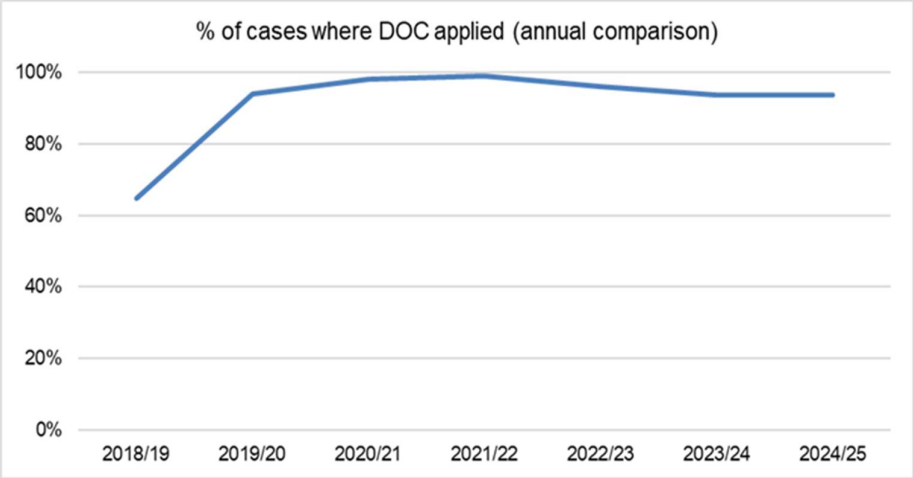
In 2024–25, the Trust identified 618 cases where Duty of Candour was applicable. This represents a 34% decrease compared to the previous financial year.

- 578 cases (93.5%) were completed, with communication provided either verbally or in writing to the patient or next of kin.
- 22 cases (3.5%) had documented and validated reasons for non-completion.
- 18 cases (3%) remain in progress.

This data reflects the Trust’s continued commitment to transparency and learning, in line with the principles set out in the Francis Report (2013) and the Duty of Candour regulation introduced in 2014.

Figure 18 demonstrates sustained level of Duty of Candour application between 2023-24 and 2024-25.

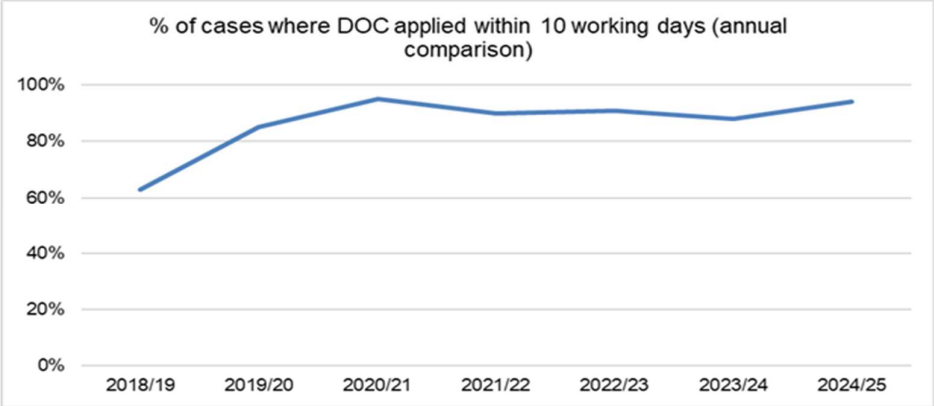
Figure 18 Percentage of Cases with Duty of Candour Applied (Annual Comparison)



Source: LTHTR Datix data

Figure 19 demonstrates an improvement in the timeliness of application of Duty of Candour within 10 working days between 2023-24 and 2024-25.

Figure 19 Percentage of Cases with Duty of Candour Applied in 10 Working Days



Source: LTHTR Datix data

Over the past year, the Trust has taken meaningful steps to strengthen its approach to Duty of Candour, particularly following the introduction of PSIRF in November 2023. A key development was the launch of a new Being Open Policy, which replaced the previous DoC policy. This updated policy aligns with PSIRF principles 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 introduced the role of the Engagement Lead, who supports communication with patients and families during investigations.

To support consistent and timely application of Duty of Candour, the Trust Incident and Risk Management System, Datix was enhanced to improve documentation and tracking. The Corporate Governance team also introduced daily and weekly situation reports and delivered targeted training sessions, which have contributed to measurable improvements in compliance.

Monitoring of Duty of Candour is now embedded in the Trust's governance processes. Compliance is reviewed weekly through the PSIRF Oversight Panel, where divisions are encouraged to escalate any anticipated exceptions or seek support. In addition, monthly performance is reported through the Safety and Quality Dashboard to the Safety and Quality Committee, ensuring continued oversight at the highest level.

The Trust remains committed to strengthening compliance with both Part 1 (initial notification) and Part 2 (sharing findings) of the Duty of Candour regulation. This includes ensuring that patients and families are promptly informed when harm occurs and receive a full, honest explanation and apology.

3.2 Review of Quality Performance - Effective Care

The Trust aims to continually provide effective care and treatment by ensuring clinical practice is evidence-based against national standards and clinical research. Being involved with national quality and benchmarking programmes including Getting it Right First Time (GIRFT) gives us opportunities to benchmark our services and improve our outcomes. Tissue viability and pressure ulcer prevention, nutritional support, management of medications and infection prevention and control are critical to the effective care and treatment of our patients.

The Trust also closely monitors mortality benchmarking data to ensure there are no emerging risks and we also learn from the deaths of patients to inform change and improve practice where required. The Medical Examiner service provides an independent review of the care and treatment of patients who have died in our Trust. Requests from the Medical Examiner to undertake a SJR Mortality Review or Serious Incident Investigation (or consider for a PSII under the PSIRF model) are responded to and learning shared.

The following sections provide details on a number of areas that support the Review of Quality Performance.

3.2.1 Getting It Right First Time (GIRFT)

The Trust remains committed to improving patient outcomes through active participation in the Getting It Right First Time (GIRFT) programme. This national initiative supports the delivery of high-quality, evidence-based care by enabling services to benchmark performance, identify variation, and implement targeted improvements.

Table 26 Key GIRFT Activities in 2024–25

Non-Ambulatory Fragility Fracture (NAFF) Pathway	A dedicated task force, led by Dr. Kate Davies, has been established to enhance care under the NAFF pathway. The group is focused on analysing current practices, setting measurable targets, and monitoring progress to drive improvements in the management of fragility fractures. The task force also promotes knowledge sharing and cross-divisional collaboration to ensure a unified approach to patient care.
Anaesthesia and Perioperative Medicine (APOM) Review	A follow-up meeting for the Lancashire and South Cumbria ICS Clinical Gateway Review was held in November 2024. This session reviewed the APOM ICS data pack, with a focus on Day Case, Elective, and Non-Elective care. The review identified best practices, challenges, and recommendations for service improvement.
Children and Young Adults (CYA) Diabetes System Review	In December 2024, the Trust participated in the L&SC ICS GIRFT System Review for CYA Diabetes. This review focused on the transition of care for patients aged 0–18 years and 19–25 years, with an emphasis on improving continuity and outcomes during this critical period.
Establishment of GIRFT Steering Group	A GIRFT Steering Group has been formed to oversee the delivery of GIRFT initiatives across the Trust. The group ensures that each specialty aligns with GIRFT objectives and contributes to the Trust's Waste Reduction Plan (WRP). Clinical and managerial representatives from each division meet regularly to provide progress updates, review opportunities identified through the Model Health System and integrate these into divisional action plans.

3.2.2 Tissue Viability - Pressure Ulcer Incidence and Prevention

3.2.2.1 Pressure Ulcer Incidence

Pressure ulcer incidence is a globally recognised indicator of patient safety and care quality. Reducing pressure ulcers remains a key priority for the Trust.

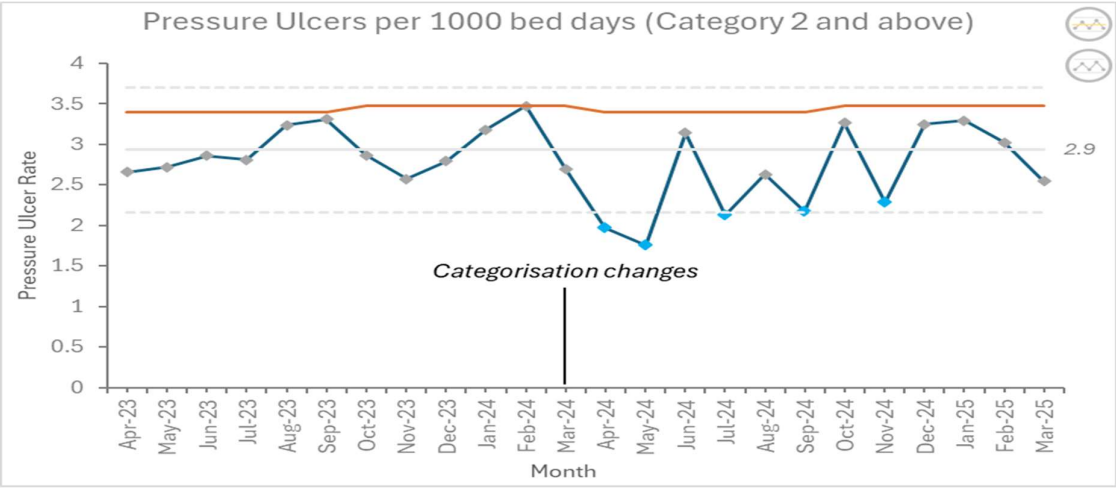
Since 2018, the Trust has seen a rise in pressure ulcer incidents. This increase is attributed to several complex factors, including:

- Higher patient acuity and frailty
- Longer stays in the Emergency Department (ED)
- Increased hospital bed capacity and patient boarding
- Extended hospital stays

Pressure ulcer data is monitored using the metric of incidents per 1,000 bed days, which allows for accurate comparison relative to Trust activity levels. To track trends over time, the Trust uses a Statistical Process Control (SPC) chart.

In March 2025, the Trust aligned its reporting practices with the latest National Guidance, which included the removal of Potential Deep Tissue Injury (PDTI) as a reportable category. This change has had a direct impact on reported figures, resulting in a noticeable reduction in pressure ulcer incidence rates.

Figure 20 Pressure Ulcer Incidents per 1,000 bed days April 2023- March 2025



The orange target line on the SPC chart represents the average number of pressure ulcers per 1,000 bed days, calculated from data over the previous three years.

Following the reporting change in March 2025, which excluded PDTI as a reportable category, a decrease in pressure ulcer incidence was observed. This reduction was expected due to the revised classification criteria.

In April 2025, the Trust will reset its target using data from the most recent 12 months to ensure alignment with the updated reporting standards.

3.2.2.2 Pressure Ulcer Improvement Plan

Despite the statistical decline, the Trust continues to place a strong emphasis on clinical care interventions, reinforcing its commitment to pressure ulcer prevention and maintaining high standards of patient safety and care quality.

In March 2024, the Trust launched a comprehensive Pressure Ulcer Reduction Improvement Plan, aligned with the National Wound Care Strategy Programme (2024). Key initiatives include:

- **Education and Training**
  - Two new e-learning modules tailored to staff roles in risk assessment
  - Mandatory e-learning every two years
  - Pressure ulcer prevention training for healthcare assistants during induction
  - Revised preceptorship program to include all professional groups
  - Student SPOKE days and interprofessional learning (IPL) sessions with Tissue Viability Nurses (TVNs)
  - Quarterly wound care training for staff involved in assessment and care
  - Ward-specific training with TVN participation
- **Strengthened Governance**
  - Weekly divisional reviews of all Trust-acquired pressure ulcers
  - Monthly ASF meetings to share learning and identify trends
  - Enhanced review process aligned with PSIRF principles, addressing concerns raised by the TVN team
  - Patient involvement in incident reviews via the Datix system
- **Clinical Practice and Equipment**
  - Ongoing review of ED equipment and monthly staff training
  - Twice-yearly Tissue Viability link practitioner days
  - Pressure ulcer prevention champions program under review for improved learning methods
  - Use of wound photography to support timely reviews and reduce dressing changes
  - Monitoring and trailing of specialised equipment, including static seat cushions for amputee patients

3.2.3 Nutrition for Effective Patient Care

The Trust's commitment to high-quality nutritional care is supported by the 7-day Integrated Nutrition and Communication Service (INCS). This multidisciplinary team includes:

- Nutrition Nursing Team
- Dietitians
- Speech and Language Therapists
- Central Venous Access Team
- Tobacco and Alcohol Care Team (formerly Hospital Alcohol Liaison Service)
- Nutritional Screening

3.2.3.1 Nutritional Screening

A key objective is to ensure that all patients (excluding maternity and day-case) admitted for more than 48 hours receive a nutritional screening assessment on admission. This is conducted using the Malnutrition Universal Screening Tool (MUST), developed by the British Association for Parenteral and Enteral Nutrition. The tool identifies patients who are malnourished or at risk and guides referrals for dietetic assessment or alternative care plans. Compliance is monitored through the STAR quality assurance system.

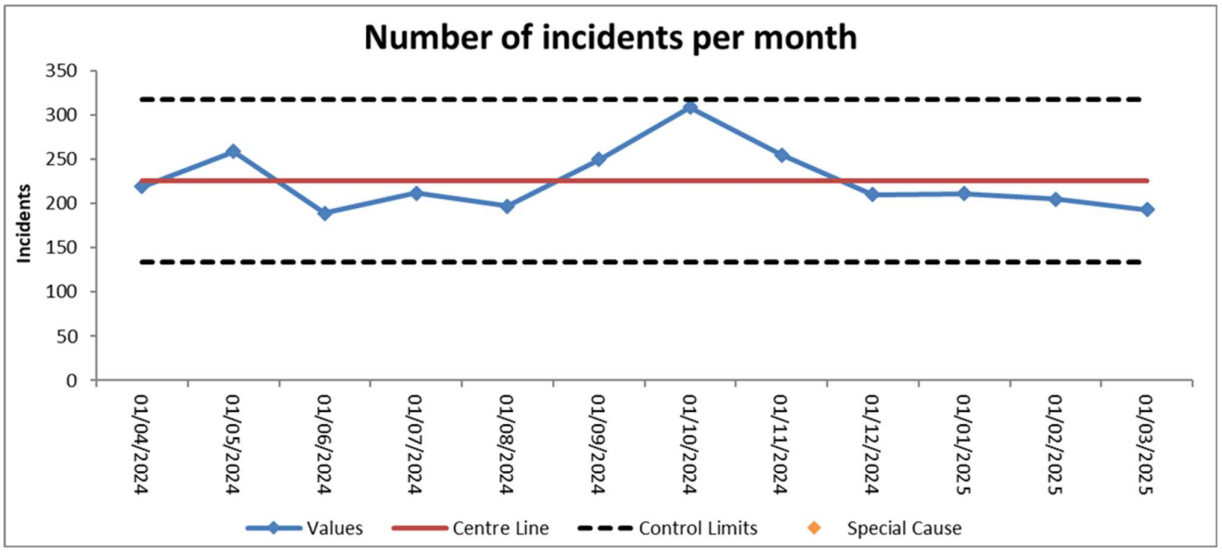
3.2.4 Medication and Incident Monitoring

3.2.4.1 Medicines Safety

At Lancashire Teaching Hospitals Pharmacy Department, medication safety is a major focus, with ongoing efforts to enhance systems and processes to minimise the occurrence of medication errors and their impact on patient safety. The Pharmacy Medication Safety team is actively involved in fostering a culture that encourages incident reporting, in line with the principles of PSIRF. The Trust's incident reporting system enables prompt reporting, thorough investigation and recording of medication errors and learning actions which have been taken.

From April 2024 to March 2025, medication incidents represented an average of 7.97% of all reported Trust incidents, with an average of 225 incidents reported per month. This reflects a 12% decrease compared to the previous year's monthly average of 258 incidents, which demonstrates a positive reporting culture.

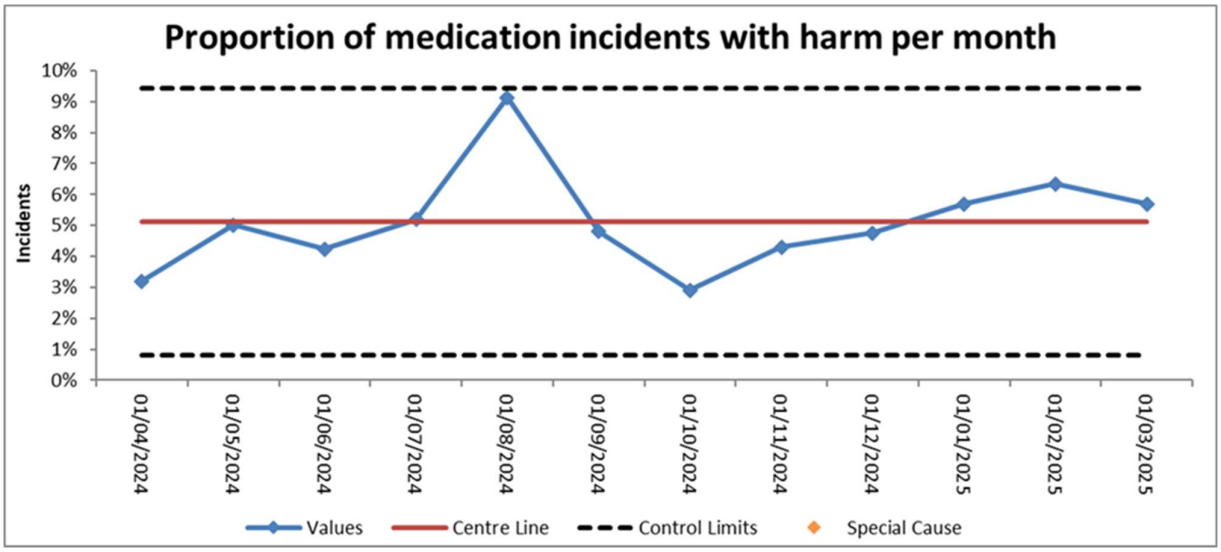
Figure 21 Number of medication incidents per month



Source: LTHTR data

The average number of medication incidents reported to have caused harm during 2024-25 was 5%. This is below the national average.

Figure 22 Proportion of medication incident with harm per month



Source: LTHTR data

3.2.4.2 Medication Safety Governance and Proactive Monitoring

The Trust has implemented a robust system for the timely review of medication incidents in line with the PSIRF. This process is led by the Corporate Governance Team, supported by the Medication Safety Team and Divisional Governance Leads, through weekly governance meetings. The approach prioritises early intervention, enabling the identification and dissemination of key learning and safety information prior to the conclusion of formal investigations, ensuring swift action and system-wide learning.

To proactively address medication safety, the Trust shares incident themes with relevant divisions and presents Medication Safety Reports during ASF meetings. A network of Medication Safety Champions, supported by the Medication Safety Team, meets monthly to exchange knowledge and serve as a platform for education and improvement.

In addition, the Trust conducts monthly performance monitoring, reporting on harm and near-miss trends to the Medicines Governance Committee. This committee operates within a risk assurance reporting cycle, aligned with the Trust's broader Risk Management agenda. This proactive and structured approach to medication safety enables continuous process improvement, harm reduction, shared learning, and the delivery of safe and effective care for all patients.

3.2.4.3 Medicines Reconciliation

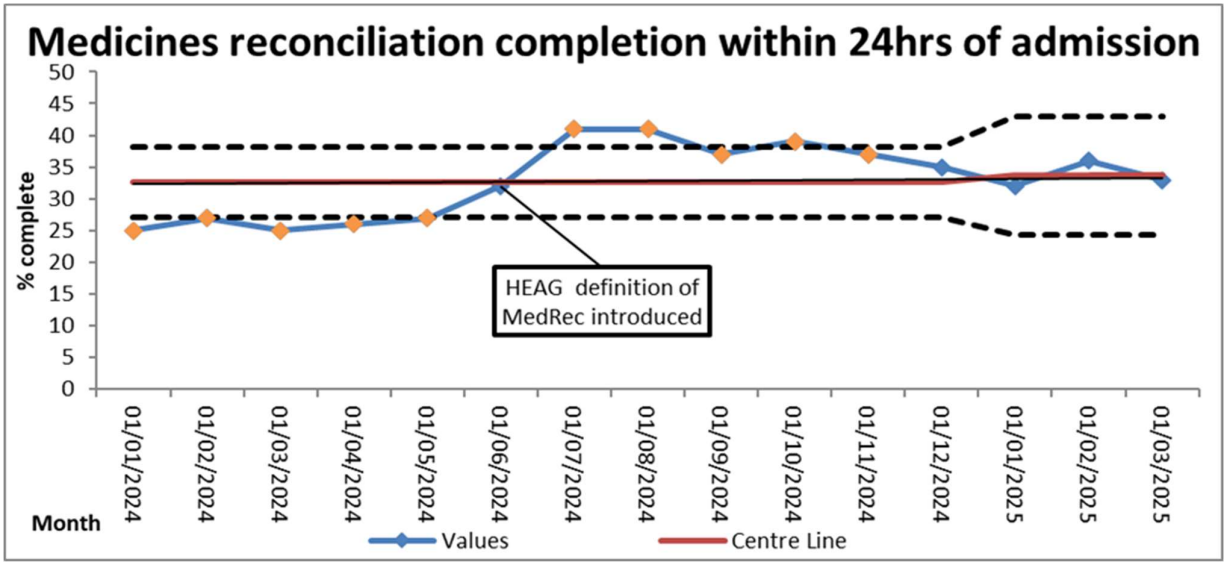
Medicines reconciliation is a critical safety process during hospital admissions, aimed at ensuring accurate and complete medication records. It involves the collection and verification of a patient's medication history, including any changes made during their hospital stay. National guidance from the National Patient Safety Agency (NPSA) and NICE recommend that this process be completed within 24 hours of admission.

Following the implementation of the Electronic Prescribing and Medicines Administration (EPMA) system across the Trust, a pharmacy dashboard was developed within the Trust's Business Intelligence (BI) portal. This dashboard draws on live EPMA data, updated every 15 minutes, to provide real-time insights into medication-related processes.

In June 2024, after benchmarking with other Trusts within the ICB, Lancashire Teaching Hospitals NHS Foundation Trust adopted the Hospital Expert Advisory Group's definition of medicines reconciliation. This definition includes both the completion and documentation of the drug history and the communication of any discrepancies. The task can be performed by both medicines management technicians and clinical pharmacists, and EPMA procedures have been updated accordingly.

Initial improvements were observed, with over 40% of patients having their medicines reconciliation completed within 24 hours. However, recent challenges, particularly increased patient flow and high volumes in the ED have contributed to a decline in this key performance indicator

Figure 23 Medicines Reconciliation (within 24 hrs)



Source: LTHTR data

3.2.4.4 Prescription Verification

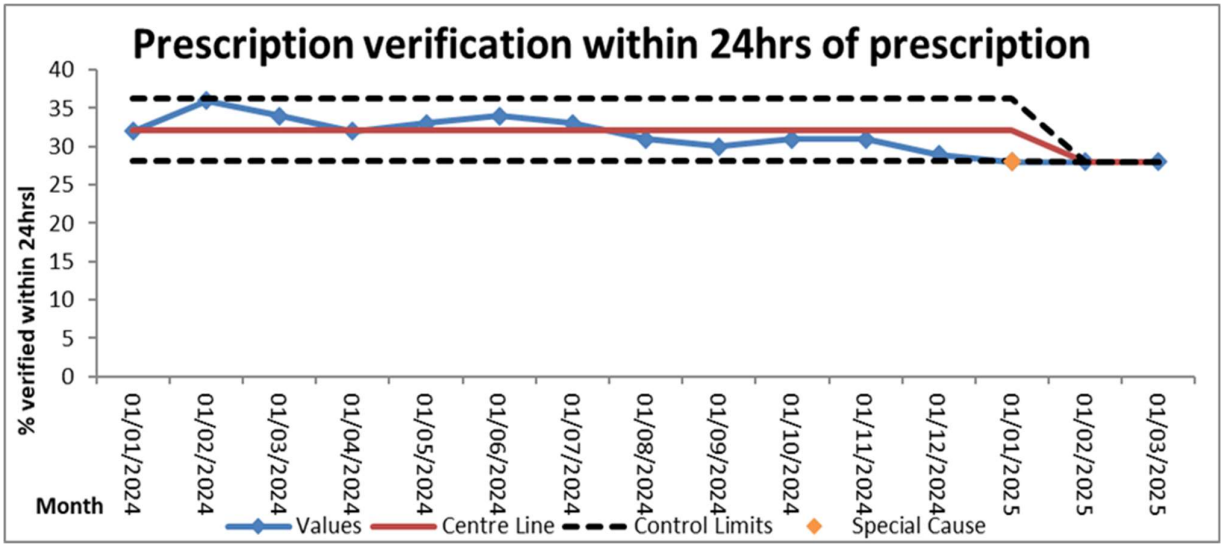
To ensure the safe and appropriate use of medicines, each prescription issued within the Trust is verified by a pharmacist. On average, 32% of prescriptions are verified within 24 hours of being written.

To prioritise patient safety, the pharmacy team uses a pharmacy whiteboard system to highlight and prioritise verification of four high-risk medication groups:

- Anticoagulants
- Insulin
- Antimicrobials
- Anti-epileptics

As of March 2025, 39% of prescriptions for these high-risk medicines were verified within 24 hours. While this represents a focused effort, the Trust recognises the need for further improvement. An improvement plan is currently underway to enhance verification rates and ensure timely pharmacist review of high-risk medications.

Figure 24 Prescription Verification



Source: LTHTR data

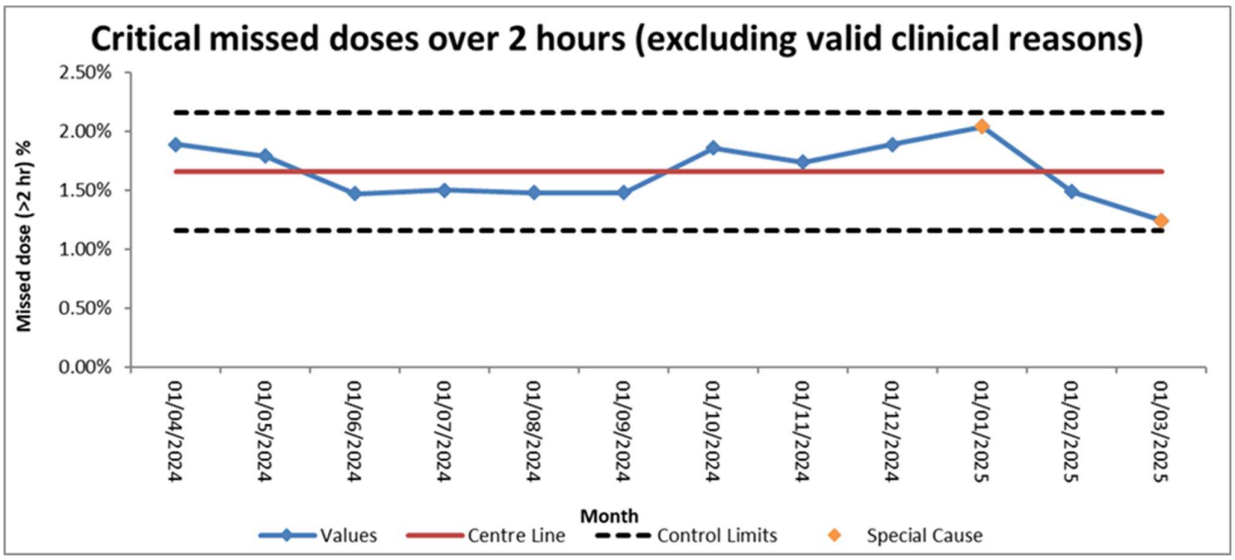
3.2.4.5 Medication Administration

The accurate and timely administration of prescribed medications is a fundamental component of safe and effective patient care. Nationally, some healthcare organisations have reported missed dose rates exceeding 20%, which can lead to suboptimal treatment outcomes and potential harm.

To address this risk, the Trust leverages data from its EPMA system to identify and monitor missed doses. This data enables pharmacy and nursing teams to take prompt action either by administering the missed dose or documenting a clinically valid reason for its omission.

The Trust remains committed to continual improvement in medication administration practices. Over the past year, a continuous improvement project has been in place, supporting individual wards in achieving the target of less than 1% missed doses of critical medicines.

Figure 25 Critical missed doses over 2 hours (excluding valid clinical reasons)



Source: LTHTR data

3.2.4.6 Antimicrobial Stewardship

Antimicrobial Stewardship is a critical component of modern healthcare, aimed at promoting the responsible use of antibiotics and other antimicrobial agents. With the growing threat of antimicrobial resistance (AMR), where bacteria and other pathogens become resistant to treatment healthcare systems worldwide are prioritising strategies to preserve the effectiveness of existing medications.

At the Trust, the Antimicrobial Stewardship Team plays a central role in this effort. They conduct regular audits across all inpatient areas, supported by automated data collection through the EPMA system. These audits include all patients prescribed antimicrobials and assess key areas such as:

- Whether the indication for antibiotic use is clearly documented.
- Compliance with Trust antimicrobial guidelines or Microbiology recommendations.
- Whether a review of the prescription is documented within 72 hours.

Table 27 Antimicrobial Stewardship Point Prevalence Audit Results

	Nº of patients on antibiotics	Nº of antibiotic prescriptions audited	% Documented Indication on the Prescription	% Compliance with Guidelines	% Compliance with Guidelines or Recommended by Microbiology	% Compliance with documented review within 72hrs
Trust Wide Q4 2024-25	368	481	92%↓	90%↑	91%↑	90%↓
Trust Wide Q3 2024-25	331	444	95%↓	83%↓	85%↓	99%↑
Trust Wide Q2 2024-25	334	439	96%↑	91%↑	92%↔	95%↓

	Nº of patients on antibiotics	Nº of antibiotic prescriptions audited	% Documented Indication on the Prescription	% Compliance with Guidelines	% Compliance with Guidelines or Recommended by Microbiology	% Compliance with documented review within 72hrs
Trust Wide Q1 2024-25	374	489	95%↓	90%↑	92%↑	97% ↔

Source: LTHTR data

These audits help ensure that antimicrobial use is appropriate, evidence-based, and timely, reducing unnecessary exposure to antibiotics and helping to combat resistance. Results are reported quarterly, and any specialties falling below compliance thresholds are required to submit action plans. The stewardship team also provides education and support to promote best practices.

In addition, the Trust is actively working to improve the timely switch from intravenous (IV) to oral antibiotics (IVOS) a key national priority. Over the past year, the proportion of IV antimicrobial use has decreased from 27.3% to below 25%, reflecting progress in this area.

3.2.5 Infection Prevention and Control (IPC)

Infection Prevention and Control (IPC) remains a key priority for Lancashire Teaching Hospitals. The IPC Team continues to reduce healthcare-associated infections and improve patient safety. The Trust's IPC leadership is provided by the Consultant Microbiologist, who serves as the Director of Infection Prevention and Control (DIPC), supported by the Matron for IPC, the Deputy CNO, IPC specialist nurses, and additional Consultant Microbiologists.

Key Achievements

In 2024–25, the Trust achieved several positive IPC outcomes, including:

- Zero hospital-acquired MRSA bacteraemia cases.
- Achievement of the C. difficile objective, with 192 cases, 7 below the national trajectory of 199 marking the first time the Trust has remained under target since 2018-19.
- Implementation of PSIRF principles, shifting focus from individual incident investigations to system-wide learning and improvement.
- Sustained >90% compliance with IPC mandatory training across all divisions.
- Continued >90% compliance with antimicrobial prescribing standards, including documentation of indication and review within 72 hours.
- Participation in the Primel® Active Hand Coating (PAHC) study, exploring innovative hand hygiene solutions.
- Progress toward implementing the National Standards of Healthcare Cleanliness (2021), with 15 wards currently compliant and a phased rollout plan in place.

Areas for Improvement

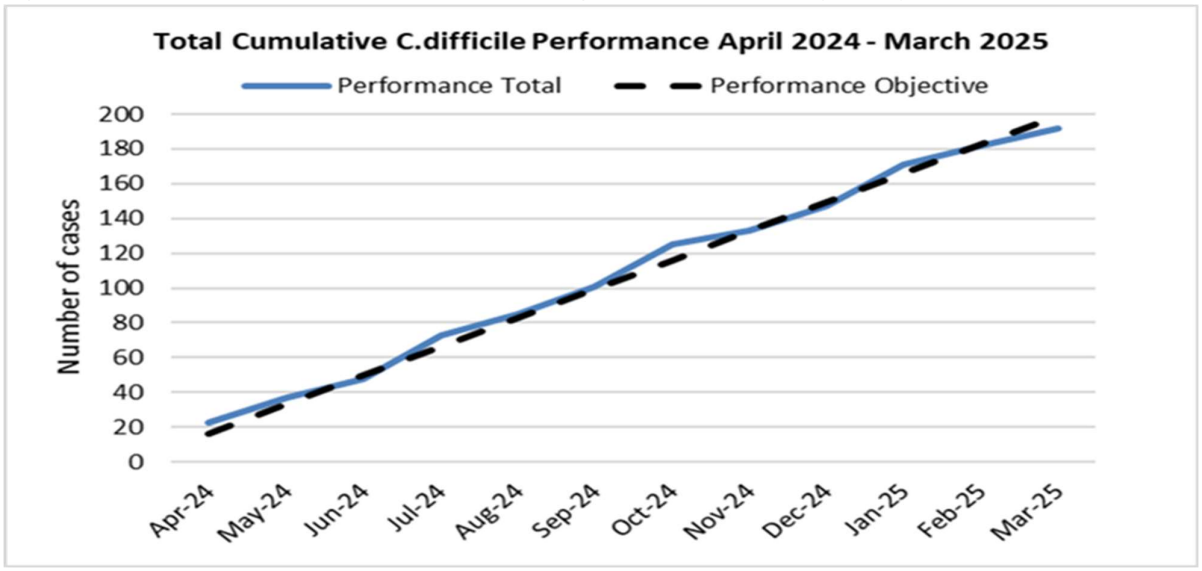
Despite these achievements, challenges persist. The Trust continues to report one of the highest rates

of C. difficile in the Northwest and exceeded its Gram-negative bacteraemia objective by 10 cases. The 2024–25 influenza season and a surge in Norovirus outbreaks, including the GII.17 variant, placed additional strain on services. Furthermore, staffing shortages within the Estates Team have impacted the frequency of key safety meetings related to water and ventilation systems.

3.2.5.1 Clostridioides difficile *(C.difficile)*

Building on the Trust's broader IPC efforts, the management of *C.difficile* infection remained a key focus throughout 2024–25. 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.

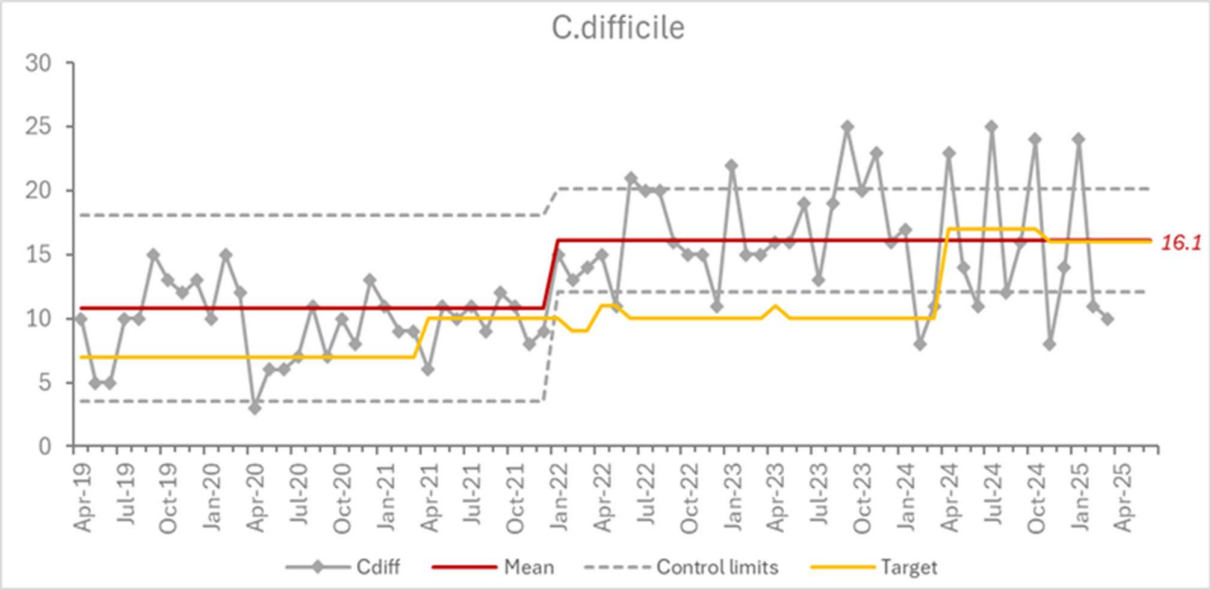
Figure 26 Performance of *C. difficile* cases against National Trajectory



Source: LTHTR data

Figure 27 is an SPC chart which tracks Hospital Associated C. *difficile* cases per month from April 2019 to April 2025. As illustrated in the SPC chart (Figure 27), a significant increase in reported cases occurred in 2022, coinciding with a 60% rise in testing following a change in Trust policy to include type 5 stools in the definition of diarrhoea, an adjustment recommended by NHS England Regional IPC Leads. Since then, although the Trust has remained within national limits, there has been no statistically significant downward trend in monthly case numbers.

Figure 27 Hospital Associated *C. difficile* Toxin positive rates per month.



Source: LTHTR data

The National and Regional picture

Nationally, the incidence of *C. difficile* continues to rise, with the Northwest region experiencing particularly high rates. The Trust currently ranks highest among major Trusts in terms of C. difficile cases per 100,000 bed days. This persistent challenge prompted executive-level intervention by the CNO and the development of a targeted *C.difficile* action plan, overseen by the Infection Prevention and Control Committee and the Estates and Facilities Partnership Board.

Table 28 *C. difficile* incidence and rate per 100,000 bed days – Northwest hospitals March 2024 - February 2025

C. difficile annual tables: cases & rates by Trust

Organisation Name	March 2024 to February 2025	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	14	22.9	Low (0.001)
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	124	46.6	
BOLTON NHS FOUNDATION TRUST	123	56.0	High (0.001)
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	90	53.3	High (0.025)
EAST CHESHIRE NHS TRUST	23	20.9	Low (0.001)
EAST LANCASHIRE HOSPITALS NHS TRUST	108	30.7	Low (0.001)
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	193	61.5	High (0.001)
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	4	7.2	Low (0.001)
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	208	37.8	Low (0.025)
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	2	7.4	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	291	35.3	
MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST	116	26.3	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	53	31.0	
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	65	30.0	
NORTHERN CARE ALLIANCE NHS FOUNDATION TRUST	194	38.7	Low (0.001)
STOCKPORT NHS FOUNDATION TRUST	94	42.7	
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	78	49.2	
THE CHRISTIE NHS FOUNDATION TRUST	59	95.7	High (0.001)
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	13	39.7	
THE WALTON CENTRE NHS FOUNDATION TRUST	6	12.4	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	87	41.7	
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	89	44.1	Low (0.025)
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	168	65.0	High (0.025)
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	70	46.9	
North West	2272	40.4	

Key Developments in 2024–25

In response to the ongoing challenges associated with Clostridioides difficile infection, Lancashire Teaching Hospitals implemented a series of targeted interventions throughout 2024–25. These initiatives were designed to strengthen infection prevention practices, enhance environmental hygiene, and support clinical teams in delivering safer care. The following developments reflect a proactive and system-wide approach to reducing infection risk, improving compliance, and embedding sustainable change across the organisation.

- **Implementation of National Standards of Healthcare Cleanliness (2021)**
  With support from UKHSA field epidemiologists, the Trust evaluated the impact of these standards across 15 pilot wards. Results showed a reduction in infection rates from 19.4 to 14.4 cases per 1,000 bed days in compliant areas. A business case for full implementation was approved in March 2025, securing £747,514 in funding and 26 WTE posts, with phased rollout planned for 2025–26.
- **PSIRF-Aligned Local Reviews**
  The Trust transitioned from individual post-infection reviews to ward-level reviews using Datix, supported by predefined quality indicators. This approach empowers ward teams to take ownership of improvement actions and fosters a culture of learning. Reports are shared at IPCC, with 2024–25 serving as the baseline year for monitoring progress.
- **Multidisciplinary Team (MDT) Reviews**
  Four wards with high incidence were selected for in-depth MDT reviews. Key themes included:
    - Non-compliance with cleanliness standards
    - Aging infrastructure and poor ward layout
    - Water leaks and macerator failures

    - Inadequate storage and overcrowding due to patient boarding
    - These insights are shaping future infection control strategies.
- **Policy Update on Laxative-Associated Diarrhoea**
  To reduce false-positive test results, the Trust revised its C. difficile testing policy to clarify procedures when diarrhoea is linked to laxative use, aligning with national guidance.
- **Introduction of Virtual Ward Rounds**
  In January 2025, weekly virtual rounds were launched involving IPC leadership and the Antimicrobial Stewardship Team. These rounds focus on high-risk patients those with recent C. difficile infection or carriage to ensure appropriate management and prevent recurrence.

Significant challenges and opportunities for 2025-26

Despite progress, the Trust continues to face significant environmental and operational challenges:

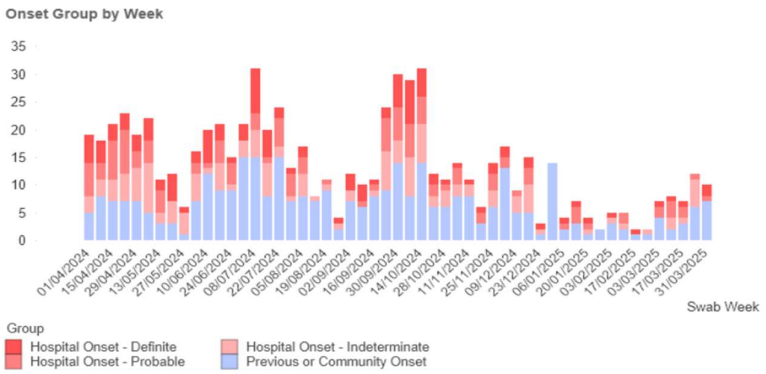
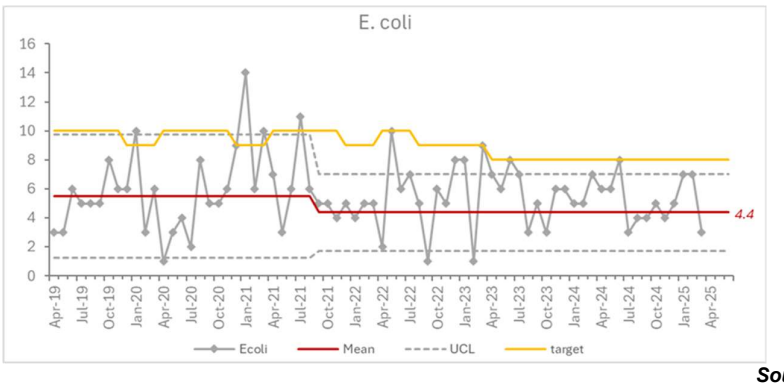
- Aging estate with limited side room capacity and outdated sewage systems
- Frequent macerator blockages, increasing contamination risk
- Overcrowding and boarding, particularly in ED and high-pressure areas

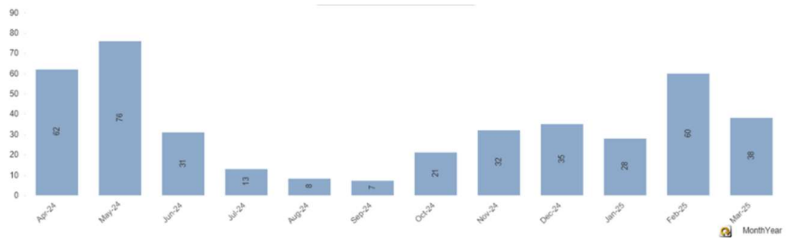
However, the full implementation of the National Standards of Healthcare Cleanliness is expected to enhance cleaning frequency and reduce environmental contamination. Ongoing monitoring will be essential to evaluate its impact and guide further improvements.

3.2.5.2 Infection Prevention and Control Performance against other organisms of concern

Table 29 Trust performance related to other organisms of concern

3.2.5.2.1 MRSA Bacteraemia	Staphylococcus aureus (S. aureus) is a common skin and mucosal bacterium, with some strains resistant to methicillin—referred to as MRSA. When MRSA enters the bloodstream, it can cause serious infections known as bacteraemia. incidence of MRSA bacteraemia over the past three years is as follows: • 2022–23: 1 hospital-onset case, 5 community-onset cases • 2023–24: 1 hospital-onset case, 7 community-onset cases • 2024–25: 0 hospital-onset cases, 2 community-onset cases In 2024–25, the Trust reported no hospital-acquired MRSA bacteraemia, marking a significant improvement. The investigation process was updated to align with PSIRF principles, though no internal investigations were required due to the absence of hospital-onset cases. The two community-onset cases were reviewed by the Community IPC Team and were not linked to the Trust
3.2.5.2.2 SARS-CoV-2 (COVID-19)	On 31st 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 Throughout 2024–25, the Trust experienced stable levels of COVID-19 infection. There were no changes to national guidance, and therefore no significant policy updates were implemented locally. The Trust continued to monitor and manage both hospital-onset and community-onset cases in line

	with established protocols. **Figure 28 Hospital Onset versus Community Onset COVID-19 infections**  ***Source: LTHTR data***
3.2.5.2.3 Gram-negative Bacteraemia	In line with NHS England's objectives to reduce bloodstream infections caused by Escherichia coli, Klebsiella species, and Pseudomonas aeruginosa, the Trust's 2024–25 performance is summarised below: • E. coli: Objective = 99 cases; Actual = 109 (10 cases above target) • Pseudomonas aeruginosa: Objective = 16 cases; Actual = 12 (4 cases below target) • Klebsiella species: Objective = 29 cases; Actual = 31 (2 cases above target) The E. coli target was not met, highlighting the need for a multi-disciplinary approach involving specialties across the Trust and the ICB. The ICB plans to establish Task and Finish groups to address Gram-negative bacteraemia, supported by the Trust's 2025–26 IPC Annual Plan, which includes initiatives focused on catheter care, continence, and bowel management. **Figure 29 Hospital Associated *Escherichia coli* positive rates per month.**  ***Source: LTHTR data***

3.2.5.2.4 Norovirus	In 2024–25, the Trust experienced 29 confirmed Norovirus outbreaks, reflecting the national trend linked to the emergence of the GII.17 variant. Outbreaks were distributed as follows: • April–June 2024: 11 outbreaks • October–December 2024: 8 outbreaks • January–March 2025: 12 outbreaks **Figure 30 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*** Increased community transmission led to a higher number of symptomatic patients presenting to ED and Assessment Units, challenging the Trust's ability to isolate and manage cases effectively. Transmission from infected staff and visitors also contributed to outbreaks. Norovirus outbreaks significantly impacted patient flow, with bay and ward closures reducing effective bed capacity and increasing ED wait times. However, the Trust benefited from rapid intestinal screening provided by the Point of Care team, enabling early identification and containment of cases. Negative results also supported IPC decisions to keep unaffected bays open. To mitigate spread, the Trust implemented: • Enhanced environmental cleaning • Fogging post-infectious period • Staff and public communications reinforcing the 48-hour symptom-free return policy

In summary, while the Trust has made significant progress in strengthening IPC, it recognises the ongoing challenges and has a clear plan in place to address risks, enhance resilience, and maintain high standards of patient safety.

3.2.6 Mortality Surveillance and Learning from Adult, Child & Neonatal Deaths

As part of the Trust's commitment to Consistently Deliver Excellent Care, mortality surveillance plays a vital role in assessing the quality of care and identifying opportunities for learning and improvement.

This section outlines how the Trust monitors mortality trends and learns from the deaths of adults, children, and neonates.

Table 30 Understanding Key Mortality Indicators

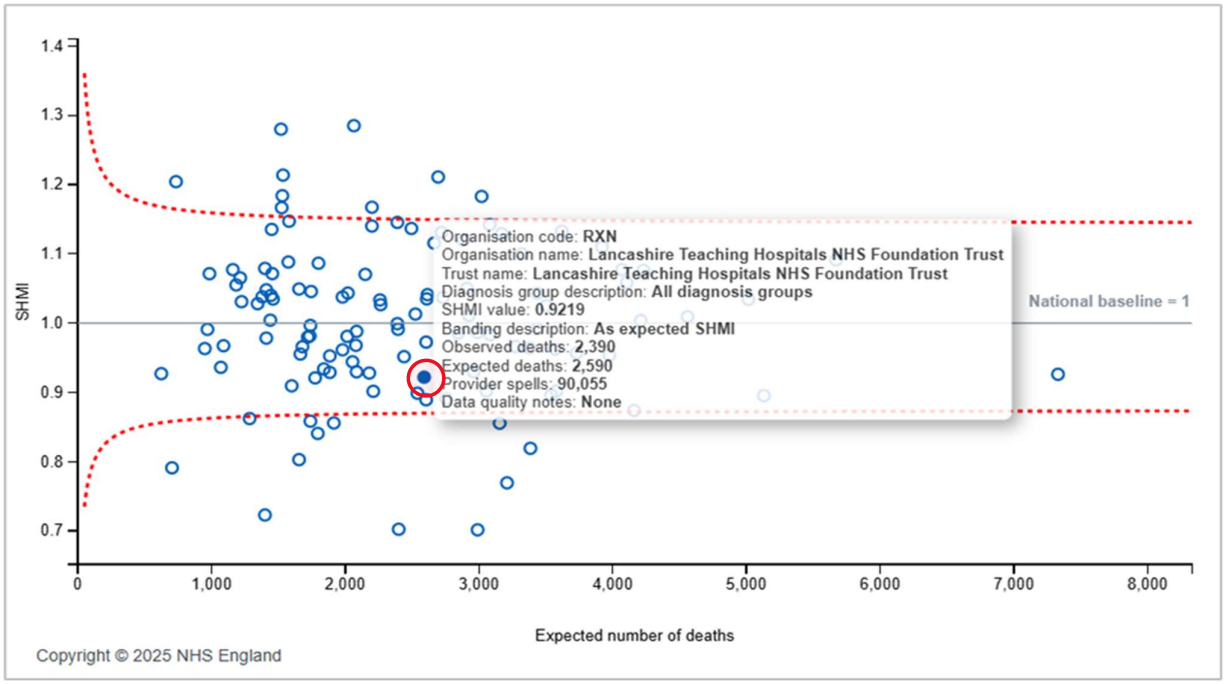
Indicator	Definition	What It Measures	Interpretation
SHMI (Summary Hospital-level Mortality Indicator)	Includes all deaths in hospital or within 30 days of discharge	All-cause mortality, not adjusted for palliative care or deprivation	A value of 100 is the national average; below 100 is better than expected
HSMR (Hospital Standardised Mortality Ratio)	Based on 41 diagnostic groups, adjusted for risk factors (accounts for approximately 80% of all hospital deaths)	Ratio of observed to expected deaths	<100 = lower than expected mortality; >100 = higher than expected
SMR (Standardised Mortality Ratio)	Broader than HSMR, includes all diagnoses	Relative risk of death compared to expected	<100 = better than expected; >100 = worse than expected

3.2.6.1 Mortality Surveillance

The SHMI for the period December 2023 to November 2024 was 92.19, which is statistically within the expected range.

Figure 31 SHMI Peer Comparison Funnel Plot shows LTHTR's position relative to national peers, confirming performance within control limits

Figure 31 SHMI Peer Comparison Funnel Plot



The HSMR, which adjusts for case mix and other risk factors, was 75.9 for the same period—lower than expected.

Figure 32 HSMR Trend illustrates a consistent downward trend over the past three years, with 8 of the most recent 12 months reporting statistically lower-than-expected mortality

Figure 32 HSMR Trend

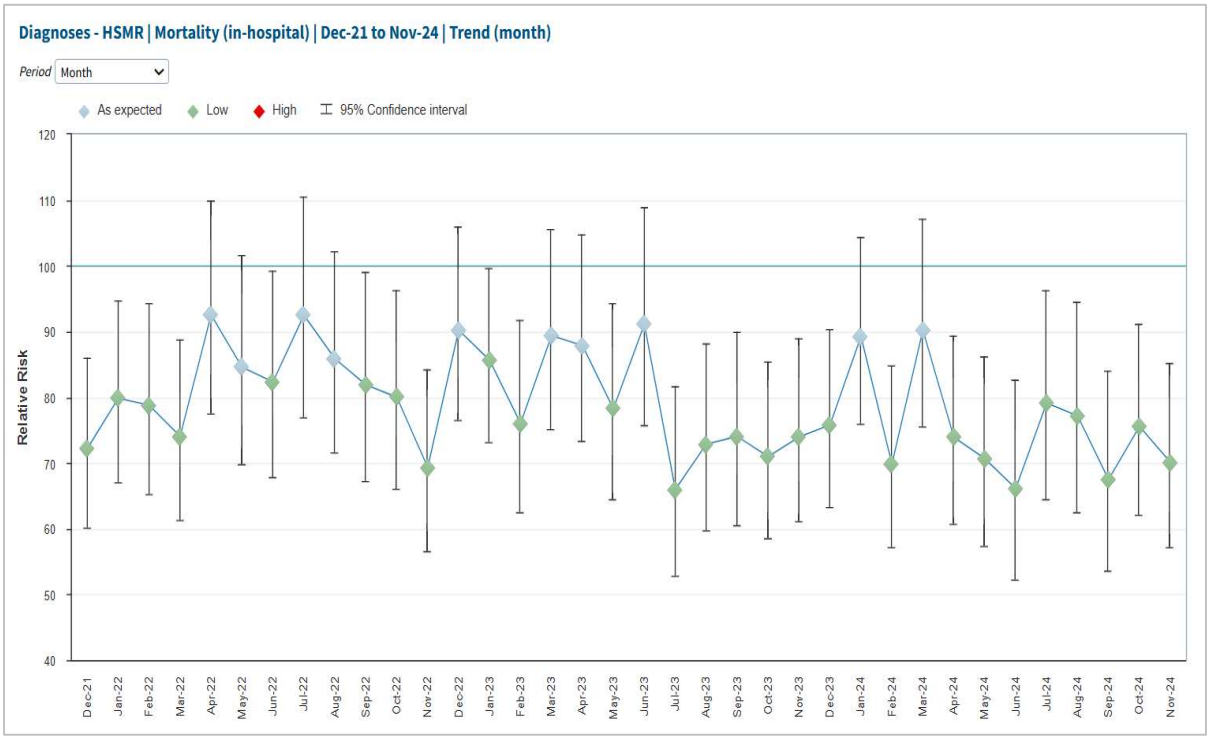
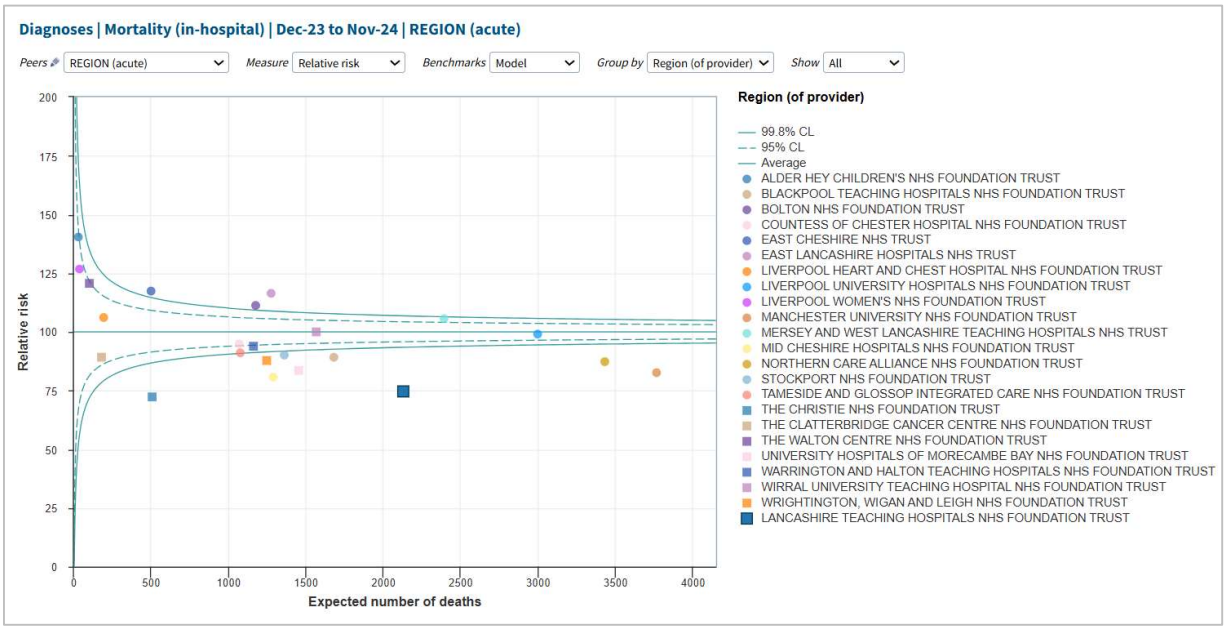


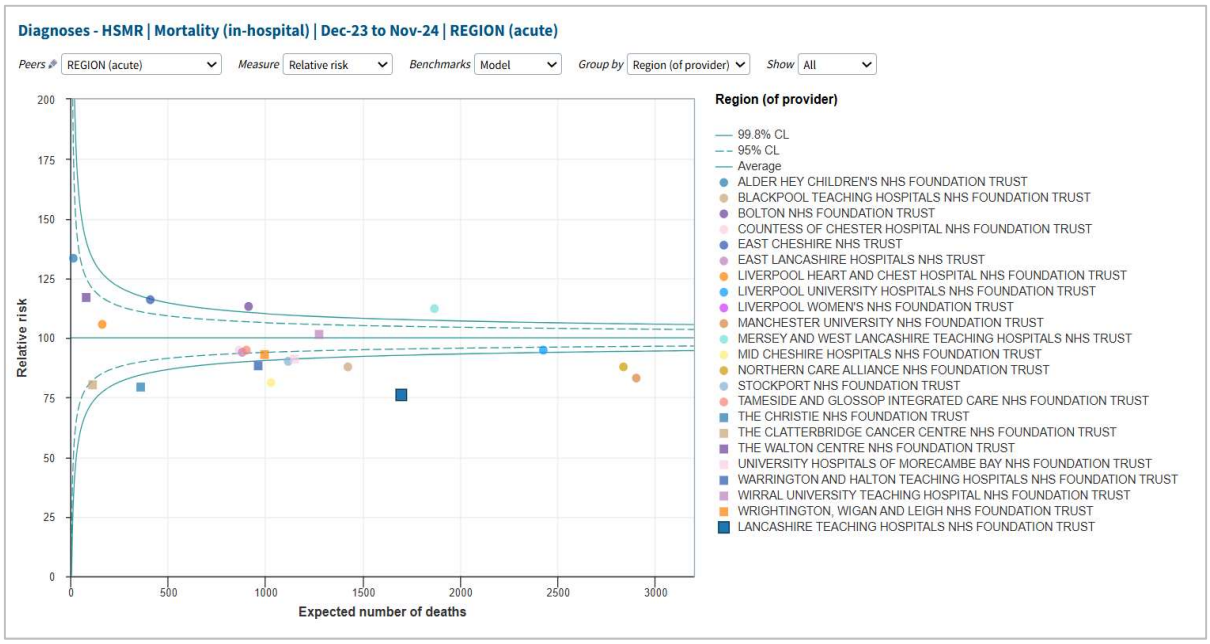
Figure 33 HSMR Regional Peer Comparison confirms LTHTR's position as one of the best performing Trusts in the region.

Figure 33 HSMR Regional Peer Comparison



The Standardised Mortality Ratio (SMR) for all diagnoses was 74.6, also lower than expected, as shown in Figure 34: SMR Regional Peer Comparison.

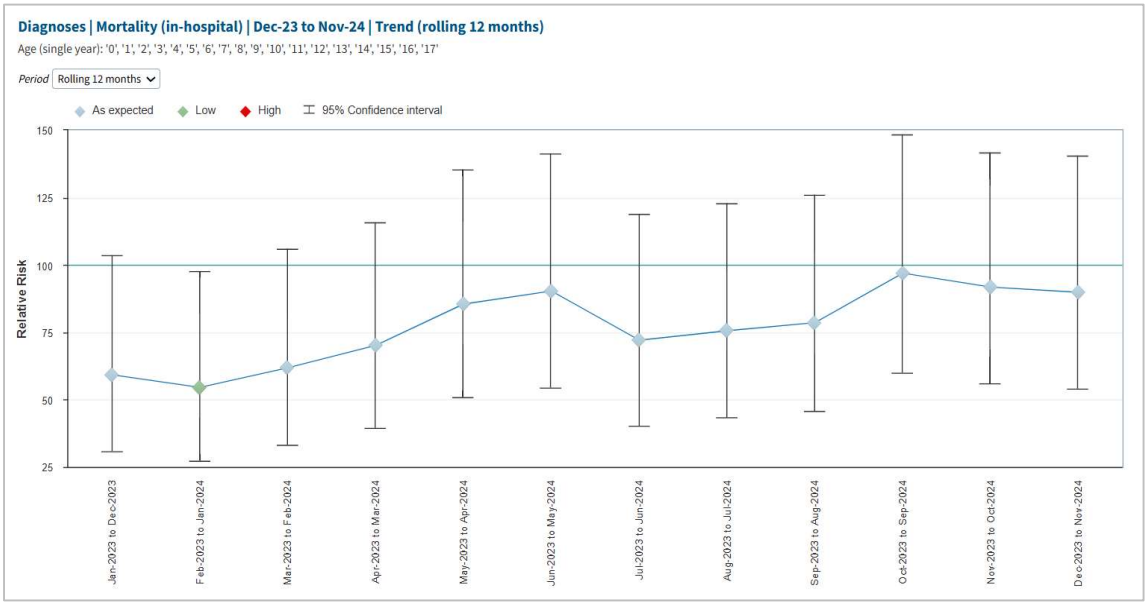
Figure 34 SMR Regional Acute Trust Benchmark Dec 2023 – November 2024



3.2.6.2 Child Deaths

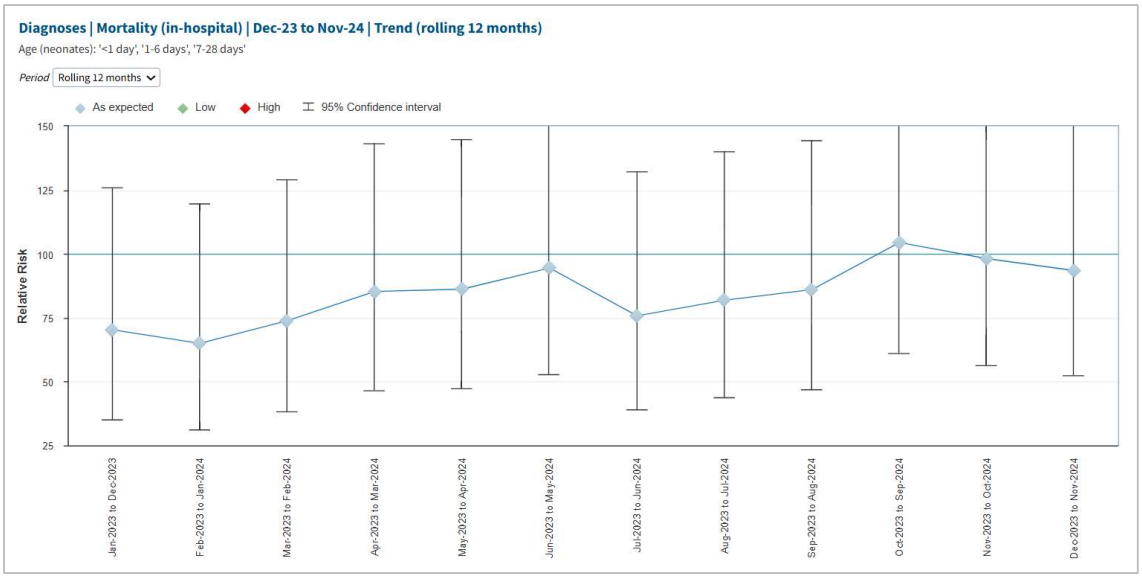
Child SMR (1–17 years): 89.9 – within expected range

Figure 35 SMR for Children



Neonatal SMR (under 28 days): 93.5 – within expected range

Figure 36 SMR for Neonatal Deaths



All child deaths are reviewed in line with national guidance and reported to the Child Death Overview Panel (CDOP). Neonatal deaths are reported to MBRRACE-UK, with local reviews conducted by the neonatal lead consultant or safeguarding lead. Findings are shared at departmental level and through the Lancashire and South Cumbria Neonatal Operational Delivery Network.

3.2.6.3 Perinatal Mortality & Perinatal Mortality Review Tool

The Trust uses the Perinatal Mortality Review Tool (PMRT) to conduct structured, multidisciplinary reviews of all eligible perinatal deaths. These reviews include parental input and result in a written report shared with families within six months. Learning is tracked through the Safety and Quality Committee and reported to the Trust Board bi-monthly.

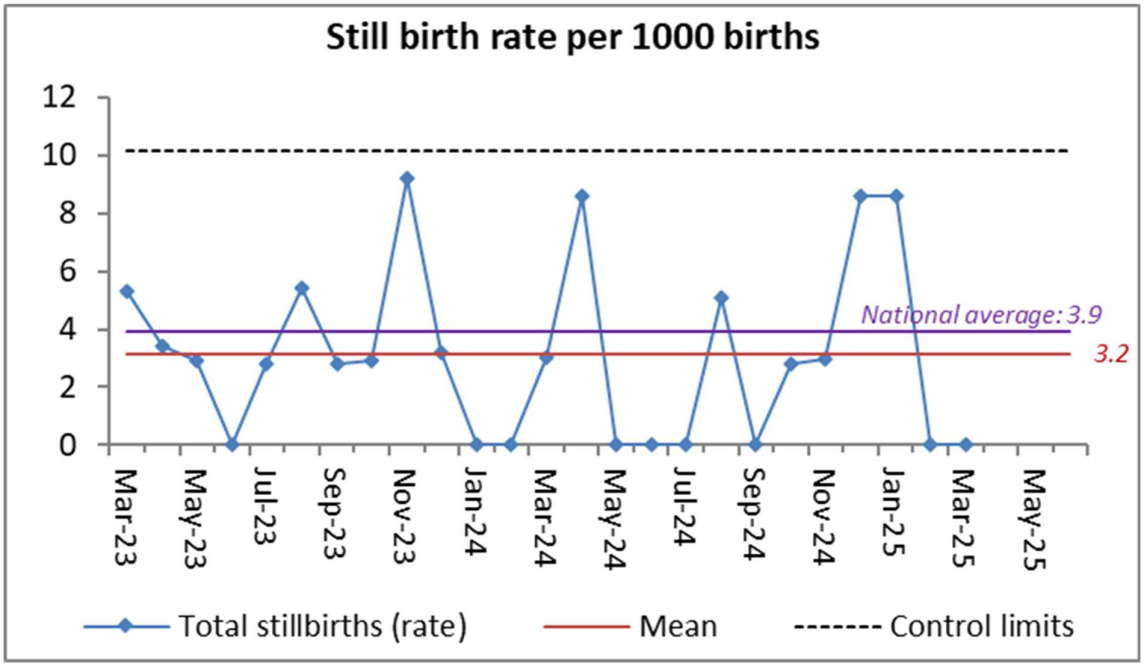
Between April 2024 and March 2025, the Trust reported 22 cases to MBRRACE-UK for PMRT review:

- 9 stillbirths
- 1 late fetal loss
- 12 neonatal deaths

The stillbirth rate remains below the national average of 3.9 per 1,000 births, with no cause for concern identified.

Figure 37 SPC Chart for Stillbirth Incidence

Figure 37 Maternity SPC analysis - Incidence of Stillbirths (per 1000 births)



3.2.6.4 Medical Examiner Service

The Medical Examiner (ME) Service plays a vital role in ensuring transparency, safety, and accountability in the certification and review of deaths. It was introduced to strengthen the scrutiny of deaths, improve the quality of death certification, support appropriate referrals to HM Coroner, and provide a meaningful opportunity for bereaved families to raise concerns and receive answers.

As of 9 September 2024, the ME Service became a statutory requirement. Under this legislation, Medical Examiners are now mandated to review all non-coronial deaths and sign the Medical Certificate of Cause of Death (MCCD) before registration can proceed. MEs are supported by Medical Examiner Officers (MEOs), who may carry out certain aspects of the scrutiny process under delegated authority. Although ME Offices are hosted by acute trusts, they operate independently, following national guidance and standards set by the National Medical Examiner Office.

At Lancashire Teaching Hospitals, deaths are referred to the ME Service only after an MCCD has been completed. The Bereavement Service is responsible for ensuring this step is carried out. However, MEs and MEOs are available to provide guidance when needed.

The scrutiny process involves three key components:

- A proportionate review of the medical records.
- A discussion with the attending practitioner.
- A conversation with the next-of-kin.

MEOs, under delegated authority, may conduct the practitioner discussion and address concerns raised by the bereaved, escalating issues to the ME as appropriate. However, only the ME can review the clinical records and sign the MCCD.

Table 31 Medical Examiner Service Performance 2024-25 data

	Number	Percentage
Inpatient & ED Deaths	1646	
ME Reviews of all Deaths	1502	91%
MEO Reviews of all Deaths	1646	100%
ME/MEO Reviews of all Deaths	1646	100%
ME/MEO Conversations with Bereaved	1468	94%
Referrals to Coroner	333	20%

Source: LTHTR Data

Of the 1,646 deaths, 144 were referred directly to HM Coroner following an initial MEO review and did not undergo ME scrutiny. An additional 189 cases were referred to the Coroner after ME review.

In cases referred directly to the coroner, conversations with the next-of-kin are typically handled by Coroner's Officers. However, MEOs may have spoken with the bereaved during their initial assessment prior to referral.

The ME Service identified 10% of cases for further review of care. This included:

- 35 cases where a Datix report was submitted.
- 134 cases where a Structured Judgement Review was requested.

The Medical Examiner Service continues to provide a robust framework for the scrutiny of deaths, ensuring that concerns are addressed, care is reviewed where necessary, and bereaved families are supported. Its statutory implementation marks a significant step forward in promoting transparency, learning, and safety across the healthcare system.

3.2.6.5 Learning from Corners Regulation 28 Report

During the reporting period, the Trust received one Regulation 28 Report to Prevent Future Deaths, which included a conclusion of neglect. The Coroner raised concerns about aspects of care provided during a patient's attendance at hospital.

In response, the Trust developed and submitted a comprehensive action plan, which was accepted by the Coroner. Actions taken include:

- Reviewing and strengthening processes for oversight and escalation in the Emergency Department
- Providing additional training to support staff in caring for patients with complex needs
- Enhancing documentation practices to ensure care plans and assessments are clearly recorded
- Reinforcing standards for personal care and comfort, including pressure area care
- Introducing additional checks to support consistent delivery of care

The Trust met with the patient's family to offer a formal apology and to explain the actions being taken. The improvement plan was shared with the family, who have been engaged in the improvement process and kept informed of progress.

Learning from this case has contributed to broader quality improvement work across the organisation, with a continued focus on delivering safe, effective and person-centred care. As part of this, the Trust is continuing to strengthen how it involves patients and families in shaping care and driving improvement. This includes improving communication and support, offering opportunities for feedback and involvement in service development, and using patient and family insights to inform training, policy, and practice. The Trust recognises the value of lived experience in driving meaningful change and remains committed to ensuring that patients and families are heard, supported, and actively involved in shaping safer, more responsive services. The Trust also remains committed to learning from coronial investigations and using these insights to improve patient safety and care quality.

3.3 Review of Quality Performance – Experience of Care

3.3.1 Patient Experience Performance Report 2024-25

The Trust's Patient Experience and Involvement Strategy for 2024–25 has continued to drive a culture of listening, learning, and acting on the experiences of patients, families, and carers. This strategy emphasises the importance of hearing from people when care goes well and when it does not and using that insight to inform meaningful improvements. Developed in collaboration with patients, carers, staff, Governors, and partner organisations, the strategy also prioritises engagement with groups representing protected characteristics, recognising the importance of intersectionality in shaping inclusive care.

The strategy is closely aligned with other key Trust initiatives, including the Equality, Diversity and Inclusion Strategy, the Mental Health, Learning Disability, Dementia and Autism Strategies, and is now embedded within the developing SIP.

The strategy is structured around three core pillars:

1. **Insight** - improving our understanding of patient experience and involvement by listening and drawing insights from multiple sources of information.
2. **Involvement** - equip patients, colleagues and partners with the skills and opportunities to improve patient experience throughout the whole system.
3. **Improvement** - design and support improvement programmes that deliver effective and sustainable change.

Highlights of 2024–25

The following highlights showcase the tangible progress made across the three pillars of the Patient Experience and Involvement Strategy: Insight, Involvement, and Improvement. These achievements reflect the Trust's commitment to embedding patient voices at every level of care delivery, fostering inclusive engagement, and driving meaningful change. The examples below illustrate how feedback has been translated into action, resulting in improved experiences for patients, families, and carers across the organisation.

Insight

- Launch of the Patient Experience Dashboard.
- Integration of patient experience into Continuous Improvement methodology, including Micro Coaching Academy and Flow Coaching Academy initiatives.
- Health Inequalities showcased through poster presentations at the Annual Members Meeting.
- Establishment of a Complaints Review Group with Governors, Patient Safety Partners, and staff.
- Friends and Family Test scores increased by 4.7%.
- Growth in the number of Patient Forums.
- Full rollout of The Health Foundation Scale, coordinated by Imperial College.
- 71% of wards/areas achieved STAR Gold status.
- National Picker Cancer Survey showed sustained improvements in Maternity services.
- Compliments increased by 76%.
- Complaints reduced by 8%.

Involvement

- Active participation of Patient Safety Partners and Maternity Neonatal Voices Partnership lead in Trust committees.
- 41% increase in Patient Advice and Liaison Service (PALS) and Complaints training uptake.
- 33% increase in volunteers, including the introduction of the 'Hospital Guide' role.
- Strengthened engagement with the Deaf community through representation in the Patient Carer Experience and Involvement Group.
- Reintroduction of 'Our Health Day' for patients with learning disabilities.
- Diverse teams conducting 'CARING' walk rounds for end-of-life patients and families.
- Patient involvement in Community of Practice events and Board stories.
- Enhanced interpretation services at first points of contact across more platforms.
- Patient feedback directly influenced the development of the new 'Patient Experience Portal'.

Improvement

- Patient, Governor, and Patient Safety Partner involvement in patient-Led Assessments of the Care Environment (PLACE), assessments, with improved ratings from 2023.
- Development of a new Acute Medical Unit.
- Achievement of Baby Friendly Initiative Stage 2.
- Improved care outcomes for patients from Black, Asian and Minority Ethnic (BAME) and ethnic backgrounds experiencing postpartum haemorrhage.
- Introduction of youth workers in Children's Services.
- Reduction in costs associated with lost property.
- Installation of STOMA-friendly bathrooms across the Trust.
- GIRFT accreditation awarded to Children's Services at the Chorley and South Ribble District General Hospital site.
- Launch of the Learning Disability Plan, supported by mandatory Level 1 training.
- Development of outpatient whiteboards to support patients requiring reasonable adjustments.

3.3.2 Complaints and Concerns

3.3.2.1 Complaints

In 2024–25, the Trust received 325 formal complaints, continuing a positive downward trend from previous years. This represents a 30-case reduction from 2023–24 and a 33% decrease over the past three years. This decline reflects ongoing efforts to improve patient experience, communication, and service delivery across all areas of care.

Table 32 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

The ratio of complaints to patient contacts has also improved significantly, with one complaint for every 2,825 patient contacts up from 1 in 2,486 the previous year demonstrating a continued focus on quality and responsiveness in care delivery.

Table 33 Trend of ratio of complaints per patient contact 2021 to 2025

Year	No of complaints	Total episodes (inpatient/outpatient)	Ratio of complaints topatient 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

Performance and Timeliness

The Trust has maintained a strong focus on timely complaint handling. 82% of complaints were closed within the Trust's internal target of 35 or 60 days, an improvement from the previous year. While there is no national mandate to respond within 35 days, this internal benchmark supports the Trust's commitment to providing timely and compassionate responses to concerns raised. Additionally, 98% of complaints were acknowledged within the required three working days, ensuring early engagement with complainants.

Complaint Distribution and Themes

The majority of complaints (79%) were related to services at Royal Preston Hospital, followed by Chorley and South Ribble Hospital (18%). The Medicine and Surgery divisions accounted for the highest number of complaints, together representing nearly 80% of the total.

Table 34 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%)

Table 35 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

The most common themes across all divisions were:

- Communication – including lack of updates, unclear explanations, or perceived dismissiveness.
- Treatment and procedures – concerns about clinical decisions, delays, or outcomes.
- Nursing care – including attentiveness, compassion, and responsiveness.

Complaint Outcomes

Of the 307 complaints due to be closed during the year:

- 6% were fully upheld, indicating that the concerns raised were substantiated and warranted corrective action.
- 58% were partly upheld, suggesting that while not all elements of the complaint were validated, there were areas for improvement.
- 33% were not upheld, where investigations found no breach in care or service.
- 3% remained open at year-end, pending further investigation or resolution.

This distribution reflects a balanced and transparent approach to complaint resolution, with a willingness to acknowledge shortcomings and take action where necessary.

Second Letters and Ongoing Engagement

The Trust received 16 second letters during the year, typically submitted when complainants felt their initial concerns were not fully addressed. These cases are treated seriously and reviewed to ensure all questions are answered and learning is captured.

3.3.2.2 Concerns and Enquiries

In addition to formal complaints, the Patient Experience and PALS Team handled:

- 2,058 concerns – informal issues raised by patients or families that were resolved without the need for a formal complaint.
- 3,302 enquiries – requests for information or clarification. There are currently 293 cases pending, awaiting further information such as consent or patient details.

This broader engagement demonstrates the Trust's proactive approach to resolving issues early and maintaining open lines of communication with patients and families.

3.3.3 The Parliamentary Health Service Ombudsman (PHSO)

Complainants who remain dissatisfied following local resolution have the right to escalate their concerns to the Parliamentary and Health Service Ombudsman (PHSO) for an independent review. Between 1 April 2024 and 31 March 2025, a total of four cases were referred to the PHSO. Of these, three remain under investigation, and one was partly upheld.

In addition, the PHSO issued final decisions on six cases that were originally submitted prior to April 2024. The outcomes were as follows:

- Three not upheld
- Two partly upheld
- One upheld

There is also one further case referred before April 2024 that remains under active investigation, with a final decision pending. These outcomes are closely monitored to ensure that any learning is captured and used to improve future complaint handling and service delivery.

3.3.4 Compliments

The Trust continues to receive a high volume of positive feedback from patients and their families. In 2024–25, a total of 6,831 compliments and thank-you cards were formally recorded a 76% increase compared to the previous year. Compliments were received across wards, departments, and via the Chief Executive's Office.

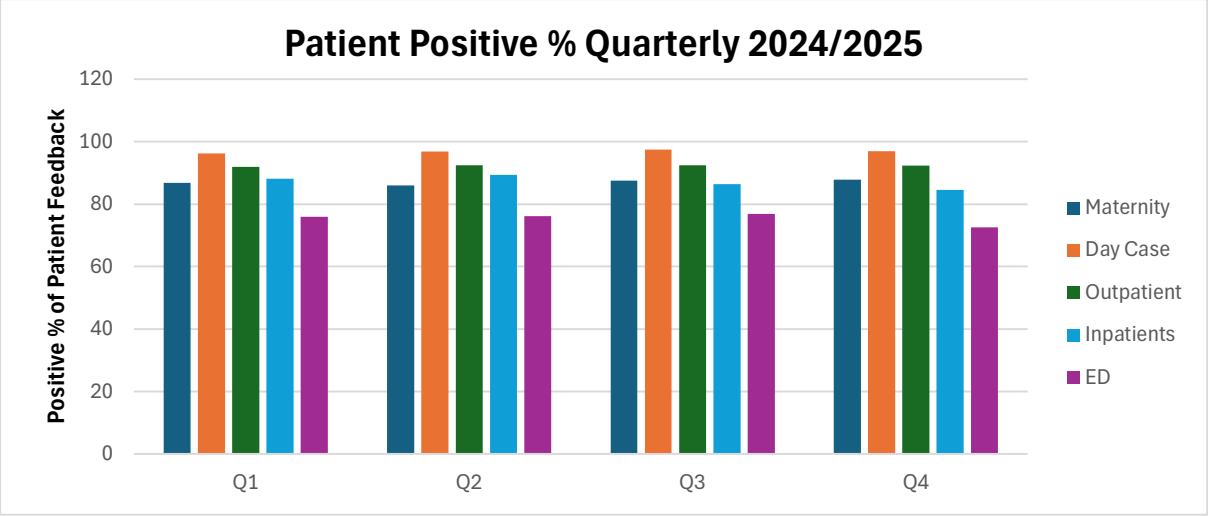
To support a culture of recognition and learning, staff are encouraged to log compliments using the dedicated module within the Trust's Risk Management System Datix system. This enables teams to celebrate success both locally and across divisions. Compliment data is now published monthly in Trust communications and discussed at divisional meetings, reinforcing the value of positive feedback in shaping a compassionate and responsive care environment.

3.3.5 Friends and Family Feedback (FFT)

The Friends and Family Test (FFT) remains a key national measure of patient experience, asking whether patients would recommend the Trust's services to others. The national requirement is to report on the following areas:

- Maternity
- Day Case
- Outpatients
- Inpatients
- ED

Figure 38 Percentage of positive responses Friends and Family by Division



Source: FFT data CIVIC

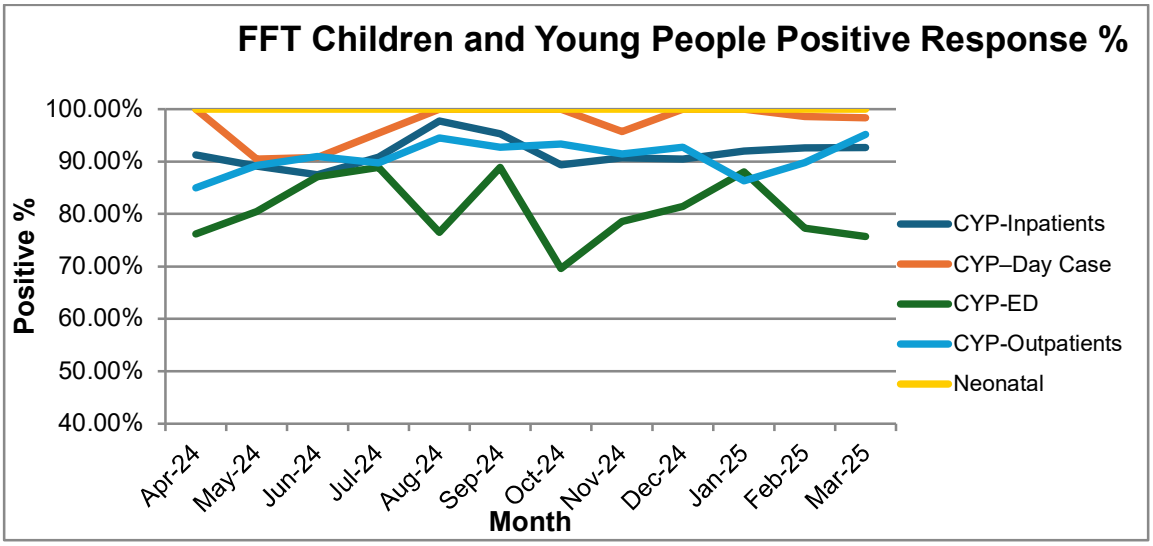
A target of 90% positive responses is set for all areas except ED, where the target is 85%. In 2024–25:

- Day Case and Outpatient services consistently exceeded the 90% target across all quarters.
- Maternity met the target in Q1 and Q4 but fell short in Q2 and Q3.
- Inpatients and ED remained below target in all four quarters.

3.3.5.1 Children and Young People (CYP) Feedback

Although not nationally mandated, the Trust also collects FFT data from Children and Young People (CYP) to ensure equity in experience measurement. Feedback from CYP using Urgent and Emergency Care (UEC) pathways indicated less favourable experiences, while day case and outpatient services performed well. The neonatal service maintained a consistent 100% positive response rate, reflecting high levels of satisfaction.

Figure 39 Children and Young People (CYP) Quarterly percentage of positive responses



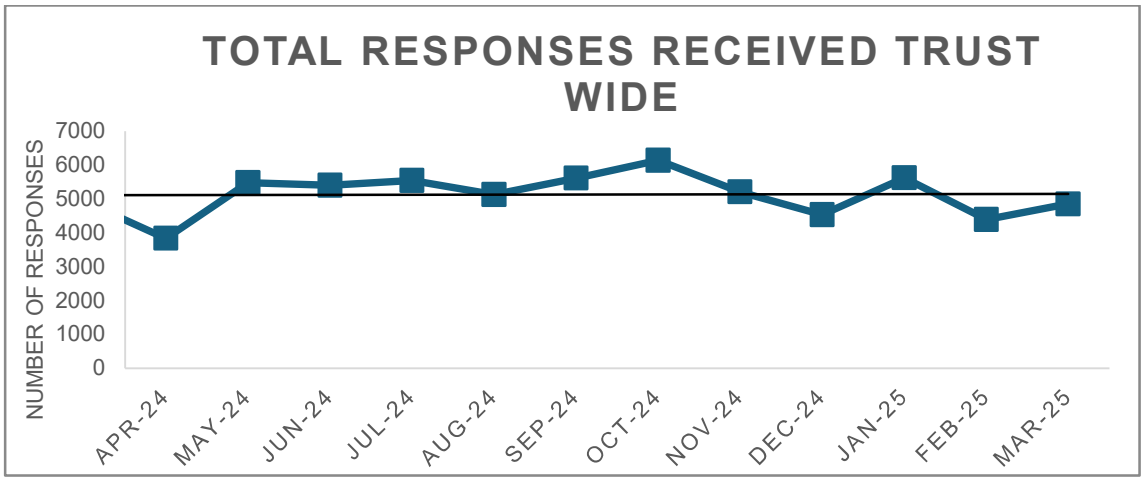
Source: FFT data CIVICA

3.3.5.2 Response Rates and Collection Methods

Understanding how patients choose to share their feedback is essential to ensuring that the Trust captures a representative and meaningful picture of patient experience.

In 2024–25, the Trust collected a total of 65,480 Friends and Family Test (FFT) responses, marking a 4.69% increase compared to the previous year. This growth reflects the Trust's ongoing commitment to improving accessibility and inclusivity in feedback collection.

Figure 40 Friends and Family % Response



Source: FFT data CIVICA

The data shows a shift in how patients are choosing to provide feedback. The breakdown of collection methods shows:

- A notable increase in paper surveys and SMS text responses
- A decline in telephone and online survey responses, possibly due to patient preference for more immediate or accessible formats

Table 36 FFT response rates

Year	QR codes/online surveys	Paper surveys	Telephone surveys	SMS text surveys	Total
2022-23	2,905	6,788	4,421	37,070	51,184
2023-24	3,016	10,944	2,112	46,471	62,543
2024-25	973	13,661	910	49,936	65,480

The increase in paper-based responses is partly attributed to proactive staff engagement, with frontline teams actively encouraging patients to complete the FFT before leaving the hospital. This face-to-face encouragement has proven effective, particularly in inpatient and day case settings.

To support this, the Trust has continued to invest in staff training, ensuring that all teams understand the importance of FFT and are confident in using the CIVICA platform to access, interpret, and act on feedback. Training also includes guidance on updating “You said, we did” boards, which visibly demonstrate how patient feedback leads to real change.

FFT data is reviewed monthly by the Safety and Quality Committee, and detailed reports are shared with divisional governance leads. This ensures that feedback is not only collected but also analysed, shared, and used to inform service improvements across the Trust.

While the Trust has made significant progress in increasing response rates, it currently lacks the ability to analyse FFT data through the lens of protected characteristics or deprivation indices. Work is underway to address this gap, with the aim of ensuring that feedback is representative of all patient groups and that any disparities in experience are identified and addressed.

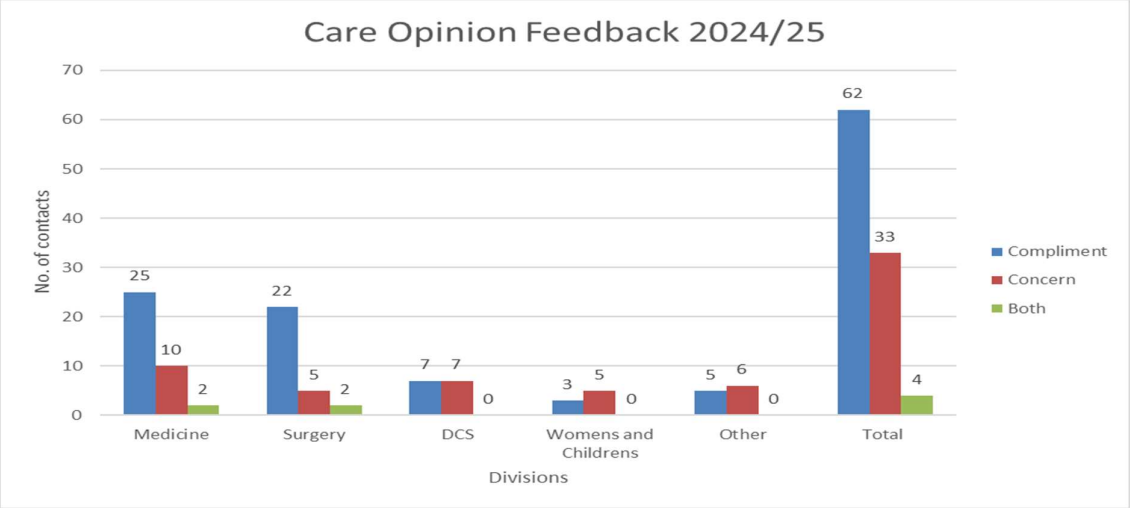
3.3.5.3 Care Opinion Website

In addition to FFT, the Trust monitors feedback submitted via the Care Opinion website. In 2024–25, a total of 198 reviews were posted:

- 124 were compliments
- 66 were concerns
- 8 contained both compliments and concerns

This platform provides a valuable, transparent channel for patients and families to share their experiences, and the Trust continues to engage with this feedback to identify opportunities for improvement and celebrate positive care stories.

Figure 41 Care Opinion feedback



3.3.5.4 Accessible Information

Lancashire Teaching Hospitals provide several approaches to ensure that patients can access information in different formats to accommodate diverse needs and preferences. These measures include:

- **Providing Information in Multiple Languages:** Big word and DA languages are services available within the hospital for people in person, on the telephone and through digital consultations. The use of these are monitored and increasing year on year.
- **Accessible Formats for Visually Impaired Patients:** Information is made available as requested in braille, large print, and audio formats for patients with visual impairments.
- **Digital Platforms:** ReachDeck is in use on the website, this is a translate and speak bar to enable users of the website to access information if they require or prefer this approach The platform allows features like text-to-speech and adjustable text sizes for users.
- **Printed Materials:** Easy read leaflets and British Sign Language Video leaflets are available for some areas as standard on the website. There is a video area of information for patients to access. This is an area we continue to grow and focus on.

- **Sign Language Interpreters:** Access is available through co-sign a local translation service. This is available for patients and their families to provide sign language interpreters to facilitate communication.
- **Patient Advocates:** Patient advocacy services are available through the safeguarding team. Lancashire County Council provide this service as a key partner.

Friends and family feedback mechanisms are accessible in easy read format and the friends and family team have this year included patient demographic measures, to ensure feedback can be increasingly understood through a number of different lenses.

3.3.6 National Patient Survey Results

National patient surveys provide a vital benchmark for understanding how patients experience care across different services and settings. These surveys, coordinated by the CQC and delivered in partnership with Picker Institute Europe, offer valuable insights into what matters most to patients and where improvements are needed. Lancashire Teaching Hospitals NHS Foundation Trust participated in several national surveys, including Maternity, Urgent and Emergency Care, Inpatient, and Cancer services. The following sections summarise the key findings, response rates, and actions being taken in response to patient feedback.

Table 37 Summary of Key Findings in the National Patient Survey Results

3.3.6.1 Maternity Survey 2024	The 2024 Maternity Survey, conducted between April and July, invited a random sample of 324 patients from Lancashire Teaching Hospitals to participate. Of the 318 eligible, 103 completed the survey, resulting in a 32% response rate—a 7% decrease from 2023 and below the Picker average of 39% across 56 trusts. Despite the lower response rate, the Trust maintained its overall position compared to the previous year. Key highlights from the 59 questions asked include: • 96% of mothers rated their overall experience positively. • 93% felt they were treated with respect and dignity during labour and birth. • 94% reported having confidence and trust in staff during labour and birth. • 94% felt involved in decisions about their care. These results reflect a continued commitment to respectful, person-centred maternity care, though the drop in response rate suggests a need to re-engage service users in feedback processes.
3.3.6.2 Urgent and Emergency Care (UEC) Survey 2024	The UEC Survey also ran between April and July 2024, with 1,250 patients invited and 1,195 deemed eligible. A total of 363 responses were received, giving a 30% response rate, which is 5% higher than in 2022 and in line with the Picker average for 64 trusts.

	The survey included 55 questions, with 19 repeated from the 2022 survey. Unfortunately, the Trust did not show significant improvement in any area and was rated significantly worse in five areas compared to 2022. Key findings include: • 65% of patients rated their overall ED experience positively. • 92% felt treated with respect and dignity. • 92% had confidence and trust in the doctors and nurses. While interpersonal care remains strong, the lower overall experience score and areas of decline highlight the need for targeted improvements in the UEC pathway, particularly around wait times, communication, and environment.
3.3.6.3 Inpatient Survey 2023	Conducted between July and November 2023, the Inpatient Survey invited 1,250 patients, with 1,176 eligible and 470 responses received—a 40% response rate, up 2% from 2022. The Picker average for 64 trusts was 43%. Out of 63 questions, 39 were repeated from the previous year. The Trust showed: • Significant improvement in two areas • One area identified as significantly worse Key results: • 76% of adult inpatients rated their experience 7/10 or higher. • 97% felt treated with respect and dignity. • 97% had confidence and trust in their doctors. These results reflect a generally positive inpatient experience, with high levels of trust and respect reported. The improvements suggest that recent quality initiatives are having an impact, though continued focus is needed on the area that declined.
3.3.6.4 Cancer Survey 2024	Published in July 2024, the Cancer Survey results continue to reflect strong performance. The Trust achieved an overall score of 9 out of 10, maintaining this high standard for the third consecutive year and performing above the national average. Notably, Lancashire Teaching Hospitals was the only Trust in the region with no responses in the lower-than-expected range for the second year running. Positive Highlights: • Colorectal, Upper GI (UGI), and Head & Neck teams scored 9.3 overall. • 99–100% of patients confirmed their care plans were reviewed with them. • High scores across all teams for: • Support from a main contact • Information on long-term side effects

	• Holistic Needs Assessments (HNA) • Personalised Stratified Follow-Up (PSFU) • Skin services scored 100% for helpfulness of main contact. • Lung services scored 100% for pain management. • UGI services scored 100% for team collaboration. • Colorectal services showed the most improvement overall.  Areas for Improvement: • Information about hormone treatment (Breast and Prostate) • Inpatient care experience (Breast, Head & Neck, Urology) • Support from primary care and voluntary services during treatment The Trust's Cancer Board and Quality Surveillance Work Programme oversee the action plan, with individual tumour site action plans monitored through the Patient Experience and Involvement Group and the Cancer Patient and Carers Forum.

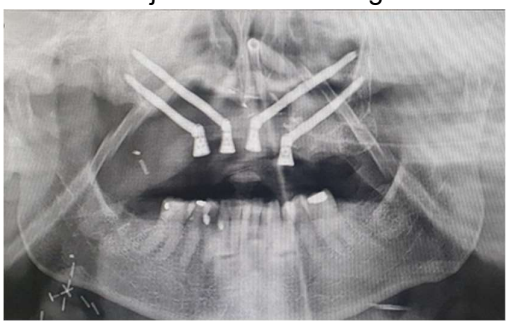
The national patient surveys give us important feedback about how patients feel about their care. Overall, the results show that many patients had positive experiences, especially in cancer, maternity, and inpatient services. Patients felt respected and trusted the staff. However, there are areas we need to improve, such as emergency care and how we provide information and support. The Trust is committed to listening to patients and using their feedback to make care better for everyone.

4. Major Service Developments and Improvements

Despite ongoing operational and financial pressures across the Lancashire and South Cumbria healthcare system during 2024–25, Lancashire Teaching Hospitals NHS Foundation Trust has continued to deliver significant service improvements. These developments have enhanced patient care, supported staff, and helped to ease system-wide pressures. From pioneering surgical techniques to expanding diagnostic and assessment capacity, the Trust has remained focused on innovation, collaboration, and improving outcomes for the communities it serves.

The following highlights showcase some of the most impactful service developments from the past year:

- **Pioneering Surgical Innovation in Maxillofacial and Restorative Care:** In July 2024, the Trust became the first in the region to perform a ZIP flap procedure a complex 12-hour surgery that reconstructed 80% of a patient's upper jaw using a Zygomatic Implant Perforated Flap. This life-saving operation, performed by the Maxillofacial and Restorative teams, significantly improved the patient's quality of life and marked a major milestone in regional cancer care.



- **First Spinal Surgery Using Intraoperative 3D CT Technology:** The Neurosurgery department successfully completed its first spinal surgery using intraoperative 3D CT and navigation technology. The use of Stryker's AIRO TruCT scanner enabled real-time, high-resolution imaging during surgery, enhancing precision, reducing complications, and improving patient outcomes.

- **Expansion of Maternal Medicine Services:** In August, the Trust launched the LeAPH Clinic (Lancashire Antenatal Pre-eclampsia and Hypertension Clinic), a dedicated service for managing high-risk pregnancies. Developed in response to the Ockenden Report, this clinic forms part of the

Trust's Maternal Medicine Centre, making it the third such centre in the region alongside Liverpool and Manchester.

- **Opening of New Acute Medical Assessment Unit (AMU): To** improve patient flow and reduce pressure on the Emergency Department, a new Acute Medical Assessment Unit opened at Royal Preston Hospital in September. The unit includes 24 bed spaces, two assessment bays, and 10 side rooms, enabling faster admissions, shorter stays, and better patient experience.


- **Sherwood Endoscopy Unit Enhances Diagnostic Capacity:** Also in September, the Trust opened the Sherwood Endoscopy Unit, adding two new procedure rooms and expanding the service to five rooms in total. Located at the front of Royal Preston Hospital, the unit supports a wide range of procedures including gastroscopy, colonoscopy, and sigmoidoscopy, with state-of-the-art equipment and facilities.


- **Paediatric Surgical Hub Gains National Accreditation:** The Paediatric Elective Surgical Hub at Chorley and South Ribble Hospital received GIRFT accreditation in September, recognising its high standards in children's surgical care. The hub supports specialties such as dental, ENT, ophthalmology, and plastic surgery, and is part of the national strategy to increase elective care capacity.
- **Launch of Regional Mohs Surgery Service for Skin Cancer:** The Trust's Plastic Surgery department launched the region's first Mohs Micrographic Surgery (used to treat certain types of skin cancers) and Reconstruction Service at Chorley and South Ribble Hospital. This gold-standard treatment offers same-day tumour removal and reconstruction for high-risk skin cancers, significantly improving outcomes and patient experience.

- **Opening of Preston Healthport Community Diagnostic Centre (CDC):** In January 2025, the Preston Healthport CDC opened in Fulwood, providing faster access to life-saving diagnostic tests. Developed in partnership with NHS England, the ICB, and NHS Property Services, the CDC delivers thousands of additional scans and checks, helping to reduce waiting times and improve early diagnosis across the region.

These developments reflect the Trust's unwavering commitment to innovation, collaboration, and patient-centered care even in the face of significant system pressures. By investing in new technologies, expanding specialist services, and improving access to diagnostics and treatment, Lancashire Teaching Hospitals continues to lead the way in delivering high-quality care for the people of Lancashire and South Cumbria.

4.1 Staff Survey and Recommendation of Our Care

4.1.1 NHS Staff Survey 2023–24

The NHS Staff Survey is conducted annually and, since 2021–22, has been aligned with the NHS People Promise, which includes seven core elements. These are complemented by two additional themes: staff engagement and morale. Each indicator is scored out of 10, based on responses to specific questions, with the overall indicator score representing the average.

In 2023–24, the Trust achieved a response rate of 39% (3,994 staff), a decline from 45% (4,539 staff) in 2022–23. This is also below the national average response rate of 49%.

4.1.2 Survey Results and Benchmarking

Scores for each indicator together with that of the survey benchmarking group (Acute and Acute and Community Trusts) are presented below.

Table 38 National Staff Survey Results - People Promise Indicators 2024-2021

Indicators ('People Promise' elements and themes)	**2023/24**		**2022/23**		**2021/22**	
	Trust score	Bench-marking group score	Trust score	Bench-marking group score	Trust score	Bench-marking group score
People Promise:						
We are compassionate and inclusive	**7.15**	7.21	**7.30**	7.24	**7.29**	7.18
We are recognised and rewarded	**5.90**	5.92	**6.06**	5.94	**5.88**	5.72
We each have a voice that counts	**6.6**	6.67	**6.77**	6.70	**6.74**	6.65
We are safe and healthy	**6.03**	6.09	**6.25**	6.08	**6.11**	5.88
We are always learning	**5.53**	5.64	**5.66**	5.62	**5.51**	5.35
We work flexibly	**6.18**	6.24	**6.42**	6.20	**6.20**	6.00
We are a team	**6.75**	6.74	**6.86**	6.75	**6.81**	6.64
Staff engagement	**6.63**	6.84	**6.91**	6.91	**6.86**	6.80
Morale	**5.72**	5.93	**6.02**	5.90	**5.89**	5.68

The 2024 survey results indicate a shift in trend following several years of steady improvement, during which the Trust consistently met or exceeded national benchmarks. Despite increased communication and engagement efforts during the survey period, the overall scores have declined across most indicators.

Table 39 Trust National Staff Survey indicators comparison to National Benchmark

Indicators Below National Benchmark:	Indicators Close to National Benchmark:	Indicator Above National Benchmark:
• Staff Engagement • Morale • We Are Always Learning • We Are Safe and Healthy • We Each Have a Voice That Count	• We Are Recognised and Rewarded • We Work Flexibly • We Are Compassionate and Inclusive	• We Are a Team (This continued strength is attributed to the sustained use of the TED Tool and the Trust's ongoing focus on team development.)

While the results are challenging, they provide a valuable snapshot of the current working environment. They reflect the impact of local and national pressures, including significant organisational change and uncertainty experienced by staff.

The Trust remains committed to listening to staff feedback and using it to inform improvement plans that support wellbeing, engagement, and a positive workplace culture.

4.1.3 Staff Engagement Results

The staff engagement score is derived from 9 questions which measure the 3 facets of engagement, namely motivation, involvement and advocacy. Table 38 below provides a question breakdown of the 2024 results along with a comparison to the previous year and to the national benchmark average.

The results show declines across the board in motivation, involvement, and advocacy however, there are some positive exceptions. We are above the national average for 'Time often/always passes quickly when I am working' and for two of the questions regarding involvement – where colleagues feel there are opportunities to show initiative and where colleagues feel they are able to make suggestions to improve the work of their team.

The largest and fastest-growing gaps are seen in the advocacy questions where all three questions have declined, and we sit below the national average for both recommending LTH as place to work and recommendation of our care.

Whilst recommending the organisation as a place to work had increased in 2023, it has taken a significant dip this year, decreasing by almost 10 percent. Our scores do fit alongside the national picture where the average advocacy scores have declined each year since 2020.

The results show there is a deteriorating perception in our colleagues with regards to if the care of patients/service users is the organisation's top priority and if a friend or relative needed treatment they would be happy with the standard of care.

Table 40 2024 Staff Engagement Question Breakdown

	LTH Results and comparison (2023 to 2024)			National Average 2024 Comparison	
Question	**LTH 2024**	**LTH 2023**	**Changes**	**National Average 2024**	**LTH comparison to National average**
Motivation					
Often/always look forward to going to work	**51.76%**	57.07%	-5.31%	54.19%	-2.43%

	LTH Results and comparison (2023 to 2024)			National Average 2024 Comparison	
Often/always enthusiastic about my job	**67.35%**	71.38%	-4.03%	67.95%	-0.60%
Time often/always passes quickly when I am working	**73.27%**	75.62%	-2.35%	70.90%	2.37%
Involvement					
Opportunities to show initiative frequently in my role	**73.89%**	76.58%	-2.69%	73.20%	0.69%
Able to make suggestions to improve the work of my team/dept	**72.97%**	75.03%	-2.06%	70.60%	2.37%
Able to make improvements happen in my area of work	**54.42%**	57.17%	-2.75%	55.73%	-1.31%
Advocacy					
Care of patients/service users is organisation's top priority	**66%**	72.57%	-6.70%	74.42%	-8.55%
Would recommend organisation as place to work	**49.77%**	59.45%	-9.68%	60.90%	-11.13%
If friend/relative needed treatment would be happy with standard of care provided by organisation	**52.15%**	58.37%	-6.22%	61.54%	-9.39%

**Key - Red – negative score when compared to 2023 (more than 5% decline), Amber – consistent score with 2023 (less than the 5% difference), Green – positive score when compared with 2023 (more than 5% improvement)*

The widening gap between the Trust and national benchmarks in staff perceptions of care quality was further reflected in the free text comments submitted as part of the 2024 NHS Staff Survey. A total of 191 comments were linked to the theme of advocacy and patient care, broken down as follows:

- 180 negative comments
- 9 positive comments
- 2 neutral comments

This represents an increase in negative sentiment compared to 56 negative comments in 2023, highlighting growing concerns among staff.

Staff feedback also revealed negative perceptions of the quality of care across the Trust currently and feedback a view that patient care and services we impacted by lack of staffing and resources due to the ongoing financial pressures. Comments also highlighted a strong link between patient safety and staff morale, with many colleagues noting that current pressures were impacting their sense of being valued and recommendation of our care.

4.1.4 Next steps and future priorities

Following the lifting of the embargo on the 2024 NHS Staff Survey results, Lancashire Teaching Hospitals NHS Foundation Trust has taken a comprehensive and multi-level approach to ensure the findings are shared, understood, and acted upon across the organisation.

- A corporate level action plan has been developed to address key themes which support organisational-wide changes along with progressing the existing People Plan strategic actions.
- Data packs have been produced for Executive Teams and Divisional Leadership Teams providing results at Trust, Divisional and Team Level.
- Communications and engagement activities have taken place to share the results and highlight key priorities including an initial all staff email update, presentations and interactive sessions at the monthly Leaders Forum, Managers Update, All Colleague Briefing to able further listening and ideas for action and regular newsletter updates.
- Discussions and facilitated workshops have begun with divisional leaders and key departments to explore the results and identify priorities, supplementing the corporate level action plan.
- Local managers have received a copy of the team results dashboard along with templates and resources to engage and have meaningful conversations with their colleagues about the results.
- Intranet area has been updated with a Staff Survey toolkit with further templates and guidance on how to have conversations and engage with team members across a range of themes from the People Promise.
- Further analysis has been undertaken to identify local teams from each division to offer enhanced team support as part of a more proactive approach to raise levels of staff engagement and satisfaction.
- In addition, this analysis has been repeated to pinpoint areas with lower scores across key focus areas in our corporate action plan e.g. Supporting Sexual Safety, Freedom to Speak Up, Civility improvement work. These areas will be prioritised as part of targeted outreach work to raise awareness, signpost or provide more bespoke support where needed.
- A comprehensive communication and engagement plan has been developed to continue this work over the next six months. The goal is to maintain open communication, foster ongoing engagement, and keep conversations active, ensuring that staff feel heard and valued.

4.1.5 Priorities and targeted actions

Building on work already underway in response to the Staff Survey results, we will continue to prioritise the following themes and areas of concern through our corporate level action plan.

These areas include:

1. **Colleague Wellbeing & Flexible Working**

- Enhance awareness of flexible working options
- Address burnout and wellbeing concerns through improved corporate support

2. **Colleague Sexual Safety**
    - Continue embedding the NHS Sexual Safety Charter
    - Address experiences of unwanted sexual behaviour highlighted in new survey questions
3. **Colleague Health, Safety and Physical Violence**
    - Strengthen the Zero Tolerance approach to tackle discrimination, bullying, harassment, and aggression
4. **Raising Concerns**
    - Improve confidence in speaking up, which has declined below the national average
5. **Recognition**
    - Expand initiatives to ensure all colleagues feel valued and appreciated, especially at team level
6. **Equality, Diversity & Inclusion (EDI)**
    - Address disparities in experience across protected characteristic groups
    - Improve team-level appreciation and inclusivity
7. **Advocacy in Patient Care and Place to Work**
    - Tackle declining advocacy scores and perceptions that financial pressures outweigh patient care priorities
8. **Support and Development for Managers**
    - Strengthen people management capability to improve individual colleague experience
9. **Bespoke Organisational Development (OD) Team Support**
    - Provide targeted development to teams with lower engagement scores
10. **Survey Response Rates**
    - Increase participation to ensure broader representation and reach national benchmark levels

Examples of work already completed in the last 12 months:

- Sexual Safety: Signed the NHS Sexual Safety Charter; launched training and outreach initiatives
- Recognition: Introduced Monthly Proud Rewards, Thank You Week, Team Recognition Kits, and expanded Our People Awards
- Culture: Delivered ‘Civility Saves Lives’ training and launched a Managers’ Toolkit
- Leadership Support: Relaunched Managers Update Sessions with improved content
- 1:1 Culture: Developed new resources and training to support regular, meaningful colleague conversations
- OD Team Support: Delivered bespoke development to low-scoring teams
- Wellbeing: Expanded psychological wellbeing services, relaunched Mental Health First Aiders, and delivered attendance management training
- Zero Tolerance: Rolled out Active Bystander training and toolkits
- Inclusion: Hosted Listening Rooms to improve experiences for minority groups
- Car Parking: Launched a car-sharing app, re-procured the parking system, and explored new tech solutions.

Examples of actions currently underway/planned in the next 12 months:

- Recognition: Pilot Retirement Reward, launch Colleague Lottery & Benefit Funds, and install 'Recognition Stations'
- Zero Tolerance: Continue training rollout and target support using new data
- Car Parking: Cleanse eligibility data and explore multi-storey development options
- Career Development: Launch an intranet hub for career pathways
- Wellbeing: Promote upcoming health and wellbeing events
- Leadership Development: Relaunch and expand leadership programmes
- Colleague Conversations: Refresh processes and provide training on probation, stay, 1:1, and leaver conversations
- People Managers: Launch a central intranet hub for tools and guidance
- Raising Concerns: Refresh Freedom to Speak Up Champion roles and communication materials
- Inclusion: Advance disability and long-term condition support and deliver on the 'Consciously Inclusive' strategy
- OD Team Support: Review and expand targeted support for low-engagement teams
- Advocacy: Increase senior leadership visibility, share positive team stories, and sustain monthly recognition focus
- Survey Response Rates: Review incentives and implement a detailed communication plan for the 2025 survey

4.1.6 Monitoring Performance and Tracking Impact

The Trust has established robust mechanisms to monitor, evaluate, and report on the impact of actions taken in response to staff feedback, particularly from the NHS Staff Survey and other engagement channels.

Regular monitor and internal reporting takes place within the OD Team, monthly Divisional Workforce Committees, Monthly SIP reports and annually to our Trust Workforce Committee and Board. Progress is tracked through analysing results of our engagement surveys, retention data, and wider colleague feedback. This enables the Trust to evaluate the effectiveness of interventions at the organisational, divisional, and team levels, identify trends over time, and inform future improvement workstreams.

Trust-wide mechanisms continue to be used (Trust Newsletters, All Colleague Briefings, Managers Updates etc.) to ensure regular updates are provided along with the opportunity to ask questions and share comments. As part of these we share 'You said, We did' style updates to demonstrate tangible actions in response to colleague feedback.

Engagement is further enabled at a local level through two-way conversations by providing tools and resources (e.g. Manager Huddle Sheets, TED Tool and Team Conversation Activities) so that managers can response directly to their team members. By continuing our work to embed these mechanisms into our culture, we ensure that engagement is not just a one-way process but is a continuous dialogue that strives to shape real change.

The Trust remains committed to keeping colleagues updated on the actions taken so they know their voice matters and that the Trust is listening. By keeping people informed and involved, we build trust, strengthen teams, and create a workplace where everyone feels valued.

4.2 Medical and Dental Workforce Rota Gaps

The Workforce Department actively monitors all vacant posts across the Trust. In accordance with the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016, Schedule 6, paragraph 11b, the Trust is required to produce a quarterly vacancy gap analysis as part of the Guardian of Safe Working Hours reporting obligations.

This analysis specifically pertains to NHS Doctors and Dentists in Training. As stipulated, the Trust must also include a plan for improvement aimed at reducing these gaps within its annual Quality Account. It is important to note that there is no equivalent requirement for Registered Nurses or Allied Health Professionals (AHPs).

Table 41 Medical and Dental Vacancies

Data is for each post as a whole time equivalent. It does not reflect gaps as a result of long-term sickness, maternity/adoption leave and working part time.

Grade	Vacant WTE	Filled WTE	Funded WTE	Vacancy Rate
FY1	0	62.92	62.28	0
FY2	3.23	36.27	39.5	8.18%
ST1-2	9.79	100.21	110	8.90%
ST3+	0	178.95	150.56	0
Junior Clinical Fellow	5.9	84.41	90.31	6.53%
Senior Clinical Fellow	8.34	106.17	114.5	7.28%
SAS	3.38	89.63	93.01	3.64%

Source: LTHTR data Feb 2025 General ledger

Vacancy data is reviewed regularly by Divisional Workforce Committees, supported by monthly reports from Workforce Business Partners. These reports inform targeted recruitment strategies and support timely decision-making in collaboration with Clinical Directors and departmental managers.

The Trust demonstrates a proactive approach to workforce planning, with low vacancy rates in key grades such as FY1 and ST3+, and structured plans in place to address moderate gaps in other areas. This work is further embedded within the SIP under the medical workforce workstream, reinforcing the Trust's commitment to safe staffing, service continuity, and high-quality patient care.

4.3 Consultant Vacancy Rates

As of March 2025, the Trust's consultant vacancy rate stands at 7.86%, showing a notable improvement from 11.44% in March 2024. These figures are reported externally through the NHS Provider Workforce Return and internally via the Workforce Committee, a sub-committee of the Board, to ensure oversight and assurance on recruitment strategies.

Recruitment challenges persist in nationally recognised shortage specialties such as Neurology, Elderly Medicine, Anaesthetics, and Gastroenterology. To maintain service continuity, the Trust currently employs long-term locums in several of these areas, including Diabetes and Haematology.

To address these gaps and strengthen the future consultant pipeline, the Trust has implemented several innovative initiatives:

- ORDER Programme: As a GMC-approved sponsor, the Trust has launched the Overseas Registrar Development and Recruitment (ORDER) Programme. This two-year initiative targets senior doctors (Senior Clinical Fellow level), offering structured development and educational qualifications to support their progression.
- CESR Development Posts: Multiple specialties now offer CESR (Certificate of Eligibility for Specialist Registration) development roles. A rotational CESR programme in Anaesthetics began in August 2023, with completion expected in February 2025, aimed at increasing the number of consultants in hard-to-fill areas.

These strategic efforts reflect the Trust’s commitment to sustainable workforce planning and reducing reliance on locum staffing.

4.4 Core Skills Training

Ensuring staff are up to date with mandatory training is a key component of delivering safe, high-quality care. The training subjects that are nationally mandated through the Core skills Training Framework are reported on a monthly basis within the Trust to identify and support areas that have not achieved the target compliance (90%) for all subjects.

An area identified by the Care Quality Commission (CQC) as requiring improvement is Core Skills Training. The Trust has demonstrated an improved end of year position in Core Skills Training. Moving and Handling Level 1 and Level 2, Resus Level 2 and Resus Level 3 have demonstrated sustained compliance since November 2024 at Trust wide level. Focused improvement work is currently underway to address areas where compliance is not being consistently achieved or maintained, particularly at the divisional and professional group levels.
Core Skills Compliance is reported to the Education, Training and Research Committee on a bi-monthly basis for Board level oversight of compliance and targeted interventions.

Please refer to Table 42 below for a detailed breakdown of the Trust wide compliance with Core Skills Training Framework metrics.

Table 42 Core Skills Training Framework Compliance (March 2024 versus March 2025)

	Mar-24	Mar-25	Target Achieved
Conflict Resolution	99%	97%	Achieved
Equality, Diversity and Human Rights	95%	98%	Achieved
Fire Safety	95%	97%	Achieved
Health, Safety and Welfare	95%	98%	Achieved
Infection Prevention and Control - Level 1	94%	97%	Achieved
Infection Prevention and Control - Level 2	93%	93%	Achieved
Info Gov: All Staff	94%	93%	Achieved
Moving & Handling L1 (Non-Clinical)	84%	94%	Achieved
Moving & Handling L2 (Clinical)	84%	91%	Achieved
Preventing Radicalisation - Awareness	95%	95%	Achieved
Preventing Radicalisation - Basic Awareness	96%	97%	Achieved
Resus - Level 1, Non-Clinical	92%	91%	Achieved
Resus - Level 2, ABLS&PBLS	84%	92%	Achieved
Resus - Level 3, ILS	56%	61%	Improving but not achieved
Resus - Level 3, NILS	84%	91%	Achieved
Resus - Level 3, PILS	50%	63%	Improving but not achieved
Safeguarding Adults (Level 1)	96%	95%	Achieved
Safeguarding Adults (Level 2)	98%	98%	Achieved
Safeguarding Adults (Level 3)	92%	92%	Achieved
Safeguarding Children (Level 1)	95%	95%	Achieved
Safeguarding Children (Level 2)	96%	97%	Achieved
Safeguarding Children (Level 3)	90%	93%	Achieved

4.5 Quality Assurance

4.5.1 Overview and Assurance Statement

This Quality Account presents the data, information, and assurance required by NHS England. The Trust has reported on statutory core performance indicators and provided assurance regarding the quality and integrity of our data. We have outlined progress against the key priorities for 2024–25, as set out in the 2023–24 Quality Account, and introduced new priorities for 2024–25 that align with our SIP.

In addition, the Trust has reviewed activity across the domains of patient safety, effective care, and patient experience, ensuring alignment with our organisational ambitions and risk appetite.

4.5.2 Governance and Oversight

The Safety and Quality Committee plays a central role in fostering a culture of safety and continuous improvement. It supports and empowers staff to enhance services and care delivery. The Committee provides assurance to the Board of Directors by:

- Ensuring robust structures, processes, and controls are in place to uphold safety and high

standards of care.

- Monitoring performance against agreed safety and quality metrics and ensuring timely and effective responses where needed.
- Ensuring compliance with NHSE requirements and CQC.

4.5.3 Governor Engagement and Assurance

Trust Governors remain actively engaged in quality improvement activities. They contribute significantly to assurance processes by participating in STAR assessments, other quality reviews, and by attending the Patient Experience Improvement Group.

Their continued involvement provides valuable insight and constructive challenge helping to drive improvements in the services we provide to patients and our wider communities.

This Quality Account for 2024–25 demonstrates the Trust's commitment to transparency, accountability, and continuous improvement in delivering safe, effective, and patient-centered care.

Annex 1 : Statements from external stakeholders

Statement from NHS Lancashire and South Cumbria Integrated Care Board in response to the Lancashire Teaching Hospitals NHS Foundation Trust Quality Account 2024-25

05 June 2025

To:
Professor Silas Nichols
Chief Executive Officer
Lancashire Teaching Hospitals Foundation Trust

Re: Lancashire Teaching Hospitals Foundation Trust Quality Account 2024/25 – Stakeholder Feedback Lancashire and South Cumbria Integrated Care Board

Lancashire and South Cumbria Integrated Care Board (LSCICB) appreciates the opportunity to review and comment on the Lancashire Teaching Hospitals Foundation Trust (LTH) Quality Account 2024/25. LSCICB would like to extend thanks to the Trust for preparing this Quality Account, including reflection on progress made over the past year and quality priorities for the coming year. We acknowledge the importance of maintaining quality at a time when Providers continue to experience challenges with demand and patient flow under increasingly pressured finances.

Commentary provided in this response letter relates to services commissioned by LSCICB as well as recognising key programmes of work that the Trust has undertaken during 2024/25. We have a continued commitment to commissioning high quality services from LTH and take seriously their responsibility to ensure that patients' needs are met by consistent and high standards of safe care, provision of effective services and that the views and expectations of patients and the public are listened to and acted upon.

LSCICB is pleased to see the focus on continuous improvement, with key achievements made in 2024/25 to leadership and culture providing a solid foundation for future improvement work. LSCICB has been encouraged by the move to a single improvement plan, to help co-ordinate and provide oversight of the improvement actions across the Trust and hope to see greater focus on impact and outcomes of these actions.

The quality account highlights impactful service developments that have been made over the past year and LSCICB is proud to see innovations that positively impact patient care being showcased such as the reconstruction of 80% of a patient's upper jaw using a Zygomatic Implant Perforated Flap and successful first spinal surgery using intraoperative 3D CT and navigation technology.

LTH has made notable improvements in operational performance reducing long waiting times for treatment and improving cancer waiting times through targeted initiatives. Despite progress, challenges remain in urgent care pathways. LSCICB is pleased to see the commitment to addressing these issues to ensure timely and effective care for all patients and would encourage focus on reducing ambulance handover times, building on the positive improvement seen in March 2025 and reducing the total time patients spend in the department.

The NHS Staff Survey revealed a decline in morale and advocacy for patient care, indicating the need for enhanced support and engagement initiatives. An increase in discriminatory reports, particularly race based discrimination, and mixed trends in bullying incidents highlight the need for ongoing efforts to create a safe and inclusive workplace.

The introduction of the Team Engagement and Development Tool (TED) to improve team satisfaction and engagement, alongside leadership training initiatives is positive, along with the promotion and increased utilisation of Freedom to Speak Up (FTSU) to address staff concerns. LSCICB hopes that these efforts, prove useful and supportive to staff and improvements are reflected within the next NHS Staff Survey.

The Trust's commitment to patient safety remains strong and LSCICB is pleased to see the progress made in delivering the Always Safety First (ASF) strategy. LSCICB supports the priorities identified for improvement in Year 3, including deteriorating patients, reducing violence and aggression, Emergency Department (ED) exit block and patient flow, rapid tranquilisation, mental health safety, C. difficile infection reduction, and pressure ulcer reduction.

The Quality Account is light on Patient Safety Incident Investigation (PSII) learning and improvements. LSCICB appreciate that this is work in development and hope to see this learning demonstrated in future accounts. Similarly, the learning from Preventing Future Deaths (PFD) in not referenced or the impact and outcomes from resulting improvements and we hope to see this narrative included in the future.

LSCICB is pleased that the STAR Quality Assurance Framework now mandates that all critical standards must be met for progression to silver and gold ratings, providing more confidence in these ratings. The focus areas of STAR include falls prevention, safeguarding, and infection control, which will help the Trust ensure that actions being taken are effective. We note the reduction in wards achieving silver status and hope to see wards being supported to meet these standards. LSCICB will track progress through our attendance at the Trust's Quality Committee and LSCICB led Quality Review Meetings.

LTH has made good progress with the Getting it Right First Time (GIRFT) programme and engage well with LSCICB system reviews. GIRFT supports delivery of high-quality evidence-based care and allows targeted improvement.

The Trust has made improvement in compliance rates with Paediatric Immediate Life Support (PILS); however, this area remains an outlier and LSCICB would like to see continuation of efforts to further improve training uptake in 2025/26.

The involvement of stakeholders is crucial in shaping priorities for improvement. The Trust has taken several steps to ensure that the voices of stakeholders are heard and integrated into their strategic planning:

1. **Engagement with Patients and Families**: Regular feedback from patients and their families is sought through surveys, focus groups, and patient forums. This feedback is invaluable in identifying areas for improvement and ensuring that patient needs are at the forefront of initiatives.
2. **Collaboration with Staff**: Staff engagement is a priority; the Trust have implemented various channels for staff to voice their concerns and suggestions. The Freedom to Speak Up (FTSU) service is instrumental in addressing staff concerns and fostering a culture of openness.
3. **Partnerships with External Organisations**: The Trust collaborates with national research organisations, regulatory bodies, and community partners to ensure that strategies are aligned with best practices and regulatory requirements.

The Trust plans to prioritise continuous improvement in patient safety, effective care delivery, and staff engagement, focusing on enhancing communication and fostering a culture of speaking up.

The Quality Account illustrates LTH's commitment to enhancing the quality of care, patient safety, and staff engagement through strategic initiatives and continuous improvement efforts. Future accounts need to focus on the impact and outcomes of these improvements.

LSCICB appreciates the amount of work involved in producing this account and values the opportunity to comment, acknowledging the contribution to public accountability in relation to quality and enhancing the provision of safe and effective care.

Yours sincerely

Kathryn Lord

Lancashire and South Cumbria Integrated Care Board
Director of Nursing, Quality Assurance and Safety

Statement from Healthwatch Lancashire In response to Lancashire Teaching Hospitals NHS Foundation Trust Quality Account 2023-24

From: Jodie Carney
Manager
Healthwatch Lancashire,
Leyland House, Lancashire Business Park
Centurion Way, Leyland
PR26 6TY

Healthwatch Lancashire

Response to Lancashire Teaching Hospitals NHS Foundation Trust Quality Accounts Report for 24-25

Introduction

We are pleased to submit the following considered response to Lancashire Teaching Hospitals NHS Foundation Trust Quality Accounts for 2024-25.

Chief Executive's Statement

It is pleasing to read that working in partnership with organisations is a continued priority for the Trust. As a Healthwatch we have appreciated this opportunity to work together to collect valuable patient feedback, which in no doubt contributes to service improvement and experience for patients. We hope that this partnership working continues to strengthen.

2.3.5 Operational Performance

It is reported here that there has been a reduction in the number of patients over 52 weeks for treatment by 50%, which is a huge improvement. This is something that needs to be communicated to patients as an achievement if it hasn't been done already.

2.5 Always Safety First (ASF)

The current Maternity and Neonatal Voices Partnership Lead has been in post since 2023 and is no longer referred to as a chair.

2.15.2 Commitment to Continuous Improvement

In terms of patient feedback, this section discusses a survey, is this survey accessible to all patients and are there considerations for other languages, easy read and British Sign Language?

There may be other methods needed to ensure that all patients have an opportunity to provide feedback on the care that they have received.

3.3.1 Patient Experience Performance Report 24-25

In relation to the growth in number of Patient Forums, it may be a good opportunity to list here the different patient forums that are available.

We can echo the Trust's involvement with the Deaf community, in a recent meeting around

Healthwatch Lancashire's report into access for people who are Deaf and use BSL to health and social care services. We have had consistent representation from the Trust who have demonstrated in meetings a desire to improve services and access for people within this community.

3.3.5 Friends and Family Feedback (FFT)
Again as mentioned above regarding the survey, is the FFT test in various accessible formats?

In accordance with the current NHS reporting requirements, mandatory quality indicators requiring inclusion in the Quality Account we believe the Trust has fulfilled this requirement. The Quality Indicators, results and supporting narrative are clear and well laid out. It was pleasing to read of the various service developments and improvements such as the new AMU.

Summary
Overall, this is a fair and well-balanced document which acknowledges areas for improvement and details comprehensive actions being taken to further improve patient treatment, care and safety.

We welcome these and as a Healthwatch we are committed to supporting the Trust to achieve them.

Jodie Carney Manager- Healthwatch Lancashire

Statement from the Lancashire County Council Health Scrutiny Committee in response to Lancashire Teaching Hospitals NHS Foundation Trust Quality Account for 2024-25.

The statement from Lancashire County Council Health Scrutiny Committee is as follows: -
"Unfortunately the Committee will not be in a position to provide a statement on the LTHTR quality accounts this year, due to ongoing training members are receiving on the role of scrutiny as part of their induction as new County councilors following the recent elections. However, the Committee will look forward to ongoing support and communication with LTHTR throughout 2024/25."

Council of Governors of Lancashire Teaching Hospitals NHS Foundation Trust Quality Account: Feedback from Council of Governors Meeting on 24th April 2025

In line with the Trust's commitment to engage and consult with the Council of Governors at a meeting of 24th April 2025, governors were invited to consider and input into the two Quality Indicators for inclusion in the 2025-26 Quality Account.

The agreed topics which support putting patients are at the heart of what we do support delivery of The Patient Experience and Involvement Strategy 2022–2025 and the Patient Safety Incident Response Framework and are as follows:

Indicator 1 Insight: The Trust improves its understanding of the patient experience by listening and gaining real insight by using multiple sources of information, including patient stories, impact

statements and patient surveys. This will ensure the patient and family voice is truly “heard,” especially of those hear less often.

Indicator 2 Involvement. The involvement of patients, families, carers when they have experienced an incident is meaningful, individualised and they are treated with respect and compassion ensuring genuine and compassionate learning from incidents, especially of those involved less often.

Annex 2: Statement of directors’ responsibilities for the Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS England has issued guidance to NHS Foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust boards should put in place to support data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust annual reporting manual 2024-25 and supporting guidance.
- The content of the Quality Report is not inconsistent with internal and external sources of information including:

- Board minutes and papers for the period April 2024 to March 2025.
- Papers relating to quality reported to the Board over the period April 2024 to March 2025.
- Feedback from Integrated Care Board 5th June 2025
- Feedback from Healthwatch 3rd July 2025
- Feedback from Overview and Scrutiny Committee 6th July 2025
- The Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 is incorporated in the Annual Patient Experience Report 2024-25.
- The Quality Report presents a balanced picture of the NHS Foundation Trust’s performance over the period covered.
- The performance information reported in the Quality Report is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review by MIAA to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- The Quality Report has been prepared in accordance with NHSI’s Quality Account manual and supporting guidance as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Professor Mike Thomas Chair Date: 9th July 2025

Silas Nicholls Chief Executive Date: 9th July 2025

Appendix 1 - List of Tables

Appendix 2 - List of Figures

Appendix 3 - Glossary of Abbreviations

AAR	After Action Review
ACP	Advance Care Practitioner
AHP	Allied Health Professionals
ASF	Always Safety First
AMaT	Audit Monitoring and Tracking System
AMG	Antimicrobial Management Group
APOM	Anaesthesia and Perioperative Medicine
BAF	Board Assurance Framework
BAME	Black Asian and Minority Ethnic
BAUS	British Association of Urological Surgeons
BOAST	British Orthopaedics Association Standards for Trauma and Orthopaedics
BI	Business Intelligence
BRC	Biomedical Research Centre
CAHPR	Council for Allied Health Professions Research
CDC	Community Diagnostic Centre
CDH	Chorley District Hospital
C.Difficile	Clostridioides Difficile
CDOP	Child Death Overview Panel
CEMD	Confidential Enquiry in Maternal Deaths
CESR	Certificate of Eligibility for Specialist Registration
CFO	Chief Finance Officer
CI	Continuous Improvement
CIWA	Clinical Institute Withdrawal Assessment for Alcohol
CK	Creatine Kinase
CKD	Chronic Kidney Disease
CMO	Chief Medical Officer
CNO	Chief Nursing Officer

CNST	Clinical Negligence Scheme for Trusts
COO	Chief Nursing Officer
COPD	Chronic Obstructive Pulmonary Disease
CP-IS	Child Protection Information Sharing System
CQC	Care Quality Commission
CQI	Commissioning for Quality and Innovation
CrCu	Critical Care Unit
CSAP	Child Safeguarding Assurance Partnership
CSPR	Child Safeguarding Practice Review Panel
CSC	Children's Social Care
CT	Computed Tomography
CXR	Chest X-ray
CYA	Children & Young Adults
DIPC	Director of Infection Prevention & Control
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
DNAR	Do Not Attempt Resuscitation
DoLs	Deprivation of Liberty Safeguards
DSPT	Data Security and Protection Tool
E.coli	Escherichia coli
ED	Emergency Department
EDI	Equality Diversity Inclusion
EOS	Early Onset of Sepsis
EPMA	Electronic Prescribing and Medicines Administration
EWS	Early Warning Score
FFFAP	Falls and Fragility Fractures Audit Programme
FFT	Friends and Family Test
FGM	Female Genital Mutilation
FTSU	Freedom to Speak Up (FTSU) guardian
FY1	Foundation Year 1

FY2	Foundation Year 2
FY3	Foundation Year 3
GAS	Group A streptococcus
GDPR	General Data Protection Regulations
GGI	Good Governance Institute
GICAP	Gastro-intestinal Cancer Audit
GIRFT	Getting It Right First Time
GMC	General Medical Council
GP	General Practitioners
GSK	Galaxo Smith Kline
H&N	Head and Neck
HCG	Human chorionic gonadotropin
HOHA	Healthcare Onset/Healthcare Associated
HSSIB	Health Services Safety Investigation Body
HSMR	Hospital Standardised Mortality Ratio
HQIP	Healthcare Quality Improvement Partnership
HVLC	High Volume, Low Complexity
IARC	International Agency for Research on Cancer
IBD	Inflammatory Bowel Disease (Programme)
ICB	Integrated Care Board
ICNARC	Intensive Care National Audit & Research Centre
ICO	Information Commissioner's Office
ICS	Integrated Care System
IDA	Iron Deficiency Anaemia
IGAS	Invasive group A Streptococcus

INCS	Integrated Nutrition and Communication Service
IPC	Infection Prevention and Control
IPL	Inter-professional learners
IT	Information Technology
LCRF	Lancashire Clinical Research Facility
LeDeR	Learning Disability Mortality Review Programme
LFPSE	Learn from patient safety events
LMNS	Local Maternity Neonatal Systems
LSAB	Lancashire Safeguarding Adults Board
LTHTR	Lancashire Teaching Hospitals NHS Foundation Trust
MASH	Multi Agency Safeguarding Hubs
MAU	Medical Assessment Unit
MBRRACE-UK	Mothers and Babies - Reducing Risk through Audits and Confidential Enquiries across the UK
MCA	Mental Capacity Act
MCCDs	Medical Certificate of Cause of Death
MDT	Multidisciplinary Team
ME/MEs	Medical Examiner/s
MEO/MEOs	Medical Examiner Officer/s
MHRA	Healthcare Products Regulatory Agency
MIAA	Mersey Internal Audit Agency
MINAP	Myocardial Ischaemia National Audit Project
MITRE	Muscle Invasive Bladder Cancer at Transurethral Resection of Bladder Audit
MRSA	Methicillin Resistant Staphylococcus Aureus

MSK	Musculoskeletal
MUST	Malnutrition Universal Screening Tool
NABCOP	National Audit of Breast Cancer in Older Patients
NACAP	National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme
NACEL	National Audit of Care at the End of Life
NAIF	National Audit of Inpatient Falls
NCAA	National Cardiac Arrest Audit
NCAP	National Cardiac Audit Programme
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NCMD	National Child Mortality Database
NCPRES	National Cancer Patient Experience Survey
NDA	National Adult Diabetes Audit
NELA	National Emergency Laparotomy Audit
NGT	Nasogastric tube
NHFD	National Hip Fracture Database
NHS	National Health Service
NHSE	NHS England
NHSI	NHS Improvement
NICE	National Institute for Health and Care Excellence
NICU	Neonatal Intensive Care Unit
NIH	National Institute of Health (USA)
NIHR	National Institute for Health and Care Research
NJR	National Joint Registry
NLCA	National Lung Cancer Audit

NMAHP	Nursing Midwifery Allied Health Professionals
NMPA	National Maternity and Perinatal Audit
NMPs	Non-Medical Prescribers
NNAP	National Neonatal Audit Programme
NOF	NHS Oversight Framework
NOGCA	National Oesophago-gastric Cancer Audit
NPCA	National Prostate Cancer Audit
NPDA	National Paediatric Diabetes Audit
NPSA	National Patent Safety Agency
NRLS	National Reporting and Learning System
NVR	National Vascular Registry
OGD	Oesophago Gastro Duodenoscopy
ORDER	Overseas Registrar Development and Recruitment
PALS	Patient Advice and Liaison Service
PAU	Paediatric Assessment Unit
PCR	Polymerase Chain Reaction
PEWS	Paediatric Early Warning Score
PHSO	Parliamentary and Health Service Ombudsman
PIRs	Post Infection Reviews
PMRT	Perinatal Mortality Review Tool
POP	Plaster of Paris
PPE	Personal protective equipment
PQIP	Perioperative Quality Improvement Programme
PROMs	Patient Reported Outcome Measures
PROMPT	Practical Obstetric Multi-Professional Training

PSCF	Procedure-Specific Consent Form
PSII	Patient Safety Incident Investigation
PSIRF	Patient Safety Incident Response Framework
PSP	Patient Safety Partner
PUL	Pregnancy of unknown location
QIPs	Quality Improvement Programmes
RAG	Red, Amber and Green
RALP	Robot-Assisted Laparoscopic Radical Prostatectomy
RCN	Royal College of Nursing
RCOG	Royal College of Obstetricians and Gynaecologists
RCP	Royal College of Physicians
REJOIN	Emergency ureteric injury management
RPH	Royal Preston Hospital
RSP	Recovery Support Programme
SAMBA	Society for Acute Medicine Benchmarking Audit
SAS	Speciality and Specialist grade
SAU	Surgical Assessment Unit
S. aureus	Staphylococcus aureus
SBAR	Situation-Background-Assessment-Recommendation
SDEC	Same Day Emergency Care
SHMI	Summary Hospital-level Mortality Indicator
SHOT	Serious Hazards of Transfusions
SIRO	Senior Information Risk Owner

SJR	Structured Judgement Review
SLT	Speech and Language Therapy
SMR	Standardised Mortality Ratio
SMRC	Specialist Mobility Rehabilitation Centre
SPC	Statistical Process Control
SPCMHT	Specialist Perinatal Community Mental Health Team
SSNAP	Sentinel Stroke National Audit Programme
ST 1-2	Speciality Trainee 1-2
ST 3+	Speciality Trainee 3+
STAR	Safety Triangulation Accreditation Review
StEIS	Strategic Executive Information System
SUDC	Sudden Unexpected Death in Childhood
SUS	Secondary User Service
TACT	Tobacco and Alcohol Care Team
TARN	Trauma Audit and Research Network
TED	Team Engagement and Development Tool
TVNs	Tissue Viability Nurses
UGI	Upper Gastro-Intestinal
UKCRF	UK Clinical Research Facility
UKHSA	UK Health Security Agency
VTE	Venous Thromboembolism
WHO	World Health Organisation

9.3 - ANNUAL SAFEGUARDING REPORT

REFERENCES

Only PDFs are attached

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

1. Purpose

1.1. The purpose of this report is to provide an annual account of safeguarding activity and assurances. The report has been received and scrutinised by the Safety and Quality Committee. The report demonstrates the organisation's commitment to safeguarding. The report will provide an overview of the increasing safeguarding activity and developments across the safeguarding agenda. The report demonstrates compliance with statutory standards and evidence of how lessons learnt from serious incidents are embedded in practice, resulting in better outcomes, improved safety and quality in the care delivered to the most vulnerable patients and families. The safeguarding team cover the safeguarding and vulnerable people agenda from "cradle to the grave". This includes Children and Young People, Adults, Maternity, Mental Health, Learning Disabilities, Autism, SEND and Dementia.

2. Governance and Accountability Arrangements

2.1. As per statutory requirements the Trust holds positions for a Head of Safeguarding, Named Doctor for Safeguarding Adults, Named Doctor for Safeguarding Children, Named Nurses for both adults and children and a Named Midwife. The team operationally report to the Head of Safeguarding with accountability and overall strategic leadership to the Deputy Chief Nursing Officer and ultimately to the Chief Nursing Officer who holds the Executive responsibility for safeguarding (Appendix 3). The Trust employs a Lead for MCA and DoLS, who holds Dementia within their portfolio, and a lead for Mental Health, Learning Disabilities and Autism, ensuring the safeguarding/vulnerable people agenda has nursing, midwifery and social work senior leadership who provide strategic direction across all portfolio areas.

2.2. Governance arrangements are robust within the Trust, with established and strengthened divisional safeguarding meetings who provide monthly exception reports and quarterly deep dive reports to provide assurance to the Safeguarding Board. The monthly Safeguarding Board provides a Chairs Report into the Safety and Quality Committee. The safeguarding agenda is triangulated into the Always Safety-First Learning and Improvement Group (ASFLIG) and Patient Safety Incident Response Framework (PSIRF) through safeguarding input into the triage process, input into PSIRF investigation process and sharing of trends, themes and learning within the ASFLIG and the safeguarding board.

3. System Partnership Working Assurance

3.1. The Trust is well represented across the local safeguarding partnership arrangements with the named professionals continuing to be active members on several sub-groups to the Lancashire Safeguarding Adults Board (LSAB), Child Safeguarding Assurance Partnership (CSAP), and Mental Health Transformation (Appendix 4). This ensures strengthening of audit activity, priority service improvements and partnership working. The Head of Safeguarding is ensuring attendance at system boards including the LSAB, CSAP Board and will be attending the newly established Special Educational Needs and Disabilities (SEND) Improvement Board in 2025-2026. Executive level representation is provided by the Chief Nursing Officer who is the Health Executive lead for provider Organisations at the Lancashire and South Cumbria Safeguarding Health Executive Group, which feeds into the LSAB and CSAP. The board agendas and priorities are linked to activities undertaken within the safeguarding annual work plan.

4. Annual Safeguarding Activities Highlights (2024/2025)

4.1. Safeguarding Single Improvement Plan

4.1.1. The mental health, dementia and learning disability practitioners have focused on the Safeguarding workstream of the Single Improvement Plan alongside the Deputy Chief Nursing Officer. This is aimed at improving the experiences of patients with mental health, learning disability, and/or autism. Work has focused on reducing the requirement for restraint and restrictive practices and continues to build on the skills of our workforce in supporting vulnerable patients. Activity has included.

- Training – externally sourced Virtual Reality (VR) dementia and autism bus, developing and embedding tier 2 dementia training, developing a mental health awareness course alongside Maudsley Hospital with focus on de-escalation and providing 1:1 care (commenced May 2025), autism training arranged in 2025/2026 from people with lived experience, compliance monitoring into the Trust Learning Disability and Neurodiversity e-learning, bespoke training in response to PSIRF learning and Champion events supported by people with lived experience.
- A review of processes in security, implementing trauma informed training and introducing the Security team representation into the Safeguarding board, with continued plans to include in 2025/2026 Single Improvement Plan reporting.
- Close working between the safeguarding team and resilience/security team – with attendance to Big Rooms, incident reviews, action plans and consideration of new equipment (for example, the potential introduction of velcro soft cuffs which would reduce the need for holds by the team, could reduce sensory distress which results from the holds, and plans for a joint review of use)
- The development and testing of a tool to guide a Multi-disciplinary Team (MDT) review in a quick approach (often called a SWARM, therefore called an MDT SWARM) to ensure patient de-brief and collaborative working with patients, families and carers and review of incidence of restraint to consider helpful and non-helpful approaches. The MDT SWARM has been utilised to review patients who frequently attend and may be admitted with significant risk behaviours associated with their mental health (self-harm, ligaturing, physical restraint to reduce risk and rapid tranquilisation) or vulnerabilities. The MDT SWARM has allowed for a multi-agency review (including mental health and security) to consider triggers, helpful strategies and safety plans.
- A review of the Rapid Tranquilisation Policy, the development of a checklist to ensure compliance with rapid tranquilisation post care requirements and evidence of de-escalation/ therapeutic intervention. The rapid tranquilisation checklist has gone live in into the patient's electronic records in Harris Flex in May 2025.
- Patient and carer feedback – focus on receiving feedback from our vulnerable patient groups including a Children's Emotional Health Family and Friends Test (FFT) and a bespoke FFT for the Emergency Department to include mental health and feeling safe. (This will continue to be a focus for 2025-2026).
- Improved governance and assurance – with rapid tranquilisation audit reports discussed at monthly Safeguarding Divisional meetings and escalated into the Safeguarding Board.

- Reporting into the Medicine Management Governance Group on prescribing compliance for rapid tranquilisation.

4.1.2. Review on Progress in Reducing Physical Restraint - Single Improvement Plan

- To drive the delivery of the Safeguarding Single Improvement Plan objective to reduce physical restraint work over the last 12 months has focused on developing data dashboards to allow a targeted focus for improvement activities. An analysis of physical restraint, self-harm and rapid tranquilisation is provided in appendix 5.
- The review of the data in appendix 5 shows; The Top 10 areas where physical restraint, rapid tranquilisation and self-harm occur. These areas are all participating in the improvement activities of the Mental Health Big Room to reduce physical restraint use.
- A full triangulated review of these areas was conducted as part of the Trust response to the Recommendations into the Independent Inquiry at the Greater Manchester Mental Health Trust. This report was presented to the Safety and Quality Committee in February 2025
- The top 10 locations are the focus for the development of calm rooms (including the consideration of sensory, activity items to aid de-escalation) and for focus on additional mental health training for the teams within these areas.
- There has not yet been a reduction in physical restraint. The review identified that a joint review of incidents with the ED and security team commenced in February 2024 which resulted in an increase in the number of incidents being categorised as restraint.
- The analysis of restraint incidents show that the majority of restraint is provided at level 1 and 2 and not Level 3 which is full restraint and incidence is often linked to repeat incidents of individuals with complex needs receiving multiagency care. In 2024/25 there were:
    - 711 Level 1 restraint incidents (low level holding of wrists and hands)
    - 487 level 2 restraint incidents (low/medium level holding of hands and arms)
    - 117 level 3 restraint incidents (high level holding techniques)
    - 2 Mechanical restraint incidents
- For some people, especially those detained under the mental health act, physical restraint may be part of their agreed risk management plan in order to maintain safety.
- Further work is required to ensure that all incident reports have a restraint level recorded. A sample review of the incidents where “no restraint level” is recorded identifies that security were called to the patient anticipating a requirement for restraint but de-escalation techniques were used successfully with no restraint required.
- Incidents of restraint affecting people with a learning disability or autism have been reviewed by the safeguarding team. This has identified that some patients did not have a formal diagnosis of learning disability or autism and so changes have been made to the Datix system to ensure this is only entered where a formal diagnosis has been made.
- Future oversight of physical restraint will continue through quarterly reporting at the safeguarding board.
- Embedding of the MDT SWARM and consideration of early identification of reasonable adjustment needs for patients with a learning disability, autism or mental health if restraint has occurred.
- A refreshed audit process for rapid tranquilisation and physical restraint commenced in June. This will continue to provide assurance on safety after rapid tranquilisation has

been given and now includes care and wellbeing for patients during and after physical restraint.

4.1.3. Violence and aggression has increased in 2024/2025 with highest incidence noted in ED, children's ward, elderly medicine, neurosurgery, gastroenterology ward and stroke. The Trust Workforce Committee receives quarterly reports on the analysis of violence and aggression incidents and the activities to reduce this. The most recent update to the Workforce Committee in May notes the increase in incidents with weapons and the actions in response to this. It is noted that:

- Security officers are equipped with protective vests and are about to be issued with slash proof gloves.
- 90% of the Security team have received trauma informed training meaning that there is always a trauma informed trained member of staff on duty.

4.2. External Audit - Mersey Internal Audit and Assurance (MIAA) Rapid Tranquilisation

4.2.1. Following the commissioned MIAA review in 2023/2024 there have been continued improvements and actions, these have also informed the Safeguarding Single Improvement Plan. During 2024/2025 further actions have included:

- Mental Capacity Assessment questions built into Harris Flex to ensure mental capacity is recorded when Rapid Tranquillisation is prescribed.
- A Rapid Tranquilisation checklist implemented that provides specific direction on the post dose monitoring requirements and a designated space to record this.
- Review of the Safeguarding Adults Levels 2 and 3 training to include further case scenario and MCA knowledge checks on understanding the practical application of the MCA
- Inclusion of consent into the Safeguarding Children and Safeguarding Adults Level 2 and 3 training.

4.2.2. All actions from the MIAA review have now been completed,

4.3. External Audit - MIAA Safeguarding Supervision

4.3.1. Following the commissioned 2023 MIAA audit for Safeguarding Supervision and Persons in a Position of Trust (PiPoT) there has been continued audit and assurance provided to the Safeguarding Board. Reporting into the Safeguarding Board has been completed to confirm compliance with policy mainly around participation and facilitation of safeguarding supervision. The safeguarding Board has been assured into the delivery of safeguarding supervision via quarterly reporting into the activity of safeguarding supervision as directed by the Safeguarding Supervision policy. This has included activity of group supervision for specialist safeguarding team, sessions provided across the Trust and receipt of supervision from the Designated Nurses from the Integrated Care Board (ICB). Further efforts are underway to enhance the offer in line with PSIRF incidents/complex cases.

4.3.2. Monthly reporting for the Managing Allegations process (Persons in Position of Trust (PiPoT) policy and the Datix process continues, with significant improvements across the divisions.

4.3.3. Safeguarding supervision has continued to be embedded across paediatric areas with a focus on social care referrals and thresholds with case specific supervision. Safeguarding

supervision is planned for the Emergency Department on a regular basis and wards have been offered in supervision sessions. Supervision is embedded within maternity and across the Trust. The Enhanced Support Midwifery Team (ESMT) have delivered 57 safeguarding supervision sessions to 229 of staff during 2024/2025 across maternity and the corporate team.

4.3.4. All actions from the review have been completed.

4.4. Learning from incidents

4.4.1. The safeguarding team continue to have been an integral part of the Trust PSIRF operationalisation receiving all incidents with safeguarding noted, and supporting the process of the PSIRF Triage and responses, including mental health, incidents, the Care Act (2014) requirements, Section 42 inquiry threshold and children safeguarding. A regular meeting has recently been established with an Adult Social Care Single Point of Contact (SPOC) to review Section 42's, to quickly understand the outcome and share the learning. Relationship meetings have been embedded with the Multi-Agency Safeguarding Hub (MASH) and Duty/Assessment Team which have assisted in sharing learning and discussion of children's challenging areas and cases.

4.4.2. The Safeguarding team attend MDT SWARM's, After Action Reviews and contribute to Patient Safety Incident Investigations (PSII's) as subject matter experts. This may include developing or holding action to reduce likelihood of future events. The safeguarding team have developed monthly safeguarding learning bulletins alongside Always Safety First/Governance colleagues to share learning from PSIRF incidents or audit (Appendix 6).

4.4.3. The safeguarding team are embedded into external agency reviews following a child death as part of the Child Death Overview Panel (CDOP) process including Joint Agency Reviews (JARS), Child Death Review Meetings (CDMR's), Safeguarding Adult Reviews (SARS), Domestic Homicide Reviews (DHR's) and in distributing the learning from Learning from Lives and Deaths – Learning Disability and Autistic People (LeDeR), with the embedding of learning as a result. An example of this is the development of reasonable adjustment flag into midwifery systems and training into the monthly midwifery public health training to ensure early recognition of learning disability or autism and strengthening health access.

4.5. Audit Activity

4.5.1. The annual safeguarding audit activity is directed by the local safeguarding board priorities, previous CQC visits and learning from local and national safeguarding practice reviews. Audit activity for 2024/2025 includes:

- Monthly audit in Emergency Department (ED), Paediatric Assessment Unit (PAU), Medical Assessment Unit (MAU), Acute Medical Unit (AMU), Acute Assessment Unit (AAU) and Surgical Assessment Unit (SAU) to monitor quality in completion of the child safeguarding checklist.
- Monthly audit into the quality of the Trust Mental Health Risk Assessment Tool with action planning to increase compliance.
- Monthly audit into DNACPR and Death certificates for our patients with a Learning Disability and Autism.

- Quarterly Trust wide audit of MCA and DoLS, Least Restrictive Practice and Enhanced Levels of Care
- Annual Trust wide themes and trends audit relating to safeguarding incident management and Section 42 enquiries.
- Annual NHSE Learning Disability and Autism Benchmarking Standards – submitted 2025 (awaiting benchmarking report publication).
- Annual National Audit of Dementia (alongside older adult consultant leads).
- Annual Maternity alcohol consumption screening audit at the initial booking appointment.
- Annual Maternity substance misuse.
- Annual Maternity Mental Health audit of the Whooley screening questions at the initial booking appointment.
- Annual Maternity domestic abuse audit regarding routine enquiry and compliance with National Institute for Health and Care Excellence (NICE) Guidance.
- Annual Maternity Safer Sleep audit regarding the compliance of the safer sleep assessment tool.
- Annual Female Genital Mutilation (FGM) audit regarding the compliance of following the correct pathway when FGM identified.
- Annual Safeguarding Assurance Framework (submitted April 2025)
- Quarterly Provider SCAT submission to NHSE.
- Annual CSAP Section 11 Safeguarding Self-Assessment (submitted October 2024)

4.5.2. Lessons Learned from Audit Activity

- The children's safeguarding checklist (Appendix 7 November 2024 bulletin) has shown variable compliance of between 60-100% over the year across the key departments (Emergency Department (ED), Medical Assessment Unit, Surgical Assessment Unit, Paediatric Assessment Unit (PAU) and Gynaecological Assessment Unit).
- The Paediatric Emergency Department has achieved 100% every month except for January which was 97%. The compliance for PAU was 60-100% over the last year, with significant improvement for the last 6 months at 100%. The compliance for 16-17 years in adult wards is the main area where improved compliance is required. The improvement actions are being overseen by the safeguarding board and all 16 and 17 yrs old on adult wards are followed up by the safeguarding team to ensure that all required actions have been taken.

4.5.3. Other lessons learned from audit include:

- Strong assurance that alcohol screening is embedded in maternity. In 100% of cases reviewed as part of the deep dive audit, women were asked the alcohol screening questions. Of the 24% of women identified to have red or amber markers at antenatal booking appointments, repeat screening identified that all women stopped drinking alcohol during the pregnancy. Whilst no women required referral to the Tobacco Alcohol Care Team (TACT) or the charitable organisation INSPIRE (Drug and Alcohol Service) , 75% of the women with amber or red markers were referred to Specialist Perinatal Community Mental Health Teams (SPCMHT) for mental health support, and the remaining mother (25%) had careful monitoring of her mental wellbeing throughout the pregnancy utilising Patient Health Questionnaire (PHQ-9) and Generalised Anxiety Disorder (GAD-7) (validated assessment tools) and a plan to reflect needs completed by the Enhanced Support Midwifery Team (ESMT).

- Good compliance regarding maternal mental health risk assessments (Whooley questions- a two-item screener for perinatal depression) being completed at maternity booking appointments. A compliance of 85% was further achieved in completing the PHQ9 and GAD7 questions if scoring positive in the two Whooley questions. For the outstanding 15% a deep dive audit indicated that appropriate clinical care was provided with midwifes completing referrals to the ESMT team for ongoing support. Further education and monitoring into the compliance of the PHQ9 and GAD7 will be completed.
- Strong assurance that screening is embedded for substance misuse in maternity. 100% of occasions women reporting substance use at the antenatal booking appointment were referred to the Enhanced Support Midwifery Team (ESMT) for complex care planning.
- Strong assurance that women are being seen alone as part of their booking appointment and that routine enquiry into domestic abuse during pregnancy is being undertaken. 4276 women out of 4277 giving birth between 1 January 2024 and 31 December 2024 were asked routine enquiry throughout the care pathway.
- Strong assurance that the safer sleep assessment tool is being completed at least once with 100% recorded in notes audited, which is consistent with the previous audit.
- The audit for ICON (babies cry you can cope campaign) shows a significant assurance with discussions held at key points (at booking of pregnancy 42% of the time, at transfer of care to the community midwives 98% (49 out of 50) and at transfer of care from the community midwives to the health visitor 96% (48 out of 50).
- The Female Genital Mutilation (FGM) audit provided a high-level of assurance that all referrals to Children's Social Care (CSC) were made by the ESMT.
- Overall compliance with the contracting and statutory requirements for safeguarding as noted via the Provider-SCAT, Safeguarding Assurance Framework (SAF) and CSAP Section 11 audit. There will be a focus on training for Trauma Informed Care in 2024/2025.

4.5.4. Multiagency Audits

The Named Nurse for Safeguarding Children and Named Midwife have contributed to multi-agency audits. These have included:

- Child Death Overview Panel (CDOP) Continuous Learning & Improvement (CLIG) audits (CDOP notification forms to improve the quality of data provided and quality of CDRMs to look at quality, consistency and attendance). There will be two audits/year. A 7 Minute briefing completed regarding CDOP notifications and disseminated across the Trust.
- A Harmful Sexual Behaviours audit was completed in collaboration with National Society for the Prevention of Cruelty to Children (NSPCC) and CSAP.
- Vicarious trauma scoping exercise to understand the support systems available for staff across the partnership. A focused survey is to be developed for practitioners.
- Integrated Care Board (ICB) Initial Health Assessment (IHA) Audit was completed with the Children in Care Nurse at the Trust to identify quality of data collected and advice given in IHAs. Initial feedback received and actions in place. Positive feedback included: comprehensive health discussions evident in some IHA's. Good evidence of health information as per statutory process, dental pathway and ongoing discussions for oral health, emotional health noted in action plans and Specific, Measurable, Achievable, Relevant and Time-bound (SMART) action plans. Improvements needed include use of drug and alcohol tool, consideration of contextual safeguarding, all practitioners to have trauma-informed training. An action plan will be completed.

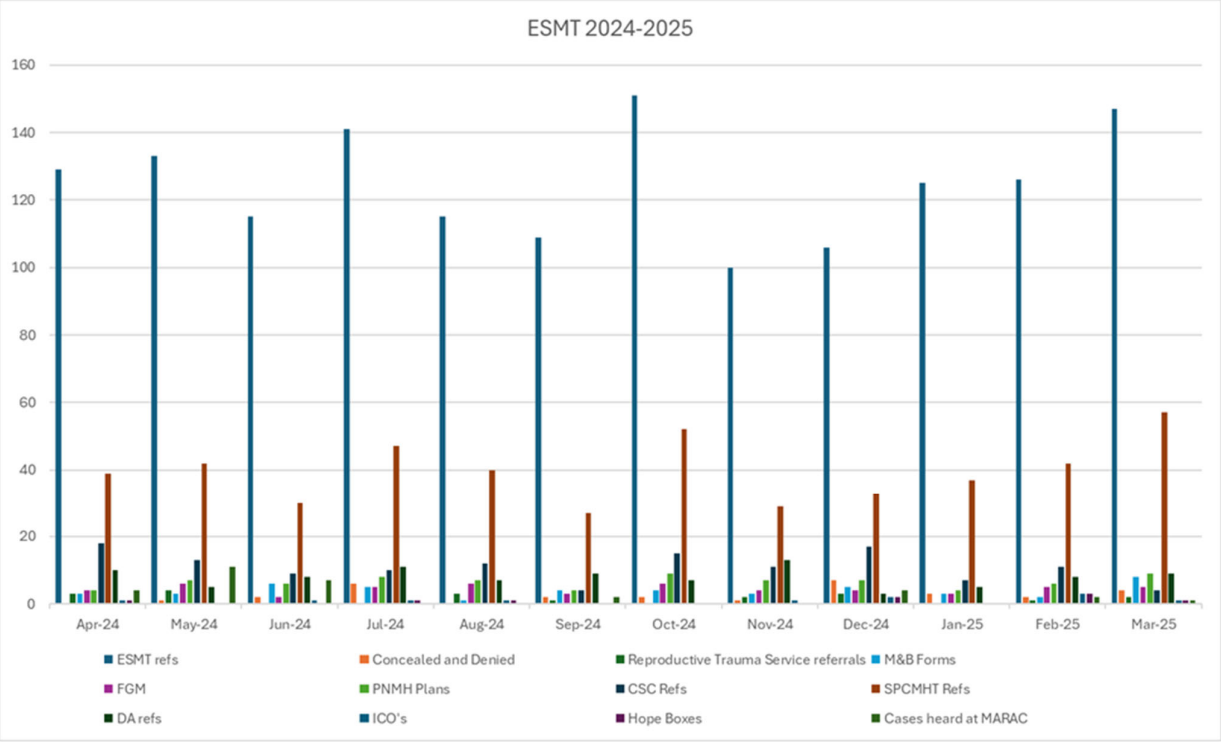
- The Named Nurse for Safeguarding Children and the Named Midwife have been part of the CSAP Engaging Male Carers audit group. This audit is in response to the Myth of Invisible Men National Panel Report published in September 2021 and the 7-minute briefing following this disseminated in June 2022 by CSAP.

4.6. Maternity

4.6.1. Summary of Maternity Safeguarding Activity (excluding audit and supervision activity).

4.6.2. Activity within Maternity Safeguarding remains significantly high (Fig.1), which is consistent with the previous year. There has been a 2% decrease in the number of referrals to the Enhanced Support Midwifery Team (ESMT) over the past year and a 15% decrease in the number of out of area referrals to the ESMT. Cases continue to be complex involving collaborative, cross boundary MDT working to ensure safeguarding of our women and babies. There has been a 19% decrease in 2024/2025 in the number of cases referred to Children Social Care (CSC) from 161 in 2023/24 to 131 this year. This may be attributable to other agencies referring the women and families to CSC such as probation or the police.

Fig.1. Maternity Safeguarding Referrals & Activity Data



4.6.3. The number of Female Genital Mutilation (FGM) referrals have increased over the past 3 years from 26 in 2022-2023, 40 in 2023-2024 and 53 during 2024-2025. This equates to a 96% increase since 2022. This increase may be attributable to the diverse changes within the local population as the team have seen an increase in people seeking asylum and refugees. These women and their families often have other complexities which require collaborative working with other agencies such as the Home Office, CSC, Sahara (voluntary organisation working to support predominantly black and ethnic minority women) and the Police. An annual FGM audit has been presented at the Safeguarding Board with recognition of increases across Lancashire and South Cumbria, and efforts to further understand being made by the ICB.

4.6.4. Referrals to the Specialist Perinatal mental health team (SPMHT) have increased by 47% in the year (252 in 2023/2024, to 475 in 2024/2025), with the specialist midwife attending MDT's / steering group. Developments to BadgerNet have been achieved allowing direct referrals to SPMHT and Talking Therapies. 78 mental health and wellbeing plans have been completed, which remains consistent with the previous year. The ESMT have received 95 domestic abuse notifications in comparison to 122 from the previous year, 31 of these cases were heard at the Multi-Agency Risk Assessment Conference (MARRAC). Internally the Enhanced Support Midwifery Team attend a daily safety huddle with 4031 case discussions this year in comparison to 3636 from the previous 12 months. This ensures that any safeguarding concerns are dealt with in a timely manner and that staff are fully supported.

4.7. Reproductive Trauma Service and Perinatal Mental Health

4.7.1. The Enhanced Support Midwifery Support Team (ESMT) continue to work with all 6 Trusts, service users, key partners and stakeholders across Lancashire and South Cumbria, offering assessment and intervention for women with severe/complex mental health difficulties and those with symptoms of Post Traumatic Stress Disorder (PTSD) following birth trauma, fear of childbirth or perinatal loss. 19 referrals to the Reproductive Trauma service (RTS) have been completed in 2024/2025 in comparison to 29 in the previous year. This is the likely positive impact mental health specialist midwife's input for women and indicates less women have experienced traumatic experiences from birth. Delivery of 139 hours of peer support and training programmes has been delivered to ensure a trauma-informed debrief approach with women and families. Birth trauma sessions have also been conducted with student midwives, and discussions are ongoing with universities and the trusts to replicate these sessions across the system.

5. Children and Young People

5.1. Summary of Children Safeguarding Activities (excluding audit and supervision activity)

5.1.1. Joint working with the Lancashire Sexual Assault Forensic Examination (SAFE) Centre has been completed and attendance to Strategy Meetings for children where sexual abuse may have occurred. This has been vital for strengthening the links between SAFE Centre, Safeguarding and Paediatrics, ensuring timely safeguarding for our children and young people and for enhancing the mutual support and knowledge of colleagues. The Named Nurse for Safeguarding Children and the Manager for the Safe Centre have been part of a working group reviewing pathways and processes between the Safe Centre, MASH and Police. As part of the learning and development for Lancashire Local Authority, a Child Sexual Abuse study day was held at County Hall with presentations from the Trust safeguarding and other organisations to highlight referral to SAFE centre and recognising sexual risk.

5.1.2. The safeguarding team have provided intensive support for young people admitted to the ward due to family/placement breakdown. As an example, during April and May 2024 37 MDT and Strategy meetings occurred for 2 young people admitted to Ward 8, who were awaiting placements.

5.1.3. The Named Nurse for Safeguarding Children and Named Midwife are members of the CDOP Continuous Learning & Improvement Group and worked in identifying priority areas in relation to the child death process and an audit plan. Participation in the Child Death Review Meeting (CDRM) audit into statutory process has been ensured, leading to the update to the Child Death Policy and input from the Medical Examiners embedding the Medical Examiner role

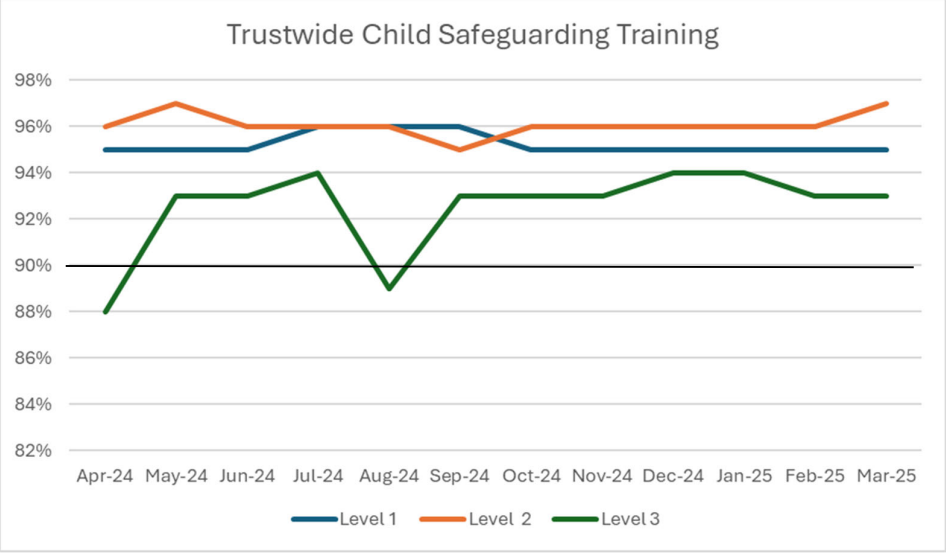
within neonatal and child deaths. A CDOP Failsafe Meeting has been developed which has improved links and information- sharing between Safeguarding, ESMT, Governance and the Bereavement Team. Additionally, the safeguarding team now review the National Child Mortality Database (NCMD) thematic reports within the Mortality Meetings, which are published twice yearly to identify learning.

5.1.4. Attendance at the Lancashire CSAP Neglect Sub-Group has been completed, with the development of a neglect tool, which be rolled out over the coming year which provides professionals with a structured assessment of whether children and young people are at risk or are experiencing parental neglect.

5.1.5. Internal policies have been updated including the Policy for the Management of Children and Young People not brought to appointments "Was Not Brought / Did not Attends", to include dentistry, strengthening of the safeguarding process, trauma-informed practice and reasonable adjustments. The Paediatric-Gynaecology Standard Operating Procedure (SOP) has been updated to include a flowchart for termination of pregnancy. Children and young people with complex social and health needs continue to be supported including concerns relating to fabricated and induced illness/perplexing presentations, medical neglect and our children in care where there may have been placement breakdown. The Children's Safeguarding Team have been commended for their proactive approach with complex children in care in our area by the ICB Cases including Fabricated illness have featured strongly in the workload during 2024/2025. The Designated Doctor and lead for fabricated illness/perplexing presentation has continued to provide invaluable oversight and advice in relation to these very challenging cases.

5.2. Child Safeguarding Training Compliance

Fig.2. Child Safeguarding Training Data (Trust wide) (Black line represents the 90% target)

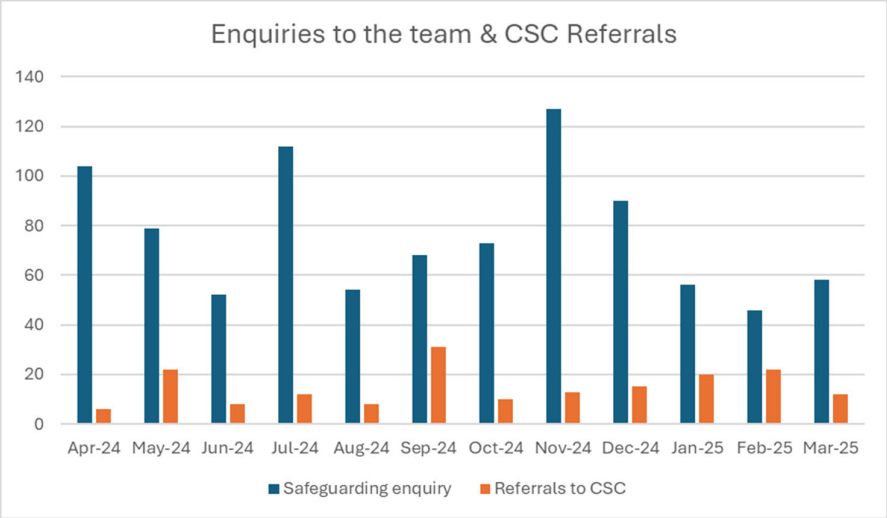


5.2.1. Fig.2 provides the Trust wide compliance with mandatory child safeguarding levels 1 to 3. The training packages and training needs analysis are in accordance with the requirements of the Royal College of Nursing (RCN) *Safeguarding Children and Young People: Roles and Competencies for Health Care Staff* (2019). Child safeguarding training across Levels 1 and 2 has remained 95% and above, with level 3 training having recovered to 93% compliance.

Foundation doctors have received level 3 Child and Adult safeguarding training with 2 face-to-face sessions delivered in August and September 2024.

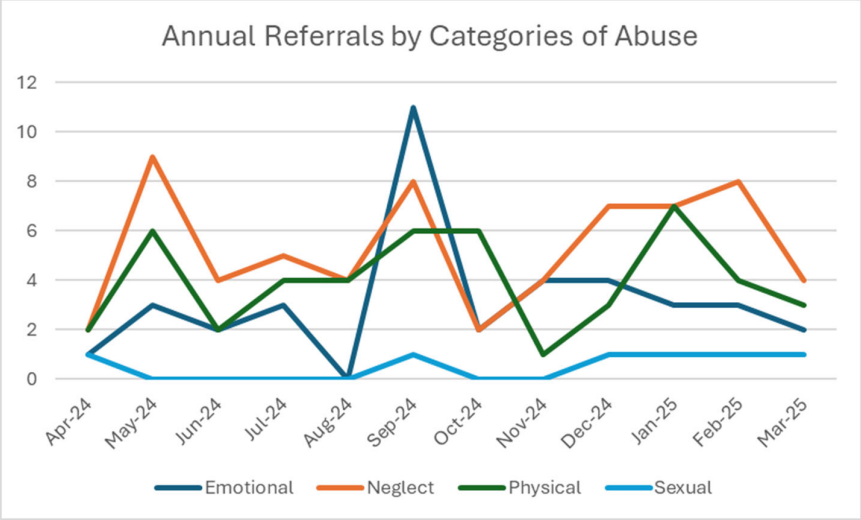
5.3. Children's Social Care Referrals

Fig.3. Referrals to Children's Social Care



5.3.1. Children safeguarding enquiries have slightly increased with 919 referrals in 2024/2025 (Fig.4) and 899 in 2023/2024. Referrals to Children's Social Care (CSC) have decreased in comparison to the previous year. In comparison to the previous year (183 referrals in 2022-23, 242 in 2023-24 and 179 in 2024-25). Processes in the Paediatric ED have been strengthened to allow the safeguarding team to monitor the referrals to CSC and completion of paediatric liaison forms (which are sent for information sharing). The safeguarding team have been sent 22 referrals for review during December-March 2025 from Paediatric ED, as opposed to 8 for the previous 8 months. The unit manager audits the shift report completed by the nursing team to check that all appropriate cases have been referred. These processes have provided strong evidence that Paediatric ED are completing referrals to CSC when appropriate.

Fig.4. Total Annual Child Safeguarding Referrals Reasons



5.3.2. During 2024/205 neglect has been the main reason for referral. This is consistent with 2023/2024. Referrals for sexual abuse remain the same as last year (6 referrals). It is acknowledged that many referrals will encompass more than one category of abuse due to the complexity of safeguarding cases.

5.4. Child Deaths

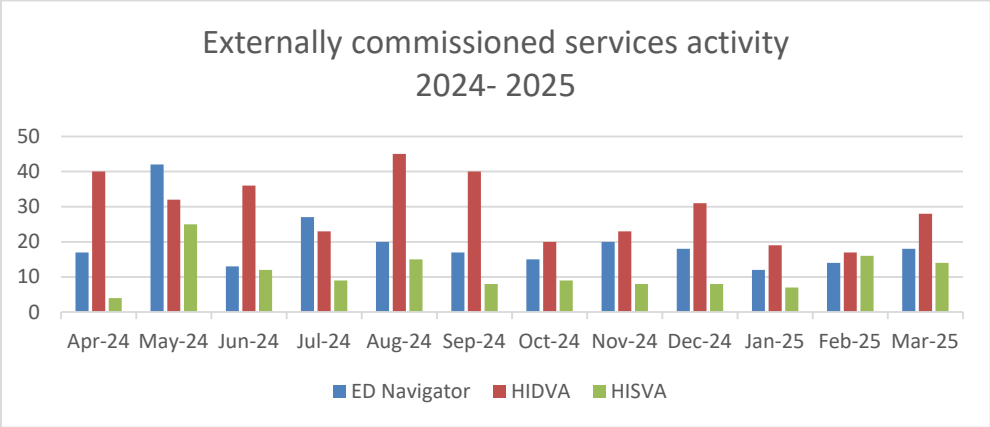
5.4.1. There has been a total of 34 deaths for 2024/2025 in comparison of 28 for the previous year. 35% (n=12) of which were unexpected in comparison to 39% in 2023/2024 and 61% (n=21) were expected in comparison to 64% last year. Of these expected deaths, 14 were neonatal deaths within the Trust and several other expected deaths were in relation to neonatal babies known to the Trust but who died at another Hospital or Derian House. Unexpected deaths over this year have included 6 cases of Sudden Unexpected Death in Childhood (SUDC), 2 children who have sadly completed suicide, one child who died of an overdose and three children and young people who been the victim of significant trauma.

5.4.2. The Trust has led one Child Death Review Meeting (CDRM) for an expected death of a child well known to Ward 8. The process for arranging the CDRM was complex and highlighted the necessity of clarity and organisation in terms of co-ordinating external professionals. The Children's Safeguarding Team continue to attend Joint Agency Response (JAR) meetings after a child has died unexpectedly and participate into the child death process fully, in addition to the child's Paediatric Consultant. The internal Mortality Meetings continue to be arranged by the Women's and Children's Governance Team and Named Doctor for Safeguarding. The meeting provides an opportunity for discussion and support from colleagues for the doctors involved, which is vital from a vicarious trauma point of view. A plan is in place to discuss the twice yearly NCMD thematic reports within the Mortality Meetings to disseminate information to all Consultants and colleagues as needed.

6. Externally Commissioned Services

6.1. The Safeguarding Team continue to benefit from three externally funded posts. The Emergency Department (ED) Navigator is funded by the Violence Reduction Network (VRN) and the Health Independent Domestic Violence Advisor (HIDVA), and the Health Independent Sexual Violence Advisor (HISVA) are funded by the Office of the Police and Crime Commissioner. Fig. 5 below highlights referral activity within these roles.

Fig. 5. *Referrals into ED Navigator, HIDVA and HISVA*



6.2. ED Navigator

6.2.1. The ED Navigator commenced their role in September 2023 and is commissioned to March 2026. The commissioned criteria for ED Navigator include children, young people and adults aged 10-25 years who are victims or perpetrators of a serious crime. The ED Navigator has received a total of 233 referrals in the period of 2024/2025. Actions may include signposting to drug and alcohol services, referrals into children's safeguarding services, referrals to community youth services or Champions programme. When appropriate the ED Navigator will maintain active involvement and provide ongoing support in the Trust or the community. The ED Navigator has built strong connections with key areas such as, the Emergency Departments, Critical Care Unit, Major Trauma Ward, and all Neuro and Neuro Rehab wards. The role has developed and matured to provide an in depth and trauma-informed approach to supporting our children and young people at risk of serious youth violence.

6.2.2. The ED Navigator has initiated and led a Lancashire ED Navigator forum which they chair on a quarterly basis. The success in Lancashire ED Navigator services have resulted in out of area ED Navigator services requested invite to the forum. The Forum now includes services from Leeds, Huddersfield, Sheffield and Rochdale. The ED Navigator has arranged two face to face conferences using funding provided by the Violence Reduction Network (VRN). Both conferences were very well attended and feedback positive.

6.3. Health Independent Sexual Violence Advisor (HISVA)

6.3.1. The HISVA commenced in November 2023 and is commissioned to March 2027. The HISVA has received 135 referrals during 2024/2025. Referrals are received following disclosures of current or historical sexual assault / abuse by patients over the age of 16 who attend the Trust. The HISVA can support from initial disclosure through the criminal justice process and signposting to external support services. Quarterly reporting to the Police Crime Commissioning Unit is completed.

6.3.2. The HISVA has also received referrals to support members of staff within the Trust Training and awareness raising is also a key role of the HISVA and has made links with many services provided by the Trust. The HISVA and safeguarding team made vital contributions to Sexual Safety policy for both patients and staff in consultation with Workforce and divisional

colleagues in response to NHS England Sexual Safety Charter (2023) launch. The policy became in effect in April 2024. As a result, a growing number of staff have come forward to discuss inappropriate sexualised behaviour in the workplace, which has been addressed through the managing allegations process. This has successfully raised awareness and promoted positive culture.

6.4. Health Independent Domestic Violence Advisor (HIDVA)

6.4.1. The current HIDVA has been in post since January 2024, and the post is commissioned to March 2026. During 2024/2025 the HIDVA has received a total of 354 referrals. The HIDVA has established strong links with external agencies such as Lancashire Victims Support, SafeNet, and various housing and refuge agencies, to ensure that all victims/ survivors of domestic abuse are supported and have safety plans in place following their discharge from LTHTR services. The HIDVA receives a large number of referrals for staff, either from Line Managers, Occupational Health or colleagues contacting the HIDVA directly. The HIDVA will often support colleagues for a longer period, as, for some, work is their only "safe space". Quarterly reporting to the Police Crime Commissioning Unit is completed.

6.4.2. The HIDVA has delivered training across the Trust, raising awareness of services, encouraging staff to recognise the signs of domestic abuse and advising them of actions when a disclosure is made.

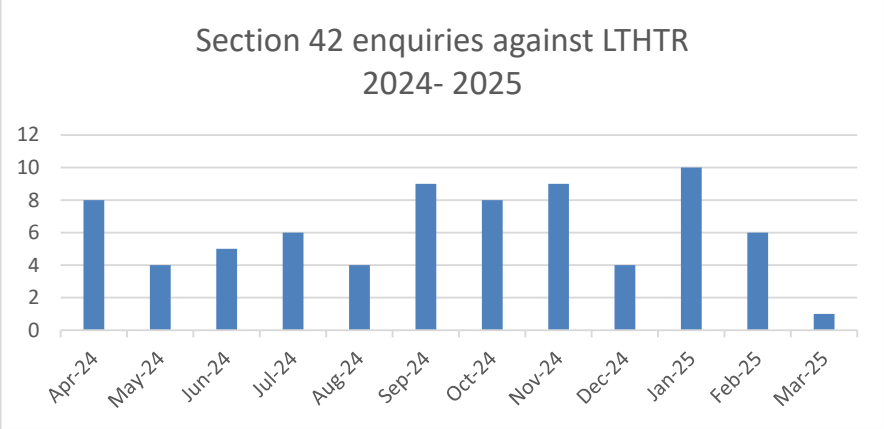
7. Adult Safeguarding

7.1. Summary of Adult Safeguarding Activities (excluding audit and supervision)

7.1.1. Section 42 safeguarding enquiries

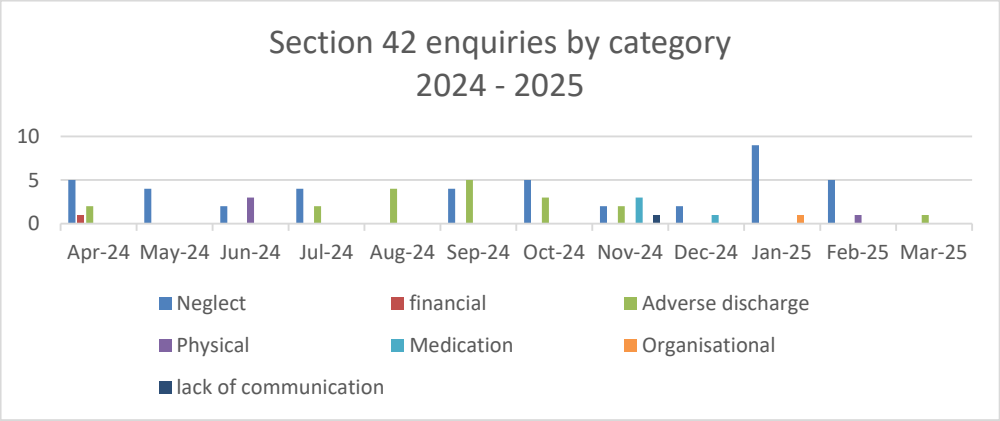
The Trust has received 74 Section 42 enquiries (Fig.6) from the Local Authority in 2024/2025 in comparison to 41 in 2023/2024. Prior to November 2023 a process was used in conjunction with the Local Authority, which meant that some incidents were subject to a local learning review. A review of this process lead by the Safeguarding team identified improvements were required to ensure there was stronger oversight of both the reviews and learning actions across the Trust. Following a restructure within Lancashire County Council (LCC), who have responsibility for oversight of the section 42 process, it was agreed that all concerns received into LCC would be logged under the umbrella of Section 42 enquiries, and the Trust Safeguarding Team worked closely with the divisional governance teams to ensure a robust investigation process and timely outcomes to share with LCC. All substantiated Section 42 enquiries are presented at the Divisional Always Safety-First safeguarding meetings to ensure the learning is shared across the division.

Fig. 6. Section 42 enquiries against LTHTR



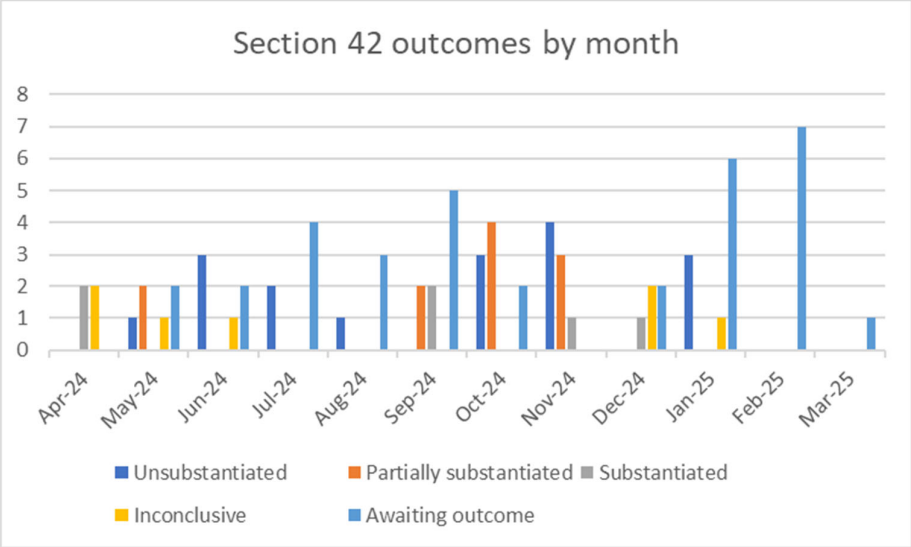
7.1.2. In 2024/2025 the most common theme for Section 42 enquiries against the Trust is under the category of neglect and omission of care (Fig. 7) including pressure ulcers and unwitnessed falls, and adverse discharges, which is largely noted due to poor communication upon discharge. These are similar to the themes found in the previous reporting period from 2023/2024. Adverse Discharges are audited and action planned by the Integrated Discharge Service (IDS) Leads and presented to the Safeguarding Board as a cycle of business. This audit work has identified improving compliance with the completion of the discharge checklist as a key priority. In addition, the IDS team have provided training across the adult inpatient wards that includes the expected standards on communicating with other care providers on discharge. Section 42 enquiries are now discussed at the monthly Safeguarding Divisional meetings and escalated to the Safeguarding Board.

Fig. 7. Section 42 enquiries by category against LTHTR



7.1.3. During 2024/2025 there were 16 substantiated Section 42's, 11 partially substantiated, 17 unsubstantiated and 7 inconclusive (Fig. 8). There remains a significant number of Section 42 enquiries awaiting outcomes from the Local Authority. Internally any learning identified through the course of the investigation is monitored through an action plan, with oversight of Divisional Always Safety-First Safeguarding meetings. The safeguarding team have recently identified a single point of contact within the local authority and are liaising to clear the backlog of outstanding outcomes from LCC.

Fig. 8. Section 42 outcomes

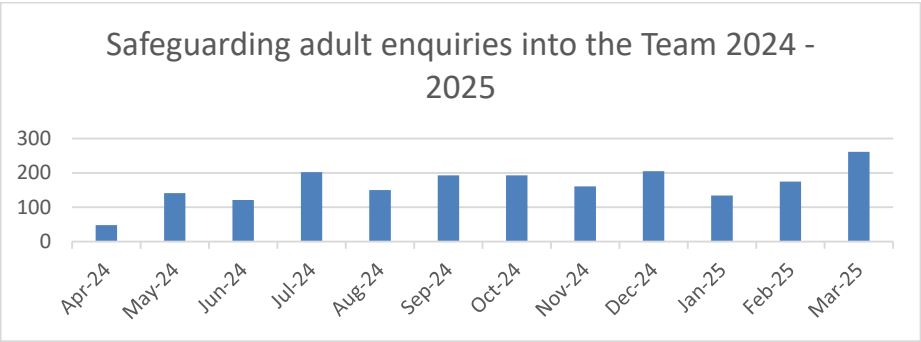


7.1.4. Although numbers of formal Section 42's have increased (due to process and recording for the Local Authority), good overall assurance is noted within the annual incident management and Section 42 enquiries themes and trends audit. Areas highlighted for improvement are adverse discharges, pressure ulcers and unwitnessed falls with close working across the Safety and Quality Directorate specialist teams /Always Safety-First agenda to look at lessons learned and opportunity for improved practice.

7.2. Referrals to LTHTR Adult Safeguarding

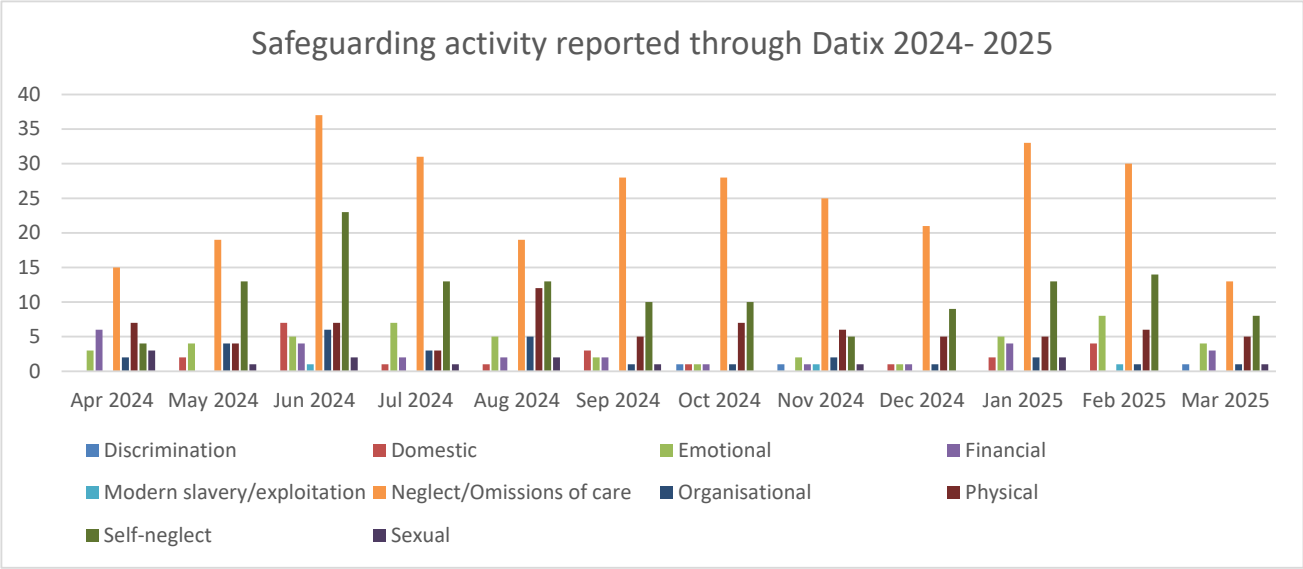
7.2.1. Fig. 9 shows the number of enquiries requiring advice or action in 2024/2025. All enquiries are responded to by the safeguarding duty practitioner or signposted to the most appropriate workstream within the safeguarding team.

Fig. 9. Referrals to LTHTR Adult Safeguarding



7.2.2. The most common themes for Datix reports in 2024/2025 are of neglect/ omissions of care and self-neglect (Fig. 10). Many these have been identified on patients' admission to hospital resulting in timely response, early support and discharge planning reducing the risk of an increase in hospital stay.

Fig. 10. Safeguarding activity through Datix

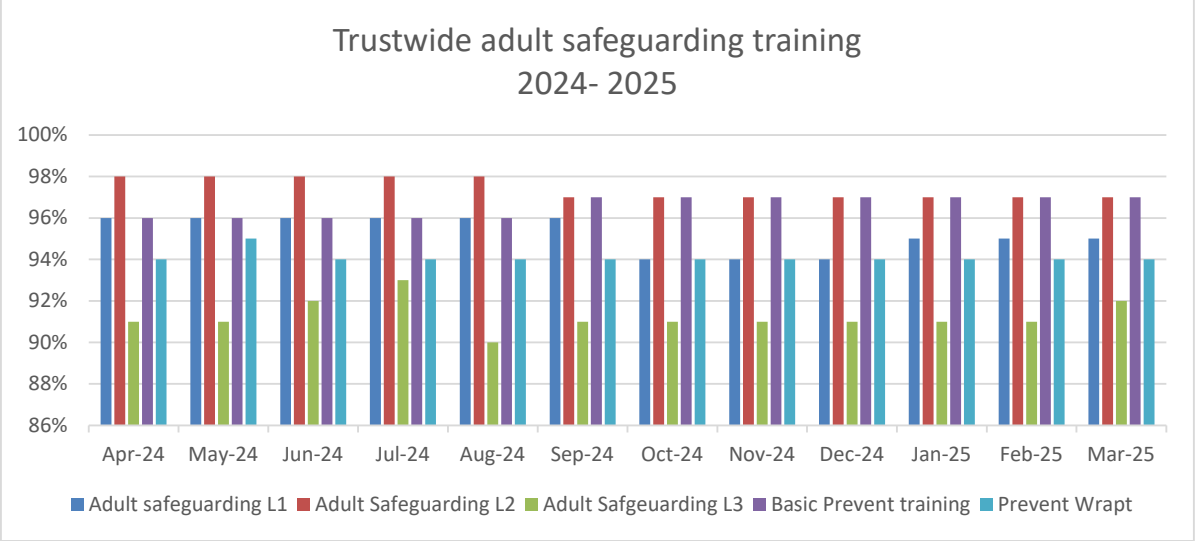


7.2.3. The MCA/DoLS Lead has played a central and proactive role in the development of the Pan Lancashire Self-Neglect Toolkit, contributing significantly to its creation and ensuring that mental capacity considerations are embedded within the toolkit. This involvement has been pivotal in both the writing process and in providing ongoing support to ensure that mental capacity is appropriately addressed in cases of self-neglect. This toolkit is designed to complement the Pan Lancashire Self-Neglect Framework, which provides comprehensive guidance and support for practitioners working with individuals who exhibit self-neglecting behaviours. The toolkit will be live in 2025.

7.3. Adult safeguarding training & PREVENT

7.3.1. Fig. 11 highlights a 90% compliance across all areas for the Trust wide adult safeguarding training 2024/2025. The PREVENT training compliance has consistently been above 90% throughout the year. The Trust submits PREVENT data around training, referrals, and attendance at meetings with multi-agency partners, this information is submitted quarterly to NHS Digital and feeds into national data sets. The Trust has submitted 3 referrals to PREVENT in the previous 12 months.

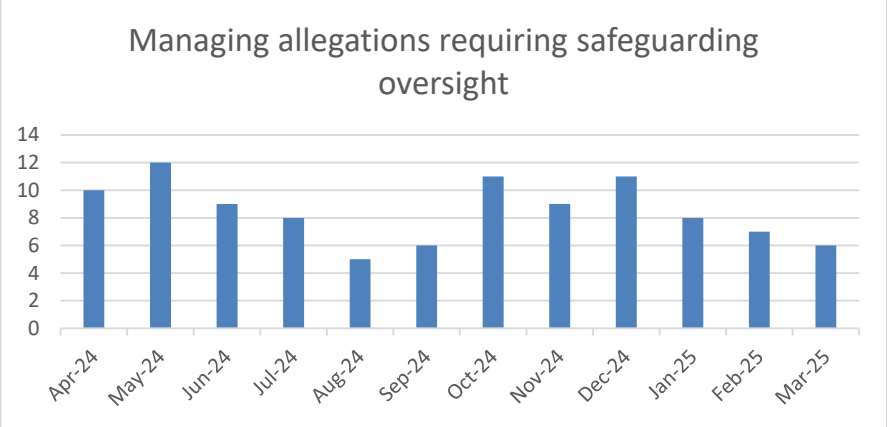
Fig. 11. Trust wide adult safeguarding training



7.4. Allegations Against Persons in a Position of Trust (PiPoT) (Managing Allegations Process)

7.4.1. The Safeguarding Team continue to audit incidents via Datix and record keeping for PiPoT/managing allegations which has shown month by month improvement. The Safeguarding Team's role in the managing allegations process is to ensure that all internal and external processes are followed and to liaise with external agencies such as the Police, Children's Social Care and Adult Social Care. Fig. 12 indicates the number of managing allegations cases the Safeguarding Team have been involved with in 2024/2025. An annual thematic review of PiPoT managing allegation cases is reported to Safeguarding Board.

Fig. 12. Managing Allegations with safeguarding oversight.



7.5. Safeguarding Adult Reviews (SARs) and Domestic Homicide Reviews (DHRs)

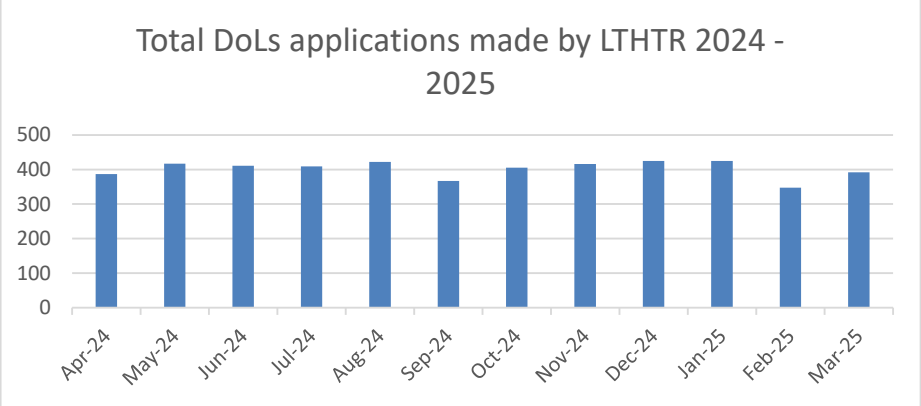
7.5.1. During 2024/2025 there have been 10 requests for information in relation to SAR referrals. A timeline is provided for patients related to SARS and attendance for panel consideration ensured. During 2024/2025 there have been no SARs commissioned which include LTHTR involvement (as cases which included LTHTR information were assessed as not meeting the SAR criteria). The Trust has not been asked to contribute to any new DHRs over the last 12-month period, however, there are a number of historical DHRs that have yet to be published by the Home Office and the Safeguarding Team continue to attend the panel meetings.

8. Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

8.1. Trust-wide MCA and DoLS Activity

8.1.1. During 2024/2025 a total of 4,823 DoLS applications were completed by the Trust. This is similar to 2023/2024, however an increase of 41% from the year 2022-2023. It was recognised in 2023/2024 that a year-on-year improved position in upholding the principles of the Mental Capacity Act (2005) had been achieved and that a 49.5% increase in DoLS activity was a positive reflection in the growth of the staff's ability to recognise additional vulnerabilities and act in accordance with the principles determined through the legislation. Given that the numbers between 2023/2024 and 2024/2025 have been sustained assurance in relation to staff understanding and compliance in the DoLS process is evident.

Fig. 13 DoLS applications 2024/2025.



8.1.2. The safeguarding team continue to notify the Local Authority of any unauthorised DoLS applications, including those that have exceeded the initial 14-day urgent authorisation and/or any patients who have regained capacity, been discharged, or have passed away. The risk of supervisory bodies not assessing and authorising DoLS remains on the risk register. This delay is reflected at a national level and recognised as a capacity issue.

8.1.3. Risk mitigation actions are in place including a quality assurance process for applications by the Safeguarding Team. The Local Authority have agreed a triage system for DoLS applications and will action and prioritise those with higher than standard restrictions or those of patients or where have challenged the application. The Least Restrictive Practice record in Harris Flex ensures review of restrictions every 72 hrs through the least restrictive best interest assessment. This provides staff with a prompt to notify the safeguarding team if those restrictions have increased. In turn, the Safeguarding Team will then escalate increased restrictions to the Local Authority and request the allocation of the case.

8.1.4. MCA/DoLS training remains compliant across the Trust and is evident within the Adult Safeguarding training compliance provided in the Adult Safeguarding section (see fig.12 above). Bespoke training for MCA has been provided to areas where learning needs have been identified following internal investigations as part of PSIRF learning. The Mental Capacity and DoLS Lead has delivered public health training to maternity services, focusing on mental capacity, consent and the Court of Protection. The Safeguarding Team have been actively involved in several maternity and adult cases which have required applications to the Court of Protection.

9. Mental Health, Learning Disabilities, Autism and Dementia

9.1. Mental Health, Learning Disabilities, Autism and Dementia Activity

9.1.1. The practitioners for mental health, learning disability and autism, dementia and High Intensity User Lead work with some of our most vulnerable patients accessing healthcare within the trust. The team drive service improvements, focus on increase staff knowledge and skills, aim to improve patient experience, reduce health inequalities and ensure compliance with the Mental Health Act (MHA) with triangulation of other safeguarding statutory requirements (i.e. Mental Capacity Act and Children's Act). The work streams continue to work on both a qualitative and quantitative basis and have a high number of complex cases. During October 2024 - April 2025 the team experienced a vacancy of the Matron, and the Head of Safeguarding has provided cover. These workstreams have been a large part of Single Improvement Plan. There continues to be one practitioner for each workstream however to

ensure a responsive service the wider team cover absences. An experienced Matron has been recruited to the vacant post and commenced in April 2025.

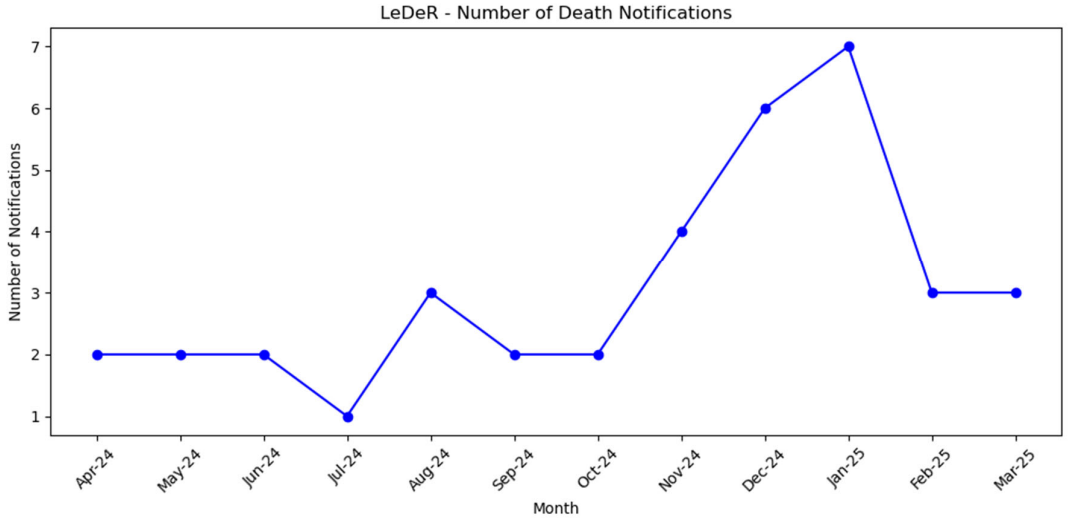
9.2. Special Educational Needs and Disabilities (SEND) Annual Activity

9.2.1. The safeguarding team have continued to drive the agenda of SEND with the Matron for mental health, learning disabilities and autism being the identified SEND Champion for the Trust, attending ICB meetings and driving the SEND agenda alongside SEND Doctor/Clinical Lead in Community Paediatrics. Annual activity has been focused on:

- Ensuring the Trust was represented in the CQC/Ofsted SEND Inspection 2024. The inspection has resulted in a Lancashire & South Cumbria Priority Action Plan (PAP) and a Trust PAP will be developed over coming months.
- The continued monthly SEND improvement group with Trust divisional representation given the 0-25 years inclusion, with full divisional representation and reporting into the monthly Always Safety-First safeguarding meetings. With review of progress against the Learning Disability Plan 2023-2026 and Autism Plan 2024-2027 which includes SEND.
- Progressing work for the Reasonable Adjustment Needs flag on patient electronic records, and improvements for these to be on ward whiteboards and outpatient whiteboards (Appendix 1).

9.3. Learning Disability and Autism

Fig.14. Learning from lives and deaths – People with a Learning Disability and autistic people (LeDeR) notifications



9.3.1. Fig.14 shows the number of LeDeR notifications during 2024/2025 which is 37 deaths. This is an increase to the previous year in 2023/2024 which stood at 25 deaths. There was an increase over the winter months which is comparable to the previous year and indicates the impact of winter medical illnesses on people with complex health needs. The Trust continues to prioritise Structured Judgement Reviews (previously known as mortality reviews to look at care). 1 death has sadly been attributed neglect and omission of care. A Patient Safety Incident Investigation (PSII) has been commissioned and immediate learning in the Trust

ensured via review of the fluid and balance policy, and an Always Safety-First Safeguarding Bulletin. During 2024/2025:

- There have been no 'national data opt out' notification recorded over the past year.
- There has been 1 child death in April 2024 which will be led by CDOP process, therefore LeDeR notification not submitted.
- 3 reviews are currently being undertaken by LeDeR reviewers for the 2024/2025 period.
- The Trust has received 12 LeDeR redacted review for deaths between 2021 and 2024. A thematic review has been completed and presented to the Safeguarding Board which highlighted positive and negative family experiences and opportunity for learning. One recent action has been to include 'Adult Was Not Brought' into the Safeguarding Adults policy.
- The 2-day LeDeR notification contract specification has ceased during 2024/2025.

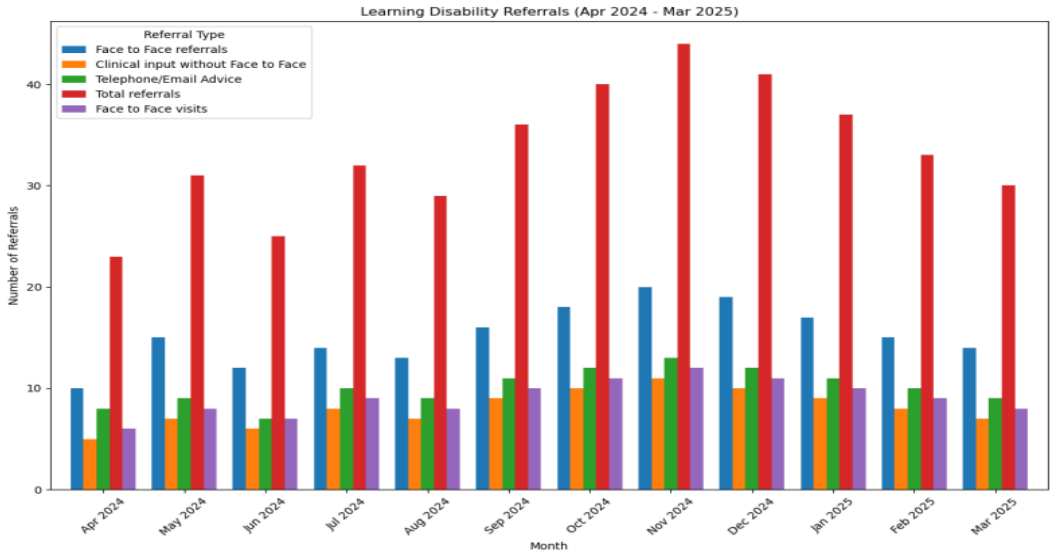
9.3.2. The Trust is committed into reducing health inequalities for people with a learning disability and / or autism. The Learning Disability Specialist Practitioner is working closely with consultant lead for Martha's rule – or 'Call for Concern' in ensuring patients with a learning disability have a voice and are appropriately assessed to avoid diagnostic overshadowing.

9.4. Learning Disability and Neurodiversity Training

9.4.1. Learning Disability and Neurodiversity training was mandated in May 2024. The Divisions and the Trust continues to be compliant (above 90%) with Tier 1 Learning Disability and Neurodiversity Core e-learning module.

9.5. Learning Disability and Autism Referrals

Fig.15. Referrals Into Learning Disability and Autism Pathway



9.5.1. Fig.15 highlights referral activity for 2024/2025. 431 referrals requesting support were received in comparison to 302 in the previous year. A spike in referrals is noted for April, October,

November 2024 and January 2025. The medicine division provides the highest number of referrals reaching 30 in October and November 2024, this would be expected in relation to winter months and non-elective attendances or admissions for complex health needs. Focus of work includes ensuring reasonable adjustments, best interest meetings, multi-agency working and maintaining access to health, for example – easy read information and social stories. There has been an increase in referrals for patients who have Attention Deficit Hyperactivity Disorder (ADHD) as a neurodiversity with sign posting, brief advice or input from the mental health workstream if appropriate provided.

9.6. Mental Health

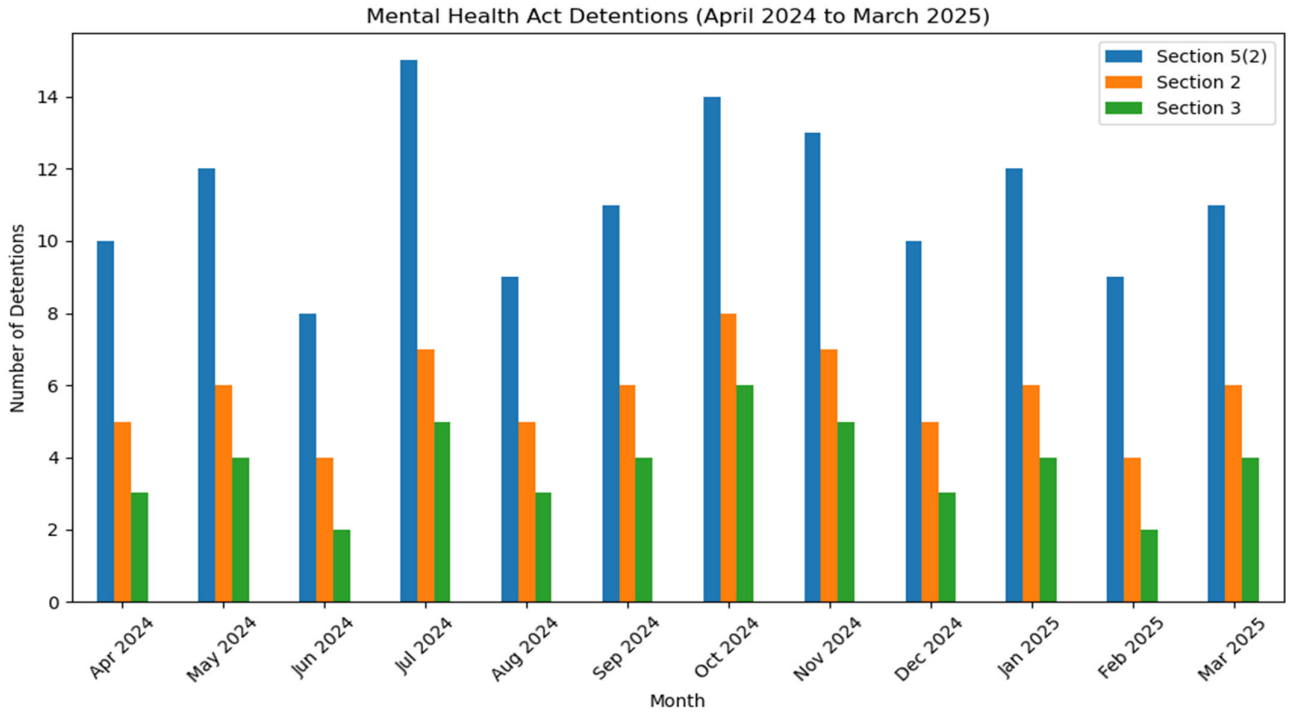
Fig.16. Mental Health Referrals

Requests for Support	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
Face to Face - 1 referral equating to face to face care (quantity of face to face not captured and face to face may include referrals from last month)	4	5	6	5	5	3	0	2	2	4	7	5	
Clinical Input (Without Direct Patient Contact)	11	10	11	3	7	3	1	4	4	8	4	2	
Brief Telephone/Email Advice Only *new referral not ongoing contact	3	5	6	11	11	10	6	4	3	7	5	4	
Total	18	20	23	19	23	16	7	10	9	19	15	11	190
Face to face-number of visits completed in total	6	5	6	7	7	6	4	3	6	7	9	5	
Women & Children	3	3	1	2	2	1	0	0	2	4	1	0	
Diagnostic Clinical Services	2	2	1	1	3	7	2	1	2	2	1	1	
Surgery	10	2	5	5	3	1	2	2	0	4	4	2	
Medicine	9	13	16	11	15	5	3	7	4	8	10	8	
Staff						2	0	0	1	1	0	0	

- Fig. 16 above shows the referral activity into the mental health pathway. There have been 190 referrals in 2024/2025 which is a reduction to the 275 in the previous year. This is likely due to the vacancy of the mental health lead, and inability for the Head of Safeguarding to fully provide clinical cover and advice associated with mental health shared across other workstreams i.e. adult and child. Processes have also been established to strengthen care and joint working for mental health patients i.e. ED have commenced a daily meeting with MHLT to review patients and Children are automatically to PAU if requiring mental health assessment after 18:00 hours. The vacant post has been recruited to and an experienced external candidate commenced in April 2025.
- Lancashire and South Cumbria NHS Foundation Trust (LSCFT) remains the commissioned mental health organisation, with the Trust Mental Health practitioner involved in complex cases, supporting the Mental Health Act (MHA) activity including patient rights, joint working with safeguarding and a focus on upskilling the workforce.
- There has been a rise in both attendances and admission for children and young people, with 694 attendances to ED in 2024/2025 in comparison to 563 in 2023/2024, 231 admitted due to mental health (mainly to PAU/ward 8) in comparison to 86 admitted in the previous year. This has been largely due to a lack of Child Adolescent Mental Health Services (CAMHS)/ Rapid Assessment Intervention Support Team (RAIST) assessment

at night, staffing issues in CAMHS delaying assessment resulting in admission and clear cut off points for referral to CAMHS and RAIST (18.00 hours). The safeguarding team (child and mental health) support the child, family, ward where complex emotional health, risk or discharge challenges are evident.

Fig.17. Mental Health Act (MHA) Detentions by Section



9.6.1. Fig.17 above highlights the sustained need for MHA detentions, either Section 5(2) holding power due to immediate risk to self or others, Section 2 for assessment and Section 3 for treatment.

- The Trust Mental Health Practitioner ensures that MHA Patient Rights are provided. The Trust holds a sub-contract with LSCFT MHA Law Office to ensure statutory requirements are upheld, referral to Tribunals and Independent Mental Health Act Advocates are completed where required.
- There has been a rise in Section 5(2)'s, 23 in 2024/2025 compared to 17 in the previous year indicating the acute risk of patients. Section 2 has slightly decreased from 30 in 2023/2024 to 26 this year and Section 3 MHA has increased from 18 in 2023/2024 to 21 in 2024/2025 indicating the need for treatment. Continued delays in mental health beds have also resulted in patients detained under Section 2 MHA have then required Section 3 as they have not yet transferred to mental health. The safeguarding team and Mental Health Liaison Team (MHLT) escalate to through the regional gold command structure when prolonged or clinical presentation indicates. Bed allocation is often needed for patients with long waits in ED and those with high risk (to self and others). The safeguarding team are involved in these patients and prompt regular MDT meetings. The risks associated with the delays for patients are reflected on the risk register and reported into the Risk Management Group.
- Patients have required detention for several clinical presentations including – eating disorders, self-neglect, severe depression, and acute psychosis.

- No children have been detained to Trust in the reporting period, which is the same as the previous year.
- There have been challenges with East Lancashire Hospital Trust ELHT not having CQC registration for the detention of patients under the MHA (Section 2 or Section 3 MHA). This has resulted in the requirement to admit a small number of people from the East Lancashire catchment area mainly for the treatment of eating disorders. Agreement is in place that admissions are via Chief Medical Officer to Chief Medical Officer agreement and there is continued work to reach a solution via the Integrated Care Board.

9.7. Mental Health Risk Tool Audit

9.7.1. The Mental Health Risk Tool (MHRT) was developed and implemented during 2020/21. The tool is for use by adult general nurses to help guide an immediate risk management plan while awaiting the assessment of mental health professionals. The tools is superseded by the specialist mental health assessment and plan and is discontinued once this is in place. The audit for the MHRT continued throughout 2024/2025 for the 4th year to assess compliance with policy, evidence of collaboration and quality of the risk management plan, and has included:

- Monthly audit results of randomly selected 50 patients who have been identified through LSCFT Mental Health Liaison Team (MHLT) Daily Situational Report, referrals to Trust mental health practitioner and Business Intelligence (BI) reports for Children/young people.
- The audit has been adapted to focus on at least 10 children per month with 16 and 17year-olds on adult wards prioritised
- The audit sample includes representation from each Division.

9.7.2. Audit Analysis

- Of the 609 cases audited, 591 patients had a mental health difficulty and an associated risk behaviour indicating that a MHRT should be completed.
- Of the 591 patients requiring a MHRT, 439 had one completed with a compliance of 74% across 2024/2025.
- The 74% compliance is slightly less but comparable to the previous year's 78%. Annual compliance is highlighted in Fig.20 and shows an increasing trend since the tool was introduced at the Trust in 2021.

Fig. 18. Annual comparison for MHRT Completion Compliance

Year	Annual compliance	Monthly variation
2021/2022	23%	9% - 53%
2022/2023	62%	56% - 74%
2023/2024	78%	73% - 84%
2024/2025	74%	61% - 81%

- The Mental Health Risk Tool training compliance and audits are discussed at the monthly Divisional Safeguarding Operational meetings to agree learning actions to improve compliance.

- Lack of completion is not consistently evidenced in one ward/area in comparison with previous year.
- The Trust mental health matron, practitioner and safeguarding team prompt completion when a referral is received if appropriate.
- MHLT practitioners also prompt the completion of the MHRT to guide risk management until MHLT assessment is completed.
- The monthly Matron STAR audit includes a specific question (question 17) on the completion of the MHRT with a requirement to audit a maximum of 5 per month. Results for the Matrons Monthly STAR question 17 for March to May 2025 are as follows:
    - Medicine (inpatients) 98.3%
    - Medicine (ED) 96.97%
    - Surgery 99.48%
    - Children 92.3%
    - Maternity 100%
- Variation in audit compliance compared to STAR is expected as the audit completed by the safeguarding team is a more detailed qualitative audit to focus on identifying training and learning. However, the questions in STAR will be reviewed against the audit tool used by the safeguarding team as part of the STAR review due to be completed in August to ensure that STAR is consistently driving improvement in practice standards.
- The mental health practitioner ensures feedback to individuals and teams is provided when evidence of good practice is identified.
- Improving compliance with the completion of the MHRT and the quality of the risk plans will remain the area of focus for 2025/2026.

9.7.3. Mental Health Risk Identification and Implementation Tool Training

- Fig.19 below shows the e-learning module compliance for the 'Mental Health Risk Identification and Implementation Tool' which has been live since January 2021. The initial target audience was for Registered Nurses in ED, MAU RPH, MAU CDH, Ward 5, Ward 24, Brindle Ward, Rookwood A, SAU, Ward 4, Ward 10, Ward 12, Major Trauma Ward, and Ward 8. The training was set as mandatory for these areas.
- This has now been widened out to all assessment units and inpatient wards including gynaecology and women services in May 2024. The Divisional Nurse Director for Children reports a new intake of staff impacting on compliance from November 2024 and again March 2025. Compliance is discussed in the monthly divisional safeguarding meetings. Significant efforts are being made to ensure compliance is achieved.

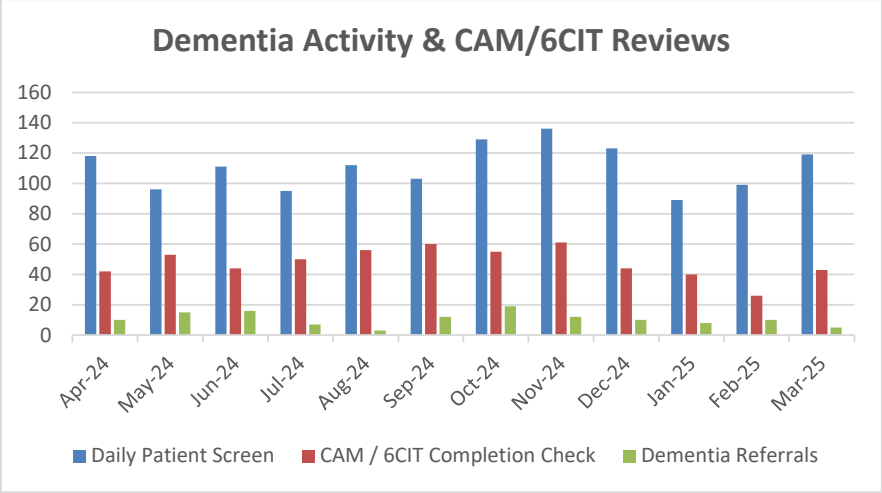
Fig.19. Trust and Division Mandatory Compliance

	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Trust Compliance	83%	85%	87%	89%	89%	89%	89%	90%	91 %	91%	93%	94%
W&C Division	92%	70%	81%	89%	88%	87%	88%	84%	85 %	84%	90%	85%

W&C – Children only	89%	86%	87%	93%	93%	90%	91%	85%	85 %	84%	90%	84%
W&C - Women's health	33%	38%	66%	89%	78%	79%	83%	83%	83 %	83%	89%	86%
Surgery	89%	95%	97%	98%	97%	97%	97%	97%	98 %	97%	98%	99%
Medicine	90%	88%	89%	90%	90%	91%	93%	93%	93 %	93%	94%	94%
Diagnostic Clinical Services	70%	73%	76%	79%	80%	80%	80%	83%	85 %	85%	88%	90%

9.8. Dementia

Fig.20. Dementia Pathway Activity and Confusion Assessment Method (CAM)/6 Cognitive Impairment Test (6CIT) Reviews



9.8.1. Fig.20 above provides data for the annual dementia pathway activities, CAM assessments and 6CIT reviews completed. Dementia referral activity has remained stable over the past two years. There continues to be significant activity to complete daily screening, to add guidance to patient notes i.e. reasonable adjustments, use of the 'Forget me Not' and consider care/helpful strategies. The CAM assessment and the 6CIT are tools used for early identification and referral need to Memory Assessment Service (MAS). The CAM and 6CIT are also reviewed to ensure discharge letter inclusion. Further Dementia activity includes;

- The Trust Dementia Strategy was reported into the ICB and supported the development of ICB Dementia Strategy in 2023/2024. The Pan Lancashire Dementia Strategy was officially launched in 2025 which highlights the multi-agency vision including Lancashire Teaching Hospitals.
- A successful charitable grant has secured funding for 2 Reminiscence Interactive Therapeutic Activities (RITA) devices. These evidence-based devices are designed to support non-pharmacological therapeutic activities. One device is already operational at the Chorley site, while the second has been purchased for the Preston site.

- Tier 2 Dementia training package has been devised and launched. This is based on Health Education England's learning outcomes and is delivered monthly across both hospital sites with 107 staff members trained so far.
- The Dementia Specialist Practitioner has been involved in the development of the new Trust delirium guideline.

10. High Intensity User (HIU) Service (Admission Avoidance)

10.1. The HIU model uses a health coaching non medicalised approach, targeting individuals who are relying heavily on unscheduled services to meet their needs. The five core principles of the HIU service are to identify, personalise, de-escalate, discharge, and manage relapse. The HIU Lead works to safely manage and co-ordinate a rolling cohort of individuals who have been identified as being high intensity users of unscheduled services. The service aims to support these individuals to flourish whilst reducing the impact on front line resources through for example, sustaining job opportunities, improving support networks, supporting holistic needs (housing and financial issues), improving physical and emotional wellbeing by using a person-centred coaching approach. Through use of multiagency support, the service aims to reduce the activity of these individuals within unscheduled services such as the Emergency Department and avoidable non elective admissions.

10.2. The service remains in place for adults aged 18 and over who attend the Emergency Department (ED) 10 times or more in 12 months, 5 times or more within 3 months or 3 times in 1 month and have an unmet need identified. An unmet need may include drug and alcohol misuse, homelessness, low level anxiety and depression, social isolation, multiple long-term conditions (and are likely to not attend routine appointments), unemployment and loneliness.

10.3. HIU Annual Activity

10.3.1. The HIU Lead triaged 65 new referrals to ensure that the inclusion criteria was met. This is the same as in the previous year. Of the 65 new referrals, 16 were accepted, 16 remained open from 2023/2024 which translates to 32 active patients on the HIU caseload. This is an increase from the 29 active patients in the previous year (10%, n =3) and a continued increase from the previous year 2022/2023 which was a 53% (n=10) increase in the HIU caseload. 15 patients are on a 'watch and wait' monitoring with Emergency Department attendances being monitored. 42 patients were screened out due to requiring mental health services, risk or no obvious coachable unmet need. 0 patients declined support/did not engage with the HIU Lead. 0 patients were uncontactable. 20 patients received one off input from HIU e.g. professional liaison, guidance plans (not previously captured). The HIU service has clear KPI's as per Fig.21 below.

10.3.2. Key Performance Indicators (KPI's)

Fig.21. HIU Key Performance Indicators

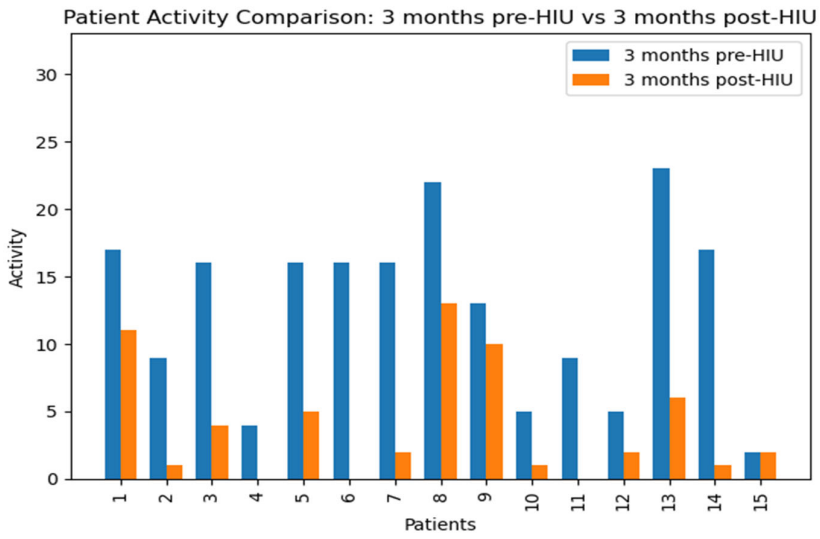
KPI	Outcome	Baseline	Target
1. Reduction in A&E attendance for this cohort of HIU patients	Improved A&E performance for this cohort of patients	Previous 12-, 3- and 1-months attendance of this cohort of patients	20% reduction on A&E's attendances cohort of patients, compared to previous 12- or 3-month position

2. Reduction of Non-Elective (NEL) admissions for this cohort of HIU patients	Improved NEL performance for this cohort of patients	Previous 12, 3 and 1 months NEL for this cohort of patients	20% reduction in NEL current position for this cohort of patients compared to previous 12- or 3-month position
3. 90% of patients from this cohort of HIU will be satisfied or extremely satisfied with the service	Patient experience	N/A	90% of patients from this cohort of patients will be satisfied or more with the service

10.3.3. Outcomes

- The KPI in relation to ED attendances show a 20% reduction for the cohort of patients, compared to the previous 12 and month position. Fig. 22 shows the ED attendance 3 months post discharge. Fig. 23 highlighted 12 month post discharge.
- There are 12 patients who have data for 12 months post discharge from the HIU service.
- There are 15 patients who have data for 3 months post discharge with the HIU Lead
- Other patients on the HIU cohort have not yet reached the KPI timeframe.

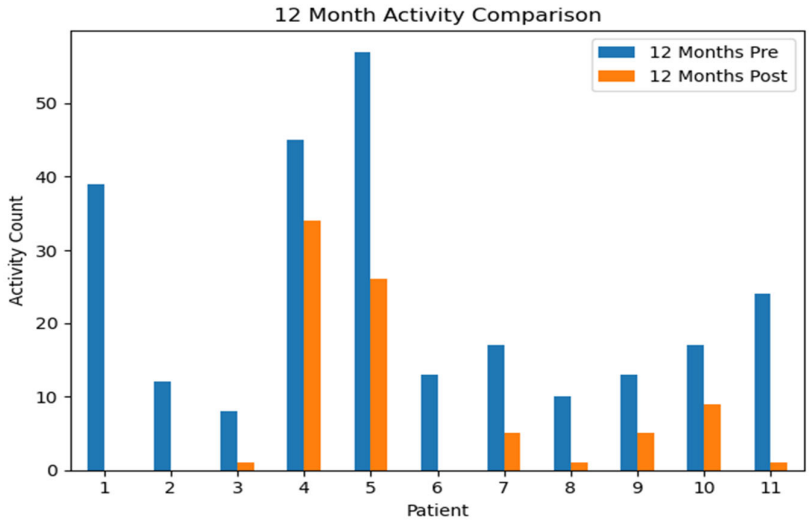
Fig.22. Emergency Department Attendances (3-Month Post HIU Contact)



- 14 out of the 15 patients had a reduction in attendances in the first 3 months post discharge. This reduction ranged from between 23%-100%. Therefore 14 patients reached or went above the 20% KPI at the 3-month HIU contact stage. This is in comparison to 7 patients in the previous year.
- 1 individuals' attendance reduced by 100% after receiving input from the HIU Lead. This is in comparison to 1 patient in 2023/2024. 2 patients reached a 90% reduction and 2 others in the 80% region.

- Fig. 23. Below shows that all patients have reached the 20% KPI reduction for 12 month post discharge from the HIU service.

Fig.23. ED Attendance 12 Months Post Discharge from HIU Service



**For noting – a 12th patient has not been added to the graph due to their pre-attendances being at 146 and the large number not being comparable to others, and therefore difficult to demonstrate in the graph. The 12th patient's attendance reduced from 146 to 18 at post 12 month discharge.*

10.3.4. Non Elective Admissions (NEA)

- The KPI for non-elective admissions is for a 20% reduction compared to the previous 3 or 12-month position. Non-elective admissions may be deemed avoidable through accessing the appropriate routine healthcare, health appointments or in building resilience and reducing health anxiety/improving the individuals overall wellbeing. Non-elective admissions for all of the cohort of patients in the last 12 months have not been a significant challenge for our patients.
- 8 out of the 12 patients with 12 months post discharge data had non-elective admissions (NEAs) in the 12 months prior to receiving support from the HIU service. (The other 4 did not have NEA's). 7 out of 8 of these patients had a reduction greater than 20% in NEAs, ranging from 80-100%. The remaining patient reduced NEAs by 17% - ongoing long term mental health and physical health – therefore NEA appropriate. 10 out of the 15 patients with 3 months post discharge data had non-elective admissions (NEAs) in the 3 months prior to receiving support from the HIU service. 8 out of 15 of these patients had a reduction greater than 20% in NEAs, ranging from 57-100%. The remaining 2 patients NEAs remained the same.

10.3.5. Patient Feedback

- In 2023/2024 the HIU Lead worked with the Trust Patient Advice and Liaison Service (PALS) to generate a QR code on the patient survey to increase return for the patient satisfaction survey on discharge. Feedback is received on; feeling listened to, respect, physical health and mental health benefits.

- Of the 24 people discharged, 8 have completed a survey with a 90% reporting positive satisfaction with the service.

11. Safeguarding Annual Plan (2025/2026)

11.1. Key Priorities Moving Forward

11.1.1. The Safeguarding Team will focus on delivering of the below for the next 12 months to ensure a safe and effective safeguarding service delivery to protect our vulnerable patients:

.

- Continued need to work across the system to reduce time spent in acute hospitals for children who require ongoing local authority placements.
- The continued to work across the system to improve access to mental health beds for children/young people and adults.
- A continued focus on supporting patients with a mental health difficulty, collaborating risk plans and reducing risk behaviours particularly when awaiting a mental health bed.
- Delivery of the key objectives of the Safeguarding workstream of single improvement plan as follows:
  - Environmental improvements to increase the number of calm spaces.
  - Develop data reporting for physical restraint and rapid tranquilisation to show reasons for use and occurrences for people with protected characteristics.
  - Increased oversight of restraint incidents by Division through reporting into Divisional Improvement Forums.
  - Delivery of the 32 recommendations following the external expert review of security services conducted in 2024.
  - Increased use and visibility of the Reasonable Adjustments Needs tab within the patients electronic records.
  - Training for key areas on mental health care in acute hospitals.
  - Deep dive reviews using Patient Safety Incident Response Framework (PSIRF) principles for the areas with the highest levels of physical restraint.
  - Compliance with rapid tranquilisation safety standards.
  - Refreshed approach to Enhanced Therapeutic Observation and Care (ETOC) and participation in the NHSE ETOC collaborative
- Increasing skills in de-escalation.
- Ensuring patient feedback within vulnerable groups.
- The continued need to ensure staff knowledge and understanding of the MCA/DoLS process.
- Strengthening the identification and implementation of reasonable adjustment needs – including actions from the Community Practice Event in February 2025.
- Reducing health inequalities for our vulnerable groups.
- Ensuring Trauma Informed Caree through increasing staff training to achieve full compliance with the Children's Safeguarding Assurance Partnership Pan – Lancashire Section 11 audit.
- Focus on increasing compliance with the use of the safeguarding checklist for 16 and 17yrs old admitted to adult wards.
- Strengthening the delivery of Enhanced Therapeutic Observation and Care (ETOC) as part of the NHSE ETOC Collaborative, ensuring ETOC is person-centred, prevents de-conditioning and increases patient safety.

- Continue to maintain strong oversight of managing allegations (PiPoT) cases and provide expert advice and training.
- Strengthen the delivery of safeguarding supervision, with greater focus on adult services in line with PSIRF incidents and within high acuity areas i.e. ED.
- Improve the compliance with the child safeguarding checklist for 16 and 17 yrs old on adult wards.
- Maintain a drive into ensuring reasonable adjustments for our children, young people and adults, ensuring reasonable adjustment needs are considered when frequent attendances are occurring and improve the reporting on compliance with following the plans for these patients.
- Embed the newly developed neglect tool in partnership with other agencies will be embedded and launched throughout the coming year.
- Highlighting and working to improve our response to children at risk of sexual harm has been a large part of our work in 2024/2025, this will continue for the forthcoming year.
- Review the offer of Learning Disability and Autism training in line with the draft code of practice and the national Oliver McGowan training.
- To develop a SEND Priority Action Plan (PAP) in line with the Lancashire & South Cumbria (L&SC) PAP. Attend the newly established L&SC systems SEND Improvement Board and Operations Board, working with key colleagues in the Children's Division to drive improvements.

12. Financial Implications

12.1. The safeguarding team attract external funding for 3 posts. The HIU service practitioner, HISVA and HIDVA. These posts serve to meet key objectives to improve outcomes for people in our local communities and also are aligned to key national priorities. The report demonstrates that the Trust benefits significantly as a result of these roles in provision of expert input and staff and patient support.

12.2. The HIU service demonstrates significant benefit on improving the health and wellbeing of vulnerable people in our communities. This also results in reduced attendance at the ED and so supports cost reduction for the Trust.

12.3. Much of the activity of the Safeguarding team focuses on supporting teams to manage people with highly complex needs this helps to progress people through their journey of care at the Trust while focusing on improving their safety and outcomes. This is likely to reduce the time spent in hospital as well as avoiding escalations in care needs both in hospital and in the community.

13. Legal Implications

13.1. The Safeguarding team are essential in ensuring that the Trust is compliant with its statutory responsibilities. The details within this report demonstrate the oversight and compliance with regulated activities.

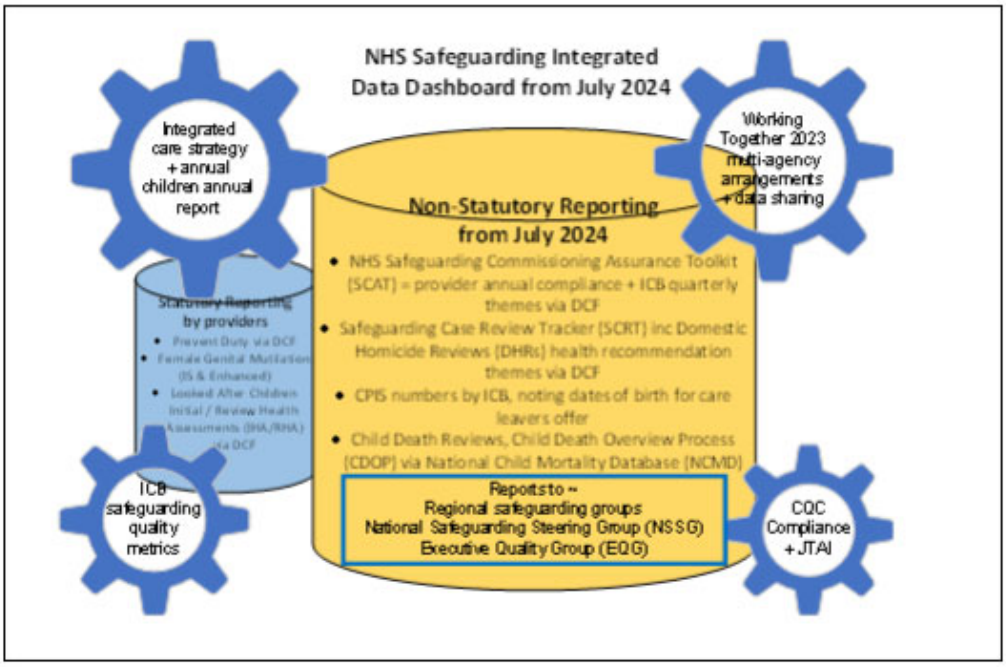
14. Recommendations

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

Appendices

Appendix 1 – NHSE Provider Safeguarding Commissioning Assurance Toolkit (P-SCAT)

Image 1 – NHS Safeguarding Integrated Data Dashboard from July 2024



Provider Safeguarding Commissioning Assurance Toolkit (P-SCAT) annual core questions

This will now be a digitally enabled self-assessment process via DCF with the provider, the ICB and the regional safeguarding teams retaining any detail and narrative at source.

For questions A1 to A7, if the provider is unable to confirm their corporate assurance in their initial quarterly report, then further quarterly reporting is required until all questions are confirmed.

A1 Leadership

A1.1 We have a Board level executive Director/s who holds accountability within the organisation for the Safeguarding Accountability and Assurance Framework (SAAF) ~ 1. Prevent Duty 2. Modern Slavery 3. Child Protection Information System and Looked After Children 4. Domestic Abuse Duty 5. Serious Violence Duty

A1.2 We employ or have access to provide strategic safeguarding advice, expertise and guidance via: 1. Named safeguarding practitioners 2. A designated nurse for children 3. A designated doctor for children 4. A designated nurse for looked after children 5. A designated doctor for looked after children 6. A designated professional for adults, (including but not exclusively lead GP, nurse, midwife, allied health professionals, social worker)

A1.3 We have a policy regarding internet and social media use which addresses safeguarding.

A1.4 We comply with the information requests and safeguarding data returns to NHS England, including for the Prevent Duty and Looked After Children initial and review health assessment reporting obligation.

A1.5 We have a safeguarding team in place in accordance with specification set out in the intercollegiate documents for adults, children and Looked After Children.

A2 Training

A2.1 We have a safeguarding training strategy which underpins the safeguarding intercollegiate documents and relevant national guidance and which covers all staff, volunteers and external contractors.

A3 Recruitment and HR

A3.1 We meet safe recruitment standards i.e. NHS Employers Disclosure and Barring Service checks for employed staff and volunteers.

A3.2 We have included safeguarding responsibilities in all job descriptions.

A3.3 Safer recruitments standards are monitored by the Executive Director and action taken where they fall short of expectations.

A3.4 We manage requests for access from volunteers, paid/unpaid charity fundraisers, celebrities and "friends of the organisation".

A3.5 We have systems in place to report unsafe practice to external professional regulators and bodies.

A3.6 We have a managing allegation against staff policy which include referrals for Local Authority Designated Officer (LADO - child abuse) and Person in Position of Trust (PiPoT - adult abuse) are aligned with Local Safeguarding Adults Boards and Children's Safeguarding Partnerships.

A4 Interagency working

A4.1 We are actively engaging with all aspects of the inter/multi-agency work of the local safeguarding strategic groups including multi-agency risk assessment conferences (MARAC); multi-agency public protection arrangements (MAPPA); local domestic homicide review (DHR) panels, community safety partnership (CSP); domestic abuse forum and Prevent Channel panels.

A5 Implementing shared learning

A5.1 We initiate local and engaged with place-based, system-led, regional and national safeguarding investigations, multi-agency case review and safeguarding practice reviews.

A5.2 We can consistently evidence learning has been embedded into practice.

A6 Patient Engagement

A6.1 We have appropriate and accessible information about our safeguarding duties and provide this for our population.

A7 Supervision

A7.1 We deliver or provide safeguarding supervision in line with the intercollegiate documents for:

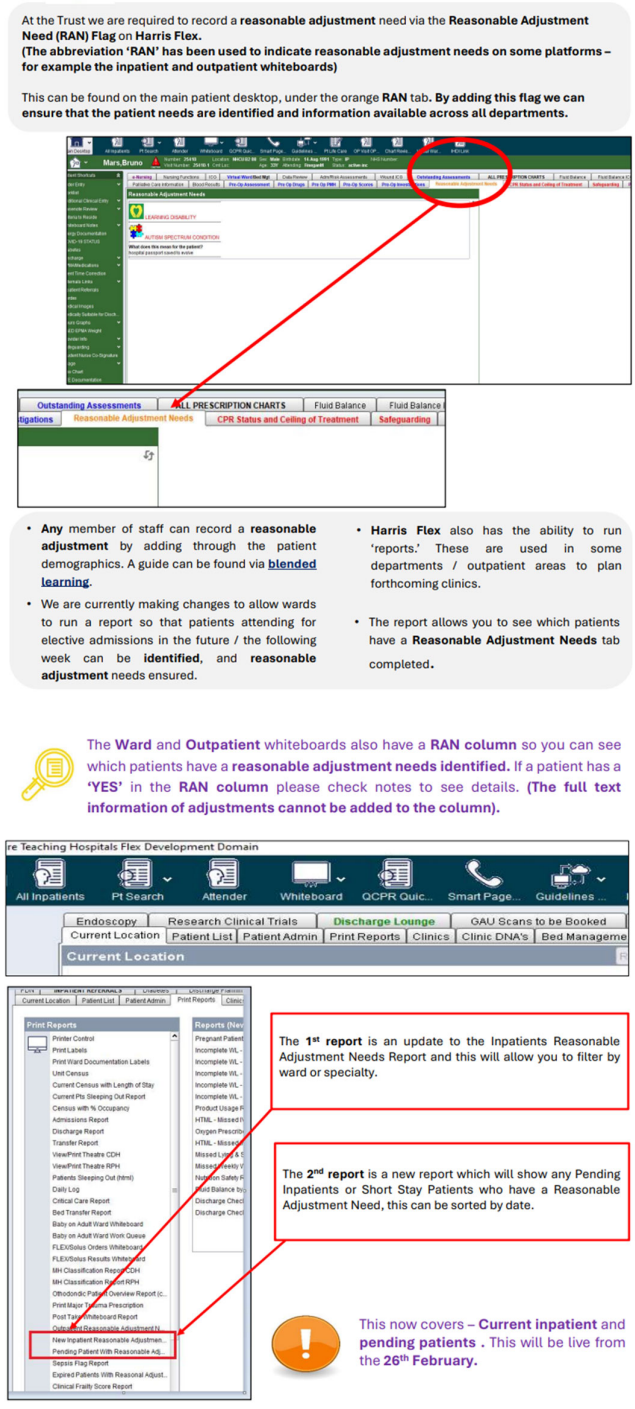
1. Children
2. Looked After Children
3. Adults

Appendix 2 – <u>Service Improvements and Initiatives in Safeguarding</u>

1 Reasonable Adjustment Needs

1.1 The continued development of the Reasonable Adjustment Needs tab, the ability to run reports planning for elective admissions and outpatient appointments. Figure 1–

Figure 1 Harris Flex



2 Learning Disability and Autism

2.1 Working with our autistic community groups / multi-agency autism partnership board to develop and pilot Hospital Passports focused on the needs of autistic people including sensory and communication strengths and reasonable adjustment needs. The pilot continues and will be finalized in 2025/2026.

3. Maternity

3.1The Named Midwife for Safeguarding has attended the Safer Sleep Task and Finish group to update the safer sleep Pan Lancashire guidance. The updated guidance includes older children, and older children with complex medical needs and babies who are on NICU. The Named Midwife for Safeguarding has also presented with Pan Lancashire multi-agency partners in webinars to promote the Safer Sleep messages, one was attended by over 200 professionals and by 170 professionals and many attendees now reporting that they have implemented Safer Sleep into their roles.

3.2 In March 2025, the Safer Sleep Subgroup launched the new professionals Toolkit with an e-learning developed with support from the Blended Learning team at LTHTR. The subgroup has also updated the 6 steps to safer sleep with the support from the Blended learning team at LTHTR. Other activities have included - LTHTR also arranging for a Burnley FC midfielder, to record a video promoting Safer Sleep messages gaining nearly 2000 views on social media.

3.3.The ICON programme (Babies Cry, You Can Cope) is a CDOP campaign which aims to help parents and carers to cope with a crying baby. The Named Midwife for safeguarding is the chair for the ICON subgroup. Activity to raise the profile of ICON has included lighting up various buildings across Pan-Lancashire, including the lighting of the maternity unit during ICON Week, a video featuring student officers in uniform from Lancashire constabulary holding ICON letters and explaining the initiative with support from the LTHTR communication team. The video was shared internally throughout the constabulary to support ICON Week. The team has also worked in conjunction with UCLAN to ensure that the ICON learning package is now part of the Midwifery core training.

3.4The safer sleep risk assessment tool introduced into the Trust last year is now well embedded within the maternity, NICU In-reach/outreach, paediatrics, urgent care, and the emergency department. Safer sleep guidelines have been updated to support staff to undertake safer sleep discussions and ensure consistent advice is being provided. Training is provided by the ESMT and safeguarding children's team for staff completing the assessment and within the mandatory monthly Midwifery Public Health/Saving babies Lives training.

3.5 Relaunch of the Inspire partnership clinic with maternity is now well established. Domestic Abuse guideline for maternity updated. Enhanced support in pregnancy guideline updated.

3.6 The Named Midwife has been invited to a meeting to review the concealed and denied pathway with the ICB and safeguarding midwives across Lancashire.

4. Dementia

4.1 The dementia specialist has also made strong internal and external relationships. Having provided training and attend meetings with Home First, Alzheimer's Society, and South Ribble Community Connections. Discussions around safe discharge, including the "Forget Me Not" initiative have been included in these meetings.

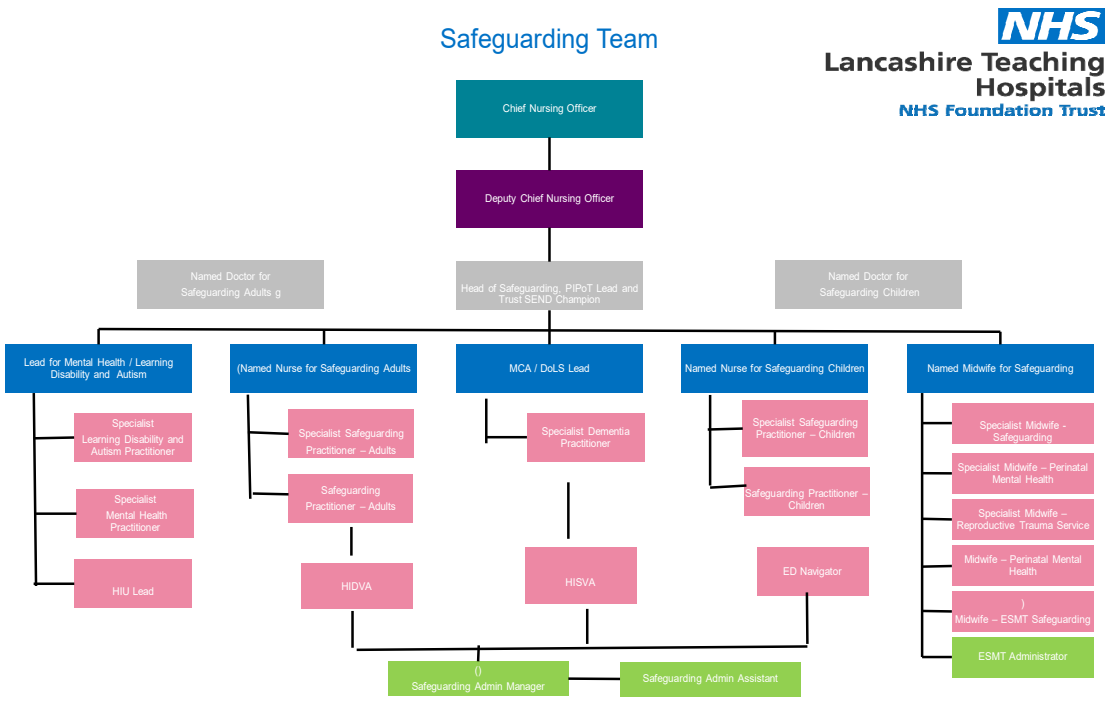
4.2 The "Forget Me Not" document has recently undergone a review, with input from staff, carers' forums, and individuals living with dementia who participate in Alzheimer's Society and Age UK dementia

cafes/groups. Although updates have been made, the document is currently on hold while considerations are made regarding the possibility of digitalising it. A fact-finding exercise is underway to assess the feasibility of this transition. The overall feeling is that the document should not be digitalised as hospital passports, Forget Me Not documents or any person-centred document should be handheld and be a working document.

4.3 In September 2024, charitable funds were successfully obtained and the Dementia Simulation Bus visited both hospital sites, offering 120 staff members the chance to experience a simulation of living with dementia. The feedback has been overwhelmingly positive, with plans to replicate this training across the Trust with developments from the LTHTR Simulation Team. The initiative was presented to the Educational Governance Group in December 2024.

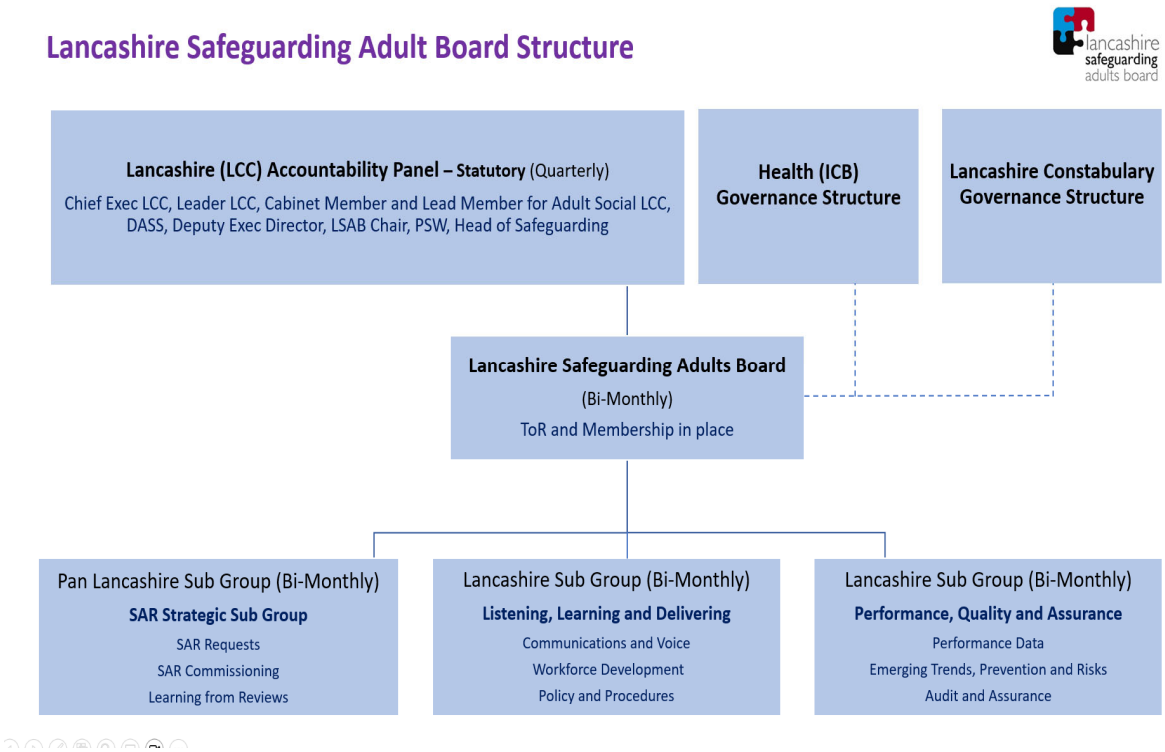
4.4 Efforts continue to ensure access to appropriate finger foods as part of the National Audit of Dementia (Round 5 and 6). This remains a challenge for dementia patients, as many items have to be sourced from the children's menu. However, recent discussions between the dementia specialist practitioner, the learning disability practitioner, and the new catering manager have led to a trial of new menu options.

Appendix 3 - Safeguarding Team Structure

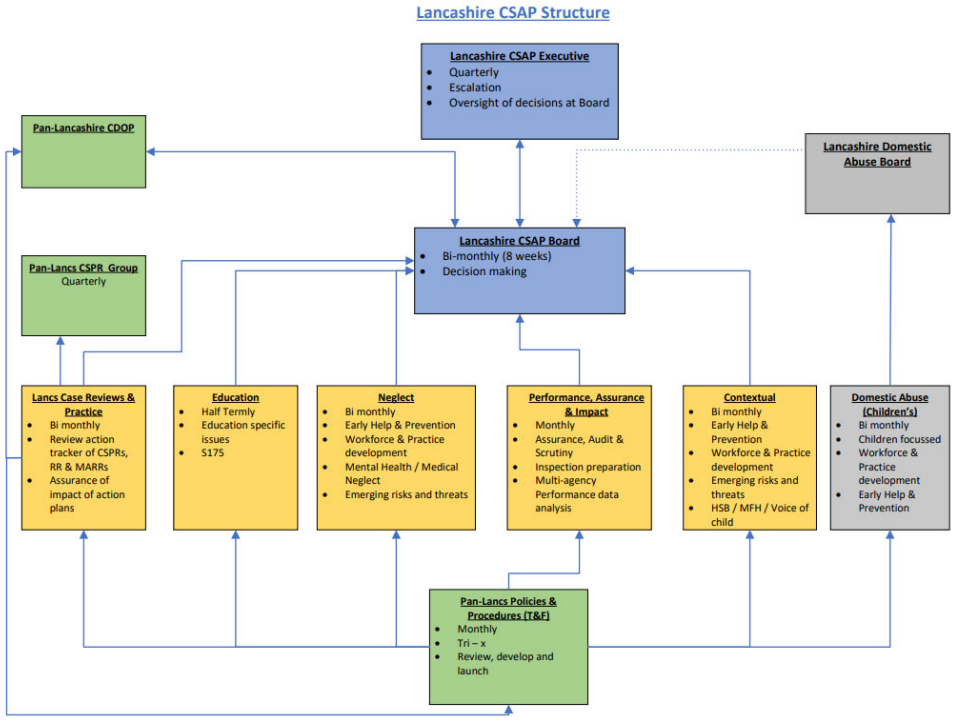


Appendix 4 Safeguarding and SEND Partnership meetings

4.1 LSAB structure (not including task and finish group i.e. self-neglect and PREVENT forum)

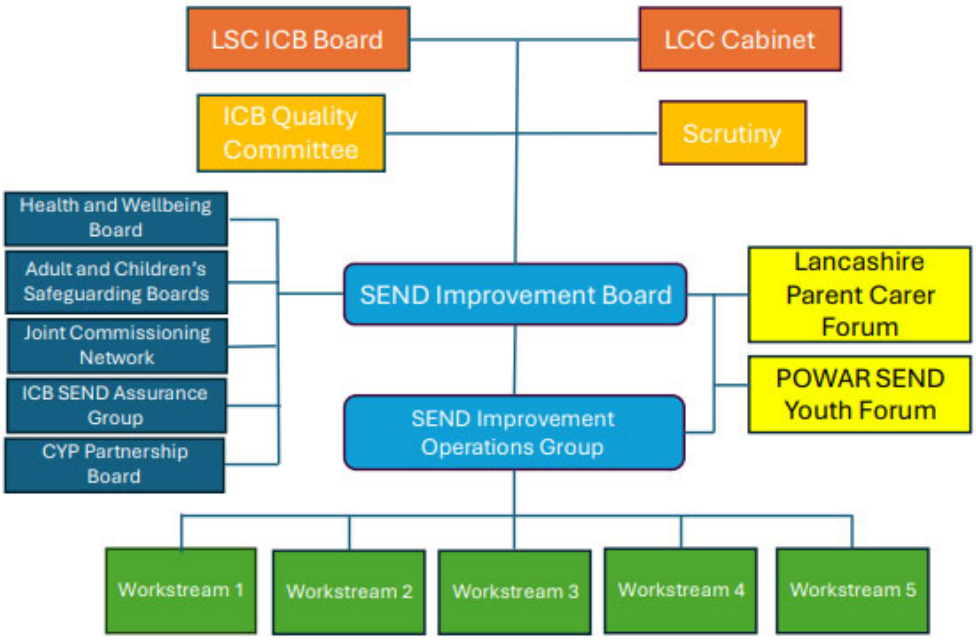


4.2 CSAP structure



4.3 SEND Partnership Governance Structure

Governance Structure



4.4 Additional multi-agency /ICB meetings

- Autism Health and Social Care group (workstream from the Autism Board)
- Autism Partnership Board
- Learning Disability Health and Social Care Group (workstream from the Partnership Board)
- Learning Disability Partnership Board
- Learning from lives and deaths – learning disability and autistic people (LeDeR Steering Group)
- LeDeR Learning into Action group
- Mental Health Agency Oversight Meetings
- Self-harm steering group
- Self-neglect group (as a workstream for Lancashire Safeguarding Adults Board).

Appendix 5 – Physical Restraint Rapid Tranquilisation and incidence of Self-harm Analysis

Dashboards capturing incidents of self-harm, physical restraint and patients with a learning disability or autistic patients

Fig.1 Self Harm Incidents by reported date 2024/25

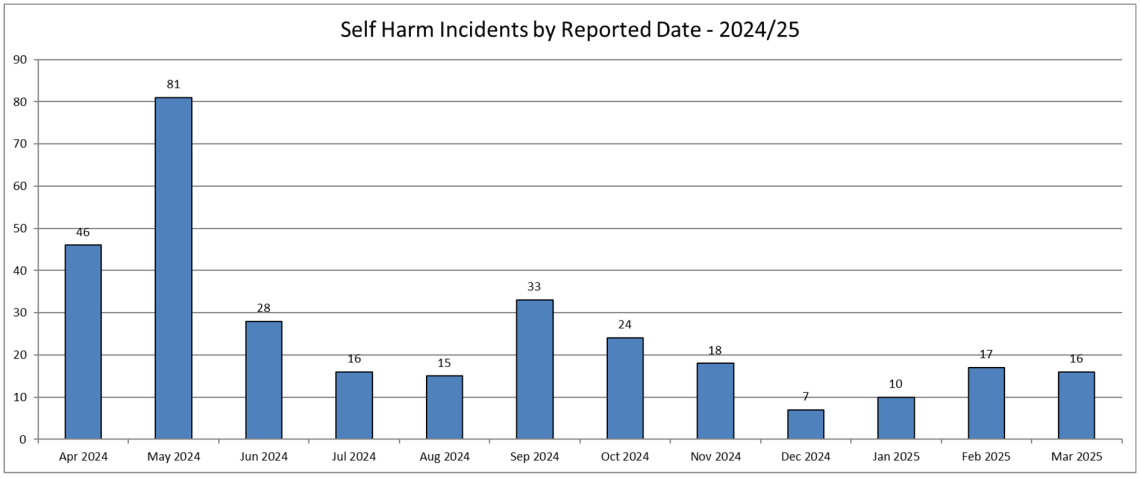


Fig.2 Top 10 locations for self-harm incidents 2024/2025

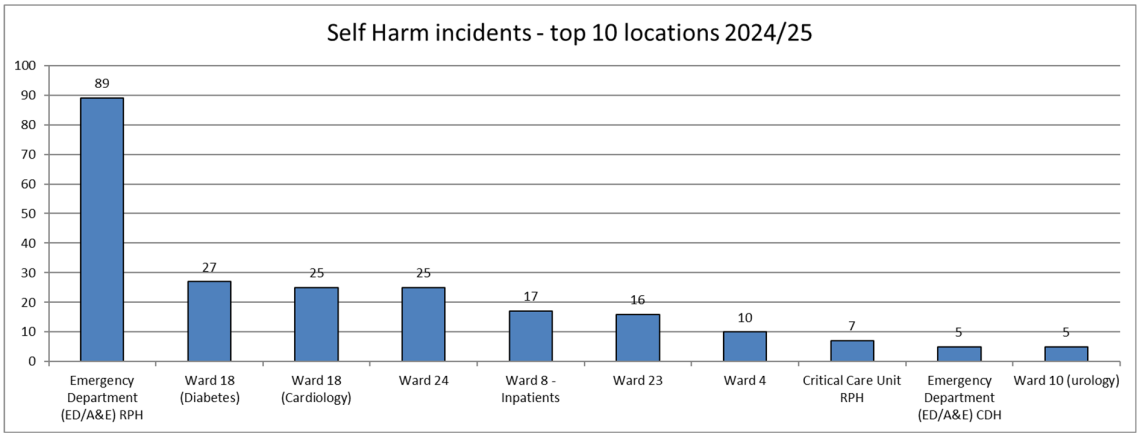


Fig.3 Was Physical Restraint used? 2024/2025

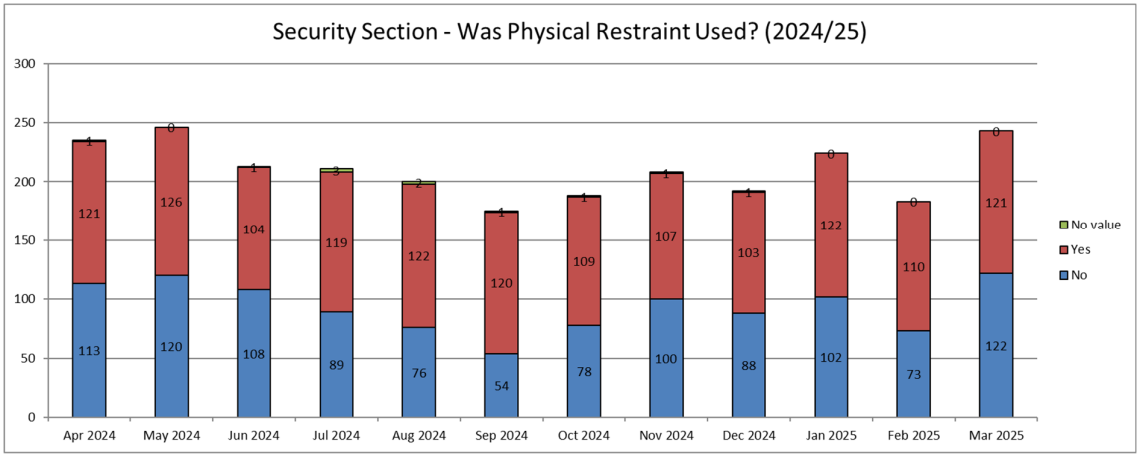
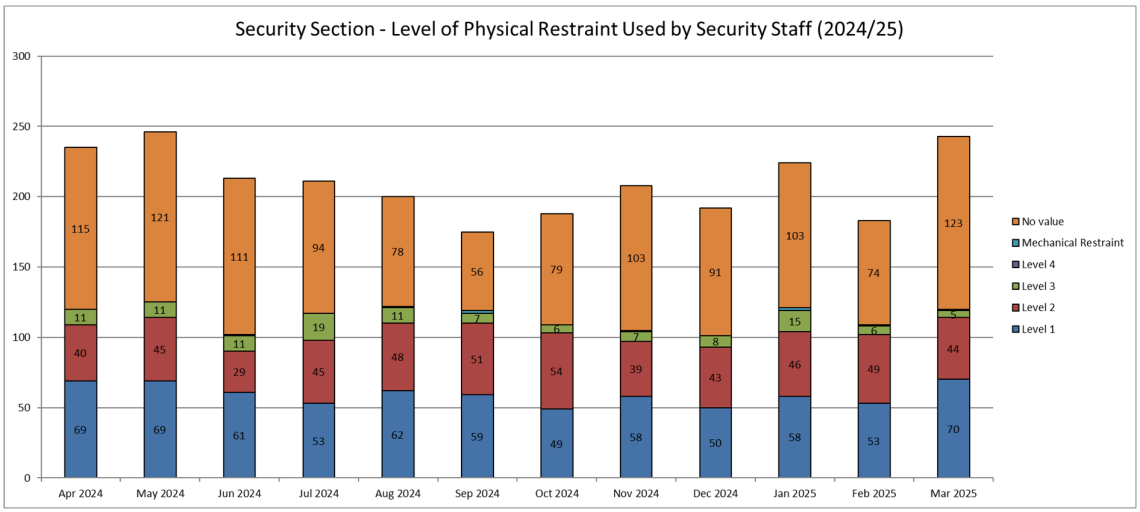


Fig.4 Level of Physical Restraint used 2024/2025



Levels of restraint:

- **Level 1** – the escorting technique where a hand is placed over the wrist of an individual to guide the patient. (Low Level Hold)
- **Level 2** – escorting technique where a hand is placed behind the palm to support the wrist, an arm is then placed behind the over the persons arm to give support and escort. (Medium Level Hold)
- **Level 3** – holding technique where the persons arm is folded into its natural folding position to shut the muscle group down so that they cannot strike out or hit out, this is required when a high level of violence and aggression is being shown. (High Level Hold)
- **Level 4 - Mechanical restraint (leg restraints**) – these will be applied in extreme violence and aggression incidents, where the person is posing a serious risk of harm to themselves, staff of other patients. The restraints are placed above the knee joint on the person thighs and above the ankles on the shin area. Once applied these will be reviewed every 5 minutes by the security officers to ascertain if they are still required. These may be applied when the patient is high risk and is attempting to kick out/harm or abscond and aggressive when taking the patient to transport.

Fig.5 Restraint used – Is the patient identified to have a learning disability? (2024/25)

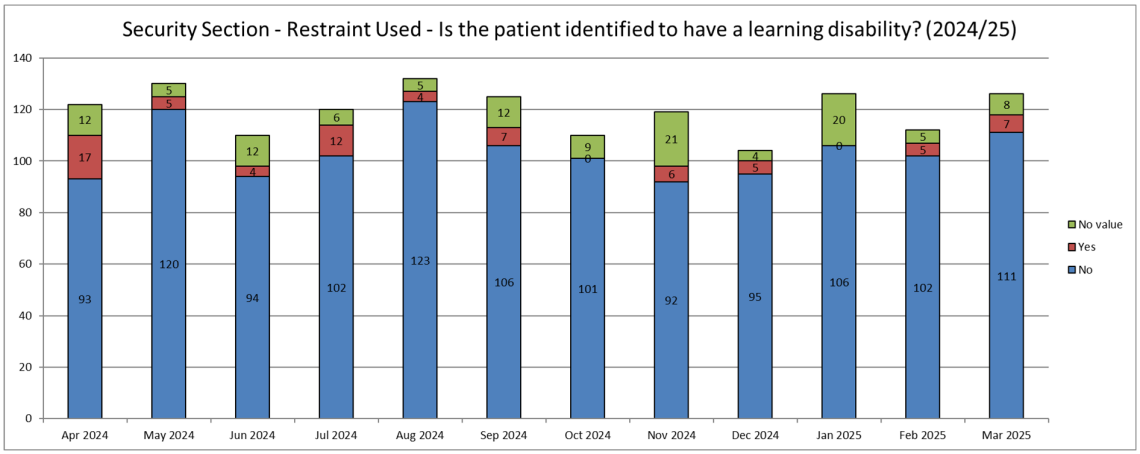


Fig.6 Restraint used – Is the patient identified to have autism? (2024/25)

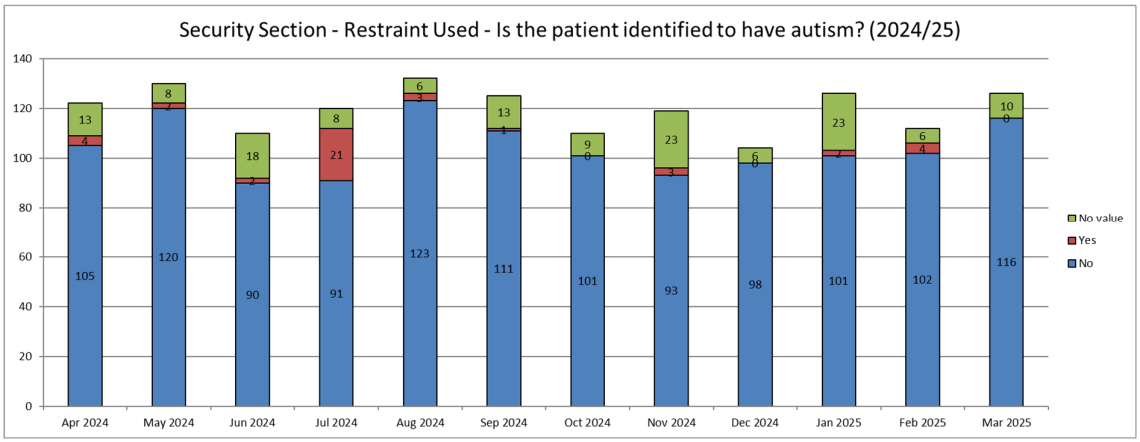
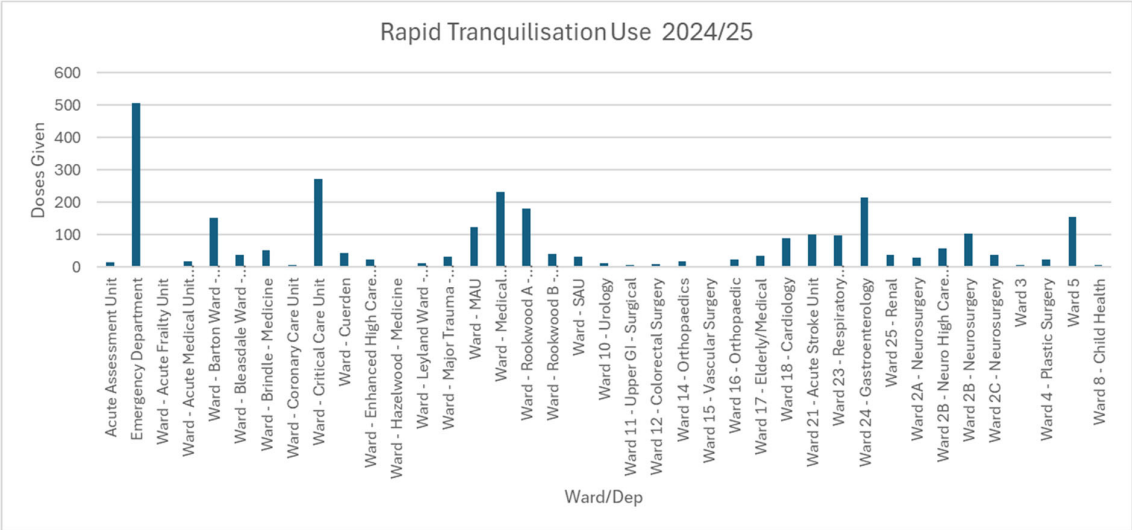


Fig.7 Rapid Tranquilisation administered by ward



Appendix 6- Safeguarding Bulletin example:

Always Safety First

Organisational Safeguarding Bulletin

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Version 1 – October 2024

FAO: All NHS Staff Working In a Healthcare Setting Within The Trust Including Bank And Agency Staff

PREVENT: Counter Terrorism Strategy

Who Should Read This?

Everyone working in healthcare settings - in the NHS or on behalf of the NHS has a duty to ensure that they understand **PREVENT** and know what to do if someone they have had contact with is at risk.

What Is PREVENT?

Prevent Strategy

- The **PREVENT** strategy is a vital component of the UK government's counter-terrorism initiative **(CONTEST).** Its primary goal is to reduce the threat of terrorism by intervening before individuals become radicalised or support extremist activities.
- **PREVENT** works to ensure that people who are susceptible to radicalisation are offered appropriate interventions, and communities are protected against radicalising influences.

Always Safety First

Organisational Safeguarding Bulletin

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Version 1 – October 2024

The Role of Healthcare Professionals

Why is PREVENT important to you?

- It is our duty to understand the **PREVENT** strategy and to recognise when someone may be at risk. This aligns with the NHS statutory duties for safeguarding as outlined in the Counter-Terrorism and Security Act 2015
- Healthcare staff, whether in the NHS or working on its behalf, are often in contact with individuals who may be vulnerable to radicalisation..
- Those who work in frontline support roles, such as healthcare settings, will often be the first to notice if someone is displaying concerning behaviors.
- Occasionally, healthcare workers have themselves become radicalised or drawn into terrorism. **It could affect one of our colleagues.**
- Healthcare staff must be able to recognise signs of radicalisation and be confident in referring individuals who can then receive support before they go any further, and harm themselves or others

Identifying The Signs Of Radicalisation

While each individual is unique, certain behaviours may indicate a person is at risk of radicalisation.

Be alert for:

- **Justifying Violence:** Expressing support for violent actions to address societal issues.
- **Changes in Appearance:** Altering dress or grooming to align with extremist ideologies.
- **Social Withdrawal:** Becoming increasingly unwilling to engage with those perceived as different.
- **Use of Extremist Symbols:** Displaying symbols or paraphernalia associated with terrorist organisations.

Organisational Safeguarding Bulletin – PREVENT – Counter Terrorism Strategy

Always Safety First

Organisational Safeguarding Bulletin

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Version 1 – October 2024

Key Actions

What to Do If You Suspect Radicalisation:

1. **Do not** rely on others to refer, **you** have a duty and responsibility to report any concerns you have about an adult or child who you think may be vulnerable to being drawn into extremism.
2. **Contact the Safeguarding Team:** If you suspect a patient may be at risk of or being radicalised, for further discussions (see supporting information for contact details).
3. **Immediate Threats:** If you believe someone is planning an act of terrorism, contact the police immediately by dialling **999**.
4. **Team leads share this bulletin in all Safety Huddles and Team meetings:** Ensure all staff are aware of this process and use it as a discussion and a training resource.
5. **Further guidance can be found within the Safeguarding adults at risk policy which incorporates the PREVENT procedure**: http://lthtr-documents/current/P287.pdf

Understanding and implementing the **PREVENT** strategy is essential for safeguarding vulnerable individuals and protecting the wider community. Your vigilance and proactive approach can make a significant difference.

Thank you for your commitment to safety and safeguarding

Supporting Information:

Contact the team:

- Ext: 3676
- External number: 01772 523676
- Duty Email: Safeguarding.Duty@lthtr.nhs.uk
- Adult Email: Adult.Safeguarding@LTHTR.nhs.uk
- Child Email: Child.Safeguarding@LTHTR.nhs.uk

- Recourses can be found on the intranet here

Organisational Safeguarding Bulletin – PREVENT – Counter Terrorism Strategy

Appendix 7 – Glossary of Terms

Adult Social Care (ASC)
Adult social care is a term that broadly describes the support and services provided to help adults, including those who are older, have disabilities, or experience mental or physical health issues, live independently and maintain their well-being. It encompasses a range of support options, including personal care, housing assistance, day services, access to information and advice and safeguarding.

Confusion Assessment Method (CAM) and 6 item Cognitive Impairment Test (6CIT)
The Confusion Assessment Method (CAM) is a standardised evidence-based tool used to assess delirium in patients. It is based on four key areas – acute onset and fluctuating, inattention, disorganised thinking and altered level of consciousness. It is used to quickly and accurately identify delirium and is a pre-cursor to the 6CIT if there are concerns regarding dementia. A 4-item delirium assessment (4AT) is a standalone rapid clinical test used in the Emergency Department and inpatient areas. The 6-CIT is a short cognitive impairment test covering 3three domains (orientation, episodic memory and attention). The CAM/6CIT is completed for patient's over 70 years to aid early identification of dementia and is completed with consent so that GP's can be informed and referral to memory assessment services be completed if scoring over 8 on the 6-CIT.

Child Death Overview Panel (CDOP)
The CDOP conduct a review of all child deaths up to the age of 18 years. The panel is a group of professionals with the main purpose of learning from deaths to help identify ways of preventing future deaths, identify any improvements that can be made to services, to improve the experience of bereaved families and support professionals to care for children and families. The CDOP was set up by the Child Death Review (CDR) partners under the requirements of the Children Act 2004 and in accordance with Working Together to Safeguard Children 2023.

Children Safeguarding Assurance Partnership (CSAP)
The CSAP is a collaboration of agencies in Lancashire including local authorities, the Lancashire Constabulary, Integrated Care Board (ICB), Health agencies. It replaced the previous local Safeguarding Children's Boards in the area. The CSAP focuses on improving how agencies work together to safeguard and promote the welfare of children. The CSAP has a board and a number of priority workstreams to drive the agenda and receive assurances.

Children Social Care (CSC)
A local authority agency to provide help to children and their families if the child – needs support with maintaining their health or development, has a disability, is in need of protection (safeguarding), is a child looked after.

Children Social Care (CSC) Strategy Meetings
Also known as a strategy discussion. A multi-agency gathering convened when there is reasonable cause to suspect a child is suffering or likely to suffer significant harm It is a crucial step in deciding to initiate child protection enquiries.

Deprivation of Liberty Safeguards (DoLS)
A legal framework designed to protect people who lack mental capacity to make decisions for themselves, ensuring that any care arrangements that restrict the persons liberty are in their best interest. This framework is part of the Mental Capacity Act 2005 and is crucial for safeguarding the rights of individuals

who may be deprived of their freedom (supervised at all times and not free to leave). The safeguarding teams has a Named Professional for Mental Capacity Act (MCA)/DoLS.

Enhanced Therapeutic Observation and Care (ETOC)
ETOC is an intervention which contributes to safe and effective care of patients. ETOC over the additional support (either by bay nursing, intermittent (more for mental health patients) and 1:1 to patients. ETOC is an opportunity to safeguard/manage risks, support and therapeutically engage. ETOC should be provided with consent and collaboration (if the patient has capacity to consent) or under a legal framework (DoLS or Mental Health Act) due to the loss of privacy and freedom for the patient.

Initial Health Assessments (IHA's)
IHA's are a statutory requirement for children are placed into care (Looked after Child). The health assessment is required for completion within 28 days of the child coming into care. The assessment considers all health including information about specialist services, dental, hearing, speech.

Learning from lives and deaths – People with a Learning Disability and autistic people (LeDeR)
A service improvement programme in NHS England designed to review the lives and deaths of individuals with learning disabilities and autistic people. The programme is aimed at identifying where care and support can be improved, ultimately leading to better health outcomes and longer healthier lives for people with a learning disability or autistic people. The Safeguarding team complete the notifications and embed learning. The Clinical Audit and Effectiveness Team ensure a Structured Judgement Review which can be shared with LeDeR reviewers.

Local Authority Designated Officer (LADO)
A statutory role within local authority, the LADO is responsible for overseeing allegations against individuals working with children, ensuring they are managed appropriately and the process for managing allegations is managed consistently to safeguard children.

Mental Health Risk Tool (MHRT)
A Trust developed risk tool following the CQC visit in 2019. The Mental Health Risk Identification and Management Tool is an evidence-based tool for staff to complete for patients with a mental health difficulty AND Risk behaviour. It was piloted in 2019 and embedded in 2020. It is intended to enable staff to feel more confident in identifying risk to self, others, vulnerability and to collaborate a risk plan. The Risk Tool is superseded by any assessment of mental health (MHLT and CAMHS), the Risk Tool is to ensure immediate patient safety until a specialist mental health plan can be received.

Multi-Agency Safeguarding Hub (MASH)
The Multi-agency Safeguarding Hub (MASH) was established in 2013 and is the single point of access for all safeguarding concern across both children's and adults. MASH received the referrals into Children and Adult Social Care when related to a safeguarding concern.

National Audit of Dementia (NAD)
The National Audit of Dementia (NAD) Care in General Hospitals is commissioned by the Healthcare Quality Improvement Partnership, which is led by a consortium of the Academy of Medical Royal Colleges and the Royal College of Nursing. The Older Adult Consultant Physicians lead on the NAD alongside key members of the Elderly Medicine team and involves audit to include delirium screens, Forget me Not documents, bed movement, food (for example). The Dementia Specialist in the safeguarding team has been involved. The actions from Round 6 NAD are currently being focused upon within the hospital.

NHS England Learning Disability Benchmarking Standards
Standards have been developed to help NHS Trusts measure the quality of care they provide to people with learning disabilities, autism or both. Standards are focused upon- respecting and protecting rights, inclusion and engagement and workforce for the Trust, the fourth standard is aimed at mental health or learning disability trusts. The Trust Learning Disability and Autism Practitioner / Lead collate business intelligence and specialist data i.e. complaints or Section 42's for submission.

NHS Safeguarding Commissioning Assurance Toolkit (SCAT)
The Integrated Care Board (ICB) input data into the SCAT. From October 2024 Providers also input via a Provider SCAT (P-SCAT). This is part of a robust safeguarding audit and data flow process for the NHS Data Collection (DCF) framework. The SCAT allows for safeguarding leads to upload statutory safeguarding data into the DCF in a timely manner, including Prevent Duty Training. This forms part of the NHS Safeguarding Integrated Data Dashboard (NHS SIDD) with the aim of being a single point of commissioning assurance data between providers, ICBs, regional safeguarding teams and the National Safeguarding Steering Group (NSSG) from 1st March 2024.

Person in Position of Trust (PiPoT)
PiPoT safeguarding refers to a process for managing allegations or concerns about professionals or volunteers working with adults with care and support needs, who may have behaved in a way that could harm or potentially harm those adults.

PREVENT
"Prevent" in the context of UK government policy refers to a counter-terrorism strategy aiming to stop people from becoming terrorists or supporting terrorism. It is one of the four strands of the CONTEST strategy, along with Pursue, Protect, and Prepare. The Prevent strategy focuses on identifying individuals who are susceptible to radicalisation and providing support and guidance to help them resist extremist ideologies. The Trust Named Nurse for Safeguarding Adults attends the Lancashire PREVENT forum.

Rapid Tranquilisation
Rapid Tranquilisation is the use of medication by the parenteral route (usually intramuscular or exceptionally intravenous) if oral medication is not possible, appropriate or effective and sedation with medication is needed. Rapid Tranquilisation is administered rapidly reduce agitation and/or aggression in situations where there is a high risk of harm to the individual or others, and when other methods/de-escalation has been unsuccessful. The administration of Rapid Tranquilisation is led by guidance from the National Institute for Health and Care Excellence (NICE) ng10.

Safeguarding Adult Reviews (SAR)
A Safeguarding Adult Review (SAR) is a multiagency process conducted by Safeguarding Adults Boards when an adult with care and support needs has dies or serious harm has been caused, and there is a suspicion or knowledge that abuse, or neglect was a factor. The primary aim is to identify lessons learned and make improvements to prevent similar incidents in the future.

Section 42
This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there) - (a)has needs for care and support (whether or not the authority is meeting any of those needs), (b)is experiencing, or is at risk of, abuse or neglect, and (c)as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it. Providers,

such as hospitals have a duty to report concerns about potential abuse or neglect under Section 42 of the Care Act 2014. This duty to report arises when there is reasonable cause to suspect an adult has needs for care and support, is experiencing or at risk of abuse or neglect, and is unable to protect themselves. The Section 42 will result in unsubstantiated, partially substantiated or substantiated outcomes with learning and actions.

Special Educational Needs and Disabilities (SEND)
SEND is part of the Children and Families Act 2014 and applies statutory duties on health and education for children and young people with special educational needs (SEN) and disabled. SEND terms up to age 25 years as young people. A child or young person has special educational needs and disabilities if they have a learning difficulty and/or a disability that means they need special health and education support. The focus on SEND is to identify support needs, to hear the child's voice, to include preparation for adulthood and this may be included in an Education Health and Care Plan (EHCP). The Trust has a SEND Clinical Lead (Community Paediatrician), SEND Champion (Head of Safeguarding) and a SEND Improvement Group feeding into the Safeguarding Board.

The Care Act (2014)
The Care Act 2014 is a key piece of legislation in England that sets the framework for adult social care. It outlines how local authorities should provide care and support to adults with care needs, including older people, and their unpaid carers. The Act also focuses on promoting the wellbeing of individuals and emphasises person-centred care

The Children and Families Act (2014)
The Children and Families Act 2014 amended the Children Act 1989 in several key areas including SEND. The legislation is mainly aimed to protect vulnerable children or those at risk. How professionals work with children and multi-agency partners is set out, with children's rights clearly identified.

The Mental Capacity Act (2005, amended 2019)
The Mental Capacity Act is a UK law that provides a framework for acting and making decisions on individuals over the age of 16 years who lack the capacity to do so for themselves. It statutes practice in relation to assuming capacity, ensuring support in decision-making best interest process and least restrictive practice. The Trust has the MCA/DoLS Lead and strong system and governance processes to ensure the patients care follows the principles of the Mental Capacity Act.

The Mental Health Act (1983, 2007)
The Mental Health Act (MHA) is a legal framework that governs the assessment, treatment, and care of people with mental health disorders. It outlines the circumstances under which individuals can be detained in a hospital against their wishes, typically when they pose a risk to themselves or others due to their mental condition. The Act supports least restrictive practice and considers insight/consent to engage prior to detention and also defines the rights of individuals who are detained – for example ability to appeal when detained under Section 2 or Section 3 MHA.

Trauma Informed Care
Trauma-informed care is an approach to services that recognises the widespread impact of trauma/adverse child experience on individuals. It emphasises safety, trust, and empowerment, and aims to prevent re-traumatisation while fostering recovery. It involves understanding how trauma affects individuals and organisations and responding in ways that are sensitive and supportive.

Vicarious Trauma

Vicarious trauma, also known as secondary traumatic stress or secondary traumatisation, refers to the emotional and psychological impact experienced by individuals who engage empathetically with survivors of traumatic events or are exposed to traumatic stories and experiences. This impact can be profound and lasting, potentially leading to symptoms similar to those of Post-Traumatic Stress Disorder (PTSD).

Whooley Screening

The "Whooley Questions" are a two-question screening tool used to identify potential depression. They are simple, easy-to-administer questions. The questions are: "During the past month, have you often been bothered by feeling down, depressed, or hopeless?" and "During the past month, have you often been bothered by having little interest or pleasure in doing things?".

9.4 - MATERNITY AND NEONATAL SAFETY REPORT

REFERENCES

Only PDFs are attached

9.4 - Maternity and Neonatal Safety Report - Ancillary report.pdf

Board of Directors

1. INTRODUCTION

The purpose of this report is to provide an overview of the safety and quality programmes of work and to present the monthly staffing position within the perinatal (maternity and neonatal) services up until the end of June 2025. The report triangulates workforce information with safety, patient experience and clinical effectiveness indicators for assurance and oversight. Supplementary information is presented in appendix 1, 2 and 3 to ensure that there is appropriate board level oversight of quality, identifying and escalating risks early, helping to ensure a positive experience and outcomes for women and their families.

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) have undertaken the first assurance visit in June 2025. Although validation of evidence does not take place this early in the reporting period, the service requested validation of the Saving Babies' Lives (SBL) compliance to demonstrate that progress had made since the end of year 6. Compliance was 91% and the updated validated position is 99%.

The service is on track will 9/10 of the standards with only 1 standard currently at risk. This continues to relate to standard 7 and MNVP attendance at Perinatal Mortality Review Tool meetings (PMRT). An action plan and escalation to Trust Board and to the Local Maternity and Neonatal System (LMNS) is required to meet the reporting requirements. Formal escalation to the LMNS board will be included in the service update report scheduled for August 2025. This will enable the Trust to meet the standard.

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 21 cases reported within the reporting period, 15 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. The standard dictates that 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. The service is on track. **NEW MIS 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. An LMNS process and rota is in place to support attendance of external panel members. However, this remains challenging to achieve for all cases. (**stretch target aim**).	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 Compliance achieved to date (April 2025)	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. July data will be used to confirm compliance with the standard. This will not be published until October 2025.					

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. The project is based on reducing term admissions associated with respiratory distress. This is the leading cause of admission. An update is provided in the body of the report.	Appendix 1 standard 3	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.					
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 recruitment is ongoing for 3 SAS doctors. The RCOG consultant attendance audit has been completed for 3 consecutive months within the reporting period and compliance over 80% has been achieved. This enables the service to meet the standard. For oversight a red flag has been added to the Datix reporting system in June 25. This will enable this standard to be tracked and validated monthly without the need for a audit.	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 be provided for 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 has commenced in May 2025 and it is anticipated that the outcome will be shared as part of the bi-annual safe staffing report which is due to be presented in October 2025.	Bi-annual Safe staffing repots April and October 2025.	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). This standard is 100% to date. All women in active labour receive one-to-one midwifery care continues to be monitored each month. In June 25 there was instance where the midwife providing 121 care was also supporting a postnatal woman.	Appendix 2 Perinatal Quality Surveillance	On Track	
		Submit a midwifery staffing oversight report that includes staffing/safety Issues and assurances to the Trust Board every six months	Shared with the Board	April 25	
			Not due	October 25 Not due	
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 an additional validation was requested by the service to demonstrate sustained improvement since year 6. Compliance has increased from 91% to 99% and the updated validated position is 99% The next validation is planned for September 2025.	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.					
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 have been reviewed by the LMNS, service and MNVP in June 2025. This will be approved by the safety Champions in September and by the LMNS in October 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. Concerns have also been escalated the MIS team about this element and an outcome is awaited. An action plan is in	Appendix 1 Safety Action 7 Action plan and update	At Risk	Not yet validated

		progress and escalations as part of this paper and to LMNS are in progress. This will enable the service to meet the required standards.			
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 **91%** overall in June 25. Areas of focus: Consultant Obstetricians 85% (11/13), trainee doctors 84% (16/19). Anaethetic trainees 61% (8/13) 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/ (96% neonatal, 94% Maternity). All neonatal medics who attend births unaccompanied are also Neonatal Life Support course trained. (100%) **FETAL MONITORING** – 96% compliance achieved overall for the full day fetal monitoring training. Compliance within the consultant group is 85%. This accounts for 2 colleagues (11/13).	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 are 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. Close oversight of staff groups below the target range is ongoing and compliance has been escalated to the clinical directors for obstetrics and anaesthetics for support to ensure all colleagues are booked onto relevant study days.					
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. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff are tracked via the Safety Champion meetings. Work is ongoing with a culture review, lead by the occupational development team. See report narrative. (6.5 in the report)					
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. 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). A summary of MNSI trend data is included in appendix 1.	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 PERINATAL QUALITY SURVIELLENCE DASHBOARD- PART 2

The Board has accountability for perinatal oversight, with a statutory duty to ensure the safety of care, including the provision of resources required. To track performance, the perinatal quality surveillance dashboard (PQSD) (Appendix 2) is presented in the maternity and neonatal safety report to ensure that there is appropriate information and oversight for the Board to undertake this function.

The statistical process control (SPC) is used to interpret 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 outcomes, complications, and mortality rates), the dashboard helps identify areas of concern early, enabling timely interventions and action.

3.1 CLINICAL SAFETY INDICATORS

3.2 STILLBIRTH

The stillbirth rate continues to be monitored monthly by the service. The current mean still birth rate is 2.8 per 1000 births. There were no stillbirths in May and one in June 2025. This was a stillbirth at 39 weeks which was identified when the mother attended for elective caesarean section. An initial review has been undertaken, and the case has been referred to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) and a reviewed using the Perinatal Mortality Review Tool (PMRT) is planned.

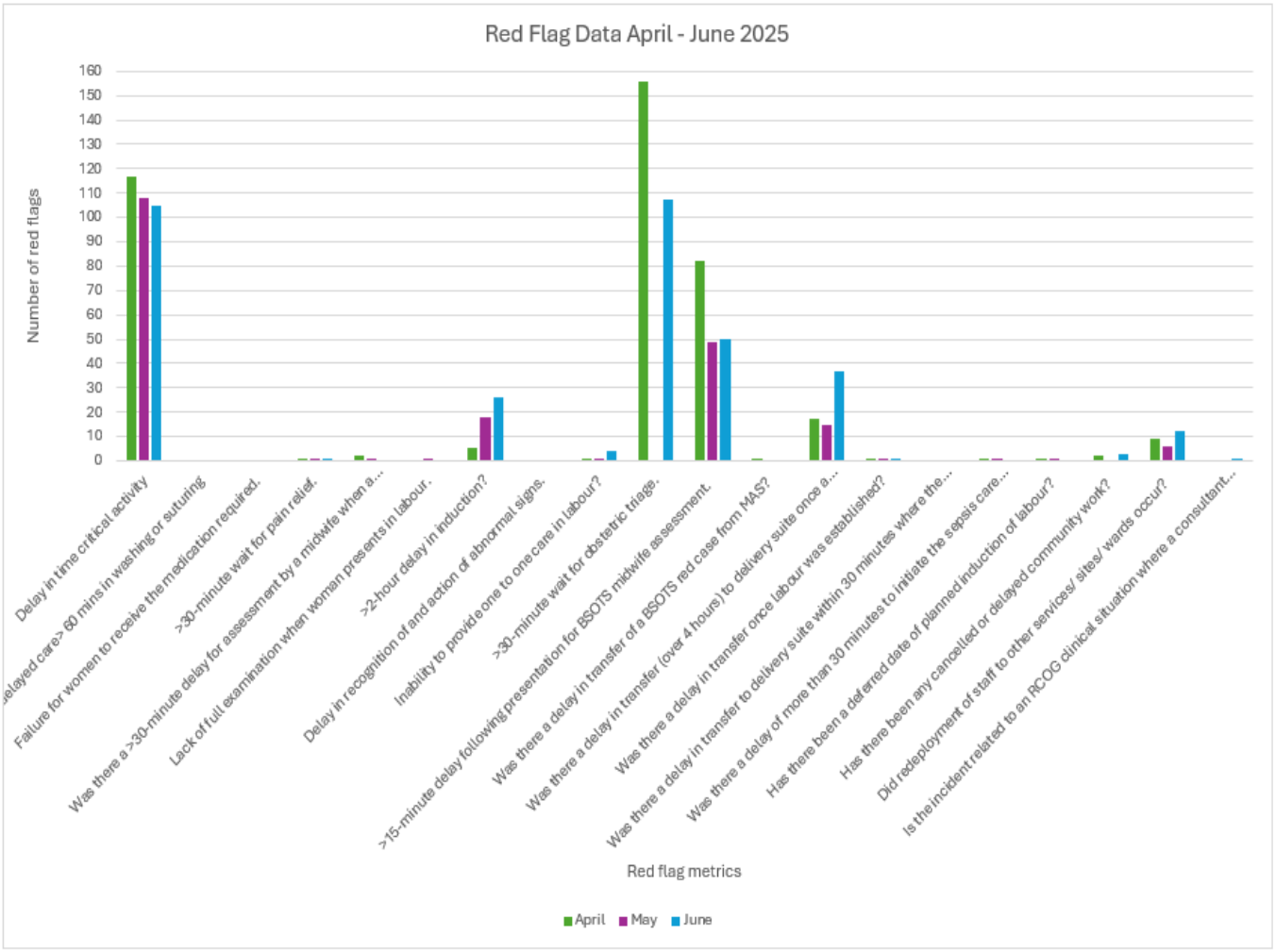
3.3 RED FLAGS QUARTERLY SUMMARY.

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 the completed quarter 1, (April- June 2025) the service reported 1,094 red flag incidents.

Work is ongoing to refresh and interrogate the data, as it is acknowledged that reporters can chose multiple red flag categories per patient making it more difficult to understand the meaning of the reporting. To ensure accuracy and efficiency of data, the Datix system administrator is reviewing the form design for incident report. Once this is completed the speciality will test the system to ensure that the most representative data is declared.

Chart 1 details the red flags that have been reported in Quarter 1. The highest number of red flags were reported in the category of delays in review by an obstetrician in the maternity assessment suite (MAS). Delay in the induction process also features in the highest reporting categories. Recruitment to the 2-tier rota aims to result in a reduction in reporting due to the model ensuring there is always an appropriate level of medical expertise available to manage both routine and emergency care. It is expected that this will be in place at the earliest by October 2025.

Chart 1 Quarter 1 (April- June 2025) Red Flags by category



3.4 DELAYS IN INDUCTION OF LABOUR

Delays in induction of labour continue to be monitored closely and the induction of labour improvement plan is progressing. A driver diagram detailing the project and performance data is included in appendix 5.

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. Since January 2025, this has been required on 6 occasions. When this happens, the records are reviewed to consider the impact and potential harm, and all women receive a letter of apology and explanation.

3.5. 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 continues to be a statistical reduction in the numbers of intrauterine transfers declined by the maternity and neonatal services, and this is evident in the SPC data analysis. This demonstrates a commitment by both services to accept intrauterine transfers whenever possible. In June 2025, there were no declined transfers from NICU and 1 from the maternity service.

3.6. CLOSURES OR DIVERTS

In the month of June 2025, there were two maternity diverts. This was due to increased unit acuity and staffing unavailability, the first lasted for 4-hours and the second for 8 hours in total. During the diverts, 8 women were transferred to alternative providers for triage assessment. All women were discharged back to care of 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.

Although this not unusual for this time of year, this is the first time that this has occurred more than once in a month. This will be monitored closely as further diverts may indicate that the service is experiencing increasing pressure and additional actions may be required.

An interim plan to support establishment gaps whilst awaiting recruitment has been agreed. This includes increasing the clinical hours worked for area managers and supplementing staffing by utilising the specialist midwives between August and October 2025. The band 5 rotation has also been altered to prioritise the complex care settings during this time.

3.7 ELECTIVE CAESAREAN SECTION CAPACITY

RISING DEMAND AND COMPLEXITY FOR CAESAREAN SECTION

The rate of caesarean sections in the UK has steadily increased over the last 5 years, with elective procedures making up a significant portion of births (BMJ 2021). Contributing factors include maternal age, medical comorbidities, maternal preference, and previous caesareans.

This rising demand places pressure on already stretched theatre capacity and resources, leading overbooked elective caesarean lists, theatre list overrunning or delay or displace planned procedures. Table 2 and 3 shows the statistical rising trend in the number of elective and emergency caesarean sections over time with the largest increase starting around 21/22 in both cases.

Table 2 Trend analysis of Elective Caesarean Section rates since 2006

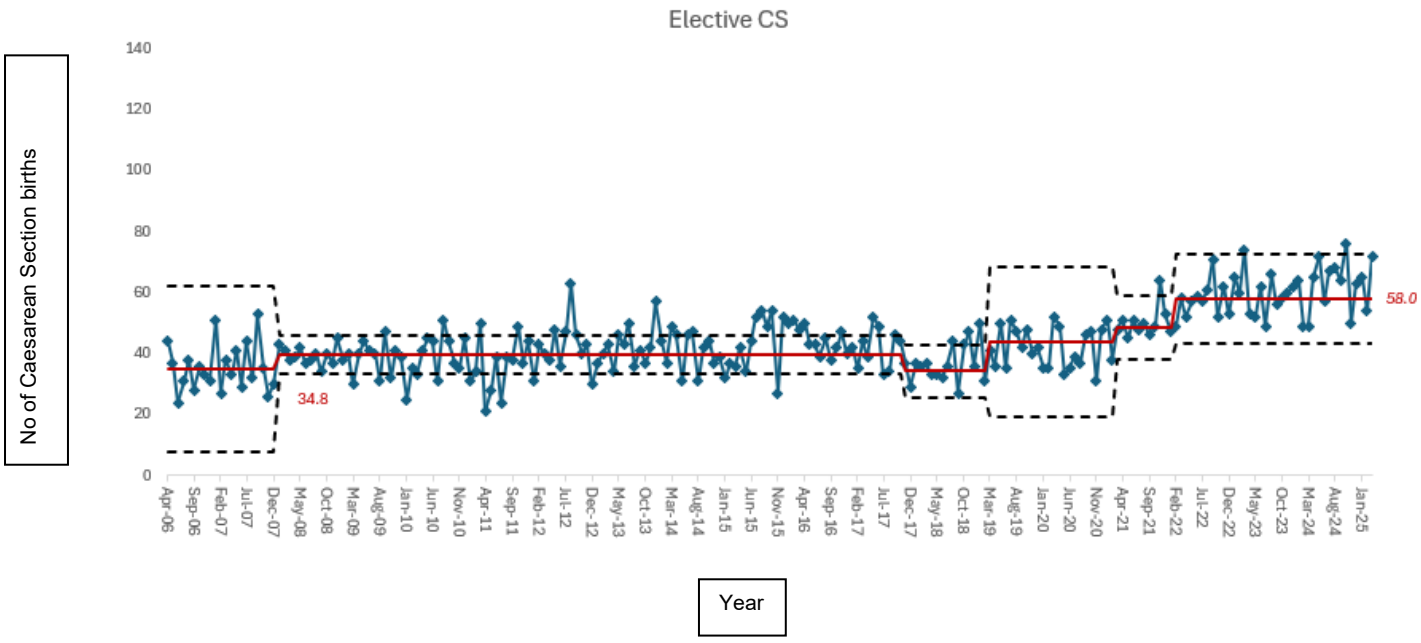
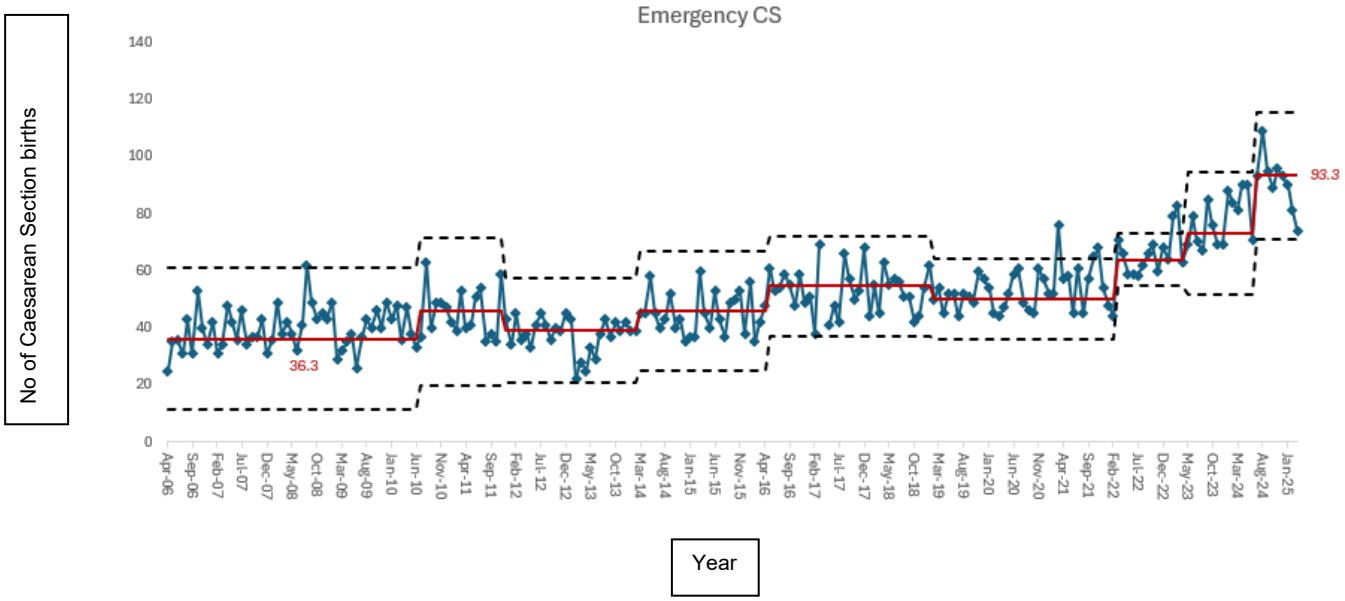


Table 3 Trend analysis of Emergency Caesarean Section rates since 2006



Previous iterations of this report have detailed that there is capacity to undertake 12 uncomplicated elective caesarean sections per week. However, due to the complexity of presenting cases this is often reduced to 10 per week to allow for additional operating and recovery time. When capacity and demand trend analysis was undertaken, it was highlighted that the service requires around 17 slots per week. This places significant pressure on the ability to manage demand, impacting on workforce requirements, theatre capacity and service user experience.

There have been several occasions in the last 12 months, when Gynaecology activity has been stood down to safely manage the maternity cases. To manage the workload, additional weekend lists have been arranged, however, this is not a cost effective and sustainable solution. Table 4 details the additional requirement for extra lists in the last 12 months and coniums that there were 20 sessions (4 hours) when Gynaecology activity was stood down.

Table 4 Extra lists and converted list between July 2024 and June 2025.

Month	Extra Lists (Based on a 4-hour session (Weekend/BH)	Lists converted from Gynae to C-Section. (Based on a 4-hour session)
July 2024	8	0
August 2024	8	2
September 2024	10	0
October 2024	2	4
November 2024	2	1
December 2024	6	4
January 2025	6	3
February 2025	6	0
March 2025	8	1
April 2025	6	4
May 2025	8	1
June 2025	10	0
TOTAL	**80**	**20**

The ability to continue to deliver additional lists is unsustainable. This is because there is only a small number of consultants (5 individuals covering 73% of weekend lists) are disproportionately carrying the workload. This reliance on a few consultants increases the risk of burnout and reduces resilience in the service. If weekend lists cease, at least two gynaecology sessions per week would need to be repurposed to meet caesarean demand. This would significantly disrupt the 62-day cancer pathway performance Referral to Treatment (RTT) target. A business case is being progressed to address this and a plan to address this is anticipated by 31 August 2025.

4.0 SAFE STAFFING INDICATORS

The maternity service continues to be presented with workforce challenges related to established vacancies, which is demonstrated by the increase in the number of red flag incidents reported overall.

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 current vacancy for registered midwives is 17.85 WTE (including maternity leave). Recruitment is ongoing and the interview date has been confirmed with 46 candidates shortlisted. A plan to offer 0.8 WTE per candidate instead of full time has been agreed, to ensure that there is resilience within the workforce for any future vacancy as it is acknowledged that most recruitment occurs between June and October each year. The plan to over offer by 5WTE, is based on annual drop off rate whilst also considering intelligence from NHS England that there is likely to be higher overall number of available midwifes within the North West. Therefore, it is anticipated that all vacancies will be filled at this time.

5.0 DAILY OVERSIGHT OF INCIDENTS.

To track incidents reported via the Datix incident system in real time, the service has introduced a daily triage for maternity and neonatal specialities. Each day, (Monday to Friday) midwifery, obstetric and neonatal colleagues attend a virtual meeting which is facilitated by the divisional governance team. Incidents are grouped by category and a rapid professional judgement review is undertaken. This process provides a live platform by which the services and its leaders can respond to safety intelligence as it happens. Early feedback indicates that allocations are more accurate and result in timely review and closure of incidents, and that colleagues know their business and early action and learning be enacted.

6.0 PERINATAL QUALITY GOVERNANCE EXPERIENCE AND REGULATION

6.1 MATERNITY AND NEONATAL INDEPENDENT INVESTIGATION

On 23 June 2025, the CEO and CNO for England wrote to each NHS organisation advising the Secretary of State for Health and Social Care has announced a rapid independent investigation into maternity and neonatal services. The instruction for Board was to take action in the following areas. LTHTR response is detailed in italics after each instruction.

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

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

- **Listen directly to families that have experienced harm at the point when concerns are raised or identified; it is important we all create the conditions for staff to speak up, learn from mistakes,**

and at the same time staff who repeatedly demonstrate a lack of compassion or openness when things go wrong need to be robustly managed

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

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

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

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

The maternity and neonatal safety Board safety champions undertake frequent walk around alone in the services to ensure colleagues have the opportunity speak up. This feedback is included in you said we did format. There is evidence within the service where attitude concerns are identified performance plans are enacted. There is evidence that learners' experiences are not consistently positive, and this is leading to further focus as part of the culture improvement work. Recent safety champion walkrounds have identified good practice in relation to the planned increase in core delivery suite posts, involvement in after action reviews, debrief led by neonatal consultants, access to TRIM trained practitioners and Professional Midwifery advocates. Walkrounds have also identified the opportunity need to strengthen the approach to understanding how learning takes place following incidents, communication of improvements and progress within the service.. These are being progressed within the service.

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

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

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

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

- **Retain a laser focus on tackling inequalities, discrimination and racism within your services, including tracking and addressing variation and putting in place key interventions; a new anti-**

discrimination programme from August will support our leadership teams to improve culture and practice

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

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

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

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

6.2 EXECUTIVE/NON-EXECUTIVE SAFETY CHAMPIONS

The Perinatal Quality Surveillance Model (PQSM, 2020) advises that safety oversight should take place as near to the patient level as possible. As such, the Chief Nursing Officer and the Non-Executive Director safety champion have continued to walk the floor, independently of the leadership team. This has given them a much more effective opportunity to speak to staff, which has been evaluated positively. The sources of monitoring perinatal safety are contained within Appendix 6.

6.3 CONTINIOUS IMPROVEMENT AND QUALITY

Services are encouraged to use an appreciative inquiry approach to continuous improvement and learning. The service is undertaking several projects aimed at proactive change outcome monitoring. At present this includes the induction of labour service review and the MIS year 7 standard 3. The project is based on reducing term admissions associated with respiratory distress. This is the leading cause of admission. (Appendix 1 standard 3)

6.4 MIDWIFERY CONTINUITY OF CARE (MCoC)

The three-year single delivery plan for maternity and neonatal care, advocate for MCoC as the default model of care and as such the service continues to monitor their ability to offer Midwifery Continuity of Carer (MCoC). Considering the principles of safe staffing, the Divisional Midwifery and Nursing Director and leadership team regularly review the service provision and workforce requirements and confirm three established continuity models can be continued without impacting on the safety of the service.

Although it has not been possible to extend this offer to prioritise vulnerable groups at this time, the service is progressing with implementation of an externally funded project to review population data and scope the next enhanced continuity team in service readiness for when this can be achieved.

6.5 PERINATAL CULTURE

The service is currently undertaking a culture review across the maternity and gynaecology services. The review is in response to themes identified in the most recent staff and SCORE survey and in relation to other feedback received over time, such as from students and trainees.

A range of different listening and engagement events in the wider teams to include each baby counts clinical escalation programme of work, specific team development sessions, coaching and leadership development days were undertaken throughout 2024. However more work to gain a deeper understanding of culture was required.

Themes already identified, which will be considered, include team working, team dynamics, management approach, stress, civility and respect. The methodology used to gain insights are open surveys, 1:1 interviews and focus groups. So far there has been over 100 responses to the survey, 50 colleagues had taken part in 1:1 conversations and most recently 30 staff have attended focus groups.

The consultation phase is expected to commence at the end of July 2025 and the outcome and action plan will be shared in October 2025.

7.0 WELL-LED/CELBRATING SUCCESS.

Following the success of the Race and Health Observatory (RHO) work reducing disparity in outcomes for women of black or ethnic women who experience postpartum haemorrhage, the service has been contacted by a national project team to share learning. This relates to the development of a saving mother lives care bundle. This will provide an opportunity for the service to contribute to national programmes of work aimed at improving maternal outcomes.

8.0 CONCLUSION

This report provides an update in relation to the safety and quality programmes of work within the maternity and neonatal services and details the position against the workstreams set out by the CNST NHS Resolution for year 7. The service confirms that it remains on track will 9 of the standards with only 1 standard currently at risk.

The perinatal quality surveillance dashboard and the red flag reporting indicates areas of pressure within the service. The number of times that the service was required to divert has increased since May 2025. This is unusual and will continue to be monitored. Overall the service is demonstrating stable outcome metrics.

A review of the instructions contained within the letter issued by Sir Jim Mackey and Duncan Burton has been completed and contained with the report. The Safety and Quality committee has discussed the response and has confirmed it is assured of the assurances in place in response to the letter.

9.0 RECOMMENDATIONS

The Board of Directors are asked to:

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

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.1 December 2024 onwards	Notification	21/21 (All eligible cases for the standard)	
	Surveillance	15/15 (All eligible cases for the standard)	
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	14/14 (All eligible cases for the standard)	
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. 12/12	
		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		

Incident Tracker

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 completed awaiting shared care Trust to finalise letter.	
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 complete and published	Action plan ongoing
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	Review complete and published	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 complete and published.	Action plan ongoing
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 completed
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 meeting completed report in finalisation processes.	
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 meeting	

							completed report in finalisation processes.	
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 completed.	Yes	98587	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing	
Datix: 200483 PMRT: 98785	23+4	Neonatal Death	Neonatal death, baby deteriorated over a few days and decision with parents was to continue medical care with no escalation no CPR or bolus adrenaline. Reported to MBRRACE surveillance, initial review arranged.	Yes	98785	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing	
Datix: 201846 PMRT: 98925	22+3	Stillbirth	Intrauterine transfer from Morecambe Bay Hospitals, 22 weeks and 3 days gestation, optimised, then decision prior to birth was to comfort care as parents' wishes. Reported to MBRRACE surveillance, initial review arranged.	Yes	98925	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing	

Datix: 202672 PMRT: 99071	39+4	Stillbirth	Still birth, at 39 weeks and 2 days gestation the mother attended for an elective caesarean section, upon admission a fetal demise in utero was noted. Reported to MBRRACE surveillance, initial review completed.	Yes	99071	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing	
Datix: 202562 PMRT: 99044	39+2	Neonatal Death	Neonatal death, transfer to Alder Hey Hospital after birth due to an undiagnosed cardiac complication. Reported to MBRRACE surveillance, initial review arranged.	Yes	99044	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 contain 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: April 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 April 2025

1.

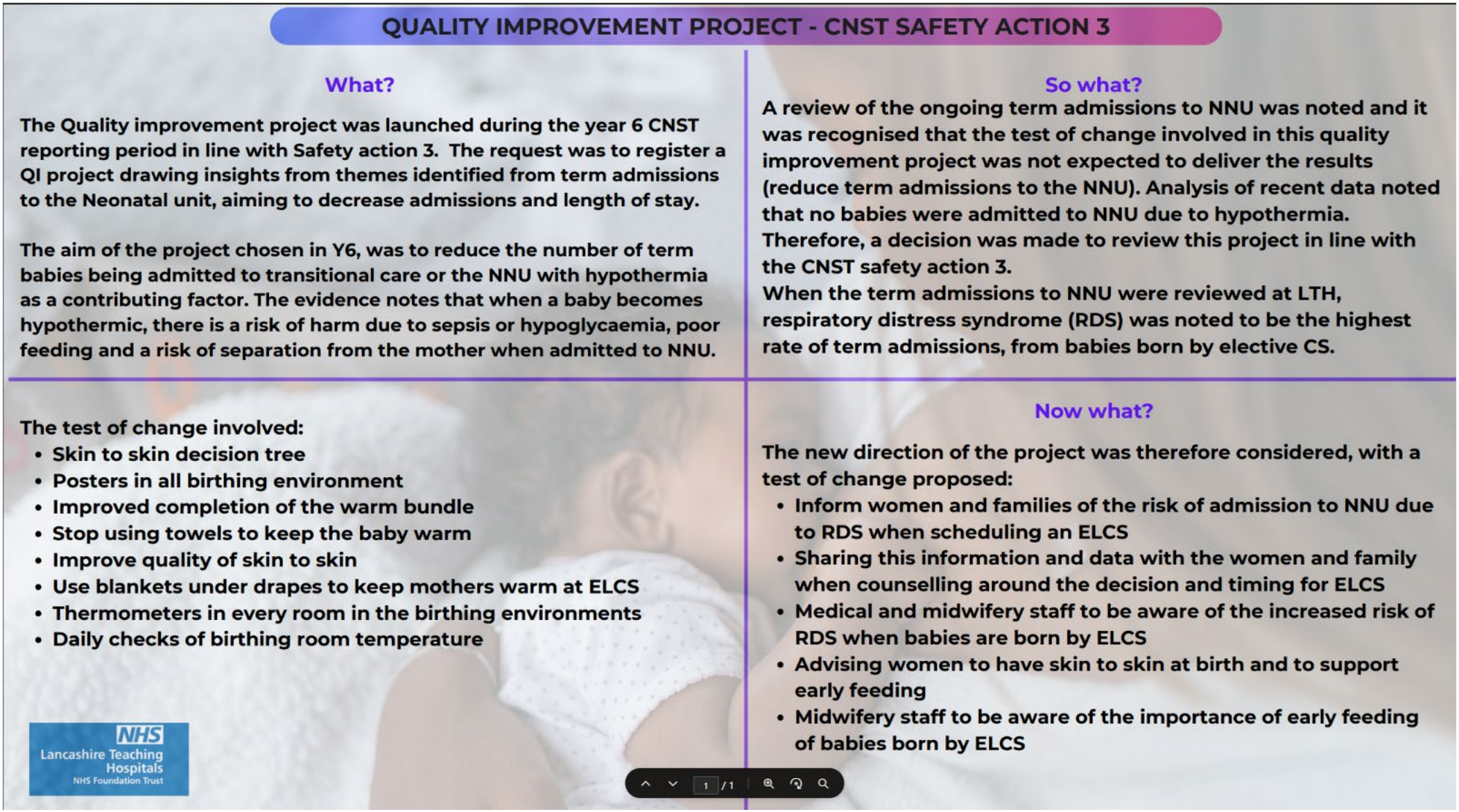
Indicator	Numerator	Denominator	Rate	Result
Birthweight DQ	395	400	98.8	Passed

Pass rate: 80%

2.

Indicator	Numerator	Denominator	Rate	Result
Ethnicity DQ	400	405	98.8	Passed

Pass rate: 90%


QUALITY IMPROVEMENT PROJECT - CNST SAFETY ACTION 3
What?
The Quality improvement project was launched during the year 6 CNST reporting period in line with Safety action 3. The request was to register a QI project drawing insights from themes identified from term admissions to the Neonatal unit, aiming to decrease admissions and length of stay.
The aim of the project chosen in Y6, was to reduce the number of term babies being admitted to transitional care or the NNU with hypothermia as a contributing factor. The evidence notes that when a baby becomes hypothermic, there is a risk of harm due to sepsis or hypoglycaemia, poor feeding and a risk of separation from the mother when admitted to NNU.
So what?
A review of the ongoing term admissions to NNU was noted and it was recognised that the test of change involved in this quality improvement project was not expected to deliver the results (reduce term admissions to the NNU). Analysis of recent data noted that no babies were admitted to NNU due to hypothermia. Therefore, a decision was made to review this project in line with the CNST safety action 3.
When the term admissions to NNU were reviewed at LTH, respiratory distress syndrome (RDS) was noted to be the highest rate of term admissions, from babies born by elective CS.
The test of change involved:
• Skin to skin decision tree
• Posters in all birthing environment
• Improved completion of the warm bundle
• Stop using towels to keep the baby warm
• Improve quality of skin to skin
• Use blankets under drapes to keep mothers warm at ELCS
• Thermometers in every room in the birthing environments
• Daily checks of birthing room temperature
Now what?
The new direction of the project was therefore considered, with a test of change proposed:
• Inform women and families of the risk of admission to NNU due to RDS when scheduling an ELCS
• Sharing this information and data with the women and family when counselling around the decision and timing for ELCS
• Medical and midwifery staff to be aware of the increased risk of RDS when babies are born by ELCS
• Advising women to have skin to skin at birth and to support early feeding
• Midwifery staff to be aware of the importance of early feeding of babies born by ELCS
NHS
Lancashire Teaching Hospitals
NHS Foundation Trust
1 / 1

SAFETY ACTION SIX SAVING BABIES LIVES VERSION 3 No 1

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)
Element 1	Smoking in pregnancy	Fully implemented	100%	Partially implemented	90%
Element 2	Fetal growth restriction	Fully implemented	100%	Fully implemented	100%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%
Element 5	Preterm birth	Fully implemented	100%	Fully implemented	100%
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%
All Elements	TOTAL	Fully implemented	100%	Partially implemented	99%

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. Action completed.	
		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. 12.06.2025 Action completed and escalation to LMNS during assurance visit.	
		Escalation via the L&CS Board Slide update	Divisional Midwifery and Nursing Director	31.08.2025	16.05.2025 Slide to include escalation in relation to resources available to meet requirement to attend PMRT. 12.06.2025 Board slide to be presented to the LMNS August 2025	
		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.	

SAFETY ACTION STANDARD 8 TRAINING MATERNITY AND NEONATAL JUNE 2025

June 2025 Neonatal	NICU Nurses	NICU nursery nurses	CONSULTANTS	ANNP's	JUNIOR DOCTOR below ST5	JUNIOR DOCTOR ST5 and above	COMPLIANCE PERCENTAGE OVERALL
Neonatal Basic life support	**95%** *73 compliant out of 77*	**100%** *7 compliant out of 7*	**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 112*
NLS certification medical staff.	*Training not required*	*Training not required*	**100 %** *9 compliant out of 9*	**100 %** *5 compliant out of 5*	*Training not required*	**100%** *7 compliant out of 7*	**100%** *21 compliant out of 21*

June 2025 Maternity	MIDWIVES(RM)/MATERNITY SUPPORT WORKERS (MSW)		CONSULTANTS	DOCTORS	ANAETHETICS CONSULTANT/ROTATION		COMPLIANCE PERCENTAGE OVERALL
GAP/GROW (Delivered on PROMPT)	**93%** *183 out of 196*		**85%** *11 out of 13*	**86%** *12 out of 14*	*Training not required*		**92%** (decrease 5%) *206 compliant out of 223*
Fetal Monitoring training Attendance at full day fetal monitoring training	**97%** *184 compliant out of 190*		**85%** *11 compliant out of 13*	**93%** 13 *compliant out of 14*	*Training not required*		**96%** (decrease 1%) *208 compliant out of 217*
CTG update (Delivered as part of PROMPT or attendance at CTG meeting)	**94%** *179 compliant out of 190*		**92%** *12 compliant out of 13*	**94%** *16 compliant out of 17*	*Training not required*		**94%** (static) *207 compliant out of 220*
Human Factors (Delivered on PROMPT)	**94%** *186 out of 197*		**85%** *11 out of 13*	**84%** *16 out of 19*	*Training not required*		**97%** (increase 1%) *223 compliant out of 229*
Obstetric Emergencies (PROMPT)	**94%** 186 out of 197	**91%** 50 out of 55	**85%** 11 out of 13	**84%** 16 out of 19	**61%** ** 8 out of 13	**92%** 11 out of 12	**91%** (decrease 5%) *282 compliant out of 309*
Pool Evacuation	**94%** 186 out of 197 (RM)	**91%** 50 out of 55 (MSW)	**85%** 11 out of 13	**84%** 16 out of 19	*Training not required*		**93%** (decrease 3%) *263 compliant out of 284*

STANDARD 10. CASES REPORTED FROM DECEMBER 1, 2024, TO JULY 2025.

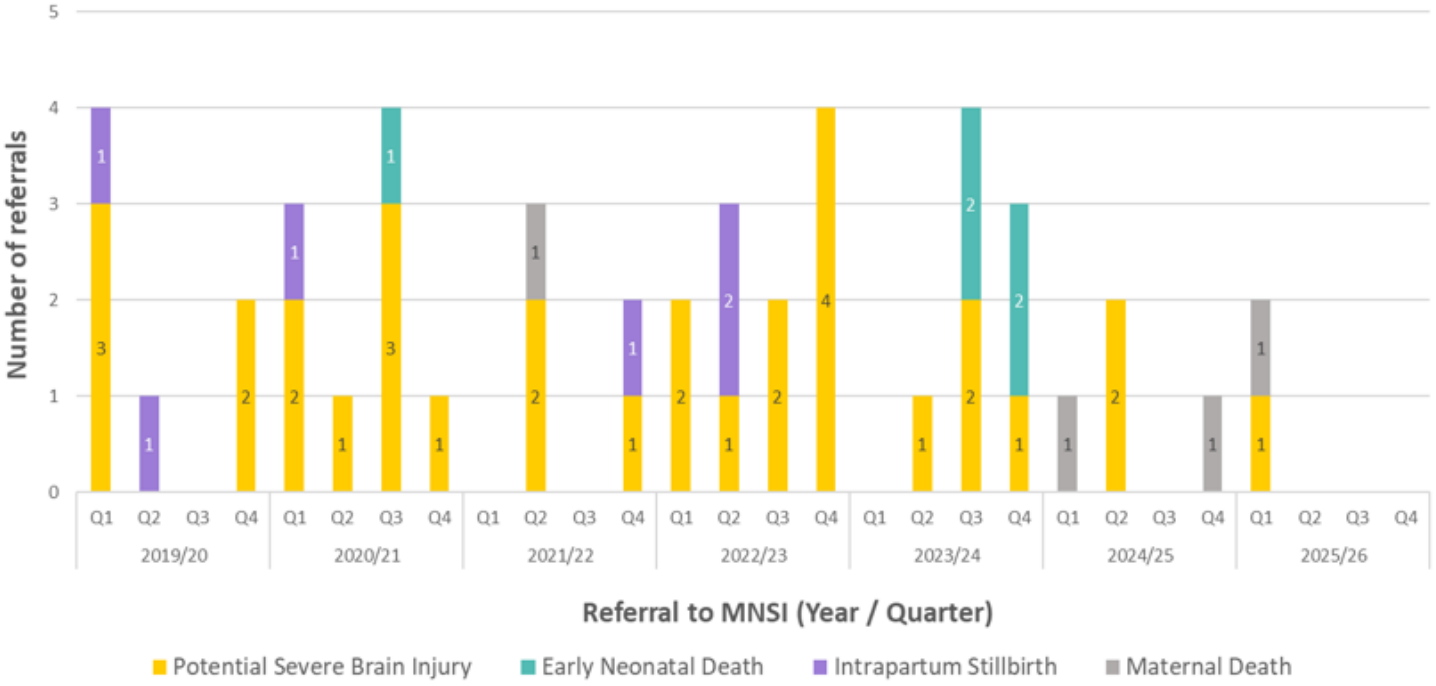
MI number	Case Summary	Early Notification applicable	Early notification completed	Status of MNSI investigation	Final MNSI report sent to legal team.	Duty of Candour.
039925 AF 3.01.2025	The Maternity service was informed on the 27.12.24 of a maternal death at 26 weeks of pregnancy. The woman was known 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. **Final report not yet received.** Action plan to follow	No	NA	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. **Final report not yet received.** Action plan to follow	No	NA	Investigation ongoing	NA - ongoing	Yes

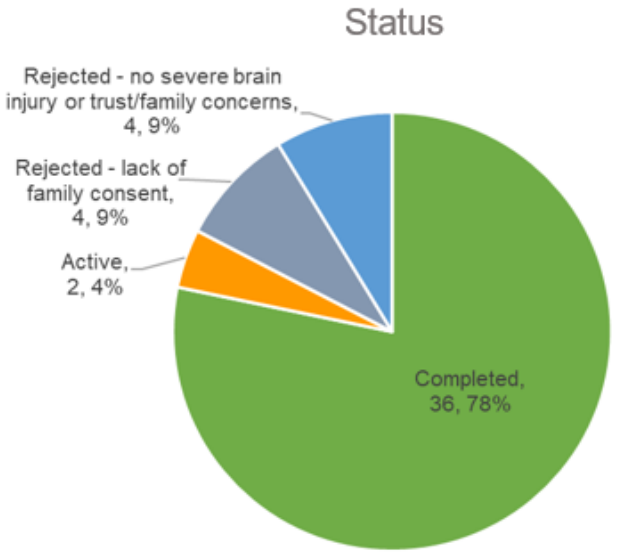
Maternity referrals - Trust

MNSI Maternity & Newborn Safety Investigations

There were 52 referrals in total. **46** met criteria* and 6 did not meet criteria**

The charts below show referrals that met criteria (01 Apr-19 to 11 Jun-25):





*Referrals that met criteria would either be progressed to investigation or rejected as either '*no family consent*' or '*no severe brain injury or trust/family concerns*'
**Referrals that did not meet criteria would be rejected as either '*duplicate*', '*congenital abnormalities*', '*MNSI criteria*' or '*sudden infant death syndrome*'

Any referrals made before 1st April 2019 have been excluded from this data set.

Trust Learning and Feedback

Feedback Wider Updates:

- Maternity Assessment Suite relocation scheduled for July 2025
- Continuous improvement projects Induction of Labour
- Tier 2 business case approved and recruitment ongoing
- Equality dashboard (disaggregation of data for clinical outcomes)
- MEWS and NEWTTS

MI-037519 Maternal Death- No safety actions Positive learning

- Ectopic pregnancy raising awareness training and resources developed and distributed to key areas across organisation. Think Ectopic lanyards and prompt credit cards have been distributed.
- Maternal medicine specialist midwife to deliver a series of webinars to share the learning from the MBRRACE 2024, to include ectopic pregnancy awareness as a key finding.

MI-036948- Update of the IOL guideline to ensure that women are counselled and booked appropriately for IOL at 41 weeks. Safety messages shared and discussed through safety and quality. Induction of labour improvement project ongoing

MI- 038553 Translation The use of translation services is being audited and based on service user feedback we are trialling a new interpretation device

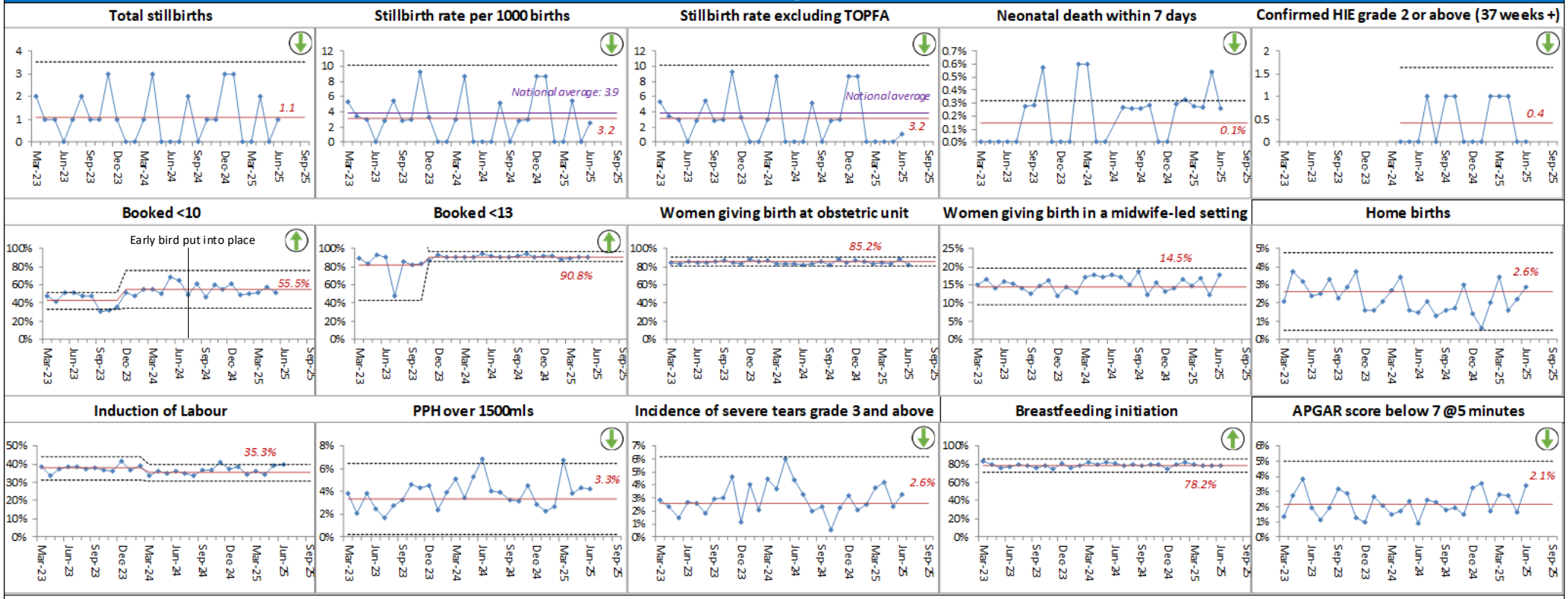
MI- 038553 Recurrent theme

- Ongoing monthly audits of cardiotocography (CTG) equipment availability for fetal heart rate monitoring in all areas led by area and fetal monitoring leads
- Case based learning in relation to holistic review of CTG used in CTG updates and fetal monitoring study day 2025.

MI037657 No safety actions Prompts related to correct risk assessment around place of birth. Presentation developed for shared learning. Inappropriate placement of CFM leads additional training undertaken with neonatal colleagues

PERINATAL QUALITY SURVIELLENCE DASHBOARD
APPENDIX 2

Clinical Safety Indicators



Stillbirth Rates excluding TOPFA is showing early signs of statistical reduction. Lower rates have been demonstrated over 5 points.

Neonatal Death currently on a run of higher points above the mean line, which is a couple higher than we would expect for normal variation. This is not showing a statistical increase currently.

Booked by: Booking compliance is on an upward trajectory since February 24.

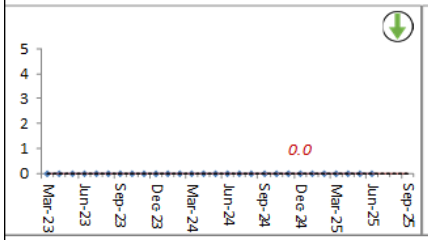
Perineal Tears – there has been a slight increase in perineal tears associated with normal births. This has been linked to births undertaken by student midwives. Feedback provided to Higher Education Establishments and a plan to consider OASI training earlier in the course is being considered.

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

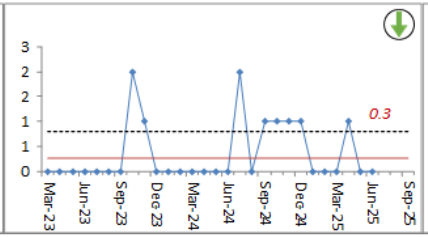
Lancashire Teaching Hospitals NHS Foundation Trust

Perinatal Quality Governance Experience and Regulation

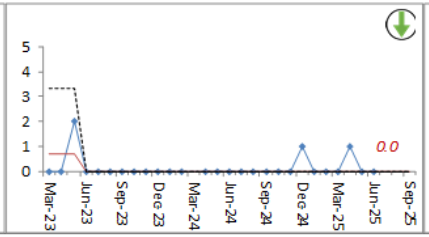
Prevention of future deaths regulation 28



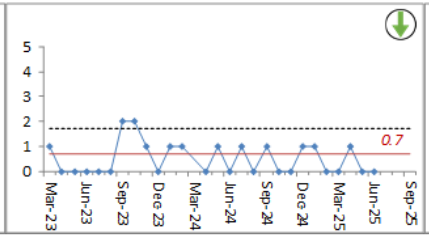
CQC Enquiries



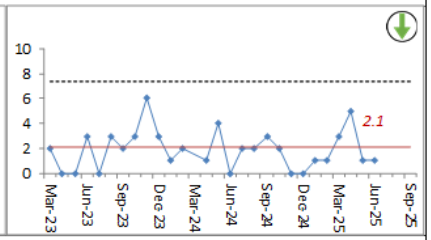
Maternal Death



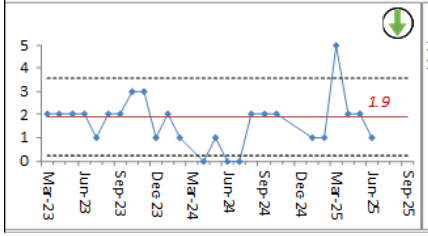
Maternity and Newborn Safety Investigations Programme (Formally HSIB referrals opened)



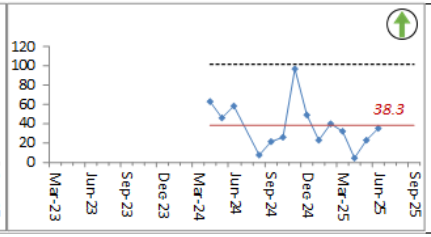
Incidents of moderate harm and above



Complaints



Compliments



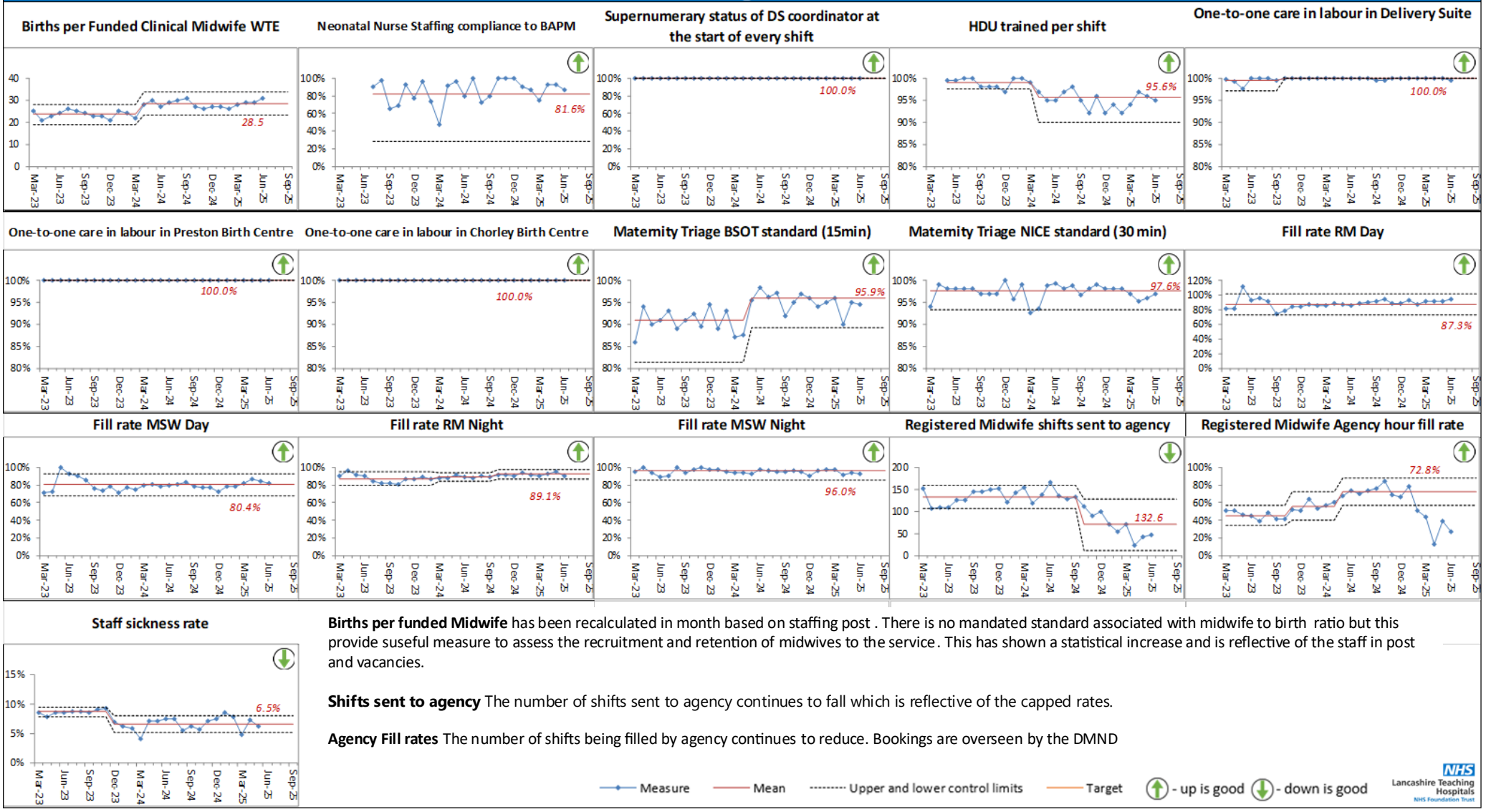
Maternal Death –There was one maternal death in April 25 which has been referred to MBRRACE and MNSI for review.

CQC enquires –There have been no CQC enquires to the service in the month of June 25.

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

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Safe staffing indicators



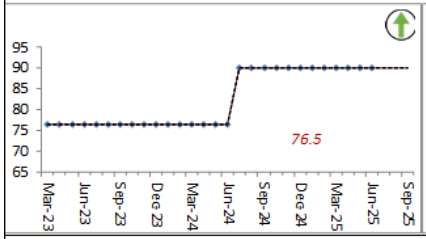
Births per funded Midwife has been recalculated in month based on staffing post . There is no mandated standard associated with midwife to birth ratio but this provide suseful measure to assess the recruitment and retention of midwives to the service. This has shown a statistical increase and is reflective of the staff in post and vacancies.

Shifts sent to agency The number of shifts sent to agency continues to fall which is reflective of the capped rates.

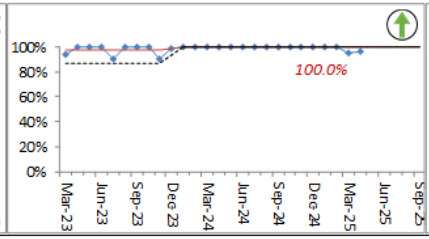
Agency Fill rates The number of shifts being filled by agency continues to reduce. Bookings are overseen by the DMND

Obstetric Medical Staffing

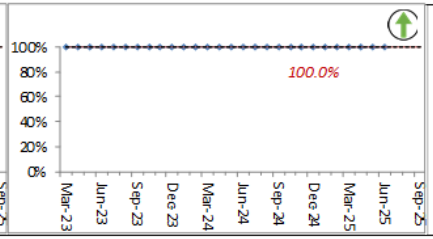
Number of Consultant hours on obstetric unit



RCOG obstetric benchmarking compliance



24-hour acute obstetric medical staffing fill rate



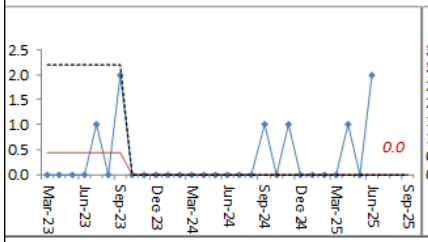
Consultant hours in the obstetric unit. The service continues to invest in consultant funding as required and an increase in hours from 76.5 to 90 hours consultant cover has been achieved. The 2-tier rota recruitment is ongoing. This will strengthen obstetric oversight and review.
RCOG attendance is no longer needs to be reported as part of CNST each month, providing the compliance is over 80% for 3 months in the reporting period. This has been achieved. Compliance will continue to be monitored via red flag reporting and all cases reported will be reviewed and validated.
Consultant fill rates for acute care continues to be 100%. The inpatient service continues to be prioritised to ensure appropriate oversight and cover.

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

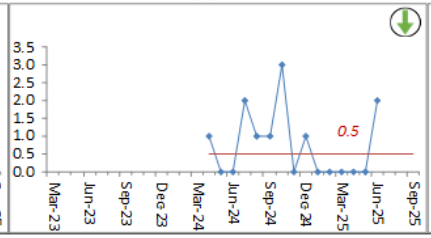
NHS Lancashire Teaching Hospitals NHS Foundation Trust

Clinical Escalation

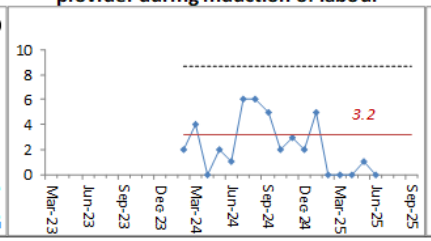
Maternity Diverts



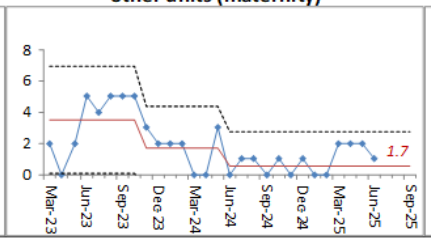
Number of times home birth service stood down



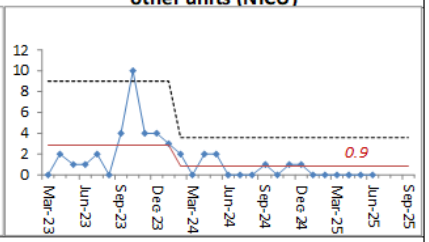
Women who transfer to an alternative provider during induction of labour



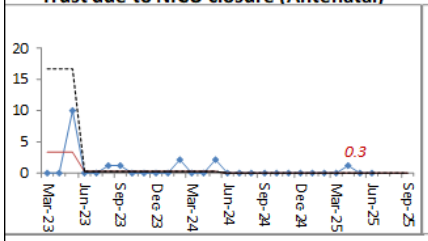
In- utero transfers declined to accept from other units (maternity)



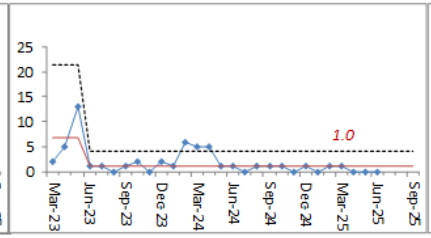
In- utero transfers declined to accept from other units (NICU)



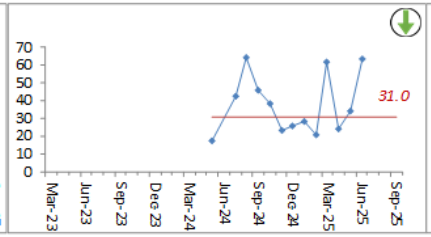
In- utero transfers from LTHTR to another Trust due to NICU closure (Antenatal)



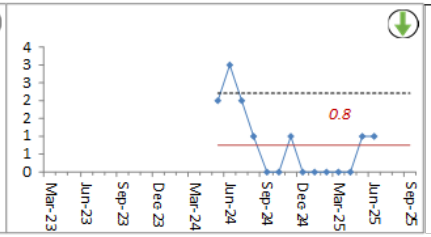
NICU Closure



Delay in inductions (New)



Elective sections stood down (New)



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

Divert There has been 2 occasions in July 25 when a unit divert was enacted to maintain safe staffing.

In- Utero Transfers (IUT) IUT decline rates have reduced for NICU. If this continues this will demonstrate statistical reduction.

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

Lancashire Teaching Hospitals NHS Foundation Trust

APPENDIX 3 RED FLAGS MARCH 2024 TO JUNE 2025

Red flag Reporting Metrics	July 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	March 25	April 25	May 25	June 25
Delay in time critical activity	18	41	61	40	44	59	32	16	16	117	108	105
Missed or delayed care> 60 mins in washing or suturing	2	0	0	1	0	1	0	0	1	0	0	0
Failure for women to receive the medication required.	1	0	1	0	0	1	0	1	2	0	0	0
>30-minute wait for pain relief.	3	0	2	0	0	0	2	1	3	1	1	1
Was there a >30-minute delay for assessment by a midwife when a problem was identified	2	0	1	0	0	0	1	1	2	2	1	0
Lack of full examination when woman presents in labour.	1	0	4	0	0	0	0	0	2	0	1	0
>2-hour delay in induction?	22	42	34	21	9	7	28	21	17	5	18	26
Delay in recognition of and action of abnormal signs.	1	0	1	1	0	0	0	2	0	0	0	0
Inability to provide one to one care in labour? (Validated)	4	1	4	0	0	0	2	0	0	1	0	2
>30-minute wait for obstetric triage.	47	20	56	41	46	47	58	61	62	156	0	107
>15-minute delay following presentation for BSOTS midwife assessment.	46	24	75	42	24	23	46	32	21	82	49	50
Was there a delay in transfer of a BSOTS red case from MAS?	0	0	0	0	1	0	1	0	1	1	0	0
Was there a delay in transfer (over 4 hours) to delivery suite once a decision has been made for transfer for induction or augmentation?	30	28	25	20	14	19	26	21	34	17	15	37
Was there a delay in transfer once labour was established?	1	1	2	0	0	0	3	0	1	1	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?	0	0	0	0	0	0	0	0	1	0	0	0
Was there a delay of more than 30 minutes to initiate the sepsis care bundle?	0	0	0	0	0	0	0	0	1	1	1	0
Has there been a deferred date of planned induction of labour?	1	0	2	0	0	0	0	0	0	1	1	0
Has there been any cancelled or delayed community work?	25	5	28	4	0	0	0	2	3	2	0	3
Did redeployment of staff to other services/ sites/ wards occur?	17	9	12	8	2	0	6	3	12	9	6	12
Is the incident related to an RCOG clinical situation where a consultant was called but did not attend (New for June 2025 Validated position.)												1
Total numbers of red flags	**221**	**171**	**308**	**178**	**140**	**157**	**205**	**161**	**179**	**396**	**336**	**362**

APPENDIX 4 SECRETARY OF STATE FOR HEALTH AND SOCIAL CARE RAPID INDEPENDENT INVESTIGATION LETTER

Classification: Official

NHS England

To:
- Trust CEOs and chairs

cc.
- ICB CEOs
- Regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

23 June 2025

Dear colleague

Maternity and neonatal care

Today, the Secretary of State for Health and Social Care has announced a rapid independent investigation into maternity and neonatal services. He has also announced an independent taskforce, alongside immediate actions to improve care.

This announcement comes on the back of significant failings in maternity services in parts of the NHS and we need – with real urgency – to understand and address the systemic issues behind why so many women, babies and families are experiencing unacceptable care.

It is clear that we are too frequently failing to consistently listen to women and their families when they raise concerns and too many families are being let down by the NHS. There remain really stark inequalities faced by Black and Asian women and women in deprived areas. In addition, we continue to have significant issues around safety and culture within our maternity workforce.

These have been persistent issues over recent years, so we now need to act with urgency to address these. The vast majority of births in England are safe and we have teams providing good and outstanding maternity and neonatal care every day. However, the variation in quality and performance across the NHS underscores why we can't accept the status quo.

So, between now and December, the independent investigation will conduct urgent reviews of up to 10 trusts where there are specific issues. We'll meet with relevant leaders of several organisations over the next month and while there will be some challenging conversations, we are really keen to hear what more we can be doing to support you to go further and faster in improving maternity and neonatal care.

In the meantime, we ask every local NHS Board with responsibilities relating to maternity and neonatal care to:

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

- Listen directly to families that have experienced harm at the point when concerns are raised or identified. It is important we all create the conditions for staff to speak up, learn from mistakes, and at the same time staff who repeatedly demonstrate a lack of compassion or openness when things go wrong need to be robustly managed.
- Ensure you are setting the right culture: supporting, listening and working, through coproduction, with your Maternity and Neonatal Voice Partnership, and local women, and families.
- Review your approach to reviewing data on the quality of your maternity and neonatal services, closely monitoring outcomes and experience and delivering improvements to both.
- Retain a laser focus on tackling inequalities, discrimination and racism within your services, including tracking and addressing variation and putting in place key interventions. A new anti-discrimination programme from August will support our leadership teams to improve culture and practice. This also means accelerating our collective plans to provide enhanced continuity of care in the most deprived neighbourhoods, providing additional support for the women that most need it.

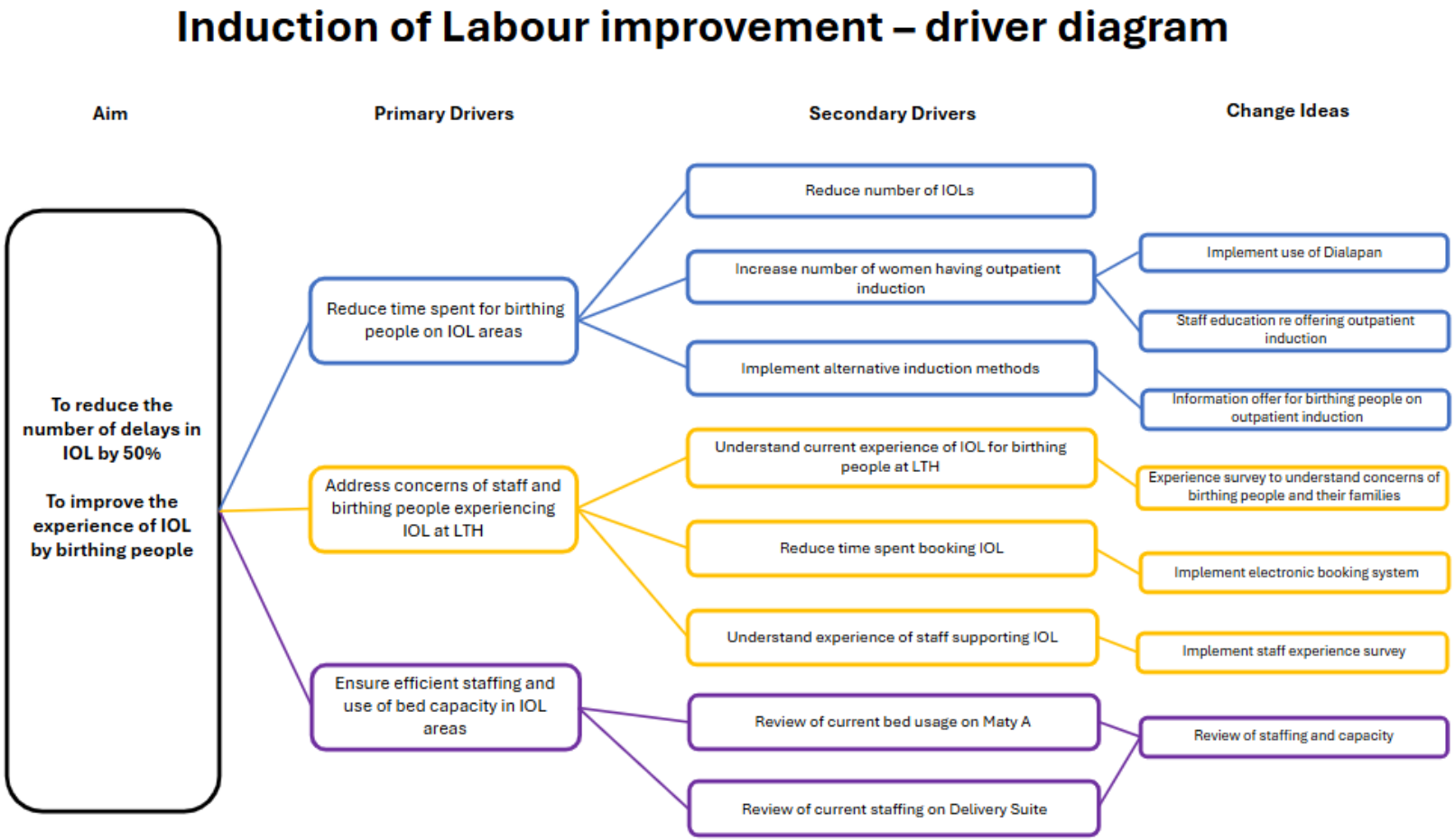
This is really challenging for all of us and the most important step we have to take to rebuild maternity and neonatal care is to recognise the scale of the problem we have and work together to fix it.

This will require us all to work together and this includes teams where care is outstanding where you will have a role to play in sharing best practice and supporting others to return their services to where their communities and staff want and need them to be. We hope you understand the importance of this and, as always, please get in touch if you want to discuss this ahead of the CEO call later in the week.

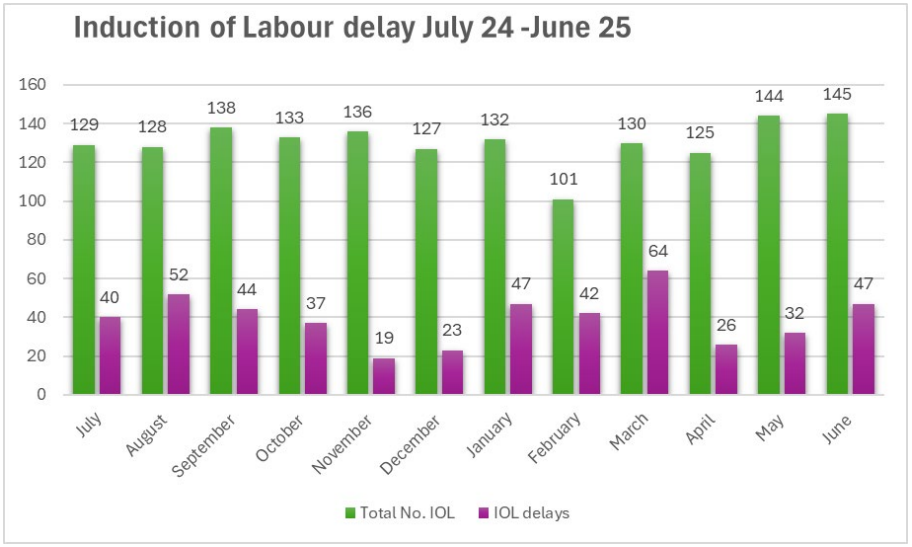
Sir Jim Mackey
Chief Executive

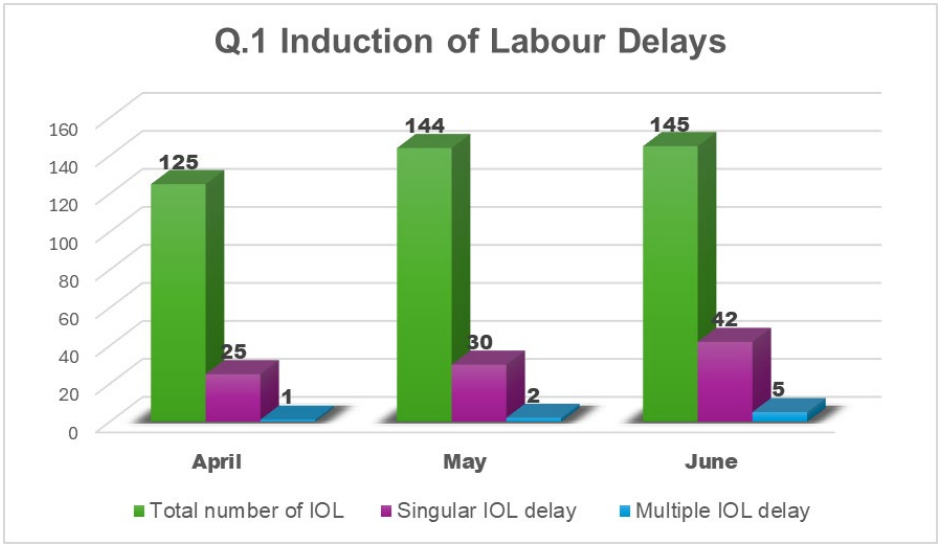
Duncan Burton
Chief Nursing Officer for England

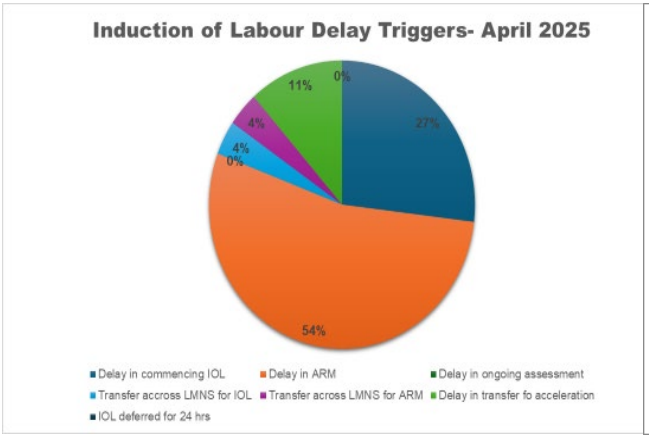
APPENDIX 5 INDUCTION OF LABOUR CONTINOUS IMPROVEMENT PROJECT

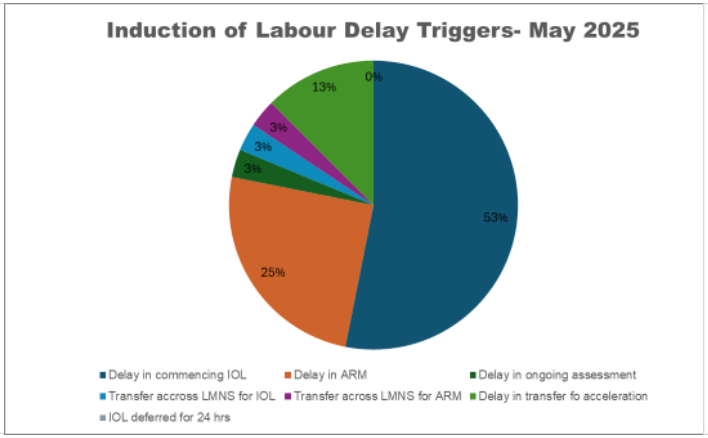


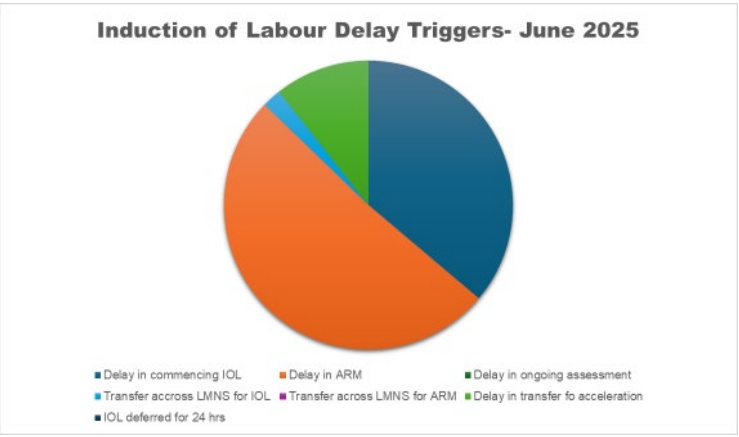
APPENDIX 5 INDUCTION OF LABOUR PERFORMANCE JULY 2024-JUNE 2025.











APPENDIX 6 SUMMARY OF THE SOURCES OF INSIGHT USED TO MONITOR PERINATAL SAFETY

Responsibility of the Board and maternity and Neonatal service	**Evidence/Insight**	**Reporting Process**
Appoint a non-executive director to work alongside the board-level perinatal safety champion to provide objective, external challenge, and enquiry.	**A Non-Executive Director** is appointed to work alongside the board-level perinatal safety champion to provide objective, external challenge and enquiry.	Reporting: Executive and Non-executive Safety Champions report directly to the Public Board of Directors.
	Safety Champions Meeting discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues, staff and service user feedback; minimum staffing in maternity services and training compliance.	Maternity Safety Champions meeting chaired by the Chief Nursing Officer. Co-chair -non executive director for maternity.
	Safety Walk rounds are in place and progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff	Outcomes shared via Maternity and Neonatal Safety Report – shared via Trust Safety and Quality and with the Board of Directors.
	Evidence that the Maternity and Neonatal Board Safety Champions (BSC) are **supporting the perinatal quadrumvirate** in their work to better understand and craft local cultures.	Bi monthly part 2 safety champions meeting
Perinatal Quality Dashboard Month by month review of maternity and neonatal safety and quality is undertaken by the trust board.	Ensure a bi-monthly **review of maternity and neonatal safety and quality indicators in dashboard** format is undertaken by the Trust Board and at the Trust Safety and Quality Committee in the interim months.	Maternity and Neonatal Safety Report – shared via Trust Safety and Quality and with the Board of Directors.
	The perinatal quality dashboard is used to monitor maternity and neonatal safety at board level meetings. Monthly review of maternity and neonatal quality is undertaken by the safety and Quality committee using a minimum data set to include a review of thematic learning of all maternity Serious Incidents (SIs) MBRRACE and Maternity and Newborn Safety Investigations (MNSI).	Maternity and Neonatal Safety Report - shared via Trust Safety and Quality and with the Board of Directors.

10.2 - GUARDIAN OF SAFE WORKING REPORT

REFERENCES

Only PDFs are attached

10.2 - GOSW Annual Report 2024 Ancillary Pack.pdf

1. Introduction

The purpose of this report is to provide assurance (or otherwise) to the Board of Directors that there are safe staffing levels at the trust, that Resident doctors are safely rostered within the trust and are working hours that are safe and in line with the new safe working rules as set out within the 2016 Resident Doctors' contract.

The report outlines the following:

- Number of exception reports submitted in the year with reasons and discussion
- Summary of areas of concern and actions undertaken by GOSW in response to exception reports
- Trust Vacancy position and discussion
- Summary of Resident Doctor Forum meetings
- Key issues arising, and actions taken

2. Discussion

2.1 Numbers of Doctors covered by this report

Table 1: Number of doctors in (Dec 24) who are covered by this report:

	No Doctors in post
Foundation Drs	128
Drs in Training*	274
Locally Employed Doctors **	152
TOTAL	**554**

** All trainees now employed on the 2016 JDC*

*** These are Drs engaged on the LTH Trust Dr contract which is a mirrored 2016 contract. We still have a small number of doctors who remain on the 2002 terms and conditions.*

2.2 Exception Reporting Summary

Table 2: Exception reports submitted over the past 3 years

Exception Reports (01/01/2022 – 31/12/2024)	2022	2023	2024
Total number of exception reports received	607	520	670
Number relating to immediate safety concerns (ISCs)	16	16	34
Number relating to hours of working	501	362	507
Number relating to pattern of work	1	11	21
Number relating to education (missed teaching)	87	58	56
Number relating to service support available to the doctor	17	67	55
Number relating to missed breaks	1	22	31

The number of exception reports submitted has increased overall from 2023 and in most categories in 2024 (apart from service support and missed teaching).

Table 3: Total Number of exception reports submitted over the past 5 years:

Year	Number of Exceptions
2020	233
2021	387
2022	607
2023	520
2024	670

This shows that there has been an almost 3x increase in exception reporting from 2020 to 2024. We hope this reflects an open, supportive and positive culture in the Trust around exception reporting.

Table 4: Number of exceptions by grade

Grade	Number of Exceptions		
	2022	**2023**	**2024**
FY1	408	325	404
FY2	76	94	102
ST1-2	48	47	88
ST3+	75	50	74
Senior Clinical Fellow	0	4	2
Grand Total	**607**	**520**	**670**

The highest number of exception reports are from FY1 doctors, with 404 (60%) exception reports and it is pleasing to see we continue to have more senior grades of doctors submitting more exceptions than in previous years. The number of exception reports increases significantly in August-December (after the new FY1 doctors start) and trends down over the year as the doctors become more experienced and confident.

Table 5: Breakdown of exceptions by specialty, grade and type of exception (as per rota)

Specialty Rota	Missed Teaching	Natural Breaks	Overtime	Pattern	Service Support	Total
Acute Medicine CDH (SCF) | Monday On-Call					1	1
Acute Medicine RPH (SCF) | Full Rota	3		6	3	3	15
Ambulatory Care (Medical Intern Year 1)			1			1
Ambulatory Care (Medical Intern Year 2)			2			2

Emergency Medicine (FY1)			1			1
Emergency Medicine (FY2) | Rota A			9			9
Emergency Medicine (JCF) | Rota B			1	1		2
Emergency Medicine (ST1-2) | Rota A			3		2	5
Emergency Medicine (ST1-2) | Rota B			1			1
GP (FY2) | Berry Lane Medical Centre	1					1
Intensive Care (FY2)	1		1		1	3
MAU (Medical Intern Year 1)	1		15		1	17
MAU (Medical Intern Year 2)			1			1
MAU CDH (FY2)			1		4	5
MAU SDEC (Junior Clinical Fellow)			1			1
Medicine CDH (FY1)	2		32	1	18	53
Medicine CDH (JCF)			2			2
Medicine CDH (ST1 - ST2)		2	2	1	3	8
Medicine CDH (ST3 - ST5)	1				1	2
Medicine RPH (FY1)		1	25		2	28
Medicine RPH (FY1) | Enhance			7			7
Medicine RPH (FY2) | Rota A	1		2			3
Medicine RPH (FY2) | Rota B	1					1
Medicine RPH (IMT3)	1		2			3
Medicine RPH (Medical Intern Year 2)			1			1
Medicine RPH (ST1 - ST2) | Rota A					1	1
Medicine RPH (ST3 - ST5)			4			4
Neonates (FY2)			1			1
Neurorehabilitation (JCF)			1			1
Obs & Gynae (FY1)			3			3
Obs & Gynae (FY1) - Enhance			8			8
Obs & Gynae (FY2)	1		11			12
Obs & Gynae (Junior Clinical Fellow)		1	1			2
Obs & Gynae (ST1 - ST2)			1			1
Obs & Gynae (ST3 - ST5)			8		1	9
Obs & Gynae (ST6 - ST8)			2			2
Oncology (FY1)	1	1	30		3	35
Oncology (JCF)			34			34
Oncology (JCF) | Non On-Call			1		1	2
Paediatrics (FY1)			1			1
Paediatrics (FY1) | Enhance Track		1	6	1		8
Paediatrics (ST1 - ST2)			12	1		13
Palliative Medicine (FY1) | St Catherine's Hospice			2			2
Plastic Surgery (ST3 - ST5)			1			1
Radiology (ST3 - ST5)			6			6
Renal Medicine (ST3 - ST5)			2			2
Surgical Specialties (FY1)	32	4	105	4	2	147
Surgical Specialties (FY2)	1	8	21			30
Surgical Specialties (Med. Intern Year 1) On-Call		1				1
Surgical Specialties (ST3 - ST5)			11	1	3	15

Trauma & Orthopaedics (FY1)	3	7	14		2	26
Trauma & Orthopaedics (FY1) - Enhance			3		2	5
Trauma & Orthopaedics (FY1) | LIFT Post			1		1	2
Trauma & Orthopaedics (FY2)			9			9
Trauma & Orthopaedics (Medical Intern Year 1)			2			2
Urology (Junior Clinical Fellow)	2	2	44			48
Vascular (FY1)	1		1			2
Vascular Surgery (Junior Clinical Fellow)	3	1	13			17
Vascular Surgery (Junior Clinical Fellow) Non O/C			13		2	15
Vascular Surgery (Senior Clinical Fellow)			4	1		5
Vascular Surgery (ST3 - ST5)			15	7	1	23
Vascular Surgery (ST6 - ST8)		2				2
Total	**56**	**31**	**507**	**21**	**55**	**670**

Large numbers of exceptions were particularly seen in Chorley Medicine (53 FY1), the Surgical Specialties at RPH (193 – all grades), Oncology (71 – all grades), Urology (JCF –48), Vascular (64 – all grades), RPH Medicine (48 all grades) and T&O (44 all grades). There was also a sharp increase in the numbers of exception reports submitted in Paediatrics (22 all grades) and O&G (37 all grades) compared to 2023 (Paediatrics –1 and O&G –6).

The highest number of exceptions relate to extra hours worked with 507 (76%) in this category. Typically, this is between half an hour to 2 hours extra work and is usually related to work left over from the day that needs to be completed or patients becoming ill towards the end of the shift and needing attention before the doctor can finish the shift.

The exceptions relating to missed educational opportunities are dealt with by the postgraduate department of education and are not covered in any detail in this report. Those reported above are mainly for missed teaching and missed SDT time.

2.3 Immediate Safety Concerns

There were 34 exceptions submitted as immediate safety concerns in 2024, more than double the 16 ISCs in 2023. The specific details of the reports are included in the 2024 GOSW quarterly reports and a summary is shown in Table 6 below.

The 2 main themes identified included lack of senior support and inadequate medical staffing levels, leading to concerns about patient safety. We encourage doctors to submit Datix for all the ISCs, so that any specific patient safety concerns can be investigated through the appropriate governance routes. GOSW also sends all the ISCs to the relevant management teams for investigation and action.

Table 6: Immediate Safety Concerns by Specialty Rota

Specialty Rota	No. ISC Received
Acute Medicine CDH (SCF)	1
Medicine CDH (FY1)	12
Medicine CDH (JCF)	2
Medicine CDH (ST1 - ST2)	1
Medicine RPH (FY1)	1

Medicine RPH (FY2)	1
Acute Medicine RPH (SCF)	1
Oncology (FY1)	1
Oncology (JCF)	2
Vascular Surgery (FY1)	2
Vascular Surgery (ST6 - ST8)	1
Vascular Surgery (ST3 - ST5)	1
Surgical Specialties (FY1) Urology	1
Surgical Specialties (FY2)	1
Surgical Specialties (ST3 - ST5)	3
T&O (FY1)	2
Intensive Care (FY2)	1
TOTAL	**34**

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

Chorley Medicine
Problems at Chorley continue from 2023, in the Department of Medicine, with high numbers of exception reports (65, 9.7%), 15 ISCs and concerns expressed in various forums (JDF and Foundation Forum) by FY1s and other Resident Doctors, regarding lack of senior supervision associated with lack of senior staff staffing support on the wards and long hours of work. These issues are persistent and have been raised consistently over the past 6 years.

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

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

Surgical Specialties RPH
The largest category of exceptions is in the RPH surgical specialties all grades (193 exceptions, 29%) and this trend started in the later part of 2021 and continued through 2022, 2023 and 2024. There were also 5 ISCs in 2023.

The high numbers of exception reports and all the ISCs have been reported to the surgical management team. The issues have also been discussed and reviewed several times in the Divisional Workforce and Wellbeing Committee meetings. A combination of inadequate number of juniors compounded by sickness, patient acuity, and an increased number of referrals to the surgical departments are the driving force for the issues. The division struggles to even employ locums or use the Hospital bank to provide cover when needed. It is busy and people are not very keen to do the extra work even if they are offered good rates of pay. This is compounded by continued issues with funding and budget, preventing progress to improve staffing levels. The H@N team is providing more cover on the surgical wards, but this can be variable.

Vascular Surgery
High numbers of exception reports (64, 10.5%) and 4 ISCs have been submitted in Vascular Surgery in 2024. A meeting was held in May 2024 with the vascular department management team, CD, GOSW and the DME to discuss the various safety concerns that have been raised by the Resident doctors, with regards to the staffing of the vascular ward and how it was affecting patient care. Concerns were also raised at the February Resident Doctor Forum and in a focus group held by the Education team (March 2024). One of the solutions discussed was for the H@N team to start accepting the calls from the surgical wards. An action plan to improve staffing was developed.

2.5 Vacancies within the Trust

Vacancies vary month on month across the trust and particularly following each rotation. Vacant posts on rotas are also confounded by trainees who are off sick/on-long term sick and on maternity leave. COVID isolation has also affected numbers working on rotas.

Junior rotas are often made up of both Trainees and local employed doctors, for completeness their vacancies have been included in the report below.

Table 7: Vacancies by Grade in December 2022, 2023 and 2024

Year	Doctors in Training				Locally Employed doctors			TOTAL
	FY1	FY2	ST1-2	ST3+	Junior Clinical Fellow	Senior Clinical Fellow	SAS	
Dec 2022	1	1	8	17	27	39	20	**113**
Dec 2023	3	2	4	12	13	20	0	**54**
Dec 2024	0	3	16	0	5	12	6	**42**

**Please note all these figures (apart from Dec 23 Locally Employed Doctors) have been manually generated from a spreadsheet held within the medical workforce team therefore may not be fully accurate as do not link into the general ledger. These figures do not include any doctors who are maternity leave or long-term sick leave or those who work less than full time in a full time slot.*
*** Dec 2023 Locally Employed Doctors figures generated from general ledger*

In the training grades the highest number of vacancies is in the ST1 category although the overall number of vacancies in 2024 has reduced from 2022 and 2023 (apart from FY2). The medical workforce team has been focusing on identification of trainee gaps with a view to highlighting these to departments as and when they occur, with a view to encouraging jobs to be advertised using TRAC to back fill any gaps identified.

It is also worth highlighting that the number of resident doctors working LTFT has increased, and this includes in FY2 grades, this results in posts being filled, but vacant slots on the rota which need to be filled through using temporary workers.

Ongoing strategies to support recruitment to medical posts include:

- Reviewing job descriptions and creation of promotional activity, aligning job descriptions to the new employment brand and elements to make posts more attractive, for example rotations and dedicated time for audit, research and teaching.
- Continuing to promote vacancies through social media and relevant online journals.
- Continuing to source doctors where required through international placement agencies.
- Continuing to source doctors through the Medical Training Initiative in liaison with the Royal Colleges and recruitment into CESR posts with ongoing work to develop and ICS model for CESR.
- Improved induction and embed the NHS international induction framework to all new international doctors.
- Continue to utilise doctors who are sourced through the Wigan MCh program to fill vacant middle grade

posts.

- Continue to utilise our medical and dental in-house banks to reduce reliance on agency workers and reduce costs. This has enabled us to utilise our own doctors to work additional hours and therefore improves quality of care because doctors are familiar with patients and the hospital. We continue to adhere to an ICS agreed medical bank rate from 1 April 2022. We brought our medical bank in-house to ensure alignment of temporary workers to the rosters and this has helped us identify critical shifts and focus on filling those.
- Focus on trainee gaps to back-fill with locally employed doctors where possible.

We have also seen huge numbers of applicants for junior posts with one job recently attracting 1600 applicants.

The medical intern program has ended, and we will not be recruiting another intake this year but year 1 interns will continue and progress to their year 2 placements in August 2025. We are currently identifying which posts this will affect and plan to ringfence these posts for FY2/interns who are not moving to specialty training in August 2025.

2.6 Trainees outside the Trust overseen by the LTHTR guardian

There are several FY2 doctors who undertake placements in either GP practice or Psychiatry, and these doctors are encouraged to report the same as all doctors working within the trust. There was 1 exception from a GP resident doctor submitted in 2023.

2.7 Resident Doctor Forum (RDF)

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

Two meetings were held on Microsoft Teams (February and June), and one was F2F in November. The GOSW quarterly reports were reviewed, and various concerns were discussed, relating to some of the rotas and working conditions (see minutes attached to the quarterly reports). One of the main issues discussed in the November meeting was the use of the RPH doctors mess by the Acute medical team for their work including clerking patients etc. The discussion identified that there was not enough space for the doctors to do their work in the ED and they felt the only option was to use the mess. This issue has also been raised at other forums, including JLNC, and actions are being taken by the Trust to find an alternative working space for the team.

The exception reporting policy is on the intranet with the GOSW contact details:

Policy: http://lthtr-documents/current/P2169.pdf.

This policy will be updated in September 2025 to reflect the upcoming significant contractual changes to exception reporting due to be implemented on 12th September 2025 (TBC).

GOSW page with links to relevant information:
https://intranet.lthtr.nhs.uk/extranet/circle/39551df6775f6d17edbaede723960525?page=42e7aaa88b48137a16a1acd04ed91125

3 Financial implications Unknown at this stage

4 Legal implications None

5 Risks:

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

this report.

6 Impact on stakeholders

The high numbers of exception reports and ISCs suggest that doctors continue to work long hours with impact on staff stress levels, moral and wellbeing; and increased patient safety risks.

7. Recommendations

It is recommended that:

The board discusses areas of risk identified, particularly with reference to medical staffing provision in Chorley Acute Medicine, Vascular Surgery and RPH surgical specialties, leading to high numbers of exception reports and ISCs.

10.3 - SOCIAL VALUE STRATEGY

REFERENCES

Only PDFs are attached

10.3 - Social Value Strategy - Ancillary Paper -.pdf

Board of Directors

1. Discussion - SOCIAL VALUE STRATEGY

FORWARD

I first came across the concept of social value in 2008. At the time, it was a revelation, an idea that reshaped how I viewed the role of public institutions in society. It helped me see, with clarity and conviction, that social value is not just a policy of a programme. It is a powerful force for change. It is the thread that weaves together economic opportunity, community wellbeing, and the fight against health inequalities.

Since then, my belief in the transformative potential of social value has only deepened. I have seen how it can uplift communities, empower individuals and create environments where people not only live – but thrive. I have come to understand that if we are serious about tackling the root causes of poor health, we must embed social value into everything we do.

Lancashire Teaching Hospitals is at the heart of the communities we serve. We are more than a healthcare provider – we are a trusted presence, a major employer and a catalyst for change. Our strong culture, rooted in compassion and commitment, gives us the ability to do more good than through the direct provision of healthcare alone. We have the power to shape lives, open doors and build a future where everyone has the opportunity to live well.

This strategy is our commitment to doing just that. It is a call to action to integrate social value into every decision, every partnership and every service we provide. Social value must not be an afterthought. It must run through our organisation like a golden thread – shaping how we employ, how we procure, how we build and how we care.

Let this strategy be more than a document. Let it be a movement, one that inspires us all to think bigger, act bolder and lead with heart.

Neil Pease – Chief People Officer

OUR COMMITMENT TO MAXIMISE SOCIAL VALUE AND FULFIL OUR ROLE AS AN ANCHOR INSTITUTE

Being an anchor institute

"Anchor organisations are rooted in a place, with strong ties to the area in which they operate and large enough to make a significant contribution to the local economy through their purchasing power. They exert a substantial draw on local people for work and training, beyond just the services they provide." NHS Providers (Being an anchor institution: Partnership approaches to improving population health 2023) Anchor institutions due to their size are unlikely to relocate and have a significant stake in the geographical area, therefore anchored to their surrounding community (Source: The Health Foundation 2019 Building healthier communities: the role of the NHS as an anchor institution).

At Lancashire Teaching Hospitals, we acknowledge the enormity of our role within the communities we serve. We are conscious of our responsibilities to advance the welfare of the local populations, recognising that we must use our voice to influence how resources are spent locally to enable community wealth building and development.

We understand the importance of looking beyond our organisational boundaries by working in partnership to play our part in improving the social, economic and environmental conditions that can shape good health and deliver a sustained positive societal impact. We recognise how health is shaped by the circumstances people live in and we have a vital role in reducing health inequalities for the people who live and work across our region not only through the services we provide, but in our role as an employer, landowner, and purchaser of goods and services.

In our role as an anchor institute, we commit to having a continually evolving set of responsibilities which will form part of our organisational way of doing things. We will not view these actions as additional one-off programmes, instead seek to integrate this ethos into our wider strategic aims in how we employ our colleagues through to supporting their development, where we purchase goods and services, how we manage our land, building and environment along with how we work in partnership.

The importance of social value

Social value is a 'catch-all' term used to describe the difference we can make to the communities we provide services too. Social value matters because it is the right thing to do.

Social value encompasses all activity across our organisation, it goes beyond the financial bottom line, it includes employment, training and education, commissioning or procurement, investment and service delivery. It also includes how we go about doing our work, such as the ethical approaches we consider, the community engagement we undertake through to the collaboration we have with partners and wider stakeholders.

The purpose of social value is to deliver an impact within the community, this can be through reducing health inequalities, increasing the diversity of our workforce, retaining and attracting talent and skills to the area, improving the health and wellbeing of our communities and colleagues, through to increasing economic prosperity in the region and improving the environment.

The concept of social value has been around for decades and continues to evolve since the introduction of the Public Services (Social Value) Act in 2012. Since the act was published the focus of social value has expanded from being a procurement framework to be more about the role large organisations such as our has in creating a sense of community, supporting the environment and the green agenda through to creating inclusive workforces who have the skills and desire to remain working in the region which in turn increases the health and wealth of our communities.

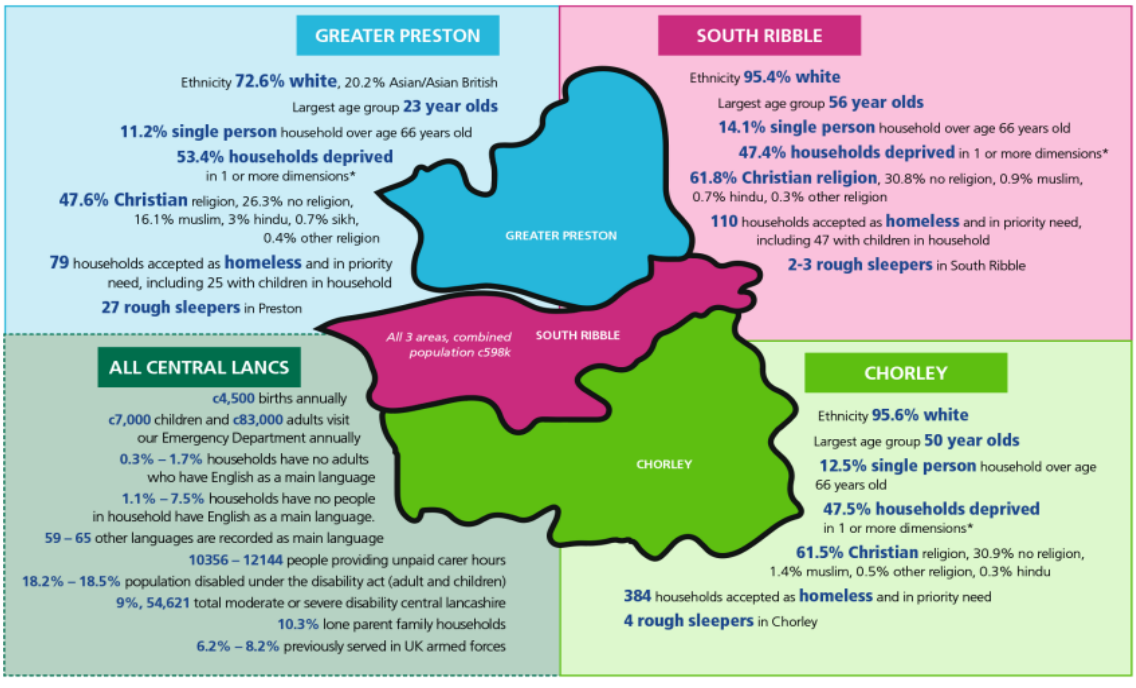
WHY DOES SOCIAL VALUE MATTER FOR OUR COMMUNITIES

Although progress is being made across the public sector partners for Lancashire and South Cumbria, our communities and indeed workforce continue to be hindered by several deep-rooted, long standing and interconnected challenges.

To summarise, this includes pockets of deprivation when compared to other areas of the country and in some cases within the northwest, high numbers of unpaid carers, with Preston having more than double 'high to severe outdoor living environment deprivation (Source: Lancashire City Council Social Value Portal and Local Needs Analysis 2022) at 50% compared to the wider northwest at 20.4%. Further to this, wider deprivation as measured by the Indices of Multiple Deprivation (deprivation is measured as a 'lack of' for factors such as income, employment, education and skills, health, crime, housing and outdoor living environment), it was found for Preston the overall level of deprivation according to this measure for Preston is 55.8% with Chorley at 19.7% compared to the Northwest region at 44.2%.

The Office of National Statistics data set for 2024 with relation to proportion of our community who are in jobs with hourly pay below the living wage for Lancashire as a whole is 19%, with Males in 15.7% of roles and 23.4% of Females in roles which do not pay above the living wage. The proportion significantly increases for those individuals in part time employment with 36.7% of our community in jobs which pay below the living wage. The Local Needs Analysis (2022) published by Lancashire County Council reported that 88.5% of businesses in Lancashire are micro businesses, with three main enterprise groups in construction, professional, scientific and technical along with retail.

As described in our Health Improvement Plan (2024) and the image below, the demographics across the 1.8 million population for Lancashire and South Cumbria published in the 2021 Census shows the proportion of our communities with protected characteristics and who are experiencing deprivation. (Source: Data from 2021 Census https://www.lancashire.gov.uk/lancashire-insight)



*dimensions of deprivation used to classify households are based on education, employment, health and housing.

Further to the information provided above, when reviewing the levels of qualifications held by members of our community, it was found that 28.2% of residents aged 16 or over had no qualifications, which is higher than the rest of England at 27.8%. For the highest level of qualification however 30.6% of residents in Lancashire as a whole had a degree level qualification or equivalent which is lower than England at 33.5%.

The Get Britain Working White Paper published in November 2024, outlines reform required nationally to tackle a number of key issues which are relevant to the trends found in the local communities of Lancashire and South Cumbria. These include developing new ways to support individuals with health conditions, caring responsibilities, it highlights that women who care for their families still experience challenges staying in and progressing in work. Equally it outlines how many employers can struggle to fill their vacancies due to labour and skill shortages, which then subsequently holds back economic growth in the local area and contributes to poor quality living standards.

It recognises that individuals with lower skill levels and from socially deprived backgrounds can struggle to enter employment and collectively we need to develop ways which enable young people to access high quality further learning, apprenticeships or support to work so they can thrive at the start of their career. The Sutton Trust report titled 'Unequal Treatment?' looks at the impact of social deprivation on ability to gain a university place to study medicine, with only 5% of applicants being from the lowest social economic group and 75% of applicants being from higher socioeconomic backgrounds.

The impact of parental occupational achievements also impacts on young people's ability to gain a medical school place, the report details how only 3% of applicants had parents who were in 'semi-routine and routine occupations', compared with 74% of applicants who had parents who were in 'higher managerial and professional occupations'. Parental educational attainment also impacted on those who applied to medical school, with 74% (2021 data) of entrants having a degree educated parent. The report examines the interaction between socio-economic group and ethnicity, illustrating stark differences by ethnicity and socio-economic group. Over half (52%) of entrants from the highest socio-economic group were White, 8% were Black and 31% were Asian; whereas among entrants from the lowest socio-economic group, 15% were White, 16% were Black and 61% were Asian.

All of these factors were also described in the Marmot Review: Health Inequalities, Fair Society, Healthy Lives (2010) outlining how the conditions in which people are born, grow, live, work and age and can lead to health inequalities and impact on the social determinants of health. Health inequalities arise from the complex interaction of many factors such as quality of housing, income levels, educational attainment, social isolation, disability - all of which are strongly affected by one's economic and social status. As a large employer in Lancashire (Source: https://www.lancashire.gov.uk/lancashire-insight/economy/major-employers/major-public-and-private-sector-employers/ last accessed May 2025) we clearly have a responsibility to not only reduce health inequalities, however play a significant role in influencing and enhancing the economic and social status of our community through meaningful employment and careers development opportunities. The Get Britain Working White Paper described how we as a large employer have a responsibility to support colleagues to upskill and get on in their career, ensuring they have access to training and ongoing development. The paper emphasises the importance of recruiting and retaining people with a disability or long-term condition, taking action to prevent people from becoming unwell at work, creating healthy workplaces and taking early intervention for sickness absence as a way to try and reduce levels of economic inactivity driven by ill health.

Our communities are our workforce, we understand that our workforce is broadly in line with the 2021 Census data, the issues which impact on our communities around deprivation, housing and caring responsibilities will be the lived experience for some of our workforce. As described in the Equality Diversity and Inclusion Strategy and highlighted in the image below which is taken from the associated most recent annual report in 2024, this illustrates our workforce demographics and protected characteristics;

Headcount
10,665 ***(10,348)***

Ethnic Minorities
26.6% ***(26.2%)***

Disability
6.2% ***(4.9%)***

LGBT+
2.9% ***(2.4%)***

Women
75.9% ***(76.2%)***

Married
53.1% ***(53.3%)***

(2023 data shown in brackets)

Our workforce is predominantly female (at 76.6%), which is higher than the general population for Lancashire and South Cumbria as outlined above. Given that the Census data indicates that as a region we have higher proportion of unpaid carers, with 10.3% lone family households, as an organisation we could make an assumption that we have more colleagues who fall into these groups and have multiple caring responsibilities and single incomes available to support their families. However as we do not hold this data as part of our employment service record it is not possible to make a data lead analysis.

As an organisation our workforce is proportionally representative for ethnicity, we have more colleagues from and Asian, Black and other ethnic group than the populations that make up Preston and Chorley. We are also proportionally representative for the majority of religions captured by the Census, with the organisation being underrepresented for Muslim, Sikh and having no religion when compared against the Preston Census data and the opposite being said when comparing this data against the Chorley Census data set.

The majority of our workforce falls between the ages of 25 – 64 years, however we are underrepresented when compared to our communities for employing colleagues who fall between 16 and 24 years (making up 6.9% of total headcount). For sexual orientation we are proportionally representative of the community we serve.

There are 4.9% of colleagues who have told us they have a disability or long-term condition, however in reality we are aware there are more colleagues with conditions who may not shared this with us as their employer. This is reflected by the 2021 Census data which indicates across Preston 24.4% and in Chorley 26.6% of the population have a long-term condition. Further to this we have within our workforce significant health and wellbeing challenges, with sickness levels being reported above the regional and national averages and an especially high prevalence of our workforce experiencing mental health problems.

OUR VISION

Our vision through this strategy is to

Improve the lives of our communities and colleagues through our role as an anchor institution

The key principles underpinning this vision statement is that all aspects of our work as an NHS organisation and employer should contribute towards the social value impact we make. The Social Value Strategy is integrated in the 5 corporate objectives of the organisation, these are:

1. **Patients** – Our ambition is to consistently deliver excellent care
2. **Performance** - Our ambition is to consistently deliver excellent care
3. **People** – Our ambition is to be a great place to work
4. **Productivity** – Our ambition is to deliver value for money
5. **Partnership** – Our ambition is to be fit for the future

This strategy is not designed to replace or supersede other core strategic aims of work. Its focus is on creating a framework which underpins and emphasises the programmes of work which acknowledge the leadership role we have in our community as an anchor institution and deliver tangible social value. The Social Value Strategy has embedded at its core the work of vital strategic programmes of work as detailed in the Equality Diversity and Inclusion Strategy, Our People Plan, Green Plan, Health Inequalities Plan and Education Strategy. There are clear correlations and intersections across all of these strategy documents in relation to Social Value.

To achieve our vision, the aims of this strategy are to put social value at the forefront of decision making across through:

CREATING CAREERS AND OPPORTUNITIES BY BEING A LOCAL EMPLOYER OF CHOICE – we know our actions speak louder than words for our colleagues and communities. To enable our region to retain its talent we will need to continue to widen access to good employment through understanding local demographics, creating opportunities, targeting positions for local people and inspiring young people into healthcare careers.

Through our drive to be a great place to work we will support the health and wellbeing of our colleagues, create inclusive teams where members of our community can see themselves reflected in our people at all levels and across all roles. We will support continual professional development and career progression along with supporting fair pay and conditions of employment to enable colleagues and our community to flourish and achieve their aspirations.

LEVERAGING OUR CONTRACTING, ESTATE, AND SUSTAINABLE PRACTICES TO DELIVER LOCAL BENEFITS AND SOCIAL VALUE – we need to put our money where our mouth is, influencing sustainable practices in the community though how we procure from local suppliers and ensure social value is embedded in all our purchasing decisions. We need to work in partnership to maximise the wider value of our estate, enabling local groups and businesses to use our facilities. Through the work delivered through our Green Plan we need to shape colleague and community behaviours encouraging their buy in for environmental sustainability.

CONNECTING COMMUNITY AND PARTNERSHIPS – we need to walk the talk, as a healthcare service provider, we have a wider role to play as an anchor institution to influence, mobilise, convene and coordinate wider activities of our partners and stakeholders for the benefit of the people in our region.

Organisationally we have a role in partnering with other anchor institutions, to develop collaboratives which support shared learning, create community engagement opportunities designed to support health, wellbeing, redressing inequalities, empowering communities and reducing deprivation within our region.

SOCIAL VALUE DELIVERY FRAMEWORK

THE PURPOSE OF THE FRAMEWORK

The Social Value Framework has been developed to provide a consistent approach to embedding Social Value across our organisation. It is also intended to ensure that we go above and beyond our current Social Value activity and explore new ways of creating, measuring and reviewing Social Value across the organisation. The Social Value Framework aims to:

Inform: Support all colleagues to understand the role of social value and identify how all parts of our organisation can contribute to fulfilling our role as an anchor institution. To do this we must provide information and practical guidance to help all teams to take ownership of social value as well as help elevate existing good practice and showcase areas where we are already creating social value.

Maximise: The key principle underpinning the Social Value Framework is that all our activities should contribute towards our vision which is to improve the lives of our communities and colleagues through our role as an anchor institution. There isn't one set of actions which will achieve this, our actions and approach must be dynamic, evolve with time and as we make progress and learn through doing.

To maximise our impact, we need to gain senior leadership and board buy-in through visible commitment and tangible actions which help embed anchor working as part of business as usual. We need to build relationships, develop shared objectives and outcomes to ensure that the benefits outweigh the challenges and make it worthwhile persevering in cross system programmes of work. The social value framework needs to provide a common language and guide for practical action to help us navigate different ways of working.

We need to empower our colleagues and teams to innovate by tapping into their core motivation, which is to improve people's lives through good health, wellbeing and help keep people out of poverty.

Measure: Develop immediate and longer-term commitments which will facilitate the creation of social value, along with clear indicators that we can use to measure, monitor and evaluate progress towards our impact in providing social value. This will involve identifying the data and information we need to benchmark and then track progress, highlight success and understand areas that need improving.

Report: We will publish an annual strategic update of our progress in delivering social value and achievements as an anchor institution. The annual update will demonstrate the progress we are making, where there are opportunities to do more, the impact our actions have had and our focus for the coming year.

CREATE CAREERS AND OPPORTUNITIES BY BEING A LOCAL EMPLOYER OF CHOICE

Our recruitment practices, widening participation opportunities, the terms and conditions of employment, the health and wellbeing support we provide colleagues, our drive towards being a consciously inclusive organisation through the delivery of our Equality, Diversity and Inclusion Strategy, through to our extensive training and education offers are all key elements of the social value we create. We are already achieving a lot in this area, for example:

- An extensive widening participation offers, with outreach and engagement in local schools, colleges, community groups where there are higher levels of unemployment.
- Extensive range of apprenticeship opportunities enabling individuals to gain a qualification whilst earning and gaining work experience.
- Attraction and support programmes which help to attract local people into employment opportunities with us and overcome barriers to entering into work.

- Working with range of community partners to promote career and development opportunities to local people.
- The range of volunteering opportunities
- We provide and extensive range of health and wellbeing initiatives for colleagues, along with provision of targeted support for colleagues with certain protected characteristics
- We operate a range of Ambassador Forums and Networks for ethnic minorities, colleagues living with a disability or long-term condition, LGBTQ+, Carers, Endometriosis and Menopause support.
- We have a comprehensive Equality, Diversity and Inclusion Strategy which sets the principles which progress us towards being consciously inclusive in everything we do for our communities and colleagues.
- Our People Plan provides the workforce and organisational development strategic direction, bringing together transformational streams of work which create the conditions for a great place to work.
- We work in partnership with Trade Unions on our employment practices.
- We hold several employer accreditations including the Care Leavers Covenant, Disability Confident, the TUC Dying to Work Charter and the Armed Forces Covenant.
- We offer flexible working opportunities from day one, reducing the barriers to employment for example for colleagues with caring responsibilities.

To evolve and improve our approach we will work towards the following future aspirations and plans. As part of the Social Value Delivery Framework we will:

- Ensure the principles of social value and our role as an anchor institution is embedded in the actions and strategic direction described in the refreshed Equality, Diversity and Inclusion Strategy and Our People Plan.
- Grow volunteer opportunities and create a volunteer to career pathway which helps local people to develop their employability skills.
- Increase community engagement and presence in our community as an employer of choice.
- Reach out to children and young people to inspire them to consider careers in health and social care, raising awareness of our apprenticeships and routes into our professions.
- Tackle health inequalities in our workforce.
- Deliver a health and wellbeing plan alongside seeking to reduce levels of sickness absence.
- Work with partner organisations to deliver health and wellbeing awareness, promotion and engagement opportunities for colleagues and wider community.
- Expand our apprenticeship programme.
- Promote and grow our widening participation offer, through working in partnership across the system to deliver a range of placement opportunities, virtual programmes, seminars and information sessions.
- To support members of our community who struggle to secure employment through delivery of range of pre-employment programmes and guidance on how to successfully apply for jobs.
- Create community connection through the implementation of a colleague volunteering scheme, supporting local partners and businesses to benefit from the skills of our workforce by enabling them to take up volunteering opportunities.
- Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.
- Increasing the proportion of minority group colleagues in all levels and across all professions.
- Continue to take action to eliminate pay gaps for all protected characteristics.
- To educate, appreciate and celebrate the rich diversity of our colleagues through diversity and inclusion training, awareness and promotion of inclusion events.
- Continuing to progress our Zero Tolerance approach to discrimination and racism.
- Deliver on the actions in the Organisational Sexual Safety Charter.

- Achieve bronze level in the Northwest Black, Asian and Minority Ethnic Assembly Anti-racist framework.
- Increase the disclosure of protected characteristics, enhance intersectional reporting and scope ways to gather socioeconomic data from our workforce to understand barriers to social mobility and career progression.
- Embed social value principles in our Leadership Develop offer to ensure managers understand the motivations behind our actions and understand how through their role and services they can contribute to delivering on this agenda.

We will measure success by:

- A workforce that understands social value through increased awareness and participation in social value training or opportunities.
- Number of permanent employees from the local area.
- Improved employability of young people, measured through numbers of full time 16–25-year-olds working in the organisation on permanent contracts or in student roles.
- Number and representation of colleagues with protected characteristics in all bands and professions.
- Understanding of our pay gaps for all protected characteristics and seeking to reduce gaps where applicable.
- Improved experience of work for colleagues with protected characteristics as measured by the NHS Staff Satisfaction Survey.
- Number of colleagues who are hired and retained who are care leavers, local armed forces veterans or have not been in education or employment.
- Number of apprenticeship opportunities completed during the year or will be supported by the organisation through to completion.
- Number of qualifications or accredited training programmes completed by colleagues in year.
- Number of colleagues with protected characteristics who access non mandatory development.
- Number of hours of support into work assistance provided through applicable widening access schemes, career mentoring, work experience placements.
- Number of volunteer hours provided by our colleagues to the local community organisations and to voluntary, community and social enterprises.
- Number of volunteers undertaking roles in our organisation who are not in education or long term employment and seeking to gain skills to return to paid work.
- Improved mental and physical wellbeing of colleagues measured through participation in multidimensional wellbeing offer, reduced sickness absence and increased colleague satisfaction.
- An engaged and empowered workforce measured through the NHS Staff Satisfactions Survey, the percentage of the workforce that has completed skills development and training and has participated in a talent management programme.

DRAFT NEED TO CONSULT AND ENGAGE SME'S ON ALL ASPECTS OF THIS SECTION

LEVERAGE OUR CONTRACTING, ESTATE AND SUSTAINABLE PRACTICES TO PROVIDE LOCAL BENEFITS AND SOCIAL VALUE

As a large landowner, we have a significant estate and capital assets across multiple sites within the region our buildings are part of the local landscape. The quality of our estate, buildings and facilities contribute to levels of colleague satisfaction and both colleague and patient wellbeing. With patient's perceptions of the quality of care we provide and their recovery impacted upon by the standard of food we provide, through to the environment in which we care for them all of which can influence both their physical health but mental wellbeing.

Our approach to environmental sustainability can have a significant impact on the wider behaviours and practices of our local suppliers. Along with how we procure and purchase services and products from suppliers from within our locality can have a profound impact on the wider economy, retention of talent and skills through to reduction in deprivation. We have an obligation to create social value through our contracting, estate and sustainable practices and already have examples of good practice being delivered. For example:

- The publication and progress made towards the Green Plan which is the organisations first ever three-year strategy towards net zero.
- Sought to reduce carbon emissions by increasing use of virtual patient consultations, encouraging agile working practices for our workforce.
- Reduction in the annual expenditure on paper.
- Increased the number of tender and business opportunities for local companies and social partnership companies to bid for.
- Made progress to increase the expenditure with local suppliers.
- Increased the number of procurement contracts incorporating net zero and social value as part of their tender specification.
- Implemented a car share scheme for colleagues.
- Increased the number of outdoor seating areas.
- Regenerated a number of the gardens and green areas across the estate.
- Created a network of sustainability champions
- Introduced a simpler recycling system.
- Promote environmental awareness days.
- Created a reupholstery scheme to give used furniture a new life.

To evolve and improve our approach we will work towards the following future aspirations and plans. As part of the Social Value Delivery Framework we will:

- Refresh and launch a new 5-year Green Plan, delivering on strategic actions and measuring impact.
- Increase the amount we spend locally and as part of annual social value strategic updates publish the percentage of expenditure on good, services and works within Lancashire and how we are proposing to continually improve this.
- Embed social value into purchasing decisions by influence our suppliers to deliver on social value and support environmental sustainability through our procurement processes.
- Develop a minimum percentage weighting for social value considerations in procurement decisions on all new contacts by XXX?
- Ensuring all suppliers pay the real living wage.

- As part of procurement processes seek to understand the protected characteristics of the organisations we are working with, this includes the characteristics of ownership and leadership.
- Develop new ways to use our estate and green spaces to support local health.
- Work in partnership to maximise the wider value of our estate such as enabling local groups to utilise our premises.

We will measure success by:

- An increased in the proportion of the total amount spent with local services, suppliers and micro, small and medium (MSME's) in Lancashire in order to provide maximum benefit to Lancashire residents.
- Evidence of how through procurement processes suppliers can demonstrate they implement ethical employment practices throughout their organisation and with the suppliers they utilise in provision of goods or services.
- Evidence of inclusion and diversity practices provided by suppliers when tendering for contracts (this will include reduction in pay gaps, representation, training etc).
- An increase in the proportion of or number of suppliers with social value principles embedded in their working practices.
- An increase in the proportion of or number of suppliers with green strategies, plans for net zero etc embedded in their working practices.
- Increased number of local community groups who utilise our estate to support community activities.
- Delivery of the Green Plan and tangible impact made for each of the strategic aims.

DRAFT NEED TO CONSULT AND ENGAGE SME'S ON ALL ASPECTS OF THIS SECTION

CONNECTING COMMUNITY AND PARTNERSHIP

Our corporate objectives emphasise the strategic importance we place on partnership, we recognise that we need to develop networks with the other anchor institutions, the voluntary sector, wider public sector services to develop shared and local approaches. We understand we must be intentional in our community engagement, and we have roles to play in outreaching to our communities to understand their needs. Through the work of this strategy, we will support our local population to feel part of a community, that we take deliberate action to cultivate a sense of cohesion, collective pride and influence the wider societal culture and identity. We are already committed to maximising social value through our role as an anchor institution as demonstrated by the following actions we have taken:

- The publication and delivery of the Health Improvement Plan developed to support the reduction in health inequalities. The plan has been developed through collaboration and partnership with other anchor institutions and local partners (local councils, healthcare providers, Northwest Ambulance, local prisons, primary care networks and Lancashire and South Cumbria Integrated Care Board).
- Submission of research grants in partnership with northwest universities.
- Increased our outreach activity to support marginalised groups across our communities including - Breast Cancer Awareness and Breast Screening with Asian women, Prostate Cancer Awareness within the Windrush community and events to raise awareness of Prostate and Testicular Cancers across male prisoners.
- Working in partnership with Healthwatch Lancashire as part of 'Share for Better Care' programmes, enabling us to gather real time experiences and feedback from patients and the public and provide opportunities to discuss experience of our care with Healthwatch as partners.
- Working with the Prison Service to increase awareness and instigate support groups around specific health conditions such as prostate and testicular cancer.
- Developing an integrated Northwest-wide service and referral pathway across 3 centres (Manchester, Alder Hey and Preston) for children and young people with severe obesity.
- Creation of extensive range of involvement forums which enable us to understand the experiences of our patients and to collaborate with charities, advocacy services and 3rd sector organisations to develop services based on their needs. As a result of the forums we have created a 7-day bereavement service, redesign the emergency department, developed day case surgery for children at Chorley, recruited a full-time bereavement lead for Gynaecology services, created a Garden of Remembrance to honour organ donors and those that lost their life during the pandemic.

To evolve and improve our approach we will work towards the following future aspirations and plans. As part of the Social Value Delivery Framework we will:

- Strengthen relationships within our communities by ensuring face to face involvement, listening to patient stories and experiences and putting their voices at the heart of our decision making.
- Consider the cultural factors which affect access to healthcare services for patients and community groups with protected characteristics.
- Build connections and relationships with excluded groups and put this learning into our plans to ensure we continue to build and grow with our communities.
- Increase the representation of minority groups of the Patient Experience and Involvement Group to enable the lived experience of those with protected characteristics to be shared and considered as part of decision making.
- Continue to provide accessible information, where necessary use interpreter services for languages and our Deaf communities with BSL to ensure public health information is understandable to all.

- Partnering with other anchor institutions across a place by establishing anchor collaboratives and networks to develop shared approaches on XXX
- Developing networks to support shared learning and spread good practice
- Community engagement to support anchor working
- Develop charitable fundraising campaigns that bring together diverse sections of our community and range of local businesses to have a shared aim and create sense of collective pride.
- Work in partnership with local organisations, voluntary sector, not for profit organisations to support health and wellbeing programmes, development of green or environmental initiatives.
- Work in partnership with other Anchor Institutions and the Integrated Care Board to increase awareness of diversity and inclusion within our communities to reduce levels of discrimination and health inequalities.

We will measure success by:

- Increase the number of charitable community engagement opportunities by working with local businesses to deliver social value projects e.g. improving outdoor spaces on hospital sites.
- Increase the number of community groups and local business who deliver fundraising challenges to support the organisations charities.
- Increase the volume and range of initiatives provided to support or engage members of the community in health interventions, leading to increased levels of participation and health outcomes.
- Increased number of partnerships with local organisations, voluntary sector, not for profit organisations in the delivery of an increased range of health and wellbeing programmes, development of green or environmental initiatives etc.
- Reduction in levels of violence and aggression, discrimination and abuse of colleagues with protected characteristics.
- Delivery of Health Inequalities Plan outcomes and improvement measures as detailed for each of the strategic actions and drivers.

GOVERNANCE AND REPORTING

To provide leadership and oversight of the delivery relating to the social value agenda we will refresh the focus of the already established working group to ensure it includes colleagues from wide variety of settings including Workforce, Organisational Development, Education, Charities, Clinical Leadership, Estates and Facilities and Procurement. The Executive lead for Social Value is Neil Pease Chief People Officer.

Clear reporting will ensure we understand the progress we are making. The governance and reporting arrangements are outlined below:

- A chairs report will be submitted to the Workforce Committee to provide regular oversight.
- An annual strategy report will report on delivery against the strategic aims and measurable impact to the Workforce Committee

2. Financial implications

None.

3. Legal implications

While NHS trusts do not have a specific statutory requirement to have a dedicated social value strategy, we are legally obligated to consider social value in our procurement processes, as outlined in the Public Services (Social Value) Act 2012. This act requires public sector bodies to consider how their purchasing decisions can improve the economic, social, and environmental well-being of their communities.

4. Risks

- Limited resources within Workforce and Organisational Development team to progress at pace core streams of work described in this strategy. Due to the vacancy control and waste reduction programme there are several vacancies in the team which would have contributed to the progression of this work.
- The 1LSC recruitment model will not include the community engagement work we have previously completed as part of our recruitment services. The community outreach and publicity surrounding vacancies has helped to recruit local people, individuals who have been out of employment for a period into role within the Trust. There is no funding available in the Trust to pick up this work as we would require 1LSC recruitment services to mobilise and implement actions.
- Due to the wider vacancy freeze, needing to hold vacancies for internal redeployment across the organisation we have less entry level administrative roles being recruited to or these roles have reduced having been removed from the establishment. This will make it more challenging to support members of the community to apply for our roles or be interviewed for a vacancy following successful completion of a widening participation programme or potentially providing a career opportunity for a volunteer who wishes to move into paid employment.
- The capacity within the 1LSC Procurement function to deliver on the social value programmes of work.

5. Impact on stakeholders

The impact of effective delivery of this strategy should be positive for the community, patients and colleagues. The impact measures under each of the strategic aims details the proposed impact which should be delivered. In summary this includes reduced health inequality, improved health outcomes, improved colleague wellbeing, increased levels of educational attainment of colleagues/our community, increased representation of colleagues with protected characteristics in all levels and professions, increased levels of prosperity within the local community, reduction in discrimination, enhanced public perception of us as an organisation and our ethos.

6. Recommendations

It is recommended that:

I. Note the contents of the draft Social Value Strategy
II. Support the proposed governance reporting arrangements

13.1 - AHP SAFE STAFFING REPORT

REFERENCES

Only PDFs are attached

13.1b - AHP Workforce Safeguards April 2025 BOD Aug 2025.pdf

Board of Directors

Allied Health Professionals Bi-annual Safety & Quality Review

Report to:	Board of Directors	**Date:**	7 August 2025
Report of:	Chief Nursing Officer	**Prepared by:**	C. Granato

Purpose of Report

For assurance		**For decision**	☐	**For information**	x

Executive Summary:

The purpose of this report is to detail the findings of the Lancashire Teaching Hospitals (LTH) bi-annual Allied Health Professionals (AHPs) workforce safeguards review for the reporting period of July 2024 to December 2024.The report has been delayed in presentation due to issues with access to data. The safety and quality committee have reviewed and scrutinised the report.

The report includes several workforce developments and celebrations, despite the current challenges. These include:

- A successful succession planning example in Speech and Language Therapy. A small profession, where replacing the Head of Service could have been difficult. 2 years ago, succession planning began through re-structuring and creating an Associate Head position, this postholder (following a competitive recruitment process) has now progressed into the Head of Service position following the retirement of the previous postholder. The transition for the service and workforce has been seamless.
- Delivery of year 2 objectives for the AHP workforce strategy, 21 of the 25 objectives were achieved in full and 4 are ongoing. The third and final years objectives are now underway and due to be completed October 2025.
- Job planning for AHPs is being rolled out, using a standardised excel template and principles that are in line with local and national guidelines, this is expected to be completed by October 2025.It will provide understanding of demand and capacity across the AHP areas and maximise efficiency.

Vacancy rates and trends continue to be captured using statistical process control (SPC) charts. Over the past 6 months 6 professions have maintained low vacancy rates and have no immediate supply concerns, their charts are in appendix 2. In section 4.4 further narrative is provided on 4 professions, the first is a positive narrative, Physiotherapy and Occupational Therapy have successfully recovered their vacancy rates. Physiotherapy have reduced from 10% to 0% and Occupational Therapy from 19% to 3%. This is due to their successful over-offer agreement for graduates in August 2024 and for Occupational Therapy an improved supply position.

There are 2 AHP areas with concerning vacancy rates, largely due to the vacancy freeze impact and held posts. The first is Speech and Language Therapy, whose vacancy rate was recovering but progress has now plateaued. The vacancy rate in December is 14% (4.17WTE) and the gaps are in some challenged clinical areas such as Head and Neck and ENT. The second area of concern is Diagnostic Radiography, in December the vacancy rate is 14% (17.85WTE) and this is causing service disruption as seen in the Datix summary (section 7). The vacancy freeze has now lifted and it is expected that recruitment will be successful for Speech and Language Therapy,

however it will be limited in Diagnostic Radiography until August/September 2025 when the new graduates become available.

Maternity leave rates are minimal and no professions are reporting pressures as a result. Absence rates are however a concern, with the exception of 3 areas that are within the Trust target (see table 3, section 4.4). There is likely an element of seasonal variation looking at the 6-month trend and no themes can be seen in the long-term absences. A deep dive into these had provided assurance that all are being managed according to policy.

The annual benchmark of AHP workforce using Model Health is included in section 5. There is no significant change compared to 12 months ago. In summary the benchmark suggests LTH are under resourced compared to peer in the following professions: Physiotherapy, Occupational Therapy and Diagnostic Radiography. Therefore, indicating a return on investment for these 3 professions (especially Physiotherapy as it is in the lowest quartile) may yield productivity benefits. This triangulates the Datix thematic analysis and the risk register in section 7.

Key areas of improvement linked to safety and quality include STAR outcomes, all 13 AHP areas have achieved gold and during this reporting period 9 were re-inspected and retained their gold status, despite the higher expectations of this standard. Risk management maturity is evident within the report, a number of AHP workforce risks have been closed as they are within risk appetite and others have been merged/re-worded to prevent duplication.

Datix reporting remains consistent, with the majority attributed to Occupational Therapy and Physiotherapy (Core Therapies collectively). Critical Care, Burns and Plastics and Acute Medicine are the clinical areas with the highest number of incidents reported as a result of workforce shortages and this correlates with the risk register. There is also a notable increase in Datix reporting for Diagnostic Radiography, mainly impacting Theatre activity and this is linked to high vacancy and sickness absence rates.

Essential training compliance is vastly improved compared to previous reporting periods with 7 of the 10 professions achieving compliance in all areas. Speech and Language Therapy and Orthoptics have 2 red metrics, but all are within the 86-88% range and equal 1 person not being compliant. The only training compliance concern with an action plan is appraisals in Therapeutic Radiography, recovery has been challenged due to delivering the radiotherapy service with a high absence rates. The action plan in appendix 2 details mitigation and plans to address all areas of concern.

Recommendation

The Board of Directors are asked to receive this report for information and assurance the safety and quality committee have scrutinised the report and confirmed it is assured of the Workforce safeguards within AHP services.

Appendix 1 – AHP Vacancy SPC Charts
Appendix 2 – Action plan

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

1.0 INTRODUCTION

This report details the findings of the Lancashire Teaching Hospitals (LTH) Allied Health Professionals (AHPs) staffing review, for the reporting period July 2024 to December 2024. This report is in response to the 2018 'Developing Workforce Safeguards' recommendations and also meets the recommendations in relation the AHP governance arrangements from the 2019 NHSE/I 'Guide to Reviewing AHP Leadership for Trust Boards and Clinicians'. The safety and quality committee have reviewed and scrutinised the report.

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

There are currently no specific guidelines or frameworks for AHP workforce safeguards, therefore professional judgement and national/local benchmarking are heavily relied on. Three clinical specialities do have workforce guidelines covering Physiotherapy, Occupational Therapy, Dietetics and Speech and Language Therapy. These include Critical Care, Stroke and Neonatal Intensive care. Compliance against guidelines for these areas will be reported annually in the August report.

2.0 SCOPE

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

3.0 METHODOLOGY

A triangulated approach to the review of staffing has been undertaken by the Chief AHP supported by the Chief Nursing Officer. In the absence of national guidance findings within the review have been cross checked using professional judgement and benchmarking data where appropriate.

4.0 WORKFORCE

4.1 Leadership

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

The Chief AHP has been on secondment 2 days per week as the joint NMAHP lead for the New Hospitals Programme. A Deputy Chief AHP commenced in post September 2021 and is currently contracted until April 2026. The Chief AHP reports to the Chief Nursing Officer and due to the timeline associated with the New Hospitals will return to the role fulltime from April 2025. The opportunity to influence and shape new models of care has been a significant advantage of the role and these skills are being used to influence the development of the community integration case.

4.2 Current Workforce Development and Planning

<u>Successful Succession Planning</u>

In October 2024 the previous Head of Speech and Language Therapy (SLT) retired, this has led to replacement and a successful succession planning example.

Approximately 2 years ago succession planning was explored and the decision made to re-structure within budget and create an Associate Head of SLT. This position is a clinical expert role with leadership responsibilities, allowing exposure and development for the individual and readiness for a 'Head of' role. The introduction of this role has resulted in the post holder (following a competitive recruitment process) progressing into the Head of SLT position and a smooth transition for all involved.

This approach has since been mirrored in Dietetics, a similar sized department where replacement of the highly experienced AHP leader could be a challenge without a dedicated succession plan.

Year 2 AHP Workforce Strategy

October 2024 marked 2 years of the AHP workforce strategy, with an over-arching aim to improve supply of AHPs and reduce vacancy rates. 25 objectives were expected to be achieved during year 2, 21 have been achieved in full and the remaining 4 have been partially achieved and are actively being worked upon.

Highlights include:

- Degree level apprentices now present in 9 out of 10 AHP groups
- Graduation of LTH's first AHP degree apprentices - 7 ODPs and 2 Radiographers
- 3 new graduates successful on the National Institute of Health and Care Research (NIHR) INSIGHT programme, a fully funded research masters
- Clinical Academic Therapeutic Radiographer awarded the 'research advocate award' from Northwest Cancer Research for their portfolio of work at LTH
- Multiple award winning AHPs, both internally and externally
- 5 AHP leaders completed the NHS England Allyship programme
- Recruitment of 3 international Occupational Therapists and 2 gaining promotions within 12 months

Delivery of the third and final year of the strategy is underway and will be reported on in October 2025. The majority of objectives are expected to be delivered, there are risks to delivery associated with the Trust's financial position and any future restrictions on recruitment.

Job Planning

The roll out of AHP job planning is underway, ideally this would have been through an electronic system, however this is currently not an option. Therefore, an Excel template has been devised and is being utilised to ensure standardisation and upload to an electronic system eventually. A set of principles for AHP job planning have also been developed and agreed with the AHP leadership team, following national and local guidance.

It is anticipated that job planning for AHPs will be completed (for all those in scope) by July 2025. It will provide understanding of demand and capacity across the AHP areas and maximise efficiency. Progress on this will be reported through the NMAHP Board.

4.3 Specialist AHP Roles

Table 1 – AHP Specialist Roles

Role	Number							Comments
	Sept 21	Mar 22	Nov 22	May 23	Nov 23	May 24	Dec 24	
Consultant AHP	7	7	8	8	8	8	7	1 Speech & Language Therapist 3 Therapeutic Radiographer 1 Sonographer 2 Physiotherapist
ACP/ASP (Trainee and qualified)	12	12	12	15	17	18	18	11 Physiotherapist 1 Occupational Therapist 4 Therapeutic Radiographer 2 Speech & Language Therapist
Research	2	2	3	2	3	2	1	1 Physiotherapist
Other roles (where being an AHP is not part of the essential criteria)	6	7	7	8	9	9	9	1 Matron (ODP) 2 SBM's (Therapeutic Radiographer & Orthoptist) 1 CI Fellow (Physiotherapist) 1 CD (Therapeutic Radiographer) 1 DD (previously a Diagnostic Radiographer) 1 Board Member (Dietitian) 2 Education (Therapeutic Radiographer & Physio)
Total	25	28	30	33	37	37	35	

Table 1 positively evidences AHPs are taking on advanced and Consultant practice roles in the organisation and also crossing professional boundaries.

Over the last 6 months there has been a small reduction in numbers, this is due to a fixed term research position coming to an end and the retirement of the Head of Speech and Language Therapy who was also a Consultant Practitioner.

These metrics are a core component of developing services of the future whilst maximising the offer of AHPs in shaping services delivered through an evolving and multi-professional team. These will be monitored, and a continued upward trend is predicted to resume as the financial position improves and based upon many roles in the organisation being open to registered professionals with the correct skills and experience.

4.4 Workforce Metrics

Registered AHP Establishment

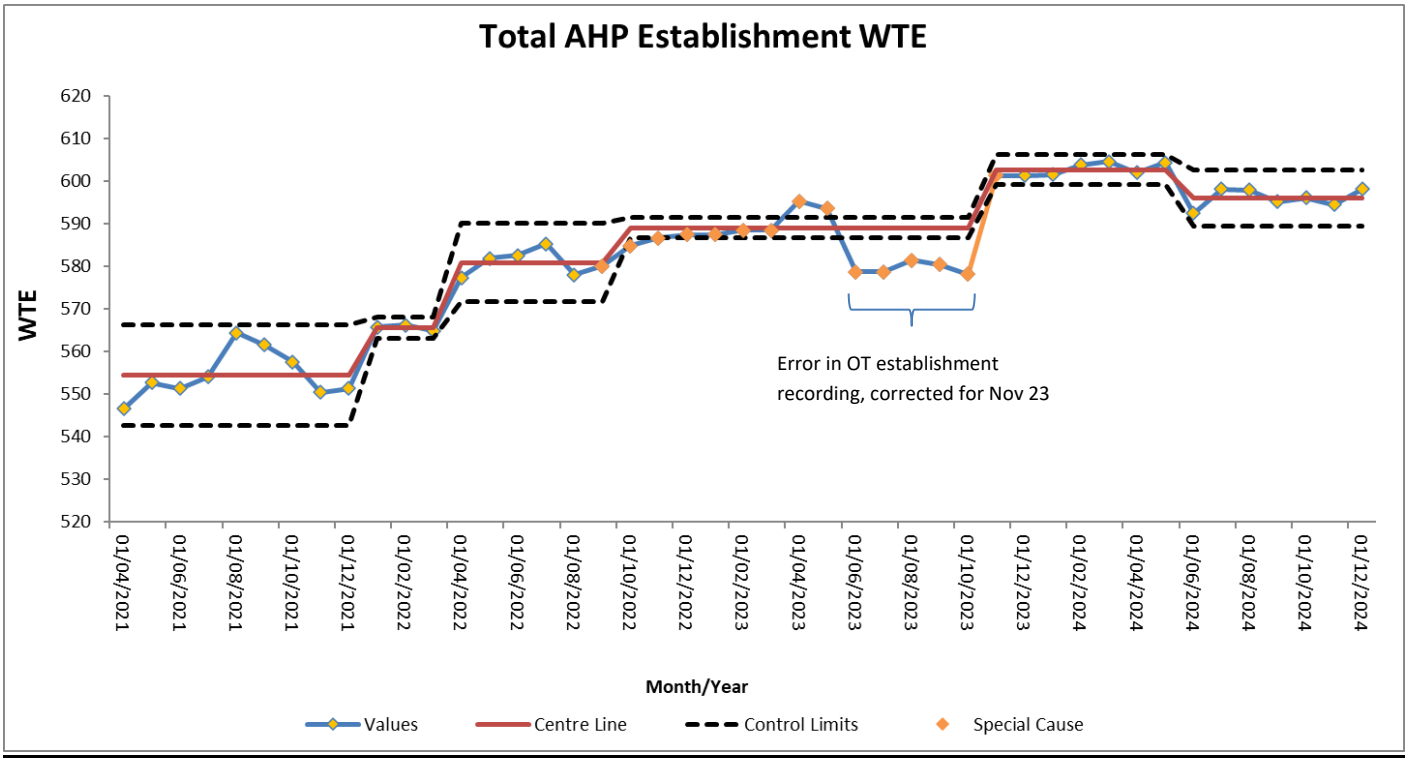
The following workforce metrics are taken from the electronic staff record (ESR). Previously an ESR cleanse was completed, providing assurance that our AHPs are aligned to the correct occupational codes.

There are 2 limitations of the ESR data set for AHPs, firstly the Prosthetist and Orthotists cannot be split out as they have the same occupational code. Secondly, the ODP data does not accurately describe

establishment/vacancy as any vacant posts are advertised to Nurses and ODP's and budget lines then moved around dependent on the outcome.

Recording and displaying of AHP establishment and vacancy data is through statistical process control (SPC) charts.

Graph 1 – AHP Establishment April 2021 onwards



Over the 6-month reporting period the total AHP establishment has remained static, with an overall -6WTE position across 10 staff groups.

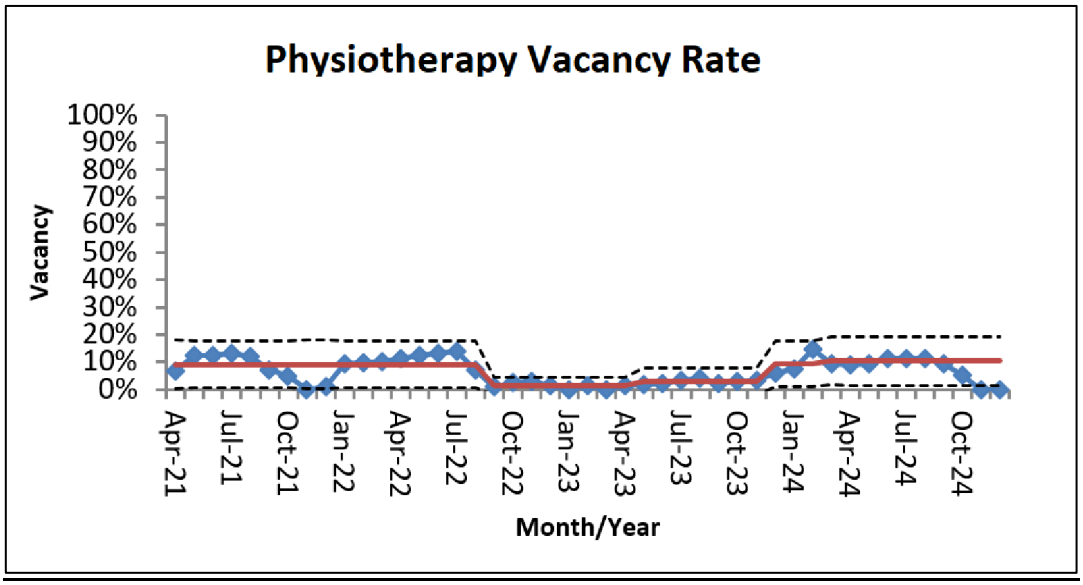
Reporting from June 2023 – October 2023 is inaccurate due to movement of Occupational Therapy establishment to fund the new admission avoidance service; in turn this removed the profession specific code from ESR and prevented it being included in reporting. This has been corrected from November 2023 to ensure Occupational Therapy establishment can be reported correctly.

Vacancy Rate

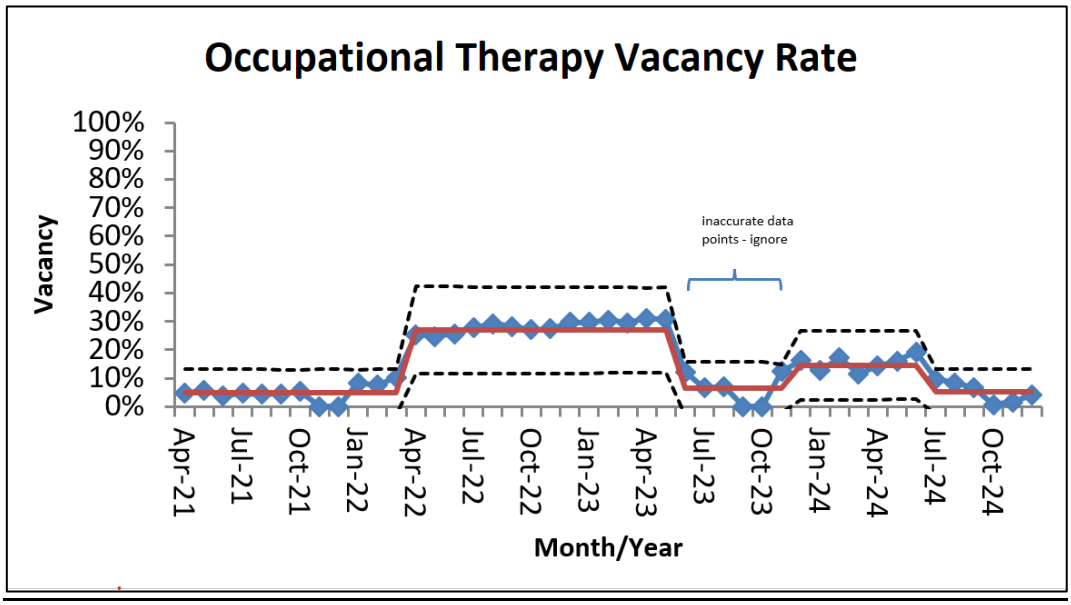
Several of the AHP groups are maintaining low vacancy rates and meeting the Trust's target. They are Dietetics, Therapeutic Radiography, Prosthetics & Orthotics, Orthoptics and ODPs and their SPC charts can be found in appendix 1. It is important to note that the SPC charts for Prosthetics & Orthotics and Orthoptics do show a vacancy rise, this looks significant on the graphs but due to the small establishments is only 1WTE.

During this reporting period an improvement to vacancy rates in Physiotherapy (graph 2) and Occupational Therapy (graph 3) has occurred. This is due to successful over-offer arrangements for new graduates. This means that the band 5 budget lines are over established but temporarily balanced by vacancy at band 6 and 7. Now the vacancy freeze has ceased it is likely a number of internal promotions will take place, rebalancing the budget lines.

Graph 2 – Physiotherapy Vacancy Rate April 2021 – December 2024



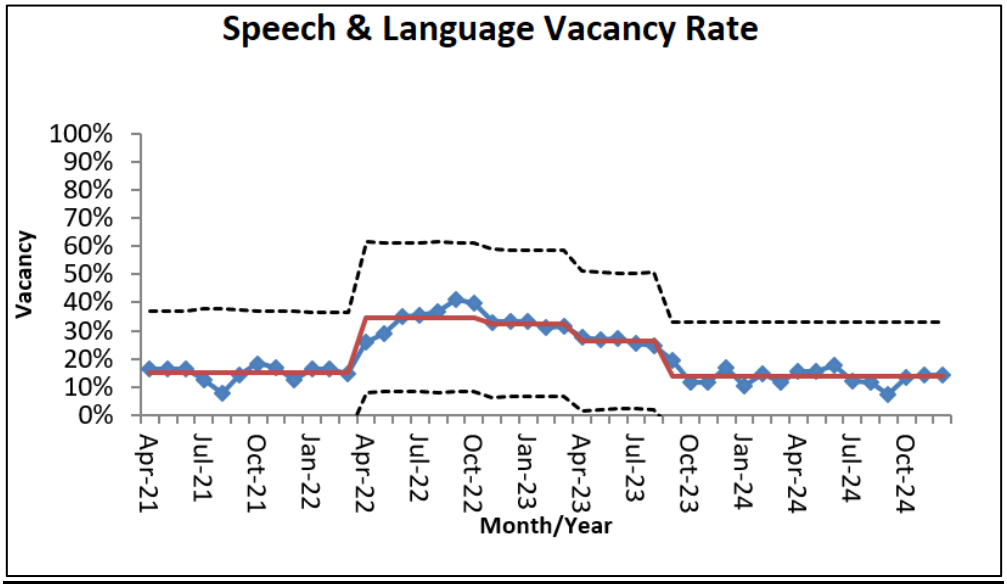
Graph 3 – Occupational Therapy Vacancy Rate April 2021 – December 2024



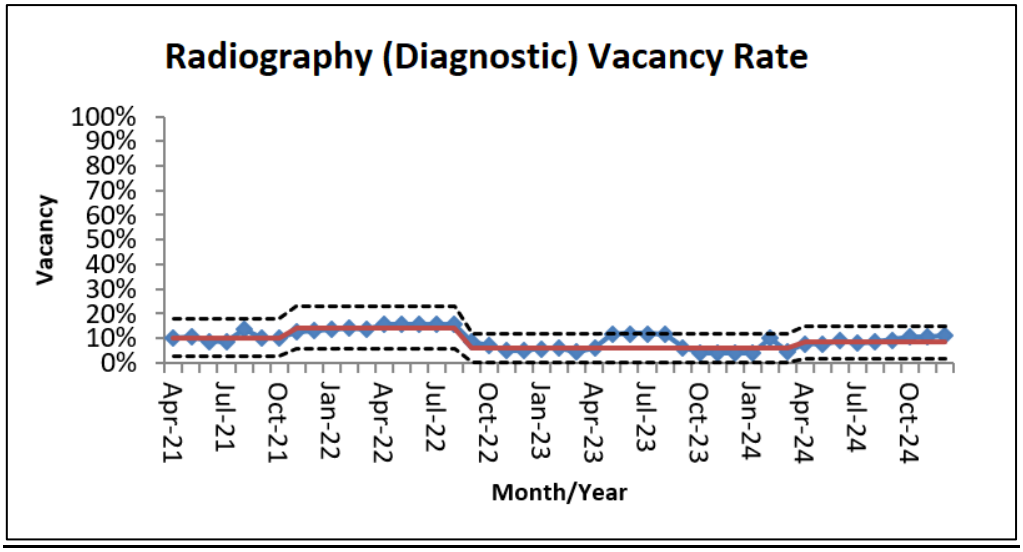
Speech and Language Therapy (graph 4) and Diagnostic Radiography (graph 5) continue to see higher than average vacancy rates which are causing some service disruption. In Speech & Language Therapy the December vacancy rate was 14% (4.17WTE) and in Diagnostic Radiography it was also 14% (17.85WTE).

Both areas have been impacted by the vacancy freeze towards the end of 2024 and Diagnostic Radiography were unable to over-offer to new graduates last summer, further impacting the position. Now the vacancy freeze has ceased it is expected that recruitment will be successful for Speech and Language Therapy, however it will be limited in Diagnostic Radiography until August/September 2025 when the new graduates become available.

Graph 4 – Speech & Language Therapy Vacancy Rate April 2021 – December 2024



Graph 5 – Diagnostic Radiography Vacancy Rate April 2021 – December 2024



Maternity Leave Rate

Table 2 – Maternity Leave by Profession July 2024 - December 2024

Profession	Jul 24 (wte)	Aug 24 (wte)	Sept 24 (wte)	Oct 24 (wte)	Nov 24 (wte)	Dec 24 (wte & %)	Trend/ RAG Rating
Dietetics	0.80	0.80	0.40	0	0	0 0%	Downward
Occupational Therapy	2.20	2.20	0.37	0.20	0.20	0.16 0.23%	Downward
ODP's	0	0	0	0	0	0 0%	Static
Orthoptics	0	0	0	0	0	0 0%	Static
Physiotherapy	1.41	1.60	1.31	2.28	2.28	2.73 2.59%	Upward
Prosthetics & Orthotics	0.09	0	0	0	0	0 0%	Static
Diagnostic Radiography	4.94	4.10	5.00	3.77	4.00	4.84 3.03%	Static
Therapeutic Radiography	3.00	3.00	2.00	2.16	3.47	3.35 3.76%	Static
Speech & Language Therapy	2.48	1.03	1.00	1.00	1.43	1.03 3.49%	Downward

During this reporting period, the impact of maternity leave is minimal. Physiotherapy is the only profession with an upward trend but remains manageable due to the new graduate over offer position. All AHP leads are proactively covering their maternity leaves where possible. Authority to recruit substantively to maternity leave (when indicated) aims to improve impact and recruitment within these specialties.

Absence

Table 3 – Absence by Profession July 2024 – December 2024 (combined long term and short term)

Profession	Jul 24 (wte)	Aug 24 (wte)	Sept 24 (wte)	Oct 24 (wte)	Nov 24 (wte)	Dec 24 (wte)	December RAG Rating
Dietetics	0.65	0.06	0.27	1.66	1.07	1.61	6.1%
Occupational Therapy	1.32	1.54	3.04	2.58	3.43	5.83	8.6%
ODP's	5.32	6.08	8.75	7.36	8.75	9.62	14.3%
Orthoptics	0.03	0	0.10	0.03	0.03	0.21	1.7%
Physiotherapy	3.68	5.47	4.23	4.01	3.53	2.91	2.8%
Prosthetics & Orthotics	0.06	0.45	1.07	1.61	0.55	0.13	0.55%
Diagnostic Radiography	7.55	7.05	6.55	6.33	7.23	10.23	6.4%
Therapeutic Radiography	3.79	4.97	8.13	9.32	5.85	5.79	6.5%
Speech & Language Therapy	0.74	0.17	0	0.49	1.12	1.76	5.9%

Absence rates in December 2024 for 3 AHP groups are meeting the Trust target and are rated green in table 3. All other groups have experienced an increase in absence rates between October and December and this is in keeping with the seasonal variation usually seen. Upon further exploration the majority is short term sickness absence, with the 2 radiographer areas experiencing a small number of long-term absences, all are being managed in line with policy. AHPs are part of the sickness improvement programme that is commencing within the organisation.

1.5 Overtime, Bank and Agency Usage

Overtime is the main source of additional resource for the AHPs, there is an identified gap in AHP bank services.

Overtime in Diagnostic Radiography is higher than other areas and correlates with their current high vacancy rate (14%) and sickness absence rate (6.4%).

The current AHP agency market is poor, even with approval to use, often no candidates can be sourced. In December 2024 2 of the 10 AHPs utilised agency, in Diagnostic Radiography this is linked to high vacancy. The agency use in Dietetics is unusual and was required to cover a specialist paediatric gap, this has since been recruited into and the agency use ceased.

There was no ODP agency spend in December, this is unlike previous reports and linked to the trusts financial recovery programme, there has however been an increase in incidents linked to theatre practitioner cover (section 7.3).

Table 4 – December 2024 WTE of overtime

Profession	Dec 24 Overtime (wte)	Dec 24 Bank (wte)	Dec 24 Agency (wte)
Dietitians	0	0	0.47
Occupational Therapists	0.58	0	0
ODP's	0.27	0.60	0
Orthoptists	0.58	0.63	0
Physiotherapy	0.14	0.14	0
Diagnostic Radiographers	3.97	1.18	0.73
Therapeutic Radiographers	1.19	0.46	0

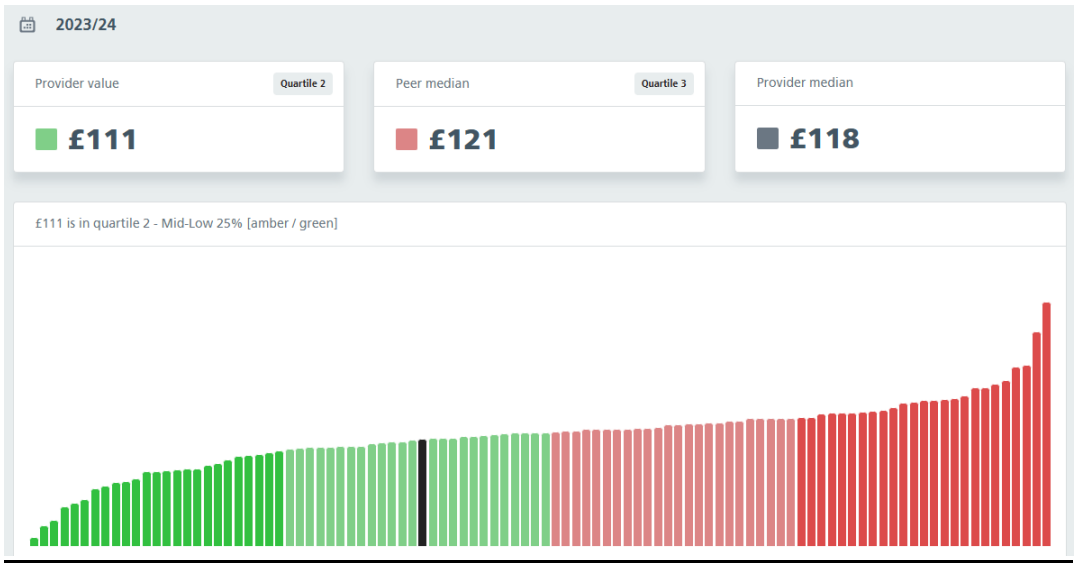
5.0 DELIVERING VALUE FOR MONEY

Model Health can be utilised to nationally benchmark some of our AHP workforce. The data currently available in Model Hospital is from 2023/24 (updated January 2025).

It does have some limitations in that the AHP establishment data can only be filtered down the following professions: Dietetics, Occupational Therapy, Physiotherapy, Speech and Language Therapy, Diagnostic Radiography and Therapeutic Radiography. It cannot be used to benchmark Orthotics, Prosthetics, Orthoptics or ODP's.

Model Health suggests a list of recommend peers, this group has been utilised below as the peer median.

Graph 6 - Workforce Output – AHP Cost per Weighted Activity Unit (2023/24)



Cost per weighted activity unit (WAU) is the headline productivity metric used within Model Health. This metric estimates the amount the organisation spends on pay for allied health professionals, both substantive and temporary, per WAU across all areas of NHS clinical activity. This is rated green from financial perspective but it is important to note that this is less than peer and national median is most likely limiting the potential impact on the productivity of patients through the inpatient services and their associated outcomes.

Table 5 - Full Time Equivalent (all AHPs – July 2024 data)

Full Time Equivalent and Cost	Data period	Provider value	Peer average	National value	National value method	Chart
Allied Health Professionals (FTE)	Q2 2024/25	588.88	658.54	568.68	Provider median	
AHPs as a proportion of all organisation staff	Q2 2022/23	6.8%	8.8%	8.5%	Provider median	

The Registered AHPs FTE is higher than national value but significantly lower than peer median (69.66 FTE less). The gap compared to peer has grown by 20 FTE over the past 12months. Indicating that similar sized Trusts with similar specialties have more registered AHPs in comparison. It is also important to note that the majority of peers are not cancer centres and do not employ Therapeutic Radiographers, which account for nearly 90wte at LTH, when these are removed from the LTH total the gap widens considerably.

Table 6 – Model Hospital Recommended Peers Benchmarking by Professional Group (2022/23 data)

Full Time Equivalent by Role	Data period	Provider value	Peer average	National value	National value method	Chart
All Allied Health Professionals (FTE)	Q2 2022/23	494.1	567.3	490.3	Provider median	
All Dietetics Staff (FTE)	Q2 2022/23	26.7	34.4	25.7	Provider median	
Registered Dieticians (FTE)	Q2 2022/23	22.1	30.5	22.9	Provider median	
Unregistered Dieticians (FTE)	Q2 2022/23	*	*	3.5	Provider median	
All Occupational Therapy Staff (FTE)	Q2 2022/23	57.0	74.3	67.6	Provider median	
Registered Occupational Therapists (FTE)	Q2 2022/23	55.1	60.9	54.9	Provider median	
Unregistered Occupational Therapists (FTE)	Q2 2022/23	*	18.3	12.0	Provider median	
All Physiotherapy Staff (FTE)	Q2 2022/23	93.4	168.9	139.3	Provider median	
Registered Physiotherapists (FTE)	Q2 2022/23	90.7	134.3	113.1	Provider median	
Unregistered Physiotherapists (FTE)	Q2 2022/23	*	36.5	26.4	Provider median	
All Speech and Language Therapy Staff (FTE)	Q2 2022/23	19.2	26.3	27.6	Provider median	
Registered Speech and Language Therapists (FTE)	Q2 2022/23	17.2	24.3	24.2	Provider median	
Unregistered Speech and Language Therapists (FTE)	Q2 2022/23	*	*	3.6	Provider median	
All Radiography Staff (FTE)	Q2 2022/23	281.6	234.3	160.6	Provider median	
Registered Radiography Staff (FTE)	Q2 2022/23	231.7	161.2	116.9	Provider median	
Unregistered Radiography Staff (FTE)	Q2 2022/23	49.9	74.8	36.1	Provider median	
Registered Radiographers (Diagnostic)	Q2 2022/23	146.1	159.0	111.2	Provider median	
Unregistered Radiographers (Diagnostic)	Q2 2022/23	47.2	46.2	31.0	Provider median	
Registered Radiographers (Therapeutic)	Q2 2022/23	85.6	38.1	38.4	Provider median	
Unregistered Radiographers (Therapeutic)	Q2 2022/23	*	*	3.2	Provider median	

Key comparisons are highlighted in yellow in the above table. This comparison data supports other sections of this report and suggests LTH are under resourced compared to peer in the following professions: Physiotherapy, Occupational Therapy and Diagnostic Radiography. Therefore, indicating a return on investment for these 3 professions may yield productivity benefits. The largest return on investment would be in Physiotherapy, where the current resource benchmark is in the lowest quartile.

The Speech and Language Therapy provider value is not accurate (LTH have an establishment of 26wte), therefore this comparison should be ignored, and work is ongoing to resolve the data submission inaccuracy.

It is important to note the higher number of Therapeutic Radiographers at LTH compared to peer average and national value, this is due to LTH being the regional provider of Radiotherapy services.

6.0 TRAINING

6.1 Training Compliance

Reporting of mandatory training for AHPs is the most accurate it has ever been, the new excel format with filters enables AHPs in isolation to be reported on in all areas.

Mandatory training compliance as of December 2024 (table 7) provides assurance of compliance in most training requirements and a much-improved position compared to previous reports. 6 of the 9 professional areas in table

7 are compliant in all metrics, this follows a period of focused attention by all the leads with the aim of delivering the mandatory training CQC 'must do'.

Orthoptists are red rated (88%) for BLS and safeguarding adults level 2, this is just 1 person due to the small size of the team. Speech and Language Therapy are in similar position with red ratings (86%) in infection control and health and safety, this equates to 2 people. Therapeutic Radiography have 1 red rated area, this is appraisals, there is a recovery action plan in place, compliance in this area has been a struggle due to their high sickness absence rate and ability to dedicate time for appraisals versus delivering cancer treatments.

Table 7 – Training metrics by Profession November 2024

Metric	Information governance	Conflict resolution	IPC	H&S	Fire	Adult BLS	Appraisal	SG Adult 2	SG Adult 3	SG Children 2	SG Children 3	M&H	Prevent
Profession	%	%	%	%	%	%	%	%	%	%	%	%	%
Dietitians	100	100	100	100	100	100	91	95	100	100	100	95	100
Occupational Therapists	96	100	93	100	100	96	91	98	91	97		97	100
ODP's	100	100	99	100	100	98	96	100	100	100		94	100
Orthoptists	95	100	94	100	94	88	94	88		94		94	100
Physiotherapists	99	98	96	98	97	94	96	97	100	98	100	97	99
Prosthetists & Orthotists	100	100	93	100	100	93	93	93		100		100	100
Diagnostic Radiographers & Sonographers	97	96	97	99	99	94	92	99	100	99	100	91	99
Therapeutic Radiographers	95	99	94	99	99	91	80	96		96		99	99
Speech & Language Therapists	97	93	86	86	100	97	97	92	100	100	100	90	95

7.0 GOVERNANCE

7.1 Star accreditation

Findings from the recent STAR Quality Assurance accreditation visits are highlighted in table 8. Of the 10 AHP groups 9 are part of the accreditation process, with 13 AHP departments accredited. AHPs contribute towards achieving STAR standards in each department they are present.

To date all 13 departments have achieved gold accreditation status. Despite recent changes to the accreditation process and it being harder to retain/achieve gold, all 9 AHP areas that were re-inspected during the 6-month reporting period retained their gold status.

Table 8 – STAR accreditation outcomes as of December 2024

Area	Star rating	1st Visit	2nd Visit	3rd Visit	4th Visit	5th Visit	6th Visit	7th Visit	8th Visit	15 Step Challenge (last visit)
Orthoptics Optometry		92%	99%	94%	95%	91%	91%	95%	97%	A
Radiotherapy outpatients		90%	97%	97%	92%	94%	98%	95%	94%	A
Specialist Mobility Rehabilitation Centre (SMRC)		93%	96%	95%	98%	98%	90%	97%	97%	A
Speech and Language Therapy		85%	99%	98%	98%	96%	92%	95%	96%	A
Interventional Radiology (IRDU)		95%	99%	99%	98%	98%	96%	97%	96%	A
MRI Scan RPH		95%	91%	94%	95%	96%	98%			A
Core Therapies RPH		72%	69%	89%	98%	96%	96%	94%	94%	B
Core Therapies CDH		79%	60%	89%	96%	89%	94%	96%	93%	A
CT Unit RPH		86%	92%	85%	90%	91%	91%	94%	95%	A
Nuclear Medicine		95%	91%	95%	96%	90%	93%	92%	97%	A
Sharoe Green Ultrasound		85%	95%	87%	93%	90%	91%	90%	94%	A
Main X-Ray RPH		91%	90%	89%	92%	93%	97%	92%	92%	B
Main X-ray CDH		87%	73%	86%	89%	89%	97%	92%	93%	A

ODP's do not have a specific accredited department like the above areas but are integral to the STAR inspections in all Theatre areas. The following 4 areas have ODP's contributing to their performance and have been awarded 3 gold stars and 1 bronze star. During this reporting period all areas except Main Theatres RPH were re-inspected, 2 retained their gold star statuses and unfortunately Sharoe Green Theatres lost their gold and reverted to bronze.

Table 9 – STAR accreditation outcomes (ODP) departments as of December 2024

Area	Star rating	1st Visit	2nd Visit	3rd Visit	4th Visit	5th Visit	6th Visit	7th Visit	8th Visit	15 Step Challenge (last visit)
Charles Beard Theatre		97%	89%	97%	94%	94%	94%	97%	98%	A
Main Theatres RPH		72%	80%	85%	89%	96%	95%	94%		A
Main Theatres CDH		98%	98%	94%	96%	95%	96%			B
Sharoe Green Theatres		79%	95%	97%	97%	95%	93%	96%	89%	A

7.2 Risk

There are currently 9 active AHP workforce related risks on the trusts risk register (see table 10). Since the last reporting period 4 have been controlled and closed (see table 11) and 1 new risk added. Over the past 12 months there has been a reduction in the number of AHP workforce risks, this is due to improved governance processes and a cleanse of the risk register, which includes combining similar risks and closing those within risk appetite.

8 out of 9 have been reviewed in the last 3 months and all have associated action plans, 1 risk requires a review.

At the last review 1 risk has increased in score:

- 1443 – Delayed listing of orthoptic appointments, has increased from a 6 to an 8

The following new risk has been added:

- 1967 - Insufficient substantive radiographers to staff the CT scanner service and scores a 12.

Table 10 – AHP Workforce Risk Overview

ID	Title	CBU	Current Score	Date of last review	Direction of score since last report	Action Plan
1967	Insufficient substantive radiographers to staff the CT scanner service	Division of Diagnostics & Clinical Support Services - RPH	12	20/11/2024	NEW	• Review Funding allocation • Complete service gap analysis
1007	Orthotic Clinical Management.	Trauma – PBC	12	30/12/24	→	• Increase staffing • Clinical spaces review

	Excessive Waiting Times					• Measure the impact
1117	SMRC Clinical Risk - Physiotherapy Referrals for Amputees	Trauma Clinical Business Unit - PBC	12	31/10/24	→	• Recruitment to additional band 6 physiotherapist.
1351	Reduced SLT Service to Workforce Pressures	Acute & Specialist Surgery - Trustwide	12	29/01/25	→	• Confirmation that B5 post(s) is funded • Review of referral form and process • Implementation of RAG rating system • Update on ongoing recruitment • Upload monitoring waiting times • Update on MCA project • Escalation SOP in place for SLT • 3 x B5s undergoing dysphagia training •
1824	Insufficient substantive anaesthetic practitioners across all theatres	Theatres & Day Case Surgery - Trustwide	10	27/11/24	→	• Active recruitment • explore if the reduction of agency hourly rate can be prevented • Providing recovery staff with anaesthetic course • All clinical Managers identifying shortfalls and following escalation pathway. • Gaining financial approval for staffing new floorplan & existing services not funded.
1818	Inability to meet inpatient service need in Core Therapies due to staffing constraints	Psychology & Therapies – RPH	10	17/01/25	→	• Big Room Deconditioning project ongoing • Discuss risk at DCS workforce committee • Outcome of Core Therapies over-recruit paper • Report for Single Improvement Plan • Burns and Plastics Business Case
1701	Insufficient AHP, pharmacy and psychology staff to consistently meet GPICS standards on CrCU	Critical Care, Pain & Outpatient Services Clinical Business Unit - RPH	9	29/01/25	→	• Look back exercise to identify and link all incidents • Identify current staffing levels across specialities in relation to GPICS
1443	Delayed listing of orthoptic appointments	Oncology, Head & Neck Clinical Business Unit - CDH	8	30/01/25	↑	• Meeting with the waiting list team to streamline booking appointments • Orthoptics Team to review and prioritise patients on the waiting list
1803	Bank Holiday working in Radiotherapy (limited number of AIMs trained staff)	Oncology, Head & Neck Clinical Business Unit - RPH	6	31/12/24	→	• Increase number of AIMs trained staff

Table 11 – Rejected and Controlled Risks

ID	Title	Updated position
614	Impact on staff well-being, recruitment and retention due to theatre over-runs	This risk has been closed and is being replaced with a new risk around theatre scheduling that will incorporate theatre overruns within this.
1122	Lack of Core Therapy on the Wards at the Weekend (Acute and specialist surgery)	Closed and linked to Trust wide therapy risk (ID 1818)
1819	Patients at risk of poor outcomes post surgery due to lack of therapy provision in out patient services	Controlled and closed
1822	Risk of patient harm due to the inability to provide a skin camouflage service	Controlled and closed

7.3 Datix Themes

Overview

A total of 125 Datix were raised between July 2024 – December 2024. All incidents were level 1 (green), with 118 categorised as 'no harm' and 7 as 'low harm'.

Of the 'no harms' 8 were a 'near miss'. 124 incidents are now closed, 1 incident is still open and under review.

In comparison to the last report to committee the theme of staff shortages continues to run throughout the narrative of all incidents raised within all categories of incidents, largely due to staff absence. This is then noted as being compounded by additional vacancies causing further stress to colleagues creating more sickness

absence. Compared to last reporting period this has continued to be present across a wide number of services and staff groups across the AHP workforce.

3 staff groups account for 90% of all Datix raised. These are Physiotherapy, Occupational therapy (referred to collectively as Core Therapies), and Diagnostic Radiography. Core therapies are consistently the top reporting area, however, compared to other reports there is a significant increase in incidents reported from Diagnostic Radiography and this triangulates with high vacancy and sickness absence creating service disruption.

Lack of staff cover was particularly highlighted for the acute medical therapy team at all locations but particularly at Chorley Hospital (CDH), burns and plastic therapists and therapy to support critical care and neurosurgery departments. Lack of cover was also a common theme for diagnostics and theatre cover.

Data Summary and Analysis

Table 13 – AHP Workforce Datix Summary

Total no. Datix	Incident Level		Level of Harm				Near miss	Datix status		
	Level 1	Level 2	Severe Harm	Moderate Harm	Low Harm	No Harm	Yes	Under Review	Closed	Monitoring
125	125	0	0	0	7	118	8	1	124	0

Severe Harm

No incidents recorded as severe harm for this reporting period.

Moderate Harm

No incidents recorded as moderate harm for this reporting period.

Low Harm

Of the 7 low harm incidents, 4 are linked to Outpatient Physiotherapy appointment availability, which is reduced due to the vacancy freeze and further compounded by a 40% administration vacancy which reduces appointment booking efficiency. 2 of the 7 were linked to ODP availability and theatre activity and 1 was due Speech and Language Therapy response times delaying a discharge.

Near Misses

The 8 identified as ‘near miss’ incidents were categorised as:

- Insufficient number of healthcare professionals (7) – Therapies and Radiographers
- Medical Devices/Equipment – not available (1) – Harris Flex downtime

AHP staff type by location with high proportion of incidents

5 specialty areas accounted for 81% of all Datix raised. These are:

1. Core Therapies CDH (Mainly Acute Medicine)
2. Theatres & Anaesthetics CDH
3. Critical Care RPH
4. Burns and Plastics Therapy
5. Theatres & Anaesthetics RPH

3 staff groups accounted for 90% of all Datix raised. These are:

1. Physiotherapists
2. Diagnostic Radiographers
3. Occupational Therapists

Summary and numbers of Datix are shown in table 14.

Table 14: AHP staff type by location with high proportion of incidents

AHP staff type by location	Physiotherapy	Core Therapies (integrated Physiotherapy and Occupational Therapy Teams)	Diagnostic Radiography
Core Therapies CDH	0	27	0
Theatres & Anaesthetics CDH	0	0	26
Critical Care RPH	1	18	0
Burns and Plastics Therapy	0	18	0
Theatres & Anaesthetics RPH	0	0	1

Core Therapies (Physiotherapy and Occupational Therapy) remain the highest reporting location. At Preston the majority of incidents are related to Critical Care, Neurosurgery and Acute Medicine and at Chorley they are all attributed to Acute Medicine.

This is the first report where Theatres have featured as a top reporting location, this is directly due to the Diagnostic Radiography resource (depleted through vacancy and absence) and the required deployment to the multiple theatres at the same time.

The next top reporting AHP group would be ODP's, with 6 incidents attributed to the availability of ODPs for Theatre activity, this correlates with no agency spend for ODP's during half of the reporting period.

Table 15 – AHP Workforce Datix Category

Datix Category	Datix Category Total
Systems & Equipment	**79**
Insufficient number of healthcare professionals	58
Insufficient number of support staff	20
Medical devices/equipment – not available	1
Clinical Care	**29**
Failure/incomplete/insufficient monitoring of patient	26
Deconditioned Patient	2
Communication between staff/teams incomplete	1
Diagnostic	**7**
Delayed diagnostic conclusion	1
Imaging investigation – delayed	5

Physical diagnostic examination not carried out	1
Treatment/Surgery	**5**
Treatment/surgery delayed	3
Treatment/surgery not available	1
Treatment/surgery not completed	1
Environment	**3**
Workplace stress/demands	3
Admission/Transfer/Discharge	**2**
Discharge delayed	1
Referral delayed	1

Although the Datix reports are split into the categories as shown in table 14, on further interrogation of the reporting narrative given almost all show root cause was staff shortages due to under resourced teams, sickness absence and vacancy rates with a few exceptions related to operational pressures.

8.0 CONCLUSION

This report details the findings of the LTH bi-annual AHP workforce review to provide an overview of the developing mechanisms in place to assess the impact of the AHP workforce on safety and quality. The report is currently heavily focused on attendance and standards within the service and is based on the best available data. The report has evolved over time to display AHP establishment and vacancy rates as SPC charts, resulting in visible and clear trends over time.

A number of successes and improvements have been delivered between July 2024 and December 2024 these include:

- Successful succession planning and recruitment into the Head of Speech and language Therapy role
- Delivery of year 2 of the AHP workforce strategy
- Improved vacancy rates in Physiotherapy and Occupational Therapy
- Reduction in agency spend for ODPs
- Significant improvement in training compliance across all AHP areas
- All 13 AHP STAR departments are gold, and all 9 re-inspected areas retained their gold status
- Risk maturity, through combining risks and closing those within risk appetite

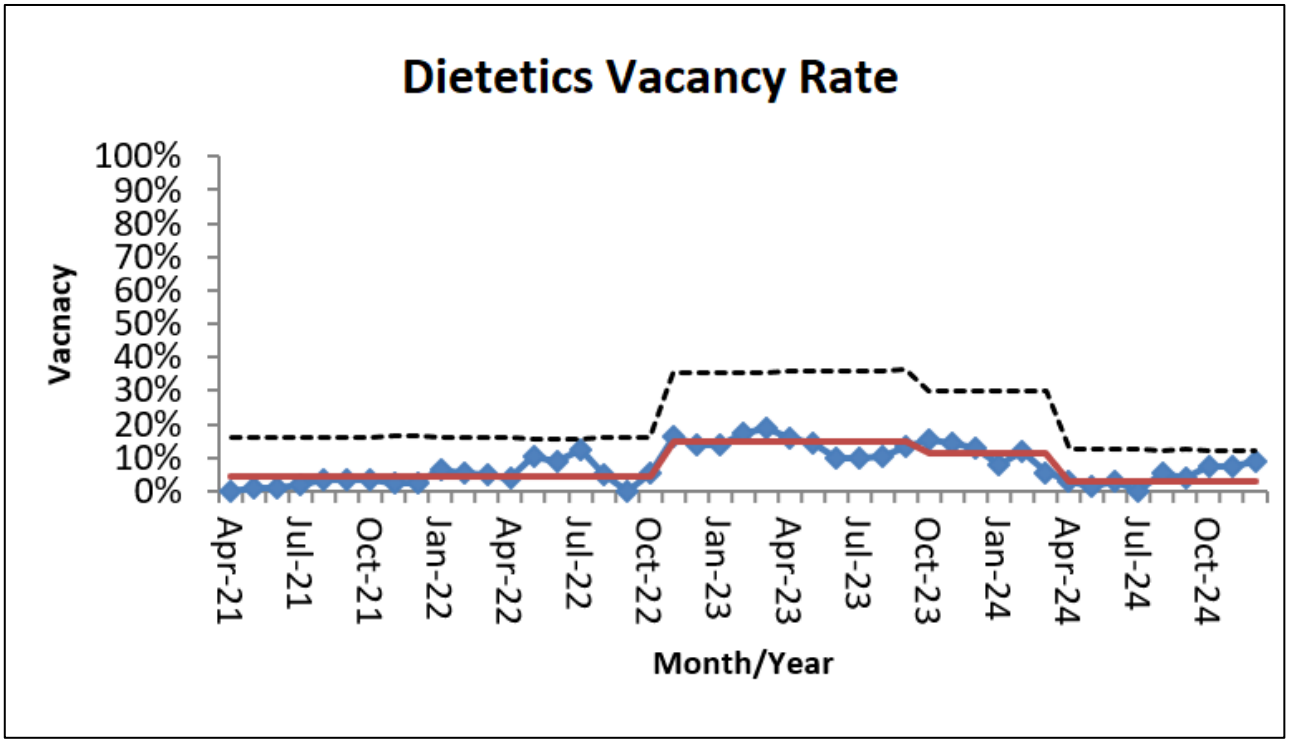
Areas for continued development are:

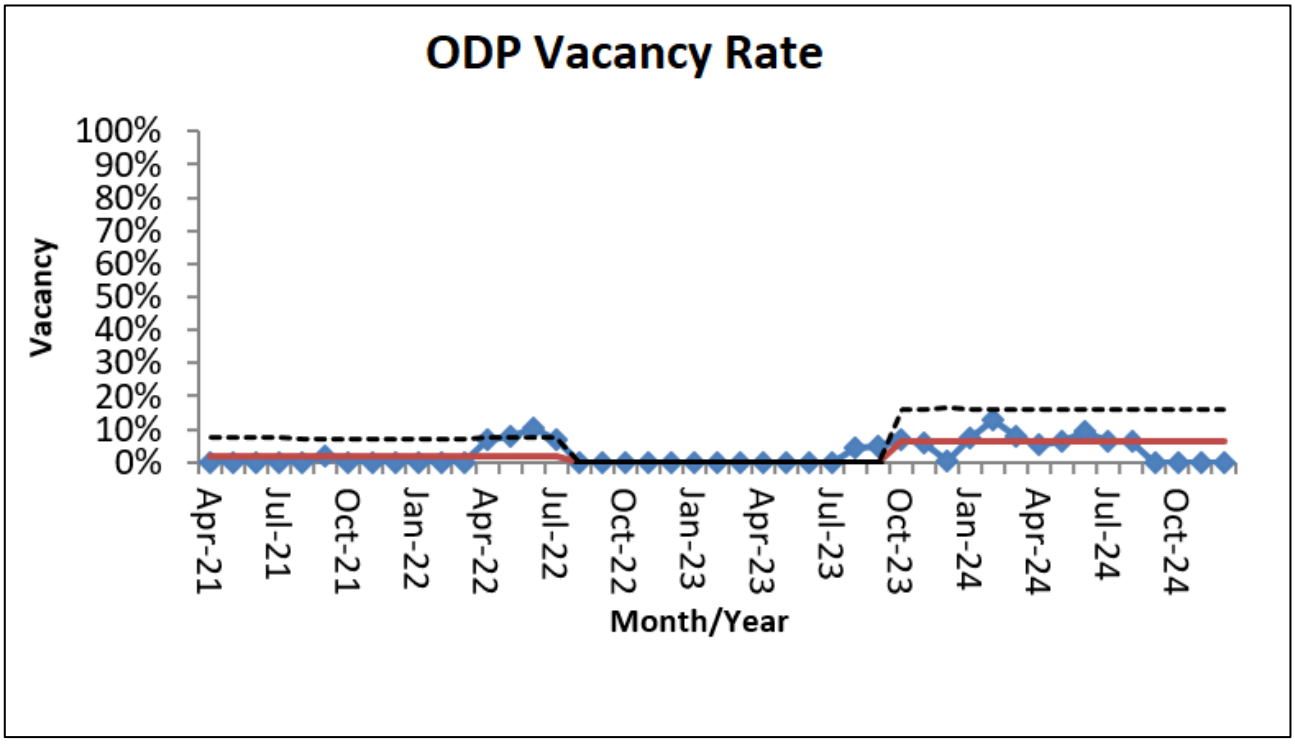
- Speech and Language Therapy and Diagnostic Radiography vacancy rates
- Sickness absence rates in all AHP areas except Orthoptics, Physiotherapy and Prosthetics & Orthotics
- Appraisal compliance in Therapeutic Radiography (recovery action plan in place)
- Physiotherapy and Occupational Therapy establishments to support, length of stay, patient flow and deconditioning as evidenced in section 5 (Model Health) and 7.3 (Datix summary)
- Job planning for AHPs

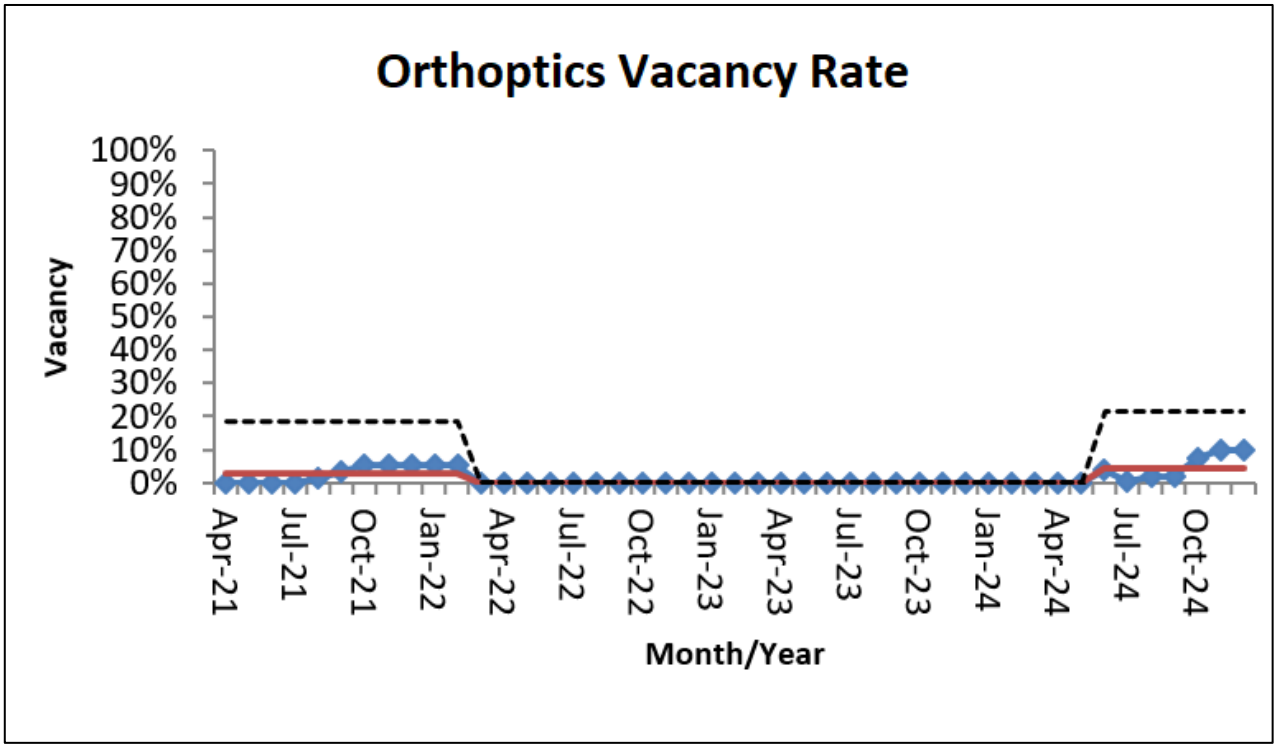
9.0 RECOMMENDATIONS

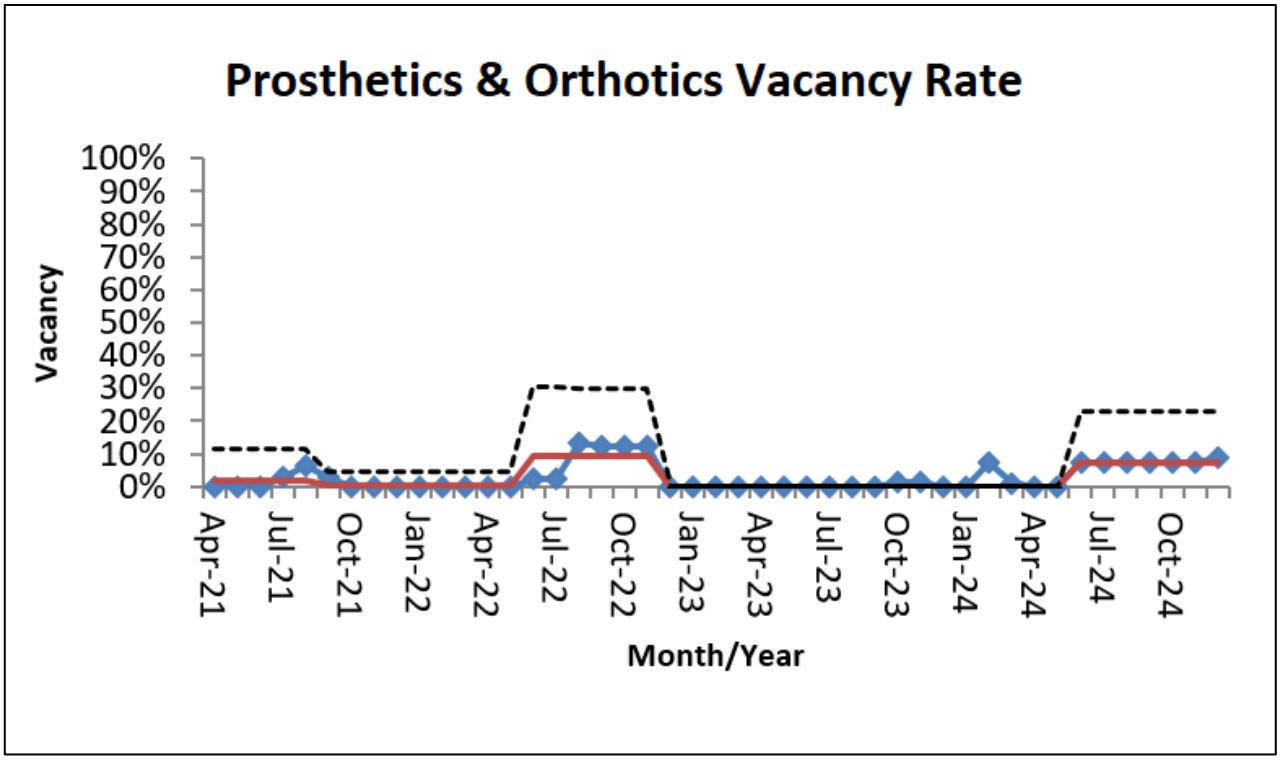
The Board of Directors are asked to receive this report for information and assurance the safety and quality committee have scrutinised the report and confirmed it is assured of the Workforce safeguards within AHP services.

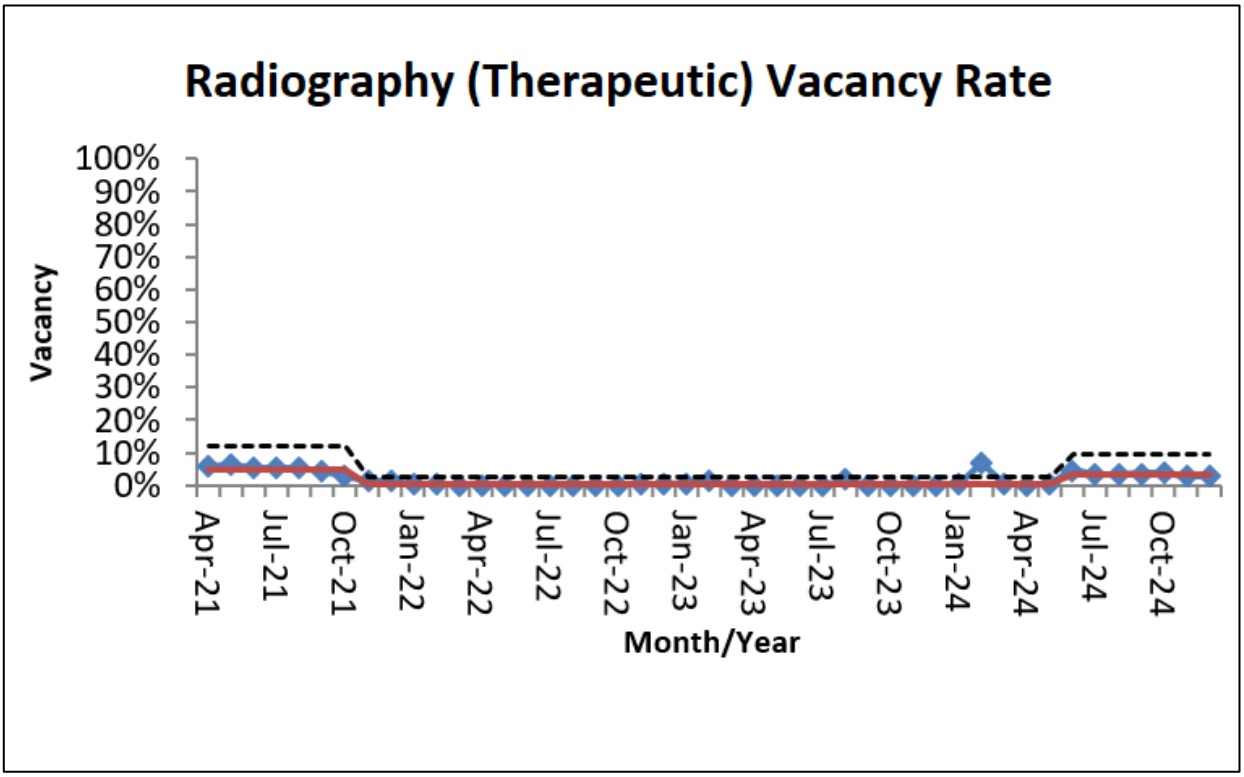
Appendix 1 – AHP Vacancy SPC Charts (areas of no concern)






Orthoptics Vacancy Rate
Vacancy
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr-21
Jul-21
Oct-21
Jan-22
Apr-22
Jul-22
Oct-22
Jan-23
Apr-23
Jul-23
Oct-23
Jan-24
Apr-24
Jul-24
Oct-24
Month/Year


Prosthetics & Orthotics Vacancy Rate
Vacancy
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr-21
Jul-21
Oct-21
Jan-22
Apr-22
Jul-22
Oct-22
Jan-23
Apr-23
Jul-23
Oct-23
Jan-24
Apr-24
Jul-24
Oct-24
Month/Year


Radiography (Therapeutic) Vacancy Rate
Vacancy
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr-21
Jul-21
Oct-21
Jan-22
Apr-22
Jul-22
Oct-22
Jan-23
Apr-23
Jul-23
Oct-23
Jan-24
Apr-24
Jul-24
Oct-24
Month/Year

Appendix 2

AHP Safety and Quality Action Plan – December 2024

Key	
Delivered	
On Track	
Overdue/Risk to delivery	

Number	Report Section	Area of Concern	Required Action	Date to be Completed	Lead(s) Responsible	Update	RAG
1	4.4	Speech and Language Therapy vacancy rate remains above Trust target (14% December 2023).	• Await progression of vacancy freeze process • Continue to exhaust all supply routes. • Innovative recruitment to ensure roles are as attractive as possible. • Focus on retention going forwards.	Aug 25	LS	• 3 posts approved end of March at VCP and out to advert -await outcome of recruitment	
2	4.4	Diagnostic Radiography vacancy rate remains above Trust target (14% December 2024).	• Await progression of vacancy freeze process • Promotion of the service/team. • Focus on retention going forwards.	Aug 25	KC	• Number of posts now approved at VCP and out to advert – await outcome of recruitment	

3	4.4	Absence rates across 6 AHP areas are high than acceptable (Dietetics, Occupational Therapy, ODPs, Diagnostic Radiography, Therapeutic Radiography & Speech and Language Therapy)	• Seasonal variation evident • Ensure all long-term absences are being followed according to policy	May 25	PC AT AB KC GC LS	• Improvement noted in March data, supporting seasonal variation. • Long-term absences discussed in Chief AHP 1-1 and assurance gained on management • No themes identified	
5	6.1	Appraisal compliance in Therapeutic Radiography (80% December 2024)	• Recovery action plan • Area of focus for the department. • Protected time for staff to complete. • Plan ahead to prevent non-compliance.	Jun 25	GC	• Action plan in place, on track for compliance by June nmtrw 2025 • Being balanced with service delivery • Continued focus required.	