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Lancashire Teaching Hospitals
NHS Foundation Trust

Lancashire Teaching Hospitals NHS Foundation Trust

Quality Account 2025/2026

Excellent care with compassion

Always Safety First

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Quality Account 2025-26

PART 1 – Chief Executive's Statement

1.1 Chief Executive's Statement

I am pleased to present the 2025-26 Quality Account for Lancashire Teaching Hospitals NHS Foundation Trust. This report reflects the progress made over the last year, the quality of services we provide, and the improvement priorities that will guide our work in 2026-27.

Patient safety, patient experience and outcomes remain our highest priority. Our first responsibility is to the patients, families and communities we serve across Preston, Chorley, Central Lancashire and the wider Lancashire and South Cumbria footprint. Every improvement described in this account is ultimately about ensuring people receive safe, compassionate, timely and effective care.

This year we have made important progress in addressing some of the underlying causes of adverse outcomes and avoidable harm. We have strengthened our safety and learning systems, further embedded the Patient Safety Incident Response Framework, developed the next Always Safety First Strategy, and used learning from incidents, mortality reviews, complaints, patient feedback and audit to target improvement where it matters most.

Our Single Improvement Plan has provided a clear framework for this work, bringing together our priorities for patients, performance, people, productivity and partnerships. Through this approach we have focused on the issues that have the greatest impact on quality of care, including urgent and emergency care, planned and cancer services, diagnostics, infection prevention, medicines safety, falls, pressure ulcers, maternity and neonatal care, and the experience of patients in our wards and departments.

There are areas where we can see positive movement. We have sustained strong compliance with core skills training and appraisal, reduced sickness absence compared with previous periods, and maintained strong retention. The staff survey showed improvements in the majority of areas compared to last year with the exception of advocacy scores for staff and patients, these are the priority for the organisation.

We have also made progress in key performance areas that directly affect quality of life for patients. The Trust has eradicated the 65-week elective wait backlog and reduced 52-week waits. Cancer services have improved, with stronger faster diagnosis and 62-day performance, helping patients receive answers and treatment more quickly. Diagnostic performance has improved, and although urgent and emergency care remains under pressure, four-hour performance has moved positively compared with the previous year.

There has been encouraging progress in patient safety and experience, including performance within the national trajectory for Clostridioides difficile, improved sepsis training compliance, stronger safeguarding audit compliance, and positive feedback in areas including maternity, cancer and children's services.

We have continued to invest in service development and innovation, including new diagnostic and assessment capacity, maternal medicine services, research partnerships and improvement programmes that help patients remain independent, reduce delays and support safer transitions of care.

We know, however, that there is more to do. Urgent and emergency care remains a significant challenge, and too many patients still experience delays, crowding or waits that fall short of the standards we aspire to provide. We must continue to improve flow, reduce long waits, strengthen diagnostic access, address infection prevention risks, improve inpatient and urgent care experience, and ensure learning from harm is translated into sustained change.

A central part of our improvement journey is engagement. During the year we have listened to patients, families, colleagues, partners and local communities, and this has shaped our new Trust Strategy. I would like to thank all colleagues across the Trust for their commitment, compassion and professionalism in delivering progress in challenging circumstances. This Quality Account is both a reflection on progress and a commitment to further action. We are proud of what has been achieved, honest about where improvement is still required, and clear that patient safety, experience and outcomes will remain at the centre of our work. With the support of the Trust's Executive Directors, I confirm that, to the best of my knowledge, the Quality Account 2025–26 complies with national requirements, accurately reflects our performance, and contains reliable information.

Professor Silas Nichols

Chief Executive Officer

PART 2 – Priorities for Improvement

2.1 Strategic Overview

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

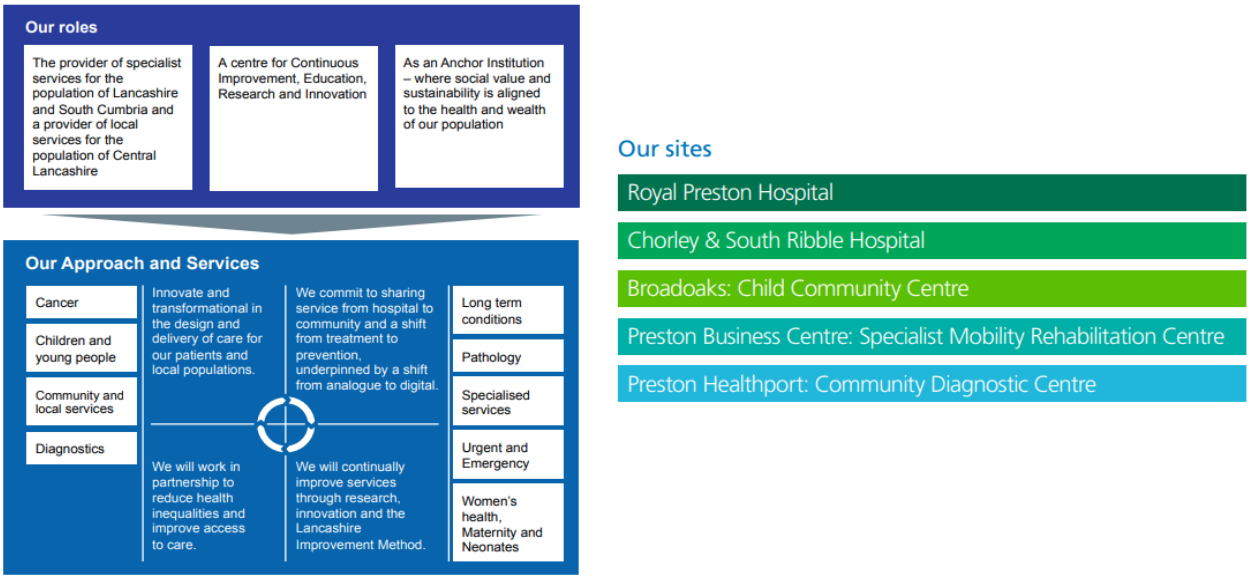
Our aim is to become a leading accountable healthcare organisation within the Lancashire and South Cumbria system. We are working with partners to deliver care that is affordable, sustainable and meets the needs of our population, while supporting wider improvements in health and wellbeing.

2.1.2 Our Strategy

Our strategy sets out the role we will play within the wider system and our ambition for our sites and clinical services. It aligns with the national Fit for the Future: 10 Year Health Plan for England.

The strategy has been shaped through engagement with our staff, patients, local communities, and partner organisations. Their views have informed our priorities and the direction of travel for the coming years.

Figure 1 Our Trust Strategy 2025–2030



2.1.3 Governance of the strategy

Delivery of the Trust's strategy is overseen by the Board through the Single Improvement Plan (SIP). The SIP turns our strategic aims into clear actions and measures. Each year, the Board agrees a set of corporate objectives based on the strategy. These objectives inform both the SIP and the Board Assurance Framework (BAF).

The Board Assurance Framework helps the Board monitor risks linked to these objectives. It sets out key risks, how they are managed, and where further action is needed. This supports decision-making on priorities, resources, and controls, and helps the Board track progress.

The SIP is organised into five priority areas (the 5Ps):

- **Patients:** improving access, experience, safety, quality of care, and outcomes, including through the use of new technology and advances in care
- **Performance:** improving how services perform to meet and exceed national standards
- **People:** supporting and developing our staff, recognising the importance of culture
- **Productivity:** making best use of resources, reducing waste, and improving services and patient experience
- **Partnerships:** working closely with health, social care, and voluntary sector partners, and with universities to support research and improve care

Each area is led by an Executive Director, who is responsible for delivery. Progress and risks are regularly reviewed by the Trust Management Board.

Board Committees provide oversight of each area of the SIP:

- The Patients portfolio is overseen by the Safety and Quality Committee
- Performance and Productivity are overseen by the Finance and Performance Committee
- The People portfolio is overseen by the Workforce Committee and the Education, Training and Research Committee
- Partnerships are supported through the SIP Partnership Board, with reporting to the Trust Management Board and the Finance and Performance Committee

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2.2 Use of Symbols in the Quality Account 2025–26

To make the document clear and easy to follow, a set of visual symbols is used throughout the Quality Account 2025–26.

2.2.1 Symbols aligned to the SIP

Figure 2 Symbols aligned to the SIP

These symbols are used to show how different sections link to the five priority areas in the Single Improvement Plan. They provide a quick reference for readers.

2.2.2 Measuring success

The following symbols are used throughout the document to show levels of achievement against key indicators. They provide a clear and simple way to understand performance at a glance. The following symbols are also used throughout the document to represent levels of achievement against different indicators.

Table 1 The symbols used to represent levels of achievement

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

These symbols provide a clear and consistent way to understand performance, helping readers see how the Trust is progressing against its priorities and where further focus is needed.

2.3 Key Achievements from 2025-26

In 2025–26, the Trust made strong progress across its five strategic priorities. Improvements were seen in staff experience, patient care, and how resources are used. These results reflect focused work across teams and with partners.

This section highlights key outcomes within each priority area and shows how the Trust is turning its plans into real improvements in care and services.

2.3.1 Partnerships

The Partnerships portfolio focused on managing risk, strengthening support services, and working with partners to improve and redesign services. Key achievements include:

- **Strategy:** Publication of the Trust Strategy, supported by key supporting strategies and plans including Estates strategy, Green Plan, Always Safety First strategy and the Social Value strategy.

- **Regulation:** All Care Quality Commission (CQC) required actions were completed
- **Education:** Agreement to develop a Health Academy with the University of Lancashire, supporting training, leadership, and partnership working
- **Research and Innovation:** Progress in securing major grants, delivering commercial contracts and developing industry partnerships; clear ambition to achieve University Hospital status
- **Continuous Improvement:** External recognition for improvement work, with a growing internal training programme and plans to expand this further
- **Communications:** Delivery of communications plans for key strategies, including the Green Plan and health inequalities

2.3.2 People

The People portfolio focused on improving staff experience, strengthening culture, and supporting effective leadership. Key achievements include:

- **Training:** Core skills training compliance reached 95.45% (Month 11), exceeding the 90% target, with only small areas below target
- **Appraisal:** Compliance remained strong at 91.91% (Month 11), above the 90% target
- **Sickness absence:** Winter absence levels were lower than the previous year, with no usual seasonal peak; rates were 5.71% in March 2026
- **Team and culture:** Team development programmes are showing positive results, with good engagement and early signs of culture change; training in supportive conversations is fully booked and well received
- **Violence and aggression:** Focused improvement work continues to reduce colleague exposure
- **Retention:** Staff turnover improved to 9.92% in March 2026 (below the 10% target), with fewer staff leaving early and overall retention remaining stable

2.3.3 Patients

The Patients portfolio focused on improving safety, quality of care, and patient experience. Key achievements include:

- **Clostridioides difficile (C. difficile):** Performance came within the national tolerance
- **Patient experience:** Over 10% increase in volunteers; improved communication on admission through video information; more patient safety feedback collected; fewer concerns about sleep in inpatient areas
- **Safeguarding:** Compliance with rapid tranquilisation and restraint standards improved to 90%
- **Critical care:** Strong training compliance in sepsis awareness (95% for adults, 97% for children); 100% compliance in neonatal blood culture standards

- **Children and young people:** Improved ward environment and security; Friends and Family Test score increased to 90.7%
- **Maternity and neonatal:** All ten standards for the Maternity Incentive Scheme (Year 7) met; national survey results show performance in line with expectations (ranked 13th of 55), with several areas performing better and none declining
- **Always Safety First:** A new five-year Safety and Learning Strategy has been developed and is due for launch; STAR accreditation achieved in 89% of areas (above the 75% target

The table below summarises Key Performance Indicators (KPIs) aligned to the Patients portfolio, overseen by the Trust Safety and Quality Committee.

Table 2 Summary of Key Performance Indicator comparable data

Supporting Standards	2024-25	2025-26	Current Period	RAG
Staffing Fill Rate Registered Nurse	100.9	99.2	% - Cumulative to end Mar 2026	Deteriorated
Staffing Fill Rate Health Care Assistant	102.2	104.3	% - Cumulative to end Mar 2026	Improved
Staffing Fill Rate Registered Midwife	94.7	93.0	% - Cumulative to end Mar 2026	Deteriorated
Staffing Fill Rate Maternity Support Worker	90.0	92.8	% - Cumulative to end Mar 2026	Improved
Complaints per 1000 bed days	1.2	1.3	Rate - Cumulative to end Mar 2026	Deteriorated
Pressure Ulcers per 1000 bed days (Category 2 and above)	2.6	3.5	Rate - Cumulative to end Mar 2026	Deteriorated
MRSA	0	0	Cumulative to end Mar 2026	Maintained
C.difficile Infections	192	122	Cumulative to end Mar 2026	Improved
Perinatal - Number of Stillbirths	11.0	13.0	Cumulative to end Mar 2026	Deteriorated
Hospital Standardised Mortality Ratio (56 Basket – Adult)	75.9	76.4	To Nov 25 - Lower than expected	Improved
Standardised Mortality Rate (All Diagnoses – Adult)	74.6	71.4	To Nov 25 - Lower than expected	Improved
Standardised Mortality Rate (Child <1 day -17 Years) (All Diagnoses)	89.9	0.0	To Nov 25 - As expected	Improved
Standardised Mortality Rate (Neonatal <1 day -28 days) (All Diagnoses)	93.5	0.0	To Nov 25 - As expected	Improved
Compliance with 60 minute ambulance turnaround time target - actual	3206.0	2418.0	Cumulative to end Mar 2026	Improved
Maximum wait of 12 hours as Total Time in Department	10.2	14.0	% - Cumulative to end Mar 2026	Deteriorated
Bed occupancy to 92%	94.8	94.7	% - Cumulative to end Mar 2026	Improved
Reduce not meeting criteria to reside to 5%	11.6	11.1	% - Cumulative to end Mar 2026	Improved

Additional Key Performance Indicators (KPIs) on operational performance, including the Accident and Emergency four-hour standard, cancer waiting times, and referral to treatment times, are included in Section 2.14.5.

2.3.4 Productivity

The Productivity portfolio focused on delivering the financial plan, reducing waste, and improving long-term sustainability. Key achievements include:

- **Waste Reduction Programme (WRP):** A Trust-wide programme identified and delivered savings of £37.5 million by Month 12. This was below the £60 million target but in line with the revised forecast.
- **Financial sustainability:** The underlying position of the Trust improved from £65.8m to £51.7m in the financial year 2025-26. A financial sustainability plan (FSP) has been developed to map out a path to underlying break even position in the next 2 financial years.

  The Trust continues to work with NHS England's Recovery Support Programme and under agreed regulatory arrangements, with positive progress indicating potential improvement in oversight rating in early 2026–27.

2.3.5 Operational Performance

The Operational Performance programme focused on improving access to services and reducing waiting times. Key achievements include:

- **Long waits:** The backlog of patients waiting over 65 weeks has been eliminated and sustained since Quarter 3. The number of patients waiting over 52 weeks reduced from 1,820 at the start of the year to 1,063, with final figures subject to validation
- **Referral to Treatment (RTT):** Performance improved to 58.2% in March 2026 (from 55.7% in March 2025), although still below the national standard
- **Cancer waiting times:**
  - The 28-day Faster Diagnosis Standard is expected to exceed the 80% national target by March 2026
  - The 62-day treatment standard is also forecast to achieve the 75% target, improving from 58.5% in March 2025
    Final positions are subject to validation
- **Diagnostics (6-week standard):** Performance improved from 58.2% in March 2025 to 62.2% in March 2026, despite ongoing capacity pressures
- **Urgent and Emergency Care (UEC):**
  - Four-hour performance improved to 71.8% (from 69.1% in March 2025), but remains under pressure
  - Twelve-hour waits improved slightly, with 12.7% compared to 13.3% the previous year

2.3.6 Forward plan for 2026-27

Progress made in 2025–26 provides a strong foundation for continued improvement. The focus on performance, financial stability, and service delivery will continue into 2026–27.

The next phase of the Single Improvement Plan is aligned to the Trust's updated strategic objectives, ensuring clear priorities and a continued focus on improving services and outcomes.

Figure 3 SIP Strategic Framework

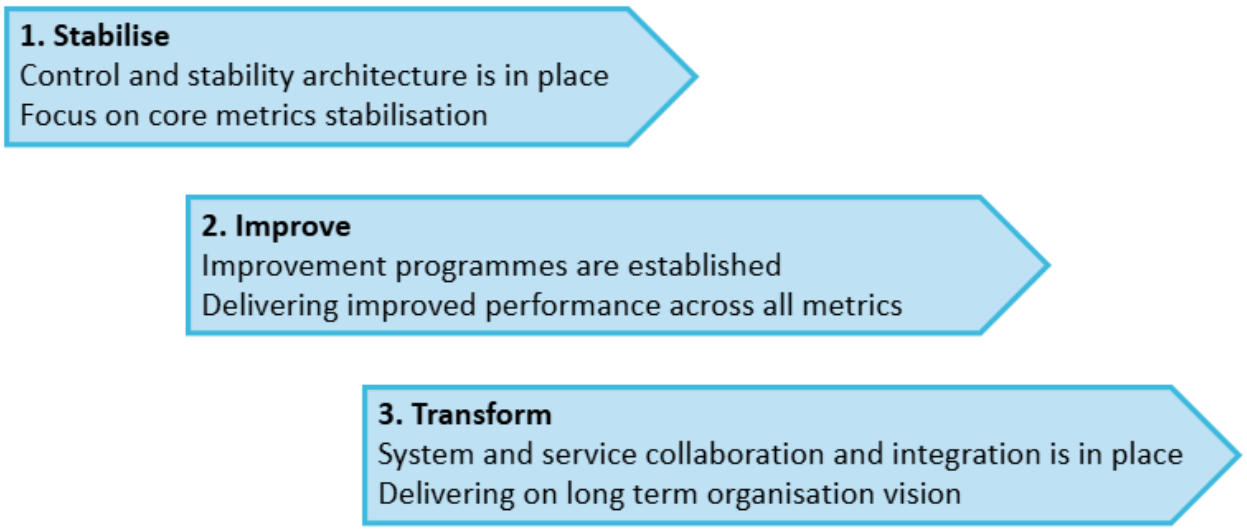
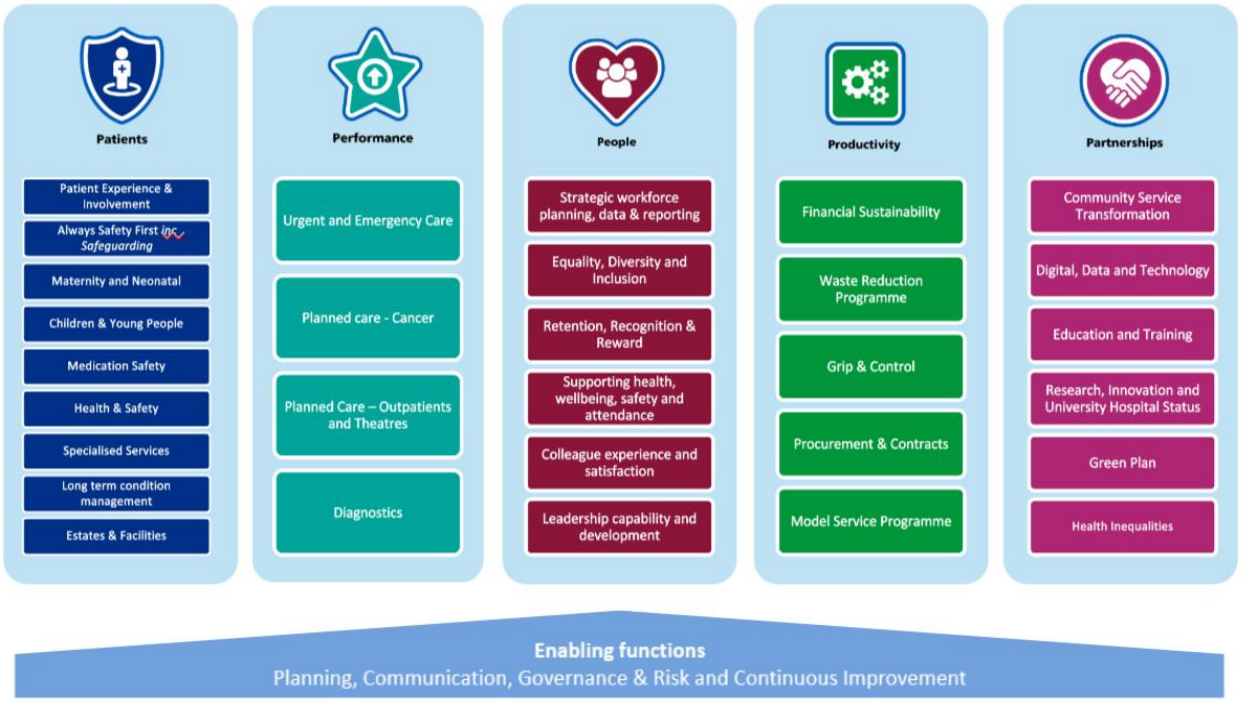


Figure 4 SIP Scope 2026-27



2.4 Continuous Improvement

During 2025–26, the Continuous Improvement (CI) programme supported safer, more reliable and more person-centred care across the Trust. A single approach, the Lancashire Improvement Method (LIM), has helped teams better understand patient journeys, reduce variation and work together to improve care.

Improving care for patients

Improvements were delivered at both team and pathway level:

- **Microsystem Coaching Academy and Local Improvement Programme:** Supported ward and service teams to improve consistency, reduce delays and prevent harm
- **Days Kept Away from Home:** Helped patients maintain independence and supported timely discharge
- **Multidisciplinary "Big Rooms":** Improved coordination across pathways such as stroke, cancer and mental health
- **National programmes:** Supported adoption of best practice, with learning shared more widely
- **Safety monitoring systems:** Strengthened how teams track and respond to risks

Delivering timely and effective care

- **Daily Management System:** Improved day-to-day oversight of activity, staffing and flow, supporting quicker decisions and safer care
- **Rapid Improvement Workshops:** Helped teams reduce delays and improve pathways across urgent, planned and diagnostic care

Supporting our people

- **CI training:** More than 900 staff completed improvement training, building skills and confidence across the workforce
- **Enhance Explore (Foundation Doctors):** Supported early-career clinicians to develop improvement and leadership skills
- **Shared learning:** A regional trainee conference and wider learning opportunities helped strengthen a culture of improvement

Improving productivity and value

- **Waste Reduction Programme:** CI methods supported delivery of savings and efficiency improvements
- **Rapid improvement weeks:** Eleven events generated a strong pipeline of costed improvement opportunities
- **Daily management system:** Contributed to a 17% reduction in non-medical temporary staffing costs, while maintaining safe care

Working in partnership

- **System partnerships:** Active involvement in regional, national and international programmes, including NHS IMPACT and the National Frailty Collaborative
- **Shared learning:** Contributed to wider improvement work, including productivity and reducing health inequalities

Looking ahead

The progress made in 2025–26 has strengthened a shared approach to improvement and built skills across the organisation. This provides a strong foundation to continue improving care, safety and sustainability in 2026–27.

2.5 Always Safety First (ASF)

The Always Safety First Strategy (2021–2024) strengthened safety across the Trust. It introduced a clearer approach to safety, improved involvement of patients, and supported a more open and learning culture. It also highlighted areas where further improvement is needed.

The updated **Always Safety First: Safety and Learning Strategy** builds on this progress. It focuses on greater consistency, stronger digital support, improved systems and a stronger focus on learning.

The strategy places more emphasis on people, recognising that safe care depends on supportive teams, open communication and a culture where staff feel able to speak up and learn.

It has been developed with input from staff, patients, communities and partners, and reflects learning from incidents, feedback and data.

2026–27 priorities

Safer culture
Focus on strengthening openness, learning and leadership:

- Compassionate support for staff after incidents
- Improving psychological safety and speaking up
- Fair and consistent incident management
- Stronger safety leadership and behaviours
- Learning from both positive practice and harm
- Better feedback for staff, patients and families
- Improved sharing and use of learning

Safer system
Strengthening the systems that support safe care:

- Improved digital systems, including the Electronic Patient Record

- Embedding safety standards for procedures
- Better risk assessment and care planning
- Focus on high-risk and high-demand areas
- Safer referral and administrative processes
- Stronger systems for sharing learning
- Improved support for frailty and end-of-life care
- Supporting more care closer to home

Safer patients
Reducing harm and improving safety outcomes:

- Improved medicines safety, including high-risk drugs
- Better care at the end of life
- Reducing falls, pressure ulcers and deconditioning
- Improved recognition of deterioration, including sepsis
- Stronger infection prevention and control
- Continued improvements in maternity and neonatal care
- Safer care for children and young people
- Support for patients with complex needs
- Improved care for alcohol withdrawal, nutrition and swallowing

Delivery will be supported through the Patients portfolio of the Single Improvement Plan, with clear measures and regular review to track progress and support continuous learning.

2.6 Risk Management

2.6 Risk Management

Alongside the focus on safety through the Always Safety First strategy, risk management remains a key part of how the Trust is run. During 2025–26, further progress has been made to strengthen how risks are identified, managed and reviewed across the organisation, with closer alignment to strategic priorities.

2.6.1 Risk Management and Risk Maturity

Risk management is supported by clear governance arrangements and a focus on openness and accountability. The Board Assurance Framework (BAF) and Risk Register are regularly reviewed and form part of routine governance processes.

Policies and guidance are available to all staff through the intranet, supporting a consistent approach. A central risk management team and health and safety team work alongside divisional governance teams to manage and monitor risks effectively.

2.6.2 Risk Management Strategy

The Risk Management Strategy 2024–27 continues to guide improvements in how risk is managed. Progress during 2025–26 includes:

- A new Trust-wide risk management system introduced in January 2026
- A reduction in high-level risks, with 20 removed during the year and 41 removed since January 2024
- A significant reduction in long-standing risks, with 55 removed, exceeding planned targets
- Introduction of Trust-wide e-learning to improve staff understanding of risk management

2.6.3 Risk Management Policy & Board Assurance Framework (BAF)

Each division is responsible for identifying and managing its risks in line with Trust policy. Risks are recorded and reviewed regularly, with actions taken to reduce them to acceptable levels.

Oversight is provided by the Risk Management Group, which reviews risks and supports escalation where needed. Significant risks can be escalated to Board Committees and the Board of Directors.

The Board Assurance Framework (BAF) brings together the most important risks linked to the Trust's strategic objectives. It is supported by the Principal Risk Register, which includes both strategic and high-level operational risks.

Executive Directors are responsible for reviewing risks and providing assurance to the Board. The Audit Committee also reviews the BAF.

By March 2026, the overall number of risks reduced from 418 to 351, and high-level risks reduced from 72 to 53. Key risks remain in areas such as financial pressures, estates, demand, capacity, and workforce.

Work continues to strengthen how risk management is used in day-to-day practice.

2.6.4 Risk Appetite and Tolerance

Risk appetite describes the level of risk the Trust is prepared to accept while delivering its objectives. Risk tolerance sets the limits within which risks can be managed.

The Trust's Risk Appetite Statement and tolerance levels were reviewed with the Board in May 2025 and approved in June 2025, with no changes required.

Table 3 The Risk Appetite set by the Board for 2025/26:

Strategic Objectives (the 5 Ps)	**Risk Appetite**	**Rationale**
Patients Deliver excellent care	Cautious	Providing safe and effective care for patients is paramount and so we have a low tolerance of risks which would adversely affect the quality and safety of clinical care. The Trust recognises that there may be an adverse impact on other Strategic Objectives but we prefer safe delivery options for patients with a low degree of residual risk, and we aim to work to regulatory standards.
Performance Deliver timely, effective care		
People To be a great place to work	Open	We are willing to accept some risk where there is a potential to improve recruitment, retention and employees' personal development.

Strategic Objectives (the 5 Ps)	Risk Appetite	Rationale
Productivity Deliver value for money	Cautious	We are committed to working within our statutory financial duties and will accept risks that may result in limited financial impacts or losses on the basis that there are clear and justifiable opportunities to enhance patient care and outcomes.
Partnership To be fit for the future	Seek	We are willing to consider all possible solutions to providing sustainable healthcare for local communities, while maintaining a low tolerance for risks to quality or patient safety.

Table 4: Risk Tolerance levels as set by the Board for 2025/26:

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

To help staff understand the Board's approach to risk in relation to its strategic objectives, the Trust has a Risk Appetite Statement. This is reviewed at least once each year to ensure it remains relevant and clear.

Table 5: The Risk Appetite Statement set by the Board for 2025/26:

Providing safe and effective care for patients is paramount and so we have a low tolerance of risks which would adversely affect the quality and safety of clinical care. However, to deliver excellent care for Patients, our Performance needs to support the delivery of timely, effective care and we recognise that, in pursuit of these overriding objectives, we may need to take other types of risk which impact on different organisational objectives. Overall, our risk appetite in relation to Patients and Performance is cautious – we prefer safe delivery options with a low degree of residual risk, and we work to regulatory standards.
We have an open appetite for those risks which we need to take in pursuit of our commitment to being a Great Place to Work for our People. By being open to risk, we mean that we are willing to consider all potential delivery options which provide an acceptable level of reward to our organisation, its staff and those who it serves. We tolerate some risk in relation to this aim when making changes intended to benefit patients and services. However, in recognising the need for a strong and committed workforce with the right skills and knowledge, this tolerance does not extend to risks which compromise the safety of our People or undermine our Trust values.
We have a cautious appetite for risks in relation to Productivity, to Deliver Value for Money. As a Trust, we are committed to working within our statutory financial duties, regulatory undertakings, and our own financial procedures. We will accept risks that may result in limited financial impacts or losses, on the basis that there are clear and justifiable opportunities to enhance patient care and outcomes.
We seek to be Fit for the Future through our commitment to working in Partnership with organisations in the local health and social care system to make current services sustainable and develop new ones. In pursuit of these aims, we will, where necessary, seek risk - meaning that we are eager to be innovative and will seek options offering higher rewards and benefits, recognising the inherent business risks.

In March 2026, the Board of Directors agreed to change the Risk Appetite for the Productivity objective from ‘Cautious’ to ‘Open’. This was formally approved at the Board meeting on 2 April 2026 alongside an updated Risk Appetite Statement.

2.6.5 Our principal risks and issues

The Trust uses the Board Assurance Framework (BAF) to identify and monitor the key risks that may affect delivery of its strategic objectives, known as the 5Ps: Patients, Performance, People, Productivity and Partnerships.

The BAF is supported by the Principal Risk Register, which includes risks that could affect delivery of these objectives, along with high-scoring operational risks escalated from divisional and corporate risk registers. This ensures that both strategic and day-to-day risks are considered together.

This approach enables the Board of Directors to review whether effective controls are in place and to take action where needed.

The BAF was reviewed at a Board workshop in May 2025. The Board approved 16 Principal Risks for 2025–26 in June 2025, including both ongoing and new risks linked to delivery of the Trust’s objectives.

An overview of these Principal Risks and their position at the end of March 2026 is set out below (Principal Risk numbers are updated each year).

Table 6: Principal Risks in 2025/26:

Ref	Principal Risk	Exec Lead	5Ps	Reporting Committee	Risk Appetite	Risk Tolerance	Score at 31.03.26
PR1 (25/26)	Patient experience within the urgent and emergency care pathway	CNO	Patients	SQC	Cautious	1-6	15
PR2 (25/26)	Higher than trajectory rates of clostridioides difficile (C.*difficile*) Infection	CNO	Patients	Recommended as Controlled – March 2026			
PR3 (25/26)	People experiencing Health inequalities	CNO	Patients	SQC	Cautious	1-6	12
PR4 (25/26)	Timely access to planned and cancer care	COO	Performance	FPC	Cautious	1-6	16
PR5 (25/26)	Timely access to urgent and emergency care	COO	Performance	FPC	Cautious	1-6	20
PR6 (25/26)	Timely access to diagnostic investigations	COO	Performance	FPC	Cautious	1-6	16
PR7 (25/26)	Reliance on temporary medical workforce	CMO	People	Controlled - February 2026			
PR8 (25/26)	Experience of staff, with specific focus on under-represented staff groups	CPO	People	WFC	Open	4-8	12
PR9 (25/26)	Sub-optimal experience of Resident Doctors	CPO	People	Stepped down from Principal Risk Status – October 2025			
PR10 (25/26)	Failure to effectively manage staff absence and achieve Trust and National target rates	CPO	People	WFC	Open	4-8	12
PR11 (25/26)	Compliance with Core Skills Training & Appraisals	CPO	People	Controlled - December 2025			

PR12 (25/26)	Failure to meet the financial plan 2025/26	CFO	Productivity	FPC	Cautious	8-12	20
PR13 (25/26)	Cash consequences of the Trust's underlying financial position	CFO	Productivity	FPC	Cautious	8-12	20
PR14 (25/26)	Ability to access required Capital to support an ageing estate	CFO	Productivity	FPC	Cautious	8-12	16
PR15 (25/26)	Research capacity and capability to enable progress towards University Hospital status	CSIO & CMO	Partnership	Recommended as Controlled – March 2026			
PR16 (25/26)	Failure to progress the configuration of Trust services to enable the delivery of the clinical strategy for LTHTR and L&SC	CSIO& CMO	Partnership	Controlled - December 2025			

All risks included in the Board Assurance Framework are reviewed by the relevant Executive Director and linked to the Trust's corporate objectives and supporting strategies. This ensures risks are clearly aligned to priorities. The Board and its Committees regularly review these risks to maintain oversight.

During 2025–26, three Principal Risks (PR7, PR11 and PR16) were reduced as far as possible and are now considered controlled. Two further risks (PR2 and PR15) were identified as controlled at the end of March 2026 and were presented to the Board in April 2026 for approval. One risk (PR9) was stepped down from the Board Assurance Framework to an operational risk in October 2025, following positive progress, with some actions still to complete.

A Board workshop in March 2026 reviewed the current risks and considered priorities for 2026–27, following agreement of the new corporate objectives. Updated proposals were presented to the Board of Directors in April 2026.

2.6.6 Operational High Risks escalated to Board:

During 2025–26, Board Committees continued to oversee operational risks with a score of 15 or above, in line with their respective areas of responsibility. No operational high risks required escalation to the Board of Directors through the Board Assurance Framework during the year.

An Internal Audit review of the Trust's assurance framework found:

- The Board Assurance Framework is structured in line with NHS requirements
- Governance and assurance arrangements are clearly defined and align with NHS England's well-led framework
- The Board and Audit Committee have clear ownership, with effective processes to identify and manage risks

- Risk appetite is regularly reviewed and used to guide risk management
- The Board Assurance Framework is actively used
- Risks reported in the framework reflect those discussed by the Board

These findings provide assurance that the Trust's approach to risk management is well established and continues to develop.

2.7 Statements of Assurance from the Board

This section of the Quality Account follows the wording required by Quality Account regulations and refers to Lancashire Teaching Hospitals NHS Foundation Trust (the Trust).

During 2025–26, the Trust provided or subcontracted 47 relevant health services.

The Trust has reviewed all available data on the quality of care across these 47 services.

Income from these services represents 100% of the total income received for providing relevant health services during 2025–26.

2.8 Participation in Clinical Audits

During 2025–26, 57 national clinical audits and three national confidential enquiries covered services provided by Lancashire Teaching Hospitals NHS Foundation Trust.

The Trust participated in 92% of the national clinical audits and 100% of the national confidential enquiries it was eligible to take part in.

The Trust did not participate in four national audits:

- National Diabetes Footcare Audit and National Diabetes Inpatient Safety Audit, due to service pressures
- National Ophthalmology Database (NOD) Cataract Audit, due to system requirements
- Royal College of Emergency Medicine (RCEM) Care of Older People Quality Improvement Programme, as priority was given to other RCEM improvement work

The national clinical audits and confidential enquiries the Trust was eligible to participate in during 2025–26 are listed below (see Table 7).

Table 7: National Audit and Confidential Enquiries – Eligible for Participation

NATIONAL CLINICAL AUDITS AND CONFIDENTIAL ENQUIRIES			
	National Programme Name	**Audit Title**	**Trust Participation**

1	The British Association of Urological Surgeons (BAUS) Data & Audit Programme	British audit of the investigation and referral of women with recurrent urinary tract infection using recent guidance (BOOMERANG)	**Yes**
2	BAUS Data & Audit Programme	Evaluating the Management Pathway for Suspected Testicular Cancer Referrals and Compliance with Standard Care Practices (EMPAST)	**Yes**
3	Breast and Cosmetic Implant Registry	As per the national audit name	**Yes**
4	British Spine Registry	As per the national audit name	**Yes**
5	Case Mix Programme (CMP)	Intensive Care National Audit a Research Centre (ICNARC)	**Yes**
6	Emergency Medicine Quality Improvement Programme (QIP)	Time Critical Medications	**Yes**
7	QIP	Mental Health Self Harm Audit	**Yes**
8	QIP	Adolescent Mental Health	**Yes**
9	QIP	Care of Older People	**No**
10	Epilepsy 12 - National Audit of Seizures and Epilepsies for Children and Young People (CYP)	Epilepsy 12	**Yes**
11	Falls and Fragility Fracture Audit Programme (FFFAP)	National Audit of Inpatient Falls	**Yes**
12	FFFAP	National Hip Fracture Database	**Yes**
13	Learning Disability Mortality Review Programme (LeDeR)	As per the national audit name	**Yes**
14	Maternal, Newborn and Infant Clinical Outcome Review Programme (MNI-CORP)	MBRRACE UK Saving Lives, Improving Mothers' Care Surveillance & Morbidity	**Yes**
15	MNI-CORP	MBRRACE UK Perinatal Mortality & Surveillance	**Yes**
16	MNI-CORP	National Perinatal Mortality Review Tool (PMRT)	**Yes**
17	Medical and Surgical Clinical Outcome Review Programme (NCEPOD)	Stabilisation of the critically ill child	**Yes**
18	FFFAP	Rib Fractures	**Yes**

19	Medical and Surgical Clinical Outcome Review Programme	Pleural Procedures	**Yes**
20	National Adult Diabetes Audit (NDA)	National Diabetes Core Audit	**Yes**
21	NDA	National Diabetes Foot Care Audit	**No**
22	NDA	Gestational Diabetes Audit	**Yes**
23	NDA	National Diabetes Inpatient Safety Audit (NDISA)	**No**
24	NDA	National Pregnancy in Diabetes Audit (NPID)	**Yes**
25	National Audit of Cardiac Rehabilitation	As per the national audit name	**Yes**
26	National Audit of Care at the End of Life (NACEL)	As per the national audit name	**Yes**
27	National Cancer Audit Collaborating Centre (NATCAN)	National Audit of Metastatic Breast Cancer (NAoMe)	**Yes**
28	NATCAN	National Audit of Primary Breast Cancer (NAoPri)	**Yes**
29	NATCAN	National Bowel Cancer Audit (NBOCA)	**Yes**
30	NATCAN	National Kidney Cancer Audit (NKCA)	**Yes**
31	NATCAN	National Lung Cancer Audit (NLCA)	**Yes**
32	NATCAN	National Non-Hodgkin Lymphoma Audit (NNHLA)	**Yes**
33	NATCAN	National Oesophago-Gastric Cancer Audit (NOGCA)	**Yes**
34	NATCAN	National Ovarian Cancer Audit (NOCA)	**Yes**
35	NATCAN	National Pancreatic Cancer Audit (NPaCA)	**Yes**
36	NATCAN	National Prostate Cancer Audit (NPCA)	**Yes**
37	National Cardiac Arrest Audit (NCAA)	As per the national audit name	**Yes**
38	National Cardiac Audit Programme (NCAP)	National Heart Failure Audit (NHFA)	**Yes**
39	NCAP	National Audit of Cardiac Rhythm Management (CRM)	**Yes**
40	NCAP	Myocardial Ischaemia National Audit Project (MINAP)	**Yes**

41	National Child Mortality Database (NCMD)	As per the national audit name	**Yes**
42	National Comparative Audit of Blood Transfusion	Management of Major Haemorrhage	**Yes**
43	National Emergency Laparotomy Audit (NELA)	As per the national audit name	**Yes**
44	National Joint Registry	As per the national audit name	**Yes**
45	National Major Trauma Registry	As per the national audit name	**Yes**
46	National Maternity and Perinatal Audit (NMPA)	As per the national audit name	**Yes**
47	National Neonatal Audit Programme (NNAP)	As per the national audit name	**Yes**
48	National Ophthalmology Database (NOD)	Cataract Audit	**No**
49	National Paediatric Diabetes Audit (NPDA)	As per the national audit name	**Yes**
50	National Respiratory Audit Programme (NRAP)	Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	**Yes**
51	NRAP	Adult Asthma Secondary Care	**Yes**
52	NRAP	Paediatric Asthma Secondary Care	**Yes**
53	National Vascular Registry (NVR)	As per the national audit name	**Yes**
54	Perioperative Quality Improvement Programme	As per the national audit name	**Yes**
55	Sentinel Stroke National Audit Programme (SSNAP)	As per the national audit name	**Yes**
56	Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	As per the national audit name	**Yes**
57	UK Cystic Fibrosis Registry	As per the national audit name	**Yes**
58	UK Interstitial Lung Disease (ILD) Registry	As per the national audit name	**Yes**
59	UK Parkinson's Audit	As per the national audit name	**Yes**
60	UK Renal Registry Chronic Kidney Disease Audit	As per the national audit name	**Yes**
61	UK Renal Registry National Acute Kidney Injury Audit	As per the national audit name	**Yes**

[1] List of national clinical audits as per specification provided by the DH cited on the HQIP website

https://www.hqip.org.uk/wp-content/uploads/2024/05/20240513_NHSE-QA-List-2024-25_FINALv2.pdf

There were 23 reports published from national clinical audits in 2025–26. These have been reviewed, and where improvement opportunities were identified, the Trust has taken actions to improve the quality of care provided.

Table 8: National Audits and Confidential Enquiries – Planned Actions

Title of Audit	Actions
MBRRACE-UK: Perinatal Mortality Surveillance (2023) Births	• Strengthen collaboration between Maternity and Neonatal services through daily safety huddles, MDT discussions, and regular joint review meetings to ensure safe and evidence-based neonatal admissions. • Maintain rigorous review processes for stillbirths and neonatal deaths through weekly PMRT meetings and participation in the LMNS rota for external MDT involvement. • Ensure compliance with the BAPM Perinatal Optimisation Pathway through guideline development, validation, and ongoing MDT engagement.
National Audit of Inpatient Falls (NAIF) 2025	• A Pressure Ulcer and Falls Panel commenced in October 2025 – to continue monthly meetings – includes oversight of the Trust falls prevention improvement plan. • Falls data is included in Safety and Quality Committee • Monthly analysis of falls data and uploading onto NAIF database
National Gestational Diabetes Audit	• To conduct a local audit on gestational diabetes audit in order to benchmark against the national results. Local results are not available for this audit.
National Joint Registry (NJR) 2024	• To monitor the consent rates for trauma patients and introduce the necessary improvements at Royal Preston Hospital • To audit the revision hip operations for periprosthetic fracture following the switch from a CPT implant.
National Kidney Cancer Audit (NKCA) 2025	• Improvement in the T3 renal cell carcinoma waiting times due to the increased capacity in the renal cancer surgeons' team. • The need to reaudit the T3 nephrectomy in last 12 months.
National Non-Hodgkin Lymphoma Audit (NNHLA) 2025	• To increase the proportion of people diagnosed with NHL discussed at a lymphoma/haematology multidisciplinary team (MDT) meeting within 4 weeks of diagnosis. • To appoint a haematology MDT coordinator
National Oesophago-Gastric Cancer Audit (NOGCA) 2025	• Roll out Direct PET CT plus CT for oesophago-gastric cancer across the network • Continue Education and Awareness: An Upper GI Study Day takes place annually where the NOGCA results are addressed.
National Ovarian Cancer Audit (NOCA)	• Fund and establish the NOCA task and finish group as a permanent subgroup that can monitor a comprehensive, ongoing and constantly evolving action plan and regular meetings.

	• Determine who is responsible for data in each Trust for imputing oncology data and data validation. • Further understanding required as to where we are as a system offering chemo to women > 75 years of age. • Review/create/access SOP regarding access to Oncology ward and finances. Contact Clinical Directors of Oncology.
National Pancreatic Cancer Audit (NPaCA) 2025	• To ensure contacts with Clinical Nurse Specialist are being recorded and that information is being submitted to the National Disease Registration Service (NDRS). • To audit pancreatic enzyme replacement therapy (PERT) prescribing in oncology – source of prescription / documentation.
National Perinatal Mortality Review Tool 7th	• To ensure that PMRT review roles are incorporated into consultant job plans and all other relevant role descriptions. • Scoping exercise is recommended to determine whether additional admin support can be secured to strengthen the review processes. • To ensure staff are trained and use the available PMRT Parent Engagement materials.
NNAP National Neonatal Audit Programme 2024	• Utilising the NNAP restricted access dashboard to review and implement any necessary quality improvement projects if needed. • Ensure parent inclusion on consultant ward rounds – to conduct an audit on parental presence on ward rounds.
The National Hip Fracture Database (NHFD) 2024	• To audit the Emergency Department fast track pathway and the times to admission and to assess where improvements can be made • To liaise with the therapy team with regards to 7 day physio service (funding has finished) • To set up an audit on quality of operation notes.

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

2.8.1 Local Clinical Audits and Resulting Actions (2025–26)

In 2025–26, the Trust reviewed 158 completed local clinical audits. These audits have supported targeted improvements in the quality of care provided.

All agreed actions are monitored through the Trust's Audit Management and Tracking (AMaT) system to ensure they are completed and sustained.

Table 9: Local Clinical Audits and Resulting Actions

Audit title	Actions completed
Acute scrotal exploration- Compliance against GIRFT guidance	• Produce an acute scrotum clerking proforma to be used by the surgical doctors: To include TWIST score, time contacted, pain timeline, time seen, decision
An audit of completion of somatic testing in women with non-mucinous ovarian cancer	• Liaise with GLH to get dataset to avoid hand searching of EPR.

	• To improve MDT documentation to ensure that all information is captured in one place.
Anaesthetic emergency grab bag evaluation	• Reminder for restocking bag, Checklist of appropriate contents updated. Adding a question into handover - QR code on restocking grab bag
Are We Following the Ottawa Ankle Rules? An Audit of Ankle Radiograph Requests in the ED.	• Arrange a teaching session or discuss this in handover • Put up posters/reminders in the ED about Ottawa ankle rules • Recommendations and advised was given to the ED Team in the handover and using the poster
Assessing the use of pre-hospital antibiotics in open fractures	• Disseminate education resources around recognition of open fractures amongst NWAS paramedics • On re-audit, assess fracture grade to check for correlation between fracture grade and likelihood of receiving antibiotics
Audit of Randomly Selected Clinical Records of Hereditary Angioedema patients	• Reminder to all clinical staff that at every outpatient clinic GP correspondence to state in the clinic letter that “benefit and adverse effects of treatment discussed with the patient and agreed to continue treatment”
Audit to assess sufficient contraceptive compliance in women of child bearing age on teratogenic medications	• Pop-up safety alerts for sodium valproate, topiramate, carbimazole and pregabalin when prescribing • Provide education to healthcare professionals in the practice
Blood Fridge collection	• Training statistics for blood component collection monitored on a monthly basis by the Transfusion Practitioner (TP) assistant • TPs and the HTC to ensure that all appropriate staff groups receive full training and maintain their competency as per their professional responsibility
Compliance with Red Cap/Packaging Cap Placement on ICU Circuits	• Include in morning huddle safety checklist. Posters displayed.
Compliance with oxygen titration and weaning in respiratory ward setting	• Staff advised to write the target saturation on the whiteboard. • To check oxygen compliance as per the prescription during each hand over and action on oxygen targets at the beginning of each shift.
Enhancing Decision-Making in Wound Closure Techniques	• Structured teaching sessions scheduled for junior doctors. These sessions will be delivered by surgical trainees and will cover wound assessment, closure methods (glue, sutures, Steri-Strips), suture and needle types, and dressing selection. • To provide a QR code linking to an educational website containing video tutorials and reference materials • Ongoing access to resources for all junior doctors, with QR codes shared after each teaching session

Paediatric Appendicectomy Length of Stay and Readmission audit	• Ambulatory patients stay at home until USS appointment confirmed • Introduce appendicitis guideline
Re-Audit DrEaMing (drinking, eating and mobilising post op) and Post Op Procedural Reviews by AAs	• To increase amount of referrals from anesthetists by promoting the post op review service within the department.
TACO Risk Assessment Compliance	• Clinicians supported to complete the TACO risk assessment electronically via the implementation of EPMA prescribing in the obstetrics and Gynaecology departments. EPMA completion of the TACO risk assessment is regularly audited by the transfusion practitioner team. • Education with theatres on the TACO risk assessment and use of the adult bedside checklist. • Include education on the TACO risk assessment into doctors induction training

2.9 Clinical Research

2.9.1 Participation in Clinical Research

During 2025–26, the Centre for Health Research and Innovation continued to strengthen its research activity, increasing participation in both national and commercial studies and improving study set-up times.

- 1,262 patients took part in research studies
- 1,002 patients were recruited to National Institute for Health and Care Research (NIHR) portfolio studies
- 60 patients participated in commercially funded studies

There were 287 active studies, with 145 open to recruitment. Commercial studies made up 32% of the portfolio (up from 26% in 2024–25), improving access to new treatments and supporting sustainability.

2.9.2 Trust Achievements in Research

Key achievements during 2025–26 include:

- Investment in facilities: £1.48 million NIHR funding secured to develop a Centre for Stroke and Neurosciences at the Rosemere Cancer Centre (opening planned for 2027)
- BioNTech partnership:

    - Six commercial cancer trials established
    - Five specialist roles created
    - Development of a research network across Lancashire and South Cumbria
- NIHR Manchester Biomedical Research Centre partnership:
    - Seven active studies
    - Progression of a joint PhD programme in colorectal research
- Digital innovation: £111,775 secured to improve digital research systems, supporting efficiency and governance

2.9.3 Research Governance

During 2025–26:

- 26 new studies were approved and opened, including 11 commercial studies
- Progress began against the national target to set up studies within 150 days
- Improvements were made to the HarrisFlex Red Triangle alert system, with updated processes and staff training to support patient safety

2.9.4 Workforce

Investment in the research workforce continued:

- Participation in national leadership programmes (NIHR Senior Leadership Programme)
- Gold STAR award achieved for the seventh consecutive year for quality, training and safety
- 125 attendees at the regional Red Rose Research event, strengthening collaboration
- Research career development supported through funded schemes and national programmes
- First respiratory PhD secured in partnership with Manchester Metropolitan University
- Ongoing growth in student nurse research placements, with positive feedback

2.9.5 Studies, Trials and Research

The Trust continued to expand its role in delivering innovative research:

- **Early access to treatment:** First UK site to recruit to a BioNTech oncology vaccine trial
- **Pioneering studies:**
    - First first-in-human study delivered, with positive published results
    - Participation in new treatment studies, including bladder cancer research
- **Recruitment performance:**
    - Top 5 UK site for EASi-KIDNEY
    - Highest recruiting UK site for a prostate cancer trial
    - Strong recruitment across multiple national studies
- **Innovation and collaboration:**
    - Successful Cancer Research UK funding bid
    - Over 400 patients recruited to a cancer prevention study
    - New specialist clinic for cerebral small vessel disease
- **Infrastructure and experience:**

    - New equipment funded to support research delivery
    - Continued investment in digital systems
    - Seventh Gold STAR audit award achieved
- **Raising awareness:**
    - A cancer trial campaign reached over 800,000 people

These achievements reflect continued growth in research activity, improving access to new treatments and strengthening the Trust's role in clinical innovation.

2.10 Registration with the Care Quality Commission

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

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

The Chief Nursing Officer and Deputy Chief Executive is the Trust's nominated individual for the CQC. The Trust remains compliant with all registration requirements.

2.10.1 CQC Finney House

Finney House Community Healthcare Hub previously provided out-of-hospital care for patients who were medically fit for discharge, with 96 single rooms across three floors.

Following a joint decision with commissioners and the Local Authority, the service closed on 31 May 2025. The Trust's CQC registration for this location has since been cancelled.

2.10.2 Trust Inspections 2025-26

No full CQC inspections took place during 2025–26. Two focused reviews were completed:

- **July 2025:** Radiotherapy services were inspected against Ionising Radiation (Medical Exposure) Regulations. Findings were positive, with no required actions
- **September 2025:** A Mental Health Act monitoring visit at Royal Preston Hospital and Chorley and South Ribble Hospital found that patients' needs were being met

One area identified for improvement was delays for patients waiting for inpatient mental health care. This reflects wider system challenges. Joint plans are in place with partners to address this, with progress monitored through the Safety and Quality Committee.

The Trust continues regular engagement meetings with the CQC.

2.10.3 CQC Inspection 2023

The last full CQC inspection took place between May and July 2023. This included both announced and unannounced visits and covered urgent and emergency care, medicine, surgery, maternity services, and leadership across the Trust.

The report, published in November 2023, gave an overall rating of Requires Improvement:

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

Some services were rated Good, including surgery at Royal Preston Hospital and urgent and emergency care and maternity services at Chorley. Other areas, including urgent and emergency care, medicine and maternity services at Preston, were rated Requires Improvement.

Figure 5 provides a summary of these ratings.

Figure 5: CQC Trust wide rating

2.10.4 CQC Inspection Outcomes and Quality Improvement Plan

Following the 2023 inspection, the Trust developed a Quality Improvement Plan (QIP) to address areas identified by the Care Quality Commission (CQC), including bed capacity, patient flow and financial performance. This work was incorporated into the Single Improvement Plan and regularly reported to the Board of Directors.

All actions from the 2023 inspection were completed during 2025–26, and the plan has now been formally closed. The Trust remains compliant with CQC registration requirements.

2.10.5 Recognition of Good Practice

The 2023 inspection also identified a number of strengths, including:

- Clear processes for identifying and managing risks
- A well-defined strategy and organisational direction
- A strong focus on patient-centred care
- Positive staff feedback on support, development and opportunities
- Effective governance and clear accountability
- Strong partnership working
- Good use of data to support improvement
- Ongoing engagement with patients, staff and local communities
- A well-established approach to quality improvement and learning

2.11 Quality of Data

2.11.1 Information Governance

The Trust continues to prioritise the quality and reliability of its data. Performance data is regularly checked to ensure accuracy, with further reviews carried out where needed.

The Digital and Health Informatics Directorate maintains data security through monitoring and independent assessment, including the NHS Data Security and Protection Toolkit. Findings inform an ongoing cyber security improvement plan, overseen by the Cyber Security Committee.

Cyber security risks are actively managed, with regular review and strengthened safeguards. These include national threat monitoring, secure data backups, and multi-factor authentication for over 11,000 staff.

2.11.2 Data Quality

High-quality data supports service improvement and patient care. The Board receives assurance through a bi-annual Data Quality Report, highlighting performance, risks and progress.

The Trust continues to achieve high levels of data completeness for national submissions:

- NHS number recorded:
    - 100% of admitted patient records
    - 99.9% of outpatient records
    - 99.4% of accident and emergency records

Accuracy for GP practice codes is also consistently high. Performance remains above national averages and has improved further over the past year.

The Trust reviews its position against the Data Security and Protection Toolkit each year. In 2024–25, 56% of standards were met, with improvement work underway. The 2025–26 submission is due in June 2026.

An internal clinical coding audit confirmed high levels of accuracy and completeness, with further improvements in recording diagnoses and procedures.

The Trust also performs strongly in the NHS Data Quality Maturity Index, remaining above the national average. National waiting list data is highly reliable, with 99.4% confidence, exceeding the national standard.

Table 10 below provides further detail on NHS Digital data quality.

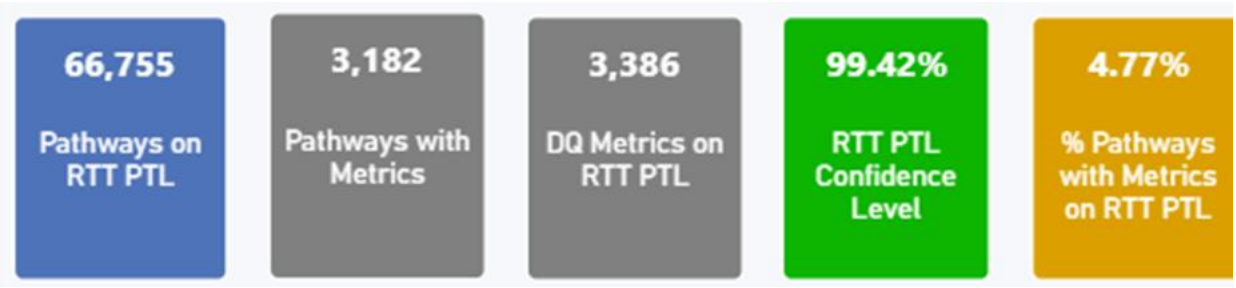
Table 10: NHS Digital Data Quality

	Emergency Care Dataset	Admitted Patient Care Dataset	Out-Patient Dataset
National Average	78.6	92.4	87.1
Lancashire Teaching	83.7	99.6	98.6

Data source NHS Data Quality Maturity Index

The Trust's National Waiting List Minimum Dataset data quality confidence level is 99.42%, above the national threshold of 95%. Detailed results below show a consistent number of records with data quality queries compared with the previous year:

Figure 6: National Waiting List Data



LUNA National Data Quality Solution

While data quality remains high, further improvements are being made. This includes enhanced validation checks within the Patient Administration System, staff training to reinforce the importance of accurate data recording, and continued work with partners to improve clinical coding and completeness.

A rolling audit programme is in place to review data collection processes. New digital tools are also being used to support accuracy, including technology to review clinical letters and identify key information, and improved linking of medical device data to patient records to strengthen outpatient coding.

2.12 Information Governance

2.12.1 Confidentiality and Information Security

The Trust is committed to protecting the confidentiality, security and integrity of information for patients, staff and the organisation. This is supported by clear policies and controls, which are regularly reviewed to remain up to date.

The Trust is registered with the Information Commissioner's Office (ICO) and meets its legal responsibilities for handling and sharing personal information securely.

As digital systems expand, the risk of data breaches remains. Robust processes are in place to report, investigate and learn from incidents. During 2025–26, three data breaches were reportable externally. Two required no further action from the ICO, and one remains under review. All have been investigated, with learning identified and acted on.

2.12.2 Data Security and Protection Toolkit (DSPT)

The Trust completes an annual assessment against the Data Security and Protection Toolkit to demonstrate compliance with national standards.

For 2024–25, the Trust achieved an "approaching standards" rating, with a small number of areas for improvement. A clear action plan is in place and progress is being monitored. The final submission for 2025–26 is due in June 2026.

2.12.3 Information Risk Management

The Trust has an established framework for managing information risks. Designated Information Asset Owners across services are responsible for identifying and managing risks, supported by staff training and clear reporting processes.

All arrangements meet the requirements of the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018.

2.12.4 Governance Structure

Overall accountability sits with the Board of Directors. Oversight is provided by the Information Governance Records Committee, reporting to the Finance and Performance Committee.

The Chief Medical Officer acts as Caldicott Guardian, and the Director of Corporate Affairs is the Senior Information Risk Owner. A supporting working group monitors risks and ensures compliance.

2.12.5 Information Governance Management Framework

The Trust's approach is informed by national standards, audits and assurance programmes. This supports ongoing improvement and ensures high standards of data security and information management.

2.13 Adult Mortality Reviews

2.13.1 Overview of Mortality Governance

The Trust has well-established processes to review, report and learn from patient deaths. Since 2017–18, this has included the nationally recognised Mortality Review process using the Structured Judgement Review (SJR) method.

This approach is used for adult inpatient and Emergency Department deaths. Deaths involving babies and children are reviewed through separate national processes.

The Medical Examiner Service provides additional independent review.

2.13.2 Structured Judgement Reviews (SJRs)

During 2025–26, there were 1,675 patient deaths across the Trust.

By March 2026:

- 926 Structured Judgement Reviews had been completed
- 19 Patient Safety Incident Response Framework (PSIRF) reviews were undertaken
- 8 cases were identified as more likely than not to have been influenced by problems in care
- 11 cases remain under review

Thirteen cases were referred to the Coroner:

- 5 inquests have concluded
- 2 were discontinued
- 6 remain ongoing

2.13.3 Deaths Due to Problems in Care

Two deaths were identified as more likely than not linked to problems in care:

- A patient fall in the Emergency Department where one-to-one supervision was not in place
- A case where anticoagulation treatment was stopped, leading to a pulmonary embolism

Some cases remain under review, and further conclusions will be informed by ongoing inquests.

2.13.4 Learning from Structured Judgement Reviews

Learning from deaths is regularly shared across the Trust through governance meetings.

Areas of strong practice included:

- High standards of record keeping
- Good communication with families
- Early involvement of palliative care
- Regular senior clinical review
- Timely escalation of care

Areas identified for further focus included:

- Earlier recognition of patients approaching end of life
- Clearer documentation of care planning and resuscitation decisions
- Continued improvement in clinical documentation

This learning continues to inform improvements in patient safety and care.

2.14 Reporting Core Indicators 

2.14.1 Overview

The Trust monitors performance across a range of safety, access and patient experience indicators in line with national requirements.

During 2025–26, demand remained high across urgent and planned care. This reflects an ageing population, increasing complexity of need, and sustained pressure on Urgent and Emergency Care services. Waiting times and flow through services remain areas of focus.

2.14.2 Operational Pressures and System Challenges

Key factors affecting performance included:

- High bed occupancy
- Increased length of stay and more patients who do not meet criteria to remain in hospital
- Industrial action impacting services
- Ongoing elective care backlogs
- Workforce and financial constraints limiting capacity

2.14.3 System-Wide Transformation Initiatives

The Trust continued to work with partners to improve care across the system:

- Expansion of virtual wards, supporting care closer to home

- Improved community and urgent care integration, helping more patients avoid hospital admission
- Support for relocation of community inpatient services to maintain patient flow and reduce delays

2.14.4 Performance Highlights and Areas for Improvement

Performance improved in a number of areas during 2025–26, although some pressures remain.

Urgent and Emergency Care (UEC):

- Four-hour performance was 72.2%, below the 78% target
- Twelve-hour waits increased to 12.7% (from 10.2%)
- Ambulance handover within 45 minutes achieved 87%, below the 98% target

Planned care:

- 52-week waits: Reduced to 894 patients (1.4% of the waiting list), better than the 2.5% target
- 18-week referral to treatment: Improved to 59.4%, up 4.6% from April 2025

Cancer performance:

- 62-day standard: Achieved 76.6%, above the 75% target and a significant improvement over the year
- 28-day Faster Diagnosis Standard: Achieved 83.5%, above the 80% target

Diagnostics:

- Performance remained below the 65% target at 60.45%, although the number of longest-waiting patients reduced significantly (87% reduction)

2.14.5 Summary of Performance against Core Indicators

Table 11: Core Standards 2025-2026

Core Standards	2024-25	2025-26	Current Period	Comparion
A&E - 4 hour standard	69.8	70.1	% - Cumulative to end Mar 2026	Improved
Cancer - 2 week rule (All Referrals)	87.1	86.7	% - Cumulative to end Mar 2026	Deteriorated
Cancer - 2 week rule - Referrals with breast symptoms	76.3	82.0	% - Cumulative to end Mar 2026	Improved
Cancer - 31 day target	89.4	91.9	% - Cumulative to end Mar 2026	Improved
Cancer - 31 Day Target - Subsequent treatment – Surgery	66.3	68.5	% - Cumulative to end Mar 2026	Improved
Cancer - 31 Day Target - Subsequent treatment – Drug	98.3	98.7	% - Cumulative to end Mar 2026	Improved
Cancer - 31 Day Target - Subsequent treatment -Radiotherapy	93.7	93.2	% - Cumulative to end Mar 2026	Deteriorated
Cancer - 62 day Target	62.7	63.3	% - Cumulative to end Mar 2026	Improved
Cancer - 62 Day Target - Referrals from NSS (Summary)	36.0	25.0	% - Cumulative to end Mar 2026	Deteriorated
28 day faster diagnosis standard – compliance	77.8	78.6	% - Cumulative to end Mar 2026	Improved
MRSA	0	0	Cumulative to end Mar 2026	Maintained
C.difficile Infections	192	122	Cumulative to end Mar 2026	Improved
18 weeks - Referral to Treatment - % of Incomplete Pathways < 18 Weeks	56.4	54.8	% - Cumulative to end Mar 2026	Deteriorated
18 weeks - Referral to Treatment -Number of Incomplete Pathways > 104 Weeks	0.0	0.0	End Mar 2026 census position	Maintained
18 weeks - Referral to Treatment -Number of Incomplete Pathways > 78 Weeks	0.0	0.0	End Mar 2026 census position	Maintained
18 weeks - Referral to Treatment -Number of Incomplete Pathways > 65 Weeks	19.0	0.0	End Mar 2026 census position	Improved
18 weeks - Referral to Treatment -Number of Incomplete Pathways > 52 Weeks	1372.0	896.0	End Mar 2026 census position	Improved
% of patients waiting over 6 weeks for a diagnostic test	49.9	39.7	% - Cumulative to end Mar 2026	Improved

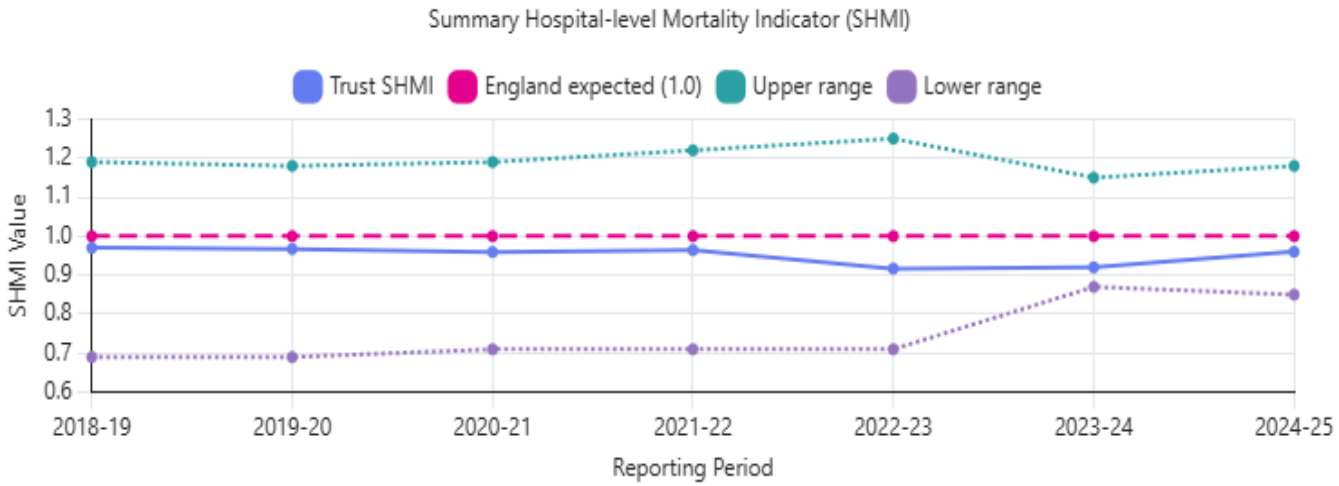
2.14.6 NHS Digital Data and Performance Indicators

The following performance indicators are based on nationally published data from NHS England, in line with Quality Account requirements. The data reflects the most recent reporting periods available and allows comparison with other acute (non-specialist) NHS trusts.

To support clarity, data is presented using charts and summary tables, providing an accessible view of performance trends.

Indicator	Figure Reference	Reporting Period
Summary Hospital-level Mortality Indicator (SHMI)	Figure 7	2024-25
Emergency Readmissions within 30 Days of Discharge	Figure 8	2024-25
Venous Thromboembolism (VTE) Risk Assessment	Figure 9	2024-25
Clostridioides difficile (C. difficile) Infection	Figure 10	2024-25
Patient Safety Incidents	Figure 11	2024- 25 .

Figure 7: Summary Hospital-Level Mortality Indicator (SMHI) * most current data

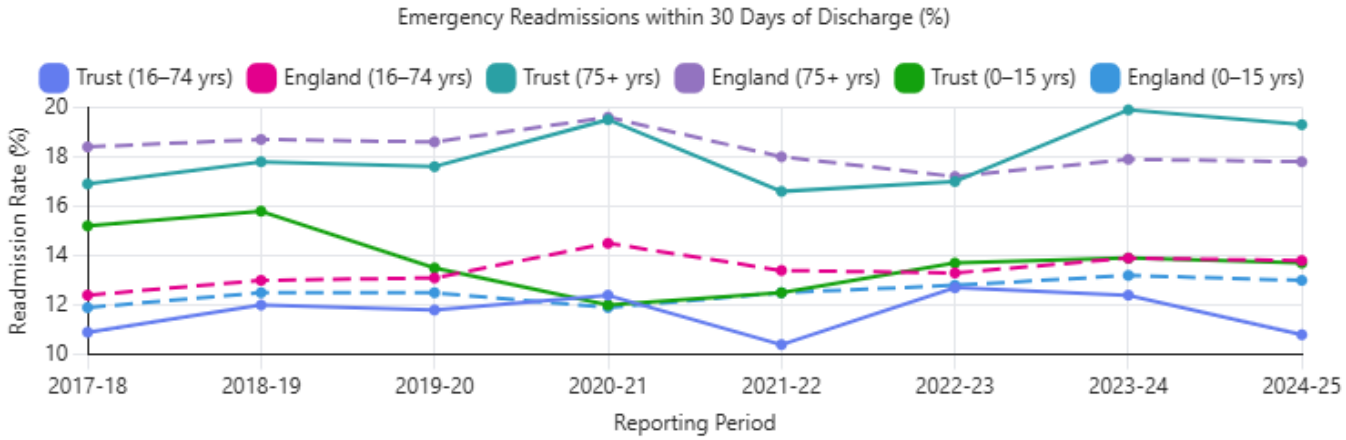


The Summary Hospital-level Mortality Indicator (SHMI) compares the number of deaths recorded with the number expected, where a score of 1 represents the national average.

The Trust's SHMI has remained below 1.0, indicating outcomes are within the expected range. In the most recent reporting period (2024–25), the SHMI was **0.96**, a slight increase from the previous year but still below the national average.

Mortality data continues to be reviewed alongside Structured Judgement Reviews and other quality measures to support learning and ongoing improvement in care.

Figure 8: Emergency Readmissions within 30 Days of Discharge



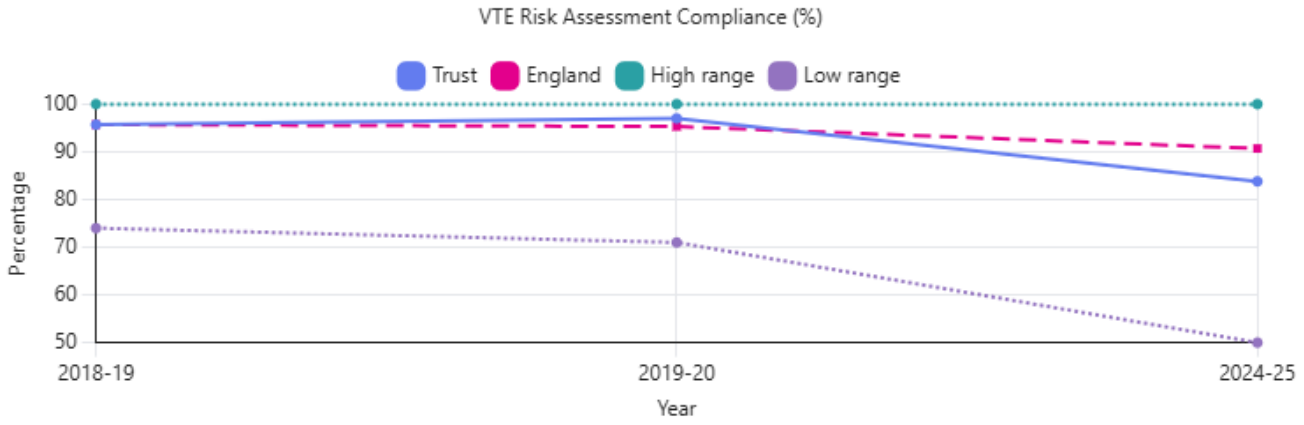
Emergency readmissions within 30 days of discharge are an important measure of how well care and discharge planning meet patient's needs.

The Trust's performance varies by age group. For patients aged 16–74, readmission rates are generally below the England average. For patients aged 75 and over, rates are similar to or slightly above the national average, reflecting the more complex needs of this group.

For children and young people (aged 0–15), readmission rates remain above the national average, although the gap has reduced over time.

Work continues to strengthen discharge planning, follow-up care and community support, with a focus on reducing avoidable readmissions and improving outcomes

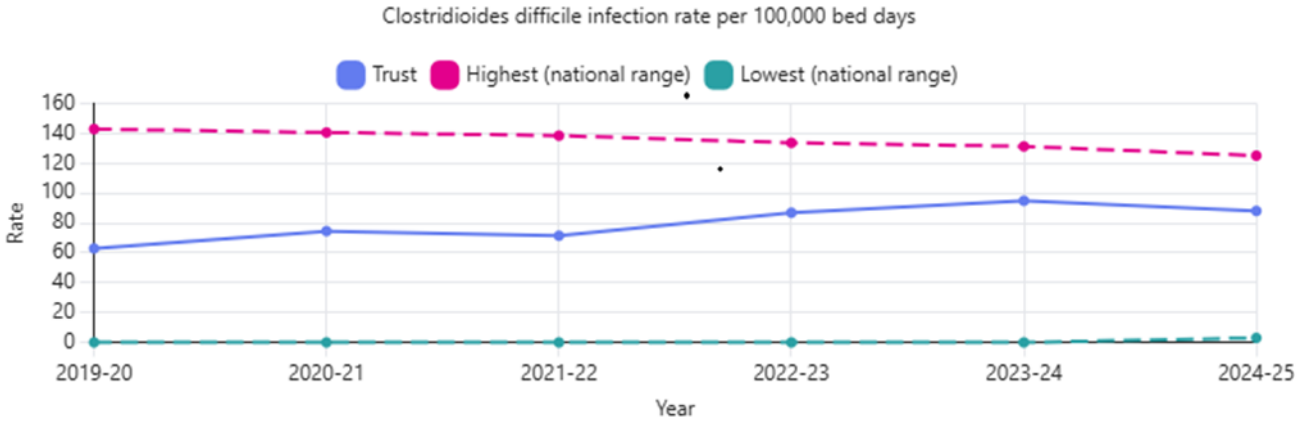
Figure 9: Venous Thromboembolism (VTE) Risk Assessment * most current data



Compliance with Venous Thromboembolism (VTE) risk assessment was reported at a compliance rate of 83.8%, below the national average of 90.7%. A specific improvement programme has focused on data quality, capture and compliance in areas below the standard. It is expected this will improve

during 26/27. The Trust continues to monitor performance closely and has maintained internal assurance processes during the period when national data was not available.

Figure 10: Clostridioides Difficile (C. difficile) Infection * most current data

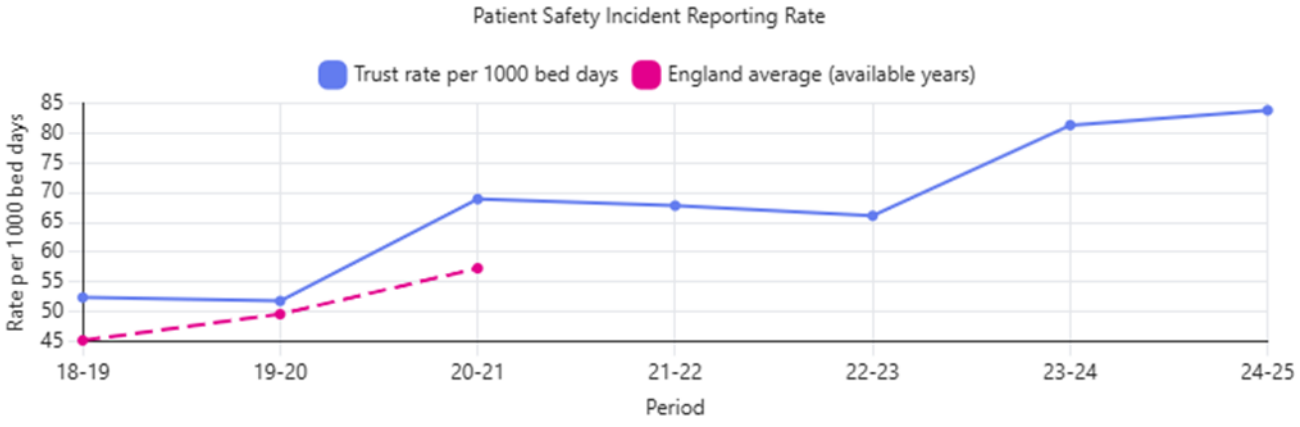


The Trust's rate of Clostridioides difficile (C. difficile) infection has varied over time, rising from 62.9 per 100,000 bed days in 2019–20 to 94.8 in 2023–24, before reducing to 88 in 2024–25.

Rates have remained within the national range, and the reduction in 2024–25 reflects improvements made in infection prevention and control.

In 2025–26, the Trust met its annual objective, reporting 122 cases, below the level set by NHS England. Ongoing work continues to focus on antimicrobial stewardship, environmental cleanliness, and early identification and management of infection to maintain progress and support patient safety.

Figure 11: Patient Safety Incidents * most current data



The rate of patient safety incident reporting has increased, with 83.8 incidents per 1,000 bed days reported in 2024–25. This continues an upward trend and reflects an open and proactive reporting culture.

Where national comparisons are available, the Trust reports at a higher rate than the England average. Higher reporting levels support earlier identification of risks and opportunities for improvement. Comparable national data has not been available since 2021.

Summary for NHS Digital Data and Performance Indicators

Overall, these indicators show that the Trust is performing within expected national ranges while continuing to strengthen safety and quality.

Mortality remains within the expected range, and infection rates for Clostridioides difficile have improved in the most recent year. Readmission rates vary across age groups, reflecting differences in patient need, with a continued focus on improving rates in children and older people.

The Trust also continues to show a strong reporting culture, with increasing incident reporting and fewer cases of severe harm. Together, these trends reflect a continued focus on safe, effective care and ongoing improvement.

2.15 Patient experience performance indicator

2.15.1 Adult Inpatient Survey 2024

Results from the Care Quality Commission (CQC) Adult Inpatient Survey show that patients continue to report positive experiences of care.

Scores for respect and dignity (Q47) remained high at 97–98%, and kindness and compassion (Q46) stayed strong at 96–97%, in line with national averages.

Overall satisfaction remains positive, although there has been a reduction in the proportion of patients rating their care 7 out of 10 or higher (Q48), from 81% in 2022 to 76% in 2023 and 2024. This is below the national average of 83%, highlighting an area for further focus.

Overall Patient Experience – Historical and External Comparison

Table 12: Adult inpatient survey Questions 46- 48

Overall Adult Inpatient Survey 2024

Historical

Question	Description	2020	2021	2022	2023	2024	Picker Average	Trust
Q46	Treated with kindness and compassion	-	-	-	96%	97%	98%	97%
Q47	Treated with respect and dignity overall	98%	97%	98%	97%	98%	98%	98%

Q48	Rated overall experience as 7/10 or more	80%	80%	81%	76%	76%	83%	76%

2.15.2 Commitment to Continuous Improvement

The Trust continues to use patient feedback to improve services and address areas of concern. In response to the 2024 survey, improvement work is focused on:

- Improving communication with patients
- Strengthening discharge arrangements and information
- Creating a more restful environment, including reducing overnight moves
- Improving meal choice and access to food outside mealtimes
- Supporting patients who need help with eating
- Increasing patient involvement in decisions about their care

Performance measures are being developed to track progress and support ongoing improvement. These actions form part of the Trust's Single Improvement Plan, ensuring patient experience remains central to care delivery.

2.16 Staff experience performance indicator

Each year, NHS staff are invited to complete the NHS Staff Survey, providing feedback on their experience of working in the organisation and the care they deliver. Since 2021, the survey has been aligned to the NHS People Promise, which aims to make the NHS a better place to work.

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

This reflects staff confidence in the quality and safety of care. At Lancashire Teaching Hospitals NHS Foundation Trust, the percentage of staff agreeing with this statement has reduced over the past four years:

Table 13: Staff Recommendation as a Provider of Care LTH

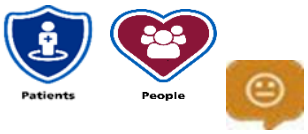
Q25d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation. (%)	**2021**	**2022**	**2023**	**2024**	**2025**
	62.1%	60.0%	58.3%	51.9%	48.4%

This downward trend suggests fewer staff feel confident in recommending the organisation. The Trust recognises the importance of understanding and addressing this change. In response, work is underway to explore the reasons behind this, including staff engagement sessions, review of internal

data, and aligning actions with the NHS People Promise. The Trust has launched ‘your voice’ events to provide a townhall type approach to listening to colleagues and what is influencing this deterioration. The Urgent and Emergency Care pathway is the key area of focus and as such additional focus on this area has been enacted in 25/26 and will continue into 26/27.

The Trust remains committed to supporting its workforce and strengthening staff experience. By improving engagement and wellbeing, the aim is to increase staff confidence and ensure patients continue to receive safe, high-quality care.

2.17 Freedom to Speak Up



Lancashire Teaching Hospitals NHS Foundation Trust is committed to high standards of care and a culture where staff feel supported to raise concerns.

The Freedom to Speak Up (FTSU) service provides a safe and confidential way for staff to raise concerns. Speaking up supports improvements in staff experience, patient safety and the quality of care.

2.17.1 Service Delivery

Staff are supported to speak up through:

- **FTSU Guardian:** An independent and confidential contact for advice and support
- **Accessible reporting routes:** Concerns can be raised by email, phone, online or directly
- **FTSU Champions:** A network of trained staff offering local support
- **Training and awareness:** Ongoing work to promote openness
- **Confidentiality and protection:** Concerns are managed sensitively, with safeguards in place
- **Support and follow-up:** Ongoing support with feedback on actions taken
- **Board oversight:** Regular reporting to support improvement

Overview of FTSU Activity and Trends in 2025

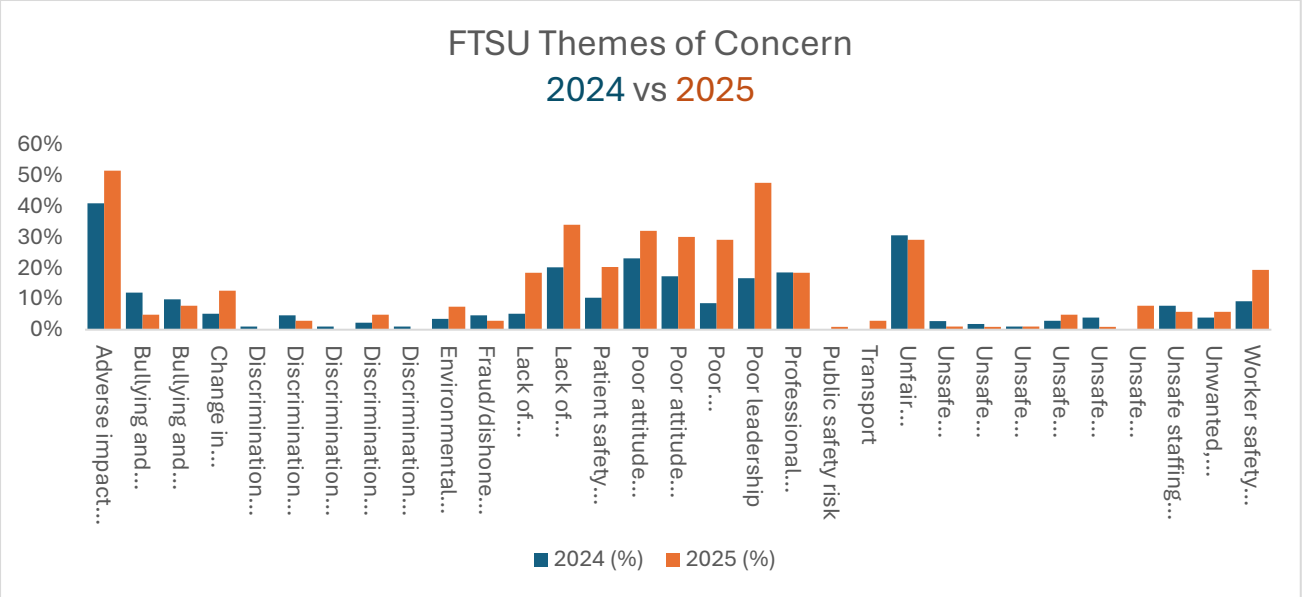
- 103 concerns raised (reduced from 160 in 2024)
- 23.4% raised anonymously (increase from the previous year)
- Most concerns raised by registered nurses, healthcare assistants and administrative staff

Staff survey results for 2025 show:

- 55.7% felt safe to speak up (down from 58.5% in 2024)
- 42.3% felt concerns would be addressed (down from 44.1% in 2024)

These results show that while reporting routes are in place and used, further work is needed to strengthen confidence in speaking up.

Figure 12: FTSU Themes of Concerns



Over the past year, changes in speaking up trends highlight areas where further focus is needed to maintain a supportive and safe working environment. Key themes include:

- **Health and wellbeing:** 51.5% (up from 41.7%), often linked to bullying, harassment and working conditions
- **Lack of involvement:** Increased by 13.2%, particularly around organisational change
- **Management response:** Delays or limited feedback increased by 13.8%
- **Behaviours:** 30% of concerns (up by 12.8%), including incivility and bullying
- **Leadership:** 47.6% (up by 30.9%), with staff reporting feeling unheard or unsupported
- **Worker safety:** 19.4% (up from 9.2%)

2.17.2 Key Priorities

Priorities for 2026 have been updated in response to these themes and staff feedback:

Strengthening visibility and trust

- Improve awareness of how to raise concerns, particularly for new staff and students
- Promote clear and accessible reporting routes

Developing the FTSU Champion network

- Expand the network in key areas
- Support learning and development through regular sessions

Creating a positive speaking up culture

- Share learning and examples of improvement
- Support managers to respond effectively and provide feedback
- Increase understanding of speaking up and related processes

- Support leaders to encourage open conversations

Understanding staff experience

- Improve how the Trust monitors and understands staff experience after raising concerns

These priorities support safer care by encouraging early identification of risks, strengthening teamwork, and using staff feedback to improve services.

The Trust remains committed to a culture where speaking up is encouraged, supported and acted on, helping to create a safer and more inclusive environment for both staff and patients.

PART 3 - Review of Quality Performance

3.1 Review of Quality Performance - Patient Safety

Patient safety remains a key priority for the Trust. Performance is closely monitored, with a continued focus on reducing harm and improving the safety of care.

The Trust's safety programme, Always Safety First, was introduced in response to the NHS National Patient Safety Strategy and has continued to be led by the Chief Nursing Officer and Chief Medical Officer, supported by governance, nursing and continuous improvement teams. The programme promotes a consistent focus on safety across the organisation and includes input from patients and the public.

In 2026, this programme was refreshed with the launch of the new Always Safety First: Safety and Learning Strategy (2026–2030). This forms part of the Single Improvement Plan and sets out a clear approach to improving safety through learning from incidents, near misses and other sources of insight. It also supports the development of a strong culture of safety, learning and continuous improvement across all services.

Key areas of focus within the programme are outlined below:

Table 14: Key areas of focus within the ASF programme

Safer Culture	Safer Systems	Safer Patients
• Create the conditions for psychological safety speaking up and learning together • Implement a compassionate Incident	• Strengthen digital safety infrastructure (EPR, Wi-Fi, devices) • Embed NatSSIPs 2 and LocSSIPs to improve procedural safety	• Medicines safety, including insulin/diabetes, anticoagulation and VTE prevention

Support Framework for colleagues • Consistently embed Being Fair and trauma-informed approaches • Strengthen visible safety leadership and clear behavioural expectations • Embed Safety-II thinking, learning from what goes well as well as what goes wrong • Consistent, high-quality PSIRF learning responses and debriefs • Improve the quality and timeliness of feedback to staff, patients and families • Build leadership capability to model behaviours and deliver sustained change • Strengthen how learning is shared, applied and evidenced in practice	• Improve risk assessment quality and personalised care planning • Strengthen assurance and oversight from Ward to Board • Deliver a Training Needs Analysis for safety-critical roles • Use data-informed huddles, handovers and standardised Ward-to-Board rounds • Clarify leadership accountability for Safety Improvement Programmes • Strengthen safety pathways in ED, assessment and high-occupancy areas • Improve administrative safety for patients awaiting treatment • Strengthen system learning, referral pathways, frailty identification and end-of-life planning • Build on community-focused models, including high-intensity user support.	• Improve recognition, support and care of the dying patient • Reduce avoidable harm through Harm-Free Care (pressure ulcers, falls, deconditioning, discharge safety) • Sepsis and Deterioration pathways, including Martha's Rule Strengthen • Infection Prevention and Control • Continue delivery of Maternity and Saving Babies' Lives Care Bundles • Address risks for children and young people in unsuitable settings • Improve personalised care and reduce diagnostic overshadowing • Strengthen alcohol-withdrawal management • Improve safe eating and drinking for patients at risk of aspiration or malnutrition.

3.1.1 The Patient Safety Incident Response Framework (PSIRF)

Patient Safety Incident Response Framework (PSIRF)

In line with the National Patient Safety Strategy, the Trust moved from the Serious Incident Framework to the Patient Safety Incident Response Framework (PSIRF) in November 2023. PSIRF focuses on learning, improvement and preventing harm, with a stronger emphasis on compassionate engagement with patients, families and staff.

During 2025–26, this approach has continued to develop, supported by an updated PSIRF Policy and Patient Safety Incident Response Plan (2026). These reflect learning from implementation and align with national guidance and the Trust's wider strategy.

PSIRF uses a range of proportionate and timely review methods. While some incidents require a full Patient Safety Incident Investigation, most are reviewed through approaches such as After Action Reviews, SWARM reviews, Rapid Learning Reviews and thematic reviews. This supports earlier learning and faster improvement.

Refreshed PSIRF Policy and Plan

The updated 2026 plan sets a more focused and data-led approach, targeting areas where the greatest improvements can be achieved.

Key local priorities are:

- Patients remaining in inappropriate care settings leading to deterioration
- Lack of personalised care for vulnerable patients
- System-wide issues across pathways and handovers
- Emerging risks

These priorities are based on safety data, staff and patient feedback, and learning from early PSIRF implementation.

Governance has been strengthened through daily and weekly review processes and oversight from the PSIRF Oversight Panel. This supports consistent and timely decision-making across the Trust.

Work has also continued to strengthen safety culture, promoting openness, fairness and involvement. Patient Safety Partners play an important role in shaping learning and improvement.

Patient and Family Engagement and Compassionate Involvement

A key part of PSIRF is involving patients, families and carers in learning following incidents. The Trust aims to ensure people are treated with openness, respect and compassion.

Patients and families are offered opportunities to:

- Share their experience
- Ask questions
- Contribute to learning and improvement

This approach applies across all types of review, not only formal investigations.

Key developments include:

- Implementation of the Being Open Policy, supporting early and honest communication in line with Duty of Candour
- Involvement of Patient Safety Partners in governance and improvement work

Staff are also supported through this approach, recognising the emotional impact of incidents and promoting a fair and supportive culture.

Priorities for 2026-27

- Ensuring learning leads to clear and measurable improvements
- Strengthening links between incident learning and improvement programmes
- Developing staff capability in delivering high-quality reviews
- Increasing involvement of patients and families in all aspects of safety

This approach supports a more responsive and learning-focused system, helping to improve patient safety over time.

3.1.2 Safety Triangulation Accreditation Review (STAR)

The STAR Quality Assurance Framework is the Trust's approach to monitoring care standards, providing assurance, and supporting improvement across clinical areas. It brings together audit, accreditation and performance information, with oversight through Divisional forums, the Safety and Quality Committee and the Trust Board.

Of 118 clinical areas, 90% achieved a silver rating or above, with 63% rated gold. There were no red ratings. At 31st March 2026, 106 areas were green and 12 were amber, with overall ratings of 12 bronze, 32 silver and 74 gold. A further three areas have achieved silver and are progressing towards gold.

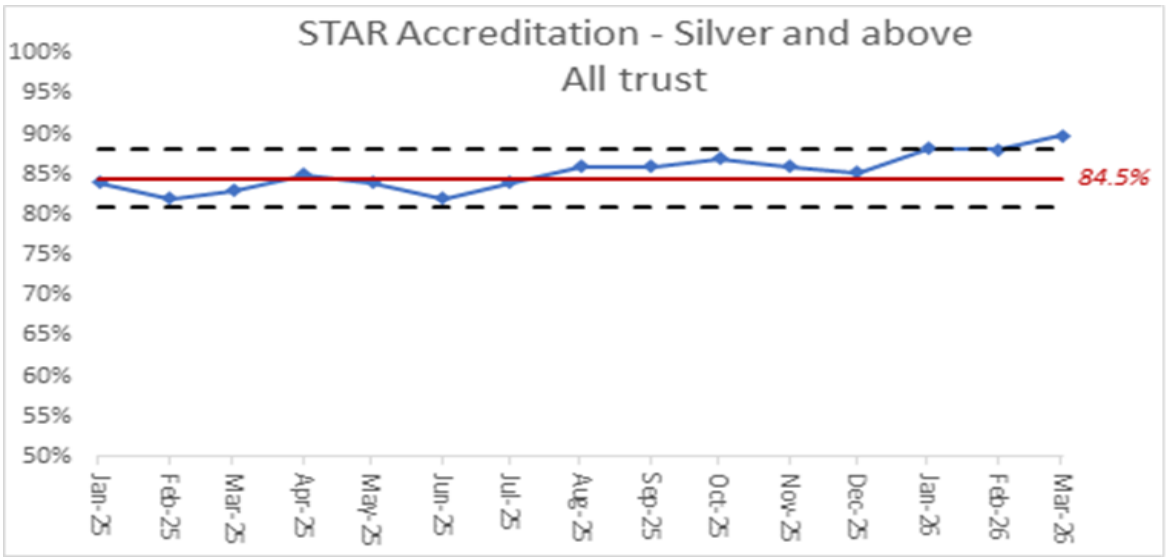
Performance improved during the year, with areas rated silver or above increasing from 83% to 90%, exceeding the Trust target of 75%. Changes to standards in 2024 strengthened requirements for progression, and many areas have since improved, supported by the Gold Panel process introduced in 2025.

STAR reviews are carried out monthly and assess safety, quality and patient experience. Where challenges are identified, additional support is provided through the STAR Enhanced Oversight Panel. Of the five areas currently receiving this support, two have already progressed to silver.

Ward, theatres and ED are disaggregated to ensure oversight of the highest risk areas within the organisation.

Targeted assurance reviews are also carried out in response to risks, including work on patient flow, escalation and care for vulnerable patients. Learning is shared across the Trust to support continued improvement and spread good practice.

Figure 13: STAR Accreditation Trust-wide and STAR Wards, EDs and Theatres Compliance by Month



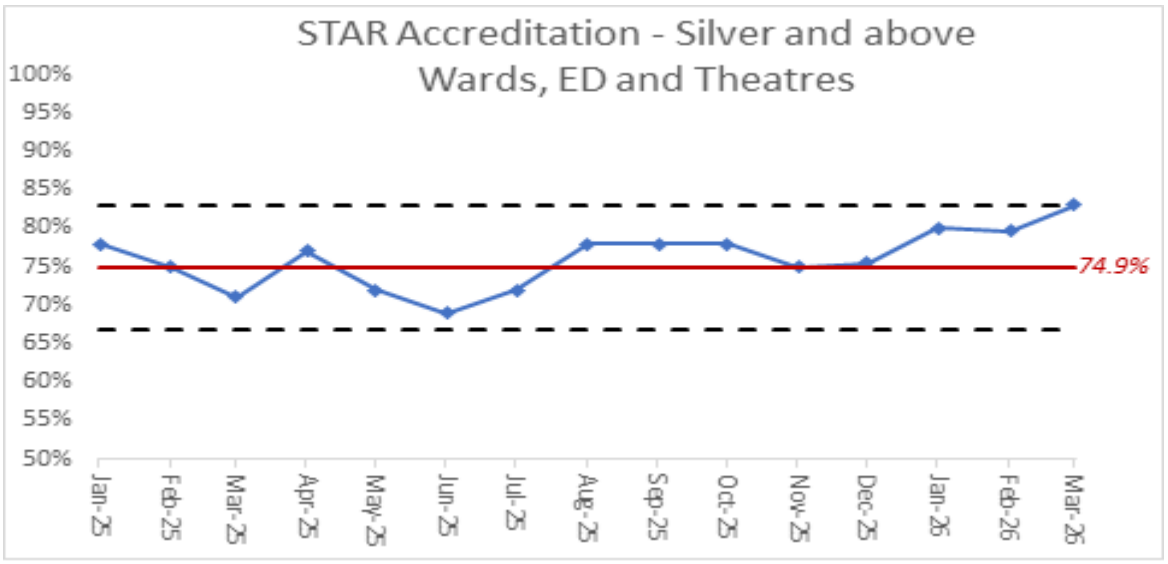
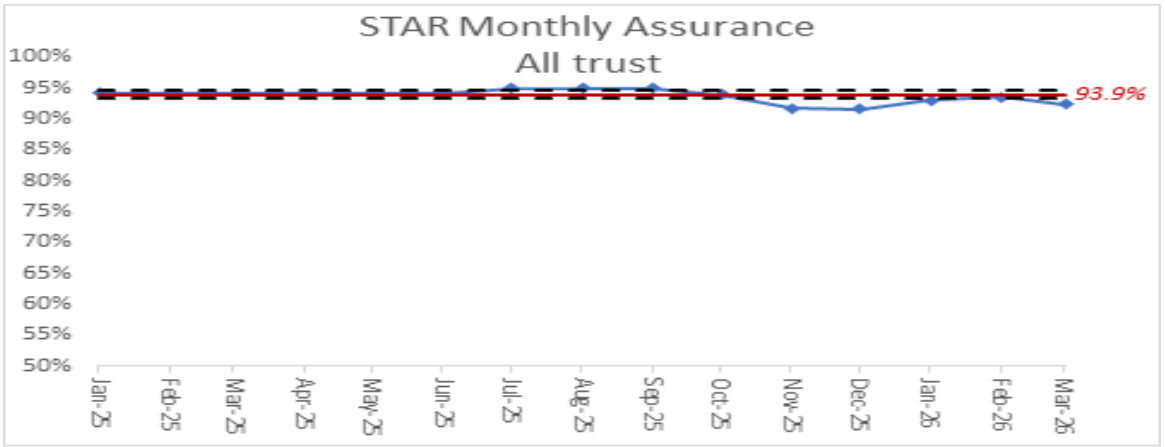
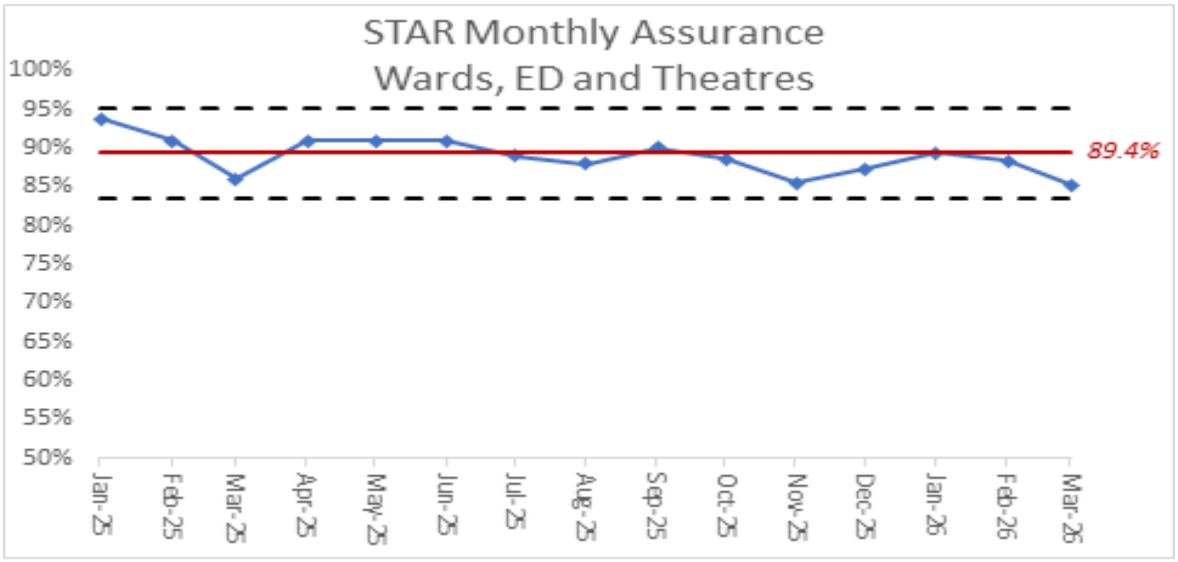


Figure 14: STAR Monthly Review Trust-wide Compliance and STAR Monthly for Wards, ED and Theatres by Month





3.1.3 Falls Prevention

Falls prevention remains a priority within the Single Improvement Plan. During March 2025 to April 2026, improvement work continued, including intentional rounding, review of nursing risk assessments, prevention of deconditioning, and reducing days patients spend away from home. These actions support safer care and aim to reduce the risk of falls.

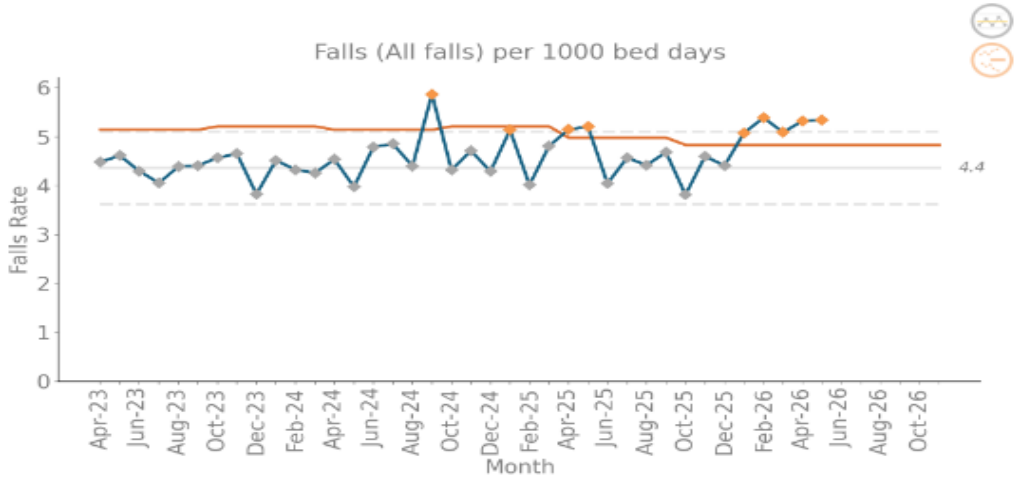
A new Falls and Pressure Ulcer Prevention Panel has been introduced, chaired by the Deputy Chief Nursing Officer. The panel reviews incidents causing severe harm and shares learning across the Trust. A Trust-wide action plan is in place and is monitored through this forum.

Figure 15: Falls Data 2025–26

- **Total inpatient falls** (excluding faints, collapses, and seizures):
  - **2025-26**: 1,457 falls
  - **2024–25:** 1,504 falls
  - **2023–24:** 1,443 falls
  - **Change:** Increase of **3%**
- **Falls resulting in major harm or above (severe harm or death):**
  - **2025-26:** 7 incidents (6 severe, 1 death)
  - **2024–25:** 12 incidents (9 severe harm, 3 deaths)
  - **2023–24:** 17 incidents (14 severe harm, 3 deaths)
  - **Change: 42% Reduction** in high-harm falls

While the total number of falls has increased, this reflects higher patient numbers, greater levels of need and frailty, and increased hospital occupancy. To provide a clearer picture of performance, the Trust uses falls per 1,000 bed days. This measure takes activity into account and gives a more consistent view of trends over time, as shown in Figure 16.

Figure 16: Inpatient falls per 1000 bed days (excluding assisted falls, faints, collapses, seizures)



Source: LTHTR Datix data

3.1.3.1 Falls Risk Management and Governance

Risks related to inpatient falls and associated harm are actively monitored through divisional risk registers, including Surgery, Medicine and the Emergency Department.

Falls prevention is a regular focus within Always Safety First divisional meetings. The Falls and Pressure Ulcer Prevention Panel reviews all incidents resulting in severe harm, alongside reviews through Patient Safety Incident Response Framework (PSIRF) triage processes.

The Trust also participates in the Royal College of Physicians National Audit of Inpatient Falls, with findings used to inform the Trust-wide falls action plan. An annual falls report was presented to the Safety and Quality Committee in August 2025.

Falls prevention remains a key priority within the Always Safety First strategy, supporting ongoing improvements in patient safety.

3.1.4 Safeguarding (including Maternity, Children and Adults)

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

Safeguarding protects children, young people and adults at risk from harm. The Trust is committed to providing safe, respectful and appropriate care across all services.

The Trust meets all legal safeguarding requirements and has clear leadership in place. This includes senior leads for adults, children and maternity, supported by specialists in mental capacity, learning disabilities, autism, mental health and dementia.

These roles provide oversight and help ensure safeguarding is part of everyday practice. The Safeguarding Team includes both Trust-funded and externally funded roles, which will continue into 2026–27.

3.1.4.2 Safeguarding Activity

The Safeguarding Team provides advice and support for concerns involving people of all ages. Referrals are received from staff, partner organisations, and directly from patients, families and carers.

Many cases are complex and require joint working with services such as social care, police, mental health services and ambulance services. This helps ensure people receive coordinated and timely support.

The Trust meets NHS England safeguarding standards and works closely with the Children's Safeguarding Assurance Partnership and the Lancashire Safeguarding Adults Board. Learning from reviews, audits and incidents is shared across the organisation.

Regular audits, reviews and staff training support ongoing improvement, and safeguarding is fully linked to wider patient safety work.

3.1.4.3 Externally commissioned services

The Trust also works with externally funded specialist roles, including Independent Domestic Violence and Sexual Violence Advocates and an Emergency Department Navigator.

These roles provide immediate support for people experiencing abuse or vulnerability and help them access specialist services.

Table 15: Safeguarding Teams externally funded specialist roles

ED Navigator • Funded by: Violence Reduction Network • Commissioned until: 31 March 2027	• From April 2024 to March 2025, the ED Navigator received 217 referrals which is a 6.8% reduction on last year. The ED navigator reviews all Emergency Department presentations with indicators or risks of serious violence and/or exploitation, • The ED navigator has been involved in several initiatives over the last 12 months which includes, Training, Education and Prevention Work, active participant in Multi-Agency Safeguarding and Strategic Panels.
Health Independent Sexual Violence Advisor (HISVA) • Funded by: Office of the Police and Crime Commissioner • Commissioned until: 31 March 2027	• The HISVA has received 86 referrals from April 2024 – March 2025) which is a decrease of 36.2%, providing specialist, trauma-informed support to victims of sexual abuse and/or sexual violence who present within the hospital setting.

Health Independent Domestic Violence Advisor (HIDVA) • Funded by: Office of the Police and Crime Commissioner • Commissioned until: 31 March 2027	• In the same reporting period, the HIDVA received 368 (increase 3.9% on the previous year) referrals, with 11.7% of contacts with regards Trust staff. This service has a multi-agency referral pathway with requests being received internally and form external partners including police and NWAS. • The HIDVA frequently provides workplace support to staff requiring longer term support.

3.1.4.4 Maternity Safeguarding Activity

Safeguarding activity in maternity services remains high, reflecting the increasing complexity of needs for women and families. Referrals to the Enhanced Support Midwifery Team have increased, mainly for safeguarding and mental health concerns.

Notifications for domestic abuse and referrals for Female Genital Mutilation have also risen, reflecting wider population trends. These cases are managed through close partnership working to support the safety of women and babies.

3.1.4.4.1 Key Activities and Achievements

Key developments during the year include:

- **Bereavement support:** A clear directory of support services has been developed, helping families access timely support following bereavement
- **ICON programme (infant safety):** A new multi-agency video provides consistent advice to parents on infant crying and safer care
- **Supporting families:**
  - Introduction of HOPE Boxes to support families during separation
  - Use of sensitive photography (with consent) to support emotional connection and memory-making
- **Education and workforce development:**
  - Enhanced safeguarding training for maternity students, including simulation-based learning
  - Positive feedback for teaching on mental health and trauma-informed care
- **Raising awareness:**
  - Delivery of Safer Sleep Week activity
  - Development of new safer sleep resources and videos
  - Wider communication through digital platforms and partner organisations
- **Specialist support services:**
  - Launch of the Young Persons Midwifery Service (Blossom Team), providing tailored support for parents under 20
  - Continued focus on access to maternal mental health services
- **Partnership working:**
  - Joint training with partners, including police and safeguarding teams

- Shared learning from reviews and incidents to improve responses to complex cases

These developments have strengthened support for families, improved staff skills, and enhanced partnership working across maternity services.

3.1.4.5 Children and Young People

The Trust is committed to keeping children and young people safe through strong safeguarding practice, effective partnership working, and timely responses to risk.

This approach supports early intervention and ensures that children, young people and their families remain at the centre of care.

3.1.4.5.1 Summary of Safeguarding Activities

Strengthening partnership working
Collaboration with safeguarding leads in neighbouring Trusts has increased, supporting shared learning and more consistent practice. Joint work on Medical Neglect and Was Not Brought policies has improved clarity and multi-agency response.

Improving response to child sexual harm
Closer working with the Sexual Assault Forensic Examination (SAFE) Centre has strengthened safeguarding responses, including joint attendance at strategy meetings and improved coordination between services.

Child Protection Information Sharing (CP-IS)
Progress continues in implementing CP-IS systems to support timely information sharing. Areas for improvement have been identified, with interim measures in place and further development ongoing across the system.

Supporting children in care
Work to improve Initial Health Assessments has reduced missed appointments and improved engagement. New information materials and a quarterly reporting framework have strengthened oversight and planning.

Professional challenge and escalation
Use of the professional challenge process has increased, showing greater confidence in raising concerns. Most cases have led to improved decision-making and care planning.

Strengthening safeguarding practice
Updates to the Child Safeguarding Checklist and local audit processes have improved guidance for staff and strengthened compliance across services.

Emergency Department Navigator
The Emergency Department Navigator role continues to support vulnerable children and young people, contributing to multi-agency work and targeted initiatives such as violence prevention programmes.

Overall, these developments have strengthened partnership working, improved safeguarding practice, and supported earlier intervention for children and young people.

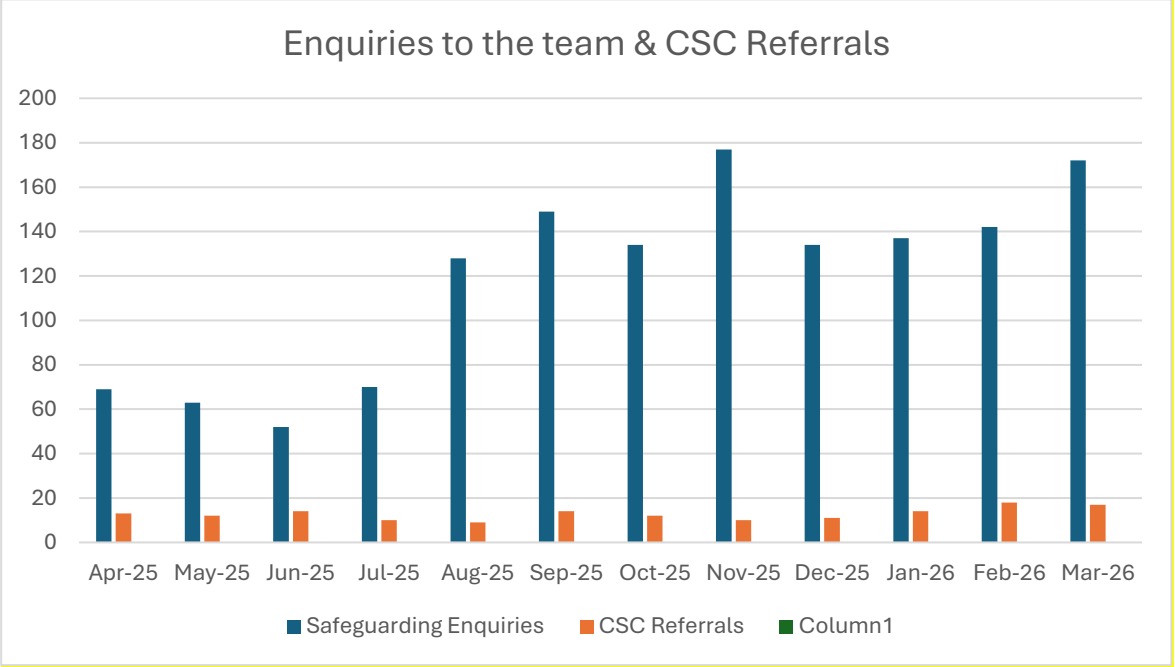
3.1.4.5.2 Child Safeguarding Training mandatory Compliance

Safeguarding training meets national standards set out in the Intercollegiate Document (2025).

Training compliance across the Trust has remained high, with rates between 93% and 100% across all levels during the year.

3.1.4.5.3 Social care referrals

Figure 17: Referrals into the Trust Child safeguarding and Children's Social Care (CSC)



Source: LTHTR Datix/Ulysses data

3.1.4.5.4 Children's Social Care Referrals

Referrals to Children's Social Care reduced slightly, from 179 in 2024–25 to 154 in 2025–26. Most children attending paediatric services already have appropriate support in place. Processes continue to be reviewed to ensure concerns are identified and referrals are made where needed.

3.1.4.5.5 Child Deaths

Between April 2025 and March 2026, there were 36 child deaths, representing an 8.8% increase from the previous year. Of these, 22 deaths (62.86%) were classified as expected, while 12 (34.29%) were classified as unexpected. One case (2.85%) was not categorised within the available data. The majority of deaths (70.27%) occurred in children under five years of age. Of the 12 unexpected child deaths recorded this year, a range of causes have been identified. These include ligature, drowning, suffocation, seizure or brain injury, suspected sepsis, and hypoxic ischaemic encephalopathy.

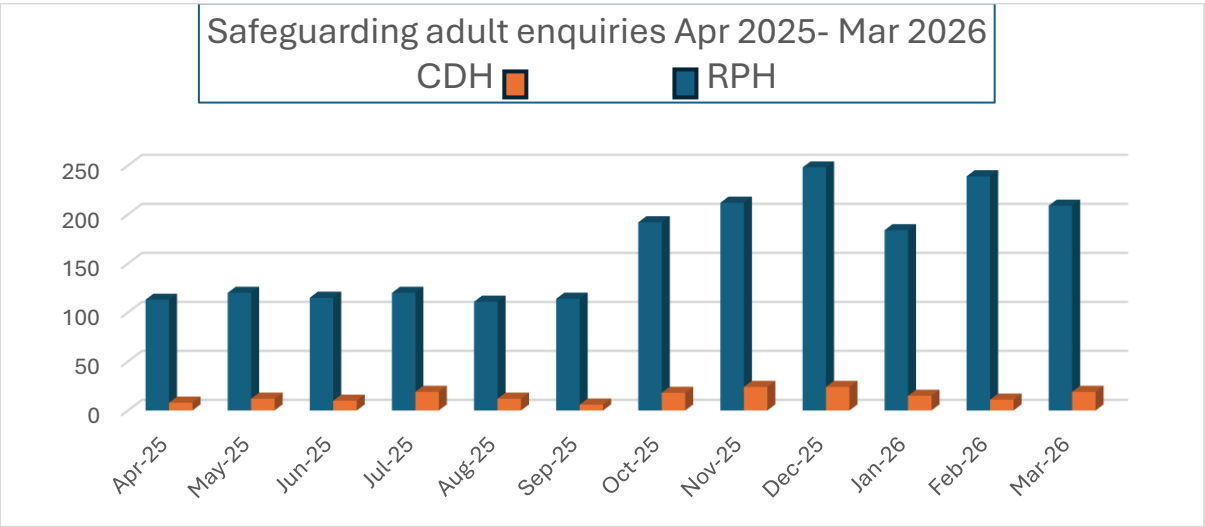
Child Mortality Review Meetings continue to be chaired by the Named Doctor for Children's Safeguarding, providing clinical leadership and professional oversight. Meetings are formally recorded, with agreed actions monitored through the Women's and Children's governance structure to ensure clear accountability, oversight and follow-up.

3.1.4.6 Safeguarding Adult Activity

Safeguarding concerns are received through a range of routes, including telephone, email, the Trust's incident reporting system, and electronic patient records.

Each enquiry is reviewed by a safeguarding practitioner, who provides advice, takes action where required, or directs the individual to the most appropriate service.

Figure 18: Safeguarding Adult enquiries



Source: LTHTR Datix/Ulysses data

3.1.4.6.1 Section 42 enquiries

A Section 42 enquiry, under the Care Act 2014, is led by the Local Authority when an adult with care and support needs is at risk of abuse or neglect and may be unable to protect themselves.

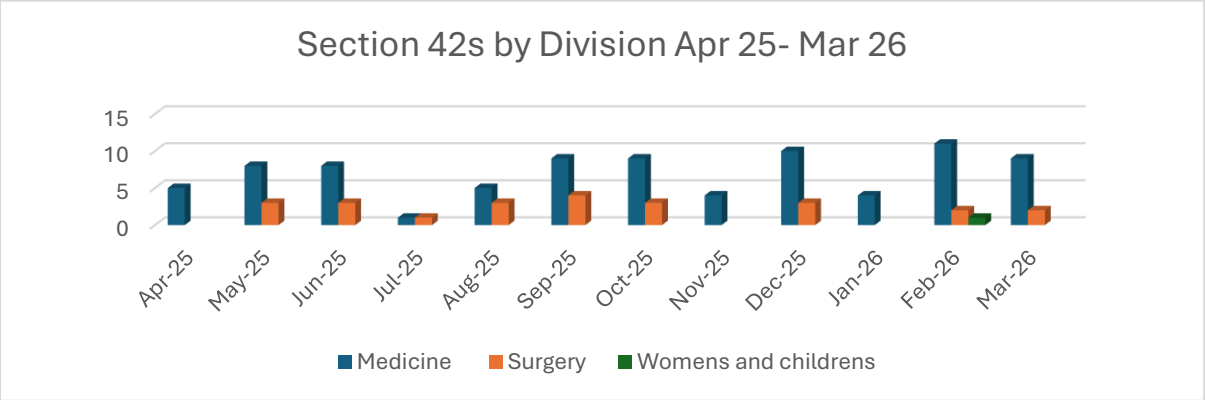
The Trust has clear processes to respond to these enquiries. Adult Safeguarding Practitioners lead internal reviews and act as the link with the Local Authority.

Most responses are completed within expected timescales, although more complex cases can take longer. Learning is identified following each enquiry and shared with partners, with the Local Authority responsible for confirming outcomes and closing cases.

Delays in receiving outcomes have affected timely closure. In response, a joint task and finish group has been set up to improve the process, including the introduction of a standard reporting format to support greater consistency and timeliness.

Figure 19 below shows the number of Section 42 enquiries raised between April 2025 and March 2026.

Figure 19: Section 42 by Division

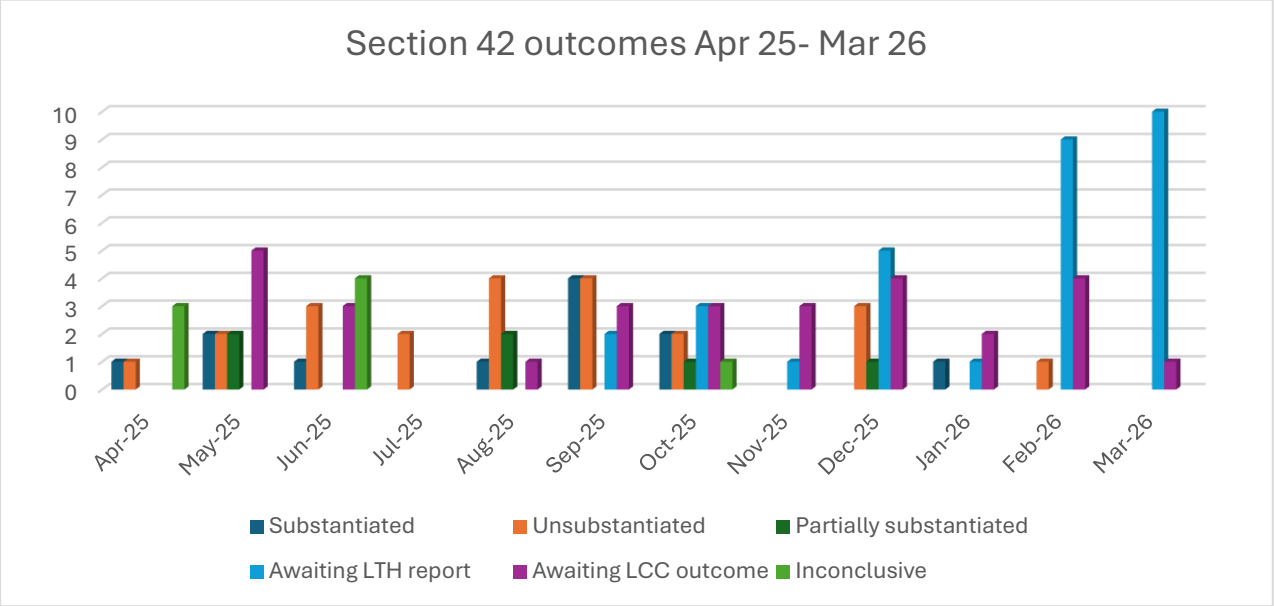


Source: LTHTR Datix/Ulysses data

Between April 2025 and March 2026, the Trust received 108, Section 42 enquiries from the Local Authority. Outcomes include a mix of substantiated, partially substantiated and unsubstantiated cases, with some still in progress.

The Safeguarding Team maintains oversight of all enquiries and works closely with divisional teams to support timely review and response. Ongoing work with Lancashire County Council continues to support progress and help resolve outstanding cases.

Figure 20: Section 42 by outcomes



Source: LTHTR Datix/Ulysses data

3.1.4.6.2 Adult safeguarding training & PREVENT

Training compliance for adult safeguarding and PREVENT has remained high, at over **92%** across the Trust.

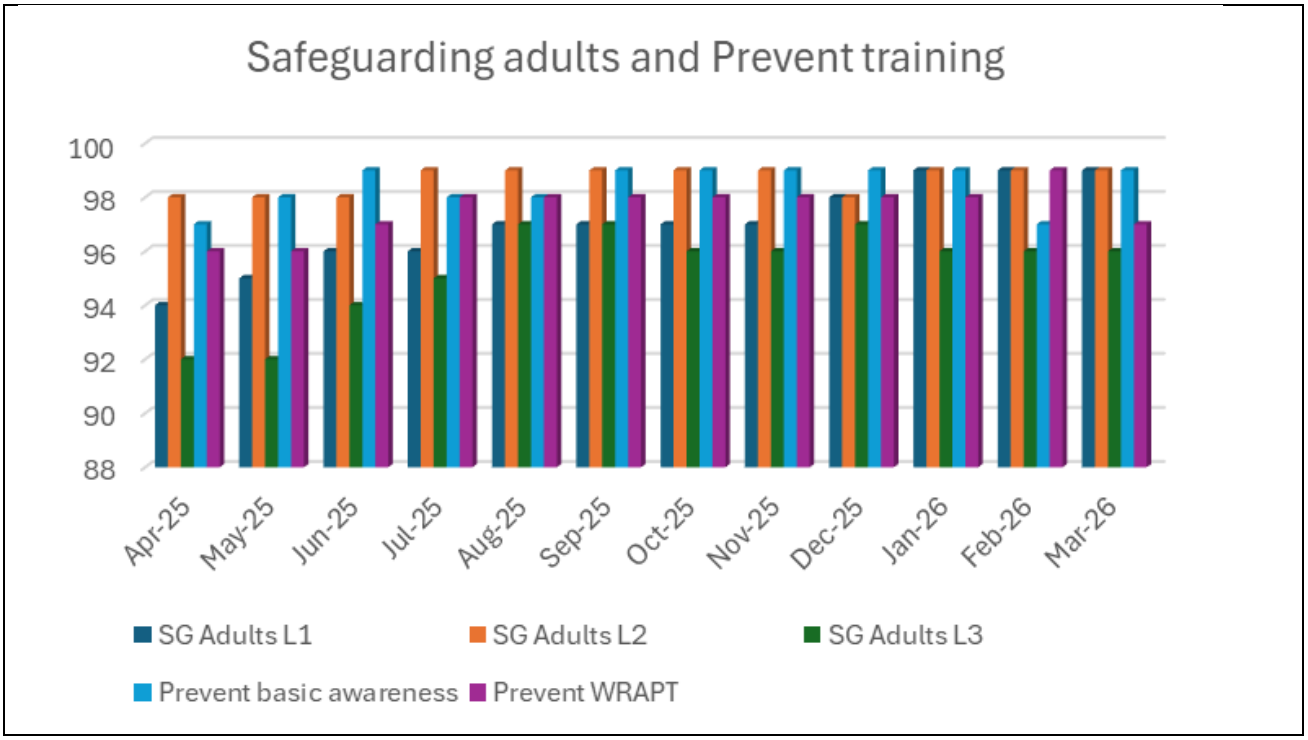
The Trust continues to work with regional and national partners to identify and respond to risks linked to radicalisation and exploitation.

In the past year:

- Two PREVENT referrals were submitted
- The Safeguarding Team supported the Channel Panel with 72 information requests over six months

This reflects ongoing multi-agency working and sustained focus on safeguarding vulnerable individuals.

Figure 21: Safeguarding and Prevent Training



Source: LTHTR Datix/Ulysses data

3.1.4.6.3 Managing Allegations Persons in Position of Trust (PiPoT)

The Safeguarding Team supports the management of allegations involving Persons in a Position of Trust (PiPoT), ensuring concerns are handled safely, proportionately and in line with requirements. This includes working closely with divisions and partner agencies such as the Police and Local Authority.

The Trust updated its PiPoT policy in 2024, strengthening governance, decision-making and oversight. Improvements to record keeping and regular audits have helped establish a consistent and transparent approach, with clear processes and assurance to the Board.

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

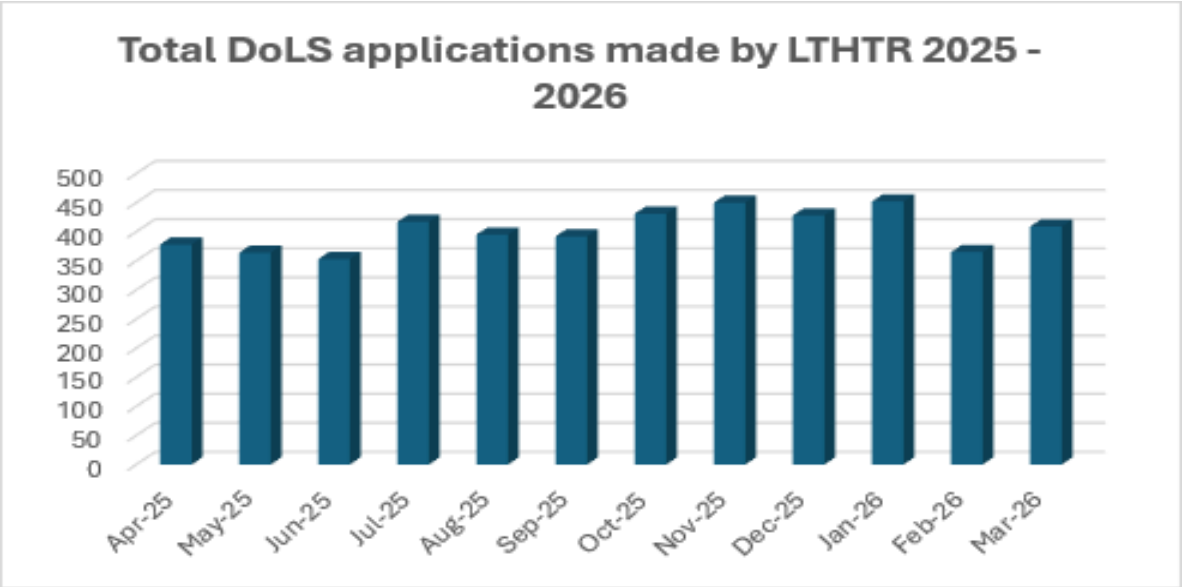
The Trust uses an electronic system to support the Mental Capacity Act and Deprivation of Liberty Safeguards processes, helping ensure decisions are lawful, consistent and centred on the patient.

Between April 2025 and March 2026, 4,834 DoLS applications were made, a small increase on the previous year. This reflects continued identification and support for patients who may require safeguarding.

Regular audits and ongoing training support compliance, with additional training planned for the Emergency Department.

The national introduction of Liberty Protection Safeguards remains delayed. The Trust continues to follow current legislation and will adapt when further national guidance is confirmed.

Figure 22: Total DoLS applications made by LTHTR 2025-2026



Source: LTHTR Datix/Ulysses data

3.1.4.6.5 Safeguarding Supervision

The Safeguarding Team provides regular supervision to children's services, with additional support available to adult services when needed. A duty service is also in place to offer timely advice and guidance on safeguarding concerns.

3.1.4.6.6 Mental Health, Learning Disabilities, Autism and Dementia

The Mental Health, Learning Disability, Autism and Dementia Team supports some of the Trust's most vulnerable patients. Working within the Safeguarding Team, the service focuses on improving patient experience, strengthening staff skills and ensuring compliance with legal requirements. The team also

leads work on High Intensity Users and acts as the Trust's Special Educational Needs and Disabilities (SEND) Champion.

Safeguarding Single Improvement Plan (SIP):
Work has focused on improving care for patients with mental health needs, learning disabilities and autism. This includes reducing restrictive practices, improving de-escalation and supporting staff to manage complex needs.

Training and workforce development:
Progress includes:

- Simulation-based learning, dementia training and trauma-informed care
- A mental health awareness course developed with Maudsley Hospital
- High compliance with learning disability and neurodiversity training
- Strong progress with Oliver McGowan Mandatory Training (98% e-learning compliance)

Patient and family engagement:
New tools support patient and family feedback, helping to gather insight and improve care experiences.

Data, governance and assurance:
Improved oversight includes:

- Dashboards to monitor restraint, rapid tranquilisation and self-harm
- Updated policies, audits and regular reporting
- Positive feedback from the Mental Health Act inspection in September 2025

Wider improvement work:
Key developments include:

- Hospital Passports to support personalised care
- Progress through the SEND Improvement Group
- Work with Martha's Rule to improve escalation and communication
- Development of the Reasonable Adjustment Needs Tool, with further work planned

These developments have strengthened support for patients and improved coordination of care across services.

3.1.5 Incidents

Staff are encouraged to report all incidents, including near misses and no harm events. This supports early identification of risks, trends and opportunities for improvement and aims to create an open culture where learning is cultivated within teams.

In 2025–26, a total of 36,457 incidents were reported, showing continued growth in reporting and supporting our continued aim of creating an open and transparent safety culture.

The proportion of incidents resulting in moderate harm or above was 2.5%, consistent with 2024–25. This indicates stable control of higher-harm incidents alongside increased reporting.

The Trust continues to use this information to inform learning, take action and improve systems, with a focus on reducing harm while maintaining high levels of reporting.

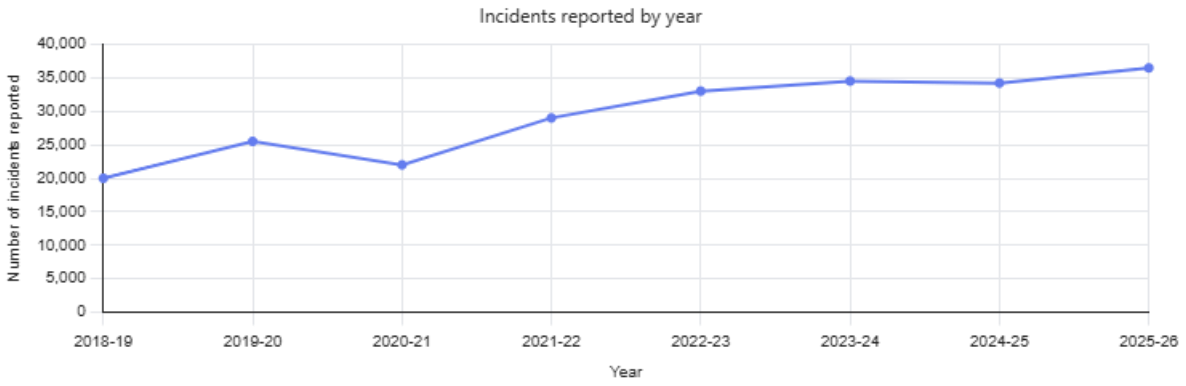
Table 16: Level of Harm Related to Incidents 2025-26

Trust Attributable Level of Harm	Number of Incidents Reported
No Harm	25,750
Low Harm	9561
Moderate Harm	959
Severe Harm	168
Death	19
Total	36,457

Source: LTHTR Datix data

Incident reporting has continued to improve over recent years, with a further increase seen during 2025–26.

Figure 23: Incidents Reported 2018-19 to 2025-26



Data is correct as of 26 May 2026 and may change as investigations are completed and Duty of Candour processes progress.

3.1.6 Never Events

Never Events are serious, largely preventable incidents that should not occur if safety measures are in place. They can cause harm and affect patient confidence. All Never Events are managed through the Patient Safety Incident Response Framework (PSIRF) and reported nationally to support learning.

All investigations for this reporting period have been completed. Harm levels ranged from no harm to moderate harm. Reviews found that most incidents were linked to system factors rather than individual error.

In response, the Trust has strengthened safety processes, including improved checks for invasive procedures, greater standardisation, and increased focus on team working and human factors.

Learning continues to be shared across the organisation and with partners to support ongoing improvements in patient safety.

Table 17: Never events incidence April 2025 to March 2026

Period reported	StEIS ref	Datix ID	Incident Date	StEIS Reported Date	Division	Location of Incident	Category	Level of Harm and investigation status
25/26	2025/1921	192854	20/03/2025	01/04/2025	Surgery	Theatre 11 - Chorley	Wrong site surgery	No Harm Investigation complete
25/26	2025/2688	189825	31/01/2025	09/05/2025	Surgery	Theatre 5 - Chorley	Wrong site surgery	Low Harm Investigation complete
25/26	2025/3003	199287	19/05/2025	19/05/2025	Surgery	Lancashire Eye Centre - CDH	Wrong site surgery	Moderate Harm Investigation complete
25/26	2025/4814	188329	04/02/2025	02/09/2025	DCS	Theatre 15, RPH	Retained Foreign object	Moderate Harm Investigation complete
25/26	2026/128	215558	03/10/2025	12/01/2026	DCS	Theatre 15, RPH	Wrong Implant/Prosthesis	No Harm Investigation complete
25/26	2026/1111	224338	15/01/2026	15/03/2026	Surgery	Orthopaedics, RPH	Retained Foreign object	Low Harm Investigation complete

3.1.7 Duty of Candour

Duty of Candour is a legal requirement that ensures patients and families are informed openly and promptly when harm has occurred. This includes providing an explanation, an apology and appropriate support.

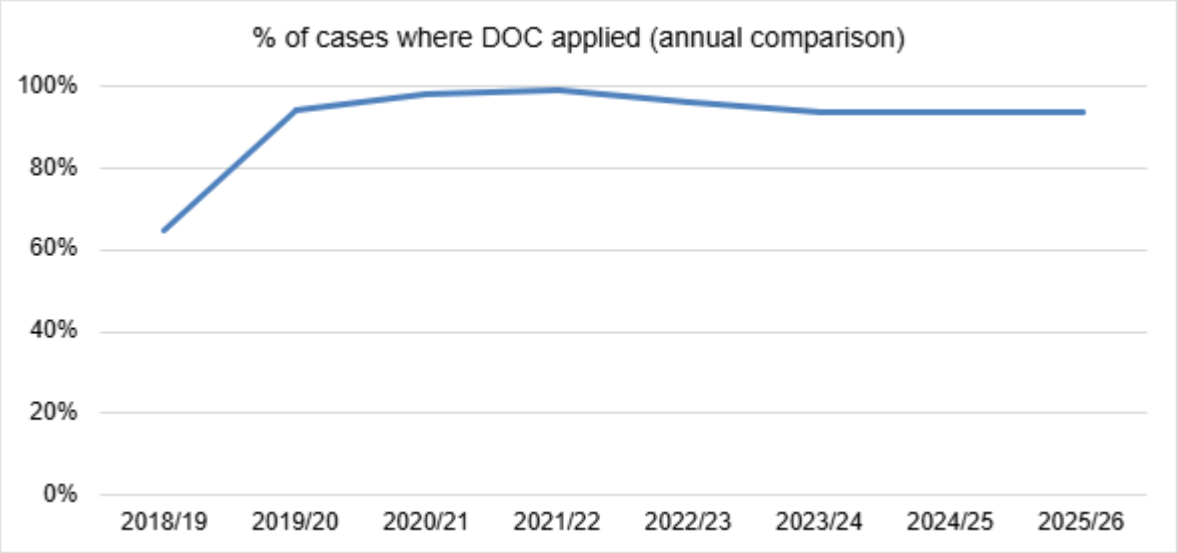
In 2025–26, **552 cases** met the criteria for Duty of Candour, an **11% reduction** from the previous year:

- **517 cases (93.6%)** were completed, with communication provided to patients or families
- **35 cases (6.3%)** had valid reasons recorded for non-completion
- **0 cases** remain in progress

This demonstrates continued application of Duty of Candour principles and a consistent approach to openness and communication.

Figure 24 shows a stable level of Duty of Candour activity between 2024–25 and 2025–26.

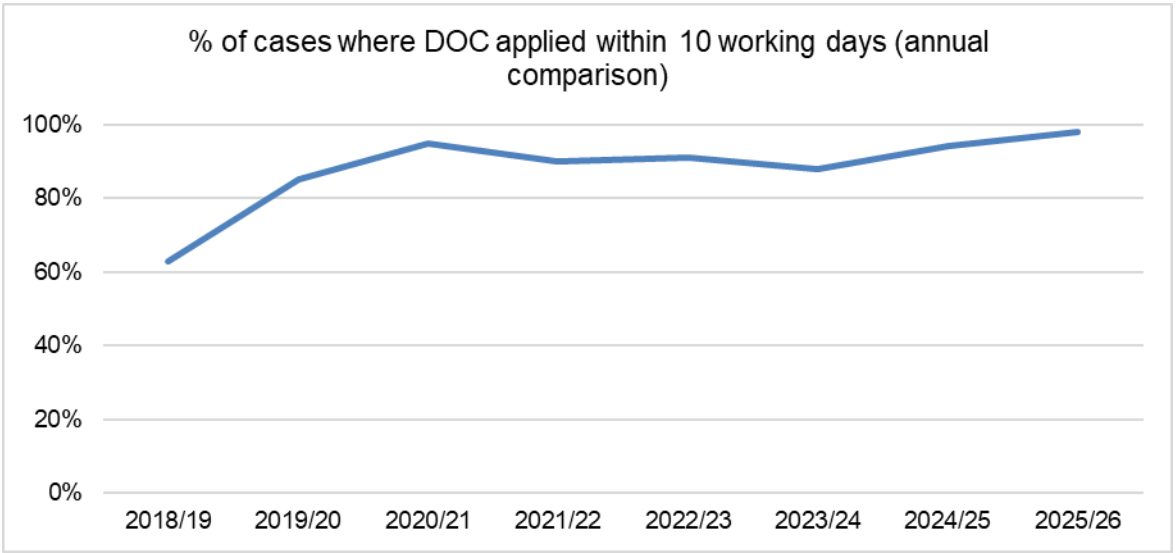
Figure 24: Percentage of Cases with Duty of Candour Applied (Annual Comparison)



Source: LTHTR Ulysses data

Figure 25 shows an improvement in the timeliness of Duty of Candour, with more cases completed within 10 working days in 2025–26 compared to 2024–25.

Figure 25: Percentage of Cases with Duty of Candour Applied in 10 Working Days



Source: LTHTR Ulysses data

There has been a continued focus across the Trust to improve Duty of Candour (DoC). This has included updated policies, clearer processes, and improved access to DoC data to support timely oversight and action.

Enhancements to the Ulysses system have improved the consistency and accuracy of recording, making processes easier to follow and strengthening data quality.

Monitoring has also been strengthened through regular Patient Safety Incident Response Framework (PSIRF) governance meetings and the introduction of clear Key Performance Indicators (KPIs). These support accountability, improve tracking, and help ensure timely and effective application of DoC.

3.2 Review of Quality Performance - Effective Care

The Trust aims to provide effective care by ensuring practice is based on evidence and national standards. Participation in national programmes, including *Getting it Right First Time (GIRFT)*, supports benchmarking and ongoing improvement.

Key areas of focus include pressure ulcer prevention, nutrition, medicines management, and infection prevention and control.

Mortality data is regularly reviewed to identify risks and support learning. The Medical Examiner Service provides independent review of deaths and may request further review, including Structured Judgement Reviews or investigations under the Patient Safety Incident Response Framework.

The following sections provide further detail on areas supporting effective care.

3.2.1 Getting It Right First Time (GIRFT)

The organisation is aligning the *Getting it Right First Time (GIRFT)* programme with the Single Improvement Plan (SIP). Delivery will be overseen by the Deputy Chief Medical Officer and Deputy Director (Programme Management Office), linked to the Performance, Patients and Productivity priorities.

Central oversight

- A central GIRFT SharePoint site has been created, bringing together all documentation in one accessible place
- A single action plan tracker has been developed, combining actions from previous GIRFT reviews to support progress and engagement with services
- A gap analysis against the ‘Manchester model’ has been completed, identifying improvements in governance, clearer roles at divisional level, and stronger accountability arrangements
- Updates are being made to the GIRFT Steering Group and reporting processes to strengthen oversight

GIRFT Steering Group

The GIRFT Steering Group brings together clinical and operational leaders with the Programme Management Office to oversee delivery and monitor progress. Meetings take place every two months, focusing on areas requiring improvement.

Ten specialty deep dive sessions

Over the next 12 months, focused reviews will be carried out across nine specialties to support improvement and strengthen outcomes for patients.

No.	Service
1	Neurology
2	Interventional Radiology
3	Vascular
4	Breast
5	Cardiology
6	Endoscopy
7	Renal
8	Pain
9	Plastics

Table 18: Key GIRFT Activities in 2025–26

Activity	Description
GIRFT reviews taken place since March 2025	• Breast (May 2025) • Cardiac Transformation Programme – implementation of GIRFT and Physiological Science Programme recommendations – Virtual visit (July 2025) • Interventional Radiology (8 December 2025) • Vascular Network (11 March 2026). Follow on actions and recommendations will be taken forward and managed with the relevant speciality and Division to ensure improvements are made as required.
Urgent & Emergency Care GIRFT agenda and	On the 6th February Professor Tim Briggs, NHS England National Director for Clinical Improvement and Elective Recovery wrote to NHS Trusts on the prevalence of corridor care which represents a material and escalating patient safety risk across the NHS. The

improvement programme	letter highlighted that prolonged ED stays, corridor placement, and excessive ambulance handover delays had exposed patients to avoidable harm, compromised privacy and dignity, and created significant clinical risk—particularly for frail and elderly cohorts at heightened risk of delirium. In response to this the Trust has set out a focused six month Urgent and Emergency Care Improvement Programme designed to address the Trust's deteriorating patient experience and performance against national standards. Despite stable demand, an independent review has highlighted that current challenges stem primarily from service design, operational control, and pathway flow issues rather than activity pressures.
GIRFT Further Faster agenda	The GIRFT 'Further Faster' programme has been set up nationally to deliver rapid clinical transformation with the aim of reducing patient waiting times and particularly 52-week waits. The work brings together hospital trust clinicians and operational teams with the challenge of collectively going 'further and faster' to transform patient pathways and working to reduce unnecessary follow-up outpatient appointments and to improve access and waiting times for patients.

3.2.2 Tissue Viability - Pressure Ulcer Incidence and Prevention

3.2.2.1 Pressure Ulcer Incidence

Pressure ulcers are a recognised measure of patient safety and quality of care. Preventing them remains a key priority for the Trust.

Between April 2025 and March 2026, there was an increase in reported pressure ulcers. This reflects a number of contributing factors, including:

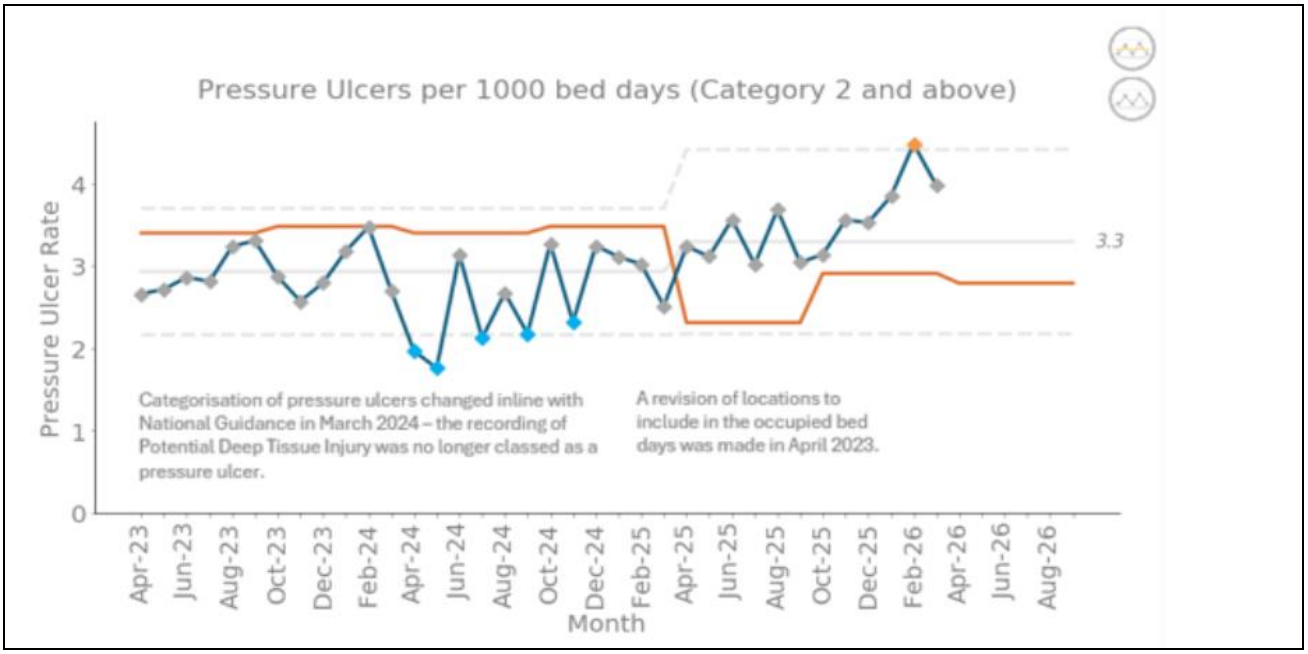
- Increasing patient frailty and complexity
- Longer stays in the Emergency Department
- More patients being cared for in temporary ward areas
- Delays in discharge for patients waiting for community support or placements

Pressure ulcers are monitored using rates per 1,000 bed days, allowing meaningful comparison over time and taking account of overall activity levels.

Statistical Process Control (SPC) charts are used to track trends and identify variation, helping to highlight where further action may be needed.

In March 2024, reporting was updated in line with national guidance, including the removal of Potential Deep Tissue Injury as a separate reporting category.

Figure 26: Pressure Ulcer Incidents per 1,000 bed days April 2023- March 2026



The orange line on the SPC chart shows the Trust's target for reducing pressure ulcers, based on the previous year's average rate.

Since March 2025, the rate of pressure ulcers has increased, with a more noticeable rise in the last five months. This has led to further review and strengthened improvement actions and oversight across the Trust.

3.2.2.2 Pressure Ulcer Improvement Plan

Preventing pressure ulcers and reducing harm remains a key priority. Work during the year has focused on strengthening learning, improving practice and supporting staff.

Learning from Incidents

In December 2025, a Pressure Ulcer and Falls Panel was introduced to review all severe harm incidents chaired by the Deputy Chief Nursing Officer. This supports:

- Cross-divisional learning
- Greater oversight and accountability
- Identification of gaps in care

In March 2026, pressure ulcer risk reduction rounds were introduced, focusing on early identification of risk and immediate action at ward level.

Education and Training
Ongoing training supports staff to prevent pressure ulcers, including:

- Mandatory e-learning every two years
- Role-specific modules on risk assessment and prevention
- Inclusion in Healthcare Assistant induction and preceptorship programmes
- Student learning opportunities with Tissue Viability Nurses
- Regular wound care training and ward-based sessions

Strengthened Governance
Governance arrangements have been strengthened to improve oversight and shared learning:

- Weekly divisional reviews of all Trust-acquired pressure ulcers
- Monthly Always Safety First meetings to review themes and trends
- Reporting from the Pressure Ulcer and Falls Panel to PSIRF oversight
- A Trust-wide improvement plan linked to risk management processes

Clinical Practice and Equipment
Improvements in care and equipment include:

- Regular development sessions for Tissue Viability Link Practitioners
- Use of wound photography to support faster specialist review
- Trialling of specialist equipment and new training methods
- Introduction of risk reduction rounds to provide ward-level support and early intervention

3.2.3 Nutrition for Effective Patient Care

The Trust supports high-quality nutritional care through the 7-day Integrated Nutrition and Communication Service (INCS). This multidisciplinary team includes:

- Nutrition Nursing Team
- Dietitians
- Speech and Language Therapists
- Central Venous Access Team
- Tobacco and Alcohol Care Team

3.2.3.1 Nutritional Screening

All patients staying more than 48 hours (excluding maternity and day cases) receive a nutritional screening assessment on admission.

This uses the Malnutrition Universal Screening Tool (MUST) to identify patients who are malnourished or at risk, ensuring timely referral for dietetic support or appropriate care planning.

Compliance is monitored through the STAR quality assurance system.

3.2.4 Medication and Incident Monitoring

3.2.4.1 Medicines Safety

Medicines safety remains a key priority for the Pharmacy Department. Systems and processes continue to be strengthened to reduce medication errors and improve patient safety.

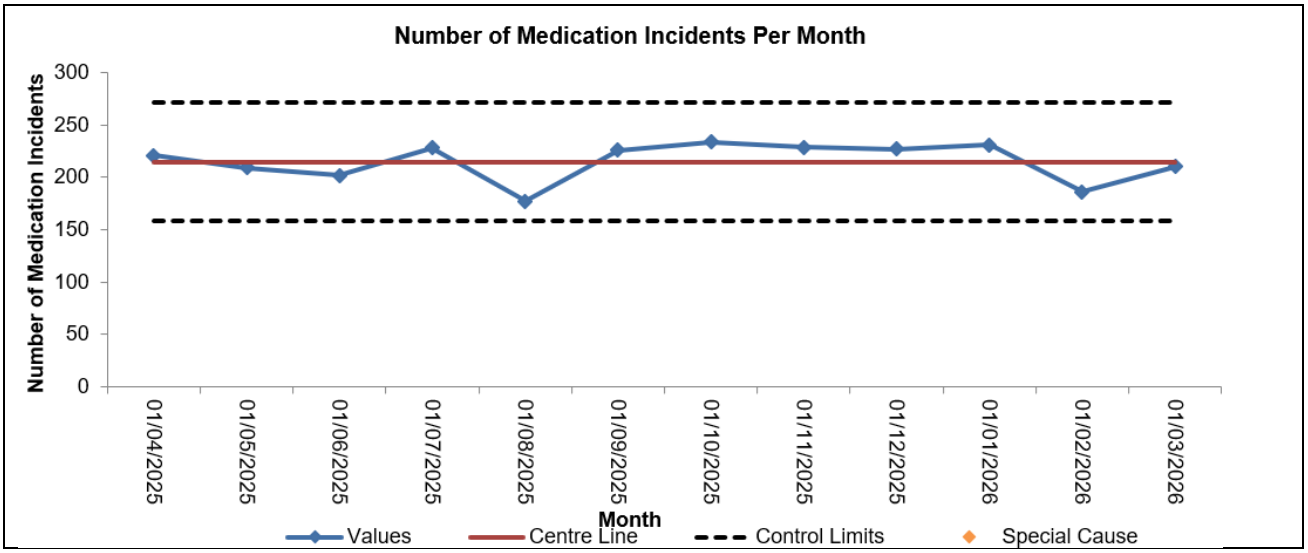
The Medication Safety team promotes a culture of incident reporting in line with the Patient Safety Incident Response Framework (PSIRF). Reporting is supported through the Ulysses system, introduced in February 2026.

Between April 2025 and March 2026:

- Medication incidents made up 7.94% of all reported incidents
- An average of 215 incidents per month were reported
- This represents a 4% reduction from the previous year (225 per month)

This reflects continued engagement in reporting alongside a reduction in overall incidents.

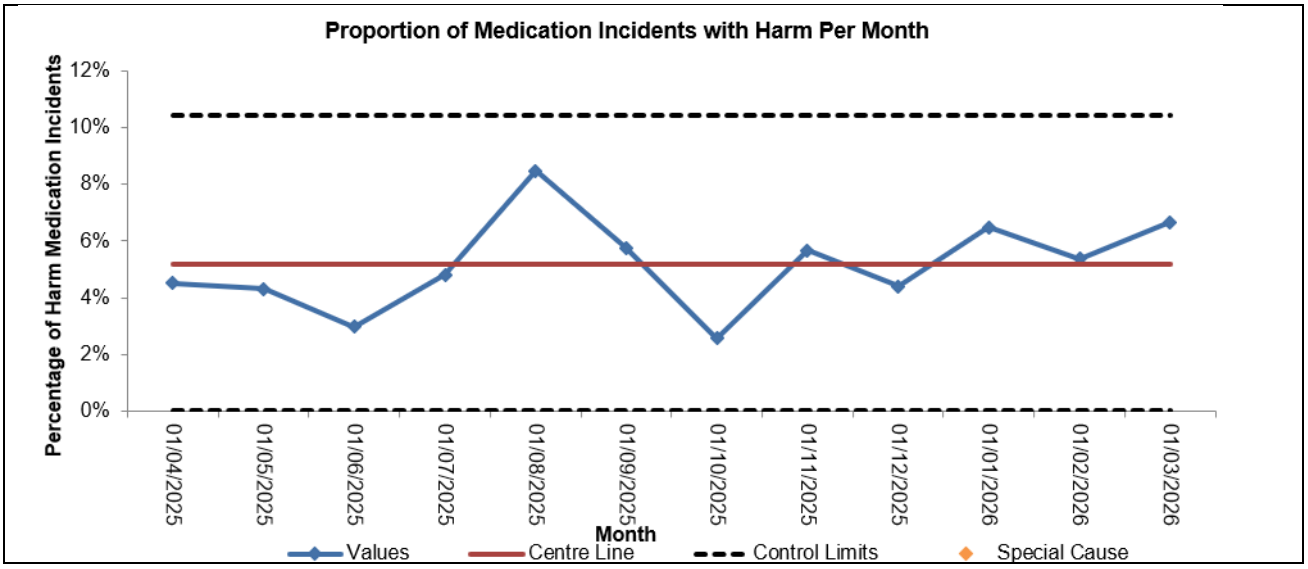
Figure 27: Number of medication incidents per month



Source: LTHTR data

The proportion of medication incidents resulting in harm during 2025–26 was 5%, consistent with 2024–25 and below the Model Hospital benchmark of 12%.

Figure 28: Proportion of medication incident with harm per month



Source: LTHTR data

3.2.4.2 Medication Safety Governance and Proactive Monitoring

The Trust has a structured approach to reviewing medication incidents in line with the Patient Safety Incident Response Framework (PSIRF). Weekly governance meetings, led by the Corporate Governance Team and supported by the Medication Safety Team and divisional leads, enable early review and timely sharing of learning.

Key themes and learning are shared with divisions and discussed at Always Safety First meetings. A network of Medication Safety Champions meets monthly to support learning, improvement and staff engagement.

Monthly reports on harm and near misses are reviewed by the Medicines Governance Committee as part of the Trust's wider risk management processes. This approach supports early action, continuous learning and safer care.

3.2.4.3 Clinical Pharmacy Service

The clinical pharmacy service supports safe prescribing and timely supply of medicines across inpatient, outpatient, day case, chemotherapy and virtual ward settings.

Recent work to better match capacity and demand has included:

- Agreed job plans for all staff, providing clarity on clinical capacity
- A clinical prioritisation tool to focus on high-impact activities, prioritised as:
    1. Discharge prescribing
    2. Verification of high-risk medicines (for example anticoagulants, insulin and antibiotics)
    3. Medicines reconciliation

4. Verification of other medicines

3.2.4.4 Discharge

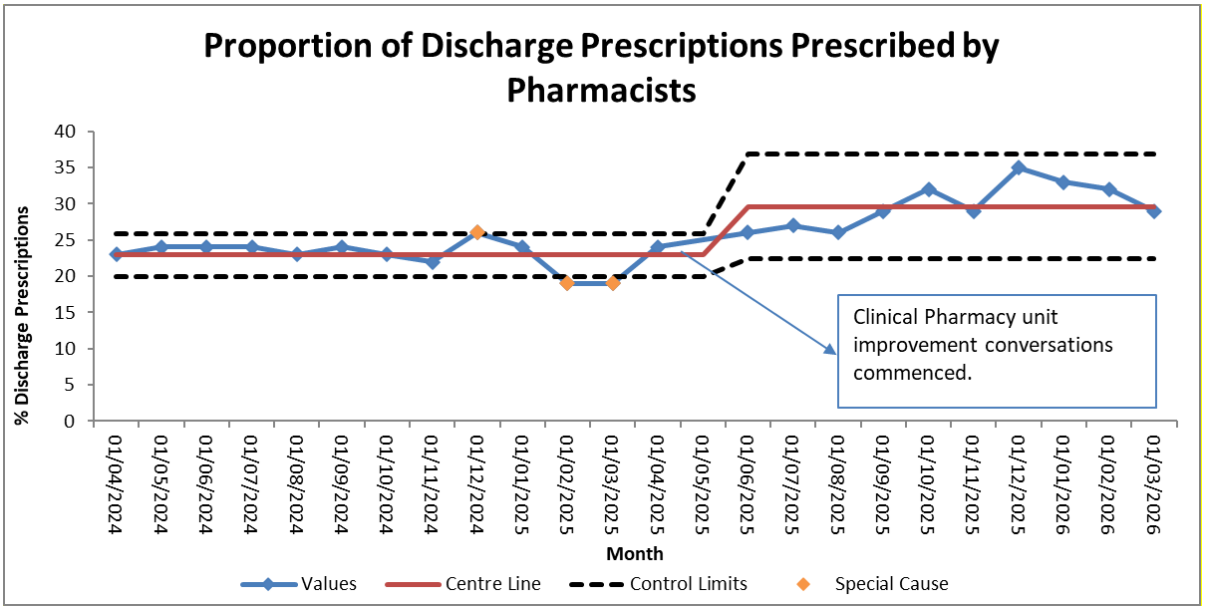
Discharge medicines remain a priority, supporting timely patient discharge and improving flow through the hospital.

The increasing number of prescribing pharmacists has improved the discharge process by:

- Reducing delays
- Allowing medical staff to focus on patient care
- Reducing prescribing errors
- Improving overall timeliness of discharge

Further work is planned to increase the proportion of discharges prescribed by pharmacists to over 40%, supporting continued improvement in patient flow and safety.

Figure 29: Proportion of Discharge Prescriptions Prescribed by Pharmacists April 2024- March 2026



Source: LTHTR data

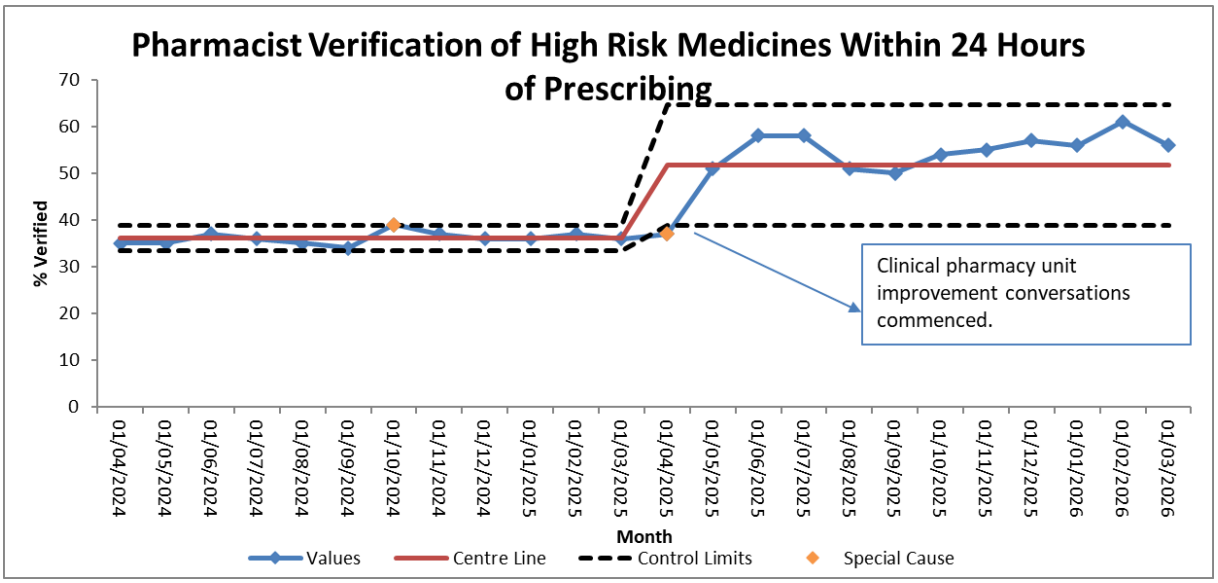
3.2.4.5 High risk medicines

Clinical incident data shows that most medication-related harm is linked to four high-risk groups: anticoagulants, antimicrobials, anti-epileptics and insulin.

These medicines are prioritised for pharmacy review within 24 hours of prescribing, helping to ensure treatment is safe and appropriate for each patient.

The current target is for 90% of high-risk medicines to be verified within this timeframe. While this level has not yet been reached, performance has improved significantly over the past year.

Figure 30: Pharmacist Verification of High Risk Medicines Within 24 Hours of Prescribing



Source: LTHTR data

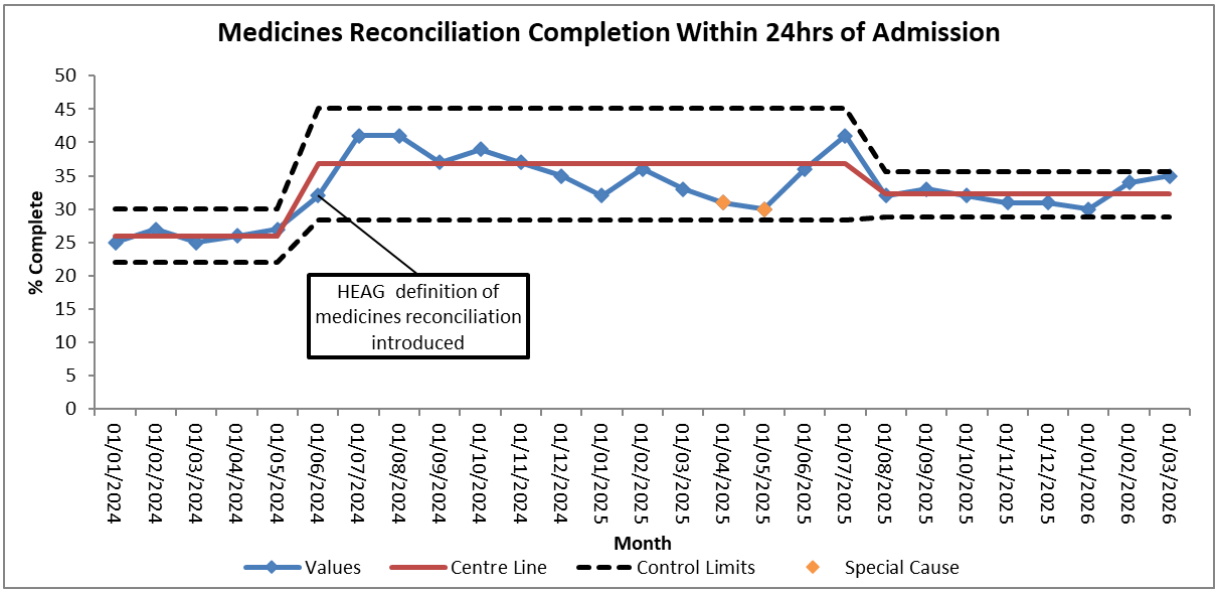
3.2.4.6 Medicines reconciliation

Medicines reconciliation is a key safety process during hospital admission, ensuring that patients' medication records are accurate and complete. It involves checking a patient's medication history and documenting any changes made during their stay. National guidance recommends this is completed within 24 hours of admission.

Medicines reconciliation is the third priority for the clinical pharmacy team, with patients on high-risk medicines prioritised.

While just over 30% of reconciliations are completed within 24 hours, 75% of patients have a documented reconciliation during their hospital stay, and all patients receive a reconciliation at discharge. Work continues to improve timely completion.

Figure 31: Medicines Reconciliation Within 24hr of Admission



Source: LTHTR data

Following detailed demand and capacity modelling in 2024, service levels for the clinical pharmacy team were clearly defined. The service is currently working towards achieving the 'bronze level' standard.

Within existing resources, improvements continue, supported by:

- Better use of data to guide service delivery
- Clearer processes and standardised procedures
- Development of roles, including clinical pharmacy technicians supporting discharge medication checks

A biannual safe staffing review is being developed to support ongoing assessment of capacity and ensure the service continues to meet patient needs effectively.

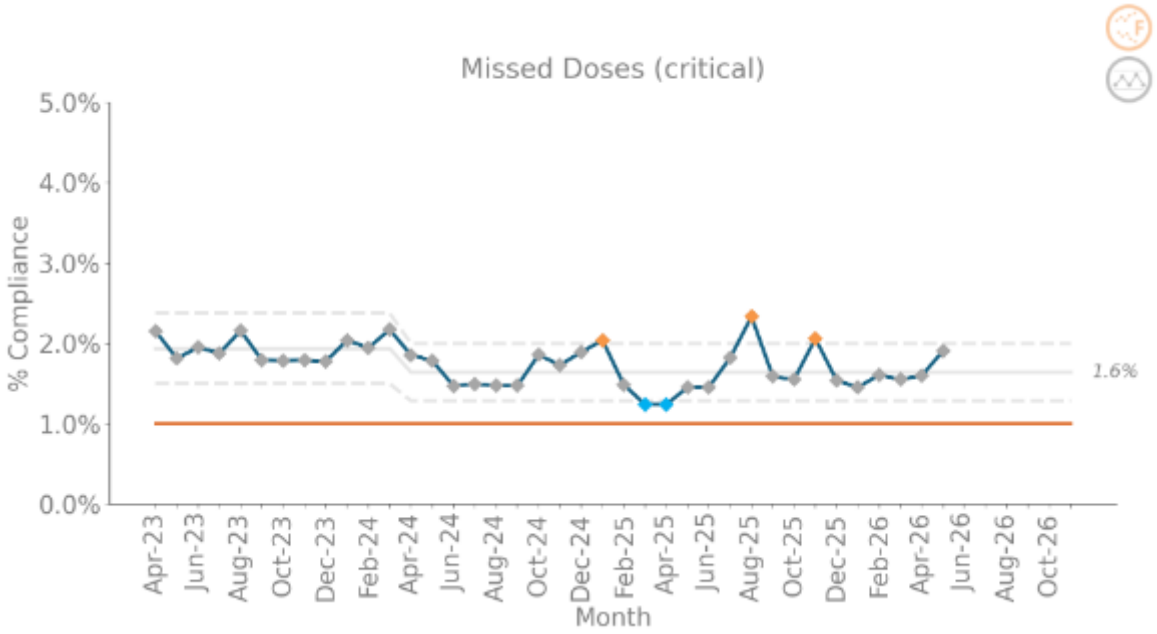
3.2.4.7 Medication Administration

Safe and timely administration of medicines is essential to patient care. Nationally, missed dose rates can exceed 20%, which may lead to poorer outcomes.

The Trust uses data from its Electronic Prescribing and Medicines Administration (EPMA) system to monitor missed doses. This supports prompt action, either by administering the dose or recording a clear clinical reason for omission.

Improvement work over the past year has supported wards to reduce missed doses of critical medicines, with a target of less than 1%.

Figure 32: Critical Missed Doses Over 2 Hours (excluding valid clinical reasons)



Source: LTHTR data

3.2.4.5 Antimicrobial Stewardship

Antimicrobial stewardship focuses on the safe and appropriate use of antibiotics and other antimicrobial medicines. This is important in reducing antimicrobial resistance, which is recognised as a significant national risk.

The Trust has an established Antimicrobial Stewardship Team, which oversees this work. Regular audits are carried out across inpatient areas using data from the Electronic Prescribing and Medicines Administration (EPMA) system.

These audits review:

- Whether the reason for prescribing antibiotics is clearly recorded
- Compliance with Trust guidelines or microbiology advice
- Whether prescriptions are reviewed within 72 hours

This approach supports appropriate prescribing, reduces risk, and helps maintain the effectiveness of antimicrobial treatments.

Table 19: Antimicrobial Stewardship Point Prevalence Audit Results

	Nº of patients on antibiotics	Nº of antibiotic prescriptions audited	% Documented Indication on the Prescription	% Compliance with Guidelines	% Compliance with Guidelines or Recommended by Microbiology	% Compliance with documented review within 72hrs
Trust Wide Q4 2025-26	404	561	90%↓	83%↓	86%↓	92%↓
Trust Wide Q3 2025-26	359	482	93%↓	90%↔	92%↔	96%↑
Trust Wide Q2 2025-26	333	446	96%↑	90%↔	92%↑	90%↑
Trust Wide Q1 2025-26	313	410	94%↑	90%↔	91%↔	53%↓

Source: LTHTR data

These audits support safe and effective use of antimicrobials, ensuring treatment is appropriate, evidence-based and regularly reviewed. This reduces unnecessary use of antibiotics and helps tackle antimicrobial resistance.

Results are reported quarterly, and services below expected standards are required to put improvement plans in place. The Antimicrobial Stewardship Team also provides education and guidance to support best practice.

Further improvements during the year include:

- Promoting timely switch from intravenous to oral antibiotics
- Introducing clear stop dates for antibiotic courses
- Implementing guidance to review and remove incorrect penicillin allergy labels

These actions have contributed to a reduction in overall antimicrobial use during 2025–26, supporting safer and more effective care.

3.2.5 Infection Prevention and Control (IPC)

Infection Prevention and Control (IPC) remains a key priority for the Trust, supporting patient safety and reducing healthcare-associated infections. Leadership is provided by the Director of Infection Prevention and Control, supported by specialist teams.

Key Achievements

During 2025–26, progress included:

- **Clostridioides difficile (C. difficile):**
  - 122 cases reported, 45 below the NHS England target of 167

    - Second consecutive year below trajectory, with a reduction in incidence per 100,000 bed days
    - No longer the highest rate in the North West
- **Cleanliness standards:** Most wards are now meeting the National Standards of Healthcare Cleanliness (2021)
- **Training:** Over 90% compliance with IPC mandatory training across all divisions
- **Antimicrobial stewardship:**
    - High compliance with documentation and 72-hour review
    - Strong adherence to prescribing guidelines
    - Best performance locally for reducing use of higher-risk antibiotics
- **Research:** Completion of the Primel hand hygiene study, published in March 2026

Areas for focus

- Appointment of a permanent decontamination lead
- Ongoing pressures in sterile services, including reliance on temporary staff
- Two hospital-acquired Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia cases, with improvements needed in communication, screening and treatment

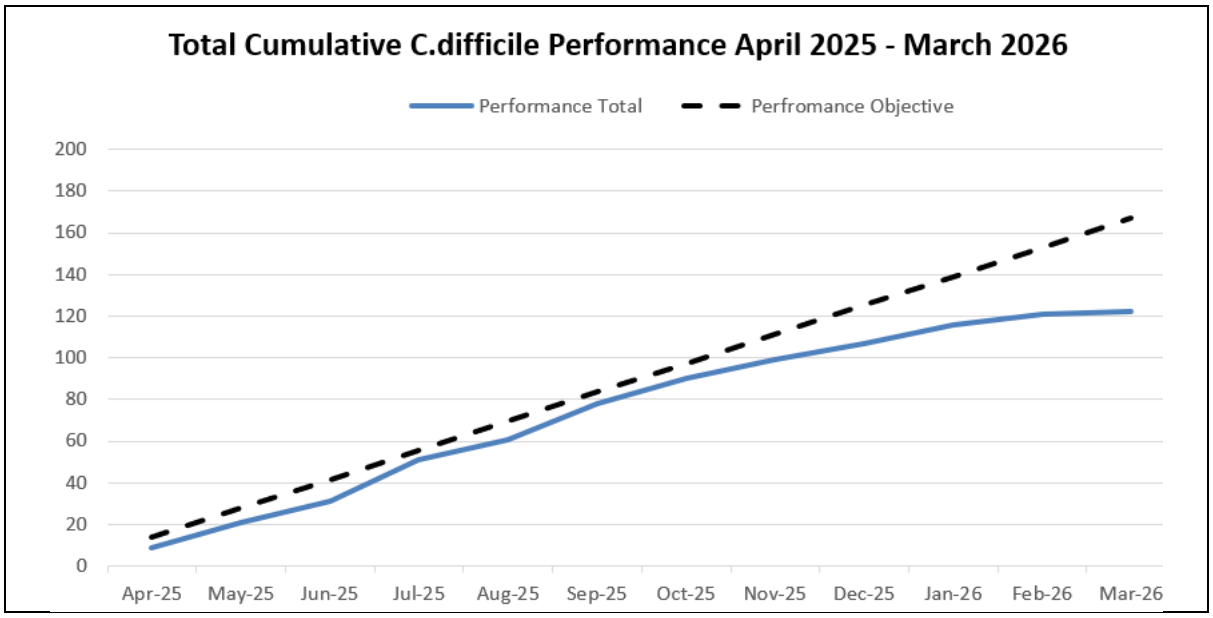
3.2.5.1 Clostridioides difficile *(C.difficile)*

In 2025–26, the Trust reported 122 hospital-associated cases, below the annual target of 167. This continues a positive trend, with reductions seen over the past three years:

- 2025–26: 122 cases
- 2024–25: 192 cases (target 199)
- 2023–24: 203 cases (above target)

This sustained improvement reflects targeted work to strengthen infection prevention and control practices while maintaining a continued focus on further reduction.

Figure 33: Performance of *C. difficile* cases against National Trajectory



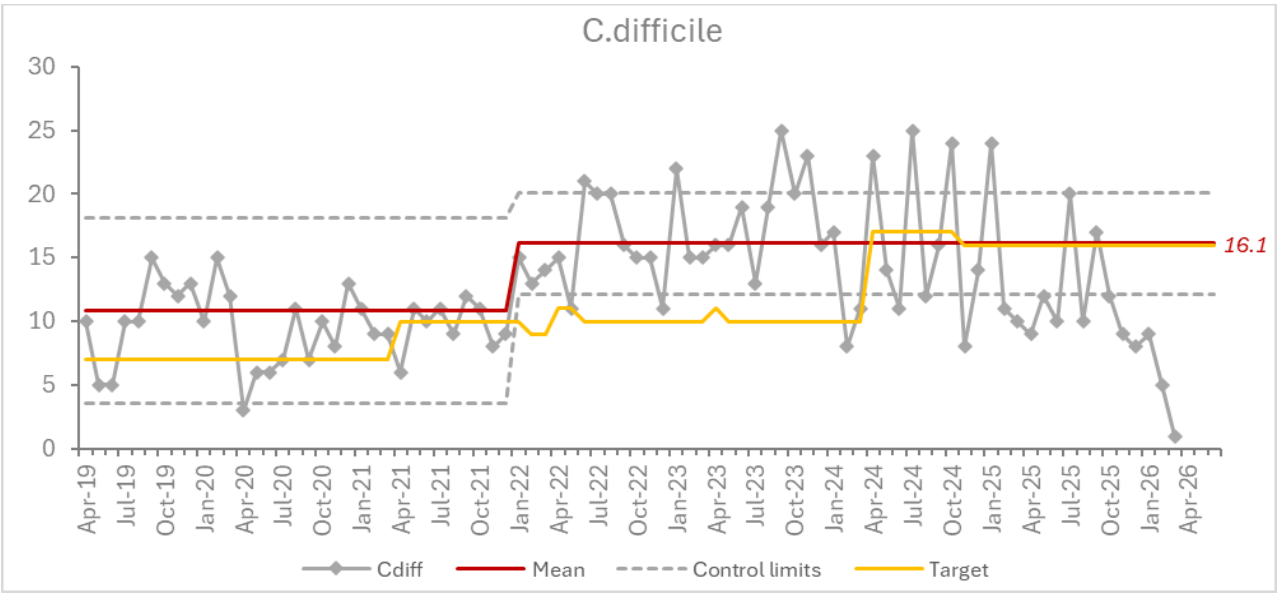
Source: LTHTR data

Figure 33 shows a Statistical Process Control (SPC) chart of monthly hospital-associated *Clostridioides difficile* cases from April 2019 to March 2026.

An increase in cases is seen in 2022, following a change in Trust policy which broadened the definition of diarrhoea to include type 5 stools.

Since October 2025, there has been a consistent and statistically significant reduction in cases.

Figure 34: Hospital Associated *C. difficile* Toxin positive rates per month.



Source: LTHTR data

The National and Regional picture

Since 2022–23, the Trust has experienced higher rates of infection. This led to executive oversight and a targeted action plan, monitored through the Infection Prevention and Control Committee and Estates and Facilities Partnership Board.

The rate has since reduced from 62.3 to 43.5 per 100,000 bed days. While this remains an area of focus, the Trust is no longer the highest in the region, with six hospitals now reporting higher rates.

Key developments during 2025-26

National standards of cleanliness
Implementation of the National Standards of Healthcare Cleanliness has continued following approval of a £747,514 investment, including 26 additional staff. Rollout is ongoing:

- **High-risk areas:**
  - Royal Preston Hospital: 13 of 16 compliant
  - Chorley District Hospital: 18 of 18 compliant
- **General ward areas:**
  - Royal Preston Hospital: 27 of 42 compliant
  - Chorley District Hospital: 13 of 18 compliant

C. difficile testing
New system alerts now prompt staff to review and stop laxatives before testing, reducing the risk of false-positive results and improving adherence to guidance.

Digital dashboard
A new Infection Prevention and Control dashboard allows ward teams to monitor compliance and track infections in real time. Work is underway to standardise its use across the Trust.

National surveillance programme
The Trust joined the UK Health Security Agency sentinel surveillance programme in April 2025. Early findings show no evidence of direct patient-to-patient transmission, with ongoing monitoring in place.

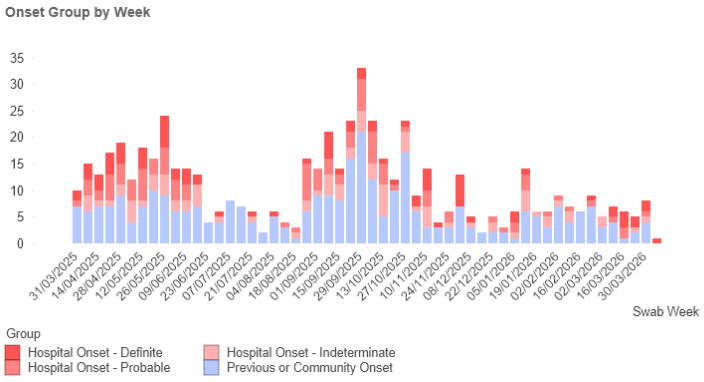
Significant challenges and opportunities for 2026-27

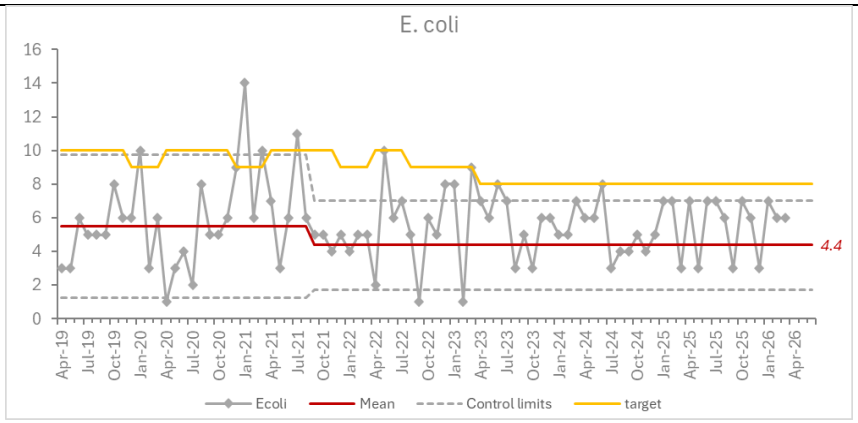
Estates and infrastructure
Ageing buildings and limited single-room capacity continue to present challenges. Issues with drainage systems and infrastructure remain under review, with plans for improvement.

Capacity pressures
Ongoing pressure on emergency and inpatient services, including patient boarding, increases the risk of infection. Improving patient flow and ensuring appropriate facilities remain key priorities.

3.2.5.2 Infection Prevention and Control Performance against other organisms of concern

Table 20: Trust performance related to other organisms of concern

3.2.5.2.1 MRSA Bacteraemia	*Staphylococcus aureus* is a bacterium that commonly colonises human skin and mucosa. Most strains of S. *aureus* are sensitive to the more commonly used antibiotics, and infections can be effectively treated. However, some S. *aureus* bacteria are more resistant. Those resistant to the antibiotic methicillin are termed methicillin-resistant S. *aureus* (MRSA). Bacteraemia occurs when bacteria get into the bloodstream. In 2025-26 there was 2 incidents of hospital onset MRSA bacteraemia and 3 cases of community onset MRSA. Themes identified included lack of communication of MRSA status between hospitals on transfer, delays in decolonisation treatment and limited patient adherence to treatment plans.
3.2.5.2.2 SARS-CoV-2 (COVID-19)	LTHTR experienced steady levels of COVID-19 infection throughout 2025/2026. Unlike the early pandemic years, there were no major surges or changes in national IPC guidance during the reporting period. Hospital-onset and community-onset cases continued to occur, requiring ongoing vigilance in patient placement, testing, and PPE compliance. **Figure 35: Hospital Onset versus Community Onset COVID-19 infections for 2025/2026.**  ***Source: LTHTR data***
3.2.5.2.3 Gram-negative Bacteraemia	The 2025/26 Objective for *E. coli* bloodstream hospital associated infections was 99. The Trust ended the year with a Total of 115 Hospital associated E. coli cases, which was 16 cases above the Objective. Tackling *E. coli* infection will require concerted action by multiple specialities and stakeholders including the Integrated care board (ICB). The IPC Annual plan 2026/2027 also includes several initiatives to address these infections. **Figure 36: Hospital Associated Escherichia coli positive rates per month.**



Source: LTHTR data

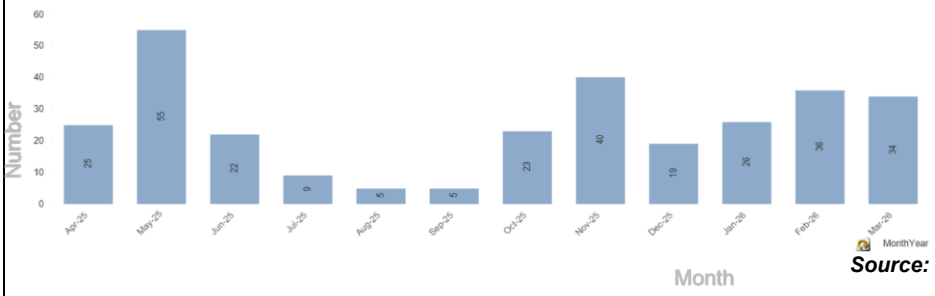
The 2025/2026 Objective for *Pseudomonas aeruginosa* Bacteraemia Hospital Associated Infections was 13. LTHTR ended the year with a Total of 14 Hospital Associated *Pseudomonas aeruginosa* Bacteraemia cases for 2025/2026, this is 1 case over the objective.

The 2025/2026 objective for *Klebsiella* species bloodstream Hospital Associated Infections was 26. The Trust ended the year with a Total of 38 Hospital Associated Klebsiella species cases for the year 2025/2026, this is 12 cases above the objective.

3.2.5.2.4 Norovirus

The year 2025/2026 saw 25 Confirmed Norovirus Outbreaks (4 outbreaks less than in 2024/25). This matched the current National picture with increased spread of new variant of Norovirus (GII.17) to a more susceptible population that had not been exposed to such viruses during the COVID-19 Pandemic.

Figure 37: Number of confirmed positive Norovirus Patients April 2025 – March 2026 (excluding patients identified in outbreaks that are likely Norovirus positive but not tested)



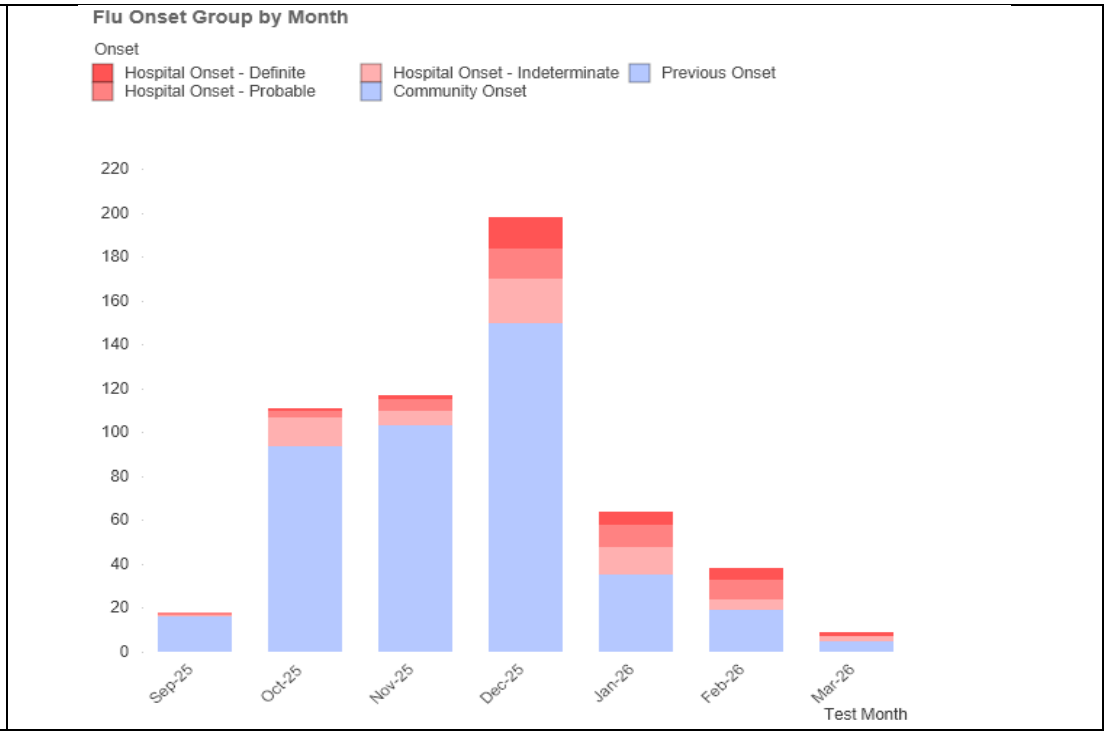
Source: LTHTR data

3.2.5.2.5 Influenza

The Influenza season at LTHTR began in September 2025 and peaked earlier in the winter than in previous years in line with national trends. In December 2025 there were concerns about the potential of an exceptionally severe winter season, due to the emergence of new circulating influenza strains. As a precautionary step, in late December 2025 and early January 2026 universal mask wearing was implemented on admission areas. However, LTHTR remained within expected seasonable patterns, and this was withdrawn.

Figure 38: Influenza cases in the 2025/26 season.

Source: LTHTR data



In summary, the Trust has strengthened its approach to infection prevention and control, with clear improvements in key areas. Ongoing challenges remain, and focused plans are in place to manage risks, improve resilience and continue to support safe, high-quality care.

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

Patients

Mortality surveillance is an important part of how the Trust reviews the quality of care and identifies opportunities for learning and improvement.

This section outlines how the Trust monitors mortality trends and learns from the deaths of adults, children and babies, supporting improvements in care and outcomes.

Table 21: Understanding Key Mortality Indicators

Indicator	Definition	What It Measures	Interpretation
SHMI (Summary Hospital-level Mortality Indicator)	Includes all deaths in hospital or within 30 days of discharge	All-cause mortality, not adjusted for palliative care or deprivation	A value of 100 is the national average; below 100 is better than expected

HSMR (Hospital Standardised Mortality Ratio)	Based on 41 diagnostic groups, adjusted for risk factors (accounts for approximately 80% of all hospital deaths)	Ratio of observed to expected deaths	<100 = lower than expected mortality; >100 = higher than expected
SMR (Standardised Mortality Ratio)	Broader than HSMR, includes all diagnoses	Relative risk of death compared to expected	<100 = better than expected; >100 = worse than expected

3.2.6.1 Mortality Surveillance

The Summary Hospital-level Mortality Indicator (SHMI) for December 2024 to November 2025 was 0.96, which is within the expected range.

Figure 39: [SHMI Peer Comparison Funnel Plot] shows the Trust's position compared to similar organisations, confirming performance remains within expected limits.

Figure 39: SHMI Peer Comparison Funnel Plot

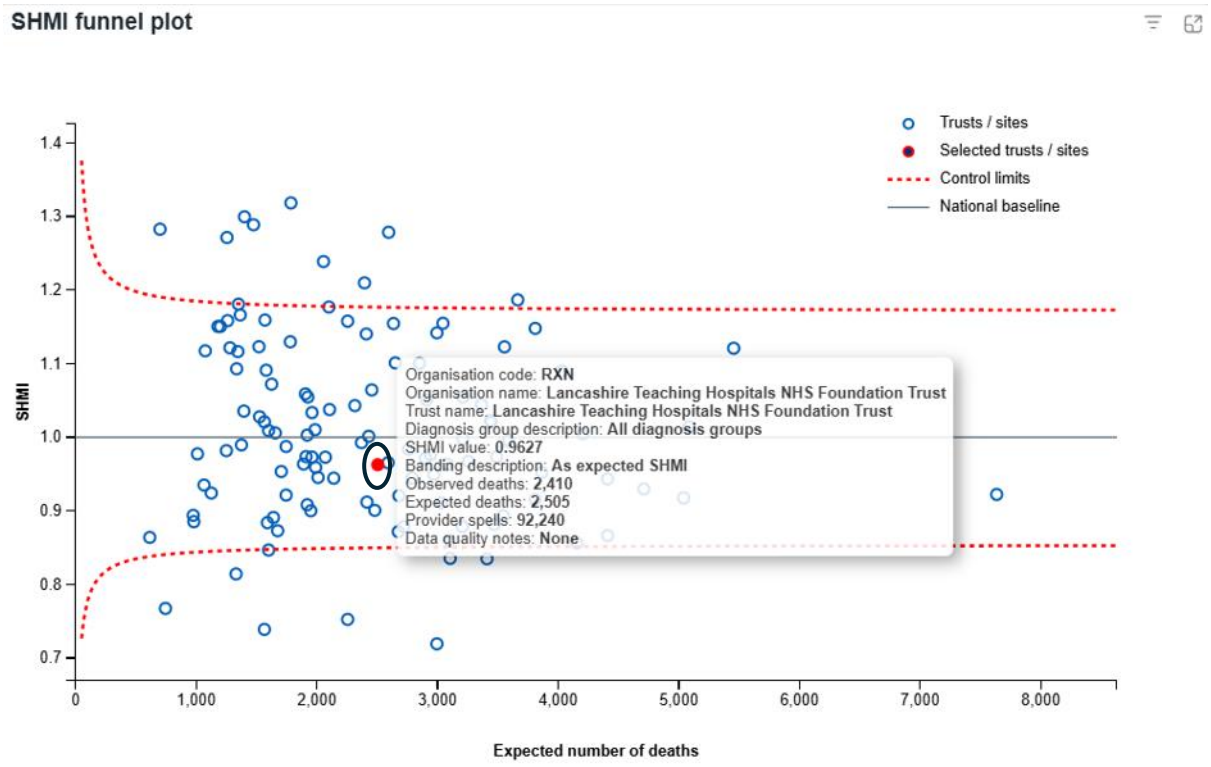


Figure 40: Monthly HSMR Trend

Most months have reported a statistically lower than expected HSMR over the last 3 years.

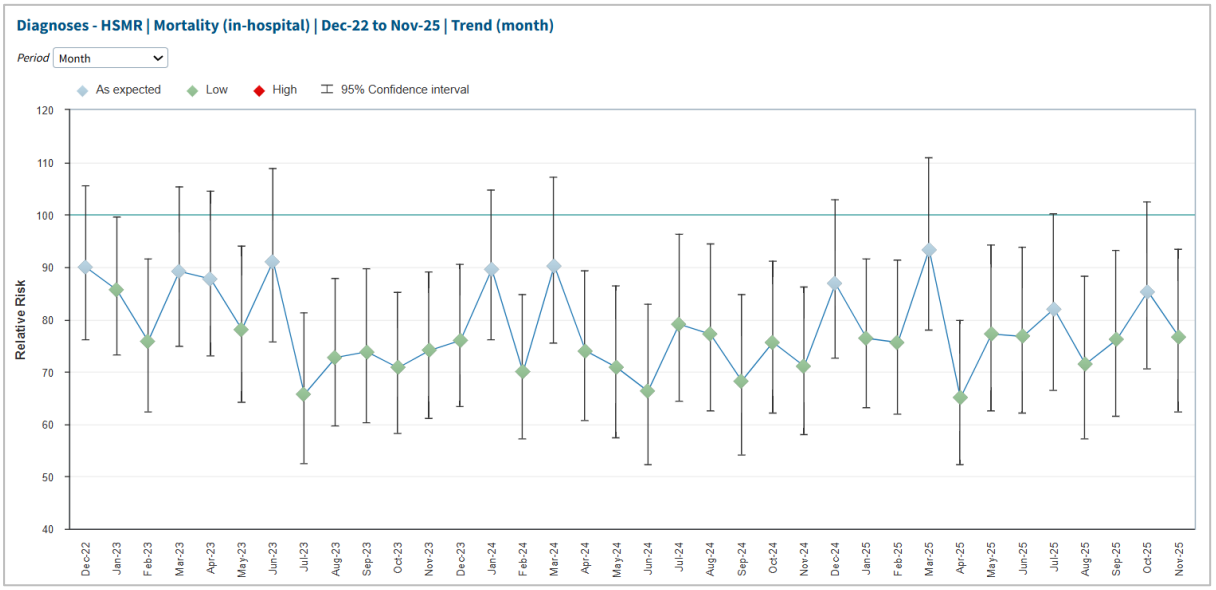


Figure 41: Rolling 12-month HSMR Trend

The Hospital Standardised Mortality Ratio (HSMR), which adjusts for patient risk factors and case mix, was **78.7** for the same period, indicating mortality lower than expected.

The rolling trend shows that the Trust has consistently reported HSMR below the national benchmark over the past three years, reflecting sustained performance within the expected range.

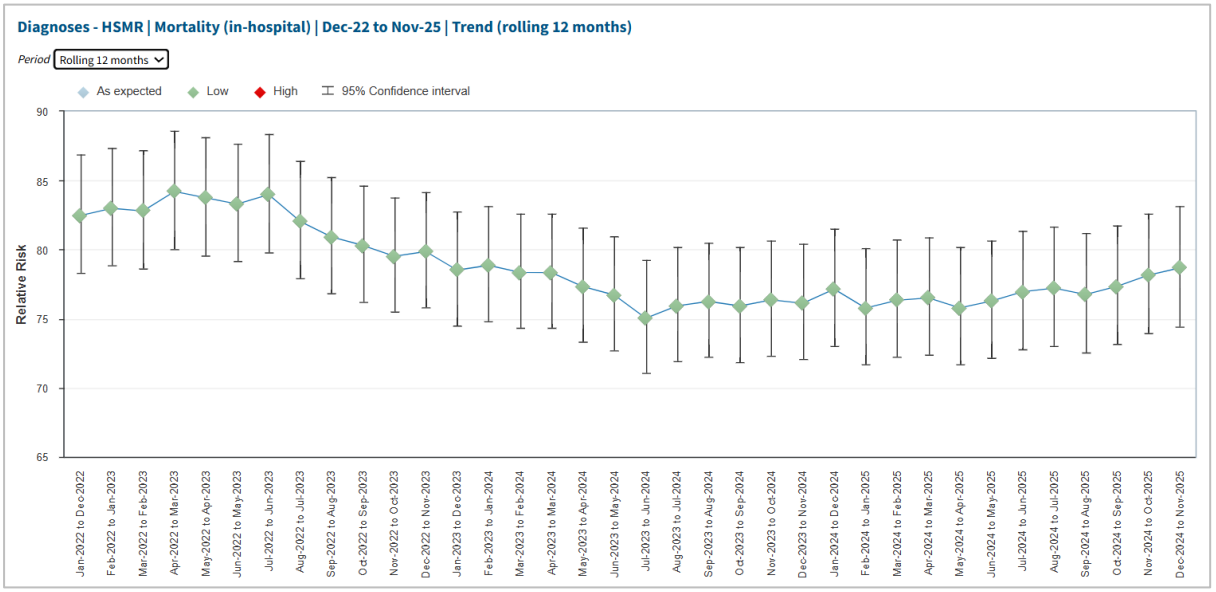


Figure 42: HSMR Regional Peer Comparison

Figure 42 shows that the Trust's Hospital Standardised Mortality Ratio (HSMR) compares favourably with other organisations in the region, indicating strong performance against peer benchmarks.

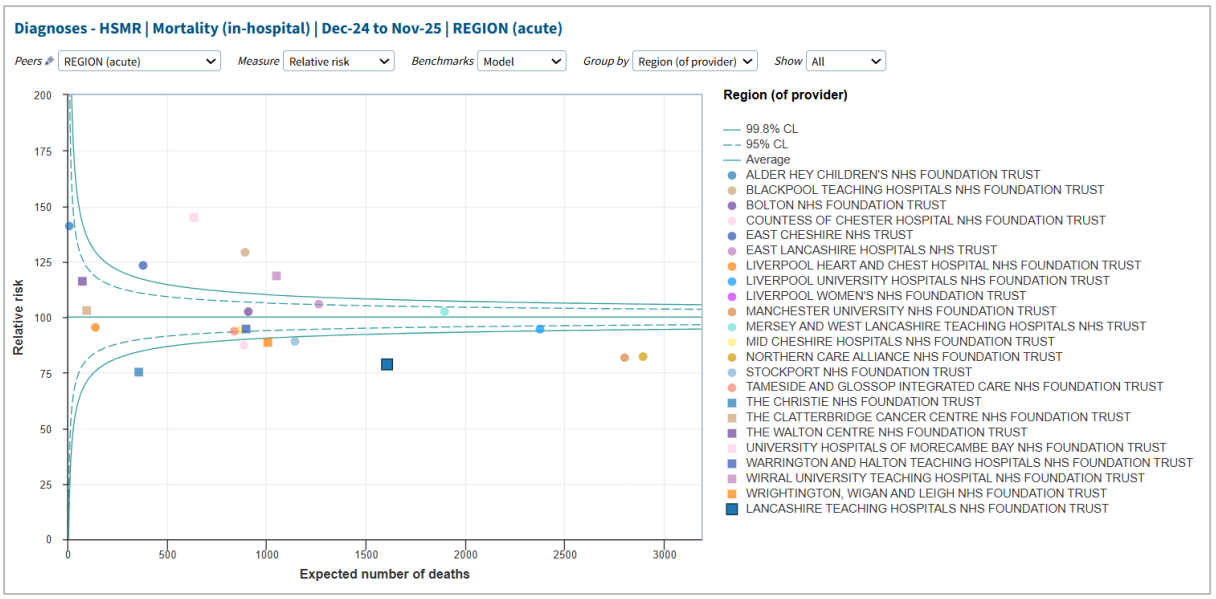
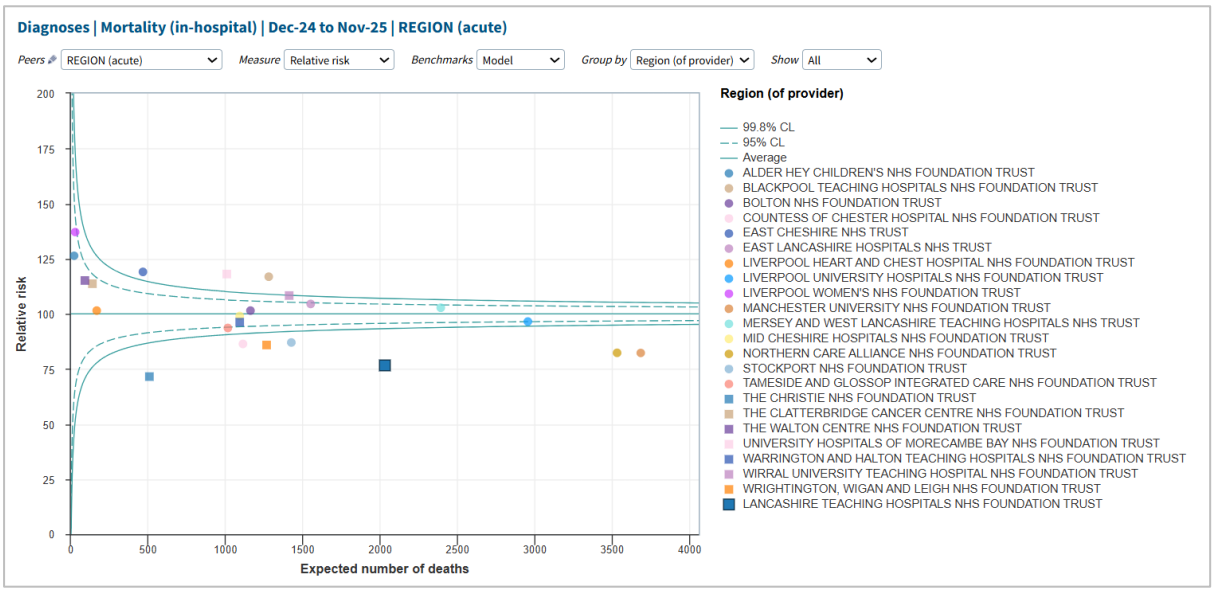


Figure 43: SMR Regional Acute Trust Benchmark December 2024 – November 2025

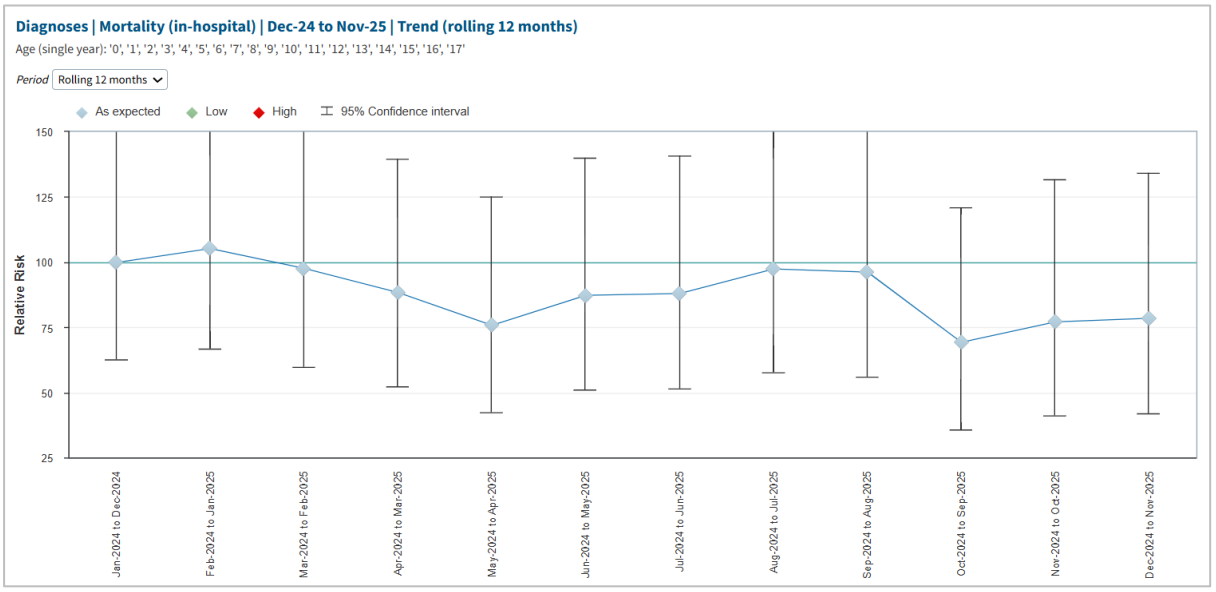
The Standardised Mortality Ratio (SMR) for all diagnoses was **76.6**, indicating mortality lower than expected. This is shown in the figure below, demonstrating performance compared to regional acute trusts.



3.2.6.2 Child Deaths

Figure 44: SMR for Children

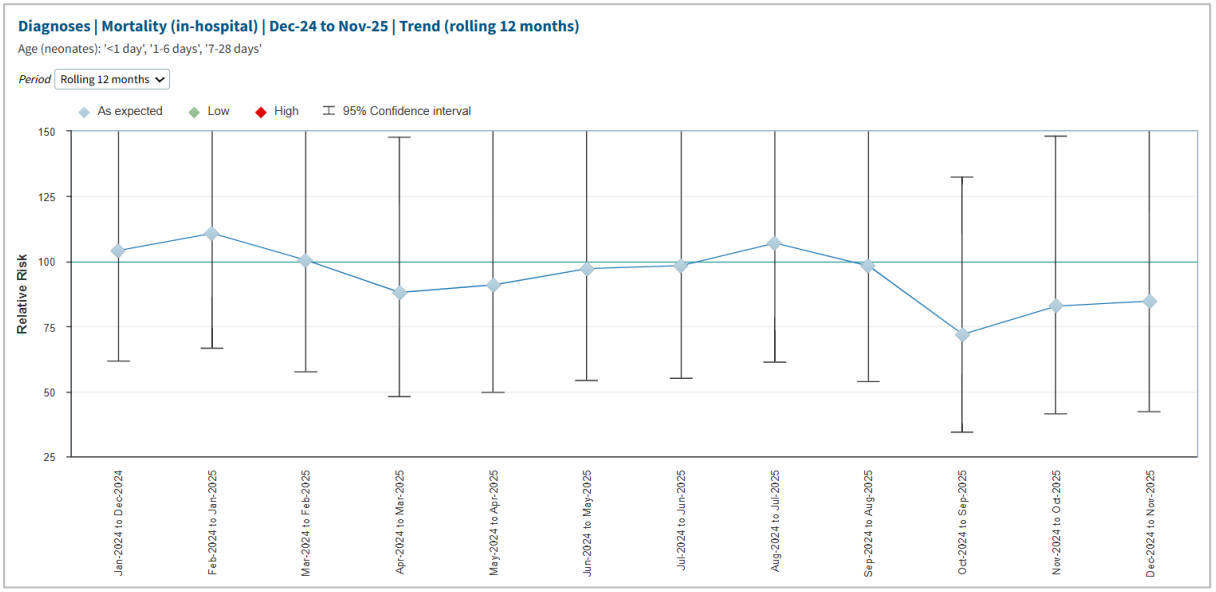
Child SMR (0–17 years): 78.4 – within expected range



All child deaths are reviewed in line with national guidance and reported to the Child Death Overview Panel (CDOP). Local reviews are also carried out by the neonatal lead consultant or safeguarding leads, ensuring learning is identified and shared.

Figure 45: SMR for Neonatal Deaths

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



All neonatal deaths are reported to the MBRRACE-UK programme and reviewed using the Perinatal Mortality Review Tool (PMRT). This supports structured, multidisciplinary review of each case.

Local reviews are also carried out by the neonatal service, with learning shared within the department and across the Lancashire and South Cumbria Neonatal Operational Delivery Network.

The Trust's stabilised and adjusted neonatal mortality rate (within 28 days of birth) is 1.99 per 1,000 births, which is in line with similar Trusts. Excluding deaths due to congenital anomalies, the rate is 1.49 per 1,000 births, also comparable with peers.

Between 1 April 2025 and 31 March 2026, there were 13 neonatal deaths. These continue to be reviewed to support learning and improvements in care.

3.2.6.3 Perinatal Mortality & Perinatal Mortality Review Tool

The Trust uses the Perinatal Mortality Review Tool (PMRT) to carry out structured, multidisciplinary reviews of all eligible perinatal deaths. These reviews include the perspectives of families, with findings and outcomes shared within six months.

Learning is monitored through the Safety and Quality Committee, with key themes reported to the Trust Board for oversight.

Between April 2025 and March 2026:

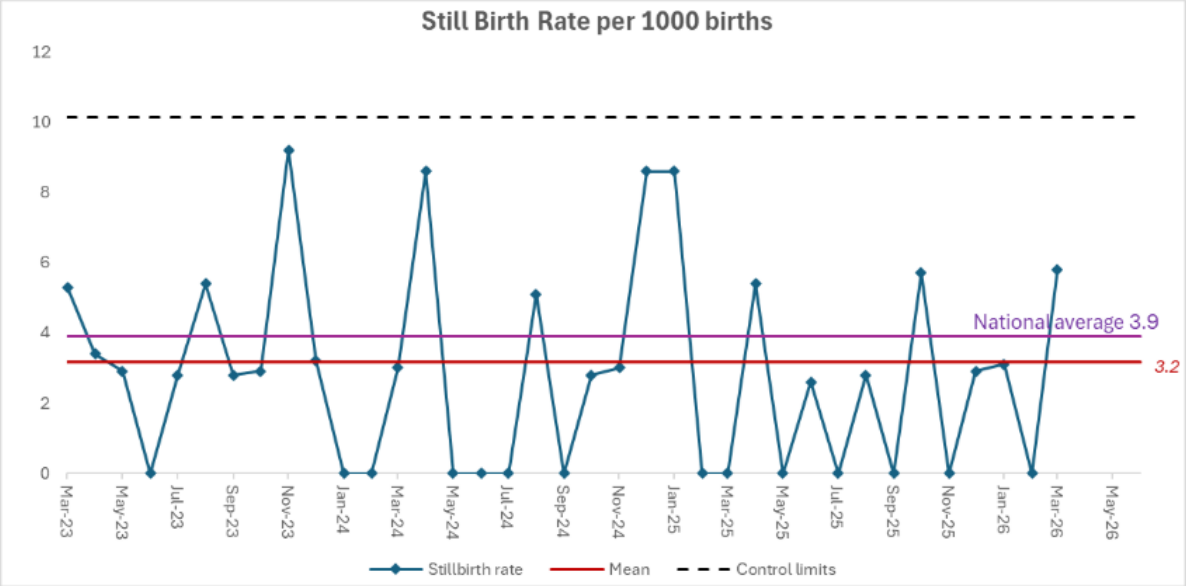
- 25 cases were reported to MBRRACE-UK
- 20 cases met the criteria for full review

The stabilised and adjusted stillbirth rate is 3.45 per 1,000 births (2024), which is in line with similar Trusts. Excluding congenital anomalies, the rate is 2.98 per 1,000 births, which is below the average for comparable organisations. The national average for England and Wales was 3.9 per 1,000 births (2024).

For the period 1 April 2025 to 31 March 2026, there were 7 stillbirths (excluding terminations for fetal abnormality).

These reviews continue to support learning and improvements in maternity and neonatal care.

Figure 46: Maternity SPC analysis - Incidence of Stillbirths (per 1000 births)



3.2.6.4 Medical Examiner Service

The Medical Examiner (ME) Service provides independent oversight of deaths to improve transparency, safety and the accuracy of death certification. It also offers families an opportunity to ask questions and raise concerns.

Since September 2024, the service has been a statutory requirement. Medical Examiners review all non-coronial deaths and must sign the Medical Certificate of Cause of Death (MCCD) before registration. They are supported by Medical Examiner Officers, who assist with the review process.

At the Trust, deaths are referred to the ME Service after the MCCD has been completed, with support available to clinical teams where needed. The service operates independently, in line with national standards.

The review process includes:

- A proportionate review of medical records
- Discussion with the treating clinician
- A conversation with the patient's family or next of kin

Medical Examiner Officers may support discussions and manage concerns, with escalation to the Medical Examiner where required.

Table 22: Medical Examiner Service Performance 2025-26 data

Total Figures for April 2025 – March 2026

April 2025- March 2026	Number	Percentage
Inpatient & ED Deaths	1826	
ME Reviews of all Deaths	1500	82.1%
MEO Reviews of all Deaths	1826	100%
ME/MEO Reviews of all Deaths	1826	100%
ME/MEO Conversations with Bereaved	1496	81.92%
Referrals to Coroner	315	17.2%
Referred for further review	33	1.80%
Datix Submitted	67	3.66%
LEDER Reported	12	0.65%

Of 1,826 deaths, 228 cases were referred directly to HM Coroner following initial review and did not require further Medical Examiner scrutiny. A further 143 cases were referred after Medical Examiner review.

For cases referred directly, communication with families is usually managed by the Coroner's Office, although initial contact may be made by Medical Examiner Officers where appropriate.

The Medical Examiner Service identified 10% of cases for further review of care, including:

- 67 cases where an incident report was raised
- 33 cases where a Structured Judgement Review was requested

Key themes identified included:

- Delays in recognising end of life
- Delays in radiology reporting
- Stroke patients not receiving thrombectomy due to gaps in service

This learning continues to inform improvements in care and supports ongoing work to strengthen patient safety.

3.2.6.5 Learning from Corners Regulation 28 Report

During the reporting period, the Trust received two Regulation 28 Reports to Prevent Future Deaths.

- The first case (May 2025) raised concerns about the absence of a 24/7 thrombectomy service
- The second case (September 2025) related to aspects of care during treatment for cardiac pacemaker complications

In both cases, the Trust developed and submitted action plans, which were accepted by the Coroners.

Key actions included:

- Implementation of a 24/7 thrombectomy service from February 2026
- Improvement to pathology result tracking processes within the cardiology service

Since February 2026, there have been no gaps in thrombectomy service provision. The Trust is now delivering a high volume of thrombectomy procedures relative to stroke admissions.

Work continues with regional partners to strengthen resilience and support a coordinated approach to thrombectomy services across the North West.

3.3 Review of Quality Performance – Experience of Care

3.3.1 Patient Experience Performance Report 2025-26

The Single Improvement Plan for 2025–26 places a strong focus on understanding and responding to patient experience. This includes learning from both positive and negative feedback and using it to improve care.

The plan was developed with input from patients, families, staff, governors and partner organisations, ensuring a shared focus on improving services.

Key objectives include:

- Improving inpatient survey results
- Developing consistent approaches to stakeholder engagement
- Reducing complaints per 1,000 bed days
- Improving feedback from protected groups
- Expanding the volunteer workforce

Patient experience is measured through surveys such as the Friends and Family Test, Envoy and Picker, alongside staff feedback from the Staff Survey and monthly pulse surveys.

Targeted engagement work has also supported greater involvement from a wider range of communities.

3.3.2 Complaints and Concerns

3.3.2.1 Complaints

During 2025–26, the Trust received 329 formal complaints, a small increase from the previous year.

Response times have improved, with 81% of complaints responded to within 35 or 60 days over the year. This reflects continued focus on timely communication and addressing concerns raised by patients and families.

Table 23: Comparator data for Complaints 2023 to 2026

Year	Complaints received	Increase/reduction
2023-24	355	-132
2024-25	325	-30
2025-26	329	+4

Source: LTHTR Datix/Ulysses

During 2025–26, the Trust received 329 formal complaints, an increase of 4 cases (1.23%) compared to 2024–25. This represents a small rise, with complaints generally becoming more complex in nature. Trends in complaints relative to patient activity over the past three years are shown in Table 25.

Of the complaints received:

- 289 (88%) related to care at Royal Preston Hospital
- 40 (12%) related to Chorley and South Ribble Hospital

Table 24 : Number of Complaints by Division – April 2025 to March 2026

Division	Number (%)	Division	Number (%)
Medicine	120 (36%)	Women and Children's Services	54 (16%)
Surgery	127 (39%)	Diagnostics and Clinical Support	21 (6%)
Estates and Facilities	3 (0.5%)	Corporate Services	4 (1.5%)

Source: LTHTR Datix/Ulysses

Table 25 : Trend of ratio of complaints per patient contact 2022 to 2026

Year	No of complaints	Total episodes (inpatient/outpatient)	Ratio of complaints to patient contacts
2022-23	487	849,328	1:1,744
2023-24	355	882,589	1:2,486
2024-25	325	917,962	1:2,825
2025-26	329	952,167	1:2,896

Source: LTHTR Datix/ Ulysses

During 2025–26, 253 complaints were closed. Outcomes were:

- 14 (5.5%) upheld
- 154 (60%) partly upheld
- 72 (28%) not upheld
- 15 (6.5%) not investigated under the complaints process, as they were managed through alternative routes

NHS Complaints Regulations require acknowledgement within three working days. During this period, 94% of complaints were formally acknowledged within this timeframe through the Patient Experience and Patient Advice and Liaison Service (PALS) Team. All patients received an acknowledgement either by email or telephone. The 94% reflects the point at which cases were recorded on the Trust's incident management system and a response was issued by the case manager.

During the year, 9 second letters were received where further clarification or response was requested.

Overall, 81% of complaints were closed within the Trust's 35- or 60-day response timeframe, supporting more timely communication with patients and families.

In addition, the Patient Experience and PALS Team managed:

- 1,654 concerns
- 4,739 enquiries

These interactions continue to provide valuable insight to support service improvement and patient experience.

Table 26: Top 3 themes from complaints by division

Division	Themes
Diagnostic and Clinical Support	1. Treatment/procedure 2. Clinical Assessment 3. Diagnostics
Women and Children	1. Treatment/procedure 2. Communication 3. Staff Treatment, procedure. Staff Behaviour/Diagnosis/Clinical Assessment
Medicine	1. Appointments 2. Communication 3. Treatment/procedure
Surgery	1. Treatment/procedure 2. Communication 3. Appointments

3.3.3 The Parliamentary Health Service Ombudsman (PHSO)

If a complaint is not resolved locally, complainants can request an independent review by the Parliamentary and Health Service Ombudsman (PHSO).

Between 1 April 2025 and 31 March 2026, 4 cases were referred to the PHSO:

- 2 cases are ongoing
- 1 case was partly upheld
- 1 case was not upheld

During the same period, the PHSO issued final reports for 4 cases opened before April 2025. All were partly upheld, providing further learning to support improvements in care and response handling.

3.3.4 Compliments

The Trust receives both formal and informal compliments from patients and their families about their care experience.

During 2025–26, a total of 8,230 compliments and thank you messages were received across wards, departments and the Chief Executive's Office.

This represents a 20% increase compared to the previous year. Teams are encouraged to record compliments on the Trust's Ulysses system, supporting recognition of good practice and enabling learning to be shared.

Compliments are now reported regularly through Trust communications and discussed at divisional meetings, providing opportunities to recognise staff contributions and celebrate positive patient experiences.

3.3.5 Friends and Family Feedback (FFT)

The Friends and Family Test (FFT) is a national measure used to understand whether patients would recommend Trust services to others.

The Trust reports FFT feedback across the following areas:

- Maternity

- Day case
- Outpatients
- Inpatients
- Emergency Department

3.3.5.1 Children and Young People (CYP) Feedback

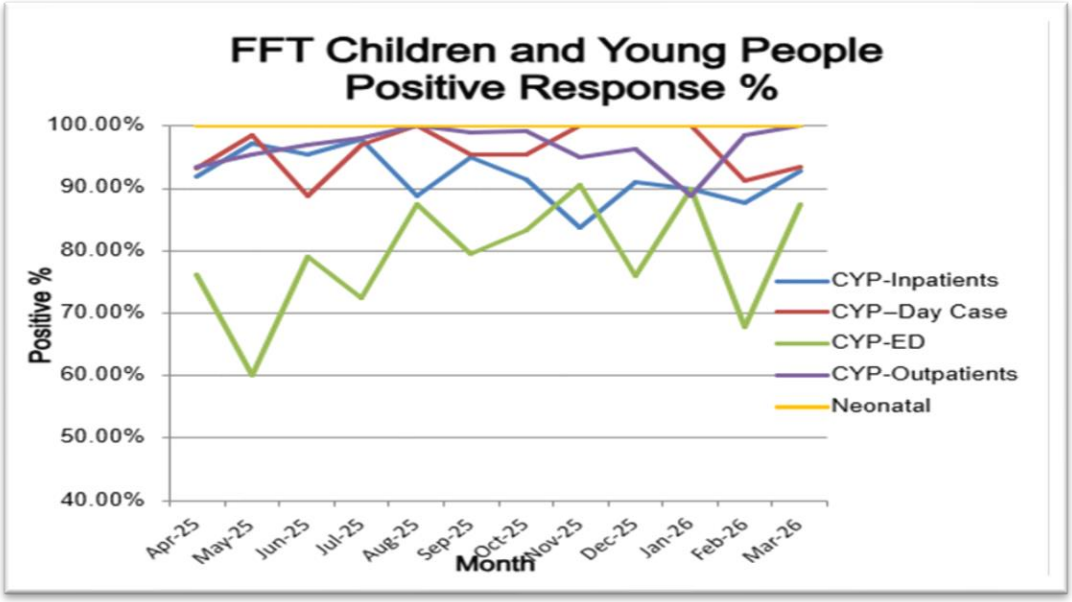
Although not a national requirement, the Trust also collects feedback from Children and Young People to ensure their experiences are understood.

Feedback shows variation across services:

- Urgent and Emergency Care: Lower satisfaction, reflecting the pressures in this area
- Day case and outpatient services: Stronger and more positive feedback
- Inpatient care: Showing improvement over time
- Neonatal services: Sustained high performance, with 100% positive feedback

This feedback continues to inform improvements, particularly in areas where experience is less consistent.

Figure 47: Children and Young People (CYP) Quarterly percentage of positive responses



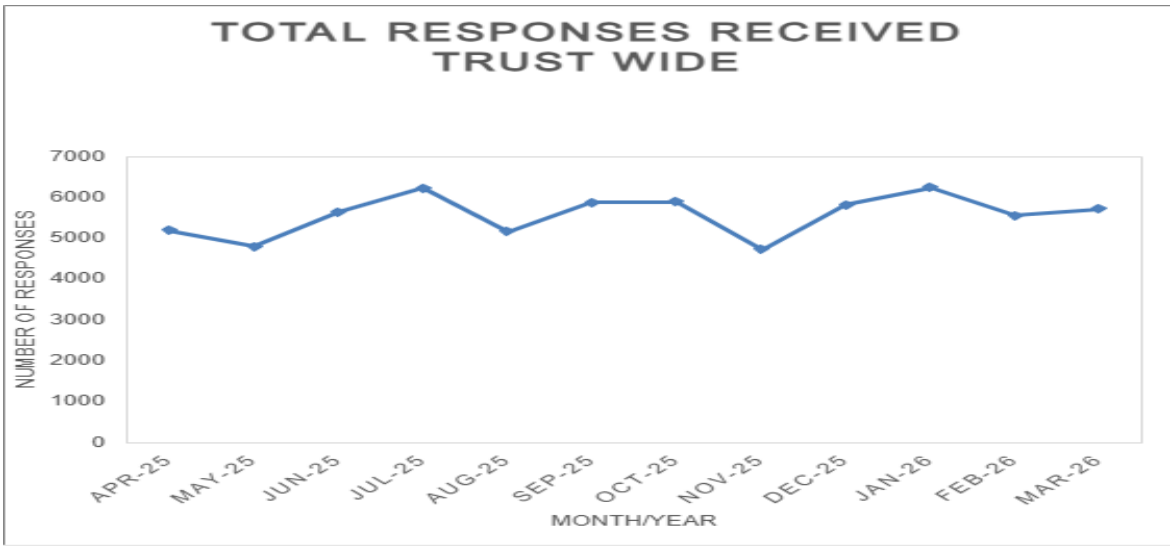
Source: FFT data CIVICA

3.3.5.2 Response Rates and Collection Methods

Expanding how feedback is collected has helped the Trust better understand what matters to patients. Increasing response rates has been a key focus, with 3,555 more responses received compared to 2024–25.

In 2025–26, the Trust received 65,480 Friends and Family Test (FFT) responses, a 4.69% increase on the previous year. This reflects continued work to make it easier for patients to share their views and ensures a broader and more representative range of feedback.

Figure 48: Friends and Family % Response



Source: FFT data CIVICA

Figure 48 shows an overall increase in responses, along with greater use of a wider range of feedback collection methods.

Table 27: FFT response rates

Year	QR codes/online surveys	Paper surveys	Telephone surveys	SMS text surveys	Total
2023-2024	3,016	10,944	2,112	46,471	62,543
2024-2025	973	13,661	910	49,936	65,480
2025-2026	1,217	15,587	404	51,827	69,035

There has been an overall increase in response rates of 5.43% compared to the previous year. Increases were seen across paper, online and SMS surveys, while telephone responses reduced, reflecting changing preferences in how patients provide feedback.

Staff continue to encourage patients to complete the Friends and Family Test before leaving hospital, supporting improved response rates, particularly for paper surveys.

Training for staff continues, with a focus on using feedback systems effectively and keeping patient experience boards up to date with “You said, we did” information. FFT results are monitored through the Safety and Quality Committee, with monthly reports shared across divisions to support learning and improvement.

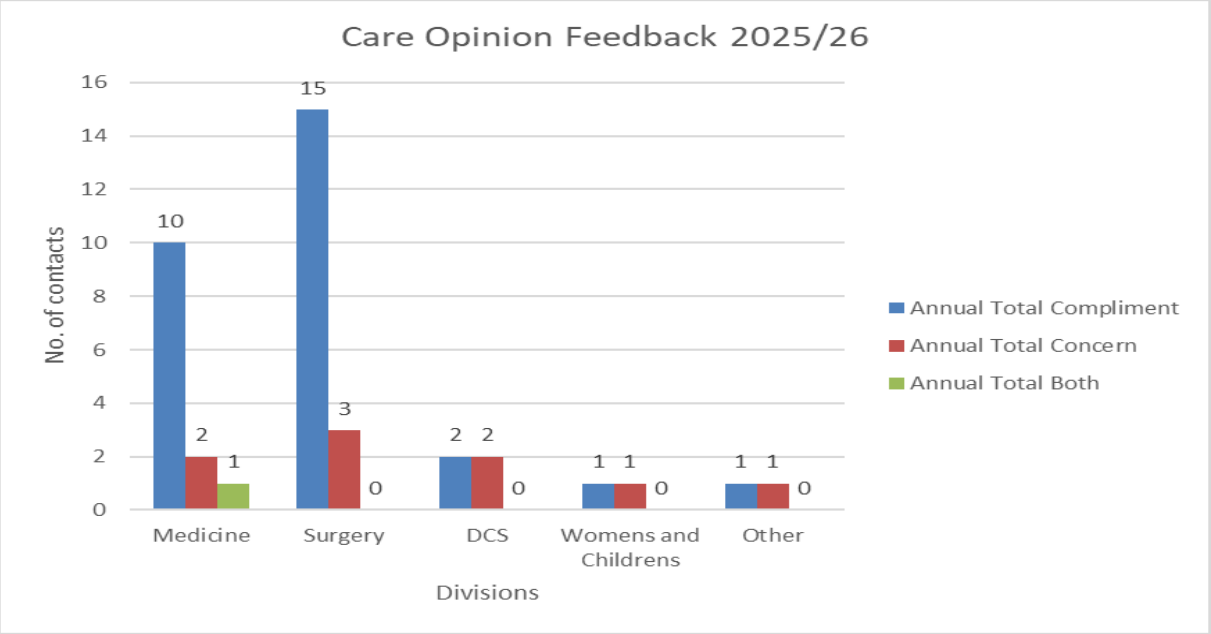
3.3.5 Care Opinion Website

During 2025–26, **39 reviews** were posted on the Care Opinion website relating to the Trust. These included:

- **29 compliments**
- **9 concerns**
- **1 mixed review** (both compliments and concerns)

This feedback provides additional insight into patient experience and supports ongoing service improvement.

Figure 49: Care Opinion feedback



3.3.6 National Patient Survey Results

Maternity Survey 2025

The survey included mothers who received care between April and July 2025. Compared to 2024, the Trust improved in four areas, with no areas showing a decline.

Of the 89 questions, 58 were comparable with the previous year. Feedback remains strongly positive:

- 98% rated their overall care positively
- 97% felt treated with respect and dignity
- 98% had confidence and trust in staff
- 98% felt involved in decisions during labour and birth

These results show continued improvement across key areas of patient experience.

Inpatient Survey 2024

The survey included patients treated between January and April 2024:

- 1,200 eligible patients, with 450 responses (38% response rate)
- Slight decrease from 2023 and below the national average of 41%

Of the 63 questions, 45 were comparable with 2023:

- No areas showed significant improvement
- One area worsened
- Most areas showed no significant change

Compared with other trusts:

- Several areas were in line with national performance, including staff care and dignity
- Some areas were below average, particularly ward environment (temperature and sleep), involvement in decisions, and overall experience

While some improvement is evident over time, performance remains mixed, with continued focus needed in key areas.

Children and Young People's Survey 2024

The survey included patients treated between March and May 2024:

- 1,239 eligible patients, with 239 responses (19% response rate)
- Below the national average of 22%

Changes to the survey mean results are not comparable with previous years, including:

- Updated timing of the survey
- Introduction of online responses and text reminders
- Changes to survey content

Most results were reported as similar to other trusts, providing a baseline for future improvement.

4. Major Service Developments and Improvements

Despite ongoing pressures across the health system, including sustained demand and industrial action, 2025–26 saw a number of significant service developments. These have improved access, strengthened clinical outcomes, and increased capacity across the Trust.

Key developments

24/7 Thrombectomy Service

In February 2026, Royal Preston Hospital became a **24/7 thrombectomy centre**, providing round-the-clock treatment for stroke patients across Lancashire and South Cumbria.

This service improves access to a highly effective treatment for stroke, reducing disability and supporting better recovery. It also strengthens the Trust's role as a regional centre for specialist stroke care.

More details are available on the Trust website

New hospital site progress

In March 2026, the Trust completed the purchase of land for a proposed **replacement Royal Preston Hospital** as part of the national New Hospital Programme.

This marks an important step towards future development, with further public consultation planned.

The full story is available on the Trust website.

Helipad refurbishment

A **£720,000 upgrade** to the Royal Preston Hospital helipad, funded by the HELP Appeal, has improved safety and reliability for emergency transfers.

Work included new landing facilities, lighting, safety features and updated systems, ensuring continued access for critical patients.

Medicine reconfiguration programme

Work began in January 2026 to improve patient flow, supported by the **Days Kept Away from Home** approach.

Dedicated areas for patients medically fit for discharge are helping to:

- Reduce delays
- Free up specialist beds
- Improve flow from the Emergency Department

Pathology Service transformation

Plans were approved to create a single pathology service across Lancashire and South Cumbria from April 2026.

This will support service standardisation, digital development and improved diagnostic services across the system.

Robotic surgery milestone

The Trust completed its **1,000th robotic prostatectomy**, highlighting continued use of minimally invasive techniques that improve recovery and outcomes for patients.

The full story is available on the Trust website.

New radiotherapy equipment

A new **linear accelerator (LINAC)** was introduced at the Rosemere Cancer Centre, improving reliability and expanding access to advanced cancer treatments.

This supports more targeted treatment and reduces disruption caused by equipment failures.

The full story is available on the Trust website.

Dialysis service development

A new partnership with Diaverum will deliver dialysis services at Clifton Hospital, supporting care closer to home and increasing capacity for patients with kidney disease.

The full story is available on the Trust website.

Robotic rectal cancer surgery

The Trust introduced robotic Transanal Minimally Invasive Surgery (TAMIS), becoming one of a small number of centres nationally offering this approach.

This enables more precise treatment, reduces the need for major surgery and improves recovery for patients.

The full story is available on the Trust website.

4.1 Staff Survey and Recommendation of Our Care

4.1.1 NHS Staff Survey 2024-25

The NHS Staff Survey is carried out each year and is aligned with the NHS People Promise, which includes seven key areas, alongside staff engagement and morale. Each area is scored out of 10, based on staff responses.

In 2024–25, the Trust achieved a response rate of 45.1%, with 4,271 staff participating. This is an improvement from 39% (3,994 staff) in the previous year, representing a 6.1% increase.

While the response rate remains slightly below the national average, the increase shows improved staff engagement.

4.1.2 Survey Results and Benchmarking

Scores for each survey indicator, alongside comparison with similar organisations (acute and combined acute/community trusts), are presented below.

Table 28: National Staff Survey Results - People Promise Indicators 2025-2022

Indicators ('People Promise' elements and themes)	**2024/25**		**2023/24**		**2022/23**	
	Trust Score	Benchmarking group score	Trust score	Benchmarking group score	Trust score	Benchmarking group score
People Promise:						
We are compassionate and inclusive	**7.12**	7.28	**7.15**	7.21	**7.30**	7.24
We are recognised and rewarded	**5.83**	5.87	**5.90**	5.92	**6.06**	5.94
We each have a voice that counts	**6.51**	6.60	**6.60**	6.67	**6.77**	6.70

We are safe and healthy	**6.04**	6.07	**6.03**	6.09	**6.25**	6.08
We are always learning	**5.54**	5.57	**5.53**	5.64	**5.66**	5.62
We work flexibly	**6.19**	6.22	**6.18**	6.24	**6.42**	6.20
We are a team	**6.71**	6.75	**6.75**	6.74	**6.86**	6.75
Staff engagement	**6.49**	6.74	**6.63**	6.84	**6.91**	6.91
Morale	**5.68**	5.84	**5.72**	5.93	**6.02**	5.90

Following year-on-year improvement between 2021 and 2023, survey results declined in 2024, reflecting wider financial, operational and workforce pressures across the NHS.

The 2025 results show a more stable position. While scores remain slightly below the national average across several People Promise themes, including staff engagement, morale, learning, safety and having a voice, the gap is generally small.

Table 29 shows performance compared to the national benchmark. Most areas are close to the national average, with strengths seen in team working, recognition and reward, flexible working and safety.

Larger gaps remain in overall staff engagement and morale, indicating areas for continued focus.

Table 29: Trust National Staff Survey indicators comparison to National Benchmark

Indicators below national benchmark:	Indicators slightly behind national benchmark:	Indicators close to national benchmark:
• Staff Engagement (6.49 vs 6.74) GAP 0.25 • Morale (5.68 vs 5.84) GAP 0.16	• We each have a voice that counts (6.51 vs 6.60) GAP 0.09 • We are compassionate and inclusive (7.12 vs 7.28) GAP 0.16	• We are recognised and rewarded (5.83 vs 5.87) GAP 0.04 • We are safe and healthy (6.04 vs 6.07) GAP 0.03 • We are always learning (5.54 vs 5.57) GAP 0.03 • We work flexibly (6.19 vs 6.22) GAP 0.03 • We are a team (6.71 vs 6.75) GAP 0.04

While it is disappointing that results remain below the national benchmark following previous improvement, this pattern reflects the ongoing pressures experienced across services. Encouragingly, there has not been a significant decline compared to the previous year.

The improved response rate suggests stronger engagement with the survey. This is likely linked to a more coordinated approach, including clearer communication, targeted engagement and consistent

messaging. The approach combined an honest reflection of challenges with recognition of staff contribution, reinforcing the importance of staff voice.

The results provide a clear picture of the current working environment and reflect the impact of organisational change, uncertainty and wider system pressures.

Team cohesion, compassion and local leadership relationships have remained stable. This suggests strong support between colleagues and continued professional commitment. Recent initiatives, including leadership development, team programmes, recognition, flexible working and wellbeing support, are likely contributing positively.

4.1.3 Staff Engagement Results

The staff engagement score is based on nine questions covering motivation, involvement and advocacy. Table 30 below provides a breakdown of results for 2025, with comparison to the previous year and national averages.

Table 30: 2025 Staff Engagement Question Breakdown

	Organisational Results and comparison (2024 to 2025)			Benchmark Average 2025 Comparison	
Question	**LTH 2025**	**LTH 2024**	**Changes**	**Benchmark Average 2025**	**LTH comparison to benchmark**
Motivation					
Often/always look forward to going to work	**49.53%**	51.76%	-2.23%	52.04%	-2.51%
Often/always enthusiastic about my job	**64.62%**	67.37	-2.75%	66.05%	-1.43%
Time often/always passes quickly when I am working	**72.35%**	73.26%	-0.91%	70.00%	2.35%
Involvement					
Opportunities to show initiative frequently in my role	**72.88%**	73.87%	-0.99%	72.51%	0.37%
Able to make suggestions to improve the work of my team/dept	**72.09%**	72.97%	-0.88%	69.85%	2.24%
Able to make improvements happen in my area of work	**52.72%**	54.42%	-1.70%	54.54%	-1.82%
Advocacy					
Care of patients/service users is organisation's top priority	**62.26%**	65.87%	-3.61%	71.63%	-9.37%
Would recommend organisation as place to work	**45.43%**	49.76%	-4.33%	56.3%	-10.87%
If friend/relative needed treatment would be happy with standard of care provided by organisation	**48.46%**	52.14%	-3.68%	60.83%	-12.37%

***Key**: Red – decline from 2024 and/or performance below national benchmark; Amber – broadly consistent with 2024 (less than 1% difference) and/or close to benchmark; Green – improvement from 2024 (more than 1% difference) and/or above*

benchmark. Please note colours reflect both Trust result changes and national benchmark position, so interpretation should consider when reviewing.

While overall survey scores suggest relative stability and only small gaps to national benchmarks, a more detailed analysis shows a more challenging picture beneath this. Declines are evident across all staff engagement measures, including motivation, involvement and advocacy.

Motivation has reduced, with fewer colleagues reporting that they look forward to work or feel enthusiastic. One positive indicator remains that staff report time passing quickly at work, suggesting aspects of day-to-day experience remain positive.

Involvement shows a mixed position. While staff feel able to contribute ideas and demonstrate initiative, confidence in the ability to make improvements happen has declined. This suggests a gap between staff voice and perceived impact.

The most significant decline is in advocacy. Scores across all measures have reduced and remain notably below the national benchmark. This includes confidence in care standards, recommending the Trust as a place to work, and perceptions of patient care as a priority.

Free text feedback supports this picture. Staff highlighted pressures related to staffing, patient flow and capacity, and the impact these have on delivering the standard of care they expect. Many comments reflected strong professional commitment, alongside frustration where staff feel unable to deliver the care they aspire to.

Overall, while team-level support and day-to-day working relationships remain strong, confidence in the wider organisation has reduced. This is important, as perceptions of care quality are closely linked to staff advocacy and retention.

4.1.4 Next steps and future priorities

Survey results have been shared across the organisation to support action at all levels. Key actions include:

- Development of a corporate action plan aligned to People Plan priorities
- Production of data packs for Trust, divisional and team-level review
- Engagement activity through staff briefings, leadership forums and communications
- Workshops with divisional teams to identify priorities and actions
- Tools and resources for managers to support team conversations and engagement
- Targeted support for teams with lower engagement scores, alongside review of links to patient outcomes
- Focused work on priority themes such as Freedom to Speak Up, civility and safety
- Ongoing communication and engagement plan to maintain visibility and dialogue

4.1.5 Priorities and targeted actions

Key areas of focus include:

1. **Health and wellbeing** – addressing burnout and supporting staff wellbeing
2. **Sexual safety** – embedding the NHS Sexual Safety Charter
3. **Safety and violence** – strengthening zero tolerance approaches
4. **Raising concerns** – improving confidence to speak up
5. **Recognition** – strengthening appreciation and reward
6. **Equality, diversity and inclusion** – addressing variation in staff experience
7. **Advocacy and confidence** – improving trust in care quality and organisation
8. **Manager support** – improving people management capability
9. **Targeted team development** – bespoke support for lower-scoring teams
10. **Response rates** – improving participation and representation

Examples of work delivered in 2025-26:

A wide range of initiatives have supported staff experience, including:

- Launch of a Colleague Engagement Strategy and “Your Voice” events
- Expanded wellbeing and psychological support services
- Relaunch of Mental Health First Aiders
- Development of manager tools and training
- Strengthening Freedom to Speak Up visibility and support
- Enhanced recognition programmes, including Thank You Week and reward schemes
- Delivery of EDI initiatives, including inclusion events and neurodiversity support
- Leadership development through “Leadership at Lancs”
- Targeted organisational development support for teams

4.1.6 Monitoring Performance and Tracking Impact

The Trust has established robust arrangements to monitor progress and impact.

Performance is reviewed through:

- Organisational Development governance
- Divisional workforce committees
- Single Improvement Plan reporting
- Workforce Committee and Trust Board oversight

Progress is tracked using staff survey data, retention metrics and ongoing feedback.

Communication continues through trust-wide updates, with “You said, we did” feedback demonstrating action taken. Local engagement is supported through tools and resources to help teams continue meaningful conversations.

The Trust remains committed to ensuring staff feel heard, supported and valued, and to maintaining an open dialogue to drive improvement.

4.2 Medical and Dental Workforce Rota Gaps

The Medical Workforce Department continues to monitor vacancies across medical and dental staff. As of February 2026, the overall vacancy rate was 3.29%, indicating a broadly stable position across the Trust.

Workforce pressures remain in some specialties, particularly at consultant and senior SAS level, with challenges seen in areas such as Emergency Medicine, Stroke Medicine, Haematology, Radiology and Neurology. These reflect national workforce shortages.

The Trust manages these pressures through workforce planning, targeted recruitment and retention initiatives, and flexible staffing models to support safe service delivery and training.

Vacancy risks are regularly reviewed through divisional and corporate governance processes and are aligned to the Trust's Strategic Workforce Plan.

A quarterly vacancy report is also produced for the Guardian of Safe Working Hours and presented to the Board.

Table 31: Medical and Dental Vacancies

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

Grade	Funded WTE	Filled WTE	Vacant WTE	Vacancy Rate
FY1	68.60	68.00	0.60	0.41%
FY2	44.00	40.90	3.10	7.05%
ST1-2	120.00	108.06	11.94	9.95%
ST3+	144.56	175.12	N/A	N/A
Junior Clinical Fellow	85.81	89.62	N/A	N/A
Senior Clinical Fellow	123.34	106.48	18.86	13.67%
SAS	94.86	92.75	2.11	2.22%
Consultant	520.72	480.27	40.45	7.77%
Total	1,201.29	1.161.80	39.49	3.29%

Source: LTHTR data Feb 2026 General ledger

4.3 Consultant Vacancy Rates 

As of March 2026, the Trust's consultant vacancy rate is 7.26%, showing continued improvement from 7.86% in March 2025 and 11.44% in March 2024. This reflects progress in recruitment and retention, supported through internal governance and national reporting.

Despite this, challenges remain in nationally recognised shortage specialties, including Neurology, Elderly Medicine, Haematology, Stroke Medicine and Gastroenterology.

To manage these pressures, the Trust continues to:

- Use long-term NHS locum arrangements where needed
- Develop sustainable workforce models to reduce reliance on agency staff
- Support clinicians through the CESR route to achieve specialist registration
- Introduce Specialist Doctor roles to strengthen senior clinical capacity

Workforce plans are being developed in partnership with HR to review and improve staffing models in areas with the greatest challenge. Recruitment approaches have also been strengthened, highlighting opportunities in research, leadership and education to position the Trust as an employer of choice.

4.4 Core Skills Training 

4.3 Core Skills Training

Keeping staff up to date with mandatory training is essential for safe and effective care. Core Skills Training is monitored through the Education, Training and Research (ETR) Report, with oversight from the ETR Committee.

Previous performance identified areas for improvement, particularly in resuscitation training, where compliance was below the 90% target.

Focused improvement work has now addressed these gaps, and the Trust has achieved compliance across all Core Skills Training metrics.

Further detail is provided in Table 32.

Table 32: Core Skills training metrics

	Mar-26
Equality, Diversity and Human Rights	99%
Fire Safety	98%
Health, Safety and Welfare	99%

Infection Prevention and Control - Level 1	99%
Infection Prevention and Control - Level 2	96%
Info Gov: All Staff	95%
Moving & Handling L1 (Non-Clinical)	99%
Moving & Handling L2 (Clinical)	94%
Preventing Radicalisation - Awareness	97%
Preventing Radicalisation - Basic Awareness	99%
Resus - Level 1, Non-Clinical	97%
Resus - Level 2, ABLS&PBLS	94%
Resus - Level 3, ILS	93%
Resus - Level 3, NILS	96%
Resus - Level 3, PILS	96%
Safeguarding Adults (Level 1)	99%
Safeguarding Adults (Level 2)	99%
Safeguarding Adults (Level 3)	96%
Safeguarding Children (Level 1)	99%
Safeguarding Children (Level 2)	98%
Safeguarding Children (Level 3)	97%

4.5 Quality Assurance

4.5.1 Overview and Assurance Statement

This Quality Account provides the information and assurance required by NHS England. It includes performance against statutory indicators, alongside assurance on the quality and reliability of data.

The Trust has reported progress against its 2024–25 priorities and set new priorities for 2025–26, aligned to the Single Improvement Plan.

Quality of care has been reviewed across patient safety, clinical effectiveness and patient experience, ensuring alignment with organisational priorities and risk appetite.

4.5.2 Governance and Oversight

The Safety and Quality Committee plays a central role in overseeing quality and supporting continuous improvement. It provides assurance to the Board by:

- Ensuring effective systems and controls are in place to maintain safety and standards
- Monitoring performance against key quality and safety metrics
- Supporting timely action where improvement is needed
- Overseeing compliance with NHS England requirements and Care Quality Commission standards

4.5.3 Governor Engagement and Assurance

Governors continue to play an active role in quality oversight. This includes involvement in STAR assessments, participation in quality reviews, and engagement with the Patient Experience Improvement Group.

Their input provides valuable insight and constructive challenge, supporting ongoing improvements in care and services.

This Quality Account demonstrates the Trust's continued commitment to transparency, accountability and continuous improvement in delivering safe, effective and patient-centred care.

Annex 1 : Statements from external stakeholders

Statement from NHS Lancashire and South Cumbria Integrated Care Board in response to the Lancashire Teaching Hospitals NHS Foundation Trust Quality Account 2025-26

Our ref: QA2025-26 SD 001

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Lancashire and South Cumbria
Integrated Care Board

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22nd June 2026

Professor Silas Nichols
Lancashire Teaching Hospital NHS Trust

Dear Silas

Re: Lancashire and South Cumbria ICB Response to Lancashire Teaching Hospitals NHS Foundation Trust Quality Account 2025/26

Lancashire and South Cumbria Integrated Care Board (LSCICB) welcomes the opportunity to review and comment on Lancashire Teaching Hospitals NHS Foundation Trust's Quality Account for 2025/26. We recognise the significant work undertaken by the Trust during a period of sustained operational, workforce and financial pressure and thank staff across the organisation for their continued commitment to delivering care for the population of Lancashire and South Cumbria. The Quality Account provides a comprehensive overview of performance, improvement activity and

organisational priorities, and demonstrates a continued focus on improving patient safety, experience and outcomes.

The ICB acknowledges the considerable achievements reported throughout the year. We welcome the Trust's continued focus on strengthening patient safety through implementation of the Always Safety First Strategy and the embedding of the Patient Safety Incident Response Framework (PSIRF). The strong reporting culture demonstrated by the volume of incident reporting provides evidence of a mature approach to safety, learning and openness. We also recognise improvements in sepsis training compliance, progress against STAR accreditation targets, reductions in high-harm falls, strong infection prevention performance and mortality indicators that remain within, or better than, expected ranges. These achievements demonstrate continued investment in quality governance, organisational learning and patient safety.

The Trust should be commended for the progress made in elective recovery and cancer performance. The elimination of 65-week waits, significant reductions in 52-week waits and achievement of key cancer standards demonstrate a sustained commitment to improving timely access to care and supporting recovery across elective pathways. These improvements represent a significant contribution to both local and national priorities.

The ICB further recognises the progress reported within maternity and neonatal services, including achievement of all ten standards within the Maternity Incentive Scheme. This demonstrates a continued focus on maintaining safety and quality within a high-risk service area and reflects the commitment of staff working across maternity pathways.

We also welcome the completion of actions arising from the previous Care Quality Commission inspection and the closure of the associated improvement programme. Continued investment in governance, risk management, quality oversight and organisational learning is particularly encouraging. The implementation of

a new enterprise risk management system provides an opportunity to further strengthen organisational oversight, accountability and assurance arrangements.

The report highlights several areas of innovation and service development, including the introduction of a 24-hour thrombectomy service, expansion of robotic surgery, investment in diagnostic capacity and continued growth in research activity. The ICB also welcomes the Trust's investment in improvement capability through the Lancashire Improvement Method, Microsystem Coaching Academy and wider staff improvement training programmes. The breadth of staff engagement in improvement activity demonstrates a commitment to embedding continuous improvement across clinical and operational services and provides a strong foundation for sustainable change.

Whilst acknowledging the significant progress described within the Quality Account, the ICB notes that several longstanding challenges remain. Given the scale of these issues and their potential impact on patient outcomes, experience and operational resilience, the ICB expects the Trust to demonstrate sustained improvement throughout 2026/27, supported by robust governance, clear delivery trajectories and evidence of measurable impact.

The Quality Account identifies ongoing pressures within urgent and emergency care pathways. Whilst improvements in four-hour performance and reductions in long waits are noted, performance remains below national expectations. Continued challenges relating to crowding, ambulance handover delays, patient flow and capacity constraints present ongoing risks to patient experience and safety. Whilst the ICB recognises the wider system pressures contributing to these challenges, we expect the Trust to demonstrate clear improvement trajectories and provide evidence that actions implemented are

delivering sustained reductions in delays and improvements in operational performance.

The ICB also notes the continued challenges relating to patient flow, delayed discharges and high bed occupancy. These remain significant organisational and system risks that are intrinsically linked to operational performance, patient safety and patient experience. Future reporting should clearly articulate the effectiveness of interventions undertaken and provide demonstrable evidence of sustained improvement in discharge processes, bed utilisation and flow through the hospital system. The ICB will continue to seek assurance regarding progress through established quality and performance oversight arrangements.

Whilst the Quality Account highlights significant areas of progress, the ICB also notes several indicators where deterioration has been reported during the year, including increases in pressure ulcers and complaints. The ICB also notes that the Trust's stillbirth rate remained below the national average during the reporting period. The Trust's transparency in reporting these issues is welcomed; however, future reporting should demonstrate more clearly the underlying causes, actions taken and evidence that improvement measures are resulting in effective and sustained reductions in harm and unwarranted variation.

The ICB notes the reported decline in aspects of workforce experience and engagement. Whilst improvements in Consultant vacancy rates, mandatory training compliance, appraisal completion and retention are welcomed, staff survey findings identify reductions in engagement, morale and organisational advocacy. The ICB also notes reported reductions in fill rates within some professional groups, including maternity services. Given the importance of workforce culture in delivering safe and effective care, the ICB would expect a continued focus on addressing the underlying drivers of these findings. Future reporting should provide greater transparency regarding improvement plans, measurable outcomes and progress against workforce-related risks.

The report demonstrates a continued commitment to listening to patients and using feedback to inform service development. Whilst positive patient experience outcomes are reported in several areas, the decline in overall patient experience ratings indicates that further work is required to understand and address the

drivers of dissatisfaction. The ICB would welcome future Quality Accounts demonstrating more clearly how patient insight is translated into measurable improvements in care and experience, particularly for communities that experience poorer outcomes or face barriers in accessing care.

The ICB recognises the significant financial challenges facing NHS organisations and notes the Trust's ongoing focus on efficiency, transformation and service improvement. As financial pressures continue across the system, it will be important that future reporting demonstrates how quality and safety are protected alongside delivery of financial recovery and operational improvement programmes. The Quality Account describes a substantial programme of improvement activity. In several areas, the report provides evidence of activity and governance arrangements but less clarity regarding the extent to which actions taken have resulted in measurable and sustained improvements for patients and staff.

The ICB welcomes the Trust's continued investment in quality improvement capability and the alignment of improvement activity through the Single Improvement Plan. As this work matures, future reporting should increasingly demonstrate the measurable impact of improvement programmes, the spread of successful initiatives across services, and how patient and staff feedback is informing improvement priorities and service redesign.

The ICB will continue to seek assurance that:

- Significant quality and safety risks are identified, escalated and mitigated in a timely and effective manner.
- Improvement programmes are supported by clear metrics, defined trajectories and regular evaluation of impact.
- Learning from incidents, complaints, patient feedback and mortality reviews is translated into demonstrable improvements in practice and outcomes.
- Workforce engagement, wellbeing and organisational culture are actively monitored and improved.
- Challenges relating to urgent and emergency care performance, patient flow and discharge delays show evidence of sustained improvement rather than short-term recovery.

A key area for development in future Quality Accounts will be demonstrating a clearer link between improvement activity, outcomes achieved and benefits realised for patients and staff. Strengthening the focus on impact, rather than activity alone, will provide stronger assurance regarding the effectiveness and
sustainability of the Trust's quality improvement programmes.

The ICB values its ongoing partnership with Lancashire Teaching Hospitals NHS Foundation Trust and recognises the considerable work undertaken by staff throughout the reporting period. Whilst significant progress has been achieved across many areas, the challenges outlined within the Quality Account require continued focus and effective delivery of improvement programmes. Through established quality, performance and contractual mechanisms, the ICB will continue to monitor progress closely, seeking assurance that improvement activity is delivering tangible and sustained benefits for patients, staff and services. We look forward to continuing to work collaboratively with the Trust to support continuous improvement and the delivery of safe, effective and high-quality care for the communities we serve.

Yours sincerely

Claire Lewis

Associate Director Quality Assurance
Lancashire and South Cumbria Integrated Care Board.

Statement from Healthwatch Lancashire In response to Lancashire Teaching Hospitals NHS Foundation Trust Quality Account 2025-26

Healthwatch response to Lancashire Teaching Hospitals NHS Foundation Trust

2025–26 Quality Account

As Assistant Head of Service for Healthwatch, I welcome the opportunity to review and respond to this Quality Account. It is encouraging to see the Trust's continued commitment to transparency and improvement, particularly through the Single Improvement Plan, and the overarching prioritisation of patient safety, experience and outcomes.

Patient engagement and experience

The Trust demonstrates a clear commitment to engaging with patients, carers and communities, and this is reflected in several positive developments. Notably, there has been a 4.69% increase in Friends and Family Test responses (65,480 in total) and a 20% rise in compliments (8,230), suggesting improved opportunities for patients to share feedback and recognition of good care.

The reported 10% increase in volunteers is also welcome, as volunteers often play a vital role in enhancing patient experience, particularly for those who are vulnerable or require additional support.

However, while the Adult Inpatient Survey shows high levels of dignity and compassion (97–98%), it also reveals a decline in overall satisfaction to 76%, below the national average of 83%. This is a significant finding. While patients continue to report kind and respectful care, their overall experience is being impacted by other factors, including delays, communication challenges, and ward environment pressures, which are acknowledged within the report.

Similarly, feedback highlights lower satisfaction in urgent and emergency care, aligning with known pressures in these services. From a Healthwatch perspective, this reflects what we frequently hear locally: that long waits, crowding, and communication gaps can undermine otherwise compassionate care.

The Trust's work to improve communication on admission, strengthen discharge processes and increase patient involvement in decisions is therefore particularly important. Continued focus on closing the loop with patients – demonstrating how feedback leads to change – will be key to strengthening trust and public confidence.

Patient safety

The Quality Account provides a comprehensive overview of patient safety, showing both strong progress and areas requiring continued attention.

A key positive is the Trust's strong reporting culture, with 36,457 incidents reported in 2025–26 and a reporting rate above the national average (83.8 per 1,000 bed days). This should be recognised as good practice, as high reporting levels are essential to identifying risks and driving improvement.

Importantly, the proportion of incidents resulting in moderate harm or above remains stable at 2.5%, indicating that increased reporting is not associated with worsening harm.

There are also clear improvements in specific safety outcomes which indicate that targeted safety programmes – such as *Always Safety First* and the enhanced focus on learning from incidents – are having a measurable impact.

The Trust is also to be commended for embedding the Patient Safety Incident Response Framework (PSIRF) and for strengthening patient and family involvement following incidents, including through Duty of Candour processes, which were completed in 93.6% of cases.

However, there are areas where risks remain, including:

- Pressure ulcers have increased, particularly in recent months, highlighting ongoing challenges linked to patient acuity, delays in flow, and capacity pressures.
- Emergency care performance remains below target, with the four-hour standard at around 72% and 12-hour waits rising to 12.7%. These are not just operational issues—they represent patient safety risks, particularly for frail and vulnerable individuals.
- Two deaths were identified as more likely than not linked to problems in care, reinforcing the need for continued focus on learning and prevention.

From a Healthwatch perspective, the Trust's recognition of these challenges – and its openness in reporting them – is positive. However, sustained improvement will require continued focus on flow, discharge, and system-wide collaboration, as many of these risks extend beyond the hospital setting.

Staff experience and safety culture

A strong safety culture depends on staff feeling supported and able to speak up. While there is evidence of a structured Freedom to Speak Up offer, there are concerning trends. Only 55.7% of staff feel safe to speak up, and staff confidence in care has declined significantly, with only 48.4% recommending the Trust as a place for treatment (down from 62.1% in 2021).

This is one of the most significant declines in the report. From a Healthwatch standpoint, this is a critical indicator, as staff experience is closely linked to both patient safety and patient experience. Addressing this should be a priority, particularly through visible leadership, improved feedback mechanisms, and meaningful engagement with frontline teams.

In summary

Overall, this Quality Account demonstrates that the Trust has made measurable progress in patient safety and engagement, particularly in areas such as infection control, falls reduction, and incident reporting culture. These are important achievements that should be recognised.

However, there remains a clear gap between activity and outcomes in patient experience, with declining satisfaction and ongoing challenges in urgent and emergency care. Additionally, the decline in staff confidence presents a significant risk to future improvement if not addressed.

Healthwatch would therefore encourage the Trust to prioritise:

- Strengthening patient involvement and co-production, ensuring feedback drives visible change.

- Improving urgent and emergency care experience, particularly communication and waiting times.
- Continuing to embed learning from incidents with meaningful patient and family involvement.
- Taking targeted action to improve staff confidence and speaking up culture.

We look forward to continuing to work with the Trust to support these priorities and to ensure that the voices of patients, carers and communities remain central to service improvement.

Kind regards,

Kate Rees

Assistant Head of Service for Healthwatch in Lancashire and Cumbria

Statement from the Lancashire County Council Health Scrutiny Committee in response to Lancashire Teaching Hospitals NHS Foundation Trust Quality Account for 2025-26.

The statement from Lancashire County Council Health Scrutiny Committee is as follows: -
"The Health and Adult Services Scrutiny Committee acknowledged receipt of the request to review the Lancashire Teaching Hospitals (LTH) Quality Account for 2025/26.

Whilst the Committee was unable to provide comments on the 2025/26 Quality Account at this time, it confirmed its continued interest in the performance and service delivery of LTH. The Committee remains committed to maintaining a constructive and ongoing dialogue with the Trust throughout 2026/27 and looks forward to future engagement opportunities to support scrutiny and improvement."

Council of Governors of Lancashire Teaching Hospitals NHS Foundation Trust Quality Account: Feedback from Council of Governors Meeting on 23rd April 2026

In line with the Trust's commitment to engage and consult with the Council of Governors at a meeting of 23rd April 2026 governors were invited to consider and input into the two Quality Indicators for inclusion in the 2025-26 Quality Account.

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

Indicator 1 Insight: The Trust improves its understanding of the patient experience by listening and gaining real insight by using multiple sources of information, including patient stories, impact statements and patient surveys. This will ensure the patient and family voice is truly "heard," especially of those hear less often.

Indicator 2 Involvement. The involvement of patients, families, carers when they have experienced an

incident is meaningful, individualised and they are treated with respect and compassion, ensuring genuine and compassionate learning from incidents, especially those involved less often.

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

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

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

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

• The content of the Quality Report meets the requirements set out in the NHS Foundation Trust annual reporting manual 2025-26 and supporting guidance.

• The content of the Quality Report is not inconsistent with internal and external sources of information including:

- Board minutes and papers for the period April 2025 to March 2026.
- Papers relating to quality reported to the Board over the period April 2025 to March 2026.
- Feedback from Integrated Care Board 22nd June 2026
- Feedback from Healthwatch 29th June 2026
- Feedback from Overview and Scrutiny Committee 18th June 2026
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 is incorporated in the Annual Patient Experience Report 2025-26.
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered.
- The performance information reported in the Quality Report is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review by MIAA to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- The Quality Report has been prepared in accordance with NHSI's Quality Account manual and supporting guidance as well as the standards to support data quality for the preparation of the Quality Report.
- The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Professor Mike Thomas Chair Date: 30 June 2026

Silas Nicholls Chief Executive Date: 30 June 2026

Appendix 1 - List of Tables

Appendix 2 - List of Figures

Appendix 3 - Glossary of Abbreviations

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

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

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

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

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

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

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

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