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Lancashire Teaching Hospitals
NHS Foundation Trust

Lancashire Teaching Hospitals NHS Foundation Trust

Quality Account 2024/2025

Excellent care with compassion

Always Safety First

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Quality Account 2024-25

PART 1 – Chief Executive's Statement

1.1 Chief Executive's Statement

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Professor Silas Nichols

Chief Executive Officer

PART 2 – Priorities for Improvement

2.1 Strategic Overview

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

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

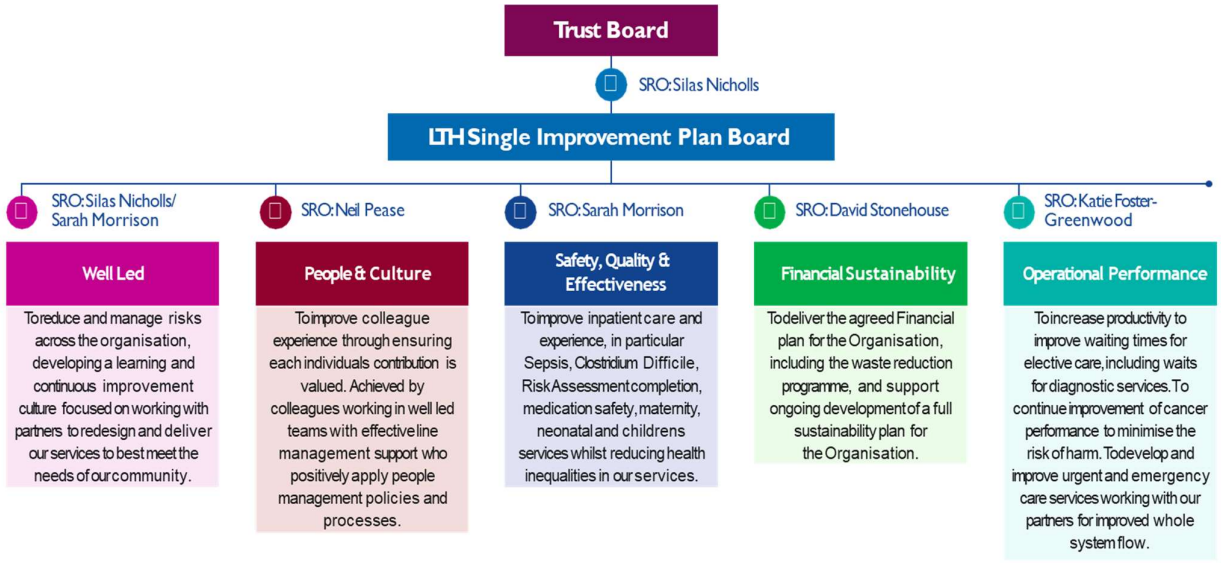
2.1.2 Integration of various sub-strategies

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

2.1.3 Mapping of ambitions to portfolios

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

Figure 1 SIP portfolios and ambitions



2.2 Use of Symbols in the Quality Account 2024–25

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

2.2.1 Symbols aligned to the SIP

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

Figure 2 Symbols aligned to the SIP

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

2.2.2 Measuring success

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

Table 1 The symbols used to represent levels of achievement

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

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

2.3 Key Achievements from 2024-25

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

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

2.3.1 Well Led

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

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

2.3.2 People & Culture

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

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

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

2.3.3 Safety & Quality

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

- **Maternity and Neonatal Improvement and The Patient Safety Incident Response Framework (PSIRF)**: Significant progress was made in the Maternity and Neonatal Improvement programme, including the implementation of the PSIRF. This framework provided a structured approach to managing and learning from patient safety incidents.
- **Clinical Effectiveness**: The Clinical Effectiveness Programme drove improvements in medical staffing, outpatient transformation, and the development of a clinical strategy. These efforts aimed to enhance clinical outcomes and patient care.
- **Clostridioides difficile (C.difficile):** The National cleaning standards frequency of cleaning is now visible and monitored through the safety and quality dashboard and the business case for implementation of the national cleaning standards was approved in March 2025, demonstrating a commitment to high standards of cleanliness and infection prevention and control.

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

Table 2 Summary of Key Performance Indicator comparable data

Supporting Standards	2023-24	2024-25	Current Period	Comparison
Staffing Fill Rate Registered Nurse	98.4	100.9	% - Cumulative to end Mar 2025	Improved
Staffing Fill Rate Health Care Assistant	101.0	102.2	% - Cumulative to end Mar 2025	Improved
Staffing Fill Rate Registered Midwife	92.4	94.7	% - Cumulative to end Mar 2025	Improved
Staffing Fill Rate Maternity Support Worker	91.9	90.0	% - Cumulative to end Mar 2025	Maintained
Complaints per 1000 bed days	1.3	1.2	Rate - Cumulative to end Mar 2025	Improved
STAR Accreditation all trust (Silver and Above)	92	83	% - Cumulative to end Mar 2025	Deteriorated
Pressure Ulcers per 1000 bed days (Category 2 and above)	2.9	2.6	Rate - Cumulative to end Mar 2025	Improved
MRSA	0	0	Cumulative to end Mar 2025	Maintained
C.difficile Infections	203	192	Cumulative to end Mar 2025	Improved
Maintain compliance with 10 Clinical Negligence Scheme for Trusts Safety actions	100	100	% - Cumulative to end Mar 2025	Maintained

Perinatal - Number of Stillbirths	11.0	11.0	Cumulative to end Mar 2025	Maintained
Hospital Standardised Mortality Ratio (56 Basket – Adult)	76.2	75.9	Dec 23- Nov 24 compared to Dec 22 - Nov 23	Within the expected range
Standardised Mortality Rate (All Diagnoses – Adult)	77.4	74.6	Dec 23- Nov 24 compared to Dec 22 - Nov 23	Within the expected range
Standardised Mortality Rate (Child <1 day -17 Years) (All Diagnoses)	59.2	89.9	Dec 23- Nov 24 compared to Dec 22 - Nov 23	Within the expected range
Standardised Mortality Rate (Neonatal <1 day -28 days) (All Diagnoses)	70.3	93.5	Dec 23- Nov 24 compared to Dec 22 - Nov 23	Within the expected range
Compliance with 60 minute ambulance turnaround time target - actual	2025.0	3206.0	Cumulative to end Mar 2025	Deteriorated
Maximum wait of 12 hours as Total Time in Department	9.6	10.2	% - Cumulative to end Mar 2025	Deteriorated
Bed occupancy to 92%	97.3	94.8	% - Cumulative to end Mar 2025	Improved
Reduce not meeting criteria to reside to 5%	9.0	11.6	% - Cumulative to end Mar 2025	Deteriorated

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

2.3.4 Financial Sustainability

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

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

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

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

2.3.5 Operational Performance

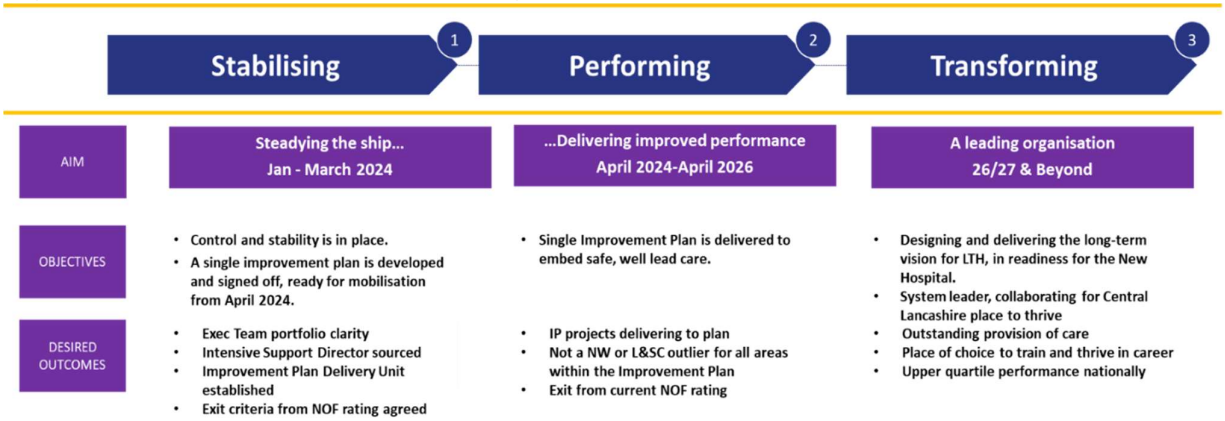
The Operational Performance programme focused on improving service delivery and patient outcomes. Key achievements include:

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

2.3.6 Forward plan for 2025-26

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

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



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

2.4 Continuous Improvement

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

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

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

The Trust has participated in a number of national improvement programmes including the HandsFirst2 improvement collaborative, the Acute Thrombolysis in Stroke Care (TASC) collaborative which led to improvements in thrombolysis rates and the NHS England Race & Health Observatory (RHO) Collaborative which led to a reduction in post-partum haemorrhage rates among black and ethnic minority women and birthing people.

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

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

2.5 Always Safety First (ASF)

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

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

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

  with evaluation demonstrating positive safety outcomes and reinforcing the value of this training.
- To further strengthen safety culture and leadership visibility, Leadership Patient Safety Visits were introduced. These monthly visits, based on Safety I (learning from what goes wrong) and Safety II (learning from what goes well) principles, are conducted by senior nursing, midwifery, allied health profession (AHP), and clinical governance leadership teams. The themes of the visits are informed by insight and intelligence from the ASF programme, and learning is triangulated from both areas requiring improvement and those demonstrating good practice.
- The Trust also began developing its approach to Safety II, with a dedicated working group led by Continuous Improvement clinical fellows. This work aims to complement traditional safety approaches by learning from what goes well in everyday practice.
- Patient involvement in safety governance was further enhanced through the recruitment of three Patient Safety Partners (PSPs), who commenced in post in November 2023. Their early contributions have been positive, and their role will be formally evaluated in terms of outcome measures. Recruitment of additional patient safety volunteers is also underway to support this work.
- The Trust also introduced Martha's Rule (Call for Concern), empowering patients and families to escalate concerns about care.
- The Trust also launched its Learning Disability Plan, supported by the rollout of mandatory Oliver McGowan Level 1 training for all staff, further strengthening inclusive and person-centred care.
- In maternity and neonatal services, a Maternity Neonatal Voices Partnership Lead was appointed in 2023 to ensure that the voices of women and families are heard and embedded in service design and delivery. The Trust also successfully delivered all ten Year 5 Clinical Negligence Scheme for Trusts (CNST) safety actions, demonstrating continued compliance with national safety standards.

- In 2024, the Trust welcomed a site visit from its Magnet twin partner, Hackensack University Medical Centre in the United States. The learning from this visit has influenced a range of projects, including the development of the trust's Proud Rewards and the concept of Shared Decision-Making Councils, which are currently being developed.
- The ASF programme also supported themed analysis to identify improvement priorities for Year 3. These include deteriorating patients, reducing violence and aggression, Emergency Department (ED) exit block and patient flow, rapid tranquilisation, mental health safety, C. difficile infection reduction, and pressure ulcer reduction.
- To support real-time safety monitoring, the ED safety surveillance system was completed, rolled out, and embedded. Safety surveillance systems are now in place across all adult inpatient acute and general wards, enabling the identification of organisational safety risks as they emerge. The Trust also launched a Deteriorating Patient Dashboard, enabling the Critical Care Outreach Team to proactively review patients at risk of deterioration.
- Additionally, a Critical Care Delivery Group was established to improve outcomes for patients in critical and enhanced care environments, with a focus on achieving compliance with perioperative care standards.
- The impact of these efforts is evident in medicines safety, where the Trust recorded a low rate of harm, just 4% of incidents involving medicines, compared to the national benchmark of 12% reported in the Model Hospital. Medicines safety metrics have also been incorporated into the SIP to ensure continued oversight.
- Venous thromboembolism (VTE) risk assessment compliance improved and was sustained above 90% throughout the year. A recent dip in performance was attributed to the inclusion of community healthcare hub data, which is being addressed.
- Focused work on falls and pressure ulcers has led to a reduction in incidents over the course of the strategy, although further progress is needed to meet target reductions.
- The National Staff Survey showed an improvement in safety scores, reflecting the positive impact of the Trust's safety culture initiatives.

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

2.6 Risk Management

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

2.6.1 Risk Management and Risk Maturity

The Trust's risk management arrangements are underpinned by a clear governance structure and a commitment to transparency and accountability. The Board Assurance Framework (BAF) and Risk

Register have been regularly scrutinised through internal and external reviews and are embedded within the Trust's governance processes.

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

2.6.2 Risk Management Strategy

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

- Implementation of the Risk Management Group, which commenced in March 2024. The Group supported enriched discussion regarding risk management, risk themes and trends and has become the conduit for wider discussion regarding risk escalation and collaborative response.
- Risk Management training rolled out in the form of workshops. Positive feedback received from those attending the sessions.
- Risk Management reports to Risk Management Group, Committees of the Board and Board have been re-designed. Improved reporting has allowed for clearer, more focused discussion on risk at the relevant meetings, enabling oversight of risk progress more easily and improved understanding of the Trust Risk Profile against Strategy.
- Reduction in long standing risks (risks active for 5 years or more) has been reduced by 49, which exceeded the strategy target of 15% (circa 13).
- Reduction of operational high scoring risks by 21 high risks, which exceeded the Year 1 goal by 6.
- Completion of an Annual Risk Maturity Assessment across all Divisions in the Trust. The Assessment saw improvements in the measured characteristics across the Trust, although there was variation across individual Divisions and Corporate Departments. Action plans to improve maturity are in progress.

2.6.3 Risk Management Policy & Board Assurance Framework (BAF)

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

The Risk Management Group oversees Risk Management arrangements within the Trust, and this is chaired by the Chief Executive. The group has a cycle of business, and this includes consideration of

Divisional / Departmental reports on a cyclical basis to allow oversight, monitoring and escalation of risk areas. The Risk Management Group is able to escalate operational risks of concern to the appropriate Committee of the Board for further consideration when required and the Committee in turn is able to choose to escalate an operational risk of concern to the Board of Directors for oversight.

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

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

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

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

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

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

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

2.6.4 Risk Appetite

The Trust's Risk Appetite Statement and tolerance levels were reviewed and discussed at a workshop

with the Board of Directors in May 2024, and approved at the Board of Directors in June 2024, with no changes from the previous year.

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

The Risk Appetite Statement outlines the level of risk that the Trust is prepared to accept, after balancing the potential opportunities and threats a situation presents. The risk tolerance levels outline the boundaries within which the Board is willing to allow the true day-to-day risk profile of the Trust to fluctuate while executing strategic objectives.

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

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

Providing safe and effective care for patients is paramount and so we have a low tolerance of risks which would adversely affect the quality and safety of clinical care. However, to **Consistently Provide Excellent Care**, we recognise that, in pursuit of this overriding objective, we may need to take other types of risk which impact on different organisational aims. Overall, our risk appetite in relation to consistently providing excellent care is cautious – we prefer safe delivery options with a low degree of residual risk, and we work to regulatory standards. We have an open appetite for those risks which we need to take in pursuit of our commitment to create a **Great Place to Work.** By being open to risk, we mean that we are willing to consider all potential delivery options which provide an acceptable level of reward to our organisation, its staff and those who it serves. We tolerate some risk in relation to this aim when making changes intended to benefit patients and services. However, in recognising the need for a strong and committed workforce this tolerance does not extend to risks which compromise the safety of staff members or undermine our trust values. We also have an open appetite for risk in relation to our strategic ambition to **Deliver Value for Money** and our strategic aim to **offer a range of high-quality specialist services to patients in Lancashire and South Cumbria,** maintaining and strengthening our position as the leading tertiary care provider in the local system, where we can demonstrate quality improvements and economic benefits. However, we will not compromise patient safety whilst innovating in service delivery. We are also committed to work within our statutory financial duties, regulatory undertakings, and our own financial procedures which exist to ensure probity and economy in the trust's use of public funds. We seek to be **Fit for the Future** through our commitment to working with partner organisations in the local health and social care system to make current services sustainable and develop new ones. We also seek to lead in **driving health innovation through world class Education, Training & Research** by employing innovative approaches in the way we provide services. In pursuit of these aims, we will, where necessary, seek risk - meaning that we are eager to be

innovative and seek options offering higher rewards and benefits, recognising the inherent business risks.

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

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

2.6.5 Risk Tolerance

In addition, the Trust's risk tolerance levels were also updated to outline the boundaries within which the Board is willing to allow the true day-to-day risk profile of the Trust to fluctuate while executing strategic objectives.

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

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

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

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

2.6.6 Our principal risks and issues

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

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

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

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

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

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

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

Table 7 Strategic risk summary

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

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

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

Table 8 Principal Risks identified following the BAF review

Ref	Principal Risk	Exec Lead	5Ps	Reporting Committee	Risk Appetite	Risk Tolerance	Score at 31.03.25
PR1 (24/25)	Patient experience within the urgent and emergency care pathway	CNO	Patients	SQC	Cautious	1-6	15
PR2 (24/25)	Higher than trajectory rates of clostridioides difficile (C.*difficile*) Infection	CNO	Patients	SQC	Cautious	1-6	20
PR3 (24/25)	People experiencing Health inequalities	CNO	Patients	SQC	Cautious	1-6	12
PR4 (24/25)	Timely access to planned and cancer care	COO	Performance	FPC	Cautious	1-6	16
PR5 (24/25)	Timely access to urgent and emergency care	COO	Performance	FPC	Cautious	1-6	20
PR6 (24/25)	Reliance on temporary medical workforce	CMO	People	WFC	Open	4-8	16
PR7 (24/25)	Experience of under-represented staff groups	CPO	People	WFC	Open	4-8	12
PR8 (24/25)	Sub-optimal experience of Resident Doctors	CPO	People	ETR	Open	4-8	12
PR9 (24/25)	Failure to effectively manage staff absence and achieve Trust and National target rates	CPO	People	WFC	Open	4-8	12
PR10 (24/25)	Compliance with Core Skills Training & Appraisals	CPO	People	ETR	Open	4-8	12
PR11 (24/25)	Failure to meet the financial plan 2024-25	CFO	Productivity	FPC	Open	8-12	20
PR12 (24/25)	Cash consequences of the Trust's underlying financial position	CFO	Productivity	FPC	Open	8-12	12
PR13 (24/25)	Ability to access required Capital	CFO	Productivity	FPC	Open	8-12	16
PR14 (24/25)	Readiness for the New Hospital Programme	CFO	Partnership	NHP	Seek	8-12	4
PR15 (24/25)	Research capacity and capability to enable progress towards University Hospital status	DIRI & CMO	Partnership	ETR	Seek	8-12	12

Ref	Principal Risk	Exec Lead	5Ps	Reporting Committee	Risk Appetite	Risk Tolerance	Score at 31.03.25
PR16 (24/25)	Implementing the long term strategy for the Trust	DIRI & CMO	Partnership	FPC	Seek	8-12	12

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

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

2.6.7 Operational High Risks escalated to Board:

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

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

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

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

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

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

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

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

2.7 Statements of Assurance from the Board

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

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

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

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

2.8 Participation in Clinical Audits

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

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

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

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

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

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

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

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

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

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

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

Table 10 National Audits and Confidential Enquiries – Intended Actions

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

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

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

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

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

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

Table 11 Local Clinical Audits and Resulting Actions

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

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

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

2.9 Clinical Research 

2.9.1 Participation in Clinical Research

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

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

Key participation figures include:

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

2.9.2 Trust Achievements in Research

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

2.9.3 Research Governance

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

2.9.4 Workforce

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

2.9.5 Studies, Trials & Research

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

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

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

Additional highlights:

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

2.10 Registration with the Care Quality Commission

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

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

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

2.10.1 CQC Finney House

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

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

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

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

2.10.2 Trust Inspections 2024-25

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

2.10.3 Inspection 2023-24

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

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

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

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

Specific service ratings included:

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

Figure 4 CQC Trust wide rating

2.10.4 CQC Inspection Outcomes and Quality Improvement Plan

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

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

2.10.5 Recognition of Good Practice

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

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

with all relevant stakeholders.

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

2.11 Quality of Data 

2.11.1 Information Governance

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

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

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

2.11.2 Data Quality

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

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

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

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

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

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

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

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

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

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

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

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

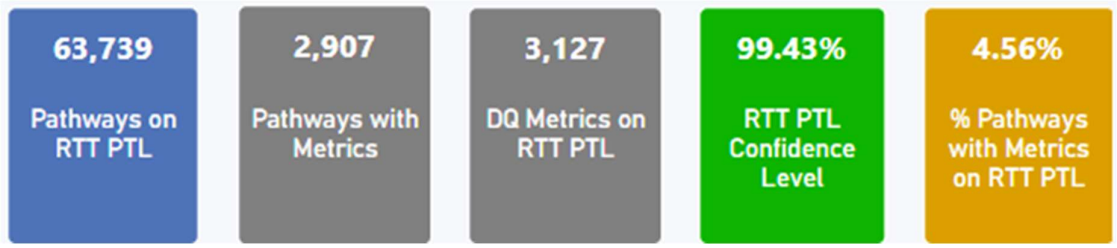
Table 12 NHS Digital Data Quality

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

Data source NHS Data Quality Maturity Index

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

Figure 5 National Waiting List Data



LUNA National Data Quality Solution

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

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

2.12 Information Governance

2.12.1 Confidentiality and Information Security

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

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

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

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

2.12.2 Data Security and Protection Toolkit (DSPT)

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

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

- Not Achieved
- Partially Achieved
- Achieved

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

2.12.3 Information Risk Management

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

Key components include:

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

2.12.4 Governance Structure

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

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

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

- Ensuring decisions are made in accordance with Trust policies

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

2.12.5 Information Governance Management Framework

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

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

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

2.13 Adult Mortality Reviews

2.13.1 Overview of Mortality Governance

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

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

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

2.13.2 Structured Judgement Reviews (SJRs)

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

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

Source: Trust Data Warehouse

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

Of the 21 PSIRF Learning Responses:

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

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

The number of deaths reviewed or investigated per quarter was:

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

Source: Trust Mortality Review Database & Datix

2.13.3 Deaths Due to Problems in Care

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

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

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

2.13.4 Learning from Structured Judgement Reviews

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

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

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

Positive Themes Identified (2024–25)

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

Areas for Improvement (2024–25)

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

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

2.14 Reporting Core Indicators 

2.14.1 Overview

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

2.14.2 Operational Pressures and System Challenges

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

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

2.14.3 System-Wide Transformation Initiatives

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

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

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

2.14.4 Performance Highlights and Areas for Improvement

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

Urgent and Emergency Care (UEC)

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

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

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

Elective

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

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

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

Diagnostics

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

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

In addition, the following key initiatives were also implemented:

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

Cancer Services

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

Key achievements include:

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

2.14.5 Summary of Performance against Core Indicators

Table 13 Core Standards 2024-25

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

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

2.14.6 NHS Digital Data availability

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Table 18 Patient Safety Incidents * most current data

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

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

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

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

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

2.15 Patient experience performance indicator

2.15.1 Adult Inpatient Survey 2023

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

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

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

Table 19 Adult inpatient survey Questions 47- 50

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

2.15.2 Commitment to Continuous Improvement

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

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

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

2.16 Staff experience performance indicator

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

One of the key questions in the survey asks staff:

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

This question serves as a meaningful measure of staff trust in the quality and safety of care delivered. At Lancashire Teaching Hospitals NHS Foundation Trust, the percentage of staff who agreed with this statement has declined over the past four years:

Table 20 Staff Recommendation as a Provider of Care

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

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

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

2.17 Freedom to Speak Up

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

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

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

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

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

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

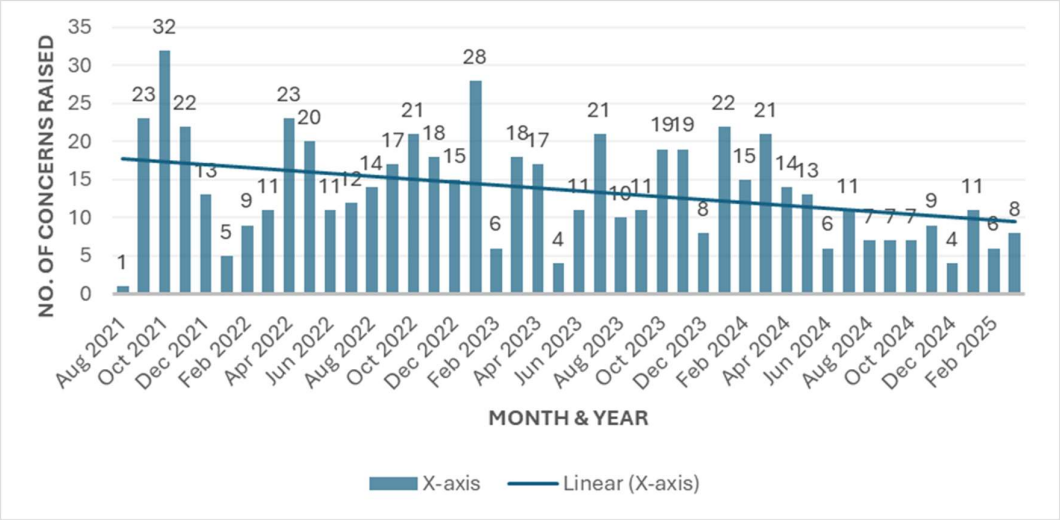
2.17.1 Service Delivery

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

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

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

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



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

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

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

- 58.5% of colleagues would feel safe to speak up about anything this concerns me in this organisation (reduced from 62.8% in 2023).

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

Table 21 FTSU Themes of Concerns

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

	Overall Concerns %	Last 12 months %	Change (+/-) *
(*Note – this was a new category added in 2024)			
Worker safety risk	12.3%	17.5%	+5.2%

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

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

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

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

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

- **Adverse Impact on Health and Well-being**: Reports of concerns related to health and well-being have decreased from 48.1% to 41.7% (-7.1%). This reduction suggests improvements in workplace conditions and support systems, although continued vigilance is necessary to maintain and further enhance staff well-being.
- **Bullying and Harassment:** There has been a mixed trend in bullying and harassment reports. Peer-related bullying and harassment have increased from 9.3% to 12.6% (+3.3%), indicating a need for stronger peer support and conflict resolution mechanisms. Conversely, manager-related bullying and harassment have significantly decreased from 12.3% to 5.8% (-6.5%), suggesting progress in managerial conduct and leadership training.
- **Discrimination:** Reports of discrimination have shown varied changes. Discrimination based on race has notably increased from 2.5% to 6.8% (+4.3%), highlighting need for targeted interventions and diversity training. Discrimination based on disability has also risen from 3.2% to 5.8% (+2.6%), while age and gender discrimination have seen smaller increases. These trends underscore the importance of fostering an inclusive and equitable workplace.
- **Communication and Leadership:** Concerns about poor communication have risen from 9.7% to 15.5% (+5.8%), and poor leadership reports have increased from 13.3% to 22.3% (+9%). These changes indicate a need for enhanced communication strategies and leadership development programs to ensure clear, effective, and supportive interactions across all levels of the organisation.
- **Professional and Safety Concerns:** Reports of professional concerns have increased from 20.3% to 26.2% (+5.9%), reflecting ongoing challenges in professional conduct and standards. Patient safety risk concerns have decreased from 22.3% to 16.5% (-5.8%), suggesting improvements in patient care practices, although continued focus on safety protocols is essential.
- **Unfair Treatment and Bias:** Reports of unfair treatment, bias, and breach of policy have risen from 28.2% to 36.8% (+8.6%). This significant increase calls for continued review of policies and practices to ensure fairness and equity in all aspects of employment.
- **Worker Safety:** Concerns about worker safety have increased from 12.3% to 17.5% (+5.2%), indicating a need for enhanced safety measures and support systems to protect staff from harm.
- **New Category - Unwanted Sexual Behaviours:** The introduction of this new category in 2024

has resulted in 5.8% of reports, highlighting the importance of addressing and preventing inappropriate and harmful sexual behaviours in the workplace.

2.17.2 Key Priorities

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

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

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

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

PART 3 - Review of Quality Performance

3.1 Review of Quality Performance - Patient Safety

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

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

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

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

Key areas of focus within the programme are as follows:

Table 22 Key areas of focus within the ASF programme

Patient Safety	Clinical Effectiveness	Patient Experience
• PSIRF • The Trust STAR programme. • Falls Prevention. • Safeguarding Adults. • Safeguarding Children. • Maternity Safeguarding and Safety. • Incident Management and Never Events. • Duty of Candour. • Becoming a Learning Organisation • VTE improvement work. • Safe Discharge improvement plan.	• The Getting it Right First Time (GIRFT) programme. • Tissue Viability – Pressure Ulcer Incidence and Prevention. • Nutrition for Effective Patient Care. • Medication Incident Monitoring. • Infection Prevention and Control. • C Difficile • Methicillin-resistant Staphylococcus Aureus (MRSA). • Influenza and SARS coronavirus-2 (SARS-CoV-2) – COVID-19. • Mortality Surveillance and Learning from Neonatal, Child and Adult Deaths • Medical Examiner Service.	• Complaints and Concerns & Compliments. • The Parliamentary Health Service Ombudsman (PHSO) • Friends and Family Test (FFT) & Care Opinion • National Survey Results

3.1.1 The Patient Safety Incident Response Framework (PSIRF)

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

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

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

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

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

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

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

Embedding Organisational Learning

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

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

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

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

Patient and Staff Engagement

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

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

Looking Ahead: Priorities for 2025–26

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

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

Planned areas of focus for the year ahead include:

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

3.1.2 Safety Triangulation Accreditation Review (STAR)

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

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

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

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

Figure 7 STAR Accreditation Trust-wide Compliance by Month

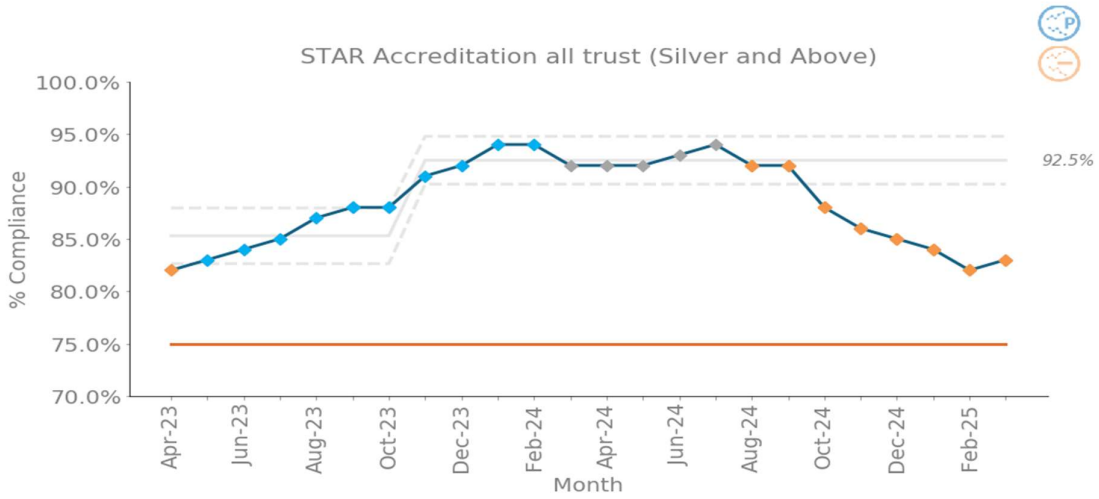
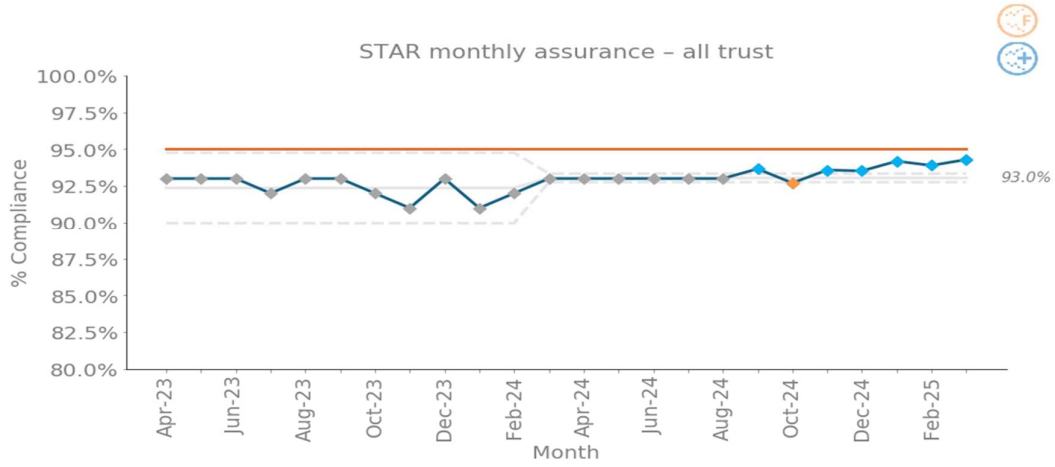


Figure 8 STAR Monthly Review Trust-wide Compliance by Month



3.1.3 Falls Prevention

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

Throughout this reporting period, the Trust has continued to utilise the Falls Prevention Big Room, employing continuous improvement methodologies developed through the Flow Coaching Academy. This initiative has been combined with the Deconditioning Prevention Big Room to drive team improvements.

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

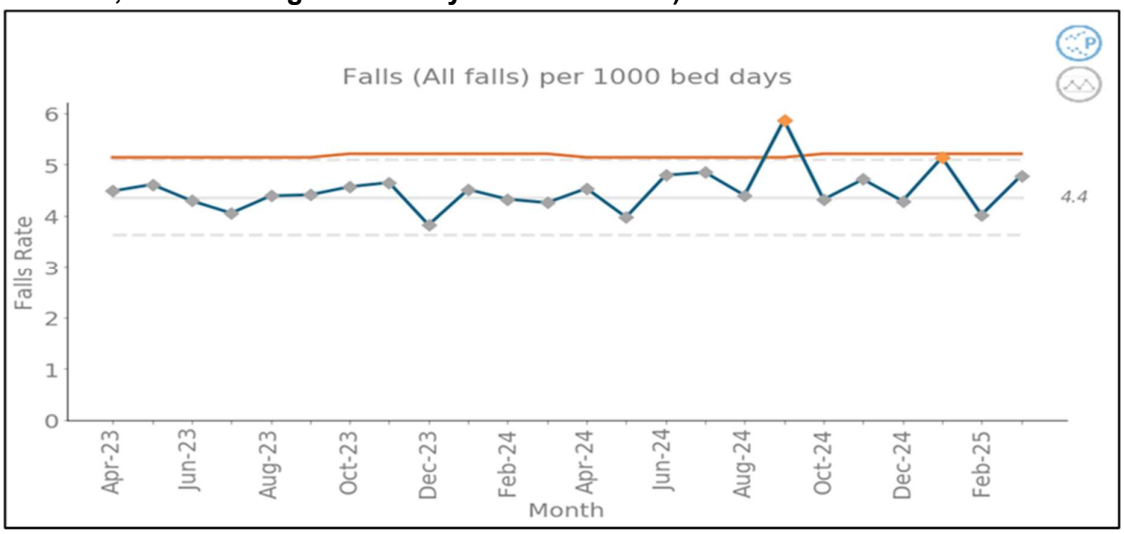
Figure 9 Falls Data 2024–25

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

While the total number of falls has increased, it is important to note that this occurred alongside a rise

in patient numbers and hospital occupancy. Therefore, the Trust uses falls per 1,000 bed days as a more accurate measure of performance. This metric provides a more stable and contextualised view of falls trends, as illustrated in Figure 10.

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



Source: LTHTR Datix data

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

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

These were reported as:

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

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

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

3.1.3.2 Falls Risk Management and Governance

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

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

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

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

3.1.4 Safeguarding (including Maternity, Children and Adults)

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

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

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

3.1.4.2 Safeguarding Activity

The Safeguarding team hold a duty function to ensure a responsive all age service, with referrals of enquires into the team from Lancashire Teaching Hospitals NHS Foundation Trust, multi-agency partners, patients, families and carers. The diverse nature of the Safeguarding Team at the Trust encourages multi-professional and multi-agency working both within and outside of the Trust, and complex cases are worked between a number of colleagues including Safeguarding Leads/Practitioners, Domestic Violence Advisors, The Trust Mental Health, Learning Disability or High

Intensity User (HIU) Practitioner, Police, North West Ambulance Service (NWAS), Social Care and commissioned mental health services.

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

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

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

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

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

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

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

3.1.4.3 Externally commissioned services

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

Table 23 Safeguarding Teams externally funded specialist roles

ED Navigator • Funded by: Violence Reduction Network	• From April 2024 to March 2025, the ED Navigator received 233 referrals. Each referral is reviewed to ensure it meets criteria, followed by direct patient contact to offer support.

• Commissioned until: 31 March 2026	• The ED Navigator has established and chairs the Lancashire ED Navigator Forum, which now includes services from Leeds, Huddersfield, Sheffield, and Rochdale, reflecting the growing regional interest in this model. • Two face-to-face conferences were organised using VRN funding, both of which were well-attended and received positive feedback.
Health Independent Sexual Violence Advisor (HISVA) • Funded by: Office of the Police and Crime Commissioner • Commissioned until: 31 March 2027	• Since starting in November 2023, the HISVA has received 135 referrals (April 2024 – March 2025), supporting patients aged 16+ following disclosures of current or historical sexual abuse. • The HISVA also supports Trust staff, contributing significantly to the Sexual Safety in the Workplace Charter. This has encouraged more staff to report inappropriate sexualised behaviour, which is addressed through the managing allegations process, promoting a safer and more respectful workplace culture.
Health Independent Domestic Violence Advisor (HIDVA) • Funded by: Office of the Police and Crime Commissioner • Commissioned until: 31 March 2026	• In the same reporting period, the HIDVA received 354 referrals, with a significant number involving Trust staff. Referrals often come from line managers, Occupational Health, or direct contact. • The HIDVA frequently provides long-term support, particularly for staff who view the workplace as a safe space.

3.1.4.4 Maternity Safeguarding Activity

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

3.1.4.4.1 Key Activities and Achievements

- The ESMT supported a Trust-wide awareness campaign, collaborating with the Reproductive Trauma Service (RTS) to promote understanding and access to maternal mental health support.
- The team also delivered two full days of safeguarding simulation training to third-year midwifery students at the UCLan. These sessions included a simulated postnatal home visit in forensic houses, designed to reflect real-life safeguarding concerns such as drug misuse, domestic abuse, mental health issues, neglect, unsafe sleeping environments, ICON (coping with crying babies), and unsafe home conditions.
- The Named Midwife for Safeguarding chairs the ICON Subgroup. In collaboration with the Blackburn with Darwen, Blackpool, and Lancashire Child Death Overview Panel (CDOP), the

subgroup launched a digital media campaign titled “Hush Little Baby.” This campaign, delivered through ICON and Bauer Media, targeted adults across Lancashire and ran for six weeks starting on 12 August 2024, coinciding with ICON Week (23–27 September 2024).

- In partnership with NHS Charities, the ESMT successfully secured funding for a fixed-term contract to recruit two Young Person’s Midwives (supporting individuals aged 19 and under) and a Maternity Support Worker. These roles are expected to enhance continuity of care for young parents.
- The Named Nurse for Safeguarding Children and the Named Midwife are active members of the Safer Sleep Subgroup. During Safer Sleep Week 2025 (10–16 March), which is part of the Lullaby Trust’s national awareness campaign, the subgroup led a Pan-Lancashire initiative to promote safer sleep practices. This included professional and public engagement, as well as the launch of a new Professionals Toolkit and an eLearning package developed with support from the Trusts Blended Learning Team.
- The ESMT has received positive feedback from staff regarding the training delivered in collaboration with the corporate team during monthly Public Health Study Days. These sessions included contributions from colleagues in Learning Disability and Autism services and the HIDVA and were informed by learning from Child Safeguarding Practice Reviews (CSPR) and Domestic Homicide Reviews (DHR). Future training will also cover the MCA and Deprivation of Liberty Safeguards (DoLS).
- Families have also shared positive feedback about the care they received from the ESMT. One particularly touching message was shared by the CDOP Chair, who relayed feedback from a family following the birth of twins. The family praised the Trust’s safer sleep and ICON messaging, noting that staff were diligent in ensuring accurate advice was given. They also described the staff on the Neonatal Intensive Care Unit (NICU) as “superheroes,” highlighting the compassionate and knowledgeable care provided.

3.1.4.5 Children and Young People

3.1.4.5.1 Summary of Safeguarding Activities

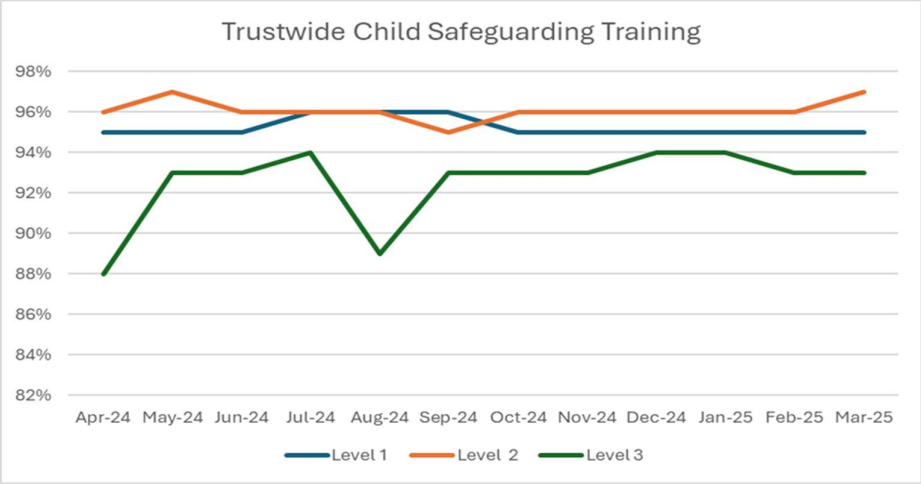
- Over the past 12 months, there have been many changes and improvements in relation to multi-agency working and collaboration. This is particularly evident in relation to close working and sharing of information and guidance with other acute Trusts as well as the ICB, Social Care and LSCFT. Relationship meetings with the Multi-Agency Safeguarding Hub (MASH), Duty and Assessment Team have assisted in sharing learning and discussion of challenging areas and cases. Close working with other acute Trusts and LSCFT has resulted in the production of a Neglect Tool which will be launched this year.
- Over the year, there has been increased joint working with the Sexual Assault Forensic Examination Centre (SAFE) Centre and attendance at Strategy Meetings for children where sexual abuse may have occurred. This has been vital for strengthening the links between SAFE Centre, Safeguarding and Paediatrics for the benefit of our children and young people and for enhancing the mutual support and knowledge of colleagues. Highlighting and working to improve our response to children at risk of sexual harm has been a large part of our work over the past year and this will continue.
- Safeguarding supervision has continued to be embedded across paediatric areas with a focus on social care referrals and thresholds, but with a focus upon case specific supervision.

- The Child Death Policy was updated this year. The primary updates related to the role of the Medical Examiner within neonatal and child deaths. Due to changes in process with neonatal deaths under 28 weeks old, a CDOP Failsafe Meeting has been developed which has improved links and information- sharing between Safeguarding, ESMT, Governance and the Bereavement Team. A process has been embedded to review the National Child Mortality Database (NCMD) thematic reports within the Mortality Meetings.
- There has been on-going work with Gynaecology, Safeguarding and the ESMT over this year. Work has been completed and the Paediatric-Gynaecology SOP updated as has the 'Was Not Brought (WNB)/Did Not Attend (DNA)' flowchart for termination of pregnancy. The Termination of Pregnancy proforma for Children and Young people has also been updated.
- The WNB Policy has been updated. Changes have included a section for dentistry, updates regarding the safeguarding process and trauma-informed practice and reasonable adjustments.
- There has been positive work in relation to Initial Health Assessments (IHAs) with our Child in Care Nurse at LTH and Doctors in developing ways to mitigate missed appointments and was not brought with a range of proactive strategies to encourage attendance. ICB Initial Health Assessment (IHA) Audit was completed with the Children in Care Nurse at the Trust to identify quality of data collected and advice given in IHAs. Initial feedback received and actions are now in place. Work will continue over the following year.
- The escalation pathway in regard to Children's Social Care has been successfully utilised over the past year, with three formal escalations in the past few months which have been resolved at Level one.
- The Safeguarding team have continued to support and be heavily involved in children and young people with complex social and health needs including where there are concerns in relation to fabricated and induced illness/perplexing presentations, medical neglect and our children in care where there may have been placement breakdown. The Children's Safeguarding Team have been commended for their proactive approach with complex children in care in our area and facilitating MDT, where there is high chance of ED attendance and complex support needs.

3.1.4.5.2 Child Safeguarding Training

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

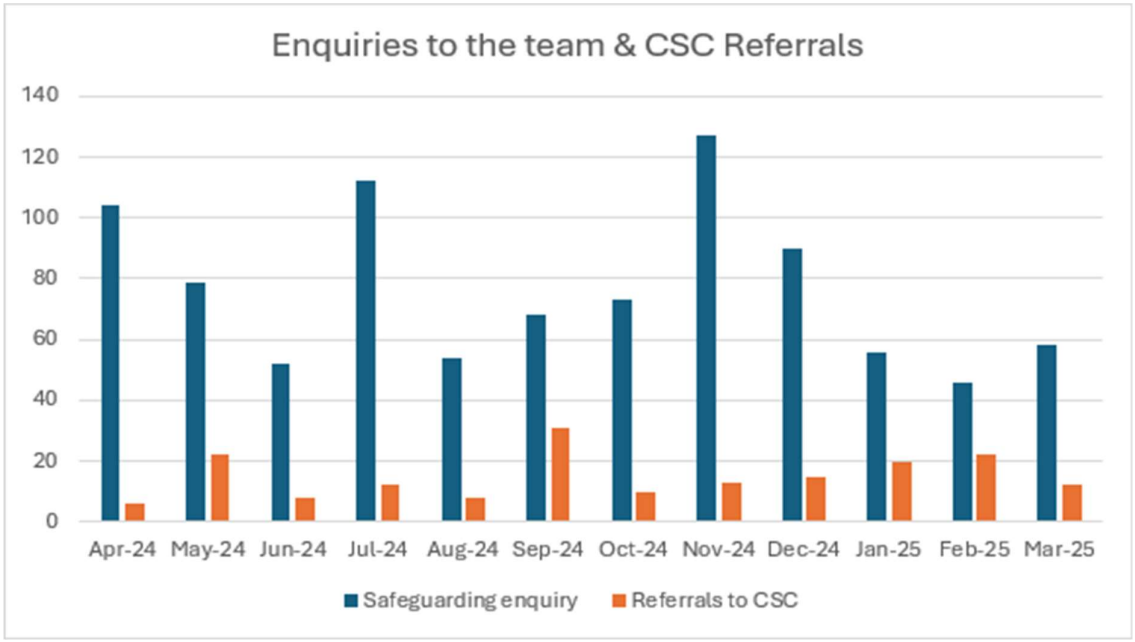
Figure 11 Child Safeguarding Training Mandatory Compliance



Source: LTHTR Datix data

3.1.4.5.3 Social care referrals

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



Source: LTHTR Datix data

3.1.4.5.4 Children's Social Care Referrals

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

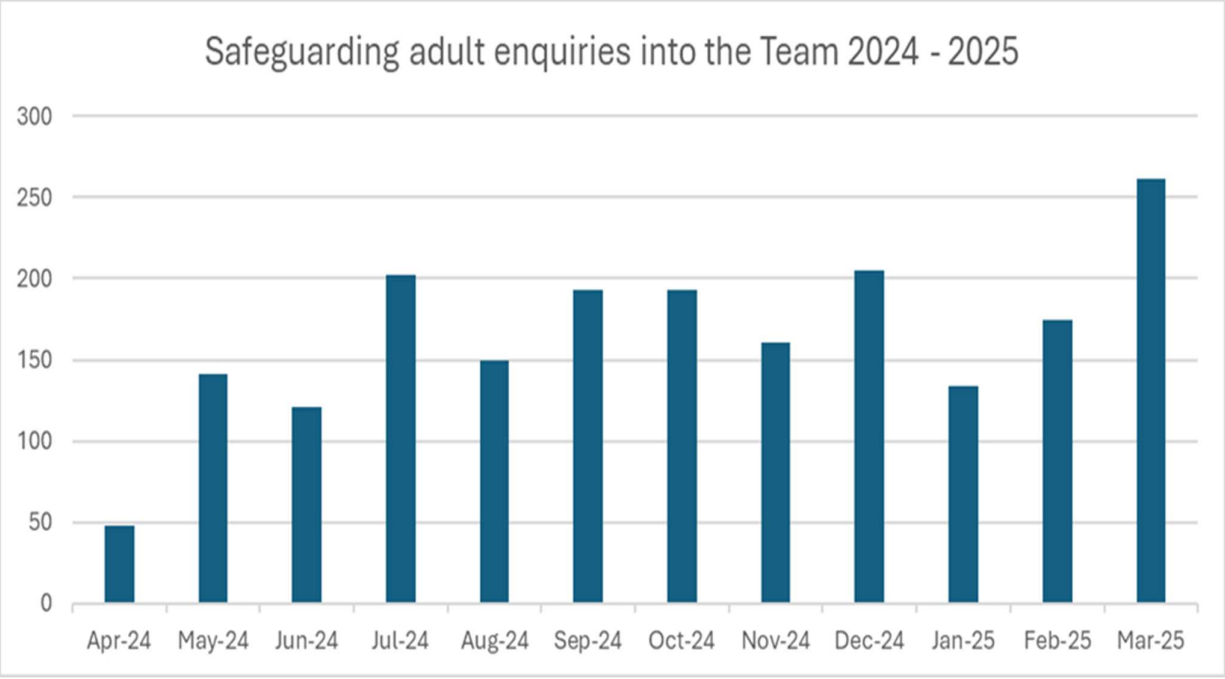
3.1.4.5.5 Child Deaths

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

3.1.4.6 Safeguarding Adult Activity

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

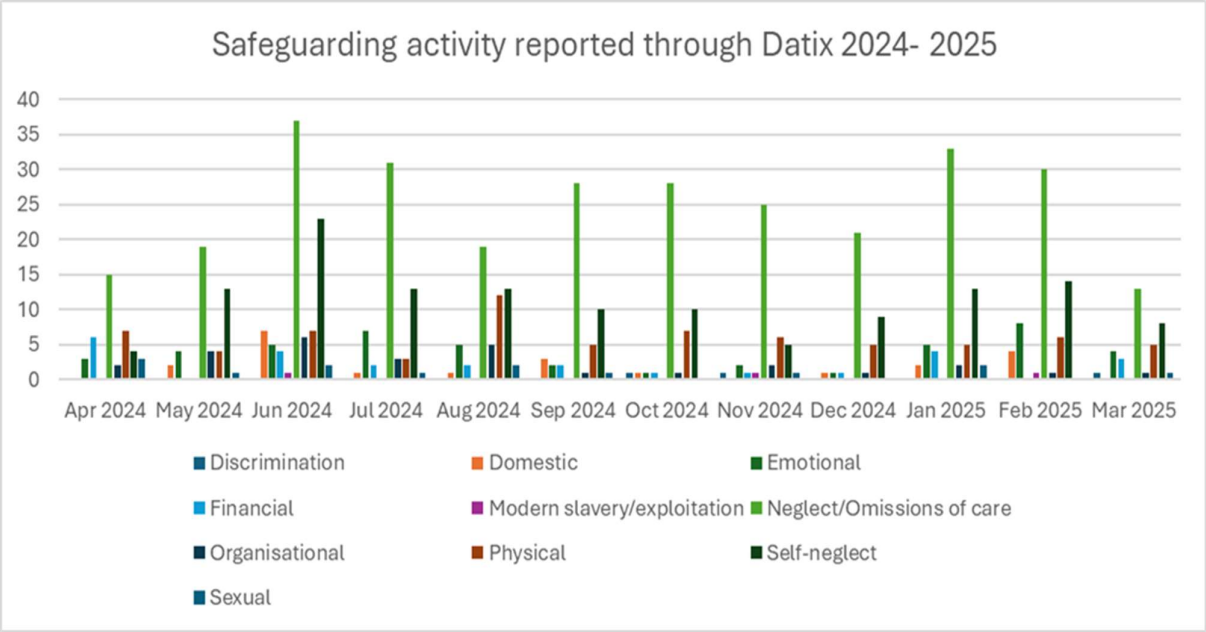
Figure 13 Safeguarding Adult enquiries



Source: LTHTR Datix data

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

Figure 14 Safeguarding activity reported through Datix



Source: LTHTR Datix data

3.1.4.6.1 Section 42 enquiries

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

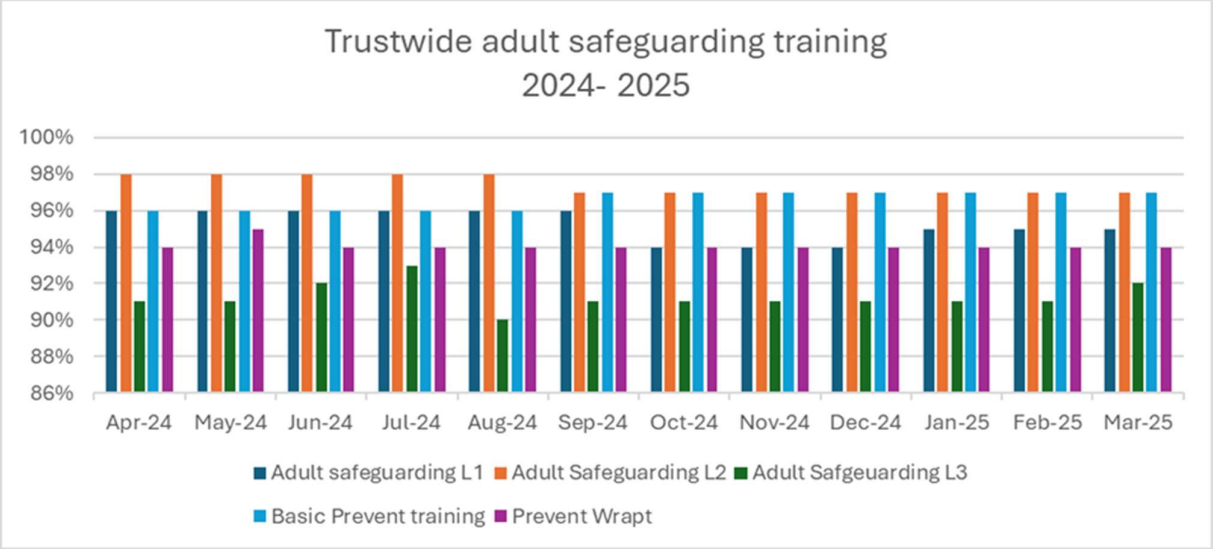
The Trust has a robust process that is followed upon receipt of a Section 42 notification from the Local Authority. The Adult Safeguarding Practitioners instigate an internal investigation and act as the link between the Trust and the Local Authority. While the majority of enquiries are responded to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

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

3.1.4.6.2 Adult safeguarding training & PREVENT

Figure 15 below shows the figures for safeguarding adults and PREVENT training compliance over the previous 12 months. The training matrix identifies colleague training requirements in accordance with the intercollegiate document. As seen below, training is consistently over 90% compliance in all areas. Training figures are reported by each division in the monthly safeguarding meetings and feed into the Safeguarding Board. Any drops in compliance are discussed at Divisional Safeguarding meetings and action plans formed after identifying areas of concern. The PREVENT training compliance has consistently been above 90% throughout the year. The Trust submits PREVENT data around training, referrals, and attendance at meetings with multi-agency partners, this information is submitted quarterly to NHS Digital and feeds into national data sets. The Trust has submitted three referrals to PREVENT in the previous twelve months.

Figure 15 Adult safeguarding and PREVENT training



Source: LTHTR Datix data

3.1.4.6.3 Managing Allegations Persons in Position of Trust (PiPoT)

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

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

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

To support this, the Safeguarding Team conducts a monthly audit of managing allegations cases recorded in the Datix system. The audit focuses on monitoring compliance with documentation

standards, particularly the timely uploading and updating of relevant records. This process was introduced following MIAA's identification of documentation gaps within Datix.

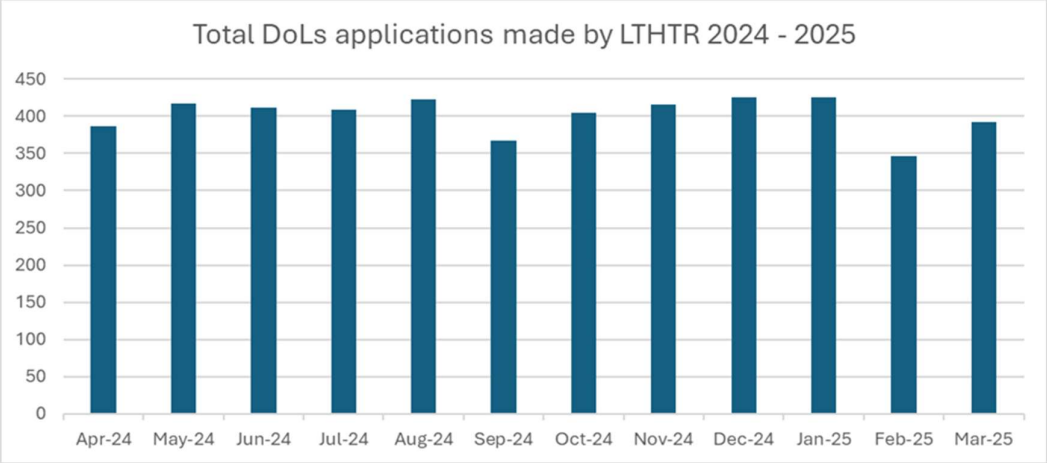
The audit findings have shown month-on-month improvements in compliance, reflecting the effectiveness of the revised processes. As a result, the audit will now move to a bi-annual schedule.

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

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

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

Figure 16 Total DoLS applications 2024-25



Source: LTHTR Datix data

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

3.1.4.6.5 Safeguarding Supervision

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

3.1.4.6.6 Mental Health, Learning Disabilities, Autism and Dementia

The Mental Health, Learning Disability, Autism, and Dementia Team continues to play a vital role in supporting some of the most vulnerable patients accessing care within the Trust. Embedded within the Safeguarding Team, the service is responsible for driving continuous improvement, enhancing

staff knowledge and skills, ensuring compliance with statutory frameworks including the Mental Health Act, MCA and Children's Act and promoting a positive patient experience.

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

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

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

Broader initiatives have also included:

- **Hospital Passports:** Developed in collaboration with autistic community groups and the Autism Partnership Board, these passports focus on sensory needs, communication preferences, and reasonable adjustments.
- **SEND Improvement Group:** A monthly forum with divisional representation continues to respond to findings from the SEND CQC and Ofsted inspection.
- **Collaboration with Martha's Rule:** The team works closely with the lead for the Trust's "Call for Concern" initiative, attending the Learning Disability and Autism Partnership Boards to improve communication and physical health assessments.
- **Training Compliance and Future Planning:** Trust-wide compliance with Learning Disability and Neurodiversity e-learning stands at 98%. A training needs analysis is underway, and the team is actively engaged with ICB and NHSE to implement the Oliver McGowan training in the coming year.

- **Autism Plan 2024:** Launched as part of the Safeguarding SIP, the plan outlines a comprehensive approach to improving care for autistic individuals.
- **Audit and Reporting:** Audits have been conducted on the completion of the Trust's Mental Health Risk Tool and mandated e-learning, with findings reported to the Safeguarding Board.
- **Reasonable Adjustment Needs Tool:** The team continues to develop this tool to ensure personalised care planning and accessibility for all patients requiring adjustments.

3.1.5 Incidents

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

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

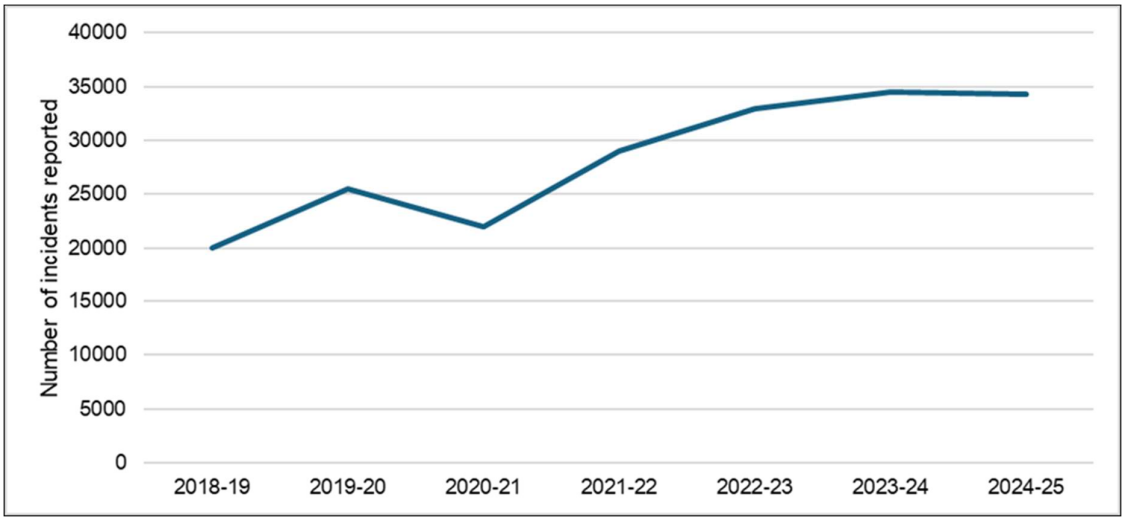
Table 24 Level of Harm Related to Incidents 2024-25

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

Source: LTHTR Datix data

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

Figure 17 Incidents Reported 2018-19 to 2024-25



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

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

3.1.6 Never Events

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

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

Table 25 Never events incidence April 2024 to March 2025

StEIS Ref	Datix ID	Incident Date	Division	Category	Level of Harm	Status
2024/4465	158281	25/04/2024	Surgery	Wrong site surgery – wrong side anaesthetic block	Low Harm	Investigation completed – action plan ongoing
2024/5035	161249	20/05/2024	Surgery	Wrong site surgery – wrong eye intravitreal injection	Low Harm	Investigation completed – action plan ongoing
2024/7201	169810	13/08/2024	Surgery	Wrong site surgery – wrong side anaesthetic block	Low Harm	Incident closed with complete action plan.

3.1.7 Duty of Candour

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

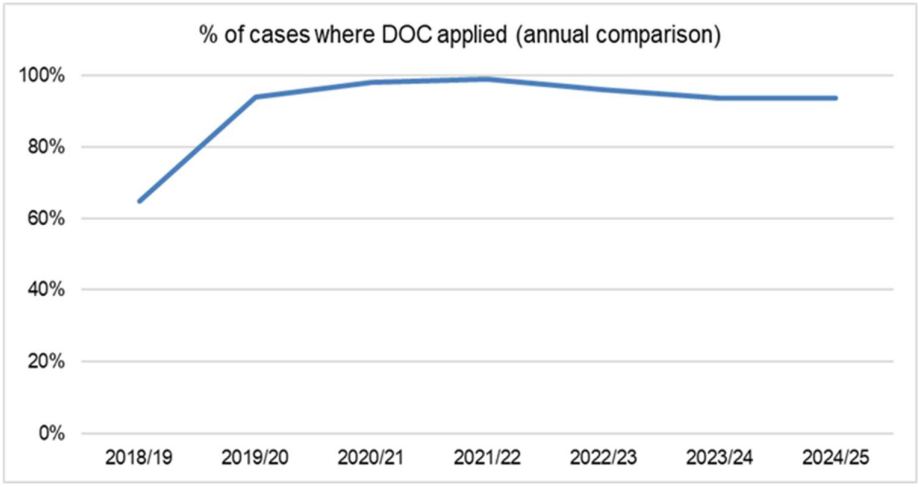
In 2024–25, the Trust identified 618 cases where Duty of Candour was applicable. This represents a 34% decrease compared to the previous financial year.

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

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

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

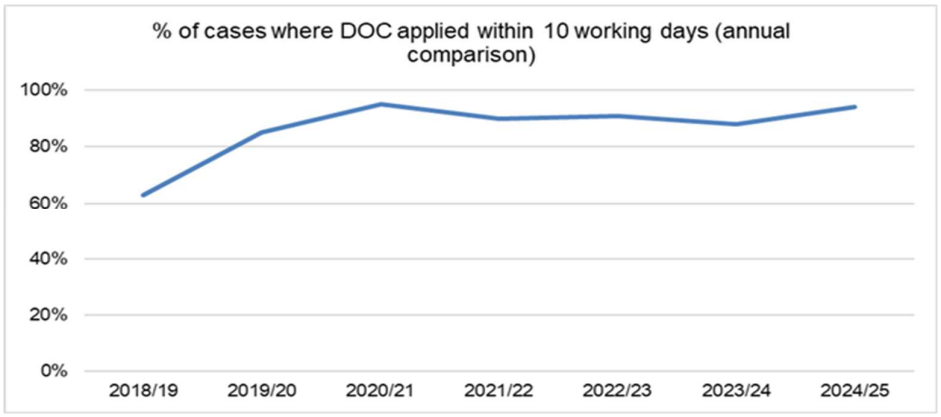
Figure 18 Percentage of Cases with Duty of Candour Applied (Annual Comparison)



Source: LTHTR Datix data

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

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



Source: LTHTR Datix data

Over the past year, the Trust has taken meaningful steps to strengthen its approach to Duty of Candour, particularly following the introduction of PSIRF in November 2023. A key development was the launch of a new Being Open Policy, which replaced the previous DoC policy. This updated policy aligns with PSIRF principles and outlines the Trust's approach to open communication, including in cases that do not meet the threshold for a notifiable safety incident. It also introduced the role of the Engagement Lead, who supports communication with patients and families during investigations.

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

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

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

3.2 Review of Quality Performance - Effective Care

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

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

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

3.2.1 Getting It Right First Time (GIRFT)

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

Table 26 Key GIRFT Activities in 2024–25

Non-Ambulatory Fragility Fracture (NAFF) Pathway	A dedicated task force, led by Dr. Kate Davies, has been established to enhance care under the NAFF pathway. The group is focused on analysing current practices, setting measurable targets, and monitoring progress to drive improvements in the management of fragility fractures. The task force also promotes knowledge sharing and cross-divisional collaboration to ensure a unified approach to patient care.

Anaesthesia and Perioperative Medicine (APOM) Review	A follow-up meeting for the Lancashire and South Cumbria ICS Clinical Gateway Review was held in November 2024. This session reviewed the APOM ICS data pack, with a focus on Day Case, Elective, and Non-Elective care. The review identified best practices, challenges, and recommendations for service improvement.
Children and Young Adults (CYA) Diabetes System Review	In December 2024, the Trust participated in the L&SC ICS GIRFT System Review for CYA Diabetes. This review focused on the transition of care for patients aged 0–18 years and 19–25 years, with an emphasis on improving continuity and outcomes during this critical period.
Establishment of GIRFT Steering Group	A GIRFT Steering Group has been formed to oversee the delivery of GIRFT initiatives across the Trust. The group ensures that each specialty aligns with GIRFT objectives and contributes to the Trust's Waste Reduction Plan (WRP). Clinical and managerial representatives from each division meet regularly to provide progress updates, review opportunities identified through the Model Health System and integrate these into divisional action plans.

3.2.2 Tissue Viability - Pressure Ulcer Incidence and Prevention

3.2.2.1 Pressure Ulcer Incidence

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

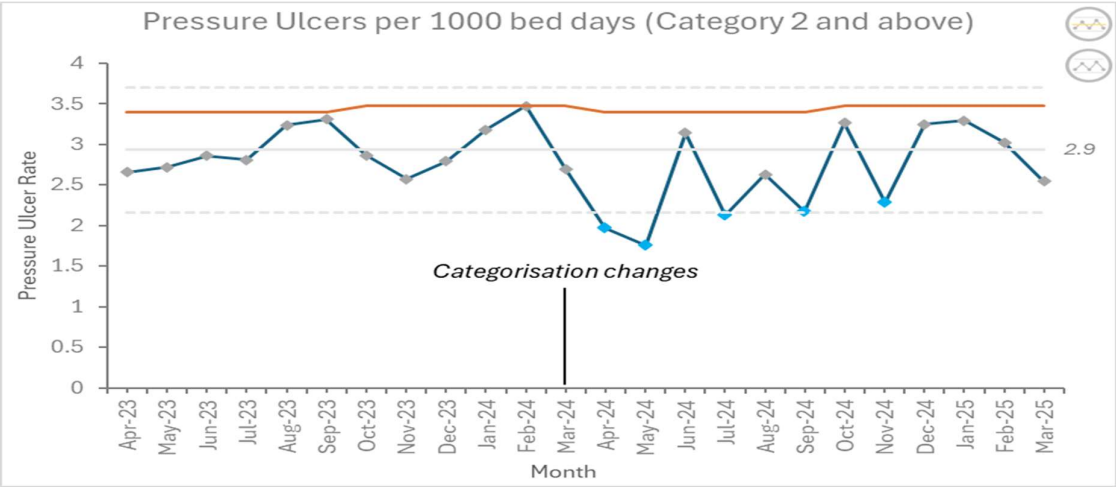
Since 2018, the Trust has seen a rise in pressure ulcer incidents. This increase is attributed to several complex factors, including:

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

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

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

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



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

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

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

3.2.2.2 Pressure Ulcer Improvement Plan

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

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

- **Education and Training**
  - Two new e-learning modules tailored to staff roles in risk assessment
  - Mandatory e-learning every two years
  - Pressure ulcer prevention training for healthcare assistants during induction
  - Revised preceptorship program to include all professional groups
  - Student SPOKE days and interprofessional learning (IPL) sessions with Tissue Viability Nurses (TVNs)
  - Quarterly wound care training for staff involved in assessment and care
  - Ward-specific training with TVN participation
- **Strengthened Governance**
  - Weekly divisional reviews of all Trust-acquired pressure ulcers
  - Monthly ASF meetings to share learning and identify trends
  - Enhanced review process aligned with PSIRF principles, addressing concerns raised by the TVN team

    - Patient involvement in incident reviews via the Datix system
- **Clinical Practice and Equipment**
    - Ongoing review of ED equipment and monthly staff training
    - Twice-yearly Tissue Viability link practitioner days
    - Pressure ulcer prevention champions program under review for improved learning methods
    - Use of wound photography to support timely reviews and reduce dressing changes
    - Monitoring and trailing of specialised equipment, including static seat cushions for amputee patients

3.2.3 Nutrition for Effective Patient Care

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

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

3.2.3.1 Nutritional Screening

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

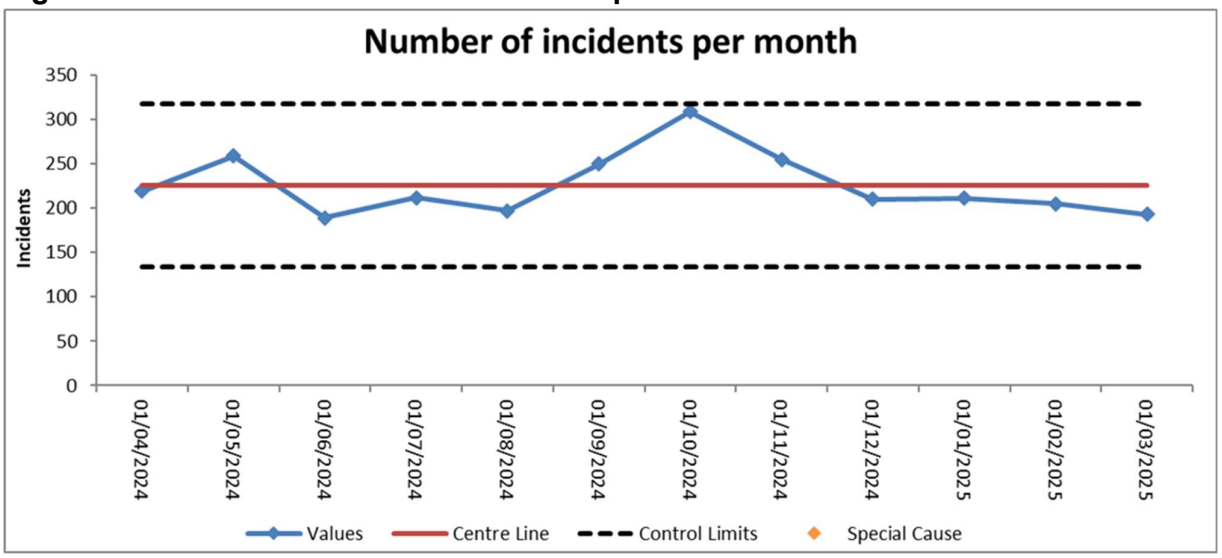
3.2.4 Medication and Incident Monitoring

3.2.4.1 Medicines Safety

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

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

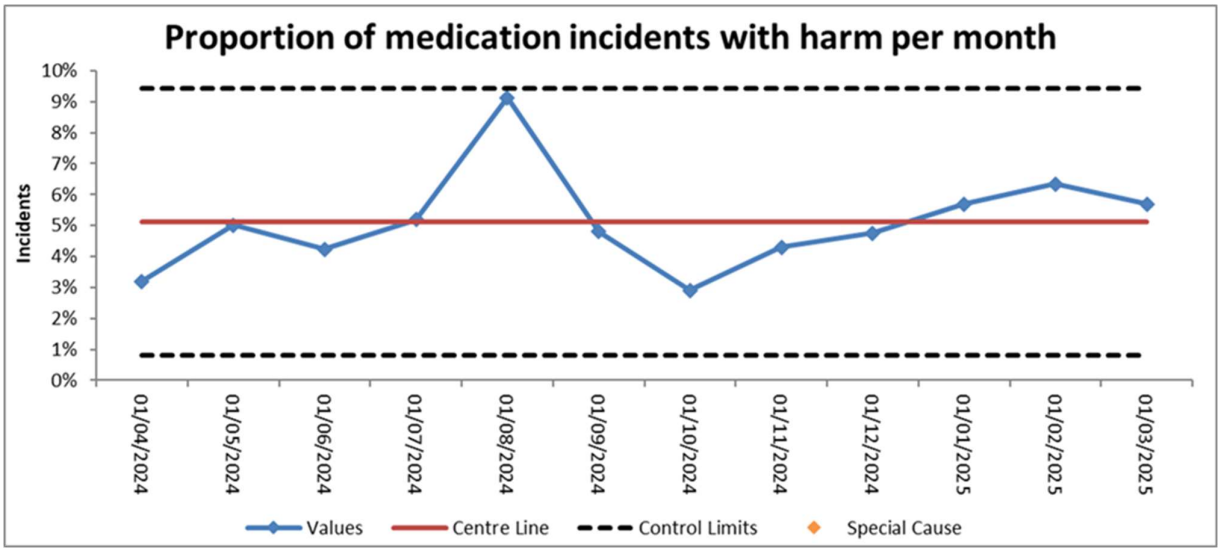
Figure 21 Number of medication incidents per month



Source: LTHTR data

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

Figure 22 Proportion of medication incident with harm per month



Source: LTHTR data

3.2.4.2 Medication Safety Governance and Proactive Monitoring

The Trust has implemented a robust system for the timely review of medication incidents in line with the PSIRF. This process is led by the Corporate Governance Team, supported by the Medication

Safety Team and Divisional Governance Leads, through weekly governance meetings. The approach prioritises early intervention, enabling the identification and dissemination of key learning and safety information prior to the conclusion of formal investigations, ensuring swift action and system-wide learning.

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

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

3.2.4.3 Medicines Reconciliation

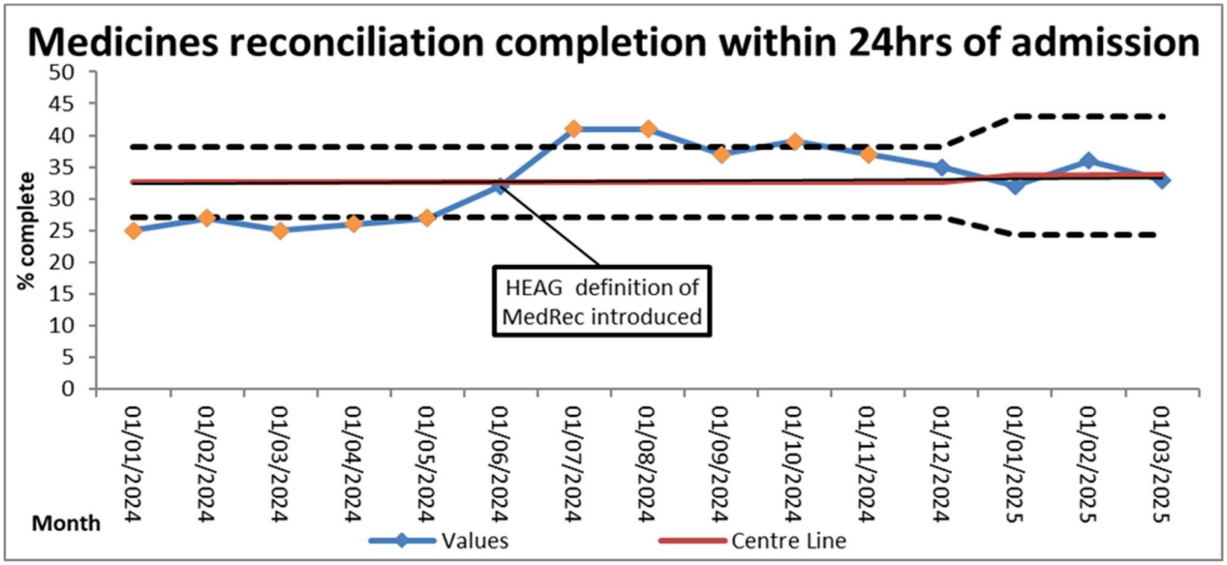
Medicines reconciliation is a critical safety process during hospital admissions, aimed at ensuring accurate and complete medication records. It involves the collection and verification of a patient's medication history, including any changes made during their hospital stay. National guidance from the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

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

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

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

Figure 23 Medicines Reconciliation (within 24 hrs)



Source: LTHTR data

3.2.4.4 Prescription Verification

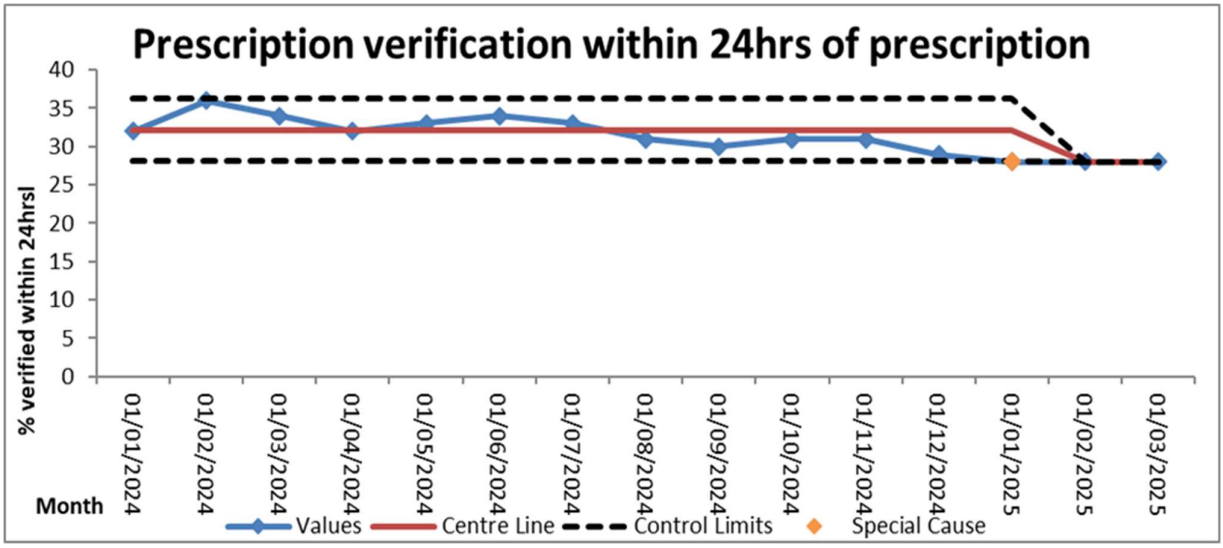
To ensure the safe and appropriate use of medicines, each prescription issued within the Trust is verified by a pharmacist. On average, 32% of prescriptions are verified within 24 hours of being written.

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

- Anticoagulants
- Insulin
- Antimicrobials
- Anti-epileptics

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

Figure 24 Prescription Verification



Source: LTHTR data

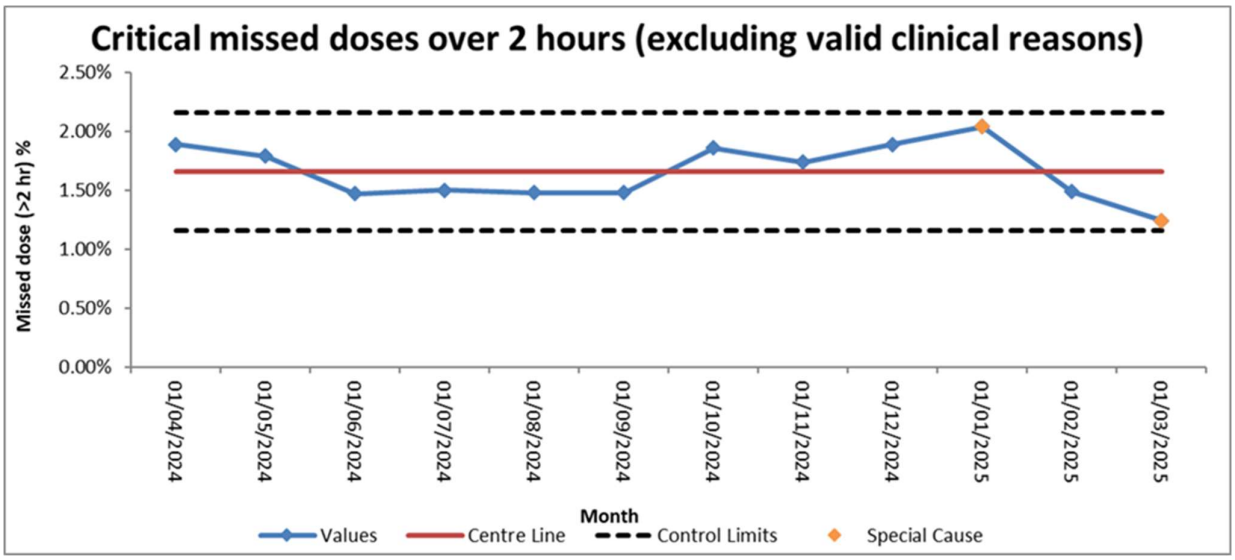
3.2.4.5 Medication Administration

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

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

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

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



Source: LTHTR data

3.2.4.6 Antimicrobial Stewardship

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

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

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

Table 27 Antimicrobial Stewardship Point Prevalence Audit Results

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

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

Source: LTHTR data

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

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

3.2.5 Infection Prevention and Control (IPC)

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

Key Achievements

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

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

Areas for Improvement

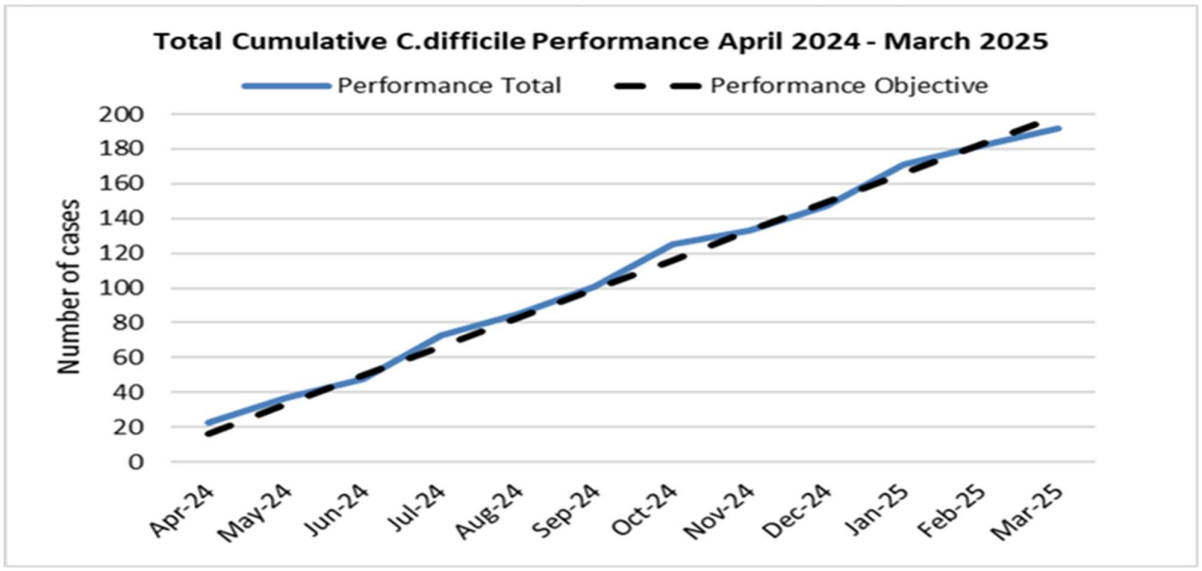
Despite these achievements, challenges persist. The Trust continues to report one of the highest rates

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

3.2.5.1 Clostridioides difficile *(C.difficile)*

Building on the Trust's broader IPC efforts, the management of *C.difficile* infection remained a key focus throughout 2024–25. The Trust reported 192 hospital-associated cases, successfully meeting the national objective of 199 cases, and achieving this target for the first time since 2018. This represents a 5% reduction from the previous year's total of 203 cases, despite the national threshold increasing from 121 to 199.

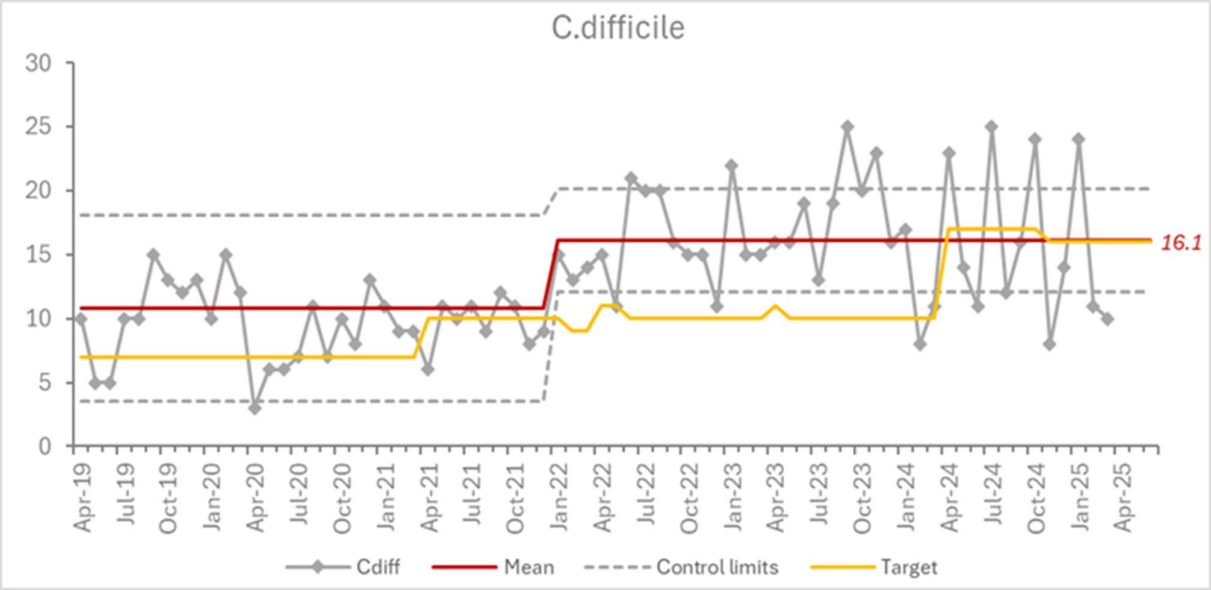
Figure 26 Performance of *C. difficile* cases against National Trajectory



Source: LTHTR data

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

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



Source: LTHTR data

The National and Regional picture

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

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

C. difficile annual tables: cases & rates by Trust

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

Key Developments in 2024–25

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

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

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

Significant challenges and opportunities for 2025-26

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

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

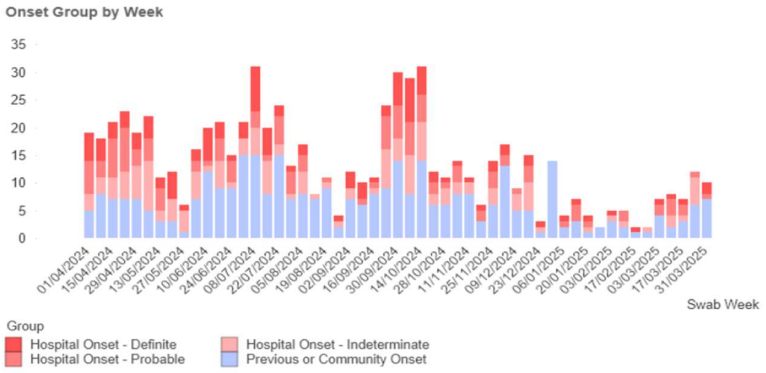
However, the full implementation of the National Standards of Healthcare Cleanliness is expected to enhance cleaning frequency and reduce environmental contamination. Ongoing monitoring will be essential to evaluate its impact and guide further improvements.

3.2.5.2 Infection Prevention and Control Performance against other organisms of concern

Table 29 Trust performance related to other organisms of concern

3.2.5.2.1 MRSA Bacteraemia	Staphylococcus aureus (S. aureus) is a common skin and mucosal bacterium, with some strains resistant to methicillin—referred to as MRSA. When MRSA enters the bloodstream, it can cause serious infections known as bacteraemia. incidence of MRSA bacteraemia over the past three years is as follows: • 2022–23: 1 hospital-onset case, 5 community-onset cases • 2023–24: 1 hospital-onset case, 7 community-onset cases • 2024–25: 0 hospital-onset cases, 2 community-onset cases In 2024–25, the Trust reported no hospital-acquired MRSA bacteraemia, marking a significant improvement. The investigation process was updated to align with PSIRF principles, though no internal investigations were required due to the absence of hospital-onset cases. The two community-onset cases were reviewed by the Community IPC Team and were not linked to the Trust
3.2.5.2.2 SARS-CoV-2 (COVID-19)	On 31st December 2019, World Health Organisation (WHO) was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan, Hubei Province, China. A novel coronavirus SARS coronavirus-2 (SARS-CoV-2) was subsequently identified. The virus is mainly transmitted by respiratory droplets and aerosols, and by direct or indirect contact with infected secretions. There Throughout 2024–25, the Trust experienced stable levels of COVID-19 infection. There were no changes to national guidance, and therefore no significant policy updates were implemented locally. The Trust continued to monitor and manage both hospital-onset and community-onset cases in line with established protocols.

Figure 28 Hospital Onset versus Community Onset COVID-19 infections



Source: LTHTR data

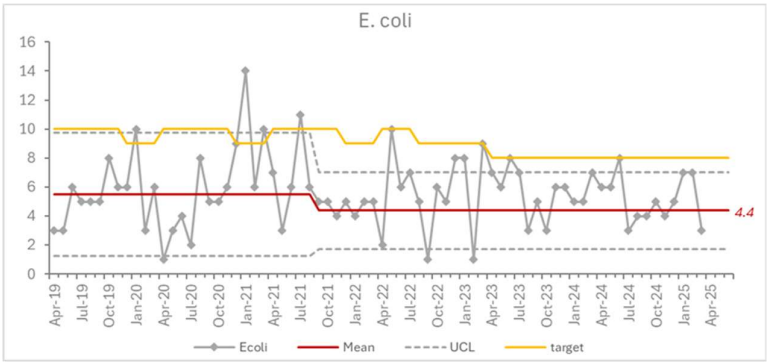
3.2.5.2.3 Gram-negative Bacteraemia

In line with NHS England's objectives to reduce bloodstream infections caused by Escherichia coli, Klebsiella species, and Pseudomonas aeruginosa, the Trust's 2024–25 performance is summarised below:

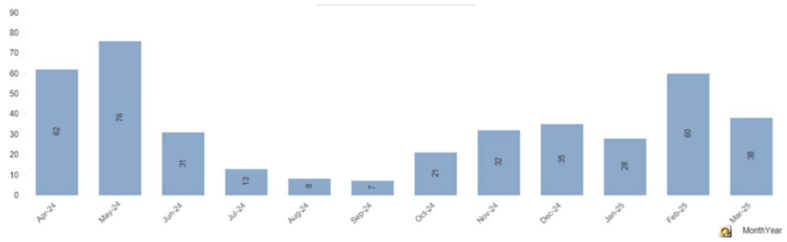
- E. coli: Objective = 99 cases; Actual = 109 (10 cases above target)
- Pseudomonas aeruginosa: Objective = 16 cases; Actual = 12 (4 cases below target)
- Klebsiella species: Objective = 29 cases; Actual = 31 (2 cases above target)

The E. coli target was not met, highlighting the need for a multi-disciplinary approach involving specialties across the Trust and the ICB. The ICB plans to establish Task and Finish groups to address Gram-negative bacteraemia, supported by the Trust's 2025–26 IPC Annual Plan, which includes initiatives focused on catheter care, continence, and bowel management.

Figure 29 Hospital Associated *Escherichia coli* positive rates per month.



Source: LTHTR data

3.2.5.2.4 Norovirus	In 2024–25, the Trust experienced 29 confirmed Norovirus outbreaks, reflecting the national trend linked to the emergence of the GII.17 variant. Outbreaks were distributed as follows: • April–June 2024: 11 outbreaks • October–December 2024: 8 outbreaks • January–March 2025: 12 outbreaks **Figure 30 Number of confirmed positive Norovirus Patients April 2024 – March 2025 (excluding patients identified in outbreaks that are likely Norovirus positive but not tested)**  ***Source: LTHTR data*** Increased community transmission led to a higher number of symptomatic patients presenting to ED and Assessment Units, challenging the Trust's ability to isolate and manage cases effectively. Transmission from infected staff and visitors also contributed to outbreaks. Norovirus outbreaks significantly impacted patient flow, with bay and ward closures reducing effective bed capacity and increasing ED wait times. However, the Trust benefited from rapid intestinal screening provided by the Point of Care team, enabling early identification and containment of cases. Negative results also supported IPC decisions to keep unaffected bays open. To mitigate spread, the Trust implemented: • Enhanced environmental cleaning • Fogging post-infectious period • Staff and public communications reinforcing the 48-hour symptom-free return policy

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

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

As part of the Trust's commitment to Consistently Deliver Excellent Care, mortality surveillance plays a vital role in assessing the quality of care and identifying opportunities for learning and improvement. This section outlines how the Trust monitors mortality trends and learns from the deaths of adults, children, and neonates.

Table 30 Understanding Key Mortality Indicators

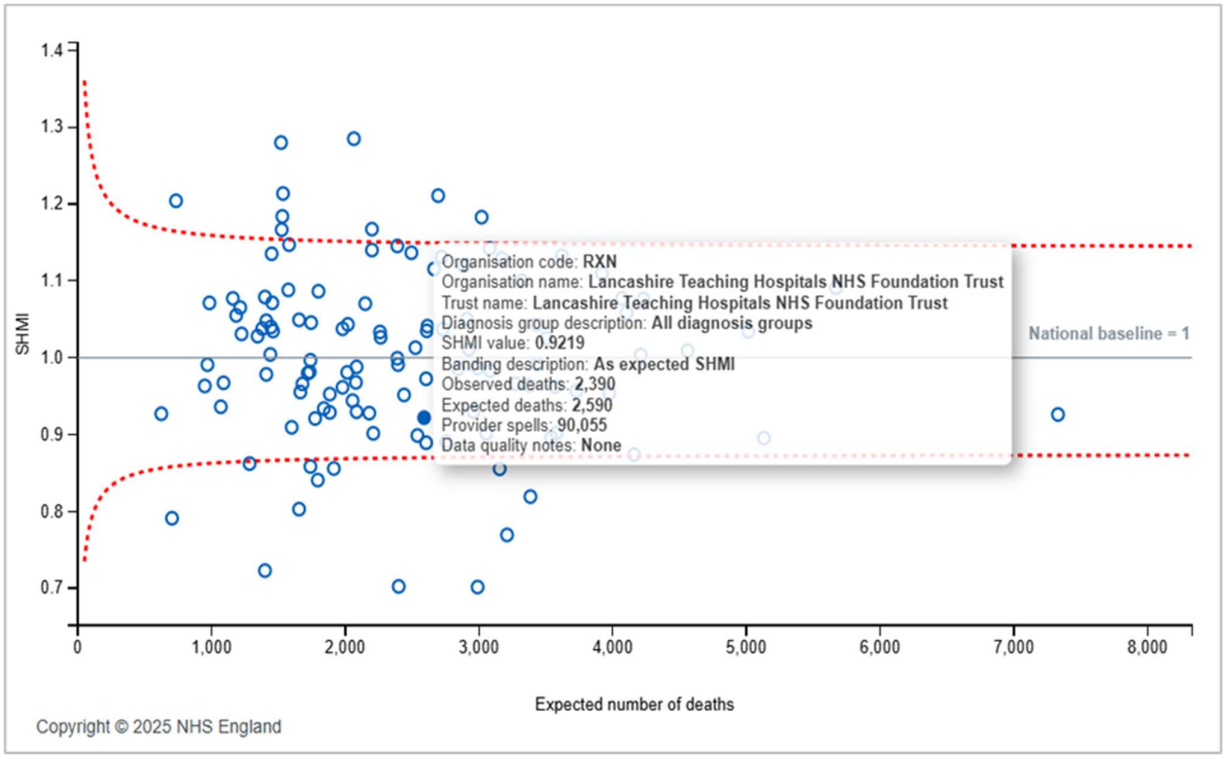
Indicator	Definition	What It Measures	Interpretation
SHMI (Summary Hospital-level Mortality Indicator)	Includes all deaths in hospital or within 30 days of discharge	All-cause mortality, not adjusted for palliative care or deprivation	A value of 100 is the national average; below 100 is better than expected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

3.2.6.1 Mortality Surveillance

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

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

Figure 31 SHMI Peer Comparison Funnel Plot



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

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

Figure 32 HSMR Trend

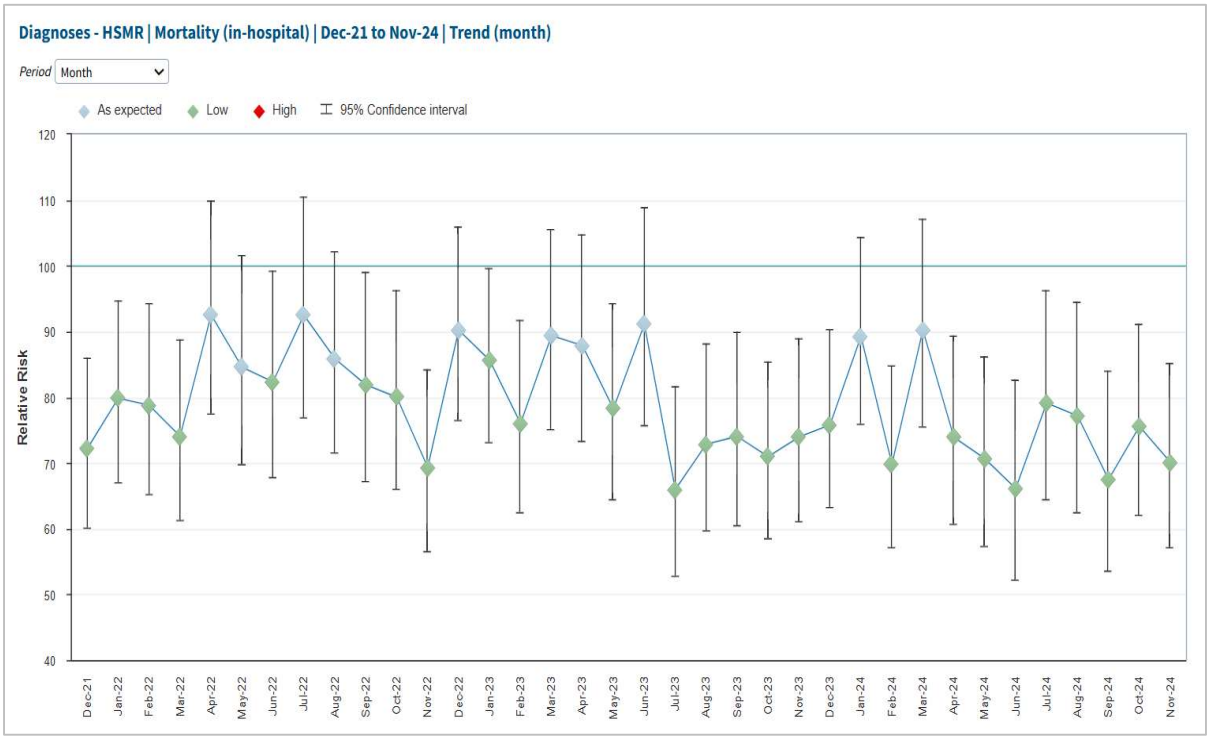
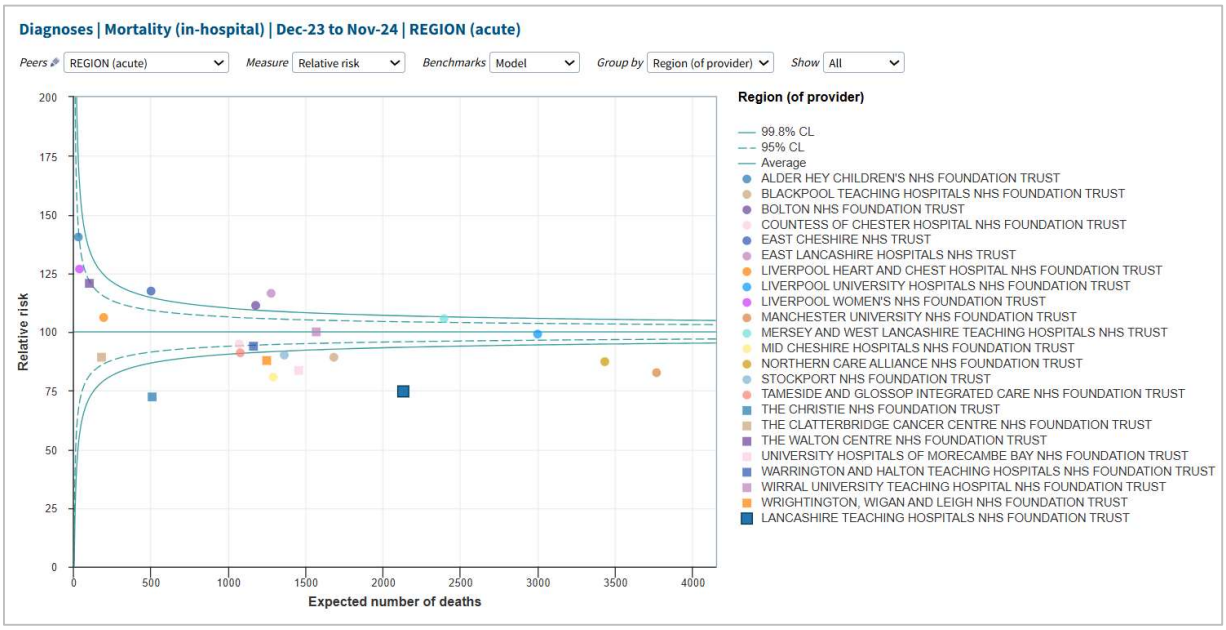


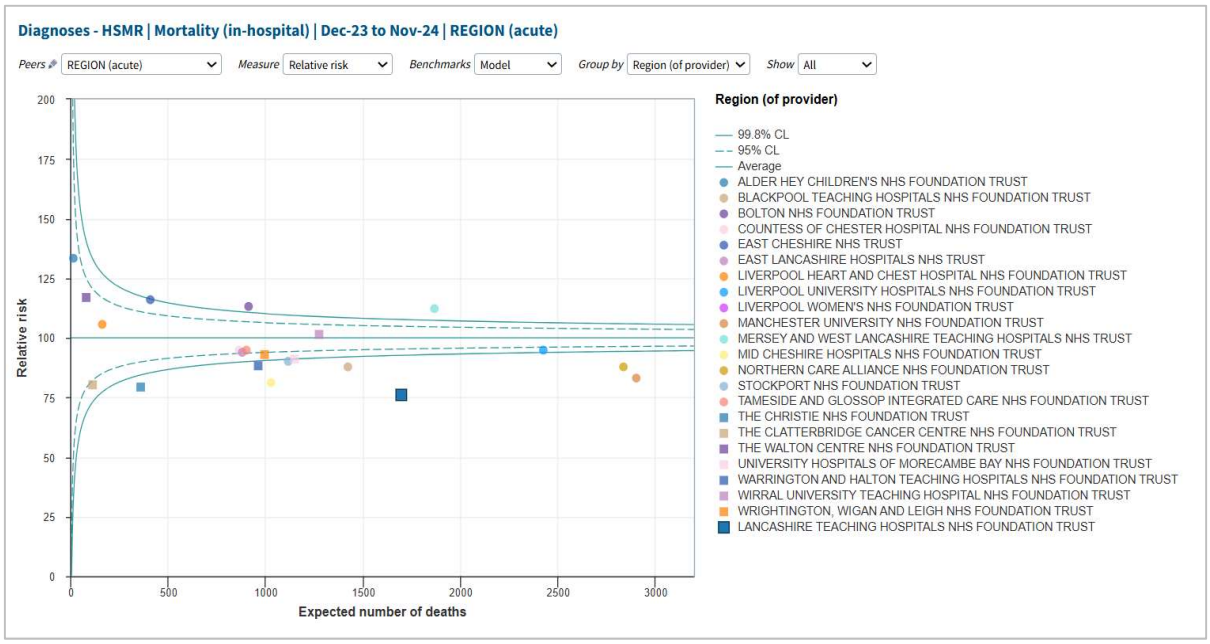
Figure 33 HSMR Regional Peer Comparison confirms LTHTR's position as one of the best performing Trusts in the region.

Figure 33 HSMR Regional Peer Comparison



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

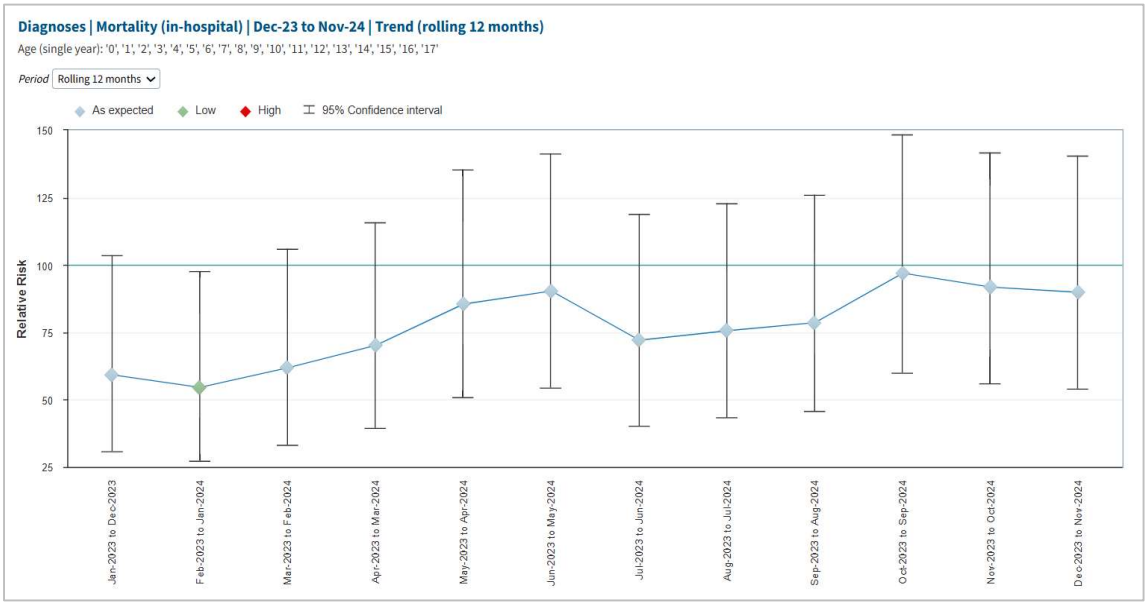
Figure 34 SMR Regional Acute Trust Benchmark Dec 2023 – November 2024



3.2.6.2 Child Deaths

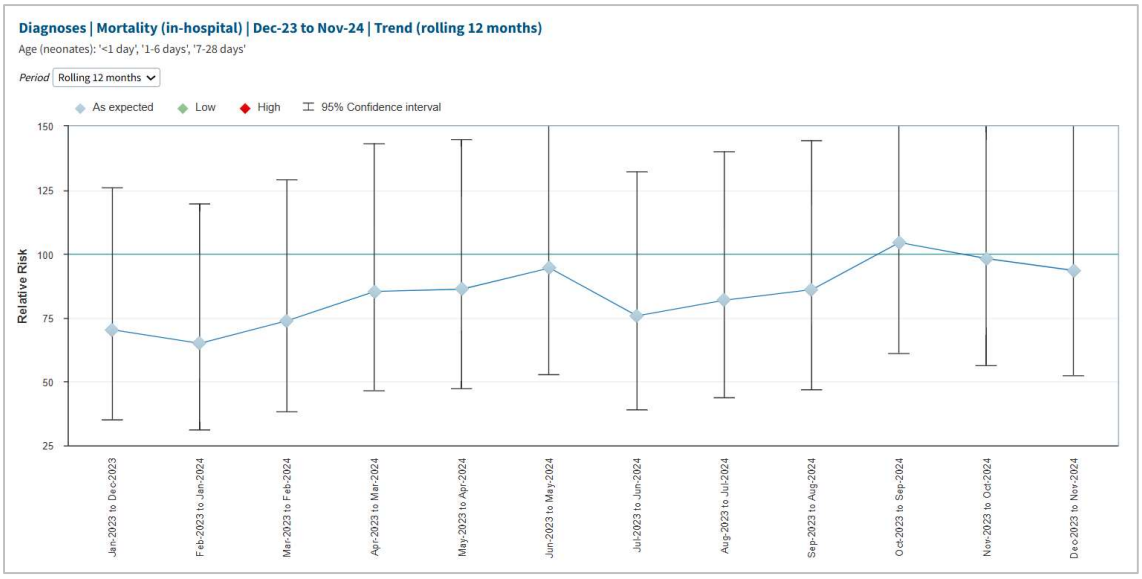
Child SMR (1–17 years): 89.9 – within expected range

Figure 35 SMR for Children



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

Figure 36 SMR for Neonatal Deaths



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

3.2.6.3 Perinatal Mortality & Perinatal Mortality Review Tool

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

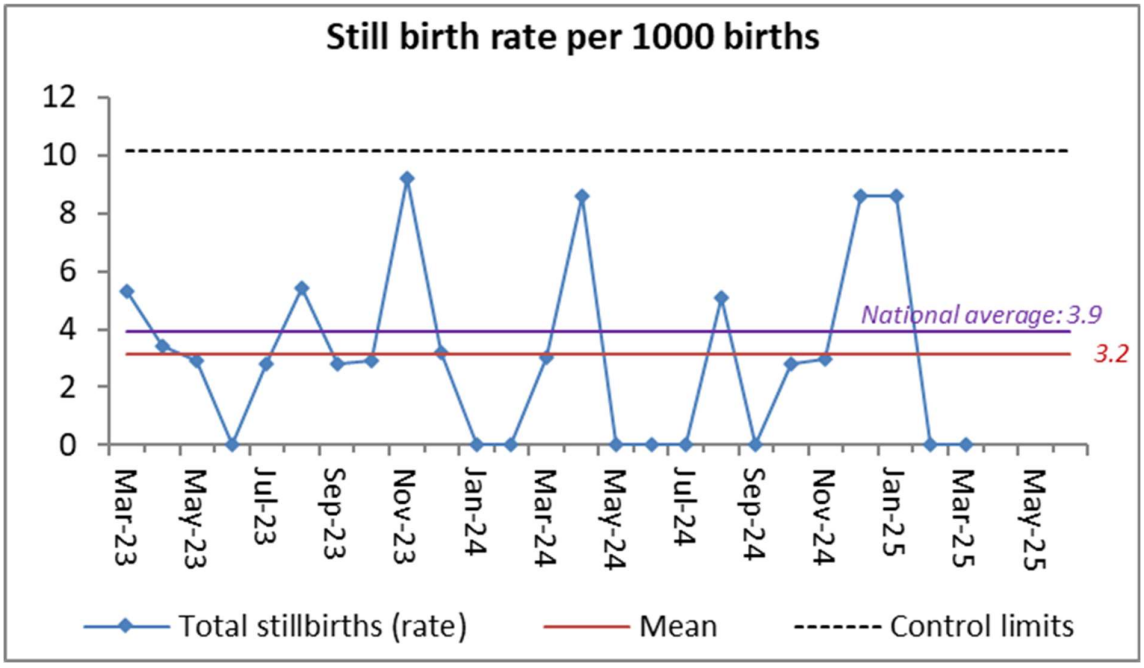
Between April 2024 and March 2025, the Trust reported 22 cases to MBRRACE-UK for PMRT review:

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

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

Figure 37 SPC Chart for Stillbirth Incidence

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



3.2.6.4 Medical Examiner Service

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

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

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

The scrutiny process involves three key components:

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

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

Table 31 Medical Examiner Service Performance 2024-25 data

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

Source: LTHTR Data

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

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

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

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

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

3.2.6.5 Learning from Corners Regulation 28 Report

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

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

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

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

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

3.3 Review of Quality Performance – Experience of Care

3.3.1 Patient Experience Performance Report 2024-25

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

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

The strategy is structured around three core pillars:

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

Highlights of 2024–25

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

Insight

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

Involvement

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

Improvement

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

3.3.2 Complaints and Concerns

3.3.2.1 Complaints

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

Table 32 Comparator data for Complaints 2022 to 2025

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

Source: LTHTR Datix

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

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

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

Source: LTHTR Datix

Performance and Timeliness

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

Complaint Distribution and Themes

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

Table 34 Number of Complaints by Division – April 2024 to March 2025

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

Table 35 Top 3 themes from complaints by division

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

The most common themes across all divisions were:

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

Complaint Outcomes

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

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

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

Second Letters and Ongoing Engagement

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

3.3.2.2 Concerns and Enquiries

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

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

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

3.3.3 The Parliamentary Health Service Ombudsman (PHSO)

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

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

- Three not upheld
- Two partly upheld
- One upheld

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

3.3.4 Compliments

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

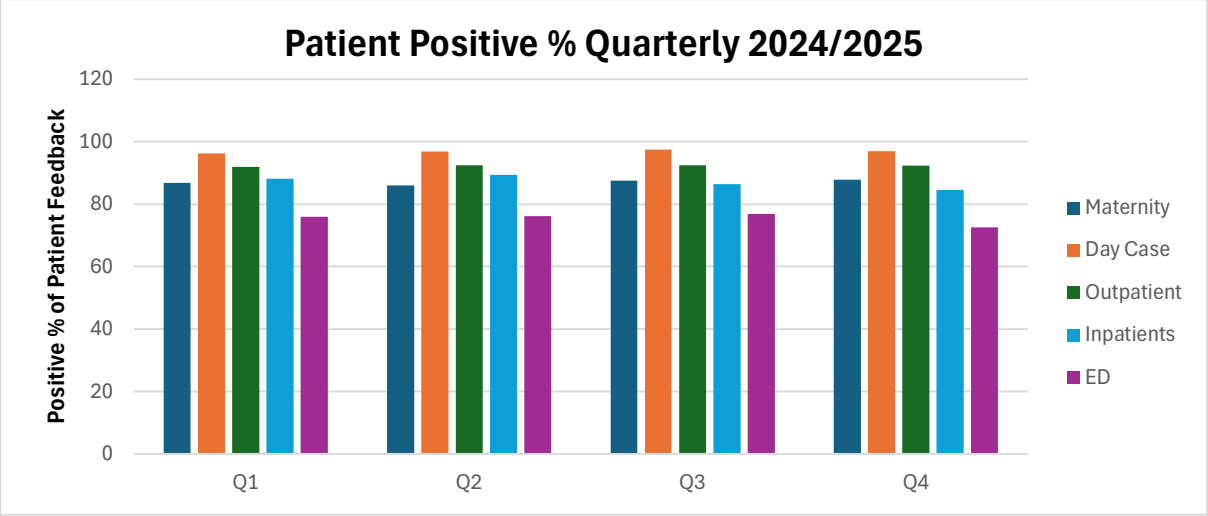
To support a culture of recognition and learning, staff are encouraged to log compliments using the dedicated module within the Trust's Risk Management System Datix system. This enables teams to celebrate success both locally and across divisions. Compliment data is now published monthly in Trust communications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

3.3.5 Friends and Family Feedback (FFT)

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

- Maternity
- Day Case
- Outpatients
- Inpatients
- ED

Figure 38 Percentage of positive responses Friends and Family by Division



Source: FFT data CIVIC

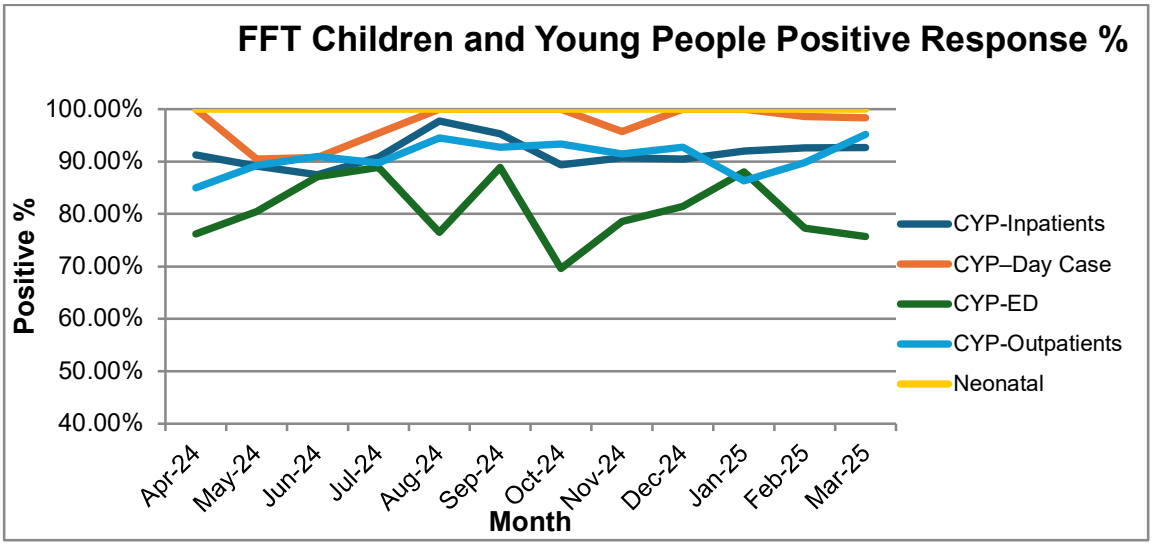
A target of 90% positive responses is set for all areas except ED, where the target is 85%. In 2024–25:

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

3.3.5.1 Children and Young People (CYP) Feedback

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

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



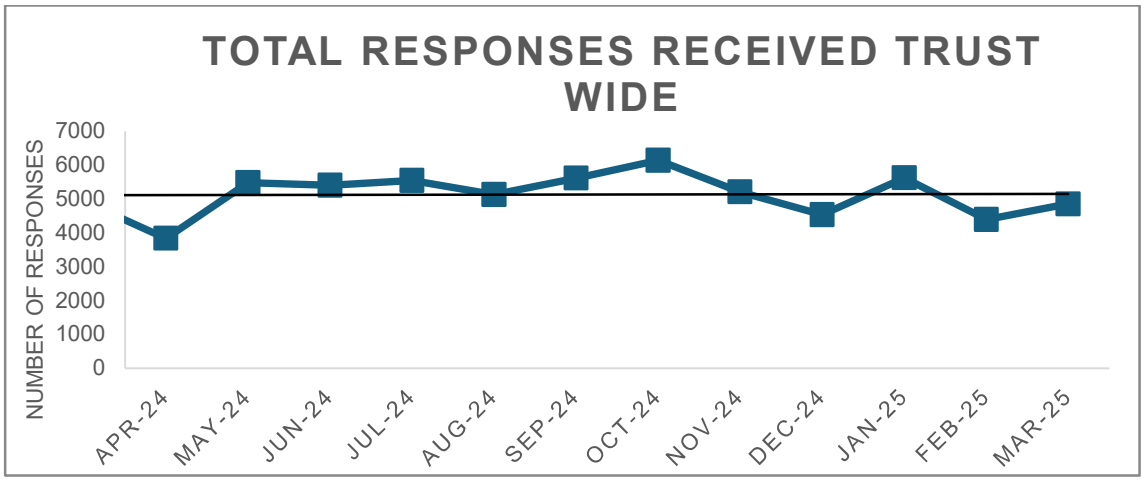
Source: FFT data CIVICA

3.3.5.2 Response Rates and Collection Methods

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

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

Figure 40 Friends and Family % Response



Source: FFT data CIVICA

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

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

Table 36 FFT response rates

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

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

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

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

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

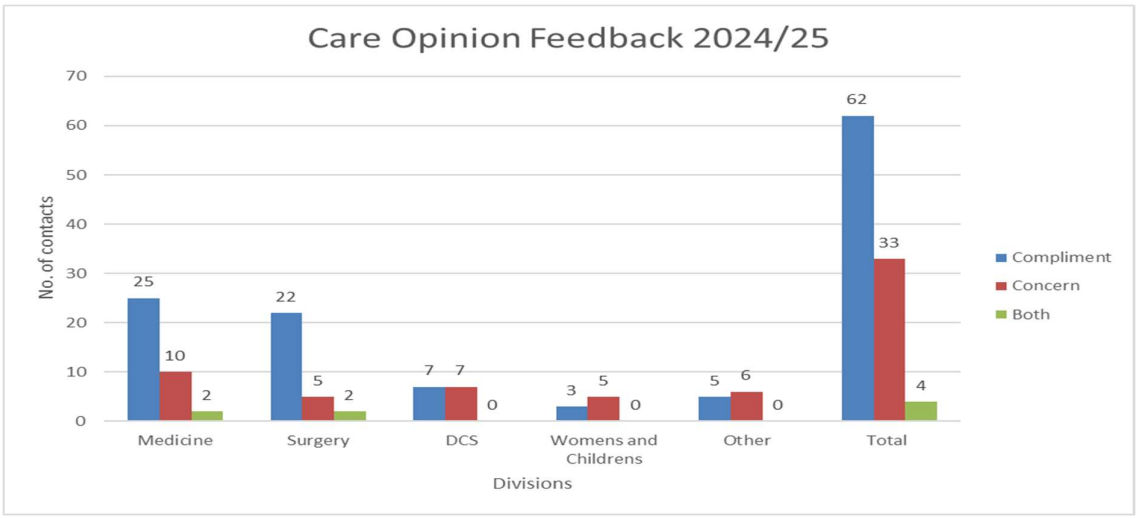
3.3.5.3 Care Opinion Website

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

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

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

Figure 41 Care Opinion feedback



3.3.6 National Patient Survey Results

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

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

3.3.6.1 Maternity Survey 2024	The 2024 Maternity Survey, conducted between April and July, invited a random sample of 324 patients from Lancashire Teaching Hospitals to participate. Of the 318 eligible, 103 completed the survey, resulting in a

	32% response rate—a 7% decrease from 2023 and below the Picker average of 39% across 56 trusts. Despite the lower response rate, the Trust maintained its overall position compared to the previous year. Key highlights from the 59 questions asked include: • 96% of mothers rated their overall experience positively. • 93% felt they were treated with respect and dignity during labour and birth. • 94% reported having confidence and trust in staff during labour and birth. • 94% felt involved in decisions about their care. These results reflect a continued commitment to respectful, person-centred maternity care, though the drop in response rate suggests a need to re-engage service users in feedback processes.
3.3.6.2 Urgent and Emergency Care (UEC) Survey 2024	The UEC Survey also ran between April and July 2024, with 1,250 patients invited and 1,195 deemed eligible. A total of 363 responses were received, giving a 30% response rate, which is 5% higher than in 2022 and in line with the Picker average for 64 trusts. The survey included 55 questions, with 19 repeated from the 2022 survey. Unfortunately, the Trust did not show significant improvement in any area and was rated significantly worse in five areas compared to 2022. Key findings include: • 65% of patients rated their overall ED experience positively. • 92% felt treated with respect and dignity. • 92% had confidence and trust in the doctors and nurses. While interpersonal care remains strong, the lower overall experience score and areas of decline highlight the need for targeted improvements in the UEC pathway, particularly around wait times, communication, and environment.
3.3.6.3 Inpatient Survey 2023	Conducted between July and November 2023, the Inpatient Survey invited 1,250 patients, with 1,176 eligible and 470 responses received—a 40% response rate, up 2% from 2022. The Picker average for 64 trusts was 43%. Out of 63 questions, 39 were repeated from the previous year. The Trust showed: • Significant improvement in two areas • One area identified as significantly worse Key results: • 76% of adult inpatients rated their experience 7/10 or higher. • 97% felt treated with respect and dignity. • 97% had confidence and trust in their doctors.

	These results reflect a generally positive inpatient experience, with high levels of trust and respect reported. The improvements suggest that recent quality initiatives are having an impact, though continued focus is needed on the area that declined.
3.3.6.4 Cancer Survey 2024	Published in July 2024, the Cancer Survey results continue to reflect strong performance. The Trust achieved an overall score of 9 out of 10, maintaining this high standard for the third consecutive year and performing above the national average. Notably, Lancashire Teaching Hospitals was the only Trust in the region with no responses in the lower-than-expected range for the second year running. Positive Highlights: • Colorectal, Upper GI (UGI), and Head & Neck teams scored 9.3 overall. • 99–100% of patients confirmed their care plans were reviewed with them. • High scores across all teams for: • Support from a main contact • Information on long-term side effects • Holistic Needs Assessments (HNA) • Personalised Stratified Follow-Up (PSFU) • Skin services scored 100% for helpfulness of main contact. • Lung services scored 100% for pain management. • UGI services scored 100% for team collaboration. • Colorectal services showed the most improvement overall.  Areas for Improvement: • Information about hormone treatment (Breast and Prostate) • Inpatient care experience (Breast, Head & Neck, Urology) • Support from primary care and voluntary services during treatment

	The Trust's Cancer Board and Quality Surveillance Work Programme oversee the action plan, with individual tumour site action plans monitored through the Patient Experience and Involvement Group and the Cancer Patient and Carers Forum.

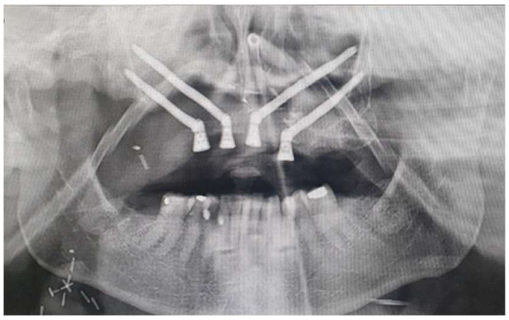
The national patient surveys give us important feedback about how patients feel about their care. Overall, the results show that many patients had positive experiences, especially in cancer, maternity, and inpatient services. Patients felt respected and trusted the staff. However, there are areas we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

4. Major Service Developments and Improvements

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

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

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



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


- **Expansion of Maternal Medicine Services:** In August, the Trust launched the LeAPH Clinic (Lancashire Antenatal Pre-eclampsia and Hypertension Clinic), a dedicated service for managing high-risk pregnancies. Developed in response to the Ockenden Report, this clinic forms part of the Trust's Maternal Medicine Centre, making it the third such centre in the region alongside Liverpool and Manchester.
- **Opening of New Acute Medical Assessment Unit (AMU): To** improve patient flow and reduce pressure on the Emergency Department, a new Acute Medical Assessment Unit opened at Royal Preston Hospital in September. The unit includes 24 bed spaces, two assessment bays, and 10 side rooms, enabling faster admissions, shorter stays, and better patient experience.


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


- **Paediatric Surgical Hub Gains National Accreditation:** The Paediatric Elective Surgical Hub at Chorley and South Ribble Hospital received GIRFT accreditation in September, recognising its high standards in children's surgical care. The hub supports specialties such as dental, ENT, ophthalmology, and plastic surgery, and is part of the national strategy to increase elective care capacity.

- **Launch of Regional Mohs Surgery Service for Skin Cancer:** The Trust's Plastic Surgery department launched the region's first Mohs Micrographic Surgery (used to treat certain types of skin cancers) and Reconstruction Service at Chorley and South Ribble Hospital. This gold-standard treatment offers same-day tumour removal and reconstruction for high-risk skin cancers, significantly improving outcomes and patient experience.

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

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

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4.1 Staff Survey and Recommendation of Our Care

4.1.1 NHS Staff Survey 2023–24

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

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

4.1.2 Survey Results and Benchmarking

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

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

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

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

Table 39 Trust National Staff Survey indicators comparison to National Benchmark

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

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

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

4.1.3 Staff Engagement Results

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

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

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

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

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

Table 40 2024 Staff Engagement Question Breakdown

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

	LTH Results and comparison (2023 to 2024)			National Average 2024 Comparison	
Question	**LTH 2024**	**LTH 2023**	**Changes**	**National Average 2024**	**LTH comparison to National average**
Motivation					
Often/always look forward to going to work	**51.76%**	57.07%	-5.31%	54.19%	-2.43%
Often/always enthusiastic about my job	**67.35%**	71.38%	-4.03%	67.95%	-0.60%
Time often/always passes quickly when I am working	**73.27%**	75.62%	-2.35%	70.90%	2.37%
Involvement					
Opportunities to show initiative frequently in my role	**73.89%**	76.58%	-2.69%	73.20%	0.69%
Able to make suggestions to improve the work of my team/dept	**72.97%**	75.03%	-2.06%	70.60%	2.37%
Able to make improvements happen in my area of work	**54.42%**	57.17%	-2.75%	55.73%	-1.31%
Advocacy					
Care of patients/service users is organisation's top priority	**66%**	72.57%	-6.70%	74.42%	-8.55%
Would recommend organisation as place to work	**49.77%**	59.45%	-9.68%	60.90%	-11.13%
If friend/relative needed treatment would be happy with standard of care provided by organisation	**52.15%**	58.37%	-6.22%	61.54%	-9.39%

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

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

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

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

4.1.4 Next steps and future priorities

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

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

4.1.5 Priorities and targeted actions

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

These areas include:

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

Examples of work already completed in the last 12 months:

- Sexual Safety: Signed the NHS Sexual Safety Charter; launched training and outreach initiatives
- Recognition: Introduced Monthly Proud Rewards, Thank You Week, Team Recognition Kits, and expanded Our People Awards
- Culture: Delivered ‘Civility Saves Lives’ training and launched a Managers’ Toolkit
- Leadership Support: Relaunched Managers Update Sessions with improved content
- 1:1 Culture: Developed new resources and training to support regular, meaningful colleague conversations
- OD Team Support: Delivered bespoke development to low-scoring teams
- Wellbeing: Expanded psychological wellbeing services, relaunched Mental Health First Aiders, and delivered attendance management training
- Zero Tolerance: Rolled out Active Bystander training and toolkits

- Inclusion: Hosted Listening Rooms to improve experiences for minority groups
- Car Parking: Launched a car-sharing app, re-procured the parking system, and explored new tech solutions.
-

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

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

4.1.6 Monitoring Performance and Tracking Impact

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

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

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

Engagement is further enabled at a local level through two-way conversations by providing tools and resources (e.g. Manager Huddle Sheets, TED Tool and Team Conversation Activities) so that managers can response directly to their team members. By continuing our work to embed these

mechanisms into our culture, we ensure that engagement is not just a one-way process but is a continuous dialogue that strives to shape real change.

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

4.2 Medical and Dental Workforce Rota Gaps

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

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

Table 41 Medical and Dental Vacancies

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

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

Source: LTHTR data Feb 2025 General ledger

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

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

4.3 Consultant Vacancy Rates

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

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

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

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

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

4.4 Core Skills Training

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

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

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

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

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

4.5 Quality Assurance

4.5.1 Overview and Assurance Statement

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

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

4.5.2 Governance and Oversight

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

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

standards of care.

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

4.5.3 Governor Engagement and Assurance

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

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

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

Annex 1 : Statements from external stakeholders

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

05 June 2025

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Yours sincerely

Kathryn Lord

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

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

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

Healthwatch Lancashire

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

Introduction

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

Chief Executive's Statement

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

2.3.5 Operational Performance

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

2.5 Always Safety First (ASF)

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

2.15.2 Commitment to Continuous Improvement

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

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

3.3.1 Patient Experience Performance Report 24-25

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

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

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

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

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

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

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

Jodie Carney Manager- Healthwatch Lancashire

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

The statement from Lancashire County Council Health Scrutiny Committee is as follows: -

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

Account: Feedback from Council of Governors Meeting on 24th April 2025

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

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

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

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

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

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

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

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

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

- Board minutes and papers for the period April 2024 to March 2025.
- Papers relating to quality reported to the Board over the period April 2024 to March 2025.
- Feedback from Integrated Care Board 5th June 2025
- Feedback from Healthwatch 3rd July 2025

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

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

By order of the Board

Professor Mike Thomas Chair Date: 9th July 2025

Silas Nicholls Chief Executive Date: 9th July 2025

Appendix 1 - List of Tables

Appendix 2 - List of Figures

Appendix 3 - Glossary of Abbreviations

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

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

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

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

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

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

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

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