NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS ANCILLARY PACK

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2 October 2025

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AGENDA

BOARD OF DIRECTORS PART I ANCILLARY PACK

Items:
9.1 - Trust Strategy
9.2 - Winter Plan
10.2 - Green Plan
11.2 - GMC Revalidation Report (Medical Appraisal Report)
12.2 - Mid-year - Maternity Service Safe Staffing Report
12.3 - Mortality Annual Report
12.4 - Mid-year Nurse Staffing Report
14.1 - Data Quality assurance report
14.2 - Social Value Strategy

9.1 - TRUST STRATEGY

REFERENCES

Only PDFs are attached

9.1 - Trust Strategy - Final Version for Board 300925.pdf

Lancs Improvement Method

NHS
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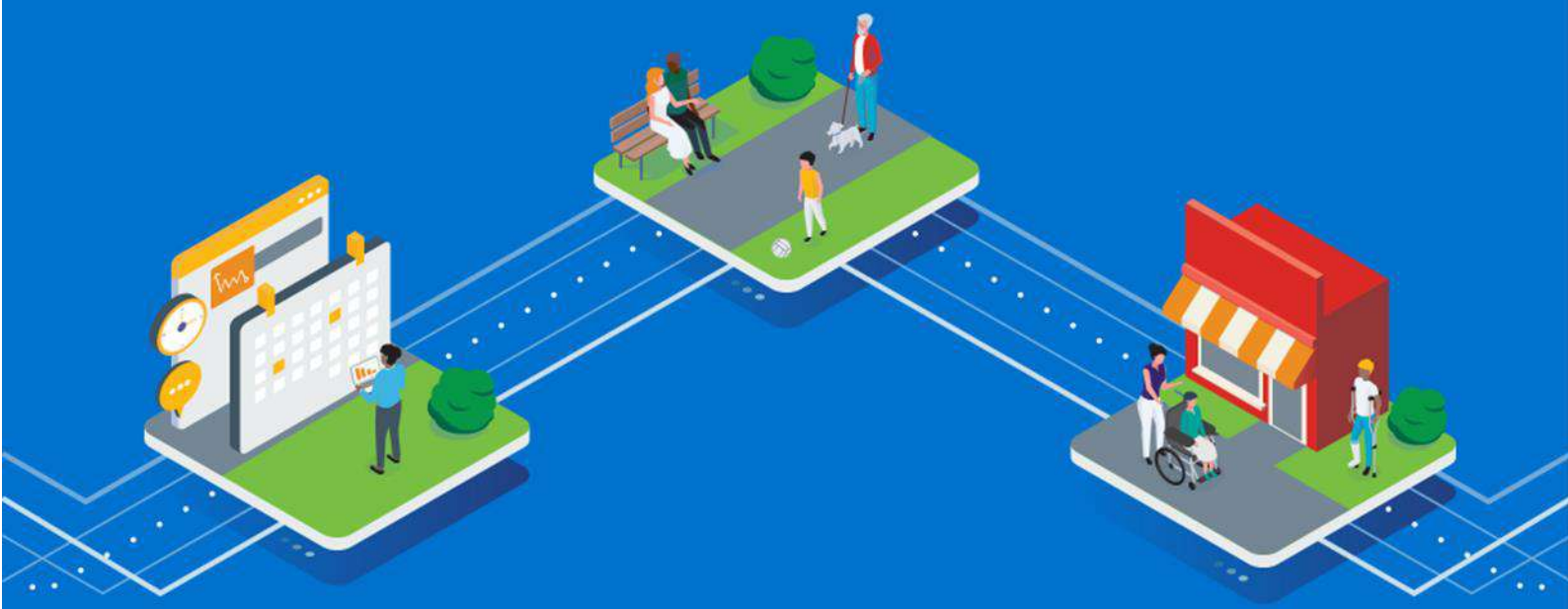
NHS Foundation Trust

Our Trust Strategy
2025 - 2030



From analogue to digital

From sickness to prevention

From hospital to community

Contents

Our Trust Strategy 2025-2030

Patients | Performance | People | Productivity | Partnership

Our Trust Strategy

Our roles

- The lead provider for specialist services in Lancashire and South Cumbria and a provider of excellent local services.
- A leading centre for Continuous Improvement, Education, Research and Innovation.
- A leader in reducing health inequalities.
- An Anchor Institution putting social value and sustainability at the centre of our work with our communities.

Our Approach and Services

- Cancer
- Children and young people
- Community and local services
- Diagnostics

Innovate and transformational in the design and delivery of care for our patients and local populations.

We commit to sharing service from hospital to community and a shift from treatment to prevention, underpinned by a shift from analogue to digital.

We will work in partnership to reduce health inequalities and improve access to care.

We will continually improve services through research, innovation and the Lancashire Improvement Method.

- Long term conditions
- Pathology
- Specialised services
- Urgent and Emergency
- Women's health, Maternity and Neonates

Our Sites

- Royal Preston Hospital
- Chorley and South Ribble Hospital
- Broadoaks
- Preston Business Centre
- Community Diagnostic Centre

Welcome

to our Trust Strategy 2025-2030

Introduction

Our aim is to become a leading **Accountable Healthcare Organisation** within the Lancashire and South Cumbria system. In doing so, we will develop an affordable and sustainable model of healthcare for our organisation and the local population. This strategy provides a blueprint for the roles we aim to play as an organisation within our system and outlines our vision for our sites and the redesign of our clinical services in line with the national Fit for the Future 10 Year Health Plan for England[1]. It has been developed through engagement and listening sessions with our people, our patients and local population and our partners who have all shared their vision and ambitions for the future with us. We extend our sincere thanks to them.

Our Trust strategy sets out the context for our organisation, and outlines how we will develop services fit for the future by focusing on our five Ps:

- **Patients:** we will improve access, patient experience, safety, quality of care and outcomes by leveraging advanced technologies and developments in science.
- **Partnerships:** We will strengthen collaborations with local health and social care providers and the Voluntary Community, Faith and Social Enterprise sector to integrate care services to ensure seamless and coordinated patient care. We will also strengthen our partnerships with local universities building our research to improve patient outcomes.
- **People:** we will invest in the development of our colleagues to be the best version of us; our culture counts.
- **Performance:** we will implement performance improvement programmes to monitor and enhance the quality of care provided, ensuring that we work towards meeting and then exceeding national standards.
- **Productivity:** we will focus on optimising our resources and reducing inefficiencies within our healthcare system to improve infrastructure and patient experience and outcomes.

Each year we will establish annual corporate objectives which will ensure we stay on track to deliver this strategy. Our progress will be reported to Board through the Single Improvement Plan.

Our Changing Context

As we have developed this strategy we have focused on the organisation's long standing financial deficit and have identified the top five drivers of deficit which have been incorporated into our planning as we effectively tackle the deficit and plan for an affordable and sustainable model for the future. The following current and significant shifts in context have informed the development of our strategy:

1. **Changes to the NHS infrastructure:** NHS England and the Integrated Care Boards are undergoing major change with a plan for NHS England to transition its functions to the Department of Health and Social Care and the role of ICBs is changing for them to become more focused on commissioning
2. **The Clinical Vision for Lancashire and South Cumbria**: The clinical blueprint and ICB 2030 roadmap for the Integrated Care System recommends Lancashire Teaching Hospital as the specialist centre for Lancashire and South and this vision has underpinned the planning of this strategy
3. **An increased focus on reducing health inequalities:** partners across our system have been working together on a shared vision and commitment to reduce health inequalities. Our commitment as a Board is to continue to work in partnership to deliver on this commitment.
4. **The changing demographics of our local population**: the modelling undertaken for the New Hospital Programme has highlighted the changing demographics of our local population and illustrates the transformation needed to develop fit for the future clinical models of care
5. **Optimising the use of digital, science and technology** as we redesign our services. The Fit for the Future 10 Year health Plan for England sets out the vision for digital, artificial intelligence, personalised medicine and science; this vision has been fully considered in developing our strategy.

[1] Fit For The Future, 10 Year Health Plan for England, https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future/fit-for-the-future-10-year-health-plan-for-england-executive-summary

Overview

Our Trust Strategy has three main sections:

Our ambition and Role

- Our ambition to become an Accountable Healthcare Organisation within Lancashire and South Cumbria and in doing so deliver an affordable and sustainable model for the future
- Our role as the provider of specialist services for the population of Lancashire and South Cumbria and a provider of local services for the population of Central Lancashire.
- Our role as a centre for Continuous Improvement, Education and Research and Innovation
- Our role as an Anchor Institution – as a large public sector organisation we are committed to improving the health and wellbeing of the population that we serve

Our Services

Our vision for all our clinical services and the clinical services we plan to provide over the next 5 years are in line with the Integrated Care System clinical blueprint and priorities. Our vision for these services is shaped by the Fit for the Future 10 Year health Plan for England[1]. This seizes the opportunities provided by new technologies, medicines and innovations to deliver better care for all our patients. We will work with partners to make 3 big shifts in how we work and deliver care:

- From hospital to community
- From analogue to digital
- From sickness to prevention

We will work to improve our clinical services across the following themes:

- Cancer
- Children and Young People
- Community and local services
- Diagnostic and clinical support services
- Long term conditions
- Pathology
- Specialised services
- Urgent and Emergency care
- Women's health, maternity, and neonates

Delivering our Strategy

The National Health Service (NHS) is at a historic crossroads following Lord Darzi's investigation that revealed the NHS was in a 'critical condition' necessitating major reform. The Fit for the Future 10 Year health Plan for England is a plan to create a new model of care, fit for the future. The plan retains the NHS's founding principles of universal care, free at the point of delivery, based on need and funded through general taxation - and from those foundations, entirely reimagines how the NHS designs and delivers care so that patients have real choice and control over their health and care.

Our commitment through this strategy is to ensure science and technology are central to this reinvention, as we work towards offering instant access to advice and appointments. We will move towards a service that predicts and prevents ill health rather than simply diagnosing and treating it. In line with the national plan our aim is to create a patient-controlled system, in place of centralised bureaucracy and one where frontline staff are empowered to reshape services. Through this strategy we will design our services with the core principles and values of the NHS but with the know-how of a wider network of technology, life sciences, local government, civil society and third sector organisations, working in partnership to improve the health of our local population, narrowing health inequalities.

Despite the scale of the challenge we face, there are many reasons for optimism. The NHS is well placed to harness the advances in artificial intelligence (AI) and genomic science. We are also well placed to build on the extensive work we have undertaken to improve the access, quality of care, safety and the experience of all the patients that we serve. We will deliver this strategy through our Single Improvement Plan, working in partnership across our system.

Professor Mike Thomas
Chair

Professor Silas Nicholls
CEO

Developing the strategy

Our Context

Financial Sustainability: Our Commitment

Lancashire Teaching Hospitals, like many NHS trusts, has faced significant historic financial challenges arising from increasing demand on services, rising operational costs, and the necessity to maintain an ageing estate and equipment. These pressures have, at times, limited the pace of investment in new models of care and innovation, making it more difficult to deliver the high standards our communities deserve.

To address this, the Trust has strengthened its financial governance, established value-driven improvement programmes, and pursued efficiencies through system-wide collaboration. Our approach includes working with partners to ensure effective use of our resources, better allocation of resources, better partnerships and collaborative working with neighbouring organisations, and exploring new models of care and service delivery to ensure affordability and financial sustainability. By systematically reviewing expenditure, investing in preventative care, and harnessing digital transformation, we are building a more robust foundation for long-term affordability in line with the NHS England ten-year health plan for England.

We are firmly committed to developing affordable, sustainable health care for the people of Lancashire as we move towards becoming a fully accountable healthcare organisation. This means making decisions transparently, holding ourselves to the highest standards and continually striving for best value.

The benefits for Lancashire and South Cumbria will be considerable: enhanced access to care, reduced health inequalities, and the ability to invest in local services that best serve our population. By pursuing financial sustainability, we safeguard the future of high-quality care, foster local innovation, and create a healthcare system that is resilient and truly responsive to the needs of our communities.

Our approach to the development of this strategy

Throughout 2024/2025 we have engaged with our people, patients, local population and partners, hosting listening events. We have also reviewed key publications including the Fit for the Future 10 Year health Plan for England, The Dr Penny Dash review[2], the Lancashire and South Cumbria 2023 roadmap and clinical blueprint and Professor Sir Chris Ham's report Improving Health and care and scale[3]. The intelligence and insights gained from these key publications and the views and opinions collated from our engagement events have been used to inform the development of this strategy.

[2] Department of Health and Social Care. (2025). Review of patient safety across the health and care landscape. *Chaired by Dr Penny Dash*.
[3] Ham, C. (2023). Improving health and care at scale. *NHS Confederation*, 2023-11.

Our Strategic Framework

Our new strategic framework is built upon our vision, purpose and values, and is organised around five priorities (our 5 Ps). These will be the focus of the next five years to achieve our strategy. This framework summarises the key areas for our development and improvement, forming the basis of our annual corporate objectives and guiding decision-making.

Strategic Priorities

Patients

We aim to put patients at the core of everything we do, treating them with respect and dignity to deliver personalised care and a patient experience of the highest quality. Our priorities include working with patients, families, and carers to better manage their health and wellbeing, reducing health inequalities through prevention strategies, earlier diagnosis, and delivering outstanding care and treatment, often closer to home with seamless integrated services.

Partnerships

We believe in delivering high-quality healthcare through strong partnerships, transforming services, and making a positive contribution to our local communities, recognising that we are stronger together through collaboration and shared purpose.

Performance

We will implement performance improvement programmes to monitor and enhance the quality of care provided, ensuring that we work towards meeting and then exceeding national standards to improve health outcomes.

People

We strive to ensure we have the right number of people, in the right place, with the right skills, creating an inclusive environment where our colleagues can reach their full potential and be the best version of themselves, as our culture counts.

Productivity

We are committed to working smarter to deliver better care, optimising our resources, and reducing inefficiencies within our healthcare system to improve infrastructure and enhance patient experience and outcomes.

Our values and enabling strategies

Our values were created by our staff over ten years ago and, despite being reviewed and developed, they have remained the bedrock of our organisation, guiding everything we do as we grow to achieve our vision.

Our Enabling Strategies

These strategic objectives are supported by key enabling strategies, including technology and digital, always safety first, estates and facilities, continuous improvement, finance, and workforce. This framework helps individual services align their priorities and plans with our overarching Trust objectives.

- **Always Safety First**
- **Digital**
- **Estates & Facilities**
- **Financial sustainability plan**
- **Social Value**
- **Workforce**

Aligning our Strategy to the Fit for the Future NHS 10 year Health Plan

Patient-Centred Care:

Prioritise the needs and preferences of patients in all aspects of care delivery, ensuring that services are tailored to individual needs and that patients are actively involved in their care decisions.

1. **Integrated Care** - Foster collaboration and integration across primary, community, and hospital care to provide seamless and coordinated services, reducing fragmentation and improving patient outcomes.
2. **Innovation and Technology** - Embrace and leverage advanced technologies, such as telemedicine, electronic health records, and AI-driven diagnostics, to enhance patient care, improve efficiency, and streamline healthcare processes.
3. **Workforce Development** - Invest in the continuous professional development of healthcare staff, ensuring they have the skills and knowledge to meet the evolving needs of the healthcare system and provide high-quality care.
4. **Preventive Health** - Focus on preventive measures by promoting healthy lifestyles, early detection of diseases, and regular health screenings to reduce the burden of chronic diseases and improve overall population health.
5. **Equity and Inclusion** - Address health inequalities by ensuring that all individuals, regardless of their socio-economic status, have equal access to healthcare services and that care is culturally sensitive and inclusive.
6. **Sustainability** - Implement environmentally sustainable practices in healthcare delivery, reducing the carbon footprint and promoting the efficient use of resources to ensure the long-term sustainability of healthcare services.
7. **Quality and Safety** - Maintain a relentless focus on quality and safety, continuously monitoring and improving the standards of care to ensure that patients receive the best possible outcomes.
8. **Patient and Public Engagement** - Actively engage with patients, carers, and the public to gather feedback, understand their needs, and involve them in the design and delivery of healthcare services.
9. **Resilience and Adaptability** - Build a resilient healthcare system that can adapt to changing circumstances, such as emerging health threats and evolving patient needs, ensuring continuity of care and preparedness for future challenges.

Our Strategic Priorities

Our commitment through this strategy is to ensure science and technology are central to the reinvention of the NHS, as we work towards offering instant access to advice and appointments and moving towards a service that predicts and prevents ill health rather than simply diagnosing and treating it. In line with the national plan, our aim is to create a patient-controlled system, in place of centralised bureaucracy, where frontline staff are empowered to reshape services. We will design our services based on the core principles and values of the NHS, enhanced by the expertise of a wider network of technology, life sciences, local government, civil society, and third-sector organisations, working in partnership to improve the health of our local population and narrow health inequalities.

To strengthen our system role, we will focus on:

- **Being a collaborative system partner**: Working with partners across Lancashire and South Cumbria to prevent ill-health, reduce health inequalities, invest in research and innovation, and develop fully integrated care, bringing together our teams to develop integrated pathways across primary, community, and secondary care.
- **Being a recognised centre of excellence for specialist care**: Building on existing examples of excellence to deliver nationally recognised specialist care, striving to be an exemplar for access to services, patient experience, quality, safety, and clinical outcomes. This will be achieved through enhanced collaboration with academia, aligning with our ambition to achieve University Hospital Status, and stronger links with industry.

Becoming an Accountable Healthcare Organisation: Our Commitment and Approach

To further our dedication to equity, sustainability, quality, and patient engagement, we are committed to applying for designation as an Accountable Healthcare Organisation (AHO), aligning with the ambitions of the NHS England Long Term Plan and guidance from both NHS England (NHS E) and the Department of Health and Social Care (DHSC). This move will formalise our responsibilities for population health outcomes, financial stewardship, and integrated care delivery, ensuring we deliver better results for our community.

Alignment with National Strategy

The NHS England Long Term Plan sets out a clear vision for transforming health and care through integrated care systems, prevention, and a relentless focus on reducing health inequalities. Becoming an AHO enables us to take collective responsibility for the health and care needs of our defined population, working in partnership with local authorities, primary care networks, and community organisations. Our application to become an AHO will be rooted in national guidance, including the "Integrated Care Systems: Implementation Guidance" and "Delivering the NHS Long Term Plan," which emphasise accountable, place-based leadership, strategic commissioning, digital innovation, and outcomes-based care.

We will ensure our approach reflects national priorities, such as:

- Reducing unwarranted variation in clinical outcomes and experience
- Proactive management of long-term conditions and prevention of ill health
- Delivering services closer to home, supported by digital health solutions
- Building strong collaborative networks across providers, commissioners, and local partners
- Delivering financial and operational sustainability, with transparent reporting
- Promoting equality, diversity, and inclusion for staff and patients

Our Application Process

Our journey will begin with a comprehensive review of our readiness, using the NHS England's self-assessment tools and maturity matrices for system working and integration. We will engage our Board, clinical leaders, staff, patients, and partners in shaping our application, ensuring it reflects both local needs and national expectations. Key steps will include:

- Developing a robust case for change, demonstrating improved outcomes and value
- Outlining governance structures for accountability and population health management
- Detailing our approach to digital transformation and data-driven decision-making
- Establishing clear mechanisms for patient and community involvement
- Committing to transparent reporting, benchmarking, and continuous improvement

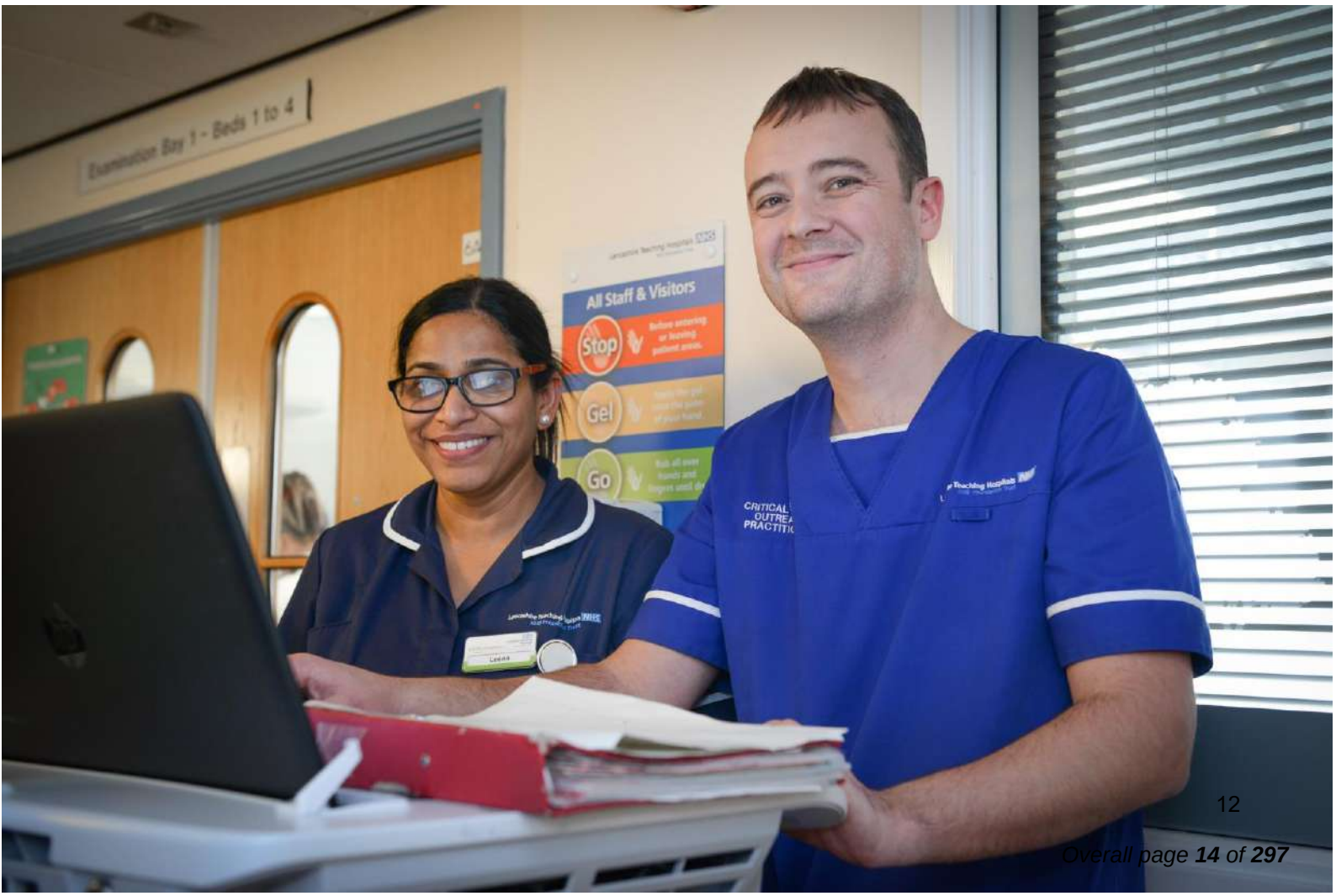
We will submit our application with supporting evidence of our track record in collaboration, quality improvement, and financial stewardship, and set out clear metrics for success. Ongoing support and oversight from NHS E and DHSC will guide our development.

Benefits of Becoming an Accountable Healthcare Organisation

Embracing AHO status will bring significant benefits to our organisation, our staff, and, most importantly, our population:

- Improved Health Outcomes: Integrated, patient-centred care pathways will result in better health and wellbeing for our population, with a focus on the most vulnerable.
- Reduced Inequalities: Systematic approaches to addressing inequalities will ensure fair access and outcomes for all, regardless of background or circumstances.
- Enhanced Patient Experience: Proactive engagement and co-design will make services more responsive to what matters most to patients and carers.
- Workforce Empowerment: Staff will benefit from a supportive, collaborative culture and opportunities for continuous learning and improvement.
- Financial Efficiency: Shared accountability for resources will drive efficiency, value, and sustainability in the use of public funds.
- Resilience and Innovation: Integrated leadership and data-driven approaches will make the system more adaptable to emerging challenges.

Our aim is to become a model for accountable care, one that delivers outstanding outcomes, reduces health inequalities, and puts patients and communities at the heart of everything we do. By applying for AHO status, we are taking the next step towards building a healthier, fairer, and more sustainable future for all.



Becoming a Well Led Organisation

The board has undertaken engagement with our local population, partners and colleagues over the last year to listen to what matters the most to our local people. We have developed and are launching this new five-year Trust Strategy to ensure that we have a credible strategy to provide quality, sustainable services to patients and that there is a robust plan to deliver this through our Single Improvement Plan and our Accountability Framework. As a clinical organisation we have incorporated our commitments for the development of our clinical services into this Trust Strategy, so this is also our Clinical Strategy.

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

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

Our values

- Caring and compassionate
- Building team spirit
- Recognising individuality
- Seeking to involve
- Taking personal responsibility

Our priorities

- Patients
- Performance
- People
- Partnerships
- Productivity

As we implement the strategy, we see our role developing in three important areas

1. **As the Provider of Specialist care** for Lancashire and South Cumbria and the **provider of local services** for Central Lancashire
2. **As a leading centre** for continuous improvement, education, research and innovation, gaining University Hospital status
3. **Our role as an Anchor Institution**, provides long-term sustainability linked to the wellbeing of the population we serve

The focus of our Board

Is curious

- **Proactively** looks for problems
- Supports **thematic** reviews
- **Triangulates** multiple sources to identify potential problems
- Listens, learns and asks **why?**

Ensures effective board and committee **structures and behaviours** in place

Takes necessary actions

- **Understands** the issues
- Identifies options
- Allocates **resources**
- Agrees **timing and delivery**

Encourages **open reporting** up and down the organisation

Receives **timely** information

The board

Sets **priorities** across the organisation

Follows up on decisions

Requires continuous assurance

Reviews:

- **quality of care**
- progress against **strategy**
- meeting of **standards**
- delivery of **improvement**

Uses third party information and benchmarks

Supports staff and system

- 'Takes the pulse' of **patients and staff**
- Sets an **example**
- Is **diverse** and **representative**
- Is **transparent** to staff and public
- Works with **system partners**

Is **approachable** and **visible**

Engages **face-to-face** with care users and staff

Governance of the Strategy

The delivery of our Trust's strategy will be governed by the Board through the Single Improvement Plan (SIP), which serves as the operational framework for translating strategic intent into measurable action. Each year, the Board of Directors will develop and approve a set of Corporate (strategic) objectives, directly informed by the Trust's strategy. These objectives will form the foundation for both the Board Assurance Framework (BAF) and the SIP.

The Board Assurance Framework is a key governance mechanism that enables the Board to maintain oversight of strategic risk and assurance. It maps the Trust's corporate objectives to associated risks, identifies sources of assurance, and highlights any gaps that require mitigation. The BAF ensures that the Board is able to make informed decisions about risk appetite, resource allocation, and the effectiveness of internal controls. It also provides a structured approach to tracking progress against our strategic objectives and supports the Board in fulfilling its statutory responsibilities.

The SIP is structured around the Trust's strategic priorities, organised into five key domains (the 5Ps):

Patients, Performance, People, Productivity, and Partnerships

Each domain reflects a core strategic priority and is led by an Executive Director, who is accountable for the delivery of their respective portfolio. The Trust Management Board, comprising the Executive Team and the Trust's senior operational leaders, receives regular updates on progress and risks from each Executive Director.

Each Committee of the Board oversees the respective elements of the SIP aligned to its remit:

- The Patients portfolio is overseen by the Safety and Quality Committee.
- The Performance and Productivity portfolios are overseen by the Finance and Performance Committee.
- The People portfolio is overseen by the Workforce Committee and the Education, Training and Research Committee.
- The Partnerships portfolio is primarily delivered through the SIP Partnership Board which is reported to the Trust Management Board and the Finance and Performance Committee.

The Finance and Performance Committee holds overarching responsibility for the governance and delivery of the Single Improvement Plan.

Progress against the SIP is monitored through the Integrated Performance Report (IPR), which is presented to the Board of Directors at each meeting. This report provides assurance on milestone delivery, outcome measures, and overall progress, all of which are directly informed by the Trust's strategic ambitions and reflected in the BAF.

The strategic priorities are present through the Single Improvement Plan Boards present within each department across the organisation highlighting each departments contribution to the overarching strategy of the organisation.

The divisional governance structures mirror that of the committees of the Board ensuring robust governance arrangements are in place from ward to Board.

This governance structure ensures that strategic delivery is embedded within the organisation's operational rhythm, with clear lines of accountability, oversight, and assurance. It supports a culture of transparency, continuous improvement, and strategic alignment across all levels of the Trust.

Achieving Financial Sustainability

The Board recognises that achieving financial sustainability is fundamental to securing the long-term future of our Trust and delivering outstanding care for our communities.

Our commitment is underpinned by our current focus on financial turnaround with the support of external partners and the Recovery Support team at NHS England. The Trust has an ambitious financial recovery programme in place, with robust governance structures, which ensure transparency, accountability, and strategic oversight of all financial decisions. Our progress is reported via the Finance and Performance Committee and Board to our regulators. Our aim is to achieve financial balance by the end of the financial year 2026/27.

The Board regularly reviews financial performance against plan, proactively addressing risks and variances through targeted interventions. We have established clear lines of accountability for budget holders and promote a culture of value and stewardship, ensuring that resources are deployed where they will have the most significant impact on patient outcomes and organisational resilience.

To drive sustainability, we are implementing a multi-faceted approach that includes:

- **The development of a three-year financial sustainability plan** – this will be delivered through rigorous financial planning and forecasting, using data-driven insights and scenario modelling to underpin medium- and long-term plans.
- **Efficiency and productivity programmes**: Delivering waste reduction programmes without compromising quality or safety, including clinical pathway redesign, workforce optimisation, and digital innovation.
- **System partnership:** Collaborating across Lancashire and South Cumbria and integrating with community services to reduce duplication, share resources, and leverage system-wide efficiencies.
- **Investment in transformation:** Prioritising investments that deliver both immediate and sustainable financial benefits, such as modernising estate and expanding outpatient care closer to home.
- **Continuous monitoring and reporting:** Providing the Board and its committees with timely, accurate financial information to support evidence-based decision making.

A strong focus on risk management, quality governance, and organisational learning ensures that financial decisions are aligned with our strategic objectives and our duty to provide safe, effective care. The Board's unwavering commitment is to not only achieve financial balance without compromising safety but to also ensure that every pound spent delivers maximum value for our patients, staff, and wider community.

Our role as a provider of specialist and local care

We have much to be proud of at Lancashire Teaching Hospitals NHS Foundation Trust; we are one of the larger teaching trusts in England, delivering compassionate specialist and local care to the population of Lancashire and South Cumbria.

We serve as the designated Major Trauma Centre, Cancer Centre (Rosemere), and Neurosciences Centre, encompassing both neurosurgery and neurology, for Lancashire and South Cumbria. In addition to these core specialties, we provide a wide range of other specialist services, including Allergy and Clinical Immunology, Disablement Services, Plastic Surgery, Renal Medicine, specialist Vascular Surgery, complications of paediatric excessive weight gain, paediatric neurology, regional ventilation service and Maternal and Foetal Medicine. These services reflect our commitment to delivering high-quality, comprehensive care across a broad spectrum of clinical needs for our population.

Over the next 5 years as we deliver this strategy, we will further strengthen our role within the system through

- Being a collaborative and engaged system partner
- Integration of community pathways
- Delivery of care closer to home where appropriate
- Co-location of specialist services when clinically beneficial
- Be the recognised specialist provider for Lancashire and South Cumbria

At Lancashire Teaching Hospitals we are here to deliver high quality services for:

Our Patients

By providing excellent compassionate care

Our People

By being a great place to work

Our Partners

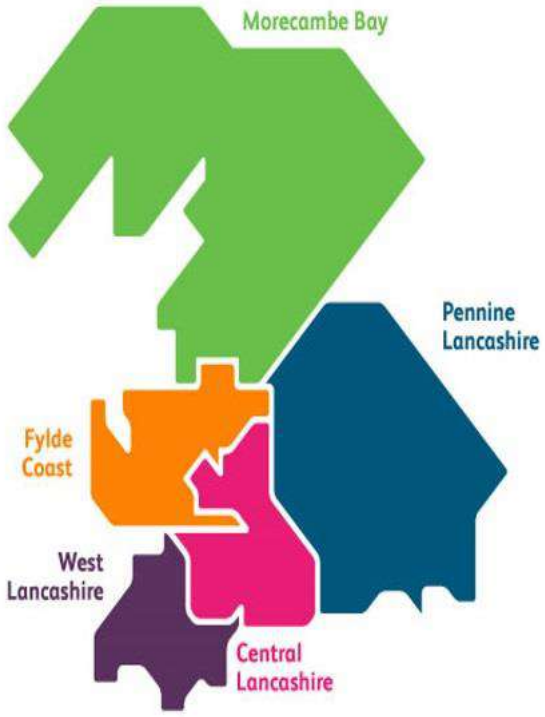
We are stronger together through collaboration and shared purpose

As a provider of Specialist and Local Care

Integrated Care Systems (ICS) are partnerships that bring together health and social care organisations to plan and deliver coordinated, patient-centred services. By working together, we aim to improve population health, reduce inequalities, and enhance the efficiency of healthcare services.

Lancashire Teaching Hospitals play a vital role within the ICS by providing specialised services and acting as a hub for clinical expertise. The hospital collaborates with other healthcare providers, local authorities, and voluntary organisations to deliver better coordination of services, improved patient outcomes, and more effective use of resources.

The success of our ICS relies on collaboration among all stakeholders. Effective communication, mutual trust, and a shared vision are essential for achieving integrated care goals. By working together, organisations can overcome barriers, streamline processes, and create a more responsive healthcare system, ultimately leading to better health outcomes and a sustainable healthcare system as outlined in the Fit for the Future 10 year health plan for England.



At LTH we will focus on strengthening our system role through:

Being a collaborative system partner

We will work with partners across Lancashire and South Cumbria to focus on preventing ill-health, reducing health inequalities, invest in research and innovation and develop fully integrated care, bringing together our teams to develop integrated pathways of care across primary, community and secondary care.

Being a recognised centre of excellence for specialist care

Our aim is to build on the examples of excellence for specialised care, to deliver nationally recognised specialist care, striving to be an exemplar for access to our services, patient experience, quality and safety and clinical outcomes. This will also be enhanced through better collaboration with academia in line with our ambition to achieve University Hospital Status and better links and partnerships with industry.

This commitment to excellence not only enhances patient outcomes but also solidifies the hospital's reputation as a leader in specialised healthcare.

Developing our role as an Anchor Institution

Anchor institutions are large, established organisations that are deeply rooted in their local communities and have a significant impact on the local economy and social fabric. As a large hospital trust we play a crucial role in supporting community development and economic stability. We have substantial resources, including employment opportunities, purchasing power, and infrastructure, which we can leverage to benefit our local population.

As an anchor institution we are committed to improving the wellbeing of our local communities by addressing social determinants of health, promoting education and workforce development, and fostering economic growth. Anchor institutions work collaboratively with other local organisations and stakeholders to create a positive and sustainable impact on the community. By prioritising local procurement, investing in community initiatives, and supporting local businesses, anchor institutions help to build stronger, more resilient communities.

Over the next five years we will develop our role as an Anchor Institution by:

- **Strengthening Community Partnerships**: We will enhance our collaboration with local organisations, businesses, and educational institutions to support community development and economic growth.
- **Investing in Local Workforce**: By providing training and employment opportunities, we will focus on developing a skilled local workforce, ensuring that our community benefits from sustainable job creation.
- **Promoting Health and Wellbeing**: We will implement initiatives aimed at improving the health and wellbeing of our community, addressing social determinants of health and reducing health inequalities.
- **Supporting Local Procurement**: We will prioritise sourcing goods and services from local suppliers, contributing to the economic stability, wealth and growth of the region.
- **Fostering Environmental Sustainability**: We will adopt environmentally sustainable practices and initiatives to reduce our carbon footprint and promote a healthier environment for our community.

Our People Strategy

Our People Plan, sets out our vision for creating a great place to work at Lancashire Teaching Hospitals NHS Foundation Trust. This strategy responds to what our colleagues told us they value and expect from us. It sets out the steps we will take to improve the experience of work for all colleagues, how we plan to influence the tone in the organisation through evolving the culture we wish to foster to enable everyone to achieve, feel engaged and able to deliver our organisational vision and ambitions.

Our People Plan supports the organisations values and is an enabling strategy, designed to support other strategic workstreams and organisational priorities to be achieved. To do this, this strategy focusses in on creating the right working conditions, providing colleagues with a voice, seeking to improve their experience of work, having transformational policies and procedures, creating a supportive, inclusive and compassionate culture, which attracts, retains and rewards high calibre team members.

To achieve this Our People Plan has 6 strategic aims which are:

- To attract, recruit and resource
- To be inclusive and supportive
- To be well led
- To deliver a responsive, future focussed and enabling service
- To create a positive organisational culture
- To engage, retain, reward and recognise

Across all of the strategic aims there are comprehensive strategic action plans the purpose of which are to deliver tangible improvements on the following metrics: sickness absence, turnover, staff satisfaction and levels of colleague's engagement, increased representation and improved experience of minority group colleagues, improved time to hire, increased roster efficiency and reduction in variable pay.

Continuous Improvement, Education, Research and Innovation

Our aim is to become a University Hospital and a Centre for modern health care education and continuous improvement. At Lancashire Teaching Hospitals, we are dedicated to continuous improvement through the Lancashire Improvement Method. This approach empowers our staff to identify and implement changes that enhance patient care and operational efficiency. By fostering a culture of innovation and collaboration, we ensure that every team member contributes to our mission of delivering exceptional healthcare.

The Lancashire Improvement Method focuses on using data-driven insights and evidence-based practices to drive sustainable improvements. Through regular training, feedback, and support, we equip our staff with the tools and knowledge needed to continuously refine our processes and achieve excellence in all aspects of patient care. We will embed improvement in every service and team, delivering the maximum benefits to our patients and local population, by making the most of our expertise and skills as we scale up improvement across the organisation and system.

We will achieve this by

1. Equipping all our colleagues, including the Board, with the improvement skills, knowledge and confidence to drive improvements within their teams and services

We will set the right pace for sustained improvement through the design and implementation of our Single Improvement Plan, setting expectations in ways that build commitment to using improvement to address our priorities. We will continue to build on our growing culture of improvement by supporting our colleagues with further training and support to drive improvements in patient experience, safety and outcomes as well as efficiency, effectiveness and performance. Working with partners we will continue to strengthen the collaboration between education, research and innovation and improvement to improve patient care. Enabling learning across our teams and the wider system will continue to be a focus of our work.

2. Further developing our partnerships in Education

At Lancashire Teaching Hospitals, we are committed to continuing to develop strong partnerships in education to enhance the learning and development of our people and future healthcare professionals. By collaborating with leading universities, colleges, and training institutions, we aim to provide comprehensive educational opportunities fit for future healthcare education. These partnerships will enable us to offer a diverse range of training programmes, clinical placements, and research opportunities, ensuring that our people and students are equipped with the knowledge and skills needed to excel in their roles. Through these collaborative efforts, we will foster a culture of continuous learning and innovation, ultimately improving patient care and outcomes.

3. Improving research and innovation

Lancashire Teaching Hospitals is deeply committed to advancing research and innovation to enhance patient care and outcomes. By fostering a culture of scientific inquiry and collaboration, we aim to drive medical breakthroughs through participating in leading edge research. Our investment in research initiatives and partnerships with leading academic institutions ensures that we stay at the forefront of advances in research. This commitment to innovation not only improves the quality of care we provide but also offers our patients access to the latest clinical trials and treatment. We will further build our partnerships with industry to optimise supporting commercial research.

Our commitment to population health

Health Improvement Plan

Our ambition is to work with system partners to reduce health inequalities across Lancashire and South Cumbria. Almost every aspect of our lives impacts our health and ultimately how long we will live. Where we live can dictate the extent to which it facilitates exercise, a good diet and social connections. These factors are often referred to as the wider determinants of health that create health inequity. This includes:

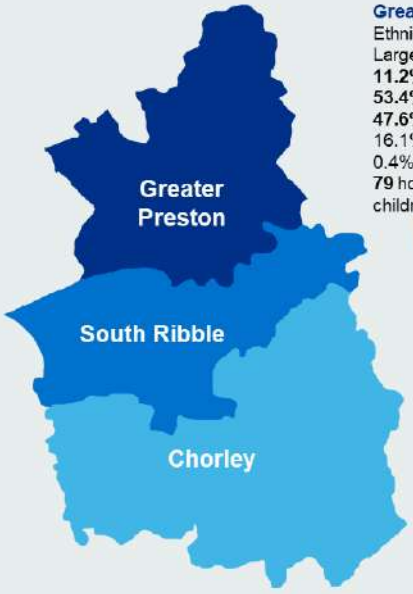
- Our homes,
- Our access to education,
- Our access to employment opportunities,
- Our public transport networks,
- Our social networks,
- Whether we experience poverty and discrimination.

This population demographic map shows differences across areas and wards within our own locality and differing needs of each population we serve.

Health inequity is not only avoidable and unfair but is as a result of systematic differences across our communities.

At Lancashire Teaching Hospitals, we are dedicated to transforming into a 'health improvement organisation' that not only treats illness but also actively promotes health and well-being.

By focusing collectively on prevention, education, and creating supportive environments, we aim to ensure that everyone has the opportunity to lead a healthy life. Together, we can make a significant impact on the health and well-being of our community, now and for future generations.



All 3 **areas**, combined population **c598k**

Greater Preston
Ethnicity **72.6% white**, 20.2% Asian/Asian British
Largest age group **23 year olds**
11.2% single person household over age 66 years old
53.4% households deprived in 1 or more dimensions*
47.6% Christian religion, 26.3% no religion,
16.1% muslim, 3% hindu, 0.7% sikh,
0.4% other religion
79 households accepted as **homeless** and in priority need, including 25 with children in household **27 rough sleepers** in Preston

South Ribble
Ethnicity **95.4% white**
Largest age group **56 year olds**
14.1% single person household over age 66 years old
47.4% households deprived in 1 or more dimensions*
61.8% Christian religion, 30.8% no religion, 0.9% muslim,
0.7% hindu, 0.3% other religion
110 households accepted as **homeless** and in priority need,
including 47 with children in household
2-3 rough sleepers in South Ribble

Chorley
Ethnicity **95.6% white**
Largest age group **50 year olds**
12.5% single person household over age
66 years old
47.5% households deprived in 1 or more dimensions*
61.5% Christian religion, 30.9% no religion,
1.4% muslim, 0.5% other religion, 0.3% hindu
384 households accepted as **homeless** and in priority need
4 rough sleepers in Chorley

All Central Lancs

c4,500 births annually
c7,000 children and **c83,000** adults visit our Emergency Department annually
0.3% - 1.7% households have no adults who have English as a main language
1.1% - 7.5% households have no people in household have English as a main language.
59 - 65 other languages are recorded as main language

10356 - 12144 people providing unpaid carer hours
18.2% - 18.5% population disabled under the disability act (adult and children)
9%, 54,621 total moderate or severe disability central lancashire
10.3% lone parent family households
6.2% - 8.2% previously served in UK armed forces

Our approach to Technology and Digital

Our aim is to leverage technology and digital innovations to transform healthcare delivery and improve patient outcomes.

Learning from Leading Organisations

We will actively engage with and learn from leading healthcare organisations that have successfully integrated technology and digital solutions into their operations. This includes collaborating with institutions known for their advancements in AI-driven diagnostics, telemedicine, electronic health records, and personalised medicine. By studying their implementation strategies, challenges, and successes, we can tailor our approach to meet the unique needs of our Trust and the population we serve.

Developing an Implementation Plan

Our implementation plan will be developed through a collaborative process involving key stakeholders, including clinical leaders, IT experts, and patient representatives. The plan will outline clear objectives, timelines, and milestones to ensure a structured and phased rollout of digital initiatives. Key components of the plan will include:

- **Assessment and Planning**: Conducting a thorough assessment of our current digital capabilities and identifying areas for improvement.
- **Stakeholder Engagement**: Involving staff, patients, and partners in the planning process to ensure their needs and perspectives are considered.
- **Technology Selection**: Choosing the most appropriate technologies and solutions that align with our strategic goals and enhance patient care.
- **Training and Support**: Providing comprehensive training and support to staff to ensure they are equipped to use new technologies effectively.
- **Monitoring and Evaluation**: Establishing mechanisms to monitor progress, evaluate outcomes, and make necessary adjustments to the implementation plan.

Optimising Opportunities

We will optimise several key opportunities to enhance our digital capabilities and improve patient care:

- **Federated Data Platform**: Utilising the federated data platform to integrate and analyse data from multiple sources, enabling more informed decision-making and personalised care. This platform will facilitate secure data sharing and collaboration across different healthcare providers, improving care coordination and patient outcomes.
- **AI and Machine Learning**: Implementing AI and machine learning algorithms to enhance diagnostics, predict patient outcomes, and optimise treatment plans. These technologies will enable us to provide more accurate and timely care, reducing the burden on healthcare professionals and improving patient experiences.
- **Telemedicine and Remote Monitoring**: Expanding our telemedicine services to provide remote consultations and monitoring, ensuring patients have access to care regardless of their location. This will be particularly beneficial for managing chronic conditions and reducing hospital admissions.
- **Digital Health Records**: Transitioning to fully digital health records to streamline information sharing, reduce administrative burdens, and improve the accuracy and accessibility of patient data.
- **Patient Engagement Tools**: Developing digital tools and platforms to enhance patient engagement, such as mobile apps for appointment scheduling, medication reminders, and health education.

Our Services

Cancer

Improving access to cancer care and cancer outcomes for our local population through eliminating all avoidable 'lost days' awaiting diagnosis and treatment

Where are we?

- In the top quartile for cancer patient experience
- In the lowest quartile for cancer performance metrics
- Introduced surface guided radiotherapy
- Providing general cancer care to 390,000 people in our local population
- Delivering specialist care to 1.8 million people across Lancashire and South Cumbria

Where we aim to get to?

- In the upper quartile for cancer performance metrics
- Achieve above average for all cancer performance metrics
- Become a regional leader in integrated, research-enabled cancer care
- Driving future cancer innovations in partnerships with universities

- **Deliver our health improvement plan to prevent and detect early cancer in our local population:** We are committed to working with local partners to implement a comprehensive health improvement plan that focuses on both the prevention and early detection of cancer within our local communities. This involves targeted public health campaigns, increased access to screening services, and proactive engagement with underserved populations to reduce health inequalities. By playing our part in promoting healthy lifestyles, raising awareness of cancer symptoms, and ensuring timely access to diagnostic services, we aim to identify cancers at an earlier, more treatable stage.
- **Improve patient experience through a focus on valuing patients' time by developing streamlined pathways and better communication, leading to the delivery of national standards for cancer:** We recognise that valuing patients' time is a key component of compassionate and effective care. To achieve this, we are redesigning care pathways to be more efficient, reducing unnecessary delays and handoffs. Improved communication, both between healthcare professionals and with patients, will ensure that individuals are well-informed, supported, and actively involved in their care journey. These efforts will help us meet and exceed national cancer standards, ensuring timely diagnosis, treatment, and follow-up, while fostering trust and confidence in our services.
- **Strengthen partnerships with academic institutions to embed research and innovation in cancer pathways:** To drive continuous improvement in cancer care, we are deepening our collaborations with academic institutions and research partners. These partnerships enable us to embed cutting-edge research and innovation directly into clinical pathways, ensuring that our patients benefit from the latest advancements in diagnostics, treatments, and care models. This not only enhances the quality and effectiveness of our services but also positions our organisation as a leader in cancer innovation and education.

Diagnostics

Delivering timely access to diagnostics to ensure our patients are on the right pathway as early as possible

Where are we?

- Improved patient experience through diagnostics at our first community diagnostic centre
- Lowest quartile DM01 performance
- Providing local and specialist diagnostics across all modalities for LSC, with increasing demand

Where we aim to get to?

- Increase in closer to home diagnostics
- Reducing travel for patients by enabling local diagnostics for specialist patients
- Achieve and sustain 95% of diagnostic tests completed within 6 weeks, achieving upper quartile of performance
- Integrate diagnostics across the ICS with shared systems and workforce initiatives

- **Expand CDCs and mobile diagnostics to improve access and reduce health inequalities:** Expanding Community Diagnostic Centres (CDCs) and mobile diagnostic services is a critical step in improving access to timely and effective healthcare, particularly for underserved and remote populations. Mobile units and strategically located CDCs allow for quicker assessments, reduce travel burdens, and help address health inequalities by reaching communities that traditionally face challenges in accessing care. This approach not only enhances patient convenience but also supports earlier diagnosis, which is key to improving outcomes and reducing the long-term strain on acute services.
- **Invest in digital infrastructure and AI tools to support faster, more accurate diagnostics:** By enhancing connectivity, data integration, and system performance, we can support faster and more accurate diagnostics across a range of specialties.
  AI-enabled tools can assist clinicians in interpreting complex imaging and pathology results, identifying patterns, and flagging anomalies with greater precision and speed.
  This not only reduces diagnostic delays but also improves consistency and supports earlier intervention.
  A robust digital foundation also enables remote access, multidisciplinary collaboration, and the integration of real-time data into clinical decision-making, ultimately leading to safer, more efficient care.
- **Implement the Integrated Care System-wide diagnostics strategy, including unified PACS/RIS and cardiology systems:** The implementation of a unified diagnostics strategy across the Integrated Care System (ICS) is a key enabler of seamless, high-quality care. By standardising Picture Archiving and Communication Systems (PACS), Radiology Information Systems (RIS), and cardiology platforms across organisations, we can ensure interoperability, reduce duplication, and improve the flow of information between providers. This unified approach supports more coordinated care pathways, facilitates timely access to diagnostic results, and enhances the ability to share expertise across sites.

Pathology

Optimal delivery model across Lancashire and South Cumbria in partnership with local Universities

Where are we?

- Patients waiting longer than average for results
- Designated as the lead provider for the Pathology Collaboration
- Local delivery partner for the 100,000-genome project
- Provider of a range of pathology sub-specialties: cellular pathology, micro & molecular biology, immunology, clinical biochemistry, haematology and blood transfusion

Where we aim to get to?

- Deliver faster, more accurate results to support early diagnosis and treatment
- Implement a successful lead provider model for pathology
- Use digital pathology and AI to enhance diagnostic precision and efficiency and capacity within our workforce

- **Implement a unified Laboratory Information System across the ICS:** Implementing a unified Laboratory Information System (LIS) across the Integrated Care System (ICS) is a strategic priority that will significantly enhance diagnostic efficiency, data sharing, and clinical decision-making. A single, interoperable LIS will streamline laboratory workflows, reduce duplication, and enable real-time access to test results across multiple care settings. This integration supports faster turnaround times, improves accuracy, and facilitates better coordination between primary, secondary, and community care providers.
- **Invest in digital pathology infrastructure and AI-enabled reporting:** Investing in digital pathology and AI-enabled reporting represents a transformative opportunity to modernise diagnostic services and improve clinical efficiency. Digital pathology allows for faster, more accurate analysis of tissue samples, enabling remote consultations and second opinions without the delays associated with physical slide transport. Integrating artificial intelligence into reporting processes can further enhance diagnostic accuracy, reduce human error, and support clinicians in managing increasing workloads. This investment will also lay the foundation for more collaborative, data-driven research and innovation, positioning our services at the forefront of precision medicine and personalised cancer care.
- **Scale up point-of-care testing through neighbourhood health services to improve earlier access:** Scaling up point-of-care testing (POCT) through neighbourhood health services is a vital strategy for enabling earlier diagnosis and intervention. This decentralised approach not only improves patient convenience but also reduces pressure on hospital-based services. POCT empowers frontline healthcare professionals to act swiftly, particularly in detecting early signs of cancer or monitoring chronic conditions, ultimately contributing to better health outcomes and more efficient use of healthcare resources.

Urgent and emergency care

Improving patient experience, responsiveness, and admission avoidance

Where are we?

- Patients experience a below average performance and experience for UEC
- Patients experience long length of stay when presenting with mental health symptoms in Central Lancashire
- Fragmented provider model and increasing pressure on UEC across the system, with emergency departments on two sites (one open 12 hours)

Where we aim to get to?

- Ensure ED waiting times compare to national average leading to improved experience for patients and families
- Ensure people can access high quality, safe and affordable care, in the right place by the right professional
- Embrace opportunities for innovation

- **Implement sustainable clinical models in partnership with ICS urgent care networks:** To ensure long-term resilience and effectiveness in urgent care delivery, it is essential to develop and implement sustainable clinical models in close collaboration with Integrated Care System (ICS) urgent care networks. This approach promotes consistency, reduces duplication, and enhances patient outcomes by aligning services across organisational boundaries. By working in partnership, we can co-design models that are responsive to local needs, support workforce sustainability, and make best use of available resources. These models should be data-driven, patient-centred, and adaptable to evolving healthcare demands, ensuring that urgent care remains accessible, efficient, and equitable.
- **Implement the strengths-based approach Days Kept Away from Home across all services:** The "Days Kept Away from Home" approach represents a shift towards strengths-based, person-centred care that prioritises the individual's wellbeing and autonomy. Implementing this approach across all services means embedding a culture that values independence, supports recovery, and reduces unnecessary hospital admissions. It also fosters multidisciplinary collaboration, enabling teams to work together to create care plans that are proactive, preventative, and tailored to each person's strengths and circumstances.
- **Be an active partner in the development of the neighbourhood health service and Place, focusing on community settings and digital first initiatives:** Active participation in the development of neighbourhood health services and Place-based care is vital to building a more integrated and responsive health system. This involves working collaboratively with local partners to design services that are rooted in community settings, where people live and work. Emphasising digital-first initiatives allows for more accessible, flexible, and efficient care, particularly for those who may face barriers to traditional service models.

Women's health, maternity, and neonatal services

Delivery of high-quality safe services that the public have confidence in

Where are we?

- Top quartile for maternity patient experience
- Chorley Birth Centre recognised as a Beacon site
- Developed offer of early pregnancy service
- Provider of maternity and neonatal specialist services

Where we aim to get to?

- Achieve Birthrate Plus compliance
- Maintain positive patient experiences
- Deliver safe, personalised, and equitable care for all women and babies.
- Become a centre of excellence for maternal medicine and neonatal care

- **Implement the national Maternity and Neonatal Improvement Plan:** We are committed to delivering the national Maternity and Neonatal Improvement Plan, which sets out a comprehensive framework for enhancing the safety, quality, and equity of care for mothers and babies. This includes strengthening clinical leadership, improving workforce capacity, and embedding evidence-based practices across maternity and neonatal services. Implementation will be supported by robust governance, continuous learning, and collaboration across the Integrated Care System to ensure consistent delivery and measurable improvements.
- **Expand continuity of carer models and personalised care planning:** Expanding continuity of carer models is central to improving maternity outcomes and patient experience. This approach ensures that women receive care from a consistent team throughout their pregnancy, birth, and postnatal period, fostering trust and improving clinical outcomes. Alongside this, personalised care planning will be embedded to support informed decision-making and tailor care to individual needs, preferences, and circumstances. Delivered through neighbourhood health services and supported by digital tools, this model promotes equity, enhances safety, and empowers women to be active participants in their care journey. It also supports better workforce utilisation and more efficient service delivery.
- **In partnership with the Race and Health Observatory and the Institute for Healthcare Improvement (IHI), support the development of the national approach to health inequalities in maternity and neonatal services:** In partnership with the Race and Health Observatory and the Institute for Healthcare Improvement (IHI), we will deliver improvement that tackles disparities in access, experience, and outcomes. This includes identifying and addressing systemic barriers, improving cultural competence, and ensuring services are responsive to the needs of diverse communities.

Community and local services

Delivering integrated care closer to home through integrated neighbourhood teams

Where are we?

- Shared community service offer between LTH/LSCFT
- In the lowest quartile for community investment per head of population
- Provider of community and neurodevelopmental services for children and young people

Where we aim to get to?

- Provide integrated community services through a single point of access
- Reduce unplanned hospital admissions through prevention and early intervention
- Develop and implement a neighbourhood health service

- **Develop innovative service models for urgent care and long-term conditions in community settings:** To meet the evolving needs of our population, we are committed to developing innovative service models that deliver urgent care and manage long-term conditions closer to home. By shifting care into community settings, we can provide more responsive, personalised, and accessible services that reduce pressure on acute hospitals. These models will be designed around patient needs, integrating multidisciplinary teams and digital tools to support proactive care, early intervention, and continuity.
- **Relocate and redesign services to be closer to patients, including high street hubs:** Relocating and redesigning services to be more accessible is central to our ambition of delivering care that is truly patient-centred. By establishing health and care hubs with partners in high street locations and other community-based venues, we can bring services into the heart of the communities we serve. These hubs will offer diagnostic, treatment, and support services in a convenient, welcoming setting, reducing travel time, improving uptake, and fostering greater engagement. This model also supports collaboration between health, social care, and voluntary sector partners.
- **Horizontal integration with community services, providing comprehensive pathways for Central Lancashire working with primary and social care:** In Central Lancashire, we are working closely with primary care, community providers, and social care partners to develop comprehensive, joined-up pathways that span prevention, diagnosis, treatment, and ongoing support. Vertical integration ensures that patients experience continuity across different levels of care, from community to hospital, while horizontal integration strengthens collaboration between services operating at the same level. This whole-system approach enables more coordinated, efficient, and equitable care, ensuring that people receive the right support at the right time, in the right place.

Long term conditions

Driving pro-active condition management through early intervention and innovation

Where are we?

- Commitment to move all specialties to a community centric model
- Currently Lancashire Teaching Hospitals provides care for patients with long-term conditions through a predominantly hospital-based model working with local partners
- Care is often more reactive than preventative with traditionally commissioned pathways
- Fewer patents die in their preferred place of care in Central Lancashire

Where we aim to get to?

- Deliver proactive, personalised care that supports self-management and prevention
- Integrate services across acute, community, and primary care
- Improve quality of life and reduce avoidable hospital admissions
- Enable end of life patients to die in their preferred place of care

- **Prioritise Core20PLUS5 populations to reduce health inequalities:** Reducing health inequalities remains a central priority, and we are committed to targeting efforts towards the Core20PLUS5 populations. This includes the most deprived 20% of the population, as well as groups with additional vulnerabilities such as ethnic minorities, people with learning disabilities, and those experiencing homelessness. Learning from the work already completed, we will tailor interventions that address specific barriers to care, improve access to services, and promote equity in health outcomes. This targeted approach will be embedded across all service redesigns and improvement programmes, ensuring that no one is left behind in our efforts to deliver high-quality, inclusive care.
- **Embed personalised care planning to optimise long-term condition care through neighbourhood health services and digital by default:** Personalised care planning is essential for improving the management of long-term conditions and empowering individuals to take control of their health. By embedding this approach within neighbourhood health services, we can deliver care that is locally accessible, coordinated, and tailored to individual needs. Leveraging digital-by-default solutions, such as remote monitoring and virtual consultations we will further enhance the efficiency and responsiveness of these services. This model supports proactive care, reduces unnecessary hospital visits, and ensures that patients receive the right support at the right time.
- **Undertake a fundamental specialty redesign adopting the principles of the ten-year health plan:** To future-proof our services and meet the evolving needs of our population, we will undertake a fundamental redesign of those specialties involved in long term care, guided by the principles of the ten-year health plan. This involves rethinking how services are delivered, integrating care across settings, and aligning clinical pathways with population health priorities. The redesign will focus on prevention, early intervention, and multidisciplinary collaboration, ensuring that specialty services are more accessible and efficient.

Specialised services

Bringing together our specialist services to create a centre of excellence for Lancashire and South Cumbria, ensuring services with clinical interdependencies are co-located

Where are we?

- Key provider of specialised services across Lancashire and South Cumbria
- Pioneer for specialist clinical services, for example, developing new techniques for surgical procedures
- Specialist Mobility Rehabilitation Centre is a recognised Centre of Excellence

Where we aim to get to?

- Continue to develop as the provider of specialist services for Lancashire and South Cumbria
- Strengthen our role as a centre of excellence for specialised services, sustainably improving outcomes and access.
- Enable resilient future service models through redesigning services and maximising access close to home for our tertiary patients

- **Take a lead for the system in the continued development of high quality specialised services and expertise, reducing variation in access and outcomes:** As the key provider it is essential to take a proactive and strategic role in driving the ongoing development of high-quality specialised services across the system. This involves fostering clinical excellence, investing in specialist expertise, and ensuring that services are designed and delivered in a way that meets the diverse needs of the population. By championing innovation and collaboration, we can reduce unwarranted variation in both access to care and patient outcomes, ensuring that every individual receives equitable, timely, and effective treatment regardless of geography or circumstance.
- **Recognise the asset specialist services are to the organisation and the important role they play at LTH, delivering cutting edge care and being a catalyst for innovation and pioneering clinical practice:** Specialist services are a vital asset to Lancashire Teaching Hospitals (LTH), playing a central role in delivering cutting-edge care that sets the standard for clinical excellence. These services not only provide advanced treatment options for complex conditions but also act as a hub for innovation, research, and the development of pioneering clinical practices. Their presence enhances the organisation's ability to attract and retain top-tier talent, foster multidisciplinary collaboration, and contribute to national and international advancements in healthcare.
- **Invest in robotic technology to improve patient outcomes:** Investing in robotic technology represents a transformative opportunity to enhance the quality and precision of patient care. Beyond clinical benefits, this investment also supports workforce development by equipping clinicians with cutting-edge tools and fostering a culture of innovation. As Lancashire Teaching Hospitals continues to evolve as a centre of excellence, prioritising robotic technology will be key to improving patient outcomes, increasing efficiency, and maintaining a lead role in specialised care delivery.

Children and young people

Generating the right start in life for future health and well-being with in-reach from specialist regional providers, delivering care locally

Where are we?

- Improving children and young people's experience
- Higher than average number of children and young people accessing hospital based UEC services
- Renovated Broadoaks children's community centre
- GIRFT accredited Children's elective hub
- Acute, community and specialist service provider

Where we aim to get to?

- To fully deliver integrated family centred and child focused care
- Reduce the time children wait for community neurodevelopmental paediatrics
- Defined commissioned services
- Improve transition of children with dysregulated behaviour to specialist providers

- **Design and deliver a children's and young people's plan to improve access to urgent and emergency care:** To ensure timely and equitable access to urgent and emergency care we will design and implement a comprehensive Children's and Young People's Plan. This plan will be developed in collaboration with healthcare professionals, education providers, local authorities, and—most importantly—children, young people, and their families. It will focus on identifying and addressing barriers to care, streamlining referral pathways, and enhancing the capacity and responsiveness of urgent care services. By embedding a child-centred approach and aligning with national priorities, we aim to create a more accessible, responsive, and inclusive urgent care system.
- **Deliver community models of acute care utilising technology to aid responsiveness:** We will develop and implement innovative community-based models of acute care that leverage digital technology to enhance responsiveness and continuity of care. These models will bring care closer to home, reducing the need for hospital admissions and enabling timely interventions in familiar, supportive environments. By integrating remote monitoring tools, virtual consultations, and real-time data sharing across multidisciplinary teams, we can ensure that children and young people receive the right care at the right time. These models will be co-designed with service users and frontline staff to ensure they are practical, scalable, and tailored to local needs.
- **Level up children's and young people's services:** We are committed to reducing health inequalities and ensuring that all children and young people. To achieve this, we will develop and deliver a strategic plan aimed at levelling up children's and young people's services across the region. This plan will focus on addressing disparities in health outcomes, access to care, and service provision, particularly in underserved and disadvantaged communities. By aligning with national levelling-up priorities and working in partnership with education, social care, and voluntary sectors, we will create a more consistent and fair system that supports every child to thrive.

Our Sites

At Lancashire Teaching Hospitals we work across several hospital sites and many other locations across the system.

*Note – these are co-located within our site but delivered by partners

The following section describes a summary of the patient facing facilities at the sites and recent strategic capital investments. The list is not exhaustive and changes according to the needs of the local population, services commissioned and pathways.

LTH proudly delivers services from a number of networked hospital sites and locations across the integrated care system in partnership with other providers and services. Although not listed in detail in this strategy due to the volume, it is recognised the critical role they play in all the delivery of specialist and local service provision. This will continue through the time covered in this strategy.

In addition to these facilities the infrastructure and support services for all the clinical activity is co-located across the sites and a vital part of the provision of patient care. The estates enabling strategy will cover further detailed strategic decisions and follows a programme of stakeholder engagement and technical expert assessment of the sites and infrastructure.

Broadoaks

Ambulatory Services	Diagnostics Outpatients Specialist play therapeutic and assessment equipment

Broadoaks - Child Community Centre

"Broadoaks is a community facility owned and managed by Lancashire Teaching Hospitals NHS Foundation Trust. It plays a vital role in delivering community and neurodevelopmental services for children and young people across Chorley, South Ribble, and Greater Preston. Children's community clinics and services are also delivered across the community in Ashton, Fulwood and Brookfield centres"

Recent Investments at Broadoaks

- Creation of new diagnostic and treatment rooms and a welcoming, child-friendly environment
- Full roof replacement and internal upgrades
- Modernised toilet and baby change facilities for improved accessibility

Why This Matters

Diagnostic and treatment rooms strengthens Broadoaks role in shifting children's care closer to home, supporting the Trust's ambition to reduce hospital reliance and improve outcomes through early intervention and coordinated pathways.

Estate improvement works signal a long-term commitment to establishing Broadoaks as a sustainable, modern paediatric facility, capable of supporting expanded clinical use and integrated neighbourhood team models under the 10-Year NHS Plan

Modernised accessible facilities Outpatient and community service development highlights the importance of delivering children and young people services in accessible, child-friendly sites, ideal for delivering clinic-based care, improving family experience, and supporting the Trust's strategic pillar for Children and Young People.

Preston Business Centre

Ambulatory Services	Outpatients Physical assessment and rehabilitation gymnasium Wheelchair and prosthesis manufacture and fitting facilities

Preston Business Centre - SMRC

"Preston Business Centre is home to the Specialist Mobility Rehabilitation Centre (SMRC) a centre of excellence for Veterans, one of nine centres in England that provides enhanced prosthetic services for military veterans with service-attributable injuries, a regionally unique service for patients with specialist wheelchair, prosthetic limb, and orthotic rehabilitation needs"

Recent Investments at Preston Business Centre

- The creation of a centralised location for support services and functions with One LSC

Why This Matters

Centralising services and functions in Preston Business Centre provides the opportunity to understand how functions can work more effectively together, maximising digital pathway changes whilst also aiming to reduce transaction costs, improve procurement power, and deliver a consistent employee experience.

Preston Healthport - Community Diagnostic Centre

Ambulatory Services	Outpatients Diagnostics Clinical interventions unit Endoscopy Suite Physiotherapy Renal dialysis

"The Community Diagnostics Centre at Preston Healthport is a flagship development supporting Lancashire Teaching Hospitals' strategic aim to expand diagnostic capacity, reduce acute site pressure, and improve patient access to timely investigations"

Recent Investments at the Community Diagnostics Centre

- CT and MRI equipment
- Outpatient rooms and Physiological Science testing equipment
- Pathology facilities

Why This Matters

CT and MRI equipment improves access with community-based location, with good parking and transport links.

Outpatient facilities increase the capacity for diagnostics such as full lung function testing and sleep studies

Pathology facilities support the vision for integrated community-based care

Chorley and South Ribble Hospital

Acute Services	Emergency Department / Urgent Treatment Centre 22 Medical Assessment Unit Beds 83 Medicine Inpatient beds Birth Centre
Inpatient Services	24 Stroke Rehabilitation beds
Ambulatory Services	Outpatients Diagnostics Clinical interventions unit Endoscopy Suite Physiotherapy Renal dialysis Chemo daycase ward
Elective Surgical Hub	34 Elective hub surgery beds 22 daycase beds 13 theatres Lancashire Eye Centre

"A site fit for the future providing high quality UEC, planned and ambulatory services and community-focused innovation for the LSC population"

Recent Investments at Chorley Hospital

- Three storey new build Lancashire Eye Centre
- Surgical Elective Hub and Paediatric Elective Accredited Surgery Hub
- Ward Modernisation & MAU redesign

Why This Matters

Elective hub capability strengthens Chorley's role in moving low-acuity, high- volume elective services away from high-cost acute sites.

Purpose-built ophthalmology investment demonstrates the viability of service consolidation and high-quality diagnostic/ planned care on site.

Ward improvement investments signal commitment to establishing Chorley as a sustainable, modern facility capable of expanding clinical use.

Outpatient development plans highlight Chorley's potential as a highly accessible, modern site ideal for expanding clinic-based services and improving patient experience.

Royal Preston Hospital

Acute Services	Emergency Department / Urgent Treatment Centre 50 Medical Assessment Beds 184 Medicine inpatient beds inc. Comprehensive Stroke Centre 194 Surgical inpatient beds Maternity Unit 30 Paediatric inpatient beds/Paediatric Assessment Unit
Specialist Inpatient Services	25 Renal inpatient beds 82 Neurosciences inpatient beds 10 Major Trauma beds 33 Vascular inpatient beds 22 Plastic inpatient beds 24 Medical/Clinical Oncology beds
Ambulatory Services	Outpatients Diagnostics Lancashire Elective Surgical Unit (inc. Daycase) Physiotherapy Renal dialysis Radiotherapy unit Chemotherapy daycase
Interventions	20 theatres Cardiac Catheter suites Interventional Radiology suites Endoscopy suites

"As the system's major specialist hospital, we play a critical role in providing both local and specialist care, with growing focus on emergency and complex services. In meeting our rising demand, our strategic priority is to strengthen clinical capability and system responsiveness, while addressing the challenges of an aging estate to ensure our hospital is sustainable, resilient and fit for the future"

Recent Investments at Royal Preston Hospital

- Medical Assessment refurbishments
- Neurointerventional suite
- Lancashire Elective Surgical Unit
- Endoscopy suites

Why This Matters

Medical Assessment refurbishments signal commitment to maintaining the modernisation of clinical space in the areas seeing increasing demands that will continue to be required on an acute site.

Neurointerventional suite enables a service to maintain planned care alongside modern developments and increases in stroke interventions for the population of Lancashire and South Cumbria.

Lancashire Elective Surgical Unit created a more resilient elective pathway with an improved patient experience for our most complex surgical patients from all of Lancashire and South Cumbria and unlocked key estate to increase assessment space in the right location.

Endoscopy suite investment strengthens the offer for inpatient and ambulatory endoscopy, responding to increased demand and the requirement to provide resilient cancer screening services.

How will our sites change in the future?

Over the next 5 years we need our physical space to meet the needs of our population and the enable us to deliver alignment to the 10 year health plan for England. The use of our sites will remain flexible to the evolving ways in which healthcare will be delivered.

Although not specifically covered in this strategy we continue to work with the national new hospital team as a wave three partner, ensuring strategic decisions fit with future national direction for hospital infrastructure and ensuring investment opportunities for enabling works are maximised.

How will our Strategy be delivered

Our new strategy will be delivered through a detailed implementation plan using our Trust's Single Improvement Year.

Lancashire Teaching Hospitals Single Improvement Plan

Lancashire Teaching Hospitals Single Improvement Plan (SIP) 2024-2027 has been designed to simplify our approach to what we need to improve across the organisation. Our priorities have been chosen through a combination of feedback from patients, colleagues and our regulators, and alignment to our corporate objectives. The 5 portfolios contain programmes that aim to improve:

- **Safety and quality outcomes for our patients**
- **Experience for our people**
- **Financial sustainability for our organisation**
- **Operational performance in our organisation**
- **Partnership working for our communities**

The Single Improvement Plan delivery mechanism and key metrics enable us to understand how we are progressing towards the corporate objectives. By all of us playing our part in delivering local actions aligned to our Single Improvement Plan together we can achieve our organisational vision.

We will achieve this by underpinning our approach with improvement methodology and working in line with our organisation's values

- Being caring and compassionate
- Recognising individuality
- Seeking to involve
- Building team spirit
- Taking personal responsibility

We will now work together across our teams, services and the system to embed this strategy and use it to help us to reshape our services and the ways we work. We look forward to working together to make our new shared vision a reality.

SRO: Silas Nicholls

LTH Single Improvement Plan

SRO: Sarah Morrison / Steve Canty

Patients

To improve inpatient care and experience, in particular Sepsis, Clostridium difficile, risk assessment completion, medication safety, maternity, neonatal and children's services whilst reducing health inequalities in our services.

SRO: Katie Foster- Greenwood

Performance

To increase productivity to improve waiting times for elective care, including waits for diagnostic services. To continue improvement of cancer performance to minimise the risk of harm. To develop and improve urgent and emergency care services working with our partners for improved whole system flow.

SRO: Neil Pease

People

To improve colleague experience and create a positive organisational culture. Achieved by effective, supportive, inclusive and performance focused line management. Aiming to reduce sickness absence, achieve compliance in appraisal and core skills, increase levels of team effectiveness and engagement, resulting in higher levels of colleague satisfaction and retention.

SRO: Sarah Morrison

Partnerships

To reduce and manage risks across the organisation, developing a learning and continuous improvement culture focused on working with partners to redesign and deliver our services to meet the needs of our community.

SRO: Craig Carter

Productivity

To deliver the agreed financial plan for the organisation, including the waste reduction programme, and support ongoing development of a full sustainability plan for the organisation.

Thank you

Keep In Touch:

If you would like to know more about our strategy, please contact Communication@LancsHospitals

www.Lancsteachinghospitals.nhs.uk

Follow us on: (Facebook, Instagram, YouTube, X) @LancsHospitals

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

Our Strategy for 2025-2035

Published by Lancashire Teaching Hospitals NHS Foundation Trust, September 2025

9.2 - WINTER PLAN

REFERENCES

Only PDFs are attached

9.2 - Winter Plan.pdf

Winter Planning 25/26

Board Assurance Statement (BAS)

NHS Trust

Introduction

1. Purpose

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

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

Section A: Board Assurance Statement

Please double-click on the template header and add the Trust's name.

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

Section B: 25/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 25/26 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2025.**

Provider:	Lancashire Teaching Hospitals NHS Trust

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the Trust Winter Plan for 2025/26.	Y	
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Y	
The Trust's plan was developed with appropriate input from and engagement with all system partners.	Y	
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Y	
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Y	
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.	Y	Delivery of sufficient surge capacity is linked to additional resource outlined within the Regional Transformation Fund bids – a decision re RTF bids is awaited. There is a risk to mobilisation in the event of delayed decisions.
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	Y	Delivery of sufficient surge capacity is linked to additional resource outlined within the Regional Transformation Fund bids – a decision re RTF bids is awaited. There is a risk to mobilisation in the event of delayed decisions.
The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against the trajectories	Y	Delivery of sufficient surge capacity is linked to additional resource outlined within the

already signed off and returned to NHS England in April 2025.		Regional Transformation Fund bids – a decision re RTF bids is awaited. There is a risk to mobilisation in the event of delayed decisions. The Trust is in Tier 2 for UEC and has imp0rivement plans in place.

Provider CEO name	Date	Provider Chair name	Date
S Nichols		M Thomas	

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	Y	
Capacity		
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	Y	Delivery of sufficient surge capacity is linked to additional resource outlined within the Regional Transformation Fund bids – a decision re RTF bids is awaited. There is a risk to mobilisation in the event of delayed decisions.
3. Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	Y	
4. Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	Y	
5. Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Y	Delivery of sufficient cancer/diagnostic capacity is linked to additional resource outlined within the Regional Transformation Fund bids – a decision re RTF bids is awaited. There is a risk to mobilisation in the event of delayed decisions. The Trust has been placed in Tier 1 for Elective and Cancer performance and has improvement plans for all specialities and tumour groups.
Infection Prevention and Control (IPC)		
6. IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	Y	

7.	Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.	Y	
8.	A patient cohorting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.	Y	
Leadership			
9.	On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Y	
10.	Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Y	
Specific actions for Mental Health Trusts			
11.	A plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	Y	
12.	Any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	Y	

Your reference number is FS-Case-750397393.

Thank you for submitting Equality Quality Impact Assessment - (EQIA)

Case Reference: FS-Case-750397393

Division: Corporate Services

Clinical Business Unit/Directorate: Chief Executive

Speciality Business Unit/Department: Corporate

EQIA Type: Safety & Quality Improvement

Are you the scheme owner?: Yes

Scheme Owner: Sarah Morrison

Scheme Owner Email Address: Sarah.Morrison@LTHTR.nhs.uk

Secondary Contact Email: Katie.Foster-Greenwood@lthtr.nhs.uk

Date: 18/09/2025

Is this EQIA related to a previous EQIA? : No

Scheme Title: Winter Plan 2025.26

Scheme Summary: The winter plan for 2025/26 has been developed to manage the risks associated with winter surge and the associated impact.

Does the scheme impact staff and/or patients?: Staff and Patients

Comments: The development of the plan considers the feedback from patients and families through complaints, friends and family and the national UEC survey.

As a direct consequence of this scheme, is there ANY impact (positive or negative) to:: Safety & Quality, Patient & Carer Experience, National Standards & Indicators

Safety & Quality: Negative Impact

Provide evidence to support your response: The unmitigated impact of winter is between 0.5-4.5% 4 hour ED performance deterioration and a bed deficit of 9-69 beds. This will impact on the safety and quality patients experience by increasing occupancy within the ED and inpatient wards leading to delays in accessing care and treatment.

Patient and carer experience: Negative Impact

Provide evidence to support your response: The unmitigated position will impact further the adverse experience patients and families report within the UEC pathway.

National Standards & Indicators: Negative Impact

Provide evidence to support your response: The unmitigated impact of winter is between 0.5-4.5% 4 hour ED performance deterioration and a bed deficit of 9-69 beds.
The current quarter 1 SEDDIT data reflects LTHTR is in the lowest quartile for patient outcomes linked to admitted patient delay metrics.
The acknowledged risks associated with UEC patient delays are likely to impact a variety of indictors including but not limited to HSMR, pressure ulcer incidence, complaints and concerns and sickness.

Consequence: 4

Likelihood: 5

Please show below how any identified risks shown above will be mitigated: The formulation of the Trust wide winter plan includes
- ED attendance avoidance
- admission avoidance
- prevent overcrowding
- reduce length of stay
- flu vaccination
- infection prevention and control
- mental health and physical health

The plan has been developed with system partners and tested at a north west regional event.
The plan has been developed in partnership with divisional leadership teams and scrutinised through the Executive Management Team and Finance and Performance committee.
The Plan will be presented to the Board of Directors on 2 October 2025.

Consequence: 4

Likelihood: 4

As a direct consequence of this scheme, is there ANY impact (positive or negative) to:: Workforce, Estates or Facilities, Tech Services, External Stakeholders

Impacted: Yes

Consulted?: Yes

Name/Dept of person consulted: JNCC

Provide full details of the impact, consultations taken place and other mitigations: 1. Flu vaccination strategy
2. IPC BAF enactment
3. Mobilisation of winter planning earlier this year to ensure recruitment can commence.
4. Limited bed expansion plan in place in response to the impact of stretching the workforce, the plan focuses on admission avoidance, length of stay reduction and compliments the current UEC strengths based approach.
5. Continuation of current health and well being offer
6. Collaborative forums to share decision making.
7. The continued focus on fire safety as part of the health and safety improvement plan.
8. All schemes are supported through bank staff, there are no request to terms and conditions. However, there may be a requirement fro staff to work flexibly and respond to patient demands.

Impacted: Yes

Consulted?: Yes

Name/Dept of person consulted: Sean Ashworth through SLT 19.9.25

Provide full details of the impact, consultations taken place and other mitigations: 1. Increased number of patients in the hospital will lead to increase in facilities requirements, increased patient movement and overall requests of the service.
Whilst demand has remained stable this year and the pressures associated with the increase are consistent with previous years the services are required to work at a higher level of demand.

Impacted: Yes

Consulted?: Yes

Name/Dept of person consulted: Janet Young

Provide full details of the impact, consultations taken place and other mitigations: The opening of a short

term ward will require technical services.

Impacted: Yes

Consulted?: Yes

Name/Dept of person consulted: Dave Suet

Provide full details of the impact, consultations taken place and other mitigations: The UEC and winter plan provides the mitigations to reduce the risks associated with additional demand.
The organisation has completed a bid for Regional Transformation Fund to reduce the risk further given the ongoing pressures within UEC.
There is a potential handover times will be affected as a result of winter given previous years impact.

Lead Assessor: Sarah Morrison

Date of assessment: 19/09/2025

What groups have you consulted with?: Service Users, Staff Side Colleagues

Please give details: JNCC on 30.10.25
Service users through feedback in complaints, friends and family feedback and UEC survey.

Please select all equality groups for which there is a positive/negative impact: Age, Disability

Impact: Negative

Comments: Given the age of presentation to the UEC pathway, it is likely more older people will experience extended length of stay in the winter.

Impact: Negative

Comments: Patients with disabilities are more likely to become unwell over the winter period. The consequences of boarding is more likely to affect people with disabilities if manual handling support is required given the limitations on space.

If a negative impact has been identified, where will the impact be monitored and escalated? : The impact will be monitored through internal site pressure metrics and three times monitoring and action meetings. Incidents will continue to be reported and action taken as outlined in the incident management policy.

Name Of Scheme Owner: Sarah Morrison

Scheme Owner Email Address: Sarah.Morrison@LTHTR.nhs.uk

Email Address Of DD or Head Of Department: Katie.foster-greenwood@lthtr.nhs.uk

Trust:	Lancashire Teaching Hospital

Area of Concern	Key Lines of Enquiry	Areas for Consideration	Response	Risk Rate
				Risk rate this area of concern using the following scale 1-3 Unlikely to cause extraordinary issues / poses some concern but
Patient Safety and Risk	What processes will be in place to ensure that, across all parts of the acute trust footprint, there is absolute focus on safety, quality of care and patient experience this winter?		Quality & Safety of patients is a priority for the organisation at all times of the year and is embedded in the governance and assurance processes across the organisation. We also have a strong, visible clinical leadership model with Matrons, Clinical Directors and AHP leads across all divisions who are accountable and oversee Safety & Quality standards. There are 3 times daily site pressures meetings with representation from all divisions that enable colleagues to raise concerns and ask for help when needed to manage increased times of pressure and risk. There are divert arrangements in place for maternity and children that work reliably. In addition there are twice daily safe nurse staffing meetings 7 days a week where safe care is reviewed and any risk to safety is mitigated with documented actions. This meeting includes oversight of adult, children, neonatal and maternity staffing across inpatient areas. There is a full, triangulated analysis report that is provided to the Safety & Quality committee monthly and this includes the ED dashboard and metrics for inpatient areas including boarding. There is a weekly PSIRF triage meeting that involves a review of incidents in week that provides early access to any themes or trends so that action can be taken to manage the risk associated with this. This is presented to the Chief Nursing Officer weekly through a PSIRF Oversight group and shared at an executive level weekly. There is a critical care outreach service in place 24/7 on both site that use indicators to proactively review deteriorating patients and support ward staff and ED in the management of deterioration. The Trust advocates Martha's Rule/Call for Concern and posters are visible in all clinical areas to promote the ability for patients and their relatives to request a second opinion if they are worried. The Trust has a Quality Assurance Framework "STAR" which provides an independent assessment of standards of care aligned to the CQC KLOEs and is led by a Qulality Assurance Matron. This accreditation system ensures that consistency of standards are aplied to clincial areas and gives a rating from bronze to gold which ensures that enhanced support can be provided to bronze areas. Between accreditation visits are monthly matron STAR audits that provide assurance of minimum standards between accreditation visits. The Trust's Single Improvement Plan (SIP) sets out the organisation's key priorities, within which there is a dedicated improvement plan for safety and patient experience. Oversight of progress is provided monthly through the SIP Board, chaired by the Chief Executive.	3
	How do you intend to mitigate the risk of patients spending >12 hours in ED this winter?		The ED exit block risk is a 20 with 2 principle risks in relation to this. We have relaunched continuous flow to support with the timely movement of patients across the hospital. The ED department have a planned approach to deploying additional nursing staff into the department when patient numbers increase. We also have an acute physician allocated each day to ensure a consultant review is undertaken on all patients who are waiting. People with increased vulnerabilities are identified in the safety huddle, the appropriate resource will then be allocated. As part of the Central Lancashire Operational Delivery Board, we have an ongoing piece of work around Days Kept away From Home. This workstream involves moving patients from pathway 2 to 1 and 1 to 0, to reduce overall LoS and facilitate timely discharge which will support with flow out of ED. Our Board Assurance Framework has been updated over the last 12 months and now reflects the "Principal Risks" facing the organisation. The Principal Risks are aligned to the sub committees of the Board and detail the controls, actions and assurances in place. There are 2 Principal Risks in relation to urgent and emergency. 1 of these risks details the timely access to care and treatment for people on urgent and emergency care pathways. The second describes patient experience through urgent and emergency care pathways. Both risks including the actions, controls and assurances are reviewed monthly through the aligned sub committees of the Board. One of the key operational actions in place to mitigate the risk of long stays for patients in ED is the use of the Continuous Flow Model (CFM). The use of CFM allows the transfer of patients from the ED to assessment units and from assessment units to wards at fixed times during the morning rather than waiting to allocate patients from ED to transfer to assessment units and inpatient wards following patient discharges. There is a policy in place to guide staff on how to safely manage the CFM and each ward has completed a risk assessment that details the steps in place to manage any risks associated with patients being cared for in temporary escalation spaces resulting in the deployment of the CFM. Deployment of CFM is managed operationally via the hree times daily Site Pressure Meetings and compliance data on emergency admissions before midday is reported through divisional dashboards. The Safety and Quality Commitee have received a "deep dive" report on the CFM in June 2025. The ICB are present at the Safety and Quality committee and continue to be	7

			actively involved in the review of incidents through the interaction with the governance team and through Safety and Quality committee. There are mitigations in place in those situations where patients do remain in ED beyond the 12 hours, safe nurse staffing in ED is a priority and our revised safe staffing policy considers the additional nurse and HCA requirements for ED when it is overcrowded. This is based on SNCT data, professional judgement and capacity and demand analysis and serves as a guide to provide minimum safe staffing levels. This also includes a "helicopter " nurse - an addition added to teh senior nursing team on a shift by shift basis to have oversight of all areas and ensure patients needs are met. There is provision for hot meals, snacks and wash facilities.	
	How is the trust using SAMIT 75 data to forecast the % of patients over 75 that may wait over 12 hours in ED? What is the trust's fast track process for this group?		We have a frailty assessment team who have a designated unit. The team in reach into the ED to assess and ensure that the CGA is completed with a plan in place. The Trust has recently initated a change in approach to working with the community 2 hour response team. There is a weekly improvement meeting to increase the utilisation and the capapcity within the 2 hour response team. Recognised gap is the ability to respond to changes in packages.	4
	What plans are in place to eliminate corridor care?		We are working to eliminate corridor care and this is monitored via the Quality & Safety Group. There is a risk with the implementation of the 45 minute NWAS handover that we will not be able to achieve this aspiration. Principal Risk 1 (ID 2102) "Patient experience within the urgent and emergency care pathways" details the actions, control and assurances in specifically in relation to corridor care in ED alongside the operational risk of "ED exit Block" The Safety and Quality Commitee receives an update these risks each month alongside the Commitee Dashboard that triangulates the number of patients "boarded" in the ED and inpatient wards with safety and quality outcome metrics	6
	Where corridor care does occur, how are you assured that patients cared for in corridors or temporary escalation spaces receive the appropriate level of care? How is this monitored?		There is a nurse staffing plan which is overseen by the Matrons to deploy additional staff to support patients who are in temporary escalation spaces and /or on corridors. ED has a Band 7 nurse lead 24/7 to oversee and manage risks. There is a designated peripatetic nurse who oversees the care for patients in non-bed spaces. This is monitored via UEC reporting and into the appropriate governance. Principal Risk 1 (ID 2102) as detailed above outlines the actions, controls and assurances. There are mitigations in place in those situations where patients do remain in ED beyond the 12 hours, safe nurse staffing in ED is a priority and our revised safe staffing policy considers the additional nurse and HCA requirements for ED when it is overcrowded. This is based on SNCT data, professional judgement and capacity and demand analysis and serves as a guide to provide minimum safe staffing levels. This also includes a "helicopter " nurse - an addition added to teh senior nursing team on a shift by shift basis to have oversight of all areas and ensure patients needs are met. There is provision for hot meals, snacks and wash facilities.	6
	What processes are in place for the escalation of deteriorating patients?		There is a full policy in place that utilises scoring and escalation of clinical risk to ensure that patients are managed appropriately. Compliance of this policy is monitored via the assurance framework and is a key part of the Trust Single Improvement plan, and is reported into the Quality & Safety committee. We have a comprehensive ME service with mortality reviews of deaths taking place. There is a critical care outreach service in place 24/7 on both sites that use indicators to proactively review deteriorating patients and support ward staff and ED in the management of deterioration. The Trust advocates Martha's Rule/Call for Concern and posters are visible in all clinical areas to promote the ability for patients and their relatives to request a second opinion if they are worried	3
	What plans are in place to achieve all ambulance handovers occurring within 45 minutes (as set out in the national UEC plan for 25/26)?		We have developed actions cards which identify where we will place patients depending on the current pressures. There is also a clear escalation route to the Executive team. This is an area of significant concern due to a number of factors including; bed reduction, limited community capacity to support discharge (no CHH/Longridge reduction) delays in funding decisions to support timely discharge.	7

Vaccination and Wider Prevention	How do you intend to improve flu vaccine uptake among your staff ahead of this winter?	Plans should include: a 100% occupational health vaccination offer for eligible staff throughout the programme; October 2025 to March 2026, that includes onsite bookable and walk-in appointments, detailing how success will be monitored; in and out-of-hours arrangements in place to advertise available flu clinics and other opportunities for staff vaccination with a focus on delivering vaccination close to areas of practice e.g. mobile units or on-ward vaccination; communication plans in place to advise staff of the need for vaccination, it's importance and value together with plans to monitor success. Trusts have vaccine champions to drive uptake.	A full vaccination plan has been developed to deliver the 100% offer of vaccination to all staff, this will commence in September 2025. There will be additional support from the corporate nursing teams with peer vaccination and out of hours provision. Vaccine uptake will be monitored and reported weekly with oversight at Executive level. Flu Vaccination Campaign Update •The written instruction has been signed off. •Seasonal training for vaccinators went live on the Blended Learning System at the end of last week, and rostering is now being worked through to plan staffing. •Delivery will be through a combination of pop-up stands/sessions and roving teams covering all areas of our hospitals, from daytime into late evening. •Pop-up sessions will be promoted on the intranet two weeks in advance and, wherever possible, aligned to high-footfall areas such as Education Centres during training and induction events. •Larger staff groups (PBC, Pathology, Pharmacy, Rosemere, Maternity/Gynae and others) will receive planned team visits. •A small number of "Vaxathons/Fluathons" will again be run across the patch, building on their success in boosting uptake early in last year's campaign. •Communications activity is underway, including: opromotional video clips with Dr Munavvar, oMS Teams backgrounds, oe-mail signatures, odesktop screensavers, and ointranet carousel banners (with a countdown to launch). •Posters and flyers will focus on two key themes: "3 good reasons to get your flu vaccine" and "How do I get my vaccination?" (with QR codes for easy access). •Work is underway to expand our peer vaccinator network, supported by an information flyer being developed by Catherine Gregory (Deputy CNO). •Intranet access has been improved, with a new dashboard tile providing direct access to vaccination information, addressing last year's accessibility issues. System-wide update •Colleagues will be able to receive their vaccination at whichever Trust site is most convenient. •The ICB has commissioned external providers to support healthcare support worker communications and campaign artwork. •Data reporting will improve this year: a background system will feed vaccinations given elsewhere directly into our records, ensuring uptake counts towards our frontline targets (although some data matching issues may occur). •Regional communications are being coordinated across partners. •The ICB vaccination bus will also visit our sites, offering vaccinations to colleagues, visitors and the public. Next steps: We are awaiting confirmation on when vaccines will be physically received. Our plan was to launch the campaign on 15th September, but there is currently some uncertainty as it has been intimated that NHS England have indicated that no Trusts should begin before October. It would be helpful to clarify if this is the case.	4
	What target uptake rate (%) for staff flu vaccination are you aiming for this year (25/26), noting the expectation set out in the national UEC plan for 25/26 for all providers to		70%	3
	Do you have a named Executive Lead for staff vaccination? If so, please detail who this is.		Neal Pease - CPO	1
	What mechanisms are in place to ensure frontline staff details on ESR are correct to enable accurate reporting on FDP?		All staff are able to update their personal information in ESR and there are regular comms throughout the year to remind people to update personal information. In addition to this, whenever there is any change to an individual's role i.e. acting up/secondment/new work base, personal details are checked and amended on the system.	1

IPC	What plans will be in place to promote optimisation of IPC practices and affect Healthcare Associated Infection (HCAI) prevention/reduction in your organisation?	IPC Improvement Plan IPC Board Assurance Framework (BAF) Infection surveillance Education and training i.e., PPE, management of infectious patient/s	IPC is a mandatory training requirement for all staff and Sepsis training is mandatory for all clinical staff. We have comprehensive policies and processes in relation to IPC. A business case has been approved to provide domestic staff to achieve compliance with the national standards for cleanliness. We have an IPC team that supports all clinical areas with the management of HCAI and provide specialist advice when needed. PPE is available for all staff. Monitoring compliance with standards is embedded into the assurance framework with board level reporting. There is an IPC annual improvement plan and a C.Diff Improvement plan in place with aligned audit and assurance frameworks in place. The delivery of these plans are managed through the Trust Infection Control Committe. The Infection Control Commitee oversees Divisional compliance with IPC assurance framework. There is monthly reporting in place from the Trust Infection Control Commitee to the Safety and Quality Commitee on triangulated infection surveillance, incidents and audit metrics. The Board Assurance Framework includes IPC with C.Diff reflected as a Principal Risk . There is now an IPC dashboard in place that provides visible data and assurance of IPC practices which includes multiple data sets including time to isolation for patient placesment, time to fogging, environmentala audits, hand hygiene audits and PPE compliance. This is available at ward level to give greater scrutiny of gaps in practice. IPC committee recieves an overview report on all incidents and complaints each month and highlights themes and learning so that actions can be put into place. a member of the IPC team attends the daily capacity meetings to operationally support patinet flow and placement based on IPC practices. There is a microbiologist on call 24/7 for advice.	2
	How are you prepared for surges in admissions of people infected / potentially infected within the UEC pathway?	Provision of rapid diagnostics Procurement and supply chain resilience i.e., PPE, hand rub, testing kits, cleaning products Vaccination – staff in particular - Flu, COVID-19, MMR Identification of potentially vulnerable staff members Cleaning / decontamination, enhanced cleaning, rapid response cleaning teams, provision of decant area for whole area cleaning Isolation provision, temporary escalation spaces, cohort wards /	See above response - this applies across the whole organisation including ED. Also see staff vaccination updates. The IPC team will provide specialist advice when needed and work with the community teams for specific cases. Rapid access swabbing and results are in place for Flu, COVID and patients presenting with loose stools. This helps to prioritise isolation capacity for patients with confirmed or highly likely infections and reduces risk of nosocomial spread. The Trust has embedded point-of-care testing (POCT) across admission areas and inpatient wards, supported by a clear policy and guidance on appropriate use. This has enabled infection outbreaks to be minimised despite ED overcrowding and limited availability of side rooms (20% across sites). In the ED, POCT is available for respiratory patients, allowing early identification of RSV and influenza. For children, an extended respiratory panel supports the appropriate management of vulnerable patients. Gastrointestinal POCT (PCR-based) facilitates rapid identification of norovirus, C. difficile and other infections. This approach serves three key purposes: Early identification of patients requiring admission and isolation. Confidence to discharge patients (e.g. with norovirus) where acute care is not required. Rapid rule-out of infections, preventing unnecessary isolation and optimising use of limited side-room capacity. POCT is available 24/7, avoiding delays associated with laboratory results (up to 24 hours, with the pathology lab closing at 6pm weekdays and 1pm weekends). The gastrointestinal POCT uses a rectal swab, eliminating the need to wait for a diarrhoeal sample	2
	What systems and processes will be in place this winter to mitigate against delays in discharge and other related pressures caused by increases in infection rates?	Transfer of care processes both internal and external System – discharge processes, social care, admissions to and from patients' place of residence potentially out-of-hours, confidence in other settings managing	The IPC nurses work closely with colleagues across community to manage patients and support the wider community (including care homes) in relation to managing patients with infection, to ensure there are no delays in discharge. We have isolation rooms/side rooms to support patients who are infectious or clinically vulnerable which supports with discharge planning and effective use of bays in wards albeit, due to our estate challenges our side room capacity is lower than peers and needs closely monitoring to ensure appropriate use. The IPC team have close oversight of the patients in side rooms and in winter do daily side room audits to de-escalate quickly and maximise the use of this essential resource and prioritise the use based on balance of risk.	3
Leadership and Control	Is there a Senior Responsible Officer who will act as the Executive Winter Director for your organisation this winter? If so, please detail who this will be.		Katie Foster-Greenwood, Chief Operating Officer (COO)	1

	How will daily oversight of operational pressures across the acute trust footprint be delivered this winter?		Regular site updates direct to the COO & Deputy COO which starts at 6am each day. Daily routine includes three site management meetings, with clinical & operational leads for each division and corporate service. Feedback from daily SCC meetings direct to COO/Deputy COO. Site escalation policy has been refined with action cards providing clarity around escalation and decision making for silver/gold internal meetings. In addition there are twice daily safe nurse staffing meetings 7 days a week where safe care is reviewed and any risk to safety is mitigated with documented actions. This meeting includes oversight of adult, children, neonatal and maternity staffing across inpatient areas.	2
	How will the trust ensure executive visibility and support in the ED department this winter?		The Chief Medical Officer, Chief Nursing Officer & Chief Operating Officer chair and attend an ED safety meeting with clinicians, they also participate and support with site pressure meetings & chair internal gold meetings. There is regular attendance and engagement with the ED team. In addition to ad hoc visibility in response to times of pressure, there is a monthly patients safety visit with members of the senior team and executive team visiting clincial areas to connect with front line staff and have conversations about safety.	3
System Working	What plans will be in place to ensure effective joint working with all system partners (especially relevant local authorities and social care) this winter, particularly in relation to both admission avoidance and hospital discharge processes?		Pilot currently underway delivering joint review/assessment of patients who are on pathway 1 & 2, in order to release time efficiencies and support timely decision making. Regular, daily calls with the local authority team and good working relationships with social care and the discharge team. Strengthened relationships with Executive team at Lancashire Teaching Hospitals (LTH) and Executive team at Lancashire County Council (LCC), with regular meetings and escalation. Exploring the opportunity to have more Social Workers on wards which will further strengthen relationships.	3
	How will the trust work with system partners to ensure there is a proactive approach taken to managing operational pressures this winter, using early warning to pre-empt situations		We have shared our escalation policy with partners and have tested this recently during times of operational pressure which has resulted in positive outcomes. Site escalation score with associated actions in place. Strengthened relationships with both Lancashire & South Cumbria Foundation Trust (LSCFT) and LCC via the Central Lancashire Operational Delivery Group.	3
	How will the provider maximise the role of VCSE partners this winter?		One of the Central Lancashire priorities this year is to expand our hospital avoidance and community offer via Care Connexions. There is an element of this workstream that looks at maximising the VCSFE offer in Central Lancashire. We are currently working with Age UK (who sit as part of Care Connexions) and LCC to look at opportunities to expand.	3
Primary Care and Community	How will primary care services across your local acute trust footprint support management of winter pressures?	Need to see a robust PC offer - a good marker is advanced care planning; where this is in place inappropriate admissions are reduced	Introduction across General Practice of Modern General Practice Access which increases usage of triage systems and online services for patients. We can monitor activity on same day, following day and 14 day access for providers to see where providers are enacting their own winter plans. Intention to increase utilisation of Pharmacy First across providers and refer more patients to pharmacy services where clinically appropriate. The ICB Long Term Conditions LES has increased funding into General Practice that will support patients in particular need, and reduce potential appointments in other areas of the system. We routinely monitor appointments offered and utilised across General Practice. We monitor 111 utilisation and monitor variation between practices.	3
	How will local care homes be supported this winter in supporting their residents to remain well, access timely support, care, treatment, and advice if/when required and to remain in the care home for their care and treatment		Each care home is supported by a nominated PCN who undertakes specific activities to look after the registered residents in those homes. The EHCH framework is followed by those providers.	3
Mental Health	How will your local system ensure that Mental Health pressures are managed as effectively as possible this winter, particularly in relation to provision of services other than ED for MH patients?		An assessment process is conducted in the Emergency Department to determine if a patient can safely wait at home. Daily visits are provided by HBTT / CMHT (OA) / RITT to monitor patients who are awaiting admission. Multidisciplinary team (MDT) network calls are held regularly to coordinate care. A robust escalation process is implemented. Efforts are made to minimise the number of patients awaiting assessment in the community. Recovery houses and Assessment and Treatment Services (ATS) are considered as alternatives to inpatient admission where appropriate. Admission wait times are reviewed and overseen four times daily to ensure timely intervention. Strong links with voluntary sector organisations are maintained through enhanced MDT meetings on a weekly basis.	3
	What processes will be in place this winter to mitigate against unintended harm to patients with a Mental Health condition?	Risk assessment, ligature risk assessments, MHMOA	Shared Care between ED and MHLT. Robust collaborative care plans for people waiting admission for MH bed in ED. MHLT maintaining KPIs for routine and urgent ward referrals.	3

	What processes are in place to reduce the number of patients who remain in an emergency department for longer than 24 hours whilst waiting for a Mental Health admission?		Refreshed escalation protocols to ensure prompt action: Timely assessments, reviews and clear gatekeeping assessments. Additional communication regarding IRS, HBTT, CMHT, and recovery house services (as alternative to admission). Optimised staffing levels within community teams and bed hubs. Regular Multi-Agency Discharge Events (MADEs) and system-wide support to enable timely discharges. Scheduled bed calls, prompt escalations, and increased awareness of Out-of-Area Placements (OAPs). Addressing Mental Health Act Assessment (MHAA) delays through rapid escalation via the bed hub and discussion at the weekly HBPOS meeting. Twice-weekly safe flow huddles with executive involvement. Weekly learning reviews for all patients who have breached.	7
	How will the trust assure the implementation of the National MH ED Waits Actions Cards including ensuring there are clear escalation processes for ED and partner MH Trusts where there is delay in receiving specialist support?		Distribution of cards to appropriate teams and people. Review of the effectiveness in interface meetings between LTH and LSCFT. Escalations via Gold calls.	5
	How will the trust enable and support staff awareness of local MH UEC services to support timely access for patients?		The ED department work closely with LSCFT colleagues who will always look at alternatives to ED. Good working relationships between the site management team and the MH leadership team which ensures effective communication around plans.	5
Workforce	How will the trust ensure adequate staffing levels are in place to meet anticipated demand this winter?		Safer staffing levels are established in all clinical areas with Healthroster as the tool to manage and predict shortfalls. Matron of the day role in each division to manage staffing across all units with the site management team picking up this role out of hours. Staff bank process in place. There is a safe staffing policy in place that covers the process for setting safe nurse and midwifery staffing levels and these levels are monitored daily through the twice daily (each shift) safe staffing meeting which is held days a week. Oversight of safe staffing levels are presented monthly to Safety and Quality Committee. This includes CHPPD at ward and departmental level, planned versus actual fill rate and any red flags that have been raised. The safe staffing policy also covers day to day risk assessment and deployment of staff and describes the Trust embedded process for having oversight of safe staffing using safe care, red flags and adding mitigations so areas of risk are known. The safe staffing policy applies to adult, children and maternity services and has been widely promoted through the community of practice sharing information to all leaders. The Trust has developed a data set using live data in a system called Daily Management system which gives real time oversight of risk. Whilst minimum safe staffing levels in nursing and midwifery are planned using SNCT data and methodology, a professional judgement	2
	What plans are in place to minimise the spend on agency staff over winter to ensure the Trust meets the cost reduction ambitions set out in		There are comprehensive and robust plans in place to manage staffing and variable pay as part of our financial recovery. The use of agency staff (non-medic) is not in place and requires Executive or Deputy approval.	2
	How will staff wellbeing be improved or maintained across winter?		Management of staff via HealthRoster allows for visibility of hours worked to ensure that adequate breaks are taking place. Visible Clinical Leadership across all divisions is in place. Support available via the Organisational Development team for all teams, as well as access to Employee Assist.	4
	What training is provided to staff to recognise and address health inequalities in emergency care settings?		Included within mandatory training is equality, diversity and inclusion, which focusses on understanding protected characteristics and how to support colleagues and patients appropriately. Also included is LDA training which recognises the risk of adverse health outcomes and how to consider this to support care needs. Safeguarding adults and children training is also mandatory. For ED staff there is also Mental Health awareness training.	2
Bank Holiday Preparations	Please describe what additional actions will be taken to ensure core services remain accessible to the public over the festive period – specifically between week commencing 15th December and week ending 11th January?		All services will be delivered over the holiday period as per usual, this is managed via the submission of a divisional Bank Holiday plan, which ensures that annual leave levels are appropriate and that there are clinical and operational leads identified each shift. In addition to the divisional plans, the site management team will continue to operate over the Bank Holiday period as they do throughout the year, 7 days a week. MADE events will take place prior to the holiday period to support with flow and discharge.	2
High Intensity Users	How is the Trust integrating High Intensity Use services within the UEC (UEC) Plan to proactively support patients who frequently present at A&E, ensuring appropriate alternative care pathways, addressing underlying health and social needs, and reducing avoidable emergency attendances?		We have a High Intensity User (HIU) practitioner who manages 10 patients - we do not have a service. We do however work with our Mental Health teams with their HIU and share care planning with ED.	7

Health Inequalities and Prevention	1.Understanding your Population: How does your Trust's UEC Plan specifically address health inequalities? I.e. deprivation, protected characteristic groups and inclusion health groups. a.How is health inequalities intelligence/data		See line 44 re mandatory training. Health inequality data is available and used to look at the types of patients presenting in ED, this is also monitored via the health inequalities group.	4
	2.Access: What steps have been taken to reduce language, cultural, and digital barriers in accessing UEC?		We have implemented a translation service that is accessible via an iPad in the ED department to ensure that there is 24hr access to interpreters, in order to reduce delays/treatment to non-English speaking patients.	2
	3.Prevention: What sustainable prevention programmes (linked to modifiable risk factors) are in place to reduce avoidable A&E admissions, particularly among disadvantaged communities? a.How is the Trust ensuring robust and effective pathways are in place for timely follow-up with community teams after patients present at A&E with acute issues—especially		We are working closely with community providers to ensure a more joined up approach for patients who are more vulnerable. This includes follow up visits and accepting into other community provision without waiting for referrals to be accepted. The Virtual Ward and 2hr Urgent Care Response team are working towards the delivery of a hospital avoidance service that flexes to demand and is able to provide additional support during times of surge (to note this cannot be sustained long term). The hospital frailty team work with the community frailty team to ensure consistency in provision and more effective use of clinical time. The Mental Health team and the ED team work in the same department to ensure that patients discharged from ED have follow up appointments with the right community Mental Health service.	4
	4.Partnerships: How is the Trust working with local authorities, the ICB, voluntary organisations i.e. patient voice, and social care providers to address health inequalities in		Whilst health inequalities is part of the conversation on the Central Lancashire Operational Delivery Group with all providers, the focus this year is around strengthening the community provision to avoid admission and timely discharge of patients back into the preferred place of residence (Days Kept Away from Home - DKAfH). Both of these work programs will support with patient flow and access.	3
EPRR & System Resilience	In the event of operational pressures escalating into incident declarations, what plans are in place to ensure incident management and operational delivery ensure incident resolution with clear criteria for escalation and de-escalation (this includes		As described above. There is a robust escalation policy that has been developed over 4 months and revised 'live' to try and ensure that it incorporates all scenarios. Robust escalation action cards with clarity around areas to escalate/decision making/escalation. This is then used by the site management team to ensure that there is de-escalation as soon as it is safe to do so. Incident declarations are made based on site pressure scores, plans and discussion with the COO/Deputy COO.	3
Discharge & Long Length of Stay	What are the main reasons for hospital-related discharge delays and what steps are being taken to address these issues?		Funding requests - follow the agreed process and escalate. Home First assessments - there is an improving picture in relation to this with a pilot to allocate more slots on the same day. Transport - inability to arrange PTS on the day or at specific times for community appointments. Working with families to support with transport and we also have improvement trajectories to improve the utilisation of the current capacity. Internal process - a number of internal processes were highlighted during the recent MADE event as impacting on timely discharge, these are all managed in the respective divisions and monitored.	7
	What is the process for reviewing patients with lengthy discharge delays? How will this be improved in time for winter?		We have weekly length of stay meetings throughout the year which identifies barriers and provides an escalation. Regular point prevalence takes place and over the winter period we will implement a long length of stay meeting chaired by the Deputy CNO.	3
	What reviews have taken place of in-hospital flow and what have they identified in improvements that can be made? How are		As per previous points. We have implemented continuous flow across wards and streaming out of ED into assessment units. This is monitored via the UEC plan and via Divisional Governance meetings with Trust Executives.	3
	Which are the key pathways that require improvement in time for winter? What actions will take place, what impact do you expect and how will this be measured?		DKAfH - this is a system program with LTH, LCC & LSCFT working on moving patients through pathways and optimising with the least amount of support needed. The aspiration is to reduce LoS and get patients back to their preferred place of residence as soon as they are clinically optimised. This is monitored via Central Lancashire Operational Delivery Group and internally reported through divisions and into the exec team. It is monitored on a weekly basis in a meeting chaired by the COO.	6
	What performance discharge target is being		We are working to the nationally defined target.	5
	What performance discharge targets are being set collectively by trust and local authority partners for Pathway 1, 2 and 3 patients?		We are working to the nationally defined target.	5
	How will the local system manage surges in demand for step-up and step-down services		Community services will support with a 'pull model' to move appropriate patients out of the department and utilise the Virtual Ward for more complex patients.	5

UTCs/Streaming	How will the Trust optimise use of alternatives to ED, including for patients who walk-in to ED?		The integrated urgent care service for Central Lancashire is provided by gtd healthcare. There is direct referral to clinical assessment services 24/7 by NHS 111 and NWAS. Additionally, there is a local clinical assessment service providing direct CAS support for Preston and Chorley patients. Referrals include category 3 & 4 calls. These pathways are mature and offer access to booked appointments in urgent care and home visits in the out-of-hours period. There is a step-down facility for the virtual ward programme. Annually, 13,000 patients are offered care across digital and physical presenting patients. In partnership with Lancashire Care teaching hospitals, self-presenting patients are streamed 24/7, largely to Urgent or Emergency care services. There is an opportunity to expand pathways alternative to both urgent and emergency care by strengthening links with Care Connexions to enable rapid access to the 2-hour community response. There is also the potential to add the NHS streamer & redirection tool to support management of patient flow inward and outward as community service pathways are strengthened. Care ConneXions will expand the alternative-to-ED offer by combining rapid access to the 2-hour Urgent Community Response (UCR) with increased Virtual Ward (VW) utilisation. From September, streamlined call handling and a single clinical triage model will enable direct referrals from 111, ambulance crews, and primary care into community pathways, diverting patients away from ED. The Hospital @ Home generalist model and “ACP of the Day” approach will provide same-day assessment and treatment in the home, with 7-day cover (8am–8pm). By scaling VW utilisation to 80 beds and increasing UCR activity by 25%. Continuous monitoring of referrals, acceptance rates, and VW bed utilisation will allow dynamic adjustment of staffing and pathways, ensuring resilience throughout the winter period. Go2Doc provide the UTC service at Preston and Chorley, and are part of the Central Lancashire Operational Delivery Group. Care ConneXions will expand the alternative-to-ED offer by combining rapid access to the 2-hour Urgent Community Response (UCR) with increased Virtual Ward (VW) utilisation. From September, streamlined call handling and a single clinical triage model will enable direct referrals from 111, ambulance crews, and primary care into community pathways, diverting patients away from ED. The Hospital @ Home	4
Elective Programme	How does the Trust intend to maintain its elective programme through winter in the face of rising non-elective pressures?		The elective program will be prioritised to maintain delivery, particularly in the areas where there are recovery plans in place. High priority will be placed on urgent/cancer/P2 and long waits. Scheduling of electives will focus on the Elective Hub site and day surgery at time of peak pressure. A further roll out of Continuous Flow and the DKAFH programme will seek to reduce LOS and reduce bed pressures. Core escaltion controld are in place re the authorisation of outliers. Where this is essnetial for safety reasons, patients with a next day discharge will be identifed to support electiove flow the following day. Additional trauma capacity will be established with regular monitoring of delays to theatre to allow early remedial action. Decision making to cease/pause elective activity due to winter pressures can only be made via escalation to the Executive team (or deputies).	5

10.2 - GREEN PLAN

REFERENCES

Only PDFs are attached

10.2 - Green Plan 2025-2028.pdf

Sustainability
Working together to create a greener future

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Lancashire Teaching Hospitals NHS Foundation Trust

Green Plan 2025–2028

Contents

Foreword

The serious threat that climate change poses to the environment has been well-documented and presents an immediate and growing threat to health. The UK is already experiencing more frequent and severe floods and heatwaves, as well as worsening air pollution. What is perhaps slightly less recognised is the damaging impact this also presents for the delivery of high-quality patient care and the health and wellbeing of our communities.

This is why the National Health Service has a clear ambition to become the world's first healthcare system to reach net zero carbon emissions.

Building on the work achieved over the last three years, Lancashire Teaching Hospitals Green Plan sets out further plans for working towards this target with the support of our colleagues and the communities we serve. As we stand at the crossroads of environmental sustainability and economic growth, it is essential that we develop a plan that not only addresses the pressing challenges of our time but also paves the way for a greener, more sustainable future.

As an anchor organisation and major teaching hospital trust we take every opportunity to provide the employment and educational opportunities that can have such a positive effect on individual and collective health, wealth and fulfilment.

This plan outlines our strategic priorities, key actions, and measurable targets that will guide our efforts over the next three years, aligning with our Trust strategy. By focusing on renewable energy, waste reduction, sustainable transportation, and biodiversity conservation, we aim to create a resilient and thriving environment for generations to come.

We will continue to work collaboratively with other health organisations and our local communities in Lancashire and South Cumbria as we move towards delivering new models of care. Coupled with our enabling strategies around digital and estates and facilities, this will underpin the green plan, whilst sharing best working practices which promote greater efficiency and enhanced saving opportunities.

We are excited to continue on this journey and look forward to the positive changes that the Green Plan 2025–2028 will bring. Let us work together to build a sustainable future that we can all be proud of.

Professor Mike Thomas, Chair

Introduction

About us

Lancashire Teaching Hospitals NHS Foundation Trust employs over 9000 staff and has a volunteer workforce of over 650 people, most of whom live within our area.

We provide general hospital services to 390,000 people in Preston, South Ribble and Chorley and specialist care to 1.8 million people across Lancashire and South Cumbria.

As one of the largest organisations in the area, we have a significant impact on the local environment. The activities and services we deliver create considerable amounts of waste as well as greenhouse gas emissions, all of which contribute to air quality and climate change. Whilst we have made good progress over the last three years in working towards a greener NHS, we recognise that this is limited without substantial investment.

Why do we need a green plan

In 2020, the NHS became the world's first health system to commit to reaching net zero emissions. The Delivering a Net Zero National Health Service report set out the scale of ambition, highlighting that left unchanged climate change will disrupt care, with poor environmental health contributing to major diseases, including cardiac problems, asthma and cancer. The Health and Care Act 2022 reinforced this commitment, placing new duties on NHS foundation trusts to consider statutory emissions and environmental targets in their decisions.

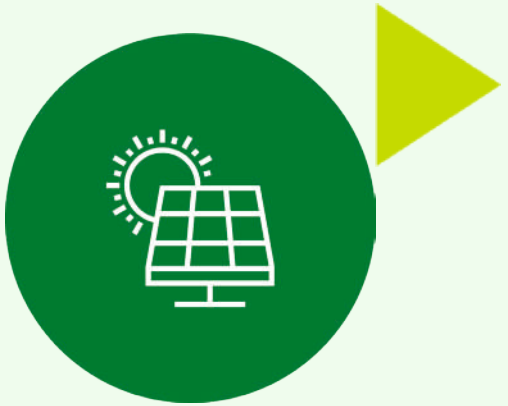
Trusts are expected to meet these duties through the delivery of board-approved green plans. These plans now need to be refreshed in line with the statutory guidance by 31 July 2025.

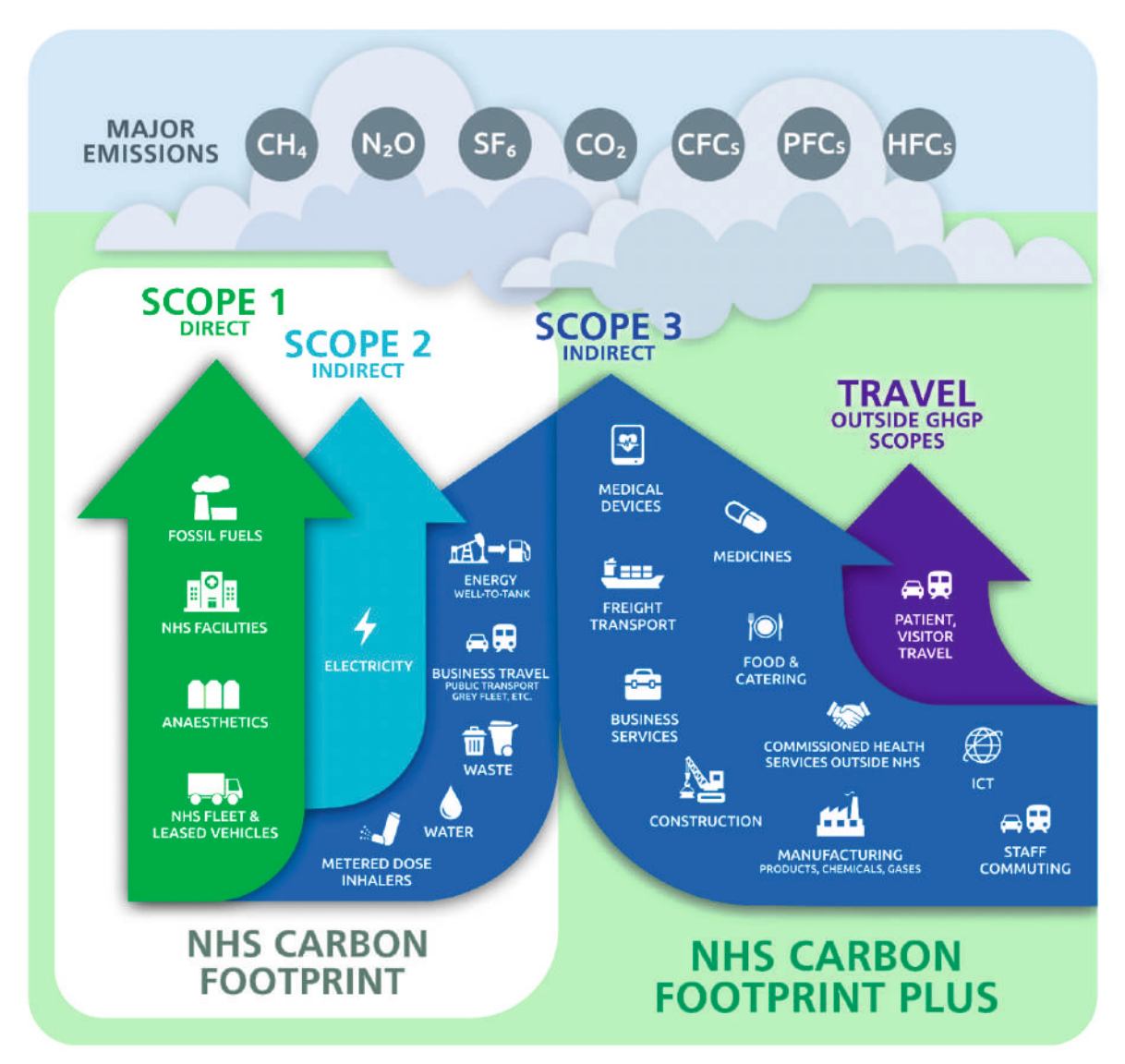
The refreshed Green Plan sets out further plans for reducing the Trust's environmental impact, aligning to the recently published national guidance under each of the nine domains https://www.england.nhs.uk/long-read/green-plan-guidance/ . This was further reinforced in Lord Darzi's recent report stating, "Given the global health imperatives, the NHS must stick to its net zero ambitions. There is no trade-off between climate responsibilities and reducing waiting lists. Indeed, often health and climate are mutually reinforcing goals: cleaner air is good for the environment and good for respiratory health" (Darzi, 2024).

What are we seeking to achieve

This Green Plan sets out our vision, strategy, and aims for reducing the Trust's environmental impact, improving its resilience, and helping us manage resources effectively. It is underpinned by our strategic framework, spanning across all of the five P's, Patients, People, Partnership, Productivity and Performance and aligns with the Trust strategic priorities, currently being finalised as part of the Trust strategy.

The Plan will enable us to deliver high-quality sustainable healthcare that is environmentally sustainable, socially responsible and economically viable working towards achieving the commitments set out in the Delivering a Net Zero National Health Service.





This includes two clear targets as outlined below;

Achieve Net Zero by 2040 for the NHS Carbon Footprint, with an ambition for an 80% reduction (compared with a 1990 baseline) by 2028 to 2032 (scope 1–2)

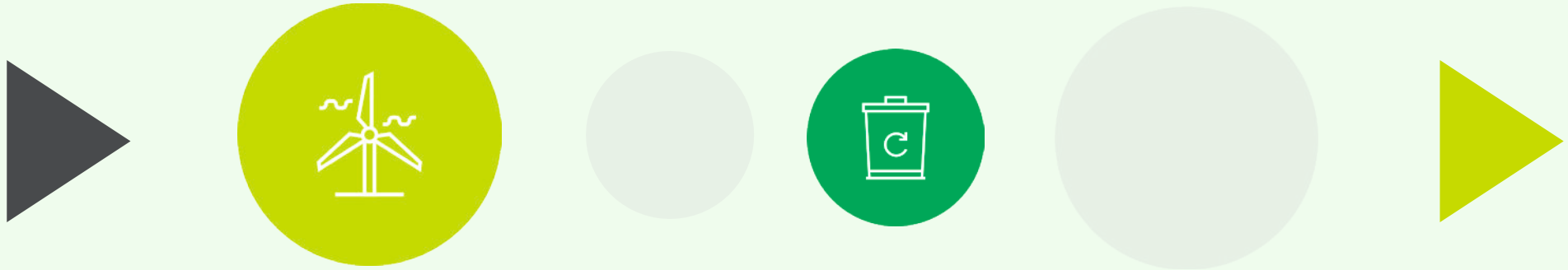
Achieve Net Zero by 2045 for the NHS Carbon Footprint Plus, with an ambition for an 80% reduction (compared with a 1990 baseline) by 2036 to 2039 (scope 3)

Here at Lancashire Teaching Hospitals, we believe our long-term sustainability is tied to the wellbeing of the population we serve, we are committed to collaborating with other stakeholders to deliver a common goal of using our resources responsibly to help protect the needs of future generations. All of us have a part to play in delivering this plan and by working together, we can provide sustainable healthcare which is fit for our future. The development and delivery of the Green Plan is embedded in our Trust governance processes, which sets out the strategic ambitions of our organisation. Our Chief Finance Officer is the Board lead for this area of work and is fully committed to build on the work already undertaken to drive sustainability across the Trust, further reducing our carbon footprint.

Our progress so far

Progress on the Green Plan will continue to be reported in the annual report. Some of the key achievements from the current Green Plan are detailed below;

- Cool sticks implementation within Pharmacy for Critical Care and Theatres to reduce the usage of Ethyl Chloride spray, resulting in both a cost saving and environmental saving
- Office 365 roll out across the Trust supporting home usage and cloud computing
- Successful funding bid enabled the installation of LED lighting at the Chorley site and part of the Preston site
- Funding bid approved for heat decarbonisation scheme to reduce steam output at the Preston site
- 30 Green Champions recruited across the Trust
- Dedicated Travel plan produced
- Established working group to develop and deliver the Green Plan
- Single use plastics removed from front of house catering outlets
- The catering team achieved the Bronze status award from the SOIL Association
- Warp – It scheme in place across the Trust to encourage re-use of equipment
- 30 small trees and 40 hedge row whips planted at the Chorley site in the last year
- Dedicated e-learning module 'for a greener NHS' available for staff to complete
- Collaborative working across the Integrated Care System sustainability groups to work as a partnership in delivering the green plan



Developing this plan

The refresh of the Green Plan has been developed in line with the national guidance published 4th February 2025 and through the Trust sustainability working group. It identifies the key areas for future efforts, building on progress made within the workstreams in the Green Plan 2022–25, as well as feedback from staff engagement undertaken within the Trust.

We have engaged with staff through a sustainability survey, online Teams sessions via the Leaders forum and all colleague briefing, through the sustainability Champions and held promotional stands on Trusts sites to gather feedback whilst promoting some of the current schemes around sustainability across the Trust.

Staff feedback, collated through surveys and engagement sessions held, indicate the importance of having SMART (Specific, Measurable, Achievable, Relevant, Timely) actions and to ensure we are able to measure our progress in the future. The below gives results from the staff survey demonstrating how staff have ranked the ten areas of focus, according to what they believed the Trust should prioritise on. The highest ranked being digital transformation, followed by travel and transport then supply chain and procurement. This aligns with the national ambition and Trust strategy around moving from analogue to digital to support how services are delivered in the future, along with bringing care closer to home, therefore reducing the need to travel and getting the best value for money.

1. Digital transformations
2. Travel and transport
3. Supply chain and procurement
4. Estates and Facilities
5. Sustainable models of care
6. Food and nutrition
7. Medicines
8. Workforce and system leadership
9. Climate adaptation
10. Green spaces and biodiversity

Working with our partners

Externally, engagement with the Integrated Care Board and their refreshed green plan, along with other Trusts locally within Lancashire and South Cumbria, ensures we are aligned to the priorities across the system, as we work collaboratively to deliver services for our population in the future. We have developed strong working relationships with the sustainability leads across the providers, sharing best practices through both formal and informal forums.

This provides opportunities for wider system working, in particular where we may face challenges in the future relating to the effects of climate change resulting in more frequent or severe floods or extreme heat. Within Lancashire six Climate Action Juries/ Assemblies, undertaken by councils in Lancashire & South Cumbria since 2020 have gathered well informed public opinion and priorities. These groups outlined the need for education programmes on climate, promoting and improving active travel and making public transport more accessible and joined up.

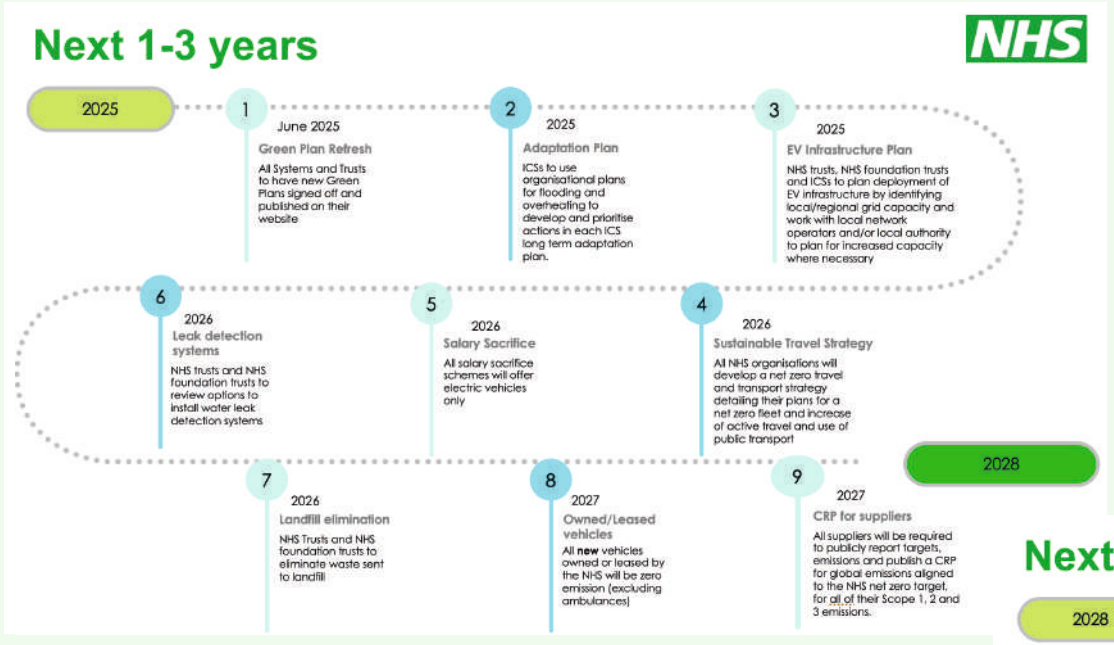
As the Trust works towards stronger links with academic partners, this also provides further opportunity to engage in research and innovation activities which can support delivery of achieving the net zero targets.

Areas of focus for 2025–2028

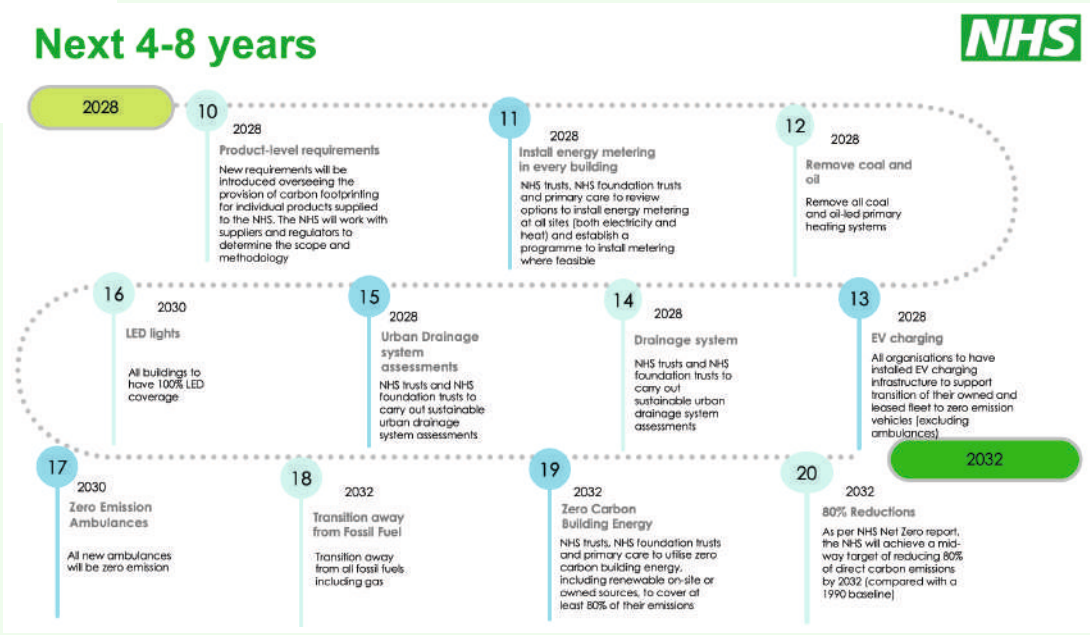
The current plan extends to twelve areas of focus however on reflection and review of the plan, it was decided to reduce these to ten. This will ensure we are able to align with national guidance and report on the measures for each of the ten areas, detailed below;

- Workforce and leadership
- Sustainable models of care / Net zero clinical transformation
- Digital transformation
- Travel and transport
- Estates and facilities
- Medicines
- Supply chain and procurement
- Food and nutrition
- Adaptation
- Green space and biodiversity

The key milestones across the areas of focus over the next three years are summarised in the following graphic.



Looking ahead past 2028, further key milestones laid out will need to be considered as we continue with the net zero journey, working towards meeting the ambition to reduce our emissions by 80% by 2028–2032.



1. Workforce and Leadership

This chapter outlines our aim to engage, develop and support our workforce to learn, innovate and embed sustainability into everyday actions, defining and delivering carbon reduction initiatives and broader sustainability goals.

Progress and next steps

Following the introduction of the Green Plan 2022–2025, there is a dedicated sustainability Hub on the Trust intranet for staff to increase knowledge and awareness of the various initiatives in place. We have established 30 sustainability champions across various specialties and departments and have an e-learning module 'For a greener NHS' available for staff to complete. Since the introduction of the green plan in 2022, the board level lead assigned to oversee this has now left the Trust. This presents as opportunity to appoint a new lead to support the work going forward.

The following actions will build on the work undertaken over the last couple of years and will ensure environmental sustainability is embedded in everyday decision-making and that as a Trust, we are equipped to achieve the ambitious green targets to reach net zero.

Action	KPI(s)
1.1 Appoint a permanent board level net zero lead to oversee green plan delivery with operational support.	Confirmation through Board meeting by June 2026
1.2 Increase the current number of sustainability champions across the three Trust sites to act as advocates, support sustainability initiatives and share good practice.	Baseline of 30 champions - increase to 100 over the next 3 years aiming for 50 by March 2026, 75 by March 2027 and 100 by March 2028
1.3 Embed the sustainability training e-learning module into local induction for all staff	Embed within induction programme by March 2026
1.4 Promote specialist training for staff groups who underpin the delivery of green plans across the key focus areas	Specialist training sessions arranged and delivered to key staff by March 2026

2. Sustainable Models of Care

Embedding net zero principles across all clinical services is critical, with this section considering carbon reduction opportunities in the way care is delivered. By using technology along with new models of care, carbon emissions associated with healthcare delivery can be reduced. Through our transformation of care programmes, we can make an impact on how clinical care is delivered through the care closer to home programme, seeking alternatives to admission by increasing the provision of virtual wards, telephone follow up and community support. The prevention focussed care programme has an emphasis on preventative health, examples of this being frailty assessments, personalised care, shared decision making and promotion of self-management.

Progress and next steps

Some examples of where this has been achieved to date are the implementation of a robust Electronic Patient Record and Electronic Document Management System, the implementation of the Hospital Home Care service, preventing patients needing to travel to hospital sites, and the move to remote outpatient appointments where appropriate.

Social prescribing is a holistic approach which connects people to local, non-clinical activities which can also contribute to addressing the root cause of health problems. Some examples of this include support groups, exercise or green spaces, all of which the green plan can help to facilitate through the work we are committing to deliver.

Linking to the national guidance, the key opportunities going forward include the requirement to identify a clinical lead to support with sustainability across the clinical services. This will support provision of care closer to home, reducing unwarranted variations in care delivery and outcomes that result in unnecessary increases in carbon emissions, in particular the work focusing on the implementation of the green theatre checklist https://www.rcseng.ac.uk/-/media/images/rcs/about-rcs/sustainability/greentheatrecompendiumofevidence.pdf

Other areas of clinical consideration include the use of short stay and day case surgery where clinically appropriate. Reducing duplication of imaging and tests, pathway reviews to streamline and make as efficient as possible and to reduce waste (time, duplication, minimise late starts and cancellations), consider sustainability in product selection and where clinically safe, reduce the number of single-use items. Engaging with clinicians in procurement processes is key to making change happen. The Royal Colleges across the UK are playing a critical leadership role in supporting the NHS ambition to reach Net Zero by 2040–2045. Their contributions help align clinical practice, training and research with sustainability goals, empowering clinicians to embed green thinking into everyday care. The Royal College of Physicians advocates embedding sustainability into clinical guidelines and quality improvement. The Royal College of Anaesthetists are leading work on greener anaesthesia. The Royal College of Nursing actively supports nursing leadership in sustainability and produces guidance on sustainable nursing practice, waste reduction, PPE usage, all of which we are advocating The Royal College of Paediatrics are strong advocates on climate change.

Key actions for this section are outlined below.

Action	KPI(s)
2.1 Identify a clinical lead to support net zero clinical transformation	Confirmation from the Trust Board by 30/08/25
2.2 Establish a multidisciplinary working group to identify a quality improvement project in at least one key clinical area focusing on reducing emissions and share learning / outcomes	Working group project plan with implementation by 31/03/27
2.3 Agree and implement the Green Theatre checklist at both Chorley and Preston sites	Agree a project plan for both sites and implement by 31/03/27

3. Digital Transformation

Digital technologies has the potential to reduce carbon emissions while improving efficiency, significantly supporting the move to a net zero NHS. This section seeks to focus on ways to harness existing digital technology and systems to streamline service delivery and supporting functions while improving the associated use of resources and reducing carbon emissions.

Progress and next steps

The NHS Long Term Plan https://www.longtermplan.nhs.uk/ commits all NHS bodies to focus on digital transformation by establishing a 'digital front door', enabling patients to be able to engage through the use of the NHS App linked to hospital Patient Engagement Portals (PEPs), providing patients with a simple and secure way to access services on their smartphone.

Transitioning from paper based processes to digital systems has significantly reduced paper waste in the Trust resulting in further reductions seen in printing compared to previous years. MS Teams is fully embedded throughout the organisation with further work underway to integrate across the other four providers in Lancashire and South Cumbria to enable better joined up working. Robotic process automation processes are live across the Trust on a daily basis with plans to expand this on this work further.

To build on the success during the last three years, and post-pandemic, with the introduction of videoconferencing, remote consultations and agile working to reduce the amount of travel required by both patients and staff, further workstreams are outlined below aligning to the national guidance to continue to develop the use of digital technology to reduce the carbon footprint.

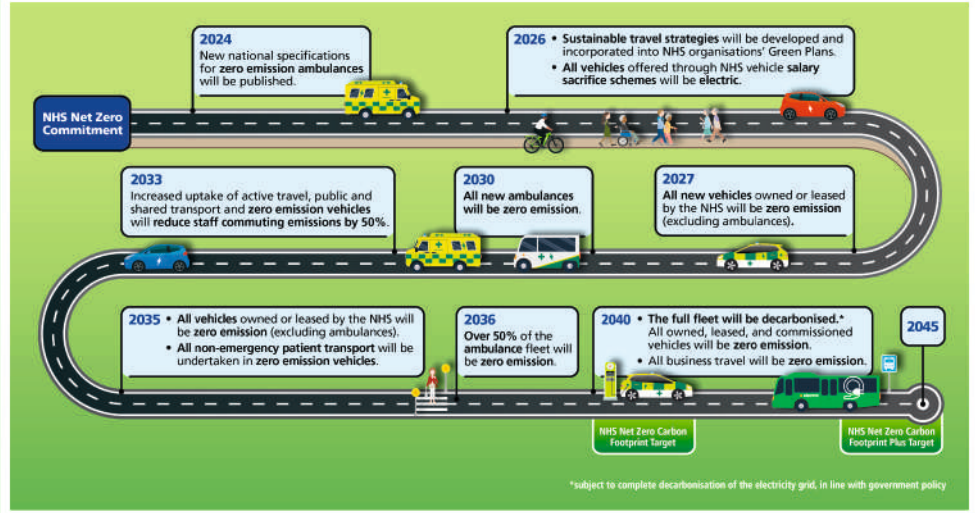
Action	KPI(s)
3.1 Conduct a mapping exercise across specialties to identify further opportunity for robotic process automation and implement to increase usage	Complete exercise by 31/03/26 Increase the use by 31/03/27
3.2 Increase the use of specialist advice across specialities to minimise the need for referrals and reduce volume of patients attending the hospital	Model hospital data extract current performance 11.3, to increase to peer average of 25 by 31/03/26
3.3 Implementation of a system wide EPR	Phased approach April 2025 – 2028/29
3.4 Implementation of patient engagement portal rolled out across specialties	Staged approach June 2025 – March 2027

4. Travel and Transport

The Trust aim within this chapter is to ensure that travel and transport activities associated with Lancashire Teaching Hospitals support an improvement in local air quality and health and a reduction in carbon emissions. Since the introduction of the green plan in 2022, the Trust has developed a travel plan with detailed recommendations and actions to take forward (appendix 1).

Progress and next steps

The NHS Net Zero Travel and Transport Strategy sets out a roadmap, illustrated below, with a set of clear targets to 2040. The importance of transport, fleet, electric vehicles and active travel has been identified as part of the development of the Trust Travel Plan finalised in 2023.



Although we have a travel plan set out, progress with implementation has been limited. This has identified the requirement to introduce a dedicated travel co-ordinator role, to help progress the actions detailed in the travel plan and reduce our carbon footprint associated with the travel to our hospital sites. Much of our staff and patients travel onsite in single-occupancy cars, which not only produce carbon emissions but also put additional demand on the car parking across sites. By increasing levels of active travel and discounted public transport, this can help to reduce the volume of cars travelling to sites whilst also reducing these emissions.

Results from a staff travel survey conducted in July 2023, with 862 responses, indicated that petrol/diesel car usage is the main method of travelling to work for staff, with 66% of staff choosing to commute this way (see fig 1). Other than private car the next most popular responses were public bus and walking, with only 5% of staff travelling via electric car.

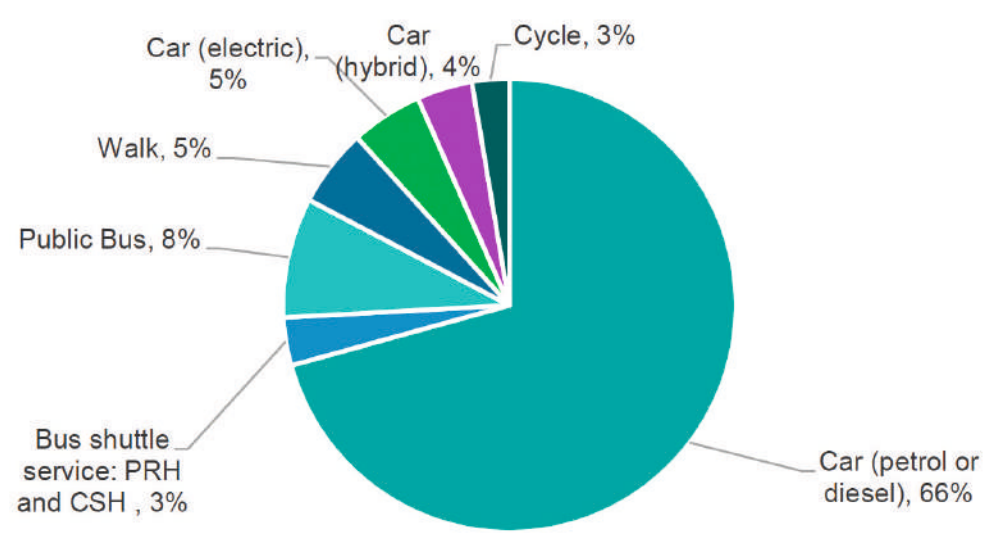


Figure 1 : Source staff travel survey July 2023, Lancashire Teaching Hospitals travel plan

To understand the travel behaviour of outpatients and visitors to/from sites, a travel survey was carried out during a 6 week period in June and July 2023, where a total of 1679 responses were collected (see fig 2). The results indicate that car (petrol/diesel) is one of the main methods of travelling to site for visitors and patients, alongside private motorised transport (combination of car petrol/diesel/electric/hybrid and motorcycle) accounting for 38% in total. In terms of sustainable transport, travelling by bus was the most popular mode followed by cycling at 11%.

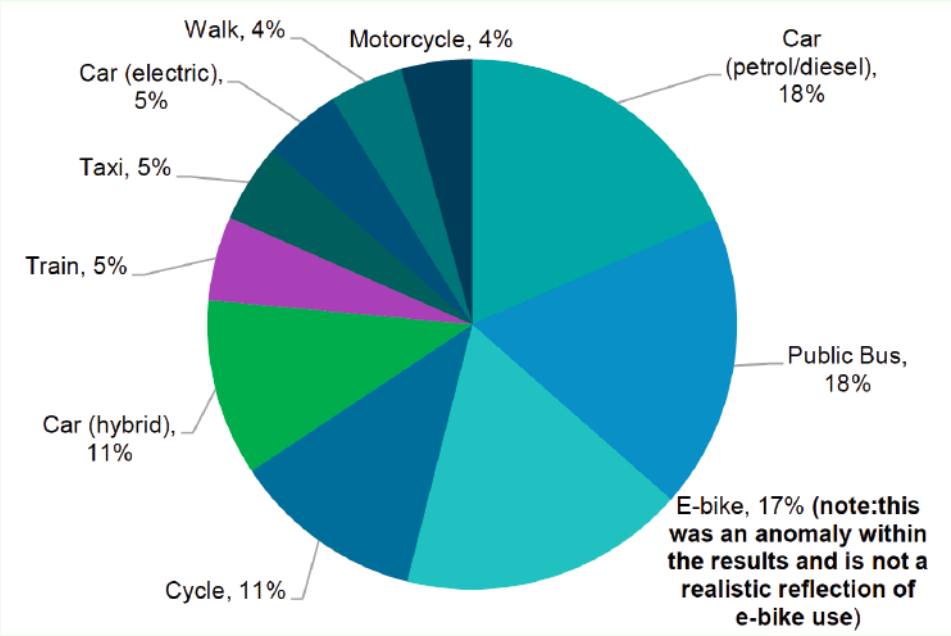


Figure 2: Source Outpatient and visitor travel survey June-July 2023, Lancashire Teaching Hospitals travel plan

Since the green plan was established in 2022, we have agreements in place for free and discounted use of public transport to reduce private car use. There are electric vehicle charging points available on all three sites and staff have access to a vehicle salary sacrifice scheme offering zero-emission vehicles and bicycles. The latest reported data shows that out of the 700+ vehicles currently leased through the salary sacrifice scheme, just over 74% of these are zero emission vehicles. We have recently introduced a staff car share scheme to further reduce the volume of cars travelling to site, work is underway to increase uptake of this new initiative.

Engagement events held with Love to Cycle and Lancashire County Council to promote outdoor walking routes/space has taken place, and staff are able to purchase a bicycle through the salary sacrifice scheme should they wish. Below are the actions outlined to help drive forward the work identified in the travel plan over the next three years, aligning to the guidance.

Action	KPI(s)
4.1 Travel co-ordinator role to be recruited to which will oversee the implementation of the travel plan	Confirmation of travel co-ordinator in post by end of Q2 2025
4.2 Review and implement outstanding recommendations / actions made within the travel plan relating to active travel	Travel co-ordinator role to oversee this once in post – review to be undertaken by end of Q3 2025 – with implementation thereafter October 25 – March 27
4.3 Develop and agree targeted communications throughout each year to increase awareness and uptake of car share scheme, active travel options and public transport within the Travel Plan developed	Comms plan to be developed with quarterly updates by 01/03/25
4.4 Monitor uptake of car share scheme to allow for planned targeted increases each year	Provide quarterly update on uptake in year 1 from April 2025 to provide baseline and increase per year
4.5 Procure secure bike storage at LTH as per travel plan to include electric charging points	Develop targeted fund raising plan to reach goal to cover costs along with national or local funding by end of Q3
4.6 Plan to purchase or enter into new leases for zero-emissions vehicles only from December 2027 onwards	Develop Plan in line with fleet vehicle lease arrangements due to expire in year 2,3,4
4.7 Consider salary sacrifice scheme to offer zero-emission only vehicles from December 2026	Phase out of vehicles on offer to align with the national ambition of zero-emission

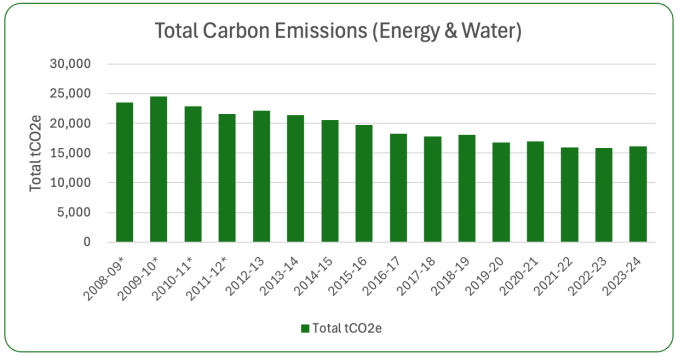
5. Estates and Facilities

Our buildings must be efficient and resilient to withstand the effects of climate change and reduce our impact on the environment. This means refurbishing existing and designing new buildings with sustainability as the core focus; reducing emissions and saving money over time. The NHS Net Zero Building Standard published on 22nd February 2023 lays the foundation for major construction and refurbishment projects in the NHS expected over the next decade. Increasing green space is also essential to mitigating climate change. Furthermore, improving access to green spaces help us to increase biodiversity, encourage outdoor activity and reduce stress, air pollution, noise pollution.

This chapter focuses on reducing the carbon emissions arising from the organisation's buildings and infrastructure, including improving energy efficiency and reducing energy usage, decarbonising heating and hot water systems, waste reduction and the circular economy, and building design and refurbishments.

Progress and next steps

Trust performance against the baseline carbon emissions (1990) has seen an overall reduction in the data submitted as part of the Estate Returns Information Collection (ERIC), however, there has been a slight increase in 2023–24 compared with the previous year (fig 3). Automatic meter reading (AMR) technology has now been installed on all main incomers at the Preston site for both energy and water to help monitor the consumption, this shows an overall reduction in electricity consumed, whilst gas appears to fluctuate each year (fig 4). Water consumption is also variable with an increase seen in the last year (fig 5).



28.7% Carbon reduction from 2008-09 to 2019-20
27.6% Carbon reduction from 2008-09 to 2020-21
21.6% Carbon reduction from 2013-14 to 2019-20
20.4% Carbon reduction from 2013-14 to 2020-21
25.8% Carbon reduction from 2013-14 to 2022-23
24.5% Carbon reduction from 2013-14 to 2023-24

Figure 3: Source Lancashire Teaching Hospital ERIC submission 2023/24

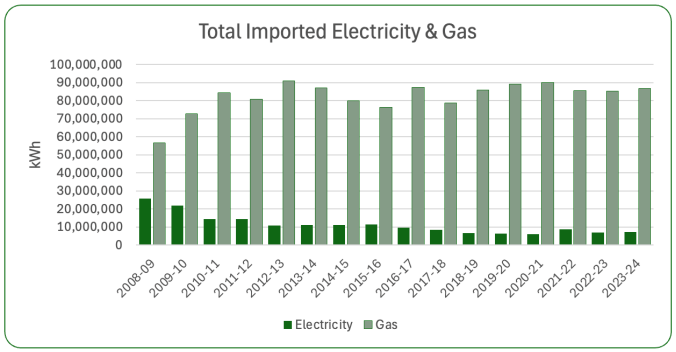


Figure 4: source Lancashire Teaching Hospital ERIC submission 2023/24

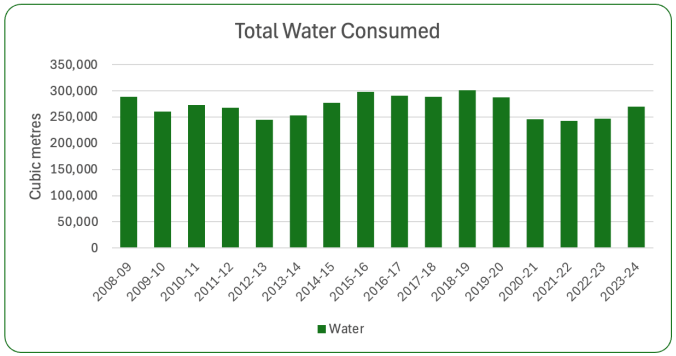


Figure 5: source Lancashire Teaching Hospital ERIC submission 2023/24

Since developing the previous green plan, work has progressed to make improvements to the estate, however this has been limited due to the reliance on external funding. The New Hospitals Programme (NHP) will ensure the Trust complies with the requirement for all new buildings to be carbon compliant in the future. However, with the significant delay from the original schedule, this programme of work is now being expected to start between 2035 and 2039, therefore the current estate across both Chorley and Preston sites, will require significant funding to enable progress aligning with national guidance to reach the 80% net zero reduction by 2028–2032.

NHS Improvement announced the release of £46 million for NHS Trusts, to provide investment in their infrastructure, to drive down wasted energy as well as save money on energy bills to lower carbon emissions. A bid was submitted for this funding, with the NHS Energy Efficiency Fund (NEEF) which was successful and has enabled installation of LED lighting at the Chorley site with further funding approved to continue with the upgrade of this at the Preston site for 2025. This will provide multiple environment benefits for patients and staff alike, providing better quality lighting as well as financial and carbon emission savings. Another funding bid submitted as part of the government Public Sector Decarbonisation Scheme has been successful, this will support the reduction of steam output therefore reducing our carbon footprint at the Preston site. A detailed plan is now being developed to take this forward over the next there years.

A further funding bid submitted towards the implementation of Solar Photovoltaics, the technology that converts sunlight into electricity using solar panels to generate own energy has been unsuccessful, however further options are being explored for this.

The Trust has implemented a waste hierarchy which focuses on Prevention, Reuse, Recycling, Recovery and Disposal (fig 6). One initiative from this is the Trust 'Warp it' scheme, an online system that redistributes reusable items like desks from areas where they are unused to those who need them. Along with a re-upholstery service for furniture, the trust has seen cost savings of £53,000 during the last year, along with a reduction of 5.85 tonnes of waste, resulting in 28 tonnes of carbon reduction. Increased communications to promote these schemes has taken place during the last year with further work ongoing.

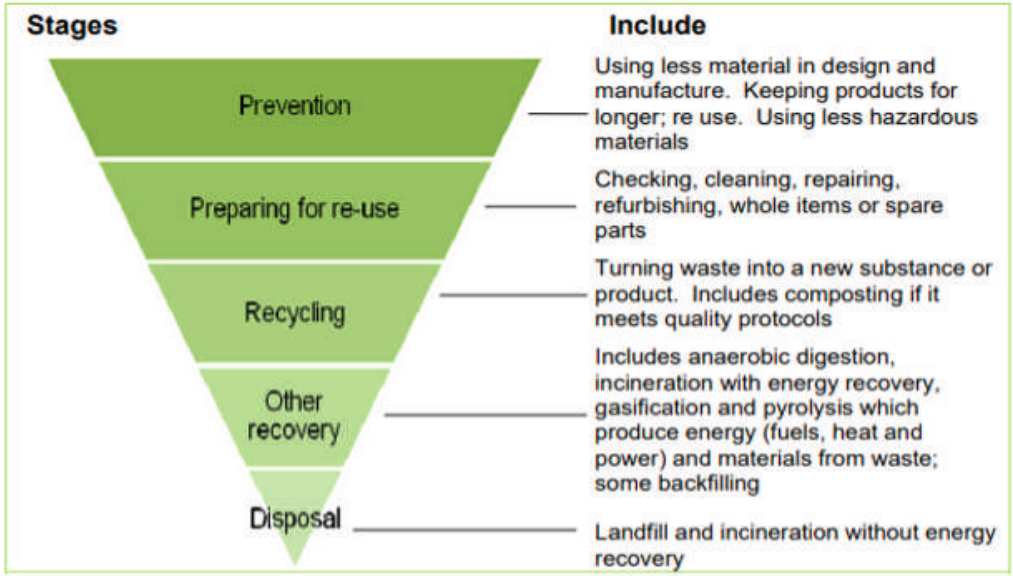


Figure 6 : Source GOV.UK Waste Hierarchy Guidance 2011

Actions aligned with both the current estates strategy and national guidance have been set out below as we continue to strive with improvements to the estate, whilst we await the new hospital build, however these will be reviewed annually to ensure that any further changes are incorporated.

Action	KPI(s)
5.1 Improve carbon literacy amongst the Trust Project Managers and ensure full compliance with related certification (BREEAM, WELL Building standards) to maximise the carbon benefits through new build and refurbishment of the existing estate	Deliver internal training sessions to relevant staff by 31/03/26
5.2 Develop a strategy and plan to remove the high temperature steam distribution system from the RPH site which will allow the transition to low temperature technology such as heat pumps and so enable the pathway to removing fossil fuel boilers using PSDS grant funding	Develop detailed strategy and plan by 31/03/26 Implementation of project 01/04/26 – 31/03/28
5.3 Enhance the efficiency of the existing estate by seeking funding and developing business cases for energy efficiency and carbon reduction schemes such as LED lighting / Solar PV / Improved controls and monitoring / water usage	LED installation at Preston site by 31/03/26. Explore further funding opportunities as they arise throughout each year
5.4 Develop a strategy for the removal of further fossil fuel boilers following the completion of 5.2	Develop strategy by 31/03/28
5.5 Develop a Waste Management Strategy/Plan, focused on compliance and implementation of the Waste Hierarchy (reduction, reuse, recycling and recovery)	Develop plan by 31/03/26
5.6 Increase Waste Hierarchy awareness and promote compliance initiatives across the organisation, providing training and awareness for staff, patients and visitors	To be completed by 31/03/26
5.7 Develop Standard Operation Procedures (SOPs) for certain key waste streams to provide clarity for compliance, best practice and sustainable waste management systems	Develop SOP by 31/12/25
5.8 Work with key departments, staff and contractors to investigate, implement and promote sustainable waste management opportunities - relating to product and service procurement, local procedures and good practice	To be completed by 31/03/26

6. Medicines

Embedding net zero principles across all clinical services is seen as a key enabler for change. Within medicines, this is critical as they account for 25% of the NHS carbon footprint plus (scope 3) from production, through to transportation and disposal. Overprescribing and the improper disposal of unused medicines can all contribute to harming the environment. Through education and harnessing digital technology to support better ways of working, this can help to reduce the impact on the environment.

Progress and next steps

Key opportunities to reduce carbon emissions further relates to the organisation's prescribing and use of medicines and medical products. Some examples of work achieved to date include the Cool sticks implementation within Pharmacy for Critical Care and Theatres, aimed at reducing the usage of Ethyl Chloride spray, resulting in both a cost saving and environmental saving. The installation of new pharmacy robots at the Chorley and Preston sites allowed for the old robots to be recycled rather than going to landfill. The implementation of a prescription tracker to reduce double prescribing and loss of medication, has resulted in reducing waste and provided a cost saving. Electronic prescribing has been rolled out across the Emergency Department and paediatrics

Within anaesthetics there are certain types of gases that have significant carbon emissions, contributing to 5% of the NHS carbon footprint. Desflurane, an anaesthetic gas with a Global Warming Potential (GWP) more than 2,500 times higher than CO2, is no longer used within the Trust. Nitrous oxide is a potent greenhouse gas that makes up at least 80% of the total emissions from the ozone-depleting medical gases in the NHS. It has significant global warming potential, around 300 times that of carbon dioxide. Piped manifolds produce a higher number of emissions than portable cylinders due to possible leakage from the system and higher potential waste.

The focus going forward is now to review possible reductions in piped nitrous oxide and mixed nitrous oxide as per the national guidance and nitrous oxide toolkit developed Nitrous-oxide-toolkit-for-reducing-waste-in-NHS-trusts

The key actions and KPI's for the next three years are outlined below.

Action	KPI(s)
6.1 Develop a plan to remove piped Nitrous Oxide across both sites using the nitrous oxide toolkit • Chorley District Hospital • Royal Preston Hospital	Plan to be developed and implementation with set target agreed for each site Q4 2025/26 Q4 2027/28
6.2 Reduce pharmaceutical waste within the pharmacy department	37.5% reduction of the total pharmacy waste
6.3 Established ward-based recycling of medicines	Achieve £100k waste reduction
6.4 Reduce duplicate dispensing activity in pharmacy to reduce waste	Achieve £60k waste reduction
6.5 Established access to Electronic Prescribing System (EPS) in Outpatients to support dispensing closer to home	Implemented by Q4 2025/26
6.6 Roll out of electronic prescribing and medicines administration (EPMA) across Neonate (Inpatient)	Implemented by Q1 2025/26

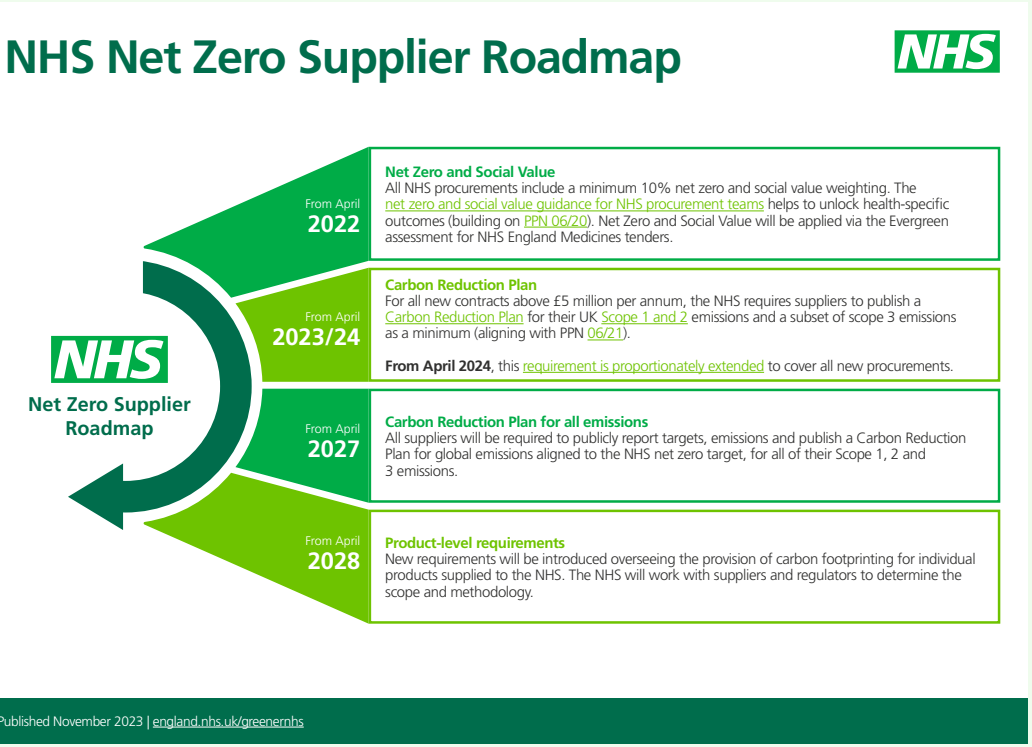
7. Supply Chain and Procurement

The NHS supply chain accounts for approximately 62% of total carbon emissions, encompassing raw materials, production, packaging and transportation. Unsustainable consumption and procurement of materials has a huge impact on the planet and on our carbon footprint therefore reducing these emissions is essential for the NHS to achieve net zero. Sustainable Procurement has the most positive environmental, social and economic impact possible, across the entire life cycle of a consumable, medical device, service or building works and strives to minimise adverse impacts. It offers an opportunity to deliver social value, such as creating jobs in disadvantaged areas, which can improve health and reduce inequalities.

Working together, staff procuring across the Trust have a leading role in encouraging the re-use of goods, specifying more sustainable products and encouraging manufacturers to recycle, reduce waste, use fewer damaging materials and processes and incorporate social value into the organisation.

Progress and next steps

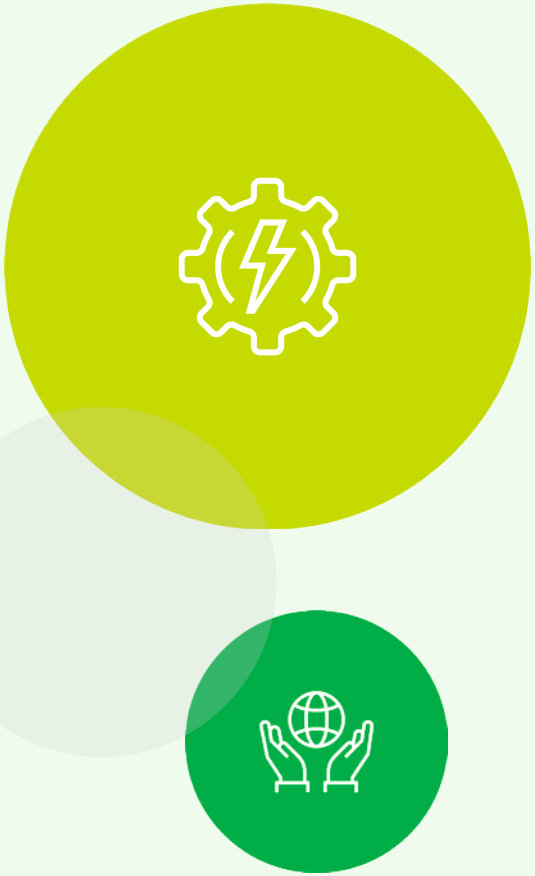
Procurement is managed through the Lancashire Procurement Cluster (LPC) now part of the One Lancashire and South Cumbria collaboration (One LSC). The LPC have produced and implemented a business strategy to ensure compliance with NHS Standard Terms and Conditions for all procurement processes. This provides greater influence and opportunity to procure goods and services across the wider footprint, maximising buying power alongside promoting sustainable procurement. Most of our goods and services are procured through the NHS Supply Chain and NHS approved frameworks, therefore promoting standardised requirements for suppliers. This ensures that we are buying from approved suppliers who have had all the necessary checks to ensure they comply with the Evergreen assessment, whilst aligning to our green plan aims and meet the requirements of the NHS Net Zero Supplier Roadmap:



In line with the Net Zero Supplier Roadmap requirements, the LPC has implemented a minimum 10% net zero and social value weighting to all contracts that are over the World Trade Organisation's (WTO) Government Procurement Agreement (GPA) Thresholds and those tendered.

To build on the current processes already in place with suppliers and align with the national guidance for procurement and supply chain management, we have outlined below key aims for the next three years to further enhance sustainability performance within the procurement team working towards delivering net zero.

Action	KPI(s)
7.1 Embed NHS net zero supplier road map requirements into all relevant procurements and ensure they are monitored via KPI's where appropriate	Strategy document in date KPI's agreed and monitored phased by 01/04/27 - 31/03/28
7.2 Ensure suppliers engage with the Evergreen sustainability supplier assessment as appropriate	Evidence within strategy document and contracts
7.3 Consider how to safely incorporate reducing single use products when working with specialties on projects	Evidence collated of case studies resulting in a change taken place
7.4 Ensure supplier Carbon Reduction Plans are reviewed as part of relevant procurement processes as appropriate	Evidence included as part of bid/review for award proces



8. Food and Nutrition

This chapter considers ways to reduce the carbon emissions from the food made, processed or served within Lancashire Teaching Hospitals. Where possible, this may include reducing overall food waste and ensuring the provision of healthier, locally sourced and seasonal menus high in fruits and vegetables, and low in heavily processed foods. As a healthcare provider, we have a responsibility to provide the highest levels of care possible, including providing quality and nutritional options of food and drink to patients, staff and visitors.

Progress and next steps

From a national perspective the National Standards for Healthcare Food and Drink outlines asks for Hospital Trusts to implement https://www.england.nhs.uk/long-read/national-standards-for-healthcare-food-and-drink/#4-improving-sustainable-procurement-and-reducing-food-waste

The in house catering team at our Hospitals provides food for staff, patients and visitors across the ward areas and café/restaurant outlets. The team has recently achieved the Bronze status award from the SOIL Association, this sets out standards that define how organic products must be grown, farmed or made. This includes animal welfare, protecting human health and safeguarding the environment.

The catering team purchase locally for items such as bread, milk, cake, meat and sandwiches and are continuing to work with procurement, linking in with Lancashire County Council to identify other possible opportunities to use local suppliers where possible. Single use plastics have been removed from the front of house catering outlets with further plans to review back of house functions. Below are the key actions set out for the next three years to align with the new national guidance and build on the work undertaken so far.

Action	KPI(s)
8.1 Formulate a plan to achieve Silver status SOIL accreditation for the in house catering service and submit	Gain silver status by 01/03/28
8.2 Review and reduce single use plastics back of house through a phased approach	Reduce single use plastics back of house by 31/03/28 - Evidence though replacement products quarterly
8.3 Measure food waste in line with ERIC and set reduction target	Measure food waste in line with ERIC by 31/03/26 Reduction target to be set for 2026/27 once full year of new process embedded
8.4 Reduce food waste in the restaurants, cafes and on the wards using stepped approach	Monitor and collaborative working undertaken by 31/03/26. Annual target to be set from April 2026
8.5 Reduce the amount of processed and red meat on the menu and increase the vegetable choices to help support the Plant Based ethos	Increase vegetable choices on the menu to provide 50% of coverage on plated food by 01/03/26

9. Adaptation

Adaptation is our adjustment to the effects of climate change. Climate change poses significant challenges to the NHS's ability to deliver essential services both now and in the future. The impacts of climate change include more frequent and severe weather conditions such as droughts, extreme heat and cold events, shifts in disease patterns, and an increased likelihood of infrastructure failures. These threats are already affecting demand for services, which is why it is important the Trust is prepared to manage strategically and operationally the effects of climate change, particularly extreme weather events, including surface water flooding, high winds, extreme high /low temperatures, and storms to ensure we are fit for the future.

Progress and next steps

As part of the NHSE Emergency Preparedness, Resilience and Response (EPRR) Core Standards compliance https://www.england.nhs.uk/ourwork/eprr/ the Trust has an Adverse Weather and Health Plan that is activated during periods of extreme weather, such as heatwaves and cold spells. It's the EPRR's role to ensure the Trust has effective arrangements in place to respond to such events. The plan provides guidance for staff on measures to improve the temperature of the estate during extreme weather, whether this involves increasing or decreasing heat, depending on the situation. Additionally, EPRR is responsible for warning and informing colleagues about upcoming extreme weather events so they can make necessary preparations. Beyond the Adverse Weather and Health Plan, there are local business continuity plans (BCPs) in place across divisions. These plans require services to identify mitigations to ensure critical activities are maintained during challenges such as staff shortages, surges in service demand, or loss of utilities/IT. These challenges may, but do not always, result from extreme weather events, for example:

- Snow may cause travel disruptions, reducing staff numbers
- Slips, trips, and falls during icy conditions may result in increased service demand
- Power outages due to storms could disrupt utilities or IT systems
- High temperatures or poor air quality may lead to heat-related illnesses or respiratory issues, increasing service demand
- BCPs are locally owned, with EPRR's role being to ensure BCPs are in place, fit for purpose, and regularly tested through exercises. Compliance is monitored via EPRR Committee meetings.

While EPRR is critical for immediate preparedness and response, it doesn't oversee infrastructure upgrades to enhance the resilience of healthcare facilities against extreme weather, nor does it lead on service delivery planning to adapt healthcare services for changing health needs due to climate change. It is the estates and facilities role in ensuring the physical resilience of the Trusts infrastructure to withstand conditions such as flooding, heatwaves and cold weather.

To ensure that we have the appropriate plans in place to manage the effects of climate change effectively whilst delivering healthcare we have outlined key actions below.

Action	KPI(s)
9.1 Adverse Weather and Health Alert System: Implement a system to notify key personnel when severe weather warnings or health risks (e.g., heatwaves, cold snaps) are issued	Evidence of system in place to notify key personnel of severe weather warnings or health risks Local procedures and mitigation to be developed to address comfort issues during heatwaves by 31st March each year
9.2 Annual Review of Plans: Annually review and update the Adverse Weather and Health Plan to ensure alignment with the latest national guidance on climate risk assessments and evolving operational challenges	Provide evidence of the annual EPRR assurance submission undertaken with a minimum overall rating of Substantial Compliance
9.3 Business Continuity Planning: Ensure the Trust's business continuity plans address potential issues arising from adverse weather and climate change, such as IT outages, utility interruptions, demand surges (e.g., respiratory issues, slips, and falls), and potential staffing shortages (e.g., up to 30% of staff being unavailable due to extreme weather and related travel disruptions or pandemic)	Provide evidence of the annual EPRR assurance submission aligning to the nationally defined Core Standards with a minimum outcome of Substantial Compliance
9.4 Scenario-Based Exercises: Conduct regular scenario-based exercises, simulating adverse weather events, to test the effectiveness of business continuity mitigation strategies	Provide an evidence log of the exercises carried out each year, detailed within the annual review undertaken

Action	KPI(s)
9.5 Flood Risk Assessment: Review existing flood risk assessment for all Trust properties with recommendations as appropriate	Evidence of annual review to be completed by 31st March each year
9.5.1 Implement necessary flood prevention measures and drainage systems in high-risk areas as highlighted from annual review	Action plan developed following annual review by 30th April each year, with actions completed within recommended timescales
9.6 Buildings Energy System: Undertake annual review of estate	Evidence of annual audit undertaken
9.7 Air Conditioning Systems: Undertake constant review of air conditioning systems and submit annual bids for capital to install and upgrade air conditioning systems in vulnerable areas (e.g., emergency departments, ICUs) to ensure patient and staff comfort during heatwaves	Evidence of annual bids submitted
9.8 Temperature Monitoring: Wards and departments to implement temperature monitoring in critical areas (e.g., wards, patient rooms) to ensure effective regulation and comfort during extreme weather conditions. Severe exceptions to be reported to Estates as evidence to support the need for further capital investment in ventilation and cooling systems.	Monitoring in place throughout year with exceptions reported to Estates by 31st March each year

10. Green Space and Biodiversity

There are significant opportunities across the Lancashire Teaching Hospitals estate to develop space and reconnect with nature. The Trust contains much vegetation, outdoor space and habitats to ecological systems. Developing our green space can conserve these groups and also support the health and wellbeing, recovery and resilience of patients, employees and communities.

To maximise the quality of our green assets and use them to improve the physical and mental health of both staff and patients whilst support biodiversity, we felt it was important as a Trust to continue to incorporate this within our Green Plan.

Progress and next steps

The employee wellbeing team have supported a number of initiatives during the last three years, some examples of what has been achieved include; in conjunction with the grounds maintenance team, 15 outdoor seating installations completed across the Preston and Chorley sites, the Trust has purchased and planted trees from the NHS Forest scheme, and a funding bid for 20 walking leaders to be trained was submitted to Preston City Council and has now been approved.

Action	KPI(s)
10.1 Develop a plan with conservation organisation to seek recommendations in supporting wildlife around the Trust – Beehives	31st March each year
10.2 Develop plan and implement raised planters and wild flower meadows as agreed with grounds maintenance lead	31st March each year
10.3 Identify staff to receive training for walking route and arrange dates to complete	30th June 2026
10.4 Improve communication to staff and patients of no smoking policy in place	31st March each year

Governance and accountability

The Green Plan is a living document outlining how we will fulfil our responsibility as an anchor institution and mitigate our impact on climate change. It is aligned to the national guidance and standards, with a more detailed framework and action plan to be developed defining what will be achieved over the next three years.

To ensure delivery of the Green Plan, a clear governance structure will be embedded in line with the appointed board level net zero executive lead Craig Carter, Chief Finance Officer. The plan will also require senior leadership input from a range of functions, including; the chief medical director, chief nursing, chief pharmacist, chief allied health professional, directors of estates and facilities, procurement, digital and finance.

The Green Plan sits within the Trust Single Improvement Plan framework under the Partnership arm, to be fit for the future. To fulfil our Anchor and Green Plan ambitions, we need to ensure we develop effective partnerships across Lancashire and South Cumbria, which maximises population health and support services that are clinically and financially sustainable.

We will continue to monitor progress though the monthly working group meetings and establish a quarterly Green Plan delivery board to strengthen our current governance arrangements, these will feed into Trust Board via the finance and performance committee.

The Green Plan will be reviewed annually to update on progress and make any amendments to account for any new priorities, change to guidance, alignment to the Trust strategy document, technology and other enablers.

Reporting

Clear leadership is required to ensure that we successfully deliver our Green Plan therefore it is essential we have dedicated leads for each of the ten areas of focus identified, alongside a sustainability lead clinician, and the board level director.

Reporting mechanisms are outlined below;

Quarterly submission to Greener NHS data collection will be used to measure our progress on sustainability and to inform annual plans

Annual ERIC return (Estates Return Information Collection) – this is a mandatory data collection for all NHS trusts, required by the Department of Health

The Greener NHS Dashboard will be used as the source of data to measure our performance and benchmark against our peers

Transport return

Annual sustainability staff survey

Progress reports

Quarterly update report for Finance and Performance Committee

Bi-annual progress report to Board

Trust sustainability report – there is a requirement for sustainability to be reported annually to the Board and publish this as part of our annual report. This report will include;

- narrative updates on progress to date and key achievements
- delivery of key milestones and risks to future delivery
- quantitative assessment of progress against defined targets

Risk Management

An overarching risk has been developed as several risks have been identified to the successful delivery of the Green Plan including, financial limitations, gaps in areas of the green plan, lack of engagement due to competing priorities. This will be actively managed and reviewed as part of the Trust risk management policy.

Communication and Embedding the Plan

To ensure we drive change across the organisation, we plan to produce a robust communication plan to keep staff, patients and our stakeholders informed about out Green Plan and initiatives throughout the year.

We are refreshing our sustainability hub page on the Trust intranet along with improved, more regular updates via the health and wellbeing bulletins. We will also provide updates and share announcements through social media and the All colleague briefing.

Our Green Champions will continue to promote sustainability within their areas of work, encouraging staff to get involved and highlight achievements.

MOTT MACDONALD

Lancashire Teaching Hospitals
NHS FoundationTrust

Lancashire Teaching Hospitals NHS Foundation Trust Travel Plan

November 2023

Issue and Revision Record

Revision	Date	Originator	Checker	Approver	Description
1	October 2023	Kirsty Alebon	Annabel Shaw	Sarah Cherry	Draft for client review
2	November 2023	Kirsty Alebon	N/A	Sarah Cherry	Minor updates following client review

Document reference:

Information class: **Standard**

1. Introduction

1 Introduction

Background

Mott MacDonald was appointed by the Lancashire Teaching Hospitals NHS Trust ('the Trust") to produce a Travel Plan (TP) for the Trust's estate:

- Royal Preston Hospital
- Chorley and South Ribble Hospital
- Preston Business Centre

The TP provides a strategy to encourage staff and visitors to travel in a sustainable and environmentally friendly manner where possible.

The Lancashire Teaching Hospitals NHS Foundation Trust provides a range of medical services to 390,000 people in Preston, Chorley, and South Ribble.

Additionally, Royal Preston Hospital and Chorley and South Ribble Hospital provide care to 1.5 million people across the region with specialist centres pertaining to cancer, major trauma, and vascular treatments.

Preston Business Centre specialises in mobility rehabilitation for those across the north-west.

There are 8,000 staff employed across the three sites.

Royal Preston Hospital

Royal Preston Hospital is an acute general hospital located north of Preston City Centre, in Fulwood, with the main entrance accessed off Sharoe Green Lane.

Chorley and South Ribble Hospital

Chorley and South Ribble Hospital is an acute general hospital approximately nine miles south of Preston centre, in the town of Chorley. The main entrance is accessed through Euxton Lane. The hospital is situated close to Junction 8 of the M61.

Preston Business Centre

Preston Business Centre is just over a mile south of Royal Preston Hospital, with the main entrance being accessed via Watling Street Road. Disabled parking and wheelchair access is found at the rear of the building site.

What is a Travel Plan?

A TP is a long-term management strategy that sets clear objectives, targets, and desired outcomes, whilst identifying ways to increase sustainable transport modes and reduce single occupancy car journeys.

As part of the TP, new data has been collected to provide a detailed understanding of the travel patterns of staff, visitors, volunteers, outpatients, and contractors. The TP will also help engagement with local stakeholders on local transport and travel matters and will support the Trust with any future development of their sites.

This TP sets out the scope and objectives which include:

- Reduce the Trust's carbon footprint (by reducing the number of single occupancy car journeys);
- Increase the health and wellbeing of Trust staff;
- Increasing the use of sustainable modes of transport.

Benefits of the Travel Plan

The main benefits that can be expected from implementing a TP are as follows:

- A workplace that is easier to access by all forms of transport, reducing anxiety and frustration for all user groups;
- Reducing CO_2 emissions to deliver on NHS England sustainability commitments;
- Being an environmentally-responsible employer to help satisfy any planning requirements;
- Being a better neighbour to the surrounding community; and
- Health benefits to staff and visitors via an increase in exercise from active travel and reduced conflicts.

Why is the Travel Plan required?

- As a health-promoting organisation that recognises the direct and indirect health impacts of climate change, the Trust is seeking to reduce its overall carbon footprint, including that generated by transport.
- To assist in the management of car parking demand across its sites.
- The Trust is a major local employer / anchor institution within Lancashire.

TP Structure

This TP has been prepared in consideration of relevant planning, transport and NHS policies and guidance. Following this introductory chapter, this TP is set out as follows:

- **Chapter 2, 3 and 4** – set out the existing site conditions at each of the Trust sites and transport conditions in the vicinity, including travel by public transport, car, walking and cycling.
- **Chapter 5** – sets out the findings from the 2023 staff travel survey.
- **Chapter 6 –** sets out the findings from the 2023 outpatient and visitor travel survey.
- **Chapter 7** – sets out the objectives and targets that have been developed for this TP.
- **Chapter 8** – sets out the initial measures that have been developed and will need to be implemented.
- **Chapter 9** – provides details on how the TP will be marketed and monitored going forward to ensure it is effective.
- **Appendix A - Policy Context**– national and local policies that this TP supports.

2. Site and Accessibility Audit – Royal Preston Hospital

2 Site and Accessibility Audit – Royal Preston Hospital

Introduction

The Royal Preston Hospital (RPH) is an acute general hospital located in Fulwood, Preston. The hospital is managed by Lancashire Teaching Hospitals NHS Foundation Trust.

The hospital is situated approximately three miles north of Preston City Centre. It is located on Sharoe Green Lane which is accessed via the A6 Garstang Road and several residential streets. There are two available access points for all users along Sharoe Green Lane which provide access to a small internal network of roads between individual hospital buildings inside the main perimeter. 2,679 staff are located at Royal Preston Hospital, the largest number across all the Trust's sites.

The hospital offers a multitude of in and outpatient services, some of which have been summarised below:

- Emergency services
- Children's clinic
- Urgent care centre and;
- Medical rehabilitation unit

Site Access

There are two access points to the site along Sharoe Green Lane and there is an additional pedestrian and cycle access on Sharoe Green Lane opposite St Clare's Roman Catholic Church. The site is not accessible via any official cycleway on the main road network.

There are three visitor car parks and several additional staff car parks which vary in capacity and are located around the outer perimeter of the site.

There are two bus stops on site with additional bus stops situated on the surrounding road network.

Figure 1 shows a detailed map of the site location.

Figure 1: Royal Preston Hospital Site Location

Car Access

Visitor Car Parking

A total of 707 parking spaces are provided for outpatients and visitors at RPH.

The RPH car parks operate a Pay and Display parking system. Table 1 shows standard visitor car parking charges and Table 2 shows concession car parking arrangements.

Table 1: Standard Visitor Car Parking Charges

Time	Cost
Up to 30 minutes	FREE
Up to 1 hour	£2.80
Up to 2 hours	£3.80
Up to 4 hours	£6.00
Up to 6 hours	£6.60
Up to 8 hours	£8.80
Up to 24 hours	£10.00
Weekly	£30.00

Source: Lancashire Teaching Hospitals NHS Trust (2/11/23)

Table 2: Concession Car Parking

Concession	Cost
Disabled parking	Free
Frequent outpatient attendees, defined as those who are required to attend hospital for an appointment at least three times within a month for at least three months.	Free
Parents or guardians of sick children staying overnight in the hospital	Free
Outpatients with a life-long condition requiring two or more hospital visits per week	Free
Family visitors to a gravely ill inpatient	£2.50 a day
Family visitors to a relative with an extended stay in hospital beyond 21 days	£2.50 a day

Source: https://www.lancsteachinghospitals.nhs.uk/car-parking-concessions

Staff Car Parking

There are several locations allocated for staff parking, with over 1,200 spaces available. Staff can apply for a car parking permit. Permits are awarded based on a set of criteria which considers a range of factors, such as early and late travel times, out of hours duties, regular business travel, public transport availability and disability.

Car parking permit charges can be paid on a weekly, monthly, or annual basis with charges banded based on salaries and hours worked per week. These charges are shown in Table 3. Student staff can access discounted parking charges; these are provided within Source: Lancashire Teaching Hospitals NHS Trust (2/11/23)

Table 4.

Table 3: Qualifying Staff Parking Charges

	Over 30 Hours	Over 25 - 30	Over 18 - 25	Over 10 - 18	Up to 10
Salary Band £0 - £22,815.99					
Weekly	£3.56	£2.86	£2.15	£1.41	£0.76
Monthly	£15.46	£12.43	£9.33	£6.13	£3.25
Annual	£185.59	£149.17	£112.05	£73.53	£39.21
Salary Band £22,816- £50,951.99					
Weekly	£4.04	£3.24	£2.42	£1.62	£0.82
Monthly	£17.51	£14.06	£10.50	£7.05	£3.55
Annual	£210.11	£168.78	£126.06	£84.74	£42.73
Salary Band £50,952 - £99,890.99					
Weekly	£4.58	£3.69	£2.76	£1.87	£0.94
Monthly	£19.83	£15.99	£11.96	£8.10	£4.07
Annual	£238.12	£191.90	£143.57	£97.35	£49.02
Salary Band £99,891+					
Weekly	£10.23	£8.18	£6.09	£4.04	£1.94
Monthly	£44.35	£35.49	£26.38	£17.51	£8.41
Annual	£532.27	£425.81	£316.55	£210.11	£100.85

Source: Lancashire Teaching Hospitals NHS Trust (2/11/23)

Table 4: Qualifying Student Staff Parking Charges

	Over 30 Hours	Over 25 - 30	Over 18 - 25	Over 10 - 18	Up to 10
Salary Band £0 - £22,815.99					
Weekly	£2.90	£2.33	£1.75	£1.15	£0.61
Monthly	£11.61	£9.33	£7.01	£4.60	£2.45
Annual	£139.28	£111.95	£84.10	£55.19	£29.43

Source: Lancashire Teaching Hospitals NHS Trust (2/11/23)

Offsite Parking

The Trust have negotiated 699 off-site parking spaces which are available to staff. Staff are also able to access a 50% discount when parking at one of these sites. A breakdown of the number of spaces available at these sites is presented within Table 5.

Regarding other options for off-site parking, double yellow lines are present on the surrounding roads, and nearby residential roads, therefore restricting on street parking. However, some spaces can be found along Heversham Avenue, allowing 2 hours of free parking. The nearest non-NHS car park is at 'Booths'- located 0.2 miles north of RPH.

Electric Vehicle Parking

Electric vehicle spaces with charging capabilities are available in three locations across the RPH site. 10 spaces are provided. Usual parking charges are applicable to those who park in EV spaces.

For those who wish to charge their vehicle, a mixture of charging speeds is available. RPH has two spaces which charge at a speed of 7kW and eight spaces, offering rapid charging at 22 kW. A charging tariff of 28p/kWh is also applicable.

Accessible Parking

There are 79 accessible parking spaces available at RPH.

Car Parking Summary

Many parking spaces are available on site for the use of Trust Staff. Permits are allocated based on criteria for use of onsite spaces. A smaller number of visitor/outpatient parking spaces are also provided in convenient locations around the site.

Table 5 provides a summary of the car parks available to staff or visitors and outpatients at RPH.

Table 5: Car Park Summary

Car Park	Users	Number of Spaces	Of which are EV Charging Spaces	Of which are Accessible Spaces
On-site Parking				
All car parks	Staff	1343	8	79
All car parks	Outpatients and Visitors	707	2	
Off-site Parking				
Grasshoppers Rugby Club	Staff	200	0	
Preston College	Staff	155	0	
Preston Business Centre	Staff	344	0	
	Total	2749	10	79

Source: Lancashire NHS Trust, provided August 2023 (Updated November 2023)

Local Highway Network

Sharoe Green Lane runs from the Sharoe Green Lane/ A6 Garstang Road/ Black Bull Lane junction, northwest of the site, down to the Sharoe Green Lane/ Watling Street Road/ East Road junction. It is a two-way single carriageway, subject to 30mph (miles per hour) speed limit with No Waiting At Any Time (NWAAT) restrictions on the whole length of the road.

A6 runs from Luton, Bedfordshire to Carlisle, Cumbria. The section of the A6 west of the hospital, is the A6 Garstang Road, which runs from the Aqueduct Street/ A6 North Road/ St George's Road/ A6 Garstang Road junction to Broughton Roundabout where the A6 meets with the M55. It is a two-way carriageway, with sections comprising both two and three lanes. This section is subject to a 30mph speed limit with NWAAT restrictions on various sections of the road.

Public Transport

Bus Services

There are several bus routes that serve RPH. Two bus stands are located on North Drive at the hospital main entrance; there is also a turning circle located at the end of the cycle access at East Drive which serves three bus stops.

Figure 2 displays the location of bus stops within the vicinity of RPH.

Table 6 details the bus routes that serve these stops.

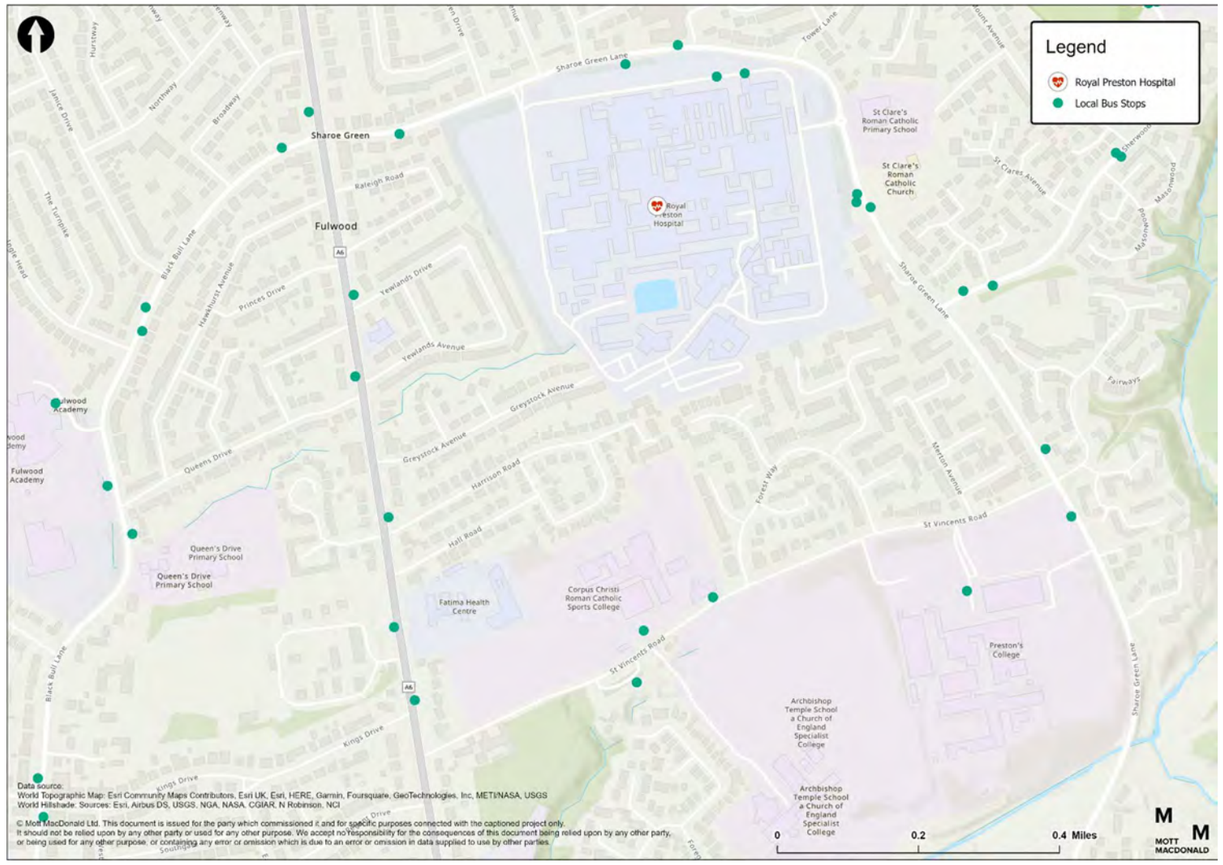
Table 6: Bus Services

Route		Weekday		Saturday		Sunday	
		Frequency	Hours of operation	Frequency	Hours of operation	Frequency	Hours of operation
19	Preston Bus Station – Royal Preston Hospital	Every 10 - 20 minutes	06:00 to 23:00	Every hour	07:20 to 22:50	Every 30 minutes to an hour	07:50 to 22:50
23	Preston Bus Station - Preston Bus Station	Every 10 minutes to half an hour	05:00 to 23:55	Every 20 to 30 minutes	05:00 to 23:55	Every 20 to 30 minutes	06:35 to 23:55
40 /40A	Morecambe Bus Station – Preston Bus Station	Every 30 minutes	06:55 to 00:35	Every 30 minutes	06:30 to 00:35	Every hour to hour and a half	09:00 to 22:40
45	Preston Bus Station – Blackburn Bus Station	Every hour to hour and a half	06:00 to 20:40	Every hour	06:30 to 20:30	Every 2 hours	09:35 to 19:20
88	Larches to Royal Preston Hospital	Every hour to hour and a half	06:00 to 18:20	No Service	No Service	No Service	No Service
125	Preston - Bolton	Every 20 minutes	06:25 to 23:20	Every 30 minutes	06:05 – 23:20	Every 30 minutes	08:30 – 20:00
Shuttle bus service	RPH – C&SR	Hourly (Staff service only between 7-9AM and 4-6PM).	07:20 – 18:15	No Service	No Service	No Service	No Service

Bus shelters with seating and ample standing space which are segregated from the highway have been provided at all bus stops in the vicinity of RPH.

There is a public bus which stops at Preston Business Centre and Royal Preston Hospital which will accept Trust staff for free upon presentation of their staff ID. This service will be publicised in staff newsletters and on the staff intranet.

Figure 2: Royal Preston Hospital – Local Bus Stops



Rail Services

Preston Rail Station is four miles from RPH, to the southeast of Preston City Centre.

Figure 3 shows the location of the rail station in comparison to RPH. Travel from the station to the hospital is possible via cycle, bus, or taxi, as detailed in Table 7.

Table 7: Travel from Preston Rail Station to RPH

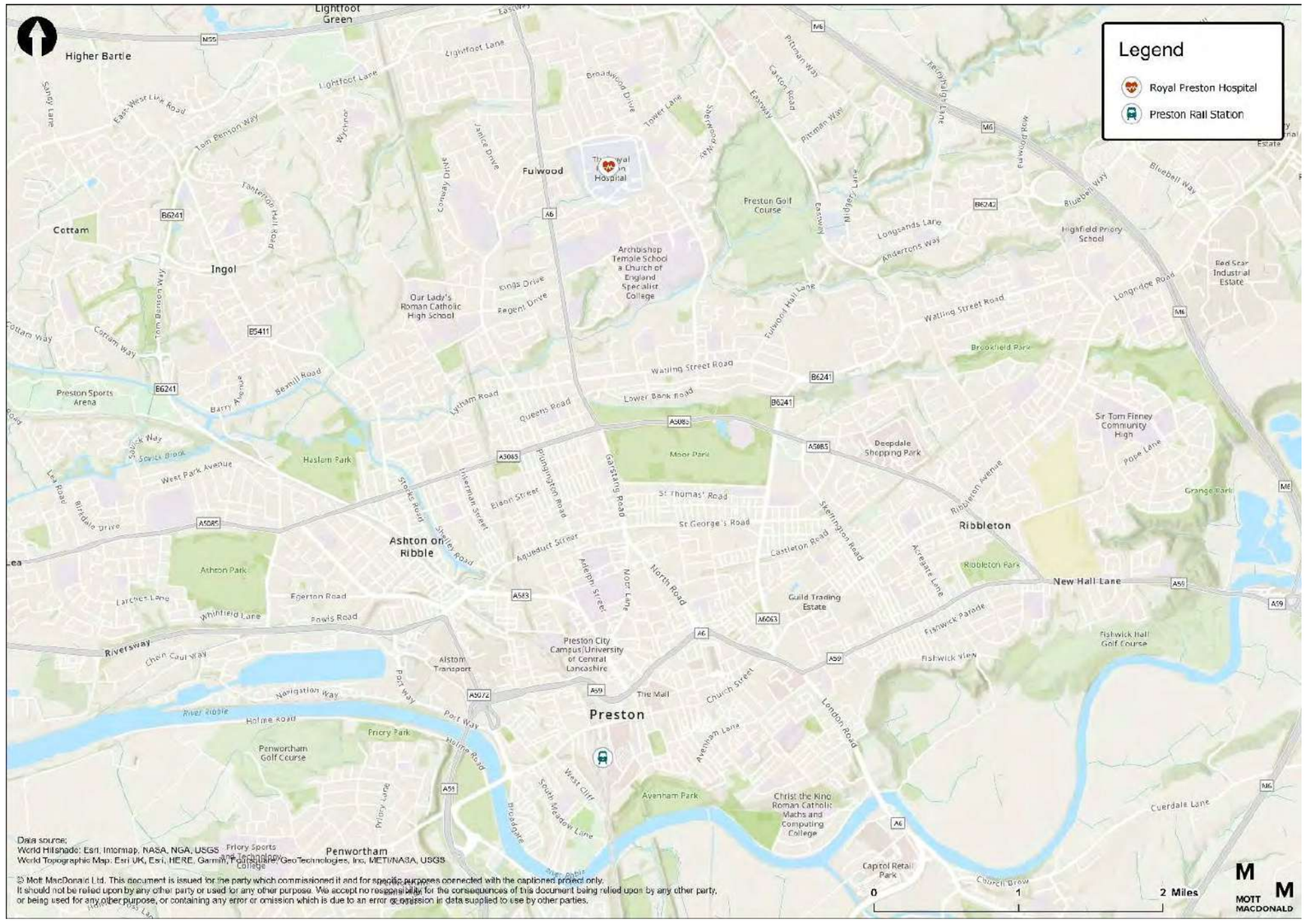
Mode	Time	Details
Cycle	Approximately 20 minutes	There are three main cycle routes from Preston Rail Station to RPH each between 3.1 and 3.4 miles long. • via A6, Moor Lane and A5071 which is 3.1 miles long and takes approximately 17 minutes. • via Garstang Road/A6 which is 3.3 miles long and takes approximately 18 minutes. • via A6 only which is 3.4 miles long and takes approximately 17 minutes. The route is downhill for most of the journey.
Bus	30 to 35 minutes, depending on route	Direct services on routes 23 or 43 or 19 takes 32 or 34 minutes from Preston Rail Station.
Taxi	20 minutes	
Walking	Approximately 1 hour 5 minutes	There are three main walking routes from Preston Rail Station to Royal Preston Hospital. The journeys are 2.9 miles long, 3.0 miles long and 3.1 miles long respectively. • Via Garstang Road/A6 – approximately 1 hour 5 minutes. • Via Black Bull Lane – approximately 1 hour 8 minutes. • Via Sharoe Green Lane – approximately 1 hour 8 minutes.

The station is a regional hub with trains departing to and arriving from a range of destinations across England. Table 8 below shows these services.

Table 8: Rail Services from Preston Rail Station

Destination	Weekday		Saturday		Sunday	
	Frequency	Hours of operation	Frequency	Hours of operation	Frequency	Hours of operation
Blackpool North	4 per hour	05:00-23:55	4 per hour	06:40-23:55	2 per hour	09:00-00:00
Blackpool South	1 per hour	06:40-22:25	1 per hour	06:50-23:25	1 per hour	08:30-20:30
Glasgow Central	2 per hour	05:40 – 21:40	2 per hour	05:40 – 21:40	2 per hour	11:00 – 21:40
Manchester Airport	4 per hour	05:25 – 23:50	4 per hour	05:25 – 23:30	2 per hour	08:40 – 22:20
London Euston	3 per hour	05:30 – 21:00	2 per hour	06:00 – 18:20	2 per hour	08:40 – 19:20
Liverpool Lime Street	2 per hour	06:30 – 22:40	1 per hour	06:00 – 22:40	1 per hour	08:20 – 22:30
York	1 per hour	05:40 – 20:40	1 per hour	05:40 – 21:40	1 per hour	09:45 – 21:45

Figure 3: Preston Rail Station



Public Transport Accessibility Summary

RPH is well served by bus services between Preston and surrounding areas. All the local bus routes run until at least 22:00 with only one route ceasing on a Sunday. The frequency of the available buses could be improved upon; only the 19, 23 and 125 routes run every 10-20 minutes. All other routes have frequencies of between 30 and 90 minutes.

Rail service provision at Preston Rail Station is extensive and provides access in every direction across the UK on both weekdays and weekends. However, to access Preston Rail Station, it is too far to walk from the hospital and requires an additional bus journey; this may result in fewer people utilising this mode.

Active Travel

Walking

Pedestrian routes exist in the vicinity of the hospital, with a mixture of signalised and un-signalised crossing points, the majority of which give priority to pedestrians. A 15mph speed limit exists across the site which should support safe walking around the site.

Sharoe Green Lane has a footway on both sides that is approximately 1.5m wide. All sections of Sharoe Green Lane are lit by street lighting, including areas where bus stops are situated. This could make walking in darker hours feel safer and more attractive to staff, outpatients and visitors. Sharoe Green Lane has been observed as a relatively busy B-road which could impact on how attractive walking to the site could be for staff, outpatients and visitors.

Cycling

There are no cycle paths provided on site, however cycle parking in the form of Sheffield stands have been provided throughout the site which has enough spaces for 35 bikes across seven locations. Table 9 shows the number of cycle stands at each location.

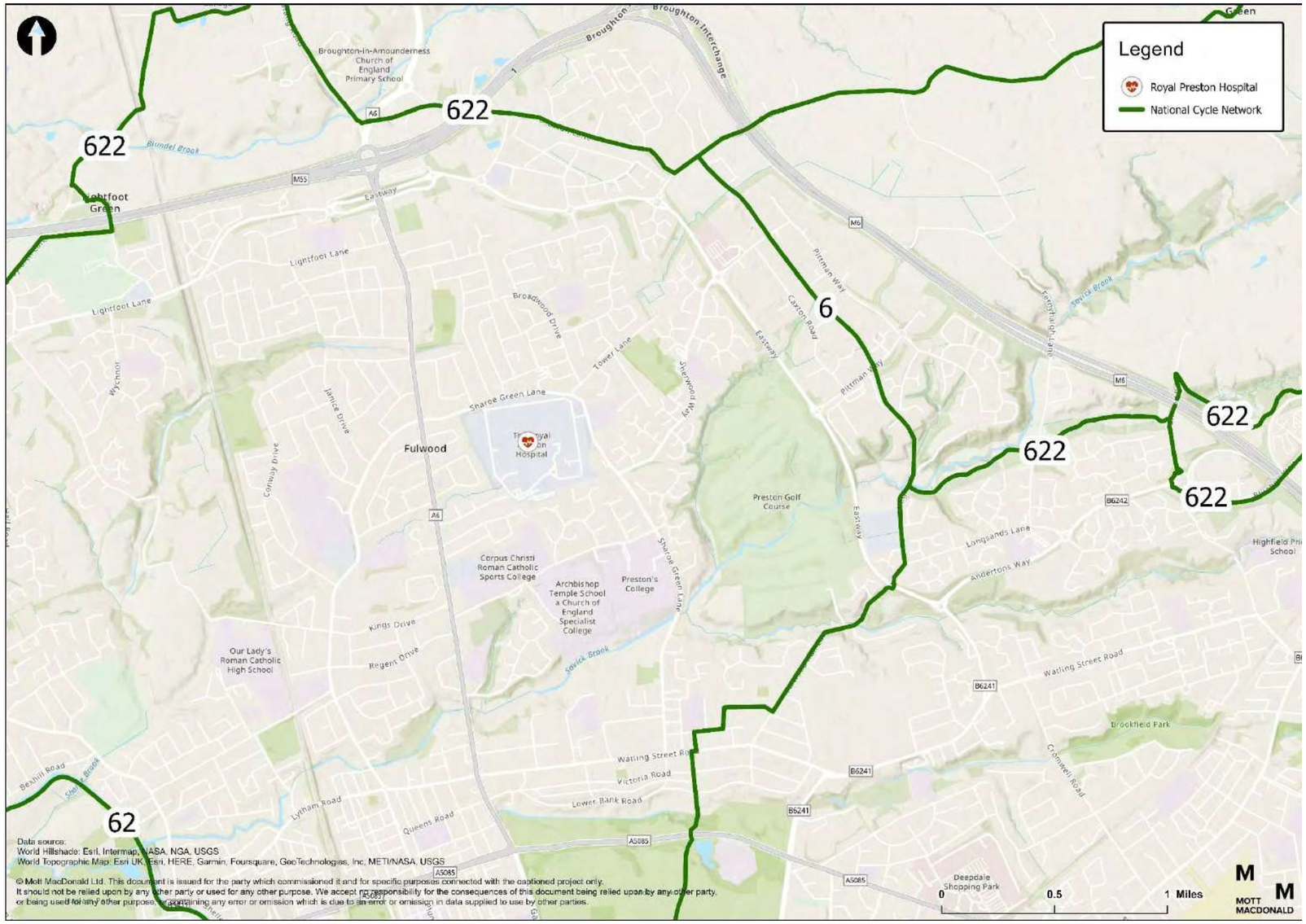
Table 9: Cycle Parking Locations

Location	Number of cycle areas
Car Park E / Linen Room	8
Maternity Unit	7
Staff Car Park E	5
Car Park B / Emergency Department	5
Sec Management Offices	3
Rosemere	2
Rehabilitation Unit	2
Avondale Unit	1
Ed Centre	1
Total	**34**

Shower and changing facilities are also available for staff travelling to RPH.

Figure 4 shows the cycling infrastructure in the vicinity of RPH. It shows National Cycle Network (NCN) Route 6 which runs from Preston City Centre to the north. The NCN 622 is a circular greenway known as the 'Preston Guild Wheel' which encircles the city of Preston and can be accessed from Pitman Way 1.5 miles east of RPH.

Figure 4: National Cycle Network around RPH



3. Site and accessibility Audit – Chorley and South Ribble Hospital

3 Site and Accessibility Audit – Chorley and South Ribble Hospital

Introduction

Chorley and South Ribble Hospital (CSRH) is in Chorley, Preston. It is approximately 8.8 miles from Preston City Centre and 1.6 miles from Chorley Town Centre. The hospital is bordered by the A6 Preston Road and Euxton Lane.

Site Access

There is one access point at the eastern side of the site along the A6 Preston Road, and two additional access points on Euxton Lane.

There is a variety of visitor car parks and staff car parks ranging in capacity.

There is one bus stop on site and additional bus stops situated on the surrounding road network.

Figure 5 shows a detailed map of the site location.

Figure 5: Chorley and South Ribble Hospital Site Location

Car Access

Visitor Car Parking

A total of 221 parking spaces are provided for outpatients and visitors across the CSRH site.

The CSRH car parks operate a pay and display parking system. Table 10 shows standard visitor car parking charges and Table 11 shows concession car parking arrangements.

Table 10: Standard Visitor Car Parking Charges

Time	Cost
Up to 30 minutes	FREE
Up to 1 hour	£2.80
Up to 2 hours	£3.80
Up to 4 hours	£6.00
Up to 6 hours	£6.60
Up to 8 hours	£8.80
Up to 24 hours	£10.00
Weekly	£30.00

Source: Lancashire Teaching Hospitals NHS Trust (2/11/23)

Table 11: Concession Car Parking

Concession	Cost
Disabled parking	Free
Frequent outpatient attendees, defined as those who are required to attend hospital for an appointment at least three times within a month for at least three months.	Free
Parents or guardians of sick children staying overnight in the hospital	Free
Outpatients with a life-long condition requiring two or more hospital visits per week	Free
Family visitors to a gravely ill inpatient	£2.50 a day
Family visitors to a relative with an extended stay in hospital beyond 21 days	£2.50 a day

Source: https://www.lancsteachinghospitals.nhs.uk/car-parking-concessions

Staff Car Parking

There are 671 car parking spaces. Staff can apply for a car parking permit. These are awarded based on a set of criteria which considers a range of factors, such as early and late travel times, out of hours duties, regular business travel, public transport availability and disability.

Car parking permit charges can be paid on a weekly, monthly, or annual basis with charges banded based on salaries and hours worked per week. These charges are shown in **Error! Reference source not found.**. Student staff are able to access discounted parking charges; these are provided within **Error! Reference source not found.**.

Table 12: Qualifying Staff Parking Charges

	Over 30 Hours	Over 25 - 30	Over 18 - 25	Over 10 - 18	Up to 10
Salary Band £0 - £22,815.99					
Weekly	£3.56	£2.86	£2.15	£1.41	£0.76
Monthly	£15.46	£12.43	£9.33	£6.13	£3.25
Annual	£185.59	£149.17	£112.05	£73.53	£39.21
Salary Band £22,816- £50,951.99					
Weekly	£4.04	£3.24	£2.42	£1.62	£0.82
Monthly	£17.51	£14.06	£10.50	£7.05	£3.55
Annual	£210.11	£168.78	£126.06	£84.74	£42.73
Salary Band £50,952 - £99,890.99					
Weekly	£4.58	£3.69	£2.76	£1.87	£0.94
Monthly	£19.83	£15.99	£11.96	£8.10	£4.07
Annual	£238.12	£191.90	£143.57	£97.35	£49.02
Salary Band £99,891+					
Weekly	£10.23	£8.18	£6.09	£4.04	£1.94
Monthly	£44.35	£35.49	£26.38	£17.51	£8.41
Annual	£532.27	£425.81	£316.55	£210.11	£100.85

Source: Lancashire Teaching Hospitals NHS Trust (2/11/23)

Table 13: Qualifying Student Staff Parking Charges

	Over 30 Hours	Over 25 - 30	Over 18 - 25	Over 10 - 18	Up to 10
Salary Band £0 - £22,815.99					
Weekly	£2.90	£2.33	£1.75	£1.15	£0.61
Monthly	£11.61	£9.33	£7.01	£4.60	£2.45
Annual	£139.28	£111.95	£84.10	£55.19	£29.43

Source: Lancashire Teaching Hospitals NHS Trust (2/11/23)

Off-site Parking

The Trust have negotiated 40 off-site parking spaces at Morrisons Chorley which are available to staff. Staff also able to access a 50% discount when parking at one of these sites.

Regarding other options for off-site parking, double yellow lines are present on surrounding roads. The nearest non-NHS car park is 'B&Q Car Park', located towards Chorley Town Centre, which is a 0.6 mile walk away.

Electric Vehicle Parking

Electric vehicle spaces with charging capabilities are available in two locations across the CSRH site. Six spaces are provided. Usual parking charges are applicable to those who park in EV spaces.

For those who wish to charge their vehicle, a mixture of charging speeds is available. CSRH has four spaces which charge at a speed of 7kW and two spaces offering rapid charging at 22kW. A charging tariff of 28p/kWh is also applicable.

Accessible Parking

There are 40 accessible parking spaces available at CSRH.

Car Parking Summary

Many parking spaces are available on site for the use of Trust staff with permits allocated based on criteria for use of onsite spaces. There is also a variety of NHS car parks provided for outpatients and visitors.

Table 14 provides a summary of the car parks available to staff or visitors and outpatients at CSRH.

Table 14: Car Park Summary

Car Park	Users	Number of Spaces	Of which are EV Charging Spaces	Of which are Accessible Spaces
On-site Parking				
All car parks	Staff	671	6	40
All car parks	Outpatients and Visitors	221	0	
On-site Parking				
Morrisons Chorley	Staff	40	0	
	Total		10	

Source: Lancashire Teaching Hospitals Foundation NHS Trust

Local Highway Network

A6 Preston Road to the east of the site is a dual carriageway (with some sections characterised by one lane), which runs from the A6 Preston Road/ Church Road/ Walton Summit Road roundabout to Chorley Hall Road/ A6 Preston Road/ A6 Preston Street junction. It is a two-way dual carriageway with NWAAT restrictions, subject to a 30mph speed limit.

Euxton Lane, north of the site, runs from A6 Preston Road/Euxton Lane junction to Runshaw Lane/ Wigan Road/ Euxton Lane junction. It is a two-way carriageway, with a varying number of lanes at different places with sections of NWAAT restrictions. It is subject to speed limits ranging from 30 – 40 mph.

Public Transport

Bus Services

There are several bus routes that serve CSRH. Two bus stands are located on Euxton Lane, four on the A6 Preston Road and one located within the site.

Table 15 details the public bus services that serve these stops.

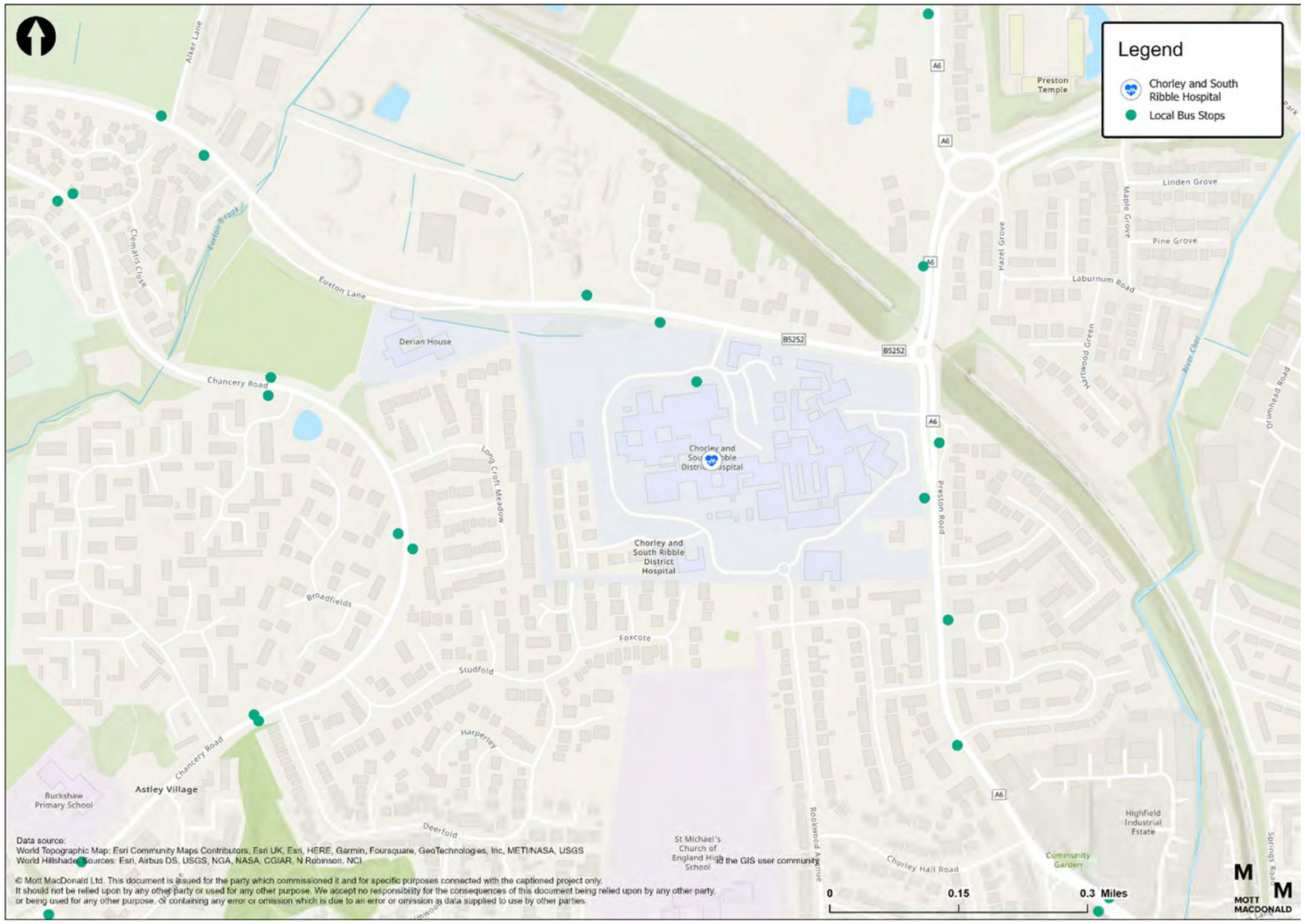
Table 15: Bus Services

Route		Weekday		Saturday		Sunday	
		Frequency	Hours of operation	Frequency	Hours of operation	Frequency	Hours of operation
114	Clayton Brook Village – Leyland Tesco	1 per hour	07:12 - 18:43	1 per hour	07:28 – 18:38	No service	No service
125	Royal Preston Hospital - Bolton	7 per hour	05:48 – 23:53	4 per hour	05:53 – 23:50	2 per hour	09:20 – 23:47

Source: Preston Bus Services | Preston Bus/Live Bus Times & Timetables | Stagecoach (stagecoachbus.com)

Bus shelters with seating and ample standing space which is segregated from the highway have been provided at all bus stops in the vicinity of CSRH.

Figure 6: Chorley and South Ribble Hospital - Local Bus Stops



Rail Services

Chorley Rail Station is 1 mile from CSRH, located within Chorley Town Centre.

Figure 7 shows the location of Chorley Rail Station in comparison to the location of the hospital.

Travel from the station to the hospital is possible via cycle, bus or taxi as detailed in Table 16.

Table 16: Travel from Chorley Rail Station to CSRH

Mode	Time	Details
Cycle	Approximately 10 minutes	There are three main cycle routes from Chorley Rail Station to CSRH each between 1.4 and 1.5 miles long which are: • Via the A581, 10 minutes/1.4 miles long. • Via Rookwood Avenue, 9 minutes/ 1.5 miles long. • Via Friday Street and Rookwood Avenue, 9 minutes/1.5 miles long.
Bus	15 – 30 minutes, depending on route	There are two main bus service to get to the hospital from the train station, which are: • Route 125 gold for 4 minutes/6 stops. Total journey time of 15 minutes. • Route 119 for 8 minutes/8 stops. Total journey time of 30 minutes.
Taxi	5 – 10 minutes.	There is no active taxi rank at the train station, however Uber operates here. There is also a free phone available in the hospital lobby
Walking	Approx 25 minutes	There are two main routes from Chorley Rail Station to Chorley and South Ribble Hospital. The journeys are 1.1 miles long and 1.2 miles long respectively. • Via Rockford Avenue – approximately 25 minutes. • Via Preston Road/A6 – Approximately 27 minutes.

Source: Google

The station is a local hub and provides frequent services to and from strategic destinations such as Manchester Airport for connections into Manchester City Centre and beyond, and Blackpool North. Table 17 shows all rail services from Chorley Rail Station.

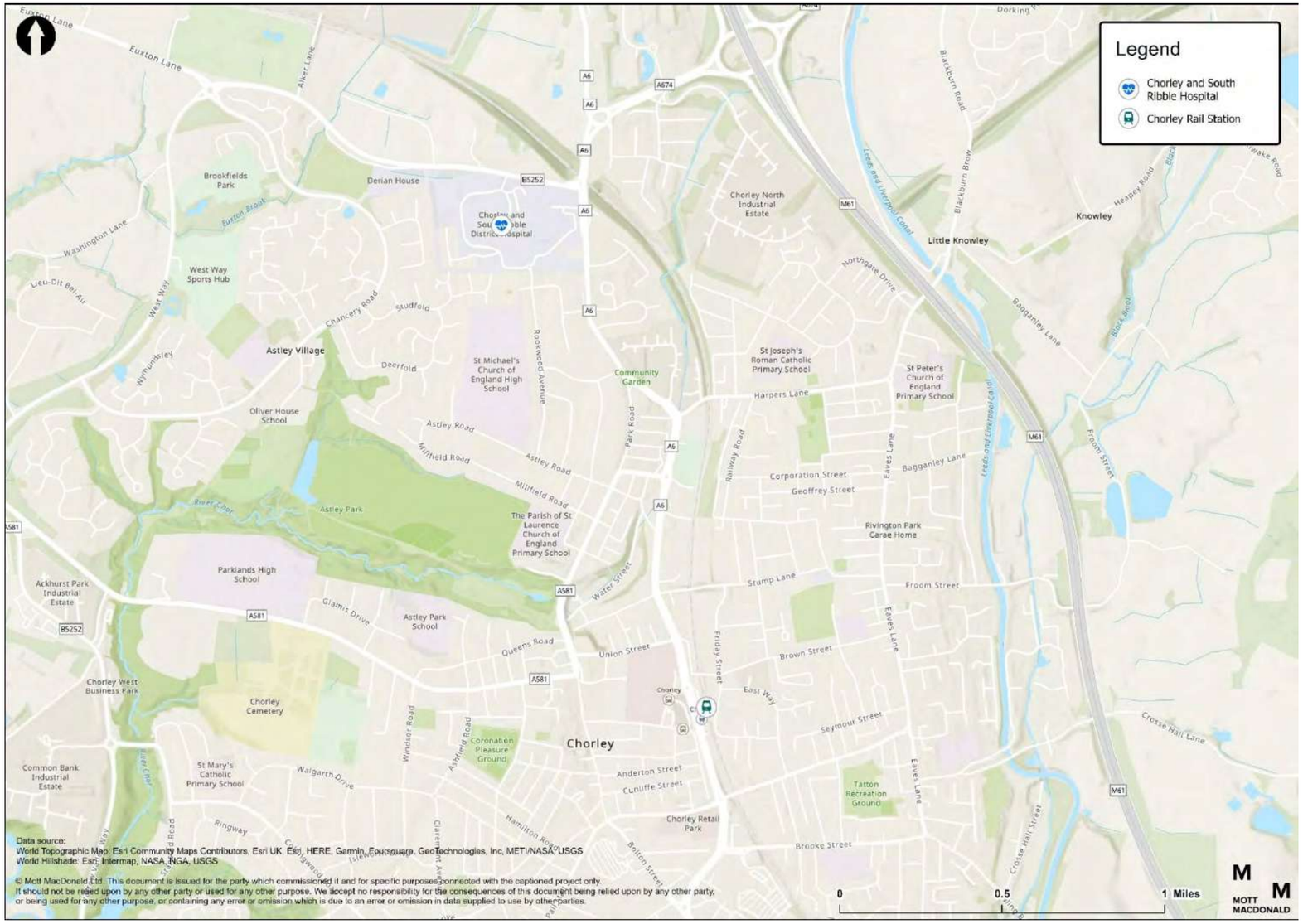
Table 17: Rail Services from Chorley Rail Station

Destination	Weekday		Saturday		Sunday	
	Frequency	Hours of operation	Frequency	Hours of operation	Frequency	Hours of operation
Manchester Airport	3 per hour (none between 00:39 – 05:38)	00:03 – 23:03	3 per hour (none between 00:03 – 05:38)	00:03 – 23:48	1 - 2 per hour	08:31 - 23:04
Blackpool North	3 per hour (non between 00:39 0 05:36)	00:09 – 23:37	3 per hour (none between 00:39 – 05:36)	00:09 - 23:37	1 per hour (none from 00:09 – 08:39)	00:09 23:40
Windermere*	3 per day	09:21 – 18:23	4 per day	09:21 – 18:23	4 per day	09:21 – 18:21
Barrow-in-Furness*	Every 1 – 3 hours	06:20 – 22:52	Every 1 – 2 hours	06:20 – 22:51	Every 1 to 2 hours	10:23 – 20:22

Source: National Rail Enquires

**Direct trains only.*

Figure 7: Chorley Rail Station.



Public Transport Accessibility Summary

CSRH is well-served by buses from Chorley and surrounding areas however, only the 125 route runs until 23:00, with the rest ending between 18:30 and 19:30 and no services on Sundays, excluding the 125.

Rail service provision to Chorley Rail Station is extensive and provides access to the local stations nearby.

Active Travel

Walking

Pedestrian routes exist in the vicinity of the hospital, with a mixture of signalised and un-signalised crossing points, and the majority give priority to pedestrians; a 10mph speed limit exists across the site which should support safe walking around the site.

The A6 Preston Road has a footway both sides of the carriageway, which are approximately 1.5 metres wide. All sections of the A6 Preston Road are lit by street lighting, including areas where bus stops are situated.

Cycling

There are no cycle paths provided on site however cycle parking in the form of Sheffield stands is provided throughout the site which has enough spaces for 11 bikes across five locations.

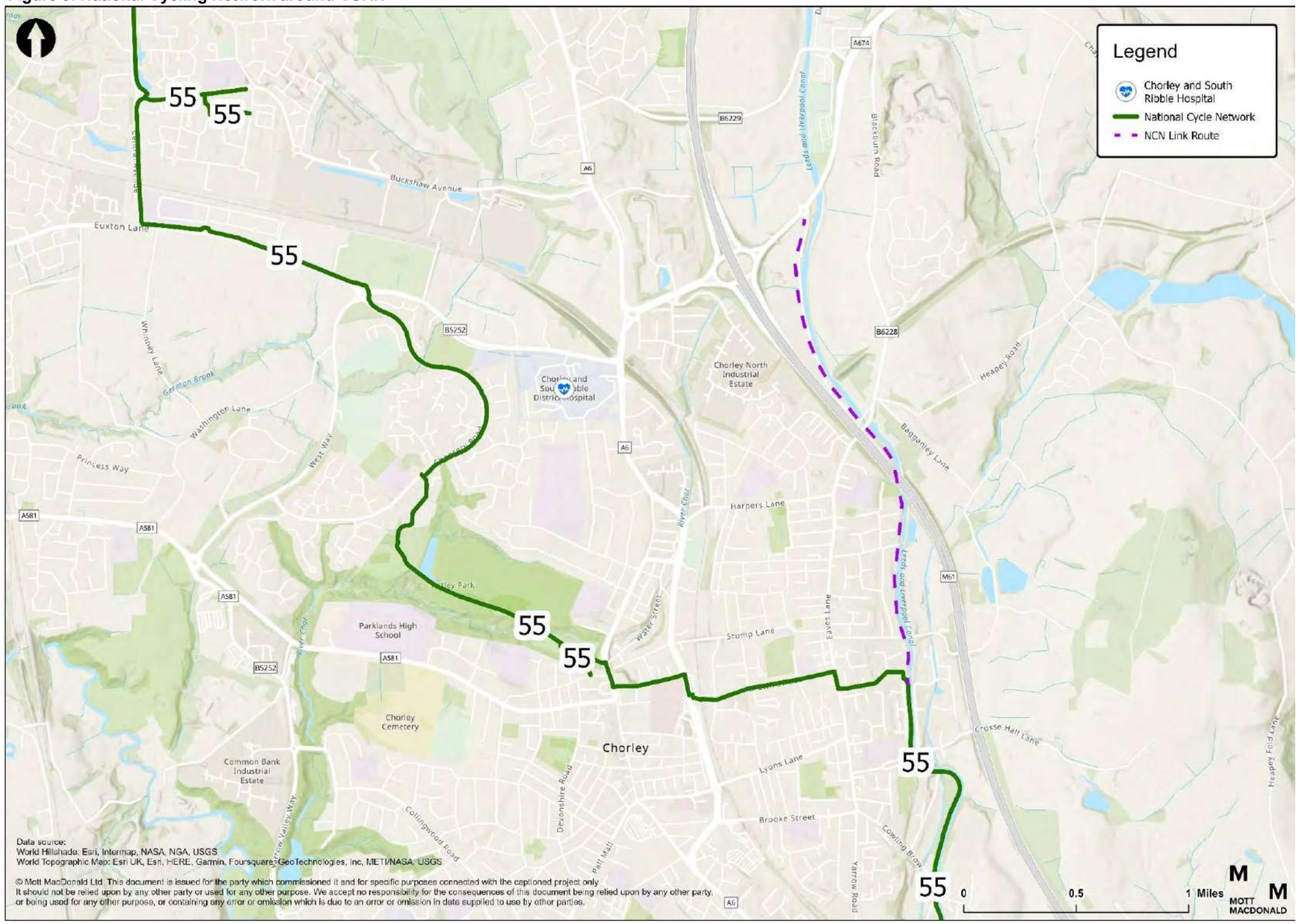
Table 18 shows the number of cycle stands at each location.

Table 18: Cycle Parking Locations

Location	Number of cycle spaces/bins
Stores/Porters Hub	3
Car Park B – Preston Road	3
Car Park I	2
Main Entrance	2
Estates Car Park	1
Total	**11**

Figure 8 shows the cycling infrastructure in the vicinity of CSRH. This figure shows National Cycle Network Route 55 which runs from Ironbridge to Preston via Cheshire and Greater Manchester; a section around Stockport and Chorlton uses NCN Route 62.

Figure 8: National Cycling Network around CSRH



4. Site and Accessibility Audit – Preston Business Centre

4 Site and Accessibility Audit – Preston Business Centre

Introduction

Preston Business Centre (PBC) is in Fulwood, Preston. It is approximately 1.8 miles from Preston City Centre and bordered by Watling Street Road and Bhailok Square.

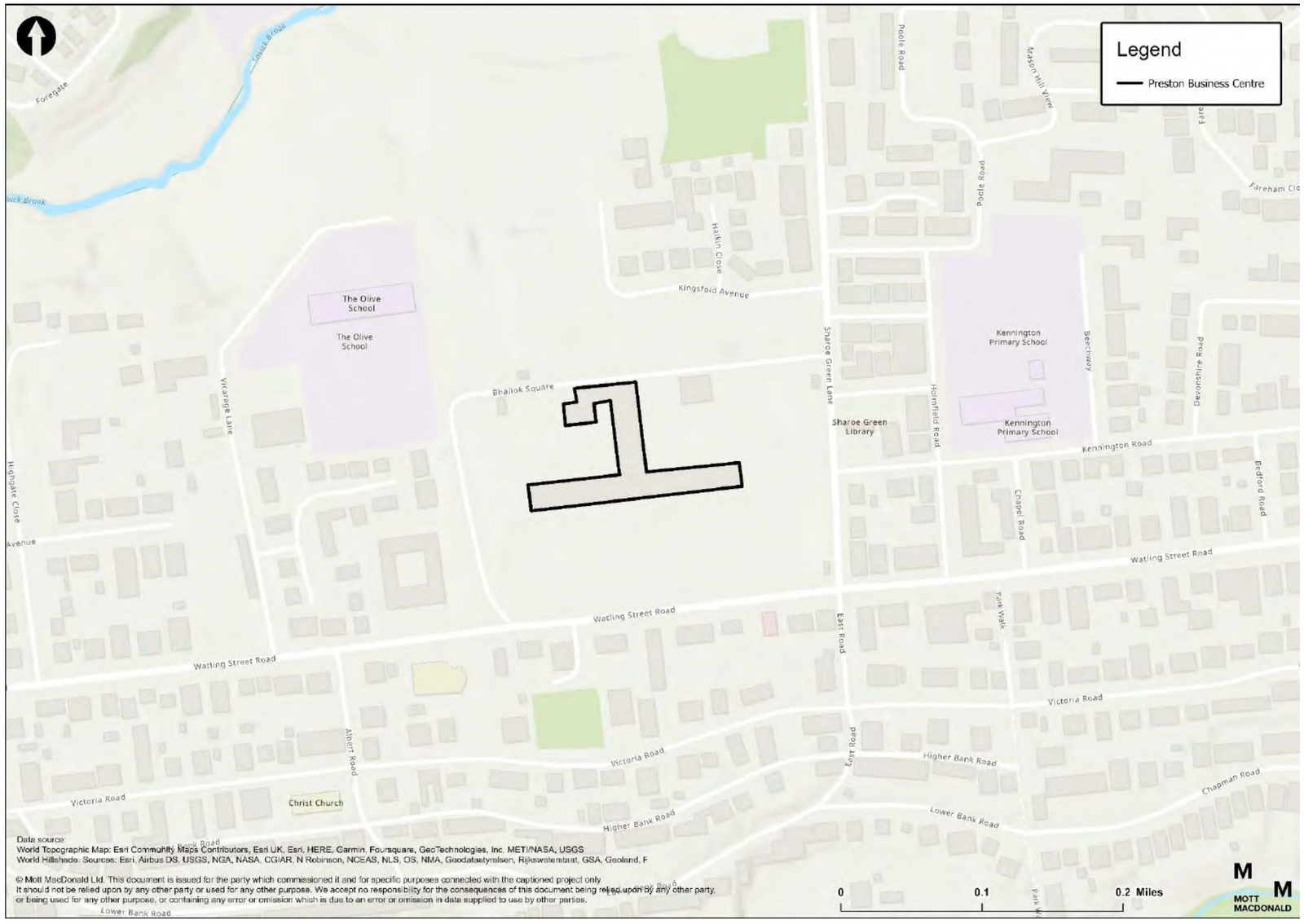
Site Access

There is one access point to the site at Bhailok Square which is accessed via both Sharoe Green Lane and Watling Street Road. The car park and main entrance can be accessed this way.

There is one onsite car park available for both outpatients and staff, along with six bus stops on site and situated on the surrounding road network.

Figure 9 shows a detailed map of the site location.

Figure 9: Preston Business Centre Site Location



Car Access

Visitor Car Parking

There is one car park for outpatients which has 344 car spaces along with 23 accessible parking spaces. The car park operates a pay and display parking system. Table 19 shows standard visitor car parking charges.

Table 19: Standard Visitor Car Parking Charges

Time	Cost
Up to 30 minutes	FREE
Up to 1 hour	£2.80
Up to 2 hours	£3.80
Up to 4 hours	£6.00
Up to 6 hours	£6.60
Up to 8 hours	£8.80
Up to 24 hours	£10.00
Weekly	£30.00

Source: Lancashire Teaching Hospitals NHS Trust (2/11/23)

Staff Car Parking

There is one designated location where staff can park on site. It contains 344 spaces along with 23 accessible bays. Staff can apply for a car parking permit. These are awarded based on a set of criteria which considers a range of factors, such as early and late travel times, out of hours duties, regular business travel, public transport availability and disability.

Car parking permit charges can be paid on a weekly, monthly, or annual basis with charges banded based on salaries and hours worked per week. These charges are shown in Table 20.

Table 20: Qualifying Staff Parking Charges

	Over 30 Hours	Over 25 - 30	Over 18 - 25	Over 10 - 18	Up to 10
Salary Band £0 - £22,815.99					
Weekly	£1.78	£1.43	£1.07	£0.71	£0.38
Monthly	£7.73	£6.21	£4.66	£3.07	£1.63
Annual	£92.80	£74.59	£56.03	£36.77	£19.61
Salary Band £22,816- £50,951.99					
Weekly	£2.03	£1.62	£1.21	£0.81	£0.41
Monthly	£8.76	£7.03	£5.26	£3.53	£1.77
Annual	£105.05	£84.39	£63.03	£42.38	£21.36
Salary Band £50,952 - £99,890.99					
Weekly	£2.29	£1.85	£1.38	£0.94	£0.47
Monthly	£9.92	£7.99	£5.98	£4.05	£2.04
Annual	£119.06	£95.95	£71.79	£48.67	£24.52
Salary Band £99,891+					
Weekly	£5.11	£4.09	£3.04	£2.03	£0.97
Monthly	£22.17	£17.75	£13.19	£8.76	£4.20
Annual	£266.14	£212.91	£158.28	£105.05	£50.42

Offsite Parking

There are no parking restrictions on surrounding roads. The nearest car park off site is ‘Moor Park Car Park’ which is one mile/15 minutes away walk from PBC.

Electric Vehicle Parking

Electric vehicle spaces with charging capabilities are available in one location within the PBC site. Two spaces are provided. Usual parking charges are applicable to those who park in EV spaces.

For those who wish to charge their vehicle, these spaces charge at a speed of 7kW and a charging tariff of 28p/kWh is also applicable.

Accessible Parking

There are 23 accessible parking spaces available at PBC.

Car Parking Summary

Many parking spaces are available on site for the use of Trust Staff. Permits are allocated based on criteria for use of on-site spaces. A smaller number of visitor/outpatient parking spaces are also provided in convenient locations around the site.

Table 21 provides a summary of the spaces available to staff or visitors and outpatients at PBC.

Table 21: Car Parking Summary

Car Park	User	Number of spaces	Of which EV Charging Spaces	Of which are Accessible Spaces
Onsite	All	344	2	23

Local Highway Network

Bhailok Square runs from Watling Street Road/Bhailok Square junction to Sharoe Green Lane/Bhailok Square junction, around PBC. It is a single lane, two-way carriageway, subject to 10mph speed limit with NWAAT restrictions.

Watling Street Road runs from the A6 Garstang Road/ Lytham Road/ Watling Street Road junction to Fulwood Row/Watling Street Road junction. It is two-way single lane carriageway, with some NWAAT restrictions of a 30mph speed limit.

Public Transport

Bus Services

There are several bus routes that serve PBC. There are four bus stops located on the southern side of the site, along the B6242. Two bus stops are located on the eastern side of the site, along Sharoe Green Lane, and there is one bus stop located on the northern side, along Bhailok Square.

Various bus services serve the PBC site and are detailed in Table 22 below.

Bus shelters with seating and ample standing space, which is segregated from the highway, have been provided at both bus stops along Sharoe Green Lane and at one bus stop along the B6242. However, one bus stop located along the B6242 has no seating or ample standing space which is segregated from the highway.

Figure 10 shows the bus stops within the vicinity of PBC.

Table 22: Bus Services

Route		Weekday		Saturday		Sunday	
		Frequency	Hours of operation	Frequency	Hours of operation	Frequency	Hours of operation
125 gold	Preston bus station – Preston bus station	3 per hour	06:28 – 21:36	3 per hour	06:08 – 21:36	2 per hour	08:36 – 20:06
19	Preston Bus Station – Royal Preston Hospital.	6 per hour	06:23 – 22:38	4 per hour	07:38 – 22:38	2 per hour	08:08 – 22:38
45	Preston Bus Station – Blackburn Bus Station	1 per hour	06:28 – 20:30	1 per hour	06:38 – 20:38	No service	No service -
99	Fulwood ASDA – Longridge HS	1 per day	15:17 – 16:01	No service	No service	No service	No service

Rail Services

Preston Rail Station is 2.4 miles from PBC, located within Preston City Centre.

Figure 11 overleaf shows the location of Preston Train Station in relation to the location of PBC.

Travel from the station to the hospital is possible via cycle, bus or taxi as detailed in Table 23.

Table 23: Travel from Preston Rail Station to PBC

Mode	Time	Details
Cycle	Approximately 15 minutes	There are three main cycle routes from Preston Rail Station to PBC each between 2.5 and 2.8 miles long which are: • Via NCN Route 6, 14 minutes / 2.5 miles long. • Via Brook Street, 16 minutes / 2.8 miles long. • Via Plungington Road, 15 minutes / 2.6 miles long.
Bus	32 minutes	There is one main bus service to get to the hospital from the train station, which is: • Route 19 from Sharoe Green Library – 10 stops to Arrival Stand. Followed by a 15-minute walk to the station.
Taxi	15 – 20 minutes	There an active taxi rank at the station and the journey takes 15 – 20 minutes.
Walking	Approximately 50 minutes	There are three main routes from Preston Rail Station to Preston Business Centre. The journeys are 2.1 miles, 2.2 miles long and 2.3 miles long respectively. • Via St Pauls Road – Approximately 48 minutes • Via Garstang Road/A6 – Approximately 49 minutes • Via Plungington Road – Approximately 52 minutes

Source: Google Maps

The station is a local hub with a variety of destinations; Table 24 below shows these services.

Table 24: Rail Services from Preston Rail Station

Destination	Weekday		Saturday		Sunday	
	Frequency	Hours of operation	Frequency	Hours of operation	Frequency	Hours of operation
Manchester Airport	3 per hour (none between 00:39 – 05:38)	00:03 – 23:03	3 per hour (none between 00:03 – 05:38)	00:03 – 23:48	1 - 2 per hour	08:31 -23:04
Blackpool North	3 per hour (non between 00:39 0 05:36)	00:09 – 23:37	3 per hour (none between 00:39 – 05:36)	00:09 - 23:37	1 per hour (none from 00:09 – 08:39)	00:09 23:40
Windermere*	3 per day	09:21 – 18:23	4 per day	09:21 – 18:23	4 per day	09:21 – 18:21
Barrow-in-Furness*	Every 1 – 3 hours	06:20 – 22:52	Every 1 – 2 hours	06:20 – 22:51	Every 1 to 2 hours	10:23 – 20:22

Source: National Rail Enquires **Direct trains only*.

Public Transport Accessibility Summary

PBC is served well by buses from Preston and surrounding areas with some services running six per hour Monday – Friday. Some services also run two per hour on a Sunday. Hours of operation are also adequate with services running from 06:30 – 22:30 most days.

Bus service provision to Preston Rail Station is extensive and provides access to the local station.

Figure 10: Local Bus Stops

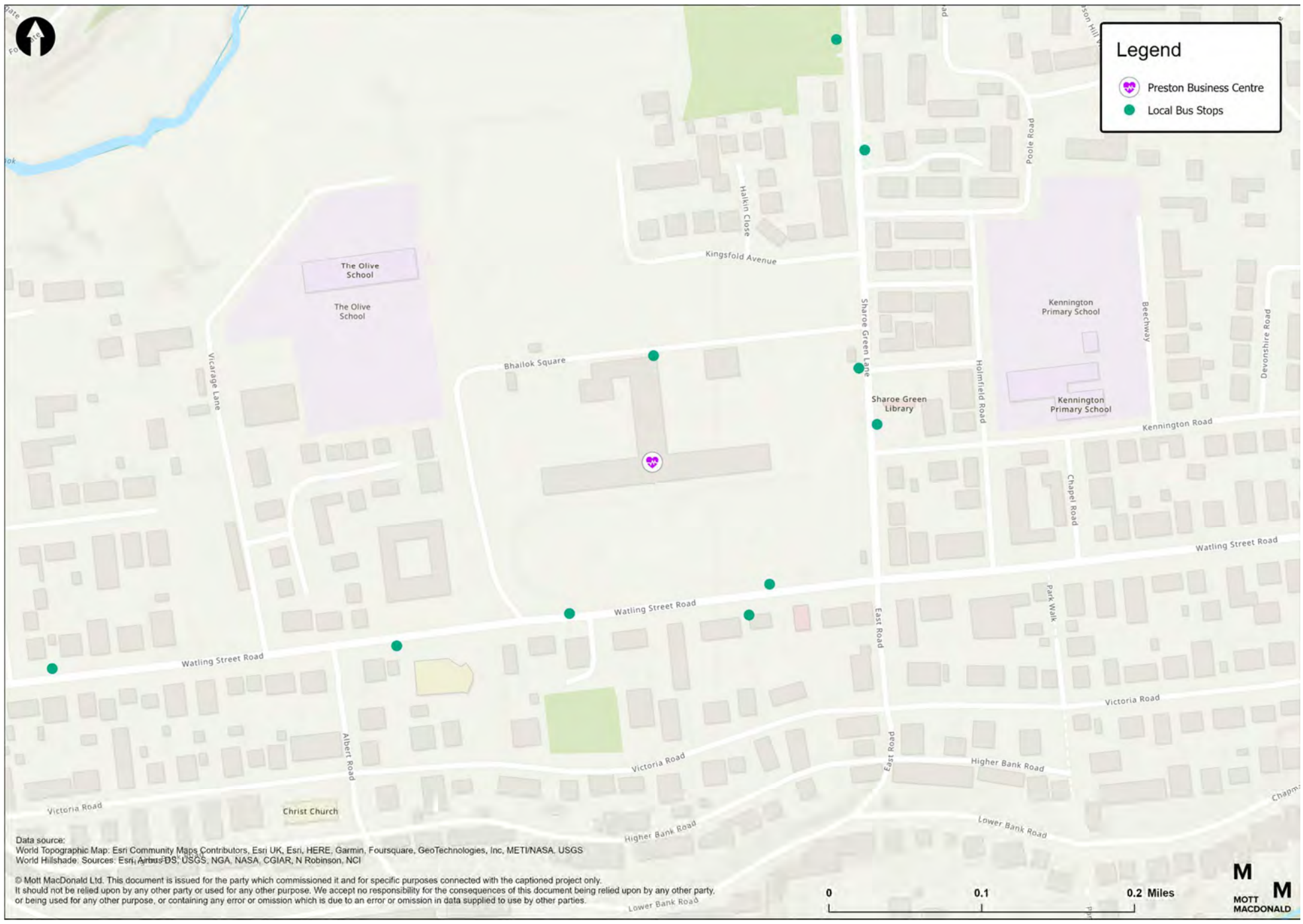
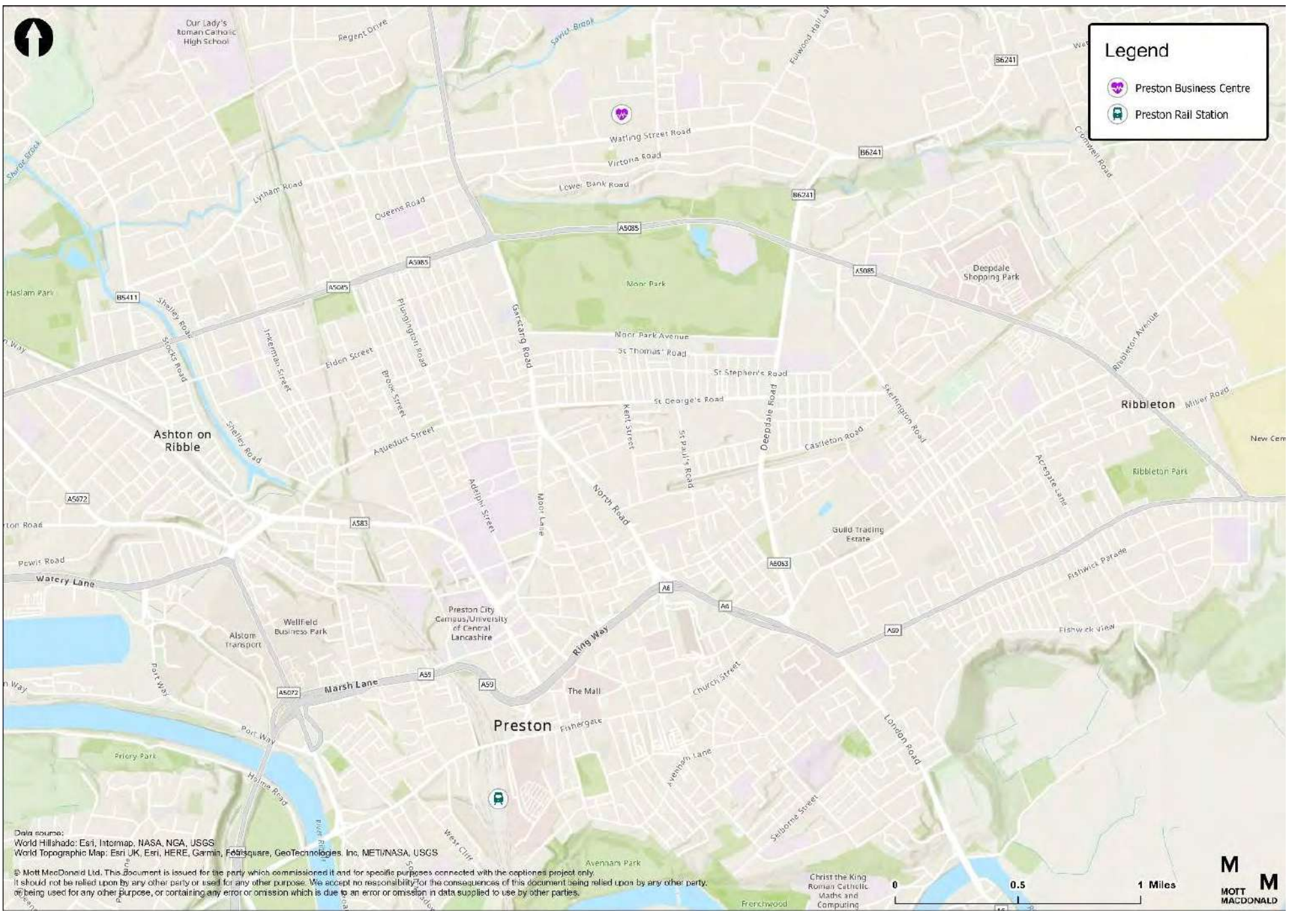


Figure 11: Preston Rail Station



Active Travel

Walking

There are pedestrian routes in the vicinity of the hospital, with a variety of crossing points, and the majority give priority to pedestrians. A 10mph speed limit exists across the site which should support safe walking around the site.

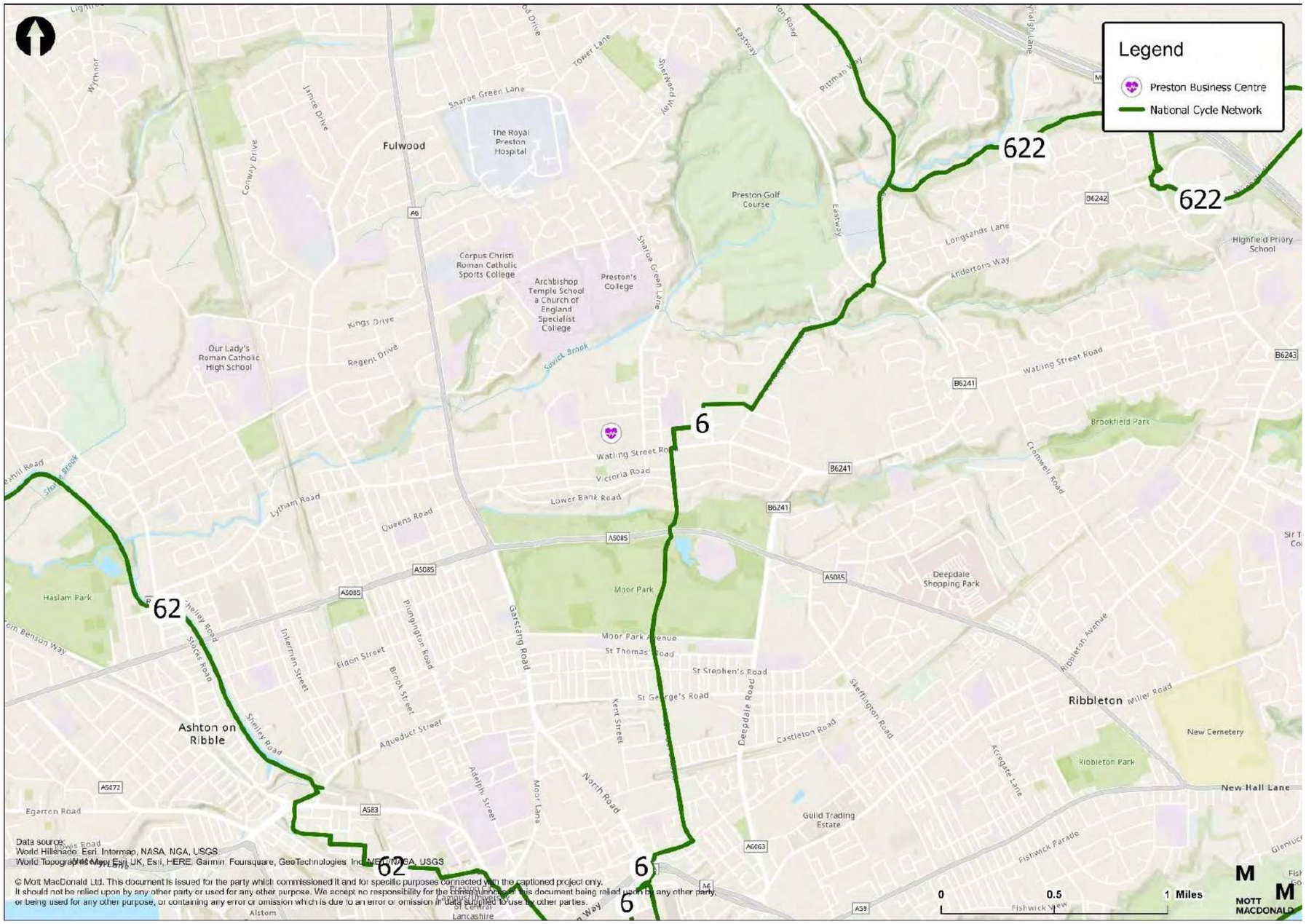
Sharoe Green Lane has a footway on both sides that is approximately 1.5m wide. All sections of Sharoe Green Lane have street lighting, including areas where bus stops are situated. This could make walking in darker hours feel safer and more attractive to staff, outpatients and visitors. Sharoe Green Lane has been observed as a relatively busy road which could impact on how attractive walking to the site could be for staff, outpatients, and visitors.

Cycling

There are no cycle stands available at PBC.

The cycling infrastructure in the vicinity of PBC is shown within Figure 12 This figure shows National Cycle Network Route 6 which runs from Ironbridge to Preston via Cheshire and Greater Manchester, a section around Stockport and Chorlton uses NCN Route 62. It also shows Route 62, which connects Fleetwood on the Fylde region of Lancashire with Selby in North Yorkshire and forms the west and central sections of the Trans Pennine Trail which is a long-distance path running from coast to coast across northern England.

Figure 12: National Cycling Network around PBC



5 Staff Travel Patterns

5 Staff Travel Patterns

Introduction

To understand current staff travel behaviour and to support travel and access to the three Lancashire Teaching Hospital NHS Foundation Trust sites, a staff travel survey was conducted in July 2023.

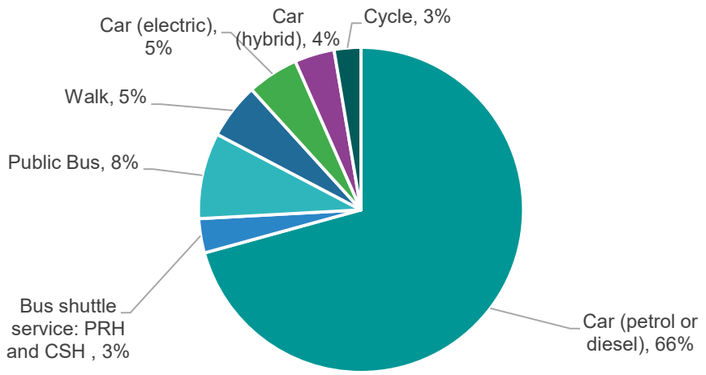
An online survey was emailed to all staff members and was promoted via several methods including the staff intranet, staff Facebook, reminders on the staff intranet, posters, and digital screens in communal areas. In total, 862 responses were received, providing a 20.5% response rate.

Survey Results

This section seeks to provide an insight into the main barriers and likely incentives that could influence staff travel behaviour. Understanding these elements, and constructing relevant measures, can ensure the most effective impact towards the targets of this TP.

Figure 13 shows the modal split for Trust staff.

Figure 13: How did you travel to site today?



The results of the survey indicate that petrol/diesel car usage is the main method of traveling to work for staff, with 66% of staff choosing to commute this way.

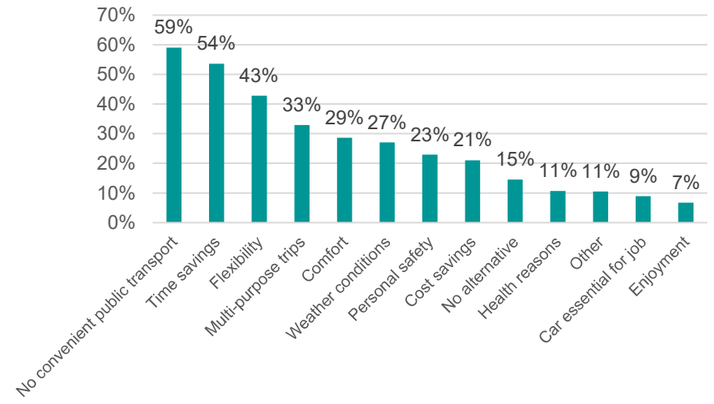
Other than private car the next most popular responses were:

- 8% of staff travelled via Public Bus
- 5% of staff walked
- 5% of staff travelled via electric car

Car Travel

Figure 14 summarises why people chose to drive to the hospital.

Figure 14: What are the most important reasons for your choice of mode of travel to the hospital?



As shown in Figure 14, the main reasons why people chose to drive are:

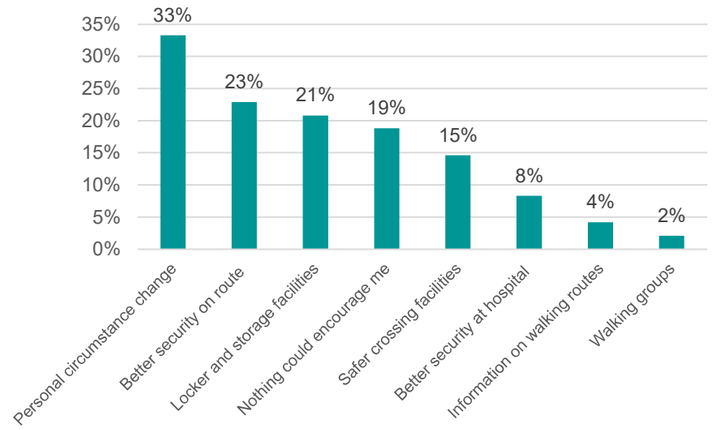
- Lack of convenient public transport (59%)
- Time savings (54%)
- Flexibility (43%)

Sustainable Travel

To understand what would encourage staff to use more sustainable modes, two questions were asked about what would need to be implemented/ changed for travellers to use active travel or public transport.

The answers from both questions are summarised in Figure 15 and Figure 16.

Figure 15: Which of the following would encourage you to travel to and from your workplace by walking or cycling?



As shown by the above graph, a high percentage of staff would require a 'personal circumstance change' to encourage them to walk/cycle to work (33%). However, 23% of staff said how better street lighting along routes would encourage them and 21% said adequate locker and storage facilities at work would result an increased likelihood of them choosing to walk or cycle to work.

Figure 16: Which of the following would encourage you to travel to and from your workplace by public transport?

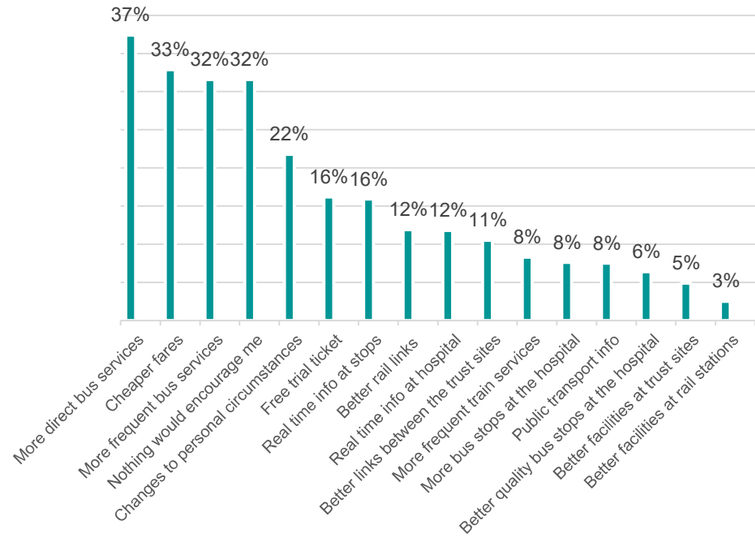


Figure 16 suggests that staff would be more likely to use public transport to reach the Trust sites if the below were provided (top three reasons):

- More direct bus services (37%)
- Subsidised/cheaper fares (33%)
- More frequent bus services (32%)

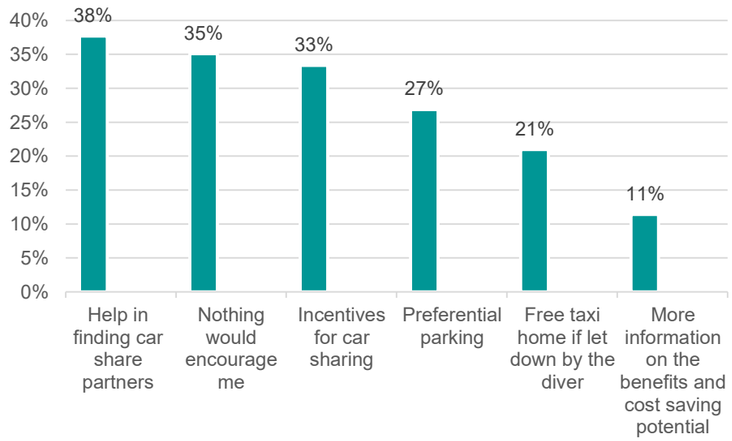
Awareness

The Trust offers a car sharing scheme to its employees through the 'Parking Eye' parking management system. Currently there are 10 priority parking spaces which are in the most convenient locations and are policed by a local parking officer to ensure only car sharers have access to these spaces. There will be a regular review of the car sharing scheme and more priority spaces will be increased if the demand increases.

As part of the travel survey, a question was asked to gain an idea of what could possibly increase car sharing in the future.

Figure 17 shows the possible measures and what percentage of staff would be interested in each one.

Figure 17: What would encourage you to car share?



As shown in Figure 17, staff said the following would encourage them to car share:

- Help in finding a car share partner with similar work/travel patterns (38%)
- Incentives for car sharing (33%)
- Preferential parking (27%)

Staff Home Locations

Figure 18 shows a heat map of staff home locations. Areas of red and yellow indicate where there are higher densities of staff home locations.

Figure 19 and Figure 20 show staff home locations within a two-mile and five-mile radius of the site respectively. Areas of red and yellow indicate higher densities of staff home locations. The number of staff this represents is outlined within Table 25.

Examples of sustainable transport measures could include improved car sharing and bus route improvements.

Table 25:Staff home locations within two and five miles of the site.

Site	Distance from site	Number of staff who live within this distance
Royal Preston Hospital	Two miles	210
	Five miles	828
Chorley and South Ribble	Two miles	53
	Five miles	263
Preston Business Centre	Two miles	244
	Five miles	868

Figure 18: Staff Home Locations

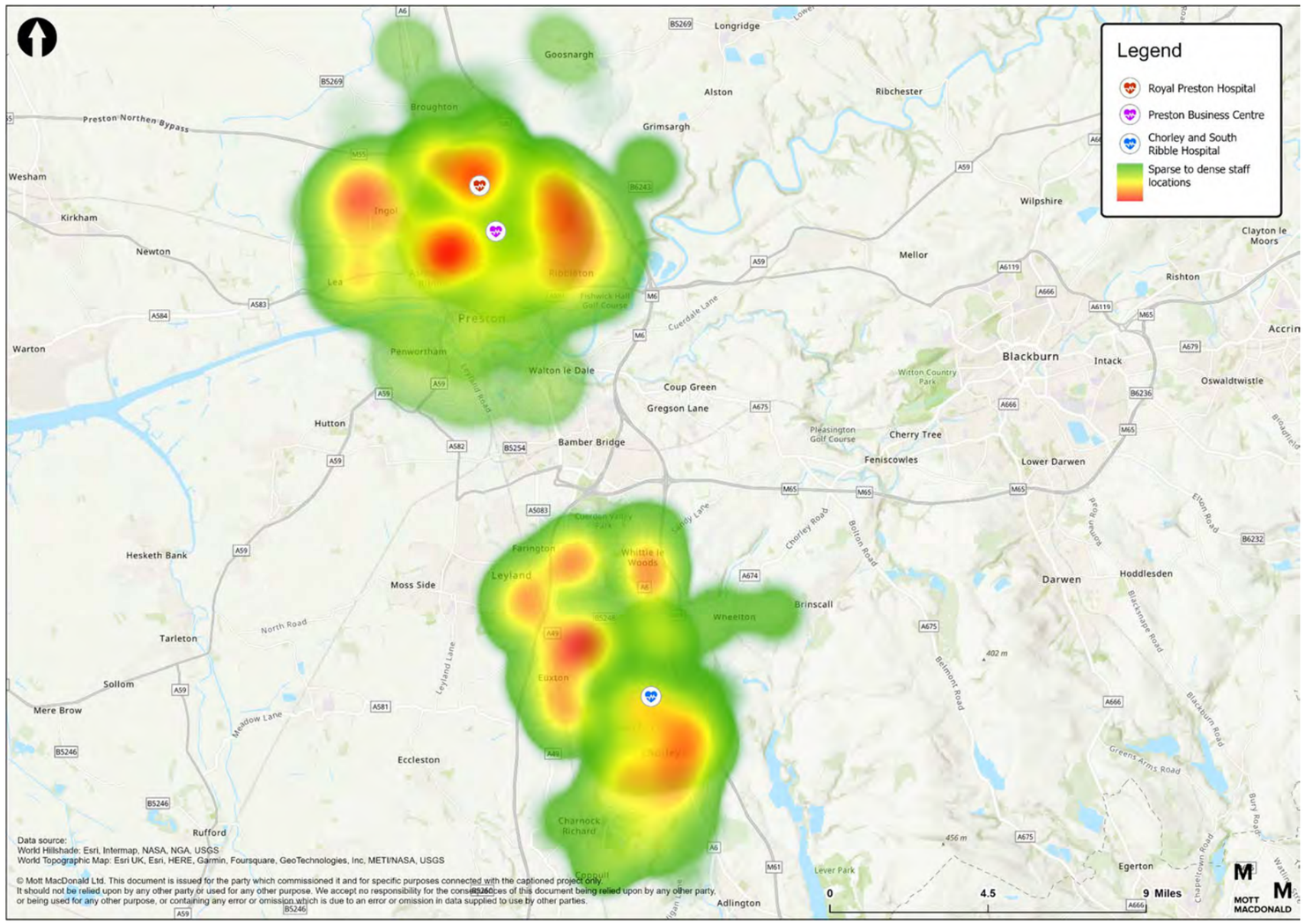
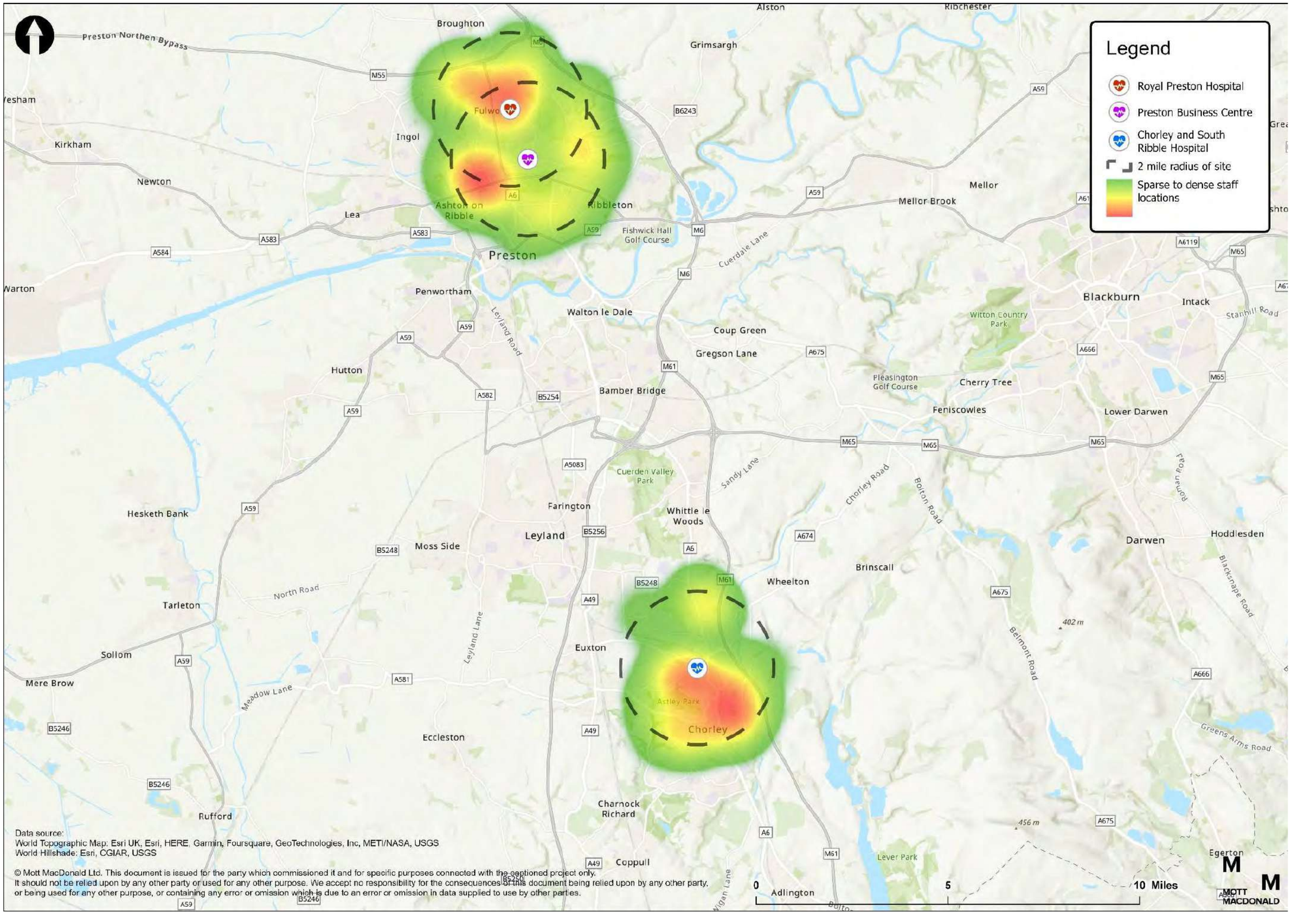


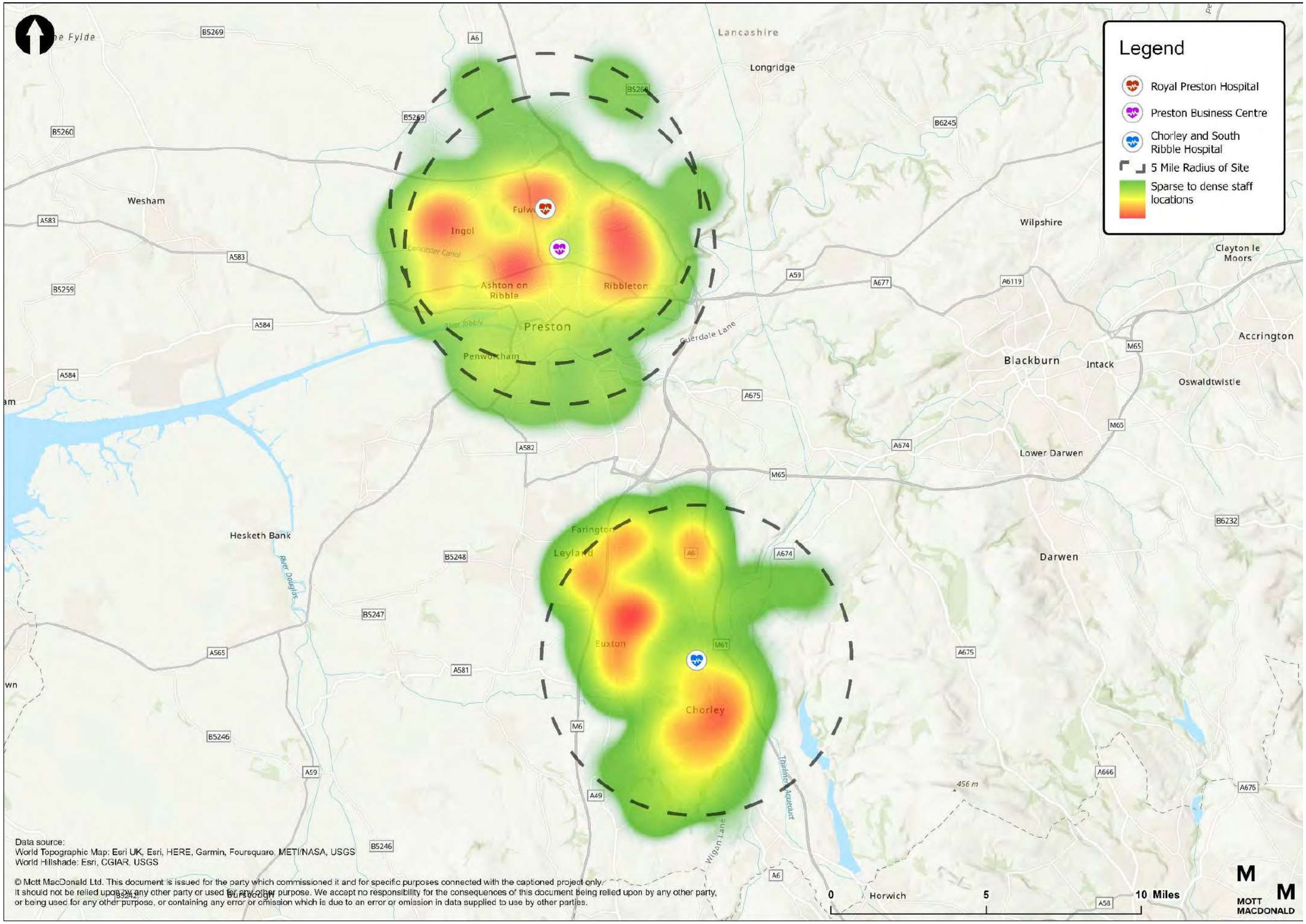
Figure 19: Staff home locations within 2 miles of the site



Data source:
World Topographic Map: Esri UK, Esri, HERE, Garmin, Foursquare, GeoTechnologies, Inc, METI/NASA, USGS
World Hillshade: Esri, CGIAR, USGS

MOTT MACDONALD

Figure 20: Staff home locations within 5 miles of the site



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6 Outpatient and Visitor Travel Patterns

6 Outpatient and Visitor Travel Patterns

Introduction

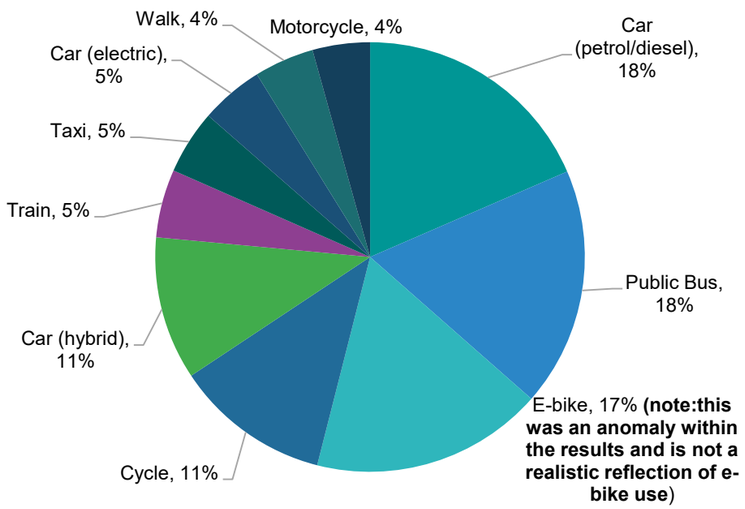
To understand the current travel behaviour of outpatients and visitors to/from the sites, a travel survey was carried out over a 6-week period (in June and July 2023), where a total of 1,679 responses were collected. The travel survey aimed to understand how outpatients and visitors travel, the reasons why they chose that mode and what would encourage them to use more sustainable modes.

Survey Results

This section seeks to provide an insight into the main barriers and likely incentives that could influence patient and visitor travel behaviour. Understanding these elements, and constructing relevant measures, can ensure the most effective impact towards the targets of this TP.

Figure 21 shows the modal split between the Outpatients and visitors of the Trust.

Figure 21: How did you travel to site today?



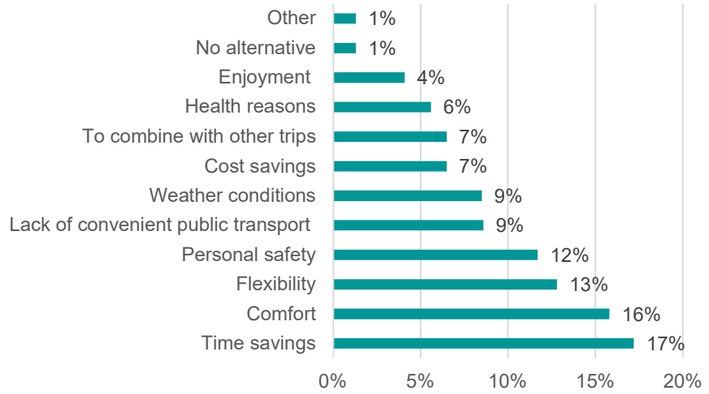
The results of the survey indicate that car (petrol/diesel) is one of the main methods of traveling to the site for visitors and outpatients, with 18% of visitors and outpatients choosing to commute this way. Private motorised transport (a combination of car (petrol/diesel), car (hybrid), car (electric) and motorcycle) accounts for 38% of outpatients and visitors.

In terms of sustainable transport, travelling by bus is the most popular mode of travel (18%) for outpatients and visitors, whilst 4% and 11% walk and cycle respectively. (It should be noted that there is an anomaly in these results which show an unrealistically high proportion of those using e-bikes to access Trust sites).

Car Travel

There are many reasons why, for outpatients and visitors, driving is their preferred option for travelling to Trust sites. Figure 22 summarises these reasons.

Figure 22: What are the most important reasons for your choice of mode of travel to the hospital?

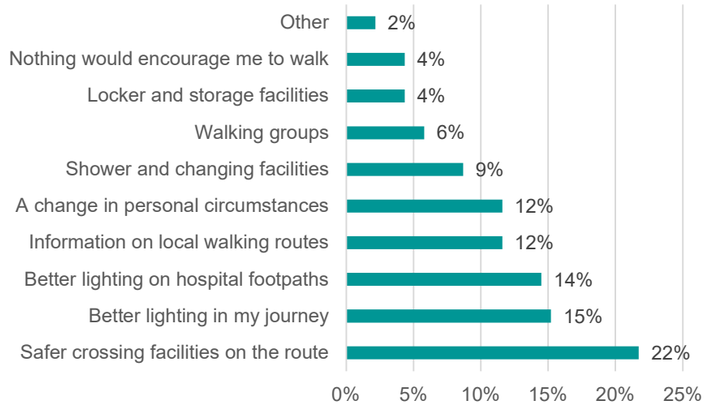


The main response from people regarding why they chose to travel by car was ‘Time savings’ (17%) followed by ‘Comfort’ (16%), and ‘Flexibility’ (13%).

Sustainable Travel

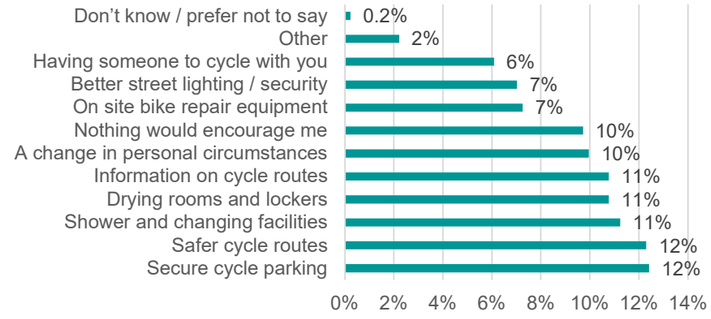
To understand what would encourage outpatients and visitors to use more sustainable modes, three questions were asked about what would need to be implemented/changed for people to use active travel or public transport. The answers these questions are summarised in Figure 23, Figure 24 and Figure 25.

Figure 23: Which of the following would encourage you to travel to and from the hospital by walking?



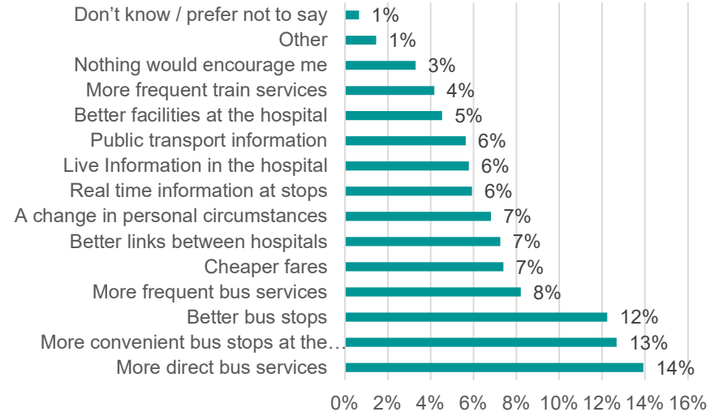
22% of respondents said ‘Safer crossing facilities on the route to work’ would encourage them to walk, followed by ‘Better street lighting/security on the route to the hospital’ (15%), and ‘Better street lighting/security on hospital footpaths’ (15%).

Figure 24: Which of the following would encourage you to travel to and from the hospital by cycling?



The main response from people regarding what would encourage them to cycle to the hospital was ‘Secure cycle parking’ (12%) followed by ‘Safer cycle routes’ (12%).

Figure 25: Which of the following would encourage you to travel to and from the hospital by using public transport?

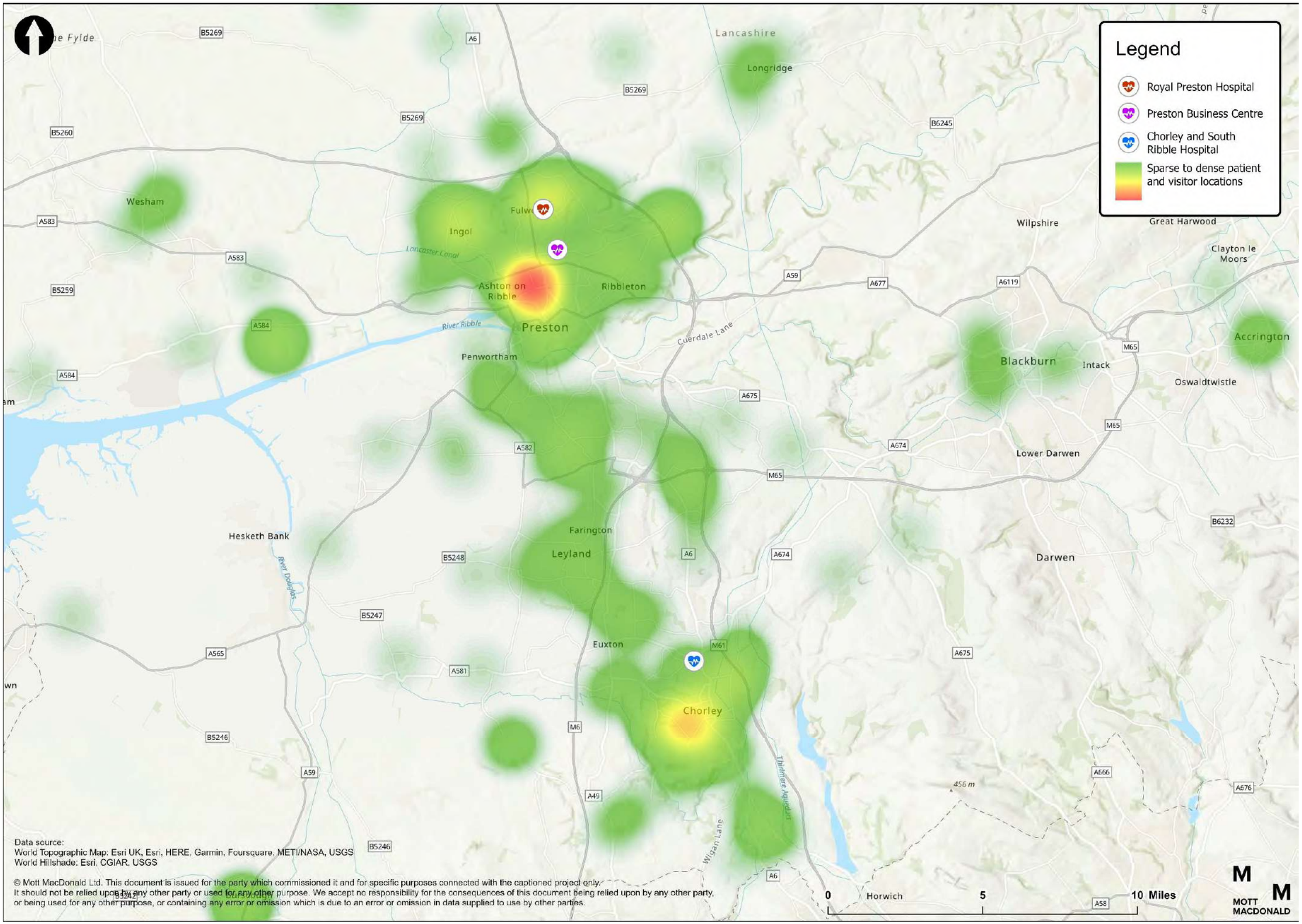


As shown in Figure 25, the main things that would encourage people to use public transport were:

- There were more direct services (14%)
- There were more convenient bus stops at the site (13%)
- More secure/better quality bus stops at the site (12%)

Outpatient and Visitor Home Locations

Figure 26: Outpatient and Visitor Home Locations



7 Travel Plan Objectives and Targets

7 Travel Plan Objectives and Targets

7.1 Objectives

The TP objectives have been developed through understanding the unique challenges and opportunities across the Trust. The objectives focus on bringing about meaningful and positive change to make the estate more sustainable whilst supporting Trust staff in the best way it can.

The objectives of the TP are:

1	**Align with NHS (Green Strategic Plan) and national, regional, and local policy sustainability targets and the Trust's Estates Strategy.**
2	**Improve access and provide greater choice of transport modes for staff, outpatients and visitors.**
3	**Reduce single occupancy car trips, encourage the use of active travel, car sharing and use of public transport.**
4	**Increase awareness of the advantages and potential for travel by more environmentally friendly methods or modes.**
5	**Introduce physical and management measures that will assist travel by other modes.**
6	**Ensure further development considers TP objectives by assessing future developments for access to transport and opportunities for travel behaviour.**
7	**Contribute to the health and wellbeing of staff, visitors and outpatients.**

7.2 Targets

A TP must have targets that are quantifiable and measurable over time. The targets can be used to assess whether the TP measures have been successful in influencing travel behaviour. They must be ambitious enough to provide the Trust with the incentive to make significant changes in travel patterns, yet be realistic and achievable.

7.2.1 Mode share targets

The principal objective in relation to mode share is Objective 3, which is to 'reduce single occupancy car trips, encourage the use of active travel, car sharing and public transport'. In response to this objective, specific mode share targets have been established.

Mode share targets for visitors and staff have been formulated in line with best practice and national, regional, and local policy aspirations. Both the staff and visitor mode share targets focus on a reduction in the number of single occupancy car trips and a consequent increase in active travel, car sharing and public transport. The resulting targets are presented in Table 26.

These targets have been set against baseline modal shares derived through travel surveys undertaken in 2023. Further details of how these baseline mode shares have been established and analysis of the findings is provided in Sections 5 and 6.

Table 26: Baseline Staff Mode Share and Targets

Mode of Travel	Results from 2023 survey	2026 Proposed Target	2028 Proposed Target
Car (petrol or diesel)	**65.0%**	**55.0%**	**47.0%**
Car (electric/hybrid vehicle)	**8.4%**	**15.0%**	**20.0%**
Total Car	**73.4%**	**70.0%**	**67.0%**
Of which Car share	**12.0%**	**14.0%**	**16.0%**
Total Public Transport	**14.9%**	**17.4%**	**19.4%**
Walk	**5.1%**	**5.5%**	**6.5%**
Cycle/E-bike	**2.8%**	**3.0%**	**3.5%**
Total Active Travel	**7.9%**	**8.5%**	**10.0%**
Motorcycle	**0.7%**	**1.0%**	**1.0%**
Other (please specify):	**3.0%**	**3.0%**	**3.0%**
Total	**100%**	**100%**	**100%**

8 Measures and Action Plan

8 Travel Plan Measures and Action Plan

The main component of a TP is its package of recommended measures, which can be a mixture of different types of actions or incentives and infrastructure improvements.

These measures include actions to be taken forward by a number of different individuals and groups, however the Travel Plan Coordinator (TPC) will be responsible for progressing the measures and being a contact point with regards to sustainable transport.

The TP will be approved by the TPC who will also:

- Set tasks and priorities;
- Monitor and review progress
- Ensure the TP is coordinated with other policies and activities;
- Provide management support required to take ideas forward e.g. revisions to HR policies; and
- Identify any necessary funding required to deliver the TP.

This long list of potential measures focuses principally on promoting alternative forms of travel to single occupancy car drivers.

8.1 Car Measures

Below are several measures which will make driving to the site more sustainable for those staff, visitors and outpatients that need to drive to site.

Table 27: Car Measures

Measure	Description	Who benefits? (staff only / all users)	Responsibility	Timescale/frequency
Provision of EV charging facilities	Review the number of EV charging spaces which are reserved for EV vehicles in all car parks based on usage levels (20 EV charging spaces are currently available across the sites)	Staff only	Estates Engineering manager	Usage to be checked and reviewed every 6 months
Review staff vehicle leasing scheme	Review current scheme (e.g.: lease of a low emission vehicle and/or fuel-efficient vehicle through salary sacrifice). Update if necessary to ensure the Trust is still on track to reach TP and sustainability targets.	Staff only	NHS Fleet	Ongoing
Discounts on motorcycle testing	Engagement with motorcycle testing centres to explore potential discounts for staff wanting to get their motorcycle license.	Staff only	N/A	Within 3 years

8.2 Car Parking Measures

The measures outlined below involve car parking management as part of the TP.

Table 28: Car Parking Measures

Measure	Description	Who benefits? (staff only / all users)	Responsibility	Timescale/frequency
Review parking permit application process	Update the current process of car parking permit allocation to staff. Criteria and permit eligibility is currently reviewed yearly.	Staff only	Parking Permit Provider	Within 1 year
Staff parking tariffs	Consider changes to current parking tariffs for staff.	Staff only	Board Approval	Within 1 year

8.3 Car Sharing Measures

By encouraging car sharing, as outlined in the measures below, the Trust will look to make car sharing an attractive proposition for those who travel to the site.

Table 29: Car Sharing Measures

Measure	Description	Who benefits? (staff only / all users)	Responsibility	Timescale/frequency
Provision of a car sharing scheme	To reduce the number of single occupancy car trips, a car sharing scheme will be provided through the parking management app. This will allow employees to find other colleagues with similar journeys to work and to arrange to car share.	Staff only	Transport Planner and Parking Manager	Within 1 year
Priority parking spaces for car sharers	A total of 10 priority parking spaces are currently provided to car sharers. These spaces are in the most convenient locations and usage of these spaces is checked and enforced by a local parking officer. As the number of car sharers increases, the number of spaces will be reviewed and increased if needed to ensure demand is met.	Staff only	Car Parking Manager	6 monthly reviews of car sharing numbers and demand for priority parking spaces
Assistance with finding a lift home for car sharers	If a car sharer must return home in an emergency, leaving their car share partner stranded, the travel plan coordinator will help to find them an alternative journey home. This may be by finding another car sharer that can give them a lift home. In exceptional circumstances, a taxi home could be provided. A process will be defined where requests for assistance would go through the TPC.	Staff only	To be included in policy by TPC	TBC
Promotion of car sharing scheme	To encourage more staff to sign up to the car sharing scheme, the car sharing scheme and the benefits of car sharing will be promoted to all staff (for example, information will be displayed on notice boards and included in newsletters).	Staff only	Parking Manager	Within 1 year and ongoing to follow
Set up a car sharers coffee club	To incentivise staff to car share, car sharers will be invited to a car sharing coffee club where they will receive a free coffee and meet other car sharers.	Staff only	TPC	Within 1 year and then 6 monthly

8.4 Walking Measures

These measures are designed to prioritise the safety of pedestrians to promote walking as a sustainable and healthier alternative to single occupancy car. By enhancing pedestrian infrastructure, road safety, and wayfinding, the Trust aims to create a more secure and inviting environment that encourages walking as the preferred mode of travel where feasible.

Table 30: Walking Measures

Measure	Description	Who benefits? (staff only / all users)	Responsibility	Timescale/frequency
Walking maps and signage	Clear maps showing walking routes around the site will be provided. On site signage for pedestrians will also be improved.	All users	TPC	Within 1 year
Improved network/footpath maintenance	The TPC will work with Estates and Facilities to make sure that the needs of pedestrians, cyclists and bus users are considered when maintaining and improving on-site facilities.	All users	TPC and Estates & Facilities team	Regular review as part of maintenance programme
Provision of personal alarms, step-o meters and umbrellas	Items will be provided to encourage staff to walk. (for example personal alarms to make staff feel safer walking alone in the dark, step-o meters and umbrellas).	Staff only	TPC / Lancashire County Council Meeting	Within 1 year
Provision of shower/changing facilities	Improvements will be made to showers/changing facilities to make it easier for more staff to walk to work. The location of shower and changing facilities will also be promoted to staff through newsletters and posters.	Staff only	TPC	Ongoing
Walking events	Promotional events will be arranged, such as lunchtime walks and walking breakfasts.	Staff only	TPC	Quarterly
Walk to work/buddy schemes	The TPC will help staff match up with colleagues who live within walking distance and share a similar shift pattern so they can start walking to work together.	Staff only	TPC	Within 1 year and ongoing

8.5 Cycling Measures

These measures are designed to prioritise the safety of cyclists at Trust sites while promoting cycling and a more sustainable and healthier alternative to single occupancy car travel. By enhancing cycling infrastructure and services, the Trust aims to create a more secure and inviting environment that encourages cycling, as the preferred mode of travel where feasible.

Table 31: Cycling Measures

Measure	Description	Who benefits? (staff only / all users)	Responsibility	Timescale/frequency
Coffee club for cyclists	To incentivise cyclists, cyclists will be invited to a coffee club where they will receive a free coffee and can meet other cyclists. This will be also an opportunity for the TPC to get feedback from cyclists as to what improvements are needed to encourage more staff to cycle.	Staff only	TPC	Within 1 year and then 6 monthly
Cycle to work scheme	The trust is part of the cycle to work scheme which gives staff tax savings on the purchase of a new bike as part of salary sacrifice. This will be promoted to staff at bike week events.	Staff only	TPC	Ongoing
Cycle training	Cycle training to improve cycling ability, safety awareness and confidence on roads is provided by Lancashire County Council. The TPC will provide information to staff about the free cycle training available.	Staff only	TPC	Ongoing
Cycle maps and signage	Clear maps showing cycle routes around the site will be provided. On site signage for cyclists will also be improved.	Staff only	TPC	Within 1 year
Dr Bike sessions/bike maintenance sessions	To encourage cycling, Dr Bike sessions will be made available to staff to improve confidence in bike maintenance and minor repairs.	Staff only	TPC	Quarterly
Review of cycle mileage rates for journeys for work	Staff cycling for work purposes (eg: to meetings) can claim this as an expense. The cycle mileage rate will be reviewed by the TPC to make sure that it is in line with best practice.	Staff only	TPC	Within 3 years
Cycle parking and shelters on site	To make sure all cyclists are provided for, the number of cycle parking spaces and shelters on site will be reviewed regularly. The cycle parking areas should be lockable, (and covered by CCTV) and should be sheltered. The provision of E-bike charging outlets will also be reviewed on a regular basis.	Staff only	TPC	Within 1 year and then quarterly reviews
Promotion of national travel events e.g., bike week.	To increase awareness of cycling, national travel events, such as bike week will be promoted to staff through notice boards, social media posts and newsletters.	All Users	TPC	Quarterly
Liaison with Lancashire County Council regarding improvements to local active travel infrastructure	The Trust will contact Lancashire County Council to discuss possibilities for improved active travel infrastructure near to sites.	All users	TPC (through transport working group)	Through quarterly meetings with LCC as part of the transport working group
Provision of shower/changing facilities	Improvements will be made to showers/changing facilities to make it easier for more staff to cycle to work. The location of shower and changing facilities will also be promoted to staff through newsletters and posters.	Staff only	TPC	Ongoing and to be reviewed quarterly
Bike buddy scheme	Staff that are interested in trying cycling will be offered a 'bike buddy' to accompany them on their first few rides to work. This will be coordinated by the TPC.	Staff only	TPC	Ongoing

8.6 Public Transport Measures

The measures outlined below are designed to make public transport more attractive for both staff and visitors.

Table 32: Public Transport Measures

Measure	Description	Who benefits? (staff only / all users)	Responsibility	Timescale/frequency
Public transport information	Public transport information will be provided on the intranet and as part of the staff onboarding process. This information will be checked and updated regularly.	Staff only	TPC	Within 1 year (and then 6 monthly checks/updates)
Provision of real time bus information (if feasible)	The provision of live public transport departure information will be investigated. If it is feasible, it will be displayed in foyers and on the staff intranet.	All users	TPC	Within 1 year
Discounted tickets	Staff are already entitled to discounted bus fares. The TPC will work with bus operators to request further discounted tickets for outpatients and staff	All users	TPC	Within 1 year
Improvements to existing services	The TPC will work with bus operators to request improvements to safety, frequency and better stop information for those travelling to Trust sites	All users	TPC	Within 1 year
Free staff travel	There is a public bus which stops at Preston Business Centre and Royal Preston Hospital which will accept Trust staff for free upon presentation of their staff ID. This service will be publicised in staff newsletters and on the staff intranet.	Staff only	TPC	Ongoing
Staff shuttle bus service between the hospital sites and main town centres	Investigate the potential for a shuttle bus operating with a service for staff between the hospital sites and the main town centres within a 5 mile radius. The schedule could be aligned with shift patterns which do not correlate with public transport timetables.	Staff only	Estates and Facilities	Investigate within 1 year
Interest free season ticket loan	Staff can purchase a discounted bus pass (weekly/monthly). This service will be publicised in staff newsletters and on the staff intranet.	Staff only	TPC	Ongoing
Better connections to local bus stops	The TPC will work with Estates and Facilities to improve access to local bus stops.	All users	TPC/Estates and Facilities	Ongoing

8.7 Information and Awareness

The measures below are designed to provide improved information and raise awareness of TP measures. This is to improve take up of these measures which will in turn positively influence behaviour change in line with the targets of this TP.

Table 33: Information and Awareness Measures

Measure	Description	Who benefits? (staff only / all users)	Responsibility	Timescale/frequency
Promotion and raising awareness	To raise awareness of alternative forms of travel, the TPC will provide travel information to staff through posters on notice boards, pop-up events and the provision of travel information packs for new staff or outpatients.	All users	TPC	Ongoing
Personal travel advice	The TPC will offer to help new members of staff to plan their journey to work.	Staff only	TPC	Ongoing
Live travel updates	A permanent travel and transport section will be included within newsletters providing links to live traffic and travel information.	Staff only	TPC	Within 6 months and then ongoing

8.8 Management Measures

The measures identified below show how the objectives and targets of the TP will be managed. Measures include the appointment of a travel plan coordinator (TPC) and ongoing monitoring measures to ensure that TP is on track to meet the targets set.

Table 34: Management Measures

Measure	Description	Who benefits? (staff only / all users)	Responsibility	Timescale/frequency
Appointment of a travel plan coordinator (TPC).	A TPC will be appointed to ensure that the TP is delivered successfully.	N/A	The Trust	Within 1 month
TP monitoring and evaluation	The TPC will monitor the uptake of TP measures (e.g.: cycle parking, priority parking spaces, car sharing scheme) and will oversee the repeat of the staff and visitor travel surveys.	N/A	The Trust	Ongoing (and then repeat travel surveys after 3 years and after 5 years)
Travel working group	A travel working group will be set up to include the local councils and Transport for the North (TfN).	N/A	TPC	Established within 1 year / with meetings every 6 months
Trust transport strategy	Develop an overall transport strategy which would show how future demand will be accommodated.	N/A	Transport Manager, TPC and Parking Manager	Within 1 year and reviewed annually
Review the commercial viability of a low emission fleet on a 6 monthly basis	Every 6 months, review progress towards operating a low emission fleet.	N/A	Transport Manager	Every 6 months

9 Travel Plan Monitoring

9 Travel Plan Monitoring

This section describes how the TP will be monitored on an ongoing basis. This methodology is designed to ensure that the TP is a ‘living document’, continually evolving in-line with the latest data on mode share and travel habits. Monitoring allows the success (or failures) of the TP to be assessed.

As outlined in Table 35, full travel surveys will be undertaken in years 3 and 5 and smaller snapshot travel surveys will be undertaken at the end of year 1, 2 and 4. This will allow targets and measures to be altered if needed to reflect progress and ensure that final targets are realistic and achievable. In this way, the TP document should be a continually evolving document.

Table 35: Monitoring programme

Travel Plan Year	Month and Year	Survey
Year 0	July 2023	Full Staff Travel Survey
Year 1	July 2024	Snapshot Travel Survey
Year 2	July 2025	Snapshot Travel Survey
Year 3	July 2026	Full Staff Travel Survey
Year 4	July 2027	Snapshot Travel Survey
Year 5	July 2028	Full Staff Travel Survey and Travel Plan Review

In addition to travel surveys, car parking, cycle parking and motorcycle parking usage will be monitored as well as business mileage and the take up of TP measures.

A. Policy Context

Consideration has been given to the following documents:

9.1 National Policy

National Planning Policy Framework (2012 – updated 2023)

The National Planning Policy Framework (NPPF) was published by the Government in March 2012 and updated in September 2023.

It sets out the government's planning policies for England and how they are expected to be applied. At its heart is the presumption towards sustainable developed as stated in paragraph 110 of NPPF:

"*In assessing sites that may be allocated for development in plans, or specific applications for development, it should be ensured that:*

1. *Appropriate opportunities to promote sustainable transport modes can be – or have been – taken up, given the type of developments and its location;*
2. *Safe and suitable access to the site can be achieved for all users;*
3. *The design of streets, parking areas, other transport elements and the content of associated standards reflects current national guidance, including the National Design Guide and the National Model Design Code 46; and*
4. *Any significant impacts from the development on the transport network (in terms of capacity and congestion), or on highway safety, can be cost effectively mitigated to an acceptable degree."*

With regards to transport the NPPF (paragraph 113) set outs the following guidelines:

"All developments that will generate significant amounts of movement should be required to provide a travel plan, and the application should be supported by a transport statement or transport assessment so that the likely impacts of the proposal can be assessed."

National Planning Practice Guidance (2021)

National Planning Practice Guidance (NPPG) outlines the purpose of various transport documents, TPs, Transport Assessments and Statements, and sets out what should be included in these for developments that generate a significant amount of traffic movement. According NPPG, a transport document should consider the following:

- "*Information about the proposed development and site layout;*
- *Information about neighbouring uses, amenity and character, existing functional classification of the nearby road network;*
- *Data about existing public transport provision;*
- *A description of travel characteristics of the proposed development, including movements across all modes of transport that would result from the development;*
- *Data about current traffic flows on links and at junctions within the study area, and identification of critical links and junctions on the highways network;*
- *An analysis of the injury accident records on the public highway in the vicinity of the site access for the most recent 5-year period;*
- *A description of parking facilities in the area and the parking strategy for the development; and*
- *Measures to mitigate any residual impacts of the development"*

9.2 Regional Policy

Transport for the North: Our Strategic Transport Plan

The Transport for the North Strategic Transport Plan sets the vision, strategic ambitions, and the North's long term strategic transport priorities up to 2050, creating a consistent framework for our work with government, local transport bodies and delivery bodies. The document sets out the following vision:

"*By 2050 the North of England will have become a thriving, socially inclusive region. Our communities, businesses and places will all benefit from sustainable economic growth, improved health and wellbeing and access to opportunities for all. This will be achieved through a transformed zero emission, integrated, safe and sustainable transport system, which will enhance connectivity, resilience, and journey times for all users."*

Lancashire County Council: Central Lancashire Highways and Transport Masterplan (2013)

Lancashire County Council has a Central Lancashire Highways and Transport Masterplan that sets out the priorities for future investment in highways and transport which involves seeing new road space built, public transport prioritised along key corridors, and public realm investments through till 2026. Some of the proposals set out include:

- A major new road linking Preston and southern Fylde to the M55 and associated link roads;
- An investment focus on nine public transport priority corridors that all follow the main routes into Preston City Centre;
- Introduction of more bus-only lanes to improve reliability and speed up journeys; and
- More space to be given over to pedestrians and cyclists, and to greening public spaces.

Lancashire County Council: Actively moving forward – a ten-year strategy for cycling and walking (2018)

In partnership with Blackpool Council and Blackburn with Darwen Borough Council, Lancashire County Council produced a strategy for cycling and walking in 2018. The main goals of this strategy are:

- "*A doubling in the number of people cycling;*
- *A 10% increase in the number of people walking;*
- *Level of physical inactivity in every Lancashire District brought below the national average"*

Alongside the goals, the following aims are set out:

- "*A safe, high quality and joined up active travel network for everyday travel and leisure activities;*
- *Convenient and direct access to our network to reduce distance and travel times;*
- *High quality and vibrant public spaces which attract people to live, work, study, and shop in these areas."*

Lancashire County Council & Blackburn with Darwen Council Joint Bus Service Improvement Plan (2021)

Lancashire County Council's Bus Service Improvement Plan was produced with the aim of making the bus network more attractive to the population of Lancashire. Working with all bus operators within the region, the council aims to support and improve the public transport network, by improve the waiting environment, ensuring it is accessible for all and that it has easy to understand real time information.

Lancashire County Council Local Cycling and Walking Infrastructure Plans

Lancashire County Council are currently working in partnership with Blackpool Council to develop a Local Cycling and Walking Infrastructure Plan (LCWIP). In which they aim to plan and improve the conditions for active travel by:

- *Identifying cycling and walking infrastructure improvements for future investment in the short, medium, and long term*
- *Ensuring that consideration is given to cycling and walking within both local planning and transport policies and strategies*
- *Providing the evidence base to make the case for future funding for walking and cycling infrastructure*[1]

The Council are currently within the 'develop plans and public engagement' stage, with the document aiming to be finalised by early 2024.

9.3 Local Policy

Preston City Transport Plan (2019)

Preston City Transport Plan (PCTP) is a 20-year vision for movement and connectivity in the city – focusing on travel to, from, and within the city centre. It is a long-term strategy for reducing congestion, providing great public transport, and transforming the city's streets and spaces. As set out in the document:

"*Preston needs a transport network that is fit for a modern, growing city. But crucially we want to build a city that works for everyone. This means providing more attractive alternatives to car use than exist today, transforming the city's streets, ensuring residents are happy and healthy, and support a resurgent Central Lancashire economy which, in turn, will support a strong Lancashire economy."*

9.4 NHS Strategies

NHS Long Term Plan (2019)

The NHS Long Term Plan, published in January 2019, outlines the commitments the NHS has made to reduce the impacts of air pollution. The Plan commits the NHS to reduce both business mileages and fleet air pollutant emissions by 20% by 2023/24 with at least 90% of NHS fleet using low emission engines (and 25% being Ultra-Low Emissions) by 2028. It also commits to providing digital first primary care for every outpatient to give

them the choice of quick telephone or online consultations, saving time waiting and travelling.

Delivering a 'Net Zero' National Health Service (2020)

The NHS published the 'Delivering a Net-Zero National Health Service in 2020 which sets out a practical, evidence-based, and quantified path to a 'net zero NHS'. The document sets out a strategy and two clear targets to respond to this challenge:

- Net Zero by 2040 for the emissions the NHS controls directly, with an ambition to reach an 80% reduction by 2028 to 2032.
- Net Zero by 2045 for the emissions the NHS can influence, with an ambition to reach an 80% reduction by 2036 to 2039.

The plan identifies that 'approximately 3.5% (9.5 billion miles) of all road travel in England relates to outpatients, visitors, staff and suppliers to the NHS, contributing around 14% of the system's total emissions.' It outlines a several interventions to reduce emissions, these include:

- Reduce travel due to the digital care pathway redesign.
- Preventative medicine and reduce health inequalities.
- Active travel from staff, outpatients, and visitors
- Zero emission ambulances
- Electrification of outpatients and visitors' vehicles
- Electrification of the rest of the NHS Fleet and staff vehicles

NHS Green Plan for requirement 2022/23 – 2024/25

Each integrated care system is now required to develop its own Green Plan to match the increased net zero ambition by focusing on the following three outcomes:

- Support the NHS-wide ambition to become the world's first healthcare system to reach net zero carbon emissions.
- Prioritise interventions which simultaneously improve outpatient care and community wellbeing while tackling climate change and broader sustainability issues.
- Plan and make prudent capital investments while increasing efficiencies.

The 'How to produce a Green Plan' guidance provided by the NHS highlights that the following should be included within the Travel and Transport chapter:

- An outline of plans to reduce the carbon emissions arising from the travel and transport associated with each organisation.
- Explore interventions such as:
  - Increasing levels of active travel and public transport
  - Investing in ultra-low emission and zero-emission vehicles for owned and leased fleets
  - Maximising efficiencies in the transport of goods and services commissioned by the organisation, such as outpatient transport, courier services and deliveries.

9.5 Trust Policies

Lancashire Teaching Hospital NHS Trust Green Plan: A three-year strategy towards net zero

The Lancashire Teaching Hospital NHS Trust Green Plan sets out the vision, strategy, and objectives for reducing the Trust's environmental impact, improving its resilience, and helping to manage resources effectively. The Plan enables the Trust to deliver high quality sustainable healthcare with the available social, economic, and environmental resources.

The Green Plan sets out the Trust's goals regarding sustainable travel and transport. As set out in the document:

- "*Make progress towards net zero emissions from our [Trust's] fleet.*
- *Support staff and outpatients to reduce their emissions whilst improving their health and wellbeing"*

11.2 - GMC REVALIDATION REPORT (MEDICAL APPRAISAL REPORT)

REFERENCES

Only PDFs are attached

11.2 - NW FQAI Annual Medical Appraisal and Revalidation Report Ancillary Pack.pdf

Board Report

2024-2025 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

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

	Name	Contact Information
Responsible Officer (RO)	Dr Geraldine Skailes	DrGeraldine.Skailes@lthtr.nhs.uk
Chief Medical Officer (CMO)	Dr Geraldine Skailes	As above
Medical Appraisal Lead (MAL)	Dr John Anderton (from 1st July 2024)	John.anderton@lthtr.nhs.uk
Revalidation and Appraisal Manager (RAM)	Debbie Kellett (from 22nd July 2024)	Debbie.Kellett@LTHTR.nhs.uk
Head of Medical Workforce	Lisa Eccles	Lisa.eccles@lthtr.nhs.uk
Deputy CMO Professional Standards	Mr Eric Mutema	Eric.mutema@lthtr.nhs.uk

Service Level Agreement

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

Yes

If yes, who is this with?

Organisation: **St Catherines Hospice**
Please describe arrangements for Responsible Officer to report to the Board: **Act as RO for doctors employed by St Catherines Hospice**
Date of last Responsible Officer Report to the Board: 09/07/2024
Action from last year: Continue with process for presentation of report to Board

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

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

Section 1 – Qualitative/narrative

Section 2 – Metrics

Section 3 - Summary and conclusion

Section 4 - Statement of compliance

Section 1 Qualitative/narrative

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

Reporting period 1 April 2024 – 31 March 2025

1A – General

The board/executive management team of Lancashire Teaching Hospitals NHS Foundation Trust can confirm that:

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

Y/N	Yes
Action from last year:	None
Comments:	Dr Geraldine Skailes remains Responsible Officer for Lancashire Teaching Hospitals.
Action for next year:	Dr Skailes is retiring in late 2025. Mr Steven Canty has been appointed as her successor.

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

Y/N	Yes
Action from last year:	Review resource associated with appraisal and revalidation as Peer Review in 2023 identified the Appraisal and Revalidation team was very small and funded time allocated for appraisals was very short (0.025 PAs per appraisal) compared with peers.
Comments:	A new Medical Appraisal Lead (MAL) was appointed from 01/07/2024. A new Revalidation and Appraisal Manager (RAM) was appointed from 22/07/2024. No change in funded time allocated. Trust financial position has not allowed for any increase in resources.
Action for next year:	Continue to review and benchmark resourcing for Appraisal and Revalidation administration.

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

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

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

Y/N	Yes
Action from last year:	Complete policy review and re-publish
Comments:	Medical Appraisal Policy was reviewed and refreshed with publication in April 2025; review date is 30 April 2028
Action for next year	Update to include Physician Assistants and Physician Assistants (PAs) and Physician Assistants in Anaesthesia (PAAs) in response to GMC registration of this staff group

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

Y/N	No
Action from last year:	Summary provided in 2024 report of outcome and actions completed following the last peer review in July 2023
Comments:	The Trust have attended all North West Peer Review Group Meetings which provide the opportunity to discuss any challenges regionally to enable improvements to be made throughout the year. In addition to the above, the Revalidation & Appraisal Manager attends the North West Managers Group to work collaboratively to share best practice.
Action for next year:	Next Peer Review will be due in 2026

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

Y/N	Yes
Action from last year:	Ensure all bank doctors receive adequate support from the Appraisal & Revalidation

	team to ensure they meet the requirements of General Medical Council (GMC) revalidation.
Comments:	The trust has an established medical bank. In October 2024, the Bank was moved in-house resulting in a reduction in the number of doctors working via an Agency. Doctors engaged through the bank work ad-hoc hours, some more than others. Some bank doctors require the trust to act as their designated body when they undertake most of their work at Lancashire Teaching Hospitals whereas others may be employed elsewhere, and this employer acts as the designated body. For those with a prescribed connection to LTH as their designated body, the doctors will undertake an annual appraisal and be supported through revalidation by the Trust. For those doctors without a prescribed connection, support for revalidation is provided on a case-to-case basis (e.g. completed exit report). All new doctors including bank doctors who have a prescribed connection are invited to attend training sessions on appraisal and revalidation.
Action for next year	Continue to ensure all bank doctors receive adequate support from the Appraisal & Revalidation team to ensure they meet the requirements of GMC revalidation. Set minimum clinical activity requirement to enable a doctor to have a prescribed connection to the trust.

1B – Appraisal

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

Y/N	Yes
Action from last year:	Embed Good Medical Practice 2024 into medical appraisal.
Comments:	Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a General Medical Council (GMC) license to practice. Each doctor is allocated an appraisal month and should complete their appraisal in that specified month. This appraisal is completed using an online system and includes all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. This online system has been updated to include reference to Good Medical Practice 2024. Reference to Good Medical Practice (GMP) has been included in • Appraiser training in early 2024 in preparation for the 2024/25 appraisal year. • Appraiser QA feedback for the 2024/25-year • New appraiser training and training sessions for new doctors • The revised Medical Appraisal Policy. Requirement for inclusion of letters of good standing for external practice has been shared with doctors and is now monitored robustly.
Action for next year:	Continue to include reference to Good Medical Practice in training and feedback

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

Y/N	Yes
Action from last year:	Review reminders issued to ensure timely. Review reporting of late appraisal completed using L2P as currently no option to report completed late on the system.
Comments:	Notifications and non-engagement escalation process has been reviewed and included in the revised Trust Medical Appraisal Policy The trust issues a series of reminders to doctors when appraisals are not completed, and these escalate if action is not taken by the individual doctor to complete the appraisal. The reminders sent are as follows: L2P – Notifications that appraisal is due (8,4 & 2 weeks before appraisal month, day 1 of appraisal month and day 1 of month after appraisal month) RAM - sends reminders half-way through month before appraisal month, appraisal month and month after appraisal month before escalating to formal reminders. 1st reminder – sent one month and one week following end of appraisal month. MAL and appraiser included. MAL contacts doctor to meet. 2nd reminder – sent 1 month later. MAL, CD & appraiser included. 3rd reminder – Non engagement notification sent 1 month later. MAL, CD, DMD & Deputy CMO included. At this stage the Deputy CMO will ask to meet the doctor to understand the reasons for the appraisal not being completed and set a target completion date. The trust also enables doctors to submit a postponement form where they have identified a delay these are considered by the appraisal team and then if agreed completion is monitored according to the postponement date agreed. Doctors with a prolonged period of absence e.g. parental leave and long-term sick leave may be classified as ‘approved-missed appraisal’ depending on the circumstances. Discussion with L2P in relation to developments has been initiated with a response awaited.
Action for next year:	Continue to work with L2P to improve reporting

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

Y/N	Yes

Action from last year:	This policy is currently under review as due for review May 2024. To incorporate the new GMC Good Medical Practice domains.
Comments:	Medical Appraisal Policy was reviewed and refreshed with publication in April 2025 following Trust approval process. Good Medical Practice is referenced within the policy.
Action for next year:	Update as required

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

Y/N	Yes
Action from last year:	Review appraiser: appraisee ratio to ensure proficiency and quality assurance.
Comments:	During 2024-25 the trust had 167 trained appraisers for 790 doctors due for appraisal. This averages just under 5 appraisals per appraiser. The trust is aware that this is at the lower end of the working benchmark range. Appraiser allocation is usually within specialty; however, this may extend to the wider division if necessary. A review of appraiser: appraisee ratios was conducted with targeted communications in areas where a lower ratio was identified along with broader communications. An additional 6 new appraisers were trained in February 2025 with a view to them starting to appraise in the 2025-26 year. Additional appraiser training dates and attendees within the first quarter of the 2025-26 year have been identified.
Action for next year:	Continue to review appraiser: appraisee ratios and undertake new appraiser training as required

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

Y/N	Yes
Action from last year:	Further development of training and network events, this is something the new MAL will be leading upon. Review of quality assurance/performance review process.

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

Comments:	Regular update events are delivered locally to inform appraisers of national updates and L2P system changes. Appraisers can link evidence of attendance/learning into their own appraisal. The focus of these events in the 2024-25 year was to introduce the new MAL & RAM with a back-to-basics approach looking at some areas that had already been identified as requiring improvement and allowed for general discussion. Feedback on the events was sought from appraisers and areas for inclusion in future events identified. Performance review (Quality assurance) should be completed by the RAM for 20% of appraisals, with feedback being provided to individual appraisers. This was completed for all active appraisers for the 2024-25 year with 167 appraisals undertaken in the 2024-25 year reviewed using a scoring tool. This represents 21% of the appraisals undertaken within the 2024-25 year and meets the minimum recommended threshold. The feedback from appraisees is collated by L2P and is available for appraiser development.
Action for next year:	Appraiser update sessions to include items identified via QA process and by appraisers themselves

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

Y/N	Yes
Action from last year:	Review QA processes
Comments:	The QA process for appraisal was reviewed and a SOP developed. Scores were RAG rated: Total score possible: 48 RED – 15 or below AMBER – 16 to 23 GREEN – 24 to 48 Green further subdivided into Satisfactory, Very Good and Excellent No appraisers were identified as RED A small number of appraisers were identified as AMBER and are receiving support from the MAL. Post appraisal Questionnaire (PAQ) summary reports are being provided from the L2P system for those appraisers who have received 3 or more completed feedback questionnaires from appraisees. All appraisers are provided with: - An email explaining the QA process and their scoring - Information about the scores across all appraisers - A copy of their QA scoring tool with comments - A copy of their PAQ report as above - A certificate of acknowledgement indicating the number of appraisals undertaken

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

1C – Recommendations to the GMC

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

Y/N	Yes
Action from last year:	Continue to work towards further reduction of deferrals due to non-completion of 360 Multi source feedback. Allocation of 360 2 years before revalidation has already been implemented but further chasers to be developed by the new RAM starting July 2025.
Comments:	178 recommendations were made to the GMC between 1 April 2024 and 30 March 2025. These were as follows: • 153 Positive Recommendations • 25 Deferrals • 0 non-engagers. The number of deferrals was roughly equivalent in number to the 2023-24 year, however as there were more recommendations submitted, this has reduced from 18% to 14%. Of the 25 deferred, all were due to insufficient evidence. 8 of these were due to interrupted practice such as long-term sickness, maternity leave or periods of no employment meaning there was insufficient appraisal evidence and/or 360 feedback. The remaining 17 were all due to 360 MSF not being completed. Allocation of 360 feedback 2 years before revalidation was implemented in 2024. The process and communications have been revised by the RAM with messaging informing doctors and appraisers to commence collection of 360 feedback 2 years ahead of revalidation included in appraiser CPD sessions and appraisal for new starters sessions. This has resulted in doctors contacting the RAM proactively to request undertaking the process. Updated communication to doctors when 360 has been allocated which includes system guidance has been well-received. The RAM monitors progress of the 360 feedback via system reporting for all doctors and direct communication in the 6 months ahead of revalidation due dates.
Action for next year:	Continue to work towards further reduction of deferrals due to non-completion of 360 Multi source feedback.

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

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

Y/N	Yes
Action from last year:	None
Comments:	All doctors receive confirmation of their revalidation recommendation promptly. Action plan completed and sent to all doctors who are deferred. Completion of the actions identified is monitored by the RAM.
Action for next year:	No further actions

1D – Medical governance

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

Y/N	Yes
Action from last year:	Repeat of benchmarking exercise by November 2025 to review progress against the above improvements and actions identified above.
Comments:	Process underway
Action for next year:	Complete benchmarking exercise by November 2025

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

Y/N	Yes
Action from last year:	None
Comments:	Membership of the Responsible Officer Advisory Group (ROAG) has been reviewed and this meeting takes place on a monthly basis. Membership of this group includes: • Chief People Officer • Chief Medical Officer/Responsible Officer • Deputy Chief Medical Officer (Professional Standards) • Head of Workforce Advice • Head of Medical Workforce • Revalidation and Appraisal Manager

	Logging and filing of information in relation to conduct and performance have been reviewed and updated to facilitate ready access to information both current and historical. Decision Making Group (DMG) meetings are convened as required to review new cases as they are identified to agree an initial action plan. Additionally, the DMG is informed in appropriate cases by the Trust Managing Allegations process. In addition to the above the Chief Medical Officer /RO has regular meetings with the GMC and when required meetings are held with the Practitioner Professional Advice Service (which is part of NHS Resolution) to discuss individual cases. The L2P appraisal system has a RO note function which allows a flag to be placed on the appraisal record of any doctor for whom there are conduct or performance concerns. The Trust case management system is used to monitor and track all MHPS cases to ensure these are being processed in a timely manner Clinical Directors (CDs) and Divisional Medical Directors (DMDs) have a role in supporting colleagues at a local level and will escalate to the ROAG as required.
Action for next year:	None

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Yes
Action from last year:	Further review to be carried out to ensure clinical incidents and complaints reports are always uploaded into the appraisal document.
Comments:	Process for requesting clinical incident and complaints reports has been revised with RAM sending a list of doctors due for appraisal to the relevant teams a month before appraisal is due. The reports are then directly to the doctor for upload into their appraisal. The new process has been welcomed by doctors as they receive the reports in a timely fashion. The Datix and PALS teams have also welcomed the change as it allows then to plan their work more effectively than when receiving multiple ad-hoc requests. Both indicated this has significantly increased the number of reports being produced. The RAM looks for evidence of upload into appraisals when submitted by appraisers and compliance has increased.
Action for next year:	None

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

Y/N	Yes
Action from last year:	None
Comments:	The Trust 'Handling Concerns about doctors & Dentists Conduct & Capability' Policy details how concerns are responded to and is currently under review. All ongoing Conduct and Performance concerns are reviewed monthly by the Chief Medical Officer, Deputy Chief Medical Officer (Professional Standards), Chief People Officer, Head of Workforce Advice, Head of Medical Workforce and the Revalidation and Appraisal Manager. Regular meetings are also held with the NHS Resolution Practitioner Performance Advice (PPA) and the GMC ELA (Employer Liaison Advisor) to review active cases. As well as these planned meetings, urgent cases are discussed by a decision-making group (membership as above) and referred where necessary for PPA/GMC ELA advice.
Action for next year:	Complete review of 'Handling Concerns about doctors & Dentists Conduct & Capability' Policy with consideration of PPA Fairness and Proportionality: Principles and framework for healthcare organisations managing performance concerns

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

Y/N	
Action from last year:	Annual report will be produced and presented to Workforce Committee in accordance with the cycle of business.
Comments:	This information is presented to the Workforce Committee annually in the 'Doctors Employee relations report'. The 2024 report was prepared by the Head of Workforce Advice according to the Committee in November 2025.
Action for next year:	The annual report will be produced and presented to Workforce Committee in November 2025.

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

Y/N	Yes
Action from last year:	None

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

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

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

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

Y/N	**Yes**
Action from last year:	None
Comments:	The Trust has a policy for responding to inquiries or other national reviews. This sets out the systems and processes in place to monitor learning opportunities from the wider system such as local/national reviews and the outcomes of national inquiries. Some examples of where the Trust have implemented changes in response to national/local reviews include, implementing changes in response to the Ockenden requirements and more recently the Trust have reviewed the outcomes of Phase 1 of the Fuller Inquiry at the Board of Directors meeting. The Trust are also reviewing the outcomes of the Greater Manchester Mental Health review. Where learning is identified, actions are taken to improve culture, policy, practice and process.
Action for next year:	

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

Action from last year:	Inclusion of Physician Associates
Comments:	The GMC is now preparing to regulate Physician Assistants (PAs) and Physician Assistants in Anaesthesia (PAA)s and the Trust has agreed that the CMO will be the Board level professional lead for these groups of staff. The RAM will be responsible for ensuring appraisal processes are in place and the CMO will oversee any concerns raised relating to conduct and capability of individuals.
Action for next year:	None

1E – Employment Checks

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

Y/N	Yes
Action from last year:	None
Comments:	All doctors recruited to the Trust (whether substantive, fixed term or bank) are subject to the same pre-employment checks as defined by NHS Employment Check Standards Each check when completed is recorded on the Trust recruitment system (TRAC). All documents are seen and verified in person and are scanned as evidence
Action for next year:	None

1F – Organisational Culture

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

Y/N	Yes
Action from last year:	Annual review of strategy (“To create a positive organisational culture”) to ensure that the focus and priorities of work remain aligned to the current context

Comments:	As part of Our People Plan and Leadership Development Offer we have a comprehensive programme of work in place to help the culture to evolve. Over the last year, the organisation has made significant strides in embedding cultural improvement through the continued implementation of the Best Version of Us framework. Key areas of focus have included Sexual Safety in the Workplace, Civility and Kindness, and Compassionate Leadership. These themes have been supported by a range of targeted interventions, including new policies, training offers, leadership engagement, and bespoke team support. Notable achievements include: • Launch of a new Sexual Safety Policy and alignment with the NHS Sexual Safety Charter. • Delivery of Team Culture Masterclasses, Active Bystander training, and Compassionate Performance Conversations. • Enhanced support for leaders through coaching, diagnostics, and tailored interventions in high-priority areas. • Strengthened processes for raising concerns, including the development of a Culture Risk Protocol and a centralised log for whistleblowing and protected disclosures. • Completion on a number of culture reviews into clinical areas which have flagged through different sources as indicating their could be cultural challenges impacting on colleagues satisfaction, team working and potentially patient care. Further to the cultural improvement actions detailed above, the organisation has a comprehensive leadership development offer, this includes dedicated programmes for all new consultants, aspirant senior clinical leaders who are consultants and a Clinical Directors development programme. As part of all these programmes cultural awareness training sessions and cultural improvement interventions are included as part of the taught programmes.
Action for next year:	Implement the revised leadership and management development offer. Continue to implement the cultural improvement actions as detailed under Our People Plan.

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

Y/N	Yes
Action from last year:	None
Comments:	We have an Equality, Diversity and Inclusion Strategy which focus is to take action to ensure we are consciously inclusive in everything that we do for patients and colleagues. As part of this strategic programme of work it includes, the promotion and growth of the EDI Ambassador Forums as a platform to provide minority ethnic group colleagues with a voice and to identify the changes which will enhance their experience of the workplace.

	It includes the delivery of programmes of work in relation to: • Achievement of the actions aligned within the antiracist framework, • Supporting colleagues with neurodiversity and providing guidance to line managers. • Embedding of our zero tolerance approach to discrimination and poor behaviours. • Removing sources of bias from recruitment practices. • Delivery of relevant training relation to cultural competence, understanding steps managers can take to create equity in teams.
Action for next year:	The future focus to ensure we continue to deliver the strategic aims, of the EDI Strategy includes: • An expanded focus on intersectional reporting of our workforce centred data to help us interrogate our data across other areas i.e. talent management, retention, performance management etc. in a more meaningful way. • Developing intelligence around our data collection capturing patient experience to ensure we hear from patient groups who have traditionally been hard to reach, including those who experience deprivation or other health inequalities. • To further increase educational opportunities to support colleague and leaders understanding of their role in enabling equality, diversity and inclusion as well as bringing about improvements in health inequalities. • To review process and approaches across the colleague lifecycle to understand how we can create more inclusive practices which support the recruitment, retention, staff satisfaction and career progression of colleagues with protected characteristics.

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

Y/N	*Yes*
Action from last year:	None
Comments:	We have a Freedom To Speak Up (FTSU) strategic action plan in place, this details the organisation wide programme of work to support colleagues to feel safe to speak up, have their concerns responded to and to embed a just and restorative culture. As described under responses to questions Fi and Fii, the FTSU service contributes to running of training, campaigns and culture change interventions to support responses to concerns or challenges. Alongside this we have an active FTSU service, with bi-monthly raising concerns group which is a board level sub-committee. This meeting allows for a multi-disciplinary approach to be taken to the triangulation of concerns with multiple data sources ranging from student satisfaction, colleague engagement, patient safety concerns and complaints, with people related metrics including grievances,

	mediations, cultural concerns. Following discussion MDT approaches are allocated and follow up reported into the meeting. A Raising Concerns and Whistleblowing Policy is in place detailing the support in place for colleagues who raise concerns, this is in line with national guidance and recommendations.
Action for next year:	Implement the actions from the FTSU strategic action plan

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

Y/N	Yes
Action from last year:	None
Comments:	Complaints regarding the appraisal process are addressed through the Trust early resolution policy (Grievance policy). This is documented in the current policy Any complaints about MHPS process are managed through the MHPS process. Anyone involved in an MHPS process is provided with a None-Executive Director who they can raises any concerns to in relation to the management and handling of the process.
Action for next year:	None

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

Y/N	Yes
Action from last year:	An action for next year is to include details in the report relating to the country of primary medical qualification.
Comments:	The annual report (see 1D(v) submitted to the organisation's Workforce Committee includes the key demographics of the medical workforce who are the subject of formal disciplinary processes. This includes race and gender and from 2025 will include the country of primary medical qualification. This data is now collected as standard so it can be included in the annual report.
Action for next year:	The annual report will be produced and presented to Workforce Committee in accordance with the cycle of business.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not

restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	
Action from last year:	Ensure new RAM and MAL are invited to regional events and network meetings.
Comments:	The RAM and MAL have attended North West Responsible Officer Network meetings on 12/09/2024, 14/11/2024 and 05/02/2025 RAM has attended North West Managers Group meetings on 24/09/2024, 11/12/2024, 25/02/2025 The RAM and MAL attended Northwest Peer Review Group meeting on 29/10/2024
Action for next year:	Continued participation in networking events

Section 2 – Metrics

Year covered by this report and statement: 1 April 2024 – 31 March 2025.

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

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	821
Total number of appraisals completed	779
Total number of appraisals approved missed	34
Total number of unapproved missed	0
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	178
Total number of late recommendations	0
Total number of positive recommendations	153
Total number of deferrals made	25
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	9
Total number of trained case managers	3
Total number of concerns received by the Responsible Officer[2]	5
Total number of concerns processes completed	4
Longest duration of concerns process of those open on 31 March (working days)	103 days
Median duration of concerns processes closed (working days)[3]	134 days
Total number of doctors excluded/suspended during the period	0
Total number of doctors referred to GMC	1
Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	89*
Total number of new employment checks completed before commencement of employment	89
Total number claims made to employment tribunals by doctors	1**
Total number of these claims that were not upheld[4]	0 (withdrawn)

**This does not include FY Drs, Resident Drs on placement or bank/agency Drs.*
*** Claim made by agency locum*

Section 3 – Summary and overall commentary

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

General review of actions since last Board report
An update on all actions identified in last year's annual submission has been undertaken and is detailed in section 1 above Significant effort has been put into the new MAL and RAM building relationships within the Trust. Both are now well-established and are continuing to build on this positive start. Many processes have been reviewed with significant improvements as below: • Full review and update of the Trust Medical Appraisal Policy

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

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

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

- Streamlining of process to transfer information between ROs for doctors joining and leaving the Trust
- Development of the Revalidation & Appraisal dashboard
- Reinstatement of the appraisal Quality Assurance programme
- Embedding of Good Medical Practice 2024 in appraisal
- Establishing structured support for doctors new to the Trust
- Increased number of appraisers
- Review of bank workers connected to the Trust
- Embedding the 360-feedback process including monitoring of completion
- Review and re-establishment of appraisal reminders
- Streamlining of leadership and educational reviews to ensure appraisals encompass whole scope of practice
- Review and improvement of filing system for information in relation to concerns
- Implementation of new log to record concerns and ongoing actions. Log now also includes country of primary qualification and length of time a concern is open
- Identification of improvements to electronic system used for appraisals and job-planning (L2P) which have been passed to L2P for implementation

Actions still outstanding

An update on all actions identified in last year's annual submission has been undertaken and is detailed in section 1 above

Current issues

There has been a significant increase in the number of connected doctors – from 772 on 31/03/2024 to 821 on 31/03/2025. A significant proportion of these connections are due to the Bank being brought into the Trust and has resulted in a requirement for additional appraisers above and beyond that already identified. Further work on setting minimum clinical activity for Bank doctors in order for the RO to act effectively in that capacity is required.

A number of improvements to the L2P system to improve reporting and enhance functionality of both appraisal and job planning have been requested. Response to these requests is still awaited with no timeframe currently identified by L2P which is impacting on efficiency of processes within the Trust.

Further development of Trust internal reporting of appraisal completion within planned appraisal months is required. Ongoing development of the appraisal dashboard and L2P reporting will facilitate improved and timely reporting to CDs, Specialty Business Managers and other leaders to support improved compliance levels.

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

Actions for the next year are summarised below:

- Continue to review and benchmark resourcing for Appraisal and Revalidation administration.
- Update to include Physician Assistants and Physician Assistants in Anaesthesia in response to GMC registration of this staff group
- Next Peer Review will be due in 2026
- Continue to ensure all bank doctors receive adequate support from the Appraisal & Revalidation team to ensure they meet the requirements of GMC revalidation.
- Consider setting minimum clinical activity requirement to enable a doctor to have a prescribed connection to the trust.

- Continue to include reference to Good Medical Practice in training and feedback
- Continue to work with L2P to improve reporting
- Update medical appraisal policy as and when required
- Continue to review appraiser:appraisee ratios and undertake new appraiser training as required
- Appraiser update sessions to include items identified via QA process and by appraisers themselves
- Continue to refine QA processes
- Continue to work towards further reduction of deferrals due to non-completion of 360 Multi source feedback.
- Complete benchmarking exercise by November 2025
- Complete review of 'Handling Concerns about doctors & Dentists Conduct & Capability' Policy with consideration of PPA Fairness and Proportionality: Principles and framework for healthcare organisations managing performance concerns
- The annual report re managing concerns about a Doctor will be produced and presented to Workforce Committee in accordance with the cycle of business.
- Implement the revised leadership and management development offer. Continue to implement the cultural improvement actions as detailed under Our People Plan
- The future focus to ensure we continue to deliver the strategic aims, of the EDI Strategy includes:
    - An expanded focus on intersectional reporting of our workforce centred data to help us interrogate our data across other areas i.e. talent management, retention, performance management etc. in a more meaningful way.
    - Developing intelligence around our data collection capturing patient experience to ensure we hear from patient groups who have traditionally been hard to reach, including those who experience deprivation or other health inequalities.
    - To further increase educational opportunities to support colleague and leaders understanding of their role in enabling equality, diversity and inclusion as well as bringing about improvements in health inequalities.
    - To review process and approaches across the colleague lifecycle to understand how we can create more inclusive practices which support the recruitment, retention, staff satisfaction and career progression of colleagues with protected characteristics.
- Implement the actions from the FTSU strategic action plan
- Continued participation in networking events

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

This has been a year of significant change within appraisal and revalidation team but despite a period of change the new Appraisal & Revalidation team have made some significant progress in developing the process and systems linked to appraisal and revalidation and this is demonstrated within the report provided.

We have embedded a continuous improvement philosophy and continue to work towards further streamlining and enhancements to processes.

Section 4 – Statement of Compliance

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

Signed on behalf of the designated body

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

Official name of the designated body:	Lancashire Teaching Hospitals NHS Foundation Trust

Name:	Mr Silas Nicholls
Role:	Chief Executive Officer
Signed:	
Date:	

Name of the person completing this form:	
Email address:	

12.2 - MID-YEAR - MATERNITY SERVICE SAFE STAFFING REPORT

REFERENCES

Only PDFs are attached

12.2 - Maternity Service Safe Staffing Report (1).pdf

Board of Directors

Maternity Service Safe Staffing Report

1.0 INTRODUCTION

This report details the findings of the Lancashire Teaching Hospitals NHS Foundation Trust, second midwifery staffing review for 2025. The review triangulates workforce information with safety, patient experience, and clinical effectiveness indicators to provide an overview of safe staffing and workforce metrics for the last 6 months within the maternity service.

The report fulfils both the requirement outlined in the National Quality Board (NQB) staffing guidance for maternity services (NQB 2018) and the Maternity Incentive Scheme (MIS) recommending that services should undertake a bi-annual safe staffing review to demonstrate that there is an effective system of midwifery workforce planning in place.

The review continues to be set out using the three National Quality Board expectations for safe, sustainable, and productive staffing levels adapted for maternity services, namely right staff, right skills and right place and time. Additional local measures are included in Table 1 (**7.0**) which describe the insight, involvement and inclusion measures that are utilised to support oversight of the perinatal service.

Table 1: National Quality Board's expectations for safe, sustainable, and productive staffing (2016) adapted for maternity settings.

Right Staff (4.0)	**Right Skills (5.0)**	**Right place and time (6.0)**	**Monitor and Learn (7.0)**
Evidence-based workforce planning every 6 months Appropriate skill mix Review staffing using the BR+ workforce planning tool annually and with a midpoint review.	Multiprofessional mandatory training development and education Working as a multi-professional team Recruitment and retention	Productive working Efficient deployment and flexibility including robust escalation. Workplace national drivers.	Insight, involvement and inclusion Perinatal Quality Surveillance dashboard Safety Culture: Optimising collaborative working across the much wider multi-professional team. Actively seeking the views of women working in partnership with them to develop and improve services.

2.0 SCOPE

This report details the arrangements for midwifery leadership and staffing provision across all inpatients, community, and specialist midwifery services.

It is acknowledged that a safe and effective workforce planning for maternity services must include core medical services. References to the obstetric, neonatal, medical and nursing workforce aligned to national priorities are also included because of the co- interdependence with midwifery.

3.0 METHODOLOGY

A planned safe staffing review is undertaken by the Chief Nursing Officer, Divisional Midwifery and Nursing Director, Finance Business Partner and Midwifery Matrons every 12 months, with a further desk top review at 6-month intervals. This approach provides opportunity for joint review of staffing requirements, which are cross checked using professional judgement and clinical indicators of perinatal safety. Other factors that are considered include patient acuity levels, seasonal variation in demand, service developments, contract commissioning and staff availability based on workforce trend data.

Although the findings of the review continue to be mandated by the requirements of Birth Rate Plus (BR+) a combined approach provides valuable safety intelligence and ensures that appropriate check and challenge of staffing levels are applied regularly at all levels.

4.0 RIGHT STAFF

Maternity teams must have sufficient and appropriate staffing capacity and capability to ensure safe, and cost-effective care for women and their babies always. Staffing decisions must be aligned to operational and strategic planning and must be able to demonstrate sufficient flexibility, capacity and workforce planning to meet demand safety. (The right staff)

4.1 BIRTH RATE PLUS (BR+)- EVIDENCE BASED WORKFORCE PLANNING

The Three-Year Delivery Plan for Maternity and Neonatal services (March 2023) states that services should undertake regular workforce planning reviews and where they do not meet the staffing establishment levels set by BR+ do so as soon as possible no later than by 2027/2028.

BR+ looks at both the midwife-to-birth ratio and the considers acuity and complexity of case mix, making it maternity-unit specific. Although the service birth rate has remained stable over the last 4-5 years (approximately 4,200), there had been a significant change in the complex care requirements associated with the increase in induction of labour and caesarean section rates which is comparable nationally. The Maternal Medicine Centre (MMC) at the Trust, has also increased the numbers of women who require highly specialist medicine which has contributed to the complex case mix overall. There has also been a significant increase in families who need additional safeguarding support.

The BR+ assessment conducted at the end of 2022 identified a required uplift of 29.7 WTE (midwives and postnatal support workers). Since the review was commissioned, there has been significant financial investment over two phases to align midwifery and support staffing to these recommendations, enabling the service to achieve compliance with the 2022 BR +.

In line with national recommendations an updated Birth Rate Plus assessment was instructed in May 2025 (3-year cycle). The service is awaiting the draft report which is anticipated by the end of October 2025. This will then be validated by the Chief Nursing Officer and Divisional Midwifery and Nursing Director before being shared with the Safety and Quality Committee for oversight and then presented to the Board of Directors.

4.2 APPROPRIATE SKILL MIX

The last BR + advised that the additional specialist workforce equated to around 10% of the funded clinical midwifery establishment to support for the provision of a safe service. This requirement is anticipated to increase to reflect the additional specialist workforce recommendations in the Ockenden and Three-year plan deliverables. Appendix 4 details the current specialist workforce for oversight. This will be updated in response to the findings of the ongoing BR+ reassessment once completed.

4.3 NEWLY QUALIFED REGISTERED MIDWIVES- SKILL MIX

Strategies to improve retention are ongoing with sustainability, leadership and adequate resources being prioritised because of their strong association with turnover rates. (Appendix 5 leadership structure) The updated workforce plan 2025 focuses on three clear priority areas, train, retain and reform, in line with the NHS Long Term Workforce Plan and is detailed in Appendix 8

The service has an externally funded preceptorship lead midwife who oversees recruitment and retention, and this has had a positive impact on retention rates. Most newly recruited midwives are early careers registrants and to ensure a smooth transition, the service has a supernumerary period, robust training and support, including a comprehensive preceptorship programme, and ongoing professional development opportunities. Chart 1 details the retention rates of new midwives since 2022 at 6,12 and 24 months

Chart 1 Retention of newly qualified midwives (NQM) at 6, 12 and 24 months since 2022.

4.4 SERVICE DEVELOPMENT FUNDING WORK STREAMS (OCKENDEN)

NHS England continues to support key national priorities within midwifery and obstetrics. Posts that are expected to be moved to baseline by the Local Maternity and Neonatal System (LMNS) in 2025 are the recruitment and retention lead midwife, bereavement lead midwives and the band 4 maternity support worker education lead. Leadership PAs for Clinical Directors (CD) are also expected to continue.

4.5 FILL RATES- ESTABLISHMENT

The midwifery establishment trajectory tracker monitors and tracks staff in post, adjusting for maternity leave to ensure that the establishment meets safe staffing requirements. The midwifery vacancy is 18.25 WTE which includes vacancy, maternity leave and some of the over offer posts. All vacancies have now been recruited to an onboarding is in progress. It is anticipated that graduated starts will commence over the next 2-3 months (10 in September 6 in October and the remaining in November 2025) and that all the anticipated 18.25 WTE will have completed the supernumerary period by the end of February 2026. The service is monitoring vacancies and drop off rates and any further vacancy will be expedited through vacancy control processes.

Establishment vacancy has continued to be covered by temporary staff who are a valuable part of the workforce and a useful contingency for covering anticipated and unanticipated staff shortages. When the trend data has been reviewed for oversight, uptake of agency shifts has reduced over time. This is thought to be because of capped rates and a drive to employ Trust bank staff. As a result, there has been an increase in variable pay associated with bank, demonstrating that the switch over from agency to bank but confirming that this has not detrimentally affected fill rates.

4.5.1 FILL RATES- (Percentage of planned midwifery staffing hours that are filled by staff on duty)

Fill rates for registered midwives (RM) are around 90-92% for day shifts and 92-93% for nights which is a stable position overall. Fill rates for maternity support workers (81-87% day) have been influenced by long term sickness on maternity A. This has been managed appropriately with workforce support.

All vacant shifts continue to be sent to bank following budget holder approval and are as required converted to agency once a further review of fill rates and safe staffing levels has been undertaken by the Deputy/Divisional Midwifery and Nursing Director.

4.6 CONTINUITY OF CARER

The BR+ workforce assessment does not include any uplift for the rollout of Midwifery Continuity of Carer (MCoC) and therefore the service must continue to monitor its ability to offer MCoC. Considering this the Divisional Midwifery and Nursing Director and leadership team regularly review the service provision and workforce requirements associated with continuity arrangements. The service confirms that three established continuity models should be continued to maintain a safe service. Suspension of any of the established MCoC team's (specialist diabetes care and home birth and Chorley Birth Centre) would have a detrimental effect on service delivery with negligible impact on fill rates.

The service continues to explore innovative ways to increase "Enhanced Midwifery Continuity of Carer (eMCoC) by providing targeted, personalised support to women in the most deprived geographical areas and from ethnic minority backgrounds to improve maternity outcomes. A band 7 midwife/project lead and band 4 support worker have been funded by NHS England for 12 months to set up targeted antenatal and postnatal continuity teams

as a precursor for full geographical enhanced continuity. In the future, it is anticipated that NHS England will ask services to benchmark themselves against continuity metrics, when the full pathway of continuity of care is not possible. Actions to measure current enhanced continuity rates are being considered.in preparation.

4.7 NEONATAL NURSE STAFFING (The British Association of Perinatal Medicine (BAPM)) FILL RATES

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. The most recently published 2024/25 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.

Neonatal nurse staffing ratios continue to be tracked via the PQSD and neonatal dashboard monthly to ensure that staffing levels are sufficient to meet the BAPM requirements. Throughout 2024/2025, there have been periods of workforce unavailability and high intensive care cot requirements that have affected BAPM ratios. However, overall, the neonatal service has been able to redeploy staff or work differently to maintain safe staffing levels for the unit.

The neonatal service is responsible for the provision of transitional care nurse staffing and although this service runs from the postnatal ward, it continues to be given the same priority as the neonatal unit. Performance is monitored via the Operational Delivery Network (ODN) and transitional care group and incidents where this cannot be delivered are reported via the Datix incident system. Between April and August 2025 there was 3 Datix incident reports related to challenges with continuous provision transitional care, none of these led to moderate or above harm. If this happens and where clinically appropriate the midwifery team support pathways of care to keep mothers and babies together.

4.8 OBSTETRIC WORKFORCE

The service confirms that it is fully recruited to all consultant posts, and a job plan review has now been completed to maximise efficiency. The consultant rota presence has been agreed and maintained at 90 hours per week based on locally calculated staffing requirements according to the birth rate case mix, acuity and complexity of caseload. (As per the Royal College of Obstetrics and Gynaecology 2022 guidance).

The implementation of a middle grade 2 tier rota on a 1:8 basis is ongoing and will provide a 24/7 safe and sustainable workforce with the ability to better manage delays in time critical activity, delay in review in triage and improve the flow for the induction of labour pathway. Recruitment is ongoing for 3 SAS doctors, and they are at varying stages of the recruitment and onboarding process.

Pressures continue to be evident related to the number of trainees who have been made available by the Deanery. The service requests 8 trainees each rotation and unfortunately not all places were allocated on the most recent rotation with 4 trainees being allocated. This has led to unanticipated gaps in the rota, and the Clinical Director is considering how this could be managed differently going forward.

4.9 NEONATAL MEDICAL WORKFORCE

A local workforce review of the neonatal medical staffing requirement to achieve British Association of BAPM standards was undertaken in 2023/24. Following this, realignment of job plans, and use of the ORDER programme has resulted in a 1:8 rota for all grades and confirms that BAPM standards for medical staffing has been achieved. (Since February 2025).

5.0 RIGHT SKILLS

Organisations must have robust mandatory training development, and education programmes for multidisciplinary teams. Boards must assure themselves that sufficient staff have attended such training and are competent to deliver safe maternity care. Staffing establishments must allow for staff to be released to undertake the required training and development. The current compliance rates for the MIS standard 8 in relation to PROMPT, fetal monitoring and neonatal resuscitation is included in tables 2-4. Reduced compliance for PROMPT and fetal monitoring below 90% has been demonstrated for the obstetric trainees and is a result of the new rotation of doctors and an action plan to recover the position as required by MIS has been agreed. (Appendix 6)

Table 2 Basic Neonatal Life Support training by staff group August 2025

	NICU Nurses	NICU nursery nurses	CONSULTANTS	ANNP's	JUNIOR DOCTORS below ST5	JUNIOR DOCTORs ST5 and above	COMPLIANCE PERCENTAGE OVERALL
Neonatal Basic life support	**94%** *71 compliant out of 76*	**100%** *5 compliant out of 5*	**100%** *9 compliant out of 9*	**100 %** *5 compliant out of 5*	**100 %** *6 compliant out of 6*	**100%** *7 compliant out of 7*	**95 %** *103 compliant out of 108*
NLS certification medical staff.			**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*

Table 3 Fetal monitoring compliance by eligible staff group August 2025

August 2025	**MIDWIVES**	**CONSULTANTS**	**DOCTORS**	**COMPLIANCE PERCENTAGE OVERALL**
GAP/GROW	**97%** *188 out of 193*	**92%** *12 out of 13*	**25%** *4 out of 16*	**92%** (decrease 3%) *compliant out of 222*
Fetal Monitoring training Attendance at full day fetal monitoring training	**99%** *188 compliant out of 190*	**92%** *12 compliant out of 13*	**50%** *8 compliant out of 16*	**95%** (decrease 2%) *208 compliant out of 219*
CTG update (Delivered as part of PROMPT or attendance at CTG meeting)	**90%** *174 compliant out of 193*	**100%** *13 compliant out of 13*	**25%** *4 compliant out of 16*	**86%** (decrease 5%) *191 compliant out of 222*
Human Factors (attended PROMPT)	**93%** *181 out of 194*	**100%** *13 out of 13*	**23%** *5 out of 22*	**87%** (decrease 3%) *199 compliant out of 229*

Table 4 PROMPT and pool evacuation training by staff group August 2025

	MIDWIVES	CONSULTANT	DOCTOR	ANAESTHETIST CONSULTANTS	ANAESTHETIST ROTATIONAL	MATERNITY SUPPORT WORKERS	COMPLIANCE OVERALL
OBSTETRIC EMERGENCIES (PROMPT INC NILS)	**93%** 181 out of 194	**100%** 13 out of 13	**23%** 5 out of 22	**100%** 12 out of 12	**92%** 12 out of 13	**96%** 55 out of 57	**89%** 3% decrease *278 compliant out of 311*
Pool Evacuation	**93%** 181 out of 194	**100%** 13 out of 13	**23%** 5 out of 22			**96%** 55 out of 57	***89%*** 4% decrease *254 compliant out of 286*

5.1 SICKNESS ABSENCE

The sickness levels within the service have been variable over the last 12 months. Between April and August 2025, the average percentage has been between 6.1 and 7.18%. This is above the expected \trust level targets but aligns to national averages for midwifery. Several interventions by the division and workforce partners, as well as a review of long-term sickness management strategies within the division, has intermittently reduced absence overall. Performance will continue to be managed as part of the new attendance management policy.

6.0 RIGHT PLACE AND TIME

The service continues to have mechanisms in place so that staff can be deployed in ways that sustainably ensure mothers and babies receive the right care first time and in the right setting. This includes effective planning, management and rostering, with clear escalation policies if concerns arise. Perinatal staffing levels continue to be subject to regular review and real-time monitoring aligned to national standards based on local service needs. Mechanisms for oversight that act as a temperature check to determine whether staffing levels are appropriate and are detailed in table 5 and formal diverts are discussed further in section 6.1.

Table 5 Daily oversight and escalation mechanisms

SAFETY CHECKING MECHANISM	**DESCRIPTION**
The Matron of the Day: (MOD)	Working hours between Monday to Friday 09:00 – 17:00 (excluding public holidays) providing oversight and leadership making decisions managing-deployment of staff as required. Out of hours this role is undertaken by the unit coordinator supported by the site management team
Daily shift-level assessments and safety huddles.	Each day safety huddles take place at 9:30am and are attended by each clinical area where a review of staffing and activity is undertaken, capacity and flow are considered, and clinical care requirements are reviewed. An additional safety huddles is completed as part of the obstetric handover at 17:00 and 20:30

Board Rounds are undertaken at 8:30am 1:30pm 5pm and 20:30 pm	Provide a structured, multidisciplinary review of obstetric women across the maternity unit. These rounds typically involve obstetricians, midwives, anaesthetists, and other healthcare professionals who collaboratively review cases, plan treatments, and ensure coordinated safe care
Community Safety Huddle	Undertaken daily by the team leader of the day to review and oversee the community midwifery activity, identify issues and ensure effective communication to workers who are remote from the main site.
Local Maternity and Neonatal Maternity and Neonatal System GOLD Call:	(Monday to Friday 10am) including the local Maternity and Neonatal System GOLD call to identify and address shortfalls proactively and safely.
Intrapartum Acuity Tool:	Birth Rate Plus acuity tool is utilised to assesses the needs of women during labour, birth and in the early postnatal period. This classification system records acuity and complexity every 4 hours, 24/7. The tool enables the service to determine if staffing is adequate in real time

6.1 CLINICAL ESCALATION UNIT DIVERT

The service confirms that appropriate escalation processes and responses are embedded into practice in line with the Northwest Maternity Escalation Policy. In addition, the daily GOLD call provides prompt system response and mutual aid in the event of high activity, or a requirement for deflection of work or emergency divert.

Maternity diverts are not currently classified as a national red flag event; however, the service continues to monitor capacity issues that have resulted a divert. Since the last safe staffing report, in April 2025, the service has diverted on 11 occasions. The time frames for divert ranged between 4 and 24 hours. This was due to increased unit acuity and established vacancy. There were no known incidents of associated harm.

The service also collates data related to inability to accept intrauterine transfers. The PQSD includes a separate breakdown of all categories of transfer associated with capacity. Sustained improvement has been noted with fewer declined IUT's across both maternity and neonatal services since Quarter 1 and 2 of 2024/25 continuing to date.

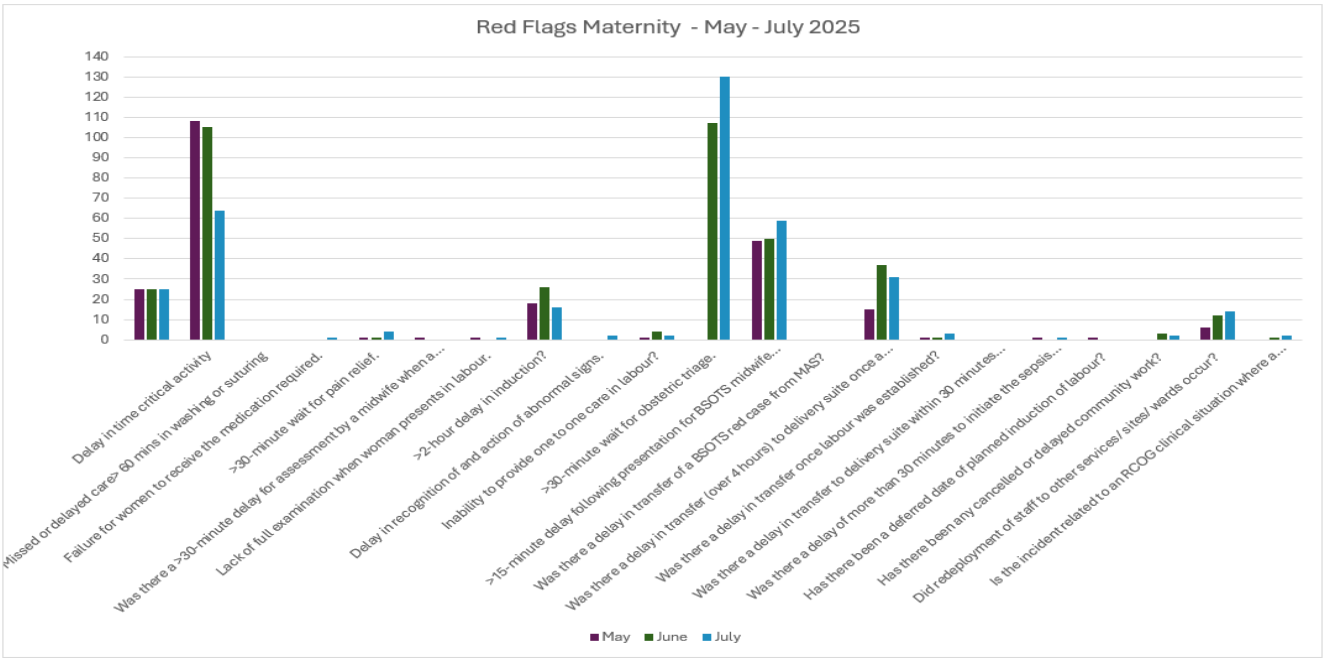
6.2 RED FLAGS

Midwifery red flags highlight potential areas of staffing concern within the service and act as a warning sign that something may be wrong with midwifery staffing levels. Therefore, the service continues to report and monitor red flag incidents monthly via the PQSD. The breakdown by category is provided in appendix 8.

The highest reporting categories throughout 2024/25 relate to delayed induction of labour, delay in obstetric review in triage of more than 30 minutes and delay in time critical activity. Whilst no harm has been directly attributed to these delays, there is a potential for psychological/emotional impact which remains difficult to assess and quantify.

Graph 1 details the red flag trends between May and July 2025. These reporting categories illustrate that the areas of pressure in the service have not changed over time. Consideration of the high reporting red flag indicators has been used to inform how funding for staff is used.

Graph 1 Red flag data



6.3 SUPERNUMERARY STATUS AND ONE TO ONE CARE

The ability to maintain supernumerary status of the delivery suite coordinator and to provide one to one care in labour provides a temperature check and reference point from which safe midwifery staffing levels can be confirmed.

The service continues to report 100% compliance with the provision of a supernumerary coordinator at the start of every shift and this consistently achieved. The staffing model with a second band 7 as unit coordinator, is an effective safety netting model to ensure this standard is met. This also provides wider flexibility for the service to safely manage unplanned gaps in the roster.

Consistently the service also reports compliance with one-to-one care for all women across 4 places of birth. When staff report a red flag associated with one-to-one care, the case notes are reviewed, and findings validated. Overall, this is a stable indicator and actions to recruit to all vacancies is in progress to reduce the associated risk.

6.4 STAFFING RELATED RISKS

Detailed below in table 6 are the open risks on the women's health risk register that are associated with safe staffing levels. There are 5 high risks which triangulate with the known pressure points.

All high risks are reviewed by owners and handlers and monitored by the maternity safety and quality committee. Each risk considers the current rating and assurances and gaps in controls, and this is overseen by the risk management group. This ensures that risks are prioritised and managed effectively. The table below (table 6) details each risk and where applicable indicates where a risk can be reviewed based on the perinatal quality surveillance statistical process control red flag reporting.

Table 6 Staffing related risks. (Maternity)

Risk ID	Title	Current risk rating
2089	Maternal Medicine Centre lacking Consultant Obstetric Physician and Specialist Input from Medical Specialities.	20 (Active risk) new
581	Maternity staffing deficit	15 (Active risk)
1592	Delays in induction of labour process	15 (Active risk)
1292	Inability to accept intra-uterine transfers from other organisations	15 (Active risk)
569	Elective caesarean demand significantly exceeds capacity impacting on patient safety and experience and risking elective gynaecology	15 (Active risk)
1708	Deferring and rearranging planned consultations in midwifery led services	15 (Active risk)
2088	Middle Grade Rota staffing does not meet the capacity and demand of the Maternity & Gynaecology Services	12 (Active risk)
1688	Maternity Assessment Suite (MAS) – partial implementation of the Birmingham symptom specific obstetric triage (BSOTS) system.	12 (Active risk)
1535	Delay in implementing a maternal medicine centre for Lancashire and South Cumbria	10 (Active Risk)
1762	Inability of the maternity service to achieve BFI full level 3 accreditation by 2024	10 (Active Risk)

6.5 MATERNITY TRIAGE RISK 1688

Compliance to the Birmingham Specific Obstetric Triage System (BSOTS standard) and (NICE Guidance for triage review within 30 minutes) continue to be audited and monitored by the service monthly. Since April 2025 over 90% of women were reviewed by a midwife within the NICE 30-minute target range. The 15-minute standard set by BSOTS for women seen by a midwife was also consistently over 90%. The service continues to experience pressure meeting the targets for obstetric review which is reflected in the red flag reporting.

Since the last maternity CQC inspection several interventions have been implemented to increase maternity and obstetric staffing in response to safety intelligence. Actions include the tier 2 business case which will provide earlier assessment of women needing obstetric review.

6.6 DELAYS IN INDUCTION OF LABOUR PROCESS RISK 1592.

Delays in induction of labour continue to be monitored as part of daily safety huddles and consultant board rounds, these are also captured as part of red flag reporting and linked to the risk register. Timing for admission for induction is overseen by the capacity and flow manager and when delays occur the on-call team are asked to review risk and plan care in partnership with the woman. The service is tracking delays and auditing including delay data to ensure that delays can be monitored and tracked over time and delay data is included in the perinatal quality surveillance dashboard. The continuous improvement work is making steady progress, and the

new electronic booking system has been implemented. Review of the service configuration is in progress, and this is discussed in 7.1.

6.7 ELECTIVE CAESAREAN DEMAND SIGNIFICNATLY EXCEEDS CAPACITY IMPACTING ON PATIENT SAFETY AND EXPERIENCE AND RSIKING ELECTIVE GYNAECOLOGY 569

The service has 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 the trend analysis of capacity was undertaken, it identified that the service now requires 17 theatre slots to manage the current demand. This places significant pressure on the ability to manage demand, impacting on workforce requirements, theatre capacity and service user experience. The division is reviewing theatre utilisation to ensure capacity and efficiency is optimised. The business case for the 4th theatre is progressing, and this must be a high priority for approval for both maternity and gynaecology.

6.8 DELAY IN IMPLEMENTING A MATERNAL MEDICINE CENTRE FOR LANCASHIRE AND SOUTH CUMBRIA 1535

Over the last 18 months the service has been establishing the Maternal Medicine Centre and has made good progress to implement specialist clinics to support the most complex women in Lancashire and South Cumbria. Initial pump prime funding was awarded to implement some key posts, and work is ongoing with the business case which is currently being taken through Integrated Care Board approval process to ensure substantive funding for staff. In the interim the maternal medicine network has offered further non recurrent funding to support PAs for specialist medical input and a band 6 midwife.

2089 MATERNAL MEDICINE CENTRE LACKING CONSULTANT OBSTETRIC PHYSICIAN AND SPECIALIST INPUT FROM MEDICAL SPECIALITIES.

This is a new risk which has been added to the register to reflect the lack of obstetric physician for the maternal medicine centre. Although several mitigations have been agreed including input from the haematology service and attendance from the obstetric leads at the other two North West Centres, this is a priority to ensure that women who require complex specialist medicine are appropriately managed.

To support risks 1535 and 2089, in the interim the maternal medicine network has offered further non recurrent funding to support PAs for specialist medical input and a band 6 midwife.

7.0 INVOLVEMENT INCLUSION AND LEADERSHIP

The maternity service requires highly skilled clinical leaders, who are responsible for the provision of safe staffing and the maintenance of safety and quality within the service. Each area is supported by band 7 leads who are overseen by matrons reporting to the Deputy/Divisional Midwifery and Nursing Director.

The Chief Nursing Officer and the Non-Executive Director hold a responsibility as named Safety Champions and have continued to walk the floor to engage with staff. Over the last few months, they have done this independently of the leadership team and this has given them an effective opportunity to speak to staff, which has been evaluated positively. Recently the Chief Nursing Officer arranged a face-to-face engagement session with the student midwives. This opportunity was also positively received.

7.1 MIDWIFERY WORKFORCE AND SERVICE RECONFIGURATION

Since the last staffing review in April 2025, the service has continued to progress with the work around its configuration because of intelligence gathered from safety metrics, and feedback from staff and service users. Over time, staff feedback has highlighted challenges related to rotation of midwives through the service. Reduced sense of belonging to a team and consistent direct line management, community on-call cover, rostering complexity, and increasing clinical acuity have resulted in less satisfaction in the workplace. Specific concerns have included, difficulties securing second midwives for births, delays in discharge due to NIPE availability, and skill mix pressures when managing complex cases.

In response, the leadership team have increased core staffing across inpatient areas, evaluated ward configurations and induction and caesarean pathways are under review. The service will be consulting with staff regarding options for service reconfiguration.

7.1 MATERNITY SPECIFIC SAFETY AND QUALITY METRICS PERINATAL DASHBOARD- IMPROVEMENT

The perinatal quality dashboard and skill mix, and establishment reviews provides the opportunity for Boards to assure themselves that the right staffing is in place. Therefore, maternity staffing metrics continue to be presented as part of the PQSD which is report submitted to Safety and Quality Committee and presented to the Board of Directors. (Appendix 1)

7.2 SYSTEM OVERSIGHT AND ASSURANCE - IMPROVEMENT MATERNITY OUTCOMES SIGNAL SYSTEM (MOSS)

Developed by NHS England's Maternity and Neonatal Outcomes Group, the MOSS is a newly developed national tool which will enable early detection of concerning trends in maternity and neonatal outcomes, prompting timely safety assessments and interventions. Designed to complements existing tools like the MBRRACE-UK real-time data monitor, the national system will offer a proactive, data-driven approach to improving maternity safety and outcomes. The agreed date for implementation has not yet been confirmed but is expected in November 2025. The single reporting portal Submit a Perinatal Event Notification (SPEN) also has a go live date of 3 November 2025. One these have been launched and embedded, a board level workshop will be arranged to ensure that the members are sighted on new reporting expectation.

7.2.1 SYSTEM OVERSIGHT AND ASSURANCE

Following the letter issued by NHS England, Sir Jim Mackey and Duncan Burton in June 2025 informing Trusts of a national maternity and neonatal investigation, Baroness Valerie Amos has confirmed the 14 hospital trusts that will be included. The terms of reference have been developed to focus on understanding the experiences of affected women and families, identifying lessons learned and driving the improvements needed to ensure high-quality and safe maternity and neonatal care across England. The service was not named as one of the 14 affected organisations and further updates, or early learning will be shared when available. It is expected interventions to ensure there is Board oversight and accountability, real time monitoring and early intervention will be prioritised.

7.3 PATIENT EXPERIENCE- INVOLVEMENT AND INCLUSION

The maternity service continues to actively seek feedback from service users to continuously improve the experience of women and families. The maternity CQC survey, complaints triangulation, lived experience feedback, maternity and neonatal voices partnership and the friends and family response rates provide a wide platform of intelligence in relation to how the service is performing.

Friends and Family Test feedback (FFT) is utilised both at ward and department level and across the division to proactively learn from experiences of care received by service users and their families. Table 7 provides a summary of performance between April and August 2025.

Table 7: Maternity friends and family survey responses April -August 2025.

Results by Directorate/Service

Hospital	Ward/Area	% Good	% Poor	Total Responses	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know
Chorley Hospital	Birth	100.00%	0.00%	4	4	0	0	0	0	0
	Postnatal ward	100.00%	0.00%	5	5	0	0	0	0	0
Royal Preston Hospital	Antenatal	83.784%	10.811%	74	33	29	3	4	4	1
	Birth	89.583%	6.25%	48	39	4	2	0	3	0
	Postnatal community	84.091%	10.227%	88	53	21	5	7	2	0
	Postnatal ward	82.857%	14.286%	70	44	14	2	6	4	0
	Total	85.121%	10.381%	289	178	68	12	17	13	1

During this time a total of 289 responses have been received indicating that work to improve response rates is required. Currently only electronic surveys are captured and work to reintroduce paper options could improve response rates. The service is exploring options to increase feedback.

7.4 MATERNITY SURVEY

The last CQC maternity survey was published in 2024. The findings of the last survey have been discussed in detail in earlier iterations of this report, and the service confirms that all associated actions have been completed. The feedback has been consistently in the upper quartile of performance overall for the past 3 years. It is anticipated that the 2025 survey is expected imminently and once the updated recommendations are available including a review of free text responses, a further action plan will be collated.

7.5 PATIENT EXPERIENCE

Learning from patient experience is a divisional priority and the maternity service meets with the corporate patient experience team on a weekly basis to ensure that there is early identification of learning from complaints, and that a timely response is provided to families.

Thematic analysis of concerns and complaints received since the April 2025 safe staffing report confirm that between April and June 2025 the maternity service received 8 concerns and 4 complaints through the Trusts patient experience team. The concerns and complaints received were reviewed and themes similar to those received in the previous quarter were identified.

All 8 concerns mentioned negative communication during the perinatal period. 5 concerns noted lack of and delay in treatment and 2 concerns noted a possible confidentiality breach in the antenatal period. This quarter, it was positive to note that there has been a decrease in the number of concerns from 12 in Q4 2024-2025 to 8 in Q1.

A total of 4 complaints were received, three of which were received in April 2025 and one complaint in June 2025. When the complaints were analysed two key themes emerged and these related to communication and staff attitude during the antenatal and postnatal period and delay in treatment in labour and birth.

Complaints regarding staff attitude, behaviours and actions, are taken seriously and education on trauma informed care has been delivered to all midwives and support workers on the maternity public health mandatory study day throughout 2025. In addition, lessons learned have been shared via the working in the Maternity and Neonatal Voice Partnership to ensure the voice of the service user is heard and respected.

The LMNS have commissioned external consent training since 2024 to be delivered by Baby Lifeline, which has been prioritised for obstetric consultants, obstetric trainees and the senior midwives.

7.6 MATERNITY AND NEONATAL VOICE PARTNERSHIP- INVOLEMENT AND INCLUSION

The maternity service remains committed to listening and learning from service user feedback to continuously improve experience for women and families, utilising various platforms to engage and co-produce provision of care. The work plan is ongoing and continues to align to the priorities of the Three-Year Delivery Plan for maternity and neonatal services and the Trust Single Improvement Plan (SIP).

7.7 CULTURE AND 'SCORE' SURVEY

Undertaking the perinatal SCORE culture survey has provided the team with valuable insights into their internal culture, enabling the QUAD to develop a data-driven action plan that will in time enhance employee engagement, improve leadership, and promote a healthier, more productive workforce (Appendix 7).

7.8 STAFF ENGAGEMENT IMPROVEMENT INVOLVEMENT AND INCLUSION

The service has been made aware by staff members of some concerns about poor attitude, behaviour, and communication and team working issues with some colleagues and teams. In response, to this and reduced staff survey results, the division has liaised with the organisational development team to commission specific pieces of independent culture work with the maternity service to enable a more comprehensive view of potential themes and areas of focus. Early insights and analysis into the findings are expected to be available by the end of September 2025. The report is being structured by staff group so that there is a clear understanding of the specific issues for each staff group as well as cross cutting themes to enable the actions to be targeted where they will have the most impact.

7.9 FREEDOM TO SPEAK UP

Since the last staffing review in April 2025, there has been 1 freedom to speak up escalation associated with the maternity service. The theme related to patient safety, poor communication and professional concerns. This has been considered, investigated and feedback provided.

8.0 CELEBRATING SUCCESS AND MILESTONE ACTIONS

The team who undertook the Race and Health Observatory project have been nominated for the Trust our people award. In addition to the team were asked to contribute to Health Equity Network Conference video montage, celebrating the positive contribution of the Postpartum Haemorrhage work on reducing health inequalities. Representatives from the maternity service have also been given the opportunity to contribute to the national planning for the future nursing and midwifery strategy attending a day of planning.

9.0 CONCLUSION

This report details the findings of the Lancashire Teaching Hospitals NHS Foundation Trust second maternity staffing review of 2025.

The maternity service continues to experience intermittent pressure resulting from higher acuity and staffing vacancies and this is reflected in the red flag Datix reporting. Colleagues work flexibly across several areas as required to ensure safety is maintained. Deflection and divert procedures are utilised to maintain safety in line with the regional escalation policy and the increase in the number of formal diverts should be noted. The impact on staff morale and families is also acknowledged and the investment in staffing will aim to address these risks.

There is a robust set of oversight arrangements in place ensuring maternity services retains a high profile within the organisation and dedicated Board level leadership. Although the workforce is relatively stable from an obstetric, neonatal medical/nursing perspective, the midwifery service awaits the onboarding of the 18.45 WTE registered midwives to provide sustained workforce stability.

There is positive progress against 9/10 Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) national priorities.

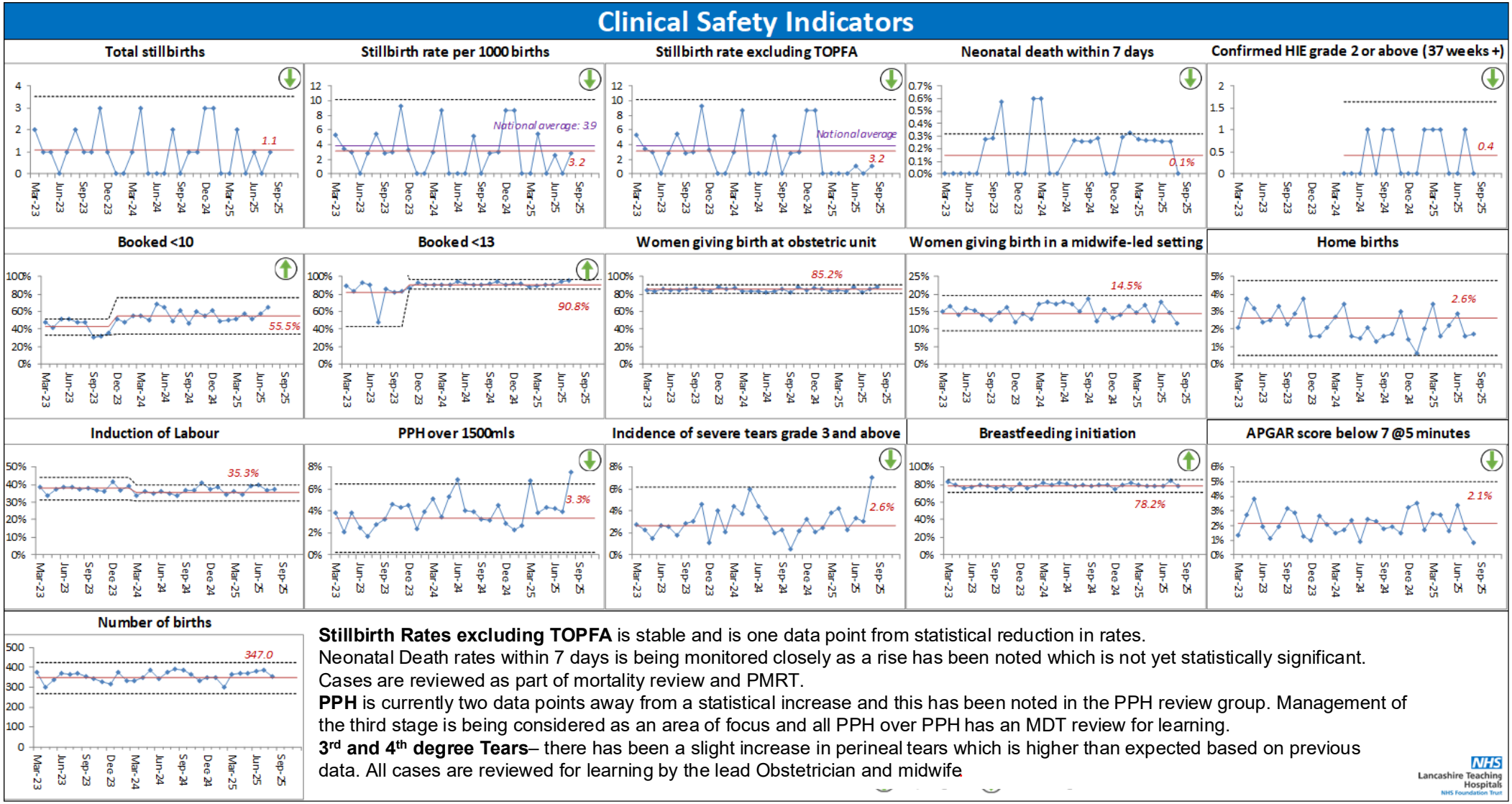
In line with the recommendation from NHS Improvement Workforce Safeguards guidance, the Divisional Midwifery and Nursing Director and the Chief Nursing Officer confirms that they are satisfied with the outcome of the bi-annual safe staffing assessment.

10. RECOMMENDATION

It is recommended the Board of Directors

i. Approve the safe staffing report, noting endorsement by the Safety and Quality committee.
ii. Note that the 3 yearly Birth Rate plus re- assessment is ongoing.
iii. Scrutinise the Perinatal Quality Surveillance Dashboard and CNST information and confirm it is assured of the outcomes presented.
iv. Acknowledge the requirement to address the current capacity gap for Caesarean section and support progression of addressing case to open the new 4th theatre through the Trust business case process.

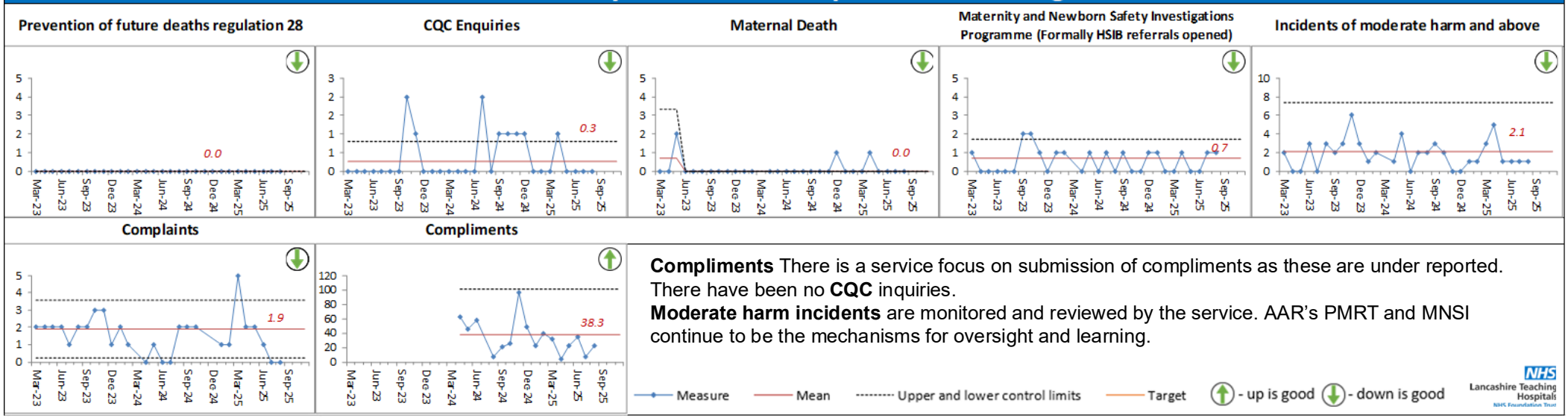
APPENDIX 1 PERINATAL QUALITY SURVIELLENCE DASHBOARD



Stillbirth Rates excluding TOPFA is stable and is one data point from statistical reduction in rates.
Neonatal Death rates within 7 days is being monitored closely as a rise has been noted which is not yet statistically significant. Cases are reviewed as part of mortality review and PMRT.
PPH is currently two data points away from a statistical increase and this has been noted in the PPH review group. Management of the third stage is being considered as an area of focus and all PPH over PPH has an MDT review for learning.
3rd and 4th degree Tears– there has been a slight increase in perineal tears which is higher than expected based on previous data. All cases are reviewed for learning by the lead Obstetrician and midwife

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Perinatal Quality Governance Experience and Regulation

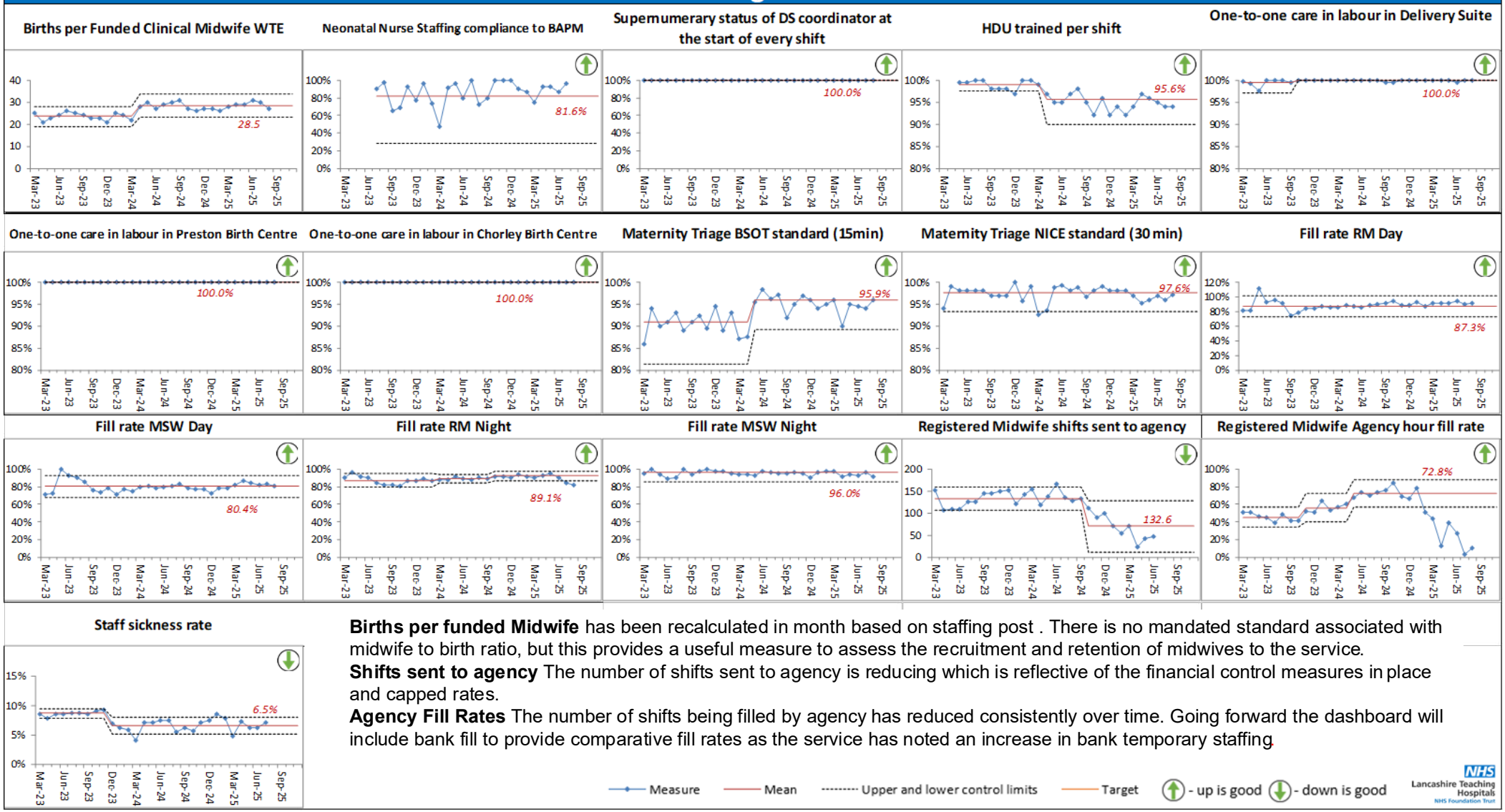


Compliments There is a service focus on submission of compliments as these are under reported. There have been no **CQC** inquiries.

Moderate harm incidents are monitored and reviewed by the service. AAR's PMRT and MNSI continue to be the mechanisms for oversight and learning.

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 provides a useful measure to assess the recruitment and retention of midwives to the service.

Shifts sent to agency The number of shifts sent to agency is reducing which is reflective of the financial control measures in place and capped rates.

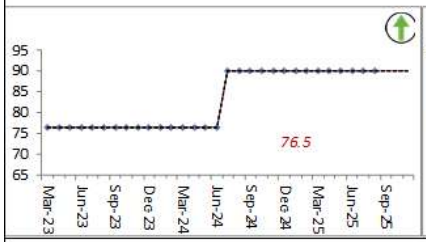
Agency Fill Rates The number of shifts being filled by agency has reduced consistently over time. Going forward the dashboard will include bank fill to provide comparative fill rates as the service has noted an increase in bank temporary staffing.

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

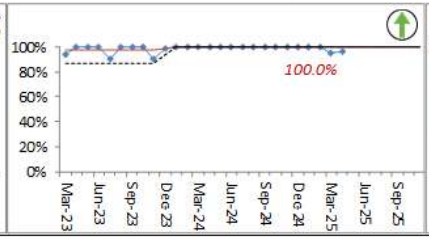
Lancashire Teaching Hospitals NHS Foundation Trust

Obstetric Medical Staffing

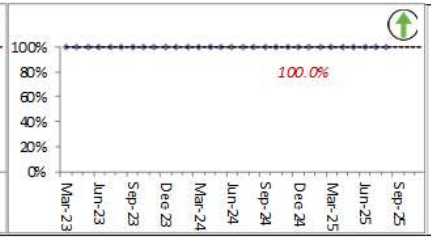
Number of Consultant hours on obstetric unit



RCOG obstetric benchmarking compliance



24-hour acute obstetric medical staffing fill rate

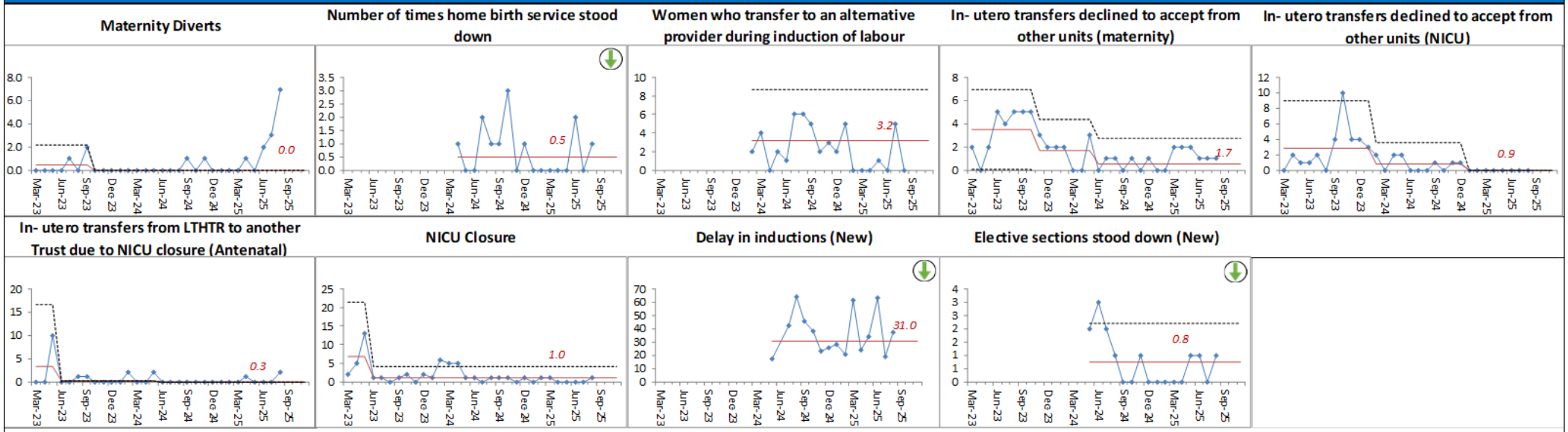


Consultant hours in the obstetric unit. The service continues to invest in consultant funding, and the service confirms an increase to 90 hours consultant cover. Diversion of resources to a middle grade rota is ongoing which will result in improved review and oversight of inductions and maternity triage as well as EPGAU.
RCOG attendance remains at 100%
Consultant fill rates for acute care continues to be 100%

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

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Clinical Escalation



In- Utero Transfers (IUT) NICU IUT decline rates have reduced. This is a demonstrable statistical reduction. Maternity declines are also reducing over time.

Maternity Diverts the number of maternity diverts in Q1 is significantly than the last 24 months. There has been a total of 11 diverts which is reflective of the 18.25 WTE vacancy and seasonal variation. The service has recruited to all vacancies and is utilising the over offer to recruit to turnover to provide stability.

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

Lancashire Teaching Hospitals NHS Foundation Trust

APPENDIX 2 PERINATAL QUALITY SURVIELLENCE DASHBOARD

	Standard	Progress	Evidence	Status-on track	Validated
Safety Action 1 **PMRT**	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 24 cases reported within the reporting period, 16 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.	Appendix 2. Standard 1	On Track	No due until after reporting period has ended 30/11/2025
		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. 8/8 reviews that have been concluded thus far in the reporting period have had external representation.		On Track	No due until after reporting period has ended 30/11/2025
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	Validated
	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.	Appendix 2 Standard 2 Compliance achieved to date (June 2025)	On Track	No due until October the end of 2025

		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.			
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 2025 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	Validated
	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.	Appendix 1 standard 3	Standard Achieved for year 7	Validated 11/09/2025
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	Validated
	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, and the service confirms that it has the right number of funded obstetricians and includes a 2-tier rota on a 1:8 basis. Recruitment to the SAS and resident obstetricians is ongoing with 1 who has commenced in post, 1 going through on boarding and one vacancy out to advert.	Shared in previous reports	Standard Achieved for year 7	Validated 11/09/2025

		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 monitored and validated monthly without the need for monthly audit.			
		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	Standard Achieved for year 7	Validated 11/09/2025
		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	Standard Achieved for year 7	Validated 11/09/2025
		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. The service is 100% compliant with this standard.	Shared in previous reports	Standard Achieved for year 7	Validated 11/09/2025
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 via the maternity and neonatal safety report and the Perinatal Quality Surveillance Model for assurance.					

Safety Action 5 **Midwifery Staffing**	Standard	Progress	Evidence	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 2022 is in place and the service confirms that it is on track to fill all vacancies. Data collection for the next Birth Rate Plus assessment has commenced in May 2025 and the draft report is awaited. Once received the findings will be scrutinised and validated by the Chief Nursing Officer and Divisional Midwifery and Nursing Director before being shared.	Bi-annual Safe staffing repots April and October 2025.	On Track	No due until October 2025
		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.	Appendix 2 Perinatal Quality Surveillance	On Track	No due until October 2025
		All women in active labour receive one-to-one midwifery care continues to be monitored each month.			
		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 October 2025	On Track Due October 2025
Safety Action 6. **Saving Babies Lives V3 (SBLV3)**	Standard	Progress	Evidence	Status	Validated
	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. Final Position	Standard Achieved for year 7	Validated 11/09/2025
There is a programme of improvement work focused on SBLV3 each of the 6 elements has a named obstetric or medical lead and all elements have now been met.					
	Standard	Progress	Evidence Source	Status	Validated

Safety Action 7 **MNVP**	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 has been reviewed by the Safety Champions and approved by the LMNS in September 2025. **On Track:** 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. An action plan has been agreed and formal escalation to the LMNS has been completed as part of the Board slide in September 2025 This will enable the service to meet the required standards.	Appendix 1 Safety Action 7 Action plan and update	On Track	Due October 2025
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 89**%** overall in August 25. Areas of focus: New trainee doctors due to the August rotation.23% 5/22. All new doctors are booked on to dates and an action plan for achievement of the standard is included in the report and will be achieved within 6 months. This enables the service to declare compliance for year 7.	Appendix 1 Safety Action 8.	At Risk – action plan in place to enable service to declare compliance once shared with Board.	No due until after reporting period has ended 30/11/2025

		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/ All neonatal medics who attend births unaccompanied are also Neonatal Life Support course trained. (100%) **FETAL MONITORING** – 95% % compliance achieved overall for the full day fetal monitoring training. Trainee doctors' performance is 50% 8/16. All new doctors are booked on to dates and an action plan for achievement of the standard is included in the report and will be achieved within 6 months. This enables the service to declare compliance for year			
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 bimonthly 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	Shared in previous iterations of the report	Standard Achieved for year 7	Validated 11/09/2025

		directorate) meeting. The report was shared in September 2025 Safety Champions meeting.			
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, led by the occupational development team.					
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	No due until after reporting period has ended 30/11/2025
A quarterly report is collated on AMAT to confirm that all qualifying cases have been reported in line with MIS year 7.					

CLINICAL NEGLIGENCE FOR TRUST MATERNITY INCENTIVE SCHEME STANDARD 1 PMRT

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	24/24 (All eligible cases for the standard)	
	Surveillance	16/16 (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	16/16 (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. 16/16	
		Completed within 6 months: On track.	
REQUIRED STANDARD (Standard D) *			
	April 2025		
	July 2025		

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	October 2025	

(Datix/PMRT)	**Stillbirth/ Neonatal death**	**PMRT upload date**	**Parents informed**	**Report drafted within 6 months**	**Actions ongoing**
Datix: 182227 PMRT: 96388	Antepartum Stillbirth	Yes	Yes	Review completed and published.	All actions completed
Datix: 182442 PMRT: 96441	Neonatal death	Yes	Yes	Review completed and published.	No Actions for Trust
Datix: 183923 PMRT: 96649	Antepartum Stillbirth	Yes	Yes	Review completed and published.	All action completed.
Datix: 184488 PMRT: 96661	Antepartum Stillbirth	Yes	Yes	Review complete and published	Action plan ongoing
Datix: 185485 PMRT: 96845	Antepartum Stillbirth	Yes	Yes	Review complete and published	Action plan ongoing
Datix: 185771 PMRT: 96909	Neonatal death	Yes	Yes	Review complete and published.	Action plan ongoing

Datix: 186495 PMRT: 97036	Antepartum stillbirth	Yes	Yes	Review completed.	Action plan completed
Datix: 190522 PMRT: 97476	Antepartum stillbirth	Yes	Yes	Review completed.	Action plan ongoing
Datix: 190652 PMRT: 97562	Neonatal death	Yes	Yes	Review completed.	Action plan ongoing.
Datix: 194158 PMRT: 98023	Neonatal Death	Yes	Yes	Review completed.	Action plan ongoing.
Datix: 199030 PMRT: 98587	Neonatal death	Yes	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing	
Datix: 200483 PMRT: 98785	Neonatal Death	Yes	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing	
Datix: 201846 PMRT: 98925	Stillbirth	Yes	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing	
Datix: 202672 PMRT: 99071	Stillbirth	Yes	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing	
Datix: 205611 PMRT: 99398	Neonatal Death	Yes	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing	

Datix: 211090 PMRT 190105	Neonatal Death	Yes	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for

MI number MNSI Cases	**Early Notification applicable**	**Early notification completed**	**Status of MNSI investigation**	**Duty of Candour.**
MI – 041706 **Datix: 197102**	No	NA	Investigation ongoing	Yes
MI-041480 **Datix: 195746**	Yes	Yes	Investigation ongoing	Yes
MI-044325 **Datix: 205611**	Yes	Yes	Investigation ongoing	Yes
MI-044943 **Datix: 207676**	Yes	Yes	Investigation ongoing	Yes
MI-046028 **Datix: 209749**	Yes	Yes	Investigation ongoing	Yes

CLINICAL NEGLIGENCE FOR TRUST MATERNITY INCENTIVE SCHEME STANDARD 2 MSDS

APPENDIX 3 BIRTH RATE PLUS

Birthrate Plus® Staffing: inclusive of 23% uplift

Clinical WTE required	
Delivery Suite: • Births • A/N cases • Postnatal Readmissions • Non-viable pregnancies • Induction of labour	45.90wte RMs
Triage - BSOTS Model	14.69wte RMs
Preston Birth Centre • Births & postnatal care • Births only • Transfers to Delivery Suite	21.36wte RMs
Antenatal Ward • A/N Admissions • Inductions of Labour Postnatal Ward • Postnatal women • NIPE • Extra Care Babies • Postnatal readmissions • Postnatal ward attenders	11.02wte RMs *min staffing 2 RMs per shift)* *38.38wte* *(Includes B3 MSWs for postnatal care)*
Outpatients Services • midwife led clinics • Obstetric/Specialist clinics • Fetal medicine • CDH clinics • Maternity Day Care Unit	11.43wte RMs 1.84wte MWs
Community Services: • Home births • Community cases • Attrition • Additional safeguarding	37.44wte RMs and B3 MSWs *(Includes 6.00wte for Homebirth Team, and MSWs -postnatal care)*
Chorley Birth Centre • Births/Triage cases	8.04wte RMs
Total Clinical WTE	**190.10wte RMs & PN MSWs**

APPENDIX 4 – SPECIALIST ROLES BREAKDOWN

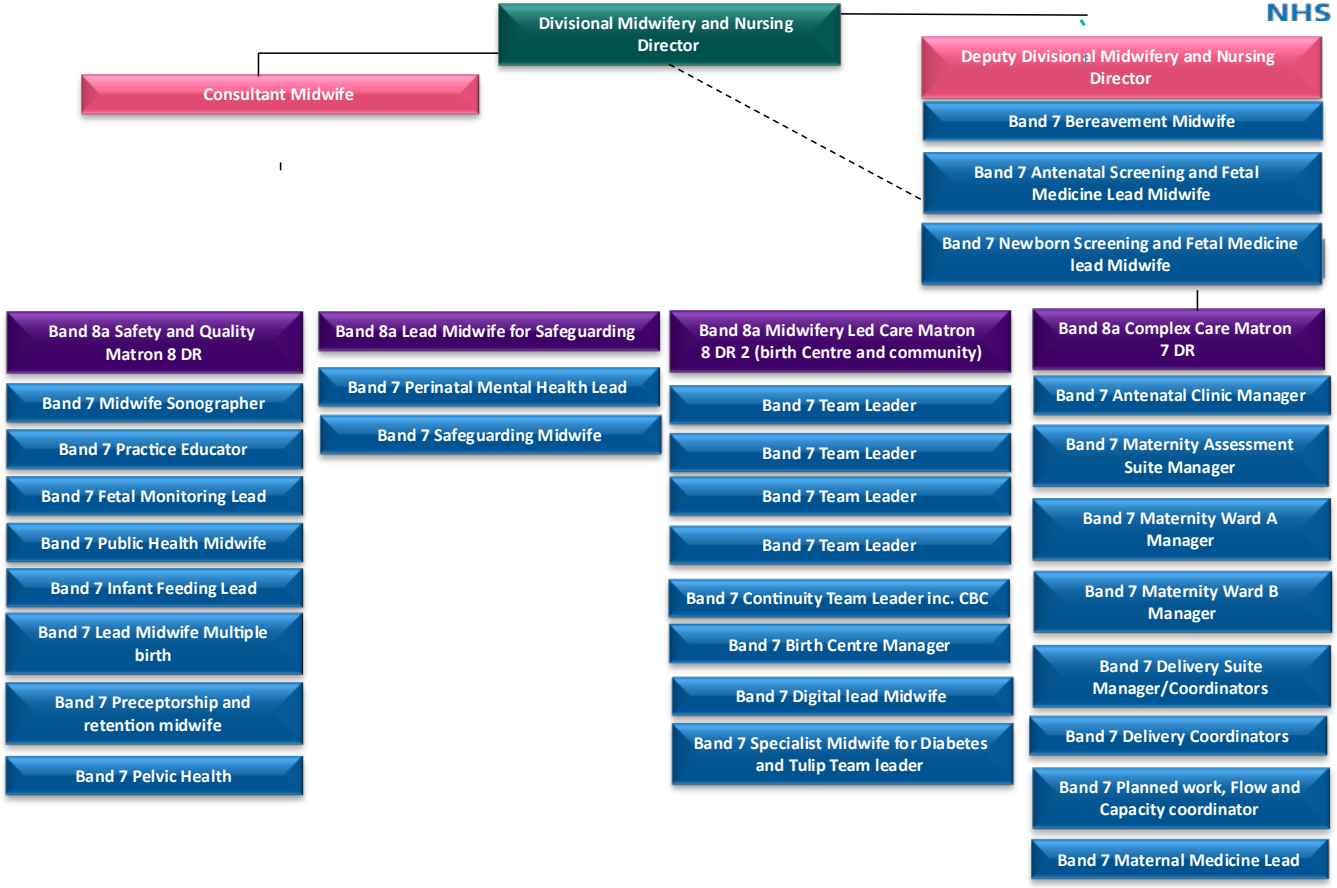
LANCASHIRE TEACHING HOSPITALS			
Date 01.08.2025			
Funded Specialist Midwives extra to clinical wte	WTE	Clinical input	Nonclinical WTE
Consultant Midwife - Band 8b	1.00		1.00
Antenatal Screening Lead Band 7	1.00	0.50	0.50
Newborn Screening lead Band 7	1.00	0.50	0.50
Digital Midwife Band 7	1.00		1.00
Capacity and flow co-ordinator Ba	1.00		1.00
Safeguarding lead midwife Band 7	1.00		1.00
Specialist Midwife for perinatal me	1.00	0.50	0.50
Infant feeding coordinator Band 7	0.80		0.80
Specialist Midwife for diabetes Ba	1.00	0.20	0.80
Public Health Midwife Band 7	1.00		1.00
Practice education and developme	0.80		0.80
Bereavement Specialist Midwife B	0.80	0.20	0.60
Bereavement Midwife Band 6 (Co	0.40	0.40	0.00
Service Improvement Midwife Ban	1.00		1.00
Information Technology Midwife Ba	1.00		1.00
Clinical Audit Midwife Band 6	1.00		1.00
Governance and Risk Midwife Bar	1.00		1.00
Fetal Monitoring lead Midwife Ban	0.60		0.60
Multiple Birth Midwife Band 7	1.00	0.40	0.60
Maternal Medicine Midwife Band 7	1.00		1.00
Vaccination Midwife Band 6 (temp	1.00	1.00	0.00
			0.00
			0.00
TOTALS	**19.40**	**3.70**	**15.70**

External Funded

APPENDIX 5 LEADERSHIP STRUCTURE

Leadership Structure

Lancashire Teaching Hospitals NHS Foundation Trust



APPENDIX 6 EDUCATION AND TRAINING RECOVERY PLAN

Action Plan – Education and Training for Maternity

Organisation:	Lancashire Teaching Hospital NHS Foundation Trust
Lead Officer:	Neesha Ridley
Position:	Safety and Quality matron

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

Version	Date
V1	09.09.25

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence	Current Status 1 2 3 4
1	**Identify**	Review compliance for individual groups against CNST SA8 technical guidance (allows for a 6-month period for agreed staff groups).	Fetal Monitoring Lead	12 September 2025	09.09.2025 Action plan shared via Maternity Safety and Quality	
		Review data and calculate compliance for training based on individual staff groups.	Fetal Monitoring Lead	12 September 2025	09.09.2025 Training data/Trajectory	
		Identify members of the maternity staffing team that need mandatory training, document this per staff group.	Fetal Monitoring Lead	12 September 2025	09.09.2025 Training data/Trajectory	
		Identify additional training dates to book staff members onto training, to support compliance and extra attendance at training days.	Fetal Monitoring Lead	12 September 2025	09.09.2025 Book training dates for colleagues who are non-compliant	

2	**Action**	Inform the medical rota co-ordinator and line managers/team leaders of the training days booked in September, October, November and December.	Fetal Monitoring Lead	30 September 2025	09.09.2025 Email	
		Contact the medical rota co-ordinator to ensure all the outstanding medical staff members who require training, are booked onto the relevant and outstanding study days.	Fetal Monitoring Lead	By 30 September 2025	09.09.2025 Email	
		Email area managers and team leaders to remind them to book the attendees on to the Roster as a study day, relevant to their training need.	Fetal Monitoring Lead	By 30 September 2025	Email	
		Send a reminder email to all members booked onto training over September, October, November and December to remind them of the need to attend the training day or contact the education lead to ensure they are booked onto an alternative date.	Matron for Safety and Quality	By 30 September 2025	Email	
3	**Evaluate**	Gather training data compliance monthly, for September, October, November and December to ensure training data is on track to achieve compliance.	Fetal Monitoring Lead	30 November 2025	Training update presented at Maternity S&Q monthly.	

APPENDIX 7 SCORE ACTION PLAN

Our People Plan - Women's & Children's Divisional SCORE ACTION PLAN

Version	Date
1	1.12.2024
2	1.03.2025
3	31.07.2025
4	01.09.2025

Lead Officers:	Perinatal Team
Site / Location of Team or Service:	Lancashire Teaching Hospitals

Status Key	
1	Actions not on target for delivery
2	Actions on target for delivery
3	All actions completed awaiting evidence
4	All actions completed and good supporting evidence provided

Standard	Key Actions Please split out the sub actions needed to deliver the standard here	Impact Measures Please detail the proposed impact to be delivered through completion	Lead Officer/ Workforce & OD Lead	Deadline for action	Progress Update Please provide supporting evidence	Current Status 1 2 3 4
To engage, retain, reward and recognise **To be well led** To create a positive organisational culture **To be inclusive and supportive – Implementing a zero-tolerance approach**	Communication – develop our approach for communicating positive messages through different methods, while taking ownership, responsibility and accountability for the cultural improvement plan	Listening event feedback from staff will be improved as colleagues feel more involved. Improved Compliance with staff surveys.	QUAD and Perinatal Leadership	~~30.06.2025~~ 30.11.2025	1.12.2024 Perinatal leadership team developing communication strategy through wider divisional culture plan. Meeting to be arranged to confirm actions agreed. 31.07.2025 Action to be aligned to the wider culture improvement plan. To discuss actions at the next perinatal meeting and await overarching improvement plan which is expected by the end of September.	

				30.06.2025	1.3.2025 Agreed to run further listening events with OD team in 2025 for all staff groups. 30.06.2025 Listening event schedule and wider cultural work being undertaken by OD. Action Closed.	
				~~30.06.2025~~ 30.11.2025	1.3.2025 Template to be developed to share positive messages in a format that is used in all key divisional meetings. 31.07.2025 Positives from the week previous included in the Divisional weekly meeting to ensure that key colleagues are aware. Action ongoing with development of template for sharing information to the team.	
	Arrange for colleagues to attend the MOMENTS training to promote positive approaches to change management.	Listening event feedback from staff will be improved as colleagues feel more involved.	QUAD and Perinatal Leadership	1.12.2025	01.3.2025 Staff allocated to attend initial MOMENTS training, led by service improvement midwife. 30.06.2025 Colleagues and service development midwife allocated to attend one off training so that this can be cascaded where appropriate. Action closed.	

	To focus on how we engage with teams across the maternity services. To actively seek out opportunities for collaborative working between teams, including colleagues from maternity, neonatal, theatres and wider to include ultrasound anaesthetics and gynaecology. To provide listening events for colleagues and teams to have the opportunity to share their views with the leadership team. To actively promote connection between more	Improved compliance with minimum percentage of staff completing the staff survey Improved GMC survey results for junior doctors Attendance of senior leaders at team meetings where appropriate.	QUAD and perinatal leadership team	1.12.2025	1.12.2025 PG tutor, divisional training lead and CD have met with training leads to discuss latest GMC survey results and agree an action plan. 31.07.2025 Update of action requested via CD to confirm this has been completed.	
					1.12.2025 Collaborative training undertaken around impacted fetal head national training trial between midwifery, obstetrics and theatre teams. Session based learning delivered on PROMPT. 01.03.2025 Bespoke training for Delivery Suite team in progress. 30.06.2025 Impacted fetal head training ongoing as part of maternity TNA for 2025 on PROMPT.	

	junior and senior colleagues. To promote engagement with feedback tools such as the staff survey, and to actively seek to promote this particularly in areas known to have lower engagement.				1.3.2025 Agreement in place to improve offer of MDT training programmes across theatres and maternity with consideration to learning outcomes. 30.06.2025 Impacted fetal head training ongoing as part of maternity TNA for 2025 on PROMPT.	
	To develop an anonymous feedback mechanism using surveys and closed loop process.	Resolution to concerns raised are managed in a timely way. Fewer escalations related to culture received over time.	QUAD and perinatal leadership team	1.12.2025	1.3.2025 Perinatal team to consider how feedback can be obtained with support from OD at regular intervals using some anonymised processes. Consider a QR code for feedback 31.07.2025 Action to be aligned to the wider culture improvement plan. To discuss actions at the next perinatal meeting and await overarching improvement plan which is expected by the end of September.	

	To continue offer of leadership development training to team leaders and doctors, aiming to improve understanding of leadership skills and the impact this can have on teams. To ensure that team leaders and those with managerial, mentoring or educational responsibilities are aware of the trust wellbeing offer and to improve communication of this within teams.	High performing team with low sickness absence rates. High retention rates after 1 and 2 years of preceptorship programme.	QUAD and Perinatal Leadership	30.06.2025	1.12.2024 Leadership development days have been provided with 3 more planned, for early 2025. curriculum includes: Objective Setting Masterclass, zero tolerance training, Recognition Masterclass, Culture Masterclass. 31.07.2025 Leadership Day programme completed. Further days can be commissioned in line with the wider culture plan. Action closed.	
	Consider mechanisms for leadership engagement with early career midwives		QUAD and Perinatal Leadership	30.12.2025	01.03.2025 2 bespoke leadership days arranged in March and May 2025 focused on early careers midwives. 31.07.2025 Chief Nursing Officer used Safety Champions as a forum to meet with student midwives and early career midwives. The first session has been held and was evaluated positively. Plans to be confirmed to widen this offer. Action closed	

	Provision of Trim training to those with educational or mentoring responsibilities. Which will improve access to psychological support.		QUAD and Perinatal Leadership	30.03.2025	01.03.2025 Funded TRIM training for 26 colleagues across perinatal team trained.	
					31.07.2025 Implementation group in progress to develop SOP and process for roll out of TRIM across all perinatal areas. 01.09.2025 Update from Consultant midwife requested.	
	Improve visibility of the Divisional Perinatal team			~~30.04.2025~~ 31.12.2025	Create a plan for multi professional walk arounds and schedule over the next 12 months 31.07.2025 Schedule of walk rounds to be agreed at next perinatal meeting. Action deadline extended.	
	Implementation of the Improve Well App across perinatal team	Staff are engaged in change processes. Staff survey results show improvement	QUAD and Perinatal Leadership	1.12.2025	1.03.2025 Service awaiting update from LMNS in relation to the Improve Well App. 31.07.2025 Action update to be requested at QAP 16/09/2025	
	To develop an approach for communication of positive messages through different methods.		QUAD and Perinatal Leadership	31.3.2025	1.12.2025 Positive escalations and culture within the unit added as a standing agenda item to consultant meetings.	

	To ensure that leaders at all levels reenforce positive messages about teamwork and leadership. To build on provision of clear expectations and shared accountability. To positively reinforce the embedding of the clinical escalation toolkit within teams.				1.12.2025 Clinical escalation toolkit training days rolled out May – July 24. Further training planned in relation to team of the shift.	
					1.12.2025 Escalation policy reinforced with document 'responsibilities of the consultant on call'	
	To encourage a culture of civility across the service. To ensure that colleagues are encouraged to report incidents of concern via the Datix system. Leaders to commit to management of any incidents of incivility, discrimination, undermining or other concerns according to trust processes, taking a zero-tolerance approach.	Reduction in numbers of Violence, Aggression, Bullying and Harassment recorded on Datix from patients, family members/community, colleagues (2022 is the baseline).	QUAD and Perinatal Leadership	~~30.06.2025~~ 31.12.2025	1.03.2025 Using Team of the Shift (RCOG), Standardised boards 31.07.2025 Quotes for standardised boards in progress. Awaiting outcome of wider culture review to determine required actions. Deadline extended.	

	Culture review including listening events 121's and team feedback	Reduction in numbers of Violence, Aggression, Bullying and Harassment recorded on Datix from patients, family members/community, colleagues (2022 is the baseline).			01.09.2025 Await the findings of the Service culture review and associated action plan	

APPENDIX 8 MATERNITY WORKFORCE ACTION PLAN

Our People Plan – Maternity Workforce Action Plan 2025/2026

Lead Officers:	Perinatal Team
Site / Location of Team or Service:	Lancashire Teaching Hospitals

Status Key	
1	Actions not on target for delivery
2	Actions on target for delivery
3	All actions completed awaiting evidence
4	All actions completed and good supporting evidence provided

Version	Date
1	1.12.2024
2	1.03.2025

Standard	Objective	Overview	Lead	Detail	Date for completion	Current Status 1 2 3 4
1.	**Train**	Scope the availability to provide further support student midwives in the clinical setting, with a focus on providing a good and supportive experience	Lead for student midwives	Review the available areas suitable for training student midwives in line with the NMC standards	31 December 2025	01.09.2025 Action ongoing meeting with Education team arranged
				Review the number of practice supervisors and practice assessors in the maternity workforce at LTH		01.09.2025 Review practice supervisors and confirm enough. Agree funding as required for further mentorship.
		Scope the plans for recruitment for diversity in the workplace. Review and understand the options and data from education providers.	Matron for Safety and Quality	Discuss with the educational providers to seek clarity on diversity and equity workforce plans during recruitment of student midwives.	30 December 2025	01.09.2025 Awaiting update from regional team
		Support offered to student midwives to prepare for qualification and employment collaboration with local education providers,	Matron for Safety and Quality	Create discussion at next LMNS workforce meeting discussion with Lead midwives for education (LME) and education providers. Request LMNS review at next regional workforce meeting.	30 December 2025	01.09.2025 Awaiting update from regional team

		the LMNS and NHS England regional team				
		Feedback from student midwives.	Lead for student midwives	Review the feedback from the three sources of data and develop an action plan to address areas where negative feedback has affected the student midwifery experience.	31 December 2025	01.09.2025 Review of feedback ongoing
				Feedback mechanisms Meet with Chief Nursing Officer to share feedback on learner experience	30 September 2025	Face to Face Meeting with CNO arranged July 2025- Outcomes shared via safety Champions
		Catch-up sessions for student midwives	Lead for student midwives	Host regular in-house catch-up sessions for student midwives, with an open agenda to support their clinical placement experience and to address any areas of development they need support with.	31 December 2025	01.09.2025 Regular catch ups in place on cycle of business led by lead for student midwives.
.2	**Retain**	Preceptorship document	Lead for NQM midwives -	Review the NQM preceptorship pack, to confirm that it is aligned with the LMNS, local and national clinical need and evidence-based practice.	30 December 2025	01.09.2025 Document reviewed annually and updated in line with LMNS working group.
		Preceptorship clinical rotation plan	Matron for Midwifery led services –	Review Newly Qualified Midwife (NQM) preceptorship clinical rotation plan in preparation of the new midwifery workforce. Consider the key areas of practice to support new midwives and the need of the clinical service.	30 October 2025	01.09.2025 Review of preceptorship programme ongoing in line with service reconfiguration.

		Retention meeting	Lead for NQM midwives	Develop a retention, regular face-to-face session for new midwives, with an open agenda to support their development and their experience as midwives at LTH.	30 December 2025	01.09.2025 Regular coffee catch up's, 121's and surveys in place delivered by preceptorship lead
		Mentor support plan	Matron for complex care and Midwifery Led services	Develop a mentor support plan, to support all new midwives for the first 12 months. A buddy mentor should be assigned to all new midwives to support them alongside their line manager	30 December 2025	01.09.2025 Matron for Safety and Quality to arrange planning meeting.
		New starter support	Lead for NQM Midwives	Include details of new starter forums, freedom to speak up, wellbeing support and inclusion forums in preceptorship packs. Share the details of these LTH trust forums with buddy mentors, to share with new midwives.	30 December 2025	01.09.2025 Discussed during induction
		Survey about development options	Lead midwife for education	Develop and send a survey to all midwives, asking what the key areas of development are of interest to them. Share the results with team leaders to support development in appraisal feedback.	30 January 2025	01.09.2025 Survey to be shared with all midwives seeking feedback on areas of development
		B7 leadership development pack	Matron for Safety and Quality	Develop a B7 leadership development pack aligned to NHS England's Labour ward co-ordinator framework, to support the learning, support and development. Document to be tested before full roll out	30 October 2025	01.09.2025 Booklet test of change in progress
		CPD funding	Lead midwife for education	Share awareness of the CPD funding to team leaders and ward managers, to share with midwives and maternity staff	30 October 2025	01.09.2025 Email to be sent to all staff in line with CPD funding availability.

		Celebrating success	Ward managers	Share with ward managers and team leaders, encouraging them to use resources Celebrate Success on the intranet, tools to help enhance feeling valued and recognised.	30 October 2025	01.09.2025 Managers to undertake TED and shared resources developed by OD team. Action ongoing.
3	**Reform**	Await the outcome of the culture review and associated action plan.	Organisational Development Team and QUAD	Action to be aligned to the wider culture improvement plan. To discuss actions at the next perinatal meeting and await overarching improvement plan which is expected by the end of September.	30 December 2025	01.09.2025 Awaiting analysis and final report from ongoing culture workstream.
		Review the service needs and staffing	Matron for Midwifery led services and complex care	Review the staffing models in each of the clinical areas – complex care and midwifery led care. Review the service needs to support women, service users to receive excellent care and review staffing numbers needed to support the needs of the service.	30 December 2025	01.09 2025 Service reconfiguration ongoing
		Annual leave and study day delegation	Ward managers –	Ward managers and team leaders to review annual leave and study day delegation to support the needs of the service and to support staff wellbeing.	30th December 2025	01.09.2025. Monthly roster reviews set up and ongoing to balance study day allocations
		Recruitment to the maternity service	Matron for Midwifery led services and complex care	Advertise vacancies for band 5 and band 6 midwives, to support recruitment to vacancies in maternity staffing gaps at LTH.	30th September 2025	01.09.2025- Vacancy of 18.45 WTE recruited. Various hours.

				Share details of the advertised posts with local educational providers to share with students.		
			Matrons	Monitor vacancies using spreadsheet trajectory	31 March 2026	01.09.2025 Monthly review and oversight ongoing
			Deputy Divisional Midwifery and Nursing Director	Use over offer to recruit to turnover to ensure sustainable workforce.	31 March 2026	01.09.2025 Over offer in place to recruit to turn over
		Recruitment to Delivery Suite	Matron for care	Advertise band 6 midwives and Core posts to support filling the vacancies in maternity staffing gaps at LTH.	30th September 2025	01.09.2025 Core post recruited to provide additional stability aligned to the outcome of staff feedback
		Recruitment to Maternity Ward	Matron for care	Advertise band 6 midwives, to support filling the vacancies in maternity staffing gaps at LTH.	30th September 2025	01.09.2025 Core post recruited to provide additional stability aligned to the outcome of staff feedback
		Oversight of data	Deputy Divisional Midwifery Director	Monitor safety data on a monthly including red flag data, BR + acuity, safety huddles, PALS concerns, complaints and service user feedback.	Monthly – data collated and feedback through the Patient experience feedback report (Quarterly)	01.09.2025 Perinatal Quality Surveillance Dashboard used to monitor data. Guideline in place and published.

		Cascading of data	Matron for Safety and Quality	Gathering and sharing of patient experience report data through the Quarterly report 2025, shared via the patient experience trust group	Patients experience feedback report (Quarterly – presented at Trust Patient experience group)	01.09.2025 Report shared via maternity safety and Quality Committee.

APPENDIX 9 RED FLAG REPORTING

Red flag Reporting Metrics	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	March 25	April 25	May 25	June 25	July 25	Aug 25
Delay in time critical activity	41	61	40	44	59	32	16	16	117	108	105	64	18
Missed or delayed care> 60 mins in washing or suturing	0	0	1	0	1	0	0	1	0	0	0	0	1
Failure for women to receive the medication required.	0	1	0	0	1	0	1	2	0	0	0	1	1
>30-minute wait for pain relief.	0	2	0	0	0	2	1	3	1	1	1	4	4
Was there a >30-minute delay for assessment by a midwife when a problem was identified	0	1	0	0	0	1	1	2	2	1	0	0	0
Lack of full examination when woman presents in labour.	0	4	0	0	0	0	0	2	0	1	0	1	0
>2-hour delay in induction?	42	34	21	9	7	28	21	17	5	18	26	16	19
Delay in recognition of and action of abnormal signs.	0	1	1	0	0	0	2	0	0	0	0	2	1
Inability to provide one to one care in labour?	1	4	0	0	0	2	0	0	1	1	0	0	0
>30-minute wait for obstetric triage.	20	56	41	46	47	58	61	62	156	0	107	130	124
>15-minute delay following presentation for BSOTS midwife assessment.	24	75	42	24	23	46	32	21	82	49	50	59	38
Was there a delay in transfer of a BSOTS red case from MAS?	0	0	0	1	0	1	0	1	1	0	0	0	0
Was there a delay in transfer (over 4 hours) to delivery suite once a decision has been made for transfer for induction or augmentation?	28	25	20	14	19	26	21	34	17	15	37	31	9
Was there a delay in transfer once labour was established?	1	2	0	0	0	3	0	1	1	1	1	3	9
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	1	0	0	0	0	1
Was there a delay of more than 30 minutes to initiate the sepsis care bundle?	0	0	0	0	0	0	0	1	1	1	0	1	0
Has there been a deferred date of planned induction of labour?	0	2	0	0	0	0	0	0	1	1	0	0	4
Has there been any cancelled or delayed community work?	5	28	4	0	0	0	2	3	2	0	3	2	5
Did redeployment of staff to other services/ sites/ wards occur?	9	12	8	2	0	6	3	12	9	6	12	14	34
Is the incident related to an RCOG situation where a consultant was called but did not attend (New June 25 Validated position.)											1	0	2
Total numbers of red flags	**171**	**308**	**178**	**140**	**157**	**205**	**161**	**179**	**396**	**336**	**364**	**329**	**270**

** Work is ongoing to review how RED flags are reported to ensure that only one category can be chosen per incident report. This will ensure that multiple categories are identified incorrect.

12.3 - MORTALITY ANNUAL REPORT

REFERENCES

Only PDFs are attached

12.3 - Annual mortality report 24-25 Final for submission to Board v1 (1).pdf

Board of Directors Report

1.0 Introduction

The purpose of this report is to provide an update and assurance to the Board of Directors that the Trust has robust governance arrangements in place to monitor, review, report and learn from patient deaths. This report presents a range of mortality information and benchmarking data to provide assurance to the Board in the following areas:

Mortality benchmarking – HSMR and SHMI	LeDeR Deaths, Reviews & Learning
Adult SJR Mortality Reviews & Learning	StEIS/PSIRF Deaths & Learning
Learning from Inquests	Perinatal, Neonatal & Child Deaths
Updates to TELSTRA methodology changes	Medical Examiner Service Activity
	Mortality improvement plans

The reporting period for TELSTRA (formerly Dr Foster) SHMI, HSMR and SMR Mortality data is December 2023 – November 2024.

The reporting period for the remaining data is April 1st 2024 – March 31st 2025.

2.0 Mortality Benchmarking

HSMR Regional Acute Peers Benchmark December 2023 – November 2024

Mortality benchmarking demonstrates that the Trust **HSMR** of **75.2** and Standardised Mortality Ratio (SMR) of **74.0** are significantly lower than expected for the 12-month period of December 2023 – November 2024.

The Trust had during the 12-month period one of the lowest SMRs in relation to regional acute peers as demonstrated in the funnel plots in Appendix 1. Page 21. Figure 2.

SMR Regional Acute trust Benchmark Child Mortality

The 12-month rolling SMR for children is **88.9** and within expected range.

SMR Neonatal mortality data (<1 day – 28 days)

The latest 12-month SMR for neonatal deaths is **92.4** and is within the expected range Appendix 1 figure 4.

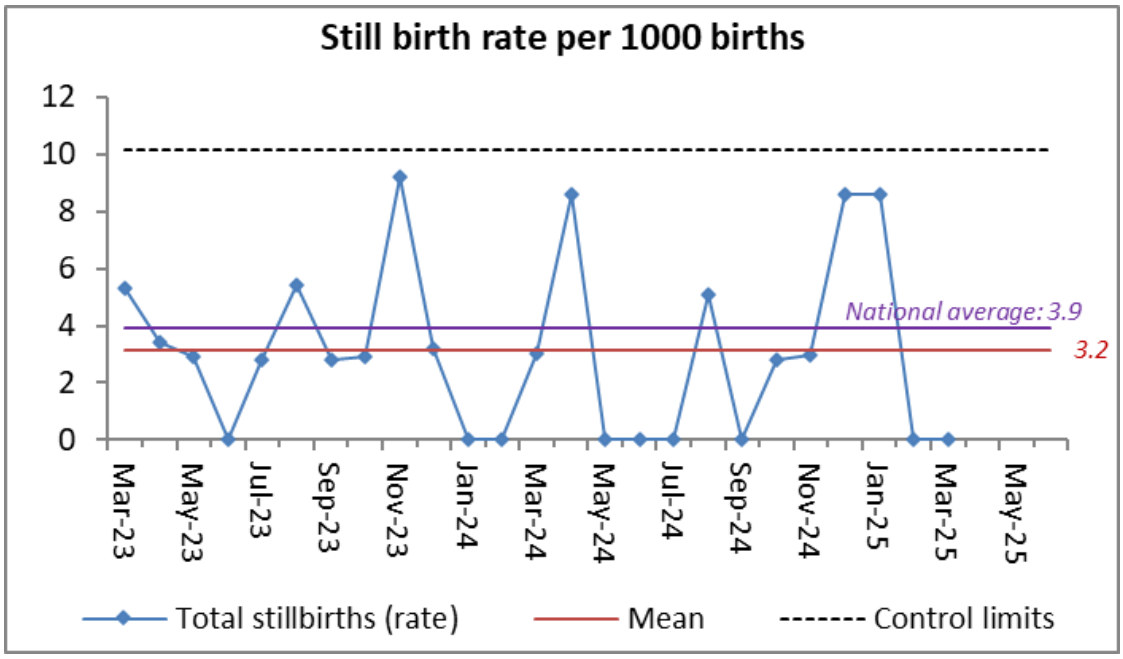
2.1 Stillbirth mortality

The new H/SMR+ models no longer include or provide risk adjustment for still birth mortality but do still provide a mortality trend in the volumes of observed deaths within this group.

There were 4 still births, during the period from Dec-23 – Nov-24. Full details are provided at Appendix 1. Page 27.

Trust data showing the number of stillbirths from March 2023 to May 2025 is outlined in Graph 1. below indicating that the Trust stillbirth rate remains below the national average.

Graph 1. LTHTR still birth rate per 1000 births March 23 – May 2025



Detailed reporting of perinatal mortality data and reviews is presented separately to the Safety and Quality committee.

2.3 Summary Hospital-level Mortality Indicator

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust, and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. The SHMI covers patients admitted to hospitals in England who died either while in hospital or within 30 days of being discharged. Deaths related to COVID-19 are excluded from the SHMI.
The Trust **SHMI** for the data period of December 2023 – November 2024 is **92.19** and within expected range.

Mortality benchmarking data is summarised in Table 2. below with full details provided at Appendix 1. Page 21.

Table 2:

Measure	Month (Nov 24)	3 Month Period (Sep 24 – Nov 24)	12 Months (Dec 23 – Nov 24)
HSMR All Ages	67.3	69.3	75.2
HSMR Adult	67.5	68.9	75.0
SMR Relative Risk - All Diagnoses All Ages	68.8	71.5	74.0
SMR Relative Risk - All Diagnoses Adult	69.4	70.8	73.8
SMR Relative Risk - All Diagnoses Child (<1 day – 17 yrs.)	**0.0**	**131.2**	**88.9**

SMR Relative Risk - All Diagnoses Neonates (<1-28 Days) *The updated model does not include still births*	**0.0**	**144.3**	**92.4**

3.0 TELSTRA methodology update

As reported in the previous Bi- Annual Mortality Report TELSTRA has recently completed a 2-year review of the methodology used for mortality benchmarking and several changes implemented. This report will be the first report that uses the new HSMR+ model. Key changes are outlined in Table 3. below.

Table 3. changes to TELSTRA model

HSMR vs New HSMR – Model Differences

	HSMR - Old Model	HSMR - New Model
Cohort	56 diagnosis groups which made up 80% of in - hospital mortality. Still births are included	41 diagnosis groups which now make up 80% of in - hospital mortality. Still births are NOT included
Variable changes:		
Deprivation	The current model uses the Carstairs Deprivation Index	The new model will use IMD (Index of Multiple Deprivation)
Covid-19	Covid-19 currently sits in the Viral Infections diagnosis group under the subgroup 'Other and unspecified viral infection'.	The new model will place Covid -19 within its own Covid-19 subgroup within the Viral Infections diagnosis group.
Comorbidity	The current model uses Charlson Comorbidity Index to identify comorbidities.	The Elixhauser-Bottle Comorbidity Index will be used within the new model to identify comorbidities.
Frailty	Frailty is not one of the casemix factors within the current HSMR model.	Frailty WILL be included within the new model, using the Global Frailty Index,
Palliative care	Currently adjusted for in the model	Not adjusted for in the model
All other casemix factors remain the same		

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4.0 Adult Mortality Structured Judgement Reviews (SJRs) & Learning

4.1 Primary Structured Judgement Reviews

The Trust overall reviewed 58% of cases, with the divisional performance presented in Table 2. below.

Although the aspiration is that all Trust deaths are reviewed, there is pragmatically a minimum target set of 20% in each directorate. There is work ongoing to support those specialties who have historically returned low review figures with continued improvement noted over the past twelve months across each of the specialities requiring support.

Table 4: Primary Structured Judgement Review Annual Performance

	April – June 2024			July - September 2024			October - December 2024			January – March 2025			Annual Totals		
	Deaths	Reviews	%	Deaths	Reviews	%	Deaths	Reviews	%	Deaths	Reviews	%	Deaths	Reviews	%

Medicine	313	148	47%	265	127	48%	343	149	43%	369	176	48%	1290	600	47%
Surgery	57	57	100%	74	74	100%	99	95	96%	88	75	85%	318	301	95%
DCS	32	23	72%	43	36	84%	46	39	85%	43	21	49%	164	119	73%
WAC	0	0	N/A	1	1	100%	0	0	N/A	0	0	N/A	1	1	100%
Total	**402**	**228**	**57%**	**383**	**236**	**62%**	**488**	**282**	**58%**	**500**	**272**	**54%**	**1773**	**1021**	**58%**

The avoidability of death score at Primary SJR is used to determine cases which require escalation for a Secondary SJR, which are those cases with scores 1-3. Some cases may be directly referred for a Datix incident review where there is already a concern that a clinical incident has occurred. Where relevant, those cases will be reviewed at the Patient Safety Incident Response Framework (PSIRF) Level 2 Triage meeting where the level of investigation will be determined. In cases requiring further investigation the avoidability of death is only finally determined after an incident investigation has been completed or after a coroner's inquest where applicable.

Table 5: Avoidability Scores at Primary Review 2024-2025

Avoidability Scores	Medicine	Surgery	DCS	WAC	TOTAL
Score 1 Definitely avoidable					
Score 2 Strong evidence of avoidability	1		1		2
Score 3 Probably avoidable (more than 50:50)	3	1	4		8
Score 4 Possibly avoidable but not very likely (less than 50:50)	14	11	8		33
Score 5 Slight evidence of avoidability	75	21	8		104
Score 6 Definitely not avoidable	461	268	98	1	828

4.2 Secondary Reviews 2024-2025

For the deaths which occurred during 2024-2025, 42 were referred for a secondary review which is a slight increase from 38 cases in the last year's annual report. It should be noted that a request for a secondary review is not always due to the avoidability of death score or poor care. Some specialities trigger a secondary review if a second opinion/specialist opinion is required, or a need to highlight an issue to another speciality involved in patient's care.

Out of the 42 cases nine patients were given an avoidability of death score of 1 or 3 at the primary review. Please see the breakdown of all the outcomes in Table 6.

Table 6: Avoidability Scores at Secondary Review

Primary SJR Avoidability Scores	Cases escalated for secondary SJR	Post Secondary Review Avoidability	
		Number of cases	Outcomes
Score 1 Definitely avoidable	0	0	N/A
Score 2 Strong evidence of avoidability	2	1	Awaiting a review
		1	Score 6 Definitely not avoidable

Score 3 Probably avoidable (more than 50:50)	8	2	Score 4 Possibly avoidable but not very
		1	Score 3 – AAR to be arranged
		4	Local Incident management review in line with PSIRF principles
		1	Awaiting review
Score 4 Possibly avoidable but not very likely (less than 50:50)*	10	1	PSII
		3	Local Incident management review in line with PSIRF principles
		5	Awaiting a review
		1	Score 5 Slight evidence of avoidability
Score 5 Slight evidence of avoidability*	5	3	No issues identified
		1	Awaiting a review
		1	Local Incident management review in line with PSIRF principles
Score 6 Definitely not avoidable*	18	3	Awaiting a review
		6	Comments requested and no issues identified
		9	Score 6 Definitely not avoidable

* Please note that cases scoring 4-6 do not require escalation for Secondary Review. A secondary review is also triggered by a poor care score.

4.3 Learning from Structured Judgement Reviews

The mortality review proforma has been designed to capture both positive and negative learning.

Learning from deaths is shared in the divisional Safety and Quality meetings and speciality governance meetings.

Key positive themes arising from the outcomes of SJR Mortality Reviews during 2024-2025:

- Good communication with the family and patient.
- Good documentation.
- Prompt investigations.
- Early identification of patient's condition and ceilings of care.
- Multi-disciplinary approach and decision making.
- Involvement of the Palliative Care Team.

Key negative themes arising from the outcomes of SJR Mortality Reviews during 2024-2025:

- DNACPR decision making and delays in initiating a DNACPR.
- Missed escalation of patients.
- Lack of /delayed involvement of the palliative care team

5.0 Learning Disabilities (LeDeR) Deaths, Mental Health Deaths Reviews & Learning

5.1 Learning Disabilities (LeDeR deaths)

There were 35 deaths of patients with Learning Disabilities or Autism in 2024-2025, all of these have had a Structured Judgement Review completed.

Table 7: LeDeR and Autism Deaths Reviews 2024-2025

	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	March	Totals
LeDeR	1	2	3	0	1*	4	1	2	3	5	4	3	29
Autism							1		2	1	1	1	6
Total	1	2	3	0	1	4	2	2	5	6	5	4	35

Figures include ED patients as well

*Patient had both LD and autism – counted once

Excellent care was reported in 7 cases. Good care was reported in 28 cases. In 27 cases death was 'Definitely not avoidable' and in 8 cases the death had a "slight evidence of avoidability' with reasoning for this judgement outlined in Table 8a below.

Table 8a. Reasoning for Score 5 allocation in LeDeR / Autism Death Reviews

Case	Score	Reasoning
1	5	Score of 5 as unsure if any missed head injury that was not immediately evident on the CT head.
2	5	Brain metastasis (intra op ICH)
3	5	The patient's cardiac arrest prior to hospitalization lead to hypoxic brain injury. Should the reason for arrest had been investigated prior to arrest, it might have been avoidable.
4	5	No cause of death has been documented.
5	5	Giving a score of 5 as there is no clear cause of death documented in the medical notes.
6	5	The death might have been avoidable had the patient been reviewed earlier in the ED, CT scan done earlier to diagnose acute hydrocephalus with posterior fossa tumour before the arrest and crash call.
7	5	Patient had out of hospital cardiac arrest. Initial resuscitation successful. Patient stabilised but unfortunately had a further cardiac arrest. Second resuscitation unsuccessful and decision taken to stop. Death referred to coroner as concerns regarding drug overdose.
8	5	The patient attended ED very unwell. He had multiple co-morbidities. He would have been very unlikely to survive the admission

Whilst currently secondary reviews are only mandated for avoidability scores of 1-3, going forwards for mental health and LEDER /autism deaths consideration will be given to extending the criteria to scores of 1-5. The secondary review should where possible include a member of the mental health/LEDER autism team.

5.2 Deaths of Patients with Mental Illness

Following the MIAA Mortality review, it was recommended to create a separate group which would include patients with the diagnosis of mental illness and specifically with the diagnosis of psychosis and bipolar disorder. It needs to be highlighted, that these patients are identified via the ICD10 codes (F20 and F30) from the hospital patient systems rather than the SMI register.

There were 22 patients in 2024-2025 who had a relevant code of mental illness in their inpatient episode.

	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Totals

Schizophrenia	1	0	0	1	1	2	2	3	0	2	0	2	14
Bipolar	1	0	0	0	1	0	1	0	1	0	2	2	8
Total	2	0	0	1	2	2	3	3	1	2	2	4	22

All the patients in this group had a primary SJR completed. Excellent or good care was reported in 95% of cases. Care for 1 patient was scored as adequate. Death was definitely not avoidable for 86% patients. For the remaining 3 patients a score of 5 was allocated – reasoning for this judgement is provided in Table 8b below.

Table 8b. Reasoning for Score 5 allocation in Mental Health Death Reviews

Case	Score	Reasoning
1	5	Giving a score of 5 as there is no clear cause of death documented in the medical notes.
2	5	No cause of death documented in the clinical notes. Has given a death a voidability score of 5 as the cause of death is unclear and not documented.
3	5	I have given an 'avoidability of death judgement score' of 5 as prolonged ventilatory support could have prolonged his life on ventilator- however not likely be in his best interest. Cause of death has not been documented.

6.0 Deaths subject to StEIS /PSIRF Investigation

Reported Incidents with outcome of death

Of the incidents reported onto the Datix Incident management system in 2024 -2025 with an outcome of death 6 were classified as deaths thought more likely than not due to problems in care. A further 2 maternal deaths met the MNSI* reporting criteria.

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

6.1 Deaths investigated by MNSI.

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

The 2 maternal death incidents which met the MNSI criteria were in relation to 1x ruptured ectopic pregnancy, 1 x mother found deceased in the community.

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

6.2 Deaths subject to Trust Patient Safety Investigation (categorised as death more likely than not due to problems in care)

Of the remaining 6 cases subject to Trust investigation 2 have concluded and 4 remain ongoing.

The 2 incidents which have concluded also have been subject to Inquests with the following Records of Inquest:

Case 1

*Ms******* died on the 5th February 2024 at the Royal Preston Hospital. She had been admitted to the hospital for drainage of a perinephric abscess which took place on the 26th January 2024. Following the procedure, Ms Ms******* appeared initially to recover well before developing a further pus collection which required intervention. In the early hours of the 5th February 2024,Ms *********suffered bleeding and blood tests indicated she required a blood transfusion. The request for cross-matched blood was not correctly completed by the clinician, who had not contacted the laboratory in advance of the request being sent to highlight the urgency of the request. This in turn led to the laboratory not contacting the ward to notify them of the rejection of the sample or the possible alternative use of nonspecific blood. These factors meant that Ms ******** did not receive a blood transfusion prior to her death. At 8:10 am Ms******* suffered a cardiac arrest due to anaemia following bleeding. Attempts to resuscitate her were unsuccessful. Ms *******'s death at this time would have been prevented if she had received the prescribed blood transfusion.*

Case 2

***** *******died on 27 July 2024 at Royal Infirmary, Lancaster in Lancashire. Mr******* was admitted to Royal Lancaster Infirmary with signs of a stroke and treated with thrombolysis. He was transferred to Royal Preston Hospital the following day where mechanical thrombectomy was attempted but failed to retrieve the clot. He was returned to Royal Lancaster Infirmary where he remained unwell. He developed pneumonia and did not recover. His death was contributed to by a delay in referring Mr ********** for thrombectomy*

Summary details of the remaining 4 cases are outlined in Table 9 below – full details are provided separately to Safety and Quality Committee.

Table 9 Summary Reporting details (cases where inquest not yet concluded)

ID	Summary Reporting details	Position
154906	Male patient admitted to BVH with sudden onset severe back pain. AAA diagnosed and referred to RPH. Issues with transfer and communication. Arrived Ward 15 (vascular))1.30 reviewed by Registrar, listed for theatre as Cat 2 (within 24 hours) Pt found unresponsive at 07.25.	Ongoing PSII
154641	Male patient presented to ELHT- request to transfer for thrombectomy – no service available. Clinical assessment and parameters indicate that patient would have been a candidate for thrombectomy	Concluded Stroke panel review
171512	Female patient admitted with worsening decompensated heart failure and hyperkalaemia.	Ongoing PSII

	Delays in obtaining further bloods overnight leading to missed opportunity to provide further treatment for hyperkalaemia	
166864	Male patient admitted to major trauma ward, some gaps in alcohol management, absconded was found outside hospital site. Brought back to major trauma ward, absconded again, found collapsed on Ward 3 service corridor- cardiac arrest and death.	Ongoing PSII

7.0 Inquests

7.1 Coroner concerns (Regulation 28, Neglect Conclusion, and formal concerns)

7.1.1 Regulation 28

The Trust has received one Regulation 28 in the reporting period. This was issued by HM Senior Coroner for Lancashire and Blackburn with Darwen in September 2024 following the inquest of a 46 year old female patient with a disability (spina bifida) who died from aspiration following an acute exacerbation of asthma in ED at RPH.

In addition to concerns regarding the management of the patient's asthma there was much focus in the inquest on the patient's basic care needs of hygiene, continence care and pressure ulcer management.

Full details have been provided in a separate report to Safety and Quality Committee

7.1.2 Neglect Conclusions

A conclusion of Neglect was received in September 2024 in relation to the above inquest. No other neglect conclusions have been issued to the Trust.

7.1.3 Letters /expressions of concern from the Coroner

During the reporting period the Trust has received one letter of concern and a further verbal concern requiring a written response

The first was issued by HM Coroner for Blackpool Fylde and Wyre in relation to lack of clear communication and documentation between Blackpool and Preston Neurosurgery Teams in relation to specialist neurosurgery advice sought. A meeting was held with clinicians and Governance Teams from both trusts and a joint response provided which has been accepted by the Coroner.

The second case was raised by HN Assistant Coroner for Lancashire and Blackburn with Darwen in relation to the inquest in August 2024 of a vascular patient who had a prolonged period of care involving a stay at Finney House Community Hub.

The concern specifically related to the family statement that the patient was not eating and drinking whilst under the care of the Community Health Care Hub (Finney House) and did not receive any assistance with managing his dietary and fluid intake. This conflicted with the documentation entered on the patient's Intentional Rounding Chart.

The Coroner's concern was that there was no checking process in place to ensure that care and observations documented on the Intentional Rounding chart reflected the actual care given and needs of the patient.

The concerns raised were discussed in detail with the Chief Nursing and Chief Medical Officers of the Trust.

In response a new audit was developed within the Trust audit system, to provide assurance of the completeness and correlation of Intentional Rounding charts at Finney House. This audit incorporated a specific question that captures “Does the care documented correlate with the care as given?” This question is to be asked in conjunction with patients and relatives. The audit question required the discussion of care delivery with 5 patients/family members per week and the results input into AMaT, the Trusts audit system. This has been completed by the unit manager for each of the two intermediate care floors within the Community Health Care Hub by the unit manager. The results are awaited and will be shared with the Coroner when available. It is not possible to continue the audit given the closure of Finney House.

7.2 Learning from Inquests

In the majority of cases learning from inquests will be evidenced in the trust investigation reports shared with the Coroner and bereaved families ahead of the inquest. However, in some cases the Coroner and families provide further challenge and feedback during the inquest which provide valuable opportunities for further learning.

In the case of family feedback this is often softer learning in relation to their own experiences and views on care.

Themes in feedback from families in 2024-2025 include:

Poor communication with clinical teams caring for their relative,

Being unaware of the severity/deterioration of the patient’s condition,

Concerns not being listened to,

Nutrition and hydration,

Misunderstanding their role in the DNACPR process,

Not accepting decisions regarding patients being medically fit for discharge / failed discharge,

Deconditioning,

Having to repeat basic information to different shifts regarding their relative.

Delays in progressing through clinical pathways

Not being allowed to remain with relatives outside of visiting hours

Delays in being informed by telephone (especially overnight) of patient deterioration /fall

Not being asked if they would provide one to one care for relatives at risk when staffing levels are low

Concerns re consent process (understanding of family role in this process)

Clinical learning points/concerns highlighted by the Coroner include:

Sub optimal communication between nursing and medical teams

VTE risk assessments

Documentation of nutrition and hydration support needs and intake differing from those of visiting family members (see above)

The Coroners collectively have also raised concerns regarding discharge processes and ongoing poor communication with families

The need for the trust to progress to a 24/7 Thrombectomy service

These matters are fed back into the divisions for consideration at Safety and Quality meetings and are formally reported through the Mortality and Learning from Deaths Annual and Bi-Annual reports to the Mortality and End of Life Committee for scrutiny and discussion.

Families have also provided positive feedback on care delivered – notably in cases involving Brindle Ward at CDH, Ward 25 and Critical Care.

Inquest learning has been shared in an Inquest learning Bulletin which is attached at Appendix 2. A further Bulletin is planned for July 2025.

8.0 Perinatal, Neonatal and Child Deaths

The report on perinatal, neonatal and child deaths and the learning from these deaths is presented in separate reports to this meeting of the Committee on a quarterly basis as per the cycle of business.

The expansion of the Medical Examiner role to include neonatal deaths has provided further scrutiny from September 2024 to align with new national Medical Examiner legislation.

9.0 Medical Examiner (ME) Service

The purpose of the ME service is to provide greater safeguards by ensuring an independent review of all non-coronial deaths. Scrutiny involves three components: discussion with the bereaved next-of-kin, discussion with the treating clinician and an independent review of the clinical record.

As referenced in the Bi-Annual Mortality Report 2024 -2025 the Medical Examiner (ME) service became statutory on September 9th 2024, with the introduction of three pieces of legislation: • The Medical Certificate of Cause of Death Regulations 2024 • The Medical Examiners (England) Regulations 2024 • The National Medical Examiner (Additional Functions) Regulations 2024.

Although hosted by the Trust for convenience, ME Offices are independent of the Trust and report directly to the National Medical Examiner Office.

9.1 Medical Examiner performance data

Performance data

The implementation of the statutory system has seen a significant increase in the number of cases being handled by the ME service over 2024-2025 The majority of the increase is due to an increase in the number of deaths referred from community services. However, changes in the way Coronial services deal with cases has also had an impact. Details of case numbers for both Inpatient / ED deaths and Community deaths for each Quarter are provided below.

Table 10a. Q1 2024-25

Q1 2024-25	In patient and ED deaths		Community Deaths	
	Number	Percentage	Number	Percentage
In-patient and ED deaths	418		223 (GP-160, Hospice- 63)	

MEO reviews	418	100%	223	100%
Direct referral to the coroner	27/418	6.4%	0/223	0%
ME reviews of non-coronial deaths	386/386	100%	223/223	100%
ME/MEO conversations with the bereaved	375/418	89.7%	216/223	96.8%
Referrals to the coroner post ME review	78/418	18.6%	4/223	1.8%
Total referrals to the coroner	105/418	25.1%	4/223	1.8%

Table 10b. Q2 2024-25

Q2 2024 -25	**Inpatient Deaths**		**Community Deaths**	
	Number	Percentage	Number	Percentage
In patient and ED deaths	402		275	
MEO reviews	402	100%	275	100%
Direct referral to Coroner	35/402	8.7%	0/275	0%
ME review of non coronial deaths	367/367	100%	275/275	100%
Referrals to Coroner post ME review	80/367	21.8%	6/275	2.2%
Total referrals to Coroner	115/402	28.6%	6/275	2.2%

Table 10c. Q3 2024-25

Q3 2024-25	Inpatient Deaths		Community Deaths	
	Number	Percentage	Number	Percentage
In patient and ED deaths	480 (4 child deaths)		469	
MEO reviews	480	100%	469	100%
Direct referral to Coroner	34/480	7.1%		
ME review of non coronial deaths	446/446	100%	275/275	100%
Referrals to Coroner post ME review	44/446	9.8%	12/469	2.7%
Total referrals to Coroner	78/480	16%	12/469	2.7%

Table 10d. Q4 2024-25

Q4 2024-25	**Inpatient Deaths**		**Community Deaths**	
	Number	Percentage	Number	Percentage
In patient and ED deaths	527 (5 child deaths)		569	
MEO reviews	527	100%	569	100%
Direct referral to Coroner	64/527	12.3%	7/569*	1.2%
ME review of non coronial deaths	463/463	100%	562/562	100%
Referrals to Coroner post ME review	21/463	4.3%	9/562	1.6%
Total referrals to Coroner	84/527	16.1%	16/569	2.8%

Community deaths referred directly to the coroner are typically referred by the community provider and are not processed via the ME office. Therefore, this number only reflects the ones referred to the ME Office.

9.2 Medical Certificates of the cause of death (MCCD)

On the 9th September 2024 a new MCCD was introduced, and legislation was implemented which changed who qualifies as an Attending Practitioner (AP). The new legislation allows any doctor who has attended the deceased during life to complete the MCCD therefore widening the number of doctors eligible to complete an MCCD and hopefully reducing delays.

The requirement to register a death within 5 days of the date of death has also been removed. However, the legislation states there should be no unnecessary delays to the completion of the MCCD, to allow families to proceed with registration and funeral arrangements.

The majority of MCCDs within the Trust are issued within 3 days of death. (21 cases not achieved in Q1).

A new Medical Examiner certificate has also been introduced. This is completed by an ME when the cause of death is known, but there is no AP available within a reasonable time frame. An ME certificate can only be completed at the direction of the senior coroner. 7 ME certificate has been issued during 2024-2025.

9.3 Early Body Release

In 2024-2025 71 requests for early body release were received to meet with faith requirements, of which 62 were achieved. We were unable to meet the request on 9 occasions due to the requirement to refer to the coroner. Since the 9th of September 2024 there is an on-call service to facilitate early body release on a weekend and bank holiday.

9.4 Concerns

Q1	LTH	Community
Deaths where a significant concern about the quality of care is raised by bereaved NOK	12	3
Deaths where a significant concern about the quality of care is raised by Medical Examiner or Staff	11	7

Of the LTH deaths where significant concerns were raised by bereaved NOK in Quarter 1:
3 were reviewed by the ME and resolved after discussion with the family
4 had an SJR requested
5 were referred to the Coroner and were taken for inquest.

Of the LTH deaths where significant concerns were raised by the ME in Quarter 1:
4 were referred to the coroner and were taken for inquest
7 were referred for an SJR
1 had a Datix incident report completed

Q2	LTH	Community
Deaths where a significant concern about the quality of care is raised by bereaved NOK	9	
Deaths where a significant concern about the quality of care is raised by Medical Examiner or Staff	8	

*one patient had concerns independently raised by the ME and NOK.

Of the LTH deaths where significant concerns were raised by bereaved NOK in Quarter 2:
4 were reviewed by the ME and resolved after discussion with the family
1 had an SJR requested
4 were referred to the Coroner and were taken for inquest.

Of the LTH deaths where significant concerns were raised by the ME in Quarter 2:
5 were referred to the coroner and were taken for inquest.
2 were referred for an SJR.
2 had a Datix incident report completed.
Of the Community Deaths 0.7% were referred for further review.

Q3	LTH	Community
Deaths where a significant concern about the quality of care is raised by bereaved NOK	7	9
Deaths where a significant concern about the quality of care is raised by Medical Examiner or Staff	8	5

In 6 cases (3 community and 3 LTHTR) concerns were raised independently by family and Medical Examiner. In all cases where concerns were raised by both the family and M.E a referral was made to the Coroner.

Of the LTH deaths where significant concerns were raised by bereaved next of kin only:

2 were reviewed by the ME and resolved after discussions with family

1 had an SJR requested

1 was referred to Coroner and taken for inquest

Of the LTH deaths where significant concerns were raised by the ME only

1 was referred to Coroner and taken for inquest

2 had an SJR requested

3 had a Datix completed *

*One patient also referred to the Coroner

Overall in Q3 10.4 % of LTH deaths and 1.7% of community deaths were referred for further review.

Q4	LTH	Community
Deaths where a significant concern about the quality of care is raised by bereaved NOK	17	9
Deaths where a significant concern about the quality of care is raised by Medical Examiner or Staff	12	8

In 3 cases concerns were raised independently by family and Medical Examiner.

Of the LTH deaths where significant concerns were raised by bereaved NOK:

• 3 had a Datix submitted (1 was also referred to the coroner)

• 4 had an SJR requested

• 4 were referred to the coroner and taken for investigation.

The remainder were resolved after discussions between the ME and family members.

Of the LTH deaths where significant concerns were raised by the ME

• 3 had a Datix completed (1 was also referred to the coroner)

• 3 had an SJR requested

• 7 were referred to the Coroner and taken for investigation

9.5. Identified themes

The medical examiners continue to identify themes and trends during scrutiny. The single biggest theme identified is a lack of recognition that someone is in the last days of life. However, excellent care at the end-of-life has also been recognised Other identified issues that have been highlighted on more than one occasion are:

- Lack of documented senior review in deteriorating patients.
- Delays in antibiotic delivery in patients suspected of having sepsis.
- Delays in cancer pathways – radiology reporting and follow up appointments.
- Delayed palliative care input.
- Incorrect information being repeatedly copied and pasted in the electronic patient record.
- No DNACPR in place
- Family unhappy with nursing care
- Poor communication between wards and families
- Delays in radiology reporting
- Lack of timely discharge summaries
- Over investigation of frail elderly patients

9.6 Challenges

Staffing and workload remain, resulting in the significant delays seen in the time to scrutiny over the last quarter. The reasons for this are multi-factorial:

• A vacancy in the ME team, which had been recruited to, but the ME did not start until April.

• A large volume of ME leave during February and March (half term and the end of the leave year). Some weeks we were 5 or more sessions down of ME time.

• Ongoing high death rates over the winter months

• Some MEs underperforming in terms of the number of cases reviewed per session. Staffing and consequently funding for Medical Examiner offices is based on the assumption an ME will review an average of 7 cases per 4-hour session. On review of cases scrutinised over a 3 month period only 4 of the 12 MEs were performing at this level, with the majority reviewing around 5 cases per session and 3 MEs reviewing less than 3 cases per session. This creates a significant deficit between the case load and the number of cases being scrutinised. All MEs who were significantly underperforming in terms of workload have been spoken to and are aware of the need to improve. The backlog has now been cleared and performance is back at the typical 24 hour turn around for the ME office. This is largely due to the efforts of 2 MEs who undertook a significant number of extra scrutinies outside of their normal session times.

This backlog has also been compounded by new guidance which came into force with the statutory system. Under previous guidance an ME could undertake a review if they did not have personal involvement with the patient. However, new guidance from the National Medical Examiner's office confirms an ME should not undertake a review if the person has been cared for by a member of their team. Nearly 40% of LTHTR MEs are Critical Care consultants which has caused some challenges ensuring a timely review on occasion. However, the team as a whole has shown flexibility in minimising this as much as possible.

Changes to coronial service practices and conflicting guidance from the Chief Coroner and National Medical Examiner, regarding the responsibilities of each service and the way cases should be dealt with, have also caused some confusion. However, the Lead Medical Examiner and Medical Examiner Officer have been meeting monthly with the Senior Coroner and Coroners Officers, and we have established local practices which have resolved these issues.

10. Mortality Improvement Plan

Key elements are outlined below:

10.1 Engineering Better Care Project – Unexpected Death investigations

With the aim of offering bereaved families a clearer and more responsive service, and to support clinicians and governance teams involved in all types of death investigation in September 2022 the Inquest and Mortality Team, supported by the Continuous Improvement Team, launched the Engineering Better Care (EBC) Project.

The implementation of Patient Safety Incident Response Framework (PSIRF)and pressures within the Divisional Governance Teams continue to significantly affect the capacity to engage in the programme. The key action that still requires work is the unification of all investigation processes in relation to a death of concern. Whilst PSIRF has had a positive impact on this process with some test cases having been subject to a collaborative approach in terms of information sharing using a file sharing portal and early involvement of the Inquest Team in After Action Reviews of death cases, there is still further work to be done. A review of the position will be taken in Quarter 2 2025-2026.

10.2 Maturity of learning from deaths framework

As evidenced in the report there are multiple opportunities for learning from deaths:

Inquests
Bereavement team
Medical examiner
SJRs
Incident investigations

The priority in 2025 is to develop the Mortality Improvement Plan, part of this work will be to establish a process for the identification of themes from the multiple sources outlined above, to identify, where these relate to ongoing improvement work or audit, and for the remainder, to review the process for actions, learning and reporting.

10.3 Inquest Education and Training

Recent engagement with senior nursing colleagues has highlighted concerns and some misconceptions from our nursing colleagues about the inquest process and the consequences of being involved as a witness, to the point where this may be one of the factors affecting some nursing practices where staff do not feel empowered and confident to make individual clinical judgements.

While the Inquest Team has consistently provided individual preparation and support for staff attending inquests receiving positive feedback from both witnesses and the Coronial service, routine regular inquest training sessions were suspended prior to the COVID-19 pandemic due to low attendance. Bespoke group training has continued to be offered on request.
To address these concerns, the Inquest Team is actively collaborating with senior nursing leaders. A dedicated resource file has been added to the Intranet, and tailored training sessions and presentations will be promoted through the NMAHP and Always Safety First forums.
An Inquest Learning Bulletin including some “myth busting” has been provided and is attached at Appendix 2. with a further bulletin planned for July 2025.
In November 2024 the Head of Inquests and Mortality and HM Coroner Mr Christopher Long provided a presentation on Inquest attendance at the Clinical Directors Development Day which was well received with high feedback scores – we plan to provide a similar presentation to Nursing and AHP colleagues in 2025 – 2026- date dependent on Coroner availability.

10.4 TELSTRA training

The TELSTRA data is provided monthly to the Trust and referenced in a number of Safety and Quality reports – however feedback is that some colleagues are unclear on the functionality - how the data is calculated, what it means, and how they might usefully use it. In response there are to be two lunchtime online training sessions planned in Quarter 2 2025-2026. These are open to all and will be provided by TELSTRA with dates to be circulated by the 30thJune 2025.

On 29th April 2025 TELSTRA provided an online training presentation to the Trust on national health inequalities – with particular reference to the relationship between deprivation, frailty and bed days. This is a valuable resource and will be added to the Inquest and Mortality intranet site.

11. Summary

Mortality benchmarking demonstrates that the Trust **HSMR** of **75.2** and SMR of **74.0** are significantly lower than expected for the 12-month period of July 2023 / June 2024.

The Trust **SHMI** for the data period of June 2023 – May 2024 is **92.19** and within expected range.

The **SMR for children** is **88.9.** and within expected range**.** The latest 12-month SMR for neonatal deaths including stillbirths is **92.4** and within expected range.

The Trust completed SJRs (Structured Judgement Reviews) for 58% of deaths during 2024 -2025. Key themes of learning from SJRs have been presented, as well as the learning from LeDeR reviews, StEIS /PSIRF reported deaths and Inquests.

Six Incidents under the category of “death more than likely due to problems in care” were reported onto StEIS during the reporting period under PSIRF and a further two cases under the MNSI framework.

One Regulation 28 has been received.

Medical Examiner review of cases remains consistently high despite statutory changes and pressures within the service.

Whilst there is much learning that has been identified and shared, there remains a need to develop a cohesive Learning from Deaths Framework going forwards.

12. Financial implications

None identified

13. Legal implications

The death related cases identified at section 6.0 may be subject to litigation.

14. Risks

The Regulation 28 issued in September 2024 represented a reputational risk to the Trust. This has been managed by a comprehensive action plan which has been shared with and accepted by the Coroner, the ICB, CQC and the patient's family.

15. Impact on stakeholders

Involvement in Inquests and other investigation processes following the death of a loved one has a significant impact on bereaved families. The trust is committed to providing compassionate communication and support to bereaved families at all touch points, and to providing the highest quality evidence to the Coroner to enable the Coroner and bereaved family to understand events leading to the death.

The learning from multiple sources described in the report that has been shared with clinical teams to date will benefit both patients and bereaved families going forwards.

16. Recommendations

It is recommended that the Safety and Quality Committee:

Endorse the report and confirm it is assured of the robust arrangements in place relating to the management of patient deaths.

Appendix 1

Mortality Benchmarking

This report is based on the M09 dataset. As there are high volumes of residual codes recorded in Dec-24, a one-month lag has been applied. The data period for this report is Dec-23 – Nov-24. This report is based on the new H/SMR+ models.

Figure 1 HSMR+ Regional Acute Peers Benchmark, Dec-23 – Nov-24

The HSMR+ for LTHTR is 75.2 and significantly 'lower-than-expected' for the most recent 12month period. This is a fractional increase from the previously reported figure (75.4).

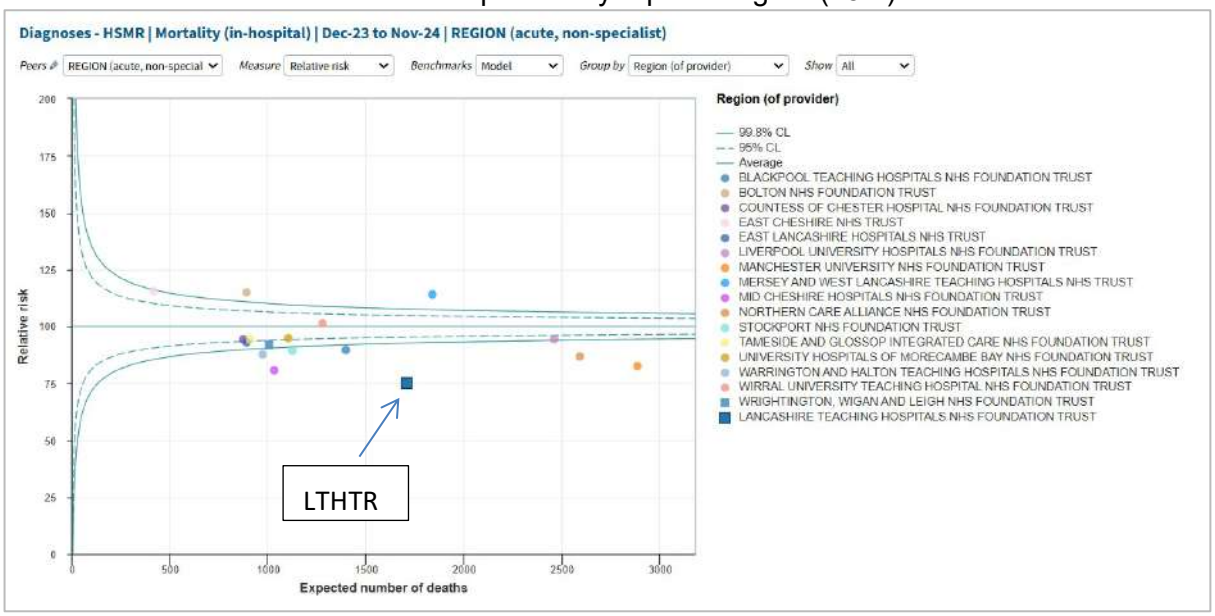
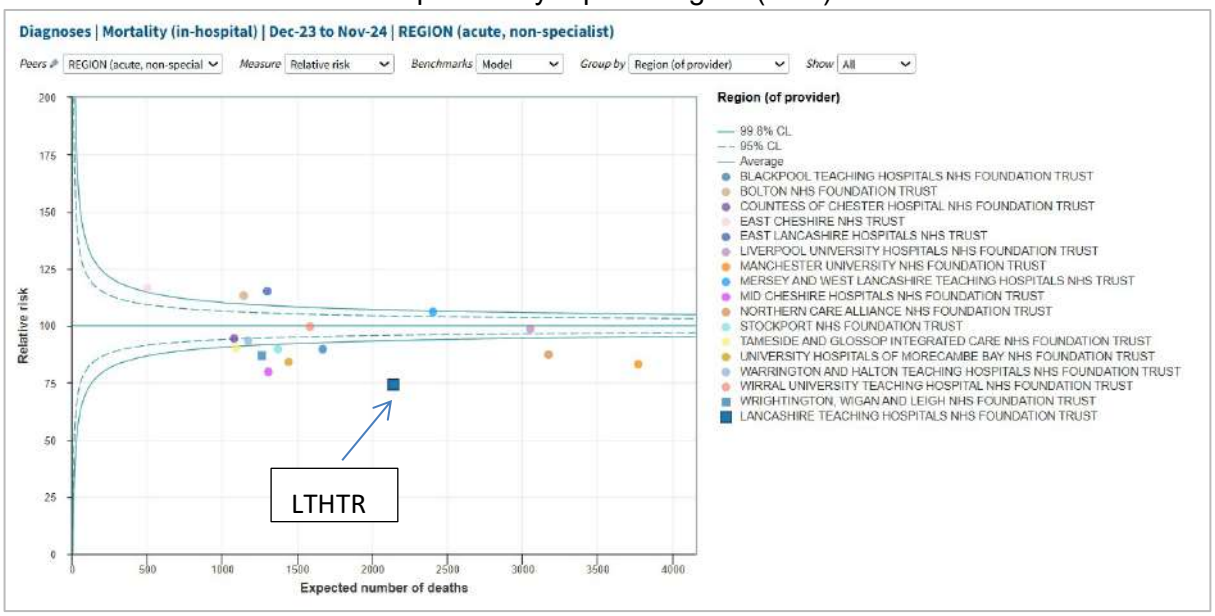


Figure 2: SMR+ Regional Acute Trust Benchmark, Dec-23 – Nov-24

The SMR+ for LTHTR is 74.0 and significantly 'lower-than-expected' for the most recent 12month period. This is a fractional increase from the previously reported figure (73.9).



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Appendix 1

Figure 3: SMR+ COVID-19 - Trust with Similar Bed Base & admissions, Dec-23 – Nov-24

The funnel plot provides a standardised mortality figure for Covid-19, which is 106.8 and within the expected range. The peer group compares the Trust against similar providers, in terms of bed base, case-mix, and the volume of admissions with either a primary or secondary COVID19 diagnosis, where U07.1 or U07.2 has been coded in any position.

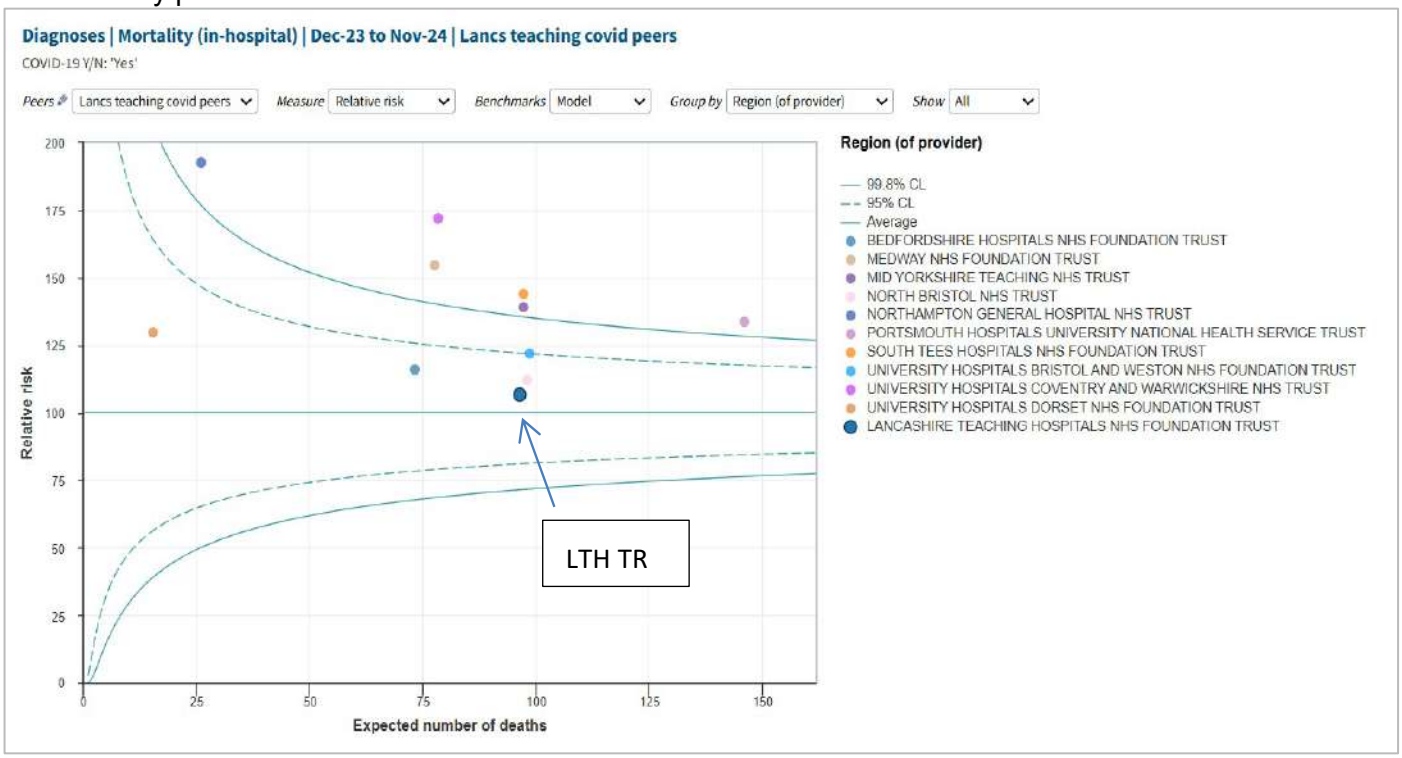
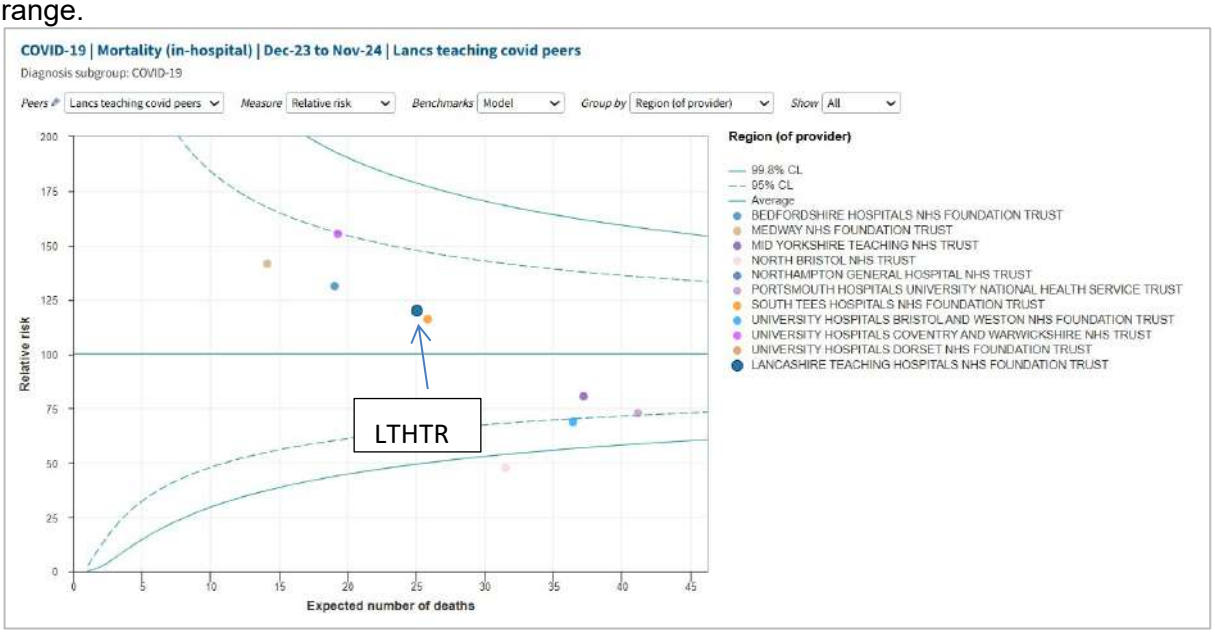


Figure 4: HSMR+ COVID-19 subgroup - Trust with Similar Bed Base & admissions, Dec-23 – Nov-24

The new HSMR+ now includes patients who presented with a primary diagnosis of COVID19, these are mapped to the COVID-19 subgroup within the viral infections group. The relative risk is 119.7, and within the expected range.



Appendix 1

Figure 5 - SMR Regional Acute Trust Benchmark Child mortality, Dec-23 – Nov-24

Please note that the new H/SMR models do not include or provide risk adjustment for still birth mortality (those within the ICD10 (3-char) P95 'Foetal death of unspecified cause' group).

The twelve-month rolling SMR for children is 88.9 and statistically 'within-expected'. There were 19 deaths during the twelve-month period, compared to an expected figure of 21.4. See figure 5a for trend analysis.

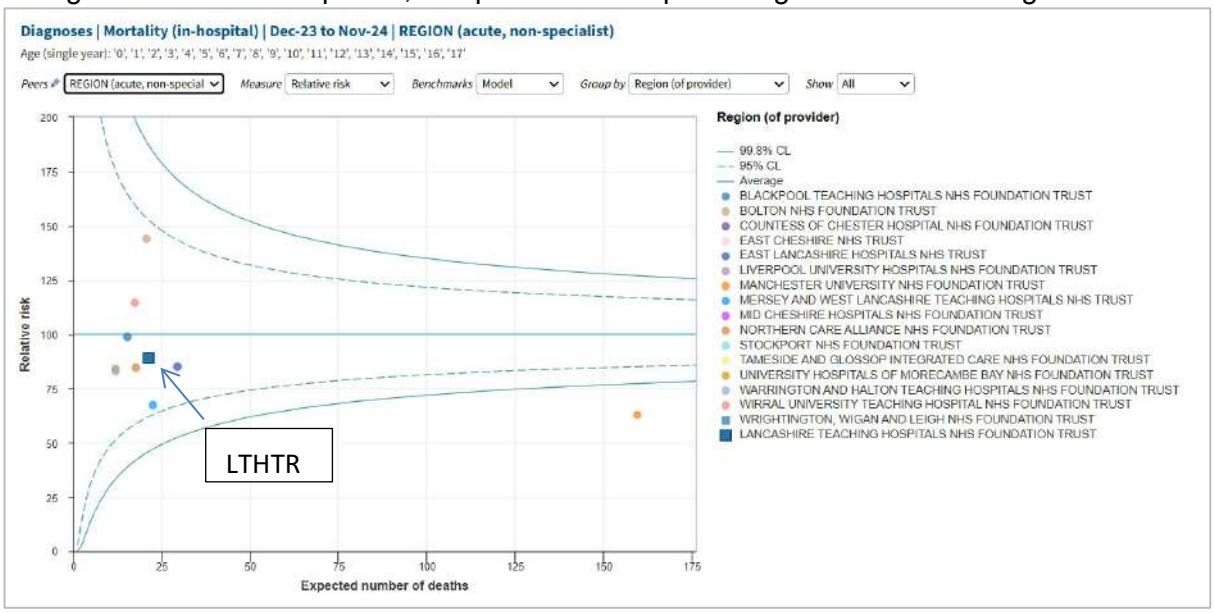
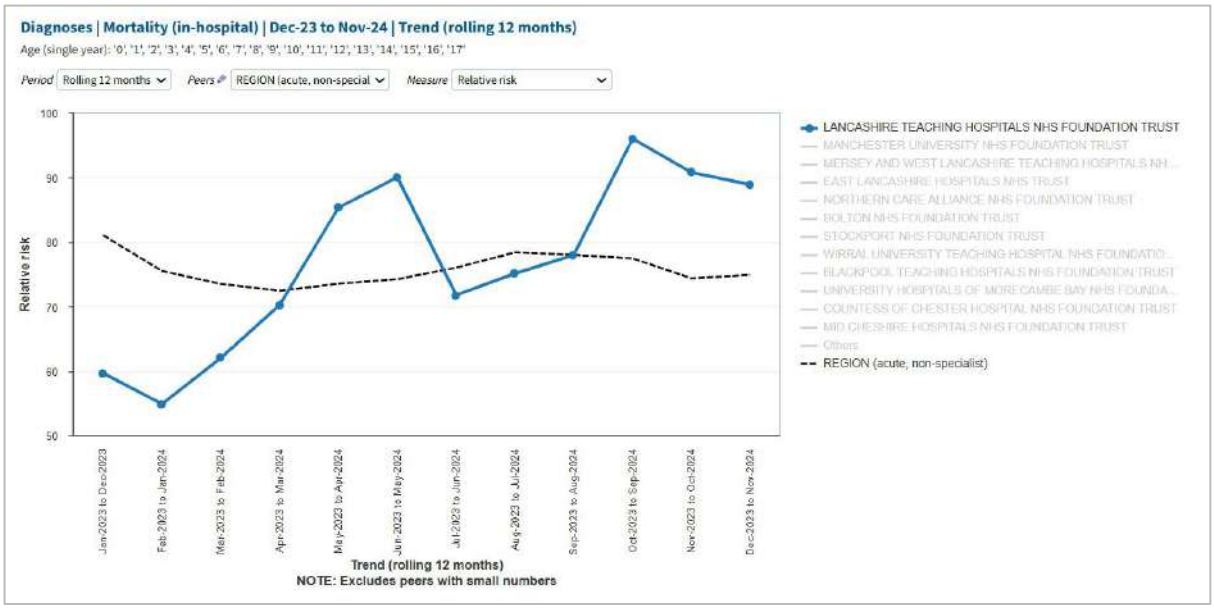


Figure 5a SMR child mortality – rolling twelve-month peer comparison



Appendix 1

5b SMR child mortality – monthly observed mortality

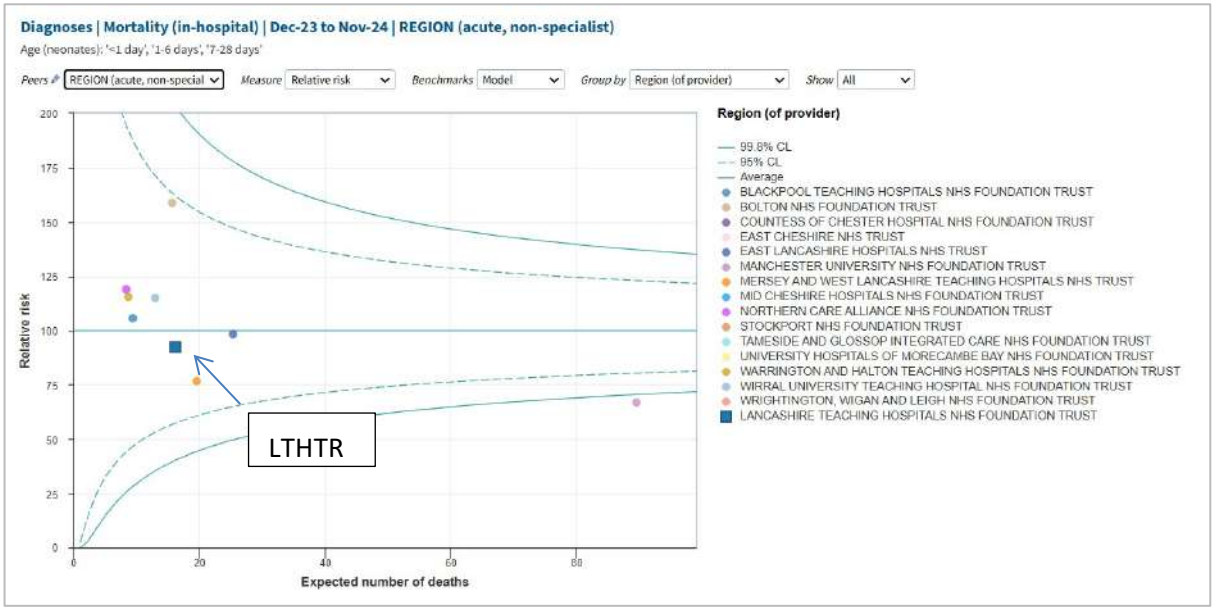
The latest data reveals a variation in the monthly relative risk and observed deaths figures.

Nov-24 observes 0 deaths and records an SMR of 0.0.

Trend (month)	Superspells	% of All	Spells	Observed	Crude rate (%)	Expected	Exp. rate (%)	Relative risk	Low CI	High CI
All	18176	100	18191	19	0.10	21.37	0.12	88.93	53.52	138.88
Dec-23	1475	8.12	1476	0	0	1.42	0.10	0	0	258.3
Jan-24	1605	8.83	1607	0	0	1.50	0.09	0	0	245.29
Feb-24	1519	8.36	1519	3	0.20	2.53	0.17	118.61	23.84	346.56
Mar-24	1540	8.47	1541	2	0.13	1.77	0.11	113.12	12.7	408.42
Apr-24	1414	7.78	1415	3	0.21	1.92	0.14	156.25	31.4	456.53
May-24	1524	8.38	1526	1	0.07	1.65	0.11	60.74	0.79	337.94
Jun-24	1416	7.79	1417	0	0	1.34	0.09	0	0	273.41
Jul-24	1516	8.34	1516	1	0.07	2.15	0.14	46.52	0.61	258.82
Aug-24	1425	7.84	1426	2	0.14	1.76	0.12	113.64	12.76	410.3
Sep-24	1477	8.13	1481	5	0.34	1.76	0.12	283.79	91.46	662.27
Oct-24	1572	8.65	1573	2	0.13	2.09	0.13	95.62	10.74	345.24
Nov-24	1693	9.31	1694	0	0	1.48	0.09	0	0	247.58

Figure 6: SMR neonatal mortality data (<1 day – 28 Days), Dec-23 – Nov-24

The latest 12-month SMR for neonates aged between zero and twenty-eight days is 92.4 and is within the expected range. The SMR value has followed an upward trajectory over the year, however the most recent data period observes a slight decrease. See figure 6a for further details.



Appendix 1

Figure 6a SMR neonatal mortality data (<1 day – 28 Days) -rolling twelve-month peer comparison

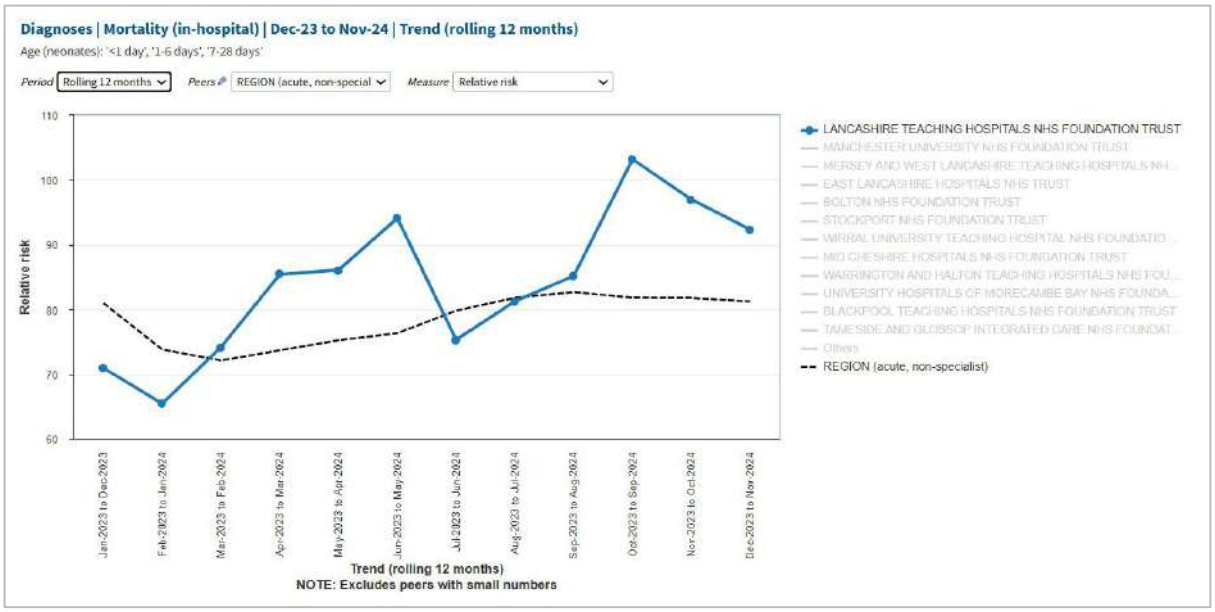


Figure 6b SMR neonatal mortality data (<1 day – 28 Days) – monthly observed mortality for the period from Dec-23 – Nov-24 No months are considered statistically significant.

Trend (month)	Superspells	% of All	Spells	Observed	Crude rate (%)	Expected	Exp. rate (%)	Relative risk	Low CI	High CI
All	5110	100	5113	15	0.29	16.24	0.32	92.36	51.65	152.34
Dec-23	387	7.57	387	0	0	0.94	0.24	0	0	388.8
Jan-24	437	8.55	438	0	0	1.11	0.25	0	0	331.7
Feb-24	398	7.79	398	3	0.75	2.08	0.52	144.06	28.95	420.93
Mar-24	407	7.96	407	2	0.49	1.32	0.33	150.95	16.95	545
Apr-24	415	8.12	416	0	0	1.59	0.38	0	0	230.6
May-24	436	8.53	436	1	0.23	1.07	0.25	93.61	1.22	520.83
Jun-24	408	7.98	408	0	0	1.08	0.26	0	0	340.64
Jul-24	458	8.96	458	1	0.22	1.45	0.32	69.16	0.9	384.8
Aug-24	472	9.24	472	2	0.42	1.45	0.31	138.40	15.54	499.71
Sep-24	442	8.65	442	4	0.90	1.45	0.33	276.15	74.29	707.01
Oct-24	444	8.69	445	2	0.45	1.53	0.34	130.92	14.7	472.68
Nov-24	406	7.95	406	0	0	1.18	0.29	0	0	310.52

Figure 6c SMR Neonatal mortality data – length of stay for the period from Dec23 – Nov-24

LOS banding '0 Days' reports as statistically significantly higher-than-expected

LOS (6 bands)	Superspells	% of All	Spells	Observed	Crude rate (%)	Expected	Exp. rate (%)	Relative risk	Low CI	High CI
All	5110	100	5113	15	0.29	16.24	0.32	92.36	51.65	152.34
'0 Days'	1221	23.89	1221	5	0.41	1.03	0.08	487.57	157.12	1137.82
'1-6 Days'	3667	71.76	3668	7	0.19	9.87	0.27	70.94	28.42	146.17
'7-13 Days'	118	2.31	120	2	1.69	2.66	2.26	75.16	8.44	271.37
'14-20 Days'	26	0.51	26	0	0	0.53	2.04	0	0	690.45
'21-27 Days'	21	0.41	21	0	0	0.45	2.14	0	0	816.42
'28+ Days'	57	1.12	57	1	1.75	1.71	2.99	58.61	0.77	326.12

Appendix 1

Still birth mortality – Dec-23 – Nov-24

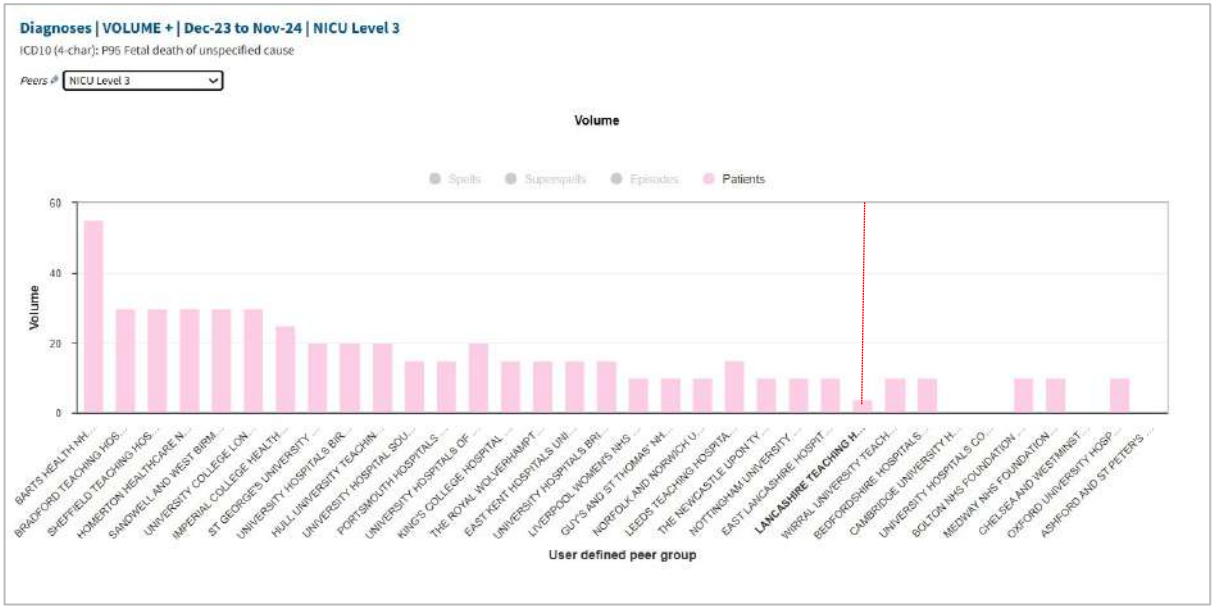
The new H/SMR+ models no longer include or provide risk adjustment for still birth mortality (those within the ICD10 (3-char) P95 'Foetal death of unspecified cause' group). The below analysis provides a mortality trend in the volumes of observed deaths within the P95 group.

There were 4 still births, during the period from Dec-23 – Nov-24. The table of data in figure 7 includes very low volumes of activity, as the code only includes deceased neonates. The Trust might want to assure themselves that where a post-mortem and or MDT case review was conducted, and the cause of death ascertained that the data and coding associated with these babies was appropriately re-coded and re-submitted in their monthly commissioning data set.

Figure 7.0- Still birth mortality – Dec-23 – Nov-24

Trend (month)	Spells	Superspells	Episodes	Patients
All	5	5	5	5
Nov-23	1	1	1	1
Dec-23	1	1	1	1
Jan-24	0	0	0	0
Feb-24	0	0	0	0
Mar-24	0	0	0	0
Apr-24	2	2	2	2
May-24	0	0	0	0
Jun-24	0	0	0	0
Jul-24	0	0	0	0
Aug-24	1	1	1	1
Sep-24	0	0	0	0
Oct-24	0	0	0	0

Figure 7a Observed Stillbirth mortality (NICU Level 3 comparison) – Dec-23 – Nov-24



Appendix 2

Always Safety First

Organisational Learning Bulletin

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Version 1 – November 2024

FAO : All Staff

Inquests Learning Bulletin

Welcome to our first Inquest Learning Bulletin – where we will share some learning and family feedback from inquests and provide useful information regarding the inquest process.

The Inquest and Mortality Team – providing an efficient and effective inquest service which supports the coronial process, bereaved families, trust witnesses and the Trust Safety and Learning Agenda

When Is An Inquest Held?

An Inquest is held when there is an unnatural element to the death, or where the events leading to death are undetermined.

What Is The Purpose Of An Inquest?

- The purpose of an inquest is twofold: The bereaved family are front and centre of the process. The inquest helps them to understand the events leading to their loved one's death and provides an opportunity for them to have any concerns and questions answered.
- At an inquest the Coroner is required to determine the following:
  - Cause of death,
  - Who When Where and How the person died
  - The Conclusion (used to be called the verdict)

Appendix 1

Always Safety First

Organisational Learning Bulletin

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Version 1 – November 2024

Myth Busting!

Attending inquest can be a very stressful time and can lead to some unfounded worries and concerns. Here are a few of the most common ones;

" Inquest ! Oh no ! – I'm going to be in trouble"

An inquest is NOT a trial – there is no prosecution or defence, and it is not a blame process – it is a fact finding exercise and we are there just to assist the Coroner in reaching his conclusions

Inquest – that's just for Consultants right?

Well actually no – whilst the majority of inquest witnesses are Consultants we have taken staff of all grades and professions to Inquests – including nurses of all grades, doctors in training, AHPs, Laboratory Managers, Medical Device Engineers, receptionist and porters. We should all see it as part of our professional duty

Inquest ? – we must have done something wrong ?

Not necessarily … in 80% of cases there are no concerns that the trust has caused or contributed to the death – but these cases are just as important – we need to explain to the family and coroner the events that led to the death – even when care has been exemplary ! ..**it is our final act of "Compassionate Care"**

So what does this mean for me - I would feel so unprepared?

No need to feel this way – The Trust has a dedicated inquest team who manage the whole process and will give you all the support and preparation you need.

Supporting Information

Here are some useful links to inquest information and guidance and our Inquest Team contact details:

- Inquest and the coroners court | Weightmans
- Guidance for attending inquest
- Martha's Rule – second opinion
- DNACPR patient leaflet
- DNACPR POLICY
- **Email:** Inquestandmortality@LTHTR.nhs.uk

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Always Safety First

Organisational Learning Bulletin

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Version 1 – November 2024

Feedback From Families

- Families do not feel that their concerns about their relative's deterioration are listened to.

Make sure that families are involved in care planning and that any concerns that they raise are documented and included in handover. Consider Martha's Rule.

- Families are not clear on their role in the **Do Not Attempt Cardiopulmonary Resuscitation** (DNACPR) or withdrawal / limitation of care and are sometimes under the impression that the decision rests with them.

DNACPR discussions are highly emotive and difficult for families – it is so important that their views on what their family member would want in these situations are taken into consideration – however we must make clear that the decision will be made by the clinical team. Providing families with written information can be helpful – and also sensitively returning to the discussion to check understanding.

- Families feel that they were not told soon enough about their relative's deterioration and approaching end of life – sometimes being given an overly optimistic view of the patient's condition – more often at weekends or out of hours.

Early communication with families regarding deteriorating patients is important so that they can come into hospital to be with their relative at this very difficult time – please make that call sooner rather than later – do seek senior nurse/clinician support if necessary

- The Hospital have the wrong date of death

This happens when the patient dies close to midnight and death is not verified until after midnight – the time death that is verified is the time that goes onto the death certificate, but families are aware that the patient's time of death is earlier. This is really important to families as one family told us " we have two death anniversary days to deal with " – please wherever possible get the death verified promptly especially when close to midnight.

- Early raising of concerns

Whilst it is paramount that we are, at all times open, honest and transparent with families it is important that we convey that whilst they may be a concern, that this will be subject to the trust processes of incident investigation and confirmation that will be shared with families.

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Always Safety First

Organisational Learning Bulletin

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Version 1 – November 2024

Patient Safety Learning From Inquest – Case Reviews

Whilst inquest cases of concern will have been subject to Learning Reviews and Action Plans within the Trust prior to the inquest, the Coroner can offer further valuable insight and additional learning. Here are some examples:

Death From Pulmonary Embolus

The Trust has had 2 inquests involving patient death from Pulmonary Embolus in the past 12 months.

- **Case 1** involved a young man who died from a PE 10 days after discharge following spinal surgery
- **Case 2** involved a patient admitted to a medical ward with a ? Urinary Tract Infection who died 6 days following her admission with sudden deterioration and collapse.
- In both cases (with different Coroners) concerns were raised regarding how sub optimal communication between nursing and medical teams may have contributed to VTE risk not being re assessed when they had been a change in the patient's condition or non - compliance with treatment.
- In **Case 1** the Coroner concluded that there had been a missed opportunity to re assess the patient's VTE risk on discharge – the patient had refused a dose of VTE prophylaxis and was non - compliant with Anti Embolic Stockings. There was no documentation in the case notes to confirm that discussions between nursing and medical staff had taken place regarding these issues.
- In **Case 2** whilst VTE assessments were completed on admission and subsequently – the fact that the patient had a further decrease in mobility from that which would have been reasonably expected, was not recognised and factored into the VTE assessments which would have provided an opportunity to further assess the risk/ benefit of VTE prophylaxis for the patient.

Learning

- How do you facilitate nursing /medical communication and documentation of such communication within your teams?
- Do nurses routinely attend ward rounds? – if so - how is their input documented?
- Do you have a multi -disciplinary board round or handover? – and how is this sharing of information documented and communicated to other colleagues and incoming shifts?
- Could you review within your teams and see if we can do this better?
- Documentation is key – in both cases above, the discussions may well have taken place, but if not documented the information is not available for the wider team to consider and at inquest " If it isn't documented it didn't happen " can get us into difficulties

Appendix 1

Always Safety First

Organisational Learning Bulletin

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Version 1 – November 2024

Cases Involving Nutrition And Hydration

Nutrition and Hydration is a common topic of discussion at many inquests even if it is not causative or contributory to the death.

Below are some quick "Do's and Don'ts" learning points from inquests to share:

Do…

✓ Weigh your patients regularly

✓ Check in with families – do you have a shared understanding of what the patient is eating and drinking and what their support need are ?

✓ Document fluid balance correctly - the trust has had a recent issue with how urine output is documented for catheterised patients. Please make sure that the follow the steps in the **Learning Bulletin**

Don't…

☒ Assume that patients are consistent in their need for assistance with eating and drinking - re assess regularly.

☒ Assume that families understand the effects of dementia on nutrition and hydration – please have sensitive conversations with families as to the decreasing drive to eat and drink for patients with end stage dementia.

Back To Basics

- In a recent high profile inquest the Coroner raised concerns that basic care involving continence, suitable clothing and pressure area management were not adequately provided for a patient in an emergency setting.
- Whilst in emergency and acute assessment areas the clinical teams are, of course very focused on the management of the patient's acute condition we must not forget the basics especially important with exit block and flow issues meaning that patients are staying for longer in emergency and assessment areas.
- Please – consider is this how we would like our relative to be cared for ? and importantly consider that whilst patients may be self - caring on initial presentation they may not be able to do so as their condition deteriorates, or they become more tired.

Call to Action

- Please ensure that you share the learning in your safety huddles and ward / departmental meetings.
- With immediate effect, all Matrons, Ward Managers, Clinical Managers, Clinical Directors, Medical Governance Leads, must ensure that all teams are aware of this process and use it as discussion and a training resource.

12.4 - MID-YEAR NURSE STAFFING REPORT

REFERENCES

Only PDFs are attached

12.4 - Mid-year Nurse Staffing Report .pdf

Board of Directors

Bi-annual Nursing and Midwifery Workforce Review

1. INTRODUCTION

This report presents the findings of the bi-annual nurse safe staffing review at Lancashire Teaching Hospitals NHS Foundation Trust 2024. The review triangulates workforce data with key indicators of patient safety, patient experience and clinical effectiveness to provide assurance that nurse and midwifery staffing levels that have been set across the Trust remain safe and appropriate to deliver high-quality care.

The report fulfils the requirement outlined in the Developing Workforce Safeguards (NHS Improvement, 2018), National Quality Board guidance (NQB, 2016), Nursing and Midwifery Code of Practice (NMC, 2015) National Institute of Clinical effectiveness (NICE, 2016) staffing guidance on safe and sustainable and productive staffing and Care Quality Commission (CQC) regulation 18 (1) ensuring that providers have sufficient numbers of suitable qualified competent, skilled and experienced staff to meet people's care and treatment needs to meet the requirements of fundamental standards of care. More specifically, these include:

- Improvement and Assessment Framework for Children's and Young People's (CYP) health services (2016).
- Safe, Sustainable and productive staffing: An improvement resource for neonatal, children and young people services (2017).
- Safe, sustainable and productive staffing – adult inpatient wards in acute hospitals (2018).
- Safe, sustainable and productive staffing an improvement resource for urgent and emergency care (2017).

2. SCOPE

The review triangulates nurse staffing and outcome data across all four clinical divisions - Surgery, Medicine, Women's and Children's and Diagnostics and Clinical Support (DCS) - encompassing admission and assessment units, as well as inpatient areas for neonates and children and young people.

Medicine Division	Surgical Division	Women's and Children	Diagnostic and Clinical Support (DCS)
ED (RPH) including ED Children's	Ward 2a	Ward 8	Critical Care Unit (CrCU)
Acute Assessment Unit	Ward 2b	Paediatric Assessment Unit (PAU)	
Bleasdale Ward	Ward 2c	Paediatric Day case	
NRU (Barton)	Ward 3	Neonatal Unit (NNU)	

AMU	Ward 4	Gynae Ward RPH	
CCU RPH	Ward 10	Gynaecology Early Pregnancy Assessment Unit	
Ward 17	Ward 11		
Ward 18	Ward 12		
Ward 21	Ward 14		
Ward 23	Ward 15		
Ward 24	Ward 16		
Ward 25	Major Trauma Ward		
Enhanced High Care Unit	Ribblesdale Unit		
ED (CDH)	Surgical Assessment Unit		
MAU (CDH)	Surgical Enhanced Care Unit (SECU)		
Brindle	Surgical Unit (CDH)		
Cardiac Unit CDH	Leyland Ward		
Rookwood A			
Rookwood B			
Hazelwood			

3. CONTEXT

Safe staffing establishments are reviewed and approved annually by the Chief Nursing Officer in collaboration with the professional judgements of the ward manager, matron, and divisional nurse/midwifery leader. Establishments are determined using an evidence-based methodology and validated audit data, in line with the requirements of the Safer Nursing Care Tool (SNCT).

This mid-year review provides a six-month update following the 2024/2025 annual review, which was approved by Trust Board in April 2025. Changes to establishments were implemented within the financial planning process from month 1 and reflected in the Health Roster system from June 202, allowing for the required six-week lead time for roster publication in accordance with Nursing and Midwifery Council (NMC) standards.

Outside of the annual safe staffing cycle of business, ward managers are empowered to take the following actions to ensure safe and responsive staffing levels:

- Substantively recruit to cover maternity leave for both Registered Nurses (RN) and Health Care Assistants (HCA).
- Request immediate bank staffing in response to changes in patient acuity or dependency, with appropriate approval controls in place via Divisional Nurse Directors (DNDs).
- Initiate an establishment review, should the ward manager, matron and DND jointly assess that the current staffing model does not meet the clinical needs of the patient population or if there has been a change to the patient cohort.

3.1. Areas requiring improvement – Update from the Annual Safe Staffing Review 2024/2025 – update

The following areas were identified for improvement as part of the 2024/2025 Annual Safe Staffing Review. This update outlines progress made to date mid-way through 2025/2026, highlighting ongoing actions and outstanding risks:

3.1.1. Healthcare Assistants (HCA)

As of May 2025, Health Care Assistant (HCA) vacancies stand at 135 WTE (Monthly trajectory is illustrated in graph 6, page 11). This remains an area of focus for the Trust as the current vacancy level presents a risk to the delivery of high-quality, safe care and a dependency on bank temporary workforce contributing to variable pay spend. However, following recent organisational changes and staff redeployments, this vacancy rate is expected to decline.

To support sustainable recruitment and development, a new apprentice pathway has been introduced specifically for senior health care support worker roles. This initiative is a critical component of the Trust's long-term workforce strategy, aiming to enhance recruitment, improve retention and support career progression, recognising that many of these individuals will go on to become the registered nursing workforce of the future.

3.1.2. Sickness absence

Sickness absence rates in inpatient units continue to exceed the 4% allocated within the headroom uplift, increasing the challenge of managing a safe effective roster within financial allocations at departmental level. The average rolling sickness rate is 6.68% as at May 2025. This is driven by multiple factors within the clinical environment, including the need for enhanced levels of care, incidents of violence and aggression, occupational stress, rising occupancy levels and complex health and home circumstances. Staff consistently report that these pressures contribute to prolonged periods of sickness absence, highlighting a fundamental link between staff well-being and safe staffing.

However, there are clinical areas with significantly lower levels of sickness absence. Learning from these teams indicates that a stable workforce, clear expectations, strong teamworking camaraderie and effective leadership create the conditions for success. In these areas, safe staffing, efficient roster management, positive patient outcomes and sound financial performance are closely aligned and mutually reinforcing. This aligns with the triangulated methodology used for setting safe nursing establishments and supports the STAR accreditation process.

The key is embedding effective sickness absence reduction across all clinical areas using the learning from what areas where this already works well. In response, a focussed programme of management and cultural interventions has been initiated. This includes the development of updated attendance management guidance and the delivery of supportive workshops for managers. In addition. a rapid improvement week launched on 7th July with a targeted focus on improving sickness management and supporting staff wellbeing at team level and it is anticipated that the actions taken should start to see some immediate improvements which will be tracked using the Daily Management System (DMS).

3.1.3. Roster Key Performance Indicators

Effective roster management is key to the delivery of safe and high-quality care. To support this, roster efficiency meetings were introduced across all divisions in January 2024 to embed a consistent approach, with standardised agendas to manage staffing and resources. These meetings ensure that

rosters are produced and published six weeks in advance, in line with best practice and are optimised to be as safe and effective as possible within the resources available.

In parallel, the development of the Daily Management System (DMS), launched February 2025 and further refined for full implementation in June 2025 is providing real-time support for workforce decision making. It enables responsive data-driven actions to ensure a safe and affordable model of care, while also identifying opportunities to reduce variable spend and dependency on the temporary workforce. The DMS is predicted to be an invaluable resource, integral to the annual safe staffing review process in all future workforce assessments and plans.

3.1.4. Enhanced Therapeutic Observations and Care (ETOC)

Enhanced Therapeutic Observation and Care also known as 1:1 or "specialing" involves allocating health care staff to provide increased visibility and supervision for patients at increased risk of harm in the hospital setting.

Improvement work commenced in January 2025 to strengthen the reliability and quality of ETOC delivery. This work identified the needs for further training among nurse leaders to improve knowledge and raise practice standards. As a result, all Matrons and Ward Managers in adult care have now completed training aligned with the Trust's ETOC Policy. This includes person centred approaches tailored to individuals needs as well as strategies to engage patients in therapeutic activity and prevent de-conditioning.

In May 2025 the Trust was selected to participate in Cohort 2 of the NHS England ETOC Improvement Collaborative. As part of the collaborative the Trust is developing a data dashboard to show the number of nursing hours per month utilised to provide ETOC, along with utilisation by ward and the reason the ETOC is required. The data for June shows that a total of 6068 hours were required to deliver ETOC across the Trust. The top 3 reasons for ETOC being required are:

- Dysregulated behaviour
- Dementia/delirium
- Mental health concerns

The overarching aim of the improvement work is to enhance clinical assessment and care planning, supporting staff to deliver high-quality, person-centred care. Where appropriate, this includes early de-escalation of ETOC requirements to reduce reliance on temporary staffing. The Trust has set a target to reduce temporary staffing usage for ETOC by 10% by March 2026 with the expectation that enhanced practices will become embedded within routine ward care.

In addition to improved workforce efficiency, delivering high-quality ETOC is expected to reduce incidents of violence and aggression toward staff and improve patient experience. The programme is being delivered through a dedicated improvement group, with strategic oversight provided by the Nursing, Midwifery and Allied Health Professionals Board**.**

Feedback from the NHS England team commended the work undertaken by the team including the use of data and implementation of the principles of the ETOC programme. Formal feedback will follow.

4. MONTHLY REPORTING FOR ASSURANCE

A comprehensive monthly report is submitted to the Safety and Quality Committee as part of the Safety and Quality dashboard. This report provides assurance through comparison of planned versus actual nurse staffing levels, care hours per patient day data (CHPPD) incident reporting and red flag indicators. It is further triangulated with Trust-wide patient safety and experience metrics, bed occupancy and Emergency Department activity, performance and outcome data.

In recognition of the risks associated with Maternity and Children these staffing reports are disaggregated and presented separately to Safety and Quality Committee triangulated against patient outcome measures specific to these specialties. This allows clear line of sight in these services.

Staffing levels are represented as percentage fill rates for each ward as submitted to NHS Choices each month. The fill rate is calculated from the number of actual hours worked by staff as a percentage of the number of hours required. The sickness and maternity leave levels are also included in the analysis. This analysis is then converted to Care Hours per patient day (CHPPD) which is monitored as part of the monthly reporting process (Appendix 2).

5. METHODOLOGY

This six month review has been conducted using a desktop methodology as per Trust policy and it applies a triangulated approach to assess staffing across all areas. It draws on outcome metrics for both patients and staff from a three month period (January 2025 – March 2025) combined with professional judgment as recommended by the NHS Improvement in Developing Workforce Safeguards (2018).

The findings of the review have been validated as being appropriate through the application of the professional judgement by the Divisional Nurse Director and/or the Divisional Nursing and Midwifery Director for each clinical division.

5.1. Safer Nursing Care Tool (SNCT)

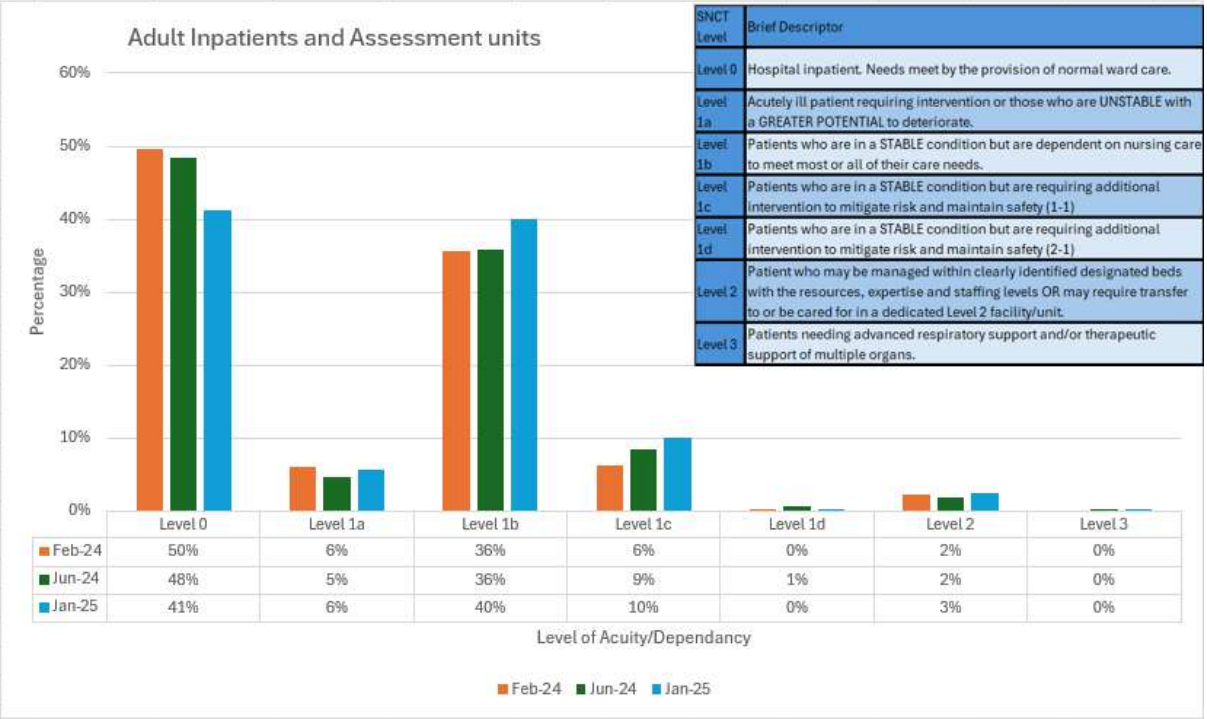
The SNCT is a NICE endorsed Acuity and Dependency Tool which has been developed by the Shelford Group chief nurses sub-group as an innovative and evidence based decision support tool to help Chief Nursing Officers and Board of Directors within acute NHS hospitals measure patient acuity and / or dependency to inform and approve safe staffing for nurses. The decision matrix allows staff to measure the acuity (how ill a patient is) and dependency of patients in a ward (how dependent a patient is on nursing staff to have their fundamental needs met e.g. moving, going to the toilet, eating and drinking). The Trust introduced SNCT into adult inpatient and assessment areas, children's inpatient areas and the Emergency Department (ED) in February 2024 and these full month data collection and validation audits have been carried out six monthly since introduction.

5.1.1. SNCT as part of workforce reviews

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

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

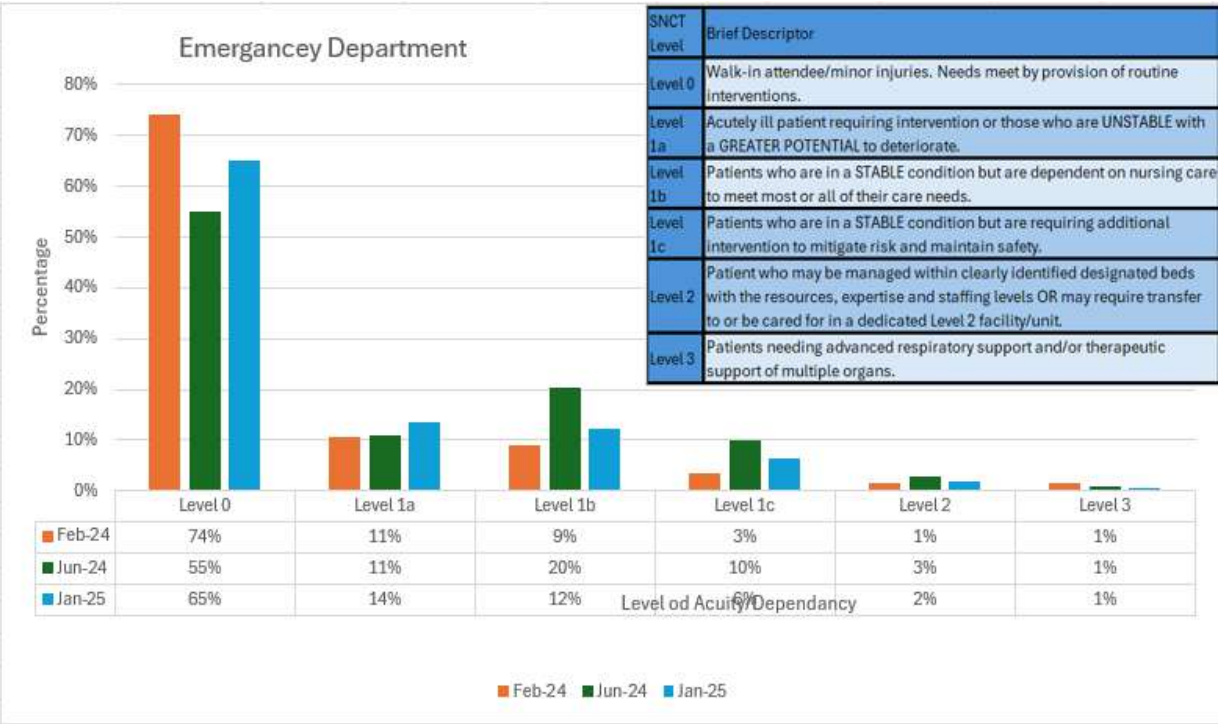
Graph 1 – Adult Inpatient and Assessment Unit Acuity Levels calculated from the validated SNCT tool.



SNCT Level	Brief Descriptor
Level 0	Hospital inpatient. Needs meet by the provision of normal ward care.
Level 1a	Acutely ill patient requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.
Level 1b	Patients who are in a STABLE condition but are dependent on nursing care to meet most or all of their care needs.
Level 1c	Patients who are in a STABLE condition but are requiring additional intervention to mitigate risk and maintain safety (1-1)
Level 1d	Patients who are in a STABLE condition but are requiring additional intervention to mitigate risk and maintain safety (2-1)
Level 2	Patient who may be managed within clearly identified designated beds with the resources, expertise and staffing levels OR may require transfer to or be cared for in a dedicated Level 2 facility/unit.
Level 3	Patients needing advanced respiratory support and/or therapeutic support of multiple organs.

The results for January 2025 demonstrate an increase in patient dependency overall with increased levels of ETOC.

Graph 2 – Emergency Department Acuity Levels

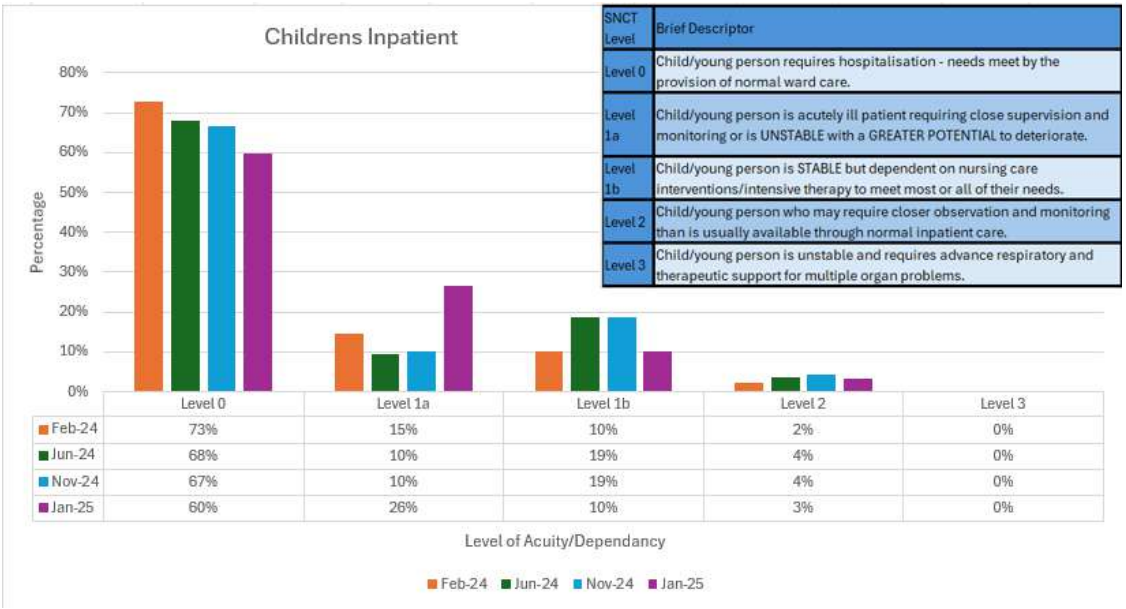


SNCT Level	Brief Descriptor
Level 0	Walk-In attendee/minor injuries. Needs meet by provision of routine interventions.
Level 1a	Acutely ill patient requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.
Level 1b	Patients who are in a STABLE condition but are dependent on nursing care to meet most or all of their care needs.
Level 1c	Patients who are in a STABLE condition but are requiring additional intervention to mitigate risk and maintain safety.
Level 2	Patient who may be managed within clearly identified designated beds with the resources, expertise and staffing levels OR may require transfer to or be cared for in a dedicated Level 2 facility/unit.
Level 3	Patients needing advanced respiratory support and/or therapeutic support of multiple organs.

	Level 0	Level 1a	Level 1b	Level 1c	Level 2	Level 3
Feb-24	74%	11%	9%	3%	1%	1%
Jun-24	55%	11%	20%	10%	3%	1%
Jan-25	65%	14%	12%	6%	2%	1%

The results for January 2025 demonstrate an increase in patient acuity within the emergency departments overall, acuity need of patients is prioritised over dependence within the evidence based SNCT tool. The SNCT tool does not currently reflect patient demand beyond those that are in the department longer than 12 hours, this is being developed nationally, therefore it is important professional judgement considers the wider influencing factors that drive patient care needs including but not limited to stays beyond 12 hours for which the trust saw 2105 patients spending longer than 12 hours in the department in June.

Graph 3 – Children's Inpatient Acuity Levels



SNCT Level	Brief Descriptor
Level 0	Child/young person requires hospitalisation - needs meet by the provision of normal ward care.
Level 1a	Child/young person is acutely ill patient requiring close supervision and monitoring or is UNSTABLE with a GREATER POTENTIAL to deteriorate.
Level 1b	Child/young person is STABLE but dependent on nursing care interventions/intensive therapy to meet most or all of their needs.
Level 2	Child/young person who may require closer observation and monitoring than is usually available through normal inpatient care.
Level 3	Child/young person is unstable and requires advance respiratory and therapeutic support for multiple organ problems.

	Level 0	Level 1a	Level 1b	Level 2	Level 3
Feb-24	73%	15%	10%	2%	0%
Jun-24	68%	10%	19%	4%	0%
Nov-24	67%	10%	19%	4%	0%
Jan-25	60%	26%	10%	3%	0%

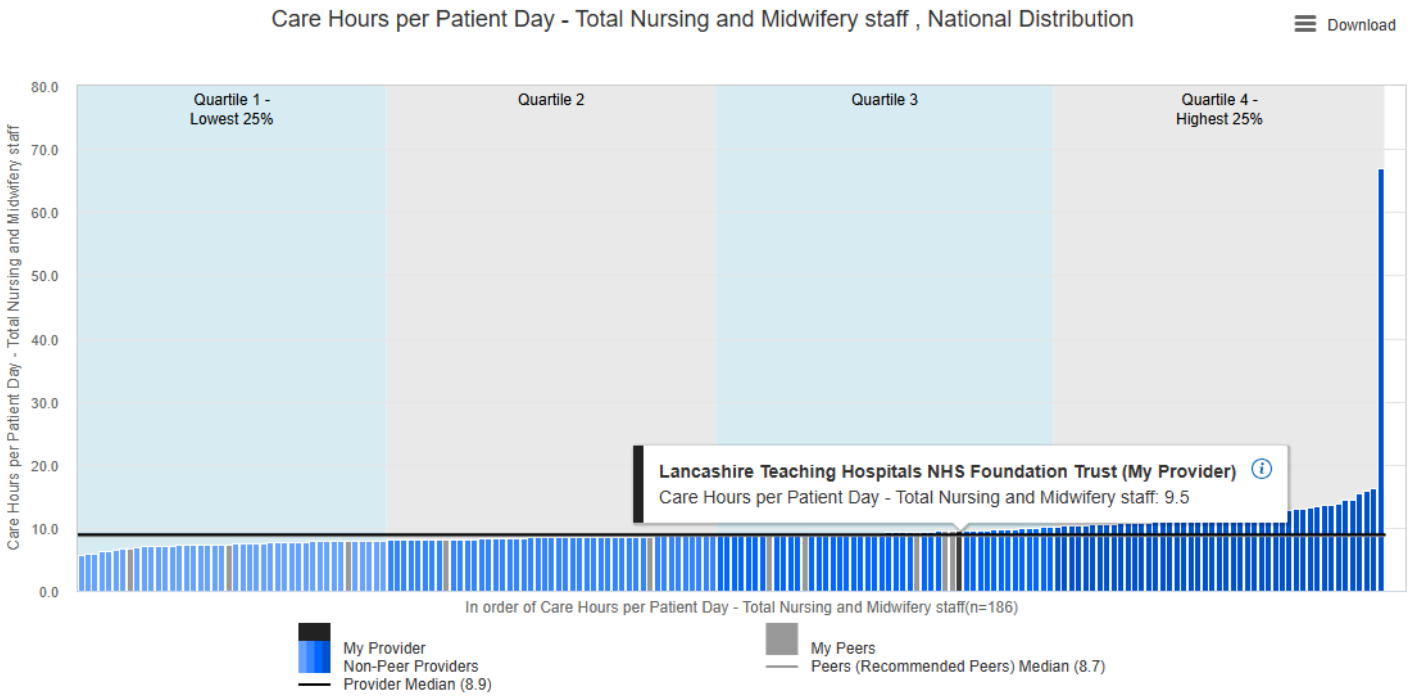
The results from January 2025 demonstrate an increase in patient acuity. Notably, the January audit being marked the first occasion where the children's inpatient areas met all the criteria required for compliance.

NHS England recommends that at least two data collections meeting all compliance criteria are completed before the data is used to inform workforce reviews. In line with guidance, The Trusts ETOC models are currently under appraisal, alongside a review of associated temporary bank spend and the use of additional shifts to support enhanced therapeutic care.

5.2. CARE HOURS PER PATIENT DAY (CHPPD)

The data in Graph 4 reflects Model hospital benchmarking data from May 2025 and places Lancashire Teaching Hospitals in the third quartile for CHPPD. This position is consistent with other tertiary providers in the North West, including Northern Care Alliance, Manchester University NHS Foundation Trust and Liverpool University Hospitals Trust.

Graph 4 – Model Hospital Lancashire Teaching using CHPPD – May 2025



CHPPD is a high level, national proxy measure for staffing to bed ratios. While some assurance can be taken from Lancashire Teaching Hospitals' position relative to peer, it is important to consider contextual factors that influence this metric. For example, the Trust operates seven enhanced care areas linked to the delivery of tertiary services as well as experiencing significant fluctuations in the number of escalation beds. These factors are not currently reflected in the Model Hospital return and therefore may limit the completeness of the data as a benchmark if taken in isolation.

Table 1 – CHPPD compared to Northwest Region and Recommended Peer Organisations. (May2025)

Organisation Name	Organisation Value	Peer	Quartile
Mid Yorkshire Teaching NHS Trust	6.9	Yes	Quartile 1
Countess of Chester Hospital NHS Foundation Trust	7.2	No	Quartile 1
Warrington and Halton Hospitals NHS Foundation Trust	7.2	No	Quartile 1
Wirral University Teaching Hospital NHS Foundation Trust	7.3	No	Quartile 1
University Hospitals Plymouth NHS Trust	7.4	Yes	Quartile 1
Royal Cornwall Hospitals NHS Trust	7.9	Yes	Quartile 1
East Lancashire Hospitals NHS Trust	8	No	Quartile 1
Mid Cheshire Hospitals NHS Foundation Trust	8	No	Quartile 2
Mersey and West Lancashire Teaching Hospitals NHS Trust	8	No	Quartile 1
University Hospitals Coventry and Warwickshire NHS Trust	8.1	Yes	Quartile 2
East Cheshire NHS Trust	8.2	No	Quartile 2
Blackpool Teaching Hospitals NHS Foundation Trust	8.5	No	Quartile 2
Tameside and Glossop Integrated Care NHS Foundation Trust	8.5	No	Quartile 2
South Tees Hospitals NHS Foundation Trust	8.6	Yes	Quartile 2
Liverpool University Hospitals NHS Foundation Trust	8.9	No	Quartile 3
Bolton NHS Foundation Trust	8.9	No	Quartile 3
North Bristol NHS Trust	8.9	Yes	Quartile 3
Wrightington, Wigan and Leigh NHS Foundation Trust	8.9	No	Quartile 3
University Hospitals of Morecambe Bay NHS Foundation Trust	9	Yes	Quartile 3
Northern Care Alliance NHS Foundation Trust	9.2	No	Quartile 3
University Hospitals of North Midlands NHS Trust	9.3	Yes	Quartile 3
Stockport NHS Foundation Trust	9.5	No	Quartile 3
Lancashire Teaching Hospitals NHS Foundation Trust	9.5	Yes	Quartile 3
Northampton General Hospital NHS Trust	9.5	Yes	Quartile 3
Manchester University NHS Foundation Trust	9.6	No	Quartile 3
Mersey Care NHS Foundation Trust	10.1	No	Quartile 3
Pennine Care NHS Foundation Trust	10.5	No	Quartile 4
Cheshire and Wirral Partnership NHS Foundation Trust	10.9	No	Quartile 4
Greater Manchester Mental Health NHS Foundation Trust	11.1	No	Quartile 4
Walton Centre NHS Foundation Trust	11.3	No	Quartile 4
Liverpool Heart and Chest Hospital NHS Foundation Trust	12.7	No	Quartile 4

5.3. PROFESSIONAL JUDGEMENT

Professional judgment is a crucial element in workforce reviews, as it balances data with expert opinions grounded in a deep understanding of the actual working environment. This ensures the determination of appropriate nurse staffing levels. By adopting this consultative approach, promotes collaboration, empowers local teams to take ownership of safe staffing, and fosters the development of leaders. It values the insights of staff who are directly familiar with the conditions they work in, while also encouraging leaders to address challenges and actively contribute to solutions.

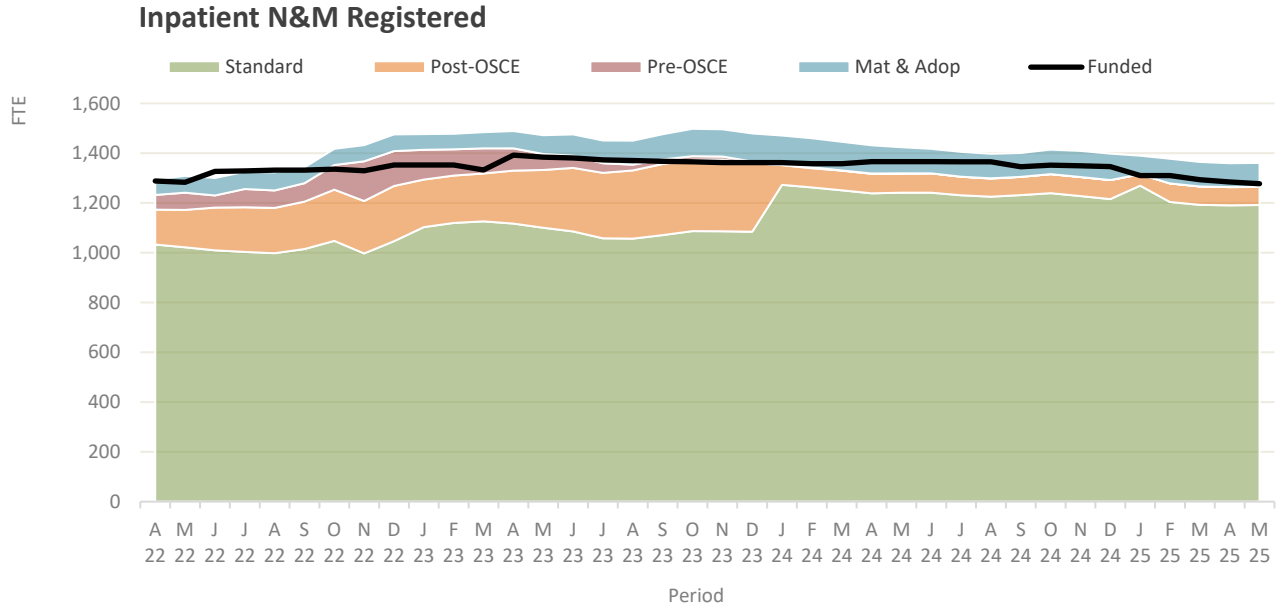
Professional judgment is not focused on requesting additional staff, it is focused on understanding the realities of working in a specific clinical area and collaboratively identifying solutions that prioritise safety and mitigate risks. This analysis is a key part of workforce reviews, where it is discussed alongside nurse-sensitive indicators, financial data, and workforce metrics. In addition to evaluating patient acuity and dependency (SNCT), other factors impacting staffing needs are also considered, including:

- The layout and design of the ward – wards with multiple single rooms or bays may require higher staffing capacity and capability.
- Line of sight of patient and ETOC required.
- The number of housekeepers and other support staff available
- Patient throughput – high throughput needing more staff to help maintain patient flow.
- The provision of supervisory time required by the Ward Manager to undertake the management requirements of the post, together with the amount of time required to support, supervise and mentor students and newly appointed staff.

5.4. VACANCY POSITION

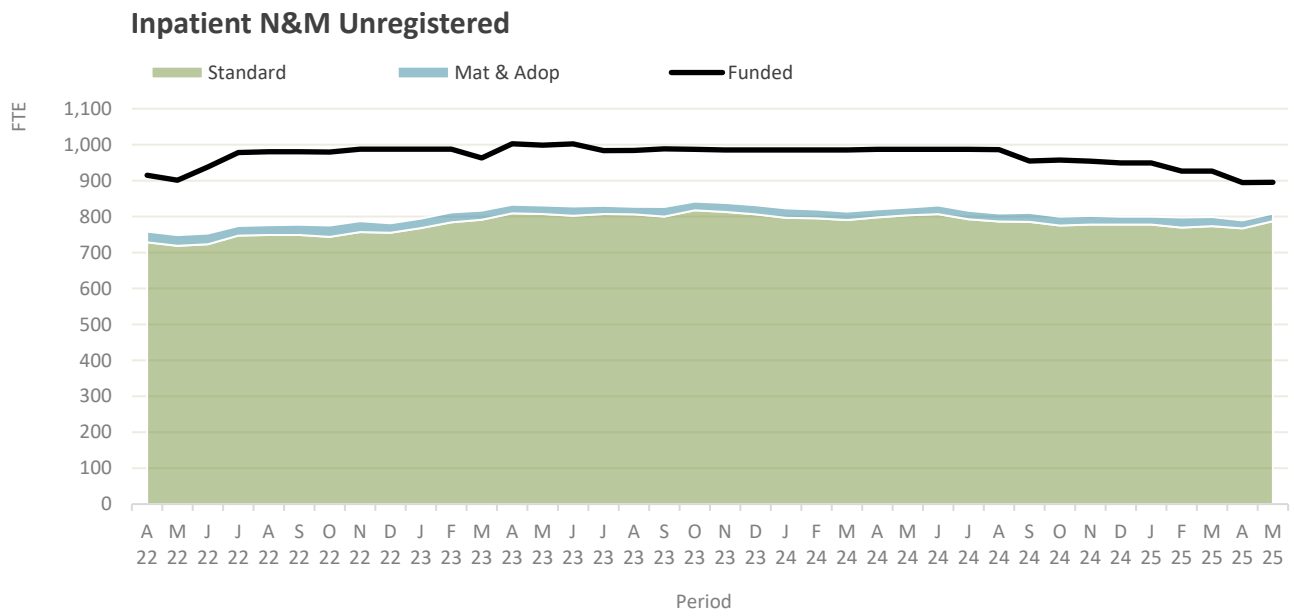
At the time of the reviews the data that was considered was May 2025. The registered nurse (RN) vacancy position has continued to improve over the last few years.

Graph 5 - Registered Nurse & Midwifery establishment versus staff in post



Health Care Assistant (HCA) recruitment has been on hold to support redeployment requirements following organisational changes.

Graph 6 - Healthcare Assistant & Maternity Support Worker establishments versus staff in post



6. OUTCOME OF REVIEW OF SIX MONTHLY SAFE STAFFING REVIEW FOR CHILDREN AND YOUNG PEOPLE

Paediatric services are on the Royal Preston Hospital site and staffing is in accordance with Royal College of Nursing (RCN) and NHS Improvement guidance. Staffing levels and child specific outcome measures are monitored through the Children and Young People Safety and Quality monthly reports, providing ongoing assurance.

In the paediatric Emergency Department (ED) staffing requirements reflect the need to safely manage both emergency resuscitation and the triage, assessment and treatment of children. These staffing models align to the RCN and NHS Improvement guidance. Professional judgement confirms that current staffing levels set in paediatric ED are sufficient to meet the needs of the service.

Ward 8 paediatric ward staffing skill mix was also reviewed as part of the bi-annual safe staffing review process. The SNCT data, triangulated with the professional judgment provided assurance that staffing levels and skill-mix are appropriate to meet the service's needs and patient demand.
Childrens ward and PAU have now reached a green star outcome.

7. OUTCOME OF REVIEW OF SIX MONTHLY SAFE STAFFING REVIEW FOR MATERNITY AND GYNAECOLOGY

Through the triangulation of SNCT data for the Gynaecology Ward and Gynae Assessment Unit (GAU) alongside safety and quality metrics and the professional judgment it was concluded that staffing levels and skill mix within maternity and gynaecology are sufficient to meet the service needs.

The Maternity safe staffing review is carried out separately and presented to Safety and Quality on a cycle of business, however the six-monthly review were assured of the recruitment plans withing maternity services for newly Qualified Midwives for September 2025 include the agreed over recruitment to cover vacancies, maternity leave and predicted attrition.

A Birthrate plus® assessment has been commissioned and fact finding activities commenced in April 2025. The report is expected in August following validation of the data. The findings will be incorporated into the annual safe staffing review process, beginning in October 2025. All inpatient areas are at a green star level now with the exception of Delivery Suite which is a 89% Bronze.

8. OUTCOME OF REVIEW OF SIX MONTHLY SAFE STAFFING REVIEW FOR THE SURGICAL DIVISION

Through the triangulation of SNCT data alongside safety and quality metrics and the professional judgment, it was concluded that staffing levels and skill mix within the surgical division are sufficient to meet the service needs.

An opportunity has been identified to explore options for increasing capacity and improving bed utilisation within the surgical wards at Chorley and South Ribble District General Hospital (CDH). This area of focus will be taken forward by the Divisional Nurse Director as part of ongoing service improvement and optimisation efforts.
All areas with the exception of Ward 2b and Surgical assessment unit are green rated in Surgery.

9. OUTCOME OF REVIEW OF SIX MONTHLY SAFE STAFFING REVIEW FOR THE CRITICAL CARE UNIT

A review of safety and quality metrics, compliance with the guidelines for the provision of intensive care services (GPICS) and professional judgment has confirmed that current staffing levels and skill mix within critical care are sufficient to meet the needs of the service and patient demand.
Critical care is currently rated a green in star.

10. OUTCOME OF REVIEW OF SIX MONTHLY SAFE STAFFING REVIEW FOR THE MEDICINE DIVISION (EXCLUDING ED)

Through the triangulation of SNCT data alongside safety and quality metrics and the professional judgment, it was concluded that staffing levels and skill mix within the medicine division are sufficient to meet the service needs. All STAR areas are green with the exception of acute assessment unit, Bleasdale, Brindle coronary care CDH, enhanced high care respiratory, Hazelwood, AMU, Rookwood A and ward 17.

11. OUTCOME OF REVIEW OF SIX MONTHLY SAFE STAFFING REVIEW FOR THE EMERGENCY DEPARTMENT, URGENT AND EMERGENCY CARE PATHWAY

The Emergency Department (ED) dashboard is presented monthly to the Safety and Quality Committee. Current indicators highlight a service under sustained pressure, with specific areas for improvement identified in the average time to see a clinician, total length of time spent in the department, patient experience metrics and the STAR quality assurance outcomes.

Risk ID 25 highlights the ongoing and significant risk within the ED at both Chorley District Hospital (CDH) and Royal Preston Hospital (RPH), specifically relating to exit block when patients requiring admission experience delays due to the unavailability of inpatient beds. This risk continues to be rated highly at a

score of 20 and, despite the presence of an active risk action plan, has remained at this level since the post-COVID period due to the sustained pressures on patient flow and acuity within the ED environment.

In response, the Trust has undertaken a comprehensive bi-annual staffing review, recognising both the clinical and operational impact of these pressures on patient safety, experience, and staff well-being. The review includes detailed analysis across both sites and acknowledges the need for a responsive staffing model that can flex to meet both the predictable and unpredictable surges in demand that are characteristic of emergency care.

The findings and associated recommendations set out below provide clear, evidence-based assurance that the Trust is actively seeking to mitigate the risks associated with exit block by ensuring that safe staffing levels are maintained in line with professional judgement and clinical acuity.

The STAR outcomes for both departments have failed to achive a green star except on 2 occasions since 2017 with RPH ED never having met the required standard. ED CDH CQC safe rating deteriorated from Good at the last inspection and RPH have a sustained requires improvement position for its CQC rating.

While the focus of this review is on safety, quality, and workforce alignment, it is acknowledged that any resulting investment requirements would follow due process through established business planning routes and financial governance mechanisms, including case of need assessments and alignment with waste recovery programmes.

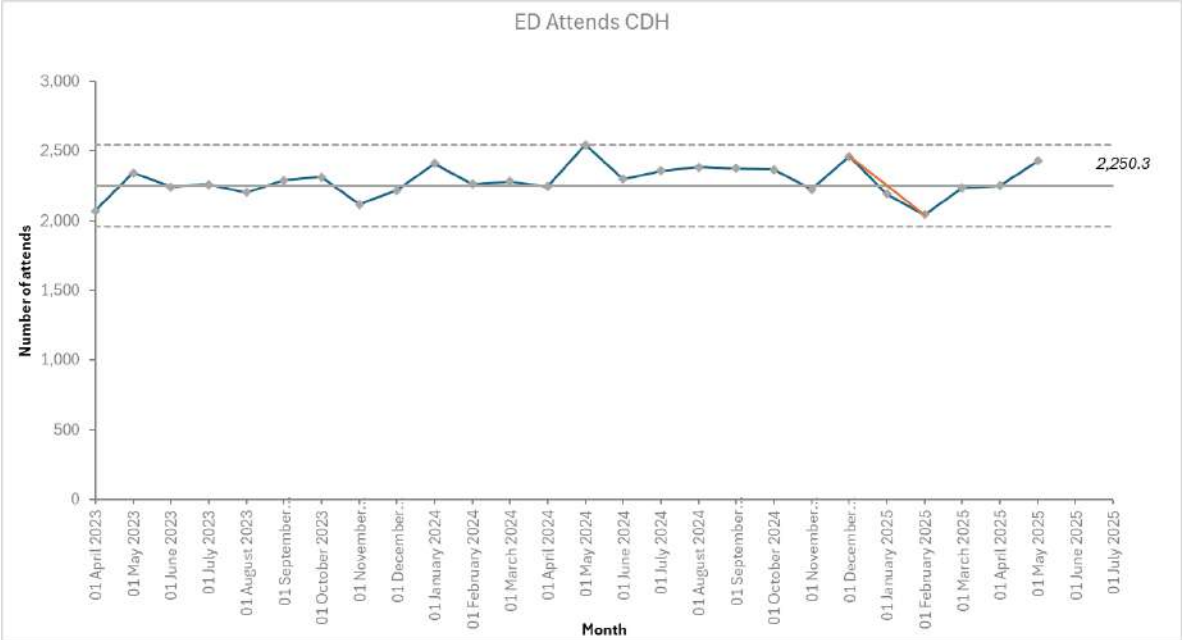
This review demonstrates the Trust's continued commitment to delivering safe, effective, and compassionate care, underpinned by a robust approach to risk management, staff support, and system-wide improvement.

11.1. Chorley District Hospital ED

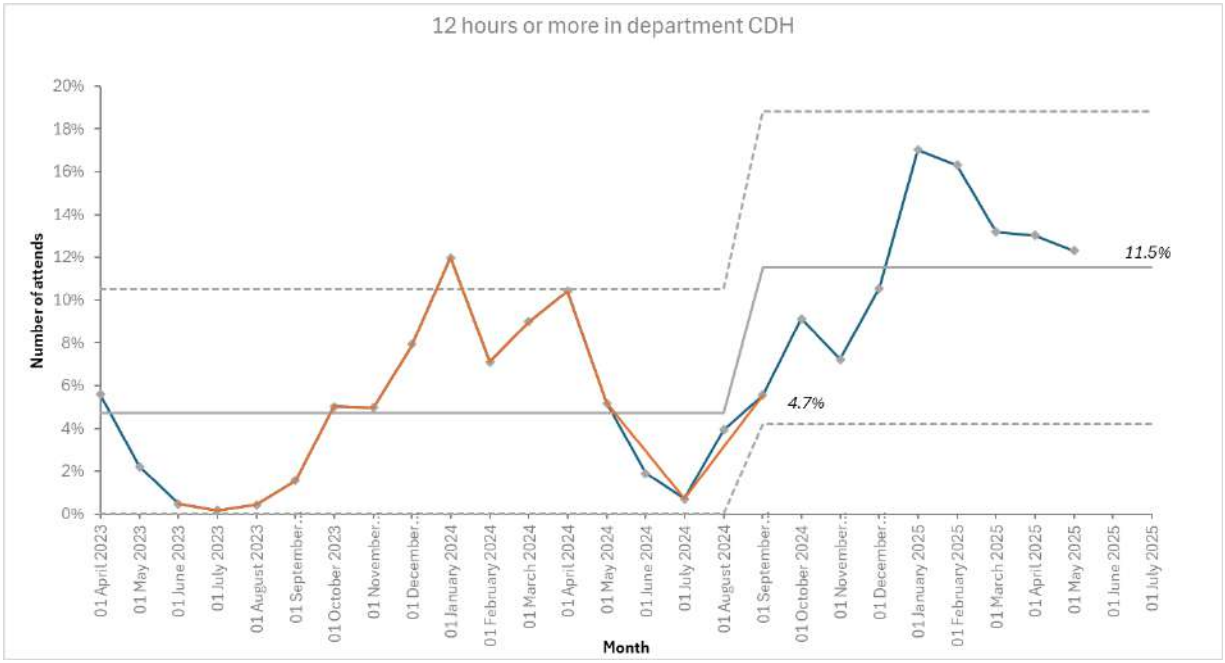
Historically the Emergency department at CDH was commissioned as a 24-hour Type 1 department. In September 2020 the hours of opening and service provision were reduced. The current commissioned hours of service are 08.00 – 22.00 seven days a week and the last ambulance admission is accepted at 18.00 and the last walk-in patient is accepted at 20.00. This configuration allows a 2 hour window to facilitate a safe discharge or admission to the Medical Assessment Unit (MAU) prior to department closure.

CDH ED currently manages approximately 2,250 attendances per month. As illustrated in Graph 7, seasonal variation in activity is minimal, indicating a consistent and predictable demand pattern. However, a notable change has been observed in patient length of stay within the department. Since September 2024, the proportion of patients remaining in the ED for over 12 hours has increased significantly—from an average of 4.7% to 11.5%, as shown in Graph 8. This shift reflects increasing challenges in patient flow and reinforces the importance of clinical review and appropriate staffing to support timely, safe care managing some of the most acutely unwell patients at the beginning of their time in hospital whilst providing the fundamentals of care and balancing within the constraints of the current operational model.

Graph 7 - Chorley ED Attends April 2023 – May 2025

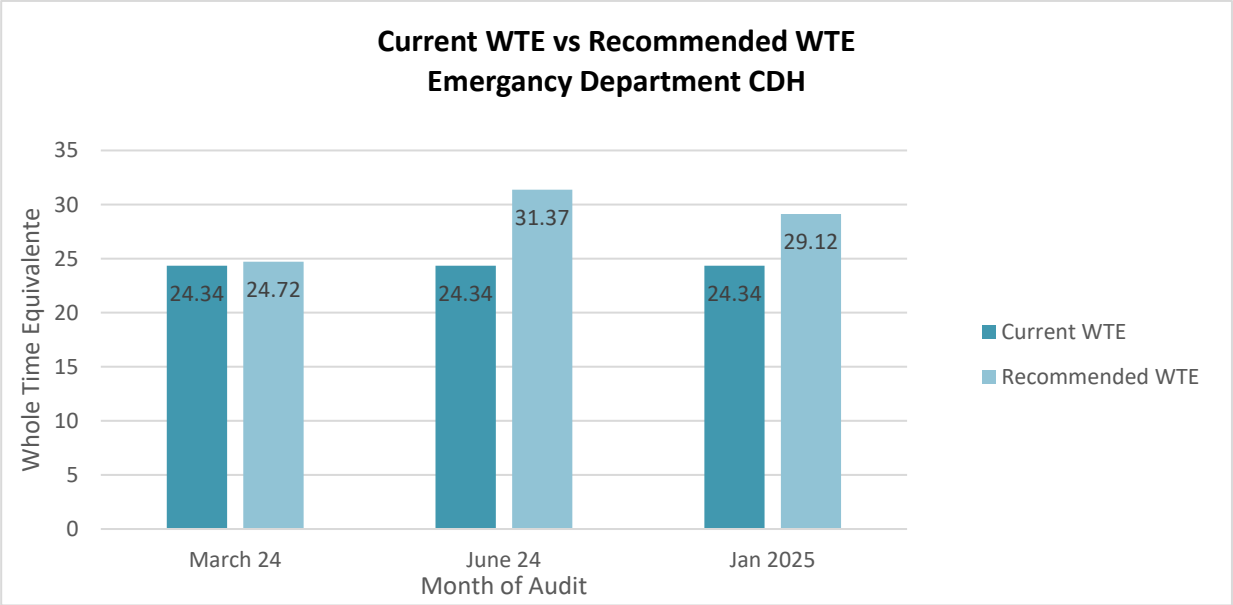


Graph 8 - Chorley ED percentage of patients in the department longer than 12 hours April 2023 – May 2025

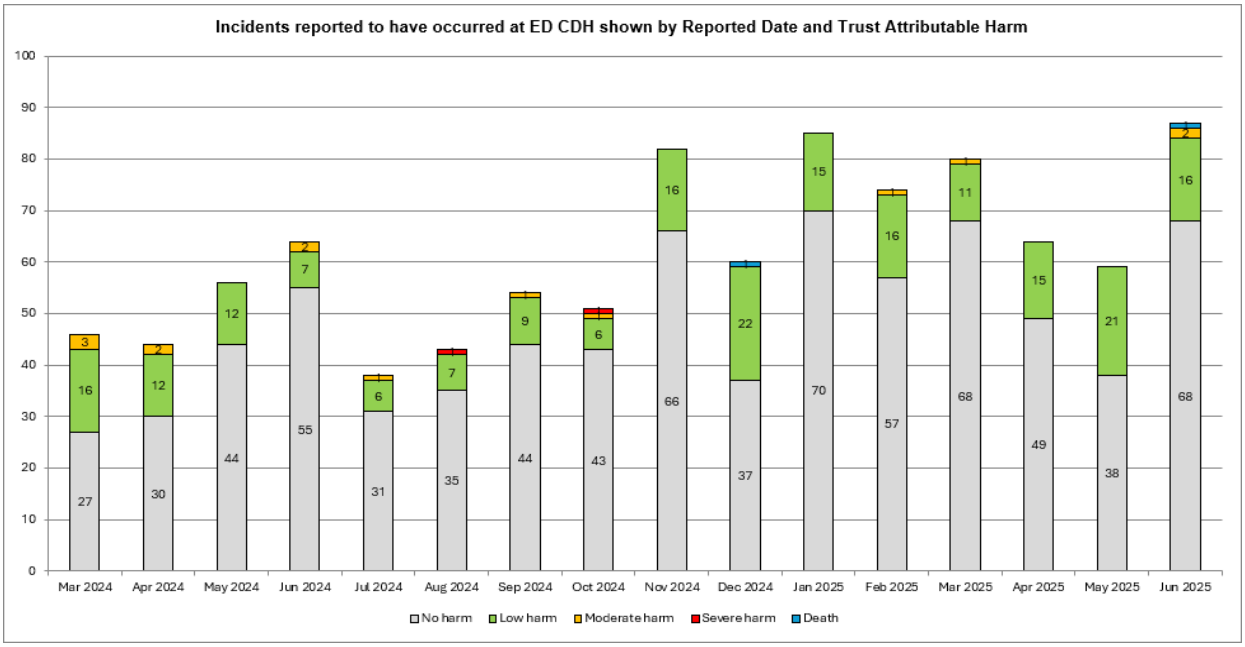


Acuity and dependency from the ED SNCT data uses evidence-based methodology to guide the recommended safe staffing for the department. Graph 9 compares the current budgeted WTE for ED CDH with the recommended WTE derived from the ED SNCT. Whilst the initial SNCT audit in March 2024 indicated that the staffing requirements, based solely on data could be met with the established WTE, the follow up audits in June 2024 and January 2025 reveal a shortfall in the number of required staff required. This discrepancy aligns with the professional judgement of the clinical leaders in ED who articulate the challenges posed daily.

Graph 9 – Funded Whole Time Equivalent vs SNCT recommended Whole Time Equivalent



Graph 10 – Incidents reported to have occurred at ED CDH shown by date and Trust attributable harm



Correlation of the SNCT data with reported incident figures shows a steady increase in overall incident reporting between 1st March 2024 and 30th June 2025, with a noticeable upward trend from July 2024 onwards. The majority of incidents were categorised as no harm (77.2%) or low harm (20.9%). However, there were also reports of moderate harm (1.41%), severe harm (0.2%), and death (0.2%), highlighting the importance of continued focus on safe staffing and timely escalation of care needs.

11.1.1. Current Operational Considerations and Assurance for CDH ED Staffing

- **Restricted Opening Hours – Leadership and Risk Mitigation**

Given the restricted operating hours of the Emergency Department at Chorley District Hospital (08:00–22:00), it is essential that appropriate levels of leadership and assurance are in place to safely manage patient care during both opening and closing transitions. The revised staffing model proposed in graph 10 below explicitly acknowledges that the period leading up to closure presents the highest risk, particularly in terms of the safe transfer or admission of patients to onward care settings. The model has been designed to mitigate this risk by ensuring the presence of senior clinical oversight and appropriate staff capacity during this critical window.

- **Increased Demand for Enhanced Care**

The extended length of stay for some patients has resulted in a rise in the number of individuals requiring enhanced therapeutic observation. This demand is further exacerbated when patients are bedded down within the department overnight due to delays in admission. The revised staffing model takes into account the increased acuity and complexity of patients remaining in the department for prolonged periods, ensuring that safe, person-centred care can be maintained.

- **Sickness Absence Management**

Sickness absence remains a challenge for the department. In May 2025, the sickness rate was recorded at 11.7%. The department is actively managing this in line with the Trust's roster policy and Attendance Management Policy, with a focus on early intervention, supportive management, and robust return-to-work processes to promote staff well-being and minimise unplanned absence. Analysis of the sickness data collected at the same time as the SNCT audits highlights a correlation between increased patient acuity and dependency and a rise in staff sickness rates. During the first SNCT audit in March 2024, when staffing levels were sufficient to meet patient needs, sickness absence was 6.97%. In contrast, during periods of higher patient acuity that exceeded baseline staffing resources, in the subsequent SNCT audits of June 2024 and January 2025, sickness rates rose significantly to 15.85% and 13.58%, respectively.

- **Training Compliance**

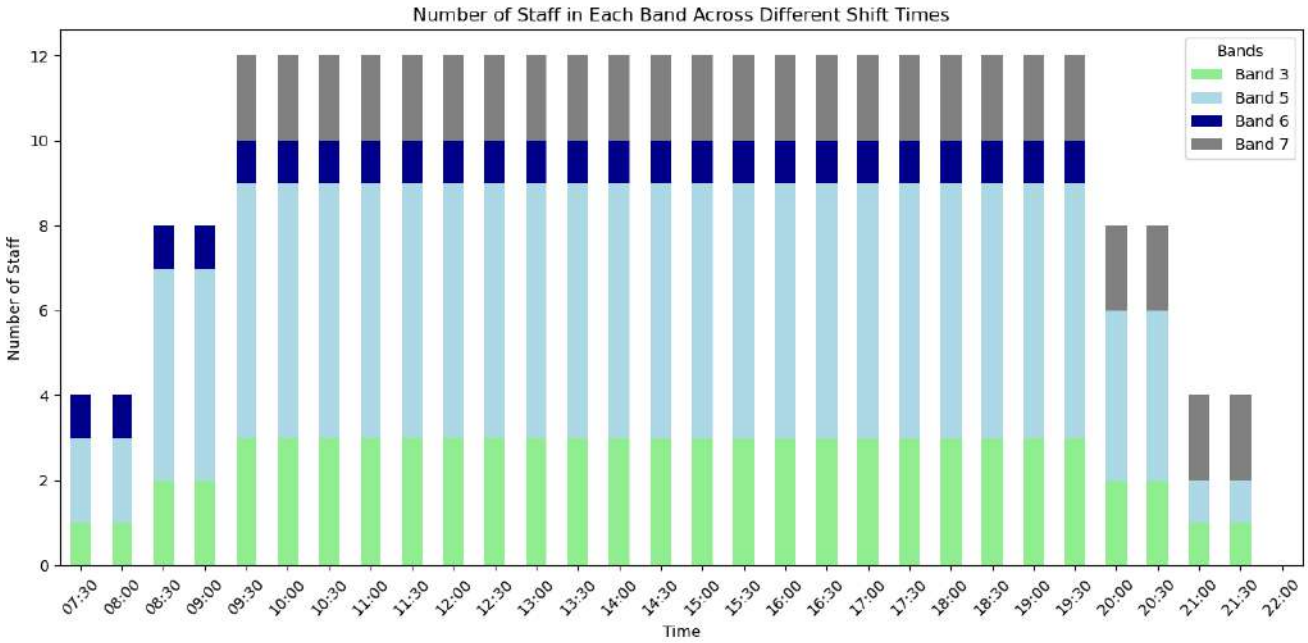
Two areas of mandatory training are currently rated Red for the department: Medication Management for all clinical staff and Moving and Handling Level 2. The Unit Manager and Clinical Educator are actively supporting staff to address these shortfalls and ensure full compliance. Focused training sessions and improved access to e-learning are part of the remedial plan but clinical care remains the priority so releasing time for education purposes has been a challenge.

- **Staffing Model Update**

The proposed staffing model reflects the evolving needs of the department and indicates the requirement for an increase of 5.5 Whole Time Equivalent (WTE) Band 5 Registered Nurses. This increase will facilitate staggered shift patterns to ensure adequate cover across peak periods and

safer closure practices. The model is designed to strengthen resilience, improve flow, and support both patient and staff experience in a department operating under time and capacity constraints.

Graph 11 – Proposed new safe staffing model at CDH ED to mitigate risks and respond to the SNCT data and professional judgement.



11.1.2. Senior Nurse Leadership at CDH ED and Emergency Response Capability

Senior Nurse Cover - In alignment with the Royal College of Emergency Medicine (RCEM) guidelines, the staffing model for the CDH Emergency Department ensures appropriate senior clinical oversight through the allocation of a designated clinical coordinator. A Band 6 registered nurse is rostered to lead the department upon opening, with Band 7 senior nurse presence established from 09:30 until departmental closure. This provides consistent senior decision-making, oversight, and leadership throughout the department's operating hours, ensuring patient safety and effective flow management.

Response to Deteriorating Patients- All Band 6 and Band 7 Registered Nurses working within the CDH ED are fully trained in Advanced Life Support (ALS) and Advanced Paediatric Life Support (APLS), equipping them to lead and manage emergency situations confidently and competently. During the early morning period (08:00–09:30), when senior nurse presence is being established, a minimum of two Emergency Nurse Practitioners (ENPs) are rostered onto shift, providing experienced clinical support and immediate response capability in the event of patient deterioration.

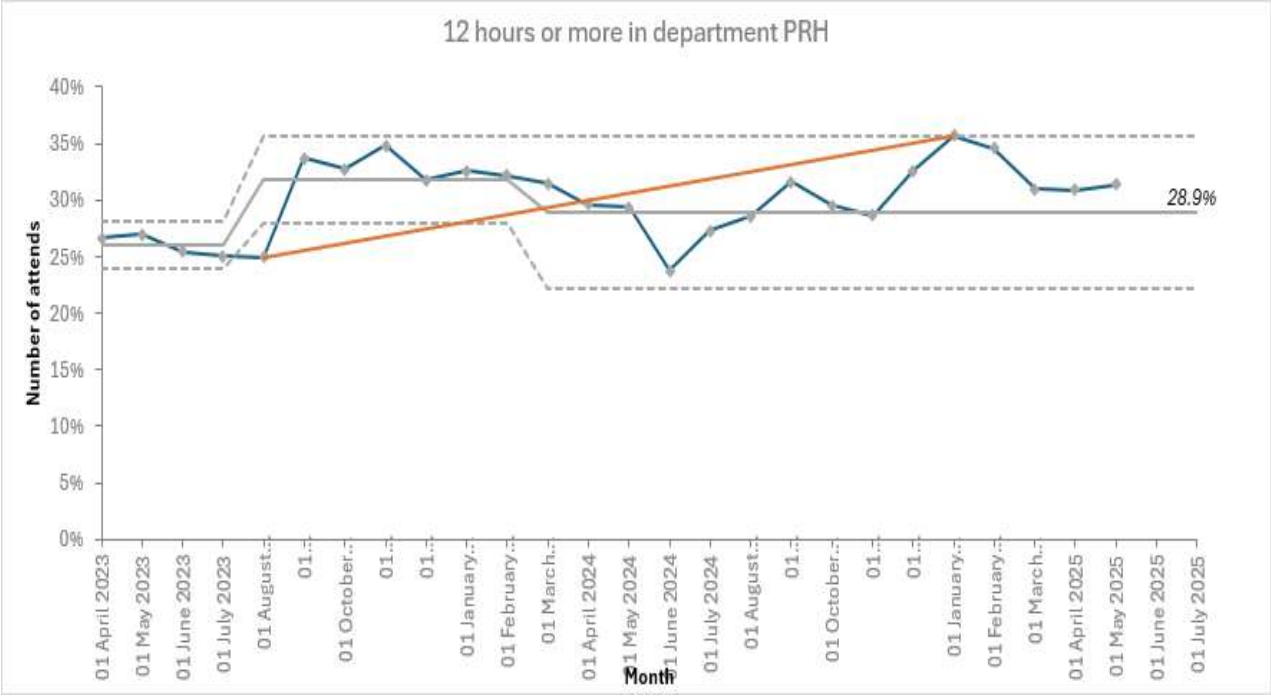
Additionally, the hospital site is supported by a 24/7 Critical Care Outreach Team, who attend the ED promptly when required. This ensures that emergency response is reinforced by a multidisciplinary escalation framework, offering a further layer of clinical assurance and resilience, particularly during high-acuity events or resuscitation scenarios.

The staffing recommendation for CDH ED is to convert 5.5WTE bank spend into substantive establishment.

11.2. Royal Preston Hospital ED

Unlike CDH ED, the ED at RPH has experienced a sustained high volume of patients awaiting inpatient beds, with an average of 40-50 patients daily. This pressure pre-dates the implementation of SNCT data at LTH making it challenging to identify clear trends over time. It is important to note that the SNCT is based on the department functioning solely as an emergency service and does not account for patients who remain in the ED for over 12 hours awaiting a bed. Therefore, while the SNCT data provides some insight, it must be viewed as limited in this context. NHS England is currently testing a new SNCT tool specifically designed for EDs which aims to better reflect the complex and evolving demands EDs are managing nationally. However, a release date for this has not yet been confirmed. In the meantime, professional judgement, supported by triangulation with other key data sets, remains essential to accurately determine and respond to staffing requirements. Despite ongoing efforts to avoid unnecessary admissions, the use of boarding capacity within the ED continues to be consistently high and does have an impact on the nurse staffing requirements.

Graph 12 – patients waiting 12 hours or more in ED at RPH



Graph 12 shows that on average 30% of patients have been in the ED over 12 hours, some of which will be delayed up to 72 hours. These are not captured in the SNCT data.

Recent organisational changes and staff redeployment have significantly reduced ED nurse vacancies, and roster efficiency has improved, with minimal gaps during roster production. Band 7 vacancies in May 2025 were 0.82WTE which have since been recruited to in June. The band 6 vacancy was 0.77WTE in May 2025 with, no band 5 vacancies but 3 staff on maternity leave, band 3 vacancies as at May 2025 are 21wte with over recruitment at band 2 by 10.26wte with plans for staff to commence the senior healthcare assistant apprenticeship to progress into the band 3 vacancies. Despite this improved position in vacancy reduction, due to the sustained high patient numbers, additional duties continue to be required on a weekly basis and there is a reliance on temporary workforce to ensure the department can safely manage surge capacity.

The Emergency Department at RPH is currently funded for 19 Registered Nurses per shift, this includes two band 7's and two band 6's. Within the current establishment, specific roles have been allocated to support the challenging environment of the department and the sustained high number of patients. These include a take-charge coordinator, a dedicated waiting room nurse and a helicopter nurse. The helicopter nurse plays a dynamic and supportive role within the emergency department due to the complexities of the environment and spread of patients round the department, primarily focused on patient safety, staff support, and operational oversight, with core responsibilities for safeguarding oversight, deteriorating patient oversight, safety huddles, and safety checks within the department. Each of these roles plays a critical part in maintaining patient safety, flow, and oversight in an increasingly pressured and complex clinical setting and is required due to the increased occupancy of the department. Their presence is essential in mitigating risk and ensuring patients receive timely and appropriate care despite the ongoing demands on the department.

There is a current risk (ID25) of ED exit block, which has been escalated to Trust Board since December 2020 due to operational pressures. The causes of exit block are noted to be complex but are correlated with an increase in the number of bed days occupied by patients who do not meet the criteria to reside in hospital. The Urgent and Emergency Care elements of the single improvement plan outlines the measures being taken by the Trust to avoid admission and reduce inpatient length of stay to reduce the occupancy of the ED. However, the plan has not been fully achieved and there is a requirement to assess the impact of the plan both on length of stay to ensure that the benefits are realised for inpatient length of stay and ED crowding.

A staffing escalation paper for RPH ED was developed in 2024 to guide a structured approach to surge staffing within the department, particularly outlining expected staffing levels during each phase of extreme escalation ranging from 19 RNs to 26 RNs for extreme escalation. The original model was based on real-time patient numbers and relied heavily on redeployment. However, this approach proved difficult to implement consistently and did not support effective forward planning.

Following a comprehensive review, the proposed plan for safe staffing has now been revised following analysis using a combination of data sources, including SNCT data, Business Intelligence (BI) portal information on capacity and demand, ED waiting times, Royal College of Emergency Medicine (RCEM) guidance, and the Royal College of Nursing (RCN) BEST modelling. This analysis offers improved insight into patterns of demand across a typical seven-day period. This data-driven comprehensive approach has enabled a detailed understanding of the current workforce against patient demand and clinical risk and enhanced the predictability of staffing requirements and enabled more robust planning to ensure safe and responsive service delivery. Staffing numbers have been modelled accordingly, and the associated level of risk has been reviewed to ensure that safe and effective care can continue to be delivered within the constraints of the existing environment.

Twelve months of BI portal data was extracted for analysis; a census was completed on the number of patients in the department and the number of decision to admit (DTA) patients at midday and midnight during the period May 2024 to May 2025. Table 2 displays the average numbers by day of the week. The data shows an increased number of patients in the department and increased number of patients with a DTA from Sunday to Wednesday each week.

Table 2 - Bi portal census summary – 2024/2025

RPH ED - Patients in Department @ 12 noon and 12 Midnight
Averages by Day of Week

	Midday		Midnight	
DoW	Avg in ED	Avg DTA's in ED	Avg in ED	Avg DTA's in ED
Mon	92	48	93	45
Tue	86	45	89	46
Wed	82	44	89	44
Thu	81	43	88	43
Fri	82	41	85	40
Sat	74	38	81	40
Sun	76	41	86	44
Grand Total	82	43	87	43

The proposed safe staffing model addresses current variation and demand by increasing the number of Registered Nurses (RNs) to 24 from Sunday to Tuesday, then adjusting to 22 RNs from Wednesday to Saturday. This model is designed to better align staffing levels with patient flow and departmental activity trends. Importantly, it also supports the planned removal of agency staff currently in place and is expected to significantly reduce the reliance on temporary staffing bank shifts to cover surge capacity, enhancing both continuity of care and workforce stability.

The recommendation is to convert bank and agency spend of 15.75 WTE Registered Nurses to substantive recruitment.

By increasing the number of Registered Nurses within the core establishment, the department will be better positioned to maintain safe staffing levels consistently. This approach enhances patient safety, reduces the risk of adverse incidents, and ensures the presence of a skilled workforce capable of managing the high acuity and complexity of the emergency care environment. It also strengthens business continuity planning, particularly in preparation for the increased pressures expected during the winter period. Additionally, this model aligns with RCEM best practice guidelines, ensuring that reliance on temporary staffing remains within safe and sustainable limits for an Emergency Department.

The operational environment is intrinsically linked to the department's ability to provide safe staffing. To respond effectively to peaks in activity, there is a clear and ongoing need to increase staffing levels. This requirement was highlighted as a key expectation by regulators and was the basis for a Care Quality Commission (CQC) "must do" action following the 2019 inspection. The action specifically called for assurance that a sufficient number of nurses are on duty to safely care for the volume of patients in the department. Meeting this requirement remains critical to delivering safe, responsive, and high-quality care.

11.3. FINANCE (to be approved via financial governance processes)

Analysis based on current run rate

ED CDH:

Following the acuity review, the professional judgement for CDH ED determines an uplift of 5.5 WTE Band 5 Registered Nurses, at a cost of £317k. The current forecasted bank spend for Band 5 Adult Nurses in 2025/2026 is approximately £330k. By increasing the core establishment, the proposal is projected to achieve a net staffing cost reduction of approximately £12k**.** This does not include potential further savings from improved sickness and absence rates, nor the financial benefit of reducing reliance on unqualified bank staff, which would contribute positively to both cost-efficiency and care quality.

ED RPH:

Following the acuity review, the professional judgement for RPH ED determines an uplift of 15.75 WTE Registered Nurses**,** at an estimated cost of £862k**.** The forecasted temporary staffing spend over the next 12 months, driven by the need to cover additional duties resulting from high patient numbers, is £1.131 million. Implementing the proposed model is expected to deliver an overall staffing cost efficiency of £215k against current spend. This efficiency may be adjusted by a 20% reduction in recognition of other Trust Waste Reduction Schemes but still represents a significant financial and operational improvement.

Both proposals are designed to enhance workforce stability, reduce dependence on temporary staffing, and improve the quality and safety of care in alignment with regulatory expectations and best practice workforce modelling.

Sickness

The ongoing financial pressures associated with covering sickness leave are the focus of improvement work as part of the single improvement plan, with a rapid improvement week 7th June 2025.

Agency

Agency use for registered nurses is now limited to ED, and theatres only. With the implementation of the staffing model in ED agency usage will cease in this area.

12. SAFE STAFFING GOVERNANCE

The Safety and Quality Committee continue to receive monthly safe staffing papers for adults, children and maternity. The papers are separated to ensure sufficient detailed oversight of the specialties is achieved and the introduction of medical staffing fill rates is evolving first through the maternity staffing paper.

Safe staffing policies are in place for each area and the DND's retain accountability for ensuring the deployment of staff in response to patient demand. The matrons operationalise these moves with site management arrangements in place 24/7 to ensure clear lines of escalation and support are available as situations change.

The changes to the ED staffing model have had an EQIA completed and will be taken forward and tracked through the waste recovery board.

13. CONCLUSION

In line with the recommendation from NHS Improvement Workforce Safeguards (2018) guidance, the Chief Nursing Officer confirms the outcome of the six-month review found that the SNCT data, triangulated with the professional judgment and patient and staff outcome metrics provided assurance that existing staffing levels and skill-mix are appropriate to meet the service's needs and patient demand for all areas with the exception of the ED departments at RPH and CDH and proposes that the revised model of nursing is endorsed (subjected to financial governance processes) to meet safe staffing requirements.

14. RECOMMENDATIONS

It is recommended that the Board of Directors:

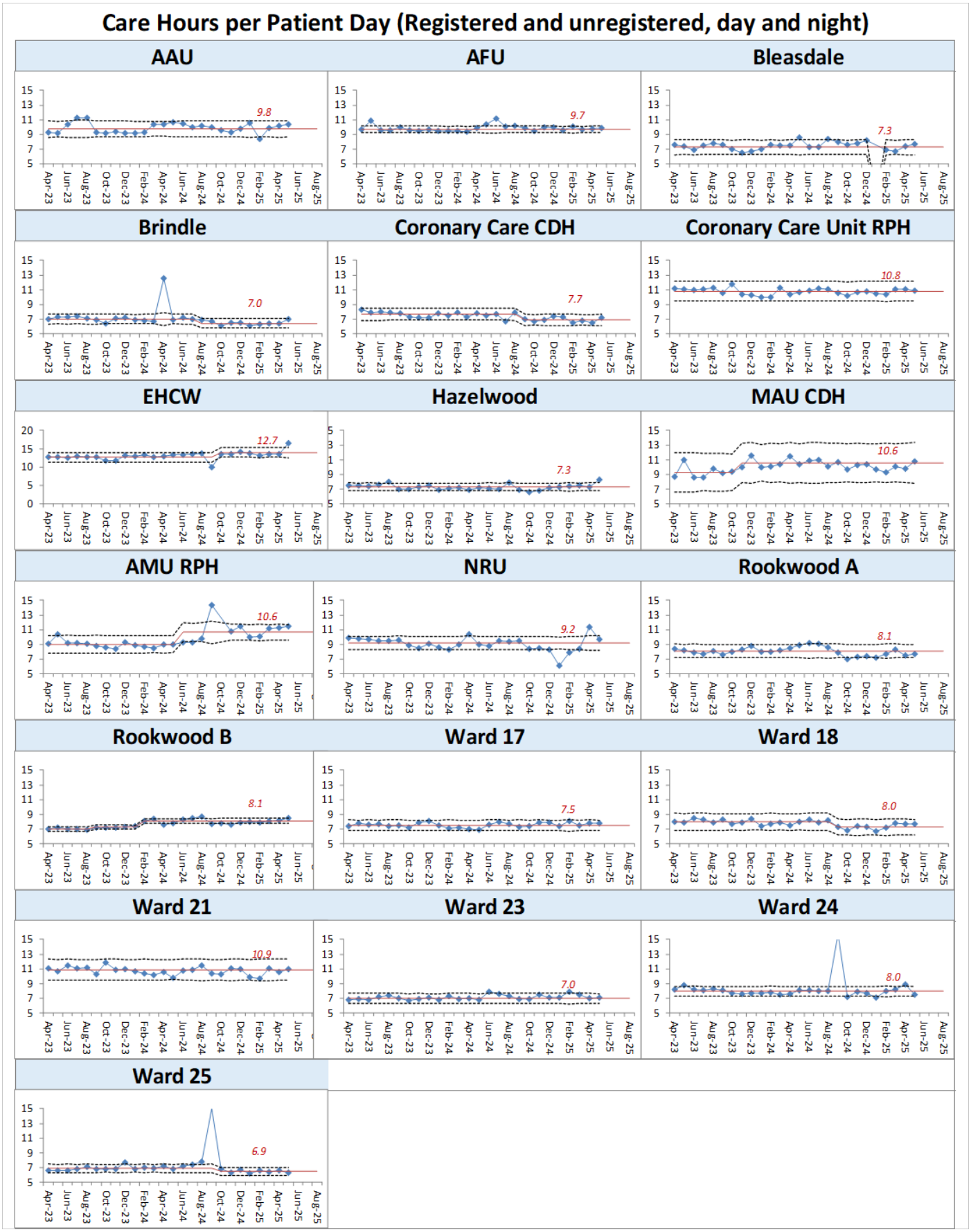
i. Approve the bi-annual staffing review, noting the endorsement by the Safety and Quality Committee.
ii. Note that in line with the recommendation from NHS Improvement Workforce Safeguards (2018) guidance, the Chief Nursing Officer confirms the outcome of the six-month review will deliver safe, effective and sustainable staffing levels for the organisation and meet the requirements of the NICE Safe Staffing Guidelines (2014) and the National Quality Board (NQB) Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time (2016).
iii. Note the decision to advance the ED staffing proposal is paused until the medicine divisional team define the service changes taking place around the urgent and emergency care pathway. Bank remains in place during this time to maintain safe staffing. This will be concluded by 31 October 2025.

Appendix 1 – Triangulated patient and workforce outcomes
Appendix 2 – CHPPD
Appendix 3 – Example Professional Judgment template

Appendix 1 - Triangulated patient and workforce outcomes

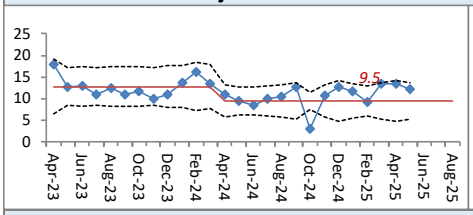
Ward/Dept	No of Beds 2024	% Fill Rate RN Days (3months - January - March)	% Fill Rate UnReg Days (3months - January - March)	% Fill Rate RN Nights (3months - January - March)	% Fill Rate UnReg Nights (3months - January - March)	Incident reports relating to Staffing (3months - January - March)	Red Flags raised (3months - January - March)	Falls (3months - January - March)	Pressure Ulcers (3months - January - March)	Clostridium difficile (3months - January - March)	Medication Errors with Harm (3months - January - March)	Rolling Sickness %	STAR rating (last accreditation audit)	Friends and family Good % (3months - January - March)	Friends and family Poor % (3months - January - March)	Friends and family Responces (3months - January - March)	Formal complaints (3months - January - March)	Compliments (3months - January - March)
ED (RPH) (adult)	62	118%	123%	126%	138%	8	0	26	17	2	7	4.22 %	89%	57%	33%	750	38	22
ED (RPH) (children)	3	93%	80%	90%	82%	1		0	0	0	0	10.56 %	89%	78%	18%	94		
AAU	18	88%	90%	89%	97%	1	11	5	4	1	1	9.24 %	89%	65%	27%	26	2	6
Bleasdale Ward	22	88%	111%	108%	110%	16	31	28	9	0	0	4.47 %	89%	88%	4%	25	6	0
NRU (Barton)	16	142%	129%	101%	195%	0	0	5	2	0	0	4.05 %	93% gold	75%	0%	4	1	0
AMU	42	86%	86%	92%	101%	1	21	22	4	1	0	8.47 %	83%	73%	15%	41	13	4
CCU RPH	6	91%	48%	100%	-	0	2	0	0	0	0	3.00 %	97% gold	100%	0%	40	0	4
Ward 17	32	110%	98%	101%	138%	3	45	23	2	2	0	10.03 %	85%	42%	42%	12	8	0
Ward 18	28	106%	86%	97%	105%	0	12	15	16	3	0	7.62 %	95%	88%	0%	8	6	0
Ward 21	24	104%	87%	100%	99%	0	1	9	6	0	0	9.00 %	96% gold	92%	0%	26	4	7
Ward 23	34	101%	97%	100%	114%	6	43	14	3	0	0	7.02 %	91% gold	87%	7%	30	1	0
Ward 24	32	101%	91%	99%	111%	0	33	10	3	2	0	9.42 %	91% gold	50%	35%	20	11	5
Ward 25	24	94%	85%	87%	117%	1	18	10	3	0	0	13.42 %	90%	65%	25%	20	0	5
Enhanced Respiratory High Care	11	95%	103%	106%	121%	1	27	5	11	2	0	5.12 %	93%	100%	0%	8	0	4
ED (CDH)	14	135%	118%	-	-	2	15	3	7	0	0	11.50 %	90%	89%	6%	720	14	13
MAU (CDH)	32	113%	119%	98%	119%	0	3	19	14	0	3	9.74 %	92% gold	81%	3%	37	6	2
Brindle	30	93%	98%	99%	111%	0	7	11	5	2	0	7.77 %	88%	74%	17%	42	9	6
Cardiac Unit CDH	10	91%	95%	101%	103%	1	20	3	5	0	0	5.88 %	98% gold	93%	3%	30	2	89
Rookwood A	24	101%	96%	102%	103%	0	22	12	3	0	0	7.53 %	89%	74%	17%	53	2	9
Rookwood B	24	91%	93%	103%	93%	0	10	8	4	3	0	8.98 %	92% gold	82%	12%	17	0	0
Hazelwood	19	104%	89%	100%	111%	0	6	12	2	2	0	9.53 %	89% gold	100%	0%	20	0	15
Ward 2a	17	98%	103%	99%	130%	0	2	4	8	0	0	7.42%	96% gold	93%	7%	15	1	17
Ward 2b	17	102%	107%	101%	134%	0	0	8	6	2	0	3.96%	98% gold	77%	15%	13	0	39
Ward 2c	17	102%	98%	101%	112%	0	0	8	2	0	0	6.51%	94% gold	95%	2%	49	1	31
Ward 3	14	106%	105%	117%	137%	0	11	2	1	1	1	5.19%	96% gold	86%	10%	21	1	19
Ward 4	26	121%	84%	123%	108%	0	4	6	2	1	0	4.93%	97% gold	90%	7%	41	0	28
Ward 10	29	105%	104%	96%	109%	0	3	11	3	1	1	3.11%	96% gold	81%	19%	57	0	29
Ward 11	22	100%	90%	114%	85%	0	4	2	2	1	1	4.32%	96% gold	92%	2%	53	0	31
Ward 12	33	110%	91%	100%	134%	0	3	5	0	0	0	5.73%	95% gold	74%	14%	50	0	1
Ward 14	25	99%	109%	96%	121%	0	14	4	11	0	1	6.07%	96% gold	79%	14%	29	4	2
Ward 15 unit 1	33	109%	77%	103%	97%	0	3	8	5	0	1	8.13%	89%	100%	0%	10	8	1
Ward 15 unit 2		112%	87%	103%	138%	0	14	8	8	1	0	8.13%	96%	100%	0%	2	0	0
Ward 16	25	100%	108%	103%	119%	1	27	7	7	2	0	7.18%	94% gold	73%	13%	15	0	0
Major Trauma Ward	10	98%	95%	100%	116%	0	5	3	5	0	1	10.41%	98% gold	92%	8%	13	0	23
Ribblesdale Unit	24	108%	95%	118%	102%	0	14	20	12	2	1	8.53%	96% gold	90%	0%	21	2	7
Surgical Assessment Unit RPH	17	98%	80%	99%	92%	0	5	5	0	0	2	12.54%	89%	65%	27%	166	7	8
SECU	4	93%	-	91%	-	0	0	0	0	0	0	7.86%	96% gold	100%	0%	38	0	0
Surgical Ward (CDH)	16	102%	93%	84%	100%	1	0	1	0	0	0	11.40%	98% gold	95%	2%	263	0	0
Leyland Ward	15	103%	78%	96%	77%	0	0	6	3	0	0	14.05%	99% gold	94%	4%	90	0	2
Ward 8	30	86%	69%	86%	100%	0	1	0	1	1	2	11.31 %	89%	93%	2%	291	0	2
PAU	12	87%	94%	100%	92%	0	N/A	0	0	0	0	6.90 %	89%	100%	0%	60	2	21
Pead Day case	7	101%	92%	-	-	0	N/A	0	0	0	1	5.97 %	99%	98%	1%	149	0	0
NNU	28	86%	72%	88%	65%	8		0	6	0	3	8.10 %	83%	100%	0%	30	2	5
Gynae Ward & DOSA RPH	14	118%	69%	125%	82%	2	13	0	0	1	0	10.48 %	98% gold	95%	4%	153	10	4
GAU	N/A	N/A	N/A	N/A	N/A	0		0	0	0	0		98%	100%	0%	1	0	0
Maternity A	12	99%	86%	96%	94%	155	154	0	0	0	2	18.62 %	94% gold				6	4
Maternity B	31	95%	80%	96%	99%	3	3	0	0	0	0	7.38 %	95% gold	86.00%	5.00%	43	0	0
Maternity Assessment Unit	7	98%	98%	98%	97%	355	355	0	0	0	1	4.20 %	98%				4	0
Delivery suit	12	91%	88%	95%	96%	10	9	0	0	0	0	5.80 %	92% gold	88%	8%	40	1	44
Critical Care	32	86%	82%	87%	86%	27	0	1	24	2	2	9.42 %	92% gold	98%	1%	206	2	238

Appendix 2 - CHPPD

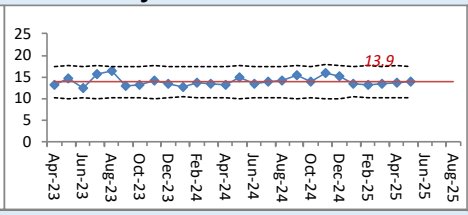


Care Hours per Patient Day (Registered and unregistered, day and night)

Leyland



Major Trauma Ward



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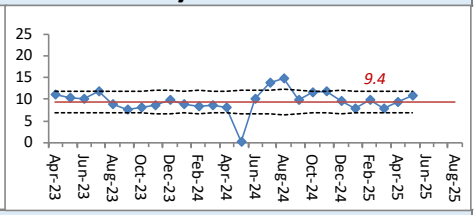

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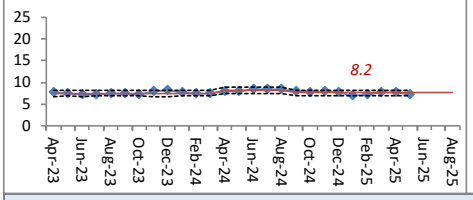

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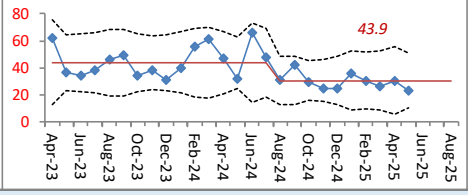

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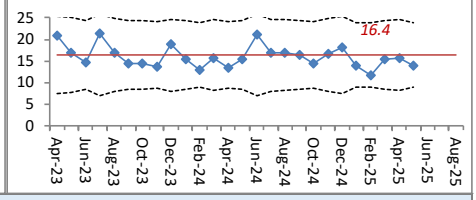

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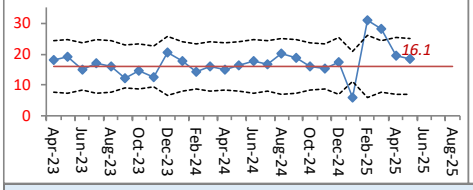
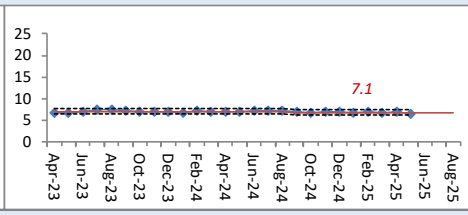


Ward 10



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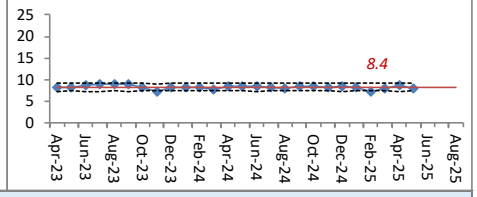

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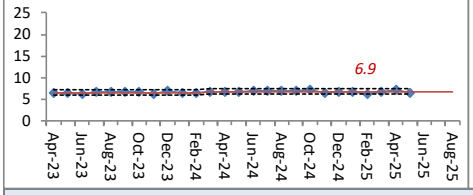

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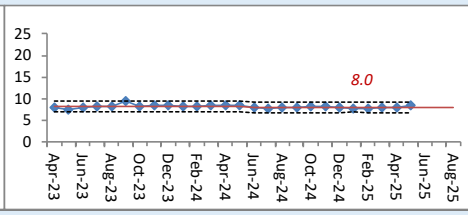

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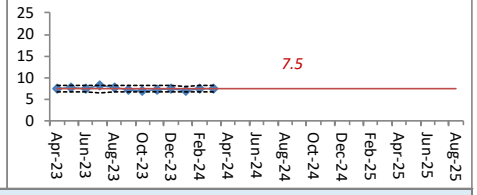
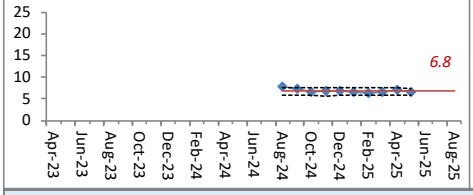


Ward 15 - Unit 1



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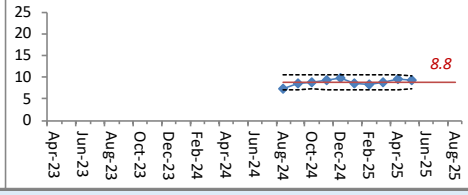

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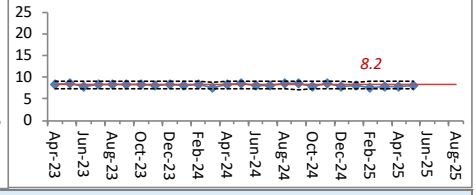

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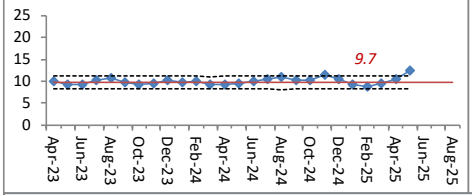

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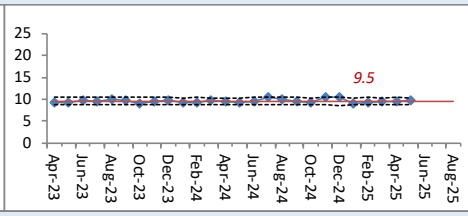

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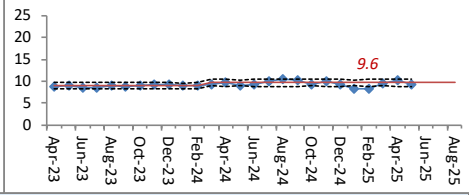

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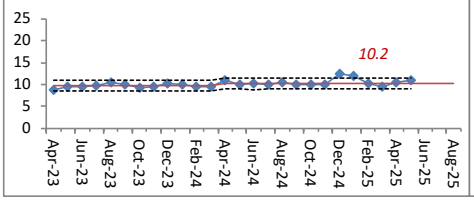

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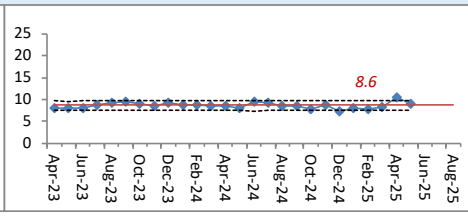
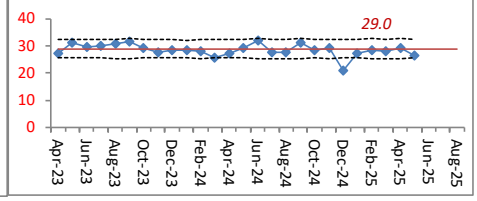
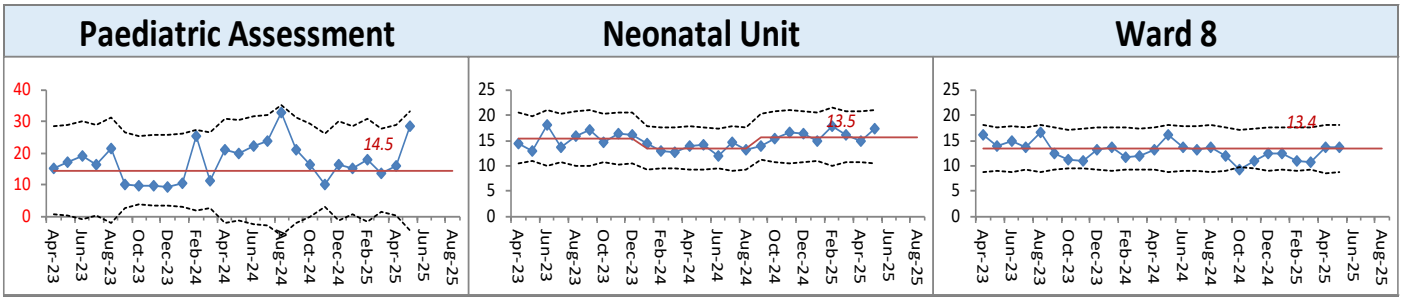


Crit care




Paediatric Assessment
Neonatal Unit
Ward 8
14.5
13.5
13.4
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
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Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Apr-25
Jun-25
Aug-25

Appendix 3 - Example Professional Judgment template

Professional Judgement Framework			
Division			
Name of reviewer (must be minimum 8a or above)			
Date of Review			

Key	
Areas of Concern	Red
Requires improvement	Amber
Compliant	Green

Evidence Required	RAG (choose from drop down)	Clinical areas / Supporting Narrative / Comments	Prompts/considerations for answering
Expectation 1: Right Staff			
Areas where there is a gap in leadership			any changes in leadership or any gaps
Areas where management time is not being achieved			is management time being allocated, is it consistent (70/30, 60/40)
Area with gaps in multiprofesssional team			are there gaps in MDT support, who/what is needed
Areas with gaps in administration/supportive roles			any changes, right skills, gaps in support, ward clerk, house keepe
Positive staff experience measures - areas of concern			Feedback mechanisms, rewards and recognition, concerns raised
Budget meets requirements, including a review of headroom			under/overspent? Is headroom sufficient for requirements
SNCT Data (or equivalent e.g BAPAN, Birth rate plus) collected by trained staff - areas of concern based on data			
Expectation 2: Right Skill			
Areas of concerns that do not have sufficient technology to support team function.			Is IT accessible and all staff trained? Any gaps, any mitigations being used?
Areas not under conpliance for appraisals (note compliance %)			Any gaps, plans in place to complete
Areas not meeting the mandatory training standard met (note compliance %)			Any gaps, plans in place to complete to Trust targets
Areas where skill mix needs to be reviewed based on data or professional judgment.			Lots of new starters/junior staff, adequate NIC cover, right skills for clinical area, any gaps?
Expectation 3: Right place and time			
Any areas that have had a change in patient length of stay effecting staffing requirements			is patient turnover higher than expected for clinical speciality, are there increased moves, outliers, long stay patients, include LOS data if approriate
Area with changes to the layout of the ward/unit effecting staff meeting the needs of the patients			layout compact, spread out, lots of siderooms, difficulty in observing patients
Area that have Enhanced Theraputic Observations of Care (ETOC) patients and there are concerns that current processes are not maintaining safety.			if high use, how much, what type of patients, are ELOC assessments completed and support this? Provide data
Area outside of sickness Trust threshold (4%)			sickness management in place?
Patient experience measures in place, any areas of concern.			FFT feedback, complaints/concerns, patient advocates used
Student feedback considered, any areas of concern			Student feedback surveys, 1:1s, listening to concerns raised

Reference List

- National Quality Board (2018)Safe, sustainable and productive staffing – adult inpatient wards in acute hospitals https://www.nice.org.uk/guidance/sg1/resources/safe-staffing-for-nursing-in-adult-inpatient-wards-in-acute-hospitals-61918998469

- National Quality Board (2016) Improvement and Assessment Framework for Children's and Young People's health services https://cdn.ps.emap.com/wp-content/uploads/sites/3/2018/02/Improvement_and_assessment_framework_for_children_and_young_people_FEB_2018_version_3.pdf

- National Quality Board (2017) Safe, Sustainable and productive staffing: An improvement resource for neonatal, children and young people services https://www.england.nhs.uk/wp-content/uploads/2021/04/safe-staffing-cyp-june-2018.pdf

- National Quality Board (2017) Safe, sustainable and productive staffing An improvement resource for urgent and emergency care https://www.england.nhs.uk/wp-content/uploads/2021/04/safe-staffing-uec-june-2018.pdf

- Care hours per patient day (CHPPD): guidance for all inpatient trusts https://www.england.nhs.uk/long-read/care-hours-per-patient-day-chppd-guidance-for-all-inpatient-trusts/

- BAPM guidance https://www.bapm.org/resources/157-calculating-unit-cot-numbers-and-nurse-staffing-establishment-and-determining-cot-capacity

- RCN CYP staffing guidance https://www.rcn.org.uk/clinical-topics/children-and-young-people/neonatal-nursing

- Guidelines for the provision of intensive care services https://www.ficm.ac.uk/sites/ficm/files/documents/2022-07/GPICS%20V2.1%20%282%29.pdf

14.1 - DATA QUALITY ASSURANCE REPORT

REFERENCES

Only PDFs are attached

14.1 - DQA Board Report Oct 25 Final.pdf

Excellent care with compassion

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Data Quality Assurance Report			
Report to:	Board	**Date:**	Oct 2025
Report of:	Chief Information Officer	**Prepared by:**	D Hudson, T Caton
Part I	√	**Part II**	

Purpose of Report (tick only one then delete this instruction)

For approval	☐	**For ratification**	☐	**For discussion**	☐	**For information**	☒

Executive Summary:

The paper informs the Board in relation to current data quality assurance activities and provides an update in relation to data quality performance.

The Report details performance in relation to:

- Data Quality Team activities
- External Data Quality Assurance
- Update in relation to Data Quality Risks
- Waiting List Minimum Dataset Data Quality
- National Data Quality Assurance Dashboard and Maturity Index

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

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

Data Quality Assurance Update Report

Background/Context

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

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

Introduction

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

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

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

This paper sets out actions to date undertaken to maintain data quality standards within the Trust.

Discussion

Internal and External Scrutiny

Information Governance

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

The Data Protection and Security Toolkit has been aligned with the Cyber Security Framework and the data quality requirements are included within the objective '*evidence around essential functions data being monitored to verify location and transmission, quantity and quality*' rather than a separate requirement. Evidence relating to the audit and validation programme has been supplied for the baseline submission. MIAA initial audit has been completed (report pending).

Data Quality Assurance Activities

Harris Flex Masterfile Maintenance

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

- Postcode

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

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

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

Data Quality audit programme

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

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

2025/26:	Total Complete:	Total CA Sent:	Total CA Received:	CA Outstanding:
Completed OPT Demographic Audits	42	3	1	2
Completed IP Demographic Audits	0	0	0	0
Completed ED Demographic Audits	1	1	1	0
Completed Reception Audits	0	0	0	0
Completed IP Casenote Audits	0	0	0	0
Completed OP Casenote Audits	0	0	0	0
Totals:	43	4	2	2

Shared Care Record - ShCR – update

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

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

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

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

The table below shows a summary of records transferred via ShCR for the GP practices April 2025 – August 2025.

Month	Total Records Sent	Total Rejected	% of records	No. EMIS issue	No. True Rejections (inc NOP, dupes etc)	True rejections as a % of all records sent	True rejections as a % of rejected records
April	57221	1110	1.94%	167	943	1.65%	84.95%
May	59326	838	1.41%	17	821	1.38%	97.97%
June	61201	834	1.36%	15	819	1.34%	98.20%
July	66288	889	1.34%	26	863	1.30%	97.08%
August	57719	829	1.44%	22	807	1.40%	97.35%
Total	**301755**	**4500**	**1.49%**	**247**	**4253**	**1.41%**	**94.56%**

Rejection Reasons:-

- Not registered at GP practice IHDI sent to
- Baby – delay in registering at GP practice
- GP patient registered with practice, not on SCR system
- Duplicate IHDIs being sent to Practices

There are minimal numbers of summaries being posted for GP practices that are not currently part of ShCR. Savings on consumables and posting for discharge summaries and letters achieved to-date in this financial year is £64,324.55

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

Due to the increased volume of documents and external partner issues across the system, resulting in increased rejections, pressure on the DQA team and potential patient clinical safety risk, a corporate risk assessment(1275) has been logged onto DATIX and is reviewed monthly.

Data Completeness and Validity

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

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

Month 2025-26	Attended	DNA	Cancelled	Pended
April	217	45	13	356
May	154	63	10	661
June	254	108	12	488
Total Appts	625	216	35	1505
Average	57	20	3	137

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

Data Quality Newsletters

The Data Quality Assurance team have published 2 newsletters in April & August 25 giving an update on:

- DQA move to One Lancashire & South Cumbria
- Right patient right visit campaign
- DQA Audit programme
- Hospital Discharge Summaries
- Unrecorded Outpatient activity
- DQ/IG Presentations
- Meet the team
- Updates on the SCR(LPRES) project
- IHDIs – new discharge notification
- Harris Flex validations
- TPro, digital dictate – transfer to GPs across ShCR
- Patient Discharge Dates


DQA Newsletter April 25.pdf


DQA Newsletter August 25.pdf

Data Quality Forums

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

Examples from last 6 months:- Discussions on enhancing stakeholder engagement and communication on data quality. Spiner User Death report. Clinical letters for patients with no GP.
Presentations on Robotic Process Automation – how to support data quality. Abandoned referrals – case study

Data Quality Risks

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

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

RA No	Risk Item	Issue	Action 2025-26	Update
54	Harris Flex GP Masterfile maintenance (current rating 12)	In-active GPs linked to patient records. In-accurate GP records in Masterfile on Harris Flex. Continued misdirected correspondence.(NOPs).	Move to ODS quarterly updates. Increase volume of documents transferred via SCR.	Harris flex team working with BI & DQA to establish process to upload files onto TEST PROD. Standing item on bi- weekly applications call with Harris team. Digital dictate process live – transfer of letters via ShCR complete
122	Corporate system recording issues. In-accurate recording of patient data/activity (current rating 12)	Variety of in-accurate event documentation. Incomplete linking across activity flows.	Review SUS issues on key data items. Continue to review functionality to improve correction of data on Harris Flex. Establish data quality forum	Further additional Harris flex validation reports implemented. Working on supporting divisions with identifying reasons for issues with activity recording. Working with BI on SUS errors highlighted.

1207	Inability to meet the monthly clinical coding submission standards (current rating 9)	Non-availability of comprehensive coded data. Timeframe for reviewing / coding data.	Ebooks – time risk assessment Review ICD11 classifications Implement coding ebook Recruit to coder position	Ongoing review / risk assessment. Ongoing review / risk assessment. New trainees using ebooks, ongoing monitoring New member of staff due to commence 30th September
1554	Inability to fully run the Trusts Data Quality programme (current rating 12)	Volume of in-accurate patient records on core patient system Harris Flex. Increase in number of rejections from sending clinical documentation via ShCR. Move from SLAM to SUS reporting (requiring additional validations) External issues with ShCR process (increasing volumes of rejections) Volume of pended outpatient appoints requiring review / documenting	ShCR resource paper – additional documentation transfer Establish data quality forum Recruit vacant DQA Assistant role RPA resource paper – additional work to ensure governance around the use of RPA processes.	Approved additional resource in principle – awaiting funding Vacancy freeze Audit programme recommenced with weekly patient demographic outpatient audits.
2175	Transfer of clinical documentation via Shared Care Record system (16)	Volume of documents transferred via ShCR high. Additional pressure on DQA team to action rejections. Ongoing issues with failed deliveries due 3rd party supplier systems.	Extend Demographic audits include ED patients. Implement Spine tracing for patients on Harris Flex Review volume of documents and % rejections to assure not increased issue	DQA Assts currently training. Harris flex team working with BI & DQA to establish process to upload files onto TEST PROD. Standing item on bi- weekly applications call with Harris team. Report completed to present at next DHI Risk meting

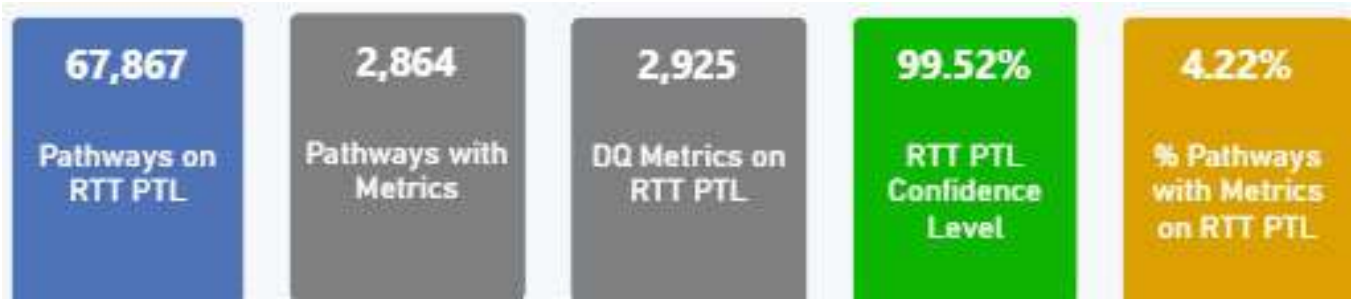
External Data Quality Assurance Monitoring

Elective Recovery - Waiting List National Minimum Dataset

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

Nationally a Data Quality Reporting tool (LUNA) has been developed to support Trusts in making improvements to the quality and consistency of the datasets. Organisations submissions are assessed against 20 key data quality standards and assigned an overall data confidence level. The current week position for the Trust is shown below. The Trust confidence level score of 99.52% is above the national target of 95%, with the weekly trend showing sustained compliance and improvement. Of the total pathways submitted just 4.22% of records have been identified with a data quality flag that may warrant further review. Actions are ongoing to further improve the completeness and validity of submissions.

Current Week – Confidence Level



Confidence Level Trend

	07/09/2025	31/08/2025	24/08/2025	17/08/2025	10/08/2025	03/08/2025	27/07/2025	20/07/2025	13/01/2025
RTT PTL Confidence Level	99.52%	99.51%	99.51%	99.52%	99.51%	99.52%	99.52%	99.52%	99.53%

Data Quality Maturity Index (DQMI)

The DQMI is a monthly national publication intended to raise the profile of data quality in the NHS by providing data submitters with timely and transparent information in relation to the quality of key data submissions. The DQMI scores are based on the completeness, validity, coverage and use of default values within core data items held within key datasets submitted nationally by the Trust to the Secondary Uses Service. Data items monitored include NHS number, date of birth, gender, postcode, speciality and consultant as well as dataset specific items. Overall and dataset specific scores for the Trust are shown below for the period to end November 2024. Scores for all datasets are extremely positive showing a consistently high-performance score during 2024/25 compared to other NHS Trusts. The Trust performs at well above the national average of 86.4% across all datasets.

	Overall	Emergency Care Dataset	Admitted Patient Care Dataset	Out-Patient Dataset
National Average	86.4	83.5	93.3	91.9
Lancashire Teaching	91.2	83.6	99.5	98.8

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

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

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

Clinical Coding Completeness

The Clinical Coding Team continues to ensure the availability of comprehensively coded data in line with the national flex and freeze timetable. During 2024/25, the Trust maintained a coding completeness level at freeze of 100%. However, the level of coding completeness at flex has dipped slightly to between 70-80% due to an increase in the number of episodes to code. The senior team have submitted a pressures paper detailing the key challenges to maintaining the current flex and freeze positions.

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

- A programme of clinical engagement to enhance quality and depth of coding
- Wider programme of internal audit to enhance coder skill sets including the appointment of a dedicated Audit & Quality Manager to drive quality improvements within the Clinical Coding team
- Fully implemented an enhanced End Coder system that supports additional quality and consistency checks. The upgrade of 3M Medicode system to Medicode 360 has provided additional audit and consistency capability.
- Engaged with IQVIA to implement their Clinical Coding Analytics tool plus 12 days consultancy during 2024/25 to identify opportunities to enhance the depth of admitted care clinical coding. Work is ongoing to action monthly opportunity reports provided by IQVIA.

Recommendations

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

Appendix 1 –DQMI Dataset Compliance

Trust coverage compared to the national average for key data items for the period to May 2025. This is a coverage dashboard not a check of the accuracy of content.

Data Item	Trust Nov 2024	National Average	Variance	Rating	Actions
OUTPATIENT KEY DATA ITEMS					
ACTIVITY TREATMENT FUNCTION CODE	99.20%	95.10%	4.10%		
ADMINISTRATIVE CATEGORY CODE	100.00%	94.70%	5.30%		
CARE PROFESSIONAL MAIN SPECIALTY CODE	99.20%	94.70%	4.50%		
CONSULTANT CODE	99.20%	80.70%	18.50%		
ETHNIC CATEGORY	92.60%	80.30%	12.30%		
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	99.90%	92.80%	7.10%		
NHS NUMBER	100.00%	91.00%	9.00%		
NHS NUMBER STATUS INDICATOR CODE	100.00%	98.00%	2.00%		
ORGANISATION CODE (CODE OF COMMISSIONER)	99.70%	96.00%	3.70%		
PERSON BIRTH DATE	100.00%	96.00%	4.00%		
PERSON GENDER CODE CURRENT	100.00%	97.00%	3.00%		
POSTCODE OF USUAL ADDRESS	99.90%	93.40%	6.50%		
SITE CODE (OF TREATMENT)	100.00%	82.30%	17.70%		
SOURCE OF REFERRAL FOR OUTPATIENTS	93.70%	88.90%	4.80%		
ADMITTED CARE KEY DATA ITEMS					
ACTIVITY TREATMENT FUNCTION CODE	100.00%	96.20%	3.80%		
ADMINISTRATIVE CATEGORY CODE (ON ADMISSION)	100.00%	96.30%	3.70%		
ADMISSION METHOD (HOSPITAL PROVIDER SPELL)	100.00%	96.80%	3.20%		

CARE PROFESSIONAL MAIN SPECIALTY CODE	100.00%	95.80%	4.20%		
CONSULTANT CODE	100.00%	90.60%	9.40%		
DECIDED TO ADMIT DATE	99.90%	65.20%	34.70%		
DISCHARGE DATE (HOSPITAL PROVIDER SPELL)	100.00%	98.60%	1.40%		
DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL)	100.00%	96.10%	3.90%		Improved to 100% from 94.9% in Nov 2023
DISCHARGE METHOD CODE (HOSPITAL PROVIDER SPELL)	100.00%	96.00%	4.00%		
ETHNIC CATEGORY	90.80%	88.40%	2.40%		
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	99.90%	94.20%	5.70%		
NHS NUMBER	100.00%	93.50%	6.50%		
NHS NUMBER STATUS INDICATOR CODE	100.00%	98.70%	1.30%		
ORGANISATION CODE (CODE OF COMMISSIONER)	99.80%	96.30%	3.50%		
ORGANISATION CODE (CODE OF PROVIDER)	100.00%	97.20%	2.80%		
PATIENT CLASSIFICATION CODE	100.00%	97.90%	2.10%		
PERSON BIRTH DATE	100.00%	97.20%	2.80%		
PERSON GENDER CODE CURRENT	100.00%	98.00%	2.00%		
POSTCODE OF USUAL ADDRESS	99.80%	95.60%	4.20%		
PRIMARY DIAGNOSIS (ICD)	99.90%	83.40%	16.50%		
SITE CODE (OF TREATMENT)	100.00%	84.50%	15.50%		
SOURCE OF ADMISSION CODE (HOSPITAL PROVIDER SPELL)	100.00%	96.60%	3.40%		
EMERGENCY CARE DATASET KEY DATA ITEMS					
CHIEF COMPLAINT (SNOMED CT)	98.70%	77.70%	21.00%		
ACUITY (SNOMED CT)	99.80%	85.00%	14.80%		
DIAGNOSIS (SNOMED CT) - FIRST	72.60%	65.30%	7.30%		Improved to above the national average
ARRIVAL DATE	100.00%	100.00%	0.00%		
ARRIVAL TIME	99.80%	98.30%	1.50%		
INITIAL ASSESSMENT DATE	100.00%	85.30%	14.70%		
INITIAL ASSESSMENT TIME	99.30%	84.20%	15.10%		
DATE SEEN FOR TREATMENT	99.00%	84.10%	14.90%		
TIME SEEN FOR TREATMENT	97.40%	81.80%	15.60%		

DEPARTURE DATE	99.20%	97.10%	2.10%		
DEPARTURE TIME	99.90%	96.10%	3.80%		
NHS NUMBER	99.50%	98.10%	1.40%		
NHS NUMBER STATUS INDICATOR CODE	99.90%	99.90%	0.00%		
ATTENDANCE SOURCE (SNOMED CT)	99.90%	89.90%	10.00%		
DISCHARGE STATUS (SNOMED CT)	99.40%	86.30%	13.10%		
DISCHARGE FOLLOW-UP (SNOMED CT)	98.70%	69.10%	29.60%		
DISCHARGE DESTINATION (SNOMED CT)	99.40%	85.70%	13.70%		
DISCHARGE INFO GIVEN (SNOMED CT)	0.40%	4.50%	-4.10%		Slight improvement since incorporation via ECDS V3.0 Implementation plan
ETHNIC CATEGORY	98.40%	86.50%	11.90%		
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	99.80%	98.10%	1.70%		
ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)	98.60%	94.10%	4.50%		
PERSON BIRTH DATE	100.00%	98.80%	1.20%		
PERSON STATED GENDER CODE	100.00%	97.40%	2.60%		
POSTCODE OF USUAL ADDRESS	99.50%	98.70%	0.80%		
ARRIVAL MODE (SNOMED CT)	100.00%	92.20%	7.80%		
ATTENDANCE CATEGORY	100.00%	90.30%	9.70%		
PROCEDURE (SNOMED CT) - FIRST	99.40%	73.70%	25.70%		
PROCEDURE DATE - FIRST	43.10%	64.80%	-21.70%		Slight deterioration
PROCEDURE TIME - FIRST	41.80%	48.60%	-6.80%		Slight deterioration
CLINICAL INVESTIGATION (SNOMED CT) - FIRST	44.50%	68.60%	-24.10%		Continued improvement since incorporation via ECDS V3.0 Implementation plan
INJURY INTENT (SNOMED CT)	11.00%	38.60%	-27.60%		Slight deterioration

14.2 - SOCIAL VALUE STRATEGY

REFERENCES

Only PDFs are attached

14.2 - Social Value Strategy 2025.pdf

Single Improvement Plan

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Social Value Strategy

2025–2030

Foreword

by Professor Silas Nicholls, Chief Executive

Lancashire Teaching Hospitals is proud to be part of the fabric of the communities we serve. We are more than a healthcare provider – we are a major employer, a partner, and a trusted presence in people's lives. This Social Value Strategy is a statement of our intent to use that position to do more: to shape opportunity, reduce inequality, and support healthier, fairer futures.

For me, this commitment is not abstract. I have seen first-hand how the circumstances people grow up in can shape their health, their prospects, and their sense of possibility. Those experiences have left me with a deep conviction that our organisation must do everything it can to widen opportunity and help people to thrive. The Board shares this conviction, and together we are determined to make social value part of how we lead, plan and act every day.

Social value is about recognising that the care we provide through our services is only one part of the difference we can make. By embedding social value into how we employ, procure, invest, and partner, we can create opportunities that uplift communities, support inclusion, and strengthen the foundations of health.

This strategy sets out our collective ambition: to ensure that social value is not an afterthought, but a golden thread woven through all that we do. It is about how we act as an employer of choice, how we support the local economy, how we protect our environment, and how we work with others to create lasting impact.

The Board and I are fully committed to this agenda. But success will not come from leadership alone. It depends on all of us – colleagues, partners, and communities – working together to ensure our organisation's positive impact extends beyond our services and into people's daily lives.

Together, we can make Lancashire a place where more people live not just longer, but better lives.

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 institution, 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 ours 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.

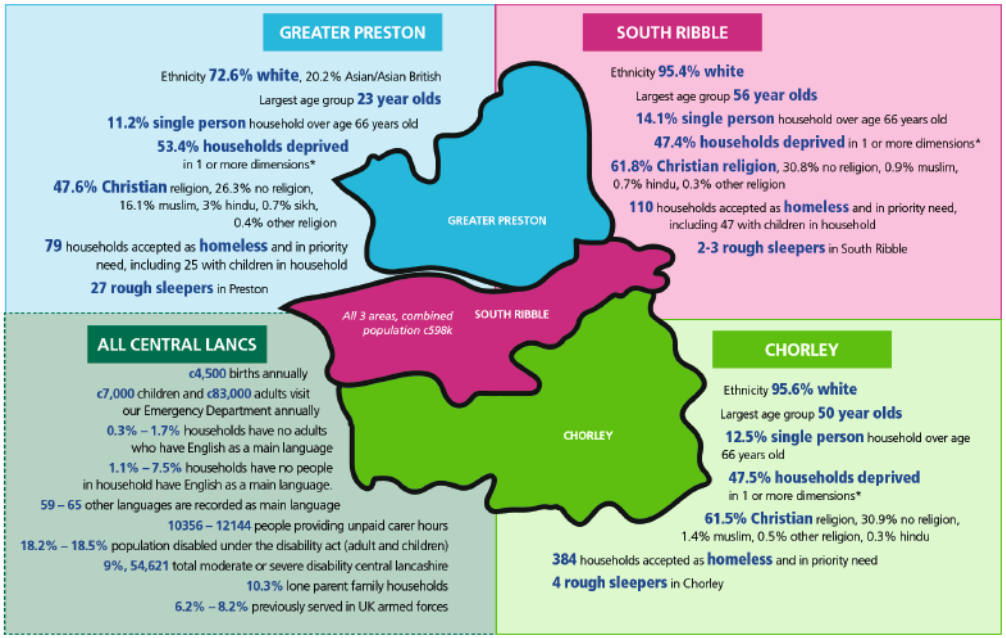
Why does social value matter for our communities

Although progress is being made across the public sector, voluntary and charitable 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. The Lancashire Skills and Employment Hub reported in 2023 that 15.9% of total employment across the Local Authority Area for Lancashire were employed in Human Health and Social Work Activities, the largest employer, with wholesale and retail next at 15.8%.

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 described by the Lancashire Skills and Employment Hub and associated paper Lancashire Skills Hub insight report (Sept 2023) titled Economic Inactivity in Lancashire: Health and Wellbeing and the Economic Threat of Inactivity, the proportion of the population that are economically inactive in the areas covered by Lancashire County Council (data set March 2025) is approximately 193,000, which is similar to the national economic inactivity rates. However when looking at Preston separately this rises to 24.2% (2.7% above the national average), which is in stark contrast to Chorley and South Ribble which are well below the national average. This inactivity has significant economic consequences, with modelling estimating an annual loss of circa £5 billion in potential economic output, therefore by helping to get a proportion of this cohort back into work it would result in significant economic gain for our region.

Looking further at the population who are economically inactive in Preston, 64.2% do not want employment, with 91% who are economically inactive in Chorley also not wanting a job. However overall employment rate across the areas covered by Lancashire County Council is at 77.5% and this is back to pandemic levels. Despite this 23% of 16–17 year olds, 31,7% of 18–24 year olds and 28% of 25–49 year olds are claiming universal credit as a result of worklessness. Across Lancashire the reasons for inactivity are due to long term sickness with 41.3% stating this as a reason, followed by 17.6% looking after family/home and 12.9% retired. This split changes when looking just at Preston, with long term sickness increasing to 50.9% and caring for family to 11.2%. There again is a stark contrast when looking at Chorley with only 39.7% inactive due to long term sickness however 15.8% caring for family and South Ribble with only 36.6% being economically inactive due to a long-term condition and 12% caring for family. The levels of inactivity due to a long-term condition are far higher in our local region than compared to the national average at 28.2% and the Northwest average at 32.3%.

As well as supporting economic gain, it could potentially reduce the demand on our healthcare services. There is strong evidence that "work is good for health and unemployment is bad for it" Health, work and health related worklessness - A guide for local authorities (2016). Furthermore, this guidance highlights how worklessness is associated with an increased risk of mortality and morbidity including cardiovascular disease, poor mental health, suicide and health-damaging behaviours. In our role as a healthcare provider and large local employer we have a dual role in supporting our community with health issues to be well enough to obtain and retain work, whilst supporting colleagues to maintain economic independence and wellbeing.

The connection between workplace heath in our organisation and population health is very close as many people live within a relatively short commute to our hospital sites. Through our actions we have the potential to play a significant role in reducing health inequalities, 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. The local authority guide titled Health, work and health related worklessness identified that by investing in keeping colleagues engaged and happy in their work it supports their wellbeing, protects against social exclusion through the provision of income whilst providing social interaction, identity and purpose. It also highlighted the benefits of investing in workplace health, with every £1 spent on health and wellbeing programmes for staff delivers a return on investment of between £2-£10 as it leads to reduced absence, increased productivity and reduced turnover.

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 75.9%), 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 an 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:

Further to this the principles of this strategy are aligned to the NHS 10-year plan which envisions a shift towards neighbourhood health services, where care is delivered closer to people's homes and within their communities through integrated, multidisciplinary team working across place. The NHS 10-year plan aims to improve access to healthcare, reduce pressure on hospitals, and promote preventative care to achieve better health outcomes, reduced health inequalities and reduced hospital admissions.

Patients
Our ambition is to consistently deliver excellent care

Performance
Our ambition is to consistently deliver excellent care

People
Our ambition is to be a great place to work

Productivity
Our ambition is to deliver value for money

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, Patient Experience 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 colleagues, create inclusive teams where members of the 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 scooping measurement opportunities and methodology, 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 the Equality, Diversity and Inclusion Strategy, through to the 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 have signed up to Lancashire Skills Pledge, demonstrating our commitment to upskilling, recruiting, and inspiring local people through our widening participation offer, apprenticeships, volunteer scheme and community engagement around our vacancies.
- 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, through working in partnership with and utilising the support offer from Lancashire Skills Hud including Connect to Work Programme, and WorkWell Lancashire.
- 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.
- Maximise through the submission of our Lancashire Skills Pledge to further demonstrate our commitment to inspiring, recruiting and developing the people of Lancashire.

- Tackle health inequalities in our workforce through increasing the declaration rates of colleagues with a long-term condition or disability, supporting colleagues to complete Disability Support Passports to enable colleagues to retain in work, to deliver target wellbeing campaigns and interventions to support colleagues from minority groups to feel well and remain in work.
- 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.
- Through understanding the experience of colleagues from different socio-economic backgrounds develop intelligence led actions to improve their levels of staff satisfaction and engagement.
- Through our vision to achieve University Hospital status attract and retain talented individuals to live and work in our community to contribute to research and advance healthcare to benefit our patients.
- Expand our apprenticeship programme to create opportunities for our current and future workforce to obtain a qualification whilst in employment in the organisation.
- 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 Development 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.
- Create opportunities as part of our Leadership Development offer to develop skills in system and partnership working where applicable, by creating opportunities for leaders in all professions to develop community partnerships with colleagues from the voluntary, charitable sector, local government and public health.

Single Improvement Plan Alignment and Success Measures

This aim of the Social Value Strategy is aligned to the following Single Improvement Plan aims and the enabling strategies to support the delivery includes:

Our People Plan

The Equality, Diversity and Inclusion Strategy

The Education Strategy

People

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.
- Understanding and where required improving the experience of work for colleagues from different socio-economic backgrounds.
- 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.
- Number of hours completed by our volunteers as recorded on a quarterly basis to NHSE.
- Improved mental and physical wellbeing of colleagues measured through participation in multidimensional wellbeing offer, reduced sickness absence and increased colleague satisfaction.
- Our performance against the annual Workplace Wellbeing Charter assessment and reaccreditation findings and recommendations.
- Uptake on health and wellbeing programmes and training sessions.
- An engaged and empowered workforce measured through the NHS Staff Satisfaction Survey, the percentage of the workforce that has completed skills development and training and has participated in a talent management programme.

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 along with 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 the local suppliers we use. 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:

- As part of our longer-term vision and strategy for our estate, create collaborative spaces where colleagues from the voluntary and charity sectors, Public Health, housing and local authority colleagues can be collocated. This will be aligned to the vision set out in the wider NHS 10 year plan which describes the shift towards neighbourhood health services which are staffed by cross organisational multidisciplinary teams.
- 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 as a way to create community cohesion.
- Refresh and launch a new 5-year Green Plan to reduce our impact on the environment, 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.

Single Improvement Plan Alignment and Success Measures

This aim of the Social Value Strategy is aligned to the following Single Improvement Plan aims and the enabling strategies to support the delivery includes:

The Green Plan and 1 LSC Procurement Strategic Plan

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.

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.
- Create opportunities for leaders in all professions to develop community partnerships through providing learning and collaboration opportunities at system and place with colleagues from the voluntary, charitable, local government and public health.
- Working towards University Hospital status by working in partnership with local university to enhance the education offer, progress cutting edge research in the heart of our community to develop new treatments, technologies and approaches to healthcare to benefit our patients.
- Be part of the Lancashire Growth Plan through aligning the aims of this strategy with those set across Lancashire in order to contribute to the innovation and economic growth of the region. This will be achieved through identifying combined projects across health and skills organisations to reverse the growth in economic inactivity, supporting the aspirations of young people through creating effective transitions from education to the world of work and investing in AI skills and innovation to release capacity, to create productivity and prevent digital exclusion of our workforce.
- Actively participate in the Lancashire Social Value Network through involvement in the bi-annual social value networks.
- 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.
- Support the reduction in poverty of our patients through signposting relevant advice and guidance on wider benefit or charitable support individuals with health needs can access.
- Using an intelligence based and intelligence lead approach to develop cross sector multidisciplinary working to manage complex health conditions and needs, social issues, substance abuse for example with patients who are high intensity or frequent users of emergency care services by taking an integrated, multi sector approach to bringing about wider place-based changes.
- Partnering with other anchor institutions across a place by establishing anchor collaboratives and networks to develop shared approaches on building community understanding of the importance of self-care and empowering communities to take greater control of their health and wellbeing.
- Developing networks to support shared learning and spread good practice.
- 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.

Single Improvement Plan Alignment and Success Measures

This aim of the Social Value Strategy is aligned to the following Single Improvement Plan aims and the enabling strategies to support the delivery includes:

The Health Inequalities Plan

Patient Experience and Involvement Plan

The Green Plan

The Equality, Diversity and Inclusion Strategy

Our People Plan

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.
- The impact we are intending to deliver will be monitored through the Single Improvement Plan metrics.