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BOARD OF DIRECTORS ANCILLARY PACK

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4 December 2025

09:15 GMT Europe/London

AGENDA

BOARD OF DIRECTORS PART I ANCILLARY PACK

Items:
9.2 - UEC Deep Dive
13.1 - GGI Report ? Action Plan Against Recommendations and Final Form RSP Exit Criteria
13.2 - Health and Safety Annual Report
14.1 - Maternity and Neonatal Services Update

9.2 - URGENT AND EMERGENCY CARE DEEP DIVE

REFERENCES

Only PDFs are attached

9.2 - LTH UEC plan.pdf

Single Improvement Plan

Patients | Performance | People | Productivity | Partnerships

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Urgent & Emergency Care Improvement Plan

2025-2028

Katie Foster-Greenwood - Chief Operating Officer

Excellent care with compassion

Always Safety First

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Section 1

Context and link to wider system UEC Improvement Plan

Context and scale of the challenge

Whilst patient attendance and admission numbers are not significantly increasing, waits for assessment and admission have increased.

There are high levels of ED and hospital overcrowding combined with unacceptably high waiting times within ED for initial assessment and admission.

The operational picture below sets out the need to outline and deliver a sustainable improvement programme:

- **4 hour A&E standard** - Despite national A&E 4-hour performance gradually improving to mid 75% by early 2025, LTH has fallen behind the national picture with performance around 68%. It is critical that performance meets the pre COVID national ambition of 95% as a minimum.
- **LTH attendance and breach position** has seen a mainly static position since 2019.
- **Ambulance handover delays** - The LTH position indicates that the % over 30 min ambulance handover delays has increased from 18% in 23/24 to 29% in 24/25. The national requirement is that 95% of all ambulance handovers are achieved within 15 mins of arrival.
- **12 hour A&E delays** - At LTH in 23/24 9.6% of patients experienced a total time in ED over 12 Hour LOS, rising to 10.21% in 24/25. In both year's, the proportion peaked in Jan.
- **Attendances and Non Elective Admissions** have remained static, but the length of time patients wait in the Emergency Department has more than doubled over recent years

Key Performance Drivers

- **High demand of local population ED attendance** – In August 2025 38% of the catchment population attended ED at RPH against an NHS England average of 29.6% (SEDIT data).
- **No medical criteria for admission** - c.50 patients are admitted per month without a clear medical reason. The resulting length of stay equates to 300 bed days being used a month.(Local Audit)
- **Deprivation** – 25% of patients that attend ED are classed in the highest two quintiles of deprivation.
- **High intensity users** – c.2% of attendees have attended more than 10 times in the last 12 months. Top 20% in of frequent attenders in their final year of life.
- **Mental Health pressure** – 32% of all Mental Health patients who attend RPH ED waited more than 12hrs against an England average of 19.9%.
- **Neighbourhood provision in Central Lancashire** – An absence of a sufficiently commissioned provision combined with a requirement to improve co-ordination between sectors is leading to increased secondary care demand. Requirement for closer working in tandem with the ICB and Primary Care Networks through increased clinical management focus is required.
- **Out of hours focus –** Drop in performance out of hours requiring increased senior focus and support.

The word cloud above is taken from clinical teams documentation of the patients "presenting complaint/reason for attending hospital"

Our Estate

Preston Emergency Department (ED) Estate and Flow Issues: The ED layout has evolved without adequate strategic planning, leading to poor flow, security concerns, and inefficient use of space. The Paediatric area does have a secure and well-functioning department, which benefits from a separate entrance and better integration with GTD (Urgent Treatment Centre provider). Adult areas however suffer from a lack of sub-waiting space, causing patients to remain in cubicles or on trolleys, impacting throughput and performance.

Assessment Unit and SDEC (Same Day Emergency Care) Location: There is a physical disconnect between the ED and the assessment unit/SDEC at Royal Preston Hospital (RPH), which therefore operates in isolation. This separation leads to poor integration, decision-making in silos, and challenges in managing patient flow. There is not currently an SDEC function at Chorley Day Hospital (CDH).

ED Majors Reconfiguration and Time to First Assessment

The current configuration of the ED 'Majors' area is not optimal for patient flow, as it consists mainly of cubicles connected to a single waiting room, which limits the ability to move patients efficiently through the department. Despite attempts to create an 'ambulatory major's area' where patients could wait together and be brought into cubicles for assessment, the space is not well configured to support this model. This poor configuration of the space impacts the department's throughput and specifically affects the time to first assessment.

Our Estate cont.

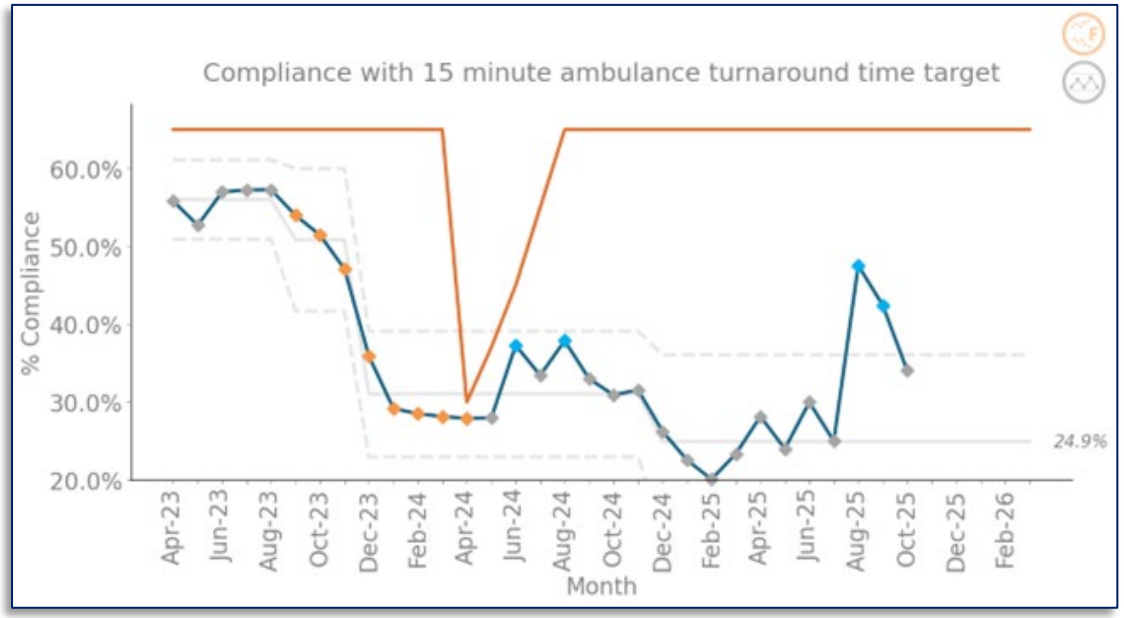
Mental Health Assessment Area Plans: There are plans to create a mental health assessment area on the RPH site, pending NHS England capital funding. The business case is being developed, with a plan to start work before the end of the financial year 25/26. The space will support joint physical and mental health multi-disciplinary working and streamline the assessment pathway, reducing waiting times.

Chorley & South Ribble Hospital - A £1.5 million Urgent Care Centre was completed at Chorley Hospital in 2015, integrating urgent care functions. The Emergency Department at Chorley is an adults-only service with limited daily hours to 8 pm however due to capacity constraints the department remains open overnight on a regular basis.

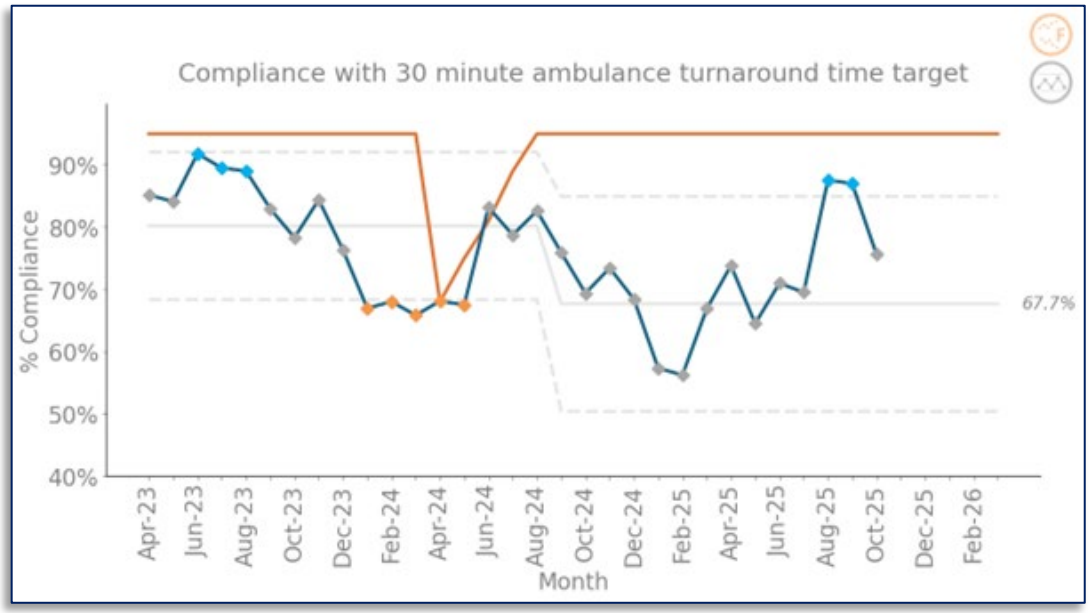
New Hospitals Programme - Confirmed in 2025 that the rebuild of the Royal Preston Hospital will not get underway until the late 2030s. The Royal Preston Hospital has a significant level of maintenance backlog.

LTH current performance trend – 1.Ambulance Handovers

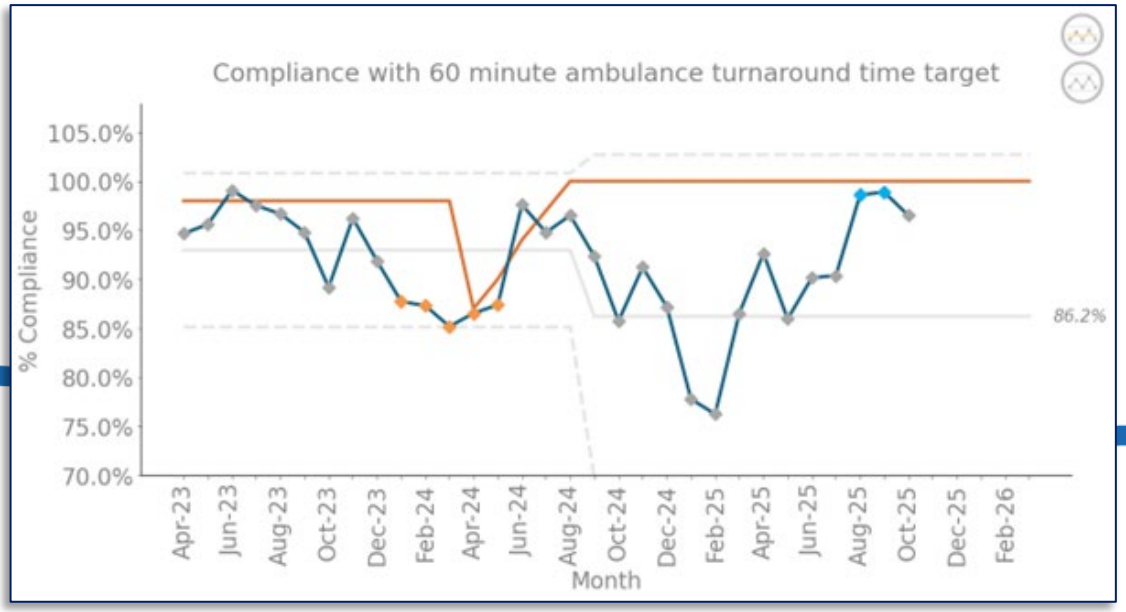
15 min handover compliance



30 min handover compliance



60 min handover compliance



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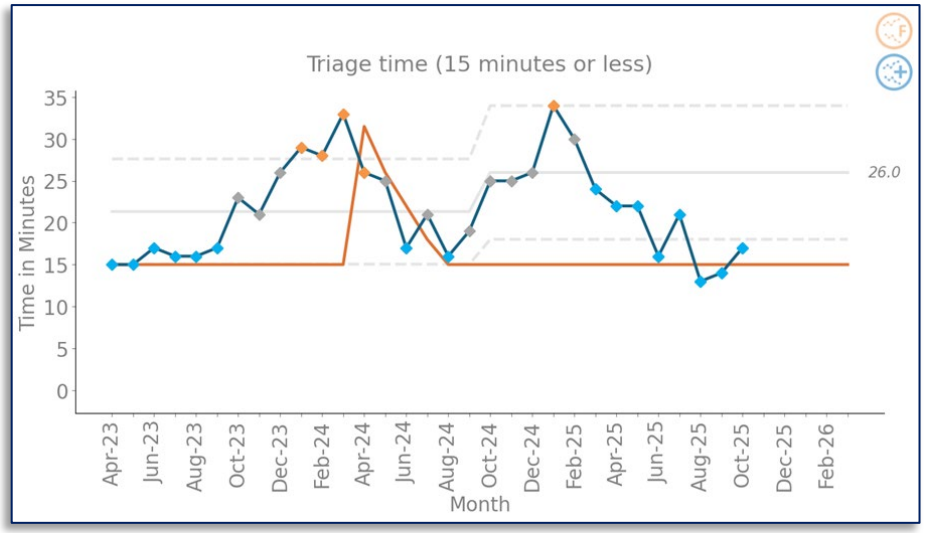
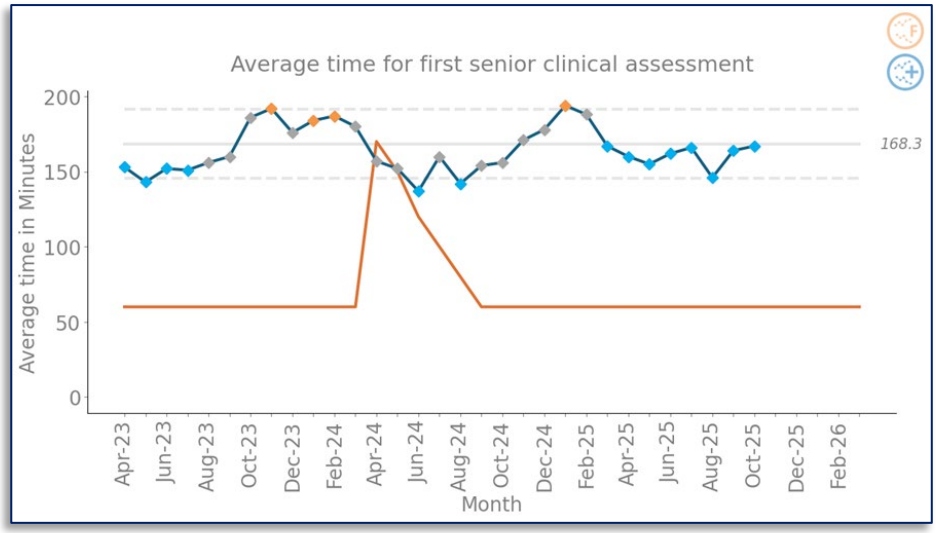
LTH current performance trend – 2.Emergency Department

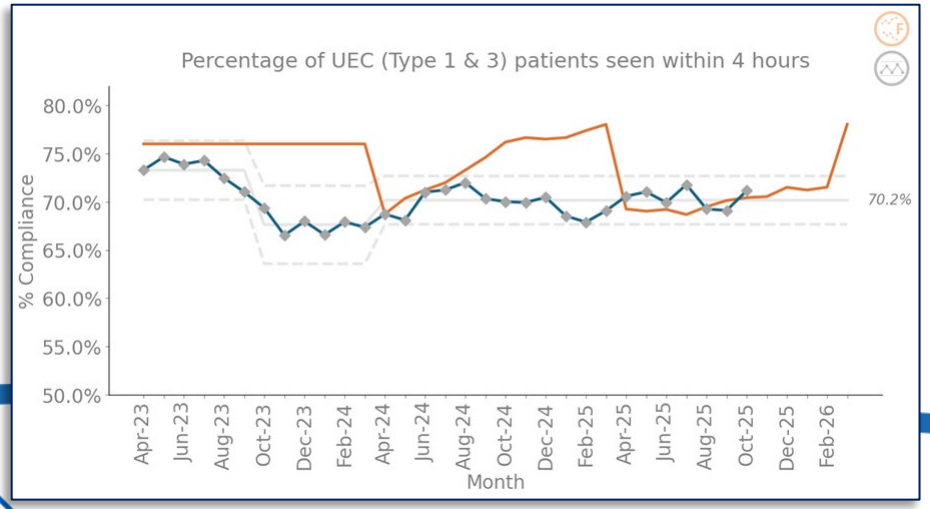
Time to triage



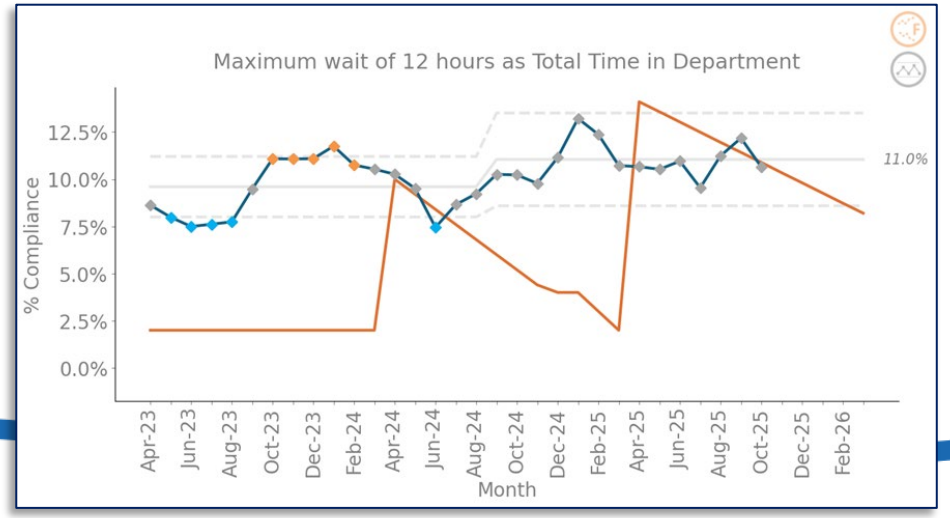
Time to first senior clinical assessment



4 hour compliance



12 hour compliance



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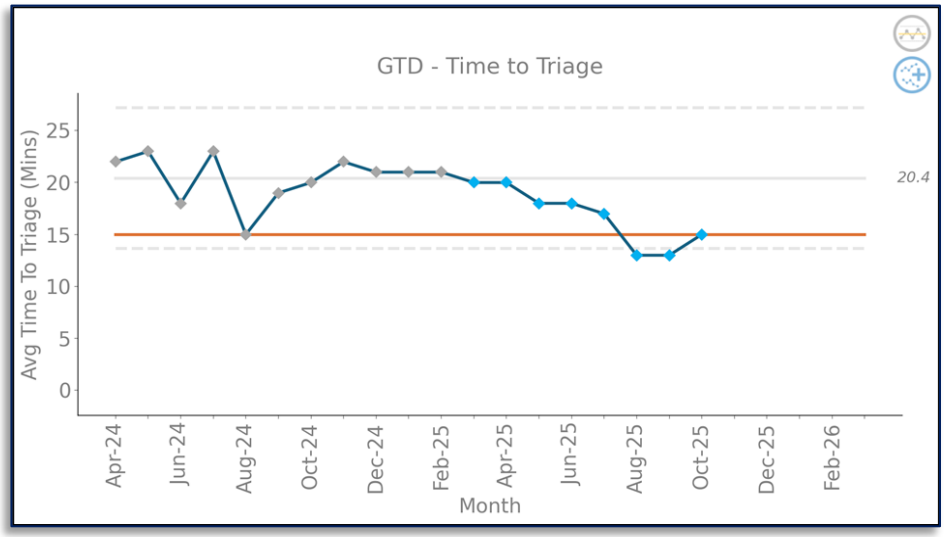
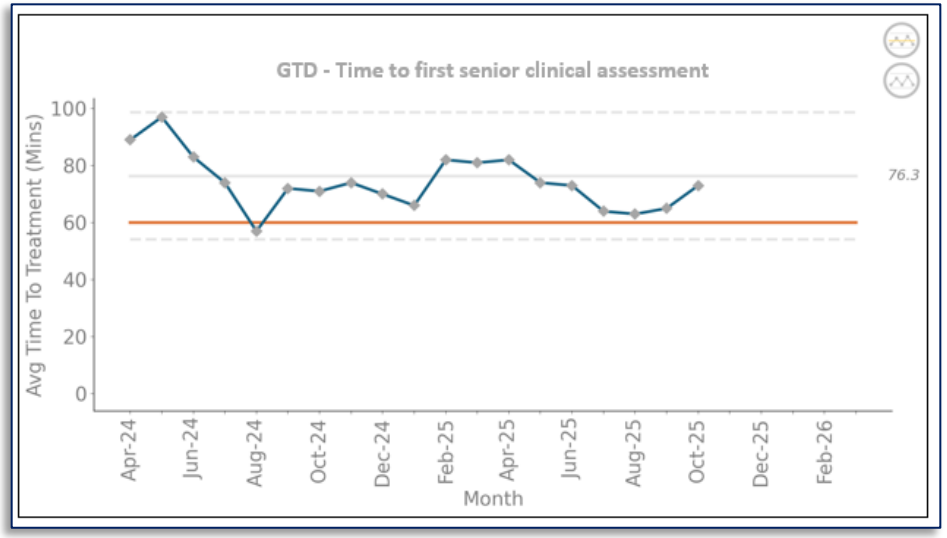
LTH current performance trend – Urgent Treatment Centre (GTD)

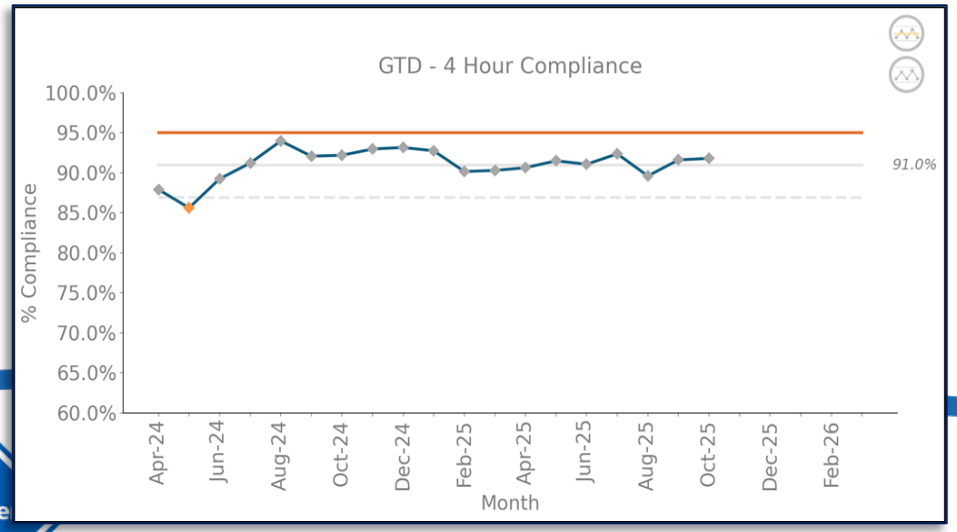
Time to triage



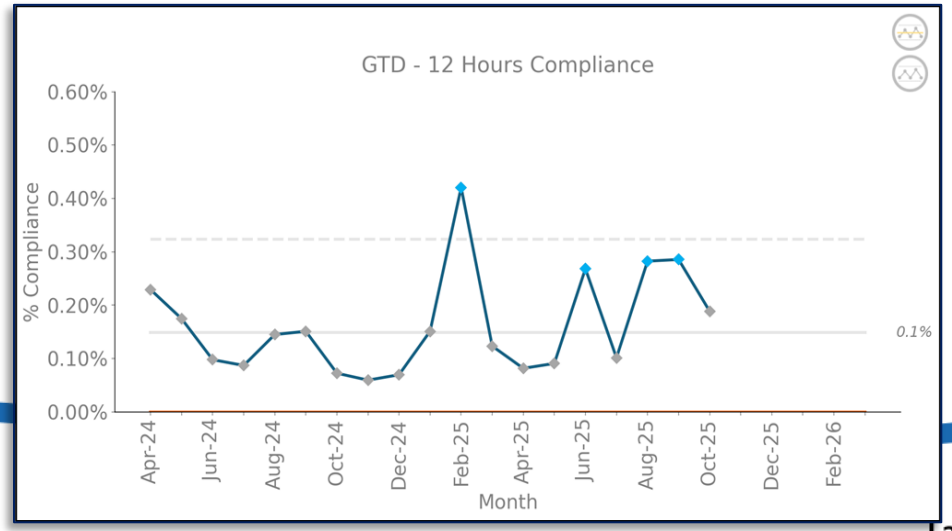
Time to first senior clinical assessment



4 hour compliance



12 hour compliance



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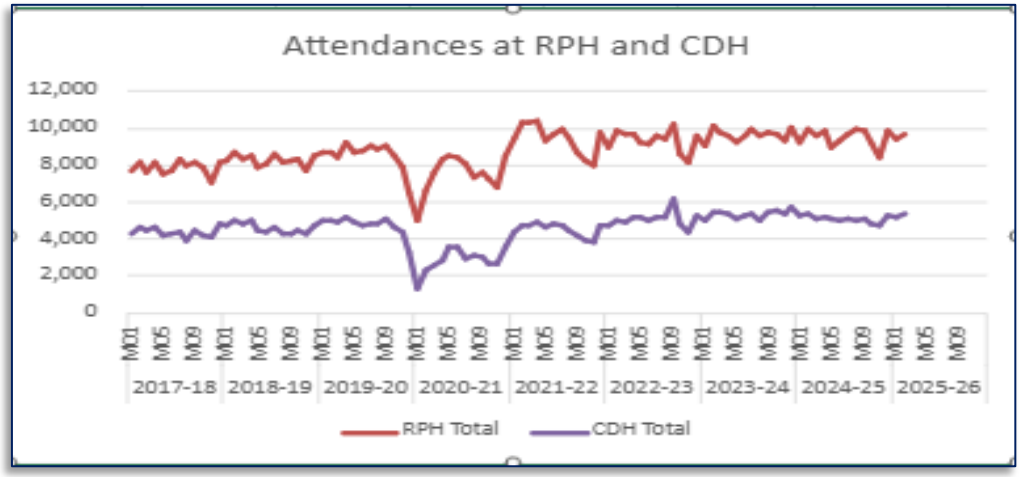
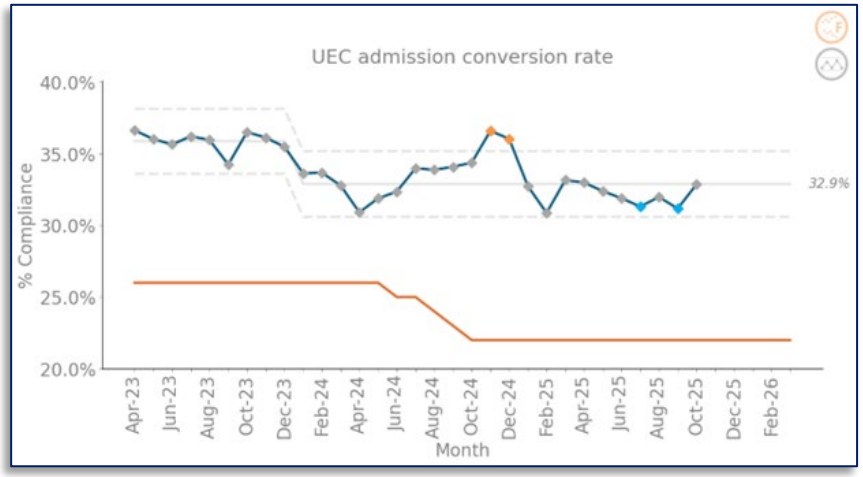
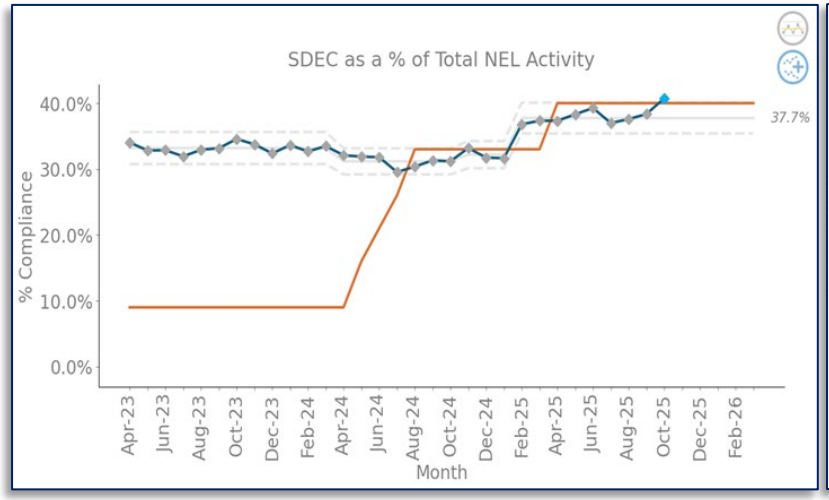
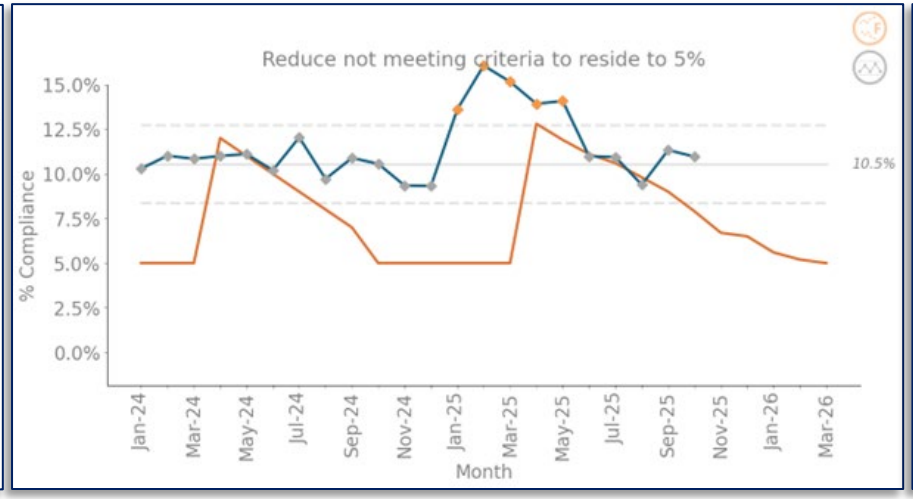
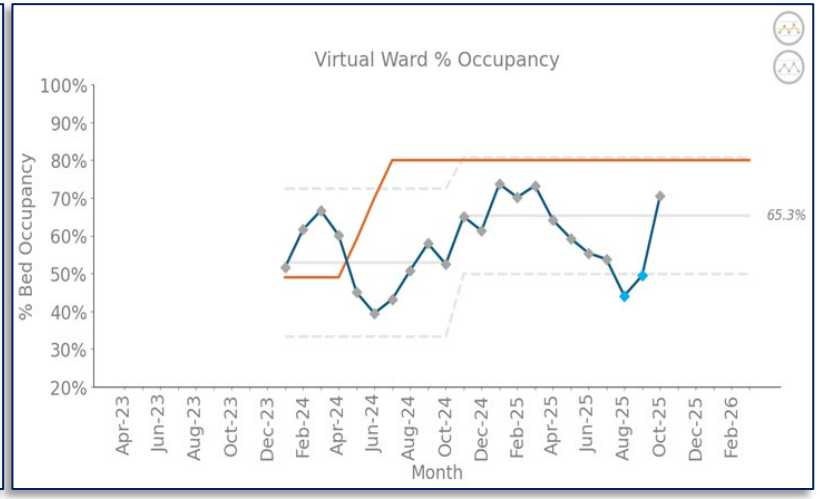
LTH current performance trend – Wider metrics











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Section 2

UEC Delivery Plan 2025-2028

From ICB strategy to LTH delivery as part of the plan

ICB core UEC Strategy to 2029

Our vision

Create an urgent and emergency care system that enables people to easily access the right care and support, at the lowest level of intervention, that best meet their needs, and delivers better outcomes and affordability

Our five aims are:

- Ensure our citizens access high quality, safe and affordable care, in the right place by the right professional
- Support preventative care and develop proactive management services to reduce avoidable contact with urgent and emergency care
- Adapt our urgent and emergency care system so that it is fit for the future to meet increasing demand
- Develop improvement plans at place
- Embrace opportunities for innovation

System priority actions

Overall UEC Improvement Approach

Central Lancs UEC Three Part Plan

Our aims:

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

1. Admission avoidance

Increasing Care at Home via Care ConneXions: Enhancing services and pathways between community and secondary care providers to support a significantly expanded Hospital @ Home provision and reduce ED attendances and admissions.

2. Hospital process improvement

Delivering an array of improvements within our hospital system to ensure quality and efficiency. This area of focus includes ambulance handover, wait to be seen, ED-specific processes as well as working with the wider hospital specialties.

3. Reducing Days Kept Away from Home:

Developing a strengths-based model supported by a critical focus to reduce deconditioning which will result in a reduction in the number of patients spending time in hospital.

Part 1 - Admission Avoidance

Intermediate Tier Services (Care ConneXions)

Scheme	Description
Incorporate Hospital @ Home model (previously virtual ward) into Care ConneXtions	Bringing existing teams together to strengthen the offer and ensure greater economies of scale to enable increased activity.
Implement a call handling function to increase responsive access for referrals and release clinical capacity	Recruitment of call handlers to support clinical staff ensuring more clinical patient facing time and uniform adherence to call centre protocols.
Develop a generalist model for Hospital @ Home, increasing step up activity	Moving to an overarching generalist model. Working to recruit a generalist GP to enhance Virtual Wards. Strengthening the model through engagement with teams. Increasing step up activity.
Increase acceptance rates of referrals into community hospital avoidance services	Increasing 2hr UCR (discussed in more detail later in slides). Clear stretch targets laid out to drive performance.
Improve clinical offer within Virtual Ward- IV antibiotics at home	SOP signed off to enable IV antibiotics to be provided in a home setting
Introduce new models of care at the front door - Establish See & Sort Stream Initiative Team	Widen membership of the multi-disciplinary team. Discussed in more detail on later slides.

Part 2 - Hospital process improvement

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Ambulance Handover

Ensuring we move toward delivering full compliance against the 15 min standard. Streaming ambulance patients to the right place first time

Org & system related actions

- Policies for patients and families declining offers/plans
- Additional clinical management support and oversight for Chorley Hospital from a Nursing, Medical and operational perspective.
- Expansion to 24hr operational senior site support

Wait to be seen

Ensuring timely assessment of patients presenting to ED

- Utilisation of See and Sort Stream Initiative Team
- Minor injury focus
- Rota reconfiguration
- Escalation protocols

Specialty pathways

Ensuring that patients get to the right clinician first time

- Criteria led discharge
- Clinical management planning
- Enhancing assessment unit offer
- Enhance specialty pathways
- Discharge team focus and education

Ward and board round standards

Embed a robust and standardised Ward & Board round process

- Pharmacy focus
- Improve virtual ward offer
- Continuous flow
- Utilisation of discharge lounge
- Consistent standards

Interprofessional standards

Clear, defined ways of working between ED and specialty teams resulting in a responsive service to safely move patients through their pathway

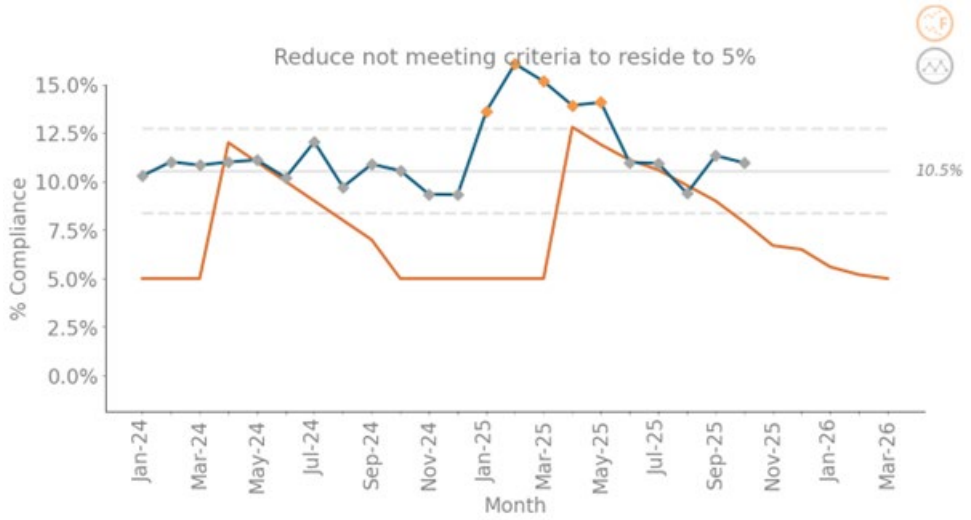
Part 3 – Reducing Days Kept Away from Home

Scheme	Workstream projects/key actions
Days Kept Away from Home: Pathway 0 Discharge Improvement Plan	Accurate Assessment of Discharge Needs
	Effective Multidisciplinary Team (MDT) Communication
	Robust Discharge Planning Processes
	Patient and Family Engagement
Days Kept Away from Home: Pathway 1 Discharge Improvement Plan	Early & Accurate Identification of Discharge Pathway
	Timely and Coordinated MDT Decision-Making
	Optimised Use of Community Resources
	Patient and Carer Involvement in Discharge Planning
Days Kept Away from Home: Pathway 2 Discharge Improvement Plan	Early Identification of Rehabilitation Needs
	Prevent deconditioning
	Effective MDT Decision-Making
	Improved Coordination with Community Rehab Services

Outputs:

- Preventing deconditioning and improving overall discharge processes.
- Operating a strengths-based approach
- Discharge more patients with less care needs
- Reduce 'no medical criteria to reside' down to 5%

Enabling a reduction in Days Kept Away from Home



Working with wider system partners

Highlighting specific areas of close working with wider community partners to support positive UEC change

Enhancement of the 2-Hour Urgent Community Response Team

- Increase in Care Assistants and Reablement Workers
- 24/7 service including overnight care

Aiming to:

- Prevent unnecessary admissions
- Support timely discharges
- Improve end-of-life care
- Reduce long-term care dependency

Increased support for patient discharge in ED

- Provision of dedicated Discharge Facilitators and Social workers based in the ED to work as an integrated part of both the ED team and the Frailty and Therapy teams.
- Participating in the ED handovers and board rounds to quickly pick up patient's and complete assessments putting in place the interventions needed to prevent hospital admission.

A dedicated social worker added to the current team would allow 2 benefits:

- Avoiding hospital admission
- Starting assessment of needs early for patients who are unwell and do need admission with the aim of reducing days "fit for discharge" for patients once recovered.
- 7 day social work cover in the ED to be piloted for 3 months to determine the benefits and impact on social work workloads.

Intermediate care provision – nursing rehabilitation

- Work with commissioners and system partners to agree a change to current operating approach to intermediate care
- Co-produce a model of care that meets the needs to the local population and prevents avoidable hospital delays.
- Maximise the reablement provision within people's own homes where safe to do so.

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Section 3

Commitments, Improvement trajectory & Governance oversight to support delivery

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Year 1 : 2025/2026

LTH commitments to Urgent & Emergency Care in Year 1: 2025/26

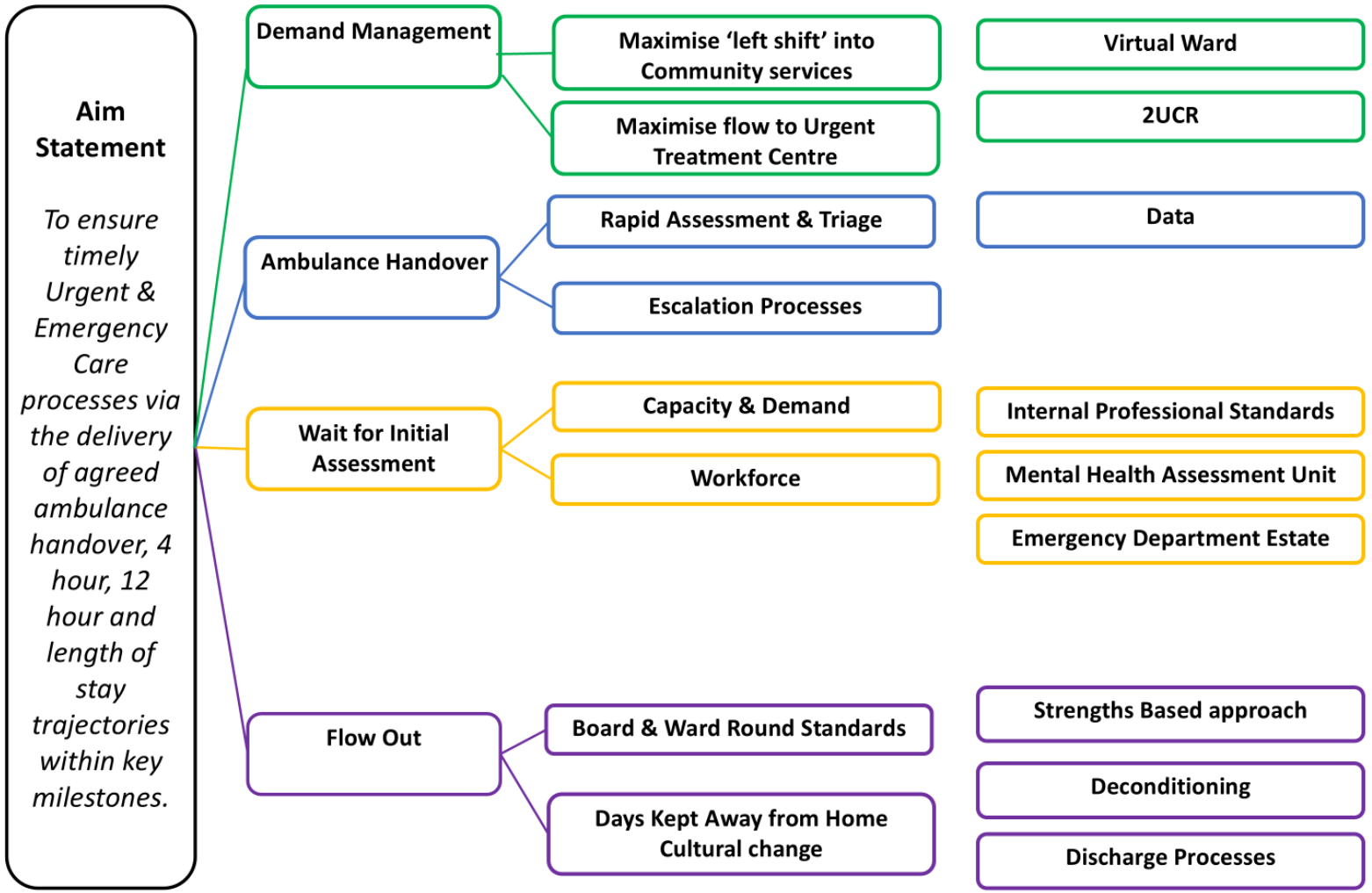
- **Demand:** The Central Lancs UEC & Community transformation board is committed to increasing care delivery in people's own homes with plans to **increase activity in 2hr UCR by 50%** and **Virtual Ward activity by 30%.** To reduce ED overcrowding activity via **SDEC will increase its capacity 20%** with plans to expand the SDEC opening hours by March 26.

- **Ambulance Handover:** LTH will significantly improve its ambulance handover performance in all categories and **eradicate >60 min handover delays** by improving flow out of the Emergency Department via the use of Continuous Flow.

- **Waiting Times: Waiting times for first clinical assessment** will reduce from166 mins (July 25) to 135 mins by March 26. **ED LOS of >12 hours from arrival** will reduce from 10.2% (24/25) to <8.2% by March 26 via the ongoing roll out of the Days Kept Away from Home (DKAFH) programme.

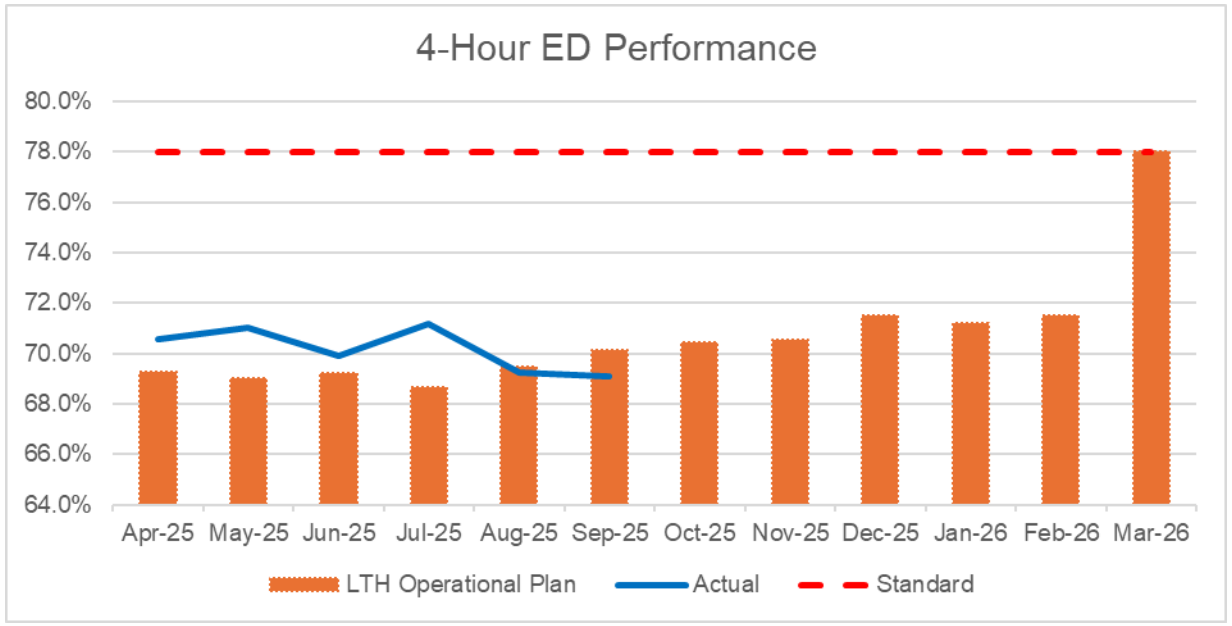
- **Length of Stay:** Non Elective Length of stay (NEL LOS), during the acute medical phase and once ready to be discharged home will reduce thus supporting optimal flow out from the Emergency Department. **NEL LOS will reduce from 7days to 5 days** and the **number of beds occupied by patients within the DKAFH cohort from 16.1% (Feb 25) to 5% by March 26**, **reducing the lost bed days by 50%.**

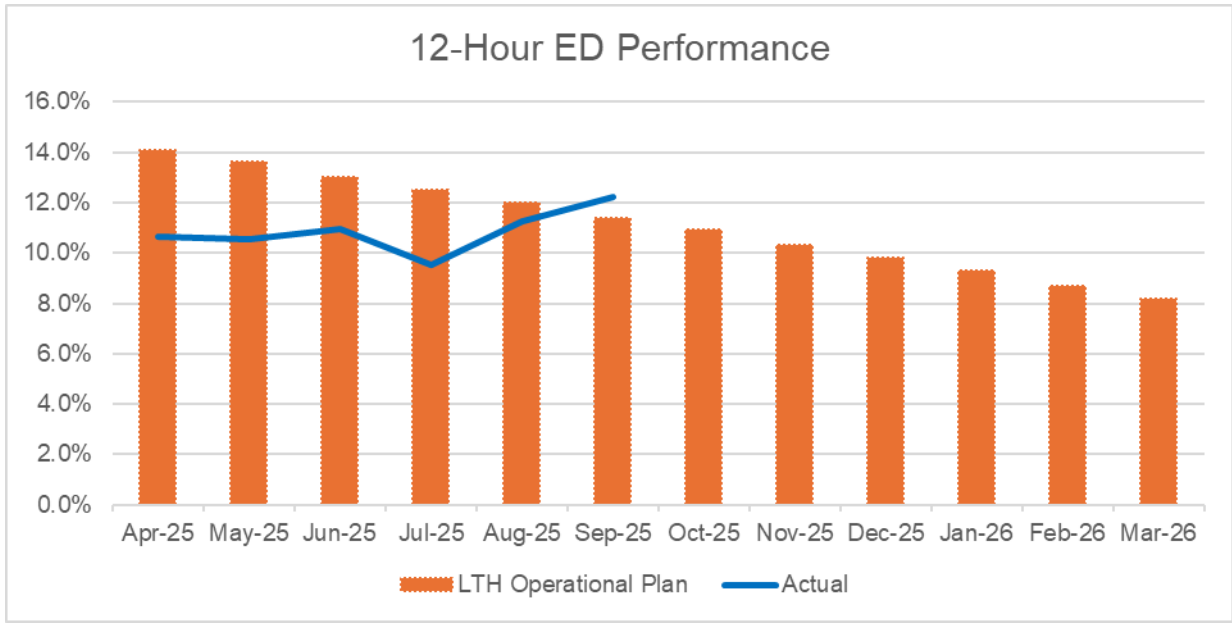
UEC Improvement Driver Diagram



Improvement trajectory 25-26 : Progress to date

The 25/26 aspirations are to improve 4 and 12 hour performance via the actions of the Central Lancashire UEC Improvement Plan

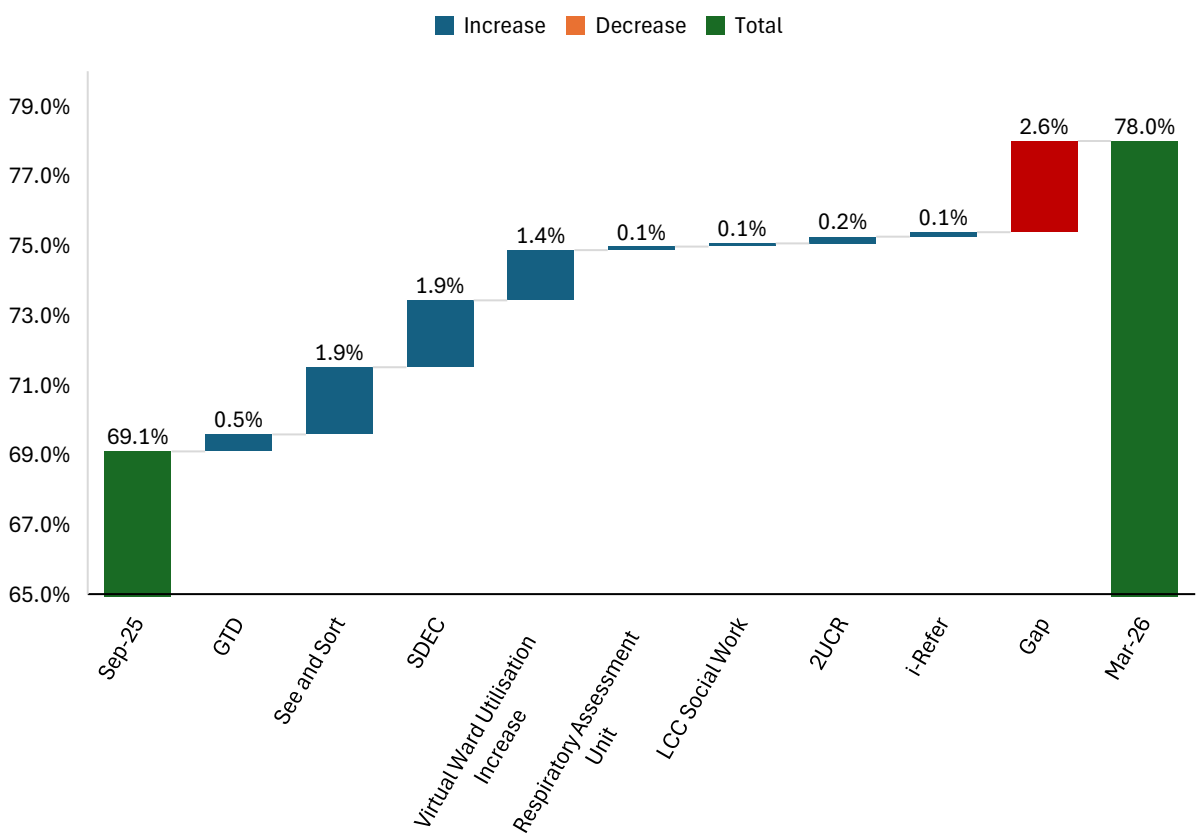




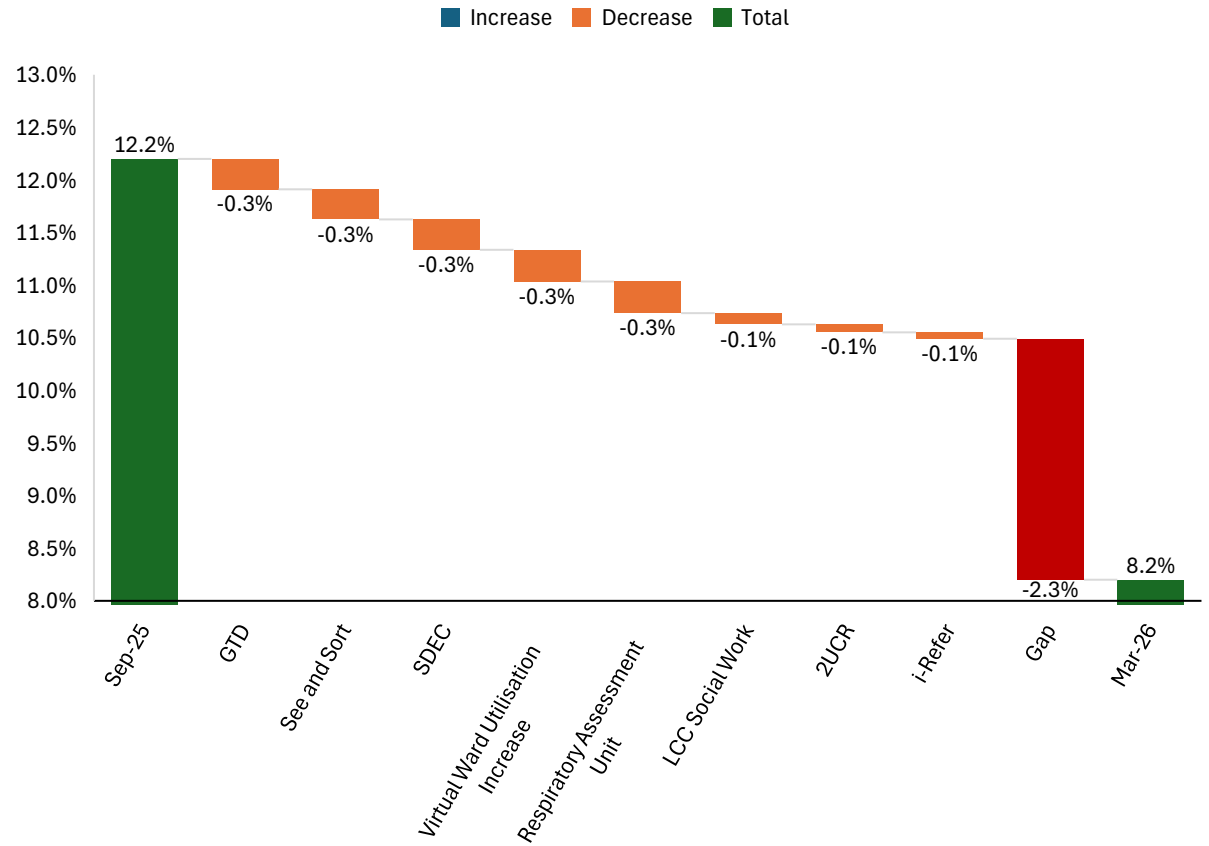
Performance against the Trusts objectives show under delivery towards the mid year point and additional stretch targets and actions have been agreed.

Improvement trajectory – stretch targets

Emergency Department 4-Hour Performance



Emergency Department 12-Hour Performance



UEC: Year 1 Improvement Actions

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April to June 2025:

- ✓ Evaluation and learning from 24/25 winter schemes
- ✓ 2 x Days Kept Away from Home cohort wards mobilised alongside cultural change programme. Results saw 25 patient care needs reduced on discharge saving 86 lost bed days
- ✓ Continuous Flow mobilised across the Trust over 7 days
- ✓ Ambulance handover protocols developed ahead of Aug launch to support 45 min R2R

July – September 2025:

- ✓ 45 min R2R launched - ~ 20% improvement in 15 and 30 min handover performance (60+ min breaches July 25 = 381, Sept 25 = 27)
- ✓ Expansion of 2UCR activity – Sept saw 22% increase in 2UCR activity versus Aug
- ✓ Days Kept Away from Home cultural change programme expanded to further 16 wards
- ✓ Site Pressure processes and ward designated daily discharge targets established

October – December 2025:

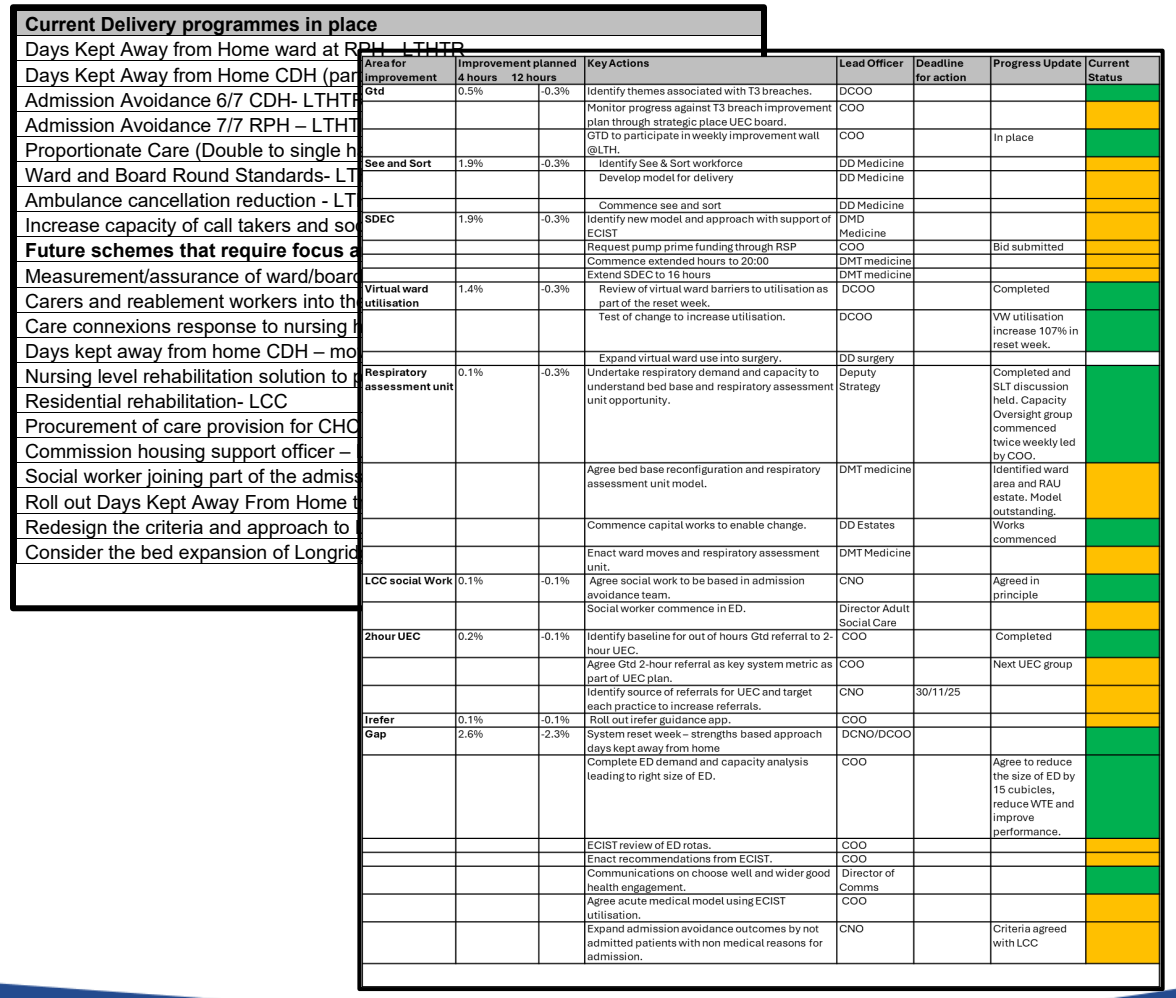
- ✓ Mobilisation of See and Sort team
- ✓ System re-set and wider learning into embedded practice WC 20.10.25
- ✓ Mobilisation of winter plans inc. expansion of SDEC hours to 8pm.
- ✓ ED C&D analysis and pathway re-modelling.
- Expansion of VW utilisation to >85%.
- ✓ Comms to be issued to Primary Care to expand 2UCR referrals.
- Rollout via enhanced comms and awareness of I-Refer guidance app to reduce diagnostic demand and waits in ED
- GTD review of Type3 breach improvement plan
- ✓ ECIST support

January – March 2026:

- Scope options to further develop SDEC 24/7
- Mobilise Respiratory Enhanced Care model changes
- Mobilise intermediate care provision to support winter flow
- Full utilisation of Community provisions (2UCR & VW)
- Admission avoidance – Social work support in ED
- Develop new Models of Care for UEC
- Expansion of Virtual Ward into Surgery

Underpinning detailed action plan

- **Detailed action plans** created to drive delivery and give confidence
- **Data-led approach** using BI to inform progress against plans
- Key workstreams with action owners assigned and timelines clearly laid out **ensuring accountability**
- Utilised at **regular forums** as outlined on the next slide.



Current Delivery programmes in place
Days Kept Away from Home ward at RPH - LTHTR
Days Kept Away from Home CDH (par
Admission Avoidance 6/7 CDH- LTHTF
Admission Avoidance 7/7 RPH – LTHT
Proportionate Care (Double to single h
Ward and Board Round Standards- LT
Ambulance cancellation reduction - LT
Increase capacity of call takers and so
Future schemes that require focus a
Measurement/assurance of ward/board
Carers and reablement workers into th
Care connexions response to nursing h
Days kept away from home CDH – mo
Nursing level rehabilitation solution to p
Residential rehabilitation- LCC
Procurement of care provision for CHC
Commission housing support officer –
Social worker joining part of the admiss
Roll out Days Kept Away From Home t
Redesign the criteria and approach to l
Consider the bed expansion of Longrid

Area for improvement	Improvement planned 4 hours	12 hours	Key Actions	Lead Officer	Deadline for action	Progress Update	Current Status
Gtd	0.5%	-0.3%	Identify themes associated with T3 breaches.	DCOO			
			Monitor progress against T3 breach improvement plan through strategic place UEC board.	COO			
			GTD to participate in weekly improvement wall @LTH.	COO		In place	
See and Sort	1.9%	-0.3%	Identify See & Sort workforce	DD Medicine			
			Develop model for delivery	DD Medicine			
			Commence see and sort	DD Medicine			
SDEC	1.9%	-0.3%	Identify new model and approach with support of ECIST	DMD Medicine			
			Request pump prime funding through RSP	COO		Bid submitted	
			Commence extended hours to 20:00	DMT medicine			
			Extend SDEC to 16 hours	DMT medicine			
Virtual ward utilisation	1.4%	-0.3%	Review of virtual ward barriers to utilisation as part of the reset week.	DCOO		Completed	
			Test of change to increase utilisation.	DCOO		VW utilisation increase 107% in reset week.	
			Expand virtual ward use into surgery.	DD surgery			
Respiratory assessment unit	0.1%	-0.3%	Undertake respiratory demand and capacity to understand bed base and respiratory assessment unit opportunity.	Deputy Strategy		Completed and SLT discussion held. Capacity Oversight group commenced twice weekly led by COO.	
			Agree bed base reconfiguration and respiratory assessment unit model.	DMT medicine		Identified ward area and RAU estate. Model outstanding.	
			Commence capital works to enable change.	DD Estates		Works commenced	
			Enact ward moves and respiratory assessment unit.	DMT Medicine			
LCC social Work	0.1%	-0.1%	Agree social work to be based in admission avoidance team.	CNO		Agreed in principle	
			Social worker commence in ED.	Director Adult Social Care			
2hour UEC	0.2%	-0.1%	Identify baseline for out of hours Gtd referral to 2-hour UEC.	COO		Completed	
			Agree Gtd 2-hour referral as key system metric as part of UEC plan.	COO		Next UEC group	
			Identify source of referrals for UEC and target each practice to increase referrals.	CNO	30/11/25		
Irefer	0.1%	-0.1%	Roll out irefer guidance app.	COO			
Gap	2.6%	-2.3%	System reset week – strengths based approach days kept away from home	DCNO/DCOO			
			Complete ED demand and capacity analysis leading to right size of ED.	COO		Agree to reduce the size of ED by 15 cubicles, reduce WTE and improve performance.	
			ECIST review of ED rotas.	COO			
			Enact recommendations from ECIST.	COO			
			Communications on choose well and wider good health engagement.	Director of Comms			
			Agree acute medical model using ECIST utilisation.	COO			
			Expand admission avoidance outcomes by not admitted patients with non medical reasons for admission.	CNO		Criteria agreed with LCC	

Single Improvement Plan

NHS
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People

Partnerships

Patients

Productivity

Performance

Year 2 & 3 : 2026/27 & 2027/28

Improvement trajectory – Year 2 & 3

NHS England – Medium Term Planning Framework – 26/27 to 28/29

Success measure	2026/27 target	2028/29 target
4-hour A&E performance	Every trust to maintain or improve to 82% by March 2027	National target of 85% as the average for the year
12-hour A&E performance	Higher % of patients admitted, discharged and transferred from ED within 12 hours across 2026/27 compared to 2025/26	Year-on-year % increases in patients admitted, discharged and transferred from ED within 12 hours
Category 2 response times	Improve upon 2025/26 standard to reach an average response time of 25 minutes	Further improvement so that by the end of 2028/29 the average response time is 18 minutes, with 90% of calls responded to within 40 minutes

Specific Acute Trust focus areas from the plan:

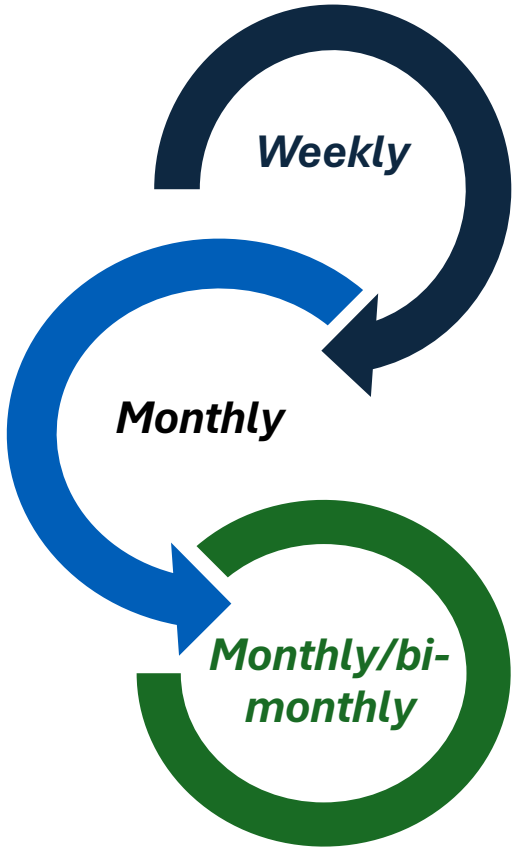
- *Acute trusts should embrace new standards and guidance on how to achieve our ambitious 4-hour performance target and use these to drive the necessary step-change, aligning with the soon to be published Model Emergency Department and clinical operational standards for the first 72 hours in hospital*
- *Providers must have a renewed and rigorous focus on ensuring that patients who are less likely to require admission are directed to a UTC by default, and that there are agreed clinical and operational processes for non-admitted patients to be seen, treated and discharged within 4 hours to reduce overcrowding in departments and improve safety*
- *Providers must also continue to improve emergency department paediatric performance, with the expectation*

LTH commitments to Urgent & Emergency Care in Year 2 & 3: 2026/27 and 2027/28

- **4 Hour ED Performance:** LTH will ensure that it meets the national ambition of 85% of all Emergency Department presentations seen, assessed, discharged or admitted within 4 hours of arrival. This will be delivered by reducing ED overcrowding because of increased capacity within community services, reduced waiting times for first clinical assessment via better alignment of workforce to meet demand and alternative clinical pathways for assessment outside of ED.
- **Ambulance Handover:** LTH will have eradicated handover delays of 45 mins and above and will deliver 95% of handovers within 30 minutes.
- **Waiting Times: Waiting times for first clinical assessment** will reduce to 120 mins by March 28. ED LOS of >12 hours from arrival will reduce to lowest quartile by March 2028 via the ongoing roll out of the Days Kept Away from Home (DKAFH) programme.
- **Length of Stay:** Non Elective Length of stay (NEL LOS) will be at peer upper quartile levels by March 28 having embedded the Days Kept Away from Home cultural change programme throughout all wards.

Governance and oversight to support delivery

LTH Governance:



Cross Divisional performance huddles

- *Cross checking UEC performance data for early warning information. Checking Divisional & placed-based actions are being progressed*

LTH Ops Board – UEC focus

- *Executive-led weekly board rotating between UEC, Cancer, RTT & Diagnostics*
- *Reviewing scorecard data to test plan delivery and progress*
- *Scrutinizing improvement plans and setting direction*

Finance & Performance Committee / Bi-monthly Public Board

- *Executive and Non-Executive oversight and assurance through formal Trust Committee and Board structure*
- *Directly aligned with the Integrated performance framework*

The Central Lancashire Operational Delivery Group

A monthly joint forum working as a wider system with community partners. An overarching approach to simplify and focus on 2 key areas.

1. *Days Kept Away from Home)*
2. *Intermediate Tier Services*

13.1 - GGI REPORT ? ACTION PLAN AGAINST RECOMMENDATIONS AND FINAL FORM RSP EXIT CRITERIA

REFERENCES

Only PDFs are attached

13.1 - GGI Report ? Action Plan Against Recommendations and Final Form RSP Exit Criteria ancillary paper.pdf

Board of Directors Report

1. Background / context or introduction

This report is presented in two parts:

i. To consider the action plan developed following a Board workshop in October in response to the GGI well led review (as presented to the PII August Board meeting); and
ii. To acknowledge the Recovery Support Programme (RSP) Exit Criteria in final form.

The GGI were commissioned by the Trust to undertake a well led review, with the initial report submitted to the August part II board meeting for consideration. In October the Board used a workshop to refine the actions to be taken to address the recommendations in the report.

2. Discussion

It is a CQC requirement for NHS Trusts to undertake a periodic independent review of its leadership function (well-led), ordinarily on a three-year cycle. This was last undertaken by the Trust in 2022. In order to assess the improvement trend from that review and to understand the impact of measures taken as a result of that review, GGI were commissioned to undertake the work. In addition, the Trust is currently receiving support from NHSE as a result of the receipt of additional licence undertakings for finance and governance. As part of the Recovery Support Programme, NHSE agreed to consider the outcome of the GGI as part of its wider review.

The GGI report in full is produced again as an appendix in the ancillary pack of papers for this meeting. The action plan to address the recommendations is included as Appendix 1 to this report.

The RSP exit criteria were considered initially in the special part II Board held in October and are reproduced here as part of the ancillary pack to recognise them in final form.

In order for the Board to be fully sighted on the completion of the actions these will be subsumed into the relevant parts of the Single Improvement Plan. Oversight of completion will then fall within the PMO and SIP Oversight Board.

3. Financial implications

Then implementation of the actions will have varying degrees of financial resource expectation. All actions will need to be implemented cognisant of the current financial position of the Trust.

4. Legal implications

The completion of a regular well led review is a CQC requirement.

5. Risks

The completion of the action plan will support the Trust journey to National Oversight Framework 2, CQC ‘good’ and exit from RSP.

6. Impact on stakeholders

The implementation of the action plan will have a positive impact on a range of internal and external stakeholders and key partners.

7. Recommendations

It is recommended that:

1. The action plan to address the recommendations as set out in the GGI well led review of August 2025 be adopted and subsumed within the Single Improvement Plan.
2. The Recovery Support Programme exit criteria be acknowledged in final form.

Strategy
Leadership
Governance

NHS
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NHS Foundation Trust

Lancashire Teaching Hospitals NHS Foundation Trust

Well-led Review

A report from GGI

July 2025

www.good-governance.org.uk

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We work to make sure that organisations are run by the most talented, skilled and ethical leaders possible and work to build fair systems that consider all, use evidence, are guided by ethics and thereby take the best decisions. Good governance of all organisations, from the smallest charity to the greatest public institution, benefits society as a whole. It enables organisations to play their part in building a sustainable, better future for all.

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Lancashire Teaching Hospitals NHS Foundation Trust

Well Led Review

Document name: Final report
Date: July 2025
Authors: Joe Roberts, Senior Consultant, GGI
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Maurizio Cuttin, Junior Consultant, GGI
Reviewed by: Janice Smith, Principal Consultant, GGI

This report has been prepared by GGI Development and Research LLP (T/A GGI) for the board of Lancashire Teaching Hospitals NHS Foundation Trust. The report highlights the conclusions drawn from the governance structures and diversification review commissioned by the board and offers an outline of future suggested actions and improvements to address identified shortcomings and strengthen the organisation's governance.

The matters raised in this report are limited to those that came to our attention during this assignment and are not necessarily a comprehensive statement of all the opportunities or weaknesses that may exist, nor of all the improvements that may be required. GGI Development and Research LLP has taken every care to ensure that the information provided in this report is as accurate as possible, based on the information provided and documentation reviewed. However, no complete guarantee or warranty can be given with regard to the advice and information contained herein. This work does not provide absolute assurance that material errors, loss or fraud do not exist.

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GGI has carried out client work with around 1,000 organisations over the last decade-and-a-half. We are part-owned by the Good Governance Institute, the EU-based independent governance reference centre focusing on the public and third sectors. We have specific expertise in governance reviews of complex public purpose organisations. Our high-quality and ethical governance consultancy is carried out by our specialist staff team, supported by subject matter expert associates and partners.

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Table of Contents

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Section 1 – Introduction

Context and scope

In April 2025, Lancashire Teaching Hospitals NHS Foundation Trust (LTH) appointed GGI to undertake a well-led review of the trust. This review includes an assessment of the effectiveness of the board and its supporting governance, in line with the Care Quality Commission's (CQC) eight well-led quality statements.

The primary scope of this review is to make recommendations on how the governance of the organisation – primarily through its Board of Directors, but also its committees, the Council of Governors and the wider control environment – ensures that the organisation is best set up to maximise impact, efficiency and effectiveness. The goal is to further evolve the governance structure in a spirit of continuous improvement and to support the board's development as they seek to realise their full potential.

This report provides a summary of the key findings and recommendations for the board to consider and includes a section of detailed findings based on eight key areas, which are:

1. Shared direction and culture
2. Capable, compassionate and inclusive leaders
3. Freedom to speak up
4. Workforce equality, diversity and inclusion
5. Governance, management and sustainability
6. Partnerships and communities
7. Learning, improvement and innovation
8. Environmental sustainability and sustainable development

Methodology

The review was undertaken using a well-established technique grounded in the triangulation of evidence. This conforms with the standard for well-led reviews set in the NHS Improvement and Care Quality Commission guidance of June 2017.

GGI's review process used a variety of materials, templates and benchmarking tools to guide various review activities, which included:

- semi-structured interviews with board members and other key personnel of LTH
- semi-structured interviews with representatives of important external stakeholders
- joint interviews with patient safety and clinical effectiveness leads
- focus groups with key staff groups and with governors
- observing meetings of the board and its assurance committees
- a review of relevant documentation
- an anonymous online *Confidence in Governance* survey circulated via trust communications

Appendix A lists the sources of evidence for our review, and appendix B summarises the results of our confidence in governance survey.

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Acknowledgements

The GGI review team would like to thank everyone who made themselves available for interviews and those who provided project support and documentation for review. In particular, we would like to thank Sarah Morrison, who was the executive sponsor for the project, and also Simon Regan and Jennifer Foote, who were key points of contact throughout.

Limitations

The review is limited to the documentation that was provided to GGI during the period described, and to the information provided by those we interviewed as part of this process or observed at those meetings we were able to attend. This, together with the other limitations detailed below, provides a caveat to the report's findings. It should also be noted that the review was mostly carried out virtually, with limited attendance on site.

Due to lack of diary availability within the time frame for our review, it was not possible to interview as many external stakeholders as originally intended, for example, at the time of writing we have not yet been able to meet with local authority representatives. Nor was it possible to observe a meeting of the Council of Governors, as none were scheduled during the time frame for our fieldwork.

This report does not assess the governance of the clinical divisions in detail. GGI will be facilitating governance improvement workshops with each division in the near future, and the outcomes of this exercise will be shared in a separate report.

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Section 2 – Executive Summary

This is the report of GGI's Well Led review of Lancashire Teaching Hospitals NHS Foundation Trust (LTH), which was undertaken between May and July 2025. This was an opportune time to conduct such a review, when the trust was facing considerable pressure but was also developing and implementing plans for change and making progress with long-standing issues, under the direction of a mostly new board and executive team.

The backdrop for the review was a severe financial deficit, which had been accumulating for several years to the point where the trust was recently placed in NHS England's Recovery Support Programme. This was a consistent topic of conversation in almost every interview or focus group which we held with board members or staff, and it is felt at every level of the organisation, day to day.

To its credit, the trust's leadership has frankly acknowledged the financial challenge and has been proactive in seeking external support and guidance. There is already evidence of progress in identifying and achieving realistic cost savings. However, there is a pressing need to communicate with staff about what is being done and why. We found concern, frustration and also a degree of confusion among the workforce about the financial squeeze and its effects, such as restrictions on recruitment and tight controls on the purchase of supplies. There is widespread recognition among staff of the seriousness of the situation and the need to control spending, but leaders need to give their people confidence that their plan will succeed in balancing the books, and to tell a story about how life will be better once it has done so. The task is to win hearts and minds by explaining how financial stability benefits patients, employees and the whole trust.

Notwithstanding the difficult environment in which it operates, the trust has not forsaken its ambitions and is working hard to make a reality of aspirations such as achieving university hospital status, improving its CQC rating and playing a greater role in the delivery of community-based health services. It has formulated a Single Improvement Plan based around its objectives and five portfolios of work. The plan balances immediate priorities with longer-term goals and includes measures of success.

LTH also has the infrastructure in place to help colleagues achieve organisational goals, in the form of a central improvement team, a restructured and better-resourced programme management office, and a home-grown improvement methodology. Both quality governance and the risk management process continue their journey of maturity. The trust has emulated good practice from elsewhere while also applying its own home-grown ideas that have made a positive difference.

The trust is part of one of the country's most financially challenged integrated care systems, serving many communities afflicted by poor health outcomes in a region marked by socio-economic inequality. The trust, which we heard was once seen as inward-looking, is now playing an active, constructive and leading role in the system. This has helped to unblock several problematic issues and to progress service reconfigurations that should improve the quality and performance of clinical and administrative services across Lancashire and South Cumbria, putting them on a more secure footing in terms of their finances and workforce. However, many of these initiatives are in the early stages of delivery – the proof of the pudding will be in the eating, in other words how the new service models are implemented and how they work in practice.

The trust's board has changed greatly since GGI last worked with LTH – there is an entirely new non-executive cohort and only a minority of directors remain from the team that was in place three years ago. This turnover has been mirrored at the divisional level, where new leadership triumvirates are taking shape. Such extensive change has been unsettling for some staff who had become accustomed to a very long-serving, stable leadership team, and new board members are still making themselves known to colleagues across the trust.

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Our impression of the new board is that it is comprised of highly capable people with a breadth and depth of experience acquired both in the NHS and the world outside. Notably, several have experience of turnaround in challenged organisations, which will be useful in confronting the financial deficit. The new directors appear to be forming a cohesive team and at board and committee meetings we saw good examples of constructive challenge and seeking assurance. Examples of working as a unitary board included executive-to-executive challenge, and individuals contributing widely to debate beyond their own portfolios. There have also been various practical changes to governance processes which, while small in themselves, will help to give board members greater clarity, and support them in asking the right questions and holding colleagues to account.

Overall, the trust has undoubted strengths that should see it through these difficult times and help it to fulfil its ambitions. The trust is clear with itself and others about the challenges it faces and is equally clear about what it needs to do, but it will need to maintain focus on delivery while ensuring that it takes its workforce with it on the journey, by listening, explaining and persuading.

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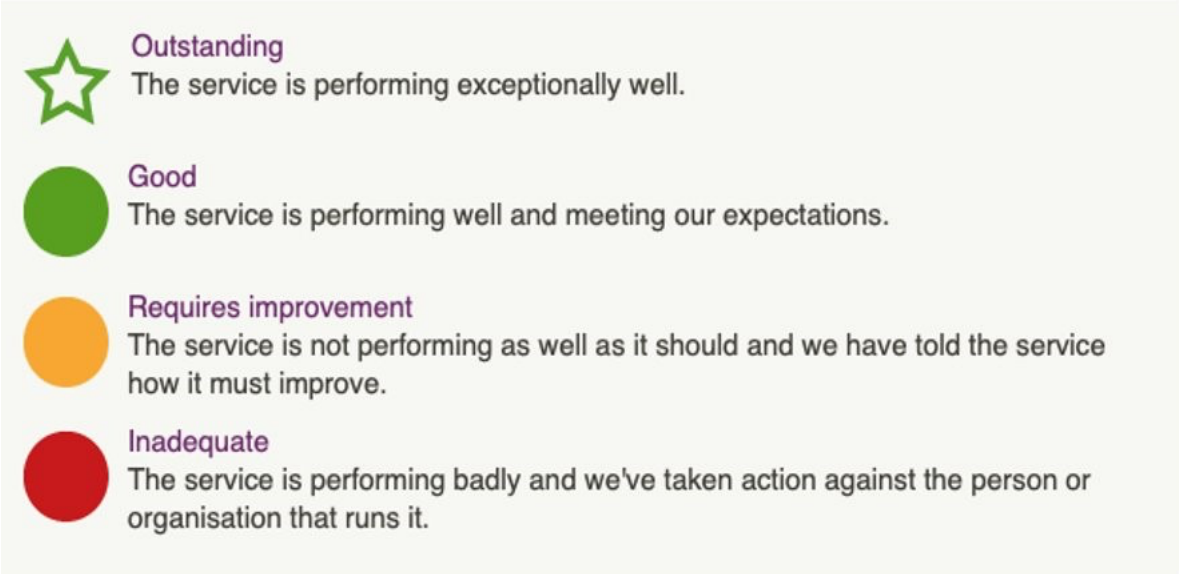
Section 3 – Background to the Well-led Review

The Care Quality inspects NHS and other care services and ask five key questions of them as set out below.

Are they safe?	Safe: you are protected from abuse and avoidable harm.
Are they effective?	Effective: your care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence.
Are they caring?	Caring: staff involve and treat you with compassion, kindness, dignity and respect.
Are they responsive to people's needs?	Responsive: services are organised so that they meet your needs.
Are they well-led?	Well-led: the leadership, management and governance of the organisation make sure it is providing high-quality care that's based around your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.

The ratings are set out below:



The CQC will carry out a well-led review as a specific inspection, in addition to considering leadership when reviewing individual services. A review will generate a rating and actions for improvement. It is important to note that the overall rating cannot be higher than the rating for the well-led domain so attention to this element of the inspection process should be an area of high priority.

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For the well-led domain, until recently there were eight key lines of enquiry (KLoEs):

These have now been replaced by quality statements and although they cover many of the same areas, there is a different emphasis with more focus on:

- partnerships (system working)
- equality, diversity and inclusion, and staff health and wellbeing
- environmental sustainability

There is also a change in language; the quality statements all begin with 'we'. They are active phrases rather than questions.

The CQC well-led quality statements are as follows:

Shared direction and culture
We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement and understanding challenges and the needs of people and our communities in order to meet these.

Capable, compassionate and inclusive leaders
We have inclusive leaders at all levels and understand the context in which we deliver care, treatment and support and embody the culture and values of the workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively. They do so with integrity, openness and honesty.

Freedom to speak up
We foster a positive culture where people feel they can speak up and their voices will be heard.

Workforce equality, diversity and inclusion
We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality and equity for people who work for us.

Governance, management and sustainability

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We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes and we share this securely with others when appropriate.

Partnerships and communities
We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

Learning, improvement and innovation
We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.

Environmental sustainability – sustainable development
We understand any negative impact of our activities on the environment, and we strive to make a positive contribution in reducing it and support people to do the same.

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Section 4 – Findings and Recommendations

Findings

Shared direction and culture

Findings

The Single Improvement Plan brings together the trust's main programmes of work and sets the direction of travel for the next three years. There is a need to raise employees' awareness of this plan and to give them confidence that the trust will overcome its financial difficulties. There is a strong commitment to excellent care at every level of the organisation and staff are very proud to work for this trust and for the NHS. However, morale has been affected by the trust's recent difficulties.

Recommendations

- The trust should communicate the key points of the Single Improvement Plan to staff using a variety of communication channels in a bite-sized, user-friendly form that is accessible to busy front-line staff.
- The trust needs to create and communicate a consistent narrative to the workforce about the trust's finances that acknowledges that while the next year or two will be difficult, there will be light at the end of the tunnel.
- This narrative should also cover how any risks to safety or patient experience arising from waste reduction proposals are identified and mitigated, and that efficiency should not come at the expense of clinical quality.
- The trust should publicise its employee wellbeing and support services to demonstrate its care for colleagues' welfare.

Capable, compassionate and inclusive leadership

Findings

Following a period of leadership turnover, there is a mostly new board in place. The board includes a wide range of talent and experience and is coming together as a unitary board but may benefit from focused development. With so many new faces at the top, it will be important to raise the profile of board members among the workforce and external stakeholders. The trust develops leaders from within through a range of training programmes and development opportunities. It aims to promote compassionate and inclusive leadership while ensuring accountability for performance and delivery.

Recommendations

- The trust should look at options that would address the need for consistency of leadership after the new NEDs' one-year terms expire next year.
- The trust should publicise the identity of members of the board as widely as possible, for example by means of posters around the sites, so that they are more widely recognised.
- The board development programme should include soft skills such as constructive challenge and working together as a unitary board, as well as topical issues and strategic discussion.
- The trust should ascertain the extent of any obstacles to staff participating in professional development activities, such as workloads and staffing shortages.

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Freedom to speak up

Findings

Speaking up has been actively promoted by the trust and staff understand how to raise their concerns and with whom. The trust takes employees' concerns seriously and monitors trends and themes, ensuring that action is taken to address them. However, over the past year the number of people raising concerns through FTSU has reduced and we heard varied views about why this might be.

Recommendations

- The trust should use corporate communications to introduce the new Guardian to the workforce and ensure they are as widely recognised as possible.
- Promotional materials and information campaigns about FTSU should emphasise changes and improvements that have been made in response to concerns raised by employees, to demonstrate that speaking up is worthwhile.
- Regular, diarised meetings should be arranged for the FTSU Guardian to check in with the Chief Executive, and periodically with the Chair.

Workplace equality, diversity and inclusion

Findings

The trust demonstrates a strong commitment to equality through a comprehensive strategy, active leadership involvement, and inclusive staff forums. Staff feel supported and engaged through a range of different initiatives. While there is room for improvement around representation and workplace culture, the trust leadership is aware of these challenges and is actively working to address them.

Recommendations

- In addition to embedding EDI into recruitment and appraisals, the trust should consider ways to specifically target diversity and representation within senior leadership roles.
- The trust should develop a communications plan around EDI, covering the context, what the trust is doing to promote equality, and what has been achieved already.
- The Trust is actively exploring ways to reduce staff sickness absence. We encourage continued focus and innovation in this area, ensuring that interventions are inclusive and responsive to the diverse needs of the workforce.
- The Trust should review the role and effectiveness of the EDI Strategy Group, particularly in terms of its ability to escalate issues both upwards to senior leadership and downwards to operational teams.
- The Trust should explore how it can ensure that the experiences of staff with protected characteristics are consistent across all divisions, to identify and address any disparities.

Governance, management and sustainability

Findings

Board and committee meetings are conducted well with a focus on constructive challenge and seeking assurance. Some management information provided to the board and committees could be more concise and focused. The trust has a suite of robust policies and procedures, including for risk management, where a great deal of work has been done. There is scope to improve how the Board of Directors and the Council of Governors interact with each other.

Recommendations

- The trust should consider whether the Workforce and Education, Training and Research Committees can be brought together as one committee.

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- Those who review papers prior to their inclusion in board and committee agenda packs should encourage report authors to condense their reports wherever possible. The trust may also consider some further training on writing reports.
- The trust should consider how, working within the current financial constraints, it could encourage more local people to become public members and to participate in trust business, such as voting in governor elections.

Partnerships and communities

Findings

The trust serves communities affected by health inequalities and poor outcomes which it cannot tackle alone. These require joint working across health and social care partners and the wider public sector to address. The trust is now playing a more active, visible and influential role in the local integrated care system. Better partnership working between providers in the system has helped to drive forward much needed reconfigurations of clinical and administrative services. However, many of these initiatives are in the early stages of implementation, so the benefits are yet to be felt.

Recommendations

- The trust should carry out a stakeholder mapping exercise to identify all external stakeholders and create an action plan for engaging with each.
- The trust should continue to focus on building a positive relationship with the ICB during this period of change.

Learning, improvement and innovation

Findings

There is a clear focus on learning, improvement and innovation throughout the trust. This is evident in messages from the top of the organisation, in plans and objectives, policies and processes, and the infrastructure that the trust has put in place. However, the results of our confidence in governance survey painted a mixed picture and not all staff are fully confident that the trust puts into practice what it has learned from incidents.

Recommendations

- As part of the communications around the new patient safety strategy to be launched later in the year, the trust should emphasise how incident reporting and investigation leads to changes for the better, giving examples where appropriate.
- The strategy should also cover how staff are supported following an incident in which they have been involved.
- Amid the immediate financial pressures, the trust should maintain the importance and profile of quality improvement work, which is crucial to ensuring its own long-term sustainability and achieving efficiencies.

Environmental sustainability

Findings

The trust was in the process of updating its Green Plan at the time of our review. The trust is committed to sustainability and can demonstrate practical measures it has taken to support the environment. These initiatives have generally been funded by successfully bidding for ad hoc funding opportunities, rather than from a core budget. Employees are willing to play their part in contributing to Net Zero, but the environmental agenda is often overshadowed by more immediate concerns such as finance, operations and quality.

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Recommendations

- The trust should consider ways to increase staff engagement with sustainability, including through support from the board and senior leadership.
- The trust should consider how it can encourage sustainable procurement in the system through OneLSC.

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Section 5 – Detailed findings

Shared direction and culture

Quality Statement: We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these.

What this quality statement means

- Leaders ensure there is a shared vision and strategy and that staff in all areas know, understand and support the vision, values and strategic goals and how their role helps in achieving them.
- Staff and leaders ensure that the vision, values and strategy have been developed through a structured planning process in collaboration with people who use the service, staff and external partners.
- Staff and leaders demonstrate a positive, compassionate, listening culture that promotes trust and understanding between them and people using the service and is focused on learning and improvement.
- Staff at all levels have a well-developed understanding of equality, diversity and human rights, and they prioritise safe, high-quality, compassionate care.
- Equality and diversity are actively promoted, and the causes of any workforce inequality are identified and action is taken to address these.
- Staff and leaders ensure any risks to delivering the strategy, including relevant local factors, are understood and have an action plan to address them. They monitor and review progress against delivery of the strategy and relevant local plans.

Summary of findings: *The Single Improvement Plan brings together all the trust's main programmes of work and sets the direction of travel for the next three years. There is a need to raise employees' awareness of this plan and to give them confidence that the trust will overcome its financial difficulties. There is a strong commitment to excellent care at every level of the organisation and staff are very proud to work for this trust and for the NHS. However, morale has been affected by the trust's recent difficulties.*

Culture and values

The bulk of our fieldwork for this review consisted of semi-structured interviews and focus groups, involving people at different levels of seniority and from a range of professions and departments. These generated rich, free-flowing and candid discussions. Through all these conversations, a desire to deliver the best quality of care possible and put patients first shone through. There was also a real sense of pride in working for the NHS and for their local hospital. Many people told us that their wards and departments were supportive and inclusive environments to work in, and that they felt comfortable approaching their managers with issues and suggestions.

The trust has a clear set of values which emphasise care both for patients and for colleagues, and balance teamwork with the needs, preferences and aspirations of the individual. It has an organisational development

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team which can support teams with positive interventions to improve line management, teamwork and communication using a Team Engagement and Development continuous improvement toolkit that has been developed in-house. We were also given some anonymised examples of individuals being held accountable for poor behaviour that was inconsistent with the trust's values.

Plans and strategies

The Single Improvement Plan (SIP) brings together the trust's objectives, and the portfolios of work that will deliver these objectives over the next three years, under the 5Ps - partnerships, people, patients, productivity, and performance. Bringing all improvement activities and plans together in one combined document like this is good practice that has helped other NHS organisations which have found themselves in a similar position to LTH. The trust does not formally have an overarching strategy, but the SIP is comprehensive and sets a clear direction of travel, so it performs a similar function. The previous *Big Plan* had reached the end of its three-year lifespan and been overtaken by events, such as the status of the trust's application to build a new hospital to replace the Royal Preston Hospital. The trust will be working on a clinical and site services strategy in the near future; the ageing estate and the long timescales for replacement of existing buildings provide extra impetus for this work.

Because of the need for swift action to stabilise the trust, the SIP was produced quickly – in 90 days – which limited the amount of consultation and stakeholder engagement that the trust could do, but executive directors did facilitate workshops with clinical leaders. Year 2 of the SIP has been developed with the leaders of the organisation. It will be communicated to staff through a comprehensive communications and engagement strategy. Executives acknowledged that staff outside the ranks of senior management were not yet familiar with the SIP.

Staff morale and engagement

The executive team endeavour to set a positive 'tone from the top' and to keep staff informed about their work and future plans, emphasising that quality, and not only financial balance, matters. For example, the Chief Executive hosts a regular team brief event that is attended by around 250 colleagues and tries to visit at least one ward or department every week. The Chief Nurse briefs matrons, ward managers and allied health professional leads every week, and the chief medical officer does similarly with consultants. There are regular board visits to clinical services, and safety visits that allow interaction with front-line staff.

However, the results of our confidence in governance survey, along with free text comments added by respondents, indicate that these messages are not consistently being received and understood by all of the workforce, and that morale has been hit by the trust's recent difficulties. This is consistent with the outcome of CQC's national staff survey conducted late in 2024, which showed a decline in overall morale and engagement, with the scores for several questions being below the national average for the first time in many years; a paper summarising the survey talked of an *"overall sense of frustration, apathy and being unheard"*.

Only 44% of respondents to GGI's confidence in governance questionnaire agreed with the statement that *"I trust the board and senior managers of Lancashire Teaching Hospitals NHS Foundation Trust to act in the best interests of patients"* and just 26% agreed that *"I trust the board and senior managers of Lancashire Teaching Hospitals NHS Foundation Trust to act in the best interests of staff"*. Opinion about whether patient safety and quality of care is the most important matter for the board and senior managers was evenly divided (51% agree, 49% disagree). More people agreed than disagreed that that the trust's priorities and objectives were clear (47% against 24%) but an unusually large proportion (29%) gave a neutral response. The responses to the statement *"I know how I can contribute towards achieving these objectives"* were very similar.

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While these results were disappointing and require to be addressed, it was encouraging that staff spoke so openly to us in focus groups about their concerns and frustrations, and that our survey attracted a respectable response rate approximating 7% of the entire workforce in just two weeks. In our wide experience of well led and governance reviews, problematic cultures are characterised by silence from below, where more junior staff are unwilling to contribute to surveys like ours or join focus groups, and are very reserved if they do participate. That was emphatically not the case here.

Recommendations

- The trust should communicate the key points of the Single Improvement Plan to staff using a variety of communication channels in a bite-sized, user-friendly form that is accessible to busy front-line staff.
- The trust needs to create and disseminate a consistent narrative to the workforce about the trust's finances that acknowledges that while the next year or two will be difficult, there will be light at the end of the tunnel.
- This narrative should also cover how any risks to safety or patient experience arising from waste reduction proposals are identified and mitigated, and that efficiency should not come at the expense of clinical quality.
- The trust should publicise its employee wellbeing and support services to demonstrate its care for colleagues' welfare.

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Capable, compassionate and inclusive leadership

Quality statement: We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively. They do so with integrity, openness and honesty.

What this quality statement means:

- Leaders have the experience, capacity, capability and integrity to ensure that the organisational vision can be delivered, and risks are well managed.
- Leaders at every level are visible and lead by example, modelling inclusive behaviours.
- High-quality leadership is sustained through safe, effective and inclusive recruitment and succession planning.
- Leaders are knowledgeable about issues and priorities for the quality of services and can access appropriate support and development in their role.
- Leaders are alert to any examples of poor culture that may affect the quality of people's care and have a detrimental impact on staff. They address this quickly.

Summary of findings: *Following a period of leadership turnover, there is a mostly new board in place. The board includes a wide range of talent and experience and is coming together as a unitary board but may benefit from focused development. With so many new faces at the top, it will be important to raise the profile of board members among the workforce and external stakeholders. The trust develops leaders from within through a range of training programmes and development opportunities. It aims to promote compassionate and inclusive leadership while ensuring accountability for performance and delivery.*

A new team at the top

At the time of our fieldwork, the trust was emerging from a prolonged period of leadership turnover. The chief executive took up his post in January 2024, and the chair came into office one year later. Both took over from predecessors who had served on an interim or short-term basis. Of the executives, the Chief Operating Officer, Chief People Officer and Chief Finance Officer have all joined the board within the past eighteen months. The trust has recently appointed a new Chief Medical Officer who will start in post in October, following a one-month handover with the existing CMO. However, it is among the non-executive membership of the board where the change has been greatest. Four of the most established non-executive directors departed early in 2025 and were replaced by newcomers, who were appointed in March this year for an initial term of only one year. These new joiners, along with other relatively recent appointees, have formed a new non-executive cohort from the non-executives who were in post when we last worked with LTH in summer 2022.

The new executive team is comprised of experienced directors who have worked in comparable roles in other large NHS trusts and have track records of leading transformation and improvement. The non-executives bring experience from medicine, healthcare management, accountancy, the law, academia and the third sector. Several have served as non-executive directors in other NHS trusts and others have held equivalent roles, such

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as governors or trustees, in different sectors. Clearly the board is a strong group of well-qualified individuals. Board members perceive that they are building good working relationships with one another and coming together as a cohesive team. There is a strong relationship between the Chair and Chief Executive based on trust and mutual respect.

Supporting the board to develop

It is unusual for so many new NEDs to join a board all at once and at such short notice. The trust has done well to support the newcomers with a very informative introductory handbook and an individualised onboarding programme of one-to-one meetings, site visits, and reading material that extends over their first few months in office. The board holds development seminars for its members in alternate months. These are mostly used to bring members up to date with topical issues affecting the NHS (for example the new CQC inspection framework or the New Hospitals Programme) or to explore strategic issues in more depth than is possible in a formal board or committee setting. They frequently have busy agendas. With so many new members on the board, it would be helpful to use some of these sessions to allow members to get to know each other better and develop further the 'soft skills' of working together as a board.

There is a real effort to enhance the visibility of the board within the organisation. Non-executives have taken advantage of the opportunity to visit different departments, to see services in action for themselves and to be seen. They are each being aligned to divisions of the trust which they will visit and liaise with regularly. One notable and innovative form of communication is a weekly vlog, which is hosted by a different executive director each week. With so many new faces around the board table, it will be necessary to raise the profile of the board further inside the trust, both individually and collectively. Anecdotally, in our focus groups, front-line staff were generally familiar with the leaders of their divisions, but less so with executive directors.

Developing leaders

While recent executive appointments have been drawn from outside, the trust does invest in home-grown talent. A strong leadership and organisational development offer has been a feature of this trust for many years, and LTH generates income which covers the cost of this work by marketing its training provision to other organisations. During our review, we spoke to people such as senior doctors who had completed the Clinical Director Development or Consultant Stretch programmes which they had found to be of great practical benefit. In the past, the trust has run 'shadow board' programmes for deputy or associate directors who are ambitious to move up to executive level. Several interviewees had also received more individualised professional development, such as one-to-one coaching, and courses covering topics such as population health or quality improvement. The trust participates in national programmes such as those run by the NHS Leadership Academy.

Staff at all levels who participated in our focus groups were aware of the range of training and development that is available to them, although as we have heard in many NHS organisations, the pressure of work can make it difficult to find time to take advantage of the opportunity. Some participants also questioned the value of taking part in view of the trust's financial deficit, which they feared would reduce opportunities for career progression in the future. Our survey shows that 44% of respondents had participated in some form of professional development over the past twelve months – this is a high figure which could include a range of activities besides formal training courses, such as work shadowing, secondments, attendance at conferences, or simply opportunities to get involved in new areas of work and practice new skills.

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Leadership style and approach

Executives aim to promote a compassionate and inclusive approach to leadership, and several gave us examples of how they try to do this in their own work. The trust has the capability in its organisational development function to undertake cultural reviews where there are indications of poor culture or inadequate leadership in teams. Some who were newer to the trust perceived that historically there had been a "paternalistic" style of leadership and were aiming to give divisions and directorates more autonomy, while at the same time making them more accountable for delivery. The trust has a well-established programme of Divisional Improvement Forums – regular meetings for each division at which the divisional leadership teams are held to account by executives. These have been supplemented with a new Accountability Framework which sets out accountabilities and how the performance management process operates, loosely based on the NHS's national oversight framework. Clarifying accountabilities in this way by bringing this information together on paper is an example of good practice that is surprisingly uncommon in NHS trusts.

Recommendations

- The trust should look at options that would address the need for consistency of leadership after the new NEDs' one-year terms expire next year.
- after the new members' one-year terms expire next year.
- The trust should publicise the identity of members of the board as widely as possible, for example by means of posters around the sites, so that they are more widely recognised.
- The board development programme should include soft skills such as constructive challenge and working together as a unitary board, as well as topical issues and strategic discussion.
- The trust should ascertain the extent of any obstacles to staff participating in professional development activities, such as workloads and staffing shortages.

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Freedom to speak up

Quality statement: We foster a positive culture where people feel that they can speak up and that their voice will be heard.

What this quality statement means:

- Staff and leaders act with openness, honesty and transparency.
- Staff and leaders actively promote staff empowerment to drive improvement. They encourage staff to raise concerns and promote the value of doing so. All staff are confident that their voices will be heard.
- There is a culture of speaking up where staff actively raise concerns and those who do (including external whistleblowers) are supported, without fear of detriment. When concerns are raised, leaders investigate sensitively and confidentially, and lessons are shared and acted on.
- When something goes wrong, people receive a sincere and timely apology and are told about any actions being taken to prevent the same happening again.

Summary of findings: *Speaking up has been actively promoted by the trust and staff understand how to raise their concerns and with whom. The trust takes employees' concerns seriously and monitors trends and themes, ensuring that action is taken to address them. Over the past year the number of people raising concerns through FTSU has reduced and we heard varied views about why this might be.*

Employee awareness

The Freedom to Speak Up (FTSU) process appears to be well known and understood by staff, along with other ways that employees can speak up such as escalating through their line managers or even approaching executives directly. 92% of the respondents to GGI's confidence in governance questionnaire said that they knew how to contact the Freedom to Speak Up Guardian if they needed to and 90% agreed with the statement, *"if I have any concerns relating to the service I work in, I know how to raise them within the trust, and with whom".*

The trust is raising awareness further by training local FTSU champions – who will promote speaking up and support the guardian but not investigate concerns themselves – during summer 2025. It has introduced new, easier ways of registering concerns such as a module in the Datix incident and risk database, and a QR code which is widely displayed around the premises. This forms part of an FTSU action plan and the trust has also refreshed the Raising Concerns Policy. The trust self-assessed its FTSU arrangements using the national guardian benchmarking tool, In response to this, a new guardian role has been created which aligns FTSU with the Culture and Organisational Development team. A new guardian was in post, with a plan to increase the service over the coming months.

We formed the impression from staff focus groups that most staff are mostly confident to raise issues and concerns although some individuals were sceptical about how much difference speaking up would make. In the answers to free text questions in the GGI survey, some respondents said that concerns about the consequences of cost savings were not well received; the anonymous nature of the survey makes this difficult for us to verify. The most recent CQC national staff survey for this trust showed a decline in the proportion of

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colleagues reporting confidence in raising concerns and LTH's score for this question fell below the national average for the first time. During the last twelve months the number of concerns raised with the guardian decreased, in contrast to the national trend of an increase in staff reporting concerns. The reasons for this decline are not immediately obvious. It was suggested to us that staff feel apathetic; they are not necessarily fearful of speaking up, but at a time when the trust is operating under such pressure, they may believe there is no capacity to act upon their concerns.

Acting on concerns

The trust puts a lot of effort into gathering and triangulating data about employee concerns. There is a Raising Concerns Group which meets six times per year to share intelligence from across different teams and ensure a consistent approach to addressing the concerns. The profile of concerns is typical of the NHS in that most concerns relate to workplace issues such as unsupportive management styles, alleged bullying and harassment, and employee wellbeing, rather than to the standard of patient care.

The trust also operates a 'restricted circulation' risk register. This has a more limited circulation than the main risk register and is mainly used to record risks relating to culture and behaviours in particular teams. This was first introduced approximately three years ago around the time of the previous GGI governance review and is now much more embedded. We see this as an example of good practice. In an NHS context, cultural and behavioural factors in teams may present serious risks to care quality and employee wellbeing but can sometimes become 'elephant in the room' issues that are known of but not documented or dealt with effectively. The restricted circulation risk register helps to ensure accountability for managing this type of issue. These issues can also be discussed in the second part of the Divisional Improvement Forum meetings.

The FTSU Guardian has regular access to the Chief People Officer and the non-executive director who acts as the board's speaking up champion but does not have routine contact with the Chief Executive or Chair. It would be useful for the CEO and chair to hear directly from the guardian, and for her to have direct access to the top of the trust.

Recommendations

- The trust should use corporate communications to introduce the new Guardian to the workforce and ensure they are as widely recognised as possible.
- Promotional materials and information campaigns about FTSU should emphasise changes and improvements that have been made in response to concerns raised by employees, to demonstrate that speaking up is worthwhile.
- Regular, diarised meetings should be arranged for the FTSU Guardian to check in with the Chief Executive, and periodically with the Chair.

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Workplace equality, diversity and inclusion

Quality statement: We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality and equity for people who work for us.

What this quality statement means:

- Leaders take action to continually review and improve the culture of the organisation in the context of equality, diversity and inclusion.
- Leaders take action to improve where there are any disparities in the experience of staff with protected equality characteristics, or those from excluded and marginalised groups. Any interventions are monitored to evaluate their impact.
- Leaders take steps to remove bias from practices to ensure equality of opportunity and experience for the workforce within their place of work, and throughout their employment. Checking accountability includes ongoing review of policies and procedures to tackle structural and institutional discrimination and bias to achieve a fair culture for all.
- Leaders take action to prevent and address bullying and harassment at all levels and for all staff, with a clear focus on those with protected characteristics under the Equality Act and those from excluded and marginalised groups.
- Leaders make reasonable adjustments to support disabled staff to carry out their roles well.
- Leaders take active steps to ensure staff and leaders are representative of the population of people using the service.
- Leaders ensure there are effective and proactive ways to engage with and involve staff, with a focus on hearing the voices of staff with protected equality characteristics and those who are excluded or marginalised, or who may be least heard within their service. Staff feel empowered and are confident that their concerns and ideas result in positive change to shape services and create a more equitable and inclusive organisation.

Summary of findings: *The trust demonstrates a strong commitment to EDI through a comprehensive strategy, active leadership involvement, and inclusive staff forums. Staff feel supported and engaged through a range of different initiatives. While there is room for improvement around representation and workplace culture, the trust leadership is aware of these challenges and is actively working to address them.*

Strategy and plans

The Trust has demonstrated a clear and ongoing commitment to embedding equality, diversity, and inclusion (EDI) within its workforce. These efforts build on existing initiatives and reflect a strategic approach to fostering an inclusive culture across the organisation.

The trust has a five-year EDI strategy *Consciously Inclusive in Everything We Do – for Our Colleagues and Communities* (2021-26). The strategy is guided by the following principles, each of which is assessed annually against specific success indicators:

- Demonstrating collective commitment to EDI
- Being evidence led and transparent

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- Recognising the importance of lived experience
- Being representative of our community
- Bringing about change through education and development

The trust's EDI strategy is among the most inclusive we have seen, as it takes into consideration not only the nine protected characteristics, but is also inclusive of carers and those affected by social deprivation. The strategy also encompasses population health by looking at the wider social determinants of health: the social and economic environment, the physical environment, and the person's individual characteristics and behaviours. These determinants are considered in the context of the Trust's local communities in Central Lancashire as well as the broader Lancashire and South Cumbria system. The strategy was informed by feedback from the Patient Experience and Involvement Group and the Council of Governors, ensuring that it reflects the needs of the community.

The Trust also has an EDI in Recruitment Action Plan. However, this plan is less detailed than the overarching strategy. It would benefit from being strengthened by making the actions SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) and by including clear deadlines.

The EDI strategy also incorporates an accountability framework that outlines how the trust will oversee and measure progress against the strategy. Oversight of the EDI strategy is provided by the Equality, Diversity and Inclusion group which reports to both the Workforce Committee and the Safety and Quality Committee, which allows each of the committees to consider EDI from a staff perspective and from a patient perspective. In addition, the trust has established an EDI strategy group comprising divisional leads and representatives from the Education, Workforce, and Partnership Teams. This group is responsible for championing and promoting the strategy across the organisation.

Leadership for equality

The senior leadership team actively engages with EDI efforts, regularly discussing EDI matters at board and committee meetings. Several executive team members serve as EDI sponsors, demonstrating visible commitment by attending staff-facing promotional events and reinforcing EDI messaging at leadership forums. This level of senior engagement is commendable and helps to embed EDI as a strategic priority across the organisation. However, despite these efforts, there remains a lack of diversity at senior levels of the trust. Workforce Racial Equality Standard (WRES) data also highlights under-representation of staff from Black, Asian and Minority Ethnic (BAME) backgrounds across most pay bands, with the exception of Band 5. The most recent available data is mixed; some indicators have improved while others have deteriorated compared to previous years. One striking figure is that white candidates are 1.5 times more likely to be appointed from shortlisting.

Focus groups with staff highlighted the Trust's clear efforts to embed EDI into everyday working practices, as well as a strong willingness among staff to engage with and support these initiatives. For example, some staff mentioned examples of the board's anti-racism framework and ongoing work to improve the Trust's demographic diversity.

Engaging and supporting staff

The Trust has established a range of inclusion forums, including groups focused on ethnicity, disability, LGBTQ+ identities, and special interest areas such as carers, menopause, and endometriosis. These forums provide valuable spaces for staff to connect, share experiences, and influence change.

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Efforts have also been made to improve workplace adjustments for staff who require them, and the Trust is exploring the development of a neurodiversity group to provide support and raise awareness. In addition, EDI principles are being embedded into recruitment, induction, and appraisal processes to ensure fair and equal opportunities for all staff. EDI is also being integrated into staff training and career development pathways.

One notable example shared was the *Leadership at Lancs* programme, which ran for 18 months and provided staff with development opportunities that led to several promotions. This demonstrates the tangible impact of the trust's investment in inclusive career progression.

The Trust demonstrates a genuine commitment to making all staff feel included, respected, and valued. In addition to the freedom to speak up service, the EDI team provides a safe and supportive space for staff to raise concerns related to equality, diversity, and inclusion. We were informed that staff are also able to raise concerns with the EDI lead and feel comfortable doing so, including for sensitive issues such as bullying and harassment. A notable initiative developed by the EDI lead is the training programme *When It's Not a Laughing Matter,* which raises awareness about inappropriate banter and promotes sensitivity around EDI-related issues. This reflects a proactive approach to fostering a respectful and inclusive workplace culture.

However, it was noted that the experience of inclusion and support varies across divisions and locations. Concerns around unprofessional behaviour, incivility, bullying and harassment were raised by staff, with these issues differing in prevalence between teams. Additionally, sickness absence, which had risen above 7% in April 2025, points to ongoing challenges related to staff wellbeing and mental health. A report to the Workforce Committee in May 2025 outlines progress in several key areas including employee wellbeing and flexible working. It also highlights actions aimed at increasing awareness and visibility of health and wellbeing initiatives across the trust.

Recommendations

- In addition to embedding EDI into recruitment and appraisals, the trust should consider ways to specifically target diversity and representation within senior leadership roles.
- The trust should develop a communications plan around EDI, covering the context, what the trust is doing to promote equality, and what has been achieved already.
- The Trust is actively exploring ways to reduce staff sickness absence. We encourage continued focus and innovation in this area, ensuring that interventions are inclusive and responsive to the diverse needs of the workforce.
- The Trust should review the role and effectiveness of the EDI Strategy Group, particularly in terms of its ability to escalate issues both upwards to senior leadership and downwards to operational teams.
- The Trust should explore how it can ensure that the experiences of staff with protected characteristics are consistent across all divisions, to identify and address any disparities.

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Governance, management and sustainability

Quality statement: We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.

What this quality statement means:

- There are clear and effective governance, management and accountability arrangements. Staff understand their role and responsibilities. Managers can account for the actions, behaviours and performance of staff.
- The systems to manage current and future performance and risks to the quality of the service take a proportionate approach to managing risk that allows new and innovative ideas to be tested within the service.
- Data or notifications are consistently submitted to external organisations as required.
- There are robust arrangements for the availability, integrity and confidentiality of data, records and data management systems. Information is used effectively to monitor and improve the quality of care.
- Leaders implement relevant or mandatory quality frameworks, recognised standards, best practices or equivalents to improve equity in experience and outcomes for people using services and tackle known inequalities.

Summary of findings: *Board and committee meetings are conducted well with a focus on constructive challenge and seeking assurance. Some management information provided to the board and committees could be more concise and focused. The trust has a suite of robust policies and procedures, including for risk management, where a great deal of work has been done. There is scope to improve how the Board of Directors and the Council of Governors interact with each other.*

Governance structures

The trust's board committee structure is fairly conventional for an NHS foundation trust, with the exception that it has an Education, Training and Research Committee, that is separate from the Workforce Committee. This reflects the importance that the trust places on these topics (see also comments under learning, improvement and innovation) and the committee clearly scrutinises them in great detail. However, we would query whether the committees could be merged, which may generate a saving in staff and board member time, in view of the many pressures on the organisation at this time.

We also looked at the structure of committees below board level, at management groups, which are chaired by executive directors or other senior managers and do not include non-executives in their membership. There is a Trust Management Group which oversees the day-to-day running of the organisation, and a series of subject groups known as 'feeder groups' which provide exception reports to board assurance committees. It was outside our scope to review the working of these groups in detail, but the range of groups is in line with what we would expect to find in an acute trust. Each clinical division has its own management board. GGI is facilitating workshops with each divisional leadership to evaluate their own governance arrangements; these had not yet taken place at the time of writing this report and the outcomes of this exercise will be reported separately, as agreed with the trust.

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Board and committee business

During our fieldwork, we observed one meeting of the Board of Directors (public and private session), the Audit Committee, and each of the four subject assurance committees. These were well-run meetings which mostly ran to time while allowing for meaningful discussion. Members were clearly engaged with the subject matter and had prepared thoroughly for the meetings. There was good constructive challenge that was directed towards obtaining assurance about delivery of plans and objectives and the management of significant risks. There were also good examples of unitary board-style discussion, with executives directing questions to one another and board members stepping outside their own portfolios or areas of professional expertise to ask questions. While members do occasionally probe into matters of operational detail, the distinction between oversight and day-to-day management is understood.

The chair and the director of corporate affairs, as the secretary to the board, are trying to improve the pace and focus of board meetings. There is more reliance on the committee chairs to provide assurance to the rest of the board about their subject area, so that the board does not simply replay conversations that have already happened at committees. The committees use the 3A report format (assure, alert, advise) to summarise their business. If a paper has already been discussed at committee but requires board approval, it will be referenced by the committee chair in their report but not presented in detail, or debated, unless board members specifically request this. Such papers form part of an ancillary agenda at the back of the agenda pack. Also, recognising that most of the scrutiny of the integrated performance report takes place in assurance committees, the board will in future receive only a condensed version of the IPR.

The meetings we attended were chaired well – for example, the chair summarised at the end of each agenda item so that all were clear what the board was being asked to decide and what the outcome was. Presenters were encouraged to use plain English when introducing their papers, for the benefit of non-board members such as governors and members of the public who were observing the meeting, by avoiding the use of jargon and acronyms or quoting lists of statistics. The balance of agenda items between the public and private sessions of Board of Directors' meetings appeared appropriate and the discussion was similarly open and challenging in both parts I and II of the meeting. The trust uses the principles behind Freedom of Information legislation as a guide to what can be discussed behind closed doors and what should be discussed in public.

Management information

The agendas of the board and the committees are populated with dense, detailed papers that include lengthy narratives and often multiple tables of figures. This is hardly untypical of the NHS, but is frustrating for non-executive directors, especially those who are new to sitting on NHS boards. The agenda pack of a recent meeting of the Safety and Quality Committee totalled 640 pages. Report writers should be encouraged to write more succinctly, and to emphasise outcomes and exceptions rather than describing activity. On a more positive note, in the cover sheets that accompany all papers we found some good examples of executive summaries that highlighted the key issues to the reader. The cover sheet template also references the paper to aims and objectives, although these are derived from the previous *Big Plan* (2021-24); we understand that the template is to be reformatted so that it links to the workstreams of the Single Improvement Plan. There is a good level of discipline around timely submission of papers for the board and committees, so that members have time to read and digest reports before meetings and formulate informed questions.

As is now common in the NHS, the Integrated Performance Report uses statistical process control data to distinguish between random statistical variation and trends that should give cause for concern. The narrative to explain each performance indicator is presented under the headings of summary, assurance and action. The

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IPR has recently been realigned so that KPIs are grouped under the '5P' portfolios of the Single Improvement Plan, minus 'partnerships', which is covered by other items on board and committee agendas.

Board members are generally confident in the completeness and accuracy of the data which they receive but have sought external assurance in instances where they have had concerns. For example, the trust commissioned an external audit of data quality in relation to the theatres system. This review encompassed Accident and Emergency, inpatient and outpatient departments. It led to an extensive programme of corrective work in outpatient services, where the discrepancies were greatest, and most actions have now been completed, bar a small number which are dependent on resource availability. The internal auditors, MIAA, also examine data quality for at least one category of clinical data per year as part of their annual audit plan. The trust gains assurance over the confidentiality and secure handling of data through the Data Security Protection Toolkit, which all providers of NHS services are required to complete annually. MIAA review a sample of the evidence which the trust has compiled to show its compliance with the criteria, and they also assess the governance processes in place to support data security. Their most recent audit (September 2024) was graded 'significant assurance'.

Policies and procedures

We reviewed a sample of 15 trust policies relating to clinical or corporate governance. These policies are typical of the NHS in format and content. They mostly follow a standard template, which starts with document control information, a definition of the purpose and scope of the policy and a list of duties for specific postholders, before describing the process step-by-step. Several include appendices that contain, for example, template documents or checklists to help with applying the policy. As is common in the NHS, these are detailed documents; some are over 40 pages long. However, the longer policies mostly include flow charts or process maps, and a short narrative summary, meaning that it is not always necessary to read the policy cover-to-cover. Policies have a standard lifespan of three years and all the policies in our sample were within their review dates. We did, however, receive some feedback from staff that policies could be difficult to locate on the intranet.

Managing risk

The trust evidently takes risk management seriously. It has a senior manager specifically responsible for co-ordinating the risk management process who has direct access to executives and regularly presents risk reports to the board and its committees; these reports stimulate a healthy discussion. The trust has a comprehensive risk management policy which outlines the process to follow, and a three-year risk management strategy (2024-27) which sets out how the trust will further embed risk management principles and practice. It specifies a series of actions including thematic review of risks, an assessment of the risk management software, and reviewing the trust's risks against the Government's national risk register.

One of the actions for year one of this strategy was to establish a Risk Management Group. This is chaired by the Chief Executive – a sign of the importance placed on risk management – and has a senior-level membership comprising executive directors and senior managers from the clinical divisions and corporate services. It performs a vital function by ensuring high-level oversight of how risk is being managed at the local level and giving senior leaders visibility of new and emerging risks.

The trust has also redesigned its board assurance framework (BAF) and redefined its risk appetite at a board seminar. The BAF is comprehensive and presented in a clear way that strikes a good balance between detail and digestibility. At divisional level, the trust has completed a risk maturity assessment for each division.

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Council of Governors

Governors can be great assets for a NHS foundation trust, providing a connection to the local community, and a sounding board for important and potentially controversial decisions. We understand that the relationships between the Board of Directors and the Council of Governors, and between the council and the corporate affairs team, have at times been strained. The trust commissioned an external review from another consultancy in November 2023 which identified several issues to address, among them: clarity about roles and responsibilities; training and administrative support for governors; techniques for questioning and scrutiny; and strengthening the links with non-executive directors. The trust acted on the findings of this report, for example by arranging training for governors which was delivered by NHS Providers.

It was not possible for us to observe the Council of Governors in action as no meetings were scheduled during the time frame for our fieldwork. However, we were able to meet individually with the Lead Governor and to organise a focus group with a group of governors. We perceive that there has been some improvement in engagement, but some governors still believe that the importance of their role and their input are not always appreciated. At the same time, some board members consider that the governors involve themselves too much in specific operational matters or are unduly critical at times.

We suggest that the priorities for work with the Council of Governors should be to build relationships with the new non-executive directors – for it is the role of governors to hold NEDs to account – and to increase public engagement. The trust has around 9,000 public members, of whom fewer than 10% normally vote in governor elections. In the coming years several governors will reach their maximum term of office and will not be eligible for re-election. It is important that there should be a good range of candidates to replace them. Also, it would be good practice for governors to have means of communicating with their constituents – to inform them of the work they are doing and understand any issues which they would like governors to pursue – although these would need to be practical and affordable, and it would be for governors to take this forward.

Shortly prior to production of this report, the Department of Health and Social Care published *Fit for the Future: the 10-year Health Plan for England.* In the section describing the future operating model for the NHS, it states that foundation trusts will no longer be required to have governors and that DHSC expects the next generation of NHS FTs to *"put in place more dynamic arrangements to take account of patient, staff and stakeholder insight"*. It is not yet clear how existing Councils of Governors would be affected and what form the alternative arrangements would take; in any case the changes will likely require legislation to be passed and so may not take effect for several years. In the meantime, the trust would be advised to maintain a watching brief.

Recommendations

- The trust should consider whether the Workforce and Education, Training and Research Committees can be brought together as one committee.
- Those who review papers prior to their inclusion in board and committee agenda packs should encourage report authors to condense their reports wherever possible. The trust may also consider some further training on writing reports.
- The trust should consider how, working within the current financial constraints, it could encourage more local people to become public members and to participate in trust business, such as voting in governor elections.

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Partnerships and communities

Quality statement: We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

What this quality statement means

- Staff and leaders are open and transparent, and they collaborate with all relevant external stakeholders and agencies.
- Staff and leaders work in partnership with key organisations to support care provision, service development and joined-up care.
- Staff and leaders engage with people, communities and partners to share learning with each other that results in continuous improvements to the service. They use these networks to identify new or innovative ideas that can lead to better outcomes for people.

Summary of findings: *The trust serves communities affected by health inequalities and poor outcomes which require it to work with partners to address. The trust is playing a more active, visible and influential role in the local integrated care system. Better partnership working between providers in the system has helped to drive forward much needed reconfigurations of clinical and administrative services. However, many of these initiatives are in the early stages of implementation, so the benefits are yet to be fully felt.*

As well as being financially challenged itself, LTH operates in one of England's most financially challenged areas. It used to be seen as insular, which is not unusual for an acute trust that has had to survive in a competitive environment, and the old strategy made no mention of community. It was described to us as *"a sleeping giant that punched below its weight"*. However, that has changed under the current leadership, and the trust now plays an active, constructive role in the system. The board understands the need for the organisation to be more outward-looking and this was evident in the discussions that we observed.

Working with other NHS providers

The trust is working to improve its relationships with other provider trusts and is a key member of the Provider Collaborative, with the trust Chair also chairing the collaborative. We were told that the partnership is strong, but the vehicle may not be the best one to take this forward. There are good working relationships between the chief executives, and the chief nurses meet regularly together every week. These meetings are useful for ironing out practical, operational issues that affect all the trusts in the system.

Improved joint working with other NHS providers has tangible benefits. It is helping to move forward tricky reconfiguration issues like pathology, vascular and oral & dental services, some of which had been effectively gridlocked for several years. The trust had supported the local community health services provider with its operational difficulties by transferring in dietetics from Lancashire and South Cumbria Foundation Trust when staffing concerns made this necessary. The external stakeholders who we interviewed were very positive about the trust's partnerships across the local area.

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The trust is part of an innovative venture called OneLSC – a hub for corporate services across the system hosted by East Lancashire Hospitals Trust. It shows that the organisations are working together to improve efficiency through economies of scale and harmonised processes. It has not yet shown practical, financial and operational benefits but proves that big changes can be made locally when there is the will to do so. We understand that Digital recently transferred to OneLSC and that Estates and Facilities are due to transfer shortly. This is something that will need to be watched carefully and supported to achieve its full potential.

Working with the Integrated Care Board

The relationship with the ICB is obviously vital and will need continued attention as the new organisational landscape of NHS commissioning and regulation takes shape. The ICB faces major challenges of its own, including the system-wide deficit and a national mandate to reduce the operating costs of ICBs. LTH is a leading player in the system thanks to its size and specialist services, and its central geographical location within the county. Interviewees felt that the working relationship with the ICB and other members of the integrated care system had improved when compared to previous arrangements. This was evidenced by the regular meetings of executives such as the CEO, Chief Nurse and Chief Medical Officer, and by recent successes such as a system improvement event with other senior leaders aimed at tackling health inequalities, and a successful bid to become part of the national frailty collaborative.

Several people shared their view that place-based working in Lancashire is underpowered and not given sufficient priority. This is an area that the trust could play a larger role in the future and engage in its role as an Anchor Institution providing contributions as a significant employer and place partner.

Working with other stakeholders

The trust has become more proactive in its relationships with MPs and councillors, but more should be done to develop better relationships with local authorities and create joint working with them. The past 18 months have seen big political changes both nationally and locally, making this especially important. More could also be done to create relationships with voluntary, community and social enterprise (VCSE) groups, particularly in view of the community focus in the NHS 10 Year Plan.

A good example of joint working is the trust's first ever Health Improvement Plan (2024-26) which aims to reduce health inequalities. It draws on input from VCSE organisations including local faith groups, patient experience groups and forums, and primary care colleagues with special interest in health inequality. Lancashire County Council's Director of Public Health, Wellbeing and Communities was actively involved in shaping the plan and his team contributed data and insight around which the plan is based.

We did not see any evidence of stakeholder mapping and recommend that this is undertaken swiftly to identify all the trust's stakeholders, their significance and what is being done to engage with them. This will enable the trust to engage with stakeholders in a more proactive and strategic way.

Recommendations

- The trust should carry out a stakeholder mapping exercise to identify all external stakeholders and create an action plan for engaging with each.
- The trust should continue to focus on building a positive relationship with the ICB during this period of change.

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Learning, improvement and innovation

Quality statement: We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.

What this quality statement means:

- Staff and leaders have a good understanding of how to make improvement happen. The approach is consistent and includes measuring outcomes and impact.
- Staff and leaders ensure that people using the service, their families and carers are involved in developing and evaluating improvement and innovation initiatives.
- There are processes to ensure that learning happens when things go wrong, and from examples of good practice. Leaders encourage reflection and collective problem-solving.
- Staff are supported to prioritise time to develop their skills around improvement and innovation. There is a clear strategy for how to develop these capabilities and staff are consistently encouraged to contribute to improvement initiatives.
- Leaders encourage staff to speak up with ideas for improvement and innovation and actively invest time to listen and engage. There is a strong sense of trust between leadership and staff.
- The service has strong external relationships that support improvement and innovation. Staff and leaders engage with external work, including research, and embed evidence-based practice in the organisation.

Summary of findings: *There is a clear focus on learning, improvement and innovation throughout the trust. This is evident in messages from the top of the organisation, in plans and objectives, policies and processes, and the infrastructure that the trust has put in place. However, the results of our confidence in governance survey painted a mixed picture and not all staff are confident that the trust puts into practice what it has learned from incidents.*

Patient safety learning

As with all NHS providers, LTH has dedicated substantial time and effort in recent years to implementing the Patient Safety Incident Response Framework (PSIRF). The aim of PSIRF is to improve how clinical teams learn from patient safety events and prevent them from recurring, by taking an approach to reviewing and investigating incidents that is more strategic and qualitative, and less process driven. The trust has been working according to its patient safety strategy, *Always Safety First* (2021-24) which is now being comprehensively reviewed and updated; the new strategy will launch in September 2025 to coincide with Patient Safety Day. The main elements of *Always Safety First* derived from the NHS *National Patient Safety Strategy* (2019).

The trust has recently completed its own annual review of PSIRF implementation and will do a more thorough review during 2025/26. The most recent review could be summarised as *"a lot done, more to do";* the trust is on a journey of maturity like all its counterparts. We were told that the early stages of implementation had been challenging due to some staffing gaps and underestimation of the amount of work that some aspects of PSIRF would require, but that the pace had picked up rapidly thereafter. There is much positive activity to

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report, including community of practice events, a weekly meeting to share and learn from incidents that is regularly attended by more than a hundred people, and feeding learning points from incidents into the STAR programme (the trust's ward-based quality assurance system). There is an upward trend in the number of staff reporting incidents through the Datix system, which is good news. Since November 2023 the trust has had three patient safety partners – lay people who work as volunteers to provide the patient's perspective on quality and safety and to help shape safety strategies and policies.

When meeting with senior doctors and nurses, we found enthusiasm for the principles of PSIRF but varying levels of confidence in applying them. We note that new patient safety strategy is likely to include further training about PSIRF and expect that colleagues will become more confident as they gain more exposure to the different learning techniques. Our confidence and governance survey, which reached a wider audience, painted a mixed picture around incident reporting and management. Overwhelmingly staff know how to report an incident (96% agreed) but only 64% were confident that all incidents which occur in their own service are reported. 58% agree that *"we have an open and learning culture that enables us to talk freely about patient safety concerns, incidents or near misses"*. Only 32% of respondents said they received timely feedback after reporting an incident and just under half (48%) agreed that *"we learn from incidents and take action to prevent them from happening again"*, with almost a quarter expressing a neutral view. Notably, fewer than one-third agreed that the trust takes action to ensure the safety and wellbeing of staff.

Continuous improvement

The trust has long understood the importance of quality improvement (QI). It has a Chief Strategy and Improvement Officer – a non-voting member of the trust board – and a central improvement team who provide support and guidance for improvement projects. This director's portfolio now includes research (where the trust has over 50 people employed on research activity) and has recently expanded to include strategy and planning and the Programme Management Office (PMO) function. This has been strengthened through a restructure to ensure that the trust can govern its major improvement programmes.

The trust has developed its own Lancashire Improvement Methodology, which builds on the strengths of previous QI approaches that have been applied at LTH. There is an e-learning module available to familiarise colleagues with the new methodology. Improvement projects are centrally co-ordinated so that they address the trust's priorities and do not duplicate one another.

LTH's approach to quality improvement has been recognised nationally – the director also serves in a part-time national role for NHS Impact (Improving Patient Care Together), which works to create a common approach to improvement across the NHS, and the trust has recently been awarded funding by the Health Foundation to support aspects of its improvement work.

Research and innovation

Research and innovation featured less prominently in our review but are important for the trust in view of its aspiration to receive university hospital status and its desire to attract the best clinical talent. The trust is reviewing its Research and Innovation Strategy, which expires in October 2025. The main aims of this strategy are: to build better links with local higher education institutions; to build capacity and capability inside the trust; to raise the trust's profile; to rebuild a sustainable R&I function in the aftermath of the pandemic; and to develop an innovation and digital plan to aid commercialisation. The trust has gained traction with this strategy despite the adverse economic climate that both NHS trusts and universities have suffered in recent years. Notably, the trust has recently signed a deal with the major biotechnology company BioNTech to increase its research capacity, being the first trust in the country to do so. It is also noteworthy that one of the new non-

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executive directors (the Chair of the Education Training and Research Committee) is a professor and heads the health faculty at the local university, which should reinforce the links between the two organisations.

Recommendation

- As part of the communications around the new patient safety strategy to be launched later in the year, the trust should emphasise how incident reporting and investigation leads to changes for the better, giving examples where appropriate.
- The strategy should also cover how staff are supported following an incident in which they have been involved.
- Amid the immediate financial pressures, the trust should maintain the importance and profile of quality improvement work, which is crucial to ensuring its own long-term sustainability and achieving efficiencies.

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Environmental sustainability

Quality statement: We understand any negative impact of our activities on the environment, and we strive to make a positive contribution in reducing it and support people to do the same.

What this quality statement means:

- Staff and leaders understand that climate change is a significant threat to the health of people who use services, their staff, and the wider population.
- Staff and leaders empower their staff to understand sustainable healthcare and how to reduce the environmental impact of healthcare activity.
- Staff and leaders encourage a shared goal of preventative, high quality, low carbon care which has health benefits for staff and the population the providers serve, for example, how a reduction in air pollution will lead to significant reductions in coronary heart disease, stroke, and lung cancer, among others.
- Staff and leaders have Green Plans and take action to ensure the settings in which they provide care are as low carbon as possible, ensure energy efficiency, and use renewable energy sources where possible.
- Staff and leaders take active steps towards ensuring the principles of net zero care are embedded in planning and delivery of care. Low carbon care is resource efficient and supports care to be delivered in the right place at the right time.

Summary of findings: *The trust was in the process of updating its Green Plan at the time of our review. The trust is committed to sustainability and can demonstrate measures it has taken to support the environment. These initiatives have been funded by successfully bidding for ad hoc funding opportunities, rather than from a core budget. Employees are willing to play their part in contributing to Net Zero but the environmental agenda is often overshadowed by more immediate concerns such as finance, operations and quality.*

Green plan

Environmental sustainability is an area of increasing importance globally and is reflected as its own key domain in the well-led framework. The CQC encourages NHS organisations to consider more deeply the significance of sustainability initiatives and the vital role they play in supporting conservation efforts.

At the time of this review, the organisation's Green Plan – available on the website – was outdated, having been published some years ago, and was in the process of being refreshed. The existing strategy is a comprehensive document that reflects on the trust's past sustainability performance and outlines its vision and approach using the *Lancashire Teaching Hospitals Social Value Framework*. The document clearly defines the trust's role in sustainability, aligns to the UN sustainable development goals, and identifies the nine key areas of focus. The new green plan (2025-28) was still in draft at the time of our fieldwork, having been discussed by executives but was pending board approval. It has been developed in accordance with updated guidance from NHS England. This new document talks not just about how the trust can help to prevent further damage to the environment, but also how it can adapt to cope with the effects of climate change that has already occurred.

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Leadership for sustainability

Responsibility for sustainability within the trust falls within the portfolio of the Chief Finance Officer (CFO). As noted elsewhere in this report, there has been turnover in the CFO role, which has affected the continuity of ownership for sustainability. During the interim period while a new CFO was being appointed, responsibility for sustainability was temporarily assigned to the chief people officer (CPO). It has only recently returned to the CFO.

As the strategic planning team has been compiling the new green plan, there has been increased engagement from the senior leadership, with sustainability now becoming a more prominent topic of discussion. While the team currently reports to the board on an annual basis, this approach is being reconsidered due to concerns that infrequent reporting may cause sustainability to lose momentum. We were informed that the trust is exploring six-monthly sustainability reports to the Finance and Performance Committee. The trust will continue to measure its performance against the green plan using its developed action tracker, which will also consider future opportunities for improvement.

Financial investment

During the interviews, the topic of sustainability was often discussed in the context of the financial constraints facing the trust. One interviewee summed up a common sentiment by stating, *"green costs more"*. The trust faces the challenge of pursuing its sustainability objectives, which often require up-front capital investment for longer term benefits, while simultaneously managing significant financial pressures. This situation is of course not unique to LTH.

Additionally, we were informed that the trust's sustainability work does not receive a dedicated annual budget and instead relies on national funding opportunities. This can work to the trust's advantage, allowing the team to progress with projects even during periods of internal cost saving measures. For example, the team successfully secured funding to decarbonise the trust's boiler system. However, it also limits the scope of what can be achieved. In view of financial limitations and a trust-wide hold on discretionary expenditure, this is unlikely to change in the short-to-medium term. Despite these constraints, the team continues to make progress where possible.

Awareness raising

The sustainability lead, with other members of the strategic planning team, has made concerted efforts to raise awareness among staff about the importance of sustainability and their role in supporting it. The trust distributes a sustainability newsletter to all staff and includes a dedicated sustainability section in the twice-weekly *Health Matters* bulletin. Additionally, the trust has designated sustainability leads – senior people from both clinical and non-clinical backgrounds – each aligned with one of the nine NHS England sustainability areas of focus.

There are also 35 sustainability champions across various departments and staff levels, with ongoing efforts to expand this network. The trust supports these efforts through a monthly sustainability group meeting, a dedicated sustainability hub accessible to all staff, and monthly working groups with the sustainability leads. Sustainability training is also offered to staff, and while not currently mandatory, we were informed that the trust is considering making it so.

In focus groups, staff shared examples of sustainability initiatives they were aware of or involved in, such as recycling schemes and promoting cycling and car-pooling to work. However, we observed that overall staff

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engagement remains quite limited. For instance, a recent sustainability survey intended to gather input for the new green plan received only 40 responses. Despite efforts such as delivering sessions at colleague briefings and leadership forums, and engaging staff at the Preston and Chorley sites, many staff remain more focused on financial pressures and their impact on service quality, which can make it difficult to prioritise sustainability.

Overall, we commend the trust for its extensive efforts to keep sustainability at the forefront. The sustainability team demonstrates clear dedication, and staff engagement could be further strengthened through supportive messaging from the board and senior leadership.

Procurement

As OneLSC continues to develop, it is important to recognise that procurement – one of its core functions – sits closely alongside sustainability. Procurement plays a critical role in enabling organisation-wide sustainability, particularly if sustainable procurement practices are adopted. It is believed that the supply chain accounts for most of the NHS's carbon emissions. There is an opportunity for the trust to position itself as a leader in sustainable procurement by actively influencing OneLSC in this area. Given OneLSC's responsibility for procurement across Lancashire and South Cumbria, local trusts could help shape a consistent and system-wide approach to sustainable procurement. This would not only benefit LTH but also support other providers across the region in embedding sustainability into their procurement practices.

Recommendation

- The trust should consider ways to increase staff engagement with sustainability, including increased support from the board and senior leadership.
- The trust should consider how it can encourage sustainable procurement in the system through OneLSC.

Section 7 – Conclusion

Our conclusion is that the trust has many strengths that should help it to overcome a period of difficulty. These strengths include capable leadership, a dedicated workforce and an improvement culture backed up by plans and systems. There is evidence of early progress in many areas. However, it was apparent to us how the recent difficulties have affected the morale of staff; indeed, it would be surprising if they had not. It is essential to make sure that everyone is aware of the plan to turn the situation around and what it means for them. This means explaining clearly how the choices being made now – some of them undoubtedly difficult and controversial – will make the trust a better place to receive care and to work in the years to come.

The next step should be to turn the broad recommendations of this report into a more granular and prescriptive action plan to be implemented over the coming months. We recommend that this process should involve the whole board so that there is collective ownership of the plan.

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Appendix A – Sources of evidence

List of Internal Interviewees

Professor Mike Thomas	Chair of the Trust
Professor Silas Nicholls	Chief Executive
Sarah Morrison	Chief Nursing Officer and Deputy Chief Executive
Dr Gerry Skailes	Chief Medical Officer
Katie Foster-Greenwood	Chief Operating Officer
Craig Carter	Chief Finance Officer
Dr Neil Pease	Chief People Officer
Professor Ailsa Brotherton	Chief Strategy and Improvement Officer
Jennifer Foote	Director of Corporate Affairs
Naomi Duggan	Director of Communications & Engagement
Dr Tim Ballard	Non-executive Director
Professor StJohn Crean	Non-executive Director and Chair of the Education, Training and Research Committee
Dr Karen Deeny	Non-executive Director and Chair of the Safety and Quality Committee
Adrian Leather	Non-executive Director and Chair of the Workforce Committee
Uzair Patel	Non-executive Director
John Schorah	Non-executive Director and Chair of the Finance and Performance Committee
Tim Wheeler	Non-executive Director and Chair of the Audit Committee
Dr Kate Davies	Deputy Chief Medical Officer – Governance
Catherine Gregory	Deputy Chief Nurse
Dr Michael Stewart	Deputy Chief Medical Officer – Audit and Effectiveness
Simon Regan	Associate Director of Risk and Assurance
Hajara Ugradar	Associate Director of Safety and Learning
Ian Ward	Head of Planning (lead for environmental sustainability)
Janet Miller	Lead Governor
Kate Holt	Freedom to Speak Up Guardian
Mandy Davies	Equality Diversity and Inclusion Lead (with network chairs)
Helen Williams	Staff Side Chair (with other union representatives)

List of External Interviewees

Sarah Blackwell	Deputy Assurance Director, MIAA
Louise Cobain	Regional Assurance Director, MIAA
Aaron Cummins	Chief Executive, University Hospitals of Morecambe Bay NHS Foundation Trust
Chris Oliver	Chief Executive, Lancashire and South Cumbria NHS Foundation Trust
Emmy Walmsley	Healthwatch representative

Focus groups

Council of Governors	5 June 2025
Matrons and Ward Managers	26 June 2025

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Band 5 & 6 Nursing Staff	27 June 2025
Administrative Staff	27 June 2025
Allied Health Professionals	30 June 2025
Clinical Reference Group	7 July 2025
Consultants*	8 August 2025

** GGI is scheduled to conduct a final focus group with consultants on 8 August 2025, after the deadline for submitting the draft report to the trust.* During the course of the project, it was agreed that the learnings from this focus group (and the divisional governance workshops) will form the basis of a separate report that goes beyond the core well-led elements covered by this governance review.

Board and committee meetings observed

Finance and Performance Committee	27 May 2025
Safety and Quality Committee	30 May 2025
Board of Directors	3 June 2025
Education, Training and Research Committee	10 June 2025
Audit Committee	24 June 2025
Workforce Committee	8 July 2025

Documentation reviewed (not an exhaustive list)

Annual reports

- Annual report and accounts
- Head of internal audit's annual opinion
- Annual report on equality, diversity and inclusion
- Annual complaints report
- Detailed results of the last national staff survey

Governance structures

- Agendas and minutes of board meetings (public and private)
- Agendas and minutes of board sub-committees
- Organogram of governance structure

Management structures

- Details of executive portfolios
- Organogram of management structure
- Performance management and accountability framework

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Risk management

- Board assurance framework
- Corporate risk register
- Risk management policy and strategy

Strategies and plans

- Trust corporate strategy
- Enabling strategies

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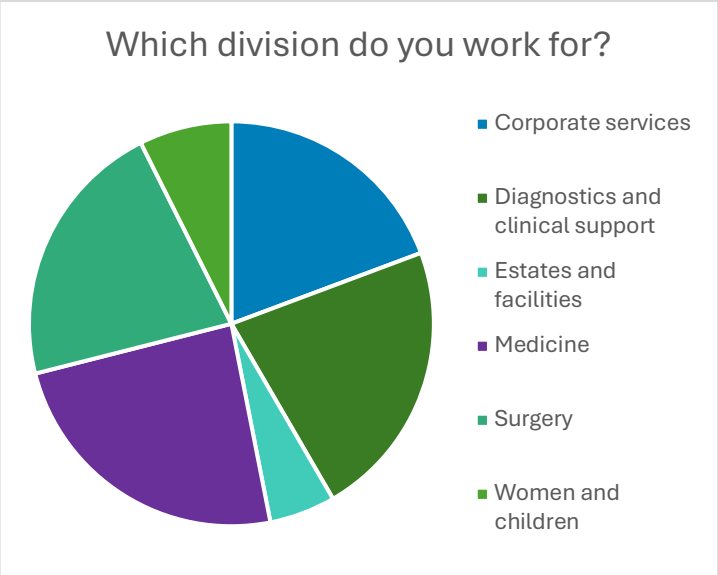
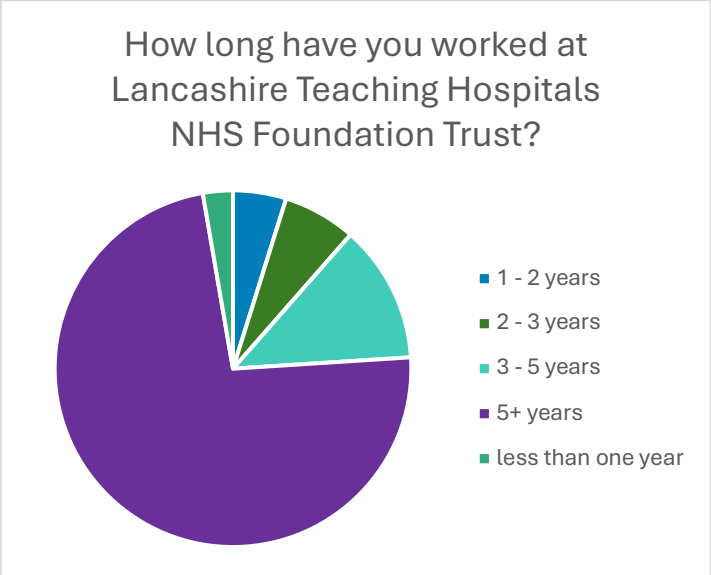
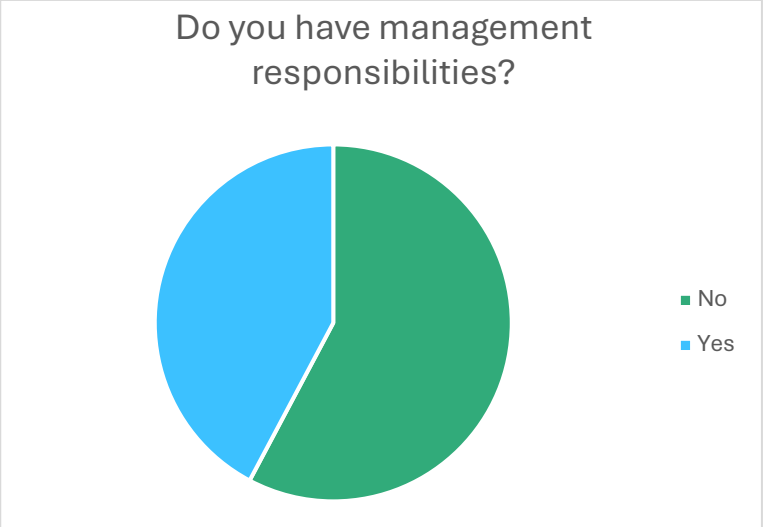
Appendix B – Summary of survey results

The survey received a total of 663 responses. The demographics of the respondents are included in the graphs below.







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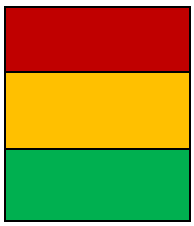
The following statements were rated on a 5-point scale from strongly agree to strongly disagree. The mean average for each division is shown on the below heat map.

		Corporate services	Diagnostics and clinical support	Estates and facilities	Medicine	Surgery	Womens and Childrens
Priorities and objectives	I trust the board and senior managers of Lancashire Teaching Hospitals NHS Foundation Trust to act in the best interests of						
	I trust the board and senior managers of Lancashire Teaching Hospitals NHS Foundation Trust to act in the best interests of						
	This trust is a learning organisation and communicates well about lessons learned.						
	It is clear to me what the trust's priorities and objectives are.						
	I know how I can contribute towards achieving these objectives.						
Leadership and accountability	It is clear who is in charge of patient care at the site where I work.						
	It is clear who is in charge of the service in which I work.						
	If there is a problem or issue affecting the service where I work, it is clear to me who I need to speak to about it.						
	Directors and managers are held accountable for the performance and quality of the services that they lead.						
	I am clear about what my own duties are and what I am accountable for.						
Learning from incidents	I know how to report an incident or near miss.						
	We have an open and learning culture that enables us to talk freely about patient safety concerns, incidents or near misses.						
	I am confident that we run a safe service for patients.						
	I am confident that we take action to ensure the safety and wellbeing of staff.						
	We receive timely feedback when we report incidents.						
	We learn from incidents and take action to prevent them from happening again.						
Risk management & raising concerns	My department effectively identifies risks that affect patients, staff or visitors.						
	My department takes effective action to manage risks that affect patients, staff or visitors.						
	When I raise risks, I am listened to.						
	I can get support or advice from within the trust on how to assess and manage risks.						
	I would be confident to challenge my colleagues in a constructive way if I am concerned over their actions.						
	I know how to report a safeguarding concern I may have about a patient or one of their family.						
Data	I am confident that the data I use in the work I do is accurate and reliable						
	I am aware of development opportunities available to me.						
	I would be confident in obtaining support and guidance from my line manager if I needed it.						

Key:



Strongly disagree

Neutral

Strongly agree

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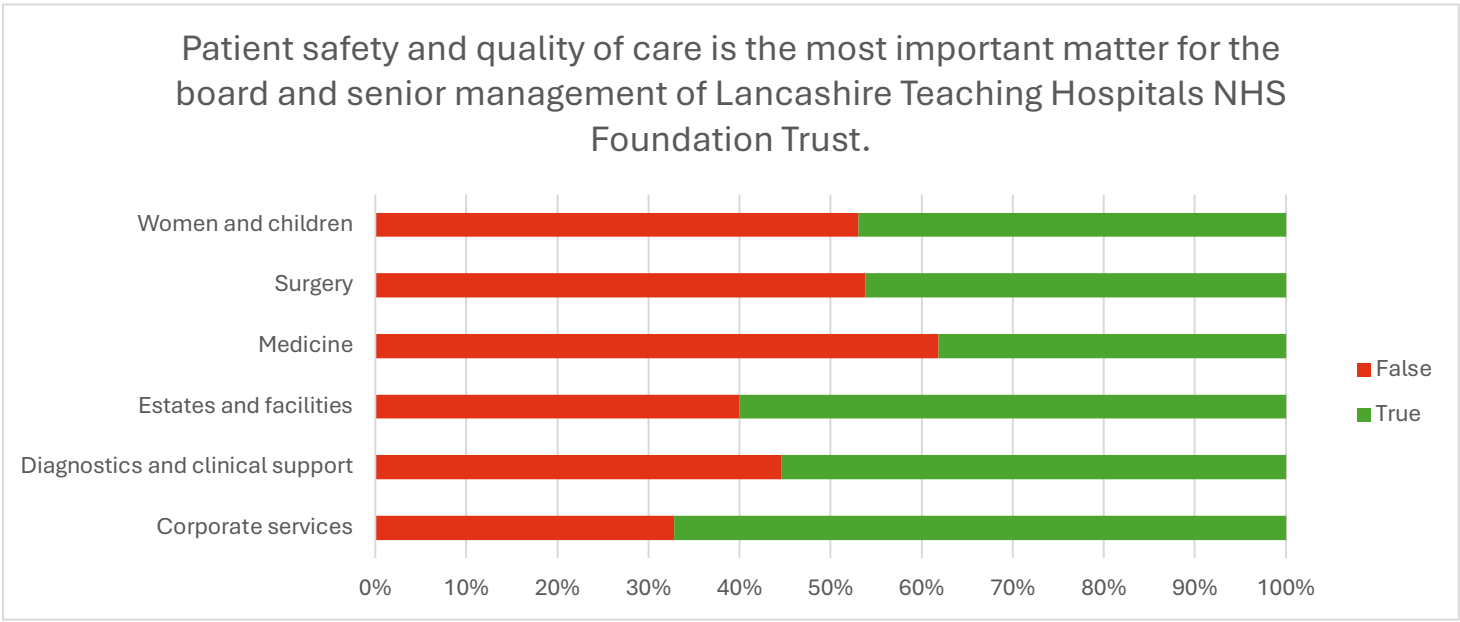

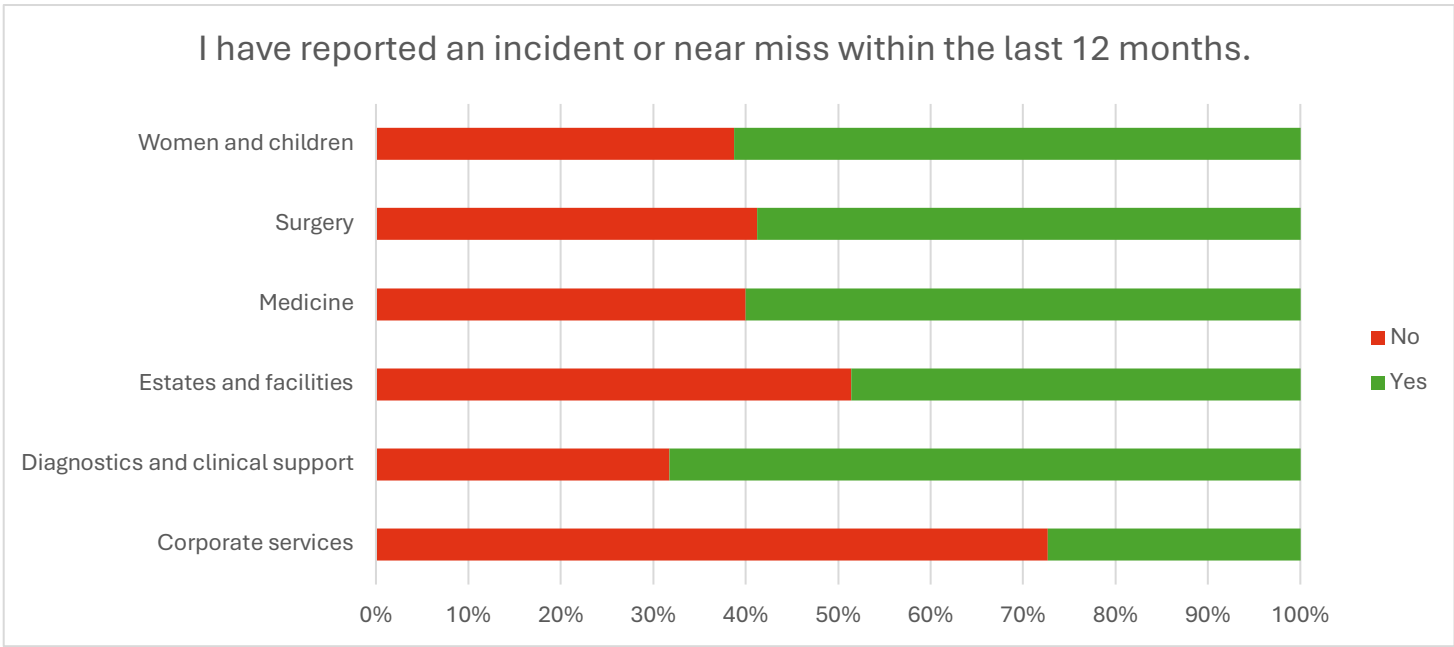

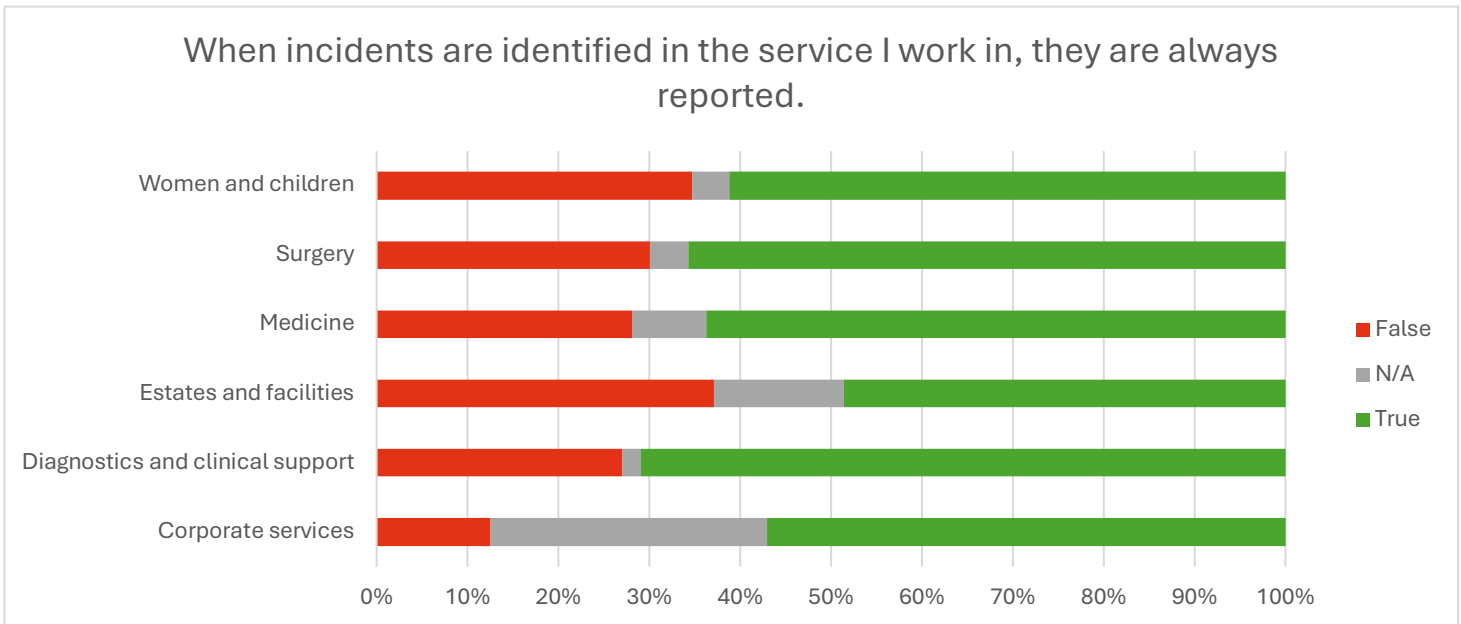

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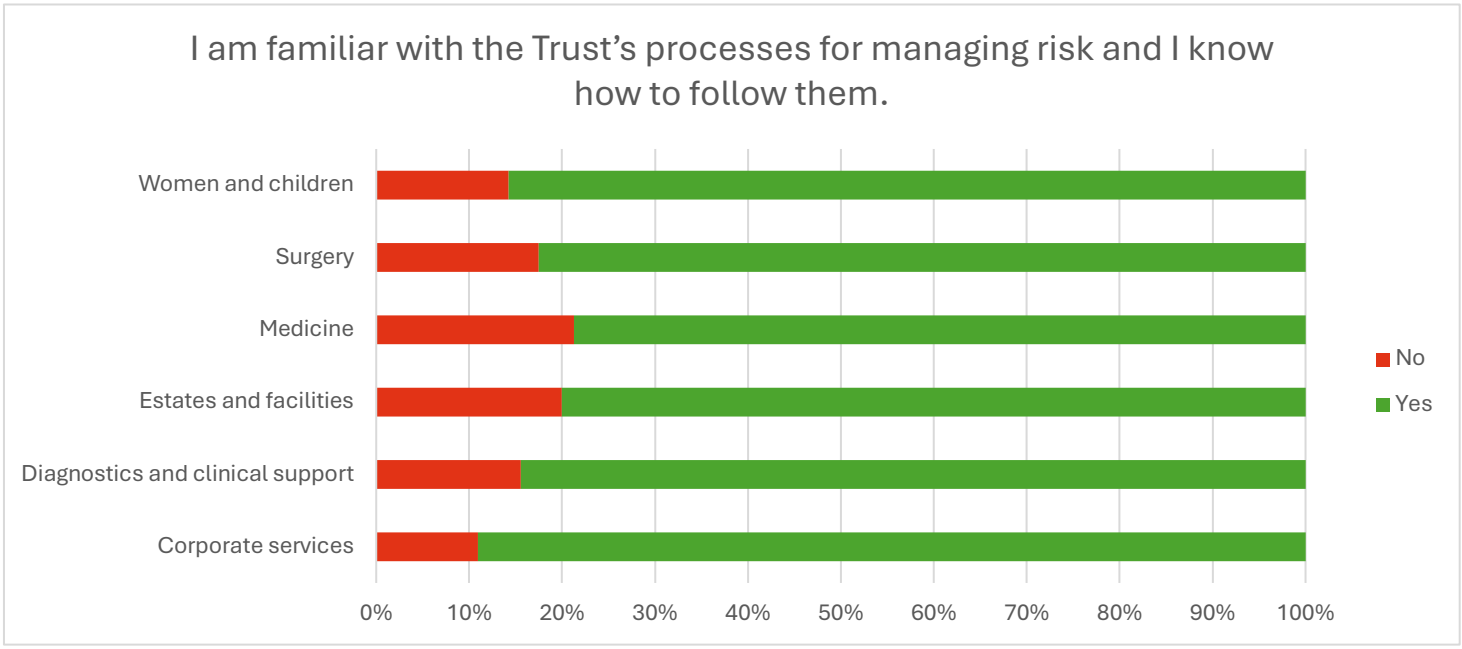

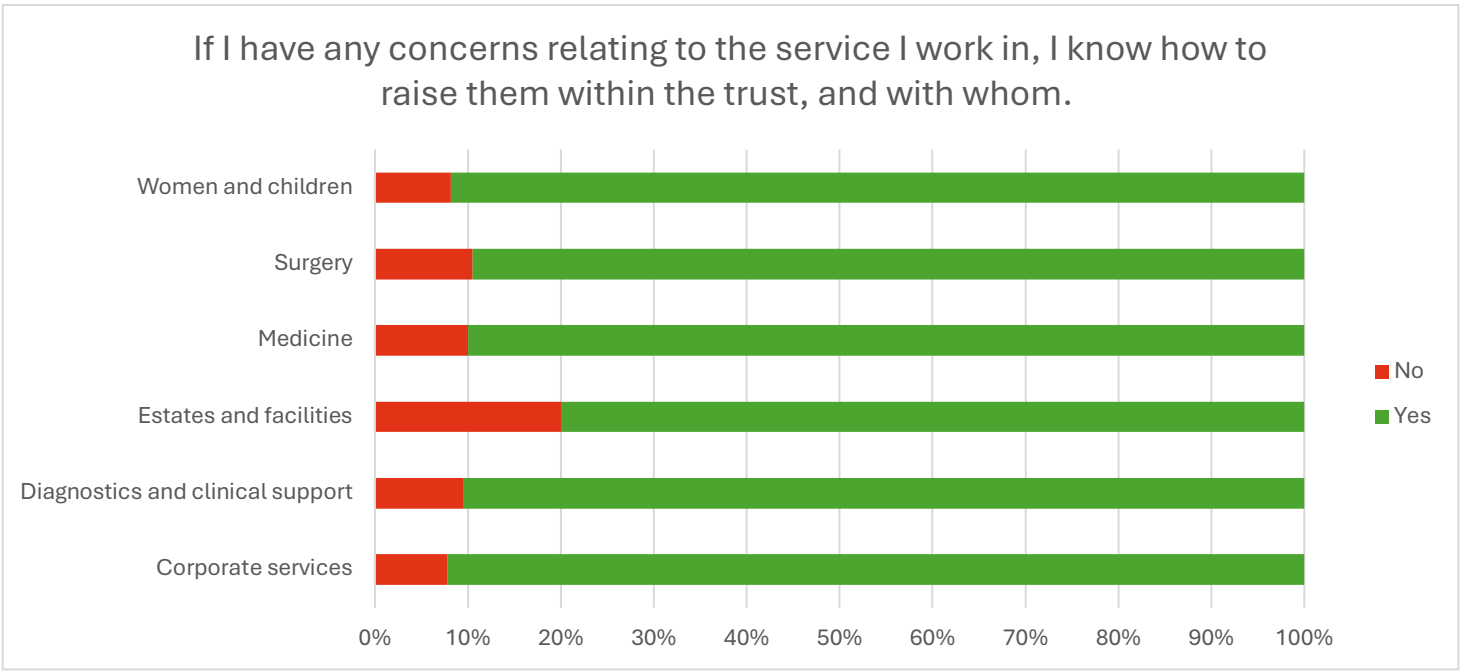

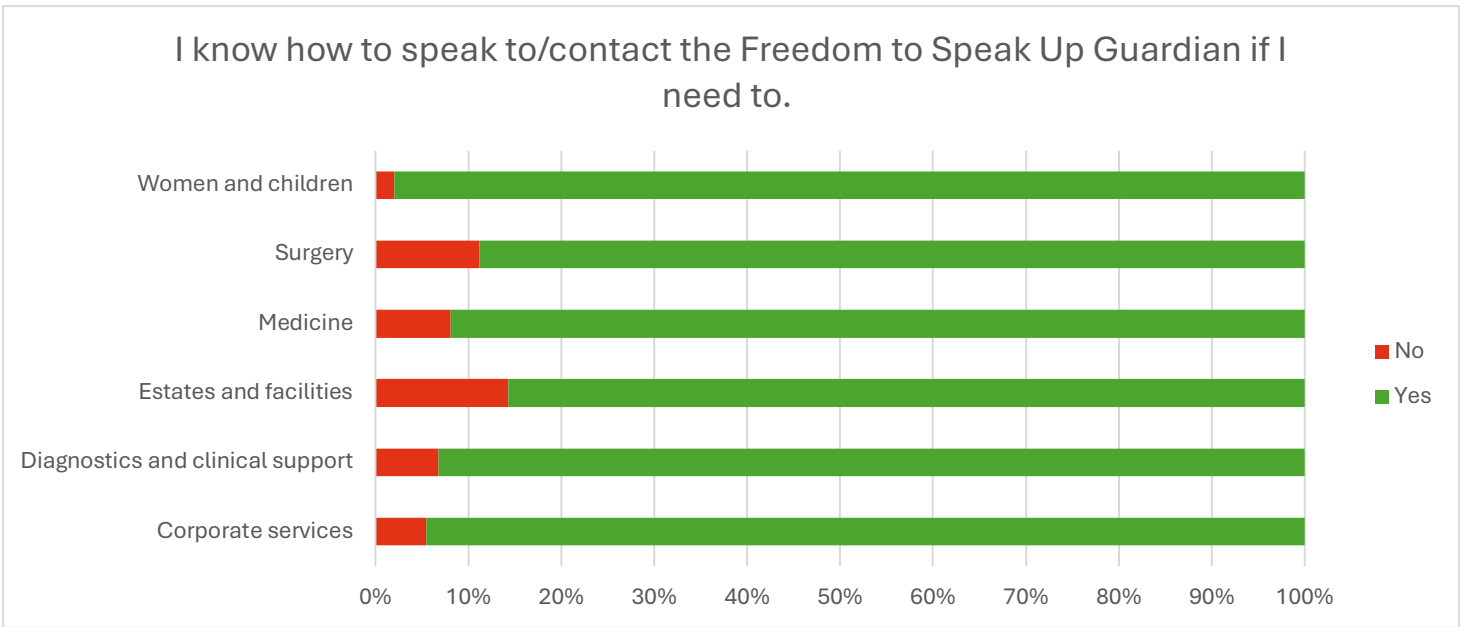

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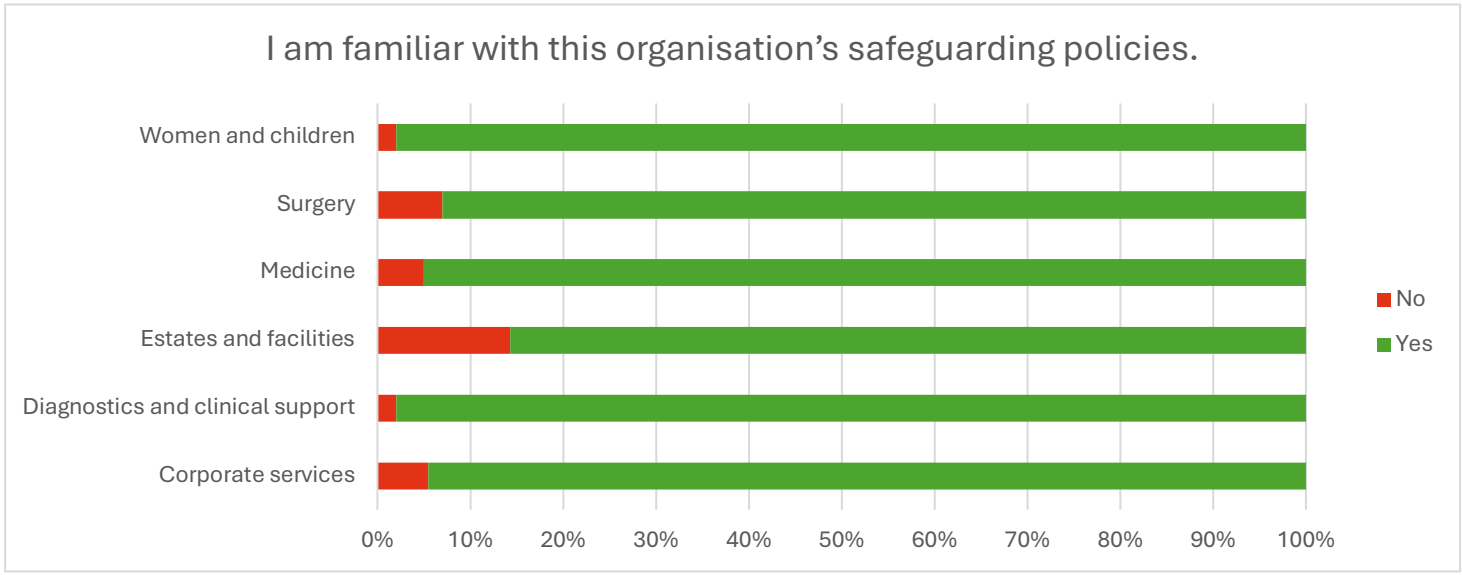

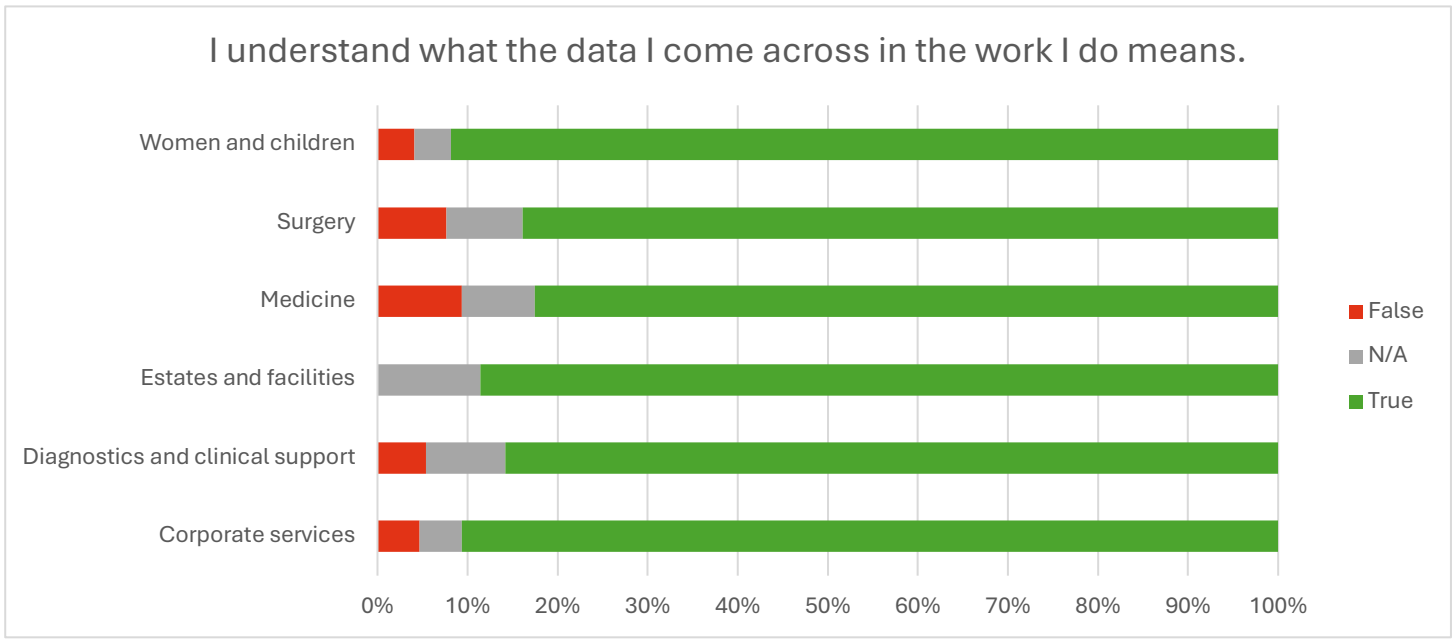

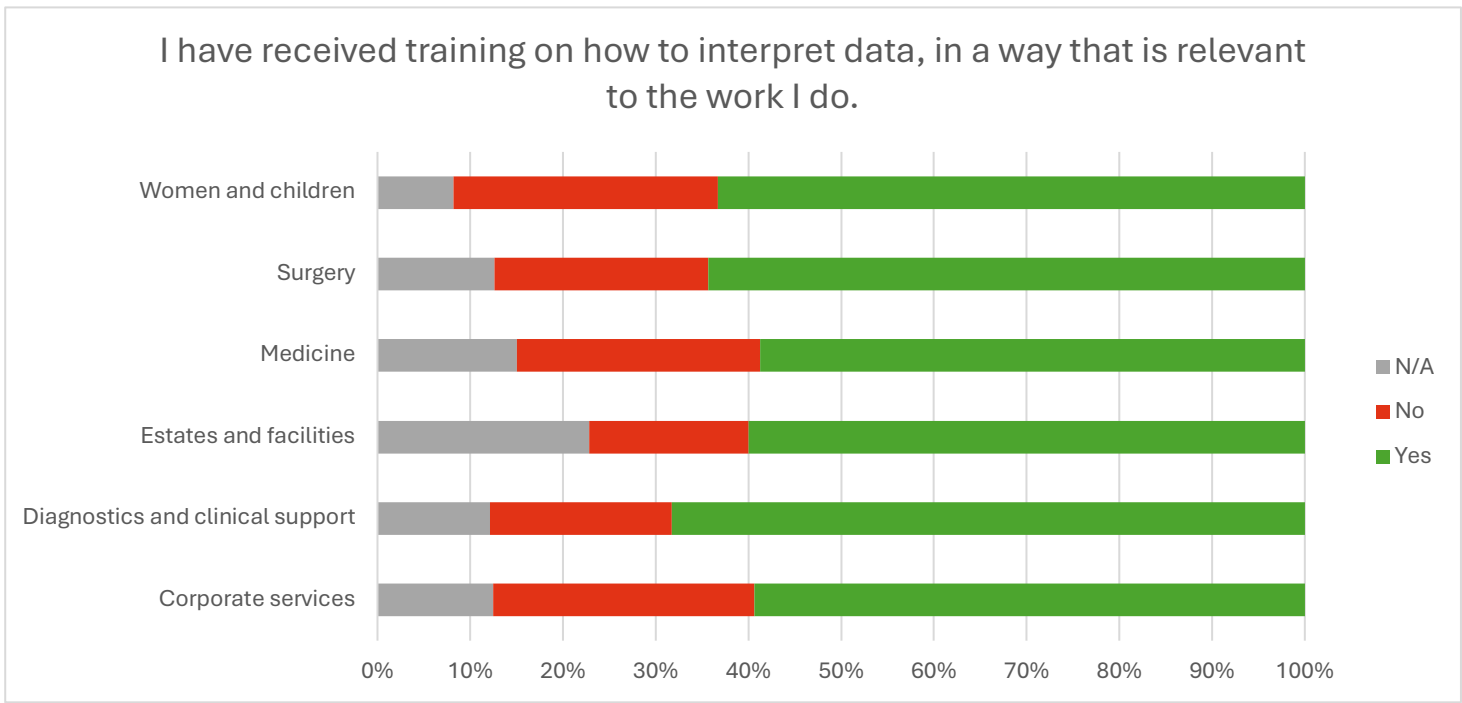

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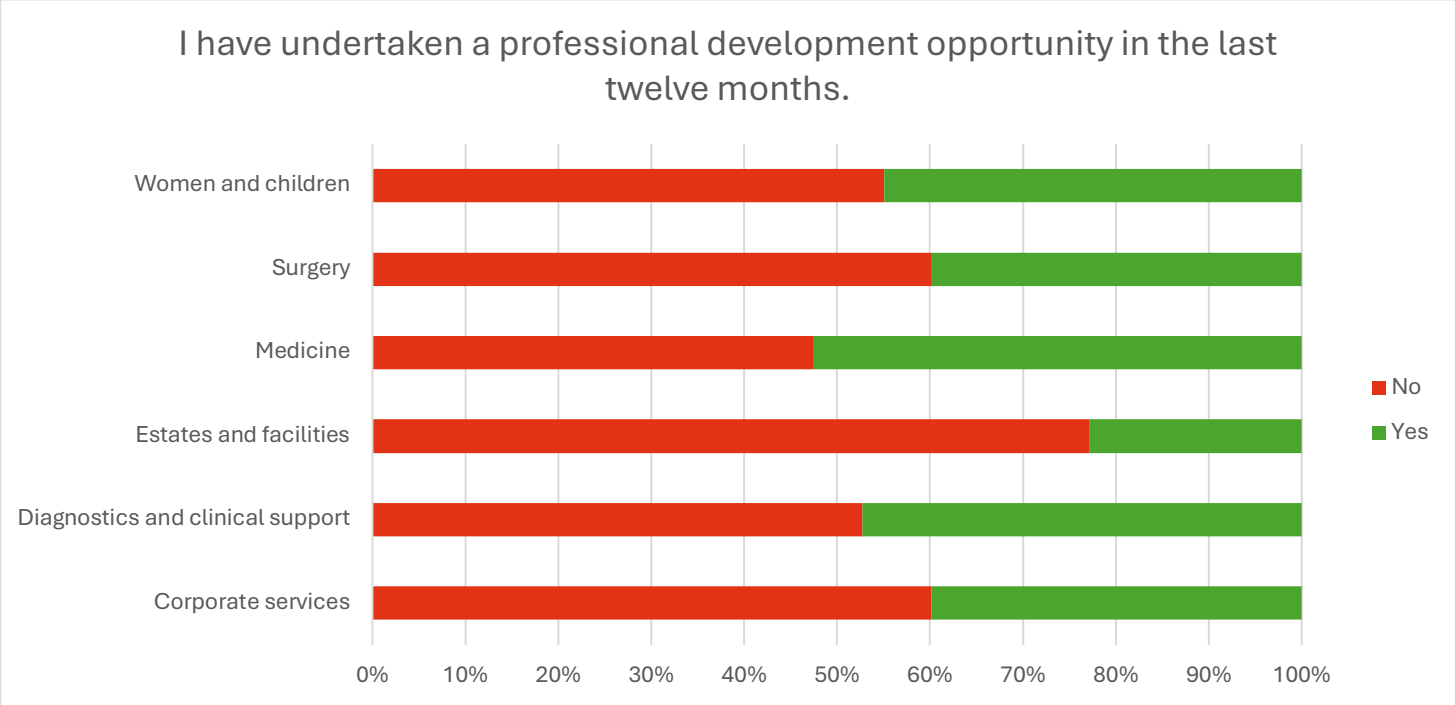

Strategy Leadership Governance

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Recovery Support Programme Draft Exit Criteria

NHS England

This document outlines proposed Recovery Support Programme (RSP) exit criteria for the Lancashire Teaching Hospitals NHS FT. This is based on the regulatory undertakings issued and agreed in February (summarised in slide 2) and expanded on with knowledge from operational delivery over the past 6 months and the work being undertaken by PwC and the Recovery Support Team.

The NHS England change programme is underway which will confirm future oversight responsibilities but in the interim we will continue to work as a regional team to oversee the LSC Integrated Care System organisations in Segment 4. The national oversight arrangements are also in transition which has impacted the process around segmentation exit criteria. The National Performance and Assurance Framework (NPAF), the updated oversight framework, is being finalised and from July more information will be shared on regional sessions to socialise and understand impacts.

It is recognised that despite these challenges clarity on expectations that are required to complete transition out of Segment 4 based on financial and governance challenges is vital for each organisation. A draft exit criteria outline has been compiled in slide 3. Whilst the core of the expectations and the overall outline are the same across all four organisations receiving RSP the criteria is bespoke recognising the specific actions that will be required to deliver financial recovery.

The criteria developed is meant as a high-level outline. It is expected that each organisation will develop a more detailed exit criteria outline to include specific lines of action relating to the published criteria e.g. the focused expenditure categories in the Waste Reduction Programme and the associated planned cost reductions. This will then be agreed through the organisation IAG meetings.

It is not expected that achievement of all exit criteria to the outlined level is the only way for organisations to transition out of Segment 4. Evidenced progress against the exit criteria and assurance of capable delivery without intensive support will be sufficient for segmentation transition. It is expected that the organisations will demonstrate significant progress by the end of Q3 when review of potential transition through Q4 will be discussed and agreed in principle as appropriate before formal agreement through the Regional Support Group and national Quality and Performance Committee.

Regulatory Undertakings: Lancashire Teaching Hospitals NHS Foundation Trust

Undertaking Focus	Key Actions
Financial Planning	1.1 Within a timeframe set by NHS England, the Licensee will agree a 2025/26 Financial Plan with NHS England.
	1.2 The Licensee will deliver a quarter-on-quarter run rate improvement from Quarter 4 2024/25 and throughout 2025/26, to enable the Licensee to deliver the financial plan as agreed with NHS England.
	1.3 The Licensee will comply with all documented actions required by the System Financial Turnaround Director through the Improvement and Assurance Group (IAG)."
Recovery Support Programme	1.1 The Licensee will evidence all reasonable steps have been taken to meet the Recovery Support Programme (RSP) Exit Criteria as set out and agreed by the IAG, in accordance with the timescales agreed by the IAG.
	1.2 The Licensee will carry out a review of progress against the RSP Exit Criteria and report to the IAG, in accordance with the timescales agreed by the IAG.
	1.3 In line with the IAG Terms of Reference and the requirements of the NHS Oversight Framework segmentation, the Licensee will cooperate fully with NHS England, health sector stakeholders and any external agencies or individuals appointed to work with or support the Licensee to address the concerns which these undertakings seek to address."
Leadership and Governance	1.1 The Licensee IAG will co-operate and engage as required with the "Governance and Leadership Review" initiated by NHS England and led by an NHS England appointed Improvement Director.
	1.2 The Licensee will inform NHS England prior to recruitment to executive board level posts and will (a) share the relevant person specifications with NHS England in draft for NHS England's comment. (b) provide a timetable for the appointment, and (c) ensure that there is NHS England representation on the interview panel.
Meetings and Reports	4.1 The Licensee will provide regular reports to NHS England through the IAG on its progress in meeting the undertakings set out above.
	4.2 The Licensee will attend monthly IAG meetings, or, if NHS England stipulates, conference calls, as required, to discuss its progress in meeting those undertakings. IAG meetings will be led by the System Financial Turnaround Director, with attendees specified by NHS England.
	4.3 Upon request, the Licensee will provide NHS England with the evidence, reports or other information relied on by its Board in relation to assessing its progress in delivering these undertakings.
	4.4 The Licensee will comply with any additional reporting or information requests made by NHS England.
Distressed Funding	2.3. The Licensee will comply with any spending approvals processes that are deemed necessary by NHS England

Recovery Support Programme Exit Criteria: Lancashire Teaching Hospitals NHS Foundation Trust

NHS England

	No.	Exit Criteria	Evidence of satisfaction of criteria	Reporting Mechanisms
Finance	1.	Deliver the financial plan submitted and agreed in April 2025 and the Waste Reduction Programme savings in May 2025.	- A 2025/26 financial outturn break-even position and overall financial deficit of no more than the £30m planned. - Achievement of the planned Waste Reduction Programme (WRP) £60m savings with fully developed Cost Improvement Plans (i.e. Board signed PIDs) in excess of £60m to offset any under delivery. - Delivery against key expenditure categories as outlined in the financial plan and WRP. - A reduction in whole time equivalent (WTE) staffing as agreed in the WRP and continued reduction in long-term staff sickness rates. - Delivery of OneLSC objectives as outlined in the financial plan/WRP. - Finalisation of commissioning intentions with the ICB along with associated costs and in-year and medium-term impact assessment. In particular completion and early implementation of plans relating to community service configuration, discharge models and urgent care provision aligned with the outputs of the Kingsgate Report and Better Care Fund review.	- Monthly financial reporting including income and outcome, and run rate, deficit support position and staffing expenditure. Reporting actual and position against plan. - Monthly IAG reports and meeting letters to identify CIP identification and delivery against plan and progress against key expenditure categories and service re-design changes.
	2.	Deliver quarter-on-quarter run rate improvement throughout 2025/26.	- The organisation with deliver a quarter on quarter run rate throughout 2025/26. - Robust expenditure controls in line with PwC recommendations.	- Quarterly regional reporting as part of Regional Support Group oversight. - Monthly IAG reports and meeting letters
	3.	Develop a medium-term financial recovery plan covering the period post 2025/26.	- A Board and IAG approved plan for financial recovery and maintenance beyond 2025/26 by the end of Q3 including plans to mitigate commissioning intention impacts.	- Monthly IAG reports and meeting letters
Leadership & Governance	4.	Demonstrate effective financial and organisational governance structures and mechanisms.	- Executive participation in the Recovery Support Team (RST) well led governance reviews. - A Board/Improvement and Assurance Group (IAG) agreed governance and leadership action plan following the publication of the RST review outcomes and recommendations and progress towards delivery of the agreed actions. - Evidence of completion of a Board development programme. - Identification of financial and organisational risks and effective controls as evidenced in Board Assurance Framework and Risk Management processes and triangulation via Triple A reporting at subcommittee and Board level. - Management of executive team vacancies in line with agreed ICB change programme mandates and through notification to and involvement with the NHS England regional team. - Demonstrable assurance that any risk to quality and patient safety through the delivery of CIP's is mitigated.	- Monthly IAG reports which identify participation in governance and leadership activity. - By end of July presentation of a governance and leadership action plan to the IAG and monthly review of progress.
Recovery Support Programme	5.	Full participation in the Recovery Support Programme.	- Executive Board attendance at monthly Improvement and Assurance Group meetings. - Engagement with the Turnaround Director and associated support executive team and response to requested actions including monthly reporting, financial planning and specific project deliverables. - Timely and accurate reporting of financial data. - Establishment of a trust wide Project Management Office (PMO) function and appointment of Senior Responsible Officers (SROs) to manage delivery of financial and organisational plans.	- Monthly IAG reports which identify participation in the RSP.

13.2 - HEALTH AND SAFETY ANNUAL REPORT

REFERENCES

Only PDFs are attached

13.2 - Health and Safety Report Supplementary Pack- Board of Directors 4 December 2025.pdf

Board of Directors Report

Meeting of the	**Board of Directors**		**4 December 2025**
	Part I ☒		**Part II** ☐
Title of Report	**Health and Safety Report**		
Report Author	Maureen Cowburn, Health and Safety Manager Hajara Ugradar, Associate Director of Safety and Learning		
Lead Executive Director	Sarah Morrison, Deputy Chief Executive / Chief Nursing Officer		
Recommendation/ Actions required	The Board of Directors is asked: • Receive the report for assurance noting the scrutiny of the report that has taken place through the Safety and Quality committee who has confirmed it is assured of the progress on Health and Safety governance improvements and progress against MIAA recommendations, whilst noting the ongoing operational challenges during the improvement phase.		
	Decision ☐	**Assurance** ☒	**Information** ☐
Appendices	Appendix A: MIAA Action Tracker Appendix B: Health and Safety Profile for Specific Areas Appendix C: Key Improvement Areas		

Main body of the Report

1. Background

1.1. The purpose of this paper is to provide assurance to the Safety and Quality Committee on the Trust's Health and Safety governance arrangements, progress since May 2025, and actions following the MIAA review, while reaffirming the Trust's commitment to meeting statutory obligations under the Health and Safety at Work Act 1974, the Management of Health and Safety at Work Regulations 1999, and associated legislation and associated regulations.

2. Discussion

2.1. Health and Safety Governance

2.1.1. The Trust continues to oversee Health and Safety through the Health and Safety Governance Group, which now meets monthly under revised Terms of Reference and Cycle of Business approved in September 2025. This change has strengthened engagement, improved representation, and enhanced oversight of statutory compliance and improved the oversight of local risk management. The Group is chaired by the Associate Director of Safety and Learning, supported by Estates and Facilities colleagues, the Health and Safety Team, subject matter experts, and the Health and Safety

Partnership Union Officer, and reports directly to the Safety and Quality Committee and, through it, to the Trust Board.

2.1.2. The Group's role is to plan, manage, and monitor compliance with health and safety requirements across the organisation. Increasing the frequency of meetings has enabled more timely escalation of issues and improved visibility of risks. To further strengthen assurance, the Chair's report is now also presented to the Executive Management Team, ensuring the Executive Team have timely visibility of key risks and improvement actions.

2.1.3. The Cycle of Business has also been strengthened to ensure the Group receives assurance either through chairs' reports from subgroups or deep dive reports covering statutory and high-risk areas including Asbestos Management, Decontamination, Fire Safety, Waste Management, Health & Safety Training Provision, Water Safety, Manual Handling and Musculoskeletal Care, Security, Medical Gas Safety, Infection Prevention and Control, Occupational Health and Wellbeing, Ventilation, Radiation Safety, and Operational Estates Management. Through the improved Cycle of Business, new governance groups have been created like the Fire Safety Group and groups previously stood down reinstated.

2.1.4. Alongside these governance improvements, the Health and Safety workstream under the Single Improvement Plan (SIP) continues to oversee delivery of recommendations from the Mersey Internal Audit Agency (MIAA) review, which provided Limited Assurance earlier this year. Detailed progress against each recommendation is provided in **Appendix A: MIAA Action Tracker**.

2.1.5. Significant progress has been made on the MIAA recommendations, with five of six actions complete: governance improvements to the Health & Safety Governance Group, completion of the HSWPG self-assessment, strengthened risk reporting, confirmation of NED scrutiny arrangements, and improved RIDDOR reporting accuracy. The remaining action full implementation of the Health & Safety governance framework is partially complete as the dashboard and KPI reporting depend on the new Incident and Risk Management System Ulysses system, with interim assurance provided through manual reporting and SMART principles embedded through governance papers.

2.1.6. All Health & Safety policies are systematically reviewed against HSG65 standards and maintained within the Trust's document management system, Heritage, which provides version control, audit trails, and accessibility for staff. This structured approach ensures transparency, consistency, and compliance with statutory obligations. There have been no significant legislative changes since the previous reporting period, and all Trust policies remain readily accessible to staff via Heritage, supporting a robust governance framework.

2.2 Health and Safety Team Resilience

2.2.1 The MIAA review earlier this year identified a vulnerability in the Health and Safety Governance Team. For a prolonged period, the team consisted of a Band 7 Manager and a Band 3 administrator, leaving a single point of failure during the long term absence of the substantive Band 7 Manager. This created a significant resilience risk. To address this, an interim Band 7 was appointed in November 2024, providing short-term continuity. Resilience improved further in August 2025 when the Physical Risk Manager transitioned from Estates into the Governance Team, a key step in strengthening capacity. Plans are in place to build a sustainable structure with improvements underway. These actions have enabled Risk ID 2075 – Single Person Reliance to be marked as controlled, with longer-term arrangements scheduled for implementation in 2026.

2.3 Health and Safety Profile (including Statutory Compliance), Risk Intelligence and Assurance

2.3.1 Health and Safety Profile and Statutory Compliance

2.3.2 Building on strengthened governance arrangements, the Health and Safety Governance Group (HSGG) is focused on triangulating intelligence and understanding the Trust's health and safety profile. This involves combining proactive assurance (audits, compliance monitoring) with reactive intelligence (incident trends and emerging risks) to provide a holistic view of organisational safety and compliance.

2.3.3 Assurance is being supported by SMART principles embedded in governance papers and structured manual reporting. The new Estates Statutory Compliance Tracker, presented to HSGG in November 2025, offers better visibility of compliance status against Health Technical Memoranda (HTMs) and other regulatory standards, enabling timely escalation and informed decision-making. Compliance with HTMs ensures the safe design, installation, and operation of specialised building and engineering systems within healthcare environments, supporting infrastructure resilience and high-quality patient care.

2.3.4 The health and safety profile spans key compliance domains, including fire safety, water safety, asbestos management, medical gas safety, decontamination, waste management, manual handling and musculoskeletal care, security, occupational health and wellbeing, radiation safety, and estates infrastructure. Oversight is provided through HSGG, supported by subject matter experts and systematic compliance monitoring. A detailed summary of compliance status for specific areas is included in Appendix B.

2.4 Risk Management

2.4.1 Risk assessments remain a cornerstone of health and safety assurance, forming the basis for identifying hazards and applying effective controls. The Workplace Risk Assessment Procedure has been refreshed to strengthen consistency. This work is separate from the wide range of connected policies (e.g., COSHH, ligature risk) that provide specific guidance for high-risk areas. These policies remain in force and continue to support compliance and safe practice.

2.4.2 To complement the procedure refresh, the Trust is introducing several initiatives to build capability and transparency:

- **Risk Assessment Training** – A new training package will be rolled out in the new year to ensure staff have the knowledge and confidence to identify hazards and apply controls effectively.
- **Central Risk Assessment Repository** – Options are being explored for a single, accessible repository to store all risk assessments, improving visibility and supporting audit processes.
- **Integration with the Trust Risk Register** – Significant risk assessments will be escalated to the Trust's main risk register, ensuring high-level risks are visible to a corporate audience for strategic planning and mitigation.

2.4.3 In addition to corporate and clinical risk assessments, the Estates division maintains a comprehensive suite of risk assessments covering key compliance areas such as water safety, fire safety, asbestos, and medical gases. These provide a strong foundation for managing estates-related hazards and demonstrate the Trust's commitment to statutory compliance. However, risks remain in certain high-risk areas, including confined spaces, pressure systems, natural gas, and F-Gas, where processes are hindered by an outdated Computer-Aided Facilities Management (CAFM) system that does not support integration of risk assessments with planned preventative maintenance schedules. To

strengthen assurance, the Trust is exploring a new CAFM system with integrated risk assessment functionality, developing specialist assessments for these high-risk areas, appointing and training Authorised Persons (APs) and Competent Persons (CPs), and introducing structured audits to monitor compliance and quality.

2.4.4 At the end of October 2025, there were 53 active health and safety-related risks recorded on the Trust's risk register, spanning infrastructure, workforce resilience, and operational processes.

2.5 Health and Safety Incident Profile and RIDDOR Compliance

2.5.1 The Trust continues to strengthen its approach to health and safety through improved responses to incidents, thorough investigations, and targeted interventions. The Health and Safety Governance Group plays a pivotal role in ensuring appropriate escalation and providing a clear route for organisational learning.

2.5.2 Under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR), the Trust has a legal obligation to report certain injuries, occupational diseases, and dangerous occurrences to the Health and Safety Executive (HSE). This process is managed by the Health and Safety Team, with reportable staff incidents divided into five categories. To date, for 2024 and 2025, there have been no requests for further action from the HSE, providing assurance that reporting and investigation processes remain robust.

2.5.3 Between October 2024 and September 2025, several notable trends were observed in health and safety incidents. Slips, trips, and falls remain the most reported RIDDOR category and the leading cause of staff injury, despite targeted interventions. To address this, the Moving and Handling team delivered accredited RoSPA Safer People Handling courses and trained 20 new Key Movers during the year, ensuring specialist support for both clinical and non-clinical staff.

2.5.4 Sharps injuries continue to occur, largely linked to design issues with the new sustainable sharps containers introduced by Daniels/Mauser. These challenges have prompted additional training in clinical areas to ensure safe handling and disposal practices.

2.5.5 Violence and aggression incidents involving patients and visitors have decreased significantly compared to the previous year, reflecting the impact of targeted interventions. However, assaults on staff have more than doubled over the past three years, creating increased physical and psychological risk. To address this, the Mental Health and Violence Prevention Big Room is developing a new approach to replace the current violence marker system with a Safety Flag, supported by multidisciplinary safety planning and restraint review processes. This aims to ensure proactive, agreed plans for patients with repeated incidents before their next admission, reducing risk to staff and improving patient care. The work is now moving into the governance phase for policy alignment and implementation. Additional assurance measures include monthly incident reviews, escalation reporting, and Body Worn Video (BWV) audits, with 400 hours reviewed in 2025 to confirm compliance with approved restraint techniques. Further actions include a permanent Emergency Department security presence, violence prevention training, and plans for a Safe Holding Systems pilot in 2026, alongside security system upgrades at the Chorley site.

2.5.6 Workplace stress incidents have risen, driven by staffing absence pressures. The Trust continues to provide wellbeing support through counselling, therapies, and a telephone service, alongside targeted initiatives such as reducing therapy waiting lists, extending psychological wellbeing partnerships, and piloting team stress risk assessments.

2.5.7 All RIDDOR cases undergo full investigation, and learning from these incidents is integrated into relevant processes and procedures, ensuring continuous improvement and compliance with statutory requirements.

2.6 Audits and Accreditation

2.6.1 The Health and Safety Team undertakes both proactive and reactive audits across all Trust sites, including monthly internal and external inspections. These audits remain challenging due to the ageing estate but continue to identify hazards and drive improvement.

2.6.2 The Safety Triangulation Accreditation Review (STAR) programme remains a key mechanism for assessing compliance with targeted health and safety standards across inpatient areas. Monthly audits highlight both good practice and areas for improvement. Overall compliance is strong, with notable achievements in COSHH storage (100%), emergency door access (99%), and oxygen and suction readiness (97.2%). Areas requiring attention include fire exit obstruction (87.3%), linked to storage constraints and linen chute issues, and sharps waste management (93%), which is being triangulated through the Sharps Working Group.

2.6.3 Audits also identified risks associated with ageing infrastructure, such as poor flooring and environmental deterioration, which may increase falls or infection risk. Despite these challenges, there is a strong reporting culture, with staff consistently escalating issues via the FM First system for timely resolution. Planned improvements include call bell upgrades (Rookwood B in December; Ward 25 early new year) and continued emphasis on checklist consistency and safe storage practices.

2.7 External Visits

2.7.1 External inspections and accreditations provide additional assurance and learning. The most recent visits aligned to HSGG recorded in Datix, include:

- **CL3 Facility and HG3 Sample Processing (May 2025):**
  Positive feedback was received on interim safety measures and the design of the new suite. The inspector raised no formal concerns, offered only minor verbal recommendations related to documentation, and praised the Trust's audit, training, and competency processes.
- **Environmental Health Inspection (July 2025):**
  Chorley Hospital café achieved a 5-star hygiene rating; minor actions completed.
- **RoSPA Accreditation (June 2025):**
  Virtual assessment confirmed compliance with safer handling training standards; no actions required.
- **Lancashire Fire and Rescue Inspections (July–August 2025):**
  Findings included obstructed escape routes, non-compliant fire doors, and defective hold-open devices. All actions have been logged on Datix with progress being tracked and monitored through the new Fire Safety Governance Group.

2.8 Training and Competency

2.8.1 Training remains a cornerstone of health and safety assurance, underpinning compliance and workforce capability. Core skills compliance across the organisation is consistently high, with September 2025 figures showing Health, Safety and Welfare at 98.4%, Fire Safety at 98.2%, Display Screen Equipment (DSE) at 96%, Infection Prevention and Control at 95%, Moving & Handling Level 1 at 92.4%, Level 2 at 91%, and Conflict Resolution at 97.3%.

2.8.2 Beyond core skills, the Trust is strengthening specialist and leadership training to address risks in voluntary roles such as DSE assessors, fire wardens, and moving and handling key movers. Initiatives include enhanced fire safety training, accredited programmes (e.g., ROSPA Safer People Handling Trainers, Emergency First Aid at Work), and exploration of dedicated IOSH training provision to embed a proactive safety culture.

2.8.3 Further developments include updates to moving and handling content, bariatric care training, and improvements to DSE compliance through revised e-learning and assessor training.

2.9 Strengthening Partnership and Staff-Side Engagement

2.9.1 In the last few months, the Associate Director of Workforce and Associate Director of Safety and Learning have been working together to strengthen the partnership working with staff-side representatives to ensure health and safety governance is underpinned by meaningful consultation and collaboration. This has included working with the appointed Health and Safety Partnership Officer to reset the purpose of the Health and Safety Joint Consultative Committee (HS JCC), transforming it from a forum that previously duplicated governance updates into a consultative body focused on staff engagement and improvement.

2.9.2 This reset is introducing structured processes to capture concerns from staff-side representatives early and escalate them effectively. Work is underway to create a clear timeline and flowchart for policy consultation, mirroring workforce policy processes, so health and safety policies receive timely and informed feedback. The committee has also prioritised greater engagement on risk assessments, supported by plans for training managers on their duty to consult.

2.9.3 Membership of HS JCC has expanded to include representatives from Unite, RCN, and Unison alongside operational colleagues, creating a stronger and more diverse voice across divisions.

2.9.4 Looking ahead, monthly representatives' meetings are proposed to build confidence in policy review and strengthen the consultative model. At a system level, the Trust is exploring regular health and safety meetings with other Lancashire and South Cumbria organisations to share best practice and address governance challenges linked to One LSC and the Single Pathology Service.

2.9.5 These developments demonstrate the Trust's commitment to transparency, partnership working, and continuous improvement, ensuring staff voices are heard and acted upon.

2.9.6 In the next few months, further engagement will take place with staff side colleagues to ensure safe and compliant governance for the Single Pathology Service transition in February, including harmonising policies, addressing any concerns, and clarifying health and safety roles and responsibilities.

2.10 Improvement Priorities

2.10.1 Whilst significant progress has been made in strengthening health and safety governance and statutory compliance, a substantial amount of work remains. The revised governance arrangements continue to identify further risks that require further work and sustained investment. Identifying these risks is an important step toward assurance; once they are clearly understood, they can be addressed. However, the scale and complexity of the required actions mean that improvement will take time.

2.10.2 Between now and March 2026, the Associate Director of Safety and Learning, together with Estates and Workforce colleagues and the Health and Safety Team, will:

- Consolidate intelligence from multiple sources including the Estates Statutory Compliance, the HSWPG Self-assessment, risks escalated through the HSGG and other assurance mechanisms and triangulate this with risks on the Trust's risk register to ensure the improvement plan reflects the full risk profile.
- Use this consolidated view to prioritise actions and inform the Health and Safety workplan for 2026/2027, providing clarity on critical areas where targeted investment is required.

This work should further inform the Health and Safety and associated workstreams in the Single Improvement Plan.

2.10.3 **Appendix C** outlines the known areas for improvement, setting out the governance, training, infrastructure, and operational priorities that will underpin delivery of sustained assurance. These actions represent the current picture based on intelligence gathered to date and will be refined as further risks are identified through strengthened governance processes.

3. Conclusion

3.1. The Trust has made significant progress in strengthening health and safety governance in the last six months, improving resilience, and taking positive actions to improve statutory compliance. Governance structures have also been strengthened, with enhanced oversight through monthly Health and Safety Governance Group meetings and direct reporting to the Safety and Quality Committee and Executive Management Team. Five of six MIAA recommendations have been completed, and interim assurance is in place for the remaining action pending full implementation of the Ulysses system.

3.2. Despite these improvements, key challenges remain. Incident trends highlight persistent risks in slips, sharps injuries, and workplace stress, while strategic risks such as fire safety backlog, water safety infrastructure, and rising security incidents require continued focus and investment. Training compliance is strong overall, but reliance on voluntary roles and resource constraints for face-to-face delivery present ongoing challenges.

3.3. The Trust's commitment to health and safety is evident through proactive engagement with unions and sustainability initiatives. However, achieving full assurance will depend on addressing high-risk areas, securing resources for infrastructure improvements, and maintaining momentum on cultural and behavioural change. Priorities for the next 12 months include completing the Health and Safety dashboard, strengthening local capability through targeted training, and embedding improved governance arrangements through the Single Improvement Plan.

4. Financial implications

4.1. Residual risks linked to ageing infrastructure (fire dampers, water safety systems, asbestos encapsulation) and security enhancements will require continued capital investment, which is being considered within the Estates programme.

5. Legal implications

5.1. The Health and Safety at Work Act 1974 imposes duties on employers to protect the 'Health, Safety and Welfare' of all their employees, as well as others on their premises, including contractors, visitors

and the general public. Appendix B provides further information on compliance with relevant Health and Safety legislation.

6. Risks

6.1. There are a number of risks related to Health and Safety on the Trust's Risk Register which may lead to non-compliance with legislation and risk to Health, Safety and Welfare of employees, as well as others on the Trust's premises. These risks relate to a variety of reasons.

6.2. All risks are managed in accordance with the trusts Risk Management Policy RMS-01 and reported and managed through divisional and corporate meetings. However, due to the ageing estate and ongoing financial challenges, it is difficult to eliminate all Health and Safety risks in their totality.

6.3. In October 2024, Risk ID 2075 was identified, highlighting operational fragility due to reliance on a single Band 7 substantive lead within the Health and Safety Governance Team. This has been controlled in October 2025.

7. Impact on stakeholders

7.1. The Health and Safety at Work Act 1974 legislation was introduced to apply broad duties and best practice in regard to the Health and Safety of organisations workforce. This includes a duty of care for employees, casual workers, self-employed workers, clients, visitors, and the general public. Robust Health and Safety governance and Physical health and Safety governance will ensure the trust delivers its regulatory duties in line with The Health and Safety at Work Act 1974.

8. Recommendations

The Board of Directors are asked to:

8.1 Receive the report for assurance noting the scrutiny of the report that has taken place through the Safety and Quality committee who has confirmed it is assured of the progress on Health and Safety governance improvements and progress against MIAA recommendations, whilst noting the ongoing operational challenges during the improvement phase.

Appendix A – Progress with MIAA actions

MIAA Recommendation	Risk Rating	Current Position Progress	Completion Status
1. **Health and Safety Governance Framework** Implement a framework to identify and provide assurance that all necessary policies and procedures are in place to manage health and safety. Include: specific and general risk assessments; processes to record outcomes; KPIs via dashboard; trend analysis; SMART reporting principles.	**High**	The Health and Safety governance framework has been strengthened through oversight in the Health & Safety workstream under the Single Improvement Plan (SIP). The overarching Workplace Risk Assessment Procedure has been refreshed, with practical guidance on storage and accessibility in development to ensure consistency across corporate, divisional, and personal risk assessments. A baseline audit of general risk assessments has informed template development, and processes for recording outcomes are being formalised. KPI development and trend analysis will be supported by a Health & Safety dashboard, which is in progress and dependent on the new Ulysses system. In the interim, assurance is provided through manual reporting and SMART principles embedded in governance papers. The Estates Statutory Compliance Tracker was presented to HSGG in November, and a cycle of policy review is in place and reported to HSGG to ensure all necessary policies and procedures remain current and aligned to statutory requirements.	**Partially Complete**
2. **Improve Health and Safety Governance Group (HSGG) Effectiveness** Improve effectiveness of HSGG including: fuller attendance; input from Responsible Officers; comprehensive papers aligned to HSG65; confirmation of subgroup effectiveness; oversight of general risk assessments; update ToR.	**High**	The Health & Safety Governance Group's effectiveness has been strengthened through updated Terms of Reference and Cycle of Business, monthly meetings, improved attendance and Responsible Officer input, and enhanced subgroup reporting aligned to HSG65. The Chair's report is presented to the Executive Management Team for timely visibility of key risks and improvement actions, with concerns escalated as required. Assurance reporting to the Safety & Quality Committee has been strengthened through AAA reporting, and delivery of MIAA recommendations continues under the Health & Safety workstream within the Single Improvement Plan (SIP). In addition, the Associate Director of Safety and Learning attends the Estates Delivery Improvement Forum (DIF), supporting	**Complete**

		triangulation and ensuring any matters arising are appropriately reflected on the HSGG agenda. The Cycle of Business has also been strengthened to ensure the Group receives assurance either through chairs' reports from subgroups or deep dive reports covering statutory and high-risk areas including Asbestos Management, Decontamination, Fire Safety, Waste Management, Health & Safety Training Provision, Water Safety, Manual Handling and Musculoskeletal Care, Security, Medical Gas Safety, Infection Prevention and Control, Occupational Health and Wellbeing, Ventilation, Radiation Safety, and Operational Estates Management.	
3. Health, Safety and Wellbeing Partnership Group (HSWPG) Self-Assessment Carry out self-assessment against NHS Staff Council's HSWPG Workplace Health & Safety Standards (May 2022) to inform improvement programme, dashboard structure, annual reporting, and policy scope.	**Medium**	The Trust has completed a self-assessment against the HSWPG standards, reviewing 274 criteria across 25 standards with the Trust showing 76% compliance. This was presented to the HSGG in November 2025. Any identified risks from the HSWPG self-assessment are being validated, with progress updates included in subject-specific reports to the HSGG and triangulated across assurance sources with confirmed risks reflected on the Trust's risk register where appropriate.	**Complete**
4. Risk Reporting to HSGG Ensure reporting of Datix health & safety risks by HSGG is focused and that any risks/trends arising from generic risks are escalated appropriately.	**Medium**	Health & Safety tag included within risks on the Datix System; Quarterly risk reports now presented to HSGG.	**Complete**
5. NED Scrutiny Confirm appointment of a Non-Executive Director to scrutinise health & safety performance.	**Low**	Following discussion, the Trust has elected not to proceed with appointing a single NED for Health & Safety. Instead, a collective assurance model has been confirmed. All three Safety and Quality NEDs will continue to receive assurance on Health & Safety matters. Among these, one also chairs the Finance and Performance Committee, where Estates reports in, and another chairs the Workforce Committee, where People	**Complete**

		reports in. This structure ensures comprehensive coverage of Health & Safety across operational, workforce, and estate domains, without the need for a dedicated NED role. This approach reflects the Trust's commitment to integrated governance and provides robust oversight through existing structures.	
6. RIDDOR Reporting Accuracy Ensure reports presented to HSGG are accurate and include both incident occurrence and reporting dates.	**Low**	Report template updated to include incident occurrence and reporting dates; Standing item maintained at HSGG.	**Complete**

Appendix B – Health and Safety Profile for Specialist Risk Areas

The table below provides an update on key compliance domains. A number of these areas are being managed through the Estates Statutory Compliance Tracker, capital prioritisation and oversight through Health and Safety Governance Group.

Asbestos	The Trust recognises its legal obligations under the Control of Asbestos Regulations 2012 to manage asbestos within its estate. Assurance is provided through a structured compliance framework: • An asbestos risk register is maintained within the Micad database, providing an up-to-date record of location, maintenance, and associated risks. • Annual directed management surveys are carried out by an appointed contractor, with systems in place to address any actions generated. • Funding from the annual capital programme has been allocated to improve asbestos encapsulation at Preston Business Centre. However, further capital investment is required with the ageing estate increasing long-term risk. • All tradesmen and estates staff have completed annual Asbestos Awareness training, delivered in a classroom format this year, and the fit-testing programme continues for all new and existing staff as required. To date, there have been no reported incidents linked to asbestos in the past 12 months.
Water Safety	Compliance with the HSE's Approved Code of Practice is supported by independent condition reports and action planning through the Water Safety Group. Water safety remains a significant risk due to ageing infrastructure and complex systems, which increase the potential for Legionella, drainage issues, and Pseudomonas contamination. Substantial investment is required to address these risks, alongside plans to strengthen internal capacity and improve maintenance schedules to ensure robust control. A business case is being developed for an in-house water safety team to strengthen internal capacity and reduce reliance on contractors.
Medical Gases Safety	Under the Control of Substances Hazardous to Health (COSHH) Regulations 2002, the Trust monitors hazardous substances to which staff may be exposed. To reduce risk, a designated scavenging system has been installed in maternity delivery rooms, preventing nitrous oxide from venting back into the environment

	when patients use Entonox. This measure significantly reduces exposure risk for midwives and supports compliance with COSHH requirements.
Decontamination	The Strategic Decontamination Committee is scheduled to meet quarterly to oversee compliance and operational performance. However due to staffing risks at senior levels these meetings have been stood down. Discussions have taken place with the Estates and Facilities Director to reinstate this meeting in the next quarter. Further challenges include infrastructure limitations particularly ageing autoclaves and insufficient storage continue. Infrastructure challenges remain, including ageing autoclaves and limited storage capacity, but mitigations are in progress. Planned investment and operational adjustments are being prioritised to address these issues. The leader position for HSDU has been assessed and a new job description that clearly outlines the HSDU and wider decontamination role of this person is being assessed and expected to be out to advert within the next month. **Endoscopy Unit Upgrades** Significant progress has been made in improving decontamination processes within endoscopy services. The upgrade of the main endoscopy unit at Preston and the opening of the Sherwood Unit introduced state-of-the-art pass-through systems, enhancing controlled cleaning processes and reducing contamination risks for thermolabile medical devices. Further investment has been allocated for the upgrade of the Endoscopy Unit at Chorley Hospital, with building work scheduled to commence in February 2026.
Waste	The Trust has introduced a colour-coded system for clinical waste streams to prevent over-treatment, ensure compliance with national guidance, and move towards more cost-effective disposal routes. This initiative supports environmental performance and sustainability objectives. Recent audits identified non-compliances, particularly medicine-contaminated waste incorrectly placed in the orange bag stream. These findings highlight not only environmental and financial risks but also staff safety concerns, as incorrect segregation can lead to exposure to hazardous substances and sharps injuries. To protect staff and maintain compliance, The Trust has taken urgent action, including: • Additional communications to all clinical areas. • Posters and signage in wards and departments. • Targeted training for clinical, domestic, and portering staff. • Plans for waste tracking systems to identify sources of non-compliance. Failure to address these issues could result in financial penalties and increased disposal costs, as non-compliant waste is charged at incineration rates. Other actions include: • Phase Two of the segregation project will expand offensive waste streams where feasible. • Updated e-learning package for waste management will launch in December 2025. • Additional signage and bin labels will be deployed across clinical areas. • Ongoing engagement through Waste Management meetings, divisional Health and Safety forums, and Trust briefings. Sustainability Initiatives

	The Trust's Sustainability Group continues to drive implementation of the Green Plan, focusing on reducing single-use plastics, promoting reuse, and embedding a culture of recycling. The Warp-it reuse portal and upholstery services remain key initiatives, reducing procurement and disposal costs while supporting environmental goals.
Radon	Under the Health and Safety at Work etc. Act 1974, the Management of Health and Safety at Work Regulations 1999, and the Ionising Radiations Regulations 2017 (IRR17), the Trust is required to monitor radon levels across its estate. If radon levels exceed 300 Becquerels per cubic metre (300 Bq/m³) as an annual average, remedial actions must be taken to reduce levels below this threshold. Monitoring has previously been carried out at Royal Preston Hospital, but radon levels have not yet been determined at Chorley Hospital. The Radiation and Medical Exposure Committee has scheduled to implement a monitoring programme in early December using a specialist independent company. A total of 800 monitors will be positioned across the site for a three-month period. Results will determine whether levels are below the threshold or if further action is required. This audit is only required to be carried out once.
Security	The Trust continues to strengthen its security management systems in line with NHS Security Management Standards, with assurance provided through the Health and Safety Governance Group. Despite these measures, security-related risks have escalated over the past three years, with a notable increase in assaults on staff and incidents involving weapons. While overall security incidents remain high, restraint incidents and red alerts show mixed trends, indicating areas for targeted intervention. Key developments include: • Incident Trends – Assaults on staff have more than doubled from 59 in 2023 to 131 in 2025, and weapon-related incidents have risen from zero in 2023 to 23 in 2025. • Mitigation Measures – Permanent 24-hour security presence in the Emergency Department, monthly incident reviews, screening protocols for known weapon carriers, and improved collaboration with local police for rapid response. • Violence Prevention Training – A programme covering de-escalation, communication skills, and early intervention strategies is in place, alongside specialist ad-hoc training for high-risk areas such as ED. • Body Worn Video (BWV) – All restraint incidents captured on BWV are reviewed to ensure compliance with approved techniques. • Future Initiatives – A pilot programme introducing Safe Holding Systems using soft cuffs will commence in early 2026 to protect patients at risk of self-harm and support staff during violent incidents. These measures aim to reduce physical and psychological harm to staff, improve confidence in managing aggression, and ensure lawful and proportionate responses to security threats.
Fire	The Trust maintains compliance with the Fire Safety (England) Regulations and Health Technical Memoranda (HTMs) through comprehensive fire risk assessments (FRAs) and structured governance. To date, 239 FRAs have been completed, all of which are in date. A risk-based review cycle ensures high-risk areas such as bedded wards are reviewed annually, medium-risk areas every two years, and low-risk areas every three years.

	Despite this structured approach, a backlog of outstanding actions remains due to financial constraints and operational pressures, compounded by the ageing estate. Key risks include fire dampers not inspected since 2020, which impacts smoke control and compartmentation, and incomplete electrical infrastructure testing at Royal Preston Hospital, limiting assurance on system integrity. These risks are being actively managed through a phased improvement plan overseen by the newly established Fire Safety Group, which provides focused governance and escalation. Recent improvements include: • Completion of fire alarm upgrades at Royal Preston Hospital, including a new fire panel in Rosemere Cancer Services. • Ongoing upgrades at Chorley Hospital, scheduled for completion by late 2025, alongside major repairs to fire-stopping systems and door replacements. • Routine maintenance of emergency lights, hydrants, risers, extinguishers, and suppression systems is fully compliant. The Trust is also planning to phase out foam extinguishers over the next five years, replacing them with fluorine-free foam or water mist extinguishers in line with sustainability goals. Fire-related incidents are reported via Datix, investigated thoroughly, and corrective actions tracked through governance processes. Training compliance remains strong for e-learning (98%), but face-to-face training is low, with resource constraints limiting delivery. A phased approach is in place to improve compliance, supported by monthly sessions for fire wardens, site managers, and evacuation techniques.
Estates Compliance and Statutory Assurance	The Trust remains committed to the statutory requirements of the Health and Safety at Work Act 1974 and associated regulations. Compliance is delivered through Health Technical Memoranda (HTMs) for engineering systems and other statutory frameworks for domains such as asbestos, waste, radon, and security. To provide independent expert assurance, the Director of Estates and Facilities is supported by Authorising Engineers (AEs) and Appointed Persons (APs). These roles deliver: • Specialist advice and direction • Risk assessment and audit • Corrective action plans submitted to Estates sub-groups and the capital programme • Training and compliance oversight In addition, the Estates division operates under a structured compliance framework aligned to the NHS Premises Assurance Model (PAM). This includes annual audits by independent Authorising Engineers and action logs for statutory risks. Shortages exist in Authorised Persons (APs), Competent Persons (CPs), and Authorising Engineers (AEs) across disciplines such as electrical systems, ventilation, confined spaces, lifts, and pressure systems. This is mitigated by Divisional Director of Estates and Facilities oversight, the strengthened health and safety governance group oversight and prioritisation of focus based on risk. Priorities include: - There is a need identified for a dedicated Estates Compliance Manager with a more up to date Computer-Aided Facilities Management (CAFM) system.

	Work is underway to prioritise confined space risk assessments and safe systems of work. - Pressure systems require Boiler Operation Accreditation Scheme (BOAS) training and updated written schemes. - Natural gas and fluorinated gas (F-Gas) require strengthened training, asset registers, and management policies. These risks are being addressed through recruitment, targeted training programmes, and system upgrades but will require investment with further actions detailed in Appendix C. Actions are being prioritised based on risk and monitored through the revised Estates Statutory Compliance Tracker which was presented to the Health and Safety Governance Group in November 2025 for the first time. This is a positive step forward in having more detailed oversight of this agenda.
Staff Psychological Wellbeing Service	The Trust continues to prioritise staff mental health through the Staff Psychological Wellbeing Service, delivered in partnership with Wellbeing Partners, a joint venture between Lancashire Teaching Hospitals NHS Foundation Trust and Wrightington, Wigan and Leigh NHS Foundation Trust. This partnership, established in 2014, has been extended until April 2027, with the transfer of services to One LSC deferred, providing continuity and stability. Between October 2024 and September 2025, there were 185 referrals to the service, with the most in-demand interventions being: • Brief Therapy • Counselling • High-Intensity Therapy Although waiting times for psychological therapies remain a concern, improvements have been achieved over the past 12 months, supported by the recruitment of a new psychologist in September 2025. This has enabled progress in reducing delays and improving access. However, outreach support for staff absent due to mental health issues has been temporarily scaled back due to capacity pressures, with a review scheduled by year-end.
Display Screen Equipment (DSE)	The Trust has refreshed its Display Screen Equipment (DSE) self-assessment package following staff feedback to improve usability. Staff are completing self-assessments, which helps identify potential ergonomic risks and supports compliance with DSE legislation. To strengthen assurance, work is underway to build local capability for addressing issues identified through these assessments. This includes finalising an in-house DSE assessor training programme and ensuring each division has trained assessors to provide timely support. Interim arrangements are in place, with the Health and Safety Team prioritising high-risk cases to prevent delays in resolving issues. Monitoring processes are being enhanced to track completion rates and follow-up actions, ensuring that assessments lead to practical improvements in staff health and wellbeing. These developments demonstrate the Trust's commitment to compliance and proactive risk management in line with statutory requirements.
Ligature Risk Management	The Trust has seen an theme of ligature-related incidents reported over the past year, prompting a thematic review covering November 2024 to November 2025. This review identified 39 relevant cases, with the majority occurring in the

	Emergency Department at Royal Preston Hospital. Patient bed spaces and toilets were the most common locations, and clothing and bedding were the primary ligature materials. A small number of patients accounted for multiple incidents, and while most resulted in no harm, three cases involved psychological harm. The Trust has commenced a Ligature Working Group which has been progressing updates to the ligature risk assessment and policy. Key actions include trialling a revised ligature risk assessment, increasing access to ligature cutters, and developing practical guidance for clinical leaders. Training needs and standardisation of equipment are also being addressed. Priorities going forward include regular environmental audits to reduce anchor points, targeted care plans for repeat ligature patients, refresher training for staff, and improved reporting of near misses. These measures aim to strengthen compliance and enhance patient safety across all high-risk areas.

All risks are being triangulated through the Health and Safety Governance Group and the triangulated Risk Report.

Appendix C – Key Improvement Actions

This appendix sets out the known improvement actions required to strengthen health and safety assurance across the Trust. These actions have been drawn from multiple intelligence sources, including statutory compliance reviews, governance group escalations, and thematic assessments and reports. They represent the current priorities and will inform resource planning and the Health and Safety workplan for 2026/27. As governance processes mature, this list will be refined to ensure alignment with emerging risks and be included in the Trust's Single Improvement Plan Health and Safety programme.

Governance and Assurance

- Develop a Health and Safety dashboard and KPI reporting.
- Establish a central repository for ward-based risk assessments and embed the new procedure.
- Establish a central repository for estates-related risk assessments.
- Introduce a structured audit programme to review risk assessment quality and completion rates.
- Consider appointment of an Estates Compliance Manager.
- Appoint Authorised Persons (APs), Competent Persons (CPs), and Authorising Engineers (AEs) across disciplines such as electrical, ventilation, lifts, confined spaces, and pressure systems and where risks have been identified.
- Reinstate the Strategic Decontamination Committee.
- Strengthen use of the Estates and Facilities Statutory Compliance Tracker for improved oversight and escalation.
- Clarify Health and Safety governance for the Pathology Collaborative.
- Continue strengthening HSJCC and Staff Side partnership working.

Training and Capability

- Deliver risk assessment training for managers and estates personnel.
- Identify and train DSE assessors in all divisions.
- Increase fire warden and evacuation training compliance.
- Improve face-to-face fire safety training compliance.
- Expand moving and handling trainer capacity.
- Deliver refresher training on ligature risk identification and cutter use.

- Implement targeted training programmes for AP and CP roles, including BOAS (Boiler Operation Accreditation Scheme) for pressure systems and specialist training for confined spaces, natural gas, and F-Gas.
- Provide accredited asbestos management training (UKATA 405) for responsible persons.
- Develop a training matrix to monitor compliance and competency.

Infrastructure and Environment

- Complete fire damper inspections and remedial works.
- Complete fire alarm upgrades at Royal Preston Hospital and continue upgrades at Chorley Hospital.
- Progress water safety improvements and maintenance schedules (including schematics, tank replacements, Legionella/Pseudomonas risk actions, and explore an in-house water safety team).
- Secure funding for asbestos encapsulation projects.
- Implement a radon monitoring programme at Chorley Hospital and act on findings.
- Address backlog maintenance for lifts, ventilation ductwork, and electrical systems.
- Continue plans to strengthen decontamination infrastructure.
- Develop specialist risk assessments for confined spaces, pressure systems, natural gas, and F-Gas compliance.

Operational Safety

- Improve waste segregation compliance through tracking and targeted training.
- Embed revised ligature risk assessment and care planning processes.
- Strengthen security measures and violence prevention initiatives.
- Reduce sharps injuries through improved container design and training.

Workforce Wellbeing

- Maintain counselling and therapy services; reduce waiting times through additional capacity.
- Pilot team stress risk assessments and review outreach support for absent staff.

Sustainability

- Continue Green Plan initiatives, including reuse portals and reduction of single-use plastics.

14.1 - MATERNITY AND NEONATAL SERVICES UPDATE

REFERENCES

Only PDFs are attached

14.1 - Maternity and Neonatal Safety Report - BOD December 2025 Supplementary pack.pdf

Board of Directors

Meeting of the	**Board of Directors**		**4 December 2025**
	Part I ☒		**Part II** ☐
Title of Report	**Maternity and Neonatal Services Safety Report**		
Report Author	J. Lambert – Deputy Midwifery & Nursing Director		
Lead Executive Director	Sarah Morrison – Chief Nursing Officer/Deputy Chief Executive Officer		
Recommendation/ Actions required	The Board of Directors is asked to: i. Receive the report, including the CNST Maternity Incentive Scheme (MIS) supplementary information pack and associated action plans for oversight and assurance noting the report has been scrutinised by the Safety and Quality committee. ii. Note the inclusion of the training action plan for MIS year 7 and record in the Board minutes that it is supportive of the action plan for achievement of 90%, based on the scrutiny at safety and Quality committee. iii. Confirm it is assured of the oversight and monitoring mechanisms within maternity services.		
	Decision ☐	**Assurance** ☐	**Information** ☒
Appendices	1. Clinical negligence scheme for trust information pack CNST year 7 2. Perinatal Quality Surveillance Supplementary Pack 3. Red Flags Data 4. Induction of labour update.		

Main Body of the Report

1. INTRODUCTION

The purpose of this report is to provide an overview of the safety and quality programmes of work and to present the monthly staffing position within the perinatal (maternity and neonatal) services up until the end of October 2025. The report triangulates workforce information with safety, patient experience and clinical effectiveness indicators for assurance and oversight. Supplementary information is presented in appendix 1 and 2 and 3 to ensure that there is appropriate board level oversight of clinical performance and outcomes.

2. MATERNITY INCENTIVE SCHEME (MIS)

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

Table 1 provides an overview of the status of all 10 safety standards and provides a high-level summary of the actions taken to meet the requirements and achieve compliance for year 7. As per the year 6 maternity incentive scheme, the Integrated Care Board (ICB) /Local Maternity and Neonatal System (LMNS) have undertaken two assurance visits to date and a third is planned at the end of the reporting period.

The report covers the period up to the end of October 2025. To date the service remains on track to deliver 9/10 MIS standards, with one standard (MIS standard 8) requiring an action plan for improvement in relation to the training compliance of 90% for medical trainees for PROMPT and fetal monitoring. For the service to declare compliance with standard, the safety and Board of Directors must acknowledge the action plan for achievement of 90%, agree the trajectory to meet the requirements and formally record discussions in the Board minutes. (See appendix 1 standard 8)

It is anticipated that 90% compliance for the trainee groups will be achieved within the 6-month period by the end of December 2025.

2.1 MIS STANDARD 8 PROMPT AND FETAL MONITORING

FETAL MONITORING

Compliance for fetal monitoring training in October 2025 is currently above 90% for midwives (94% compliance 207 of 221 compliant. Consultant compliance currently 86% (11 of 13 Consultants compliant – outstanding staff members booked on to November 2025 study day – (Update both have attended, therefore compliance by the end of November will be 100%.)

Obstetric Doctors 71% compliant –12 of 17 doctors (6% increase on September 2025 compliance). This reduction in compliance is as result of the doctors' rotation and strikes affecting attendance. Dates are arranged within 6-month window as per MIS standards will enable the service to declare compliance providing all colleagues attend. Of the 5 staff members outstanding, 4 are booked in December 2025. This will give an overall compliance rate of 95%.

PROMPT

Compliance for PROMPT training for October 2025 overall is 94%. Midwives are 94% and support workers 98%. Consultants is 92% and rotational trainees are 88%. All non-compliant staff have been booked for November 2025 and the expected compliance for all eligible groups will be over 90%.

Table 1 Details the status of all 10 safety actions

Safety Action 1 PMRT	Standard	Progress	Evidence	Status-on track	Validated
	Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths that occurred from 1 December 2024 to 30 November 2025 to the required standard?	Since 1 December 2024, there have been 27 cases reported within the reporting period, 20 of which were eligible for PMRT review. All cases to date have been notified to MBRRACE-UK within seven working days and a review has been started within two calendar months of the death. The standard dictates that PMRT should be carried out and 95% of reviews should be started within two months of the death, and a minimum of 75% of multidisciplinary reviews should be completed and published within six months. For at least 95% of all deaths of babies who died in your Trust from 1 December 2024, were parents' perspectives of care sought and were they given the opportunity to raise questions. 100% of parent's perspectives have been considered. All final reports are presented to the Trust Safety and Quality Committee and Board of directors on a quarterly basis.	Appendix 2. Standard 1	On Track	No due until after reporting period has ended 30/11/2025
		NEW MIS YEAR 7. 50% of the deaths reviewed an external member present at the multi-disciplinary review panel meeting and this should be documented within the PMRT. An LMNS process and rota is in place to support attendance of external panel members. 9/9 reviews that have been concluded in the reporting period have had external representation.		On Track	No due until after reporting period has ended 30/11/2025
A weekly failsafe report is generated to confirm that all standards are met. This is supported by a weekly failsafe meeting. Reports of reviews of all deaths are discussed with the Trust Maternity and Board Level Safety Champions. NHS Resolution use data from MBRRACE-UK/PMRT to cross-reference against Trust self-certifications.					
Safety Action 2 Maternity Services Data Set (MSDS).	Standard	Progress	Evidence	Status	Validated
	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	The service has consistently achieved 11 out of 11 CQIMs since 2022 and data integration continues to be undertaken and monitored monthly. The year 7 standards are: 1. July 2025 data contains valid birthweight information for at least 80% of babies born in the month. This requires the recorded weight to be accompanied by a valid unit entry. 2. July 2025 data contains valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing,	Appendix 2 Standard 2 Compliance achieved to date (July 2025)	Standard Met	Validation of evidence required.

		and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances.			
A data report is generated each month and checked prior to submission of the MSDS data. Performance is confirmed at a monthly data meeting by work stream leads. July 2025 data will be used to confirm compliance with the standard and the service confirms that the standard has been achieved and published.					
Safety Action 3 Transitional Care	Standard	Progress	Evidence	Status	Validated
	Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?	Pathways of care into transitional care and Avoiding Term admissions to the neonatal unit (ATAIN) continue to be prioritised, jointly agreed, and monitored by the maternity and neonatal teams and guidance is in place which supports a care pathway from 34+0 in alignment with the BAPM Transitional Care (TC) Framework for Practice. The division continues to track performance and monitor outcomes for babies requiring neonatal admission or transitional care. A Quality Improvement (QI) initiative to reduce separation is ongoing. The project is based on reducing term admissions associated with respiratory distress.	Appendix 1 standard 3	Standard Achieved for year 7	Validated 11/09/2025
The Working better together joint multiprofessional group undertakes review of all term admissions (ATAIN) to the neonatal unit and monitors transitional care (TC) activity. TC and ATAIN dashboards are generated.					
Safety Action 4 Workforce	Standard	Progress	Evidence	Status	Validated
	Can you demonstrate an effective system of clinical workforce planning to the required standard?	**Obstetric Workforce**. There has been significant investment in the obstetric consultant roles and leadership, and the service confirms that it has the right number of funded obstetricians and includes a 2-tier rota on a 1:8 basis. Recruitment to the SAS and resident obstetricians is ongoing with 1 who has commenced in post, 1 going through on boarding and one vacancy out to advert. The RCOG consultant attendance audit has been completed for 3 consecutive months within the reporting period and compliance over 80% has been achieved. This enables the service to meet the standard. For oversight a red flag has been added to the Datix reporting system in June 25. This will enable this standard to be monitored and validated monthly without the need for monthly audit.	Shared in previous reports	Standard Achieved for year 7	Validated 11/09/2025
		Neonatal Medical A local workforce review of the neonatal medical staffing requirement to achieve British Association of BAPM standards was undertaken in 2023. Realignment of job plans, and use of the ORDER programme has been utilised since February 2025 and a 1:8 rota for all grades has been	Shared in previous reports	Standard Achieved for year 7	Validated 11/09/2025

		achieved. This enables the neonatal service to declare BAPM compliance.			
		Neonatal Nursing: The Northwest Neonatal Network monitor staffing levels against BAPM standards using the Clinical Reference Group neonatal nurse calculator. Compliance with the standard is presented within the Activity Capacity Demand (ACD) report which was published 2023/24. The report confirms that the service has enough nurses within the establishment to be compliant to BAPM standards based on the average activity for the previous 3 years.	Shared in previous reports	Standard Achieved for year 7	Validated 11/09/2025
		Anaesthetic To comply with the anaesthetic medical workforce requirements associated with CNST year 7, a copy of the anaesthetic rota for all months during the reporting period is held as evidence for monitoring purposes by the service, confirming that a duty anaesthetist is immediately available for the obstetric unit 24 hours a day. The service is 100% compliant with this standard.	Shared in previous reports	Standard Achieved for year 7	Validated 11/09/2025
The Board of Directors are accountable for ensuring the fundamental quality standards are delivered, including having the appropriate workforce to deliver safe care. To meet the standard requirements for the obstetric medical workforce, regular audits and reviews and reporting will continue to be provided for via the maternity and neonatal safety report and the Perinatal Quality Surveillance Model for assurance.					
Safety Action 5	Standard	Progress	Evidence	Status	
Midwifery Staffing	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	The funding to meet the midwifery staffing requirements of Birth Rate plus 2022 is in place and the service confirms that it is on track to fill all vacancies. Data collection for the next Birth Rate Plus assessment has commenced in May 2025 and the draft report is awaited. Once received the findings will be scrutinised and validated by the Chief Nursing Officer and Divisional Midwifery and Nursing Director before being shared.	Bi-annual Safe staffing repots April and October 2025.	Standard Met	Validation of evidence required.
		The Midwifery Coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift). This standard is 100% to date.	Appendix 2 Perinatal Quality Surveillance	On Track	Not due until end of reporting period November 2025
		All women in active labour receive one-to-one midwifery care continues to be monitored each month.			
		Submit a midwifery staffing oversight report that includes staffing/safety Issues and assurances to the Trust Board every six months	Shared with the Board	April 2025 September 2025	Validation of evidence required.

Safety Action 6. Saving Babies Lives V3 (SBLV3)	Standard	Progress	Evidence	Status	Validated
	Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	The service continues to make progress against the 5 elements of the SBLV3 care bundle, and an additional validation was requested by the service to demonstrate sustained improvement since year 6. Compliance has increased from 91% to 99% and the updated validated position is 99% The next validation is planned for September 2025.	Appendix 1 Safety Action 6. Final Position	Standard Achieved for year 7	Validated 11/09/2025
There is a programme of improvement work focused on SBLV3 each of the 6 elements has a named obstetric or medical lead and all elements have now been met.					
Safety Action 7 MNVP	Standard	Progress	Evidence Source	Status	Validated
	Listen to women, parents and families using maternity and neonatal services and coproduce services with users.	The Maternity and Neonatal Voices Partnership (MNVP) and the maternity and neonatal services continue to work on the priorities defined within the joint work plan into 2025. The updated priorities have been reviewed by the LMNS, service and MNVP in June 2025. This has been reviewed by the Safety Champions and approved by the LMNS in September 2025. The work plan has also been shared at the ICB board in October 2025. The service confirms that it utilises the annual CQC maternity survey free text data to collate the action plan each year. The latest report is current embargoed, however work to collate the actions in response to 2024 findings has jointly been completed by the MNVP lead and will be shared with the Safety Champions once published. Previous iterations of this report have aligned to this standard. The requirement for year 7 now includes MNVP attendance at PMRT meetings. The capacity to attend is limited due to the commissioning agreement with the LMNS. An action plan has been agreed and formal escalation to the LMNS has been completed as part of the Board slide in September 2025 This will enable the service to meet the required standards.	Appendix 1 Safety Action 7 Action plan and update	Standard Met	Validation of evidence required.
The MNVP lead and Deputy Divisional Midwifery and Nurse Director meet monthly to review priorities and action feedback. The MNVP lead attends maternity and neonatal safety champions and safety and quality committee as key membership.					
Safety Action 8 Training	Standard	Progress	Evidence Source	Status	
	Can you evidence the following 3 elements of local training plans	The service confirms that the full Training Needs Analysis (TNA) standards continue to be fully aligned with version 2 of the Core Competency Framework (CCF), and the programme of training has been shared with the Divisional Safety Champions and MNVP	Appendix 1 Safety Action 8.	At Risk action plan in place to enable	Not due until end of reporting period

	and 'in-house', one day multi-professional training?	lead. The service also confirms that it has at least one multidisciplinary emergency scenario is conducted in the clinical area. Delivery suite and birth centres are utilised for multi-disciplinary emergency skills sessions during the PROMPY day. **PROMPT** Compliance with PROMPT is 94% overall in October 2025. **Areas of focus: Trainee doctors' compliance- 88%** **Action:** New rotational trainee doctors who commenced work on or after 1 July 2025 a lower compliance will be accepted. This is providing that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust. All outstanding doctors are booked on to dates and an action plan for achievement of the standard is included in the report. It is anticipated that all staff groups will be over 90% by the end of the reporting period. **ANAESTHETICS** For rotational anaesthetic staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. This is providing that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust Compliance for all groups over 90% **STANDARD MET all eligible groups over 90%.** **BASIC NEONATAL LIFE SUPPORT** Compliance of the neonatal and medical newborn life support is tracked in line with MIS year 7. All eligible staff groups are over 90%. including midwifery neonatal medical and nursing/ All neonatal medics who attend births unaccompanied are also Neonatal Life Support course trained. (100%) **STANDARD MET all eligible groups over 90%** **FETAL MONITORING** – 94% compliance achieved overall for the full day fetal monitoring training. **Trainee doctors'** compliance **71%** in October 2025. New rotational trainee doctors who commenced work on or after 1 July 2025 a lower compliance will be accepted. This is providing that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust.		service to declare compliance once shared with Board of Directors.	November 2025
Training requirements are tracked via maternity and neonatal safety and quality monthly, and actions are taken to ensure all staff groups have achieved 90% by the end of the reporting period. A training report is also submitted to maternity Safety and Quality Committee for oversight. Close oversight of staff groups below the target range is ongoing and compliance has been escalated to the clinical directors for obstetrics and anaesthetics for support to ensure all colleagues are booked onto relevant study days.					

Safety Action 9 Perinatal Oversight	Standard	Progress	Evidence	Status	
	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?	Analysis of the Perinatal Quality Surveillance (PQSO) continues monthly through the Safety and Quality committee and is detailed in appendix 1. The Board of Directors will continue to receive the bimonthly report on maternity and neonatal safety. The Board Safety Champions are also supporting the perinatal leadership team to better understand and local cultures, including identifying. and escalating safety and quality concerns and offering relevant support as required. Evidence that in addition to the regular Trust Board/sub-committee review of maternity and neonatal quality as described above, the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting. The report was shared in September 2025 Safety Champions meeting.	Shared in previous iterations of the report	Standard Achieved for year 7	Validated 11/09/2025
The Safety Champions meeting is chaired by the Chief Nurse and attended by the Board Non-Executive Director (NED). This meeting has a formal agenda and terms of reference and review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys and listening events, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback are standing agenda items. The service also confirms that Board Safety Champion(s) meet with the Perinatal leadership team at a minimum of bi-monthly. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff are tracked via the Safety Champion meetings. Work is ongoing with a culture review, led by the occupational development team.					

Safety Action 10 MNSI	Standard	Progress	Evidence	Status	
	Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025	The service confirms that it has reported all qualifying cases to MNSI reporting 100% compliance to the standard. It also confirms that it complies with Regulation 20 of the Health and Social Care Act 2008 in relation to appropriate and timely Duty of Candour (DOC). A summary of MNSI trend data is included in appendix 1. The standard requires that information and reports are shared with families in a format that was suitable to them. The clinical governance and risk midwife contacts all families and agrees a personalised plan for responses which may include information in their chosen language.	Appendix 1 Safety Action 10. No 1	On Track	Not due until end of reporting period November 2025
A quarterly report is collated on AMAT to confirm that all qualifying cases have been reported in line with MIS year 7.					

3.0 PERINATAL QUALITY SURVIELLENCE DASHBOARD- PART 2

The Board of Directors has accountability for perinatal oversight, with a statutory duty to ensure the safety of care, including the provision of resources required. To track performance, the perinatal quality surveillance dashboard (PQSD) (Appendix 2) is presented in the maternity and neonatal safety report to ensure that appropriate information is shared to undertake this function.

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

3.1 CLINICAL SAFETY INDICATORS

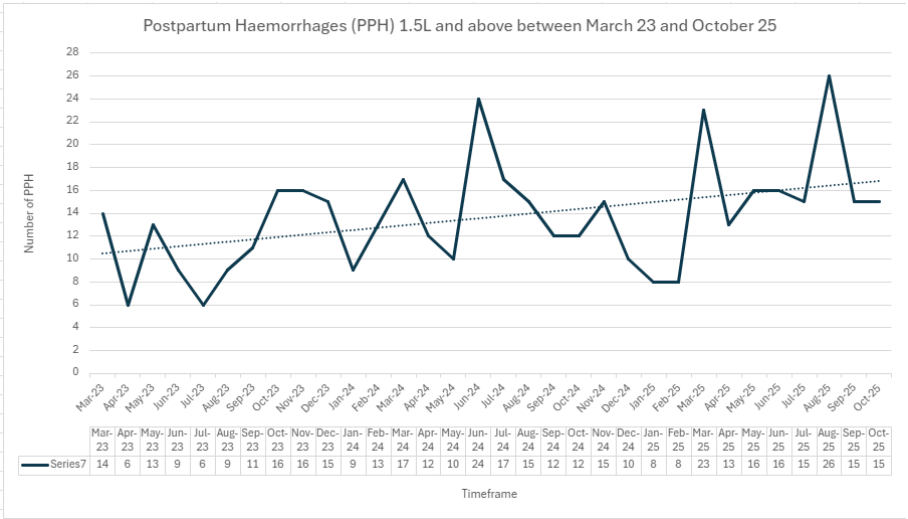
3.2 STILLBIRTH

The stillbirth rate continues to be monitored monthly by the service. The current mean still birth rate is 2.8 per 1000 births. There were 2 stillbirths in October 2025. One case was at 41+1 weeks gestation where the mother declined induction. The initial After Action Review (AAR) identified learning in relation to appropriate care planning and counselling. The second case was a mother who was 33 weeks gestation who attended with reduced fetal movement. The initial review is planned. Both cases have been reported to MBRRACE, will have a local AAR and will be subject to Perinatal Mortality Review.

3.3 POSTPARTUM HAEMORAGE (PPH)

The incidence of postpartum haemorrhage is being closely monitored due to an increase in incidence over recent months which is demonstrated via data points on the SPC chart. (see appendix 2) Chart 1 details the upward trend for rates of PPH over 1.5 litres since March 2023 and actions for improvement are being implemented. See below.

Chart 1 Postpartum haemorrhage (PPH) over 1.5 litres between March 2023- October 2025.



Actions for improvement PPH

All cases of PPH over 1 litre are audited as part of a speciality MDT review process. Themes and lessons learned are regularly shared and any actions are promptly initiated to address any issues with pathways of care.

All cases of PPH over 2 litres are reviewed by the Safety and Quality Matron and collated as part of a thematic quarterly report which is shared with the maternity safety and quality committee. In addition, a PPH task and finish group has commenced to include three workstreams to reduce rates of PPH. These include antenatal optimisation of iron, recognition and management of PPH and clinical escalation.

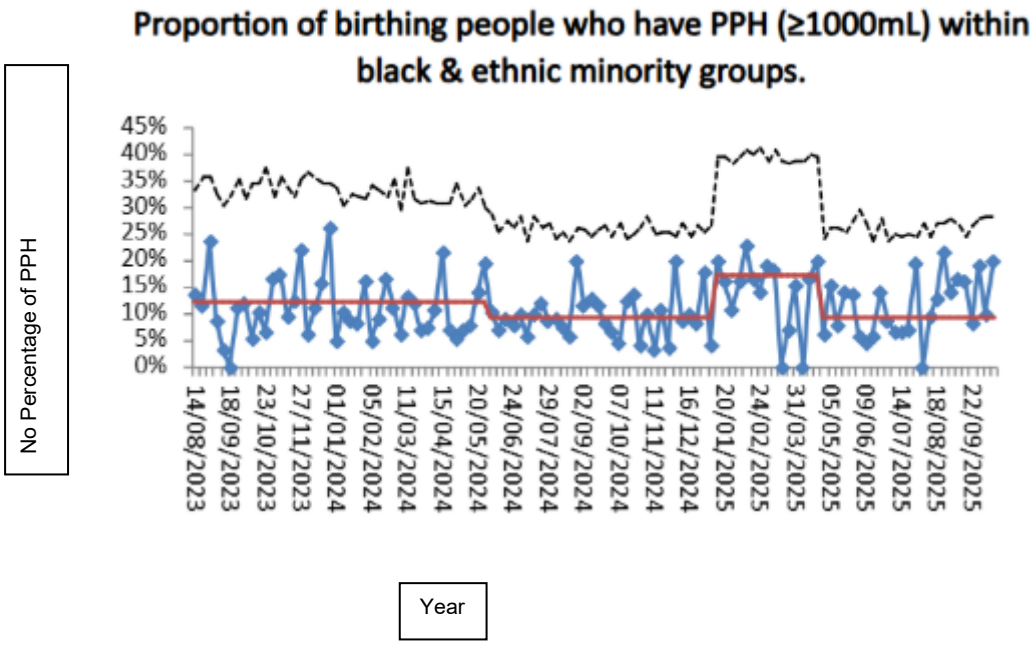
PPH will also continue to remain on the PROMPT programme in 2026 as a standing agenda item with additional skill drill sessions planned to ensure that identification and management of PPH is practised.

3.4 RACE AND HEALTH OBSERVATORY (RHO) PERFORMANCE UPDATE

An update on the statistical significance of the work with the RHO is presented within the report for information following a request by the safety and quality committee. Chart 2 represents performance over time and demonstrates absolute risk, for the proportion of birthing people from Black and ethnic minority groups experiencing PPH ≥1000 ml. It does not indicate relative risk reduction because it reports percentages rather than comparing risk between groups or against a baseline.

Targeted interventions and actions to address disparities in maternal outcomes have continued since the end of the project. Although a sustained reduction of PPH ≥1000mL from 12% to 9% for women from black and ethnic minorities has been achieved to date, the variability and periods of increased incidence noted in Quarter 4 of 2025 highlight that the work must continue to reduce the equity gap further.

Chart 2 Proportion of birthing people who have PPH (>1000mls from black and ethnic minority groups



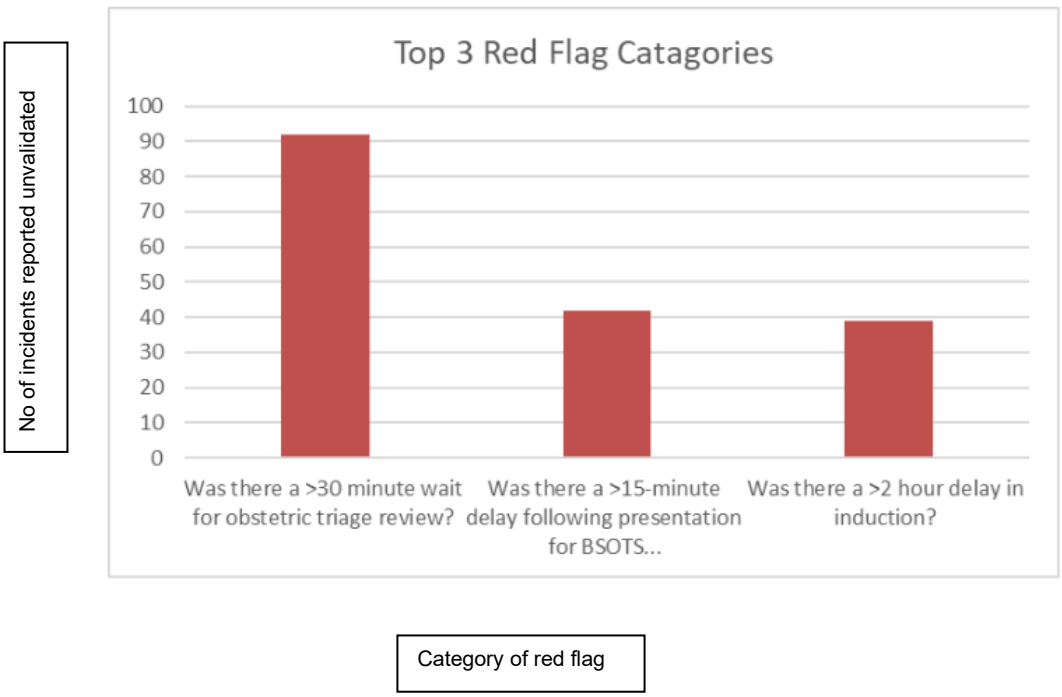
3.5 RED FLAGS QUARTERLY SUMMARY

It is recommended that Trusts monitor and include safe midwifery staffing red flags in this report, but this is not currently mandated by MIS. However, the service has continued to include red flag reporting for oversight of incidents.

It is acknowledged that the red flag data presented is unvalidated and system work is ongoing in Trust to explore how this can be achieved consistently via the incident reporting system. The Trust is transitioning to a new incident system which has the functionality to be built for specific reporting requirements. A plan to agree a system solution for validation of red flags will be included in the build considerations. This will enable the service to provide fully validated red flag data going forward.

Chart 3 details the red flags that have been reported in October 2025. The highest number of red flags were reported in the category of delays in review by an obstetrician in the maternity assessment suite (MAS). Delay in the induction process also features in the highest reporting categories. All incidents associated with delay are reviewed and monitored and linked to the risk register.

Chart 3 Top 3 Red Flag reporting Categories



3.6 DELAYS IN INDUCTION OF LABOUR

Delays in induction of labour continue to be monitored closely and the induction of labour improvement plan is progressing. The working group continues to make progress against the agreed work streams and actions. See appendix 4 for the updated performance

3.7. CLOSURES OR DIVERTS

In the last quarter (July-September 2025) the service was required to divert more frequently (10 times) and although this trend has not continued to date on into quarter 3, this is a risk indicator which requires close monitoring.

During October 2025 the escalation policy was utilised in response to acuity and staffing levels to maintain safety of the maternity service and during this time there was 1 divert for a duration for 12 hours. A total of 7 women were affected, and all cases were telephone triaged prior to being asked to attend an alternative provider. All women who were diverted required antenatal assessment in triage only and no harm has been associated with transfers out. Repeated diverts may signal sustained operational pressure which places risk on service resilience. Work to oversee timely recruitment of midwives continues and retention initiatives included in the work force plan remain in place.

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

The rate of caesarean sections in the UK has steadily increased over the last 5 years, with elective procedures making up a significant portion of births (BMJ 2021). Contributing factors include maternal age, medical comorbidities, maternal preference, and previous caesareans.

This rising demand places pressure on already stretched theatre capacity and resources, leading overbooked elective caesarean lists, theatre list overrunning or delay or displace planned procedures. Table 2 and 3 show the statistical rising trend in the number of elective and emergency caesarean sections with the largest increase starting around 21/22. Table 4 shows rates overall and demonstrates the upward trend over time.

Table 2 Trend analysis of Elective Caesarean Section rates since 2006

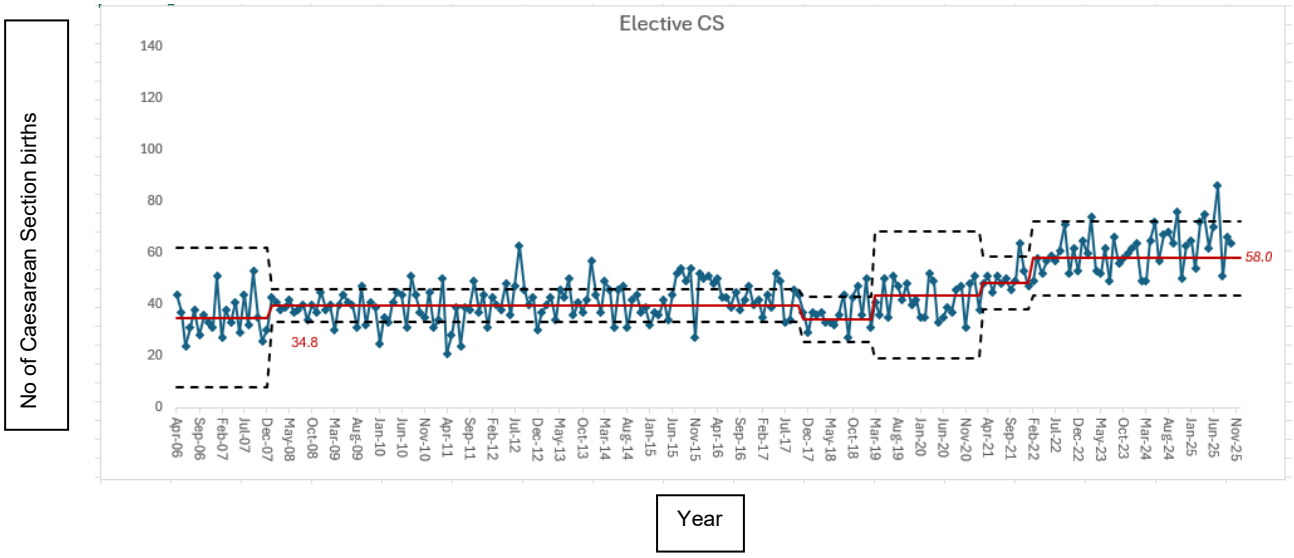


Table 3 Trend analysis of Emergency Caesarean Section rates since 2006

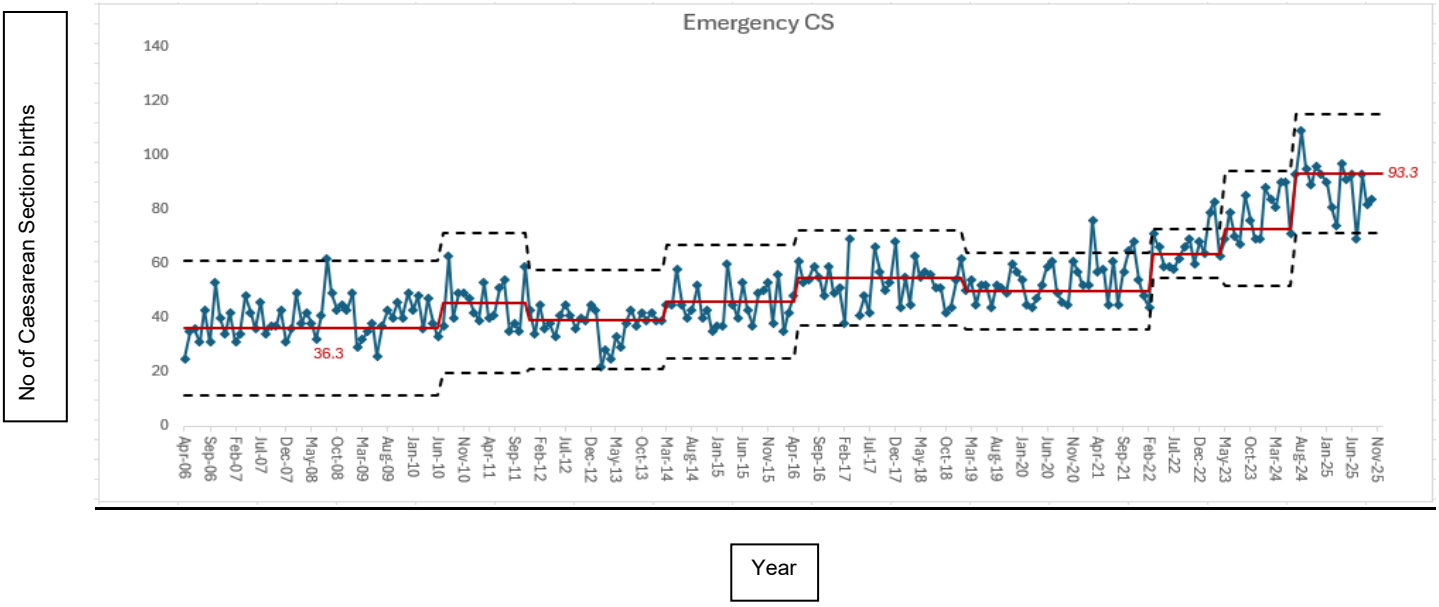
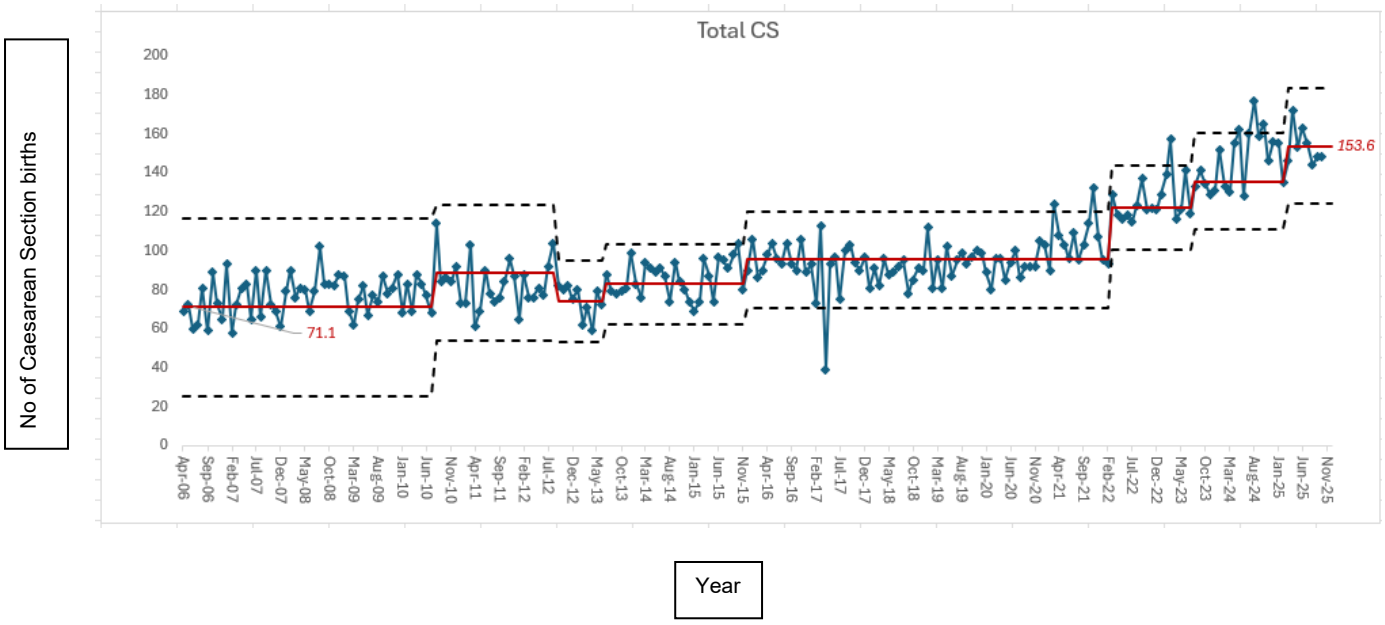


Table 4 Trend analysis of total Caesarean Section rates since 2006



There have been several occasions in the last 12 months, when Gynaecology activity has been stood down to safely manage the maternity cases. To manage the workload, additional weekend lists continue to be arranged, however, this is not a cost effective and sustainable solution. Table 5 details the additional requirement for extra lists between July 2024 and October 2025 and confirms that there were 21 sessions (4 hours) when Gynaecology activity was stood down. Over the same period 112 additional 4-hour sessions were undertaken for additional elective caesarean section requirements.

Table 5 Extra lists and converted list between July 2024 and June 2025.

Month	Extra Lists (Based on a 4-hour session (Weekend/BH)	Lists converted from Gynae to C-Section. (Based on a 4-hour session)
July 2024	8	0
August 2024	8	2
September 2024	10	0
October 2024	2	4
November 2024	2	1
December 2024	6	4
January 2025	6	3
February 2025	6	0
March 2025	8	1
April 2025	6	4
May 2025	8	1
June 2025	10	0
July 2025	8	1
August 2025	6	0
September 2025	8	0
October 2025	10	0
TOTAL	112	**21**

To mitigate the risks associated with lack of capacity for elective caesarean section the following controls have been enacted.

Weekly caesarean capacity review

A weekly theatre efficiency meeting between the speciality Business Manager, Capacity & Flow Midwife and the consultant obstetrician is undertaken to review theatre capacity versus demand for elective caesarean scheduling. Based on an assessment of risk, women are prioritised based on gestation, clinical need and level of urgency. This model enables appropriate clinical planning and provides assurance that proactive capacity management and escalation is occurring when demand exceeds capacity.

Governance & Assurance

Risk 569 Elective caesarean demand significantly exceeds capacity impacting patient safety and experience, risking elective gynaecology activity. Risk score 15. The risk was originally identified in September 2019 and since September 2020 there has been 222 incidents reported. All incidents are reviewed and to maintain oversight of incidence, harm grading, learning and action. Deferred activity for elective caesarean section has also been added to the Maternity perinatal oversight dashboard so that statistically significant changes are promptly identified and actioned.

Capacity and demand for elective caesarean section is regularly reviewed by the division and operational team, and capacity issues continue to be escalated to divisional finance and performance committee and to the executive divisional improvement forum.

An interim plan to improve efficiency of theatre lists is being proposed and all-day caesarean section lists are being arranged from the end of January 2026. This test of change is anticipated to reduce delays at the start and end of operation lists, with an overall aim to improve efficiency. This may release hours lost for additional theatre time. The business case is planned to be presented to Planning Activity Group on the 20 November 2025 and an update on the outcome will be provided in due course.

4.0 SAFE STAFFING INDICATORS

The maternity service continues to be presented with workforce challenges related to established vacancies, whilst the15 WTE midwives are onboarding. The current vacancy for registered midwives is 4.10 WTE (including maternity leave) and interviews to fill outstanding vacancy are being undertaken in November 2025. The service also continues to utilise the over offer to recruit to turn over by 5 WTE providing additional staffing resilience to counter any upcoming vacancy, leavers or maternity cover.

The fill rates for Registered Midwives (RM 97%-day, 82% night) and Maternity Support Workers (MSW 83% day and 94% night) in October 2025 demonstrate reduced fill rates for night duties for midwives and day shifts for support workers. Although rates have remained relatively stable overall there continues to be a reliance on bank to support the ongoing gaps.

5.0 PERINATAL QUALITY GOVERNANCE EXPERIENCE AND REGULATION

5.1 PERINATAL OVERSIGHT -REPORTING FOR MATERNITY SAFETY

The SPEN (Submit a Perinatal Event Notification) portal is now live providing a single point of entry for notifications including MNSI, NHS Resolution's Early Notification Scheme, MBRRACE-UK, and Child Death Overview Panels. This approach will reduce duplication, improve data accuracy, and support timely investigations and learning.

5,2 MOSS: REAL-TIME SAFETY SIGNALS FOR MATERNITY OUTCOMES

The Maternity Outcomes Signal System (MOSS) is a national NHS England initiative created in response to the East Kent maternity review to strengthen safety and oversight. It is anticipated that MOSS will provide an ability to differentiate between genuine safety concerns from normal variation, enabling trusts and Integrated Care Boards to act quickly under the Perinatal Quality Oversight Model. Although it would be expected that services would already understand their data outcomes, by improving surveillance and escalation this model would strengthen existing pathways to improve maternity safety.

5.3EXTERNAL LEARNING FROM CORONIAL CASES

Following the recent Prevention of Future Deaths report and regulatory notice issued to Manchester Foundation Trust after a maternal and neonatal death during a home birth, the maternity service is undertaking a comprehensive review of home birth provision. This review will assess service arrangements, workforce training, audit processes, governance, and assurance mechanisms to ensure safe and appropriate care for women choosing home birth. A detailed response and action plan is being developed to provide assurance and an update will be provided in future iterations of this report**.**

6.0 EXECUTIVE/NON-EXECUTIVE SAFETY CHAMPIONS

The Perinatal Quality Surveillance Model (PQSM, 2025) continues to operate to support perinatal insight and oversight, and the Chief Nursing Officer and the Non-Executive Director safety champion undertake walk the floor events throughout the year to seek perspectives from the clinical workforce. Examples of recent staff engagements include visiting clinical areas delivery suite, all birth centres, neonatal unit and maternity assessment suite. Bespoke sessions with student midwives and attendance at daily maternity triage of incidents meeting have also been undertaken. Appendix 1 details the latest summary feedback for information.

6.1 CONTINIOUS IMPROVEMENT AND QUALITY

Services are encouraged to use an appreciative inquiry approach to continuous improvement and learning. The service is undertaking several projects aimed at proactive change outcome monitoring. At present this includes the induction of labour service review and the MIS year 7 standard 3. The project is based on reducing term admissions associated with respiratory distress. This is the leading cause of admission. (Appendix 1 standard 3 for the update slides).

6.2 PERINATAL CULTURE

The service awaits the outcome of the culture review across the maternity and gynaecology services. The review is in response to themes identified in the most recent staff and SCORE survey and in relation to other feedback received over time. The draft report findings are being considered by the leadership team, and the safety and quality committee will be updated in due course.

7.0 WELL-LED/CELBRATING SUCCESS.

Following the success of the Race and Health Observatory (RHO) work reducing disparity in outcomes for women of black or ethnic women who experience postpartum haemorrhage, the service continues to work collaboratively with the RHO to develop pathways using anti racism methodology to improve outcomes. Representatives from the Lancashire Teaching project group attended a feedback session to shape future programmes and understand actions that can be taken to enable learning to be replicated using scale and spread methods.

The young people's midwifery team and service users were also interviewed by Granda Reports raising the profile of the ongoing pilot project to support and improve outcomes for young parents accessing maternity care. In addition, the bereavement midwife was interviewed for baby loss awareness week. Appearing with parents and previous service users, the broadcast focused on meaningful memory making and how this unique personalised approach provides healing for families who have experienced baby loss.

The refurbishment of a counselling room in the neonatal unit is also completed with support of the charity Baby beat and work is progressing with the restorative courtyard for staff and services users in the Sharoe Green Unit. This work is welcomed and may improve staff morale as they will have a quiet area to rest during breaks.

8.0 CONCLUSION

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

The service confirms that it remains on track will 9 of the standards with only 1 standard currently at risk. The service will meet the requirements for this standard based on the action plan for training and an agreement by the Safety and Quality Committee as a subsidiary of the board to monitor the trajectory to meet 90% compliance for trainees for PROMPT and fetal monitoring.

The perinatal quality surveillance dashboard and the red flag reporting indicate areas of pressure within the service. The number of times that the service was required to divert has increased in response to establishment gaps and this will continue to be monitored. Overall, the service demonstrates relatively stable outcome metrics

9.0 RECOMMENDATIONS

The Board of Directors is asked to:

I. Receive the report, including the CNST Maternity Incentive Scheme (MIS) supplementary information pack and associated action plans for oversight and assurance noting the report has been scrutinised by the Safety and Quality committee.
II. Note the inclusion of the training action plan for MIS year 7 and record in the Board minutes that it is supportive of the action plan for achievement of 90%, based on the scrutiny at safety and Quality committee.

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

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

SAFETY ACTION ONE – PMRT POSITION

REQUIRED STANDARD (Standard A) *	Compliance score		RAG
Notify all deaths: All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days.1 December 2024 onwards	Notification	27/27 (All eligible cases for the standard)	
	Surveillance	20/20 (All eligible cases for the standard)	
Seek parents' views of care: For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 1 December 2024 onwards.	On Track	20/20 (All eligible cases for the standard)	
REQUIRED STANDARD (Standard C) *			
Review the death and complete the review: For deaths of babies who were born and died in your Trust from 1st December 2024 onwards multi-disciplinary reviews using the PMRT should be carried out; 95% of reviews should be started within two months of the death, and a minimum of 75% of multi-disciplinary reviews should be completed and published within six months. For a minimum of 50% of the deaths reviewed an external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT.	On track	Commenced within 2 months. 20/20	
		Completed within 6 months: All cases. 9/9 cases who were eligible for external review have had an external representative.	
REQUIRED STANDARD (Standard D) *			
Report to the Trust Executive: Quarterly reports of reviews of all deaths should be discussed with the Trust Maternity and Board Level Safety Champions and submitted to the Trust Executive Board on an ongoing basis from 1 December 2024	April 2025		
	July 2025		
	October 2025		
	December 2025		

STANDARD ONE PMRT INCIDENT TRACKER

ID (Datix/PMRT)	Gestation	Stillbirth/ Neonatal death	PMRT upload date	Parents informed	Report drafted within 6 months	Actions ongoing
Datix: 182227 PMRT: 96388	35+3	Antepartum Stillbirth	Yes	Yes	Review completed and published.	All actions completed
Datix: 182442 PMRT: 96441	36+3	Neonatal death	Yes	Yes	Review completed and published.	All actions completed
Datix: 182834 PMRT ref: 96469	21+4	Neonatal death	Yes	Yes	NA	NA
Datix: 186476 PMRT ref: 96584	24+1	Feticide	Yes	Yes	NA	NA
Datix: 183923 PMRT ref: 96649	39+0	Antepartum Stillbirth	Yes	Yes	Review completed and published.	All action completed.
Datix: 184488 PMRT ref: 96661	28+4	Antepartum Stillbirth	Yes	Yes	Review complete and published	Action plan ongoing
Datix: 185485 PMRT ref: 96845	40+6	Antepartum Stillbirth	Yes	Yes	Review complete and published	Action plan ongoing
Datix: 185771 PMRT ref: 96909	22+5	Neonatal death	Yes	Yes	Review complete and published.	Action plan completed
Datix: 186495 PMRT: 97036	33+0	Antepartum stillbirth	Yes	Yes	Review completed and published	Action plan completed
Datix: N/a PMRT: 97145	24+6	Fetocide	Yes	Yes	NA	NA
Datix: 190522 PMRT: 97476	23+2	Antepartum stillbirth	Yes	Yes	Review completed and published	Action plan ongoing
Datix: 190652 PMRT: 97562	29 + 4	Neonatal death	Yes	Yes	Review completed and published	Action plan ongoing

Datix: 194158 PMRT: 98023	35+1	Neonatal Death	Yes	Yes	Review completed and published	All actions completed
Datix: 194450 PMRT: 98031	16+4	Neonatal Death	Yes	Yes	NA	NA
Datix: N/a PMRT: 98286	28+1	Fetacide	Yes	Yes	NA	NA
Datix: 199030 PMRT: 98587	29+2	Neonatal death	Yes	Yes	Review completed and published	Action plan ongoing
Datix: 200483 PMRT: 98785	23+4	Neonatal Death	Yes	Yes	Review completed and published	All actions completed
Datix: 201846 PMRT: 98925	22+3	Stillbirth	Yes	Yes	Review completed and published	Action plan ongoing
Datix: 202672 PMRT: 99071	39+4	Stillbirth	Yes	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing	Action plan ongoing
Datix: 205611 PMRT: 99398	39+1	Neonatal Death			Review ongoing, deadline not yet met. PMRT planned with deadline for publishing	Action plan ongoing
Datix: N/A PMRT: 99783	27	Feticide	Yes	Yes	NA	NA
Datix: 211090 PMRT: 100195	23+6	Neonatal Death	Yes	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing	Action plan ongoing
Datix: 213787 PMRT: 100564	41+1	Stillbirth	Yes	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing	Action plan ongoing
Datix: 215638 PMRT: 100814	33+6	Stillbirth	Yes	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing	Action plan ongoing
Datix: 216358 PMRT: 100913	29	Neonatal Death	Yes	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing	Action plan ongoing

Trust results for Maternity incentive scheme (CNST) Year 7: Safety Action 2

Title | Summary | **Scores Breakdown** | Metadata | Other DQ Priorities | Useful Links | FAQs

The tables below contain the detailed results for the selected Trust for the two measures that make up Safety action 2, covering Birthweight and Ethnicity data quality.
The full description and construction for each of the measures is available on the Metadata page in this scorecard.

Select organisation: LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST

Select reporting month: July 2025

Note: This edition of the dashboard now contains the final July data on which Trusts are assessed. It is expected that the dashboard will be refreshed less frequently following this assessment edition.

CNST: Safety Action 2 results for LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST for July 2025

1.

Indicator	Numerator	Denominator	Rate	Result
Birthweight DQ	425	425	100.0	Passed

Pass rate: 80%

2.

Indicator	Numerator	Denominator	Rate	Result
Ethnicity DQ	420	425	98.8	Passed

Pass rate: 90%

QUALITY IMPROVEMENT PROJECT - CNST SAFETY ACTION 3

What?

The Quality improvement project was launched during the year 6 CNST reporting period in line with Safety action 3. The request was to register a QI project drawing insights from themes identified from term admissions to the Neonatal unit, aiming to decrease admissions and length of stay.

The aim of the project chosen in Y6, was to reduce the number of term babies being admitted to transitional care or the NNU with hypothermia as a contributing factor. The evidence notes that when a baby becomes hypothermic, there is a risk of harm due to sepsis or hypoglycaemia, poor feeding and a risk of separation from the mother when admitted to NNU.

So what?

A review of the ongoing term admissions to NNU was noted and it was recognised that the test of change involved in this quality improvement project was not expected to deliver the results (reduce term admissions to the NNU). Analysis of recent data noted that no babies were admitted to NNU due to hypothermia. Therefore, a decision was made to review this project in line with the CNST safety action 3.
When the term admissions to NNU were reviewed at LTH, respiratory distress syndrome (RDS) was noted to be the highest rate of term admissions, from babies born by elective CS.

The test of change involved:

- Skin to skin decision tree
- Posters in all birthing environment
- Improved completion of the warm bundle
- Stop using towels to keep the baby warm
- Improve quality of skin to skin
- Use blankets under drapes to keep mothers warm at ELCS
- Thermometers in every room in the birthing environments
- Daily checks of birthing room temperature

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Now what?

The new direction of the project was therefore considered, with a test of change proposed:

- Inform women and families of the risk of admission to NNU due to RDS when scheduling an ELCS
- Sharing this information and data with the women and family when counselling around the decision and timing for ELCS
- Medical and midwifery staff to be aware of the increased risk of RDS when babies are born by ELCS
- Advising women to have skin to skin at birth and to support early feeding
- Midwifery staff to be aware of the importance of early feeding of babies born by ELCS

QUALITY IMPROVEMENT PROJECT - CNST SAFETY ACTION 3 - OCTOBER 2025 UPDATE

What?

It was decided following work from the working better together MDT group, that there would be a d focus on three key areas:

1. **Ensuring elective caesarean sections are scheduled on or after 39 weeks of pregnancy, if medically suitable to do so.**
2. **Providing parents and service users with clear information regarding reasons for term neonatal admission, with a focus on how they can support a reduction in admissions to NNU.**
3. **Educating parents and health care professionals to ensure skin-to-skin contact at birth and early breastfeeding.**

Now what?

Although the majority of term admissions for RDS following birth by ELCS were booked from 39 weeks onwards, it was recognised that there is still work to be done to ensure that all ELCS are booked from 39 weeks onwards, if medically possible.

Working with the continuous flow and elective lead, a new booking system was developed and lead by the flow and elective lead, who is taking leadership of the bookings of ELCS to review gestation prior to booking.
Workforce education also took place, with the booking teams and clinicians, sharing the aims of the QI project and the importance of 39-week scheduling, if medically possible.

So what?

Data was gathered to review all term admissions to NNU, and was presented to identify term admissions due to RDS and following elective CS.

Month	Total admissions	RDS admissions	ELLSCS RDS	Gestation 37	Gestation 38	Gestation 39	Gestation 40
Aug-24	14	9	1			1	
Sep-24	15	11	3	2		1	
Oct-24	11	7	5	2	1	2	
Nov-24	14	7	2		1	1	
Dec-24	11	5	1	1			
Jan-25	11	8	1			1	
Feb-25	7	5	1		1		
Mar-25	9	4	1			1	
Apr-25	12	7	4		3	1	
May-25	5	2	0				
Jun-25	16	9	2			2	
Jul-25	9	6	0				
Aug-25	14	6	2	1		1	

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The ongoing work to progress the 4th theatre business case, is ongoing and is pivotal to ensuring there is sufficient capacity to mee the increasing demand. The project is aware that 3 admissions to NNU with RDS were potentially linked to early booking of the ELCS due to theatre capacity.

It was noted that parents often lack clarity of understanding of why term babies may be admitted to NNU, limiting their ability to support parent led optimisation. By developing leaflets and digital content explaining common causes of term admissions to NNU, parents will become partners in the aim towards reducing term admissions to NNU.

The leaflets will allow parents to understand the information around what the main reasons are for the admission to NNU at this Trust. By aligning local practice with national guidelines on skin-to-skin and breastfeeding initiation, it is predicted based on the data that term admissions to NNU will be reduced over time. This involves providing education for staff, through team meetings and educational study days.

SAFETY ACTION 6 SAVING BABIES LIVES

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Fully implemented	100%	Fully implemented	100%
Element 2	Fetal growth restriction	Fully implemented	100%	Fully implemented	100%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%
Element 5	Preterm birth	Fully implemented	100%	Fully implemented	100%
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%
All Elements	TOTAL	Fully implemented	100%	Fully implemented	100%

SAFETY ACTION EIGHT TRAINING MATERNITY AND NEONATAL OCTOBER 2025

	NICU NURSES	NICU NURSERY NURSES	CONSULTANTS	ANNP'S	JUNIOR DOCTORS BELOW ST5	JUNIOR DOCTORS ST5 AND ABOVE	COMPLIANCE PERCENTAGE OVERALL
NEONATAL BASIC LIFE SUPPORT	91% *67 compliant out of 74*	100% *6 compliant out of 6*	100% *9 compliant out of 9*	100 % *5 compliant out of 5*	100 % *7 compliant out of 7*	100% *7 compliant out of 7*	94% *101 compliant out of 108*
NLS CERTIFICATION MEDICAL STAFF.			**100 %** ***9 compliant out of 9***	**100 %** ***5 compliant out of 5***	***Training not required***	**100%** ***7 compliant out of 7***	**100%** ***21 compliant out of 21***

	MIDWIVES	CONSULTANTS	DOCTORS	COMPLIANCE PERCENTAGE OVERALL
FETAL MONITORING TRAINING **ATTENDANCE AT FULL DAY FETAL MONITORING TRAINING**	**96%** *184 compliant out of 191*	**86%** *11 compliant out of 13*	**71%** 12 *compliant out of 17*	**94%** *207 compliant out of 221*

	MIDWIVES	CONSULTANT	DOCTORS	ANAESTHETIST CONSULTANTS	ANAESTHETIST ROTATIONAL	MATERNITY SUPPORT WORKERS	COMPLIANCE OVERALL
OBSTETRIC EMERGENCIES (PROMPT)	**94%** 185 out of 197	**92%** 12 out of 13	**88%** 15 out of 17	**93%** 13 out of 14	**91%** 10 out of 11	**98%** 54 out of 56	**94%** *290 compliant out of 308*
NEWBORN BASIC LIFE SUPPORT	**94%** 185 out of 197	**NA**	**NA**	**NA**	**NA**	**98%** 54 out of 56	**91%**

SAFETY ACTION 8 TRAINING ACTION PLAN

Version	Date
V1	09.09.25
V2	*1.11.2025*

Action Plan – Education and Training for Maternity

Ref		Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence	Current Status 1 2 3 4
1		Review compliance for individual groups against CNST SA8 technical guidance to allow rotational trainees a grace period to attend fetal monitoring and PROMPT training (allows for a 6-month period for agreed staff groups).	Fetal Monitoring Lead Practice Educator	12 September 2025	09.09.2025 Action plan shared via Maternity Safety and Quality	
				31 December 2025	1.11.2025 5 new trainees require training. Dates booked and prioritised based on rota fill and timeframe for completion. Anticipated that training trajectory will be over 90%	
		Review data and calculate compliance for training based on individual staff groups.	Fetal Monitoring Lead	~~12 September 2025~~ 31 December 2025	09.09.2025 Training data/Trajectory developed to achieve within 6 months of start date- Deadline extended to reflect the timeframe for completion	
		Identify additional training dates to book staff members onto training, to support compliance and extra attendance at training days.	Fetal Monitoring Lead Practice Educator	12 September 2025	09.09.2025 Book any required training dates for colleagues who are non-compliant	

2		Inform the medical rota co-ordinator and line managers/team leaders of the training days booked in September, October, November and December.	Fetal Monitoring Lead Practice Educator	30 September 2025	09.09.2025 Email	
		Contact the medical rota co-ordinator to ensure all the outstanding medical staff members who require training, are booked onto the relevant and outstanding study days.	Fetal Monitoring Lead Practice Educator	By 30 September 2025	09.09.2025 Email	
		Email area managers and team leaders to remind them to book the attendees on to the Roster as a study day, relevant to their training need.	Fetal Monitoring Lead Practice Educator	By 30 September 2025	Email	
		Send a reminder email to all members booked onto training over September, October, November and December to remind them of the need to attend the training day or contact the education lead to ensure they are booked onto an alternative date.	Matron for Safety and Quality	By 30 September 2025	Email	
3		Gather training data compliance monthly, for September, October, November and December to ensure training data is on track to achieve compliance.	Fetal Monitoring Lead Practice Educator	30 November 2025	Training update presented at Maternity S&Q monthly.	

SAFETY ACTION 9 PERINATAL QUALITY OVERSIGHT SAFETY CHAMPIONS FEEDBACK

Voices of Student Midwives

NHS Lancashire Teaching Hospitals NHS Foundation Trust

8 Student midwives met with LTHTRs Chief Nursing Officer and Deputy Chief Executive Sarah Morrison in August 2025

They provided the following feedback points:

Positive areas:

- The students reported they have loved the experience
- They have experienced good woman focused care
- The students appreciated the access they have to knowledgeable people
- They reported that they are treated generally well
- Experienced good mentoring in most units
- The students fed back that they would want to come and work in Maternity at LTHTR

The students expressed how valuable they found the meeting to be and how they appreciated their voices being heard by the senior leadership team

Areas to strengthen:

- IT and ipads not reliable, badgernet accessibility is patchy. **Action** : Ongoing work to consider how IT issues can be managed more effectively
- Staffing levels affect the experience. **Action** : The service has recruited to Birthrate Plus requirements. 17 new midwives are currently being onboarded with a further 5 out to recruitment.
- Some staff are more supportive than others
- Getting things signed off is hard for people on a busy units leading to stress for the students. **Action** : Outstanding Signature Process flowchart has been developed in collaboration with UCLAN and distributed to students via the induction handbook
- Some tension with people in delivery suite, but stressful and busy environment. **Action** : Culture action plan in development
- Continuity of mentorship needs to be more consistent. **Action** : Worked alongside student allocation to limit numbers of students per shift in each clinical area to improve student experience
- Continuity of placement needs to be better, moved around a lot and effects experience and continuity of learning. Action: As part of the wider action plan developed in response to student feedback, this is being raised with the allocations team in a bid to provide a more streamlined rotation
- Specific issue raised regarding one midwife. **Action** : Escalated to Divisional Midwifery Director
- Advertisement for jobs is 2 months later than other trusts, need to start much earlier in the year so students know where they are going to work. **Action** : Service utilises [illegible] vacancy tracker - will use feedback in future recruitment planning

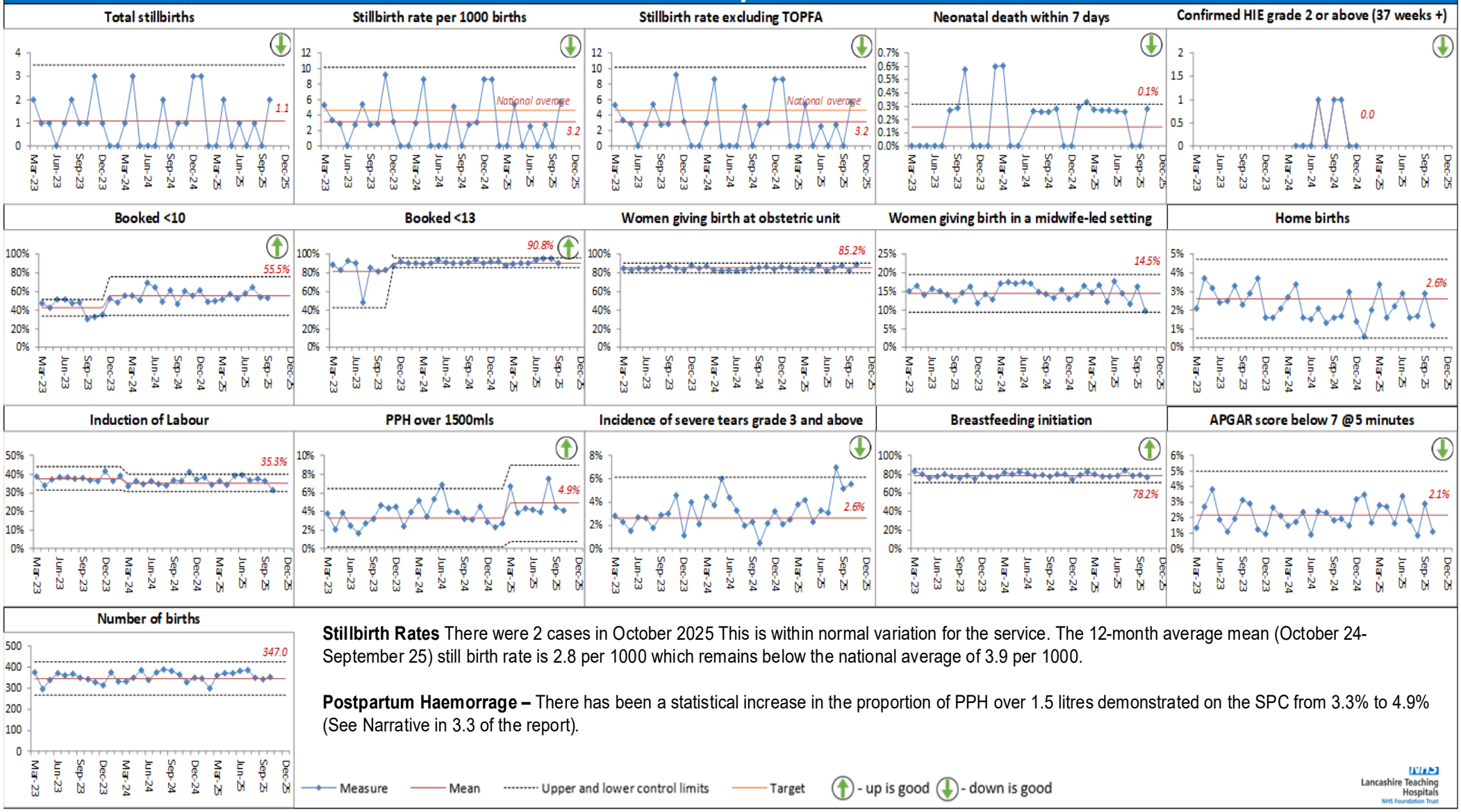
National Maternity Safety Ambition

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

MI number	Early Notification applicable	Early notification completed	Agreed format for sharing with family	Status of MNSI investigation	Duty of Candour.
MI-041706 Datix:197102	No	NA Does not qualify	Yes	Investigation ongoing	Yes
MI-041480 Datix:195746	Yes	Yes	Yes, Letter shared in chosen language Urdu	Investigation ongoing	Yes
MI-044325 Datix: 205611	Yes	Yes	Yes	Investigation ongoing	Yes
MI-044943 Datix: 207676	Yes	Yes	Yes	Investigation ongoing	Yes
MI-046028 Datix: 209749	Yes	Yes	Yes, Letter shared in chosen language Malayalam	Investigation ongoing	Yes

PERINATAL QUALITY SURVIELLENCE DASHBOARD
APPENDIX 2

Clinical Safety Indicators



Stillbirth Rates There were 2 cases in October 2025 This is within normal variation for the service. The 12-month average mean (October 24-September 25) still birth rate is 2.8 per 1000 which remains below the national average of 3.9 per 1000.

Postpartum Haemorrage – There has been a statistical increase in the proportion of PPH over 1.5 litres demonstrated on the SPC from 3.3% to 4.9% (See Narrative in 3.3 of the report).

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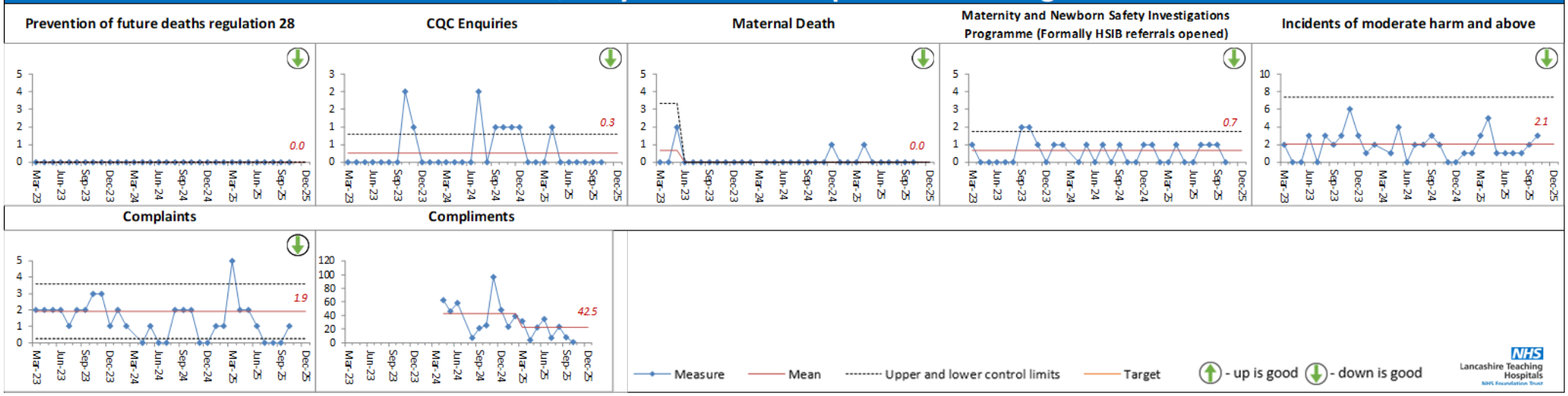
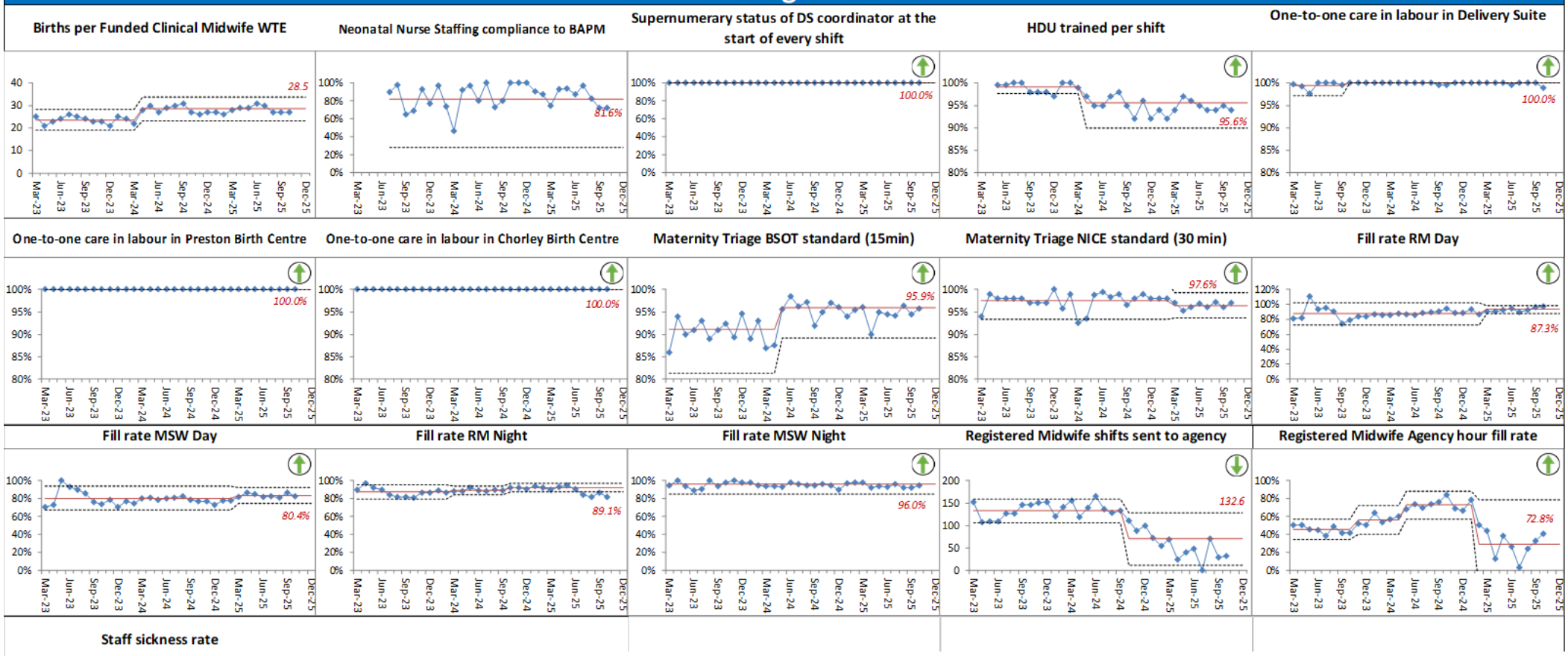
Perinatal Quality Governance Experience and Regulation



Safe staffing indicators

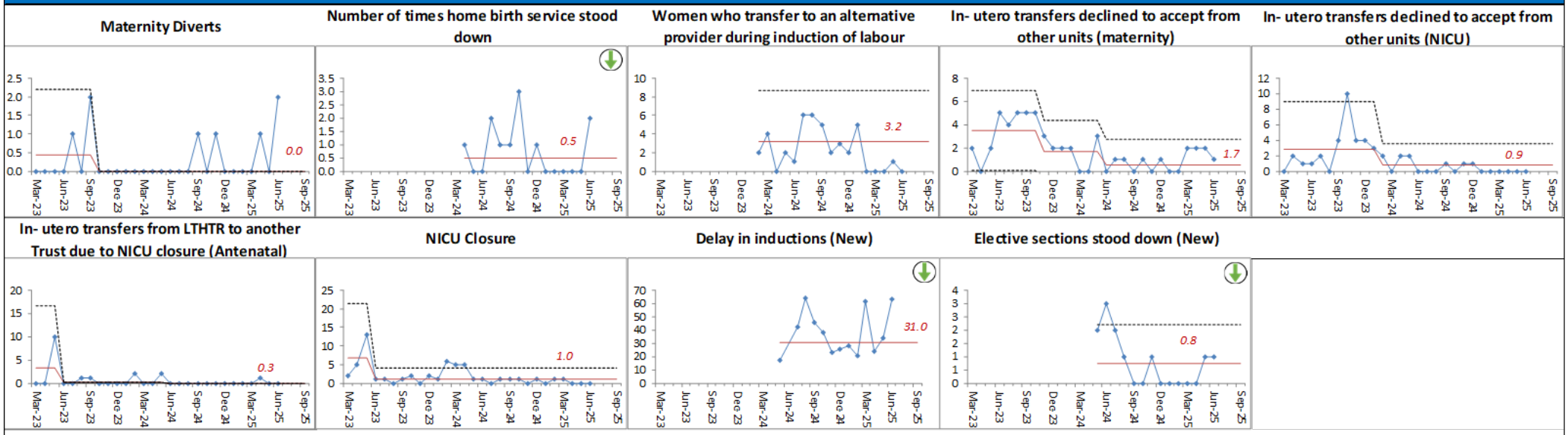


Nurse Staffing BAPM A slight reduction in nurse compliance to BAPM is reported in the last 2 months related to intensive care activity and staff is noted. This is not currently of statistical significance but will continue to be monitored.

Agency Fill rates The number of shifts being filled by agency continues to be overseen by the DMND and the downward trend has continued since quarter 1 of 2025.

Sickness absence has increased in the last 3 months. September 2025 was the highest rate seen in the last 12 months with a rate of 8.7%. Oversight of work force metrics continues, and actions are ongoing to manage absence using the attendance management policy.

Clinical Escalation



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

Divert There has been 2 occasions in July 25 when a unit divert was enacted to maintain safe staffing.

In- Utero Transfers (IUT) IUT decline rates have reduced for NICU. If this continues this will demonstrate statistical reduction.

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

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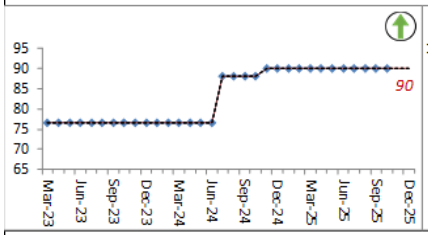
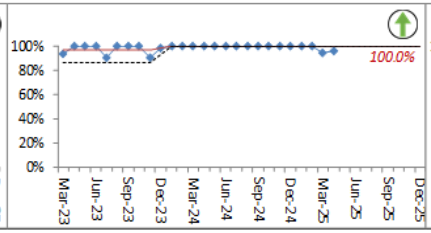
Obstetric Medical Staffing

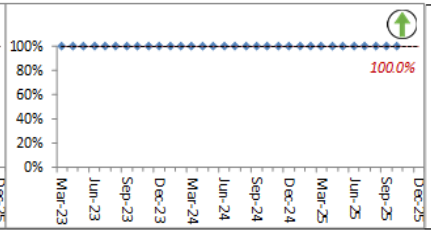
Number of Consultant hours on obstetric unit



RCOG obstetric benchmarking compliance



24-hour acute obstetric medical staffing fill rate



Consultant hours in the obstetric unit. The service continues to invest in obstetric funding and the service confirms an increase in hours from 88 to 90 hours consultant cover.

Consultant fill rates Consultant fill rates for acute care continues to be 100%

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

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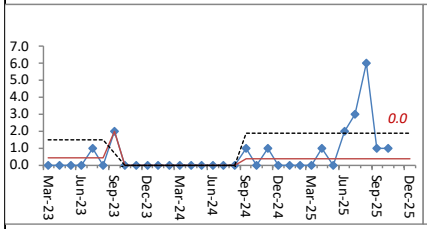
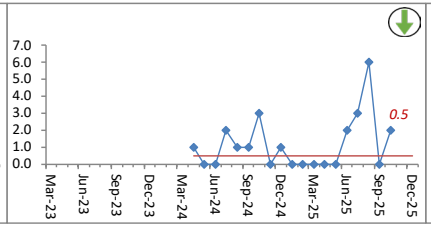
Clinical Escalation

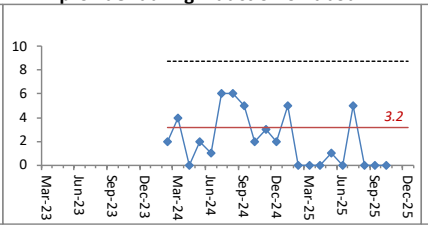
Maternity Diverts



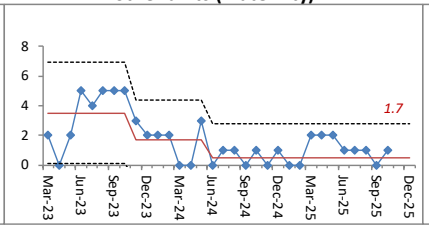
Number of times home birth service stood down



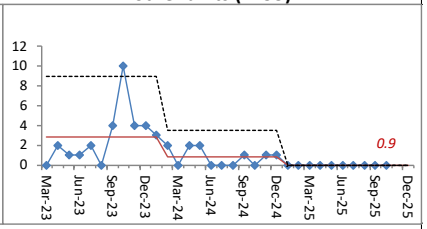
Women who transfer to an alternative provider during induction of labour



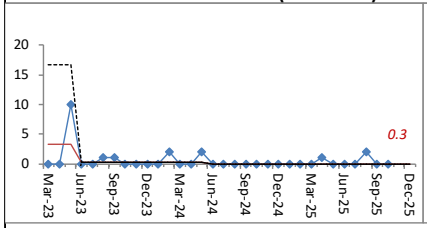
In- utero transfers declined to accept from other units (maternity)



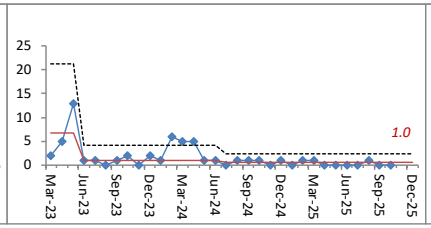
In- utero transfers declined to accept from other units (NICU)



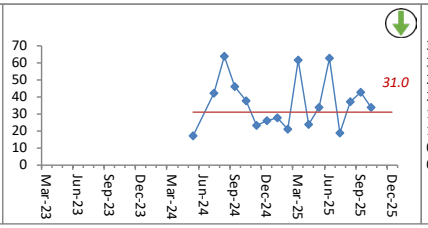
In- utero transfers from LTHTR to another Trust due to NICU closure (Antenatal)



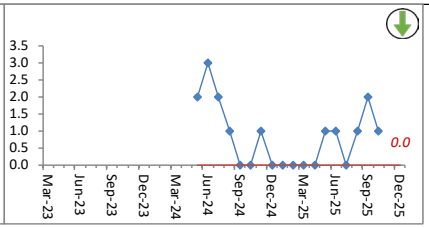
NICU Closure



Delay in inductions (New)



Elective sections stood down (New)



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

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APPENDIX 3 RED FLAGS JULY 2024 TO OCTOBER 2025

Red flag Reporting Metrics Unvalidated	July 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	March 25	April 25	May 25	June 25	July 25	Aug 25	Sept 25	Oct 25
Delay in time critical activity	18	41	61	40	44	59	32	16	16	117	108	105	64	18	9	10
Missed or delayed care> 60 mins in washing or suturing	2	0	0	1	0	1	0	0	1	0	0	0	0	1	0	0
Failure for women to receive the medication required.	1	0	1	0	0	1	0	1	2	0	0	0	1	1	2	1
>30-minute wait for pain relief.	3	0	2	0	0	0	2	1	3	1	1	1	4	4	3	3
Was there a >30-minute delay for assessment by a midwife when a problem was identified	2	0	1	0	0	0	1	1	2	2	1	0	0	0	1	0
Lack of full examination when woman presents in labour.	1	0	4	0	0	0	0	0	2	0	1	0	1	0	0	2
>2-hour delay in induction?	22	42	34	21	9	7	28	21	17	5	18	26	16	19	14	39
Delay in recognition of and action of abnormal signs.	1	0	1	1	0	0	0	2	0	0	0	0	2	1	1	2
Inability to provide one to one care in labour?	4	1	4	0	0	0	2	0	0	1	1	4	2	6	0	0
>30-minute wait for obstetric triage.	47	20	56	41	46	47	58	61	62	156	0	107	130	124	98	92
>15-minute delay following presentation for BSOTS midwife assessment.	46	24	75	42	24	23	46	32	21	82	49	50	59	38	61	42
Was there a delay in transfer of a BSOTS red case from MAS?	0	0	0	0	1	0	1	0	1	1	0	0	0	0	4	0
Was there a delay in transfer (over 4 hours) to delivery suite once a decision has been made for transfer for induction or augmentation?	30	28	25	20	14	19	26	21	34	17	15	37	31	9	14	2
Was there a delay in transfer once labour was established?	1	1	2	0	0	0	3	0	1	1	1	1	3	9	4	5
Was there a delay in transfer to delivery suite within 30 minutes where the MEWS was 6 or more or scoring a 3 on a single parameter?	0	0	0	0	0	0	0	0	1	0	0	0	0	1	1	0
Was there a delay of more than 30 minutes to initiate the sepsis care bundle?	0	0	0	0	0	0	0	0	1	1	1	0	1	0	1	0
Has there been a deferred date of planned induction of labour?	1	0	2	0	0	0	0	0	0	1	1	0	0	4	4	0
Has there been any cancelled or delayed community work?	25	5	28	4	0	0	0	2	3	2	0	3	2	5	0	1
Did redeployment of staff to other services/ sites/ wards occur?	17	9	12	8	2	0	6	3	12	9	6	12	14	34	13	15
Is the incident related to an RCOG situation where a consultant was called but did not attend (New June 25 Validated position.)												1	0	2	0	0
Total numbers of red flags	**221**	**171**	**308**	**178**	**140**	**157**	**205**	**161**	**179**	**396**	**336**	**364**	**333**	**276**	**230**	**214**

APPENDIX 4 INDUCTION OF LABOUR CONTINOUS IMPROVEMENT PROJECT