NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS ANCILLARY PACK

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5 February 2026

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AGENDA

BOARD OF DIRECTORS PART I ANCILLARY PACK

Items:
9.2 - Gender Pay Report
9.3 - Equality, Diversity and Inclusion Annual Report
11.2 - Annual Adult Safe Staffing Report
11.3 - Maternity and Neonatal Service Update
13.1 - 2026/27 Plan and Board Assurance Statement ? Approval prior to Submission
13.3 - Review of Terms of Reference
14.1 - Register of Interests

9.2 - GENDER PAY REPORT

REFERENCES

Only PDFs are attached

9.2 - Board Combined Pay Gap Report 2026 - Ancillary Report.pdf

Introduction

The purpose of this Combined Pay Gap Report is to present Lancashire Teaching Hospital's NHS Foundation Trust's (LTHTr) gender, ethnicity, and disability pay gap data, providing an overview of differences in average pay across these characteristics within our workforce. By publishing this data, we aim to identify disparities, understand their root causes, and take informed action to promote greater fairness and equity across our workforce.

This report represents a step forward in our commitment to transparency, equity, and inclusion across our workforce. In line with the UK Government's legal requirement under the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017, all public sector organisations with 250 or more employees are mandated to report annually on their gender pay gap. This report fulfils that statutory obligation by presenting a clear analysis of the differences in average earnings between women and men within our organisation.

For the second time, LTHTr is also reporting on pay disparities by ethnicity, and we also report our first analysis on pay disparities by disability. Although there is currently no legislative mandate requiring ethnicity or disability pay gap reporting, publishing this analysis aligns with the expectations set out in the national NHS Equality, Diversity and Inclusion Improvement Plan. The plan identifies pay gap reporting beyond gender as a vital action to drive forward inclusion, transparency, and accountability across the NHS. NHS England launched the Equality, Diversity and Inclusion Improvement Plan in June 2023, and set 6 High Impact Actions to support organisations to implement it. High Impact Action 3 specifies the need to "develop and implement an improvement plan to eliminate pay gaps", which requires NHS organisations to analyse pay gap data by protected characteristic and put improvement plans in place, starting with sex (gender), then ethnicity in 2024, disability by 2025 and other protected characteristics by 2026.

Moreover, with government consultation underway and potential legislation anticipated around mandated ethnicity and disability pay gap reporting, we are committed to proactively embedding these practices in anticipation of future requirements.

This is the first year we have sought to publish a Combined Pay Gap Report, which allows us to better understand the intersectional challenges faced by our workforce and to take meaningful action to close unfair pay gaps. This report provides a baseline from which we will continue to learn, improve, and ensure that all colleagues, regardless of gender, ethnicity, or disability, are treated equitably in terms of pay and progression.

Following discussions with colleagues in the Workforce Information Team, it is proposed that future combined pay gap reporting should take place in summer / Quarter 2 each year, instead of winter / Quarter 4. Adapting our reporting timescales will allow us more time to not only analyse the data in more detail but also allow us to explore longer-term actions to further explore and reduce pay gaps at our Trust. Changing

our reporting timeframes will also increase opportunities to engage with colleagues about our pay gaps, such as via our staff forums, to understand more about working practices and experiences that may impact upon pay gaps.

Workforce Summary

To compile our Combined Pay Gap Report, we have analysed data taken from the NHS Electronic Staff Record (ESR). As of the 31 March 2025, LTHTr employed 9,942 employees. This is a decrease from 10,632 employees in 2024. This figure does not include staff who are currently receiving reduced pay due to reasons such as sick leave or maternity leave. This figure also does not include agency or Bank staff.

The tables below provide a summary breakdown of our full-pay, relevant workforce by the protected characteristics of gender, ethnicity and disability:

Gender	Headcount	% of total workforce
Female	7442	75%
Male	2500	25%
Total	**9942**	**-**

Ethnicity	Headcount	% of total workforce
BME	2954	30%
White	6845	69%
Unknown	143	1%
Total	**9942**	**-**

Disability	Headcount	% of total workforce
Disabled	627	6%
Not Disabled	8111	82%
Unknown	1204	12%
Total	**9942**	**-**

Combined Pay Gap Summary

The tables below show the mean (average) and median (middle value) pay gaps for gender, ethnicity and disability:

Gender	Female	Male	Gender Pay Gap (£)	Gender Pay Gap (%)
Mean Hourly Rate	£20.05	£26.34	£6.29	23.9%
Median Hourly Rate	£18.30	£18.66	£0.36	1.9%

Ethnicity	BME	White	Ethnicity Pay Gap (£)	Ethnicity Pay Gap (%)

Mean Hourly Rate	£23.84	£20.53	£3.31	16.1%
Median Hourly Rate	£18.94	£17.63	£1.31	7.5%

Disability	Disabled	Not Disabled	Disability Pay Gap (£)	Disability Pay Gap (%)
Mean Hourly Rate	£18.36	£21.49	£3.13	14.6%
Median Hourly Rate	£18.26	£21.95	£3.69	16.8%

The mean and median are standard measures used to highlight differences in average hourly pay between groups. The mean pay gap is calculated by adding together the hourly pay of all employees in a group and dividing it by the number of employees, then comparing the result between groups. The median pay gap represents the difference between the middle point of hourly earnings when all employees' pay is listed from lowest to highest.

Presenting both the mean and median figure helps to give us a more informed picture of pay disparities across our workforce. However, it should be noted that the mean figure can be influenced by very high or very low salaries, and the median figure gives us a better indication of what an employee earns at the Trust.

Gender Pay Gap Findings

Gender pay reporting is different to equal pay. Equal pay reporting considers the pay differences between men and women who carry out the same jobs, similar jobs, or work of equal value, whereas the gender pay gap shows the difference in the average pay between all men and women in a workforce.

The Equality Act 2010 states that men and women in the same employment, performing equal work, must receive equal pay. It is unlawful to pay people unequally because of gender. If a workforce has a particularly high gender pay gap, this can indicate that there may be issues to deal with, and the six mandated calculations set out in the gender pay gap may help organisations to identify what those issues are.

As an employer, Lancashire Teaching Hospitals NHS Foundation Trust must publish six calculations showing our:

- Average gender pay gap as a mean average
- Average gender pay gap as a median average
- Average bonus gender pay gap as a mean average
- Average bonus gender pay gap as a median average
- Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment
- Proportion of males and females when divided into four groups ordered from lowest to highest pay

The Equality and Human Rights Commission has the power to enforce any failure to comply with gender pay gap reporting regulations. The Equality and Human Rights Commission advises that where there is a difference in pay related to the gender of an employee, the following measures apply:

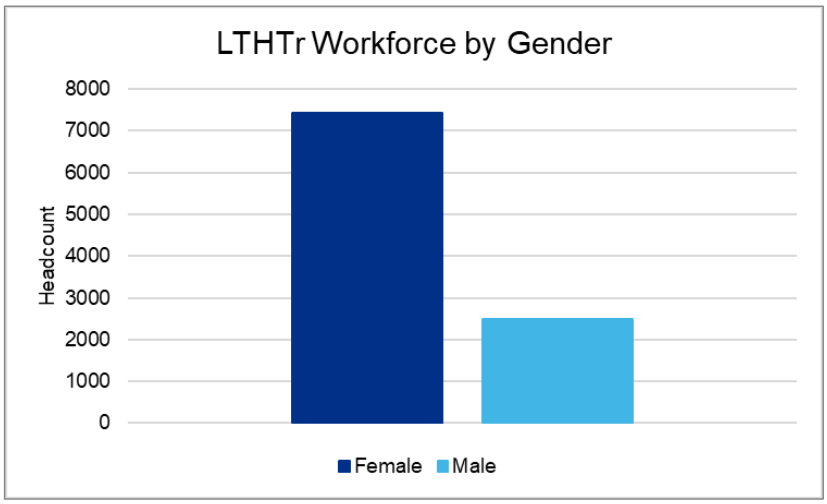
- Less than 3% difference, no action is necessary
- Greater than 3% but less than 5% difference, the position should be regularly monitored
- Greater than 5% difference, action should be taken to address the issue and close the gap

In our reporting, the **average gender pay median** is the figure which will be used as the most accurate indicator of pay to determine if further action is required.

Our workforce is 75% female and 25% male

Our Workforce Profile

Gender profile of our workforce at 31 March 2025:



The gender profile of our workforce is predominantly female.

The female / male split within the overall workforce remains consistent with our 2024 Gender Pay Gap report, at **75% female and 25% male**.

In terms of contract type, 54% of the female workforce has a full-time contract, and 46% of the female workforce has a part-time contract. In contrast, only 25% of male employees have a part-time contract, and 75% have a full-time contract.

Women occupy 75% of the lowest paid jobs and 67% of the highest paid jobs at Lancashire Teaching Hospitals NHS Foundation Trust

Our Workforce Disaggregated by Gender and Pay Quartile

The table below illustrates the headcount and percentage breakdown of female and male employees when divided into four pay quartiles, or groups, from lowest to highest pay.

To determine the proportion of employees in each quartile pay band, the following steps were used:

1. List all employees and sort by hourly rate of pay
2. Divide the list into four equal quarters
3. Express the proportion of male and female employees in each quartile band

Quartile	2025		2024		2023		2022	
	No. Female | Male	% Female | Male	No. Female | Male	% Female | Male	No. Female | Male	% Female | Male	No. Female | Male	% Female | Male

1. Lower	1857 | 628	75% | 25%	1993 | 662	75% | 25%	1968 | 582	77% | 23%	1,681 | 502	77% | 23%
2. Lower middle	1895 | 591	76% | 24%	2026 | 632	76% | 24%	1976 | 579	77% | 23%	1,689 | 494 |	77% | 23%
3. Upper middle	2022 | 449	82% | 18%	2154 | 505	81% | 19%	2084 | 469	82% | 18%	1,804 | 379	83% | 17%
4. Upper	1668 | 832	67% | 33%	1784 | 876	67% | 33%	1770 | 787	69% | 31%	1,444 | 739 |	66% | 34%
Total	**7442 | 2500** (9,942 total)	**75% | 25%**	**7,957 | 2,675** (10,632 total)	**75% | 25%**	**7,798 | 2,417** (10,215 total)	**76% | 24%**	**6,618 | 2,114** (8,732 total)	**76% | 24%**

When data is segmented by quartile, it shows that in the lower and lower middle groups, the female / male split is proportionate to our Trust's overall workforce gender profile, with females occupying three quarters of the roles that fall into each of these quartiles.

However, in the upper quartiles, there is a significant shift in representation. Females occupy 82% of roles in the upper middle group, yet representation drops notably in the Upper quartile. Male colleagues appear to be underrepresented in the upper middle quartile yet are statistically overrepresented in the Upper quartile.

While this data set is at a high level and it is therefore difficult to draw firm understanding behind pay gaps, it does suggest that the lower proportion of females working in roles in the Upper quartile may impact upon the gender pay gap at our Trust.

Our Gender Pay Gap

	Female	Male	Gender Pay Gap (£)	Gender Pay Gap (%)
Mean Hourly Rate	£20.05	£26.34	£6.29	23.9%
Median Hourly Rate	£18.30	£18.66	£0.36	1.9%

Women earn 98p for every £1 earned by men

Our data suggests that male employees generally are likely to earn more per hour than female employees, and therefore, a gender pay gap exists within LTHTr. It is important to note that while there is a gender pay gap, this does not mean that female and male employees are being paid differently for doing the same job (this would be an equal pay issue).

While data does highlight a gender pay gap within LTHTr, the current median gender pay gap of 1.9% falls below the 3% threshold of requiring further action as set by Equality and Human Rights Commission. Further exploration and analysis of our gender pay gap data set is recommended in order to identify Divisions, job roles or service areas where pay gaps exist and to understand the reasons why this may be the case. It is advisable to carry out further analysis of the data set by the end of March 2026, to allow for a detailed comparison of our gender pay gap in next year's combined pay gap report.

Analysis of Our Gender Pay Gap Over Time

Mean and Median Gender Pay Gap, 2021-2025						
	Mean hourly rate		% Difference	Median hourly rate		% Difference
	Female	Male		Female	Male	
2025	£20.05	£26.34	23.9%	£18.30	£18.66	1.9%
2024	£18.59	£24.02	22.0%	£16.75	£17.31	3.2%
2023	£17.13	£21.68	21.0%	£15.41	£15.92	3.2%
2022	£16.87	£24.69	31.7%	£14.57	£15.64	6.8%
2021	£16.00	£22.14	27.7%	£14.02	£15.04	6.8%

Gender pay gap data collected over the past five years shows that while a gender pay gap exists at our Trust, the gap is closing. The difference in median hourly rate for females and males has seen a marked decrease of almost 5% since 2021.

Proportion of Eligible Male and Female Staff in Receipt of a Bonus (Clinical Excellence Award)

0.3% of women and 3% of men were paid a bonus

The data presented in the table below shows the clinical excellence award (CEA) bonuses paid to staff split by gender and provides the mean and median bonuses paid over the past five years:

Mean and Median Bonus Pay Gap, 2021-2025						
	Mean hourly rate		Difference	Median hourly rate		Difference
	Female	Male		Female	Male	
2025	£11,512.31	£14,611.27	21.2%	£4,704.96	£9,048.00	48.0%
2024	£5,269.13	£8,213.47	35.9%	£3,014.84	£3,014.84	0.0%*
2023	£4,621.28	£8,534.87	45.9%	£2,316.00	£2,316.00	0.0%*
2022	£6,888.05	£10,441.88	34.0%	£3,818.66	£3,818.66	0.0%*

2021	£11,812.87	£15,721.28	24.9%	£6,032.04	£9,145.29	34.0%

* Please note: during the COVID-19 pandemic, the usual CEA application and selection process for medical consultants was set aside, and all eligible consultants were awarded an equal payment of £3,014.84. This resulted in no median bonus pay gap in the years 2022-2024.

The data in the table below shows the proportion of female and male colleagues who received a bonus in the past five years:

		Total head count paid Bonus	Total no. of relevant employees	% paid bonus
2025	**Female**	23	8,479	0.26%
	Male	89	2,951	3.02%
2024	**Female**	122	9403	1.30%
	Male	240	3125	7.68%
2023	**Female**	111	9622	1.15%
	Male	230	3035	7.58%
2022	**Female**	101	7,195	1.4%
	Male	233	2,203	10.6%
2021	**Female**	31	6,926	0.4%
	Male	109	2,072	5.3%

Our data shows that significantly fewer colleagues received a CEA in the financial year 2024-25 compared to the previous year. Of those who were eligible to receive a CEA, a higher proportion of male colleagues collected a payment compared to women (3.02% of eligible males compared to 0.26% of eligible females).

Looking at the 2025 mean and median pay gap data, while the mean pay gap has decreased since 2024, there is a significant mean and median pay gap between female and male colleagues receiving a CEA.

Ethnicity Pay Gap Reporting

The purpose of this section of our combined pay gap report is to present the findings, and any recommended actions, of our Ethnicity Pay Gap report for 2025. This is the second time we are presenting a report on our Ethnicity Pay Gap; there is currently no statutory obligation to publish this information however NHS England's Equality, Diversity and Inclusion Improvement Plan includes an action that specifies NHS organisations must analyse pay gap data by ethnicity and implement an improvement plan to eliminate pay gaps.

LTHTr is committed to being consciously inclusive in everything we do. We are mindful of the importance of inclusive language, and the power language has to convey respect, belonging and understanding. For the purpose of our ethnicity pay gap reporting this year, we are using the terms Black and Minority Ethnic (BME) and White, as these categories are currently used in NHS England Workforce Race Equality Standard (WRES) reporting. We acknowledge that these terms place diverse communities into broad, homogenous groups, and may mask pay gap disparities within and across ethnic groups. Following the publication of this year's pay gap reporting, it is recommended that the Trust carries out detailed analysis of data by specific ethnic group to further explore pay gaps and potential actions to mitigate them.

Ethnicity pay gap reporting is different to equal pay reporting; equal pay reporting considers the pay differences between white and ethnic minority colleagues who carry out the same jobs, similar jobs or work of equal value whereas ethnicity pay gap data shows the difference in the average hourly wage between all BME and White colleagues across the workforce. If colleagues from ethnic minority groups do more of the less well-paid jobs within an organisation, the ethnicity pay gap is usually bigger.

As an employer, Lancashire Teaching Hospitals NHS Foundation Trust will publish six calculations showing our:

- Average ethnicity pay gap as a mean average
- Average ethnicity pay gap as a median average
- Average bonus ethnicity pay gap as a mean average
- Average bonus ethnicity pay gap as a median average
- Proportion of BME and White colleagues receiving a bonus payment.
- Proportion of BME and White colleagues when divided into four groups (or quartiles), ordered from lowest to highest pay

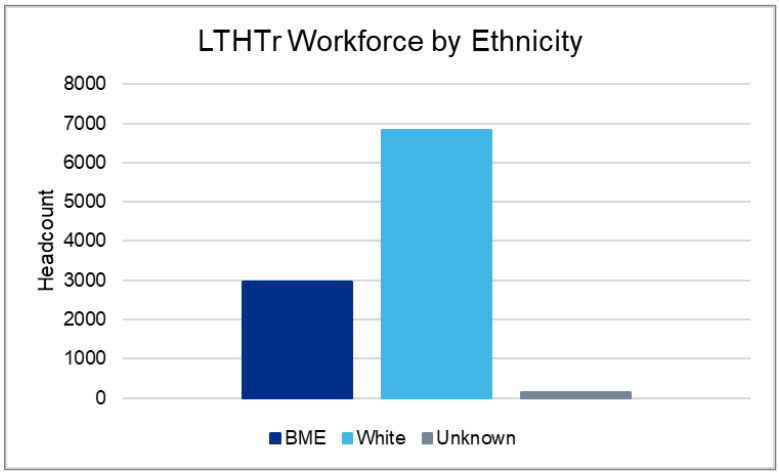
Please note: there are currently no defined thresholds, nor any requirement for us to take specific action in respect of ethnicity pay gaps. However, to be consistent across our combined pay gap reporting this year, we will follow the guidance from the Equality and Human Rights Commission in respect of the gender pay gap.

In line with Gender Pay Gap guidance, the **ethnicity pay median** is the figure which will be used as the most accurate indicator of pay to determine what further action might be required.

Our workforce is 30% BME, and 69% White

Our Workforce Profile by Ethnicity

Ethnicity profile of our workforce at 31 March 2025:



As at 31 March 2025, the ethnic profile of our workforce is predominantly White.

30% of our workforce is BME; this is an increase from 28% in 2024.

69% of our workforce is White, and 1% of our colleagues are of unknown or undisclosed ethnicity.

BME staff occupy 20% of the lowest paid jobs and 31% of the highest paid jobs

Our Workforce Disaggregated by Ethnicity and Pay Quartile

The table below illustrates the headcount and percentage breakdown of BME employees, White employees, and employees of unknown ethnicity when divided into four pay quartiles, or groups, from lowest to highest pay.

To determine the proportion of employees in each quartile pay band, the following steps were used:

1. List all employees and sort by hourly rate of pay
2. Divide the list into four equal quarters
3. Express the proportion of BME and white employees in each quartile band

Quartile	2025		2024	
	No. BME | White | Unknown	% BME | White | Unknown	No. BME | White | Unknown	% BME | White | Unknown
1. Lower	506 | 1947 | 32	20% | 78% | 1%	487 | 2125 | 43	18% | 80% | 2%
2. Lower middle	814 | 1643 | 29	33% | 66% | 1%	841 | 1788 | 29	32% | 67% | 1%
3. Upper middle	870 | 1573 | 28	35% | 64% | 1%	922 | 1705 | 32	35% | 64% | 1%
4. Upper	764 | 1682 | 54	31% | 67% | 2%	724 | 1873 | 63	27% | 70% | 2%

Total	**2954 | 6,845 | 143** (9,942 total)	**30% | 69% | 1%**	**2,974 | 7,491 | 167** (10,632 total)	**28% | 71% | 2%**

When data is segmented by quartile, it shows that in the lower and lower middle groups, the proportion of BME / White colleagues occupying the Lower middle and Upper quartiles is comparable to our Trust's overall workforce ethnicity profile, with BME colleagues occupying approximately a third of the roles that fall into each of these quartiles.

However, in the upper middle quartiles, there is a shift in representation, and BME colleagues occupy 35% of roles compared to 64% of White colleagues. There is a significant shift in representation in the Lower quartile, where at 20% the proportion of BME colleagues is considerably lower than our Trust's overall workforce ethnicity profile.

There is a much higher proportion of White colleagues occupying roles in the Lower quartile, and while this data set is at a high level and does not allow us to draw firm conclusions around the context of our ethnicity pay gap, it does suggest that the much higher proportion of White staff working in the Lower quartile may impact upon the ethnicity pay gap at our Trust.

Our Ethnicity Pay Gap

	BME	White	Ethnicity Pay Gap (£)	Ethnicity Pay Gap (%)
Mean Hourly Rate	£23.84	£20.53	£3.31	16.1%
Median Hourly Rate	£18.94	£17.63	£1.31	7.5%

BME colleagues earn £1.07 for every £1 earned by White colleagues

Our data shows a mean (average) pay ethnicity gap is 16.1% and the median ethnicity pay gap is 7.5%. BME employees generally are more likely to earn more per hour than White employees, and therefore, an ethnicity pay gap exists within LTHTr. It is important to note that while there is an ethnicity pay gap, this does not mean that BME and White employees are being paid differently for doing the same job (this would be an equal pay issue).

Applying the gender pay gap guidance published by the Equality and Human Rights Commission that advises where there are differences in pay, at 7.5% the median ethnicity pay gap is greater than 5% and therefore meets the threshold that requires action to address and close the gap.

The data shared in this report is at a high level and therefore there is a need to understand the detail, the nuance and the context of ethnicity pay gaps by division, and by specific ethnic group. It is recommended that further exploration and analysis of our ethnicity pay gap data set is undertaken, in order to identify Divisions, job groups or service areas where pay gaps exist and to understand the reasons why this may be the case. It is advisable to carry out further analysis of the data set by the end of March 2026, to allow for a detailed comparison of our ethnicity pay gap in next year's combined pay gap report.

Analysis of Our Ethnicity Pay Gap Over Time

Mean and Median Gender Pay Gap, 2021-2025						
	Mean Hourly rate		Difference	Median Hourly rate		Difference
	BME	White		BME	White	
2025	£23.84	£20.53	16.1%	£18.94	£17.63	7.5%
2024	£21.62	£19.06	13.4%	£17.56	£16.22	8.3%

As this is our second reporting year, it is challenging to make a firm analysis of change over time, as we have a limited range of information to shape our understanding. However, when compared to the previous year, our 2025 data shows that while the mean ethnicity pay gap has increased by nearly 3%, the median ethnicity pay gap has seen a slight decrease, from 8.3% in 2024, to 7.5% in 2025.

Proportion of Eligible BME and White Staff in Receipt of a Bonus (Clinical Excellence Award)

1.5% of BME colleagues and 0.7% of white colleagues were paid a bonus

The data presented in the table below shows the clinical excellence award (CEA) bonuses paid to staff split by ethnicity and provides the mean and median bonuses paid since we began to report ethnicity pay gap data:

Mean and Median Bonus Pay Gap, 2024-2025						
	Mean Hourly rate		Difference	Median Hourly rate		Difference
	BME	White		BME	White	
2025	£13,435.35	£14,572.45	7.8%	£10,358.51	£10,294.24	0.6%
2024	£6,478.34	£8,306.88	22.01%	£3,014.84	£3,014.84	0.0%

* Please note: during the COVID-19 pandemic, the usual CEA application and selection process for medical consultants was set aside, and all eligible consultants were awarded an equal payment of £3,014.84. This resulted in no median bonus pay gap in the years 2022-2024.

The data in the table below shows the proportion of BME and White staff overall who received a bonus in the two ethnicity pay gap reporting years that LTHTr has collated it:

2025	Total head count paid bonus	Total no. of relevant employees	% paid bonus

BME	54	3,689	1.5%
White	57	7,810	0.7%
2024	**Total head count paid bonus**	**Total no. of relevant employees**	**% paid bonus**
BME	160	3,209	5.0%
White	175	8,380	2.1%

Looking at the 2025 mean and median pay gap data, the mean pay gap has decreased significantly since 2024. There has been a slight increase in the median pay gap between BME and White colleagues receiving a CEA.

Significantly fewer colleagues received a CEA in this reporting year compared to the previous year. Of those who were eligible to receive a CEA, a similar number of BME and White colleagues collected a payment, however the cohort of eligible BME employees was numerically much lower compared to the White cohort, and this may be a factor in the data showing BME colleagues as being twice as likely to receive a CEA than White colleagues (1.5% compared to 0.7%).

Disability Pay Gap Reporting

The purpose of this section of our combined pay gap report is to present the findings, and any recommended actions, of our Disability Pay Gap report for 2025. This is the first time we are presenting a report on our Disability Pay Gap; there is currently no statutory obligation to publish this information however NHS England's Equality, Diversity and Inclusion Improvement Plan includes an action that specifies NHS organisations must analyse pay gap data by disability status and implement an improvement plan to eliminate pay gaps.

When considering the findings of this report, it is important to consider the potential limitations of the data set used to develop it. To calculate our disability pay gap, we have used a snapshot of disability declaration data on the ESR system on the 31 March 2025 which indicates that 6% of our workforce have declared a disability or long-term condition. From the findings of the yearly NHS Staff Survey and anecdotal intelligence, we are mindful that the data held on the ESR system regarding disability status is likely to be significantly under representative, and the actual number of colleagues living with a disability or long-term condition is likely to be higher as disabled colleagues may choose to self-report as being not disabled, or choose not to self-report their disability status at all.

Disability pay gap reporting is different to equal pay reporting; equal pay reporting considers the pay differences between disabled and non-disabled colleagues who carry out the same jobs, similar jobs or work of equal value whereas disability pay gap data shows the difference in the average hourly wage between all disabled and non-disabled colleagues across the workforce. If colleagues that have declared a disability do more of the less well-paid jobs within an organisation, the disability pay gap is likely to be bigger.

As an employer, Lancashire Teaching Hospitals NHS Foundation Trust will publish six calculations showing our:

- Average disability pay gap as a mean average

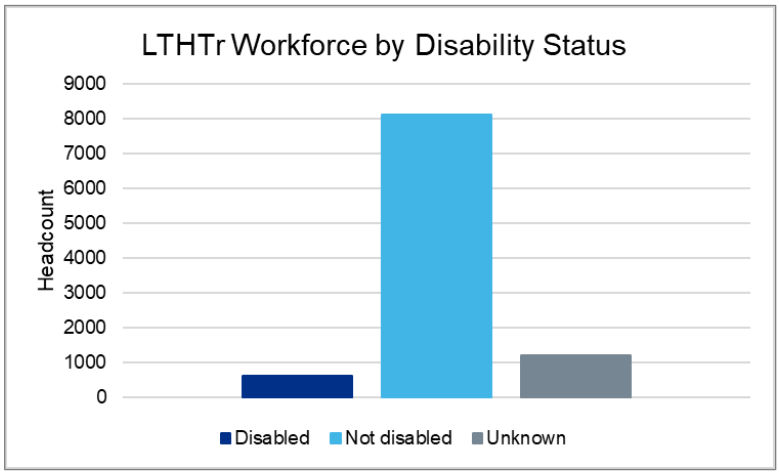
- Average disability pay gap as a median average
- Average bonus disability pay gap as a mean average
- Average bonus disability pay gap as a median average
- Proportion of disabled and non-disabled colleagues receiving a bonus payment.
- Proportion of disabled and non-disabled colleagues when divided into four groups (or quartiles), ordered from lowest to highest pay

Please note - there are currently no defined thresholds, nor any requirement for us to take specific action in respect of disability pay gaps. However, to be consistent across our pay gap reporting, we will follow the guidance from the Equality and Human Rights Commission in respect of the gender pay gap.

In line with Gender Pay Gap guidance, the **disabled pay median** is the figure which will be used as the most accurate indicator of pay to determine what further action might be required.

Our Workforce Profile by Disability status

Profile of our workforce by disability status at 31 March 2025:



ESR data shows that 6% of our workforce were self-declared as disabled, and 82% of colleagues had self-declared as not living with a disability.

12% of our colleagues are of 'unknown' or 'undisclosed' disability status.

Disabled staff occupy 8% of the lowest paid jobs and 4% of the highest paid jobs

Our Workforce Disaggregated by Disability Status and Pay Quartile

The table below illustrates the headcount and percentage breakdown of colleagues living with a disability; colleagues not living with a disability; and those with unknown disability status, when divided into four pay quartiles, or groups, from lowest to highest pay.

To determine the proportion of employees in each quartile pay band, the following steps were used:

1. List all employees and sort by hourly rate of pay
2. Divide the list into four equal quarters
3. Express the proportion of disabled and not disabled employees in each quartile band

Quartile	2025	
	No. Disabled | Not Disabled | Unknown	**% Disabled | Not Disabled | Unknown**
1. Lower	210 | 1955 | 320	8% | 79% | 13%
2. Lower middle	162 | 2073 | 251	7% | 83% | 10%
3. Upper middle	156 | 2032 | 283	6% | 82% | 11%
4. Upper	99 | 2051 | 350	4% | 82% | 14%
Total	**627 | 8111 | 1204** (9,942 total)	**6% | 82% | 12%**

When data is segmented by quartile, it shows a noticeable decline in the proportion of disabled colleagues from the Lower to the Upper grouping. 8% of colleagues occupying roles in the Lower quartile have self-reported as living with a disability, while only 4% of colleagues in the Upper quartile live with a disability. The proportion of colleagues whose disability status is unknown varies in each quartile, which may limit our understanding of the actual number / proportion of colleagues living and working with disabilities at our Trust.

The proportion of disabled colleagues occupying the upper quartile is lower than our Trust's overall workforce disability profile; ESR data states 6% of our colleagues live with a disability, yet only 4% of colleagues in the Upper quartile self-report as living with a disability.

Our Disability Pay Gap

	Disabled	Not Disabled	Disability Pay Gap (£)	Disability Pay Gap (%)
Mean Hourly Rate	£18.36	£21.49	£3.13	14.6%
Median Hourly Rate	£18.26	£21.95	£3.69	16.8%

Colleagues who have self-declared living with a disability earn 83p for every £1 earned by colleagues who do not live with a disability.

Our data shows a mean (average) disability pay gap is 16.1% and the median disability pay gap is 16.8%. This means that colleagues living with a disability are likely to earn less per hour than colleagues that do not live with a disability, and therefore, a disability pay gap exists within LTHTr.

The scale of our disability pay gap is a significant concern; guidance published by the Equality and Human Rights Commission regarding the gender pay gap advises that where there is a difference in pay that is greater than 5%, action is required to address and close it. At 16.8%, our median disability pay gap is over three times higher than the threshold for action as defined in the gender pay gap guidance and requires urgent investigation and action to mitigate it. Some caution should be applied when considering disability pay gap data however, because we know that the number of colleagues self-reporting their disability status on ESR may not be an accurate reflection of the actual number of colleagues that live with a disability. Due to gaps in our understanding of disability status in our workforce, the actual pay gap may be lower, or higher, than the figures provided in this report.

While caution around the data set is advised, it is recommended that urgent further exploration and analysis of our disability pay gap data set is undertaken, in order to identify Divisions, job roles or service areas where pay gaps exist and to understand the reasons why this may be the case. It is advisable to carry out further analysis of the data set by the end of March 2026, to allow for a detailed comparison of our disability pay gap in next year's combined pay gap report.

It is important to note that while there is a disability pay gap, this does not mean that disabled and non-disabled employees are being paid differently for doing the same job (this would be an equal pay issue).

Proportion of Eligible Staff in Receipt of a Bonus by Disability Status (Clinical Excellence Award)

0.03% of Disabled colleagues and 2.8% of Non-Disabled colleagues were paid a bonus

The data presented in the table below shows the clinical excellence award (CEA) bonuses paid to staff split by disability status and provides the mean and median bonuses paid since we began to report ethnicity pay gap data:

Mean and Median Bonus Pay Gap, 2024-2025						
	Mean Hourly rate		Difference	Median Hourly rate		Difference
	Disabled	Not Disabled		Disabled	Not Disabled	
2025	£12,667.20	£11,644.86	8.1%	£4,101.72	£7,414.96	44.7%

The data in the table below shows the proportion of staff disaggregated by disability status who received a bonus in 2025:

2025	Total head count paid bonus	Total no. of relevant employees	% paid bonus
Disabled	**<5**	*	**0.03%**

Not disabled	**65**	**2,314**	**2.8%**

* Please note, it is not possible to share the total headcount and total number of relevant employees in this report, as doing so may inadvertently disclose personally identifiable data and risk compliance with our obligations under UK General Data Protection Regulation (GDPR).

Our data shows a mean (average) disability bonus pay gap is 8.1% and the median disability pay gap is 44.7%.

The scale of the bonus pay gap (particularly the median bonus pay gap) suggests cause for concern. However, some caution should be applied when considering bonus pay gap data, due to the low number of colleagues living with a disability in receipt of a bonus, and also because we know that the number of colleagues self-reporting their disability status on ESR may not be an accurate reflection of the actual number of colleagues that live with a disability.

1. **Financial implications**
   None

2. **Legal implications**
   None

3. **Risks**

Our gender pay gap is currently below the threshold for immediate action as specified by the Equality and Human Rights Commission. However, regular monitoring is recommended, as while our gender pay gap has narrowed over recent years, a pay gap exists, and there is a need to understand why it exists, and what can be done to mitigate it and ensure any barriers to roles and opportunities in relation to gender are addressed.

Our ethnicity pay gap data shows that a pay gap does exist in relation to ethnicity at our Trust. However, there is a risk that a high level pay gap report does not capture the context and nuance of our workforce. For example, while our data set presents a mean and a median ethnicity pay gap in favour of BME employees, we know that a there is significant proportion of BME colleagues working in higher-earning medical and dental roles, which may mask ethnicity pay gap issues in other pay groups. There is a need to interrogate our data further to explore pay gaps by factors inclusion division and pay grade category, and other characteristics such as age, gender and disability status, in order to get a more holistic understanding of pay gaps.

Our disability pay gap data highlights a stark pay gap exists at our Trust. However, there is a risk that the underlying data used to calculate the disability pay gap may not be fully representative of our workforce, due to gaps in disability reporting rates on ESR.

4. **Impact on stakeholders**

Not applicable

5. **Recommendations**

Gender Pay Gap

Our organisation's mean gender pay gap is 23.9%, and our median gender pay gap is 1.9%. Currently, our median gender pay gap falls below the threshold for action set by the Equality and Human Rights Commission. However, it's important to continue to monitor our gender pay gap, and it is recommended that we explore our workforce data set in more detail to understand if there may be any divisions or areas that may be an outlier, and / or may experience disproportionate disparities. It is also recommended to understand more about the uptake of flexible working / part time options, as our data shows a low proportion of male part-time employees, compared to female employees. Understanding working practices and the balance of work life with home life, health and wellbeing, and caring responsibilities may provide insight into the prevalence of pay gaps or barriers / perceived barriers in career progression.

As noted in previous Gender Pay Gap reports, it is challenging to identify actions that make a tangible difference to our gender pay gap, as in part our policies and processes (in some cases) impact upon our ability to fully close the pay gap. For example, we actively encourage our colleagues to work flexibly and, aligned to the NHS People Plan, all our vacancies are advertised as having access to flexible working opportunities from day one. Given flexible working is seen as an employee benefit, we want colleagues to utilise it, however this may have an impact on our ability to close the gender pay gap due to the higher proportion of our workforce being female overall, and our data shows that a significantly high proportion of females hold a part-time contract.

Another challenge we face as an organisation is the pipeline of newly qualified candidates coming through degree courses and seeking employment with our Trust. If universities are unable to attract higher numbers of males into NHS Agenda for Change professions and higher numbers of females into medical and dental professions, it makes it challenging for us to meaningfully change our workforce gender split and ultimately, our gender pay gap.

Ethnicity Pay Gap

Our mean ethnicity pay gap is currently 16.1% and our median ethnicity pay gap is 7.5%. Our data shows that BME colleagues are more likely to earn more per hour than White colleagues.

BME colleagues are disproportionately represented in higher-paying job categories or roles, such as medical and dental positions, yet are underrepresented in the lowest pay quartile. Fewer BME colleagues are working in low-paying, entry-level jobs, and this contributes to the overall higher average pay for BME colleagues. However, while this is the case in our pay gap data set, we know from our Workforce Race Equality Standard (WRES) reporting that ethnic minority colleagues are still significantly underrepresented in the highest, more senior management roles within our organisation; for example, our Executive Board membership is not proportionately representative of our wider workforce.

It is recommended that further work is undertaken to break down our ethnicity pay gap data and allow us to understand pay gaps in more detail – for example by disaggregating data from broad ethnic categories of BME and White into specific groups and considering data broken down by division and professional group. Extending our analysis to incorporate an intersectional approach that looks at ethnicity, disability and gender would also be recommended as this will help us to understand the potential impacts of multiple characteristics upon pay and pay gaps.

Disability Pay Gap

Our mean disability pay gap is currently 16.1% and our median disability pay gap is 16.8%. Our data shows that non-disabled colleagues are more likely to earn more per hour than disabled colleagues.

Our disability pay gap data highlights a concern that requires focused attention; there is a clear under-representation of disabled staff in higher pay quartiles, which indicates that disabled colleagues are currently concentrated in lower-paid roles, and there may be limited opportunities for progression, because representation of disabled staff reduces significantly in the higher pay quartiles.

Our data also illuminates a concern regarding disability disclosure at our Trust. 6% of colleagues have self-reported as living with a disability; this is significantly lower than the proportion of residents living in the Lancashire-12 area that reported living with a disability in the 2021 Census (19.3%) and therefore indicates that self-reporting rates at our Trust are under representative.

A low rate of self-reporting as living with a disability may have multiple causes. There may be a low proportion of colleagues working at LTHTr that live with a disability; however anecdotal information gathered from the Trust Equality, Diversity and Inclusion Team and our Trust's Disability and Neurodiversity Staff Forum suggests there is a large community of colleagues living with a disability, and some colleagues do not disclose their disability status on ESR – instead some colleagues state they do not have a disability, or choose not to report at all.

Hesitancy in self-reporting disability status may reflect concerns about stigma, a lack of confidence in how the information will be used, or uncertainty around what constitutes a disability. Regardless of the reason/s, the absence of accurate data makes it more difficult to fully understand and address disparities in pay and representation.

To fully understand our disability pay gap, we must take steps to foster a more inclusive and supportive workplace environment that supports colleagues living with a disability to feel safe and confident to disclose their status, and where reasonable adjustments and career development opportunities are readily available and barrier-free. This will enable us to gather more representative data in the future and allow us to perform a more robust analysis of disability data gaps that may exist in our organisation.

It is recommended that the Board of Directors

i) Receive and note this Combined Pay Gap Report
ii) Approve the report for publishing on our Trust internet site by 30th March 2026

9.3 - EQUALITY, DIVERSITY AND INCLUSION ANNUAL REPORT

REFERENCES

Only PDFs are attached

9.3 - Board EDI Annual Report 2025 Ancillary Report.pdf

Together

NHS Lancashire Teaching Hospitals NHS Foundation Trust

EQUALITY, DIVERSITY & INCLUSION STRATEGY – ANNUAL REPORT 2025

Being consciously inclusive in everything we do for colleagues and our communities

INTRODUCTION

This is the fourth annual Equality, Diversity and Inclusion (EDI) update following the launch of our strategy five years ago, this report highlights the progress we have made against the strategic aims underpinning our vision which is to be **"consciously inclusive in everything we do for colleagues and our communities"**.

The five strategic aims are:

1. Demonstrating Collective Commitment to EDI.
2. Being Evidence Led and Transparent.
3. Recognising the Importance of Lived Experience
4. Being Representative of Our Community.
5. Bringing About Change Through Education and Development.

This year marks the final year for this strategy, the ambition was always to be transformational, to take a systemic approach to delivering improvements. We wanted to go deeper than surface level actions, seeking to bring patient and colleague experience together, utilising and capitalising on the opportunity that the two are inextricably linked, finding new ways to understand our data and to reflect on the health equalities in our system and the disparities experienced by colleagues, taking decisive action to bring about change. 2026 will see us resetting the direction, looking at all that has been achieved and taking targeted actions to progress the areas which are slow to show improvement.

Over the past year we have undertaken a number of actions which include:

- Proactive engagement with lesser-heard patient community groups leading to tangible changes in service provision
- Improved accessibility to patient information through leaflets being produced in accessible formats, to the Trust website being adapted for screen readers
- Increased workforce representation; ethnic minority representation increased to just over 30% (from 26.6%) whilst disability disclosure increased again to 6.7% (from 6.2%) with more colleagues completing Supporting Disability/Long Term conditions agreements.
- Delivered Health Literacy training to over 100 leaders and introduced new e-learning modules in respect of Implicit Bias and Intercultural Communication.
- Address local health disparities through initiatives such as targeted outreach, Post Partum Haemorrhage project and Healthier Wards.

Alongside the successes and areas of progress, we have also faced some challenges over the last 12 months; ensuring inclusion has a sustained focus amidst the pressures of increased activity and sustained financial challenges, as well as the impact of those financial challenges resulting in challenges procuring items to support the implementation of workplace adjustments. We have also struggled to get engagement in the staff inclusion forums with low attendance at meetings and at promotional or awareness raising events.

The information in this report represents the action and progress undertaken in compliance with our public sector duties as set out in the Public Sector Equality Duty and the Equality Act (2010), which requires public bodes to have due regard for the need to eliminate unlawful discrimination, harassment and victimisation; to advance equality of opportunity; and to foster good relations between people who share a protected characteristic and those who do not. Fostering good relations can be difficult to achieve when there are conflicting views or beliefs across protected characteristic groups or subgroups, a good example of this are the ongoing proposals to update the NHS Constitution for England, stressing the importance of biological sex in relation to same-sex accommodation and in relation to the provision of intimate care, a move which has been celebrated by some groups and which has raised significant worry and concern from Trans community members. Similar challenges can be found across other protected characteristic groups such as race and faith or belief.

The Equality, Diversity and Inclusion strategy is the golden thread that runs through the Patient Experience and Involvement Strategy. It is vitally important that as part of this strategy we are always consciously inclusive in everything we do. Whilst this year has seen a close to the Patient Experience and Involvement strategy, it's incorporation into the Trust's Single Improvement Plan (SIP) acknowledges its ongoing importance.

As an organisation we need to ensure we proactively consider how our services, including potential future changes, will affect people who belong to different protected characteristic groups and work to accommodate the needs of all patient and colleague groups.

This report highlights many of our achievements, provides a breakdown of our data for patients and colleagues and sets out our future focus to continue to progress this vital agenda.

PRINCIPLE 1 – DEMONSTRATING COLLECTIVE COMMITMENT TO EDI

This principle seeks to hardwire EDI into all aspects of the way we provide care and go about our business within our organisation, to ensure we are consciously inclusive. The principles contained in this strategy demonstrate a clear commitment to actively ensure EDI is a core part of all organisational business, led from Board and cascaded across all roles and levels in the wider organisation.

We have developed and are on the cusp of launching a **Social Value strategy** which encompasses all activity across our organisation including employment, training and education, commissioning or procurement, investment and service delivery. It focuses on **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, 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. Through this strategy, our vision 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 strategy is not designed to replace or supersede other core strategic aims of work. Its focus is on creating a framework which underpins the programmes of work which acknowledge the leadership role we have in our community as an anchor institution and deliver tangible 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
- Leveraging our Contracting, Estate and sustainable practices to deliver local benefits and social value
- Connecting Community and Partnerships

As part of our plan to reduce and eliminate Health Inequalities, our Head of Knowledge and Library Services has undertaken a significant amount of work to focus colleagues on developing their **Health Literacy Awareness** over the past twelve months; this has resulted in training being delivered to over 100 leaders to support the identification and implementation of health literacy improvement projects. An example of this is a readability pilot in respect of Cancer Patient Information leaflets which focuses on ensuring the information leaflets are accessible to all, providing the information at the right level and considering the reading age we should seek to accommodate. Collaboration with our Patient Safety team has led to improved accessibility and readability for patients in respect of posters targeted at; Eating and Drinking Well in Hospital, Blood Clots and Weight Management.

FOR PATIENTS AND OUR COMMUNITIES

ACCESSIBLE INFORMATION

Accessible information remains central to empowering patients and communities to make informed decisions about their care. The Patient Information Group comprising patients, governors, external stakeholders, and charitable partners has played a pivotal role in ensuring materials are clear, concise, and accessible, along with support of partners such as Galloways, the Visual Impairment Forum, and Co-Sign BSL interpreters. Information is available in multiple formats including translated materials, large print, easy-read photo books, audio, Braille, and British Sign Language videos. The Trust website has been recently adapted to be fully compatible with screen reader users further enhancing accessibility. Over the past 10 months, clinical staff have produced more than 350 patient information leaflets, ensuring that information about clinical services is widely available across all communities.

INTERPRETATION SERVICES

Interpretation services continue to be a cornerstone of accessibility. This year, Involvement Services introduced an on-demand video language service available across all Trust laptops and PCs, complementing the existing App available on iPads and mobile devices.

This ensures that staff can access language interpreters 24/7 from any Trust device. These services operate alongside our established face-to-face, telephone, and transcription options, while British Sign Language interpretation remains delivered through a dedicated external provider, ensuring specialist support for the Deaf community, also provided 24 hours a day, 7 days a week.

COMMUNITY ENGAGEMENT & SERVICE DEVELOPMENT

A key focus this year has been proactive engagement with lesser-heard groups. Feedback and personal stories have informed service developments such as:

- Installation of Qibla Muslim directional arrows in wards
- Use of photographs on inpatient catering menus to reduce communication barriers
- Improvements to Trust signage
- Addition of family rooms on wards
- Provision of pillows in ED waiting areas to improve comfort
- Recruitment of additional volunteer hospital guides

These changes were driven by engagement with groups including the Pukar Centre Preston, Preston Muslim Forum, Hamara Centre Preston, Quwwat Education Centre (*Grannies Support* and *Mums & Minis* groups), and the Asian Ladies Forum Chorley.

Health Inequalities

Over the past year, we've worked closely with our local communities and partners across public health, primary care, community, and social care to understand and address health inequalities in the areas we serve. Using the NHS **Core20PLUS5** framework, we have worked to listen, understand and take action. This collaboration led to the creation of our **Trust Health Improvement Plan** which was published in December 2024. We've already made significant progress but there's still much more to do and addressing health inequalities remains a key priority. The Trust continues to work in close partnership with local councils and other organisations, ensuring coordinated support and effective information sharing. Some of the work that has been undertaken this year includes:

- **Works Well Preston**: A pilot programme designed to help individuals with poor physical health or long-term conditions access and sustain employment
- **Healthier Wards Initiative**: Collaborative efforts are underway in targeted areas of Preston specifically Deepdale, Ribbleton, and St Matthews to improve community health outcomes
- **Preston Suicide & Self Harm Prevention Group**; a multi-agency strategic group overseeing a delivery plan related to suicide & self-harm prevention activities – actions have included the addition of mental health support information on the Trust website

The growth of partnership working remains a vital element in ensuring the inclusion of all communities. This collaborative approach continues to educate staff and strengthen our communication and accessibility for diverse service users.

Key partnerships include:

- The V.I (visual impairment) Forum which provides direction and feedback on policy and service development
- Galloways whose Eye Liaison Officers support patients and staff and ensure patient information is available in Braille
- Age UK, which assists with patient discharges and wider inclusion
- NCompass who deliver Deaf culture awareness training
- Deafblind UK providing guidance and staff training and support
- Disability Northwest offers guidance to the Trust Carer's Forum
- Preston and District Carers Support Group, who provide information to our Carers Forum
- Guide Dogs UK who delivers sighted guidance training both online and face-to-face for staff and volunteer Co-Sign who supports staff in the creation of video patient information in BSL
- AccessAble who continue to provide up to date information on our site supporting disabilities

Representatives from the VI Forum, RNIB, Lancashire Carers Service, Lancashire Teaching Hospitals and Preston and District Carers forum at Pukar Resource Centre in Preston for National Sight Loss Day

Together, these partnerships reinforce our commitment to accessibility, equity, and inclusive service delivery across the Trust.

FOR COLLEAGUES

MAKING INCLUSION A CORE PART OF BUSINESS

At the end of 2024, we launched a **Single Improvement Plan (SIP)** which has been designed to simplify our approach to areas we need to improve across the organisation. Our priorities have been selected based on a combination of feedback from patients, colleagues, regulators and alignment to corporate objectives. This year has seen Diversity and Inclusion incorporated into our organisation's Single Improvement Plan (SIP) under our 'People Portfolio' metrics with the measures of success noted as improvements in Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) metrics. This demonstrates a very clear intention to maintain oversight on progress or challenges and be able to scrutinise actions taken in respect of the diversity and inclusion agenda. SIP progress is updated monthly and SIP overview meetings are held following Trust Management Board meetings.

Over the past year, the **Team Engagement & Development (TED) programme** has significantly strengthened our collective commitment to EDI by embedding inclusive practice into everyday team development. We have created and promoted a suite of practical tools—covering zero tolerance, sexual safety, compassionate conversations and inclusive survey engagement—which enable Team Leaders to facilitate safe, respectful and psychologically informed discussions within their teams. These resources help hardwire EDI into routine team practice by supporting leaders to role-model inclusive behaviours, challenge discrimination, promote speaking up, and ensure all colleagues feel heard. By integrating these principles directly into team culture, feedback processes and leadership development, TED has helped make conscious inclusion a consistent part of how we work across the organisation.

Across the Workforce & OD team, we produce a number of **annual reports** for oversight and scrutiny to our **Workforce Committee**, with some going on to **Board** for approval. Examples include; Leadership & Management Development Strategy report, Appraisal Update, Engagement & Recognition Strategic Aim Update and Onboarding and Retention Strategy report. We have started to build demographic reporting and analysis into these reports as standard e.g. our Appraisal report explored staff survey data relating to appraisal split by ethnicity and long-term condition/disability and our Onboarding and Retention report provided an EDI high level overview with a commitment to undertake further analysis to understand if particular groups or roles were adversely impacted. Moving forwards, we will continue to develop the analysis of protected characteristic group data to establish whether there are differences being experienced across different colleague groups and to formulate actions required to provide parity.

In the recently completed NHS England national **Staff Experience Assessment tool**, evidence gathered demonstrated clear application of the People Promise incorporating the Trust's commitment to diversity and inclusion, as well as highlighting any areas of challenge or considerations required for the future. This ensures continued alignment of our retention workstream with our diversity and inclusion strategy.

Our **Library website** has been tested and amended to ensure enhanced accessibility, taking into account visual impairments and screen readers. We have also developed accessible library guides which have all been written as easy read documents.

RAISING AWARENESS AND LIVING OUR COMMITMENT TO CREATING AN INCLUSIVE WORKPLACE

In March we were delighted to announce the opening of a **new female Muslim Prayer Room** at Chorley and South Ribble Hospital. This was the result of significant efforts from various teams, including the generous relocation of the Community Midwives and the Volunteer Services Team.

The room has been beautifully refreshed to provide a serene and prayerful space for our female Muslim worshippers.

EMBEDDING A ZERO TOLERANCE APPROACH TO DISCRIMINATION, RACISM AND ANTISEMITISM

We have continued our approach to actively tackling discrimination and inequality, faced by people from minoritised groups, when either receiving care or working in our organisation. Towards the end of the year, we received two letters from NHS England reinforcing the importance of antiracism and antisemitism and asking us as an organisation to reiterate our Zero Tolerance stance against all forms of hatred, antisemitism, Islamophobia, racism and any form of discriminatory behaviour, which we have done and we will continue to do, through various Trust communication channels including Executive VLOGS, Leader and All Colleague briefings and Board reports.

NHS England have adopted the following International Holocaust Remembrance Alliance (IHRA) working definition of antisemitism which we have also adopted in order to reinforce our collective stance against antisemitism – whether experienced by our colleagues, our patients, our communities or our partners.

“Antisemitism is a certain perception of Jews, which may be expressed as hatred toward Jews. Rhetorical and physical manifestations of antisemitism are directed toward Jewish or non-Jewish individuals and/or their property, toward Jewish community institutions and religious facilities.”

The definition adopted includes illustrative examples of how antisemitism may manifest in modern settings, for example, denial of the Holocaust, accusations of Jewish conspiracy, and the targeting of Israel as a proxy for Jewish people. We have already started to pull together content which will update

our EDI mandatory training module to reflect and reinforce the core messages in respect of Racism, Anti-racism, Antisemitism and Islamophobia once NHSE have defined and shared their core content.

We have reminded colleagues of the requirement for us to foster good relations as part of our Public Sector Equality Duties (PSED) which is about recognising and dealing with prejudice wherever it exists but also to promote and support a shared understanding across different community groups; acknowledging that being part of a very diverse organisation is likely to mean we will hold some differing views around a number of topics however, we also have to uphold our core Trust Values in respect of Recognising Individuality and Care with Compassion at the same time as balancing our commitment to free speech. So, whilst it's perfectly acceptable to hold different views and beliefs, no one has the total freedom to express them without considering the impact on others. In 2026 we are planning on refreshing our organisational Values to make inclusive behaviours and actions more explicit.

We have formed a working group of colleagues from across our organisation, including representatives from our Ethnicity Inclusion forum, and sponsored by our Chief Executive Officer Silas Nicholls, to reaffirm our commitment to becoming an AntiRacist organisation, and to gather the evidence required to support attainment of Bronze in the **NorthWest Antiracist Framework**. A gap analysis has been undertaken of requirements to achieve Bronze status, the working group will meet early in 2026 to plan actions required to achieve a successful submission and start gathering evidence to address any gaps.

Our Ethnicity Staff Inclusion forum have an objective in respect of exploring 'discrimination' i.e. where and how it is experienced, as this has been an area highlighted in our WRES/Staff Survey results for a few years now, as an area where colleagues from ethnic minority groups are likely to be experiencing adverse impacts. Our Head of Diversity & Inclusion presented the results of the Staff Survey, including the WRES metrics to our Ethnicity Staff Inclusion forum to highlight the data in respect of discrimination and to encourage colleagues to share their understanding and experiences of how this is experienced in order that together, we can take targeted action to eliminate discrimination and improve the experience for our ethnic minority colleagues across the organisation.

Towards the end of 2024 the NHS Race and Health Observatory shared **7 Anti-Racism principles** they asked organisations to embed throughout their practices and policies;

1. **Demonstrate Leadership**, by naming racism, engaging seriously and continuously with the ways in which racism impacts the lives of patients and the public and actively working to dismantle it.

2. **Acknowledge Structural Racism**. Understand and acknowledge that structural, institutional and interpersonal racism all impact on health, and be clear about where accountability lies for improvement and progress. Create transparent pathways for raising concerns and tangible steps for addressing them.

3. **Involve Racially Minoritised Communities**. Meaningfully involve racially minoritised individuals and communities in every stage of developing a service or intervention, including

ensuring that teams and decision-making structures themselves are racially diverse and fundamentally inclusive.

4. **Data Transparency**. Collect and publish data on race inequity in its entirety, ensuring it directly informs policy, strategy and improvement. Where data is not available, change policies to ensure that data is collected.

5. **Identify Racial Bias**, in policies, decision making processes, and other areas within your organisation.

6. **Apply a Race-Critical Lens**, to the adoption of any interventions or improvements to be tested, and to the design and delivery of services.

7. **Evaluate and reflect**, on interventions using metrics that recognise the role of racism as a determinant of health. These evaluations should seek to understand the extent to which interventions mitigate the impacts of racism.

Through our Anti Racist Framework working group - we hope to demonstrate our intent to take meaningful, proactive action against racism and ultimately build a fairer, and ultimately more inclusive, organisation. We have invited colleagues from across the organisation to help us drive and shape this work so that it reflects our people.

OUR FUTURE COLLEAGUE FOCUS

- Achieve Bronze level of the NorthWest Black, Asian & Minority Ethnic Assembly Anti-racist framework. Ensuring we actively promote our Anti-Racism work internally and externally; making clear our commitment as an organisation.
- Continue to provide greater in-depth analysis, as well as intersectional analysis, of data by protected characteristic group within our Committee and Board reports; including exploration of whether Staff Survey free text comments can be categorised by protected characteristic group.
- Redesign of EDI mandatory training module to include Antisemitism and Islamophobia once NHSE have defined the core content/messaging
- Refresh our organisational Values to make inclusive behaviours and actions more explicit.
- Continue to work with our Ethnicity Inclusion forum to understand the WRES metric relating to discrimination for our ethnic minority colleagues, defining actions to address issues uncovered and eliminate discrimination.

OUR FUTURE PATIENT & COMMUNITY FOCUS

- Improved accessibility on trust website with a focus on patient information
- Introduction of live TV screens – live up to date information on waiting times and health information
- Enhanced experience as inpatient including more options for catering (click & collect) better accessible tv /radio packages- available in different language and easy read formats
- Continued work with faith communities to support improving experiences across faith groups

PRINCIPLE 2 – BEING EVIDENCE LED AND TRANSPARENT

This second principal is centred around using evidence to help inform our focus and our decision making, enabling us to recognise where the experience of patients and colleagues who belong to protected characteristic/minority groups is not where we would want it to be and empowering us to create focused actions to make the right difference. Equally this principle sets out the importance of using our data to help us reflect, understand and measure the impact we are having through the steps we are taking.

BEING TRANSPARENT WITH OUR WORKFORCE EDI DATA

As this is our third report, we are continuing to demonstrate our commitment to deliver against this principle by having a **comprehensive annual report** which sets out where our focus has been, what we have delivered in the last 12 months and future actions we are going to take. It forms part of our Trust's public sector statutory duties under the Equality Act 2010 to report on performance and delivery against equality objectives annually alongside the breakdown of protected characteristics detailing the diversity of our workforce.

Our Workforce Diversity Headlines 2025

Headcount
9,290 ***(10,665)***

Ethnic Minorities
30.4% ***(26.6%)***

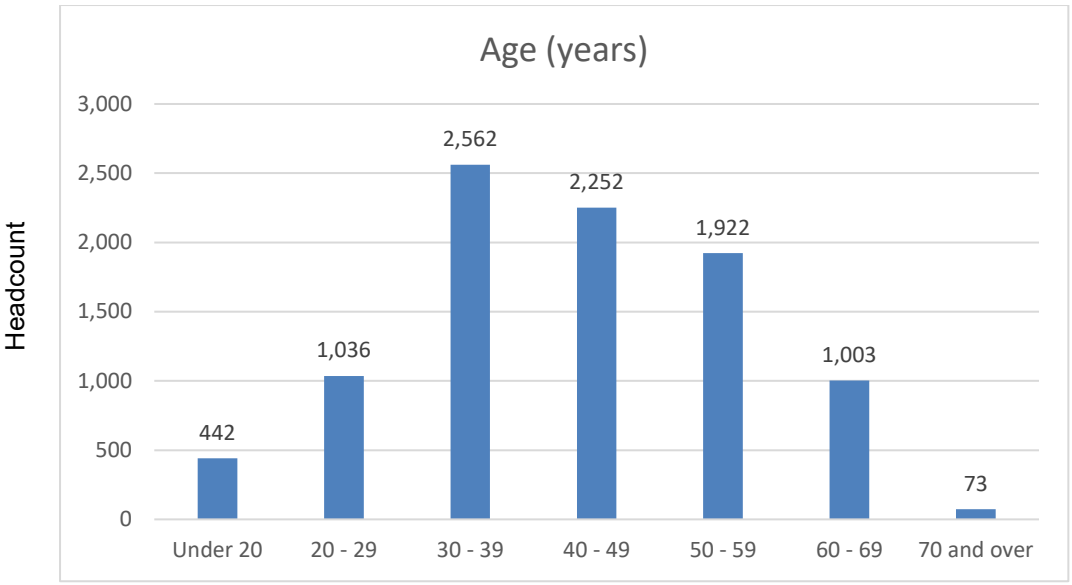
Disability
6.7% ***(6.2%)***

LGBT+
3% ***(2.9%)***

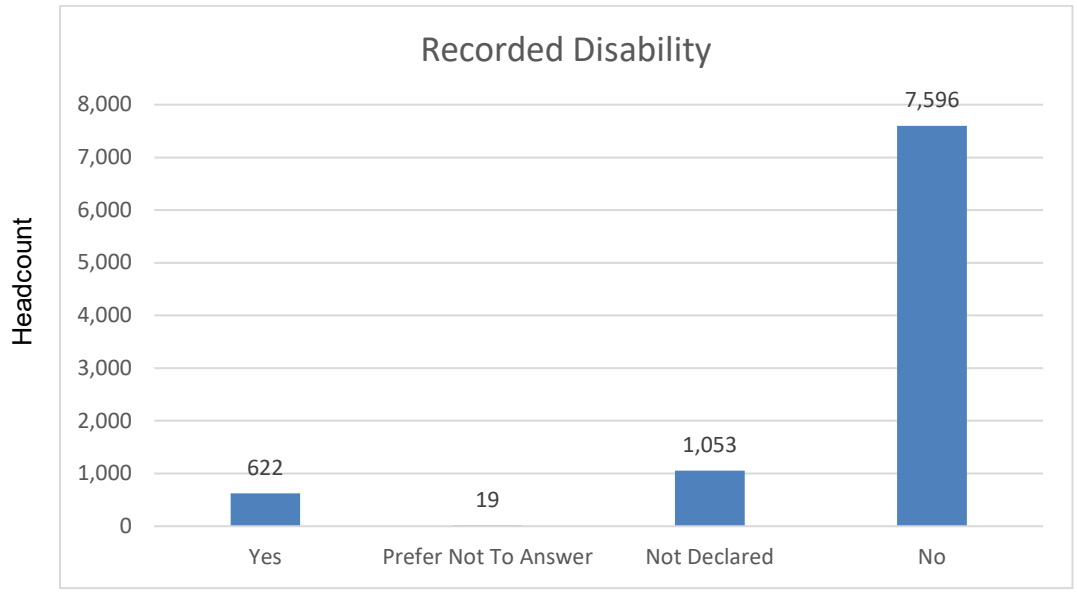
Women
76.0% ***(75.9%)***

(2024 data shown in brackets)

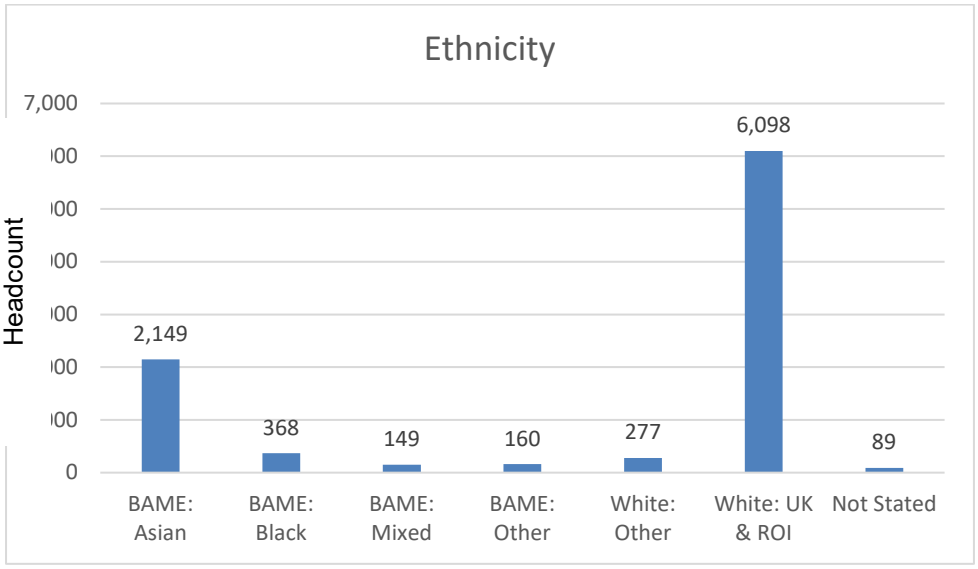
Graph 1 - Age Profile



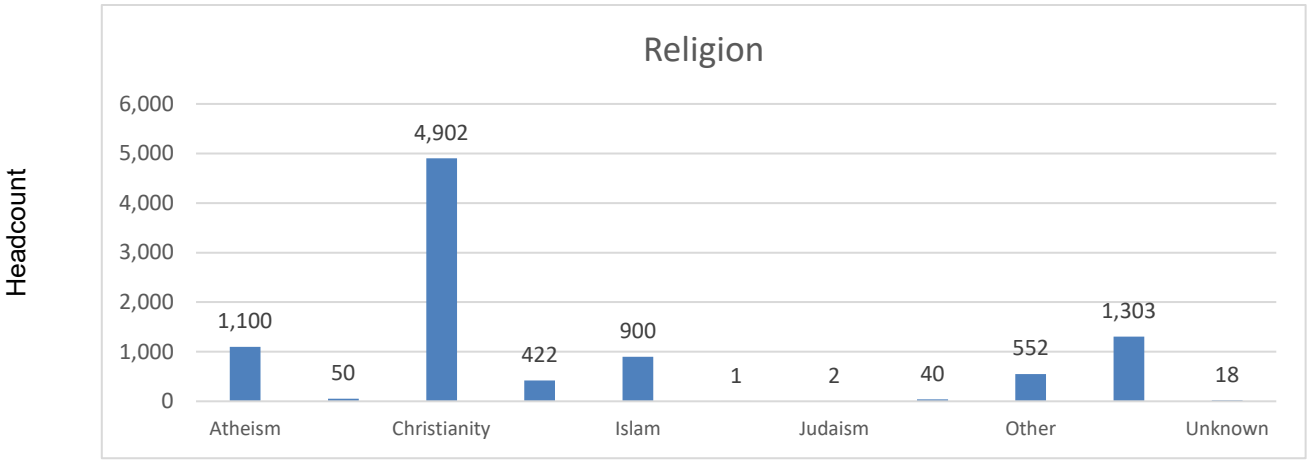
Graph 2 - Disability Profile



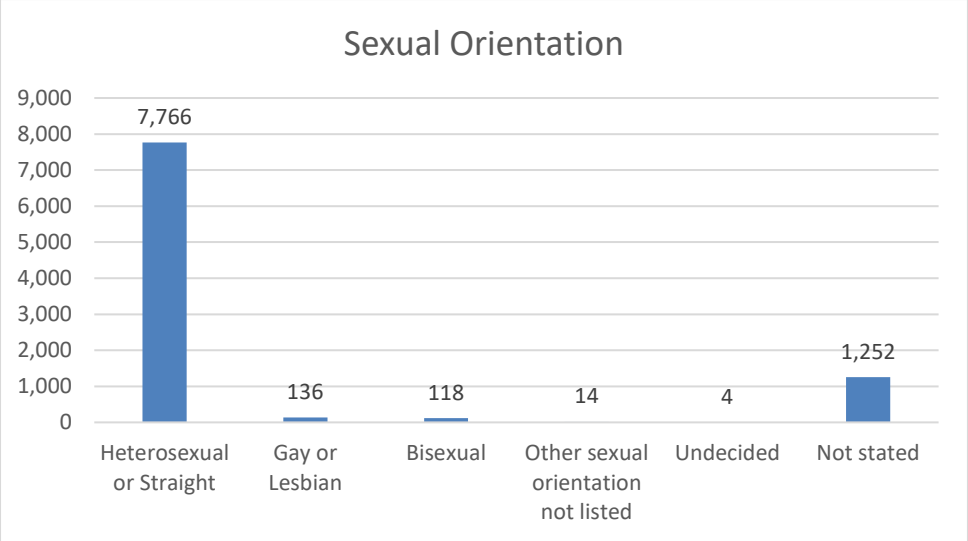
Graph 3 – Ethnicity Profile



Graph 4 - Religion and Belief Profile



Graph 5 - Sexual Orientation Profile



As signposted within last year's annual report, **our headcount has reduced by over 10%** from 10,665 to 9,290 over the last twelve months – this is partly a result of the transfer of some colleagues to One LSC, in addition to measures taken to reduce our deficit and stabilise our financial position through holding vacancies etc. It is likely the reduction in headcount will also influence metrics across the Workforce Race/Disability Equality Standards, in addition to staff survey data although we will have to wait until May 2026 to find out more. Appendix 1 and Appendix 2 display infographics capturing our annual WRES and WDES returns for 2025. The full reports can be found here.

We have continued to take opportunities to **promote and encourage colleagues to disclose any long-term conditions or disabilities** through the electronic staff record (ESR); through the All Colleague and Leaders briefings, Managers Update sessions and through the Neurodiversity toolkit. This continued focus does seem to be making a difference as we can see a sustained increase in the number of colleagues disclosing a disability/LTC which now stands at 6.7%.

FOR COLLEAGUES

We utilise **Staff Survey** data to gather insights in respect of how our colleagues experience working within our organisation, which helps improve workplace factors, overall colleague wellbeing and also evidences our progress regarding diversity and inclusion across the year. The data from our Staff Survey is used to generate detail for this report, in addition to evidencing metrics in respect of Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES). Over the last few years, we have been requesting and analysing our protected characteristic data in greater detail and we will continue to develop and expand this work to help us understand whether colleague experience varies dependant on protected characteristic group and if so, where the experiences of colleagues differs the most.

This year, Picker, who manage and coordinate our survey, have added questions in respect of socio-economic background e.g. *"When you were aged about 14, was the main or highest income earner in your household an employee, self-employed or not working?"* These questions will be used to understand whether people from different socio-economic backgrounds have the same experience(s) of working for our Trust.

The Library Services team, has undertaken a significant amount of research into **website accessibility** and developing materials that accommodate a **reading age** of under 11. This learning has been shared with colleagues in Library Services, so all material developed across the service is now created using readability and accessibility guidelines.

USING DATA AND LIVED EXPERIENCE TO IMPROVE CULTURE

Throughout the year the Board receives a number of **data sets and reports**, relating to equality diversity and inclusion, which are designed to help us understand lived experience, culture, priorities and progress we are making to reduce inequality across our organisation:

- **Workforce Race Equality Standard (WRES)**
- **Workforce Disability Equality Standard (WDES)**
- **Gender Pay Gap**
- **Ethnicity Pay Gap (introduced in 2024)**
- **Disability Pay Gap (introduced in 2025)**
- **Equality Delivery System (EDS22)**
- **NHS Staff Survey results broken down by protected characteristic**
- **Annual EDI Report**

In the Northwest region, we are also required to complete a quarterly assurance framework (referred to as LEAF) which contains a series of questions to establish a **baseline of compliance, assurance, progress, highlights and further support**.

Infographics detailing the headlines for the WRES and WDES are contained in the appendices. All reports are discussed within Workforce Committee, with escalation (and in some cases approval) by Board to enable the national publication of our data set. In addition to the suite of reports noted above, Workforce Committee also receive the annual strategy update for the Our People Plan strategic aim – to create a positive organisational culture.

In September of this year, we launched an **Equality Impact Assessment toolkit for colleagues**, to enable those who produce patient and colleague facing policies, processes, standard operating procedures or who make decisions about service developments/changes or financial improvement plans, to be able to access information at the point of need which supports them to robustly and accurately complete equality impact assessments and improve the documented evidence of mitigations taken where potentially adverse impacts are recognised.

We have continued to undertake **Equality impact assessments** on all workforce policies which have been reviewed or updated throughout the year, to understand whether the application of our employee relation policies may lead to an adverse impact for colleagues with protected characteristics, and if so, then devise and undertake actions which mitigate against any adverse impacts.

Those policies were;

- Redeployment Policy
- Disciplinary Policy
- Agile Working
- Management of the Misuse and misappropriation of Drugs, misuse of Alcohol and Other Substances by Staff
- Special Leave Policy
- Roster Management Policy
- Statutory and Mandatory Training Policy
- On Call Policy
- Raising Concerns at Work Policy and Procedure
- Organisational Change Policy and Procedure
- Attendance Management policy
- Code of Conduct
- Overtime Policy
- Parental Policy
- Appraisal Policy
- Annual Leave Policy

Our policy review and approval process sets out the need for an equality impact assessment to be undertaken for all policies in addition to the requirement for our Staff Inclusion forums to be consulted with when a policy is being developed or reviewed. As part of the equality impact assessment and review undertaken for our Attendance Management policy, we carried out benchmarking activity across Lancashire & South Cumbria NHS Trusts including analysis of absence data to assess the potential impacts of adjusted intervention points.

As a part of our **Workforce Disability Equality Standard (WDES)** and **Workforce Race Equality Standard (WRES)** analysis it was found that with regards to the **formal capability process, disabled colleagues are nearly twice as likely to be engaged in this process** (being 1.98 times more likely to enter into the formal process). This represents a slight decrease from 2.07 times more likely the previous year. The number of cases entering a formal capability process overall remains low (15-30 for Disabled colleagues per year), therefore care must be taken when drawing any conclusions from the data.

With regards to the **formal disciplinary process**, we have seen a balancing out in the percentage of colleagues from a minority ethnic background (compared to white colleagues) entering the formal stages with the results indicating that **ethnic minority colleagues are now as likely to enter the process as white colleagues** (1.15 times as likely) a figure which has increased over the last 12 months from 0.44 (less likely). We have started to develop a training module which supports leaders/managers to lead formal workforce processes inclusively and without bias – the training is being developed using the Equality Diversity Representatives training package previously delivered at regional level but will also factor in the lessons learned from investigations or research i.e. Too Hot to Handle report, the NMC Culture review findings.

If colleagues disclose that they have a long-term condition or a disability line managers are encouraged to undertake a supportive discussion and complete a **Supporting Disability or LTC in the Workplace conversation** which provides an opportunity for the line manager to understand their

team member's health condition(s), how it impacts them within the workplace and how best we can support them in work (including details of any agreed workplace adjustments). Over the past 3 years we have incorporated a health and wellbeing section into appraisals which provides space for colleagues to record whether they have a Supporting Disability or LTC Agreement (SDA) in place or whether they need one, but do not have one.

Analysis of completed appraisals completed across a 12-month period (to mid-December) showed that;

7.8% colleagues recorded having a SDA in place, almost double the 4% noted last year
64.6% colleagues didn't have (or need) an SDA, down from 69% last year
3.4% colleagues didn't have an SDA, but they needed one, up slightly from 3% last year
24.1% left the field blank, same as previous year.

As roughly a quarter of completed appraisals had left the Supporting Disability/Long-term conditions field blank, work has already commenced to mandate completion of the field within appraisals. To date changes have been made to the Team Member templates, the Leader and Interim templates will be updated early in the new year.

Whilst it's important for us to establish whether colleagues who require Supporting Disability/Long-Term conditions agreements are getting them, there is also a need for us to ascertain the quality of the conversations which have taken place in support of completing the document. Work needs to be undertaken to assess the quality of those discussions/agreements, to ensure they happen in a supportive and compassionate manner. We will start by building some related questions into the appraisal survey which is sent out to colleagues in the month following their appraisal. This will also help us to build on the work we have already started, analysing appraisal experiences and ratings by ethnicity and disability so we can identify any disparities, and take action(s) to address them.

As part of our **annual retention report**, certain demographics of our workforce were identified as being at greater risk of leaving i.e. a higher proportion of leavers were young, single and male. It was also flagged that there are higher rates of retirement at present. Over the coming year, we will explore these areas to see whether any additional work is required. We are now also monitoring demographic data through a series of questions within our **New Starter survey**, this is in the process of being analysed to consider any relevant findings. What we would like to move towards is a triangulation of all the data which is available across Organisational Development workstreams (EDI, Leadership, Freedom to Speak Up, Engagement, Retention etc) to establish a rich picture of the experience of colleagues in our organisation.

We continue with our commitment to enhance the level of reporting, analysis and assurance we provide around the **Workforce Race Equality Standard** (WRES), **Workforce Disability Equality Standard** (WDES) and **Gender Pay Gap**, all of which we publish externally here.

The **National Staff Survey** results are reviewed annually to understand if there are any differences in the experience of work for any of our minority groups. Through completing this analysis, we identified a number of themes which include:

Bullying, Abuse, Violence and Aggression

- Colleagues who **have a disability or long-term condition (LTC)** continued to report experiencing greater levels of bullying, harassment, violence and abuse from patients, their relatives or members of the public (28.1%) than colleagues without a disability or LTC (20%). Similarly, it was found that colleagues with a disability or LTC reported experiencing higher levels of bullying or abuse from colleagues (23.9% versus 15.8% for non-disabled colleagues) and managers (11.3% versus 6.7% for non-disabled colleagues). These figures are almost the same as in 2024's report. In addition, colleagues with this protected characteristic indicated that they felt less secure in raising concerns (66.6% versus 71.5% for non-disabled colleagues) and less confident that, as an organisation, we would address them (45.5% versus 55.9% for non-disabled colleagues).

- It was found that colleagues from a **White and Black Caribbean** (39.3%) background and those who identified as **Irish** reported experiencing the highest levels of bullying and harassment, violence and abuse from patients, their relatives or members of the public (36.8%) compared to the Trust average of 22.2%. This is a slight change from last year where colleagues from a **Chinese** or **Irish** background reported experiencing the highest levels. Colleagues who identified as **Any Other Ethnic background** reported experiencing the highest levels of harassment, bullying or abuse from managers (37.5%) compared to the Trust average of 8% (a change from last year where Chinese colleagues reported the highest levels). Finally, colleagues identifying as **White and Asian** noted the highest levels of harassment, bullying or abuse from other colleagues (40.9%) when compared to the Trust average of 18% (last year this was colleagues from an Arab background).

- Colleagues **below the age of 30** reported more experiences of bullying, harassment, violence and abuse from patients, their relatives or members of the public (27.1%) compared to the Trust average of 22.2%. Colleagues **between 41-50** reported experiencing greater levels of harassment, bullying or abuse from both managers (9.7%) other colleagues (20.5%) when compared to the Trust averages (8% and 18% respectively).

A significant amount of work has been undertaken over the couple of years to raise awareness of the importance surrounding organisational culture, civility and Zero Tolerance with diversity and inclusion a conscious, purposefully visible thread throughout.

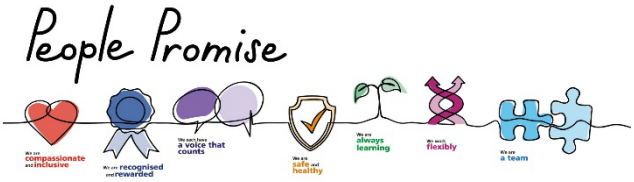
On a team level basis, our **Team Engagement and Development tool (TED)** uses survey insights and team-level feedback to shape meaningful, targeted interventions. TED helps Team Leaders interpret their team engagement results through an EDI-aware lens with the help of toolkits, encouraging them to explore variations in experience, identify underlying issues and co-create evidence-based action plans. This approach has enabled teams to make informed decisions, respond to disparities highlighted in feedback, and drive positive, measurable improvements in colleague experience and team culture.

RESPONDING TO SIGNIFICANT AND IMPACTFUL EVENTS

In October we received news of the shocking attack at a synagogue in Crumpsall, North Manchester as members of the Jewish community were celebrating Yom Kippur, an important day in the faith calendar. The potential impact on colleagues across our organisation, particularly Jewish colleagues, was acknowledged through our corporate communication channels, led by a Special Briefing message from our Executive Team. Key messages included;

- Reinforcing channels for practical, emotional, psychological and spiritual support
- Encouraging colleagues to support one another (especially line managers, asking them to proactively reach out and support team members who may be at increased risk of abuse or who may face additional barriers to speaking out)
- Reminding colleagues of our organisational values and our commitment to creating a workplace where everyone feels safe, valued and supported, regardless of their faith, background or identity.

PEOPLE PROMISE: WE ARE COMPASSIONATE AND INCLUSIVE – Diversity & Equality sub score average 8.2/10



The NHS People Promise consists of seven key elements aimed at improving the experience of NHS colleagues and fostering a supportive work environment. One of those elements is "We are compassionate and inclusive" which is measured through staff survey by colleague responses to four of the staff survey questions in relation to; acting fairly in respect of career progression, personal experiences of discrimination at work and whether the organisation respects individual differences.

- Colleagues **aged between 21-30** recorded the highest scores in respect of questions relating to diversity and equality (overall score of 9.0) whereas colleagues **aged between 31-40 and 41-50** recorded the lowest score of 8.1
- Colleagues **with a disability or long-term condition** scored 8.0 in respect of diversity and equality compared to colleagues without a disability (8.3).
- Colleagues who **identified as Arab** scored the highest in respect of questions relating to diversity and equality at 8.6 followed by colleagues who are **English/Welsh/Scottish/Northern Irish/British** at 8.4. Colleagues with the lowest scores were those from **any other ethnic background** (score of 6.4).
- **Females** scored above the organisational average for questions relating to diversity and equality (8.3) and **males** scored below the organisational average (8.0). Colleagues who selected **Prefer not to say** had the lowest scores at 7.2 with insufficient responses to generate a score for colleagues identifying as non-binary or prefer to self-describe.
- In terms of sexuality, scores relating to questions in respect of diversity and equality were lowest for colleagues who identify as **Other** (7.1). Those identifying as **Bisexual** scored the highest average with 8.3.

- With regards to religion, colleagues who stated they would **prefer not to say** had the lowest average scores relating to questions in respect of diversity and equality (7.3). Colleagues whose religion is **Christian** or who noted **No Religion or Any Other religion** recorded the highest average scores at 8.3**.** Insufficient responses were received from colleagues who identified as Buddhist or Jewish to generate a score.

COLLEAGUE ENGAGEMENT – Trust Average Engagement Score 6.6/10

The levels of engagement are measured through looking at Motivation, Involvement and Advocacy of colleagues using the responses to a number of questions which include whether colleagues look forward to coming to work, are enthusiastic about their job, are able to make suggestions to improve their work and whether they would recommend the organisation as a place to work.

- Colleagues **aged between 21-30** continue to have the lowest engagement levels (overall score of 6.5, compared to 6.8 in 2023), the most engaged group are those **aged 16-20** (score of 7.1, up slightly from 7.0 in 2023), closely followed by those **aged 66 and over** with a score of 7.0.
- Colleagues **with a disability or long-term condition** were found to have lower levels of engagement (6.2, a drop from 6.5 in 2023) compared to colleagues without a disability (6.8, a drop from 7.1 in 2023).
- Colleagues who **identified as being Indian** had the highest engagement scores at 7.5 closely followed by colleagues who are **Arab** at 7.4, **African** at 7.3 and Any Other Asian background (7.2). These scores are higher than the organisation average and also higher than white colleagues (score of 6.5). Colleagues with the lowest staff engagement levels were those from **any other ethnic background** (score of 5.6) and **any other white background** (score of 5.9).
- **Males** and **females** had similar levels of engagement with males scoring slightly lower (6.6 compared to females at 6.7). Colleagues who selected **Prefer not to say** had the lowest staff engagement levels at 5.5 with insufficient responses to generate a score for colleagues identifying as non-binary or prefer to self-describe.
- In terms of sexuality, levels of staff engagement were lowest for colleagues who **prefer not to say** (5.9) followed by colleagues who identify as **gay or lesbian**, with a score of 6.1 in comparison to heterosexual colleagues at 6.7.
- With regards to religion, colleagues who stated they would **prefer not to say** had the lowest staff engagement score (5.7) followed by colleagues who identified as having **no religion** (6.4). Colleagues whose religion is **Hindu** or **Sikh** had the highest engagement levels (7.4 and 7.5 respectively). Insufficient responses were received from colleagues who identified as Buddhist or Jewish to generate a score.

GENERAL STAFF SATISFACTION THEMES

- Colleagues **between 21-30 years reported experiencing the highest levels of work-related stress (43.2%) although colleagues in the 31-40 and 41-50 group were similar (42.4% and 42.9% respectively) and found work more emotionally exhausting and tiring, with greater feelings of burn out than other age groups**. Colleagues between 16-20 and 66+ recorded experiencing the lowest levels of work-related stress; with colleagues **between the ages of 16-20 years experiencing the greatest levels of satisfaction across the items measured in the National Staff Survey**.

- **Disabled colleagues have again reported lower levels of satisfaction across the majority of the questions in the National Staff Survey**, including factors relating to their job such as ability to make suggestions to improve the work of their team/department (9.2% lower than colleagues without a disability), feeling valued for their work (10.7% lower than colleagues without a disability) or able to achieve a good balance between work and home life (10.8% lower than colleagues without a disability). Through to how they feel working in their team; levels of respect and kindness demonstrated from colleagues and line managers (8.5% lower than colleagues without a disability) and ability to access training and development opportunities (10.2% lower than colleagues without a disability).

- Across all the staff satisfaction questions **colleagues from any other ethnic background and colleagues from any other white ethnic minority background had the highest number of red RAG rated items** compared with other ethnic minority groups and the Trust average.

- Across all the staff satisfaction indicators, **colleagues who identify as gay, lesbian or 'prefer not to say' recorded lower levels of satisfaction through a higher number of red RAG rated items,** than heterosexual or bisexual colleagues.

FOR PATIENTS AND OUR COMMUNITIES

The Trust continues to engage with local communities based on demographic insights to ensure underrepresented groups are aware of the services available to them. We have launched targeted awareness campaigns within our local areas, which have proven effective in reaching these communities. However, survey participation has improved against national averages, with feedback from individuals with protected characteristics accounting for 7% in the national inpatient 7%,16% in the maternity survey and 25% in Children's Survey. As a result, we remain committed to improving representation and engagement through evidence-led approaches, as outlined below.

REDUCING HEALTH INEQUALITIES IN MATERNITY CARE

We have been working in partnership with the Race & Health Observatory and the Institute for Healthcare Improvement to address disparities in maternal health outcomes, with a global aim to reduce postpartum haemorrhage (PPH) (≥1000mL) among Black and ethnic minority women and birthing people by 50% from 12% to 6% by January 2026.

Progress to date includes a sustained reduction in PPH rates to 9%, embedding Early Bird Preventative Group sessions as standard practice, approving maternity exemption for Ferrous Sulphate to tackle anaemia, and initiating digital innovations to integrate anti-racism principles into emergency training.

This work underscores our commitment to closing equity gaps, ensuring inclusive access to care, and embedding anti-racism principles into clinical practice and training.

TARGETED INITIATIVES

Sahara Project – World Cancer Day

Staff from Macmillan Cancer Support and our Colorectal Team visited the Sahara Centre to raise awareness of cancer signs and symptoms and emphasise the importance of bowel screening for early diagnosis.

Preston Health Mela

Our Macmillan Cancer Support and Research & Innovation teams were actively involved in this event, showcasing available support services and engaging with attendees to share information on screening and awareness programmes. The Research & Innovation team highlighted that we are a research-active trust, explained the breadth of our research, and promoted inclusivity and accessibility in research participation.

Preston Fire Station & Lancashire Police Headquarters

Macmillan and Skin Cancer teams delivered sessions on recognising cancer symptoms and provided practical advice on sun safety.

Cancer Awareness at Preston North End

During a match day in April, coinciding with Bowel Cancer Awareness Month, Macmillan and Oncology staff engaged with supporters outside the stadium, sharing information about our services, key symptoms, and the importance of Screening.

Preston Men's Muslim Forum

Hosted by Preston Muslim Girls School, this Men's Health and Wellbeing event focused on cancer awareness, symptoms, and screening for lung, bowel, prostate, and testicular cancers. Macmillan and Oncology staff attended, alongside Professor Munavvar, who spoke about lung cancer and promoted the newly launched lung screening programme.

Feedback from the Forum Chair: *"We extend our heartfelt appreciation for the in-depth and enlightening presentation. It truly highlighted the impact of cancer, an illness men often overlook and reinforced the need to be informed and vigilant for the sake of individuals and families."*

In the latter half of this year, colleagues were encouraged to share information to eligible colleagues, patients and community groups in respect of the **NHS Jewish BRCA Testing Programme**, which had already enabled over 32,000 individuals to access free genetic testing for BRCA1 and BRCA2 gene faults - these faults significantly increase the risk of breast, ovarian, prostate, and pancreatic cancers and Jewish ancestry carries a higher prevalence of BRCA gene faults (1 in 40 Ashkenazi Jews and 1 in 140 Sephardi Jews), compared to 1 in 250 in the general UK population.

Healthwatch Collaboration

Healthwatch Lancashire's Enter & View visit to the Gynaecology Outpatients Department at Royal Preston Hospital highlighted a service that is fundamentally caring, professional, and committed to patient experience. Staff interactions were consistently observed as courteous, reassuring, and patient-focused, with many patients praising the friendliness and helpfulness of both clinical and reception teams. The environment was clean, well-maintained, and equipped with accessible features such as level access and a disabled toilet, demonstrating a strong baseline commitment to inclusion.

Staff demonstrated awareness of language and communication support, including the availability of BSL interpreters and LanguageLine, and were proactive in allocating extra time for patients requiring these adjustments. Training opportunities were described as comprehensive, and staff reported feeling well-supported by their colleagues and management team, fostering a positive and collaborative culture.

While overall patient feedback was positive, the review identified opportunities to build on these strengths. Enhancing communication around appointment changes and wait times, improving wayfinding signage, and introducing dementia-friendly features would further elevate the patient experience.

These improvements will complement the strong foundations already in place. By refining communication systems, expanding accessibility measures, and continuing to prioritise staff and patient wellbeing, the service can further demonstrate leadership in equity, diversity, and inclusion. These actions support Core20PLUS5 priorities for tackling health inequalities, and reflect the Trust's commitment to delivering high-quality, person-centred care for all.

OUR FUTURE COLLEAGUE FOCUS

- Assess the quality of conversations line managers/colleagues are having in respect of the Supporting Disability/Long Term Conditions agreements through the Appraisal Completion survey.
- Develop a learning resource to support line managers to have compassionate and understanding Supporting Disability/Long Term Conditions conversations which enable the completion of an agreement form.
- Mandate the completion of the Supporting Disability/Long Term Conditions agreement question within the Leader and Interim appraisal templates in the new year.
- Develop a training module which supports leaders/managers to lead formal workforce processes inclusively (and without bias) factoring in the lessons learned from investigations or research i.e. Too Hot to Handle report, the NMC Culture review findings etc.

OUR FUTURE PATIENT & COMMUNITY FOCUS

- Develop a maternity data dashboard for ethnicity-based aggregation, exploring AI and VR solutions to enhance multidisciplinary training,
- Continued collaboration with McMillan and cancer community in-reach services
- Continued collaboration with Healthwatch with enter and view visits, gaining valuable insight into patient experience

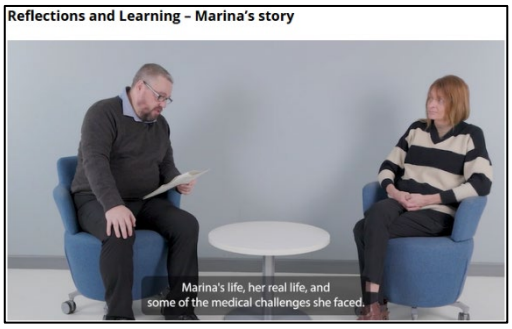
PRINCIPLE 3 – RECOGNISING THE IMPORTANCE OF LIVED EXPERIENCE

This principle emphasises the importance of understanding, valuing, and responding to the lived experience of our communities and colleagues. To provide excellent services and be a great place to work, we recognise that we need to engage with all groups but ensure the voices of minority groups in particular are engaged to co-produce and co-design as equal partners the shape of our services and type of organisation colleagues wish to work within. To implement Principle 3, the following actions have been taken forward to ensure we consciously recognise the lived experience or patients, our communities and colleagues.

Since December 2022 we have hosted a **Hospital Independent Domestic Violence Advisor** (HIDVA) which is a role integral to safeguarding patients and colleagues affected by Domestic Abuse, something which affects over 2 million people each year in England and Wales. Domestic Abuse has severe physical, mental and social consequences – it is linked to depression, homelessness, suicide and poor pregnancy outcomes. For the twelve months up to March 2025 the HIDVA provided confidential, trauma-informed support for 385 individuals (337 patients and 48 colleagues). In addition to this they delivered training to colleagues to help develop their confidence in identifying and responding to abuse and increase their competence in handling disclosures, reducing stress and risk in clinical settings.

FOR PATIENTS AND OUR COMMUNITIES

Patient stories are a powerful tool for staff learning and service development. This year, we have produced numerous videos featuring patients sharing their experiences and emotions. To make these stories more accessible, we have created a dedicated area on the staff intranet, allowing colleagues to see, hear, and engage with real-life accounts of care within our services. Previously, these stories were only shared within specific departments or at board meetings.



Patients have played a central role in shaping improvements across the Trust by sharing their lived experiences at Community of Practice events and Board meetings, actively participating in Patient Forums, and contributing to the development of the Patient Experience Portal. Their voices have influenced initiatives such as enhanced interpretation services, tailored events like ‘Our Health Day’ for patients with learning disabilities and strengthened engagement with the Deaf community.

In May we welcomed the **Autism Reality Experience Bus** from Training2Care; colleagues from across the Trust were able to attend short training sessions, giving staff the opportunity to enter the neurodiverse world and experience the sensory processing difficulties faced by people on the autism spectrum. The Autism Reality Experience challenges thinking and directly confronts you with the profound impact of the environment, communication and sensory input.

It gives an insight into:

- Hypersensitivity to the sensory environment
- How it feels to become overwhelmed
- Proprioceptive hyposensitivity
- Vestibular hypersensitivity
- Difficulty processing language and instructions
- Flexibility of thought issues
- Being in an environment that doesn't account for your needs

The training had incredibly positive feedback, with lots of staff noting how overwhelming and frightening coming to hospital must be for those with sensory needs. One colleague said: *"It was so beneficial to have some experience of what it is like to be in that person's shoes"*, while another said: *"It really made me think about our ward environment and the impact that must have on someone."*

Significant environmental changes have been implemented to improve care settings and accessibility, including the accreditation of 71% of wards with STAR Gold, installation of stoma-friendly bathrooms, development of a new Acute Medical Unit, and introduction of whiteboard systems in outpatient areas to identify patients requiring reasonable adjustments. These combined efforts reflect a commitment to person-centred care, inclusivity, and continuous improvement in both patient experience and the physical environment.

By sharing these experiences more widely, we have seen a significant increase in the creation of involvement forums and groups across various departments. These forums enable staff to gain a deeper understanding of patient experiences and work collaboratively to improve care and services, ensuring patients remain at the heart of everything we do.

Our forums also partner with external charities and organisations, helping us engage with a broader range of voices and capture a more representative view of our communities.

COMMUNITY FORUMS

Last year saw the establishment of several new in-house and collaborative partnership forums, complementing existing groups and strengthening community engagement. Forums include:

- Cancer Patient and Carers Forum
- Carers Forum
- Critical Care Patient and Relative Support Group
- Endometriosis Forum
- Mobility Matters Forum

- Patient Research Group
- Preston Dystonia and Migraine Group
- Renal Working Group
- Sepsis Support Group
- SMRC Joint User Forum
- Tracheostomy Forum
- Youth Forum
- V.I (visual impairment) Forum
- Saheliyaan Asian Women's Forum
- BSL Forum Lancashire

These forums have enabled the Trust to gather feedback directly from local communities and incorporate their perspectives into service planning and improvement.

PARTNERSHIP WORKING

Partnerships have also enabled collective improvements in accessibility. The Healthwatch initiative *One Voice in Health and Social Care for BSL Users* generated constructive feedback from the Deaf community, culminating in a report that encourages organisations to strengthen support.

In addition, the involvement services, recognising the importance of patient stories and true patient experiences collaborated with Deafways in Preston to encourage the Deaf community to share their experiences of our hospital services. Together with the Blended Learning team and permissions from our Deaf community we were able to produce video feedback with the support of our BSL interpreter contractors Co-Sign. These recordings have provided staff with valuable insights into Deaf culture, fostering greater understanding and inclusivity across the Trust.

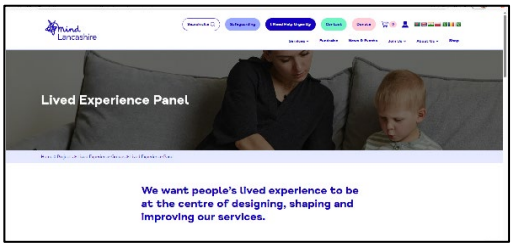
These stories from the Deaf community can be seen on our staff intranet patient story library here along with other patient stories on various services supplied by the Trust.

Healthwatch continues to conduct real-time visits to both Preston and Chorley hospital sites, gathering feedback directly from patients and visitors. This intelligence is reported to the Patient and Carers Experience and Involvement Group, which in turn informs the Safety and Quality Board, ensuring that the patient voice is embedded within oversight and decision-making processes.

(Picture above shows Representatives from Healthwatch, Ncompass, Lancashire County Council, Lancashire Teaching Hospitals and the Deaf Community at 'One Voice in Health and Social Care BSL' presentation).

FOR COLLEAGUES

In summer of this year, our Head of Diversity & Organisational Development and our Head of Employee Wellbeing were asked to contribute towards a **Best Practice Guide for Lived Experience Engagement** which was being developed by Mind Lancashire. The guide is intended to be shared with employers across Lancashire and contains a set of guiding principles and recommendations for employers to consider when inviting others to share their lived experience and personal stories.



INCLUSION AMBASSADOR FORUMS

We have **three Inclusion Ambassador forums** which have been established since 2019; **Ethnicity, Disability and Neurodiversity and LGBTQ+.** The Inclusion Ambassador Forums are each chaired by one or two colleagues (who are usually members of the community group the forum represents) each forum has an allocated support member from the EDI team and sponsorship from members of our Board and Executive Team.

In addition to the inclusion forums, we have **three support groups** which are also aligned to the health and wellbeing agenda; a **Menopause Group, a Carers Group and, an Endometriosis Awareness group**.

In the last year, the Disability Staff forum has changed its name to recognise the growing number of neurodivergent colleagues who were joining for support and to help shape the workplace to be more inclusive. Within the last couple of months, forum members have been sharing tools they utilise (or have utilised) which have helped support neurodivergence as a means of **adding some practical resources to our Neurodiversity Toolkit**. These tools have been collated and will be shared via the Inclusion pages of the Intranet as well as within our ND Toolkit.

Across the year, there has been consistent promotional activity, in line with our **Inclusion calendar** events, to raise awareness of particular days weeks or months across the year which hold significant importance to those from protected characteristic groups. We promote these events to honour inclusion, so colleagues are 'seen' and acknowledged but also to raise awareness of specific topic areas or to enhance education.

2025 has seen continued challenges in being able to maintain a consistent level of forum meetings due to; general volume of work activity and available attendees, work commitments or long-term absence of Chairs and recruitment of new Chairs. This is an area we need to look at addressing in 2026, potentially through the use of a Diversity & Inclusion champion role.

UTILISING THE LIVED EXPERIENCE OF COLLEAGUES TO SHAPE HOW WE DO THINGS

As already mentioned, we are seeking to engage with colleagues through the **Staff Inclusion forums** to shape how we do things in our organisation, especially in relation to discrimination and bullying and harassment. There are a variety of ways in which we encourage colleagues to share their

experiences; some well-established and regularly scheduled such as Staff Inclusion forum meetings, Staff Stories at Board, Leader/All Colleague briefings, Schwartz Rounds etc, and others are more on an adhoc basis as and when opportunities arise.

July's **All Colleague Briefing** saw Silas (CEO) welcome Gemma Devine who presented her personal journey to around 250 colleagues. Gemma is a HealthCare Assistant who has Multiple Sclerosis which was diagnosed in 2021 having experienced symptoms for six years. She shared how she has been supported through; completion of a Supporting Disability & Long-Term Conditions agreement, having workplace adjustments in place agreed with her line manager, wearing a Sunflower Lanyard/badge indicating a hidden disability and joining the Disability and Neurodiversity Staff Inclusion forum.

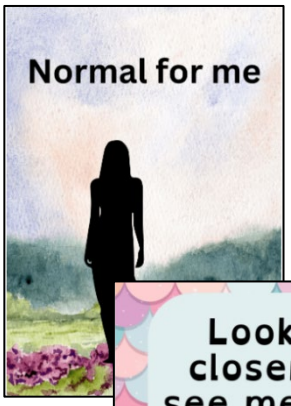
In February, Harley Walsh (an MDT Coordinator) presented her **Staff Story to Board**. Harley has multiple health conditions, including a dynamic disability which means she sometimes uses a wheelchair – the impact on her life can vary significantly on a day-to-day basis. Harley's story really brought home to the board the impact on a colleague's working life when reasonable adjustments are supported at work. She talked about the challenges experienced in the process and highlighted the delays which can impact on the Trust being able to claim monies back.

In conjunction with Black History Month, we engaged with an Arts Council England sponsored project titled '**Embers of Care'**, led by artist and internationally educated NHS nurse, Yayen John. Our colleague, Kwame (an Occupational Therapist who hails from Ghana) kindly volunteered to share his own personal journey of relocation to England which was reflected in a bespoke artwork piece, painted by Yayen. In the painting, Kwame is portrayed assisting a patient, with a soft expression of humour, humility, and resolve.

The painting tells Kwame's story; of how his journey to the UK was filled with challenges and cultural surprises which fuelled his commitment to inclusion and support for others. Kwame's first lessons in migration came wrapped in humour: *"I was really excited that I was coming in the summer,"* he recalled. *"But, I was shocked by the cold the moment I got off the plane. Coming from Ghana where it's 35, 37, 38 degrees… I checked the temperature, and it was 14. I was freezing!"*

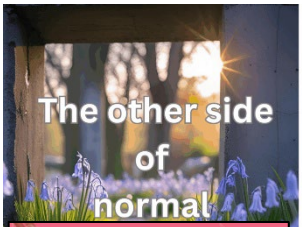
Language barriers posed a significant challenge - despite regularly listening to the BBC, Kwame struggled with UK accents and fast conversations: "*On my first day, I joined a handover and I couldn't understand anything. I was lost."* Recognising the challenge, his team enrolled him in a nine-week language integration programme which Kwame says "*really helped*."

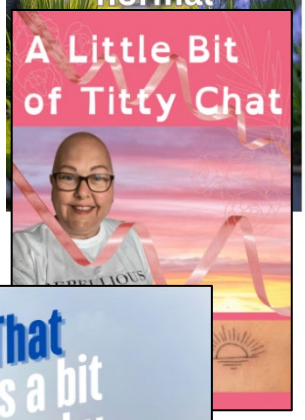
We were delighted to be invited to participate in the Embers of Care artwork series. We give our thanks to our colleague Kwame for sharing his personal experience; an insightful story that prompts us to take a moment and reflect on both the challenges that our international healthcare workers face, alongside the vast contributions they make.



Our Living Library has evolved to become our **Living Collection** with 6 human books that share and celebrate the diversity and lived experience of colleagues within the trust. Permanent displays of the Living Collection are in the libraries at Preston and Chorley and there is also a dedicated web page for colleagues through which they can request to read a book, or even become a book themselves.

Our living collection is about talking. We aim to open up talks between colleagues which wouldn't ordinarily happen - it is a simple idea, colleagues volunteer to be "human" books and tell their life story, and the borrower gets to hear the book's lived experience, in their own words.





The principle behind the scheme is that it helps to: share best practice, help to raise awareness of (and challenge) bias when due to a lack of knowledge, tackle unfairness and to hear about the trials some colleagues face every day.

Some feedback from colleagues who've attended a Living Collection event is noted below;

- *Interesting to speak to people of different backgrounds and understand their struggles in life*
- *Insight into chronic health conditions and struggles of patients*
- *Reminder to be kind - there is progress being made in terms of culture and stigma concerning disabilities in the workplace*
- *Being able to have such open conversations was appreciated*
- *Enjoyed gaining the perspective of some patients, and made me re-evaluate the structure of 'interviews' during consultations*
- *It was a friendly, safe and inclusive environment*

SCHWARTZ ROUNDS

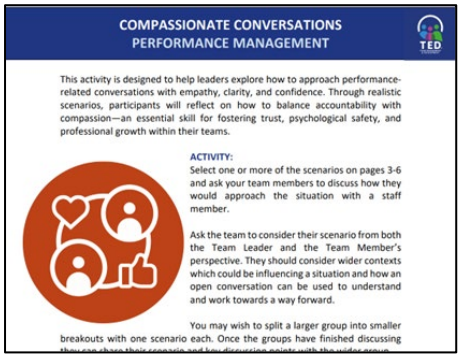
We have continued the delivery of our Schwartz Round programme throughout 2025, sharing stories of lived experiences which help colleagues 'see the person within the professional'. We are more than our job roles, we are people too and we don't often get the opportunity to discuss the emotional impact our jobs can have on us. Schwartz Rounds are designed to help support colleagues to connect on these issues and encourage a culture of kindness, compassion and empathy between one another. This year has seen Schwartz Rounds discussions span multiple topics and themes, including topics such as;

- The Human Impact of Health Care,
- Compassionate Leadership – Stories of Supporting and Being Supported,

- The Day I made a Difference,
- Civility Matters,

As well as topics which included balancing health conditions with work commitments

TEAM ENGAGEMENT DEVELOPMENT (TED) TOOL



Over the past year, our **TED tool** has created tools and guidance for facilitated discussions that encourage colleagues to share their perspectives, challenges and experiences in a psychologically safe way. Resources such as our compassionate conversations, sexual safety and zero-tolerance toolkits help teams explore real scenarios, reflect on differing viewpoints and understand the experiences of minority and under-represented colleagues. By enabling honest dialogue and co-design of team actions, TED helps ensure that lived experience directly shapes how teams work, support each other and improve their culture.

SUPPORTING THE DELIVERY OF WORKPLACE ADJUSTMENTS

November saw leads from our EDI, Workforce Advice and Health and Wellbeing teams deliver a **Managers Update session** to over 100 managers and leaders titled “Workplace Adjustments and Supporting Disability/Long-Term Conditions form”. The session was designed to support line managers to understand what their role is in managing and responding to requests for reasonable workplace adjustments, to provide the legal context and to share examples, in addition to busting some myths!

In the latter half of the year, our Health & Wellbeing team produced and promoted a video featuring a colleague and their line manager who share their experiences of accessing support via the government funded **Access to Work** scheme. This has enabled the colleague to overcome barriers, reach their full potential and have a meaningful career. The video resource will feature in a Manager’s Update session in the New Year; it has also been included within the Health and Wellbeing module of the Core People Management Skills development programme.

In response to requests from colleagues, we also shared details of a **webinar on the topic of Access to Work**, facilitated by the Department of Work and Pensions detailing; what Access to Work is, what support it can provide to customers and the eligibility criteria. The session also covered the Access to Work application process, how to report changes of circumstance and disputing an award decision. Within the session there were case studies of how Access to Work can support people to enable them to remain in or move closer to work.

RESPONDING TO HEALTH AND WELLBEING BEING NEEDS OF MINORITY GROUPS

We know that each and every one of our colleagues has their own unique, and diverse, wellbeing needs, so providing a wellbeing offer which is inclusive and aims to address health inequalities is important to us. Our Health and Wellbeing action plan outlines our five key commitments which are:

1. Ensure that our workforce, and future workforce, perceives us as an employer who takes positive action on health and wellbeing.
2. Reduce the incidence of colleagues experiencing musculoskeletal (MSK) injuries as a result of work and provide proactive support for colleagues experiencing MSK conditions
3. Develop a culture which reduces stigma around mental health, promotes resilience and provides a comprehensive model of support
4. Provide a work environment which encourages rest and hydration and enables colleagues to access healthy, nutritional choices
5. Protect our colleagues and patients from 'flu and COVID-19 viruses by ensuring optimum uptake of vaccinations.

Each year we conduct an annual health needs assessment (Health & Wellbeing Survey), the results of which are subsequently used to create a 12-month campaign calendar which also incorporates a range of national and local health promotion campaigns that are closely aligned to the five key commitments detailed above. This past year we have focused on:

- Workplace adjustments,
- Mental Health,
- Caring responsibilities and
- Colleague wellbeing

Within Lancashire there is a significantly higher rate of mortality due to cardiovascular disease, and the prevalence of hypertension in Lancashire is in the second highest quintile in England, so we engaged with FCMS (originally Fylde Coast Medical Services, a locally commissioned Social Enterprise health and wellbeing services provider) to deliver on-site **over 40s** NHS Health Checks, providing a vital opportunity for early detection and intervention to conditions such as cardiovascular disease and hypertension. Multiple dates were offered, all appointment slots were fully booked, and we experienced very low did not attend (DNA) rates which reflects the value placed on these health checks by colleagues.

Active promotion of positive **mental health and wellbeing** is essential for creating an inclusive culture and environment, the in-house colleague Psychological Wellbeing Service offers a broad range of support, available to all colleagues. Clinicians are skilled in offering support relating to all types of individual difficulties, including many circumstances where difficulties are linked to protected characteristics, providing a safe and confidential space for conversations that otherwise may not take place. Without this support mental health difficulties could worsen. The service is in the final stages of developing new individual and team stress risk assessments, both of which include a focus on belonging. The team undertake continuous professional development activities which enhance their awareness and understanding of challenges and barriers faced by colleagues who belong to protected characteristic groups; in November Lancashire Mind delivered a session for the team, based around on the barriers to accessing mental health support for ethnic minority community groups.

Throughout the process of **managing organisational change and employee relations cases**, there is a clear focus on mental wellbeing and support across a very broad range of personal issues, this is in line with the Just Culture triage process. Through taking a person-centred approach to

understanding and responding to individual needs, we ensure that colleagues are offered, or signposted to, appropriate sources of support. The Leadership & OD Team have developed a series of practical resources (available on the Intranet) to help support managers and teams who are undergoing significant organisational change.

A **Rapid Access Policy** has been developed and launched, providing a route for colleagues who are facing particularly long waits for appointments or treatment to gain Occupational Health (OH) support, who can then make a written request to explore whether appointments can be expedited. In some circumstances this support can lead to a reduction in wait times and ultimately enables quicker access to treatment and recovery.

As already noted, we have **developed People and Performance Conversation templates** to enable the recording of Supporting Disability & Long-Term Conditions Agreements and Carer Passports – this will enable improved analysis of uptake and quality.

We have continued our outreach activity to develop and **strengthen links with community partner organisations**, offers of support have been identified and promoted including grant funding from Preston City Council to implement a walk leader programme; promotion of the Preston Resident Card providing a 20% discount at local leisure centres; promotion of the WorkWell support service for individuals who have health condition and are either off work or struggling to stay in work (through the programme they are assigned a work coach and co-develop a bespoke personal support plan). We have continued regular attendance at Preston Wellfest meetings and have contributed to planning and organising collaborative local events.

OUR FUTURE COLLEAGUE FOCUS

- Ensure representational attendance at the “Your Voice” events; bands, professional groups, divisions, protected characteristic groups etc. through evaluating attendance data and targeting specific areas/groups.
- Explore adopting a Diversity & Inclusion champion role across the organisation to help with engagement and involvement, cascade and escalation of information etc.
- Continue to respond to the feedback from line managers to understand what development opportunities i.e. Managers Update sessions would help to address any learning needs or knowledge/understanding gaps.

OUR FUTURE PATIENT & COMMUNITY FOCUS

- Strengthen Community Forums - build on the success of existing forums by creating new groups and partnerships to ensure diverse voices shape service design.
- Enhance Accessibility & Inclusivity - further environmental improvements and reasonable adjustments across wards and outpatient areas, informed by patient feedback.
- Expand the Patient story Library - continue to grow the intranet-based patient story hub, making real-life experiences accessible to all staff for learning and service improvement.

PRINCIPLE 4 - BEING REPRESENTATIVE OF OUR COMMUNITY

This principle focuses inward and sets out our ambitions to increasing the diversity of our workforce so it is proportionally representative of our communities. Within the EDI Strategy we have set out

ambitious goals which includes increasing the representation of colleagues with protected characteristics, publicly demonstrating our support to recruiting individuals with protected characteristics or who are from more disadvantaged backgrounds or from deprived areas through to supporting colleagues with protected characteristics to reach their full potential and climb the career ladder should they wish.

FOR COLLEAGUES

PROPORTIONAL REPRESENTATION

The demographic of our workforce will have changed over the last twelve months as services have been transferred to One LSC. Looking at the data below, which has been taken from the 2021 Census and compared against our workforce demographic, we remain broadly representational of the communities we serve, with greater diversity across a number of areas than is seen in the South Ribble and Chorley areas aside from Disability, where our data shows lower representation.

	Greater Preston	South Ribble	Chorley	Lancs Teaching
Ethnicity	72.6% White 20.2% Asian/ Asian British 2.4% Black/ Black British 2.9% Mixed/ Multiple Ethnic Grps	95.4% White 2.1% Asian/ Asian British 0.5% Black/ Black British 1.8% Mixed/ Multiple Ethnic Grps	95.6% White 1.9% Asian/ Asian British 0.6% Black/ Black British 1.5% Mixed/ Multiple Ethnic Grps	68.6% White 23.1% Asian/ Asian British 4% Black/ Black British 1.6% Mixed/ Multiple Ethnic Grps
Largest age group	23 year olds	56 year olds	50 year olds	30-39 year olds
Religion	47.6% Christian 26.3% No religion 16.1% Muslim 3% Hindu 0.7% Sikh 0.4% Other	61.8% Christian 30.8% No religion 0.9% Muslim 0.7% Hindu 0.3% Other	61.5% Christian 30.9% No religion 1.4% Muslim 0.3% Hindu 0.5% Other	52.8% Christian 11.8% No religion 9.7% Muslim 4.5% Hindu 0.4% Sikh 5.9% Other
Disability	9.1% Disabled	7.2% Disabled	7.7% Disabled	6.7% Disabled
Sexuality	88.5% Heterosexual 1.6% Gay/Lesbian 1.8% Bisexual	92.1% Heterosexual 1.3% Gay/Lesbian 1.0% Bisexual	91.7% Heterosexual 1.3% Gay/Lesbian 1.0% Bisexual	83.6% Heterosexual 1.5% Gay/Lesbian 1.3% Bisexual

Community Demographic Data from Health Improvement Plan/Census 2021

In 2025 the Head of Recruitment and the Head of Diversity & OD undertook a review of the recruitment process from start to end to identify areas of potential bias and to identify and embed actions which could mitigate against bias throughout the process. The review has completed. As part of this review, recruitment for senior/very senior posts was brought in-house and it was agreed that representatives from the Ethnicity forum would be involved in any senior level recruitment processes. This work will be further enhanced with the learning module in respect of bias which is currently under development.

FURTHER INCREASING REPRESENTATION OF COLLEAGUES WITH PROTECTED CHARACTERISTICS

In May of this year, a meeting was held with the Allied Health Professions (AHP) Workforce Programme Lead for Lancashire & South Cumbria Integrated Care Board and the Trust's Associate Director of AHPs to explore the integration of EDI principles within AHP workforce initiatives. Various initiatives discussed to enhance diversity and inclusion - such as workforce data analysis, recruitment and retention strategies, and student supply programs with universities highlighting the importance of understanding diversity and representation in these areas to improve the overall future AHP workforce.

Through the series of annual reports we produce as part of our NHS Contract, we understand our current position with regards to representation for a number of protected characteristics, specifically:

- We have seen **consistent increases in the percentage of colleagues recorded a disability or long-term condition across our workforce over the past 5 years**, with 7.2% of our non-clinical workforce and 5.9% of our clinical workforce currently identifying as having a disability or long-term condition. In spite of this we know we still have a significant disparity between the number of colleagues who have shared their disability on our Employee Staff Record system i.e., as at 31 March 25, 587 colleagues recorded they had a disability or long-term condition yet we understand from our National Staff Survey data that 1145 colleagues who completed the staff survey recorded they had a disability or long term condition. Given the proportion of people who take part in the survey is typically 40-50% of total workforce, we could be looking at many more than this in reality across our organisation.

	% colleagues recording a long-term condition or disability	
Year	**non-clinical**	**clinical**
2025	7.2%	5.9%
2024	6.1%	5.8%
2023	4.7%	4.8%
2022	4.7%	4.0%
2021	4.2%	3.7%

  It has been positive to note a stronger representation in non-clinical colleagues identifying as having a long-term condition or disability at bands 3, 4, 5, 8a, 8b, 8c and VSM. For the majority of bands, we have seen an increase in the percentage of colleagues. For clinical roles, there has been an increase in the representation of colleagues with a disability/LTC in bands 2, 3, 4, 6, 7, and band 8a compared to the previous year.

- Through the annual Workforce Race Equality Standard report we found in the last 12 months that across a number of the agenda for change bands for clinical and non-clinical colleagues we have seen **an increase in the representation of ethnic minority colleagues within our workforce**, quite a significant increase of clinical colleagues from 27.3% in 2024 to 32.6% in 2025.

	% ethnic minority colleagues	
Year	**non-clinical**	**clinical**
2025	19.4%	32.6%
2024	18.9%	27.3%
2023	17.8%	29.5%
2022	16.3%	25.1%
2021	15.7%	20.9%

- The greatest representation of ethnic minority colleagues in non-clinical roles are in bands 3 and below (below band 1 tend to be apprentices). Across all bands with the exception of bands 1, 2 and M&D Consultant, ethnic minority colleagues are underrepresented when compared against the Trust wide ethnic minority workforce.

- From a clinical workforce perspective, the highest percentage representation of ethnic minority colleagues can be found in band 5 roles (49%), this could in part be due to the level of international recruitment which has taken place in the last few of years. With the exception of band 2 and band 5 clinical roles, again ethnic minority colleagues are underrepresented in all other bands when compared against the Trust wider ethnic minority workforce with the greatest gaps at band 8b and above.

- The **largest proportion of our workforce remains aged between 30-39** (27.6%). Over 50% of our workforce are aged between 30 and 49 with most groups making up at least 10% of the workforce. The groups that are lower in representation are the under 20s and over 70s meaning those colleagues are in the minority groups.

- The **predominant gender is female** at 76% (very similar to last year at 75.9%), which is typical for NHS organisations.

A “You Said, We Did” style presentation was delivered to the staff inclusion forums; specifically focusing on EDI related staff survey data, actions and linking to the need to hear from a greater number of colleagues across our inclusion forums to ensure representative feedback around their experience(s).

STRENGTHENING OUR SENSE OF ‘BELONGING’ FOR COLLEAGUES

Throughout the year there have been various **‘themed’ menus in Charters Restaurant;** colleagues, patients and their relatives have been able to sample delights from cuisines all over the world ranging from the rich flavours of India with a tantalising Chicken Biryani and Raita alongside Vegetable Korma and Jeera rice to flavoursome Jerk Chicken as part of our Black History Month celebrations.

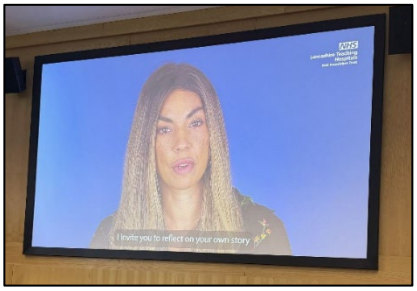
Black History Month – in October the Trust held a special event, celebrating Black excellence and learning through storytelling and discussion.

The event showcased colleagues reflecting on Black heritage, including Michael Flome and Akinkunmi Omotoso from Core Therapies, Wilhelmina Short, Emergency Department Staff Nurse, while Deputy Mayor Councillor Nweeda Khan and local chef Ibby from Uncleibby's Kitchen were guests.

Chief Executive Silas Nicholls welcomed everyone to the event: *"We have about 80 different nationalities working in our hospital today, and that's really representative of the NHS. One of the fantastic things about this international organisation is that colleagues from across the world are part of it, providing care, leading innovation, and shaping our culture in a positive way."*

"We're living in increasingly divisive times, and now more than ever, it's important that we stand shoulder to shoulder, united in the strength of our shared values and common purpose.

" I also think at times there's almost a feeling that if you come from an ethnic background, the emphasis is on you to call out racism or issues around diversity and inclusion. I think that's completely wrong. All of us, especially white people in positions of influence and authority, have great responsibility, not just because of what we do, but also because you can't ignore the historical background, the legacy of empire and colonialism. We can't change the history of our country, but we can make the future a lot better."



Sarah Jules, Head of Operational Performance, recorded a video for BHM, saying *"As a mixed heritage woman from both English and Dominican descend, my identity is woven from two cultures and two histories. It gives me a deep sense of belonging to both. I carry the strength of my ancestors and the pride of my heritage.*

"Stand firm in power and pride means embracing all parts of who I am. It means challenging assumptions and leading with authenticity. In the NHS, our strength supplies in serving communities as diverse as our workforce. When we bring our whole selves to work, our stories, our perspectives, our life experiences, we create a richer and more compassionate health system for all. In these turbulent times, celebrating diversity is not just important, it is essential. It strengthens our resilience, and it helps build a culture where everyone feels seen, valued, and empowered."

The Diversity & Inclusion team have created a number of **Inclusion Marketplace** events, intended to help colleagues celebrate, connect and collaborate. The pop-up events take place in Charters or the Education Centres, and departments across the Trust come together to demonstrate and showcase how we are delivering on conscious inclusion. Colleagues are invited to explore what's happening across the organisation, discover new ideas, and spark meaningful conversations. There are representatives from various teams such as Freedom to Speak Up, Macmillan Cancer Support Team, Staff Inclusion forum chairs, Leadership team and the Staff Survey/Engagement team.

November saw the arrival of **Disability History Month** and a commitment to "Rewrite the Narrative" which was intended to celebrate the incredible journeys of our neurodiverse and disabled colleagues — their resilience, achievements, and the powerful ways they continue to challenge and change misconceptions. More than that, it was an opportunity to reflect, reframe, and recognise the

strength in diversity. Information in respect of Disability History Month was shared across Trust communication channels such as HeaLTH Matters, Exec VLOG, All Colleague briefing and Leaders forums however attendance at the actual Rewrite the Narrative event was very disappointing.

DEMONSTRATING OUR COMMITMENT TO EQUITABLE RECRUITMENT, DEVELOPMENT AND CAREER OPPORTUNITIES IN THE WORKPLACE

Within both WRES and WDES reports we measure the **likelihood of both ethnic minority candidates and disabled candidates being appointed from shortlisting**. There has been an improvement over the last 12 months in relation to the likelihood of **disabled candidates** being appointed from shortlisting (moving from 1.19 to 1.06), this figure remains firmly within the disparity ratio of 0.8 – 1.25 indicating there is currently no potential adverse effect on disabled candidates.

For **ethnic minority candidates** the disparity ratio for this indicator has deteriorated once again moving to 1.50 in 2025 (from 1.40 in 2024, 1.34 in 2023 and 1.28 in 2022). This means that white candidates are 1.50 times more likely to be appointed from shortlisting than candidates from an ethnic minority background. The disparity ratio is above the range of 0.8 – 1.25, which means there is likely to be an adverse impact experienced by ethnic minority candidates, action has already been taken over the past twelve months with the Head of Recruitment and the Head of Diversity reviewing every stage of the recruitment process step by step to identify potential for bias and then to implement mitigation. Further action needs to be taken with the development and implementation of Equality Representatives training for all Recruiting Managers which will also be built into our Core People Management Skills programme.

In addition to promoting **Continuous Professional Development (CPD) funding** opportunities across the Trust to all colleagues, targeted communications were directed to our international nursing colleagues to highlight opportunities specifically designed to support their development and progression i.e. 100 places on the Florence Nightingale leadership course. The CPD summary report which is presented at Education, Finance & Performance Committee includes a breakdown of colleague ethnicity groups as well as by division and course themes so spending can be reviewed to ensure it has been equitably allocated. Funding for year 2024/25 shows 37.81% (459) ethnic minority colleagues have accessed funding. This is a significant increase from 2023/24's figure of 18.57% (99 staff), this increase is largely due to the targeted communications noted above.

For Nursing and Midwifery Staff:-

Ethnicity	Count	%
BME	434	41.14%
Not Stated	2	0.19%
White	619	58.67%
Grand Total	**1055**	**100.00%**

For Allied Health Professional Staff:-

Ethnicity	Count	%
BME	25	15.72%
Not Stated	4	2.52%
White	130	81.76%
Grand Total	**159**	**100.00%**

We've made sure all our **leadership and management development programmes** link back to the NHS People Promise and our EDI strategy goals, so inclusion isn't an add-on – it's built in from the start. We've kept spaces open for colleagues from under-represented groups and have worked with the ethnicity staff inclusion forum to make sure people know the leadership development opportunities available for them. Our leadership development interventions now include practical ways to lead inclusively, from accredited programmes to masterclasses on aspects such as civility and zero-

tolerance. Our future focus is to create talent pathways which include coaching support to help colleagues from under-represented groups progress their careers successfully.

CELEBRATING OUR PEOPLE AND THEIR COMMITMENT TO FOSTERING AN INCLUSIVE WORKPLACE

The **'Our People Awards'** is our annual recognition programme and a chance for us to showcase the hard work, dedication and achievement of our colleagues and teams across our organisation. There is a category dedicated to wellbeing and inclusion which recognises individuals or teams who have demonstrated exceptional commitment to promoting equality, diversity and inclusion as well as colleague health and wellbeing across the Trust. Shortlisted candidates/teams needed to demonstrate they've taken tangible actions which have led to significant improvements in patient and colleague experience, fostering an environment where everyone feels supported.

This year there were 17 nominations across the category and the judges chose the Pharmacy Cultural Health and Wellbeing Ambassador Group as the winners reflecting *"This group reshaped departmental culture by promoting inclusion, wellbeing and kindness. Since 2021 they've launched initiatives like ED&I ambassadors, tailored support and also recognition schemes, boosting colleague experience and cohesion. Their sustainable, values-led approach has made Pharmacy a model of inclusive, empowering workplace practice".*

Judging panels are made aware of the impact of cognitive bias during the process and signposted to online training available to support a fair and inclusive process. We measure how representative our applications and shortlisting are in comparison to the wider Trust demographic.

Oluchi Okoroafor, who is a Senior Healthcare Assistant here at the Trust (and a postgraduate student at the University of Salford) was shortlisted for two categories in the **2025 Student Nursing Times Awards** in June this year. Oluchi was shortlisted in the Student Nurse of the Year: Adult category and Mary Seacole Award for Outstanding Contributions to Diversity and Inclusion. Oluchi played a key role in organising the Netherlands Nursing Students Week, fostering cross-cultural exchange and delivering lectures on UK nursing practices. Oluchi also co-founded the Student Wellbeing and Academic Buddy System (SWAB) to support fellow nursing students. She was commended for her leadership, teamwork, and teaching skills. The judges said "*Passionate about cultural competency and compassionate care, Oluchi continues to inspire those around her through her dedication to nursing education and practice*."

Occupational Therapist, Rachel Diss was nominated for this year's **'**Soldiering on Awards', which are part of the coveted **Armed Forces Community Awards** run in partnership with Barclays Bank. Rachel was a finalist in the 'Defence Inclusivity' award category for the amazing work that she does on a voluntary basis at a national level to support young people within the Army Cadet Force (ACF). She has played a vital role over the past 15 years transforming policies, practices and culture to bring about meaningful change that reflects the diverse communities that the ACF serves. From launching inclusive strategies and regional forums, to delivering training and developing accessible resources, Rachel's work has led to a marked rise in engagement from underrepresented groups, empowering both cadets and volunteers to lead with confidence and pride.

BENCHMARKING EXTERNALLY, DEMONSTRATING COMMITMENT

To lay down the right foundations we have committed to several pledges, charters and covenants. The purpose of these is to assess our own position against the standards set by external bodies, to reflect on what more we should be doing, to show our commitment to our current workforce and externally to our future workforce alongside patients and the communities we serve.

We have maintained **Disability Confident Employer at Level 2** which signals that we think differently about employing disabled people in our organisation; we recognise that disabled individuals are a hugely diverse group of people with amazing skills and experience, in addition to qualities our organisation needs.

We continue to believe in the five steps set out in the **Dying to Work Charter**, which was led by our Staff Side colleagues.

We participate in the **Care Leavers Covenant**; a national inclusion programme supporting care leavers aged 16-25 to live independently. The Covenant is a promise made by our organisation that we will support Care Leavers through providing opportunities to enter the world of work, through offering access to our Pre-Employment Programme and our Reboot programme. The goals of the Covenant are to better prepare Care Leavers to live independently; to improve access to Employment, Education and Training; to support care leavers to experience stability in their lives and feel safe and secure; give improved access to health and emotional support and help them to achieve financial stability.

The idea behind the Working Smarter pledge is to reaffirm the importance of **encouraging and supporting agile and flexible working**, which can positively support elements such as colleague wellbeing and compassion towards others. It's a marked shift in focus from "presenteeism" and can act as a supportive mechanism for colleagues with a disability or long-term condition if their role enables them to work productively from home, as well as for other colleagues who need greater flexibility due to demands in their home life such as caring responsibilities. Our Managers Update session in October majored on Flexible Working, clarifying what the term meant, why it was important for us as an employer, the process, examples, an exploration of potential or perceived barriers and much, much more.

This year our Communications Team have pledged their support by signing up to the **Diversity Charter**, championing more inclusive communications across health and care. The charter contains achievable and measurable actions that can support the aim of developing a diverse communications and engagement profession for the NHS, supported by strong allyship and advocacy including commitments such as;

- I will take personal responsibility to challenge racism and champion diversity, and
- I will build and develop my professional networks of people who don't look like me. I will share my knowledge and insights about my own experience and will advocate for others.

DEVELOPING A DIVERSE TALENT POOL AND SUPPORTING CAREER PROGRESSION

Our WRES and WDES metrics/data (taken from staff survey results for 2024) tells us that:

- **53.8% of colleagues with a disability and 58.8% of colleagues without a disability believe our organisation provides equal opportunity for career progression or promotion**. The disparity ratio falls between 0.8 – 1.25 indicating for this metric there is no adverse impact for colleagues with a disability or long-term condition/illness.
- **50.8% of ethnic minority colleagues and 59.5% of white colleagues believe our organisation provides equal opportunities for career progression and promotion**. This demonstrates a steady improvement on results over the previous 4 years and keeps the disparity ratio inside the 0.8-1.25 guidelines, indicating there is currently no adverse impact for ethnic minority colleagues.
- Colleagues from ethnic minority groups are **just as likely (1.09 disparity ratio) to be able to access non mandatory and continuous professional development** than their white counterparts. This is a significant improvement from 2022, and we need to ensure this parity is maintained as far as is possible.
- **7.69% of our Board's voting membership has an ethnic minority background, compared with an overall workforce of 29.4%**. This shows our Board is not proportionately representative of our workforce.
- **With 15.4% of the Board's voting membership identifying as having a long-term condition or disability, this is almost three times greater than the 5.7% of our workforce who have recorded they have a long-term condition or disability**. Our workforce declaration rate is

greater than the NHS average of 5.7% and also shows a sustained increase over the last 3 years, from 11.1% in 2024, 10.5% in 2023 and 7.14% in 2022.

As already indicated, in 2026 our Leadership team will be developing career and talent pathways including coaching support, to help colleagues from under-represented groups progress their careers.

ENCOURAGING SOCIAL MOBILITY AND WIDENING ACCESS

The Widening participation team continues to provide career inspiration and opportunities for employment to our local community, through provision of programmes and events designed to support those who are at a disadvantage and aspire to a career in the NHS. We have designed a series of programmes which support this work;

The **Pre-Employment Programme** is an 8-week programme which supports long-term unemployed people to return to work, providing them with the necessary skills and resources to secure employment. Over the years, this programme has successfully supported individuals into healthcare and administrative roles across the organisation. Our 2024/25 outcomes are - 20 participants, 16 completed, 15 employed within the Trust.

A two-week **Reboot Programme**, an opportunity for potential employees to sharpen their skills and improve their chances of landing their dream job with us. This is a hybrid programme, for those who are more 'job ready' than those enrolled onto the Pre-Employment programme, that combines face-to-face classroom learning with experience working in departments here at the Trust - the programme is designed to provide an insight into career pathways and equip attendees with the necessary knowledge, skills, behaviour and understanding of what it's like to work in a hospital setting. Many participants have gone on to secure interviews and employment within the Trust. Over the last year this programme has supported 22 participants, 16 of whom completed, 8 successfully gaining employment within the Trust.

We also offer a 3 day **Ready, Steady, Apply** course which is designed to support candidates who are employment ready but who struggle with the application process, The programme offers guidance and interview tips, guaranteeing candidates an interview upon successful completion. Four people have been supported via this programme in the last 12 months, with one gaining employment in the Trust as a result, a second has secured employment in the voluntary sector.

The **Preston Widening Access Programme** has been delivered annually since 2014, providing disadvantaged students in our local area with the knowledge and experience necessary to pursue medicine at the University of Manchester. This year, we welcomed 26 students, of which 20 successfully completed the programme and will receive guaranteed interviews for a place on the MBCHB Medicine at Manchester university, subject to UKCAT requirements.

Finally, the **Work Familiarisation Programme** is designed to provide young students with learning difficulties and disabilities an insight into the world of work. Following completion of the programme, students can participate in work experience for two hours a week over six weeks in an area they found interesting. In 2025, 24 students completed this programme.

Other activity which has taken place to inspire young people and adults to consider career choices within the NHS include;

- An NHS Careers event at RPH, featuring 21 departments and attracting approximately 320 school/college students from across the Northwest particularly within our local footprint.
- Introduction of a new System-wide programme, Application and Interview support. this programme is designed to support anyone within Lancashire & South Cumbria who feel they need some guidance on competing a competitive application and tips on how to be successful at interview. This programme was piloted in March 2025, and we have successfully offered two of these programmes during the year, totalling 24 candidates successfully complete.
- Participation in the SHOUT Apprenticeships & Careers Expo, held twice annually, engaging over 1,000 candidates.
- Attendance at more than 30 school and college events, including speed networking, mock interviews, careers fairs, assemblies, and GCSE options support—reaching approximately 4,500 students.

Tailored activities were also delivered for diverse community groups, including ongoing support for Muslim schools and students in achieving their career aspirations. **293 work experience placements** were facilitated within the Trust this year, helping students gain valuable insight and inspiring future careers in healthcare.

ENSURING OUR COLLEAGUES AND COMMUNITY MEMBERS SEE THEMSELVES REFLECTED IN THE CONTENT WE PROMOTE

We continue to ensure that all images, videos, leaflets, training resources, written publications and animations use images which reflect the full diversity of the communities we serve and the colleagues we employ. We consciously ensure images reflect our diversity across protected characteristic groups, professions and areas of the organisation.

FOR PATIENTS AND OUR COMMUNITIES

The introduction of the Patient Safety Partner (PSP) role within the Trust has strengthened our commitment to embedding patient voices in safety and quality processes. PSPs act as advocates and critical friends, offering fresh perspectives and supportive challenge to promote patient safety. Feedback gathered through anonymised electronic forms highlights the positive impact of PSPs in areas such as participation in PSIRF meetings, improvement groups on falls and deconditioning, recruitment processes, STAR accreditation visits, and guiding patient partnership initiatives. They have also contributed to investigations and the development of patient-focused safety information. While the role is still evolving, challenges include limited IT support, low awareness among staff, and restricted involvement in final decision-making. Suggested improvements include increasing PSP engagement in incident investigations, enhancing job plans, promoting the role more widely, and ensuring regular updates on workstreams to strengthen collaboration and visibility. The Trust has successfully re-recruited Patient Safety Partners (PSPs), expanding the programme to include a more diverse group of individuals who bring a wide range of perspectives and lived experiences. This diversity strengthens the role's impact by ensuring that patient voices are represented more inclusively in safety and quality discussions. PSPs continue to act as advocates and critical friends,

contributing to investigations, improvement groups, and strategic meetings, while promoting patient-centred approaches across the organisation.

The Volunteer Service

This year has seen significant progress within the volunteer services, marked by a comprehensive revamp of recruitment practices, the introduction of new mandatory training modules, the establishment of additional volunteer roles across hospital wards and departments, and the review and update of key processes, procedures, and the volunteer policy. Recruitment is now conducted at set intervals throughout the year, supplemented by staff-initiated requests, and features information sessions and group interviews to create a more personal and engaging experience for candidates.

Graham Liver from BBC Radio Lancashire, reporting live from Preston Hospital on NHS winter pressures with volunteer Peter Becconsall explaining how the volunteer role supports staff and patients.

The new training modules, developed by NHS England and partner organisations, are tailored specifically for volunteers and designed to be more efficient than previous versions, ensuring compliance while reducing time commitments. Volunteer deployment has expanded across the Trust, with notable increases in areas such as the emergency department, ward areas across both sites, the renal unit, endoscopy, the business centre (supporting DNA reduction), the gynaecology ward, baby beat, the Rosemere coffee shop, and the meet and greet role in Rosemere radiotherapy. In total, 80 new volunteers have joined this year, the majority of whom remain active.

The *Baby Cuddler* role was introduced in 2024 to provide additional support within the Neonatal Intensive Care Unit (NICU). Volunteers offer comfort and interaction to infants, ensuring they continue to receive nurturing attention when parents need time away, for example, to rest, eat, or attend to other family responsibilities. The initiative was developed following extensive research and consultation with Alder Hey Children's Hospital, which has successfully operated a similar programme for several years. All volunteers undergo enhanced DBS checks and complete additional training modules to ensure the highest standards of safety and care.

Operational improvements have also been implemented to strengthen data recording, streamline processes, and enhance volunteer support. The updated volunteer policy reflects these changes and provides a clearer framework for ongoing development. Importantly, the recording of volunteer hours for NHS England has enabled greater visibility of the impact of volunteering across the Trust. While not all volunteers are currently submitting timesheets, nearly 8,000 hours have been logged this year, underscoring the significant contribution volunteers make to patient care and service delivery.

Increasing participation in Research

Our Centre for Health Research and Innovation hosted a visit from the Windrush CEO and founder, Adrian Murrell, around their “Race to Health” project. One of the centre's goals is to develop an approach that encourages everyone in our community to participate in our research in a way that is inclusive and welcoming, and in late 2024, we visited the local Windrush Initiatives Team in Preston, a well-established organisation which supports Black and Mixed-Race people in Preston and nearby areas.

Our Research and Innovation Department have highlighted that ethnic minority groups are underrepresented in the participants we recruit to research studies. Since then, there have been productive conversations which have flagged a number of key points, with work ongoing to address these issues:

- There are concerns and barriers that might stop people from participating in research, such as lack of awareness, mistrust, and a history of negative experiences with medicine in general and medical research involving Black participants.
- There is confusion around what research involves. Not all research is medical or clinical; some studies are focused on collecting data and listening to experiences.
- We need to help people understand the personal benefits they could gain from being involved in research.

Adrian said: *“The work with Black and mixed-race communities is essential for addressing gaps in health care. Understanding the barriers these communities face and creating inclusive solutions that facilitate their involvement is important”*

OUR FUTURE COLLEAGUE FOCUS

- Creating talent pathways for underrepresented groups including ‘Rising Stars’ and ‘Future Stars’ programmes plus a structured pathway for Consultant colleagues
- Ensuring colleagues from minority groups have adequate/specialised coaching support to support their career progression
- Develop and implement Equality Representatives training for Recruiting Managers with a plan to then build into Core People Management Skills.
- Continue to support ‘representation’ at Board level with training and development, use of Staff Stories illustrating different experiences and journeys and through sponsorship of staff Inclusion forums.

OUR FUTURE PATIENT & COMMUNITY FOCUS

- Expand PSP involvement in patient safety incident investigations and improvement workstreams.
- Increase volunteer deployment in high-impact areas such as emergency departments and wards.
- Strengthen partnerships with community organisations to address barriers to research participation.

PRINCIPLE 5 – BRINGING ABOUT CHANGE THROUGH EDUCATION AND DEVELOPMENT

Education and raising awareness are an essential part of the strategy, as it helps to inform, change mindsets and create a force for change. This section details how we are using training, education and development to support colleagues with protected characteristics, through to detailing how we are using education and awareness to raise the wider workforce understanding of their role in supporting us to deliver the aims of this strategy.

FOR COLLEAGUES

Some of the progress under this aim has already been reported under other aims including: launch of the Equality Impact Assessment toolkit for colleagues and teams who draft policies/guidelines and who scope service redesign or cost improvement programmes, our utilisation of Schwartz Rounds to focus on inclusion related topics, the ongoing work which includes Civility with a strong and consistent focus on the impact of diversity and the Living Collection.

In addition to this a range of bespoke sessions have been delivered to Pharmacy, Oncology, the SHAAPs programme, Enhance Doctors, Trust Management Board, Governors, Pathology, Health Academy team to name a few.

GENERAL EDUCATION IN RESPECT OF DIVERSITY & INCLUSION

From September, the **Oliver McGowan Code of Practice** came into effect which means it is now a legal requirement for all CQC-registered service providers to ensure their staff receive mandatory training on learning disability and autism, appropriate to their role and level of responsibility. The training is essential to improving the quality of care and reducing health inequalities experienced by autistic people and those with a learning disability. It is delivered in two tiers; the first being a mandated e-learning module and the second element an online facilitated session.

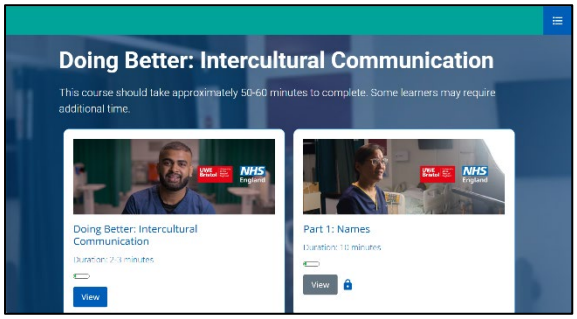
The online training is delivered by people with lived experience; in each session there is a facilitator, a person with a learning disability and a person with autism. The first phase of the rollout has been targeted to support high risk areas and wards where there are incidents are known to have happened.

As already mentioned earlier in this report we have established a training programme in respect of **Health Literacy Awareness**, the intended outcomes for participants are to;

- Understand what health literacy is
- Explore why it is important for people, ***and equally***, why it is important for health, care and community organisations
- Appreciate what it might feel like to have lower levels of health literacy
- Learn about key health literacy tools, such as “Teachback” and writing for understanding
- Know what other organisations have achieved and begin to think about how to apply it at our organisation
- Know where to go for further information

We have made **two new e-learning modules available** on our Trust e-learning & Development site. These modules have been developed by eLearning for Health and are in respect of **Implicit Bias and Intercultural Communications**.

The Implicit Bias content supports participants to identify their own implicit biases and explore practical strategies to mitigate the impact of unconscious bias in both personal and professional settings, leading to more conscious and equitable decision-making processes.



The Intercultural Communications content supports colleagues who are working alongside internationally educated colleagues to; enhance understanding of the complexity surrounding intercultural communication, improve the ability of colleagues to communicate effectively with international colleagues and learners and to increase understanding of how intercultural communication (both good and bad) can impact on experience and outcomes.

In April, our Head of Diversity & Inclusion joined Naomi Duggan for a **Leaders at LTH VLOG** to talk about various topics which might have been adversely impacting colleagues across the organisation such as how divided society seemed to be becoming over various topics, the ongoing conflicts, the Supreme Court judgment about the definition of 'woman', Sexual Safety etc., and what support is available for colleagues, encouraging colleagues to speak up if there are issues, and how to have respectful, considerate and curious conversations to learn more about community groups colleagues don't belong to or aren't familiar with.

We utilise opportunities afforded through our m**onthly All Colleague and Leader briefing sessions** to raise awareness of topics related to diversity and inclusion; to share how we support colleagues across our organisation, to be transparent around how we are performing as an organisation in respect of diversity and inclusion metrics, to showcase colleague stories about their lived experience(s) and to raise awareness or increase knowledge. Throughout 2025 we have used these sessions to;

- Highlight the Inclusion calendar/events for the year ahead i.e. Lent
- Spotlight Endometriosis and Adenomyosis, raise awareness of the conditions and their debilitating impacts and to share resources to support colleagues with the condition as well as line managers who are supporting colleagues with the condition
- Share our WRES and WDES results with areas for celebration and focus
- Promote the Sunflower (Hidden Disability) badge scheme and our Supporting Disability and Long-Term conditions agreements as part of a staff story sharing lived experience
- Encourage under-represented group participation in surveys such as the Health & Wellbeing survey and the national Staff Survey

GROWING INCLUSIVE TEAMS

Over the past year, our **Team Engagement & Development tool** (TED) has created a wide range of practical learning opportunities that build inclusive leadership capability across the organisation. Alongside developing toolkits on compassionate conversations, zero tolerance, sexual safety and inclusive engagement, the OD Projects team delivered monthly development sessions for Team Leaders and hosted a dedicated YouTube channel focused on real issues NHS teams face. Sessions on topics such as building team accountability and navigating difficult conversations have helped leaders adopt more inclusive, collaborative approaches to teamworking. By combining accessible resources with regular, interactive learning, TED has raised awareness, challenged mindsets and strengthened colleagues' understanding of their role in creating an equitable and supportive culture, particularly for those with protected characteristics.

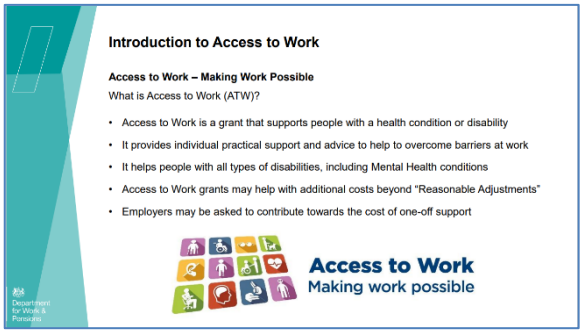
TED©
TEAM ENGAGEMENT & DEVELOPMENT

We are continuing to **consciously building inclusion into new learning and development sessions** we create, thinking about the topic areas through the lens of inclusion; factoring in what we know about the experiences of our colleagues from different protected characteristic groups and considering how the content impacts colleagues from different groups too, an example being the new Civility session we are currently piloting with a number of teams across the organisation where we incorporate discussions about microaggressions and consider the cultural barriers to speaking out.

IMPROVED EXPERIENCE FOR COLLEAGUES WITH PROTECTED CHARACTERISTICS

A range of interventions have been scheduled across the year which specifically support colleagues from under-represented groups in the workplace, or which support the leaders and managers of colleagues from under-represented groups, to lead and manage team colleagues in an inclusive, compassionate and supportive way. These include;

Access to Work webinar session arranged, delivered by the Department of Work and Pensions, covering reasonable workplace adjustments, what Access to Work is, who can get help and how they can apply for support.



Wellbeing conversations training has been delivered on an ongoing basis, including content to raise awareness relating to cultural factors that could affect wellbeing at work; developing the skills amongst line managers in being able to hold culturally sensitive and inclusive discussions to identify the support colleagues need.

Menopause training has also been delivered consistently across the year. The Menopause Support Network has seen positive growth in attendance numbers, each support network meeting is now centred around a specific health topic or theme.

Ask Workforce **Attendance Management** Bitesize learning is a popular series of 60 minute sessions designed to offer a 'deep dive' learning opportunity around specific absence related topics, including workplace adjustments, occupational health, stress risk assessments, managing short term absence and managing long term absence.

Further to the recent relaunch of **Mental Health First Aid (MHFA) training**, we have now trained a network of 100 Mental Health First Aiders. Content from the MHFA learning now includes scenarios based on racial discrimination, ensuring that trained colleagues are knowledgeable around some of the factors relating to protected characteristics that can significantly impact mental health. Moving forwards, we will focus on ensuring that the supervision and regular bulletins shared with MHFA's maintains a focus on inclusivity.

We have developed a **series of infographic resources and line manager guides** to support line managers with attendance management, including: Sickness absence myth busting, Occupational Health referral guidance, Managing disability related absence, Managing Disability Related Absence Manager's Guide, Access to Work guidance for managers. All new and refreshed resources are available via the managing sickness absence intranet page.

LEADERSHIP AND MANAGEMENT SKILLS

Our monthly **Manager's Update sessions** are a way of us keeping our leaders and managers up to date with everything they need to know to support them in managing their teams effectively. The sessions have covered a wide range of topics but each has examples of related diversity and inclusion work or data consistently running through. The 90-minute long sessions provide; guidance, regular updates on policy related matters, opportunities to ask questions from topic specialists and signpost where leaders and managers can go for further training, support or help. Over the last year there have been a range of topics which relate to areas already discussed and highlighted within this report, including;

- **Occupational Health** (January) including a significant focus on effective referrals, reasonable adjustments, supporting neurodiversity, a Q&A session and FAQ's shared.
- **Attendance Management** (April) including specific information relating to workforce advice input when managing disability related sickness absence. Increased entitlement to paid time off for fertility treatment. Encouraged a holistic, inclusive and person-centred approach to attendance management, supportive return to work plans and optimising the use of disability leave and carers leave where appropriate.
- **Flexible Working/HWB Survey** (October) including HWB survey data to highlight gaps around colleague access to supporting disability & long-term conditions agreements and carer passports, focus on increased colleague numbers not having adequate adjustments in place. Positively highlighted improved line manager confidence in holding conversations across a broad range of wellbeing topics.

- **Workplace Adjustments** (November) covering legal duty, organisational, individual and societal benefits of enabling colleagues with health conditions and disabilities to sustain employment, clarity on the role of the line manager, promotion of best practice approaches, sharing case studies to illustrate importance of an individualised planning.

Sessions are really well attended with numbers in excess of 100 managers regularly attending.

COLLABORATIVE WORKING WITH EDI COLLEAGUES ACROSS THE INTEGRATED CARE SYSTEM (ICS)

The collaborative work projects signposted in last year's annual report were largely placed on pause at the start of the new financial year due to the financial challenges facing organisations across the ICS. The need for large-scale organisational change meant some colleagues were reallocated to other workstreams. There is hope that we will be able to pick up and complete a number of these projects in early 2026, especially

- **Cultural Awareness** – content for the proposed online learning package has been collated, it will be given to the Blended Learning team to create as a module which can be shared across all organisations in the ICS.
- **Reciprocal Mentoring** – this project paused for a period of time as the lead was on long term sickness absence. Lancashire & South Cumbria FT have re-launched their Reciprocal Mentoring Scheme, it is hoped they will be able to share resources across the wider ICS to enable this project to recommence.

FOR PATIENTS AND OUR COMMUNITIES

This year marked the formal closure of the Patient Experience and Involvement Strategy, which established a strong foundation for listening more deeply to the experiences of patients and families. The strategy emphasised the importance of learning from all experiences—both positive and negative—to inform continuous improvement.

The development of the strategy was shaped through extensive engagement with patients, relatives, carers, colleagues, governors, and partner organisations. We intentionally sought feedback from groups representing people with protected characteristics and recognised the role of intersectionality in shaping people's experiences of care.

Throughout its lifetime, the strategy aligned closely with other key Trust priorities, including the Equality, Diversity and Inclusion Strategy and the Mental Health, Learning Disability, Dementia and Autism strategies. As the Trust moves forward, the focus on patient experience and involvement will now be fully incorporated into the new Single Improvement Plan, ensuring it remains central to safety, quality, and organisational development.

The strategy achieved a significant proportion of its intended objectives. For those areas where further progress is required, remaining actions will be carried forward into the patient experience and involvement section of the Single Improvement Plan.

The work delivered through the strategy has deepened our understanding of patient needs and strengthened our ability to provide holistic, person-centred care. Its outcomes highlight how patient

voices have shaped care pathways, influenced service development, and enhanced experiences across the organisation. This learning will continue to guide improvement as we transition into a single, unified approach.

STAFF EDUCATION & SUPPORT

Staff education has been a key priority in embedding inclusive practice. Involvement Services now contribute to apprenticeship programmes, delivering sessions alongside educator training. This initiative ensures that staff are comprehensively equipped with the knowledge and skills required to provide inclusive, patient-centred care. Training sessions cover a broad spectrum of topics, including:

- Language interpretation and translation support
- Carer engagement and resources
- Deaf culture awareness
- Patient information and communication standards
- Accessible Information Standards
- Patient involvement, forums, and feedback mechanisms
- Ward-based activities and engagement
- Awareness of disabilities and hidden disabilities
- Reasonable adjustments and inclusive practices

This approach helps ensure staff have the knowledge and confidence to deliver a consistently positive patient experience. In addition, continued ward walkabouts by the Involvement Services provide face-to-face support, reinforcing learning and enabling staff to apply inclusive practices in real-time.

At the beginning of the year, NCompass continued the delivery of the '*Bridging the Gap'* Deaf Culture training. This program is designed to enhance staff awareness and understanding of the needs of our Deaf community, while also highlighting the facilities and support mechanisms the Trust has in place. Over the years this training has been well received and remains available as an optional resource for all staff, reinforcing our commitment to inclusivity and accessibility across the organisation.

Earlier this year, we welcomed the Autism Reality Experience Bus from Training2Care as referenced on page 28 (Principle 3 – Recognising the Importance of Lived Experience).

The organisation is committed to bringing about change through education and training, and within the past 12 months has developed two eLearning packages to resolve concerns through local resolution to prevent these from becoming formal complaints. Of course, patients have the right to complain as part of the Health and Social Care Act and the Trust has also developed a Complaints Handling eLearning package to support colleagues in responding to complaints and reaching the best possible outcome as well as demonstrating learning and clear leadership.

We have had 3 national surveys this year and as a result of this implemented divisional and Trust wide meetings to ensure that the results from what our patients have said are reflected in upon and action taken. These plans are monitored on a monthly basis to ensure that future surveys and feedback is improved.

PATIENT & COMMUNITY EDUCATION

Our Head of Library Services has worked on a project to create a one stop shop for health information for the public called the **Lancashire Health Hub**. During Health Information Week a team of library colleagues visited a number of public libraries, had a stand at Charters also putting information on social media promoting the Health Hub.

OUR FUTURE COLLEAGUE FOCUS

- Develop the diversity and inclusion information/learning content available at point of need for colleagues across the organisation through expanding the information available on the Trust Intranet and Managers Hub.
- Enhance our Core People Management Skills development programme by including an introductory session to Equality, Diversity and Inclusion as well as information about Cognitive bias and how to mitigate against it.

OUR FUTURE PATIENT & COMMUNITY FOCUS

- Ensure that patient feedback and involvement are fully integrated into the Single Improvement Plan, aligning with safety, quality, and organisational development priorities.
- Continue to work with diverse communities, including those with protected characteristics, to ensure all voices are heard and represented in service design and improvement.
- Grow volunteer roles in high-impact areas, improve recruitment processes, and strengthen operational systems for better visibility of volunteer contributions.
- Deliver more experiential and inclusive training through Oliver McGowan training
- Develop and promote resources like the Lancashire Health Hub to provide accessible, reliable health information for patients and communities.

FINANCIAL IMPLICATIONS

Whilst there are limited direct financial implications associated with this report, there are a number of indirect costs which could be incurred if we are unable to progress against the strategic aims outlined. These include:

- Costs associated with missed appointments from patients who may have lower health literacy skills, from a poorer demographic background, or minority group.
- Increased treatment costs for patients with health inequalities.
- There is no celling for the maximum amount which could be awarded from a potential employment tribunal with a discrimination claim.
- The associated costs for colleague turnover, this includes impact on team morale which can impact on levels of productivity, impact on reputation, time to hire and needing to use temporary worker colleagues, as well as time spent recruiting and upskilling.

LEGAL IMPLICATIONS

As a public sector body, we are governed by the Public Sector Equality Duty which came into force in 2011 alongside the Equality Act 2010. As part of this we are obliged to meet the objectives set out which include:

a. eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010;
b. advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
c. foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

To ensure transparency, and to assist in the performance of this duty, the Equality Act 2010 (Specific Duties) Regulations 2011 require public authorities to publish:

- equality objectives, at least every four years,
- information to demonstrate their compliance with the public sector equality duty.

This annual report and the EDI Strategy supports the transparency with regards to the objectives we are taking to improve diversity and inclusion alongside our data profile. In conjunction with this report, the Workforce Race Equality Standard, Workforce Disability Equality Standard, the Gender Pay Gap report, the Ethnicity Pay Gap report and the Disability Pay Gap report support further transparency with regards to our data and experience of colleagues from certain protected characteristic groups.

RISKS

The risks to not progressing against the EDI strategy are in part documented within the financial and legal implications. Further to this, wider risks include:

- Ability to analyse our patient data by all 9 protected characteristics is limited due to system limitations, this makes it more challenging to understand any health inequalities that may exist, alongside measure any impact through actions taken in delivering the strategic aims.
- Negative impact on the experience of work for colleagues with protected characteristics leading to challenges with retention.
- Increased discrimination claims.
- Reduction in overall levels of colleague engagement and satisfaction as measured by the National Staff Survey and the National Quarterly Pulse Survey.

- Reduced reputation as an inclusive employer.
- A workforce that is not representative of the communities we serve, across all levels and professional groups.
- A workforce which is not consciously inclusive, or who possess the skills, knowledge, confidence and competence to tackle discrimination and deliver inclusive working practices within an increasingly more diverse workforce.
- Inability to progress social value work through increasing the diversity of our workforce which in turn supports our communities to thrive.
- Increased health inequality gap(s).
- Services are designed which do not meet the unique needs of our local populations.
- Inability to achieve CQC standards around equality, diversity and inclusion of the services we offer.
- Inability to deliver on the NHS People Plan and the NHS People Promise Element - We Are Compassionate and Inclusive.
- Failure to deliver the NHSE High Impact Actions.
- Failure to keep pace with the increasing reporting requirements requested at a local or national level
- Not keeping up with developments in diversity and inclusion from a patient, community and workforce perspective.

IMPACT ON STAKEHOLDERS

The stakeholders are patients, their families, the wider community, our current and future workforce. All these groups could be negatively impacted if we fail to deliver on all aspects of the EDI strategy.

RECOMMENDATIONS

It is recommended that Board of Directors approve the contents of the report for publishing externally on our internet pages.

11.2 - ANNUAL ADULT SAFE STAFFING REPORT

REFERENCES

Only PDFs are attached

11.2 - Annual Safe Staffing Review - Ancillary Report.pdf

Board of Directors Report

1. Introduction

This report presents the findings of the Annual Nurse and Midwifery Safe Staffing Review at Lancashire Teaching Hospitals NHS Foundation Trust for 2025. The review triangulates workforce data with key indicators of patient safety, patient experience, and clinical effectiveness to provide assurance that nursing and midwifery staffing levels across the Trust remain safe and appropriate to deliver high-quality care.

The report fulfils the requirements outlined in Developing Workforce Safeguards (NHS Improvement, 2018), National Quality Board guidance (NQB, 2016), the Nursing and Midwifery Code of Practice (NMC, 2015), and National Institute for Health and Care Excellence (NICE, 2016) guidance on safe, sustainable, and productive staffing, as well as Care Quality Commission (CQC) Regulation 18(1). These standards ensure providers maintain sufficient numbers of suitably qualified, competent, skilled, and experienced staff to meet people's care and treatment needs in line with fundamental standards of care. Specifically, this includes:

- 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 annual review undertakes a comprehensive triangulation of nursing and midwifery staffing data with associated outcome measures across all four clinical divisions: Surgery, Medicine, Women's and Children's, and Diagnostics and Clinical Support (DCS). This includes admission and assessment units, as well as inpatient areas for Neonates and Children and Young People.

Reviews for the Acute Assessment Unit, Ward 23, and the Enhanced High Care Unit were not included in this cycle due to planned service changes. A desktop review was undertaken for these areas to ensure ongoing oversight. These areas have a formal safe staffing review as part of the revised service models, ensuring compliance with safe staffing principles outside of this reporting period.

Table 1 – Areas included in the scope of the annual workforce review

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 Unit (CDH)		
Brindle	Leyland Ward		
Cardiac Unit CDH			
Rookwood A			
Rookwood B			
Hazelwood			

3. Background

Safe staffing establishments are reviewed and formally approved on an annual basis by the Chief Nursing Officer, in collaboration with Ward Managers, Matrons, and Divisional Nursing and Midwifery leaders. Establishments are determined using an evidence-based methodology, supported by validated audit data and aligned to the requirements of the Safer Nursing Care Tool (SNCT). This approach ensures that staffing models remain responsive to patient acuity and dependency while meeting national standards for safe, sustainable, and high-quality care.

Workforce planning is recognised as a continuous cycle of measurement, review, and adjustment, rather than a single event. This cycle includes:

- Measuring patient acuity and dependency over the recommended period using the most appropriate tool (SNCT for inpatient wards).
- Reviewing data alongside professional judgment frameworks to identify factors influencing staffing requirements.
- Comparing calculated establishments to current staffing levels and benchmarking against similar wards or services.
- Reflecting on recommended establishments with reference to evidence and considering implications for daily deployment.
- Justifying establishment decisions and monitoring indicators of staffing sufficiency, including patient and staff outcomes.

- Re-measuring at intervals of 6–12 months or sooner if monitoring indicates a need for change.

Outside the annual review cycle, ward managers are empowered to take immediate actions to maintain safe and responsive staffing levels, including:

- Substantive recruitment to cover maternity leave for Health Care Assistants (HCAs) and Registered Midwives (RMs) band 6.
- Fixed-term recruitment to cover maternity leave for Registered Nurses (RNs) at band 5, with exceptions only for high-turnover areas requiring a specific skill set. This includes Emergency Department (ED), medical assessment units, children's services, neonates, theatres, and endoscopy, where specialist competencies are essential to maintain patient safety.
- Requesting bank staff in response to changes in patient acuity or dependency, subject to approval controls via Divisional Nurse Directors (DNDs), to provide rapid and flexible support during periods of increased demand.
- Initiating an establishment review where the current staffing model does not meet clinical needs or where there has been a change in patient cohort, ensuring alignment with evolving service requirements and patient complexity.
- Formally twice-daily safe staffing forums are undertaken to ensure that staffing is safe and effective, provide real-time oversight, enable escalation of concerns, and allow proactive redeployment of staff across wards to mitigate risk and maintain quality standards.
- Mechanisms for site management arrangements are in place 24/7 that facilitate safe staffing. This includes escalation pathways to address staffing shortfalls promptly, ensuring resilience and continuity of care across all clinical areas.

4. Methodology and Approach

The review draws on outcome metrics for both patients and staff over a 12-month period (September 2024 – August 2025), combined with professional judgment, as recommended by NHS Improvement's Developing Workforce Safeguards (2018).

4.1. Safer Nursing Care Tool (SNCT)

The Safer Nursing Care Tool (SNCT) is a NICE-endorsed acuity and dependency tool, developed by the Shelford Group as an evidence-based decision support mechanism. It enables Chief Nursing Officers and Trust Boards within acute NHS hospitals to measure patient acuity and dependency to inform and approve safe nurse staffing levels. The decision matrix allows for the assessment of patient acuity (severity of illness) and dependency (level of nursing support required to meet fundamental care needs such as mobility, nutrition, and personal care).

The Trust implemented SNCT across adult inpatient and assessment areas, children's inpatient areas, and the Emergency Department (ED) in February 2024. Full-month data collection and validation audits have been conducted every six months since implementation.

4.1.1. SNCT in Workforce Reviews

Workforce reviews are informed by these formal six-monthly SNCT data collections. The Trust is Compliant with all SNCT requirements which include:

- Holding a valid license for use of the tool.
- Collecting a minimum of 30 days of data twice annually.

- Ensuring three senior staff per ward are trained in SNCT methodology.
- Applying external validation processes and inter-rater reliability assessments.
- Running SNCT data through licensed software using approved multipliers applied to acuity and dependency descriptors.

This structured approach ensures that staffing establishments are evidence-based, professionally validated, and aligned with national standards for safe and sustainable care.

The graphs in appendix 1 provide a breakdown of the overall SNCT data collected since commencement in February 2024.

The SNCT data demonstrates an increase in patient dependency over the past 12 months across adult inpatient and acute assessment units. When this is triangulated with coding data for non-elective (NEL), non-elective non-emergency (NELNE) and non-elective short stay (NELST) comparing M1-8 23/24 to M1-8 25/26, there is a broad increase in average tariff across all specialty areas. This suggests a richer case mix and increased patient acuity, which correlates with the trends observed in the SNCT data (appendix 8).

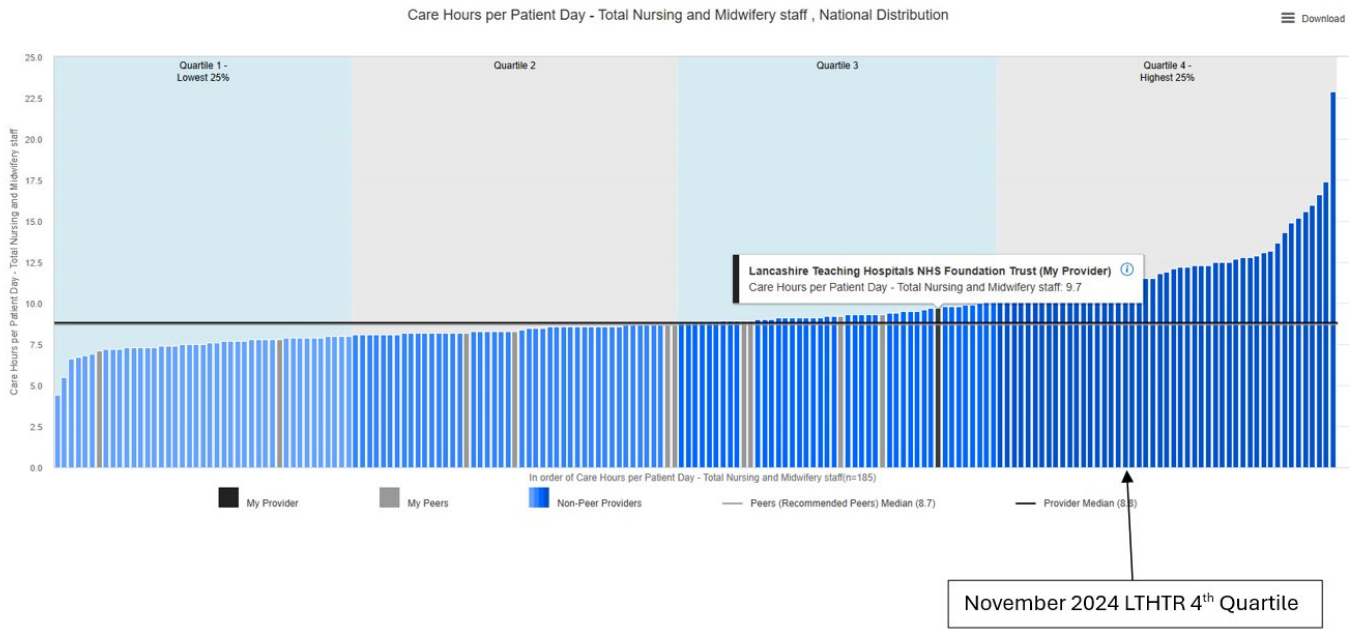
While patient acuity and dependency captured through the Emergency Department (ED) SNCT audit remain relatively stable, the current tool does not fully reflect the care requirements of patients remaining in ED beyond 12 hours. This limitation has been recognised nationally by NHS England and the Shelford Group, and a revised version of the tool was released in December 2025 to address this gap. Until the updated tool is fully implemented, professional judgment supported by established escalation and mitigation processes continue to be applied to manage the additional care demands associated with extended ED stays, providing ongoing assurance of safe staffing.

Within the children's ward there are consistent variations in acuity and dependency linked to seasonal variation that require professional judgment to ensure flexibility in deployment.

4.2. Care Hours per Patient Day (CHPPD)

The data in Graph 1 reflects Model Hospital benchmarking data from September 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 1 – Model Hospital Lancashire Teaching using CHPPD – September 2025



CHPPD is a high level, national proxy measure for staffing to bed ratios. While some assurance can be drawn from Lancashire Teaching Hospitals' position relative to peer organisations, it is important to interpret this metric in the context of local configuration and case mix. For example, the Trust operates seven enhanced high care areas in support of the delivery of tertiary services. As of September 2025, Lancashire Teaching Hospitals is positioned in Quartile 3 nationally, compared to Quartile 4 (highest 25%) in November 2024. This movement from Quartile 4 to Quartile 3 demonstrates effective workforce resource management and improved alignment of staffing to patient need without compromising safe staffing standards.

4.3. Professional Judgement

Professional judgement is a critical component of workforce reviews, providing a balanced approach that combines robust data with the expert insights of those who understand the realities of clinical practice. This ensures that decisions regarding nurse staffing levels reflect both an evidence base and the complexities of the working environment.

Embedding professional judgement within the process promotes collaboration, empowers local teams to take ownership of safe staffing, and supports leadership development. It values the perspectives of staff working directly in clinical areas, while encouraging leaders to proactively address challenges and contribute to practical solutions.

Professional judgement is not about requesting additional staff. It is about understanding the unique context of each clinical area and working collectively to identify strategies that prioritise patient safety and mitigate risk. This analysis forms a key part of workforce reviews and is considered alongside nurse-sensitive indicators, financial data, and workforce metrics.

In addition to patient acuity and dependency (SNCT), professional judgement takes into account a wide range of factors that influence staffing requirements, including:

- Ward layout and design – areas with multiple single rooms or bays often require increased staffing capacity and capability.
- Patient visibility and observation needs – including Enhanced Therapeutic Observation and Care (ETOC).

- Availability of support staff – such as housekeepers and other non-clinical roles.
- Patient throughput – higher turnover may necessitate additional staff to maintain patient flow.
- Supervisory time for Ward Managers – to fulfil management responsibilities and provide support, supervision, and mentorship for students and newly appointed staff.
- Skill mix and experience levels – balancing registered nurses, nursing associates, and healthcare support workers, and considering the proportion of newly qualified or inexperienced staff.
- Seasonal or situational pressures – such as winter pressures, flu outbreaks, or surges in elective activity.
- Staff wellbeing – recognising the impact of sustained high workload or sickness absence on team resilience.
- Training and development needs – ensuring time for mandatory training, competency development, and clinical supervision.
- Technology and equipment availability – delays or complexity in using systems can increase workload.
- Dependency on external services – for example, delays in diagnostics or discharge planning that increase patient length of stay.
- Impact of regulatory requirements – compliance with standards such as CQC, NICE guidance, or safe staffing legislation.

Professional judgement ensures that workforce planning remains responsive, realistic, and focused on delivering safe, high-quality care.

4.4. Roster Key Performance Indicators

Effective roster management is a cornerstone of safe and high-quality patient care. As part of the annual safe staffing review process, detailed analysis of rostering Key Performance Indicators (KPIs) is undertaken using comprehensive data from across all divisions. This review goes beyond operational compliance and provides strategic insight into workforce utilisation, skill mix, and patterns of additional staffing.

The annual review evaluates trends in roster performance, including the alignment of planned staffing to patient acuity, the distribution of registered and unregistered staff, and the reasons for additional duties such as enhanced therapeutic observations of care (ETOC). It also highlights areas of high acuity, dependency on temporary workforce, and the effectiveness of Safecare redeployment strategies.

This supports:

- Rosters that are structured to deliver safe staffing within available resources.
- Identification of systemic pressures such as high reliance on bank staff or recurring ETOC needs, enabling targeted workforce planning.
- Financial stewardship by monitoring patterns that drive variable spend and informing strategies to reduce reliance on temporary staffing.
- Provision of evidence for compliance with national guidance and internal governance standards.

The insights from this review, combined with real-time data from the Daily Management System (DMS), ensure that workforce planning remains proactive, responsive, and sustainable.

As part of the evaluation of grip and control arrangements and Healthroster compliance an opportunity has been identified to strengthen and standardise compliance monitoring. This will be taken forward through the development of monthly monitoring against Healthroster good practice guidance, providing improved oversight and assurance.

5. Monthly Reporting for Assurance

Recognising the significance that fill rates have on patient and staff outcomes, the single improvement plan measures fill rates, and these are reported to Trust Board as part of the integrated performance report.

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.

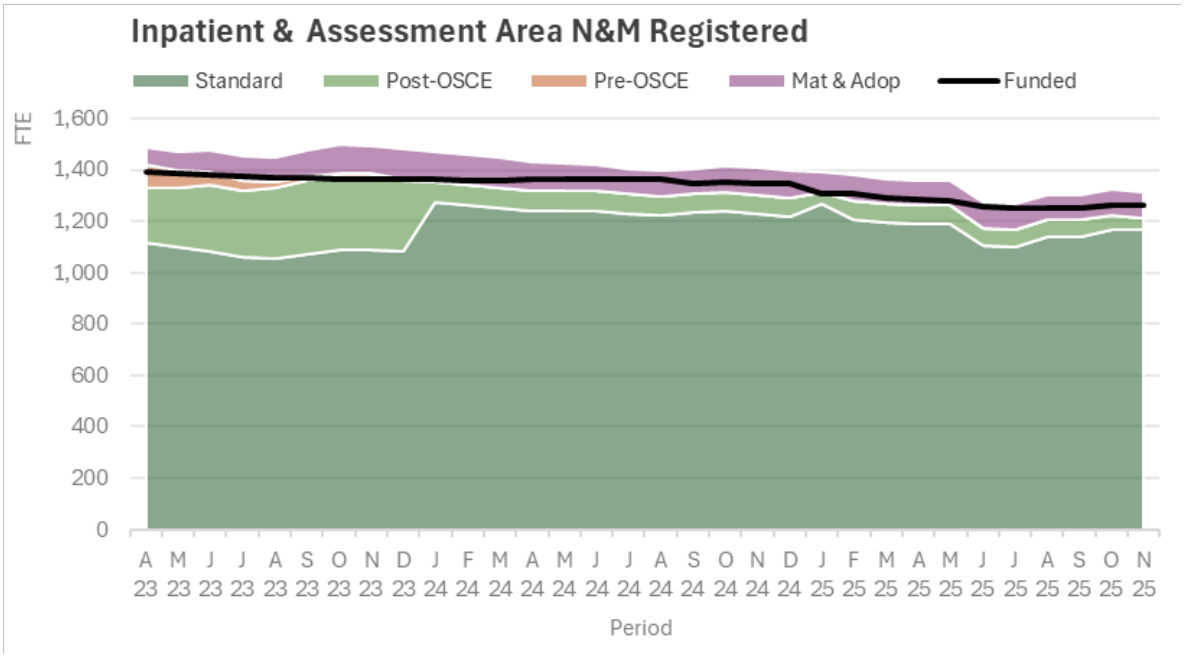
In recognition of the risks associated with Maternity and Children these staffing reports are disaggregated and presented separately to Safety and Quality Committee triangulated against patient outcome measures specific to these specialties. This allows clear line of sight in these services.

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. This analysis is then converted to Care Hours per patient day (CHPPD) which is monitored as part of the monthly reporting process.

6. Vacancy Position (inpatient areas)

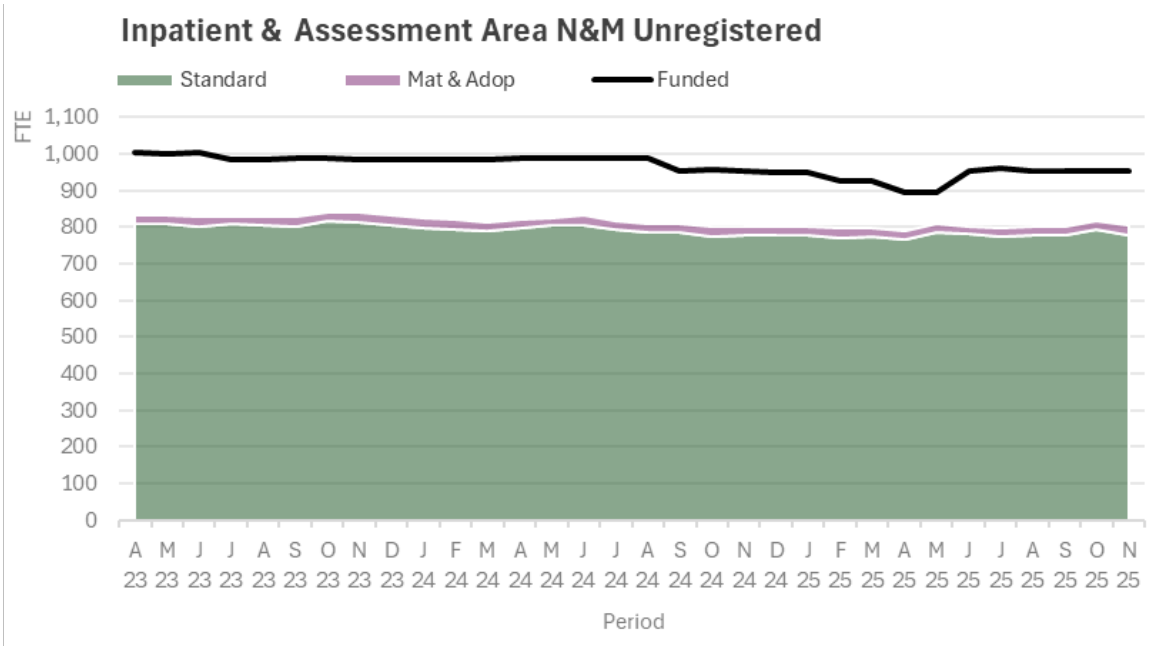
Graph 2 below illustrates the trend in Registered Nurse and Midwifery staff in post versus funded establishment. Staff in post reduced slightly over the past year, with a dip through mid-2025 and a small recovery toward year-end. Substantive staff numbers followed a similar pattern, falling through summer and improving by November. As of 30 November 2025, including staff on maternity and adoption leave, there is an over-establishment of 48.46wte on the Register Nurse/Midwifery establishment. However, when excluding maternity and adoption leave (i.e., substantive staff available to work), there is a shortfall of 51.83wte. The apparent over-establishment reflects staff on maternity/adoption leave who remain on payroll but are not available for clinical duties.

Graph 2 - Registered Nurse & Midwifery establishment versus staff in post



Graph three shows the trend for unregistered staff. The workforce has remained relatively stable overall; however, vacancies have increased slightly since early 2025, which may impact ward-level flexibility and patient support. As of 30 November 2025, there is a vacancy of 148.99wte, including maternity and adoption leave there is a vacancy of 124.6wte vacancies.

Graph 3 - Healthcare Assistant & Maternity Support Worker establishments versus staff in post



7. Outcome of the Annual Safe Staffing Review

7.1. Children and Young People

Paediatric services at Royal Preston Hospital have continued to operate in line with Royal College of Nursing and NHS Improvement guidance, with compliance monitored through monthly Children and Young People Safety and Quality reports. These reports provide assurance that staffing levels and child-specific outcomes remain safe and effective across all areas.

In the Paediatric Emergency Department, staffing models remain aligned to national standards, supporting emergency resuscitation alongside triage, assessment, and treatment. Professional judgement confirms that current arrangements are appropriate to meet service needs.

Ward 8 has maintained safe staffing throughout the year, with triangulation of SNCT data and professional judgement confirming that skill mix and capacity have remained suitable. Seasonal variation and bed occupancy have been managed effectively, ensuring continuity of care and patient safety. No changes were made to the workforce model or WTE allocation during 2025.

The Paediatric Assessment Unit retained its staffing model, although planned headroom alignment to 22.2% was not implemented at budget setting for 2025 and so will be corrected this year.

Ambulatory care transitioned from Ward 8 to the Paediatric Day Case service, improving patient flow and service efficiency without compromising safety.

The Neonatal Unit remains compliant with British Association of Perinatal Medicine standards. While sickness levels have been high, these have been managed and supported at divisional level. No structural changes were made to the staffing model, with only minor budget adjustments linked to incremental drift.

Overall, paediatric services have sustained safe staffing and compliance with national standards despite operational pressures and service changes. Workforce planning continues to focus on resilience and flexibility to meet future demand.

7.2. Gynaecology

Triangulation of SNCT data for the Gynaecology Ward and Gynaecology Assessment Unit (GEPAU), combined with professional judgement and safety metrics, confirms that staffing levels and skill mix remain appropriate to meet service needs. A staffing model adjustment for GEPAU has been agreed to manage increased triage activity, and this is achievable within budget due to headroom formulas embedded in the staffing model template. Recruitment to address Band 3 vacancies and administrative gaps is ongoing, supported by flexible rostering and bank staff utilisation.

7.3. Maternity

Maternity services continue to operate in line with national guidance and the National Quality Board standards. Recruitment plans for newly qualified midwives are on track, with phased starts from September through November 2025 and over-recruitment agreed to cover vacancies, maternity leave, and anticipated attrition. The updated Birth Rate Plus assessment, commissioned in May 2025, is underway, with findings expected by the end of the year following validation. These will inform future workforce planning and be incorporated into the annual review cycle. Current staffing models, supplemented by professional judgement, continue to meet NICE safe staffing standards, and compliance with CNST Maternity Incentive Scheme priorities remains strong.

7.4. Surgical Division

Triangulation of SNCT data, professional judgement, and safety metrics confirms that staffing levels and skill mix across surgical wards remain appropriate to meet service needs. Most surgical areas maintained their existing staffing models, with targeted adjustments to address pressure points.

In September 2025, the Surgical Enhanced Care Unit was consolidated into Leyland Ward, embedding enhanced care within the ward and improving efficiency, patient pathways, and workforce resilience. Following the annual safe staffing review, the Surgical Assessment Unit will increase housekeeping provision to align with other assessment areas and introduce a test of change for a twilight RN shift, converting one RN Day shift. This later start aims to relieve evening pressures identified as a peak activity period.

Professional judgement highlighted ongoing risks linked to patients requiring ETOC, mitigated through roster redesign and effective safe staffing deployment. Overall, surgical staffing models provide the ability to maintain safe, effective care for.

7.5. Medicine Division (excluding ED)

Triangulation of SNCT data, professional judgement, and safety metrics confirms that staffing levels and skill mix across medical inpatient wards remain broadly appropriate to meet service needs. Most wards retained their existing staffing models, with targeted adjustments to address dependency and skill-mix pressures.

Key changes include Elderly Care – Rookwood A (CDH) skill-mix review introduced a test of change to increase Band 3 staff at night and reduce Band 3 roles during the day, reflecting patient dependency and observation needs.

Ward 17 skill-mix refinements between day and night band 2 and band 3 and removed band 4 roles to increase band 5 provision during the day to better meet care needs of the patients, based on peer

review and professional judgement, skill mix undertaken with budget and will be enacted before budget setting.

Gastroenterology Ward 24 temporary changes from last year were made permanent following positive feedback, increasing RN Day cover and reducing Band 2 and Band 4 shifts. This change is within budget.

Bleasdale Ward adjustments to night skill mix (conversion of band 3 to band 4), alongside retention of additional band 6 support as an interim to manage high acuity and complexity. These changes have been achieved within budget.

The Medical Assessment Unit (MAU) at Chorley has increased its Fit to Sit capacity to support patient flow and site pressures. To maintain safety and meet rising demand, MAU has consistently been using additional duties to manage peak activity. Night-time pressures remain linked to ED demand and will be addressed through the Urgent and Emergency Care Pathway and 'Days Kept Away from Home' initiatives.

Roster analysis (Jan–Nov 2025) indicates additional shifts have reduced and stabilised at an average of 700 hours per month, equating up to 18 WTE extra per month which is leading to an overspend of £354K as of October 2025, driven by bank usage.

The proposed model converts 5.48 WTE bank usage into substantive posts at a recurrent cost of £249K, delivering savings on variable spend without increasing overall worked headcount and supporting safe, sustainable staffing.

Medicine staffing models remain aligned to national safe staffing standards, providing assurance that patient safety is maintained. While workforce pressures in some clinical areas have required daily redeployment to balance skill mix and support efficiency, these actions are managed through established escalation processes. Work is underway to strengthen Band 5 capacity, with the transfer window now open to correct establishment gaps and improve stability across the division.

A full safe-staffing review was not undertaken for AAU during this cycle due to the recent change in specialty. However, a desktop assessment has been completed, identifying key learning for areas undergoing service reconfiguration. The consultation process highlighted the need for clearer communication pathways, including defined timescales and clear endpoints when undertaking service changes. The feedback emphasised that uncertainty significantly affects staff morale and can ultimately impact patient safety. These insights will inform future service-change processes to ensure improved engagement, transparency, and operational readiness. SNCT data could not be triangulated at this stage because two full audit cycles are required following the specialty change. These will be completed in January, enabling a full triangulated review to be presented in the next reporting cycle.

7.6. Emergency Department

A business case was approved at the Trust Management Board on 12th November 2025 to convert temporary staffing expenditure into substantive posts within the Emergency Department at Chorley and South Ribble Hospital. This change delivers a 5.5 WTE uplift in registered nurses and a 2.75 WTE uplift in health care assistants, strengthening the department's ability to provide safe and sustainable

care. The business case also acknowledges the ongoing requirement for overnight escalation cover, which will continue to be managed through escalation arrangements with temporary staffing utilised as necessary.

The Trust remains committed to driving forward improvements and supporting schemes that enable overnight closure where clinically appropriate. The current ambition is to achieve closure for 3.5 nights per week, recognising that this target is challenging but achievable through collaborative working across the wider CDH site. Progress will remain dependent on hospital-wide capacity and patient flow. Further work is required to fully understand safe staffing requirements for the Emergency Department at Royal Preston Hospital, aligned to the urgent and emergency care workstreams currently in development. A proposal for a safe and effective staffing model for RPH ED will be presented as a separate paper.

7.7. Critical Care

The unit continues to operate in line with safe staffing standards and the Guidelines for the Provision of Intensive Care Services (GPICS), ensuring compliance with national benchmarks for Level 2 and Level 3 care.

A skill-mix review was undertaken during 2025/26 to reflect triggers and delayed transfers within the footprint of the unit. This resulted in a reduction of one Band 5 RN per shift. The adjustment was implemented within existing budgets and safe staffing maintained in accordance with acuity and demand which is recognised to be lower for some months of the year.

Professional judgement highlighted the need to maintain flexibility in rostering to accommodate surges in high-dependency activity and elective recovery. Safecare redeployment and daily acuity monitoring remain in place to mitigate risk. Overall, the Critical Care staffing model continues to provide assurance of safe, effective, and sustainable care for 2025/26.

8. Financial Implications (to be approved via financial governance processes)

8.1. Woman's and Children

Net impact of all ward reviews in Womens & Children's is a reduction of 0.31wte with a budgetary reduction of £10k recurrently.

Key changes:

- Paediatric Assessment Unit (PAU) - headroom aligned to 22.2% as not undertaken in 2025/26.
- Gynaecology Ward (RPH) - Additional 12 hours shift added Mon-Fri for GEPAU to support increased triage and phone activity, offset by correction of formula discrepancy in prior year (double counting headroom in 2025/26).

8.2. Surgery

Net impact of all ward reviews in Surgery is an increase of 0.77wte with a budgetary increase of £24k recurrently.

Key changes:

- Surgical Assessment Unit (SAU), which is linked to increase in House Keeper, aligned with peer assessment units - 0.77wte increase to cover longer days 7 days per week.

8.3. Medicine

Net impact of all ward reviews in medicine is an increase of 4.93wte with a budgetary increase of £14k recurrently.

Key changes:

- Medical Assessment Unit (MAU) - Review of triage data and number of patients within triage and waiting room, proposal to convert 5.48 WTE bank usage into substantive posts at a recurrent cost of £249K, delivering savings on variable spend against an exit run rate of £3,768,259, being £458k above a budget of £3,310,239 without increasing overall worked headcount.
- Bleasdale Ward - Adjustments to night skill mix, alongside retention of additional band 6 support as an interim - budgetary decrease £1k.
- Ward 24 (Gastro) - Agreed temporary changes from last year will be made permanent – budgetary decrease £58k.
- Acute Medical Unit (AMU) - Headroom to be aligned to 22.2% - not undertaken at budget setting for 2025, budget needs alignment to staffing model – budgetary decrease £102k.

8.4. DCS

Following a successful trial period of removing 1 nurse 24/7 from the Critical Care rota, agreement has been made to formally remove this from the establishment, giving rise to a recurrent saving of £306k, or 5.51WTE. This saving has already been delivered recurrently via LTH's 25/26 WRP programme.

9. Safe Staffing Governance

Safety and Quality Committee continues to receive monthly safe staffing reports for adult, children, and maternity services.

Safe staffing policies are in place across all areas, with Divisional Nurse Directors accountable for ensuring staff deployment in response to patient demand. Matrons operationalise these moves, supported by site management arrangements in place 24/7 to provide clear lines of escalation and support as situations change.

Equality and Quality Impact Assessments (EQIAs) are completed before any amendments to establishments and require approval by the Chief Nursing Officer.

Operational risks relating to staffing are detailed in Appendix 3. While not all risks directly relate to clinical areas included in this annual review, they have the potential to impact safety within those areas and are reflected within the strategic risk: Consistently Deliver Excellent Care.

10. Conclusion

The 2025/26 Annual Safe Staffing Review has been completed in line with National Quality Board (NQB) guidance, NHS Improvement Workforce Safeguards, and specialty-specific standards. Using a triangulated approach combining SNCT data, professional judgement, and safety and quality metrics

the review confirms that nursing and midwifery establishments across all divisions remain broadly appropriate to meet patient care needs.

While overall staffing is assessed as safe, effective, and sustainable, the review highlights ongoing risks that require continued oversight, particularly:

- Enhanced Therapeutic Observation and Care (ETOC) demand in high-dependency and elderly care areas.
- Persistent HCA vacancies, which impact skill mix and resilience.
- Sickness levels above target, linked to workload pressures and complexity of care.
- Seasonal variation and evening activity surges in assessment units and surgical pathways.

Mitigations are in place, including roster redesign, flexible deployment via Safecare, targeted recruitment, and competency planning for enhanced care areas. Divisional governance and monthly reporting to the Safety and Quality Committee will continue. Continuous monitoring will ensure that staffing models remain responsive to service developments, seasonal variation, and workforce challenges.

The Chief Nursing Officer confirms compliance with NICE Safe Staffing Standards, NQB recommendations, and NHS Improvement Workforce Safeguards, and is satisfied that staffing models provide assurance of safe, effective, and sustainable care for 2025/26.

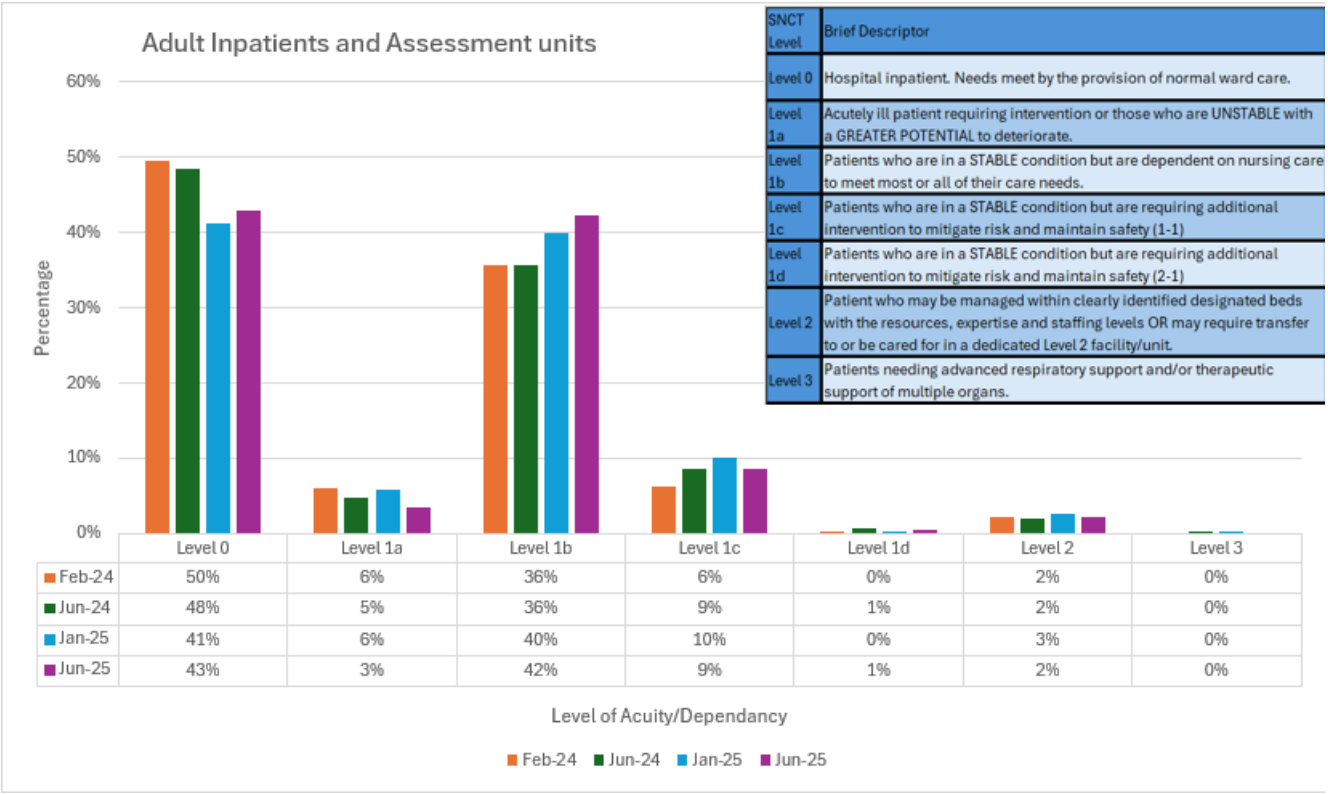
11. Recommendations

It is recommended that the Board:

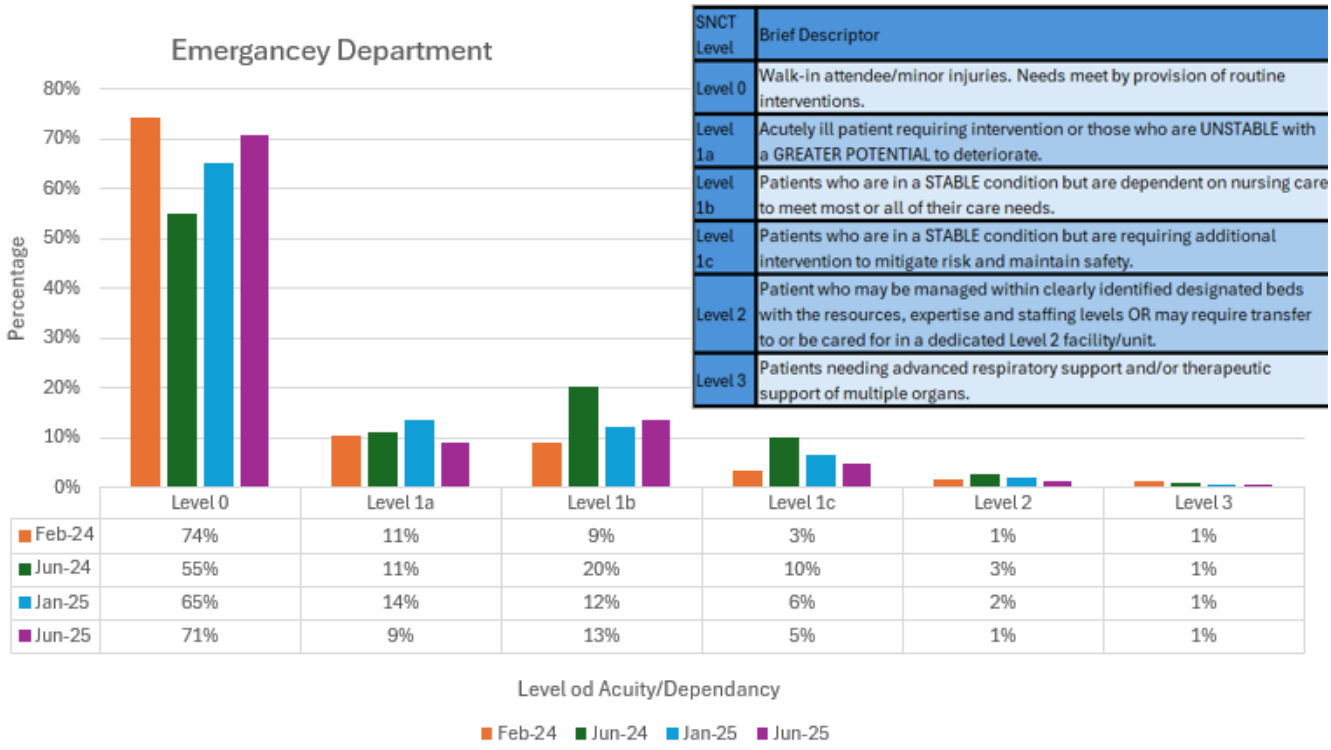
I. Approve the annual safe staffing review and confirm it is satisfied of the assurances within the report.
II. Note, in line with the recommendation from NHS Improvement Workforce Safeguards guidance, the Chief Nursing Officer confirms they are satisfied with the outcome of the annual safe staffing assessment and that whilst risks remain present staffing is safe, effective and sustainable.

Appendix 1 – Breakdown of the overall SNCT data

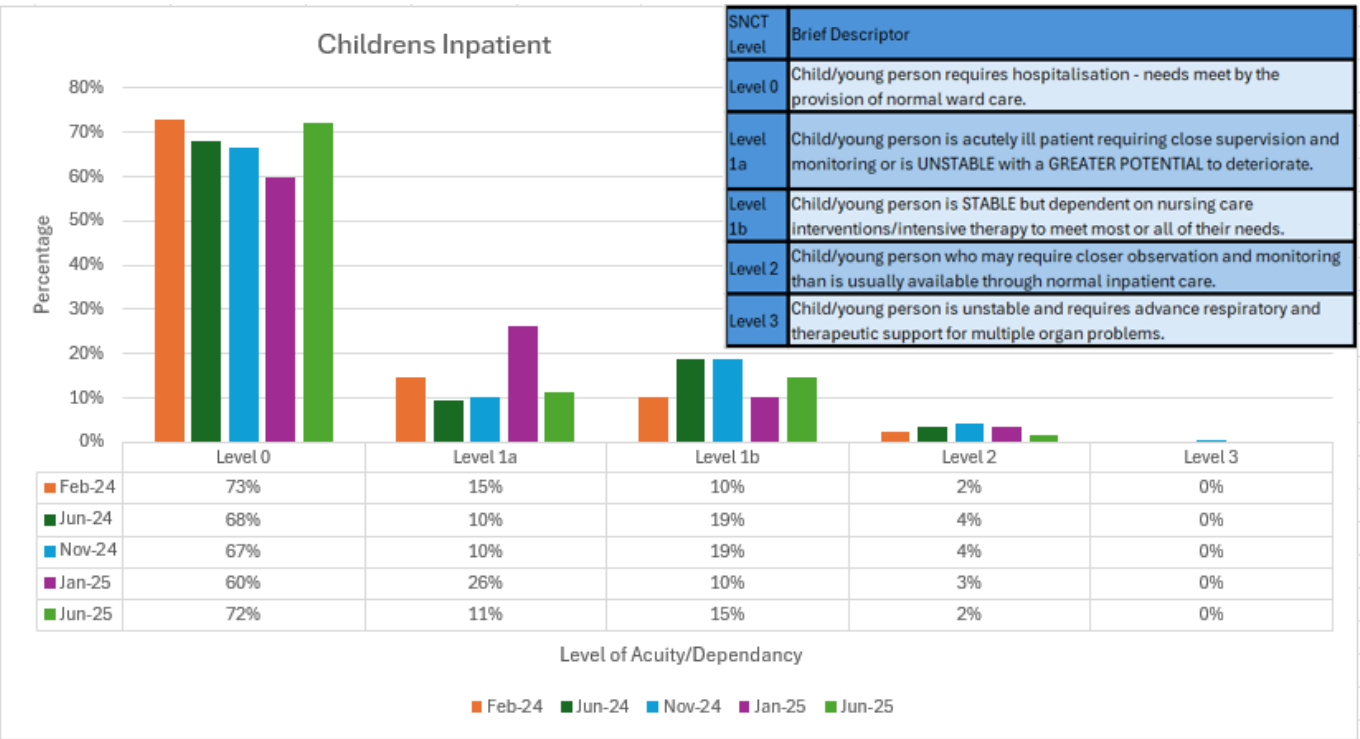
Graph 1 – Adult Inpatient and Assessment Unit Acuity Levels calculated from the validated SNCT tool.



Graph 2 – Emergency Department Acuity Levels



Graph 3 – Children's Inpatient Acuity Levels



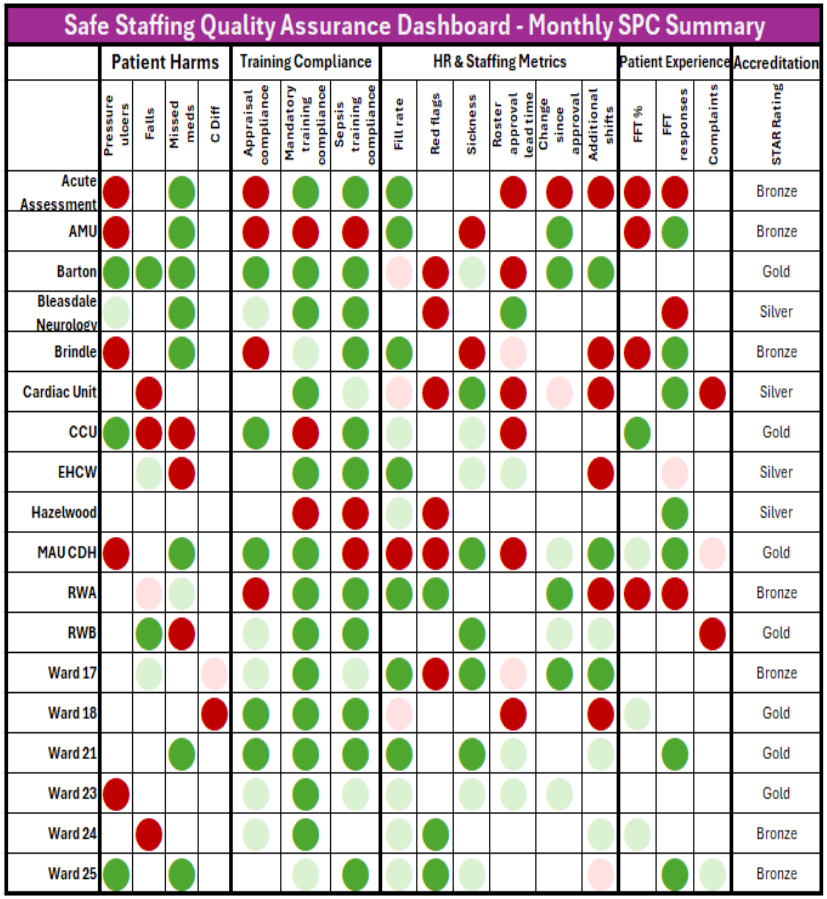
SNCT Level	Brief Descriptor
Level 0	Child/young person requires hospitalisation - needs meet by the provision of normal ward care.
Level 1a	Child/young person is acutely ill patient requiring close supervision and monitoring or is UNSTABLE with a GREATER POTENTIAL to deteriorate.
Level 1b	Child/young 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.

Appendix 2 - CHPPD compared to Northwest Region and Recommended Peer Organisations. (September 2025)

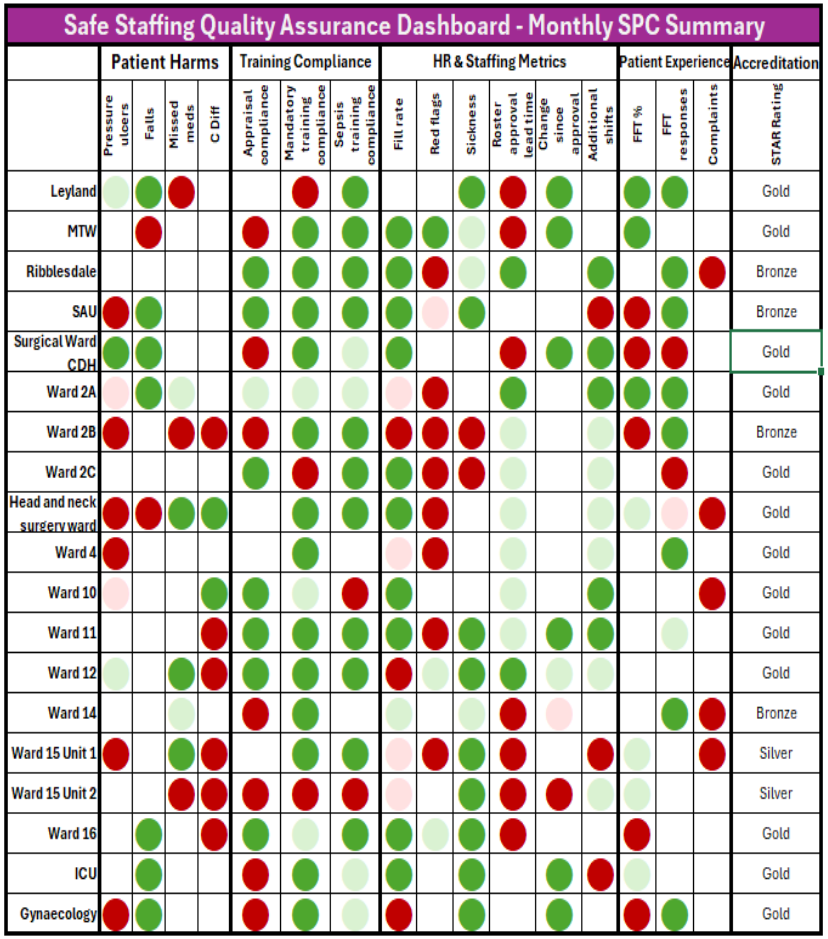
Organisation Name	Organisation Value	Peer	Quartile
Bridgewater Community Healthcare NHS Foundation Trust	5.5	No	Quartile 1
Mid Yorkshire Teaching NHS Trust	7.1	Yes	Quartile 1
Wirral University Teaching Hospital NHS Foundation Trust	7.2	No	Quartile 1
Countess of Chester Hospital NHS Foundation Trust	7.3	No	Quartile 1
Warrington and Halton Hospitals NHS Foundation Trust	7.3	No	Quartile 1
Mid Cheshire Hospitals NHS Foundation Trust	7.8	No	Quartile 1
University Hospitals Plymouth NHS Trust	7.8	Yes	Quartile 1
East Lancashire Hospitals NHS Trust	7.9	No	Quartile 1
Mersey and West Lancashire Teaching Hospitals NHS Trust	7.9	No	Quartile 1
Christie NHS Foundation Trust	8.2	No	Quartile 2
Royal Cornwall Hospitals NHS Trust	8.2	Yes	Quartile 2
Blackpool Teaching Hospitals NHS Foundation Trust	8.3	No	Quartile 2
East Cheshire NHS Trust	8.3	No	Quartile 2
University Hospitals Coventry and Warwickshire NHS Trust	8.3	Yes	Quartile 2
Bolton NHS Foundation Trust	8.5	No	Quartile 2
Clatterbridge Cancer Centre NHS Foundation Trust	8.6	No	Quartile 2
Tameside and Glossop Integrated Care NHS Foundation Trust	8.7	No	Quartile 2
South Tees Hospitals NHS Foundation Trust	8.7	Yes	Quartile 2
North Bristol NHS Trust	8.7	Yes	Quartile 2
University Hospitals of Morecambe Bay NHS Foundation Trust	8.9	Yes	Quartile 3
Northampton General Hospital NHS Trust	8.9	Yes	Quartile 3
Liverpool University Hospitals NHS Foundation Trust	9.0	No	Quartile 3
Wrightington, Wigan and Leigh NHS Foundation Trust	9.1	No	Quartile 3
Liverpool Women's NHS Foundation Trust	9.1	No	Quartile 3
University Hospitals of North Midlands NHS Trust	9.2	Yes	Quartile 3
Northern Care Alliance NHS Foundation Trust	9.3	No	Quartile 3

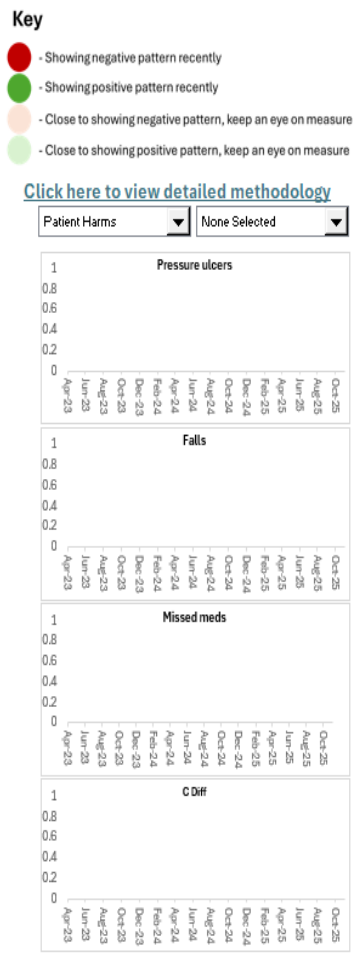
Stockport NHS Foundation Trust	9.3	Yes	Quartile 3
Manchester University NHS Foundation Trust	9.5	No	Quartile 3
Lancashire Teaching Hospitals NHS Foundation Trust	9.7	No	Quartile 3
Greater Manchester Mental Health NHS Foundation Trust	10.3	No	Quartile 4
Mersey Care NHS Foundation Trust	10.3	No	Quartile 4
Cheshire and Wirral Partnership NHS Foundation Trust	10.9	No	Quartile 4
Pennine Care NHS Foundation Trust	11.9	No	Quartile 4
Walton Centre NHS Foundation Trust	12.3	No	Quartile 4
Lancashire & South Cumbria NHS Foundation Trust	12.5	No	Quartile 4
Liverpool Heart and Chest Hospital NHS Foundation Trust	12.8	No	Quartile 4
Alder Hey Children's NHS Foundation Trust	15.6	No	Quartile 4

Appendix 3 – Safe Staffing Quality Assurance Dashboard (Adult inpatients)



Click here to see how to read/use this dashboard





Appendix 4 – Children's and young People Dashboard

Indicator	Oct -24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Senior review within 4 hours weekday %	98%	88%	87%	96%	96%	95%	92%	92%	83%	92%	96%	90%	97%
Senior review within 4 hours weekend %	97%	93%	97%	96%	94%	92%	96%	91%	78%	94%	86%	100%	97%
Consultant review within 14 hours weekday %	86%	74%	85%	61%	82%	84%	79%	80%	83%	78%	87%	64%	80%
Consultant review within 14 hours weekend %	76%	77%	77%	75%	73%	75%	71%	73%	73%	47%	71%	43%	72%
Discharges against medical advice	1	4	1	3	2	3	5	2	2	2	2	4	3
Medicines safety audit	82%	68%	68%	89%	79%	75%	68%	79%	86%	86%	93%	86%	89%
Monthly inpatient STAR	83%	82%	92%	90%	86%	84%	84%	93%	82%	83%	81%	88%	83%
Mattress audit	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Hand hygiene	90%	80%	100%	80%	100%	80%	80%	80%	x	100%	60%	80%	90%
Intra vascular devices	100%	100%	96%	97%	100%	94%	100%	93%	96%	100%	93%	93%	100%
Monthly commode audit	100%	100%	100%	100%	100%	100%	100%	100%	x	100%	100%	100%	100%
Deteriorating patient matrons audit	91%	92%	92%	88%	86%	90%	88%	93%	89%	89%	92%	88%	86%
CD audit 3 monthly	73%	#	#	100%	#	#	89%	#	#	90%	89%	90%	90%
Number of incidents	51	54	57	95	47	74	55	50	76	106	59	76	82
No harm	40	46	39	80	39	52	47	36	62	97	52	64	74
Near miss	5	0	4	1	7	9	3	7	5	7	2	4	4
Harm (low)	11	8	18	15	8	21	8	12	14	9	6	12	7
Harm (moderate and above)	0	0	0	0	0	1	0	0	0	0	1	0	1
Number of child deaths	0	0	0	0	0	1	0	0	0	0	0	0	2
Number of complaints	1	2	1	0	0	2	1	2	2	6	4	4	4
Number of PALS	12	12	2	2	8	8	3	6	3	10	0	1	1
Friends and family Inpatient	94	92	90	92	93	93	92	97	95	98	89	95	91%
Friends and family day case	100	96	100	100	99	98	93	98	89	97	100	95	95%
Friends and family Outpatients	94	97	93	86	90	95	93	95	97	98	100	99	99%
Appraisal rate	91%	90%	92%	92%	92%	94%	88%	87%	88%	89%	92%	90%	89%
Safeguarding children level 3	96%	96%	97%	98%	98%	98%	98%	99%	99%	100%	99%	100%	98%
Prevent	98%	98%	99%	99%	98%	96%	96%	98%	98%	98%	99%	99%	98%
PBLS	95%	97%	93%	93%	92%	98%	100%	97%	100%	100%	99%	100%	97%
APLS	82%	88%	79%	79%	77%	71%	NA	72%	83%	95%	90%	100%	100%
Moving and handling	88%	89%	88%	89%	83%	81%	90%	95%	98%	97%	94%	91%	93%
ANTT	92%	95%	94%	90%	93%	83%	88%	88%	92%	91%	98%	90%	91%
Ward 8 Registered Nurse Day	81%	81%	78%	88%	89%	81%	81%	83%	93%	93%	87%	86%	83%
Ward 8 Un registered Nurse Day	78%	77%	79%	70%	66%	69%	83%	81%	80%	88%	91%	90%	97%
Ward 8 Registered Nurse Nights	86%	92%	80%	89%	89%	80%	79%	81%	88%	88%	81%	87%	82%
Ward 8 Unregistered Nurse Nights	100%	122%	98%	106%	99%	94%	95%	95%	97%	98%	92%	103%	95%
Roster publishing 100%	no	no	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
RCN Compliance ward 8	86%	58%	86%	83%	90%	52%	88%	92%	90%	88%	89%	87%	66%
Ward 8 Vacancies WTE band 5	5	6	10	9*	9*	12*	14*	15*	2	2	2	2	2
ED Registered Nurse Day	98%	92%	95%	92%	94%	94%	101%	103%	107%	98%	110%	98%	109%
ED Un Registered Nurse Day	82%	81%	81%	69%	82%	89%	78%	97%	98%	86%	77%	88%	91%

Appendix 5 – Structured Professional Judgment Template

Professional Judgement Framework			
Ward/Dept Name			
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)	Supporting Narrative / Comments e.g. change in position, supporting data	Prompts/considerations for answering
Expectation 1: Right Staff			
Continuity of team leadership over the last year			any changes in leadership or any gaps
Sufficient allocated time for managerial activities			is management time being allocated, how much, is it consistent (70/30, 60/40)
Multiprofesssional team support is available			are there gaps in MDT support, who/what is needed
Administration/supportive roles available			any changes, right skills, gaps in support, ward clerk, house keepe
Positive staff experience measures			regular 1:1's, staff meetings, feedback mechanisms, reward and recognition
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			3 senior trained staff members and validated, next due to be collected
Expectation 2: Right Skill			
Sufficient technology to support team function. All staff trained to a sufficient level			Is IT accessible and all staff trained? Any gaps, any mitigations being used?
Effective appraisals are conducted (note compliance %)			Any gaps, plans in place to complete
Mandatory training standard met (note compliance %)			Any gaps, plans in place to complete to Trust targets
CPD/PDP plan for all staff in place			Do all staff have a development plan documented and reviewed regularly?
Staff supervision/reflective practice processes in place			regular clinical supervision, mentors, buddy's, PNA's
All staff have had an appropriate induction (including temporary staff), including evidence of implementation			Checklists, induction plans, competency docs used
Skill mix data reflects needs of the patients			Lots of new starters/junior staff, adequate NIC cover, right skills for clinical area, any gaps?
Expectation 3: Right place and time			
The ward has a standard level of patient turnover/throughput for clinical speciality.			is patient turnover higher than expected for clinical speciality, are there increased moves, outliers, long stay patients, include LOS data if approriate
The layout of the ward/unit is optimal, not adding excessive workload such as long distances or difficulty observing patients.			layout compact, spread out, lots of siderooms, difficulty in observing patients
The amount of work is consistent across different times of the day and days of the week. (Details to be provided if there is variation)			Is there predictable variation by time of day and day of week, do rosters match known variation? Is demand unpredictable?
Enhanced/1:1 care requirements are minimal			if high use, how much, what type of patients, how are breaks covered if enhanced care used, are ELOC assessments completed and support this?
Staff sickness within trust threshold (note % from roster analyser)			sickness management in place?
Roster published a minimum of at least 6 weeks in advance .			as per Roster Management Policy and NMC requirements
Shift patterns match patient/staff need			Sufficient staff to cover patients needs across day/night/week day variations, lengnth of shift and adequate break times
Flexible working agreements have been reviewed within the last 12months.			% of staff that have a flexable working agreement, is there any impact on the ability to maintain safe staffing levels?
Patient experience measures in place			FFT feedback, complaints/concerns, learning from complaints/concerns demonstrated, patient advocates used
Student feedback considered			Student feedback surveys, 1:1s, listening to concerns raised, students who joined the ward when qualifying
Escalation plans in place and reviewed			is staffing adjusted to allow for escalation and is this included in budget? Is safe care completed 3 times a day?

Appendix 6 – Operational risk's relating to staffing as of 10th December 2025.

ID	Opened	Title	Division	Rating (current)	Risk level (current)	Last Review Date	Approval status
65	19/12/2019	Lack of Diabetic Specialist Nurse Coverage affecting diabetic services	Division of Medicine - Trustwide	20	High Risk =>15	24/06/2025	Controlled risks
581	16/09/2016	Maternity Staffing Deficit impacting upon the quality & safety of service provided, experience and levels of satisfaction.	Division of Women's and Children's Services - RPH	15	High Risk =>15	28/11/2025	Active risks
126	20/07/2020	Unable to provide sufficient nursing establishment at BAPM standard to manage peak neonatal activity/acuity	Division of Women's and Children's Services - RPH	12	Significant 8-12	26/09/2025	Active risks
178	17/03/2016	Increased level of activity, acuity, suboptimal skill and establishment of nursing staff impacting on patient care	Division of Women's and Children's Services - RPH	12	Significant 8-12	15/10/2025	Active risks
452	11/03/2019	Gynae ward safe nurse staffing	Division of Women's and Children's Services - RPH	12	Significant 8-12	11/11/2025	Active risks
558	19/06/2023	Paediatric ED staffing	Division of Medicine - RPH	12	Significant 8-12	03/12/2025	Active risks
988	04/04/2022	Current staffing template does not reflect establishment required to achieve standards for level 1 ED & MT Centre	Division of Medicine - Trustwide	12	Significant 8-12	30/10/2025	Active risks
1004	14/12/2020	Neurology specialist nurse teams are currently under established.	Division of Medicine - RPH	12	Significant 8-12	25/06/2025	Controlled risks
1325	30/08/2022	Lack of Endocrine Specialist Nurse to support the service	Division of Medicine - Trustwide	12	Significant 8-12	24/06/2025	Controlled risks
1708	25/04/2023	Deferring and rearranging planned consultations in midwifery led services (community midwifery).	Division of Women's and Children's	12	Significant 8-12	30/09/2025	Active risks

			Services - RPH				
2030	14/11/2024	Reduced Staffing Lancashire and South Cumbria Regional Ventilation Service	Division of Medicine - RPH	12	Significant 8-12	09/09/2025	Controlled risks
942	07/12/2020	Lack of staffing resources available within our Children's Community and Specialist Nursing Teams impacting patient safety.	Division of Women's and Children's Services - RPH	10	Significant 8-12	28/11/2025	Active risks
1189	01/09/2021	HFN support for follow up of patients with heart failure across Acute and Community	Division of Medicine - RPH	10	Significant 8-12	30/06/2025	Controlled risks
647	21/10/2020	Risk to patient care due to nurse staffing gaps (HCAs and RNs)	Division of Medicine - Trustwide	9	Significant 8-12	20/10/2025	Active risks
1399	17/03/2023	Lack of Chemotherapy trained staff impacting on capacity for service delivery on the Chemotherapy Unit	Division of Surgery - RPH	9	Significant 8-12	12/11/2025	Active risks
1680	08/03/2023	Risk to patient safety and staff wellbeing due to working outside of GPICS staffing standards	Division of Diagnostics & Clinical Support Services - RPH	6	Moderate 4-5	13/01/2025	Controlled risks
2021	27/11/2024	Inability to provide 6-7 day in-patient pain service over two sites with the current nursing WTE establishment	Division of Diagnostics & Clinical Support Services - RPH	6	Moderate 4-6	14/10/2025	Controlled risks
1535	27/02/2023	Risk to Specialist Workforce & Service Continuity, affecting LTH’s role as the regional centre	Division of Women's and Children's Services - RPH	4	Moderate 4-6	13/11/2025	Controlled risks
729	11/06/2020	Lack of sexual offence examiner (SOE) rota cover for SAFE Centre	Division of Women's and Children's Services - RPH	3	Low 1-3	28/08/2025	Controlled risks

Appendix 7 – Cost Centre WTE and Budget Summary by Division

Budget Summary

	Division	Sum of Funded 25/26 WTE	Sum of Professional Judgement Nov'25	Sum of Proposed Change to Funded WTE 25/26	Sum of Proposed Change to Recurrent Budget wte	Sum of Current Annual Budget 25/26	Sum of Proposed incr/(dec) In Year budget 24/25 requirement	Proposed incr/(dec) Recurrent budget £
Acuity Review Outcome	W&Cs	326.26	350.48	-11.27	-0.31	£17,358,393	£ 1,005,245	-£ 10,507
	Surgery	682.27	683.04	0.77	0.77	£ 2,295,563	-£ 32,979	£ 23,758
	Medicine	888.94	893.87	4.93	4.93	£40,852,265	£ 28,348	£ 14,453
	DCS	204.08	198.57	-5.51	-5.51	£10,823,133	-£ 324,204	-£ 306,649
	Total	**2101.55**	**2125.96**	**-11.08**	**-0.12**	**£71,329,354**	**£ 676,410**	**-£ 278,945**
Changes / approvals outside budget setting - excluded from annual review	CrCU WRP Scheme				-5.51			-£ 306,649
	Changes / approvals outside budget setting Total	**0.00**	**0.00**	**0.00**	**-5.51**	**£ -**	**£ -**	-£ 306,649
Revised Ask / (Reduction)	W&Cs	326.26	350.48	-11.27	-0.31	£17,358,393	£ 1,005,245	-£ 10,507
	Surgery	682.27	683.04	0.77	0.77	£ 2,295,563	-£ 32,979	£ 23,758
	Medicine	888.94	893.87	4.93	4.93	£40,852,265	£ 28,348	£ 14,453
	DCS	204.08	198.57	-5.51	0.00	£10,823,133	-£ 324,204	£ -
	Revised Total	**2101.55**	**2125.96**	**-11.08**	**5.39**	**£71,329,354**	**£ 676,410**	**£ 27,704**

Appendix 8 – Tariff Comparison

		M1 - 8 25/26			M1 - 8 23/24			Tariff Change v 25/26
POD	Specialty	Spells	Price	Av Tariff	Spells	Price	Av Tariff	
NEL	Acute Medicine	4,749	25,631,553	£ 5,397	5,408	23,622,026	£ 4,368	£ 1,029
NEL	Cardiology	426	2,243,954	£ 5,265	348	1,398,895	£ 4,020	£ 1,245
NEL	Diabetes	1,046	5,770,594	£ 5,515	1,653	7,512,664	£ 4,545	£ 970
NEL	Elderly Medicine	2,457	13,780,491	£ 5,609	3,213	14,819,946	£ 4,612	£ 997
NEL	ENT	327	775,819	£ 2,374	277	534,139	£ 1,928	£ 445
NEL	Gastroenterology	194	1,265,724	£ 6,523	272	1,416,685	£ 5,208	£ 1,315
NEL	Gynaecology	267	676,795	£ 2,537	195	372,264	£ 1,909	£ 628
NEL	Max Fax/Oral	148	376,629	£ 2,550	88	242,821	£ 2,759	-£ 210
NEL	Neurology	186	2,525,914	£ 13,584	51	467,094	£ 9,159	£ 4,425
NEL	Neurosurgery	636	9,764,492	£ 15,344	591	7,677,732	£ 12,991	£ 2,353
NEL	Oncology	213	1,261,213	£ 5,935	186	949,868	£ 5,107	£ 828
NEL	Orthopaedics	1,233	11,857,227	£ 9,613	1,138	8,632,890	£ 7,586	£ 2,027
NEL	Paediatrics	4,848	6,494,667	£ 1,340	5,214	5,833,275	£ 1,119	£ 221
NEL	Plastics	463	1,508,201	£ 3,257	599	1,659,001	£ 2,770	£ 487
NEL	Renal	687	4,224,298	£ 6,147	285	1,456,103	£ 5,109	£ 1,038
NEL	Respiratory	795	4,675,066	£ 5,883	547	2,818,372	£ 5,152	£ 731
NEL	Stroke	777	6,440,963	£ 8,287	112	746,799	£ 6,668	£ 1,619
NEL	Upper GI/Colorectal	2,022	11,135,538	£ 5,506	1,855	8,041,810	£ 4,335	£ 1,171
NEL	Urology	612	2,591,751	£ 4,234	548	1,744,951	£ 3,184	£ 1,050
NEL	Vascular	270	4,478,304	£ 16,569	260	3,008,885	£ 11,573	£ 4,996
NELNE	Gynaecology	45	193,092	£ 4,247	69	119,167	£ 1,727	£ 2,520
NELNE	Midwifery	2,701	13,170,737	£ 4,876	2,407	9,296,158	£ 3,862	£ 1,013
NELNE	Neurology	27	280,588	£ 10,288	34	228,867	£ 6,731	£ 3,556
NELNE	Neurosurgery	108	1,656,384	£ 15,340	133	1,509,770	£ 11,352	£ 3,989
NELNE	Obstetrics	422	2,269,665	£ 5,383	497	2,028,469	£ 4,081	£ 1,302
NELNE	Orthopaedics	34	418,844	£ 12,278	36	379,216	£ 10,534	£ 1,745
NELNE	Paediatrics	32	76,202	£ 2,394	73	77,364	£ 1,060	£ 1,335
NELNE	Plastics	103	280,822	£ 2,715	111	337,810	£ 3,043	-£ 329
NELNE	Renal	59	427,933	£ 7,240	56	323,283	£ 5,773	£ 1,467
NELNE	Vascular	67	1,062,604	£ 15,845	78	959,084	£ 12,296	£ 3,549
NELST	Acute Medicine	5,594	4,423,840	£ 791	5,003	3,525,168	£ 705	£ 86
NELST	Cardiology	118	119,067	£ 1,013	81	78,701	£ 972	£ 42
NELST	Diabetes	628	616,637	£ 982	792	673,329	£ 850	£ 132
NELST	Elderly Medicine	1,109	1,099,723	£ 992	1,333	1,323,642	£ 993	-£ 1
NELST	ENT	297	310,525	£ 1,044	263	193,818	£ 737	£ 307
NELST	Gastroenterology	55	62,698	£ 1,134	63	67,156	£ 1,066	£ 68
NELST	Gynaecology	2,434	1,998,203	£ 821	1,759	1,186,563	£ 675	£ 146
NELST	Max Fax/Oral	43	68,619	£ 1,611	38	86,540	£ 2,277	-£ 667
NELST	Neurology	48	677,491	£ 14,002	62	732,726	£ 11,818	£ 2,184
NELST	Neurosurgery	114	1,041,530	£ 9,138	106	1,006,338	£ 9,494	-£ 356
NELST	Oncology	634	678,494	£ 1,070	16	11,879	£ 742	£ 328
NELST	Orthopaedics	213	551,139	£ 2,586	183	389,033	£ 2,126	£ 460
NELST	Plastics	485	532,687	£ 1,098	554	510,581	£ 922	£ 176
NELST	Renal	309	295,932	£ 958	167	141,831	£ 849	£ 109
NELST	Respiratory	275	297,024	£ 1,079	199	214,747	£ 1,079	-£ 1
NELST	Stroke	268	479,291	£ 1,785	63	96,205	£ 1,527	£ 258
NELST	Upper GI/Colorectal	2,036	2,146,361	£ 1,054	1,589	1,472,202	£ 926	£ 128
NELST	Urology	831	852,732	£ 1,026	641	546,203	£ 852	£ 174
NELST	Vascular	65	195,050	£ 3,023	46	123,849	£ 2,692	£ 331
Total								£ 51,417

11.3 - MATERNITY AND NEONATAL SERVICE UPDATE

REFERENCES

Only PDFs are attached

11.3 - Ancillary Maternity and Neonatal Safety Report. Feb 2026.pdf

Maternity and Neonatal Services Safety and Clinical Negligence Scheme for Trusts (CNST) Validation Report

1. INTRODUCTION

The purpose of this report is to provide an overview of the Trust's safety and quality programmes up to the end of December 2025. It includes workforce data, patient experience metrics, and clinical effectiveness indicators for assurance and oversight. The report also details the final position at the end of the Year 7 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) reporting period. Supplementary information is provided in Appendices 1, 2, and 3 to ensure appropriate Board-level oversight of performance and perinatal outcomes.

2. MATERNITY INCENTIVE SCHEME (MIS)

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

Table 1 provides an overview of the status of all 10 safety standards at the end of the reporting period (1 December 2024 to 30 November 2025) and provides high-level summary of the actions taken to meet the requirements for MIS year 7. Following validation by the Local Maternity and Neonatal System (LMNS), the service confirms that evidence of compliance against each of the ten standards has been signed off and that all ten CNST standards have been met (10/10).

To be eligible for the NHS Resolution (NHSR) incentive scheme remuneration, the Trust Board must receive a joint presentation detailing progress against the maternity safety actions which is delivered by the Director/Head of Midwifery and the Clinical Director for Maternity Services. It must occur prior to the Trust's submission and declaration of compliance to NHSR by the Chief Executive Officer (CEO) and the Integrated Care Board (ICB) Accountable Officer (AO), which is due by 12 noon on 3 March 2026.The joint presentation is included in Appendix 2.

2.1 MIS STANDARD 8 PROMPT AND FETAL MONITORING

FETAL MONITORING

Compliance for fetal monitoring training in December 2025 is currently above 90% for midwives (98% compliance (186 out of 190 compliant). Consultant compliance is 100% (11 out of 11 Consultants).

Obstetric Doctors 84% compliant –16 of 19 doctors This reduction in compliance is as result of the doctors' rotation and strikes affecting attendance. Training dates are arranged within 6-month window as per MIS standards.

PROMPT

Compliance for PROMPT training for December 2025 overall is 97%. Midwives are 99% (195 out of 196) and support workers 98% (57 out of 58). Consultant obstetricians are 100% and rotational trainees are 78%. All non-compliant staff have been booked for training within 6 months of start date. The service can declare compliance with standard 8 because an action plan has been approved by the Trust Board. This has been formally recorded in the Trust Board minutes.

Table 1 Details the status of all 10 safety actions

	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 36 cases reported within the reporting period, 27 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. For at least 95% of all deaths of babies who died in your Trust from 1 December 2024, were parents' perspectives of care sought and were they given the opportunity to raise questions. 100% of parent's perspectives have been considered. All final reports are presented to the Trust Safety and Quality Committee and Board of directors on a quarterly basis.	Appendix 1. Standard 1	Standard Achieved for year 7	Validated 17.12.2025
		NEW MIS YEAR 7. 50% of the deaths reviewed 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. 11/11 reviews that have been concluded in the reporting period have had external representation.		Standard Achieved for year 7	Validated 17.12.2025
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. 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	Detailed in previous iterations of the report Compliance achieved to date (July 2025)	Standard Achieved for year 7	Validated 17.12.2025

		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 and the service confirms that the standard has been achieved and published.					
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.	Detailed in previous iterations of the report	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. 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.	Shared in previous reports	Standard Achieved for year 7	Validated 11/09/2025
		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
		Anaesthetics 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	Standard	Progress	Evidence	Status	
Midwifery Staffing	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.	Standard Achieved for year 7	Validated 17.12.2025
		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	Standard Achieved for year 7	Validated 17.12.2025
		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. During the reporting period two safe staffing reports have been submitted at 6 monthly intervals.	Shared with the Board	April 2025 September 2025	Validated 17.12.2025

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 to 100%.	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.					
Safety Action 7 MNVP	Standard	Progress	Evidence Source	Status	Validated
	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. The work plan has also been shared at the ICB board in October 2025. The service confirms that it utilises the annual CQC maternity survey free text data to collate the action plan each year. The latest report is current embargoed, however work to collate the actions in response to 2024 findings has jointly been completed by the MNVP lead and will be shared with the Safety Champions once published. Previous iterations of this report have aligned to this standard. 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.	Detailed in previous iterations of the report	Standard Achieved for year 7	Validated 17.12.2025
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. The service also confirms that it has at least one multidisciplinary emergency scenario is conducted in the clinical	Appendix 1 Safety Action 8.	Standard Achieved for year 7	Validated 17.12.2025

		area. Delivery suite and birth centres are utilised for multi-disciplinary emergency skills sessions during the PROMPY day. **PROMPT** Compliance with PROMPT is 97% overall in December 2025. All Staff groups are over 90% except for trainee doctors' compliance- 78% **Action:** New rotational trainee doctors who commenced work on or after 1 July 2025 a lower compliance will be accepted. This is providing that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust. All outstanding doctors are booked on to dates and an action plan for achievement of the standard is included in the report. It is anticipated that all staff groups will be over 90% by the end of the reporting period or within 6 months of start dates. **ANAESTHETICS** For rotational anaesthetic staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. This is providing that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust Compliance for all groups over 90% **STANDARD MET at end of reporting period. all eligible groups over 100%.** **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%) **STANDARD MET all eligible groups over 90% at the end of the reporting period.** **FETAL MONITORING** – 97% compliance achieved overall for the full day fetal monitoring training. **Trainee doctors'** compliance **84%** in December 2025. New rotational trainee doctors who commenced work on or after 1 July 2025 a lower compliance will be accepted. This is providing that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust.			

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 directorate) meeting. The report was shared in September 2025 Safety Champions meeting.	Shared in previous iterations of the report	Standard Achieved for year 7	Validated 11/09/2025

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. The standard requires that information and reports are shared with families in a format that was suitable to them. The clinical governance and risk midwife contacts all families and agrees a personalised plan for responses which may include information in their chosen language.	Appendix 1 Safety Action 10.	Standard Achieved for year 7	Validated 17.12.2025

A quarterly report is collated on AMAT to confirm that all qualifying cases have been reported in line with MIS year 7.

3.0 PERINATAL QUALITY SURVIELLENCE DASHBOARD- PART 2

The Board of Directors has accountability for perinatal oversight, with a statutory duty to ensure the safety of care, including the provision of resources required. To track performance, the perinatal quality surveillance dashboard (PQSD) (Appendix 3) is presented in the maternity and neonatal safety report to ensure this function is undertaken.

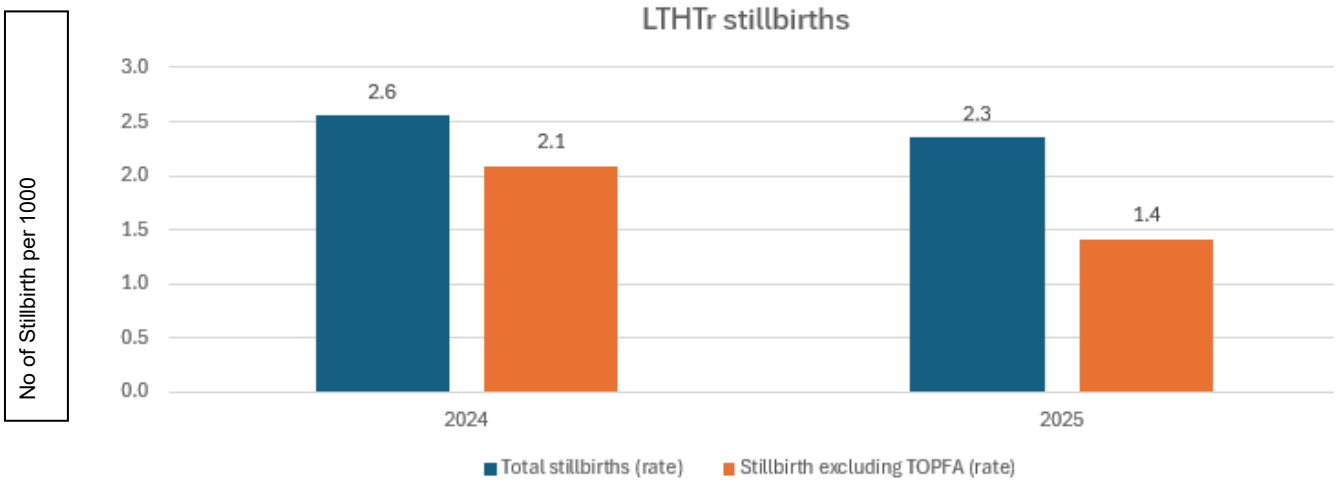
The statistical process control (SPC) is used to interpret the statistical significance of data, to identify trends and variations in care delivery and outcomes, offering insights into areas where improvements may be needed to reduce disparities in care. By tracking important indicators (e.g. maternal and neonatal outcomes, complications, and mortality rates), the dashboard helps identify areas of concern early, enabling timely interventions and action.

3.1 CLINICAL SAFETY INDICATORS

3.2 STILLBIRTH

The locally calculated stillbirth rate continues to be closely monitored monthly by the service. The mean still birth rate for 2025 is 2.3 per 1000 births. Chart 1 details the local comparison data between 2024 and 2025 for stillbirths overall including/excluding termination of pregnancy for fetal abnormalities.

Chart 1 Comparison of local stillbirth data including 2024 and 2025



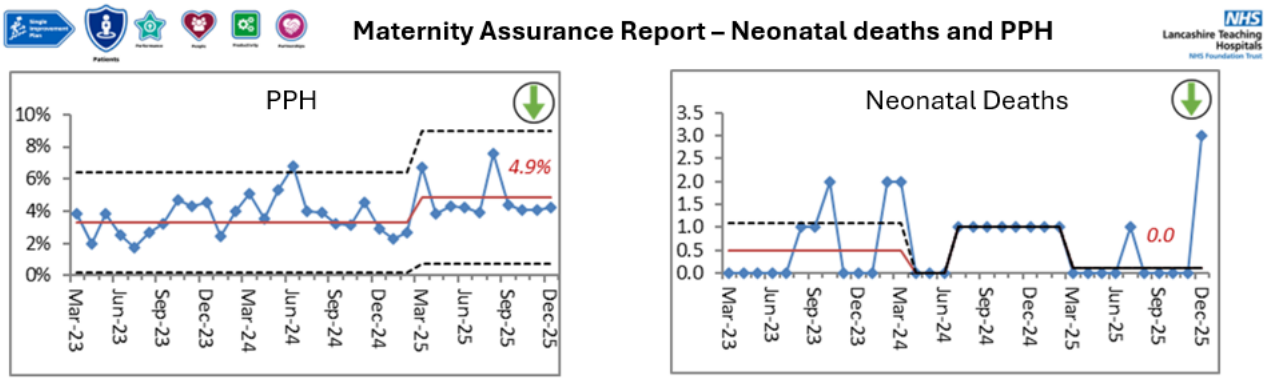
The total stillbirth rate decreased from 2.6 per 1000 to 2.3 per 100 births, while the rate excluding terminations for fetal anomaly (TOPFA) saw a more significant reduction from 2.1 per 1000 births to 1.4 per 1000 births. This trend indicates progress in reducing stillbirths, particularly in cases unrelated to fetal abnormality. All cases continue to be reported to MBRRACE via SPEN and will be subject to a Perinatal Mortality Review.

MBRRACE-UK publishes Trust-level stillbirth and neonatal death rates annually in its Perinatal Mortality Surveillance Report. These rates include both crude and adjusted figures, enabling benchmarking against population risk factors such as maternal age, ethnicity, and deprivation.

Adjusted rates are critical because they reflect care quality rather than demographic differences, ensuring that comparisons between Trusts are meaningful and equitable. Local figures will be reported alongside MBRRACE data which is expected in June 2026.

3.3 EXCEPTIONS REPORTING - NEONATAL DEATH WITHIN 7 DAYS AND POSTPARTUM HAEMORRAGE (PPH)

Analysis of the maternity dashboard indicates that Postpartum Haemorrage (PPH) and Neonatal death within 7 days is higher than expected. Chart 2 details the SPC charts for reporting by exception.



The SPC for PPH is demonstrating a statistical increase since Mar-25 going from 3.3% to 4.9% on average. This represents a 48% increase. In response, the service has commenced a PPH specific Multi professional task and finish group to consider findings from ongoing PPH thematic reviews and agree working actions for improvement. Actions to reduce PPH features in the new national maternal care bundle (See section).

Neonatal death (NND) within 7 days is unusually high in December 2025. This is related to 3 cases the first 2 being a preterm multiple pregnancy and intrauterine transfer at 25 weeks, who developed sepsis. The other case was an intrauterine transfer for a level 3 neonatal cot. The baby was born at 22 weeks following preterm ruptured membranes.

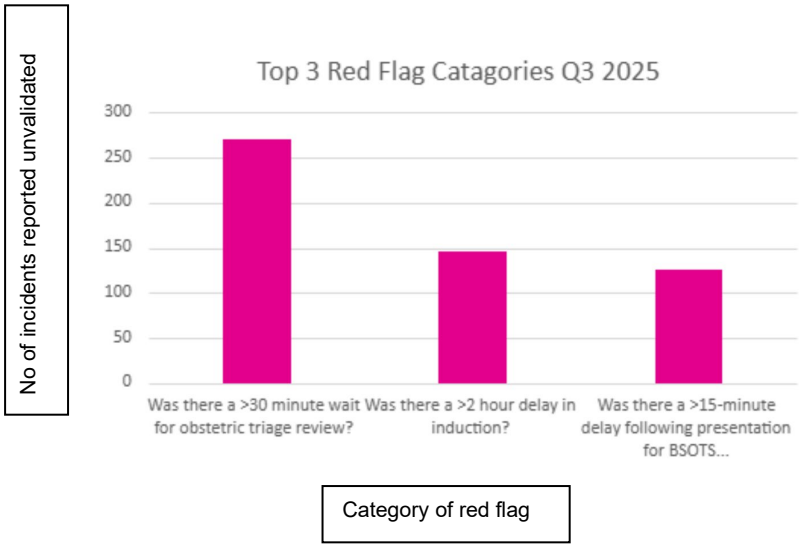
All cases will be reviewed via the Perinatal Mortality Review process and associated actions will be agreed in due course. The NND rates will continue to be closely monitored.

3.4 RED FLAGS QUARTERLY SUMMARY

It is recommended by CNST that Trusts monitor and include safe midwifery staffing red flags as part of reporting mechanisms, however this is not currently mandated. Red flags monitor safe staffing and ensure that early warning signs—such as delays in triage, delay in induction or missed observations—are systematically captured and acted upon. At a high level, this approach supports proactive risk management by linking clinical safety directly to workforce capacity.

Chart 3 details the red flags that have been reported up until December 2025. The highest number of red flags were reported in the category of delays in review by an obstetrician/midwife in the maternity assessment suite (MAS). Delay in the induction process also features in the highest reporting categories. All incidents associated with delay are reviewed and monitored and linked to the risk register. A breakdown of all red flags is included in appendix 4.

Chart 3 Top 3 Red Flag reporting Categories Quarter 3 (October to December 2025)



3.7 DELAYS IN INDUCTION OF LABOUR

Delays in induction of labour (IOL) continue to be monitored closely and performance continues to be included in the report because delay in induction directly reflects both clinical effectiveness and operational efficiency when managing maternal and fetal risk. IOL is also linked directly to patient experience outcomes for families. (Appendix 5). The service has successfully commenced a new method of non-pharmacological induction and this is being rolled out and evaluated.

3.8 CLOSURES OR DIVERTS MATERNITY/ NEONATAL

In quarter 3 (October-December 2025) the service was required to divert on 1 occasion. This is a reducing trend since quarter 1 and 2. Although this is an improved position, this risk indicator requires ongoing monitoring as repeated diverts may signal sustained operational pressure which places risk on service resilience.

In quarter 3 (October-December 2025) the neonatal service was required to close to external admissions on 4 separate occasions. Closures related to ongoing pressures with intensive care and high dependency cot capacity and staffing unavailability. This is discussed further in section 4.1

3.9 ELECTIVE CAESAREAN SECTION CAPACITY RISING DEMAND AND COMPLEXITY FOR CAESAREAN SECTION

Caesarean section rates in the UK have risen steadily over the past five years, with elective procedures forming a significant proportion of births (BMJ, 2021). Drivers include increasing maternal age, medical comorbidities, patient choice, and previous caesareans. This emerging trend is placing considerable strain on theatre capacity and resources, resulting in overbooked lists, overruns, and displacement of other planned procedures within Gynaecology.

Historically and when required gynaecology activity has been stood down to prioritise maternity cases. Additional weekend lists continue to be utilised to manage demand. From January 2026, full-day elective caesarean lists will be introduced to improve efficiency, though this is not likely to increase capacity. A longer-term solution is required and a theatre efficiency project alongside further work to understand overall capacity for all Caesarean births is ongoing led by the women's health operational team.

To address system-wide capacity challenges, a Caesarean Section Summit is being convened by the ICB with Executive leaders across the four Lancashire and South Cumbria providers to agree strategic actions to respond to this.

4.0 SAFE STAFFING INDICATORS

The Three-Year Delivery Plan for Maternity and Neonatal services (March 2023) states that services should undertake regular workforce planning reviews every 3 years. In line with recommendations the latest re-assessment has been undertaken by the service between April and December 2025. The final report has now been received and recognises the increase in complexity of cases. A workforce uplift is recommended and details of this will be provided to the Safety and Quality Committee in February 2026 as part of the annual safe staffing paper. It is anticipated that a phased approach to funding requirements will be recommended.

The projected vacancy for registered midwives is 2.93 WTE (including maternity leave) by May 2026. The vacancy continues to be tracked to ensure timely response to establishment gaps. However, delays in the vacancy control, recruitment and onboarding are affecting the services ability to fill all vacancies with escalation taking place to the CNO as required.

The fill rates for Registered Midwives (RM 88% day and 82% night) and Maternity Support Workers (MSW 79% day and 92% night) in December 2025 demonstrate reduced fill rates for midwives and day shifts for support workers. It is anticipated that fill rates will improve once all new starters are in post and have completed their supernumerary period.

4.1 NEONATAL BRITISH ASSOCIATION OF PERINATAL MEDICINE (BAPM) NURSE STAFFING

In November and December 2025, compliance with BAPM nurse staffing ratios reduced from 72.5% to 53% and 62.9% respectively. This was driven by a 34% overall staff unavailability (including 12% maternity leave and 10% sickness) alongside increased intensive care and high dependency cot demand, requiring higher nurse-to-patient ratios. There have been no adverse outcomes as a result of this. Limited bank and agency uptake further compounded pressures, resulting in reduced compliance overall. A plan to manage the high levels of maternity leave in neonatal services is in development. All vacant shifts continue to be sent to bank and agency as required with close oversight of workforce data from the Deputy/Divisional Nursing Directors.

5.0 PERINATAL QUALITY GOVERNANCE EXPERIENCE AND REGULATION

5.1 PERINATAL OVERSIGHT -REPORTING FOR MATERNITY SAFETY

On the 15 December 2025 a 4-week Maternity Daily Situation Report (SitRep) pilot commenced. Following the pilot SitRep, it has been confirmed that this process will be continued, and all maternity units will be expected to submit data daily in relation to delays in induction, deferred caesarean section and maternity and neonatal unit diverts. This will provide real-time oversight of safety and operational pressures, enabling early risk identification and rapid escalation as required. The submission will run alongside the existing LMNS GOLD provider call.

5.2 MATERNAL CARE BUNDLE

The Maternity Care Bundle, launched January 2026, sets out national best-practice standards across five critical clinical areas to reduce maternal mortality, serious illness, and health inequalities in England. It responds to rising maternal deaths (up 21% since 2009) and disparities in outcomes for Black women and those in deprived communities. This bundle promotes a whole-system, equity-focused approach, requiring collaboration across maternity, emergency, mental health, primary care, ambulance, and specialty services.

The Care Bundle focuses on five critical areas to improve safety and outcomes. It includes:

- Venous thromboembolism, ensuring early risk assessment and timely prevention
- Pre-hospital and acute care with robust escalation pathways and recognition of deterioration
- Epilepsy in pregnancy, providing access to specialist multidisciplinary support
- Maternal mental health, through consistent screening and prompt referral
- Obstetric haemorrhage, with standardised protocols for identifying and responding to bleeding.

It is expected that the CNST MIS year 8 standards will incorporate the maternal care bundle into its recommendations and further information on how the service will embed requirements will be included in the report in due course.

5.3 EXTERNAL LEARNING FROM CORONIAL CASES HOMEBIRTH

Following the recent Prevention of Future Deaths report and regulatory notice issued to Manchester Foundation Trust after a maternal and neonatal death during a home birth, the maternity service is part of a regional rapid task and finish group (12-week duration) undertaking a comprehensive review of home birth provision. Each organisation has competed a home birth service questionnaire and responses have been collated. It is anticipated that the output from the task and finish group will inform a regional home birth charter. Updates on the progress will be included in future iterations of this report. There are currently no areas of concern within the home birthing service.

The Divisional Midwifery and Nursing Director and Consultant Midwife have considered the current service provision for birth in the home. They confirm that the home birth service can continue to safely function in a continuity model, but that ongoing risk assessment will continue whilst the recommendations from the working group are finalised.

5.4 CONTINIOUS IMPROVEMENT AND QUALITY

Services are encouraged to use an appreciative inquiry approach to continuous improvement and learning. The service is undertaking several projects aimed at proactive change outcome monitoring. At present this includes the induction of labour service review and the MIS year 7 standard 3 project is based on reducing term admissions associated with respiratory distress. This is the leading cause of admission.

The service has also submitted a quality improvement bid for funding from the North West Maternal Medicine Network (MMC) The project involves developing and implementing an AI-powered training aids using an established AI platform, tailored to case-based learning for complex emergencies and maternal medicine scenarios. Following this initial submission, the team have been selected to present the project at the Maternal medicine clinical reference group. (CRG). The outcome of this will be shared in due course.

5.5 PERINATAL CULTURE

The review into the culture across maternity and gynaecology services has concluded, and the report has been shared with the Divisional Senior Leadership Team. A series of feedback meetings facilitated by the Deputy Director of Workforce and Organisational Development (OD) are being arranged for colleagues who contributed to the review, with some already having taken place. Once these have concluded an action plan will be agreed and implemented with support from the OD team

6.0 WELL-LED/CELBRATING SUCCESS.

Following the success of the Race and Health Observatory (RHO) work reducing disparity in outcomes for women of black or ethnic women who experience postpartum haemorrhage, representatives from the Lancashire Teaching hospitals are attending a national next steps for Maternity and Neonatal Health Equity, learning from the RHO Learning and Action Network Event. Members of the team are included in an expert panel to share best practice from the project.

The work to progress the restorative courtyard for staff and services users in the Sharoe Green Unit is progressing well. This work is welcomed and may improve staff morale as they will have a quiet area to rest during breaks.

7.0 CONCLUSION

This report provides an update in relation to the safety and quality programmes of work within the maternity and neonatal services and details the final position against the workstreams set out by the CNST NHS Resolution for year 7.

The service confirms that following validation by the Local Maternity and Neonatal System (LMNS)/ICB, that that all ten CNST standards have been met (10/10). Meeting criteria for MIS standard 8 is based on the approval of the action plan for training and an agreement by the board of directors to monitor the trajectory to meet 90% compliance for trainees for PROMPT and fetal monitoring within 6 months of their start date.

The perinatal quality surveillance dashboard and the red flag reporting indicate areas of pressure within the service. Areas of increased focus have been identified in relation to the management of PPH and the task and finish group will support and align to the maternal care bundle recommendations.

9.0 RECOMMENDATIONS

The Board of Directors is asked to:

i. Receive the report, including the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) supplementary information pack and associated action plans which has been scrutinised by the Safety and Quality Committee at the end of MIS year 7.

ii. Note the inclusion of the joint presentation and final position for the MIS Year 7 standards (see Appendix), confirming that the Safety and Quality Committee and LMNS/ICB are satisfied with the evidence of compliance against all 10 standards.

iii. Approve the instruction for the Trust Board to give permission to the Chief Executive Officer (CEO) to sign the Board declaration form prior to submission to NHS Resolution on the 3 March 2026.

iv. Approve the instruction to share the Board declaration with the Accountable Officer (AO) for their Integrated Care Board (ICB) for sign off prior to submission to NHS Resolution on the 3 March 2026.

v. Confirm it is assured of the oversight and monitoring mechanisms within maternity services.

CLINICAL NEGLIGENCE SCHEME FOR TRUST INFORMATON PACK
CNST MIS YEAR 7
APPENDIX 1

SAFETY ACTION ONE – PMRT POSITION

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	36/36 (All eligible cases for the standard)	
	Surveillance	27/27 (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	27/27 (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. 27/27	
		Completed within 6 months: All cases. 11/11 cases who were eligible for external review have had an external representative.	
REQUIRED STANDARD (Standard D) *			
Report to the Trust Executive: Quarterly reports of reviews of all deaths should be discussed with the Trust Maternity and Board Level Safety Champions and submitted to the Trust Executive Board on an ongoing basis from 1 December 2024	April 2025		
	July 2025		
	October 2025		
	December 2025		

STANDARD ONE PMRT INCIDENT TRACKER DECEMBER 2025 to date

ID (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: 183923 PMRT ref: 96649	Antepartum Stillbirth	Yes	Yes	Review completed and published.	All action completed.
Datix: 184488 PMRT ref: 96661	Antepartum Stillbirth	Yes	Yes	Review complete and published	Action plan ongoing
Datix: 185485 PMRT ref: 96845	Antepartum Stillbirth	Yes	Yes	Review complete and published	Action plan ongoing
Datix: 185771 PMRT ref: 96909	Neonatal death	Yes	Yes	Review complete and published.	Action plan completed
Datix: 186495 PMRT: 97036	Antepartum stillbirth	Yes	Yes	Review completed and published	Action plan completed
Datix: 190522 PMRT: 97476	Antepartum stillbirth	Yes	Yes	Review completed and published	Action plan ongoing
Datix: 190652 PMRT: 97562	Neonatal death	Yes	Yes	Review completed and published	Action plan ongoing
Datix: 194158 PMRT: 98023	Neonatal Death	Yes	Yes	Review completed and published	All actions completed
Datix: 199030 PMRT: 98587	Neonatal death	Yes	Yes	Review completed and published	Action plan ongoing
Datix: 200483 PMRT: 98785	Neonatal Death	Yes	Yes	Review completed and published	All actions completed
Datix: 201846 PMRT: 98925	Stillbirth	Yes	Yes	Review completed and published	Action plan ongoing

ID (Datix/PMRT)	Stillbirth/ Neonatal death	PMRT upload date	Parents informed	Report drafted within 6 months	Actions ongoing
Datix: 202672 PMRT: 99071	Stillbirth	Yes	Yes	Review Completed and Published Family meeting on 16.01.2026	Action plan ongoing
Datix: 205611 PMRT: 99398	Neonatal Death	Yes	Yes	Review Completed and Published. Family meeting to be arranged	Action plan ongoing
Datix: 211090 PMRT: 100195	Neonatal Death	Yes	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing	Action plan ongoing
Datix: 213787 PMRT: 100564	Stillbirth	Yes	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing	Action plan ongoing
Datix: 215638 PMRT: 100814	Stillbirth	Yes	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing	Action plan ongoing
Datix: 216358 PMRT: 100913	Neonatal Death	Yes	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing	Action plan ongoing
Datix: 220385 PMRT:101477	Neonatal Death	Yes	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing	Action plan ongoing
Datix:221771 PMRT:101653	Neonatal Death Twin 1			Review ongoing, deadline not yet met. PMRT planned with deadline for publishing	Action plan ongoing
Datix:221769 PMRT:101658	Neonatal Death Twin 2	Yes	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing	Action plan ongoing
Datix:222756 PMRT:1018202	Stillbirth Twin 2	Yes	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing	Action plan ongoing

STANDARD ONE PMRT INCIDENT COMPLETED CASES GRADING OF CARE AND LEARNING YEAR 7 PMRT CASES

ID (Datix/PMRT)	Stillbirth/ Neonatal death		Grading of Care			Key Learning
		Grading of care of the mother and baby up to the point of birth of the baby - NND	Grading of care of the mother and baby up to the point that the baby was confirmed as having died - SB	Grading of care of the mother following confirmation of the death of her baby – NND/SB	Grading of care of the baby from birth up to the death of the baby - NND	
Datix: 182227 PMRT: 96388	Antepartum Stillbirth	NA	A	A	NA	**No Actions** identified for the Trust
Datix: 183923 PMRT ref: 96649	Antepartum Stillbirth	NA	B	A	NA	Learning: Documentation: The mother's progress in labour was not monitored on a partogram. Not relevant to the outcome, and no action is needed
Datix: 184488 PMRT ref: 96661	Antepartum Stillbirth	NA	B	B	NA	**Learning:** The Trust will strengthen the guidance in relation to management of UTI in pregnancy. When women present with multiple pregnancy they must be offered a cervical length scan. When women score for sepsis, ensure amber flags are acted upon in a timely manner.
Datix: 185485 PMRT ref: 96845	Antepartum Stillbirth	NA	D- StEIS reported	A	NA	**Learning:** Review of the guideline for referral pathway for ultrasound from a community setting. Reminder to staff to be sent via ward managers the importance of interpretation services. Reduced movement visual aid to support clinical decision making. Review the guidelines to be aligned with the NW regional guideline (Small for gestational age)
Datix: 185771	Neonatal death at	B	NA	A	B	**Learning:** Decision making. Clinical risk assessment not undertaken after 12-week ultrasound.

ID (Datix/PMRT)	Stillbirth/ Neonatal death		Grading of Care			Key Learning
		Grading of care of the mother and baby up to the point of birth of the baby - NND	Grading of care of the mother and baby up to the point that the baby was confirmed as having died - SB	Grading of care of the mother following confirmation of the death of her baby – NND/SB	Grading of care of the baby from birth up to the death of the baby - NND	
PMRT ref: 96909						
Datix: 186495 PMRT: 97036	Antepartum stillbirth	NA	A	A	NA	**No Actions** identified for the Trust
Datix: 190522 PMRT: 97476	Antepartum stillbirth	NA	C	B	NA	**Learning:** Missed treatment and management of BV. Cord sample not sent for histology
Datix: 190652 PMRT: 97562	Neonatal death	B	NA	A	C	**Learning:** Delay in fetal heart monitoring Monitoring of the baby's condition should have included additional blood gas monitoring. (NICU)_ Late dose of antibiotics in NICU
Datix: 194158 PMRT: 98023	Neonatal Death	A	NA	B	A	**Learning:** Antibiotics and IV fluids were not completed within the first hour. (NICU). Placenta not sent for histology
Datix: 199030 PMRT: 98587	Neonatal death Shared case	C- Not attributed to the Trust	NA	B	A	**Learning:** Delayed cord clamping not undertaken Antibiotics were delayed in the neonatal period (NICU)
Datix: 200483 PMRT: 98785	Neonatal Death	A	NA	B	A	**Learning:** Antibiotics were given 1 hour late due to prioritisation of stabilising the neonate. Extravasation of the UVC. This would have made no difference to the outcome for the baby given the prematurity
Datix: 201846 PMRT: 98925	Intrapartum Stillbirth	NA	B	A	NA	**Learning:** When ruptured membranes was suspected a senior review was not undertaken. This would have made no difference to the outcome for the baby.

ID (Datix/PMRT)	Stillbirth/ Neonatal death		Grading of Care			Key Learning
		Grading of care of the mother and baby up to the point of birth of the baby - NND	Grading of care of the mother and baby up to the point that the baby was confirmed as having died - SB	Grading of care of the mother following confirmation of the death of her baby – NND/SB	Grading of care of the baby from birth up to the death of the baby - NND	
Datix: 202672 PMRT: 99071	Stillbirth	NA	B	A	NA	**Learning:** The ultrasound scan should have been considered when the fetal heart had a raised baseline. This would have made no difference to the outcome for the baby.
Datix: 205611 PMRT: 99398	Neonatal Death	D- To be StEIS reported	NA	A	A	**Learning:** Management of the second stage of labour was not in accordance with the guideline. Clinical escalation was not undertaken when concerns with the fetal heart monitoring. Fetal monitoring not undertaken in the second stage of labour as per guideline. Overarching action plan in place.

SAFETY ACTION EIGHT TRAINING MATERNITY AND NEONATAL OCTOBER 2025

TRAINING- DECEMBER 2025	MIDWIVES	CONSULTANTS	DOCTORS	COMPLIANCE PERCENTAGE OVERALL
Fetal Growth	**97%** *185 out of 190*	**100%** *11 out of 11*	**84%** *16 out of 19*	**96%** (3% increase) *212 compliant out of 220*
Fetal Monitoring training Attendance at full day fetal monitoring training	**98%** *186 compliant out of 190*	**100%** *11 compliant out of 11*	**84%** 16 *compliant out of 19*	**97%** (1% increase) *213 compliant out of 220*
CTG update (Delivered as part of PROMPT or attendance at CTG meeting)	**99%** *195 compliant out of 196*	**100%** *11 compliant out of 11*	**84%** *16 compliant out of 19*	**98%** (increase 1%) *222 compliant out of 226*

TRAINING- DECEMBER 2025	MIDWIVES	CONSULTANT	DOCTORS	ANAESTHETIST CONSULTANTS	ANAESTHETIST ROTATIONAL	MATERNITY SUPPORT WORKERS	COMPLIANCE OVERALL
OBSTETRIC EMERGENCIES (PROMPT)	**99%** 195 out of 196	**100%** 11 out of 11	**78%** 21 out of 27	**100%** 14 out of 14	**100%** 6 out of 6	**98%** 57 out of 58	**97%** (remains the same) *304 compliant out of 312*
Pool Evacuation	**99%** 195 out of 196	**100%** 11 out of 11	**78%** 21 out of 27			**98%** 57 out of 58	**97%** (remains the same) *304 compliant out of 312*

TRAINING- DECEMBER 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	**100%** *79 compliant out of 79*	**100%** *6 compliant out of 6*	**100%** *9 compliant out of 9*	**100 %** *5 compliant out of 5*	**100 %** *7 compliant out of 7*	**100%** *7 compliant out of 7*	**99%** *113 compliant out of 113*
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*

SAFETY ACTION 8 TRAINING ACTION PLAN

Version	Date
V1	09.09.25
V2	1.11.2025
V3	31.12.2025

Action Plan – Education and Training for Maternity CNST MIS Standard 8

Ref		Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence	Current Status 1 2 3 4
1		Review compliance for individual groups against CNST SA8 technical guidance to allow rotational trainees a grace period to attend fetal monitoring and PROMPT training (allows for a 6-month period for agreed staff groups from start dates).	Fetal Monitoring Lead Practice Educator	12 September 2025	09.09.2025 Action plan shared via Maternity Safety and Quality Committee	
				31 December 2025	1.11.2025 Dates booked for all staff and prioritised based on rota fill and timeframe for completion within 6 months.	
		Review data and calculate compliance for training based on individual staff groups.	Fetal Monitoring Lead	~~12 September 2025~~ 31 March 2026	09.09.2025 Training data/Trajectory developed to achieve within 6 months of start date- 31.12.2025 Deadline extended to reflect the timeframe for completion for trainees.	
		Identify additional training dates to book staff members onto training, to support compliance and extra attendance at training days.	Fetal Monitoring Lead Practice Educator	12 September 2025	09.09.2025 Book any required training dates for colleagues who are non-compliant	

2		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 Practice Educator	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 Practice Educator	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 Practice Educator	By 30 September 2025	09.09.2025 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	09.09.2025 Email	
3		Gather training data compliance monthly, for September, October, November and December to ensure training data is on track to achieve compliance.	Fetal Monitoring Lead Practice Educator	30 November 2025	09.09.2025 Training update presented at Maternity S&Q monthly.	

STANDARD 10. CASES REPORTED FROM DECEMBER 1, 2024, TO DECEMBER 2025.

MI number	Early Notification applicable	Early notification completed	Agreed format for sharing with family	Status of MNSI investigation	Duty of Candour.
MI-041706	No	NA Does not qualify	Yes	Investigation ongoing	Yes
MI-041480	Yes	Yes	Yes, Letter shared in chosen language Urdu	Investigation ongoing	Yes
MI-044325	Yes	Yes	Yes	Investigation ongoing	Yes
MI-044943	Yes	Yes	Yes	Investigation ongoing	Yes
MI-046028	Yes	Yes	Yes, Letter shared in chosen language Malayalam	Investigation ongoing	Yes
MI-049535	Yes	Yes	Yes	Investigation ongoing	Yes
Mi- 050634	Yes	Yes	Yes	Investigation ongoing	Yes

CLINICAL NEGLIGENCE SCHEME FOR TRUSTS MATERNITY INCENTIVE SCHEME YEAR 7 JOINT PRESENTATION. APPENDIX 2

NHS
Lancashire and South Cumbria
Integrated Care Board

Lancashire Teaching Hospital Trust

Maternity Incentive Scheme Year 7

Joint Report Divisional Director of Midwifery and Nursing and Clinical Director for Obstetrics.

LMNS Assurance Process 2025

NHS
Lancashire and South Cumbria
Integrated Care Board

- The Year 7 Quality Assurance Process included a total of 3 quarterly visits (noting additional visits would be undertaken if required)
- The December visit was the third LMNS review of MIS programme of work since the launch/publication in April 2025. Previous reviews undertaken in June and September 2025.
- To note as part of the LMNS governance meetings – MIS is a standard agenda item, to enable the Trust to formally present to panel members evidence in relation to Safety Action 3,4,5,7 and 9.

Maternity Safety Actions MIS Year 7

NHS
Lancashire and South Cumbria
Integrated Care Board

Action No.	Maternity safety action	Action met? (Y/N)	Met	Not Met	Info	Check Response	Not filled in
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes	7	0	0	0	0
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes	2	0	0	0	0
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes	5	0	0	0	0
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes	11	0	1	0	0
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes	6	0	1	0	0
6	Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes	5	0	0	0	0
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes	4	0	0	0	0
8	Can you evidence the following 3 elements of local training plans and 'in -house', one day multi professional training?	Yes	20	0	1	0	0
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Yes	9	0	0	0	0
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?	Yes	8	0	0	0	0

Safety Action 1 PMRT

NHS
Lancashire and South Cumbria
Integrated Care Board

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all eligible perinatal deaths from 1 December 2024 onwards been notified to MBRRACE-UK within seven working days? (If no deaths, choose N/A)	Yes
2	For at least 95% of all deaths of babies who died in your Trust from 1 December 2024, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Yes
3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 1 December 2024 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Yes
4	Were 75% of all reports completed and published within 6 months of death? MIS verification period: Dec 2024 to April 2025 60% of cases. 2 April 2025 to 30 Nov 2025 75% of cases	Yes
5	For a minimum of 50% of the deaths reviewed, was an external member present at the multi-disciplinary review panel meeting and was this documented within the PMRT? MIS verification period: 2 April 2025 - 30 Nov 2025	Yes
6	Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 1 December 2024 including reviews and consequent action plans.	Yes
7	Were quarterly reports discussed with the Trust Maternity Safety and Board level Safety Champions?	Yes

Safety Action 2 Maternity Services Data Set (MSDS)

NHS
Lancashire and South Cumbria
Integrated Care Board

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all eligible perinatal deaths from 1 December 2024 onwards been notified to MBRRACE -UK within seven working days? (If no deaths, choose N/A)	Yes
2	For at least 95% of all deaths of babies who died in your Trust from 1 December 2024, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Yes
3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 1 December 2024 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Yes
4	Were 75% of all reports completed and published within 6 months of death? MIS verification period: Dec 2024 to April 2025 60% of cases. 2 April 2025 to 30 Nov 2025 75% of cases	Yes
5	For a minimum of 50% of the deaths reviewed, was an external member present at the multi-disciplinary review panel meeting and was this documented within the PMRT? MIS verification period: 2 April 2025 - 30 Nov 2025	Yes
6	Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 1 December 2024 including reviews and consequent action plans.	Yes
7	Were quarterly reports discussed with the Trust Maternity Safety and Board level Safety Champions?	Yes

Safety Action 3 Transitional Care

NHS
Lancashire and South Cumbria
Integrated Care Board

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all eligible perinatal deaths from 1 December 2024 onwards been notified to MBRRACE-UK within seven working days? (If no deaths, choose N/A)	Yes
2	For at least 95% of all deaths of babies who died in your Trust from 1 December 2024, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Yes
3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 1 December 2024 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Yes
4	Were 75% of all reports completed and published within 6 months of death? MIS verification period: Dec 2024 to April 2025 60% of cases. 2 April 2025 to 30 Nov 2025 75% of cases	Yes
5	For a minimum of 50% of the deaths reviewed, was an external member present at the multi-disciplinary review panel meeting and was this documented within the PMRT? MIS verification period: 2 April 2025 - 30 Nov 2025	Yes
6	Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 1 December 2024 including reviews and consequent action plans.	Yes
7	Were quarterly reports discussed with the Trust Maternity Safety and Board level Safety Champions?	Yes

Safety Action 4 Clinical Workforce

NHS
Lancashire and South Cumbria
Integrated Care Board

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Obstetric medical workforce		
1	Has the Trust ensured that the following criteria are met for employing all short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology, demonstrated through audit of any 6-month period from February 2025 and before submission to Trust Board (select N/A if no short-term locum doctors were employed in this period): Locum currently works in their unit on the tier 2 or 3 rota OR They have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progression (ARCP)? OR They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	Yes
2	Has the Trust ensured that the RCOG guidance on engagement of long-term locums has been implemented in full for employing long-term locum doctors in Obstetrics and Gynaecology, demonstrated through audit of any 6-month period from February 2025 to 30 November 2025 (select N/A if no long-term locum doctors were employed in this period)	Yes
3	**For information only:** RCOG compensatory rest (not reportable in MIS year 7) Have you met, or are working towards full implementation of the RCOG guidance on compensatory rest where Consultants and Senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day.	Yes
4	Is the Trust compliant with the Consultant attendance in person to the clinical situations guidance, listed in the RCOG workforce document 'Roles and Responsibilities of the Consultant providing acute care in obstetrics and gynaecology' into their service. Trusts should demonstrate a minimum of 80% compliance through audit of any 3-month period from February 2025 to 30 November 2025.	Yes
5	Do you have evidence that the Trust position with the above has been shared with Trust Board?	Yes
6	Do you have evidence that the Trust position with the above has been shared with Board level Safety Champions?	Yes
7	Do you have evidence that the Trust position with the above has been shared with the LMNS?	Yes

Safety Action 4 Clinical Workforce

Lancashire and South Cumbria Integrated Care Board

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Obstetric medical workforce		
1	Has the Trust ensured that the following criteria are met for employing all short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology, demonstrated through audit of any 6-month period from February 2025 and before submission to Trust Board (select N/A if no short-term locum doctors were employed in this period): Locum currently works in their unit on the tier 2 or 3 rota OR They have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progression (ARCP)? OR They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	Yes
2	Has the Trust ensured that the RCOG guidance on engagement of long-term locums has been implemented in full for employing long-term locum doctors in Obstetrics and Gynaecology, demonstrated through audit of any 6-month period from February 2025 to 30 November 2025 (select N/A if no long-term locum doctors were employed in this period)	Yes
3	**For information only:** RCOG compensatory rest (not reportable in MIS year 7) Have you met, or are working towards full implementation of the RCOG guidance on compensatory rest where Consultants and Senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day.	Yes
4	Is the Trust compliant with the Consultant attendance in person to the clinical situations guidance, listed in the RCOG workforce document 'Roles and Responsibilities of the Consultant providing acute care in obstetrics and gynaecology' into their service. Trusts should demonstrate a minimum of 80% compliance through audit of any 3-month period from February 2025 to 30 November 2025.	Yes
5	Do you have evidence that the Trust position with the above has been shared with Trust Board?	Yes
6	Do you have evidence that the Trust position with the above has been shared with Board level Safety Champions?	Yes
7	Do you have evidence that the Trust position with the above has been shared with the LMNS?	Yes

Safety Action 5 Midwifery Workforce

Lancashire and South Cumbria Integrated Care Board

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years? (If this process has not been completed within three years due to measures outside the Trust's control, you can declare compliance but evidence of communication with the BirthRate+ organisation (or equivalent) MUST demonstrate this.)	Yes
2	Has a midwifery staffing oversight report that covers staffing/safety issues been submitted to the Board every 6 months (in line with NICE midwifery staffing guidance) on an ongoing basis. This must include at least one report in the MIS period 2 April - 30 November. Every report must include an update on all of the points below: ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall. ● The midwife to birth ratio ● Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty at the start of every shift. ● Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with the provision of one-to-one care in active labour ● Is a plan is in place for mitigation/escalation to cover any shortfalls in the points above?	Yes
3	**For Information Only:** We recommend that Trusts continue to monitor and include NICE safe midwifery staffing red flags in this report, however this is not currently mandated, This includes: •Redeployment of staff to other services/sites/wards based on acuity. •Delayed or cancelled time critical activity. •Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing). •Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication). •Delay of more than 30 minutes in providing pain relief. •Delay of 30 minutes or more between presentation and triage. •Full clinical examination not carried out when presenting in labour. •Delay of two hours or more between admission for induction and beginning of process. •Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). •Any occasion when one Midwife is not able to provide continuous one-to-one care and support to a woman during established labour. Other midwifery red flags may be agreed locally.	Yes

Safety Action 5 Midwifery Workforce Part 2

Lancashire and South Cumbria Integrated Care Board

4	Can the Trust Board evidence that the midwifery staffing budget reflects establishment as calculated? Evidence should include: • Midwifery staffing recommendations from Ockenden and of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. • The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.	Yes
5	Where Trusts are not compliant with a funded establishment based on the above, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.	N/A
6	Where deficits in staffing levels have been identified must be shared with the local commissioners.	N/A
7	Evidence from an acuity tool (may be locally developed) that 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) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.	Yes
8	**For Information Only:** A workforce action plan detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Development of the workforce action plan will NOT enable the trust to declare compliance with this sub-requirement.**	N/A
9	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with the provision of one-to-one care in active labour	Yes
10	A workforce action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Development of the improvement plan will enable the Trust to declare compliance with this sub-requirement. This improvement plan does not need to be submitted to NHS Resolution**	N/A

Safety Action 8 Training Plan Fetal Monitoring

NHS
Lancashire and South Cumbria
Integrated Care Board

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Can you demonstrate the following at the end of 12 consecutive months ending 30 November 2025? Rotational medical staff in posts shorter than 12 months can provide evidence of applicable training from a previous trust within the 12 month period using a training certificate or correspondence from the previous maternity unit.		
	Fetal monitoring and surveillance (in the antenatal and intrapartum period)	
1	90% of Obstetric consultants?	Yes
2	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2025) contributing to the obstetric rota? (without the continuous presence of an additional resident tier obstetric doctor)	Yes
3	For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
4	90% Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank midwives employed by Trust and maternity theatre midwives who also work outside of theatres)?	Yes

Safety Action 8 Training Plan Maternity Emergencies

Lancashire and South Cumbria Integrated Care Board

	Maternity emergencies and multiprofessional training	
5	90% of obstetric consultants?	Yes
6	90% of all other obstetric doctors including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows,foundation year doctors and GP trainees contributing to the obstetric rota?	Yes
7	For rotational obstetric staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
8	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres), maternity theatre midwives and bank midwives employed by Trust?	Yes
9	90% of maternity support workers and health care assistants? (to be included in the maternity skill drills as a minimum).	Yes
10	90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors?	Yes
11	90% of all other obstetric anaesthetic doctors (commencing with the organisation prior to 1 July 2025) including any anaesthetists in training, SAS and LED doctors who contribute to the obstetric anaesthetic on-call rota. This requirement is supported by the RCoA and OAA?	Yes
12	For rotational anaesthetic staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
13	Can you demonstrate that at least one multidisciplinary emergency scenario is conducted in any clinical area or at point of care during the whole MIS reporting period? This should not be a simulation suite.	Yes

Safety Action 8 Training Plan Neonatal Resusitation

Lancashire and South Cumbria Integrated Care Board

	Neonatal resuscitation training	
14	90% of neonatal Consultants or Paediatric consultants covering neonatal units?	Yes
15	90% of neonatal junior doctors (commencing with the organisation prior to 1 July 2025) who attend any births?	Yes
16	For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
17	90% of neonatal nurses? (Band 5 and above)	Yes
18	90% of advanced Neonatal Nurse Practitioner (ANNP)?	Yes
19	**For Information Only:** 90% of maternity support workers, health care assistants and nursery nurses? (dependant on their roles within the service - for local policy to determine)	Yes
20	90% of midwives? (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres), maternity theatre midwives and bank midwives employed by Trust)	Yes
21	In addition to the above neonatal resuscitation training requirements, a minimum of 90% of neonatal and paediatric medical staff who attend neonatal resuscitations unsupervised must have a valid Resuscitation Council (RCUK) Neonatal Life Support (NLS) certification or local assessment equivalent in line with BAPM basic capability guidance? Staff that attend births with supervision at all times will not need to complete this assessment process for the purpose of MIS compliance.	Yes

Safety Action 9 Perinatal Safety

Lancashire and South Cumbria Integrated Care Board

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded with evidence of working towards the Perinatal Quality Oversight Model (PQOM)?	Yes
2	Has a non-executive director (NED) been appointed and is visibly working with the Board safety champion (BSC)?	Yes
3	Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) using a minimum data set as outlined in the PQSM/PQOM at least quarterly, and presented by a member of the perinatal leadership team to provide supporting context?	Yes
4	Does the regular review include a review of thematic learning informed by PSIRF, training compliance, minimum staffing in maternity and neonatal units, and service user voice and staff feedback and review of the culture survey or equivalent?	Yes
5	Do you have evidence of collaboration with the local maternity and neonatal system LMNS/ODN/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM/PQOM?	Yes
6	Ongoing engagement sessions should be being held with staff as per previous years of the scheme. Is progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2025?	Yes
7	Is the Trust's claims scorecard reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period 2 April - 30 November)?	Yes
8	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period 2 April - 30 November) and that any support required of the Trust Board has been identified and is being implemented? **Where the infrastructure is in place, this should also include the MNVP lead as per SA7.**	Yes
9	Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented?	Yes

Safety Action 10 MNSI Early Notification

NHS
Lancashire and South Cumbria
Integrated Care Board

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you reported of all qualifying cases to MNSI from 1 December 2024 until 30 November 2025?	Yes
2	Have you reported all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 until 30 November 2025?	Yes
3	Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme in a format that is accessible to them?	Yes
4	For any occasions where it has not been possible to provide a format that is accesible for eligible families, has a SMART plan been developed to address this for the future?	N/A
5	Has there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour?	Yes
6	Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution?	Yes
7	Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme. This needs to include reporting where families required a format to make the information accessible to them and should include any occasions where this has not been possible with the SMART plan to address this?	Yes
8	Has Trust Board had sight of evidence of compliance with the statutory duty of candour?	Yes
9	When reporting EN cases, have you completed the field showing whether families have been informed of NHS Resolution's involvement? Completion of this will also be monitored, and externally validated.	Yes

Findings from 17th December 2025 Visit

NHS
Lancashire and South Cumbria
Integrated Care Board

	Safety Action	Status
1.	PMRT	**Signed off**
2.	MSDS	**Signed off**
3.	Transitional Care	**Signed off**
4.	Clinical Workforce	**Signed off**
5.	Midwifery Workforce	**Signed off**
6.	Saving Babies Lives (version 3)	**Signed off**
7.	MNVP	**Signed off**
8.	Training Plan	**Signed off**
9	Board Assurance	**Signed off**
10.	HSIB/Early Notification	**Signed off**

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

Summary LMNS ICB AAA Report

NHS
Lancashire and South Cumbria
Integrated Care Board

	Risk / Issue	Actions
Alert Areas of concern or matters that need addressing urgently	*Nil*	
Advise Areas of ongoing monitoring and any new developments	*Nil*	
Assure Areas of assurance	Compliant with all 10 safety actions	-Validated and signed off as evidence met the required standards -Robust system and processes in place to evidence how the service is meeting the technical guidance

NHS
Lancashire and South Cumbria
Integrated Care Board

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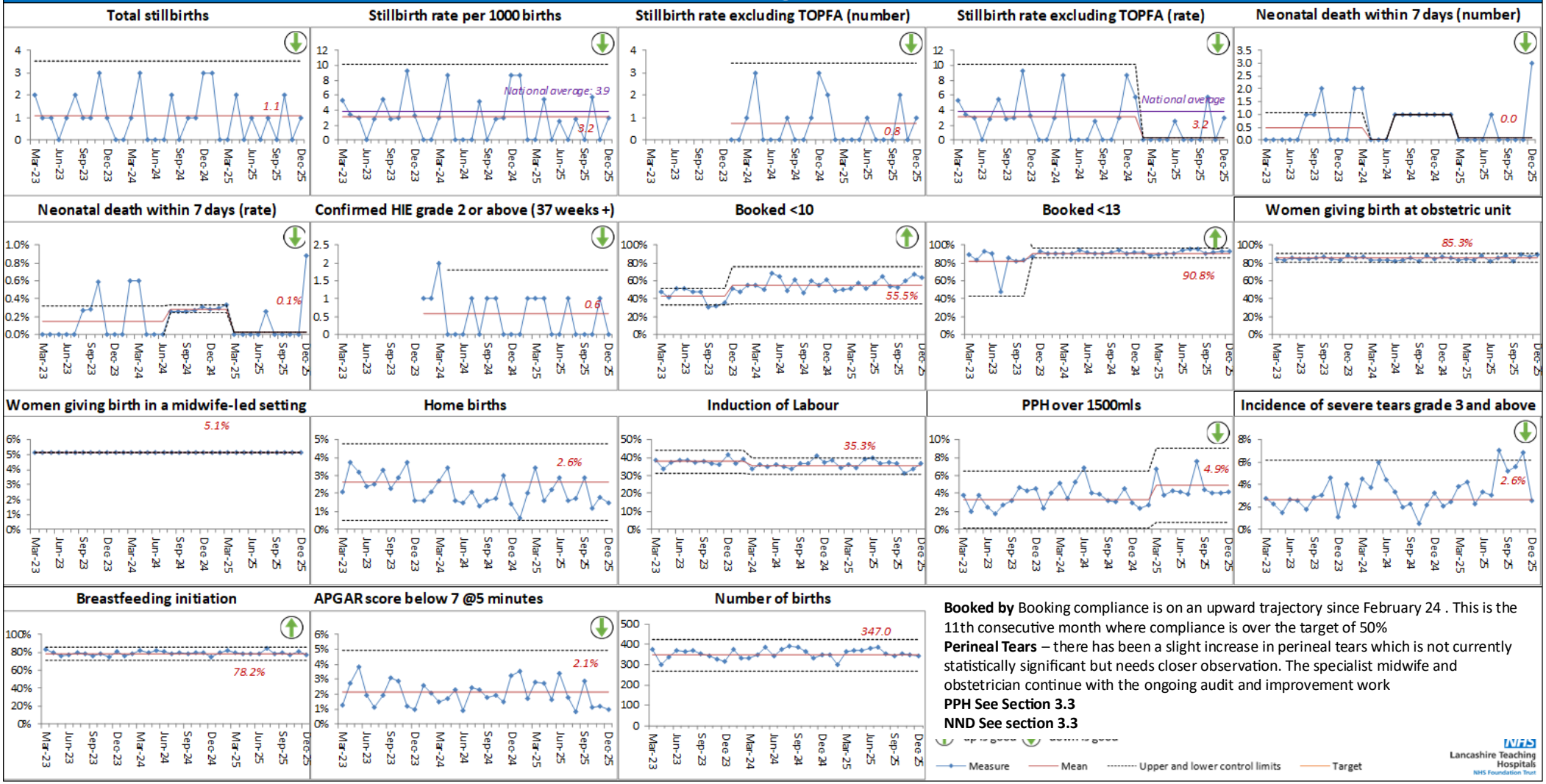
PERINATAL QUALITY SURVIELLENCE DASHBOARD
APPENDIX 3

Clinical Safety Indicators



Booked by Booking compliance is on an upward trajectory since February 24 . This is the 11th consecutive month where compliance is over the target of 50%

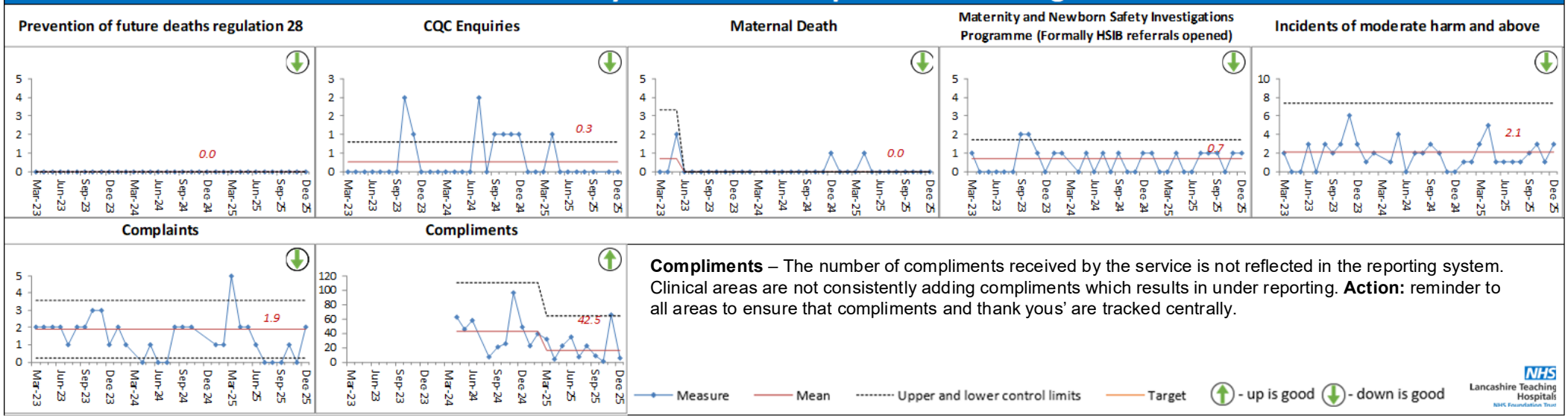
Perineal Tears – there has been a slight increase in perineal tears which is not currently statistically significant but needs closer observation. The specialist midwife and obstetrician continue with the ongoing audit and improvement work

PPH See Section 3.3

NND See section 3.3

Lancashire Teaching Hospitals NHS Foundation Trust

Perinatal Quality Governance Experience and Regulation

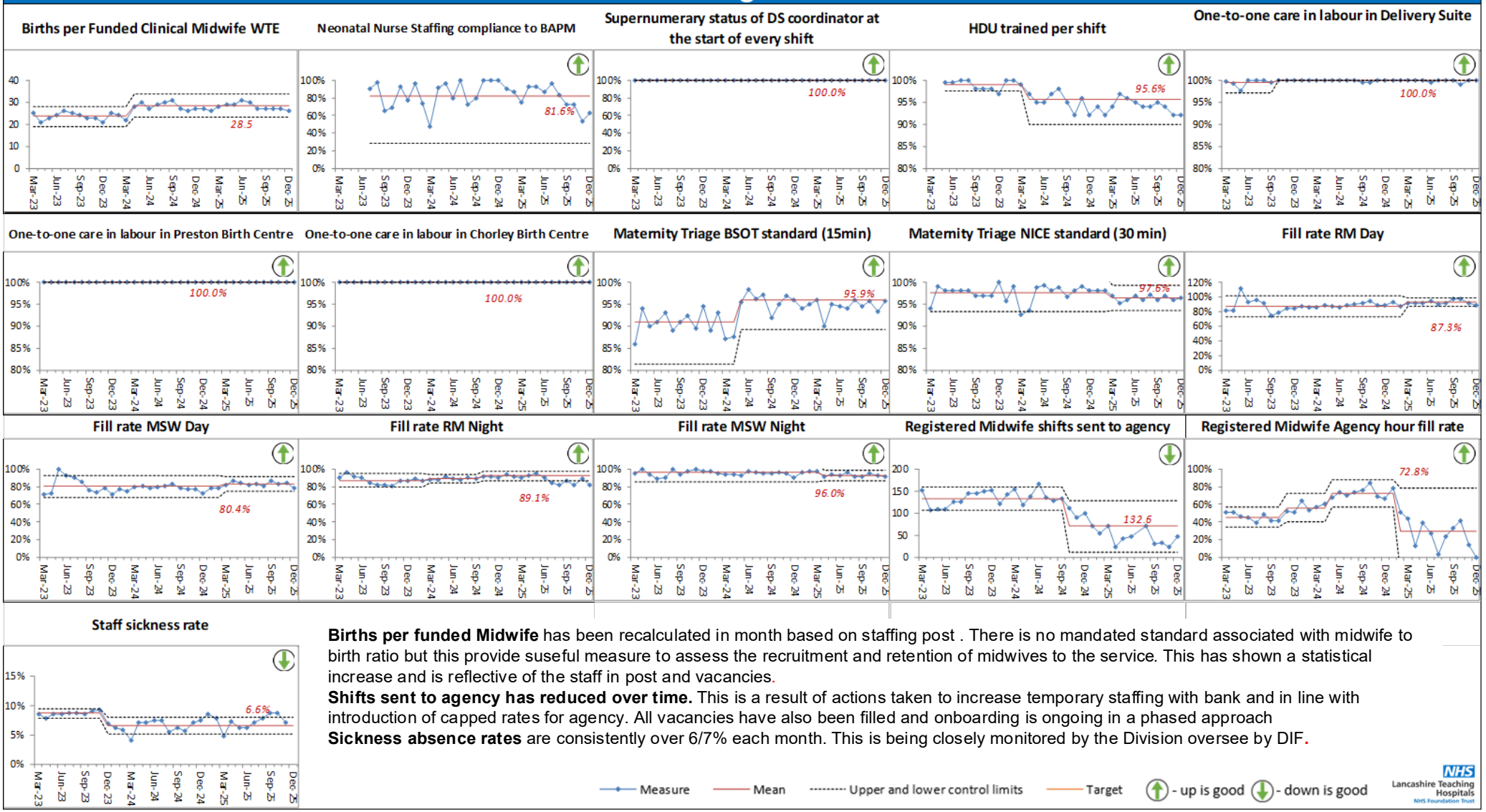


Compliments – The number of compliments received by the service is not reflected in the reporting system. Clinical areas are not consistently adding compliments which results in under reporting. **Action:** reminder to all areas to ensure that compliments and thank yous' are tracked centrally.

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

Lancashire Teaching Hospitals NHS Foundation Trust

Safe staffing indicators



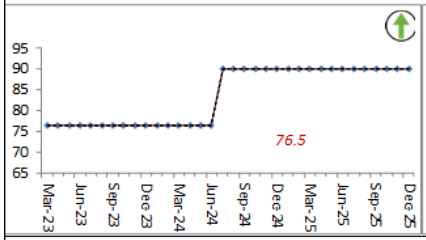
Births per funded Midwife has been recalculated in month based on staffing post . There is no mandated standard associated with midwife to birth ratio but this provide suseful measure to assess the recruitment and retention of midwives to the service. This has shown a statistical increase and is reflective of the staff in post and vacancies.

Shifts sent to agency has reduced over time. This is a result of actions taken to increase temporary staffing with bank and in line with introduction of capped rates for agency. All vacancies have also been filled and onboarding is ongoing in a phased approach

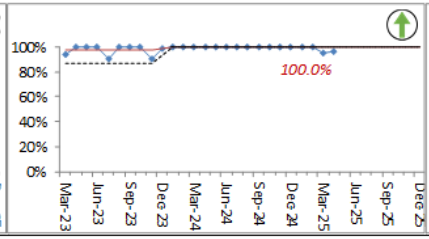
Sickness absence rates are consistently over 6/7% each month. This is being closely monitored by the Division oversee by DIF.

Obstetric Medical Staffing

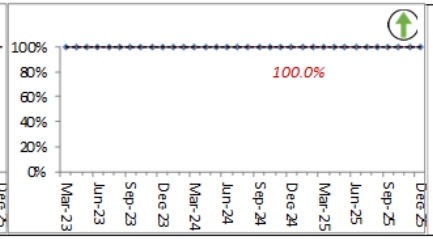
Number of Consultant hours on obstetric unit



RCOG obstetric benchmarking compliance



24-hour acute obstetric medical staffing fill rate

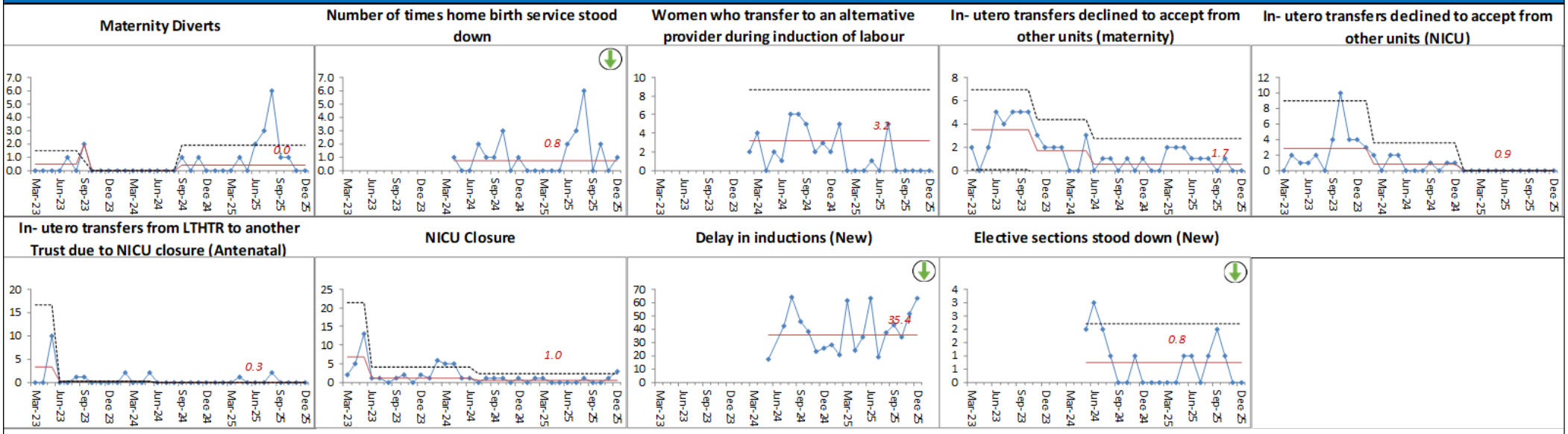


Consultant hours in the obstetric unit. Work is ongoing to recruit to the middle grade rota to move to a 2 tier workforce.
RCOG attendance remains at 100%. This parameter is not currently being captured due to changes in MIS year 7 requirements.
Consultant fill rates for acute care continues to be 100%

Measure | Mean | Upper and lower control limits | Target | - up is good | - down is good

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Clinical Escalation



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

In- Utero Transfers (IUT) IUT decline rates have reduced for maternity and neonatal . This is a statistical reduction.

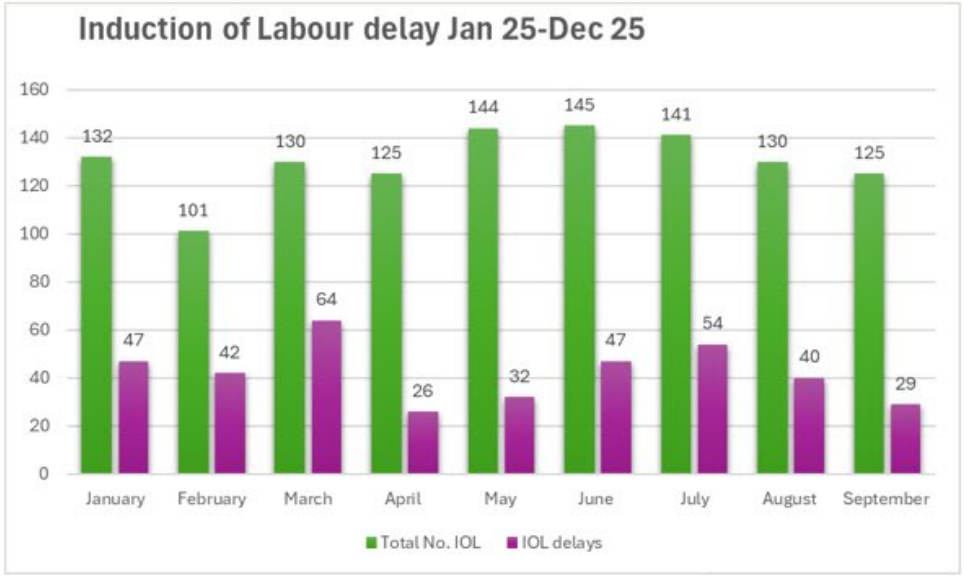
Measure — Mean ------ Upper and lower control limits — Target ↑ - up is good ↓ - down is good

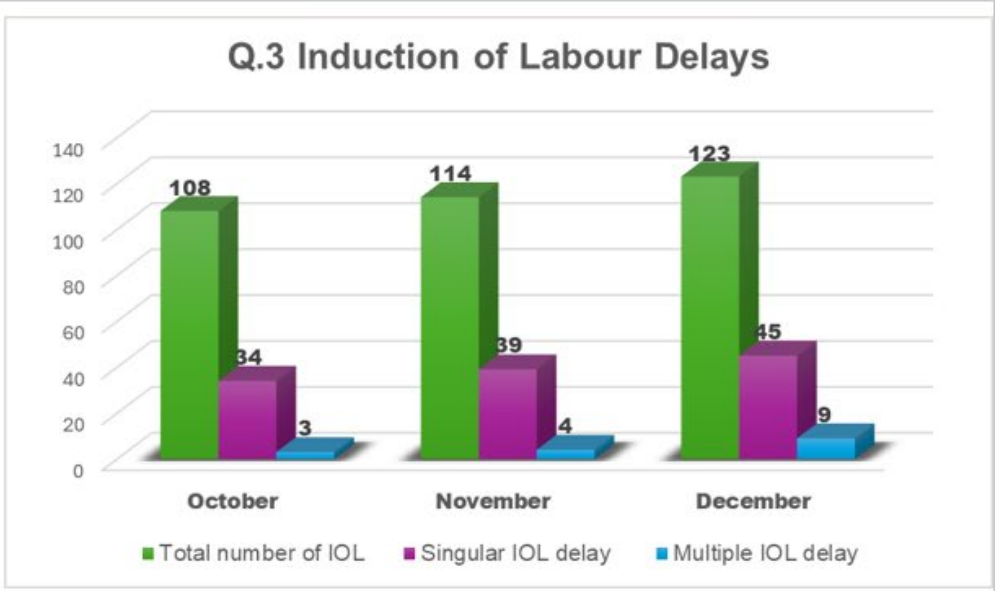
NHS Lancashire Teaching Hospitals NHS Foundation Trust

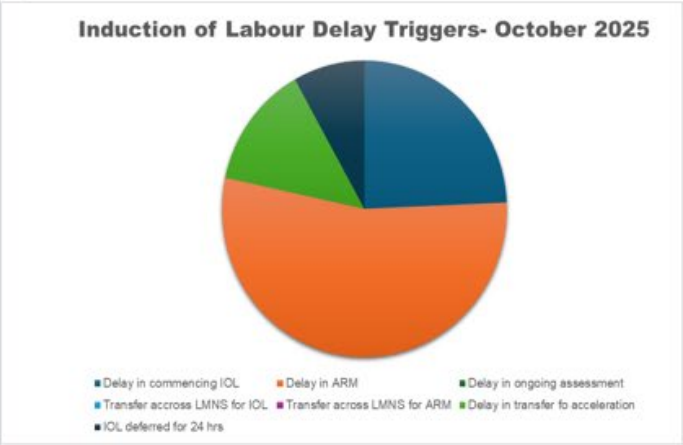
APPENDIX 4 RED FLAGS JULY 2024 TO DECEMBER 2025

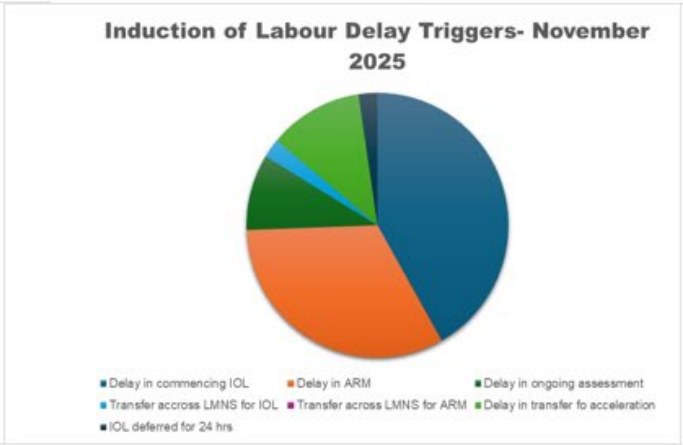
Red flag Reporting Metrics	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25
Delay in time critical activity	59	32	16	16	117	108	105	64	18	9	0	3	3
Missed or delayed care> 60 mins in washing or suturing	1	0	0	1	0	0	0	0	1	0	0	0	0
Failure for women to receive the medication required.	1	0	1	2	0	0	0	1	1	2	1	0	0
>30-minute wait for pain relief.	0	2	1	3	1	1	1	4	4	3	3	0	1
Was there a >30-minute delay for assessment by a midwife when a problem was identified	0	1	1	2	2	1	0	0	0	1	0	0	0
Lack of full examination when woman presents in labour.	0	0	0	2	0	1	0	1	0	0	2	0	1
>2-hour delay in induction?	7	28	21	17	5	18	26	16	10	14	40	43	63
Delay in recognition of and action of abnormal signs.	0	0	2	0	0	0	0	2	0	1	2	0	2
Inability to provide one to one care in labour?	0	2	0	0	1	1	4	2	6	3	2	0	0
>30-minute wait for obstetric triage.	47	58	61	62	156	0	107	130	124	98	93	65	113
>15-minute delay following presentation for BSOTS midwife assessment.	23	46	32	21	82	49	50	59	38	61	43	48	34
Was there a delay in transfer of a BSOTS red case from MAS?	0	1	0	1	1	0	0	0	0	4	0	1	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?	19	26	21	34	17	15	37	31	5	14	2	9	0
Was there a delay in transfer once labour was established?	0	3	0	1	1	1	1	3	9	4	5	0	0
Was there a delay in transfer to delivery suite within 30 minutes where the MEWS was 6 or more or scoring a 3 on a single parameter?	0	0	0	1	0	0	0	0	1	1	0	1	0
Was there a delay of more than 30 minutes to initiate the sepsis care bundle?	0	0	0	1	1	1	0	1	0	1	0	0	0
Has there been a deferred date of planned induction of labour?	0	0	0	0	1	1	0	0	4	4	0	0	0
Has there been any cancelled or delayed community work?	0	0	2	3	2	0	3	2	5	0	1	1	2
Did redeployment of staff to other services/ sites/ wards occur?	0	6	3	12	9	6	12	14	34	13	17	11	8
Is the incident related to an RCOG clinical situation where a consultant was called but did not attend (New for June 2025 Validated position.)							1	2	1	0	0	1	0
Total numbers of red flags	**157**	**205**	**161**	**179**	**396**	**336**	**364**	**335**	**261**	**233**	**211**	**184**	**227**

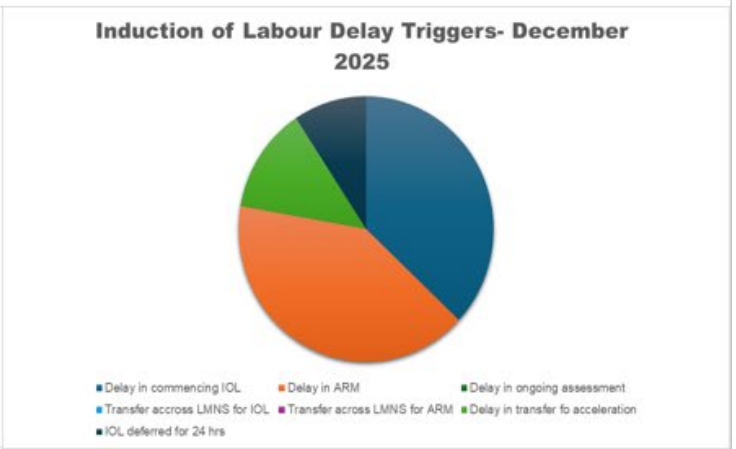
APPENDIX 5 INDUCTION OF LABOUR CONTINOUS IMPROVEMENT PROJECT











13.1 - 2026/27 PLAN AND BOARD ASSURANCE STATEMENT ? APPROVAL PRIOR TO SUBMISSION

REFERENCES

Only PDFs are attached

13.1 - 2026.27 Plan and Board Assurance Statement - ancillary pack.pdf

Board of Directors Report

1. Introduction

1.1. This paper provides the Board with an update on the planning activities since the last report in mid-December 2025. It summarises progress made across system and Trust-level planning, including executive planning huddles and contract setting activity, and highlights the key risks emerging as plans move towards the final February submission. The report also sets out the principal mitigations in place and the areas requiring continued executive and Board oversight.

2. Discussion

2.1. Draft Submission

2.1.1. Draft submissions for years 1 & 2 were made on 16th December 2025 following review and approval at a planning triangulation sign-off meeting with board delegated approval to the Chief Exec & Chair.

2.1.2. This plan submission:

- Achieved most constitutional performance targets (except for A&E)
- Met the revenue control limit set by NHSE of a £9.2m deficit in 2026/27 and break-even in 2027/28
- Included a net reduction of 448 WTE in 2026/27 and 367 WTE in 2027/28 (815 WTE reduction in years 1 + 2)
- Did not mirror the income assumptions to those contained in the initial ICB contract offer

2.1.3. 15 Board Assurance Statements were approved by Chair & Chief Exec with:

- 0 statements were rated as ‘Embedded (Full Assurance)’ in the maturity assessment
- 8 statements were rated as ‘Maturing’ in the maturity assessment
- 7 statements were rated as ‘Developing’ in the maturity assessment
- 0 statements were rated as ‘Not Embedded (No Assurance)’ in the maturity assessment

2.2. Progress to date

2.2.1. Following the submission of the initial draft plans in mid-December, planning activity has moved into an intensive iteration and assurance phase. The focus over this period has been on:

- reconciling activity, finance and performance assumptions
- strengthening the narrative and Board assurance evidence required for final submission
- aligning contract values with validated demand management and commissioning assumptions
- Governance continuity has been maintained through established Trust and system planning forums, with clear escalation routes into executive-level discussion where risks or gaps have been identified

2.2.2. Internal triangulation meetings have continued to take place on a weekly basis with relevant stakeholders and executive oversight. An additional risk has been identified and added to the planning risk log around the 'very-high' categorisation of Waste Reduction Programme (WRP) as % of operational expenditure in the Simon Worthington review, this is indicative of the trust facing similar levels of risk in achievement of next years WRP in full. the risk log is attached at Appendix 1 for information.

2.2.3. Executive planning huddles have continued on a regular basis throughout January and have been extended into early February to support delivery against the accelerated national timetable. These huddles have provided executive and senior-level oversight of progress and have been used to:

- Track resolution of legacy planning issues,
- Monitor the availability and maturity of demand management and commissioning data,
- Review the status of contract summaries and emerging contract risks, and
- Challenge deliverability of activity growth and efficiency assumptions.

2.2.4. Actions arising from the huddles have been formally logged and followed up, with particular emphasis on quantifying mitigations and ensuring that late changes to assumptions are minimised to avoid destabilising the plan.

2.2.5. Significant progress has been made through the contract setting and 26/27 re-costing group, although this remains one of the most challenging areas of the planning process. Key activities since mid-December have focused on development of a shared, standardised and stepped approach to contract modelling to iteratively reconcile provider and commissioner positions.

2.2.6. The group has also focused on embedding demand management mitigations directly into contract values (both volume and financial impact) and addressing a number of pricing anomalies and inconsistencies across providers.

2.2.7. Discussions however have highlighted ongoing uncertainty in several areas, including specialised commissioning assumptions, funding for constitutional standards, and the extent to which providers can realistically deliver the activity levels implied by current contract positions. These issues are now explicitly recognised as risks requiring continued executive oversight and clear Board-level narrative.

2.2.8. Overall, good progress has been made in moving from a draft December position to a more robust and assured planning submission. Governance has remained tight, and risks are now clearly articulated rather than implicit. Nevertheless, the remaining period to final submission is compressed, as illustrated in Figure 1 - Planning Timeline below and a number of

inter-related risks remain live, particularly around contract deliverability, demand management and financial balance.

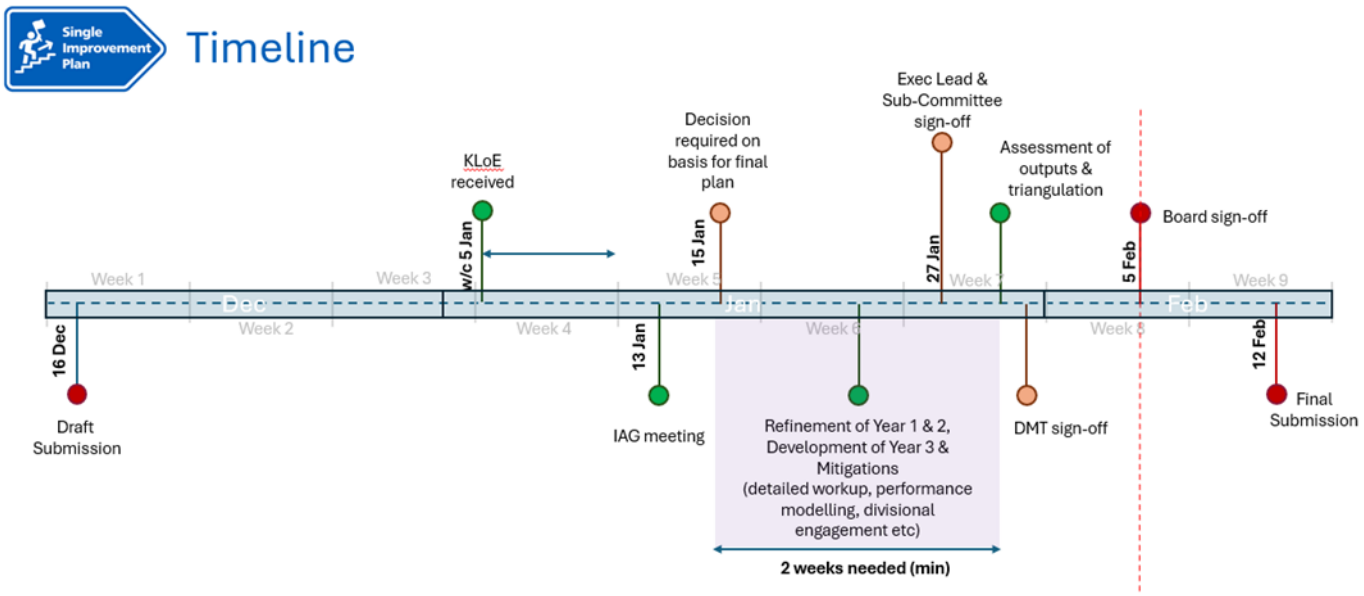


Figure 1 - Planning Timeline

2.2.9. There remains a material risk that the compressed timetable and ongoing late changes to assumptions could delay completion of a fully triangulated planning position. Each adjustment made late in the process reduces the time available for essential validation, quality checks and narrative alignment, increasing the likelihood of submitting a plan that is either incomplete or not sufficiently assured.

2.2.10. This also places pressure on internal governance, as Executive and Board sign-off windows become constrained, limiting the opportunity for leaders to provide the level of scrutiny and challenge required. Without timely decision-making, the Trust risks either missing submission deadlines or submitting a position that does not carry full internal assurance.

2.2.11. At the time of writing we do not have final plans fully constructed, there is ongoing work underway to incorporate the impacts of the various mitigations, following which further detailed work is required with both finance and workforce teams to ensure alignment and appropriate triangulation, Board are therefore asked to support extra-ordinary measures for approval of the final plans, 5 year strategic narrative and triangulation (including the final triangulation statements).

2.3. Board Assurance Process

2.3.1. The Board assurance statement has been revised from the draft submission, primarily to reflect changes in tense has been change from draft submission (we will to / we have) and level of certainty, and to ensure it accurately represents the current stage of Board review. The draft statements for consideration are included in **Appendix 2**.

2.3.2. The five-year strategic narrative has been constructed to ensure close alignment with the assurance process, scoring approach and assessment criteria.

2.3.3. The scoring and supporting narrative reflect the current maturity profile, recognising that a number of statements remain at maturing or developing status due to system dependencies, commissioning uncertainty and the compressed national timetable.

2.3.4. Three additional statements have been included to reflect alignment with the financial plan, numerical returns and the NHS 10-Year Plan.

2.3.5. The statements reflect Board challenge of key assumptions, particularly in relation to performance deliverability, workforce capacity and demand management, and confirm that associated risks are explicitly documented and will continue to be monitored through delivery of the plan and established governance routes.

2.3.6. Areas for further development are identified, including contracting positions, clinical engagement and financial alignment. Final assurance will be contingent on completion of triangulation, validation activities and confirmation of system and commissioning positions.

3. Financial Implications

3.1. The planning position continues to be financially challenging. Key financial implications arising since mid-December include:

- the requirement to align contract values more closely with validated demand management assumptions, with a risk of financial exposure if mitigations do not deliver as planned;
- ongoing pricing anomalies and reconciliation issues within contract setting, which may materially affect the Trust's income position if not resolved;
- uncertainty around funding for constitutional standards and specialised commissioning activity, particularly where performance improvement is not being explicitly funded in 2026/27; and
- emerging cost pressures from new or evolving service requirements that need to be incorporated into the final plan.

4. Legal Implications

4.1. There are no immediate legal implications arising directly from this report. However, continued uncertainty around contract terms, pricing assumptions and governance arrangements highlights the importance of robust contract management and timely escalation where agreements are not formalised, to mitigate the risk of future disputes or financial loss.

5. Risks

5.1. The key risks identified since mid-December are:

- Compressed timescales and late iteration, increasing the risk of incomplete triangulation and destabilisation of plans.
- Incomplete or unproven demand management mitigations, which may not deliver the assumed financial or activity impact.
- Contract pricing anomalies and reconciliation gaps, creating uncertainty over final income positions.
- Specialised commissioning and constitutional standards assumptions, where funding does not fully align with expected performance delivery.
- Deliverability risk, with concern that planned activity growth may not be operationally achievable.
- Governance and oversight gaps in contract management, which could result in avoidable financial leakage.

5.2. Mitigations are in place for each of these risks, primarily through executive planning huddles, system planning oversight and the contract setting group, but residual risk remains high at this stage of the process.

6. Impact on stakeholders

6.1. The following impacts are identified:

- Staff: The deliverability of plans has implications for workforce capacity, productivity expectations and change fatigue if plans are not realistic.
- System partners: Close collaboration is required to align assumptions and manage shared risks, particularly around demand management and commissioning intentions.
- Board and executive leaders: Continued oversight and timely decision-making are required to balance ambition, realism and assurance.

7. Recommendations

7.1. The Board of Directors are asked to:

i. Note the progress made in planning activity since mid-December
ii. Note the key risks and financial uncertainties that remain as plans move towards the February submission.
iii. Support continued executive-level oversight and disciplined decision-making to stabilise assumptions and minimise late changes.
iv. Endorse appropriate escalation of contract and commissioning issues where risks to financial sustainability or deliverability are identified.
v. Support the extra-ordinary approval of final plan submission.

Appendix 1 – Risk Log

Ref	Risk Description	Owner	Date Raised	Original Assessment				Mitigation action
				Probability (1 = v. unlikely, 5 = v. likely)	Impact (1 = v. low 5 = v. high)	Risk Score (1 = v. low, 25 = v. high)	Risk Profile	
1	Insufficient funding available to deliver the level of performance required (Approx £77.6m over 3 years)	ICB/Trust	13/10/2025	5	4	20	Extreme	
2	Commissioning Intentions detail not available in sufficient time to factor into planning submissions	ICB	13/10/2025	3	3	9	Moderate	The PSC supporting ICB on 10 prioritity intentions.
3	Supporting guidance not published in sufficient time to inform draft plan	National	13/10/2025	3	3	9	Moderate	Plan on what is known and document assumptions and risks
4	Capacity & Demand not completed in time to inform plan submission	Trust	13/10/2025	3	3	9	Moderate	Assessment of volume of activity to achieve standards
5	Insufficient time and resource to adequately prepare robust returns for draft submission following change to planning horizon (3 year plans)	Trust	13/10/2025	3	3	9	Moderate	Document shortfalls and explain in narrative.
6	Insufficient Theatre, Outpatient, HSDU & Bed capacity to deal with additional volumes	Trust	02/01/2026	3	3	9	Moderate	
7	Demand Management initiatives not sufficient to mitigate affordability shortfalls	ICB/Trust	02/01/2026	3	3	9	Moderate	
8	Inequalities are not sufficiently addressed in balancing the requirements to improve performance	ICB/Trust	02/01/2026	3	3	9	Moderate	
9	Level of WRP required as a % of Operational Expenditure is in the very high category as per the Simon Worthington review	Trust	27/01/2026	4	4	16	High	Full workup of year 1 of the FSP required.

Appendix 2 – Board Assurance Statements

Maturity Assessment Key	
1. Embedded [Full Assurance]	The action is fully integrated into normal operations. It is standardised, sustainable, and reinforced by policy, leadership, systems, and culture. Continuous improvement is an established norm, and outcomes are consistently positive.
2. Maturing	The action is becoming routine. There are documented processes, growing staff awareness, and increasing consistency across teams. Evaluation and improvement mechanisms may be in place but are not yet fully optimised.
3. Developing	Steps have been taken to introduce and implement this action. There may be informal processes, or isolated examples of good practice, but they lack consistency, coordination, or broad awareness.
4. Not Embedded [No Assurance]	There is little to no evidence that this action has started. If it has, it's ad hoc, inconsistent, or heavily reliant on individuals rather than being supported by systems or structures.

Category / Area For Assurance	Statement	Response at first submission (pre-populated & fixed)	Response for full submission (1-4 see key above)	Commentary (required against a response of 2-4. Limited to 500 characters - see guidance above)
Foundational activities	The board has reviewed the outputs from the foundational work undertaken as part of phase one of planning. This includes reviewing demand and capacity analysis.	3	2. Maturing	Board has reviewed phase one of D&C outputs including key constraints. Some specialty-level capacity modelling and validation continues to further align service needs; remaining gaps are tracked through the planning governance route with scheduled Board updates.
Governance and leadership	The board can confirm strong clinical leadership **has been** involved in the development of plans.	2	1. Embedded [Full Assurance]	Clinical leadership has been embedded through divisional and specialty planning, with clinical input to activity, productivity and pathway assumptions. There wil be continued clinical input to ensure consistent clinical ownership of delivery.
Governance and leadership	The board can confirm that **plans reflect the consideration of** population needs, underserved communities and inequalities when developing plans.	3	3. Developing	Plans are informed by population health need and inequalities (including CORE20PLUS5 cohorts) and reflect the expected impact on demand and outcomes. Work has been undertaken to translate system-level insight into measurable interventions within Trust delivery plans with anticipated benefits relying on wider system action.
Governance and leadership	Robust quality and equality impact assessments (QEIA) **have been** undertaken and reviewed by the board to inform the **sign off** of the organisation's plan.	2	2. Maturing	QEIA approach is in place and applied to priority schemes, with Board visibility for material changes. Not all components of the medium-term plan have completed QEIA at the same level of maturity given evolving schemes and dependencies; completion and review is being sequenced alongside finalisation of schemes/business cases. QEIA work has been undertaken at a place and system level with ICB Integrated Needs Assessments built into plans.
Governance and leadership	The board **has played** an active role in setting direction, reviewing drafts, and constructively challenging assumptions – rather than simply endorsing the final version of the plan.	1	2. Maturing	Board has provided active challenge on affordability, deliverability, workforce assumptions and dependencies, and has required a baseline control position. Ongoing engagement and ownership will continue through the Board as contracting, system funding decisions and transformation phasing are confirmed.
Governance and leadership	The board is confident that there is a data-driven and clinically-led continuous improvement approach in place. The organisation has a systematic approach to building improvement capacity and capability.	2	2. Maturing	Improvement approach is established, supported by data, benchmarking and clinically-led programmes (productivity, flow, elective/outpatient transformation). Capability-building is progressing the focus remains on standardisation, benefits realisation and to maximise benefits for delivery at scale.
Governance and leadership	The board confirms that the organisation has established structures to work effectively with commissioners and system partners, ensuring that system working is constructive and efficient.	2	2. Maturing	Formal governance exists for commissioner/provider engagement and system planning, enabling joint resolution of key issues (activity, performance, finance). Some dependencies remain unresolved (funding for performance recovery, community capacity impacts), and these are managed through escalation routes and agreed review points.
Plan development	The board can confirm that the plan is evidence-based, robust and deliverable. The board is content that the phasing of the plan across three years is realistic.	3	3. Developing	Plan is evidence-based and risk-assessed, but deliverability is constrained by affordability, workforce availability and external dependencies. Phasing is realistic for confirmed schemes; some trajectories remain contingent on commissioner funding and system enablers. Delivery risks and mitigations are explicitly stated at a service level and monitored.
Plan development	The board can confirm that plans have been triangulated across finance, workforce and performance, ensuring each element of the plan reinforces the others, making the plan internally consistent.	3	2. Maturing	Triangulation has been completed across activity, performance, workforce and finance at Trust level with clear links to productivity and cost improvement. There is still alignment needed at a detailed workforce level which has not been possible in the timeline.
Productivity	The Board **can confirm** that the organisation **has fully considered and incorporated** productivity opportunities into plans, **and that any phasing is credible and realistic. The board can provide justification where any identified opportunities cannot be fully delivered during this planning round, especially in the context of decisions to submit non-compliant financial or performance plans or plans that do not deliver the 2% productity improvement.**	2	2. Maturing	Productivity opportunities have been identified and incorporated, with credible phasing for deliverable initiatives. Full delivery is constrained by workforce, capacity and change bandwidth, and some benefits require system alignment. Where trajectories are non-compliant or below ambition, justification is documented with mitigations and support needs flagged.
Risk	The board can confirm that the organisation has a robust approach to risk management in place including the ability to demonstrate a comprehensive understanding of financial risk and an agreed approach to managing and mitigating risks in year.	2	1. Embedded [Full Assurance]	
NHS standard contract and commissioning	The board **can confirm that that the organisation has engaged with its ICB to ensure** contract values used in planning submissions are **agreed** across (commissioner and provider) activity and financial plans.	3	2. Maturing	Engagement with the ICB and NHSE is ongoing and contract values used are based on current planning positions and shared assumptions. Final agreement is subject to contract negotiation and commissioner affordability decisions; variances and risks are transparently tracked with an agreed timetable for resolution.
NHS standard contract and commissioning	The board can confirm that there is an effective process in place to manage the sign-off of contracts.	2	2. Maturing	Contracting governance and internal sign-off processes are in place with clear accountabilities and decision points. Process effectiveness is dependent on timely commissioner decisions; escalation routes are defined where delays or material changes arise.
NHS standard contract and commissioning	The board can confirm that there is a timetable in place to ensure that the board will be updated on the sign-off of contracts and any delays to signing contracts will be reviewed by the board.	3	2. Maturing	The Board is updated on contracting progress, with defined checkpoints and escalation triggers via a Board sub-committee. Any slippage or material disagreement will be brought via this route with options for risk mitigation and interim operating assumptions.
Workforce	The board can confirm the impact of the 10 Year Health Plan on the workforce **has been considered** in plans. This includes the impact of productivity gains and how staff are deployed including the three shifts - from hospital to community, from analogue to digital, from sickness to prevention.	3	2. Maturing	Workforce implications have been considered at a strategic level, including productivity expectations and changes in deployment aligned to the three shifts. Detailed implementation plans (skill-mix, new roles, digital enablement, community interfaces) have been considered and included.
Ambulance trusts only	The board, supported by the lead ambulance commissioner, can confirm that there is alignment of hospital handover trajectories in both ambulance and acute trust plans within their footprint.			
Plan development	The board can confirm that the organisation has worked with its ICB to ensure their plans are fully aligned.	N/A	3. Developing	Plans have been developed in collaboration with the ICB and reflect agreed system scenarios and commissioning assumptions. Full alignment is subject to final contracting positions and system prioritisation decisions; any remaining gaps are documented with agreed routes to resolution.
Plan development	The board can confirm plans have been developed in line with the ambition to move care from hospital to community and this shift is evident in plan returns and the integrated delivery plan.	N/A	2. Maturing	Plan supports the direction of travel to shift care where clinically appropriate, including outpatient transformation and demand management. The scale of shift achievable within the period is constrained by community capacity and funding decisions outside the Trust's control; therefore impacts are evidenced where funded and deliverable, with dependencies stated.
Plan development	The board can confirm that the five year integrated delivery plan is fully aligned with the numerical returns.	N/A	1. Embedded [Full Assurance]	The plan is aligned to current numerical returns and reflects the baseline control position. Some elements remain iterative as contracting and system assumptions are finalised; alignment will be maintained through triangulation and governance, with Board visibility of any material changes.

13.3 - REVIEW OF TERMS OF REFERENCE

REFERENCES

Only PDFs are attached

13.3 - BoD revision to committee terms of reference 5.02.26.pdf

Board of Directors Report

Meeting of the Board of Directors	**5 February 2026**		
Part I ☒		**Part II** ☐	
Title of Report	**Revision of Assurance Committee Terms of Reference – Outstanding Internal Audit Action**		
Report Author	Jennifer Foote, Director of Corporate Affairs		
Lead Executive Director	Jennifer Foote, Director of Corporate Affairs		
Recommendation/ Actions required	The Board is asked to approve the addition of the following wording to the terms of reference of the Safety and Quality Committee and the Education, Training and Research Committee, under the list of duties: *Consider the control and mitigation of strategic and operational high risks related to the business of the committee, and provide assurance to the Board that such risks are being effectively controlled and managed as part of the Board Assurance Framework.*		
	Decision ☒	**Assurance** ☐	**Information** ☐
Executive Summary	The Trust carries an outstanding internal audit action relating to an inconsistency in its assurance committees terms of reference, in that some committees refer to the committee's role in the oversight of risk, and this is missing from others. The action has been held pending the outcome of the recent GGI review. However, as no actions in relation to the revisions of terms of reference were recommended as part of that review, the board is now asked to complete the outstanding audit action by inserting appropriate wording into the terms of reference for the Safety and Quality, and the Education, Training and Research Committees.		
Link to Strategic Objectives 2025/26	**Patients – deliver excellent care:** Improve outcomes, reduce harm and deliver a positive patient experience.		☐
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.		☐
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.		☐
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.		☐
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.		☒

14.1 - REGISTER OF INTERESTS

REFERENCES

Only PDFs are attached

14.1 - BOD Register of Interests - 27 January 2026.pdf

Board of Directors: Register of Interests – 27 January 2026

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Name	Position	Declared Interest
NON-EXECUTIVE DIRECTORS		
Dr Tim Ballard	Non-Executive Director	• Care Quality Commission National Clinical Advisor for General Practice, Independent Primary Care, Digital Health and Environmental Sustainability • Chair of the Brabin's Trust • Fellow of the Royal College of General Practitioners
Professor StJohn Crean	Non-Executive Director	• Pro Vice-Chancellor (Research and Enterprise) University of Lancashire • Honorary Consultant OMFS at ELHT • Member of Preston Anchor Board • Member of Preston Health and Wellbeing Group • Named University Representative on the LSC ICP
Dr Karen Deeny	Non-Executive Director	• Vice Chair and Senior Independent Trustee, Transforming Futures Multi Academy Trust • Deputy Chair/Non-Executive Director, University Hospitals of Morecambe Bay NHS Foundation Trust
Mr Adrian Leather	Non-Executive Director	• CEO of the Charity Active Lancashire • Member of the Preston Vision Board
Mr Uzair Patel	Non-Executive Director	• Natwest Group employee • Trustee of Torus Foundation • Director of Lancashire Hospitals Services (LHS) Ltd
Mr John Schorah	Non-Executive Director	• Partner at Weightmans LLP • Trustee of Everton in the Community
Professor Mike Thomas	Chair	• Chair, NHSENW People Board • Chair, Lancashire & South Cumbria PCB • Chair, Making Space • Chair of ELHT
Professor Tim Wheeler	Non-Executive Director	• Chair of the Board Coleg Cambria Large FE College • Member of Council at Bangor University • Member of Chester Cathedral Development Committee
EXECUTIVE DIRECTORS (VOTING BOARD MEMBERS)		

Mr Steve Canty	Chief Medical Officer	• No interests to declare
Mr Craig Carter	Interim Chief Finance Officer	• No interests to declare
Ms Katie Foster-Greenwood	Chief Operating Officer	• No interests to declare
Ms Sarah Morrison	Chief Nursing Officer	• Son is a member of the Administrative Bank • Sister is Clinical Business Manager in the Women's and Children's Division • Trustee at St Catherine's Hospice
Professor Silas Nicholls	Chief Executive Officer	• Spouse is Partner with Weightmans Solicitors LLP • Visiting Professor of the University of Great Manchester • Chair, North West Leadership Academy • Lead CEO, Provider Collaborative
CORPORATE DIRECTORS (NON-VOTING BOARD MEMBERS)		
Professor Ailsa Brotherton	Chief Strategy and Improvement Officer	• Honorary Professorial role at University of Lancashire • Honorary Clinical Professor at UCLAN • Co-Chair of the British Association of Parenteral & Enteral Nutrition Facility
Ms Naomi Duggan	Director of Communications and Engagement	• Son is Regional Editor North-West at Newsquest now including the Preston area.
Mrs J Foote MBE	Director of Corporate Affairs	• Director of Lancashire Hospitals Services (LHS) Ltd • Secretary to the Joint Committee of the Lancashire and South Cumbria Provider Collaborative Board
Dr Neil Pease	Chief People Officer	• Director of Star Bay Property • Interim Chief People Officer at East Lancashire Hospitals NHS Trust from 14/05/2025