



Lancashire Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS PART I ANCILLARY PAPERS

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4 June 2026



09:15 GMT+1 Europe/London

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8. BOARD ASSURANCE FRAMEWORK

● Decision Item

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8. Board Assurance Framework Ancillary Report Board Part I 4 June 2026 .pdf

Board Assurance Framework

2026/27

Board of Directors – June 2026

 **Patients** – deliver excellent care

 **Performance** – deliver timely, effective care

 **People** – be a great place to work

 **Productivity** – delivery value for money

 **Partnership** – be fit for the future

How the Board Assurance Framework fits in



Strategy: Our strategy sets out our ambitious plans between 2025 – 2030 to enhance healthcare delivery, align with the NHS Long Term Plan, and continue our journey towards building a new hospital that meets the evolving needs of our communities that we serve both locally and across Lancashire and South Cumbria. Our new strategic framework is founded on our vision and values and organised around five strategic objectives – our ‘5 P’s’: Patients, Performance, People, Productivity and Partnership.



Corporate objectives: Each year the Board of Directors agrees corporate objectives which set out in more detail what the Trust plan to achieve over a 12-month period. The corporate objectives are designed to focus on delivery of the priorities during the year, which will support the overall delivery of the objectives identified within the strategy.



Board Assurance Framework: The Board Assurance Framework (BAF) provides a mechanism for the Board of Directors to monitor the effect of uncertainty on the delivery of the agreed objectives by the Executive Team. The BAF contains principal risks which are the risks considered most likely to materialise and those which are likely to have the greatest adverse impact on delivery of the corporate objectives, and therefore could also affect the ability to deliver the overall objectives set out in the strategy.



Seeking assurance: To have effective oversight of the delivery of our corporate objectives, the Board of Directors uses its committee structures to seek assurance on its behalf. Whilst individual corporate objectives will cross a number of our strategic objectives, each is allocated to one specific strategic objective for the purposes of monitoring. Each principal risk is allocated to a monitoring committee who will seek assurance on behalf of, and report back to, the Board of Directors.



Accountability: Each principal risk has an allocated Director who is responsible for leading on delivery. In practice, many of the principal risks will require input from across the Executive Team and from senior leaders as part of the Trust’s accountability framework. However, the lead Director is responsible for monitoring and updating the principal risks that make up the Board Assurance Framework, and has overall responsibility for the areas for improvement. Some principal risks may require external actions / improvements and where this is the case, the lead Director will be responsible for leading on behalf of the Trust and developing actions in consultation with external stakeholders.



Reporting: To make the Board Assurance Framework as easy to read as possible, we use colours to support the attention to important areas. It is recognised that elements of this document may not support accessibility standards, but this can be re-produced in an accessible form if required. Should this be required, please contact company.secretary@lthtr.nhs.uk by email.

Understanding the Board Assurance Framework

Risk Rating Matrix (Likelihood x Consequence)

Likelihood ↑	5 Almost Certain	5 Moderate	10 Significant	15 High	20 High	25 High
	4 Likely	4 Moderate	8 Significant	12 Significant	16 High	20 High
	3 Possible	3 Low	6 Moderate	9 Significant	12 Significant	15 High
	2 Unlikely	2 Low	4 Moderate	6 Moderate	8 Significant	10 Significant
	1 Rare	1 Low	2 Low	3 Low	4 Moderate	5 Moderate
		1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
		Consequence →				

DIRECTOR LEADS	
CEO	Chief Executive Officer
COO	Chief Operating Officer
CFO	Chief Finance Officer
CNO	Chief Nursing Officer
CPO	Chief People Officer
CMO	Chief Medical Officer
DCE	Director of Communications & Engagement
CSIO	Chief Strategy and Improvement Officer

Definitions	
5 P's	The 5 P's is an abbreviation to describe the five strategic objectives – Patients, Performance, People, Productivity and Partnership
Corporate Objectives	The corporate objectives are designed to focus on delivery of the priorities during the year, which will support the overall delivery of the strategic objectives.
Principal risks	Risks to the delivery of the corporate objectives, which are considered most likely to materialise and those which are likely to have the greatest adverse impact on delivery. There is also therefore the potential to affect the ability to deliver the overall strategic objectives. Principal risks populate the Board Assurance Framework. Potential risks to delivery are monitored through the Single Improvement Plan and the Integrated Performance Report. Principal Risks are approved by the Board and managed through Lead Committees and Directors.
Controls	The measures in place to reduce the likelihood and/or the consequence of the risk to secure a reasonable level of control.
Gaps in Controls	Areas which require action/attention to ensure that appropriate controls are in place to secure a reasonable level of control.
Assurances	A measure/methodology/source which provides confirmation that the control measures put in place are effective and sustainable to secure a reasonable level of control. These can be internal or external sources, depending on the risk and the appropriate level of assurance required.
Gaps in Assurances	Areas where there is limited or no assurance that the control measures put in place are effective and sustainable to secure a reasonable level of control.
Risk Treatment:	Actions required to mitigate the gap(s) in controls or assurance, with timescales and identified owners. Five T's - Terminate, Transfer, Tolerate, Treat, Take the Opportunity.

Our strategic approach at a glance



Strategic Objectives



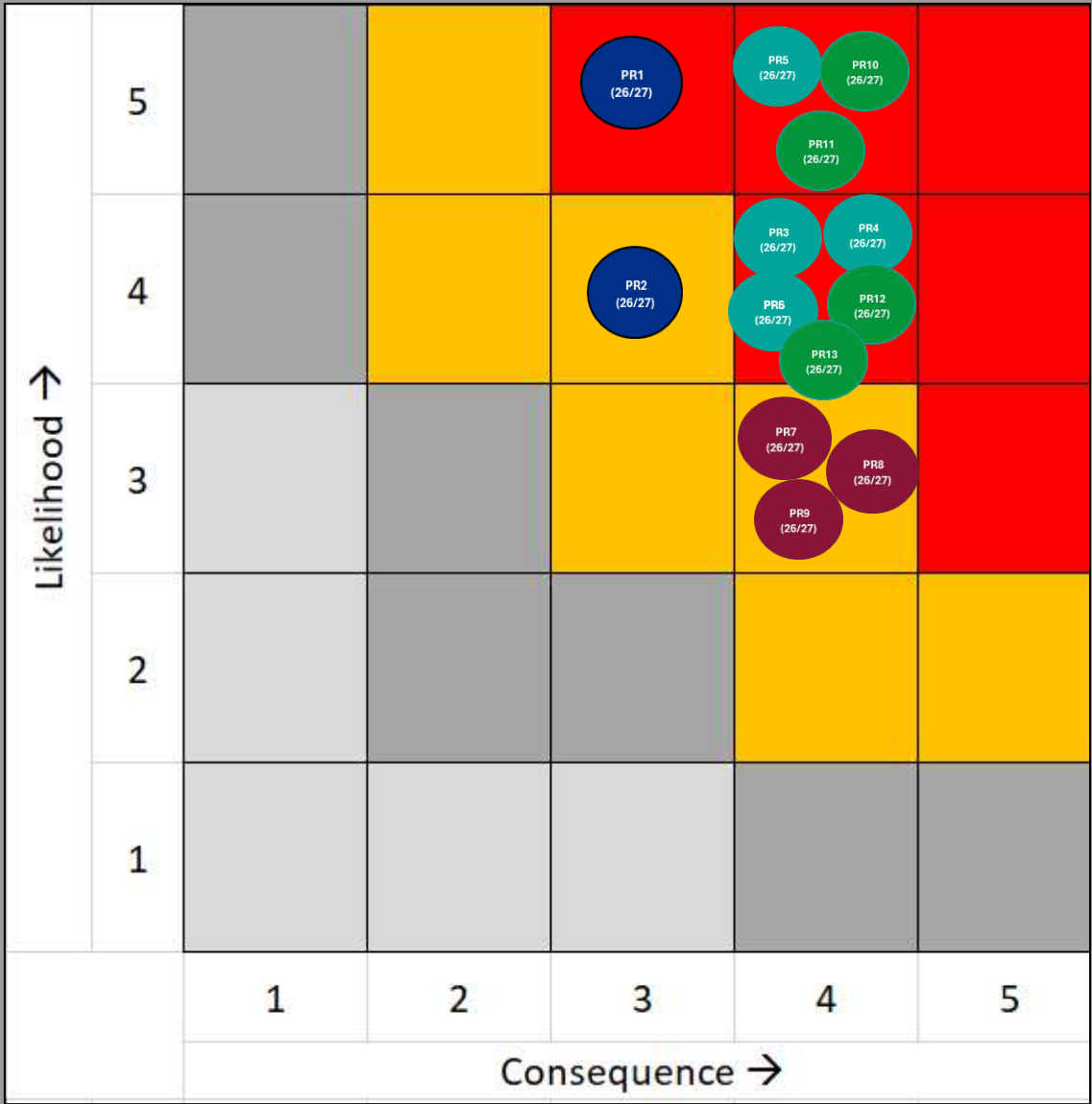
2026/27 Corporate Objectives



Principal Risk Management

Our Risk Appetite and Tolerance position is summarised in the table and the heat map shows the distribution of the principal risks based on the current score.

Ref	Principal Risk	Exec Lead	5Ps	Reporting Committee	Risk Appetite	Risk Tolerance	Current score	Direction of score since last report
PR1 (26/27)	Patient safety and experience within the urgent and emergency care pathway	CNO	Patients	SQC	Cautious	1-6	15	→
PR2 (26/27)	People experiencing Health inequalities	CNO	Patients	SQC	Cautious	1-6	12	→
PR3 (26/27)	Timely access to planned care	COO	Performance	FPC	Cautious	1-6	16	NEW
PR4 (26/27)	Timely access to cancer care	COO	Performance	FPC	Cautious	1-6	16	NEW
PR5 (26/27)	Timely access to urgent and emergency care	COO	Performance	FPC	Cautious	1-6	20	→
PR6 (26/27)	Timely access to diagnostic investigations	COO	Performance	FPC	Cautious	1-6	16	→
PR7 (26/27)	Experience of under-represented staff groups	CMO	People	WFC	Open	4-8	12	NEW
PR8 (26/27)	Experience of staff and levels of staff satisfaction	CPO	People	WFC	Open	4-8	12	NEW
PR9 (26/27)	Failure to effectively manage staff absence and achieve Trust and National target rates	CPO	People	WFC	Open	4-8	12	→
PR10 (26/27)	Delivery of the 2026/27 financial plan whilst reducing the size of the underlying financial deficit	CFO	Productivity	FPC	Open	8-12	20	→
PR11 (26/27)	Cash consequences of the Trust's underlying financial position	CFO	Productivity	FPC	Open	8-12	20	→
PR12 (26/27)	Ability to access required Capital to support an ageing estate	CFO	Productivity	FPC	Open	8-12	16	→
PR13 (26/27)	Delivery of the planned reduction in whole time equivalent workforce	CPO	Productivity	FPC	Open	8-12	16	NEW



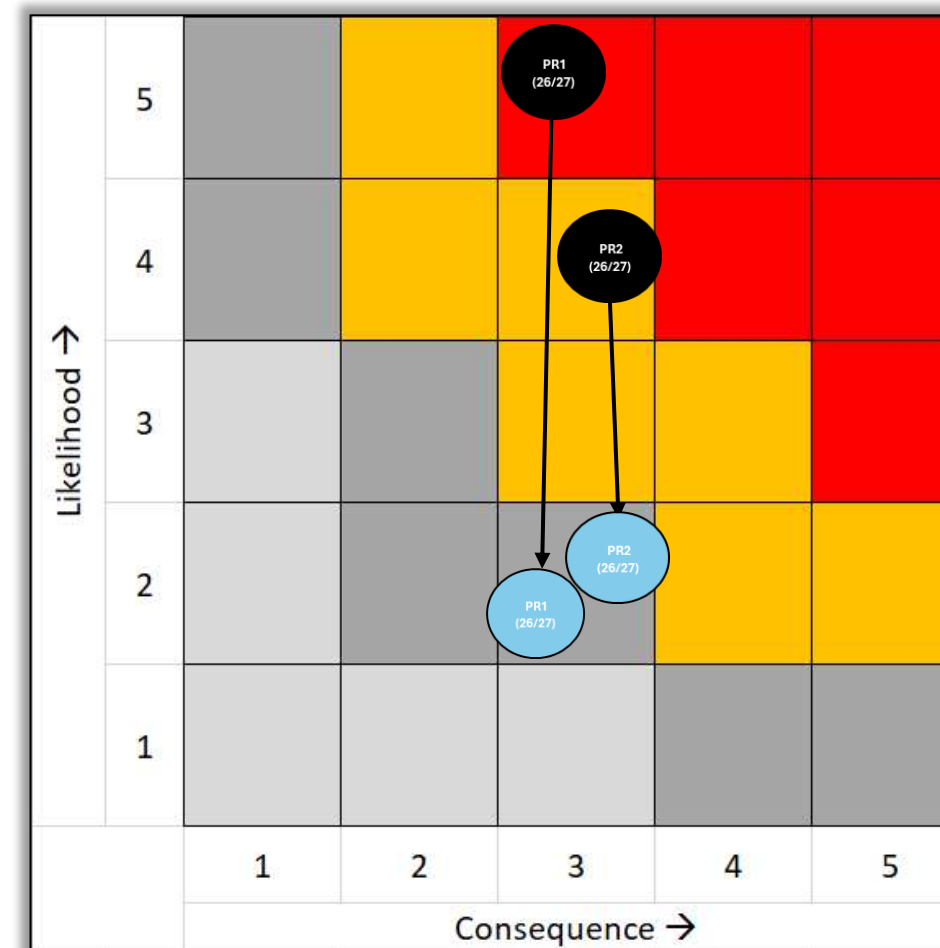
Key- Dark Blue = Patients, Turquoise = Performance, Red = People, Green = Productivity, Pink - Partnership

Patients: Deliver excellent care

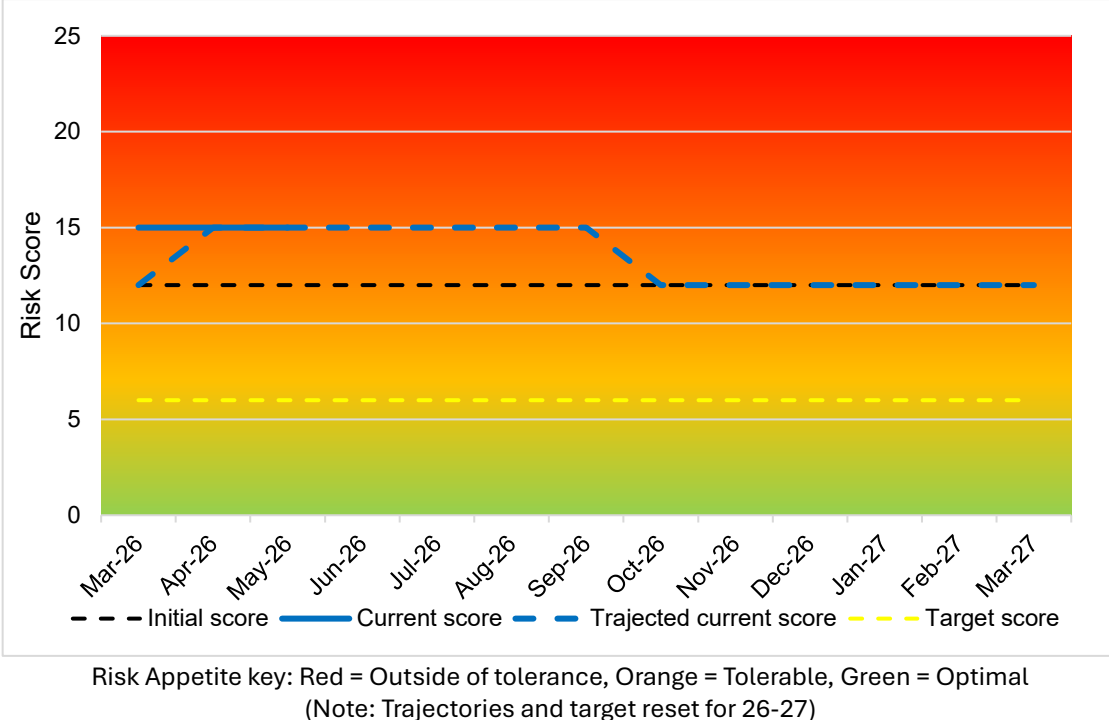
Monitored through Safety & Quality Committee

The following 2026/27 corporate objectives are aligned to the **Patients** strategic objective:

CO Ref.	Purpose of the objective	Scope and Focus of the Objective	How will we know if it has been achieved?	Status
1.1	Implement the national Maternity and Neonatal Improvement Plan and the Maternity Incentive Scheme	- Deliver the national Maternity and Neonatal Improvement Plan, which sets out a comprehensive framework for enhancing the safety, quality, and equity of care for mothers and babies. This includes - strengthening clinical leadership, - improving workforce capacity - embedding evidence-based practices across maternity and neonatal services. - Implementation will be supported by robust governance, continuous learning, and collaboration across the Integrated Care System.	- Reduction in sepsis, improved thermal stability - MEWS/NEWTT2 implementation & compliance - Adoption of evidence-based interventions - Sustained reduction in term admissions to NICU - Sustained improvements in application of Sepsis 6, smoking cessation, diabetes management - Improved staffing metrics & safety culture survey scores	No Risk identified
1.2	Undertake a fundamental specialty redesign adopting the principles of the ten-year health plan. Priority areas year 1: - Frailty - COPD - Heart Failure	- Redesign of those specialties involved in long term care, guided by the principles of the ten-year health plan. - Rethink how services are delivered, integrating care across settings, and aligning clinical pathways with population health priorities - Focus on prevention, early intervention, and multidisciplinary collaboration, ensuring that specialty services are more accessible and efficient.	- Reduction in emergency admissions for key LTC groups (e.g., COPD, heart failure, diabetes) - Reduction in avoidable 30-day readmissions - Improved LTC outcome metrics (e.g., HbA1c, spirometry stability, heart failure optimisation) - Reduced variation in outcomes between sites/services % of LTC pathways aligned to evidence-based guidance and 10-year plan principles	No Risk identified
1.3	Recognise the asset specialist services are to the organisation and the important role they play at LTH, delivering cutting edge care and being a catalyst for innovation and pioneering clinical practice	- Foster clinical excellence. - Invest in specialist expertise - Ensure that services are designed and delivered in a way that meets the diverse needs of the population. - Champion innovation and collaboration.	We can reduce unwarranted variation in both access to care and patient outcomes, ensuring that every individual receives equitable, timely, and effective treatment regardless of geography or circumstance.	No Risk identified
1.4	Design and deliver a children's and young people's plan to improve access to urgent and emergency care	Design and implement a comprehensive Children's and Young People's Plan. This plan will be developed in collaboration with healthcare professionals, education providers, local authorities, and most importantly children, young people, and their families	- Identifying and addressing barriers to care - Streamlined referral pathways - Enhancing the capacity and responsiveness of urgent care services. - Creation of a more accessible, responsive, and inclusive urgent care system.	No Risk identified
1.5	Improve outcomes and prevent harm	- Implement the Always Safety-First strategy 2026-2029 - Deliver medicines safety and optimisation programme - Continued implementation of PSIRF & demonstrate maturity in the approach to learning. - Deliver within the agreed C.difficile trajectory - Deliver annual safe staffing requirements	- Improved verification and reconciliation compliance - Delivery of Always Safety First and learning strategy - Deliver agreed C.difficile trajectory - Deliver Maternity Incentive Scheme - Deliver annual safe staffing requirements	No Risk identified
1.6	Reduce occupancy across UEC pathways	- Reduce routine boarding on ward areas - Eliminate corridor care in the Emergency Department - Reduce ambulance delays	- Reduce routine boarding on ward areas - Eliminate corridor care in the Emergency Department - Reduce ambulance delays	Risk identified
1.7	Reduction in Health Inequalities across core20plus5 for adults and children and frailty pathways	Work across all pathways to implement agreed actions to further reduce health inequalities	Work across all pathways to implement agreed actions to further reduce health inequalities	Risk identified



Heat map key: Black = current score, Blue = target score

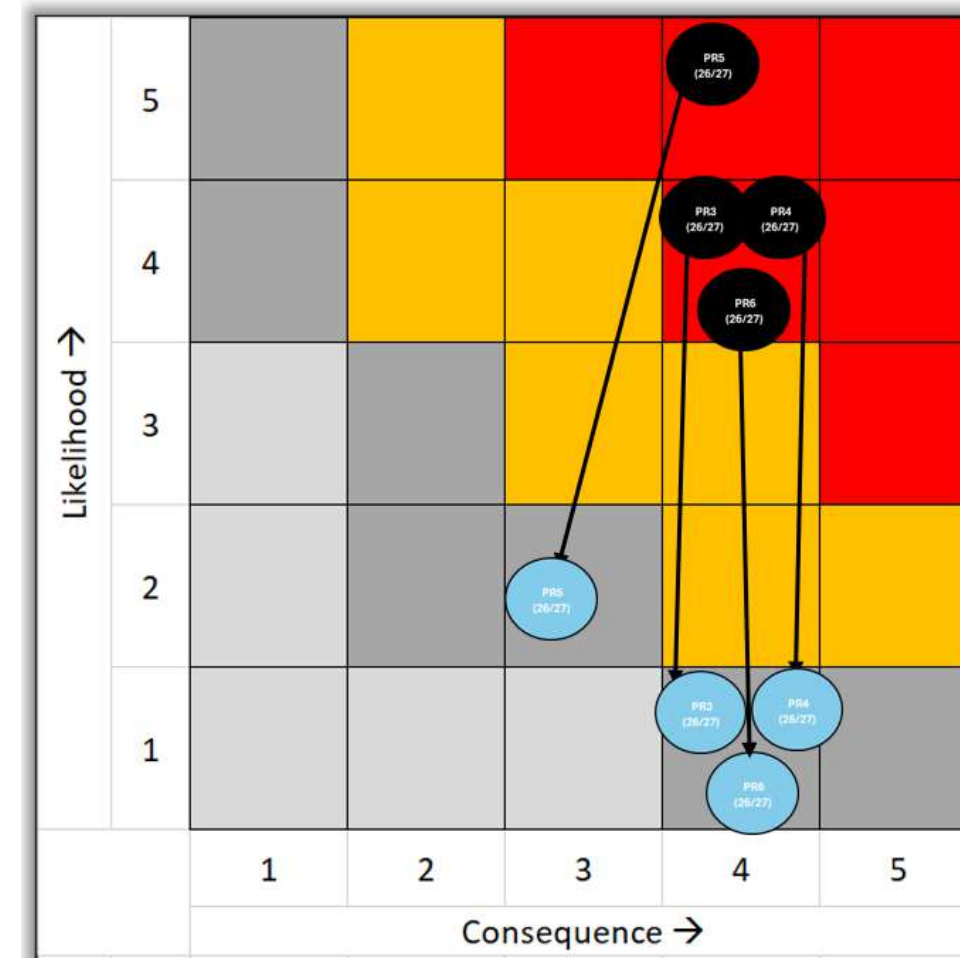
Strategic Objective: Patients				Corporate Objective: Reduce occupancy across UEC pathways				Overall Assurance Level		Low																																											
Principal risk 1 (26/27) (ID 2102)	Risk Title:	Patient safety and experience within the urgent and emergency care pathway						Risk Score Tracker 																																													
	Risk Description:	There is a risk that patient safety and experience within the urgent and emergency care pathway may be negatively impacted due to consistently high service demand, delayed handover from ambulances, long waiting times and overcrowding, affecting the ability to deliver care and communication in line with expectations. This could result in increased patient safety incidents, reduced patient satisfaction, increased complaints, poor staff experience, regulatory intervention, and potential reputational damage to the Trust.																																																			
Committee	Safety & Quality	Risk Appetite and Tolerance	Cautious	↑ Likelihood <table><tr><td>5</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>4</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>3</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>2</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>1</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr><tr><td></td><td colspan="5">Consequence →</td></tr></table> ● Initial ● Current ● Target								5						4						3						2						1							1	2	3	4	5		Consequence →				
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	Consequence →																																																				
Director	Chief Nursing Officer	5Ts status	Treat																																																		
Date risk opened	05/12/24	Date of last review	14/05/26																																																		
		Target control date	31/03/27																																																		
Controls		Gaps in Controls		Assurances				Gaps in Assurances																																													
- Twice annual nurse staffing assessments. - Patient experience and Involvement plan. - Patient Experience & Involvement Group. - National OPEL Framework. - L&SC daily Gold Command meetings. - Escalation Plan (including Full Capacity Protocol, Bed Escalation and Extreme Escalation). - Urgent & Emergency Care Delivery Board. - Urgent & Emergency Care Picker Survey Action Plan. - Discharge Improvement Plan.		- Community demand for primary and UEC services. - Community ability to increase the number of new patients being seen in 2 Hour Urgent care. - Alternatives to Emergency Care. - Ageing estate and environment. - Sub-optimal escalation areas. - Financial constraints. - Inpatient Picker survey identifies lower than expected experience outcomes. Gap in the required number of beds. - Patients cared for outside of designated bed spaces. - Not Meeting Criteria to reside >5% target.		<u>Level 1 Assurance</u> - Complaints and concerns – approx. less than 1% versus attendances. - ED dashboard provides monthly overview of safety, quality and performance metrics in ED. - Boarding position reported as part of the Safety & Quality dashboard with underpinning policy and procedure in place to ensure minimum care standards are met. - Improved position at CDH in relation to time to triage, average time to see a clinician. <u>Stable triage position at RPH.</u> - STAR patient experience has some areas of positive performance. <u>Level 2 Assurance</u> - Patient Experience & Involvement Group reports to Safety & Quality Committee - Urgent and Emergency Care Picker Survey reported to Safety & Quality Committee. <u>Level 3 Assurance</u> - Friends & Family Test – some areas of positive assurance. - UEC survey reflecting outcomes ‘about the same’ as other Trusts				- Time to see a clinician at RPH consistently exceeds the 60 min average target. - Inpatient survey identified medicine at RPH most prevalent area of less positive experiences. - The CDH site UEC pathway is demonstrating increased occupancy levels leading to longer length of stay at the start of the pathway. - Friends and Family Test – gaps related to communication, waiting times and overall experience. - Summary Emergency Department Indicator Table (SEDIT) outcomes below peer																																													
Risk Treatment																																																					
Action		Action Owner	Due Date	Done Date	Action Progress Update																																																
Increase capacity in 2 hour Urgent Care (care connexions).		S. Morrison	31.03.26 31.07.26		May 26: This action continues to be off track. This has been accepted as a key priority between the two organisations. Lead Exec meeting with nominated LSCFT lead and UEC improvement Director providing in reach.																																																
Work in partnership with LSCFT to develop a Mental health Review Centre adjacent to ED to reduce the length of time patients spend waiting with a mental health diagnosis in ED.		S. Morrison	30.09.26		May 26: Plans signed off for the new unit. Timeline due in the next month to agree start and completion dates. Meeting held with COO LSCFT and confirmed new model evaluating well in early adopter site and commitment to continue with scheme.																																																

Strategic Objective: Patients		Corporate Objective: Reduction in Health Inequalities across core20plus5 for adults and children and frailty pathways					Overall Assurance Level		Medium	
Principal risk 2 (26/27) (ID 2103)	Risk Title:	People experiencing Health inequalities						Risk Score Tracker --- Initial score — Current score - - - Trajected current score - - - Target score Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal (Note: Trajectories and target reset for 26-27)		
	Risk Description:	There is a risk that the Trust will be unable to effectively address health inequalities because of disparities in access to healthcare services, social determinants of health (such as socioeconomic status, education, and housing conditions), commissioning arrangements, and unequal distribution of resources across communities. This could result in poorer health outcomes for disadvantaged groups, increased pressure on acute and emergency services, reduced patient satisfaction, potential reputational damage for the Trust, non-compliance with regulatory standards and missed opportunities for improving population health. The Trust is part of a wider system approach to health improvement and will work with partners to affect this, recognising the limitations of single services in affecting outcomes in a material way for people.								
	Committee	Safety & Quality	Risk Appetite and Tolerance	Cautious	Likelihood ↑ 5 4 3 2 1 1 2 3 4 5 Consequence → ● Initial ● Current ● Target					
	Director	Chief Nursing Officer	5Ts status	Treat						
Date risk opened	05/12/24	Date of last review	14/05/26							
		Target control date	31/03/27							
Controls			Gaps in Controls			Assurances			Gaps in Assurances	
• Lancashire & South Cumbria Integrated Care Partnership Health and Wellbeing Strategy. • LTH Health Improvement Plan, developed in conjunction with L&SC system partners. • Health Inequalities Group. • Health Inequalities Patient Tracking List (PTL) Group. • Health literacy group relating to communication with patients. • Specific improvement programmes for adults and children (e.g. High intensity user service, prisoner referral to treatment and ED navigator role in partnership with Lancashire Violence Reduction Network).			• Commissioning arrangements are led by the ICB. • The Trust has no Public Health Consultant. • Anchor institute plan is under review to link to other plans. • Anchor institute group to be established.			Level 1 Assurance [None detailed] Level 2 Assurance • Monthly chairs reporting to Safety & Quality Committee • Bi-annual update on Health inequalities to Safety & Quality Committee. Level 3 Assurance • Annual compliance NHS statement on information on Health Inequalities – data does not suggest there are barriers for patients from areas of lower deprivation to accessing elective care services. • Quarterly Report to ICB on Health Inequalities.			• Annual compliance NHS statement on information on Health Inequalities – challenges around the completeness and accuracy of ethnicity data captured, with around 7% of patient’s ethnicity either unknown or not stated for Central Lancashire. • Inability to access primary care data that would allow improved data quality on high risk groups such as patients with a learning disability, serious mental health and/or physical disability.	
Risk Treatment										
Action			Action Owner	Due Date	Done Date	Action Progress Update				
Demonstrate progress in disaggregating data to enable understanding of health inequalities and facilitate different approaches to addressing these			R. Sansbury	30.06.26		May 26: Outline of work required prioritised in business intelligence programme of work, models of analysis discussed with CIO this month and example outline being explored. 6 month health inequality progress report prepared with additional data sets included demonstrating progress. Strategic approach to this not yet defined as BI focus is in a competing priority area. Raised and requested a plan.				
Support case to approve the data sharing agreements between primary and secondary care.			A. Brotherton	31.12.26		May 26: Awaiting outcome. No further update available. Raised again in Feb with Integrated Care System (ICS) Chief Medical Officer (CMO).				

Performance: Deliver timely, effective care
Monitored through Finance & Performance Committee

The following 2026/27 corporate objectives are aligned to the **Performance** strategic objective:

CO Ref.	Purpose of the objective	Scope and Focus of the Objective	How will we know if it has been achieved?	Status
2.1	Improve patient experience through a focus on valuing patients' time by developing streamlined pathways and better communication, leading to the delivery of national standards for cancer	Redesign care pathways to be more efficient, reducing unnecessary delays and handoffs. Improved communication, both between healthcare professionals and with patients, will ensure that individuals are well-informed, supported, and actively involved in their care journey.	- Meet and exceed national cancer standards. - Achievement of percentage compliance for Faster Diagnosis Standards, 62 day referral to treatment and 31 days for treatment following a decision to treat as agreed in the annual plan. - Ensuring timely diagnosis, treatment, and follow-up - Fostering trust and confidence in our services.	Risk identified
2.2	Improve patient experience and performance in Urgent and Emergency Care through the delivery of the 4 hour, 12 hour and ambulance handover standards	- Co-design and standardise UEC pathways across providers to reduce duplication and improve consistency, working through the ICS urgent care networks - Streamline handoffs, improve communication, and reduce waiting - Explicitly targeting below-average UEC experience and long length of stay (LoS) for people presenting with mental health needs - Reduce urgent and emergency care waiting times in line with agreed plan: Adults - 82%, Children - 95%	- Achieve and sustain performance at or better than national average - Same Day Emergency Care (SDEC) utilisation: % of eligible patients managed via SDEC pathways - Reduction in serious incidents related to deterioration/escalation delays; timely delivery of sepsis bundles in urgent pathways - ED Friends & Family Test (FFT) positive score: Sustained improvement quarter-on-quarter	Risk identified
2.3	Implement the strengths-based approach Days Kept Away from Home across all services	- Embedding a culture that values independence, supports recovery, and reduces unnecessary hospital admissions. - Fostering of multidisciplinary collaboration, enabling teams to work together to create care plans that are proactive, preventative, and tailored to each person's strengths and circumstances.	- Reduction in days kept away from home - Improvement in length of stay	No Risks identified
2.4	RTT - Eliminate 52-week breaches and achieve compliance trajectories as agreed in the annual plan	Reduce elective care waiting times in line with agreed and funded plan	- Eliminate all instances of a patient waiting longer than 52 weeks for treatment - Meet and exceed locally agreed compliance trajectories	Risk identified
2.5	Diagnostics - Achievement of the 6 week diagnostic waiting times performance trajectories	Reduce diagnostic waiting times	Meet and exceed locally agreed compliance percentages	Risk identified



Heat map key: Black = current score, Blue = target score

Strategic Objective: Performance					Corporate Objective: RTT - Eliminate 52-week breaches and achieve compliance trajectories as agreed in the annual plan					Overall Assurance Level		Medium																																			
Principal risk 3 (26/27) (ID 2314)	Risk Title:	Timely access to planned care								Risk Score Tracker --- Initial score — Current score - - - Trajected current score - - - Target score Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal																																					
	Risk Description:	There is a risk that there is insufficient capacity to deliver the required activity levels needed to achieve performance trajectories and deliver timely access to clinical assessment and treatment. Capacity constraints relate to insufficient workforce and/or physical estate shortfalls. Shortfalls in clinical capacity could result in patient harms associated with a delay in timely access to planned care, poorer patient outcomes, inability to meet national constitutional standards, claims, poor patient experience, reputational damage, and regulatory action.																																													
Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious	Likelihood ↑ <table><tr><td>5</td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>4</td><td></td><td></td><td></td><td></td><td>●</td><td>●</td></tr><tr><td>3</td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>2</td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>1</td><td></td><td></td><td></td><td></td><td>●</td><td></td></tr></table> Consequence → ● Initial ● Current ● Target									5							4					●	●	3							2							1					●	
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		Target control date	31/03/27																																												
Controls				Gaps in Controls				Assurances		Gaps in Assurances																																					
26/27 Annual activity & Performance plans have been outlined to deliver reductions in long waiting RTT targets, waiting list reduction and improved 18 week compliance in line with agreed trajectories. Plans include monthly trajectories and associated action plans. - Clear identification of clinical priorities via the use of national clinical prioritisation codes. This enables the trust to understand the clinical priority (P2 – P6) of those patients to support scheduling the most clinically urgent. - PEP+ (Patient Engagement Portal) and AI functionality to support validation of the waiting list and digital letters to support the process. The frequency of validation is monitored via Divisional and organisational performance forums. - Weekly Operations Board in place to track performance and delivery of actions linked to improvement trajectories. - A report for P2 patients waiting over 5 weeks is in place for Divisions to plan their elective capacity. 6-4-2 protocols in place to drive optimal use of theatre capacity. - Theatre efficiency programme in place, monitored through the Elective Transformation Programme and up to the Elective Transformation Board and some parts already implemented - Monitoring of benchmarking data via Model Hospital and GIRFT to drive productivity improvements. - Capacity & Demand modelling has been undertaken for key specialties. - Independent sector capacity is commissioned to support delivery of the required activity levels. - Pilot of AI Robotic (LLM) RTT validation underway with high success rates identified – being mobilised across full RTT PTL.				- Where specialties have a Capacity & Demand gap which cannot be mitigated via improved productivity, there is a need to resource additional capacity. - Restricted admin capacity to backfill short notice procedure cancellations. - Limited admin and clerical resource to support the ‘double entry’ required to accurately administrate the independent sector activity. - Limitations within the EPR (Flex Harris) system resulting in increased human administrative burden and increased risk of human error leading to data quality issues and potential patient treatment delays - Limited clinician appetite to deliver additional non-core activity required to deliver the required performance. - Independent sector (IS) capacity is insufficient to meet the requirements of the organisation or IS providers are unable or unwilling to support the case mix requested.				<u>Level 1 Assurance</u> - Live PTL performance report and Validation reports. <u>Level 2 Assurance</u> - Oversight in Divisional Improvement Forums, Operations Board and F&P Committee. - Benchmarking data analysis – model hospital, GIRFT, etc. <u>Level 3 Assurance</u> - Fortnightly tiering meetings in place to track progress. - Performance agenda established within IAGs		- Delays in concluding some harm reviews. - Data sets lack inequalities data visibility to assess the risk to poorer outcomes between patient groups on PTLs. - Limitations of EPR (Flex Harris) to link patient pathways which may result in ineffective performance management and reporting. - Lack of performance and productivity data visibility at speciality level																																					
Risk Treatment																																															
Action		Action Owner		Due Date	Done Date	Action Progress Update																																									
Review of booking, scheduling and administrative resource benchmarking options		K. Foster-Greenwood		31.03.26	16.04.26	Apr 26: PWC analysis has been completed. A design session has been programmed to take place mid-April to inform the Target Operating Model and design programme.																																									
Capacity & Demand modelling to be undertaken for core specialties		K. Foster Greenwood		31.03.26	17.04.26	Apr 26: 25 Specialities/modalities completed capacity and demand assessments.																																									
Commission and mobilise additional Independent sector capacity		K Foster Greenwood		31.05.26		May 26: Business case drafted. For CEO approval to commence procurement to be completed by 15.05.26																																									
Agree Phase 1 pilot AI PIFU specialties		K Foster Greenwood		31.05.26		May 26: Scoping of pilot within Cardiology underway. Digital team requested to produce speciality roll out plan for 26/27 by 13.05.26																																									
Mobilise Q1 Model Service Programme reviews		K Foster Greenwood		01.04.26 30.04.26	11.05.26	May 26: Q1 Model Service reviews commenced.																																									
Commission business case development for key specialties based on the C&D outputs (25/26)		K Foster Greenwood		30.04.26 30.06.26		May 26: Each service will be supported to scope a business case following review within Model Service Programme throughout Q1.																																									

Strategic Objective: Performance			Corporate Objective: Improve patient experience through a focus on valuing patients’ time by developing streamlined pathways and better communication, leading to the delivery of national standards for cancer				Overall Assurance Level		Medium		
Principal risk 4 (26/27) (ID 2315)	Risk Title:	Timely access to cancer care						Risk Score Tracker Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal			
	Risk Description:	There is a risk that there will be insufficient capacity to ensure timely access to cancer care as a result of critical workforce or other capital resource gaps such as Diagnostic equipment. This could result in patient harms associated with a delay in timely access to cancer care, poorer patient outcomes, inability to meet national constitutional standards, claims, poor patient experience, reputational damage, and regulatory action.									
Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious	● Initial ● Current ● Target							
Director	Chief Operating Officer	5Ts status	Treat								
Date risk opened	02/04/26	Date of last review	11/05/26								
		Target control date	31/03/27								
Controls				Gaps in Controls				Assurances		Gaps in Assurances	
- Weekly monitoring of cancer patient tracking lists (PTLs) to reduce any delays with tumour specific action plans in place. - Weekly Operations Board established to track performance and delivery of actions linked to improvement trajectories. 6-4-2 protocols in place to drive optimal use of theatre capacity. - Theatre efficiency programme in place, monitored through the Elective Transformation Programme and up to the Elective Transformation Board and some parts already implemented - Monitoring of benchmarking data via Model Hospital and GIRFT to drive productivity improvements.				- Where specialties have a Capacity & Demand gap which cannot be mitigated via improved productivity, there is a need to resource additional capacity. - Limited clinician appetite to deliver additional non core activity required to deliver the required performance. - Inability to successfully recruit into nationally hard to recruit to posts e.g. Oncology - Restricted admin capacity to backfill short notice procedure cancellations. - Limitations within the EPR (Flex Harris) system resulting in increased human administrative burden and increased risk of human error leading to data quality issues and potential patient treatment delays - Lack of community capacity with the closure of Community Healthcare Hub and reduced capacity at Longridge resulting in high bed occupancy and increasing the risk of capacity related elective and cancer cancellations - RTF funding secured was at half the value of the submitted bid. - Limited digital and validation capacity to support the AI Robotic RTT validation pilot.				<u>Level 1 Assurance</u> - Live PTL performance report and Validation reports. - Harm reviews process in place for >104 day cancer pathway patients. <u>Level 2 Assurance</u> - Oversight in Divisional Improvement Forums, Operations Board and F&P Committee. - Benchmarking data analysis – model hospital, GIRFT, etc. <u>Level 3 Assurance</u> - Fortnightly tiering meetings in place to track progress - Performance agenda established within IAGs		- Delays in concluding some harm reviews. - Data sets lack inequalities data visibility to assess the risk to poorer outcomes between patient groups on PTLs. - Inability to assess the risk for patients on surveillance pathways. - Limitations of EPR (Flex Harris) to link patient pathways which may result in ineffective performance management and reporting. - Lack of performance and productivity data visibility at tumour group level	
Risk Treatment											
Action		Action Owner		Due Date	Done Date	Action Progress Update					
Commission business case development for key specialties based on the C&D outputs		K Foster Greenwood		~~30.04.26~~ 30.06.26		May 26: Each service will be supported to scope a business case following review within Model Service Programme throughout Q1.					
Develop a Cancer productivity dashboard to monitor performance against best timed pathways to inform improvement plans and performance delivery.		K Foster Greenwood		~~30.06.26~~ 30.09.26		May 26: All tumour group roll out plan agreed with Digital colleagues – to be completed by end Sept 26.					

Strategic Objective: Performance					Corporate Objective: Improve patient experience and performance in Urgent and Emergency Care through the delivery of the 4 hour, 12 hour and ambulance handover standards					Overall Assurance Level		Low																																																								
Principal risk 5 (26/27) (ID 2104)	Risk Title:	Timely access to urgent and emergency care								Risk Score Tracker Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal (Note: Trajectory reset for 26/27)																																																										
	Risk Description:	There is a risk that patients may experience delays in timely access to urgent and emergency care because of high demand, insufficient out of hospital provision for patients who do not meet the criteria to reside in hospital, limited bed availability, workforce shortages, and delays in patient flow throughout the hospital and community. This could result in longer waiting times, compromised patient safety and experience, increased clinical risk, poorer health outcomes, and potential breaches of national performance targets, impacting the Trust's reputation and regulatory compliance.																																																																		
	Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious	Likelihood ↑ <table><tr><td>5</td><td></td><td></td><td></td><td></td><td>●</td><td>●</td><td></td></tr><tr><td>4</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>3</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>2</td><td></td><td></td><td></td><td>●</td><td></td><td></td><td></td></tr><tr><td>1</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td colspan="2"></td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td></td></tr><tr><td colspan="2"></td><td colspan="6">Consequence →</td></tr></table> ● Initial ● Current ● Target				5									●	●		4								3								2				●				1										1	2	3	4	5				Consequence →					
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Director	Chief Operating Officer	5Ts status	Treat																																																																	
Date risk opened	05/12/24	Date of last review	11/05/26																																																																	
		Target control date	31/03/27																																																																	
Controls				Gaps in Controls				Assurances				Gaps in Assurances																																																								
• Clinical triage processes are established. • OPEL and internal Site Pressure Score Framework and protocols are in place • L&SC daily Gold Command meetings. • Escalation and Surge Plans defined and in place. • Ambulatory and admission avoidance pathways established. • Same Day Emergency Care facilities in place. • Urgent care service provided by a third party co-located on both CDH and RPH sites. • Single Improvement Plan and Board established to track improvement delivery. • Central Lancs system wide UEC & Community Improvement Plan focusing on Hospital @ Home pathways and capacity and Days Kept Away from Home established. • Site Pressure Management processes, meetings and associated action cards established. • Clinical discharge team management of all patients classified as Days Kept Away from Home. • Virtual Ward capacity to support admission avoidance and early step down from hospital. • Care connections coordination function in place to link hospital and community provisions. • Continuous Flow Model is established to drive timely flow. • Ward & Board round process standardisation programme established. • 45 min Release to Rescue protocol implemented • Additional stretch targets agreed with system partners				• Insufficient flow within the hospital bed base to prevent ED overcrowding. • Out of hospital provision is insufficient to meet the demand. • The environment and estate is sub-optimal.				<u>Level 1 Assurance</u> • ED Safety Surveillance dashboard monitors live metrics to assess risks of patient harm. <u>Level 2 Assurance</u> • Urgent & Emergency Care and Community Transformation Board provides monthly monitoring of all improvement actions across the system. • Emergency Department Dashboard to Safety & Quality Committee • Finance and Performance Committee. <u>Level 3 Assurance</u> • Fortnightly tiering meetings in place to track progress • Performance to be added to the IAG agenda from Jan 26.				• High bed occupancy levels (above 92%). • Time to triage and first senior review are not meeting Trust targets. • Performance for the 4 hour wait times and 12 hour total wait time in the department, are not meeting the Trust targets. • Ambulance turnaround times are not meeting the Trust targets.																																																								
Risk Treatment																																																																				
Action		Action Owner		Due Date	Done Date	Action Progress Update																																																														
Conclude and evaluate Ward & Board round standardisation		R Sansbury		31.03.26	31.03.26	April 26: An audit was completed in December 2025 to assess compliance with the key MDT Board round and ward round standards across all adult inpatient areas with the results shared through Divisional forums for immediate action. The standards within the audit have been embedded into STAR from April 2026 onwards to ensure that compliance with these standards is a core part of the Trust oversight and assurance framework.																																																														
Increase Virtual Ward occupancy to minimum of 75% by March 2026.		L. Walsh		31.03.26	31.03.26	Apr 26: March year end performance = 73.1%																																																														
UEC improvement programme		S Canty		31.08.26		May 26: UEC acute medicine model of care workshop held on 27.04.26. Plans mobilised to establish an EEMAC (Extended Emergency Medicine Ambulatory Care) early June 26. Medical rota changes planned for July 26.																																																														
Publication of a Standard Operating Procedure for MDT Board and Ward Rounds with aligned audit and training program		R Sansbury		30.06.26		May 26: SOP under consultation with the aim of going through approvals processes and being live in June 2026.																																																														

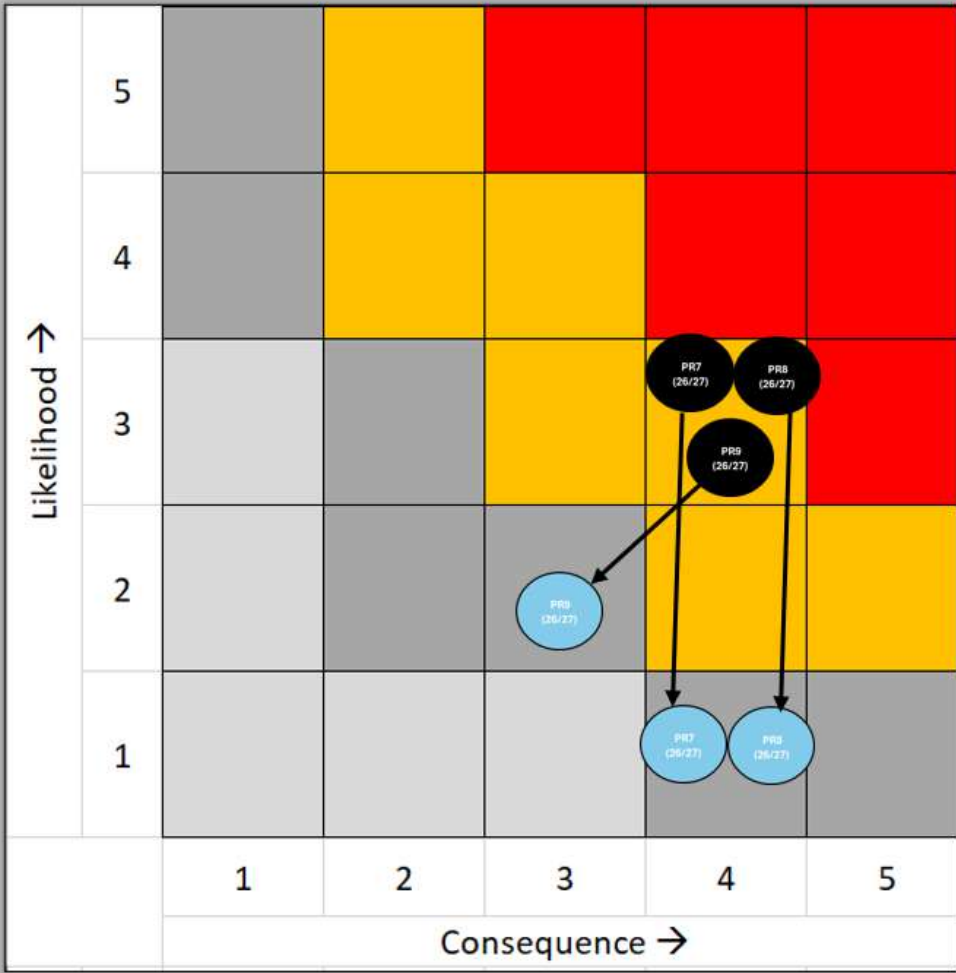
Strategic Objective: Performance		Corporate Objective: Diagnostics - Achievement of the 6 week diagnostic waiting times performance trajectories					Overall Assurance Level		Medium																																											
Principal risk 6 (26/27) (ID 2188)	Risk Title:	Timely access to diagnostic investigations							Risk Score Tracker Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal (Note: Trajectory reset for 2026/27)																																											
	Risk Description:	There is a risk of delays in the completion of diagnostic investigations linked to cancer and elective pathways of care due to high levels of demand, shortfalls in capacity, and financial restrictions limiting the ability to utilise external capacity. This could result in patient harms associated with a delay in timely diagnosis, poorer patient outcomes, inability to meet national constitutional standards, claims, poor patient experience, reputational damage, and regulatory action.																																																		
Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious	Likelihood ↑ <table><tr><td>5</td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>4</td><td></td><td></td><td></td><td></td><td>●</td><td>●</td></tr><tr><td>3</td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>2</td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>1</td><td></td><td></td><td></td><td></td><td>●</td><td></td></tr><tr><td colspan="2"></td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table> Consequence → ● Initial ● Current ● Target			5											4					●	●	3							2							1					●				1	2	3	4	5
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Director	Chief Operating Officer	5Ts status	Treat																																																	
Date risk opened	03/06/25	Date of last review	11/05/26																																																	
		Target Control date	31/03/27																																																	
Controls				Gaps in Controls			Assurances		Gaps in Assurances																																											
- Diagnostic Improvement Group has been established to monitor progress of all improvement trajectories, support demand management, the use of technology and monitor productivity. - All Diagnostic modalities have undertaken a capacity and demand analysis and set improvement trajectories. - Clear identification of clinical priorities via the use of national clinical prioritisation codes. This enables the trust to understand the clinical priority using ‘D codes’ to support scheduling the most clinically urgent. - Diagnostic waiting validation processes are in place to ensure all capacity is effectively used. - Additional capacity has been commissioned within the 26/27 agreed MTP. - Weekly monitoring of cancer PTLs to reduce any delays is in place supported by a day zero PTL approach with tumour specific action plans in place. ICB support and performance monitoring re Cancer waiting times is delivered via the Tier 1 performance framework and meetings are held fortnightly. - Weekly Chief Operating Officer monitoring forum for core diagnostic modalities. - Weekly Performance Recovery Group established to monitor performance. - Mutual aid support enacted via neighbouring Trust for Echo - Additional capacity mobilised (non-recurrently) for Echo				- Lack of capacity to deliver comprehensive diagnostic waiting list validation. - Lack of triangulation between capacity and demand gaps, benchmarking data and job planning processes. - Physical estate and capital equipment constraints limit available capacity. - Limited influence re external (primary care) demand management.			<u>Level 1 Assurance</u> - Live PTL performance report. - Validation reports. - Datix incident reporting of any treatment delay related harms – review via SI/PSIRF processes with shared learning reports. - Benchmarking data – model hospital, GIRFT, etc <u>Level 2 Assurance.</u> - Oversight in Divisional Improvement Forums, Performance Review Group and F&P Committee. - Benchmarking data analysis – model hospital, GIRFT, etc. <u>Level 3 Assurance</u> - DM01 improvement plan and trajectory in place monitored through NHS England oversight arrangements.		- Data sets lack inequalities data visibility to assess the risk of poorer outcomes between patient groups on PTLs - Datix incident reporting to assess harms of treatment delays is retrospective																																											
Risk Treatment																																																				
Action		Action Owner		Due Date	Done Date	Action Progress Update																																														
Capacity & Demand analysis to be completed for key Diagnostic modalities		K. Foster-Greenwood		31.03.26	17.04.26	Apr 26: 25 Specialities/modalities completed capacity and demand assessments. Diagnostic modalities included Endoscopy, CT, MR, Echo, NOUS.																																														
Develop a Diagnostic productivity dashboard to monitor performance against best timed pathways to inform improvement plans and performance delivery.		K Foster Greenwood		~~30.06.26~~ 30.09.26		May 26: Action date delayed due to specialist resource gap – alternative resource options being scoped. Due date extended until end Sept 26.																																														
Commission and mobilise additional Independent sector capacity		K Foster Greenwood		31.05.26	11.05.26	May 26: Business case drafted. For CEO approval to commence procurement to be completed by 15 May 26.																																														
Commission business case development for key specialities based on the C&D outputs		K Foster Greenwood		30.06.26		May 26: Each service will be supported to scope a business case following review within Model Service Programme throughout Q1.																																														

People: Be a Great Place to Work

Monitored through Workforce Committee & Education, Training & Research Committee

The following 2026/27 corporate objectives are aligned to the **People** strategic objective:

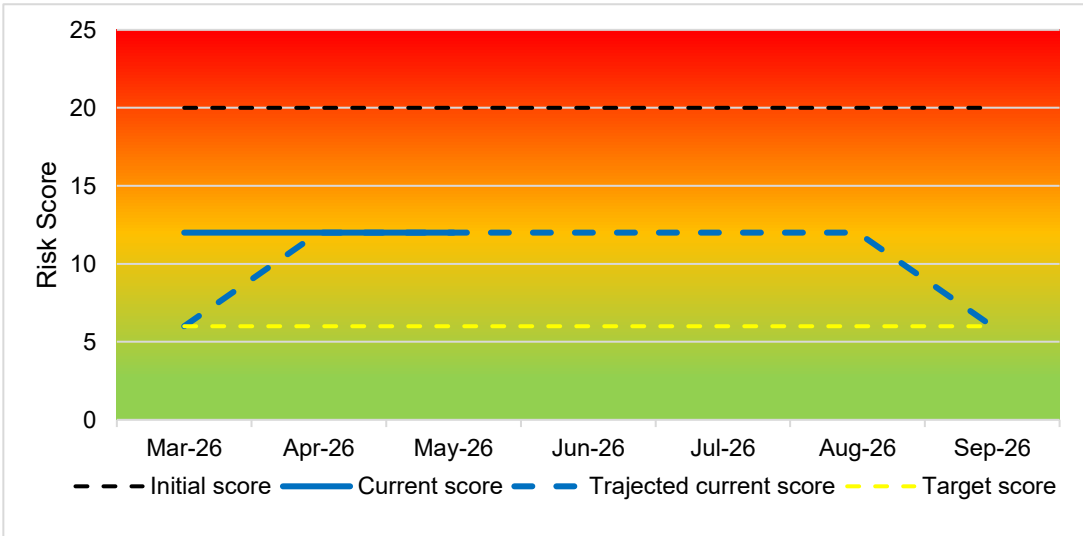
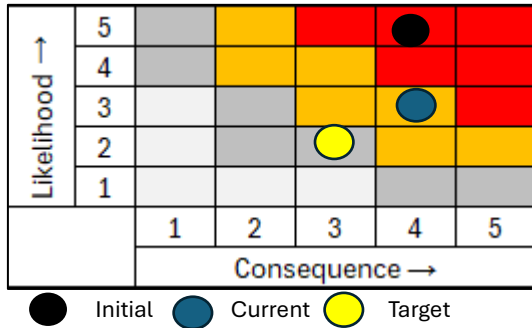
CO Ref.	Purpose of the objective	Scope and Focus of the Objective	How will we know if it has been achieved?	Status
3.1	Equip all our colleagues, including the Board, with the improvement skills, knowledge and confidence to drive improvements within their teams and services	Expand the current programme to include giving teams an understanding of the population health position	Increased % workforce training in improvement skills and methodology	No risk identified
3.2	Strengthen the confidence and capability of leaders	- Roll out a range of profession specific leadership and management development programmes. - Invest in the develop of the senior leadership team in the organisation. - Create a senior leadership development talent map and succession plan. - Increase the performance of teams through clear cascaded objective setting process and enhanced personal development planning.	- Delivery and strong attendance at leadership development programmes. - Positive evaluation feedback and improved leadership capability as measured through appraisal. - Improved staff survey outcomes linked to leadership behaviours, increased use of TED at team level, appraisal compliance and increased number of colleagues with objectives and development plans.	No risk identified
3.3	Improve the experience of work of colleagues with protected characteristics	- Complete process for Antiracist framework. - Deliver a talent programme for colleagues with protected characteristics. - Increase confidence in disclosing disability and social economic background. - To ensure staff are equipped with the skills to create inclusive cultures that deliver inclusive care.	- To achieve bronze level of Antiracist framework. - Reduced levels of discrimination reported by Black, Asian and Minority Ethnic colleagues. - Reduced levels of bullying and harassment reported by Disabled colleagues. - Increased, proportional representation at more senior levels of colleagues with protected characteristics.	Risk identified
3.4	Support the health, wellbeing, safety and attendance of our workforce	- To implement a digital sickness absence management tool. - Providing targeted health and wellbeing to support colleagues with protected characteristics or from disadvantaged social economic backgrounds to remain well at work. - Taking action to reduce levels of violence and aggression shown towards colleagues from patients, visitors and other colleagues.	- Reduction in levels of sickness absence. - Reduction in the overall incidents of violence and aggression in the workplace. - Improved staff survey outcomes in relation to wellbeing support and colleagues feeling well at work.	Risk identified
3.5	Enhance colleague experience and levels of staff satisfaction	- Embed the colleague engagement approach, to ensure colleagues have a voice and involved in sharing ideas for improvement. - Increase levels of team effectiveness and engagement through greater utilisation of the TED tool. - Support cultural transformation through relaunching our values, leadership behaviours and development of a cultural dashboard.To enhance the governance and leadership within the Board of Directors through the provision of a Board development programme.	- Improved levels of colleague engagement and staff satisfaction across all of the NHS People Promise Indicators. - Increase NHS Staff Survey response rate.	Risk identified



Heat map key: Black = current score, Blue = target score

Strategic Objective: People					Corporate Objective: Improve the experience of work of colleagues with protected characteristics					Overall Assurance Level					Medium
Principal risk 7 (26/27) (ID 2316)	Risk Title:	Experience of under-represented staff groups								Risk Score Tracker					
	Risk Description:	There is a risk that the Trust may not be considered a great place to work for colleagues or prospective employees across the Trust, including those in under-represented staff groups. This could result in negative experience for staff, adverse impact for colleagues with a protected characteristic, inability to retain a skilled and valued workforce, staff absence, regulatory intervention, and legal action.													
	Committee	Workforce Committee	Risk Appetite and Tolerance	Open											
	Director	Chief People Officer	5Ts status	Treat											
	Date risk opened	02/04/26	Date of last review	05/05/26											
		Target control date	31/03/27	Likelihood ↑ 5 4 3 2 1 1 2 3 4 5 Consequence → ● Initial ● Current ● Target											
Controls				Gaps in Controls				Assurances				Gaps in Assurances			
- Our People Plan - Equality, Diversity and Inclusion Policy and Strategy. - Single Improvement Plan. - Equality, Diversity and Inclusion mandatory training. - Supporting Disability in the Workplace policy and agreement. - Trans and non-binary policy. - Equality Impact Assessment policy and supporting toolkit. - NHSE 8 High Impact Actions. - NHS People Promise. - Action plan in response to NHS Staff Satisfaction Survey results. - Culture programme, including Zero Tolerance campaigns. - Freedom to Speak Up Policy, Process and Champions. - Employee Relations policies and processes. - Trust Values/Best Version of Us/Leadership in Lancs frameworks. - Core People Management Skills programme. - EDI resources/education/toolkits - Staff ambassador forums for colleagues with protected characteristics (Ethnicity, Disability and Neurodiversity, LGBTQ+). - Staff engagement offer - Team Engagement and Development (TED) Tool and toolkit				- No equivalent national Workforce Equality Standard for LGBTQ+ colleagues. - ESR Declaration rates for colleagues with a long-term condition or disability. - EQIA process/check and challenge in respect of EIA findings. - Gaps in localised application of inclusive management practices and in addressing poor behaviours which are not inclusive. - Continue to await mandates and directives following the High Court ruling with regards to protected characteristics of sex (not yet published).				<u>Level 1 Assurance</u> - Equality Diversity and Inclusion Annual Report - Suite of NHS Staff Survey reports and corporate level action plan. - Monthly reporting of participation with TED Tool. - Quarterly reporting of National Quarterly Pulse data. <u>Level 2 Assurance</u> - L&SC ICS ED&I Group. - Equality, Diversity and Inclusion Strategy monitoring. - Our People Plan Strategy Monitoring. - Single Improvement Plan reporting. - Workforce Committee. <u>Level 3 Assurance</u> - Internal Audit review of ED&I in 2023/24 – Substantial Assurance. - Five areas identified in the Workforce Race Equality Standards (WRES) where experience of subgroups is same/similar, and four areas identified in the Workforce Disability Equality Standards (WDES). - North West Anti-Racist Framework. - EDS2022 - North West ED&I Assurance template				- Challenges in ability to drill down into the NHS Staff Satisfaction Survey data from a minority group/divisional basis due to low numbers and confidentiality. - Areas for improvement identified in the Workforce Race Equality Standards (WRES); appointment from shortlisting, discrimination from managers, Board membership. - Areas for improvement identified in the Workforce Disability Equality Standards (WDES); entering formal capability, experience of B&H or abuse, feeling valued. - WRES/WDES report only completed on an annual basis - Staff survey; % completion rates from a subgroup level i.e. ethnic groups or colleagues with a disability - Ability to take meaningful actions which impact the Gender Pay Gap with Agenda for Change (AfC) - Ability to measure progress in Divisions and Departments with regard to actions taken to address lower levels of staff satisfaction and engagement.			
Risk Treatment															
Action		Action Owner	Due Date	Done Date	Action Progress Update										
Work to be undertaken in conjunction with the Ethnicity forum to understand more about discrimination statistics		M Davis	~~28-02-26~~ 30.09.26		May 26: Staff survey EDI/WRES results analysed on a Divisional/SBU level and shared with the Divisional Management Teams. SBU hotspot areas identified, specific actions recommended for Divisions to understand and reduce discrimination in these areas. Individual interviews being held across the next couple of months with International Midwives to understand any experiences of discrimination. Section on Cognitive Bias has been added to the start of the Core People Management Skills programme. Session scheduled for July to raise awareness with Workforce Colleagues about potential for bias to creep into formal Workforce processes/policies. Listening session to be held for colleagues in respect of discrimination and undertake some analysis in respect of NMC referrals for ethnic minority colleagues. Anti-Racist Framework group/actions are ongoing with feedback being gathered from colleagues to understand what potential areas of focus/action should be.										
Increasing the diversity of colleagues in band 8a and above as per WRES/WDES annual report		M. Davis	~~28-02-26~~ 31.05.26		Mar 26: As noted in January, further Talent Management work will be undertaken in 2026 with a focus on supporting minoritised groups. Workforce data will be reviewed as part of the WRES/WDES reporting process in May 2026. Anticipating figures will have changed as a result of fewer posts across the organisation, TUPEs etc, approx. 10% lower than the previous year.										
Work to be undertaken in conjunction with the Living with Disability forum to understand more about bullying and harassment		M Davis	~~30-04-26~~ 31.05.26		May 26: Staff survey EDI/WDES results analysed on a Divisional/SBU level and shared with the Divisional Management teams. SBU hotspot areas identified, specific actions recommended for Divisions to understand and reduce instances of bullying and harassment in these areas. As per previous update, to increase engagement, CPO has agreed to support a staff story at board, and look at the possibility of external speakers to help inform and educate staff.										
Division Level Action Plans to be developed to improve areas of underperformance in relation to Equality, Diversity and Inclusion		Divisional Directors	31.05.26		May 26: New action – Divisions to develop action plans with the aim for these to be submitted to Workforce Committee in May 26.										

Strategic Objective: People						Corporate Objective: Enhance colleague experience and levels of staff satisfaction						Overall Assurance Level						Medium	
Principal risk 8 (26/27) (ID 2317) Committee	Risk Title:	Experience of staff and levels of staff satisfaction										Risk Score Tracker Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal (Note: Initial score is same as current score and so not showing on graph)							
	Risk Description:	There is a risk that the Trust may not be considered a great place to work for colleagues or prospective employees across the Trust. This could result in negative experience for staff, adverse impact for colleagues with a protected characteristic, inability to retain a skilled and valued workforce, staff absence, regulatory intervention, and legal action.																	
	Workforce Committee	Risk Appetite and Tolerance	Open	Likelihood ↑ 5 4 3 2 1 1 2 3 4 5 Consequence → ● Initial ● Current ● Target															
	Director	Chief People Officer	5Ts status	Treat															
	Date risk opened	02/04/26	Date of last review	01/05/26															
		Target control date	31/03/27																
Controls				Gaps in Controls				Assurances				Gaps in Assurances							
- Our People Plan - Action plan in response to NHS Staff Satisfaction Survey results. - Team Engagement and Development (TED) Tool and toolkit to support team-level engagement and improvement - Single Improvement Plan. - Equality Impact Assessment policy. - NHSE 8 High Impact (EDI) Actions. - NHS People Promise. - Culture programme, including Zero Tolerance campaigns. - Freedom to Speak Up Policy, Process and Champions. - Employee Relations policies and processes. - Trust Values/Best Version of Us/Leadership in Lancs frameworks. - Core People Management Skills programme. - Leaders/All Colleague briefings - Colleague engagement strategy and offer, including the Your Voice programme with structured leadership visibility - Compassionate Performance Conversations Training & Team level civility workshops - Use of Staff Survey data to support targeted bespoke OD support for lower performing teams				- Variation in local leadership capability and application of people management practices. - Capacity and time pressures on managers limiting their ability to consistently prioritise colleague engagement, people management and follow-through on actions. - System-wide operational and financial pressures limiting improvement in day-to-day experience. - Gap between staff feedback and visible action at team and divisional level. - Inconsistent senior leader visibility and engagement with colleagues				<u>Level 1 Assurance</u> - Suite of NHS Staff Survey reports and corporate level action plan. - Monthly reporting of TED participation and team-level engagement - Quarterly reporting of National Quarterly Pulse data. - Analysis of NHS Staff Survey results, including year-on-year comparison and targeted evaluation of teams receiving bespoke OD and engagement support. <u>Level 2 Assurance</u> - Our People Plan Strategy Monitoring. - Single Improvement Plan reporting. - Workforce Committee oversight and challenge <u>Level 3 Assurance</u> - NHS Staff Survey national benchmarking and external comparator analysis - Workforce Equality Standards (WRES/WDES) reporting - CQC inspection/Well-Led findings - NHSE/National Provider Improvement Programme				- Limited ability to consistently measure and evidence the impact of actions on staff experience at team and divisional level, including variation in outcomes and visibility of improvements (“voice to action”) - Low completion rates of the National Quarterly Pulse, influenced by survey fatigue and operational pressures, reducing representativeness and confidence in real-time workforce insight							
Risk Treatment																			
Action		Action Owner	Due Date	Done Date	Action Progress Update														
Increase use of TED to support team-level engagement, involvement and local action planning		S. Kenny	31.03.26 30.09.26		May 26: Paper to be provided to Trust Management Board (TMB) in May 2026 to demonstrate plans to improve TED take up across the Trust.														
Delivery of actions in NHS Staff Survey Action Plan for 2026/27		S. Kenny	31.03.27		May 26: Staff Survey results reviewed and key priorities identified in March WFC Paper. Corporate and divisional action plan completed and to be provided to Workforce Committee in May 26.														
Strengthen senior leader visibility and engagement through structured programme of colleague engagement activity		S. Kenny	31.03.27		May 26: Actions from the April <i>Your Voice</i> events have been identified and are progressing. Design of the July events will be finalised in May, with a continued focus on strengthening the “voice to action” cycle. Senior leader visibility has been reinforced through National Recognition Days (e.g. International Nurses Day, International Day of the Midwife etc), alongside distribution of Long Service certificates and pins to Divisional Directors to enable local engagement and team visits. Planned further analysis for June to assess attendance at key leadership and communication forums (Managers’ Update, Leadership Forum, All Colleague Briefing) to determine correlation with higher staff survey advocacy scores and more positive organisational perception measures.														

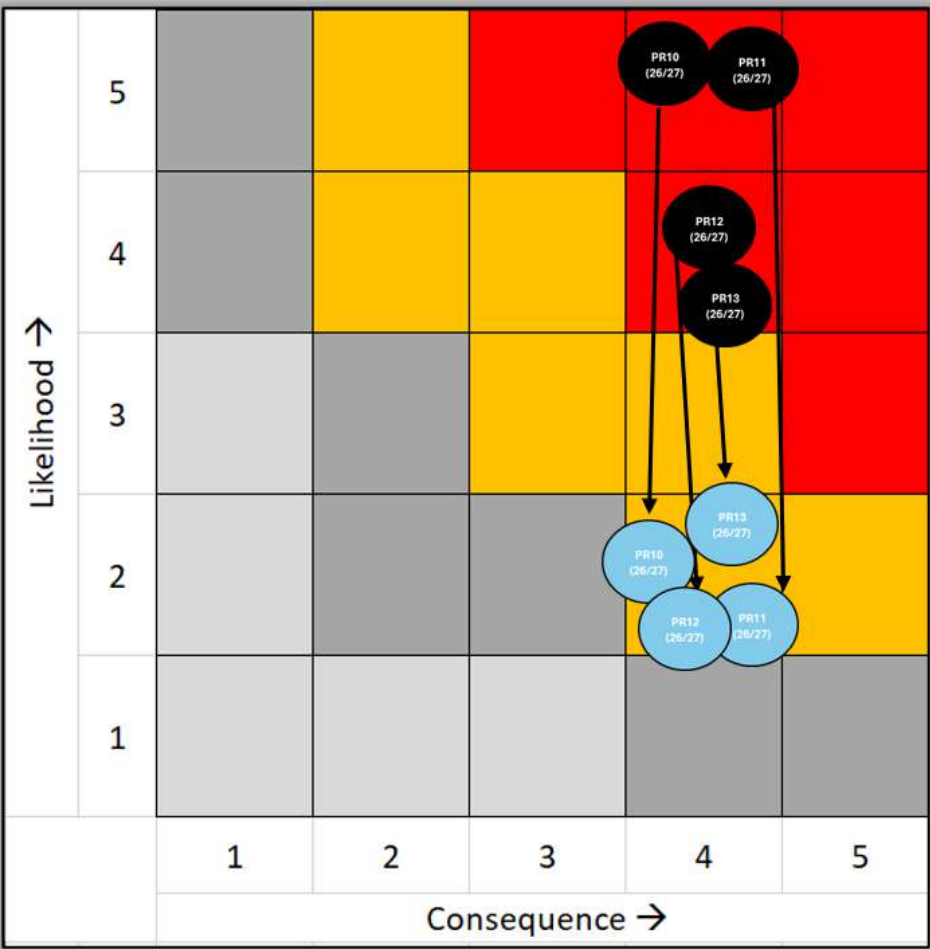
Strategic Objective: People						Corporate Objective: Support the health, wellbeing, safety and attendance of our workforce						Overall Assurance Level		Medium		
Principal risk 9 (26/27) (ID 499)	Risk Title:	Failure to effectively manage staff absence and achieve Trust and National target rates										Risk Score Tracker  Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal				
	Risk Description:	There is a risk that failure to effectively manage staff absence due to ineffective systems or processes, or managerial capability will compromise our ability to deliver safe staffing levels and continuity of care. It could also result in increased costs associated with temporary staffing, the Trust being unable to achieve Trust or National targets and could impact on staff morale.														
	Committee	Workforce Committee	Risk Appetite and Tolerance	Open	 Likelihood ↑ Consequence → ● Initial ● Current ● Target											
	Director	Chief People Officer	5Ts status	Treat												
Date risk opened	10/02/14	Date of last review	05/05/26													
		Target control date	31/03/26 30/09/26													
Controls				Gaps in Controls				Assurances				Gaps in Assurances				
- Sickness Absence Policy in place. - Core People Management Skills training in place. - Monthly reports to Divisions - check & challenge. - Accountability Framework in place which has recently been refreshed. - Toolkits and templates for Managers. "What Good Looks Like" for Managers. - Live data & reports in Health Roster. - Workforce Advisor Support in place (although at an insufficient level) - Health & Wellbeing Strategy in place. - Workforce & Organisational Development Strategy in place. - Operational processes in place Divisionally to look at staffing levels. - Dashboards in rosters to see safe staffing levels. - Rostering guidance and support in place.				- Gaps in localised management practices. - Lack of one complete absence record affecting ability to demonstrate policy compliance. - Insufficient capacity within the Workforce team to support absence management as proactively as possible. - Lack of localised risk assessments/stress risk assessments/moving & handling risk assessments. - Lack of triangulated data to support prediction/notice of warning signs for sickness absence. - Insufficient capacity within the psychological wellbeing service. - Development of mechanisms to prevent additional work/shifts which are counterintuitive to sickness absence position.				<u>Level 1 Assurance</u> - Divisional Workforce Committees. - Sickness absence reports are produced on a monthly basis which enables trend analysis of absence rates at cost centre level. These are reported through divisional workforce committees. - The Workforce team have undertaken local audits of absence management practice e.g. Return To Work Interview compliance. <u>Level 2 Assurance</u> - Workforce Committee. - Divisional Improvement Forums review absence levels. <u>Level 3 Assurance</u> [None detailed]				- Currently a manual process to monitor compliance with absence management policy and processes. - Inability to achieve the 4% target. - Internal audit of sickness absence management practices, (October 2024) provided limited assurance.				
Risk Treatment																
Action		Action Owner		Due Date		Done Date		Action Progress Update								
Pilot Empactis as a digital absence management system		R. O'Brien		31.03.26 31.07.26				May 26: the front-end of the system (absence reporting) is live in Endoscopy, Critical Care, SAU, Theatres. The remaining pilot areas go live 5 May 2026. The case management module remains delayed. There is as yet no confirmed timeline for user acceptance testing and a further meeting with the supplier will take place w/c 5 May 2026.								
Introduce Occupational Therapist into Occupational Health model		R. O'Brien		31.03.26 31.07.26				May 26: no funding can be released from the Psychological Wellbeing skill mix review to fund this post. Awaiting the end of year financial position from Wellbeing Partners to determine whether distributed surplus will fund a post for 12-months.								
Deliver absence reduction 'plan on a page' against 4 key workstreams		R. O'Brien		31.03.26 31.07.26				May 26: Full evaluation will be reported to Workforce Committee in July 2026. The plan has been re-drafted for 2026/27.								

Productivity: Deliver value for money

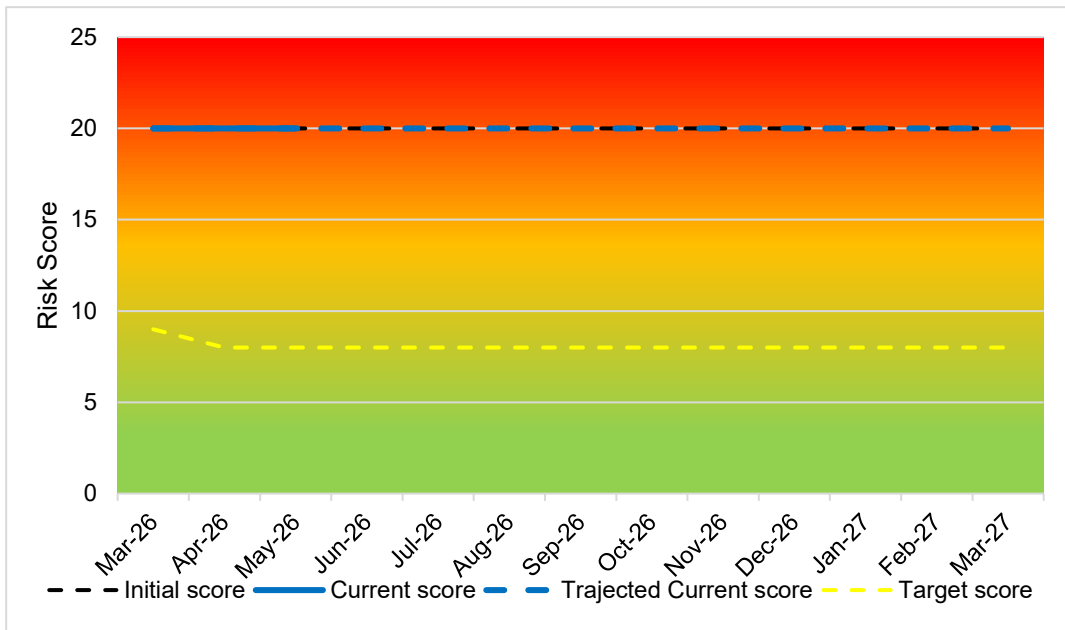
Monitored through Finance & Performance Committee

The following 2026/27 corporate objectives are aligned to the **Productivity** strategic objective

CO Ref.	Purpose of the objective	Scope and Focus of the Objective	How will we know if it has been achieved?	Status
4.1	Deliver the waste reduction programme without compromising quality or safety, including clinical pathway redesign, workforce optimisation, and digital innovation	- Delivery of agreed Waste Reduction Plan - Consistent compliance with EQIA associated governance to ensure patient care is maintained.	- Teams delivering to the forecasted plans - Progress in the Improvement and Assurance group (IAG) exit criteria to progress towards exiting National Oversight Framework (NOF) 5	Risks identified
4.2	Increase Local Procurement	Prioritise sourcing goods and services from local suppliers, contributing to the economic stability, wealth and growth of the region.	- Number of active local suppliers used - Spend through collaborative arrangements (e.g., LPC) that includes explicit local social value or supplier development commitments	No risk identified
4.3	Expand use of telemedicine and Remote Monitoring	Expansion of telemedicine services to provide remote consultations and monitoring, ensuring patients have access to care regardless of their location	Increased ability to manage chronic conditions and reducing hospital admissions	No risk identified
4.4	Implement digital Patient Engagement Tools	Development of digital tools and platforms to enhance patient engagement, such as mobile apps for appointment scheduling, medication reminders, and health education	- Outpatient efficient metrics - Outpatient friends and family feedback metrics	No risk identified
4.5	Expand the use of AI and Machine Learning	Implementing AI and machine learning algorithms to enhance diagnostics, predict patient outcomes, and optimise treatment plans	More accurate and timely care, reducing the burden on healthcare professionals and improving patient experiences	No risk identified



Heat map key: Black = current score, Blue = target score

Strategic Objective: Productivity				Corporate Objective: Deliver the waste reduction programme without compromising quality or safety, including clinical pathway redesign, workforce optimisation, and digital innovation				Overall Assurance Level		Low																																					
Principal risk 10 (26/27) (ID 1557)	Risk Title:	Delivery of the 2026/27 financial plan whilst reducing the size of the underlying financial deficit						Risk Score Tracker  Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal (Note: Trajectories and target reset for 26-27)																																							
	Risk Description:	There is a risk that the Trust may not deliver the financial plan for 2026/27 and reduce the underlying deficit. This is because of factors such as under-delivery of planned efficiency savings, inability to reduce some operational costs, rising operational demand, and insufficient external funding for some services. This could result in a significant financial deficit, reduced resources for patient care, challenges in maintaining service delivery, insufficient income to cover operational costs, inability to exit NHS Oversight Framework (NOF) segment 5, further regulatory intervention, impact on staff experience, and reputational damage.																																													
Committee	Finance & Performance	Risk Appetite and Tolerance	Open	Likelihood ↑ <table><tr><td>5</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>4</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>3</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>2</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>1</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table> Consequence → ● Initial ● Current ● Target								5						4						3						2						1							1	2	3	4	5
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Director	Chief Finance Officer	5Ts status	Treat																																												
Date risk opened	03/06/24	Date of last review	18/05/26																																												
		Target control date	31/03/27																																												
Controls		Gaps in Controls		Assurances				Gaps in Assurances																																							
- Financial plan set at the start of the year - common assumptions and principles agreed collaboratively within the ICS. - Financial plan triangulated with activity and workforce plans. - The Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation are in place to support controlling expenditure. - Budgets set at the start of the financial year and agreed with budget holders, risks identified and rated to enable the Board of Directors to approve the budgets. - There are a suite of pay controls for filling vacancies and using agencies. - Processes are in place to ensure waste reduction programme (WRP) schemes that are delivered are transacted through the ledger. - There are a range of grip and control measures in place for managing discretionary expenditure. - There is a no PO no pay system in place for managing non pay expenditure. - Established Programme Management Office (PMO). - Action plan in place following MIAA Grip and Control Review. - Rebase of contract with commissioners to accommodate increasing demand and patient complexity.		2026/27 Waste Reduction Programme (WRP) not fully developed. - Unavoidable cost pressures (industrial action and price volatility)		<u>Level 1 Assurance</u> - Ledger reconciliations - on the integrity of the financial data. - Variance and trend analysis - on the integrity of the financial data. - Grip & Control measures reported to Trust Management Board. <u>Level 2 Assurance</u> - Risks identified monthly to Finance and Performance committee. - Internal Audit - on the integrity of financial systems and variable pay processes - through Audit Committee. - Trust assessment of action in response to independent assessment of Grip and Control report by MIAA to be reported to Finance and Performance Committee. - Financial plan monitored monthly to; budget holders, DIF, F&P committee, externally through provider finance returns (PFR) monthly returns and system improvement board assurance meetings. <u>Level 3 Assurance</u> - External Audit - on the financial accounts - through Audit Committee. - Collaborative working in ICS - integrity of financial data.				- Contacts not signed with commissioners, which creates uncertainty in relation to income. - The Trust did not meet its 2025/26 financial plan. The Trust remains in segment 5 of the national oversight framework (NOF) and the Trust is awaiting the final decision on regulatory status with regards to the new National Provider Improvement Programme (NPIP). - Limitations and barriers work commissioned by the Recovery Support Programme (RSP) team not yet complete																																							
Risk Treatment																																															
Action		Action Owner	Due Date	Done Date	Action Progress Update																																										
Fully developed WRP for 2026/27 and reported to Finance & Performance Committee		C. Carter	30.04.26 31.05.26		Apr 26: Plan to be developed by 31.05.26 and reported to Finance and Performance Committee (FPC) in June 26.																																										
Submit a formally compliant financial plan to NHS England		C. Carter	30.04.26	18.03.26	May 26: The plan has been formally accepted by NHSE.																																										
Contracts to be signed no later than the end of Q1 2026/2027		C. Carter	30.06.26		May 26: New action																																										
Final version of FSP to be taken to June Board		C. Carter	30.06.26		May 26: New action																																										

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Strategic Objective: Productivity				Corporate Objective: Deliver the waste reduction programme without compromising quality or safety, including clinical pathway redesign, workforce optimisation, and digital innovation				Overall Assurance Level		Low																																					
Principal risk 11 (26/27) (ID 802)	Risk Title:	Cash consequences of the Trust’s underlying financial position						Risk Score Tracker Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal (Note: Trajectories and target reset for 26-27)																																							
	Risk Description:	There is a risk that the Trust may face cash flow challenges because of its underlying financial position, including recurring deficits, delayed delivery of financial recovery savings, or insufficient income to cover operational costs. This could result in a cash shortfall and therefore, an inability to meet financial obligations, impact on service delivery, delays in payments to suppliers, restricted investment in essential services and infrastructure, and potential further regulatory intervention or reputational damage.																																													
Committee	Finance & Performance	Risk Appetite and Tolerance	Open	Likelihood ↑ <table><tr><td>5</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>4</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>3</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>2</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>1</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table> Consequence → ● Initial ● Current ● Target								5						4						3						2						1							1	2	3	4	5
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Director	Chief Finance Officer	5Ts status	Treat																																												
Date risk opened	06/06/24	Date of last review	18/05/26																																												
		Target control date	31/03/27																																												
Controls		Gaps in Controls		Assurances				Gaps in Assurances																																							
- Cash Management committee in place. - Annual cash plan in place. - Committee approved cash management policy on prioritisation of supplier payments. - Monthly cash flow forecasting. - Management of working capital balances. - Review of capital programme and timing of expenditure. - Engaging with affected suppliers. - Internal escalation process for urgent cash issues. - NHSE process for requesting cash support. - Additional NHSE process to draw down emergency cash if necessary. - Regular review of cash position and forecasts. - Financial services team resourced for cash management and forecasts. - Weekly system partners debtors update sent to CFO & DCFO - Prepayment arrangements in place for LTH hosted services		- Lack of full compliance with “No PO, No Purchase” arrangements - Access to cash support is subject to external approval. 2026/27 Waste Reduction Programme (WRP) not fully developed.		Level 1 Assurance - Monitoring and reporting performance against 30-day deadline for payments. - Monthly Cash Review Group with CEO Level 2 Assurance - Internal Audit reporting through Audit Committee. - Monthly reporting of position including KPIs to Finance & Performance Committee. Level 3 Assurance [None detailed]				- Forecasting generally highlights potential shortfalls in cash availability. However, some invoices can be delayed in being received. - Drop in performance against 30-day deadline for payments.																																							
Risk Treatment																																															
Action		Action Owner		Due Date		Done Date		Action Progress Update																																							
Timely submissions to NHSE for cash support with Board of Director approval		C. Carter		30.04.26 30.06.26				May 26: Cash support requests remain up to date. Current forecasts indicate further support likely required by end of June to meet anticipated September demand.																																							

Strategic Objective: Productivity							Corporate Objective: Deliver the waste reduction programme without compromising quality or safety, including clinical pathway redesign, workforce optimisation, and digital innovation										Overall Assurance Level			Medium	
Principal risk 12 (26/27) (ID 2106)	Risk Title:	Ability to access required Capital to support an ageing estate										Risk Score Tracker --- Initial score — Current score - - - Trajected Current score - - - Target score Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal (Note: Trajectories and target reset for 26-27)									
	Risk Description:	There is a risk that there may be insufficient internally generated capital to support all priority areas of the Trust’s ageing estate. This is because of valuation decisions which determine capital funding allocations, the Trust’s underlying financial position, competing priorities across the healthcare system, and delays in approvals for capital investment projects. This could result in an inability to progress critical infrastructure maintenance, inability to renew essential existing equipment, potentially impacting service delivery, patient safety, and long-term sustainability.																			
Committee	Finance & Performance		Risk Appetite and Tolerance		Open		Likelihood ↑ 5 4 3 2 1 1 2 3 4 5 Consequence → ● Initial ● Current ● Target														
Director	Chief Finance Officer		5Ts status		Treat																
Date risk opened	05/12/24		Date of last review		18/05/26																
			Target control date		31/03/27																
Controls			Gaps in Controls				Assurances				Gaps in Assurances										
- Trust planning framework. - Capital Planning Forum review and determine risk-based approach and recommendations. - Capital Plan for 2026/27 agreed by Executive Team & Trust Board. - Backlog maintenance programme developed from 6 facet survey outcome, undertaken annually. - Medical Equipment Group with clinical input to support risk assessment and prioritisation. - IT provided with a budget from Capital Planning forum. - Contingency budget identified at the start of the financial year. - Emergency capital funding process for extreme situations. - Receipt of significant national capital funding - Standing financial instructions. - Standing Orders. - Scheme of Reservation and Delegation. - Estates Strategy. - External funding for key developments approved. - Estates and Facilities Partnership Board established			- Short timeframes for external bids alongside limited operational capacity reducing ability to fully cost proposals. - Impact of inflation in terms of project costs and timescales. - Ageing estate and inability to comply with latest statutory guidance.				<u>Level 1 Assurance</u> - Asset register in place to support oversight of medical equipment. - Tracking of project spend in Capital Planning Forum. <u>Level 2 Assurance</u> - Medical Device report to Safety & Quality Committee. - Capital update to Finance & Performance Committee. <u>Level 3 Assurance</u> 6 facet survey and independent annual report which details the scope and level of the situation. - Estates Returns Information Collection (ERIC) returns to support benchmarking.				- Significant backlog maintenance. - Governance around contract change notices. - Data for ERIC returns is delayed in being released via Model Hospital (2 financial years behind).										
Risk Treatment																					
<u>Action</u>			<u>Action Owner</u>		<u>Due Date</u>		<u>Done Date</u>		<u>Action Progress Update</u>												
Develop Estates Strategy			S. Ashworth		31.03.26		02.04.26		Apr 26: Strategy approved at Board of Directors in April 2026.												
Continue to pursue external funding opportunities for key developments linked to the estates strategy			S. Ashworth		31.03.27		18.05.26		May 26: External funding opportunities progressed, with confirmation received for a number of schemes aligned to estates priorities.												
Agree a fully worked up prioritised plan following confirmation all externally funded schemes			S. Ashworth		31.07.27				May 26: New action												

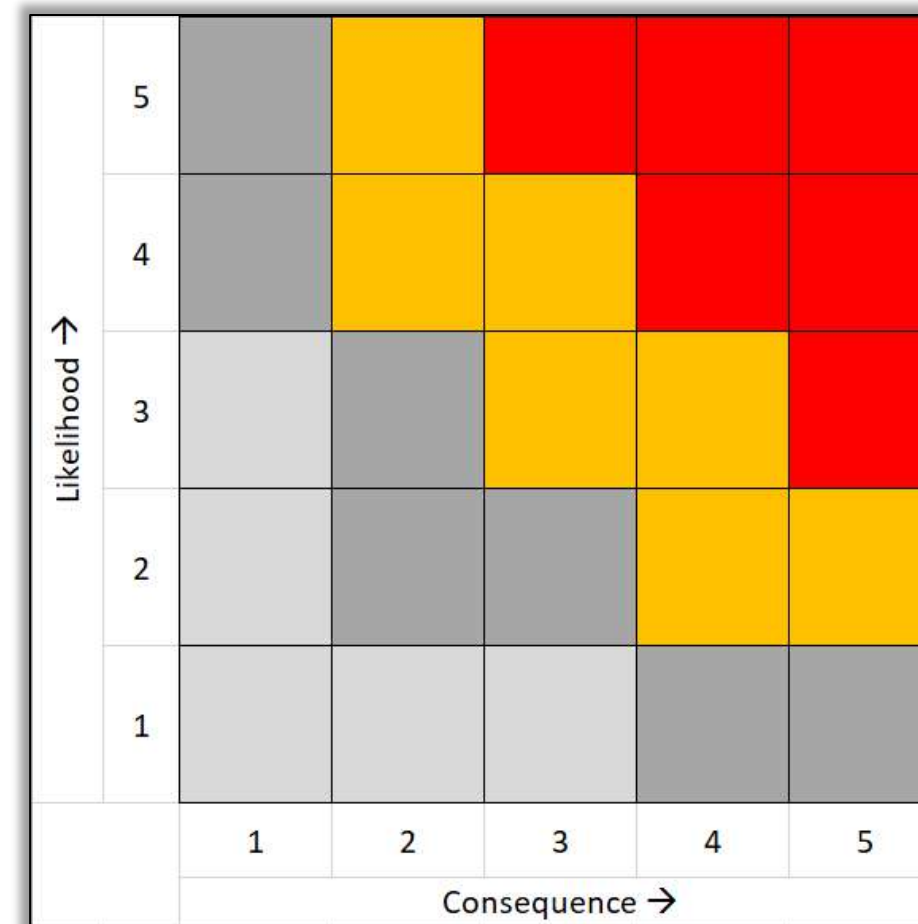
Strategic Objective: Productivity				Corporate Objective: Deliver the waste reduction programme without compromising quality or safety, including clinical pathway redesign, workforce optimisation, and digital innovation				Overall Assurance Level		Medium																																											
Principal risk 13 (26/27) (ID 2318)	Risk Title:	Delivery of the planned reduction in whole time equivalent workforce						Risk Score Tracker Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal (Note: Initial score is same as current score and so not showing on graph)																																													
	Risk Description:	There is a risk that the Trust may not achieve the planned reduction in whole time equivalent (WTE) workforce for 2026/27. This is because of the requirement to increase performance, continued urgent and emergency care pressures and increasing patient acuity requiring workforce to be maintained or grow. This could result in an inability to achieve the waste reduction programme, inability to exit NHS Oversight Framework (NOF) segment 5 and further regulatory intervention.																																																			
Committee	Finance & Performance	Risk Appetite and Tolerance	Open	Likelihood ↑ <table><tr><td>5</td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>4</td><td></td><td></td><td></td><td></td><td>●</td><td>●</td></tr><tr><td>3</td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>2</td><td></td><td></td><td></td><td></td><td>●</td><td></td></tr><tr><td>1</td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td colspan="2"></td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table> Consequence → ● Initial ● Current ● Target								5							4					●	●	3							2					●		1									1	2	3	4	5
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Director	Chief People Officer	5Ts status	Treat																																																		
Date risk opened	02/04/26	Date of last review	13/05/26																																																		
		Target control date	31/03/27																																																		
Controls				Gaps in Controls				Assurances				Gaps in Assurances																																									
- Trust planning framework. - Medium term planning submission to NHS England. - Workforce plan triangulated with activity and financial plans. - Recruitment controls in place, including Vacancy Control Panel and EQIA process to support workforce decisions. - Business Case Process to fully and accurately assess WTE impact for transformational schemes. - WTE assumptions validated through PID approval with senior workforce sign-off - WRP WTE changes transacted through the financial ledger, ensuring alignment between workforce delivery and financial reporting - Integrated governance and reporting framework in place, providing oversight of WTE performance through PMO, DDGs, FPC, Executive Team. - Real time Daily Management System (DMS) dashboards for review of premium WTE usage by area (WLI/EDP/Bank and Agency). - Daily variable pay control group to control use and associate rates. - Twice daily safe staffing oversight meetings				- Inability to fully develop and manage services within commissioned resources and in line with commissioning processes due to increasing demand, increased complexity and length of stay specifically patient Not Meeting Criteria to Reside (NMC2R) - Gap in funding for any MARS schemes to support reductions in the size of the workforce. - Operational pressures limiting management capacity to deliver schemes. - Activity plan demands driving requirement for additional WTE to support delivery. - Analyst capacity and skill in workforce information to provide level of assurance reporting required.				<u>Level 1 Assurance</u> - Grip & Control measures reported to Trust Management Board. <u>Level 2 Assurance</u> - Monthly NHSE Provider Workforce Returns (PWR) submission for monitoring of PWR effecting WTE delivery against plan. - Improvement and Assurance Group (IAG) and Waste Reduction Programme (WRP) Update to Workforce Committee. - PMO WRP reporting and WTE reporting into Finance and Performance Committee including WTE delivery and risk. <u>Level 3 Assurance</u> [None]				- The planned reduction in whole time equivalent workforce was not met for 2025/26. - WTE identified with PIDs is reliant on delivery of schemes, some of which are considered high risk. - There are schemes that will result in an improved run rate, however, may not reduce WTE, the ability to explain and demonstrate this is critical. - Workforce information capability and capacity is limiting progress on reliability of analysis and reporting.																																									
Risk Treatment																																																					
Action		Action Owner		Due Date		Done Date		Action Progress Update																																													
Robust monitoring and assessment of WTE plans and delivery through Divisional DDGs.		N. Pease		31.03.27		18.05.26		May 26: WBPs attend DDGs providing weekly WTE actuals; PMO provides WRP WTE performance against plan, with divisions articulating progress with delivery and associated risks.																																													
Assessment of WTE PID delivery ambitions to identify accurate WTE values and WTE releasing schemes and align to plan.		K. Downey/Paul Roth/Richard Morgan Evans		31.05.26		18.05.26		May 26 WTE assumptions validated through PID approval with senior workforce sign-off and aligned to the 2026/27 WRP. Delivery, assurance and risk oversight established via WRP Board, DDGs, Executive Team and FPC, supported by regular PMO reporting.																																													
Recruitment of additional workforce analyst to support financial recovery and planning.		K. Downey		31.07.26				May 26: Recruitment underway for a workforce analyst and additional BI support to strengthen PMO capacity																																													
Ensure triangulation and understanding of WTE movements in month is understood in detail through clinical, workforce, finance and operational lens.		N. Pease		30.06.26		18.05.26		May 26 Weekly WTE dashboards and Executive “Walk the Wall” reporting established. WTE reporting in place via FPC and DDGs from May 26, improving visibility of performance against plan and operational pressures.																																													
Mutually Agreed Resignation Scheme (MARS) launched for all staff with exception of medical and dental. Closing date mid-May 26.		N Pease		31.08.26				May 26: MARS scheme now live and due to close mid-May. Associated WTE reduction will be confirmed and transacted through Executive reporting.																																													

Partnership: Be Fit for the Future

Monitored as indicated through the relevant Committee of the Board

The following 2026/27 corporate objectives are aligned to the **Partnership** strategic objective:

CO Ref.	Purpose of the objective	Scope and Focus of the Objective	How will we know if it has been achieved?	Status
5.1	Be a collaborative system partner	Working with partners across Lancashire and South Cumbria to prevent ill-health, reduce health inequalities and work across organisational boundaries to develop integrated services across primary, community, and secondary care	- Delivery of provider collaborative priority clinical transformation schemes - Delivery of phase two Pathology single service objectivesTeams delivering to the forecasted plans	No Risks identified
5.2	Implement the Integrated Care System-wide diagnostics strategy, including unified PACS/RIS and cardiology systems	Standardising Picture Archiving and Communication Systems (PACS), Radiology Information Systems (RIS), and cardiology platforms across organisations to ensure interoperability, reduce duplication, and improve the flow of information between providers	- More coordinated care pathways - Improved access to diagnostic results - Enhanced the ability to share expertise across sites	No Risks identified
5.3	Implement a unified Laboratory Information System across the ICS	- To enhance diagnostic efficiency, data sharing, and clinical decision-making - Streamlining of laboratory workflows, reduced duplication, and enable real-time access to test results across multiple care settings	- Faster turnaround times - Improved accuracy - Better co-ordination between primary, secondary and community care providers	No Risks identified
5.4	Further develop our partnerships in Education	- Enhance the learning and development of our people and future healthcare professionals - Collaboration with leading universities, colleges, and training institutions placements, and research opportunities, ensuring that our people and students are equipped with the knowledge and skills needed to excel in their roles	- Provision of comprehensive educational opportunities fit for future healthcare education - Further development of a culture of continuous learning and innovation, ultimately improving patient care and outcomes	No Risks identified
5.5	Improve research and innovation	- Investment in research initiatives and partnerships with leading academic institutions ensures that we stay at the forefront of advances in research - We will further build our partnerships with industry to optimise supporting commercial research	Improvement in the offers our patients receive to access to the latest clinical trials and treatment.	No Risks identified
5.6	Vertical integration with community services, providing comprehensive pathways for Central Lancashire working with primary and social care	- Develop comprehensive, joined-up pathways that span prevention, diagnosis, treatment, and ongoing support - Vertical integration to ensure that patients experience continuity across different levels of care, from community to hospital - Strengthened collaboration between services operating at the same level	- Reduction in health inequalities, through a reduction in gaps in access, outcomes and experience - Improved management of long-term conditions (reduced emergency attendance and unpanned admissions) - Shift from reactive to preventative care	No Risks identified



Heat map key: Black = current score, Blue = target score
Note: There are no Principal Risks aligned to Partnership currently

9.1 INTEGRATED PERFORMANCE REPORT AS AT APRIL 2026 INCLUDING FINANCE UPDATE AND SINGLE IMPROVEMENT PLAN

☒ Other

Item for Assurance

REFERENCES

Only PDFs are attached



9.1 Integrated Performance Report Full Report Board Part I 4 June 26.pdf

Integrated Performance Report

June 2026 Trust Board meeting with performance to April 2026



Patients



Performance



People



Productivity



Partnerships

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Key to Metric Variation, Assurance Icons & Dashboard Headers

Key to Metric Variance and Assurance Icons

Assurance Icon			
Variation Icon	Will consistently fail target within expected variation	Could both pass or fail target within expected variation	Will consistently pass target within expected variation
	Failing Target and Getting Worse Exception Report Needed	Close to Target and Getting Worse Check additional performance flag to say if mainly above or below target Exception Report Needed	Passing target but getting worse Exception report needed
	Failing target and no change happening Process review needed. May need exception report	Close to target and no change Check additional performance flag to say if mainly above or below target May need exception report	Passing target and no change happening
	Failing the target but getting better May need exception report	Close to Target and getting better Check additional performance flag to say if mainly above or below target May need exception report	Passing target and getting better
Recent concerning pattern in the data			
Normal variation - no recent change			
Recent positive pattern in the data			

Key to Metric SPC Chart and Variance and Assurance Icons

	Mean		Process Limit
	Improving special cause		Measure
			Concerning special cause
			Target

Assurance Icons – How likely are we to hit the set target in future?			
	<i>It's possible the target could be either passed or failed within the expected month to month variation of the measure</i>		<i>The target will be consistently failed within expected variation unless the process is changed</i>
	<i>The target will be consistently passed within expected variation unless the process is changed</i>		

Variation Icons – Is the measure showing signs of change over time?			
	<i>No signs of change over time evident in recent data</i>		<i>An example of concerning change is evident in the recent data</i>
	<i>An example of positive change is evident in the recent data</i>		

Report heading explanation

Metric Description	Assurance Mar-25	Variation to Latest Actual	Target				Latest Month
			Concern	Mar-25	Latest Month Target	Latest Month Actual	
Example Measure				100.00%	98.00%	95.00%	Jul-24

The Assurance Icon indicates whether the metric is failing or passing the target, or is inconsistently passing and

A flag 'P' is generated for metrics that are calculated as requiring

The latest month target or threshold.

Data to the end of.

The name of the Metric

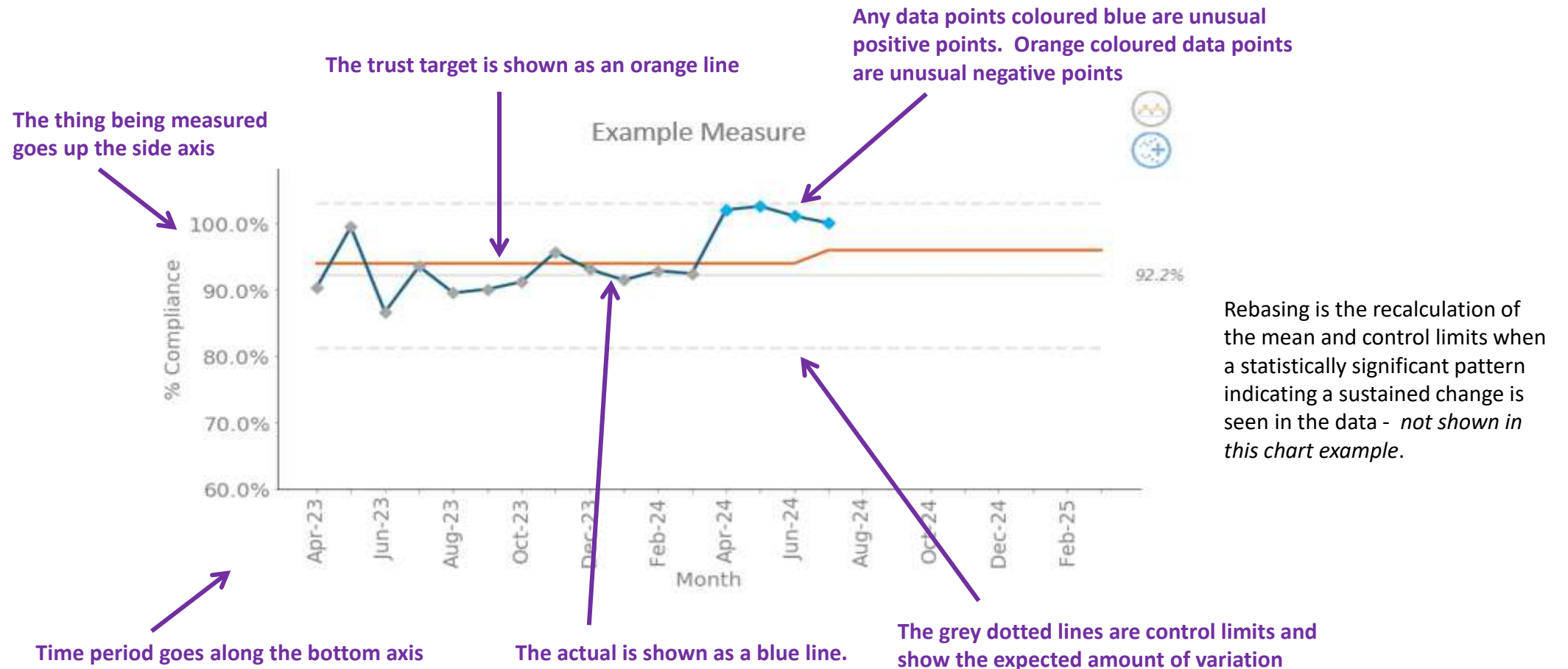
This shows whether there is a special or common cause variation of the metrics.

This March 2025 target

The current month actual performance.

How to read Statistical Process Control charts (SPC)

Statistical process control (SPC) charts are a tool used to understand change over time and variation of a process or system. They are used commonly within healthcare to understand if improvement actions are impacting the data and to give assurance around set targets.





SPC KPI Metric Grid

Assurance Variation	Will consistently fail target within expected variation	Could both pass or fail target within expected variation	Will consistently pass target within expected variation
 Recent concerning pattern in the data	- Vacancies (% FTE) - Staff Survey: Recommend Trust as place to work	- Pressure Ulcers per 1000 beds days (Category 2 and above) actions - 31 Day Cancer Standard	- Staffing Fill Rate - Registered Nurse - Staffing Fill Rate - Health Care Assistant
 Normal variation - no recent change	- Compliance with 15 minute ambulance turnaround time target - Compliance with 45 minute ambulance turnaround time target - Percentage of UEC (Type 1 & 3) patients seen within 4 hours - Average Number of boarded patients - Reduce not meeting criteria to reside - Percentage of patients that receive a diagnostic test within six weeks - Cancer 62-day performance - Staffing Fill Rate - Maternity Support Worker	- Staffing Fill Rate - Registered Midwife - Complaints per 1000 bed days - Perinatal - Number of Stillbirths - Maximum wait of 12 hours as Total Time in Department - Bed occupancy % - 85% theatre utilisation - aggregate - Capped - Cancer Faster Diagnosis Performance - Number of violence and aggression incidents toward staff	- STAR Accreditation all trust (Silver and Above)
 Recent positive pattern in the data	- Percentage of patients waiting less than 18 weeks - RTT - 52 week Waiters	- C. difficile performance against national trajectory - no more than 167 Hospital Acquired cases - Sickness Absence (%FTE) - Turnover (%FTE)	

Non SPC Metrics flagged as a concern

Non SPC Metrics

Hospital Standardised Mortality Ratio (56 Basket – Adult)	Lower Than Expected
Standardised Mortality Rate (All Diagnoses – Adult)	Lower Than Expected
Standardised Mortality Rate (Child <1 day -17 Years) (All Diagnoses)	As Expected
Standardised Mortality Rate (Neonatal <1 day -28 days) (All Diagnoses)	As Expected

Patients



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Executive Summary – Alert, Advise, Assure Report

	Issue	Action
Alert Areas of concern or matters that need addressing urgently	1. Pressure Ulcers per 1000 bed days (Category 2 and above) - recent concerning pattern over the last 4 months. This is linked to the long waiting times in the UEC pathway, increased use of waiting areas in assessment units and the effectiveness of pressure relieving interventions.	1. A refreshed comprehensive pressure ulcer improvement programme is in place based on the thematic findings from the weekly Pressure Ulcer Review Panel, which was established in November 2025. Learning is being shared across divisions and enhanced oversight of the action plan is in place. Monthly Always Safety First meetings and quarterly thematic reviews further strengthen cross divisional learning and ensure timely action in high incidence areas. 2. Proactive safety walk arounds by the Tissue Viability Team, commenced in April 2026, which enhances real time assurance and support early identification of risks, ensuring sustained improvement in pressure ulcer prevention and patient outcomes. 3. A review of the seating provision in waiting areas has resulted in improved specification seating in the Emergency Department at Royal Preston Hospital and further scoping is underway in all other assessment areas. Replacement mattresses are being purchased, where required, for ED trolleys. 4. Continued focus on quality of the interventions focused on reducing pressure damage through STAR and matron assurance processes.
Advise Areas of ongoing monitoring and any new developments	1. Maternity Support Worker/ Maternity Care Assistant fill rates - The overall maternity support worker fill rate is below the Trust target of 95% at 87.1%.	1. A successful recruitment campaign has concluded with new Maternity Support Workers (MSW) progressing through the Care Certificate and supernumerary period. Seven staff joined the numbers in January, with further starters scheduled through to May. This pipeline strengthens the establishment and will improve fill rates as onboarding completes. 2. Sickness continues to impact availability and is being managed in line with policy. 3. Recruitment and onboarding have taken longer than expected following changes within the recruitment team, and temporary bank staffing continues to be used to maintain safe staffing levels, a focus on decreasing reliance on temporary staff has commenced with recruitment team. 4. Shifts where increased risk is present are prioritised for the staffing that are available.
	2. Complaints - consistent stable performance within normal variation, themes include waiting times in the UEC pathway, boarding and delays in appointments. The focus on improving the UEC inpatient experience and improving communication with patients remain the key priority areas of focus.	1. Continue to deliver the actions outlined in the Single Improvement Plan. 2. Increase access to information regarding experience from patients with protected characteristics. 3. Development and delivery of preparing to be in hospital and preparing to go home to help manage expectations and work with families to be prepared to be cared for at home as soon as possible. 4. Continued focus on early resolution with departments and PALS. 5. Focus on use of PALS as early indicators to address concerns in areas and identify themes. 6. Estates and clinical partnership Board focused on improving the estate impact of experience.
Assure Areas of Assurance	1. Compliance with National Standards of Cleanliness - point of inspection audits for Very High- and High-Risk Areas are fully compliant at point of inspection where the cleaning standards have been implemented, confirming robust infection prevention and control measures.	1. Fully compliant at point of inspection, confirming robust infection prevention and control measures.
	2. Registered Nurse, Registered Midwife and Health Care Assistant fill rates - are achieving safe staffing levels.	2. Staffing levels consistently meet thresholds, supporting effective care delivery.
	3. STAR accreditation for all Trust.	3. Remains above target across the Trust, reflecting stabilisation following the introduction of critical standards. Continued focus on inpatient area and fundamental standards is critical in ensuring high quality outcomes are achieved for patients.
	4. CQC Must do: By the end of October 2025, the "Must Do's" included in the 2023/2024 CQC Quality Improvement Plan were delivered.	4. CQC Quality Improvement Plan has been delivered.
	5. Mortality Adult HSMR - Lower than expected, Adult SMR Adult - Lower than expected SMR Child <1 day to 17 years - As expected SMR - Neonatal <1-28 days - As expected Still Birth rate - The updated local stillbirth rate between March 2025 and February 2026 was 1.9 per 1000 births which is below the national average of 3.9 per 1000.	5. Mortality actions continue as outlined in the biannual mortality plan.
	6. C.difficile rates - New tolerance for 2026/2027 has not yet been received but based on 2025/2026 cases remain within trajectory.	6. The IPC Board Assurance Framework actions continue alongside the Infection Prevention and Control (IPC) improvement plan continue, the implementation of the cleaning standards is now in line with plan and appears to be underpinning improved performance.



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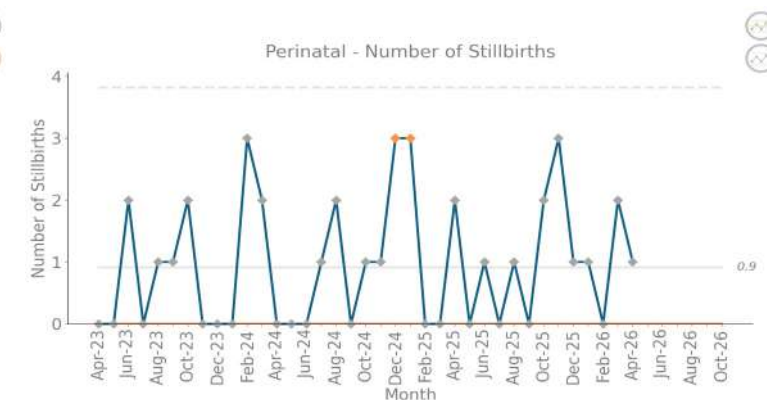
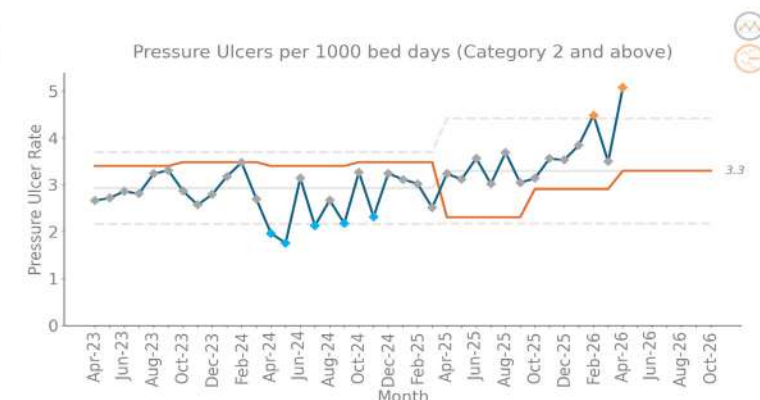
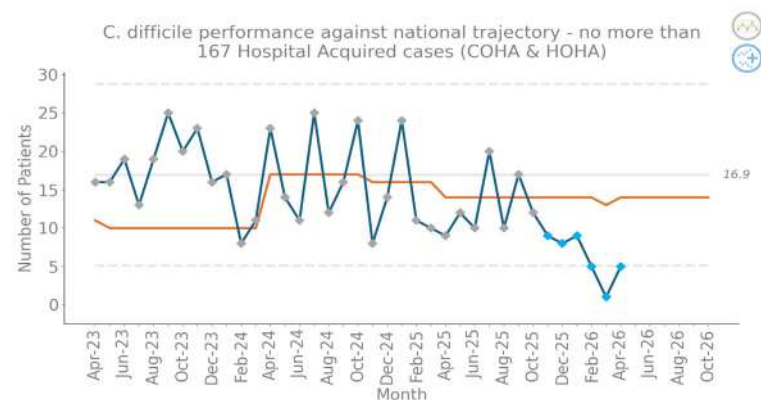
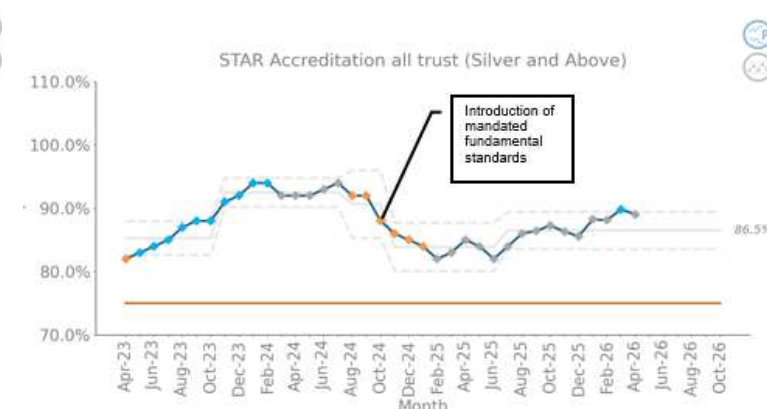
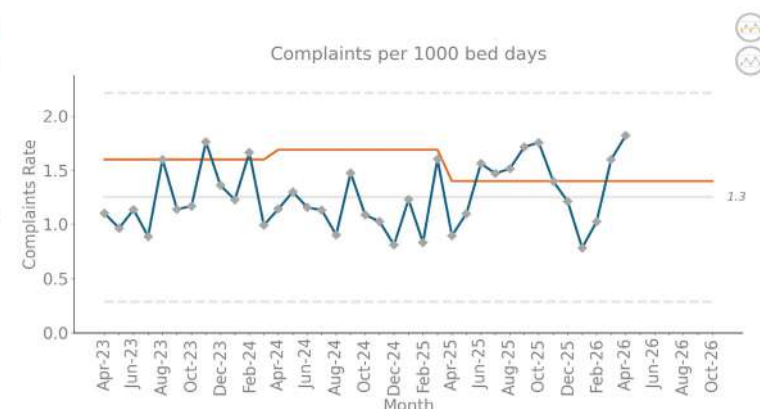
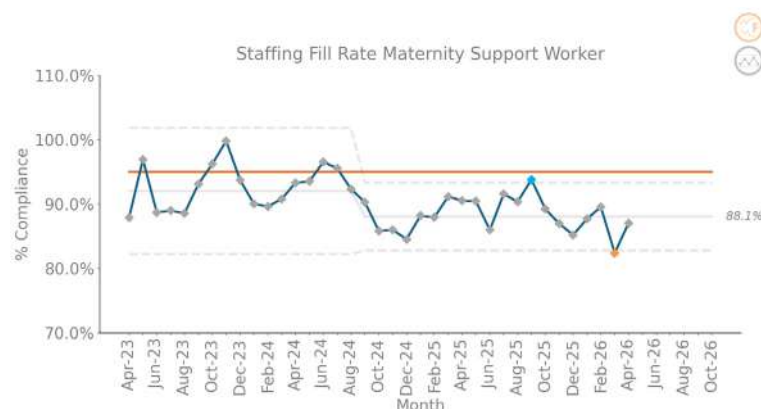
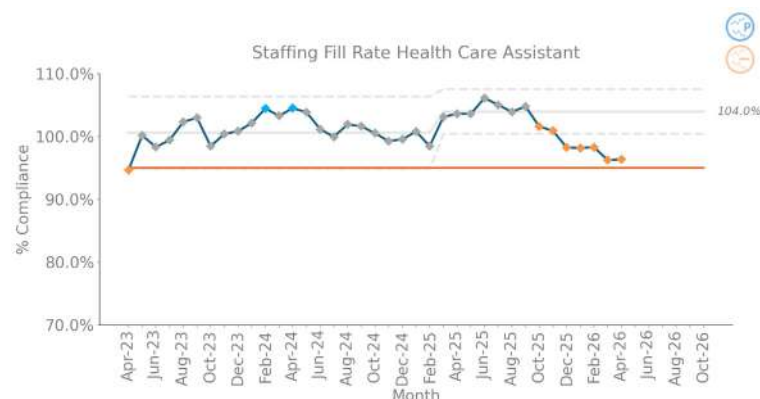
Lancashire Teaching
Hospitals
NHS Foundation Trust

Metric Description		Assurance @ Mar-27	Variation to Latest Actual	Target			Latest Month Actual	Latest Month
				Concern	Mar-27	Latest Month Target		
Deliver Annual Safe Staffing Requirements	Staffing Fill Rate - Registered Nurse				95%	95.0%	97.6%	Apr-26
	Staffing Fill Rate - Health Care Assistant				95%	95.0%	96.4%	Apr-26
	Staffing Fill Rate - Registered Midwife				95%	95.0%	97.2%	Apr-26
	Staffing Fill Rate Maternity Support Worker/Maternity Care Assistant				95%	95.0%	87.1%	Apr-26
Patient Experience and Involvement	Complaints per 1000 bed days				1.40	1.40	1.82	Apr-26
	STAR Accreditation all trust (Silver and Above)				75%	75.0%	89.0%	Apr-26
C Difficile Improvement	C. difficile performance against national trajectory - no more than 167 Hospital Acquired cases				14	14	5	Apr-26
Always Safety First	Hospital Standardised Mortality Ratio - Adult	Lower Than Expected					73.9	Dec-25
	Standardised Mortality Ratio - Relative Risk - All Diagnoses Adult	Lower Than Expected					69.3	Dec-25
	Standardised Mortality Ratio - Relative Risk - All Diagnoses Child (<1 day – 17 yrs)	As Expected					291.2	Dec-25
	Standardised Mortality Ratio - Relative Risk - All Diagnoses Neonates (<1-28 Days) <i>The updated TELSTRA model from November 2024 does not include still births</i>	As Expected					364.9	Dec-25
	Pressure Ulcers per 1000 bed days (Category 2 and above)				3.30	3.30	5.08	Apr-26
Maternity	Perinatal - Number of Stillbirths				0	0	1	Apr-26



Patients

Patients



Performance



Patients



Performance



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Alert, Advise, Assure Report

Alert Areas of concern or matters that need addressing urgently	• RTT performance - The number of follow ups >25% overdue has increased month on month since Oct 24. Capacity constraints are driving these increases however there is an opportunity to significantly demand manage via PIFU despite being close to rates. • Days Kept Away from Home - (%) has decreased slightly in Apr 26. The current position is slightly below the revised operational plan target but is consistent with the same period in Apr 25. Whilst the levels are within normal variation the data suggests a consistently failing target despite data to evidence the success of the strengths based work reducing demand. • Escalation Beds - slight decreases were noted in Apr 26 following a period of continued increases month on month since July 25	• RTT - There is ongoing work with digital partners to ensure that there is sufficient capacity to support the ambitious rollout of PIFU required to achieve the constitutional performance standards and outpatient transformation aligned to the 26/27 objectives. Additional activity is being mobilised to support the delivery of all planned care performance standards via the use of the Independent sector and via WLI's. An internal business case is undergoing Executive Check and Challenge ahead of formal consideration for approval. • Boarding/Escalation Bed utilisation/DKAFH - Work continues within the DKAFH programme with a MADE event taking place in early May and learning is informing changes into routine practice to drive reduced bed days. A development of a multi-agency Transfer of Care hub commenced on 18th May 26 with trusted assessor practices established which support step up admission into IMC. The anticipated impact from the establishment of the Transfer of Care hub is a 1 day LOS reduction for DKAFH patients in pathways 1-3. This alongside continued work on Ward and Board round processes and continued DKAFH improvement roll out will aim to see lost bed days for optimised patients reduced to within target by end March 27.
Advise Areas of ongoing monitoring and any new developments	• RTT performance - 18 week RTT performance April 26 performance is 57.4%, this is slight drop in position versus Mar 26 = 59.4% and is marginally below the M01 target. Following a period of sustained reduction DNA rates have continued to fall in Apr 26. This continues the overall downward trend in DNA rates, which remain above target. PIFU rates have increased versus Mar 26 but remain below target. • DM01 - Performance has deteriorated in April 26 to 59.73% and is below the operations plan target of 66.1%. This is due to underperformance in NOUS linked to high volumes of urgent scans, increased DNA rates linked to the IS capacity and a shortfall in capacity due to continued workforce gaps. • UEC - 4 hour performance deteriorated slightly by -0.9% in Apr compared to Mar 26 with the finalised performance = 71.28% but is above the Apr 26 operational plan target of 68%. • 12 hour + ED LOS - performance deteriorated marginally by 0.04% compared to Mar 26 and remains slightly above the revised Operational Improvement plan. •Virtual Ward - occupancy remains just below target but has improved slightly compared to Mar 26.	• RTT - Maximisation of productivity actions (DNA rates have reduced by 0.6% and theatre utilisation has increased by 2.5% versus March 26) and the mobilisation of additional capacity remains in progress to support delivery of the performance improvement plans. • DM01 - Additional capacity has been sourced via an IS provider and has been mobilised mid Feb 26. Additional capacity has been mobilised via internal colleagues undertaking additional work however there remains a shortfall. Following completion of the capacity and demand modelling a resource case is in development and all alternative provisions are being explored in the interim. • UEC - Key actions being taken to improve ambulance handover performance include increasing 'Fit to Sit' practices, improve data capture with NWAS, increased flow out of ED via continuous flow 'cycles' every 30 mins to AMU. Workforce total modelling has been undertaken with plans in place to better align rotas with demand from July 26. Scoping is underway to implement the Extended Emergency Medicine Ambulatory Care facility (as per the National model) with ambitions to implement from Q2. •VW - A Medical lead has been recruited into the service to support an expanded utilisation - await start date post pre-employment checks.
Assure Areas of Assurance	• 52 Week RTT - significant improvement in both the actual and % over 52 weeks. April 26 position shows 840 over 52 week breaches = 1.4% vs the M01 target of 2.3%. 52 weeks + breaches has reduced from a high in Aug 25 of 2158. • Cancer Performance - has exceeded target for 62 day and FDS for March 26 with a 2% improvements notes in FDS performance versus a year ago and the Trust being ranked in the top quartile nationally and an 18% improvement versus April 25 in 62 days cancer performance. The Trust has seen the 5th largest year on year improvement nationally.	



Performance

Metric Description		Assurance @ Mar-27	Variation to Latest Actual	Concern	Target Mar-27	Latest Month Target	Latest Month Actual	Latest Month
UEC In Flow	Compliance with 15 minute ambulance turnaround time target				66.30%	65.00%	26.49%	Apr-26
	Compliance with 45 minute ambulance turnaround time target				95.00%	89.00%	85.23%	Apr-26
	Percentage of UEC (Type 1 & 3) patients seen within 4 hours				82.00%	68.00%	71.28%	Apr-26
	Maximum wait of 12 hours as Total Time in Department (Type 1 and 2)				10.50%	12.50%	12.75%	Apr-26
UEC Flow	Bed occupancy %				94.00%	94.00%	95.72%	Apr-26
	Average Number of boarded patients				0	0	31	Apr-26
UEC Outflow	Reduce not meeting criteria to reside				5.00%	10.10%	9.92%	Apr-26
Elective (long waits)	Percentage of patients waiting less than 18 weeks				70.00%	57.80%	57.40%	Apr-26
	RTT - 52 week Waiters				0	1513	840	Apr-26
Elective (diagnostics)	Percentage of patients that receive a diagnostic test within six weeks				80.00%	66.10%	59.73%	Apr-26
Elective (theatre utilisation)	85% theatre utilisation - aggregate - Capped				85.00%	85.00%	84.76%	Apr-26
Elective (Cancer) (unvalidated position, subject to change)	Cancer 62-day performance				80.30%	65.10%	64.20%	Apr-26
	Cancer Faster Diagnosis Performance				80.00%	80.00%	78.70%	Apr-26
	31 Day Cancer Standard				94.00%	94.10%	87.90%	Apr-26

Performance

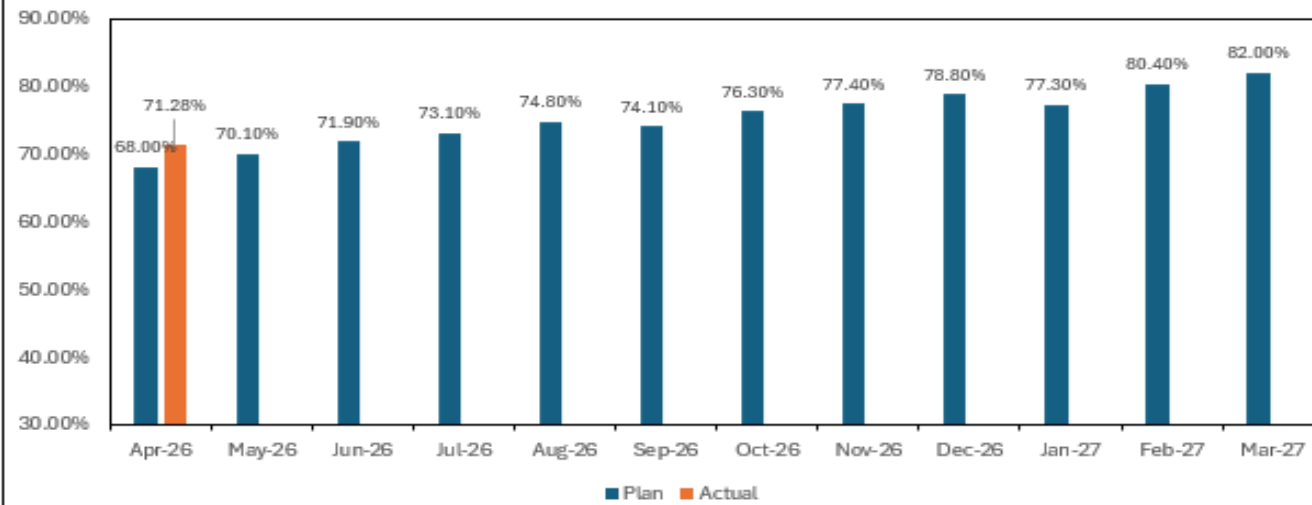




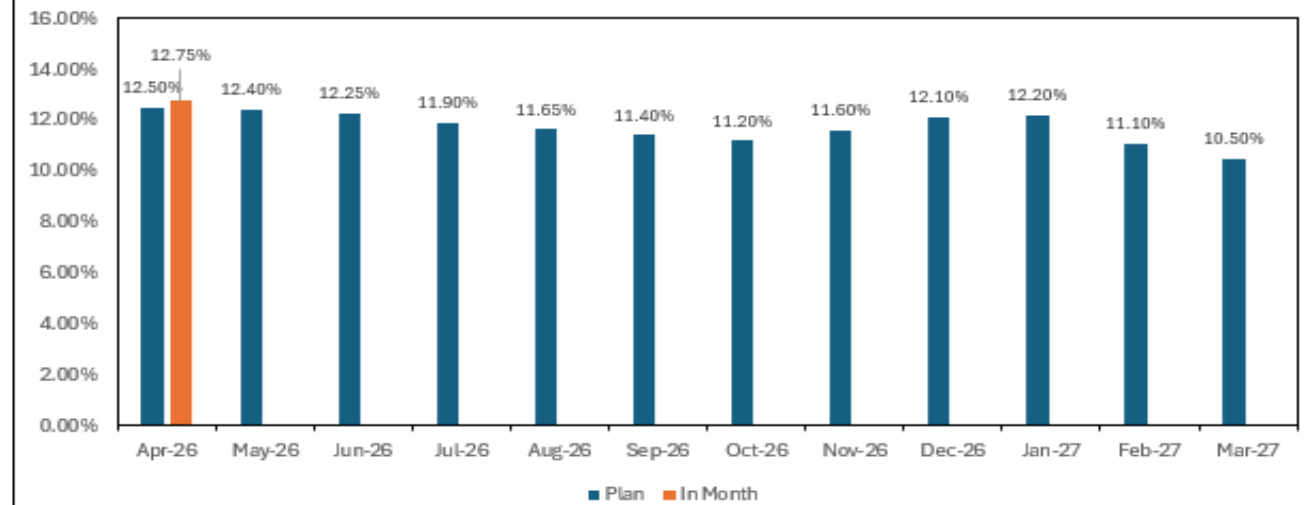
Performance

Performance - Tier 1 Charts

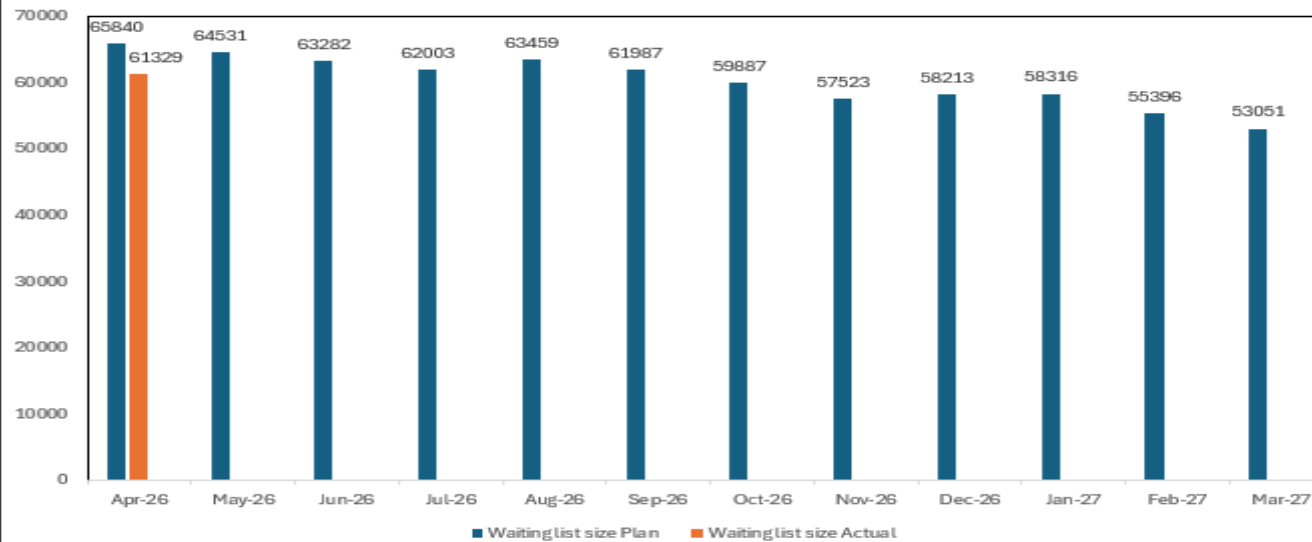
UEC 4 hour performance



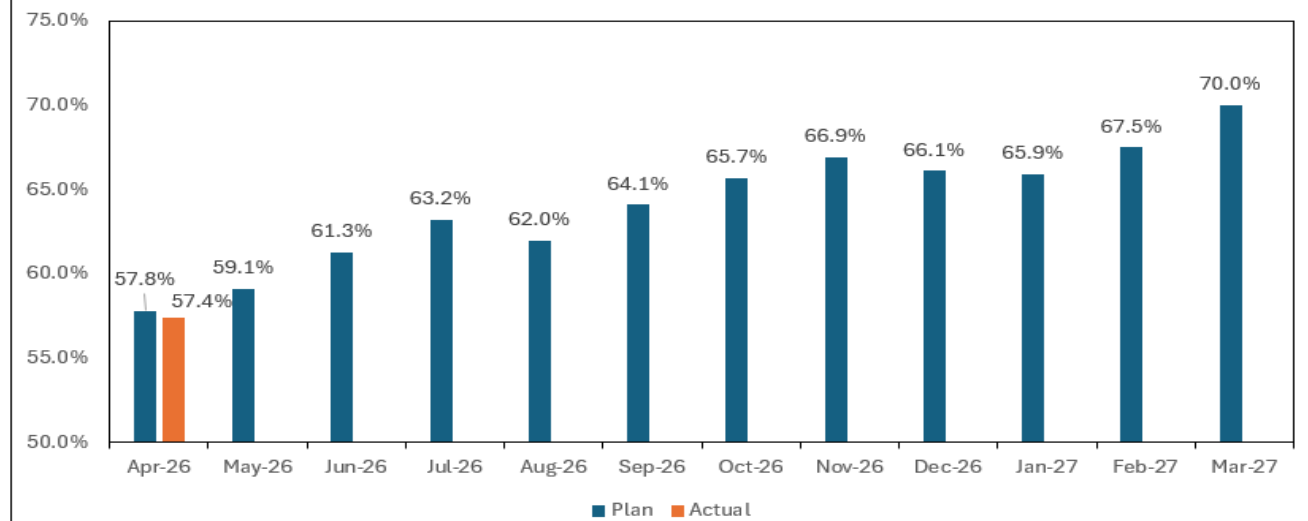
UEC 12 hour Performance



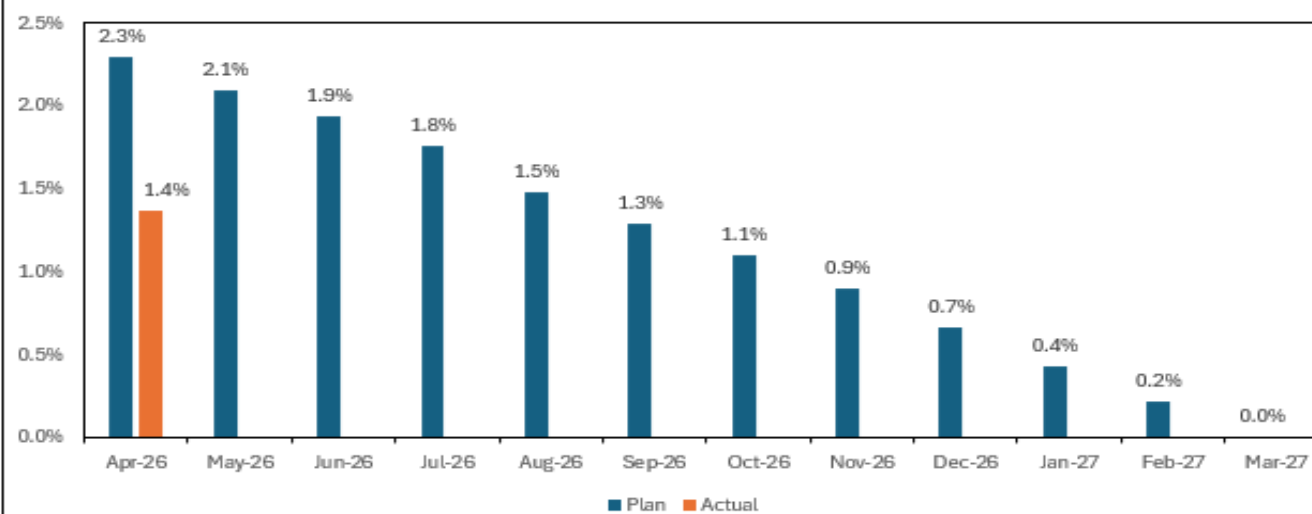
RTT Waiting List Size



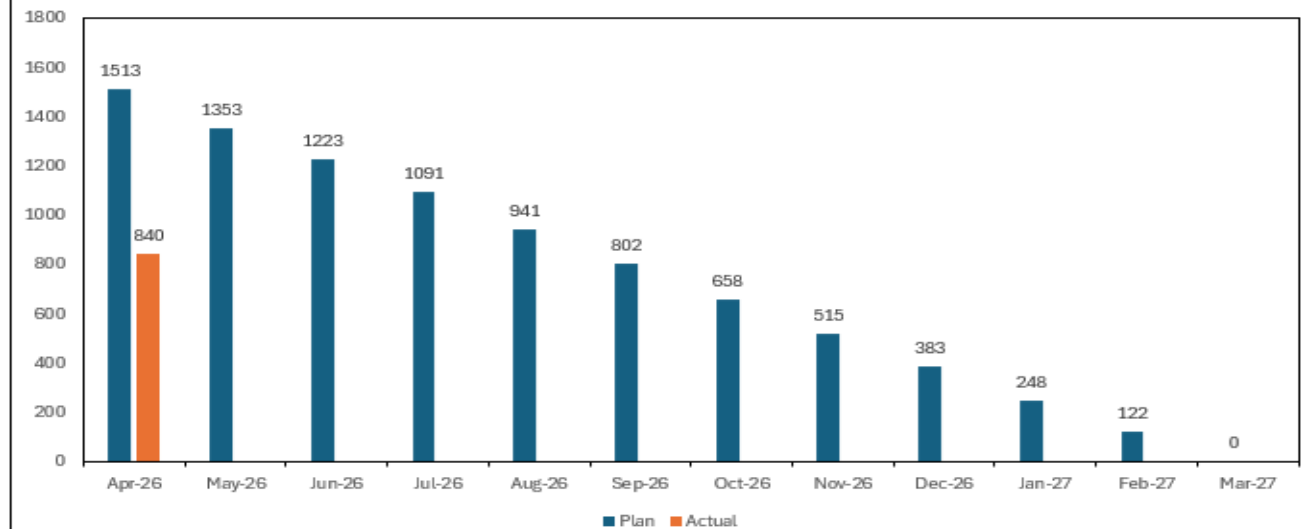
Percentage of patients waiting less than 18 weeks

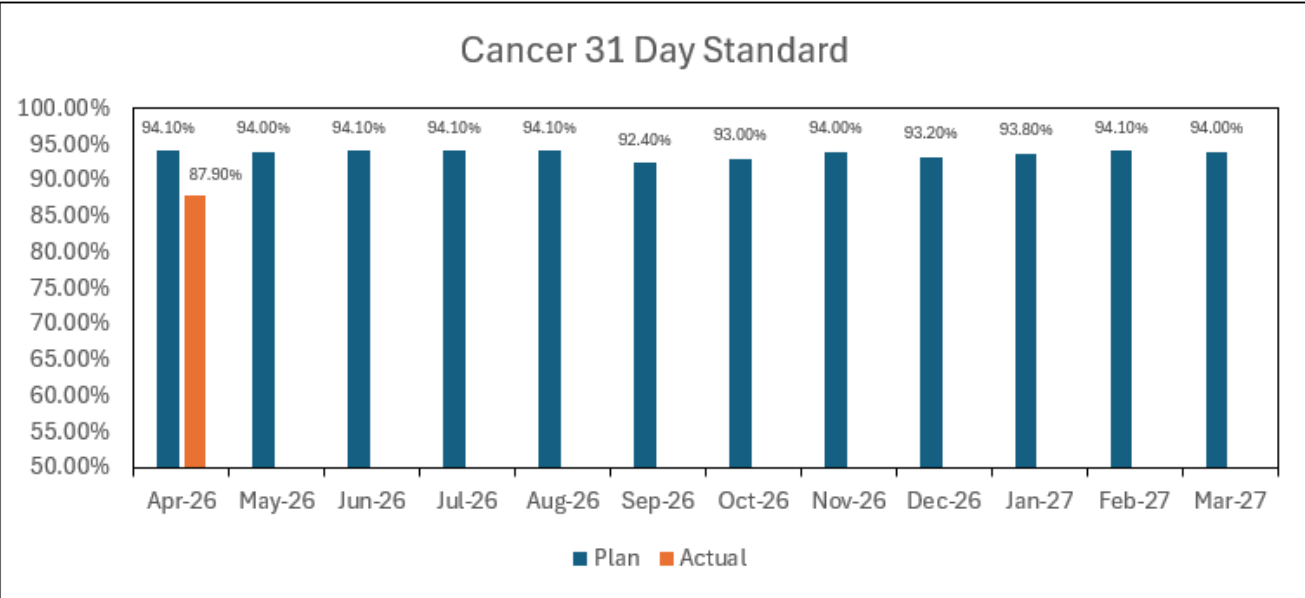
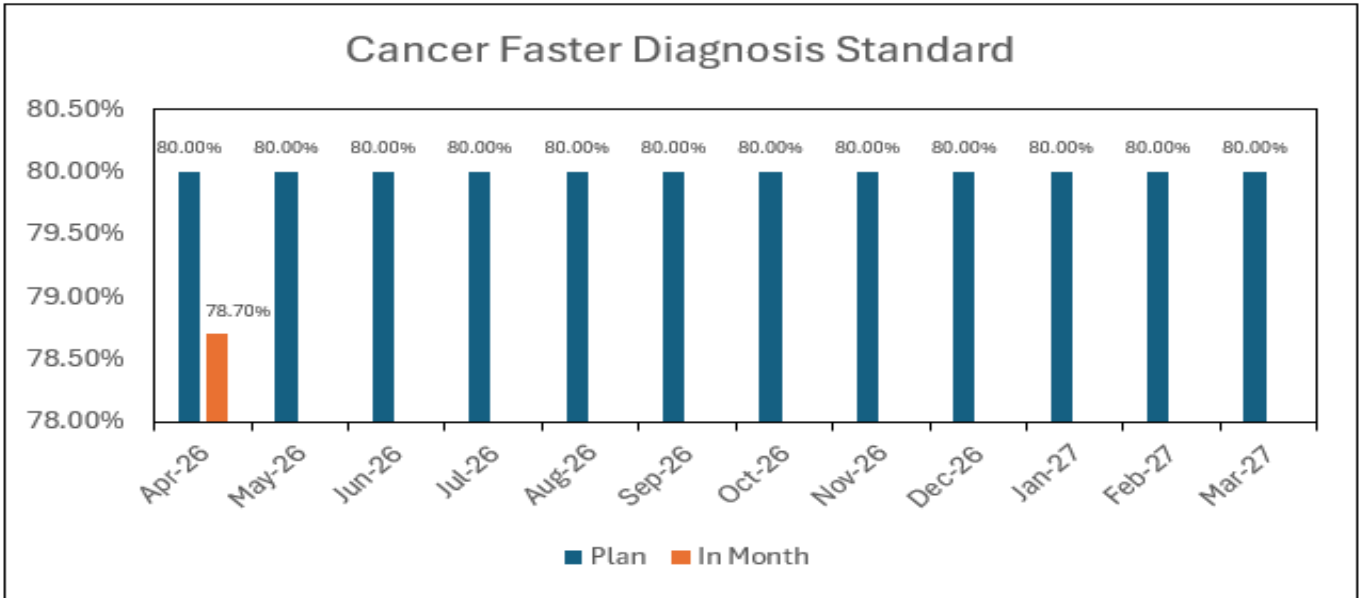
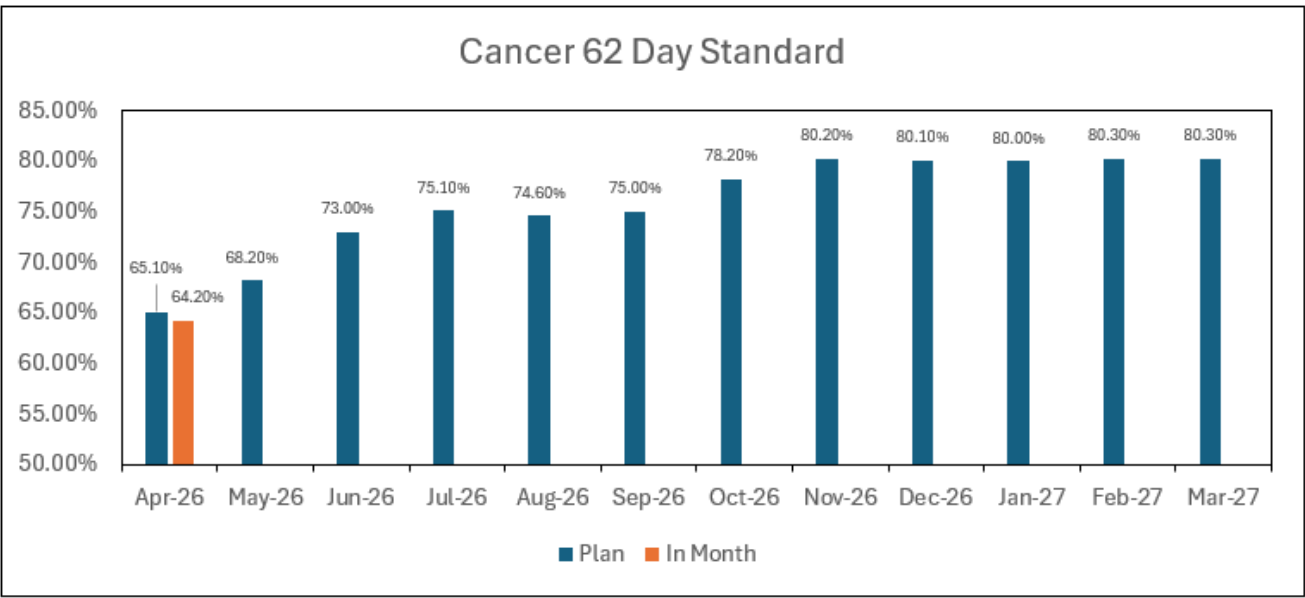
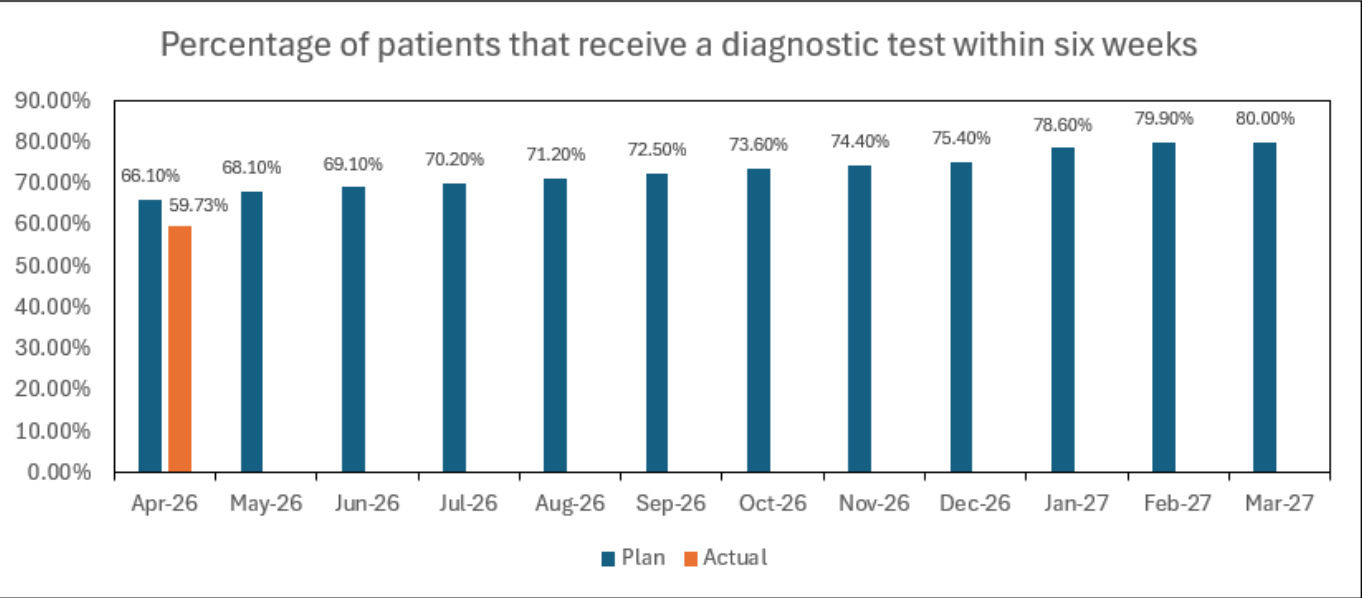


% of RTT pathways over 52 weeks



Number of pathways over 52 weeks





People



Patients



Performance



People



Productivity



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Alert, Advise, Assure Report: People

	Issue	Action
Alert Areas of concern or matters that need addressing urgently	Staff Engagement - levels of advocacy with regards to recommending the organisation as a place to work and be cared for has further declined. This is a quarterly metric - therefore position remains unchanged. Sickness - the pilot of a digital sickness absence system is not progressing well. All pilot areas are live with the first module which covers the pathway from absence reporting through to return to work interview. End user feedback is mixed and there are challenges with the functionality that we have not been able to overcome. Implementation of the second module (case management) will take approximately 6 months and there are associated contract issues. The recommendation is not to proceed any further with the system. This is a risk to delivery of the Waste Reduction Programme scheme, although there are other programmes of work ongoing to support sickness absence reduction.	Staff Engagement - further implement and embed Staff Engagement Proposal and demonstrate / communicate visible action taken in response to colleague voice. Organisation wide and divisional level action plans have been developed and presented to Workforce Committee in May 2026. Sickness - due to the scale of the sickness absence caseload within the organisation and the challenges of ensuring grip and control around policy compliance, alternative digital systems are being scoped. A business case will be required. - the Sickness Absence Reduction Plan has been refreshed for 2026/27, focusing on key actions in the domains of Data, Education, Policy and Process and Wellbeing. Following a reduction in the annualised sickness absence rate of 0.54% for 2025/26, the focus is now on the interventions that will support a further reduction of 0.5% for 2026/27.
Advise Areas of ongoing monitoring and any new developments	Vacancy - Vacancy rate remains high due to vacancy control measures, and current cap on 20 WTE approvals per month at Vacancy Control Panel. Vacancy rates have increased following the exit of F&E to One LSC due to the associated change in our WTE denominator.	Vacancy- The Finance team are undertaking an establishment cleanse vacancy review within Divisions. This exercise is ongoing and not yet transacted. This is being undertaken as part of financial recovery actions. Whilst this exercise will not reduce WTE in post it will provide greater control on any future growth. Once transacted this could reduce the Trust vacancy rate for future months. HCSW vacancies remain high however we have now our to advert for all B2 and B3 vacancies.
Assure Areas of Assurance	Appraisal compliance remains above the 90% target. Core Skills and Mandatory Training remains above the 90% compliance target for each metric at Trustwide level. Turnover remains consistently low for month 1 at 0.62%.	Appraisal - actions will focus on increasing use of objectives and personal development planning in appraisal, guidance is being developed to support appraisers to tailor their conversation based at the career and lifecycle of appraisees. Core Skills and Mandatory Training - actions focus on targeted support to increase compliance by professional group Turnover - to refresh strategic actions relating to turnover, which will include a focus on turnover in HCAs, understanding workplace motivators and retention needs based on generational and career point stages.



People

People

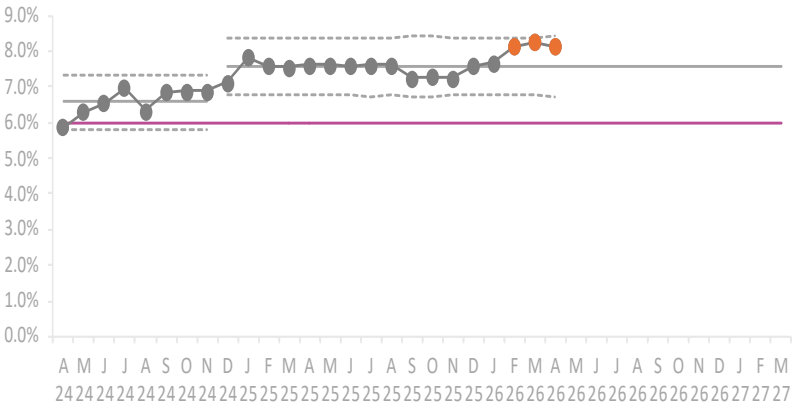
Metric Description		FY2526 Target Assurance	Latest Actual Variation	Target			Latest Actual	Latest Period
				Concern	FY2526	Latest Month Target		
People	Vacancies (% FTE) (source: General Ledger)				≤ 6%		8.13%	M01
	Turnover (% FTE) (annual assessment; ESR in-month reported)				≤ 10%		0.62%	M01
	Sickness Absence (% FTE) (annual assessment; in-month reported)				≤ 5.5%		5.57%	M01
	Number of violence and aggression incidents toward staff (annual assessment; in-month reported)				996		85	M01
	Core Skills Mandatory Training compliance (% modules) (module compliance reported)				100% of metrics at 90%		95.45%	M01
	Appraisal compliance (% HC)				≥ 90%		90.92%	M01
	Staff Survey: Recommend Trust as place to work (quarterly metric)				≥ 60%		42.54%	Q4



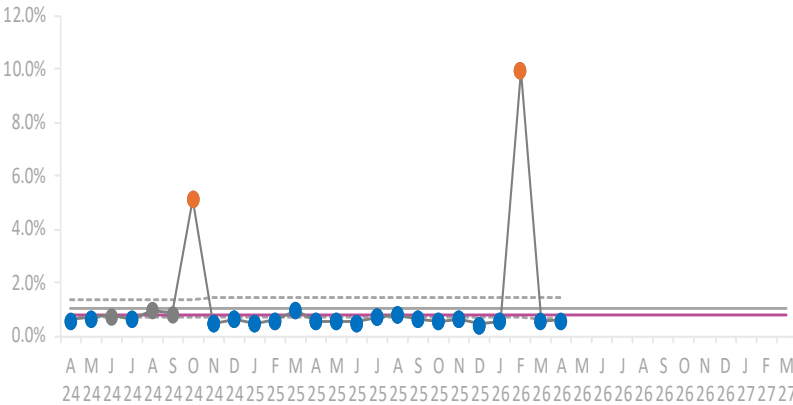
People

People

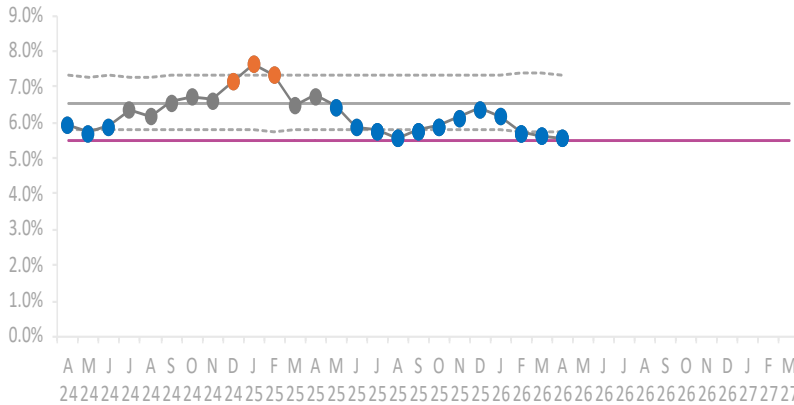
GL Vacancy Rate (% FTE)



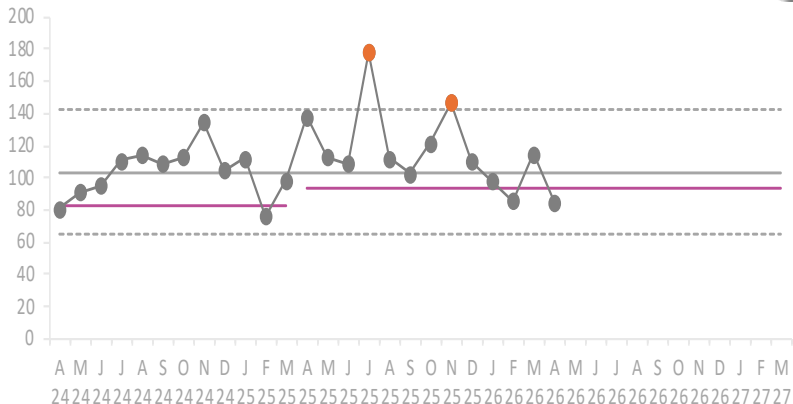
ESR Turnover (% FTE)



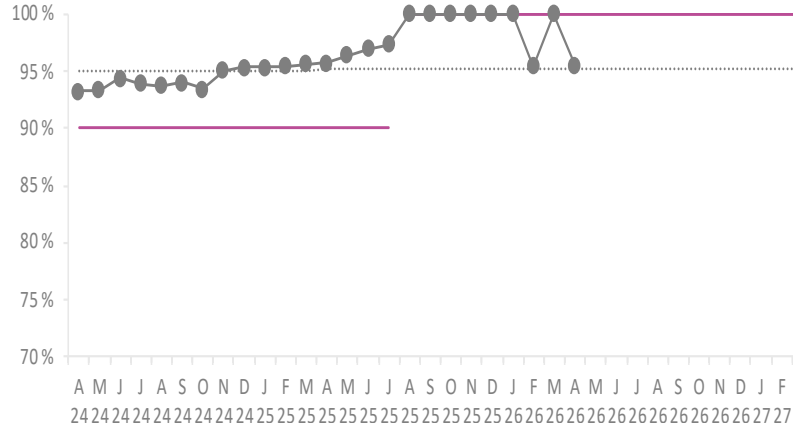
Overall Sickness (% FTE)



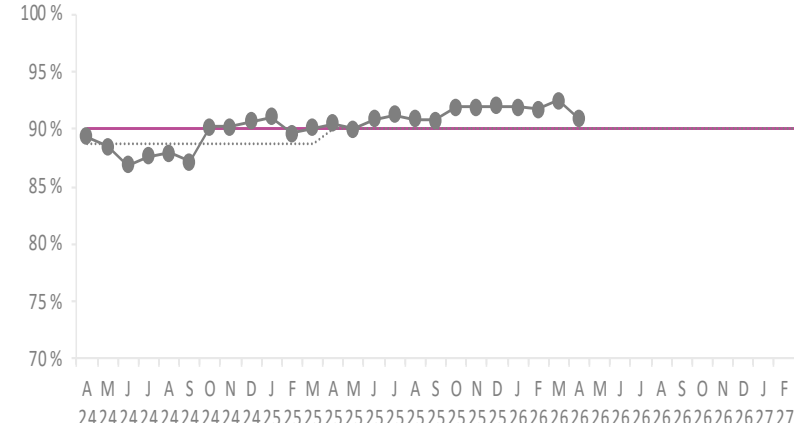
No. of Violence & Aggression Incidents Reported



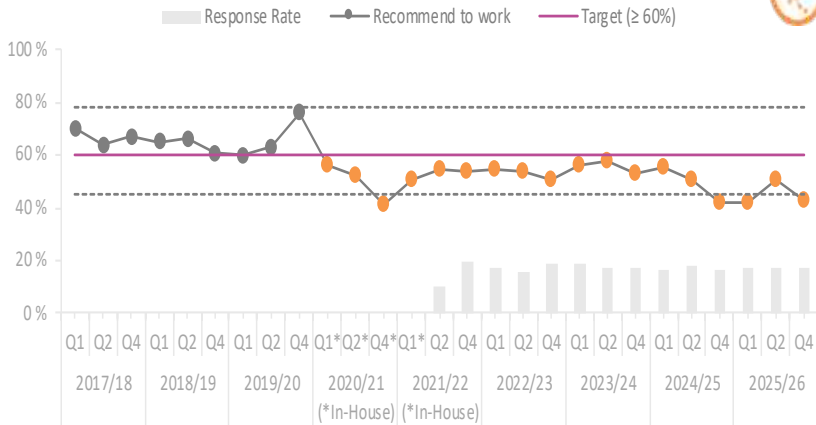
CSTF Compliance (% modules)



Appraisal Compliance (% HC)



NQPS % Recommend to Work



Productivity



Patients



Performance



People



Productivity



Partnerships

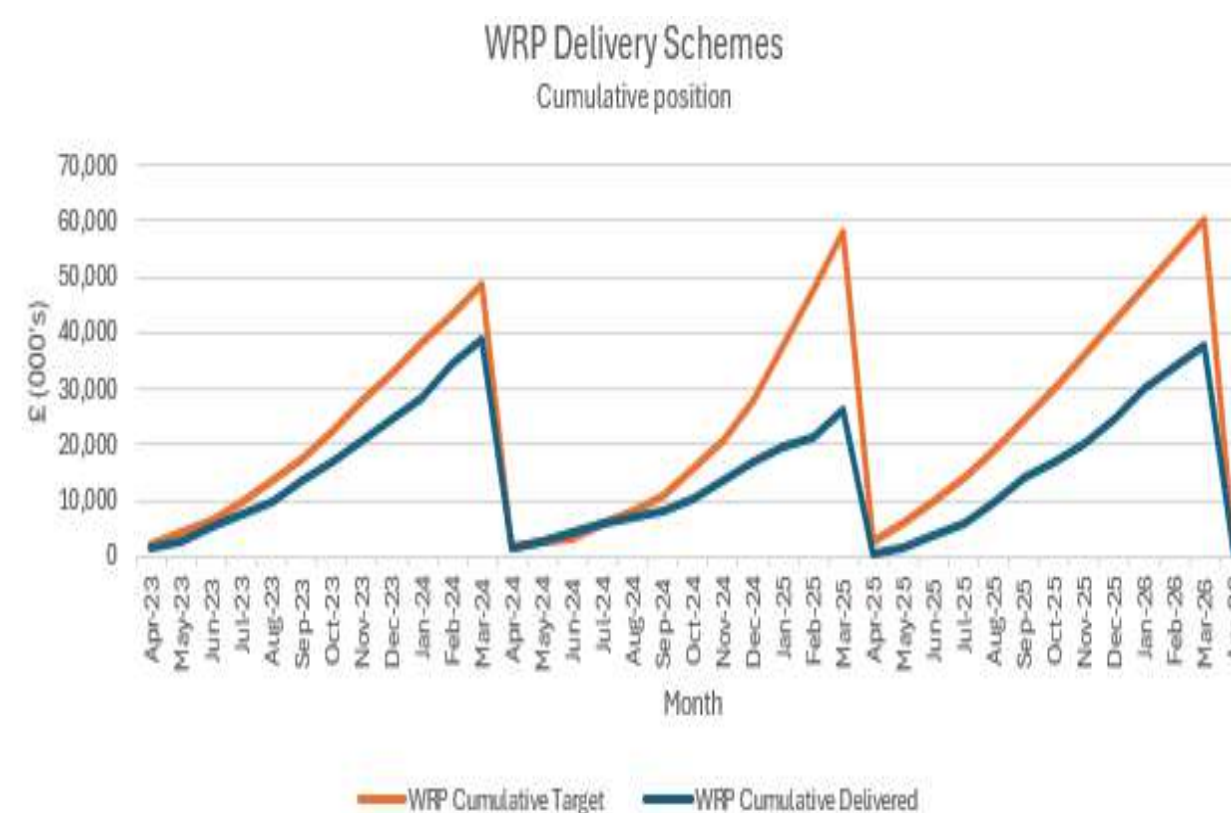
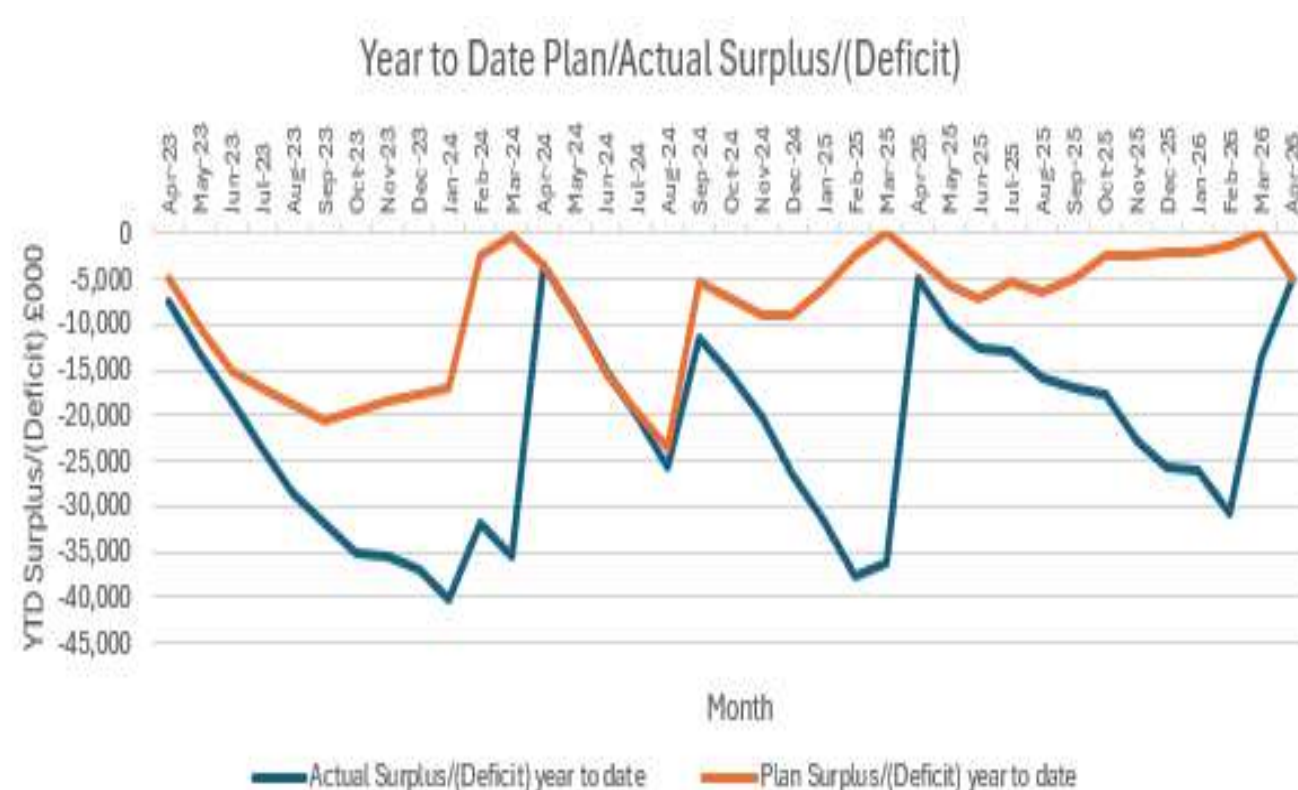
Executive Summary as at 30th April 2026

	Issue	Action	Assurance
Alert Areas of concern or matters that need addressing urgently	Cash Position		
	The capital plan for 2026/27 requires £4m of capital cash support as a result of the Trust receiving a delegated capital limit which exceeds the internally generated capital cash.	Application for capital cash support will be submitted to DHSC/NHSE as appropriate.	
		Management of WRP to ensure where possible cash releasing efficiencies are implemented.	
	The revenue plan for 2026/27 requires the receipt of £9m of DSF and the delivery of the WRP plan in full in terms of value and timing. Any slippage on either DSF or WRP will mean revenue cash support will be required.	Restriction of supplier payments in accordance with the priority list of suppliers.	
	Utilisation of internal capital cash for revenue purposes as a short-term measure.		
Advise Areas of ongoing monitoring and any new developments	Oversight Framework		
	The Trust is in Segment 5 of the 2026/27 oversight framework.	The Trust is receiving support as part of the Provider Improvement Programme (previously Recovery Support Programme), including continued support from PWC.	Enhanced Grip & Control including completion of associated actions, both internal audit and Trust actions, and associated reporting to FPC and Audit Committee.
	Segment 5 is where the organisation is one of the most challenged providers in the country, with low performance across a range of domains and low capability to improve or where the organisation is a challenged provider where NHS England has identified significant concerns.		
	Segment 5 means the Trust will be subject to NHSE's most intensive support - the Provider Improvement Programme (PIP) - to ensure it meets improvement goals. Sustained improvement is required to leave the PIP.		
	Waste Reduction Programme		
	The Trust's 2026/27 waste reduction target is £60m, 5.7% of operating expenditure.	Have a fully developed WRP Plan by the end of May 2026 in line with the commitment made to the regulator. Good progress is being made towards achieving this.	Productivity board chaired by CFO
	M1 WRP delivery was £0.5m which is in line with the NHSE Financial Plan of £0.5m.	The Trust is now embedding its own project management office structure to have a sustainable solution moving forward.	External support for specific workstreams.
	However, the full WRP Plan of £60m has not yet been fully developed and if not developed and delivered will present a risk to the delivery of the 2026/27 financial plan.	The Trust has enhanced grip and control activities to mitigate slippage in schemes.	Implementation of Divisional Delivery Groups
	For 2026/27 the Trust has implemented its Financial Sustainability Plan with areas aligned to Executive Leads, earlier planning and a focus on sustainable expenditure reduction rather than short term benefits.	Embedding of PMO	
		Revised governance arrangements for DDGs	
Assure Areas of Assurance	Capital Position		
	Capital expenditure for April was £0.9m below plan.	Plans are being worked up to deliver expenditure to the delegated capital limit.	There is no risk of slippage for the year.
	The Trust is awaiting outcomes for capital bids that were submitted to NHSE against the national allocations.	Dialogue is ongoing with the regional NHSE team.	
	The Trust spent £823k less than the capital PDC that was received for the NHP land transaction in March 2026.	The surplus funds (£823k) from the NHP capital allocation in 25/26 are being repaid to DHSC in May.	
	Cash Position		
	Current cash forecasts show that the Trust will not require revenue cash support from DHSC until September. However, that is contingent upon WRP delivering cash releasing efficiencies as per the plan targets.	Management of WRP to ensure where possible cash releasing efficiencies are implemented.	The cashflow forecast is updated daily and any emerging issues are escalated to the CFO.
		Restriction of supplier payments in accordance with the priority list of suppliers.	Monthly cashflow review by the CFO.
		Utilisation of internal capital cash for revenue purposes as a short-term measure.	
Income and Expenditure			
The M1 income and expenditure actual was a £4.9m deficit which is in line with the NHSE Financial Plan. WRP delivery was on plan at £0.5m delivered. The underlying position improvement as at M1 was £2.1m.	A re-set of the programme structure, governance and reporting for 2026/27 has taken place, including the introduction of the Productivity Board.	Grip and control Interventions and control measures	
The financial impact of industrial action in M1 has been assessed at £0.8m, which has been fully mitigated by the transfer of vacancies within the Pathology Single service and a reduction in pay run rate across clinical divisions.	The system is receiving enhanced support from NHSE as part of the provider improvement programme (formerly recovery support programme). A focus on grip and control activities continues.	Mandated national support from PWC and the Provider Improvement Programme (formerly Recovery Support Programme)	
	The Trust commissioned further external support for specific financial recovery plan workstreams and 2026/27 waste recovery programme development.		

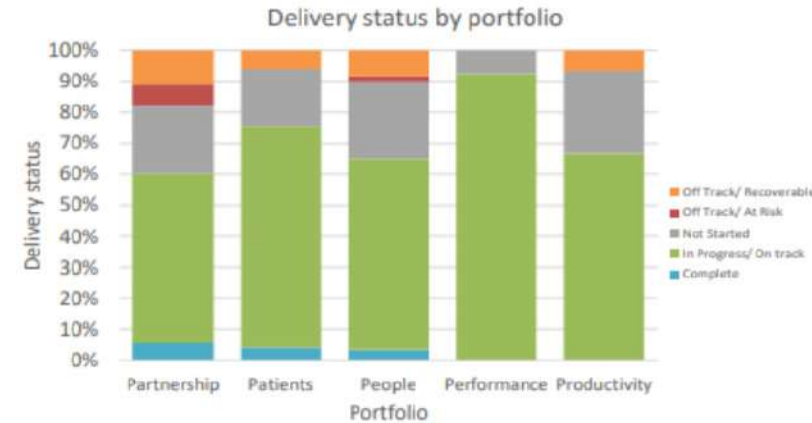
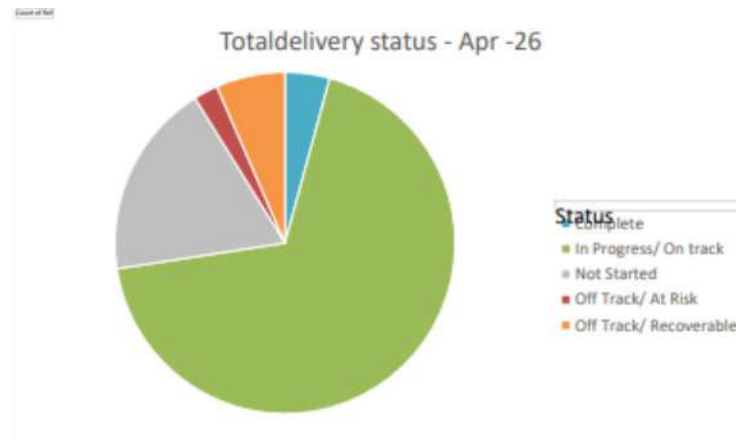


Productivity

Metric Description		Assurance @ Mar-27	Variation to Latest Actual	Concern	Target (£ 000's)		Latest YTD Actual (£ 000's)	Latest Month
					Mar-27	Latest YTD Target		
Productivity	I&E - Plan v Actual variance					-4938	-4941	Apr-26
	WRP schemes delivery				60000	450	446	Apr-26



April-26 | Single Improvement Plan delivery position



Status	Portfolio	Escalation	Key actions
Alert	PATIENTS	Restraint incidents remain high overall with majority occurring at Levels 1 and 2.	Task & Finish group established
	PERFORMANCE	Performance against 62 day cancer waiting time continues to be below target as a result of capacity shortfalls.	Focus on workforce gaps to recover capacity
	PEOPLE	- Sickness absence management Empactis remains challenging with numerous delays. - Report of racism and discrimination remain persistent with little movement in metrics.	- Consideration of alternate solutions and mitigating actions to sickness management. - Current capacity in EDI constrained, consider capacity and priorities across OD team to support.
Advise	PATIENTS	Opening date for 4th SGU theatre unconfirmed	Task & Finish group established to work through staffing, equipment and specialty issues.
	PRODUCTIVITY	On plan for NHSE Target WRP delivery M1	Focus on high risk, high value scheme deliver to ensure this continues into M2
	PARTNERSHIPS	Community partnership agreement delayed.	Shift to April-26 but being broadened to cover all interfaces.
Assure	PATIENTS	Funding secured for 24/7 maternity telephone triage and maternity day unit uplift	Recruitment underway
	PERFORMANCE	- Zero 65 week wait maintained. - Endoscopy performance improved in all modalities.	

Integrated Performance Report

Appendix 1 – Assurance Reports

June 2026 Trust Board meeting with performance to April 2026



Patients



Performance



People

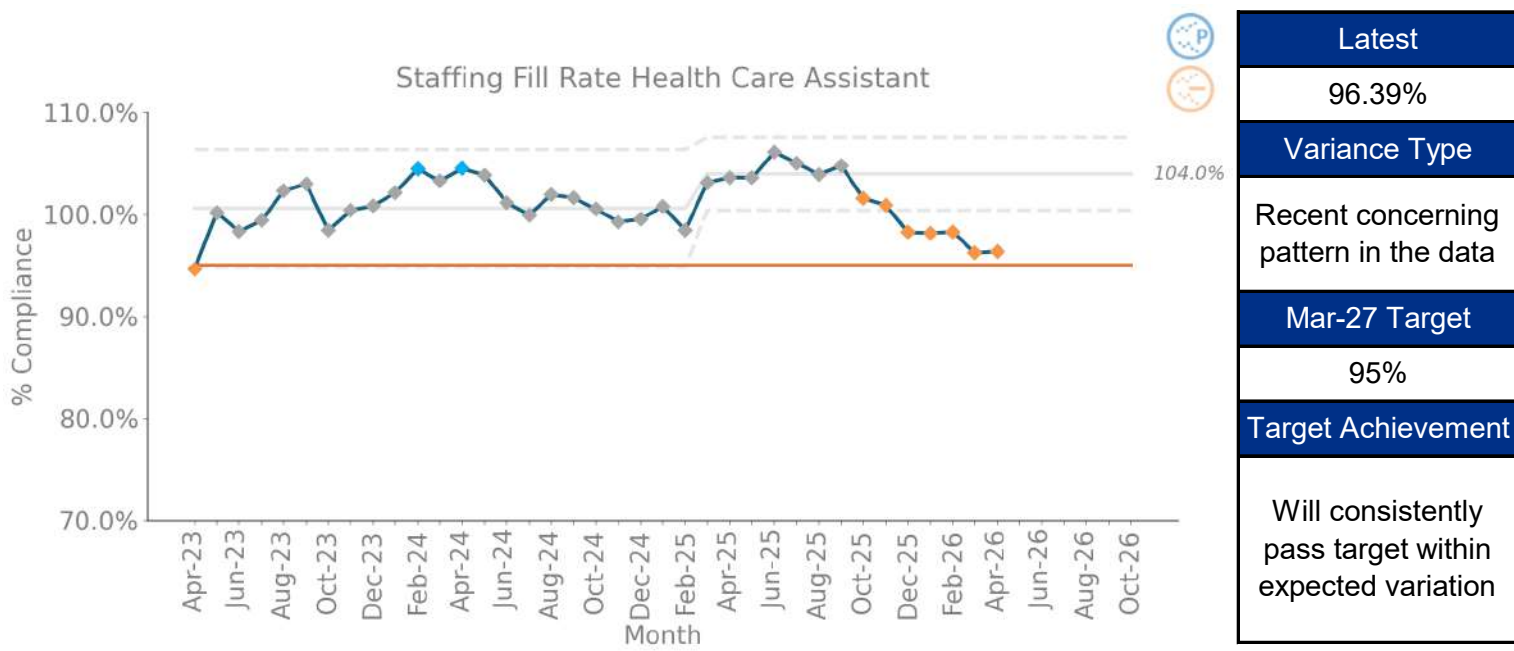
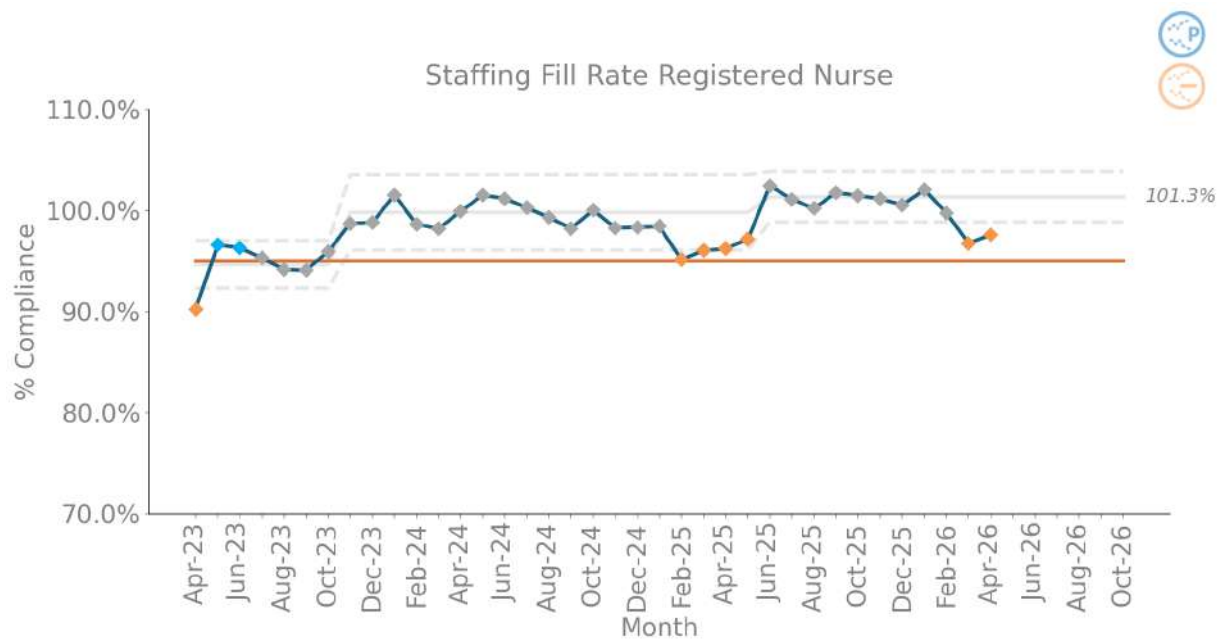


Productivity

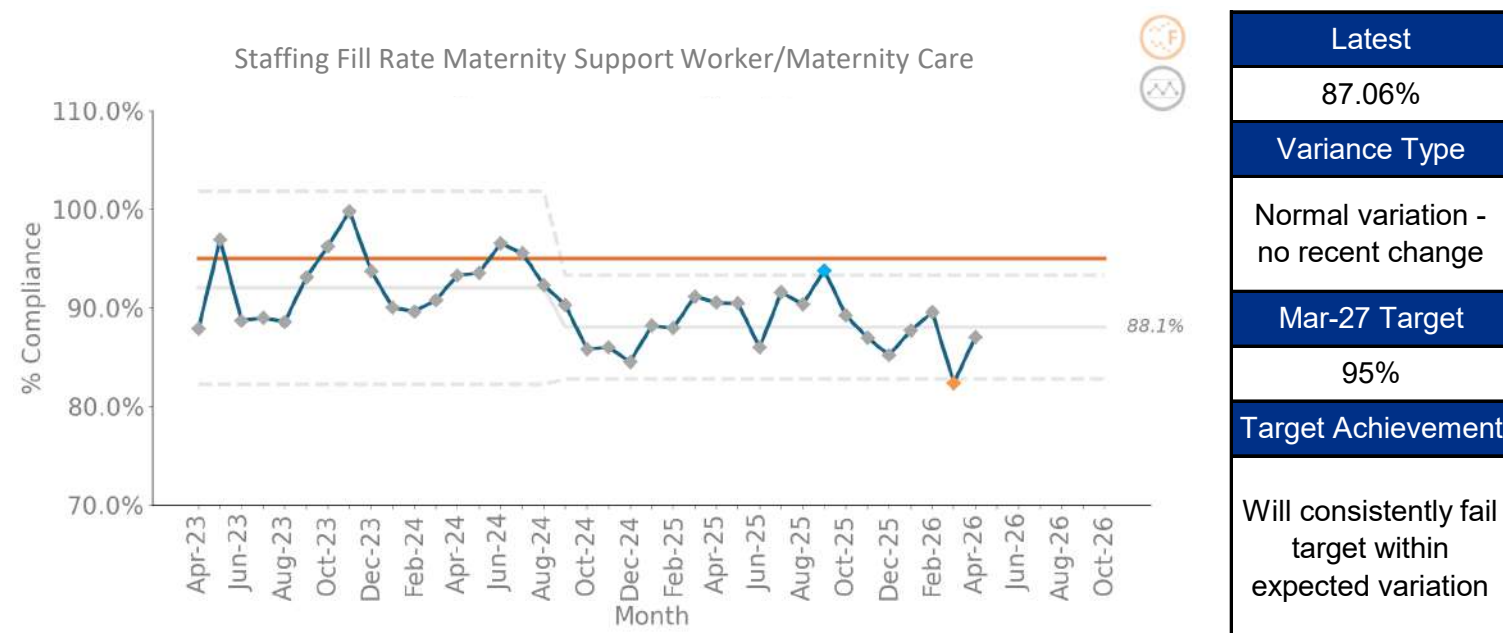
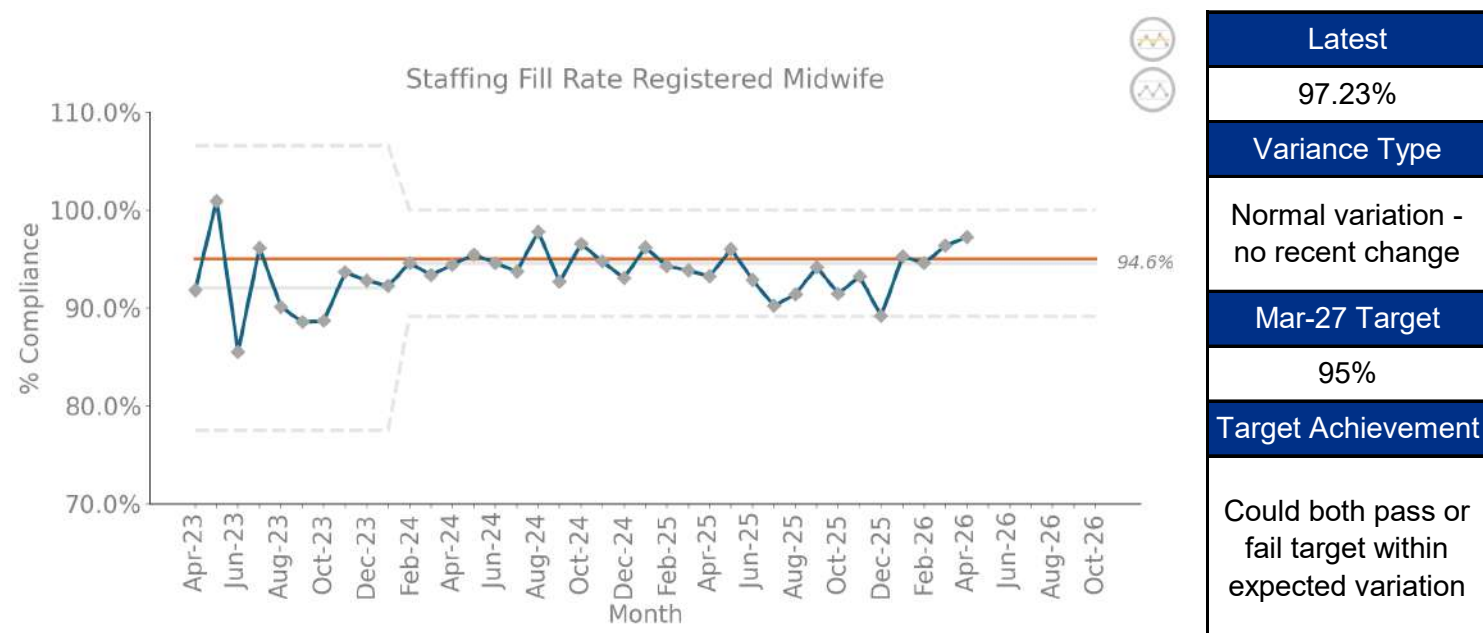


Partnerships

Patients - Deliver Annual Safe Staffing Requirements Assurance

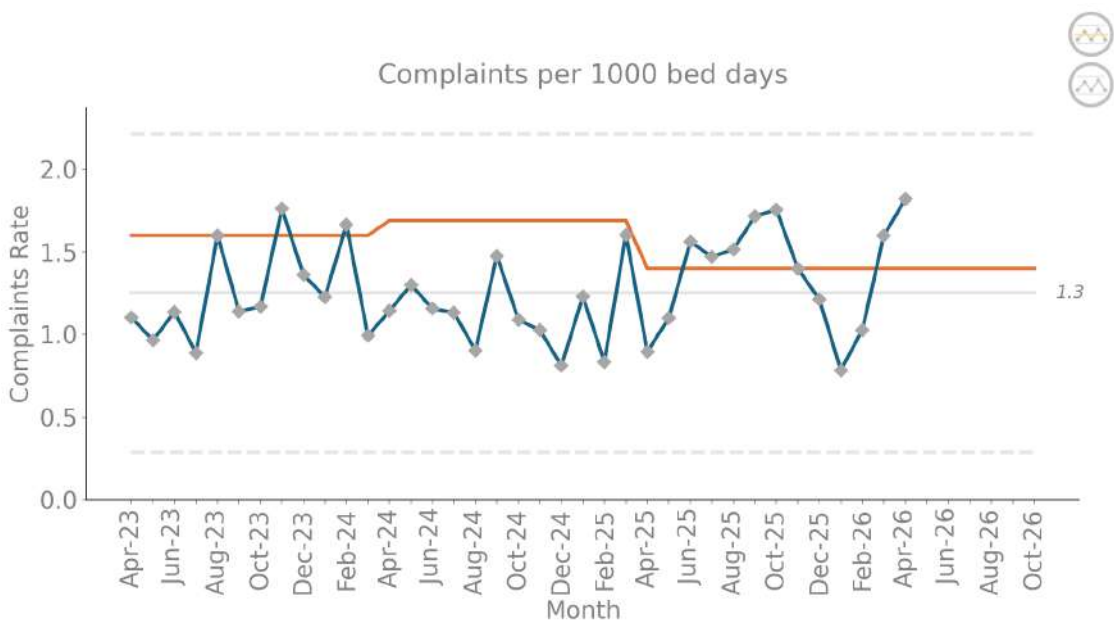


Metric	Summary	Action	Assurance
Staffing Fill Rate Registered Nurse	The Registered Nurse (RN) staffing fill rate remains stable at 97%, with Chorley District Hospital (CDH) achieving 98% and Royal Preston Hospital (RPH) 97%. This demonstrates sustained performance above the 95% target and reflects effective workforce controls and oversight. Daily staffing reviews, strengthened governance around bank and agency usage, and proactive redeployment of staff continue to support safe staffing levels across all clinical areas.	- Twice daily nurse staffing meetings are in place 7 days a week for oversight of safe staffing. - Roster sign off processes are in place and this has increased to weekly roster efficiency reviews which have commenced by the Divisional Nurse Leaders in October 25. - There is a full review of all areas where fill rate is greater than 100% and actions being taken including redeployment of staff where overestablishment is in place on a shift by shift basis . - Redeployment of staff into vacancies through organisational change and ward closures, ongoing into February 2026.	
Staffing Fill Rate Health Care Assistant	Health Care Assistant (HCA) fill rates have also been maintained at 96% overall (CDH 94%, RPH 97%), despite a high vacancy rate of 22% across inpatient wards. This indicates that mitigating actions, including use of bank staff and enhanced operational oversight, are effective in maintaining safe care delivery in the short term. However, reliance on temporary staffing remains a residual risk.	- Twice daily nurse staffing meetings are in place 7 days a week for oversight of safe staffing. - Internal Band 2–Band 3 progression route is defined and advertised, with the first cohort scheduled to begin in April 2026. - Centralised external recruitment campaign advertised in March 2026. - Band 3 apprenticeship programme out to recruitment with interviews planned 2nd June 2026.	- All clinical areas are showing a stable fill rate position. - Daily operational staffing meetings are in place, led by matrons to assess and respond to changes in pressure and demand based on acuity and dependency, red flags and professional judgement. - Approval and sign off of all agency shifts by Chief Nursing Officer - Biannual safe staffing procedures are in place in line with National Quality Board guidance. - Weekly PSIRF oversight panel reviews incident harm levels, this is triangulated through a quarterly serious incident/PSIRF report. - Involvement in National Enhanced Therapeutic Observation and Care (ETOC) improvement work. - Additional duties follow a clear governance process for request and approval by Deputy/ Divisional Nursing Director to maintain safety and efficacies.



Metric	Summary	Action	Assurance
Staffing Fill Rate Registered Midwife	The overall midwifery fill rate is 97.3% which is just above the Trust target of 95% for April 2026. This demonstrates a stabilising position and improvement is reflective of the ongoing oversight of the midwifery establishment and over offer. Unfilled shifts continue to be sent to bank and agency as required to maintain safety as required. The 2025 Birth Rate Plus has been endorsed and approved by Board of Directors (April 2026) and a 2 year phased approach to funding has been agreed. Phase 1 of targeted recruitment has commenced.	- Weekly roster efficiency reviews as required to ensure appropriate use of bank and agency. - Monthly roster efficiency meetings overseen by the deputy Divisional Midwifery and Nursing Director - The service continues to recruit to turnover using over offer of 5 WTE. - Annual staffing paper including Birth Rate Plus approved by the Safety and Quality Committee (February 2026) and Board of Directors (April 2026)	- Registered Midwife fill rates remain stable across day and night shifts. - The Safety and Quality Committee reviews fill rates and minimum RM levels for each area monthly. - Work is underway with the Safe Staffing Matron to report fill rates by area rather than cumulatively, enabling clearer identification of pressure points and targeted action. - All agency shifts require approval from the Deputy/Divisional Midwifery and Nursing Director. - Biannual safe-staffing reviews are completed in line with National Quality Board guidance. - A weekly PSIRF oversight panel reviews harm levels, supported by quarterly serious-incident/PSIRF reporting. - Red-flag reporting is monitored to identify areas requiring additional support to mitigate risk.
Staffing Fill Rate Maternity Support Worker/Maternity Care Assistant	The overall Midwifery Support Worker fill rate remains below the Trust target of 95% , but has improved in month from 85.57% for March 2026 to 87.06% in April 2026. The vacancy rate continues to be closely monitored. VCP oversight processes have affected timely recruitment and delays have been escalated where appropriate. Under funded establishment on maternity A has been included in the Birth Rate plus requirements and this has been approved at part of phase 1 . Once substantive posts are filled this will improve overall fill rate performance. To maintain safe staffing levels, there continues to be a requirement to use bank to fill shifts.	- Weekly roster efficiency reviews are ongoing to ensure appropriate use of temporary staff. - Ongoing recruitment to fill all vacancies which are tracked using a local trajectory plan. - Sickness management procedures are reviewed by Workforce Business Partner to ensure appropriate management. - Band 2 MSW vacancies in maternity A,B and Delivery suite are being progressed through VCP or onboarding process.	- The Safety and Quality Committee reviews fill rates and minimum safe-staffing levels by area each month. - Work with the Matron for Safe Staffing is underway to report area-specific fill rates to better identify pressure points and target actions. - Rosters and agency shifts are overseen and approved by the Deputy/Divisional Midwifery and Nursing Director. - Biannual safe-staffing reviews are completed in line with National Quality Board guidance. - A weekly PSIRF oversight panel reviews harm levels, supported by quarterly serious-incident/PSIRF reporting. - Red-flag reports are monitored to highlight areas requiring additional support to manage risk.

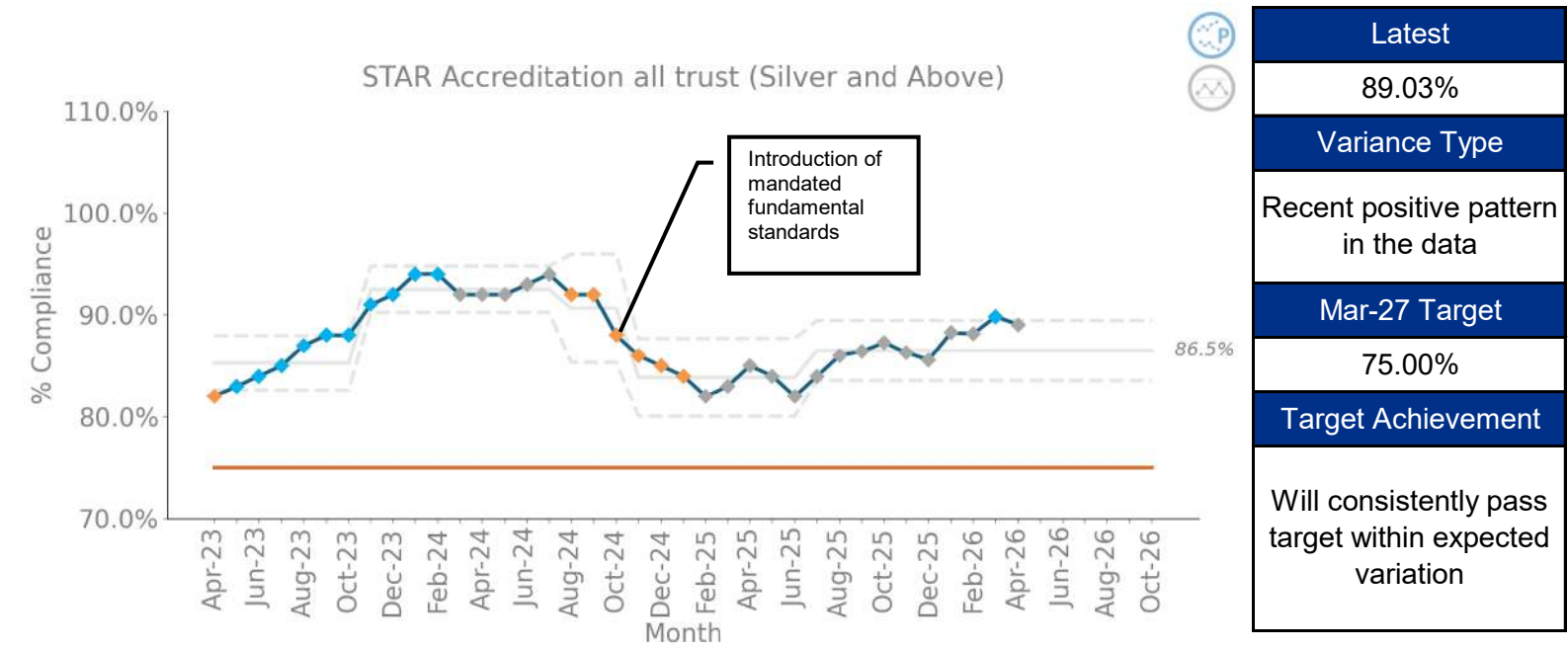
Patients - Complaints



Latest
1.82
Variance Type
Normal variation - no recent change
Mar-27 Target
1.40
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
Complaints per 1000 bed days	Complaints per 1,000 bed days from April 2023 to early 2026, with performance fluctuating around a central baseline and a stepped trajectory line indicating expected or target levels.Overall, complaint rates remain relatively stable, typically ranging between approximately 0.8 and 1.8, with no sustained upward trend over time. The Trust’s Single Improvement Plan is guiding both immediate service improvements and longer-term system change to support sustained reduction.	1. Continue to deliver the Single Improvement plan - Patients 2. Continue to deliver the Patient Safety Incident Response Framework with a focus on family liaison roles 3. Monitor actions in relation to National picker Surveys . 4. To deliver the PALS and local early resolution training. 5. Continue to progress the complaints review group using patient safety partners and governors 6. Where concerns have not been responded to locally escalatre to managers.	1. Annual patient experience reports to Safety and Quality committee. 2. Friends and family monthly reporting in place for all departments. 3. Inclusion of patient experience in STAR. 4. Chief Nursing Officer reviews all complaints and signs off responses. 5. Monitor picker survey action plans through Patient, Carer, Experience and Involvement Group.

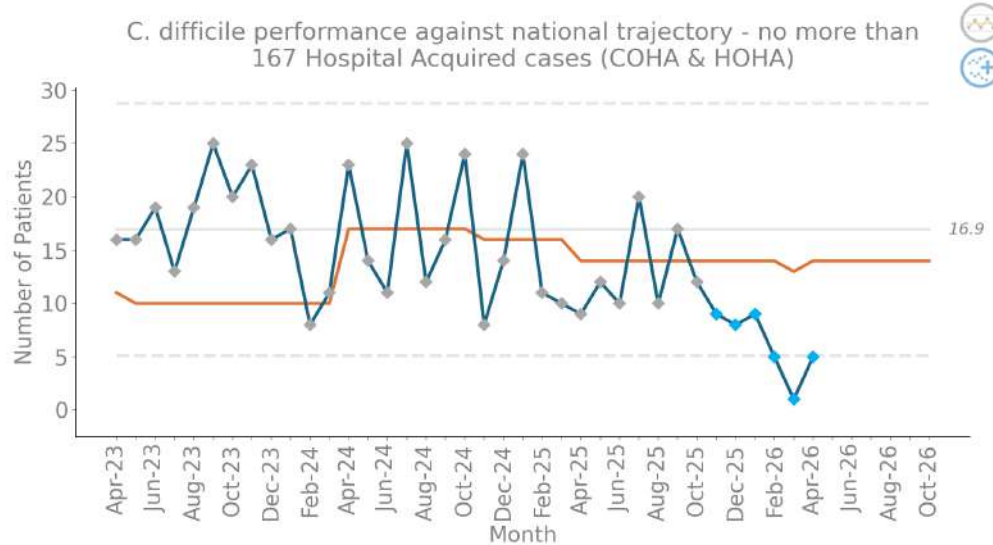
Patients - Quality Assurance STAR Accreditation



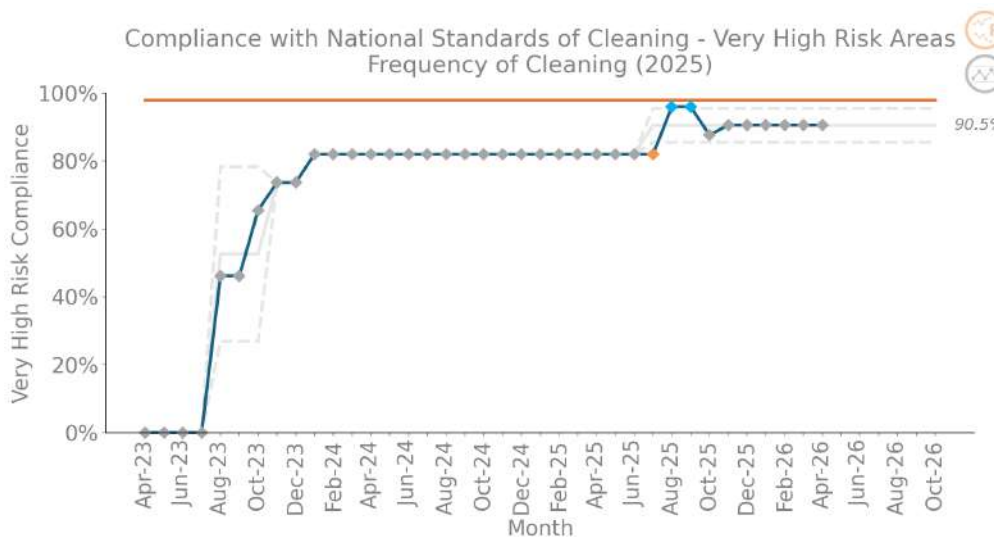
Metric	Summary	Action	Assurance
STAR Accreditation all trust (Silver and Above)	There are 119 clinical areas registered for the STAR Quality Assurance Framework. There are 2 clinical area with a red star rating, 11 areas with an amber rating and 106 areas rated green. This results in 13 bronze stars, 32 silver stars and 74 gold stars. Of those 32 areas with silver stars, there are 4 areas who have achieved 3 consecutive silver stars and are awaiting approval at the Gold Star Panel. There are 89% of areas rated silver or above. During April, there were 2 areas with a reduced STAR rating, 1 area had their first visit (rated red), 1 area had an increase to silver and others maintained their star rating. There is one area rated C for the 15 steps. Themes for improvement include the mandated 'critical' standards of the essentials of care, infection prevention and control, risk assessments in particular MUST and weights, STAR audit action completion and mandatory training. Recurrent themes are included within the STAR report, these include patient and staff experience, patient experience impacted upon by boarding and escalation areas, provision of meals and drinks in some areas, fluid balance management, assessment and delivery of enhanced therapeutic observations and care (ETOC). A bespoke assurance assessment of the boarding standards was presented to the NMAHP Board during February. There are 78 % of wards, ED and theatres scoring silver and above for STAR accreditation visits.	- Any standards which are not achieved require an improvement action which is monitored within division through divisional assurance processes and via STAR monthly reviews and STAR accreditation visits. - The monthly STAR report includes trustwide and divisional STAR data and highlights good practice, areas for improvement, themes for learning and an overarching STAR improvement action plan, which is cascaded and discussed through the divisional always safety first meetings. The STAR report includes CQC (2023) learning and standards which continue to require improvement. - The STAR action plan has been updated to include recurrent themes and now included learning and actions from the Safety Visits undertaken by the senior leadership teams. - STAR monthly report updated to highlight those areas who are rated red or amber for STAR visits of less than 90% for STAR monthly. - The STAR enhanced oversight panel involves 5 areas to drive action and support with STAR safety and quality actions. Learning and actions are included within the STAR report shared via NMAHP Board.	- The STAR report is shared with the divisional leadership teams, good practice is shared and celebrated and that actions are developed where improvement is required. - Ward/department managers, matrons and professional leads provide assurance that actions are completed and monitored for effectiveness through the 1:1 with matrons and Divisional Nurse Directors. - The AMaT system supports with STAR audit data management and oversight and management of improvement actions. - There is a BI STAR page available to enable data triangulation. - STAR accreditation visits are scheduled depending on star rating, areas with a bronze star rating are reassessed within 2-3 months. (red every 2 months, amber every 3 months). Any area with a 15 steps result of C or below will receive a reassessment within one month. - Any immediate risks or serious concerns identified are addressed at the time and followed up to seek assurance that actions are in place.



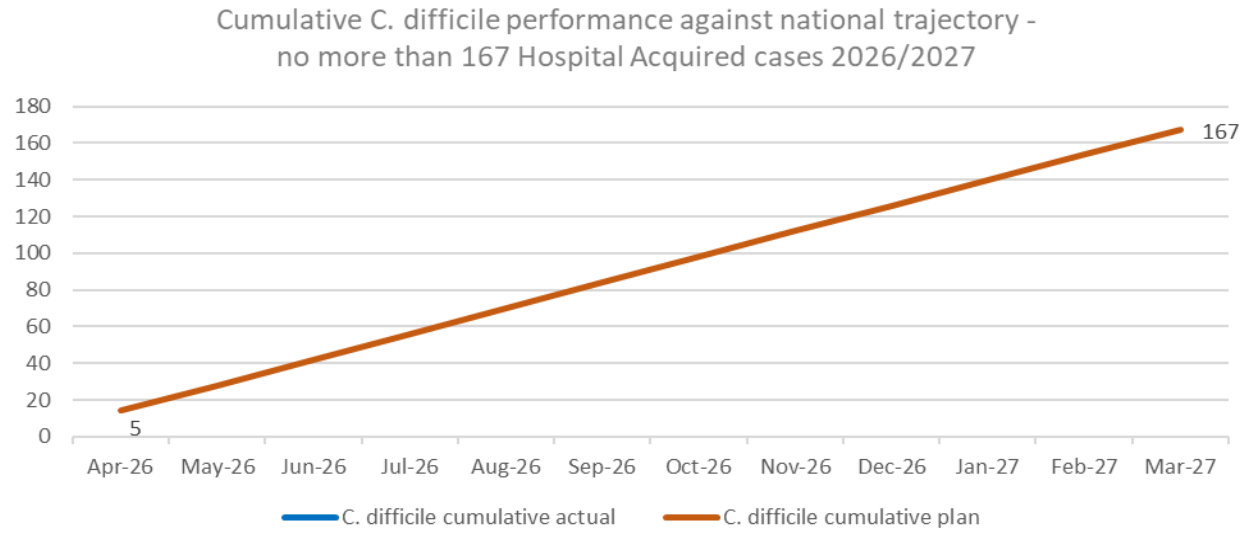
Patients - C Difficile Improvement Programme Assurance



Latest
5
Variance Type
Recent positive pattern in the data
Mar-27 Target
14
Target Achievement
Could both pass or fail target within expected variation



Latest
90.60%
Variance Type
Normal variation - no recent change
Mar-27 Target
98.00%
Target Achievement
Will consistently fail target within expected variation



Latest
68.64%
Variance Type
Recent positive pattern in the data
Mar-27 Target
95.00%
Target Achievement
Will consistently fail target within expected variation

Metric	Summary	Action	Assurance
C. difficile performance against national trajectory - no more than 167 Hospital Acquired cases	During April 2026 there was a total of 5 cases for the month, with a total of 5 cases for 2026 / 2027 to date. The Trust's National objective for 2026/2027 has not been set, therefore the previous year's objective will be used until it is released (167 cases) The focused work on CDI reduction and the improvement plan continues to be monitored through the Infection Prevention and Control Committee each month and also the Estates and Clinical Partnership Board. The National Standards of Healthcare Cleanliness (2025) for frequency of cleaning is now visible and monitored through the dashboard alongside the quality checks of those areas not yet achieving the frequency of cleaning standards. Current compliance 90.60% for frequency 1 areas, 68.65% for FR 2 area. Due to ongoing vacancy pressures and associated process delays affecting release and recruitment the service cannot deliver further roll out until resources are aligned to the agreed staffing model.	1.Implementation of the approved business case to be compliant in high risk areas with National Standards of Healthcare Cleanliness (2025) - vacancy impacting full roll out across the Trust, escalated and progressing. 2. Continued focus on IPC practice through STAR monthly and accreditation processes each month. 3. Continue to monitor key performance assurance indicators through Infection Prevention and Control committee each month.	1. IPC BAF report reviewed and shared at IPCC for assurance. 2. IPC Dashboard. 3. IPC monthly revalidation audits such as Hand Hygiene, Commodes, Environmental checks and Mattress checks. 4. Monthly reporting into S&Q, IPCC and Divisional IPC meetings, along with bi-monthly reporting into H&S Committee. 5. STAR encompasses IPC audits and cleaning checklist compliance, with all audit information available within AMAT. 6. NHS England review of IPC assurances. 7. Antimicrobial stewardship oversight and assurance reporting.



Patients

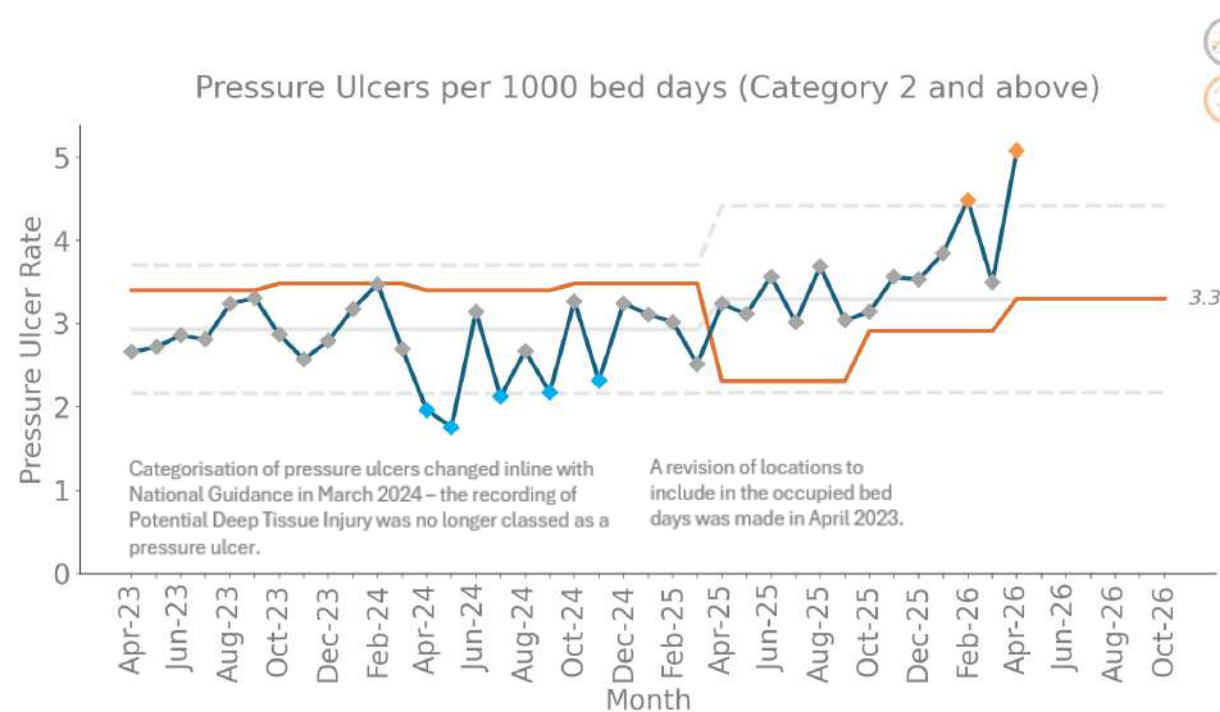
Performance

People

Productivity

Partnerships

Patients - Pressure Ulcers Assurance



Latest
5.08
Variance Type
Recent concerning pattern in the data
Mar-27 Target
3.30
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
Pressure Ulcers per 1000 bed days (Category 2 and above)	Pressure ulcers remain a key indicator of care quality and performance continues above the revised Trust threshold. A comprehensive improvement plan is in place focusing on prevention, consistent standards and strengthened review processes. Oversight has been enhanced through the Pressure Ulcer Panel, supporting cross-divisional learning, alongside pressure ulcer risk reduction rounds led by the Tissue Viability Team, which provide proactive intervention, real-time feedback and education to ward teams. A data quality issue has also been identified relating to the inclusion of incidents that have subsequently been rejected. This is currently under review, with work underway to implement a solution and ensure accuracy of reporting. These measures strengthen oversight and support early intervention while performance remains above target.	1. Monthly sharing of cross-divisional learning, key themes and trends through Always Safety-First (ASF) meetings (from January 2026). 2. Quarterly thematic review of high-incidence pressure-ulcer areas, with findings fed back into monthly ASF meetings to ensure responsive action. 3. Pressure Ulcer Review Panel to review harms, identify themes and trends, and generate actions to improve practice (commenced November 2025). 4. Pressure ulcer risk reduction rounds lead by the tissue viability team, shifting to a proactive assurance model (commenced March 2026). 5. Review and strengthen data quality processes to address the inclusion of rejected incidents within reporting, system/process improvements to ensure accuracy and reliability of pressure ulcer data.	1. Divisional Always Safety First Committees provide oversight of the pressure ulcer improvement plan and monitor progress against key actions. 2. Monthly monitoring of pressure ulcer incidence continues as a priority quality metric, with trends reviewed at divisional and Trust level. 3. STAR compliance for key questions 8d and 9c is monitored monthly as leading indicators of prevention practice. 4. Weekly Pressure Ulcer Panel, with a consolidated monthly learning report submitted to PSIRF Oversight. 5. Monthly oversight group for review and monitoring of actions from Pressure ulcer panel with division leadership representative.

Patients - Always Safety First Assurance - Mortality

Achievement	Position	Month
Lower Than Expected	73.9	December 2025
Lower Than Expected	69.3	December 2025
As Expected	291.2	December 2025
As Expected	364.9	December 2025

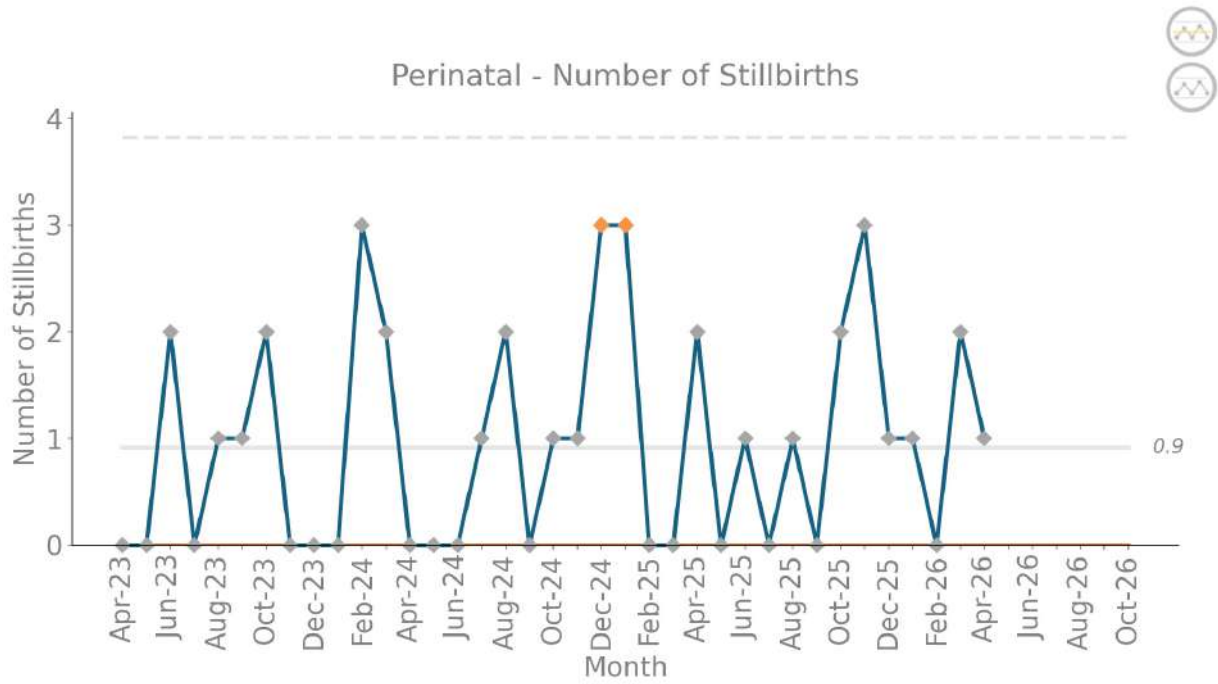
Hospital Standardised Mortality Ratio - Adult
Standardised Mortality Ratio - Relative Risk - All Diagnoses Adult
Standardised Mortality Ratio - Relative Risk - All Diagnoses Child (<1 day – 17 yrs)
Standardised Mortality Ratio - Relative Risk - All Diagnoses Neonates (<1-28 Days) <i>The updated TELSTRA model from November 2024 does not include still births</i>

Source Data: Telstra (Dr Foster)

Metric	Summary	Action	Assurance
Hospital Standar dised Mortality Ratio - Adult	HSMR is within Upper and Lower Control Limits and lower than expected when compared to peers.	1. Continue with structured judgement review process. 2. Use mortality reviews to establish themes where care or experience could be improved. 3. Continue to work with the medical examiners office to review deaths in line with guidance. 4. Continue to use incident reporting processes where an incident occurs under Patient safety Incident Response Framework (PSIRF). 5. Continue to implement the 10 CNST safety actions for maternity and neonatal 6. Marthas rule (Call for Concern)implementation is underway.	1. Mortality and End of Life committee chaired by Deputy Chief Medical Officer with responsibility for mortality. 2. Twice annual reports to safety and Quality committee. 3. Telstra system utilised to generate mortality data ensuring objective peer data is used to establish reported key performance indicator. 4. Speak Up arrangements are well established in the organisation. 5. Maternity Neonatal report provides assurance of compliance with Maternity neonate Safety Investigation branch for appropriate cases. 6. The Child Death Overview process ensures peer review takes place of all child deaths and is reported through the annual safeguarding report and the mortality reporting arrangements. 7. ED and maternity and neonatal safety forums in place with executive leads identified to encourage speak up in high risk areas. 8. Dr Foster (reverted back from TELSTRA) data will be used to review individual conditions which alert on the HSMR SHMI data. A narrative will be included in Mortality Reports to Safety and Quality Committee. 9.The Trust has been validated against all 10 CNST maternity and neonatal safety actions and is now progressing through the formal sign-off process. 10.Further Dr Foster training sessions will be provided for LTHTR in 2026 -2027.
Standardised Mo rtality Ratio - Relative Risk - All Diagnoses Adult	SMR is within Upper and Lower Control Limits and lower than expected when compared to peers.		
Standardised Mo rtality Ratio - Relative Risk - All Diagnoses Child (<1 day – 17 yrs)	SMR (Child <1 day -17 Years) (All Diagnoses) is within Upper and Lower Control Limits and within expected range compared to peer.		
Standardised Mo rtality Ratio - Relative Risk - All Diagnoses Neonates (<1-28 Days)	SMR (Neonatal <1 day -28 days) (All Diagnoses) is within Upper and Lower Control Limits and within expected range compared to peer.		



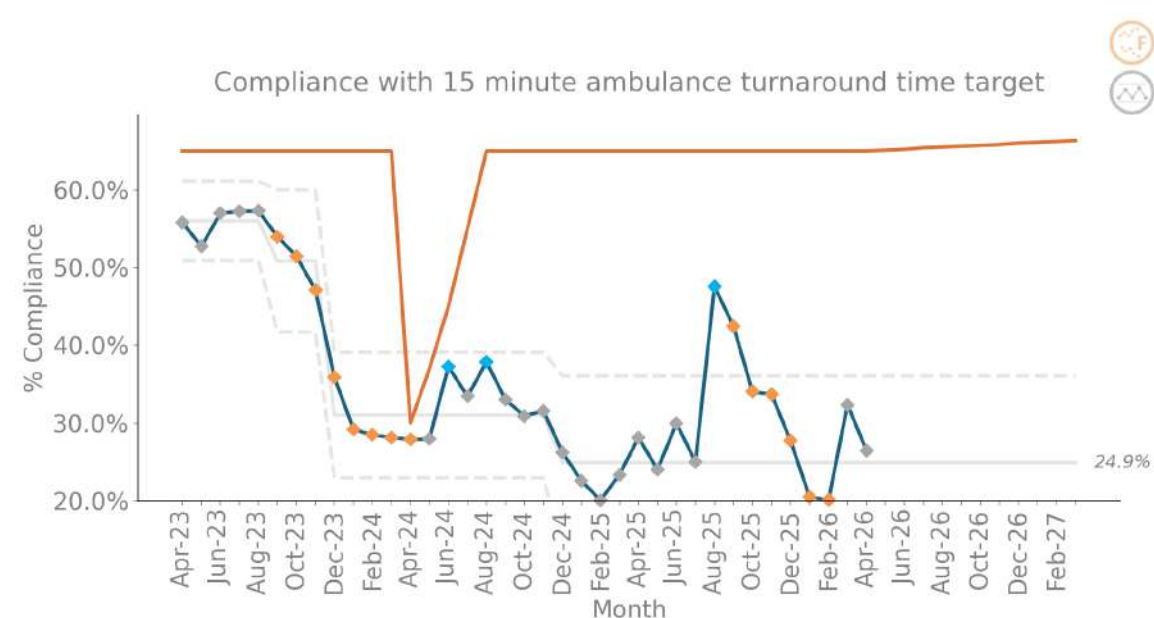
Patients - Stillbirths Assurance



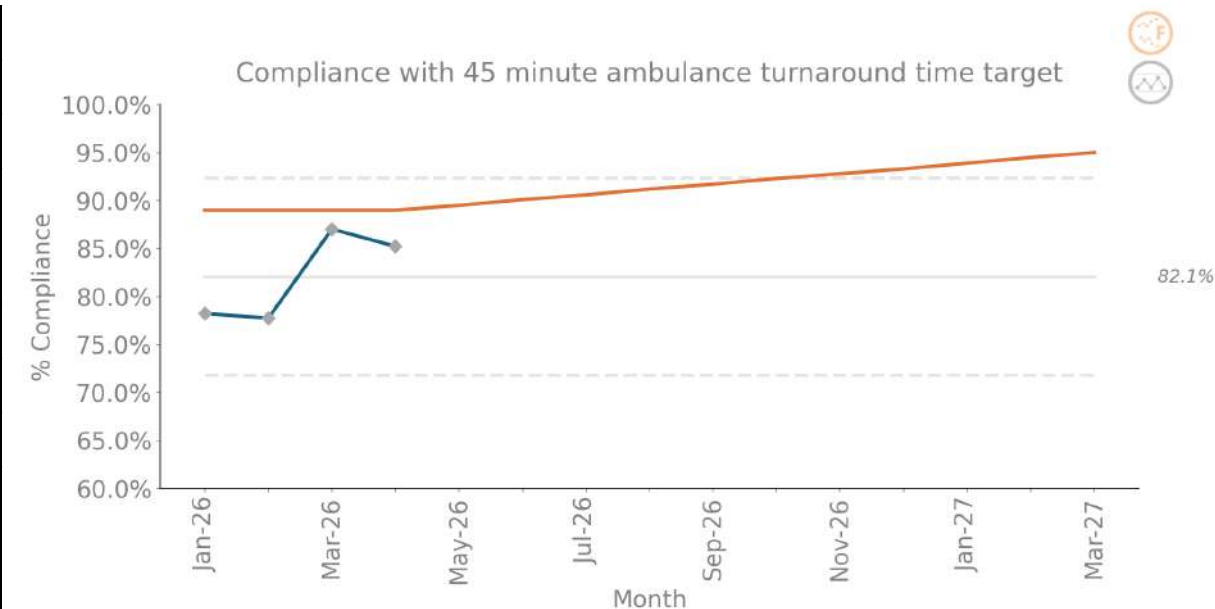
Latest
1
Variance Type
Normal variation - no recent change
Mar-27 Target
0
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
Perinatal - Number of Stillbirths	The service continues to track the rates of stillbirth and review each case in line with national guidelines and reporting requirements. In April 2026 there was one case. The 12-month local average mean still birth rate is 2.1 per 1000 (May 2025 to April 2026 excluding TOPFA) which remains below the national average of 3.9 per 1000 births.	1. Implementation of the Maternity Incentive Scheme (MIS Year 8) safety standards. 2. Implementation of Single Improvement Plan (SIP) actions to improve outcomes for mothers, babies and families. 3. Report all cases via Submit a Perinatal Event Notification (SPEN) 4. Use National Maternity Dashboard analysis to review to provide peer comparison data for continuous improvement	1. Perinatal Quality Surveillance dashboard analysis shared via the maternity and neonatal safety report (to Trust Safety and Quality Committee). 2. Peer comparison data included within the reporting for oversight 3. National MBRRACE reporting provides overview of national themes to ensure learning is understood. 4. The Maternity Outcomes Signal System (MOSS) is now in place which provides real-time monitoring of key maternity outcome—such as term stillbirths, to detect early warning signals and prompt rapid intervention

Performance - UEC Assurance



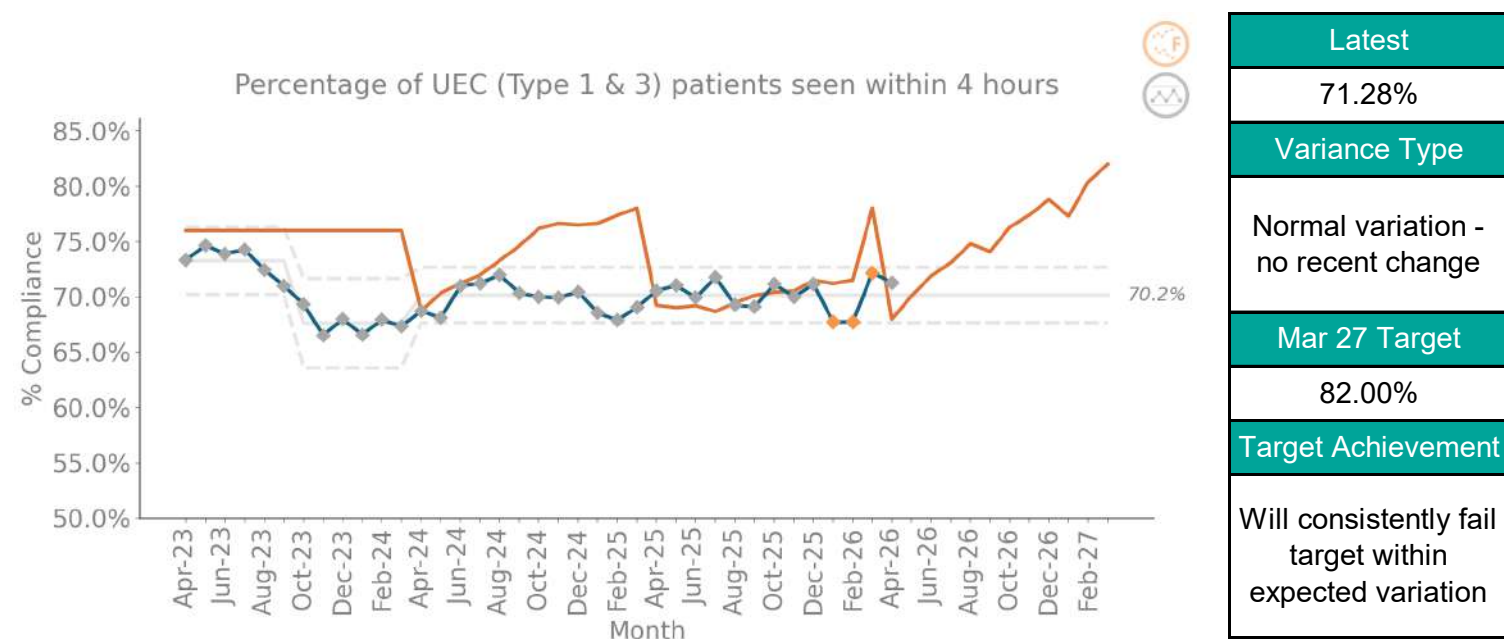
Latest
26.49%
Variance Type
Normal variation - no recent change
Mar 27 Target
66.3%
Target Achievement
Will consistently fail target within expected variation



Latest
85.23%
Variance Type
Normal variation - no recent change
Mar 27 Target
95%
Target Achievement
Will consistently fail target within expected variation

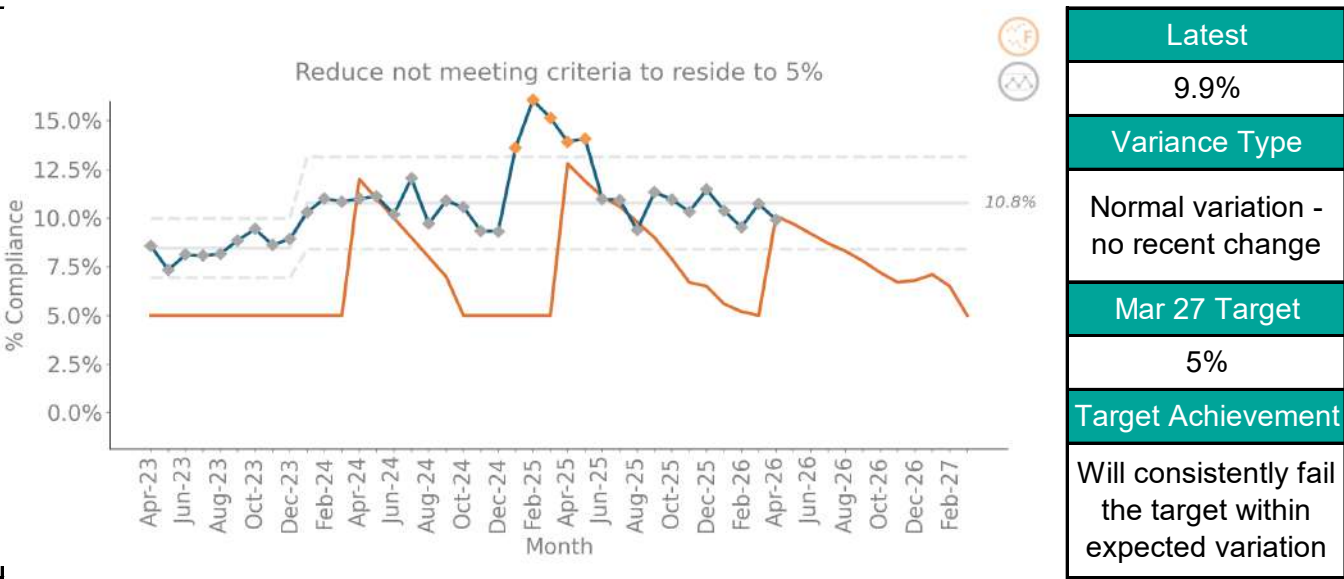
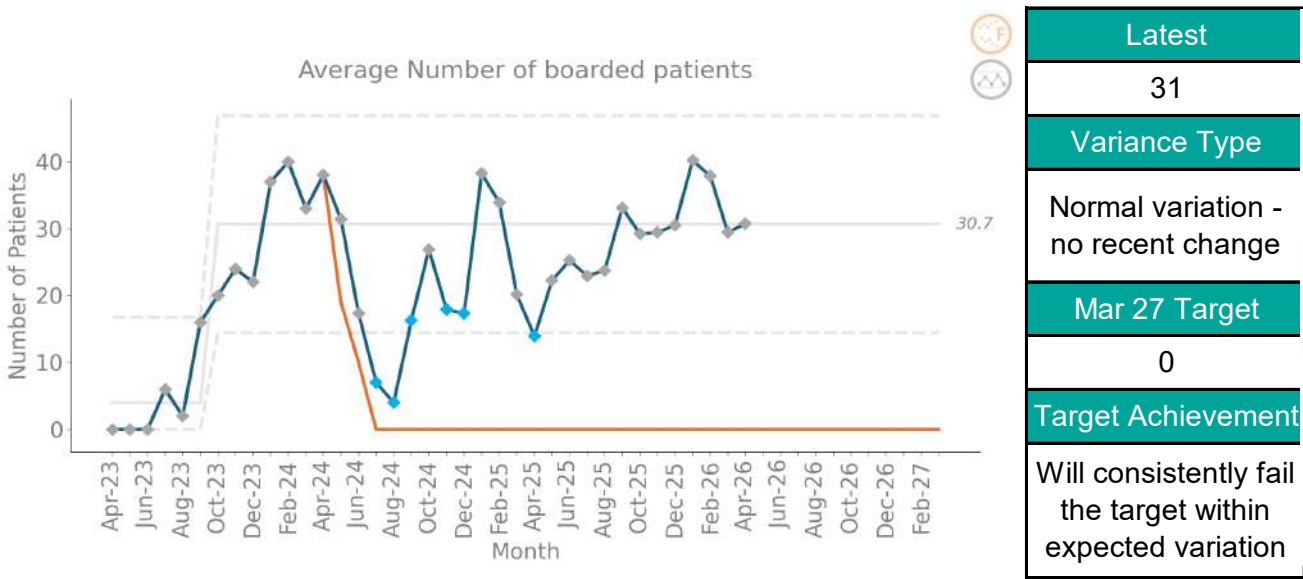
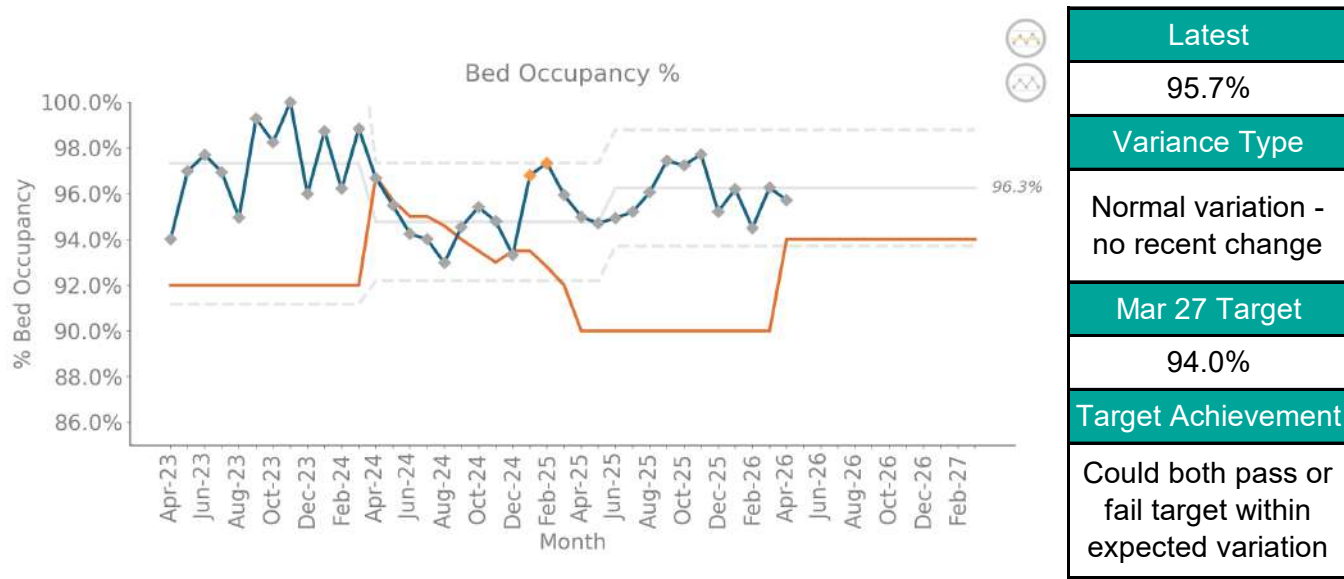
Metric	Summary	Action	Assurance
Percentage of Ambulance Handovers within 15 minutes - Trust	In April 26.49% of patients were handed over from NWAS within 15 minutes, a deterioration of -5.81%, after a significant improvement the previous month. However the current position shows normal variation and could either pass or fail the target within expected variation.	Ambulance handover delays remain a high priority, linked with SDEC and EEMAC actions these will see improved flow from the ED and reduce handover delays. Additionally work continues within the DKAFH programmed with a MADE event taking place in early May and learning informing changes into routine practice to drive reduced bed days. Development of a multi agency Transfer of Care hub commenced on 18th May 26 with trusted assessor practices established which support step up admission into IMC. The anticipated impact from the establishment of the Transfer of Care hub is a 1 day LOS reduction for DKAFH patients in pathways 1-3. This alongside continued work on Ward and Board round processes and continued DKAFH improvement roll out will aim to see lost bed days for optimised patients reduced to within target by end March 27.	Monitoring of ambulance demand is undertaken via the weekly Ambulance handover group. Comparison to both the national and regional performance positions for April 26 indicates that the Trust is below the national performance of 36.9% for 15 minute handovers and above the NW performance position of 29.9% of handovers within 15 minutes.
Percentage of Ambulance Handovers within 30 and 45 and 60 minutes - Trust	In April 382 patients waited between 30-60 minutes to be handed over from NWAS to the Trust, a slight increase of 23 from last month. 230 patients waited over 60 minute to be handed over from NWAS to the Trust in April, an increase of 39 compared to the previous month. In April 85.2% of patients were handed over within 45 minutes, a 1.8% deterioration compared to the previous month.		Monitoring of ambulance demand is undertaken via the weekly Ambulance handover group. Comparison to both the national and regional performance positions for April 26 indicates that the Trust is below the national performance position of 77% for 30 minute handovers and slightly below the NW performance position of 74%.

Performance - UEC Assurance



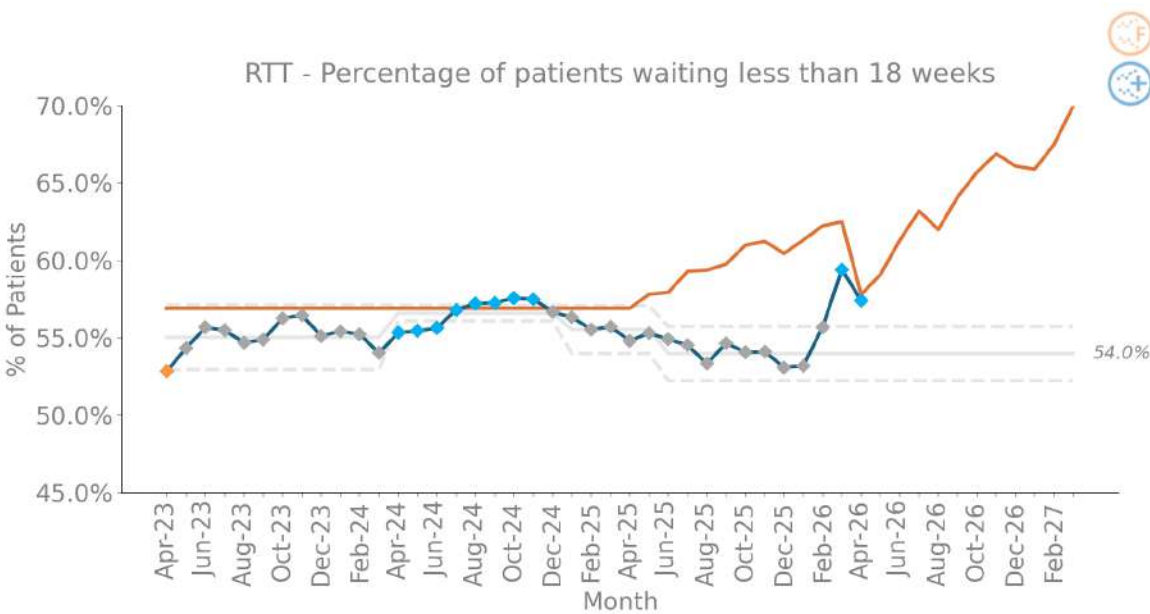
Metric	Summary	Action	Assurance
ED 4 Hour Performance - Trust	Performance against the national 4 hour access standard deteriorated slightly in April 2026. The performance improvement was -0.9% compared to March. Performance is above the Operational Plan target for Apr 26. April 26 experienced a higher daily attend than March 26 of approximately 17 per day.	Key actions include increasing 'Fit to Sit' practices, improving data capture with NNAS, and increasing flow out of ED via continuous flow 'cycles' every 30 mins to AMU. Workforce modelling undertaken with plans to better align rotas with demand from July 26. Scoping underway to implement Extended Emergency Medicine Ambulatory Care facility (national model) with Q2 implementation ambitions	Improvements have been seen in SDEC activity throughout 2025, although not yet achieving the stretch target. Virtual ward occupancy has improved since Aug 25 but is not yet reaching target or showing an embedded improvement. Deflections into community services via 2UCR have increased month on month since Sept 25. Comparison of 4 hour performance to the latest published national benchmarks indicates that the Trust is below the national average for April 26 of 76.9% and was ranked 90 out of 118 trusts nationally.
Maximum wait of 12 hours as Total Time in Department (Type 1 and 2)	The number of patients waiting over 12 hours (admitted and non-admitted Type 1 only) in ED increased in April to 12.75%, an increase of 0.04% compared to March. The position remains slightly above the revised Operational Improvement plan.	Work continues within the DKAFH programme. MADE event held in May 26 - learning informing changes to routine practice. Multi-agency Transfer of Care hub commenced 18th May 26 with trusted assessor practices supporting step-up admission into IMC. Anticipated 1 days LOS reduction for DKAFH patients in pathways 1-3. Target: lost bed days for optimised patients reduced to target by end March 27.	Overall Bed Occupancy was at 95.7% with a range between 92% - 97% over the last 12 months. The level of boarded patients increased in April with an average of 31 patients per day. The volume of Days Kept Away from Home patients is slightly below the revised operational plan target but is consistent with the same period in Apr 25 Comparison within Model Health System indicates the Trust is above the provider median and within Quartile 3.

Performance - UEC Assurance

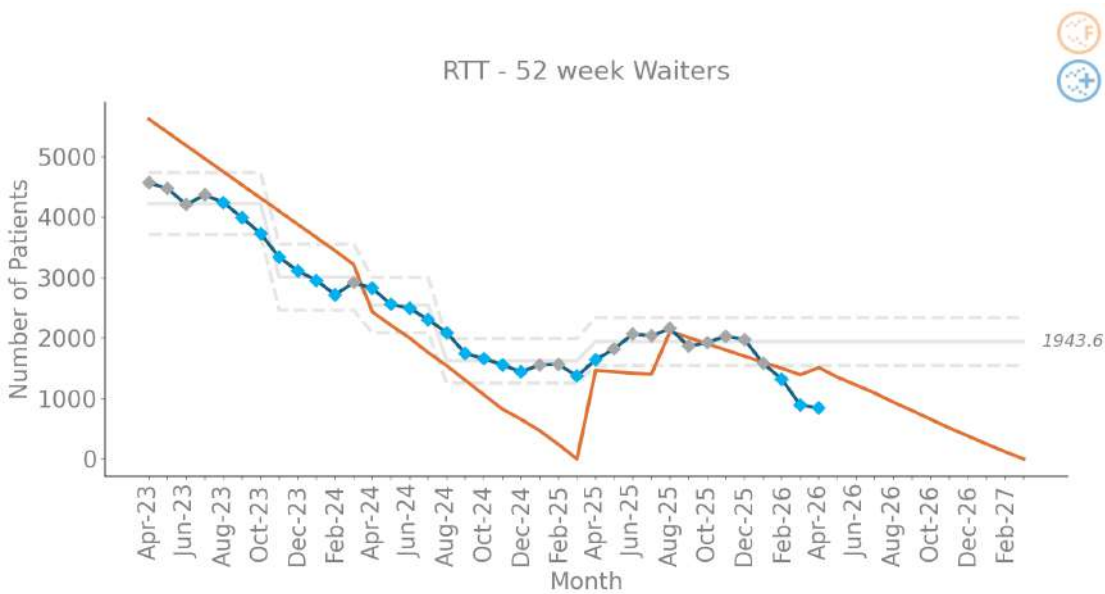


Metric	Summary	Action	Assurance
Bed occupancy %	The position shows an occupancy rate for April 26 of 95.7%, a drop of 0.6% compared to March 26. The data shows normal variation and will consistently fail the target.	Bed occupancy remains significant above target. Work continues linked to the DKAFH programme. A MADE event which took place in early May provided learning and is informing changes into routine practice to drive reduced bed days. A multi-agency Transfer of Care hub commenced on 18th May 26 with trusted assessor practices established to support step up admission into IMC. The anticipated impact is a 1 day LOS reduction for DKAFH patients in pathways 1-3. Continued work on Ward and Board round processes alongside DKAFH improvement roll out will aim to see lost bed days for optimised patients reduced to within target by end March 27.	Assurance via the Urgent Care Improvement Board and Urgent Care Improvement Plan
Average Number of Boarded Patients	On average 31 patients were boarded each day across both sites during April 26 with 922 associated bed days. This is a slight increase compared with the March 26 position. These are predominantly medical patients requiring admission to an acute medical ward. The position shows normal variance and will consistently fail the target within expected variation.	Work continues within the DKAFH programme with a MADE event taking place in early May and learning informing changes into routine practice to drive reduced bed days. A development of a multi-agency Transfer of Care hub commenced on 18th May 26 with trusted assessor practices established to support step up admission into IMC. The anticipated impact from the establishment of the Transfer of Care hub is a 1 day LOS reduction for DKAFH patients in pathways 1-3. This alongside continued work on Ward and Board round processes and continued DKAFH improvement roll out will aim to see lost bed days for optimised patients reduced to within target by end March 27.	Incident levels of harm are monitored on a monthly basis alongside patient feedback. UEC and In-patient survey feedback does reflect patient concerns regarding the practice of boarding. This is also reflected within the staff survey.
Reduce NMC2R to 5%	The number of patients in our hospitals that do not meet the nationally defined clinical criteria to reside for inpatient care in acute hospitals (NMCTR) decreased in April (9.9% = daily average of 85 patients). Compared to the March position this is a decrease of 0.8%. Whilst the levels are within normal variation the data suggests a consistently failing target despite data to evidence the success of the strengths based work reducing demand.		Monitoring of NMC2R data is undertaken via the Central Lancs Urgent Care Delivery Board

Performance - Elective Care Assurance



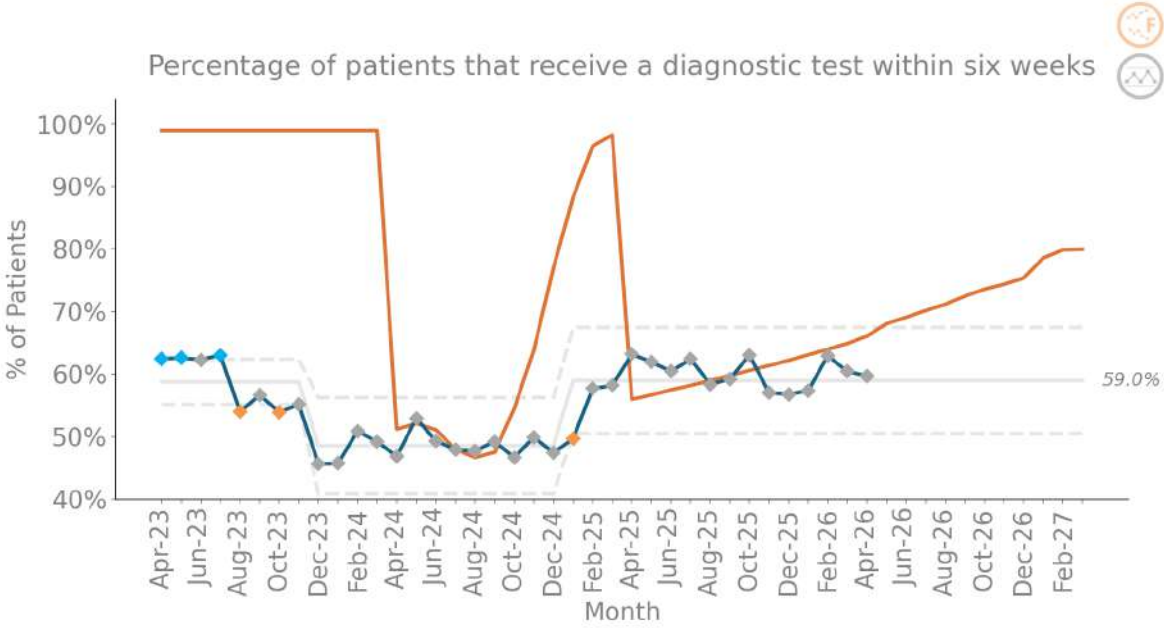
Latest
57.40%
Variance Type
Recent positive pattern in the data
Mar 27 Target
70.00%
Target Achievement
Will consistently fail target within expected variation



Latest
840
Variance Type
Recent positive pattern in the data
Mar 27 Target
0
Target Achievement
Will consistently fail target within expected variation

Metric	Summary	Action	Assurance
Percentage of patients waiting less than 18 weeks	The April 26 position of 57.4% is a 2% deterioration compared to March 26 %. Analysis suggests a recent positive pattern in the data and that the target will be consistently failed. The Operational Plan 2026/27 year end target has been set at 70%.	Ongoing work with digital partners to ensure capacity for ambitious PIFU rollout for constitutional standards and outpatient transformation. Additional activity mobilising via Independent Sector and WLIs. Internal business case undergoing Executive Check and Challenge. DNA rates reduced by 0.6% and theatre utilisation increased by 2.5% versus March 26.	Comparison to the latest national performance position (Mar 26) indicates that the Trust is below the national position of 65.3% waiting under 18 weeks. The Trust is ranked 107 out of 118 trusts nationally for Mar 26 performance.
RTT - 52 week Waiters	The over 52 week waiter position in April was 840, a further decrease of -56 compared to the March position. Analysis suggests a recent positive pattern in the data and that the target may be consistently failed.	Weekly 52 week breach reduction targets are in place for all specialties and is monitored at the weekly COO led Operations Board. Close monitoring of breach risks and capacity shortfalls are in place.	Local monitoring of all speciality RTT clock stop/performance is undertaken via the weekly Operational Board Comparison to the latest national performance position (Feb 26) indicates that the Trust at 1.4% is above the national picture which is 1.3% waiting over 52 weeks. The Trust was ranked 79 out of 118 trusts that submitted data for Mar 26 performance.

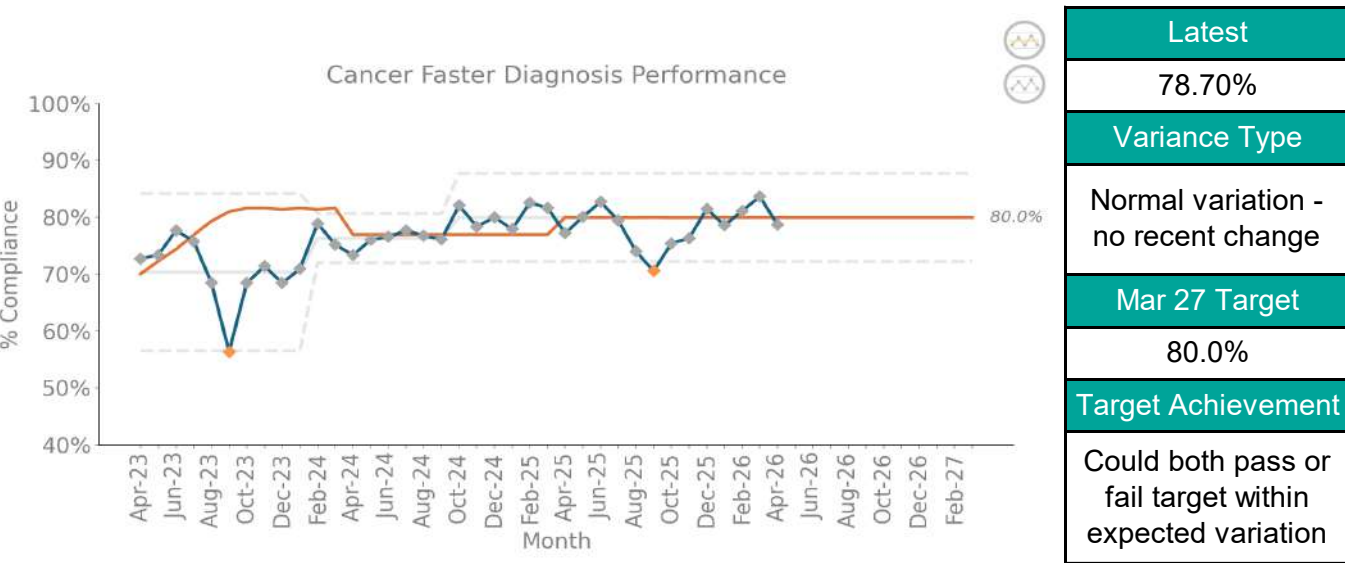
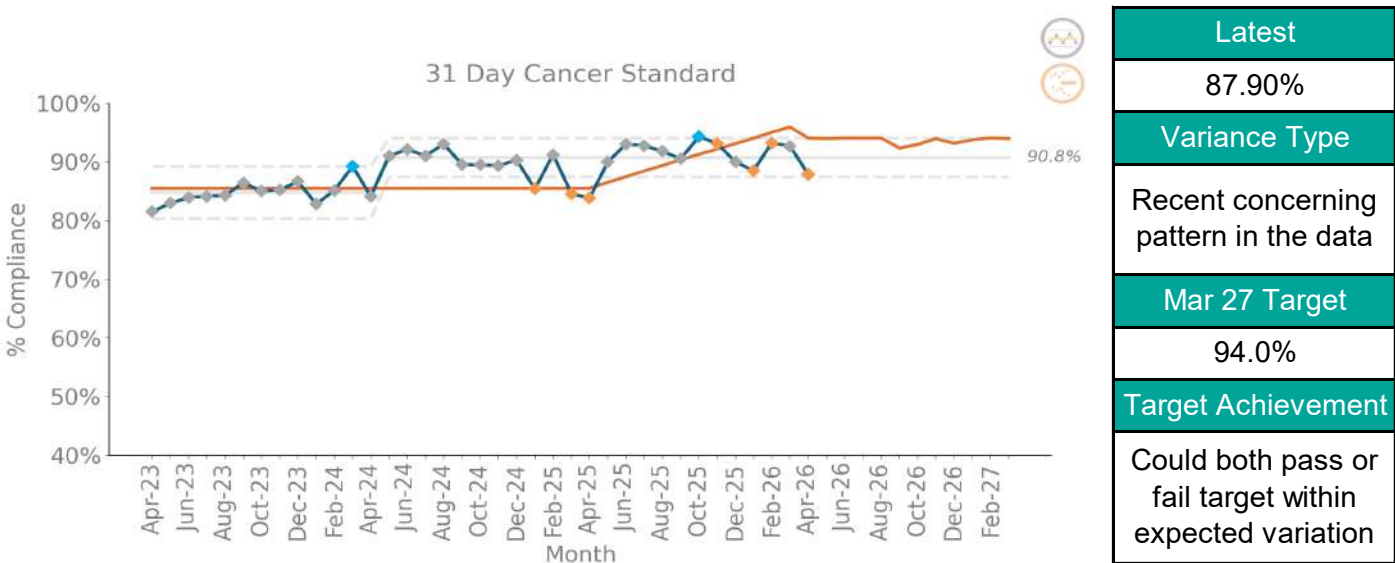
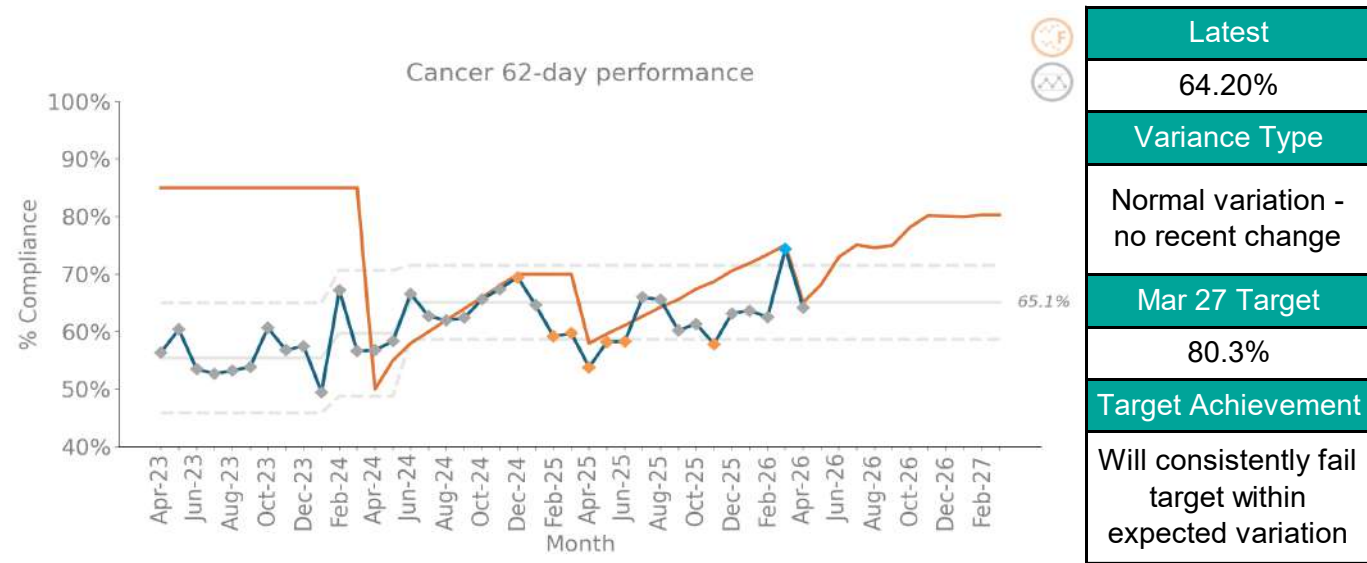
Performance - Elective Care Assurance



Latest
59.73%
Variance Type
Normal variation - no recent change
Mar 27 Target
80.00%
Target Achievement
Will consistently fail target within expected variation

Metric	Summary	Action	Assurance
Percentage of patients that receive a diagnostic test within six weeks	Diagnostic under 6 week performance was 59.73% in April compared to 60.45% in March, a 0.7% deterioration on the March position and below trajectory. The performance has been driven by a deterioration in Audiology, NOUS, Sleep Studies. Urgent and cancer patients are prioritised and seen within 2 weeks. Performance shows normal variation but may consistently fail the target.	NOUS is the main driver of performance deficit. Additional capacity sourced via IS provider, mobilised mid-Feb 26. Internal colleagues undertaking additional work but shortfall remains. Capacity and demand modelling completed: resource case in development with alternative provisions being explored.	The areas of focus are capacity optimisation, productivity, transformation and system working. Review of the latest published data (Mar 26) indicates that LTH is 109th out of 117 trusts that submitted data, the worst performing Trust in the ICB and significantly below the national average of 78.8%.

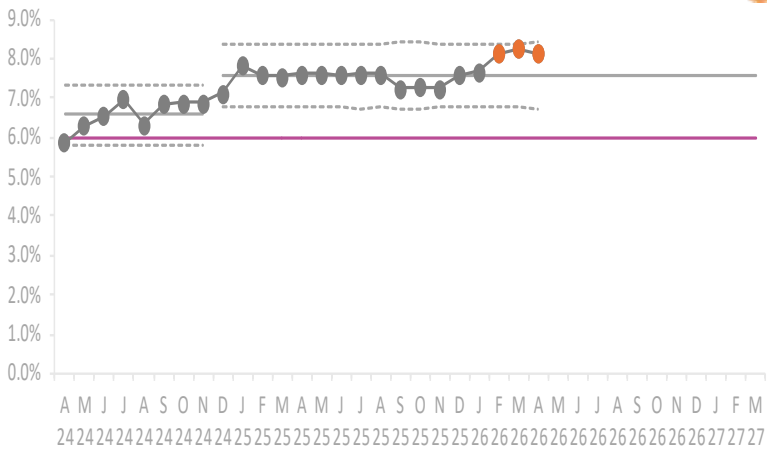
Performance - Elective Care Assurance



Metric	Summary	Action	Assurance
62 Day Cancer Standard	Performance to the end of April 26 (currently unvalidated) has deteriorated compared to last month, and is slightly below the revised monthly operational plan target of 65.1%. Analysis shows normal variation in the data and will consistently fail the target.		March 26 performance exceeded target for 62-day ad FDS. Trust ranked in top quartile nationally. 18% improvement versus Apr 25 in 62-day performance. 5th largest year-on-year improvement nationally.
31 Day Cancer Standard	Performance to the end of April 26 (currently unvalidated) is below last months position, and below the monthly operational plan target of 94.1%, however is expected to improve once validation is complete. Analysis shows a recent concerning pattern in the data and could both pass or fail the target within expected variation.	Whilst Cancer performance is improving there remains a close focus on individual tumour group improvement plans. Capacity and demand modelling has been completed for the majority of specialties. A Cancer dashboard is in development with the first specialty now live and plans are in place to roll out for all tumour groups by the end of September which will provide live information to inform improvement plans. A Trust wild PTL weekly review has been implemented to track patient pathways. A Reducing Sleepless Nights campaign to provide a core focus on the waits patients experience whilst on a cancer pathway has been launched.	31 day Decision to Treat performance a focus this year, with the requirement to reach 94% by the end of this year and then achieve 96% Operational standard in the following year. The Trust's latest position for this standard is 93.3%, having made a 7.5% points year on year improvement over the last year, putting the Trust in a strong position to achieve this years 94% target.
Cancer Faster Diagnosis Performance	Performance to the end of April 26 (currently unvalidated) is below last months position, and just below the monthly operational plan target of 80%, and is expected to improve once validation is complete. Analysis shows normal variation and could both pass or fail the target within expected variation.		Faster Diagnosis Standard performance is 83.5% with the year end target of 80% achieved, and performance nearly 2% points higher than a year ago. The Trust is in the top quartile nationally ranking 28th/118.

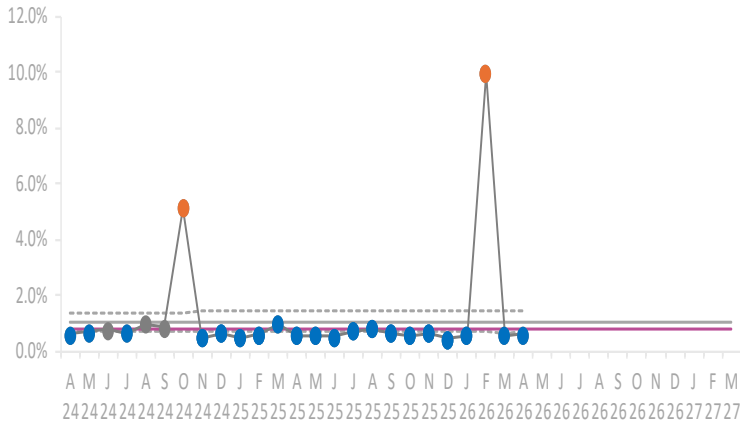
People - Workforce Assurance 1

GL Vacancy Rate (% FTE)



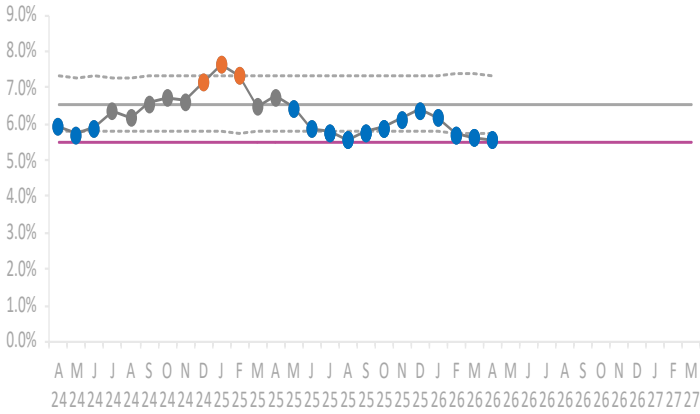
Latest
8.13%
Variance Type
Recent concerning pattern in the data
Mar 27 Target
≤ 6%
Target Achievement
Will consistently fail target within expected variation

ESR Turnover (% FTE)



Latest
0.62%
Variance Type
Recent positive pattern in the data
Mar 27 Target
≤ 10%
Target Achievement
Could both pass or fail target within expected variation

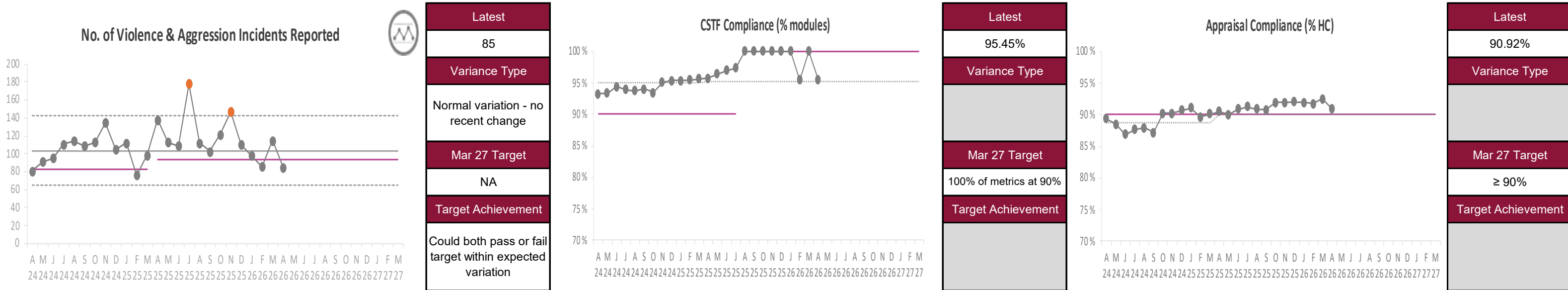
Overall Sickness (% FTE)



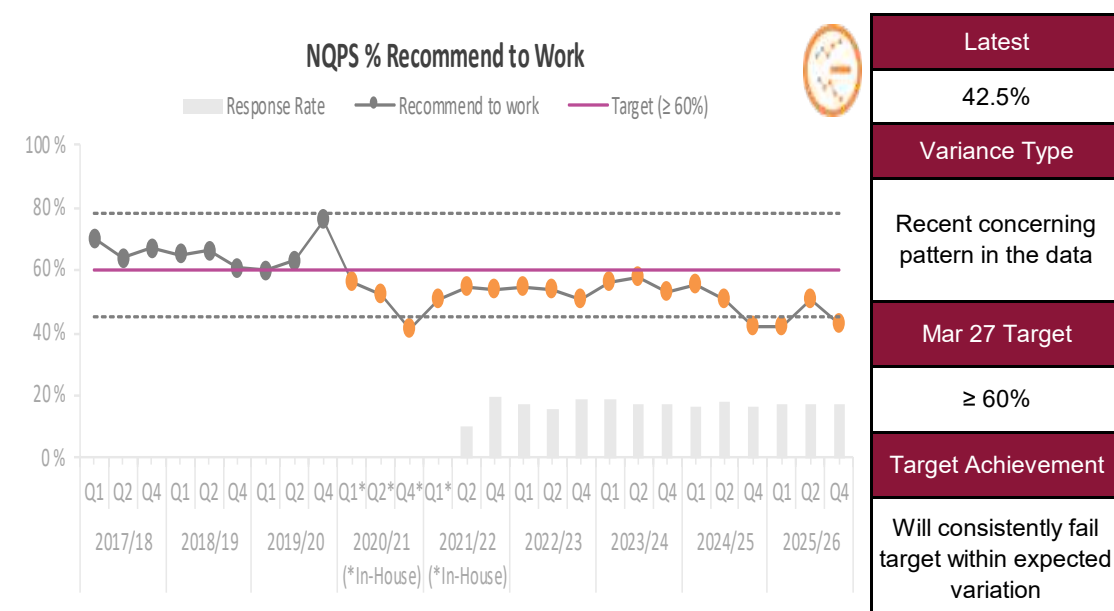
Latest
5.57%
Variance Type
Recent positive pattern in the data
Mar 27 Target
≤ 5.5%
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
Vacancies (% FTE)	Vacancy rate remains high due to vacancy control measures and is not currently scored from a Divisional Improvement Forum perspective.	Divisional management teams reviewing all long-standing vacancies enabling cleansing of establishments Strategies to address Band 3 Healthcare Support Worker gaps being jointly developed by nursing, education and workforce teams Vacancy control process updated to include defined times for holding posts for redeployment and internal/external advertising. Internal first approach to advertising vacancies.	Vacancy rate monitored through Board reporting, Workforce Committee and Divisional Improvement Forums Safe staffing levels monitored daily in clinical areas New People Operations Group to include a focus on resourcing EQIA process utilised to support vacancy control decision-making
Turnover (% FTE)	Turnover remains stable and below tolerance level at 0.62%. Spike in turnover in M11 was due to F&E TUPE.	To refresh strategic actions relating to turnover, which will include a focus on turnover in HCAs, understanding workplace motivators and retention needs based on generational and career point stages. To increase scrutiny of probationary process.	Annual retention strategy update report provided to Workforce Committee. Delivery of retention strategic action plan at corporate level, working with Divisions, Departments and Teams to support improvement in hot spot areas.
Sickness Absence (% FTE)	Sickness absence has reduced in M1 to 5.57% just slightly over our 5.5% target.	The Sickness Absence Reduction Plan has been refreshed for 2026/27, focusing on key actions in the domains of Data, Education, Policy and Process and Wellbeing. Following a reduction in the annualised sickness absence rate of 0.54% for 2025/26, the focus is now on the interventions that will support a further reduction of 0.5% for 2026/27.	Twice yearly assurance reports to Workforce Committee Actions resulting from the MIAA Sickness Absence Management audit monitored through Audit Committee 'Failure to manage sickness absence management effectively' is a Principal Risk and subject to monthly risk management review Fortnightly sickness absence task and finish group in place to monitor actions of the sickness absence reduction plan Paper to May TMB outlined actions completed, ongoing or newly developed.

People - Workforce Assurance 2



Metric	Summary	Action	Assurance
Number of violence and aggression incidents toward staff	Violence and aggression incidents have reduced in month.		Twice-yearly deep dive reports around incidents and actions to Workforce Committee Incident data reviewed through Health & Safety Governance Group
Core Skills Mandatory Training compliance (% modules)	Overall Trustwide Core Skills and Mandatory training compliance is 95.45%	Bi-weekly weekly grip and control meetings are supporting targeted work to ensure those areas of non-compliance are supported to achieve the requirements. Non-compliant staff receive weekly email reminders. Divisional performance is presented by professional group in divisional workforce committees.	Trustwide compliance is meeting the 90% threshold in all core skills and nationally mandated metrics.
Appraisal compliance (% HC)	Appraisal compliance was 90.92% in April which is above the target of 90%.	Actions will focus on increasing use of objectives and personal development planning in appraisal, guidance is being developed to support appraisers to tailor their conversation based at the career and lifestage of appraisees.	Annual Appraisal Update presented to Workforce Committee in May 2026. Divisional Performance metrics shared in Divisional Workforce Committees and Divisional Improvement Forums.



Metric	Summary	Action	Assurance
Staff Survey: Recommend Trust as place to work	Please note: This is a quarterly metric; therefore, there is no update this month. Levels of advocacy with regards to recommending the organisation as a place to work and be cared for has further declined.	To further implement and embed Staff Engagement Proposal and demonstrate / communicate visible action taken in response to colleague voice. Organisation wide and divisional level action plans have been developed and presented to Workforce Committee in May 2026.	Workforce Committee reports detailing the programme of work in response to NHS Staff Survey data and national benchmarking. Delivery of the corporate action plan progressed through collaboration with relevant teams and leads addressing priorities/themes. Divisional action plans are scheduled for monthly review through Divisional Workforce Committees - frequency and depth of reporting varies across Divisions. Enhanced team support activity is ongoing in targeted areas of concern, with progress tracked and reviewed through Organisational Development operational meetings.

Productivity - Assurance



Latest YTD Actual (,000s)
-4,941
Latest YTD Target (,000s)
-4,938
April 26 YTD Target (,000s)
-



Latest YTD Actual (,000s)
446
Latest YTD Target (,000s)
450
April 26 YTD Target (,000s)
60,000

Metric	Summary	Action	Assurance
I&E - Plan v Actual variance	The M1 income and expenditure actual was a £4.9m deficit which is in line with the NHSE Financial Plan. WRP delivery was on plan at £0.5m delivered. The underlying position improvement as at M1 was £2.1m. The financial impact of industrial action in M1 has been assessed at £0.8m, which has been fully mitigated by the transfer of vacancies within the Pathology Single service and a reduction in pay run rate across clinical divisions.	A re-set of the programme structure, governance and reporting for 2026/27 has taken place, including the introduction of the Productivity Board. The system is receiving enhanced support from NHSE as part of the provider improvement programme (formerly recovery support programme). A focus on grip and control activities continues. The Trust commissioned further external support for specific financial recovery plan workstreams and 2026/27 waste recovery programme development.	Grip and control Interventions and control measures Mandated national support from PWC and the Provider Improvement Programme (formerly Recovery Support Programme)
WRP schemes delivery	The Trust's 2026/27 waste reduction target is £60m, 5.7% of operating expenditure. M1 WRP delivery was £0.5m which is in line with the NHSE Financial Plan of £0.5m. However, the full WRP Plan of £60m has not yet been fully developed and if not developed and delivered will present a risk to the delivery of the 2026/27 financial plan.	Have a fully developed WRP Plan by the end of May 2026 in line with the commitment made to the regulator. Good progress is being made towards achieving this. The Trust is now embedding its own project management office structure to have a sustainable solution moving forward. The Trust has enhanced grip and control activities to mitigate slippage in schemes. For 2026/27 the Trust has implemented its Financial Sustainability Plan with areas aligned to Executive Leads, earlier planning and a focus on sustainable expenditure reduction rather than short term benefits.	Productivity board chaired by CFO External support for specific workstreams. Implementation of Divisional Delivery Groups Embedding of PMO Revised governance arrangements for DDGs

10.1 WORKFORCE COMMITTEE CHAIR'S REPORTS FOR CONSIDERATION

A) WORKFORCE DISABILITY EQUALITY STANDARD (WDES) RETURN 2026

● Decision Item

REFERENCES

Only PDFs are attached

 10.1a Workforce Disability Equality Standard Return 2026 Summary Board Part I 4 June 26.pdf

 10.1a Workforce Disability Equality Standard Return 2026 Report Board Part I 4 June 26.pdf



Board of Directors Report

Meeting of the	Board of Directors		4 th June 2026		
	Part I	☒	Part II	☐	
Title of Report	Lancashire Teaching Hospitals NHS Foundation Trust Workforce Disability Equality Standard (WDES) Submission 2026				
Report Author	Gemma Aspinall, Diversity and Inclusion Practitioner				
Lead Executive Director	Neil Pease, Chief People Officer				
Recommendation/ Actions required	The Board of Directors is asked to: receive and approve this report for external publication of our WDES data.				
	Decision	☒	Assurance	☐	Information
Executive Summary	The purpose of this report is to share our Trust’s data and analysis, which will form the submission and subsequent publication of the 2025 Workforce Disability Equality Standard (WDES) for our Trust. It sets out priority areas for action based on analysis of the results which include workforce data and findings from the latest NHS Staff Survey. Our WDES data shows the following key points: • Disability status declarations on our ESR system have decreased overall, however workforce data shows increased representation of disabled colleagues in non-clinical roles and higher clinical pay bands • Non-disabled candidates are slightly more likely to be appointed to roles at our Trust from shortlisting than disabled candidates, though the disparity remains small and within national NHS target range • Disabled colleagues are twice as likely to enter into formal capability processes than their non-disabled counterparts, although numbers are low so caution should be taken in interpretation of the results. • Nearly a third of disabled colleagues (30.5%) experienced harassment, bullying or abuse from patients, service users or the public, a 2% increase on last year • Disabled colleagues were almost twice as likely to experience harassment, bullying or abuse from managers compared to non-disabled colleagues (13.6% compared to 7.4%) • Disabled colleagues remain more likely to experience harassment, bullying or abuse from other colleagues (23%, compared to 15% of non-disabled colleagues) • Reporting of harassment, bullying or abuse has increased among both disabled and non-disabled colleagues over the past year				

	• Colleague confidence in equal career progression and promotion opportunities has declined for all staff, with a significant drop for disabled colleagues (from 53.8% to 47.7%) • Reports of feeling manager pressure to attend work despite ill health have increased, with a sharper rise among disabled colleagues (22.7% to 30.1%) • Disabled colleagues are significantly less likely to feel valued, with only 28.4% expressing they felt our Trust values their work, compared to 44.5% of non-disabled colleagues • Satisfaction with workplace adjustments among disabled colleagues has declined slightly, falling from 79.1% to 77.1% over the past year • Staff engagement scores have decreased slightly across all staff in this reporting year. The Committee is asked to review and approve the contents of the report for publication.	
Link to Strategic Objectives 2025/26	Patients – deliver excellent care: Improve outcomes, reduce harm and deliver a positive patient experience.	☐
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.	☐
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.	☒
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.	☐
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.	☐
Due Diligence	To give the Trust Board assurance, please complete the following:	
Committee Approval:	Name of Committee: Workforce Committee	Date: 12 th May 2026
Operational Group Review:	Name of Operational Group: Trust Management Board	Date: 13 th May 2026
Link to Board Assurance Framework:	Principal Risk 7 (26/27) - Experience of under-represented staff groups	
Appendices	State whether there are any appendices and list them. For example: Appendix 1: Full Report	

APPENDIX 1 – FULL WORKFORCE DISABILITY EQUALITY STANDARD REPORT

Introduction

Measuring disability equality in the workplace is essential to understanding how inclusive our organisation truly is. The Workforce Disability Equality Standard (WDES) is a mandated requirement for our Trust through the NHS Standard Contract. Launched in April 2019, the WDES provides a nationally consistent framework for measuring and reporting workforce disability equality across NHS organisations.

Now in its eighth reporting year, the WDES enables us to assess progress across ten workforce metrics and ensures we remain accountable for improving the experiences and outcomes of disabled colleagues at Lancashire Teaching Hospitals NHS Foundation Trust (LTHTr) and understand how our organisation performs compared to other NHS Trusts across the country.

Definitions

There are several NHS systems and administrative processes through which personal information is captured, including information relating to disability status. How, when, or whether individuals disclose this information can vary, and may be influenced by personal understanding of disability, confidence in disclosure, and the context in which information is requested.

WDES data is compiled from a number of data sources, including self-reported workforce information. It is recognised that some colleagues may be classed as disabled under the Equality Act 2010 but may not identify as such, or may choose not to disclose this information. Our disability data is shaped by individual disclosure and understanding, and may not fully capture hidden, fluctuating or long-term conditions. Therefore, our recorded disability data may not fully reflect the lived experiences of all colleagues.

Variation across systems and reporting practices means that a degree of caution is required when analysing and interpreting our Trust's WDES data. These factors should be taken into account when reviewing trends, outcomes and comparative findings

WDES Data Sources

The information presented in our WDES report is taken from the following sources:

- Electronic Staff Record (ESR) as of 31 March 2026
- NHS Jobs / TRAC recruitment data: 01 April 2025 – 31 March 2026
- Formal capability process information: 01 April 2025 – 31 March 2026
- NHS National Staff Survey results for Lancashire Teaching Hospitals NHS Foundation Trust: 2025

Please note, our WDES reporting data does not include bank only employees.

Interpreting our WDES Data

The WDES considers data regarding **representation** of disabled colleagues at an NHS organisation, as well as data regarding **experiences** of disabled colleagues and applicants. To interpret our Trust's data

around colleague experience (metrics 4-7), we are using the approach used by NHS England’s national equality team called the four-fifths (or ‘80 percent’) target.

This rule helps us to understand whether organisational practices may have an **adverse impact** on an identified group, e.g. colleagues with a disability. For example, if the relative likelihood of an outcome for one sub-group compared to another is **less than 0.8 or higher than 1.25**, then the process would be identified as potentially having an adverse impact on one of those sub-groups. This will be referred to as the Disparity Ratio throughout the report.

WDES Key Findings

- Disability status declarations on our ESR system have decreased overall, however workforce data shows increased representation of disabled colleagues in non-clinical roles and higher clinical pay bands
- Disabled candidates are slightly more likely to be appointed to roles at our Trust from shortlisting than non-disabled candidates, though the disparity remains small and within national NHS target range
- Disabled colleagues are twice as likely to enter into formal capability processes than their non-disabled counterparts, although numbers are low so caution should be taken in interpretation of the results.
- Nearly a third of disabled colleagues (30.5%) experienced harassment, bullying or abuse from patients, service users or the public, a 2% increase on last year
- Disabled colleagues were almost twice as likely to experience harassment, bullying or abuse from managers compared to non-disabled colleagues (13.6% compared to 7.4%)
- Disabled colleagues remain more likely to experience harassment, bullying or abuse from other colleagues (23%, compared to 15% of non-disabled colleagues)
- Reporting of harassment, bullying or abuse has increased among both disabled and non-disabled colleagues over the past year
- Colleague confidence in equal career progression and promotion opportunities has declined for all staff, with a significant drop for disabled colleagues (from 53.8% to 47.7%)
- Reports of feeling manager pressure to attend work despite ill health have increased, with a sharper rise among disabled colleagues (22.7% to 30.1%)
- Disabled colleagues are significantly less likely to feel valued, with only 28.4% expressing they felt our Trust values their work, compared to 44.5% of non-disabled colleagues
- Satisfaction with workplace adjustments among disabled colleagues has declined slightly, falling from 79.1% to 77.1% over the past year
- Staff engagement scores have decreased slightly across all staff in this reporting year.

Breakdown of Lancashire Teaching Hospitals NHS Foundation Trust WDES Data Set 2025-2026

Metric 1: Representation

WDES Metric 1 considers the percentage of colleagues by disability status in each AfC pay band, Medical and Dental groups, and VSM (including executive Board Members). The table below provides an overview of our Trust’s workforce:

	2024-25	2025-26
Number of staff employed within the organisation	9,471	8,257

Number of staff self-reporting their disability status	655	579
Proportion of disabled staff (%)	6.9%	7.0%

As of 31 March 2026, the Trust Headcount was 8,257. Our data shows that 579 of our colleagues have recorded they have a long-term condition or disability with ESR which equates to 7.0% of our workforce. We understand from the most recent National Staff Survey completion however that 26.6% of colleagues who took part in the staff survey indicated they have a long-term condition/disability (1137 colleagues). If these colleagues updated ESR to reflect their long-term condition/disability, this would support our Trust to collate more accurate data for WDES Metrics 1 and Metric 3 which are in respect of representation and likelihood of entering a formal capability process.

Fluctuations in our workforce may present challenges when interpreting our WDES data, as major workforce change can affect year-on-year comparability of data, limit the scope of trend analysis, and add complexity to the identification of patterns of experience or outcomes. Continued system and service changes may also impact upon action planning over the course of the year. These factors are important to consider when reviewing our WDES data and planning proportionate, meaningful actions.

The tables below show a breakdown of our workforce by NHS Agenda for Change (AfC) pay band, and by Medical and Dental grade:

Agenda for Change Workforce

Disabled Non-Clinical Staff			Disabled Clinical Staff		
	2024-25	2025-26		2024-25	2025-26
<Band 1	100%	0%	<Band 1	11.1%	13.6%
Band 1	-	-	Band 1	-	-
Band 2	6.6%	8.0%	Band 2	7.4%	7.0%
Band 3	10.5%	12.3%	Band 3	8.4%	8.2%
Band 4	10.4%	10.9%	Band 4	12.1%	11.3%
Band 5	10.6%	11.2%	Band 5	6.0%	6.0%
Band 6	3.8%	6.0%	Band 6	7.7%	7.7%
Band 7	5.8%	10.0%	Band 7	5.9%	6.2%
Band 8a	10.9%	11.8%	Band 8a	7.7%	8.3%
Band 8b	12.5%	15.0%	Band 8b	3.2%	0%
Band 8c	5.6%	0%	Band 8c	5.3%	12.5%
Band 8d	0%	10.0%	Band 8d	0%	7.7%
Band 9	0%	0%	Band 9	0%	0%
VSM	0%	0%	VSM	50.0%	50.0%
Total	8.3%	10.4%	Total	6.5%	6.4%

Our workforce data indicates a stronger representation of disabled colleagues within non-clinical Agenda for Change roles, with the proportion of disabled colleagues in these roles increasing by 4% over the past year.

However, it is important to note that the overall headcount of colleagues who have declared their disability status on ESR has decreased compared to the previous reporting year (from 655 to 579). As a result, the observed increase in the proportion of disabled colleagues within non-clinical roles may, in some part, reflect changes in the underlying data set, rather than signify an absolute increase in disabled staff representation.

For clinical roles, this year's data set is largely consistent with last year, however it is interesting to note increases in disabled representation in pay bands 7, 8a, 8c and 8d. While a measure of caution is required

due to the overall decrease in colleagues disclosing their disability status via ESR, it is positive to see increases in representation in leadership levels.

Medical and Dental Workforce

	Disabled Staff 2024-25	Disabled Staff 2025-26
Consultants	1.0%	1.4%
[Consultant] Senior Medical Manager	-	-
Non-consultant career grade	3.2%	1.9%
Trainee grades*	4.2%	3.2%

*Please note this data does not include Lead Employer Medical and Dental Trainees

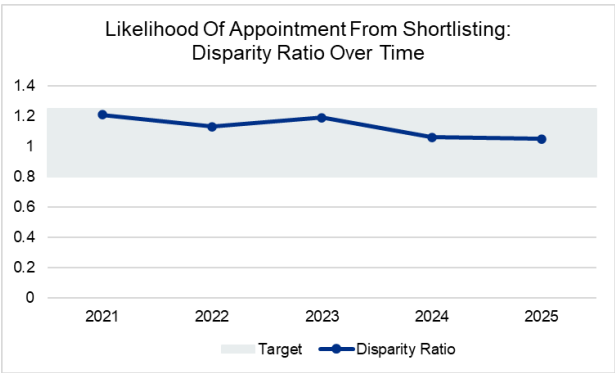
Our medical and dental workforce data shows some change, particularly in the proportion of non-consultant career grade colleagues declaring disability.

As with our data set for Agenda for Change colleagues, observed changes in the proportion of disabled colleagues within medical and dental grade roles may, in some part, reflect changes in the underlying data set, rather than signify an absolute increase in disabled staff representation.

Metric 2: Likelihood of Appointment from Shortlisting

The table below summarises our Trust’s recruitment data for the year 2025-2026. Data for the previous reporting year is included for comparison:

	2024-25	2025-26
Number of shortlisted applicants	5,486	4,337
Total number appointed from shortlisting	1,786	1,388
Number of Disabled applicants shortlisted	474	365
Disabled colleagues appointed from shortlisting	140	111
Relative likelihood of appointment from shortlisting for:		
a) Disabled colleagues	a) 29.5%	a) 30.4%
b) Non-disabled colleagues	b) 31.4%	b) 31.8%
Disparity ratio	1.06	1.05



The disparity ratio for this WDES Metric shows that non-disabled candidates are 1.05 times more likely to be appointed to a role from shortlisting compared to disabled candidates.

The disparity ratio has remained consistent, and while it does highlight that non-disabled candidates are slightly more likely to be appointed to roles at our Trust, the difference is marginal and remains within NHS England’s target range.

Metric 3: Likelihood of Entering Formal Capability Processes

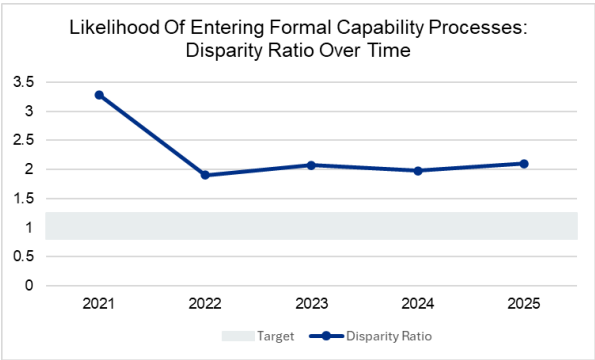
The table below details data held regarding the number of colleagues that have entered formal capability

processes in the reporting year. Data for the previous reporting year is included for comparison:

	2024-25	2025-26
Percentage of disabled colleagues entering the disciplinary process	1.71%	1.47%
Percentage of non-disabled colleagues entering the disciplinary process	0.86%	0.70%
Disparity ratio	1.98	2.10

Metric 3 indicates disabled colleagues are 2.10 times more likely to enter the formal capability process, whilst the percentage of disabled colleagues entering the process has reduced, the percentage of non-disabled colleagues has reduced too leading to a further deterioration in the disparity ratio.

This remains an area of focus as it falls outside of the 0.8-1.25 disparity ratio however attention must be drawn to the fact that the average cases for this metric continue to be very low in number therefore care must be taken before drawing a conclusion; across 2025-26 there was an average of 30 formal capability cases per year involving disabled colleagues and an average of 118 for non-disabled colleagues.



As can be seen from the graph, this metric has never fallen within the 0.8 - 1.25 disparity ratio guidelines since 2021 when it peaked at 3.28. It has reduced since then and has been relatively stable over the past 4 years, albeit remaining outside of the recommended disparity range.

Metrics 4-7: NHS Staff Survey Data

Data presented for WDES Metrics 4-7 is sourced from the national NHS Staff Survey. For each Metric, the data is compared for disabled colleagues and non-disabled colleagues. Where applicable, national staff survey averages and Trust results for the last five years have been included in this report for comparative purposes to the WDES metric being reviewed.

It is important to highlight that the data detailed in Metrics 4-7 is drawn from responses to the NHS Staff Survey and therefore reflects the views of staff who completed the survey. In total, 4271 (45%) colleagues completed the 2025 NHS Staff Survey. Looking at our survey completion rates by disability status, a total of 1137 disabled colleagues completed the survey, compared to a total of 2987 non-disabled colleagues. Not all staff complete the survey, and the data should be interpreted with this context in mind; while the data supports us to learn more about our colleagues’ experiences, it may not be fully representative of the whole workforce, or indeed representative of any particular demographic subgroup of that workforce.

This year, as part of our Staff Survey analysis, Divisional EDI Packs have been developed and shared with the Divisional Leadership teams to share results at both a divisional level and a Specialty Business Unit (SBU) level. The Organisational Development and EDI Teams will work with each Division to review

data sets and support meaningful action planning for the coming year. At present, this analysis purely relates to the WDES indicators which are generated through staff survey, moving forwards we would like to extend this analysis for the workforce and demographic metrics when capacity in the Workforce Information team is able to support this.

METRIC 4: Experiences of Bullying, Harassment or Abuse

WDES Metric 4 considers experiences of bullying, harassment of abuse at work from public and colleague groups, and details whether such experiences were reported.

Metric 4A: Percentage of staff experiencing harassment, bullying or abuse from patients, service users or the public in the last 12 months

The table below displays our Trust’s data for this WDES Metric broken down by disability status of survey respondents, compared to the NHS Staff Survey national benchmark.

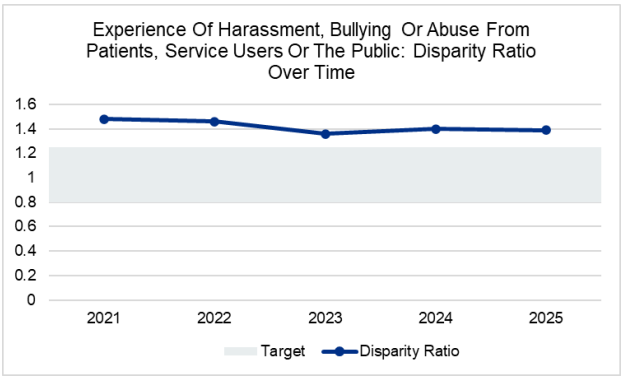
	National Benchmark	Lancashire Teaching Hospitals
Disabled Colleagues	29.7%	30.5%
Non-disabled Colleagues	23.4%	22.0%
Disparity Ratio	1.27	1.38

The data shows that disabled colleagues at our Trust were more likely to experience bullying, harassment or abuse from patients, service users or members of the public compared to non-disabled colleagues. At 1.38, our Trust’s disparity ratio for this metric falls outside the 0.8-1.25 range and indicates that disabled colleagues are likely to be experiencing an adverse impact compared to non-disabled colleagues.

Comparing our Trust’s data to the national NHS Staff Survey benchmark, our Trust’s disparity ratio is also higher than the national benchmark. This suggests that the difference in experience between disabled and non-disabled colleagues for this indicator is greater at our Trust than nationally, suggesting a marked experience gap compared to the national average.

Analysis of LTHTr Data Over Time

	Disabled Colleagues	Non-disabled Colleagues	Disparity Ratio
2025	30.5%	22.0%	1.38
2024	28.1%	20.0%	1.40
2023	27.7%	19.9%	1.36
2022	27.0%	18.5%	1.46
2021	27.7%	18.7%	1.48



There has been a slight improvement in the disparity ratio in 2025 compared to the previous reporting year, however, our Trust’s performance continues to be an area that requires improvement. The slight change in disparity ratio does not appear to be a result of a reduction in the proportion of disabled colleagues experiencing bullying, harassment or abuse from patients, service users or members of the public. The reduction in the disparity ratio appears to have occurred due to an **increase** in both disabled and non-disabled colleagues experiencing bullying, harassment or abuse.

The disparity ratio for this indicator has consistently remained outside of the recommended range. Work to understand and improve colleague experience has been ongoing and must continue as a matter of urgency to reduce bullying, harassment and abuse experienced by our colleagues.

Metric 4B: Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months

The data displayed in the table below focuses on colleagues who have experienced harassment, bullying or abuse from managers at our Trust, and the NHS Staff Survey national benchmark data for comparison:

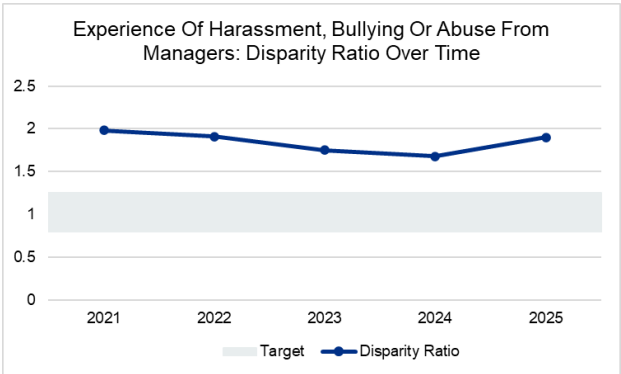
	National Benchmark	Lancashire Teaching Hospitals
Disabled Colleagues	13.6%	12.7%
Non-disabled Colleagues	7.4%	6.7%
Disparity Ratio	1.84	1.89

Our data shows that disabled colleagues are nearly twice as likely to report experiencing harassment, bullying or abuse from managers compared to non-disabled colleagues. Our Trust’s disparity ratio for this metric is 1.89, which falls significantly outside the 0.8-1.25 range and indicates that disabled colleagues experience adverse impact compared to non-disabled colleagues.

Comparing our Trust’s data to the national NHS Staff Survey benchmark, the experience of colleagues within our organisation is better than the national benchmark data, with 12.7% of disabled colleagues disclosing that they had experiencing bullying, harassment or abuse from a manager over the past year compared to 13.6% nationally. However, our Trust’s disparity ratio is greater compared to the national figure, which suggests there is a wider gap in experience of colleagues by disability status at our Trust than the national average.

Analysis of LTHTr Data Over Time

	Disabled Colleagues	Non-disabled Colleagues	Disparity Ratio
2025	12.7%	6.7%	1.89
2024	11.3%	6.7%	1.68
2023	11.7%	6.7%	1.75
2022	13.2%	6.9%	1.91
2021	14.7%	7.4%	1.98



While disabled staff have historically been more likely to experience bullying, harassment or abuse from managers at our Trust, our data captures a continuous period of improvement between 2022-2024. In 2021 we reported our worst position regarding this Metric since WDES reporting was initiated. However, our most recent WDES data set shows a 1% increase in the proportion of disabled colleagues experiencing bullying, harassment or abuse from a manager; it may be the case that an increase following a period of improvement is an isolated change, however it will be important to monitor in future reporting years.

The disparity ratio for this indicator has consistently remained outside of the recommended range (0.80-1.25). Work to understand and improve colleague experience has been ongoing and must continue as a matter of urgency to reduce bullying, harassment and abuse experienced by our colleagues.

Metric 4C: Percentage of staff experiencing harassment, bullying or abuse from colleagues in the last 12 months

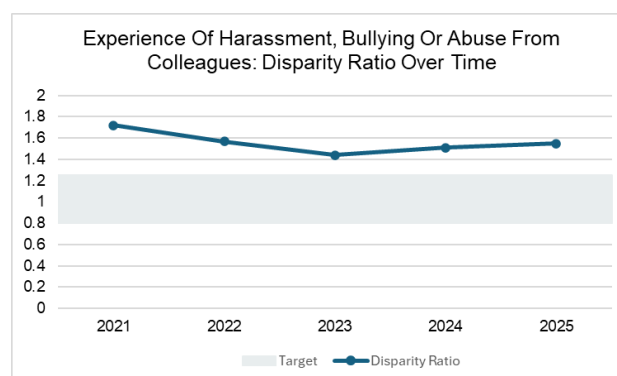
The data displayed below focuses on colleagues who have reported experiencing harassment, bullying or abuse from other colleagues, along with and NHS Staff Survey national benchmark data for comparison.

	National Benchmark	Lancashire Teaching Hospitals
Disabled Colleagues	23.0%	23.2%
Non-disabled Colleagues	14.8%	15.0%
Disparity Ratio	1.55	1.54

While in line with the national NHS Staff Survey benchmark figure, our data shows a slightly higher proportion of disabled colleagues experiencing harassment, bullying or abuse from other colleagues over the past year compared to their non-disabled peers. Our data indicates an adverse impact for disabled colleagues, and therefore a need for action.

Analysis of LTHTr Data Over Time

	Disabled Colleagues	Non-disabled Colleagues	Disparity Ratio
2025	23.2%	15.0%	1.54
2024	23.9%	15.8%	1.51
2023	23.0%	16.0%	1.44
2022	25.4%	16.2%	1.57
2021	24.2%	14.0%	1.72



Performance for this WDES Metric over time has been mixed. Some progress was made during 2021-2023 to improve the experience for disabled colleagues in relation to this metric and there was a reduction in the percentage of disabled and non-disabled colleagues experiencing bullying, harassment or abuse from colleagues. However, our data collection shows that while experiences of bullying, harassment and abuse from other colleagues continues to decrease for non-disabled colleagues, the proportion of disabled colleagues experiencing these behaviours has remained static around 23-24%. As a result, our Trust's disparity ratio for this WDES metric is widening and demonstrates a distinct disparity between the experiences of disabled and non-disabled colleagues.

Metric 4D: Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it

The following dataset focuses on the proportion of colleagues who have stated in the NHS Staff Survey that they (or another colleague) reported their experience of harassment, bullying or abuse from other colleagues. The NHS Staff Survey national benchmark data is also included for comparison:

	National Benchmark	Lancashire Teaching Hospitals
Disabled Colleagues	54.9%	46.8%

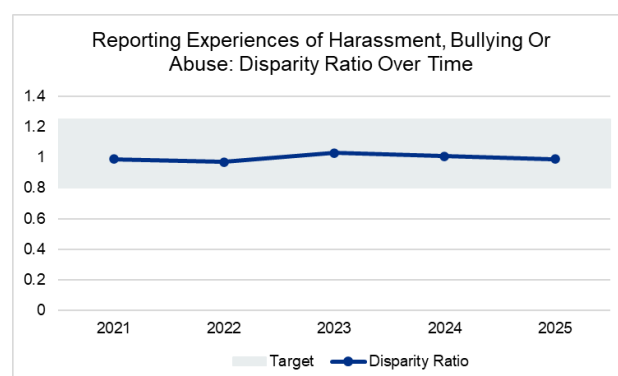
Non-disabled Colleagues	54.9%	46.3%
Disparity Ratio	1.00	0.99

Our data shows that 46.8% of disabled colleagues shared that they, or a colleague reported a workplace experience of bullying, harassment or abuse, compared to a slightly lower proportion of non-disabled colleagues (46.3%) who did the same. At 0.99, the disparity ratio highlights that disabled and non-disabled colleagues experience on this WDES metric is almost the same.

While it is notable that a lower proportion of disabled colleagues reported their experience compared to the national benchmark, our organisational scores are similar to the national data set.

Analysis of LTHTr Data Over Time

	Disabled Colleagues	Non-disabled Colleagues	Disparity Ratio
2025	46.8%	46.3%	0.99
2024	51.9%	52.2%	1.01
2023	50.6%	52.0%	1.03
2022	53.2%	51.7%	0.97
2021	46.6%	46.1%	0.99



There has been a slight improvement in the disparity ratio this year, however our Trust's performance for this indicator over time has remained stable, with the disparity range falling around the 1.00 mark.

An increase in the proportion of colleagues reporting their experience may be viewed both positively and negatively – while it is concerning to see that incidences of harassment, bullying or abuse occur at our Trust, an increase in the proportion of staff reporting their experience may indicate that colleagues feel aware of, and able to engage with, Trust policies and procedures intended to support them

Metric 5: Career Progression and Promotion

WDES Metric 5 looks at colleague experience regarding career progression and promotion and reports the percentage of colleagues who believe our Trust provides equal opportunities for career progression or promotion. The table below illustrates our Trust's data for Metric 5, compared to the NHS Staff Survey national benchmark:

	National Benchmark	Lancashire Teaching Hospitals
Disabled Colleagues	48.9%	47.7%
Non-disabled Colleagues	55.7%	55.1%
Disparity Ratio	1.14	1.15

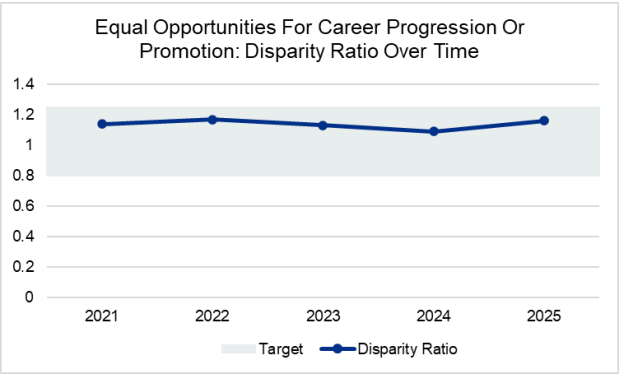
Our NHS Staff Survey reports that just under 48% of disabled colleagues stated they believe our Trust provides equal opportunities for career progression or promotion. This is slightly below the national benchmark figure of around 49%.

There is a significant difference in the views of disabled and non-disabled colleagues at our Trust with our data suggesting that the experiences of progression and promotion at our organisation are perceived

differently and may vary by disability status, disabled staff currently feel there are fewer opportunities to progress and develop compared to non-disabled colleagues.

Analysis of LTHTr Data Over Time

	Disabled Colleagues	Non-disabled Colleagues	Disparity Ratio
2025	47.7%	55.1%	1.15
2024	53.8%	58.8%	1.09
2023	53.9%	61.0%	1.13
2022	52.4%	61.4%	1.17
2021	52.8%	60.0%	1.14



As with the previous WDES Metric, while there has been a slight deterioration in the disparity ratio this year, our Trust’s performance for this indicator over time has been static, with the disparity range falling around the 1.10 mark.

Metric 6: Pressure to Come to Work When Not Feeling Well Enough

WDES Metric 6 provides detail of the proportion of disabled colleagues and non-disabled colleagues who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. The NHS Staff Survey national benchmark figures are also presented for comparison:

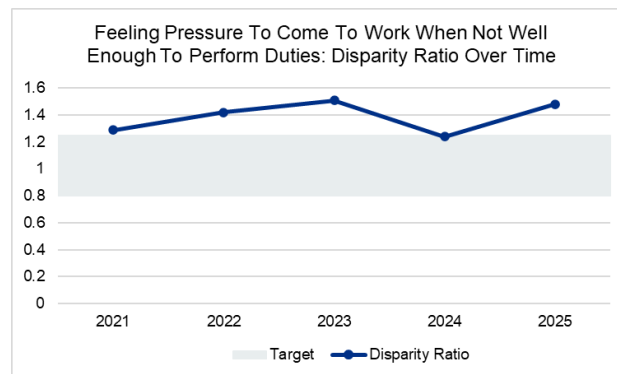
	National Benchmark	Lancashire Teaching Hospitals
Disabled Colleagues	25.6%	30.1%
Non-disabled Colleagues	17.5%	20.3%
Disparity Ratio	1.46	1.48

The data shows that 30.1% of colleagues with a disability and 20.3% of non-disabled colleagues felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. These figures are higher than the NHS Staff Survey national benchmark, inferring that more people at our Trust feel pressure to present at work when they are not well enough to do so compared to other NHS Trusts nationally. This may be as a result of changes made to our Attendance Management policy over the last 12 months which have introduced earlier trigger points for more formalised discussions.

The disparity ratio for this indicator falls outside of the recommended range (0.80-1.25). Work to understand and improve colleague experience has been ongoing and must continue over the next 12 months.

Analysis of LTHTr Data Over Time

	Disabled Colleagues	Non-disabled Colleagues	Disparity Ratio
2025	30.1%	20.3%	1.48
2024	22.7%	18.3%	1.24
2023	24.3%	16.0%	1.51
2022	26.1%	18.4%	1.42
2021	27.9%	21.7%	1.29



Looking at our data over time for Metric 6, our disparity ratio has consistently remained outside of the recommended range. While there has been some variability in the figure over recent years, there has been a marked deterioration over the past year that must be investigated further and understood.

Metric 7: Feeling Valued

This WDES Metric details the percentage of colleagues who disclosed in the NHS Staff Survey that they were satisfied with the extent to which our Trust values their work. The data in the table below is broken down by disability status, and the NHS Staff Survey national benchmark figures are provided for comparison:

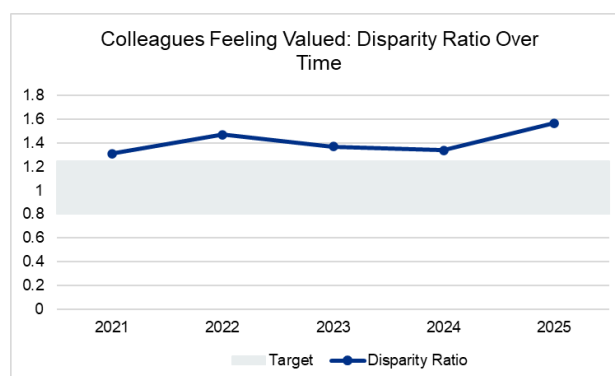
	National Benchmark	Lancashire Teaching Hospitals
Disabled Colleagues	34.4%	28.4%
Non-disabled Colleagues	46.1%	44.5%
Disparity Ratio	1.34	1.56

Our data suggests there is a notable difference in how valued our colleagues are feeling currently; the proportion of disabled colleagues (28.4%) stating that they were satisfied with the extent to which our Trust values their work is not only significantly lower than the proportion of non-disabled colleagues that expressed the same sentiment, but also significantly lower than the national benchmark figure.

The disparity ratio falls outside of the 0.80 – 1.25 range at 1.56 indicating a substantial difference in experience at our Trust based upon disability status.

Analysis of LTHTr Data Over Time

	Disabled Colleagues	Non-disabled Colleagues	Disparity Ratio
2025	28.4%	44.5%	1.56
2024	34.0%	45.6%	1.34
2023	36.3%	49.8%	1.37
2022	33.0%	48.4%	1.47
2021	35.8%	47.0%	1.31



Data collected for this metric over time highlights that the disparity ratio has consistently fallen outside the 0.80-1.25 range and therefore is a cause for concern that our Trust needs to understand and mitigate as a priority.

While there has been a decrease in the proportion of both disabled and non-disabled colleagues who feel satisfied with the extent to which our Trust values their work, the decline among disabled colleagues has been notably steeper. Since 2020, there has been an approximate 7% decrease in non-disabled colleagues expressing this sentiment, compared to a 12.6% decrease among disabled colleagues. This widening gap indicates an urgent need to better understand why feelings of being valued have declined overall, and why this decline has disproportionately affected disabled colleagues.

Metric 8: Reasonable Adjustments

This metric is concerned with the percentage of disabled colleagues stating that our Trust has made adequate adjustments to enable them to carry out their work:

	National Benchmark	Lancashire Teaching Hospitals
Disabled Colleagues	74.9%	77.1%

77.1% of colleagues with a disability, long term condition or illness stated they felt our Trust made adequate adjustments to enable them to carry out their work. Our organisation's score is better than the NHS Staff Survey national benchmark figure, which is likely to reflect the work we continue to do within Managers Update sessions (and more generally) to raise awareness around workplace adjustments and the *Supporting Disability and Long-Term Conditions Agreement*.

Analysis of LTHTr Data Over Time

	Disabled Colleagues
2025	77.1%
2024	79.1%
2023	78.3%
2022	75.1%
2021	72.6%

Collated data for this Metric shows the journey our Trust has taken over the past few years in terms of raising awareness of the importance of making reasonable adjustments to support our colleagues. Since 2021, when the proportion of colleagues feeling that our Trust made adequate workplace adjustments significantly decrease, work to raise awareness has corresponded with a year-on-year increase in disabled colleagues expressing they felt adequate adjustments had been made to support them at work.

However, our 2025 data indicates a 2% decrease in disabled colleagues expressing that adequate workplace adjustments have been made. Although this figure is relatively small, this decline interrupts a positive upward trend seen over several years and may signal a change in experience or implementation of reasonable adjustments. This highlights the importance of further understanding what may be contributing to this shift, to ensure that our awareness-raising activity is translating consistently into lived experience.

Metric 9: Engagement and Having a Voice

Metric 9A: Staff Engagement Score

WDES Metric 9A considers how engaged our colleagues feel:

	National Benchmark	Lancashire Teaching Hospitals
Disabled Colleagues	6.3	6.0
Non-disabled Colleagues	6.9	6.7
Disparity Ratio	1.10	1.12

When completing this question on the NHS Staff Survey, colleagues are asked to score between 1 – 10 (a higher score represents feeling more engaged). Our organisation’s scores for this WDES metric are slightly lower than the national benchmark, indicating that colleagues at the Trust report lower overall engagement compared to colleagues nationally.

Our data also shows a disparity in engagement scores between disabled and non-disabled colleagues. Disabled colleagues reported an average engagement score of 6.0, compared to 6.7 among non-disabled colleagues. This indicates that disabled colleagues who completed the NHS Staff Survey feel less engaged at work than their non-disabled peers and highlights a differential experience within the organisation.

Analysis of LTHTr Data Over Time

	Disabled Colleagues	Non-disabled Colleagues	Disparity Ratio
2025	6.0	6.7	1.12
2024	6.2	6.8	1.09
2023	6.5	7.1	1.09
2022	6.4	7.0	0.92
2021	6.4	7.0	0.92

Engagement scores have fallen in 2025 compared to the previous year. Our collated data also shows a gradual widening of the disparity ratio since 2021; this suggests there is an increasing difference in engagement by disability status, which would benefit from further exploration to better understand the drivers of this trend.

Metric 9B: Facilitating the Voices of Disabled Staff

We have an active Disability and Neurodiversity Forum, which is a safe space where disabled colleagues and non-disabled allies can come together to share experiences, learn from each other, and discuss how our Trust creates a more equitable and inclusive environment for all. We also have a number of awareness raising or support groups on topics such as menopause and endometriosis, and we have active Health and Wellbeing representatives who offer support for our colleagues.

Metric 10: Board Membership

20% of the Board's membership identify as having a disability. Disability-representation at Board level is currently around three times higher than overall disability representation within our Trust workforce (7.0%).

Such a level of representation presents an opportunity for the Board to play a visible role in championing disability inclusion and influencing positive organisational culture.

WDES Action Plan

WDES mandates NHS organisations to produce an action plan that elaborates on priority areas identified in our report and sets out the next steps with milestones for expected progress against WDES Metrics.

Specific WDES actions will be formulated in collaboration with colleagues who participate in our Disability and Neurodiversity Forum, and with our Partnership Team. To ensure our WDES actions are maintained over the course of the year, we will incorporate them with EDI-related actions in our Trust's wider strategic planning, including our Single Improvement Plan.

Our WDES data set outlines two priority areas that our Trust should focus upon in the next twelve months:

- Action 1: deepen understanding of lived experience of disabled colleagues

Our WDES report illuminates areas where the working experience of our colleagues varies by disability status, such as in experiences of bullying, harassment and abuse. While our WDES and NHS Staff Survey Data highlights areas of different experience, it does not provide us with the context, and in order to mitigate or remove disproportionate experiences, we need to better understand lived experience.

Over the coming year, the Equality, Diversity and Inclusion Team will work with our Disability and Neurodiversity Forum, our OD Projects (Staff engagement) colleagues, our Partnership Team, and with colleagues across our Workforce team to collate evidence of lived experience. It is recommended to utilise mechanisms our Trust already has in place to efficiently gather information, such as via our Your Voice events, individual/group meetings with colleagues, and responding to intelligence received via staff sickness data, recruitment and retention data and anecdotal information shared by colleagues.

A richer, qualitative and quantitative understanding of WDES data will support proportionate, evidence-based actions.

- Action 2: develop and share divisional WDES data packs to support local actions

As mentioned at the outset, the Equality, Diversity and Inclusion Team has developed divisional WDES data packs to enable local interpretation of staff experience/survey data. These packs will support divisions to identify priorities, and align local actions within existing operational workstreams. Divisional WDES packs will support local accountability for WDES improvement, with actions that are tailored, targeted, and integrated into divisional plans rather than operating as standalone initiatives.

Whilst the Equality, Diversity and Inclusion Team have analysed the NHS Staff Survey EDI/WDES Data at divisional and Specialty Business Unit level, we hope to work alongside the Workforce Information Team to source divisional level data sets for WDES workforce Indicators 1-4 to further support divisions to understand their own WDES profiles.

Next steps:

- This report will be shared with our Disability and Neurodiversity Forum to seek members' views and lived experience in relation to these findings as well as to understand additional actions they believe will help to reduce inequality and increase inclusion.
- To consult and co-produce with the Disability and Neurodiversity Forum on the strategic action plan for equality, diversity and inclusion and seek their views on the content, understand what else forum members would want to see and make further amendments based on feedback.
- Communicate our WDES data and action plan to our workforce through organisational-level briefings and communications including Managers Update sessions and All-Colleague Briefings
- Sharing divisional-level WDES data packs
- Submit our WDES data to NHS England via the NHS online Data Collection Framework system
- Publish our results and action plan externally on our Trust website

FINANCIAL IMPLICATIONS

Research evidence indicates that, when organisations are more diverse and have a greater focus on inclusion colleagues report greater engagement, there is a correlation with safer care for patients, reduced turnover, less sickness absence and improved financial performance.

LEGAL IMPLICATIONS

Unsatisfactory progress may leave the Trust open to legal challenges. We are required to demonstrate all staff have access to provision of services and are not discriminated against because of a protected characteristic.

RISKS

Unsatisfactory progress would be a risk to our reputation; both as a provider of Excellent Care with Compassion but also as an employer of choice. There are a number of risks which are impacting on our ability to deliver actions at pace against this agenda, this includes the lack of dedicated staffing resources to support the EDI agenda.

The size and scale of the programmes of work needed to deliver improvements for disabled colleagues is significant, especially when considered next to and needing to balance progress for colleagues with other protected characteristics. Combined with the level of understanding by the wider workforce with regards to their role in also delivering improvements for disabled colleagues, this work predominantly falls to the colleagues within Organisational Development – EDI team to drive forward transformation, increase awareness whilst supporting individual colleagues who have had negative experiences in their place of work.

IMPACT ON STAKEHOLDERS

Research evidence within the NHS tells us that the experiences of our colleagues acts as a good barometer for the experience of our patients; the more positive the experience of our colleagues, the more positive the experience of our patients.

RECOMMENDATIONS

It is recommended that the Committee:

- Receive the report and note the content
- Approve publication of our results externally

The Workforce Disability Equality Standard (WDES) is a set of ten specific metrics which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. The infographic below (for 2026) highlights the differences between the experience and treatment of Disabled colleagues and Non-Disabled colleagues, as an organisation we are committed to closing those gaps through the development and implementation of actions to bring about continuous improvement over time.

OUR DATA AND KEY FINDINGS

REPRESENTATION

7.0% of colleagues have declared they have a disability or long-term health condition.

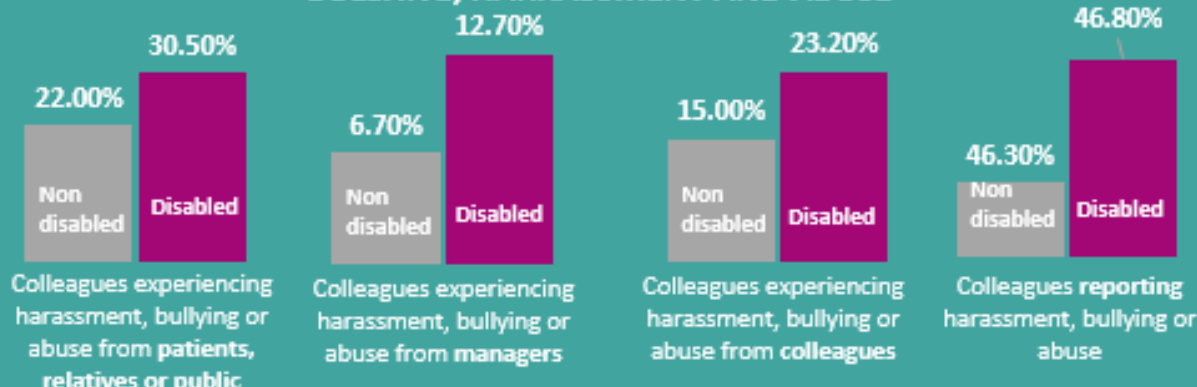
SHORTLISTING

Non-disabled colleagues are **1.05** times more likely to be appointed from shortlisting.

CAPABILITY PROCESS

Disabled colleagues are **2.10** times more likely to enter the formal capability process.

BULLYING, HARRASSMENT AND ABUSE



CAREER PROGRESSION

47.7% of Disabled colleagues believe that the Trust provides equal opportunities for career progression or promotion, compared with 55.1% of Non-Disabled colleagues.

PRESSURE TO WORK

30.1% of disabled colleagues have felt pressure from their manager to come to work, despite not feeling well enough to perform duties., compared with 20.3% of Non-Disabled colleagues.

FEELING VALUED

28.4% of Disabled colleagues are satisfied with the extent to which their organisation values their work, compared with 44.5% Non-Disabled Colleagues.

REASONABLE ADJUSTMENTS

77.1% Of Disabled colleagues saying their employer has made adequate adjustments to enable them to carry out their work.

STAFF ENGAGEMENT SCORE

Disabled colleagues feel less engaged at work
6.0/10 Disabled
6.7/10 Non-disabled

BOARD MEMBERSHIP

3 Board Members (2 voting) identify with having a disability or long-term health condition out of a total of 15 Board Members

B) WORKFORCE RACIAL EQUALITY STANDARD (WRES) RETURN 2026

● Decision Item

REFERENCES

Only PDFs are attached



10.1b Workforce Racial Equality Standard Return 2026 Summary Board Part I 4 June 26.pdf



10.1b Workforce Racial Equality Standard Return 2026 Report Board Part I 4 June 26.pdf



Board of Directors Report

Meeting of the	Board of Directors		4 th June 2026		
	Part I	☒	Part II	☐	
Title of Report	Lancashire Teaching Hospitals NHS Foundation Trust Workforce Race Equality Standard (WDES) Submission 2026				
Report Author	Gemma Aspinall, Diversity and Inclusion Practitioner				
Lead Executive Director	Neil Pease, Chief People Officer				
Recommendation/ Actions required	The Board of Directors is asked to: receive and approve this report for external publication of our WRES data.				
	Decision	☒	Assurance	☐	Information
Executive Summary	The purpose of this report is to share our Trust’s data and analysis, which will form the submission and subsequent publication of the 2025 Workforce Race Equality Standard (WRES) for our Trust. It sets out priority areas for action based on analysis of the results which include workforce data and findings from the latest NHS Staff Survey. Our WRES data shows the following key points: • BME representation has reduced significantly in our non-clinical workforce, largely due to the transfer of colleagues from our Trust to One LSC. This change may materially impact our Trust’s workforce profile in future years • BME colleagues continue to be underrepresented at Board level, with BME voting members accounting for 12.5% of the Board compared to 30.6% representation across our wider Trust workforce • White candidates are more likely to be appointed from shortlisting to roles at our Trust compared to BME candidates • BME colleagues are very slightly less likely to enter the disciplinary process than white colleagues. • There has been an increase in the % of White and BME colleagues accessing non-mandatory training and CPD, the percentage increase for White colleagues is greater than for BME colleagues which has led to an increase in the disparity ratio, yet it’s still within expected boundaries. • Reports of bullying, harassment or abuse from the public have increased, with a much sharper rise among BME colleagues, increasing from 10.7% in 2024–25 to 25.2% in the current reporting year • While experiences of harassment, bullying or abuse from colleagues have slightly decreased for White colleagues, they have increased for BME colleagues				

	• Colleague confidence in equal opportunities for career progression and promotion has declined for both BME and White colleagues, with a significant decrease among White colleagues (59.3% to 53.9%) • Reported experiences of discrimination among BME colleagues have remained largely unchanged, with a marginal improvement of 0.1% (14.3% to 14.2%) The Committee is asked to review and approve the contents of the report for publication.	
Link to Strategic Objectives 2025/26	Patients – deliver excellent care: Improve outcomes, reduce harm and deliver a positive patient experience.	☐
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.	☐
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.	☒
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.	☐
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.	☐
Due Diligence	To give the Trust Board assurance, please complete the following:	
Committee Approval:	Name of Committee: Workforce Committee	Date: 12 th May 2026
Operational Group Review:	Name of Operational Group: Trust Management Board	Date: 13 th May 2026
Link to Board Assurance Framework:	Principal Risk 7 (26/27) - Experience of under-represented staff groups	
Appendices	State whether there are any appendices and list them. For example: Appendix 1: Full Report	

APPENDIX 1 – FULL WORKFORCE RACE EQUALITY REPORT

Introduction

Measuring race equality in the workplace is essential to understanding how inclusive our organisation truly is. The Workforce Race Equality Standard (WRES) is a mandated requirement for our Trust through the NHS Standard Contract. Launched in 2015, the WRES provides a nationally consistent framework for measuring and reporting workforce disability equality across NHS organisations.

Now in its twelfth reporting year, the WRES enables us to assess progress across nine workforce indicators and ensures we remain accountable for improving the experiences and outcomes of Black and Minority Ethnic colleagues at Lancashire Teaching Hospitals NHS Foundation Trust (LTHTr) and understand how our organisation performs compared to other NHS Trusts across the country.

Definitions

There are several NHS systems and administrative processes through which personal information is captured, including information relating to ethnicity. How, when, or whether individuals disclose this information can vary and may be influenced by confidence in disclosure, and the context in which information is requested. WRES data is compiled from a number of data sources, including self-reported workforce information. Variation across systems and reporting practices means that a degree of caution is required when analysing and interpreting our Trust's WRES data. These factors should be considered when reviewing trends, outcomes and comparative findings

NHS England's national NHS WRES guidance and reporting metrics use the term Black and Minority Ethnic (BME) to define those of all ethnicities other than White British, White Irish, or any other White background. Lancashire Teaching Hospitals NHS Foundation Trust is committed to being consciously inclusive in everything we do. We are mindful of the importance of inclusive language, and the power language has to convey respect, belonging and understanding. In our WRES report, we use the terms Black and Minority Ethnic (BME) and White, as these categories align with NHS England WRES reporting. We acknowledge that the terms currently utilised in WRES reporting place diverse communities into broad, homogenous groups, and impact upon our understanding of representation and experience within and across ethnic groups.

Following the submission of our WRES report to NHS England, it is recommended that the Trust carries out detailed analysis of data by specific ethnic group to further explore representation and experience in more detail and consider potential actions to mitigate them.

WRES Data Sources

The information presented in this report is taken from the following sources:

- Electronic Staff Record (ESR) data as of 31 March 2026
- NHS Jobs / TRAC recruitment data: 01 April 2025 – 31 March 2026
- Formal disciplinary information: 01 April 2025 – 31 March 2026
- Learning and development records: 01 April 2025 – 31 March 2026
- NHS National Staff Survey results for Lancashire Teaching Hospitals NHS Foundation Trust: 2025

Please note, our WRES reporting data does not include bank only employees.

Interpreting Our WRES Data

The WRES considers data regarding representation and workplace experiences of Black, Asian, and Minority Ethnic (BME) staff compared to White staff at an NHS organisation.

To interpret our Trust's data around staff experiences (indicators 5-8), we are using the approach used by NHS England's national equality team called the four-fifths (or '80 percent') target.

This rule helps us to understand whether organisational practices may have an **adverse impact** on an identified group, e.g. an ethnic group. For example, if the relative likelihood of an outcome for one ethnic group compared to another is **less than 0.8 or higher than 1.25**, then the process would be identified as potentially having an adverse impact on one of those groups. This will be referred to as the Disparity Ratio throughout the report.

Key Findings

- BME representation has reduced significantly in our non-clinical workforce across bands 1 and 2, likely due to the transfer of colleagues from our Trust to One LSC. This change may materially impact our Trust's workforce profile in future years
- BME colleagues continue to be underrepresented at Board level, with BME voting members accounting for 12.5% of the Board compared to 30.6% representation across our wider Trust workforce
- White candidates are more likely to be appointed from shortlisting to roles at our Trust compared to BME candidates
- BME colleagues are very slightly less likely to enter the disciplinary process than white colleagues.
- There has been an increase in the percentage of both White and BME colleagues accessing non-mandatory training and CPD, the percentage increase for White colleagues is greater than for BME colleagues which has led to an increase in the disparity ratio, yet it's still within expected boundaries.
- Reports of bullying, harassment or abuse from the public have increased, with a much sharper rise among BME colleagues, increasing from 10.7% in 2024–25 to 25.2% in the current reporting year
- While experiences of harassment, bullying or abuse from colleagues have slightly decreased for White colleagues, they have increased for BME colleagues
- Colleague confidence in equal opportunities for career progression and promotion has declined for both BME and White colleagues, with a significant decrease among White colleagues (59.3% to 53.9%)
- Reported experiences of discrimination among BME colleagues have remained largely unchanged, with a marginal improvement of 0.1% (14.3% to 14.2%)

Breakdown of Lancashire Teaching Hospitals NHS Foundation Trust WRES Data Set 2025-2026

Indicator 1: Representation

WRES Indicator 1 considers the percentage of colleagues by ethnicity in each AfC pay band, Medical and Dental groups, and VSM (including executive Board Members). The table below provides an overview of our Trust's workforce by broad BME group.

	2024-25	2025-26
Number of staff employed within the organisation	9,471	8,257
Proportion of staff self-reporting their ethnicity on ESR	98.8%	99.1%
Proportion of BME staff	28.6%	30.6%

As of 31 March 2026, the Trust Headcount was 8,257. Breaking down our workforce data by broad ethnic group, 2,523 (30.6%) of colleagues are BME, 5,660 (68.5%) are White, and 74 (0.9%) are ethnicity unknown.

There has been significant workforce change over the past year, with colleagues transferring into our organisation, and colleagues transferring to other organisations. Fluctuations in our workforce may present challenges when interpreting our WRES data, as major workforce change can affect year-on-year comparability of data, limit the scope of trend analysis, and add complexity to the identification of patterns of experience or outcomes. Continued system and service changes may also impact upon action planning over the course of the year. These factors are important to consider when reviewing our WRES data and planning proportionate, meaningful actions.

The tables below show a breakdown of our BME workforce by NHS Agenda for Change (AfC) payband, and by Medical and Dental grade:

Agenda for Change Workforce

BME Non-Clinical Staff			BME Clinical Staff		
	2024-25	2025-26		2024-25	2025-26
<Band 1	-	100%	<Band 1	11.1%	13.6%
Band 1	33.3%	0%	Band 1	0%	0%
Band 2	30.4%	12.2%	Band 2	32.4%	33.2%
Band 3	15.4%	17.0%	Band 3	16.5%	18.5%
Band 4	9.9%	10.3%	Band 4	10.9%	11.3%
Band 5	6.4%	8.6%	Band 5	49.0%	50.3%
Band 6	7.7%	7.5%	Band 6	21.1%	22.7%
Band 7	2.9%	2.0%	Band 7	10.3%	11.0%
Band 8a	3.1%	2.0%	Band 8a	12.0%	12.1%
Band 8b	0%	10.0%	Band 8b	4.8%	3.6%
Band 8c	5.6%	7.7%	Band 8c	0%	0.0%
Band 8d	11.1%	10.0%	Band 8d	8.3%	7.7%
Band 9	0%	0.0%	Band 9	0%	0%
VSM	0%	0.0%	VSM	0%	0%
Total	19.3%	11.6%	Total	32.7%	30.5%

Our workforce demographic data shows a substantial reduction in the proportion of BME colleagues within non-clinical roles, particularly in Band 1 and Band 2 positions, over the past year.

This change is likely to reflect the transfer of Estates and Facilities colleagues from our Trust to One LSC, which will undoubtedly have had a significant impact on the overall Trust workforce profile. Our data highlights that Estates and Facilities roles historically represented a significant entry point for BME colleagues into our organisation, and their transfer to another organisation therefore represents the loss of a major route through which the Trust recruited and developed BME talent. The reduction in BME

representation in these roles should not be viewed in isolation but understood in the context of wider organisational change and its implications for future workforce representation and diversity.

In contrast, BME representation within clinical roles has remained broadly consistent with last year’s data, suggesting relative stability across clinical staff groups despite changes to the non-clinical workforce.

Medical and Dental Workforce

	BME Staff 2024-25	BME Staff 2025-26
Consultants	53.5%	53.2%
[Consultant] Senior Medical Manager	47.5%	48.2%
Non-consultant carer grade	67.7%	69.9%
Trainee grades*	72.3%	77.9%

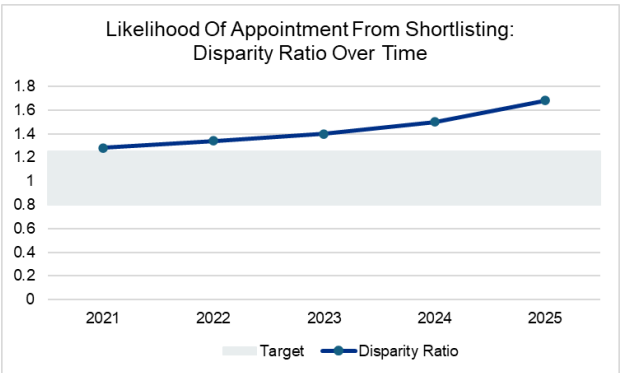
*Please note this data does not include Lead Employer Medical and Dental Trainees

Our medical and dental workforce demographic data this year has remained largely consistent with last year’s dataset.

Indicator 2: Likelihood of Appointment from Shortlisting

The table below summarises our Trust’s recruitment data for the year 2025-2026. Data for the previous reporting year is included for comparison:

	2024-25	2025-26
Total number of shortlisted applicants	5,486	4,337
Total number appointed from shortlisting	1,786	1,388
BME colleagues appointed from shortlisting	651	496
Relative likelihood of appointment from shortlisting for:		
a) BME colleagues	a) 24.9%	a) 23.6%
b) White colleagues	b) 37.4%	b) 39.7%
Disparity ratio	1.50	1.68



The disparity ratio for this indicator shows that White candidates are 1.68 times more likely to be appointed to a role from shortlisting compared to BME candidates.

The disparity ratio has increased this reporting year from 1.50 to 1.68. The widening gap in experience requires investigation to understand why BME applicants are becoming less likely to be appointed to roles compared to White peers.

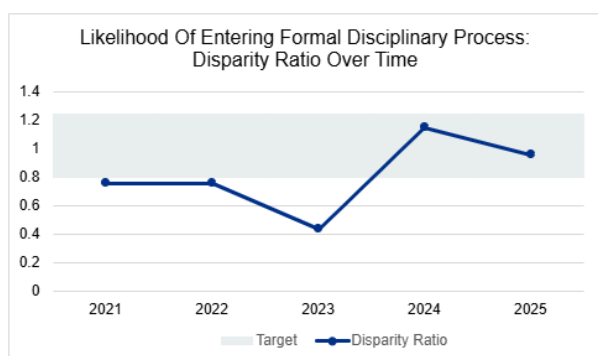
Looking at our Trust’s disparity ratio over time, it has consistently fallen outside NHS England’s target range, which highlights an urgent need to gain insight and mitigate the growing gap in experience.

Indicator 3: Likelihood of Entering the Formal Disciplinary Process

The table below details data held regarding the number of colleagues that have entered formal disciplinary processes in the reporting year. Data for the previous reporting year is included for comparison:

	2024-25	2025-26
Total number of colleagues entering the disciplinary process	61	63
Number of BME colleagues entering the disciplinary process	20	18
Number of White colleagues entering the disciplinary process	41	42
Disparity ratio	1.15	0.96

The data displayed in the table below shows that for this reporting year we have seen the disparity ratio decrease which indicates that ethnic minority colleagues are slightly less likely to enter the disciplinary process than white colleagues.

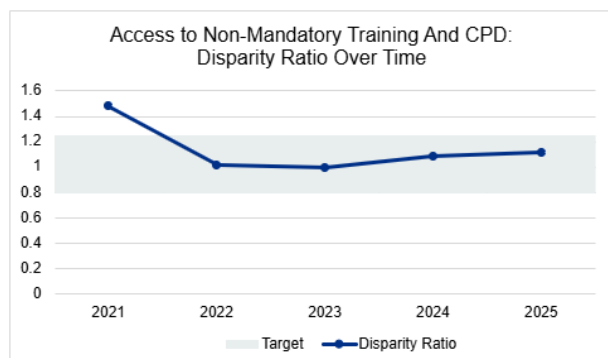


A ratio of 1 means both groups are as likely to enter the process as one another; it remains within the disparity ratio boundaries of 0.8 – 1.25 meaning colleagues are not likely to be experiencing an adverse consequence or unfair outcome of the application of this policy – it is not a priority area for action in this reporting year.

Indicator 4: Access to Non-Mandatory Training and Continuous Professional Development (CPD)

	2024	2025
Percentage of BME colleagues accessing non-mandatory training and CPD	24.5%	28.1%
Percentage of White colleagues accessing non-mandatory training and CPD	26.6%	31.6%
Disparity ratio	1.09	1.12

The results for this indicator show that a greater percentage of colleagues across both groups have accessed non-mandatory training and CPD over the past 12 months; there has been a slightly greater increase in the percentage of white colleagues which is reflected in the rise of the disparity ratio from 1.09 last year to 1.12 this year. The disparity ratio is still within the 0.80 - 1.25 range as it has been for the last four years. Since 2024 the data now includes continuous professional development educational activities which have been funded through Health Education England.



This metric has remained steady over the past four years and consistently lies within the disparity ratio boundaries of 0.8 – 1.25 meaning colleagues are not likely to be experiencing an adverse consequence or unfair outcome in this area, as such it is not a priority area for action in this reporting year.

Indicators 5-8: NHS Staff Survey Data

Data presented for WRES Indicators 5-8 is sourced from the national NHS Staff Survey. For each Indicator, the data is compared for BME and White colleagues. Where applicable, national staff survey averages and Trust results for the last five years have been included in this report for comparative purposes to the WRES Indicator being reviewed.

It is important to highlight that the data detailed in Indicators 5-8 is drawn from responses to the NHS Staff Survey and therefore reflects the views of staff who completed the survey. In total, 4271 (45%) colleagues completed the 2025 NHS Staff Survey. Looking at our survey completion rates by ethnicity, a total of 1044 BME colleagues completed the survey this year, compared to a total of 3171 White colleagues.

Not all staff complete the survey, and the data should be interpreted with this context in mind; while the data supports us to learn more about our colleagues' experiences, it may not be fully representative of the whole workforce or indeed a particular demographic subgroup within the workforce.

This year, as part of our Staff Survey analysis, Divisional EDI Packs have been developed and shared with the Divisional Leadership teams to share results at both a divisional level and a Specialty Business Unit (SBU) level. The Organisational Development and EDI Teams will work with each Division to review data sets and support meaningful action planning for the coming year. At present, this analysis purely relates to the WRES indicators which are generated through staff survey, moving forwards we would like to extend this analysis for the workforce and demographic metrics when capacity in the Workforce Information team is able to support this.

INDICATOR 5: Experiences of Bullying and Harassment from the Public

WRES Indicator 5 considers the percentage of colleagues experiencing harassment, bullying or abuse from patients, relatives, or other members of the public during the past 12 months. The table below illustrates our Trust's data for this Indicator, compared to the NHS Staff Survey national benchmark:

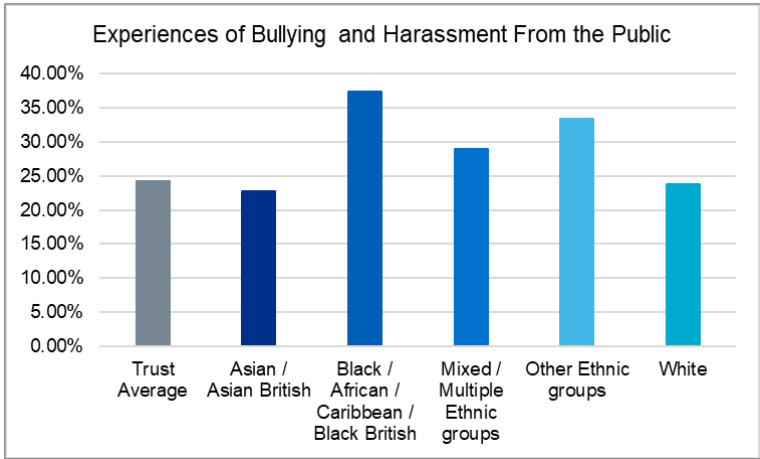
	National Benchmark	Lancashire Teaching Hospitals
BME Colleagues	29.2%	25.2%
White Colleagues	23.5%	23.8%
Disparity Ratio	1.24	1.06

The data shows that BME colleagues at our Trust were more likely to experience bullying, harassment or abuse from members of the public compared to White colleagues yet when comparing our Trust's data to the national NHS Staff Survey benchmark, our disparity ratio is lower than the national benchmark. This indicates that while disparities do exist at our Trust, the difference in reported experience between ethnic groups for this indicator is smaller than other organisations. The metric also falls within the disparity ratio boundaries of 0.80 – 1.25 indicating there is not likely to be an adverse impact on one particular subgroup.

Nevertheless, any level of bullying or harassment from members of the public is a concern, and continued focus is needed to ensure that experiences are bullying and harassment from members of the public is not normalised or accepted, and that all colleagues feel protected and supported.

Expanded Ethnicity Breakdown of Our Data

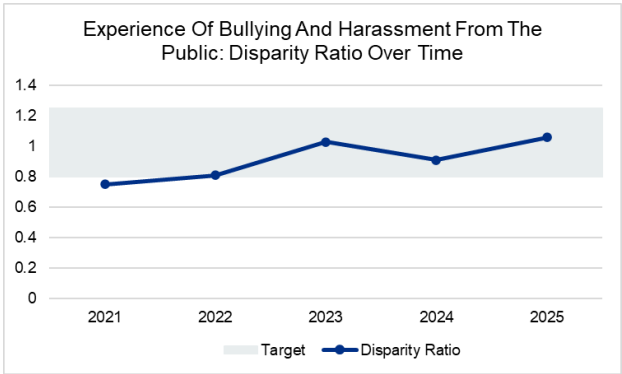
To better understand patterns of experience within our workforce, we have produced an expanded ethnicity breakdown of the data for this WRES indicator:



Reviewing NHS Staff Survey Data for this WRES indicator by ethnic group, there is some variation in reported experience. Colleagues identifying as Black ethnic groups and colleagues identifying as Other ethnic groups report significant higher incidences of bullying and harassment from the public over the past year compared to other groups.

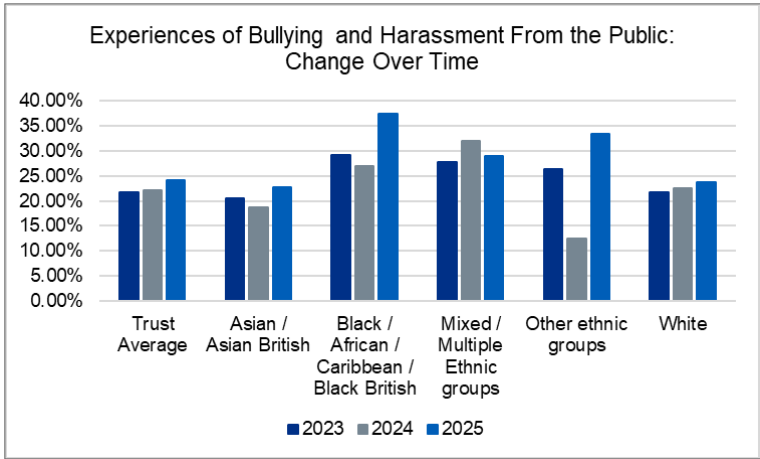
Analysis of LHTTr Data Over Time

	BME Colleagues	White Colleagues	Disparity Ratio
2025	25.2%	23.8%	1.06
2024	20.7%	22.6%	0.91
2023	22.5%	21.7%	1.03
2022	17.2%	21.2%	0.81
2021	16.2%	21.6%	0.75



NHS Staff Survey collated over time shows a relatively consistent picture of colleague experience by ethnic group, however, there appears to be a significant deterioration in experience of BME colleagues in 2025 compared to 2024, with the percentage of BME colleagues experiencing bullying, harassment and abuse from members of the public increasing by over 5%.

Expanded Ethnicity Breakdown of Our Data Over Time



Reviewing NHS Staff Survey Data for this WRES indicator by ethnic group, there is some variation in reported experience over time. In particular, colleagues identifying as Black ethnic groups and colleagues identifying as Other ethnic groups report significant increases in experiences of bullying and harassment from the public over the past year.

While our data does not provide

contextual insights into the specific circumstances of colleague experiences, the marked upward trend seen for these groups in the past year highlights a need for further exploration to better understand colleague experience and to inform appropriate preventative and support measures.

Indicator 6: Experiences of Bullying and Harassment from Other Colleagues

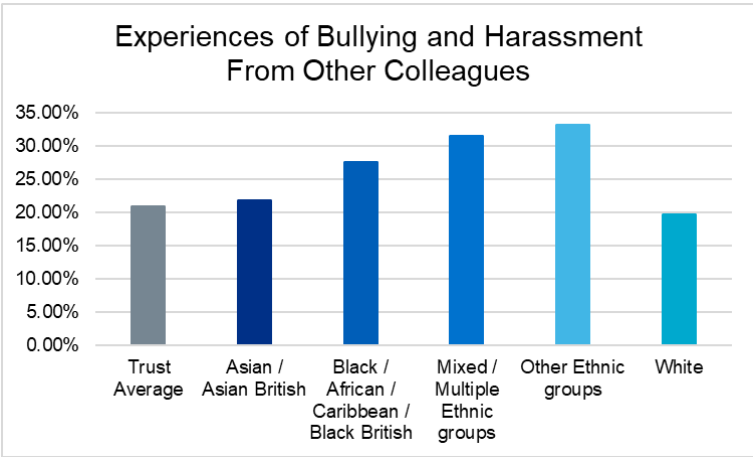
WRES Indicator 6 reports the percentage of colleagues experiencing harassment, bullying or abuse from other colleagues during the last 12 months. The table below illustrates our Trust’s data for Indicator 6, compared to the NHS Staff Survey national benchmark:

	National Benchmark	Lancashire Teaching Hospitals
BME Colleagues	23.4%	23.7%
White Colleagues	19.6%	19.7%
Disparity Ratio	1.19	1.20

The data shows that BME colleagues at our Trust reported they were more likely to experience bullying, harassment or abuse from other colleagues compared to White colleagues. This metric once again falls within the disparity ratio boundaries of 0.80 – 1.25 indicating there is not likely to be an adverse impact on one particular sub group.

Comparing our Trust’s data to the national NHS Staff Survey benchmark, our Trust’s disparity ratio is similar to the national benchmark figure. This suggests that the difference in experience between ethnic groups for this indicator is comparable to the national average.

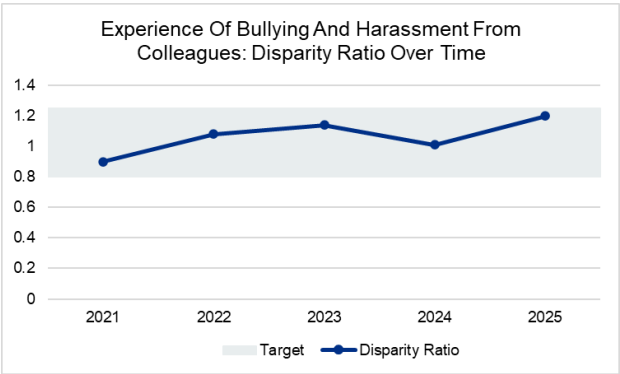
Expanded Ethnicity Breakdown of Our Data



Disaggregating our data indicates that colleagues identifying as Black, Mixed or Multiple, and Other ethnic groups experienced bullying and harassment more frequently over the past year compared to colleagues identifying as Asian or White. Our NHS Staff Survey / WRES data does not provide contextual insight into colleague experiences and suggests a need for further exploration to better understand experiences at work.

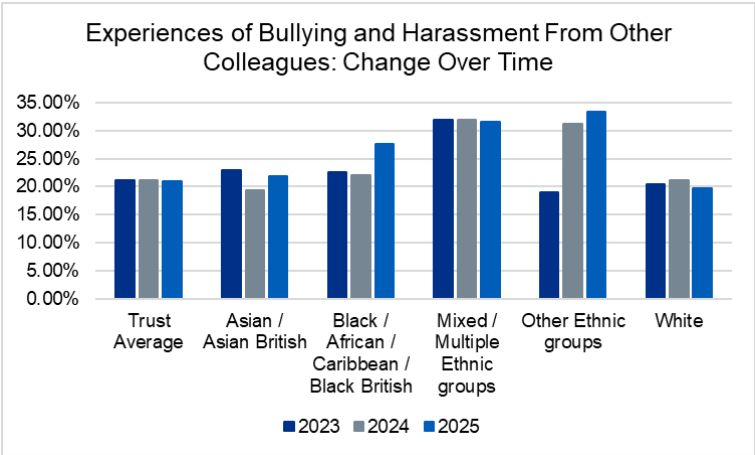
Analysis of LTHTr Data Over Time

	BME Colleagues	White Colleagues	Disparity Ratio
2025	23.7%	19.7%	1.20
2024	21.3%	21.1%	1.01
2023	23.4%	20.4%	1.14
2022	22.7%	20.9%	1.08
2021	18.2%	20.3%	0.90



When looking at NHS Staff Survey data over time for this WRES Indicator, while the disparity ratio has consistently sat within the 0.8-1.25 range, there has been variation in colleague experience by ethnic group. Our Trust's 2025 data shows a slight deterioration in experience of BME colleagues in 2025 compared to 2024, while the experience of White colleagues has improved slightly. The trajectory for the disparity ratio has been on an upward trend since 2024 and, if it continues is likely to be an area which will fall outside of the disparity ratio boundaries next year without targeted action being taken.

Expanded Ethnicity Breakdown of Our Data Over Time



Colleagues who identify as being from Mixed / Multiple ethnic groups, and those who identify as Other Ethnic group backgrounds have consistently reported a higher incidence of bullying, harassment and abuse from colleagues.

Furthermore, there appears to be an upward trend in colleagues identifying as Other Ethnic groups experiencing bullying and harassment from other colleagues, which warrants further exploration.

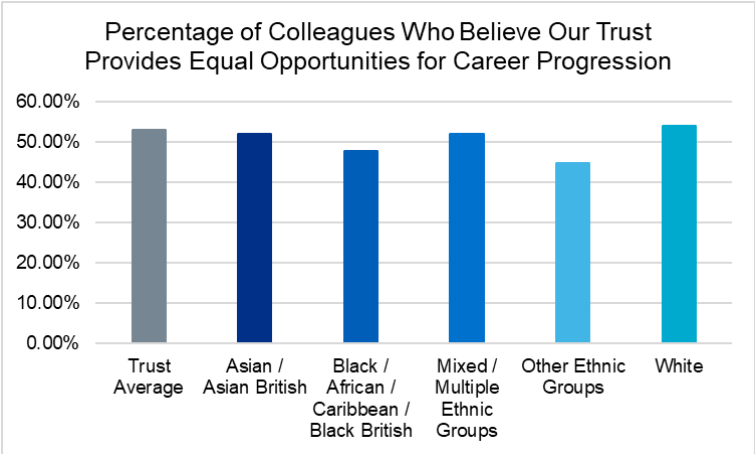
Indicator 7: Career Progression and Promotion

WRES Indicator 7 looks at colleague experience regarding career progression and promotion and reports the percentage of colleagues who believe our Trust provides equal opportunities for career progression or promotion. The table below illustrates our Trust's data this Indicator, compared to the NHS Staff Survey national benchmark.

	National Benchmark	Lancashire Teaching Hospitals
BME Colleagues	49.7%	50.7%
White Colleagues	55.9%	53.9%
Disparity Ratio	1.12	1.06

Our Trust's NHS Staff Survey results and disparity ratio are very similar to the national benchmarks this year. The data for this indicator shows 50.7% of BME colleagues and 53.9% of White colleagues believe our organisation provides equal opportunities for career progression and promotion. The disparity ratio of 1.06 is within the recommended range (0.8-1.25) and suggests there is no potential adverse impact on BME colleagues.

Expanded Ethnicity Breakdown of Our Data

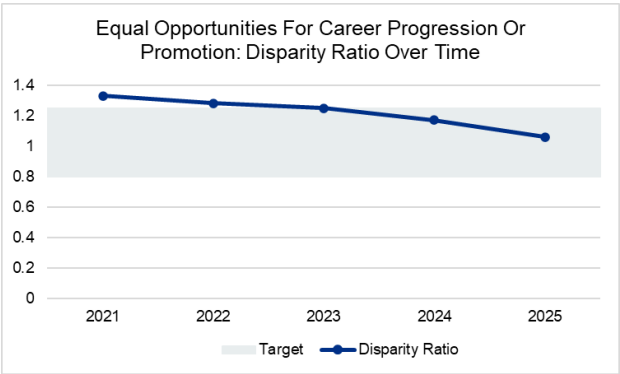


Analysis of our data in more detail indicates variation in perceptions of equal opportunities for career progression and promotion at our Trust. A lower proportion of colleagues identifying as Black and Other ethnic backgrounds reported that they believe our organisation provides equal opportunities for career progression when compared to colleagues from other ethnic backgrounds.

This suggests a need for further investigation to better understand colleague experiences and views and inform actions our Trust may need to take to promote fairness, transparency and equitable access to development opportunities.

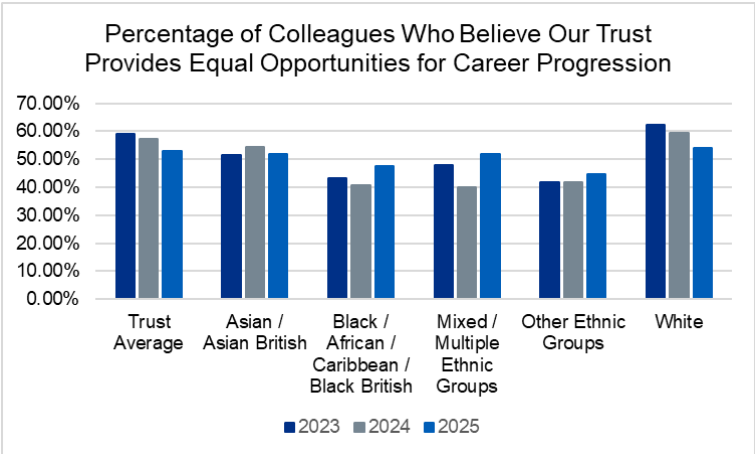
Analysis of LTHTr Data Over Time

	BME Colleagues	White Colleagues	Disparity Ratio
2025	50.7%	53.9%	1.06
2024	50.8%	59.5%	1.17
2023	49.7%	62.4%	1.25
2022	48.5%	62.0%	1.28
2021	49.5%	60.7%	1.33



Performance for this indicator has shown sustained improvement since 2022 and currently falls in the recommended disparity ratio range. However, it is of note that while the percentage of BME colleagues responding with the view that our Trust provides equal opportunities for career progression and promotion has remained on or around 50%, the percentage of White colleagues who feel there are equal opportunities for career progression and promotion has decreased over the past three years.

Expanded Ethnicity Breakdown of Our Data Over Time



While the average percentage of colleagues who believe our Trust provides equality Opportunities for career progression has generally declined over time, colleagues from Black, Mixed / Multiple Ethnic, and Other Ethnic groups have consistently been more likely to state they did not believe there are equal opportunities for career progression or promotion.

Indicator 8: Experiences of Discrimination from Manager or Colleagues

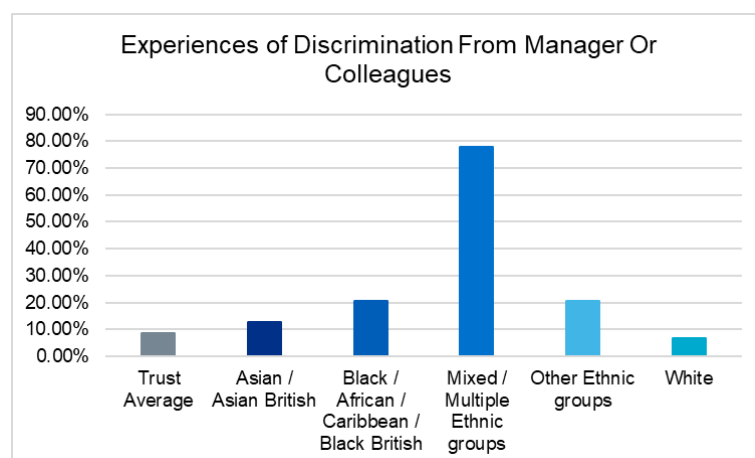
WRES Indicator 8 considers colleague experiences of discrimination from a manager, a team leader, or other colleagues at our Trust. The table below illustrates our Trust's data for this indicator compared to the NHS Staff Survey national benchmark:

	National Benchmark	Lancashire Teaching Hospitals
BME Colleagues	13.9%	14.2%
White Colleagues	6.5%	6.6%
Disparity Ratio	2.14	2.15

Our data shows that 14.2% of BME colleagues and 6.6% of White colleagues reported experiencing discrimination at work from a manager, team leader or other colleagues. The disparity ratio data for this indicator highlights that BME colleagues are more than twice as likely to experience discrimination from colleagues compared to White colleagues

At 2.15, the disparity ratio for this indicator is the worst performing out of all our Trust WRES indicators measured this year and strongly suggests that BME colleagues are more likely to experience considerable negative impacts compared to White colleagues.

Expanded Ethnicity Breakdown of Our Data

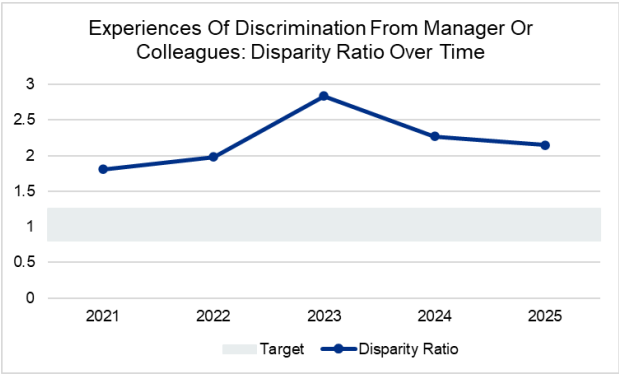


When analysing our data for this WRES Indicator in more detail, significant variation in reported experience is evident across ethnic groups. Colleagues from all ethnic backgrounds reported experiencing discrimination from their manager or other colleagues. However, our NHS Staff Survey data indicates that colleagues identifying as Black, Mixed or Multiple ethnic groups, and Other ethnic groups reported higher incidences of discrimination compared to colleagues identifying as Asian and White ethnicity.

Our data does not provide the context of colleague experiences; however, the findings suggest that some colleagues may be more likely to experience discrimination at work. This highlights the importance of further exploration to better understand the colleague experiences and inform targeted actions to improve inclusion and colleague experience across the organisation.

Analysis of LTHTr Data Over Time

	BME Colleagues	White Colleagues	Disparity Ratio
2025	14.2%	6.6%	2.15
2024	14.3%	6.3%	2.26
2023	15.6%	5.5%	2.84
2022	12.9%	6.5%	1.98
2021	12.5%	6.9%	1.81

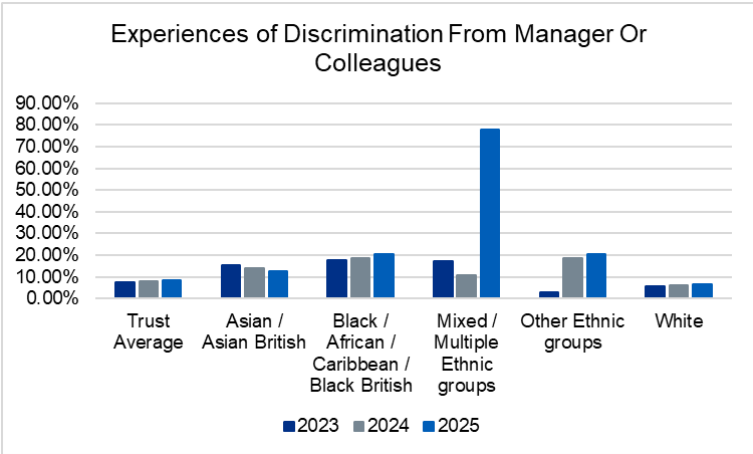


This year, our Trust has continued to build upon the improvement seen in 2024 as there has been a slight improvement in the disparity ratio for this metric.

However, it is important to note that the overall improvement in this indicator is not a result of discrimination decreasing at our Trust. The percentage of BME colleagues experiencing discrimination has remained static over the past three years; the reduction in the disparity ratio appears to have occurred due to an **increase** in White colleagues experiencing discrimination.

As shown in the line graph above, the disparity ratio for this indicator has consistently remained outside of the recommended range set by NHS England. Work to understand and improve colleague experience has been ongoing and must continue as a matter of urgency to reduce discrimination experienced by colleagues from BME and White communities.

Expanded Ethnicity Breakdown of Our Data Over Time



Our data indicates that over time, experiences of discrimination from managers or other colleagues have, and continues, to vary by ethnic group. The experience of colleagues of Mixed or Multiple ethnic backgrounds is significantly variable, with a marked increase in incidences of discrimination occurring over the past year. A similarly upward trend is also observed among colleagues identifying as Other ethnic backgrounds.

These trends require further exploration to better understand colleague experience and inform actions to mitigate and reduce reported experiences of discrimination.

Indicator 9: Board Membership

Our current Board membership includes two BME voting members. At 12.5% of the total Board membership, BME representation is lower than overall BME representation within our Trust workforce, which is 30.6% (please see WRES Indicator 1 for further detail).

WRES Action Plan

WRES mandates NHS organisations to produce an action plan that elaborates on priority areas identified in our report and sets out the next steps with milestones for expected progress against WRES indicators.

WRES actions will be formulated in collaboration with colleagues who participate in our Ethnicity Forum, our Anti-Racist Framework Working Group, and with our Partnership Team. To ensure our WRES actions are maintained over the course of the year, we will incorporate them with EDI-related actions in our Trust's wider strategic planning, including our Single Improvement Plan.

Our WRES data set outlines two priority areas that our Trust should focus upon in the next twelve months:

- Action 1: deepen understanding of lived experience of BME colleagues

Our WRES report illuminates areas where the working experience of our colleagues varies by ethnicity, such as recruitment, access to training and development, visibility in senior roles, and experiences of bullying, harassment and discrimination. While our WRES and NHS Staff Survey Data highlights areas of different experience, it does not provide us with the context, and in order to mitigate or remove disproportionate experiences, we need to better understand lived experience.

Over the coming year, the Equality, Diversity and Inclusion Team will work with our Ethnicity Forum, our OD Projects (Staff Engagement) colleagues, our Anti-Racist Working Group, our Partnership Team, and with colleagues across Workforce to collate evidence of lived experience. It is recommended to utilise mechanisms our Trust already has in place to efficiently gather information, such as via our Your Voice events, individual/group meetings with colleagues, and responding to intelligence received via staff sickness data, recruitment and retention data and anecdotal information shared by colleagues.

A richer, qualitative and quantitative understanding of WRES data will support proportionate, evidence-based actions.

- Action 2: develop and share divisional WRES data packs to support local actions

As mentioned at the outset, the Equality, Diversity and Inclusion Team has developed divisional WRES data packs to enable local interpretation of staff experience/survey data. These packs will support divisions to identify priorities, and align local actions within existing operational workstreams. Divisional WRES packs will support local accountability for WRES improvement, with actions that are tailored, targeted, and integrated into divisional plans rather than operating as standalone initiatives.

Whilst the Equality, Diversity and Inclusion Team have analysed the NHS Staff Survey EDI/WRES Data at divisional and Specialty Business Unit level, we hope to work alongside the Workforce Information Team to source divisional level data sets for WRES workforce Indicators 1-4 to further support divisions to understand their own WRES profiles.

Next steps:

- This report will be shared with the Ethnicity Forum to seek their views and lived experience in relation to these findings as well as to understand additional actions they believe will help to

reduce inequality and increase inclusion.

- To consult and co-produce with the Ethnicity Forum on the strategic action plan for equality, diversity and inclusion and seek their views on the content, understand what else forum members would want to see and make further amendments based on feedback.
- Communicate our WRES data and action plan to our workforce through organisational-level briefings and communications including Managers Update sessions and All-Colleague Briefings
- Sharing divisional-level WRES data packs
- Submit our WRES data to NHS England via the NHS online Data Collection Framework system
- Publish our results and action plan externally on our Trust website

FINANCIAL IMPLICATIONS

Research evidence indicates that when BME colleagues report greater engagement, there is a correlation with safer care for patients, reduced turnover, less sickness absence and improved financial performance.

LEGAL IMPLICATIONS

Unsatisfactory progress may leave the Trust open to legal challenges. We are required to demonstrate all colleagues have access to provision of services and are not discriminated against because of a protected characteristic.

RISKS

Unsatisfactory progress would be a risk to our reputation; both as a provider of Excellent Care with Compassion but also as an employer of choice.

IMPACT ON STAKEHOLDERS

There is a wide body of research evidence within the NHS which tells us that the experiences of our ethnic minority colleagues acts as a good barometer for the experience of our patients; the more positive the experience of our ethnic minority colleagues, the more positive the experience of our patients.

RECOMMENDATIONS

It is recommended that the Committee:

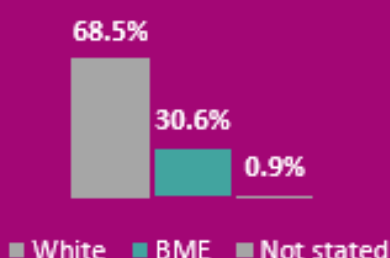
- Receive the report and note the content
- Approve the priority areas for action
- Approve publication of our results externally

THE WORKFORCE RACE EQUALITY STANDARD 2026

The NHS Workforce Race Equality Standard (WRES) was devised to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. There are nine WRES indicators. The infographic (for 2026) below highlights any differences between the experience and treatment of White colleagues and Ethnic Minority colleagues, as an organisation we are committed closing those gaps through the development and implementation of actions to bring about continuous improvement over time.

OUR DATA AND KEY FINDINGS

REPRESENTATION



APPOINTMENTS

White candidates are **1.68** times more likely than ethnic minority candidates to be appointed from shortlisting

DISCIPLINARY PROCESS

Ethnic minority colleagues are **0.96** slightly less likely to enter a formal disciplinary process than white colleagues

TRAINING AND DEVELOPMENT

White colleagues are slightly more likely **1.12** to access non-mandatory training and CPD compared to ethnic minority colleagues

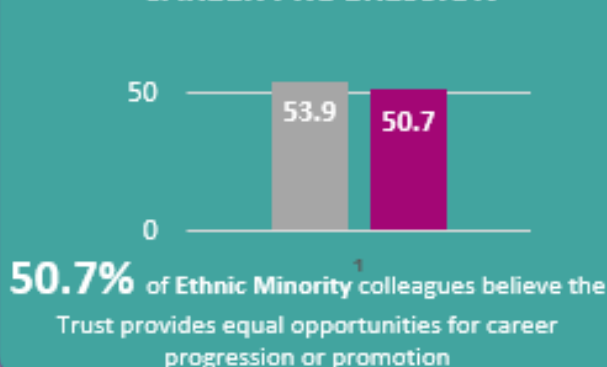
BULLYING AND HARRASSMENT FROM PATIENTS AND THE PUBLIC



BULLYING AND HARRASSMENT FROM COLLEAGUES



CAREER PROGRESSION



DISCRIMINATION



BOARD MEMBERSHIP

2 Board Members identify as belonging to an ethnic minority group, out of a total of 16 Board Members

C) C)?FREEDOM TO SPEAK UP REPORT

☐ Other

Item for Assurance

REFERENCES

Only PDFs are attached



10.1c Freedom to Speak Up Report Summary Board Part I 4 June 26.pdf



10.1c Freedom to Speak Up Report Board Part I 4 June 26.pdf

Board of Directors Report

Meeting of the	Board of Directors		4 th June 2026
	Part I ☒	Part II ☐	
Title of Report	Freedom to Speak Up Report		
Report Author	Christine Cain – Freedom to Speak Up Guardian		
Lead Executive Director	Neil Pease, Chief People Officer		
Recommendation/ Actions required	The Board of Directors is asked to: Receive and note the content of the report		
	Decision ☐	Assurance ☒	Information ☐
Executive Summary	This report provides assurance to the Board of Directors of the Freedom to Speak Up (FTSU) service activity covering the period of January to April 2026, bringing together case activity, colleague perceptions of speaking up, thematic analysis and progress against agreed actions. It also reflects a period of transition and consolidation, including the appointment of the FTSU Guardian and the implication of a new Trust risk management system. The reporting period coincides with the transition from Datix, end January, to the Ulysses risk management system, during which full comparative and longitudinal reporting has been temporarily limited. As the Ulysses reporting functionality continues to be embedded and aligned with historic data, routine comparative analysis has had to be paused over the last three months to allow data validation, system configuration and assurance of reporting accuracy following the system change. The system and reporting configuration does not reflect a reduction in FTSU activity or quality of the service to users. Once fully established, Ulysses is expected to provide improved data quality, consistency and opportunities for more analysis, strengthening assurance over time. The report also reflects the early months following the appointment of a new FTSU Guardian, who is continuing to build on the existing speak up agenda and original 2025 Speak Up Reflection and Planning programme. Focus during this period has included stabilising core processes, strengthening relationships with divisions, supporting colleagues raising concerns and aligning FTSU activity with emerging staff survey findings and system changes. This work provides a strong foundation for the next phase of development and cultural improvement. During this period, a total of 73 concerns were recorded between January and April 2026 with trends broadly consistent with previous reporting. Following initial peak in January, associated with targeted working in a specific area, activity stabilised over the subsequent months. Surgery and Medicine continue to generate the highest volume of concerns, reflecting workforce size, service		

	pressure and established reporting patterns. Divisional leaders will received regular reporting intelligence to support learning escalation and assurance through reporting ready for triangulation and evaluation during Divisional Improvement Forums. While overall reporting volumes have remained broadly stable, colleague perceptions of speaking up have continued to decline, as evidenced by the 2025 NHS Staff Survey. Confidence in feeling safe to speak up and in concerns being addressed remains below national benchmarks, reflecting both local and national trends. These finding reinforce the ongoing importance of psychological safety, leadership behaviours, visible follow-through and consistency communication, rather than reliance on report volumes alone as an indicator of culture. Thematic analysis continues to identify shifting and persistent concerns relating to leadership, communication, unfair treatment, peer to peer behaviours, discrimination which in turn impacts on health, wellbeing and patient safety. Qualitative feedback both identified both in the survey and during Guardian visits on wards and clinical areas, reflect strengths such as strong local teamwork, professionalism and commitment to patient care, and areas of cultural fragility where staff report feeling unheard or unsafe to raise concerns. In response, the FTSU strategic focus for 2026 has been refreshed to align with both reporting insights and staff survey outcomes. Priorities include strengthening visibility and trust in speaking up, development and diversifying the Speak Up Champion network, supporting leaders and managers to respond well to concerns, and improvement understanding and prevention of detriment. Divisions are invited to take locally owned, supportive approach to embedding speaking up as part of everyday leadership and management practice. In summary, this report provides assurance that FTSU arrangements remain accessible, effective and valued by colleagues who use them. However, it also highlights clear system, cultural and leadership concerns requiring sustained and visibility leadership attention.	
Link to Strategic Objectives 2025/26	Patients – deliver excellent care: Improve outcomes, reduce harm and deliver a positive patient experience.	☐
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.	☐
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.	☒
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.	☐
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.	☐
Due Diligence	To give the Trust Board assurance, please complete the following:	
Committee Approval:	Name of Committee: Workforce Committee	Date: 12 th May 2026
Operational Group Review:	Name of Operational Group: Raising Concerns Group	Date: 21 st April 2026
Link to Board Assurance Framework:	Principal Risk 8 (26/27) - Experience of staff and levels of staff satisfaction	
Appendices	State whether there are any appendices and list them. For example: Appendix 1: Full Report	

APPENDIX 1 – FULL FREEDOM TO SPEAK UP BIENNIAL REPORT

BACKGROUND

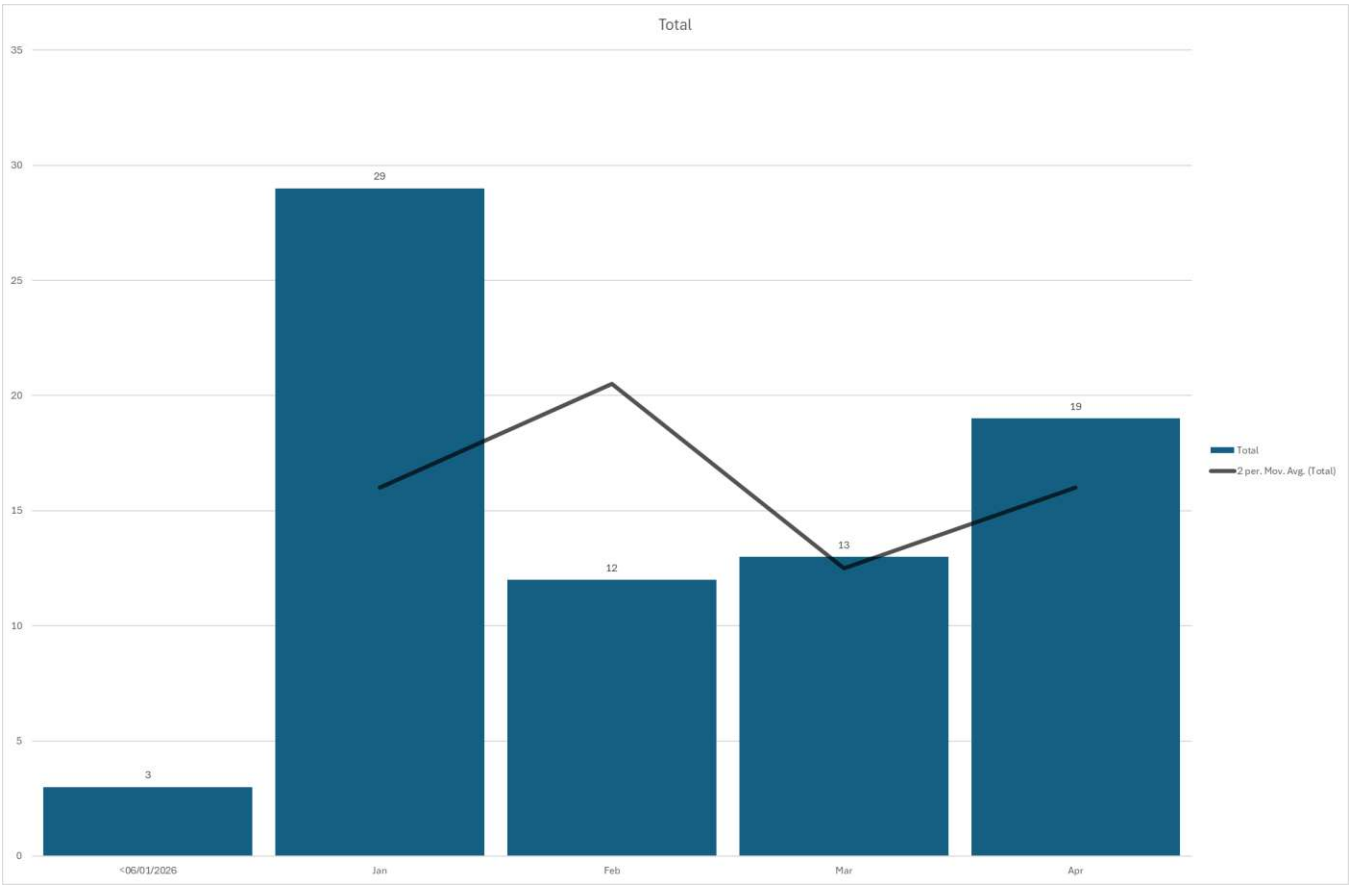
This report provides an update on Freedom to Speak Up (FTSU) activity over the last four months (January 2026 – April 2026). It brings together colleague feedback on speaking up from this year, outlines progress against actions agreed in the previous report, and sets out clear priorities for the year ahead.

During the current transition from Datix to Ulysses, the full twelve-month comparative dataset normally disclosed in this report, is not yet available. While the reporting functionality continues to be embedded, this report presents a clear and meaningful picture of current FTSU activity and themes. As the system becomes fully established, future reports to this forum, through Raising Concerns and to divisions will reintroduce routine comparative analysis, strengthening insight and assurance over time.

PART 1: FREEDOM TO SPEAK UP ACTIVITY

- Organisational Activity

Over the last 4 months, the number of cases show an initial peak in Jan (n = 29) likely due to bespoke work in a specific area of the organisation, this was followed by a reduction in Feb (n = 12). Case numbers then increase gradually in March (n = 10) and April (n = 19). The data for January (<06/01/2026”) is not a valid data set as this reflects the issues with data quality due to the transfer from Datix to Ulysses, this is currently under review and will be amended once the data set is transferred.



The national picture for 2024/2025 (National Guardian Office) is that the number of colleagues raising FTSU concerns has increased by 18.6% from the previous year. More recent national data (for 2025/2026) will be shortly available and further analysis against this national trend will be undertaken at this point.

a) Divisional Activity

Over the last 4 months, the two largest Divisions (Surgery and Medicine) generated the greatest number of concerns, this is in part reflective of the larger numbers of staff working in these divisions.

Division	No. of concerns raised Jan 2026– April 2026
W&Cs	13
Surgery	24
Medicine	21
E&F	1
DCS	7
Corporate	7
Total	73

Previously Divisional level reporting had been established, however since the start of 2026 it has not been possible to run these reports due to challenges from moving from Datix to Ulysses. However once reporting is re-established, the Divisional Management Team (Divisional Director, Medical Lead, Nursing Lead and Workforce Business Partners) will be provided with monthly reports on the nature, distribution and themes of concerns to enable learning and improvement. These have been and will continue to be provided in advance of the monthly Divisional Improvement Forums – Part 2, to ensure this information can be referred to as appropriate in these meetings. The reports will also indicate to the Divisional Management Team when 3 or more concerns have been raised from within a particular service/SBU within the last 12 months, this enables the Division to identify if there is an emerging cultural concern requiring further investigation and facilitate further discussions on potential cultural concerns or issues arising from these areas.

PART 2: SPEAKING UP THEMES

• Themes of Concerns

Between January and April 2026, Speak Up concerns were primarily driven by health and wellbeing pressures and cultural issues such as communication, leadership behaviour, and fairness, with ongoing, but lower-level patient safety and professional concerns, reinforcing staff survey findings on psychological safety and confidence in follow-through.

The changes (table below) reflect evolving dynamics within our workplace and highlight areas where we need to focus our efforts to ensure a supportive and safe environment for all colleagues here at LTH:

- **Health & Wellbeing**, impact the dominant driver of concerns, indicated continued pressure on staff and the cumulative effect of workload stress and working conditions event where patient safety is not the primary issue raised.
- **Behavioural & Cultural**, concerns are prominent: particularly poor communication, poor leadership, unfair treatment and peer to peer behaviour. These themes suggest variability in leadership quality and team dynamics rather than isolated incidents.
- **Patient safety, professional standards**, and unsafe practice concerns continue to feature, though at lower volumes, indicating that staff are still raising risk-based concerns alongside cultural and relational issues.
- **Concerns relating to discrimination, fear of detriment, and lack of response** from managers appear at lower frequency but persist, reinforcing staff survey findings about reduced confidence in speaking up and trust in follow-through.

Overall, the themes reflect a shift from single-issue safety concerns towards broader cultural, behavioural, and leadership related issues.

Ulysses Themes from Jan to April 26				
	January	February	March	April
Adverse impact on health and well being	13.73%	9.09%	15.94%	12.90%
Bullying and harassment - manager	3.92%	1.82%	1.45%	3.23%
Bullying and harassment - peer	10.46%	9.09%	4.35%	6.45%
Change in working conditions	0.00%	0.00%	1.45%	1.61%
Discrimination - disability	0.65%	0.00%	0.00%	0.00%
Discrimination - gender	0.65%	0.00%	0.00%	1.61%
Discrimination - race	0.65%	1.82%	0.00%	0.00%
Fear of detriment?	1.96%	1.82%	1.45%	3.23%
Fraud/dishonesty	1.31%	0.00%	0.00%	0.00%
Lack of involvement/consultation	3.92%	5.45%	1.45%	4.84%
Lack of response for manager	5.23%	5.45%	2.90%	4.84%
Patient safety risk	3.92%	5.45%	7.25%	4.84%
Poor attitude and behaviour - manager	3.92%	1.82%	2.90%	3.23%
Poor attitude and behaviour - peer	9.15%	5.45%	4.35%	6.45%
Poor communication	11.76%	16.36%	14.49%	16.13%
Poor leadership	12.42%	5.45%	4.35%	8.06%
Professional concerns	7.84%	10.91%	8.70%	4.84%
Public safety risk	1.31%	1.82%	4.35%	1.61%
Unfair treatment/bias/breach of policy	1.96%	10.91%	4.35%	4.84%
Unsafe practice - infection control	0.00%	0.00%	1.45%	0.00%
Unsafe practice - non-clinical	0.00%	0.00%	0.00%	1.61%
Unsafe practice - Workwear compliance	0.65%	0.00%	0.00%	0.00%
Unsafe practice- clinical	1.96%	3.64%	2.90%	4.84%
Unsafe practice- individual	0.00%	1.82%	1.45%	1.61%
Unsafe staffing levels	1.31%	0.00%	4.35%	0.00%
Unwanted, inappropriate and/or harmful sexual behaviour	1.31%	1.82%	1.45%	0.00%
Worker safety risk	0.00%	0.00%	8.70%	3.23%

• Anonymous Concerns

There has been a total of three anonymous reporting from Jan 26 – April 26. The Ulysses system clearly highlights that staff can raise concerns anonymously; while these will be actioned and responded to as fully as possible, staff are advised that anonymous reporting may limit follow-up, feedback, and the level of assurance compared to confidential reporting.

Welcome to the Freedom to Speak Up Platform. Following the Freedom to Speak Up report (2015) led by Sir Robert Francis QC, we created this formal incident reporting form to help standardise how NHS staff can raise concerns safely. This secure space is accessed only by the Freedom to Speak Up Guardian. We encourage you to share your name so we can contact you and offer full support; your details remain confidential and are not shared without your agreement. You may raise a concern anonymously if you prefer, though this may limit our ability to respond or update you. Once you submit your concern, someone will be in touch. For more information, please visit the Freedom to Speak Up intranet page or access our training for staff, managers and leaders.

Where concerns are raised anonymously by email, the FTSU service continues to promote supportive engagement and information sharing to help concerns be progressed appropriately, while respecting the individual's wish to remain anonymous.

• Concerns By Professional Group

Clinical staff continue to raise the most concerns. Over the last 4 months Registered Nurses, HCAs and AHPs collectively raised 52% of concerns. The “blank” reflects either limitations in the transfer of data between systems or instances where information has been withheld to preserve staff anonymity.

Staff Group	Number	Percent
Admin/Clerical/Management	4	6.67%
Agency/Bank Nursing	1	1.66%
Allied Health Professional	10	16.65%
Ancillary/Estates Staff	1	1.67%
Biomedical Scientist	1	1.67%
Consultant	2	3.32%
Nursing/Midwifery	20	33.25%
Specialist Trainee	3	4.96%
(blank)	34	30.15%

PART 3: PERCEPTIONS OF SPEAKING UP

a) Organisational Perceptions

Data from our 2025 NHS Staff Survey results suggest that there has been a decline in the way our staff feel about speaking up and raising concerns in comparison to the 2024 NHS Staff Survey Results. This continues to reflect the national trend. There is a continued decline in colleagues reporting that they feel safe to speak up (Q25e) and feeling that the organisation would address the concerns they raised (q25f) scoring below the national benchmark.

Question No.	Description	Organisational Score 2023	Organisational Score 2024	Organisational Score 2025	National Avg. 2025
Q25e	Feel safe to speak up about anything that concerns me in this organisation.	62.8%	58.5%	55.4%	59.1%
Q25f	Feel organisation would address any concerns I raise.	50.1%	44.2%	42.2%	46.3%

Results show declining confidence in reporting unsafe clinical practice and in concerns being addressed, with scores below national averages. While perceptions of bullying and harassment have improved over the past

three years, they remain slightly below national benchmarks, and reported violence has improved and now sits above the national average. Overall, the findings reinforce the need for continued focus on psychological safety, respectful behaviours, and confidence in raising concerns.

Question No.	Description	Organisational Score 2023	Organisational Score 2024	Organisational Score 2025	National Avg. 2025
Q13d	Last experience of physical violence reported.	74.1%	72.5%	73.7%	73.2%
Q14d	Last experience of bullying, harassment or abuse reported.	51.5%	52.6%	53.3%	53.7%
Q19b	Encouraged to report errors, near misses & incidents.	87.6%	86.0%	85.3%	85.8%
Q20a	Would feel secure raising concerns about unsafe clinical practise.	70.6%	70.1%	67.3%	69.6%
Q20b	Would feel confident that organisation would address concerns about unsafe clinical practice.	55.4%	53.2%	50.5%	53.9%

b) Divisional Perceptions

Reviewing colleague feedback via the NHS Staff Survey 2025 by Division, it is noted that there are differences in perceptions based on the Division colleagues work. The scores noted in green indicate the highest scoring divisions, and those in red the lowest. Corporate and DCS perform more strongly overall, with DCS colleagues notably more likely to report errors, near misses and incidents, while Surgery reports higher confidence in raising concerns about unsafe clinical practice. In contrast, some areas continue to score lower on management support and speaking up, and most Medicine areas now sit in a more neutral position compared to last year, indicating a softening of confidence rather than sustained improvement.

Question No.	Description	W&Cs	Surgery	Medicine	E&F	DCS	Corporate
Q9h	Immediate manager cares about my concerns.	68.4%	70.7%	68.2%	61.3%	67.8%	77.3%
Q9i	Immediate manager helps me with problems I face.	61.8%	68.5%	63.8%	58.9%	65.0%	75.4%
Q25e	Feel safe to speak up about anything that concerns me in this organisation.	54.5%	57.0%	52.5%	51.4%	55.9%	59.7%
Q25f	Feel organisation would address any concerns I raise.	40.9%	43.3%	40.4%	43.9%	40.7%	42.2%
Q13d	Last experience of physical violence reported.	93.8%	66.3%	82.7%	78.8%	51.6%	73.7%
Q14d	Not experienced of bullying, harassment or abuse reported.	90.4%	92.3%	90.6%	90.2%	93.3%	92.3%

Q19b	Encouraged to report errors, near misses & incidents.	87.8%	85.2%	84.1%	74.8%	88.9%	88.5%
Q20a	Would feel secure raising concerns about unsafe clinical practise.	69.7%	70.4%	67.1%	52.1%	70.2%	67.4%
Q20b	Would feel confident that organisation would address concerns about unsafe clinical practice.	49.6%	52.9%	47.9%	48.4%	51.6%	50.2%

c) Team Perceptions

In conjunction with wider staff survey team-level analysis, several areas have been identified where perceptions of speaking up are lower as indicated in the table below highlighting the areas of focus. These teams will be offered direct support to review the findings and identify opportunities for improvement. Divisions will also be encouraged to strengthen Speak Up Champion representation, particularly in higher risk areas, and to support leaders and managers to undertake the NHS – National Guardian Office Speak Up training to help embed a positive and open speaking up culture.

Teams where these scores are particularly high detailed in the table below under the column titled areas of stability, it is planned that these teams will also be contacted to explore opportunities for learning and positive practise which can then be shared more widely

Areas of Focus	Areas of Stability
• Emergency Medical • Anaesthetics Medical • Obstetrics • Pathology • Radiology • Students & Trainee Placement Support	• Endoscopy • SBU Renal Unit, 2nd year • SBU Pharmacy • Neurosurgery Ward 2nd year • Oncology Medical – 2nd year

• Individual Perceptions/FTSU Service Feedback

The feedback process in place for colleagues who have accessed the Freedom to Speak Up service. In this period, five responses have been received and will continue to be reviewed as further feedback is gathered. Early findings indicate positive experiences of speaking up, with little negative experiences. Over the next six months, there is a clear aim to increase feedback volumes to enable more robust analysis and ongoing service improvement.

In addition to the 2025 Staff Survey, the free text comments provide insights into colleague's experiences of speaking up and raising concerns. While these comments represent a small number of respondents (few than 10 colleagues), they are helpful in illustrating contrasting experiences across the organisation.

Many colleagues describe strong professional values, supportive local teams and pride in patient care, which act as important protective factors. However, these strengths are undermined in some areas by low psychological safety, inconsistent leadership behaviours, limited confidence that concerns will be acted upon, and fear of detriment after speaking up.

Recurring themes include bullying and incivility, inconsistent application of policies, discrimination, confidentiality concerns and sustained workforce pressure contributing to burnout and patient safety risk. Taken together, the feedback reinforces the need for visible leadership, consistent follow-through and continued focus on building trust in speaking up arrangements.

PART 4: PRIORITIES AND ACTIONS FOR THE FREEDOM TO SPEAK UP SERVICE

The priorities and actions set out below directly respond to the 2025 NHS Staff Survey data and Speak Up thematic analysis, particularly declining confidence to speak up, concerns about leadership behaviour and follow-through, and fear of detriment

Key areas for focus include:

Strengthening Visibility and Trust – this will be achieved by ensuring colleagues have the capability, knowledge and skills to speak up themselves and to support others to speak up. Actions to support this include increasing visibility of the FTSU service to all new starters and students through regular attendance at induction and update of materials, along with increasing the visibility of how colleagues can raise concerns using different methods to contact the FTSU service.

Building and Developing the FTSU Champion Network this will be achieved by continuing to strengthen the Champion Network, their confidence and visibility. To deliver this we will seek to recruit Champions from areas which are underrepresented in terms of raising concerns or in high risk. We will continue to hold quarterly forums with Champions with the purpose of peer networking, sharing, ongoing development and lessons learnt opportunities so that themes, progress and challenges can be explored and support offered as required.

Creating a Positive FTSU Culture – this will be delivered by:

- Sharing good news stories (that are anonymised) via the whole Trust communication channels.
- Using anonymised staff stories to raise awareness around concerns relating to detriment, needing to anonymously report concerns.
- Sharing the themes and trends relating to Line Managers (e.g. importance of closing the feedback loop and providing timely responses to concerns with regards to what actions can be taken along with what may not be possible and why) to support manager to recognise how their role has an impact on colleague perceptions that their issues and concerns are taken seriously.
- Supporting Leaders and Managers to understand their role in creating a FTSU culture and the steps they can take to encourage colleagues to speak up locally.
- Helping Leaders and Managers to understand what whistleblowing is and examples of what may constitute detriment or negative repercussions because of raising a concern.

How Will We Know This is Making a Difference: Themes relating to leadership response and follow-through will be shared with Divisional Leadership Teams to support reflection, challenge and improvement, with repeated themes escalated through Raising Concerns governance.

Understanding Levels of Detriment and Costs of Raising Concerns: the actions to progress this aim include scoping and designing a method in which to measure levels of detriment experienced by colleagues who have raised concerns. In the interim, detriment concerns continue to be monitored through Guardian follow-up, confidential check-ins and escalation through Raising Concerns governance where risks are identified.

PRIORITIES AND ACTIONS TO ENCOURAGE SPEAKING UP REQUESTED FROM DIVISIONS

To respond to the continued decline in staff confidence to speak up, divisions are encouraged to prioritise locally owned, targeted actions that reinforce speaking up as everyone's business. Rather than mandating activity, Divisions are invited to actively promote and support engagement with the Trust's blended learning awareness package - Listen Up for managers and Follow Up for leaders, to strengthen compassionate listening, effective responses and appropriate follow-through; participation can be monitored and reported for assurance.

Divisions are also asked to consider supporting a minimum of 10 Speak Up Champions per Division from under-represented groups, particularly lower-banded roles and areas requiring focus. The recruitment of the champions will be led by the Guardian and in line with fair appointment processes. Additionally, Divisions are asked to consider hosting informal twice-yearly half hour "tea and chat" session with local champions. These sessions would provide a safe space to share high-level themes of concerns being raised (without breaching confidentiality), any proactive work they are doing in their area, any, what could be getting in the way and what they think would help staff feel safer to raise concerns. This will provide the Divisions with local insight, visibly reinforce the importance, credibility, and value of the champion role, helping champions feel recognised, supported, and confident to continue supporting colleagues and enabling earlier, trust-building interventions where staff confidence is lowest

FINANCIAL IMPLICATIONS

None

LEGAL IMPLICATIONS

There are no legal implications associated with this report. However, Trust arrangements for raising and responding to concerns are referenced in the standard NHS contract; are subject to review by the Care Quality Commission (CQC) as part of the Well-led domain; and are monitored by the National Guardians Office (NGO), which is sponsored by the CQC and NHS England (NHSE). Failure to address concerns being raised within the organisation could result in external concerns being raised including legal action such as employment tribunals or because of safety concerns not being appropriately resolved.

RISKS

Risks include:

- While actions are underway to strengthen Freedom to Speak Up arrangements, FTSU workforce capacity constraints have impacted the pace and scope of delivery of wider cultural and engagement activity. This risk is reflected in the 2025 Lancashire Teaching Hospitals NHS Foundation Trust Staff Survey, which highlights lower levels of confidence among staff that concerns raised will be followed up effectively.
- Failure to receive an adequate response to concerns raised and to implement lessons learnt may impact on the credibility and confidence colleagues have of the FTSU service.
- The continued issues with Ulysses is preventing effective oversight of FTSU data, ability to interrogate data and compare current trends with past data sets. Whilst progress is being made, it is not clear when issues will be resolved.

RECOMMENDATIONS

The Board of Directors is asked to:

Note the information and assurance relating to Freedom to Speak Up activity and themes of concerns, the actions which are being taken to address issues and strengthen confidence in the FTSU service.

D) SOCIAL VALUE STRATEGY ANNUAL REPORT

● Other

Item for Assurance

REFERENCES

Only PDFs are attached



10.1d Social Value Strategy Annual Report Summary Board Part I 4 June 26.pdf



10.1d Social Value Strategy Annual Report Board Part I 4 June 26.pdf



Board of Directors Report

Meeting of the	Board of Directors	4 th June 2026	
	Part I ☒	Part II ☐	
Title of Report	Social Value Strategy Update Report		
Report Author	Louisa Graham, Deputy Chief People Officer		
Lead Executive Director	Neil Pease, Chief People Officer		
Recommendation/ Actions required	The Board of Directors is asked to: review the contents of this report and note the strategy delivery plan for the next 12 months		
	Decision ☐	Assurance ☒	Information ☐
Executive Summary	The Social Value Strategy 2025–2030 which was approved by Board of Directors in October 2025 sets out the organisation’s ambition to improve the lives of our communities and colleagues through our role as an anchor institution. The strategy aligns directly with the organisation’s corporate objectives (the 5 P’s) and acts as an umbrella framework, drawing together and complementing delivery through the Health Inequalities Plan, Green Plan, Our People Plan and the Equality, Diversity and Inclusion Strategy. It is underpinned by three strategic aims: 1. Creating careers and opportunities by being a local employer of choice 2. Leveraging our contracting, estate and sustainable practices to deliver local benefits and social value 3. Connecting community and partnerships This report outlines how the strategy will be embedded across the organisation though communication and awareness campaigns, it describes the proposed approach to measuring social value impact, and the 12-month delivery plan for Aim 1, which is primarily led through Workforce, Organisational Development and Education teams. The strategic focus for Aim 1 includes actions to improve workforce health and wellbeing, create inclusive recruitment and progression, widening participation, volunteering, building leadership capability, increasing our widening participation offer and enhancing the skills of our wider workforce. There has been some early progress made this includes engagement with internal leaders and external partners, the establishment of governance through a dedicated Social Value Delivery Group, refreshed communications, and co creation of priority actions for the next year. Notable achievements that already demonstrate social value in action, include the winning of a national award for the Lancashire Health Hub by our Libraries and Knowledge Management Services, which exemplifies collaborative working to reduce health inequalities and improve health and digital literacy locally.		

	As part of the early actions delivered, this report describes the approach to measurement of impact which is core to the 'Inform, Maximise, Measure and Report' approach described as a framework for progressing social value actions in our organisation. Following a critical review of available approaches and products, the proposed approach combines the National Themes, Outcomes and Measures (TOMs) with internal quantitative and qualitative impact measures. This approach will hopefully enable the organisation to align with nationally recognised public sector standards while capturing meaningful outcomes for colleagues, communities and partners. There are no direct financial implications associated with delivery, though evidencing social value will strengthen the organisation's position in potential commercial bids and wider community partnerships. Key risks relate to capacity and resource constraints, particularly within Workforce and Organisational Development within LTH, but also within 1LSC services Procurement, Estates and Facilities and recruitment.	
Link to Strategic Objectives 2025/26	Patients – deliver excellent care: Improve outcomes, reduce harm and deliver a positive patient experience.	☐
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.	☐
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.	☒
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.	☐
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.	☒
Due Diligence	To give the Trust Board assurance, please complete the following:	
Committee Approval:	Name of Committee: Workforce Committee	Date: 12 th May 2026
Operational Group Review:	Name of Operational Group: Social Value Delivery Group	Date: 21 st April 2026
Link to Board Assurance Framework:	N/A - No aligned to a Principle Risk	
Appendices	State whether there are any appendices and list them. For example: Appendix 1: Full Report	

APPENDIX 1 – FULL SOCIAL VALUE REPORT

INTRODUCTION

The Social Value Strategy 2025 - 2030 (Appendix 1) was approved by Board of Directors in October 2025 and an initial draft was first presented to Workforce Committee back in July 2025. The Social Value Strategy sets out our vision which is to **'Improve the lives of our communities and colleagues through our role as an anchor institution'**. The Social Value Strategy is integrated in the organisations 5 P's which are our corporate objectives. The strategy describes the social value delivery framework which is designed to provide a consistent approach to embedding social value across the organisation, through informing colleagues of their role and how all parts of the organisation can contribute to fulfilling our role as an anchor institution. Maximising the social value impact of the actions we take across all strategic programmes of work through to proactively seeking to measure the impact we make in creating social value.

This strategy is an umbrella strategy, as the aims and our role as an anchor institution cannot be delivered without the focussed work described in the Health Inequalities Plan, Green Plan, Our People Plan and the Equality, Diversity and Inclusion Strategy. To achieve the vision described in the Social Value Strategy, the following strategic aims are proposed:

1. Creating careers and opportunities by being a local employer of choice
2. Leveraging our contracting, estate and sustainable practices to deliver local benefits and social value
3. Connecting community and partnerships

The focus of this report is to provide an overview of how the strategy will be embedded and the proposed measurement framework to enable us to calculate the level of social value provided to our local areas, alongside organisational impact measures. This report will also outline the direction of travel and the detailed actions for the next 12 months designed to support the delivery of Aim 1, as this aim is predominantly delivered through the Workforce, Organisational Development and Education functions and therefore the focus more relevant for this committee. Aim 2 is aligned with the Green Plan and Estates Strategy and Aim 3 includes the work of the Health Inequalities Plan alongside wider strategic partnership work is reported to other relevant Trust sub board committees.

DISCUSSION

Since the draft strategy was last presented, the following groundwork has been achieved –

- Consultation and engagement with Trust Management Board members on the focus and direction of the Social Value Strategy.
- Presentation of the aims of the Social Value Strategy to the Health Inequalities Group.
- Engagement with Lancashire Skills and Employment Hub and Lancashire Combined County Authority to develop partnership working with regards to their social value programmes (Connect to Work, WorkWell Lancashire and the Lancashire Skills Pledge) and understand their approach to measurement for social value.
- Delivery of Social Value Strategy overview as part of the all the Leaders briefing in October 2025.
- Refreshed the internal and external social value web pages.
- Design and delivery of a Social Value Strategy setting session with Workforce, Organisational Development and Education team leaders to cocreate the next 12 months strategic actions to enable the delivery of aim 1.

- Establishment of a Social Value Delivery Group for Aim 1 which is a subgroup of Workforce Committee with Chairs Reports reportable on a quarterly basis.
- Developed an [animation](#) to describe the social value strategy and what it means to be an anchor institution in partnership with Blended Learning Team. The animation to be launched across the Trust as part of wider communications around social value approach.
- Our Library and Knowledge Management Services submitted an entry and won the award for The [Lancashire Health Hub](#) at the LILAC conference which was held in Sheffield in March this year. The award is for outstanding UK based practice, the judges highlighted the collaborative approach involving public libraries and health libraries across Lancashire, the targeting of the most vulnerable public through outreach work, and the longevity of the hub being a trusted and reliable source of health-related information.

The Health Hub uses local government data, with easy read and accessible content, the hub was created and designed specifically to support the local population to understand the world around them in a health care and digital context. Whilst targeting deprivation through signposting to free data SIMS and courses to support employability, it also supports the health and digital literacy skills of health and social care staff through the professionals' side of the site.

As part of their prize, £500 was donated to Sure-Start Central Lancashire to allow them to support families and continue to develop and promote their important work. The project will also be shared with Manchester University population health students as an example of good practice in reducing health inequalities and improving health literacy skills.

SCOPING MEASUREMENT APPROACH

The Social Value Strategy sets out the consistent approach to embedding and aligning social value into all aspects of the work in the organisation, through application of a standardised framework which is to

The Social Value Framework has been developed to provide a consistent approach to embedding Social Value across our organisation. It is also intended to ensure that we go above and beyond our current Social Value activity and explore new ways of creating, measuring and reviewing Social Value across the organisation. The Social Value Framework aims to:

Inform: Support all colleagues to understand the role of social value and identify how all parts of our organisation can contribute to fulfilling our role as an anchor institution.

Maximise: The key principle underpinning the Social Value Framework is that all our activities should contribute towards our vision which is to improve the lives of our communities and colleagues through our role as an anchor institution. There isn't one set of actions which will achieve this, our actions and approach must be dynamic, evolve with time and as we make progress and learn through doing.

Measure: Develop immediate and longer-term commitments which will facilitate the creation of social value, along with clear indicators that we can use to measure, monitor and evaluate progress towards our impact in providing social value. This will involve scoping measurement opportunities and methodology, identifying the data and information we need to benchmark and then track progress, highlight success and understand areas that need improving.

Report: We will publish an annual strategic update of our progress in delivering social value and achievements as an anchor institution. The annual update will demonstrate the progress we are making, where there are opportunities to do more, the impact our actions have had and our focus for the coming year.

As part of the approach to determining the most effective methodology to understand the social value delivered and the organisational impact measures the following approaches were reviewed and evaluated against our organisational and community context:

Accreditation Schemes

This method has been used as part of the last Social Value Strategy. From undertaking a critical appraisal of this approach, it was found that the benefits of utilising an external accreditation process is that it provides a quality mark which organisations can utilise to promote their social value work. The levels of previously used **Social Value Quality Mark** ranged from bronze to platinum, this approach enabled organisations to influence the focus and to self assess against a series of pledges and share evidence as part of the accreditation process. The limitations of this approach, along with the cost – although minimal, was it did not have any proxies in which to measure social value impact delivered as a quantitative and standardised measure.

Validation and Measurement Platforms and Approaches

There are a number of global, national, paid for and free measurement platforms and approaches for measuring social value. Some of the UK based platforms are predominantly qualitative impact measures in their focus, requiring significant resource to be focussed on the gathering of free text views of stakeholders.

The **Global Sustainable Development Goals** are broad in focus, with 100 global monitoring indicators suggested. Whilst the focus of these measures is more quantitative, in many cases the measures are beyond what a typical NHS Trust could influence through their work and purpose. Some of the indicators include measures around the number of broadband subscriptions through to measures relating to the conservation of oceans and seas, through to sustainable farming and food production.

The **National Themes, Outcomes and Measures or TOMs** are the UK's most widely used framework for defining, measuring and comparing social value. The National TOMs are the only measurement framework underpinned by government data, endorsed and used extensively by the Local Government Authority and other public sector bodies. This approach provides common language for social value, a standardised way for public bodies and suppliers to specify what social value they want and how it will be evidenced and quantified. The National TOM's were last updated and republished in 2022.

The themes measured in this national framework all fall under 5 core themes which are relevant to the work of the Trust. These are:

- Jobs – Promote local skills and employment
- Growth – Supporting growth of responsible regional businesses
- Social – Healthier, safer and more resilient communities
- Environment – Decarbonisation and safeguarding the planet
- Innovation – Promoting social innovation and impact-led solutions

The outcomes for each of the themes describe the change each activity is intended to make such as:

- More local people in employment
- More opportunities for disadvantaged groups
- Improved skills and employability
- Reduced carbon emissions
- Stronger community cohesion

The National TOM's also translate social, economic and environmental benefits into measurable and monetised outcomes (often expressed as £ of social value). The measures can include volume measures, such as the number of full-time local jobs created, the number of apprenticeships provided, the tonnes of carbon emissions avoided. However, they also provide financial proxy values, converting this activity into the financial contribution of this activity towards delivering social value for our community. For example for each employee who is provided with professional support for anxiety and depression through CBT or equivalent it equates to a social value financial proxy of £140 per person. By adopting the National TOM's we would be consistent with the social measures used in wider public sector organisations.

The limitations of the national TOM's is that they were last updated in 2022 and some of the TOM's refer to covid recovery which was clearly relevant at that point in time. However, it is possible to select and map across only the relevant TOM's to the strategic actions and ambitions of this strategy. The wider limitation is the lack of qualitative evaluation which we would need to address as part of the design of our internal impact measures to ensure stakeholders, staff and hard to reach groups have a voice and are engaged in us understanding the difference we may have made.

The approach being taken forward to enable impact to be measured as part of the Social Value Strategy is to utilise relevant National TOM's alongside internal impact measures this will include both qualitative and quantitative evaluation.

STRATEGIC FOCUS FOR THE AIM - CREATING CAREERS AND OPPORTUNITIES BY BEING A LOCAL EMPLOYER OF CHOICE

The strategic work programme for this aim is detailed fully in Appendix 2. This work programme predominantly is the responsibility of Workforce, Organisational Development and Education. It is aligned to our health and wellbeing approach, leadership development offer, Our People Plan, Equality, Diversity and Inclusion Strategy, the People Portfolio and Partnership Portfolio as part of the Single Improvement Plan, our aspirations to achieve University Hospital Status and be a centre of excellence for healthcare training and education.

The work programme embeds the measurement approach as described earlier in this paper and demonstrates how relevant National TOM's alongside internal evaluation methods will be utilised to determine progress and impact. Each of the points described below have a series of actions which will enable progress is made. Where relevant within Appendix 2 we have indicated when an action is also aligned to actions within the Single Improvement Plan to reduce duplication.

The focus of strategic actions for this aim for the **Workforce and Organisational Development Portfolio** are:

- Create awareness and commitment to our role as an Anchor Organisation.
- Deliver a health and wellbeing plan which supports reduction in levels of sickness absence and supports colleagues to feel well at work.
- Work with partner organisations to deliver health and wellbeing awareness, promotion and engagement opportunities for colleagues and the wider community.
- Through understanding the experience of colleagues from different socio-economic backgrounds develop intelligence led actions to improve their levels of staff satisfaction and engagement.
- Create community connection through the implementation of a colleague volunteering scheme, supporting local partners and businesses to benefit from the skills of our workforce by enabling to take up volunteering opportunities.

- Embed social value principles in our Leadership Development offer to ensure managers understand the motivations behind our actions and recognise through their role and services they contribute to delivering on this agenda.
- Ensure colleagues from minority groups or disadvantaged backgrounds are able to achieve their career aspirations.
- Tackle health inequalities in our workforce through increasing the declaration rates of colleagues with a long-term condition or disability, supporting colleagues to complete Disability Support Passports to enable colleagues to remain in work.
- Improving the quality of the work experience and enhancing representation of colleagues with protected characteristics at all organisational levels.
- To educate, appreciate and celebrate the rich diversity of our colleagues through diversity and inclusion training, awareness and promotion of inclusion events.
- Develop the skills and prosperity of staff, students, and local population through the provision of professional information, health and digital literacy education and advice.

The strategic focus for the **Education Portfolio** aligned to social value is:

- Advance personalised and equitable care by strengthening workforce capability in inclusive, person centred communication and practice
- Strengthen career progression pathways and talent pipelines across all professional groups through clear learning routes, role specific curricula and progression frameworks.
- Expand widening participation and anchor inclusion programmes that increase opportunity, inclusion and social mobility, supporting local people into education, employment and careers in healthcare.
- Position the organisation as a high-quality Apprenticeship Training Provider, expanding provision while maintaining compliance, quality and financial sustainability.
- Advance and expand innovation and enterprise within education and training to strengthen our anchor-institution role and maximise health, social and economic benefits for our communities.

The focus of future Workforce Committee Reports in relation to the social value strategy update, will report upon the progress made against the delivery of the above actions and measurement of impact outlined also in Appendix 2.

FINANCIAL IMPLICATIONS

There are no direct financial implications in relation to the delivery of the Social Value Strategy. However, if the organisation were to commercially bid for work, it may be required to provide evidence which demonstrates its commitment to and progress towards enabling social value as part of any bid applications or tenders.

LEGAL IMPLICATIONS

While NHS trusts do not have a specific statutory requirement to have a dedicated social value strategy, we are legally obligated to consider social value in our procurement processes, as outlined in the Public Services (Social Value) Act 2012. This act requires public sector bodies to consider how their purchasing decisions can improve the economic, social, and environmental well-being of their communities.

RISKS

- Limited resources within Workforce and Organisational Development team to progress at pace core streams of work described in this strategy.

- The 1LSC recruitment model will not include the community engagement work we have previously completed as part of our recruitment services. The community outreach and publicity surrounding vacancies has helped to recruit local people, individuals who have been out of employment for a period into role within the Trust. There is no funding available in the Trust to pick up this work as we would require 1LSC recruitment services to mobilise and implement actions.
- Due to the wider vacancy freeze, needing to hold vacancies for internal redeployment across the organisation we have less entry level administrative roles being recruited to or these roles have reduced having been removed from the establishment. This will make it more challenging to support members of the community to apply for our roles or be interviewed for a vacancy following successful completion of a widening participation programme or potentially providing a career opportunity for a volunteer who wishes to move into paid employment.
- The capacity within the 1LSC Procurement function to deliver on the social value programmes of work.

IMPACT ON STAKEHOLDERS

The impact of effective delivery of this strategy should be positive for the community, patients and colleagues. The impact measures under each of the strategic aims details the proposed impact which should be delivered. In summary this includes reduced health inequality, improved health outcomes, improved colleague wellbeing, increased levels of educational attainment of colleagues/our community, increased representation of colleagues with protected characteristics in all levels and professions, increased levels of prosperity within the local community, reduction in discrimination, enhanced public perception of us as an organisation and our ethos.

RECOMMENDATIONS

It is recommended that Board of Directors - review the contents of this report and note the strategy delivery plan for the next 12 months.

11.1 SAFETY & QUALITY COMMITTEE CHAIR'S REPORTS FOR CONSIDERATION

A) INFECTION PREVENTION AND CONTROL ANNUAL REPORT

● Other

Item for Assurance

REFERENCES

Only PDFs are attached

 11.1a Infection Prevention and Control Annual Report Summary Board Part I 4 June 26.pdf

 11.1a Infection Prevention and Control Annual Appendices Board Part I 4 Jun 26.pdf



Board of Directors Report

Meeting of the	Board of Directors	Date of meeting: 4 June 2026	
	Part I ☒	Part II ☐	
Title of Report	Infection Prevention and Control (IPC) Annual Report 2025 / 2026		
Report Author	Director of Infection Prevention and Control (DIPC) Dr D Orr IPC Matron S Marsh		
Lead Executive Director	Sarah Morrison - Chief Nursing Officer / Deputy Chief Executive Officer		
Recommendation/ Actions required	The Board of Directors is asked to: - Note assurance and accept the contents of the Annual report and confirm that it is assured of action to control infection and progress against the 2025/26 Annual Plan (Appendix 1). - Approve the IPC Annual Plan 2026/2027 (Appendix 2).		
	Decision ☐	Assurance ☒	Information ☐
Executive Summary	The purpose of this Annual report is to provide an overview of the progress made against the Infection Prevention and Control plan for 2025/2026 and assure the Safety and Quality Committee on the Trust's performance against key areas of Infection Prevention and Control (IPC). Throughout the 2025/2026 period, there were high levels of community transmission of Norovirus and Influenza with subsequent spread in hospitals. This led to sustained operational pressures on the National Health Service (NHS). In 2025/2026 the summary points of the IPC speciality include: - There is stable leadership of IPC practice with Dr David Orr holding the position of Director of Infection Prevention and Control (DIPC), Dr Robert Shorten the associate DIPC, and Sarah Marsh providing Nursing Leadership as the Infection Prevention and Control Matron - There were 2 hospital acquired Methicillin-Resistant <i>Staphylococcus aureus</i> (MRSA) Bacteraemia cases. - The <i>Clostridioides difficile</i> (<i>C. difficile</i>/CDI) objective was achieved, with 122 cases reported— 45 below the allocated trajectory by NHS England of 167. This is the 2nd consecutive year that the Trust has been below trajectory and seen a reduction, and the incidence per 100,000 bed-days has reduced from 62.3 to 43.5. Although <i>C. difficile</i> remains a significant concern, LTHTR is no longer the highest incidence Trust in the Northwest: 6 hospitals now have higher rates than LTHTR. Overall, there has been a reduction in cases as 2024/2025 resulted in 203 cases.		

- The Objective for *Escherichia coli* Bacteraemia was exceeded by 16 cases with 115 cases out of an objective of 99. In addition, the Trust exceeded its objectives for *Pseudomonas aeruginosa* bacteraemia (14 cases out an objective of 13) and *Klebsiella species* (38 out of and objective of 26).
- The Influenza season was sustained over 5 months from September 2025 to February 2026 which reflected the national picture.
- Norovirus - The year 2025/2026 saw a very high number of Confirmed Norovirus Outbreaks (25 outbreaks, 4 less than the previous year) across the Trust and these had a significant operational impact.
- The continued utilisation of the Patient Safety Incident Response Framework (PSIRF) focussing on system learning and advocating that time should be spent on value added improvement actions rather than investigating individual incidents that draw a conclusion of no new learning.

The National Standards of Healthcare Cleanliness (2021) have not been fully implemented across all clinical areas within the Trust; however, significant progress has been made, with 13 out of 16 high risk areas at Royal Preston Hospital (RPH) compliant and full compliance 18 out of 18 at Chorley District Hospital (CDH). For high risk areas 27 out of 42 areas at RPH are compliant and 13 out of 18 at CDH are compliant.

- There is increased assurance of IPC and cleaning processes via STAR.
- The IPC Team are working with Estates to improve completion of remedial work requests that have an IPC impact.
- All Divisions are achieving their target of over 90% compliance with IPC Mandatory training, and this is consistent throughout the year.
- Antimicrobial Stewardship - The Trust has remained $\geq 90\%$ compliant with documented indication of antibiotics on the drug chart over the past year and documented review within 72hrs for the past 3 quarters. Compliance with Antimicrobial choice in line with guidelines or recommended by Microbiology was 90% for the most quarters. LTHTR has the best result within the local ICB for performance against the NHS standard contract directive for reduction in 'Watch' and 'Reserve' category antibiotics
- Water Safety – The Trust Water Safety Group (WSG) continues to provide strategic oversight and governance of all water safety-related matters across the estate. Although operational pressures, staffing vacancies and a trust vacancy freeze within the Estates staffing structure have caused delays to the regular WSG meeting schedule, statutory and risk-based activities have remained in place. Assurance continues to be provided to both the Health and Safety Governance Committee and the Infection Prevention and Control Committee.
- Ventilation – The Estates services department continues to implement relevant guidance to control the risk of airborne transmission of infection. A proportion of ventilation systems are approaching or exceeding recommended lifecycle. They are managed using a risk-based approach, informed by clinical use, infection risk, and independent assurance. Ventilation governance is provided through the Ventilation Safety Group (VSG).
- Decontamination. The Trust has not had an official permanent decontamination lead. This represents a significant risk for the organisation; however, this will be addressed by a planned appointment in 2026/27. Despite this ISO inspections have confirmed no major or minor concerns with reliable management systems and processes in

	place. In 2025/26, the Sterile Services Department (HSDU) was challenged by increasing clinical demand, workforce pressures, and infrastructure constraint. This led to a significant increase in clinical incidents which were monitored via the Infection Prevention and Control Committee (IPC). An action plan was developed and the frequency of incidents reduced. • Waste - The Trust has begun implementing a new colour-coding system for clinical waste streams across its sites which has included the change from yellow to orange bags. The IPC Continue to support the waste manager by attending monthly waste management meetings and continue to contribute to waste management initiatives. • Research – Primel Study - In October/November 2024, the IPC team led in the implementation of a research study investigating a new hand hygiene product – Primel® Active Hand Coating (PAHC). The research was accepted for publication in the Journal of Hospital Infection in March 2026. The report contains an update on the actions delivered in the 2025/26 IPC plan, the majority of which were completed but where a delay has occurred the reason for this is given alongside the plan for how this is being addressed. This closes the IPC plan for 2025/26 and presents the 2026/2027 IPC plan for approval.	
Link to Strategic Objectives 2026/27	Patients – deliver excellent care: Improve outcomes, reduce harm and deliver a positive patient experience.	☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.	☒
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.	☐
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.	☐
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.	☒
Due Diligence	Infection Prevention and Control Committee	
Committee Approval:	Infection Prevention and Control Committee	Date: 21/05/2026
	Safety and Quality Committee	Date: 29/05/2026
Link to Board Assurance Framework:	Principal Risk 2 (25/26) - Higher than trajectory rates of clostridioides difficile (C.difficile) Infection	
Appendices	Appendix 1: IPC 2025 / 2026 Annual Plan Appendix 2: IPC 2026 / 2027 Annual Plan Appendix 3 – Infection, Prevention and Control Structure	

1. Introduction

The purpose of this report is to provide an overview of the progress made against the Infection Prevention and Control Annual plan for 2025/2026 and update the Safety and Quality committee on the Trust's performance against the Annual Objective for Methicillin-Resistant *Staphylococcus aureus* (MRSA) bloodstream infection and *Clostridioides difficile* infection (*C. difficile*/CDI).

Infection Prevention and Control (IPC) remains a key priority for Lancashire Teaching Hospitals (LTHTR). The IPC Team continues to work closely with other providers across the Health Economy. Dr David Orr, a Consultant Microbiologist, currently holds the Director of Infection Prevention and Control (DIPC) role and the Matron for Infection Prevention and Control, Sarah Marsh, is the Senior Nursing Lead. The DIPC is supported by the Deputy Chief Nursing Officer, Catherine Gregory and the Associate Director of Infection Prevention and Control (ADIPC), Dr Robert Shorten, the IPC Specialist Nurses, and Consultant Microbiologists. Sarah Morrison, Chief Nursing officer, is the executive lead.

Hospitals across the UK faced significant challenges during 2025/2026 driven by a substantial increase in inpatients admissions. This led to overcrowding in Emergency Departments and Assessment Units, as well as an increased reliance on boarding practices (where patients are placed in additional temporary or non-designated clinical areas due to a lack of available beds).

This report presents the details of IPC performance at Lancashire Teaching Hospitals Trust (LTHTR) in 2025/2026 with the focus on key IPC issues and includes the 2025/2026 programme which details the completion of improvement actions in line with the ten domains of the Hygiene Code which accompanies the Health and Social Care Act 2022.

The Infection Prevention and Control Annual Plan 2025/2026 is attached for information and closure. The 2026/26 IPC Annual Plan was ambitious, and most actions have been delivered, however, because of unprecedented demand, financial limitations, multiple infections, and staffing levels (both within LTHTR and the Integrated Care Board) there have been some which have been delayed and are carried over to the annual plan 2025/2026. These include:

- 2.1.5 - Work with Patient Partners to improve patient's awareness of IPC principles to prevent cross-infection
- 4.3.3 – Urinary catheter management and documentation - Devise a list of actions in response to the Point Prevalence audit results which will include key messages to staff through safety bulletins
- 6.2.1 - To be compliant with the National Standards of Healthcare Cleanliness 2025
- 6.1.1 - Provide bi-monthly reports to IPCC on Water safety
- 6.3.1 – Decontamination - Develop key metrics of data that must be monitored through IPCC
- 6.3.2 – Decontamination - Ensure that there is a substantive Trust Decontamination Lead who has sufficient time to perform this role
- 6.3.3 - Decontamination - Provide quarterly reports to IPCC on Decontamination management including track and trace and remedial actions from findings
- 6.3.4 - Decontamination - Provide monthly reports to divisional IPC meetings to strengthen the current audit and for feedback and improvement for assurance of current gaps in audits
- 6.4.1 – Ventilation - Provide bi-monthly reports from the Ventilation Working Group to IPCC

The 2026/2027 Annual Plan is attached for approval. This will expand and build on improvements made in 2025/2026.

TRUST PERFORMANCE RELATED TO ORGANISMS OF CONCERN

1.1. MRSA Bacteraemia

Staphylococcus aureus is a bacterium that commonly colonises human skin and mucosa. Most strains of *S. aureus* are sensitive to the more commonly used antibiotics, and infections can be effectively treated. However, some *S. aureus* bacteria are more resistant. Those resistant to the antibiotic methicillin are termed methicillin-resistant *S. aureus* (MRSA). Bacteraemia occurs when bacteria get into the bloodstream.

Infection Prevention and Control continues to be a key priority for the Trust, and the incidence of MRSA has seen an improvement during the reporting period and comparison to previous data is outlined below:

- In 2024-25 there was 0 incidents of hospital onset MRSA bacteraemia and 2 cases of community onset MRSA.
- In 2025-26 there was 2 incidents of hospital onset MRSA bacteraemia and 3 cases of community onset MRSA. Themes identified included lack of communication of MRSA status between hospitals on transfer, delays in decolonisation treatment and limited patient adherence to treatment plans.

1.2. *Clostridioides difficile* Infection

Clostridioides difficile (*C. difficile*) is an anaerobic bacterium that is present in the gut. It can be found in healthy people, where it causes no symptoms (up to 3% of adults and 66% of infants). In some instances, strains of *C. difficile* can grow to unusually high levels and attack the intestines, causing mild to severe diarrhoea. Patients who are commonly affected are elderly and/or immunocompromised; exposed to antibiotics and *C. difficile* from spores within the environment.

NHS England define the report of *C. difficile* Toxin positive cases into the below grouping:

- Hospital Onset Healthcare Associated (HOHA): cases that are detected in the hospital two or more days after admission.
- Community Onset Healthcare Associated (COHA): cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.
- Community Onset Indeterminate Association (COIA): cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent four weeks.
- Community Onset Community Associated (COCA): cases that occur in the community (or within two days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks.

The National Objective for the Trust encompasses both HOHA and COHA cases.

In 2025/2026 the Trust recorded 122 Hospital Associated cases against an Annual Objective of 167, successfully being within tolerance by 45 cases below the threshold. This marks a positive trend with a reduction in Hospital Associated *C. difficile* cases. In 2024/2025 there were 192 hospital associated cases reported out of an annual objective of 199 cases. This is also the 2nd consecutive year that the Trust has been below trajectory and seen a reduction in *C. difficile* incidence. In 2023/24 there were 203 cases, exceeding the annual objective of 121 cases.

Figure 1 Performance of *C. difficile* cases against National Trajectory

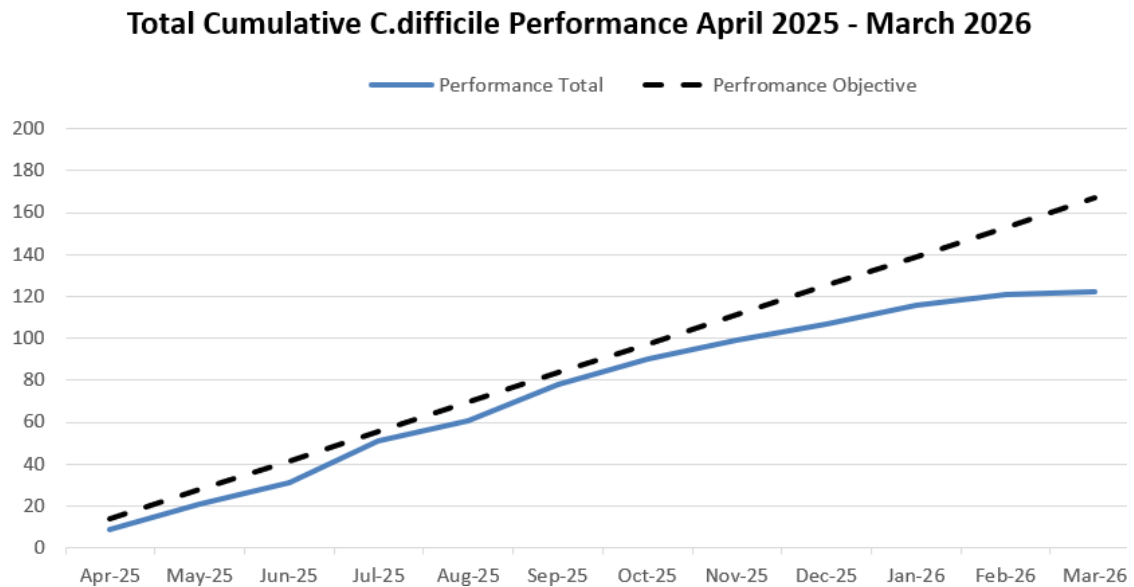
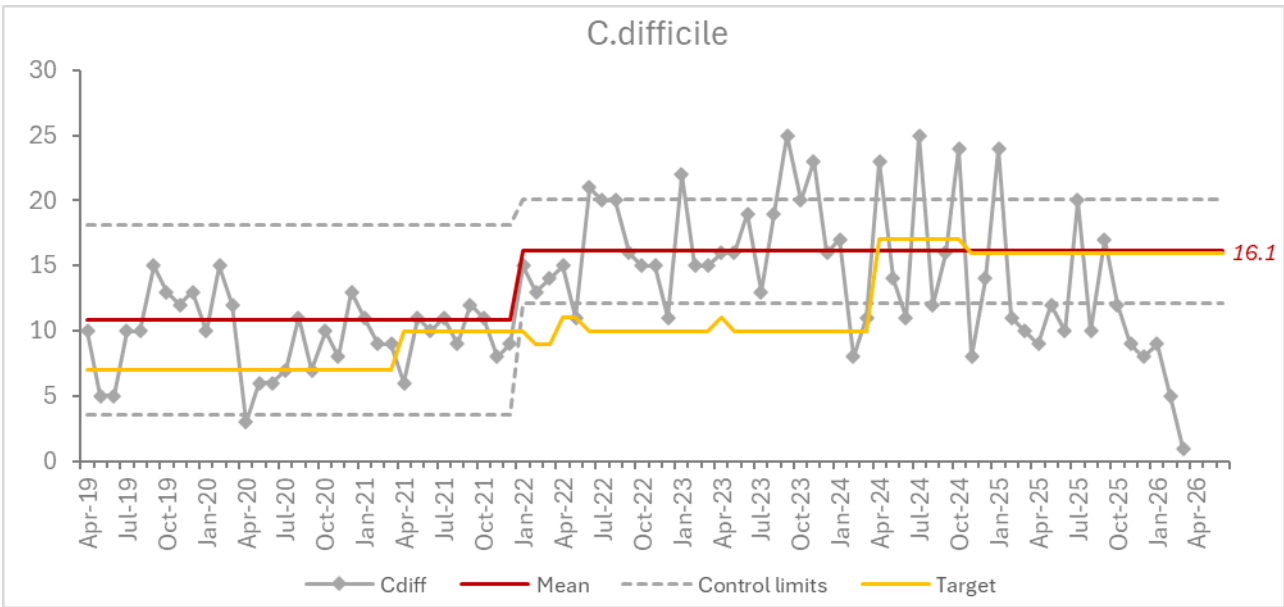


Figure 2 presents a Statistical Process Control (SPC) chart illustrating the monthly trend of Hospital Associated *C. difficile* cases per month from April 2019 to April 2026. A notable increase in cases is evident in 2022, which aligns with a Trust-wide policy change that expanded the definition of diarrhoea to include type 5 stools. Since October 2025 we have seen consistent reduction in *C. difficile* cases which is statistically significant.

Figure 2 Hospital Associated *C. difficile* Toxin positive rates per month.



1.2.1. The National and Regional picture

Table 1 provides data on *C. difficile* trust-attributable incidence and rates per 100,000 bed days for hospitals in the Northwest. LTHTR has had particularly high rates of *C. difficile* Infection since the financial year 2022/23 onwards and this led to executive level intervention by the Chief Nursing Officer and the development of a specific *C. difficile* action plan which was monitored through the monthly Infection

Prevention and Control Committee and the Estates and Facilities Partnership Board. (Appendix 3). The incidence per 100,000 bed-days has reduced from 62.3 to 43.5. Although *C. difficile* remains a significant concern, LTHTR is no longer the highest incidence Trust in the Northwest: 6 hospitals now have higher rates than LTHTR (Table 1).

Table 1. *C. difficile* incidence and rate per 100,000 bed days – Northwest hospitals March 2025 - February 2026 (available at the time of report writing)

C. difficile annual tables: cases & rates by Trust

Organisation Name	March 2025 to February 2026	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	19	33.5	Low (0.001)
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	112	41.9	
BOLTON NHS FOUNDATION TRUST	102	48.8	High (0.001)
COUNTRESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	68	39.7	High (0.025)
EAST CHESHIRE NHS TRUST	20	18.7	Low (0.001)
EAST LANCASHIRE HOSPITALS NHS TRUST	94	27.5	Low (0.001)
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	131	43.5	High (0.001)
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	4	7.4	Low (0.001)
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	177	32.5	Low (0.025)
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	2	7.5	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	221	29.1	
MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST	107	24.3	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	36	20.8	
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	47	23.3	
NORTHERN CARE ALLIANCE NHS FOUNDATION TRUST	172	33.0	Low (0.001)
STOCKPORT NHS FOUNDATION TRUST	51	23.4	
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	77	47.8	
THE CHRISTIE NHS FOUNDATION TRUST	38	62.4	High (0.001)
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	20	62.5	
THE WALTON CENTRE NHS FOUNDATION TRUST	16	33.8	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	71	34.9	
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	81	40.3	Low (0.025)
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	136	52.5	High (0.025)
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	80	43.6	
North West	1882	34.0	

1.2.2. Main developments during 2025/2026

- Continued implementation of the National Standards of Healthcare Cleanliness, 2021 (now updated to include the newly released National Standards of Cleanliness, 2025 released in January).

In March 2025 a business case was written for full implementation of National Standards of Healthcare Cleanliness went to Trust Management Board and was approved. This involves £747,514 new funding for cleaning at LTHTR and the equivalent of 26 WTE additional posts, implementation being rolled out in a phased manner through 2025 /2026.

The position as of March was:

Functional risk 1 areas compliant (High risk areas such as critical care) –

- RPH – 13 out of 16
- CDH – 18 out of 18

Functional Risk 2 areas compliant (includes inpatient general wards)

- RPH – 27 out of 42

- CDH – 13 out of 18

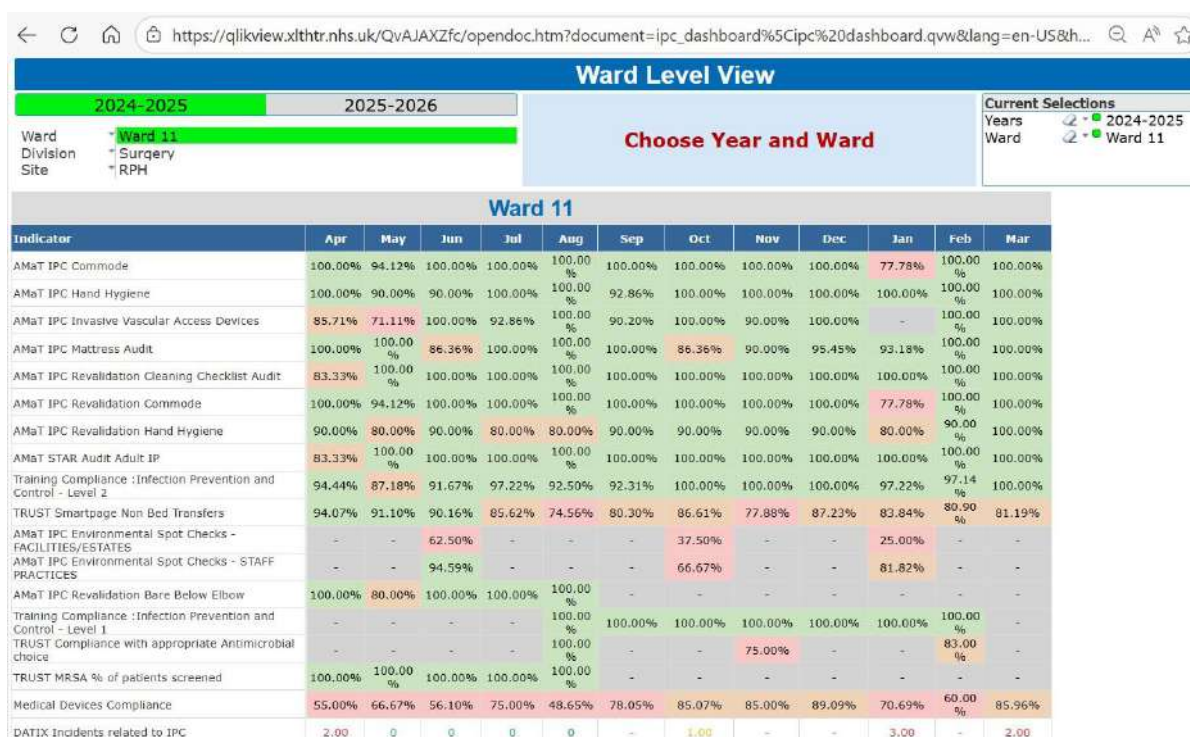
- Introduction of specific alerts when requesting faecal cultures prompting staff to review laxatives and stop any before testing (an initiative that arose out of the continued weekly virtual *C. difficile* ward rounds which were described in the previous annual report).

Inappropriate stool testing of non-infectious patients who have diarrhoea due to Laxatives can lead to false-positive *C. difficile* test results in some patients. This is the reason why the national guidelines advise *C. difficile* testing in patients with unexplained diarrhoea. In 2024/25 the *C. difficile* policy was reviewed and updated. The alerts will improve awareness of policy.

- Development of electronic IPC dashboard in the Business Intelligence (BI) portal

This innovation allows ward managers at glance to assess their compliance with IPC practice against the full range of audit measures. If there have been reportable Healthcare Associated Infections (HCAIs) on the ward, then these are also displayed. An example from ward 11 is displayed in Figure 3.

Figure 3. Example of IPC dashboard



In the coming year we plan to standardise the approach to dissemination and utilisation of the dashboard and assess the impact.

- Participation in the UKHSA CDRN Sentinel Surveillance programme

In April 2025, LTHTR was enrolled in the national UKHSA *C. difficile* Sentinel Surveillance scheme which involved sending the first 10 *C. difficile* positive faecal samples of each month for full Whole Genome Sequencing (genetic fingerprinting) of the isolates. Thus far, there have been no detected incidents of direct transmission from patient to patient although such incidents can now be identified.

1.2.3. Significant challenges and opportunities for 2026/27

Estate and infrastructure risks

LTHTR will continue to operate within the constraints of a poor and aging estate, including limited single side-room capacity. Additionally, the Trust's current aging single-stack sewage infrastructure remains a concern due to its frequent blockages, including issues with macerators. Funding has been secured to replace the sewage stack and to address the backlog maintenance IPC risks in the ward block and will result in a general environmental upgrade addressing many of the IPC risks over the next 3 years. A Multi-disciplinary (MDT) approach to the work has commenced and will ensure a risk-based approach is taken.

Emergency demand and capacity pressures

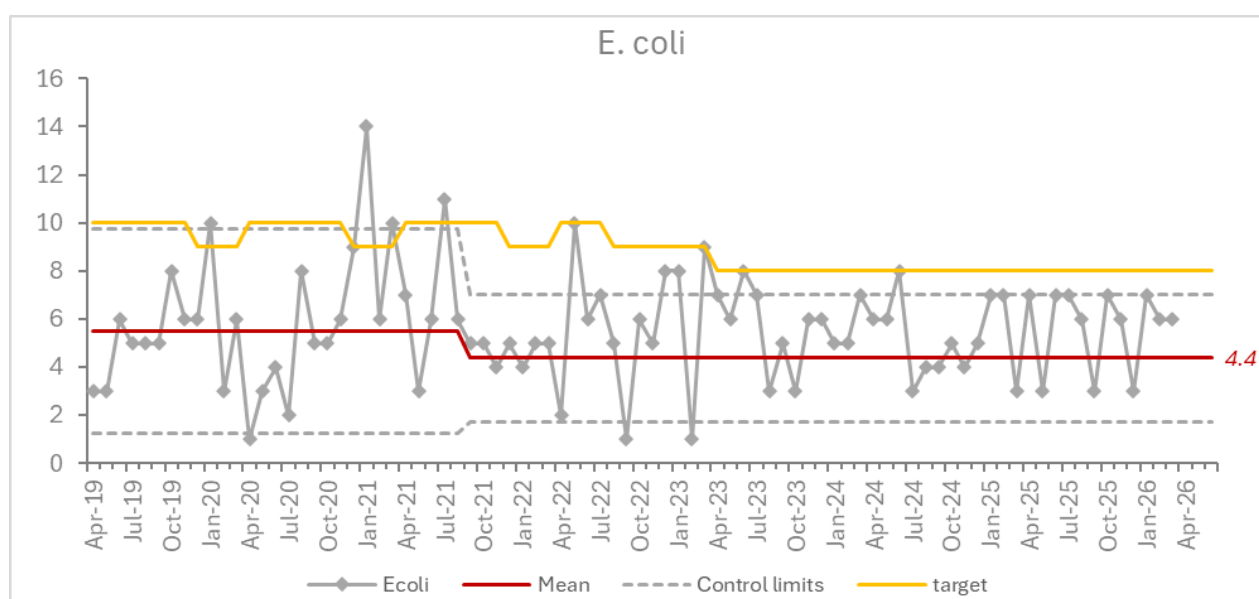
An urgent emergency care improvement plan is underway with the vision and aim to eradicate corridor care, however current capacity constraints are expected to persist into 2026/2027 whilst the actions become embedded. These challenges contribute to overcrowding in clinical and non-clinical areas that are not optimally equipped with appropriate facilities, such as adequate toilet access and dirty utility provisions. This situation increases the risk of healthcare associated infection transmission and remains a key operational and clinical concern. Recognising the current size and occupancy of the Emergency department (ED) is not conducive to modern IPC standards, a scoping survey has been commissioned to understand future options to bid for capital money to improve this area and subsequent outcomes for patients and colleagues.

1.3. Gram-Negative Bacteraemia

NHSE introduced objectives for Trusts to reduce *Escherichia coli* (*E. coli*), *Klebsiella species*, and *Pseudomonas aeruginosa* in 2022/23.

The 2025/26 Objective for *E. coli* bloodstream hospital associated infections was 99. The Trust ended the year with a Total of 115 Hospital associated *E. coli* cases, which was 16 cases above the Objective. Tackling *E. coli* infection will require concerted action by multiple specialities and stakeholders including the Integrated care board (ICB). The IPC Annual plan 2026/2027 also includes several initiatives to address these infections.

Figure 4. Hospital Associated *Escherichia coli* positive rates per month. New SPC chart needed



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

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

1.4. OTHER OUTBREAK INVESTIGATIONS IN 2025/2026

1.4.1. Norovirus outbreaks

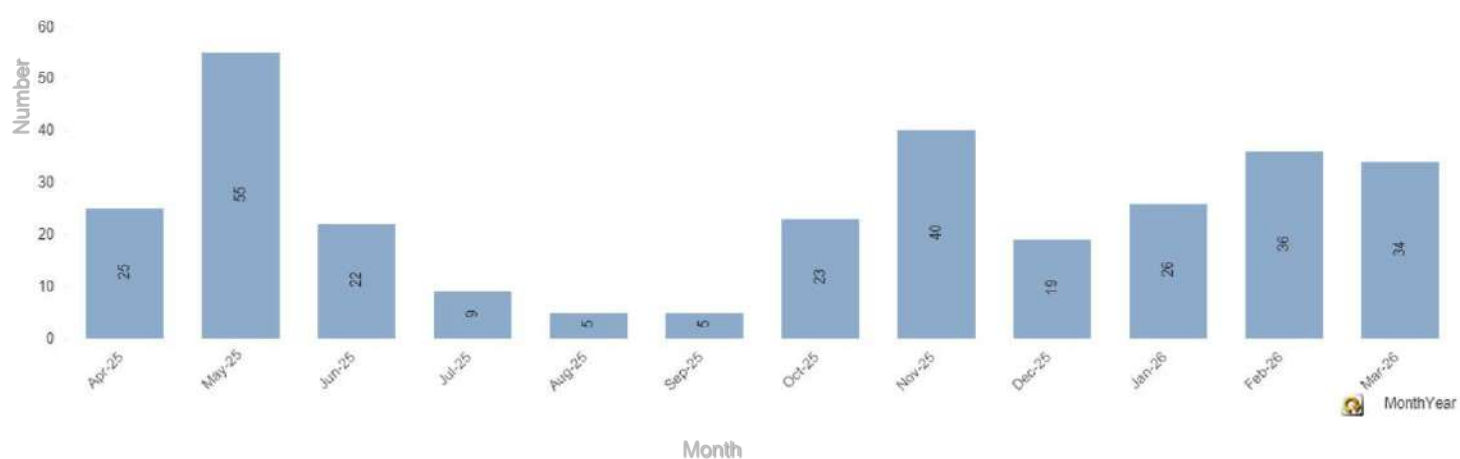
The year 2025/2026 saw 25 Confirmed Norovirus Outbreaks (4 outbreaks less than in 2024/25). This matched the current National picture with increased spread of new variant of Norovirus (GII.17) to a more susceptible population that had not been exposed to such viruses during the COVID-19 Pandemic.

There was an observed increase in the number of patients presenting to the Emergency Department and Assessment Units with symptoms of diarrhoea and vomiting, originating from community settings. This trend placed significant pressure on the Trust's capacity to appropriately isolate symptomatic individuals, thereby increasing the risk of healthcare-associated transmission. Additionally, there was evidence indicating that some outbreaks were initiated by symptomatic staff and visitors, further contributing to the transmission of viral gastroenteritis within inpatient areas.

Norovirus outbreaks have a disruptive impact on patient flow during times of high incidence due to closure of bays and sometimes wards across both sites. The resulting trapped beds reduce the hospitals effective bed capacity and prolong E.D. waits. Whilst the norovirus outbreaks that we experienced were significant, the Trust benefits from the availability of a rapid intestinal screening test (provided by the point of care team) which allows for early identification of patients with Norovirus in E.D. and in ward areas. Negative tests also support the IPC team in their decisions to keep unaffected bays on outbreak wards open, minimising disruption.

As a Trust there has been increased focus on Enhanced cleaning to reduce the bioburden of infection within the Environment, IPC precautions to mitigate the risk of spread, and the completion of Fogging following the infectious period to mitigate the risk of the transmission of the virus to new patients. This prevents further waves of outbreaks. Communications were circulated reiterating protocols to staff to ensure that they refrain from work until 48 hours clear of symptoms. Communications were also circulated to the public, so visitors do not attend to visit patients at the Hospital when they unwell with symptoms.

Figure 5. Number of confirmed positive Norovirus Patients April 2025 – March 2026 (excluding patients identified in outbreaks that are likely Norovirus positive but not tested)



Source: *LTHTR data*

1.4.2. Respiratory Viruses – Influenza and COVID-19

Influenza and SARS-CoV-2 (COVID-19) are acute viral respiratory infections that spread easily from person to person and continue to pose a significant risk within healthcare settings. Both viruses are primarily transmitted by respiratory droplets and aerosols, as well as by direct and indirect contact with contaminated secretions or surfaces.

Influenza viruses circulate seasonally in temperate climates, typically peaking during the winter months between January and March. There are two main types that cause infection in humans — Influenza A and Influenza B. Influenza epidemiology remains unpredictable due to ongoing viral evolution, which necessitates annual vaccine reformulation.

SARS-CoV-2, first identified in December 2019, continues to circulate at endemic levels. During 2025/26 there were no significant changes to national guidance relating to COVID-19 management, and LTHTR maintained established infection prevention and control measures throughout the year.

1.4.2.1. Transmission and Prevention

Both Influenza and COVID-19 are transmitted predominantly via droplets generated during coughing, sneezing, talking, or breathing. Aerosol-generating procedures (AGPs), such as bronchoscopy and non-invasive ventilation, can produce smaller particles capable of remaining airborne for longer periods and travelling further distances.

Prevention strategies include:

- Vaccination (where eligible)
- Prompt testing of symptomatic patients
- Isolation in single rooms where available
- Cohorting of confirmed cases when single room capacity is exceeded
- Appropriate use of personal protective equipment (PPE)
- Reinforcement of hand hygiene and respiratory etiquette

The Emergency Department (ED) continues to be supported by a 24/7 point-of-care testing service, providing rapid Influenza and COVID-19 testing. Patients presenting with respiratory symptoms compatible with these infections are tested at triage and asked to wear a mask while waiting, to minimise transmission risk. The service also supports inpatient testing to assist outbreak management and patient placement decisions.

1.4.2.2. Influenza Season 2025/2026

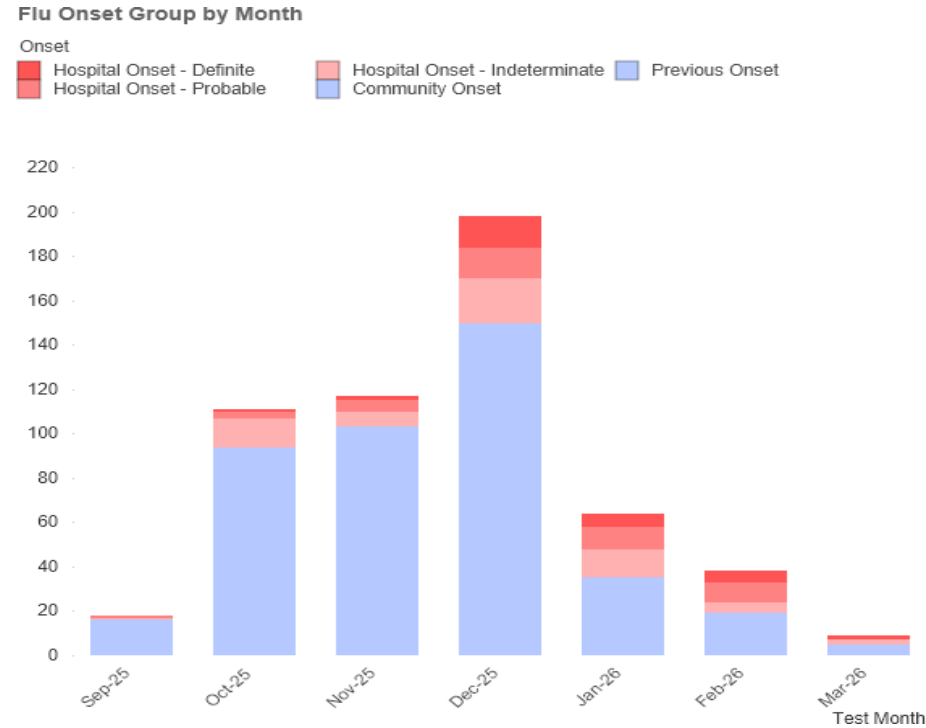
The Influenza season at LTHTR began in September 2025 and peaked earlier in the winter than in previous years in line with national trends. In December 2025 there were concerns about the potential of an exceptionally severe winter season, due to the emergence of new circulating influenza strains. As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

A proportion of cases were identified ≥3 days after admission, consistent with potential hospital-onset infection. This highlights ongoing challenges in patient flow and isolation capacity during peak respiratory virus activity.

The Trust benefits from having access to 24/7 rapid testing for respiratory viruses, however, operational pressures mean that, despite positive test results, it is not always possible to immediately isolate patients. During periods of high demand, some patients are also managed in corridor spaces or multi-occupancy areas while wearing masks, increasing the risk of transmission.

Figure 6 shows Influenza positive patients by onset, with community-onset cases represented in blue and potential hospital-onset cases in shades of red.

Figure 6. Influenza cases in the 2025/26 season.



Source: LTHTR data

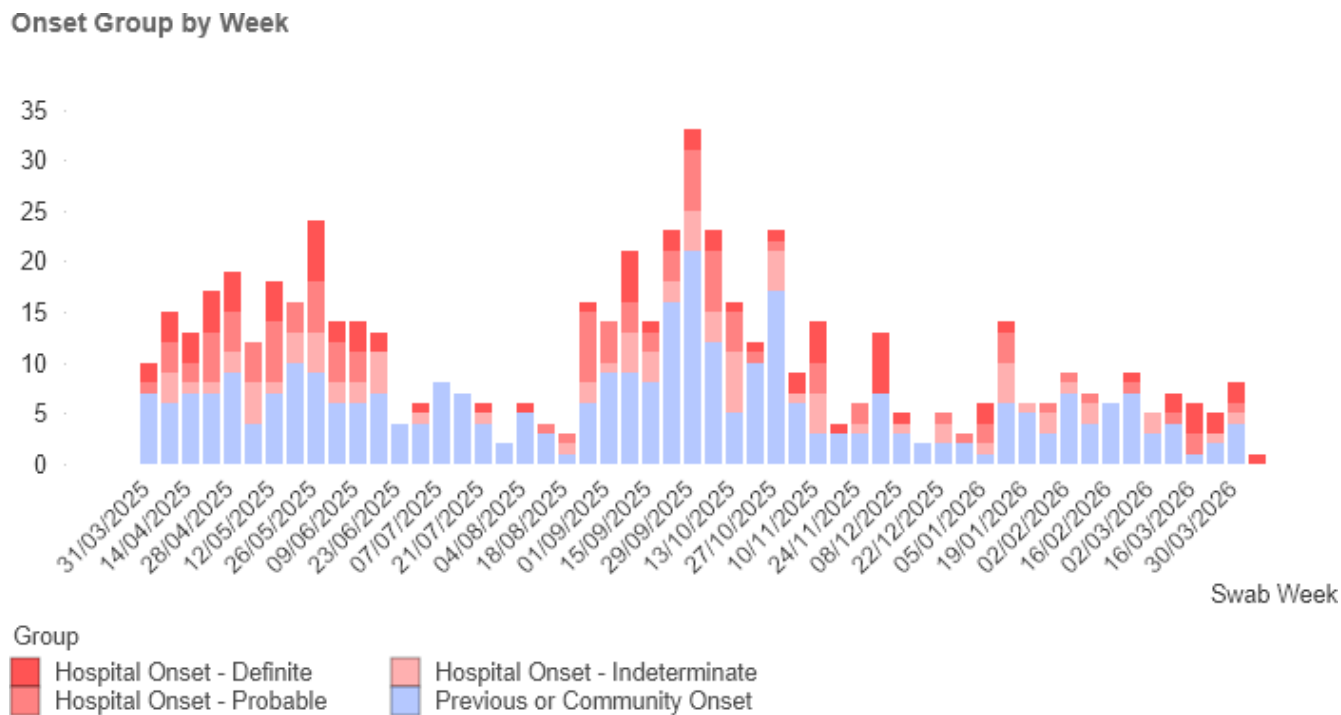
1.4.2.3. COVID-19 Activity 2025/2026

LTHTR experienced steady levels of COVID-19 infection throughout 2025/2026. Unlike the early pandemic years, there were no major surges or changes in national IPC guidance during the reporting period.

Hospital-onset and community-onset cases continued to occur, requiring ongoing vigilance in patient placement, testing, and PPE compliance.

Figure 7 shows Hospital Onset versus Community Onset COVID-19 infections for 2025/2026.

Figure 7. COVID-19 case between April 2025 – March 2026



Source: LTHTR data

1.4.2.4. Summary

Respiratory viruses continue to represent a significant seasonal and endemic pressure on acute hospital services. While Influenza activity in 2025/26 was similar to the previous season, the potential hospital-onset cases and operational constraints within ED remain areas of concern.

Maintaining rapid diagnostic testing, appropriate isolation and cohorting, vaccination uptake, and adherence to IPC measures remains essential to minimise transmission risk within LTHTR.

1.4.2.5. Measles National Outbreak

Measles activity nationally in the UK remains elevated. In early 2026, provisional data show ongoing transmission (predominately in children aged ≤ 10 years), particularly in London and other urban areas, underscoring persistent immunity gaps and the importance of improving vaccination uptake to prevent further spread.

However, throughout 2025/26, the local risk of community outbreaks remained low. In July/August 2025, two children who were siblings presented to Royal Preston Hospital ED and tested positive for measles. The first child who presented to hospital twice was not isolated during the first presentation (due to initially non-specific symptoms). A contact tracing exercise was performed by the Microbiology/IPC team as per policy and none of the contacts developed the infection.

A Trust-wide policy for the management of patients with Measles remains on heritage and has been disseminated to staff. The Occupational Health Department has also conducted a review of measles immunity status among staff working in identified high-risk roles and departments to ensure appropriate protection and preparedness.

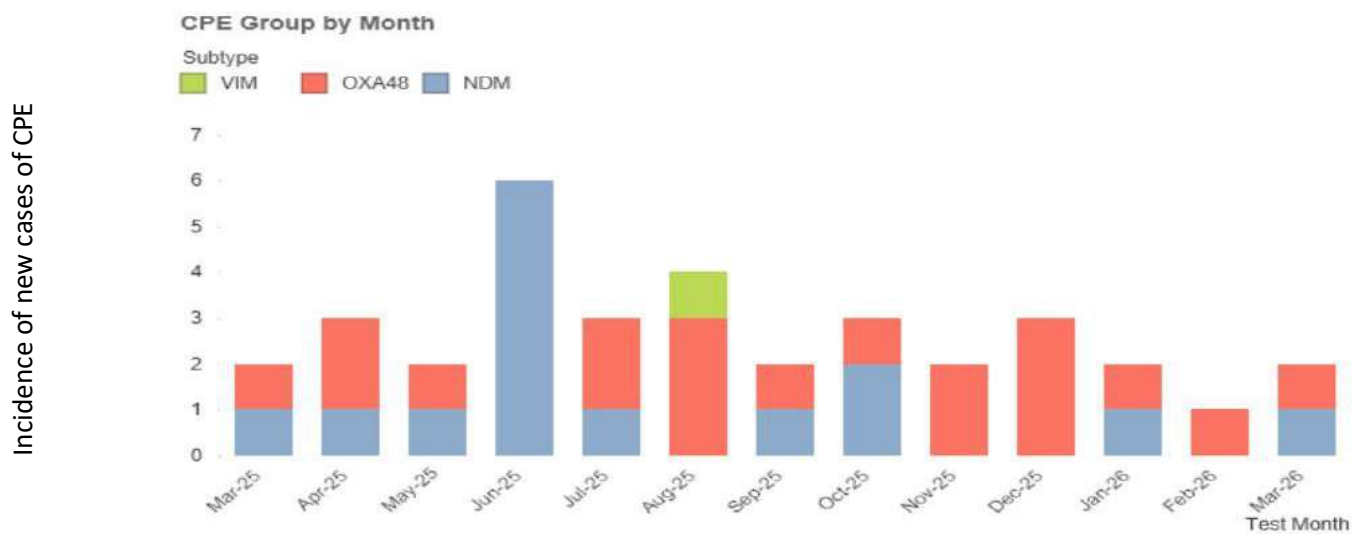
1.4.2.6. Carbapenemase-producing Enterobacterales (CPE)

Enterobacterales producing acquired Carbapenemases are referred to as CPE. The most prevalent enzymes in the UK are KPC, OXA-48-like, NDM, VIM, and IMP. Increasing gut colonisation with these resistant bacteria will inevitably lead to an increase in difficult-to-treat infections. These strains of bacteria are highly resistant, only treatable with novel, expensive antimicrobials, and often linked with higher mortality rates.

The IPC Team is supported by data on the internal Trust application, QlikView that shows a CPE dashboard which provides an overview of active CPE colonised patients in the hospital and allows them to assess trends in the incidence. New positive results are also transmitted to the IPC Microbiology alert list for action in real time. The IPC Team create an infection alert on Harris Flex to ensure historic patients are isolated on admission and screened as per policy.

In 2024/2025 the IPC Team identified 32 new CPE positive cases (similar to the previous year: 31 cases); 17 OXA-48 positive patients; 12 NDM positive patients, and 3 KPC positive patients. There were no outbreaks, and the patients had risk factors for acquisition of the organism abroad or in other hospitals.

Figure 8. New cases identified with Carbapenemase-producing Enterobacterales by month April 2025 – March 2026



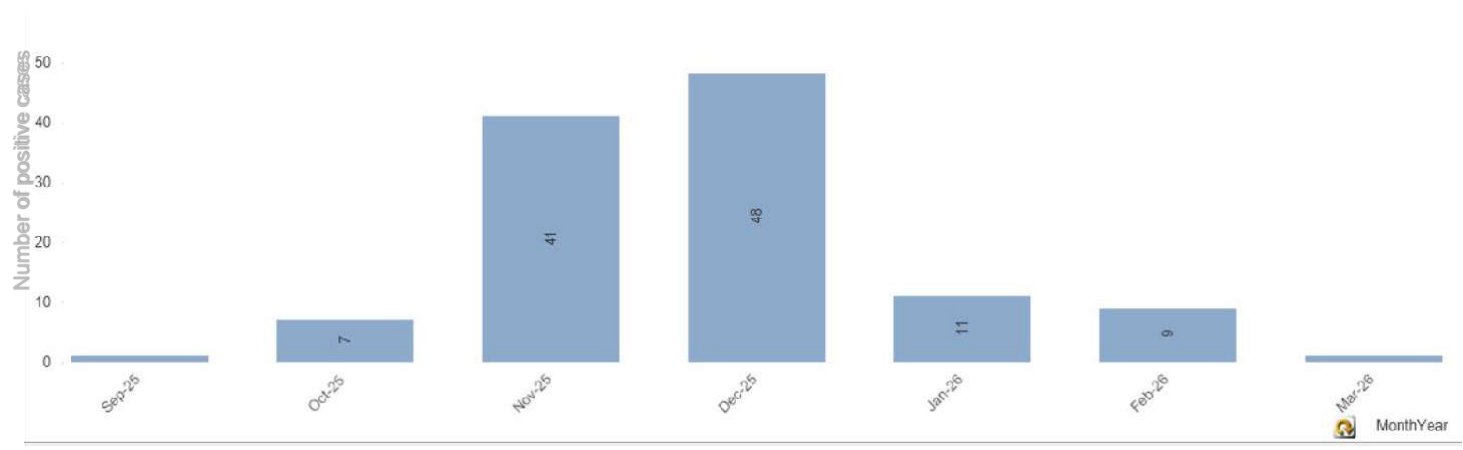
Source: LTHTR data

1.4.2.7. **Respiratory Syncytial virus (RSV)**

Respiratory syncytial virus (RSV) is an enveloped RNA virus, in the same family as the Human Parainfluenza Viruses and Mumps and Measles viruses. RSV is one of the common viruses that cause coughs and colds in winter, however, infants under 1 year are at particular risk of severe infection requiring admission to hospital (e.g., croup).

In 2025/2026, RSV peaked in December and the RSV season was more severe than in 2024/2025. The peak month in 2025/2026 season saw 48 RSV positive children presenting to hospital, as compared to 28 cases in the peak month of the 2024/2025 season.

Figure 9. Volume of Respiratory syncytial virus (RSV) positive cases September 2025 – March 2026



Source: LTHTR data

1.4.2.8. **IPC incidents/investigations**

Aspergillus infection on the Neonatal Intensive care unit (NICU)

In June 2025, a 9-day-old 24/40 pre-term baby on NICU became unwell and was found to have a skin infection caused by *Aspergillus flavus*. This is an environmental fungus which does not normally colonise humans. The infection immediately led to an investigation.

Although the exact route of acquisition of the infection could not be ascertained, there was learning including the following:

- Estates – poor temperature control leading staff to use fans to cool equipment
- Lack of cleaning schedules for air ducts
- Surfaces that were not accessible to cleaning
- Lack of procedures for notification of estates work to IPC so that they can advise on appropriate mitigation

Actions were taken to resolve the issues identified and there have been no further cases of aspergillus infection. A risk remains on the risk register relating to ventilation which is non-compliant to current HTM (due to the age of the building) and an old oxygen supply which needs to be replaced and is difficult to clean.

Neonatal Pseudomonal sepsis incident

In December 2025, two premature (25-week gestation +1) neonates died of sepsis within 72 hours of birth. Both babies were found to be colonised with *Pseudomonas aeruginosa* with hours of birth and one of the babies died of confirmed Pseudomonal sepsis (from blood cultures).

Pseudomonas is an environmental organism associated with water (sinks and taps) and therefore the IPC performed an investigation including swabbing of sinks and culturing tap water on delivery suite and NICU. Although, as expected, *Pseudomonas* isolates were cultured from sink traps that were swabbed, typing demonstrated that these isolates were different from those isolated from the babies. It is possible that the infection occurred prior to admission to hospital from domestic water sources.

However, as part of the incident investigation, it was highlighted that, as per Royal College of Obstetricians and Gynaecologists (RCOG) guidelines, the practice was to use tap water in gauze applied to the perineal during delivery to prevent tears. This practice was reviewed and suspended for premature births and the risk escalated nationally via NHSE IPC, UKHSA and RCOG leads. A letter has been written for submission to a scientific journal for publication to highlight the risk.

CPE outbreak Major Trauma Ward

In June 2025, the IPC team detected an outbreak of a Carbapenemase-Producing *E.coli* on the Major Trauma ward (MTW) at Royal Preston Hospital. The initial patient had a positive urine culture and then 2 additional asymptomatic cases were detected after a contact tracing exercise. Typing at the reference laboratory confirmed that the patients all had the same strain, confirming the outbreak.

Positive patients were isolated in side-rooms, the area deep cleaned and IPC practice re-enforced including Hand Hygiene, Commode cleaning and safe water management. Follow-up weekly screening on the unit did not detect any further patients.

Tuberculosis (TB) exposure incidents

In 2025 there were 2 incidents in which infectious TB patients were not isolated initially on admission to hospital. This led to contact tracing exercises and a total of 8 patients received “inform and advise” letters, alerting them to the contact, explaining the symptoms of TB and advising them to seek medical advice in the unlikely event that they became unwell. This reinforces the need to consider TB as a possibility in patients with admitted with symptoms and signs consistent with the infection, although these symptoms/signs can be non-specific initially.

1.4.2.9. Public health alerts for dissemination and action

In 2025/26, the IPC team received 8 UKHSA alerts for dissemination and action. The IPC led on ensuring that the relevant areas were notified and that there was an appropriate response.

- June 2025 – Infectious risks associated with the Hajj, particularly MERS-CoV and meningococcal meningitis
- June 2025 – Recommendations for the use of rabies immunoglobulin, in response to heightened public concern after a case.
- July 2025 – Update on the epidemiology of toxigenic *Corynebacterium diphtheria* in asylum seekers
- July 2025 – Iatrogenic botulism associated with cosmetic botulinum toxin injections
- November 2025 – Marburg Virus Disease in Ethiopia

- January 2026 – Cereulide contamination of specific batches of infant formula
- February 2026 – Increase in Mpox incidence in England
- March 2026 – Risk of reduced detection of emerging COVID-19 variant BA.3.2. by some tests

1.5. KEY INTERVENTIONS TO PREVENT NOSOCOMIAL INFECTION

1.5.1. Staff Training

Staff training compliance

IPC Mandatory training, including ANTT compliance, is reviewed at the Divisional IPC / Always Safety-First monthly meetings with oversight at IPC Committee within the IPC Team report broken down Divisionally. Areas that are not over 90% compliant are flagged and escalated negatively to the Safety and Quality Board via Chair's report.

Figure 10. Infection Prevention and Control Level 1 and Level 2 E-learning compliance 2025/2026

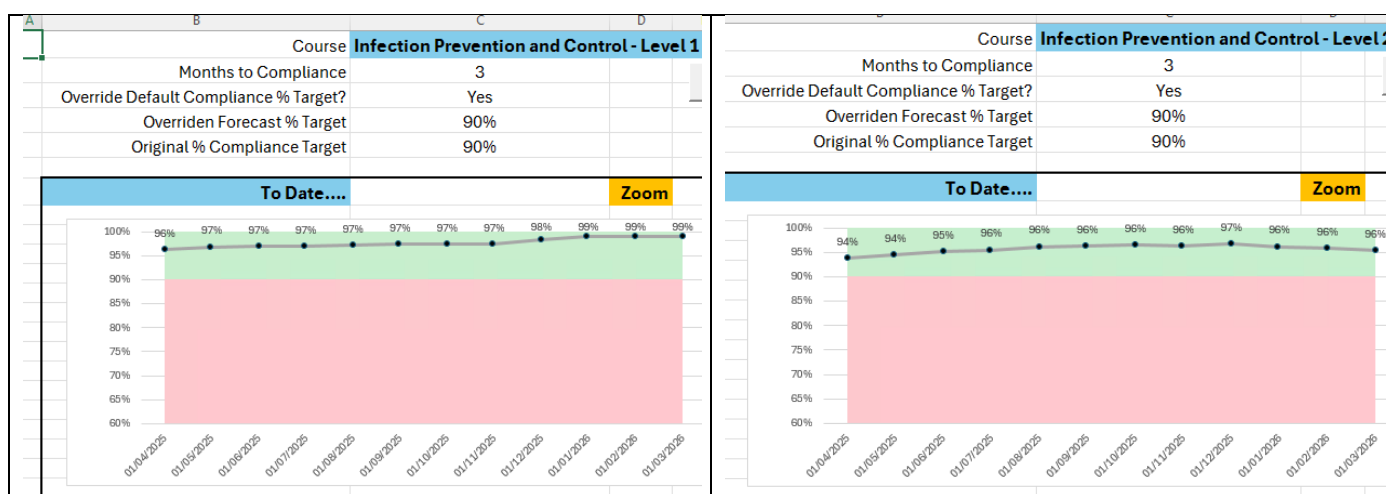


Figure 10 demonstrates that the Trust is achieving its target of over 90% compliance with IPC Mandatory training and this is consistent throughout the year. All Divisions are achieving this target (data not shown).

1.5.2. Assurance Platform

The IPC Committee identified the need for specific process and outcome data to be available at departmental level. The Business Intelligence Team developed an IPC Dashboard which includes data fields such as IPC Audits, STAR Audits, Average days to isolation, CDI numbers, IPC Datix incidents, IPC Complaints, Training compliances, and non-bed transfers. The data fields allow for triangulation of IPC compliance with levels of Hospital Acquired Infections. The availability of this data will support early escalation, action and prediction of risk and is considered by IPC committee to be an essential action for further reduction in hospital acquired infections.

The accreditation process STAR audits are also reflected within the IPC Teams report. The Matron for IPC and STAR meet regularly to review the IPC elements of STAR with the compliance of Infection Prevention and Control being reviewed and audited frequently as part of the mandatory checks.

Figure 11. STAR accreditation compliance for Infection Prevention and Control (Environment clean, tidy and clutter free)

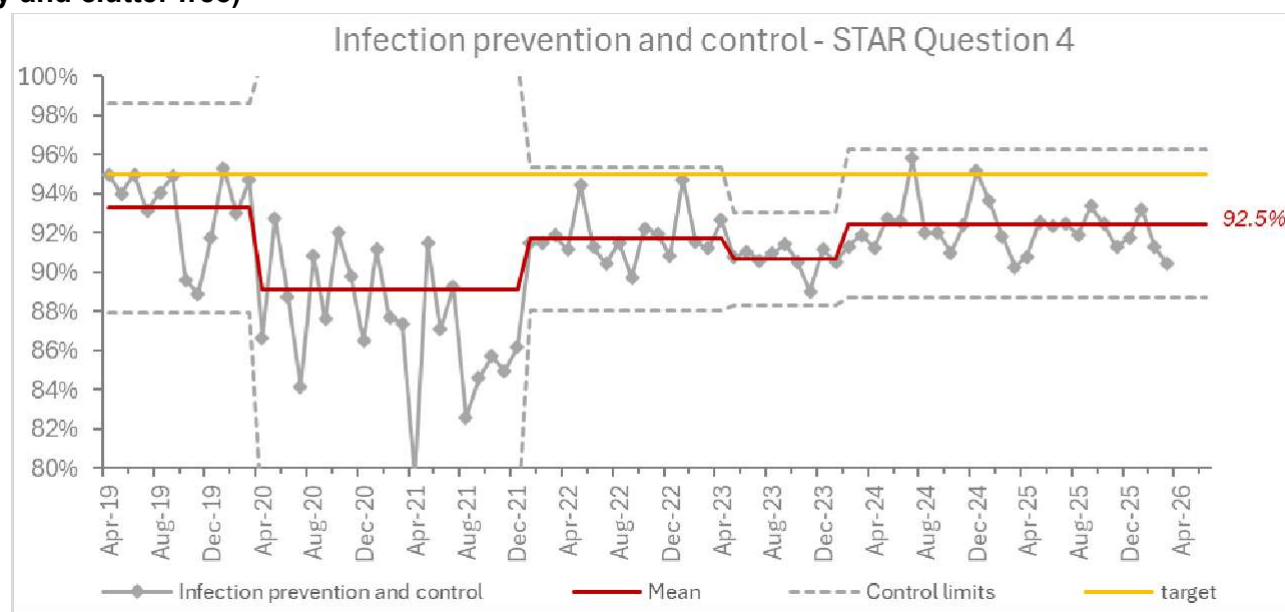
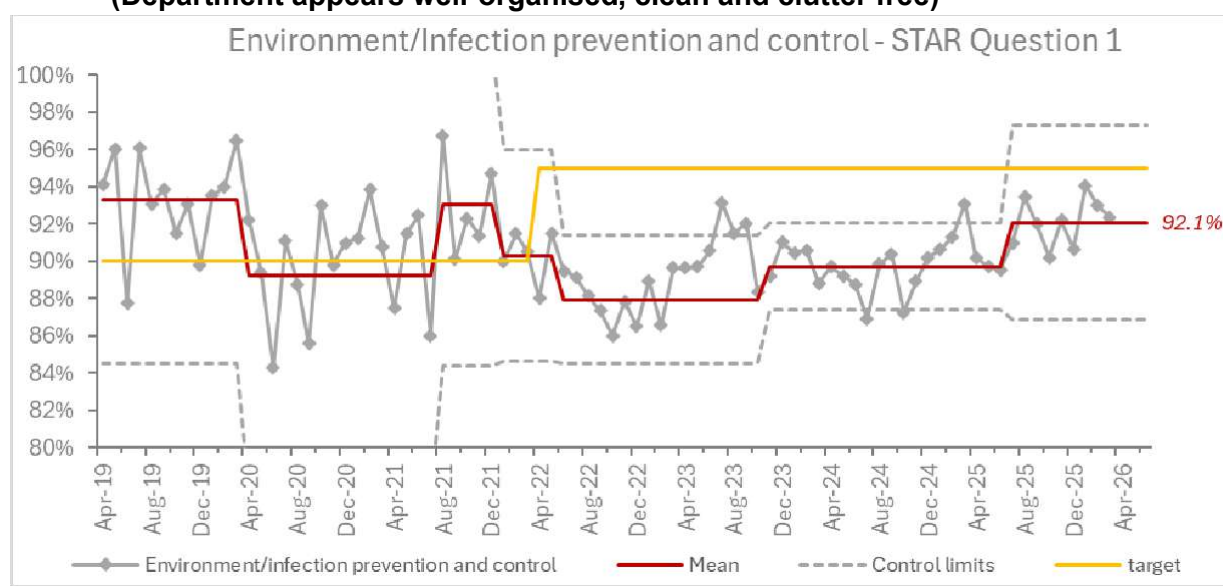


Figure 12. STAR accreditation compliance for Environment/Infection Prevention and Control (Department appears well-organised, clean and clutter free)



1.5.3. Antimicrobial Stewardship

The Trust Antimicrobial Management Group (AMG) meets every two months to review antimicrobial stewardship and includes representation from Microbiology, Pharmacy in both LTHTR and the community, Sepsis Lead nurse and the Infection Prevention and Control Team.

In 2025/2026 Antimicrobial Stewardship (AMS) was included in both the Trust Single Improvement Plan and Waste Reduction Program, with the key objective to reduce inappropriate use of IV antimicrobials. This has many benefits including potential reduced length of stay, improved patient outcomes and significant cost savings. Level of IV antibiotic doses reduced over summer months however remained high over winter months. At the end of February, over £60,000 saving has been achieved in antimicrobial spend compared to last financial year.

The AMS Team have continued with a broad range of AMS activities including guideline updates, antimicrobial ward rounds, audit, and teaching. Additional highlights for the year include: a new antimicrobial guideline app to support accessibility, a novel Gentamicin Dosing and Monitoring Tool to improve patient safety and introduction of a Penicillin Allergy DE-labelling guideline.

Quarterly antibiotic prescription points prevalence audits are undertaken to promote AMS. The Trust has remained $\geq 90\%$ compliant with documented indication on the drug chart over the past year and documented review within 72hrs for the past 3 quarters. Compliance with Antimicrobial choice in line with guidelines or recommended by Microbiology was 90% for the most quarters whilst in Q4 it was 86%. Specialities that have consistent non-compliance are requested to make an action plan to address this.

LTHTR has the best result within the local ICB for performance against the NHS standard contract directive for reduction in 'Watch' and 'Reserve' category antibiotics, (as defined by the World Health Organisation) from 2019 baseline. The result for Q3 is a 19% reduction in daily defines doses per 1000 admissions. This metric has been added to the single improvement plan for the next financial year, and antimicrobial spend will continue to be monitored to support the Waste Reduction Program.

The AMS Team together with the Director of Infection Prevention and Control presented to Trust Board in January, sharing national context, update on current Antimicrobial Resistance position, strengths, risks and improvement areas. Alongside reduction in 'Watch' and 'Reserve' category antibiotics, two further objectives for the next financial year are to promote penicillin allergy de-labelling and improve blood culture time to incubation.

1.5.4. Water Safety

The Trust Water Safety Group (WSG) continues to provide strategic oversight and governance of all water safety-related matters across the estate. Although operational pressures, staffing vacancies and a trust vacancy freeze within the Estates staffing structure have caused delays to the regular WSG meeting schedule, statutory and risk-based activities have remained in place. Assurance continues to be provided to both the Health and Safety Governance Committee and the Infection Prevention and Control Committee. Issues of non-conformance particularly where waterborne infection risks are identified are escalated to the IPC team. During 2025–2026, the estates team aspire to strengthened operational support by initiating plans via budget application for a dedicated Operational Estates Water Safety Manager. WSG meetings continue to be held virtually via MS Teams. Attendance has been affected by operational pressures, escalation routes remain available, ensuring urgent matters are addressed promptly. Core membership to the water safety group includes Estates (Operational and Capital), Facilities, Infection Prevention and Control, Authorising Engineer (Water), Authorised Persons (APs), and specialist clinical areas including Renal, Endoscopy, Sterile Services and Hydrotherapy.

The Trust Water Safety Plan (WSP) remains in place and is used to guide operational, remedial and capital investment decisions. The Authorising Engineer for Water (Hydrop) updated the WSP in line with revised HTM 04 guidance and completed the Trust's annual Water Safety Audit in January 2026. The trust is still awaiting the formal report but early conversations with the AE in the water safety group haven't highlighted any immediate concerns. Despite challenges associated with the ageing estate and staffing gaps, the audit produced a positive overall outcome, and an action plan has been agreed for improvement areas. Hydrop has also completed a full Legionella Risk Assessment Review across Royal Preston Hospital and Chorley and District Hospital. The resulting recommendations and remedial actions are being assessed by the Estates operational team, with funding applications progressing.

Legionella sampling continues in line with the revised programme agreed in 2022. Augmented care areas have been reviewed with operational estates, the DIPC and IPC Matron to ensure the sampling approach continues to reflect clinical risk. Out-of-range results are managed in accordance with the WSP and HTM, with follow-up samples taken after all remedial works. All outstanding Legionella positives from the previous round have now been treated and are awaiting final re-test. Routine Pseudomonas testing continues every six months in Augmented Care in accordance with HTM 04-01. Out-of-range results remain infrequent and are managed under the WSP. A neonatal/delivery suite incident review found no matching pseudomonas strain within the Trust's water system. As a precaution, additional targeted Pseudomonas sampling will be introduced to Delivery Suite WHB outlets during the next testing round, without reducing sampling volumes in augmented care.

Estates Hotel Services continues to deliver routine outlet flushing across all areas and will provide dip-sample evidence to strengthen compliance assurance. To further enhance Legionella control, the Trust has appointed a specialist contractor to manage, disinfect and maintain all Thermostatic Mixing Valves (TMVs), ensuring alignment with statutory requirements and industry best practice.

The Trust Water Safety Group continues to deliver effective strategic oversight of water safety despite operational pressures. Assurance processes remain strong, supported by robust actions from Estates, IPC, AE Water, and specialist clinical teams. Forthcoming strategic estates work and strengthened communication arrangements will further enhance system safety and resilience.

1.5.5. Ventilation

The Estates Services Department continues to manage ventilation systems in line with HTM 03 01 and associated Health Building Notes, recognising the role ventilation plays in reducing the risk of airborne transmission of infection.

The Trust estate comprises a wide range of ventilation systems designed and installed over several decades. As HTM standards have evolved and are not retrospective, there is significant variation in design, condition, and performance across sites. A proportion of systems are now ageing and approaching or exceeding recommended lifecycle, particularly within some inpatient areas at Royal Preston Hospital. These constraints are managed using a risk-based approach, informed by clinical use, infection risk, and independent assurance.

Ventilation governance is provided through the Ventilation Safety Group (VSG), which includes Estates, Infection Prevention & Control, clinical representation, and the Trust's independent Authorising Engineer (Ventilation). During 2025–26, the VSG strengthened its oversight arrangements, including refreshed Terms of Reference, structured action tracking, and increased clinical engagement. Where audit risk scores were elevated, meeting frequency was temporarily increased to provide assurance.

Independent re-verification of critical ventilation systems continues to be undertaken by specialist contractors in line with HTM guidance and the Trust Ventilation Policy. A revised HTM compliant planned preventative maintenance (PPM) regime has been implemented across the Trust. Work has progressed to improve the accuracy of asset registers and PPM scheduling, including separating individual AHUs onto discrete maintenance tasks to support traceability and compliance.

Audit activity during the year identified areas requiring improvement, including high risk findings at Chorley and South Ribble Hospital. Action plans were developed and monitored through the VSG, with re-audit

arrangements agreed to confirm the effectiveness of remediation. This structured audit and assurance process represents a significant improvement on previous years.

Where ventilation deficiencies cannot be immediately resolved through infrastructure upgrades, mitigation measures have been applied in partnership with IPC. This includes the deployment of mobile air purification units to higher risk inpatient areas. During 2025–26, governance weaknesses relating to tracking, maintenance, and ownership of these units were identified. In response, a Trust wide air purifier amnesty and audit was initiated to re-establish asset control, confirm ongoing clinical need, and ensure servicing arrangements are appropriate. Care is being taken to ensure units required for infection control are not removed without IPC agreement.

Training and competence continue to be a key focus. Authorised Person (Ventilation) capability is maintained within Estates management teams, and a refreshed programme of Competent Person training has been commissioned following staff turnover. Ongoing toolbox talks and engagement support operational awareness of ventilation risks.

Ventilation related capital investment during the year was prioritised towards patient safety and infection control, including upgrades to air handling units serving neonatal, maternity, pathology, Radio pharmacy, Endoscopy, and Diagnostic areas. The need for earlier Authorising Engineer and Authorised Person involvement in capital schemes and improved handover documentation has been identified and is being progressed.

Overall, ventilation risks remain actively managed through governance, audit, maintenance, mitigation, and targeted capital investment. Key priorities for 2026–27 include completing outstanding re-audits, strengthening governance of local exhaust ventilation systems, embedding improved asset control for air purification units, and continuing to prioritise high risk clinical areas in capital planning.

1.5.6. Decontamination

1.5.6.1. The Sterile Services Department

The Sterile Services Department (HSDU) continues to provide a comprehensive, 24/7 decontamination service in support of theatres, Endoscopy, and other procedural areas across the Trust. The department remains based at Chorley and South Ribble Hospital and operates as a legal manufacturer of systems and procedure packs under the UK Medical Devices Regulations. Throughout 2025–26, HSDU has continued to deliver safe, effective, and compliant services within a challenging operational context characterised by increasing clinical demand, workforce pressures, and infrastructure constraints. These led to a significant increase in clinical incidents which were monitored via the IPCC. These incidents included residue on instruments, water ingress, foreign material present, holes in wrapping, missing equipment etc. An action plan was developed and the frequency of incidents reduced. HSDU/Theatres decontamination incidences continue to be monitored monthly via IPCC.

Despite these pressures, the department has maintained service continuity and regulatory compliance, supported by a robust Quality Management System, strong local leadership and close multidisciplinary working with Engineering, Infection Prevention and Control, and clinical teams.

1.5.6.2. Compliance with HTM 01 01 Standards

Throughout 2025–26, the Sterile Services Department has maintained compliance with HTM 01 01 requirements for the management and decontamination of surgical instruments. Decontamination processes, equipment testing, environmental controls, and documentation have continued to be monitored through routine internal audits, validation programmes, and management review.

Authorised testing, validation and routine monitoring of washer disinfectors and sterilisation equipment have been undertaken in line with statutory requirements, with no significant findings impacting patient safety. Improvements to water quality infrastructure and equipment monitoring during the year have further strengthened assurance against HTM standards. Where risks have been identified, these have been escalated through established governance routes and addressed via local mitigation plans.

1.5.6.3. ISO 13485 Compliance

The Trust maintains certification to ISO 13485:2016, reflecting its role as a legal manufacturer under the UK Medical Devices Regulations. During 2025–26, the Sterile Services Department underwent an external ISO 13485 and UKCA surveillance audit, which provided strong independent assurance.

The audit concluded with no major or minor nonconformities identified, and certification was continued without restriction. Auditors noted evidence of a mature and effective Quality Management System, including robust management review, internal audit arrangements, corrective and preventive action processes, equipment validation, vigilance reporting, and post market surveillance. This outcome represents a strengthening of the Trust's assurance position compared to the previous year and confirms continued compliance with regulatory requirements.

1.5.6.4. Capital Replacement Programme

The 2025–26 capital replacement programme has continued to support service capacity, resilience, and compliance. Investment during the year included the installation of additional washer disinfectors and autoclaves, alongside enhanced digital monitoring capability to improve oversight of equipment performance and availability.

Further infrastructure improvements, including water quality system upgrades, have addressed known historical risks and improved operational stability. While this investment has materially strengthened the decontamination estate, capacity and resilience constraints remain in some theatre-based areas, particularly where single machine dependency persists. These risks continue to be monitored through engineering, estates and decontamination assurance governance arrangements and inform future capital planning priorities.

1.5.6.5. Decontamination in Other Areas of the Trust

As in previous years, the Trust does not currently have a permanently appointed Trust Decontamination Manager with dedicated responsibility for Trust wide decontamination oversight. During 2025–26, this function has continued to be supported by the HSDU Manager, who provides expert advice, audit input, and professional guidance across non HSDU decontamination areas alongside substantive operational responsibilities.

Support has continued for theatres, Endoscopy units and day case areas, including audit activity, compliance reviews, and advice on HTM 01 01 requirements. Inspections of areas undertaking unaccredited flexible endoscopy have been completed jointly with Infection Prevention and Control, with findings reported through appropriate governance committees.

The absence of a dedicated Trust wide role remains a recognised governance risk, limiting strategic capacity and long-term sustainability. Whilst ISO inspections have confirmed no major or minor concerns with reliable management systems and processes in place. Recruitment to this position remains a priority and is planned and expected to strengthen leadership, assurance and consistency of decontamination practice across the organisation.

1.5.7. Environmental Cleaning/Disinfection

1.5.7.1. Domestic Services Cleaning Practices – 2025/2026

The Domestic Services Team utilise a range of cleaning and disinfection methods to maintain high standards of environmental cleanliness across the Trust. These practices provide assurance that national and local standards of cleanliness are consistently met and support patient, staff, and visitor safety.

The current operating practices include:

- Scheduled Cleaning
- Enhanced Cleaning
- Terminal (Vacation) Cleaning
- Deep Cleaning
- Hydrogen Peroxide Vapour (HPV) Disinfection
- UV C Light Disinfection – the use of ultraviolet light to disinfect surfaces and air, particularly within high risk and high throughput areas.

1.5.7.2. HPV Cleaning

Hydrogen Peroxide Vapour (HPV) cleaning is used within the Trust as a specialist environmental decontamination method to support infection prevention and control. HPV is deployed as an adjunct to manual cleaning, not a replacement, and is utilised in situations where there is an increased risk of transmission of harmful microorganisms.

HPV cleaning involves the controlled release of vaporised hydrogen peroxide into a sealed environment. The vapour disperses throughout the room, reaching surfaces and areas that are difficult to clean manually, including high touch points and complex equipment surfaces. Once the decontamination cycle is complete, the vapour is safely neutralised and aerated before the area is returned to use.

HPV cleaning is typically deployed in the following circumstances:

- Following identification or suspected presence of high risk or multi drug resistant organisms
- As part of terminal (vacation) cleaning following patient discharge where enhanced decontamination is required
- During outbreak management, as directed by Infection Prevention and Control (IPC)
- In clinical areas requiring deep environmental decontamination prior to re occupation

1.5.7.3. UV C Technology

UV C devices are widely recognised and used within healthcare environments for room and surface decontamination. This state-of-the-art equipment delivers high intensity UV C light to automatically decontaminate rooms and surfaces efficiently and effectively. UV C technology is used as a supplement to manual cleaning, particularly in scenarios where there is an increased risk of transmission of harmful organisms.

The technology is especially beneficial in high throughput clinical areas, where frequent patient admissions and discharges occur. It supports rapid room turnaround times, helps prevent operational backlogs, and enhances patient safety without compromising cleaning standards.

The Domestic Services Team has embedded regular UV C cleaning of sluice rooms, supported by the Rapid Response Team, further strengthening infection prevention and control measures.

1.5.7.4. National Standards of Healthcare Cleanliness

Following approval of the business case in 2024/2025, domestic services commenced preparatory work to implement the National Standards of Healthcare Cleanliness (2021 & 2025). This included early engagement between Domestic Services, Infection Prevention and Control (IPC), Estates, and Clinical teams to plan a structured and phased roll out aligned to national requirements and local operational priorities.

Initial activity focused on risk-based prioritisation of clinical areas, reviewing cleaning frequencies and responsibilities, mapping risk-based cleaning categories, and assessing workforce, training, and resource implications. This preparatory phase ensured that the Trust had a clear understanding of the standards and the changes required to achieve full compliance. During this period, the revised National Standards of Healthcare Cleanliness (2025) were issued nationally. A gap analysis was undertaken to assess the impact of the revised standards against the implementation plan.

In light of delayed funding release and significant delays to recruitment, a decision was taken to pause implementation of the standards, to safeguard wider service needs. This pause was a deliberate and controlled action to allow for vacant posts to be approved, advertised and recruited into to enable further progress. Importantly, this pause did not represent a reduction in cleaning standards or service delivery. Core cleaning activities, enhanced cleaning regimes, audit processes, and IPC oversight has continued, maintaining safe and effective environmental hygiene across the Trust.

The pause has provided an opportunity to refine monitoring arrangements and ensure a sustainable and consistent approach to implementation once staff are in post. An extended phased roll out is now required, aligned to the revised national standards, with clear milestones, staff engagement, and assurance mechanisms built into delivery. This approach will be necessary to ensure implementation is robust, compliant, and embedded effectively, supporting patient safety, staff assurance, and regulatory expectations. Domestic services will continue to work in partnership with IPC to integrate standards effectively aligned to wider IPC priorities and operational pressures.

At the time of writing this report in March 2026, the compliance figures are:

FR1 areas - RPH – 13 out of 16
 CDH – 18 out of 18

FR2 areas – RPH – 27 out of 42
CDH – 13 out of 18

This represents:

- 9 of 9 ward areas covered in CDH
- 25 of 28 ward areas covered at RPH

1.5.8. Waste management

Over the past year, the Trust has begun implementing a new colour-coding system for clinical waste streams across its sites which has included the change from yellow to orange bags. This initiative helps to prevent over-treatment of waste, ensure compliance with national guidance and move towards more cost-effective disposal routes.

This has been a challenging process and due to the incorrect segregation of certain wastes, requires additional work before the offensive waste stream can be moved forward. Standardising waste segregation will improve environmental performance, reduce unnecessary costs, and support sustainability objectives.

We still separately recycle certain waste streams such as; cardboard, plastic bottles, wood, metal waste electrical and electronic equipment, batteries, mattresses, fluorescent tubes, confidential paper waste (following shredding), cooking and engine oils. Further work is required to introduce the government Simpler Recycling requirements by introducing a “mixed recycling” option for paper/card, plastics and metals.

The Trust's reuse portal for furniture, equipment and stationery continues growing in membership and has saved the Trust £83,000, avoided 7.6 tonnes of waste and 37 tonnes of carbon over the last 10 months. This includes the repurposing of a large number of items from the closure of Finney House. Where feasible our wards and departments have furniture reupholstered using a local service, which again reduces waste and cost and works towards our sustainability targets.

The mobility aids reuse project is progressing slowly, working other Lancashire based Trusts. Finding suitable storage space to expand this work has proved difficult but our staff are still reusing crutches, walking sticks and frames on a smaller scale.

Work is still required to review our suppliers/providers with regard to their sustainability policies and procedures, as per our Green Plan commitments and sustainability. This will include less reliance on single use products, in particular plastics. This requires local responsibility from all wards and departments to make more informed purchasing decisions aimed at reducing waste completely, or where this is not possible, ensuring waste can be reused, recycled or recovered more easily.

A key element of making changes to our waste management systems will involve raising awareness and staff training, which will be introduced alongside the colour coding changes. This will hopefully encourage our staff to think differently about waste and prioritise minimisation, reuse, recycling and recovery over disposal, whilst still ensuring compliance with health and safety.

1.6. RESEARCH

1.6.1. Primel study

In October/November 2024, the IPC team successfully led the implementation of a research study investigating a novel hand hygiene product with residual activity – Primel® Active Hand Coating (PAHC).

In March 2025/26 the research paper was accepted for publication in the Journal of Hospital Infection.

2. Financial implications

Effective management of Infection Prevention and Control in acute hospitals is not only critical for patient safety and clinical outcomes but also delivers substantial financial benefits to healthcare systems. By reducing the incidence of healthcare-associated infections (HCAIs), robust IPC programs help avoid the significant costs associated with extended hospital stays, additional treatments, readmissions, and antimicrobial resistance.

Each prevented infection translates to considerable cost savings depending on the type and severity of the infection. Furthermore, strong IPC measures reduce staff sick leave, enhance bed availability, and improve patient flow, which contributes to operational efficiency and resource optimisation.

IPC is a high-impact, cost-effective strategy. It protects patients and staff, supports better clinical outcomes, and delivers measurable financial returns across the entire health system.

In the reporting period the main schemes to reduce healthcare associated infection rates are:

- Co-production of an investment case for extra domestic resource to become compliant with 2021 National Standards of Healthcare Cleanliness – 750K
- Maintenance of rapid testing approach to ensure isolation capacity continues to be used efficiently.
- Water testing
- Ongoing drainage repairs and need for investment
- Estate remedial works

These will be managed through the Trusts governance processes.

3. Legal implications

Failure to comply with Infection Prevention and Control (IPC) standards in healthcare settings can lead to legal consequences for both institutions and individual healthcare professionals. These may include:

1. Regulatory Sanctions

Healthcare facilities are subject to oversight by national and regional health authorities. Non-compliance can result in enforcement actions such as fines, suspension of services, revocation of licenses, or mandatory corrective action plans.

2. Litigation and Liability

If a patient acquires a healthcare-associated infection (HAI) due to poor IPC practices, the institution may face civil lawsuits for negligence. Courts may find the hospital liable if it is shown that standard precautions were not followed and harm resulted.

4. **Risks**

ID	Title	Current Score
1157	Increased <i>C. difficile</i> Infection	20
1302	Insufficient side rooms to meet Infection prevention & control requirements & demand	12

5. **Impact on stakeholders**

Infection control plays a critical role in patient safety and experience outcomes. Infection leads to increase in treatments and length of stay and colleague sickness. Therefore, the prevention of infection plays an important role in the available bed and colleague capacity within the services.

6. **Recommendations**

It is recommended that:

- I. The Safety and Quality committee note the contents of the Annual report and confirm that it is assured of actions to control Infection and progress against the 2025/2026 Annual Plan (Appendix 1).
- II. Approve the IPC Annual Plan 2026/2027 (Appendix 2).

Appendix 1 – IPC 2025/26 Annual plan

Appendix 2 – IPC 2026/27 Annual plan

Appendix 3 – Infection, Prevention and Control Structure

Infection Prevention and Control (IPC) Annual Programme 2025/2026

The annual programme for 2025/2026 will continue to have a strong focus on effective communication, education and learning to provide clean, safe care. It will strengthen and embed actions implemented in 2024/2025. In order to improve patient safety and reduce healthcare associated infections, infection prevention and control must continue to have a high profile as an evidence-based specialty and patient safety issue within the organisation.

Communication of any new learning and shared good practice, is a key strategy to support the Annual Programme. The PSIRF process introduced in 2024/2025 continues to be strengthened. This process comprises a multidisciplinary team meeting including clinical teams, support services and governance and has been applied to a range of infection prevention and control incidents.

The annual programme is based upon SMART principles and has 9 sections, all of which have the relevant Health & Social Care Act Hygiene Code criteria assigned. The 9 sections are as follows: 1) IPC Team Infrastructure 2) Education & Development 3) Information sharing and communication 4) Audit & Surveillance 5) Review of incidents & risks 6) Environment 7) Antimicrobials 8) IPC preparedness & Resilience 9) Policies & Procedures

This annual programme details developments and changes to the IPC service, which will be introduced to improve patient safety, reduce healthcare associated infections and strengthen learning and communication.

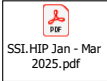
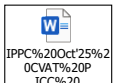
The Divisions and IPC team will be responsible for delivery of this programme and progress will be monitored monthly at the Trust Infection Prevention and Control Committee (IPCC) meetings

Compliance Criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

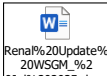
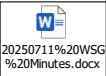
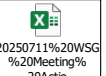
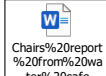
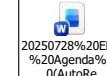
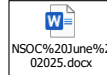
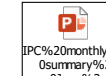
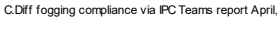
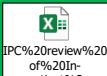
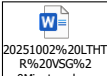
Ongoing Task Milestone										
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	1.1.0									
Inter-relations / Wider Community / Strategic working	1.1.1	Support Task and Finish groups with the ICB colleagues	1,2,3,4,5,6,7, 8,9	Matron IPC / DIPC	Work collaboratively within the ICB providing IPC strategic working, expertise and driving future changes	Matron IPC / DIPC	Q3			
	1.1.2	Share learning from incidents across the ICB	1,2,7,9	Matron IPC / DIPC	Share any new learning with ICB in monthly IPC meeting	Matron IPC / DIPC	Q4			Quarterly reports send to ICB for assurance, IPC lead attends meeting quarterly. This was more of a focus for the ICB IPC team on GNBSI's as a whole, so we picked 4x topics to look at each quarter and we would involve other providers as and when required. Our work was discussed as the quarterly HCAI locality meetings, where we provided feedback/information on the work, next steps etc. So for example- in Q1 we focussed on community wound care, Q2 bladder and bowel care (which is why we did the work on promoting catheter passports, we linked with primary care and community teams on catheter care, we attended awareness days etc). Q3 invasive devices, we are linking in with acute trusts on their decontamination process (what they used for skin decontamination etc), we worked closely on the process in primary care/provided training etc on ANTT. Q4- we are just starting to look at oral health- we have done some promotional work with primary care, linked in with local authorities on care home education etc. In terms of dentistry- this is on my radar, but a huge piece of work and probably something I investigate, alongside all the work I am doing with primary care In an ideal world I would like to do a much deeper dive into all of the above topics and link in with micro etc, but capacity is a real issue.

Ongoing Task Milestone										
Domain	Reference	Aim	Relevant Hygiene Code Criterion	Lead	Actions	Action By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
Education Programme	2.1.0									
	2.1.1	Ensure that there is a comprehensive IPC education programme that follows national guidance	4, 6, 10	Matron IPC	To review and update the mandatory Infection Prevention and Control education in line with national guidance that's delivered to clinical and non-clinical staff	IPC Lead Nurses / Blended Learning team	Q4			This is currently under review
	2.1.2	Continue the Infection Prevention and Control face-to-face study days throughout the Trust to strengthen IPC communication and cascade IPC training for frontline staff	1,2	Lead IPC Nurse	Continue with education sessions for IPC across the Trust	IPC Team	Q1,2,3,4			 Link%20Nurse%20Day%20May%202025.docx  IPC%20Champions%20July%202025%2  IPC%20Champions%20October%202025
	2.1.3	Reduce reoccurring themes and trends identified in MDT reviews and/or outbreaks.	1,2,3,4,5,6,7	Matron IPC	Provide bespoke IPC training for departments following MDT reviews or outbreaks	Lead IPC Nurses / IPC Team	Q1, Q3		 Thematic%20review%20for%20Clostridioides	IPC Team to provide any bespoke training on the back of Ward 24 MDT, to be confirmed.
	2.1.4	Improve compliance with mandatory IPC / ANTT training with Foundation (Junior) Doctors	1,4,6	Educational Supervisor Lead / DND's	Create a mandatory IPC / ANTT training plan for Foundation (Junior) Doctors	Educational Supervisor Lead / DND's	Q1			Evidence saved on Share point
	2.1.5	Improve patient education on the importance of IPC principles	1,2,4,9	IPC Team / Patient Safety Partners	Work with Patient Partners to improve patient's awareness of IPC principles to prevent cross-infection	IPC Team / Patient Safety Partners	Q3			New patient safety partners now recruited we will link in
	2.1.6	Improve Sbar to include red Triangle/ infection status/ Suspected infectious status	1,2,3,4,5,6,7, 9	IPC Lead/ IPC Matron	To Include patients infectious status in trust sbar	Divisional Nursing Director Medicine	Q2			 ED%20Infection%20Ward%20Infection%20status

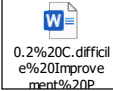
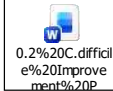
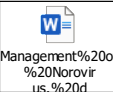
Ongoing Task Milestone										
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
Electronic Communications	3.1.0									
	3.1.1	Enhance communication, education and awareness of IPC issues in the Trust via Trust comms, safety bulletins, and social media	4,6	Matron IPC	Communicate Trust-wide regarding immediate safety and learning concerns, and celebrate good practice.	IPC Team	Q 1,2,3,4			Recent comms regarding Norovirus circulated. Recent comms regarding Influenza circulated in December and January
Patient Lived Experience	3.2.0									
	3.2.1	Share learning and examples of good practice around IPC within the Trust.	1, 4, 6	Divisional Leads	Divisional leads to share learning and good practice or lessons learnt from MDT reviews, patient lived experience / story, and outbreaks	Divisional Leads	Q 1,2,3,4			 Medicine%20Q4%20IPCC%20report.docx  W&C%20Q4%202025%20IPC%20Report.docx  IPCC%20report%20Q4%20DCS%2020202425.docx  Medicine%20Division%20IPC%20Report%20
IPC Campaigns	3.3.0									
	3.3.1	To educate all staff across the Trust on different IPC campaigns	1,9	Matron IPC	Continue to promote IPC best practice	IPC Lead Nurses, IPC Team, Divisional Leads	Q 1,2,3,4			IPC Team linked in with Coms team to regularly share IPC updates across the year. Next IPC Link Nurse day will be completed in March

Ongoing Task										
Milestone										
Domain	Reference	Aim	Relevant Hygiene Code Criterion	Lead	Actions	Action By	Completion Due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
Infection Prevention and Control Reports	4.1.0									
	4.1.1	To communicate the LTHTR performance against mandatory infection objectives in the IPC Team report and Board papers for 2025/2026	1,4	DIPC	Review IPC Team report to reflect changes in mandatory reporting and the objectives for 2025/2026	DIPC / IPC Matron	Q2			 01.%20IPC%20Team%20Report%202025-2026.docx
Star Assurance Framework	4.1.2	To ensure IPC sections of star is reviewed annually	1,2	DIPC	To include a specific question regarding the decontamination of Medical devices between patients use	Quality Assurance Matron/ IPC Matron	Q4			IPC section of star reviewed with KD and JH.
Surgical Site Infection	4.2.0									
	4.2.1	Ensure that LTHTR is compliant with reporting on mandatory surgical site infection surveillance in orthopaedics and completes actions for continuous improvement	1,4	Orthopaedic Directorate	To report collated quarterly data and ongoing actions for improvement to IPCC	Divisional Nursing Director/ Mandatory SSI lead	Q 2,4			 SSI.Knee. Jan - Mar 2025.pdf  SSI.HIP Jan - Mar 2025.pdf
	4.2.2	To reduce vascular device associated bloodstream infections	4,6	Divisions	To report progress biannually to IPCC and quarterly to Divisions	Divisions with support of CVAD team	Q 2,4			 IPCC%20Oct25%20CVAT%20PCC%20.docx Will also be due in Q4
	4.3.0									
Patient Safety and Health Promotion	4.3.1	Improve intelligence and tackle contributory factors for Gram negative bacteraemia in LTHTR	1,5,6,8	DIPC / IPC Matron / Lead IPC Nurses	Contribute to the ICB lead initiatives to reduce gram-negative bacteraemia.	DIPC / IPC Matron / Lead IPC Nurses	Q4			Same evidence as 4.3.4
	4.3.2	Reduce Catheter associated UTIs	1,5,6,8	DIPC / IPC Matron / Divisional Nursing Directors	Devise a Point Prevalence questionnaire for Ward Matrons / Divisional lead to audit. Report findings to IPCC.	DIPC / IPC Matron / Divisional Nursing Directors	Q3			Meeting scheduled to review current UCAM form with a view to update this as part of the workstream for electronic care plans
	4.3.3	Reduce Catheter associated UTIs	1,5,6,8	DIPC / IPC Matron / Divisional Nursing Directors	Devise a list of actions in response to the Point Prevalence audit results which will include key messages to staff through safety bulletins	DIPC / IPC Matron / Divisional Nursing Directors	Q4			
	4.3.4	Improve continence and bowel care across the ICB	1,5,6,8	DIPC / IPC Matron / Lead IPC Nurses	Contribute to the ICB led task and finish groups to improve continence and bowel care	DIPC / IPC Matron / Lead IPC Nurses	Q4			Quarterly reports sent to ICB for assurance, IPC lead attends meeting quarterly. This was more of a focus for the ICB IPC team on GNBSTs as a whole, so we picked 4x topics to look at each quarter and we would involve other providers as and when required. Our work was discussed as the quarterly HCAI locality meetings, where we provided feedback/information on the work, next steps etc. So for example- In Q1 we focussed on community wound care, Q2 bladder and bowel care (which is why we did the work on promoting catheter passports, we linked with primary care and community teams on catheter care, we attended awareness days etc). Q3 invasive devices, we are linking in with acute trusts on their decontamination process (what they used for skin decontamination etc), we worked closely on the process in primary care/provided training etc on ANTT. Q4- we are just starting to look at oral health- we have done some promotional work with primary care, linked in with local authorities on care home education etc.
Surveillance	4.4.0									
	4.4.1	Annual review of IPC audits.	1,2	Matron IPC / Lead Nurses IPC	Review and update IPC audits to reflect current themes and trends identified.	Matron IPC / Lead Nurses IPC	Q4			
	4.4.2	Participate in the national CDRN sentinel surveillance scheme which genotypes the 1st 10 CDI positive cases per month, to provide information on transmission	1,2	DIPC	Submit the 1st 10 CDI positive samples per month	DIPC	Q1			
Sepsis management improvement	4.5.0									In terms of dentistry- this is on my radar, but a huge piece of work and probably something I investigate, alongside all the work I am doing with primary care
	4.5.1	To improve sepsis management in LTHTR	4,6	Divisional Nursing Directors / Matron IPC	To present a quarterly report on progress around improving the management of sepsis and monitor the actions set in IPCC	Sepsis Lead	Q1,2,3,4			 Obsterics%20Q2%20Report.docx  Q3%20Paediatric%20Report-Matrn.docx  Q3%20Master%20Report-Surgery%20.docx  Q3%20Master%20Report%20Medicine.docx  Q3%20ED%20Anonymous%20Report.docx  Obsterics%20Q3%20Anonymous%20Report.docx
	4.5.2	To improve sepsis management in LTHTR	4,6	Divisional Nursing Directors / Matron IPC	To present a report on progress around improving the management of sepsis and monitor the actions set in IPCC	Sepsis Lead	Q1,2,3,4			 June%20Sepsis%20Report%202025.docx In an ideal world I would like to do a much deeper dive into all of the above topics and link in with micro etc, but capacity is a real issue.

Ongoing Task										Milestone	
Domain	Reference	Aim	Relevant Hygeine Code Criterion	Lead	Actions	Action By	Completion Due	Complete Y/N	RAG	Embedded Evidence Y/N N/A	
	5.1.0										
Patient Safety Incident Reporting Framework	5.1.1	Ensure that all HOHA CDI cases have a screening tool completed	1,4,6	Divisional nursing directors or deputy	Ward managers and matrons to ensure that screening tool is completed within 7 days of case being reported	Ward managers and matrons	Q 2				
	5.1.2	Streamline the process for report gathering from CDI screening tool datixs for presentation at divisional IPCC meetings	1,4,6	Head of Risk & Datix Systems	Divisional leads to meet with the head of Risk & Datix Systems to develop the reports	Head of Risk & Datix Systems	Q 2			Divisional leads have met with head of risk	
	5.1.3	To identify, share and embed themes and trends to promote learning through CDI incidents reported using PSIRF	1,4,6	DIPC	Produce a bi-annual report that outlines themes of trends for CDI infection	DIPC	Q 1,3				
	5.1.4	Ensure IPC incidents, complaints, patient feedback and IPC risk register are visible in IPCC	1,4,6	DIPC	Compile a monthly report of Datixs for IPCC	DIPC	Q1,2,3,4				
	5.1.5	Share learning from Outbreak management to highlight good practice and areas for learning and improvement	1,4,6	Matron IPC	Include any outbreaks and periods of increased incidents within the IPC Team report	IPC Team	Q1,2,3,4				

Ongoing Task Milestone										
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
Water safety	6.1.0									
	6.1.1	Provide assurance to IPCC in regards to water safety management	2	Assistant Director of Estates	Provide bi-monthly reports to IPCC on water safety management including abnormal results and remedial actions	Water Safety Group / Head of Operational Estates	Q 1,2,3,4		Aw aiting Assurance report	    
Environmental and Equipment Cleaning	6.2.0									
	6.2.1	To improve the cleanliness of the environment	2	Assistant Director of Facilities	To implement the national standards of healthcare cleanliness in a phased approach through 2025/26	Head of Facilities	Q1, Q4			
	6.2.2	Monitor Estate and Facilities workstreams - Capital, Maintenance, Remedial works, Waste, Cleanliness and Linen	2	Director of Estates & Facilities	Monthly Chairs report from the Estates and Facilities partnership board to be presented at IPCC	Chair of Estates & Facilities partnership board	Q1,2,3,4			
	6.2.3	Provide assurance of the Trust's environmental cleanliness and report the findings to Divisions and IPCC on a monthly basis.	2	Director of Estates & Facilities	Monitor progress and compliance and report monthly to IPCC	Hotel Services Manager / IPC Matron	Q1,2,3,4			   
	6.2.4	To ensure cleaning and fogging is completed following CDI cases.	2	IPC Matron / Head of facilities	Explore methods to monitor compliance of fogging following CDI cases to reported to IPCC monthly via facilities report (in the absence of the data analyst)	IPC Matron / Head of facilities	Q1,2,3,4			
	6.2.5	To ensure any improvement works are reviewed and prioritised from an IPC perspective.	2	IPC Matron / Head of Estates/ Head of Capital / Head of Domestic Services	IPC Matron to complete monthly walkrounds with Estates and Facilities to review the Estates from an IPC perspective and provide recommendations for best practice.	IPC Matron / Head of Estates/ Head of Capital / Head of Domestic Services	Q1,2,3,4			
Decontamination	6.3.0									
	6.3.1	To provide assurance to the IPCC in regards to Decontamination management	2	DIPC/ IPC Matron / Head of Estates/ Departmental Leads / Decontamination Lead	Develop key metrics of data that must be monitored through IPCC relating to decontamination.	DIPC/ IPC Matron / Head of Estates/ Departmental Leads / Decontamination Lead	Q1			Daily decontamination meetings are ongoing, decontamination assurance meetings to be re-enstated
	6.3.2	Ensure that there is a Trust decontamination lead	2	Director of Estates & Facilities	Ensure that there is a substantive Trust Decontamination Lead who has sufficient time to perform this role	Director of Estates & Facilities	Q4			JD has been completed aw aiting recruitment process
	6.3.3	To provide assurance to the IPCC in regards to Decontamination management	2	Decontamination Lead	Provide quarterly reports to IPCC on Decontamination management including track and trace and remedial actions from findings	Decontamination Lead	Q1,2,3,4			Still Aw aiting assurance report
	6.3.4	Identify and report Decontamination audit gaps in standards through divisional IPC	2	Decontamination Lead	Provide monthly reports to divisional IPC meetings to strengthen the current audit and for feedback and improvement for assurance of current gaps in audits	Decontamination Lead	Q1,2,3,4			Still Aw aiting assurance report
Ventilation	6.4.0									
	6.4.1	Monitor ventilation across the estate.	1,2	Head of Operational Estates	Provide bi-monthly reports from the Ventilation Working Group to IPCC	Head of Operational Estates	Q2, 4			

Ongoing Task Milestone										
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	7.1.0									
Antimicrobial stewardship	7.1.1	Provide assurance of Trust performance against Start Smart and Focus antimicrobial stewardship standards'	3	AMS Lead	Quarterly report on point prevalence audits	AMS Team	Q1, Q2,Q3,Q4			 Trustwide Antimicrobial Point Prevalence Audit  Trustwide Antimicrobial Point Prevalence Audit
	7.1.2	Reduce the use of IV antimicrobials	3	AMS Lead	Monitor proportion of IV vs Oral antimicrobial use	AMS Team	Q4			 AMR%20Act%20no w%20-%20Board%
	7.1.3	Reduce the use of "watch and reserve" antimicrobials	3	AMS Lead	Monitor Antibiotic usage	AMS Team	Q4			
	7.1.4	To introduce penicillin allergy de-labelling guidance	3	ADIPC and AMS lead	Publish the guideline for implementation of penicillin de-labelling	ADIPC and AMS lead	Q3			http://lhtr-documents/current/P2573.pdf

Ongoing Task										
Milestone										
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	8.1.0									
C. difficile	8.1.1	Reduce Hospital Acquired CDI	1,2,3,4,5,6, 7,8,9	Chief Nurse / Deputy Chief Nurse / DIPC	Monitor progress in the CDI Action Plan monthly at IPCC.	IPC Matron / DND's / Head of Facilities / Head of Estates	Q1,2,3,4			 0.2%20C.difficile%20improvement%20P  0.2%20C.difficile%20improvement%20P  0.2%20C.difficile%20improvement%20P
	8.2.0									
Norovirus	8.2.1	Improve Norovirus management and knowledge across the organisation	5, 6	Deputy Chief Nurse	Ensure the Norovirus policy is shared within the Divisions and educated to Link Nurses and implemented in outbreak management	DIPC/Matron IPC	Q2			 IPC%20Champions%20October%202025  Management%20of%20Norovirus%20d
	8.3.0									
Influenza	8.3.1	IPC preparation including POCT for seasonal influenza in place	5, 6	Deputy Chief Nurse	Ensure the Influenza policy is shared within the Divisions and educated to Link Nurses and implemented in outbreak management	DIPC/Matron IPC	Q2			Completed in October link nurse day and has been sent to all ward managers and matrons for circulation to their teams
	8.4.0									
Candidozyma auris	8.4.1	Ensure processes are in place for the control of candidozyma auris	1,2,3,4,5,6, 7,8,9,10	DIPC/Matron for IPC	Produce a trust IPC policy for candidozyma auris which follows national guidance	DIPC/Matron for IPC	Q 2			On the agenda needs to go through certain working groups to go live
	8.4.2	Ensure processes are in place for the control of candidozyma auris	1,2,3,4,5,6, 7,8,9,10	DIPC / Matron IPC	Communicate and educate concern the new policy and procedures	DIPC / Matron IPC	Q 2			
	8.5.0									
XDR Multidrug resistant organisms	8.5.1	Mitigate risk of multidrug resistant waterborne infections.	1,2,3,4,5,6, 7,8,9	DIPC/Matron for IPC	Communicate and educate concerning the policy for safe use of water on clinical areas	DIPC/Matron for IPC	Q 2			Shared out
	8.6.0									
Emergency Preparedness	8.6.1	Review the emergency preparedness plan	1, 2, 5, 6	Head of EPRR and Patient Flow	Review and update the emergency preparedness plan collaboratively	DIPC / Head of EPRR and Patient Flow / IPC Matron	Q 4			http://lthtr-documents/current/P2406.pdf
	8.6.2	Ensure that we are prepared for any future epidemics and / or pandemics	1, 2, 5, 6	Divisional nursing directors or deputy	Monitor and escalate any concerns relating to FFP3 fit masking compliance	Divisional nursing directors or deputy	Q 4			Divisional Leads reporting to IPCC each month

Ongoing Task Milestone										
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	9.1.0									
Policies and procedures	9.1.1	Provide assurance policies and procedural documents are in date and complete to enable the prevention of infections and education of staff	1,4,9	IPC Matron / DIPC	Provide assurance through the monthly IPC report of the status of policies owned by IPC and that they are in date and reviewed within the required time	IPC Matron / DIPC / IPC Team	Q1, 2, 3, 4			(C auris, Rapid intestinal testing, TB, Outbreak policy, Multidrug resistant, Norovirus, Hand hygiene and VHF and Covid)

Infection Prevention and Control (IPC) Annual Programme 2026/2027

The annual programme for 2025/2026 will continue to have a strong focus on effective communication, education and learning to provide clean, safe care. It will strengthen and embed actions implemented in 2025/2026. In order to improve patient safety and reduce healthcare associated infections, infection prevention and control must continue to have a high profile as an evidence-based specialty and patient safety issue within the organisation.

Communication of any new learning and shared good practice, is a key strategy to support the Annual Programme. The PSIRF process introduced in 2024/2025 continues to be strengthened. This process comprises a multidisciplinary team meeting including clinical teams, support services and governance and has been applied to a range of infection prevention and control incidents.

The annual programme is based upon SMART principles and has 9 sections, all of which have the relevant Health & Social Care Act Hygiene Code criteria assigned. The 9 sections are as follows: 1) IPC Team Infrastructure 2) Education & Development 3) Information sharing and communication 4) Audit & Surveillance 5) Review of incidents & risks 6) Environment 7) Antimicrobials 8) IPC preparedness & Resilience 9) Policies & Procedures

This annual programme details developments and changes to the IPC service, which will be introduced to improve patient safety, reduce healthcare associated infections and strengthen learning and communication.

The Divisions and IPC team will be responsible for delivery of this programme and progress will be monitored monthly at the Trust Infection Prevention and Control Committee (IPCC) meetings

Compliance Criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

Ongoing Task Milestone										
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	1.1.0									
Inter-relations / Wider Community / Strategic working	1.1.1	Continue to collaborate with ICB colleagues	1,2,3,4,5,6,7,8,9	Matron IPC / DIPC	Work collaboratively within the ICB providing IPC strategic working, expertise and driving future changes	Matron IPC / DIPC	Q3			
	1.1.2	Share learning from incidents across the ICB	1,2,7,9	Matron IPC / DIPC	Share any new learning with ICB in monthly IPC meeting	Matron IPC / DIPC	Q4			

Ongoing Task Milestone										
Domain	Reference	Aim	Relevant Hygiene Code Criterion	Lead	Actions	Action By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
Education Programme	2.1.0									
	2.1.1	Ensure that there is a comprehensive IPC education programme that follows national guidance	4, 6, 10	Matron IPC	To review and update the mandatory Infection Prevention and Control education in line with national guidance that's delivered to clinical and non-clinical staff	IPC Lead Nurses / Blended Learning team	Q4			
	2.1.2	Continue the Infection Prevention and Control face-to-face study days throughout the Trust to strengthen IPC communication and cascade IPC training for frontline	1,2	Lead IPC Nurse	Continue with education sessions for IPC across the Trust	IPC Team	Q1,2,3,4			
	2.1.3	Reduce reoccurring themes and trends identified in MDT reviews and/or outbreaks.	1,2,3,4,5,6,7	Matron IPC	Provide bespoke IPC training for departments following MDT reviews or outbreaks	Lead IPC Nurses / IPC Team	Q1, Q3			
	2.1.4	Improve patient education on the importance of IPC principles	1,2,4,9	IPC Team / Patient Safety Partners	Work with Patient Partners to improve patient's awareness of IPC principles to prevent cross-infection, and develop resources for patients on emergency and elective pathways and their families (e.g., patient information leaflets or information on letters).	IPC Team / Patient Safety Partners	Q3			
	2.1.5	Provide bespoke training to volunteers	1,2,4,9	IPC Team	Arrange face-to-face training for newly recruited volunteers across the trust	IPC Team	Q2			

		Ongoing Task			Milestone					
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	3.1.0									
Electronic Communications	3.1.1	Enhance communication, education and awareness of IPC issues in the Trust via Trust comms, safety bulletins, and social media	4,6	Matron IPC	Communicate Trust-wide regarding immediate safety and learning concerns, and celebrate good practice.	IPC Team	Q 1,2,3,4			
	3.2.0									
Share learning	3.2.1	Share learning and examples of good practice around IPC within the Trust.	1, 4, 6	Divisional Leads	Divisional leads to share learning and good practice or lessons learnt from MDT reviews, patient lived experience / story, and outbreaks	Divisional Leads	Q 1,2,3,4			
	3.3.0									
IPC Campaigns	3.3.1	To educate all staff across the Trust on different IPC campaigns	1,9	Matron IPC	Communicate IPC best practice via a range of mechanisms (e.g., meetings, campaigns, alerts and bulletins etc)	IPC Lead Nurses, IPC Team, Divisional Leads	Q 1,2,3,4			
	3.3.2	Raise awareness of Candida auris and educate staff about the importance of screening at-risk patients as per policy and as prompted by the admission screening tool	1,9	DIPC/Matron IPC	Develop and implement a communication plan which will include presentation at NMAHP and a bulletin	DIPC/Matron IPC	Q 1			

Domain	Reference	Aim	Relevant Hygiene Code Criterion	Lead	Actions	Action By	Completion Due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	4.1.0									
Infection Prevention and Control Reports	4.1.1	To communicate the LTHTR performance against mandatory infection objectives in the IPC Team report and Board papers for 2025/2026	1,4	DIPC	Review IPC Team report to reflect changes in mandatory reporting and the objectives for 2025/2026	DIPC / IPC Matron	Q2			
Audit	4.1.2	To monitor utilisation of IPC dashboards and standardise how they are used to ensure accountability from departmental leads	1,4	DIPC/ IPC Matron/ DNDs	Obtain data on the utilisation of the IPC dashboards from BI and then work with DNDs to agreed on standard usage	DIPC/ IPC Matron/ DNDs	Q3			
Star Assurance Framework	4.1.3	To ensure IPC sections of star are reviewed annually	1,2	DIPC	Meet with the STAR team and review the questions	Quality Assurance Matron/ IPC Matron	Q4			
	4.2.0									
Surgical Site Infection	4.2.1	Ensure that LTHTR is compliant with reporting on mandatory surgical site infection surveillance in orthopaedics and completes actions for continuous improvement	1,4	Orthopaedic Directorate	To report collated quarterly data and ongoing actions for improvement to IPCC	Divisional Nursing Director/ Mandatory SSI lead	Q 2,4			
	4.2.2	Review education and documentation relating to Central Venous Access	4,6	Divisions	To report progress biannually to IPCC and quarterly to Divisions	Divisions with support of CVAD team	Q 2,4			
	4.3.0									
Patient Safety and Health Promotion	4.3.1	Improve intelligence and tackle contributory factors for Gram negative bacteraemia in LTHTR	1,5,6,8	DIPC / IPC Matron / Lead IPC Nurses	Contribute to the ICB lead initiatives to reduce gram-negative bacteraemia.	DIPC / IPC Matron / Lead IPC Nurses	Q4			
	4.3.2	Reduce Catheter associated UTIs	1,5,6,8	DIPC / IPC Matron / Divisional Nursing Directors	Devise a Point Prevalence questionnaire for Ward Matrons / Divisional lead to audit, and then devise an action plan for improvement. Report findings to IPCC.	DIPC / IPC Matron / Divisional Nursing Directors	Q3			
	4.4.0									
Surveillance	4.4.1	Annual review of IPC audits.	1,2	Matron IPC / Lead Nurses IPC	Review and update IPC audits to reflect current themes and trends identified.	Matron IPC / Lead Nurses IPC	Q4			
	4.5.0									

Sepsis management improvement	4.5.1	To improve sepsis management in LTHTR	4,6	Sepsis management team	To present a quarterly report on progress around improving the management of sepsis and monitor the actions set in IPCC	Sepsis Lead	Q1,2,3,4			
	4.6.0									
Sepsis management improvement	4.5.1	Ensure timely decolonisation of MRSA	4,6	DIPC	Perform an audit of time to decolonisation from first detection of MRSA	DIPC	Q1			

Ongoing Task										
Milestone										
Domain	Reference	Aim	Relevant Hygiene Code Criterion	Lead	Actions	Action By	Completion Due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	5.1.0									
Patient Safety Incident Reporting Framework	5.1.1	Ensure that all HOHA CDI cases have a screening tool completed	1,4,6	Divisional nursing directors or deputy	Ward managers and matrons to ensure that screening tool is completed within 7 days of case being reported	Ward managers and matrons	Q 2			
	5.1.2	Ensure that the Ulysses system replicates the process for report gathering from CDI screening tool for presentation at divisional IPCC meetings	1,4,6	Head of Risk & Ulysses Systems	Confirm the system is operating as intended	Head of Risk & Ulysses Systems	Q 1			
	5.1.3	To identify, share and embed themes and trends to promote learning through CDI incidents reported using PSIRF	1,4,6	DIPC	Produce a bi-annual report that outlines themes of trends for CDI infection	DIPC	Q1,3			
	5.1.4	Ensure IPC incidents, complaints, patient feedback and IPC risk register are visible in IPCC	1,4,6	DIPC	Compile a monthly report of incidents for IPCC	DIPC	Q1,2,3,4			
	5.1.5	Share learning from Outbreak management to highlight good practice and areas for learning and improvement	1,4,6	Matron IPC	Include any outbreaks and periods of increased incidents within the IPC Team report	IPC Team	Q1,2,3,4			

Ongoing Task										
Milestone										
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	6.1.0									
Water safety	6.1.1	Provide assurance to IPCC in regards to water safety management	2	Assistant Director of Estates	Provide bi-monthly reports to IPCC on water safety management including abnormal results and remedial actions	Water Safety Group / Head of Operational Estates	Q 1,2,3,4			
	6.2.0									
Environmental and Equipment Cleaning	6.2.1	To improve the cleanliness of the environment	2	Assistant Director of Facilities	To continue to implement the national standards of healthcare cleanliness in a phased approach through 2026/27	Head of Facilities	Q1, Q4			
	6.2.2	Monitor Estate and Facilities workstreams - Capital, Maintenance, Remedial works, Waste, Cleanliness and Linen	2	Director of Estates & Facilities	Recieve summary of action plan from the Estates and Facilities partnership board - to be presented at IPCC.	Chair of Estates & Facilities partnership board	Q1,2,3,4			
	6.2.3	Provide assurance of the Trust's environmental cleanliness and report the findings to Divisions and IPCC on a monthly basis.	2	Director of Estates & Facilities	Monitor progress and compliance and report monthly to IPCC.	Hotel Services Manager / IPC Matron	Q1,2,3,4			
	6.2.4	To ensure cleaning and fogging is completed following CDI cases.	2	IPC Matron / Head of facilities	To continue to monitor compliance of fogging following CDI cases and report figures in monthly IPC reports	IPC Matron / Head of facilities	Q1,2,3,4			
	6.2.5	To ensure any improvement works are reviewed and prioritised from an IPC perspective.	2	IPC Matron / Head of Estates/ Head of Capital / Head of Domestic Services	IPC Matron to complete monthly walkrounds and prioritise capital works (for 2026/27 and after) to reduce healthcare associated infection including C. difficile	IPC Matron / Head of Estates/ Head of Capital / Head of Domestic Services	Q1,2,3,4			
	6.3.0									
	6.3.1	To provide assurance to the IPCC in regards to Decontamination management	2	DIPC / IPC Matron / Head of Estates/ Departmental Leads / Decontamination Lead	Develop key metrics of data that must be monitored through IPCC relating to decontamination.	DIPC / IPC Matron / Head of Estates/ Departmental Leads / Decontamination Lead	Q3			
	6.3.2	Ensure that there is a Trust decontamination lead	2	Director of Estates & Facilities	Ensure that there is a substantive Trust Decontamination Lead who has sufficient time to perform this role	Director of Estates & Facilities	Q2			

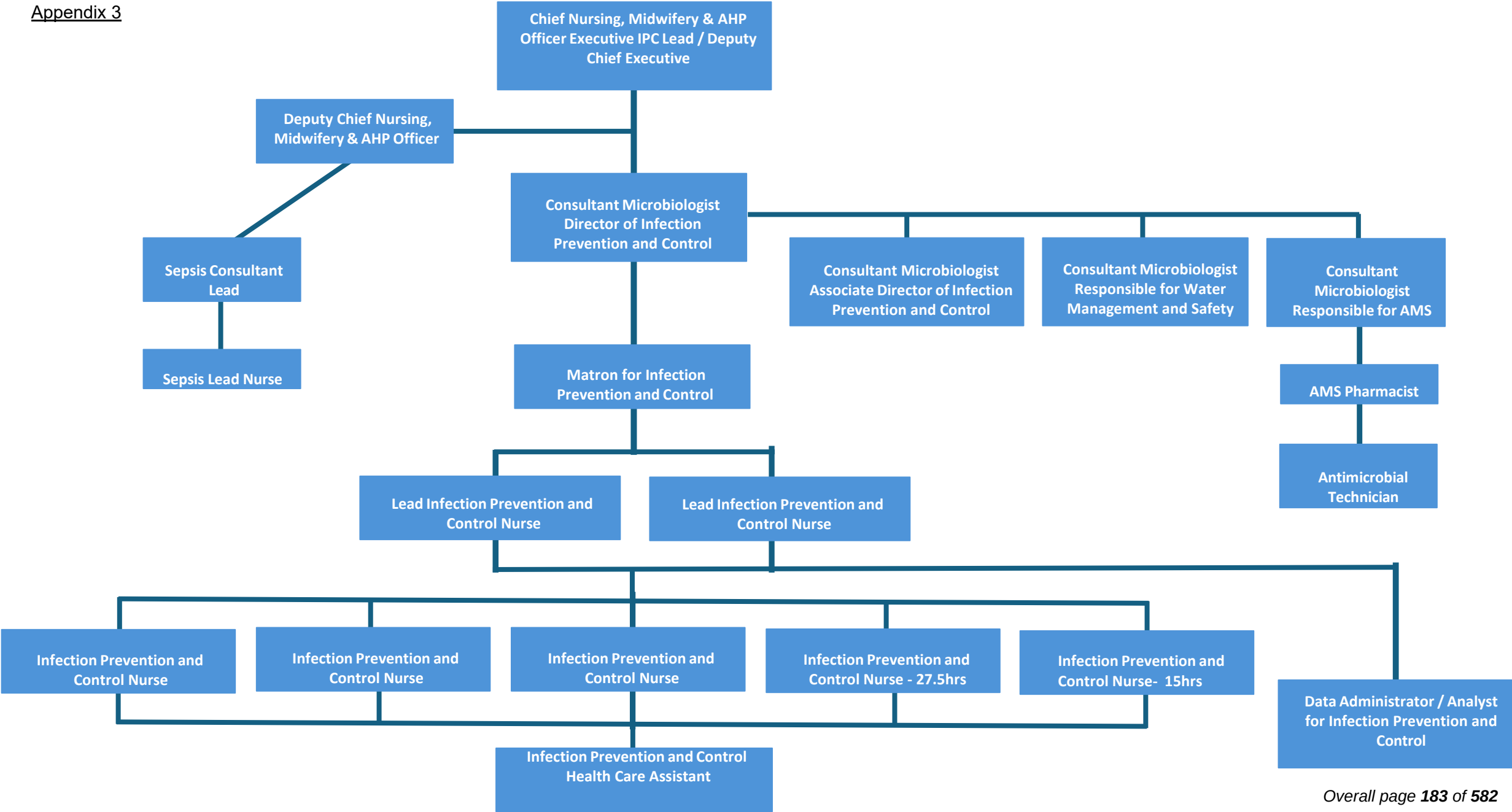
Decontamination	6.3.3	To provide assurance to the IPCC in regards to Decontamination management	2	Decontamination Lead	Provide quarterly reports to IPCC on Decontamination management including track and trace and remedial actions from findings	Decontamination Lead	Q1,2,3,4			
	6.3.4	Identify and report Decontamination audit gaps in standards through divisional IPC.	2	Decontamination Lead	Provide monthly reports to divisional IPC meetings to strengthen the current audit and for feedback and improvement for assurance of current gaps in audits	Decontamination Lead	Q1,2,3,4			
	6.4.0									
Ventilation	6.4.1	Monitor ventilation across the estate.	1,2	Head of Operational Estates	Provide bi-monthly reports from the Ventilation Working Group to IPCC	Head of Operational Estates	Q2, 4			

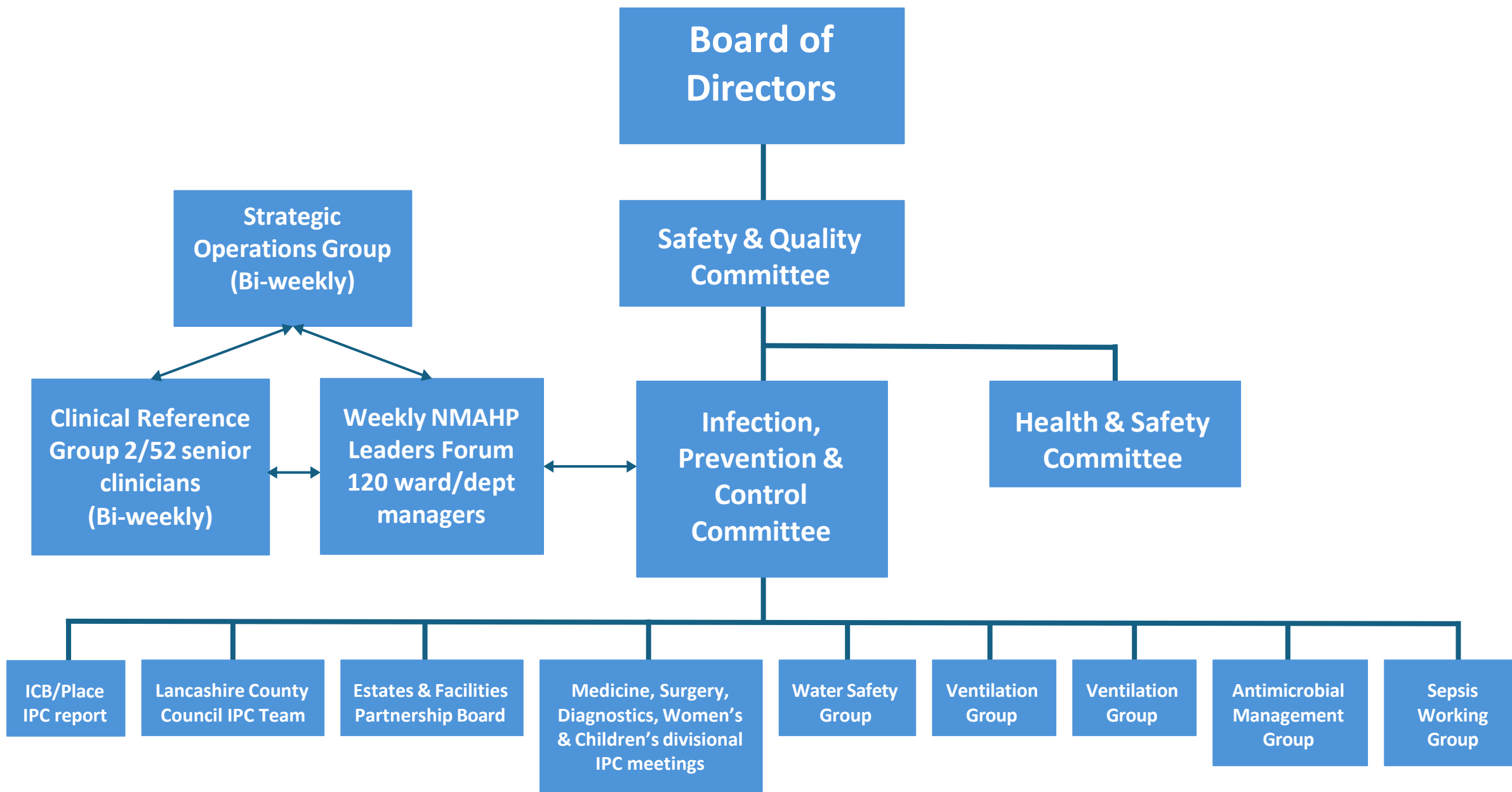
Ongoing Task Milestone										
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	7.1.0									
Antimicrobial stewardship	7.1.1	Provide assurance of Trust performance against Start Smart and Focus antimicrobial stewardship standards'	3	AMS Technician	Quarterly report on point prevalence audits	AMS Team	Q1, Q2,Q3,Q4			
	7.1.2	Reduce the use of IV antimicrobials	3	AMS Lead	Monitor proportion of IV vs Oral antimicrobial use	AMS Team	Q4			
	7.1.3	Reduce the use of "watch and reserve" antimicrobials	3	AMS Lead	Monitor Antibiotic usage	AMS Team	Q4			
	7.1.4	Promote Antimicrobial Stewardship in paediatrics	3	AMS Team	To implement pneumonia order-set for paediatrics	AMS Team	Q2			
	7.1.5	To involve the pharmacy team in penicillin allergy de-labelling process	3	ADIPC and AMS Team	Incorporate penicillin-allergy review in pharmacy medicines reconciliation process	AMS Team	Q2			

Ongoing Task Milestone										
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	8.1.0									
C. difficile	8.1.1	Reduce Hospital Acquired CDI and meet national objective	1,2,3,4,5,6,7, 8,9	Chief Nurse / Deputy Chief Nurse / DIPC	Monitor progress via the IPC team report and implement additional actions where required	IPC Matron / DND's / Head of Facilities / Head of Estates	Q1,2,3,4			
	8.1.2	Expand the scope of IPC nurses to review general care of patients with C. difficile before virtual rounds (including fluid balance and nutrition)	1,2,3,4,5,6,7, 8,9	Chief Nurse / Deputy Chief Nurse / DIPC	Review training requirements of IPC nurses and ensure that CPD is maintained (training in nutrition and hydration).	IPC Matron / DND's / Head of Facilities / Head of Estates	Q3			
	8.1.3	Ensure that C. difficile patients (carriers and cases) are treated promptly and appropriately and monitored during treatment	1,2,3,4,5,6,7, 8,9	DIPC / Ward and Divisional teams	Weekly C. difficile virtual rounds with a microbiologist, IPC nurse and antimicrobial pharmacist present.	IPC lead nurse / Ward and Divisional teams	Q1,3			
	8.1.4	Identify and assess patients with diarrhoea promptly	1,2,3,4,5,6,7, 8,9	DIPC / Ward and Divisional teams	IPC nurses to utilise the "Diarrhoea dashboard" on a daily basis and the patients reviewed on rounds	IPC lead nurse	Q1,3			
	8.2.0									
Norovirus	8.2.1	Improve Norovirus management and knowledge across the organisation	5, 6	DIPC/Matron for IPC	Ensure the Norovirus policy is shared within the Divisions and education sessions provided for Link Nurses and implemented in outbreak management	DIPC/Matron IPC	Q2			
	8.3.0									
Influenza	8.3.1	IPC preparation including POCT for seasonal influenza in place	5, 6	DIPC/Matron for IPC	Ensure the Influenza policy is shared within the Divisions and education sessions provided for Link Nurses and implemented in outbreak management	DIPC/Matron IPC	Q2			
	8.4.0									
Candidozyma auris	8.4.1	Ensure processes are in place for the control of candidozyma auris	1,2,3,4,5,6,7, 8,9,10	DIPC/Matron for IPC	Monitor Candida auris testing per month in the IPC report to demonstrate that the screening policy is being utilised	DIPC/Matron for IPC	Q 2			
	8.5.0									
XDR Multidrug resistant organisms	8.5.1	Mitigate risk of multidrug resistant waterbourne infections.	1,2,3,4,5,6,7, 8,9	DIPC/Matron for IPC	Communicate and educate concerning the policy for safe use of water on clinical areas	DIPC/Matron for IPC	Q 2			
	8.6.0									

Emergency Preparedness	8.6.1	Review the emergency preparedness plan	1, 2, 5, 6	Head of EPRR and Patient Flow	Perform and real-life exercise related to ED and viral haemorrhagic fever and review and update the emergency preparedness plan collaboratively	DIPC / Head of EPRR and Patient Flow / IPC Matron	Q 1			
	8.6.2	Ensure that we are prepared for any future epidemics and / or pandemics	1, 2, 5, 6	Divisional nursing directors or deputy	Monitor and escalate any concerns relating to FFP3 fit-masking compliance	Divisional nursing directors or deputy	Q 4			

Ongoing Task Milestone										
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	9.1.0									
Policies and procedures	9.1.1	Provide assurance policies and procedural documents are in date and complete to enable the prevention of infections and education of staff	1,4,9	IPC Matron / DIPC	Provide assurance through the monthly IPC report of the status of policies owned by IPC and that they are in date and reviewed within the required time	IPC Matron / DIPC / IPC Team	Q1, 2, 3, 4			
	9.1.2	Ensure that staff workwear does not pose a risk to HCAI and that staff are bare below the elbows when necessary	1,4,9	Deputy chief nursing officer	IPC to contribute to new workwear policy	IPC Matron / DIPC / IPC Team	Q2			
	9.1.2	Improve response to IPC alert organisms by theatre staff	1,4,9	IPC Matron / DIPC / IPC Team / Theatres matrons	IPC to ensure that policies are in place so that theatre staff respond appropriately to IPC alert organisms and that there is communication to all relevant staff	IPC Matron / DIPC / IPC Team / Theatres matrons	Q2			





B) PATIENT EXPERIENCE, INVOLVEMENT AND ENGAGEMENT ANNUAL REPORT

● Other

Item for Assurance

REFERENCES

Only PDFs are attached



11.1b Patient Experience Involvement & Engagement Annual Report Summary - Board Part I 4 June 26.pdf



11.1b Patient Experience Involvement & Engagement Annual Report Full - Board Part I 4 June 26.pdf



Board of Directors Report

Meeting of the	Board of Directors		4 th June 2026
	Part I ☒	Part II ☐	
Title of Report	Patient Experience, Involvement and Engagement annual report		
Report Author	John Howles – Associate Director Quality, Experience and Engagement		
Lead Executive Director	Sarah Morrison, Chief Nursing Officer		
Recommendation/ Actions required	The Board is asked to I. Receive the report and take assurance that robust arrangements are in place to capture, triangulate and act on patient experience intelligence, and that patient voice is effectively embedded within governance, quality improvement and risk management processes across the Trust II. Endorse the continued focus within the Single Improvement Plan on strengthening communication reliability at key points of the patient journey (including delays, discharge and transitions of care), recognising communication as the primary driver of patient experience, complaint escalation and emotional wellbeing.		
	Decision ☐	Assurance ☒	Information ☐
Executive Summary	This report provides Board assurance that the Trust’s arrangements for capturing, triangulating and acting on patient experience intelligence are effective and are delivering measurable improvement in several priority areas during 2025/26. Quantitative outcomes show a mixed but overall improving picture. • The Trust received 329 formal complaints in 2025/26, four more than in 2024/25, but the complaints rate improved against rising activity, with the ratio of complaints to patient contacts improving from 1:2,825 to 1:2,896. • Complaint responsiveness also improved, with 81% of complainants receiving a response within the agreed 35- or 60-day timescale and 94% of complaints acknowledged within three working days. In addition, the Patient Experience and PALS Team managed 1,654 concerns and 4,739 enquiries, demonstrating sustained demand for responsive patient support. • The volume of patient feedback increased materially during the year. Friends and Family Test responses rose from 65,480 to 69,035, an increase of 3,555 responses (5.43%), providing a broader evidence base for improvement. • Compliments increased by 20% to 8,230, and Care Opinion recorded 39 reviews, of which 29 were positive. Together, these indicators show both high engagement and continued recognition of compassionate care despite sustained operational pressure. • National survey outcomes provide further assurance.		

	○ In the 2025 Maternity Survey, the Trust improved significantly in four areas, with no areas significantly worse, and rose to 13th of 55 Trusts, from 15th of 56 in 2024. Positive ratings were high, including 98% for overall care, 97% for dignity and respect during labour and birth, and 98% for confidence and trust in staff. ○ In the 2025 National Cancer Patient Experience Survey, the Trust sustained an overall score of 9.0/10, above the national average, with a 53% response rate and feedback from 796 patients, the largest sample in the region. ○ The 2024 Inpatient Survey showed no significant improvement areas and three domains somewhat worse than expected, confirming that inpatient environment, involvement in decisions and overall experience remain priorities. ○ The 2024 Children and Young People's Survey showed most ratings were reported as about the same as other Trusts, indicating a broadly average position with clear scope for further improvement. • The report also evidences progress in involvement and inclusive improvement. Volunteer Services deployed 316 active volunteers who recorded 9,846 hours, with over 150 new volunteers recruited during the year. The Patient Information Group produced 63 new leaflets and reviewed 120 existing leaflets. • However, the report also confirms that assurance is weaker for some underserved groups: FFT demographic data shows women accounted for 60% of respondents compared with 34% men, while 85% of respondents identified as White and only 8% came from minority ethnic groups, highlighting the need for more targeted engagement and equity-focused improvement. Overall, the report demonstrates measurable progress in responsiveness, feedback reach, maternity experience, cancer experience and co-produced service improvement. It also confirms that communication, waiting pressures, care environment and health inequalities remain the principal drivers of patient experience risk and therefore the main focus of the Single Improvement Plan for 2026/27.	
Link to Strategic Objectives 2025/26	Patients – deliver excellent care: Improve outcomes, reduce harm and deliver a positive patient experience.	☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.	☒
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.	☒
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.	☐
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.	☐
Due Diligence	To give the Committee assurance, please complete the following:	
Operational Group Review:	Patient Experience and Involvement Group	28 th April 2026
Link to Board Assurance Framework:	Principal Risk 1 (2025/26) – Patient experience within the urgent and emergency care pathway	
Appendices	Appendix 1: Complaints data Appendix 2: Friends and Family Test data Appendix 3: Care Opinion feedback Appendix 4: Age, sex and ethnicity data	

	Appendix 5: Divisional thematic review of complaints and feedback

***Supplementary Report**

Meeting of the	Board of Directors		4th June 2026
	Part I ☒	Part II ☐	
Title of Report	Patient Experience, Involvement and Engagement annual report		
Report Author	John Howles – Associate Director Quality, Experience and Engagement		
Lead Executive Director	Sarah Morrison, Chief Nursing Officer		
Recommendation/ Actions required	The Board is asked to I. Receive the report and take assurance that robust arrangements are in place to capture, triangulate and act on patient experience intelligence, and that patient voice is effectively embedded within governance, quality improvement and risk management processes across the Trust II. Endorse the continued focus within the Single Improvement Plan on strengthening communication reliability at key points of the patient journey (including delays, discharge and transitions of care), recognising communication as the primary driver of patient experience, complaint escalation and emotional wellbeing.		
	Decision ☐	Assurance ☒	Information ☐

1. Background

This report provides assurance on the Trust's arrangements for capturing, triangulating and acting on patient experience intelligence during 2025/26, and highlights the key areas of progress, risk and priority action.

Evidence from complaints, FFT, surveys, patient stories and involvement activity shows improvement in several areas, while confirming that communication, waiting pressures and equity of access remain the main drivers of risk.

The report therefore focuses on the outcomes achieved, the areas where assurance is strongest, and the targeted actions being taken through the Single Improvement Plan where improvement remains required.

The annual report also provides assurance on the Trust's performance against key patient experience and involvement indicators, including complaints, response quality, Friends and Family Test results, patient surveys and compliments. Delivering care for and with patients strengthens outcomes and supports a model of care that is more efficient, productive and cost-effective.

Oversight of the strategy and its associated performance measures is maintained through the Patient, Carer Experience and Involvement Group (PCEIG), which provides a monthly Chair's Escalation Report to the Safety and Quality Committee. This ensures strong governance, transparency and continued scrutiny of progress.

2. Discussion

Together, this evidence provides a clear line of sight from feedback to action, supported by governance through the Patient, Carer Experience and Involvement Group and escalation to the Safety and Quality Committee.

The Patient Experience and Involvement approach has set a clear expectation across the Trust to listen more deeply and act on what patients and families tell us, whether their experiences are positive or reflect areas needing improvement. In shaping the strategy, we engaged patients, relatives, carers, colleagues, governors and partner organisations. We also actively sought feedback from groups representing people with protected characteristics and recognised the importance of intersectionality in interpreting and responding to their experiences.

Patient Experience and Involvement is strongly aligned with other key Trust strategies, including Equality, Diversity and Inclusion, Mental Health, Learning Disability, Dementia and Autism. This work will now be embedded within the developing Single Improvement Plan, further strengthening the role of patient voice in driving improvement across all aspects of care.

2.1. Assurances

Quantitative feedback

Complaints and Concerns (Appendix 1)

During 2025/26, the Trust received 329 formal complaints, an increase of four complaints (1.23%) compared with 2024/25. Although volume rose slightly, the overall complaints rate continued to improve when considered against patient activity, indicating that complaint growth has not kept pace with rising demand. Response timeliness also improved, with 81% of complainants receiving a response within the locally agreed 35- or 60-day timescale by year end. This represents important progress in responsiveness and supports a better patient experience, even though further improvement is still required.

Complaints received during the year were noted to be increasingly complex. The ratio of complaints to patient contacts over the past three years is detailed in the table below. Of the 329 complaints received between April 2025 and March 2026, 289 (88%) related to care or services provided at Royal Preston Hospital and 40 (12%) related to Chorley and South Ribble Hospital. All complaints were received within the 12-month timescale set out in the NHS Complaints Procedure.

During the financial year, 253 complaints were closed. Of these, 14 (5.5%) were upheld, 154 (60%) were partly upheld, and 72 (28%) were not upheld. A further 15 cases (6.5%) were rejected as they were more appropriately managed through alternative processes rather than the formal complaints route. In addition, nine second

letters were received during the year, reflecting ongoing dissatisfaction or requests for further clarification following the initial response.

In line with NHS Complaints Regulations, complaints should be acknowledged within three working days of receipt. During the reporting period, 94% of complaints received by the Patient Experience and PALS Team were formally acknowledged within this timeframe. All complainants received either verbal or email acknowledgement, with the 94% figure reflecting the point at which cases were opened on the Ulysses Governance system and the case manager made direct contact. Alongside complaint handling, the Patient Experience and PALS Team managed 1,654 concerns and responded to 4,739 enquiries during the year, demonstrating continued high levels of demand across patient experience services.

Top 3 themes from complaints by division:

- **Diagnostic and Clinical Support**
Feedback relating to Diagnostic and Clinical Support focuses on treatment and procedures, clinical assessments, and diagnostic processes.
- **Women and Children**
For Women and Children's services, feedback centres on treatment and procedures, communication, and staff behaviour, including diagnosis and clinical assessment.
- **Medicine**
Within Medicine, key themes include appointments, communication, and treatment or procedures.
- **Surgery**
In Surgical services, feedback most commonly relates to treatment and procedures, communication, and appointments.

Friends and Family (Appendix 2)

The Friends and Family Test (FFT) is used as a national measure to assess whether patients would recommend Trust services to their friends and family. National reporting requirements cover Maternity, Day Case, Outpatients, Inpatients, and the Emergency Department. The Trust target is for 90% of respondents to recommend services across all areas, with the exception of the Emergency Department where a target of 85% applies. During 2025/26, Day Case and Outpatient services consistently exceeded the 90% target in all four quarters. Maternity services did not meet the target throughout the year, while Inpatients and the Emergency Department remained below target across all quarters, although inpatient performance showed sustained improvement quarter on quarter.

Although not a national requirement, the Trust also undertakes Friends and Family surveys within Children and Young People's Services to ensure an equitable approach to measuring patient experience. Feedback indicates that children and young people accessing urgent and emergency pathways reported less favourable experiences, while Day Case and Outpatient services demonstrated more positive performance, with inpatient services showing signs of improvement. The Neonatal Service

maintained a consistently high level of performance, achieving a sustained recommendation rate of 100% throughout the year.

Overall, the data demonstrates both improved reach and stronger engagement with feedback processes. During 2025/26, the Trust received 69,035 FFT responses, an increase of 3,555 compared with 2024/25, representing year-on-year growth of 5.43%. This increase provides a broader evidence base for understanding patient experience and suggests that efforts to widen access to feedback through paper, online and SMS methods are having a positive effect.

Staff continue to actively encourage patients to complete FFT feedback prior to leaving hospital, which has supported increased completion of paper surveys. Ongoing staff training ensures effective use of the FFT system, and patient experience boards are regularly updated with “You said, we did” information and relevant reports generated through CIVICA. FFT performance and resulting improvement actions are monitored through the Safety and Quality Committee, with monthly reports shared with governance and divisional leads to ensure feedback is reviewed, acted upon, and communicated consistently across the Trust.

The Parliamentary Health Service Ombudsman (PHSO)

Complainants have the right to request that the Parliamentary and Health Services Ombudsman (PHSO) undertakes an independent review into their complaint in instances where local resolution has not been achieved. Between the period 1st April 2025 to 31st March 2026 there were 4 cases referred to the PHSO; 2 are ongoing, and 1 was partly upheld, and 1 was not upheld.

During this period, the PHSO sent final reports for 4 cases which were opened prior to April 2025 and the outcome of these were that all 4 were partially upheld.

Compliments

The Trust receives formal and informal compliments from patients and their families in relation to their experience of care. During 2025/26 a total of 8,230 compliments and thank you cards were received by wards, departments and through the Chief Executive’s Office. There has been a 20% increase in the number of compliments received this year. Departments are being encouraged to actively log compliments on the Ulysses system which has its own module for this purpose. This provides teams with the opportunity to celebrate success locally and as part of their wider teams and divisions. The results from divisional compliments are now published monthly in the Trust Communications and discussed as part of divisional meetings.

Care Opinion Website (Appendix 3)

During the past financial year there have been a total of 39 reviews posted on the Care Opinion website relating to care and treatment at Lancashire Teaching Hospitals NHS Foundation Trust. These have consisted of 29 compliments and 9 concerns and 1 that has provided both concerns and compliments.

National Patient Survey Result

Maternity Survey 2025

The survey invited responses from mothers who received care during April and July 2025. Compared with the 2024 survey, Lancashire Teaching Hospitals improved significantly in four areas, with no areas identified as significantly worse. The service is now ranked 13th out of 55 Trusts surveyed by Picker, improving from 15th out of 56 in 2024. This demonstrates sustained progress in maternity experience and provides strong assurance that targeted improvement work is translating into better reported care.

A total of 89 questions were included in the 2025 survey, of which 58 were comparable with the previous 2024 survey. Overall, Lancashire Teaching Hospitals has improved its position. Mothers reported very positive experiences, with 98% rating their overall care positively, 97% feeling treated with respect and dignity during labour and birth, 98% expressing confidence and trust in staff, and 98% feeling involved in decisions about their care during labour and birth.

Based on the Care Quality Commission (CQC) published data the Trust showed substantial positive movement across several core patient experience indicators when compared with the 2024 CQC Maternity Survey and show year on year improvements.

Inpatient Survey 2024 (Published September 2025)

The survey is based on a sample of inpatients during January and April 2024. A total of 1250 patients from Lancashire Teaching Hospitals were randomly selected to take part in the survey. 1200 patients were eligible for the survey, of which 450 returned a completed questionnaire, giving a response rate of 38%. This is a 2% decrease on the 2023 survey. The average response rate for the 64 'Picker' trusts in 2024 was 41%.

A total of 63 questions were used in the 2024 survey, of these 45 questions were asked in the 2023 survey. Compared to the 2023 survey, Lancashire Teaching Hospitals has significantly improved in 0 areas, with 1 area identified as significantly worse in 2023, 40 areas show no significant difference. Overall comparison of the 131 Trusts surveyed shows that 8 areas were 'about the same as other NHS Trusts including: admission to hospital; basic needs; doctors; nurses; virtual wards; leaving hospital; kindness and compassion and respect and dignity. 3 areas were (1) 'somewhat worse than expected including: the hospital and ward, specifically room temperature and sleep at night. (2) Care and treatment, specifically involvement in decisions. (3) Overall experience, specifically feeling that they had a very good experience.

Based on the Care Quality Commission (CQC) published data the Trust shows measurable improvements in several areas between the 2023 and 2024 inpatient surveys. The improvement is not uniform, some areas remain unchanged or still below the national averages. The CQC's benchmarking report explicitly includes change over time analysis, confirming that the Trust's scores have moved positively in multiple domains.

National Cancer Survey 2025

The 2025 National Cancer Patient Experience Survey shows that Lancashire Teaching Hospitals continues to deliver strong, patient-centred cancer care. The Trust sustained an overall rating of 9.0/10, above the national average, and with a 53% response rate received feedback from 796 patients, the largest sample in the region. This provides a robust evidence base and demonstrates consistently strong performance across personalised care, care planning, radiotherapy information, teamworking and the availability of a reliable main point of contact.

Several tumour groups, particularly Brain, Colorectal, Head & Neck and Prostate, scored above expected national ranges. Areas requiring focused improvement include discharge information, immunotherapy information, clarity about chemotherapy response, primary care support, and inpatient experience in Breast, Colorectal and Lung pathways.

Engagement from minority ethnic groups remains low, with targeted community outreach under way. Workforce pressures in areas such as Lung services continue to pose risks, alongside rising patient demand. A comprehensive action plan is in place covering communication, personalised care, tumour-specific improvements, health inequalities and GP engagement and will be monitored through established governance groups to ensure continued improvement and assurance in patient experience.

Children and Young People's Survey 2024 (Published May 2025)

The survey is based on a sample of inpatients during March and May 2024. A total of 1250 patients from Lancashire Teaching Hospitals were randomly selected to take part in the survey. 1239 patients were eligible for the survey, of which 239 returned a completed questionnaire, giving a response rate of 19%. The average response rate for the 54 'Picker' trusts in 2024 was 22%.

The last survey was carried out in 2020 and since then the Care Quality Commission (CQC) have implemented several changes:

- Timing of the survey - to reflect variations in people's feelings, situations and the healthcare environment throughout the year.
- Methodology – The 2020 survey collected responses only on paper. In 2024, patients could respond via paper or online, with SMS text reminders introduced.
- Survey content – The CQC has reassessed the survey and made a number of changes to the content to reflect changing priorities in children and young people's healthcare.

Lancashire Teaching Hospitals is ranked 43rd out of the 54 Trusts surveyed by Picker. Due to the change in sample period, data collection period, methodology and content the survey is not comparable to previous years.

Based on the Care Quality Commission (CQC) we cannot compare the 2020 survey with the information in the 2024 survey due to the significant changes, most ratings were 'About the Same' compared to other Trusts.

Qualitative patient feedback

Board Patient Stories

Board patient stories continued to show that compassionate, timely communication and coordinated care improve confidence and reduce anxiety, while delays, poor transitions and pressured environments weaken experience. In response, the Trust has strengthened escalation, discharge and personalised-care arrangements, demonstrating that patient stories are informing service change as well as assurance.

Person-centred approaches focused on what matters most to individuals consistently improved confidence and reduced anxiety. A strong theme across all stories was the role of families as partners in care, whether advocating, supporting decision-making or helping staff understand patient needs. In response to the issues raised, the Trust has strengthened escalation pathways, increased senior oversight of care environments, advanced work on discharge processes, and continued to embed personalised and coordinated care. These changes demonstrate how patient stories are being translated into practical improvements rather than being used for reflection alone.

Complaints Learning Overview

The complaints review confirms that communication remains the main cause of dissatisfaction, particularly around delays, discharge, expectations and cross-agency coordination. Improvement activity has therefore focused on clearer written responses, better expectation setting, proactive updates and stronger organisational learning so that themes are translated into measurable service change.

Timeliness also remains a recurring theme in formal complaints. While internal teams generally meet response standards, significant delays occur when complaints require joint input from partner agencies such as the ICB or social care. These delays can extend the investigation period by several months, during which patients may feel forgotten or ignored despite work progressing behind the scenes. A key learning point this year has been the importance of offering proactive updates, even when no new developments are available, as the absence of communication is often interpreted as a lack of care. The review also shows that early clinical engagement, or local resolution, is highly effective in resolving concerns informally; however, this early contact must be followed by a timely and structured written response to ensure closure and clearly articulate the learning achieved.

Expectation management is another significant area for improvement. Complaints often arise when patients or families feel unprepared for waiting times, theatre cancellations, emergency department pressures or the complexity of discharge processes involving social care. Many patients do not fully understand the wider system pressures influencing their experience, which can lead to frustration and dissatisfaction. Providing more comprehensive explanations up front, ensuring consistent messaging across different teams and offering written summaries following key discussions would help patients feel more informed and reduce avoidable concerns.

The review also shows that inter-agency coordination has a substantial impact on both the timeliness and quality of complaint handling, particularly where discharge is involved. Patients often describe confusion caused by unclear roles, inconsistent information or delays linked to communication between hospital teams and social care partners. Strengthening relationships, clarifying escalation pathways and improving shared communication tools would support a more seamless approach and reduce complaints that arise from cross-boundary working.

Another important learning theme relates to how the organisation captures and shares learning from complaints. While specialties frequently take corrective action, this learning is not always shared consistently across the Trust. Some complaint responses refer to reflection or insight gained without describing the tangible changes made as a result. The Trust's New Always Safety First Plan reinforces the need for a robust, systematic process to capture learning, disseminate it effectively and evidence resulting improvements, ensuring that these changes are embedded and sustained in practice.

Several improvements have already been implemented to strengthen complaint learning and assurance. Enhancing communication has been a central priority, supported by the development of a clear Trust-wide template for complaint performance that promotes empathy, clarity and a consistent approach to ensuring we capture what patients and families require. Standardised scripts have been introduced to support staff during challenging conversations, especially when discussing delays, cancellations or discharge arrangements, helping to reduce variation in the information patients receive. The Trust has also strengthened its expectation setting tools through written leaflets and short videos that explain what patients can expect during a hospital stay, helping them better understand their journey and reducing uncertainty. Additional work has focused on improving inter-agency discharge pathways, clarifying named contacts, reinforcing accurate documentation and embedding organisational learning more effectively.

Across all reporting periods, patients consistently praised the compassion, professionalism and dedication of staff. Many described staff as kind, caring and attentive, emphasising that they felt listened to, respected and reassured during vulnerable moments. Named staff and teams appeared regularly in feedback, demonstrating the powerful personal impact of compassionate interactions. This positive feedback remained consistent throughout the year, even during periods of heightened operational pressure.

Despite these strengths, patient accounts also highlighted several persistent challenges that shaped their experiences. Prolonged waiting times were a dominant theme, especially in emergency care, while waiting for a ward bed and during diagnostic and discharge processes. Some patients reported spending long periods in chairs or corridors, including overnight stays, which contributed to discomfort and anxiety. These waits were often compounded by inconsistent communication or a lack of updates, leaving patients uncertain about what was happening and what to expect next. Communication gaps whether related to treatment plans, test results or discharge arrangements regularly influenced how safe, supported and informed patients felt.

Environmental conditions also played a major role in patient experience. Many patients described excessive heat on wards and in waiting areas, lack of air flow, noise, overcrowding and limited seating, all of which were particularly difficult for those waiting for extended periods. Feedback on food quality was mixed: while some patients were satisfied, others reported cold food, missed meals and difficulties related to dietary, cultural or religious requirements. Several patients from the Asian Elders community highlighted instances of inappropriate or non-halal food being provided, indicating a need to improve catering practices and cultural sensitivity.

The ongoing challenges relating to health inequalities and inclusion with Feedback from the Deaf community highlighted barriers to communication, particularly the inconsistent availability of qualified BSL interpreters. Deaf patients stressed the importance of having interpreters available throughout their care journey, not only at key moments, and described the distress caused when these needs were not met. These findings align with broader system work across the Trust to strengthen Deaf awareness, improve interpreter access and explore the introduction of mandatory Deaf awareness training. Engagement with culturally diverse groups, including the Preston Muslim Forum and the Grannies Support Group, also reinforced the importance of meeting cultural and religious needs consistently. Some patients emphasised the importance of halal food, prayer spaces with qibla signs on the ceiling, and the update in policy for female clinicians for intimate care. Several patients described experiences that compromised their privacy or dignity, including being treated in crowded environments or being examined by clinicians of the opposite sex despite expressing discomfort.

Feedback from children and young people showed high levels of emotional safety and satisfaction, with 97% reporting a positive experience and all respondents agreeing that staff were caring and supportive. Children frequently commented on staff friendliness and the reassurance they received. However, the feedback also suggests opportunities to improve support during stressful events, provide clearer explanations using age-appropriate language and strengthen discharge communication, particularly for young people with mental health or emotional needs. Long waits and overstimulating environments, such as noisy emergency departments, contributed to distress for some children, particularly those with autism, sensory needs or dysregulated behaviour.

Across both adult and paediatric services, psychological wellbeing emerged as a critical component of the overall patient experience. Many individuals reported feeling anxious or overwhelmed during long waits or periods of uncertainty. In some cases, poor communication or dismissive interactions amplified emotional distress. Conversely, small acts of empathy such as clear explanations, a calm tone, eye contact or acknowledging feelings were repeatedly highlighted as helping to reduce anxiety and build trust. These insights reinforce the importance of trauma-informed and psychologically aware care, particularly in high-pressure environments such as ED and surgical assessment unit.

While compassionate interpersonal care remains a core strength across the Trust, systemic pressures linked to capacity, flow, communication and environment continue

to shape patient experience. Continuing to Strengthen communication reliability, improving waiting environments, embedding trauma informed practice and ensuring equitable, culturally sensitive care will all be essential to improving patient outcomes, satisfaction and wellbeing. These insights are the essentials of the Single Improvement Plan for patients and reinforce the importance of placing patient voices at the heart of service design and delivery.

2.2. Involvement and Co-Production

The Trust's involvement and co-production work has expanded its reach into local communities and strengthened assurance that service change is being informed by a broader range of lived experience, particularly from groups whose voices are often less visible in routine datasets.

The Patient Voice

These forums provide structured routes for patient and carer voice to influence improvement, policy development and service design across the Trust.

Forums include:

- The Cancer Patient and Carer Forum
- Endometriosis UK Lancashire Forum
- The Patient Information Group
- Specialist Mobility Rehabilitation Centre (SMRC) Mobility Matters Forum
- The Patient Research Group
- Preston Dystonia and Migraine Group
- The Sepsis Patient Support Group
- The Cancer Patient Information Group
- The Carers Forum
- The SMRC Joint User Forum
- The Youth Forum
- Maternity Voices Partnership
- The Critical Care Ex Patients & Relatives Support Group
- The Lancashire Learning Disability and Autism Partnership
- The V. I. (Visual Impairment) Forum
- The Patient and Carers Experience and Involvement Group
- The Preston and District Carers Forum
- The Preston and District over 50's Forum
- Lancashire British Sign Language Forum
- The Preston Muslim Forum – Hamara Centre (Mums and Mini's Group)
- Muslim Grannies Group – Quwwat Education Centre Preston

Muslim Elders (The Grannies)

The Grannies Muslim Group at the Quwwat Education Centre in Preston is made up of older Muslim women who are long-standing users of Trust services. Their insight has directly shaped service improvements, particularly in relation to dignity, accessibility, culturally responsive care and communication support for patients with limited English proficiency.

Throughout the year, they shared several themes:

1. Language & Interpretation: Many members speak little or no English, making interpretation essential for safe care. They highlighted inconsistent access to interpreters, particularly at the point of discharge.
 2. Comfort & Dignity: Concerns were raised about long waits on trolleys, limited privacy, and a lack of pillows in A&E and SDEC.
 3. Cultural & Religious Needs: Requests included clearer Qibla signage and better support for emotional and spiritual wellbeing.
 4. Dietary Needs: Members reported limited staff awareness of Halal requirements
 5. Accessibility of Menus: They suggested using photographs on menus to support patients who struggle with written English.
6. Policy: Shared thoughts on Intentional rounding and enhanced care
- In response, the Trust implemented a series of practical changes to improve experience and address the issues raised. These actions demonstrate clear evidence of co-production leading to service change.
- increased pillows across ED areas to improve comfort and dignity.
 - Developed photographic inpatient menus to improve accessibility for patients with limited English proficiency.
 - Updated and circulated a list of female Muslim volunteers to all wards and switchboard to support female Muslim patients more effectively.
 - Established plans for ongoing dialogue and follow-up visits to maintain transparency, monitor progress, and ensure accountability for the improvements implemented.
 - Contributed in development of new updated intentional rounding policy and development of Enhanced therapeutic Observation d of care policy (ETOC)

Mums and Minis' Group

Based at the Hamara Centre, Preston, the Involvement Services attend the Mums and Minis Group, which also maintains strong links with the Trust's Gynaecology and Maternity Departments and contributes regularly to Maternity Voices Partnership meetings.

Over the year feedback and actions have included:

- Providing Support for the Friends and Family questionnaires
- Supported in that Qurans are available for inpatients, with the group offering to donate additional copies

The Carers Forum

The forum is run in collaboration with the Lancashire Carers Services and continues to involve carers and help provide them with information about support available to them in our communities and within our hospital settings. To mark 'Carers Day' the Trust's Forum updated their 'Carers Charter' and 'The Essential Carers' leaflets, which supports carers by providing information on what support is available when they visit our hospitals. The leaflets are available to read on our Trust website. Carers have played an active role in shaping Trust services for many years through the long

established forum. Their feedback and involvement have contributed to a wide range of developments, including:

- LTHTR Carers Charter
- Improvements to discharge processes, with feedback shared directly with professional leads
- Enhancements to Occupational Therapy and Physiotherapy inpatient services
- DNACPR policy for staff
- The Dementia 'Forget Me Not' document
- Lancashire Carers Service Charter
- Virtual Ward Programme
- Chaperone Policy
- Prioritised Mealtimes Policy

These contributions reflect the Trust's commitment to ensuring carers' voices remain central to service design, policy development, and continuous improvement.

Age UK Lancashire

The trust supports The Living Well Support Service supports adults aged 18+ in Lancashire who require assistance following a hospital stay, illness, or major life event. This service is a great support with our patient and carers and provides:

- Transport home from hospital and help settling in
- Support to remain safely at home
- Prevention of avoidable hospital readmissions
- Practical and emotional support
- Connections to community groups and local health services
- Help with shopping, prescription collection, and other essential tasks post discharge

Saheliyaan Asian Women's Forum

The Asian Ladies Forum at the Community Centre in Chorley, are visited regularly with the goal of gathering feedback from the community and ensuring that our services remain accessible and user-friendly.

In the past the Trust experienced a lack of engagement and insufficient feedback from the community, during conversation the group identified several key factors contributing to these issues:

- The Friends and Family survey was available only in English
- Many members are uncomfortable with digital formats, and paper versions can be difficult to read without proficiency in English. They expressed a preference for translations in Urdu, Arabic, or Gujarati
- Some attendees admitted that, even if paper surveys were provided in their language, they might hesitate to complete them or voice concerns during treatment for fear of being treated differently if their feedback was negative, especially if they were still using the service

- They praised the iPad and DA Video calling services in maternity and gynaecology, which have significantly improved their understanding of procedures and expectations
- The group also commended the availability of halal food for inpatients but noted challenges in understanding menus, which are exclusively in English. Many rely on family members or staff for assistance but feel reluctant to ask due to the demands on staff. They expressed a desire for translated menus to help them make informed choices
-

Actions have been put in place to address all these points:

- Demonstrations given from the Involvement Services on how to use the Trust website and change the website into different languages, so information is accessible to all the community.
- Breast Care nurse attending the centre and providing education in breast screening services, which has since seen an increase in the number of screenings from the community.
- Provided with friends and family in their own language

Lancashire V.I (Visual Impairment) Forum / Pukar Disability Centre

While the Trust continue to have a great working relationship with the VI Forum, who in the past have contributed to provide direction and feedback on Trust policies, such as the Assistance Dog Policy. Provision of guidance for hospital guides, with the assistance of Guide Dogs UK. Assistance in the provision of information for visual impairment patients and support with guidance on Trust signage and poster creation.

The Trust was proud to support the collaboration between the Visual Impairment Forum Lancashire and the Pukar Disability Resource Centre in Preston for Sight Loss Day, which is a significant event aimed at fostering inclusion and providing essential resources for individuals with visual impairments. The brought together professionals, charities, and community members to share knowledge and support services. The event focused on breaking down barriers and ensuring accessibility, with specialist services offering guidance on available assistance, technology solutions, and general support for sight loss. Some of the key organisations involved included Al-Qalam Vision Institute, Galloways, Glaucoma UK, RNIB, Disability Equality Northwest, Healthwatch, Lancashire Teaching Hospitals NHS Trust Involvement Services, Lancashire Carers Services, Lancashire County Council Sensory Rehabilitation Team and Sight Line.

Our Deaf Community-Strengthening Long Standing Partnerships

Our Deaf community has maintained a close and collaborative relationship with the Trust for many years. This year, members generously shared their personal experiences of accessing our services. Working in partnership with Deafway, these stories were captured on film, supported throughout by British Sign Language (BSL) interpreters to ensure full and accurate understanding.

These filmed accounts provide powerful insights into the barriers faced by Deaf patients, highlight examples of good practice, and identify opportunities to further enhance accessibility and service quality. To maximise their impact, the videos have

been added to the staff intranet, where they continue to inform, educate, and inspire colleagues across the Trust. This work builds on our involvement in Healthwatch's project One Voice in Health and Social Care in BSL, reinforcing our commitment to inclusive communication and equitable access.

Lancashire BSL Forum Event

The Lancashire British Sign Language Forum Event took place at Preston County Hall in March 2025 and January 2026. The recent event was chaired by Mark Heaton, who provided an overview of the history and achievements of Deaf rights campaigns and outlined future priorities to strengthen accessibility and equality of opportunity for the Deaf community. Key contributions and updates:

- Presentations highlighted service improvements made over the past year
- Lancashire County Council shared updates on the newly appointed BSL social worker, funded through social services.
- LTHTR Involvement Services presented actions taken in response to the Healthwatch project, including ongoing discussions about introducing mandatory Deaf Culture Awareness e learning for all staff.
- Deafway engagement leads introduced their services and explained how they support the local Deaf community.
- Lancashire County Council also outlined available home adaptations to support independent living, including specialist baby monitors, alarms, and lifeline equipment designed for Deaf users.

BSL interpreters were present throughout the event, ensuring full accessibility. Attendees were encouraged to ask questions and engage directly with presenters. Feedback has been overwhelmingly positive, describing the event as informative, welcoming, and impactful. LTHTR received thanks for its strong commitment and active participation.

Children's Services

Over the past year, Ward 8 and paediatric services have delivered a comprehensive programme of improvements designed to enhance the experience, comfort, and wellbeing of children, young people, and their families. Working closely with clinical teams, families, volunteers, youth forum and external partners, a wide range of initiatives have been implemented to strengthen care quality, improve environments, increase accessibility, and ensure that the voices of CYP meaningfully shape service development.

- Food and nutrition, including expanding the menu with more child-friendly options, establishing fortnightly monitoring meetings with Catering, trialling baby food (with a new supplier now being sourced), introducing gluten-free sandwiches, and launching a meal survey with CYP.
- Feedback through FFT and "tops" is now consistently positive. Child-friendly bed boards were designed, audited, commercially produced, and fully implemented. To support clinical and emotional needs, DigiBete app leaflets were distributed to newly diagnosed diabetes patients, a new parent and carer information leaflet

was introduced, and a Children's Emotional Wellbeing and Mental Health Survey was implemented for CYP experiencing poor mental health or dysregulation.

- Enhancements to Cubicle 32 were co-designed with the Youth Forum, resulting in a new "anchor bag" of safe resources and CYP-selected wall art funded through donations. Volunteers were successfully reintroduced to the ward, and an entrance/exit audit with families led to updated signage and a simplified flow.
- A comprehensive programme of environmental enhancements was completed, including sea-themed corridors, a child-friendly "find your way" navigation game, the introduction of the "Otto the Octopus" mascot, a multilingual sea-life welcome display, CYP-painted "Meet the Staff" artwork, QR-code information boards, a new baby-changing unit, and additional sanitary bins.
- A new SEND display board now supports neurodiverse, hearing-impaired, EAL, and complex-needs CYP with visual aids and procedural explanation cards. Hospital passports have been refreshed and are being prepared for rollout across Broadoaks, Fulwood, Ashton Clinics and ED.
- A dual-language book project with LCC was introduced for children aged 3–5, providing books in six community languages to promote home reading.
- An ISystems audit across all RPH children's areas has been completed, with an action plan to follow focusing on reducing procedural trauma. Work has also begun on establishing a parent/carer peer support group for families of CYP with long-term conditions.
- FFT with QR codes has been introduced for specialist nursing areas at Broadoaks, and Fulwood Clinic has benefitted from new waiting-room toys, including a play kitchen and toy hovers.
- At the Rawcliffe fortnightly clinic, FFT has been rolled out for the Play Team remit.
- A rich programme of activities and events has been delivered throughout the year, including cultural celebrations (Easter, Eid toy donations, Holi, Chinese New Year, Halloween, Christmas), themed engagement events (World Book Day, National Storytelling Week, National Superhero Day), and educational or enrichment activities delivered by UCLan's Teddy Bear Hospital, Mascots Delights, North West Brick Community CIC, and the Box4Kids programme.

Quality improvement projects

Stoma Accessible Public Toilets: the introduction of stoma friendly public toilets across Royal Preston Hospital and Chorley and District Hospital sites, which was linked to a campaign ran by Colostomy UK making accessible toilets 'stoma friendly'.

Following a successful application to LTHTR Charities for funding this resulted in 27 accessible toilets over the Preston and Chorley sites, which now have hooks to hang personal belongings, shelves to provide a sanitary surface, a full-length mirror to make changing stoma bags easier, a sanitary bin for the disposal of used stoma bags positioned, and signage for doors – "Not all disabilities are visible" as the British Standard recommends. This has been a welcomed introduction by both patients and staff at the Trust.

Family Rooms: LTHTR Charities we also saw the introduction of a family room based in SAU. This has enabled a personal space for patients, allowing conversations to take place in a private comfortable environment and a space for patients and families to have a quiet space. The room has been furnished with a bookcase, sofa, armchair and religious and cultural artefacts which can be used by patients if required.

Volunteers

During 2025/26, Volunteer Services continued to make a significant contribution to patient, visitor and staff experience across the Trust. A total of 316 active volunteers supported services across both hospital sites, delivering a wide range of roles including ward support, hospital guides, meet and greet services, neonatal baby cuddling, chaplaincy support, hospital radio and volunteer dog visits. Recorded volunteer activity totalled 9,846 hours, although this reflects only around 30% of the active volunteer workforce, indicating a substantially wider impact.

Volunteer recruitment remained strong, with over 150 new volunteers welcomed during the year, supported by a revised recruitment model focused on information sessions to ensure role suitability. Improvements to volunteer-specific mandatory training, engagement through newsletters and networks, and enhanced recognition initiatives have strengthened volunteer experience and retention. The service continues to expand its reach through partnerships with third-sector organisations and plans to further develop community-based volunteering opportunities in the coming year.

Patient Information Group

The Patient Information Group has continued to play a vital role in ensuring that Trust leaflets and patient communications remain clear, accurate, evidence based, and accessible. High quality patient information is essential in supporting individuals to understand their care pathway, make informed decisions, and feel confident in planning the next steps of their treatment. Key achievements this year include:

- Production of 63 new leaflets and booklets, with review of 120 existing leaflets, all transposed onto the current Trust template to ensure consistency, clarity, and uniformity across patient information materials
- A full review of all existing patient information resources.
- Delivery of the Annual General Meeting, presenting progress and achievements from the previous year.

Support for Staff

During the reporting period, the trust strengthened organisational capability through a new partnership with the apprenticeship programme. As part of this collaboration, the trust now contributes to the Level 3 Senior Healthcare Support Worker apprenticeship curriculum. This work ensures that new staff receive structured, early exposure to key principles of inclusive, patient-centred care. Training content covers core areas including the use of interpretation services, carer engagement, Deaf culture and BSL awareness, patient communication standards, the Accessible Information Standard, patient involvement mechanisms, ward-based engagement approaches, disability awareness (including hidden disabilities), and the delivery of reasonable adjustments. Embedding these components within apprenticeship teaching supports the

development of a confident, informed workforce capable of meeting the diverse needs of the Trust's population.

2.3. Equity, Equality and Health Inequalities (appendix 4)

Demographic analysis of FFT responses shows that while feedback volumes are strong overall, assurance is uneven because younger people, men and minority ethnic communities remain underrepresented. This limits confidence in how fully the Trust understands experience for some groups and reinforces the need for targeted, equity-focused engagement.

Women are over-represented compared to men, which may reflect the mix of services captured in the data, such as outpatient and maternity activity, as well as a higher likelihood of survey completion among women. Female respondents comprise 60% of the sample compared with 34% male respondents, resulting in an approximate 2:1 female-to-male ratio, with a further 6% either preferring not to say or not stating their sex.

In terms of ethnicity, the dataset is not representative of the local population, participation from minority ethnic groups is very low and is further affected by high levels of non-response. This significantly limits confidence in drawing robust conclusions about health inequalities from the data. Ethnically, 85% of respondents identify as White, with minority ethnic groups combined representing only 8% of responses; Asian / Asian British respondents form the largest minority group at 4%. A further 7% did not state their ethnicity, representing a notable data quality limitation. Taken together, these patterns show that while the Trust has a strong overall volume of feedback, assurance is weaker for younger people, men and minority ethnic communities because their voices remain underrepresented in the dataset. This is a significant improvement issue rather than only a data-quality issue, and it reinforces the need for targeted engagement, more inclusive feedback mechanisms and clearer equity-focused measures within the Single Improvement Plan.

Health Inequalities / Partnership working

The Trust continues to contribute to Preston's Suicide and Self Harm Group, coordinated by Preston City Council. As part of the citywide Suicide and Self Harm Action Plan, there is a strong focus on promoting key awareness campaigns throughout the year to ensure important messages reach residents and communities across Preston.

The Communications Team supported delivery of awareness days and campaigns that was over the year. Alongside this, the Digital Team will continue to amplify national and regional NHSE public health campaigns through Trust social media channels, including those relating to flu, mental health, and appropriate use of NHS services with the 'Your Health Campaign'.

To strengthen collaboration across local public services, a shared Padlet is being developed. This will act as a central hub for partners to upload campaign materials, ensuring consistent messaging and improving public access to information.

Addressing Health Inequalities Across Preston

The trust is participating in a series of new initiatives aimed at addressing health inequalities across local communities. Initial meetings focused on the St Matthews Ward, followed by discussions centred on the Ribbleson Ward. These sessions, chaired by Preston City Council, brought together representatives from a wide range of organisations

Community Engagement and Initiatives The group emphasised the importance of building a robust communication network to share community events and ensure stakeholders and residents have timely access to relevant information. Several initiatives were discussed, including:

- City wide Food Access Leaflet: A resource in development to improve awareness of food support services across Preston
- Winter Support Packs: Plans to distribute packs containing coats, essential items, and information on local services
- Art Based Community Project: A funding opportunity with St Catherine's Hospice to facilitate open conversations around death and dying
- Men's Mental Health Event: Westview Leisure Centre, focusing on mental wellbeing and encouraging open dialogue
- Winter Campaign Collaboration: LTHTR shared its winter campaign materials to support wider public health messaging

Other Local Public and Patient Engagement

The trust also visits local GP practices to participate in their Patient Participation Groups. This provides an opportunity to share continued improvement work by the Trust, news and updates and also allows the GP Services to share their developments and request any support needed.

Healthwatch

The trust supported Healthwatch with a number of visits and conducted surveys to feedback vital information from our patients. Along with this, work alongside the trust in projects that support the community and strengthen the voice of the patient and carer from all backgrounds, projects this year include:

The trust alongside Healthwatch Lancashire started an engagement project to understand the experiences of Deaf individuals who use BSL when accessing health and social care services. Two key themes emerged:

- Access Barriers to Booking Appointments: Many participants struggled with phone only booking systems and limited alternatives for arranging appointments.
- Communication Barriers During Appointments: Participants frequently reported a lack of qualified interpreters and unreliable video interpretation services, resulting in distressing and inaccessible care experiences.
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Building on the recommendations the trust is part of a group to monitor progress against commitments made by organisations while promoting the active involvement

of Deaf individuals who use British Sign Language (BSL) in relevant projects and initiatives.

Women's Health Engagement

The trust attended a Healthwatch organised event focused on women's health issues across Lancashire. The event aimed to highlight service provision within the Trust's catchment area and share key findings relating to access, quality, and gaps in women's health support. The event provided insight into the availability and accessibility of services relating to:

- Menstruation and menstrual health
- Reproductive screening programmes
- Menopause support pathways
- Gynaecological care
- Mental health concerns linked to inadequate service access

Following feedback received, an action plan was developed focusing on improvements to the environment, communication processes, and staff wellbeing. Within the environment, signage at the reception desk was reviewed to ensure clarity, information boards were updated, and the nurse call system was assessed after it was identified that the disabled toilet had no pull cord. A new system has since been installed in SGU, ensuring the disabled WC is now equipped with an appropriate plastic pull cord. In relation to bookings and communication, we addressed concerns regarding cancellations made via the patient portal by establishing with the administration team that confirmation and cancellation calls are now consistently undertaken to prevent patients attending cancelled appointments.

A suggestion to offer bookings a year in advance was escalated to operational management, and the trust tested a move to a six-week booking model. Staff have also been provided with updates on supporting patients with additional needs, with a focus on translation and interpreting services. To support staff wellbeing, information has been shared on access to clinical supervision and emotional support, and clinic templates continue to be reviewed regularly to minimise late-running sessions.

Vulnerable Patient Groups Feedback

Qualitative feedback shows continued inequities for several underserved groups, particularly where communication, accessibility, environment and reasonable adjustments are inconsistent. This supports the need for sustained work on inclusive communication, culturally responsive care and psychologically safer care environments.

Patients with sensory, cognitive or emotional vulnerabilities experience disproportionate distress linked to overcrowded, noisy environments, long waits and inconsistent communication, all of which undermine psychological safety and contribute to unequal experiences of care. Engagement with Black and minority ethnic communities shows reduced confidence in navigating healthcare services and a need for more sustained Trust visibility and culturally responsive engagement. Although staff were consistently praised, some children reported uncertainty about care plans and

discharge, especially when environments were unsuitable or communication was not adapted to their developmental needs.

Cross-Cutting Health Inequalities Themes

Across all groups, several systemic inequalities recur:

- Communication gaps particularly during extended waits, at discharge, or when interpreter or accessible formats are required.
- Environmental discomfort and overstimulation, including heat, noise, overcrowding and lack of quiet spaces disproportionately affecting vulnerable patients.
- Cultural competence gaps, especially around religious practices, dietary requirements, gender-concordant care and inclusive facilities.
- Access barriers, particularly for communities with limited English proficiency, lower health literacy or reduced confidence in NHS systems.
- Inconsistent application of reasonable adjustments, including interpreter use, sensory adaptations, and support for cognitive or emotional needs.

Alignment with Core20PLUS5

The Core20PLUS5 priorities highlight several targeted actions to reduce health inequalities across the Trust. For maternity, strengthening relationships with community groups such as the Mums & Minis group will support continuity of care, culturally safe maternity information, and trusted engagement with women from diverse backgrounds.

In relation to severe mental illness, continued education on trauma-informed practice across all services is essential to reducing distress caused by long waits, overstimulation and uncertainty during care processes, particularly for patients with neurodivergence, cognitive impairment or emotional vulnerability with Charity support in improving the environment and sensory pack in the Emergency Department.

To improve early cancer diagnosis, the Trust will continue its well established community outreach routes such as mosques, Black community centres and Deaf community organisations to promote screening, improve early symptom recognition and create trusted referral pathways that reduce diagnostic delay in underserved groups.

2.4. Learning and Improvement

Three cross-cutting themes continue to shape patient experience across the Trust and now provide the main focus for improvement action and assurance oversight.

Communication is the biggest driver of patient experience:

Patients need clearer, more consistent information especially about delays, discharge and next steps.

Actions Taken:

- Intentional Rounding has been fully developed and commenced within the Emergency Departments, with ongoing monitoring incorporated into the STAR programme.
- Volunteer capacity has increased by 10%, with a more representative group now supporting wards and departments across the Trust.
- New patient-facing screen messages have been introduced across UEC pathways, providing clear waiting-time information and directing patients to appropriate alternative services.
- Post-discharge experience audits are now routinely undertaken each quarter, capturing feedback from at least ten patients, families and carers.
- Engagement with VCSFE partners has been completed, providing valuable insight into discharge challenges and identifying further community support options.
- The Virtual Ward has been added to the ward-round proforma to strengthen continuity of care, and focused DKAFH work on discharge, admissions and Length of Stay has been delivered and integrated into ongoing improvement activity.

Long waits and system pressures affect dignity and wellbeing

Extended waits in ED, diagnostics and for beds cause anxiety, discomfort and loss of confidence, particularly where communication is limited.

Actions Taken:

- Stronger partnerships have been established with local voluntary and community sector organisations, enabling co-delivery of services and extending reach to underrepresented groups.
- In-patient experience has improved through consistent completion of new intentional rounding, enhanced care practices and full implementation of “About Me” boards across wards.
- The rollout of a new patient-focused “What to Expect in Hospital” video on all Trust iPads, with viewing activity now routinely monitored.
- Pain-score audits within the Medical Division completed, alongside the implementation of noise-reduction measures and a strengthened temperature-management solution for the Acute Medical Unit.
- Food provision has been improved within the Emergency Department and ward areas, with the introduction of a snack trolley, although this remains a concern and will be carried over to next year

Person-centred care and empathy significantly improve experience

Simple actions clear explanations, checking understanding and acknowledging feelings reduce anxiety and increase trust.

Actions Taken:

- Compliance with training has improved, although the target of 90% completion has not yet been achieved for the PALS e-learning module for all staff or for complaints and local-resolution training for Band 6 and above clinical staff. This work will continue through the 2026/27 Single Improvement Plan.
- Further rollout of Martha’s Rule has taken place, alongside the addition of a wellbeing question within Flex to strengthen personalised care and escalation.

- The diversity of the Patient Safety Partner role has been strengthened, ensuring broader representation and lived-experience insight.
- Divisions have also addressed the Trust's top three cross-cutting themes by focusing attention on emerging trends and delivering targeted actions.
- Qualitative patient-experience feedback for individuals with a learning disability, mental-health needs or dysregulated behaviour is now completed quarterly, with case findings presented to PCEIG to inform learning and ongoing improvement.

2.5. Forward plan and priorities

The 2026/27 Patient Experience Plan sets a clearer Trust-wide approach to improving communication, fundamentals of care, inclusion, responsiveness and the use of patient voice in decision-making.

Delivery will be supported by clearer standards, stronger ward-level leadership, improved access to patient experience intelligence and continued Board oversight through triangulated reporting.

Robust governance arrangements provide Board-level assurance through triangulation of qualitative and quantitative data, including FFT, complaints, PALS, patient stories and safety metrics, with clear divisional accountability. Successful delivery will be evidenced by improved patient feedback, fewer experience-related complaints, stronger communication at key transition points, more equitable insight from seldom-heard groups, and demonstrable learning from patient voice leading to sustained service improvement.

3. Financial implications

While no specific financial costs are associated with producing this annual report, it is recognised that patient experience has a direct impact on clinical outcomes, operational efficiency and overall productivity. By prioritising and improving patient experience, the organisation strengthens its ability to deliver care more effectively and make best use of resources

4. Legal implications

The Trust has a range of legal, regulatory and statutory obligations relating to patient experience, involvement and engagement. Failure to meet these requirements could lead to regulatory intervention, legal challenge, reputational damage and a loss of public confidence.

5. Risks

ED exit block (risk id 25) remains a key operational pressure. A comprehensive UEC Improvement Plan is in place, focusing on admission avoidance initiatives including the new See and Sort Stream Team alongside strengthened hospital flow processes and actions to reduce the number of days patients spend away from home.

Patients cared for in inappropriate area due to the impact of exit block (risk 1427) and reduced capacity within the main department, there is an increased risk of patients not being cared for in the most appropriate setting. This includes patients within the Emergency Department who require monitoring or treatment in a cubicle being managed in waiting rooms or on trolleys in corridors for extended periods of time, which can adversely affect safety, dignity and overall patient experience.

6. Impact on stakeholders

6.2. Trust Board

The continued presence of Trust Executives and Non-Executive Directors during patient safety visits across both hospital sites has created valuable opportunities for staff and patients to share real-time feedback on emerging safety, quality and experience issues affecting care across the organisation.

Staff Themes

Across all areas visited, staff consistently reported working under significant and sustained pressure, driven by high levels of boarding, space constraints, delayed discharges and prolonged escalation.

These pressures contributed to low morale, feelings of being unable to deliver the standard of care they are trained for, and in some teams, experiences of moral injury and Datix fatigue. Despite this, a strong theme of commitment, professionalism and teamwork was evident, with many areas demonstrating visible leadership, open communication channels and supportive team cultures. Staff described exhaustion in some units, particularly where vacancies, redeployment uncertainty or continuous over-capacity were impacting day-to-day functioning.

Nevertheless, teams valued leadership visibility, the opportunity to be heard and the recognition offered during the visits. Concerns around the safety and sustainability of escalation areas especially overnight were repeatedly raised, alongside challenges linked to environmental issues, equipment availability, and the impact on their ability to maintain dignity, privacy and timely care..

Patient Themes

Patient feedback was mixed but highlighted clear, recurring themes. Where staffing was stable and environments were calm, patients expressed high levels of confidence, feeling safe, well-cared for and able to ask questions, with many praising communication and nursing care particularly on wards such as 14, 17, 19 and 20.

Conversely, in escalation areas and the Emergency Department, patients described prolonged waits, boarding in corridors or unsuitable spaces, and challenges affecting privacy, dignity, sleep, comfort and hygiene. Some patients experienced delays in pain relief, food provision and medical review, although many remained understanding of pressures and expressed gratitude towards staff.

Patients consistently emphasised the importance of clear communication about delays, discharge, bed moves and what to expect next. In areas with improved

leadership visibility and proactive environment enhancements (e.g., MAU CDH), patients' experiences were notably more positive.

6.3. Council of Governors

The Trust continues to support patient experience through the active involvement of Governors in a range of assurance and engagement activities. Governors regularly participate in Golden STAR walkabouts, providing feedback on the first 15 steps of care and gathering patient experience insight to ensure services meet the standards required to achieve and sustain Gold accreditation.

As part of complaints assurance, Governors are members of the Complaints Review Group, where they review complaint responses, analyse themes and discuss learning from complaints received each month. This process supports transparency, honesty and meaningful learning, ensuring patients feel listened to and that appropriate action is taken in response to their feedback.

Additional feedback is provided through the Quality and Safety Subgroup, chaired by a Governor, which enables Governors to raise patient-led questions following walkabouts and direct feedback from patients. This forum allows the Patient Experience Lead to provide assurance that actions have been taken and improvements implemented. Governors are also supported as part of their induction through dedicated training sessions delivered by the Patient Experience Team, covering complaints and concerns, safety and quality, and the effective use of patient experience data to inform improvement across the Trust.

Recommendations

This report provides assurance that robust systems are in place to capture and act on patient experience intelligence, and that patient voice is informing governance, improvement and risk management across the Trust.

It also confirms that communication, waiting pressures, environment and health inequalities remain the principal drivers of experience risk, with targeted action in place through the Single Improvement Plan.

Overall, the paper provides appropriate assurance while identifying clear priorities for continued improvement.

It is recommended that:

- III. The Committee is asked to note and take assurance that robust arrangements are in place to capture, triangulate and act on patient experience intelligence, and that patient voice is effectively embedded within governance, quality improvement and risk management processes across the Trust
- IV. The Committee is asked to endorse the continued focus within the Single Improvement Plan on strengthening communication reliability at key points of the patient journey (including delays, discharge and transitions of care), recognising communication as the primary driver of patient experience, complaint escalation and emotional wellbeing.

Appendix 1

Complaints data

All information from Ulysses

Comparator data for Complaints 2023 to 2026

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

Number of Complaints by Division – April 2025 to March 2026

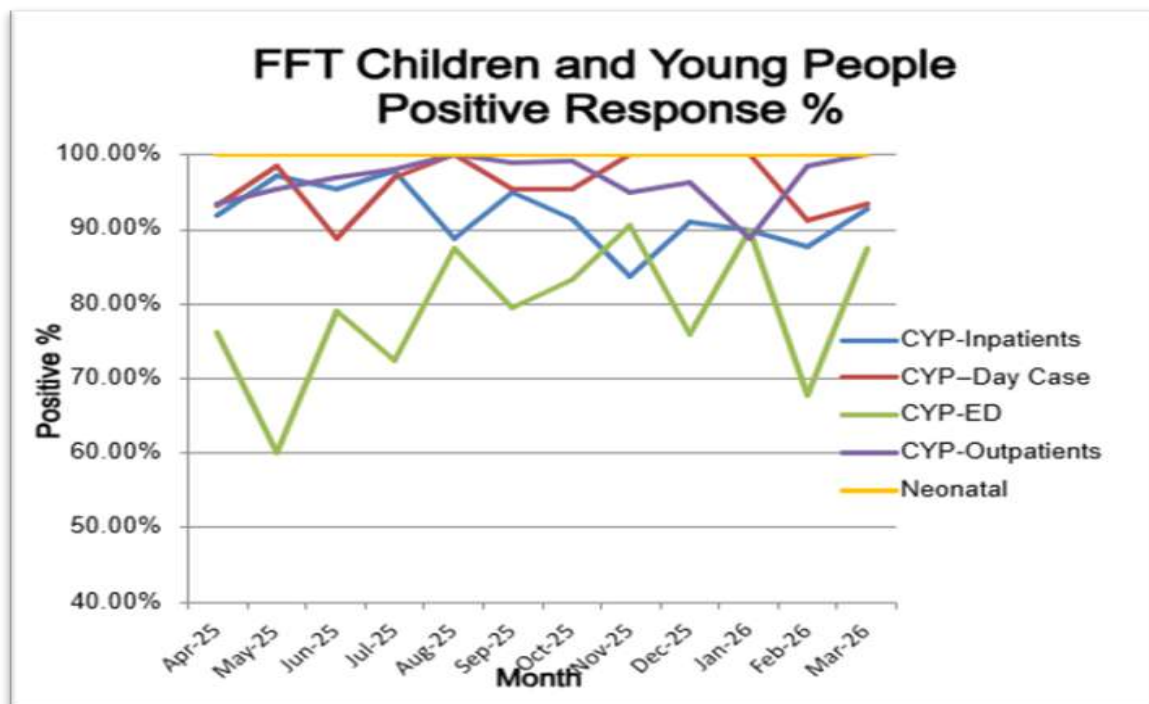
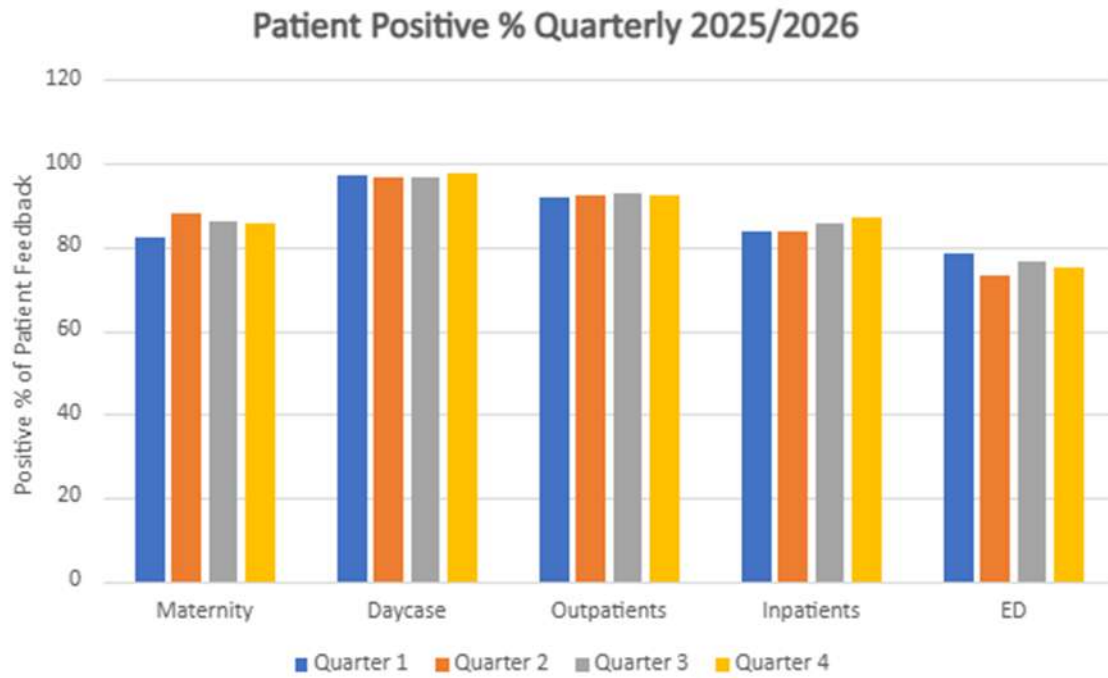
Division	Number (%)	Division	Number (%)
Medicine	120 (36%)	Women and Children's Services	54 (16%)
Surgery	127 (39%)	Diagnostics and Clinical Support	21 (6%)
Estates and Facilities	3 (0.5%)	Corporate Services	4 (1.5%)

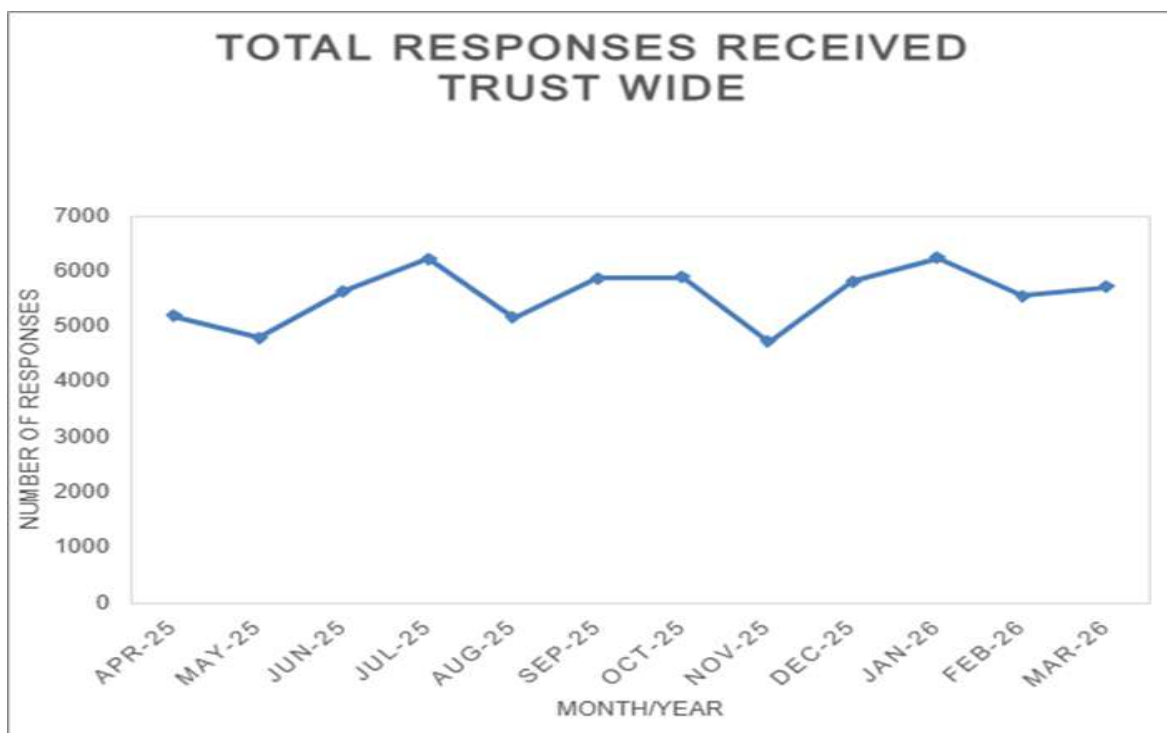
Trend of ratio of complaints per patient contact 2022 to 2026

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

Appendix 2

Friends and Family data (FFT data from Civica)



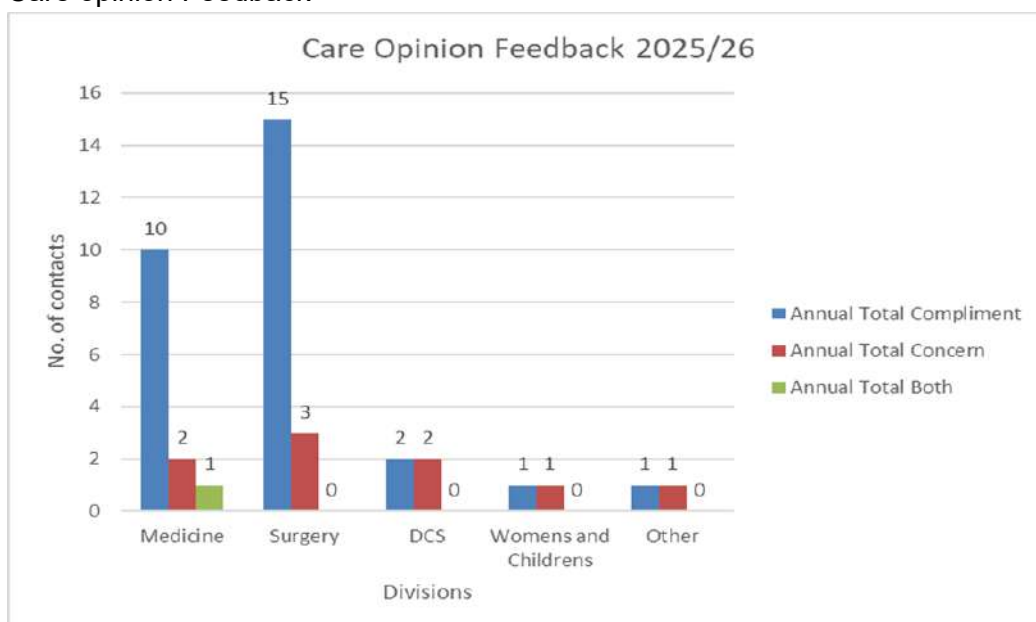


Friends and Family – response rate

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

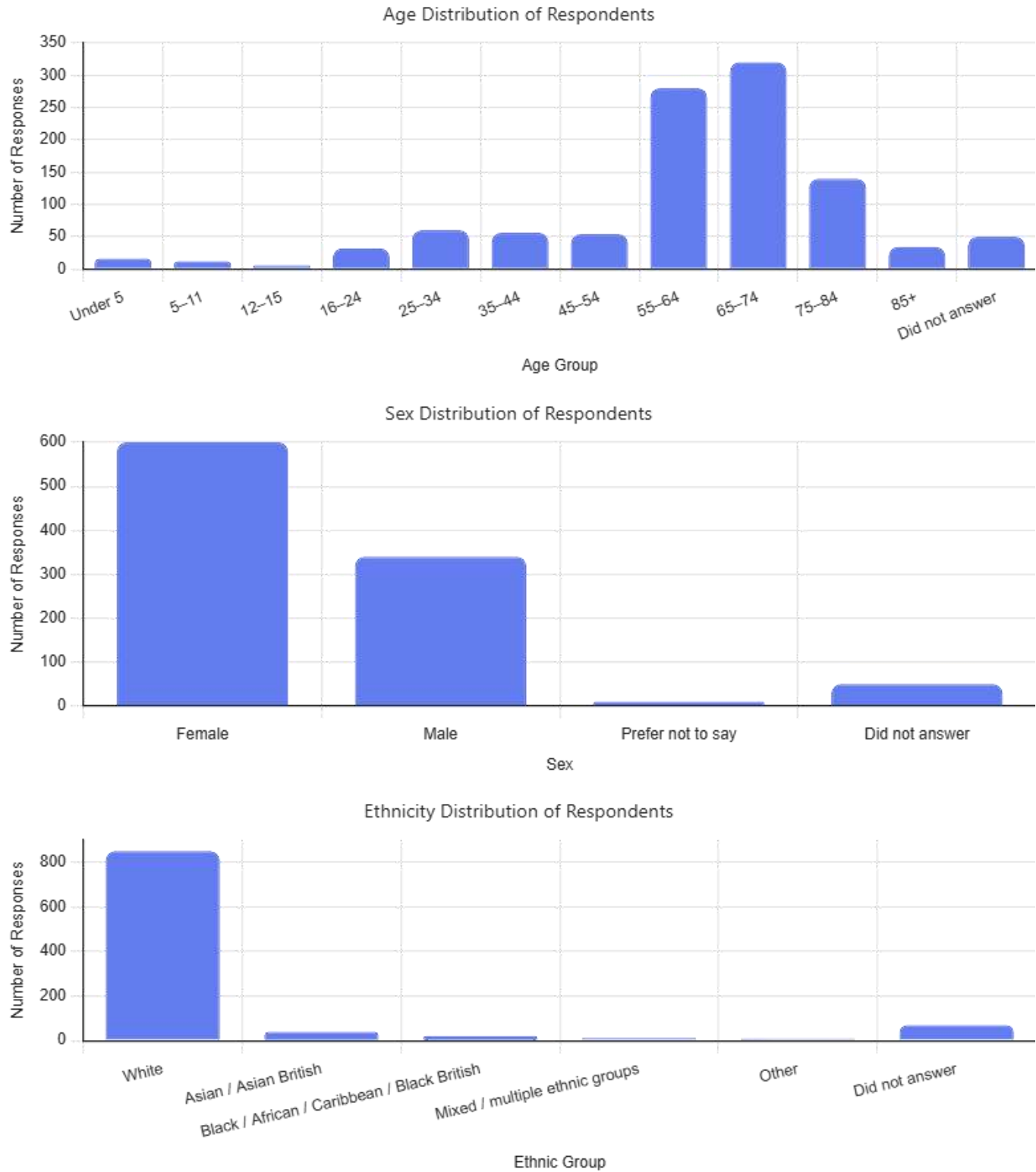
Appendix 3

Care opinion Feedback



Appendix 4 (data from civica)

Age, Sex and Ethnicity data



Appendix 5 – Divisional deep dive on themes and learning from complaints and feedback

Women and Children's Divisional Complaints Review

The complaints across Women and Children's Services reveal a clear and consistent pattern, with communication failures emerging as the most prominent theme. Patients frequently reported unclear explanations, inconsistent information and feeling insufficiently prepared for critical aspects of their care, particularly highlighted in maternity where families described poor preparation around induction of labour and limited explanation of delays. Similarly, Gynaecology and Breast services identified communication breakdowns as the single largest sub-theme, with patients experiencing avoidable anxiety due to insufficient updates or abrupt staff interactions.

A second theme relates to delays in care, including postponed appointments, extended waiting times and procedural delays, which had a marked emotional impact on service users. Maternity complaints describe delays in triage and time critical observations, while women undergoing induction often felt distressed by prolonged waits compounded by a lack of timely information. Staff attitude and behaviour also feature strongly, with some patients in gynaecology describing dismissive interactions and children and young people reporting that staff appeared too busy, unresponsive or reliant on security rather than trauma-informed approaches to de-escalation.

A range of targeted improvements have been implemented to enhance patient experience, including clearer reception signage, updated information boards, and accessibility improvements through the upgrade of the nurse call system. Booking and communication processes have been strengthened to ensure appointment cancellations are clearly communicated, alongside ongoing review of booking timeframes and enhanced staff guidance on supporting patients with additional needs. Staff wellbeing continues to be supported through access to clinical supervision and reviews of clinic templates to address delays. Quality improvement work has also focused on improving pain management during gynaecology procedures through environmental enhancements, staff education, and revised clinical practices. In addition, relocating Bulkamid procedures to the outpatient setting has improved patient experience, supported continuity of care, and released theatre capacity.

Diagnostic and Care Service Divisional Complaints Review

Analysis of complaints across the Division of Diagnostics and Clinical Support reveals several consistent and interconnected themes, most notably delays in appointments and results, communication shortcomings, and concerns around staff attitude. Delays particularly within Radiology and Pain Services were the predominant issue and often acted as the trigger for wider dissatisfaction, with long waits for imaging, reporting and follow-up appointments creating uncertainty for patients. These operational pressures directly fuelled communication complaints, as patients frequently reported a lack of timely updates, unclear information pathways, and difficulty contacting services.

Additional issues, such as administrative errors, and pathway inefficiencies, highlighted pressure points in high volume diagnostic environments. The learning from these themes emphasises the continued importance of proactive communication, redesigning and improving capacity such as within Fracture Clinic who have improved their phone line and patient contact to improve experience. Alongside this, the presence of high volumes of compliments signals a strong foundation of positive staff behaviours that can be built upon to embed consistent, division-wide improvements in patient experience.

Surgical Divisional Complaints Review

The complaints data highlights three consistent and recurring themes: failures in communication, dissatisfaction with treatment outcomes, and inefficiencies or delays within the treatment pathways, including appointment cancellations. Communication issues were the most dominant, with patients and relatives frequently reporting a lack of updates, unclear explanations, and poor information during delays. Concerns around treatment outcomes often related to unmet expectations or unclear post-operative information. Flow-related complaints particularly in high-pressure areas such as SAU reflected ongoing operational strain.

The learning arising from these themes emphasises the need for stronger, more structured communication practices, including clearer expectation setting and proactive updates; the division has focused on embedding of proactive patient contact methods such as the “5 Ps” intentional rounding model. Additional learning includes the continued work on the importance of accessible, personalised communication through reasonable adjustments, and scaling up successful local improvements such as environment changes and enhanced patient support tools across the division to create more consistent, patient-centred care.

Medicine Division Complaints Review

Patient experience feedback within the Division of Medicine demonstrates a consistent pattern of complaints centred on three core themes: appointments, communication, and treatment/procedures. These themes remain unchanged across all reporting periods and indicate long-standing systemic challenges that continue to affect patient satisfaction and confidence. The most prominent area of concern relates to appointments, with patients repeatedly reporting cancelled appointments, unclear arrangements for follow-up after discharge, and delays in receiving key diagnostic results, such as CT scans, X-rays and echocardiograms. These issues contributed to confusion and anxiety for patients awaiting ongoing care and reflect the need for more robust, predictable pathways

Communication concerns were similarly widespread, highlighting gaps in how information is conveyed between staff and to patients. Patients frequently reported conflicting information from staff on the same ward, insufficient detail in discharge communications, and inadequate handovers between departments particularly

between the emergency departments and inpatient wards. Communication challenges in both emergency departments were also noted during periods of high operational pressure. These findings underscore the importance of improving communication practices across the division as a core element of patient safety and experience

Treatment and procedure-related complaints persisted throughout all quarters, often linked to delays in care caused by capacity pressures or variation in how treatment information was explained to patients. Patients expressed uncertainty about expected timeframes and experienced frustration when delays were not clearly communicated. Capacity and environmental issues especially corridor care, overcrowding, and lengthy waits for inpatient beds further contributed to dissatisfaction. Patients described discomfort, lack of dignity, and limited access to facilities while waiting, particularly within the Royal Preston Hospital Emergency Department. These issues highlight the direct impact of hospital flow pressures on patient experience and dignity.

Despite these challenges, the division demonstrated meaningful learning and improvement activity. Several initiatives have been implemented to address communication issues, improve patient flow, and enhance the care environment. These include communication improvement projects, the introduction of dignity spaces within emergency departments, enhanced cleaning programmes, and increased volunteer involvement supporting patient comfort. Additionally, a renewed emphasis on positive patient feedback including improved capture of compliments and a divisional compliments award has helped boost morale and reinforce good practice.

C) PSIRF ANNUAL REPORT 2025-26

● Other

Item for Assurance

REFERENCES

Only PDFs are attached



11.1c PSIRF Annual Report 2025-26 Board Part I 4 June 26.pdf



11.1c PSIRF Annual Report 2025-26 Report & Appendices Board Part I 4 June 26.pdf

Board of Directors

Meeting of the	Board of Directors	4 th June 2026	
	Part I ☒	Part II ☐	
Title of Report	PSIRF Annual Report 2025-26		
Report Author	Helen Hodgson, Head of Investigation and Learning		
Lead Executive Director	Sarah Morrison, Deputy Chief Executive / Chief Nursing Officer		
Recommendation/ Actions required	It is recommended that the Safety and Quality Committee: i. Receive the PSIRF Annual Report and confirm assurance on the management of incidents; ii. Approve the refreshed PSIRF Local Priorities and associated PSIRF Plan and Policy (see Appendix 1, 2 and 3).		
	Decision ☒	Assurance ☒	Information ☐
Executive Summary	The purpose of this paper is to provide an annual update on the implementation of the Patient Safety Incident Response Framework (PSIRF) and an overview of incidents reported to the Learning From Patient Safety Events System (LFPSE) and Strategic Executive Information System (StEIS) between 1 April 2025 and 31 March 2026. Implementation of PSIRF During 2025/26, the Trust has continued to mature its PSIRF approach following the transition from the Serious Incident Framework. PSIRF is now fully embedded within routine governance, supported by a robust structure including a two-tier triage process, weekly executive-led oversight through the PSIRF Oversight Panel (PSOP), and triangulation of learning through the Always Safety First approach. The 2024/25 Mersey Internal Audit Agency (MIAA) review awarded the Trust Substantial Assurance for PSIRF, confirming robust implementation. The review identified areas for development including undertaking a refresh of the Trust’s local priorities and strengthening the reporting to Safety and Quality Committee in relation to health inequalities, training and capacity, and the timeliness of completing learning responses; these have now been addressed or embedded within routine governance during 2025/26. A formal review of the Trust’s safety profile has been undertaken, resulting in a refreshed PSIRF Policy, Plan, and local priorities aligned to organisational learning, emerging risks, and the Always Safety First Strategy.		

The introduction of the Ulysses Risk Management System has further supported this maturity by improving reporting and enabling more data-driven learning, although reporting functionality continues to develop.

The Trust continues to work collaboratively with system partners and the Integrated Care Board (ICB) to support shared learning and alignment. The ICB remains a standing member of the PSIRF Oversight Panel, providing oversight and facilitating system-wide collaboration.

Incident Reporting Overview

In 2025/26, a total of 21 incidents were reported to StEIS, compared to 19 incidents in 2024/25.

Of the incidents reported:

- 8 were classified as deaths thought more likely than not due to problems in care. This includes all cases where a patient sadly passed away and where acts or omissions in care were a contributory factor, or where the death was unexpected and required further investigation.
- 6 were Never Events, which is an increase from 3 in the previous year.). 4 occurred within the Surgical Division. 3 of these were categorised as Wrong Site Surgery (wrong site cataract operation, lesion removed from the incorrect site and an incision to the wrong eye during surgery) and 1 was a Retained Foreign Object (retained bung from a syringe). The remaining 2 Never Events reported occurred within the Division of Diagnostics Support Services (DCS). 1 was categorised as Retained Foreign Object (retained Angioplasty Catheter Balloon) and 1 reported under the category of Wrong Implant/Prosthesis (wrong size stent). All Never Events were fully investigated. There were no cases of severe harm or death, and learning has informed improvement actions.
- 7 met the Maternity and Neonatal Safety Investigations (MNSI) criteria. 2 of these incidents were in relation to 1 Maternal Death and 1 Neonatal Death. Maternity-related incidents continue to be consistently reported in line with national requirements reflecting appropriate escalation of cases meeting national criteria and does not, in isolation, indicate poor care. All cases have been managed in line with national requirements, with external investigation where appropriate and local oversight maintained for learning and governance.
- No incidents were reported under the Trust's Local PSIRF Priorities. However a series of thematic reviews against 4 of 5 of the Local Priorities was undertaken providing meaningful learning. The outputs of these were shared with the Safety and Quality Committee.

Reporting remains aligned with activity levels, reflecting a stable and engaged reporting culture. The Trust continues to perform strongly nationally, ranking 8th out of 118 acute Trusts for incidents reported per 1,000 bed days, demonstrating a mature approach to identifying and escalating patient safety concerns.

	During the reporting period of 2025/26, there have been 2 cases reported to StEIS/LFPSE which are also subject to a claim, 1 case which is subject to a formal complaint and 8 cases with the outcome of Death reported within this year are also subject to inquest. During 2025/26, the Trust received two Regulation 28 reports, resulting in targeted improvements including the introduction of a 24/7 thrombectomy service and strengthened processes for infection management, communication, and safety within surgical pathways in Cardiology. Key Safety Themes and Learning Analysis of incidents and thematic reviews has identified cross-cutting themes, including: • Variability in patient pathway tracking and follow-up • Nutrition, hydration, and patient weight monitoring • Digital system challenges • Reliability of safety checklists for invasive processes, particularly outside theatre settings • Pathways in Cardiology These insights have informed targeted improvement activity and supported a more system-level approach to learning through triangulation within the Always Safety First Strategy. While no direct inequalities were identified, patients with communication barriers, social vulnerability, or reduced ability to engage with care may require additional support to ensure equitable access, experience and outcomes. Learning is further supported through leadership engagement, including safety visits and structured forums to share insight across teams. Improvement and Impact The Trust has strengthened its approach to organisational learning, with increased use of thematic reviews and system-level improvement. This has supported measurable progress, including: • Introduction of a 24/7 thrombectomy service, improving timely access to care • Strong performance against the C. difficile trajectory • Improved endoscopy capacity and reduction in backlog risks • Targeted improvement programmes addressing high-frequency harms such as pressure ulcers • A Trust-wide programme to strengthen patient pathway tracking and oversight is also underway, recognising this as a key organisational priority. Never Events and Safety Improvement

The Trust continues to adopt a learning-focused approach to Never Events. A forensic review and Trust-wide deep dive identified system-level issues relating to safety processes, human factors, and system reliability. In response, improvement work has focused on strengthening Local Safety Standards for Invasive Procedures (LocSSIPs), standardising processes, and improving consistency in the application of safety controls.

Separately, an external review by the Royal College of Ophthalmologists, was also undertaken in October 2025 following a cluster of Never Events in Ophthalmology. High level feedback from the review recognised strong service performance, professionalism, and teamwork, with no immediate safety concerns identified. However, the final report is currently still awaited and will be shared with the Safety and Quality Committee when available.

Patient and Staff Engagement

The Trust continues to place patients, families, and carers at the centre of safety and learning, supported by Patient Safety Partners and positive Duty of Candour compliance. The introduction of the Being Fair approach is supporting the development of a more open and compassionate culture for staff.

PSIRF Policy, Plan and Local Priorities

During 2025/26, the Trust undertook a comprehensive review of its patient safety profile, drawing on a wide range of safety intelligence. This has informed the development of refreshed PSIRF Local Priorities (see Appendix 1) and updates to the PSIRF Policy and Plan (see Appendix 2 and 3), aligned to the Always Safety First Strategy.

Consultation on the local priorities has been completed and was presented to the Safety and Quality Committee in May 2026. The Committee was asked to endorse the refreshed priorities alongside the updated PSIRF Policy and Plan. It should be noted that consultation on the Policy and Plan is running concurrently with this submission; any amendments arising will be reported verbally to the Trust Board in June 2026. Subject to Board approval, the documents will then proceed to the ICB for final approval.

Looking Ahead: Priorities for 2026/27

With priorities now clearly defined through the Always Safety First Strategy, the focus for 2026/27 is on demonstrating measurable improvements in outcomes and experience for both patients and staff.

Additional priorities include:

- Developing an Incident Support Framework to support managers in fostering psychological safety and strengthening a culture of Being Fair, openness and transparency
- Delivering more structured in-house PSIRF training to strengthen capability across the Trust, enabling Divisional Governance Teams to support a broader range of safety and quality improvement activities.
- Strengthening data-driven learning through Ulysses
- Strengthening the tracking and impact of learning and safety actions

	- Enhancing triangulation of safety intelligence to better inform improvement programmes - Increasing the use of thematic and system-level reviews to maximise organisational learning and impact - Strengthening the focus on health inequalities - Strengthening the quality of Duty of Candour, while ensuring this is balanced with appropriate support for staff experience and wellbeing. - Improving support resources for patients, families, and staff Summary The Trust has made significant progress in embedding PSIRF and strengthening its learning-focused approach to patient safety. The next phase will focus on evidencing impact, ensuring that learning is consistently translated into improved patient outcomes, safer systems, and a positive experience for both patients and staff.	
Link to Strategic Objectives 2026/27	Patients – deliver excellent care: Improve outcomes, reduce harm and deliver a positive patient experience.	☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.	☐
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.	☒
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.	☐
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.	☐
Due Diligence	To give the Committee assurance, please complete the following:	
Committee Approval	Safety and Quality Committee	August 2025, November 2025 February 2026, May 2026
Operational Group Review:	PSIRF Oversight Panel	Weekly
Link to Board Assurance Framework:	Not applicable	
Appendices	Appendix 1 – Full report and PSIRF Local Priorities Appendix 2 – PSIRF Policy Appendix 3 – PSIRF Plan	

1. Background

- 1.1** This report provides an overview of incidents reported under the Patient Safety Incident Response Framework (PSIRF) to the Learning from Patient Safety Events (LFPSE) and Strategic Executive Information System (StEIS) between 1 April 2025 and 31 March 2026.
- 1.2** It brings together analysis of incident activity (including Never Events), highlights key areas of organisational learning, summarises findings from thematic reviews, and outlines progress in response to identified risks. It also provides an update on PSIRF maturity, training and capability, and considers key risks and legal matters.

2. Discussion

2.1 PSIRF Implementation and Maturity

- 2.1.1** During 2025/26, PSIRF has become embedded within routine governance, representing a transition from implementation into a more stable and mature operating model. Learning responses are now well established and consistently applied across the organisation, supporting a proportionate and insight-focused approach to incident management.
- 2.1.2** This position is supported by the 2024/25 Mersey Internal Audit Agency review, which provided a rating of Substantial Assurance, confirming that robust systems and governance arrangements are in place.
- The review highlighted key strengths, including the Trust's PSIRF Policy and Plan, incident management processes, and governance structures. This includes the two-tier triage model and the executive-led PSIRF Oversight Panel, which provide clear oversight and accountability.
 - Areas for development identified through the review included refreshing local priorities and the PSIRF Plan; strengthening reporting on health inequalities; enhancing assurance in relation to role-specific training, competence, and capacity; and improving oversight of the timeliness of learning responses. These actions have now either been completed or embedded within routine governance arrangements during 2025/26.
 - A formal review of the Trust's safety profile has been undertaken, resulting in a refreshed PSIRF Policy, Plan, and local priorities. These are aligned to organisational learning, emerging risks, and the refreshed Always Safety First Strategy, ensuring that the Trust's approach remains dynamic and evidence-based. These documents are included within this paper for endorsement by the Safety and Quality Committee (see Section 3).
 - Health inequalities, assurance regarding role-specific training, competence and capacity, and oversight of the timeliness of learning responses are now incorporated as routine areas of reporting to the Safety and Quality Committee.
- 2.1.3** The introduction of the Ulysses risk management system in January 2026 is intended to further support this maturity. Improved usability has contributed to increased reporting rates, reflecting a positive reporting culture. However, while reporting into the system has improved, reporting and dashboard capability out of the system is still maturing, with further development underway to enhance reporting and analytical capability. These are expected to improve over time, strengthening the Trust's ability to use safety data to inform improvement.

- 2.1.4** The Trust continues to work collaboratively with system partners and the Integrated Care Board (ICB) to support shared learning and alignment. The ICB remains a standing member of the PSIRF Oversight Panel, providing oversight and facilitating system-wide collaboration.

2.2 Incident Reporting and Analysis

2.2.1 Incident Reporting Overview 2025/26

- 2.2.1.1** Incident Reporting Culture remains positive and stable, indicating a strong safety culture and consistent identification of risk.
- Reporting remains aligned with activity levels, reflecting a stable and engaged reporting culture. The Trust continues to perform strongly nationally, ranking 8th out of 118 acute Trusts for incidents reported per 1,000 bed days, demonstrating a mature approach to identifying and escalating patient safety concerns.
 - The Safety and Quality Dashboard, presented monthly to the Safety and Quality Committee, provides oversight of harm levels associated with patient-related incidents over time. This shows that incidents resulting in moderate harm or greater remain low in proportion to the overall volume of patient-related incidents reported.
 - Incidents continue to be regularly reviewed through PSIRF governance forums, where themes and trends are triangulated with other sources of intelligence and acted upon. Learning is shared through safety bulletins, supporting timely dissemination and reinforcing a culture of continuous improvement.

2.2.2 PSIRF Reporting to StEIS

2.2.2.1 PSIRF National Priorities

- 21 incidents met PSIRF national criteria in 2025/26 compared to 19 in 2024/25.
 - **8 deaths more likely than not due to problems in care**, including cases where acts or omissions were contributory factors, or where death was unexpected and required further investigation
 - **6 Never Events**, comprising:
 - 4 within the Surgical Division: 3 Wrong Site Surgery - wrong site cataract operation, lesion removed from incorrect site, incision to wrong eye and 1 Retained Foreign Object - retained syringe bung
 - 2 within Diagnostics and Clinical Support: 1 Retained Foreign Object retained angioplasty catheter balloon and 1 Wrong Implant/Prosthesis - incorrect stent size.
 - **7 cases meeting Maternity and Neonatal Safety Investigation (MNSI) criteria**, which are reviewed by an independent national body, with the Trust responsible for Duty of Candour and immediate safety actions
 - 1 related to a maternal death (amniotic fluid embolism), now closed
 - 1 intrapartum death was referred but subsequently closed following post mortem, with a full PMRT review completed locally. In line with standard process, external agencies were informed, and no further action was required. The Trust completed a full PMRT review to ensure appropriate governance and learning, and the case was closed.
 - The remaining cases related to term babies admitted to the Neonatal Unit (2 cases are now closed, with 3 remaining under investigation).
 - Maternity-related incidents continue to be consistently reported in line with national requirements, with MNSI cases identified in each quarter. This reflects appropriate escalation of cases meeting national criteria and does not, in isolation, indicate poor

care. All cases have been managed in line with national requirements, with external investigation where appropriate and local oversight maintained for learning and governance.

2.2.2.2 PSIRF Local Priorities

- The Trust's current local priorities are:
 - Delayed recognition of a deteriorating patient, due to gaps in monitoring (including all pregnant women).
 - Delayed, missed or incorrect cancer diagnosis.
 - Prescribing or administration error or near miss of anticoagulation medication.
 - Adverse discharge due to gaps in communication or misinformation.
 - Delay in responding to a critical pathology finding.
- No incidents met local priority criteria for an individual Patient Safety Incident Investigation during the year, compared to 5 during 2024/25.
- However, thematic reviews have been undertaken across all local priority areas except delays in responding to critical pathology findings (outputs from the reviews have been shared with the Safety and Quality Committee). This has enabled system-level insight and learning, reducing reliance on multiple individual PSIs and reflecting a more mature, proportionate application of PSIRF principles.
- The absence of PSI activity reflects the need to further refine priorities to maximise actionable learning. In response, a formal review of PSIRF local priorities has been undertaken during 2025/26, identifying the need for a smaller number of more focused priorities, alongside clearer guidance on when a full investigation is required.

2.2.2.3 Other Learning Response Activity Analysis

- The Trust applies a range of learning responses under PSIRF, proportionate to the nature, complexity, and learning potential of each incident, reflecting a mature and flexible approach to learning.
 - Learning responses include After Action Reviews (AARs), Patient Safety Incident Investigations (PSIs), thematic and multidisciplinary reviews, and rapid approaches such as SWARM huddles and Rapid Learning Reviews for lower-complexity incidents.
 - As per 2024/25, the most utilised Learning Response undertaken against PSIRF National and Local Priorities this year was the AAR.
 - Many incidents initially identified to meet National and Local Priorities did not progress to a Learning Response as initial fact-finding indicated that further investigation was unlikely to yield additional learning. This approach reflects the principles of proportionality within PSIRF and supports timely, local improvement.
 - A key development during 2025/26 has been the shift away from high volumes of individual investigations towards thematic and system-level learning. This approach has enabled the Trust to identify cross-cutting contributory factors including communication challenges, digital system limitations, and workforce issues and to develop more targeted and effective improvement actions.
 - Analysis of activity has highlighted opportunities to further strengthen the use of rapid learning approaches, particularly SWARM huddles, which have been used less frequently than intended. SWARMs are designed to support immediate, frontline learning and are typically led by operational leaders, whereas AARs, PSIs and thematic reviews continue to rely heavily on governance teams, indicating over-reliance on these functions.
 - In response, the Trust has introduced Rapid Learning Responses for pressure ulcers, delivered by clinical leaders to enable timely, local learning. There are plans to

expand this approach more broadly, increasing the use of rapid, leader-led learning methods. This shift aims to strengthen real-time learning, improve local ownership, and reduce pressure on governance teams, enabling them to focus on higher-complexity investigations and system-level analysis

2.2.2.4 Never Events

- A forensic review undertaken in June 2025, prompted by recurring incidents within ophthalmology, identified areas for learning. These included strengthening application of safety-critical processes (such as 'prep, stop, block'), gaps in Local Safety Standards for Invasive Procedures (LocSSIPs) and associated checklists, and challenges relating to psychological safety
- These findings confirmed that incidents were primarily driven by system-level issues rather than isolated human error, particularly in relation to the reliability and consistency of safety controls across teams and specialties.
- In response, a comprehensive action plan was developed and is being implemented, focusing on strengthening system controls, improving human factors awareness, embedding consistent safety processes across specialties, and enhancing support for staff involved in incidents.
- The Trust has also initiated a comprehensive LocSSIP improvement programme, focused on:
 - Standardising safety-critical processes across specialties
 - Strengthening governance, oversight, and audit processes
 - Improving human factors awareness and team behaviours
 - Embedding consistent use of safety checks and procedural standards
- This programme represents a shift from reacting to individual incidents towards proactively strengthening system reliability, ensuring that key safety controls are applied consistently in practice
- In addition, an external review by the Royal College of Ophthalmologists, undertaken in October 2025, recognised strong service performance, professionalism, and teamwork, with no immediate safety concerns identified. The final report is awaited, with a draft expected in June 2026 which will be shared with the Safety and Quality Committee once finalised.
- At a national level, the Never Events Framework remains under review, and the Trust will ensure alignment with any updated guidance as it is published.

2.2.2.5 Legal Claims, Complaints, Inquest and Regulation 28 Activity aligned to incidents in 2025/26

- During 2024/25, there were:
 - 2 incidents linked to legal claims
 - 1 linked to a complaint
 - 8 cases subject to inquest (4 completed, 1 case is not yet listed, and 3 cases are due to be heard between May and August 2026).
- During the 2025/26 reporting period, the Trust received two Regulation 28: Report to Prevent Future Deaths from the Coroner.
 - The first case related to delays in access to thrombectomy services following a stroke. In response, the Trust implemented a 24/7 thrombectomy service in February 2026, significantly improving access to time-critical intervention.
 - The second case related to sepsis associated with an infected pacemaker site, where concerns were raised about clinical decision-making, escalation, and communication of microbiology results. Actions taken include strengthening wound swab tracking, enhancing communication processes, and introducing additional safety checks within surgical pathways.

2.2.2.6 Duty of Candour Compliance

- Duty of Candour compliance has remained consistently high, supported by strong governance and oversight processes. A temporary reduction linked to system implementation was quickly resolved, with compliance returning to expected levels.
- A Duty of Candour quality audit is currently underway to assess the quality of letters and communications with patients and families, with findings to be reported to the Safety and Quality Committee.
- A key priority for 2026/27 is to sustain high compliance while improving the quality and consistency of communication, informed by the audit findings, and ensuring this is balanced with appropriate support for staff experience and wellbeing.

2.2.2.7 Quarterly Activity

- The Safety and Quality Committee receives three quarterly PSIRF reports during the year, with the annual report incorporating Quarter 4 2025/26 activity. Detailed case summaries of new and closed cases meeting PSII criteria are provided within these reports.

2.2.2.8 Legacy Position (under previous Serious Incident Framework)

- There are no open Level 3 SIF investigations. A small number of Level 1 and 2 non-StEIS SIF cases remain open to support completion, assurance, and embedding of improvement actions prior to formal closure and are being actively monitored by the PSIRF Oversight Panel, with a continued downward trajectory.

2.2.2.9 PSIRF Review, Activity Trends and Key Performance Indicators

- To support effective monitoring of timeliness and delivery, the Trust measures activity via the following Key Performance Indicators (KPIs) in February 2025:

PSIIs:	• Red: >182 days since commissioning • Amber: 153–182 days • Green: ≤153 days
AARs:	• Red: >30 days since commissioning • Green: ≤30 days

Timeliness of learning responses remains broadly compliant, supported by strengthened governance oversight through PSOP. Performance has improved significantly compared to 2024/25, with a notable reduction in the number of ongoing and overdue PSIIs, indicating improved grip and delivery.

2.2.2.10 Key Themes

- Learning from incidents has identified themes such as delays in diagnosis and pathway progression, weaknesses in patient tracking, digital system limitations, and challenges in communication, escalation, and team coordination.
- In response, the Trust has progressed targeted improvement programmes focused on strengthening pathway reliability, improving digital oversight, enhancing multidisciplinary working, and reducing variation in practice, including specific work on high-frequency incidents.
- These improvements are supported by wider safety initiatives, including work on patient pathway tracking, pressure ulcer prevention, and system-level improvement programmes.
- The identified themes are reflected within the Trust's risk profile, including risks relating to pathway tracking, cancer pathways, digital infrastructure, and Never Events.
- Further cross-cutting risks have been identified through Never Event reviews, forensic analysis, and PSIRF Oversight Panel discussions, particularly relating to digital safety (e.g.

lack of an integrated Electronic Patient Record, Wi-Fi instability, documentation constraints, alert fatigue, and data quality). Work is underway to formally incorporate these into the Digital and IT Risk Register in collaboration with clinical and digital leads.

- Nutrition and patient weight monitoring have also been identified as a theme across incidents, with a targeted workstream underway to improve early identification, prevention, and oversight.
- Cardiology pathway themes have been highlighted through incident review and external findings, particularly in relation to referrals, inter-hospital transfers, and coordination of care. A formal improvement plan is in place, supported by thematic review, strengthened governance, and system-wide collaboration.

2.2.2.11 Additional Themes (Health Inequalities)

- As part of all PSIs, the Trust routinely considers a set of additional factors to understand whether underlying issues may have contributed to the event. This includes assessing the potential impact of health inequalities, protected characteristics, communication between staff, patients and families, and whether staffing levels were adequate at the time. These considerations are also embedded within MNSI.
- Analysis of closed cases during 2025/26 found no direct evidence that health inequalities or protected characteristics resulted in differential impact on patient safety events. However, several indirect factors were identified, including inconsistent access to interpretation services, communication barriers, and challenges faced by patients with complex needs or reduced ability to engage with care. Patients whose needs fall outside standard pathways, including those with repeated non-attendance or social vulnerability, were noted to be at increased risk.
- During 2026/27, this insight will inform wider health inequalities work, ensuring that patient safety intelligence contributes to identifying at-risk groups and shaping targeted interventions. This will be aligned to the Always Safety First Strategy, with a strengthened focus on incorporating inequality and vulnerability data into safety insight, involving Patient Safety Partners and lived experience, and ensuring that pathway redesign explicitly considers communication, access, and personalised care.

2.2.2.12 Achievements and Impact

- Significant progress has been made in improving safety within time-critical pathways. The Trust's thrombectomy service transitioned to a 24/7 model from 2 February 2026, addressing delays in access identified through incidents and Regulation 28 findings.
- The Trust has delivered strong performance against the C. difficile trajectory, reporting 122 cases against a target of 167. This reflects sustained improvements in infection prevention and control and system-level reliability.
- Endoscopy capacity and pathway reliability have improved significantly, with reductions in waiting lists and backlog risks. Improvements to validation, tracking, and follow-up processes have reduced risks associated with delayed diagnosis, particularly within cancer pathways.
- A Waiting List Safety Group has been established to strengthen oversight of patient pathways and support the identification and escalation of potential risks. The group is in the early stages of implementation, with initial work focused on improving visibility of patient tracking processes, understanding variation across specialties, and identifying priority areas for improvement. This will inform the development of a more standardised and consistent approach to pathway management and oversight across the Trust.
- Targeted improvement work has been undertaken in relation to high-frequency harms, particularly pressure ulcers. This includes a multidisciplinary improvement programme and the introduction of a weekly Pressure Ulcer Harm Review Panel, supporting proactive monitoring and early intervention.

- High-frequency incidents continue to be managed through targeted improvement programmes and dedicated oversight forums, with a focus on prevention and sustained improvement

2.2.2.13 Challenges

- Despite progress, a number of challenges remain in embedding and sustaining improvements.
- Capacity pressures within Divisional Governance Teams continue to impact the timely co-ordination of learning responses, alongside increasing demand and complexity.
- While the Ulysses Risk Management System has improved incident reporting, reporting and dashboard functionality is still developing, presenting some limitations in oversight and analysis.
- Variability remains in the consistent application of proportionate learning responses, with continued reliance on governance teams highlighting an opportunity to strengthen frontline team led learning.
- Digital system constraints, including lack of integration, data quality issues, and workflow limitations, continue to present cross-cutting risks affecting pathway management and access to information.
- External pressures, including Coroner's Direction Orders and regulatory requirements, add complexity and can impact timelines and resource.

2.2.2.14 PSIRF Training, Capability and Workforce Capacity

- The Trust continues to prioritise the development of patient safety capability and capacity to support effective delivery of PSIRF. Training compliance remains high across core programmes, including patient safety essentials and role-specific training for staff involved in learning responses.
- Targeted PSIRF training has strengthened capability in systems-based investigation, engagement, and analysis. Staff leading Patient Safety Incident Investigations (PSIIs) are required to complete the national Systems Approach to Investigation training or work under appropriate supervision where this is in progress.
- A workforce review undertaken in 2025/26 highlighted the significant time and resource required for learning responses, particularly complex PSIIs, and reinforced the importance of a proportionate, skill-mixed approach. In response, the Trust will be reviewing its model to ensure:
 - Complex investigations are led by trained senior staff
 - Clinical staff in divisions deliver thematic and locally-led learning
 - The wider workforce supports rapid, proportionate learning responses
- While compliance with training is strong, variability remains in the consistent application of learning in practice. The Trust is therefore focused on strengthening role-specific capability, supervision, and practical application of training.
- National constraints in access to formal PSIRF training continue to impact delivery. To address this, the Trust will develop an in-house PSIRF training programme in 2026/27 to improve access, build capability at scale, and support consistent, high-quality learning responses.
- Full training compliance data is provided to the Safety and Quality Committee.

2.2.2.15 Safety and Learning Culture and Looking Ahead: Priorities for 2026/2027

- The Trust has continued to strengthen its learning culture during 2025/26, with increasing emphasis on system-wide learning, multidisciplinary engagement, and patient involvement. The Patient Safety Partner model is in place, and the introduction of the Being Fair approach is supporting the development of a more open, transparent, and psychologically safe culture.
- Learning is supported through a range of mechanisms, including leadership safety visits, structured engagement forums, thematic reviews, and the dissemination of Patient Safety

Learning Bulletins. These approaches ensure that learning from incidents is translated into clear, actionable messages and shared consistently across teams, supporting a continuous feedback loop between frontline staff and organisational leadership.

- The Trust has also strengthened its approach to system-level learning, with increasing use of thematic and multidisciplinary reviews to identify cross-cutting contributory factors and support coordinated improvement. This reflects a shift away from isolated incident learning towards a more proactive and insight-driven model.
- The refreshed Always Safety First Strategy (2026–2030) provides a clear framework for this work, aligning PSIRF activity with wider organisational priorities through a focus on safer culture, safer systems, and safer patients. With priorities now clearly defined, the focus moving forward is on demonstrating the impact of learning through measurable improvements in outcomes and experience for both patients and staff.
- During 2026/27, the Trust will focus on further embedding PSIRF, strengthening the use of safety data and insight, and improving how learning is translated into sustained improvement. There will be particular emphasis on evidencing change and ensuring that learning from incidents leads to safer care, improved patient journeys, and a more supportive and psychologically safe working environment for staff.
- **Key areas of focus include:**
 - Further development and maturity of the Ulysses Risk Management System to enhance reporting, oversight, and data-driven learning
 - Delivery of a comprehensive in-house PSIRF training programme to build capability, consistency, and confidence across the organisation
 - Embedding Being Fair principles to strengthen a proactive, safety-focused culture
 - Development of governance dashboards to improve visibility of performance, learning response timeliness, and key patient safety metrics
 - Implementation of refreshed PSIRF Local Priorities, Plan and Policy, aligned to the Always Safety First Strategy
 - Strengthening the validation, tracking, and impact assessment of safety actions, ensuring learning leads to measurable and sustained improvement
 - Enhancing triangulation of safety intelligence, bringing together incidents, complaints, claims, audits, and patient experience
 - Increasing the use of thematic, multidisciplinary, and system-level reviews to support deeper insight and coordinated improvement
 - Strengthening the incorporation of health inequalities within patient safety analysis and improvement activity
 - Enhancing support for patients, families, and staff, ensuring compassionate engagement and meaningful involvement throughout
- The Trust will also explore the use of advanced analytical approaches, including tools to support the analysis of large volumes of safety data, to identify emerging risks and opportunities for improvement.

3. PSIRF Policy, Plan and Local Priorities

- 3.1** During 2025/26, the Trust undertook a comprehensive review of its patient safety profile, drawing on incident data, thematic reviews, complaints, claims, and wider safety intelligence. This has informed the development of a refreshed set of PSIRF Local Priorities, aligned to the Always Safety First Strategy and shaped through engagement with clinical and corporate teams.

- 3.2** In parallel, the PSIRF Policy and Plan have been updated to reflect organisational learning, increased maturity, and national expectations. Key updates include strengthening the focus on safety culture, introducing the Being Fair approach and supporting its ongoing embedding across the organisation, aligning with the Always Safety First Strategy, and clarifying the application of proportionate learning responses.
- 3.3** This review reflects national expectations that PSIRF arrangements remain dynamic, focused, and informed by safety intelligence. It has resulted in a smaller number of more clearly defined priorities, ensuring that learning is targeted where it will have the greatest impact on patient safety outcomes.
- 3.4** Consultation on the local priorities has been completed and was presented to the Safety and Quality Committee in May. The Committee was asked to endorse the refreshed priorities alongside the updated PSIRF Policy and Plan. It should be noted that consultation on the Policy and Plan is running concurrently with this submission; any amendments arising will be reported verbally to the Trust Board in June 2026. Subject to Board approval, the documents will then proceed to the ICB for final approval.

4. Financial implications

- 4.1** None

5. Legal implications

- 5.1** PSIRF remains a contractual requirement under the NHS Standard Contract. Some incidents may result in legal claims, and the Trust must ensure timely and high-quality Duty of Candour processes to avoid potential enforcement action by the CQC. The Trust must also be mindful of new Coroner Directions Orders, which set more prescriptive timeframes for evidence submission and may impact PSIRF timelines.

6. Risks

- 6.1** The Trust continues to manage key patient safety risks through established governance processes, informed by learning from incidents, thematic reviews, and wider safety intelligence.
- 6.2** Current risks reflect the key themes identified within this report, including patient pathway tracking, delayed diagnosis (particularly cancer pathways), digital system limitations, and the ongoing risk of Never Events. These are supported by targeted improvement programmes and system-level actions.
- 6.3** Significant progress has been made in mitigating a number of risks during 2025/26, including improvements in thrombectomy access, endoscopy capacity, and infection prevention. This demonstrates the Trust's approach to translating learning into measurable improvement.
- 6.4** However, ongoing risks remain in relation to:
- Variability in patient pathway tracking and follow-up processes
 - Reliability and integration of digital systems
 - Consistency in application of safety-critical processes (including LocSSIPs)
 - Demand, capacity and workforce pressures impacting timely delivery of learning responses

7. Impact on stakeholders

- 7.1** There may be a negative impact on patients, families and staff who are affected by serious incidents. The findings of investigations together with the recommended corrective actions are always offered

to be shared with the patient and family. Staff are also supported following the incident, during the investigation and after the investigation as concluded, should this be required.

8. Recommendations

8.1 It is recommended that the Safety and Quality Committee:

- i. Receive the PSIRF Annual Report and confirm assurance on the management of incidents;
- ii. Approve the refreshed PSIRF Local Priorities and associated PSIRF Plan and Policy (see Appendix 1, 2 and 3).

Appendix 1 - Current PSIRF local priorities and agreed new local priorities

No	Current PSIRF Local Priorities	Number of PSIRs predicted per year as per the PSIRF Plan	Number of PSIRs commissioned since Nov 23
1.	Delayed recognition of a deteriorating patient (including maternity)	5	3
2.	Delayed/missed cancer diagnosis	5	0
3.	Prescribing or administration error or near miss of anticoagulant medication	5	1
4.	Adverse discharge due to communication gaps	5	1
5.	Delay in responding to critical pathology findings	5	0

Although fewer PSIRs were commissioned than anticipated, this has been mitigated through alternative learning responses, including thematic reviews focused on local priorities (details of these have been shared with the Safety and Quality Committee and have informed some of the Always Safety First Strategy Priorities).

Suggested new PSIRF Local Priorities

Proposed PSIRF Local Priorities and examples		
1.	<i>Patients remaining in inappropriate care settings leading to deterioration</i>	• Mental health patients remaining in emergency departments or assessment units because no suitable mental health bed is available. • Patients placed in temporary or overflow areas that lack the suitable requirements for their condition. • Children or young people cared on adult wards, resulting in unmet specialist needs.
2.	<i>Care not personalised for patients with specific vulnerabilities</i>	• Patients with learning disabilities, autism, or mental health needs who are not provided with appropriate sensory, psychological, or behavioural support • Patients with dementia, or cognitive impairment requiring enhanced support • Individuals lacking capacity and advocacy
3.	<i>System-level failures across pathways, interfaces and handovers</i>	• Delays or errors in cancer or non-cancer tracking pathways • System level incidents occurring at pathway interfaces or with parallel care pathways • Pathway-related incidents across multiple points of care
<i>Additional Category: Emerging Risks</i>		A category to capture new, evolving, or not yet well-defined risks that require early visibility and monitoring.

See Appendix 3 PSIRF Plan for more information on how these priorities were identified.



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AMENDMENT HISTORY				
Version No.	Date of Issue	Page/Selection Changed	Description of Change	Review Date
1.0	19 th October 2023	New Policy	New Policy	New Policy
1.1	16 th October 2024	Addendum throughout policy	Policy updated to reflect revised PSIRF meetings, updated training and resource approach in line with national standards (including removal of mandatory Band 8a for	30 November 2027

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			leading learning responses), expanded MDT definition, and minor editorial amendments.	
2.0	TBC	Addendum throughout policy	Updated to reflect the refreshed Trust Strategy, service information, revised priorities and timeframes, introduction of Rapid Learning Reviews, and refreshed governance arrangements.	

Does this document meet the requirements of the Equality Act 2010 in relation to Race, Religion and Belief, Age, Disability, Gender, Sexual Orientation, Gender Identity, Pregnancy & Maternity, Marriage and Civil Partnership, Carers, Human Rights and Social Economic Deprivation discrimination? **Yes**

Document for Public Display: **Yes**

Evidence reviewed by Library Services 22/05/2026

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1.0 Purpose

This policy supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF) and sets out Lancashire Teaching Hospitals NHS Foundation Trust's approach to developing and maintaining effective systems and processes for responding to patient safety events and issues for the purpose of learning and improving patient safety.

Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have, or did, harm one or more patients.

The PSIRF replaced the Serious Incident Framework (SIF), (2015) at the Trust in November 2023. The PSIRF makes no distinction between "patient safety incidents" and "serious incidents". It removes the "serious incidents" classification and the threshold for it. Instead, the PSIRF promotes a proportionate approach to responding to patient safety events by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

The PSIRF is not a different way of describing what came before; it fundamentally changes how the NHS responds to patient safety events for learning and improvement.

The PSIRF advocates a co-ordinated and data-driven response to patient safety events. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- compassionate engagement and involvement of those affected by patient safety events,
- application of a range of system-based approaches to learning from patient safety events,
- considered and proportionate responses to patient safety events and safety issues,

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- supportive oversight focused on strengthening response system functioning and improvement.

This policy should be read in conjunction with our current patient safety incident response plan ([PSIRP](#)), which is a separate document setting out how this policy will be implemented.

2.0 Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across or involving **Lancashire Teaching Hospitals NHS Foundation Trust**.

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error,' are stated as the cause of an incident.

Where other processes exist with a remit of determining liability or to apportion blame, preventability or cause of death, their principal aims differ from that of a patient safety response which is conducted for the purpose of learning and improvement. Such processes as those listed below are therefore outside of the scope of the policy.

- claims management,
- investigations into employment concerns,
- professional standards investigations,
- information governance concerns,
- estates and facilities concerns,
- financial investigations and audits,
- safeguarding concerns,
- coronial inquests and criminal investigations,
- complaints (except where a significant patient safety concern is highlighted).

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For clarity, whilst the Trust considers these processes as separate from any patient safety investigation, the Trust acknowledges that during the process of conducting a patient safety investigation, the Trust may identify the need to initiate another type of response. Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response. The Trust also recognises that there may be some overlap in these processes when engaging with patients, families, carers and staff and will endeavour to ensure a streamlined approach to create a positive experience and reduce unnecessary distress.

3.0 Our patient safety culture

3.1 Always Safety First

In 2021, Lancashire Teaching Hospitals NHS Foundation Trust introduced its first Always Safety First Strategy (2021-2024). This marked the introduction of the 'Always Safety First' philosophy and mindset which made patient safety everyone's priority.

The Trust Board leads this commitment, ensuring that patient safety is embedded in how the organisation is run, how decisions are made and how services are improved. The Board provides oversight through established governance processes, including the Safety and Quality Committee, maintaining visibility of safety risks across the organisation and ensuring that learning and improvement are prioritised at the highest level. Through this approach, the Board maintains a clear line of sight from ward to Board and provides visible leadership and accountability for patient safety.

The first strategy established strong foundations for safer care. It introduced a shared understanding of patient safety, strengthened the involvement of patients and families, and supported the development of a more open and transparent culture where staff feel able to speak up and learn. It also established key elements of safety governance, surveillance and learning systems, supporting the Trust's transition towards a more systematic, organisation-wide approach to patient safety.

Building on this foundation, the Trust has introduced the Always Safety First: Safety and Learning Strategy (2026–2030). This represents a significant evolution in our approach.

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While the original strategy focused on establishing systems and processes, the new strategy places a stronger and more explicit emphasis on safety culture, behaviours and the conditions required for learning and improvement, recognising that sustainable improvements depend on both reliable systems and psychologically safe teams.

The strategy aligns with national frameworks, including the NHS Patient Safety Strategy and the Patient Safety Commissioner Principles ensuring that the Trust's approach reflects national expectations and best practice in patient safety.

The strategy is built around three key areas:

- Safer Culture – creating a supportive, open and fair environment where staff feel confident to speak up
- Safer Systems – designing care processes that are reliable and reduce variation
- Safer Patients – ensuring care is safe, personalised and equitable for everyone

These are supported by:

- insight – improving understanding of safety, patient experience and involvement by listening and drawing insights from multiple sources of information,
- involvement – to equip patients, colleagues and partners with the skills and opportunities to improve safety and patient experience throughout the whole system,
- improvement – to design and support improvement programmes that deliver effective and sustainable change.

Together, this approach supports a shift from reacting to incidents towards building a system where learning is continuous, improvement is embedded in everyday practice and patient safety is at the centre of all activities.

The Trust takes a proactive approach to safety through the regular review of safety information, including incidents, risks, patient experience, complaints, audit findings and clinical outcomes. This intelligence is used to identify priorities and inform improvement activity, which is co-designed with staff and patients and delivered through collaborative working across teams and services.

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Continuous improvement is embedded as a way of working across all levels of the organisation. Teams are supported to understand problems, test changes safely and implement improvements using structured approaches aligned to the Trust's improvement methodology.

A compassionate, just and psychologically safe culture underpins this work. The Trust applies Being Fair principles to ensure staff are supported appropriately following patient safety incidents, with a focus on learning rather than blame.

Openness and transparency with patients, families and carers are fundamental to this approach and are delivered in line with the Trust's Being Open Policy and Duty of Candour requirements.

3.2 Patient Experience and Involvement

Improving patient experience is a key ambition for the Trust and an important part of a positive safety culture. Listening to, and acting on, feedback from patients, families and carers is central to achieving this. This includes seeking the views of diverse patient groups, particularly those with protected characteristics, and recognising the importance of understanding how different experiences and needs can intersect.

The Patient Experience and Involvement Group, made up of governors, patient representatives, carers, voluntary sector organisations and staff, provides oversight and assurance to the Trust's Safety and Quality Committee. This helps ensure that patient feedback is used effectively to inform improvements in care.

3.3 Reporting Culture

The Trust promotes a culture where staff are actively encouraged to report patient safety events openly, promptly and without fear of blame or retribution. Reporting is seen as a positive action that supports learning and improvement.

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All patient safety incidents are recorded using the Trust's Ulysses incident reporting system, which supports timely reporting, consistent data capture and effective tracking of actions and learning.

The Trust also supports staff to raise concerns through Freedom to Speak Up channels, ensuring there are multiple routes for staff to voice concerns safely.

Staff are encouraged to come together to understand what has happened, who was affected and what needs to be done to put things right. Reporting is viewed as a learning opportunity to prevent similar events from recurring.

This approach supports psychological safety, ensuring staff feel confident to speak up, knowing they will be listened to and supported. By focusing on learning when things go wrong, the Trust promotes a culture that leads to safer care, improved patient outcomes and better staff wellbeing.

3.4 Being Fair

As a learning organisation, the Trust is committed to fostering a compassionate, inclusive and psychologically safe culture. This underpins the ongoing development of a high-quality, safe patient care system and a fair learning culture.

The Trust has adopted the principles of 'Being Fair', replacing the NHS England Just Culture Guide. The Being Fair Tool is designed to support fair and compassionate decision-making following patient safety incidents, particularly where concerns arise about an individual's conduct or fitness to practise.

This approach supports the principles of the PSIRF by ensuring that responses to patient safety incidents focus on understanding systems and learning, rather than attributing blame.

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Responses to incidents are proportionate to the learning need, rather than applying a one-size-fits-all investigation approach.

A 'Fair and Restorative Culture' recognises that actions of staff involved in a patient safety event should not automatically be examined using the 'Being Fair Tool' but that it can be a useful tool if a learning response indicates a concern about an individual.

The Trust aims to do this through embracing change in how we support our staff members through an event with a compassionate and fair approach, ensuring there is no focus on blame or punitive measures for individuals involved. The Trust encourages working collaboratively across services and teams to ensure a supportive and fair approach in the management of safety events that is consistent across all areas and teams.

The Trust is committed to promoting a fair and restorative culture to its learning response methodology and will explore the full range of factors which may have contributed to the situation to fully understand what has happened in order to learn from patient safety events, ensure the right support is provided to staff and to prevent harm in the future.

In this context the wellbeing of our workforce is paramount and as such staff involved in safety events will be signposted to our Health and Wellbeing Service, which includes a Psychological Wellbeing Service.

Although staff should feel confident reporting patient safety events, it is recognised that reporting concerns may be difficult and a stressful process. Therefore, the Trust does have other routes where concerns can be raised and is summarised in the flow chart in [Appendix 1](#).

3.5 Safety Training

In recognising the vital role staff play in speaking up, the Trust introduced 'Speak Up – Core Training' via the Trusts E-learning platform for all staff, including bank and agency staff. This mandatory training was introduced in May 2023 to raise awareness of the

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support available for staff to raise concerns and to encourage a healthy speaking up culture for the benefit of patients and workers.

This training is supported by a range of other safety training across the organisation, including the Level 1 Essentials of Patient Safety E-learning Training, which focusses on the essentials for creating patient safety. The training is mandated for all staff, including bank and agency staff and includes the following content:

- listening to patients and raising concerns,
- the systems approach to safety, where instead of focusing on the performance of individual members of staff, we try to improve the way we work,
- avoiding inappropriate blame when things do not go well,
- creating a Being Fair culture that prioritises safety and is open to learning about risk and safety.

Board and Senior Leadership Teams are also expected to complete the Level 1 Essentials of Patient Safety for Boards and Senior Leadership Teams E-learning Training. The session builds on the 'Essentials of Patient Safety for All' session and introduces patient safety measurement, monitoring, and governance for patient safety for Boards and Senior Leaders. It also focuses on Board opportunities and responsibilities in patient safety, human and financial costs, and safety aspects.

A wide range of multi professional senior leaders have had bespoke training on Safety II, which considers variations in everyday performance to understand how the organisation can learn from things that have gone well.

The Trust's Safety and Learning Team have also delivered bespoke Training for Consultants, Senior leaders and Governance Teams. This includes training on:

- recognising and responding to safety concerns
- understanding systems and human factors
- applying 'Being Fair' principles
- contributing to learning and improvement processes

3.6 Learning From Patient Safety Events

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The Trust uses the Learn from Patient Safety Events (LFPSE) system, a national NHS system for the recording and analysis of patient safety events, integrated with Ulysses, to support learning both locally and nationally.

This system enables the Trust to share patient safety events in real time with the national Patient Safety Team, contributing to system-wide learning and improvement. It also supports transparency by enabling appropriate access for regulators to patient safety data.

The system supports improved understanding of safety events by capturing information about perceived physical and psychological harm, as well as the level of concern expressed by the reporter. This enhances the quality of data available for learning and analysis.

The LFPSE system is designed to support the identification of patterns, themes and emerging risks, enabling earlier action to improve patient safety.

Learning from patient safety events is shared across the organisation and used to inform improvement activity, ensuring that insights lead to meaningful and sustained changes in practice.

3.7 Working collaboratively.

Delivery of the Always Safety First Strategy involves input from a wide group of individuals including:

- Patient Safety Specialists.
- Patients, families and carers, visitors and partners and advocacy services.
- Clinical Specialities and frontline teams
- Divisional Leadership teams
- Education and Training
- Organisational Development

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- Human Factors Specialists
- Governance Professionals
- Digital and technology
- Research and innovation
- Continuous Improvement
- Medicines Safety Officer
- Medical Examiner and Mortality
- Safeguarding, Mental Health, Learning Disability and Autism

This collaborative approach supports a culture of shared ownership, continuous learning and improvement, ensuring that patient safety is everyone's responsibility.

3.8 Testing our Safety Culture

The Trust is committed to continuously understanding and improving its safety culture. A positive safety culture is essential to delivering safe, high-quality care and supporting staff to speak up, report concerns and engage in learning.

To assess and strengthen safety culture, the Trust uses a range of information sources and approaches, including:

- Staff feedback and surveys, including the NHS Staff Survey and local pulse surveys, to understand how safe and supported staff feel and whether they feel confident to speak up
- Patient safety data, including incident reporting trends, themes and patterns, to identify variation in reporting behaviours and safety outcomes
- Patient and family feedback, to understand experiences of care and identify opportunities for improvement
- Freedom to Speak Up data, providing insight into staff confidence, concerns raised and organisational response
- Quality and safety metrics, including clinical outcomes, complaints and audit findings

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This information is triangulated to provide a comprehensive understanding of safety culture across the organisation, enabling the identification of both strengths and areas for improvement.

The Trust also benchmarks its performance against other organisations and uses external review to support shared learning and the adoption of best practice.

Findings are reviewed through governance structures, including divisional forums and the Safety and Quality Committee. This ensures that themes are identified, actions are taken and progress is monitored over time.

The Trust is committed to acting on this insight to strengthen psychological safety, improve staff experience and ensure that patient safety is continuously improved. This maintains a clear and ongoing understanding of its safety culture and can take timely action to strengthen it where required.

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4.0 Patient Safety Partners

The Trust has fully embedded the national Patient Safety Partner (PSP) model as a key component of its approach to delivering PSIRF. PSPs ensure that the voices of patients, families and the public are central to how the Trust understands, learns from and improves patient safety.

The Trust appointed its first cohort of three PSPs in November 2023. These individuals patients, carers and members of the public played an important role in establishing patient partnership within safety governance and learning processes. Their tenure concluded in July 2025, marking a significant milestone in embedding meaningful involvement within the Trust's patient safety approach.

A second cohort of PSPs was appointed in December 2025, ensuring continuity of the role and enabling further development of patient and public involvement in safety. The transition between cohorts provided an opportunity to reflect on learning from the initial implementation, strengthen role clarity and improve how PSPs are supported and integrated into the Trust's safety infrastructure.

Under PSIRF, the involvement of patients and families is a core principle. PSPs support this by ensuring that patient perspectives are actively incorporated into learning responses, governance processes and improvement activity.

PSPs are core members of key forums, including:

- the PSIRF Oversight Panel
- the Patient Experience and Involvement Group

Through their participation, PSPs contribute to:

- providing independent and constructive challenge
- shaping how the Trust understands safety events and risks
- influencing decision-making and improvement priorities
- ensuring that learning reflects what matters most to patients and families

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Beyond formal governance, PSPs support a wide range of safety activity across the organisation, including:

- contributing to patient safety improvement programmes (e.g. pressure ulcers, falls and medication safety)
- participating in recruitment panels for patient safety and quality roles
- attending safety walk-rounds and reviews following serious incidents to provide patient-centred insight
- contributing to the development and review of patient-facing information and communication materials

PSPs also play an important role in supporting the delivery of the PSIRP including contributing to the identification and review of local priorities.

PSPs will continue to support delivery of the Always Safety First: Safety and Learning Strategy by ensuring that patient voice is consistently embedded across strategic priorities and improvement workstreams.

Through the PSP role, the Trust strengthens its commitment to openness, transparency and meaningful involvement, ensuring that learning is informed by the experiences of those who use its services and that improvements are shaped in partnership with patients and communities.

5.0 Addressing Health Inequalities

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them.

The Trust recognises that at both a national and local level the NHS has a pivotal role in reducing health inequalities through a focus on:

- providing equity of access to healthcare services,
- providing equity of experience of healthcare services,
- providing equity of outcomes from healthcare services.

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The conditions in which we are born, grow, live, work and age can impact our health and wellbeing. These are sometimes referred to as wider or social determinants of health.

Wider determinants of health are interconnected and can significantly impact an individual's health and ability to access care. As a result, some groups are more likely to experience poorer health outcomes and barriers to accessing services, including those living in areas of deprivation, people from Black, Asian and minority ethnic communities, and other inclusion health groups such as those experiencing homelessness or social vulnerability.

The Trust serves a population with significant levels of deprivation and long-term health conditions, and recognises the need to take a targeted and system-wide approach to reducing inequalities.

As an anchor institution, the Trust plays an important role in improving the health and wellbeing of the communities it serves. The Trust's approach to health inequalities is informed by its Health Improvement Plan and aligned to system-wide priorities across Lancashire and South Cumbria.

This includes a focus on prevention and early intervention, improving access and reducing barriers to care, addressing wider determinants of health, strengthening health literacy and communication, working in partnership with system and community organisations

The Trust adopts a population health approach, using data, insight and engagement to identify groups most at risk and target improvement activity where it will have the greatest impact.

The Trust is committed to improving how it captures and uses data to understand and address health inequalities.

Patient demographic information is recorded through electronic systems and strengthened through the Learn from Patient Safety Events (LFPSE) system, enabling better understanding of how patient safety events may affect different population groups.

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This supports the identification of variation in safety, experience and outcomes, improved understanding of risk across different groups and development of targeted improvement initiatives.

The Trust continues to strengthen its data capability, including the development of health inequalities dashboards, to support decision-making and governance.

In our response toolkit, we will continue to consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.

The Trust uses the national Core20PLUS5 approach to support targeted action on health inequalities. This focuses on the most deprived 20% of the population, additional locally identified groups at risk, key clinical areas requiring improvement. The Trust works collaboratively with system partners, including the Integrated Care System, local authorities and community organisations, to deliver targeted interventions that improve access, experience and outcomes for those most at risk.

The Trust is also engaging with organisations from across the ICS including the voluntary sector to work collaboratively to reduce health inequalities. Examples include, working with primary care networks, participation in local conferences for system partners and participation in place based boards.

By establishing our local priorities, plan and policies aligned to the PSIRF we will work to triangulate intelligence, ensuring that potential inequalities are considered. Where data suggests additional areas for improvement this will be aligned to future PSIRF plans and this policy. As a Trust we are aware that data continuously provides up-to-date intelligence in association with addressing health inequalities and therefore the use of our incident management system, aligned to patient characteristics and local intelligence, is pivotal to supporting health equality and the reduction of inequalities.

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The Trust is committed to ensuring that patients, families and carers are able to participate fully in their care and in patient safety processes. This includes provision of interpretation and translation services, accessible information formats, including Easy Read and reasonable adjustments to meet individual needs. This approach helps ensure equitable involvement in care and learning from patient safety events.

The Trust is committed to providing fair, inclusive and non-discriminatory care to all patients, families, carers and staff. This includes meeting its statutory responsibilities under the Equality Act 2010. This commitment is led by the Trust Board and supported by the Equality and Inclusion Strategy. It underpins all patient safety, improvement and cultural development work across the organisation.

6.0 Engaging and involving patients, families and staff following a patient safety event

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety events (including patients, families and staff).

This involves working with those affected by patient safety events to understand and answer any questions they have in relation to the incident and signpost them to support as required.

We are committed to continuous improvement throughout the services we provide. We want to learn from any event where care does not go as planned or expected by our staff, patients, their families, carers, and other organisations.

6.1 Patient and Family Liaison

Getting involvement right with patients and families in how we respond to safety events is crucial, particularly to support improving the services we provide. Part of this involves our key principle of being open and honest whenever there is a concern about care not being as planned or expected or when a mistake or an omission in care has been made.

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The Trust complies with the statutory Duty of Candour, which requires organisations to be open and transparent with patients and families when a notifiable patient safety incident has occurred. This is a key component of the Trust's Being Open Policy and underpins all engagement with patients and families.

Where Duty of Candour applies, the Trust will:

1. Tell the person/people involved (including family where appropriate) that the patient safety incident has taken place.
2. Apologise. For example, "we are very sorry that this happened."
3. Provide a true account of what happened, explaining whatever you know at that point.
4. Explain what else you are going to do to understand the events. For example, review the facts and develop a brief timeline of events.
5. Follow up by providing this information, and the apology, in writing, and providing an update. For example, talking them through the timeline.
6. Keep a secure written record of all meetings and communications.

The Trust promotes openness and transparency for all patient safety incidents, not only those meeting the statutory Duty of Candour threshold, as this is fundamental to building trust and supporting learning. Further details are included in the Trust's Being Open Policy.

It is expected that an 'Engagement Lead' is appointed following each incident. This would be a senior member of staff or a member of our multi-professional governance team who is nominated to be the key contact for communication with patients, families and carers during a patient safety incident review.

6.2 The Patient Experience and Patient Advice and Liaison Service

The Trust has a Patient Experience and Patient Advice and Liaison Service (PALS). Our Patient Experience and PALS work with patients to find solutions early in patient

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pathways that contribute towards avoiding safety events and reducing the need to complain, accepting that when this occurs, we have failed to take the action required to prevent an adverse experience. People with a concern, comment, complaint or compliment about care or any aspect of the Trust services are encouraged to speak with a member of the care team. Should the care team be unable to resolve the concern then PALS can provide support and advice to patients, families, carers, and friends.

Our Patient Experience and PALS team provide confidential support to patients, their families and carers and can:

- Actively listen and respond to concerns, suggestions or queries to help improve patients' experiences.
- Provide information on NHS Services.
- Offer advice on the NHS Complaints process and provide information on how to seek independent advice if you wish to make a complaint.
- Feedback views to relevant staff, including the Chief Executive.
- Help the organisation learn from feedback and concerns to improve your experience.

Our Patient Experience and PALS team can be contacted Monday to Friday, 9am – 4pm (excluding Bank Holidays). The team can be contacted by calling 01772 522972 or emailing PALS@lthtr.nhs.uk.

Further information about how to raise a concern or complaint can be found on our [website](#).

6.3 Information resources for patients, families and carers

The information provided to patients and their relatives has also been reviewed with new resources created, including a new PSIRF page on the Trust's website along with a series of public facing PSIRF resources to make it easy for patients, families and their carers to understand PSIRF and our local priorities. These resources have been developed in conjunction with the Trust's Patient Experience and Involvement Group and other

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advocacy groups who have contributed to the design and development of these resources.

6.4 National sources of support

We recognise that there might also be other forms of support that can help those affected by a patient safety incident and will work with patients, families, and carers to signpost to their preferred source for this. The table below provides an overview of the additional support available:

Support Available	Link	Detail
Help is at Hand – For those Bereaved by Suicide	https://supportaftersuicide.org.uk/resource/help-is-at-hand/	This guidance is specifically for those bereaved by suicide and offers practical support and guidance to those who have suffered loss in this way.
Mental Health Homicide Support	NHS England – London >> Mental health homicide support	This guidance is aimed at staff and families. This information has been developed by the London region's independent investigation team in collaboration with the Metropolitan Police. It is recommended that, following a mental health homicide or attempted homicide, the principles of the duty of candour are extended beyond the family and carers of the person who died, to the family of the perpetrator and others who died, and to other surviving victims and their families.

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Child Death Support	Grieving for a child of any age Child Bereavement UK Bereavement support after the death of a baby or child – The Lullaby Trust	Both sites offer support and practical guidance for those who have lost a child in infancy or at any age.
Complaint's Advocacy	VoiceAbility NHS complaints advocacy	The NHS Complaints Advocacy Service can help navigate the NHS complaints system, attend meetings and review information given during the complaints process.
Healthwatch	https://www.healthwatch.co.uk/ You can find your local Healthwatch from the listing (arranged by council area) here: https://www.healthwatch.co.uk/your-local-healthwatch/list	Healthwatch are an independent statutory body who can provide information to help make a complaint - including sample letters.
Parliamentary and Health Service Ombudsman	https://www.ombudsman.org.uk/	The Parliamentary and Health Service Ombudsman makes the final decisions on complaints patients, families and carers deem not to have been resolved fairly by the NHS in England, government departments and other public organisations
Citizens Advice Bureau	https://www.citizensadvice.org.uk/	The Citizens Advice Bureau provides UK citizens with information about healthcare rights, including how to make a

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		complaint about care received.

6.5 Supporting staff following Patient Safety Events

The Trust is committed to the principles of the NHS Being Fair Tool for ensuring the fair, open and transparent treatment of staff who are involved in patient safety events. The Trust recognises the significant impact being involved in a patient safety event can have on staff and will ensure staff receive the support they need to positively contribute to the review of the incident and continue working whilst this takes place.

All staff with knowledge of the events being reviewed are encouraged to actively participate in learning responses. That may be through submitting written information, joining a debrief meeting or a one-to-one conversation with the incident review team. Review teams will agree with staff the timescales for feedback of progress and findings in accordance with the type of review method being utilised. All contact with staff will involve the collection of their account of the events along with their views and opinions on how systems can be improved.

When a colleague reports a patient safety event or is providing their insights into the care of a patient for an investigation, the Trust will actively encourage a safe space to discuss the events, explore the system in which they work and listen openly without judgement, using the nationally recognised National Patient Safety Agency (NPSA) Being Fair Tool to ensure fair and equitable treatment when undertaking learning responses.

Local managers, with support from our multi-professional governance teams, will advise and signpost staff involved in patient safety events to the most appropriate information about the patient safety incident review process and further support functions.

There are a variety of psychological interventions available for staff at the Trust through the Trust's Health and Wellbeing Service, which includes a Psychological Wellbeing Service. Information on how to access these services can be found in the **Trust's Work Related Incidents and Staff Debrief and Support Policy**.

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The Trust's Freedom to Speak Up Guardian also provides a confidential service for staff if they have concerns about the organisation's response to a patient safety event. [Appendix 1](#) within this document describes how staff can raise concerns to the Freedom to Speak Up team.

Second Victim (<https://secondvictim.co.uk>) is a website resource for healthcare staff and managers involved in patient safety events.

6.6 Information resources for staff

The Trust provides a range of resources to support staff in understanding their role in patient safety and PSIRF. These include policies, procedures and guidance, training and development opportunities, communication through governance and professional forums

Information is shared through established governance routes, organisational communications and structured engagement programmes to ensure staff are supported and informed.

The Trust remains committed to ongoing engagement with staff to support the implementation of PSIRF and the continuous development of its patient safety approach.

7.0 Patient safety incident response planning

The PSIRF supports organisations to respond to patient safety events and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety events relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

The Trust will take a proportionate approach to its response to patient safety events to ensure that the focus is on maximising improvement. To fulfil this, we will undertake planning of our current resource for patient safety response and our existing safety improvement workstreams. We will identify insight from our patient safety and other data sources both qualitative and quantitative to explore what we know about our safety position and culture.

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Our PSIRP details how this has been achieved, as well as how the Trust will meet both national and local focus for patient safety incident responses and any specific contractually required variations to these.

7.1 Resources and training to support patient safety incident response

The Trust has governance arrangements in place to ensure that learning responses are not led by staff who were involved in the patient safety incident itself or by those who directly manage those staff.

Responsibility for the proposal to designate leadership of any learning response sits within the senior leadership team of the relevant Division and the Trust Safety and Learning Team. A learning response lead is nominated by the Division, and the individual should have an appropriate level of seniority and influence within the Trust, this may depend on the nature and complexity of the incident and response required-.

The Trust will have governance arrangements in place to ensure that learning responses are not undertaken by staff working in isolation. Divisional leadership leads will manage the selection of an appropriate learning response lead to ensure the rigour of approach to the review and will maintain records to ensure an equitable allocation. The Trust Safety and Learning team will support learning responses wherever possible and can provide advice on cross-system and cross-divisional working where this is required.

Those staff affected by patient safety events will be afforded the necessary managerial support and be given time to participate in learning responses. All Trust managers will work within our being fair principles and utilise other teams such as Health and Wellbeing to ensure that there is a dedicated staff resource to support such engagement and involvement. Divisions will have processes in place to ensure that managers work within this framework to ensure psychological safety.

The Trust will utilise both internal and, if required, external subject matter experts with relevant knowledge and skills, where necessary, throughout the learning response

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process to provide expertise (e.g., clinical, or human factors review), advice and proofreading.

7.2 Training

The Trust recognises that meaningful learning and improvement following a patient safety event can only be achieved if supportive systems and processes are in place. To do this effectively, appropriate training and education will be provided to staff to ensure safety events are investigated in line with PSIRF guidance and the experiences of those affected by patient safety events is managed in line with best practice.

The Trust has committed to ensuring that we fully embed the PSIRF and meet its requirements. We have therefore used the NHS England Patient Safety Response Standards (2026) to frame the resources and training required to allow for this to happen.

The Trust has already implemented a series of patient safety training packages to ensure that all staff are aware of their responsibilities in reporting and responding to patient safety events and to comply with the NHS England Health Education England Patient Safety Training Syllabus as follows:

Level 1 - Essentials of Patient Safety	The Trust provides Essentials of Patient Safety for all training via the Trusts E-learning platform. It is a mandated training requirement for all staff, including substantive, bank and agency staff and focuses on the essentials for creating patient safety. The content includes: • listening to patients and raising concerns. • the systems approach to safety, where instead of focusing on the performance of individual members of staff, we try to improve the way we work. • avoiding inappropriate blame when things do not go well. • creating a fair culture that prioritises safety and is open to learning about risk and safety.

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Level 1 - The Essentials of Patient Safety for Boards and Senior Leadership teams	The session builds on the Essentials of Patient Safety for All' session and introduces patient safety measurement, monitoring, and governance for patient safety to Board and Senior Leaders. It is mandated training requirement for all staff 8a and above or equivalent including middle grade medical staff, Consultants and Board members and captures the following: • The human, organisational and financial costs of patient safety • The benefits of a framework for governance in patient safety • Understanding the need for proactive safety management and a focus on risk in addition to past harm • Key factors in leadership for patient safety • The harmful effects of safety events on staff at all levels. The training can be accessed via the Trust's E-learning platform.

As part of the Trust's Training Needs Analyses all staff, including substantive, bank and agency staff are mandated to complete 'Speak Up – Core Training' via the Trust's E-learning platform.

The table below provides an overview of the specific mandated training requirements for staff involved in patient safety investigations:

Topic	Minimum Duration	Content	Learning Response Leads	Engagement Leads	PSIRF Oversight Role Leads
Systems approach to learning from patient safety events**	2 Days / 12 Hours	- Introduction to complex systems, systems thinking and human factors. - Learning response methods: including interviewing and asking questions, capturing work as done, data	Yes		-

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		synthesis, report writing, debriefs and after-action reviews. - Safety action development, measurement, and monitoring.			
Oversight of learning from patient safety incidents	1 Day / 6 Hours	- NHS Patient Safety Incident Response Framework and associated documents - Effective oversight and supporting processes - Maintaining an open, transparent and improvement focused culture - PSII commissioning and planning.			Yes
Involving those affected by patient safety incidents in the learning process**	1 Day / 6 Hours	- Duty of Candour. - Being Fair. - Being open and apologising. - Effective communication. - Effective involvement. - Sharing findings. - Signposting and support.		Yes	
Patient safety syllabus level 1: Essentials for patient safety	eLearning – mandatory for all Trust staff	- Listening to patients and raising concerns - The systems approach to safety: improving the way we work, rather than the	Yes	Yes	Yes

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		performance of individual members of staff. - Avoiding inappropriate blame when things do not go well. - Creating a Being Fair culture that prioritises safety and is open to learning about risk and safety			
Patient safety syllabus level 1: Essentials for patient safety (for boards and leadership teams)	eLearning – mandatory for board and senior leadership team	The human, organisational and financial costs of patient safety The benefits of a framework for governance in patient safety Understanding the need for proactive safety management and a focus on risk in addition to past harm Key factors in leadership for patient safety The harmful effects of safety incidents on staff at all levels			Yes
Patient safety syllabus level 2: Access to practice	eLearning - mandatory for all Trust staff	- Introduction to systems thinking and risk expertise: Human factors Safety culture	Yes	Yes	Yes
Continuing professional	At least annually	- To stay up to date with best	Yes	Yes	Yes

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development (CPD)		practice (e.g., through conferences, webinars etc.) - Contribute to a minimum of two learning responses			

Staff must be compliant with the above training requirements to fulfil their respective roles within a patient safety investigation. A training delivery plan is in place, with training compliance records being held centrally by the Trust's Education and Training team and being monitored at both Corporate and Divisional Level.

Board members will also receive specific face-to-face training from the Healthcare Services Safety Investigation Body (HSSIB) on Safety Investigation for Strategic Decision Makers and Senior Leaders in Healthcare.

****Due to availability of national accredited training programmes, 'Systems approach to learning from patient safety events' and 'Involving those affected by patient safety incidents in the learning process' training will be prioritised for those leading Patient Safety Incident Investigations. Those leading other learning responses or involved in engaging with patients and families will receive local level guidance to support them in their roles, with an intention to offer the national training more widely to these individuals when capacity permits in the future.**

7.3 Our patient safety incident response plan

Our plan sets out how **Lancashire Teaching Hospitals NHS Foundation Trust** intends to respond to patient safety events over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

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7.4 Reviewing our patient safety incident response policy and plan

Our PSIRP is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety events. We will review the plan every 12 to 18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months.

Updated plans will be published on our website, replacing the previous version.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

8.0 Responding to patient safety events

8.1 Patient safety incident reporting arrangements

All staff are responsible for recording and reporting potential or actual patient safety events on our Trust incident reporting system (Ulysses) when it is identified. This includes safety events that may have been identified during mortality or coronial processes. Further information on the reporting and management of safety events can be found in our **Adverse Incident Reporting, Management and Investigation Policy and Procedure**.

Support and advice are available from the Divisional governance teams, who will also share reminders on key timescales and support interpretation of the Trust's Standard Operating Procedures.

Divisions will highlight to the Trust Safety and Learning Team any incident which appears to meet the requirement for external referral. This will allow the Trust to work in a

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transparent and collaborative way with our ICB or regional NHS teams if an incident meets the national criteria for a Patient Safety Incident Investigation (PSII) or if supportive co-ordination of a cross-system learning response is required.

The Trust Safety and Learning Team will act as a liaison with external bodies and partner providers to ensure effective communication.

The Trust has a defined Governance Structure which details the decision-making process for patient safety incidents. This is detailed in [Appendix 2](#).

8.2 Patient safety incident response decision-making

8.2.1 Daily Triage

The Trust will have daily review mechanisms in place to ensure that patient safety events are responded to proportionately and in a timely manner and will involve a two tier approach. This will include consideration and prompting to service teams where Duty of Candour applies.

Triage – Level 1 (Divisional Level – led by the Divisional Governance Teams)	All reported patient safety events will be reviewed at the next working day's 'Daily Triage' meeting for each Division by their respective Governance Teams. All patient safety events meeting the local and national priorities will - be escalated to a weekly Trust wide PSIRF Triage meeting led by the Trust Safety and Learning Team. All other remaining patient safety events will be assessed to determine whether the event will be managed locally or whether a 'learning response' is required and a summary of decision-making presented to the weekly Trust wide PSIRF Triage meeting led by the Trust Safety and Learning Team as required
Triage – Level 2 (Trust wide Level – led by the	The Trust wide PSIRF Triage meeting will discuss decisions made by the Divisional Governance Teams and will also allow for consideration of any concerns raised via other

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Trust Safety and Learning Team)	processes (e.g., complaints, coronial processes, or safeguarding events) that may also require a learning response. The meeting will enable staff to escalate events of concern and will agree whether a safety event will be managed at a local level or agree the appropriate learning response. The group will also discuss cases for consideration of a PSII if appropriate. Events of concern will be escalated to the Trust's weekly PSIRF Oversight Panel for oversight, challenge, and support. If a safety critical event occurs outside of meeting timeframe, this will be escalated immediately to the Chief Nursing Officer, Chief Medical Officer, Associate and Deputy Associate Director for Safety and Learning and Patient Safety Specialists.

8.2.2 Learning Response Types

Learning Responses available include:

Patient Safety Incident Investigation (PSII)	A PSII offers an in-depth review of a single patient safety event or cluster of safety events to understand what happened and how. These will be undertaken using Systems Engineering Initiative for Patient Safety (SEIPS) methodology.
Multidisciplinary (MDT) Team Review	An MDT review supports health and social care teams to identify learning from multiple patient safety incidents (including incidents where multiple patients were harmed or where there are similar types of incidents). This could include incidents that occurred in the significant past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. The aim is, through open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting(s)), to agree

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	the key contributory factors and system gaps that impact on safe patient care
Rapid Learning Review (RLR)	A structured, short-cycle review used to quickly understand what happened and identify immediate learning following an incident. Typically used where timely insight is required to mitigate ongoing risk or where a full PSII is not proportionate. May include brief case review, staff discussion and early identification of contributory factors.
SWARM	The swarm huddle is designed to be initiated as soon as possible after an event and involves an MDT discussion. Staff 'swarm' to the site to gather information about what happened and why it happened as quickly as possible and (together with insight gathered from other sources wherever possible) decide what needs to be done to reduce the risk of the same thing happening in future
After action review (AAR)	AAR is a structured facilitated discussion of an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT and can be used to discuss both positive outcomes as well as safety events. It is based around four questions: 1. What was the expected outcome/expected to happen? 2. What was the actual outcome/what actually happened? 3. What was the difference between the expected outcome and the event? 4. What is the learning?
Thematic Review	A thematic review can identify patterns in data to help answer questions, show links or identify issues. Thematic reviews typically use qualitative (i.e., Incident reports,

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	Complaints data etc.) rather than quantitative data to identify safety themes and issues. Thematic Reviews can be used for multiple purposes, including: • Developing or revising our Safety Improvement Profile • Aggregating information from many diverse sources of safety intelligence datasets. • Gathering insight about gaps / safety issues across a pathway or as part of an overarching safety theme to direct further analysis • Aggregating findings from multiple incident responses to identify interlinked contributory factors to inform / direct improvement efforts. • Presenting summary data to show the impact of ongoing safety improvement work.

The Trust's weekly PSIRF Oversight Panel will ensure all safety events are assessed against the PSIRP. The PSIRF Oversight Panel will assess safety events against the focus areas and take a decision on which merit the additional resource a systems level response requires. This meeting will support the identification and dissemination of learning.

Where decision making is not clear, this will be escalated to the Chief Nursing Officer and Chief Medical Officer.

8.3 Responding to cross-system safety events/issues

As a tertiary service, the Trust is committed to taking a system wide approach to learning from patient safety events and this, on occasion, may involve working closely with other organisations.

If it is identified that a patient safety incident requires input from another organisation, this will be flagged immediately to the Trust's Safety and Learning Team. The Safety and

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Learning Team will contact the organisation in question and arrange for a cross-system review to take place.

When contacting another organisation for input into a patient safety event staff must provide the following:

- A clear rationale for involving the organisation.
- A clear explanation as to why we are making contact – This could be for information sharing purposes or for collaborative working on an investigation.
- Any questions should be clearly articulated by the staff member requesting involvement.

The Trust will also support any organisation that requires our involvement. The Safety and Learning Team will agree an appropriate response time with the partner organisation which staff across the Trust must adhere to.

The Trust will also support any organisation that requires our involvement. The Patient Safety Team will agree an appropriate response time with the partner organisation which staff across the Trust must adhere to.

Wherever possible the Trust will work collaboratively with local partners to ensure system wide learning.

As a Trust we are committed to the ICB cross organisation patient safety event operating principles which are outlined below:

- We will all commit to one learning response rather than silo working for cross organisational patient safety events. We will agree collaboratively through a multidisciplinary approach how to allocate defined roles and responsibilities across all organisations involved including leadership/oversight, co-ordination and will agree a method of escalation.
- We will ensure patient, family and staff involvement as part of cross Trust delivery of the PSIRF, ensuring co-design of a jointly owned safety culture within a well-functioning safety system.

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- We will promote openness and transparency to share concerns and allow for growth with clearly defined roles/leads for each area to promote consistency and adapt as required.
- We will be flexible and adapt our communication methods to ensure that everyone is included and has access and will encourage sharing of information and ideas, promoting kind provocation.
- We will create a safe space where we can have open and honest discussions and we will demonstrate mutual respect focussing on the collective goal embracing what other organisations can bring.
- We will provide a safe environment for all to be open/transparent to share learning from safety events.
- Compassion and empathy will underpin our approach, ensuring we provide support with kindness when interacting with patients, families, staff and colleagues.
- We will commit to being honest and disclose all relevant information. We will be upfront about challenges we have faced and what we have learned and make our goals and outcomes visible to all who are affected.
- We will agree our shared goals and the principles and values we need in place to make these happen and we will adapt as we learn and progress.
- We will actively connect and collaborate on these shared goals. To help us achieve this we will collectively create a safe, responsive space where a culture of civility and constructive feedback is the norm.
- We will continue to reflect on and respond to the lessons we learn to ensure we are continuously improving our health system at scale.

8.4 Timeframes for learning responses

Timeframes must be set where possible for all response methods. A response must start as soon as possible after an event is identified. The specific timeframe must be agreed with the patient, family or carers in line with timeframes set out in the PSIRP.

The timeframe for completing a Patient Safety Incident Investigation (PSII) should be agreed with those affected by the incident, including patients, families and carers as part

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of setting the terms of reference – assuming they are willing to be involved in that decision.

PSIIs should take no longer than 6 months and not exceed timeframes agreed with those affected. If these are exceeded processes must be reviewed to understand how timeliness can be improved.

In exceptional circumstances (e.g., when a partner organisation requests an investigation is paused), a longer timeframe may be needed to respond to an event. In this case, any extension should be agreed with those affected (patient, family, carers and staff).

The time needed to conduct a response must be balanced against the impact of long timescales on those affected by the event. This should also consider the risk that for as long as findings are not described, action may not be taken to improve safety or further checks will be required to ensure the recommended actions remain relevant.

Where external bodies (or those affected by patient safety events) cannot provide information, to enable completion within six months or the agreed timeframe, the local response leads should work with all the information they have to complete the response to the best of their ability. The response may be revisited later, should new information indicate the need for further investigative activity.

8.5 Safety action development and monitoring improvement

The Trust adopts the view that the first step when embarking on a process to learn and improve after a patient safety incident is to make efforts to understand the context and develop a deep understanding of work processes. A thorough understanding of the work system using a learning response method is therefore vital but only the first step.

Trust templates will support staff to take the next step from identifying the learning to implementation of the lessons. The final stages of investigation will therefore focus on the process for designing, implementing, and monitoring safety actions, alongside how to reduce risk and limit the potential for future harm.

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After identifying and agreeing those aspects of the system where change could reduce risk and potential for harm, learning actions to reduce risk will be generated in relation to each defined area for improvement. Following this, measures to monitor safety learning actions will be defined. The term 'areas for improvement' will be used instead of 'recommendations' to reduce the likelihood of arriving at a solution at an early stage of the safety action development process.

Understanding contributory factors and work as done should not be confused with developing safety actions. Areas for improvement set out where improvement is needed without defining how that improvement is to be achieved. Safety actions in response to a defined area for improvement depend on factors and constraints outside the scope of a learning response.

The Trust emphasises the importance of a collaborative approach throughout, including involvement of those beyond the immediate professional groups involved in the event and working closely with those with improvement expertise, particularly the Safety and Learning and Continuous Improvement Teams. The Trust is clear that imposed solutions fail to engage staff and lack sustainability as a result.

8.6 Safety improvement plans

Safety improvement plans bring together findings from various responses to patient safety events and issues. The Trust has several improvement and transformation groups in place, many of which are aligned to Always Safety First Programmes of work or Continuous Improvement workstreams and have been adapted to respond to the outcomes of improvement efforts and other influences such as national safety improvement programmes.

The Trust's PSIRP has outlined local priorities for focus or response under the PSIRF. These were developed due to the opportunity they offer for learning and improvement

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across areas where there is no existing plan or where improvement efforts have not been accompanied by reduction in risk or harm.

All final PSII reports and other learning response reports where indicated will be presented to the Trust PSIRF Oversight Panel for discussion of the improvement plan and agreement on whether 'areas for improvement' will be monitored at local or organisational level. The trust will use the outcomes from existing patient safety reviews and any relevant learning response to inform future improvement plans and Divisions and Corporate Teams will work together to ensure there is an aligned approach to development of plans and resultant improvement efforts.

In response to patient safety events where complex organisational learning and improvement is required, the PSIRF Oversight Panel will determine whether new improvement activity is needed. This may include commissioning new improvement groups or aligning learning with existing programmes of work.

The PSIRF Oversight Panel provides strategic oversight, ensuring that learning is appropriately translated into improvement activity and aligned to organisational priorities. Where improvement activity is commissioned, an appropriate group will be identified to provide operational oversight. This group will be responsible for reviewing organisational improvement plans, providing support, and ensuring that appropriate improvement methodology is applied.

Once processes are matured, the PSIRF Oversight Panel will receive assurance on PSIRF Improvement Plans relating to the Trust's Patient Safety Priorities and will receive assurance on progress against agreed learning actions and outcomes to ensure effective improvements are implemented and sustained. Where necessary, if factors relating to culture and leadership are identified, the PSIRF Oversight Panel will work with the workforce and organisational development or appropriate colleagues to triangulate or identify new learning.

This will also enable Trust-wide lessons to be identified and agreement made on how best to facilitate cascade of relevant information across the Trust. This may include the

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use of Always Safety-First Bulletins or learning through corporate governance meetings, Divisional Always Safety First meetings, Divisional Safety and Quality meetings, Speciality Governance meetings, Ward meetings, Safety Huddles and a range of improvement groups. This may begin from the point a patient safety incident is reported.

Where appropriate, local monitoring of actions via audit should be considered when improvement plans are complete, to ensure that changes are embedded and continue to deliver the desired outcomes.

9.0 Oversight roles and responsibilities

The leadership and management functions of PSIRF oversight are wider and more multifaceted compared to previous response approaches. When working under PSIRF, organisations are advised to design oversight systems to demonstrate improvement rather than compliance with centrally mandated measures.

The Trust will work with partners to develop a local board-led and commissioner and integrated care system assured architecture around investigations and seek alternative responses to patient safety events, which promote ownership, rigour, expertise and efficacy. The Trust will adhere to NHS England's specification on oversight roles and responsibilities.

9.1 Roles and responsibilities

In order to meet these ambitions, the Trust has identified a number of key internal roles and responsibilities:

Role	Responsibility
Chief Executive Officer	The Chief Executive Officer has the ultimate responsibility for all aspects of patient safety which includes the management of safety events. This includes ensuring that appropriate structures are in place to enable appropriate investigation,

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	analysis and learning and ensuring resources are available to comply with this policy. The Chief Executive is responsible for the provision of appropriate policies and procedures for all aspects of health and safety (Health and Safety at Work Act 1974).
Chief Nursing Officer/Deputy Chief Executive Officer	The Chief Nursing Officer is the Executive Lead for PSIRF and responsible for ensuring the organisation meets national patient safety incident response standards. The Executive Lead will ensure PSIRF is central to overarching safety governance arrangements and is responsible for ensuring there is an Executive review of all PSII reports in line with the patient safety incident response standards and that each is signed off as finalised. The Executive Lead alongside the Chief Medical Officer will also provide direct leadership, advice, and support in complex/high profile cases, and liaise with external bodies as required.
All Other Executive / Non-Executive Directors	All Directors who sit on the Trust Board (either Executive or Non-Executive) have responsibility for adhering to, championing and supporting the implementation of this patient safety policy within the remits of their identified portfolios.
Associate Director of Safety and Learning (also Patient Safety Specialist)	The Associate Director of Safety and Learning will support the Chief Nursing Officer with all elements of their portfolio in relation to Patient Safety and Learning. The Associate Director of Safety and Learning has overall responsibility as the lead manager for the Trust's Patient Safety and Learning function and will provide strategic direction in relation to the development and implementation of this policy. This includes:

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	• defining the Trust's patient safety and safety improvement profile, • ensuring thorough review of available patient safety incident insight, • engagement with internal and external stakeholders, • ensuring the voice of patients, families and carers is heard at all levels of the organisations in relation to patient safety activity, • ensuring necessary training is sourced in relation to PSIRF, • ensuring sufficient support is given to those undertaking patient safety incident investigations and learning responses. They will also provide leadership and direction to the Trust Safety and Learning Team to maintain this policy and ensuring emerging themes and trends relating to patient safety are incorporated into this document.
Patient Safety Specialists (Deputy Chief Nursing Officer and Deputy Chief Medical Officer)	The Patient Safety Specialists will support the Associate Director of Safety and Learning with all elements of their portfolios and provide senior day-to-day leadership in relation to patient safety and learning which includes ensuring the successful implementation of this policy.
Associate Director of Risk and Assurance and Deputy Associate Director of Risk and Assurance,	The Associate Director of Risk and Assurance and Deputy Associate Director of Risk and Assurance will support the Associate Director of Safety and Learning with all elements of their portfolios in relation to the successful implementation of this policy. This will include identifying patient safety priorities based on current and emerging risks to the organisation.
Deputy Associate Director of Safety and Learning and	The Deputy Associate Director of Safety and Learning and Head of Investigation and Learning will operationally manage the patient safety and learning function within the Trust. This

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Head of Investigation and Learning	includes ensuring an appropriate system is in place for staff to report, manage and investigate patient safety events in line with this policy. They will also be responsible for maintaining this policy and ensuring emerging themes and trends relating to patient safety are incorporated into this document. They will also provide senior day-to-day leadership to the Associate Director of Safety and Learning in relation to patient safety and learning which includes ensuring the successful implementation of this policy.
Head of Risk and the Corporate Governance and Risk Team	The Head of Risk and the Corporate Governance and Risk Team are responsible for ensuring the Learning From Patient Safety Events (LFPSE) system functions effectively in line with expectations whilst working in partnership with Divisional Management Teams and governance professionals to implement PSIRF within the organisation.
Head of Safeguarding	The Head of Safeguarding will be responsible for operationally leading the Trust's established Safeguarding processes. In addition to this, the Head of Safeguarding will be responsible for ensuring appropriate safeguarding cases, which meet the national requirements for investigation are identified and escalated as appropriate.
Medical Examiners / Deputy Chief Medical Officer (leading Mortality)/ Head of Mortality and Coronial Management	The Medical Examiners and Deputy Chief Medical Officer (leading Mortality) and Head of Mortality and Coronial Management will ensure deaths are reviewed in accordance with national policy. Any learning identified through these processes will feed into established processes and any deaths felt to be preventable will be escalated for review in line with the national priorities set out in this policy.
Associate Director of Quality and Experience	The Associate Director of Quality and Experience will support the Safety and Learning Team with the implementation of this document by ensuring the voice of patients, families and carers is heard at all levels of the organisations in relation to patient

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	safety activity. They will also support the Associate Director of Safety and Learning with all elements of their portfolios in relation to the successful implementation of this policy.
Patient Safety Partners (PSPs)	The PSPs will play a pivotal role in the implementation of this policy by ensuring the voice of patients, families and carers is heard at all levels of the organisation in relation to patient safety activity. Patient Safety Partners will: • Participate and join key conversations and meetings within the Trust that address patient safety. • Support compliance monitoring and how safety issues should be addressed, providing appropriate challenge to ensure learning and change. • Represent the patient's/family voice, to ensure the Trust is 'walking in the patient's shoes.' • Co-design the developments of Patient Safety initiatives. Ensure that learning responses consider and prioritise the service user, patient, carer and family perspective and champion a diversity of views
Divisional Leadership Team and other senior leaders	The Divisional Leadership Team and other senior leaders have responsibility for adhering to, championing and supporting the implementation of this policy within the remits of their identified portfolios.
Divisional Governance and Risk Managers/Leads	Divisional Governance and Risk Managers/Leads are responsible for acting as the conduit between their allocated Division and the Trust Safety and Learning Team. They will proactively champion the policy and will flag any emerging themes. The Divisional Governance Risk Managers/Leads will ensure Divisions proactively respond to patient safety events appropriately and proportionately. Any learning identified as

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	part of any patient safety activity will be assessed and shared through established routes as appropriate.
Divisional Governance Professionals	Divisional Governance Professionals are responsible for promoting an open, honest, and fair culture and ensuring that the Policy is implemented consistently throughout their sphere of responsibility. Divisional Governance and Risk Managers/Leads will provide practical support during the identification of suitable incident, review learning responses, support investigations, monitor implementation of safety actions and ensure relevant learning is discussed at local meetings and disseminated. Emerging themes and trends will be escalated as and when appropriate
Learning Response Leads (Lead Investigator)	Learning response leads are responsible for completing appropriate training and continuous professional development in incident response skills and knowledge. Learning response leads will contribute to a minimum of two learning responses per year, gathering qualitative and quantitative information from a wide range of sources and summarising their findings in a clear and logical report.
Engagement leads	Engagement leads are responsible for completing appropriate training and continuous professional development in incident response skills and knowledge. Engagement leads will communicate and engage with patients, families, staff, and external agencies in a positive and compassionate way. They will maintain clear records of contact with those affected, identify key risks affecting the involvement of patients, families, and staff and will recognise when those affected by patient safety events require onward signposting or referral to support services.
All Other Staff	All staff across the organisation are responsible:

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	• For promoting an open, honest, and fair culture. • completing all relevant training in relation to PSIRF for their role. • ensuring any patient safety incident is reported within 24 hours of occurrence or becoming aware of the incident. • adhering to this policy.

9.2 Committee/Group Roles and Responsibilities

Committee/Group	Responsibility
Trust Board	The Trust Board has a responsibility to ensure that it receives assurance that the PSIRF policy and plan is being implemented, that lessons are being learnt, and areas of vulnerability are improving. The Trust Board will receive assurance on the implementation of PSIRF and ongoing and emerging issues from the PSIRF Oversight Panel by escalation through monthly chairs reports to the Safety and Quality Committee and by escalation from the Safety and Quality Committee to the bi-monthly Trust Board meeting. The Trust Board will also receive assurance regarding the implementation of PSIRF and associated standards through an annual PSIRF report to the Trust Board of Directors meeting. This will contain sufficient information to ensure that the Trust Board has a formative and continuous understanding of organisational safety. Where concerns are identified relating to the implementation of PSIRF, compliance with PSIRF standards and robustness of lessons learned and associated improvement plans, the Trust Board will seek assurances that these concerns are being acted upon.
Safety and Quality Committee	The Safety and Quality Committee is responsible for providing assurance to the Board of Directors that PSIRF is being

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	implemented, that lessons are being learnt, and areas of vulnerability are improving. The Trust Board will receive assurance on the implementation PSIRF and ongoing and emerging issues from the PSIRF Oversight Panel by escalation through monthly chairs reports and a quarterly report to the Trust Safety and Quality Committee. The quarterly reports will contain a summary of learning from patient safety incident investigations and assurance regarding the implementation of PSIRF and associated standards. Where concerns are identified relating to the implementation of PSIRF, compliance with PSIRF standards and robustness of lessons learned and associated improvement plans, the Safety and Quality Committee will seek assurances that these concerns are being acted upon. Where there are remaining concerns, these will be escalated to the Trust Board.
PSIRF Oversight Panel	The Trust weekly PSIRF Oversight Panel ensure that 'learning responses' are conducted to the highest standards and will support the executive sign off processes for learning responses and ensure that learning is shared, and safety improvement work is adequately directed. The PSIRF Oversight Panel will oversee the implementation of PSIRF, associated policies and the PSIRP and provide assurance to the Trust Safety and Quality Committee of its progress and escalate any ongoing or emerging issues.
Divisions	Divisions will report their patient safety event learning responses and outcomes at the weekly PSIRF Oversight Panel. This will include reporting on ongoing monitoring and delivery of safety actions and improvement. Divisions will have arrangements in place to manage the local response to patient safety events and ensure that escalation procedures as described in the patient safety incident response section of the PSIRF policy are effective.

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		Divisions will also be responsible for sharing identified learning.
Integrated Board (ICB)	Care	The ICB is responsible for approving this policy and the PSIRP and ensuring collaborative work across the local integrated care system (ICS). The ICB will act as a key stakeholder providing oversight and support to the Trust in the implementation of this plan. A representative from the ICB will attend the Trust's PSIRF Oversight Panel to oversee and ensure the quality of investigations undertaken by the Trust.

The Trust will source necessary training such as the Health Education England patient safety syllabus and other patient safety training across the organisation as appropriate to the roles and responsibilities of its staff in supporting an effective organisational response to safety events.

Updates will be made to this policy and associated plan as part of regular oversight. A review of this policy and associated plan should be undertaken at least every 3 years to comply with Trust guidance on policy development alongside a review of all safety actions.

9.3 Quality assuring learning response outputs.

The Trust weekly PSIRF Oversight Panel will ensure that 'learning responses' are conducted to the highest standards and will support the executive sign off processes and ensure that learning is shared, and safety improvement work is adequately directed.

A representative from the ICB will attend the Trust's PSIRF Oversight Panel to oversee and ensure the quality of investigations undertaken by the Trust.

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10.0 Complaints and appeals

Lancashire Teaching Hospitals NHS Foundation Trust always aim to provide excellent care with compassion and communicate effectively with all our patients, their relatives and carers in line with our Trust values.

Although the Trust works hard to offer a high standard of service, sometimes things do not always go to plan and patients, their relatives and carers may have questions that need answers. If this happens, we welcome the opportunity to make things better and ask that patients, their relatives and carers tell us about what their concerns are, and we will do our best to make things better. This includes affording the opportunity for complaints and appeals relating to the organisation's response to patient safety events.

In the event a patient, carer or relative has concerns regarding any aspect of the investigation process, it is recommended that the following steps are followed:

1. If appropriate, seek to resolve the matter locally through a discussion between the patient, family or carer, the Patient Safety Incident Investigator and the nominated engagement lead.
2. Escalate the concern to the Divisional Leadership Team for local resolution.
3. Refer the matter to the Trust's Patient Experience and PALS Team.

Further information is available on the Trust's [website](#).

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11.0 AUDIT AND MONITORING

Aspect of compliance or effectiveness being monitored	Monitoring method	Individual responsible for the monitoring	Frequency of the monitoring activity	Group / committee which will receive the findings / monitoring report and act on findings.	Group / committee / individual responsible for ensuring that the actions are completed
Entire Document	Report	Associate Director of Safety and Learning or appropriate deputy	Quarterly Report	Safety and Quality Committee	PSIRF Oversight Panel
Entire Document	Report	Associate Director of Safety and Learning or appropriate deputy	Annual	Trust Board	Safety and Quality Committee/ PSIRF Oversight Panel
Learning Responses	Report	Associate Director of Safety and Learning or appropriate deputy	Weekly	PSIRF Oversight Panel	PSIRF Oversight Panel

12.0 TRAINING

TRAINING		
Is training required to be given due to the introduction of this policy? Yes Please delete as required		
Action by	Action required	Implementation Date
See Page 27	See Page 27	06 November 2023

13.0 DOCUMENT INFORMATION

ATTACHMENTS	
Appendix Number	Title
1	Raising a Concern Flow Chart
2	Governance arrangements in relation to how the Trust will respond to a Patient Safety
3	Equality, Diversity & Inclusion Impact Assessment Form

OTHER RELEVANT / ASSOCIATED DOCUMENTS		
Unique Identifier	Title and web links from the document library	
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Plan-27	Patient Safety Incident Response Plan
RMP HS 114	Reporting, investigation and management of incidents (including incidents under PSIRF)
TP-149	Being Open Policy (incorporating Duty of Candour and PSIRF engagement)
SOP-394	Complaints Policy and Procedure
HRP-02	Raising concerns at work policy and procedure (incorporating Freedom to Speak Up and Whistleblowing)
TP-96	Work Related Incidents and Staff Debrief and Support Policy.
	Always Safety First Strategy 2021–2024 (LTHTR)
RMP M 54	Development and management of procedural documents
See Reporting, investigation and management of incidents (including incidents under PSIRF) for links to other Associated Documents	

SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS

References in full

Checked by library ET 22/05/2026

Number	References
1	Patient Safety Incident Response Framework (NHS England, 2022)
2	Engaging and Involving Patients, Families and Staff Following a Patient Safety Incident (HSSIB, Learn Together and NHS England, 2022)
3	Regulation 20: Duty of Candour (CQC, 2025)
4	Being Fair Tool (NHS England, 2025)
5	The NHS Patient Safety Strategy (NHS England, original strategy 2019, plus various updates)
6	Patient Safety Principles (Patient Safety Commissioner, no date given)
7	Framework for involving patients in patient safety (NHS England, 2021)
8	Core20PLUS5 (adults) – an approach to reducing healthcare inequalities (NHS England, 2021)
9	Equality Act 2010
10	Patient safety incident response standards (NHS England, 2026)
11	NHS Patient Safety Syllabus (Academy of Medical Royal Colleges, 2022)

DEFINITIONS / GLOSSARY OF TERMS

Abbreviation or Term	Definition
AAR	After Action Review A learning response tool consisting of a structured facilitated discussion of an event/incident
CQC	Care Quality Commission Independent regulator for health and social care in England
CSP	Community Safety Partnership Statutory partnerships of organisations who work together in an area to reduce crime and the fear of crime, anti-social behaviour, alcohol, and drug misuse and reducing re-offending
Core20PLUS5	Core20PLUS5

Lancashire Teaching Hospitals NHS Foundation Trust

ID No. RMP-C-278

Version No: 2

Next Review Date: 30/11/2027

Title: Patient Safety Incident Response Policy

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	A national NHS England approach to inform action and reduce healthcare inequalities at both national and system levels, focused initially on the experience of adults, but has now been adapted to apply to children and young people
DHR	Domestic Homicide Review A review into the circumstances around a death of a person following domestic abuse
HealthWatch	HealthWatch A health and social care champion service who obtain the views of people about their needs and experience of local health and social care services
HSSIB	Healthcare Services Safety Investigation Body The independent national investigator for patient safety in England
ICB	Integrated Care Board A statutory organisation who are responsible for developing a plan for meeting the health needs of the local population, managing the NHS budget, and arranging for the provision of NHS services in a geographical area
ICS	Integrated Care System Partnerships of organisations which come together to deliver joined up health care services and improve the lives of people who live in the area
IOPC	Independent Office for Police Conduct A non-departmental public body in England and Wales who are responsible for overseeing the system for handling complaints made against police forces in England and Wales
LeDeR	Learning Disability and Mortality Review A service improvement programme for people with a learning disability and autistic people who look at key episodes of health and social care the person received that may have been relevant to their overall health outcomes
LFPSE	Learning from Patient Safety Events The new national NHS service for the recording and analysis of patient safety events
LTHTR	Lancashire Teaching Hospitals NHS Foundation Trust
MDT	Multi-Disciplinary Team A group of staff from different areas in healthcare
NRLS	National Reporting and Learning System The current national central database for recording and analysing patient safety incident reports
PALS	Patient Experience and Liaison Service

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	The Trust's team which provides support for patients, families, and carers
PPO	Prison and Probation Ombudsman A public body that carries out independent investigations into complaints and deaths in custody
PSIRF	Patient Safety Incident Response Framework A new and innovative approach to the way the NHS responds to patient safety incidents/events.
PSIRP	Patient Safety Incident Response Plan The plan which sets out how NHS organisations intend to respond to patient safety incidents/events under PSIRF
PSP	Patient Safety Partners The role that patients, carers and other lay people can play in supporting and contributing to a healthcare organisations' governance and management processes for patient safety
PSII	Patient Safety Incident Investigation A learning response tool which is undertaken when an incident or near miss indicates significant patient safety risks and the potential for new learning
RLR	Rapid Learning Review A learning response tool used to quickly understand what happened and identify immediate learning following an incident.
Safety I	Safety I Identifying causes and contributing factors in patient safety events as the focus point in an attempt to stop them occurring
Safety II	Safety II Considering variations in everyday performance to understand how things usually go right
SEIPS	Systems Engineering Initiative for Patient Safety A methodology for understanding outcomes within complex socio-technical systems
SIF	Serious Incident Framework The current process by which the NHS ensures serious incidents are identified, investigated, and learned from to prevent the likelihood of similar incidents happening again. This framework will be replaced by PSIRF
SOP	Standard Operating Procedure A guide/step by step instructions compiled by an organisation to help staff to carry out routine tasks/processes
SpHA	Special Healthcare Authority An authority who provides a health service to the whole of England, not solely to a local community

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STP	Sustainability and Transformation Partnership Where local NHS organisations and Local Authorities draw up shared proposals to improve health and care in the areas they serve

CONSULTATION WITH STAFF AND PATIENTS

Enter the names and job titles of staff and stakeholders that have contributed to the document

Name	Job Title	Date Consulted
NMAHP group	Senior Nurses, Ward Managers, AHP leads	20/9/23
Visually Impaired Forum	Patients	22/9/23
Clinical Reference Group	Senior Clinicians	25/9/23
Patient Experience and Involvement Group	Staff, Patients and Advocacy Services	26/9/23
Carers forum	Patients	27/9/23
Cancer Forum	Patients	3/10/23
Dementia Strategy Meeting	Staff and Patients	5/10/23
EDI forum	Staff	9/10/23
Safety and Quality Committee	Executives, Non Executives, Senior Leaders	29/9/23
Board of Directors Public Meeting	Directors and Public	5/10/23
Sarah Cullen	Chief Nursing, Midwifery & AHP Officer	15/09/2023
Emma Ashton	Divisional Midwifery Director	15/09/2023
Joanne Connolly	Divisional Nursing Director	15/09/2023
Lisa Elliott	Divisional Nursing Director	15/09/2023
Catherine Gregory	Deputy Chief Nursing Officer	15/09/2023
Rachel Sansbury	Divisional Nursing Director	15/09/2023
Kate Smith-Probert	Deputy Divisional Nursing Director	15/09/2023
Jacqueline Murray	Deputy Divisional Nursing Director	15/09/2023
Cathy Owen	Divisional Clinical Governance Lead	15/09/2023
Rachel Moxham	Divisional Clinical Governance Lead	15/09/2023
Clare Shaw	Compliance & Governance Officer	15/09/2023
Emma Holden	Safety and quality matron for maternity	15/09/2023
Karin Colbeck	Divisional Clinical Governance Lead	15/09/2023
Sarah Howarth	Divisional Clinical Governance Lead	15/09/2023

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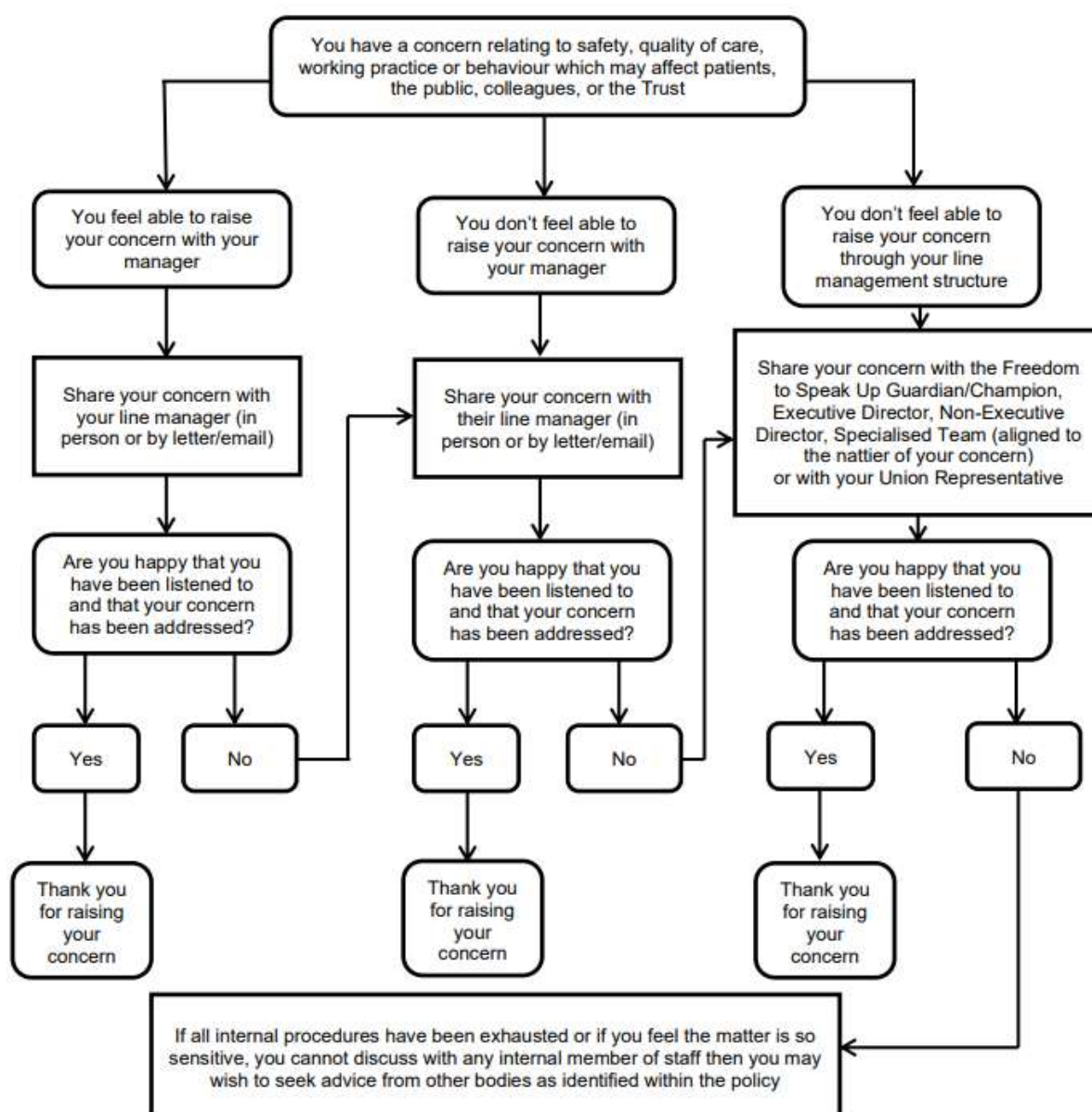
Joanne Lambert	Deputy Divisional Nursing & Midwifery Director	15/09/2023
Simon Regan	Associate Director of Risk & Assurance	15/09/2023
John Howles	Associate Director of Patient Experience & Engagement	15/09/2023
Anne Kirkham	Head of Community Services	15/09/2023
Katy Clay	Governance & Risk Manager	15/09/2023
Michelle Durkin	Deputy Associate Director of Safety & Learning	15/09/2023
Michael Stewart	Deputy Medical Officer	15/09/2023
Claire Granato	Chief AHP	15/09/2023
Lauren O'Brien	Deputy Director of Education	15/09/2023
Christopher Taylor	Head of Training Performance & Compliance	15/09/2023
Arnab Bhowmick	Deputy Medical Officer	15/09/2023
Lousie Gracie	Deputy Divisional Nursing Director	15/09/2023
Gareth Price	Chief Pharmacist	15/09/2023
Caroline Marshall	Associate Director of Patient Safety, ICB	19/09/2023
Kimberley Ciraolo	Patient Safety Manager, ICB	19/09/2023
Louisa Graham	Deputy Director of Workforce & OD	18/09/2023
Kate Holt	Organisational Development & Culture Lead	18/09/2023
Amanda Davis	Head of Diversity & OD	18/09/2023
Jennifer Carroll	Continuous Improvement Clinical Fellow	18/09/2023
Kurt Bramfitt	Senior Associate Director of Continuous Improvement	18/09/2023
Elizabeth Midwinter	Continuous Improvement Clinical Fellow	18/09/2023
Stuart Clough	Senior Associate Director of Continuous Improvement	18/09/2023
PSIRF Oversight Panel	Members of PSIRF Oversight Panel	24/10/2024
PSIRF Oversight Panel	Members of PSIRF Oversight Panel	28/05/2026
Safety and Quality Committee	Members of Safety and Quality Committee	29/05/2026

DISTRIBUTION PLAN		
Dissemination lead:	Lisa Elliott/Helen Hodgson/Michelle Durkin	
Previous document already being used?	Yes	
If yes, in what format and where?	Heritage	
Proposed action to retrieve out-of-date copies of the document:		
To be disseminated to:	Trust wide	
Document Library	Yes	
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Proposed actions to communicate the document contents to staff:	Include in the LTHTR Monthly Procedural documents communication. Document uploaded to the Document Library. Circulate via relevant stakeholder groups.

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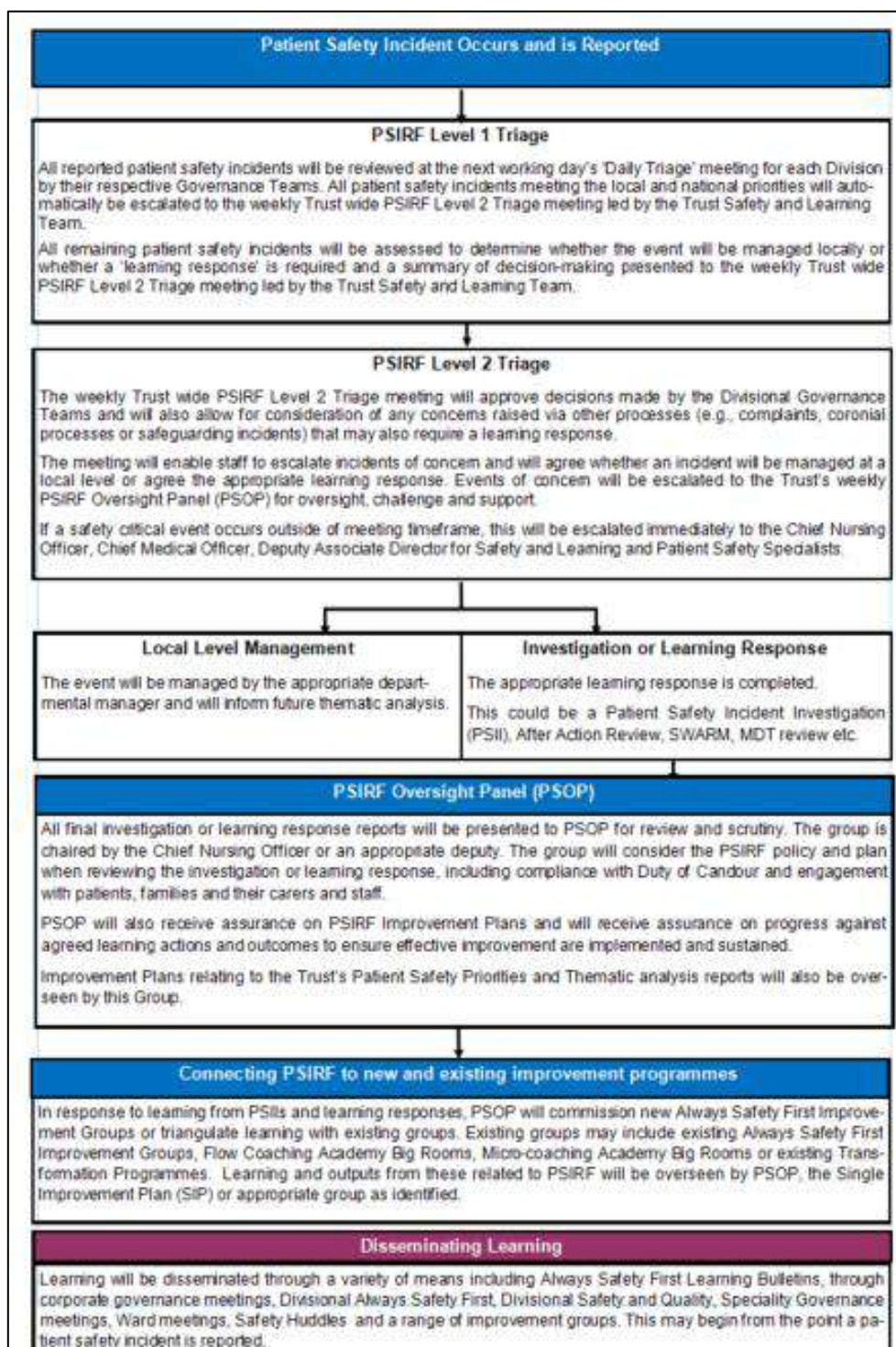
Appendix 1 – Raising a Concern Flow Chart



NOTE: If your concern is about any incident, near miss or issue that could or did have a harmful effect on a patient, colleague, contractor, or member of the public, then this should be reported to your line manager and also recorded in Ulysses

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Appendix 2 – Governance arrangements in relation to how the Trust will respond to a Patient Safety Event



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Appendix 3 - Equality, Diversity & Inclusion Impact Assessment Form

Department/Function	Corporate			
Lead Assessor	Hajara Ugradar			
What is being assessed?	Impact of document on equality.			
Date of assessment	Reviewed 21/05/2026 and still appropriate			
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	Equality of Access to Health Group	☐	Staff Side Colleagues	☒
	Service Users	☒	Staff Inclusion Network/s	☒
	Personal Fair Diverse Champions	☐	Other (Inc. external orgs)	☒
	Please give details:			

1) What is the impact on the following equality groups?		
Positive:	Negative:	Neutral:
➢ Advance Equality of opportunity ➢ Foster good relations between different groups ➢ Address explicit needs of Equality target groups	➢ Unlawful discrimination, harassment and victimisation ➢ Failure to address explicit needs of Equality target groups	➢ It is quite acceptable for the assessment to come out as Neutral Impact. ➢ Be sure you can justify this decision with clear reasons and evidence if you are challenged
Equality Groups	Impact (Positive / Negative / Neutral)	Comments:
Race (All ethnic groups)	Positive	➢ Provide brief description of the positive / negative impact identified benefits to the equality group. ➢ Is any impact identified intended or legal? In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.
Disability (Including physical and mental impairments)	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.
Sex	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing

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		safety improvement actions and this will inform our system learning and improvement priorities.
Gender reassignment	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.
Religion or Belief (includes non-belief)	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.
Sexual orientation	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.
Age	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.
Marriage and Civil Partnership	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.
Pregnancy and maternity	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.
Other (e.g. caring, human rights, social)	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.

2) In what ways does any impact identified contribute to or hinder promoting equality and	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions

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diversity across the organisation?	and this will inform our system learning and improvement priorities.

3) If your assessment identifies a negative impact on Equality Groups you must develop an action plan **to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised.**

- This should include where it has been identified that further work will be undertaken to further explore the impact on equality groups
- This should be reviewed annually.

ACTION PLAN SUMMARY

Action	Lead	Timescale
NA	NA	NA

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HOW THE NHS CONSTITUTION APPLIES TO THIS DOCUMENT

WHICH PRINCIPLES OF THE NHS CONSTITUTION APPLY? Click here for guidance on Principles	Tick those which apply	WHICH STAFF PLEDGES OF THE NHS CONSTITUTION APPLY? Click here for guidance on Pledges	Tick those which apply
1. The NHS provides a comprehensive service, available to all. 2. Access to NHS services is based on clinical need, not an individual's ability to pay. 3. The NHS aspires to the highest standards of excellence and professionalism. 4. The patient will be at the heart of everything the NHS does. 5. The NHS works across organisational boundaries. 6. The NHS is committed to providing best value for taxpayers' money. 7. The NHS is accountable to the public, communities and patients that it serves.	✓ ✓ ✓ ✓ ✓ ☐ ✓	1. Provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability. 2. Provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities. 3. Provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential. 4. Provide support and opportunities for staff to maintain their health, wellbeing and safety. 5. Engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families. 6. To have a process for staff to raise an internal grievance. 7. Encourage and support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Employment Rights Act 1996.	✓ ✓ ✓ ✓ ✓ ✓
WHICH AIMS OF THE TRUST APPLY? Click here for Aims	Tick those which apply ✓ ✓ ☐	WHICH AMBITIONS OF THE TRUST APPLY? Click here for Ambitions	Tick those which apply ✓ ✓ ☐ ✓

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DOCUMENT TYPE: Plan		UNIQUE IDENTIFIER: Plan-27	
DOCUMENT TITLE: Patient Safety Incident Response (PSIRF) Plan		VERSION NUMBER: 2	
		STATUS: Draft	
SCOPE: Trust Wide		CLASSIFICATION: Organisational	
AUTHOR: Hajara Ugradar	JOB TITLE: Associate Director of Risk, Assurance & Corporate Affairs	DIVISION: Corporate	DEPARTMENT: Safety and Quality
REPLACES: Version 1.1		HEAD OF DEPARTMENT: Sarah Morrison , Chief Nursing Officer	
VALIDATED BY: Board of Directors ICB Quality Committee		DATE: 04 June 2026	
RATIFIED BY: Procedural Documents Ratification Group		DATE: Click here to enter a date.	
(NOTE: Review dates may alter if any significant changes are made).		REVIEW DATE: Click here to enter a date.	

AMENDMENT HISTORY				
Version No.	Date of Issue	Page/Selection Changed	Description of Change	Review Date
1.1	16 th October 2024	Addendum throughout policy, audit and monitoring section and flowchart in section 8	Policy updated to reflect new PSIRF meetings. Safety and Learning Group replaced with PSIRF Oversight Panel and Always Safety First Learning and Improvement	16 th October 2024

			Group. Removed reference to PSIRF Implementation Group	
1.1	16 th October 2024	Section 9	Learning Response Timeframes reviewed and definition of PSIRF MDT expanded	16 th October 2024
2.0	TBC	Addendum throughout policy	Updated to reflect the refreshed Trust Strategy, service information, revised priorities and timeframes, introduction of Rapid Learning Reviews, and refreshed governance arrangements.	TBC

Does this document meet the requirements of the Equality Act 2010 in relation to Race, Religion and Belief, Age, Disability, Gender, Sexual Orientation, Gender Identity, Pregnancy & Maternity, Marriage and Civil Partnership, Carers, Human Rights and Social Economic Deprivation discrimination? **Yes**

Document for Public Display: **Yes**

Evidence reviewed by Library Services 22/05/2026

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1.0 Foreword

We are delighted to present our revised and updated Patient Safety Incident Response Plan (PSIRP) for **Lancashire Teaching Hospitals NHS Foundation Trust**. This plan sets out how we intend to respond to patient safety events in line with the National Patient Safety Strategy for England and the Patient Safety Incident Response Framework (PSIRF).

PSIRF represents a significant change in how the NHS learns from and responds to patient safety events. It is not simply a change in process, but a fundamental shift in culture and approach moving from a focus on investigation and report production towards a system centred on learning, improvement and the prevention of future harm.

Our focus is therefore no longer on producing reports to meet predetermined criteria, but on ensuring that learning from patient safety events leads to meaningful and sustained improvements in care. PSIRF provides the flexibility to deliver responses that are proportionate to the circumstances of each event, while maintaining alignment with national standards and system oversight.

We welcome this opportunity to take greater ownership of how we respond to patient safety events, ensuring that our efforts are directed towards understanding what has happened, why it has happened, and how care can be improved. We recognise that previous approaches often placed greater emphasis on the completion of reports, rather than demonstrating how learning translates into improvement, and this plan reflects our commitment to changing that.

A key principle of PSIRF is the meaningful involvement of patients, families and carers. We are committed to ensuring that their voices are central to how we learn and improve. Through our Patient Safety Partners and engagement processes, we will ensure that experiences and perspectives of those affected are actively listened to, understood and reflected in our responses.

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Since implementing PSIRF in November 2023, we have continued to develop a ‘being fair’ and restorative, where staff feel supported to speak up and contribute openly to learning. We recognise the importance of compassionate engagement with both those affected by patient safety events and the staff involved, ensuring that our approach supports learning, reflection and wellbeing.

We recognise that developing and embedding this approach is an ongoing journey. We will continue to review and refine our processes, learning from our experience and adapting where needed to ensure that our approach remains effective, proportionate and focused on improving patient safety.

Most importantly, this plan reflects our commitment to delivering safe, effective and compassionate care. By focusing on meaningful learning and continuous improvement, we aim to reduce harm, improve outcomes and strengthen our safety culture for the benefit of our patients, service users, families and staff.

2.0 Purpose

This patient safety incident response plan sets out how **Lancashire Teaching Hospitals NHS Foundation Trust** intends to respond to patient safety events following initial review of our 24 month PSIRF implementation journey . The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and safety events occurred and the needs of those affected.

This document should be read in conjunction with the Trust's [Patient Safety Incident Response Policy](#) which supports the requirements of the NHS England PSIRF and sets out how the Trust will approach the development and maintenance of effective systems and processes for responding to patient safety events and issues for the purpose of learning and improving patient safety. One key aim of PSIRF is to ensure considered and proportionate responses to patient safety events.

3.0 Scope

This patient safety incident response plan (PSIRP) will detail the Trust’s approach to responding to patient safety events and should be followed by all staff across the

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organisation. This plan is not a permanent tenet that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and safety events occur and the needs of those affected.

As part of this revised plan, we have consulted with our staff, patients and governance teams and have reviewed our safety data from the last two years to review and redefine our local priorities.

4.0 Our services

Lancashire Teaching Hospitals NHS Foundation Trust is a large acute NHS Trust consisting of Chorley and South Ribble District General Hospital, Royal Preston Hospital, the Specialist Mobility Rehabilitation Centre, and a range of community and satellite services.

We serve a core population of around 390,000 people across Chorley, Preston and South Ribble as well as providing a range of highly specialist services to 1.8 million people across Lancashire and South Cumbria.

Our organisation has a workforce of approximately 9000 substantive staff, making it one of the largest employers in the region and a successful volunteers scheme, with nearly 600 volunteers providing support in a variety of roles.

4.1 Our Trust Strategy

Our vision for the next five years is aligned to the Lancashire and South Cumbria Integrated Care System (ICS) clinical blueprint and the national *Fit for the Future 10 Year Health Plan for England*. This sets out a clear ambition to deliver better care through innovation, new technologies and improved models of care.

Our ambition is to become an accountable healthcare organisation within Lancashire and South Cumbria and in doing so deliver an affordable and sustainable model for the future.

To achieve this, we have three key strategic roles:

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- providing specialist services for the population of Lancashire and South Cumbria, alongside local services for Central Lancashire
- acting as a centre for Continuous Improvement, Education, Research and Innovation
- acting as an Anchor Institution, where social value and sustainability are aligned to improving the health and wellbeing of our population

Working with our partners, we will deliver three key shifts in how care is provided:

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

These changes will enable more personalised, accessible and sustainable care, improving outcomes for the population we serve.

Our Trust Strategy (2025–2030) is underpinned by five strategic priorities (the “5Ps”):



Patients

Better care,
faster access,
safer services.



Performance

Meet and
exceed national
standards.



People

Support and
develop our
staff.



Productivity

Use our resources
wisely and
reduce waste.



Partnerships

Work closely with
other health and
care organisations.

These strategic objectives are supported by a number of key enabling strategies, including Always Safety First, Digital, Estates and Facilities, Financial Sustainability, Social Value and Workforce.

Together, this provides a clear framework that ensures all services align their priorities and plans with the Trust’s overarching strategic objectives, enabling the consistent delivery of safe, high-quality and sustainable care across the organisation.

4.2 Our Values

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We are a values-driven organisation. Our values were designed by our staff and patients and are embedded in the way we work on a day-to-day basis:

- Caring and compassionate: We treat everyone with dignity and respect, doing everything we can to show we care.
- Recognising individuality: We respect, value, and respond to every person's individual needs.
- Seeking to involve: We will always involve you in making decisions about your care and treatment and are always open and honest.
- Team working: We work together as one team, and involve patients, families, and other services, to provide the best care possible.
- Taking personal responsibility: We each take personal responsibility to give the highest standards of care and deliver a service we can always be proud.

4.3 Acute and Specialist Services

Royal Preston Hospital provides a full range of district general hospital services including emergency medicine, critical care, general medicine including elderly care, general surgery, oral and maxillo-facial surgery, ear nose and throat surgery, anaesthetics, children's services, neonatal intensive care, women's health and maternity, and several specialist regional services including cancer, neurosurgery, renal, plastics and burns, rehabilitation, and the major trauma centre for Lancashire and South Cumbria.

Chorley and South Ribble Hospital provides a full range of district general hospital services including emergency department for adults (8am-8pm), general medicine including elderly care, general surgery, orthopaedics, anaesthetics, stroke rehabilitation, midwifery-led maternity care, and a breast service.

The Urgent Care Centres on both sites are commissioned by the Integrated Care Board (ICB) and are not provided by the Trust.

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The Trust is a regional specialist centre for adult allergy and clinical immunology, cancer, disablement services, major trauma, neurosciences (including neurosurgery and neurology), renal and vascular services.

The Surgical Elective Care Hub based at Chorley and South Ribble Hospital is where patients come for day case or short inpatient surgery stays and has received the highly accredited 'NHS Surgical Hub status', meaning that our patients can be assured of the highest standards of patient care and safety, with the Getting it Right First Approach (GIRFT).

Our specialist mobility rehabilitation centre provides specialist wheelchair, prosthetic limb and orthotic services for people across the Northwest, including war veterans and is one of just nine centres of excellence in the UK.

Our community services are provided in people's homes, community centres, clinics, GP Practices, community hospitals and our main hospitals.

4.4 Education, Training and Research

We have a clear ambition to become a University Hospital and a recognised centre for continuous improvement, education, research and innovation.

We are committed to embedding improvement methodologies across all our services, ensuring that learning, research and innovation directly improve patient care and outcomes.

We are the only National Institute for Health and Care Research (NIHR) Clinical Research Facility in Lancashire and South Cumbria. The Centre for Health Research and Innovation is based within the Lancashire Clinical Research Facility at Royal Preston Hospital. However, the Research team work across both the Preston and Chorley sites as well as a number of community and satellite units.

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We are also a leading provider of undergraduate education and play an important role in training the future healthcare workforce. In addition, we work in partnership across the Lancashire and South Cumbria Provider Collaborative, supporting system-wide learning, innovation and improvement.

4.5 Care Quality Commission Registration (CQC)

We are registered with the CQC without conditions to provide the following regulated activities:

- diagnostic and screening services
- maternity and midwifery services
- surgical procedures
- termination of pregnancies
- treatment of disease, disorder or injury
- management of supply of blood and blood-derived products
- assessment or medical treatment for persons detained under the Mental Health Act 1983
- accommodation for persons who require nursing or personal care.

4.6 Organisational Structure

To support delivery, services are organised across four clinical divisions: Medicine, Surgery, Women and Children's Services, Diagnostics and Clinical Support Services

These are supported by Estates and Facilities and Corporate Services, ensuring effective governance, operational delivery and continuous improvement across the organisation.

4.7 Link to Patient Safety and PSIRF

The breadth and complexity of services we provide requires a coordinated, system-based approach to patient safety, ensuring that everyone is clear about how their individual role, responsibility and behaviour supports the delivery of this plan.

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This Patient Safety Incident Response Plan reflects that context by ensuring that:

- patient safety priorities are informed by data and intelligence (insight) — drawing on a range of data and intelligence sources to identify and continuously refine our PSIRF priorities
- patients, families, carers, staff and stakeholders are actively involved in learning (involvement) — engaging those affected in our response and equipping staff with the skills, knowledge and opportunities to improve patient safety across the whole system
- improvement programmes are designed to deliver effective and sustainable change (improvement) — supporting programmes of work focused on the most important areas for change, with the aim of reducing patient harm and strengthening our safety culture.

Through this approach, we aim to reduce harm, improve outcomes and strengthen our safety culture, ensuring that learning leads to meaningful and lasting improvements across the organisation.

5.0 Defining our patient safety events profile

The Trust is committed to undertaking high quality learning responses following a patient safety event to ensure continuous improvement across our services and sustainable reductions in the frequency of incidents and their associated opportunity to harm our patients.

The national PSIRF sets out the opportunity for organisations to identify their own local areas of highest risk and to ensure that both investigation activity and improvement resource are directed towards those areas where there is the greatest need and potential for learning. These local priorities sit alongside nationally mandated priorities that require continued focus, such as incidents meeting the definition of a Never Event.

Since implementing PSIRF in November 2023, the Trust has developed a more mature understanding of its patient safety profile. This understanding has been informed through a combination of retrospective data, real-time learning from incident responses, thematic reviews and improvement activity across the organisation.

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As part of this refresh, the Trust has reviewed its priorities to ensure that they are focused on areas of greatest risk, aligned to PSIRF principles and targeted where there is potential for new learning. This reflects the national direction that investigation activity should be proportionate, targeted and focused on generating meaningful insight.

5.1 Data Sources

The Trust recognises that in order to truly understand its patient safety incident profile it must review data from a range of sources, ensuring a comprehensive and triangulated understanding of risk, harm and variation in care.

To support this refresh, we undertook a review of safety intelligence across the organisation, including:

- Patient Safety Incidents
- Safeguarding Concerns
- Complaints and Patient Experience Feedback
- Patient Advice and Liaison Service (PALS) concerns
- Risk Register data
- Mortality Reviews and Learning from Deaths processes
- Claims and Litigation data
- CQC enquiries
- Friends and Family Test feedback
- Freedom to Speak Up concerns

This review draws on a combination of:

- a two-year retrospective dataset to identify established patterns of harm and risk, and
- learning from PSIRF implementation between November 2023 and December 2025, including insight from Patient Safety Incident Investigations (PSIIs), After Action Reviews (AARs), SWARMs, thematic reviews and daily triage processes

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This blended approach aligns with PSIRF expectations and ensures that the Trust's patient safety incident profile reflects both historical trends and real-time learning, supporting a more dynamic and responsive understanding of risk.

The initial retrospective analysis identified a range of patient safety themes for further consideration. These themes were subsequently refined through stakeholder engagement and further analysis to ensure focus on areas of greatest learning potential.

5.2 Stakeholder Engagement

To ensure that our patient safety incident profile reflects both data and lived experience, we undertook engagement with a wide range of stakeholders across the organisation and system partners.

This included representation from:

- Clinical teams across all divisions
- Senior medical and nursing leadership
- Divisional and corporate governance professionals
- Patient safety and safeguarding teams
- Patient experience teams and patient representatives
- Pharmacy and allied health professionals
- Workforce and organisational development teams
- ICB

Stakeholders were involved through structured discussions, review meetings and feedback mechanisms, enabling them to:

- review and validate themes identified through data analysis
- highlight areas of concern or emerging risk
- provide insight into operational and system-level challenges
- support the refinement of themes based on potential for learning and improvement

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This approach ensured that the Trust’s patient safety incident profile is both data-informed and clinically grounded, reflecting the realities of care delivery as well as organisational learning.

5.3 Refinement of themes and learning from PSIRF implementation

The initial review of safety intelligence identified a broad range of patient safety themes across the organisation. These themes were further explored and refined through triangulation of data sources and engagement with stakeholders to determine which represented the most significant risks and the greatest opportunities for learning.

Since implementation of PSIRF in November 2023, the Trust has gained further insight through the application of a range of learning responses in practice.

Analysis of activity between November 2023 and December 2025 has enabled the Trust to assess how effectively the original priorities supported meaningful learning and improvement. This has demonstrated that:

- the number of Patient Safety Incident Investigations (PSIIs) commissioned under local priorities has been lower than originally anticipated
- a significant proportion of incidents have been more appropriately managed through proportionate learning responses, including After Action Reviews (AARs), SWARMs and thematic reviews
- several previously identified priority areas were broad or frequently occurring, resulting in repetition of well-established contributory factors
- in many areas, risks were already being addressed through existing improvement programmes or governance processes, limiting the additional value of further investigation

This learning reflects a key principle of PSIRF: that investigation activity should be focused on areas where there is uncertainty, system complexity or opportunity for new organisational insight, rather than duplicating known findings.

As part of this refresh, themes were therefore reviewed and refined to ensure that local priorities:

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- focus on areas of highest risk and harm, particularly those affecting vulnerable patient groups
- reflect system-level risks, including issues that occur across pathways, interfaces and transitions of care
- avoid duplication of areas where learning is already well understood
- enable a more targeted and proportionate approach to commissioning Patient Safety Incident Investigations

Through this process, overlapping and related themes were consolidated into a smaller number of focused priorities, aligned to areas where further investigation is most likely to generate meaningful system-wide learning and improvement.

5.4 Local Priorities

Based on a review of safety data, stakeholder engagement and learning from PSIRF implementation, the Trust has identified a small number of key areas where focused learning is expected to have the greatest impact. These are listed below.

These priorities reflect areas where there is a higher risk of harm, where themes affect multiple services or patient groups, and where further understanding is needed to improve how care is delivered.

These priorities do not represent all areas of patient safety activity. Instead, they are areas where the Trust will focus its more in-depth learning responses to generate the most meaningful insight and improvement.

1. Patients remaining in inappropriate care settings leading to deterioration

Rationale: *We know that patients receive the safest care when they are in the right place, with the right team and environment to meet their needs. Our learning has shown that risks can increase when patients are cared for in areas that are not designed for their condition.*

This can include situations where:

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- patients wait for specialist beds or services
- patients are cared for in temporary or overflow areas
- vulnerable groups, such as children or patients with mental health needs, are cared for in settings that are not specifically designed for them

In these situations, monitoring, communication and access to specialist care can be more challenging. By focusing on this priority, we aim to better understand how these risks occur and how we can improve the way we support patients when pressures on services arise.

2. Care not personalised for patients with specific vulnerabilities

Rationale: *Some patients have additional needs that require care to be adapted to them as individuals. This includes people with learning disabilities, autism, mental health needs, dementia, or those who may need extra support to communicate or make decisions.*

Our learning has shown that when care is not fully tailored to a person's needs, there is a risk that:

- important symptoms may not be recognised
- changes in condition may be missed
- patients may not receive the support they need

In some cases, behaviours or symptoms may be misunderstood or linked to an existing condition rather than being fully assessed. This can lead to delays in identifying physical health concerns.

By focusing on this priority, we aim to improve how we recognise and respond to individual needs, ensuring that all patients receive care that is safe, personalised and inclusive.

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3. System-level issues across pathways, services and handovers

Rationale: Modern healthcare involves many different teams and services working together. While this brings benefits, it also means that risks can arise at points where care is handed over or shared between teams.

Our learning has shown that some incidents happen not because of one single issue, but due to gaps in communication or coordination between services. This can include:

- delays in test results or treatment pathways
- unclear responsibility for patient care
- information not being communicated effectively between teams

These challenges can affect the continuity of care and may lead to delays or missed opportunities to act.

By focusing on this priority, we aim to better understand how these system-level risks occur and how we can strengthen communication, coordination and reliability across the whole patient journey.

4. Emerging risks

Rationale: Healthcare is constantly evolving, and new risks can arise as services change or new ways of working are introduced.

We want to ensure that we remain responsive to any new or unexpected patient safety concerns. This includes:

- unusual or complex incidents
- early warning signs of new risks
- rare but serious events

This priority gives us the flexibility to identify and learn from these situations, ensuring that we continue to improve and adapt our approach to patient safety.

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6.0 Our patient safety incident response plan: national requirements

In addition to its local priorities, the Trust will meet all nationally mandated patient safety requirements. These include specific types of incidents that must be responded to in line with national guidance, such as care-related deaths, Never Events, maternity and neonatal investigations, safeguarding reviews and other statutory processes.

In addition to the five local patient safety priorities, the Trust must comply with the following national patient safety event response requirements.

No.	National Priorities	Action Required	Lead Body for response
1.	Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII)	Locally Led PSII.	The Trust
2.	Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)	Locally Led PSII.	The Trust
3	Incidents meeting the Never Events criteria 2018, or its replacement.	Locally Led PSII or proportionate response.	The Trust
4	Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII. Locally-led PSII may be required.	As decided by the RIIT

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5	Maternity and neonatal incidents meeting Maternity and Newborn Safety Investigations (MNSI) criteria or Special Healthcare Authority (SpHA) criteria when in place MNSI will investigate the following maternity safety incidents; • Intrapartum stillbirth: the baby was thought to be alive at the start of labour but was born showing no signs of life. • Early neonatal death: the baby died, from any cause, within the first week of life (0 to 6 days). • Potentially severe brain injury diagnosed in the first seven days of life and the baby was diagnosed with grade III hypoxic–ischaemic encephalopathy; or was therapeutically cooled (active cooling only); or – had decreased central tone, was comatose and had seizures of any kind. • Maternal deaths: death while pregnant or within 42 days of the end of the pregnancy from any cause related to or aggravated by the pregnancy or its	Refer to MNSI or SpHA for independent PSII. Where such an investigation is undertaken, a separate local patient safety learning response is not required. However, organisations should complete Duty of Candour requirements (ahead of handover to HSSIB for further involvement of patients/families in the investigation) as set out below, and report on the relevant incident reporting system(s) as described below. Organisations must also take any immediate actions identified as necessary to avoid and/or mitigate further serious and imminent danger to patients, staff and the public. In relevant cases, the organisation should also use the Perinatal Mortality Review Tool (in parallel with and with the assistance of HSSIB as it works through its independent investigation).	MNSI (or SpHA)

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	management, but not from accidental or incidental causes (excludes suicides).		
6	Child deaths	Refer for Child Death Overview Panel review. Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel.	Child Death Overview Panel
7	Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally-led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this.	LeDeR programme
8	Safeguarding incidents in which: - Babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence. - Adults (over 18 years old) are in receipt of care and support needs from their local authority. - The incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	Refer to local authority safeguarding lead. Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards.	Refer to the local designated professionals for child and adult safeguarding

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9	Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally led learning response. See: Guidance for managing incidents in NHS screening programme.	The organisation in which the event occurred
10	Deaths in custody (e.g., police custody, in prison, etc) where health provision is delivered by the NHS	Any death in prison or police custody will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations. Healthcare organisations must fully support these investigations where required to do so.	PPO or IOPC
11	Domestic homicide	A domestic homicide is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and requests the establishment of a DHR panel.	CSP

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		The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs.	

7.0 Our patient safety incident response plan: local focus

The Trust applies a proportionate response model. This means that not all patient safety events will lead to a full investigation. Instead, the response will be tailored to the nature of the event and the potential for learning.

Decisions about the appropriate response are made through structured governance processes, including Daily Divisional Triage and Trust-wide PSIRF Triage. These processes bring together multiple sources of safety intelligence and ensure that responses are timely, proportionate and focused on learning.

The Trust will undertake a targeted number of Patient Safety Incident Investigations (PSIIs), focusing on areas where there is the greatest opportunity for new learning.

Typically, up to three PSIIs will be undertaken for each priority area, where appropriate. Patient safety events do not automatically require a PSII. Each event will be assessed through the triage process to determine the most appropriate response. This approach ensures that resources are used effectively and that learning is translated into improvement as quickly as possible.

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The table below details the number of Patient Safety Incident Investigations (PSII) which will be undertaken for the Trust's identified priorities:

No	Priority	Planned response	Number of PSIs
1	Patients remaining in inappropriate care settings leading to deterioration Incidents where patients remain in environments not designed for their clinical needs, resulting in compromised care and escalation failures. Examples: • Mental health patients in Emergency Departments awaiting specialist beds • Children cared for in adult environments • Patients placed in overflow or non-specialist areas Rationale*: Persistent system-wide issue involving capacity, pathway interfaces and vulnerability. Demonstrates high harm potential and unclear ownership across services.	Patient Safety Incident Investigation (PSII)	Up to 3
2	Care not personalised for patients with specific vulnerabilities	Patient Safety Incident Investigation (PSII)	Up to 3

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	Incidents where care is not adapted to meet individual patient needs, leading to harm. Examples: • Patients with learning disability, autism or mental health needs • Patients with dementia or cognitive impairment • Patients lacking capacity or advocacy support Rationale*: Strong evidence of diagnostic overshadowing and unmet needs, particularly in vulnerable groups, with high potential for new learning around assessment, escalation and individualised care.		
3	System-level failures across pathways, interfaces and handovers Incidents arising from gaps between teams, services or organisations. Examples: • Failures in diagnostic or cancer tracking pathways • Communication failures at transitions of care • Cross-boundary incidents involving multiple services	Patient Safety Incident Investigation (PSII)	Up to 3

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	Rationale*: Repeated patterns of harm linked to interfaces rather than individual actions, with significant opportunity for system-level improvement.		
4	Emerging Risks A category to identify and respond to new, evolving or low-frequency high-severity risks that fall outside defined priorities. Rationale*: Ensures the Trust remains responsive and learning-oriented while maintaining focus on core priorities.	Patient Safety Incident Investigation (PSII)	Flexible
*Application of Rationale <i>The rationale supports decision-making regarding the commissioning of Patient Safety Incident Investigations (PSIIs).</i> <i>Incidents meeting the criteria do not automatically require a PSII. Where appropriate, proportionate alternative learning responses will be considered.</i>			

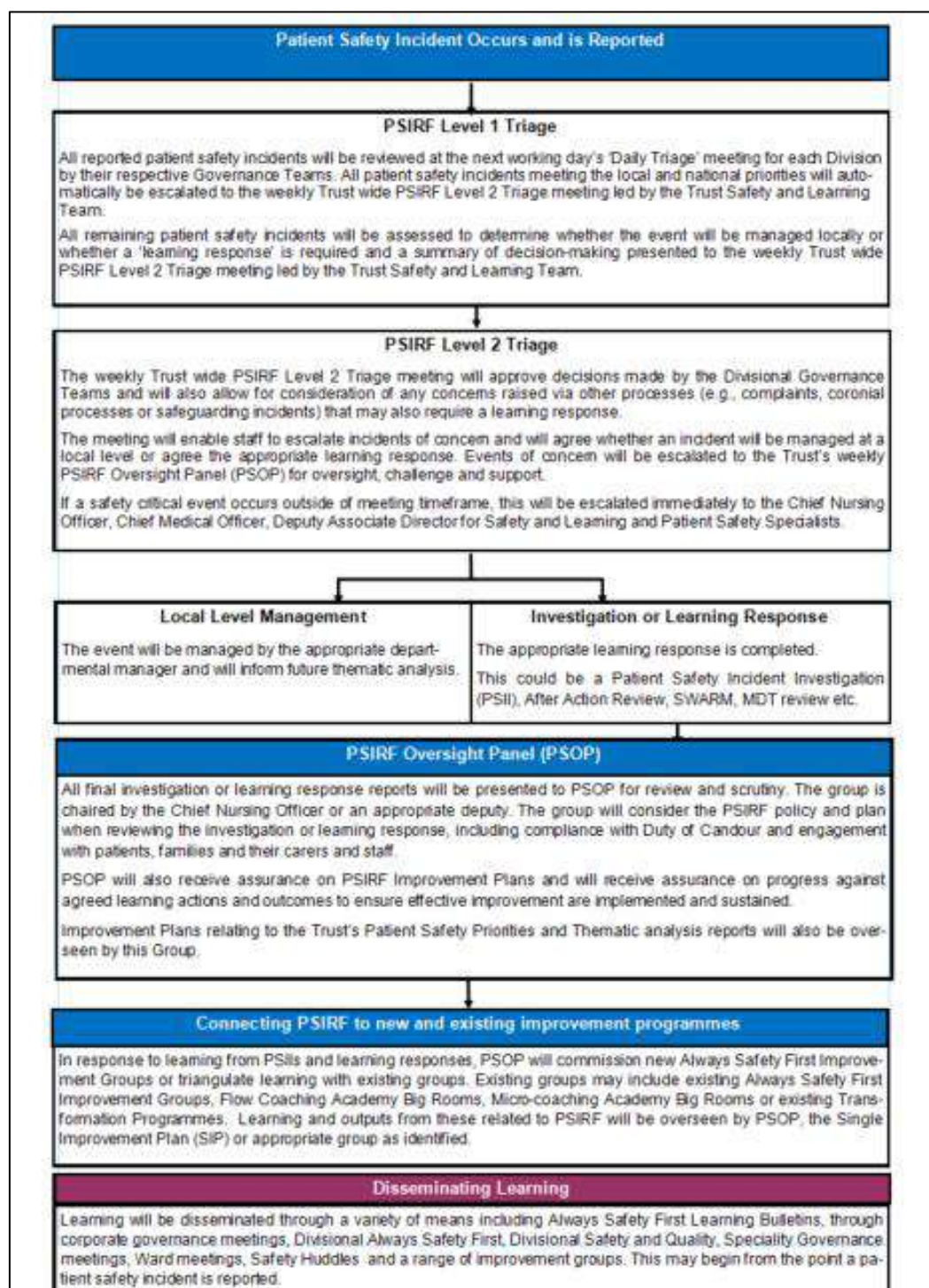
Safety events which previously met the Serious Incident Framework's definition of a 'serious incident' do not need to be routinely investigated using the PSII process.

By undertaking PSII investigations for events that do not meet the criteria of the identified patient safety priorities, the Trust runs the risk of recreating the Serious Incident Framework.

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8.0 How we will respond to patient safety events

The infographic below describes the governance arrangements in relation to how the Trust will respond to a patient safety event.



The infographic below describes how patient safety events assessed under the national priorities, local priorities and local level criteria will be managed and how improvement plans will be developed.

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How We Will Respond to Patient Safety Events				
Patient Safety Event Occurs	National Priorities	Event	Approach	Improvement
		Maternity Incidents meeting HSSIB criteria	Referred to Maternity and Newborn Safety Investigations (MNSI)	Respond to recommendations from external referred agency/organisation as required.
		Neonatal Incidents meeting HSSIB criteria		
		Child Death	Initiate child death review process	Learning and improvement plans will feed into improvement programmes where appropriate.
		Death of person with learning disabilities	Refer for Learning Disabilities Mortality Review (LeDeR)	
		Safeguarding incidents meeting criteria	Reported to Local Authority and Trust's Safeguarding Team	
		Incidents in screening programmes	Reported to Public Health England (PHE)	
		Death of patients in custody/prison/probation	Reported to Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC)	
		Mental Health related homicides	Referred to NHSE Regional Independent Investigation Team for consideration of independent PSII	
		Domestic homicides	Identified by the Police in partnership with Community Safety Partnership (CSP) who will review the case	
	Local Priorities	Incidents resulting in death (thought more likely than not) due to problems in care	Patient Safety Incident Investigation (PSII)*	Create local organisational recommendations and actions.
		Incidents meeting the Never Event criteria		Learning and improvement plans will feed into improvement programmes where appropriate.
		Death of patient detained under the MHA or where the MCA applies		
Local Level	Local Priorities	Patient Safety Priorities: • Patients remaining in inappropriate care settings leading to deterioration • Care not personalised for patients with specific vulnerabilities • System-level failures across pathways, interfaces and handovers • Emerging Risks	Patient Safety Incident Investigation (PSII)*	Create local organisational recommendations and actions. Learning and improvement plans will be developed in conjunction with the improvement programme aligned to the relevant local priority.
		Incidents resulting in moderate or severe harm to patient	Appropriate learning response agreed at Daily Triage	Inform thematic analysis of ongoing patient safety risks.
Local Level	Local Priorities	No or Low Harm Patient Safety Incident	Local management with data reviewed for themes and trends, or appropriate learning response agreed at daily triage	Learning and improvement plans will feed into improvement programmes where appropriate.
		*Refer to the Patient Safety Incident Response Plan for guidance on when a PSII or a proportionate alternative learning response, may be undertaken if appropriate.		

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9.0 Learning Responses

The PSIRF emphasises that not all patient safety events require a full Patient Safety Incident Investigation. Instead, organisations should utilise a range of proportionate learning responses, selecting the approach that is most likely to generate meaningful insight and support improvement.

In line with this, the Trust has embedded a range of learning response methodologies, enabling us to respond flexibly and appropriately depending on the nature, complexity and context of the incident. This ensures that:

- learning is captured in a timely way
- staff and patients are engaged at the appropriate level
- investigation effort is proportionate to the potential for learning and risk

This approach supports both Safety I and Safety II principles, recognising the importance of learning not only from harm, but also from what works well in practice.

Some patient safety events will not require a PSII but may benefit from a different type of examination to gain further insight or address queries from the patient, family, carers or staff. A clear distinction is made between the activity, aims and outputs from reviews and those from PSIIIs.

The timeframes set are intended to be used as a guide and should be flexible if there are circumstances that require more in depth understanding.

9.1 Types of learning responses

The table below gives an overview of the different types of learning responses.

Type of learning response	Description	Timeframe
Patient Safety Incident Investigation (PSII)	A PSII offers an in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how. These	To be agreed in discussion with those affected, particularly the patient(s) and/or their carer(s), where
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Type of learning response	Description	Timeframe
	will be undertaken using Systems Engineering Initiative for Patient Safety (SEIPS) methodology.	they wish to be involved in such discussions. Depending on discussions with stakeholders, to be completed within 3 months and/or no longer than 6 months.
Multidisciplinary (MDT) Team Review	An MDT review supports health and social care teams to identify learning from multiple patient safety incidents (including incidents where multiple patients were harmed or where there are similar types of incidents). This could include incidents that occurred in the significant past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. The aim is, through open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting(s)), to agree the key contributory factors and system gaps that impact on safe patient care.	Ordinarily within 20 working days of being commissioned.
Rapid Learning Review (RLR) - slightly more	A structured, short-cycle review used to quickly understand what happened and identify immediate learning	Ordinarily within 10 working days of the event being

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Type of learning response	Description	Timeframe
structured, documented rapid review	following an incident. Typically used where timely insight is required to mitigate ongoing risk or where a full PSII is not proportionate. May include brief case review, staff discussion and early identification of contributory factors.	identified to allow for RLR and documentation to be completed.
SWARM - immediate response	The swarm huddle is designed to be initiated as soon as possible after an event and involves an MDT discussion. Staff 'swarm' to the site to gather information about what happened and why it happened as quickly as possible and (together with insight gathered from other sources wherever possible) decide what needs to be done to reduce the risk of the same thing happening in future	Ordinarily within 10 working days of the event being identified to allow for SWARM and documentation to be completed.
After action review (AAR)	AAR is a structured facilitated discussion of an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT and can	Ordinarily within 20 working days of the event being reported.

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Type of learning response	Description	Timeframe
	be used to discuss both positive outcomes as well as incidents. It is based around four questions: 1. What was the expected outcome/expected to happen? 2. What was the actual outcome/what actually happened? 3. What was the difference between the expected outcome and the event? 4. What is the learning?	
Thematic Review	A thematic review can identify patterns in data to help answer questions, show links or identify issues. Thematic reviews typically use qualitative (I.e., Incident reports, Complaints data etc.) rather than quantitative data to identify safety themes and issues. Thematic Reviews can be used for multiple purposes, including: • Developing or revising our Safety Improvement Profile • Aggregating information from many diverse sources of safety intelligence datasets.	As agreed by the PSIRF Oversight Panel or Divisional Management Team or relevant other

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Type of learning response	Description	Timeframe
	- Gathering insight about gaps / safety issues across a pathway or as part of an overarching safety theme to direct further analysis - Aggregating findings from multiple incident responses to identify interlinked contributory factors to inform / direct improvement efforts. - Presenting summary data to show the impact of ongoing safety improvement work.	

9.2 Anticipated time commitment for completion of learning responses

The PSIRF recognises that high-quality learning responses require the right level of time, skill and resource to ensure meaningful understanding and improvement.

As part of this refresh, the Trust has reviewed the original estimated time commitments for learning responses against actual delivery over the first two years of PSIRF implementation. This has helped to develop a more realistic understanding of the time required, based on:

- practical experience of undertaking investigations
- feedback from investigators and staff involved in reviews
- benchmarking with other organisations

This review has shown that the time required to complete learning responses can vary depending on the complexity of the incident, the level of engagement required with patients, families and staff, and the depth of analysis needed.

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Response type	Anticipated Time
SWARM (immediate response)	Undertaken as soon as possible, often at or near the bedside. The active learning discussion typically takes no longer than 15–30 minutes, focused on rapid information gathering, understanding what happened, and identifying any immediate actions to reduce risk. Total time (typically 1–4 hours in total) may be required for preparation, documentation, and write-up following the SWARM.
Rapid Learning Review (RLR)	The learning response should typically take no more than 30–60 minutes to complete and is undertaken soon after the initial event, enabling timely capture of learning. It focuses on understanding what happened, identifying contributory factors, and agreeing immediate actions to reduce risk. A total time of 4–8 hours may be required to support preparation and documentation.
After Action Review (AAR)	The learning response should typically take no more than 1 hour to complete and is undertaken soon after the initial event to capture learning while it is still fresh, focusing on understanding what happened, identifying contributory factors, and agreeing immediate risk-reduction actions. Total time (typically 10–12 hours) may be required to support preparation, coordination, documentation, and formal reporting.
Multidisciplinary Team (MDT) Review	Review time may vary depending on the number of cases. Individual review sessions should typically take no more than 1.5 – 2 hours; where additional time is required, further sessions will be arranged. Total time (typically 15–25 hours) is required to support preparation, coordination and formal write-up.

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Thematic Review	Typically requires 35 to 60 hours overall, depending on scope, number of cases reviewed and depth of analysis.
Patient Safety Incident Investigation (PSII)	Typically requires 50 to 100 hours in total , depending on complexity. This includes detailed analysis, engagement with patients, families and staff, and report development.

9.3 Anticipated number of learning responses

The PSIRF promotes a move away from high volumes of investigations towards a more proportionate and learning-focused approach, where the type of response is matched to the nature and complexity of the incident.

As part of this refresh, the Trust has reviewed its original assumptions about the number of learning responses required, using data from our experience of implementing PSIRF between November 2023 and September 2025. This has enabled us to develop a more accurate and realistic picture of the level and type of activity required.

Our analysis has shown a clear shift in how patient safety incidents are managed. In particular:

- fewer Patient Safety Incident Investigations (PSIIs) are required than originally planned
- there is increased use of rapid and proportionate learning responses, such as SWARMS, Rapid Learning Reviews and After Action Reviews
- thematic and aggregated reviews provide greater insight for system-wide learning, particularly for lower harm incidents

The anticipated activity set out below reflects this shift, with a focus on:

- timely, proportionate responses
- targeting detailed investigations where they add the greatest value
- ensuring that learning is captured, documented and used to improve care

It is important to note that these figures are indicative estimates, based on current experience and available data. Actual activity may vary depending on changes in

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demand, incident profile and emerging risks. The Trust will continue to review this regularly to ensure that its approach remains responsive, sustainable and aligned to improving patient safety.

Response type	Category	Anticipated Volume (2 years)	Rationale
PSII	Local priorities	10–20	Reflects targeted approach following refinement of local priorities, focusing on cases with highest learning potential
PSII	National priorities (deaths more than not due to problems in care)	20–30	Based on recent activity levels and expected continuation of current trends
PSII	Mental Capacity Act / Mental Health Act related deaths	0–4	Low incidence expected; dependent on improved identification and reporting
PSII or proportionate response	Never Events	8–12	Reflects recent increase in reported events and use of proportionate response approaches where appropriate
Proportionate response (AAR, SWARM, RLR, MDT/ Thematic Review)	Moderate and severe harm incidents	220–260	Broadly aligned with recent activity, with emphasis on proportionate and timely learning methods
Proportionate response (AAR, SWARM, RLR, MDT/ Thematic Review)	Low and no harm incidents	Approximately 500	Significant reduction from previous volumes due to aggregation of learning and increased use of thematic approaches

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The table above does not capture learning responses for those patient safety events that may need to be reported externally that do not fit into the current PSIRF national and local priorities criteria. The table is also based on data at the time of producing this incident response plan and likely to be subject to some variation.

10.0 Our patient safety improvement approach

The Trust is committed to ensuring that learning from patient safety events leads to meaningful and sustained improvements in care. The PSIRF is central to this approach, ensuring that learning responses are directly connected to improvement activity across the organisation.

Our approach reflects the Trust's Always Safety First: Safety and Learning Strategy (2026–2030), which focuses on developing safer culture, safer systems and safer care for patients. This ensures that learning from patient safety events is not considered in isolation, but forms part of a wider system of continuous learning and improvement across the organisation.

Learning identified through Patient Safety Incident Investigations (PSIIs) and other learning responses is considered alongside wider safety intelligence to inform improvement activity at:

- organisation level, where Trust-wide priorities and system risks are addressed
- pathway level, where improvements focus on how care is delivered across services
- local level, where teams and departments are supported to improve practice

Where opportunities for learning are identified, these will be aligned to existing improvement activity wherever possible. This includes both:

- reactive learning, where care has not gone as expected (Safety I)
- proactive learning, including learning from positive practice (Safety II), to understand and replicate what works well

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Where gaps in improvement are identified, the Trust will establish new improvement activity through established governance processes.

10.1 Developing and delivering improvement

Learning from patient safety events is translated into improvement through a structured approach. This includes:

- identifying clear areas for improvement based on learning responses
- working collaboratively with staff, patients and partners to understand systems and design solutions
- developing actions and measures to reduce risk and improve safety
- embedding changes in practice and monitoring their impact over time

This approach reflects the Trust's policy, which emphasises that understanding the system is the first step, followed by the design, implementation and ongoing monitoring of safety actions.

Improvement activity will be delivered using a range of approaches, depending on the nature and complexity of the issue. These include multidisciplinary collaboration, targeted improvement initiatives, thematic and cross-service work, and service transformation or pathway redesign.

This flexible approach ensures that improvement activity is proportionate, practical, sustainable. and monitored to ensure improvements are implemented, sustained and demonstrably improve patient safety.

Improvement activity will be aligned to, and delivered through, programmes within the Trust's Single Improvement Plan as appropriate.

10.2 Governance and oversight

The Trust has established governance arrangements to ensure that learning leads to improvement and that progress is monitored effectively.

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- The PSIRF Oversight Panel reviews learning from patient safety incident responses and agrees how improvement will be taken forward
- Improvement activity is delivered through existing Trust groups or dedicated programmes aligned to patient safety priorities
- Progress is monitored through divisional and Trust-wide governance structures.
- Assurance is provided to the Safety and Quality Committee and the Trust Board that improvements are being implemented and sustained

This approach ensures clear oversight, accountability and visibility of how learning is translated into improvement.

Our approach

Our approach ensures that:

- learning from incidents is acted upon, not just identified
- improvements are co-designed with those delivering and receiving care
- changes are evidence-informed and focused on reducing harm
- learning is clearly documented, shared and monitored
- This supports a system where patient safety improvement is continuous, coordinated and embedded in everyday practice, ensuring safer care for our patients.

To strengthen alignment with evolving PSIRF expectations, the Trust will further consider its approach to patient, family and staff involvement across all learning responses, ensuring meaningful co-production of learning and improvement. This includes embedding clear processes for capturing lived experience and demonstrating how this directly influences safety actions. In addition, learning responses will more explicitly consider health inequalities and patient-specific factors as part of incident analysis and prioritisation. The Trust will also enhance its approach to safety action development and impact measurement, ensuring that improvement actions are outcome-focused, tested for reliability, and demonstrate a measurable reduction in harm. This will be supported through strengthened governance and oversight to ensure that learning translates into sustained system improvement

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11.0 Implementation of PSIRF

The Trust began implementing the PSIRF in November 2023, following approval by the Trust Board and ICB. This was undertaken as a phased transition from the previous Serious Incident Framework to a proportionate, learning-focused approach to patient safety.

Implementation was supported through engagement with patients, families, carers, staff, system partners and external stakeholders, including the ICB, CQC and advocacy organisations.

Since implementation, the Trust has continued to review and refine its approach, learning from experience and embedding PSIRF principles across its patient safety systems and processes. This has included a review of capacity, which has identified the need to expand training to ensure a wider cohort of staff are equipped to facilitate learning responses and supporting a more sustainable approach. This is identified as a key priority within the refreshed Always Safety First: Safety and Learning Strategy (2026-2030)

This plan reflects that learning and represents the next phase in the Trust's ongoing development of a more mature, effective and improvement-focused patient safety response system.

12.0 AUDIT AND MONITORING

Aspect of compliance or effectiveness being monitored	Monitoring method	Individual responsible for the monitoring	Frequency of the monitoring activity	Group / committee which will receive the findings / monitoring report and act on findings.	Group / committee / individual responsible for ensuring that the actions are completed
Entire Document	Report	Associate Director of Safety and Learning or appropriate deputy	Quarterly Report	Safety and Quality Committee	PSIRF Oversight Panel
Entire Document	Report	Associate Director of Safety and	Annual	Trust Board	Safety and Quality Committee/

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		Learning or appropriate deputy			PSIRF Oversight Panel
Learning Responses	Report	Associate Director of Safety and Learning or appropriate deputy	Weekly/ Monthly	PSIRF Oversight Panel	PSIRF Oversight Panel

13.0. TRAINING

TRAINING

Is training required to be given due to the introduction of this policy? Yes

The Trust has committed to ensuring that we fully embed the PSIRF and meet its requirements. We have therefore used the NHS England patient safety response standards (to frame the resources and training required to allow for this to happen. A summary of the training requirements can be found in the [PSIRF Policy](#).

14.0. DOCUMENT INFORMATION

ATTACHMENTS

Appendix Number	Title
Appendix 1	Assessment criteria for identifying local priorities.
Appendix 2	Equality, Diversity & Inclusion Impact Assessment Form

OTHER RELEVANT / ASSOCIATED DOCUMENTS

Unique Identifier	Title and web links from the document library
RMP-C-278	Patient Safety Incident Response Policy
RMP HS 114	Reporting, investigation and management of incidents (including incidents under PSIRF)
TP-149	Being Open Policy (incorporating Duty of Candour and PSIRF engagement)
SOP-394	Complaints Policy and Procedure
HRP-02	Raising concerns at work policy and procedure (incorporating Freedom to Speak Up and Whistleblowing)
TP-96	Work Related Incidents and Staff Debrief and Support Policy.
	Our Trust Strategy 2025–2030 (LTHTR, 2025)
See Reporting, investigation and management of incidents (including incidents under PSIRF) for links to other Associated Documents	

SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS

References in full

Checked by Library ET 22/05/2026

Number	References
1	Patient Safety Incident Response Framework (NHS England, 2022)
2	Engaging and Involving Patients, Families and Staff Following a Patient Safety Incident (HSSIB, Learn Together and NHS England, 2022)
3	Regulation 20: Duty of Candour (CQC, 2025)
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4	Being Fair Tool (NHS England, 2025)
5	The NHS Patient Safety Strategy (NHS England, original strategy 2019, plus various updates)
6	Fit for the future: 10 Year Health Plan for England (Department of Health & Social Care, 2025)
7	Mental Health Act 1983
8	Mental Capacity Act 2005
9	Never events (NHS England, 2018)
10	Domestic Violence, Crime and Victims Act 2004

DEFINITIONS / GLOSSARY OF TERMS

Abbreviation or Term	Definition
AAR	After Action Review A learning response tool consisting of a structured facilitated discussion of an event/incident
CQC	Care Quality Commission Independent regulator for health and social care in England
CSP	Community Safety Partnership Statutory partnerships of organisations who work together in an area to reduce crime and the fear of crime, anti-social behaviour, alcohol, and drug misuse and reducing re-offending
Core20PLUS5	Core20PLUS5 A national NHS England approach to inform action and reduce healthcare inequalities at both national and system levels, focused initially on the experience of adults, but has now been adapted to apply to children and young people
DHR	Domestic Homicide Review A review into the circumstances around a death of a person following domestic abuse
HealthWatch	HealthWatch A health and social care champion service who obtain the views of people about their needs and experience of local health and social care services
HSSIB	Healthcare Services Safety Investigation Body The independent national investigator for patient safety in England
ICB	Integrated Care Board A statutory organisation who are responsible for developing a plan for meeting the health needs of the local population, managing the NHS budget, and arranging for the provision of NHS services in a geographical area
ICS	Integrated Care System

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	Partnerships of organisations which come together to deliver joined up health care services and improve the lives of people who live in the area
IOPC	Independent Office for Police Conduct A non-departmental public body in England and Wales who are responsible for overseeing the system for handling complaints made against police forces in England and Wales
LeDeR	Learning Disability and Mortality Review A service improvement programme for people with a learning disability and autistic people who look at key episodes of health and social care the person received that may have been relevant to their overall health outcomes
LFPSE	Learning from Patient Safety Events The new national NHS service for the recording and analysis of patient safety events
LTHTR	Lancashire Teaching Hospitals NHS Foundation Trust
Magnet4Europe	Magnet4Europe A four-year Horizon project that aims to improve mental health and wellbeing among health professionals in Europe
MDT	Multi-Disciplinary Team A group of staff from different areas in healthcare
NRLS	National Reporting and Learning System The current national central database for recording and analysing patient safety incident reports
PALS	Patient Experience and Liaison Service The Trust's team which provides support for patients, families, and carers
PPO	Prison and Probation Ombudsman A public body that carries out independent investigations into complaints and deaths in custody
PSIRF	Patient Safety Incident Response Framework A new and innovative approach to the way the NHS responds to patient safety incidents/events.
PSIRP	Patient Safety Incident Response Plan The plan which sets out how NHS organisations intend to respond to patient safety incidents/events under PSIRF
PSP	Patient Safety Partners The role that patients, carers and other lay people can play in supporting and contributing to a healthcare organisations' governance and management processes for patient safety
PSII	Patient Safety Incident Investigation

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	A learning response tool which is undertaken when an incident or near miss indicates significant patient safety risks and the potential for new learning
Safety I	Safety I Identifying causes and contributing factors in patient safety events as the focus point in an attempt to stop them occurring
Safety II	Safety II Considering variations in everyday performance to understand how things usually go right
SEIPS	Systems Engineering Initiative for Patient Safety A methodology for understanding outcomes within complex socio-technical systems
SIF	Serious Incident Framework The current process by which the NHS ensures serious incidents are identified, investigated, and learned from to prevent the likelihood of similar incidents happening again. This framework will be replaced by PSIRF
SOP	Standard Operating Procedure A guide/step by step instructions compiled by an organisation to help staff to carry out routine tasks/processes
SpHA	Special Healthcare Authority An authority who provides a health service to the whole of England, not solely to a local community
STP	Sustainability and Transformation Partnership Where local NHS organisations and Local Authorities draw up shared proposals to improve health and care in the areas they serve

CONSULTATION WITH STAFF AND PATIENTS

Enter the names and job titles of staff and stakeholders that have contributed to the document

Name	Job Title	Date Consulted
NMAHP group	Senior Nurses, Ward Managers, AHP leads	20/9/23
Visually Impaired Forum	Patients	22/9/23
Clinical Reference Group	Senior Clinicians	25/9/23
Patient Experience and Involvement Group	Staff, Patients and Advocacy Services	26/9/23
Carers forum	Patients	27/9/23
Cancer Forum	Patients	3/10/23
Dementia Strategy Meeting	Staff and Patients	5/10/23
EDI forum	Staff	9/10/23

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Safety and Quality Committee	Executives, Non Executives, Senior Leaders	29/9/23
Board of Directors Public Meeting	Directors and Public	5/10/23
Sarah Cullen	Chief Nursing, Midwifery & AHP Officer	15/09/2023
Emma Ashton	Divisional Midwifery Director	15/09/2023
Joanne Connolly	Divisional Nursing Director	15/09/2023
Lisa Elliott	Divisional Nursing Director	15/09/2023
Catherine Gregory	Deputy Chief Nursing Officer	15/09/2023
Rachel Sansbury	Divisional Nursing Director	15/09/2023
Kate Smith-Probert	Deputy Divisional Nursing Director	15/09/2023
Jacqueline Murray	Deputy Divisional Nursing Director	15/09/2023
Cathy Owen	Divisional Clinical Governance Lead	15/09/2023
Rachel Moxham	Divisional Clinical Governance Lead	15/09/2023
Clare Shaw	Compliance & Governance Officer	15/09/2023
Emma Holden	Safety and quality matron for maternity	15/09/2023
Karin Colbeck	Divisional Clinical Governance Lead	15/09/2023
Sarah Howarth	Divisional Clinical Governance Lead	15/09/2023
Joanne Lambert	Deputy Divisional Nursing & Midwifery Director	15/09/2023
Simon Regan	Associate Director of Risk & Assurance	15/09/2023
John Howles	Associate Director of Patient Experience & Engagement	15/09/2023
Anne Kirkham	Head of Community Services	15/09/2023
Katy Clay	Governance & Risk Manager	15/09/2023
Michelle Durkin	Deputy Associate Director of Safety & Learning	15/09/2023
Michael Stewart	Deputy Medical Officer	15/09/2023
Claire Granato	Chief AHP	15/09/2023
Lauren O'Brien	Deputy Director of Education	15/09/2023
Christopher Taylor	Head of Training Performance & Compliance	15/09/2023
Arnab Bhowmick	Deputy Medical Officer	15/09/2023
Lousie Gracie	Deputy Divisional Nursing Director	15/09/2023
Gareth Price	Chief Pharmacist	15/09/2023
Caroline Marshall	Associate Director of Patient Safety, ICB	19/09/2023
Kimberley Ciralo	Patient Safety Manager, ICB	19/09/2023
Louisa Graham	Deputy Director of Workforce & OD	18/09/2023
Kate Holt	Organisational Development & Culture Lead	18/09/2023

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Amanda Davis	Head of Diversity & OD	18/09/2023
Jennifer Carroll	Continuous Improvement Clinical Fellow	18/09/2023
Kurt Bramfitt	Senior Associate Director of Continuous Improvement	18/09/2023
Elizabeth Midwinter	Continuous Improvement Clinical Fellow	18/09/2023
Stuart Clough	Senior Associate Director of Continuous Improvement	18/09/2023
PSIRF Oversight Panel	Members of PSIRF Oversight Panel	24/10/2024
Safety & Quality Committee	Members of Safety & Quality Committee	29/05/2026

DISTRIBUTION PLAN	
Dissemination lead:	Lisa Elliott/Helen Hodgson/Michelle Durkin
Previous document already being used?	No
If yes, in what format and where?	NA
Proposed action to retrieve out-of-date copies of the document:	NA
To be disseminated to:	Trust wide
Document Library	Yes
Proposed actions to communicate the document contents to staff:	• Include in the LTHTR procedural documents communication. • Document uploaded to the Document Library. • Circulate via relevant stakeholder groups.

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Department/Function	Corporate			
Lead Assessor	Hajara Ugradar			
What is being assessed?	Impact of document on equality.			
Date of assessment	Reviewed 22/05/2026 and still appropriate			
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	Equality of Access to Health Group	☐	Staff Side Colleagues	☒
	Service Users	☒	Staff Inclusion Network/s	☒
	Personal Fair Diverse Champions	☐	Other (Inc. external orgs)	☒
	Please give details:			

1) What is the impact on the following equality groups?		
Positive:	Negative:	Neutral:
➢ Advance Equality of opportunity ➢ Foster good relations between different groups ➢ Address explicit needs of Equality target groups	➢ Unlawful discrimination, harassment and victimisation ➢ Failure to address explicit needs of Equality target groups	➢ It is quite acceptable for the assessment to come out as Neutral Impact. ➢ Be sure you can justify this decision with clear reasons and evidence if you are challenged
Equality Groups	Impact (Positive / Negative / Neutral)	Comments:
		➢ Provide brief description of the positive / negative impact identified benefits to the equality group. ➢ Is any impact identified intended or legal?
Race (All ethnic groups)	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.
Disability (Including physical and mental impairments)	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.
Sex	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.

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Gender reassignment	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.
Religion or Belief (includes non-belief)	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.
Sexual orientation	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.
Age	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.
Marriage and Civil Partnership	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.
Pregnancy and maternity	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.
Other (e.g. caring, human rights, social)	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.

2) In what ways does any impact identified contribute to or hinder promoting equality and diversity across the organisation?	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.

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- 3) If your assessment identifies a negative impact on Equality Groups you must develop an action plan **to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised.**
- This should include where it has been identified that further work will be undertaken to further explore the impact on equality groups
 - This should be reviewed annually.

ACTION PLAN SUMMARY

Action	Lead	Timescale
NA	NA	NA

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HOW THE NHS CONSTITUTION APPLIES TO THIS DOCUMENT

WHICH PRINCIPLES OF THE NHS CONSTITUTION APPLY? Click here for guidance on Principles 1. The NHS provides a comprehensive service, available to all. 2. Access to NHS services is based on clinical need, not an individual's ability to pay. 3. The NHS aspires to the highest standards of excellence and professionalism. 4. The patient will be at the heart of everything the NHS does. 5. The NHS works across organisational boundaries. 6. The NHS is committed to providing best value for taxpayers' money. 7. The NHS is accountable to the public, communities and patients that it serves.	Tick those which apply ✓ ✓ ✓ ✓ ✓ ☐ ✓	WHICH STAFF PLEDGES OF THE NHS CONSTITUTION APPLY? Click here for guidance on Pledges 1. Provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability. 2. Provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities. 3. Provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential. 4. Provide support and opportunities for staff to maintain their health, wellbeing and safety. 5. Engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families. 6. To have a process for staff to raise an internal grievance. 7. Encourage and support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Employment Rights Act 1996.	Tick those which apply ✓ ✓ ✓ ✓ ✓ ✓ ✓
WHICH AIMS OF THE TRUST APPLY? Click here for Aims 1. To offer excellent health care and treatment to our local communities. 2. To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria. 3. To drive innovation through world-class education, teaching and research.	Tick those which apply ✓ ✓ ☐	WHICH AMBITIONS OF THE TRUST APPLY? Click here for Ambitions 1. Consistently deliver excellent care. 2. Great place to work. 3. Deliver value for money. 4. Fit for the future.	Tick those which apply ✓ ✓ ☐ ✓

Lancashire Teaching Hospitals NHS Foundation Trust		ID No. Plan-27
Version No: 2	Next Review Date:	Title: Patient safety incident response plan
Do you have the up to date version? See the intranet for the latest version		

D) HEALTH INEQUALITIES AND HEALTH IMPROVEMENT PLAN ANNUAL UPDATE

☒ Other

Item for Assurance

REFERENCES

Only PDFs are attached



11.1d Health Inequalities and Health Improvement Plan Annual Update 4 June 26.pdf



11.1d Health Inequalities and Health Improvement Plan Annual Update Appendices Board Part I 4 June 26.pdf

Board of Directors Report

Meeting of the	Board of Directors		4th June 2026
	Part I	☒	Part II ☐
Title of Report	Health Inequalities and Health Improvement Plan Annual Update		
Report Author	Rachel Sansbury Deputy Chief Nursing Officer		
Lead Executive Director	Sarah Morrison Deputy Chief Executive and Chief Nursing Officer		
Recommendation/ Actions required	The Board of Directors is asked to note the progress with the Health Improvement Plan		
	Decision ☐	Assurance ☒	Information ☐
Executive Summary	The purpose of this report is to share an update on progress since publishing the first Lancashire Teaching Hospitals Health Improvement plan: A plan to reduce health inequalities 2024 – 2026 in December 2024 (appendix 4). The plan was developed through an extensive consultation exercise to ensure appropriate engagement with key internal and external stakeholders across organisations. The plan reflects the shared ambition of our partners who are equally crucial to its success. The Director of Public Health, Wellbeing and Communities at Lancashire County Council was influential in steering our approach to this work and has shared generously his expertise and knowledge, ensuring what is produced aligns to the local priorities of both the Integrated Care Partnership, Integrated Care Board and Lancashire County Council as well as the more recently published NHS 10-year plan. A specific area of challenge is consistent and useable data related to health inequalities. Providing a dataset and an operational metric dashboard with a health inequality lens is still an ambition but is delayed in delivery due to other demands on limited business intelligence resource. In mitigation for this the annual health inequality dataset 2025/26 (appendix1) is updated and shared through the Health Inequalities Group to allow high level analysis and identify where more focused investigation of the data is required. The data includes analysis using Indices of Multiple Deprivation (IMD) with IMD 1 representing the most deprived communities and IMD 10 representing the least deprived communities. Analysis of the data in appendix 1 shows the following key themes: Children (under 18 years) - Children from the most deprived communities (both male and female) make up the biggest percentage of inpatient elective activity with 14% of children from communities at IMD 1 compared to 8% at IMD 10. - Over the last 2 years there has been an overall reduction in the number of inpatient elective procedures for children. - The reduction in activity is proportionally higher in children in IMD 1 compared to the years 2019/20 to 2023/24. This may indicate an emerging risk of a widening of inequalities for children in the most deprived communities.		

- Emergency activity for children shows higher levels of children from IMD 1-3 accessing emergency care compared to children in IMD 8-10 groups.
- The number of Asian/Asian British children in IMD 1-3 accessing emergency care is disproportionately higher than less deprived groups which is similar to the previous year.
- Tooth extractions are sentinel indicator of child health inequality. 496 tooth extractions were carried out in children under 10 years over the last 12 months with 86 procedures for children in IMD 1 compared to 22 in IMD 10.
- Overall, the data analysis indicates well understood themes on the impact of the wider determinants of health for children and young people and reinforces the importance of the actions outlined within the health improvement plan

Adults

- Adults in IMD 1 and IMD 8 groups make up the biggest proportion of elective activity in a persistent pattern over the last 7 years.
- 34% of elective activity undertaken over the last year was for IMD 1-3 groups compared to 32% in IMD 8-10 groups.
- There was a reduction overall in adult inpatient elective activity in 2025/26 compared to the previous year. There is an emerging theme of a greater proportionate reduction in IMD 1-3 compared to IMD 8-10 groups. This highlights a potential widening inequality and requires further analysis.
- Elective activity for adults shows an increase across all IMD groups compared to the baseline position of 2019/20.

In summary the report describes delivery progress and impact to patients experience and outcomes and highlights areas of good practice. Highlights of these include:

- **Improvement in Children and young People's (CYP) Health:** The number of children who were not brought (WNB) for appointments improved significantly from 10.52% in 2024/25 to 5.98% in March 2026.
- **CYP Diabetes Management:** 99% of children under the paediatric diabetes team are on Continuous Glucose Monitoring. 70% of children are on insulin pumps compared to 65% in 2024/25.
- **CYP - Violence Interventions:** ED Navigators continue to provide trauma-informed support to children and young people at risk of serious youth violence
- **Health Inequality Training:** Training sessions have been provided to Nursing Midwifery and Allied Health Professional (NMAHP) Leaders on "very brief interventions" to help patients access support on stopping smoking and reducing alcohol intake.
- Lancashire and South Cumbria Cancer Alliance and the Trust cancer education hub have delivered health inequality training to cancer alliance members
- **Health Literacy awareness:** Over 100 leaders trained across several staff groups including Advanced Clinical Practitioners, NMAHP leaders, Pharmacy, Enhance Program Foundation Years trainee doctors with health literacy now embedded in professional preceptorship programmes.
- **Community Engagement:** The Associate Director of Quality and Experience has been working closely with a wide range of community services and building partnerships that extend beyond the hospital. This includes strong links with groups such as Deaf Ways, Preston Muslim Forum, and the Asian Elders Group.
- **Health Promotion:** The Tobacco and Alcohol Care Team (TACT) has seen a significant increase in the 4-week quit rate, with an average of 75 patients per month agreeing to continue with stop smoking support. The Trust Child Excessive Weight service has also received excellent patient feedback.

- **Support for Vulnerable Groups:** The HIU programme has seen 92% of patients accessing the service reduce ED attendances by 25% or more. Patients accessing the service have also had overall reduction of 20% in hospital admissions. The ED Navigator has received 233 referrals for interventions, including signposting to drug and alcohol services and referrals to community youth services.
- **Maternity care:** The Trust has been focusing on reducing post-partum haemorrhage (PPH) for minority ethnic groups. This effort has resulted in a nationally recognised improvement, with a 3% reduction in PPH and improved patient experience.
- **Prisoner Waiting List Management:** Continued reduction in waiting times for prisoners with now 0 patients waiting over 65 weeks and continued reduction of those waiting over 52 weeks.
- **The Lancashire Health Hub:** Has received a national award from the University of Sheffield for the work to increase resources to address health literacy. The Lancashire Health Hub is now widely signposted through the Trust and through digital platforms.

Whilst there is positive evidence of progress, this has remained in early stages and is still to be expanded and broaden areas of good practice across services Trust wide. The plan has been challenging to deliver due to reduced resource and lack of specific funding for health inequalities to enable the organisation to prioritise and promote this work over the last 12 months. In the latter part of the year improvement events with clinical leaders have taken place to develop a prioritised approach to the work focusing on what is achievable in current resources in the coming year. This has resulted in the following priorities that are detailed within the Single Improvement Plan:

- Development of a health inequalities data dashboard to allow data to be embedded in key operational and divisional forums.
- Continued training development for EDI and health inequalities.
- Compliance with the updated NHSE standards for Reasonable Adjustment Needs published in February 2026.
- Conversion of patient information leaflets into Easy Read format and multiple languages
- Maximising the use of the NHS Shared Care record to allow transfer of information between primary, secondary and community care.
- Develop options to expand the provision of the High Intensity User model.
- Develop data reporting into the operational board to include stage of cancer diagnosis split by protected characteristics and IMD.
- Further develop the high-risk case finding approach in the Plus 5 groups for adults and children.
- Development of standards and a guidance framework to reduce the risks of digital exclusion.
- Delivery of the Dementia plan aligned to the Lancashire and South Cumbria Dementia Strategy.
- Improving standards of care for children, young people and adults who are at high risk of being vulnerable in a hospital setting.

Link to Strategic Objectives 2025/26

Patients – deliver excellent care: Improve outcomes, reduce harm and deliver a positive patient experience.	☒
Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.	☒
People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.	☐
Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.	☐
Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.	☒

Due Diligence		
Committee Approval:	Name of Committee: Safety & Quality	Date: 29.05.26
Operational Group Review:	Name of Operational Group: Health Inequalities Group	Date: 14 th May 2026
Link to Board Assurance Framework:	Principal Risk 3 (25/26) - People experiencing Health inequalities	
Appendices	Appendix 1: Annual Health Inequality Data Set 2025/26 Appendix 2: Improvement Measures Dashboards Appendix 3: Appendix 3 Easy Read Health improvement plan poster Appendix 4: Lancashire Teaching Hospitals Health Improvement plan: A plan to reduce health inequalities 2024 – 2026	

***Supplementary Report ***

Meeting of the	Board of Directors		4th June 2026
	Part I ☒	Part II ☐	
Title of Report	Health Inequalities and Health Improvement Plan Annual Update		
Report Author	Rachel Sansbury Deputy Chief Nursing Officer		
Lead Executive Director	Sarah Morrison Deputy Chief Executive and Chief Nursing Officer		
Recommendation/ Actions required	The Board of Directors is asked to: is asked to note the progress with the Health Improvement Plan and endorse the report for submission to the Trust Board of Directors		
	Decision ☐	Assurance ☒	Information ☐
Executive Summary	The purpose of this report is to share an update on progress since publishing the first Lancashire Teaching Hospitals Health Improvement plan: A plan to reduce health inequalities 2024 – 2026 in December 2024 (appendix 4). The plan was developed through an extensive consultation exercise to ensure appropriate engagement with key internal and external stakeholders across organisations. The plan reflects the shared ambition of our partners who are equally crucial to its success. The Director of Public Health, Wellbeing and Communities at Lancashire County Council was influential in steering our approach to this work and has shared generously his expertise and knowledge, ensuring what is produced aligns to the local priorities of both the Integrated Care Partnership, Integrated Care Board and Lancashire County Council as well as the more recently published NHS 10-year plan. A specific area of challenge is consistent and useable data related to health inequalities. Providing a dataset and an operational metric dashboard with a health inequality lens is still an ambition but is delayed in delivery due to other demands on limited business intelligence resource. In mitigation for this the annual health inequality dataset 2025/26 (appendix1) is updated and shared through the Health Inequalities Group to allow high level analysis and identify where more focused investigation of the data is required. The data includes analysis using Indices of Multiple Deprivation (IMD) with IMD 1 representing the most deprived communities and IMD 10 representing the least deprived communities. Analysis of the data in appendix 1 shows the following key themes: Children (under 18 years) - Children from the most deprived communities (both male and female) make up the biggest percentage of inpatient elective activity with 14% of children from communities at IMD 1 compared to 8% at IMD 10. - Over the last 2 years there has been an overall reduction in the number of inpatient elective procedures for children. - The reduction in activity is proportionally higher in children in IMD 1 compared to the years 2019/20 to 2023/24. This may indicate an emerging risk of a widening of inequalities for children in the most deprived communities. - Emergency activity for children shows higher levels of children from IMD 1-3 accessing emergency care compared to children in IMD 8-10 groups.		

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Link to Strategic Objectives 2025/26	Patients – deliver excellent care: Improve outcomes, reduce harm and deliver a positive patient experience.	☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.	☒

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	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.		☐
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.		☒
Due Diligence			
Committee Approval:	Name of Committee: Safety & Quality	Date: 29.05.26	
Operational Group Review:	Name of Operational Group: Health Inequalities Group	Date: 14 th May 2026	
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1. Background

In December 2024 Lancashire Teaching Hospitals published its first Health Improvement plan: Our plan to reduce health inequalities 2024 – 2026. The plan was developed through an extensive consultation exercise to ensure appropriate engagement with key internal and external stakeholders across organisations. The plan reflects the shared ambition of our partners who are equally crucial to its success. The Director of Public Health, Wellbeing and Communities at Lancashire County Council was influential in steering our approach to this work and has shared generously his expertise and knowledge, ensuring what is produced aligns to the priorities of both the Integrated Care Partnership, Integrated Care Board and Lancashire County Council.

The plan reflects our ambition to transform into a 'health improvement organisation' that not only treats illness but also actively promotes health and wellbeing for our patients, their families and carers, and our colleagues. The plan is aligned to the NHS 10-year plan focusing collectively on prevention, education, and creating supportive environments, we aim to ensure that everyone has the opportunity to lead a healthy life in Lancashire and South Cumbria.

2. Discussion

2.1 Approach

The Health Improvement Plan was developed using Quality Improvement methodology which includes structuring the plan using a driver diagram method. This helps to translate high-level

improvement goals into a logical set of underpinning drivers and projects which have been split into strategic and operational drivers.

The plan was published in December 2024 and set out the expected timescales for completion of the strategic and operational aims. During 2025/26 the plan detailed work specifically for the Patients segment Trust Single Improvement Plan (SIP) with detailed timescales and metrics to monitor delivery. For 2026/27 the Health Improvement Plan priorities have transitioned into the Partnerships section of the SIP reflecting the stronger alignment with the Partnerships portfolio including the digital workstream.

The Health Improvement Plan will be due for update and review at the end of 2026. At this point a longer-term strategy will be developed as our organisation grows its understanding and maturity in reducing health inequalities working alongside the development of the Neighbourhood plans developed by the Health and Wellbeing Board in Lancashire.

2.2Detailed progress

Table 1 and table 2 below articulate the progress against the strategic and operational plan, whether the work has been delivered, partially delivered or not delivered and a narrative update on progress. As shown in the table most of this work has started and is now maturing to expand on pilots or broaden examples of good practice across the organisation into all services. Where actions are identified as partially delivered these will continue to be ongoing work over the coming 12 months. This will be monitored via the Trust Health Improvement Group providing a monthly Chairs report to the Safety and Quality Committee and the specific priorities that are identified within the SIP being reported into the SIP Board.

Table 1. Strategic Plan

Driver	Contributing Work	Outcome	Measures (Outcome, process and balance)	Delivered	Progress to date (May 2026)
AWARENESS	EDUCATION: Develop an educational offer that ranges from core skills to practitioner level understanding of health inequalities and Making Every Contact Count (MECC). Includes enhancing current Equality Diversity and Inclusivity (EDI) training provision to broaden scope and include health inequalities	Increased awareness of health inequalities to make a shift in the way we deliver our services	% Completion of health inequality awareness training	✓ Partially delivered	Training session provided in July 2025 to Nursing Midwifery and Allied Health Professional (NMAHP) Leaders on “very brief interventions” to help patients access support on stopping smoking. Training session provided in November 2025 for NMAHP Leaders on factors causing health inequalities and practical examples to increase health equity from the Health Improvement Plan. Lancashire and South Cumbria Cancer Alliance and the Trust cancer education hub have delivered health inequality training to cancer alliance members. E-learning module developed providing awareness training and outlining the Trusts Health Improvement Plan. Structured approach now in place to for appropriate health inequality content to be included in all mandatory and role specific training as part of the 3 yearly review cycle. EDI training offer in development. Alongside inclusion of health inequalities key subject matter in mandatory training for Patient Safety and Safeguarding. Significant national legislative changes for EDI enacted 2025 have required a large volume of

					updates to the EDI mandatory training offer. The revised training is expected to be available in September.
	HEALTH PROMOTION: Provide staff training and tools on health coaching and signposting for each of the core determinants of health	Increase in uptake of services that support improving socio-economic and health issues	Patient assessment documentation to reflect the socioeconomic determinants of health	 Partially delivered	Targeted work has taken place within surgery on pre-op optimisation, but this is not yet standardised into ways of working across all services. Training session provided in November 2025 for NMAHP Leaders on factors causing health inequalities and practical examples to increase health equity and how to take a trauma informed approach to working with people.
	ACCESSIBILITY: Thread into Single Improvement Plan (SIP) to ensure digital or other communication platforms reflect literacy levels, digital capabilities, and communication needs	Ensure digital and communication solutions do not create barriers to accessing our services	Provision of explicit alternatives for easy read/non digital options	 Partially delivered	During 2025 a small number of leaflets have been published in Easy Read format. Using digital technology to allow all leaflets to be converted to Easy Read format is a priority within the SIP for 2026/27. Signposting advertising the Lancashire Health Hub has been displayed at the main outpatient entrances to the Trust. The Lancashire Health Hub links to the Easy Health website which holds many of the national patient information leaflets in Easy Read format. The Trust has implemented "ReachDeck" on the external internet page. This technology allows all PDF patient information leaflets to be read out loud and many leaflets to be converted into multiple different languages.

CULTURE					The SIP for 2026/27 includes the requirement to focus on Digital exclusion. The Chief Nursing Information Officer is developing the approach to minimise the risks of Digital exclusion across all acute providers in Lancashire and South Cumbria.
	SERVICE COLLABORATION: Explore partnership with Public Health England (PHE) to provide signposting and support to patients, for example whilst waiting in ED or in discharge lounge	Increase in uptake of services that support improving socio-economic and health issues	Patient discharge documentation reflects signposting undertaken regarding social determinants of health	 Partially delivered	The development of the Lancashire Health Hub over the last 12 months has replaced the requirement to partner with PHE. Signposting, information leaflets and posters for the Lancashire Health Hub are in place at the main outpatient entrances and the discharge lounge.
	CONNECTIONS AND TRUST: Engage in existing and emerging partnership networks beyond traditional health and social care providers to deeply listen and understand what our population requires. Engage across Voluntary, Community, Faith, and Social Enterprise (VCSFE) partners to develop long term relationships across organisations	Following evidence based practice to be effective in tackling barriers and sustaining improvements in this work	Outcomes to be determined based on engagement with VCFSE groups in response to feedback and codesign approaches.	 Delivered	The Associate Director of Quality and Experience has continued to work closely with a wide range of community services and building partnerships that extend beyond the footprint of the hospital. Strong links have been established with groups such as Deaf Ways, Preston Muslim Forum, and the Asian Elders Group, among 21 other groups. More recently there has been engagement with the Windrush generation and the Black community group to increase understanding of their experiences of care at the Trust. These collaborations have enabled gathering valuable insights into how these communities perceive their care and how the Trust can work together to improve both their experience and health outcomes. Their voices have directly influenced the development of new policies, including intentional rounding and enhanced therapeutic observations and care.

PREVENTION	ENGAGEMENT AND OUTREACH: Direct engagement with our local communities, inviting them to actively contribute what matters to them in health, and design our services that enable better access and experience for our communities			✓ Delivered	Outreach and community engagement activities have been undertaken building local networks and relationships with VCFSE and other stakeholders, including 'Empower Her' and 'Living Well in Preston' events. The Patient, Carer Experience and Engagement Group is now well embedded with a designated involvement section on the agenda each month that focuses on feedback from Patient Safety Partners, governors and VCFSE groups. Some examples of the actions taken because of this engagement are as follows: • Development of photographic menus for those with limited English • Breast Care nurses attendance at the Saheliyaan Asian Women's Forum to provide education on breast screening • The Trust Friends and Family Test survey can now be converted to multiple languages and participants protected characteristics included (if patients choose to state) for analysis • Creation of 27 "stoma accessible" toilets across both hospital sites
	POPULATION HEALTH APPROACH: Take a targeted and specific population improvement methodology in this work that is effective in change to those most at need			✓ Partially delivered	National Outpatient Programme 'Was Not Brought' (WNB) focussing on children who are not brought to their appointments. Explored root causes and analysed data with health inequality lens. Interventions include improved information for parents/carers, proactive telephone call reminders and support for transport issues resulting in WNB reducing from 10.52% in 24/25 to 5.98% in March 2026.
	SCREENING AND VACCINATION: Focus on delivering prevention improvement work linked to Core20PLUS5 including: • Pneumococcal and influenza vaccination status for COPD, Lung health checks,	Reduction of long-term conditions and preventable diseases	• % Pneumococcal and influenza vaccination vaccine uptake • % cancer diagnosis stage 1 & 2	✓ Partially delivered	Institute for Health Care Improvement and Trust accelerator collaborative focussed on early cancer diagnosis for colorectal cancer and took a population health approach analysing data at ward level with focussed intervention. This included delivering cancer awareness sessions to increase uptake of bowel screening. 80% of participants stated they would take up bowel screening.

	• Cancer Alliance led earlier cancer diagnosis programme				The Cancer Alliance is now working to increase awareness of screening for prostate and lung cancer. Internally the priority for the Cancer Operational Group in 2026 is to review stage 1 and 2 cancer diagnosis by speciality. The top 5 tumour groups will be reviewed on a quarterly basis from August 2026 onwards. The national ambition is to achieve a 20% increase in early diagnosis by 2035. While offering vaccination is predominately led by primary care, during winter 2025/26 the Trust actively offered vaccination for influenza for patients both while as inpatients and those attending for outpatient clinics. This was supported by an ICB team that offered Flu and Covid vaccination to patients and members of the public. This took place alongside the Trust annual staff vaccination campaign.
	COLLABORATION WITH PARTNERS: Join up services expanding on work commenced with Care Connexions to bring services together from across organisations under one umbrella support of community physical health services.	Making services more accessible by removing barriers and delivering what the patient needs when it is needed by the most appropriate teams.	10% increase in the number of patients referred to Care Connexions by primary care for support services	✓ Partially delivered	Improvement work led by community services at Lancashire and South Cumbria Foundation Trust (LSCFT) has had a positive impact on maximising the clinical capacity available within the teams resulting in an 18% increase in primary care referrals in 2025/26 to Care Connexions compared to 2024. Achieving a significant increase in the number of patients referred by primary care is recognised to require service transformation. The Integrated Care Board has been leading on the development and commissioning of a Single Point of Access service.

Table 2. Operational Plan

Driver	Contributing Work	Outcome	Measures	Delivered	Progress to date (May 2026)

			(Outcome, process and balance)		
ENABLING	EDUCATION: Develop an educational offer that ranges from core skills to practitioner level understanding health literacy	Increased awareness of health literacy to make a shift in the way we communicate	Train 100 leaders in health literacy training	 Delivered	Over 100 leaders trained across several staff groups including Advanced Clinical Practitioners, NMAHP leaders. A Health and Digital Literacy E-Learning module has been created to allow staff to access training. Health literacy training is now embedded in early career professionals training and preceptor programmes for pharmacists, nurses and foundation years doctors.
	RESOURCES: Provide staff and public access to skills and resources to reduce inequalities by signposting to accessible digital health information through the Lancashire Health Hub	Increase access to information that supports lifestyle changes and increases access to support.	Evidence of signposting at discharge	 Partially delivered	Marketing materials for Lancashire Health Hub are in place in the main outpatient entrances and the discharge lounge. The Trust has created dedicated pages on the public facing internet site which contains a range of information on health inequalities and links to the Lancashire Health Hub. Internally in the Trust an intranet a page has been created that outlines the Trust approach to reduce health inequalities through both the Health Improvement Plan and Social Value Strategy. The page contains useful information and resources for staff including further education and training. Attached in appendix 3 is the easy read poster to support the communication of the Health Improvement Plan.
	ACCESS: Implement clear signage and differentiated access to patient information and increase use of digital translation solutions.	Become an accredited health literacy friendly organisation and reduce waits and delays during procedures and appointments to improve patient experience.	LTH Health Literacy Accreditation Create pathways that facilitate patients at increase risk of inequalities to access services with increased support	 Partially delivered	The implementation of "ReachDeck" and signposting to the Lancashire Health Hub have improved access to digital translation and Easy Read materials. This remains a focused part of the priorities within the SIP for 2026/27 with the plan to transition the top 20 most frequently used patient information leaflets to Easy Read by September 2026.

INTERVENTIONS	INTELLIGENCE: Health equity data as a part of board performance packs focusing on unwarranted variation across Urgent and Emergency Care (UEC) and Elective services for ethnicity and deprivation demographics	Focussed work to enable reducing unwarranted variation and ensure equity in access to services	Evidence of change programmes implemented as a result of the data	 At risk	Availability of health inequality data to inform future improvement work is still a challenge. The Chief Information Officer is leading this work as an approach across OneLSC however this has not yet been delivered due to competing priorities and limited resource.
	CORE DETERMINANTS: Promotion and connecting services that improve core determinants of health including • Smoking drug and alcohol cessation interventions • Excessive childhood obesity clinics • Optimisation of elective patients through signposting services to support modifying risk factors ahead of surgery	Increase in uptake of interventions that improve core determinants of health affecting long term conditions for both adults and children and young people	• Increased 4 week Quit rate • Maintenance of mortality within expected range • Evidence determinant changes following pre op health coaching	 Partially delivered	The Tobacco and Alcohol Care Team (TACT) have seen 4-week quit rate increase with patients agreeing to continue with stop smoking support increase by average 75 patients per month. Nicotine replacement prescriptions have increased from 4020 per year in 2024/25 to 7080 in 2025/26. The data in appendix 2 table 2 shows a consistent position of 100% of patients meeting the criteria on alcohol assessment being referred for advice or intervention by TACT. The position for tobacco interventions has increased over the last 12 months from 60% to 86%. Over the last 6 months TACT have taken a focused approach to increase referrals for tobacco dependency with high impact specialities. This approach has demonstrated significant impact with referrals from respiratory medicine increasing from 132 in 2024/25 to 259 in 2025/26. Next steps are to develop this approach with stroke and cardiology teams. The Trust Child Excessive Weight currently has 83 active patients. There is excellent feedback from patients and families Outcomes for the service are positive in supporting both a reduction in Body Mass Index and complications. The demand on the service is high with service provision limited to the scope of commissioned services. There is currently a 12 month waiting time for new patient appointments. 229 patients were optimised for surgery through signposting to support for smoking cessation, weight management, alcohol/drugs advice and mental health advice.

	CORE20: Focus on delivering targeted improvement work linked to Core20PLUS5 including High Intensity User (HIU) programme, Integrated neighbourhood teams, Emergency Department (ED) navigators	Reduced attendance in ED and inpatients admissions through promoting a cycle of change and different way to manage unmet needs	• 25% reduction attendance in ED of patients receiving intervention • 25% reduction in admissions of patients receiving intervention • 20% more 25 years and under signposted for violence interventions	✓ Partially delivered	The HIU programme has seen 92% of patients accessing the service reduce ED attendances by 25% or more. Patients accessing the service have also had overall reduction of 20% in hospital admissions. Feedback from the service lead identifies patients with increasing complex needs over the last 12 months requiring more intensive support. Over the last 12 months the ED Navigator has received 233 referrals for interventions which have included signposting to drug and alcohol services, referrals into children's safeguarding services, referrals to community youth services or Champions programme. When appropriate the ED Navigator will maintain active involvement and provide ongoing support in the Trust or the community. The ED Navigator has built strong connections with key areas such as the Critical Care Unit, Major Trauma Ward, and all Neuro and Neuro Rehab wards. The role has developed and matured to provide an in depth and trauma-informed approach to supporting children and young people at risk of serious youth violence.
	5 PRIORITY CLINICAL AREAS: Focus on delivering accelerate improvement work to linked to Core20PLUS5 including • Continuity of carer and Postpartum Haemorrhage (PPH) for minority ethnic groups • Discharge referral to community nursing to reduce salbutamol/weaning plan for asthmatic children • Diabetes real-time access to glucose monitor and insulin pumps for children • Reducing wait for tooth extractions for children under 10 yrs old	Deliver focused improvement in areas leading to long term conditions in both adults and children.	• 10% reduction in post partum haemorrhage for minority ethnic groups • 10% increase in smoking interventions • 10% increase in alcohol interventions • Decreased number of asthma attacks for children (% to be determined) • 95% real time glucose monitoring in place, 60% insulin pump for children	✓ Partially delivered	Nationally recognised improvement work has continued focussed on reducing post-partum haemorrhage for minority ethnic groups resulting in 3% reduction in PPH with improved patient experience (see appendix 2 table 1) Annual audits in maternity services identified 99% compliance with women being routinely screened for tobacco and alcohol. In women where alcohol screening was met trigger criteria 100% were offered appropriate support and interventions. A focused improvement group is in place for children with asthma. Over the last year the group have focused on increasing compliance with the asthma discharge bundle and asthma

					management education for nursing staff across ED and paediatrics.
					Getting it Right First Time (GiRFT) improvement work is underway for children with diabetes. 99% of children under the paediatric diabetes team are on Continuous Glucose Monitoring. 70% of children are on insulin pumps compared to 65% in 2024/25.
	PLUS GROUPS: Focus on delivering targeted improvement work linked to Core20PLUS5 including - Prisoner waiting list management	Demonstrate improvement in outcomes for groups most at need identified through Trust data.	Reduction >65 week patients in prisons. Further groups to be identified as part of the data analysis	 Partially delivered	Health Inequality patient waiting list tracking continues to focus on population groups. The first cohort being prisoners; aiming to reduce waits for prisoners who have a longer length of wait than other patient cohorts. Longest waiter in 2024 was 93 weeks. Data detailed in appendix 2 table 3 shows continued reduction in waiting times for prisoners over the last 12 months. There are now 0 prisoners waiting over 65 weeks and a significant reduction over 52 weeks despite there being a small increase in the numbers of prisoners on an 18 week pathway (appendix 2 table 4). Weekly meetings with speciality performance managers and the prison continue to ensure prisoners are booked appropriately and in a timely manner.

POPULATION HEALTH	Work with partner organisations across health and social care to focus on key factors that impact population health for children and adults including • Safeguarding and Mental health champions in clinical areas • Develop an approach to patient and family education whilst interacting with services • Dementia strategy and access for early support for families and patients	Families will understand how to access support for their loved ones	Determine a baseline of referral activity to support services and aim to increase this once baseline understood.	 Partially delivered	A monthly carers forum has been established in partnership with Lancashire County Council to provide support for people caring for a loved one. This forum not only focuses on ensuring carers receive the structured financial and health support they are entitled to for their loved one but also provides signposting for wellbeing input for carers. Age UK work in proactive partnership with the Trust Dementia Practitioner and the Discharge Team to support people to access the benefits and support they are entitled to. There is an established network of Safeguarding, Mental Health and Learning Disabilities Champions across the Trust who meet on a bimonthly basis facilitated by the specialist practitioners in the Safeguarding team. Recent forums have focused on cascading the resources utilised to adopt “Martha’s rule”, Call for Concern approach for people with a learning disability to ensure their health outcomes are improved. In September 2025 the Trust commenced the Oliver McGowan Tier 2 training. This is an additional full day training for clinical staff on caring for people with a Learning Disability or Autism. 830 staff have now completed this training. Compliance with Oliver McGowan Tier 1 training is at 96%. The new Pan Lancashire Dementia Strategy was launched on 1st October 2025. Key clinical leaders including the Trust Dementia Practitioner have inputted to the development of this strategy. A local Trust Dementia plan has been developed to support delivery of the aims within the strategy. The implementation of the Trust Dementia Plan is a key milestone within the Patients section of the SIP for 2026/27.

2.3 Moving to a population health approach as business as usual

Over the last 12 months there has been continued focus on transitioning to a population health approach as part of core business as usual processes. Examples of this are:

- Health inequalities being embedded into the Patient Safety Incident Response Framework with After Action Reviews and Patient Safety Incident Investigations considering the impact of health inequalities as routine part of the investigative process.
- The Trust's Always Safety First Strategy was updated and published in April 2026. The strategy outlines the approach to insight, involvement and improvement with a population health lens
- Within education and training all requests to create new training now include a specific prompt to consider appropriate relevant population health content and reference to the Trust Health Improvement Plan. Next steps are to include this in the 3 yearly cycle of review for all existing mandatory and role specific training.
- The population health approach has been strengthened in the Lancashire Improvement Method with the improvement team prompting using population health data as part of the "understand" phase of improvement work. The training courses that the improvement team provide showcase the example of the work to reduce PPH in black and Asian women as a best practice standard.

2.4 Areas of good practice

The Trust learning disabilities and autism specialist practitioner has developed a range of short videos of the Emergency Department, assessment units and the more frequently utilised outpatient services/procedures. These videos have been developed to show people what their visit to the hospital may be like, including photographs and staff involved in care. The objective is providing key information to enable people to make informed decisions about their care and treatment. The videos are shared with people when it is anticipated that they may need to come into hospital and are also published onto the Trust's public facing website. The videos are an example of making reasonable adjustments to help people make decisions about their care in a way that is more likely to improve health outcomes.

In 2022 the Office for National Statistics Veterans Survey reported that 48.7% of Veterans reported having a disability indicating that this group could be at risk poorer health outcomes. The Trust was accredited as a Veteran Aware Trust in 2019 and has retained this accreditation through the annual assessment process since that time. Veteran status can now be identified on the patient's electronic patient record, and this allows the Trust to ensure that patients are flagged to champions who have access to a range of support services via the Veterans Advisory Northwest service. The support offered includes access to grants for specialist equipment and adaptations to

the home as well as mental health support and interventions. The Veterans Advisory Service has links to a wide range of VCFSE groups to ensure people have access to support to address the wider determinants of health and wellbeing.

The Blossom Team was launched in June 2025 focused on supporting young mums and mums to be up to age 19. The service is funded via the Baby Beat charity for a 12 month pilot period. The service has delivered 690 appointments in its first 6 months, including 236 home visits, safeguarding coordination, education, and public health interventions. Early outcomes include reduced non-attendance for booked appointments and improved breastfeeding rates reflecting stronger engagement and increased continuity of care. A full evaluation of the service is underway to allow consideration of commissioning and funding beyond the 12 month pilot.

2.5 Data analysis - annual health inequality dataset

The annual health inequality dataset is included in appendix 1. The data utilises Indices of Multiple Deprivation (IMD) with lower scores representing the most deprived communities and higher scores representing the least deprived communities. Analysis of the data over the last 12 months shows the following trends:

Children (under 18 years)

- Children from the most deprived communities (both male and female) make up the biggest percentage of inpatient elective activity with 14% of children from communities at IMD 1 compared to 8% at IMD 10. This is a consistent pattern over the last 7 years.
- Over the last 2 years there has been an overall reduction in the number of inpatient elective procedures for children, especially in comparison to the position in 2023/24.
- The reduction in activity is proportionally higher in children in IMD 1 compared to the years 2019/20 to 2023/24. This may indicate an emerging risk of a widening of inequalities for children in the most deprived communities. This is being further analysed by the surgical leadership teams.
- Emergency activity for children shows higher levels of children from IMD 1-3 accessing emergency care compared to children in IMD 8-10 groups.
- The number of Asian/Asian British children in IMD 1-3 accessing emergency care is disproportionately higher than less deprived groups which is similar to the previous year.
- Tooth extractions are sentinel indicator of child health inequality. 496 tooth extractions were carried out in children under 10 years over the last 12 months with 86 procedures for children in IMD 1 compared to 22 in IMD 10. There were 502 tooth extractions in 2024/25.
- Overall the data analysis indicates well understood themes on the impact of the wider determinants of health for children and young people and reinforces the importance of the actions outlined within the health improvement plan

Adults

- Adults in IMD 1 and IMD 8 groups make up the biggest proportion of elective activity in a persistent pattern over the last 7 years.
- 34% of elective activity undertaken over the last year was for IMD 1-3 groups compared to 32% in IMD 8-10 groups.
- There was a reduction overall in adult inpatient elective activity in 2025/26 compared to the previous year. There is an emerging theme of a greater proportionate reduction in IMD 1-3 compared to IMD 8-10 groups. This highlights a potential widening inequality and requires further analysis.
- Elective activity for adults shows an increase across all IMD groups compared to the baseline position of 2019/20.

2.4 Areas of challenge and priorities for 2026/27

Since publishing the plan although the ambition and appetite for change is still strong, capacity for delivery is currently limited and over the last year priority has been given to the Trust financial recovery plan in the short-term. Alongside this there is no specific Public Health Consultant resource within the organisation to lead this work and there has been reduced support from the Integrated Care Board meaning the plan has not been fully delivered to time. Improvement events took place in December 2025 and February 2026 to gain feedback from clinical leaders on where improvements are possible through maximising existing resources. This has led to the priority areas aligned to delivery of the Health Improvement Plan being included in the Partnerships SIP for 2026/27. The key milestones outlined within the SIP are:

- Development of a health inequalities data dashboard to allow data to be embedded in key operational and divisional forums.
- Continued training development for EDI and health inequalities.
- Compliance with the updated NHSE standards for Reasonable Adjustment Needs published in February 2026.
- Conversion of patient information leaflets into Easy Read format and multiple languages
- Maximising the use of the NHS Shared Care record to allow transfer of information between primary, secondary and community care.
- Develop options to expand the provision of the High Intensity User model.
- Develop data reporting into the operational board to include stage of cancer diagnosis split by protected characteristics and IMD.
- Further develop the high risk case finding approach in the Plus 5 groups for adults and children.
- Development of standards and a guidance framework to reduce the risks of digital exclusion. As outlined within the Digital workstream of the Partnerships SIP.
- Delivery of the Dementia plan aligned to the Lancashire and South Cumbria Dementia Strategy. As outlined in the Patients section of the SIP.
- Improving standards of care for children, young people and adults who are at high risk of being vulnerable in a hospital setting. As outlined in the Patients section of the SIP.

A specific area of challenge is consistent and useable data related to health inequalities. Providing a dataset and an operational metric dashboard with a health inequality lens is still an ambition but is delayed in delivery due to other demands on limited business intelligence resource. In mitigation for this the annual health inequality dataset 2025/26 (appendix 1) is updated and shared through the Health Inequalities Group to allow high level analysis and identify where more focused investigation of the data is required.

3. Financial implications

The HIU service and ED navigator roles outlined in the progress against the Health Improvement Plan result in patients being proactively supported and reducing the requirement to access emergency hospital care. It is likely that this will have avoided expenditure for the Trust although the cost savings are not identified. The NHS 10-year plan provides a continued case for investment in work to reduce health inequalities.

4. Legal implications

None

5. Risks

There are no new risks associated with the content of this report

6. Impact on stakeholders

Key stakeholders are identified within the Health Improvement Plan and the plan outlines the communication and engagement that has taken place.

7. Recommendations

The Safety & Quality Committee is asked to note the progress with the Health Improvement Plan and endorse the report for submission to the Trust Board of Directors.

8. Appendices

Appendix 1: Annual health inequality dataset 2025/26

The NHSE Statement on Information on Health Inequalities sets out the expectation in relation to the collection, analysis and publication of information to support addressing health inequalities. Organisations should publish relevant information based on a list of indicators alongside their relevant annual report for 2025/26. Relevant information for NHS acute Trusts is as follows:

- Elective activity vs pre-pandemic levels for under 18s and over 18s
- Emergency admissions for under 18s
- Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under

Data to be analysed by:

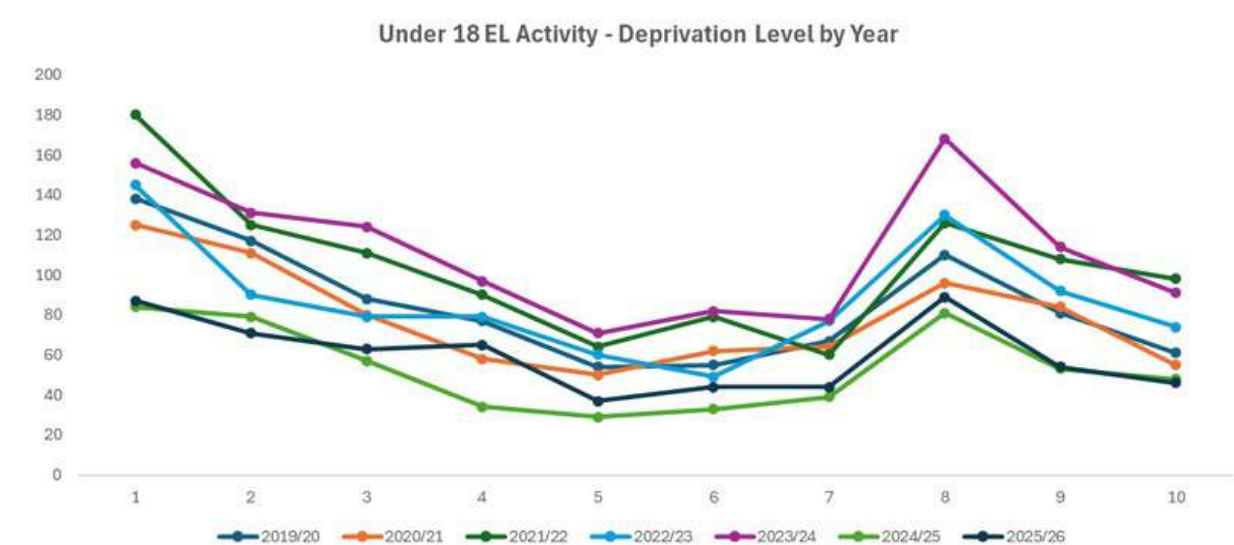
- Year where relevant
- Ethnicity
- Gender
- Deprivation – Indices of multiple deprivation are used (IMD) with lower score representing the most deprived communities and higher scores representing the least deprived communities.
- Age

Elective In-Patient activity vs pre-pandemic levels Under 18 Years Analysis by Deprivation

Year	Deprivation Level											Total
	1	2	3	4	5	6	7	8	9	10	Unknown	
2019/20	138	117	88	77	54	55	67	110	81	61	6	854
2020/21	125	111	80	58	50	62	64	96	84	55	20	805
2021/22	180	125	111	90	64	79	60	126	108	98	24	1065
2022/23	145	90	79	79	60	49	77	130	92	74	25	900
2023/24	156	131	124	97	71	82	78	168	114	91	36	1148
2024/25	84	79	57	34	29	33	39	81	53	48	30	567
2025/26	87	71	63	65	37	44	44	89	54	46	40	640
Grand Total	916	726	605	504	370	410	436	808	595	483	181	5979

Year	Deprivation Level % by Year											Total
	1	2	3	4	5	6	7	8	9	10	Unknown	
2019/20	16%	14%	10%	9%	6%	6%	8%	13%	9%	7%	1%	100%
2020/21	16%	14%	10%	7%	6%	8%	8%	12%	10%	7%	2%	100%
2021/22	17%	12%	10%	8%	6%	7%	6%	12%	10%	9%	2%	100%
2022/23	16%	10%	9%	9%	7%	5%	9%	14%	10%	8%	3%	100%
2023/24	14%	11%	11%	8%	6%	7%	7%	15%	10%	8%	3%	100%
2024/25	15%	14%	10%	6%	5%	6%	7%	14%	9%	8%	5%	100%
2025/26	14%	11%	10%	10%	6%	7%	7%	14%	8%	7%	6%	100%
Grand Total	15%	12%	10%	8%	6%	7%	7%	14%	10%	8%	3%	100%

Elective In-Patient activity vs pre-pandemic levels Under 18 Years Analysis



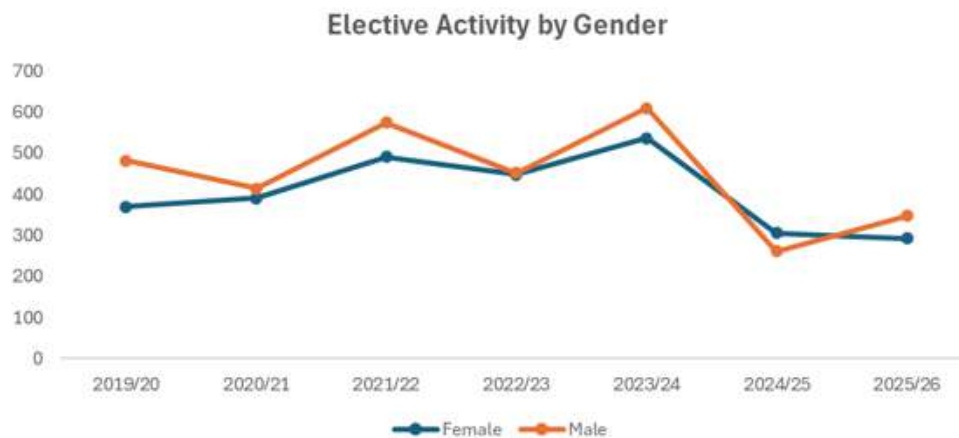
Elective In-Patient activity vs pre-pandemic levels Under 18 Years Analysis by Ethnicity

Activity by Ethnicity and Year								
Ethnicity	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	Total
Asian/Asian British	75	82	126	95	116	60	76	630
Black/African/Caribbean/Black British	6	6	12	12	15	11	10	72
Mixed/Multiple Ethnic Group	16	9	21	29	24	4	16	119
Not Asked/Not Known/Not Stated	67	46	48	65	116	47	58	447
Other Ethnic Group	8	5	11	10	15	9	8	66
White	682	657	847	689	862	436	472	4645
Grand Total	854	805	1065	900	1148	567	640	5979

Ethnicity	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	Total
Asian/Asian British	9%	10%	12%	11%	10%	11%	12%	11%
Black/African/Caribbean/Black British	1%	1%	1%	1%	1%	2%	2%	1%
Mixed/Multiple Ethnic Group	2%	1%	2%	3%	2%	1%	3%	2%
Not Asked/Not Known/Not Stated	8%	6%	5%	7%	10%	8%	9%	7%
Other Ethnic Group	1%	1%	1%	1%	1%	2%	1%	1%
White	80%	82%	80%	77%	75%	77%	74%	78%
Grand Total	100%	100%	100%	100%	100%	100%	100%	100%

Elective In-Patient activity vs pre-pandemic levels Under 18 Years Gender Analysis

Year	Female	Male	Unknown	Total	% Female	% Male	% Unknown
2019/20	370	482	2	854	43.3%	56.4%	0.2%
2020/21	390	414	1	805	48.4%	51.4%	0.1%
2021/22	491	574		1065	46.1%	53.9%	0.0%
2022/23	448	452		900	49.8%	50.2%	0.0%
2023/24	537	610	1	1148	46.8%	53.1%	0.1%
2024/25	306	261		567	54.0%	46.0%	0.0%
2025/26	293	347		640	45.8%	54.2%	0.0%
Grand Total	2835	3140	4	5979	47.4%	52.5%	0.1%



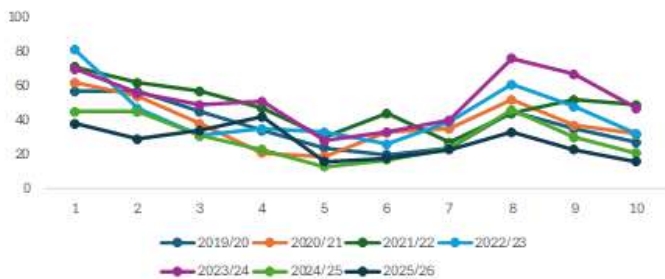
Elective In-Patient activity vs pre-pandemic levels

Under 18 Years Gender & Deprivation Analysis

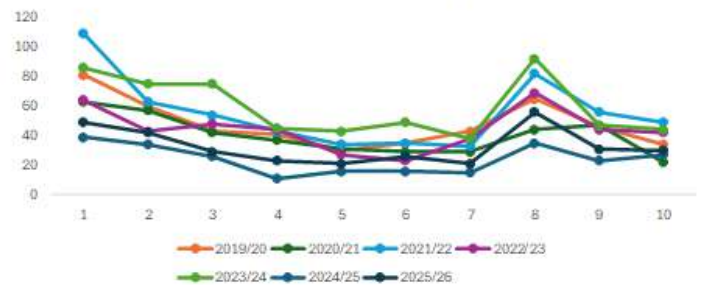
Year	Female Gender by Deprivation											Total
	1	2	3	4	5	6	7	8	9	10	Unknown	
2019/20	57	57	45	34	24	20	24	45	35	27	2	370
2020/21	62	54	38	21	19	33	35	52	37	32	7	390
2021/22	71	62	57	47	30	44	27	44	52	49	8	491
2022/23	81	47	31	35	33	26	39	61	48	32	15	448
2023/24	70	56	49	51	28	33	40	76	67	47	20	537
2024/25	45	45	31	23	13	17	24	46	30	21	11	306
2025/26	38	29	34	42	16	18	23	33	23	16	21	293
Grand Total	424	350	285	253	163	191	212	357	292	224	84	2835

Year	Male Gender by Deprivation											Total
	1	2	3	4	5	6	7	8	9	10	Unknown	
2019/20	81	60	43	41	30	35	43	65	46	34	4	482
2020/21	63	57	42	37	31	29	29	44	47	22	13	414
2021/22	109	63	54	43	34	35	33	82	56	49	16	574
2022/23	64	43	48	44	27	23	38	69	44	42	10	452
2023/24	86	75	75	45	43	49	38	92	47	44	16	610
2024/25	39	34	26	11	16	16	15	35	23	27	19	261
2025/26	49	42	29	23	21	26	21	56	31	30	19	347
Grand Total	491	374	317	244	202	213	217	443	294	248	97	3140

Female by Deprivation and Year



Male Gender by Deprivation and Year

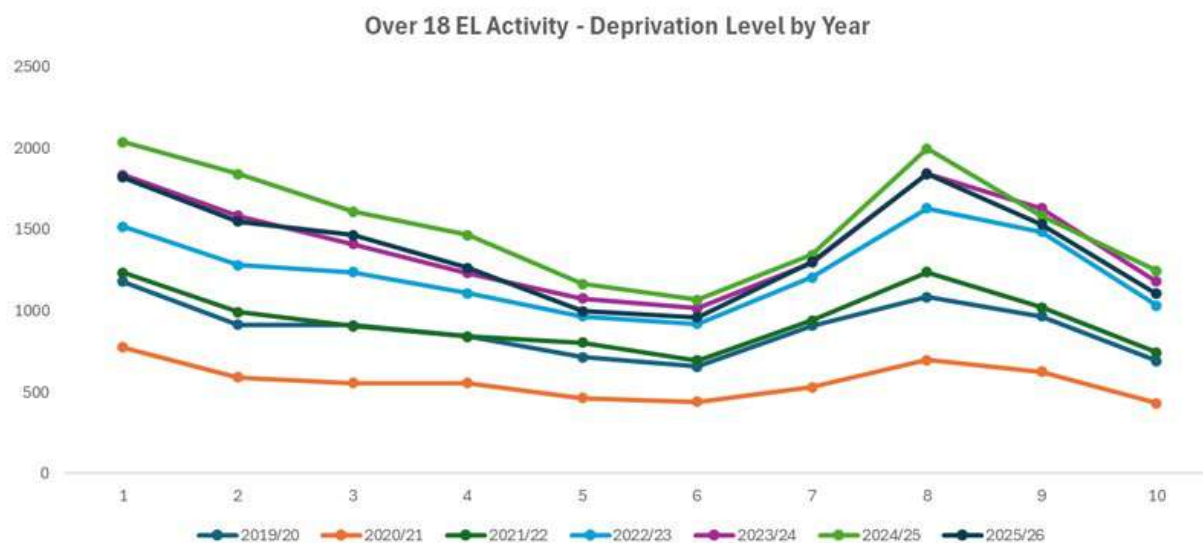


Elective In-Patient activity vs pre-pandemic levels Over 18 Years Analysis by Deprivation

	Deprivation Level											
Year	1	2	3	4	5	6	7	8	9	10	Unknown	Total
2019/20	1180	914	912	842	715	658	910	1084	966	692	35	8908
2020/21	775	591	555	557	464	441	531	698	625	431	47	5715
2021/22	1234	993	905	842	806	695	939	1239	1021	744	160	9578
2022/23	1518	1281	1238	1107	965	920	1207	1632	1486	1034	212	12600
2023/24	1837	1584	1410	1233	1076	1016	1296	1845	1631	1179	357	14464
2024/25	2039	1843	1612	1466	1165	1068	1346	1997	1585	1247	606	15974
2025/26	1822	1550	1467	1265	997	962	1303	1843	1532	1104	470	14315
Grand Total	10405	8756	8099	7312	6188	5760	7532	10338	8846	6431	1887	81554

	Deprivation Level % by Year											
Year	1	2	3	4	5	6	7	8	9	10	Unknown	Total
2019/20	13%	10%	10%	9%	8%	7%	10%	12%	11%	8%	0%	100%
2020/21	14%	10%	10%	10%	8%	8%	9%	12%	11%	8%	1%	100%
2021/22	13%	10%	9%	9%	8%	7%	10%	13%	11%	8%	2%	100%
2022/23	12%	10%	10%	9%	8%	7%	10%	13%	12%	8%	2%	100%
2023/24	13%	11%	10%	9%	7%	7%	9%	13%	11%	8%	2%	100%
2024/25	13%	12%	10%	9%	7%	7%	8%	13%	10%	8%	4%	100%
2025/26	13%	11%	10%	9%	7%	7%	9%	13%	11%	8%	3%	100%
Grand Total	13%	11%	10%	9%	8%	7%	9%	13%	11%	8%	2%	100%

Elective In-Patient activity vs pre-pandemic levels Over 18 Years Analysis by Deprivation



Elective In-Patient activity vs pre-pandemic levels Over 18 Years Analysis by Ethnicity

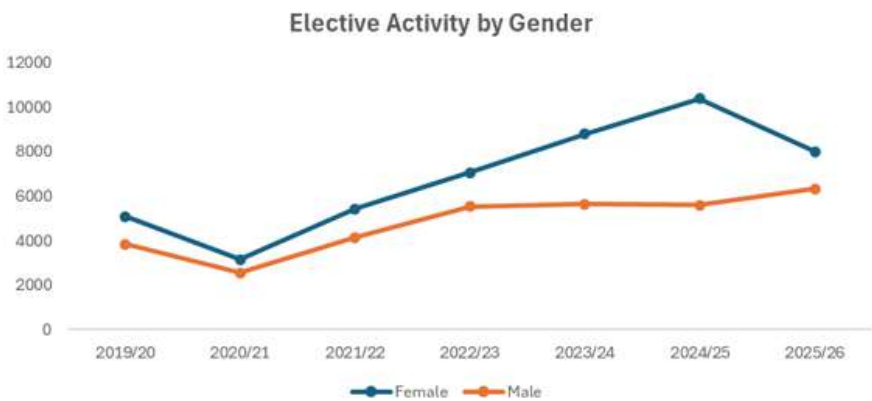
Ethnicity	Activity by Ethnicity and Year							Total
	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	
Asian/Asian British	346	221	445	600	896	1347	885	4740
Black/African/Caribbean/Black British	51	35	64	105	153	328	194	930
Mixed/Multiple Ethnic Group	60	25	71	74	162	44	116	552
Not Asked/Not Known/Not Stated	559	471	1041	1545	1789	1539	1463	8407
Other Ethnic Group	49	29	76	89	122	199	160	724
White	7843	4934	7881	10187	11342	12522	11497	66206
Grand Total	8908	5715	9578	12600	14464	15979	14315	81559

Ethnicity	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	Total
Asian/Asian British	4%	4%	5%	5%	6%	8%	6%	6%
Black/African/Caribbean/Black British	1%	1%	1%	1%	1%	2%	1%	1%
Mixed/Multiple Ethnic Group	1%	0%	1%	1%	1%	0%	1%	1%
Not Asked/Not Known/Not Stated	6%	8%	11%	12%	12%	10%	10%	10%
Other Ethnic Group	1%	1%	1%	1%	1%	1%	1%	1%
White	88%	86%	82%	81%	78%	78%	80%	81%
Grand Total	100%	100%	100%	100%	100%	100%	100%	100%

Elective In-Patient activity vs pre-pandemic levels

Over 18 Years Analysis by Gender

Year	Female	Male	Unknown	Total	% Female	% Male	% Unknown
2019/20	5073	3831	4	8908	56.9%	43.0%	0.0%
2020/21	3158	2557		5715	55.3%	44.7%	0.0%
2021/22	5430	4144	4	9578	56.7%	43.3%	0.0%
2022/23	7057	5542	1	12600	56.0%	44.0%	0.0%
2023/24	8806	5646	12	14464	60.9%	39.0%	0.1%
2024/25	10381	5598		15979	65.0%	35.0%	0.0%
2025/26	7995	6320		14315	55.9%	44.1%	0.0%
Grand Total	47900	33638	21	81559	58.7%	41.2%	0.0%

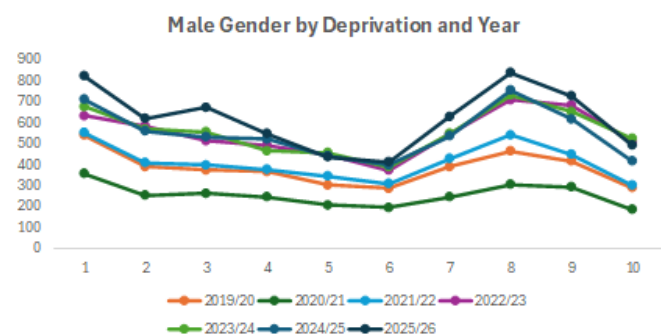
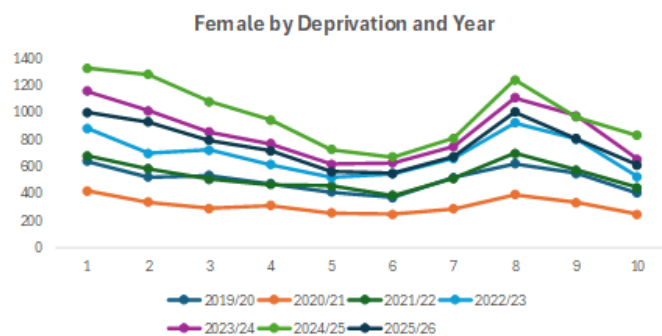


Elective activity vs pre-pandemic levels

Over 18 Years Gender & Deprivation Analysis

Year	Female Gender by Deprivation											
	1	2	3	4	5	6	7	8	9	10	Unknown	Total
2019/20	640	523	536	474	412	372	520	620	549	404	23	5073
2020/21	419	338	292	313	257	246	286	393	333	246	35	3158
2021/22	681	585	507	466	458	387	512	697	574	444	119	5430
2022/23	884	698	724	615	520	548	661	924	803	524	156	7057
2023/24	1160	1013	855	768	619	626	748	1110	975	656	276	8806
2024/25	1329	1283	1080	945	726	670	811	1243	967	831	495	10380
2025/26	1000	931	795	717	562	549	673	1005	806	613	344	7995
Grand Total	6113	5371	4789	4298	3554	3398	4211	5992	5007	3718	1448	47899

Year	Male Gender by Deprivation											
	1	2	3	4	5	6	7	8	9	10	Unknown	Total
2019/20	540	391	375	367	302	286	390	463	417	288	12	3831
2020/21	356	253	263	244	207	195	245	305	292	185	12	2557
2021/22	552	408	398	376	345	308	427	542	447	300	41	4144
2022/23	633	583	514	492	445	372	546	708	683	510	56	5542
2023/24	676	570	555	465	456	389	547	731	653	523	81	5646
2024/25	710	560	532	521	439	398	535	754	618	416	111	5594
2025/26	822	619	672	548	435	413	630	838	726	491	126	6320
Grand Total	4289	3384	3309	3013	2629	2361	3320	4341	3836	2713	439	33634

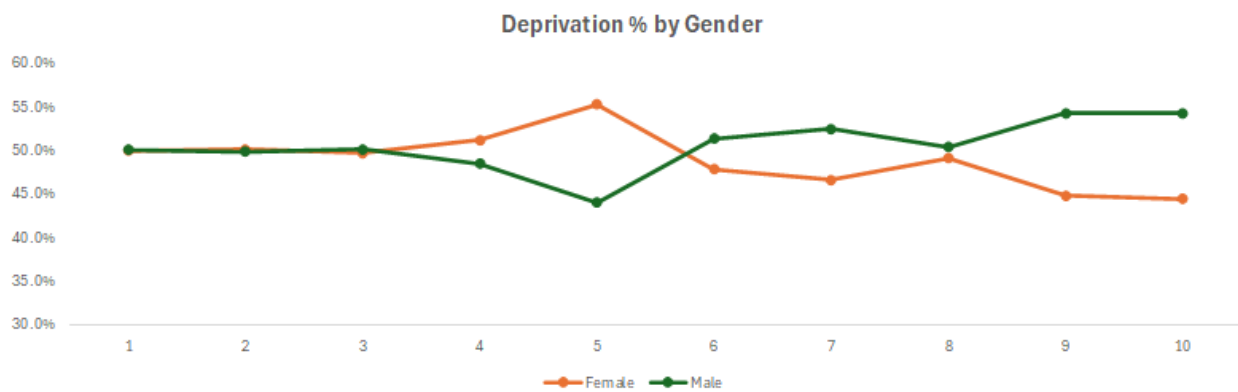


Emergency activity 2025/26

Under 18 Years Analysis by Gender & Deprivation

Gender	Deprivation Level										Unknown	Total
	1	2	3	4	5	6	7	8	9	10		
Female	605	640	503	441	334	301	308	634	373	316	330	4785
Male	606	637	507	418	266	323	347	650	452	386	374	4966
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total	1212	1279	1013	863	605	630	662	1292	834	712	704	9751

Gender	1	2	3	4	5	6	7	8	9	10	Unknown	Total
Female	49.9%	50.0%	49.7%	51.1%	55.2%	47.8%	46.5%	49.1%	44.7%	44.4%	46.9%	49.1%
Male	50.0%	49.8%	50.0%	48.4%	44.0%	51.3%	52.4%	50.3%	54.2%	54.2%	53.1%	50.9%
Unknown	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Grand Total	100%	100%	100%	100%	99%	99%	99%	99%	99%	99%	100%	100%

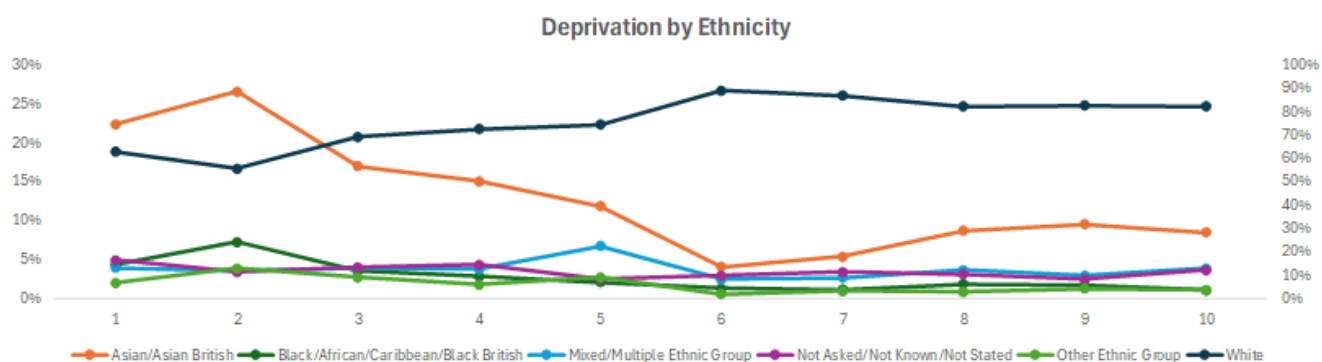


Emergency activity 2025/26

Under 18 Years Analysis by Ethnicity & Deprivation

Ethnicity	Deprivation Level										Unknown	Total
	1	2	3	4	5	6	7	8	9	10		
Asian/Asian British	271	339	171	129	71	25	35	111	78	59	31	1320
Black/African/Caribbean/Black British	52	92	35	24	12	8	7	23	13	7	46	319
Mixed/Multiple Ethnic Group	47	45	39	32	40	15	17	46	24	27	35	367
Not Asked/Not Known/Not Stated	59	43	40	37	15	18	22	39	20	25	29	347
Other Ethnic Group	24	49	27	15	16	3	6	10	10	7	11	178
White	758	709	698	622	446	555	568	1055	680	577	552	7220
Grand Total	1211	1277	1010	859	600	624	655	1284	825	702	704	9751

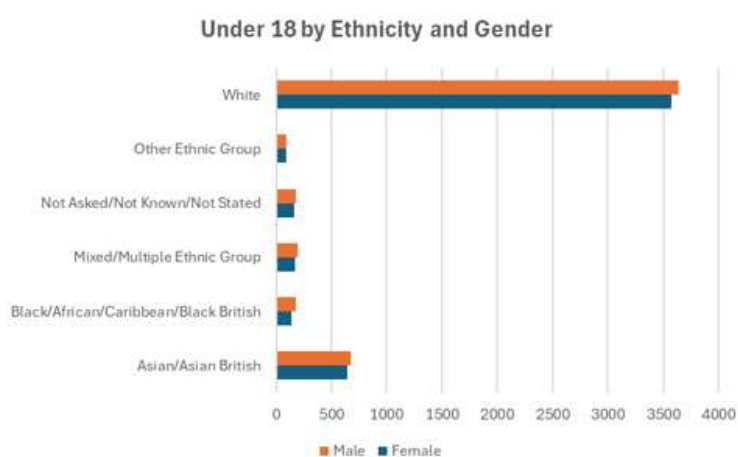
Ethnicity	Deprivation Level										Unknown	Total
	1	2	3	4	5	6	7	8	9	10		
Asian/Asian British	22%	27%	17%	15%	12%	4%	5%	9%	9%	8%	4%	14%
Black/African/Caribbean/Black British	4%	7%	3%	3%	2%	1%	1%	2%	2%	1%	7%	3%
Mixed/Multiple Ethnic Group	4%	4%	4%	4%	7%	2%	3%	4%	3%	4%	5%	4%
Not Asked/Not Known/Not Stated	5%	3%	4%	4%	3%	3%	3%	3%	2%	4%	4%	4%
Other Ethnic Group	2%	4%	3%	2%	3%	0%	1%	1%	1%	1%	2%	2%
White	63%	56%	69%	72%	74%	89%	87%	82%	82%	82%	78%	74%
Grand Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%



Emergency activity 2025/26

Under 18 Years Analysis by Ethnicity & Gender

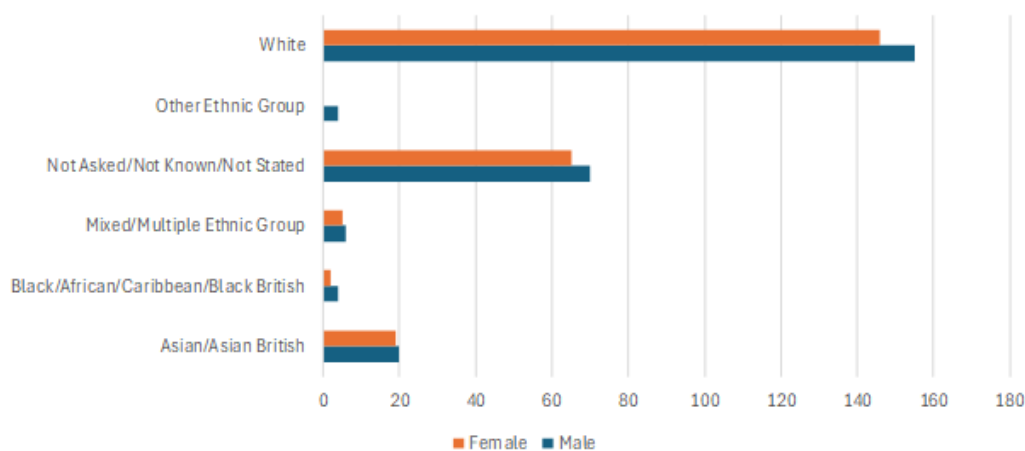
Ethnicity	Female	Male	Unknown	Total	% Female	% Male
Asian/Asian British	641	679	0	1320	48.6%	51.4%
Black/African/Caribbean/Black British	137	182	0	319	42.9%	57.1%
Mixed/Multiple Ethnic Group	174	193	0	367	47.4%	52.6%
Not Asked/Not Known/Not Stated	165	182	0	347	47.6%	52.4%
Other Ethnic Group	90	88	0	178	50.6%	49.4%
White	3578	3642	0	7220	49.6%	50.4%
Grand Total	4785	4966	0	9751	49.1%	50.9%



Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under 2025/26

Ethnic Group	Male	Female	Grand Total	% Male	% Female
Asian/Asian British	20	19	39	7.7%	8.0%
Black/African/Caribbean/Black British	4	2	6	1.5%	0.8%
Mixed/Multiple Ethnic Group	6	5	11	2.3%	2.1%
Not Asked/Not Known/Not Stated	70	65	135	27.0%	27.4%
Other Ethnic Group	4		4	1.5%	0.0%
White	155	146	301	59.8%	61.6%
Grand Total	259	237	496	100.0%	100.0%

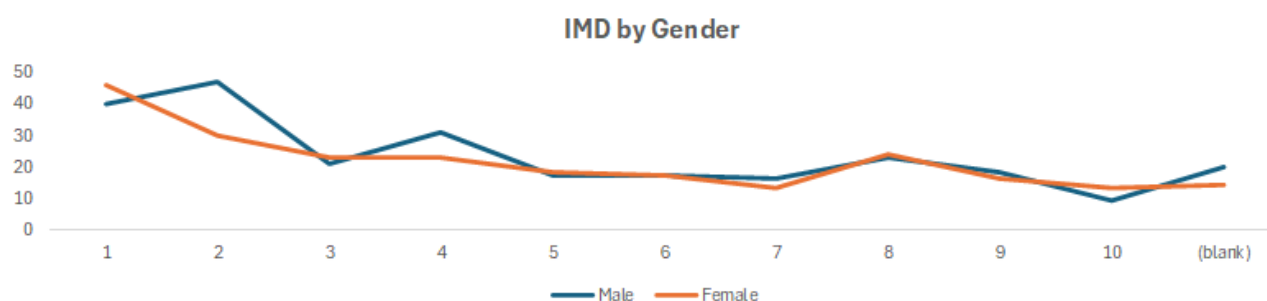
Tooth Extractions 10 years and Under - Gender & Ethnicity



Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under 2025/26

Ethnicity	1	2	3	4	5	6	7	8	9	10	(blank)	Total
Asian/Asian British	15	7	3	4	3		2	3	1	1		39
Black/African/Caribbean/Black British	2	1				1				1	1	6
Mixed/Multiple Ethnic Group	3	2	2	1	1					1	1	11
Not Asked/Not Known/Not Stated	24	23	9	13	8	11	6	16	13	9	3	135
Other Ethnic Group	3								1			4
White	39	44	30	36	23	22	21	28	19	10	29	301
Grand Total	86	77	44	54	35	34	29	47	34	22	34	496

Gender	1	2	3	4	5	6	7	8	9	10	(blank)	Total
Male	40	47	21	31	17	17	16	23	18	9	20	259
Female	46	30	23	23	18	17	13	24	16	13	14	237
Grand Total	86	77	44	54	35	34	29	47	34	22	34	496



Appendix 2: Improvement measures dashboards

Table 1 – Post Partum Haemorrhage (PPH) in black and ethnic minority groups showing an overall reduction of 3% in PPH from a baseline of 12% to 9%

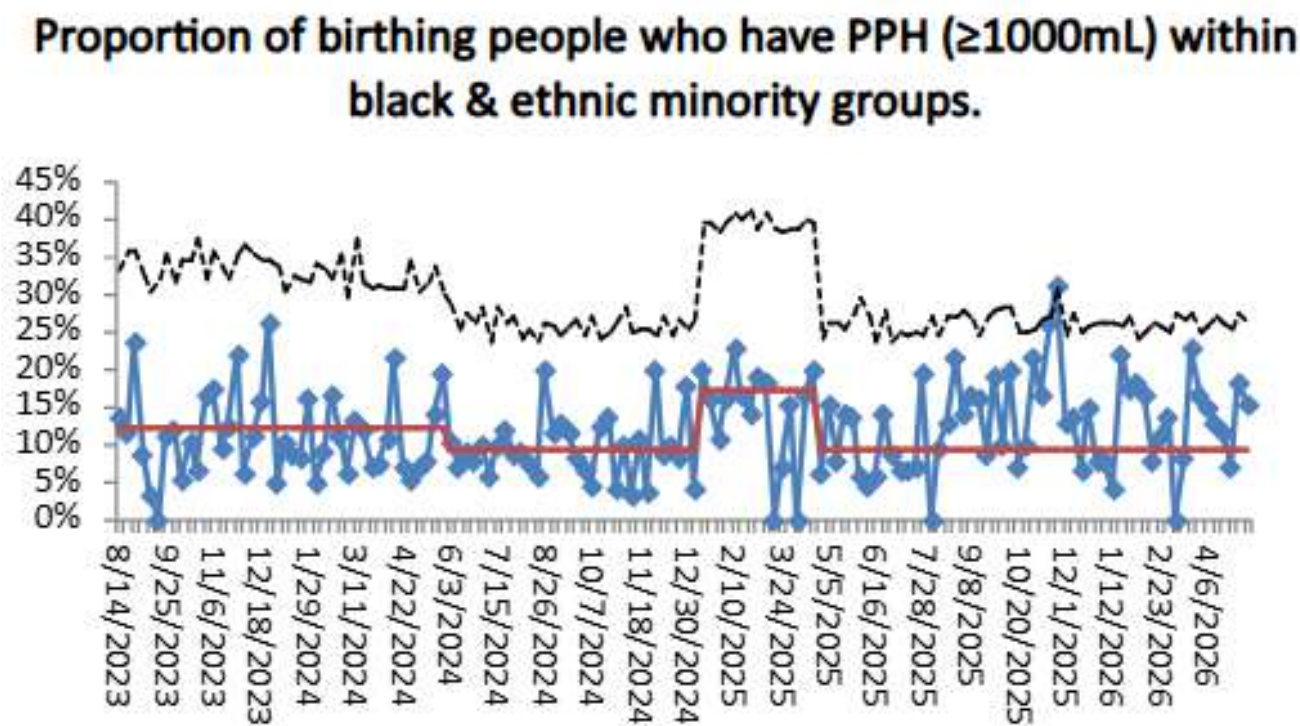


Table 2 - Compliance with tobacco and alcohol assessment and advice given

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Smoking Prevention Intervention	60.14%	60.29%	62.95%	61.51%	57.83%	59.87%	57.97%	89.98%	89.21%	90.91%	86.33%	86.40%
Alcohol Prevention Intervention	97.28%	96.93%	97.89%	98.85%	98.11%	98.07%	97.91%	100.00%	100.00%	100.00%	100.00%	100.00%

Table 3 – Prisoners waiting over 52 and 65 weeks December 2025 to March 2026

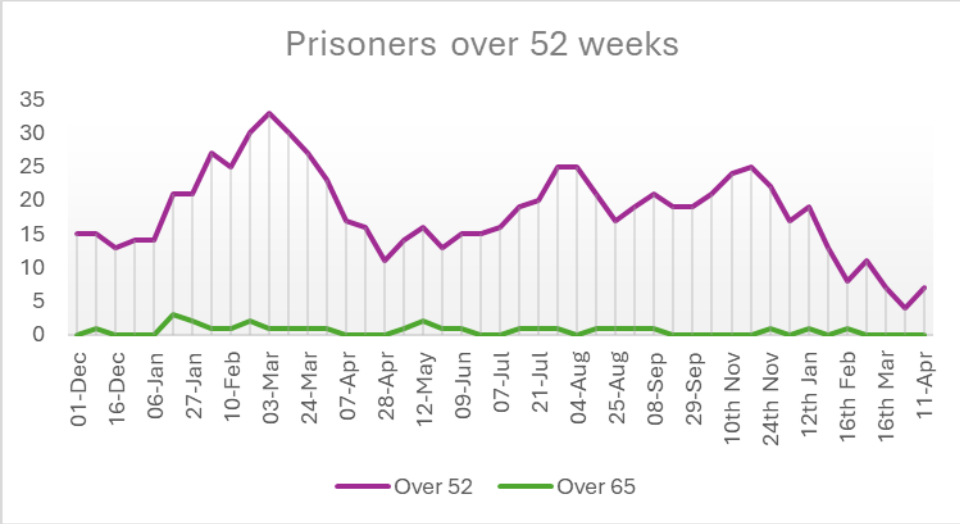
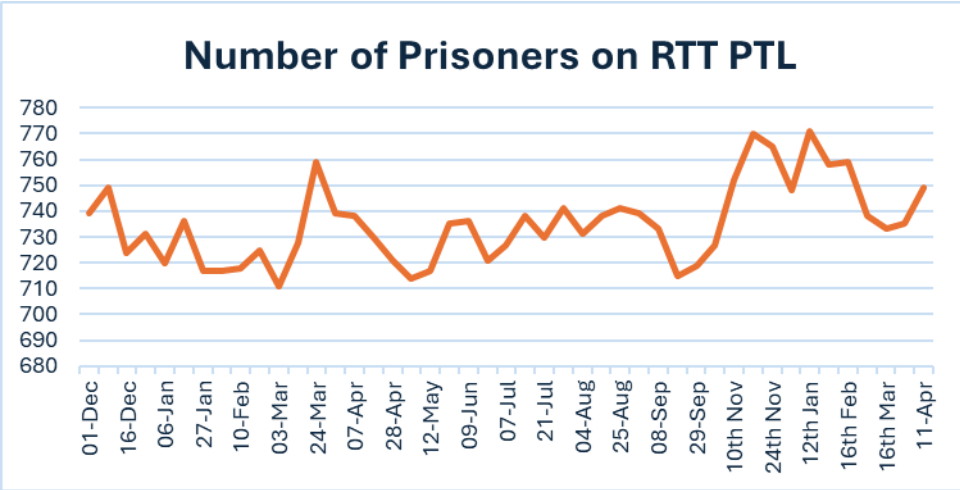


Table 4 – Total number of patients on a 18 week Referral to Treatment (RTT) Patient Tracking List (PTL) December 2025 to March 2026

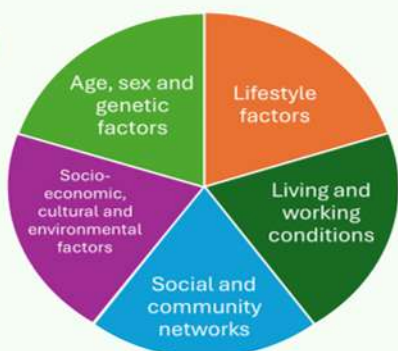


Appendix 3 Easy Read Health improvement plan poster



Our **Health Improvement Plan** aims to achieve a safer, fairer and **healthier** Lancashire

We will work with our partners across the health and social care system to build a future where everyone can live a healthy and fulfilling life



Almost every part of our lives impacts our health and life expectancy

2 out of 3 of adults are overweight

1 out of 4 5-year-olds have tooth decay

13% of our community smoke

The poor health of our local community means change is needed for adults, young people and children to live healthy lives

1 out of 4 adults binge drink alcohol

High level of heart disease in adults

Health Improvement plan focus of work



HEALTH EQUITY AWARENESS AND UNDERSTANDING



ENGAGEMENT WITH LOCAL COMMUNITIES



POPULATION HEALTH APPROACH TO IMPROVEMENT WORK



Health Improvement Plan | Scan to find help and resources



Appendix 4 Health improvement plan: Our plan to reduce health inequalities 2024 – 2026



 **Our plan to reduce health inequalities** 

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Lancashire & South Cumbria

Health Inequalities..... page 9

Life expectancy page 10

Ill health page 11

Central Lancashire

Our Population page 12

Our Partners page 13

Health Risk Factors..... page 14

Health Improvement Plan

Key Principles page 15

The population health approach page 16

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Work already underway in primary and community setting pages 18–19

Action plan and metrics 2024–2026 pages 20–26

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Foreword



As the Director of Public Health for Lancashire, I am honoured to present Lancashire Teaching Hospital's Health Improvement Plan, a comprehensive strategy aimed at reducing health inequalities across our region. This is a testament to the organisation's unwavering commitment to fostering a healthier, fairer society where everyone can thrive.

Health inequalities are a persistent challenge, deeply rooted in the social, economic, and environmental conditions in which people are born, grow, live, work, and age. These disparities are not only unjust but also preventable. The Trust's mission is to address these inequalities head-on, ensuring that every individual, regardless of their background or circumstances, can lead a healthy and fulfilling life.

The foundation of this Health Improvement Plan is built upon improving the social determinants of health. By focusing on these determinants, we aim to create an environment where health equity is the norm, not the exception. This approach is holistic, encompassing a wide range of factors that influence health outcomes, from education and employment to housing and community support.

One of the key components of the plan is the Core20PLUS5 framework, which targets the most deprived 20% of our population and identifies specific groups at increased risk of poor health outcomes. This targeted approach allows us to concentrate our efforts where they are needed most, ensuring that our interventions are both effective and equitable. By addressing the unique needs of these populations, we can make significant strides in reducing health disparities and improving overall health outcomes.

This plan also highlights the importance of collaboration and partnership. Health improvement is not the sole responsibility of the healthcare sector; it requires a concerted effort from all sectors of society. We are committed to working closely with our partners in health and social care, education, housing, and the voluntary and community sectors. Together, we can create a supportive network that promotes health and well-being at every stage of life.

Our Health Improvement Plan is not just a document; it is a call to action. It is a roadmap for creating a healthier, more equitable society, and it requires the commitment and participation of everyone in our community. As we move forward, we will continue to engage with our residents, listen to their needs, and adapt our strategies to ensure that we are making a meaningful impact.

I am confident that, with the dedication and collaboration of our partners and the resilience of our community, we can achieve our vision of a safer, fairer and healthier Lancashire. Together, we can build a future where health inequalities are a thing of the past, and every individual can live a healthy, fulfilling life.

Sincerely,

Dr Sakthi Karunanithi

Director of Public Health, Wellbeing and Communities,
Lancashire County Council.



Introduction



As the CEO of Lancashire Teaching Hospitals, I am deeply committed to addressing the health inequalities that persist within our community. These inequalities are not only avoidable and unfair but also systematic differences in health that affect various groups of people. In 2010, Professor Sir Michael Marmot's strategic review¹ of health inequalities provided us with a clear roadmap for improvement through six key recommendations:

1: Give every child the best start in life

2: Promote education and life-long learning

3: Ensure fair employment and good working conditions

4: Secure the minimum income necessary for a healthy life

5: Create healthy and sustainable environments and communities

6: Adopt a social determinants approach to prevention and healthy lifestyles

To implement these recommendations effectively, it requires concerted, coordinated, and long-term action from the entire community. At Lancashire Teaching Hospitals, we are dedicated to transforming into a 'health improvement organisation' that not only treats illness but also actively promotes health and well-being.

At Lancashire Teaching Hospitals we provide a full range of general hospital services not only to our local population of 390,000 people in Preston, Chorley and South Ribble but also provide specialist care to the 1.8 million people across the region. To effectively implement a health improvement approach to not only to the local population of Central Lancashire but across the region to the patients we serve we will need to work in partnership with our wider health and

social care network and the voluntary, community, faith and social enterprise partner organisations to achieve the shared goal of healthier and happier lives in Lancashire. Across the Lancashire and South Cumbria region there are high levels of deprivation and persistent poverty in coastal areas, rural communities as well as in its towns and cities, all of which contribute to unfair and wide inequalities in health and poor health.

Our role is crucial, and we take it very seriously. We are committed to working collaboratively with our partners and the community to tackle the root causes of health inequalities and have aligned our work to that of the Lancashire and South Cumbria Integrated Care Partnership strategy 2023–2028 and the life course approach of Starting well, Living well, Working well, Ageing well and Dying well. By focusing collectively on prevention, education, and creating supportive environments, we aim to ensure that everyone has the opportunity to lead a healthy life. Together, we can make a significant impact on the health and well-being of our community, now and for future generations. It is our mission to lead this change and to inspire others to join us in this vital endeavour.

Prof. Silas Nicholls

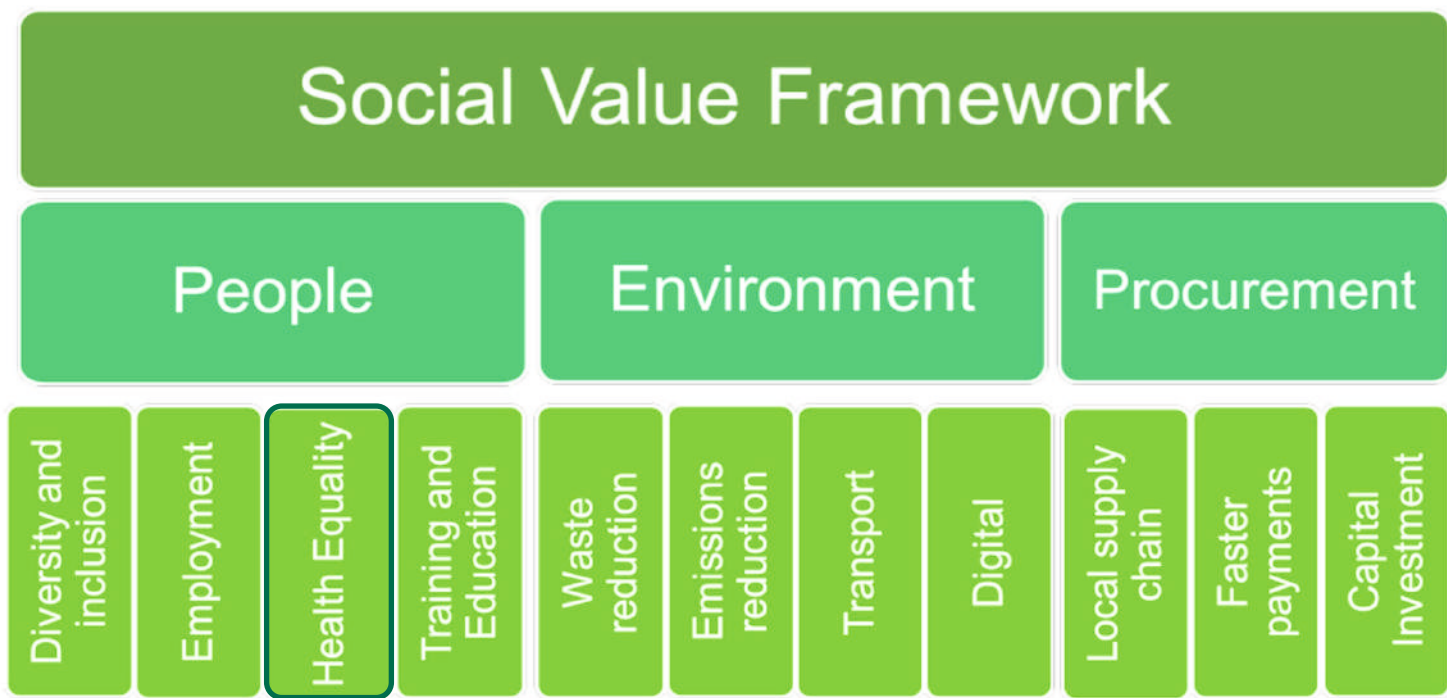
Chief Executive,
Lancashire Teaching Hospitals.

[1. Strategic Review of Health Inequalities in England post-2010. \(2010\). Fair society, healthier lives: The Marmot review](#)



Lancashire Teaching as a Health Improvement Organisation

The LTH **Social Values Framework** supports the Trust to align associated priorities, agree improvements, mobilise change and celebrate improvement. The framework for Lancashire Teaching Hospitals has 3 main lenses: **people**, **environment** and **procurement**.



Anchor Institution Framework – to drive improvements in the wider determinants of health through our corporate functions such as recruitment, procurement, managing our estate and partnership working.



Health Improvement Plan – working with our partners aligned to the Lancashire and South Cumbria Health and Wellbeing Partnership Strategy to improve health for the population of Lancashire

Green Plan – to reduce our environmental impact and adapt our services to the changing climate



Social determinants of health

Almost every aspect of our lives impacts our health and ultimately how long we will live. This includes:

Our jobs

Our homes

Our access to education,

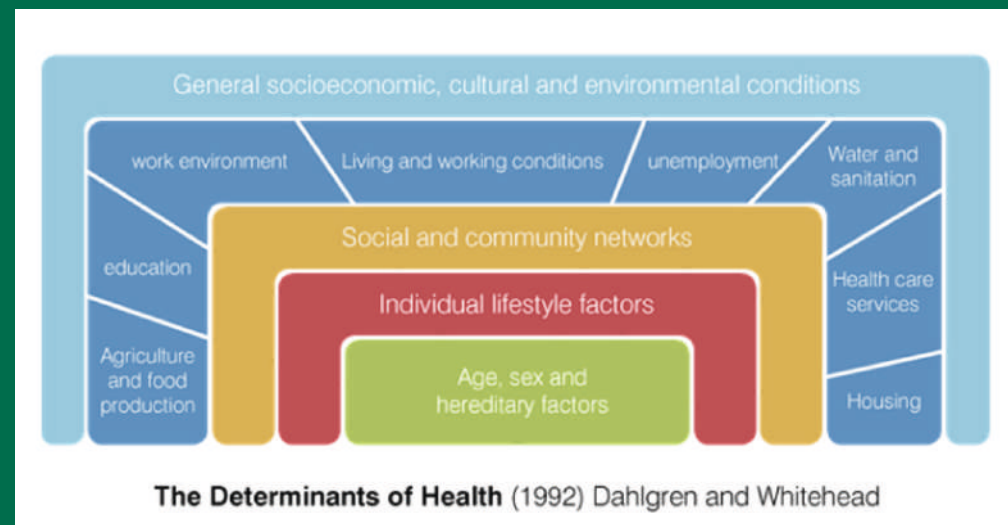
Our access to employment opportunities

Our public transport networks

Our social networks

Whether we experience poverty

Whether we experience discrimination.



These factors are often referred to as the wider determinants of health. Where we live can dictate the extent to which it facilitates exercise, a good diet and social connections.

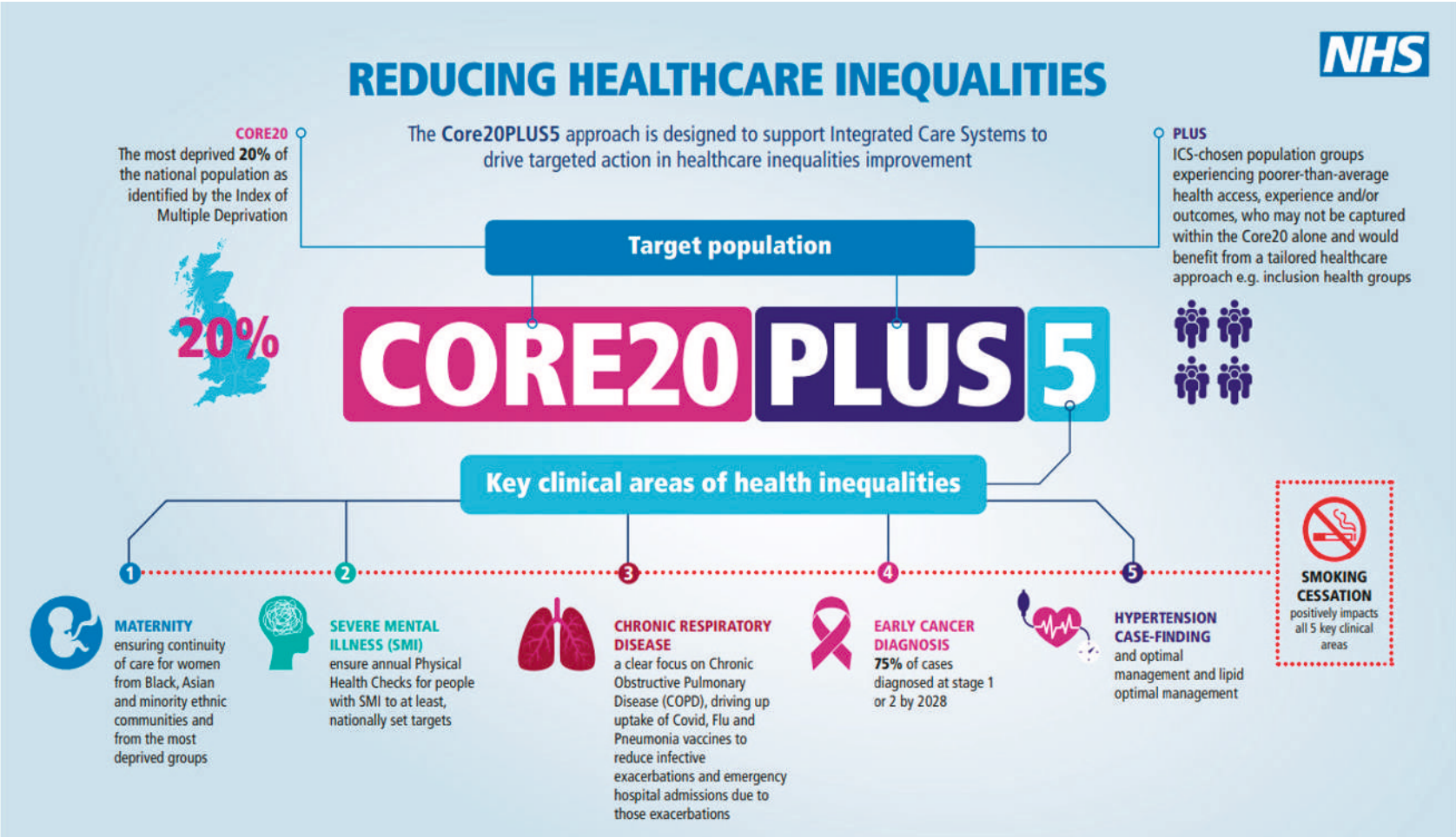
This is a challenge for those who want to address the widening inequalities in health across the country. When people see how jobs, homes, hardship and discrimination link to health, they are more likely to understand how they can help address the inequalities many of our population in Lancashire and South Cumbria face.

Source: The Health Foundation (2022) *How to talk about the building blocks of health*.

Dahlgren G, Whitehead M. *Policies and Strategies to Promote Social Equity in Health*. Stockholm: Institute for Futures Studies.

Core20PLUS5: Adults

This is an NHS framework to inform action on reducing healthcare inequalities at a national and system level based on the theory of social determinants of health. The approach defines a target population – the ‘Core20’ most deprived 20% of the population, ‘PLUS’ population groups that are at increased risk within our area, and identifies ‘5’ focus clinical areas requiring accelerated improvement and drive action in healthcare inequality improvement. The Core20PLUS5 framework forms the basis of our clinical interventions for adults.

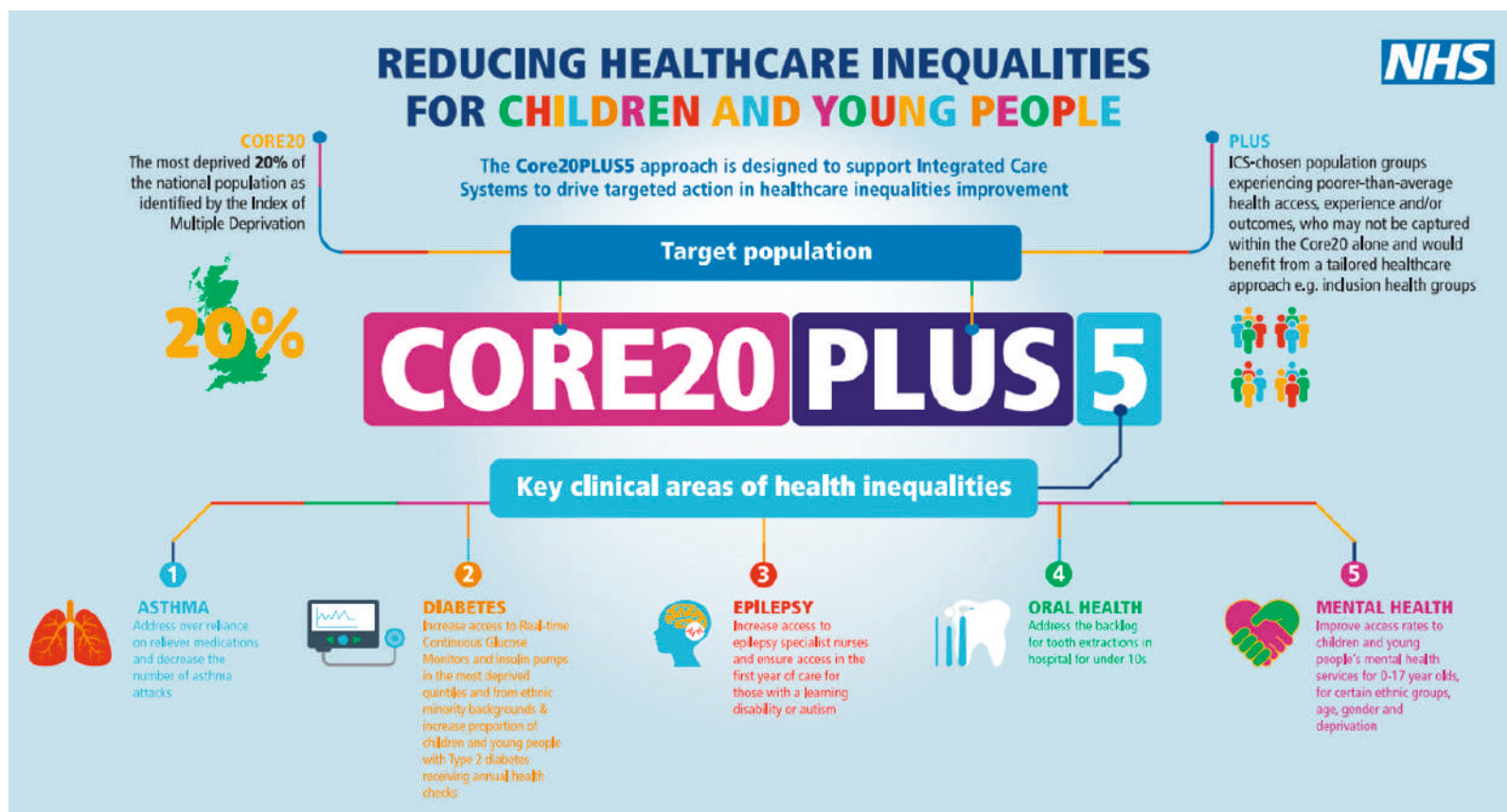


Core20PLUS5: Children and Young People

Focussing on children's health ensure they have best start in life. Children and Young people need special attention for health inequalities because:

- **Critical Development:** Early years are crucial for growth and development.
- **High Vulnerability:** Children and Young people are more affected by poor living conditions.
- **Preventable Issues:** Many health problems in children and young people can be prevented.
- **Long-term Benefits:** Healthier children and young people lead to healthier adults.
- **Educational Impact:** Poor health affects school performance and future opportunities.

The **Core20Plus5** priorities form the basis of our clinical interventions for children and young people.



Health Inequalities in Lancashire & South Cumbria

The Lancashire and South Cumbria ICS has a population of 1.8m people, as the specialist provider it is important we think about inequalities across the whole of Lancashire and south Cumbria as well as the local Central Lancashire footprint.

This summary table shows our key population demographics and prevalence across Lancashire and South Cumbria in line with the priorities in the Core20PLUS5 framework

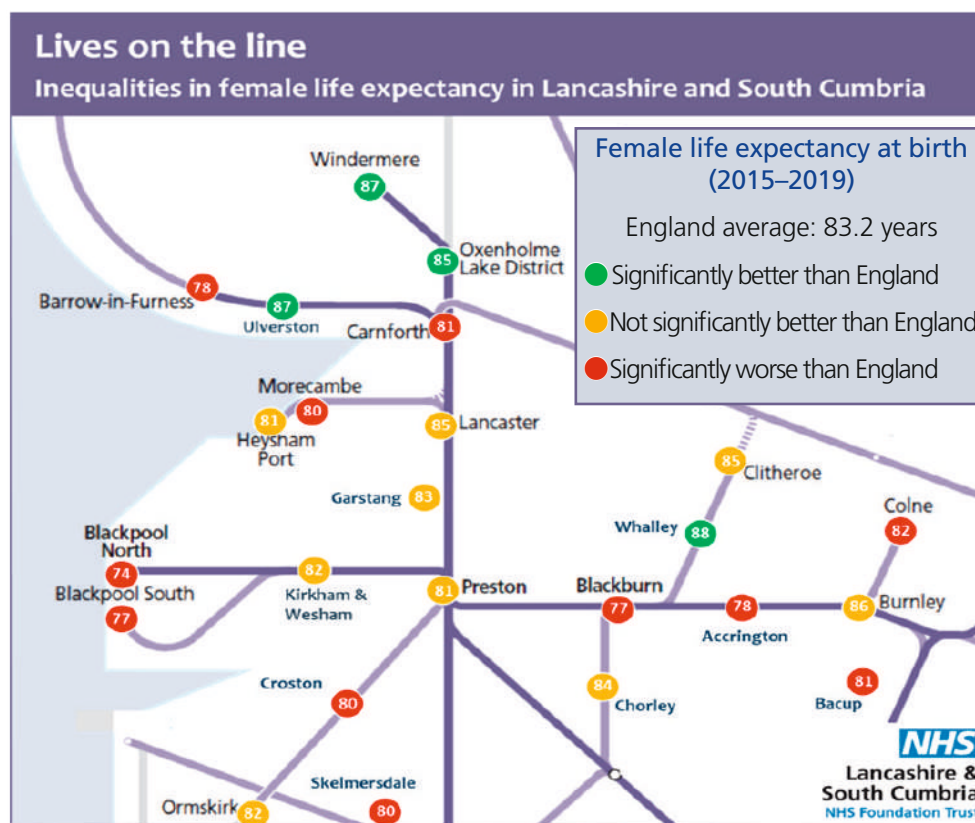
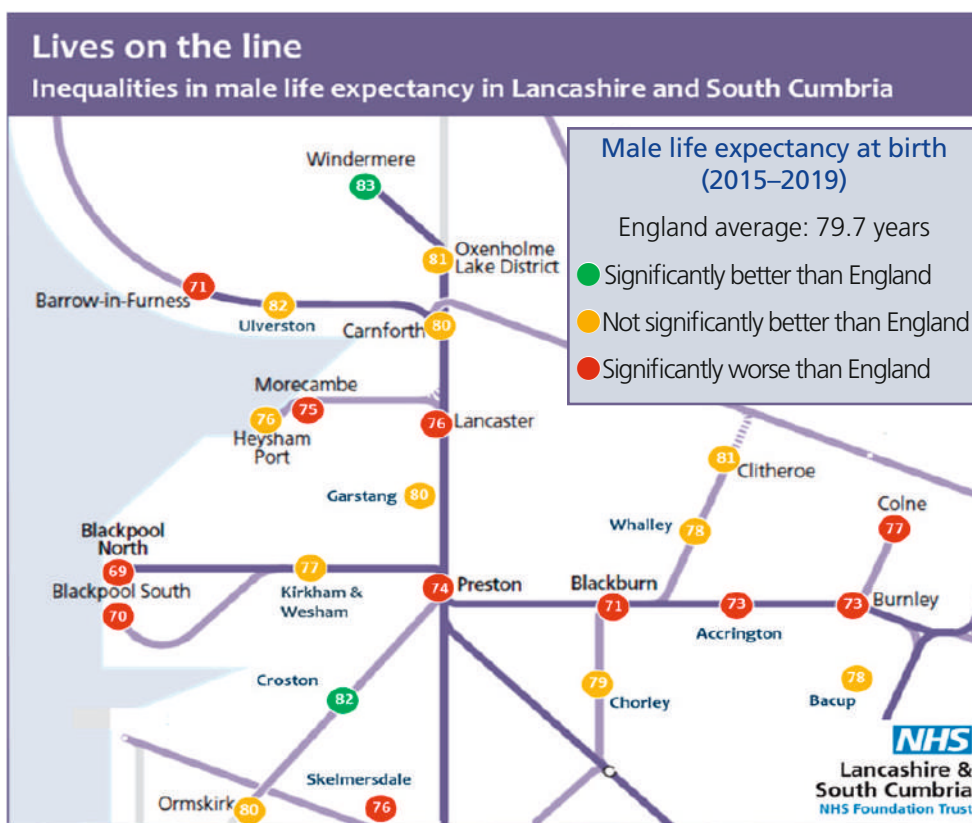
Core20	PLUS		5	
Deprivation	Diverse	Aging population	Long Term Conditions	Core Determinants
The 'Core20' accounts for 31% of our population. In some of our places it is a much higher proportion. In Blackpool 70% of the population are within the 20% most deprived areas. Up to 25% of children are living in poverty and 20% of over 65s are living in poverty.	17% of people in Pennine Lancashire are in minority ethnic groups. Population in rural communities is 20.4% vs national average for England is 17%. Locally determined groups include: • LGBTQ+ and transgender, • BAME, • Sex workers • People in contact with justice system • Victims of modern slavery • Gypsy Romany travellers • Asylum seekers and refugees • Veterans • Homeless.	Over 75s will double by 2035. Population over 65 is 19.9% vs national average for England is 18.2%. One person households with people aged 65 or over is 14% vs national average for England is 12.4%.	High levels of mental health conditions including depression. High levels of other long term health conditions including: • Cardiovascular disease, • Heart failure • Hypertension • Asthma • Dementia.	High rates of: • Alcohol and smoking/ respiratory related admissions, Obesity and digestive related conditions • Late-stage cancer diagnosis.



Life expectancy

These maps show that life expectancy in Lancashire and South Cumbria is lower than the national average – by almost a decade in some areas. There is also a large variation in the number of years people can expect to live a healthy life. Babies born in this area today have a healthy life expectancy that is lower than the expected state pension age of 68. In some areas, healthy life expectancy is as low as 46.5 years, although this varies significantly across our communities.

Diseases that contribute to the gap in life expectancy between the most and least deprived areas are circulatory disease, cancer, respiratory conditions. Around 21,000 people across Lancashire & South Cumbria who are currently registered with a GP practice have 5 or more long-term health conditions, and a disproportionate number of these are from the areas of greatest disadvantage.

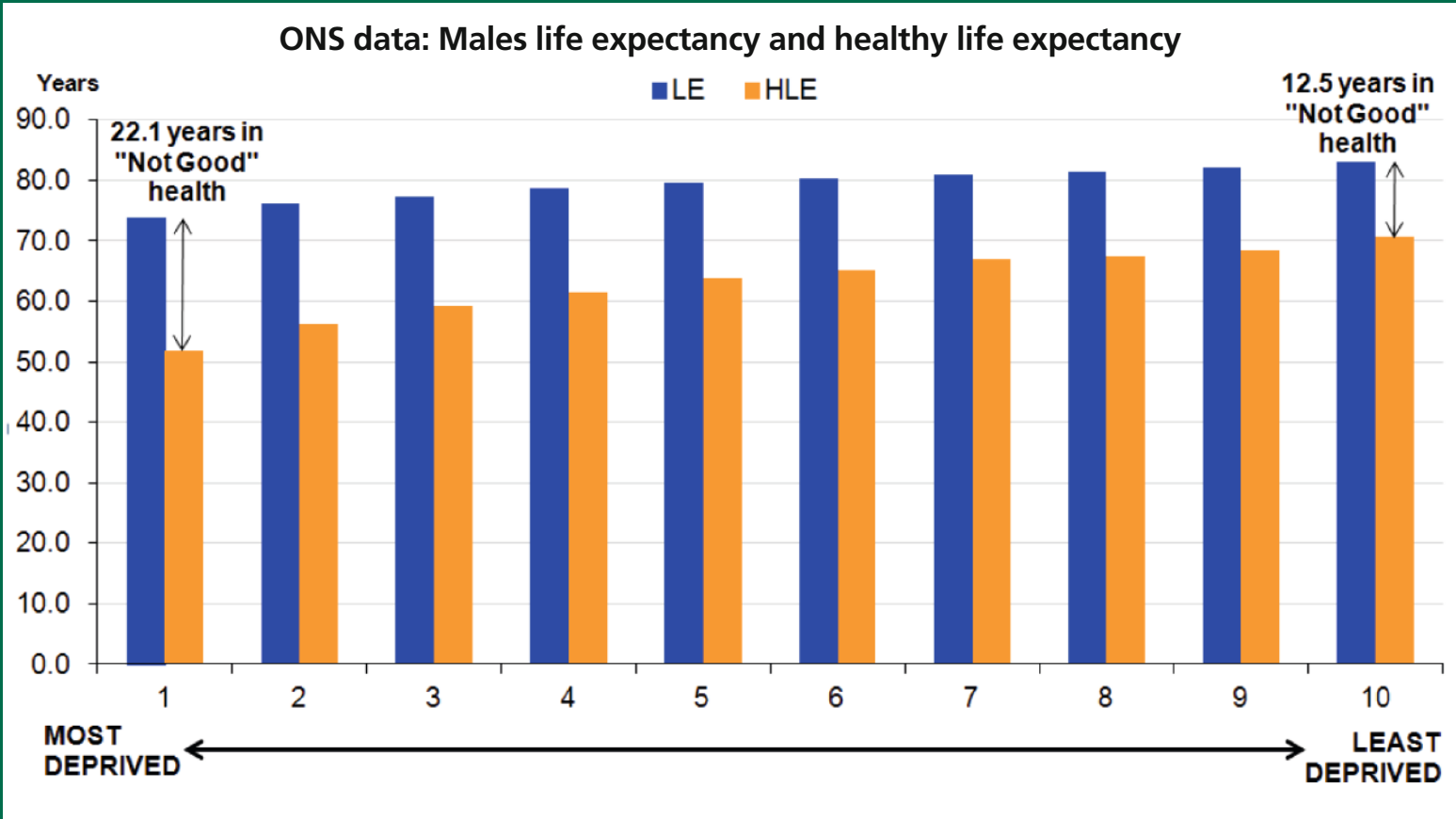


Number of years spent in ill health

This chart shows the national life expectancy and healthy life expectancy for Males by national declines in England for 2013-2015. As deprivation decreases (moving from left to right on graph), both life expectancy (LE) and healthy life expectancy (HLE) increase. This indicates a correlation of better income levels and health life expectancy in less deprived areas.

The gap between expected years spent in ill health also decreases in less deprived areas showing a 10 year difference in good health of the most and least deprived population groups.

Source: [ONS HLE and LE](#)

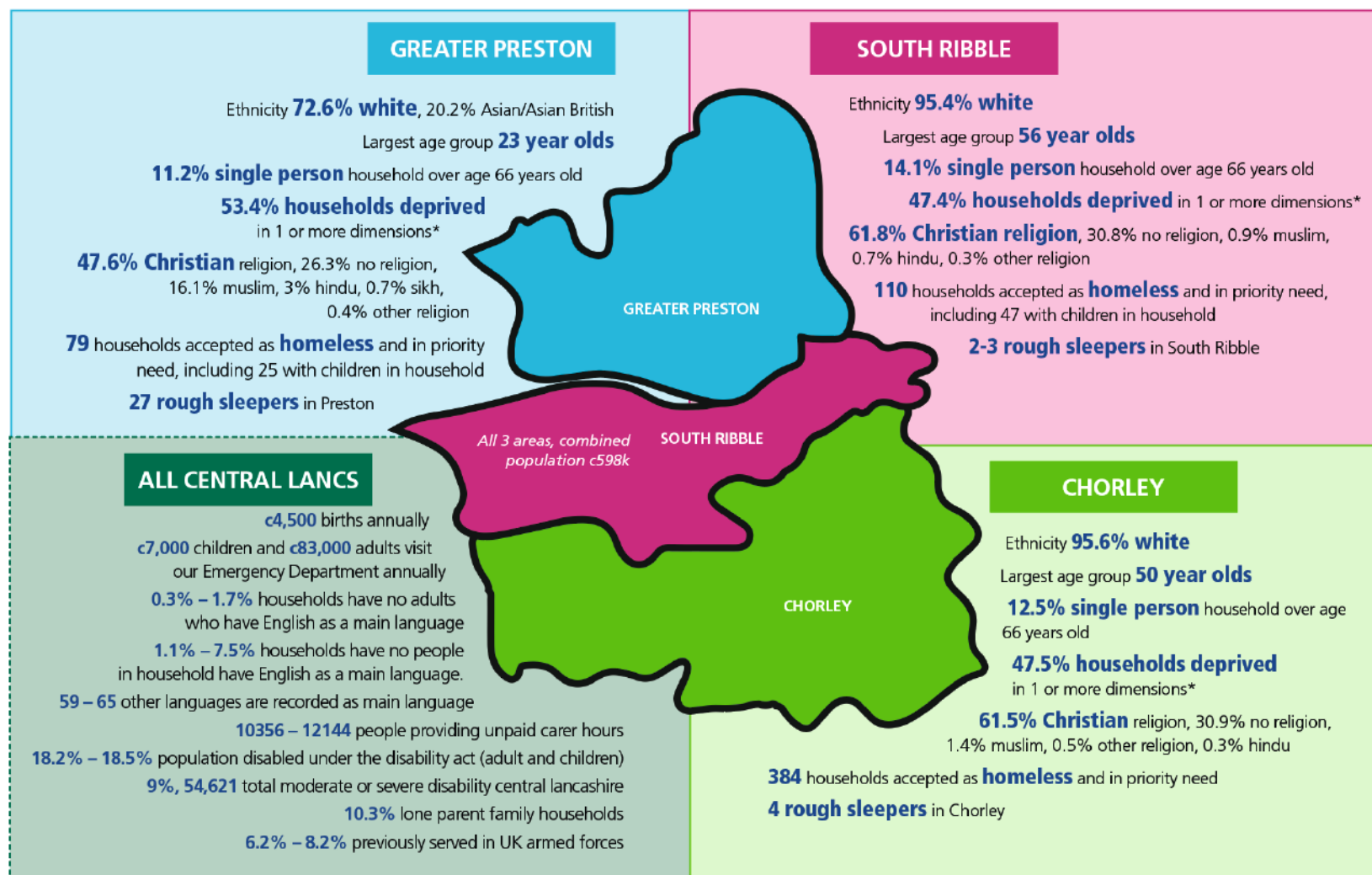


Our population in Central Lancashire

Mapping population demographics shows the differences across areas and wards within our own locality and differing needs of each population.

Source: Data from 2021 Census

<https://www.lancashire.gov.uk/lancashire-insight>



*dimensions of deprivation used to classify households are based on education, employment, health and housing.

Our partners in Central Lancashire

Successfully reducing health inequalities will require working in partnership with stakeholders in and outside of health. Across partner organisations there is a synergy in the ambition, but also individual responsibility where each organisation can help to connect either data, intelligence or programmes of work that have the same aims. The Place based health inequalities strategy is developed in partnership between the Lancashire & South Cumbria Integrated Care Board (ICB) and Lancashire County Council (LCC) through the Health & Wellbeing Boards. There is a health and well-being board for Chorley and for Preston.

Voluntary, Community, Faith and Social Enterprise Partners (VCFSE)

There are approximately 50 VCFSE partners actively working with LTHTR across Central Lancashire and ongoing work to engage with more partners.

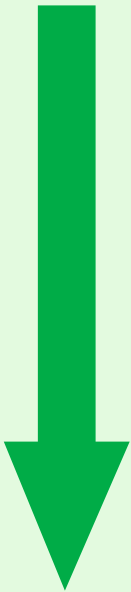
Supporting to improve patients' and families experience inclusive of 9 protected characteristics:

- 9 protected characteristics
- Carers
- Bereavement
- Community support
- Health promotion and resources



Health & Social Care partners across the system

- Derian House Children's Hospice
- St Catherine's Hospice
- Lancashire & South Cumbria Integrated Care Board
- Lancashire & South Cumbria Foundation Trust
- North West Ambulance Service
- 3 Preston Primary Care Network
- 3 Chorley Primary Care Networks
- 3 South Ribble Primary Care Networks
- Preston City Council
- Chorley Council
- South Ribble Borough Council
- His Majesty's Prison Service
- Lancashire County Council



Joining together under the Lancashire and South Cumbria Integrated Care Partnership Strategy with the vision for a safer, fairer and healthier Lancashire. 3 key priorities



Achieving the very best start in life for our children, young people and families



Reducing the changes of heart disease, stroke, diabetes, dementia and cancer



Improving wellbeing and reducing addiction, self-harm and loneliness



Health and lifestyle factors in Central Lancashire

Health behaviours, such as diet and exercise, can improve or damage the health of individuals. These are determined by the choices available in the places where people live, learn, work and play. Behaviours such as stopping smoking, moderation of alcohol intake, healthy eating, physical activity, sexual practices and disease screening can reduce the risks of developing serious illnesses such as cancer, heart disease and type 2 diabetes.²

Health Factor	Chorley	South Ribble	Greater Preston	England average
Children overweight (obese) by age 4–5 years old	22.2%	21.1%	22.2%	21.3%
Hospital admission caused by unintentional/ deliberate injuries (0–14 yrs old)	98.1	108.9	99.5	75
Under 18s conception rate	19.4	14.4	20	13.1
Overweight (obesity) prevalence in adults	65.4%	66.4%	64.6%	64%
Smoking prevalence in adults	15%	13.6%	16.3%	12.7%
Smoking status at time of delivery	8.9%	9.4%	9.4%	8.8%
Admission episodes for alcohol related conditions	479	410	482	475
Estimated diabetes diagnosis rate	73%	75.6%	88.5%	78%
Cancers diagnosed stages 1 and 2	55.5%	54.3%	51.7%	54.4%
High anxiety score reported	17.9%	17.5%	25.8%	23.3%

Source: <https://fingertips.phe.org.uk/profile/public-health-outcomes-framework> 2023 data, shown values per 1,000 population or %

When compared to England average most health risk factors are higher in Central Lancashire.

Lancashire Teaching Hospitals Health Improvement Plan

Effective delivery of this work will rely on 3 key principles that will be threaded throughout this plan to ensure our organisation can embed and sustain change, and grow our understanding in reducing health inequalities.

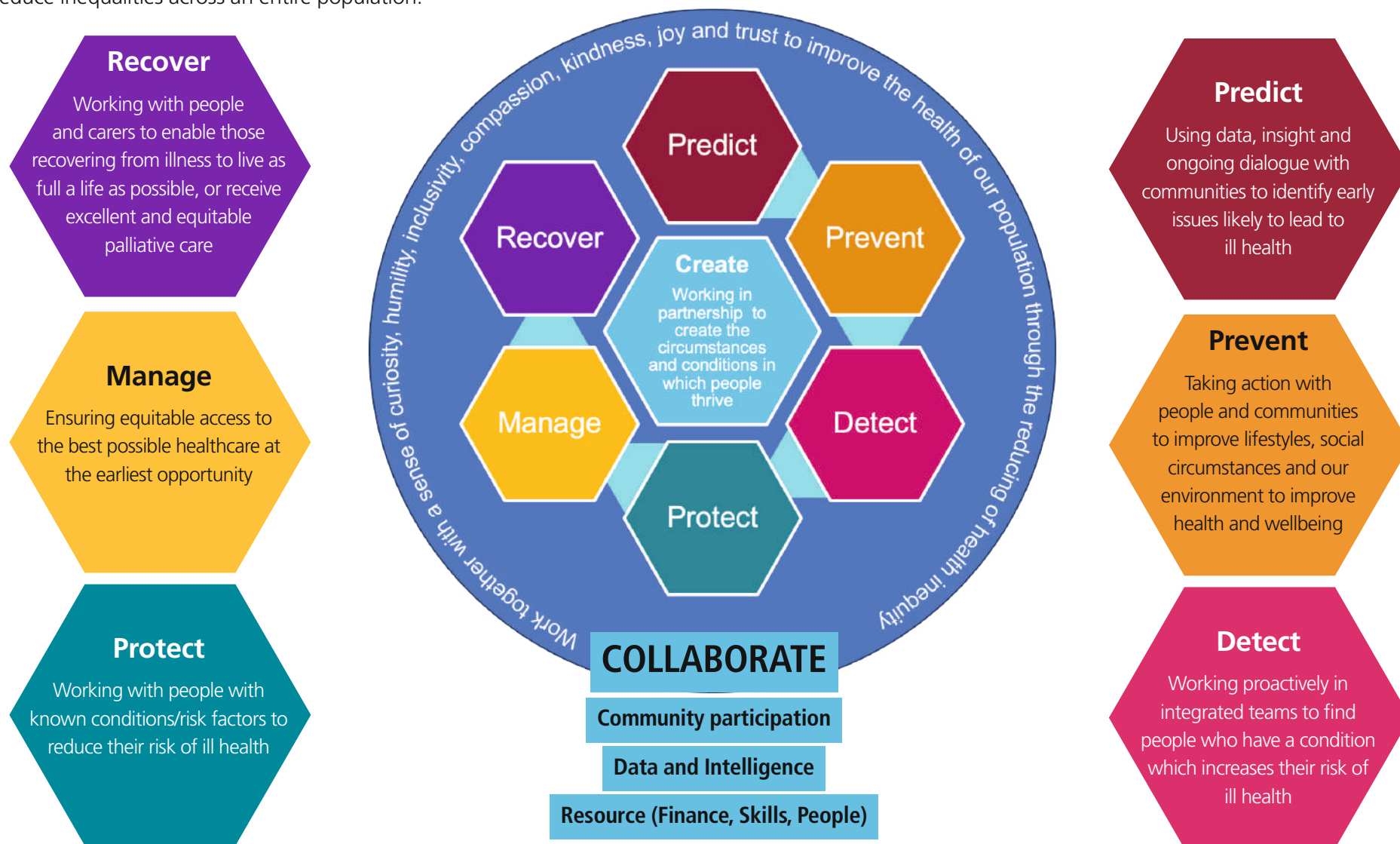
This table describes the high-level structure and approach for our **Health Improvement Plan**. Detailed drivers, actions and outcomes support the delivery and monitoring of the plan.

Principle	Driver	How will we do this?
To give everyone a 'health equity attitude'	Through better awareness, understanding and visibility we can then act to improve access, experience and outcomes for our patients	• Health inequalities education: a new approach to health equity education • Health inequality data visibility: mandated collection, sharing and use of data to understand inequalities • Active health promotion: for patients, families and colleagues • Connection – Understand our role as an anchor institution and the Social Values Framework.
To actively engage with local communities to improve services for their needs	Engaging our local communities and co-produce improvement must be at the centre of this work. We need to genuinely listen to understand with an appreciation that our communities are best placed to co-produce the solutions to the problems that we seek to solve.	• Lived Experience: Learning from the experience of people on whom a social or combination of issues has had a direct impact on the person • Co-production: A way of working together underpinned by principles that support inclusion, equity, shared decision and ownership for what is produced and the impact of has at all levels, especially strategically.
To take a population health approach to improvement work	An approach to be effective in enacting sustainable change that makes an impact to the group most in need.	• Structure: Following the 6-step approach for population health intervention • Data led: Using data to drive areas that require improvement • Focussed: Targeted population specific solutions, not generalised solutions that may not be effective



The Population Health approach

L&SC ICB have developed a population health model to provide a structured, consistent and effective approach across Lancashire and South Cumbria. Population health management takes a risk-based approach to improve health outcomes and reduce inequalities across an entire population.



Adults – Population health improvement work

Examples of improvement work already underway within the Lancashire Teaching Hospitals specific to adults.

	Improvement work	Improvement aim	Outcomes
ADULTS	Race & Health Observatory project: Postpartum Haemorrhage for Black, Asian and Minority Ethnic	Reduce post-partum haemorrhage ($\geq 1000\text{mL}$) experienced by black & ethnic minority women & birthing people by 50% (from 12% to 6%) by March 25.	Reduction in post-partum haemorrhage ($\geq 1000\text{mL}$) in women & birthing people from black & ethnic minority groups from 12% to 9%.
	Institute for Healthcare Improvement Accelerator Collaborative: Early cancer diagnosis for Black, Asian and Minority Ethnic	Engage population group to co-produce solutions to increase earlier stage cancer diagnosis.	Successful and continuing community engagement. Positive feedback from community with increased awareness of cancer symptoms and body vigilance.
	High Intensity User service	Reduce repeat emergency Department attendances using a psychosocial Multi-disciplinary Team model of intervention.	7/10 patients had a reduction in attendance, ranging from 25–100% fewer emergency presentations.
	Prisoner Referral to treatment	To reduce the time prisoners wait on the waiting list.	>65weeks reduced from 12 to 5. Prior to the work zero prisoners had a date to be treated, now all are dated to receive treatment by 45 weeks.
	Tobacco and Alcohol Cessation Team interventions	Increase in inpatient referrals to smoking cessation service and increase in patients receiving nicotine replacement therapy.	4 week quit rate increased by 433% Nicotine Replacement Therapy prescription increase from 14% in 2021 to 44% in 2023.

**13%
of our
community
smoke**

**46%
of cancers are
diagnosed late at
stage 3 and 4**

**65%
of adults are
overweight**

**569 admissions
to hospital due
to alcohol related
conditions**

**79% estimated
diabetes
diagnosis rate**

*average across Central Lancashire. Shown values per 1,000 population or %



Children – Population health improvement work

Examples of improvement work already underway within the Lancashire Teaching Hospitals for Children and Young People

	Improvement work	Improvement aim	Outcomes
CHILDREN	Emergency Department navigator role in partnership with Lancashire Violence Reduction Network.	Navigate 10 to 25-year-olds away from violence towards a more positive lifestyle.	Increase from 4 to 17 patients intercepted per month to support making positive plans to disrupt the cycle of violence.
	Paediatric complications of excessive weight gain service integration	Develop an integrated Child Excessive Weight service and referral pathway with three centres (Manchester, Alder hey and Preston) to provide care close to home.	Multi-disciplinary Team integration established. Hub and spoke model implemented with 33 follow up and 28 new patients.
	Children in Care team	Provide Individual Health Assessments and expand the service to include 16 and 17-year olds following increase in unaccompanied asylum seeker children.	Implemented a trauma informed training programme, aid understanding and approach to care leading to willingness to disclose and support underlying issues.
	Children's Elective Surgery Hub Chorley District General Hospital	Become accredited elective hub and reduce the number of children waiting for surgery by implementing dedicated theatre lists.	Dec 23: 108 patients waiting >65 weeks, now zero. Current there are 16 patients waiting for oral surgery.

**18 under 18s
conception rate**

**102 hospital
admissions
caused by
accidents or
violence for
0–14 year olds**

**22%
of children are
overweight by
5 years old**

**25%
of 5 year olds
have tooth decay**

*average across Central Lancashire. Shown values per 1,000 population or %

Community population health improvement work

To align with our partners, it's important to have an awareness and understanding of the work underway within primary care and the community across Central Lancashire. This ensures we are joined up and effective in our work across Central Lancashire. Included below are examples of work underway within primary care networks that are focussed on either a specific population group or clinical areas requiring acceleration of prevention or interventions.

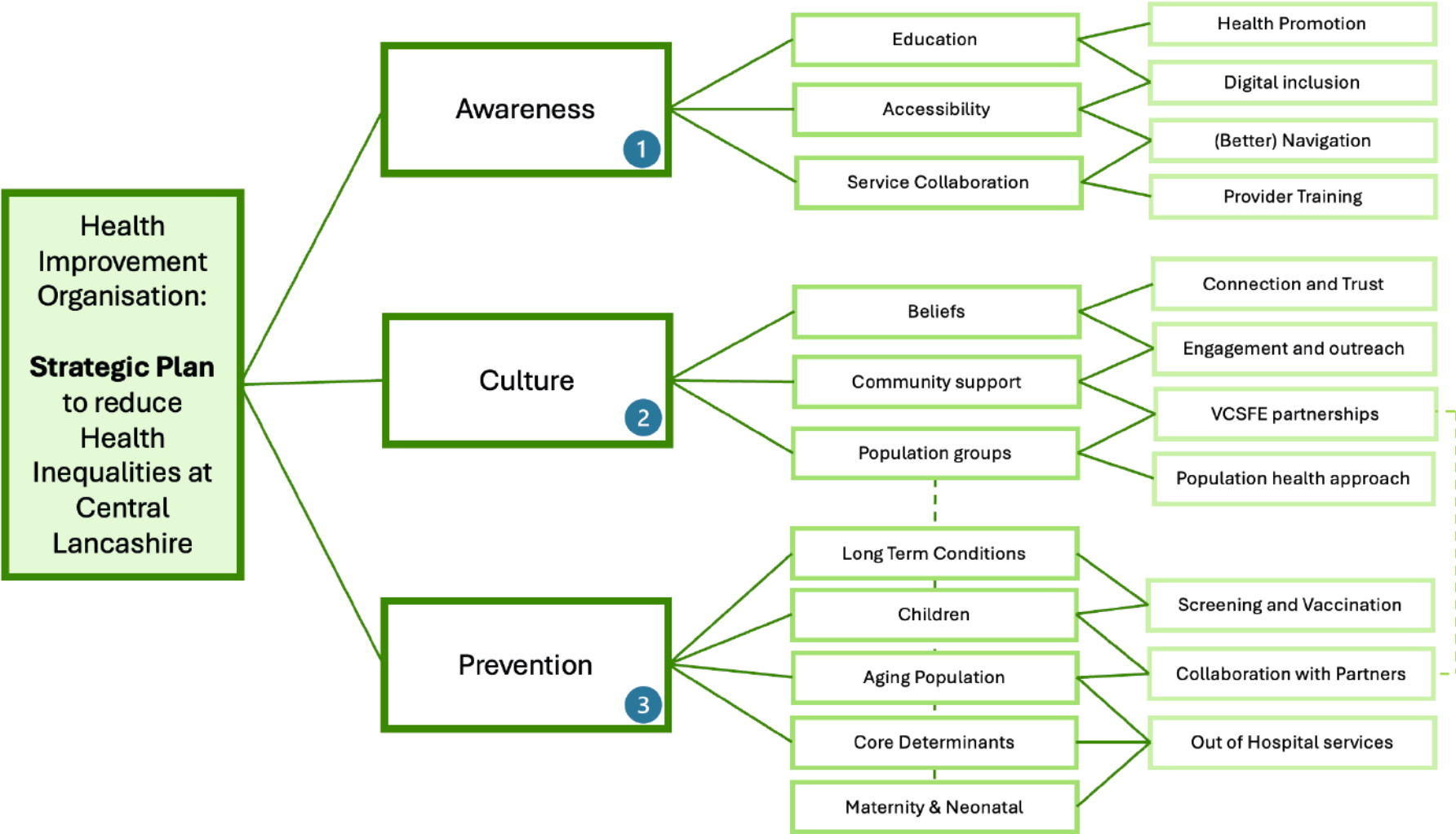
Targeted population improvement	Prevention and detection improvement
Enhanced health checks in the evening and weekends, including target on vulnerable groups	Promotion of national screening participation
Trauma informed care training for health professionals	Veterans breakfast club – focus on undiagnosed cardiovascular disease
Proactive identification of streets not accessing primary care	Hepatitis C and liver screening
Target newly diagnosed mental health patients	Suicide prevention, bereavement and mental health support
Target patients not engaged in primary care 3–5 years	Ethnic minority group prostate risk screening
Priority wards – provide outreach services targeting support	Living well events
Bilingual outreach workers	Children peer support programmes enhancing well being for children and young people age 10 – 19 and up to age 25 Special Educational Needs and Disabilities
Food banks and community support for families living in poverty	Oral health education, fluoride varnish programmes in schools, promoting regular dental checks and reduced sugar intake.



2024–2026 Action plan and measures: Strategic Drivers

The **Health Improvement Plan** has been developed using Quality Improvement methodology which includes structuring the plan using a driver diagram method. This helps to translate a high level improvement goal into a logical set of underpinning drivers and projects which have been split into strategic and operational drivers.

This plan details work specific for our Patients which features as part of the Trust Single Improvement Plan (SIP) with detailed timescales and metrics to monitor delivery. Following this plan for 2024 – 2026 a longer-term strategy will be developed as our organization grows its understanding and maturity in reducing health inequalities.



Strategic Actions

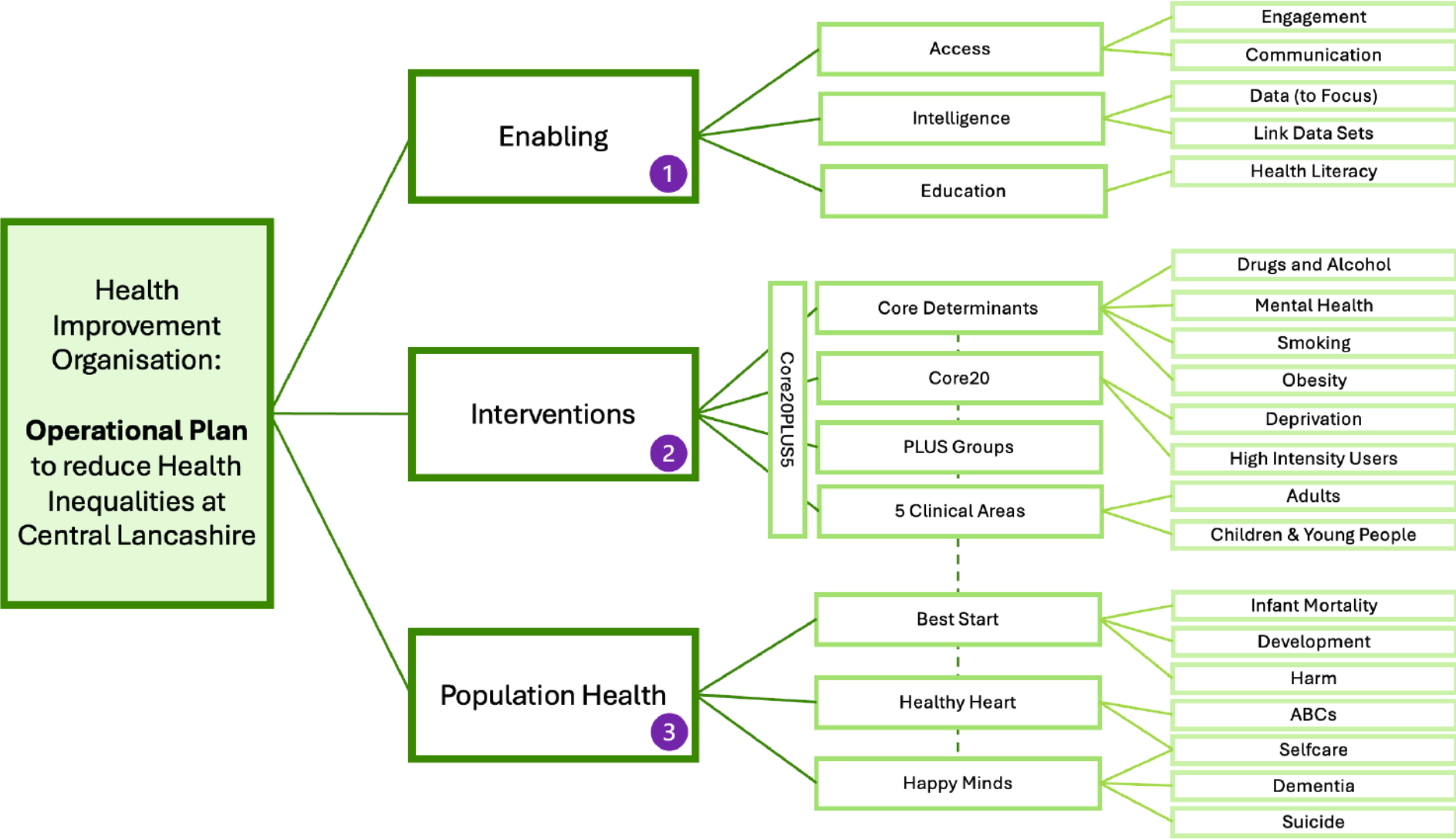
Alignment	Driver	Contributing Work	Timeframe	Outcome	Measures (Outcome, process and balance)
1	AWARENESS	EDUCATION: Develop an educational offer that ranges from core skills to practitioner level understanding of health inequalities and Making Every Contact Count (MECC). Includes enhancing current EDI training provision to broaden scope and include health inequalities	Q4 2024–25	Increased awareness of health inequalities to make a shift in the way we deliver our services	% Completion of health inequality awareness training
		RESOURCES: Provide staff and public access to skills and resources to reduce inequalities by signposting to accessible digital health information through the Lancashire Health Hub	Q4 2024–25	Increase in uptake of services that support improving socio-economic and health issues	Patient assessment documentation to reflect the socioeconomic determinants of health
		ACCESS: Implement clear signage and differentiated access to patient information and increase use of digital translation solutions.	Q4 2024–25	Ensure digital and communication solutions don not create barriers to accessing our services	Provide explicit alternatives for easy read/non digital options
		SERVICE COLLABORATION: Explore partnership with PHE to provide signposting and support to patients, for example whilst waiting in ED or in discharge lounge	Q3 2024–25	Increase in uptake of services that support improving socio-economic and health issues	Patient discharge documentation reflects signposting undertaken regarding social determinants of health
2	CULTURE	CONNECTIONS AND TRUST: Engage in existing and emerging partnership networks beyond traditional health and social care providers to deeply listen and understand what our population requires. Engage across VCFSE partners to develop long term relationships across organisations	Ongoing	Following evidence-based practice to be effective in tackling barriers and sustaining improvements in this work	Outcomes to be determined based on engagement with VCFSE groups in response to feedback and codesign approaches
		ENGAGEMENT AND OUTREACH: Direct engagement with our local communities, inviting them to actively contribute what matters to them in health, and design our services that enable better access and experience for our communities	Ongoing		
		POPULATION HEALTH APPROACH: Take a targeted and specific population improvement methodology in this work that is effective in change to those most at need	Ongoing		



Alignment	Driver	Contributing Work	Timeframe	Outcome	Measures (Outcome, process and balance)
3	PREVENTION	SCREENING & VACCINATION: Focus on delivering prevention improvement work linked to Core20PLUS5 including: • Pneumococcal and influenza vaccination status for COPD, Lung health checks, • Cancer Alliance led earlier cancer diagnosis programme,	Ongoing	Reduction of long-term conditions and preventable diseases	• % Pneumococcal and influenza vaccination vaccine uptake • % cancer diagnosis stage 1 & 2
		COLLABORATION WITH PARTNERS: Join up services expanding on work commenced with Care Connexions to bring services together from across organisations under one umbrella support of community physical health services.	2024–25	Making services more accessible by removing barriers and delivering what the patient need when it is needed by the most appropriate teams.	10% increase in the number of patients referred to Care Connexions by primary care for support services



2024–2026 Action plan and measures: Operational Drivers



Operational Plan

Alignment	Driver	Contributing Work	Timeframe	Outcome	Measures (Outcome, process and balance)
1	ENABLING	EDUCATION: Develop an educational offer that ranges from core skills to practitioner level understanding health literacy	Q4 2024–25	Increased awareness of health literacy to make a shift in the way we communicate	Train 100 leaders in health literacy training
		RESOURCES: Provide staff and public access to skills and resources to reduce inequalities by signposting to accessible digital health information through the Lancashire Health Hub	Q3 2024–25	Increase access to information that supports lifestyle changes and increases access to support	Evidence of signposting at discharge
		ACCESS: Implement clear signage and differentiated access to patient information and increase use of digital translation solutions	2025–26	Become an accredited health literacy friendly organisation and reduce waits and delays during procedures and appointments to improve patient experience	LTH Health Literacy Accreditation Create pathways that facilitate patients at increase risk of inequalities to access services with increased support
		INTELLIGENCE: Health equity data as a part of board performance packs focusing on unwarranted variation across UEC and Elective services for ethnicity and deprivation demographics	Q4 2024–25	Focussed work to enable reducing unwarranted variation and ensure equity in access to services	Evidence of change programmes enacted as a result of the data

Alignment	Driver	Contributing Work	Timeframe	Outcome	Measures (Outcome, process and balance)
2	INTERVENTIONS	CORE DETERMINANTS: Promotion and connecting services that improve core determinants of health including: • Smoking drug and alcohol cessation interventions • Excessive childhood obesity clinics • Optimisation of elective patients through signposting services to support modifying risk factors ahead of surgery	Ongoing	Increase in uptake of interventions that improve core determinants of health affecting long term conditions for both adults and children and young people	Increased 4 week Quit rate Maintenance of mortality within expected range Evidence determinant changes following pre op health coaching
		CORE20: Focus on delivering targeted improvement work linked to Core20PLUS5 including: • High intensity user programme • Integrated neighbourhood teams • ED navigators	Ongoing	Reduced attendance in ED and inpatients admissions through promoting a cycle of change and different way to manage unmet needs	25% reduction attendance in ED of patients receiving intervention 25% reduction in admissions of patients receiving intervention 20% more 25years and under signposted for violence interventions
		5 PRIORITY CLINICAL AREAS: Focus on delivering accelerate improvement work to linked to Core20PLUS5 including: • Continuity of carer and Postpartum Hemorrhage for minority ethnic groups • Discharge referral to CCN and reduce salbutamol/weaning plan for asthmatic children • Diabetes real-time access to glucose monitor and insulin pumps for children • Reducing wait for tooth extractions for children under 10 yrs old	2025–26	Deliver focused improvement in areas leading to long term conditions in both adults and children	10% reduction in post partum haemorrhage for minority ethnic groups 10% increase in smoking interventions 10% increase in alcohol interventions Decreased number of asthma attacks for children (% to be determined) 95% real time glucose monitoring in place, 60% insulin pump for children
		PLUS GROUPS: Focus on delivering targeted improvement work linked to Core20PLUS5 including: • Prisoner PTL management • Veteran status identification	2025–26	Demonstrate improvement in outcomes for groups most at need identified through LTH data.	Reduction >65 week patients in prisons Further groups to be identified as part of the data analysis Implement an approach to identifying Veteran status



Alignment	Driver	Contributing Work	Timeframe	Outcome	Measures (Outcome, process and balance)
3	POPULATION HEALTH	Work with partner organisations across health and social care to focus on key factors that impact population health for children and adults including • Safeguarding and Mental health champions in clinical areas • Develop an approach to patient and family education whilst interacting with services • Dementia strategy and access for early support fro families and patients	Ongoing	Families will understand how to access support for their loved ones	Determine a baseline of referral activity to support services and aim to increase this once baseline understood.



Governance and reporting

Leadership at every level of the organisation as well as a commitment to working with partners will be essential to successfully deliver this plan. We will continue to engage with our partner organisations building connections and relationships to ensure we work together an aligned approach across our Health & Social Care system.

Clear reporting will ensure we understand the progress we are making. The governance and reporting arrangements are outlined below

Annual Reporting

- We will publish on our website the national inequality data submission in line with duty under section 13SA of the National Health Service (NHS) Act 2006

Progress reports

- We will continue to produce twice annual reports to provide assurance on the progress on this topic to the Safety & Quality committee
- We will continue to report progress via Integrated Care Board quarterly stock take for System Oversight Framework (SOF)

Acknowledgements

With thanks to

Dr Sakthi Karunanithi, Director Public Health at Lancashire County Council

Dr Tammy Boyce, Institute of Health Equity

Dr Heather Catt, Consultant of Public Health at Blackpool Teaching Hospitals NHS Foundation Trust

Dr Chris Chiswell, Consultant of Public Health at University Hospitals Morecambe Bay NHS Trust

The Lancashire and South Cumbria Population Health Academy

Governance structure

- A working group is in place and includes colleagues from a wide variety of settings ranging from patient experience, operational, library and knowledge, improvement, clinical and data scientists.
- The Executive lead for Health Inequalities is Sarah Cullen, Chief Nursing Officer.
- The plan to reduce health inequalities is part of the Trust's Single Improvement Plan (SIP) within the Chief Nursing Officer's safety, quality and effectiveness portfolio, which will follow reporting arrangement as a part of the SIP governance structure.
- In addition to provide close oversight to the Trust Board, monthly chairs reports from the HIG are submitted into sub- board Safety & Quality committee as well as the twice annual detailed progress reports.



Glossary of terms

Term	Definition	Term	Definition
LTHTR	Lancashire Teaching Hospitals NHS Foundation Trust	IHI	Institute for Healthcare Improvement
GP	General Practitioner	TACT	Tobacco and Alcohol Care Team
LGBTQ+	Lesbian, gay, bisexual, transgender, queer or questioning, or another diverse gender identity	ED	Emergency Department
BAME	Black, Asian and Minority Ethnicity	MDT	Multi-Disciplinary Team
HLE	Health Life Expectancy	PPH	Post Partum Haemorrhage
LE	Life Expectancy	NRT	Nicotine Replacement Therapy
ONS	Office for National Statistics	CEW	Children's Excessive Weight
FT	Foundation Trust	CDH	Chorley District General Hospital
ICB	Integrated Care Board	CYP	Children and Young People
PCN	Primary Care Network	Hep C	Hepatitis C
VCFSE	Voluntary, community, faith and social enterprise partners	CVD	Cardiovascular Disease
L&SC	Lancashire and South Cumbria	SEND	Special Educational Needs and Disabilities

11.2 MATERNITY AND NEONATAL SERVICES SAFETY REPORT

● Other

Item for Assurance

REFERENCES

Only PDFs are attached



11.2 Maternity and Neonatal Services Safety Appendices Board Part I 4 June 26.pdf

Meeting of the	Board of Directors	4 June 2026	
Meeting	Part 1 x	Part 2	
Title of Report	Maternity and Neonatal Services Safety Report		
Report Author	Jo 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 and scrutinise the report, including the Clinical Negligence Scheme for Trusts (CNST) Year 8 Maternity Incentive Scheme (MIS) supplementary information pack and associated action plans ii. Note the changes to the requirements commenced in year 8 MIS iii. Confirm it is assured of the oversight and monitoring mechanisms used to monitor safety and quality within maternity and neonatal services, noting the Safety and Quality committee have received the report and provided scrutiny to its contents.		
	Decision ☐	Assurance ☒	Information ☐

1. INTRODUCTION

The purpose of this report is to provide the Board of Directors with an overview of the perinatal safety and quality workstreams up to the end of March 2025. Workforce data, patient experience metrics, and clinical effectiveness indicators are included to support assurance and oversight, aligned to the requirements of the Perinatal Quality Surveillance Model (PQSM).

The report details the pre-requisites for the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) year 8, following the publication of the updated standards in March 2026. The service confirms that it has received formal confirmation from NHS Resolution that the Year 7 Maternity Incentive Scheme (MIS) outcome has been validated and published, with the service achieving all 10 standards.

2. MATERNITY INCENTIVE SCHEME (MIS)

As a key enabler, the CNST maternity scheme incentivises the delivery of core safety standards as a lever for the provision of safer maternity and neonatal care.

Compared to earlier years and iterations of the scheme, Year 8 MIS represents a significant step change. With a focus on six core safety actions replacing the original ten, the clearer structure enables Trusts to prioritise areas and embed processes that have the greatest impact on outcomes. The updated standards support targeted focus on workforce, learning from events, clinical standards, culture, and improving experiences for women and families, alongside strengthened Board oversight and accountability.

To note the Local Maternity and Neonatal System/Integrated Care board (ICB) validation and oversight will not continue in Year 8. Trusts must ensure that the Board and designated committees regularly review maternity and neonatal quality and safety intelligence. This includes reporting to the Board of Directors. Any issues identified at committee level must be formally escalated to the Board for oversight, and where local mitigation is insufficient, clear escalation must occur to the regional maternity team in line with PQOM requirements. Chart One (1) provides a pictorial summary of the new MIS thematic actions.

Chart 1 details the MIS safety Actions



Table 1 detailed below provides a detailed benchmark analysis of the six new safety standards and requirements for MIS year 8. It outlines examples of embedded processes or best practice which the service has implemented over the previous years and where action is now required.

Appendix 1 provides a high-level overview of the Year 8 requirements to support the Trust Safety and Quality Committee and Board of Directors to understand, recognising the significant changes introduced. The level of detail is provided for this reporting cycle only and will not be included in full in future reports once standards are embedded.

TABLE 1 DETAILS THE STATUS OF MIS YEAR 8 REQUIREMENTS

Safety Action A Workforce and Capacity	Safety action A combines perinatal workforce requirements into one multi-professional action. Trusts must demonstrate that funded establishments for obstetric, midwifery, neonatal, anaesthetic, and perioperative teams meet nationally recognised workforce standards.		
	Standard	Good Practice Requirements and Progress	Status
	Sets clearer expectations for consultant presence, anaesthetic cover, neonatal staffing and locum use.	Local audit of consultant presence is undertaken monthly and performance is included in the perinatal quality surveillance dashboard for assurance. If there are occasions when the consultant has not attended, the reasons are reviewed by the Clinical Director (CD) for Obstetrics for learning.	On Track
		The service has a-specific locum register that includes all short-term locums, with recorded dates of eligibility verification and most recent review. Each locum working less than 2 weeks, is confirmed to have a valid NHS Certificate of Eligibility for Locums (CEL) or, where applicable, documented evidence of specialist registration and recent NHS experience. All new appointments are reviewed by the CD to confirm that all key pre-employment checks such as GMC status, references, and mandatory training are in date prior to the locum commencing any clinical work.	On Track
		NEW Action: Work to mirror the approach for neonatal and anaesthetics is ongoing. It is acknowledged that perinatal staffing is already included in the annual safe staffing report, however more detail will be added to future iterations as per year 8 standards.	Action Required
	Removes supernumerary coordinator and 1:1 labour care from MIS, but mandates that services should still monitor via red flag reporting. (But requires this to be monitored by red flag or perinatal dashboard)	1:1 care and supernumerary status is audited and tracked monthly via the Perinatal Quality Surveillance dashboard. (Appendix 2)	On Track
	Trusts must demonstrate that capacity is sufficient to deliver timely elective and emergency maternity/neonatal care.	Caesarean Section Workforce and Capacity	
		An annual demand–capacity review showing how planned Caesarean activity compares with available theatre time, staffing, recovery and post-natal ward capacity needs to be formalised. Action: Although this has been included in Board reporting in year 7 a formal review should be undertaken in year 8.	Action Required
	Includes operational capacity monitoring, including elective Caesarean activity via daily SitRep. (New)	NEW The service completes the daily SitRep to NHS England to record delay data and monitor capacity and acuity pressures in real time.	On Track
		The service is aware that this has not always been completed consistently. Actions to improve this to 100% are ongoing to ensure submissions are embedded in daily work flow. Action: The perinatal team have requested access to the dashboard for local monitoring and improvement of submissions.	Action Required

	Continues to require funded midwifery establishment (BirthRate+) and introduces funded neonatal establishment requirements.	Midwifery Workforce	
		A Birth Rate Plus (BR+) assessment was repeated in 2025, and the findings have been presented as part of the April 2026 annual staffing oversight report. Midwifery, obstetric, neonatal nurse/medical and as required anaesthetics are included in the report for oversight given the interdependence between the services. The BR + report was endorsed by the Board of Directors in April 2026. A two-year funding plan with targeted recruitment was agreed. Phase 1 recruitment is ongoing.	On Track
		NEW Neonatal Nursing workforce is included in the Child Health Safe Staffing report shared monthly with the Trust Safety and Quality Committee. Annual staffing reviews are undertaken with the Chief Nursing Officer using a local calculator. The service remains compliant with BAPM as per the 3 yearly ACDC report.	On Track
		NEW Neonatal medical BAPM compliance	
		A neonatal workforce dashboard or report is regularly discussed in the neonatal safety and quality committee.	On Track
		A recent neonatal workforce review should be undertaken detailing how the funded posts compare with what BAPM standards. Action This was undertaken in 2024 and should be repeated in the year 8 reporting period.	Action Required
		Workforce pressures (for example, cot closures, staffing related transfers, red flags are included in the perinatal quality surveillance dashboard so that performance can be tracked with actions taken in response to statistically reduced compliance or performance. Transitional care to be added to the PQSD	On Track
		Anaesthetic Workforce	
		Rotas that clearly show 24/7 obstetric anaesthetic cover, with arrangements for planned and unplanned leave to maintain safe staffing.	On Track
Safety Action B. Training	Trusts should aim to ensure all staff have attended the required annual training listed below. A minimum of ≥90% compliance must be achieved for every required staff group at two points during the MIS year (April 26-November 26): 30 November (mandatory MIS checkpoint), and one other Trust selected checkpoint, declared in advance through Quality Governance Committee (QGC).		
	Standard	Good Practice Requirements and Progress	Status
	Training continues to cover fetal monitoring, maternity emergencies and neonatal resuscitation with 90% compliance for each eligible staff group.	The service confirms that the full Training Needs Analysis (TNA) standards continue to be fully aligned with version 2 of the Core Competency Framework (CCF), and the programme of training has been shared with the Divisional Safety Champions and MNVP lead.	On Track
	Anaesthetic training requirement reduced to a half-day to support attendance. (Change)	PROMPT Compliance. The overall compliance for PROMPT is 96% overall All eligible staff groups are over 90% except for new obstetric trainees who started in April 2026. Compliance for trainees is 78% and equates to 6 trainees/ 5 of these are booked on training in May and June 2026.	On Track

		BASIC NEONATAL LIFE SUPPORT Compliance of the neonatal and medical newborn life support is tracked in line with MIS year 8. All eligible staff groups are above 90%. Neonatal medics who attend births unaccompanied are also Neonatal Life Support course trained. (100%)	On Track
		FETAL MONITORING – 99% compliance achieved overall for the full day fetal monitoring training. All eligible staff groups are over 90%.	On Track
	In-situ simulation required in both hospital and community settings. (New)	The service also confirms that multidisciplinary emergency scenario is conducted in the clinical area. Delivery suite and birth centres are utilised for multi-disciplinary emergency skills sessions during the PROMPT day.	On Track
		New Action: arrangements to include community scenario training at least once in the reporting period is being considered as part of the year 8 requirements. The ambulance SIM and facilitates at University of Lancashire are being considered.	Action needed
	Impacted Fetal Head (IFH) scenarios must be included by year end to align with Avoiding Brain Injury in Childbirth (ABC) preparation.	The service was part of the impacted fetal head training and will continue to teach the ABC in training and on inductions.	On Track
Safety Action C. Learning from Reviews and Investigations	Year 8 strengthens triangulation of reviews with wider safety intelligence, ensuring early identification of themes and meaningful family involvement. All eligible events must be notified through the NHSE Submit a Perinatal Event Notification (SPEN) portal to MBRRACE-UK, NHSR Early Notification Scheme (EN) and Maternity and Newborn Safety Investigations (MNSI) as soon as possible after the death/diagnosis. For the deaths of all babies in your trust eligible for PMRT review ensure parents are multiple opportunities to meaningfully provide their experience of all elements of care and the impact of that care and raise any questions and comments they may have prior to the PMRT review starting.		
	Standard	Good Practice Requirements and Progress	Status
	The Trust should use the Perinatal Mortality Review Tool (PMRT), MNSI and Early Notification (EN) learning aligned, with Submit a Perinatal Event Notification (SPEN) as the single national notification route for external reporting	This process is set up and embedded in day-to-day process. The requirements are aligned to MBRRACE-UK, MNSI and NHS Resolution. (See Appendix 1)	On Track
	Perinatal Mortality Review Tool (PMRT) external review threshold increased to 60% .	Compliance is monitored and recorded on the PMRT tool for assurance. Current compliance is detailed in appendix 1. External panel members attending PMRT to date is 100%. (See Appendix 1)	On Track
	A clear, sensitive process for approaching parents at appropriate times, ensuring they are offered more than one opportunity to share their views in the way that feels right for them (written, verbal, virtual or in person).	The service has established processes via the bereavement team and governance structures to ensure that family perspectives are considered during PMRT reviews. This is recorded on the incident management system and evidence folders.	On Track
	Use of supportive materials such as leaflets and discussion prompts that explain the PMRT process and encourage parents to reflect on all aspects of their care experience.	PMRT tools are utilised in relevant languages to explain PMRT processes. The service provides a letter to all eligible families to ensure that verbal information is supported by a written Professional/legal Duty of Candour.	On Track

	Parents are proactively offered a meeting with the appropriate specialists (e.g. neonatology, obstetrics, midwifery, bereavement leads) once review findings are available, with the offer made in a sensitive and timely way.	Process in place for family feedback once the PMRT review is concluded. All families receive a copy of the PMRT report and outcome letter. The bereavement midwife and PMRT leads (Obstetric and Neonatal) have established allocated time to meet with families in a location which is chosen and suitable for the circumstances of case.	On Track
	NEW Quarterly Board-level thematic reports required. Greater focus on learning → action → impact.	Thematic learning and PSIRF serious incidents are reported the Trust Board of Directors part 2 in a report at least quarterly. Action: Format of the report to be strengthened to include themes from incidents to ensure that the data is rich with safety intelligence.	Action Required
Safety Action D. Service-User Voice and Equity	Standard	Good Practice Requirements and Progress	Status
	Strengthened focus on communication equity, ensuring women and families can understand their care and participate fully with appropriate language support and reasonable adjustments. Service-user-led improvement, using lived experience to identify priorities and barriers to safe, respectful care. Emphasis on equity, using local data to identify groups with poorer access or outcomes and addressing identified gaps. Maternal and Neonatal Voices Partnership (MNVP) guidance issued by NHS England still applies. However, recognising capacity is sometimes limited, it is no longer a requirement for MIS. Where capacity is limited, trusts must ensure diverse and representative service user voices inform priorities, improvement work and governance.	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. The updated priorities are reviewed regularly by the LMNS, service and MNVP. The service confirms that it utilises the annual CQC maternity survey free text data to collate the action plan each year. The MNVP has core membership at Safety Champions meetings	On Track
Safety Action E. Care Bundles	The provider must report quarterly to the Trust Board on progress against SBLCBv3.2 implementation. Quarterly reports should demonstrate how the Trust has prioritised the requirements of the Care Bundle based on local progress, implementation status, and any relevant safety intelligence, including learning from local adverse incidents		
	Standard	Good Practice Requirements and Progress	Status
	Year 8 introduces a more targeted local approach to Saving Babies' Lives Care Bundle (SBLCB) alongside preparation for the new Maternity Care Bundle (MCB).	The service continues to monitor the 5 elements of the SBL v3.2 care bundle and has achieved 100% compliance against the standards.	On Track
	Quarterly SBLCBv3.2 reports required at Trust Board, reflecting local progress, implementation, incidents and safety intelligence.	Progress against the standards for SBLV3.2 is reported via the maternity and neonatal safety Report	On Track

	In collaboration with all relevant services, a plan to implement the Maternal Care Bundle (MCB) with a implementation plan must be shared quarterly with the Board of Directors oversight. by March 2027.	Work has commenced to implement the MCB overseen by the continuous improvement lead midwife. A benchmarking exercise is ongoing, and the service awaits the publication of the Futures tool to demonstrate compliance and progress. Action: Progress against the implementation plan will be shared in future iterations of the report.	Action Required
	In light of the recent NHSE and RCOG fetal growth chart safety communication, Trusts should include a brief review within their local SBL priorities to confirm safe and appropriate fetal growth surveillance, confirming that fetal growth charts and surveillance pathways meet most recent national safety advice and identifying any local risks or improvement actions relating to fetal growth restriction (FGR) detection as highlighted	Review undertaken and included in section 5.2. Confirmation will also be shared via PSIRF Oversight for assurance.	Completed
	NEW Trusts must develop a standardised, equitable, and governance-approved guideline for neonatal pulse oximetry testing, aligned to the BAPM framework.	A single Trust-wide guideline, or an adopted regional guideline must be developed describing consistent screening and escalation processes across all birth settings. Action: Lead neonatal consultant and midwife to be agreed to progress work	Action Required
Safety Action F. Board Oversight, Governance, Culture and Leadership	Trusts must demonstrate that, through established governance routes, the Board routinely receives, reviews and responds to a comprehensive assessment of maternity and neonatal quality and safety. This assessment should cover training, workforce, staff and service user experience, and progress against the care bundles as outlined in Safety Actions A–E.		
	Trusts must also ensure that findings arising from detailed scrutiny at the Quality Governance Committee are formally escalated to the Executive Board, providing full oversight in line with good governance practice and the expectations of the Perinatal Quality Oversight Model (PQOM). (To Note this is included in the Maternity and Neonatal Safety Report)		
	Standard	Progress	Status
	Clearer expectations for Board-level assurance and use of safety intelligence.	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, bringing together key themes from training, workforce, incidents, complaints, service-user feedback, clinical outcomes and care bundle progress. 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) meetings.	On Track
	NEW Routine use of the Maternity Outcomes Signal System (MOSS) and associated SOPs. An accountable trust Board Executive (i.e. Chief Nurse, Chief	Standard Operating Procedure has been updated to reflect and describe safety signal process. Action: Awaiting publication on Heritage. If no signals are received a mock test drill should be performed in the reporting period. For oversight learning from this will be shared with PSIRF Oversight.	Action Required

	Medical Officer or Executive Trust Board Safety Champion) must approve completed checks, including drills.		
	Trusts must demonstrate that Maternity and Neonatal Board Safety Champions are actively supporting the perinatal leadership team (including the MNVP Lead where they are in commissioned in line with MNVP guidance), embedding a positive local safety culture, with regular two-way communication and clear escalation to the Trust Board	The Service has established Safety Champion meetings chaired by the Chief Nursing Officer and Executive Safety Champion. The meeting is split into part 1 and 2 to enable opportunity to discuss key issues and ensure oversight of the Board and Executive and non-executive safety champions.	On Track
	Live Perinatal Culture Improvement Plan required, with quarterly Board review	Culture work is ongoing and the culture plan is shared as part of the maternity and neonatal safety report regularly. Wider culture issues affecting perinatal care is included in Trust Safety and Quality Committee Part 2. This is supported by an action plan. The 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.	On Track
	Examples of improvements or policy changes made in response to Board scrutiny, demonstrating that oversight leads to measurable changes in safety, quality and experience.	Quality Improvement projects and the Single Improvement Plan (SIP) actions are aligned to key maternity quality and safety priorities. These are discussed at safety champions and updates are included in the maternity and Neonatal safety Report.	On Track

3.0 PERINATAL QUALITY SURVEILLANCE 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 this function is undertaken.

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

Clinical outcome data is also drawn from the National Maternity Dashboard (source Maternity Service Dataset MSDS) which contains comparative benchmarking against other providers to support analysis of performance, oversight and assurance. Although not in real time, with the most recent data available for January/February 2026 this source is used to identify any areas of potential outlier status to support wider safety intelligence and action. Appendix 3 provides details of ethnicity and Index of Deprivation (IOD) datasets for Lancashire Teaching Hospitals to demonstrate the footprint in which we are operating and to enable focused action.

3.1 CLINICAL SAFETY INDICATORS. EXCEPTIONS REPORTING

Positive performance is demonstrated in outcome data associated with stillbirths, booking by 10 and 13 weeks, 1:1 care in labour, supernumerary coordinator and sickness absence rates. (See appendix 2)

Analysis of the maternity dashboard indicates that postpartum haemorrhage (PPH) and third- and fourth-degree tears (perineal tears) have been identified as areas for focused improvement.

3.2 – POSTPARTUM HAEMORRHAGE (PPH)

Chart 2 details performance relating to PPH, taken from the local PQSM dashboard. The SPC for PPH continues to demonstrate a statistical increase in haemorrhage of 1500 ml since March 2025, rising from 3.3% to an average of 4.9%, with the mean for March 2026 at 4.71%. This represents a 48% increase over time.

Chart 2 PPH Performance March 2023-March 2026

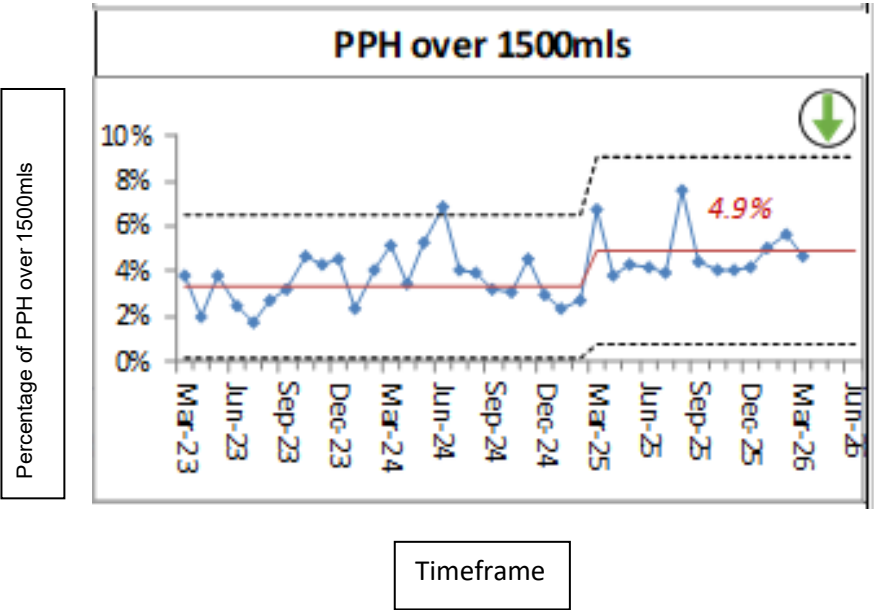
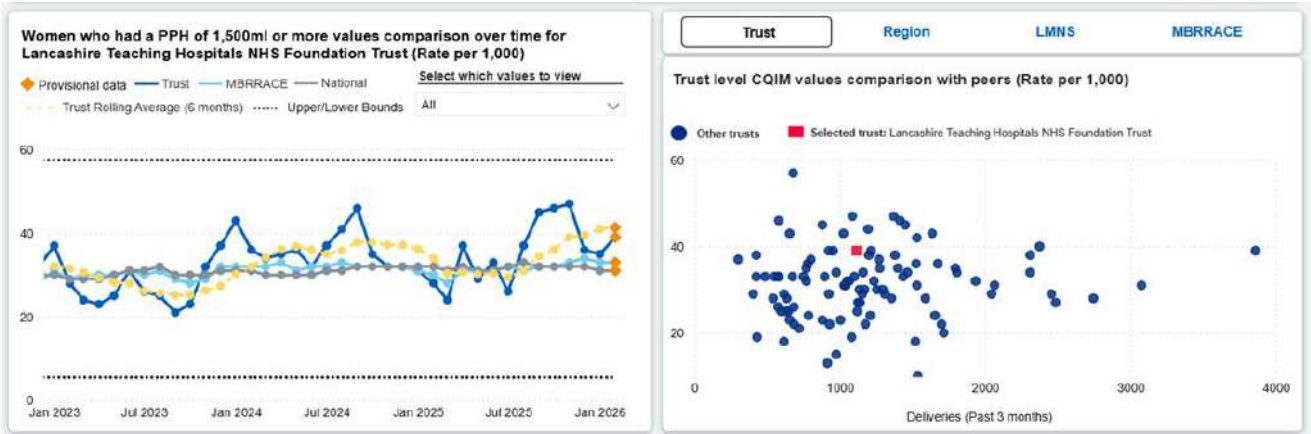


Chart 3 provides the comparator data, taken from the National Maternity Dashboard. This provides comparisons between the Trust, MBRRACE and national performance (up to Jan 2026). The Trust is within the upper range demonstrating that improvements are required to improve clinical outcomes.

Chart 3 National Dashboard comparison data for PPH



Postpartum haemorrhage continues to be a focus of targeted continuous improvement aligned to the Maternal Care Bundle. A working group is in place to review cases, and thematic reports are completed quarterly to define actions and improvement workstreams. Actions include review of the current guideline, transition to the regional guideline, implementation of the Maternal Care Bundle requirements (MCB), as well as skills-drills training.

PERINEAL TEAR (3rd and 4th DEGREE)

In Quarter 3, the service reported a rise in perineal tear rates and were asked to provide a response to the LMNS on the actions taken to improve performance. Chart 4 details the national dashboard comparator data and details the performance for Lancashire Teaching Hospitals. (Up to Jan 2026)

Chart 4 National Maternity Dashboard comparisons Jan 2023 to Jan 2026

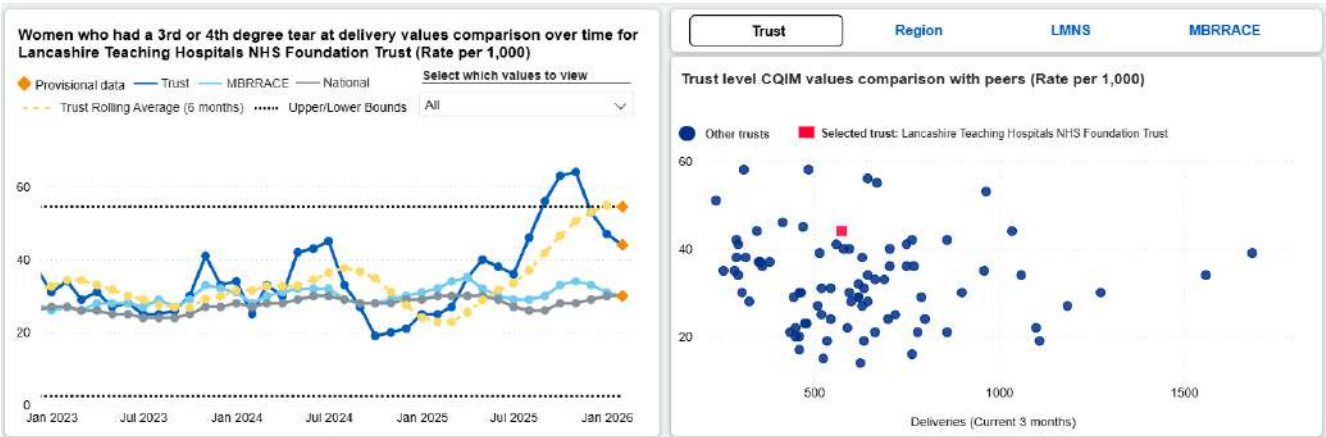
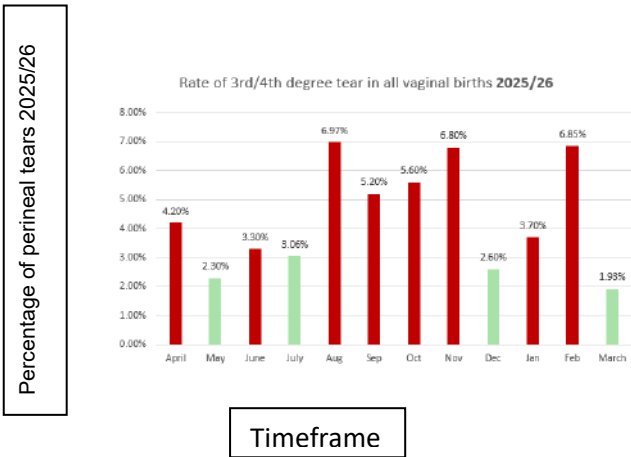


Chart 5 Rates of 3rd/4th degree tears in all vaginal births April 2025-March 2026



Quarter 4 data demonstrates that perineal tear rates (March 2026) have returned to within expected variation, providing, however, this is too early to indicate a consistent improvement. However, all cases of 3rd and 4th degree tears continue to undergo comprehensive multidisciplinary audit by the Lead Midwife and Obstetrician, with no specific concerns identified.

Training compliance remains strong, with over 90% of eligible staff trained in the Obstetric Anal Sphincter Injury (OASI) care bundle (Appendix 1, Safety Action B). However, given the increased rates in Quarter 3, additional targeted training has been delivered to trainees, alongside enhanced sessions delivered within mandatory training. This approach is designed to strengthen the quality of training and ensure consistent application of techniques in clinical practice.

3.4 RED FLAGS QUARTERLY SUMMARY

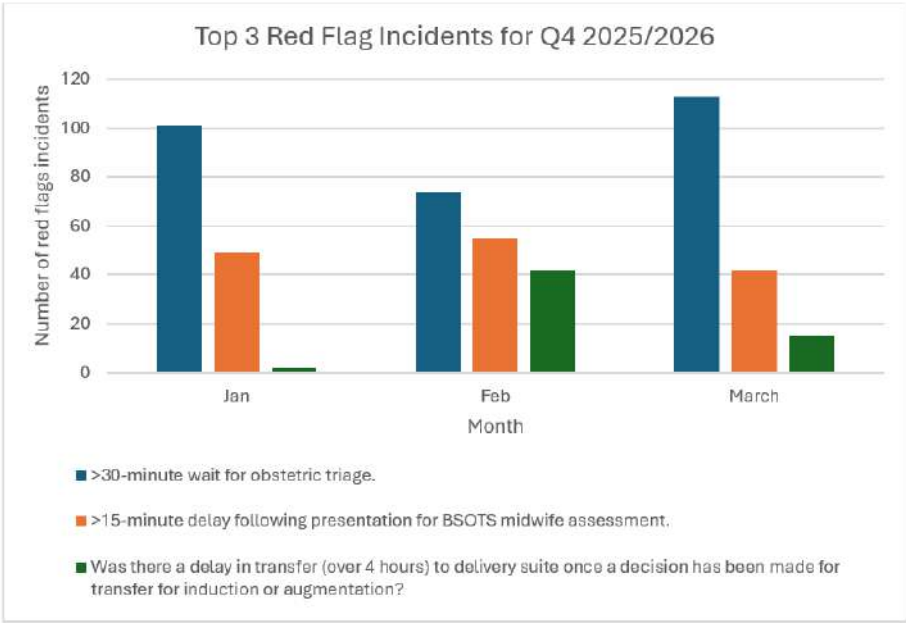
It is recommended that Trusts monitor and include safe midwifery staffing red flags as part of reporting mechanisms. Red flags monitor safe staffing and ensure that early warning signs, such as delays in triage, delay in induction or missed observations are systematically captured and acted upon. At a high level, this approach supports proactive risk management by linking clinical safety directly to workforce capacity.

As highlighted in previous iterations of this report, work is underway to strengthen the processes used to identify and escalate red flag indicators relating to safe staffing and clinical concerns. This includes collaboration with the Trust Matron for Safe Staffing to review and implement more robust reporting approaches, with consideration being given to use of Safe Care and the Birthrate Plus acuity tool as alternatives to incident reporting.

The service recognises limitations in the current system linked to Ulysses, whereby multiple red flags can be recorded within a single incident report, resulting in a risk of over-reporting. In addition, there is currently no formal validation process for red flag entries reported in this way. Work is therefore focused on improving the accuracy and consistency of red flag reporting within the most appropriate tool, and an update will be provided in due course.

Chart 6 details the red flags that have been reported in quarter 4 (Jan-March 2026) The highest number of red flags were reported in the category of delays in review by an obstetrician/midwife in the maternity assessment suite (MAS). Delay in the induction process also features in the highest reporting categories. Although the afore mentioned challenges in reporting exist the service is confident that the highest category of reporting is accurate. All incidents associated with delay are reviewed and monitored and linked to the risk register. A breakdown of all red flags is included in appendix 4.

Chart 6 Top 3 red flag reporting categories, Quarter 4 (January to March 2026)



Actions to improve compliance with obstetrician review within MAS are focused on strengthening medical staffing through recruitment to SAS roles and establishing a two-tier rota. This approach is intended to support more timely obstetric reviews in line with the Birmingham Specific Obstetric Triage System. Progress has been limited by recruitment challenges; however, two of the three posts are now filled, and implementation of the enhanced rota will proceed once the final post is in place.

Timely midwifery review within 15 minutes is monitored monthly, with compliance consistently exceeding 90%, providing assurance that women are seen promptly on arrival. Further improvement in performance will be achieved through increasing the establishment of midwives to independently staff the telephone line, enabling midwives to prioritise direct clinical care, reducing the competing demands of telephone triage. Funding for a separate telephone triage has been agreed as part of phase one of BR+ 2025 and recruitment to 24/7 telephone staffing model has commenced.

In addition, phase one of the BR+ has included additional establishment for the Maternity Day Unit. This will enable the final planned work to be relocated away from MAS. This will enable the triage service to prioritise the highest risk unplanned maternity attendances. Implementation of these outstanding actions will enable the service to be fully compliant with BSOTS standards and the Royal College of Obstetrics what good looks like paper.

3.7 DELAYS IN INDUCTION OF LABOUR

Delays in induction of labour (IOL) continue to be monitored closely and performance continues to be included in the report because delay in induction directly reflects both clinical effectiveness and operational efficiency when managing maternal and fetal risk. IOL is also linked directly to patient experience outcomes for families.

The induction of labour continuous improvement group is working through several actions in response to service user feedback. This relates to co production of patient information and the development of a series of fact sheets to support informed decision making. These have been shared across the LMNS and have received positive feedback from other providers and service users.

The 15 steps Maternity Neonatal Voice Partnership (MNVP) assessment undertaken in March 2026 focused on induction of labour and the report has been received in draft. Once reviewed and finalised an action plan will be developed to inform any future development. (A summary slide of some initial findings is detailed in appendix 1 Safety Action D).

3.8 CLOSURES OR DIVERTS MATERNITY/ NEONATAL

In quarter 4 (January to March 2026) the service was required to divert on one (1) occasion, with the last occasion being in January 2026. Whilst this is an improved position, the divert position for maternity services continues to be tracked via the perinatal quality dashboard as an indicator of operational and clinical pressure.

For the same period, the neonatal service was required to close to external admissions on four (4) separate occasions (January 2026). Closures related to ongoing pressures with intensive care and high dependency cot capacity and staffing unavailability. Performance continues to be tracked, and actions associated with recruitment to vacancies and maternity leave are ongoing.

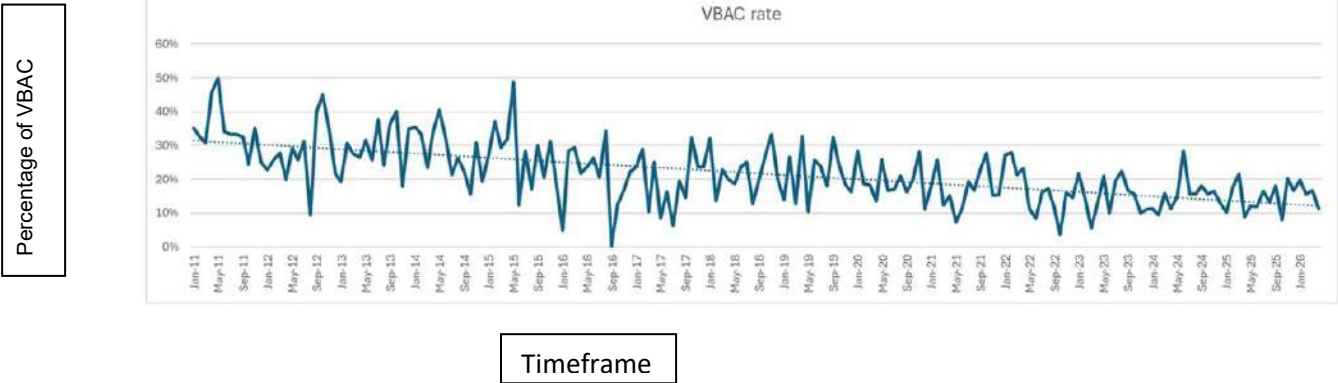
3.9 ELECTIVE CAESAREAN SECTION CAPACITY RISING DEMAND AND COMPLEXITY FOR CAESAREAN SECTION

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

To understand the impact of this, a new requirement for MIS Year 8 mandates that the service must complete an annual assessment of demand and capacity for planned Caesarean Section births. A mapping exercise of the entire pathway from pre-operative assessment through to theatre, recovery and into postnatal care must be considered. Whilst previous work has been undertaken in year 7, capacity and demand profiling will support identification and escalation when capacity does not meet demand. Work continues to operationalise the 4th theatre.

In addition, the service recognises that the Vaginal Birth after Caesarean (VBAC) rates are declining. Chart 7 demonstrates the rates of VBAC overtime.

Chart 7 Vaginal Birth after Caesarean (VBAC) Rates Jan 2011-Jan 2026



To improve equitable access to timely, high-quality subsequent birth planning for women who have undergone a previous caesarean section a quality improvement project is ongoing with a focus on women from lower IMD deciles and/or who are non-English speakers. The actions centre around ensuring birth planning conversations are facilitated within 3 months following an emergency caesarean section, and women with a previous caesarean section receive standardised (VBAC) Elective Repeat Caesarean Section (ERCS) counselling with documented discussion by 18 weeks' gestation in subsequent pregnancies. These actions aim to improve experience and informed choice for women at risk of inequity of care.

4.0 SAFE STAFFING INDICATORS

The vacancy for registered midwives is 8.06 WTE and 5.34 WTE for Maternity support workers/maternity care assistants. Recruitment to vacant posts is ongoing and expected to improve fill rates, reduce reliance on temporary staffing, supporting greater workforce stability. Use of the over offer has continued to maximise recruitment opportunities for registered midwives. Interviews are planned for the 15 May 2026.

The fill rates for Registered Midwives (RM 97 % day and 94% night) and Maternity Support Workers (MSW 77% day and 90% night) in March 2026 which demonstrates reduced fill rates for support workers and Maternity HCA's (MHCA's). This is primarily driven by a combination of high sickness absence notably on Maternity MAS (34.5%) and Maternity A (22.24%), vacancy and under establishment (0.96 WTE Maternity A and this under establishment has been included in the BR+ 2025 requirements that have been approved). Actions are ongoing to mitigate risk including targeted sickness management, continued roster oversight and recruitment to address the establishment gaps.

4.1 SERVICE RECONFIGURATION/MODELLING

The service proactively uses a range of safety intelligence including PQSM data, MNVP feedback, learning from regulatory and prevention of deaths notices (regionally and nationally) and workforce insights to identify risk, drive continuous improvement and service transformation. Workstreams associated with homebirth and midwifery led intrapartum care including on call arrangements, training, operating procedures and documentation are being explored following the prevention of future deaths seen across the country. Wider consideration of work modelling is also ongoing to ensure that the workforce is placed optimally to improve outcomes and experience for families and colleagues. These actions have been developed as above and through consultation and staff feedback and are largely viewed positively; however, implementation is taking time, with some resistance to changes in established working practices.

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

In Quarter 4 2025, compliance with BAPM nurse staffing ratios were 59.6%, 73.2%, 98.3% respectively. This was driven by overall staff unavailability including 9-12% maternity leave rates and 9-12% sickness absence alongside increased intensive care and high dependency cot demand, requiring higher nurse-to-patient ratios. Limited bank and agency uptake further compounded pressures, resulting in reduced compliance overall.

Reduced BAPM fill rates are also affecting the ability to provide transitional care consistently. A transitional care working group is being convened to review service delivery and to review escalation operating procedures when TC is affected by acuity or increased intensive care capacity. Incident reports are submitted on any occasion where the midwifery team have been required to support care requirements. It has been agreed that the workforce challenges will be discussed at Safety Champions in May 2026. This is to ensure that there is appropriate oversight and understanding of associated risk. The Children and Young People safe staffing paper will also track trends going forward.

All vacant shifts continue to be sent to bank, and agency as required with close oversight of workforce data from the Deputy/Divisional Nursing Directors.

4.3 OBSTETRIC STAFFING

Consultant workforce availability and leadership arrangements have recently been impacted by a combination of sickness absence, vacancies, and maternity leave. Unavailability of key members of the leadership team is affecting service continuity, and the QUAD are working with executive colleagues with stabilising actions. One of which is support from medical directors and the appointment of an interim 3-month Clinical Director (CD) for Obstetrics and Gynaecology.

Workforce arrangements are being actively managed by the Interim CD and Operational team, with a weekly oversight meeting in place to review forward plans and ensure appropriate cover is identified for obstetric rota

gaps. Where required, locum and agency staff are utilised to maintain safe service delivery, alongside ongoing targeted recruitment actions to address vacancies and strengthen substantive workforce resilience. Table 2 details the current position aligned to vacancies and provides the status of each post. Recruitment to strengthen the Maternal Medicine Centre (MMC) has been prioritised to ensure robust clinical oversight of women with complex pregnancies. This approach supports the delivery of safe, high-quality care by enhancing the specialist workforce capacity.

In the interim whilst recruitment is in progress mutual aid has been requested via the Local Maternity and Neonatal System (LMNS) lead Obstetrician along with the Regional Obstetrician. Table details the vacancy and status update.

Table 2 Progress and actions to recruit to establishment and obstetric workforce unavailability.

Vacancy	Status
Consultant Obstetrician for Maternal Medicine (Substantive)	Recruited start date August 2026
Consultant for Obstetrics and Gynaecology (Substantive)	Out to advert
Consultant with special interest in maternal medicine. (Substantive)	Out to advert
SCF doctor for complex Obstetrics (Substantive)	Awaiting advert

5.0 PERINATAL QUALITY GOVERNANCE EXPERIENCE AND REGULATION

5.1 REGIONAL MATERNITY OVERSIGHT AND RESPONSIBILITY

Following changes to oversight and accountability arrangements for perinatal services, providers will transition from Local Maternity and Neonatal System (LMNS) oversight to the Model Region Blueprint, with the responsibility for performance and oversight of key workstreams, safety signals, and critical safety checks transferring to regional team. During this time there may be duplicate reporting requirements as new processes are agreed and established.

To note these changes do not alter the principles of the perinatal surveillance model where safety oversight should take place as near to the patient-level as possible and be led by the service, Trust and Board of Directors. (See section 3.0)

5.2 INTERGROWTH ESTIMATED FETAL WEIGHT CHARTS SAFETY ALERT

In December 2025, NHS England and the Royal College of Obstetricians and Gynaecologists (RCOG) issued an urgent safety alert regarding the use of Intergrowth estimated fetal weight (EFW) charts, following evidence that they may underestimate the detection of small for gestational age (SGA) cases. This reduced detection rate means some babies who would normally receive enhanced monitoring may not have been identified.

In response, the service provides assurance to the safety and Quality Committee that current fetal growth surveillance practices follow the latest Saving Babies' Lives (SBL) priorities and that the perinatal team use GROW 2.0 to support the effective detection and management of fetal growth restriction. Therefore, no action is required following the safety alert.

5.3 DAILY SITREP REPORTING

Following the national pilot, the daily situational reporting where all maternity units are required to submit data on induction delays, deferred caesarean sections, and maternity and neonatal unit diverts has been mandated.

This enhanced reporting provides real-time visibility of safety and operational pressures, supporting early identification of risk and timely escalation where required. During the transition, the service is aware of some occasions when the service has not consistently submitted or has been entered after the deadline. Actions to ensure that reporting is embedded into business as usual and the service is awaiting access to the national reporting dashboard to enable real time monitoring of performance.

5.4 MATERNITY OUTCOMES SIGNAL SYSTEM (MOSS)

The Maternity Outcomes Signal System (MOSS) was developed by NHS England in response to the findings of the East Kent 'Reading the Signals' report, with a focus on improving intrapartum safety. It provides a structured, safety surveillance system that uses routinely collected maternity and neonatal outcome data to identify potential declines in the safety of care enabling timely escalation and response.

Since its inception at the end of 2025, the service has not had any safety signals associated with clinical outcomes and has not yet tested the roles and responsibilities process. It is expected that if a provider does not receive a signal within the reporting period that a drill scenario is undertaken to ensure that appropriate governance and assurance mechanisms are in place (MIS year 8 standard).

5.5 MATERNAL CARE BUNDLE (MCB)

The Maternity Care Bundle, launched in January 2026, sets out national best-practice standards across key clinical areas to improve maternal outcomes and reduce health inequalities, with full implementation required by March 2027 as part of MIS Year 8 requirements. The programme promotes a whole-system, equity-focused approach, requiring coordinated working across maternity, emergency, mental health, primary care, ambulance and specialist services.

Initial benchmarking has commenced to assess current compliance and identify gaps, and an implementation plan with clear milestones and actions is being developed. Delivery will be monitored via established governance arrangements (maternity Safety and Quality Committee and Safety Champions), with ongoing oversight and assurance provided via regular updates to the Trust Safety and Quality Committee (See appendix 1 safety Action E).

6.0 PERINATAL CULTURE

Following the culture review, as described in previous iterations of this report, feedback has been shared across all professional groups, alongside opportunities for staff to reflect on their experiences and contribute to improvement actions. Overall, findings provide assurance that staff remain committed and derive satisfaction from delivering high quality care to women, babies and families. Teams value professional autonomy, their skills, and working within established team structures.

The review has identified key areas requiring improvement, including the tolerance of poor behaviours, inconsistent unit cohesion across teams and professions, limited psychological safety, and ongoing workforce pressures contributing to stress and burnout., Unit cohesion with regards to cross team and multi profession team effectiveness, psychological safety, staffing levels and staffing challenges, levels of stress and feelings of burnout.

A comprehensive action plan to support cultural improvement has been collated comprising of coordinated actions across professional groups and multidisciplinary teams. Delivery is underway, with clear governance, defined ownership, and regular progress oversight. Good progress has been achieved within the nursing and midwifery workforce, including the establishment of Cultural Improvement Sessions (CIS) with Matrons and Band 7 Managers across Maternity and Gynaecology specialties.

Initial sessions have successfully focused on agreeing behavioural standards, developing a shared understanding of key challenges, confirming action plan priorities and ownership, and beginning to clarify roles and responsibilities. This provides a strong foundation for sustained cultural improvement.

Progress within the medical workforce has been comparatively limited, reflecting current challenges within the leadership structure. Similarly, engagement with administrative colleagues has been constrained by workforce vacancies. Mitigating actions are in place, including targeted recruitment and plans to strengthen and agree interim and longer-term leadership. These groups have been identified as priorities for the next phase of delivery to ensure full multidisciplinary alignment.

7.0 WELL-LED / CELEBRATING SUCCESS

Following the success of the Race and Health Observatory (RHO) work reducing disparity in outcomes for women of black or ethnic women who experience postpartum haemorrhage, representatives from the Lancashire Teaching hospitals have presented outcome data to the National Chief Midwifery Officer Summit and are due to be part of a panel session for the NHS Expo event in June 2026.

NHS England's Antenatal and Newborn Screening Quality Assurance team has confirmed that the service will remain under light-touch oversight for 2026/27, managed through routine quarterly performance meetings. This reflects sustained high performance across all key antenatal and newborn screening indicators, with the service consistently meeting or exceeding national standards. As a result, there is no requirement for additional enhanced oversight or a formal quality assurance visit.

This position recognises the continued improvement and robust delivery across the screening pathway, providing strong assurance of quality and compliance. Furthermore, the service has been invited to contribute to system-wide learning by sharing best practice with other providers and presenting its equality audit work at dedicated study sessions.

8.0 CONCLUSION

This report provides assurance that effective governance, oversight and improvement arrangements are in place to monitor maternity and neonatal safety, aligned to MIS Year 8 and PQOM.

The service demonstrates strong performance across most safety actions, with high training compliance, established governance processes and full achievement of MIS Year 7 standards. Workforce planning is in place, although some pressures remain which is associated with the obstetric workforce and neonatal BAPM compliance for nurse ratios, intermittently affecting BAPM compliance and transitional care.

Key areas requiring continued focus include clinical outcomes (PPH), workforce capacity, patient flow delays, consistency of oversight processes, and further development of care bundle implementation and thematic learning as well as continued focus on ongoing workstreams associated with induction of labour and maternity triage.

9.0 RECOMMENDATIONS

The Safety and Quality Committee is asked to:

- iv. Receive and scrutinise the report, including the Clinical Negligence Scheme for Trusts (CNST) Year 8 Maternity Incentive Scheme (MIS) supplementary information pack and associated action plans
- v. Note the changes to the requirements commenced in year 8 MIS
- vi. Confirm it is assured of the oversight and monitoring mechanisms used to monitor safety and quality within maternity and neonatal services.

**CLINICAL NEGLIGENCE SCHEME FOR TRUSTS INFORMATION PACK
– CNST MIS YEAR 8
APPENDIX 1**

MATERNITY INCENTIVE SCHEME SUMMARY REQUIREMENTS YEAR 8.

Safety Action A Workforce and Capacity	Standard	Outcome	Minimum Requirement
	Year 8 combines all maternity and neonatal workforce requirements into one multi-professional action.	Board oversight of effective multidisciplinary (MDT) workforce and capacity planning. Ensuring the maternity and neonatal service have funded establishments for obstetric, midwifery, neonatal, anaesthetic, and perioperative teams meeting nationally recognised workforce standards.	Staffing Consultant attendance (obstetric workforce) compliance with RCOG standard: ≥80% consultant presence in defined acute care situations.
			Short-term locum certification (obstetric workforce) Trusts must ensure and maintain a local (Trust-specific) continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas. Eligibility must be verified before first engagement and reviewed annually for all locums on the register.
			Neonatal workforce establishment (nursing & medical) Trusts must have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant for their unit designation (Neonatal Intensive Care Unit (NICU), Local Neonatal Unit (LNU), Special Care Unit (SCU)) and the MIS acknowledges the updated medical staffing standards for LNU and SCU As this is new and includes significant changes, for year 8 the previous staffing standards or the updated version will be accepted as meeting the requirements.
			Midwifery Workforce Establishment Trusts must have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline. In addition, further adjustments based on professional judgement of the Director and Head of Midwifery should be added where appropriate. Regional Chief Midwives can support this process if required.
			Anaesthetic workforce Trusts must ensure that obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2.
			Trusts must demonstrate that capacity is sufficient to deliver timely elective and emergency maternity/neonatal care. Trusts do not need to prove that delays ever occur. They must demonstrate that delays are detected, analysed, reported and that persistent issues are escalated. As such Planned Caesarean birth capacity mapping Trusts must undertake annual demand–capacity mapping for planned Caesarean birth lists, covering the full pathway (preoperative assessment → theatre → recovery →

			postnatal ward). Trusts should use existing NHS England regional maternity SitRep data wherever possible to avoid duplication. Board and governance oversight (as detailed in Safety Action F) Trusts must have a governance system that ensures workforce and capacity risks are monitored, scrutinised and escalated appropriately. This should include a six-monthly integrated workforce report covering maternity and neonatal staffing levels and rota gaps across medical, midwifery, neonatal, anaesthetic and perioperative teams.
Safety Action B. Training	Standard	Outcome	Minimum Requirement
		Effective Board oversight of maternity and neonatal MDT training and competency. Ensuring all maternity, neonatal and anaesthetic staff are trained, assessed and supported to maintain the knowledge, skills and behaviours required for safe, high quality multidisciplinary care.	Trusts should aim to ensure all staff have attended the required annual training listed below. A minimum of ≥90% compliance must be achieved for every required staff group at two points during the MIS year (April to November 2026): 30 November (mandatory MIS checkpoint), and one other Trust selected checkpoint, declared in advance through Quality Governance Committee. Please see the technical guidance (in the supplementary guidance document) for further details of training, and identification of staff that may be excluded from this calculation, including new and rotational staff in their first 3 months, and staff on maternity and long-term sick-leave. Obstetric emergency training Trusts must ensure that maternity staff attend annual multidisciplinary Safety Action B obstetric emergency training that incorporates local learning, human factors, communication, teamwork, escalation pathways and situational awareness. Anaesthetists working in maternity are required to attend at least half of the MDT training day as a minimum, during which obstetric emergencies requiring anaesthetic input (e.g. Postpartum haemorrhage (PPH)), escalation pathways, call chains, teamwork, communication and human factors are rehearsed. Trusts must ensure that an impacted fetal head (IFH) scenario is incorporated into obstetric emergency training by the end of MIS Year 8 (November 2026) as a preparatory step for Avoiding Brain Injury in Childbirth (ABC) implementation, aligning to the proposed ABC methodology. There is not an expectation that all staff will have received training Neonatal resuscitation As a minimum, trusts must ensure that all staff who may act as an unsupervised first attender or primary resuscitator at any birth (including all midwives) complete annual neonatal resuscitation training and are assessed as meeting at least basic capability, as defined in the BAPM Neonatal Airway Safety Standard. Where further enhanced training is in place for additional staff groups, this should continue (e.g. NLS (Newborn Life Support) course or equivalent).

			Fetal monitoring training Trusts must ensure that all staff who provide care in antenatal or intrapartum settings, whether substantively or when responding in escalation, complete annual fetal surveillance training. In situ multi-professional perinatal emergencies simulations Trusts must deliver at least two in-situ multiprofessional perinatal emergencies simulations during the MIS reporting period. One that begins in a hospital area (e.g. labour ward, obstetric theatre, triage, ED, NICU) and another that begins in a community area. Where possible there should be involvement with relevant partners such as paramedics, ED and theatre teams. These should be based on local and/or national learning and include real time practice of escalation pathways. Training compliance oversight (as detailed in Safety Action F) Board Assurance Trust Boards must have oversight of training compliance for all maternity and neonatal staff groups. Compliance must be reported quarterly through established governance routes, presented in a clear trend-based format (ideally using Statistical Process Control (SPC) charts), monitored against a trajectory towards 100 percent and working towards maintaining ≥90 percent compliance throughout the following year
Safety Action C. Learning from Reviews and Investigations	Standard	Outcome	Minimum Standards
	Year 8 strengthens triangulation of reviews with wider safety intelligence, ensuring early identification of themes and meaningful family involvement.	Effective Board oversight of thematic learning and progress with actions arising from local and national reviews of adverse incidents	Notify all qualifying events All eligible events must be notified through the NHSE Submit a Perinatal Event Notification (SPEN) portal to MBRRACE-UK, NHR EN and MNSI as soon as possible after the death/diagnosis.
			Seek parents' views of care For the deaths of all babies in your trust eligible for PMRT review ensure parents are given multiple opportunities to meaningfully provide their Safety Action C experience of all elements of care and the impact of that care and raise any questions and comments they may have prior to the PMRT review starting.
			External multi-disciplinary reviewers For a minimum of 60% of the deaths reviewed, external members of relevant specialties must be present at the multi-disciplinary review, and this should be documented within the PMRT
			Provide relevant information Provide relevant information regarding the role of MNSI, NHR EN scheme and PMRT reviews to families in a format that is relevant and accessible to them. Information about duty of candour must be provided for all parents where the event is eligible for duty of candour.

			Offer parents a meeting with relevant specialists Offer parents a meeting with relevant specialists to share the findings with them from reviews and investigations, and relevant incident reports. Thematic reports of learning and actions The Trust must produce thematic reports that summarise learning and progress on actions arising from MNSI and NHSR EN reports, local PMRT and PSIRF reviews, MOSS critical safety checks, NHSR claims scorecards and relevant national reports. Trusts must also use demographic data to identify and understand any disparities in outcomes. These thematic reports must be reviewed with the Trust Perinatal and Board level Safety Champions and submitted to the Trust Executive Board at least quarterly. Reports should clearly demonstrate the measures implemented to address recurrent themes, and progress with these, including how learning has been shared and, where appropriate, incorporated into existing multidisciplinary training.
Safety Action D. Service-User Voice and Equity	Standard	Outcome	Minimum Standards
	Strengthened focus on communication equity, ensuring women and families can understand their care and participate fully with appropriate language support and reasonable adjustments.	The voices and experiences of all women accessing maternity and neonatal services are used to drive local improvements, using local population demographics to understand and target efforts to support a reduction in inequities in experience and outcomes	Communication equity, language support and accessible information Trusts should demonstrate continued progress towards ensuring that women and families, including those who may require translation, interpreting support, or reasonable adjustments, are supported to understand their care, options, and decisions at key points in the perinatal journey. Trusts should recognise that where information is not understood, consent may not be informed, valid or lawful. Reliance on family members, friends or informal interpretation must be treated as patient safety, safeguarding and human rights risk Service-user voice driving safety and quality improvement. Trusts must demonstrate that insights from women, families and carers using maternity and neonatal services are captured and used to inform service improvement plans. Trusts must use demographic data to understand their local population and demonstrate that the voices of women and families from different demographic groups, are actively captured and used to shape priorities within the service. Oversight and Assurance Progress with this work should be monitored through established governance routes quarterly to ensure that actions lead to measurable improvements in safety, quality, or experience.
	Standard	Outcome	Minimum Standard

Safety Action E. Care Bundles	Year 8 introduces a more targeted local approach to Saving Babies' Lives Care Bundle (SBLCB) alongside preparation for the new Maternity Care Bundle (MCB).	Board oversight of progress with implementation of Saving Babies' Lives Care Bundle (SBLCBv3.2), a plan to implement the Maternal Care Bundle by March 2027, and assurance that a guideline for neonatal pulse oximetry testing has been developed in line with national guidance	Saving Babies' Lives Care Bundle (SBLCBv3.2) - Quarterly reporting to the Trust Board. The provider must report quarterly to the Trust Board on progress against full SBLCBv3.2 implementation. Quarterly reports should demonstrate how the Trust has prioritised the requirements of the SBLCB based on local progress, implementation status, and any relevant safety intelligence, including themes and learning from local adverse incidents
			GROW In light of the recent NHSE and RCOG fetal growth chart safety communication, Trusts should include a brief review within their local SBL priorities to confirm safe and appropriate fetal growth surveillance, confirming that fetal growth charts and surveillance pathways meet most recent national safety advice and identifying any local risks or improvement actions relating to Safety Action E fetal growth restriction (FGR) detection as highlighted
			Maternal Care Bundle – Implementation Plan In collaboration with all relevant services, the provider agrees a plan with the Trust Board to implement the Maternal Care Bundle by March 2027. Progress with implementation is reviewed quarterly through established governance routes
			Neonatal pulse oximetry testing Trusts must develop a standardised, equitable, and governance approved guideline for neonatal pulse oximetry testing, aligned to the BAPM framework. The guideline must describe the required clinical processes, data entry standards, and pathways for all birth settings (including homebirths) to ensure that every baby receives pulse oximetry screening between 2 and 24 hours of age, with clear escalation processes for babies in the amber and red pathways
Safety Action F. Board Oversight, Governance, Culture and Leadership	Standard	Outcome	Minimum Standards
	Clearer expectations for Board-level assurance and use of safety intelligence.	The Trust Board has effective oversight of the quality and safety of their maternity and neonatal services.	Board Oversight of Maternity and Neonatal Quality and Safety. Trusts must demonstrate that, through established governance routes, the Board routinely receives, reviews and responds to a comprehensive assessment of maternity and neonatal quality and safety. This assessment should cover training, workforce, staff and service user experience, and progress against the care bundles at the frequencies outlined in Safety Actions A–E .
			Trusts must also ensure that findings arising from detailed scrutiny at the Quality Governance Committee (or equivalent) are formally escalated to the Executive Board, providing full oversight in line with good governance practice and the expectations of the Perinatal Quality Oversight Model (PQOM). Where Trust level mitigation to concerns is insufficient, escalation to Regional Midwifery Officer teams should be documented, alongside PQOM aligned actions.
			Maternity Outcomes Signal System

			Trusts must evidence that the critical safety check (Annex 1 of the MOSS standard operating procedures) was completed in the event of signals, or that a test drill (Annex 9) was carried out if no signals occurred. An accountable trust board executive (i.e. Chief Nurse, Chief Medical Officer or Executive Trust Board Safety Champion) must approve completed checks, including drills. This will be externally validated through regional assurance - services Safety Action F must send a completed copy of critical safety check(s) or test drill to regions, for forwarding to the national team at england.moss@nhs.ne Maternity and Neonatal Board Safety Champions Trusts must demonstrate that Maternity and Neonatal Board Safety Champions are actively supporting the perinatal leadership team (including the MNVP Lead where they are in commissioned in line with MNVP guidance), in creating and embedding a positive local safety culture, with regular two-way communication and clear escalation to the Trust Board where any concerns are identified. Perinatal Culture Improvement Plan Trusts must demonstrate that they have an agile perinatal culture improvement plan in place which triangulates data and engagement from multiple sources, uses recognised improvement methodology to evidence progress and impact, and is reviewed by the Trust Board at least six monthly.

SAFETY ACTION B TRAINING

MARCH 2026	MIDWIVES	CONSULTANTS	DOCTORS	COMPLIANCE PERCENTAGE OVERALL
Fetal Growth (GROW)	96% 200 out of 209	100% 11 out of 11	79% 15 out of 19	95% (3% increase) 226 compliant out of 239
Fetal Monitoring training Attendance at full day fetal monitoring training	99% 206 out of 209	100% 11 out of 11	100% 19 out of 19	99% (3% increase) 236 compliant out of 239
CTG update (Delivered as part of PROMPT or attendance at CTG meeting)	99% 206 out of 209	91% 10 out of 11	100% 19 out of 19	98% (1% decrease) 235 compliant out of 239
Human Factors (attended PROMPT)	98% 204 out of 209	91% 10 out of 11	78% 21 out of 27	95% (1% decrease) 235 compliant out of 247
Saving Babies Lives – study day	97% 202 out of 209			

MARCH 2026	MIDWIVES	CONSULTANT	DOCTORS	ANAESTHETIST CONSULTANTS	ANAESTHETIST ROTATIONAL	MATERNITY SUPPORT WORKERS	COMPLIANCE OVERALL
OBSTETRIC EMERGENCIES (PROMPT) Including Neonatal life support	98% 204 out of 209	91% 10 out of 11	78% 21 out of 27	100% 14 out of 14	100% 6 out of 6	98% 56 out of 57	96% (static) 311 compliant out of 324
Pool evacuation	94% 197 out of 209	100% 11 out of 11	67% 18 out of 27	100% 14 out of 14		88% 50 out of 57	91% (increase 3%) 294 out of 324
Action: New intake of GPST/FY doctors started in April 2026, therefore compliance within the doctors decreased this month. 6 doctors not yet completed PROMPT- 5/6 booked on for May and June 2026 dates.							

<u>March 2026</u>	NICU Nurses	NICU nursery nurses	CONSULTANTS	ANNP's	JUNIOR DOCTORS below ST5	JUNIOR DOCTORS ST5 and above	COMPLIANCE PERCENTAGE OVERALL
Neonatal Basic life support	93% 76 compliant out of 79	100% 6 compliant out of 6	100% 8 compliant out of 8	100 % 5 compliant out of 5	100 % 7 compliant out of 7	100% 6 compliant out of 6	97% 108 compliant out of 111
NLS certification medical staff.			100 % 8 compliant out of 8	100 % 5 compliant out of 5	Training not required	100% 6 compliant out of 6	100% 19 compliant out of 19

OASI CARE BUNDLE TRAINING

<u>March 2026</u>	MIDWIVES	CONSULTANTS	DOCTORS	COMPLIANCE PERCENTAGE OVERALL
OASI Care Bundle	95% 213 compliant out of 225	100% 11 compliant out of 11	94% 15 compliant out of 16	95% 239 compliant out of 252

SAFETY ACTION C LEARNING FROM REVIEWS AND INVESTIGATIONS

SAFETY ACTION C	Compliance score		RAG/% met the standard
Notify all qualifying events All eligible events must be notified through the NHSE Submit a Perinatal Event Notification (SPEN) portal to MBRRACE-UK, NHR EN and MNSI as soon as possible after the death/diagnosis. For the reporting period the table details the cases between 1 December 2025 to 30 November 2026	Notification	(All cases requiring notification) 14	100%
	Surveillance	(Cases requiring surveillance only) 11/14	100%
	Full review	(Cases requiring full review) 10/14	100%
Seek parents' views of care: For the deaths of all babies in your trust eligible for PMRT review ensure parents are given multiple opportunities to meaningfully provide their experience of all elements of care and the impact of that care and raise any questions and comments they may have prior to the PMRT review starting. 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	(Cases requiring full review) 10/14	100%
Provide relevant information Provide relevant information regarding the role of MNSI, NHR EN scheme and PMRT reviews to families in a format that is relevant and accessible to them. Information about duty of candour must be provided for all parents where the event is eligible for duty of candour	All Women receive Duty of Candour and		
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 60% 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. 10/14	100%
		Completed within 6 months: (N/A) cases who were eligible for external review have had an external representative. 2/2	On track.

SAFETY ACTION C CASES REPORTED TO MATERNITY AND NEONATAL SAFETY INVESTIGATION FROM 1 DECEMBER 2025- 30 NOVEMBER 2026

MI number	Early Notification applicable	Early notification completed	Agreed format for sharing with family	Status of MNSI investigation
MI-050634	Yes	Yes	Yes	Investigation ongoing
MI-055103	No	NA	Letter shared in Bengali	Investigation ongoing

SAFETY ACTION C PERINATAL MORTALITY REVIEW TOOL (PMRT) CASES 1 DECEMBER 2025- 30 NOVEMBER 2026

PMRT cases eligible for a review (1 December 2025- 30 November 2026)					
ID (Incident/PMRT)	Stillbirth/ Neonatal death	PMRT upload date	Parents informed	Report drafted within 6 months	Actions ongoing
Incident: 220385 PMRT: 101477	Neonatal Death	04.06.2026	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing within 6 months.	Action plan ongoing
Incident: 221771 PMRT:	Neonatal Death	17.06.2026	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing within 6 months.	Action plan ongoing
Incident: 221771 PMRT:	Neonatal Death	17.06.2026	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing within 6 months.	Action plan ongoing
Incident: 222757 PMRT: 101820	Stillbirth	30.06.2026	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing within 6 months.	Action plan ongoing
Incident: 223406 PMRT: 101926	Stillbirth	06.07.2026	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing within 6 months.	Action plan ongoing
Incident: 226121 PMRT: 102287	Neonatal Death	31.07.2026	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing within 6 months.	Action plan ongoing
Incident: 226356 PMRT: 102318	Neonatal Death	03.08.2026	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing within 6 months.	Action plan ongoing
Incident: 229685/ 229809 PMRT: 102788	Neonatal Death	10.09.2026	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing within 6 months.	Action plan ongoing
Incident: 230094 PMRT: 102822	Stillbirth	12.09.2026	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing within 6 months.	New case incident being reviewed.
Incident: 234457 PMRT: 103502	Stillbirth	25.10.2026	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing within 6 months.	New case incident being reviewed.

Preston, Chorley & South Ribble Maternity Voices Partnership LSC LMNS Board Report

May 2026 / Reporting month March 2026

MNVP Workplan

Workplan Priority area	Deliverable	RAG	Update/Rationale
Outreach – Building community connections to ensure equity and equality of service.	Ensuring that we are accessing and targeting engagements within areas where seldom heard and ethnic minority families live. Ensuring that we have awareness and attendance at any events within these.		The current strategy focuses on targeted engagement with specific groups to enhance connections and gain insights. Efforts to increase MNVP's visibility among community members and local services are ongoing, with relationship-building progressing at various levels. Activities have included shadowing community midwives and attending clinics, groups, and one-stop shops at Family Hubs. By strengthening community links, we aim to promote equity and inclusion for minority and seldom-heard voices.
Induction of Labour	Scenario-based videos covering IOL consultation. Tailored information leaflets for specific clinical reasons for induction. 15 Steps walkaround focused specifically on the IOL journey		15 Steps Review took place on 27 th March. Full report to follow. The leaflets were identified as a key strength for feeling better prepared and able to make informed choices. Further feedback would be beneficial in this area from service users.

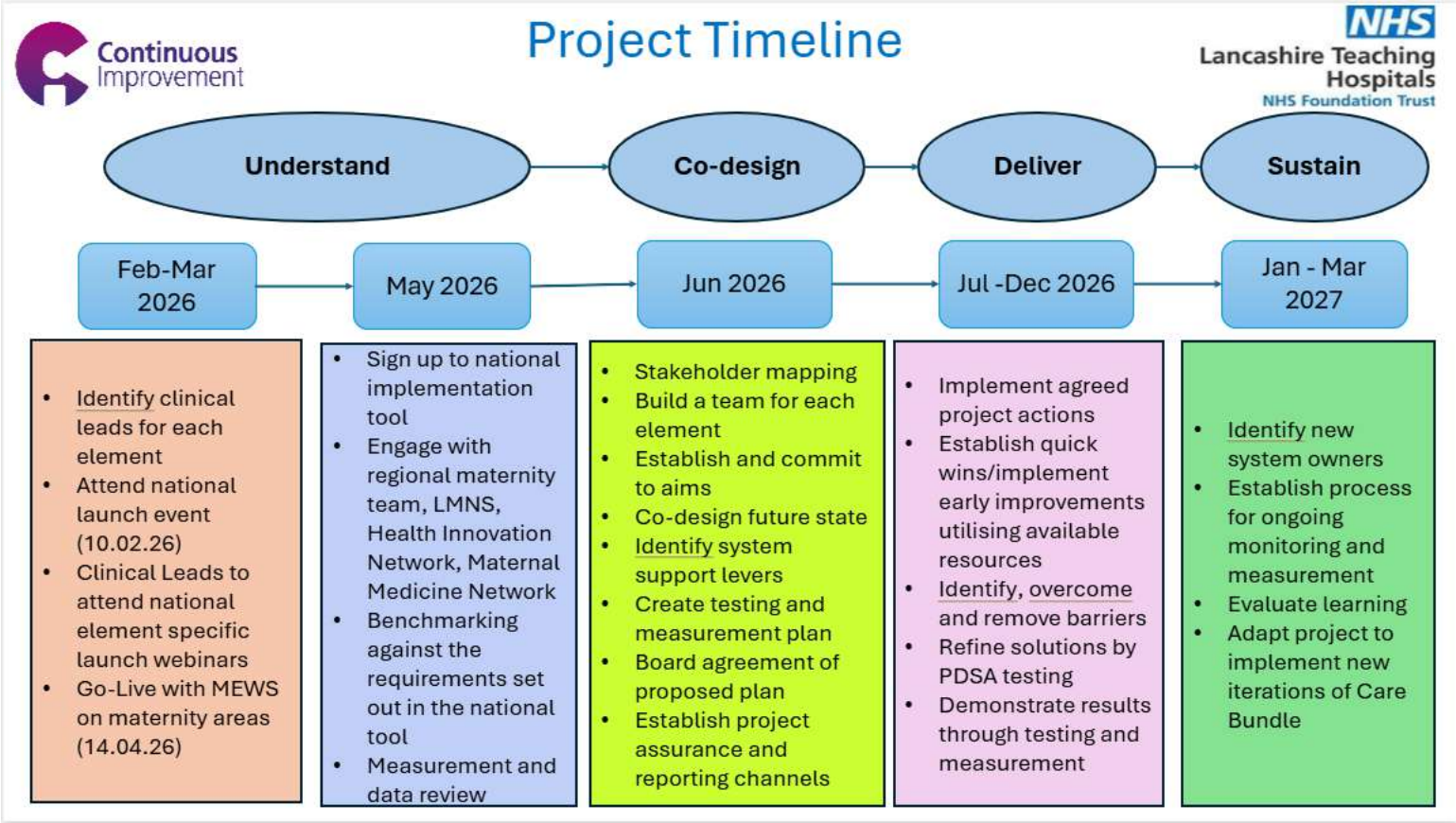
Service user insight and feedback – Fifteen Steps



Compassionate, Professional Care	Overall experience is consistently described as calm, clean and compassionate, with strong professionalism and midwifery advocacy highly valued.
Clear Information Builds Confidence	Clear, condition-specific written information is a key strength, particularly induction leaflets with simple visual process maps that support preparation and confidence.
Communication Matters Most	Communication is the biggest driver of experience, especially during waiting, delays and transitions.
Waiting and Transfers Are Challenging	Waiting periods and transfers are the most challenging points. Proactive updates significantly reduce anxiety, particularly when there is clarity about delays, prioritisation and next steps.
Opportunities for Improvement	Clearer arrival guidance, realistic expectations of a 2–6 day IOL process, regular check-ins during waits, and stronger discharge signposting.

SAFETY ACTION E CARE BUNDLES

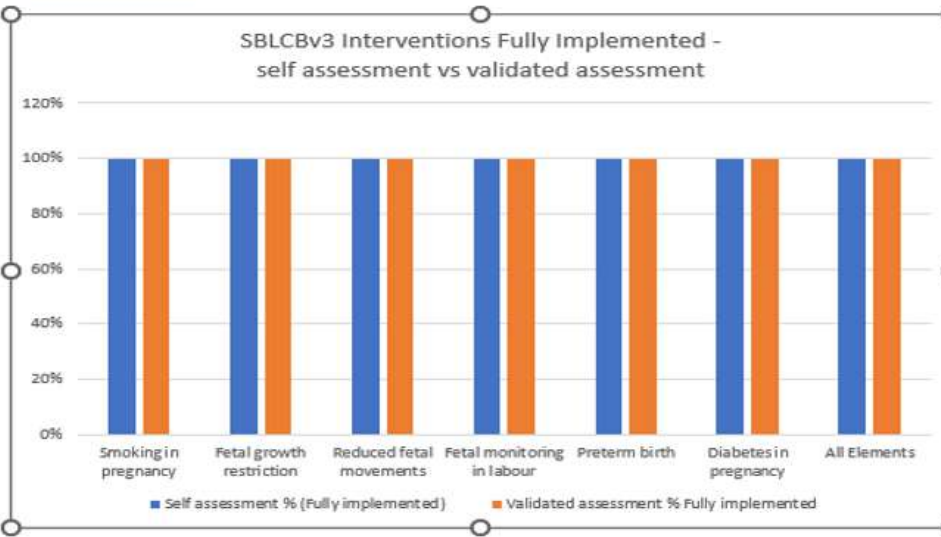
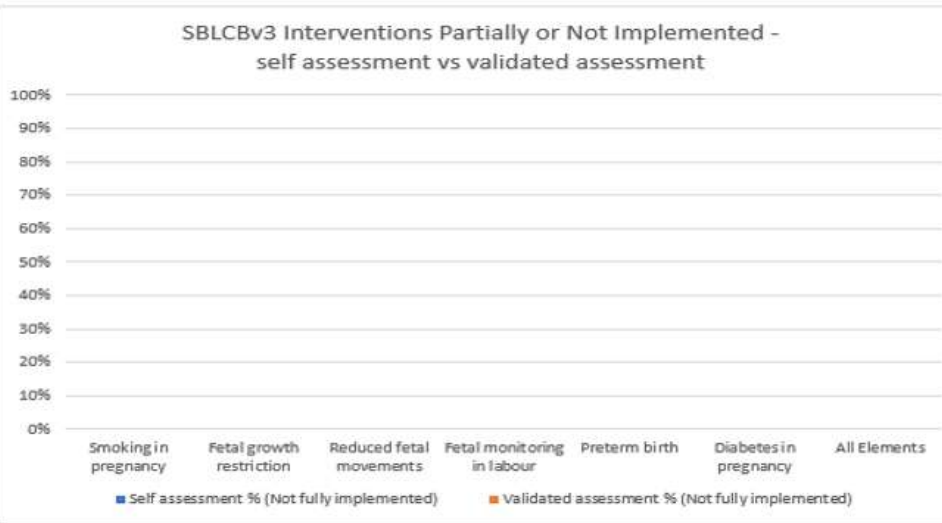
MATERNAL CARE BUNDLE UPDATE



SAFETY ACTION E CARE BUNDLES SAVING BABIES LIVES CARE BUNDLE V3.2

Implementation Progress

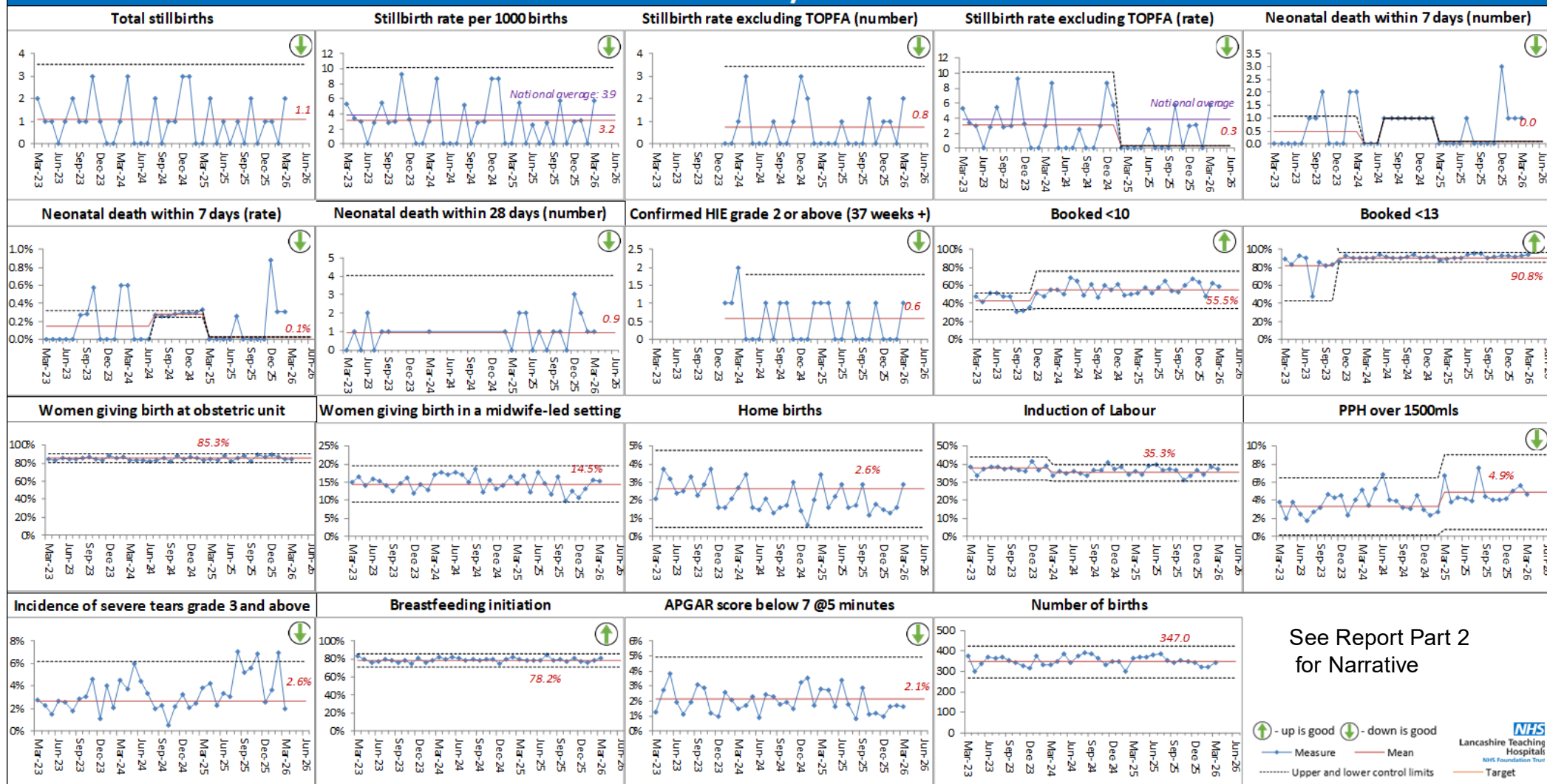
Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Fully implemented	100%	Fully implemented	100%
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%



PERINATAL QUALITY SURVIELLENCE DASHBOARD

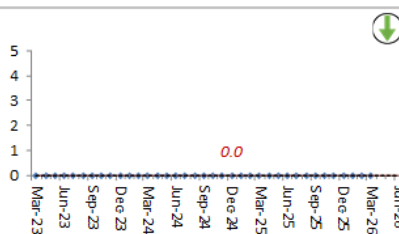
APPENDIX 2

Clinical Safety Indicators

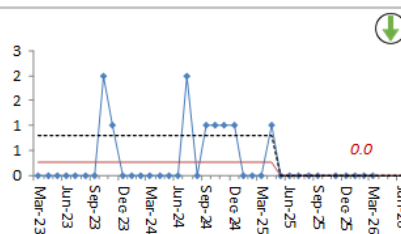


Perinatal Quality Governance Experience and Regulation

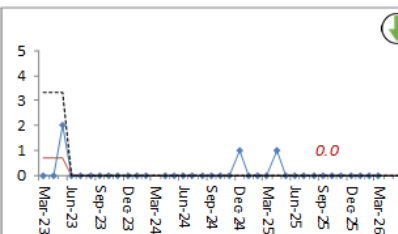
Prevention of future deaths regulation 28



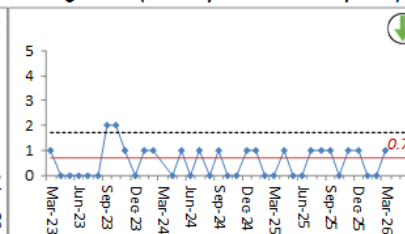
CQC Enquiries



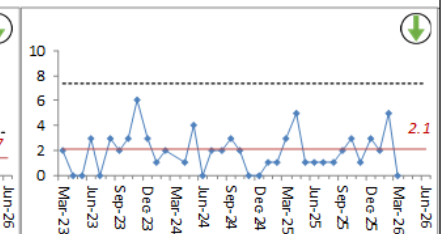
Maternal Death



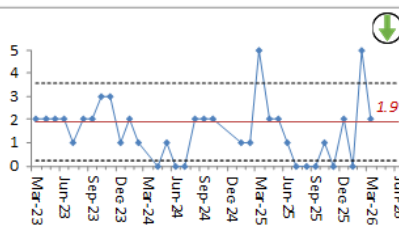
Maternity and Newborn Safety Investigations Programme (Formally HSIB referrals opened)



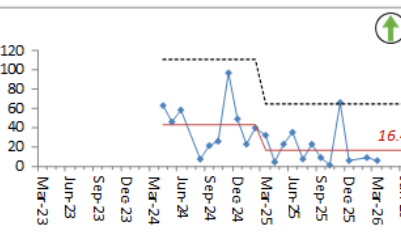
Incidents of moderate harm and above



Complaints



Compliments

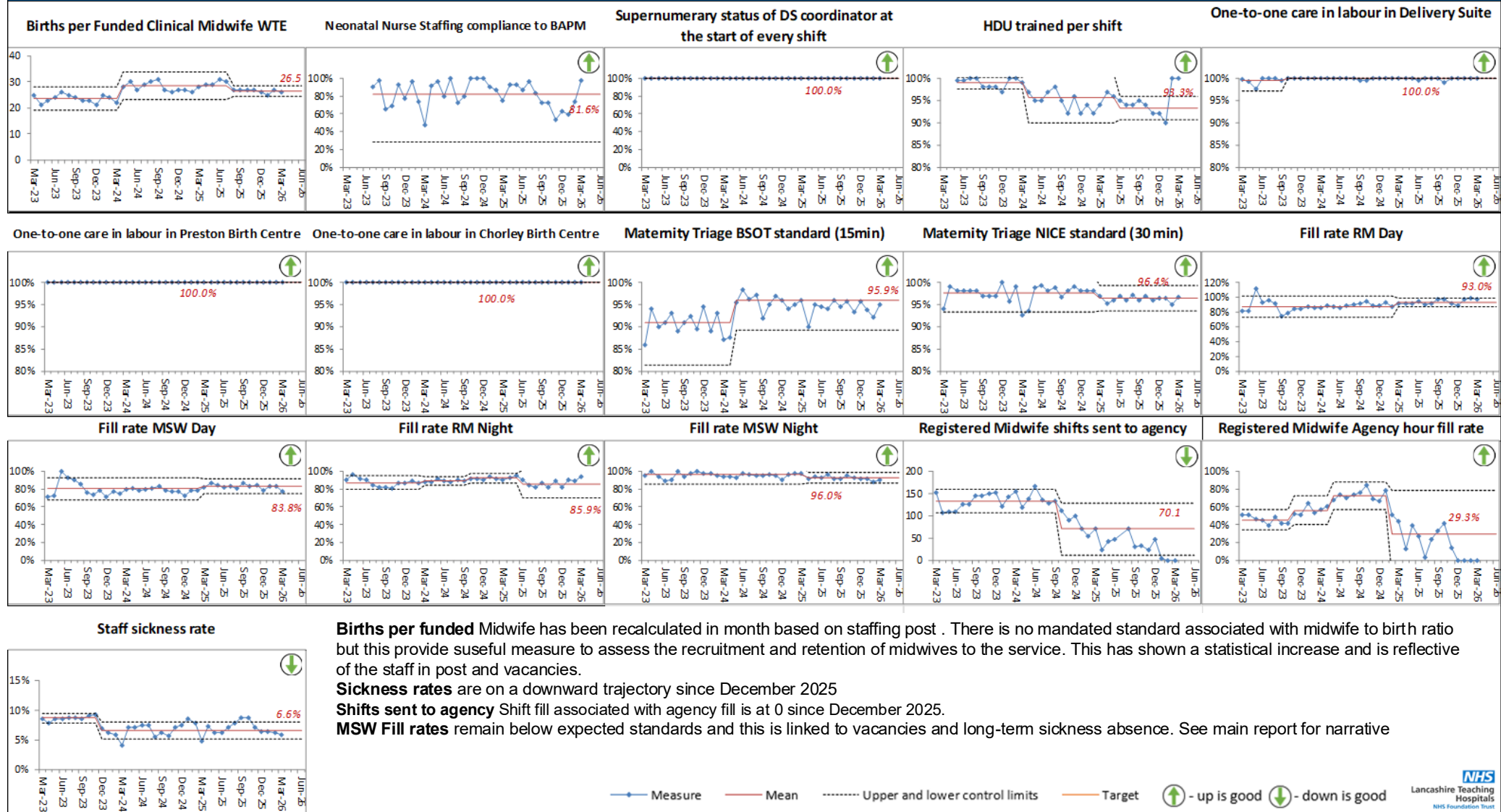


Compliments are not being recorded consistently, and the number of reports are disproportionate to the verbal feedback provided at ward and department level. Low reporting has been affected by the change of reporting system from Datix to Ulysess.

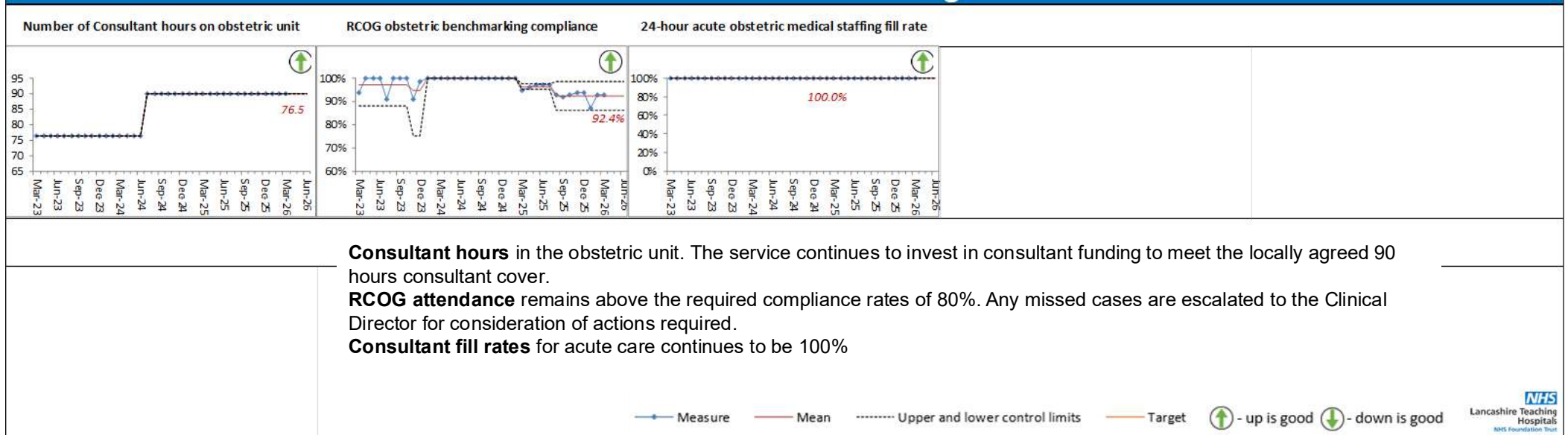
There has been no prevention of future death regulations or CQC enquires.

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

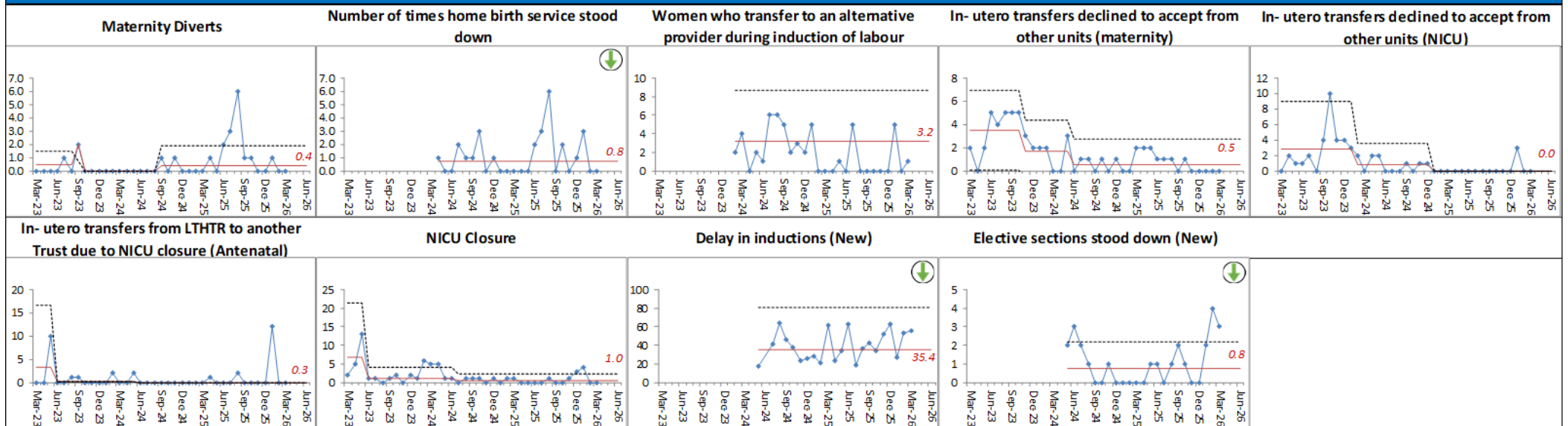
Safe staffing indicators



Obstetric Medical Staffing



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. A letter is sent to all women who transfer care due to capacity.

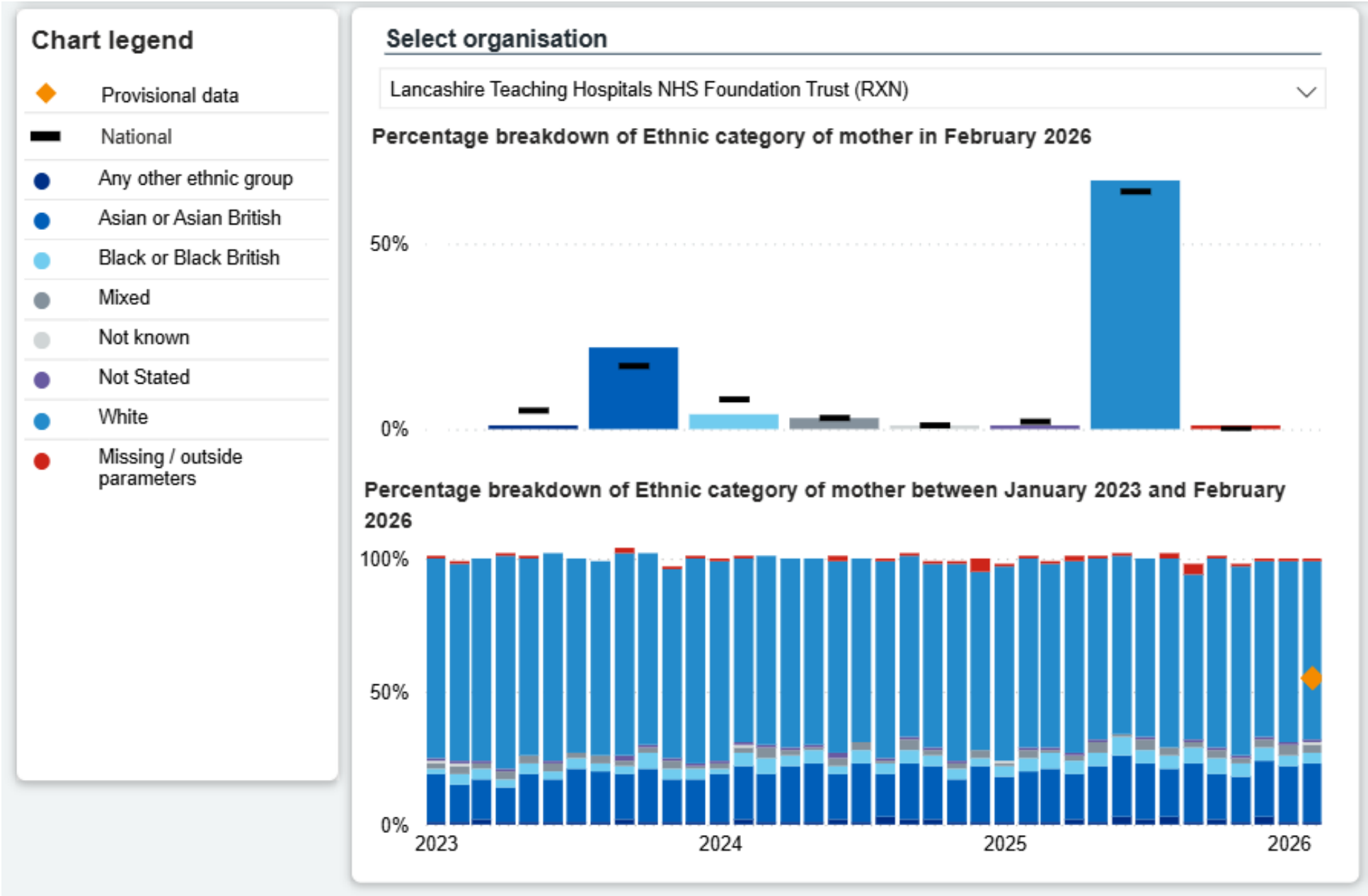
Delayed Elective caesarean sections has seen a rise since December 2025. This is reflective of the capacity issues within the substantive workforce affecting availability of colleagues to undertake additional lists to meet capacity. See report.

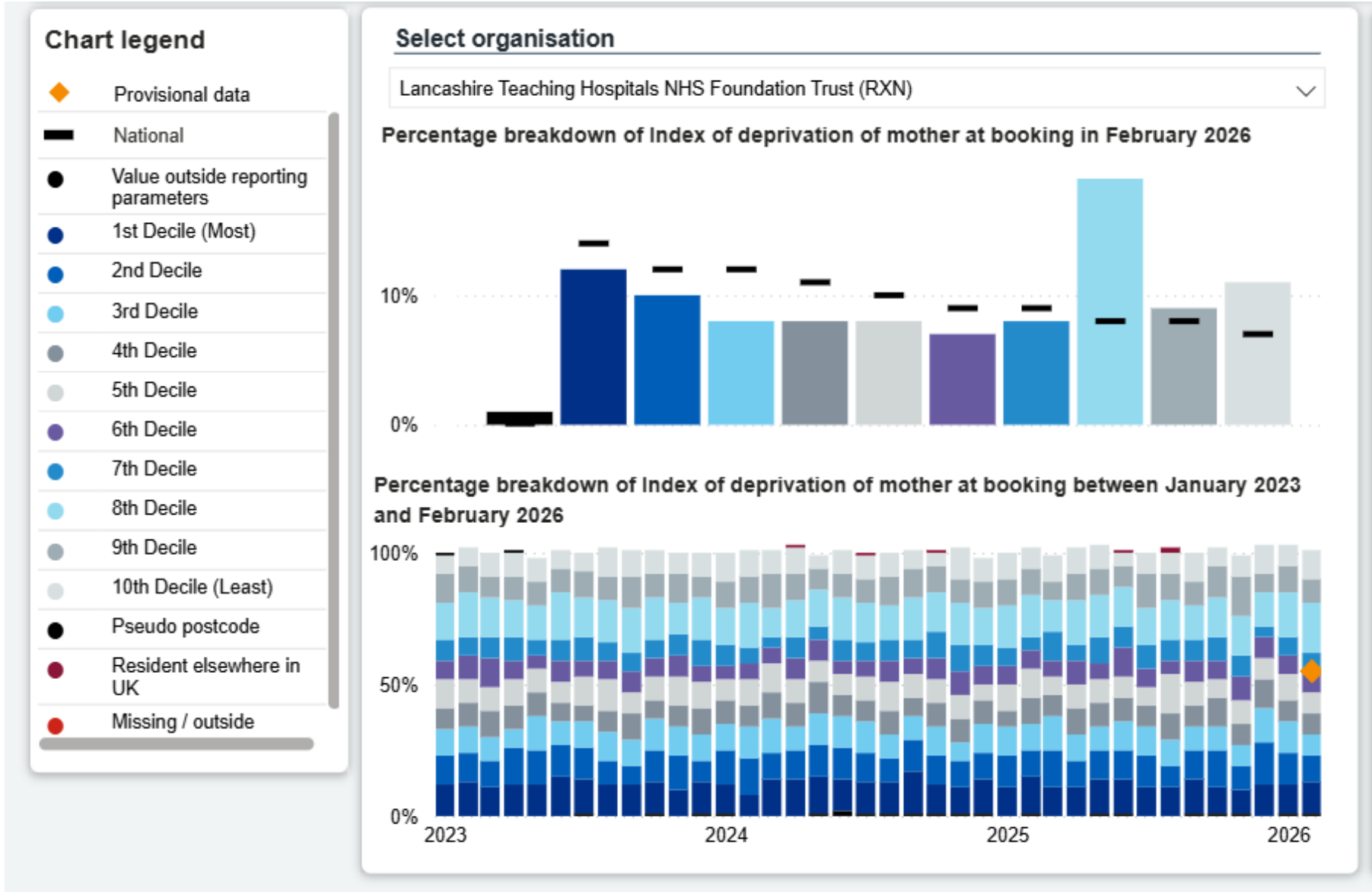
NICU closures are being closely monitored linked to a reduction in BAPM nurse ratios and intermittent inability to manage the Transitional care activity. See Report

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

NATIONAL MATERNITY DASHBOARD COMPARISONS (2023-2026)

APPENDIX 3





APPENDIX 3 RED FLAGS MARCH 2025 TO MARCH 2026

Unvalidated Red flag Reporting Metrics	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
	25	25	25	25	25	25	25	25	25	25	26	26	26
Delay in time critical activity	16	117	108	105	64	18	9	0	3	3	2	1	4
Missed or delayed care> 60 mins in washing or suturing	1	0	0	0	0	1	0	0	0	0	0	0	1
Failure for women to receive the medication required.	2	0	0	0	1	1	2	1	0	0	0	1	0
>30-minute wait for pain relief.	3	1	1	1	4	4	3	3	0	1	1	0	1
Was there a >30-minute delay for assessment by a midwife when a problem was identified	2	2	1	0	0	0	1	0	0	0	1	1	0
Lack of full examination when woman presents in labour.	2	0	1	0	1	0	0	2	0	1	0	0	0
>2-hour delay in induction?	17	5	18	26	16	10	14	40	43	63	22	11	11
Delay in recognition of and action of abnormal signs.	0	0	0	0	2	0	1	2	0	2	0	0	0
Inability to provide one to one care in labour?	0	1	1	4	2	6	3	2	0	0	0	0	0
>30-minute wait for obstetric triage.	62	156	0	107	130	124	98	93	65	113	101	74	113
>15-minute delay following presentation for BSOTS midwife assessment.	21	82	49	50	59	38	61	43	48	34	49	55	45
Was there a delay in transfer of a BSOTS red case from MAS?	1	1	0	0	0	0	4	0	1	0	0	1	0
Was there a delay in transfer (over 4 hours) to delivery suite once a decision has been made for transfer for induction or augmentation?	34	17	15	37	31	5	14	2	9	0	2	42	15
Was there a delay in transfer once labour was established?	1	1	1	1	3	9	4	5	0	0	0	0	0
Was there a delay in transfer to delivery suite within 30 minutes where the MEWS was 6 or more or scoring a 3 on a single parameter?	1	0	0	0	0	1	1	0	1	0	0	0	0
Was there a delay of more than 30 minutes to initiate the sepsis care bundle?	1	1	1	0	1	0	1	0	0	0	0	0	0
Has there been a deferred date of planned induction of labour?	0	1	1	0	0	4	4	0	0	0	0	0	0
Has there been any cancelled or delayed community work?	3	2	0	3	2	5	0	1	1	2	0	0	1
Did redeployment of staff to other services/sites/ wards occur?	12	9	6	12	14	34	13	17	11	8	2	4	0
Is the incident related to an RCOG clinical situation where a consultant was called but did not attend (New for June 2025 Validated position.)				1	2	1	0	0	1	0	0	2	1
Total numbers of red flags	179	396	336	364	335	261	233	211	184	227	180	192	192

12.2 LTH DIGITAL ENABLING STRATEGY

● Decision Item

REFERENCES

Only PDFs are attached



12.2 Digital Enabling Strategy Board Part I 4 June 26.pdf



Digital

Digital Enabling Strategy 2025–2030

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





Digital

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OUR TRUST STRATEGY 2025–2030

Our roles

The provider of specialist services for the population of Lancashire and South Cumbria and a provider of local services for the population of Central Lancashire

A centre for Continuous Improvement, Education, Research and Innovation

As an Anchor Institution – where social value and sustainability is aligned to the health and wealth of our population

Our Approach and Services

Cancer

Children and young people

Community and local services

Diagnostics

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

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



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

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

Long term conditions

Pathology

Specialised services

Urgent and Emergency

Women's health, Maternity and Neonates

Our sites

Royal Preston Hospital

Chorley & South Ribble Hospital

Broad Oaks: Child Community Centre

Preston Business Centre: Specialist Mobility Rehabilitation Centre

Preston Healthport: Community Diagnostic Centre

Introduction

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

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

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

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

Welcome to our
Digital Strategy

2025–2030



Professor Mike Thomas
Chair



Professor Silas Nicholls
Chief Executive

Our strategic framework

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

Our 5 Ps Strategic Priorities



Patients

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



Performance

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



People

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



Productivity

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



Partnerships

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

Our changing context

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

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



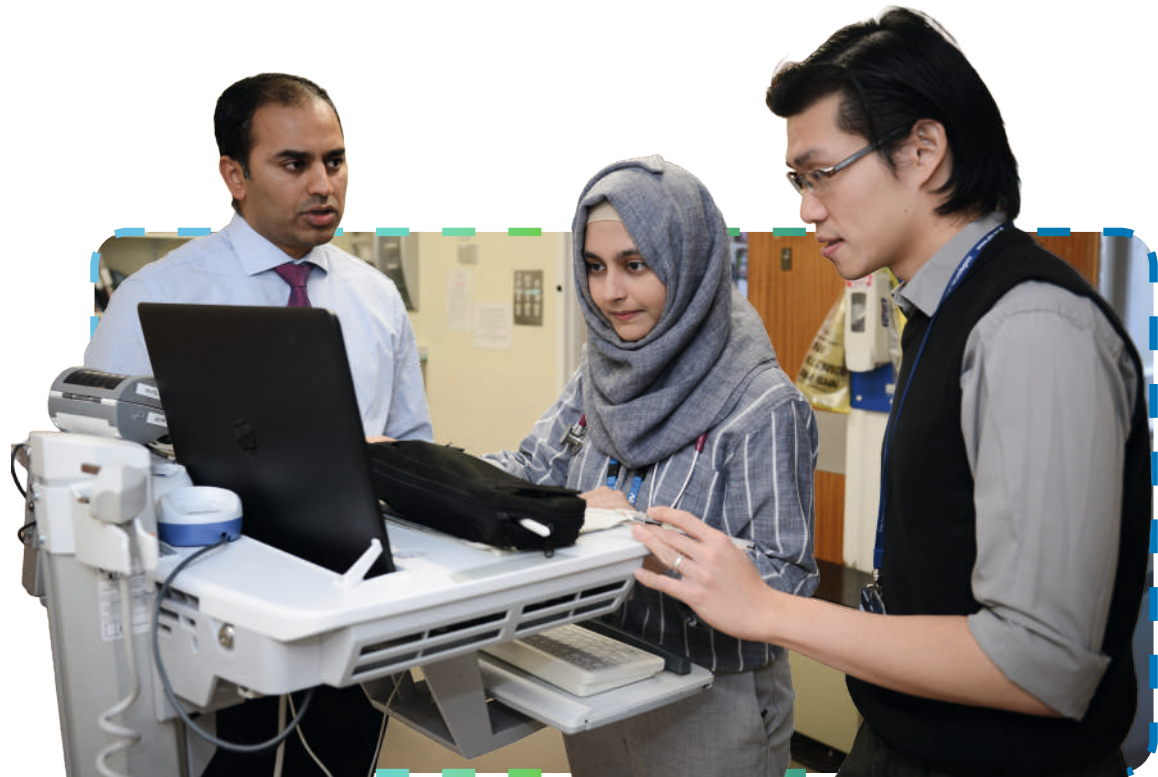
Our ambition and role

Our ambition is to become an accountable healthcare organisation within Lancashire and South Cumbria and in doing so deliver an affordable and sustainable model for the future. The strategic priorities as part of this focus on:

Our role as the provider of specialist services for the population of Lancashire and South Cumbria and a provider of local services for the population of Central Lancashire.

Our role as a centre for Continuous Improvement, Education and Research and Innovation

Our role as an Anchor Institution – where social value and sustainability is aligned to the health and wealth of our population



Our Services

Our vision for all our clinical services and the clinical services we plan to provide over the next 5 years are in line with the ICS clinical blueprint and priorities. Our vision for these services is shaped by the Fit for the Future 10 Year Health Plan for England¹. This seizes the opportunities provided by new technologies, medicines and innovations to deliver better care for all our patients. We will work with partners to make three big shifts in how we work and deliver care:

From hospital to community

From analogue to digital

From sickness to prevention

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

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



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

Delivering our Strategy

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

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

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



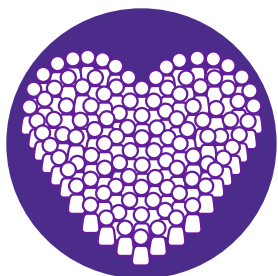
Our values and enabling strategies

Our values

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

Our enabling strategies

Our strategic objectives are supported by: Always Safety First, Digital, Estates & Facilities, Financial Sustainability, Social Value and Workforce. This framework helps individual services align their priorities and plans with our overarching Trust objectives.



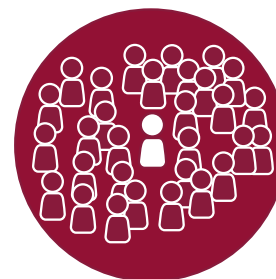
Being Caring & Compassionate



Building Team Spirit



Seeking To Involve



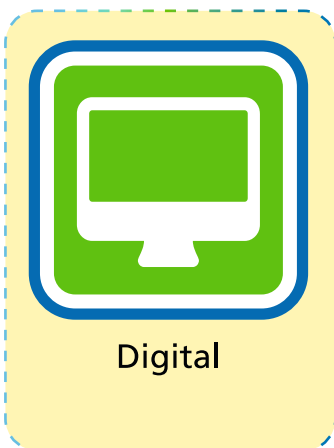
Recognising Individuality



Taking Personal Responsibility



Always Safety First



Digital



Estates & Facilities



Financial Sustainability



Social Value



Workforce

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

Patient-centred care

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

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

Developing the Digital Strategy

The context for Digital

Digital technology is woven into our modern lives and healthcare is no different. Digital processes are in every ward and department of the hospital and the wider healthcare community. This requires a huge support infrastructure to run smoothly: WIFI and computers, cybersecurity, digital teams, trainers and clinicians. Despite these, many people find digital healthcare frustrating. For this reason, we are committed to continually review and optimise our systems to improve the experience of staff and the safety of patients.

Technology is changing at a fast pace, creating exciting opportunities to change how we work. We are introducing AI solutions that can write letters and clinical notes. We are exploring how this can save clinical staff time to care, and free up operational teams to work more efficiently. There are increasing opportunities to share information with patients. They will soon have access to their electronic letters and be able to make and change appointments online. Patients will increasingly collect personalised data like their blood pressure, empowering them to take ownership of their care and improve their health.

The digital teams across Lancashire and South Cumbria have joined together under One LSC. One LSC stands for 'One Lancashire and South Cumbria' and reflects the Lancashire and South Cumbria System ambition to have one team serving Lancashire and South Cumbria in a joined-up way. It is jointly run by the five Trusts as a collaborative partnership. One LSC brings together the Digital, Data and Technology, Estates and Facilities, Finance, People Services and Procurement and Logistics services from each of the provider Trusts to create one central community of professionals.

This strategy has been developed to enable our staff, patients and wider stakeholders to understand the direction of travel for digital and the priorities for Lancashire Teaching Hospitals. National priorities, system plans and local feedback have been vital in its development to ensure this gives us a firm foundation to build on for the future.

Overarching digital strategic aims

- 1 Introduce new technology that improves that experience of staff and the safety of patients.
- 2 Continually review and improve our digital systems to ensure the best experience for staff.
- 3 Give patients access to their information to allow them to maintain good health and get the right care when they need it.
- 4 Share data across Lancashire and South Cumbria to improve population health and remove health inequalities.





Patients

Improve patient care and experience, in particular Sepsis, Clostridium Difficile, risk assessment completion, medication safety, maternity, neonatal and children's services whilst reducing health inequalities in our services.

Where are we?

Most communication with patients still takes place using posted paper letters that can be significantly delayed.

Most patients don't have access to our electronic record, but they can sometimes get results via their GP and the NHS app.

Patients are not involved in digital developments.

There isn't any support for patients when contacting the hospital or navigating the site.

Where we aim to get to?

We are developing a local Patient Engagement Portal (PEP+) solution so patients can see all their letters, book and change appointments.

Create a "digital frontdoor" for patients so that they have all the information they need to make visiting hospital stress free.

Ensure patient representatives are involved in key digital developments.



Ensure patients have digital, user friendly booking, correspondence and information that is accessible and system wide to enable seamless pathways.

Provide patients with a consistent, intuitive digital experience across the system, including online booking, appointment management, communications, and access to information, ensuring services are accessible, inclusive, and easy to use. This will involve implementing platforms that enable patients to move seamlessly between providers without duplication or confusion, supported by real-time updates, digital letters, and personalised information, whilst ensuring alternative options are available for patients who may be digitally excluded. By improving transparency, communication, and self-service options, this ambition will enhance patient experience, reduce missed appointments, and support more efficient pathway management across organisational boundaries.



Develop remote monitoring, tools and diagnostics to enable care closer to patients homes.

Develop and scale remote monitoring and digital diagnostic capabilities to support delivery of care closer to home, reducing the need for hospital attendance and enabling earlier intervention. This will include the use of wearable devices, home-based testing, and virtual platforms that allow clinicians to monitor patients' conditions in real time, particularly for long-term conditions and post treatment follow-up. Integration with clinical systems will enable timely decision making and proactive management, while supporting system capacity and improving patient convenience and outcomes.



Deliver systems that enable safer medicine administration. Complete the roll out of the Electronic Prescribing and Medicines Administration (EPMA) that improves the safety, accuracy, and efficiency of medicines management across care settings. These systems reduce medication errors, ensure adherence to clinical guidelines, and provide real-time visibility of prescribing and administration practices.



Use data and information available to drive improvements in reducing health inequalities. Strengthen the availability, quality, and use of data to better understand and address health inequalities across the population, enabling more targeted and effective interventions. This will include improving the capture of demographic and deprivation data, linking datasets across health and care systems, and developing analytics that identify variation in access, experience, and outcomes. By embedding these insights into planning and operational decision making, the system will be better equipped to design inclusive services, target resources to areas of greatest need, and track progress in reducing inequalities over time.





Performance

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

Where are we?

Single programme approach to digital diagnostics across One LSC.

Single system in place for maternity care across Lancashire and South Cumbria.

There is a lot of variation in how patient pathways are managed and many don't use optimal digital solutions.

Where we aim to get to?

Digitally enabled pathways and learning to reduce variation and unnecessary steps.

AI supported diagnostics.

Minimal system downtime.



Deliver digitally enhanced pathways to support performance improvement, particularly across RTT, cancer, ED, and flow management. Design and implement end to end digitally enabled clinical pathways across RTT, cancer, urgent and emergency care, and flow management, embedding real-time decision support and enabling system wide visibility of patient journeys. This will reduce variation, improve triage and prioritisation, and support earlier intervention, whilst expanding virtual care and digital triage to improve access and reduce demand. All pathway developments will align with clinical transformation programmes to drive measurable improvements in waiting times, throughput, and patient experience.



Enable data that predicts performance and enables interventions at an earlier stage where performance is deteriorating. Develop a system-wide analytics capability that shifts from retrospective reporting to predictive and prescriptive insights, using forecasting and advanced analytics to anticipate demand, capacity pressures, and performance risks. This will be supported by real-time dashboards, integrated data flows, and early warning triggers embedded in operational processes, enabling rapid, proactive intervention. Building capability across teams will ensure insights are acted upon, supporting consistent, data-driven decision-making and improved outcomes.



Roll out single systems for diagnostics to reduce delays across multi-provider pathways. Implement shared, interoperable diagnostic systems across providers to enable seamless booking, reporting, and results sharing for imaging, pathology, and other services. This will support standardised pathways, improve utilisation of capacity, and reduce duplication and delays, particularly for patients moving between organisations. Networked diagnostic models, including Community Diagnostics Centres (CDC), will be underpinned by digital workflow tools and integrated access to results within clinical systems, enabling faster decision-making and more efficient, coordinated care.





People

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

Where are we?

Colleagues find our electronic patient record difficult to use. They have told how it increases stress and adds to burnout.

We have a year-on-year improvement plan to make our EPR easier to use and release colleagues time to care.

We are improving all our training and adding online lessons and face to face updates.

Where we aim to get to?

A positive staff experience with systems that are safe and user friendly.

Reporting that is real time and highlights variation.

Provide digital career paths for our local population.



Make it easier for staff to find the right information and tools in one place, so there is less paper and manual processes, to release more time to support patients. Create a streamlined digital working environment that integrates key clinical and operational systems into a single, intuitive environment, enabling staff to quickly access the information, tools, and patient records they need. This will reduce the need to navigate multiple platforms, minimise duplication, and standardise workflows across services. By improving interoperability and usability and reducing reliance on paper-based processes, staff will spend less time searching for information and more time delivering care, ultimately improving productivity, staff satisfaction, and patient outcomes.



Use clearer reports and dashboards so teams can see what is working, spot issues earlier and keep improving services. Design and deploy clear, user friendly dashboards and reporting tools that provide real time visibility of performance, quality, and operational pressures at team, service, and system level. These tools will present consistent, easy-to-understand data that supports rapid interpretation, enabling staff to identify what is working well, detect emerging issues earlier, and take timely action. Embedding these insights into routine management and clinical decision making will foster a culture of continuous learning and improvement, supporting better outcomes and more responsive services.



Reduce time spent on administration by improving digital systems and using tools such as voice dictation and automation, so staff can focus more on care. Transform administrative processes by optimising digital systems and introducing automation solutions such as voice recognition, structured documentation, and workflow automation. These tools will reduce duplication, streamline data entry, and eliminate unnecessary manual tasks, improving both efficiency and accuracy. By redesigning processes around digital capabilities, staff will spend significantly less time on administrative burden and more time on direct patient care, while also improving data quality and consistency across the system.



Invest in digital skills and training, work with local education partners, and make better use of existing equipment while improving consistency in our core clinical systems across services. Develop a digitally confident workforce through targeted training programmes, ongoing support, and partnerships with local education providers, ensuring staff are equipped to use digital tools effectively and safely. Alongside this, maximise the value of existing infrastructure and equipment, while driving greater consistency and standardisation in core clinical systems across services. This combined approach will reduce variation, improve user experience, and enable more joined-up care delivery, ensuring that digital investments translate into tangible improvements in productivity, quality, and patient outcomes.





Productivity

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

Where are we?

Previously all organisations would purchase digital systems independently prior to One LSC.

Roll out of projects could be delayed due to unexpected issues.

Where we aim to get to?

We need to understand how to build the optimal patient pathways so patients get the right care at the right time.

Patient's care need to move seamlessly between hospitals when required.

Enable the clinical services to deliver savings in an efficient timescale when digital improvements are required



Minimise administrative burden by ensuring digital systems and hardware are consistently available, reliable, and high performing, reducing disruption to clinical activity and staff workflows. This will include improving system stability, reducing downtime through proactive maintenance and monitoring, and ensuring devices are fit for purpose and quickly replaced or repaired when issues arise. Alongside this, tools such as voice dictation and automation will streamline documentation and routine tasks but always built on a dependable digital infrastructure. By prioritising uptime, responsiveness, and seamless access to systems, staff will experience fewer interruptions, spend less time working around technical issues, and more time focused on delivering high quality patient care.



Support more flexible, modern care by expanding the use of mobile devices and making it easier for people to check in for appointments (including self check-in), so staff are not tied to a desk or fixed PC. Enable more agile, responsive models of care by expanding the use of mobile devices and strengthening digital access for both staff and patients. This will allow clinicians and teams to securely access systems, update records, and deliver care across a range of settings, without reliance on fixed workstations. Patient facing solutions, including self check-in, digital wayfinding, and streamlined appointment management, will improve flow and reduce administrative bottlenecks. Together, these capabilities will support more efficient use of workforce time, enhance patient experience, and enable services to better adapt to changing demand and care models.



Get better value for money and reduce waste by buying smarter across the system and making the best use of existing digital equipment repairing, reusing and repurposing devices where possible, in line with sustainability goals. Utilise the coordinated, system wide approach to digital procurement, asset management, and lifecycle planning to maximise value for money and reduce unnecessary expenditure. This will include standardising equipment where appropriate, improving visibility of assets, and extending the life of devices through repair, reuse, and repurposing. Procurement decisions will align with both financial and sustainability objectives, reducing environmental impact while ensuring staff have reliable, fit for purpose technology. By embedding these principles into planning and operations, the organisation can deliver more efficient, sustainable digital services that support long-term resilience and system wide benefit.





Partnerships

We believe in delivering high quality healthcare through partnerships. Transforming services whilst making a positive contribution to the local community, recognising we are stronger together through collaboration and shared partnerships.

Digital, Data and Technology (DDaT) functions are critical to the daily operation and strategic growth of modern healthcare services. Centralising DDaT services under the partnership in the One LSC unified structure now presents a significant opportunity to improve service quality, drive innovation, and reduce overall costs.

Where are we?

Regional wide area networks well developed and implemented across the system

Some shared system wide working already in place around end user device procurement

A number of core infrastructure elements are unnecessarily duplicated across organisations providing opportunities for rationalisation

Significant work on Shared Care Record (ShCR) in place already allowing hospitals and GPs to view each other's information.

Where we aim to get to?

A high functioning, efficient digital offer for the whole system.

Seamless systems across organisational boundaries.



Deliver our role as part of an anchor organisation across Lancashire, promoting digital careers. Act as a leading anchor organisation across Lancashire by promoting digital careers, supporting local talent pipelines, and strengthening system wide digital capability. This will include working with schools, colleges, universities, and training providers to raise awareness of digital roles in health and care, create clear pathways into employment, and support ongoing professional development. By investing in skills, apprenticeships, and inclusive recruitment, the organisation will help build a sustainable workforce, reduce reliance on external resources, and contribute to wider economic and social value across the region.



Enable OneLSC collaboration across providers through aligned digital governance and procurement, with regional consistency across platforms (EPR, pathology, PACS). Support stronger collaboration across One Lancashire and South Cumbria by aligning digital governance, decision making, and procurement processes, enabling more consistent and coordinated investment across providers. This will include driving greater standardisation of core platforms such as EPR, pathology, and PACS, reducing duplication and variation while improving interoperability and value for money. Through shared approaches and joint planning, the system will be better positioned to deliver integrated care, scale innovation, and maximise the impact of digital transformation across organisational boundaries.



Expand the Shared Care Record across settings, health and social care partners, and neighbourhood health hubs. Expand the Shared Care Record to include community services, care homes, hospices, and social care, ensuring that all professionals involved in a person's care have timely, secure access to relevant information. This will enable more joined-up, coordinated care, particularly for individuals with complex or long-term needs, whilst reducing duplication and the need for patients to repeat their information. By embedding the Shared Care Record within neighbourhood partnership models and supporting emerging neighbourhood health hubs, and ensuring it is intuitive and accessible to use, this approach will strengthen multidisciplinary working, improve decision-making and patient safety, and enhance collaboration across the wider health and care system.



How will our strategy be delivered

Delivery of this strategy will be achieved through strong system governance, linked to the Patient Safety Incident Reporting Framework (PSIRF) and alignment with NHS England standards. A “One LSC” approach that ensures all new digital projects and systems are reviewed and assured at system level prior to approval, supporting the priorities of the Integrated Care Board (ICB) and wider provider collaborative. Clinical digital safety will be embedded throughout in line with NHS Digital Clinical Safety Standards, including formal hazard workshops to identify, assess, and mitigate risks, alongside robust safety case development. Cybersecurity will be managed in accordance with National Cyber Security Centre guidance and Data Security and Protection Toolkit requirements, ensuring systems are secure by design and resilient. All procurement will follow NHS assurance frameworks and regulatory requirements, including Digital Technology Assessment Criteria (DTAC), Medicines and Healthcare products Regulatory Agency and Care Quality Commission standards, ensuring compliance, safety, and value, while enabling interoperable, scalable solutions that deliver integrated care and maximise system-wide benefit.



Our vision of a digital future for staff and patients is system wide, resilient, and intuitive.

Prevention and demand avoidance

- ✓ Remote monitoring and early intervention
- ✓ Reduced duplication and digital triage
- ✓ Targeted reduction in health inequalities



The digital front door for patients

- ✓ Outpatient check-in and accessible patient information
- ✓ Digital pathway enhancement and management
- ✓ Long term condition monitoring in patients homes
- ✓ Diagnostics access and results



The clinical applications layer for clinicians

- ✓ Electronic patient record (One LSC EPR)
- ✓ Clinical monitoring device integration
- ✓ Clinical productivity and AI
- ✓ Clinical LaunchPad
- ✓ EPMA
- ✓ Integrated diagnostics



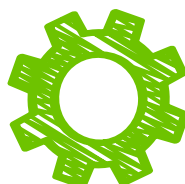
Digital support tools for all staff

- ✓ People digital lifecycle management
- ✓ Office365
- ✓ Robotic processing/Agentic AI
- ✓ Unified corporate service platform
- ✓ Digital case management (people/hr)



Data and tech layer

- ✓ Federated data platform
- ✓ Shared care records
- ✓ Integration engine (single ICS approach)
- ✓ Single active directory
- ✓ Cybersecurity programme
- ✓ Telephony rationalisation
- ✓ Intuitive data and analytics



Aims

- Introduce new technology that improves that experience of staff and the safety of patients
- Continually review and improve our digital systems to ensure the best experience for staff
- Give patients access to their information to allow them to maintain good health and get the right care when they need it
- Integrate systems and data across Lancashire and South Cumbria to improve population health and reduce health inequalities

Digital Enabling Strategy 2025–2030

Thank you

Keep in touch:

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

Communication@lthtr.nhs.uk

www.Lancsteachinghospitals.nhs.uk

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

@LancsHospitals



Our Digital Strategy 2025–2030

Published by Lancashire Teaching
Hospitals NHS Foundation Trust,
September 2025

13.2 RECOVERY SUPPORT PROGRAMME ? EXIT CRITERIA

● Other

Item for Assurance

REFERENCES

Only PDFs are attached

-  13.2 Recovery Support Programme Exit Criteria & Enforcement Undertakings Appendices - Board Part I 4 June 26.pdf



Assessment of the Progress Made against the Enforcement Undertakings and RSP Exit Criteria.

Lancashire Teaching Hospitals NHS Foundation Trust had Enforcement Undertakings as set out in July 2024, these were ‘replacement undertakings’ that superseded those set out in 2021. In February 2025, variations were made to the undertakings. The table below summarises the Trust’s progress against these undertakings in preparation for a review of the progress made by the Trust in meeting the RSP exit criteria. For completeness, the changes made to the Enforcement Undertakings are outlined below alongside a summary of the Trust’s progress. Further details are included in the accompanying slide set which details progress against each of the exit criteria.

Key:

Undertakings as set out in July 2024 (the “replacement undertakings” that supersede those set out in 2021)
Variation to undertakings as set out Feb 25
Undertaking deleted or replaced in Feb 25

Undertakings as set out in July 2024 (the “replacement undertakings” that supersede those set out in 2021)				
Ref	Theme	Notes	Action	Achieved
1.Financial Planning				
1.1	The Licensee will take all reasonable steps to achieve financial balance by the 2024/25 financial year.	Deleted in variation of undertaking letter Feb 25	N/A	
1.2	The licensee will deliver the licensee’s 2024/25 Financial Plan unless otherwise agreed	Deleted in variation of undertaking letter Feb 25	N/A	
1.3	The licensee will keep the Financial Plans and their delivery under review. Where matters are identified which materially affect the Licensee’s ability to meet the requirements of paragraph (1.1), whether identified by the Licensee or another party, the Licensee will notify NHS England as soon as practicable and update and resubmit the Financial Plan within a timeframe to be agreed with NHS England.	Deleted in variation of undertaking letter Feb 25	N/A	
1.1	Within a timeframe set by NHS England the licensee will agree a 2025/26 Financial Plan with NHS England.	Link to EC1	Through the RSP and IAG processes the Trust agreed the financial plan for 2025/26. Although the WRP was not delivered in	Partially achieved

	The Plan should be consistent with the medium-term system plan currently in production, which sets out a trajectory for the Integrated Care System to achieve underlying financial balance by 2026/27.		totality, the Trust has delivered a larger WRP than in previous years, achieving £26.1m in 24/25 increasing by 30% to £37m in 25/26. Learning has been implemented to support development of a more robust WRP plan for 2026/27 achieving greater than > £35m Green by M1 with a plan to reach £60m green by M2 26/27. <i>See slide 1-6</i>	
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	Link to EC2	The Trust has delivered a significant reduction in exit run rate from £65.8m in 24/25 to £51.7m in 25/26. This demonstrates an improvement in the overall financial run rate position between the years after taking into account £17m net inflation pressures. There was however variation between quarters <i>See slide 10</i>	Overall run rate achieved but some variation between quarters
1.3	The Licensee will comply with all documented actions required by the System Financial Turnaround Director through the Improvement and Assurance Group (IAG)	NA	The Trust has complied with the requests made from the System Turnaround Director through the IAG. Some progress has been slower than anticipated as a result of operational pressures and factors such as Industrial Action however, the Trust is in a stronger financial position at the start of 2026/27 than it was at the start of 2025/26 as a result of the work undertaken. <i>See slide 23</i>	

1A Leadership and Governance				
1A.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.	Link to EC4	The Trust has fully engaged with the Governance and Leadership review which contained positive feedback regarding the structures in place and recent work undertaken alongside recommendations. The action plan developed in response demonstrates 58 actions delivered with 16 outstanding which have been incorporated into the 2026/27 Single Improvement Plan. <i>See slide 15-21</i>	Achieved
1A.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.	Link to EC4	The Trust has liaised with NHS England regional colleagues for the approval of the Executive positions; the Chief Finance Officer and the Chief Medical Officer. The Trust has also liaised with NHS England to seek permission to extend the contracts of the Non-Executive Directors. This has been actioned. <i>See slide - 20</i>	Compliant

1B Recovery Support Programme				
1B.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		The Trust has fully engaged with the RSP programme and has attended monthly IAGs and responded to all requests via the IAGs for reporting. <i>See slide deck</i>	Achieved
1B.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		The Trust has reviewed progress against the Exit Criteria and is presenting the review to IAG (Part 2) on 15 th April 2026.	Achieved – with evidence uploaded
1B.2	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		The Trust has engaged fully and co-operated with health sectors stakeholders, the RSP Improvement Director and wider team, the internal turnaround directors and PwC. There has also been good engagement with stakeholders who have supported the delivery of the recovery programmes, including those leading the governance review and the CSU colleagues who supported the PMO function.	Achieved
2.Distressed Funding				
2.1	Where interim support financing or planned term support financing is provided by the Secretary of State for Health and Social Care to the Licensee pursuant to section 40 of the NHS Act 2006, the Licensee will comply with any terms and conditions which attach to the financing.		The Trust has complied with terms and conditions of the financial support received.	Compliant
2.2	The Licensee will comply with any reporting requests made by NHS England in relation to any financing provided or to be provided to the Licensee by the Secretary of State for Health and Social Care pursuant to section 40 of the NHS Act 2006.		The Trust has been compliant with reporting requests.	Compliant
2.3	The Licensee will comply with any spending approvals processes that are deemed necessary by NHS England.		The Trust has complied with spending approvals processes.	Compliant

3.Quality of Care				
3.1	The Licensee will take all reasonable steps to address and rectify the breaches identified in the CQC report dated 24 November 2023 within such timescales to be agreed with NHS England. The Licensee will agree any amendments to the Quality Improvement Plan with NHS England and the ICB.		The Trust has no undelivered must and should do recommendations and has engaged fully in CQC site visits and relationship meetings.	Achieved
3.2	The Licensee will develop and submit to Lancashire and South Cumbria ICB and NHS England, a Quality Improvement Plan detailing actions which it will take to ensure compliance with paragraph 3.1 above, including key milestones and timelines, for approval by NHS England and the ICB.		The Trust has complied with this requirement evidenced through the presentation of the CQC report at Safety and Quality Committee attended by the ICB Quality lead.	Compliant
3.3	Specifically, and in line with the actions set out as required in the CQC report, the Licensee will ensure the Quality Improvement Plan includes actions that will ensure robust governance processes in relation to timely identification and management of risk including processes for shared learning.		The Trust has complied with this requirement. The Trust has evidenced robust ward to board risk arrangements, tested through both the GGI report and the RSP team. The Trust has a quality assurance system in place and a Board Assurance Framework that demonstrates a proactive approach to operational and strategic risk management.	Compliant
3.4	The Licensee will, as part of the Quality Improvement Plan, set out a workforce strategy to ensure sufficient numbers of suitably qualified, competent and experienced staff are available to enable them to meet all regulatory requirements.		The Trust is compliant with the National Quality Board staffing guidance and workforce safeguards. This was reviewed and confirmed by NHS England.	Compliant

3.5	The Licensee will ensure that its oversight and assurance processes in relation to the delivery of the actions in the Quality Improvement Plan are robust. The Licensee will demonstrate progress against the Plan in line with the agreed timelines through the Licensee's internal governance arrangements and enabling external oversight by the ICB and NHS England. Progress against the Quality Improvement Plan will be presented monthly to the System Improvement Board (SIB) until otherwise agreed with NHS England and the ICB.		The Trust's Single Improvement Plan has been monitored through the Portfolio Board (chaired by the CEO) and reported through to Finance and Performance Committee monthly with reporting to the Board through the Trust's IPR which was updated at the start of the year to focus on key metrics. The SIP reports have been shared with NHS England regional colleagues in the IAGs and the RSP team have observed the SIP Domain boards and Portfolio board and provided feedback to strengthen the governance which has been implemented in year.	Achieved

3.6	The Licensee will keep the Quality Improvement Plan and its delivery under review. Where matters are identified which materially affect the Licensee's ability to meet the requirements of paragraph 3.1, whether identified by the Licensee or another party, the Licensee will notify the ICB and NHS England as soon as practicable and update and resubmit the amended Quality Improvement Plan for NHS England and ICB approval within the timeframe agreed with NHS England and the ICB.		The Trust's Single Improvement Plan has been monitored through the Portfolio Board (chaired by the CEO) and reported through to Finance and Performance Committee monthly with reporting to the Board through the Trust's IPR which was updated at the start of the year to focus on key metrics. The SIP reports have been shared with NHS England regional colleagues in the IAGs.	Achieved
3.7	The Licensee will ensure that the Plan is updated as necessary, with the agreement of NHS England and the ICB, to include any quality related recommendations from external independent investigations.		The Single Improvement Plan has remained a live plan with updates regularly throughout the year. The CQC must and should dos are the outstanding external recommendations and these are now delivered.	Achieved

3.8	The Licensee will take all reasonable steps to deliver the Quality Improvement Plan, in accordance with the timeframes set out in the Plan, unless otherwise agreed with NHS England.		The Trust has complied with this undertaking (see 3.6 above)	Achieved
3.9	The Licensee will work in partnership with the Provider Collaborative and ICB to support the timely delivery of the System Clinical Strategy.		The Trust has worked closely with partners to progress the implementation of the clinical strategy priorities at a system level. These include establishing a 24/7 thrombectomy service for Lancashire and South Cumbria, becoming the lead provider for pathology services and progressing the vascular reconfiguration work. The Trust is also participating in the national frailty collaborative and working with ICB colleagues and primary and community care to redesign the clinical model of care for frailty in line with national best practice.	Achieved
4.Reporting				
4.1	The Licensee will provide regular reports to NHS England on its progress in meeting the undertakings set out above.	Deleted in variation of undertaking letter Feb 25	NA	
4.2	The Licensee will attend SIB meetings, or, if NHS England stipulates, conference calls, at such times, and with such attendees, as may be required by NHS England, to discuss its progress in meeting the undertakings. The SIB meetings will take place once a month unless NHS England otherwise stipulates, at a time and place to be specified by NHS England and with attendees specified by NHS England.	Deleted in variation of undertaking letter Feb 25	NA	

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.	Deleted in variation of undertaking letter Feb 25	NA	
4.4	The Licensee will comply with any additional reporting or information requests made by NHS England.	Deleted in variation of undertaking letter Feb 25	NA	
4.1	The Licensee will provide regular reports to NHS England through the IAG on its progress in meeting the undertakings set out above		The Trust has been compliant with the submission of regular reports.	Achieved
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.		The Trust has attended all the meetings requested and is therefore compliant with this undertaking.	Achieved
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.		The Trust has shared the evidence, reports and other information requested and is compliant with this undertaking. The evidence supporting the review of our RSP Exit Criteria has been collated in a folder and shared with RSP colleagues and NHS England regional colleagues.	Achieved
4.4	The Licensee will comply with any additional reporting or information requests made by NHS England.		The Trust has complied with all requests for additional information and is compliant with this undertaking.	Achieved

RSP Exit Criteria Progress 2026

Our RSP programme of work

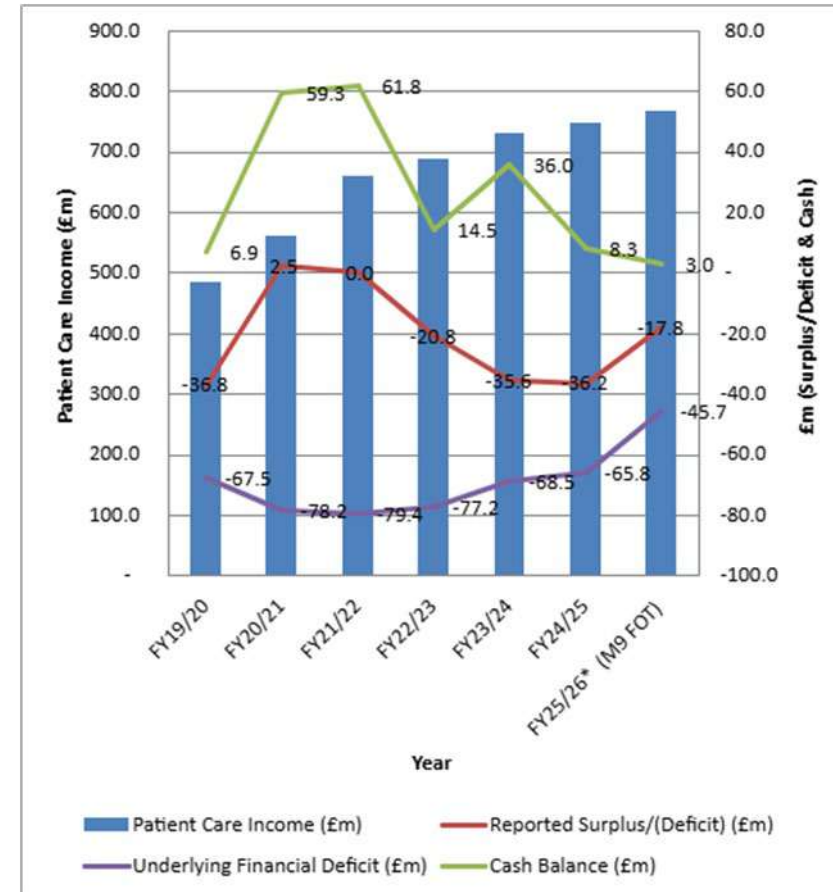
1. Where we were at the commencement of RSP
2. The work we have undertaken and how we have met/partially met the exit criteria
3. Our readiness to fully embed and sustain the work

Context: where we were at the commencement of RSP

- A long-standing structural deficit with no improvement in the underlying deficit for a decade and a worsening financial position from 2020/21
- Annual CIP programmes with a large proportion of non-recurrent CIP
- A recent history of a high turnover of CEOs and chairs (3 CEOs in 3 years; 4 if the interim is counted)
- Significant performance challenges and high-volume waiting lists (a proportion caused as a direct result of day case theatre closures in the pandemic to create a Covid majors ED).
- An ageing estate causing issues for safety metrics, specifically Clostridium Difficile

Priority Actions taken quickly:

- The new Chair recruited new Non-Executive Directors
- A number of new Executives recruited with investment in Executive team development.
- Development of a new Single Improvement Plan that collated all of the Improvement work together in one place



Single Improvement Plan | Portfolios and Programmes



Partnerships

People

Patients

Productivity

Performance



Patients

- Patient Experience & Involvement
- Always Safety First *inc Safeguarding*
- Maternity and Neonatal
- Children & Young People
- Medication Safety
- Health & Safety
- Specialised Services
- Long term condition management
- Estates & Facilities



Performance

- Urgent and Emergency Care
- Planned care - Cancer
- Planned Care – Outpatients and Theatres
- Diagnostics



People

- Strategic workforce planning, data & reporting
- Equality, Diversity and Inclusion
- Retention, Recognition & Reward
- Supporting health, wellbeing, safety and attendance
- Colleague experience and satisfaction
- Leadership capability and development



Productivity

- Financial Sustainability
- Waste Reduction Programme
- Grip & Control
- Procurement & Contracts
- Model Service Programme



Partnerships

- Community Service Transformation
- Digital, Data and Technology
- Education and Training
- Research, Innovation and University Hospital Status
- Green Plan
- Health Inequalities

Enabling functions

Planning, Communication, Governance & Risk and Continuous Improvement

We have developed our Financial Sustainability Plan and commenced delivery

- To support delivery of the Trust's future WRP and Financial Sustainability Plan (FSP), we have identified key transformation themes focused on sustainable, long-term change. Executive leads/support have been initially aligned to each area and initial discussions are taking place to highlight priorities and timelines
- Following a 1,384 increase since FY19/20, workforce WRP is now driving reductions, with WTE down by 184
- The Trust already has the infrastructure in place to build on and deliver this FSP



And are focused on decreasing our workforce: following a 1,384 increase since FY19/20, workforce WRP is now driving reductions, with WTE down by 184 and plans to date for a further 360 WTE reduction in 2026/27 (with more planned to achieve target)

WTE Growth

The increase in WTE across various staff groups highlights the organisation's commitment to addressing the staffing needs and improving service delivery.

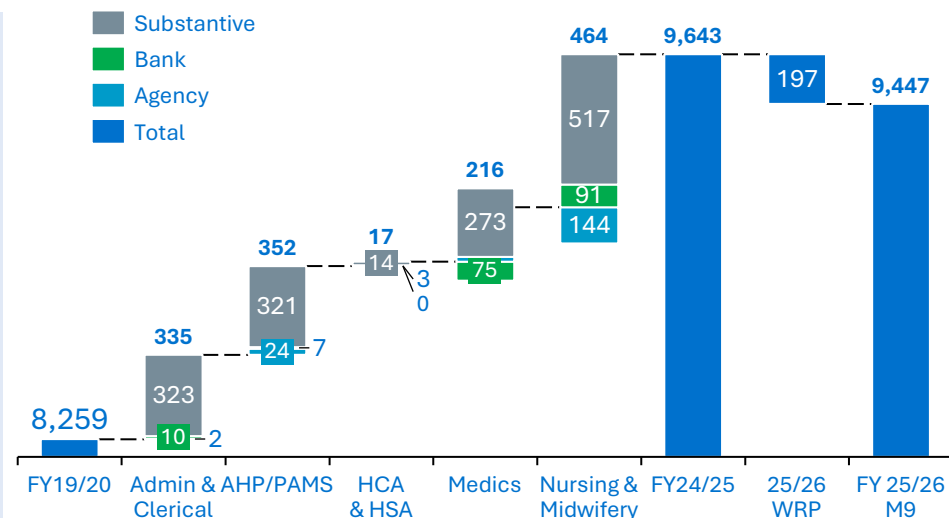
The organisation's total WTE worked (substantive and temporary workforce) increased by 1,384 WTE (+16.8%) between FY19/20 to FY24/25.

WTE increased year-on-year from FY19/20 to FY23/24, before declining in FY24/25 following a strengthened focus on workforce WRP. **As at Month 9 FY25/26, WTE stands at 9,447, representing a reduction of 197 WTE driven by continued workforce WRP focus.**

The main drivers of WTE growth between FY19/20 and FY24/25 were:

- 1. Nursing and Midwifery – 483 WTE** – Increase of 527 WTE substantive and 100 WTE bank reducing the reliance on agency staffing which saw a reduction of 144 WTE largely driven by recruitment into vacancies, unfunded G&A bed requirements and ED pressures.
- 2. Admin and Clerical – 305 WTE** – Increase of 305 substantive WTE partly driven by absorption of ELFS payroll services.
- 3. Medics – 216 WTE** - an increase mainly driven by growth across non-consultant grades, where c.140 additional WTE have been secured. This reflects both improved training grade allocations - following work with the Deanery to address historic shortfalls and strengthened recruitment into previously hard-to-fill roles previously covered by bank/locum.

Source for workforce WTE and £s from the financial ledger



Reported Pay	FY19/20	FY20/21	FY21/22	FY22/23	FY23/24	FY24/25	Movement
Substantive	£324.2m	£362.8m	£382.4m	£438.2m	£477.3m	£544.0m	£219.8m
Bank	£28.2m	£34.2m	£38.9m	£43.6m	£44.3m	£43.3m	£15.2m
Agency	£13.8m	£18.3m	£20.8m	£20.7m	£20.1m	£9.5m	£-4.3m
Total	£366.2m	£415.3m	£442.1m	£502.5m	£541.6m	£596.8m	£230.7m
<i>Normalised</i>	<i>£431.9m</i>	<i>£466.5m</i>	<i>£482.5m</i>	<i>£528.4m</i>	<i>£569.6m</i>	<i>£596.8m</i>	<i>£165.0m</i>

WTE	FY19/20	FY20/21	FY21/22	FY22/23	FY23/24	FY24/25	Movement
Substantive	7,463.74	8,031.30	8,367.49	8,942.65	9,182.86	8,911.76	1,448.02
Bank	621.84	744.87	769.47	916.75	827.59	657.37	35.53
Agency	173.46	263.09	216.15	233.29	71.99	74.77	£-98.69
Total	8,259.04	9,039.26	9,353.11	10,092.69	10,082.44	9,643.91	1,384.87

We have established the Trusts Programme Management Office and have built their expertise to support the continued development and delivery of the FSP

PwC PMO support will cease at the end of April 2026

A central Waste Reduction Programme (WRP) PMO has been established to coordinate, support and oversee the development and delivery of the Trust's Waste Reduction Plans (WRPs). The PMO provides the backbone of programme governance, ensuring a consistent process, reliable reporting and an agreed rhythm of meetings that collectively drive progress, accountability and assurance.

Drumbeat

A consistent weekly rhythm of reporting and review ensures transparent oversight, rapid escalation of risks and clear accountability for delivery across Divisions and Themes.

Process & Gateway

A structured Hopper-to-Delivery pipeline, governed by the PMO, ensures all schemes are evidence-based, fully signed off and progressed at pace to support the financial plan.

PMO Role

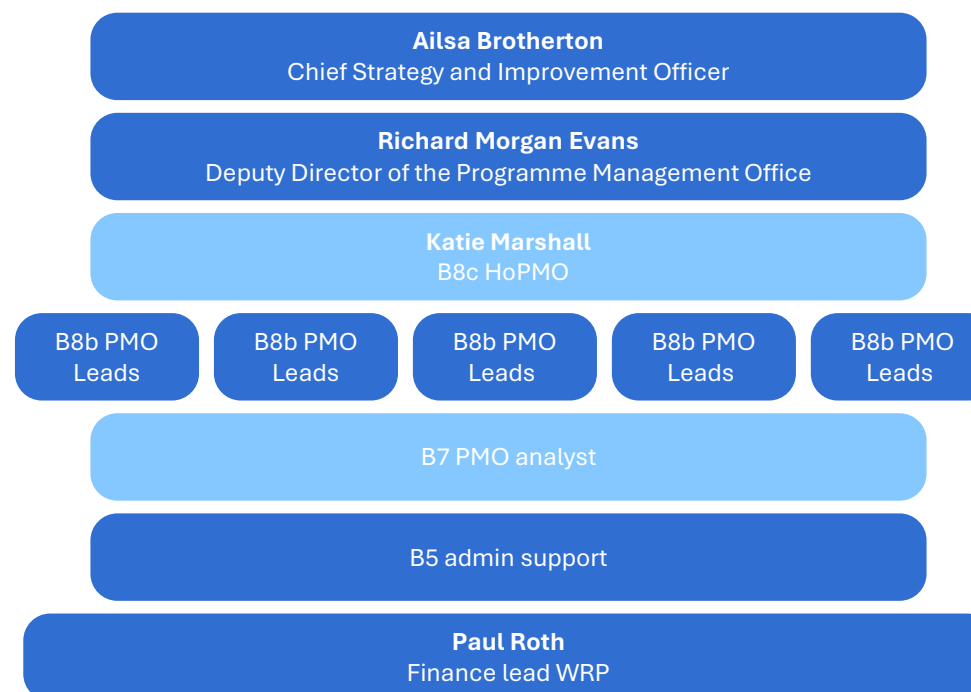
The PMO provides robust governance, data-driven insight and challenge, maintaining the single source of truth for WRP performance and enabling informed executive decision-making.

Divisional & Theme Support

Lead the coordination between operational, clinical and finance leads to support PID development. Provide continued support and delivery support for schemes to unblock issues and drive delivery of savings opportunities.

Overall Strategy

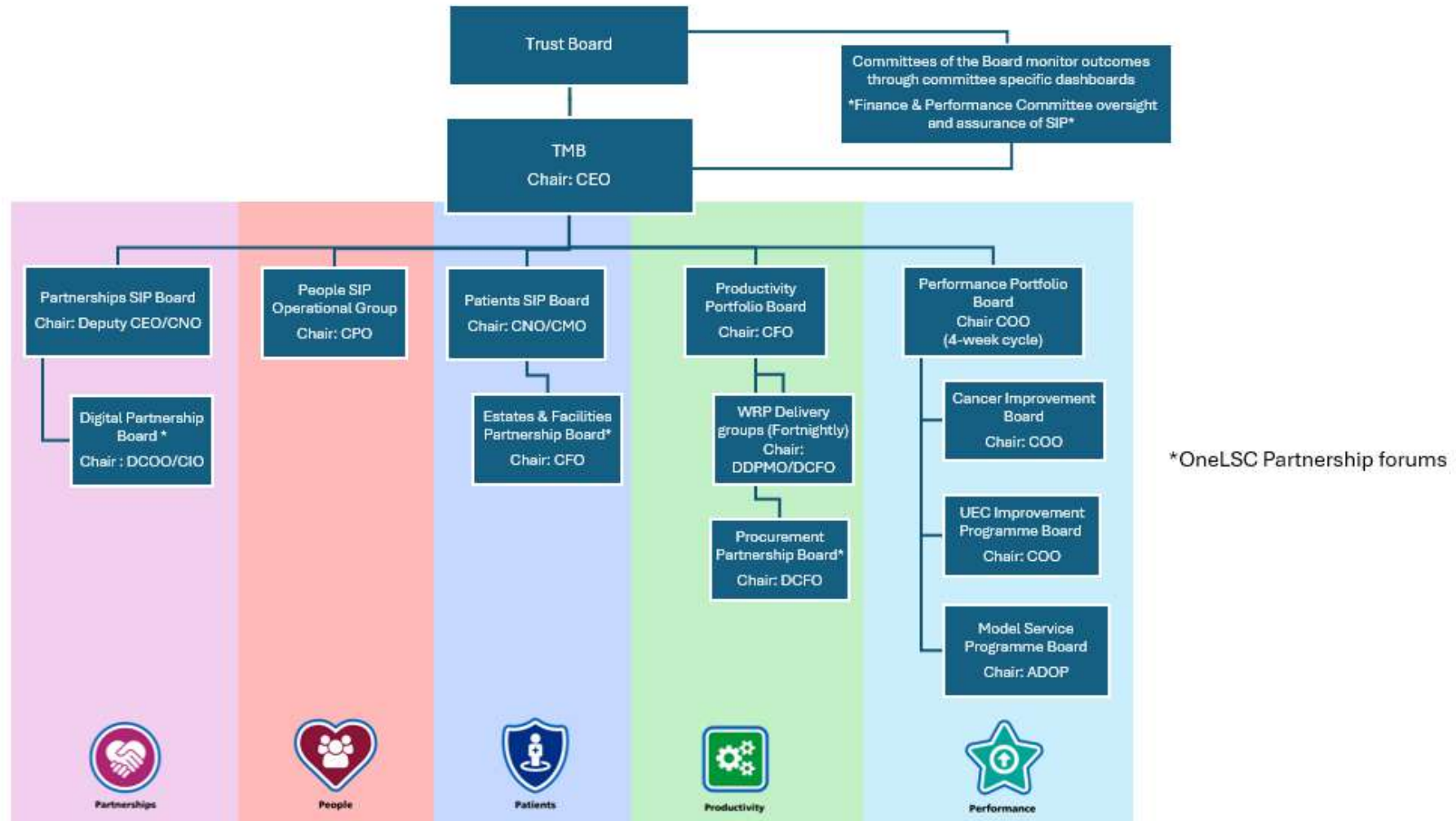
Through disciplined governance, reliable reporting and proactive support, the PMO underpins the Trust's financial recovery by ensuring credible plans and consistent delivery against targets.



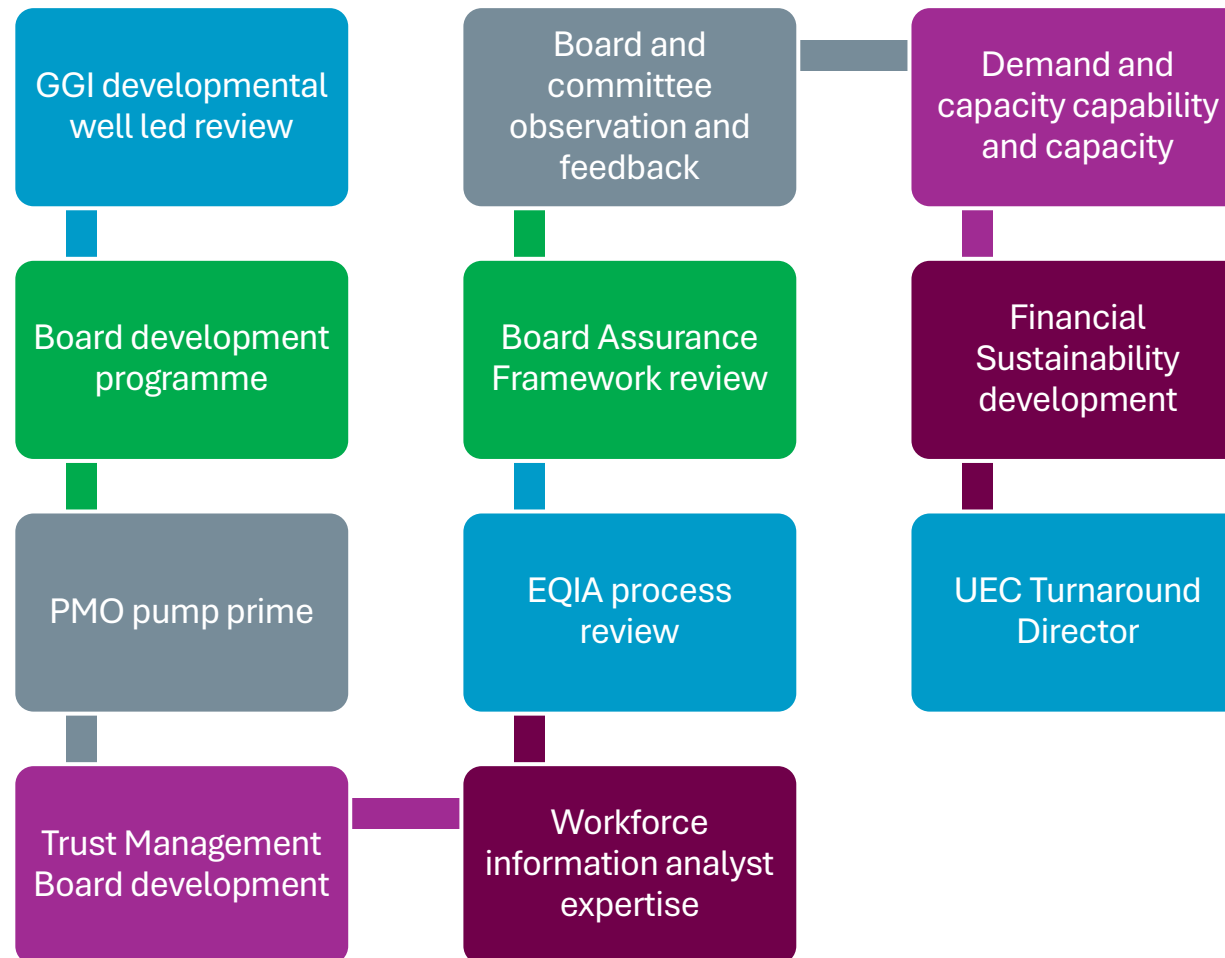


Proposed governance structure 2627 | Board assurance framework to monitor SIP and WRP delivery by portfolio

*Meetings are monthly unless otherwise stated



RSP Governance and Leadership Support 25/26



The Recovery Support Team input has enabled a number of assurance activities, alongside building capacity and capability in the organisation, building confidence in the governance arrangements and creating structures that will facilitate robust oversight, monitoring and management of delivery and risk management.

Achievement of RSP Exit Criteria: self-assessment

Finance Exit Criteria	
1.1 Deliver the financial plan submitted and agreed in April 2025 and the Waste Reduction Programme savings in May 2025	Partially achieved
1.2 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.	Partially Achieved
1.3 Delivery against key expenditure categories as outlined in the financial plan and WRP	Partially Achieved
1.4 A reduction in whole time equivalent (WTE) staffing as agreed in the WRP	Partially Achieved
1.5 Continued reduction in staff sickness absence rates, particularly long-term	Achieved
1.6 Delivery of One LSC objectives as outlined in the financial plan/WRP	Partially Achieved
1.7 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	Achieved (just awaiting final contract)
2.1 Deliver a quarter on quarter run rate improvement throughout 2025/26. Achieved overall	Achieved (overall)
2.2 Robust expenditure controls in line with PwC recommendations	Achieved
3 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 (final version to be approved at Board then shared with IAG)	Achieved

Leadership and Governance Exit Criteria	
4.1 Executive participation in the Recovery Support Team (RST) well led governance reviews	Achieved
4.2 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.	Achieved
4.3 Evidence of completion of a Board development programme	Achieved
4.4 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	Achieved
4.5 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	Achieved
4.6 Demonstrable assurance that any risk to quality and patient safety through the delivery of CIP's is mitigated	Achieved

Recovery and Support Programme Exit Criteria	
5.1 Engagement with the Turnaround Director and associated support executive team and response to requested actions including monthly reporting, financial planning and specific project deliverables	Achieved
5.2 Timely and accurate reporting of financial data	Achieved

Finance

1. Deliver the financial plan submitted and agreed in April 2025 and the Waste Reduction Programme savings in May 2025
2. Deliver a quarter on quarter run rate improvement throughout 2025/26.
3. Develop a medium term financial recovery plan covering the period post 2025/26

1.1 Deliver the financial plan submitted and agreed in April 2025 and the Waste Reduction Programme savings in May 2025

- Financial Plan 2025/26 – break-even plan £90m deficit supported by £60m WRP programme and £30m deficit support funding
- Financial position as at March 2026 – forecast deficit £13.7m
- WRP Plan £60m in year forecast delivery £37m, exit run rate £38m.
- Further detail relating to performance against the financial plan and associated WRP performance can be found within slides 4 and 5.

1.2 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.

The forecast in year savings delivery as at month 11 WRP reporting is £37.1m. Month 11 delivered £3.99m against a full plan of £7.5m). The YTD under-delivery against full plan stands at £18.5m. The total in-year WRP delivery at M11 is £36.4m.

The breakdown of this in year savings plan is listed below, grouped by theme area. This includes a M11 focus as well as a plan vs forecast comparison.

	Theme	M11 YTD Plan £	M11 Act £	M11 YTD Variance £	In Year Plan £	Total FOT	FOT vs. Plan
Workforce	Workforce-Medical	£2,021,353	£1,019,897	-£1,001,456	£2,275,927	£1,131,326	-£1,144,602
	Workforce-Clinical non-medical	£6,328,517	£2,947,868	-£3,380,649	£7,353,813	£3,459,185	-£3,894,628
	Workforce-Other	£7,165,813	£4,231,983	-£2,933,830	£8,377,368	£4,363,075	-£4,014,293
Operational	Outpatients	£2,519,761	£796,964	-£1,722,798	£2,942,183	£868,453	-£2,073,729
	Diagnostics	£779,660	£230,462	-£549,198	£932,252	£254,162	-£678,090
	UEC - Care Connections	£0	£0	£0	£0	£0	£0
	UEC - Days kept away	£0	£0	£0	£0	£0	£0
	UEC - Divisional	£120,979	£144,150	£23,171	£137,585	£144,150	£6,565
	Capacity Reduction	£7,364,774	£4,335,739	-£3,029,035	£8,384,219	£4,779,864	-£3,604,355
	Pharmacy	£3,045,373	£2,268,536	-£776,837	£3,362,345	£2,480,789	-£881,556
	Divisional schemes	£4,241,354	£4,728,836	£487,482	£4,807,011	£5,068,656	£261,645
	Procurement	£10,429,538	£1,563,590	-£8,865,947	£11,993,420	£2,335,578	-£9,657,842
Back office	Grip & Control	£2,579,522	£8,962,162	£6,382,640	£2,830,775	£9,109,536	£6,278,761
	Estates & Facilities	£1,272,773	£724,319	-£548,454	£1,413,817	£830,238	-£583,580
	One LSC Finance	£751,929	£350,352	-£401,578	£902,315	£399,835	-£502,480
System	Strategic Cost Reduction	£3,953,704	£1,722,419	-£2,231,285	£4,614,016	£1,882,376	-£2,731,640
	Total	£52,575,050	£34,027,276	-£18,547,774	£60,327,045	£37,107,221	-£23,219,824

1.3 Delivery against key expenditure categories as outlined in the financial plan and WRP.

£m	FY24/25 Actuals						FY25/26 Actuals											FY25/26		
	M7	M8	M9	M10	M11	2 (normal)	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	YTD Plan	YTD Act	YTD Var
Income	78.4	68.6	65.4	67.1	64.9	72.8	68.8	68.9	71.0	74.1	69.9	70.7	73.9	68.9	71.2	68.7	70.6	779.9	776.7	(3.2)
Pay	(56.4)	(48.1)	(47.8)	(45.4)	(46.4)	(45.6)	(48.9)	(48.8)	(48.4)	(50.1)	(48.4)	(47.9)	(48.4)	(48.9)	(48.6)	(47.6)	(47.7)	(511.4)	(533.7)	(22.3)
Non Pay	(25.3)	(24.5)	(22.7)	(25.8)	(23.7)	(26.9)	(24.2)	(24.3)	(24.4)	(23.8)	(23.7)	(22.9)	(25.5)	(24.3)	(24.6)	(21.0)	(26.9)	(261.9)	(265.7)	(3.8)
Non Operating Items	(0.6)	(0.8)	(0.9)	(0.9)	(0.9)	1.0	(0.7)	(0.8)	(0.7)	(0.7)	(0.7)	(0.7)	(0.8)	(0.7)	(0.7)	(0.8)	(0.8)	(8.2)	(8.2)	0.0
Total Surplus / Deficit	(3.9)	(4.7)	(6.1)	(5.1)	(6.2)	1.3	(5.0)	(4.9)	(2.5)	(0.6)	(3.0)	(0.9)	(0.8)	(5.1)	(2.7)	(0.6)	(4.7)	(1.5)	(30.9)	(29.3)
Less: DSF	0.0	0.0	0.0	0.0	0.0	0.0	(2.5)	(2.5)	(2.5)	(2.5)	(2.5)	(2.5)	(2.5)	0.0	0.0	0.0	0.0	(27.5)	(17.5)	10.0
Less: WSF	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0	0.0	0.0
Total Surplus / Deficit - (WSF + DSF)	(3.9)	(4.7)	(6.1)	(5.1)	(6.2)	1.3	(7.5)	(7.4)	(5.0)	(3.1)	(5.5)	(3.4)	(3.3)	(5.1)	(2.7)	(0.6)	(4.7)	(29.0)	(48.4)	(19.3)

At the end of February, the Trust is behind plan by £29.3m. £20m of the negative variance relates to under delivery of the WRP. The impact of the withdrawal of DSF funding from the ICB at month 11 is £10m, the Trust has had local operational pressures of £2.6m, Strike £1.2m net benefit supported by release of technical flexibility £2.1m.

The Month 11 position vs the Month 10 forecast was on plan. There are however variances between income and non-pay which offset. This is due to an increase in non-clinical income received, which in the main is offset by non-pay expenditure.

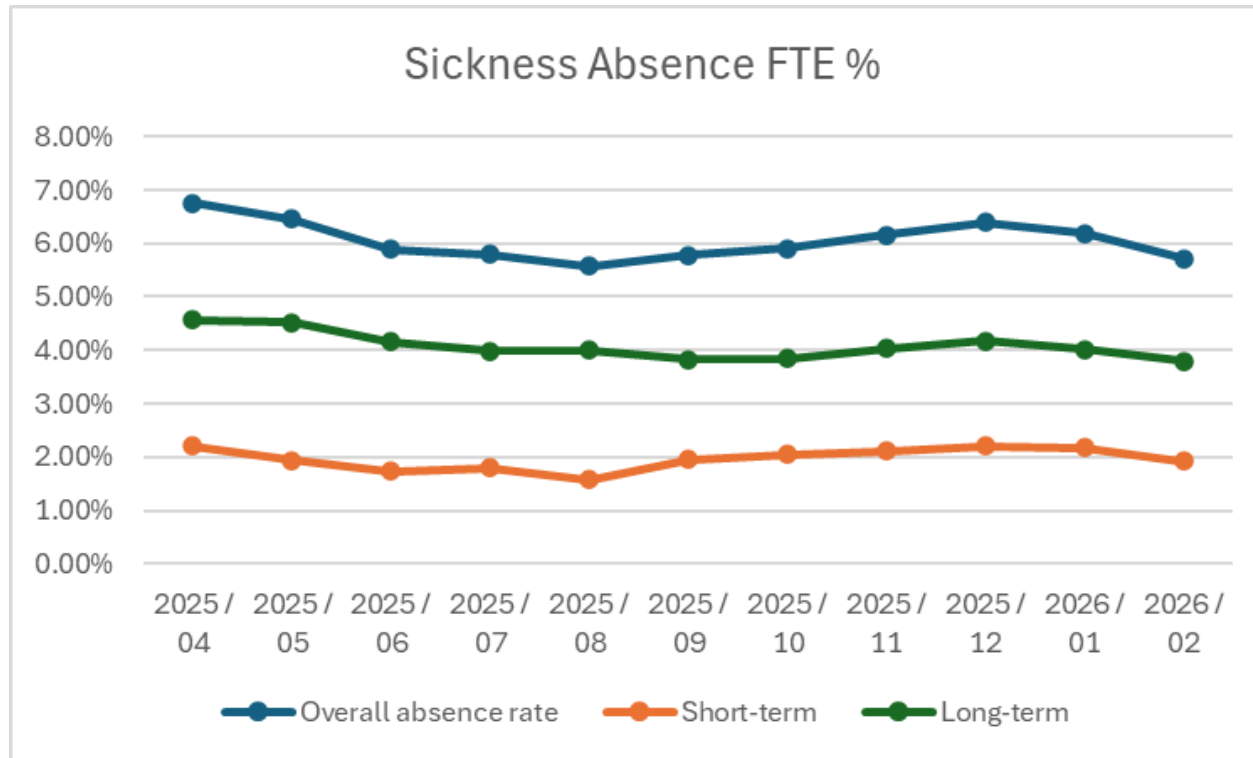
I&E	In Month			In Month Forecast		
	Plan	Actual	Variance	Forecast	Actual	Variance
	£m's			£m's		
Income	70.9	70.6	(0.2)	68.1	70.6	2.5
Pay	(45.4)	(47.7)	(2.3)	(47.7)	(47.7)	(0.1)
Non Pay	(24.8)	(27.6)	(2.8)	(25.1)	(27.6)	(2.5)
Total	0.7	(4.7)	(5.4)	(4.7)	(4.7)	(0.0)

1.4 A reduction in whole time equivalent (WTE) staffing as agreed in the WRP

Workforce (WTE)	FY24/25						FY25/26											
	M7	M8	M9	M10	M11	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Actual Substantive	8,967	8,957	8,906	8,908	8,897	8,860	8,810	8,770	8,722	8,689	8,691	8,712	8,747	8,735	8,706	8,715	8,722	
Planned Substantive	8,974	8,961	8,952	8,935	8,932	8,889	8,906	8,822	8,864	8,767	8,884	8,905	8,904	8,910	8,903	8,909	8,913	8,601
Actual Bank	742	664	687	737	689	801	643	685	647	678	671	624	623	615	574	614	590	
Planned Bank	627	612	602	582	619	639	638	637	633	602	599	599	551	551	550	550	549	554
Actual Agency	58	46	52	62	57	67	61	56	51	43	37	35	20	19	18	15	18	
Planned Agency	67	67	65	63	57	54	54	54	54	42	42	42	42	42	42	42	42	42
Total Actual	9,767	9,667	9,645	9,708	9,651	9,728	9,514	9,512	9,420	9,411	9,399	9,371	9,391	9,368	9,298	9,344	9,330	
Total Planned	9,668	9,640	9,619	9,580	9,608	9,581	9,597	9,513	9,552	9,411	9,526	9,546	9,497	9,503	9,495	9,501	9,504	9,197
Re-forecasted Plan	-	-	-	-	-	-	9,509	9,459	9,459	9,420	9,411	9,468	9,455	9,350	9,240	9,130	9,020	8,910

- Overall headcount reduction delivered in 25/26 is 184 WTE (to month 11)
- The substantive headcount reduction achieved since month 1 is 88 WTE (M1 – 8810 WTE to M11 8722)
- The remaining headcount reduction has been delivered through reductions in temporary staffing usage. Over the last 12 months, we have achieved:
 - 70% reduction in agency WTE (from 61 WTE month 1 to usage of 18 WTE in month 11)
 - 14% reduction in bank WTE (compared with month 11 in 24/25)
- Transfer of staff into LTH in 25/25 is 15.4 WTE increase (M4 – NWAS 4.6 WTE, M5 – Dietetics 6.8 WTE and M7 – Mellors 4 WTE)
- There have been no transfers out of staff to other organisations in this financial year, however from 1st April 2026 the following transfers out are to be transacted: 368 WTE for 1LSC (TUPE October 2024).
- The 762.68 WTE (TUPE March 2026) for Estates and Facilities remains in our workforce plan at present. There is a further 553 WTE due to transfer into the Trust for Pathology Collaboration from 1st April 2026, however at present the WTE remains in wider 1LSC respective Trusts headcount.

1.5 Continued reduction in staff sickness absence rates, particularly long-term



- Overall sickness absence rate has reduced in 2025/26 with the **M11 position of 5.71%** significantly lower than 7.47% in M11 2024/25
- Anticipated annualised rate for 2025/26 will be approx. **0.5% reduction on 2024/25**
- National benchmarking data published M9 2025/26. Our **average** sickness absence rate of **5.98% for M1 to M9**, compares to:
 - National average – 5.23%
 - NW average – 6.09%
 - L&SC average – 6.52%
- When compared to NW acute trusts over the same period, LTH ranks 13th out of 23 trusts.
- Particular progress has been made in reducing long-term absence (M1 - 4.56%, M11 – 3.79%), through targeted focus on absence duration. M1 – 74 cases >4 months, M11 – 45 cases
- Key enablers include rapid improvement workshops, divisional engagement, new Attendance Management policy and continued expansion of wellbeing offer

1.7 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.

- Outcome of the Kingsgate report owned by ICB
- Commissioning intentions do not currently reflect vertical integration, discussions positive in this direction
- In the interim, close working with LSCFT on areas of community and agreed priority areas of Frailty, 2 hour UCR, Single point of access
- Successful partnership on reprovision of Longridge and agreement to explore broadening specification within cost envelope
- Exploring formal mechanism of joint working
- National frailty improvement programme early adopter site
- Demand management mitigations were included in our plans round Unwarranted Variation in Referrals, Single Point of Access and Headache / Migraine Pathway changes which we accepted the 'High' confidence in delivery / implementation. (Y1: -£0.9m, Y2: -£1.5m, Y3: -£0.9m – total -£3.3m reduction over MTP)
- UEC demand management was also included in plans using the 'Low' confidence in delivery / implementation at -£1.6m impact.
- Trust led UEC improvement programme to stabilise ED and ambulance performance and improve patient flow
- Supporting work around Neighbourhood Health Centre development to support Left Shift agenda

2.1 Deliver quarter on quarter run rate improvement throughout 2025/26

FY25/26 QoQ Metrics Tracker - LTH

Key

Favourable

Adverse

NHS

Lancashire and South Cumbria Integrated Care Board

£m	FY 25/26										
	Q1		Q2			Q3			Q4 (Draft)		
	Plan	Act	Plan	Act	Q2 vs Q1	Plan	Act	Q3 vs Q2	Plan	Act	Q4 vs Q3
0. Reported run rate		(12.4)		(4.5)	7.9		(8.6)	(4.1)		11.9	20.5
1. Normalised Run-Rate		(20.0)		(13.6)	6.4		(15.2)	(1.6)		Not yet available	
2. Expenditure	213.7	219.0	209.5	216.8	(2.2)	209.9	220.4	3.5	207.0	Not yet available	
3. Pay	140.8	146.1	142.2	146.4	0.3	136.2	145.9	(0.5)	136.4	Not yet available	
4. Waste Reduction Programme	3.6	3.6	12.8	10.4	6.8	21.1	10.4	(0.0)	22.8	13.2	2.8
5. WTE	9,459	9,420	9,468	9,371	(48.6)	9,240	9,298	(73.2)	8,910	Not yet available	

Commentary

Normalised run rate – the main increase in Q3 from Q2 is non-pay of which £2.4m is pass through drugs and devices and other drugs and clinical supplies, note clinical income is not normalised for seasonal case mix and working days and this has distorted the quarterly position.

Expenditure – the increase between Q2 and Q3 is non-pay of which £3.9m is pass through drugs and devices and other drugs and clinical supplies (variable income increased by £1.9m), £0.5m is seasonal utilities there are reductions in non-pay other.

Pay – there was an increase in bank in Q2 likely to be associated with the holiday period.

WRP – scheme delivery has plateaued as schemes have got progressively more difficult to implement due to the nature of the schemes / themes planned to deliver in later quarters, e.g. Service Reviews. However, some of these schemes / themes have been moved to 2026/27 and will be developed and monitored through the 2026/27 Waste Reduction Programme.

The Trust has delivered a significant reduction in exit run rate from £65.8m in 24/25 to £51.7m in 25/26.

This demonstrates an improvement in the overall financial run rate position between the years after taking into account £17m net inflation pressures.

There was however variation between quarters

2.2 Robust expenditure controls in line with PwC recommendations

PWC G&C Action Plan

- In Q3 2025/26 the Trust undertook intensive activities to update the PWC G&C action plan. This was reported to Trust Management Board in November 2025.
- Of the 110 G&C actions (96 / 87%) were deemed to have adequate controls in place with no further action.
- Of the remaining 14 G&C actions, 11 have subsequent actions and a further 3 were stood down due not being applicable.

MIAA (internal audit) G&C Actions

- In Q3 2025/26 the MIAA (internal audit) carried out a review of our PWC G&C checklist and some of our pay controls.
- The objective of the audit was to review and assess the processes and progress being made by the Trust in response to the recommendations raised in the PWC Grip and Control report. The audit focused on the overarching governance arrangements and a small sample of pay controls.
- The audit report was issued in December 2025 it concluded that “the Trust has recently significantly enhanced its pay expenditure control environment, and this has resulted in measurable improvements such as reductions in overtime of 65% since April 2024, as well as in agency usage of 50%”.
- It further noted that “the approvals process for pay expenditure is strong, and of the panels that we observed, check and challenge of resourcing requests is robust”.

Grip & Control Amalgamated Action Plan

- The table shows progress towards the PWC G&C actions and the MIAA G&C actions.
- All MIAA internal audit actions have been closed, with evidence provided and accepted by MIAA.
- Intensive activities are ongoing to ensure that all actions are complete with appropriate evidence.
- This will be monitored within the Productivity SIP portfolio during 2026/2027 led by CFO.

	Status
G&C Action Plan - March 2025 Report (LTH)	11
Awaiting evidence	4
Ongoing	7
G&C Response Review Assignment Report 2025/26 (MIAA)	11
Closed	11
Grand Total	22

3. 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

The Trust is operating with an underlying deficit, driven by rising workforce costs, inflationary pressures, and activity growth that outpaces available funding. Despite one-off mitigations, these factors have created a structural gap between income and expenditure. Without a credible plan, we risk continued reliance on temporary national support, heightened regulatory scrutiny, and reduced ability to invest in future service development.

This Financial Sustainability Plan (FSP) is essential to:

- Address the underlying cost base rather than relying on non-recurrent fixes.
- Release efficiencies that improve productivity and value for money.
- Enable us to continue to meet the needs of our population within the financial envelope set for our system.
- Demonstrate to NHS England and our system partners that we can take ownership of our financial position, building confidence in the Trust’s governance and leadership.
- Provide a clear rallying point for all 8,718 substantive staff, aligning the organisation around a shared focus on financial improvement over the coming years.

Our approach will be underpinned by:

- **Strong clinical engagement and leadership** - clinicians at the centre of pathway redesign and productivity improvement.
- **System alignment** - working with Lancashire and South Cumbria ICB and neighbouring providers to avoid duplication and share resources.
- **Robust governance** - clear accountability through a Waste Recovery Programme Board, with progress monitored monthly against agreed milestones and benefits.
- **Culture change** - embedding a “value mindset” where all staff understand their role in sustainability and service transformation.

LTH Summary		2025/26	2026/27	2027/28	2028/29	2029/30	2030/31
		£m	£m	£m	£m	£m	£m
Underlying	Forecast outturn Month 10 - risk adjusted WRP £41.8m with estates scheme	(9.2)	(51.7)	(9.2)	0.0	0.0	0.0
	Deficit Support Funding	(30.0)					
	Historic deficit repayment	4.1					
	Non-recurrent efficiencies incl estates scheme	(21.0)					
	FYE efficiencies - to deliver £38m of £60 target	8.6					
	Impact of Industrial Action	1.8					
	Non-recurrent operational pressures	6.9					
	Non-recurrent mitigations	(6.1)					
	Industrial action funding	(3.0)					
	FYE 2025/26 local pressures	(3.8)					
Underlying Position before inflation		(51.7)	(51.7)	(9.2)	0.0	0.0	0.0
Inflation	Cost inflation		(16.3)	(16.7)	(16.7)	(16.7)	(16.7)
	Income inflation		0.2	0.0	0.0	0.0	0.0
	Underlying Position after inflation	(51.7)	(67.7)	(25.9)	(16.6)	(16.6)	(16.7)
New year pressures	Growth to meet performance standards - income		17.7	33.7	4.6	0.0	0.0
	Growth to meet performance standards - expenditure		(17.7)	(33.7)	(4.6)		
	Convergence 0.2% 2026/27 rising to 0.5%		(0.9)	(3.3)	(3.3)	(3.3)	(3.3)
	Historic Deficit Repayment		0.0	(4.0)			
	Specialist funding from national deficit support monies		7.5				
	Commissioner balance to 2.5%		(2.4)				
	Service developments funded by commissioners - income		13.3				
	Service developments funded by commissioners - expenditure		(13.3)				
	CNST Premium increase net of national inflation above		(2.1)	(2.1)	(2.1)	(2.1)	(2.1)
	Local pressures		(3.5)	(3.5)	(3.5)	(3.5)	(3.5)
Underlying Position for year before WRP		(51.7)	(69.2)	(38.8)	(25.6)	(25.6)	(25.6)
WRP	Target Efficiency		60.0	38.8	25.6	25.6	25.6
	Underlying Position for year after WRP		(9.2)	0.0	0.0	0.0	0.0
DSF	National Deficit Support Funding		9.2	0.0	0.0	0.0	0.0
Operating surplus/(deficit) for system monitoring		(51.7)	0.0	0.0	0.0	0.0	0.0

Learning from 25/26 - working differently in 2026/27 to ensure delivery

- **Board-owned, Single improvement plan year 2**
 - Aligned to new Trust strategy, communicated through the organisation the focus of improvement for the year.
 - Underpinning governance and oversight of the plan transitioning to Trust Management Board to ensure delivery at pace.
 - Recognition of the need to create capacity to deliver the work at pace required.
- **Focused recovery of constitutional standards**
 - Targeted delivery of RTT, diagnostics, cancer and UEC standards, underpinned by improved capacity modelling and realistic trajectories.
 - UEC improvement Director appointed
 - Arrangements strengthened to facilitate increased Executive focus on performance. .
- **WRP planning**
 - The WRP themes have been identified from the FSP and aligned to Executive leads
 - Planning commenced much earlier so we now >£35m on the tracker
 - Divisional delivery groups are in place (fortnightly) to ensure Executives have oversight of delivery
 - From 2026/27 planning of WRP schemes will be a rolling quarterly programme
- **Digital redesign**
 - 3 specific transformation programmes focused on a reduction in WTE and analogue to digital transformation
- **Clinician-led pathway redesign**
 - Redesign of high-impact pathways (including frailty, UEC and electives) to reduce length of stay, variation and avoidable delays.
 - Internal focus on productivity, increased articulation/expectation of data informed focus .
 - ICB support to progress vertical integration.
- **Sustainable productivity and workforce redesign**
 - Shift from short-term mitigations to recurrent productivity and waste reduction, with workforce aligned to redesigned pathways and safety-critical roles protected.
- **Barriers and limitations insights**
 - Focused response to the insights ensuring focus on high impact areas

Leadership and Governance

4. Demonstrate effective financial and organisational governance structures and mechanisms.

4.1 Executive participation in the Recovery Support Team (RST) well led governance reviews

- GGI Development well led review completed
- Action plan overview below with 16 amber actions outstanding, completion date set at 30 September 2026
- To ensure oversight the outstanding actions are incorporated into the SIP portfolios as indicated below

Quality Statement	Number of actions	Actions delivered	Actions outstanding	Detail	SIP Portfolio – Exec Lead
Shared Direction and Culture	18	11	1	1. Communicate FSP once finalised	Productivity - CFO
Capable, compassionate and inclusive leadership	16	13	3	2. Enhance arrangements on NED safety visits to close the loop on feedback. 3. Consider Board to Board meetings with system partners. 4. Address obstacles for staff accessing professional development.	People - CPO
Freedom to Speak Up	8	7	1	5. Publicise examples of changes as a result of speaking up as a mechanism to promote.	People - CPO
Governance, management and sustainability	14	10	4	6. Review planned for ETR and workforce committee 7. TMB development will include writing for assurance development. 8. Ancillary pack approach to be rolled out to committees of the Board. 9. Awaiting national guidance on governor role in foundation trusts.	Governance and Risk SIP – Enabler to all portfolios - DCEO
Partnerships and communities	9	7	2	10. Health improvement plan actions to be identified within each portfolio of the SIP. 11. Stakeholder map in draft, to finalise.	Partnerships - DCEO
Learning, improvement and innovation	10	6	4	12. Deliver psychological safety training for PSIRF. 13. Complete roll out of 'being fair' in Trust policy and procedures. 14. Improve feedback to people reporting incidents. 15. Branding of the Lancashire Improvement Method.	Learning & Improvement SIP – Enabler to all portfolios - DCEO
Environmental sustainability	5	4	1	16. Green plan actions to be identified within each portfolio of the SIP	Partnerships - DCEO
Total	80	58	16		

4.2 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.

- The GGI review undertaken in July 2025 was agreed as the mechanism to review this.
- Action plan overview on slide 15.
- Agreed with RSP team.

4.3 Evidence of completion of a Board development programme

- Board Development programme commissioned with Healthskills and under way for 2026/27.
- Plot the dots session and Integrated Performance report review completed - 2025
- Insightful Provider Board Self Assessment completed - March 2026
- Dr Aidan Fowler, National Director of Patient Safety NHS England developmental session completed – 2026
- Application submitted to NHS England to be front runner for NHS England Board development programme
- There was a significant refresh of Board membership in February 2025. This new Board was required to coalesce as a team very quickly (a process that usually happens over months and years). The Board development allowed for the new Board to develop an understanding of how each member worked, thereby building the trust required for a high performing Board in a very short timescale. This in turn allowed for a transparent and open debate to take place, and for Board members to focus fully on the issues before it rather than using time gradually to test networks and relationships.
- The Board has used the learning from this development in the last 12 months, incorporating constructive and positive feedback to undertake the insightful board self assessment as part of the Board development programme.
- The RSP team have continued to provide feedback, this has been responded to and there is evidence this has been implemented in practice. Eg recent session where reflections from the Curious Board data session were discussed and applied within the Safety and Quality committee.

4.4 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

- Review of the BAF undertaken by NHS England – appropriate assurance framework confirmed
- Subcommittee observed by RSP team 25/26 and feedback provided and acted upon
- Risk management structure in place with Risk Management Group chaired by CEO
- Triple A reporting structures in place
- Corporate Objectives agreed in Feb 26 used to create the revised BAF, following Board workshops and finalised corporate objectives and BAF in Board April 2026.

4.5 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

- Executive appointment of the Chief Financial Officer conducted in line with requirements.
 - Executive appointment of the Chief Medical Officer conducted in line with requirements
 - There have been no other executive appointments.
-
- NHSE agreed vacancy extension of 3 years for Non-Executive Directors

4.6 Demonstrable assurance that any risk to quality and patient safety through the delivery of CIP's is mitigated

- Equality Quality Impact Assessment policy update July 2025
- Quarterly reports on COB to Safety and Quality Committee
- Reporting enhanced to include transformation programmes, vacancy control posts and rejected schemes where the impact on safety and quality has been demonstrated through the EQIA process, reporting also includes the list of schemes.
 - e.g Neurosurgery Occupational therapy
 - Surgical and gynaecology bed reductions
- Evidence of reversal of schemes when tested and impact established.
 - e.g women's and children administrative reduction

Recovery Support Programme

5. Full participation in the Recovery Support Programme

5.1 Engagement with the Turnaround Director and associated support executive team and response to requested actions including monthly reporting, financial planning and specific project deliverables

External Support

- Commencement of RSP Programme – Present - RSP Improvement Director and allocated team members
- Engagement with PwC from commencement of the RSP
- Support provided through RSP funding – CSU team, additional posts

Internal Turnaround Directors

- 12 March 2025 – 23 December 2025 - Financial Turnaround Director in position
- 10 March 2026 – 31 August 2026 - UEC Improvement Director appointed

5.2 Timely and accurate reporting of financial data

- a) Standard One LSC financial template and National PFR sent monthly on working day 10 to PWC
- b) Monthly Finance and Performance Committee Report
- c) Monthly IAG slides
- d) Budget holder statements
- e) Financial reporting free from material error as confirmed by external audit (2025/26 not yet audited)

Appendix

- Performance
- Summary of the Evidence

There were no specific performance RSP exit criteria but a summary of key performance metrics have been included

Performance against 25/26 Operational Standards

Measure	25/26 Operational Plan	RTF/Sprint Revised target	April 25 Start position	March 26 performance	Target delivery
RTT Waiting List Size	52,150	58,263	61,521	FOT ~69,000	N
RTT 18 week performance	62.5%	6.1%	54.8%	FOT 60%	Y
RTT 52 week performance	2.5%	1.9%	2.7% (1467)	FOT 1.5% (<980)	Y
RTT 65 week performance	Zero by March 26	Zero by March 26	17	0	Y
Cancer 62 Day	75%		53.1%	FOT 74.6%	N
Cancer FDS	80%		77.8%	FOT 83.7%	Y
DM01	65%		63.2%	FOT 62.3%	N
UEC 4 hour	78%		70.58%	72.18%	N
UEC 12 hour	8.2%		13.47%	12.71%	N

LTH Recovery Support Programme Exit Criteria Evidence 2025/2026



Criteria theme	Ref	Exit criteria	Evidence required	Evidence submitted	Ongoing monitoring arrangements	Executive Lead
Finance	1.	Deliver the financial plan submitted and agreed in April 2025 and the Waste Reduction Programme savings in May 2025	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.	Monthly reporting pack to IAG, FPC and WFC on WRP and WTE reduction plans showing development in year and transparent communication to committees of the Board. IAG pack (s)	During 26/27 monitoring of WRP will continue via CEO chaired board and reported monthly to Finance & Performance Committee. Improvement Director is now in post for 2026/27 to focus support to Urgent & Emergency Care. CEO has requested Improvement Director recovery plan to be submitted by 17/04/26. This will be monitored via the UEC Steering Group during 2026/2027, next occurrence due 16/04/26.	Craig Carter Chief Finance Officer
			Delivery against key expenditure categories as outlined in the financial plan and WRP.	FPC Finance papers (s) WRP Development - April 2026.pdf WRP FPC papers(s) FPC Chairs report(s)		
			A reduction in whole time equivalent (WTE) staffing as agreed in the WRP and continued reduction in long-term staff sickness rates.	WFC minutes re WTE WFC Chairs report(s)		
			Delivery of OneLSC objectives as outlined in the financial plan/WRP.	Plans submitted in line with NHSE requirements and reflects requirements to deliver performance and financial outcomes.		
			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.	Kingsgate review will be considered as part of the UEC Improvement Director recovery and support plan.		
				- Internal and external discharge models will also be tested as part of UEC improvement direct portfolio. - LTH now has a seat on Better Care Fund group, and is better able to influence decision making, decision making ultimately sits with the ICB.		

Criteria theme	Ref	Exit criteria	Evidence required	Evidence submitted	Ongoing monitoring arrangements	Executive Lead
Finance	2.	Deliver quarter-on-quarter run rate improvement throughout 2025/26.	The organisation will deliver a quarter on quarter run rate throughout 2025/26.	Monthly reporting pack to IAG and FPC on financial position showing development in year and transparent communication to committees of the Board. IAG pack (s) FPC Finance papers (s) FPC chairs/minutes as previously shared item 1.	During 26/27 monitoring of WRP will continue via CEO chaired board and reported monthly to Finance & Performance Committee.	Craig Carter Chief Finance Officer
			Robust expenditure controls in line with PwC recommendations.	Reporting to FPC on Grip and Control showing development in year and transparent communication to committees of the Board articulating gaps and plans to improve. FPC Grip & Control paper Grip & Control action plan LTH MIAA Grip and Control Outstanding Actions Mar-26.pdf	During 26/27 monitoring of the G&C action plan will be via SIP Productivity portfolio which is reported monthly to the CEO chaired SIP Oversight Board. This will also be reported quarterly to Finance & Performance Committee.	Craig Carter Chief Finance Officer
Finance	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.	Reporting to FPC on Financial Sustainability planning showing development in year and transparent communication to committees of the Board articulating long term planning and areas of opportunity. Financial Sustainability Plan (draft) FPC and Trust Board minutes re FSP 20260413 FSP Communications and Engagement plan DRAFT V0.2.pdf	The FSP is currently draft with final version to be confirmed on acceptance of national medium term plan submission. During 26/27 monitoring of year 1 FSP will be via SIP Productivity portfolio which is reported monthly to the CEO chaired SIP Oversight Board.	Craig Carter Chief Finance Officer

Criteria theme	Ref	Exit criteria	Evidence required	Evidence submitted	Ongoing monitoring arrangements	Executive Lead
Leadership & Governance	4.	Demonstrate effective financial and organisational governance structures and mechanisms.	Executive participation in the Recovery Support Team (RST) well led governance reviews.	The GGI review was undertaken in July 2025. This provided a gap analysis to target areas of good controls and areas of improvement required. A full action plan was then enacted.	Outstanding actions from the GGI review will be embedded into SIP 26/27. This will be monitored via the CEO chaired SIP Oversight Board.	Sarah Morrison Deputy Chief Executive/ Jennifer Foote Director of Corporate Affairs
			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.	GGI full board report GGI report to Board and Action Plan Trust Board minutes re GGI report Good Governance Institute (GGI) action plan		
			Evidence of completion of a Board development programme.	- Board Development programme commissioned with health skills and under way for 26/27. - Plot the dots session completed - 2025 - Aiden Fowler developmental session completed – 2026 - Insightful Provider Board Self Assessment completed- March 2026 - Application submitted to NHS England to be front runner for NHS England Board development programme	Monitoring of the Board Development Plan will be via monthly report to CEO chaired Executive Management Group. Following this a completion report will be submitted to the Trust Board.	Jennifer Foote Director of Corporate Affairs
				Board Development workshop contents Board and Workshop attendance		

Criteria theme	Ref	Exit criteria	Evidence required	Evidence submitted	Ongoing monitoring arrangements	Executive Lead
Leadership & Governance	4.	Demonstrate effective financial and organisational governance structures and mechanisms.	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.	- Review of the BAF undertaken by NHS England – Appropriate assurance framework confirmed - Subcommittee observed by RSP team 25/26 and feedback provided and acted upon - Risk management Structure in place with Risk management committee chaired by CEO - Triple A reporting structures in place - Corporate Objectives agreed in Feb 26 used to create the revised BAF, following Board workshops and finalised corporate objectives and BAF in Board April 2026. Trust Board and Workshop minutes re BAF and principle risks Board Workshop - Risk Training, BAF, Appetite and Tolerance Board Assurance Framework Report (BAF) Policy for delivering the oversight and accountability framework Risk Management Policy	Monitored via CEO chaired Risk Management Group and reported to Trust Board	Ailsa Brotherton Chief Strategy & Improvement Officer
			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.	- Executive appointment of the Chief Financial Officer and Chief Medical Officer conducted in line with requirements. - There have been no other executive appointments.		Jennifer Foote Director of Corporate Affairs Silas Nicholls Chief Executive Officer

Criteria theme	Ref	Exit criteria	Evidence required	Evidence submitted	Ongoing monitoring arrangements	Executive Lead
Leadership & Governance	4.	Demonstrate effective financial and organisational governance structures and mechanisms.	Demonstrable assurance that any risk to quality and patient safety through the delivery of CIP's is mitigated.	- Equality Quality Impact Assessment policy update July 2025 - Quarterly reports to Safety and Quality Committee - Reporting enhanced to include EQIAs specific to large scale change programmes shared to committee for visibility and VETO activity also includes the list of schemes. - Quarterly reporting to SQC shows transparent communication on progress of EQIA policy development and EQIA transaction to show adherence to policy and escalation of any relevant EQIAs to committee. EQIA policy RSP assessment and feedback SQC EQIA Paper (s) SQC Chairs report(s)	During 2026/2027 EQIA will continue to be monitored via quarterly reports to Safety & Quality committee	Sarah Morrison Chief Nursing Officer
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.	- Completed as required during 2025/2026 IAG Pack (s) as previously included - Completed as required during 2025/2026. - Turnaround Director was appointed and in post to focus support on Finance Recovery and WRP during 2025/2026. - Turnaround Director engagement evidence in IAG attendance and reporting. - Engagement with RSP team during 2025/2026	Improvement Director is now in post for 2026/27 to support broader portfolio and focus support to Urgent & Emergency Care. CEO has requested Improvement Director recovery plan to be submitted by 17/04/26. This will be monitored via the UEC Steering Group during 2026/2027.	Silas Nicholls Chief Executive Officer Sarah Morrison Deputy Chief Executive Silas Nicholls Chief Executive Officer

Criteria theme	Ref	Exit criteria	Evidence required	Evidence submitted	Ongoing monitoring arrangements	Executive Lead
Recovery Support Programme	5.	Full participation in the Recovery Support Programme	Timely and accurate reporting of financial data.	Completed as required during 2025/2026		Craig Carter
			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.	- PMO established from May 2025, during 2025/2026 interim support from PWC and the TU were in place whilst the PMO is transitioning to full establishment. PMO substantive structure chart 2026/2027 - PMO is the vehicle providing oversight of delivery across the SIP as well as priority focus on WRP delivery. 2526 SIP outline, 2627 SIP outline and monthly reporting to sub-board committees showing transparent communication on delivery, data metric position and risks associated to the programmes within the SIP. Single Improvement Plan 2025/2026 overview structure with aligned SROs Draft Single Improvement Plan Scope and Structure 2026/20267 SIP FPC paper(s) - FPC chairs report as previously shared	PMO substantial recruitment to be completed by Q1 2026/2027 and cease interim support Draft SIP is due to be finalised during April-26 Trust Management Board. During 2026/2027 monitoring of the SIP is via the CEO chaired SIP Oversight Board. This will continue to be reported monthly to Finance & Performance Committee.	Ailsa Brotherton Chief Strategy & Improvement Officer Sarah Morrison Deputy Chief Executive

13.3 ASSURANCE COMMITTEE REALIGNMENT REPORT

● Decision Item

REFERENCES

Only PDFs are attached



13.3 Assurance Committee Realignment Report Appendices Board Part I 4 June 26.pdf

LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST

SAFETY AND QUALITY COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

- 1.1 The Board of Directors hereby resolves to establish a Committee of the Board, to be known as the Safety and Quality Committee (hereinafter referred to as 'the Committee'). The Committee is a non-executive body and therefore has no executive powers, save as may be expressly provided within these terms of reference.
- 1.2 In these terms of reference:
- i. "Board" means the Board of Directors as specified in the Trust's Constitution
 - ii. "director" means those directors appointed to the Board by virtue of paragraph 12.2 of the Trust's Constitution
 - iii. "member" refers to a member of the Committee as specified at paragraph 4.1 of these terms of reference

2. PURPOSE

- 2.1 The overall purpose of the Committee is to promote and lead a safety and quality strategy that continues to improve and maintain an 'Always Safety First' culture in which staff are supported and empowered to improve services and care.
- 2.2 Specifically, the Committee shall:
- i. monitor performance delivery of the Trust-wide safety and quality metrics within the any strategic or forward plan and associated sub-measures as defined by the Always Safety First Strategy;
 - ii. provide the Board of Directors with assurance on the effectiveness of the safety and quality performance management framework and that the patient experience and outcomes of care are optimised by:
 - ensuring that adequate structure, processes and controls are in place to promote safety and excellence in the standards of care and treatment;
 - monitoring performance against agreed safety and quality metrics, identifying and understanding significant variation and ensuring appropriate and effective response on all services the Trust provides;
 - monitoring performance and progress in respect of contractual quality schedules directly and indirectly including those services contracted out to third parties monitoring performance and progress in respect of the quality improvement programme and ensuring compliance with CQC standards and regulatory frameworks; and

- monitoring performance and progress in respect of the Quality Improvement Programme and ensuring compliance with CQC standards and regulatory frameworks.

3. RESPONSIBILITIES

- 3.1 To co-ordinate delivery of the Trust's Quality Accounts in line with national guidance and present to the Board of Directors.
- 3.2 To confirm that the Trust considers and, where appropriate, implements recommendations and guidance from external bodies and national enquiries.
- 3.3 To ensure that internal and external assurance programmes are in place in response to published standards, internal and external reviews, audits and surveys.
- 3.4 To ensure that clinical audit activity as described within the forward plan is relevant and comprehensive.
- 3.5 To monitor compliance with the plan and to review performance against nationally recognised clinical standards as demonstrated through national and local clinical audit reports.
- 3.6 To ensure appropriate responses to NICE and other external bodies including commissioning benchmarking exercises as required.
- 3.7 To confirm that appropriate action is taken in response to adverse clinical incidents, complaints and litigation.
- 3.8 To promote and ensure sharing of lessons learned and dissemination of good practice.
- 3.9 To gain assurance that action plans developed to control identified strategic and operational quality and safety risks are fit for purpose.
- 3.10 To receive Chair reports from the subgroups set out in paragraph 3.14 below in respect of areas of identified concern, seeking assurance that robust actions have been identified to address/resolve these issues/concerns.
- 3.11 To inform the Board of Directors where it has significant concerns about standards of care and treatment within the Trust or where it considers any service (or part of it) to be unsafe by use of the risk escalation process contained within the Chair's report.
- 3.12 To ensure due regard is given to the views of Trust governors, members and stakeholders and there is appropriate involvement in safety and quality programmes via the Council of Governors.
- 3.13 To provide oversight of any relevant programmes/projects set out in the Trust's Planning Framework.
- 3.14 To review and gain assurance that the Trust's obligations with respect to health & safety are met and that there are robust plans in place to address any identified weakness (including the approval of remedial action plans).

- 3.15 To commission, receive and review performance reports and improvement plans from internal oversight groups as may be determined from time to time.
- 3.16 Consider the control and mitigation of strategic and operational high risks related to the business of the committee, and provide assurance to the Board that such risks are being effectively controlled and managed as part of the Board Assurance Framework

4. COMPOSITION AND CONDUCT OF THE COMMITTEE

- 4.1 Membership shall comprise up to four non-executive directors (one of whom shall be chair) and three voting executive directors.
- 4.2 Such officers of the Trust shall attend as required by the Committee for the furtherance of its business. Only members of the Committee shall be permitted to vote.
- 4.3 **Quorum:** Three members including at least two non-executive directors and one executive director.
- 4.4 **Frequency of meetings:** The Committee will, as a minimum, meet 10 times per year
- 4.5 **Support:** The meeting shall be supported by the Corporate Affairs Team

5. DELEGATED AUTHORITY

- 5.1 As an assurance committee, the committee shall have no authority delegated to it by the Board for decision making but shall be able to recommend to the Board the approval of items or a course of action as the occasion may arise.

6. RELATIONSHIP WITH THE BOARD/REPORTING ARRANGEMENTS

- 6.1 The Committee will report in writing to the Board through its minutes and Chair's report the basis for its recommendations. The Board will use that report as the basis for its decisions but shall remain accountable for taking the decision.

7. REVIEW

- 7.1 The Committee effectiveness and performance will be reviewed as part of the annual Board effectiveness review.
- 7.2 The terms of reference shall be reviewed every three years, or sooner should the need arise.

LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST

FINANCE AND PERFORMANCE COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

- 1.1 The Board of Directors hereby resolves to establish a Committee of the Board, to be known as the Finance and Performance Committee (herein referred to as “the Committee”). The Committee is a non-executive body and therefore has no executive powers, save as may be expressly provided within these terms of reference.
- 1.2 In these terms of reference:
- i. “the Board means the Board of Directors as specified in the Trust’s Constitution
 - ii. “director” means those directors appointed to the Board by virtue of paragraph 12.2 of the Trust’s Constitution.
 - iii. “member” refers to a member of the Committee as specified at paragraph 3.1 of these terms of reference.

2. PURPOSE

- 2.1 The overall purpose of the Committee is to obtain assurance on behalf of the Board in respect of operational and workforce performance, financial performance and planning processes, in particular that the Trust’s financial and operational plans are viable and that relevant risks have been identified and mitigated. The Committee will also seek assurance on the effectiveness of the Trust’s key processes and key controls as relevant to the Committee’s responsibilities.
- 2.2 Consider the control and mitigation of strategic and operational high risks related to the business of the committee, and provide assurance to the Board that such risks are being effectively controlled and managed as part of the Board Assurance Framework.
- 2.3 Specifically, the Committee shall:

Operational performance

- i. Monitor and review the Trust’s operational performance against national and local standards and seek assurance on mitigations where activity has deviated from plan.
- ii. Monitor agreed activity plans and seek mitigations where there is an adverse variance or a negative trajectory.
- iii. Provide assurance that operational performance reporting is robust.
- iv. Monitor and review procurement effectiveness including the supplier net promotor scores.

Workforce performance

- i. Monitor and review the Trust's workforce performance metrics against national and local standards and seek assurance on mitigations where activity has deviated from plan.
- ii. Monitor agreed activity plans and seek mitigations where there is an adverse variance or a negative trajectory.
- iii. Provide assurance on workforce data key performance indicators and that workforce performance reporting is robust.

Financial performance

- i. Monitor the Trust's performance in relation to financial benchmarks, metrics and targets (as they may be set both internally and externally). Seek assurance on the mitigations where performance is off track.
- ii. Monitor the delivery of capital programme expenditure.
- iii. Monitor delivery of cost improvement programmes (productivity and efficiency savings) and seek assurance on variances from plan and relevant recovery actions.
- iv. Review the cash flow forecasts, liquidity position and aged debt position of the Trust.
- v. Assess the financial implications of performance against the Trust's principal contracts.
- vi. Assess any proposed borrowing arrangements and make appropriate recommendations to the Board.

Strategy, Planning and Change Delivery

- i. Monitor and oversee the effectiveness of the Trust's planning processes and annual business plan supported by:
 - a. Reviewing the effectiveness of the Trust's activity planning methodology (approach to planning).
 - b. Oversee the preparation and negotiation of annual contracts with commissioners.
 - c. Oversee overall contract performance and assurance of contract fulfilment
- ii. Annual review of the Trust's annual financial plan and ensure that key assumptions are both realistic and explicit.
- iii. In line with the annualised planning processes, undertake a specialty-based review, including derogations, contractual performance of commissioned service.
- iv. Monitor and oversee the effectiveness of the Trust's planning framework (quarterly).
- v. Monitor and oversee the effectiveness of the specific aligned programmes from the planning framework to seek assurance they remain on track to achieve their stated outcomes.
- vi. Act as a point of escalation and assurance on aligned programmes within the planning framework.
- vii. Emergency Preparedness, Resilience and Response – monitor and gain assurance on the Trust's business continuity plans to recover and sustain key services in the event of an emergency.
- viii. Oversee digital security risks planning and performance.
- ix. Oversee information governance planning and performance.

Governance and compliance

- i. Review the robustness of the Trust's key processes and key controls in relation to the aligned metrics of the Committee.
- ii. Oversee and monitor compliance with NHSE/I oversight framework.
- iii. Oversee the strategic risk profile aligned to Committee along with any escalated

operational risks to ensure they remain relevant to current threats and that mitigations are adequate (quarterly).

- iv. Monitor progress against the agreed risk mitigations ensuring they address the identified gaps in assurance and control.
- v. Commission deep dive reviews for any metrics within the Committee's remit to seek additional assurance when needed.
- vi. Refer appropriate risk matters to the Audit Committee for their due consideration.

2. COMPOSITION AND CONDUCT OF THE COMMITTEE

- 2.1 Membership shall comprise up to four non-executive directors (one as Chair) and up to three voting executive directors. :
- 2.2 Such officers of the Trust shall attend as required by the Committee for the furtherance of its business, including an expectation of attendance of representatives of operational areas of the Trust. Only members of the Committee shall be permitted to vote.
- 2.3 **Quorum:** Three members, at least two non-executive directors and at least one executive director
- 2.4 **Frequency of meetings:** The Committee will, as a minimum, meet ten times per year.
- 2.5 **Support:** The meeting shall be supported by the Corporate Affairs Team

3. DELEGATED AUTHORITY

- 3.1 As an assurance committee, the committee shall have no authority delegated to it by the Board for decision making but shall be able to recommend to the Board the approval of items or a course of action as the occasion may arise.

4. RELATIONSHIP WITH THE BOARD/REPORTING ARRANGEMENTS

- 4.1 The Committee will report in writing to the Board the basis for its recommendations. The Board will use that report as the basis for its decisions but shall remain accountable for taking the decision.

5. REVIEW

- 5.1 The Committee effectiveness and performance will be reviewed as part of the annual Board effectiveness review.
- 5.2 The terms of reference shall be reviewed every three years, or sooner should the need arise.

LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST

PEOPLE AND PARTNERSHIPS COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

- 1.1 The Board of Directors hereby resolves to establish a Committee of the Board, to be known as the People and Partnerships Committee ("the Committee). The Committee is a non-executive Committee of the Board and has no executive powers, other than those specifically delegated within these terms of reference.

2. REMIT AND FUNCTIONS OF THE COMMITTEE

- 2.1 The Committee is established to:
- oversee the development and implementation of the workforce and organisational development strategy for the organisation
 - review human resources policies and procedures relating to contractual or legislative changes on behalf of the Board of Directors and recommend any revisions to the Board.
 - provide assurance to the Board on the development, implementation and review of the Trust's workforce and organisational development strategy and workforce plan in order to support service improvement and to meet the needs of patients, staff, regulators and commissioners
 - develop strategic workforce recommendations for approval by the Board
 - give consideration to the strategic direction and funding plans for the Trust in relation to research, education and training and make recommendations to the Board on these matters.
- 2.2 Consider the control and mitigation of strategic and operational high risks related to the business of the committee, and provide assurance to the Board that such risks are being effectively controlled and managed as part of the Board Assurance Framework
- 2.3 The main functions of the Committee are to:
- i. Contribute to the development of an effective workforce and organisational development strategy and to make appropriate recommendations to the Board for approval
 - ii. Receive assurance on behalf of the Board that the Trust's workforce and organisational development strategy and related policies satisfy relevant national, regional and organisational requirements.
 - iii. Consider the control and mitigation of workforce-related risks as identified in the Board assurance framework and provide assurance to the Board that such risks are being effectively controlled and managed
 - iv. Obtain assurances that the Trust's workforce plan supports the development aims of the organisation through the identification of an appropriate workforce model and development plan

- v. Consider proposals on all research and development activity in the Trust together with national and local priorities to guide activities in relation to education and training and research and development
- vi. Receive summary reports and action plans in relation to quality assurance reports from external bodies on behalf of the Board, and to escalate any matters that may need to be brought to the attention of the Board of Directors
- vii. Inform the strategic and funding plans for education, research and training activity in line with service development.
- viii. Review educational performance within the operational delivery of the Trust's service, ensuring that activity complies with relevant statutory and regulatory frameworks and guidance.
- ix. Receive Chair reports from subgroups (as may be established from time to time) in respect of areas of identified concern, seeking assurance that robust actions have been identified to address/resolve these issues/concerns.

3. COMPOSITION AND CONDUCT OF THE COMMITTEE

- 3.1 Membership shall comprise up to four non-executive directors (one as Chair) and up to three voting executive directors.
- 3.2 Such officers of the Trust shall attend as required by the Committee for the furtherance of its business. Only members of the Committee shall be permitted to vote.
- 3.3 **Quorum:** Three members, at least two non-executive directors and at least one executive director.
- 3.4 **Frequency of meetings:** The Committee will normally meet six times a year.
- 3.5 **Support:** The meeting shall be supported by the Corporate Affairs Team

4. DELEGATED AUTHORITY

- 4.1.1 As an assurance committee, the committee shall have no authority delegated to it by the Board for decision making but shall be able to recommend to the Board the approval of items or a course of action as the occasion may arise.

5. RELATIONSHIP WITH THE BOARD OF DIRECTORS AND ITS COMMITTEES

- 5.1 The Committee will report in writing to the Board of Directors the basis for its recommendations. The Board of Directors will use that report as the basis for their decisions but will remain accountable for taking the decision.

6. REVIEW

- 6.1 The Committee effectiveness and performance will be reviewed as part of the annual Board effectiveness review.
- 6.2 The terms of reference shall be reviewed every three years, or sooner should the need arise..

LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST

REMUNERATION COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

- 1.1 The Remuneration Committee ("the Committee") is constituted as a standing Committee of the Board of Directors ("the Board").
- 1.2 The Committee is authorised by the Board to act within its terms of reference. All members of staff are directed to cooperate with any request made by the Committee.
- 1.3 The Committee is authorised by the Board to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.
- 1.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.
- 1.5 When appointing the Chief Executive, the Committee shall be the Committee described in schedule 7, paragraph 17(3) of the National Health Service Act 2006 ("the 2006 Act"). When appointing the other executive directors, the Committee shall be the Committee described in schedule 7, paragraph 17(4) of the 2006 Act.

2. PURPOSE

- 2.1 The Committee shall be responsible for identifying and appointing candidates to fill all the executive director positions on the Board, and also for those posts designated as very senior managers (VSM) posts ("the vsm posts"), and for determining their remuneration and other conditions of service.
- 2.2 The Committee shall be responsible for approving the establishment and/or agreement to enter into a contract of employment with any post determined as very senior manager (VSM) for any service hosted by the Trust but shall not otherwise be engaged in the appointment process for hosted VSM posts.
- 2.3 The Committee shall be responsible for ongoing review of the performance and remuneration of executive directors and senior staff appointed by the Committee as detailed in section 6 below.

3. RECRUITMENT AND APPOINTMENTS

- 3.1 The Committee shall:
 - 3.1.1 Agree those posts which will be designated vsm posts.

- 3.1.2 give full consideration to succession planning for the Chief Executive and other executive directors, taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future.
- 3.1.3 be the appointing authority to new vsm posts including the level of remuneration.
- 3.1.4 identifying and appointing candidates to fill posts within its remit (clause 2.1) as and when they arise.
- 3.15 approve the establishment of vsm posts as may be required as part of any hosted, collaborative or system-wide initiative (though this will not extend to the approval of terms and conditions, role specification, candidate requirements, interviewing of candidates and offer of employment).
- 3.1.6 when a vacancy is identified, the Committee shall consider the balance of skills, knowledge and experience on the Board, and its diversity, and in the light of this evaluation approve a description of the role and capabilities required for the particular appointment (such a description having been prepared for the Committee by appropriate persons internal or external with the appropriate level of expertise). In identifying suitable candidates the Committee shall use open advertising or the services of external advisers to facilitate the search; consider candidates from a wide range of backgrounds; and consider candidates on merit against objective criteria.
- 3.1.7 receive a report on a proposed executive director's other significant commitments (if applicable) before appointment and that any changes to their commitments are reported to the Board via the Committee as they arise.
- 3.1.8 consider any matter relating to the continuation in office of any executive director, including the suspension or termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their service contract.

4. REMUNERATION AND TERMS OF EMPLOYMENT

- 4.1 The Committee shall:
 - 4.1.1 Establish and keep under review a remuneration policy in respect of very senior staff.
 - 4.1.2 Consult the Chief Executive about proposals relating to the remuneration of the VSM staff.
 - 4.1.3 Receive a formal report from the Chair on the annual performance of the Chief Executive as part of the annual appraisal process. The report will be used to support decision-making in terms of the annual salary review for the Chief Executive.
 - 4.1.4 Receive a formal report from the Chief Executive on the annual performance of individual executive directors performance as part of the annual appraisal process. The report will be used to support decision-making in terms of the annual salary review for officers identified in section 6 below.

4.1.5 In accordance with all relevant laws, regulations and Trust policies, decide and keep under review the terms and conditions of office of very senior managers, including (without limitation):

4.1.5.1 salary review on an annual basis, including a review of any performance-related pay or bonus

4.1.5.2 other terms and conditions such as benefits (including pensions and cars), allowances, payable expenses and compensation payments.

4.1.6 In adhering to all relevant laws, regulations and Trust policies:

4.1.6.1 establish levels of remuneration which are sufficient to attract, retain and motivate executive directors of the quality and with the skills and experience required to lead the Trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the Trust;

4.1.6.2 use national guidance and market benchmarking analysis in the annual determination of remuneration of executive directors on locally-determined pay, while ensuring that increases are not made where Trust or individual performance do not justify them; and

4.1.6.3 be sensitive to pay and employment conditions elsewhere in the Trust.

4.1.7 Advise upon and oversee contractual arrangements for executive directors, including but not limited to termination payments to avoid rewarding poor performance.

5. MEMBERSHIP

5.1 The membership of the Committee shall consist of all voting Non-Executive Directors.

5.2 The Chair shall Chair the Committee. In his or her absence, the Committee shall be Chaired by the Vice Chair.

5.3 A quorum shall be three non-executive directors, including either the Chair or Vice-Chair.

6. THE EXECUTIVE DIRECTORS

6.1 The voting executive directors of the Trust are:

- Chief Executive
- Chief Finance Officer
- Chief Nursing, Midwifery and AHP Officer
- Chief Medical Officer
- Chief Operating Officer

6.2 The non-voting executive director posts are:

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- Chief People Officer
- Chief Strategy and Improvement Officer
- Director of Communication and Engagement
- Director of Corporate Affairs

7. SUPPORT

- 7.1 The Corporate Affairs Team shall provide support to the Committee.

8. ATTENDANCE

- 8.1 Only members of the Committee, the Chief Executive, the Chief People Officer and the Director of Corporate Affairs have the right to attend Committee meetings.
- 8.2 Other persons may be invited by the Committee to attend a meeting so as to assist in deliberations.
- 8.3 Any non-member will be asked to leave the meeting should their own conditions of employment be the subject of discussion.

9. FREQUENCY OF MEETINGS

- 9.1 Meetings shall be called as required but at least twice in each financial year.

10. MINUTES AND REPORTING

- 10.2 The minutes of meetings will be circulated with the agenda for approval at the next Committee meeting. Due to the nature of the business discussed by the Committee, circulation of the minutes shall be restricted to Committee members and those in attendance. No officer shall receive any minute as it relates to their own employment or post.

11. PERFORMANCE EVALUATION

- 11.1 To be undertaken as part of the Board's annual performance review process.

12. DELEGATED AUTHORITY

- 12.1 The Committee is authorised by the Board to:
- i. investigate any activity within its terms of reference;
 - ii. seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee; and
 - iii. obtain independent professional advice, and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.
 - iv. Make decisions relating to the remuneration, terms and conditions of service of named senior posts as set out in these terms of reference

LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST

CHARITABLE FUNDS COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

- 1.1 Lancashire Teaching Hospitals NHS Foundation Trust is the Corporate Trustee of the group of charitable funds registered with the Charities Commission under the name of Lancashire Teaching Hospitals Charity with the charity registration number 1051194 and under the name of the Rosemere Cancer Foundation Charity with the charity registration number 1131583 (together referred to herein as “the Charities”). The directors of the Corporate Trustee are not Trustees; however, they act on behalf of the Corporate Trustee. The Charities are separate from the Trust and independent of it. The Corporate Trustee can delegate certain powers to agents and/or employees but will always retain the ultimate responsibility for the management of the Charities.
- 1.2 The Board of Directors hereby resolves to establish a Committee of the Board, to be known as the Charitable Funds Committee (hereinafter referred to as “the Committee”). The Committee will oversee the Charities’ operation on behalf of the Corporate Trustee and report directly to it. Its constitution and terms of reference shall be set out below, subject to amendment from time to time.
- 1.3 In these terms of reference:
- i. “Board” means the Board of Directors as specified in the Trust’s Constitution.
 - ii. “Director” means those directors appointed to the Board by virtue of paragraph 12.2 of the Trust’s Constitution.
 - iii. “Member” refers to a member of the Committee as specified at paragraph 3.1 of these terms of reference.

2. PURPOSE

- 2.1 The overall purpose of the Committee is to oversee the operation of the Charities to ensure they are managed and operated in accordance with their governing documents and comply with relevant legislation and guidance from the Charities Commission.
- 2.2 Specifically, the Committee shall:
- i. Determine fundraising strategies for the Charities that are aligned with the Trust’s priorities.
 - ii. Consider any application for the creation of any new fund within the Charities or for any re-designation of monies between funds (where in excess of £30,000).
 - iii. Decide whether donations given with restrictions applied should be accepted by the Charities or whether the Corporate Trustees applies restrictions.

- iv. Receive reports detailing the establishment of new funds and all new staff appointments made from charitable funds.
- v. Receive reports detailing balances of the charitable funds.
- vi. Receive reports on all individual charitable non-pay transactions in excess of £10,000.
- vii. Approve expenditure of all individual charitable non-pay transactions valued £30,000 or more. Where there is an urgent requirement for an order to be placed, the equivalent of a quorum may give approval by email and the decision recorded at the next Committee meeting.
- viii. Review the spending plans and balances held within individual charitable funds.
- ix. Recommend the appointment of Investment Managers to provide investment advice and manage the Charities' investment portfolios.
- x. In conjunction with Investment Managers, agree an investment policy which lays down guidelines in respect of:
 - the balance required between income and capital growth;
 - the balance of risk within the portfolio; and
 - any categories of investment which the Corporate Trustee does not wish to include in the portfolio on ethical grounds.
- xi. Determine a policy for the distribution, or otherwise, of realised and unrealised gains or losses on investments.
- xii. Review the impact on the Charities of changes in legislation both of a charitable and non-charitable nature and make appropriate recommendations to the Trust Board, as Corporate Trustee, as to how any new requirements will be met.
- xiii. Ensure compliance with the Trust's Standing Financial Instructions, Financial Control Procedures and Scheme of Delegation.
- xiv. Receive audit reports on the Charities' controls.
- xv. Review all fundraising developments and existing fundraising efforts.
- xvi. Consider and approve the Charities' annual report and accounts.
- xvii. Review and approve the annual work plan for the Charities.

3. COMPOSITION AND CONDUCT OF THE COMMITTEE

- Membership shall be three Non-Executive Directors and one Executive Director (or their alternate as defined by Standing Orders).

- 3.1 A Non-Executive Director shall be the Chair of the Committee.
- 3.2 **Quorum:** The quorum necessary for the transaction of Committee business shall be three members including at least two non-executive directors and at least one executive director.
- 3.3 **Frequency of meetings:** The Committee will, as a minimum, meet quarterly.
- 3.4 **Administration:** The Committee shall be supported administratively by the Corporate Affairs Team.

4. DELEGATED AUTHORITY

- 4.1 The Committee is authorised by the Board of Directors, for an on behalf of the Corporate Trustee, to:
- i. Instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the exercise of its functions.
 - ii. Obtain such internal information as is necessary and expedient to the fulfilment of its functions.
 - iii. Establish subgroups for specific purposes or appeals and receive relevant Chair's reports.
 - iv. Committee members have delegated powers to ensure that the Charities act within the terms of their governing documents, appropriate legislation, Charities Commission guidance and to provide assurance to the Trust Board that the Charities are properly governed and well-managed across their full range of activities.

5. RELATIONSHIP WITH THE BOARD/REPORTING ARRANGEMENTS

- 5.1 The Committee will report in writing to the Board the basis for its recommendations. The Board will use that report as the basis for its decisions but shall remain accountable for taking the decision.
- 5.2 The Chair of the Committee will present a report to the next ensuing meeting of the Board of Directors summarising the decisions of the Committee.

6. REVIEW

- 6.1 The Committee effectiveness and performance will be reviewed as part of the annual Board effectiveness review.
- 6.2 The terms of reference shall be reviewed every three years, or sooner should the need arise..

LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST

AUDIT COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

- 1.1 In accordance with the Trust's Constitution and as set out in the NHS Foundation Trust Code of Governance, the Board of Directors hereby resolves to establish a Committee of Non-Executive Directors as an Audit Committee.
- 1.2 The Committee is a non-executive Committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.

2. MEMBERSHIP

- 2.1 The Audit Committee of Lancashire Teaching Hospitals NHS Foundation Trust shall consist of at least four of the Non-Executive Directors, not including the Trust Chairman, although he/she can be required to attend meetings where the issues discussed are relevant to the whole Board or to the Chair directly.

3. ATTENDANCE

- 3.1 The Chief Finance Officer, the Director of Corporate Affairs and the Associate Director of Risk and Assurance shall normally attend meetings.
- 3.2 At any time (and in any event at least once per year) the Committee shall meet privately with the External and Internal Auditors without any executive board member present.
- 3.3 Other executive directors will be invited as attendees when appropriate.
- 3.4 Minutes shall be taken by the Corporate Affairs Team.

4. AUTHORITY

- 4.1 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.
- 4.2 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

- 4.3 Where the Audit Committee feels that there is evidence of *ultra vires* transactions, evidence of improper acts or if there are other important matters that the Committee wishes to raise, the Chair of the Committee will raise these at a full meeting of the Board of Directors and, if appropriate, exceptionally to any relevant external agency.

5. DUTIES

- 5.1 The duties of the Committee are as follows:

5.2 Governance, Risk Management and Internal Control

- 5.2.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management (including review of the Trust Risk Register) and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

- 5.2.2 In particular, the Committee will review the adequacy of:

- i. all risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with Care Quality Commission standards), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board
- ii. the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- iii. arrangements for the review of policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements (for the avoidance of doubt, the Committee shall not take primary responsibility for reviewing such policies)
- iv. the policies and procedures for all work related to fraud and corruption as set out in the NHS Standard Contract and as required by NHS Counter Fraud Authority.

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from Directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

- 5.2.3 This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

5.3 Internal Audit

- 5.3.1 The Committee shall ensure that there is an effective internal audit function established by management, which meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- i. Consideration of the provision of the Internal Audit service, the cost of the audit and any questions or resignation and dismissal.

- ii. Review and approval of the Internal Audit and Counter Fraud strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit and counter fraud needs of the organisation as identified in the Assurance Framework.
- iii. Consideration of the major findings of internal audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources.
- iv. Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation.
- v. Annual review of the effectiveness of internal audit.

5.4 External Audit

5.4.1 The Committee shall review the work and findings of the External Auditor appointed by the Council of Governors and consider the implications and management's responses to their work. This will be achieved by:

- i. Consideration of the appointment and performance of the External Auditor.
- ii. Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan.
- iii. Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.
- iv. Review all External Audit reports, including agreement of the annual audit letter before submission to the Board and any work undertaken in addition to the annual Audit Plan, together with the appropriateness of management responses.

5.4.2 At least once in each five-year period, the Committee shall oversee the market-testing of the external audit contract

5.4.3 The Committee shall be responsible for making recommendations in respect of the appointment, re-appointment and removal of the External Auditor.

5.4.4 The Committee shall also prepare and maintain a policy on the supply of non-audit services to the Trust by the External Auditor.

5.5 Clinical Audit

5.5.1 The Committee will receive on an annual basis a written report outlining the progress and completion of actions associated with national, regional and local clinical audits.

5.6 Counter Fraud

5.6.1 The Audit Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. In so doing this the Audit Committee will:

- i. consider the provision of the LCFS service;
- ii. review and approve the annual LCFS work plan;
- iii. review the periodic LCFS status reports; and
- iv. review and approve the annual LCFS report.

5.7 Other assurance functions

- 5.7.1 The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.
- 5.7.2 These will include, but will not be limited to, any reviews by the Department of Health and Social Care (DHSC) Arms' Length Bodies or Regulators/Inspectors, and other appropriate agencies, as well as professional bodies with responsibility for the performance of staff or functions such as the Royal Colleges and relevant accreditation bodies.
- 5.7.3 In addition, the Committee may review the work of other Committees within the organisation, in order to provide relevant assurance to the Audit Committee's own scope of work.

5.8 Management

- 5.8.1 The Committee may request and review reports and positive assurances from Directors and managers on the overall arrangements for governance, risk management and internal control.

5.9 Financial Reporting

- 5.9.1 The Audit Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:
- i. the wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee
 - ii. changes in, and compliance with, accounting policies and practices
 - iii. unadjusted mis-statements in the financial statements
 - iv. significant adjustments resulting from the audit
- 5.9.2 The Committee shall also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

6. QUORUM

- 6.1 A quorum shall be three Non-Executive Directors.

7. FREQUENCY OF MEETINGS

- 7.1 Meetings shall be held not less than four times a year. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

5. RELATIONSHIP WITH THE BOARD OF DIRECTORS AND ITS COMMITTEES

- 5.1 The Committee will report in writing to the Board of Directors the basis for its recommendations. The Board of Directors will use that report as the basis for their decisions but will remain accountable for taking the decision.

6. REVIEW

- 6.1 The Committee effectiveness and performance will be reviewed as part of the annual Board effectiveness review.
- 6.2 The terms of reference shall be reviewed every three years, or sooner should the need arise.

Safety & Quality Committee

Cycle of business

June 2026

Executive Leads: Chief Nursing Officer and Chief Medical Officer

	Presenter	Contact	Purpose	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
STANDING ITEMS															
Review of strategic risk register	Associate Director of Risk and Assurance	Associate Director of Risk and Assurance	Assurance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Items for escalation to the Board or items to/from other sub-committees	Chair	Corporate Affairs Officer	Information	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
QUALITY PERFORMANCE															
Safety and Quality Dashboard including Adult Nurse Inpatient staffing	Chief Nursing Officer	Deputy Chief Nursing Officer	Assurance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Quarterly PSIRF report	Associate Director of Risk and Assurance	Associate Director of Risk and Assurance	Assurance					✓			✓			✓	
Annual PSIRF Report	Associate Director of Risk and Assurance	Associate Director of Risk and Assurance	Assurance		✓										
CQC update	Associate Director of Risk and Assurance	Associate Director of Risk and Assurance	Assurance	✓			✓			✓			✓		

	Presenter	Contact	Purpose	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Staffing Reports: - Children & Young People staffing - Maternity staffing	Chief Nursing Officer	Deputy Chief Nursing Officer	Assurance	✓	✓	✓		✓	✓	✓	✓	✓		✓	✓
Medical Staffing Report: (added 26/09/2025)	Chief Medical Officer	Chief Medical Officer	Assurance						✓						
Annual adult and children safe staffing review (with 6-month update in July)	Chief Nursing Officer	Deputy Chief Nursing Officer	Assurance				✓						✓		
Annual AHP staffing report (and 6 month update)	Associate Director of AHPs	Associate Director of AHPs	Assurance					✓						✓	
Annual AHP Productivity and Quality Report (action 150/25)	Associate Director of AHPs	Associate Director of AHPs	Assurance	✓											
Annual maternity safe staffing review (and 6 month review)	Chief Nursing Officer	Deputy Chief Nursing Officer	Assurance					✓						✓	
Maternity and Neonatal services report	Chief Nursing Officer	Divisional Midwifery and Nursing Director	Assurance		✓		✓		✓		✓		✓		✓

	Presenter	Contact	Purpose	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Responsive reports (<i>reported as necessary</i>): - Patient Experience e.g. Patient surveys/PHSO - Safety (e.g. level 3 reports/STEIS/Never events) - Effectiveness (e.g. Mortality reports) - Safeguarding - Whistleblowing - External Reviews	Associate Director of Risk and Assurance	Associate Director of Risk and Assurance	Assurance												
Annual mortality, LEDER and PMRT report (and 6 monthly review in Dec)	Chief Medical Officer	Associate Director of Safety and Learning	Assurance			✓						✓			
Annual STAR report	Chief Nursing Officer	Deputy Chief Nursing Officer	Assurance				✓								
Clinical Audit and outcome report	Head of Clinical Effectiveness	Head of Safety and Learning	Assurance					✓							✓
Sub-contract monitoring assurance report	Head of Contracts	Head of Contracts	Assurance		✓						✓				
Annual Safeguarding Report	Chief Nursing Officer	Deputy Chief Nursing Officer	Assurance			✓									
Infection Prevention and Control Annual plan Report	Chief Nursing Officer	Director of Infection Prevention and Control	Assurance		✓										

	Presenter	Contact	Purpose	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Equality & Quality Impact Assessment Report	Senior Assistant Finance Director	Senior Assistant Finance Director	Assurance	✓			✓			✓			✓		
Annual Medicines Governance Report (and 6 month update in Dec)	Chief Medical Officer	Chief Pharmacist	Assurance			✓						✓			
Bi-annual Sepsis report	Lead Consultant (Dr C Roberts) Consultant	Deputy Chief Nursing Officer	Assurance					✓						✓	
Pathology annual report	Lead Consultant/ Divisional Director of DCS	Chief Medical Officer	Assurance				✓								
Health Inequalities Update (6 month update, annual goes to Board)	Chief Nursing Officer	Chief Nursing Officer	Assurance		✓										
Continuous Flow and Boarding Updates	Chief Nursing Officer	Chief Nursing Officer	Assurance			✓						✓			
National Inpatient Survey 2024	Chief Nursing Officer	Lead Cancer Nurse	Assurance							✓					

	Presenter	Contact	Purpose	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
National Cancer Patient Experience Survey 2024	Chief Nursing Officer	Associate Director of Patient Experience	Assurance							✓					
Bi-Annual Freedom to Speak Up Report	Deputy Chief People Officer / Kate Holt	Organisational Development & Culture Lead Kate Holt	Assurance		✓						✓				
STRATEGY AND PLANNING															
Annual Patient Experience Report	Deputy Chief Nursing Officer	Deputy Chief Nursing Officer	Assurance		✓										
GOVERNANCE AND COMPLIANCE															
Annual Health and Safety review	Associate Director Safety and Learning	Associate Director of Safety and Learning	Assurance				✓								
Review of cycle of business and terms of reference	Company Secretary	Company Secretary	Information												✓
Central Alert System Assurance Report	Chief Nursing Officer	Associate Director of Safety and Learning	Assurance							✓					
Guardian of Safe Working Report	Guardian of Safe Working Vinod Varughese	Chief Medical Officer	Assurance		✓ Jan-Mar report		✓ April-June report		✓ Annual report		✓ July – Sept report		✓ Oct-Dec report		
Civil Claims annual report	Associate Director of Risk and Assurance	Head of Legal Services (SK-F)	Assurance					✓							

	Presenter	Contact	Purpose	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Annual Quality Account	Associate Director Safety and Learning	Associate Director Safety and Learning	Decision			✓									
Medical Device Assurance report	Director of Estates and Facilities	Director of Estates and Facilities	Assurance			✓						✓			
Restricted Meeting Divisional Improvement Forum Part II Circulated Risks Assurance	Associate Director of Risk and Assurance	Associate Director of Risk and Assurance	Assurance		✓		✓		✓		✓		✓		✓
FEEDER GROUP CHAIRS' REPORTS															
Infection Prevention and Control Group	----	Deputy Chief Nursing Officer	Information	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Safeguarding Board	----	Deputy Chief Nursing Officer	Information	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mortality and End of Life Care Committee	----	Chief Medical Officer	Information	✓		✓		✓		✓		✓		✓	
Medicines Governance Committee	----	Chief Pharmacist	Information	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

	Presenter	Contact	Purpose	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
PSIRF Oversight Panel	----	Associate Director of Safety and Learning	Information	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Patient Experience Involvement Group	----	Deputy Chief Nursing Officer	Information	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Health and Safety Governance	----	Associate Director Safety and Learning	Information	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Health Inequalities Report	----	Business Support Manager	Information	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Raising Concerns Group	----	Freedom to Speak Up Guardian	Information						✓						✓

Finance & Performance Committee

Cycle of business

June 2026

Executive Lead: Chief Finance Officer

	Presenter	Contact	Purpose	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
STANDING ITEMS															
Review of the Strategic Risk Register (Inc Workforce)	Chair/ Executive Lead	Associate Director of Risk and Assurance	Decision	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Items for escalation to the Board or items to/from other sub-committees	Chair	Corporate Affairs Officer	Information	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
OPERATIONAL PERFORMANCE															
Performance assurance progress report	Chief Operating Officer	Head of Business Intelligence	Assurance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Winter Plan Previous Year Review	Chief Operating Officer	Chief Operating Officer	Assurance				✓								
Winter Plan Report	Chief Operating Officer	Chief Operating Officer	Assurance						✓						
EPRR Core Standards Annual Return	Chief Operating Officer	Emergency Preparedness Resilience & Response (EPRR) Manager	Assurance				✓								
Model Service Programme and GIRFT update	Chief Operating Officer / Chief Medical Officer	Deputy Director of PMO / Chief Operating Officer / Chief Medical Officer	Assurance			✓			✓			✓			✓

	Presenter	Contact	Purpose	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
WORKFORCE PERFORMANCE															
Workforce Performance Metrics	Associate Director of Workforce Resourcing & Transformation Kathryn Downey	Associate Director of Workforce Resourcing & Transformation Kathryn Downey	Assurance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Fragile Services Report	Associate Director of Workforce Resourcing & Transformation Kathryn Downey	Associate Director of Workforce Resourcing & Transformation Kathryn Downey	Assurance				✓						✓		
FINANCIAL PERFORMANCE															
Month xx Finance Position and General Finance Update	Chief Finance Officer	Deputy Finance Director	Assurance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Divisional Delivery Group Report	Divisional Director	Chief Finance Officer	Assurance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Service Line Reporting Update	TBC	TBC	Assurance	✓			✓			✓			✓		

	Presenter	Contact	Purpose	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
IAG Update (including actions)	Chief Finance Officer	Chief Finance Officer	Assurance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
OneLSC update (incorporating supplier scores)	Director of Procurement	Director of Procurement	Assurance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Trading Accounts (inc. Deficit Protocol Controls)	Chief Finance Officer	Assistant Finance Director Contracts, Income, Costing.	Information	✓			✓			✓			✓		
Corporate Services Benchmarking	Assistant Finance Director – Financial Advice	Assistant Finance Director – Financial Advice	Information									✓			
Budget Setting	Chief Finance Officer	Deputy Director of Finance	Decision												✓
Contract Performance	Assistant Finance Director Contracts, Income, Costing.	Assistant Finance Director Contracts, Income, Costing.	Information	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Quarterly Grip and Control Update	Chief Finance Officer	Chief Finance Officer	Assurance		✓			✓			✓			✓	
WRP and PMO Update (Inc Workforce)	Deputy Director of PMO	Deputy Director of PMO	Assurance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
STRATEGY AND PLANNING															
SIP Update	Chief Strategy and Improvement Officer	Chief Strategy and Improvement Officer	Assurance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

	Presenter	Contact	Purpose	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Annual Plan, Forward Plan and 3 year financial and operational plan.	Chief Strategy and Improvement Officer	Chief Strategy and Improvement Officer		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Quarterly Green Plan Report (Feb to go to Apr Board and Aug to Oct Board)	Chief Strategy and Improvement Officer	Chief Strategy and Improvement Officer	Decision		✓			✓ Bi-annual			✓			✓ annual	
Estate benchmarking and backlog (incorporating the NIFES survey)	Director of Estates and Facilities	Director of Estates and Facilities	Assurance					✓							
Digital and information strategy and review (OneLSC Update)	Chief Information Officer	Chief Information Officer	Assurance	✓								✓			
Continuous Improvement Annual Report	Chief Strategy and Improvement Officer	Chief Strategy and Improvement Officer	Information	✓											
LHS Ltd Update	Chief Pharmacist	Chief Pharmacist	Assurance			✓			✓			✓			✓
GOVERNANCE AND COMPLIANCE															
Annual review of the cycle of business	Director of Corporate Affairs	Director of Corporate Affairs	Decision												✓
Cyber security update	Chief Information Officer	Head of Technical Services	Information			✓			✓			✓			✓

	Presenter	Contact	Purpose	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Review of draft/updated contractual policies (as required)	Chief People Officer	Head of Workforce Advice	Information		✓		✓		✓		✓		✓		✓
Gender Pay Gap Report	Deputy Chief People Officer	Head of Diversity & OD Amanda Davis	Decision						✓						
Ethnicity Pay Gap Report	Deputy Chief People Officer	Head of Diversity & OD Amanda Davis	Decision						✓						
Disability Pay Gap Report	Deputy Chief People Officer	Head of Diversity & OD Amanda Davis	Decision						✓						
Staff Suspensions Report	Chief People Officer Neil	Chief People Officer	Information				✓				✓				✓
FEEDER GROUP CHAIRS' REPORTS															
Emergency Preparedness, Resilience and Response (EPRR) Committee	----	Deputy Chief Operating Officer	Information	✓			✓			✓			✓		
Information Governance and Records Committee	----	Head of Information Governance	Information			✓			✓				✓		✓
Senior Information Risk Owner/ Asset Information Owner Working Group	----	Head of Information Governance	Information		✓			✓			✓			✓	
Digital and Health Informatics Divisional Board	----	Chief Information Officer	Information	✓				✓				✓			
ELFS Management Board Minutes	----	ELFS Managing Director	Information	✓			✓			✓			✓		
IAG Minutes/summary (as and when received)	----	Chief Finance Officer	Information												
LHS Minutes	----	Chief Pharmacist	Information	✓			✓			✓			✓		

	Presenter	Contact	Purpose	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Temporary Staffing Group	----	Associate Director of Workforce Resourcing &	Information		✓		✓		✓		✓		✓		✓

People & Partnership Committee
Cycle of business
June 2026
Executive Lead: Neil Pease

	Presenter	Contact	Purpose	May	July	September	November	January	March
STANDING ITEMS									
Review of committee owned risk on Board Assurance Framework and Divisional Risk Report (Strategic Risk Register)	Chair	Associate Director Risk and Assurance	Assurance	✓	✓	✓	✓	✓	✓
PERFORMANCE									
People Accountability Oversight Framework Workforce Compliance Metrics	Chief People Officer Neil Pease	Associate Director of Workforce Resourcing & Transformation Kathryn Downey	Assurance	✓	✓	✓	✓	✓	✓
Core skills training report	Deputy Director of Education	Deputy Director of Education	Assurance		✓		✓		✓
Educational Governance Report	Deputy Director of Education	Deputy Director of Education	Assurance	✓		✓		✓	
Apprenticeships Annual Report	Deputy Director of Education	Deputy Director of Education	Assurance	✓					

	Presenter	Contact	Purpose	May	July	September	November	January	March
NHSE Annual Self-Assessment for Placement Providers	Deputy Director of Education	Deputy Director of Education	Decision			✓			
R&I Bi-Annual Financial Assurance Update	Deputy Director of Research & Innovation	Deputy Director of Research & Innovation	Assurance	✓ year end & new forecast			✓ 6 month review		
STRATEGY AND PLANNING									
Research and Innovation Annual Report Strategy	Chief Strategy and Improvement Officer	Head of Research and Innovation	Assurance	✓ (full report)			✓ (interim review)		
SIP – Education	Deputy Director of Education	Deputy Director of Education	Assurance	✓	✓	✓	✓	✓	✓
SIP – Research and Innovation (changed from Quarterly)	Deputy Director of Research & Innovation	Deputy Director of Research & Innovation	Assurance	✓	✓	✓	✓	✓	✓
University Hospital Status Update (changed from Quarterly)	Chief Strategy and Improvement Officer	Deputy Director of Research & Innovation	Assurance	✓		✓		✓	
Edovation annual updates [quarterly review moved to LHS Ltd] (moved from April & Oct)	Chief Strategy and Improvement Officer	Deputy Director of Research & Innovation	Information	✓			✓		
KLS (Knowledge and Library Services) Annual report (moved from Oct)	Library & Knowledge Services Manager	Library & Knowledge Services Manager	Assurance			✓			

	Presenter	Contact	Purpose	May	July	September	November	January	March
TO ATTRACT RECRUIT AND RESOURCE									
OneLSC Biannual – Shared Service Performance Report for LTH	TBC	Michelle Kaye Director of People Services for OneLSC	Assurance					✓	
Health Roster Strategy Report	Associate Director of Workforce Resourcing & Transformation Kathryn Downey	Head of e-Solutions and Temporary Staffing Kathryn Downey	Assurance				✓		
Annual Workforce Plan	Associate Director of Workforce Resourcing & Transformation Kathryn Downey	Associate Director of Workforce Resourcing & Transformation Kathryn Downey and Deputy	Assurance			✓			
Annual Job Planning Report	Associate Director of Workforce Resourcing & Transformation Kathryn Downey	Head of Medical Workforce Lisa Eccles	Assurance		✓				
TO DELIVER A RESPONSIVE, FUTURE FOCUSSED AND ENABLING SERVICE									
Annual Employee Relations Update and Equality Impact of Policies Report <i>to include Workforce Policy Equality Impact Assessment for medical and AFC colleagues</i>	Associate Director of Workforce Business Partnering & Advice Rachel O'Brien	Head of Workforce Advice Laura Chapman	Assurance		✓				
Annual Partnership Update Report	Associate Director of Workforce Business Partnering & Advice Rachel O'Brien	Head of Workforce Advice Laura Chapman	Assurance					✓	
Social Value Strategy Annual Report	Deputy Chief People Officer Louisa Graham	Deputy Chief People Officer Louisa Graham	Decision	✓					

	Presenter	Contact	Purpose	May	July	September	November	January	March
TO BE INCLUSIVE AND SUPPORTIVE									
Annual Health and Well-being Strategy Report	Associate Director of Workforce Business Partnering & Advice Rachel O'Brien	Head of Health & Wellbeing Lindsey Wharrie	Assurance		✓				
Bi-annual Violence and Aggression report	Associate Director of Workforce Business Partnering & Advice Rachel O'Brien	Associate Director of Workforce Business Partnering & Advice Rachel O'Brien	Assurance			✓			✓
Annual Equality, Diversity and Inclusion Strategy Report	Deputy Chief People Officer Louisa Graham	Amanda Davis Head of EDI and Organisational Development	Decision					✓	
TO BE WELL LED									
Annual Leadership Development Strategy Report	Deputy Chief People Officer Louisa Graham	Leadership & OD Manager Paul Tremain	Assurance				✓		
Annual Appraisal and Talent Management Report	Deputy Chief People Officer Louisa Graham	Deputy Chief People Officer Louisa Graham	Assurance	✓					
Appraisal, Revalidation and Medical Governance annual report	Deputy Medical Director & Professional Standards Lead	Medical Workforce Revalidation & Appraisal Manager Debbie Kellet	Assurance		✓				
TO CREATE A POSITIVE ORGANISATIONAL CULTURE									
Annual Culture Strategy Report	Deputy Chief People Officer Louisa Graham	Head of Culture and FTSU Kate Holt	Assurance			✓			

	Presenter	Contact	Purpose	May	July	September	November	January	March
Biannual Freedom to Speak Up Report	Deputy Chief People Officer Louisa Graham	Head of Culture and FTSU Kate Holt	Assurance	✓			✓		
TO ENGAGE, RETAIN, REWARD AND RECOGNISE									
Staff survey report and action plan	Deputy Chief People Officer Louisa Graham	Head of OD Programmes Samantha Kenny	Information and Assurance	✓				✓	✓
Engagement and Recognition Strategic Aim Update Report	Deputy Chief People Officer Louisa Graham	Head of OD Programmes Samantha Kenny	Assurance				✓		
Annual Onboarding and Retention Strategy Report	Deputy Chief People Officer Louisa Graham	Head of OD Programmes Samantha Kenny	Assurance			✓			
GOVERNANCE AND COMPLIANCE									
Review Cycle of Business	Chair	Company Secretary	Information	✓					
Workforce Disability Equality Standard (WDES) Return	Deputy Chief People Officer Louisa Graham	Head of Diversity & OD Amanda Davis	Decision	✓					
Workforce Racial Equality Standard (WRES) Return	Deputy Chief People Officer Louisa Graham	Head of Diversity & OD Amanda Davis	Decision	✓					
Strategic Risk Register Review	Associate Director of Risk & Assurance	Associate Director of Risk & Assurance	Decision	✓	✓	✓	✓	✓	✓
Items for escalation to the Board or items to/from other Committees	Chair	Corporate Affairs Officer	Information	✓	✓	✓	✓	✓	✓

	Presenter	Contact	Purpose	May	July	September	November	January	March
Annual income and expenditure accounts (education and training) (moved from Aug)	Senior Financial Business Partner	Deputy Director of Education & Senior Finance Business	Decision			✓			
NIHR CRF annual report and feedback	Chief Strategy and Improvement Officer	Head of Research and Innovation	Information					✓	
CHAIR'S REPORTS FROM FEEDER GROUPS/WORKSTREAMS									
Social Value Delivery Group	----	Deputy Chief People Officer Louisa Graham	Information			✓			✓
Training Compliance & Assurance Committee	Deputy Director of Education	Deputy Director of Education	Information	✓	✓	✓	✓	✓	✓
Education Governance and Risk Sub-Committee	Deputy Director of Education	Deputy Director of Education	Information	✓	✓	✓	✓	✓	✓
Education Finance & Performance Sub-Committee	Deputy Director of Education	Deputy Director of Education	Information	✓	✓	✓	✓	✓	✓
Research and Innovation Sub-Committee	Head of Research and Innovation	Head of Research and Innovation	Information	✓	✓	✓	✓	✓	✓

Committee	Productivity and Performance Committee	Patients Committee	Audit Committee	People and Partnerships Committee	Charitable Funds Committee	Remuneration Committee
Quorum	2 NEDs, 1 Exec	2 NEDs, 1 Exec	3 NEDs	2 NEDs, 1 Exec (voting or non-voting)	2 NEDs, 1 Exec	3 NEDs, inc Chair or Vice Chair
NED	John Schorah	Karen Deeny	Tim Wheeler	StJohn Crean	Tim Ballard	Mike Thomas or Adrian Leather
	Adrian Leather	Tim Ballard	Karen Deeny	Tim Ballard	Tim Wheeler	All voting NEDs
	Uzair Patel	John Schorah	John Schorah	Adrian Leather	Uzair Patel	
	Karen Deeny	tbc	Uzair Patel	Tim Wheeler		
Exec	Craig Carter	Sarah Morrison		Neil Pease	Craig Carter	
	Katie Foster-Greenwood	Steve Canty		Steve Canty	Sarah Morrison	

	Sarah Morrison	Katie Foster- Greenwood		Ailsa Brotherton		

14.1 ANNUAL FIT AND PROPER PERSON ASSESSMENT

● Information Item

REFERENCES

Only PDFs are attached



14.1 - Annual Fit & Proper Person Assessment 2025-26.pdf

Board of Directors Report

Meeting of the	Board of Directors		4 June 2026
	Part I ☒	Part II ☐	
Title of Report	Annual Fit and Proper Person Assessment		
Report Author	Nicola Compton, Corporate Affairs Officer		
Lead Executive Director	Jennifer Foote, Director of Corporate Affairs		
Recommendation/ Actions required	The Board of Directors is asked to note the successful outcome of the Fit and Proper Persons Annual Assessment for 2025-26.		
	Decision ☐	Assurance ☐	Information ☒
Executive Summary	In line with NHS England's Fit and Proper Persons Test (FPPT) Framework for Board Members, the annual FPPT assessment was undertaken covering the period 1 April 2025 up to and including 31st May 2026. The assessment involved a review of the Chair, Non-Executive and Executive Directors, including starters and leavers during the reporting period, to ensure that very senior directors of the Trust were fit and proper to serve as Board members. The annual assessment involved completion of a range of documents including declarations, self-attestations, and checks completed on central registers, such as Companies House, the Insolvency Register, professional governing bodies and social media platforms. Confirmation of the satisfactory completion of an annual appraisal was also required. The outcome of the assessment confirms that all Board members meet the requirements of the Fit and Proper Persons Test. The annual FPPT assessment has been submitted to NHS England in line with reporting deadlines. Legal implications Compliance with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014		
Link to Strategic Objectives 2026/27	Patients – deliver excellent care: Improve outcomes, reduce harm and deliver a positive patient experience.	☒	
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.	☐	

	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.	☒
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.	☐
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.	☒
Due Diligence	To give the Trust Board assurance, please complete the following:	
Link to Board Assurance Framework:	N/A - No aligned to a Principle Risk	
Appendices	State whether there are any appendices and list them. For example: None	