



Lancashire Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS PART I ANCILLARY PACK



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6 August 2026



09:15 GMT+1 Europe/London



Lecture Room 1, Education Centre 1, Royal Preston Hospital



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9.1 INTEGRATED PERFORMANCE REPORT

● Other

Item for assurance

As at August 2026 including Finance update and Single Improvement Plan

REFERENCES

Only PDFs are attached



9.1 Integrated Performance Report as at 30 June 2026 - Ancillary Paper.pdf

Integrated Performance Report

August 2026 Trust Board meeting with performance to June 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

Key to Metric SPC Chart and Variance and Assurance Icons

	Mean		Measure
	Process Limit		Concerning special cause
	Improving 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

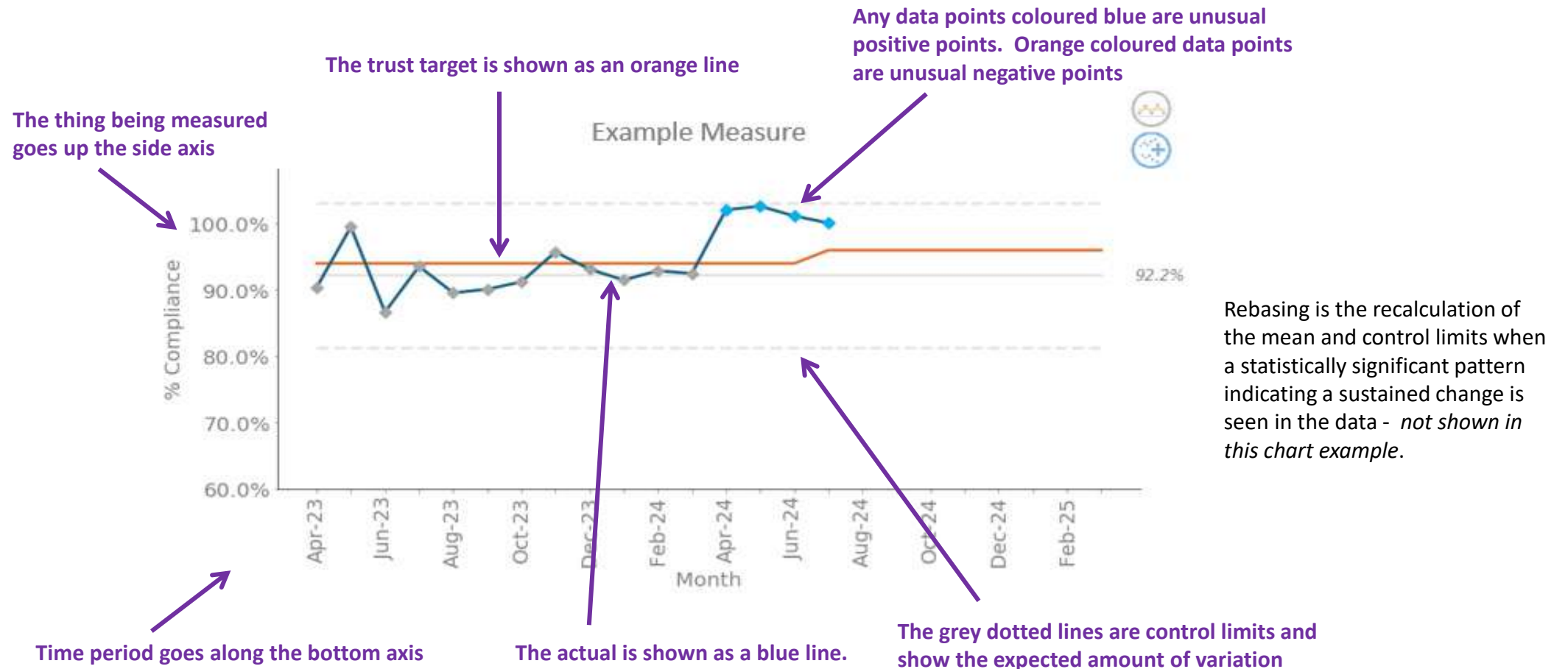
This shows whether there is a special or common cause variation of the metrics.

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	- Staff Survey: Recommend Trust as place to work	- Complaints per 1000 bed days	- 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 - Average Number of boarded patients - Reduce not meeting criteria to reside - Cancer 62-day performance - Merged - Staffing Fill Rate - Maternity Support Worker	- Staffing Fill Rate - Registered Midwife - Pressure Ulcers per 1000 beds days (Category 2 and above) actions - Perinatal - Number of Stillbirths - C. difficile performance against national trajectory Hospital Acquired cases (COHA & HOHA) - Maximum wait of 12 hours as Total Time in Department - Bed occupancy % - 85% theatre utilisation - aggregate - Capped - Cancer Faster Diagnosis Performance - 31 Day Cancer Standard - Merged - Number of violence and aggression incidents toward staff	- STAR Accreditation all trust (Silver and Above)
 Recent positive pattern in the data	- Percentage of UEC (Type 1 & 3) patients seen within 4 hours - Percentage of patients waiting less than 18 weeks - RTT - 52 week Waiters - Percentage of patients that receive a diagnostic test within six weeks - Vacancies (% FTE)	- 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



Patients



Performance



People



Productivity



Partnerships





Patients

Performance

People

Productivity

Partnerships

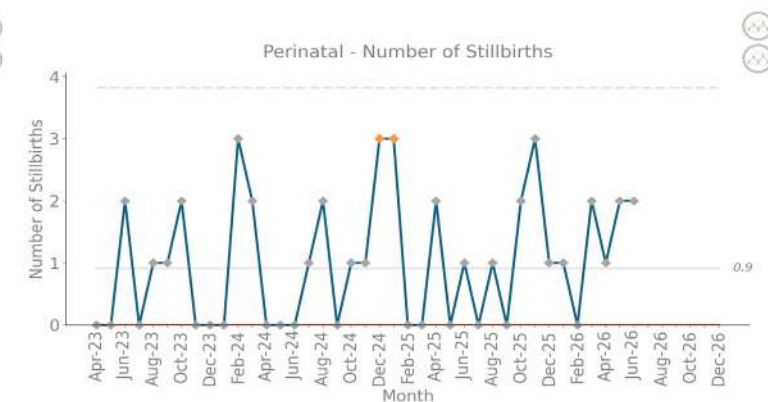
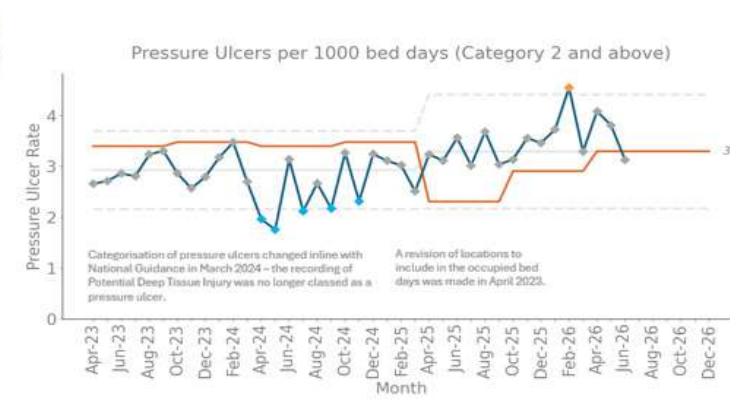
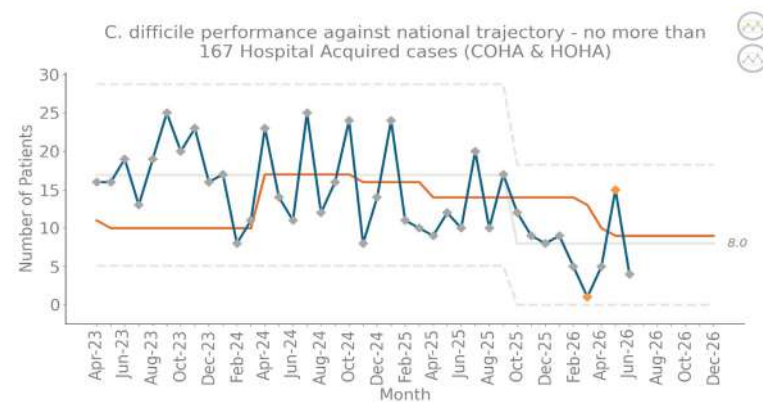
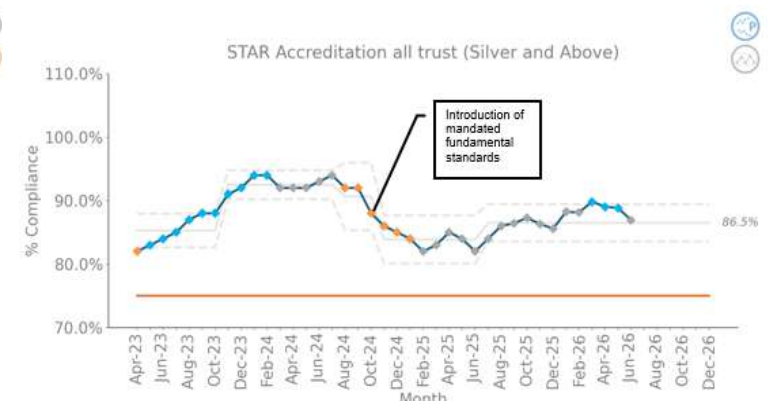
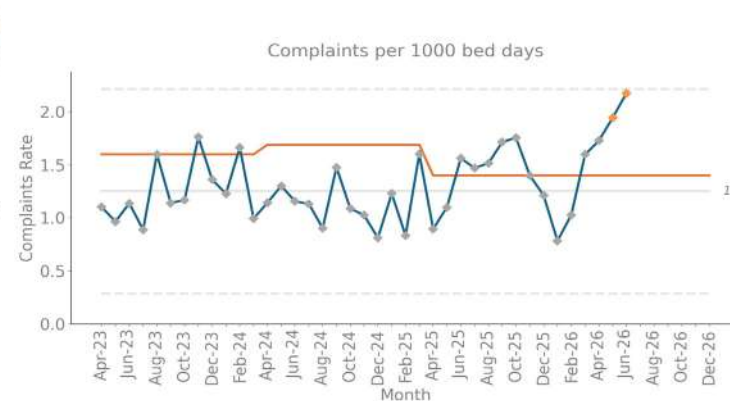
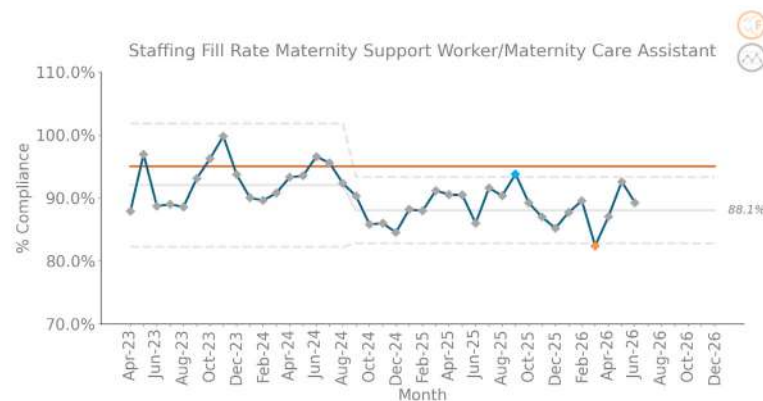
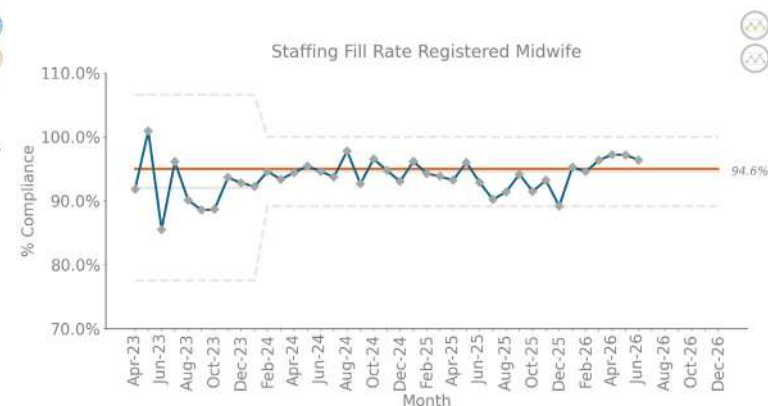
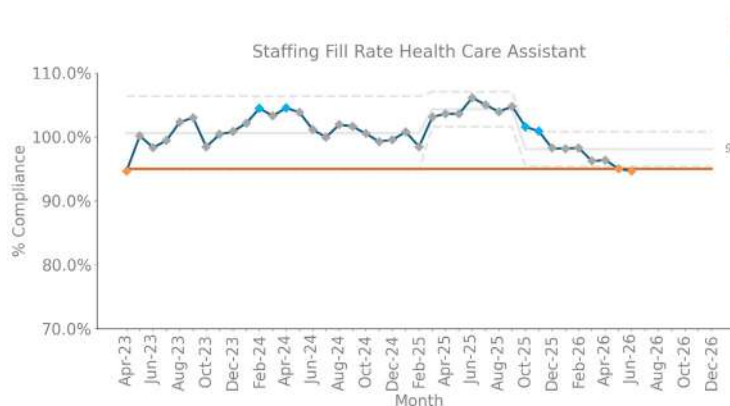
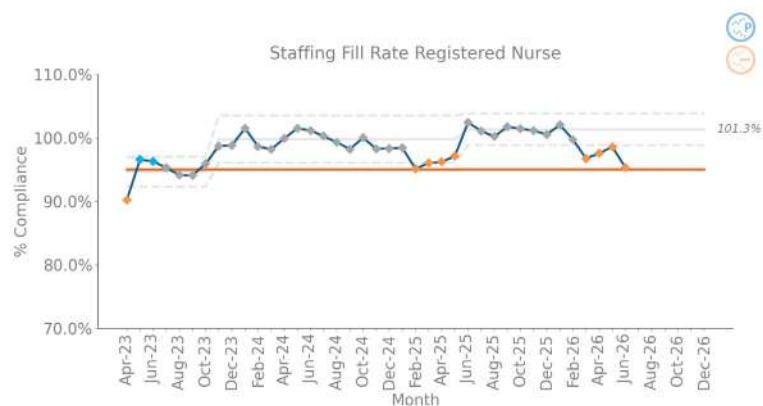
Patients

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%	95.3%	Jun-26
	Staffing Fill Rate - Health Care Assistant				95%	95.0%	94.6%	Jun-26
	Staffing Fill Rate - Registered Midwife				95%	95.0%	96.4%	Jun-26
	Staffing Fill Rate Maternity Support Worker/Maternity Care Assistant				95%	95.0%	89.3%	Jun-26
Patient Experience and Involvement	Complaints per 1000 bed days				1.40	1.40	2.18	Jun-26
	STAR Accreditation all trust (Silver and Above)				75.0%	75.0%	86.9%	Jun-26
C Difficile Improvement	C. difficile performance against national trajectory Hospital Acquired cases (COHA & HOHA)				9	9	4	Jun-26
Always Safety First	Hospital Standardised Mortality Ratio - Adult	Lower Than Expected					84.3	Feb-26
	Standardised Mortality Ratio - Relative Risk - All Diagnoses Adult	Lower Than Expected					84.1	Feb-26
	Standardised Mortality Ratio - Relative Risk - All Diagnoses Child (<1 day – 17 yrs)	As Expected					52.8	Feb-26
	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					73.0	Feb-26
	Pressure Ulcers per 1000 bed days (Category 2 and above)				3.30	3.30	3.13	Jun-26
Maternity	Perinatal - Number of Stillbirths				0	0	2	Jun-26



Patients

Patients



Performance



Patients



Performance



People



Productivity



Partnerships



Performance

Alert, Advise, Assure Report

Category	Performance Driver	High Impact Actions	Performance Recovery
ALERT Areas requiring urgent attention	• RTT 18 week performance - June 26 performance at 58.72% was a 1.3% improvement compared to May 26. However performance remains under the Operational Performance target. 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. • Boarding & Days Kept Away from Home - (%) has increased by 0.1% in June 26. The position remains significantly above the operational plan target and is higher than June 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.	• RTT - Additional capacity internal and external is being mobilised. Increased activity has been noted in June with additional capacity coming on-line late July/early Aug 26. The Cardiology AI PIFU pilot is in development with clinical protocols agreed and testing underway. Progress has been limited due to the absence of outcome for resource from an NHS Digital bid which will provide data science capacity to progress AI PIFU at greater pace. • Boarding/DKAFH - Transformation of the Acute Medical model of care will see a MAC launched at the end of July which will provide a 24/7 SDEC facility. A Frailty SDEC provision will commence at the end of September 26.	• RTT: An RTT forecasting methodology is being developed in conjunction with GIRFT. High level assessments project a return to operational standard performance for 18 weeks by the end of Q3. • UEC/Boarding: The anticipated 4 hour performance benefit of MAC is forecast to be between 1.2-1.4%. The anticipated 4 hour performance benefit of Frailty SDEC is forecast to be ~1.2%. Modelling of the impact on ED overcrowding and boarding will be reviewed at the end of Q2.
ADVISE Areas of ongoing monitoring	• UEC 12 hour + ED LOS - performance deteriorated by 1.15% compared to May 26 but is below the Operational Improvement plan target of 12.3% for the second month. • Virtual Ward - occupancy remains below target and has improved slightly compared to May 26. • Cancer Performance (May) - improved compared to the previous month and exceeded the Trusts operational target. 62 day performance for May has improved 26 national ranking places. June performance is expected to improve following validation. 62 day performance for June 26 show improvement compared to June 25. The May 31 day performance is below target by 0.5% although improved versus April.	• UEC - Key actions being taken to improve performance include - Workforce data 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 in July. A Frailty SDEC will be launched in Q2. • VW - Medical posts have been recruited into the service to support an expanded utilisation - pre employment checks are underway. A review of wider VW staffing is underway to scope an increase in out of hospital capacity. • Cancer Performance - Key actions relating to recruitment of critical workforce in Gynae and Oncology continue with start dates for new colleagues in July and August and additional treatment capacity being mobilised in June & July for Skin.	• UEC 12 Hour : The Trust is on trajectory to meet the operational performance targets. • Cancer: Performance forecasting suggests 62 Day cancer performance will meet operational standards by Nov 26, with 31 day performance achieving standard from July 26 onwards.
ASSURE Areas of positive assurance	• UEC 4 Hour performance - The LTH operational performance target for June 26 re 4 hour performance was achieved. Performance showed an improvement of 2.7% in June compared to May 26. June 26 performance improved by 23 national ranking places and constitutes the highest performance since July 2023. • RTT Waiting List Reduction & 52 week performance - The final position for June 26 shows that waiting list size has continued to reduce and is ahead of target. Similarly the reduction in over 52 week waits continues to exceed target at 1.1% of the total waiting list and is now below the latest national average of 1.4% (May 26). • DM01 - Performance improved further in June 26 to 71.13% and is now above the operations plan target of 69.1%. Significant improvement in over 6 week waiters in NOUS, Echo and Sleep Studies. June 26 performance is the highest performance noted at LTH for the past 4 years. • Cancer Performance - has exceeded the June target for 28 days (FDS). Trust performance is ranked 53rd out of 118 providers.		



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%	65.20%	24.86%	Jun-26
	Compliance with 45 minute ambulance turnaround time target				95.00%	95.00%	69.88%	Jun-26
	Percentage of UEC (Type 1 & 3) patients seen within 4 hours				82.00%	71.90%	73.22%	Jun-26
	Maximum wait of 12 hours as Total Time in Department (Type 1 and 2)				10.50%	12.25%	11.15%	Jun-26
UEC Flow	Bed occupancy %				94.00%	94.00%	95.52%	Jun-26
	Average Number of boarded patients				0	0	28	Jun-26
UEC Outflow	Reduce not meeting criteria to reside				5.00%	9.20%	11.34%	Jun-26
Elective (long waits)	Percentage of patients waiting less than 18 weeks				70.00%	61.30%	58.72%	Jun-26
	RTT - 52 week Waiters				0	1223	666	Jun-26
Elective (diagnostics)	Percentage of patients that receive a diagnostic test within six weeks				80.00%	69.10%	71.13%	Jun-26
Elective (theatre utilisation)	85% theatre utilisation - aggregate - Capped				85.00%	85.00%	81.96%	Jun-26
Elective (Cancer) (unvalidated position, subject to change)	Cancer 62-day performance - Merged				80.30%	73.00%	70.72%	Jun-26
	Cancer Faster Diagnosis Performance				80.00%	80.00%	83.50%	Jun-26
	31 Day Cancer Standard - Merged				94.00%	94.10%	90.95%	Jun-26



People



Patients



Performance



People



Productivity



Partnerships



People

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 - Waiting times for the psychological wellbeing service (in particular for more complex support) and the capacity of the Workforce Advice team to support casework continue to present barriers to the sickness absence reduction plan.	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 - The sickness absence reduction plan has been updated, which includes proactive work in 10 areas with persistently high sickness absence. Sickness absence data will be triangulated with other metrics and intelligence to enable development of appropriate actions.
Advise Areas of ongoing monitoring and any new developments	Sickness Absence - The pilot of the digital sickness absence system has now been completed and due to issues relating to the implementation, we will not be pursuing a full roll out. An alternative system has been identified; and due diligence checks are currently being undertaken prior to the development of a business case. Vacancy - The Trust Vacancy rate has reduced significantly in month due to recent finance vacancy/establishment review.	Vacancy - Health Care Support Worker (HCSW) recruitment continues to address high level of vacancy in this area with Support to Nursing staff group as a whole carrying c 300 vacancies and HCSW being 280 WTE of these. We have 81 WTE HCSW applicants under offer with an overall pipeline under active recruitment of 231 WTE. We are starting to see HCSW commencing in post in M4. We would expect c 60-70% of the pipeline offers converting to starts. Medical Hard to Fill plans are in place and a review is underway of Medical RRP policy.
Assure Areas of Assurance	Sickness - Rates have reduced again in month to 5.38% over 1% lower than the same period last year. 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 2 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 lifestage 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

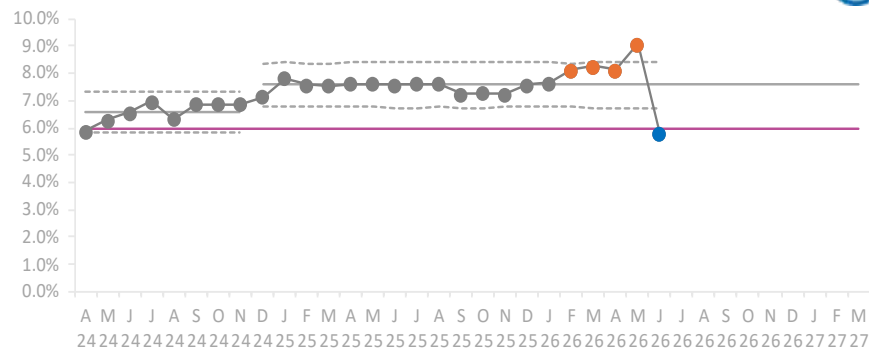
Metric Description		FY2627 Target Assurance	Latest Actual Variation	Target			Latest Actual	Latest Period
				Concern	FY2627	Latest Month Target		
People	Vacancies (% FTE) (source: General Ledger)				≤ 6%		5.77%	M03
	Turnover (% FTE) (annual assessment; ESR in-month reported)				≤ 10%		0.41%	M03
	Sickness Absence (% FTE) (annual assessment; in-month reported)				≤ 5.5%		5.81%	M03
	Number of violence and aggression incidents toward staff (annual assessment; in-month reported)				996		128	M03
	Core Skills Mandatory Training compliance (% modules) (module compliance reported)				100% of metrics at 90%		100.00%	M03
	Appraisal compliance (% HC)				≥ 90%		92.60%	M03
	Staff Survey: Recommend Trust as place to work (quarterly metric)				≥ 60%		40.97%	Q1



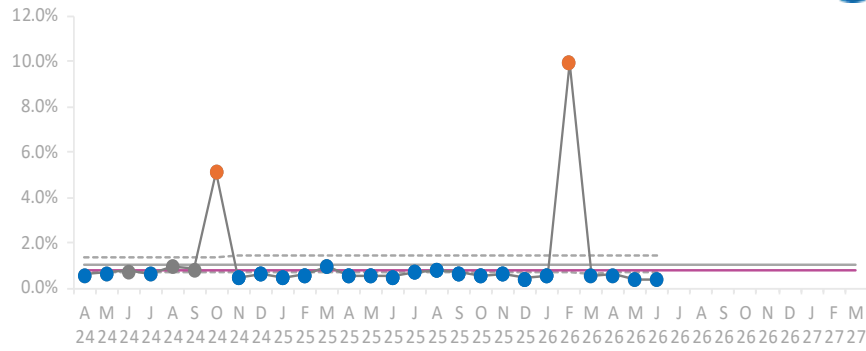
People

People

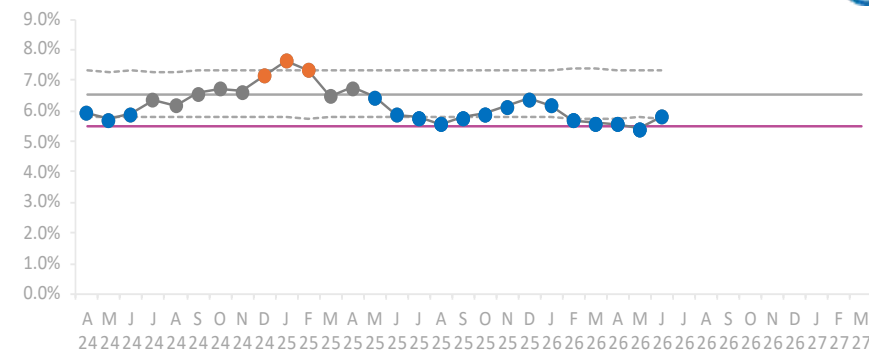
GL Vacancy Rate (% FTE)



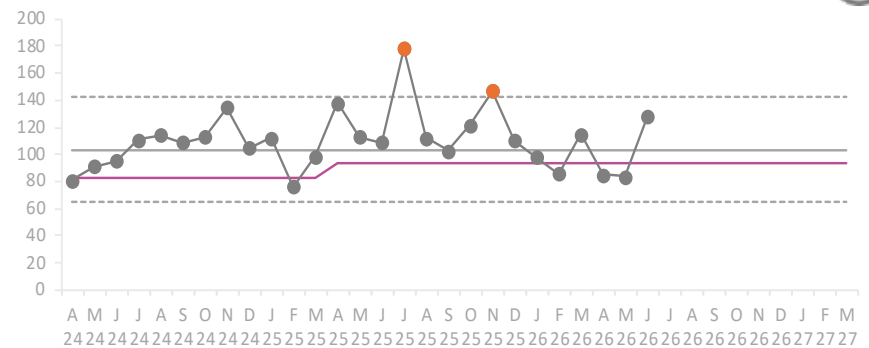
ESR Turnover (% FTE)



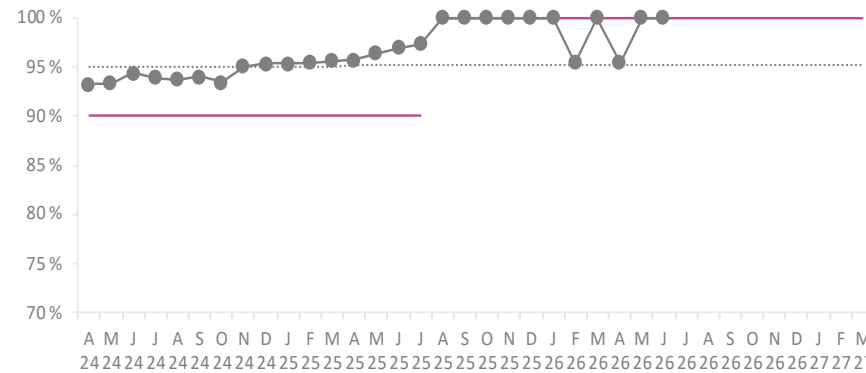
Overall Sickness (% FTE)



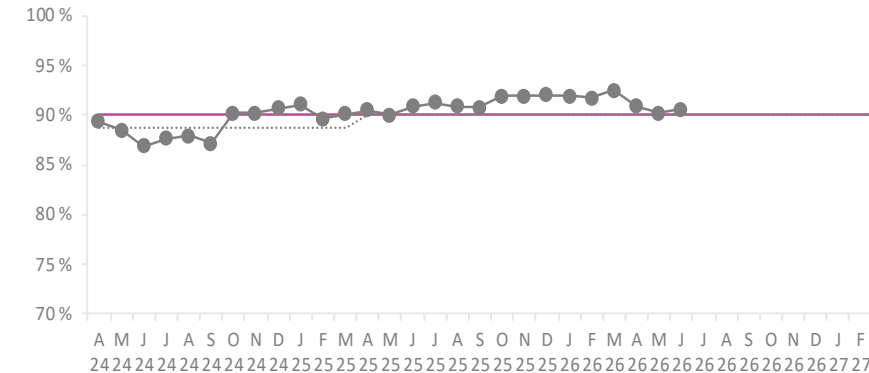
No. of Violence & Aggression Incidents Reported



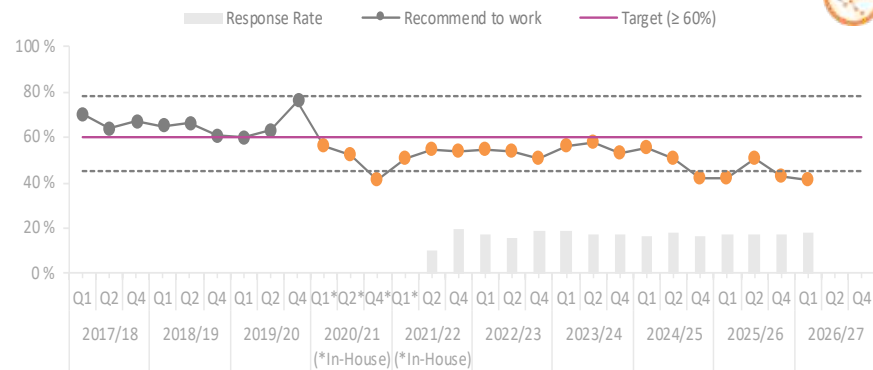
CSTF Compliance (% modules)



Appraisal Compliance (% HC)



NQPS % Recommend to Work



Productivity



Patients



Performance



People



Productivity



Partnerships



Productivity

Alert, Advise, Assure Report

Executive Summary as at 30th June 2026

	Issue	Action	Assurance
Alert Areas of concern or matters that need addressing urgently	Waste Reduction Programme		
	The Trust's 2026/27 waste reduction target is £60m, 5.7% of operating expenditure. Whilst Month 3 WRP delivery was in line with the NHSE Financial Plan the phasing of the plan is heavily weighted to later in the year. The in year Waste Reduction Programme has fully been identified at £60.0m with fully developed schemes to this value. Forecasting of WRP will follow and is assumed to be £60.0m. Confidence levels are being reviewed at DDGs with a risk adjusted forecast to be developed. Scheme development is continuing to ensure that any WRP plan slippage is mitigating.	The Trust has introduced a process to help mitigate the gap on WRP plan. This requests that Divisions review their recruitment pipeline to see what posts can be held to enable realignment to the expected WRP headcount reduction. 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
Advise Areas of ongoing monitoring and any new developments	Cash Position		
	The Trust has been advised that Q2 DSF will be withheld by NHSE. However, mitigations are being developed, therefore it is likely that the need for cash in September can be managed. Any slippage on WRP will mean revenue cash support may be required.	Application for capital cash support will be submitted to DHSC/NHSE as appropriate, after the mitigating actions (to be approved by Board at the end of July) have been actioned. Management of WRP to ensure where possible cash releasing efficiencies are implemented. 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.	The cashflow forecast is updated daily and any emerging issues are escalated to the CFO. Monthly cashflow review by the CFO/ CEO
Assure Areas of Assurance	Capital Position		
	Capital expenditure for the year to date was £2.5m below plan, with the slippage being due to unforeseen site complications on the decarbonisation scheme. The contractor is confident the project will still deliver as per plan by the year-end. A positive response has been received from NHSE regarding capital bids against national allocations. To date we have received confirmation for £20.411m from NHSE. However work continues to ensure the remaining £24.241m funding available to the trust is approved.	Plans are being worked up to deliver expenditure to the delegated capital limit. The Trust is producing business cases for capital bids that have received approval to proceed to the next stage against the national allocations. Dialogue is ongoing with the regional NHSE team.	The capital plan will be updated as approvals are received. A system wide approach is being developed to support optimal use of national allocations.
	Income and Expenditure		
	The Trust is reporting a £0.07m favourable position to plan to the end of June 2026. The Trust has a YTD £13.60m deficit against a £13.66m planned deficit including planned DSF funding of £2.29m. M3 in month WRP delivery is £3.63m against an in month NHSE Financial Plan of £3.56m, resulting in a positive variance to in month plan of £0.07m.	A re-set of the programme structure, governance and reporting for 2026/27 has taken place, including the introduction of the Productivity Board. Actions taken to reduce headcount include: The trusts MARs scheme has been implemented (15.00 wte) A review of posts within the recruitment pipeline to see what can be removed. One Lsc have also implemented and delivered a MARs scheme	Grip and control Interventions and control measures are constantly being reviewed

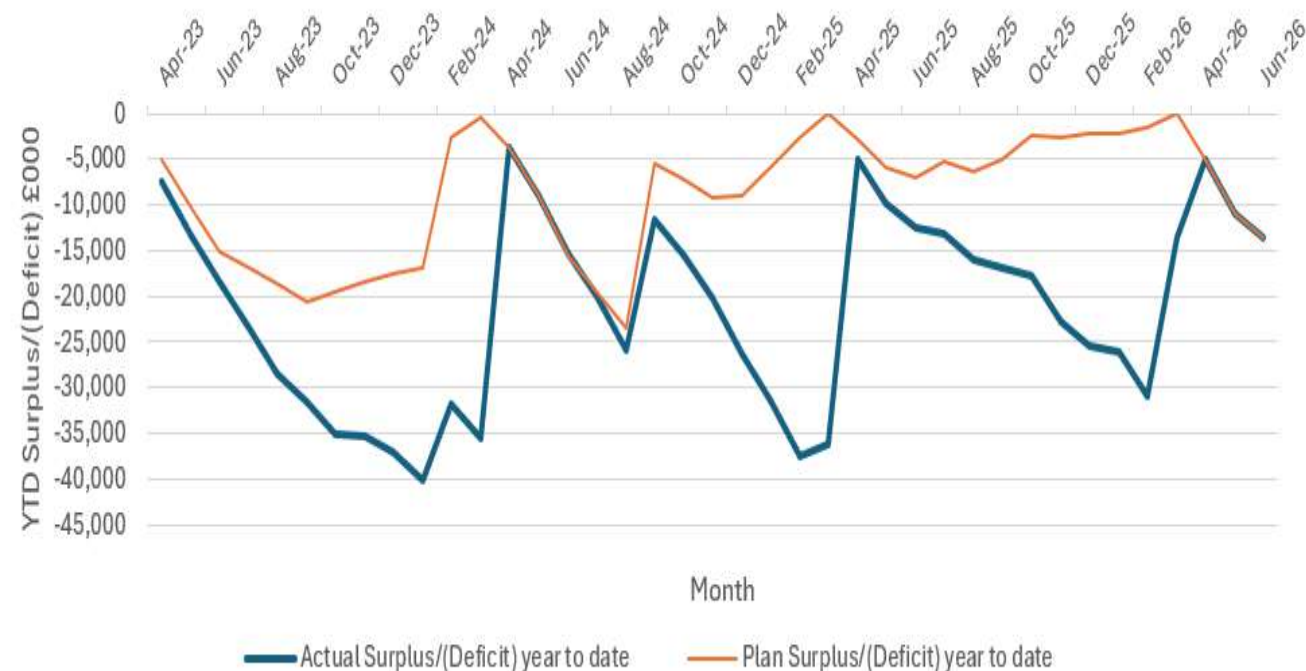


Productivity

Productivity

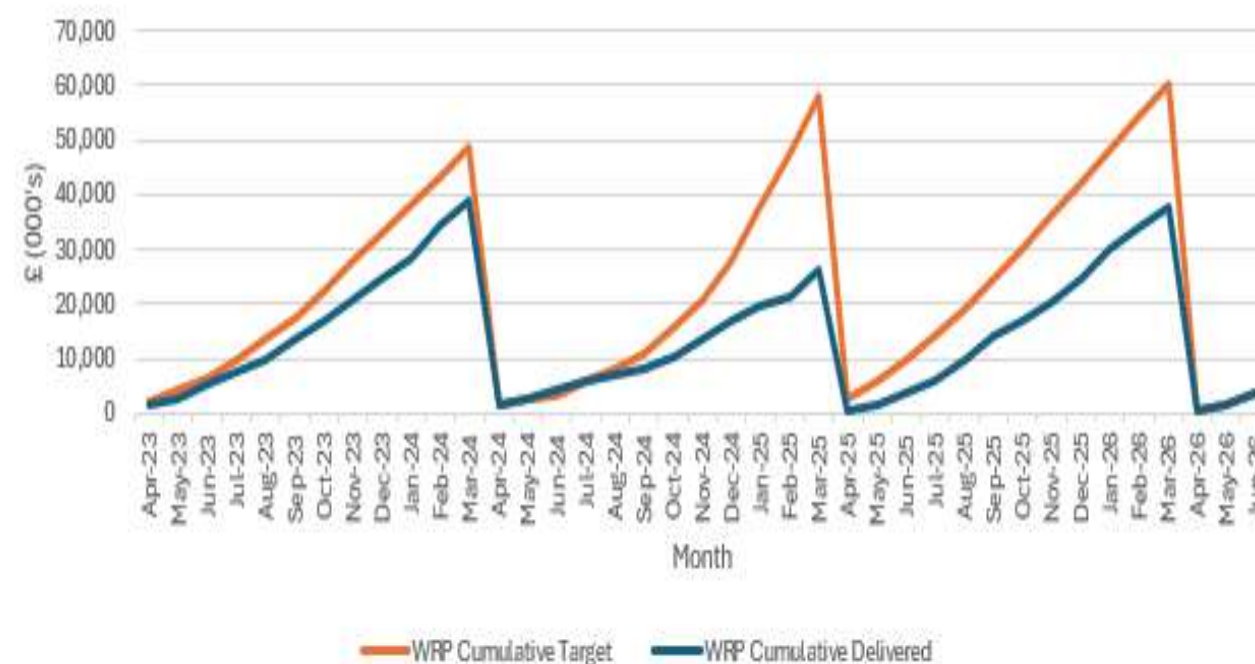
Metric Description		Assurance @ Mar-27	Variation to Latest Actual	Target (£ 000's)			Latest YTD Actual (£ 000's)	Latest Month
				Concern	Mar-27	Latest YTD Target		
Productivity	I&E - Plan v Actual variance					-13662	-13595	Jun-26
	WRP schemes delivery				60000	3563	3628	Jun-26

Year to Date Plan/Actual Surplus/(Deficit)



WRP Delivery Schemes

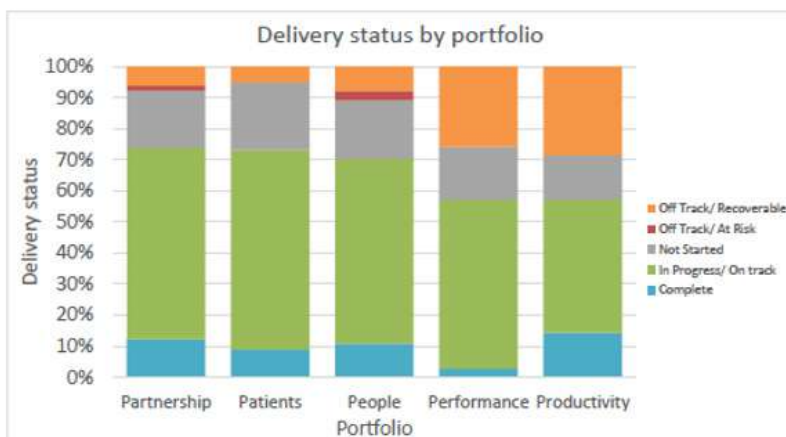
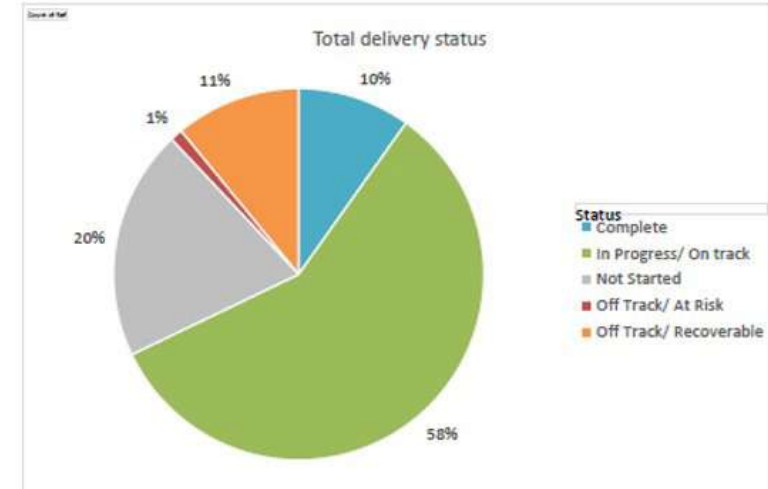
Cumulative position



June-26 | Single Improvement Plan delivery position

AAA	Portfolio	Issue	Action
Alert	Productivity	WRP Q1 delivery	Focus on increasing delivery confidence and key actions and enablers required to deliver.
	Patients	Paediatric UEC improvement plan experiencing continued delays due to lack of medical leaderships	DCMO in place to support progress
	People	Lack of engagement in Inclusion forums and increase in bullying and harassment.	SLT commitment to prioritise enabling access to inclusion forums and supporting output actions to make sustainable cultural changes.
Advise	Productivity	Model Service Programme progress at pace limited by BI resource capacity. Wave 1 has commenced with good engagement with specialty teams but reliant on sole person.	BI Analyst role in process to appoint, exploring if supporting functions such as CI can provide any data support to bridge the gap.
	Performance	RTT - Continue to work through backlog and improvement has been seen in Q1 however some hotspot areas such as Audiology Elective activity increase required to step up in Q2	External company to provide PTL review and analysis COO is exploring options for insourced provision for elective activity
	People	Improved overall turnover rate except in HCAs B2/B3	HCA recruitment pipeline and new employee assistance programme to support retention
Assure	People	Good engagement in 'Your Voice' events	
	Performance	Endoscopy backlog recovery success	

Overall positive momentum with more work starting and completing, and fewer items at critical risk. There has been an increase in 'off track/recoverable' delivery status indicating slippage against planned delivery dates or early warning of not being able to meet intended date.



Integrated Performance Report

Appendix 1 – Assurance Reports

August 2026 Trust Board meeting with performance to June 2026



Patients



Performance



People

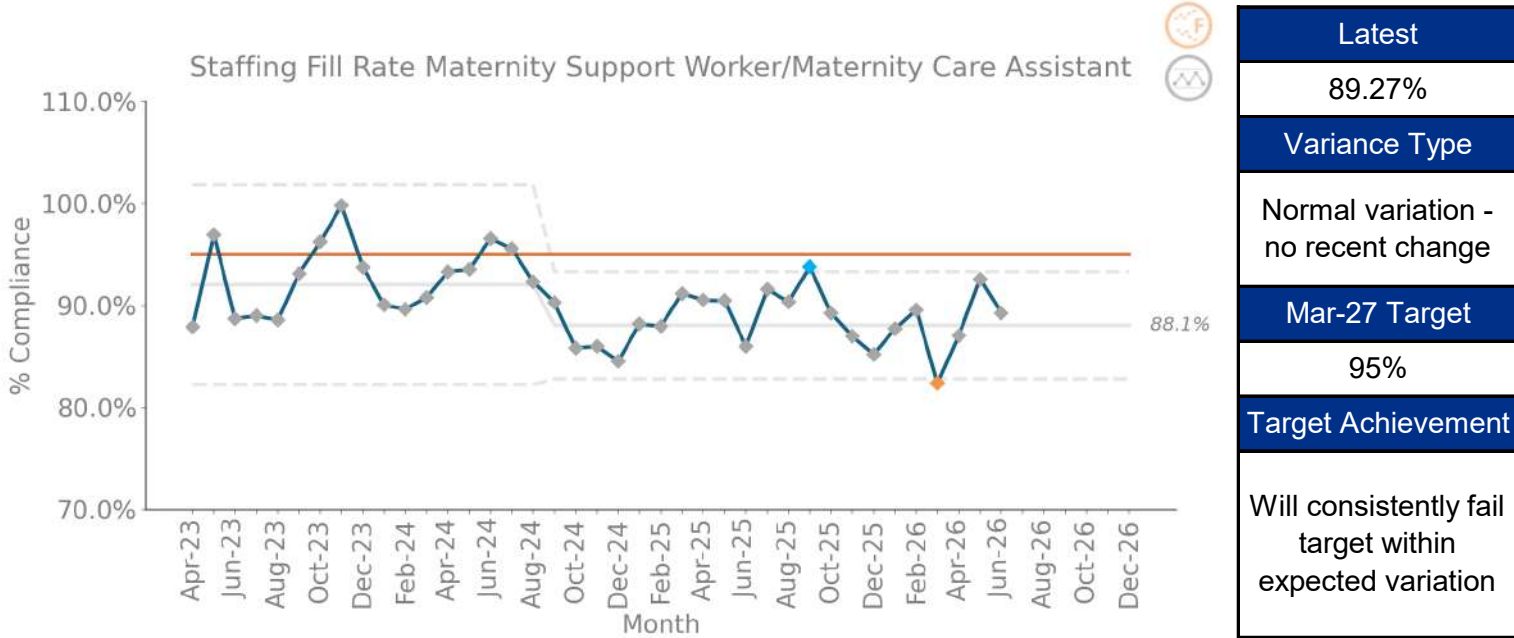
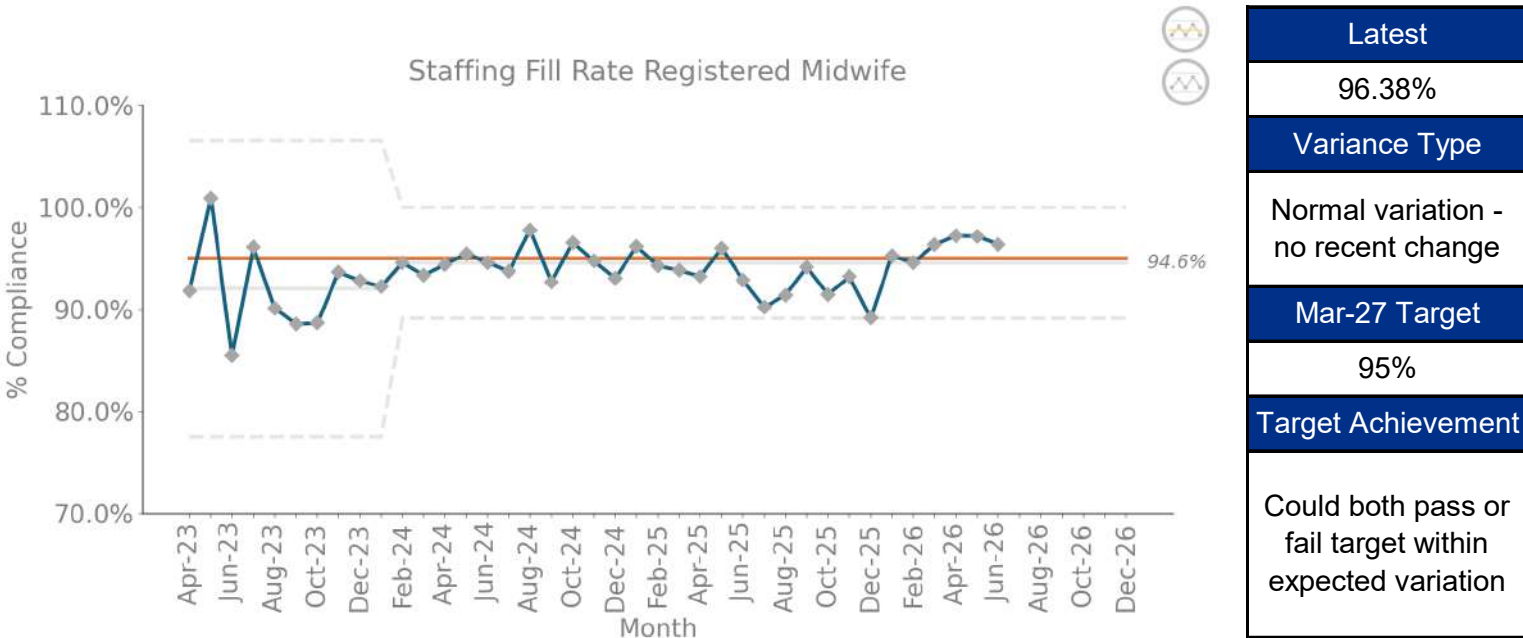


Productivity



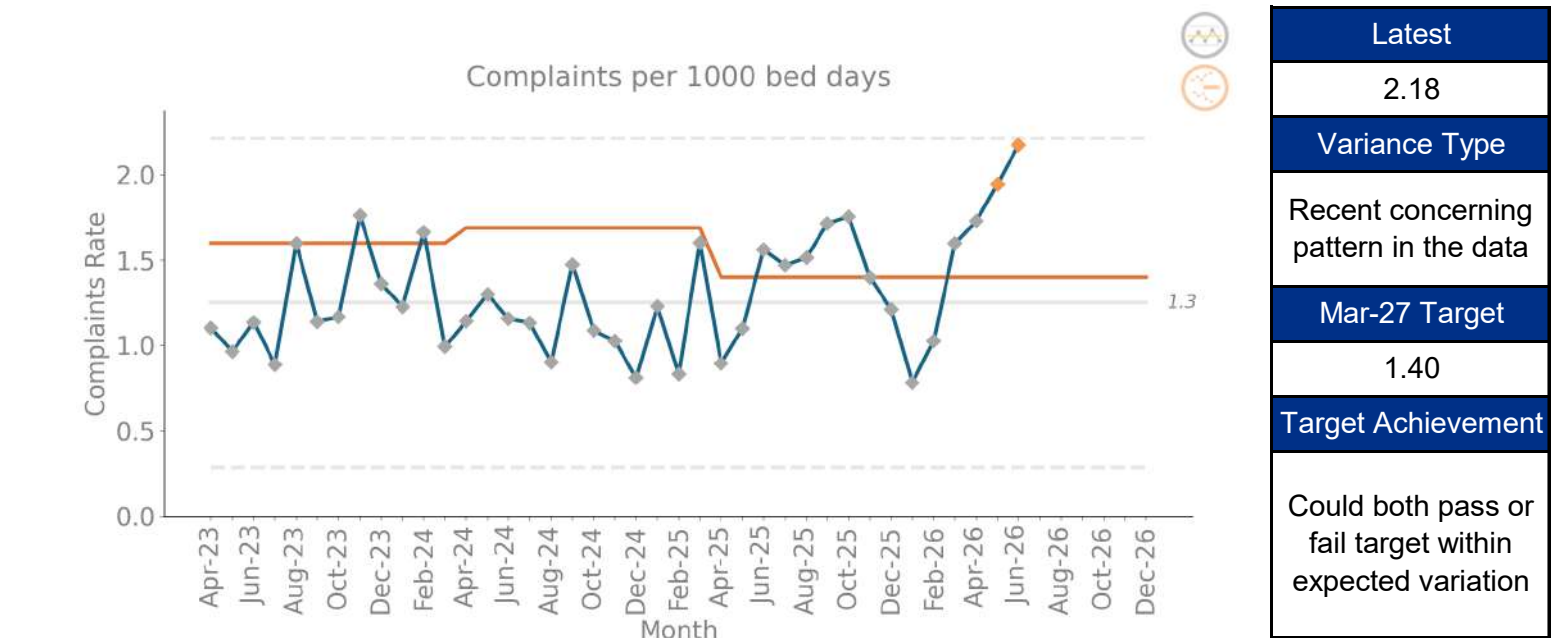
Partnerships

Patients - Deliver Annual Safe Staffing Requirements Assurance



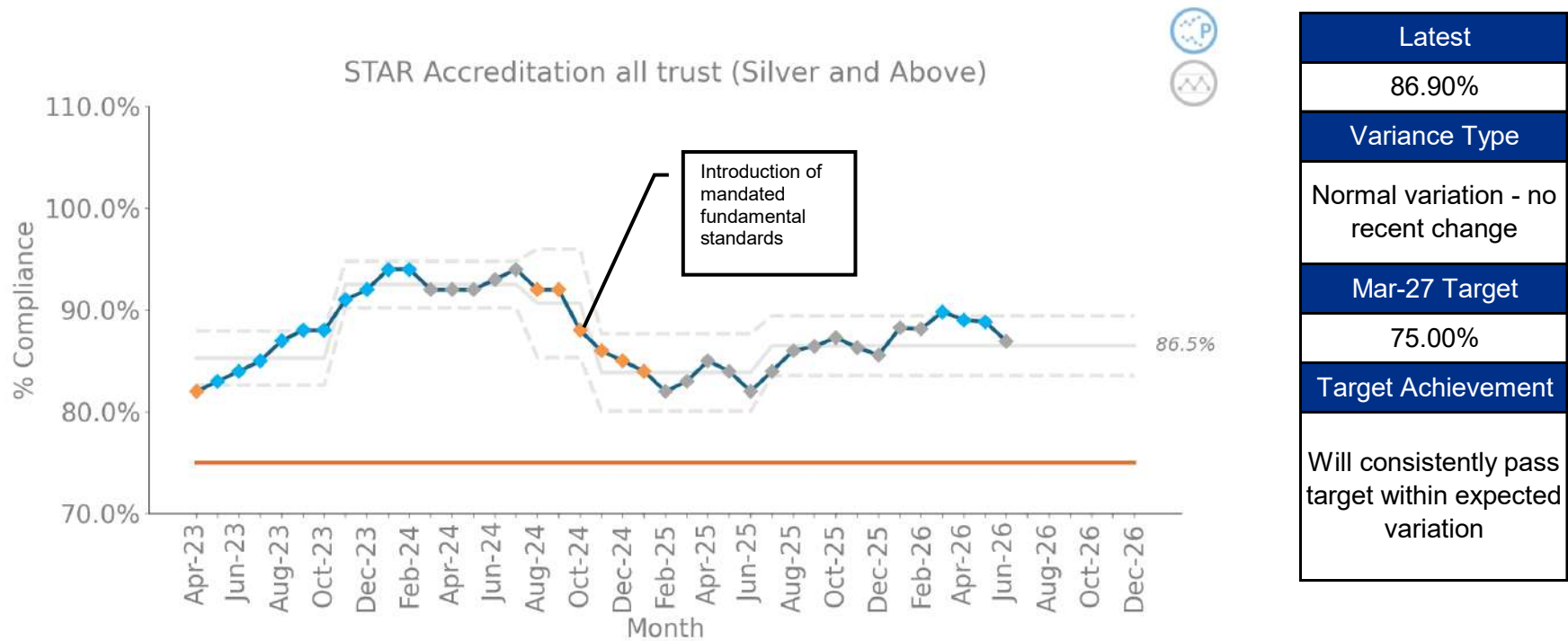
Metric	Summary	Action	Assurance
Staffing Fill Rate Registered Midwife	The overall midwifery fill rate is 96.3% which remains above the Trust target of 95%. This has been the case for the past four months. Unfilled shifts continue to be sent to bank and agency to maintain safe staffing as required. The over-offer recruitment approach is being utilised to maximise the opportunity to recruit newly qualified midwives following qualification in the coming months. This supports workforce sustainability recognising anticipated turnover and vacancies.	- Monthly roster efficiency meetings overseen by the deputy Divisonal Midwifery and Nursing Director - The service continues to recruit to turnover using over offer between 5 and 10 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. - 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 Maternity Support Worker staffing fill rate remains below target level at 88.1%. Whilst recent months have shown some improvement following a low point in early 2026, there has not yet been sufficient sustained improvement to demonstrate a stable shift in performance. Reduced fill rates are predominantly associated with vacancies. Delays in VCP have impacted on the ability to recruit band 2 and 3 support staff, however, approval for external recruitment has just been agreed to maximise the opportunities for successful recruitment.	- 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 and 3 MSW vacancies have been approved for external recruitment (21.07.2026)	- 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

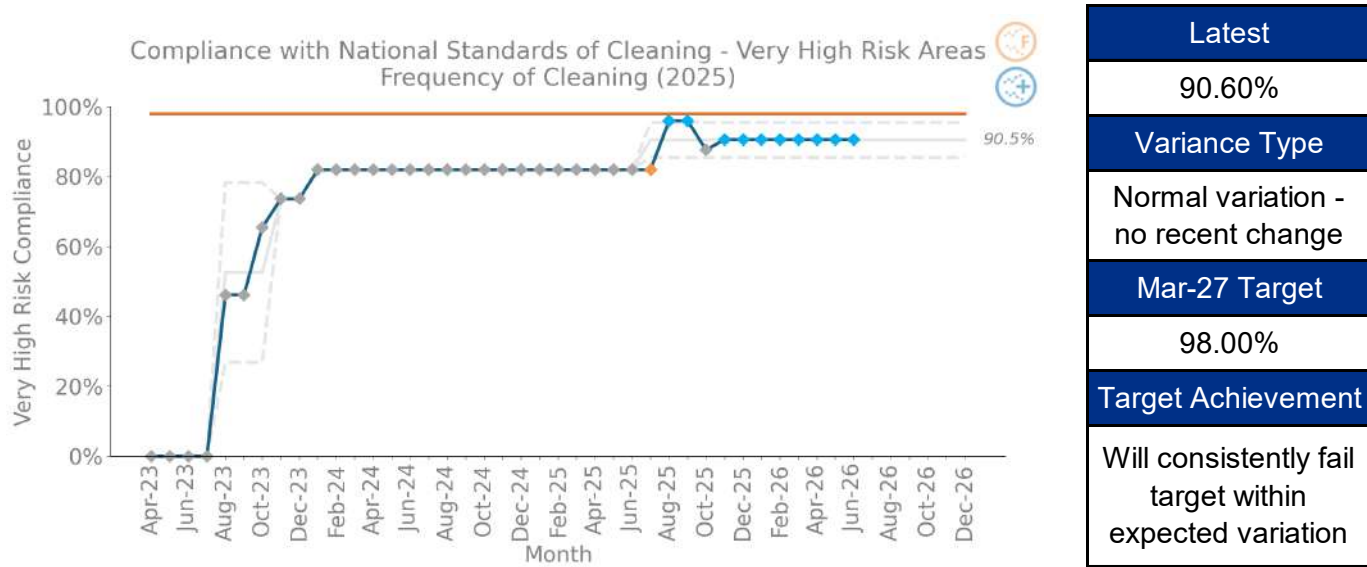
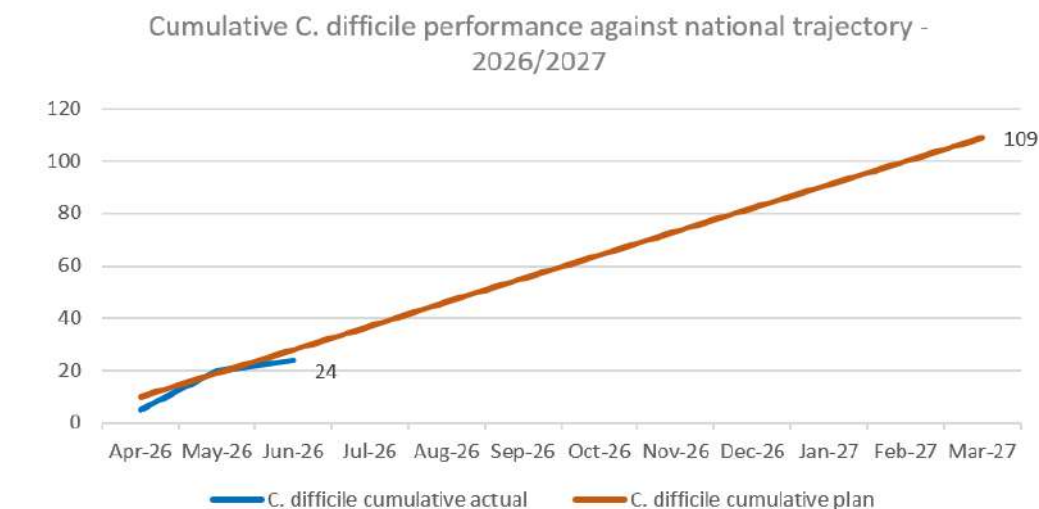
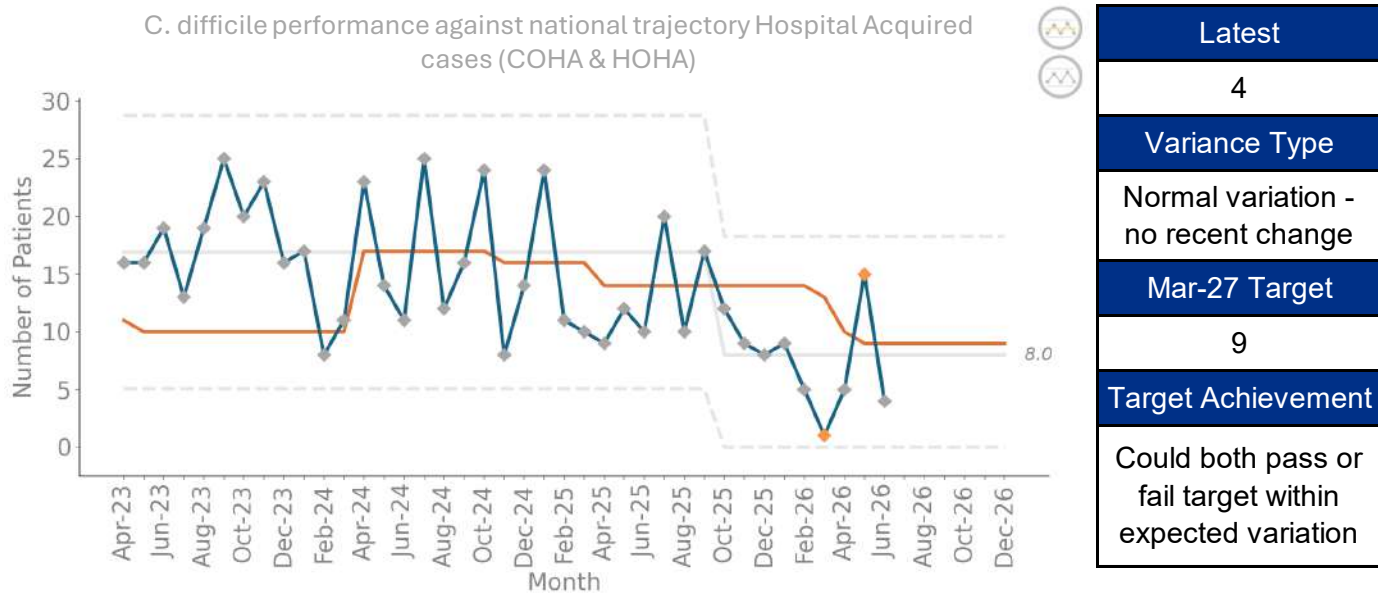


Metric	Summary	Action	Assurance
Complaints per 1000 bed days	Complaints per 1,000 bed days from April 2023 to early 2026, with performance fluctuating around a central baseline and a stepped trajectory line indicating expected or target levels. Overall, complaint rates have increased this month from 1.94 in May to 2.18 in June. There has been an increase in complaints although no particular themes identified. The Trust's Single Improvement Plan is guiding both immediate service improvements and longer-term system change to support sustained reduction.	- Continue to deliver the Single Improvement plan - Patients - Continue to deliver the Patient Safety Incident Response Framework with a focus on family liaison roles - Monitor actions in relation to National picker Surveys . - To deliver the PALS and local early resolution training. - Continue to progress the complaints review group using patient safety partners and governors - Where concerns have not been responded to locally escalate to managers. - E Learning training for PALS concerns and a seperate package for Complaints Handling are now on training records.	- Annual patient experience reports to Safety and Quality committee. - Friends and family monthly reporting in place for all departments. - Inclusion of patient experience in STAR. - Chief Nursing Officer reviews all complaints and signs off responses. - Monitor picker survey action plans through Patient, Carer, Experience and Involvement Group.

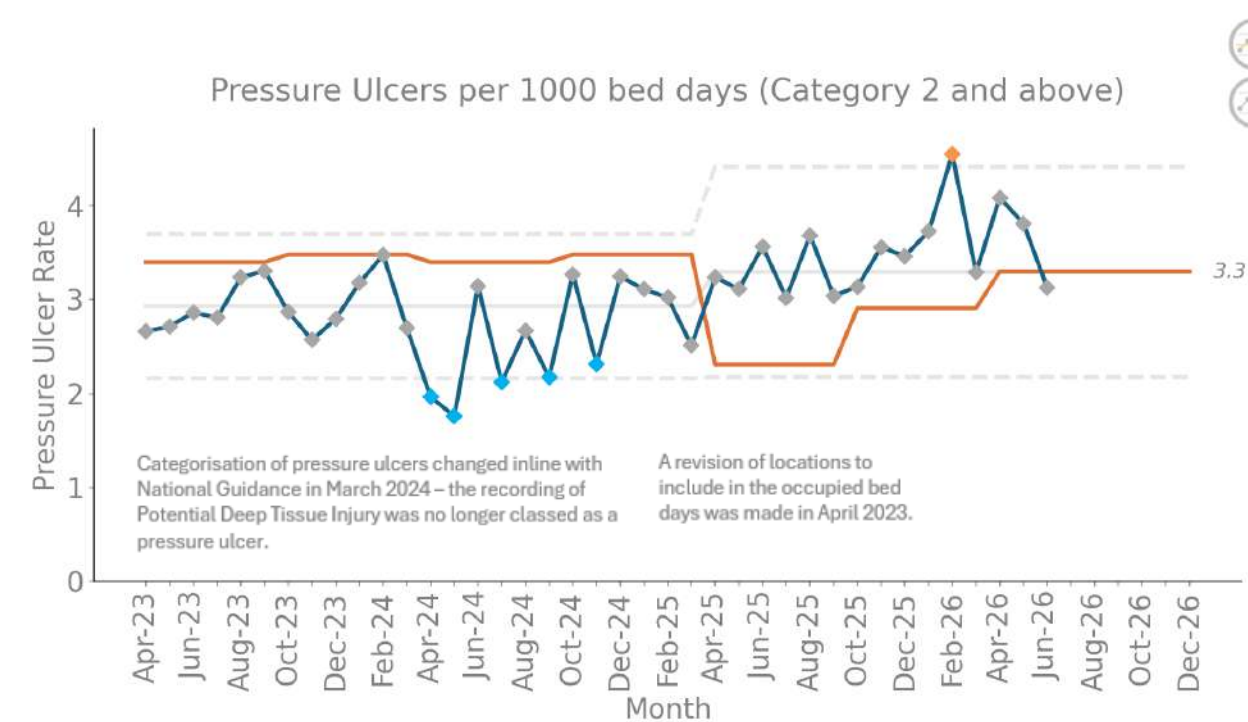
Patients - Quality Assurance STAR Accreditation



Patients - C Difficile Improvement Programme Assurance



Metric	Summary	Action	Assurance
C. difficile performance against national trajectory - no more than 109 Hospital Acquired cases	During June 2026 there have been a total of 4 cases for the month, with a year to date total of 24 cases for 2026 / 2027. The Trust's National objective for 2026/2027 has been set as 109 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. Vacancies have been successfully recruited to, with staff progressing through onboarding. A clear delivery plan to achieve compliance is due in September.	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 but has been escalated and is 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.



Latest
3.13
Variance Type
Normal variation - no recent change
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, to provided proactive intervention, real-time feedback and education to ward teams. These measures strengthen oversight and support early intervention with a Trust focus on pressure ulcer prevention in line with the Trsut imprevemnt plan.	- Monthly divisional review of pressure ulcer incidents, themes and trends through ASF meetings, translating learning into targeted actions to reduce harms. - Weekly Pressure Ulcer Review Panel to review harm, identify factors, and drive actions to prevent recurrence, with learning escalated through governance (from Nov 2025). - Proactive risk reduction rounds led by the tissue viability team, providing real-time support and challenge to improve prevention and reduce avoidable harm (from Mar 2026). - Delivery of an evidence-based improvement plan addressing key incident themes, with impact measured through reduced pressure ulcer incidence. - Strengthened data quality through housekeeping and reporting processes to ensure consistent, reliable data for monitoring trends and providing credible assurance.	- Divisional Always Safety First Committees provide oversight of the pressure ulcer improvement plan and monitor progress against key actions. - Monthly monitoring of pressure ulcer incidence continues as a priority quality metric, with trends reviewed at divisional and Trust level. - STAR compliance for key questions 8d and 9c is monitored monthly as leading indicators of prevention practice. - Weekly Pressure Ulcer Panel, with a consolidated monthly learning report submitted to PSIRF Oversight. - 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	84.3	February 2026
Lower Than Expected	84.1	February 2026
As Expected	52.8	February 2026
As Expected	73.0	February 2026

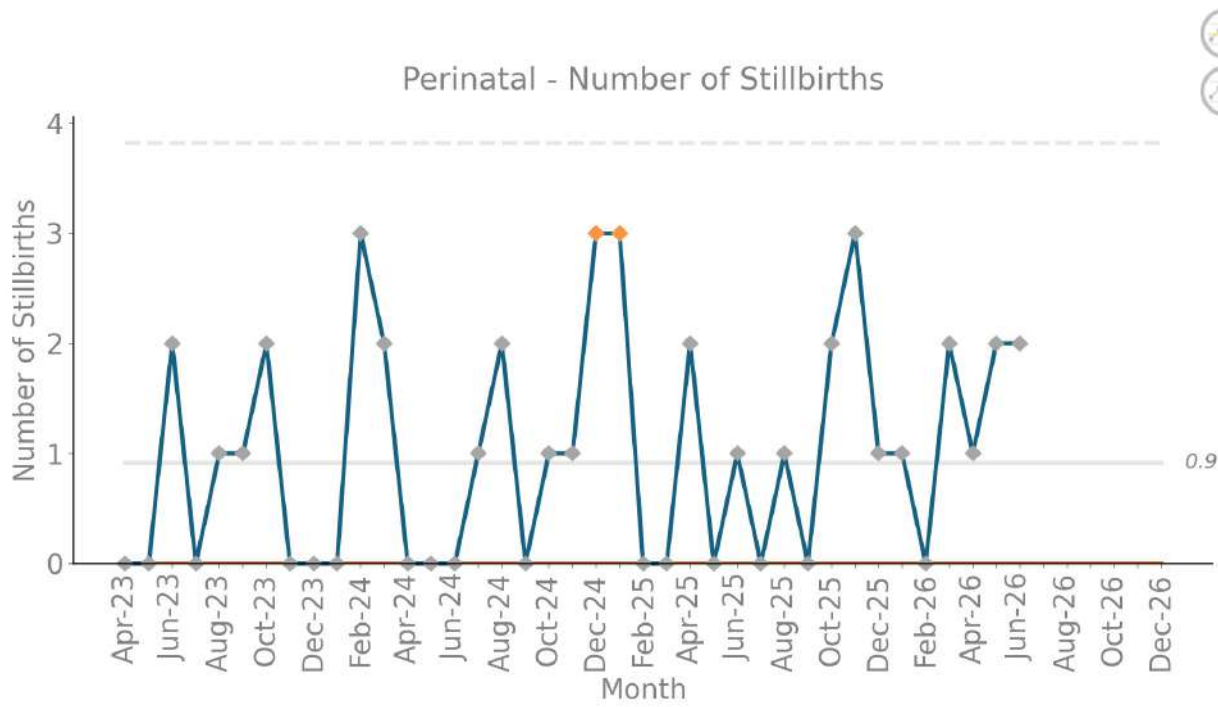
Hospital Standardised Mortality Ratio - Adult
Standardised Mortality Ratio - Relative Risk - All Diagnoses Adult
Standardised Mortality Ratio - Relative Risk - All Diagnoses Child (<1 day – 17 yrs)
Standardised Mortality Ratio - Relative Risk - All Diagnoses Neonates (<1-28 Days) <i>The updated TELSTRA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

Source Data: Telstra (Dr Foster)

Metric	Summary	Action	Assurance
Hospital Standardised 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. 7. Review the interface of Medical Examiner Reviews, Incident Reporting and Structured Judgement Reviews to ensure timely identification of harm level associated with patient deaths.	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 Mortality Ratio - Relative Risk - All Diagnoses Adult	SMR is within Upper and Lower Control Limits and lower than expected when compared to peers.		
Standardised Mortality 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 Mortality 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.		

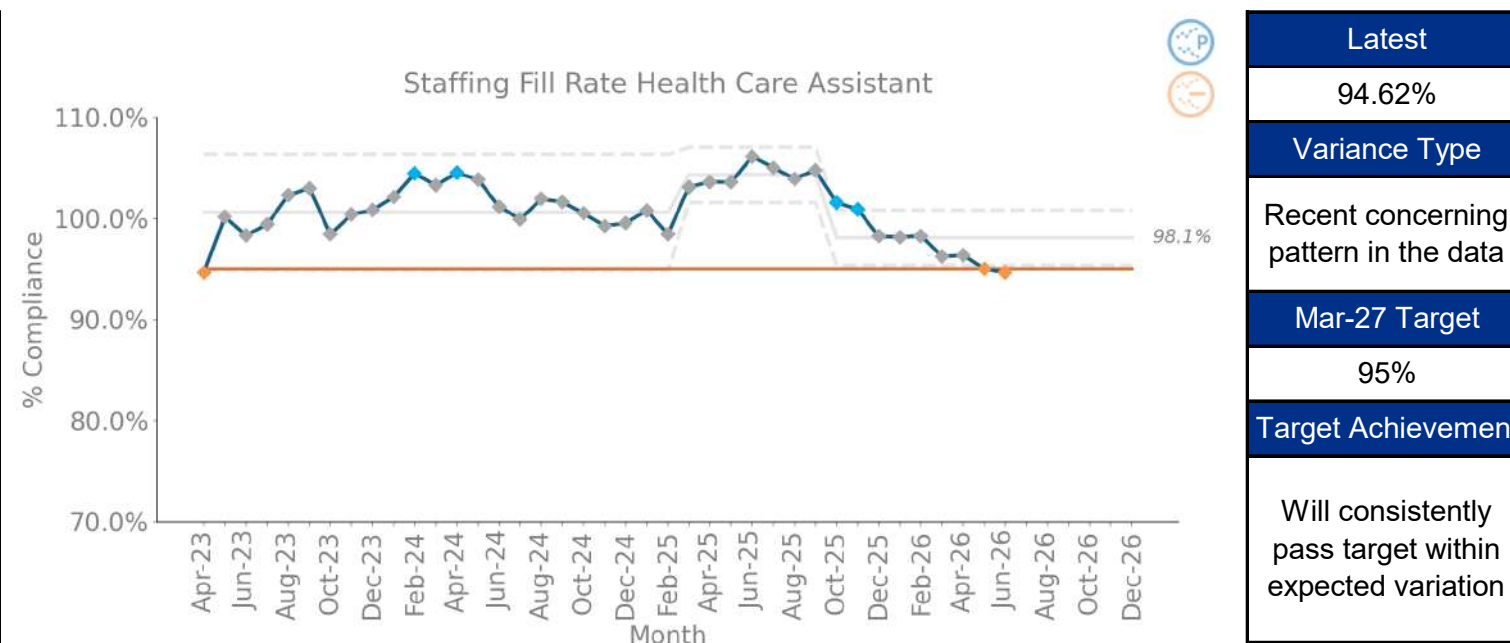


Patients - Stillbirths Assurance



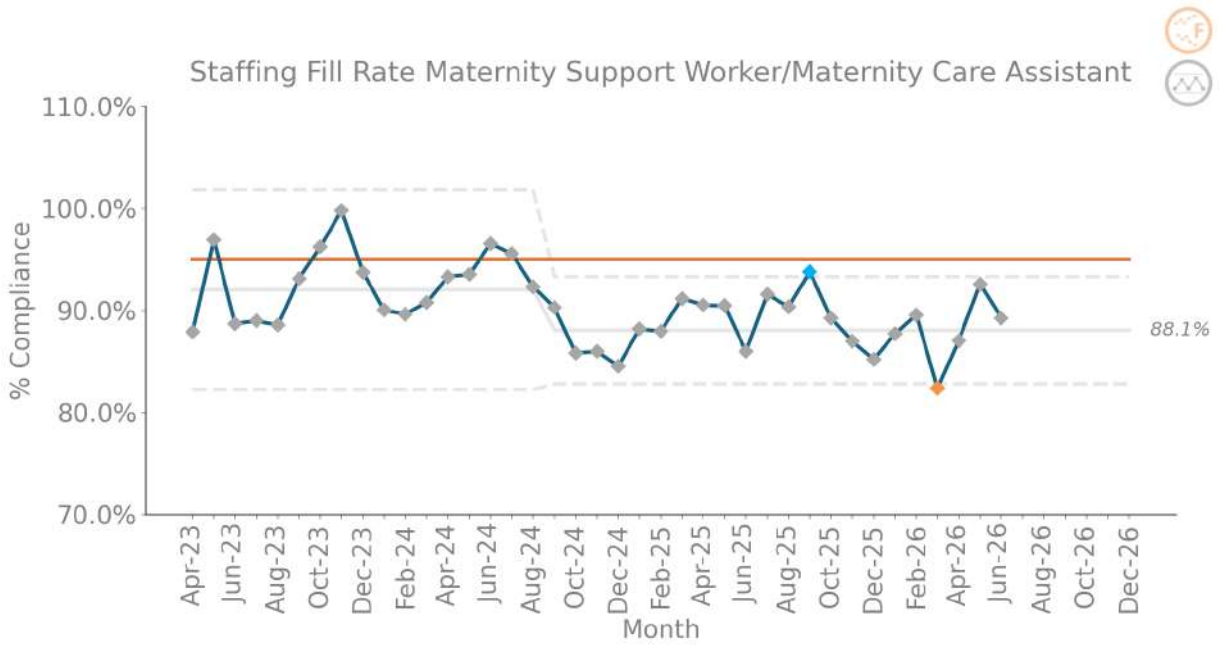
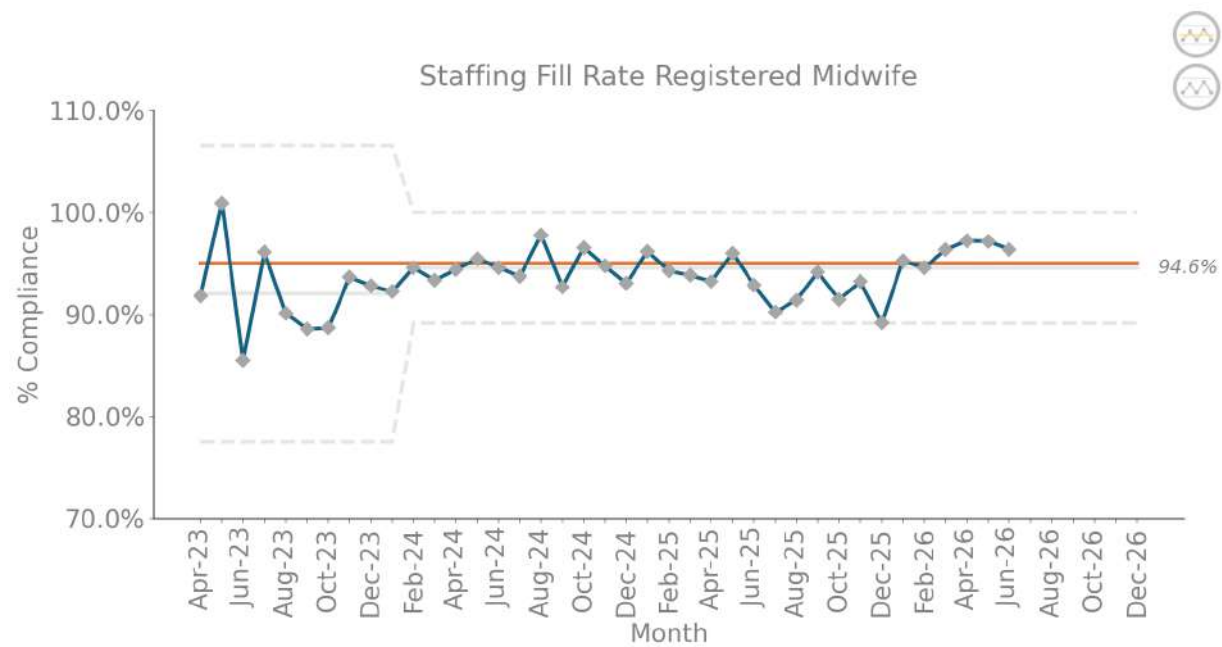
Latest
2
Variance Type
Normal variation - no recent change
Mar-27 Target
0
Target Achievement
Could both pass or fail target within expected variation

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



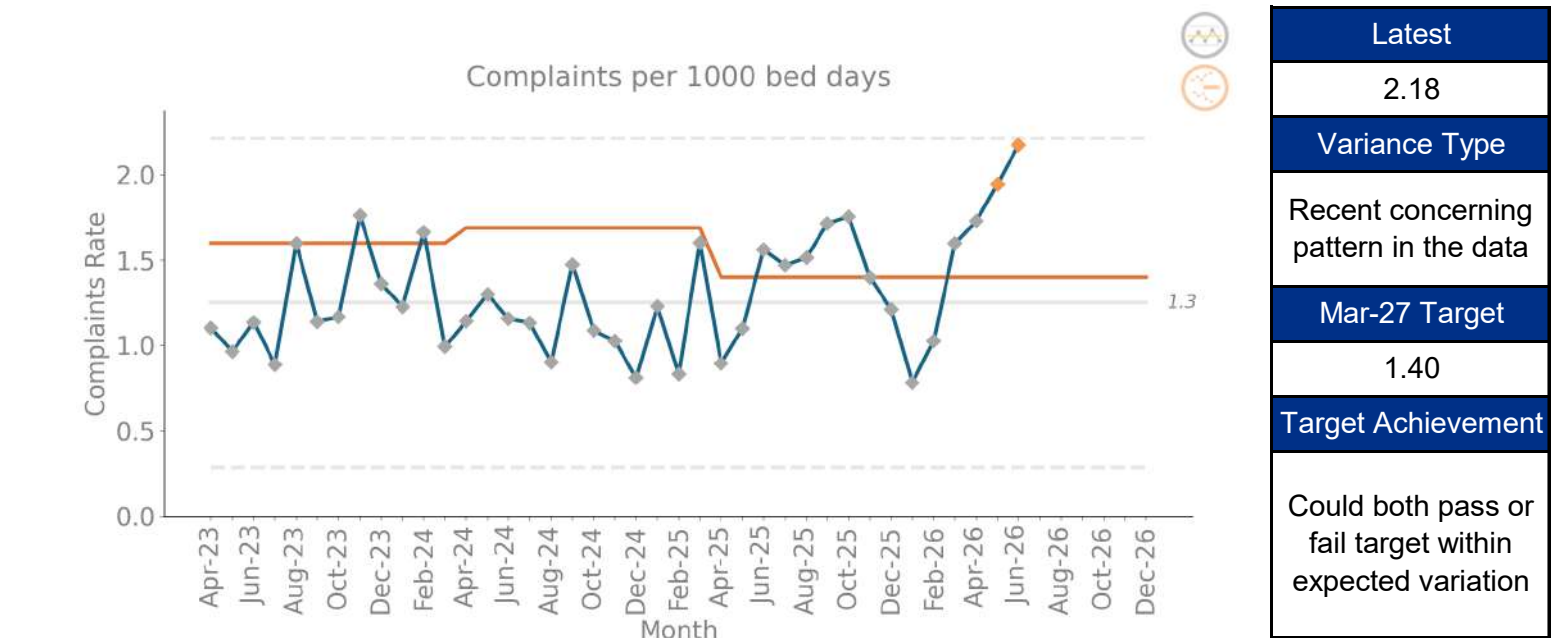
Metric	Summary	Action	Assurance
Staffing Fill Rate Registered Nurse	The Registered Nurse (RN) staffing fill rate for June 2026 was 95.34%, remaining within the Trust target range. Chorley District Hospital (CDH) achieved a fill rate of 98.22%, while Royal Preston Hospital (RPH) reported 94.94%. Overall performance continues to provide assurance that safe staffing levels are being maintained, supported by daily staffing reviews, proactive workforce deployment and established escalation processes. Staffing levels continue to be monitored alongside patient acuity, quality indicators and red flag events to ensure emerging risks are identified and managed appropriately.	- 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.	- 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. - Delegated authority for bank approval in place to support budget holders in achieving bank approval permissions with clear standards, targets and monitoring.
Staffing Fill Rate Health Care Assistant	Health Care Assistant (HCA) fill rates have shown a downward trend and have been rebased from this month to reflect the impact of high vacancy levels across inpatient wards. The overall fill rate in June was 94.62% (CDH 93.98%, RPH 94.74%), marginally below the Trust target range. Temporary staffing and proactive workforce management continue to support safe care delivery and mitigate immediate risks; however, vacancy levels and ongoing reliance on bank staffing remain a workforce risk that continues to be closely monitored.	- 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 began in April 2026. - Centralised external recruitment campaign - currently recruited to 64.55wte Band 2, 54.91wte band 3. - Level 3 apprenticeship due to commence September 26, level 2 apprenticeship interviewed with a planned commencement in October 26.	

Patients - Deliver Annual Safe Staffing Requirements Assurance



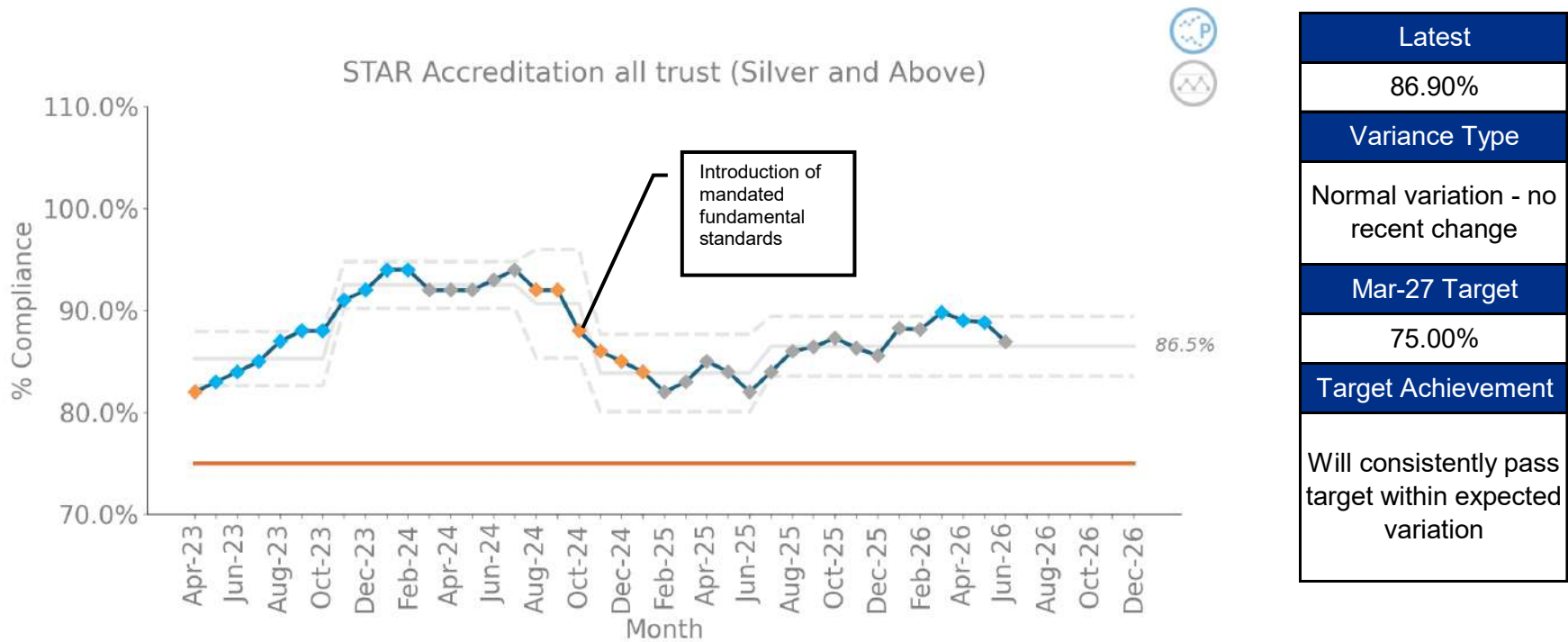
Metric	Summary	Action	Assurance
Staffing Fill Rate Registered Midwife	The overall midwifery fill rate is 96.3% which remains above the Trust target of 95%. This has been the case for the past four months. Unfilled shifts continue to be sent to bank and agency to maintain safe staffing as required. The over-offer recruitment approach is being utilised to maximise the opportunity to recruit newly qualified midwives following qualification in the coming months. This supports workforce sustainability recognising anticipated turnover and vacancies.	1. Monthly roster efficiency meetings overseen by the deputy Divisonal Midwifery and Nursing Director 2. The service continues to recruit to turnover using over offer between 5 and 10 WTE. 3. Annual staffing paper including Birth Rate Plus approved by the Safety and Quality Committee (February 2026) and Board of Directors (April 2026)	1. Registered Midwife fill rates remain stable across day and night shifts. 2. The Safety and Quality Committee reviews fill rates and minimum RM levels for each area monthly. 3. 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. 4. Biannual safe-staffing reviews are completed in line with National Quality Board guidance. 5. A weekly PSIRF oversight panel reviews harm levels, supported by quarterly serious-incident/PSIRF reporting. 6. Red-flag reporting is monitored to identify areas requiring additional support to mitigate risk.
Staffing Fill Rate Maternity Support Worker/Maternity Care Assistant	The Maternity Support Worker staffing fill rate remains below target level at 88.1%. Whilst recent months have shown some improvement following a low point in early 2026, there has not yet been sufficient sustained improvement to demonstrate a stable shift in performance. Reduced fill rates are predominantly associated with vacancies. Delays in VCP have impacted on the ability to recruit band 2 and 3 support staff, however, approval for external recruitment has been agreed to maximise the opportunities for successful recruitment.	1. Ongoing recruitment to fill all vacancies which are tracked using a local trajectory plan. 2. Sickness management procedures are reviewed by Workforce Business Partner to ensure appropriate management. 3. Band 2 and 3 MSW vacancies have been approved for external recruitment (21.07.2026)	1. The Safety and Quality Committee reviews fill rates and minimum safe-staffing levels by area each month. 2. Work with the Matron for Safe Staffing is underway to report area-specific fill rates to better identify pressure points and target actions. 3. Rosters and agency shifts are overseen and approved by the Deputy/Divisional Midwifery and Nursing Director. 4. Biannual safe-staffing reviews are completed in line with National Quality Board guidance. 5. A weekly PSIRF oversight panel reviews harm levels, supported by quarterly serious-incident/PSIRF reporting. 6. Red-flag reports are monitored to highlight areas requiring additional support to manage risk.

Patients - Complaints



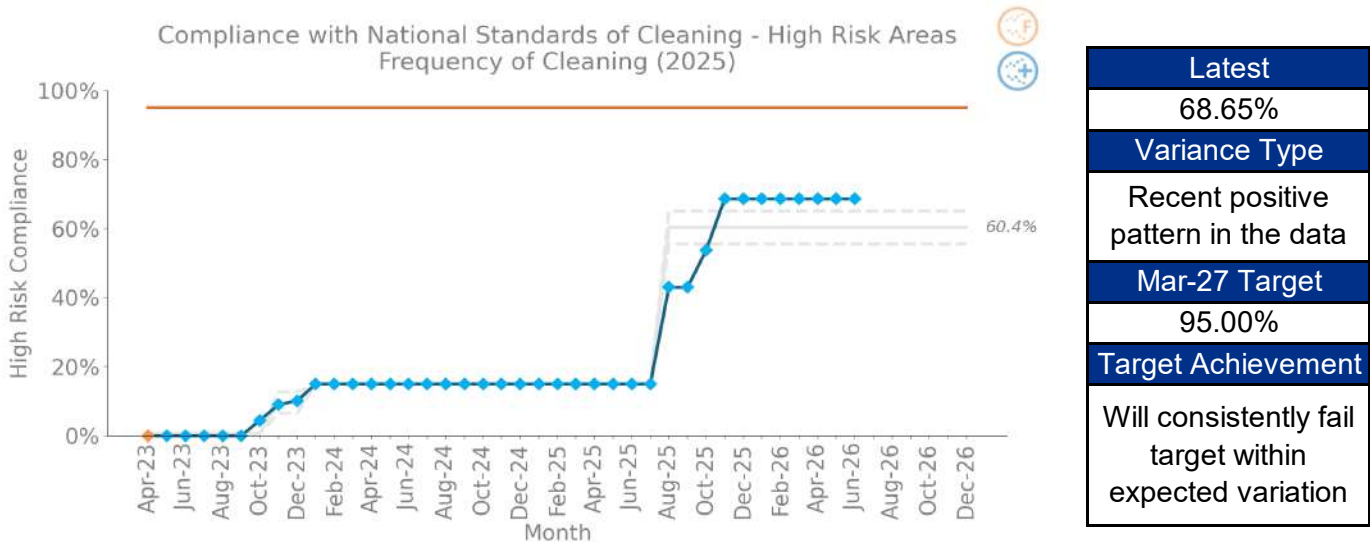
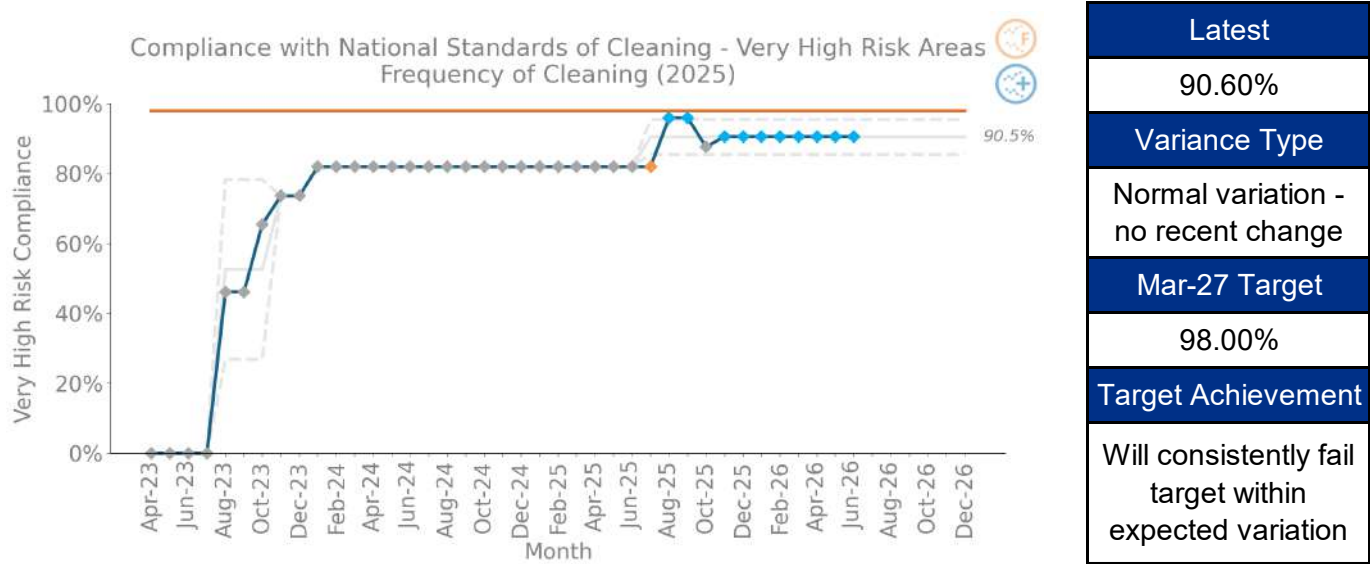
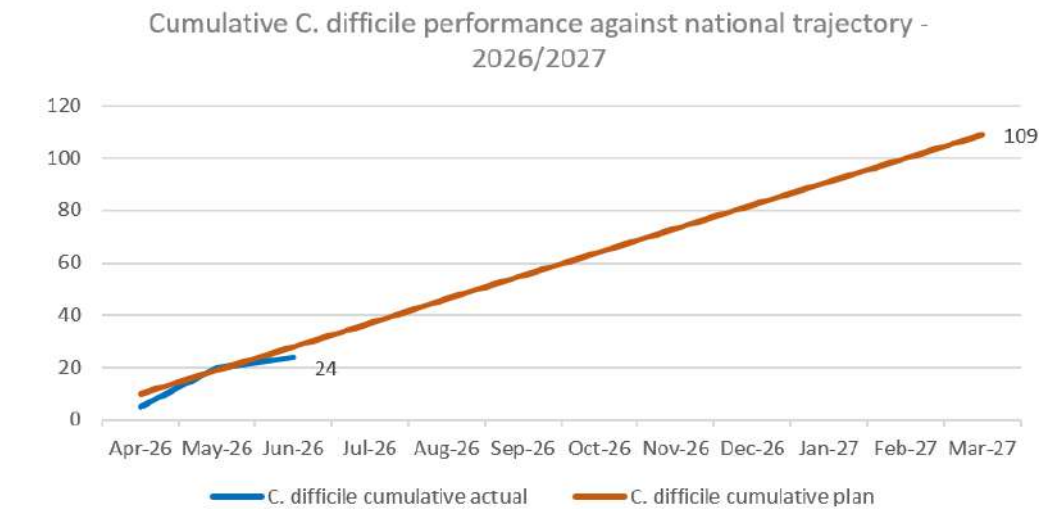
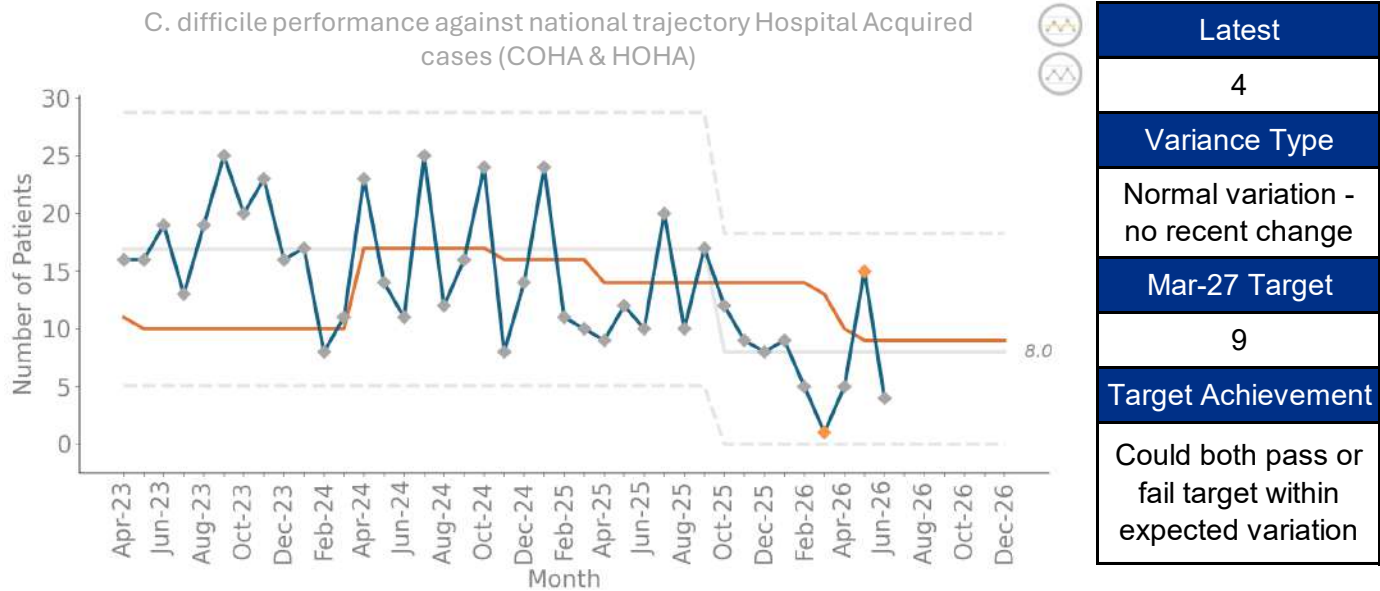
Metric	Summary	Action	Assurance
Complaints per 1000 bed days	Complaints per 1,000 bed days from April 2023 to early 2026, with performance fluctuating around a central baseline and a stepped trajectory line indicating expected or target levels.Overall, complaint rates have increased this month from 1.94 in May to 2.18 in June. There has been an increase in complaints in line with the frequent areas that require continued focus. Complaints continue to be predominantly driven by communication failures, delays in care and discharge processes. Patients consistently report frustration when expectations are not managed, information is inconsistent, or updates are not provided. Operational pressures, particularly waiting times, discharge complexity, corridor care and environmental challenges, remain significant contributors to dissatisfaction. Accessibility, cultural responsiveness and equitable communication also remain important themes for improvement. The Trust’s Single Improvement Plan is guiding both immediate service improvements and longer-term system change to support sustained reduction.	- Continue to deliver the Single Improvement plan - Patients - Continue to deliver the Patient Safety Incident Response Framework with a focus on family liaison roles - Monitor actions in relation to National picker Surveys . - To deliver the PALS and local early resolution training. - Continue to progress the complaints review group using patient safety partners and governors - Where concerns have not been responded to locally escalate to managers. - ELearning training for PALS concerns and a seperate package for Complaints Handling are now on training records.	- Annual patient experience reports to Safety and Quality committee. - Friends and family monthly reporting in place for all departments. - Inclusion of patient experience in STAR. - Chief Nursing Officer reviews all complaints and signs off responses. - Monitor picker survey action plans through Patient, Carer, Experience and Involvement Group.

Patients - Quality Assurance STAR Accreditation



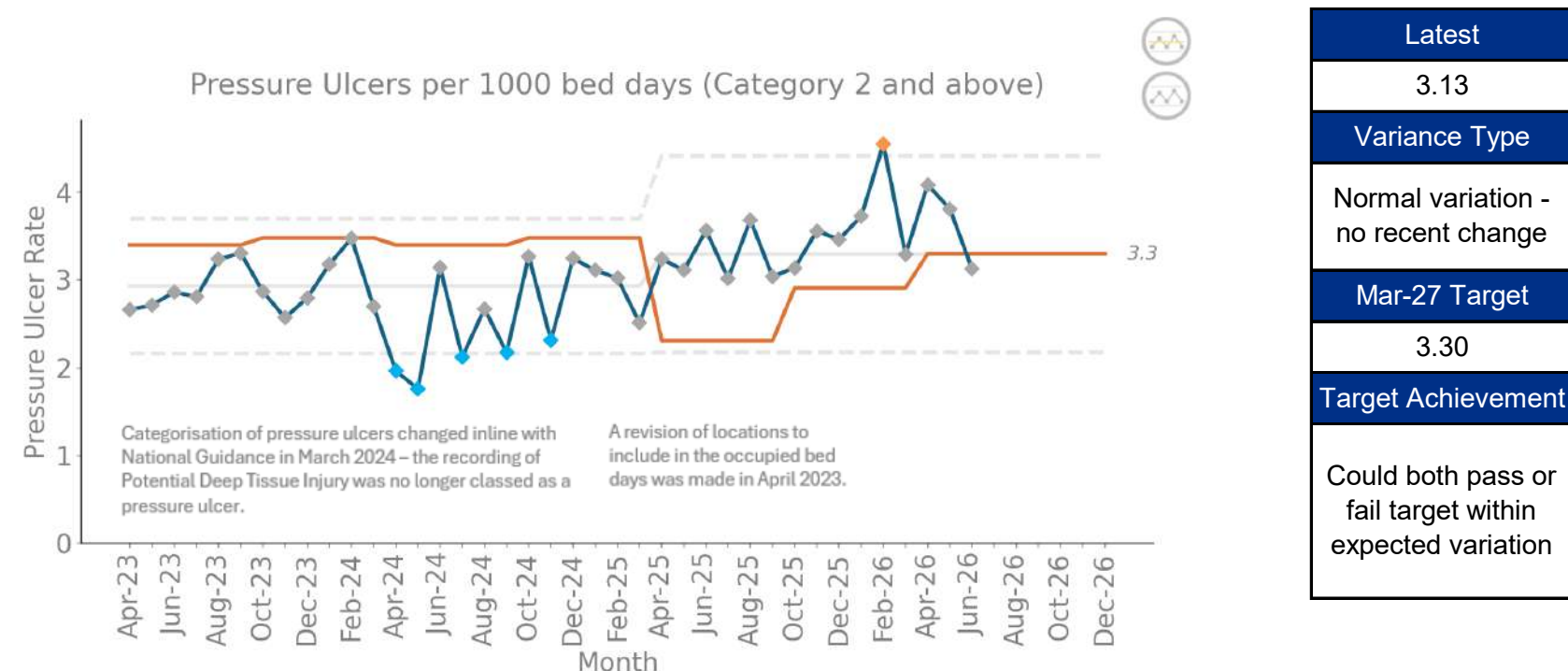
Metric	Summary	Action	Assurance
STAR Accreditation all trust (Silver and Above)	There are 118 clinical areas registered for the STAR Quality Assurance Framework. There are 102 areas rated green, 13 areas rated amber and 2 areas rated red. This results in 73 gold stars, 29 silver stars and 15 bronze stars. Of those 29 areas with silver stars, there are 5 who have achieved 3 consecutive silver stars and are awaiting gold panel approval. The Trust achieved 86% of areas rated silver and above and 68% of areas are rated gold for STAR accreditation visits. During June, there were 3 areas who maintained a bronze star rating, 1 area reduced from silver to bronze, 2 areas reduced from gold to bronze, 1 area achieved their 3rd silver star and 2 areas achieved their first silver star. 11 areas maintained their gold star rating. Themes for improvement include a new emerging theme about missed appointments with patients attending clinics to be told the clinic has been cancelled, expired consumables including enteral feed and supplements, recurring gaps in safety checks and equipment assurance, risk assessments in particular weights and MUST as well as inconsistencies with fluid and food dietary charts. Recurrent themes are included within the STAR report, these include patient experience, staff experience relating to workforce pressures, IPC practice and intentional rounding and repositioning chart compliance. The Trust achieved 88% of Wards, ED and Theatres rated silver and above and 64% of these areas rated gold for the STAR accreditation visits.	- Any standards which are not achieved require an improvement action which is monitored within the division through divisional assurance processes and via STAR monthly reviews and STAR accreditation visits. - The monthly STAR report includes trust wide and divisional STAR data and highlights good practice, areas for improvement, themes for learning and an overarching STAR improvement 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 for 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 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



Metric	Summary	Action	Assurance
C. difficile performance against national trajectory - no more than 109 Hospital Acquired cases	During June 2026 there have been a total of 4 cases for the month, with a year to date total of 24 cases for 2026 / 2027. The Trust's National objective for 2026/2027 has been set as 109 cases, this is a further reduction from the tolerance of 167 cases in 25/26. 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. Vacancies have been successfully recruited to, with staff progressing through onboarding. A clear delivery plan to achieve compliance is due in September.	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 but has been escalated and is 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 - Pressure Ulcers Assurance



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, to provided proactive intervention, real-time feedback and education to ward teams. These measures strengthen oversight and support early intervention with a Trust focus on pressure ulcer prevention in line with the Trsut imrovement plan.	- Monthly divisional review of pressure ulcer incidents, themes and trends through ASF meetings, translating learning into targeted actions to reduce harms. - Weekly Pressure Ulcer Review Panel to review harm, identify factors, and drive actions to prevent recurrence, with learning escalated through governance (from Nov 2025). - Proactive risk reduction rounds led by the tissue viability team, providing real-time support and challenge to improve prevention and reduce avoidable harm (from Mar 2026). - Delivery of an evidence-based improvement plan addressing key incident themes, with impact measured through reduced pressure ulcer incidence. - Strengthened data quality through housekeeping and reporting processes to ensure consistent, reliable data for monitoring trends and providing credible assurance.	- Divisional Always Safety First Committees provide oversight of the pressure ulcer improvement plan and monitor progress against key actions. - Monthly monitoring of pressure ulcer incidence continues as a priority quality metric, with trends reviewed at divisional and Trust level. - STAR compliance for key questions 8d and 9c is monitored monthly as leading indicators of prevention practice. - Weekly Pressure Ulcer Panel, with a consolidated monthly learning report submitted to PSIRF Oversight. - 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	84.3	February 2026
Lower Than Expected	84.1	February 2026
As Expected	52.8	February 2026
As Expected	73.0	February 2026

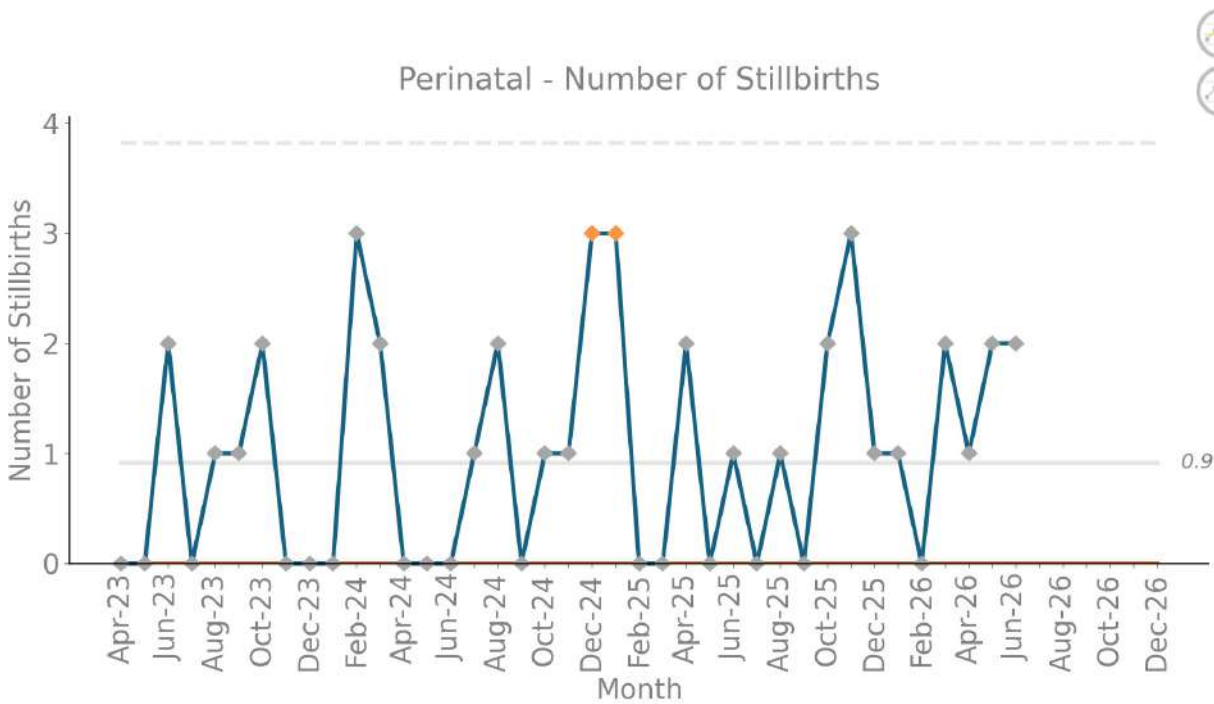
Hospital Standardised Mortality Ratio - Adult
Standardised Mortality Ratio - Relative Risk - All Diagnoses Adult
Standardised Mortality Ratio - Relative Risk - All Diagnoses Child (<1 day – 17 yrs)
Standardised Mortality Ratio - Relative Risk - All Diagnoses Neonates (<1-28 Days) <i>The updated TELSTRA 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. 7. Review the interface of Medical Examiner Reviews, Incident Reporting and Structured Judgement Reviews to ensure timely identification of harm level associated with patient deaths.	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.		



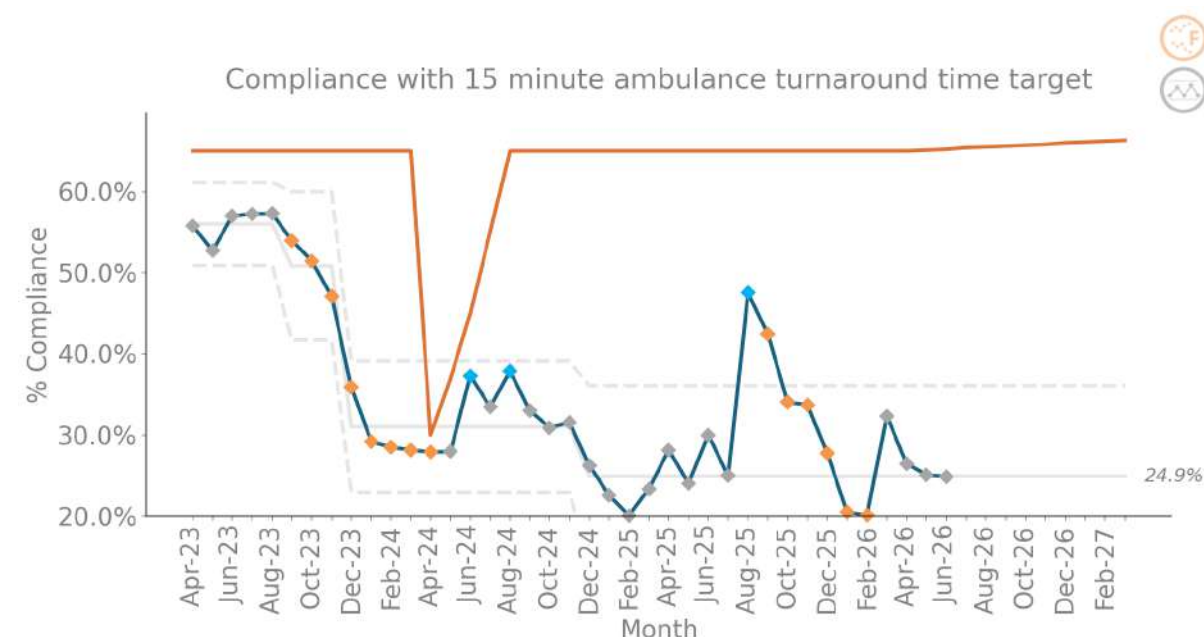
Patients - Stillbirths Assurance



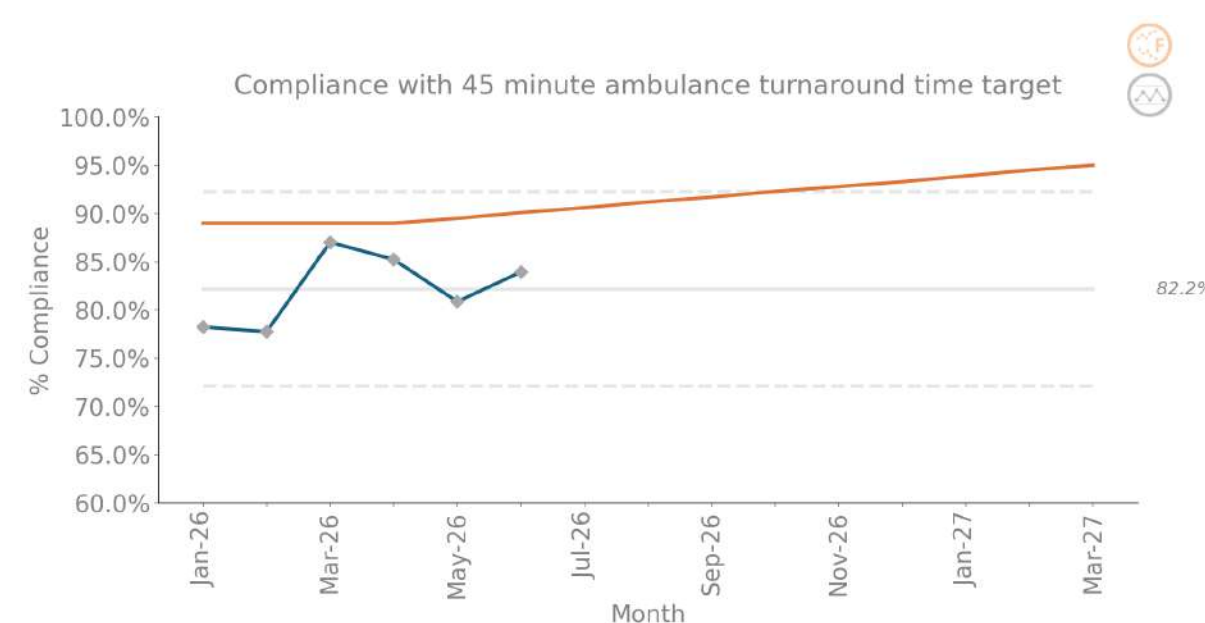
Latest
2
Variance Type
Normal variation - no recent change
Mar-27 Target
0
Target Achievement
Could both pass or fail target within expected variation

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. The 12-month local average mean still birth rate is 2.1 per 1000 (May 2025 to April 2026 excluding TOPFA) 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 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., there are no live signals at this time.

Performance - UEC Assurance



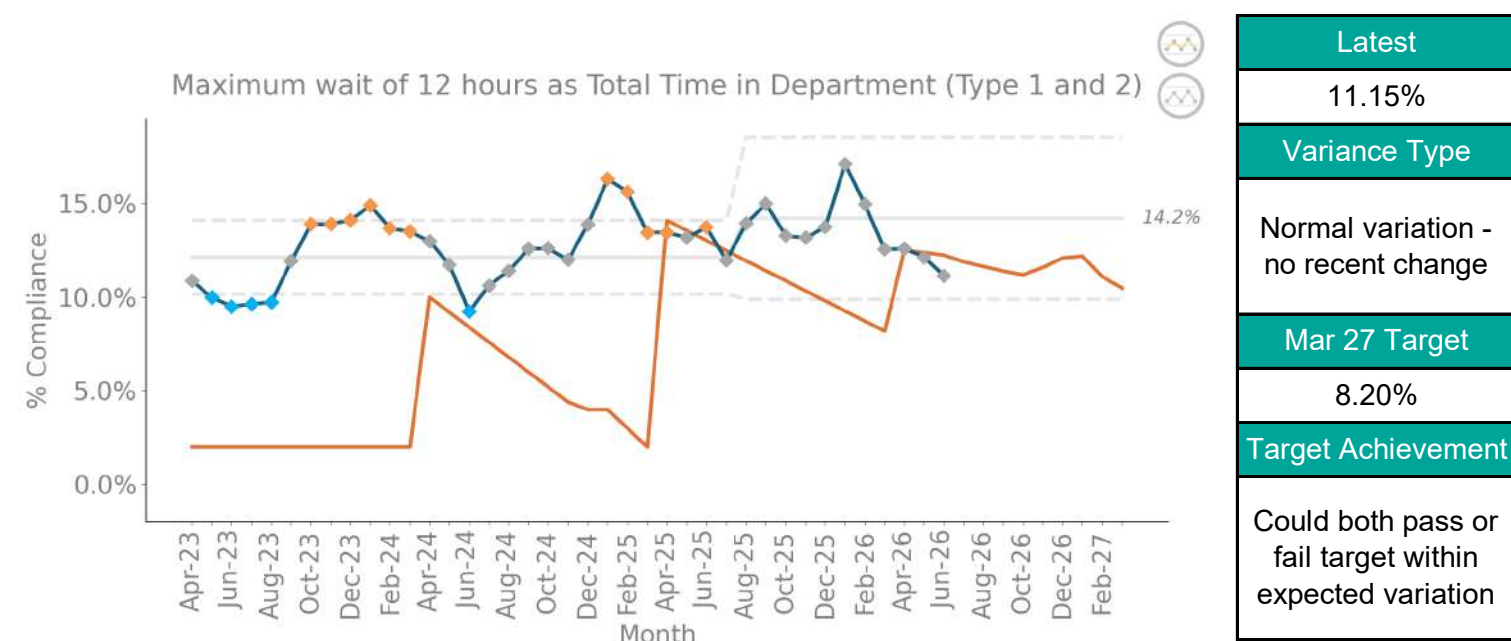
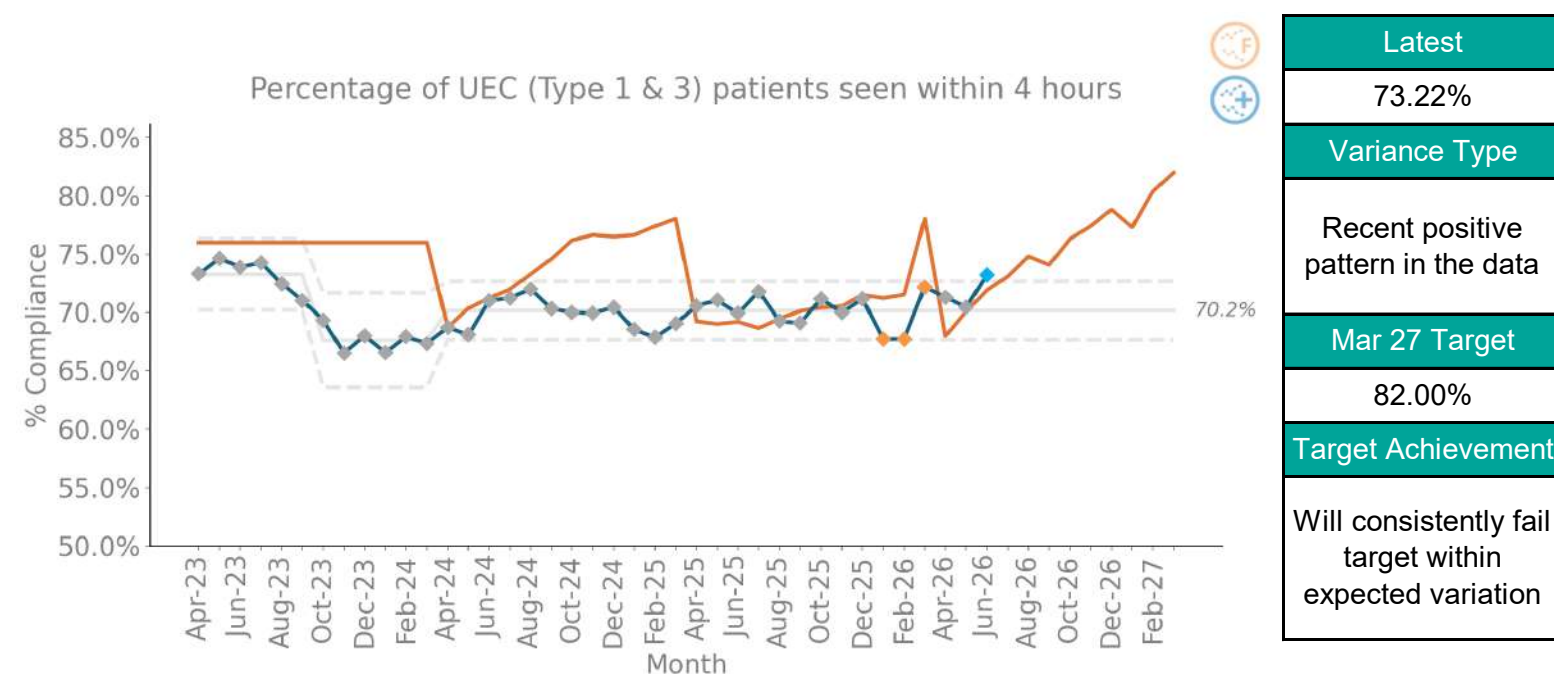
Latest
24.86%
Variance Type
Normal variation - no recent change
Mar 27 Target
66.3%
Target Achievement
Will consistently fail target within expected variation



Latest
83.94%
Variance Type
Normal variation - no recent change
Mar 27 Target
95%
Target Achievement
Will consistently fail target within expected variation

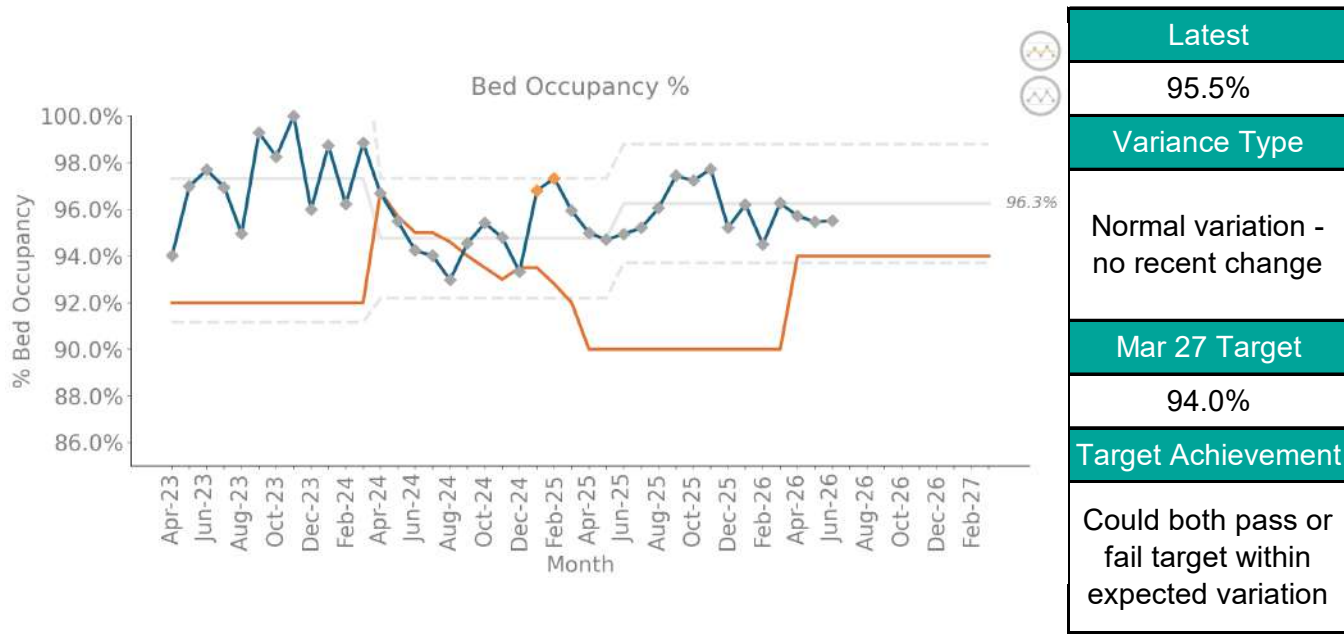
Metric	Summary	Action	Assurance
Percentage of Ambulance Handovers within 15 minutes - Trust	In June 24.86% of patients were handed over from Nwas within 15 minutes, a deterioration improvement of -2.79%. However the current position shows normal variation and will consistently fail the target within expected variation.	Improvement actions to support timely ambulance handover will be supported via the launch of the EEMAC, re-designed Acute Medical model and 24/7 SDEC which will commence at the end of July 26. 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 will support delivery of a 1 day LOS reduction for DKAFH patients in pathways 1-3, thus reducing bed occupancy and aiding timely flow from ED. 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.	Comparison to both the national and regional performance positions for June 26 indicates that the Trust is below the national performance of 34.8% for 15 minute handovers and below the NW performance position of 30.1% of handovers within 15 minutes.
Percentage of Ambulance Handovers within 30 and 45 and 60 minutes - Trust	In June 464 patients waited between 30-60 minutes to be handed over from Nwas to the Trust, a marginal increase of 54 from last month. 258 patients waited over 60 minute to be handed over from Nwas to the Trust in June, an decrease of 58 compared to the previous month. In June 83.94% of patients were handed over within 45 minutes, a 2.44% improvement compared to the previous month.		Comparison to both the national and regional performance positions for June 26 indicates that the Trust is below the national performance position of 74.4% for 30 minute handovers and below the NW performance position of 74.3%.

Performance - UEC Assurance

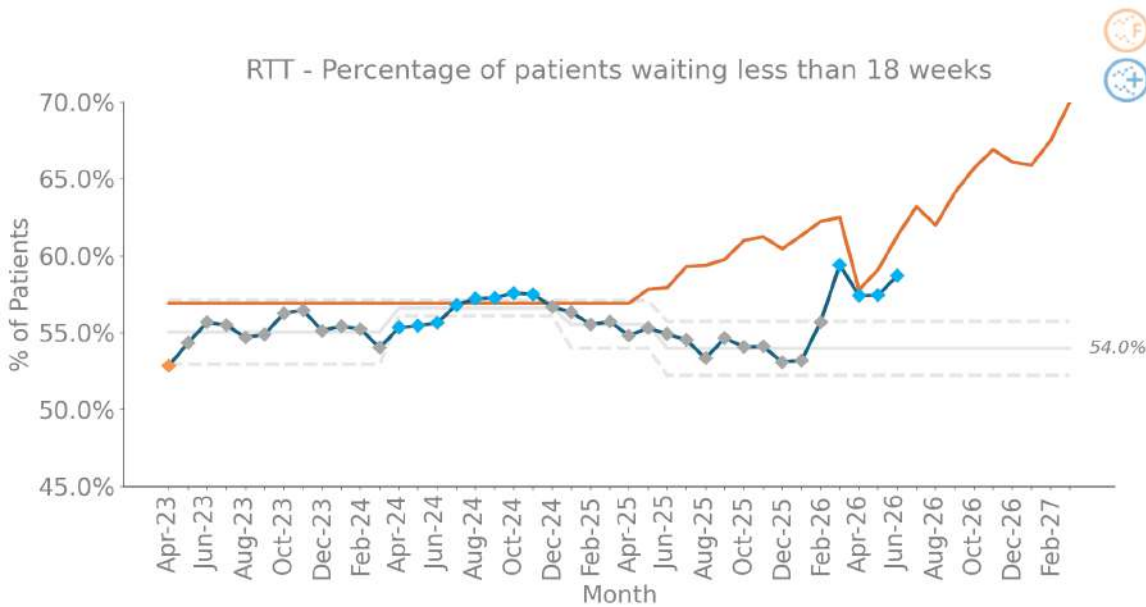


Metric	Summary	Action	Assurance
ED 4 Hour Performance - Trust	Performance against the national 4 hour access standard improved in June 2026. Performance was 2.7% higher than May 26, and is above the Operational Plan target for June 26. This is the third consecutive month above target and represents the highest performance the Trust has seen since July 2023. June 26 experienced a higher daily attend than May 26 of approximately 14 per day.	Progress continues with the Trusts UEC Transformation programme with key themes focusing on re-designed pathways Pre and Post hospital, the acute medical model of care, SDEC, Frailty and site escalation. To accompany this, workforce modelling has been completed and takes effect in July 26 to better align the clinical workforce to times of patient presentations. An Extended Emergency Medicine Ambulatory Care facility has been launched in July. Ther re-designed Acute Medical Model (MAC) will commence on 29th July providing 24/7 SDEC provision and a Frailty SDEC service will be launched in Q2.	Comparison of 4 hour performance to the latest published national benchmarks indicates that the Trust is below the national average for June 26 of 75% and was ranked 69 out of 118 trusts nationally, an improvement of 23 places compared to May 26.
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 decreased further in June to 11.15%, a decrease of -1.15% compared to May. The position shows normal variation and could both pass or fail the year end target.	Work continues within the DKAFH programme. . 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.	The level of boarded patients decreased marginally in June with an average of 28 patients per day. The volume of Days Kept Away from Home patients is far in excess of the target and above the June 25 position.

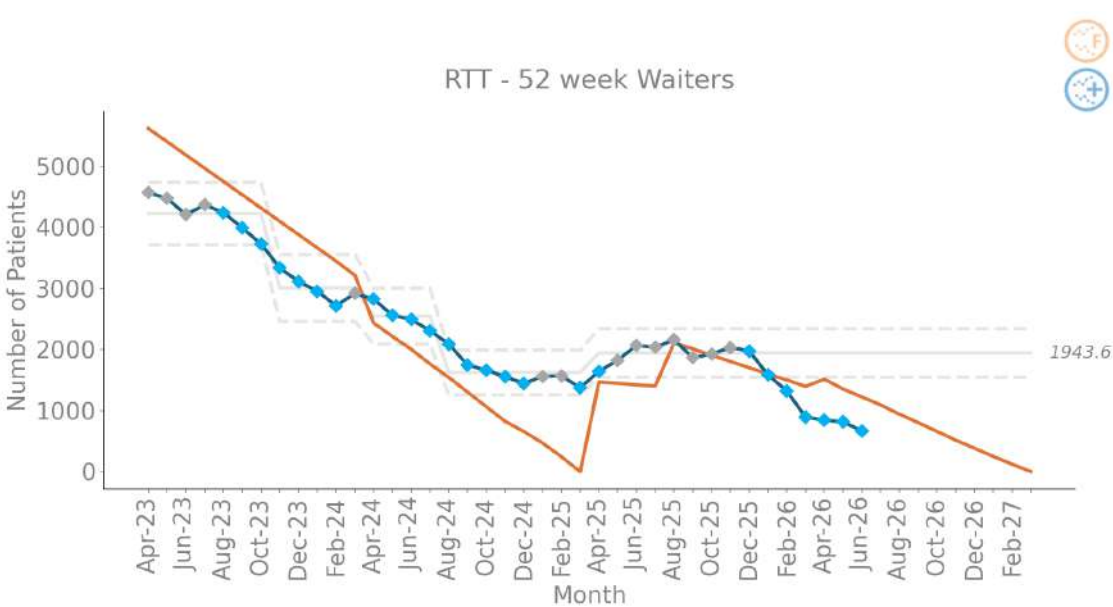
Performance - UEC Assurance



Performance - Elective Care Assurance



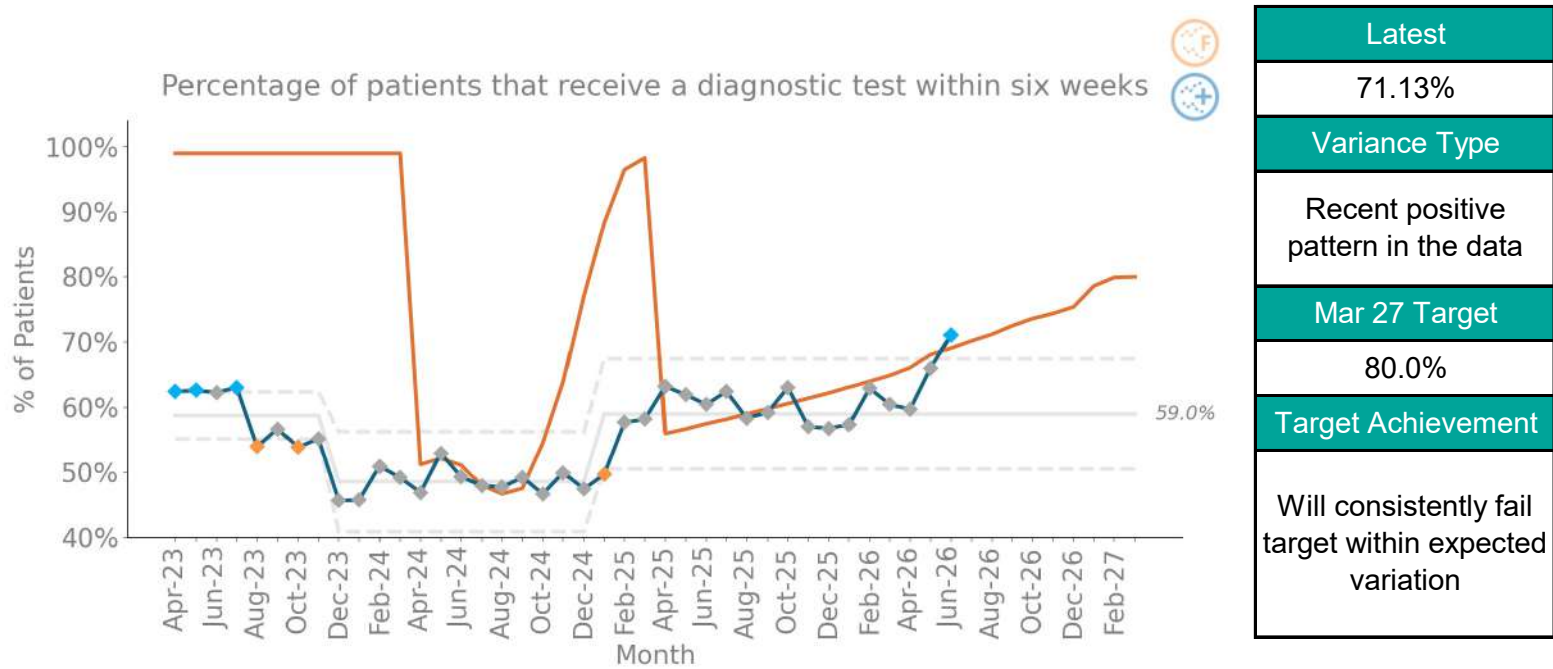
Latest
58.72%
Variance Type
Recent positive pattern in the data
Mar 27 Target
70.00%
Target Achievement
Will consistently fail target within expected variation



Latest
666
Variance Type
Recent positive pattern in the data
Mar 27 Target
0
Target Achievement
Will consistently fail target within expected variation

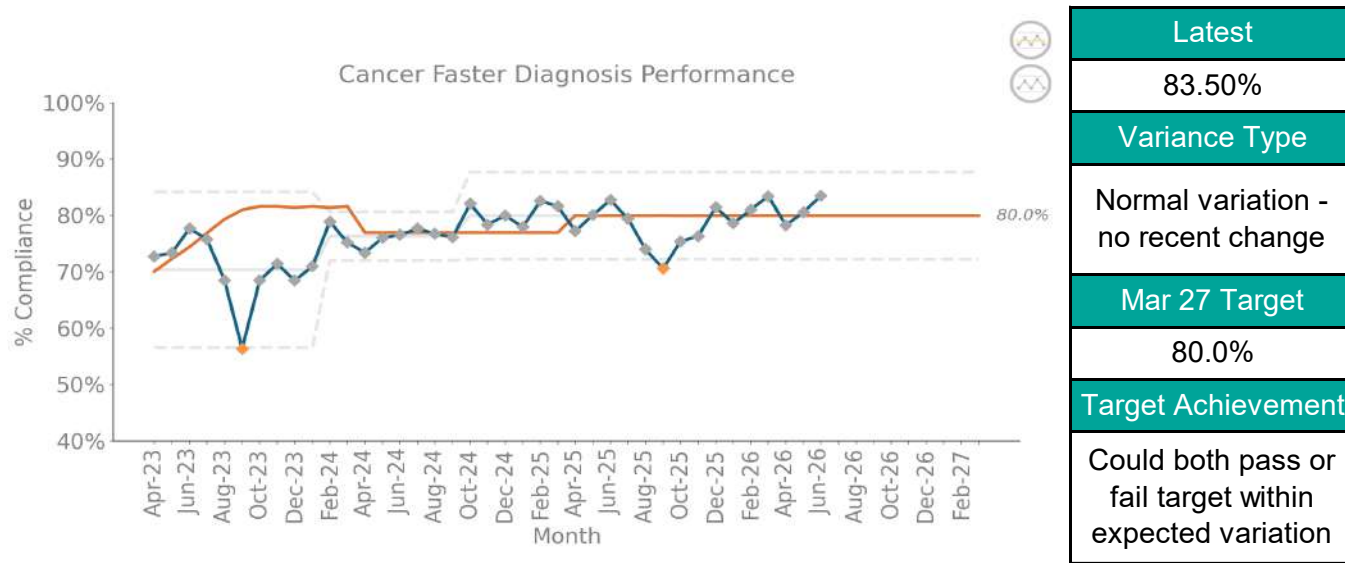
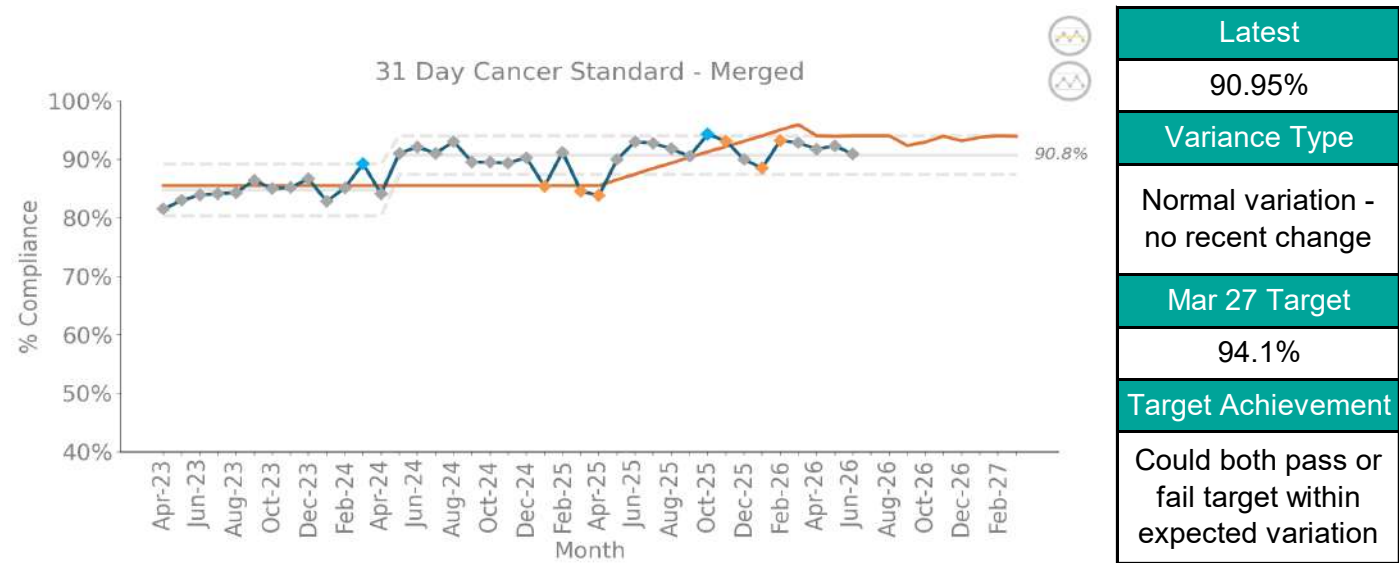
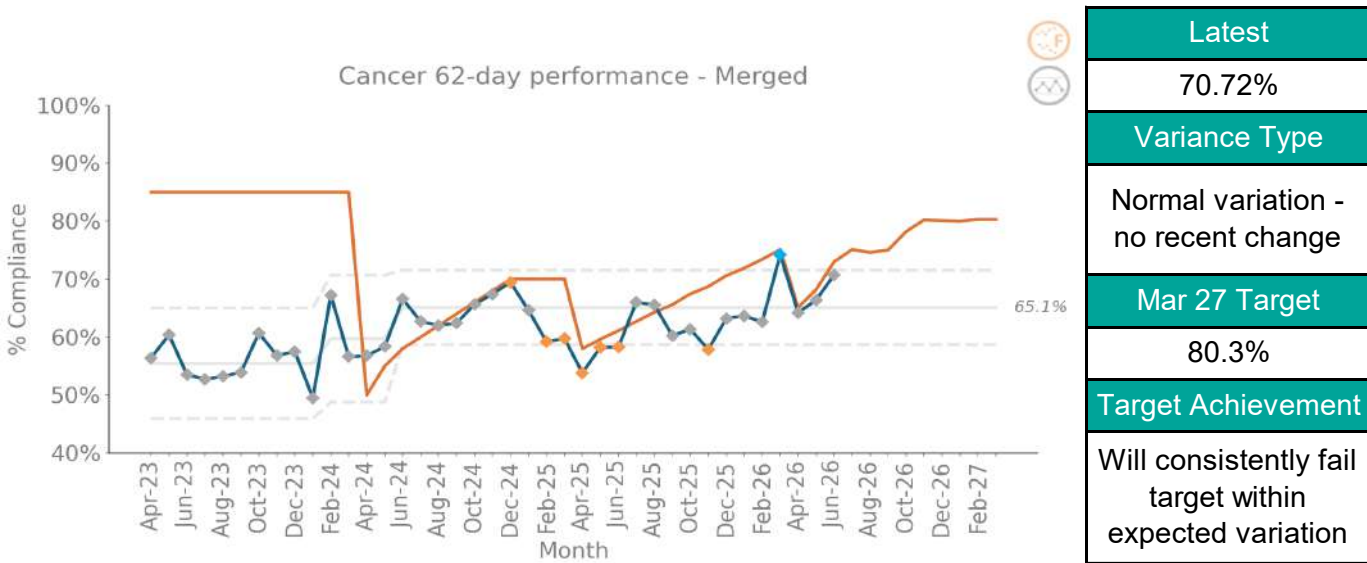
Metric	Summary	Action	Assurance
Percentage of patients waiting less than 18 weeks	The June 26 position of 58.7% is a 1.3% improvement compared to May 26. Analysis suggests a recent positive pattern in the data and that the target will be consistently failed. The Operational Plan 2026/27 year end target 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 a further 0.5%.	Comparison to the latest national performance position (May 26) indicates that the Trust is below the national position of 65.6% waiting under 18 weeks. The Trust is ranked 113 out of 118 trusts nationally for May 26 performance.
RTT - 52 week Waiters	The over 52 week waiter position in June was 666, a further decrease of -149 compared to the May 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 (May 26) indicates that the Trust at 1.3% in May was below the national picture of 1.4% waiting over 52 weeks. June continues that trend at 1.1%. The Trust was ranked 69 out of 118 trusts that submitted data for May 26 performance.

Performance - Elective Care Assurance



Metric	Summary	Action	Assurance
Percentage of patients that receive a diagnostic test within six weeks	Diagnostic under 6 week performance was 71.13% in June compared to 66.02% in May, a further 5.11% improvement on the May position and above the trajectory for June of 69.1%. The June 26 DM01 performance is the highest reported since March 2020. The performance has been driven by further improvements in NOUS, Echo and Sleep Studies over 6 week waiters. Urgent and cancer patients are prioritised and seen within 2 weeks. Presently 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 is impacting on the improved position. Internal colleagues undertaking additional work but shortfall remains. Capacity and demand modelling completed and recruitment and increased IS capacity are being mobilised.	The areas of focus are capacity optimisation, productivity, transformation and system working. Review of the latest published data (May 26) indicates that LTH is 99th out of 118 trusts that submitted data, an improvement of 7 places compared to April but significantly below the national average of 76%.

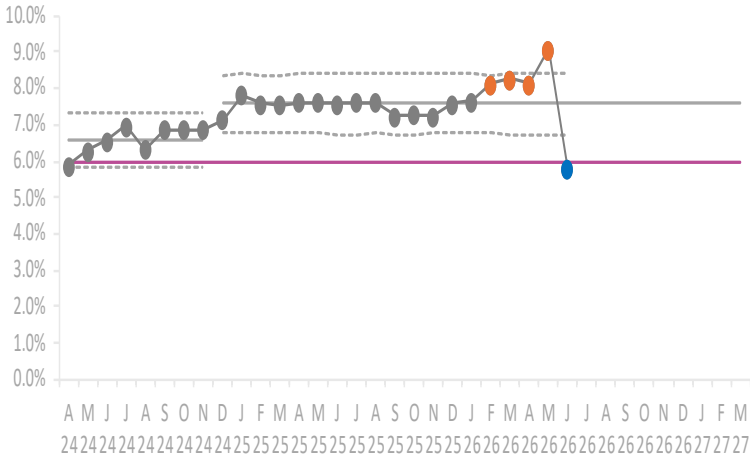
Performance - Elective Care Assurance



Metric	Summary	Action	Assurance
62 Day Cancer Standar - Merged	Performance to the end of June 26 (currently unvalidated) has improved compared to last month, and is below the monthly operational plan target of 73%. Analysis shows normal variation in the data and will consistently fail the target within expected variation.		June 26 performance is above the national performance of 69.6% (May 26), the trust was ranked 71 out of 119 trusts for May performance, an improvement of 26 places.
31 Day Cancer Standard - Merged	Performance to the end of June 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 normal variation 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 10 specialties 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. Recruitment into key clinical vacancies has commenced with postholders due to commence in role starting 03/08/26.	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 June latest position for this standard at 90.95% is 1.85% below the national average (May 26). The Trust is currently ranked 78th out of 117 Trusts (May 26).
Cancer Faster Diagnosis Performance	Performance to the end of June 26 (currently unvalidated) is above last months position, above 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 month on month target of 80% achieved. The Trust is currently ranked 53rd/119 trusts.

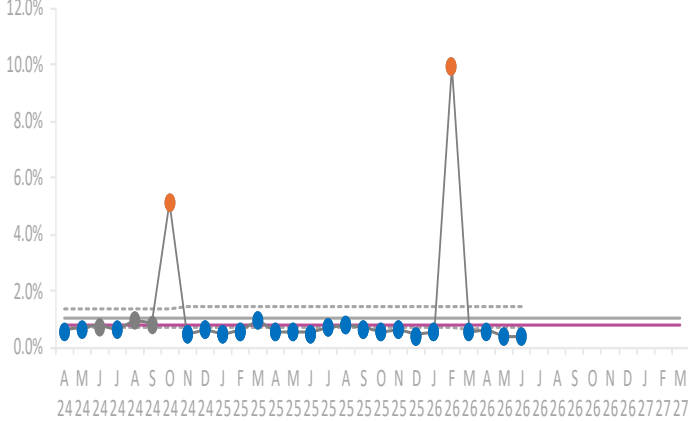
People - Workforce Assurance 1

GL Vacancy Rate (% FTE)



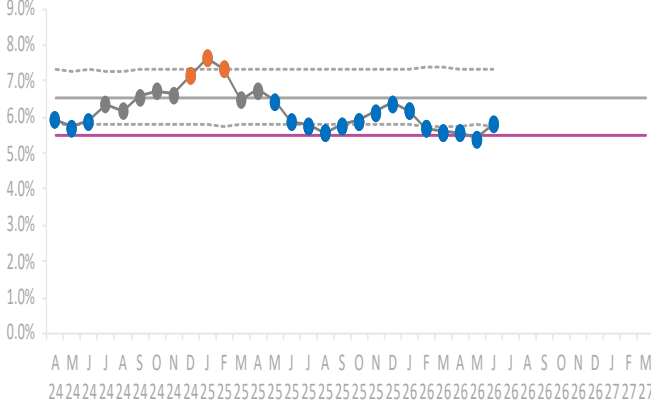
Latest
5.77%
Variance Type
Recent positive pattern in the data
Mar 27 Target
≤ 6%
Target Achievement
Will consistently fail the target within expected variation

ESR Turnover (% FTE)



Latest
0.41%
Variance Type
Recent positive pattern in the data
Mar 27 Target
≤ 10%
Target Achievement
Could both pass or fail target within expected variation

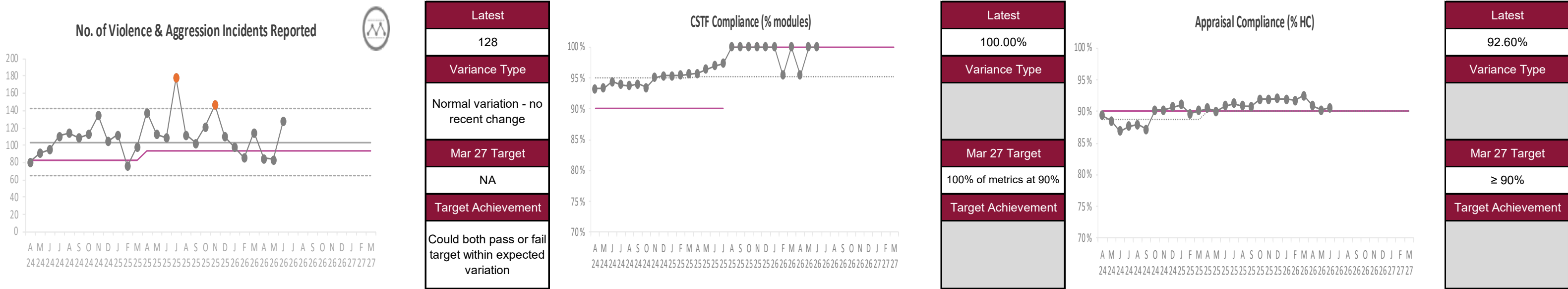
Overall Sickness (% FTE)



Latest
5.81%
Variance Type
Recent positive pattern in the data
Mar 27 Target
≤ 5.5%
Target Achievement
Could both pass or fail target within expected variation

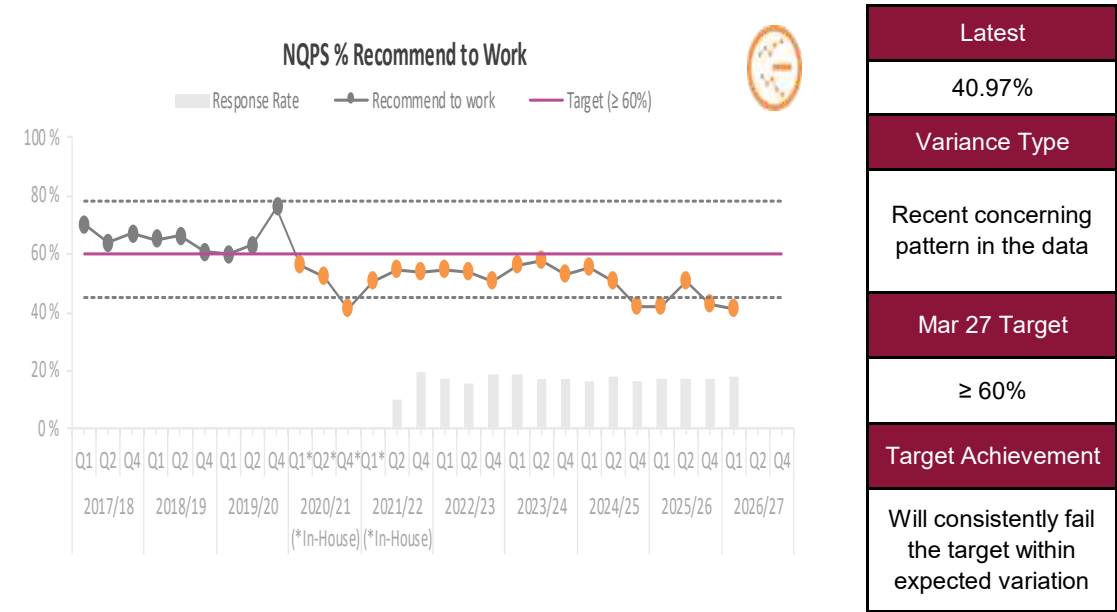
Metric	Summary	Action	Assurance
Vacancies (% FTE)	Vacancy rate has reduced significantly in month due to the recent establishment cleanse and vacancy removal schemes.	Strategies to address Band 2/3 Healthcare Support Worker gaps being jointly developed by nursing, education and workforce teams Vacancy control process updated to include defined times for holding posts for redeployment and internal/external advertising All posts currently held for redeployment under review	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)	In-month turnover significantly reduced in M3 and is below target.	Leaver and exit interview data continues to be monitored to identify any patterns or themes of concern. Any issues are escalated to Workforce BP colleagues and themes/trends discussed through the Monthly Recruitment and Retention Group and Divisional Workforce Committees. New Trust Welcome event has been rolled out, with new starter Forums planning underway for delivery in July to understand colleague experience during onboarding/first year.	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. 6 monthly retention updates provided to Divisions.
Sickness Absence (% FTE)	Sickness absence increased in M3, with increases in both short-term and long-term absence. The factors driving this are being analysed, including possible correlations with environmental factors during the hot weather.	Due diligence is continuing around a potential alternative digital sickness absence system and an Outline Business Case has been developed. Sickness absence reduction 'Plan on a Page' developed for 2026/27 with a range of actions around policy/process, data, education and wellbeing Health and Wellbeing 'Plan on a Page' also developed for 2026/27 with a broad range of actions to support wellbeing	'Failure to manage sickness absence management effectively' is a Principal Risk and subject to risk management review Annual Health and Wellbeing report, including a deep dive around sickness absence was presented to the July 2026 People & Partnerships Committee Waste Recovery Scheme around sickness absence reduction devolved to divisions and monitored through Divisional Delivery Group and Divisional Improvement Forums

People - Workforce Assurance 2



Metric	Summary	Action	Assurance
Number of violence and aggression incidents toward staff	The number of reported violence and aggression incidents continues to fluctuate monthly, with an increase in M3 (128 incidents). The highest number of incidents consistently occur in Emergency Department and other areas where the nature of the patient's condition makes them more prone to violent and aggressive behaviour.	New violence marker process developed and tested in Harris Flex, with a change in focus to a safety marker, recorded immediately and at source to mitigate further risks to colleagues and patients Violence Prevention and Reduction Rapid Improvement Event held on 13 July 2026 with good engagement from multi-disciplinary colleagues and three new test of change ideas developed Mental Health Big Room continues to focus on continuous improvement relevant to reducing violence and aggression at a local and system level.	Annual deep dive reports around incidents and actions to People and Partnerships Committee Incident data and reviewed through Health & Safety Governance Group
Core Skills Mandatory Training compliance (% modules)	Trust-wide compliance meets or exceeds the 90% threshold across all Core Skills and nationally mandated metrics, supported by established governance, reporting and escalation arrangements.	Divisional management teams are provided with both percentage compliance data and non-compliant staff numbers to support local accountability, prioritisation and escalation in accordance with the Mandatory Training Policy. For practical training requirements, session and assessment capacity is routinely reviewed, with targeted support implemented where additional capacity or improvement action is identified.	People and Partnerships Committee receives assurance on the Trust's governance, monitoring and escalation arrangements for statutory and mandatory training,
Appraisal compliance (% HC)	Appraisal compliance was 92.6% in June which is above the target of 90%. This has increased since May.	All Divisions and Department have received Appraisal compliance data via Workforce Business Partner and Education Compliance Teams, asking to develop plans to achieve 90%. Trust wide communications have been sent to all colleagues with regards to the Standard Operating Procedures which are now being deployed with regards to centralised close when Appraisal target dates have passed however appraisal not closed in a 4 week time period.	Annual Appraisal Update presented to Workforce Committee in May 2025. Divisional Performance metrics shared in Divisional Workforce Committees and Divisional Improvement Forums.

People - Workforce Assurance 3

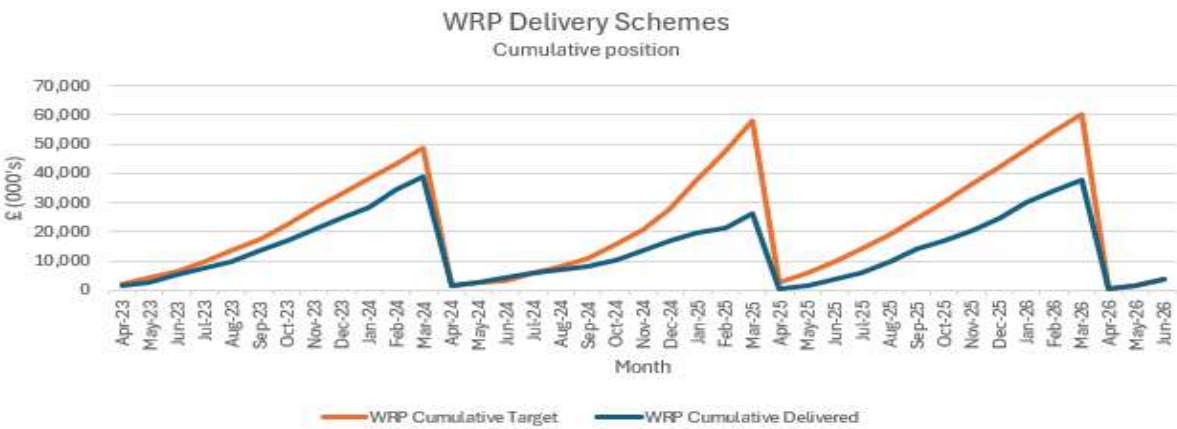


Metric	Summary	Action	Assurance
Staff Survey: Recommend Trust as place to work	Please note: This is a quarterly metric; therefore there is no update this month. The next quarterly data set is due towards end of July 2026.	A corporate-level action plan, developed in response to the NHS Staff Satisfaction Survey, was presented in May and approved by the Workforce Committee. The plan focuses on addressing areas of dissatisfaction that are contributing to lower levels of colleague engagement, as measured in both the National Quarterly Pulse Survey data and National Staff Survey. Staff survey results have been shared through multiple forums. All Divisions, Departments and Managers have been asked to review their local results and develop targeted action plans to drive improvement. A comprehensive communication plan is in place, with weekly updates and targeted interventions currently being delivered across a range of workstreams.	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)
-13,595
Latest YTD Target (,000s)
-13,662
Jun 26 Annual Target (,000s)
-



Latest YTD Actual (,000s)
3,628
Latest YTD Target (,000s)
3,563
Jun 26 Annual Target (,000s)
60,000

Metric	Summary	Action	Assurance
I&E - Plan v Actual variance	The Trust is reporting a £0.07m favourable position to plan to the end of June 2026. The Trust has a YTD £13.60m deficit against a £13.66m planned deficit including planned DSF funding of £2.29m. M3 in month WRP delivery is £3.63m against an in month NHSE Financial Plan of £3.56m, resulting in a positive variance to in month plan of £0.07m.	A re-set of the programme structure, governance and reporting for 2026/27 has taken place, including the introduction of the Productivity Board. Actions taken to reduce headcount include: The trusts MARs scheme has been implemented (15.00 wte) A review of posts within the recruitment pipeline to see what can be removed. One Lsc have also implemented and delivered a MARs scheme	Grip and control Interventions and control measures are constantly being reviewed
WRP schemes delivery	The Trust's 2026/27 waste reduction target is £60m, 5.7% of operating expenditure. Whilst Month 3 WRP delivery was in line with the NHSE Financial Plan the phasing of the plan is heavily weighted to later in the year. The in year Waste Reduction Programme has fully been identified at £60.0m with fully developed schemes to this value. Forecasting of WRP will follow and is assumed to be £60.0m. Confidence levels are being reviewed at DDGs with a risk adjusted forecast to be developed. Scheme development is continuing to ensure that any WRP plan slippage is mitigating.	The Trust has introduced a process to help mitigate the gap on WRP plan. This requests that Divisions review their recruitment pipeline to see what posts can be held to enable realignment to the expected WRP headcount reduction. 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 SAFETY AND QUALITY CHAIR'S REPORTS - FOR CONSIDERATION

10.1a - Annual Safeguarding Report

10.1b - Annual Mortality, LEDER and PMRT Report

A) ANNUAL SAFEGUARDING REPORT

☐ Decision Item

REFERENCES

Only PDFs are attached

 10.1A Annual Safeguarding Ancillary pack.pdf

Meeting of the	Board of Directors	6 August 2026
Title of Report	Annual Safeguarding Report 2025/26	
Report Author	Rich Wright- Head of Safeguarding	
Lead Executive Director	Sarah Morrison – Chief Nursing Officer and Deputy Chief Executive	
Recommendation/ Actions required	The Board of Directors are asked to i. Scrutinise the report and confirm that it is assured by the arrangements in place to safeguard patients, noting the considered review undertaken by Safety and Quality Committee.	
	Decision ☐	Assurance ☒
		Information ☐

1.1 The Trust has maintained effective safeguarding governance and statutory compliance across adult, children's, maternity, mental health, learning disability, autism, dementia and SEND portfolios during 2025/26. The safeguarding structure is well established, with executive accountability through the Chief Nursing Officer, operational leadership through named professionals and specialist practitioners, and formal assurance through divisional safeguarding meetings, Safeguarding Board, PSIRF Oversight Panel and Safety and Quality Committee reporting. The Safeguarding Board receives a detailed annual report. This report summarises the detail to provide an assurance report outlining the key deliverables during 2025/26.

1.2 Safeguarding activity demonstrates increasing complexity and demand across children's, maternity, adult safeguarding, mental health, learning disability, domestic abuse and sexual violence services.

1.3 Key activity indicators include:

- 1,427 referrals to the Child Safeguarding Team.
- 36 children identified as being in unsuitable hospital settings.
- 337 maternity domestic abuse notifications.
- 1,765 referrals to the Enhanced Support Midwifery Team.
- 108 Section 42 enquiries.
- 4,834 Deprivation of Liberty Safeguards applications.
- 94 People in a Position of Trust allegations.
- 549 referrals to the Trust Mental Health Specialist Practitioner.
- 36 LeDeR notifications.
- 86 High Intensity User referrals.
- 368 HIDVA referrals and 86 HISVA contacts.
- Audit and assurance findings are broadly positive, with evidence of sustained compliance and improvement across key safeguarding standards.
- Safeguarding children training compliance remains between 93% and 100%.
- Adult safeguarding and PREVENT training compliance remain above 92%.
- Maternity audit provides strong assurance on routine enquiry.

- Domestic abuse audit showed 100% DASH completion where domestic abuse was disclosed.
- MCA and DoLS STAR audit compliance is consistently 90–95%.
- Mental health risk tool STAR compliance has remained above 90% across divisions since October 2025.
- Rapid tranquilisation audit compliance recovered to 91.4% by March 2026.
- Mental Health Act Section 132 rights compliance reached 100% by year end.

1.4 Areas requiring continued focus include:

- Children and young people in unsuitable hospital settings.
- Implementation of Child Protection Information Sharing (CP-IS) Phase 2 across remaining scheduled care areas.
- Consistency of Mental Health Act documentation.
- System delays for patients awaiting transfer to mental health inpatient settings.
- Reasonable Adjustment Digital Flag compliance.
- Sustained delivery of Oliver McGowan Mandatory Training.
- Sustainability of single-practitioner or externally funded services, including the High Intensity User service and Blossom team.

2. Key Assurance Dashboard

Domain	Activity / assurance	Committee assurance
Governance	Safeguarding Board receives divisional exception reports, quarterly deep dives and PSIRF learning; monthly Chair's Report to Safety and Quality Committee.	Established executive, operational and system governance with clear escalation routes.
Children's safeguarding	1,427 safeguarding team referrals; 14 formal professional escalations; 36 children in unsuitable hospital settings; 36 child deaths reported through relevant pathways.	High activity and improved escalation; further outcome metrics required for unsuitable settings.
Children's audit and training	Training compliance 93–100%; SAFE Centre invited to 42% of relevant strategy meetings in joint audit; STAR audit strong overall.	Good training assurance; action plan in place to improve SAFE Centre involvement.
Maternity safeguarding	337 domestic abuse notifications; 34 MARAC cases; 62 FGM referrals; 1,765 ESMT referrals; 135 referrals to Children's Social Care; 18 Interim Care Orders.	Sustained high complexity with strong multi-agency response and audit assurance.
Adult safeguarding	108 Section 42 enquiries; all 2025/26 Trust investigations completed by June 2026; 7 adult statutory reviews; 2 PREVENT referrals and 72 Channel Panel information requests.	Timely Trust investigation; continued focus on embedding statutory review learning through PSIRF.
MCA / DoLS	4,834 DoLS applications; STAR audit compliance 90–95%.	Strong statutory awareness; targeted MCA training planned for Emergency Department.
People in a Position of Trust	94 allegations managed; highest volumes in Medicine and Surgery.	Policy, triage, strategy meetings and workforce learning routes in place.

Mental health	549 referrals to Trust Mental Health Specialist Practitioner; average 5.75 Mental Health Act detentions per month; rights compliance reached 100% by year end.	Governance strengthened following CQC visit; documentation and transfer delays remain priorities.
Learning disability, autism and SEND	36 LeDeR notifications; 1,402 staff completed Oliver McGowan training; Tier 1 compliance 96%, Tier 2 compliance 12.9% by March 2026.	Governance and reporting embedded; Tier 2 delivery and reasonable adjustments remain key priorities.
Dementia and vulnerable patient experience	Dementia referrals, cognitive screening and daily guidance increased; 191 staff trained in Tier 2 dementia by April 2026; tailored FFT introduced.	Positive progress; need to move from individual good practice to consistently embedded systems.
Externally commissioned roles	HIU service triaged 86 referrals; HIDVA received 368 referrals; HISVA completed 86 contacts; Blossom delivered 690 appointments in six months.	Strong impact and patient experience; sustainability and recurrent funding require oversight.

3. Strategic Assurance Narrative

3.1 The Trust's safeguarding arrangements provide a clear line of sight from frontline practice to Board-level assurance. Safeguarding intelligence is triangulated through divisional governance, specialist review, audit, PSIRF processes and system partnership forums including the Lancashire Safeguarding Adults Board, Children's Safeguarding Assurance Partnership and mental health transformation structures. This supports learning, escalation and accountability across statutory safeguarding responsibilities.

3.2 Children's safeguarding activity has increased, particularly in relation to internal safeguarding advice and support. The increase from 919 to 1,427 Child Safeguarding Team referrals suggests improved visibility and early specialist involvement. Professional challenge has also increased, with 14 formal escalations compared with 6 in the previous year, mainly relating to children in unsuitable settings, delayed discharge and the need for strategy discussion or step-up to Children's Social Care. This indicates a stronger use of escalation routes where risk persists.

3.3 Maternity safeguarding remains a high-demand area with increasing acuity. Domestic abuse notifications increased by 14%, FGM referrals increased from 26 in 2022/23 to 62 in 2025/26, and ESMT referrals increased by 18%. Audit findings provide strong assurance that routine enquiry, DASH assessment and referral pathways are embedded. The Blossom team has demonstrated early improvement in engagement for parents aged under 20, but recurrent funding remains an open sustainability issue.

3.4 Adult safeguarding activity demonstrates sustained statutory demand. The Trust received 108 Section 42 enquiries during the reporting period. At 31 March 2026, 31 were under Trust investigation and 29 were awaiting Local Authority outcome confirmation; by June 2026 all 2025/26 Trust investigations had been completed with no Trust-related delay. This provides positive assurance on internal responsiveness, while continued partnership working is required to ensure timely external closure and feedback.

3.5 Mental health, learning disability, autism, dementia and SEND activity continues to reflect increasing complexity in acute care. Mental health referrals increased to 549, and delays for patients

clinically ready to transfer to mental health inpatient settings remain a significant system risk. The Trust has mitigations in place through training, policy updates, enhanced therapeutic observation and care, rapid tranquillisation governance, ligature risk management and capital funding for a co-located mental health assessment area within the Emergency Department.

3.6 Audit data provides assurance that improvement actions are having effect. Rapid tranquillisation compliance improved from a low of 79.3% in November to 91.4% by March 2026. Mental Health Risk Tool annual compliance improved to 81% in 2025/26, with monthly variation narrowing to 72–84%. Matron's monthly STAR compliance for the Mental Health Risk Tool has been consistently above 90% across divisions from October 2025 onwards.

4. Key Risks

- Children and young people in unsuitable hospital settings remain a priority, with 36 cases identified and further outcome metrics required to demonstrate impact.
- CP-IS Phase 2 is not yet fully implemented across all scheduled care areas, although an implementation plan is in place for completion by the end of September 2026.
- Mental Health Act documentation, AMHP referral recording and rights documentation require continued focus despite improved compliance by year end.
- Mental health transfer delays remain partly outside Trust control and require continued system escalation with LSCFT and commissioners.
- Oliver McGowan Tier 2 compliance remains low at 12.9% by March 2026 and requires sustained delivery capacity. Plans are in place to roll out however the intensity of the full day training limits the speed.
- The HIU service and some specialist roles demonstrate strong outcomes but have sustainability risks due to single-practitioner models or time-limited funding.
- Positive patient experience for vulnerable groups is evident, but some feedback suggests reliance on individual staff efforts rather than consistently embedded systems.

5. Priorities for 2026/27 included in the Single Improvement Plan

1. Improve experience and outcomes for patients with dementia, mental health needs, learning disabilities, autism and complex vulnerabilities through mandated role-specific Enhanced Therapeutic Observation and Care training from September 2026.
2. Progress the dedicated Mental Health Assessment space within the Emergency Department and associated joint protocols with system partners.
3. Increase compliance with the Reasonable Adjustment Digital Flag across Trust services by September 2026.
4. Continue to reduce restrictive practice and restraint through audit, learning and analysis of disproportionate impact across patient groups at risk of health inequalities.
5. Deliver the Trust Dementia Plan aligned to the Lancashire and South Cumbria Integrated Care System Dementia Strategy.
6. Improve partnership response and outcome measurement for children and young people in unsuitable hospital settings.
7. Deliver the Trust SEND improvement action plan and strengthen Trust-wide SEND assurance arrangements.
8. Further develop the High Intensity User programme to support vulnerable frequent attenders and reduce avoidable hospital attendance and length of stay.

Appendix 1

Expectations for LTHTR taken from 2026/27 NHS Standard Contract Service Conditions (Shorter Form) <https://www.england.nhs.uk/publication/shorter-form-nhs-standard-contract-2026-2-particulars-service-conditions-general-conditions/> (Appendix 2, Table 37)

SC32 Safeguarding Children and Adults 32.1 The Provider must: 32.1.1 ensure that Service Users are protected from abuse, exploitation, radicalisation, serious violence, grooming, neglect and improper or degrading treatment; and 32.1.2 must take appropriate action to respond to any allegation or disclosure of any such behaviours in accordance with the Law; and; 32.1.3 proactively take steps to prevent abuse and neglect by responding early to relevant risk factors or indications.	All
32.2 The Provider must nominate: 32.2.1 Safeguarding Leads and/or a named professional for safeguarding children (including looked after children) and for safeguarding adults, in accordance with Safeguarding Guidance; 32.2.2 a Child Sexual Abuse and Exploitation Lead; and 32.2.3 a Mental Capacity and Liberty Protection Safeguards Lead, and must ensure that the Co-ordinating Commissioner is kept informed at all times of the identity of the persons holding those positions.	All
32.3 The Provider must comply with the requirements and principles in relation to the safeguarding of children, young people and adults, including in relation to deprivation of liberty safeguards and child abuse and sexual exploitation, domestic abuse, radicalisation and female genital mutilation (as relevant to the Services, set out or referred to in Law and Guidance (including Safeguarding Guidance and Child Sexual Abuse and Exploitation Guidance)).	All
32.4 The Provider has adopted and must comply with the Safeguarding Policies and MCA Policies. The Provider has ensured and must at all times ensure that the Safeguarding Policies and MCA Policies reflect and comply with: 32.4.1 Law and Guidance; and 32.4.2 the local multi-agency policies and any Commissioner safeguarding and MCA requirements.	All
32.5 The Provider must implement comprehensive programmes for safeguarding (including in relation to child sexual abuse and exploitation and domestic abuse) and MCA training for all relevant Staff and must have regard to Intercollegiate Guidance in Relation to Safeguarding Training.	All

Appendix 2 – Supplementary Data Charts and Tables

This appendix brings together the supporting data charts and tables referenced throughout the main report. The material is grouped by safeguarding theme to support systematic review, triangulation and assurance.

Section	Tables included
Governance and children's safeguarding	Tables 1–4
Maternity safeguarding	Tables 5–9
Adult safeguarding	Tables 10–15
Learning disability, autism and mental health	Tables 16–29
Dementia, patient experience and high intensity users	Tables 30–33

A. Governance and children's safeguarding data

Table 1 Governance Structure

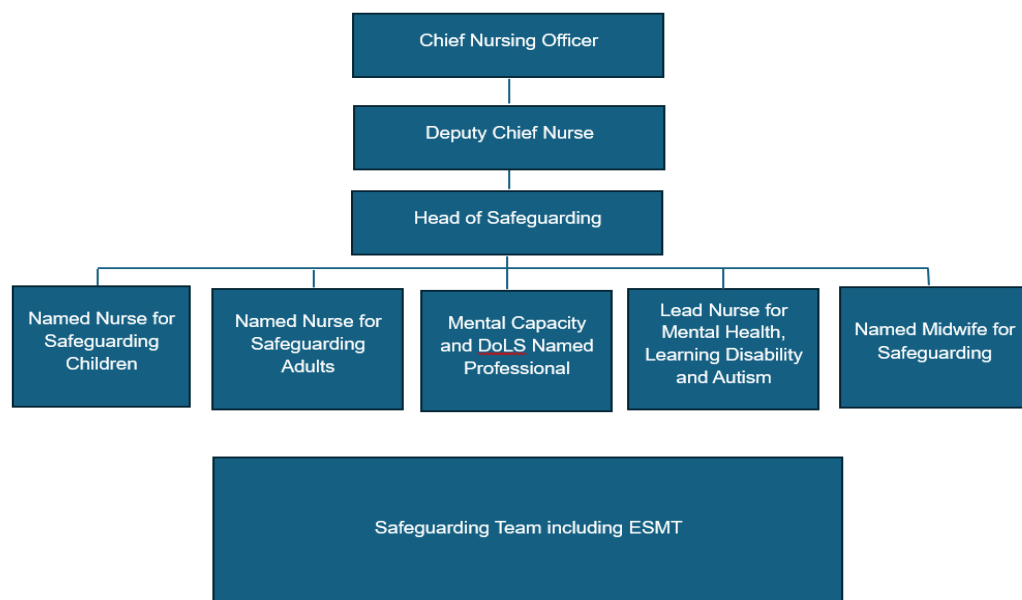


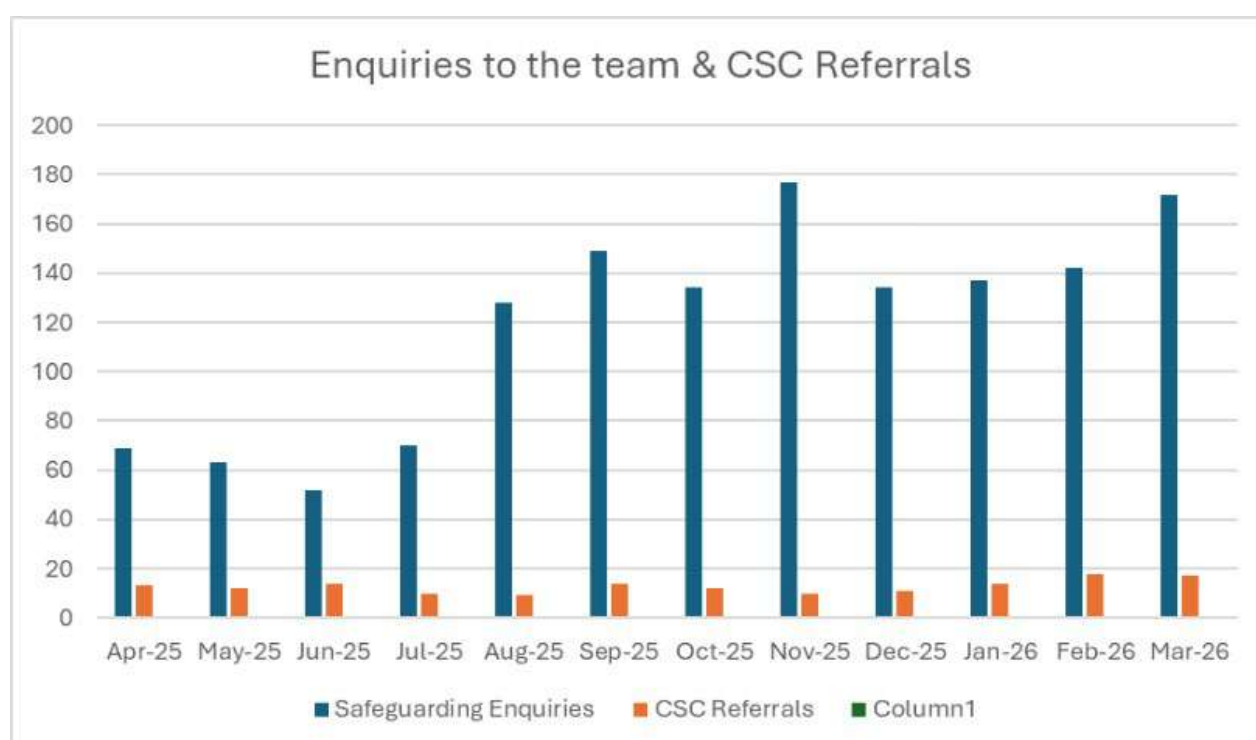
Table 2 Children in Care Initial Health Assessments

Table 1	September	October	November	December	January	February
Total number of health assessments received	20	21	20	22	22	32
Total number of health assessments completed	20	19	19	21	20	28
Total number of health assessments completed within 12 days	16	19	9	16	9	15
Outstanding to date	0	0	0	0	0	0
Number of appointments which the children were not brought	1	3	0	7	1	1

Table 3 Trust wide Child Safeguarding Training April 2025-March 2026



Table 4 Enquires to Trust Children's Safeguarding Team & Children's Social Care Referrals



B. Maternity safeguarding data

Table 5 ESMT referrals by source and reason

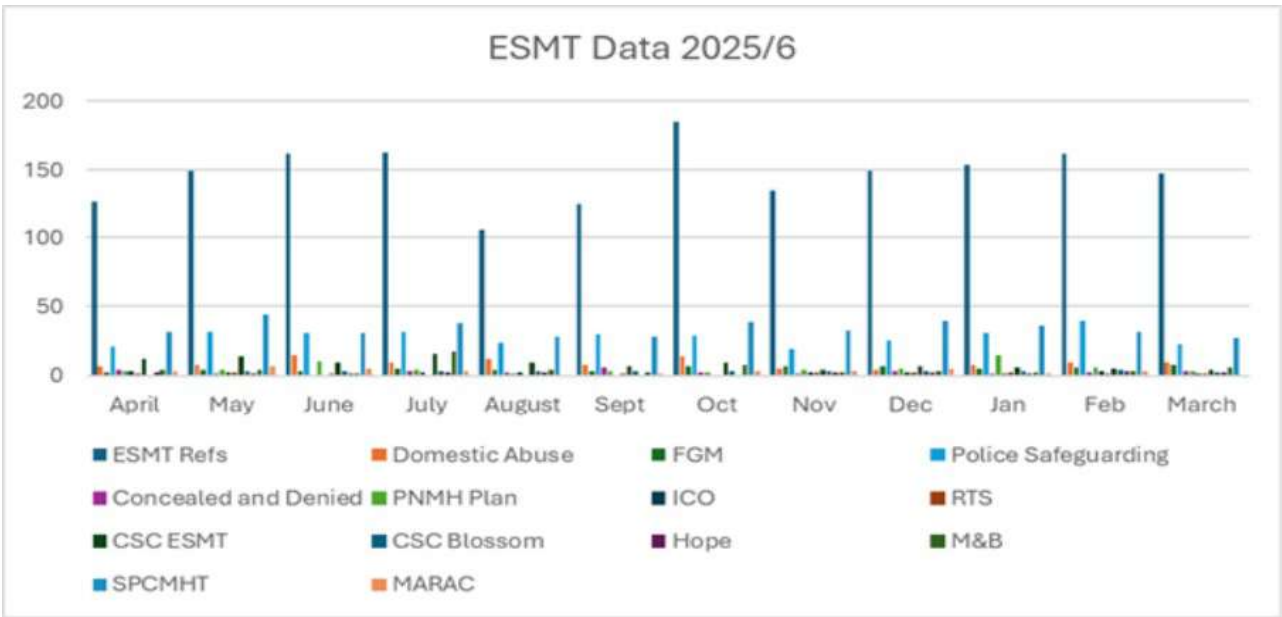


Table 6 Maternity Interim Care Order activity

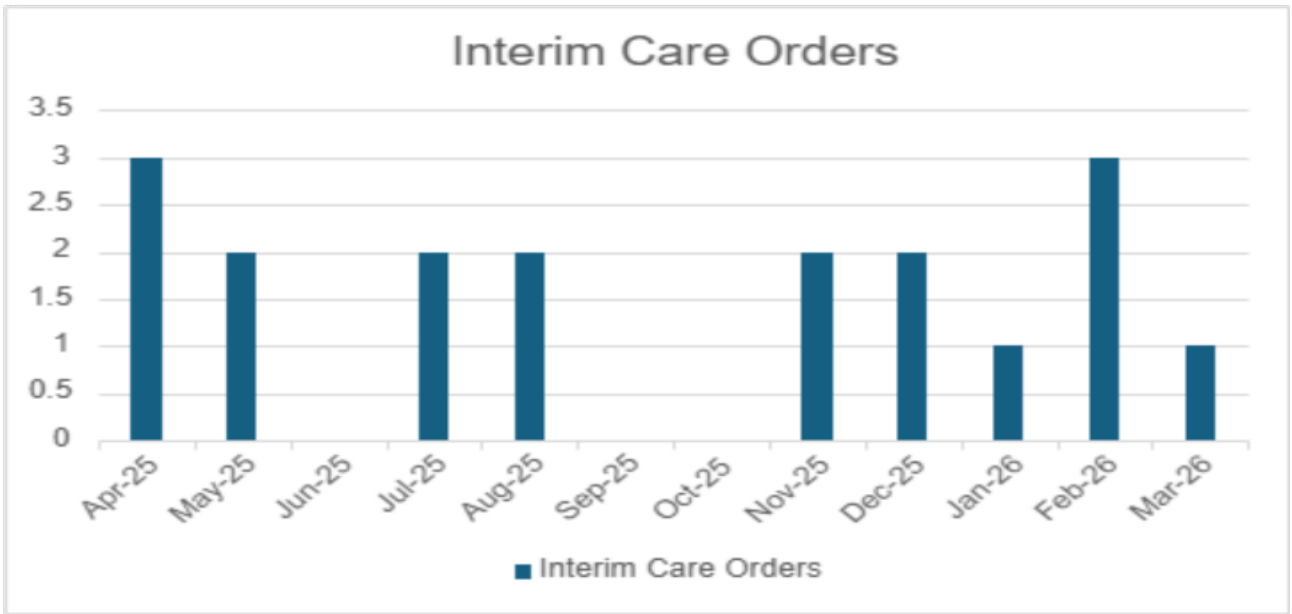


Table 7 Blossom Team- reduction in the percentage of appointments that were missed by young people

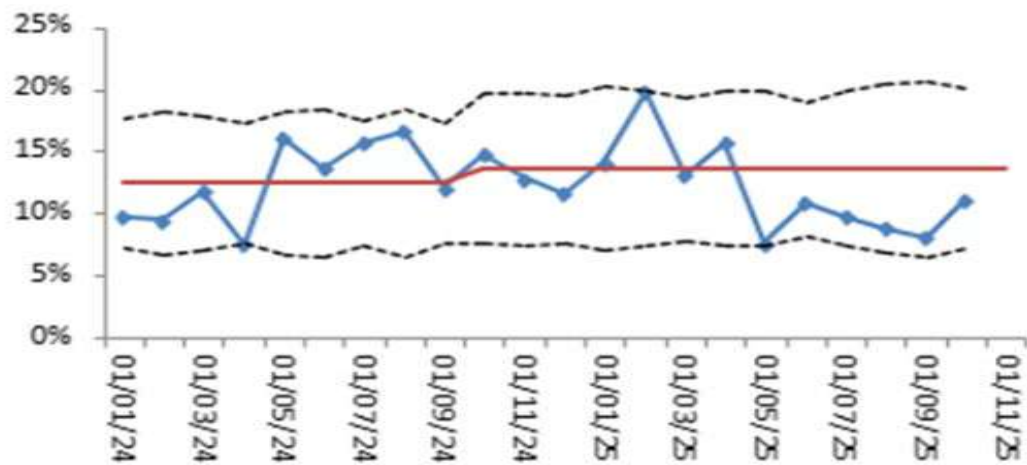


Table 8 Blossom Team- percentage of young people breastfeeding

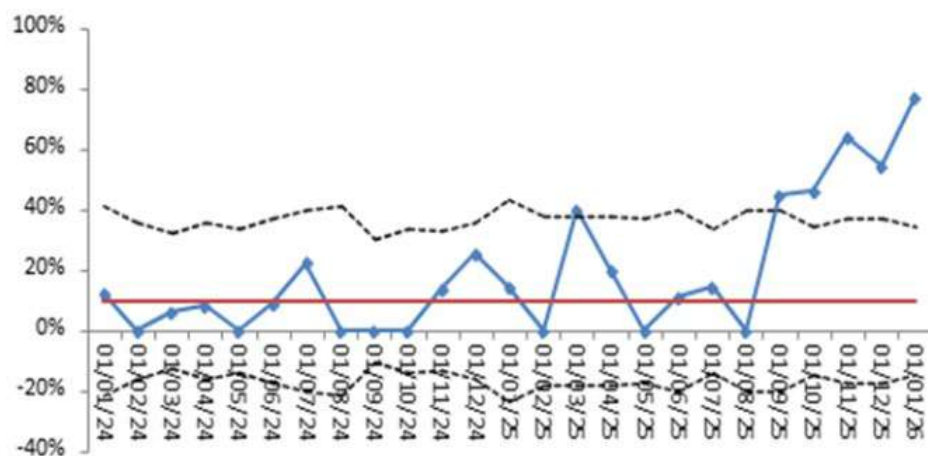
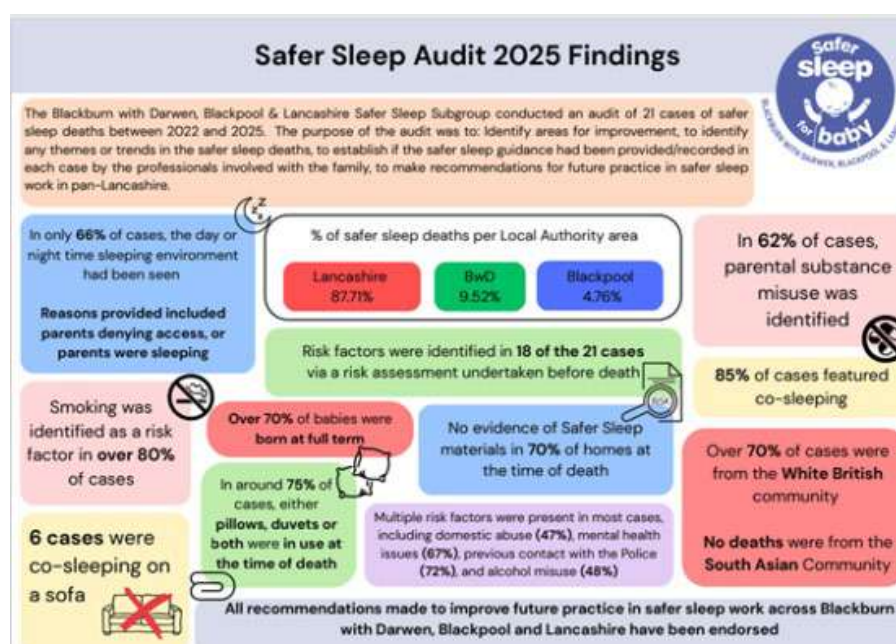


Table 9 - Safety Sleep Audit 2025



C. Adult safeguarding data

Table 10 Safeguarding Adult enquires Apr 2025- Mar 2026

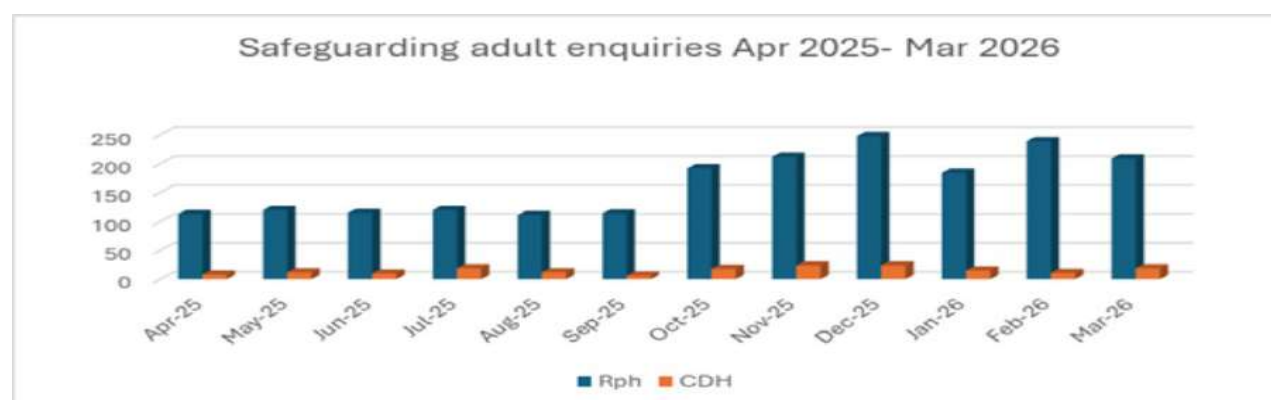


Table 11 Section 42s by division Apr 25- Mar 26

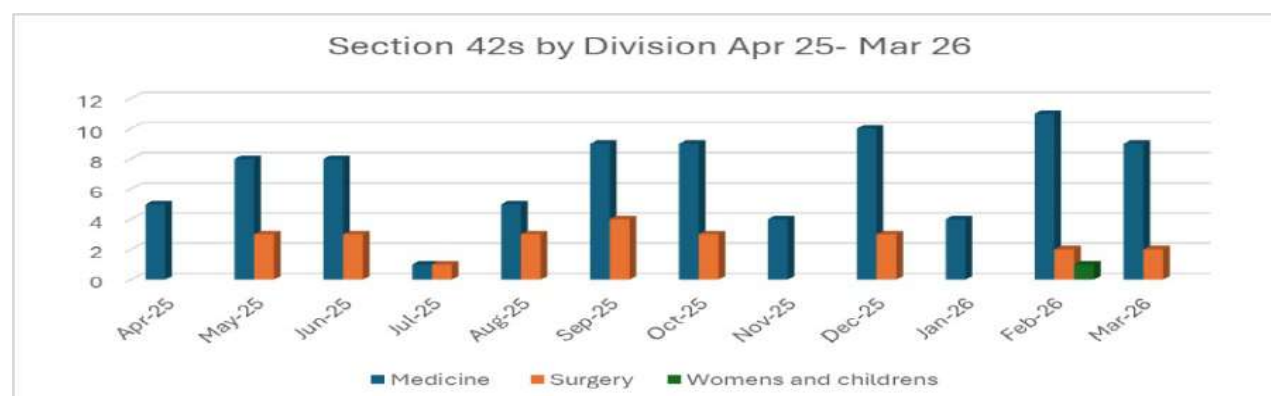


Table 12 Section 42 outcomes Apr 25- March 2026

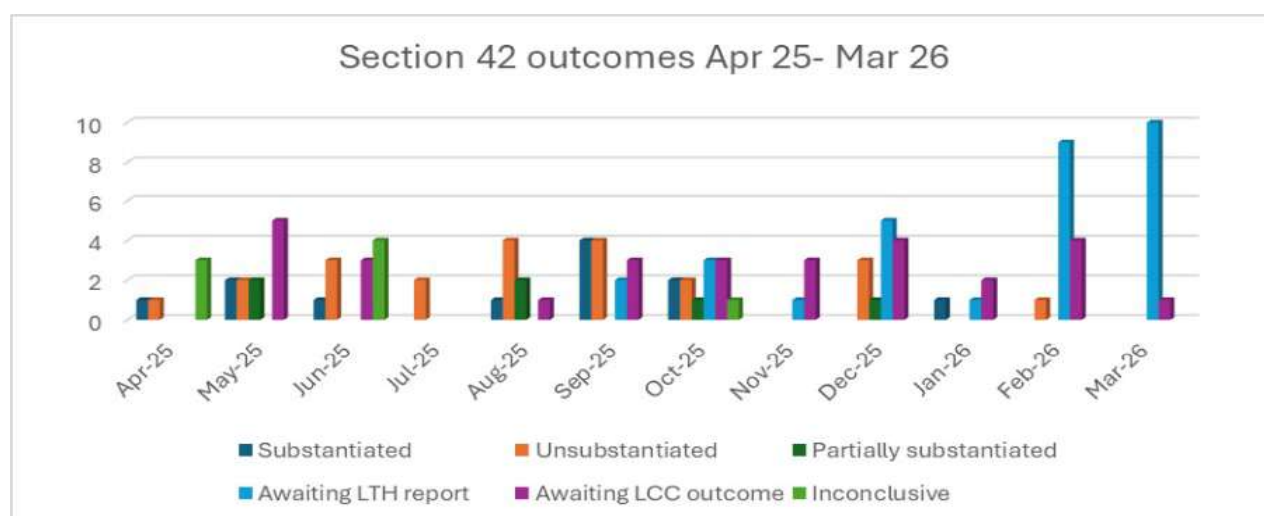


Table 13 Safeguarding adults and prevent training

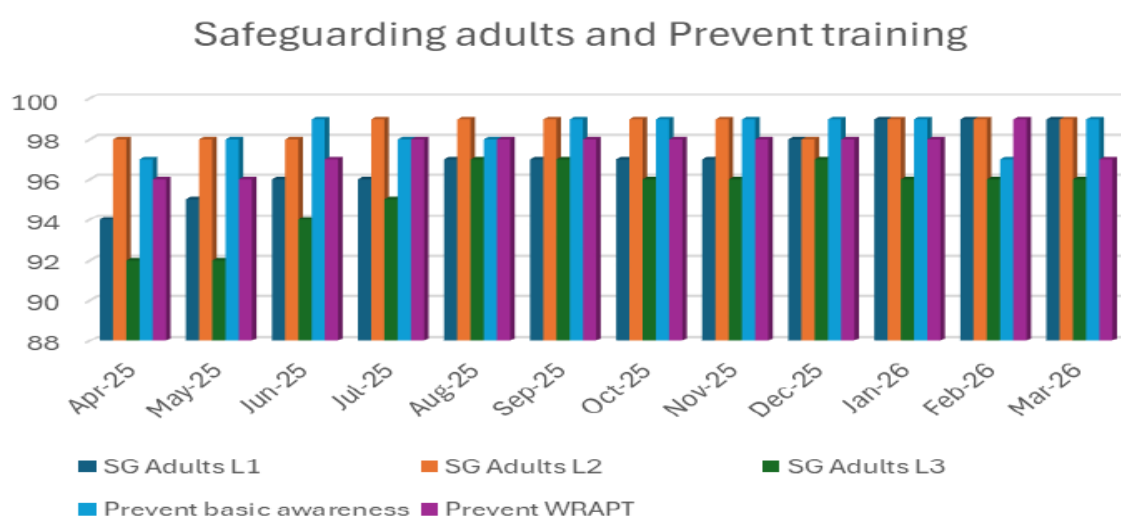


Table 14 Total DoLS applications 2025-2026

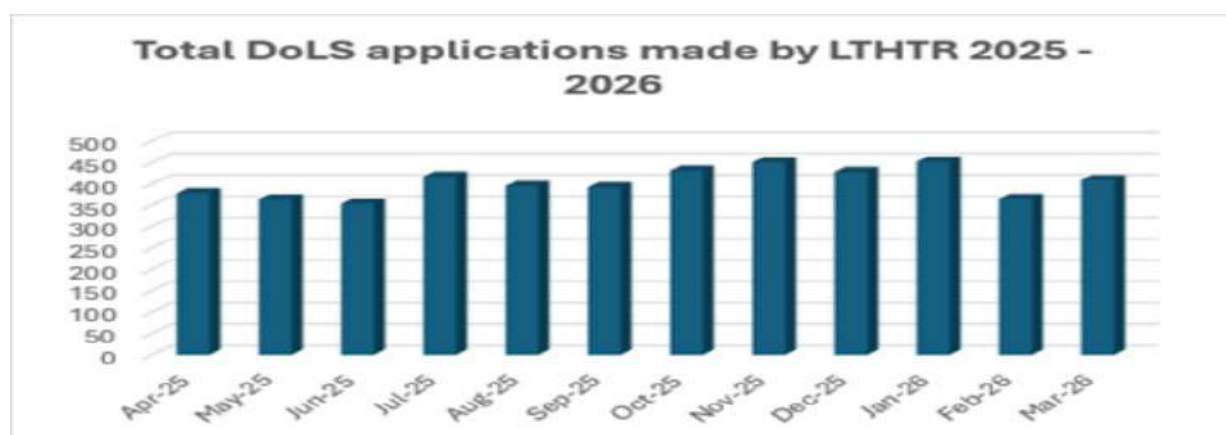


Table 15 Number of allegations against PiPoT by division April 2025- March 2026

Division	No. of allegations
Medicine	41
Surgery	24
DCS	7
Womens & Childrens	11
Estates and Facilities	8
Corporate	1
Temporary Staffing	2

D. Learning disability, autism and mental health data

Table 16 Annual LeDeR Notifications

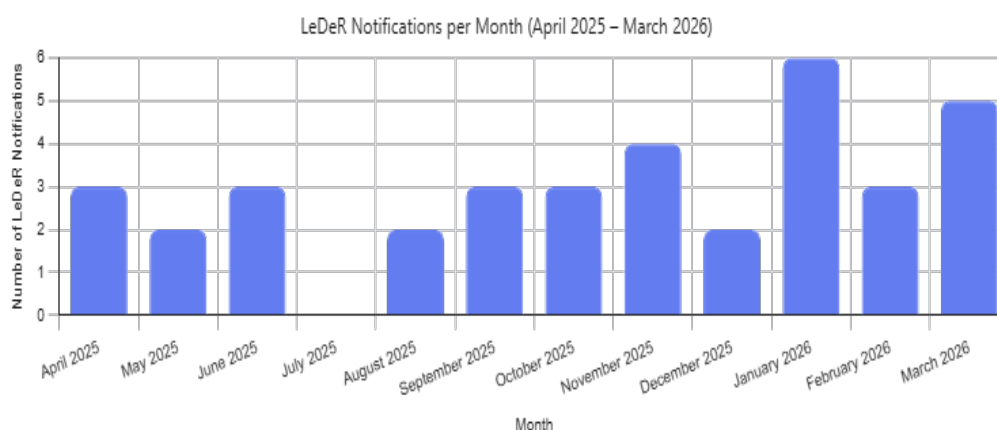


Table 17 Oliver McGowan Mandatory Training (OMMT) E-Learning Compliance

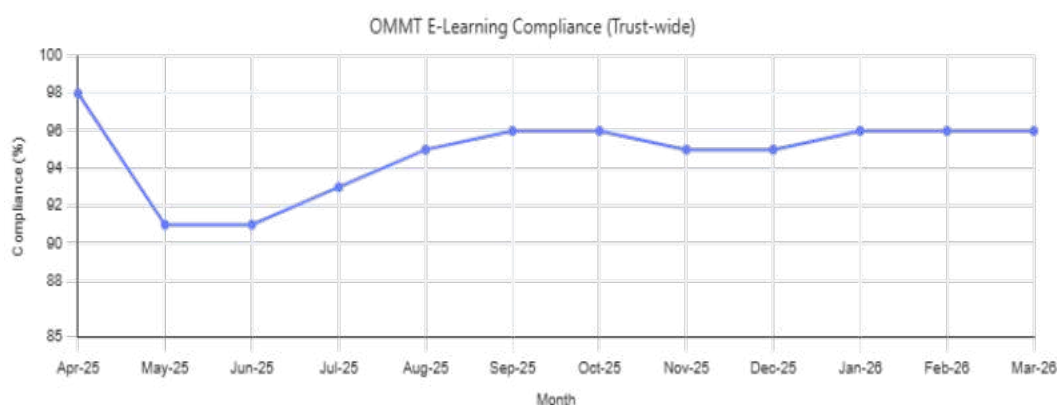


Table 18 Oliver McGowan Mandatory Training (OMMT) Tier 1 and Tier 2 with Overall Compliance

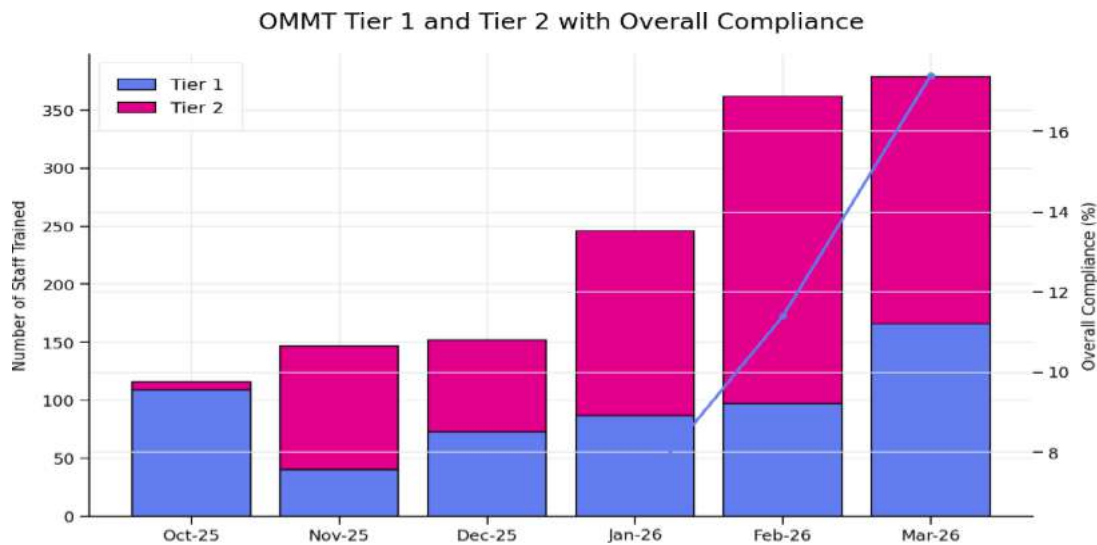


Table 19 Request for Support to Learning Disabilities and Autism Practitioner (Apr 2025- Mar 2026)

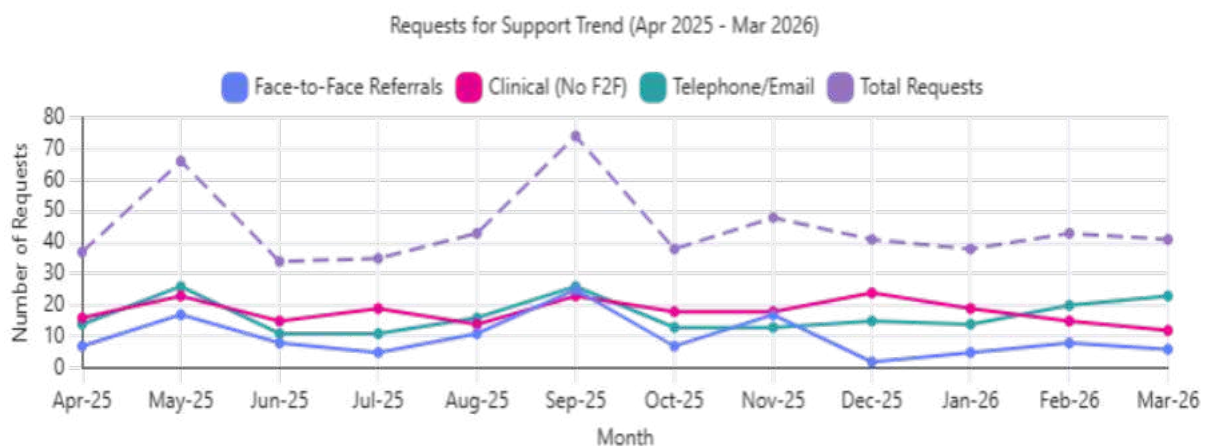


Table 20 Referrals to the Trust Mental Health Specialist Practitioner

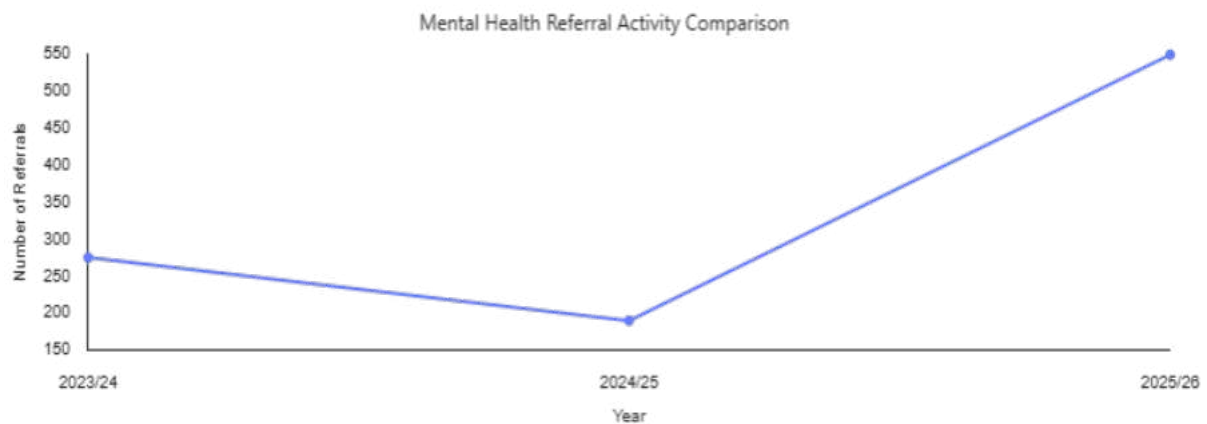


Table 21 Monthly Mental Health Referral Activity 2025/26

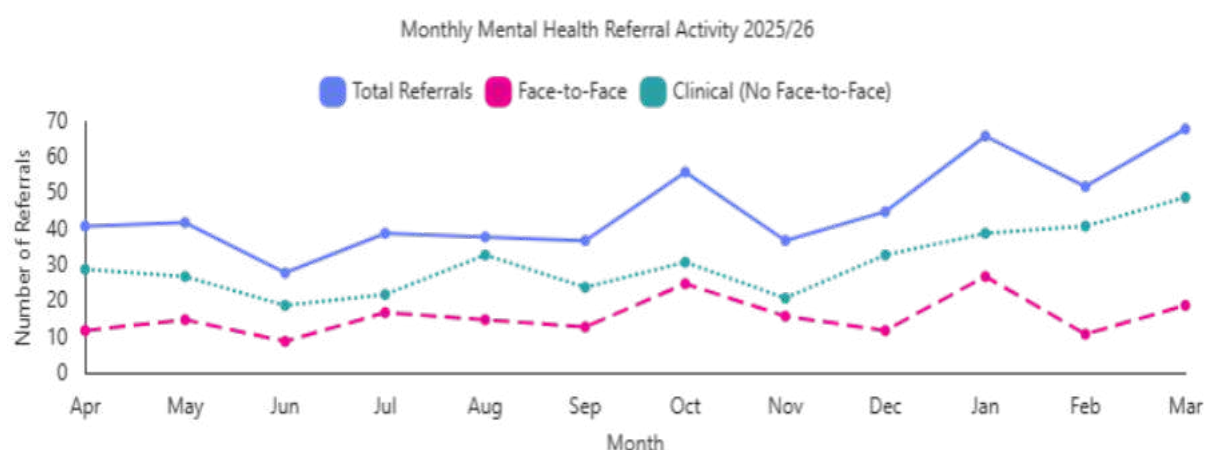
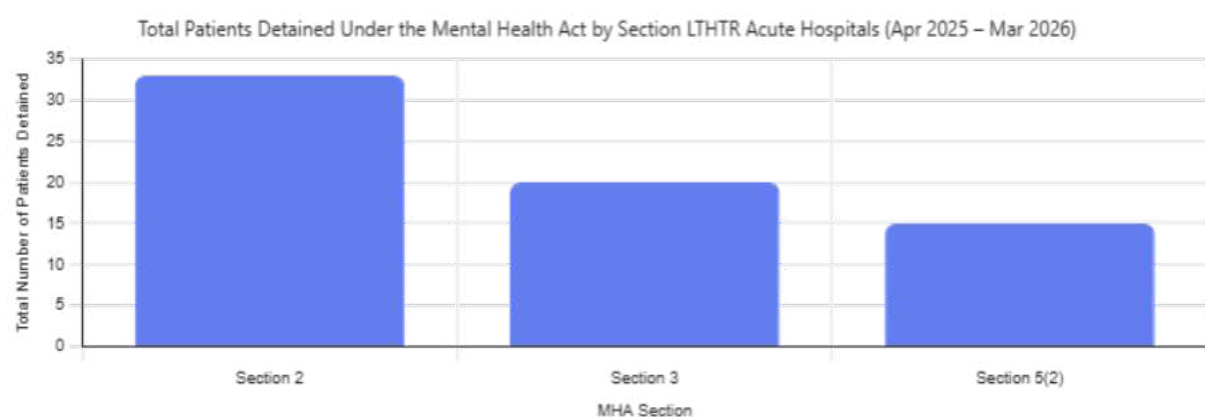


Table 22 Total patients detained under the mental health act by section to the Trust including monthly breakdown table



	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Total
Sec 2	3	4	3	3	3	3	3	3	1	1	3	3	33
Sec 3	2	2	2	0	3	2	4	1	2	1	1	0	20
Section 5 (2)	0	0	0	0	0	1	5	1	0	2	4	2	15
Grand Total	5	6	5	3	6	6	12	5	3	5	8	5	69
Total Detained	N/A	N/A	N/A	N/A	N/A	N/A	15	6	3	7	10	6	47

Table 23 Compliance with provision of section 113 patient rights within 72 hours

	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
Within 72 hrs	0%	17%	0%	67%	67%	66%	43%	25%	100%	80%	57%	100%
Over 72 hours	80%	50%	80%	0%	0%	17%	14%	25%	0%	0%	0%	0%
Not Completed	20%	33%	20%	33%	33%	17%	43%	50%	0%	20%	43%	0%

Table 24 Lancashire Police data for s136 detentions to RPH between October 2025 and January 2026

Month/Year	Total S136 Detentions	Central & West Lancs	
		Total	RPH
Oct-25	100	23	20
Nov-25	88	18	12
Dec-25	77	22	15
Jan-26	89	37	24

Table 25 Rapid Tranquillisation Monthly Audit Compliance (Trustwide)

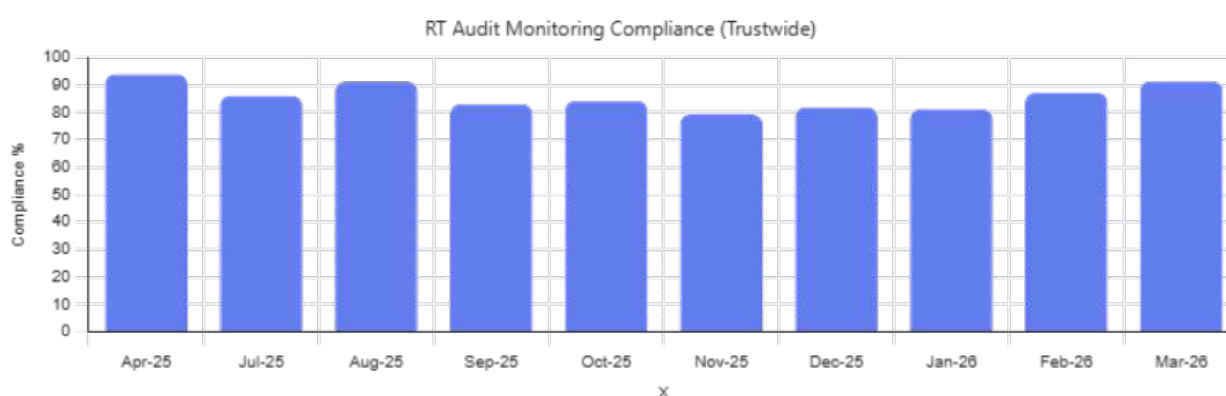


Table 26 Mental Health Risk Tool Qualitative Deep Dive Audits Quater (Apr 2025- Mar 2026)



Table 27 Mental Health Risk Tool Qualitative Deep Dive Audit Annual comparison

Year	Annual compliance	Monthly variation
2021/2022	23%	9% - 53%
2022/2023	62%	56% - 74%
2023/2024	78%	73% - 84%
2024/2025	74%	61% - 81%
2025/2026	81%	72% - 84%

Table 28 Mental Health Risk- Mandatory Training Compliance by Division (Apr 2025- Mar 2026)



Table 29 Matron's monthly STAR audit results for Mental Health Risk Tool Compliance Julu 2025 to March 2026

MH Risk Tool STAR compliance Question 17a- number completed and 17b - risk plan is appropriate 17c daily review - 17d MH team advice plan (as of September 2025)	Jul-25	Aug-25	Sep-25	Risk Tool Star compliance -Amended as of October 2025 11e - has a risk tool been completed; 11f - referral to MHIT made; 11g - training compliance.	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Women&Children Q17a	Nil	50%	100%	Women&Children Q11e	100%	100%	N/A	N/A	100%	100%
Women&Children 17b	Nil	50%	100%	Women&Children Q11f	100%	100%	100%	N/A	100%	100%
Women&Children 17c	Nil	0%	100%	Women&Children Q11g	99%	100%	100%	100%	100%	100%
Women & Children 17d			100%							
Surgery Q17a	100%	100%	100%	Surgery Q11e	98%	100%	100%	100%	100%	100%
Surgery Q17b	100%	100%	100%	Surgery Q11f	100%	100%	100%	100%	100%	100%
Surgery Q17c	100%	100%	77.78%	Surgery Q11g	100%	100%	100%	100%	93%	100%
Surgery Q17d			100%							
Medicine Q17a	100%	100%	100%	Medicine Q11e	96%	93%	100%	100%	100%	100%
Medicine Q17b	100%	100%	100%	Medicine Q11f	99%	100%	100%	100%	100%	100%
Medicine Q17c	100%	100%	100%	Medicine Q11g	100%	100%	100%	100%	95%	95%
Medicine Q17d			100%							

E. Dementia, patient experience and high intensity user data

Table 30 Dementia Activity Trends (April 2025- March 2026)

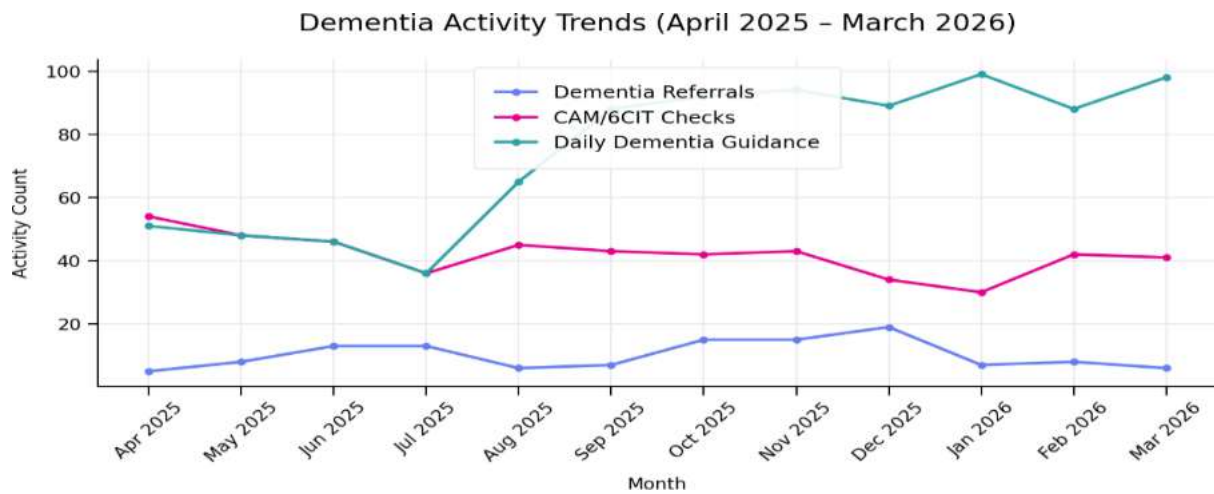


Table 31 Vulnerable patient Friends and Family Responses by Service

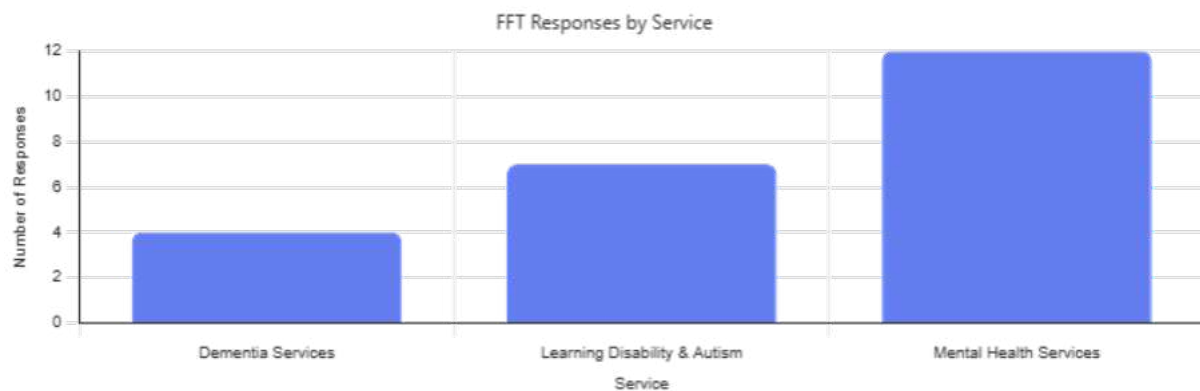


Table 32 Vulnerable patient Friends and Family Responses by Sentiment

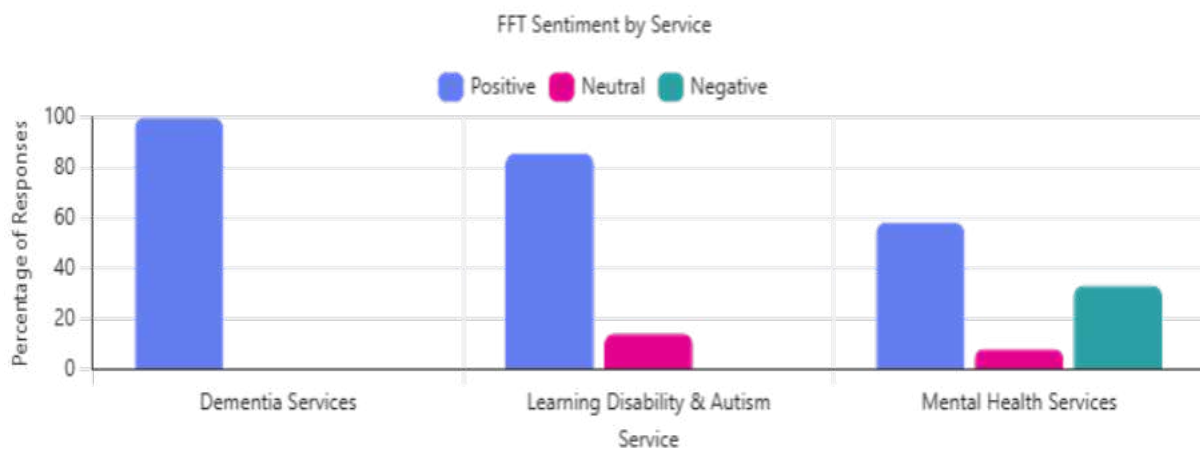
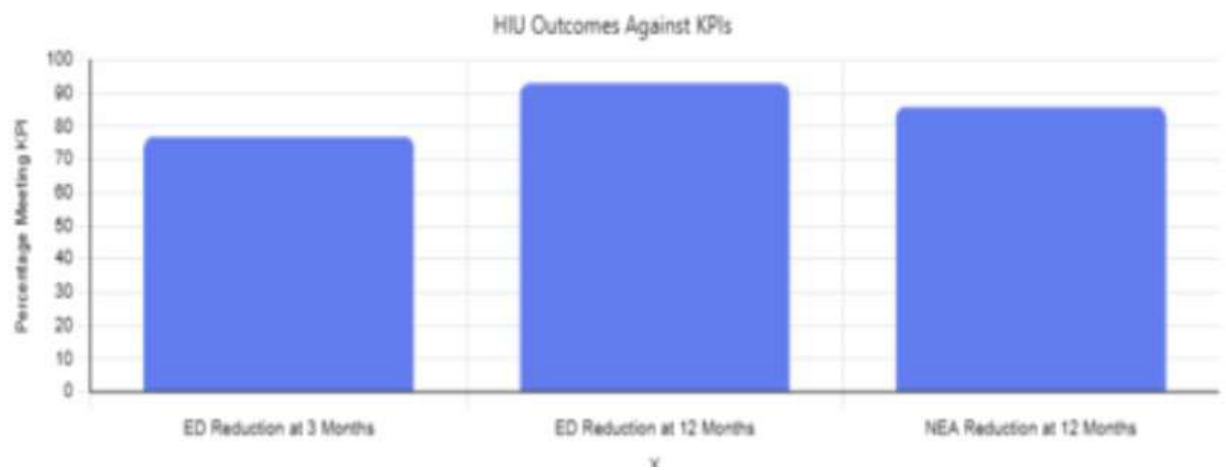


Table 33 High Intensity User Service outcomes and ED attendance reduction



Appendix 4



Appendix 5

Partnership Meetings

Lancashire Safeguarding Adults Board (LSAB)	Lancashire Children's Assurance Partnership (CSAP)	Mental Health Transformation
LSAB Board (Monthly)	CSAP Board (bi-monthly)	Mental Health Interface meeting
Lancashire Sub Group – Listening, Learning and Development (Monthly)	Child Death Oversight Panel (CDOP), Strategic (Quarterly)	Mental Health Act contract review (Quarterly)
Lancashire Sub Group - Performance, Quality and Assurance (PQA) (Monthly)	Pan Lancashire CDOP (Monthly) alternating full and half day	SEND Improvement group
SAR Strategic Sub group (2 workshops annually)	Pan Lancashire Child Safeguarding Practice Review (CSPR) (Quarterly)	STAR monthly Audit
	CSPR case reviews (bi-monthly)	
	Performance, Assurance, Impact (PAI) – (bi-monthly)	
	Contextual Safeguarding	

Appendix 6 – Children and Young People

Table 1 - Children & Young Admitted to an Unsuitable Hospital Setting (Paediatric & Adult Areas, including the Emergency Department) from 28/02/2025 – 07/05/2026.

Monthly analysis table

Month	Cases	Total LOS	LOS since fit	Most common legal framework	Most common reason
Feb 2025	1	232	168	MHA Section 3 / DoLS	Other social admission
Aug 2025	2	19	15	Parental responsibility (parents)	Mixed (social + MH bed)
Sep 2025	12	58	45	PR (Parents & CSC mixed)	Awaiting MH review / placement
Oct 2025	2	22	18	PR (Parents / CSC)	Mixed
Nov 2025	1	7	6	PR (CSC)	Section 20 (social)
Dec 2025	1	33	31	PR (CSC)	Other social admission
Jan 2026	1	4	4	PR (Parents)	Other social admission
Feb 2026	5	38	35	PR (Parents)	Parents decline / social admission
Mar 2026	5	54	50	Mixed (Parents / CSC / DoLS)	Social admission / placement breakdown
Apr 2026	3	18	13	PR (CSC)	Placement breakdown
May 2026	3	1	1	Not specified / PR	Minimal delay

Table 2 Monthly STAR Emergency Department - Patients with mental health difficulties or risk behaviours will have a risk tool and management plan in place and staff will follow policy/procedure for any reports of domestic violence, stalking or harassment

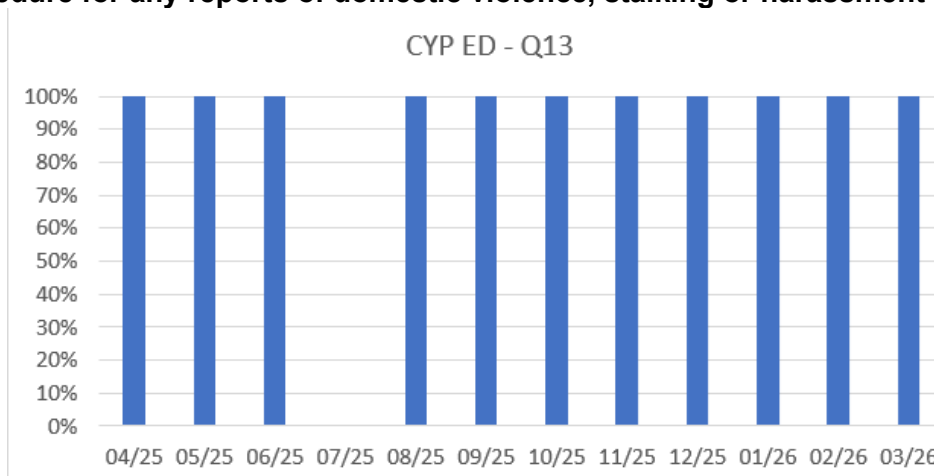


Table 3 Monthly STAR Emergency Department - Children, young people and their relatives/carers, including patients with additional needs (including learning disabilities or sensory/communication difficulties) will always feel supported and receive good care during their time on the department (where possible, please prioritise feedback from patients with additional needs)

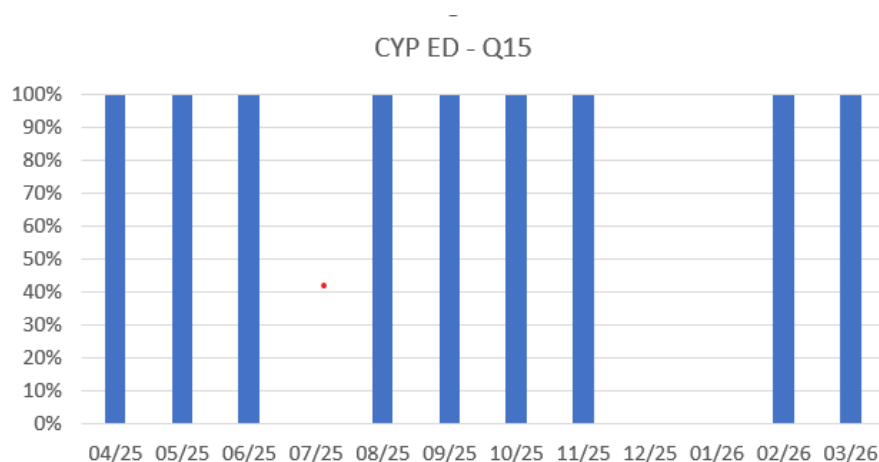


Table 4 Monthly STAR Inpatients - 'Staff will always describe how they would assess a CYP appropriately for medical treatment, care, hospitalisation in terms of age of consent, Gillick competency and CYP aged 16 and 17 years old.'

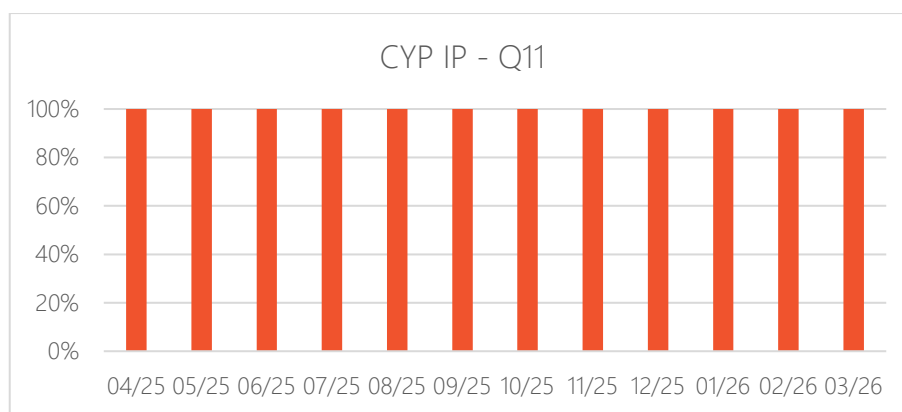


Table 5 Monthly STAR Inpatients CYP IP - Q13 - Children and young people presenting with mental health difficulties and associated risk behaviours will have a completed risk assessment plan and staff consistently adhere to policy and procedures in cases involving domestic violence, stalking or harassment'

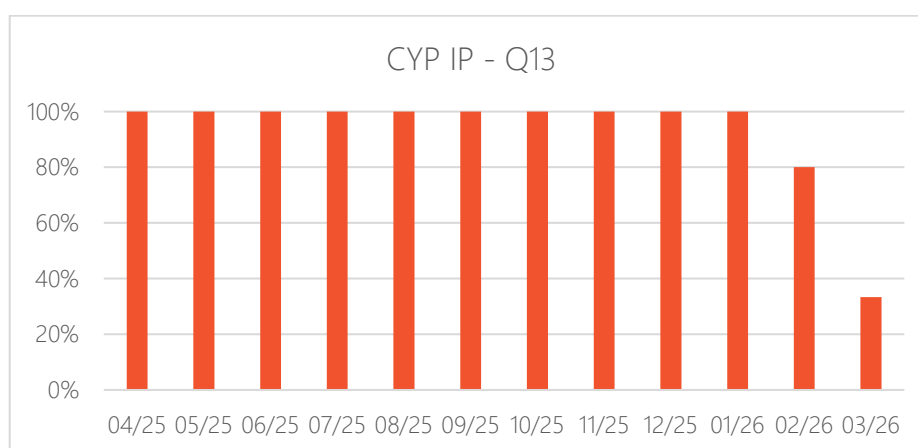


Table 6 Monthly STAR Inpatients CYP IP - Q11 -'Staff will always be able to assess a CYP appropriately for medical treatment and care, in terms of age of consent, Gillick competency and CYP aged 16 and 17 years old.'

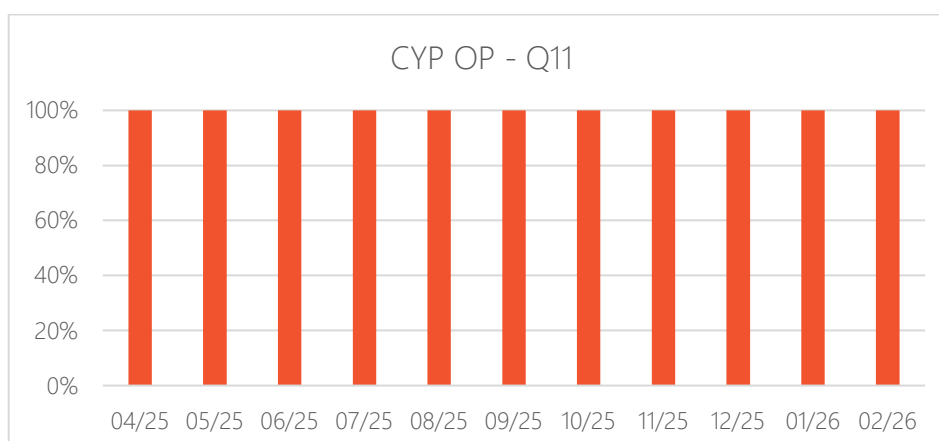


Table 7 Monthly STAR Inpatients CYP OP - Q13 - Staff will follow policy and procedures domestic violence, stalking and harassment and ensure that patients with mental health

difficulties or associated risk behaviours have a completed mental health risk assessment and an appropriate management plan in place

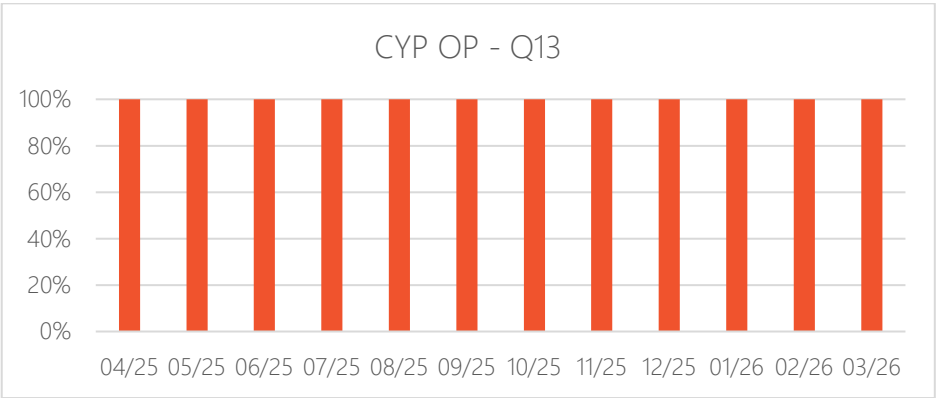
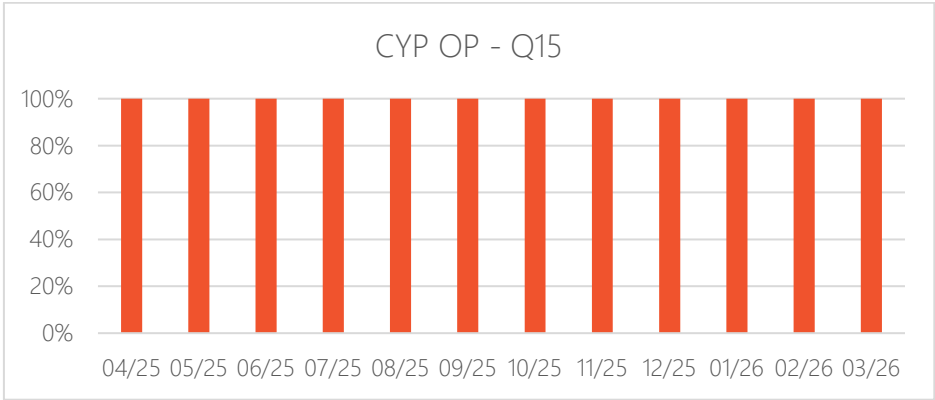


Table 8 Monthly STAR Inpatients CYP OP - Q15 - Children, young people and their relatives/carers, including patients with additional needs (including learning disabilities or sensory/communication difficulties) will always feel supported and receive good care during their time on the unit/department (where possible, please prioritise feedback from patients with additional needs)



9. Continue targeted safeguarding, MCA, mental health, learning disability, dementia, trauma-informed and equality training programmes.

6. Recommendation

The Board of Directors are asked to:

- i. Scrutinise the report and confirm that it is assured by the arrangements in place to safeguard patients, noting the considered review undertaken by Safety and Quality Committee.

B) ANNUAL MORTALITY, LEDER AND PMRT REPORT

● Decision Item

REFERENCES

Only PDFs are attached



10.1b Annual mortality report ancillary papers.pdf

APPENDIX 1. Mortality benchmarking and Dr Foster report

The reporting period for TELSTRA / Dr Foster SHMI, HSMR and SMR Mortality data is December 2024 – November 2025 which is the latest data period available.

1. Mortality Benchmarking (provided by TELSTRA /Dr Foster)

1.1 HSMR Regional Acute Peers Benchmark December 2024 – November 2025

Mortality benchmarking demonstrates that the Trust **HSMR** of **78.7** and Standardised Mortality Ratio (SMR) of **76.6** are significantly lower than expected for the 12-month period of December 2024 – November 2025.

During the 12-month period, the Trust had one of the lowest SMRs in relation to regional acute peers as demonstrated in the funnel plots in the Dr Foster report Figure 2.0.

SMR Regional Acute Trust Benchmark Child Mortality

The 12-month rolling SMR for children is **78.0** and within expected range.

SMR Neonatal mortality data (<1 day – 28 days)

The latest 12-month SMR for neonatal deaths is **84.3** and is within the expected range.

Within the Trust all child deaths are reviewed in line with national guidance and reported to the Child Death Overview Panel (CDOP). Local mortality reviews are also conducted by the neonatal lead consultant or safeguarding leads, as appropriate.

Neonatal deaths are reported to MBRRACE-UK using the Perinatal Mortality Review Tool (PMRT) to conduct structured, multidisciplinary reviews of all eligible cases. Local mortality reviews are also conducted by the neonatal service. Key learning or findings are shared at departmental level and through the Lancashire and South Cumbria Neonatal Operational Delivery Network.

1.2 Stillbirth mortality

The new H/SMR+ models no longer include or provide risk adjustment for still birth mortality but do still provide a mortality trend in the volumes of observed deaths within this group.

There were 7 still births recorded by TELSTRA / Dr Foster during the period from Dec-24 – Nov-25. This does not align with the Trust figure of 6 which is attributed to a reporting error within the Trust. Since a validation process has been initiated no further anomalies have been identified to date.

The Trust stabilised and adjusted neonatal mortality rate (under 28 days) is 1.99 per 1000 births. This is average for similar Trusts. Excluding deaths due to congenital anomalies, the Trusts stabilised and adjusted neonatal mortality rate is 1.49 per 1000 births. This is around average for similar Trusts. There were thirteen (13) neonatal deaths (under 28 days) for the period of 1st April 2025 to 31st March 2026.

1.3 Summary Hospital-level Mortality Indicator

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust, and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. The SHMI covers patients admitted to hospitals in England who died either while in hospital or within 30 days of being discharged. Deaths related to COVID-19 are excluded from the SHMI.

The Trust **SHMI** for the data period of December 2024 – November 2025 is **96.27** and within expected range.

Mortality benchmarking data is summarised in Table 1. below with full details provided at Appendix 1.

Table 1:

Lancashire Teaching Hospitals Mortality Table M09 Apr-26

Measure	Month (Nov 25)	3 Month Period (Sep 25 – Nov 25)	12 Months (Dec 24 – Nov 25)
HMSR All Ages	76.2	78.7	78.7
HSMR Adult	76.4	78.9	78.8
SMR Relative Risk - All Diagnoses All Ages	70.7	74.2	76.6
SMR Relative Risk - All Diagnoses Adult	71.4	74.2	76.6
SMR Relative Risk - All Diagnoses Child (<1 day – 17 yrs.)	0.0	71.2	78.0
SMR Relative Risk - All Diagnoses Neonates (<1-28 Days) The updated model does not include still births	0.0	105.5	84.3

Measure (Observed deaths)	Month (Nov 25)	3 Month Period (Sep 25 – Nov 25)	12 Months (Dec 24 – Nov 25)
Still births	0	2	7

Mortality Benchmarking

This report is based on the M09 dataset. As there are high volumes of residual codes recorded in Dec-25, a one-month lag has been applied. The data period for this report is Dec-24 – Nov-25. This report is based on the new H/SMR+ models.

Figure 1: HSMR+ Regional Acute Peers Benchmark, Dec-24 – Nov-25

The HSMR+ for LTHT is 78.7 and significantly 'lower-than-expected' for the most recent 12-month period. This is a small increase since the previously reported figure (77.6).

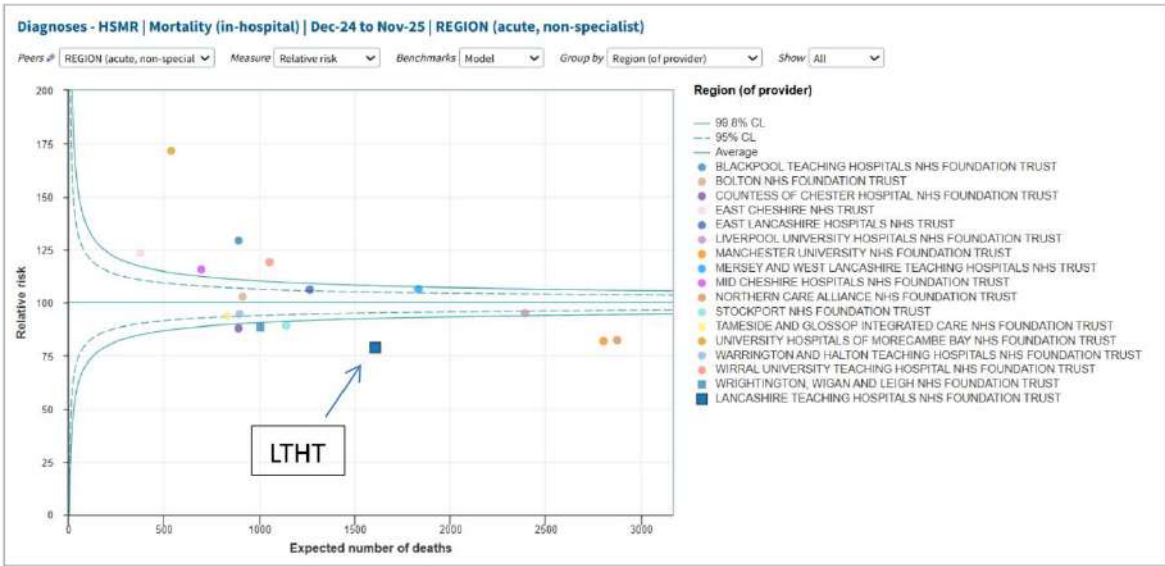


Figure 2: SMR+ Regional Acute Trust Benchmark, Dec-24 – Nov-25

The SMR+ for LTHT is 76.6 and significantly 'lower-than-expected' for the most recent 12-month period.

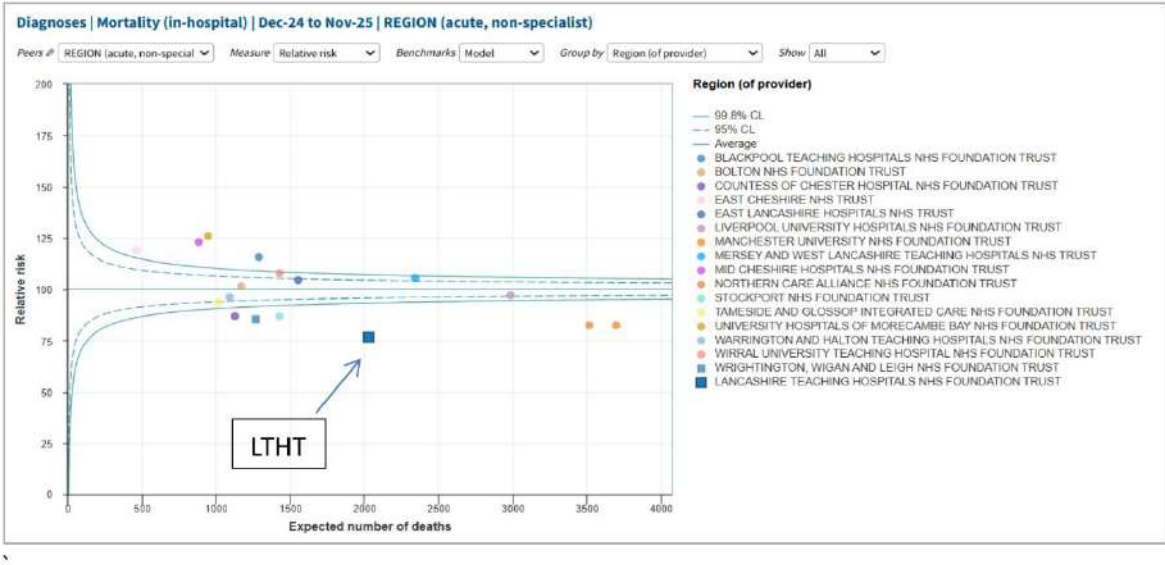


Figure 3: SMR+ COVID-19 - Trust with Similar Bed Base & admissions, Dec-24 – Nov-25

The funnel plot provides a standardised mortality figure for Covid-19, which is 120.2 and within the expected range. The peer group compares the Trust against similar providers, in terms of bed base, case-mix, and the volume of admissions with either a primary or secondary COVID-19 diagnosis, where U07.1 or U07.2 has been coded in any position.

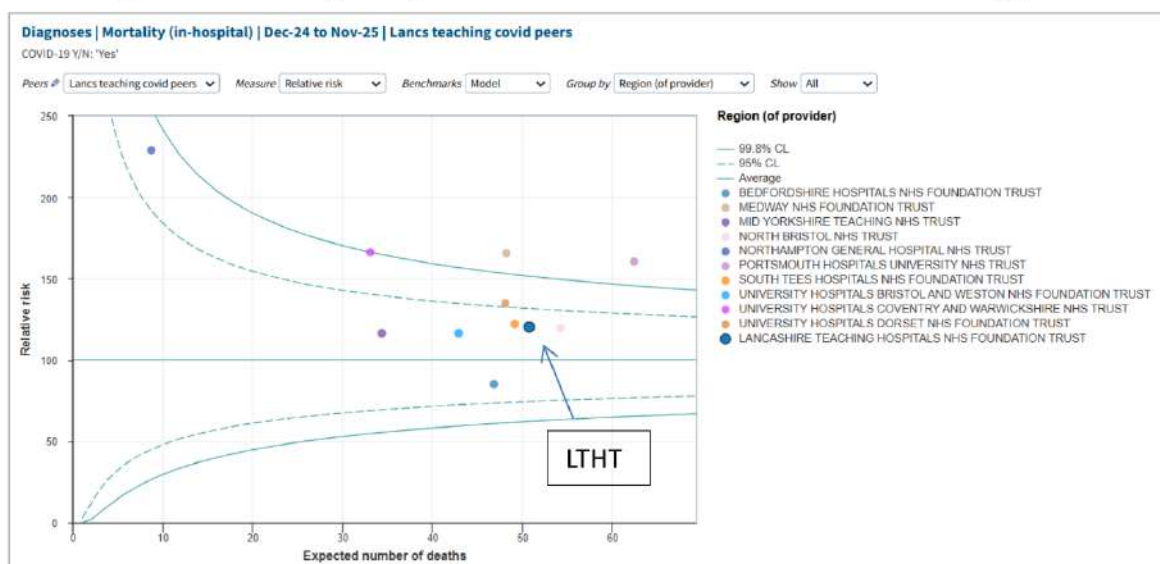


Figure 4: HSMR+ COVID-19 subgroup - Trust with Similar Bed Base & admissions, Dec-24 – Nov-25

The new HSMR+ now includes patients who presented with a primary diagnosis of COVID-19, these are mapped to the COVID-19 subgroup within the viral infections group. The relative risk is 139.4, and within the expected range.

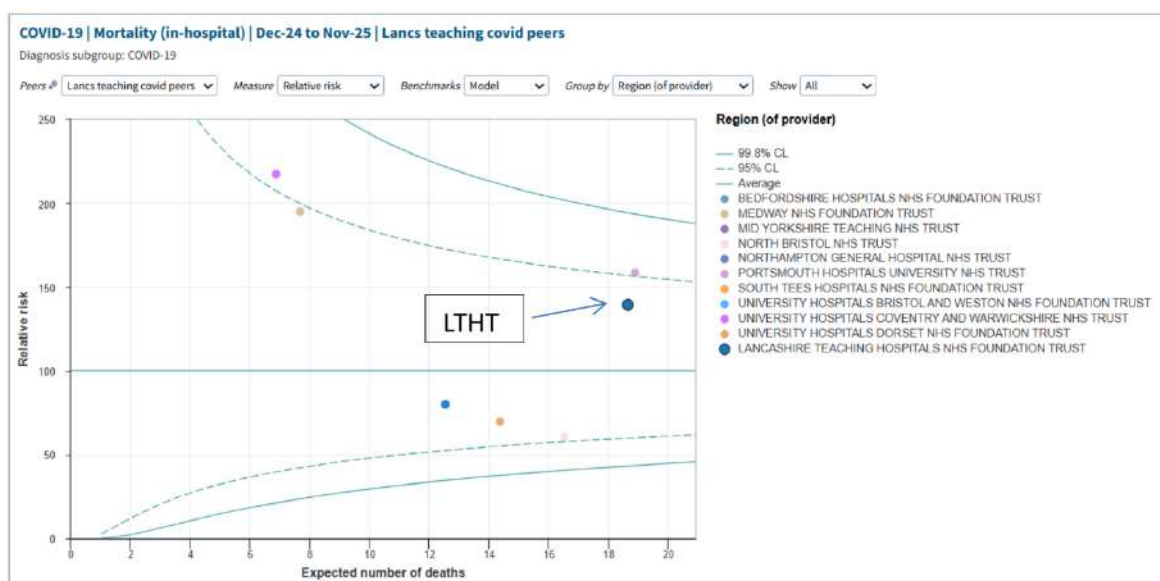


Figure 5: SMR Regional Acute Trust Benchmark Child mortality, Dec-24 – Nov-25

Please note that the new H/SMR models do not include or provide risk adjustment for still birth mortality (those within the ICD10 (3-char) P95 'Foetal death of unspecified cause' group).

The twelve-month rolling SMR for children is 78.0 and statistically 'within-expected'. This is an increase in relative risk since the previously reported figure (69.7). There were 13 deaths during the twelve-month period, compared to an expected figure of 16.7. See figure 5a for trend analysis.

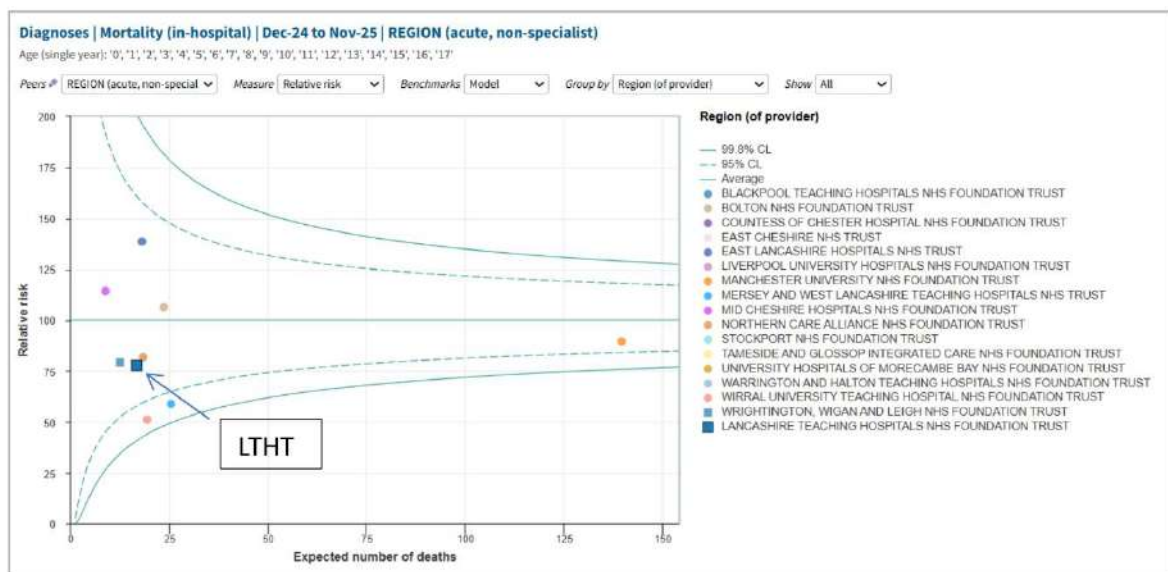


Figure 5a: SMR child mortality – rolling twelve-month peer comparison

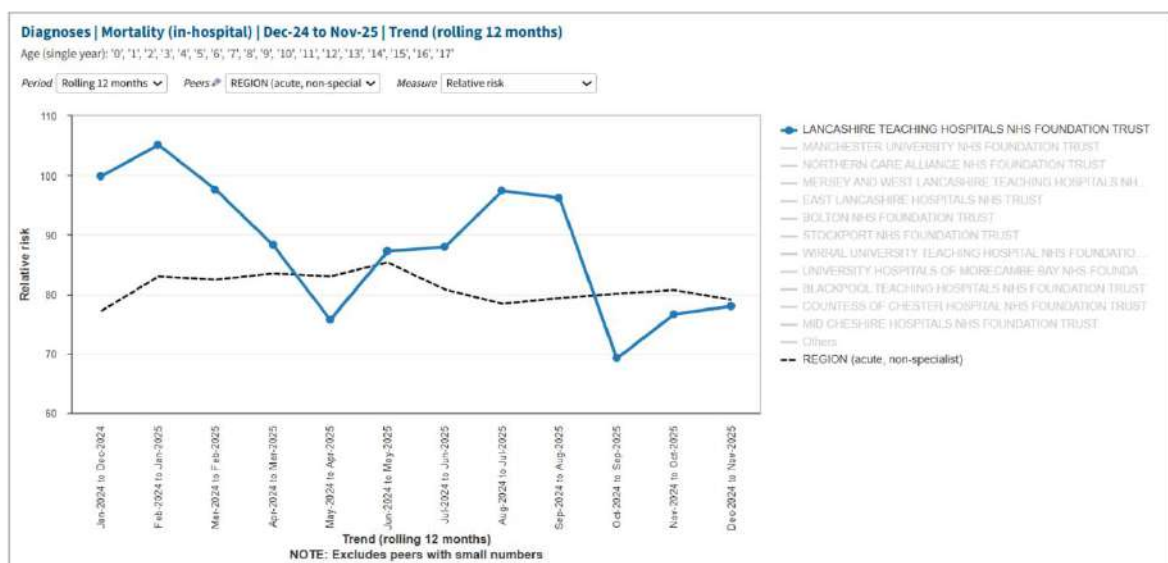


Figure 5b: SMR child mortality – monthly observed mortality

The latest data reveals low volumes in observed deaths across the individual months.

Trend (month)	Superspells	% of All	Spells	Observed	Crude rate (%)	Expected	Exp rate (%)	Relative risk	LCI	HCI
All	17834	100	17859	13	0.07	16.67	0.09	77.98	41.48	133.36
Dec-24	1475	8.27	1476	2	0.14	2.18	0.15	91.86	10.32	331.67
Jan-25	1515	8.50	1517	1	0.07	1.35	0.09	74.12	0.97	412.42
Feb-25	1295	7.26	1297	0	0	1.19	0.09	0	0	307.48
Mar-25	1551	8.70	1554	0	0	1.54	0.10	0	0	238.84
Apr-25	1468	8.23	1474	0	0	1.40	0.10	0	0	262.32
May-25	1464	8.21	1466	3	0.20	1.31	0.09	229.57	46.14	670.75
Jun-25	1467	8.23	1467	0	0	1.21	0.08	0	0	302.94
Jul-25	1450	8.13	1452	2	0.14	1.31	0.09	152.67	17.15	551.23
Aug-25	1304	7.31	1306	2	0.15	1.02	0.08	195.25	21.93	704.95
Sep-25	1532	8.59	1533	0	0	1.42	0.09	0	0	259.05
Oct-25	1674	9.39	1676	3	0.18	1.62	0.10	184.70	37.12	539.67
Nov-25	1639	9.19	1641	0	0	1.13	0.07	0	0	325.89

Figure 6: SMR neonatal mortality data (<1 day – 28 Days), Dec-24 – Nov-25

The latest 12-month SMR for neonates aged between zero and twenty-eight days is 84.3 and is within the expected range. The SMR value has followed an overall downward trajectory. See figure 6a for further details.

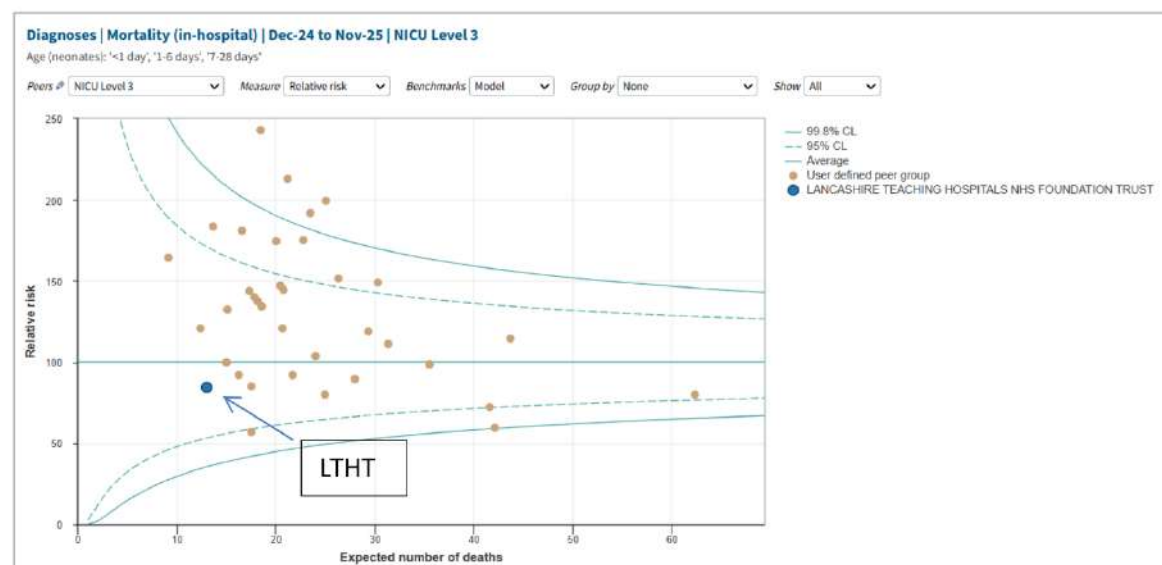


Figure 6a: SMR neonatal mortality data (<1 day – 28 Days) -rolling twelve-month peer comparison

The below shows the relative risk at the Trust (in blue), compared to the NICU Level 3 peer group average. The Trust has reported a lower relative risk than peers over the 5 most recent data periods. Earlier data periods have been excluded from the trend series due to small number suppression.

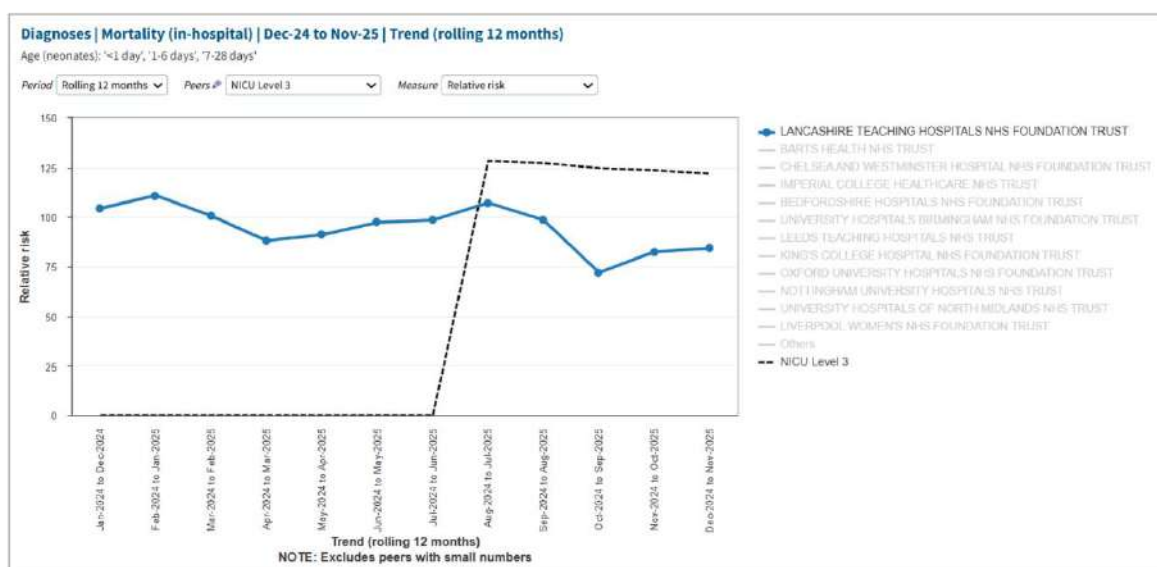


Figure 6b: SMR neonatal mortality data (<1 day – 28 Days) – monthly observed mortality for the period from Dec-24 – Nov-25

No months are considered statistically significant.

Trend (month)	Superspells	% of All	Spells	Observed	Crude rate (%)	Expected	Exp rate (%)	Relative risk	LCI	HCI
All	5010	100	5020	11	0.22	13.04	0.26	84.34	42.05	150.92
Dec-24	427	8.52	427	2	0.47	1.92	0.45	104.13	11.69	375.96
Jan-25	443	8.84	443	1	0.23	0.98	0.22	101.70	1.33	565.83
Feb-25	360	7.19	361	0	0	0.92	0.26	0	0	396.64
Mar-25	434	8.66	435	0	0	1.26	0.29	0	0	291.01
Apr-25	403	8.04	406	0	0	1.14	0.28	0	0	321.64
May-25	439	8.76	440	2	0.46	1.13	0.26	177.07	19.89	639.3
Jun-25	437	8.72	437	0	0	0.92	0.21	0	0	399.39
Jul-25	468	9.34	469	2	0.43	1.16	0.25	172.41	19.36	622.48
Aug-25	410	8.18	411	1	0.24	0.76	0.19	131.31	1.72	730.57
Sep-25	382	7.62	383	0	0	1.09	0.29	0	0	336.63
Oct-25	401	8.00	401	3	0.75	0.92	0.23	324.70	65.26	948.73
Nov-25	406	8.10	407	0	0	0.83	0.20	0	0	442.34

Figure 6c: SMR Neonatal mortality data – length of stay for the period from Dec-24 – Nov-25

All LOS bandings now report as 'within-expected', except for the 1-6 days banding, which reports as statistically 'lower-than-expected'.

LOS (6 bands)	Superspells	% of All	Spells	Observed	Crude rate (%)	Expected	Exp rate (%)	Relative risk	LCI	HCI
All	5010	100	5020	11	0.22	13.04	0.26	84.34	42.05	150.92
'0 Days'	1080	21.56	1082	4	0.37	0.56	0.05	711.39	191.38	1821.31
'1-6 Days'	3698	73.81	3704	1	0.03	7.78	0.21	12.85	0.17	71.47
'7-13 Days'	137	2.73	137	3	2.19	2.22	1.62	135.39	27.21	395.59
'14-20 Days'	22	0.44	22	0	0	0.40	1.80	0	0	926.61
'21-27 Days'	13	0.26	15	0	0	0.32	2.49	0	0	1131.02
'28+ Days'	60	1.20	60	3	5	1.76	2.93	170.54	34.28	498.29

Still birth mortality, Dec-24 – Nov-25

The new H/SMR+ models no longer include or provide risk adjustment for still birth mortality (those within the ICD10 (3-char) P95 'Foetal death of unspecified cause' group). The below analysis provides a mortality trend in the volumes of observed deaths within the P95 group.

There were 7 still births, during the period from Dec-24 – Nov-25. The table of data in figure 7 includes very low volumes of activity, as the code only includes deceased neonates. The Trust might want to assure themselves that where a post-mortem and or MDT case review was conducted, and the cause of death ascertained that the data and coding associated with these babies was appropriately re-coded and re-submitted in their monthly commissioning data set.

Figure 7.0: Still birth mortality, Dec-24 – Nov-25

Trend (month)	Spells	Superspells	Episodes	Patients
All	7	7	7	7
Dec-24	2	2	2	2
Jan-25	2	2	2	2
Feb-25	0	0	0	0
Mar-25	0	0	0	0
Apr-25	0	0	0	0
May-25	0	0	0	0
Jun-25	1	1	1	1
Jul-25	0	0	0	0
Aug-25	0	0	0	0
Sep-25	0	0	0	0
Oct-25	2	2	2	2
Nov-25	0	0	0	0

Figure 7a: Observed Stillbirth mortality (NICU Level 3 comparison), Dec-24 – Nov-25



Advisory notice on the use of HSMR+ for Perinatal Mortality Assessment

The Hospital Standardised Mortality Ratio (HSMR+) is designed to assess adult inpatient mortality using Hospital Episode Statistics data and should be used with caution, when evaluating perinatal outcomes. Several methodological and data limitations undermine its validity in this context:

- **Exclusion of Still births:** Stillbirths (using the discharge method coding) are excluded from the model so there are no risk scores calculated for stillbirth episodes
- **Inappropriate diagnostic groupings:** HSMR+ CCS group categories do not accurately capture key causes of perinatal mortality, such as prematurity, congenital anomalies, and birth-related complications.
- **Incomplete risk adjustment:** Essential clinical variables—such as gestational age, birth weight, and APGAR scores—are not included in the model, limiting its ability to account for case-mix differences.
- **Data quality concerns:** Inconsistent capture of neonatal episodes and variability in coding practices across Trusts can bias results.
- **Outcome-based coding:** Many neonatal diagnoses reflect outcomes rather than admission risk, compromising the integrity of risk adjustment.
- **Low volumes and referral effects:** Small numbers of deaths and inter-hospital transfers introduce statistical noise and may disproportionately affect tertiary centres with specialist NICU units.

Recommended Approach

To more accurately assess perinatal outcomes, we recommend using neonatal-specific metrics such as:

- Crude neonatal mortality rates, stratified by gestational age and birth weight
- Risk-adjusted tools (e.g. CRIB II, SNAPPE II)
- National datasets such as those produced by MBRRACE-UK

Conclusion: HSMR+ is not designed to provide a comprehensive assessment of perinatal mortality outcomes and its application in this context may be limited. Consequently, more specialist analytical tools should be utilised for more valid and meaningful evaluation.

1.5 Conditions flagging as having higher than expected mortality

1.5.1 Clostridium Difficile Deaths

In June 2024, concerns were raised by the Regional IPC Lead for NHSE regarding the Trust’s mortality rate for *Clostridium difficile* (C. difficile), which appeared higher than expected.

In response, a thematic review was undertaken. This did not support the initial concern. The review concluded that the apparent discrepancy was due to data anomalies, as the reported high mortality rate included only hospital-onset cases. These patients are typically more unwell and therefore have a higher risk of mortality.

Subsequently, the United Kingdom Health Security Agency (UKHSA) mortality report was updated to include hospital-onset cases within its methodology. Using this revised model, the Trust is performing better than the published national average.

In 2022/23 (the most recent year of published data), 20% of hospital-associated cases nationally died within 30 days of diagnosis with C. difficile. A recent audit by the IPC team found that 15% of hospital-associated cases at LTH died within a comparable timeframe (28 days from diagnosis).

The tables below demonstrate the Trust’s performance for C. difficile as compared its objective over the period 2025–2026. The *Clostridioides difficile* (C. difficile/CDI) objective was achieved, with 122 cases reported— 45 below the allocated trajectory by NHS England of 167. This is the second 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.

Clostridioides difficile infection (CDI)

For 2025/26 the cases assigned to LTHTR’s Objective includes both Hospital Onset Healthcare Associated cases (HOHA) and Community Onset Healthcare Associated cases (COHA) where the patient has been an inpatient in LTHTR in the preceding 4 weeks.

For 2025/26, the Annual Objective for CDI cases is 167

In March 2026 there was 1 HOHA cases and 0 COHA cases.

We are currently 45 cases below trajectory at the time of writing.

Total Clostridioides difficile cases for the year 2025/2026:

- HOHA – 84
- COHA – 38
- COIA – 27
- COCA – 65

Hospital Onset including Community Onset Healthcare Associated C.difficile Cases April 2025 - March 2026

Month	HOHA	COHA
Apr-25	7	2
May-25	5	7
Jun-25	5	5
Jul-25	15	5
Aug-25	7	3
Sep-25	10	7
Oct-25	9	3
Nov-25	7	2
Dec-25	7	1
Jan-26	6	3
Feb-26	5	0
Mar-26	1	0

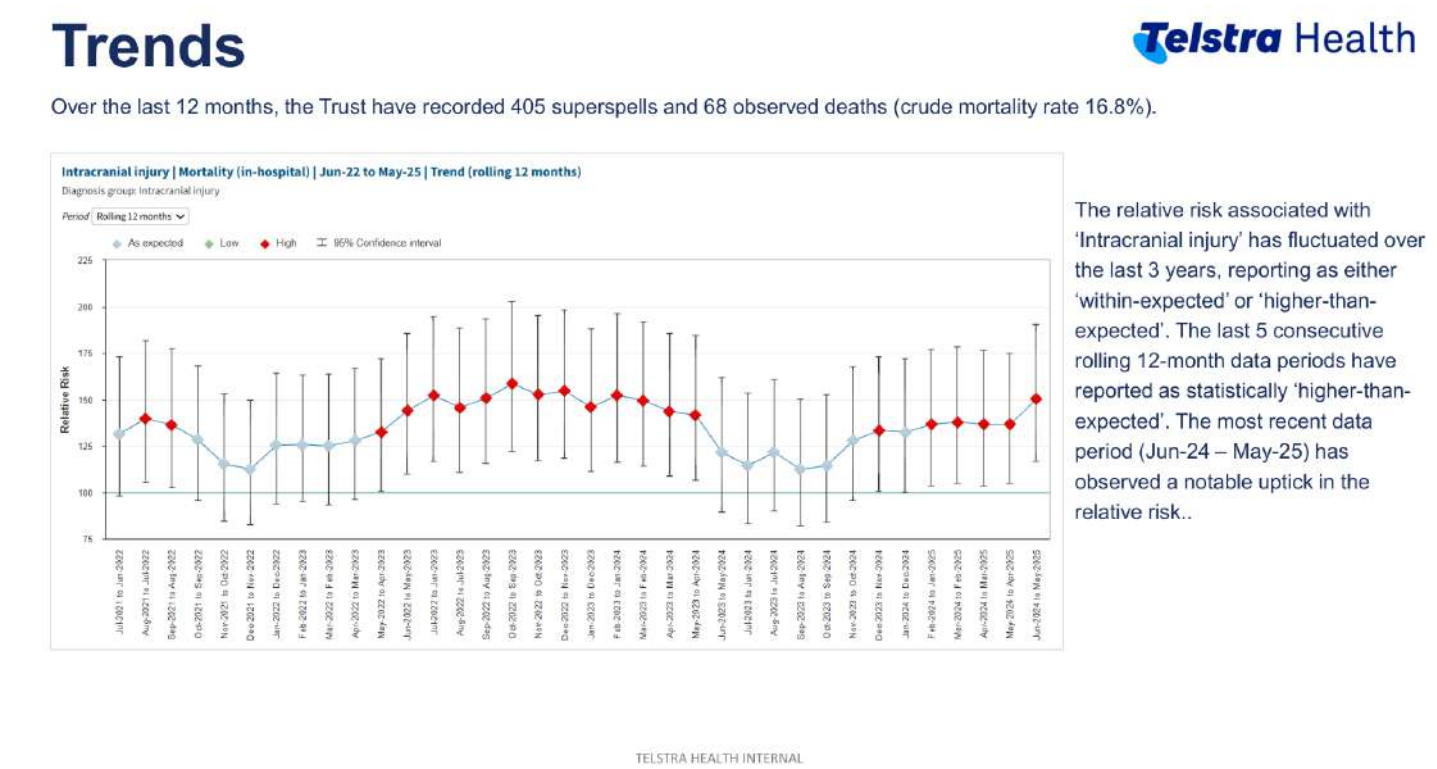
Total Cumulative C.difficile Performance April 2025 - March 2026

Month	Performance Total	Performance Objective
Apr-25	10	10
May-25	20	25
Jun-25	35	40
Jul-25	50	55
Aug-25	65	70
Sep-25	80	85
Oct-25	95	100
Nov-25	105	115
Dec-25	115	130
Jan-26	120	145
Feb-26	122	160
Mar-26	122	167

1.5.2 Intra cranial injury

Relative risk associated with intracranial injury had shown a significant increase from June 2024 to May 2025 using Dr Foster data for the Trust as demonstrated in Table 2 below.

Table 2.



Frailty

60.3% of patients are <75yrs LTHTR. This compares to 45.1% MTC average.

This will be a significant driver for higher than expected risk as a larger proportion of our patients will not be risk-adjusted for frailty (39.7% LTHTR compared with 52.9% MTC average)

Specialty

77.9% of cases are under neurosurgery. This is very different to the MTC average of 41.5% intracranial injury deaths

Deprivation

Broadly similar – slightly less than MTC peers.

HMP Garth

There were 2 deaths from Garth Prison. This has flagged suggesting a new and emerging treatment group; however, the numbers are small, and we should perhaps simply see if this is repeated over the next time interval

Conclusion

Our higher-than-expected deaths from June 2024 to May 2025 are not significantly different to the national MTC average. The main driver from the data appears to be a younger cohort which is therefore less risk-adjusted for frailty

Intracranial Injury
Dr Foster
June 2024-May 2025
Nick Park
Consultant Neurosurgeon

Introduction

- Relative risk associated with intracranial injury has shown significant increase from June 2024 to May 2025 using Dr Foster data for the Trust

Trends

Over the last 12 months, the Trust have recorded 405 superspells and 68 observed deaths (crude mortality rate 16.8%).



The relative risk associated with 'Intracranial injury' has fluctuated over the last 3 years, reporting as either 'within-expected' or 'higher-than-expected'. The last 5 consecutive rolling 12-month data periods have reported as statistically 'higher-than-expected'. The most recent data period (Jun-24 – May-25) has observed a notable uptick in the relative risk..

Trends

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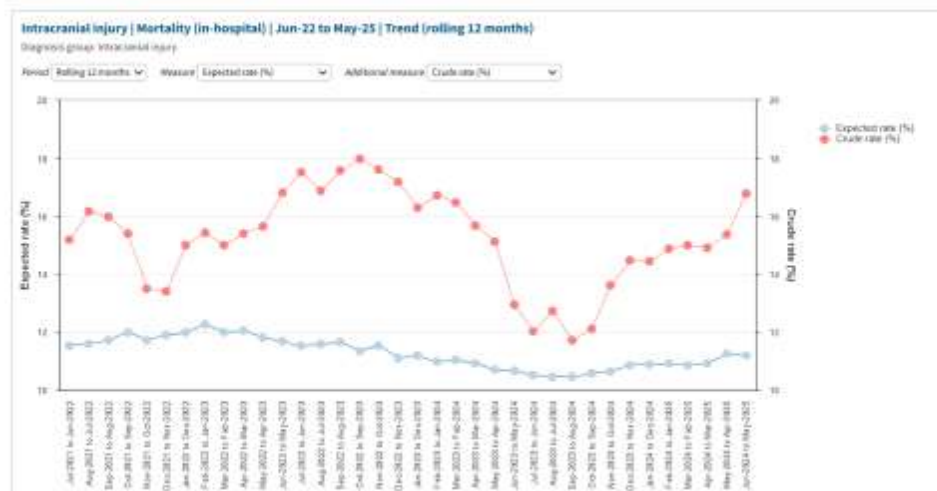
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TELSTRA HEALTH INTERNAL

Superspells

- Over the last 3 years the number of intracranial injury superspells has gradually increased
- Intracranial injury accounts for 4.3% of LTHTR MTC deaths (MTC average 3.1%)

Trends



The volume of superspells within the diagnosis group has increased over the last 3 years. Intracranial injury' represents a larger proportion of LHT's observed deaths compared to Major Trauma Centre peers. In the last 12 months, the diagnosis group accounted for 4.3% of LHT's deaths, which is higher the Major Trauma Centre average (3.1%).

TELSTRA HEALTH INT

Over the years, the crude mortality rate has fluctuated, and has seen a sharp increase since data period Sep-23 – Aug-24. This is being driven by a notable increase in the volume of observed deaths within the diagnosis group.

The expected mortality rate has reported a stable but declining trend over the last 3 years. The divergence between the crude mortality rate and the expected mortality rate is what is driving the 'higher-than-expected' relative risk. There has been a slight increase in the expected rate recently, however.

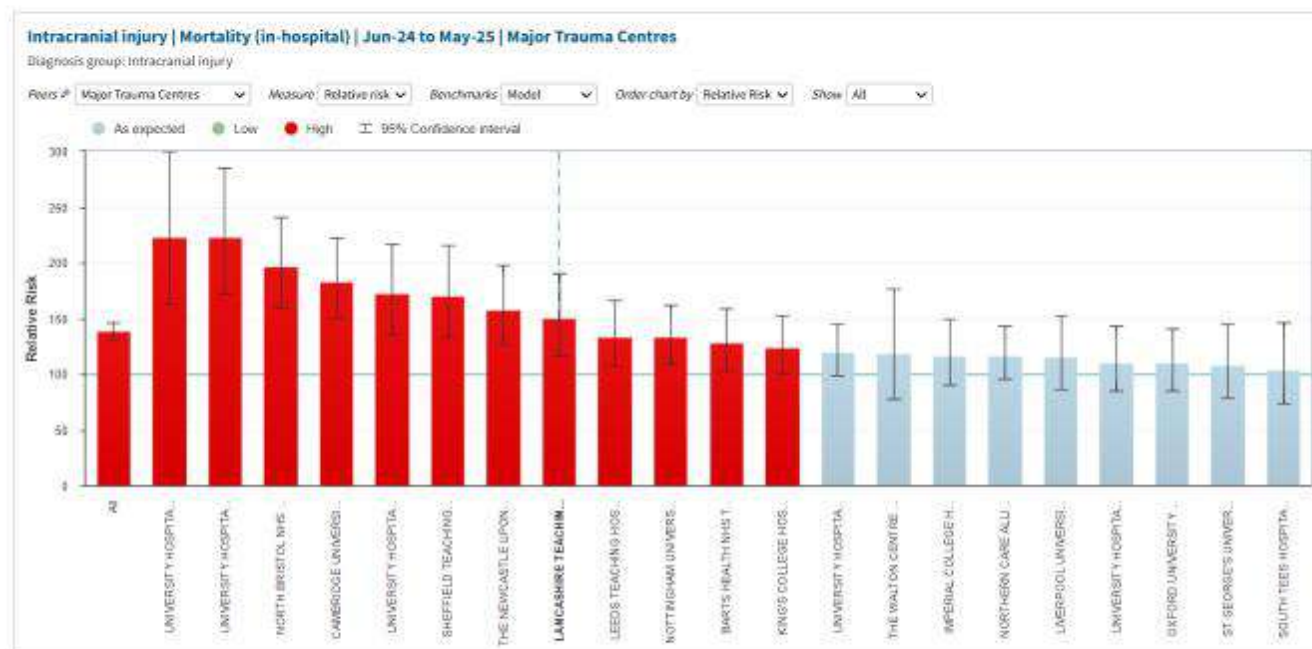


Peer comparison

- There are 12 MTC's with higher than expected deaths.
- LTHTR is not significantly different to the peer average

Peer comparison

The Trust is 1 of 12 within the Major Trauma Centre peer group which alerts as 'higher-than-expected' for the diagnosis group. The peer group as a whole also reports as 'higher-than-expected', so the Trust are not statistically different to the average relative risk for this group. The Trust report a higher relative risk and crude mortality rate than the peer average, as well as a higher expected mortality rate.



Relative risk

Lancs Teaching – 150.1

MTC peers – 138.4

Crude rate

Lancs Teaching – 16.8%

MTC peers – 14.2%

Expected rate

Lancs Teaching – 11.2%

MTC peers – 10.3%

Peer comparison

The Trust is 1 of 12 within the Major Trauma Centre peer group which alerts as 'higher-than-expected' for the diagnosis group. The peer group as a whole also reports as 'higher-than-expected', so the Trust are not statistically different to the average relative risk for this group. The Trust report a higher relative risk and crude mortality rate than the peer average, as well as a higher expected mortality rate.



Relative risk

Lancs Teaching – 150.1
 MTC peers – 138.4

Crude rate

Lancs Teaching – 16.8%
 MTC peers – 14.2%

Expected rate

Lancs Teaching – 11.2%
 MTC peers – 10.3%

Case-mix analysis

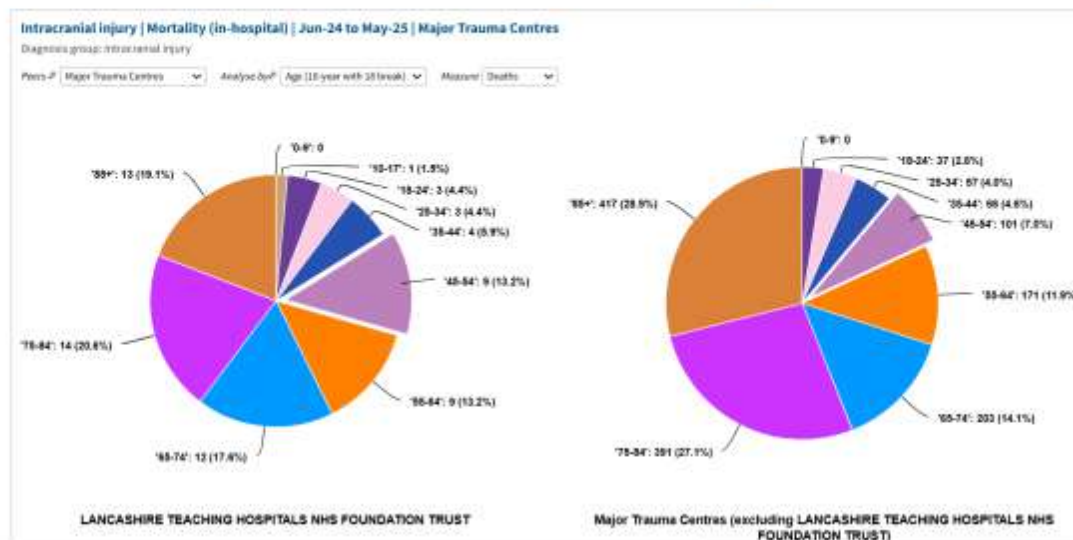
Age

- Our cohort is younger compared to MTC peers
- In particular we seem to have a higher number of deaths in the 45-54 age bracket (13.2% LTHTR vs 7.0% MTC average)

Age

LTHT see a generally younger cohort of patients compared to MTC peers. Currently, age banding '45-54' report as statistically higher-than-expected'. The majority of patients within the diagnosis group are aged 65+, however.

In comparison to MTC peers, the Trust report higher proportions of deaths within the 45-54 banding (13.2% LTHT, 7.0% national). There has been a rise of observed deaths in this age group since May-23 – Apr-24.

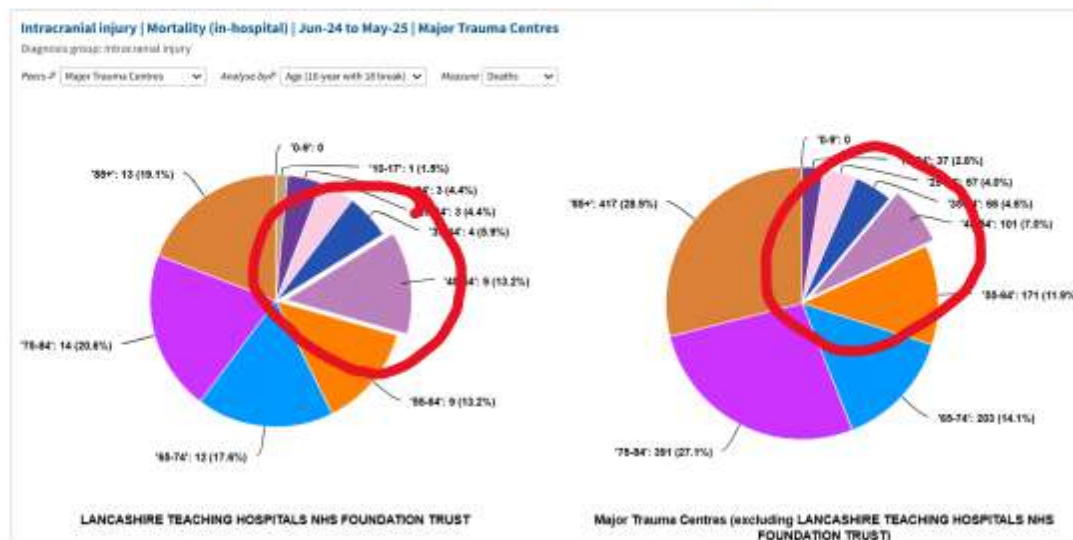


Age (10-year with 10 break)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LD	HI
All	405	100.0%	405	68	16.8%	45.3	11.2%	22.7	150.1	116.5	190.2
'0-9'	5	1.2%	5	0	0.0%	0.0	0.4%	-0.0	0.0	0.0	17096.8
'10-17'	8	2.0%	8	1	12.5%	0.1	1.4%	0.9	883.0	11.5	4913.0
'18-24'	22	5.4%	22	3	13.6%	1.5	7.0%	1.5	196.0	39.4	572.7
'25-34'	22	5.4%	22	3	13.6%	1.3	5.7%	1.7	237.7	47.8	694.5
'35-44'	23	5.7%	23	4	17.4%	1.4	6.2%	2.6	278.7	75.0	713.3
'45-54'	31	7.7%	31	9	29.0%	2.2	7.1%	6.8	408.9	186.6	776.4
'55-64'	55	13.6%	55	9	16.4%	4.8	8.7%	4.2	188.8	95.2	358.5
'65-74'	68	16.8%	68	12	17.6%	7.0	10.3%	5.0	170.9	88.2	298.6
'75-84'	98	24.2%	98	14	14.3%	14.0	14.3%	0.0	100.1	54.6	167.9
'85+'	73	18.0%	73	13	17.8%	13.0	17.8%	0.0	100.2	53.3	171.3

Age

LTHT see a generally younger cohort of patients compared to MTC peers. Currently, age banding '45-54' report as statistically higher-than-expected'. The majority of patients within the diagnosis group are aged 65+, however.

In comparison to MTC peers, the Trust report higher proportions of deaths within the 45-54 banding (13.2% LTHT, 7.0% national). There has been a rise of observed deaths in this age group since May-23 – Apr-24.



Age (10-year with 10 break)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LD	HI
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'25-34'	22	5.4%	22	3	13.6%	1.3	5.7%	1.7	237.7	47.8	694.5
'35-44'	23	5.7%	23	4	17.4%	1.4	6.2%	2.6	278.7	75.0	713.3
'45-54'	31	7.7%	31	9	29.0%	2.2	7.1%	6.8	408.9	186.6	776.4
'55-64'	55	13.6%	55	9	16.4%	4.8	8.7%	4.2	188.8	95.2	358.5
'65-74'	68	16.8%	68	12	17.6%	7.0	10.3%	5.0	170.9	88.2	298.6
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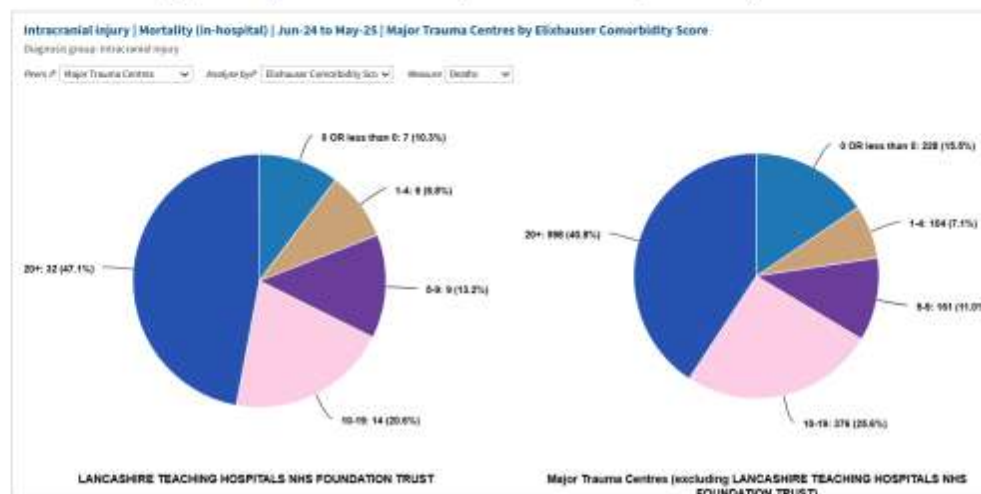
Co-morbidity

- LTHTR patients have higher co-morbidity scores than MTC average)
- This implies a stronger coding depth and also a more complex case mix than peers

Comorbidity

Patients admitted with intracranial injury typically have lower recorded comorbidity scores, as these cases often result from acute traumatic events rather than underlying disease. Many patients are younger or previously healthy, and as a Major Trauma Centre, the Trust treats a higher proportion of severe single-system injuries, contributing to a case mix with high injury severity but low comorbidity burden. This profile can influence expected mortality calculations, occasionally making relative risk appear higher than anticipated. This explains why there are a number of patients who had no or low comorbidity scoring.

The majority of the observed deaths had high comorbidity scores. In comparison to MTC peers, the Trust report higher proportions of deaths with a 20+ comorbidity score (47.1% LTHT, 40.8% national). This indicates that the Trust has a stronger depth of coding, and that the patient case-mix is more complex and acute than MTC peers.

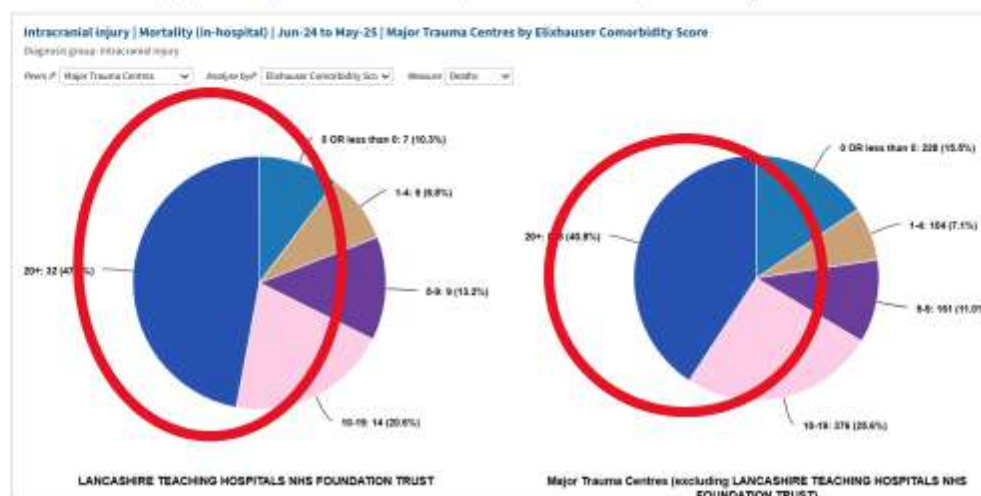


Elixhauser Comorbidity Score	Superspell	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	405	100.0%	405	68	16.8%	45.3	11.2%	22.7	150.1	116.5	190.2
0 OR less than 0	79	19.5%	79	7	8.9%	3.1	3.9%	3.9	225.8	90.5	465.3
1-4	47	11.6%	47	6	12.8%	3.2	6.8%	2.8	186.7	68.2	406.4
5-9	63	15.6%	63	9	14.3%	4.9	7.8%	4.1	184.2	84.0	349.7
10-19	94	23.2%	94	14	14.9%	11.0	11.7%	3.0	127.1	69.4	213.2
20+	122	30.1%	122	32	26.2%	23.1	18.9%	8.9	138.5	94.7	195.6

Comorbidity

Patients admitted with intracranial injury typically have lower recorded comorbidity scores, as these cases often result from acute traumatic events rather than underlying disease. Many patients are younger or previously healthy, and as a Major Trauma Centre, the Trust treats a higher proportion of severe single-system injuries, contributing to a case mix with high injury severity but low comorbidity burden. This profile can influence expected mortality calculations, occasionally making relative risk appear higher than anticipated. This explains why there are a number of patients who had no or low comorbidity scoring.

The majority of the observed deaths had high comorbidity scores. In comparison to MTC peers, the Trust report higher proportions of deaths with a 20+ comorbidity score (47.1% LTHT, 40.8% national). This indicates that the Trust has a stronger depth of coding, and that the patient case-mix is more complex and acute than MTC peers.



Elixhauser Comorbidity Score	Superspell	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	405	100.0%	405	68	16.8%	45.3	11.2%	22.7	150.1	116.5	190.2
0 OR less than 0	79	19.5%	79	7	8.9%	3.1	3.9%	3.9	225.8	90.5	465.3
1-4	47	11.6%	47	6	12.8%	3.2	6.8%	2.8	186.7	68.2	406.4
5-9	63	15.6%	63	9	14.3%	4.9	7.8%	4.1	184.2	84.0	349.7
10-19	94	23.2%	94	14	14.9%	11.0	11.7%	3.0	127.1	69.4	213.2
20+	122	30.1%	122	32	26.2%	23.1	18.9%	8.9	138.5	94.7	195.6

Frailty

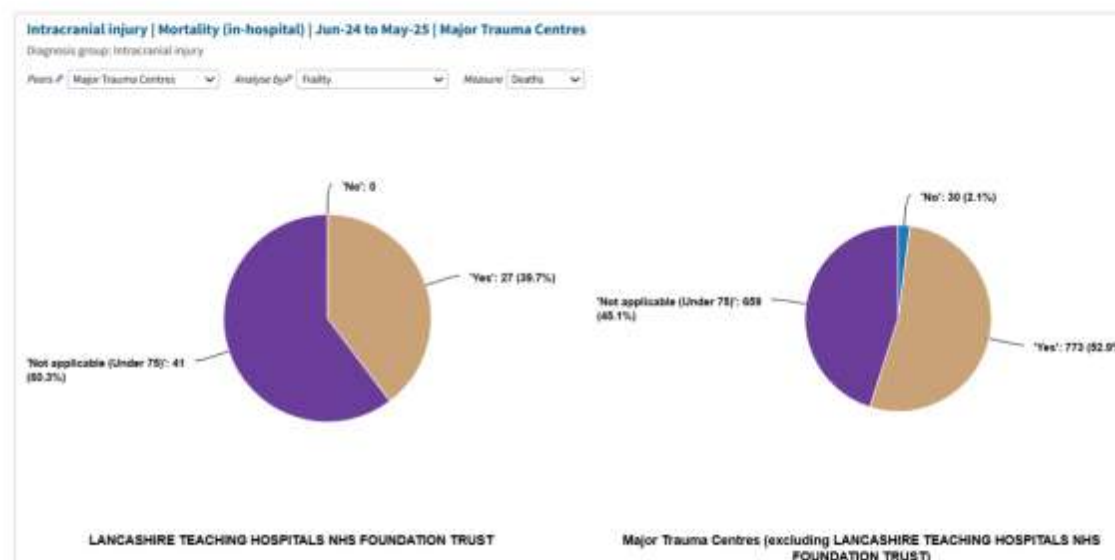
- 60.3% of patients are <75yrs LTHTR
- This compares to 45.1% MTC average
- **This will be a significant driver for higher than expected risk as a larger proportion of our patients will not be risk-adjusted for frailty (39.7% LTHTR compared with 52.9% MTC average)**

Frailty

Similarly, patients with intracranial injury often have lower recorded frailty levels, as many cases involve younger or previously independent individuals affected by sudden traumatic events. As a result, frailty coding may not fully reflect patients' pre-injury functional status, which can influence risk adjustment and expected mortality calculations within models such as HSMR and SHMI.

Over the last 12 months, 60.3% of LHT's observed deaths within the 'Intracranial injury' diagnosis group are under 75 years (compared to 45.1% MTC). This will be a significant factor for driving the 'higher-than-expected' relative risk, as a larger proportion of LHT's patients won't be risk adjusted for frailty.

LHT's record 39.7% of their observed deaths with a frailty indicator, compared to 52.9% MTC.



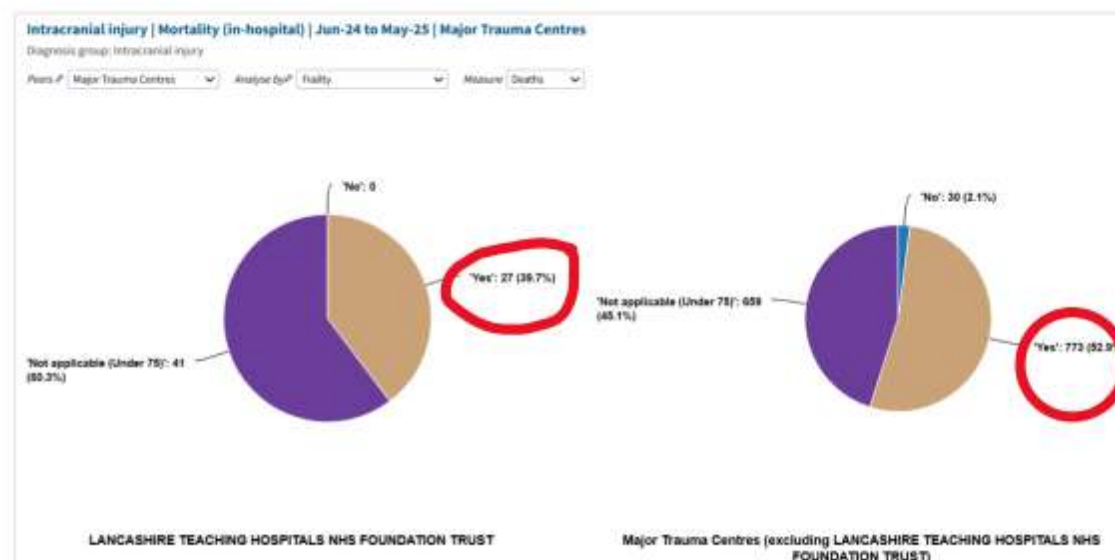
Frailty	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	405	100.0%	405	68	16.8%	45.3	11.2%	22.7	150.1	116.5	190.2
'Not applicable (Under 75)'	234	57.8%	234	41	17.5%	18.3	7.8%	22.7	223.4	160.3	303.1
'Yes'	164	40.5%	164	27	16.5%	26.1	15.9%	0.9	103.4	68.1	150.4
'No'	7	1.7%	7	0	0.0%	0.8	12.1%	-0.8	0.0	0.0	433.9

Frailty

Similarly, patients with intracranial injury often have lower recorded frailty levels, as many cases involve younger or previously independent individuals affected by sudden traumatic events. As a result, frailty coding may not fully reflect patients' pre-injury functional status, which can influence risk adjustment and expected mortality calculations within models such as HSMR and SHMI.

Over the last 12 months, 60.3% of LHT's observed deaths within the 'Intracranial injury' diagnosis group are under 75 years (compared to 45.1% MTC). This will be a significant factor for driving the 'higher-than-expected' relative risk, as a larger proportion of LHT's patients won't be risk adjusted for frailty.

LHT's record 39.7% of their observed deaths with a frailty indicator, compared to 52.9% MTC.



Frailty	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	405	100.0%	405	68	16.8%	45.3	11.2%	22.7	150.1	116.5	190.2
'Not applicable (Under 75)'	234	57.8%	234	41	17.5%	18.3	7.8%	22.7	223.4	160.3	303.1
'Yes'	164	40.5%	164	27	16.5%	26.1	15.9%	0.9	103.4	68.1	150.4
'No'	7	1.7%	7	0	0.0%	0.8	12.1%	-0.8	0.0	0.0	433.9

Speciality

- 77.9% of cases are under neurosurgery
- This is very different to the MTC average of 41.5% intracranial injury deaths

Deprivation

- Broadly similar (slightly less) than MTC peers

HMP Garth

- There were 2 deaths from Garth Prison
- This has flagged suggesting a new and emerging treatment group
- However the numbers are small and we should perhaps simply see if this is repeated over the next time interval

Summary

- LTHTR has higher than expected deaths for intracranial injury from Jun 2024 to May 2025
- However this is not significantly different to the national MTC average over that period
- Our cohort is younger and are therefore much less risk-adjusted for frailty (39.7% LTHTR vs 52.9% MTC average).

Summary

- We have larger proportion of deaths in the 45-54 yr category.
- These patients are likely to have more co-morbidities than younger patients, but will not flag for frailty
- Our cohort has more co-morbidities than the MTC average (47.1% vs 40.8%). This suggests either our coding is better or our case mix is more complex or both.

Conclusion

- Our higher-than-expected deaths from June 2024 to May 2025 are not significantly different to the national MTC average
- The main driver from the data appears to be a younger cohort which is therefore less risk-adjusted for frailty

Thank you

APPENDIX 2. Structured Judgement Reviews

1. Adult Mortality Structured Judgement Reviews (SJRs) & Learning

1.1 Primary Structured Judgement Reviews

The Trust overall reviewed 60% of cases, with the divisional performance presented in Table 3 below.

Although the aspiration is that all Trust deaths are reviewed, there is pragmatically a minimum target set of 20% in each directorate. There is work ongoing to support those specialties who have historically returned low review figures with continued improvement noted over the past twelve months across each of the specialties requiring support.

Table 1: Primary Structured Judgement Review Annual Performance 2025-2026

	April – June 2025			July - September 2025			October - December 2025			January – March 2026			Annual Totals		
	Deaths	Reviews	%	Deaths	Reviews	%	Deaths	Reviews	%	Deaths	Reviews	%	Deaths	Reviews	%
Medicine	279	143	51	263	142	54	339	165	49	331	164	50	1212	614	51%
Surgery	77	77	100	78	75	96	80	80	100	82	60	73	317	292	92%
DCS	30	21	70	34	32	94	40	29	73	38	23	61	142	105	74%
WAC	2	2	100	0	0	0	0	0	N/A	1	0	0	3	2	67%
Total	388	243	63	375	249	66	459	274	60	452	246	54	1674	1012	60%

The avoidability of death score at Primary SJR is used to determine cases which require escalation for a Secondary SJR, which are those cases with scores 1-3. Some cases may be directly referred for a Ulysses incident review where there is already a concern that a clinical incident has occurred. Where relevant, those cases will be reviewed at the Patient Safety Incident Response Framework (PSIRF) Level 2 Triage meeting where the level of investigation will be determined. In cases requiring further investigation the avoidability of death is only finally determined after an incident investigation has been completed or after a Coroner's inquest where applicable.

Table 2: Avoidability Scores at Primary Review 2025-2026

Avoidability Scores	Medicine	Surgery	DCS	WAC	TOTAL
Score 1 Definitely avoidable	0	0	0	0	0
Score 2 Strong evidence of avoidability	0	1	0	0	1
Score 3 Probably avoidable (more than 50:50)	1	0	2	0	3
Score 4 Possibly avoidable but not very likely (less than 50:50)	12	4	5	1	22
Score 5 Slight evidence of avoidability	61	11	10	0	82
Score 6 Definitely not avoidable	497	276	88	2	863

1.2 Secondary Reviews 2025-2026

For the deaths which occurred during 2025-2026, 32 were referred for a secondary review which is a decrease from 42 cases in the last year's annual report. It should be noted that a request for a secondary review is not always due to the avoidability of death score or poor care. Some specialities trigger a secondary review if a second opinion/specialist opinion is required, or a need to highlight an issue to another speciality involved in patient's care.

Out of the 32 cases three patients were given an avoidability of death score of 1 or 3 at the primary review. Please see the breakdown of all the outcomes in Table 5.

Table 3: Avoidability Scores at Secondary Review

Primary SJR Avoidability Scores	Cases escalated for secondary SJR	Post Secondary Review Avoidability	
		Number of cases	Outcomes
Score 1 Definitely avoidable	0	0	N/A
Score 2 Strong evidence of avoidability	1	1	PSII
Score 3 Probably avoidable (more than 50:50)	1	1	Awaiting review
Score 4 Possibly avoidable but not very likely (less than 50:50)*	9	2	Score 4 Possibly avoidable but not very likely
		4	Score 5 Slight evidence of avoidability
		1	Score 6 Definitely not avoidable
		1	AAR
		1	N/A
Score 5 Slight evidence of avoidability*	6	3	Tracked via Ulysses
		1	Score 5 Slight evidence of avoidability
		1	Score 6 Definitely not avoidable
		1	Awaiting review
Score 6 Definitely not avoidable*	14	1	Score 5 Slight evidence of avoidability
		6	Score 6 Definitely not avoidable
		1	Reviewed without the score
		3	Tracked via Ulysses
		3	Awaiting review

Score at Primary Review Not Available (Emergency Department proforma)	1	1	Score 6 Definitely not avoidable

* Please note that cases scoring 4-6 do not require escalation for Secondary Review. A secondary review is also triggered by a poor care score.

1.3 Learning from Structured Judgement Reviews

The mortality review proforma has been designed to capture both positive and negative learning.

Learning from deaths is shared in the divisional Safety and Quality meetings and speciality governance meetings.

Key positive themes arising from the outcomes of SJR Mortality Reviews during 2025-2026:

- Good communication with the family and patient.
- Good documentation.
- Early identification of patient's condition and ceilings of care.
- Multi-disciplinary approach and decision making.
- Involvement of the Palliative Care Team.

Key negative themes arising from the outcomes of SJR Mortality Reviews during 2025-2026:

- Delays in recognising the deteriorating patient
- Lack of or delayed involvement of the palliative care team

2. Learning Disabilities (LeDeR) Deaths, Mental Health Deaths Reviews & Learning

2.1 Learning Disabilities (LeDeR deaths)

There were 30 deaths of patients with Learning Disabilities or Autism in 2025-2026, all of these have had a Structured Judgement Review completed.

Table 4: LeDeR and Autism Deaths Reviews 2025-2026

	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	March	Totals
LeDeR	3	2*	2*	0	0	0	1	2	2	4	2	5*	23
Autism	0	0	0	0	0	1	1	0	1	2	1	1	7
Total	3	2	2	0	0	1	2	2	3	6	3	6	30

Figures include ED patients as well

*Patient had both LD and autism – counted once

Excellent care was reported in 4 cases. Good care was reported in 26 cases. In 27 cases death was 'Definitely not avoidable' and in 3 cases the death had a "slight evidence of avoidability" with reasoning for this judgement outlined in Table 7a below.

Table 4a. Reasoning for Score 5 allocation in LeDeR / Autism Death Reviews

Case	Score	Reasoning
1	5	Score 5 given as the cause death is not clear.
2	5	Giving a death avoidability score of 5 as the precise cause of death is still unclear, however it's unlikely to have been treatable considering the poor clinical state of the patient.
3	5	Presented in extremis with aspiration pneumonia.

Whilst currently secondary reviews are only mandated for avoidability scores of 1-3, going forwards for mental health and LEDER /autism deaths consideration will be given to extending the criteria to scores of 1-5. The secondary review should where possible include a member of the mental health/LeDeR autism team.

2.2 Deaths of Patients with Mental Illness

Following the MIAA Mortality review in 2024, it was recommended to create a separate group which would include patients with the diagnosis of mental illness and specifically with the diagnosis of psychosis and bipolar disorder. It needs to be highlighted, that these patients are identified via the ICD10 codes (F20 and F30) from the hospital patient systems rather than the SMI register.

There were 26 patients in 2025-2026 who had a relevant code of mental illness in their inpatient episode.

	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Totals
Schizophrenia	1	0	2	2	6	1	1	0	1	3	0	0	17
Bipolar	2	1	2	0	1	1	0	0	1	0	1	0	9
Total	3	1	4	2	7	2	1	0	2	3	1	0	26

All the patients in this group had a primary SJR completed. Excellent or good care was reported in 92% of cases. Care for 2 patients was scored as adequate. Death was definitely not avoidable for 88% patients. 2 patients were given a score of 5 and 1 patient's death was scored as possibly avoidable but not very likely (Score 4)–reasoning for this judgement is provided in Table 8b below.

Table 4b. Reasoning for Score 4 and 5 allocation in Mental Health Death Reviews

Case	Score	Reasoning
1	4	Cause of death was felt to be cardiac related but, in the notes, there is a question over whether this is clozapine withdrawal causing a seizure.

APPENDIX 3. Deaths subject to PSIRF Investigation

1. Deaths subject to PSIRF Investigation

1.1 Reported Incidents with outcome of death

In the reporting period the Trust had initiated 19 death related Learning Responses under the PSIRF with 8 reported as death more likely than not due to problems in care under PSIRF national priority, 3 cases reported under PSIRF priority of MNSI, and a further 8 reported onto the Datix/Ulysses system with an initial harm level recorded as death with initial outcome undetermined.

Of the 19 PSIRF Learning Responses:

11 have been completed (including 1 Patient Safety Incident Investigation [PSII], 9 After Action Reviews [AAR], and 1 Thrombectomy Panel Review.

Full details of the above cases are reported quarterly to Safety and Quality Committee.

1.2 Deaths investigated by MNSI.

** When an incident meets the criteria for the MNSI programme, it is reviewed by an independent national team. These investigations focus on understanding what happened and how care can be improved, rather than placing blame. Once accepted by MNSI, the Trust does not carry out a separate local investigation. However, it remains responsible for meeting legal duties such as the duty of candour and taking any urgent safety actions. MNSI works closely with families and staff, and shares findings and recommendations to support learning and improve maternity and neonatal care both locally and nationally.*

APPENDIX 4. Inquests and Coronial Matters

1. Coronial referrals and Learning Responses

1.1 PSIRF death related cases

Of the 19 PSIRF Learning responses 8 cases reported under PSIRF priority as “death more likely than not due to problems in care” have all been reported to the Coroner. A further 2 cases of the 8 reported onto Datix/ Ulysses under the category of death were also reported to the Coroner with 1 concluded and 1 awaited (the remaining 6 did not meet coronial referral criteria).

In total 10 cases were referred to the Coroner, with 6 inquests concluded and 4 pending as of 31st May 2026.

A further 11 death related cases reported either under PSIRF national priorities or Datix under category of death **prior to 1st April 2025** had Inquests/Coronial Investigations concluded during the reporting period of 1st April 2025 -31st March 2026 and have been included here for completeness.

1.2 MNSI death related cases

Of the 3 MNSI cases one neonatal death case has been referred to the Coroner with proceedings delayed due to the requirement to await the outcome of a Police Investigation.

The MNSI maternal death cases has been subject to discussion between the Trust and MNSI due to significant differences in conclusion on the cause of death. An addendum to the Trust AAR has been added outlining the differences which will be shared with the Coroner following recent approval at Patient Safety Oversight Panel.

The remaining MNSI neo natal death is not subject to coronial investigation or inquest

Details of all Coronial investigations /inquests that were reported under PSIRF national priority/local priority that were concluded in 2025/26 regardless of date of initial reporting are outlined on page 55 for ease of reference – this includes Coroner conclusions and formal Records of Inquest where available.

2. Coroner concerns (Regulation 28, Neglect Conclusions, and formal concerns)

2.1 Regulation 28 reports received

The Trust has received two Regulation 28 reports in the reporting period.

Case 1. Thrombectomy Service (May 2025)

This was issued by HM Coroner for Lancashire and Blackburn with Darwen in May 2025 following the inquest of a 46-year-old female patient who died from an ischaemic stroke at Lancaster Infirmary having not been transferred to RPH thrombectomy service as no service available at that time. A full response was provided to the Coroner outlining plans to commence a 24/7 service from February 2026. The service has been operational since February with no gaps in service.

A further 2 inquest cases involving the thrombectomy service at LTHTR have been heard in May 2026 both with conclusions that the lack of 24/7 service possibly contributed to death. The Coroner requires further assurances regarding mutual aid and business continuity across the three Trusts in the North West Region who provide thrombectomy services namely Northern Care Alliance, Walton Hospital and LTHTR. Work is ongoing to provide a response which is due by 16th June 2026. NHSE and the ICB are also involved in this work.

There are 2 remaining inquest cases involving the lack of 24/7 thrombectomy services one due to be heard on 13th July 2026 and the final case on 5th /6th October 2026. Updates and conclusions will be provided in due course.

Case 2. Cardiology Pacemaker Procedure (September 2025)

The second Regulation 28 was received in September 2025 issued by the Assistant Coroner for South Manchester involving a lady who underwent a pacemaker procedure in the Cardiac Catheterisation Laboratory. The Coroner's concern relates to preoperative planning with regard to sharing of wound swab results and consideration of national guidance. A response and action plan has been provided to the Coroner with no further communication received.

Full details of both Regulation 28 reports issued have been provided in separate reports to Safety and Quality Committee.

2.2 Neglect Conclusions

There have been no Neglect conclusions received in the reporting period, however, a conclusion of Neglect was received in relation to an inquest concluded on 16th April 2026 (a historic case reported onto Datix in 2024) the matters of concern were specifically related to a staff nurse not monitoring a diabetic patient's blood sugars on multiple occasions throughout the night which resulted in a cardiac arrest and death, and delays to initiating CPR.

All actions were completed ahead of the inquest and accepted by the Coroner. This case has been included here for early notification and transparency.

2.3 Formal letters of concern

One expression of concern was raised by the Area Coroner for Preston and Blackburn with Darwen in relation to family reported radiology delays for a Plastics/Oncology patient. Investigation found imaging was largely within expected timescales, but communication issues were identified and escalated to PSOP. A full response was provided to the Coroner with no further correspondence having been received.

3.0 Regulation 28 Action Plan monitoring

The Trust continues to monitor four Regulation 28 Action Plans which are presented to PSIRF Oversight Panel for regular review and final sign off:

Table 1.

ID + Reg 28 issue date	Case details	Progress
Datix 121144 15.01.24	Death from PE for a neurodivergent patient with high BMI who underwent spinal surgery under the care of Neurosurgery	Majority of actions complete and meaningful improvement demonstrated through repeat audits. Digital prompt solution is actively being developed to strengthen compliance. Extension of audit scope for system-wide application underway.
Datix 88279 08.10.24	Death from posterior circulation stroke. LTHTR Thrombectomy service not available (referenced at section 1.1.1 above)	All actions complete. Awaiting formal sign off following implementation of 24/7 Thrombectomy service in February 2026 with no gaps in service.
Datix 345603		

02.06.25	Cardiology case. Wound swab Investigations results not shared with team ahead of procedure in Cardiac Catheterisation Suite. (CCS)	Revised documentation into the management of wound swab results by CCS has been completed and implemented. Alignment with impending digitalisation is being considered.
Datix 181528 26.09.25	Emergency Department. preventable death, due to asthma, caused by neglect characterised by a gross failure to provide appropriate assessment and medical care and an inadequate escalation of her management and lack of assessment of basic care needs.	Majority of actions completed included those related to management of asthma. Undergoing a series of audits to test embeddedness of actions. The final outstanding action relates to the new Care Admission Booklet which has been submitted for printing. ED leadership team agreed to undertake PALS e-learning during the absence of national PSIRF training; PSIRF-aligned training is now being re-established and will be explored with ED leadership team.

3. Learning from Inquests

Learning from inquests continues to provide valuable insight into patient safety, communication, and family experience. While most learning is identified through Trust-level investigations before inquest hearings, several themes have been reinforced during 2025 -26.

Themes in feedback from families include:

- Not being asked to support nurses with care where this would assist;
- Late contact /incorrect family member contacted after significant incident or deterioration (especially overnight);
- Poor communication with and between clinical teams caring for their relative;
- Late recognition of dying;
- Families being unaware of the severity/deterioration of the patient's condition;
- Family concerns not being listened to;
- Perceived inaccurate nutrition and hydration recording;
- Families misunderstanding their role in the DNACPR process;
- Not accepting decisions regarding patients being medically fit for discharge /failed discharge;
- Deconditioning;
- Having to repeat basic information to different shifts regarding their relative;
- Concerns re poor estate in patient areas;
- Pressure ulcer care;

Clinical learning points highlighted by the Coroner include:

- Management of alcohol withdrawal – with particular reference to awareness of heightened risk at 72 hours since last alcohol consumption;
- Consideration of advance treatment planning for patients who have frequent admissions for alcohol withdrawal;

- Requesting help from families in providing one to one observation of their relative when Trust staffing cannot provide for this;
- The Coroners collectively have also continued to raise concerns regarding discharge processes and ongoing poor communication with families;
- Lack of business continuity /mutual aid across NW Thrombectomy services.

Positive Feedback

Families have provided positive feedback on care delivered, and on the openness, honesty and transparency /due diligence in AAR reports, and notably on the compassion and clarity of evidence given in court by Trust inquest witnesses.

Local Coroners have also provided positive feedback on the quality of evidence and testimony provided by Trust witnesses across a range of specialities – notably, whilst this has in the main been directed at experienced witnesses, we have, this year, also seen excellent written and verbal evidence from a number of consultants attending inquests for the first time.

Governance and Dissemination

Themes are shared through Divisional Safety & Quality meetings and monitored via the Mortality & End of Life Committee.

External Learning from Inquests

From January 2026 the Inquest Team have begun a process to review all Regulation 28s recorded on the National Judiciary Website. Those of interest to Acute Trusts are forwarded to Divisional Governance Teams and specialties for review and discussion in Safety and Quality meetings.

From Quarter 4 2025 -26. 24 Regulation 28 reports were identified as relevant to our Trust and shared for information and learning across all divisions and multiple specialties.

Whilst this process is being established the current focus is primarily on sharing identified risks from the Coroners concerns - going forwards a more formal framework will be developed to provide assurance that identified risks either do not apply/ are adequately managed, or action plans are in progress to mitigate. Additionally, a quarterly summary report will be provided to Patient Safety Oversight Panel.

Feedback from specialties so far has been very positive with many colleagues already volunteering feedback.

Examples include:

- Candesartan medication to be avoided in pregnancy
- Provision of dietician/specialist nutritional services at weekends
- Use of lowest oxygen flow rate parameters
- Delayed diagnosis of endocarditis in pacemaker patient
- Communication pathways between GPs and MAU /ED
- Systems to support early recognition, escalation and care for patients experiencing serious immunotherapy toxicity
- Fragility of Endoscopy services

5. Coroners Directions Orders and Schedule 5 Notices

The jurisdiction of Lancashire and Blackburn with Darwen was, during 2025, an outlier for the timely completion of Coronal investigations and inquests, partly due to the late submission of evidence - a situation that Mr Long HM senior Coroner for Preston and Blackburn with Darwen was determined to address.

The Head of Inquest and Mortality and the Deputy Chief Medical Officer with responsibility for the oversight of Inquest management were invited to a multi organisational working group where the Coroner set out his concerns and plans to improve the situation by revising the Court Directions Orders. A Court Directions Order is

the Coroner's formal legal instruction which clearly sets out expectations, deadlines, and responsibilities for the provision of evidence, helping the inquest proceed efficiently and transparently.

The revised orders were implemented from January 1st 2026, and set out clear deadlines for the provision of evidence and witness availability to attend the inquest if required. Timescales for submission vary between 6 to 18 weeks from the date of the order depending on the complexity of the case. One extension request is permissible.

The Trust have well established processes and working relationships for the provision of factual witness evidence from our consultants, however challenges occasionally arise when there is complexity in the patient's journey, sick leave or dispute as to who may be best placed to provide an overview statement.

The greater risk is associated with the provision of PSIRF investigation reports (SWARM, AAR, PSII). While timescales stated in Trust policy would be compliant with the directions orders for inquests, current performance across the Trust does not consistently achieve these timescales. However, we are seeing an improving picture during Quarter 1 2026/27.

In order to enforce compliance with the Directions Orders Mr Long intends to use his powers under Schedule 5 of the Coroners Act which may include summons to attend court to explain delays, and fines to individuals of up to £1000. In practice Schedule 5 notices usually are preceded by a final warning with a short deadline.

To robustly manage this situation the Inquest Team have developed a dashboard which reports into PSOP bi-weekly in addition to their usual case tracking processes. Additionally, we have attended many consultant / specialty and divisional meetings to raise awareness and provide support.

The dashboard shows separate tabs for those cases that have an associated PSIRF investigation and those that are factual witness statements only.

Quarter 4 2025/26 compliance is as follows:

Cases with associated PSIRF – 10 cases in total, 5 submitted late or ongoing and overdue, 4 submitted on time, 1 submitted within an agreed extension date.

Cases with factual witness statements only: 44 in total, 36 submitted within set timescales, 3 submitted within an agreed extension date 5 submitted late (sick leave / emerging case complexities/admin error).

APPENDIX 5. Medical Examiners Service

1. Medical Examiner (ME) Service

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

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

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

The scrutiny process involves three key components:

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

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

Table 1 Medical Examiner Service Performance 2025-2026 data

Total Figures for April 2025 – March 2026

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

Of the 1826, 228 were referred directly to HM Coroner following an initial MEO review and did not undergo ME scrutiny. An additional 143 cases were referred to the Coroner after ME review.

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

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

- 67 cases where a Datix report was submitted
- 33 cases where a Structured Judgement Review was requested

Themes identified included:

- Delays in recognition of end-of-life
- Delays in radiology reporting
- Stroke patients not receiving a thrombectomy due to a gap in service

APPENDIX 6. Mortality Improvement Plan

Ongoing Maturity of Governance arrangements in relation to Mortality and Learning from deaths

1. Mortality Improvement Plan

The Head of Inquest and Mortality along with the Deputy Chief Medical Officer oversee a Mortality Improvement Plan (MIP) via the Mortality and End of Life Committee. The plan remains on track, with clear progress achieved in learning, education and early thematic analysis. It continues to function as a live document, with new tasks added as required. Key achievements to date include strengthened coronial learning processes, improved collaboration with the Medical Examiner service, creation of an inquest learning SharePoint site, standardisation of learning from deaths, enhanced coordination of complex deaths, increased mortality data capability, and initiation of the TELSTRA contract renewal process.

The focus going forwards will include working with TELSTRA to expand the review of conditions currently alerting within HSMR and SHMI, strengthening links between mortality data and the Trust's Health Inequalities work, and developing a more transparent mortality reporting process that enables enhanced oversight of alerting diagnoses.

1.1 Mortality and End of Life Learning Event

A Trust-wide Learning Event took place in September 2025 to understand how learning from deaths is gathered and used across the organisation, and to support the development of a more mature Learning from Deaths framework aligned with national expectations.

The event highlighted that learning comes from two principal sources, patient safety reviews and bereaved family feedback and that while strong practice exists in areas such as palliative care, NACEL and mortality review processes, learning remains variable across specialties. Collaboration across ME, Governance, PALS and the Inquest and Mortality Team has strengthened, but processes require further standardisation to ensure learning is consistently applied.

Participants agreed to develop a Learning Maturity Matrix, identify priority learning themes for both patient safety and family feedback, and establish a MEOL subgroup. This work will further inform the Mortality Improvement Plan

The event demonstrated strong engagement and commitment to learn from deaths across multiple teams and ultimately improve family and carer experience.

In response to the priority learning themes identified below there has been continued focus on education and quality improvement within End of Life Care during quarters 3 and 4 2025/26.

- Delayed recognition of the dying phase
- The need for more comprehensive and holistic assessment of symptoms, including the need to review interventions
- The importance of clear, compassionate, and consistent communication across the patient, their family, and the multidisciplinary team, requiring coordinated care

Education provision remains a key priority, with staff across all clinical areas expected to attend and actively participate in role-specific *Transforming End of Life Care* training. This ensures a consistent baseline of knowledge, promotes best practice, and supports the delivery of compassionate, patient-centred care. In addition, plans are in place to provide monthly mortuary tours and a review of the course delivery of and reinstating End of Life and Bereavement Study Days.

The CARING Walk Rounds led by the palliative care team continue to be a valuable initiative, providing opportunities for real-time education, reflective discussion, and supportive engagement with multidisciplinary teams. These walk rounds facilitate both ad hoc teaching and meaningful conversations around patient care.

Through this work, several recurring themes have been identified which align the priority themes identified above.

A significant and newly emerging theme is a misunderstanding of terminal lucidity. This has led, at times, to clinicians and healthcare professionals misinterpreting a temporary improvement in alertness as recovery. This misunderstanding can contribute to uncertainty within teams and can cause further distress for families, particularly when the patient subsequently deteriorates and dies within a short timeframe. Addressing this through targeted education remains a key focus. Parallel planning and managing uncertainty of recovery remains a key focus area for development.

The Lead Clinical Educator for End-of-Life Care and Consultant in Palliative Care continue to play an integral role in specialty-specific education, attending team away days within Stroke, Gastroenterology, and Respiratory services. These sessions are tailored to the needs of each specialty and emphasise the fundamental principles of high-quality end of life care, including:

- Compassion and dignity
- Effective communication
- Recognition of dying
- Application of the *Priorities of Care for the Dying Person*

In addition, the one-day Mayfly Advance Care Planning and Communication Skills Course is facilitated generally on a monthly/bi-monthly basis. This programme supports staff to develop confidence and competence in initiating and navigating sensitive conversations, ensuring that patient wishes and preferences are identified, respected, and documented appropriately.

Following a comprehensive review, the Dignity in Death e-learning programme is now live and accessible to all staff across the Trust. This resource reinforces key principles of dignified, person-centred care and provides a flexible learning option to complement face-to-face training.

Overall, these coordinated education and quality improvement initiatives demonstrate a sustained commitment to enhancing the standard of end of life care, supporting staff development, and improving patient and family experience across the organisation.

1.2 Complex Deaths – Strengthening Coordination of Multiple Investigations

The Trust has continued to strengthen the way it manages complex deaths that is, cases where more than one type of investigation may be required, such as incident investigation, inquest preparation, mortality review, safeguarding or complaint handling. Work to improve coordination and reduce duplication across these parallel processes has progressed well over the reporting period.

Collaboration across Divisional Governance Teams, the Inquest and Mortality Team (IMT), Legal Services and the Patient Experience Team has significantly improved. The IMT now attends After Action Review (AAR) meetings for cases involving death-related learning responses and undertakes Datix checks on all new coronial referrals to identify linked incidents or complaints early. Collaboration has improved through bi-weekly meetings with Legal Services, a trial SharePoint workspace to support real-time joint working, and regular meetings between the Lead ME and Deputy Chief Medical Officer.

A process for death-related complex complaints to be reviewed at PSOP has been initiated, ensuring unified oversight and single-plan responses across all investigation routes.

Overall, this work is enhancing consistency, strengthening governance and improving the quality of Trust responses in complex death cases.

1.3 External Learning from Deaths

As referenced at section 7. from January 2026, the Inquest and Mortality Team has resumed regular review of the Chief Coroner's database to identify any Regulation 28 reports relevant to services provided by LTHTR, enabling wider organisational learning. Relevant reports are shared with specialties for consideration and action, and a quarterly summary will be incorporated into the Mortality and End of Life Committee cycle of business, with key points also reflected in the Annual Mortality Report to the Safety and Quality Committee. This process has previously been undertaken by the Inquest and Mortality Team but suspended during the Covid 19 pandemic and not recommenced until now due to capacity constraints.

1.4 Dr Foster training

The Dr Foster (formerly TELSTRA) data is provided monthly to the Trust and referenced in a number of Safety and Quality reports – however feedback is that some colleagues remain unclear on the functionality - how the data is calculated, what it means, and how they might usefully use it. In response TELSTRA provided a training session on these matters in 2025- there are to be further lunchtime online training sessions planned in Quarter 2 2026-2027.

On 29th April 2025 TELSTRA also provided an online training presentation to the Trust on national health inequalities – with particular reference to the relationship between deprivation, frailty and bed days. This is a valuable resource and will be added to the Inquest and Mortality intranet site.

1.5 Coroner Directions Orders monitoring and support

The Inquest Team have developed a tracking system and dashboard to manage compliance with the Coroner Directions Orders referenced at section 7. Additionally, a programme of awareness raising and support has been undertaken and will be continued throughout 2026.

1.6 Learning Bulletins

The Inquest learning bulletin below was produced and circulated in Quarter 2 2025 – to provide education and support with positive feedback received.

Further bulletins have been delayed due to capacity pressures within the Corporate Governance Team which have now been resolved. A further bulletin is now in development which will focus on key themes from feedback from families at Inquest with advice to staff on how to make things better/identify relevant trust improvements and signpost staff to further information.

FAO: All Staff

Inquests Learning Bulletin: Support Staff Preparing For Inquests



The Inquest and Mortality Team – providing an efficient and effective inquest service which supports the coronial process, bereaved families, trust witnesses and the Trust Safety and Learning Agenda



HELP! I Need To Write A Statement And Attend An Inquest...

Your first reaction might be to panic - but there's no need. At Lancashire Teaching Hospitals (LTHTR), we have a **dedicated inquest team ready to support and guide you every step of the way**. This guide addresses **common questions, concerns, and provides practical reassurance and resources**.

WHAT?

Is An Inquest, And Why Is It Held?

An inquest is held when there is an unnatural or unexplained element to a person's death. It is a fact-finding process, not a trial.

The Coroner's Role Is to Determine:

- Who the deceased was
- When and where they died
- How they died
- The cause of death
- The conclusion (formerly called the verdict)

The bereaved family are at the centre of this process - they deserve answers and clarity. Your statement and attendance help support that goal.





You are being asked to assist the Coroner - not to defend yourself or the Trust. Think of this as a professional responsibility, similar to documentation or handover.



Typically Attends?

Here are some statistics:

- **90% of our witnesses are Consultants:**

- Which is as we would expect, as our agreed process is wherever possible for inquests to be covered by our most senior staff.

- **21 Senior Nurses attended inquests in 2024 -25:**

- Senior nurses are most likely to attend to present a nurse led trust investigation/ to give an evaluation of care/ specialist evidence



Occasionally, junior staff or non-clinical professionals attend to give factual or specialist evidence

Here are some grades / professions of staff that we have taken to inquest over the past few years that you might not have expected:

• Medical Engineers	• Speech and Language Therapists (SALT)
• Porters	• Nutrition Nurses
• Emergency Department (ED) Reception Staff	• Allied Health Professionals (AHPs) Physios, Occupational Therapists (OTs)
• Health Care Assistants (HCA's) and Staff Nurses	• Speciality Business Unit (SBU) / Clinical Business Unit (CBU) staff

Writing A Statement – What If I’ve Never Done It Before?

We as the inquest team are here to help:

- We will **highlight** what we need you to cover and review your final statement with you **before** we submit it.
- We also have some **excellent examples** on file to share with you.
- We provide written and video guidance which is readily available on [Weightmans - Witness guidance](#)



But the statement is yours - in your words and views, there is no such thing as a “trust statement” if your evidence does not show the trust at its best – so be it.



Your senior colleagues will also be able to help and review your statement for factual accuracy.

Will I Lose My Pin Or Professional Registration?



• **Highly Unlikely:** In the past 12 years, only one nurse was referred to the Nursing and Midwifery Council (NMC) in connection with an inquest and this occurred **before** the inquest.

• **Medical Staff:** If a Coroner is likely to criticise a doctor’s practice, they may be advised to self-refer to the General Medical Council (GMC). These cases are rare, fewer than 10 over 12 years.

• **Coroner Criticism:** Usually directed at the **Trust**, not individuals. This may take the form of:

- **A Neglect conclusion** – which is the Coroners assessment of poor care.
- **A Regulation 28 notice** – issued when future care is considered unsafe.

Learning & Improvement: The Trust’s last three Regulation 28 notices, along with actions taken, are available via the [Chief Coroners Website](#).

My Involvement In An Inquest Is Making Me Really Stressed ?

It's completely normal to feel nervous.

If basic mental health strategies and reassurance from your senior team and ourselves are not working – we have other things that can help you:

- **Health and Well being /clinical psychology team:**
 - This can be on the lead up to the inquest and if necessary, our Clinical Psychology team will attend the inquest to provide before and after support.
- **Peer support:**
 - There is nothing like hearing from someone of your own grade and profession who has been through the inquest process and can share their experience with you – most colleagues say it was not as challenging as they expected and retrospectively value the experience.

We have a list of colleagues from across professions and grades who have kindly volunteered to support their colleagues - just ask!



FAMILY MEMBER SUPPORT

An inquest is a public hearing – bring who ever you need to help support you – we have taken, partners / friends / parents and grandparents.

All are welcome if it helps to make the process easier for you.





WHAT?

Is The Inquest Like?

We'll provide:

- The date, time, and location.
- Advice on court etiquette and expectations.
- An opportunity for a court visit if needed.



✗ "I must have done something wrong."

✓ Not necessarily — in 80% of cases, the Trust is not found to have contributed to the death.

✗ "Inquests are just for consultants."

✓ No — all professions may be involved. Your factual input is often essential.

✗ "This will be a legal battle."

✓ No — an inquest is not a trial. There is no prosecution or defence.



The best advice is to keep the bereaved family at the forefront of your mind. This is our final act of compassionate care for our patients to support their family in their grieving and understanding.

! Call To Action

- Please ensure that you share the learning in your safety huddles and ward / departmental meetings.
- **With immediate effect**, all Matrons, Ward Managers, Clinical Managers, Clinical Directors, Medical Governance Leads, must ensure that all teams are aware of this process and use it as discussion and a training resource.

📍 Supporting Information

For further support and guidance please contact the Inquest Team:

Email: Inquestandmortality@LTHTR.nhs.uk

Useful links:

- [Guidance for attending inquest](#)
- [Inquest and the coroners court | Weightmans](#)
- [Chief Coroners Website](#)

10.2 MATERNITY AND NEONATAL SERVICES REPORT

☐ Other

Item for assurance

REFERENCES

Only PDFs are attached

 10.2 Maternity and Neonatal Safety Report Ancillary Pack - August 2026 paper 1.pdf



Patients



Performance



People



Productivity



Partnerships

Maternity & Neonatal Trust Board Safety Report

Quarter 1 (April-June 2026)

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6	MIS Year 8 Standard A Workforce and Capacity MIS Safety Standard A Perinatal Workforce
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15	MIS Year 8 Standard C Thematic Learning from PMRT Reviews Quarter 1 April –June 2026
16	MIS Year 8 Standard C Maternity and Newborn Safety Investigation Programme (MNSI) 1 December 2025 to 30 November 2026 Accepted Cases
17	MIS Year 8 Standard C Maternity and Newborn Safety Investigation Programme (MNSI) 1 December 2025 to 30 November 2026 Declined Cases
18	MIS Year 8 Standard C High Level Learning from MNSI Investigations Quarter 1 April- June 2026
19	MIS Year 8 Standard C Thematic learning from cases from Q1 April June 2026
20	MIS Year 8 Standard C NHS Resolution scorecard Q4 2025/26

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25	MIS Year 8 Standard F Board Oversight Coroners' Reports and External Reporting
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30	MIS Year 8 Standard F Board Oversight Performance Metrics Triage
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32	10 Point for Maternity and Neonatal services
33	Maternity and Neonatal Improvement Support Team Diagnostic
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Executive Slide Set Summary

The purpose of this report is to provide the Trust Board of Directors with an overview of the perinatal safety and quality workstreams up to the end of June 2026. Workforce data, patient experience metrics, and clinical effectiveness indicators are included in the slide set to support assurance and oversight, aligned to the requirements of the Perinatal Quality Surveillance Model (PQSM) and Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 8.

In line with these standards and the updated expectations of MIS year 8, the format for reporting has been aligned with the nationally developed side set and this replaces the previous Maternity and Neonatal Safety report. This approach ensures greater focus on workforce, clinical standards, learning from events, culture, and the experiences of women and families, while enabling the Trust Safety and Quality Committee and Board of Directors to quickly understand key safety intelligence, clinical outcomes, and areas requiring action.

The slide set has been structured to mirror the six Maternity Incentive Scheme (MIS) Year 8 Safety Standards, **A-F Workforce and Capacity Training, Learning from Reviews and Investigations, Service User Voice, Equity, Care Bundles, Board Oversight, Governance, Culture and Leadership**. This format provides a clear line of sight between clinical care and outcomes enabling effective Board oversight and assurance. The Divisional Midwifery and Nursing Director will attend the Board of Directors alongside representatives from the wider perinatal team, including obstetric and neonatal Clinical Directors to ensure comprehensive multi-disciplinary input.

The Perinatal Quality Dashboard has also been updated to align more closely with the format used by the Trust Safety and Quality Committee which is presented as an accompanying slide set.

The publication of both the Ockenden Report and the Amos National Maternity Review has reinforced the importance of safe, personalised and equitable maternity and neonatal care, strong clinical leadership, effective multidisciplinary working, and a culture that listens to women, families and staff. In addition to these two national reports the service has received a National 10-point plan with immediate actions and the new National Maternity Triage Framework specification.

The service has undertaken an initial benchmarking review of the recommendations of these national documents and is actively progressing local actions where these are required, whilst awaiting further information, guidance and toolkits from the national team and publication of the national implementation and accountability framework. **(See Slide 31).**

The maternity and neonatal teams remain committed to being an open, learning organisation that continuously seeks feedback, responds with robust governance candour and compassion, and works in partnership with women, families and staff to improve safety, experience and outcomes. As such the executive board have invited the Maternity and Neonatal Improvement Support Team (MNIST) to undertake an independent external review of services. **(Slide 32)**

Progress to achieve NHS Resolution Maternity Incentive Scheme Year 8

Table 1	Key Milestones achieved in Q1	Progress	Actions Required
A – Workforce and Capacity	Caesarean Section Capacity and demand review ongoing.	On Track/Partially Met	An annual demand–capacity review showing how planned Caesarean activity compares with available theatre time. Perinatal workforce/ safe staffing Report to include Obstetrics, Neonatal and Anaesthetics due October 2026 A recent neonatal workforce review should be undertaken detailing how the funded posts compare with what BAPM standards.
B - Training	Mid Point Check Performed in June 2026. 90% and over compliance with all staff groups for Emergency training, fetal monitoring and neonatal resuscitation Impacted Fetal Head (IFH) embedded on cycle of business.	On Track/Partially Met	Demonstrate 90% compliance for all eligible staff groups for Emergency training, fetal monitoring and neonatal resuscitation by 30 November 2026 . Arrangements to include community scenario training at least once in the reporting period is being considered as part of the year 8 requirements.
C - Learning from reviews and investigations	Thematic learning and PSIRF serious incidents report shared with the Trust Board of Directors in Q1	On Track/Partially Met	Complete MOSS drill to test response to safety signal by the end of the reporting period 30 November 2026 Thematic learning and PSIRF serious incidents report shared quarterly to Board of Directors
D - Service User Voice and Equity	Limited engagement with MNVP in Q1. Interim arrangement for MNVP cover agreed with Health Watch (Maternity leave).	On Track/Partially Met	Continue to utilise all opportunity for seeking service user feedback. Attendance at key maternity and neonatal safety meetings
E - Care Bundles	Maternal Care Bundle toolkit launched June 2026. Benchmarking ongoing	At Risk	Achieve maternal care bundle requirements by March 2027 Trusts must develop a standardised, equitable, and governance-approved guideline for neonatal pulse oximetry testing, aligned to the BAPM framework. See Slide 21
F - Board Oversight, Governance, Culture and Leadership	Board Report presented by the perinatal team to the Board of Directors Q1. Safety Champions meeting held in May 2025. MOSS data reviewed and shared	On Track/Partially Met	Bimonthly Board Safety Champion meetings with MNVP involvement to continue. Trusts must also ensure that findings arising from detailed scrutiny at the Quality Governance Committee (or equivalent) are formally escalated to the Executive Board of Directors.

Maternity Staffing.

The current vacancy rate for Registered Midwives 6.51 WTE. In addition to this there are 9.22 WTE on maternity leave, resulting in a total of 15.73 WTE posts that are required to meet establishment. (Includes BR+ 2025). Key actions including use of the over offer (up to 10 WTE) to maximise recruitment opportunities to ensure that all vacancies are filled during the forthcoming qualification period for new midwives.

Obstetric Staffing

Consultant workforce availability and leadership capacity have been impacted by sickness absence, vacancies and maternity leave. The QUAD is working with executive colleagues to stabilise the service, including recruitment to additional substantive Consultant posts and a review of future workforce requirements to meet increasing demand for elective caesarean births. The current position presents a risk that is being managed as the service is dependent on temporary cover and limited specialist capacity. Weekly oversight of the obstetric workforce is in place, and interim staffing arrangements via agency are in place to cover the substantive shortfall. The service is awaiting 1 WTE consultant to start in post in August 2026, and recruitment is ongoing to a further substantive consultant post to cover unavailability (maternity leave, absence). This will enhance workforce resilience.

Neonatal Staffing Medical Staffing

Neonatal medical staffing continues to be reviewed regularly against BAPM standards and compliance against medical workforce is achieved.. A comprehensive workforce diagnostic across all three tiers of the neonatal medical workforce will be repeated and reported through the bi-annual Safe Staffing Report to the Board of Directors in October 2026. Workforce plans are progressing to strengthen service resilience, including recruitment to a current 2.3 WTE Tier 1 vacancy and implementation of recommendations from a completed skill mix review of Band 8a and 8b roles to enhance Tier 2 capacity. In addition, work is underway to establish an interim consultant post to support the continued delivery of the 1:8 consultant rota, while options to address a remaining 4-hour consultant funding shortfall are being considered and actioned.

Neonatal Nurse Staffing

Neonatal workforce indicators have improved during May and June 2026 with BAPM compliance increasing to 84% and 90.1% There has also been a reduction in sickness absence to 11% (May 2026), although staff wellbeing continues to be impacted by high acuity and recent neonatal deaths, with targeted wellbeing and workforce support measures in place. Maternity leave remains elevated at 7% and is expected to increase further. The ongoing Qualified in Specialty (QIS) training programme and effective deployment of unregistered staff within the special care nursery continue to help mitigate staffing pressures and support the safe delivery of care.

Anaesthetics Staffing.

Anaesthetic obstetric job plans continue to be prioritised to ensure compliance against ACSA standards. Regular review of the rosters fill rates and workforce capacity also provide assurance that staffing arrangements align with MIS requirements, with escalation processes in place as required. To date there have been no occasions when a specialist obstetric anaesthetist has not been available for 24/7 cover.

Safe Maternity Staffing Fill rates Quarter 1

Registered Midwife Fill rate Table 2	April 2026		May 2026		June 2026	
Site /Area	Day	Night	Day	Night	Day	Night
	Actual	Actual	Actual	Actual	Actual	Actual
Overall Fill Rate (Delivery Suite, Maternity A&B MAS)	98%	96%	101%*	94%	98%	96%

Maternity Support Workers Table 3	April 2026		May 2026		June 2026	
Site /Area	Day	Night	Day	Night	Day	Night
	Actual	Actual	Actual	Actual	Actual	Actual
Overall Fill Rate (Delivery Suite, Maternity A&B MAS)	80%	97%	89%	96%	86%	92%

Tables 2&3 provide details of the actual fill rate data for registered midwives and support workers for delivery suite, maternity wards A&B and Maternity Assessment Suite. It is acknowledged that this data does not capture the midwifery led intrapartum areas and work is progressing to reconfigure midwifery cost centers to separate intrapartum and community services. This will provide more accurate visibility of staffing establishments, vacancies and fill rates across each care setting.

* The 101% fill rate for registered staff on days in May reflects new starters and supernumerary allocation.

Midwifery Red Flags Q1 April - June 2026



Safety Standard A	Workforce and Capacity

A red flag is an important component of safe staffing oversight within maternity services. They are indicators that staffing levels, skill mix, workload, or acuity may be impacting the ability to provide care in line with expected standards. Monitoring and reviewing red flags enables maternity services to identify areas of pressure, assess potential risks to women and babies, and implement timely actions to maintain safe and effective care.

Work is underway, in collaboration with the Trust Matron for Safe Staffing, to strengthen the identification, validation and escalation of red flag indicators relating to safe staffing and clinical concerns. (They are currently unvalidated)

This includes reviewing current reporting arrangements and exploring the use of Safe Care and the Birthrate Plus acuity tool to support more accurate and meaningful reporting. Training on functionality of Safe Care is also planned to ensure that reporting is reflective of actual risk and is managed in real time.

As previously reported, the service has identified limitations within the current Ulysses reporting process, where multiple red flags may be recorded within a single incident.

This process has potential to adversely affecting the overall Trust red flag performance, with a high level of reporting inadvertently implying that that staffing issues are more pronounced than they are in practice.

Actions are being taken to implement a more robust and consistent approach to red flag reporting, with further updates to be provided as part of the biannual safe staffing report in October 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). Delays in the induction process also feature among the highest reporting categories.

Table 4 Red flag Reporting Metrics Unvalidated	Apr	May	Jun
	26	26	26
Delay in time critical activity	3	7	2
Missed or delayed care> 60 mins in washing or suturing	0	1	0
Failure for women to receive the medication required.	0	0	0
>30-minute wait for pain relief.	2	4	0
Was there a >30-minute delay for assessment by a midwife when a problem was identified	0	1	1
Lack of full examination when woman presents in labour.	0	0	0
>2-hour delay in induction?	7	15	12
Delay in recognition of and action of abnormal signs.	0	0	0
Inability to provide one to one care in labour?	0	0	0
>30-minute wait for obstetric triage.	116	127	137
>15-minute delay following presentation for BSOTS midwife assessment.	50	108	83
Was there a delay in transfer of a BSOTS red case from MAS?	0	0	0
Was there a delay in transfer (over 4 hours) to delivery suite once a decision has been made for transfer for induction or augmentation?	19	50	27
Was there a delay in transfer once labour was established?	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?	0	0	0
Was there a delay of more than 30 minutes to initiate the sepsis care bundle?	0	0	0
Has there been a deferred date of planned induction of labour?	3	0	0
Has there been any cancelled or delayed community work?	2	1	0
Did redeployment of staff to other services/ sites/ wards occur?	6	6	2
Is the incident related to an RCOG clinical situation where a consultant was called but did not attend (New for June 2025 Validated position.)	0	1	1
Total numbers of unvalidated red flags	209	321	265

Maternity Training compliance for all staff groups MIS Year 8 Midpoint Check (June 2026)

June 2026 Table 5	Midwives	Consultant Obstetricia ns	Trainee Doctors	MSWs	Anaesthetic Consultant	Anaesthetic Rotational	Neonatal medics (split by consultant/ other Dr)	Neonatal nurses (Nrs/ ANNP)	Overall Compliance
Fetal monitoring and surveillance	100% 205/205	100% 10/10	100% 20/20	*	*	*	*	*	100% 235/235
Multi professional Maternity Emergencies training	99% 203/205	90% 9/10	100% 28/28	100% 61/61	100% 14/14	100% 6/6	+	*	99% 321/324

In line with the MIS Year 8 standards Trusts are required to report training compliance for multi- professional maternity emergency and fetal monitoring training (aligned to the Core Competency framework V2) evidencing that all eligible staff groups have achieved 90% or over on 2 occasions during the reporting period. The service confirms that the June 2026 training compliance has been declared in advance as the first of the checkpoints required. The Clinical Education team are monitoring the trajectory for maintaining compliance or achieving 100% consistently.

* Grey indicates that staff group are not required to undertake this training.

Maternity/Neonatal Training compliance for all staff groups MIS Year 8 Midpoint Check (June 2026)

June 2026 Table 6	Midwives	Obstetricians (split by consultant/ other Dr)	MSWs	Neonatal Consultants	Neonatal trainees Junior Doctors ST 5 and below	JUNIOR DOCTORS ST5 and above	Neonatal Nurses	Nursery Nurses	ANNP	Overall Compliance
Neonatal Resuscitation training	99% 203/205	*	*	100% 9/9	100% 9/9	100% 6/6	96% 73/76	100% 7/7	100% 6/6	98% 313/318
NLS certification medical staff.	*	*	*	100% 9/9	*	100% 6/6	*	*	100% 6/6	100% 21/21

In line with the MIS Year 8 standards Trusts are required to report training compliance for multi- professional maternity emergency and fetal monitoring training (aligned to the Core Competency framework V2) evidencing that all eligible staff groups have achieved 90% or over on 2 occasions during the reporting period. The service confirms that the June 2026 training compliance has been declared in advance as the first of the checkpoints required. The Clinical Education team are monitoring the trajectory for maintaining compliance or achieving 100% consistently.

* Grey indicates that staff group are not required to undertake this training.

Perinatal Mortality Data Summary 1 April –June 2026

Safety Standard C	Learning

Table 7	April 26	May 26	June 26
Total Stillbirth Rate per 1000 births	3.0	5.0	0.0
Total Stillbirth Number	1 case	2 case	0 case
Stillbirth Excluding TOPFA rate per 1000	3.0	5.0	0.0
Neonatal Death within 28 days	0 case	0 case	1 case

Table 8 shows numbers and rates for stillbirths and neonatal deaths for Q1 2026/27. In April 2026 there was one case of stillbirth over 37 weeks following suspected placental abruption. In May 2026 there was one stillbirth associated with known fetal abnormality at 33 weeks, and one stillbirth associated with placental abruption. In June 2026 there was one case of neonatal death at 31 weeks associated with known placenta praevia and Antepartum Haemorrhage (APH).

All Perinatal deaths continue to be reported to MBRRACE UK via SPEN and all eligible cases are reviewed as part of the Maternity and Neonatal Safety Investigation (MNSI) or Perinatal Mortality Review Tool (See slide 13 and 14). Any cases which are graded C or D for stillbirths and neonatal death are taken through Trust PSIRF oversight and where appropriate StEis reported. The live MBRRACE tool is also utilised to track performance. **See slide 12**

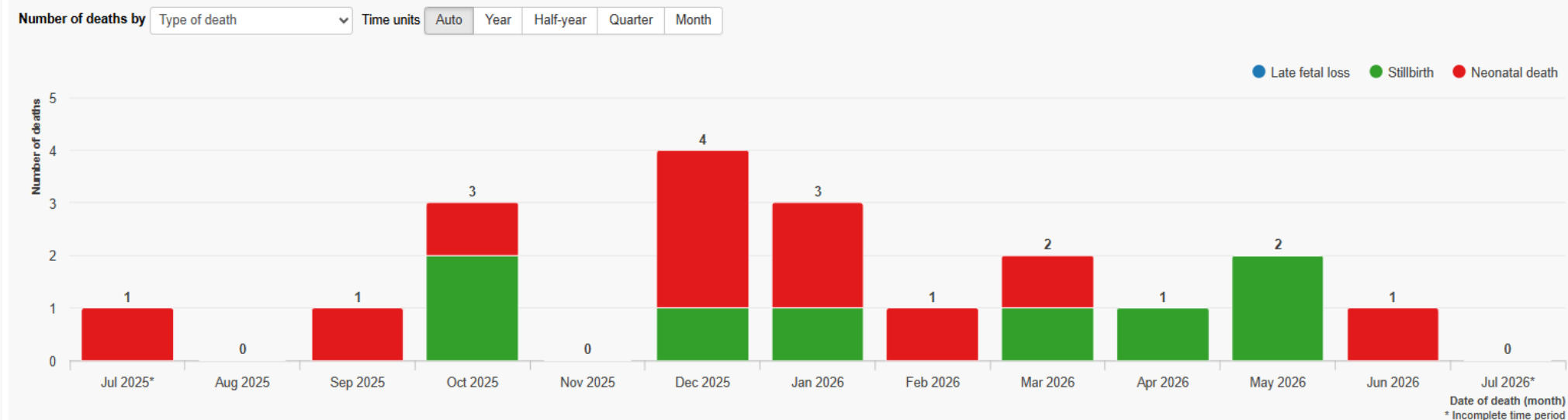
For MIS Year 8 (Safety Action C – Learning from Reviews and Investigations, Trusts are expected to demonstrate robust multidisciplinary review processes that incorporate independent challenge and external scrutiny where appropriate. This includes ensuring that a minimum of 60% of PMRT reviews receive external multidisciplinary scrutiny through involvement of an external reviewer or panel member who is independent of the care being reviewed. The current compliance to this standard is **100%** for the MIS year 8 reporting period.

Perinatal Mortality Data Summary 2 July 2025–June 2026

(Source MBRRACE live tool)

Safety Standard C

Learning



Perinatal Mortality Review Tool 1 December 2025 to 30 November 2026

Safety Standard C

Learning

PMRT cases eligible for a review (1 December 2025- 30 November 2026) Table 8

ID (Incident/PMRT)	Stillbirth/ Neonatal death	PMRT Case Opened	Parents informed	External Panel Member	Report drafted within 6 months	Grade	Actions ongoing
Incident: 220385 PMRT: 101477	Neonatal Death	04.12.2025	Yes	Yes	Review completed published within 6 months.	B,B,C	Action plan ongoing
Incident: 221771 Twin 1 PMRT: 101653	Neonatal Death	17.12.2025	Yes	Yes	Review completed published within 6 months.	C,B,A Antenatal care delivered at another Trust not attributable	Action plan ongoing
Incident: 221771 Twin 2 PMRT: 101653	Neonatal Death	17.12.2025	Yes	Yes	Review completed published within 6 months.	C,B,A Antenatal care delivered at another Trust not attributable	Action plan ongoing
Incident: 222757 PMRT: 101820	Stillbirth	30.12.2025	Yes	Yes	Review completed published within 6 months.	B,B	Completed
Incident: 223406 PMRT: 101926	Stillbirth	06.01.2026	Yes	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing within 6 months.	A,A	Action plan ongoing
Incident: 226121 PMRT: 102287	Neonatal Death	30.01.2026	Yes	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing within 6 months.	C,B,B	Action plan ongoing

Perinatal Mortality Review Tool continued 1 December 2025 to 30 November 2026 Table 9

Safety Standard C	Learning

ID (Incident/PMRT)	Stillbirth/ Neonatal death	PMRT Case Opened	Parents informed	External Panel Member	Grade	Report drafted within 6 months	Actions ongoing
Incident: 226356 PMRT: 102318	Neonatal Death	03.02.2026	Yes	Yes	B,B,A	Review completed published awaiting sign off	Action plan ongoing
Incident: 229685/ 229809 PMRT: 102788	Neonatal Death	10.03.2026	Yes	Yes		Review ongoing, deadline not yet met. PMRT planned with deadline for publishing within 6 months.	Action plan ongoing
Incident: 230094 PMRT: 102822	Stillbirth	12.03.2026	Yes	Yes	B,B	Review completed published awaiting sign off	Action plan ongoing
Incident: 234457 PMRT: 103502	Stillbirth	25.04.2026	Yes	Yes		Review completed awaiting sign off	Awaiting final PMRT
Incident: 23661 PMRT: 103797	Stillbirth	17.05.2026	Yes	Yes		Review completed awaiting sign off	Awaiting final PMRT
Incident: 236762 PMRT: 103787	Stillbirth	18.05.2026	Yes	Yes		Review completed awaiting sign off	Awaiting final PMRT
Incident: 241215 PMRT: 104472	Neonatal Death	24.06.2026	Yes			Review ongoing, deadline not yet met. PMRT planned with deadline for publishing within 6 months.	New case incident being reviewed.
Incident: PMRT: 104703	Stillbirth	14.07.2026	Yes			Review ongoing, deadline not yet met. PMRT planned with deadline for publishing within 6 months.	New case incident being reviewed.

Grading of Care Neonatal Death



1. Grading of care of the mother and baby up to the point of the birth of the baby.

- A** – The review group concluded that there were no issues with care identified up to the point that the baby was born.
- B** – The review group identified care issues which they considered would have made no difference to the outcome for the baby.
- C** – The review group identified care issues which they considered may have made a difference to the outcome for the baby.
- D** – The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby.



2. Grading of care of the baby from birth up to the death of the baby.

- A** – The review group concluded that there were no issues with care identified from birth up to the point that the baby died.
- B** – The review group identified care issues which they considered would have made no difference to the outcome for the baby.
- C** – The review group identified care issues which they considered may have made a difference to the outcome for the baby.
- D** – The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby.



3. Grading of care of the mother following the death of her baby.

- A** – The review group concluded there were no issues with care identified for the mother following the death of her baby.
- B** – The review group identified care issues which they considered would have made no difference to the outcome for the baby.
- C** – The review group identified care issues which they considered may have made a difference to the outcome for the mother.
- D** – The review group identified care issues when they considered were likely to have made a difference to the outcome for the mother.

Grading of Care Stillbirth



1. Grading of care of the mother and baby up to the point that the baby was confirmed as having died.

- A** – the review group concluded that there were no issues with care identified up to the point that the baby was confirmed as having died.
- B** – The review group identified care issues which they considered would have made no difference to the outcome for the baby
- C** – The review group identified care issues which they considered may have made a difference to the outcome for the baby.
- D** – The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby.



2. Grading of care of the mother following confirmation of the death of her baby.

- A** – the review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby.
- B** – The review group identified care issues which they considered would have made no difference to the mother
- C** – The review group identified care issues which they considered may have made a difference to the outcome for the mother.
- D** – The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother.

Thematic Learning from PMRT Reviews Quarter 1 April –June 2026

Table 10

Theme	Actions	Responsible (role)	By when
Clinical Escalation	The service continues to deliver the Royal College of Obstetrics and Gynaecology Clinical Escalation Toolkit.	Education Team	Ongoing 2026
SBAR Handover	Infographics and learning briefs shared with teams via email	Clinical Governance and Risk Midwife	March 2026
Interpretation	There is an ongoing translation workstream lead by the consultant midwife with actions to improve translation offers including implementation of Pocket Talk	Consultant Midwife	Ongoing 2026
Documentation	The service is exploring a documentation audit for each clinical area to understand local themes and to agree actions for improvement.	Digital Lead Midwife and Matrons	September 2026
Sepsis Recognition	Audit of sepsis bundle and pathway undertaken by Sepsis Lead Nurse. Learning from incidents also included in 2026 mandatory training.	Lead Nurse for Sepsis and Education team	Ongoing 2026

Maternity and Newborn Safety Investigation Programme (MNSI) 1 December 2025 to 30 November 2026 Accepted Cases Table 11

MNSI Ref	Reason for referral	Referral Accepted	Family Informed	Duty of candour complete Y/N	Early Notification	Status of MNSI investigation
MI-050634	Therapeutic Cooling	Yes	Yes	Yes	Yes	Investigation ongoing
MI-055103	Neonatal Death	Yes	Letter shared in Bengali	Yes	NA	Investigation ongoing

Maternity and Newborn Safety Investigation Programme (MNSI) 1 December 2025 to 30 November 2026 Declined Cases Table 12

Incident no/PMRT	Reason for referral	Referral Accepted	Family Informed	Duty of candour complete Y/N	Early Notification,	Status of MNSI investigation	Outcome	Status
227322	Therapeutic Cooling	No- Parents declined	NA	Yes	Submitted via SPEN	Investigation being undertaken by Trust AAR - Ongoing	HIE Grade	Ongoing
233802	Therapeutic Cooling	Referral declined by MNSI due to concerns with maternal mental health	Yes	Yes	Submitted via SPEN	Investigation being undertaken by Trust AAR -	Hyperkplexia seizures not related to birth injury	Ongoing
233893	Potential Brain Injury	Referral submitted via SPEN – declined by MNSI as did not meet criteria	NA	NA	NA	Investigation being undertaken by Trust AAR	Appear to be no neurological concerns	Ongoing
234457 PMRT10 3502	Stillbirth	Referral submitted via SPEN- Parents declined referral	Yes	Yes	NA	Investigation being undertaken by Trust AAR PMRT Case		Ongoing
234782	Potential Brain Injury	Referral submitted via SPEN – declined by MNSI as did not meet criteria	NA	NA	NA	Investigation being undertaken by Trust AAR	CFM normal Cranial Ultrasound Normal	Ongoing

High Level Learning from MNSI Investigations Quarter 1

April- June 2026 Table 13

Safety Standard C	Learning

Theme	Issue	Actions	Responsible (role)	By when
Clinical Assessment	MEOWS guidance required updates related to care in latent labour	National Maternity Early Warning Score to be implemented in line with national recommendations	Service Development Midwife	March 2026- Completed.
Communication	Incomplete SBAR communication	Infographics and learning briefs	Clinical Governance and Risk Midwife	March 2026
Equipment	CTG equipment not always available in theatre	AMAT audit of CTG equipment and oversight from Delivery suite and theatre matrons	Delivery Suite and theatre Matrons	January 2026
Guidelines	Hypertension, pre-eclampsia and LeaPH guidance not aligned regarding BP profile parameters	Consultant to update all guidance to ensure recommendations are consistent	Consultant	August 2026
Risk Assessment	Recognition of the risk factors for Neonatal Hypoglycaemia	Updated Guideline Infographic update for staff Senario based learning to be shared	Deputy Divisional Midwifery and Nursing Director Clinical Governance and Risk Midwife	January 2026

Thematic learning from cases from Q1 April June 2026

Perinatal Mortality Review Tool (PMRT) 5 Cases in total 2 stillbirths 3 Neonatal Deaths	Maternity and Neonatal Safety Investigation (MNSI) 4 MNSI cases referred 2 MNSI case did not meet criteria 1 MNSI case declined by the family 1 MNSI case declined due to capacity
Moderate and Severe Harm Incidents Harm- Psychological//Physical April 3. May 5, June 2 Attributable harm 0 per quarter. ((NB Harm grading is subject to change based on clinical review or change in outcome)	Rapid Incident review(RIR)/Thematic (OASI, PPH and Term Admission (TA) PPH- (1.5 litres or more – 49 cases OASI- 22 cases Term Admissions to the Neonatal Unit- 41

MNSI

- Clinical Assessment
- Communication
- Equipment (CTG equipment in theatre)
- Guidance
- Risk Assessment

Moderate and Severe harm

- Recognition of second stage of labour
- Management of neonatal hypoglycemia

PMRT

- Clinical Escalation
- Preterm Birth
- SBAR handover
- Interpreter services
- Sepsis recognition
- Administration of appointments for specialist clinics

RIR/Thematic (OASI, PPH & TA)

- Documentation (OASI)
- PPH associated with IOL (PPH)
- Uterine atony (PPH)
- Unavailability of Transitional Care Nurse (TA)

Maternity Incentive Scheme:
Safety Action C - The Trust must produce thematic reports that triangulate information and summarise learning and progress on actions arising from MNSI and NHSR EN reports, local PMRT and Patient Safety Incident Response Framework (PSIRF) reviews, Maternity Outcomes Signal System (MOSS) critical safety checks, NHSR claims scorecards and relevant national reports

Learning Q1

- Clinical escalation and communication pathways needed to be improved – using closed loop and SBAR formats
- Guidelines on the same subject matter to mirror treatment and management pathways
- CTG equipment is not always readily available in the theatre environment, due to the space being used to multiple specialities
- Sepsis care bundle not consistently being completed (Coagulation)
- Fetal monitoring in the second stage of labour in midwifery led settings not always completed in line with national guidance

High Level Actions- All workstreams report on a cycle of business to Maternity Safety and Quality Committee as required.
Postpartum haemorrhage (monitored via Maternal care bundle and PPH Task and Finish
Induction of labour (monitored by the Induction of labour Continuous improvement workstream.
RCOG clinical escalation tool kit on maternity training (Training needs analysis)
Divisional guideline oversight process
Interpretation workstream (Consultant Midwife)
Transitional Care Working Group (Multi disciplinary Team)
MEOWS working group – (Continuous improvement and health innovation workstream)
Intrapartum Care over arching action plan (birth forum)

Claims Scorecard Q4 (Latest Version Available)

Top injuries by volume: - Brain damage - Unnecessary pain - Fatality - Stillborn - Unnecessary / additional operations	Top injuries by value: - Brain damage - Cerebral Palsy - Hypoxia - Unnecessary pain
Top causes by volume: - Failure to monitor first stage of labour - Failure in antenatal screening - Failure to monitor second stage of labour - Failure / Delay treatment - Equipment malfunction	Top causes by value: - Failure / Delay treatment - Failure to monitor first stage of labour - Failure to monitor second stage of labour - Failure in antenatal screening - Equipment malfunction - Failure / Delay admitting to hospital

Complaints Q4 25-26

- Communication - Staff attitude - Lack of / delay in treatment - Delayed diagnosis/care - Medication

Incidents Q4 25-26

- Monitoring and escalation of care - Management of high-risk pregnancies - Communication and use of interpretation services - Recognition and management of fetal compromise

Maternity Incentive Scheme - SA9

Quarterly review of Trust's claims scorecard alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting

Themes across Sources Q4 25-26

- Communication failures - Delays or failure to provide treatment - Women and families not feeling listened to - Staff attitude and behaviors - Failure to monitor appropriately during labour - Antenatal screening failures - Compassionate communication during busy periods

Learning Q4 25-26

- Continue trauma-informed care education for all maternity staff. - Reinforce effective communication and active listening with women and families. - Improve informed consent processes and shared decision-making. - Strengthen antenatal education regarding birth options, induction and labour expectations. - Continue implementation of the Saving Babies Lives Care Bundle. - Monitor compliance with Core Competency Framework v2 training requirements. - Share learning from complaints, MNSI investigations and Birth Afterthoughts feedback through Safety & Quality meetings. - Improve support pathways for women experiencing birth trauma and psychological distress. - Review monitoring in labour practices, particularly CTG interpretation and escalation processes.

Action Plan Q4 25-26

Continue trauma-informed care training	
Review labour monitoring and escalation practices	
Continue communication and listening-focused education	
Strengthen listening and debrief services for families	
Share complaints, claims and incident learning through Safety & Quality meetings	

Maternal Care Bundle Action Progress Table 14			Safety Standard D	Care Bundles
Workstream / Requirement	Actions Required	Lead / Stakeholders	Status	Target Date for Completion
National MEWS (Maternity Areas)	Maintain compliance and monitoring arrangements	Maternity Project Group	✅ Complete	Implemented
National MEWS (Non-Maternity Areas)	Complete implementation and staff training	Maternity / Acute Care Teams	🟡 In Progress	Sept 2026
BadgerNet System Developments (9 interventions)	Deliver system updates including Whooley reporting, EPDS and VTE assessment within referral pathways	System C, Digital Team, Maternity Informatics	🟡 In Progress	As per national deadlines
Maternal Medicine Network Requirements (6 interventions)	Agree required specialist input, referral pathways and governance arrangements for epilepsy and maternal medicine pathways aligned to the maternal medicine centre.	NW Maternal Medicine Network, Obstetric Team	🟡 Awaiting Input NW Maternal Medicine Network	Sept 2026
Data Reporting and Compliance Monitoring (4 interventions)	Develop complex data extraction and reporting from BadgerNet and FLEX	BI Team, Maternity Data Team	🟡 In Development	Q2/Q3 2026
Audit and Governance Framework (6 interventions)	Establish new audit schedules, governance processes and assurance reporting mechanisms	Maternity Governance Team	🟡 In Development	Q3 2026
Guideline Reviews (5 interventions)	Review and update local, regional and Trust-wide policies and clinical guidance	Clinical Leads, Governance Team	🟡 In Progress	Q3 2026
NWAS / Estates Requirement (1 intervention)	Confirm stakeholders, agree model and identify funding requirements	NWAS, Estates, Maternity Leads	🔴 Not Started	To be confirmed (TBC)
Laboratory Service Agreement (1 intervention)	Develop and agree Service Level Agreement	Laboratory Services, Maternity Team	🔴 Planning Stage	TBC
VTE Risk Assessment on FLEX (1 intervention)	Present proposal to VTE Group and implement electronic risk assessment process	FLEX Team, VTE Group	🟡 Awaiting Approval	Q3 2026
LMWH Prescribing Pathway (1 intervention)	Develop and embed pre-booking prescribing pathways	Primary Care, ED, EPAU, Maternity Team	🟡 In Progress	Q3 2026

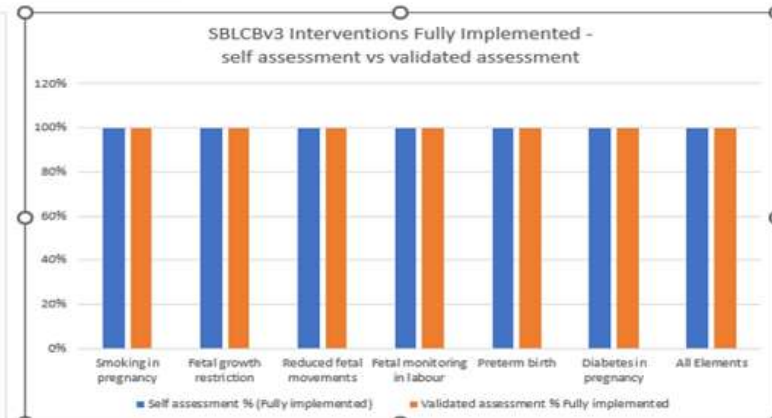
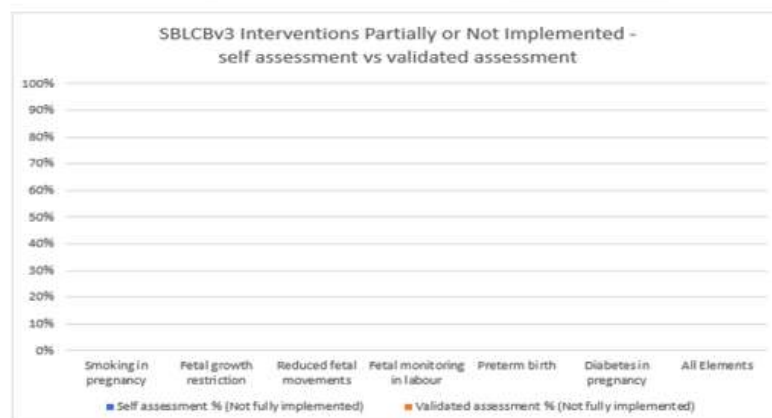
Saving Babies V 3.2 Lives Progress Update

Safety Standard D

Care Bundles

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%



The service confirms that it remains fully compliant with the requirements of the Saving Babies' Lives Care Bundle version 3.2 (SBLCB v3.2). Compliance is monitored through an established performance dashboard, which enables ongoing oversight of key actions, supports the tracking of recommendations, and provides assurance that clinical practice continues to align with national standards and evidence-based guidance.

Regular review of performance data supports the timely identification of any areas requiring action and helps sustain improvements in maternity safety and outcomes.

Performance Metrics

Number of times services were deferred/diverted

2026 Table 15	Month		
	Apr	May	June
Obstetric unit	2	0	1
Alongside Birth Centre	3	7	9
Freestanding Birth Centre	0	0	0
Homebirth service uncovered call	5	1	2
Neonatal unit (internal)	4	9	0
Neonatal unit (external)	8	12	8

Safety Standard E	Governance, Culture and Leadership

Reason for Alongside Birth Centre Escalation

Preston Alongside Birth Centre Table 16	Total Episodes of Closure	Internal Escalation	Preston Birth Centre staffing	Supporting Chorley Birth Centre and Ivy home birth)
April 2026	3	2	1	0
May 2026	7	4	1	2
June 2026	9	7	1	1

Between April and June 2026, there were eight occasions where the homebirth on-call service was uncovered due to staffing pressures and reduced duties (five in April, one in May and two in June). Despite these challenges, service continuity was maintained with no missed homebirth opportunities across the three-month period.

The Alongside Birth Centre experienced increasing internal escalations between April and June 2026, rising from 2 in April 2026 to 7 in June 2026, predominantly due to staffing pressures, capacity challenges and the need for workforce support on delivery suite or the midwifery led intrapartum services (Chorley Birth Centre and Ivy home birth team). Despite these operational demands, staffing support was maintained throughout the period, with additional assistance provided from wider maternity teams when required.

The Neonatal Unit experienced both internal and external closures during Q1, reflecting ongoing capacity demand for intensive care cots and unavailability of the neonatal nursing workforce. There has been an un-usually high number of multiple births and admissions of babies requiring intensive care for prolonged periods. External closures remained high with 8 episodes of varying length in April 2026 12 in May 2026 and 8 in June 2026. Internal closures were recorded on 4 occasions in April 2026 and 9 occasions in May 2026, with no internal closures reported in June 2026. Despite these operational challenges, the reduction in internal closures by June 2026 indicates an improvement in BAPM compliance with is demonstrated in the improved BAPM rates (90.1%) by the the end of the quarter.

Home births Quarter 1 April- June 2026

Incident Category Table 17	Number of Birth- April 26	Number of Births May 26	Number of Birth June 26	
Home Birth Total Q1 21	7 Births	8 Births	6 Births	Following the external Prevention of Future Deaths (PFD) regulation in Manchester Foundation Trust relating to homebirth services, a comprehensive benchmarking exercise has been undertaken to review the safety and sustainability of the service. This work has been completed by the Consultant Midwife. The benchmarking demonstrates significant progress in aligning homebirth services with emerging regional and national expectations. The revised Homebirth Operational Policy benchmarks favourably when considered alongside the wider maternity governance framework. The principal recommendation is continued integration and cross-referencing of existing governance arrangements, rather than development of multiple new processes. Overall, the review provides assurance that LTHTR homebirth services are supported by robust governance arrangements and continue to evolve in response to emerging national recommendations, regional standards and learning from maternity safety reviews, whilst maintaining women's autonomy, personalised care and informed choice. Improvement work is ongoing including service user involvement to codesign a suite of information resources. In addition, the existing audit is being reviewed.

Incident Category Table 18	Number for April 26	Number for May 26	Number for June 26
Home Birth Outside of Guidance Total Q1- 9	4 - Declined Induction of labour for post maturity. - History of Post partum Haemorrhage (PPH) /Manual Removal of Placenta - Vaginal Birth After Caesarean - Anaemia	1 1 (declined routine care & Induction of Labour)	4 2 x declined Induction of Labour 41/40 - Vaginal Birth After Caesarean
No. of births at home where there was an agreed personalised out of guidance plan in place	4	1	2 2 declined to see Obstetric team for plan)
No. of homebirths transferred into obstetric led delivery suite Total Q1-10	6 3 labour – PV bleeding, Bradycardia, hypertension, 3 Postnatal transfers - hypertension, PPH, Small for gestation age (SGA)	3 1 labour - hyperstimulation 2 Postnatal transfers Meconium, PPH	1 Labour – Fetal Bradycardia /meconium

Coroners’ Reports and External Reporting



Late Maternal Death

Safety Standard E	Governance, Culture and Leadership

Steis Number	Case	Summary
2387	Late Maternal Death (56 days) in June 2026	The case has been referred to the coroner and is outside of maternity service reporting requirements. A Board Briefing was shared with the CQC and Integrated Care Board and a detailed AAR has been undertaken. No issues with care were identified.

Regulation 28 report issued

Identifier	Cases	April 26	May 26	June 26	Summary
NA	NA	None to date	None to date	None to date	NA

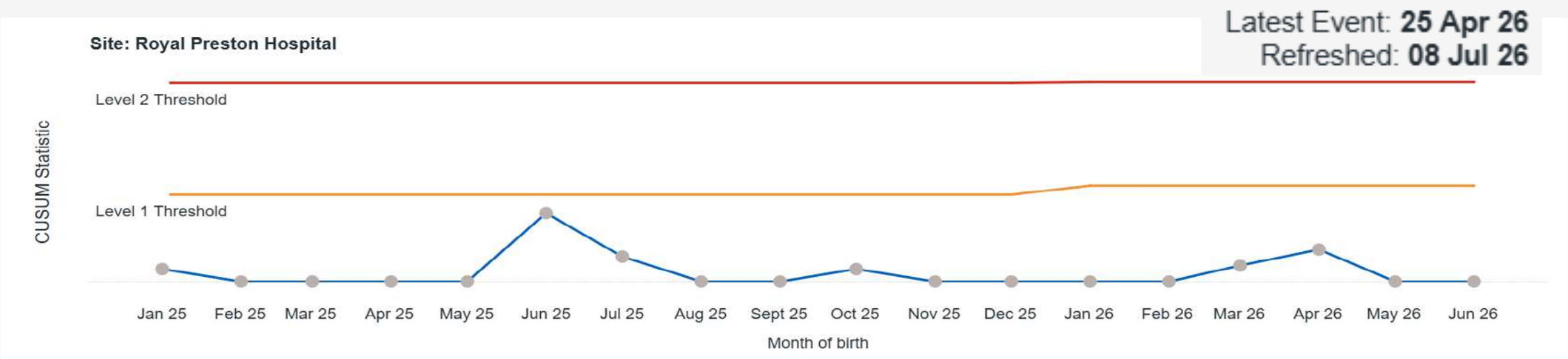
Care Quality Commission (CQC) Enquiries

Identifier	Cases	April 26	May 26	June 26	Summary
NA	Total	No Enquiries	No Enquiries	1 Enquiry	June 2026 Trust notification to the CQC in relation to the late maternal death as above.

Whistle Blowing or Freedom to Speak up

Identifier	Cases	April 26	May 26	June 26	Summary
Whistle blowing	Total 1	0	0	1 maternity case	An information of concern was shared with the Trust in relation to incidents not being reported in line with statutory requirements or not being investigated independently. A formal response was provided to the CQC. MNIST invited review commissioned to ensure known position triangulates with external review.
Freedom to Speak up	Total 4	3	1	0	Themes raised included concern to speak up, with staff reporting concerns about raising issues and confidence in how concerns are addressed. Concerns also related to workplace behaviours, multidisciplinary working and communication, including the management of professional challenge and escalation, describing an impact on wellbeing, including stress, anxiety, and reduced confidence at work.

Maternity Outcomes Safety Signals System (MOSS)



** To note there is an error in July 25 which records no cases but shows 1 on the chart. There was 1 neonatal Death in July 25..

Date of Term Birth Table 19	Events (Term only)
25.04.2026	1 Term Stillbirth
06.03.2026	1 Term Neonatal Death
04.10.2025	1 Term Stillbirth
20. 06.2025	1 Term Stillbirth
08.06.2025	1 Term Neonatal Death
12.01.2025	1 Term Stillbirth

The MOSS portal is accessed by the maternity and Neonatal Governance team as part of weekly oversight of perinatal safety surveillance, which provides direct access to safety signals associated with term stillbirth and neonatal death within 28 days. Trusts must evidence that the critical safety check of the MOSS standard operating procedures) has been completed in the event of any live signals which meet level 1 or level 2 thresholds, or that a test drill (Annex 9) was carried out if no signals occurred.

The service confirms that in Q1 there were no MOSS critical alerts for the Maternity or Neonatal services.

Thematic Rapid Incident Review

Table 20 Post Partum Haemorrhage (PPH) 1.5 Litres and above

Incident Category	Number of Cases- April 26	Number of Cases May 26	Number of cases June 26	Outcome/Learning/Action
PPH >1500mls Total 31	9 cases	11 cases	11 cases	All cases of PPH over 1.5 litres are audited and any learning or clinical concern are escalated for a Multi professional review. All cases of PPH 2.0 litres are reviewed via an MDT rapid review. Thematic reports are then generated quarterly to share key learning and actions. Recent actions have been linked to Haemoglobin optimisation, communication when Major Obstetric Haemorrhage (MOH) is declared between professional groups and management of uterine atony.
PPH > 2000mls Total 18	3 cases	9 cases	6 cases	

Table 21 Perineal Tear 3rd and 4th Degree

Incident Category	Number of Cases- April 26	Number of Cases May 26	Number of cases June 26	Outcome/Learning/Action
Perineal Tear Total 22	3a-3b 4 cases 4 th - 0 cases	3a-3b 8 cases 4 th - 1 cases	3a-3c 9 cases 4 th - 0 cases	All Cases of 3rd and 4th Degree perineal tear are reviewed by the Lead Midwife and Obstetrician against the standards for the Obstetric Anal Sphincter Injury (OASI). 8/22 cases were following instrumental delivery. The national rate for OASI is 5.4% following an assisted birth. The Trust rate is 10.3%. Review of the cases identified that the period coincided with the rotation of a less experienced trainee medical workforce. Whilst no direct causal relationship can be established, it is possible that reduced levels of previous operative obstetric experience may have contributed to the observed increase in instrumental births and associated third and fourth-degree perineal tears. To strengthen competency and support safe operative practice, the incoming trainee cohort commencing in August 2026 will undertake a dedicated full-day obstetric skills programme, including simulation and practical training in the management of postpartum haemorrhage (PPH) and the prevention, recognition and management of obstetric anal sphincter injuries (OASI). Findings from the multi disciplinary review confirm that OASI care bundle was fully completed in 21/22 cases. 13/22 were of British heritage and 6/22 were of Indian heritage There is an ongoing plan for improvement and all staff working in intrapartum areas have completed the in-house training.

Term Admission to the Neonatal Unit (NNU) Table 22

Incident Category	Number of Cases- April 26	Number of Cases May 26	Number of cases June 26	Outcome/Learning/Action
Term Admission Total 41	12	13	16	The latest term admission rate taken from the maternity dashboard is 4.94% which is below the national average. The working better together meeting is held on a fortnightly basis to review all admissions to NNU. The highest reason for admission respiratory distress (29/41). Of the 29 cases 2 were born by Elective caesarean section and 15 were born by Emergency Caesarean Section.

Maternity Assessment (Triage)

NHS England published the National Maternity Triage Specification on **1 July 2026** following the Baroness Amos Independent Investigation. Trusts are required to undertake a Board-level review of maternity triage services within a three-month timeframe, complete a gap analysis against the national specification, develop an implementation plan and report progress to NHS England.

Full compliance with the specification is expected within 12 months of publication. The review focuses on safe staffing, timely assessment, governance, performance monitoring and consistent access to high-quality maternity triage services. Table 23 provides a high-level prospective action plan with expected timelines for completion.

Table 23	
Action	Timescale
Board-level maternity triage audit completed	Within 3 months of publication (by 1 October 2026)
Gap analysis and implementation plan developed	Within 3 months of publication (by 1 October 2026)
Progress reported through the Trust Board of Directors and shared with NHS England	Within 3 months (by 1 October 2026)
Full implementation of the National Maternity Triage Specification	Within 12 months of publication (by 1 July 2027)

Maternity Assessment (Triage)

Q1 2026/27 Table 24	Apr-26	May-26	Jun-26
Total women seen	1012	1016	1080
Seen within 15mins by midwife	95.10%	87.40%	89.50%
Seen 16 - 30mins by midwife	3.70%	6.90%	6.40%
Seen 31 - 60mins by midwife	1.10%	4.20%	3.60%
Seen 61 - 120mins by midwife	0.20%	1.30%	0.50%
Over 120mins before seen	0.00%	0.20%	0.00%

Telephone Calls Received table 25		
	Apr-26	May-26
Antenatal calls	1018	1082
Postnatal calls	63	107
Unspecified	1317	1396
Dropped calls	46	62
Total calls	2452	2647

An established monthly maternity triage audit is in place, which will be updated and aligned to the National Maternity Triage Specification (July 2026). The audit provides assurance against standards including timely clinical assessment by a midwife, telephone triage, attendance data, responsiveness, escalation, medical review times, and service user experience.

Actions to strengthen the audit to include **compliance with timely initial clinical assessment, including the 15-minute midwifery assessment standard. Delays in clinical escalation and medical review. Telephone triage performance, including call volumes, response times and unanswered calls, Service user experience and feedback. Safe staffing and skill mix within triage services. Equity of access and outcomes for women and families.**

Safety Standard E		Governance, Culture and Leadership	
MAS Triage Attendance Data Q1 2026/27 Table 26			
	Apr-26	May-26	Jun-26
Total	1012	1016	1080
Reduced FM	345	376	403
Raised BP	121	107	112
PV Bleed	87	59	53
Unwell/Other	133	112	142
? SROM	73	68	61
? Labour	49	73	84
Abdo pain	86	102	111
Postnatal	43	68	59
Scan review	55	44	33
Unspecified	0	0	0
CTG monitoring	20	7	22

8. Safety Champions Meeting

Meeting Log Table 27

The perinatal leadership team and Board safety Champions met on the 14 May 26. In addition, the Board safety champions have continued to seek direct safety intelligence from walk the floor events with various staff groups and the latest's you said we did is detailed on table .

Date	Role	Attendance
14.05.2026	Board Safety Champion Chief Nursing Officer	In attendance
14.05.2026	Board Safety champion Non-Executive Director	In attendance
14.05.2026	Perinatal Obstetric Lead	Awaiting interim CD to commence
14.05.2026	Perinatal Midwifery lead	In attendance
14.05.2026	Perinatal Neonatal lead	In attendance
14.05.2026	Perinatal Service Improvement Management lead	In attendance
14.05.2026	MNVP lead	Not in attendance awaiting interim cover
Next meeting 9 th July 2026		

Safety Champions feedback

Safety Standard E	Governance, Culture and Leadership

Table 28 You said..... Chief Nursing Officer	We did....
Maternity	
Staffing investment and recent birthrate plus would make a real difference to be able to provide care in the way the team want to	Shared the recently approved uplift in establishment and the intention for the number of midwives to increase on delivery suite by 1 Rm per shift
Whilst the consultation is causing some unrest, it is clear the motives for this are in response to previous feedback raising concerns regarding too few core midwives on delivery suite and this is welcomed	Work to remodel service continues to progress
You were aware of the recent homebirth incident in a different region, and the learning had been discussed on the unit and has led to some discussions on how community staff rotate and how this could be managed	The Trust is currently benchmarking homebirth service following regional task and finish group and will await the recommendations from the national homebirth workstream.
You felt confident the leaders understood the key issues and were taking steps to improve practical and cultural areas of improvement and that leaders on the unit understood their role in supporting this.	Matron leadership and Band 7 away days in progress as part of culture improvement plan. Wider feedback
Neonatal	
Estates improvement work of the electrical columns was escalated as a priority work stream	Replacement of the columns is seen as an important improvement; colleagues were pleased this was now planned.
Recent experiences of baby loss had been difficult for the team; having built positive relationships with family they felt understandably sad and were taking steps to support each other. Psychology on the unit was seen as a priority; staff knew how to access health and well being psychology.	Continue to influence the network to fund a psychology model to support NNU. Highlight HWB psychology and mechanisms to access Explore other ways that colleagues feel would help them recover from these sad times. Spiritual care provided by chaplaincy team. Hot/Cold debriefs available for colleagues
Nursing students have loved their experience on the unit, felt very supported and wanted to work on the NNU.	Positive Feedback to be shared with Neonatal Unit at team meetings or safety huddles
CYP Nurses coming to support NNU due to staffing pressures felt welcomed and supported on the unit and found the rotation helpful in maintaining skills	Thank you email to be circulated from Deputy/DMND to ward 8 Leadership team Overall page 170 of 430

Table 29 - Benchmarking against the 10-Point Plan Response to Ockenden and AMOS Independent Maternity Investigations

Requirement	Actions Required	Status	Target Date for completion
1. Listening to women and their families by rolling out Martha’s Rule	Fully implement Martha’s Rule across maternity and neonatal services	 In Progress	To be confirmed (TBC) following webinar in September 2026
2. Listen to women and families using real time and transparently reported outcomes and experience and clinical audit data are acted upon	Awaiting further national information. Monthly cycle of business to be developed. Current audits to be reviewed.	 In Progress	TBC
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care	Medical Director engagement with Maternity and Neonatal services alongside Chief Nurse. Clinical Directors and Directors of Midwifery to attend boards when maternity or neonatal matters are discussed.	 In Progress	August 2026
4. ‘Amos into action’ staff listening exercise	National action – no local action required	 No action required	
5. Addressing inequalities in maternity and neonatal outcomes	Complete Perinatal Equity and Antidiscrimination Programme (launch date 4/9/26) Inclusion of trends from inequalities data into Board report Full compliance with Maternal Care Bundle By End March 2027	 In Progress	March 2027
6. Ensuring 24/7 safety and responsiveness of maternity and neonatal services	Benchmarking and development of redeployment SOP	 In Progress	October 2026
7. Trusts to review their homebirth services	Benchmarking against Regional standards and Action plan in place Waiting for National homebirth framework to be released (end September 2026) then will re-benchmark and assess any changes needed.. Service reconfiguration - ongoing	 In Progress	December 2026
8. Responding to patient safety incidents, complaints and concerns with humanity, candour and a trauma-informed approach	Awaiting National Blueprint	 Not Started	TBC
9. Delivery safe and effective triage in maternity services	New National Triage specification released (7/7/26). Awaiting National Maternity Triage Diagnostic tool to benchmark/audit against – report to Board in 3 months. Fully implement within 12 months	 In progress	July 2027
10. Post Death Care	Respond to board assurance statement by 31/7/26. Review 10 years of records in mortuary in	 In progress	Overall page 171 of 430 December 2026

Diagnostic Visit

**National Maternity and Neonatal Improvement Advisors from NHS England's Maternity and Neonatal Improvement Support Team will be visiting the Trust on
27th to 30th JULY 2026**

The team will be visiting all areas and there will be focus groups to enable staff to talk to the team and share successes and challenges.

If you would like to speak to the team separately, or feel you need longer with them please contact the lead for the diagnostic:

sarah.latham11@nhs.net

The aim of the visit is supportive to enable advice and solutions to be provided to the senior midwifery, obstetric, neonatal and executive teams along with the sharing and learning of good practice identified within other units.

We look forward to meeting you all



To share your feedback about how the diagnostic went after the visit takes place, please scan the QR code above.



Conclusions and Recommendations

The purpose of this report is to provide the Safety and Quality Committee with an overview of the perinatal safety and quality workstreams up to the end of June 2025. Workforce data, patient experience metrics, and clinical effectiveness indicators are included in the slide set to support assurance and oversight, aligned to the requirements of the Perinatal Quality Surveillance Model (PQSM) and Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 8.

Maternity and Neonatal Services continue to demonstrate a strong commitment to safety, quality improvement and learning, with 5 of the 6 NHS Resolution MIS Year 8 standards rated on track, providing assurance that most national safety requirements are being progressed as planned.

Workforce pressures remain the principal risk to service delivery, particularly within obstetric and neonatal services. However, robust oversight, active recruitment, workforce reviews and escalation processes remain in place to maintain safe care and support service resilience.

Training compliance remains compliant with all eligible staff groups achieving the MIS Year 8 requirement of greater than 90% compliance for maternity emergency skills, fetal surveillance and neonatal resuscitation training.

Governance, learning and investigation processes are well established, with learning from PMRT, MNSI, PSIRF reviews, complaints, incidents, claims and national reports being triangulated and translated into improvement actions across maternity and neonatal services.

Neonatal and maternity capacity pressures continue to require close oversight, particularly in relation to neonatal intensive care demand, maternity triage activity and elective caesarean section capacity. Nevertheless, there are encouraging signs of improvement in neonatal staffing compliance, sickness absence and service resilience.

The service remains focused on implementing key national priorities from the Ockenden and Amos Reports, including the Maternal Care Bundle, National Maternity Triage Specification and the NHS 10-Point Plan, whilst maintaining oversight through established Divisional and Board governance and Safety Champion arrangements.

Maternity Safety, Quality and Effectiveness Report

August 2026 Board of Directors
Performance upto June 2026



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

Key to Metric SPC Chart and Variance and Assurance Icons

	Mean		Measure
	Process Limit		Concerning special cause
	Improving 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

Report Heading Explanation

Assurance icon indicates whether the target is consistently passing, consistently failing or is inconsistently passing and failing

A flag icon is generated when a measure is capable of hitting target within expected variation but hasn't for the last 5 months or more

How the target is defined

Metric Description	Assurance	Variation	Target		Latest actual month	Latest month	
			Concern	Latest month target			Target rationale
Example Measure				3.2	National	5	May-26

Name of the metric

Variation icon indicates whether the most recent month is showing an unusual pattern of variation positive or negative

The target value

The most recent value

Most recent month

Assurance icon indicates whether the target is consistently passing, consistently failing or is inconsistently passing and failing

A flag icon is generated when a measure is capable of hitting target within expected variation but hasn't for the last 5 months or more

How the target is defined

Name of the metric

Variation icon indicates whether the most recent month is showing an unusual pattern of variation positive or negative

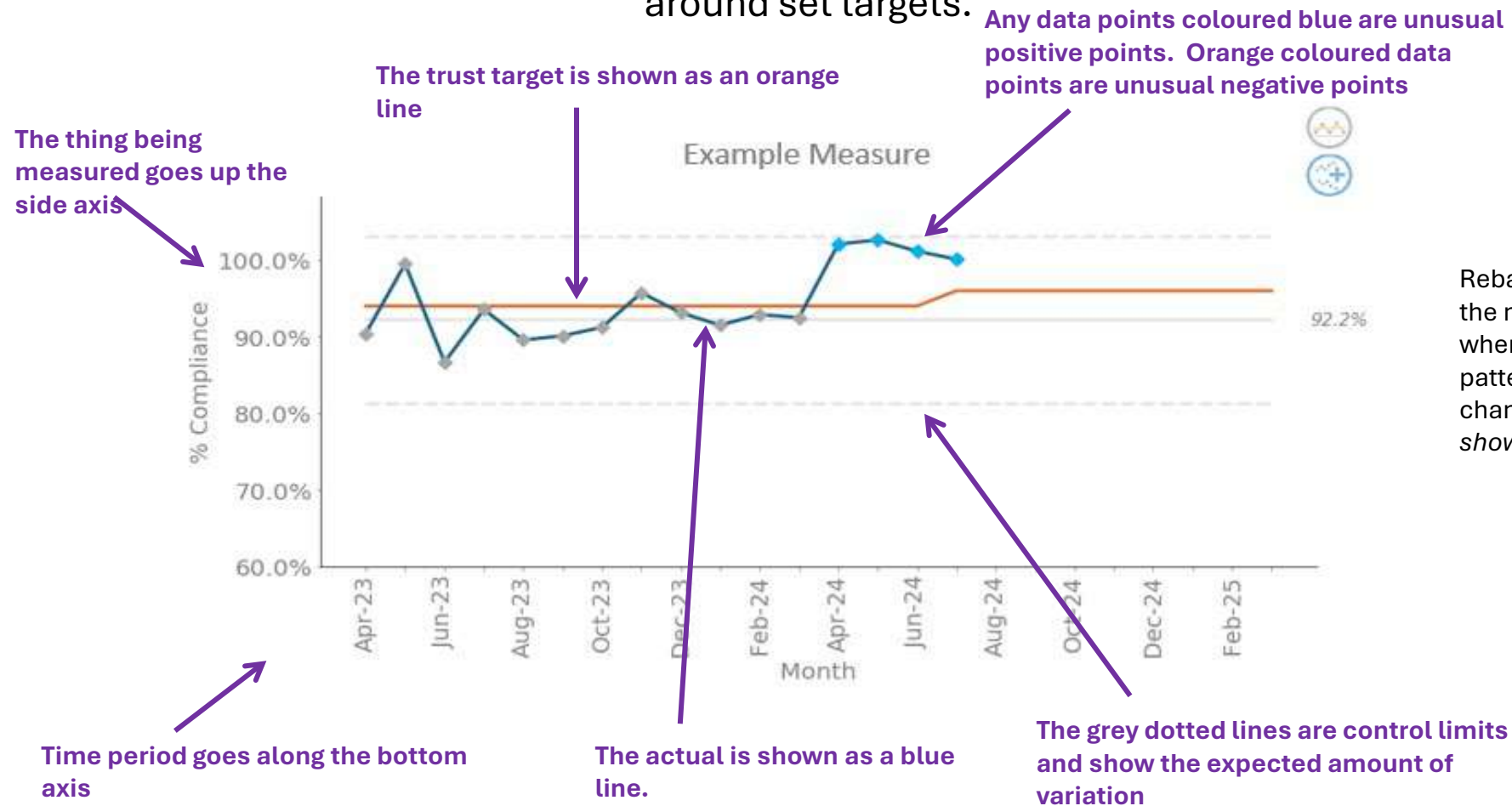
The target value

The most recent value

Most recent month

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.



Executive Summary SPC Metric Grid

Single Improvement Plan- Patients – SPC Metric Grid

	Measures
 Recent concerning pattern or missing target	- Booked <10 - CQC Enquiries - Complaints - Maternity Triage BSOT standard (15min) - Maternity Triage NICE standard (30 min) - Fill rate MSW Day - In- utero transfers declined to accept from other units (NICU) - Elective sections stood down
 Normal variation and on/around target	- Total stillbirths (number) - Total stillbirths (rate per 1000 births) - Stillbirth excluding TOPFA (number) - Stillbirth excluding TOPFA (rate per 1000 births) - Neonatal death within 28 days (number) - Neonatal death within 28 days (rate per 1000 births) - APGAR score below 7 @5 minutes - PPH over 1500mL - Incidence of severe tears grade 3 and above - Breastfeeding initiation - In- utero transfers from LTHTR to another Trust due to NICU closure (Antenatal) - NICU Closure - Delay in inductions - Confirmed HIE grade 2 or above (37 weeks +) - Prevention of future deaths regulation 28 - Maternal Death within 42 days - Maternity and Newborn Safety Investigations (accepted for review) - Incidents of moderate harm and above - Compliments - Neonatal Nurse Staffing compliance to BAPM - Supernumerary status of DS coordinator at the start of every shift - One-to-one care in labour in Delivery Suite - One-to-one care in labour in Preston Birth Centre - One-to-one care in labour in Chorley Birth Centre - Fill rate RM Night - Fill rate MSW Night - Number of Consultant hours on obstetric unit 24-hour acute obstetric medical staffing fill rate - Maternity Diverts - Number of times home birth service stood down - Women who transfer to an alternative provider during induction of labour - In- utero transfers declined to accept from other units (maternity)
 Recent positive pattern or passing target	- Booked <13 - HDU trained per shift - Fill rate RM Day - Registered Midwife shifts sent to agency - Registered Midwife Agency hour fill rate percentage - Staff sickness rate - RCOG obstetric benchmarking compliance
 Topic of high interest (always flagged for assurance report)	- APGAR score below 7 @5 minutes - PPH over 1500mL - Incidence of severe tears grade 3 and above

The Perinatal Quality Surveillance Model (PQOM) was updated in 2025 and in line with the Maternity Incentive Scheme (MIS) Year 8 standards which requires Trusts to carry out dynamic monitoring of safety, quality and effectiveness supported by a Statistical Process Control (SPC) maternity and neonatal dashboard. This combined oversight function provides the Board with a clear and systematic view of safety, quality and clinical outcomes across maternity and neonatal services. Statistical Process Control (SPC) methodology is used to distinguish normal variation from true signals of improvement or deterioration, enabling earlier identification of emerging risks, unwarranted variation and opportunities for intervention or learning.

The Dashboard data includes the period up to the end of June 2026. Overall clinical outcomes remain relatively stable. Positive performance is demonstrated in outcome data associated with stillbirths, booking by 13 weeks, 1:1 care in labour, supernumerary coordinator, APGAR scores less than 7, sickness absence rates and HDU care.

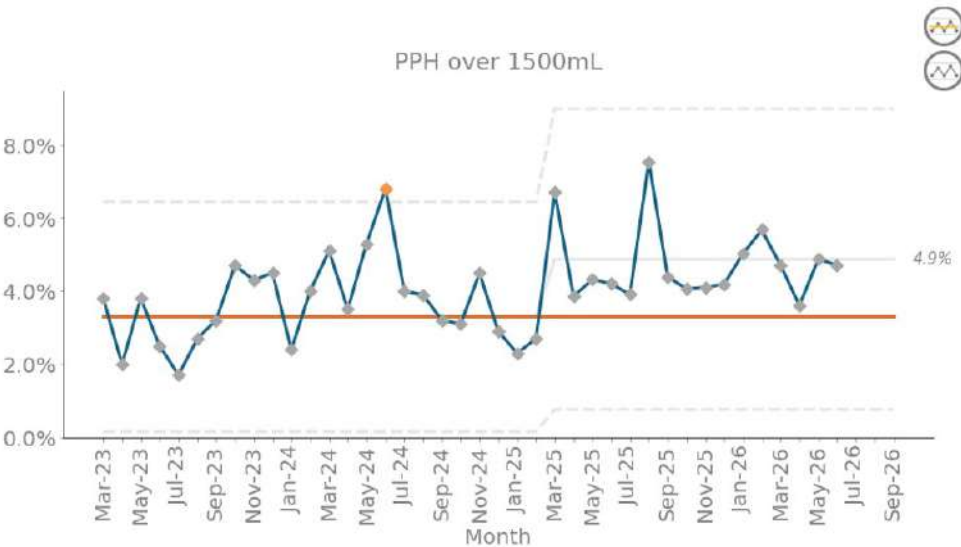
SPC methodology is used to identify variation and trends in performance where a measure demonstrates an improvement or deterioration, sustained variation or special cause. Analysis of the maternity dashboard has identified postpartum haemorrhage (PPH), third and fourth-degree tears (perineal tears), CQC enquires, complaints, maternity triage review timeframes and neonatal closures as key areas requiring focused improvement and ongoing monitoring. Detailed analysis is provided in the slideset for metrics demonstrating special cause variation, sustained trends, or where targeted improvement workstreams are underway, enabling enhanced oversight of performance, outcomes and the effectiveness of improvement activities.

To support clear interpretation of performance, SPC analysis is used to categorise each metric according to one of four reporting themes: recent concerning variation or missed target; normal variation with performance on or around target; recent positive variation or achievement of target; and areas of high organisational interest that are routinely reported for assurance purposes irrespective of current performance. (Slide 4)

Dashboard 1 - Clinical Safety Indicators

Metric Description		Assurance	Variation	Target			Latest actual month	Latest month
				Concern	Latest month target	Target rationale		
Clinical Safety indicators	Births			No Target Set			361.0	Jun-26
	Total stillbirths (number)			No Target Set			0.0	Jun-26
	Total stillbirths (rate per 1000 births)				3.2	National	0.0	Jun-26
	Stillbirth excluding TOPFA (number)			No Target Set			0.0	Jun-26
	Stillbirth excluding TOPFA (rate per 1000 births)			No Target Set			0.0	Jun-26
	Neonatal death within 28 days (number)			No Target Set			1.0	Jun-26
	Neonatal death within 28 days (rate per 1000 births)				6.0	National	2.8	Jun-26
	Booked <10				80.0%	Local	61.9%	Jun-26
	Booked <13				90.0%	Local	93.7%	Jun-26
	Induction of Labour rate			No Target Set			33.5%	Jun-26
	Women giving birth at obstetric unit			No Target Set			82.0%	Jun-26
	Women giving birth in a midwife-led setting			No Target Set			17.5%	Jun-26
	Home birth			No Target Set			2.2%	Jun-26
	APGAR score below 7 @5 minutes				1.2%	MBRRACE	1.2%	Jun-26
	PPH over 1500mL				3.3%	MBRRACE	4.7%	Jun-26
	Incidence of severe tears grade 3 and above				3.2%	MBRRACE	4.6%	Jun-26
	Breastfeeding initiation				81.0%	National	81.2%	Jun-26
	Confirmed HIE grade 2 or above (37 weeks +)			No Target Set			0.0	Jun-26

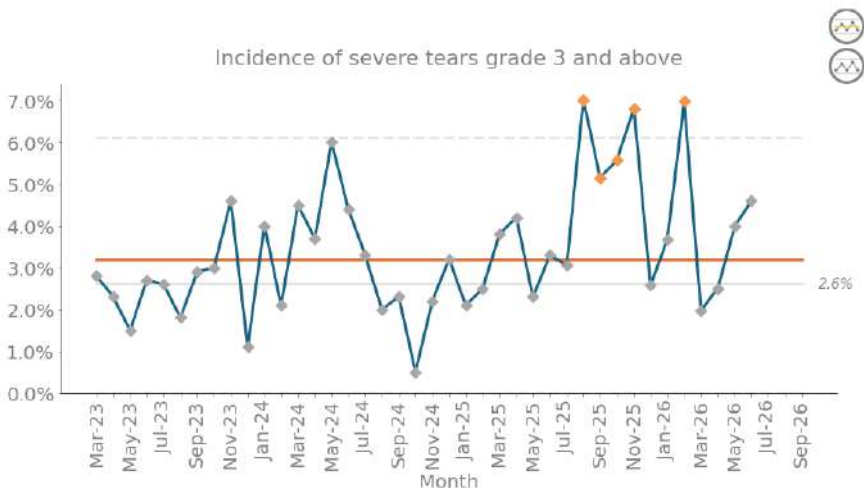
Assurance Report – PPH



Latest
4.7%
Variance Type
Normal Variation – no recent change
Target
3.3% (MBRRACE)
Target achievement
Could both pass or fail target within expected variation

Metric	Summary	Actions	Assurance
Post partum Haemorrhage (PPH) over 1500ml	Performance relating to Postpartum Haemorrhage (PPH) $\geq 1500\text{ml}$ continues to be monitored monthly. Analysis of the SPC chart demonstrates that whilst performance remains within expected variation based on historical data, the operational target of 3.3% has not been achieved since February 2025 following the statistical rebase in March 2025. Improvement work continues through the established PPH Working Group and implementation of the Saving Babies' Lives Care Bundle Element 5 (Obstetric Haemorrhage), with a focus on cumulative blood loss measurement, earlier recognition of deterioration and timely intervention. Progress against some improvement actions has been slower than planned due to ongoing pressures within the obstetric workforce; however, the planned recruitment of additional consultant colleagues is expected to provide the capacity required to undertake a more detailed review of PPH performance and support further improvement activity.	- The PPH working group will continue to oversee the improvement programme and coordinate actions arising. (Noting that progress with this has been delayed by workforce pressures) - Training compliance for eligible staff groups will continue to be closely monitored to ensure sustained compliance with maternity emergency training compliance. - All cases of PPH $\geq 1500\text{mls}$ will continue to undergo audit and multidisciplinary review to identify learning opportunities and support continuous improvement. - Case based learning and targeted feedback will continue to be provided and embedded into education and learning sessions to strengthen learning from incidents. - The appointment of a second clinical educator will enable an expanded programme of skills and simulation training to be undertaken to expand competency and preparedness for managing PPH. (Expected start date September 2026)	- Performance relating to PPH $\geq 1500\text{ml}$ continues to be reviewed through monthly performance monitoring process (SPC). - Findings are collated and reported through quarterly governance reporting arrangements to provide organisational oversight. - All cases of PPH $\geq 1500\text{mls}$ undergo audit and multidisciplinary review to identify themes, learning opportunities and areas for improvement. - Established multiprofessional review processes provide ongoing assurance regarding the identification of risks, dissemination of learning and monitoring of improvement actions - Local performance will continue to be benchmarked against national maternity dashboard data to provide assurance regarding performance trends, identify unwarranted variation and support the evaluation of improvement initiatives

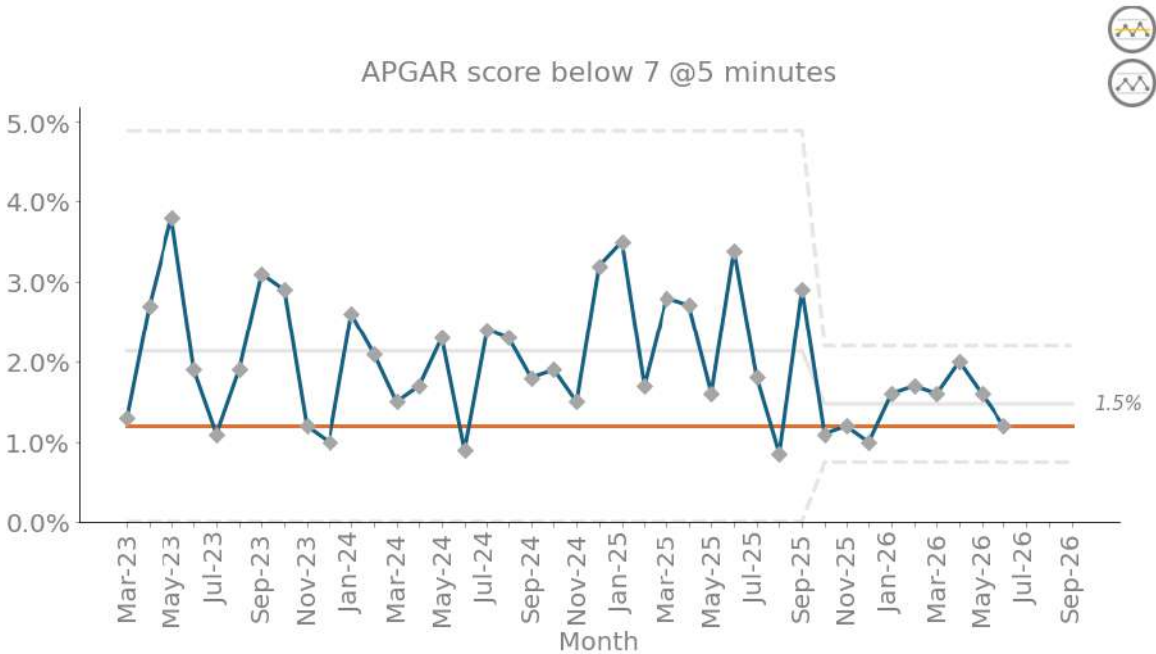
Assurance Report – OASI



Latest
4.6%
Variance Type
Normal Variation – no recent change
Target
3.2% (MBRRACE)
Target achievement
Could both pass or fail target within expected variation

Metric	Summary	Actions	Assurance
Incidence of severe tears grade 3 and above (Obstetric Anal Sphincter Injury OASI)	Performance relating to the incidence of severe perineal tears (Grade 3 and 4 OASI) continues to be monitored monthly. Analysis of SPC trend data identified a period of special cause variation between July 2025 and February 2026. The national tear rate for OASI is 5.4% following an assisted birth. The Trust assisted birth tear rate is 10.3%. Although performance remains within the expected range of variation, the Trust rate has been consistently around 5% higher than the national benchmark. As a result, this continues to be a key area of focus for the service, with ongoing work to understand and improve outcomes. Review of the cases identified that the period coincided with the rotation of a less experienced trainee medical workforce. Whilst no direct causal relationship can be established, it is possible that reduced levels of previous operative obstetric experience may have contributed to the observed increase in instrumental births and associated third and fourth-degree perineal tears	- Continue to monitor compliance with OASI Care Bundle training across all eligible staff groups. - Continue case-based learning and targeted feedback where elements of the OASI Care Bundle have not been fully implemented. - Increase education and training during induction and onboarding programmes for medical staff. From the August 2026 trainee rotation, clinical skills training will include OASI prevention and management, assisted birth techniques and episiotomy practice to strengthen competence and reduce variation in practice. - Consider peer review of outcomes with another comparable organisation	- Performance relating to Grade 3 and 4 tears continues to be reviewed through monthly performance monitoring processes. - All cases of 3rd and 4th degree tears undergo audit and multidisciplinary review to identify themes, learning opportunities and areas for improvement. - Compliance with the OASI Care Bundle is reviewed through the established maternity governance framework, including reporting via the Maternity Safety and Quality Committee. - Training compliance is monitored routinely and remains above 90% across all eligible staff groups.(May 2025) - Local performance will continue to be benchmarked against national maternity dashboard data to provide assurance regarding performance trends, identify unwarranted variation and support the evaluation of improvement initiatives.

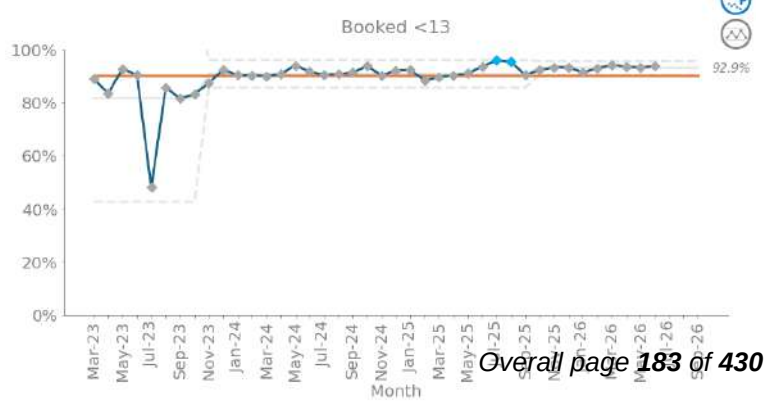
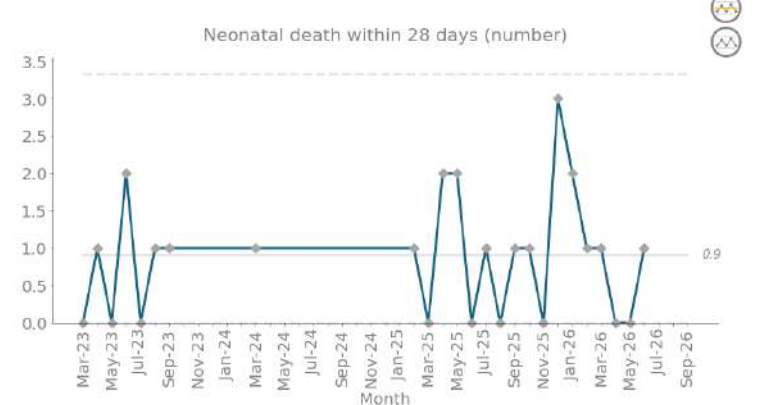
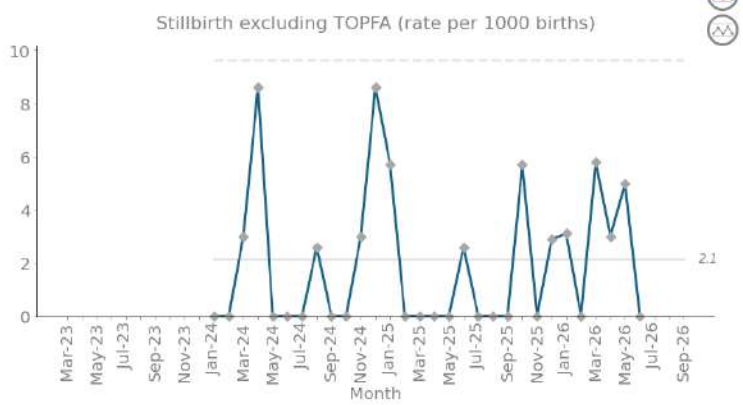
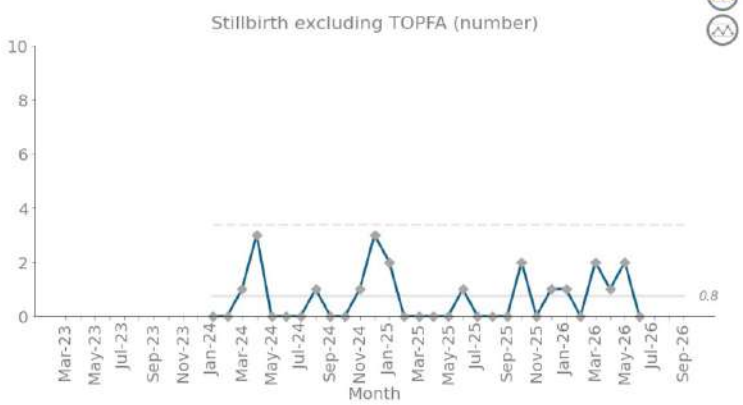
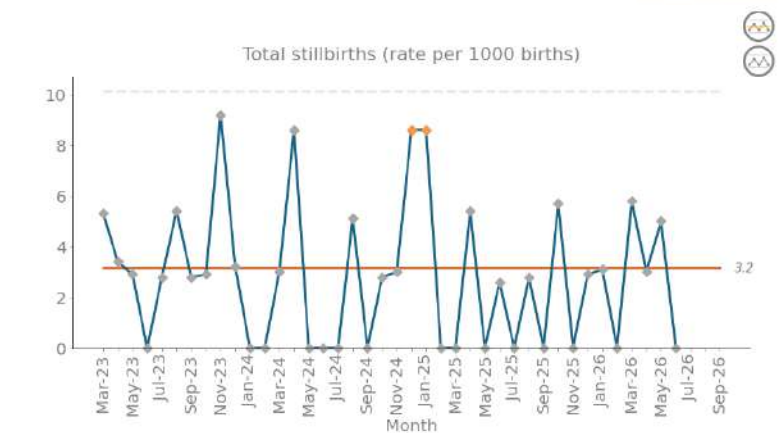
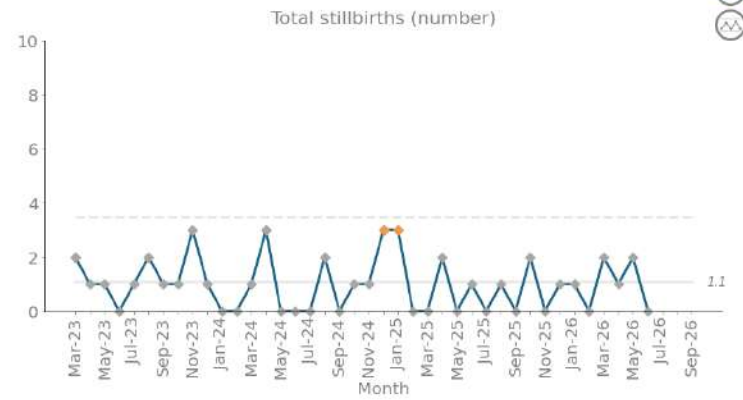
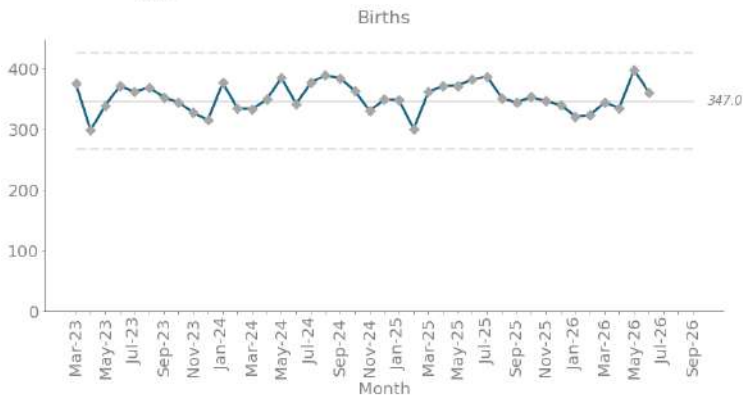
Assurance Report – APGAR



Latest
1.2%
Variance Type
Normal Variation – no recent change
Target
1.2% (MBRRACE)
Target achievement
Could both pass or fail target within expected variation

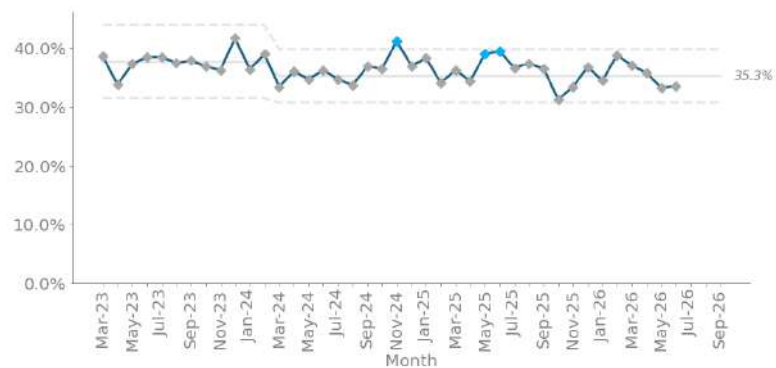
Metric	Summary	Actions	Assurance
APGAR score below 7 @ 5 minutes	Performance against APGAR scores below 7 at 5 minutes is monitored via the SPC dashboard because of the direct correlation with safe intrapartum care and the immediate clinical condition of the newborn at birth. The SPC chart demonstrates a statistical reduction from October 2025 which has been sustained over time indicating an improvement in performance rather than normal variation. This is a positive indicator that fewer babies require immediate resuscitative support at birth.	- Continue to monitor APGAR scores below 7 at 5 minutes through monthly performance and quality review process. - Continue to promote learning from incident reviews, case discussions and multidisciplinary education forums to support improvements in intrapartum care. - Maintain compliance with mandatory maternity emergency training and neonatal resuscitation training. - Continue to embed evidence-based intrapartum care practices and learning from local and national maternity safety initiatives	Performance relating to APGAR scores below 7 at 5 minutes continues to be monitored through established maternity governance and performance reporting arrangements. SPC analysis demonstrates a sustained improvement in outcomes since October 2025.

Dashboard 1- Graphs Normal variation and on/around target

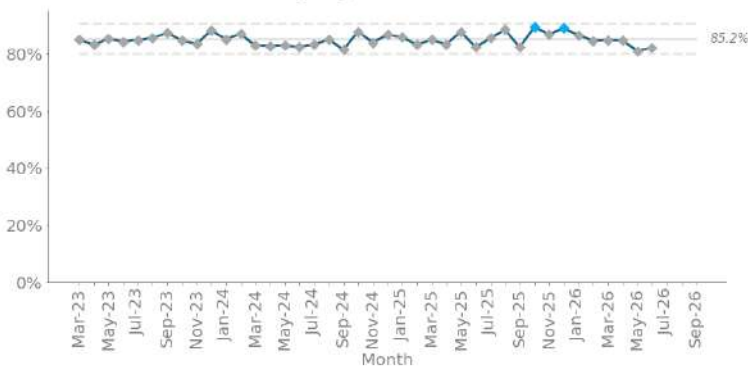


Dashboard 1- Graphs Normal variation and on/around target

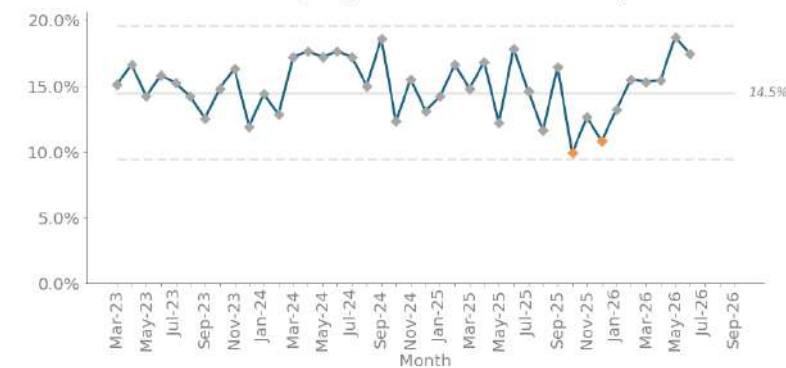
Induction of Labour rate



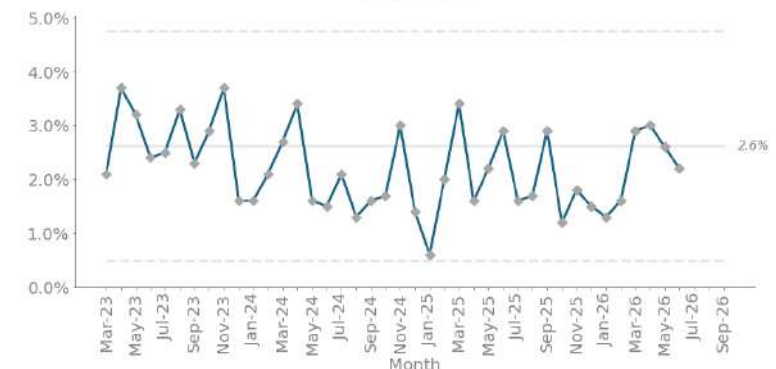
Women giving birth at obstetric unit



Women giving birth in a midwife-led setting



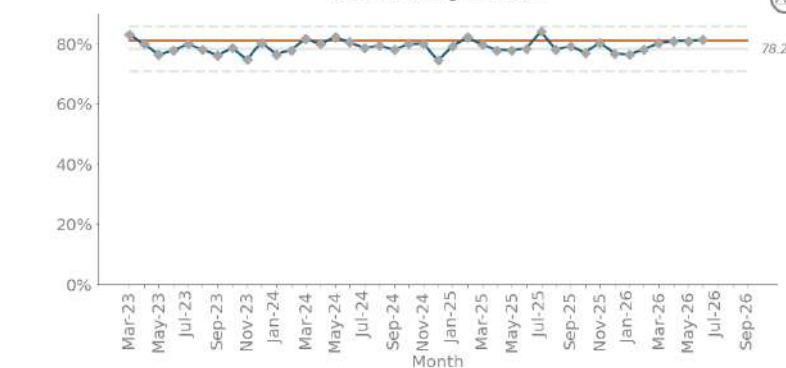
Home birth



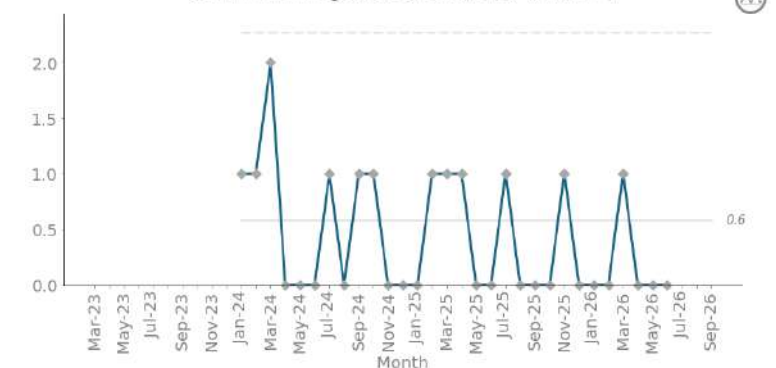
Incidence of severe tears grade 3 and above



Breastfeeding initiation

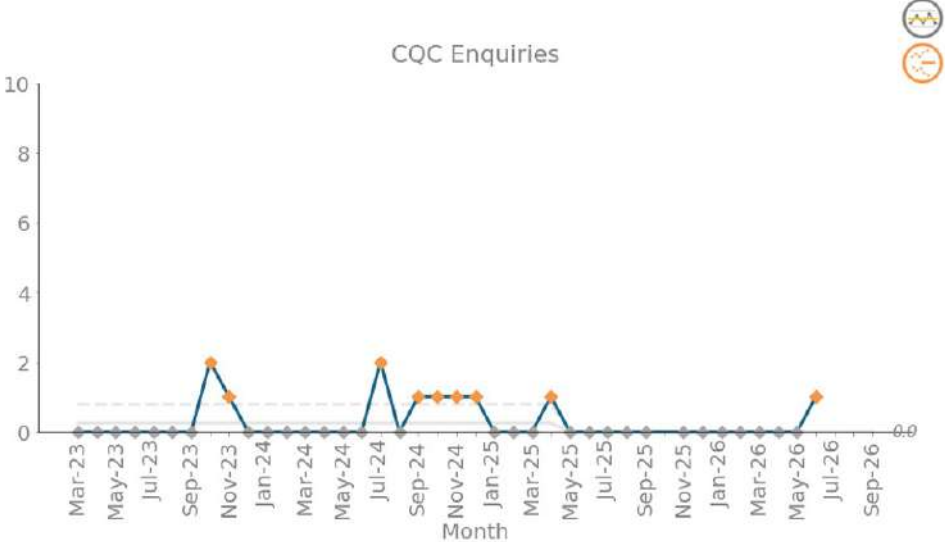


Confirmed HIE grade 2 or above (37 weeks +)



Metric Description		Assurance	Variation	Target			Latest actual month	Latest month
				Concern	Latest month	Target rationale		
Perinatal Quality, Governance, Experience and Regulation	Prevention of future deaths regulation 28				No Target Set		0	Jun-26
	CQC Enquiries				No Target Set		1	Jun-26
	Maternal Death within 42 days				No Target Set		0	Jun-26
	Maternity and Newborn Safety Investigations (accepted for review)				No Target Set		0	Jun-26
	Incidents of moderate harm and above				No Target Set		0	Jun-26
	Complaints				No Target Set		4	Jun-26
	Compliments				No Target Set		6	Jun-26

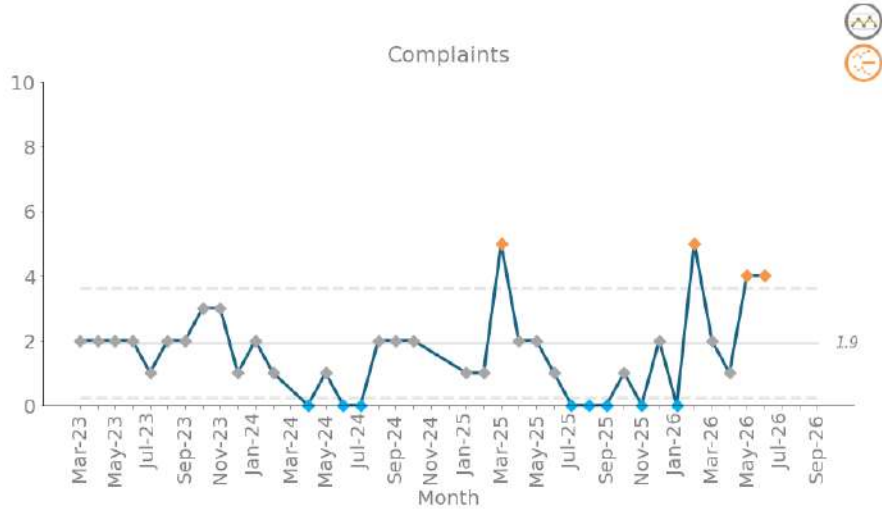
Assurance Report – CQC Enquiries



Latest
1
Variance Type
Recent concerning pattern in the data
Target
No Target Set
Target achievement
No Target Set

Metric	Summary	Actions	Assurance
Care Quality Commission (CQC) Enquiries	Performance relating to CQC enquiries is monitored through established corporate governance processes. The SPC chart demonstrates a high data point (1 enquiry) in June 2026 following 11 consecutive months with no enquiries. This related to incidents not being reported in line with statutory requirements or not being investigated independently. Whilst this represents special cause variation within the dataset, it should be interpreted proportionately given the very low overall volume of enquiries received. At present, there is insufficient evidence to indicate an emerging trend, and the position will be monitored closely over the coming months to determine whether any recurring themes or patterns are identified. The service provided a formal response to the enquiry in June 2026 and following review, no immediate actions were required	- Continue to monitor CQC enquiry data through monthly governance and performance review processes.(SPC) - Triangulate CQC enquiry data with other sources of safety intelligence, including Freedom to speak up reporting, staff surveys, trainee and student feedback, to monitor organisational culture and identify any emerging risks or concerns requiring action. - Ensure timely responses to all CQC enquiries in line with regulatory requirements. - The Maternity and Neonatal Improvement Team have been invited to undertake a review of the service.	All enquiries subject to review. The current increase represents a single data point following a prolonged period with no enquiries. This will continue to be monitored to determine whether this reflects normal variation or an emerging trend requiring further action

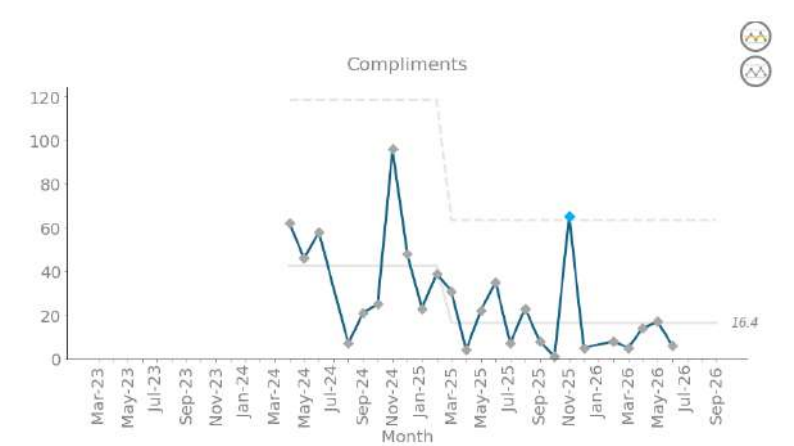
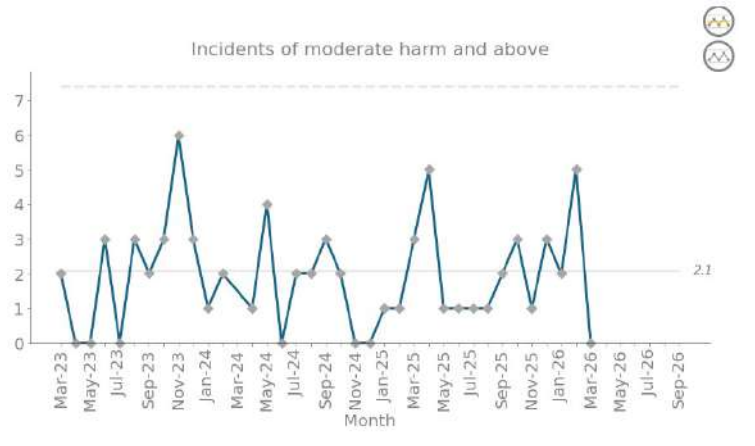
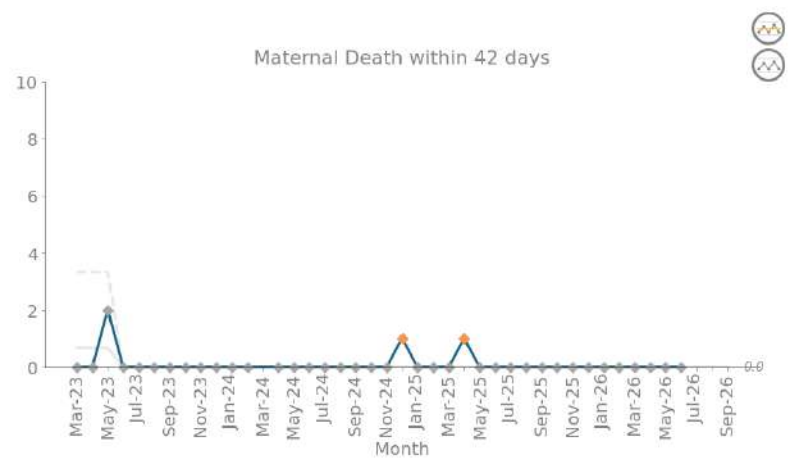
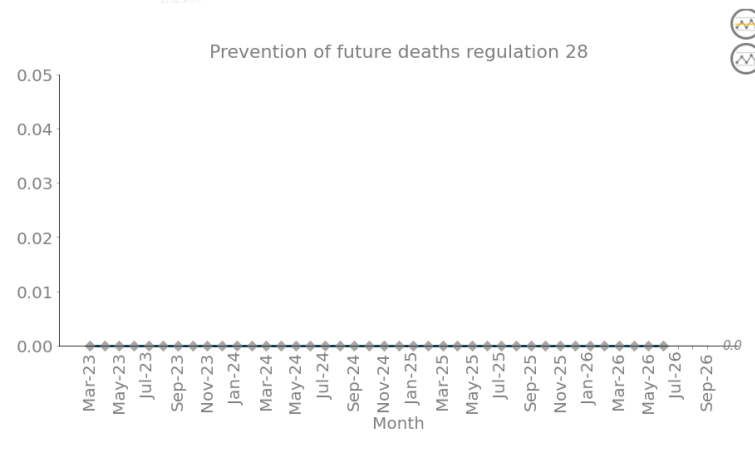
Assurance Report – Complaints



Latest
4
Variance Type
Recent concerning pattern in the data
Target
No Target Set
Target achievement
No Target Set

Metric	Summary	Actions	Assurance
Complaints	Performance relating to complaints is monitored through established governance processes. The SPC chart demonstrates unusually high numbers of complaints received in May 2026 (4 each month) when compared with historical performance. High level themes relate to communication and care pathways. One complaint was historic from 2023 . The service welcomes feedback received through complaints, recognising that it provides an important opportunity to listen to women and families, understand their experiences and drive improvements in the quality and safety of care. Whilst the increase in complaints requires ongoing observation, volumes remain relatively low overall. The position will continue to be monitored through established oversight arrangements to identify any emerging trends, themes or areas requiring intervention.	- Weekly multidisciplinary oversight of complaints will continue to ensure timely review, escalation and resolution of concerns. - Learning from complaints, claims, investigations and service user experience will continue to be reviewed through the Maternity and Neonatal Safety and Quality Committee and reported through Board governance arrangements and Safety Champions. - A dedicated claims scorecard review has been arranged with NHS Resolution to support deeper analysis of claims trends and opportunities for organisational learning. - Continue to review wider sources of safety and culture intelligence, including Freedom to Speak Up (FTSU) reporting, staff survey findings, trainee and student feedback, patient experience information and incident data, to identify emerging themes, monitor organisational culture and inform improvement actions	- Complaints continue to be monitored through established governance and performance review processes, including weekly multidisciplinary oversight arrangements. - Quarterly triangulation of complaints, claims, incidents and patient experience data provides assurance that themes, risks and opportunities for improvement are identified and addressed.

Dashboard 2 - Graphs



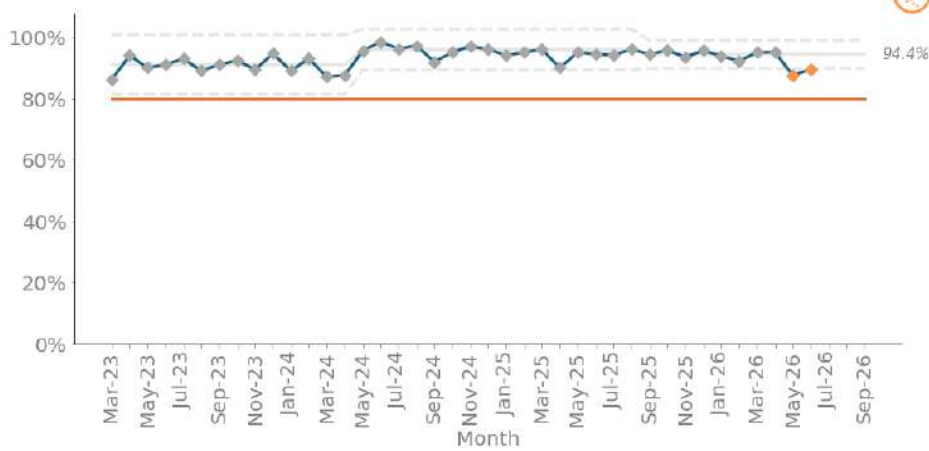
Dashboard 3 – Safe Staffing indicators

Metric Description		Assurance	Variation	Target			Latest actual month	Latest month
				Concern	Latest month	Target rationale		
Safe Staffing Indicators	Births per Funded Clinical Midwife WTE			No Target Set			29	Jun-26
	Neonatal Nurse Staffing compliance to BAPM				90.0%	Local	90.1%	Jun-26
	Supernumerary status of DS coordinator at the start of every shift				100.0%	Local	100.0%	Jun-26
	HDU trained per shift				90.0%	Local	100.0%	Jun-26
	One-to-one care in labour in Delivery Suite				100.0%	Local	100.0%	Jun-26
	One-to-one care in labour in Preston Birth Centre				100.0%	Local	100.0%	Jun-26
	One-to-one care in labour in Chorley Birth Centre				100.0%	Local	100.0%	Jun-26
	Maternity Triage BSOT standard (15min)				80.0%	Local	89.5%	Jun-26
	Maternity Triage NICE standard (30 min)				90.0%	Local	93.6%	Jun-26
	Fill rate RM Day				95.0%	Trust	98.0%	Jun-26
	Fill rate MSW Day				95.0%	Trust	86.0%	Jun-26
	Fill rate RM Night				95.0%	Trust	96.0%	Jun-26
	Fill rate MSW Night				95.0%	Trust	92.0%	Jun-26
	Registered Midwife shifts sent to agency			No Target Set			0	Jun-26
	Registered Midwife Agency hour fill rate percentage			No Target Set			0.0%	Jun-26
	Staff sickness rate				5.2%	Trust	4.3%	May-26



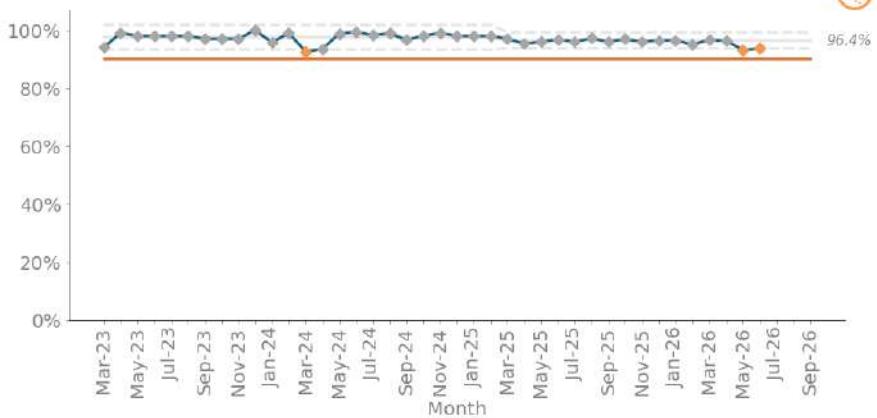
Assurance Report – Triage Standards

Maternity Triage BSOT standard (15min)



Latest
89.5%
Variance Type
Recent concerning pattern in the data
Target
80.0% (Local)
Target achievement
Will consistently pass target within standard variation

Maternity Triage NICE standard (30 min)



Latest
93.6%
Variance Type
Recent concerning pattern in the data
Target
90.0% (Local)
Target achievement
Will consistently fail target within standard variation

Metric	Summary	Actions	Assurance
Maternity Triage BSOT standard (15min)	Performance against the Maternity Triage BSOTS 15-minute/30-minute assessment standard continues to be monitored through established performance and governance arrangements. SPC analysis demonstrates a small reduction in performance against review times within the Maternity Assessment Suite, reflecting ongoing operational and workforce challenges experienced by the service.	1. Continue recruitment activity in support of the approved Two-Tier Obstetric Business Case. 2. Progress recruitment to the additional 5.51 WTE establishment for the Maternity Assessment Suite, supporting the implementation of a dedicated telephone triage. 3. Continue recruitment to Band 5 and Band 6 vacancies to strengthen workforce capacity and resilience. 4. Progress recruitment to the additional 1.0 WTE Day Unit post to ensure planned activity can be fully delivered within the antenatal clinic footprint. 5. Monitor performance against the BSOTS 15-minute/30-minute standard through routine operational and governance review processes to assess the impact of workforce interventions	1. Performance against the BSOTS 15-minute triage/30-minute NICE standard continues to be reviewed through established operational, performance and governance arrangements. 2. The service maintains oversight of workforce capacity, sickness absence and rota gaps to understand the impact on service delivery and within the Maternity Assessment Suite. 3. Although recent performance has reduced, historical compliance above 90% provides assurance that the service has previously demonstrated sustained delivery of the standard.
Maternity Triage NICE standard (30min)	During Quarter 1, the Maternity Assessment Suite managed periods of reduced staffing resilience associated with sickness absence, alongside workforce gaps within the obstetric consultant and trainee rotas. These pressures have impacted the timeliness of triage assessments, particularly during out-of-hours periods. Implementation of the planned two-tier obstetric rota has been delayed due to recruitment challenges and difficulties in appointing experienced colleagues to vacant posts. Whilst there has been a reduction in performance, it is important to note that performance against the standard has historically been consistently above 90%. Recruitment activity remains ongoing to strengthen workforce resilience and support improvements in timeliness of assessment.		



Latest
98.0%
Variance Type
Recent positive pattern in the data
Target
95.0% (Trust)
Target achievement
Could both pass or fail target within expected variation

Fill rate MSW Day

Month	Fill Rate (%)
Mar-23	72
May-23	100
Jul-23	92
Sep-23	88
Nov-23	78
Jan-24	75
Mar-24	80
May-24	80
Jul-24	82
Sep-24	80
Nov-24	75
Jan-25	78
Mar-25	88
May-25	82
Jul-25	85
Sep-25	88
Nov-25	82
Jan-26	85
Mar-26	78
May-26	88
Jul-26	85
Sep-26	85

Fill rate MSW Night

93.2%

Month

Month	Fill Rate (%)
Mar-23	95.0
May-23	92.0
Jul-23	98.0
Sep-23	95.0
Nov-23	98.0
Jan-24	95.0
Mar-24	92.0
May-24	95.0
Jul-24	95.0
Sep-24	95.0
Nov-24	92.0
Jan-25	98.0
Mar-25	98.0
May-25	95.0
Jul-25	95.0
Sep-25	95.0
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Jan-26	95.0
Mar-26	90.0
May-26	95.0
Jul-26	95.0
Sep-26	95.0

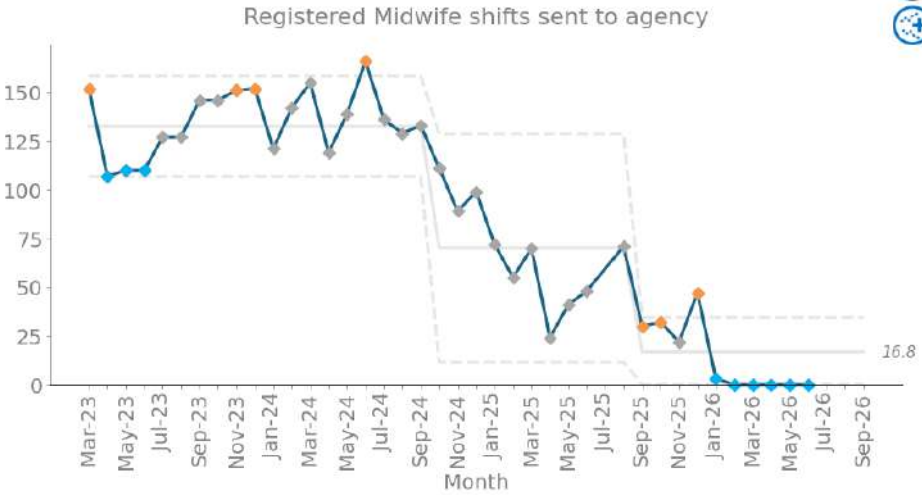
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Assurance Report – Fill Rate Narrative

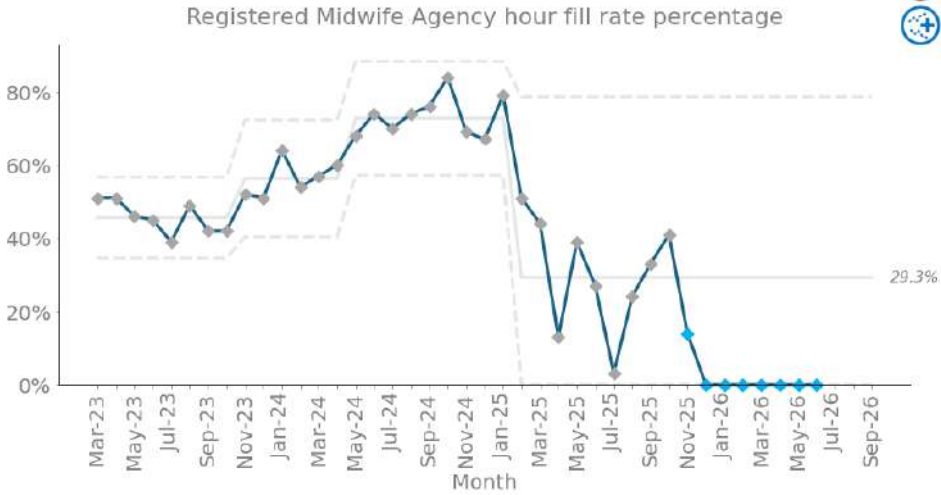
Metric	Summary	Actions	Assurance
Fill rate RM	The overall midwifery fill rate is 96.3% which remains above the Trust target of 95%. This has been the case for the past three months. Unfilled shifts continue to be sent to bank and agency to maintain safe staffing as required. The over-offer recruitment approach is being utilised to maximise the opportunity to recruit newly qualified midwives following qualification in the coming months.	1. Monthly roster efficiency meetings overseen by the deputy Divisional Midwifery and Nursing Director 2. The service continues to recruit to turnover using over offer between 5 and 10 WTE. 3. Annual staffing paper including Birth Rate Plus approved by the Safety and Quality Committee (February 2026) and Board of Directors (April 2026) 4. Prompt shortlisting and prompt recruitment processes in place.	1. The Safety and Quality Committee reviews fill rates and minimum levels for each area monthly. 2. 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. 3. Biannual safe-staffing reviews are completed in line with National Quality Board guidance. 4. Red-flag reporting is monitored to identify areas requiring additional support to mitigate risk.
Fill rate MSW	The Maternity Support Worker staffing fill rate remains below target level at 88.1%. Whilst recent months have shown some improvement following a low point in early 2026, there has not yet been sufficient sustained improvement to demonstrate a stable shift in performance. Reduced fill rates are predominantly associated with vacancies. Delays in VCP have impacted on the ability to recruit band 2 and 3 support staff, however, approval for external recruitment has just been agreed to maximise the opportunities for successful recruitment.	1. Ongoing recruitment to fill all vacancies which are tracked using a local trajectory plan. 2. Sickness management procedures are reviewed by Workforce Business Partner to ensure appropriate management. 3. Band 2 and 3 MSW vacancies have been approved for external recruitment (21.07.2026)	



Assurance Report – Agency



Latest
0
Variance Type
Recent positive pattern in the data
Target
No Target Set
Target achievement
No Target Set



Latest
0.0%
Variance Type
Recent positive pattern in the data
Target
No Target Set
Target achievement
No Target Set

Metric	Summary	Actions	Assurance
Registered midwife shifts sent to agency	Performance relating to agency staffing usage continues to demonstrate a positive and sustained position across maternity services. The SPC chart shows that agency staffing usage has remained at zero since January 2025, reflecting continued success in reducing reliance on temporary agency workers whilst maintaining safe staffing levels through the appropriate use of bank staff.	1. Monitor bank fill rates through established workforce performance reporting arrangements to assess staffing resilience and effectiveness of workforce planning. 2. Continue recruitment and retention initiatives to support sustainable workforce capacity and reduce dependency on temporary staffing solutions. 3. Review workforce escalation and staffing processes regularly to ensure safe clinical cover is maintained across maternity services	1. Agency staffing usage has remained at zero since January 2025, providing assurance that safe staffing levels are being maintained without reliance on temporary agency workers. 2. Established workforce planning, escalation and staffing management processes continue to support safe service delivery and appropriate deployment of staff. 3. Workforce metrics are routinely reviewed through governance and performance reporting arrangements to provide oversight of staffing capacity and resilience. 4. Bank staffing continues to be utilised appropriately to maintain safe clinical cover where required, with performance monitored through workforce reporting mechanisms.
Registered midwife agency hour fill rate percentage	Historically, this indicator has provided assurance regarding workforce planning, escalation processes and the ability of the service to maintain safe staffing levels. Given the sustained performance achieved, it is proposed that this metric be replaced with bank fill rates from the next reporting cycle. This will provide a more meaningful measure of workforce resilience and the effectiveness of staffing arrangements used to maintain safe clinical cover. NB removal of the dashboard parameter will not prevent agency use to maintain safe staffing.		

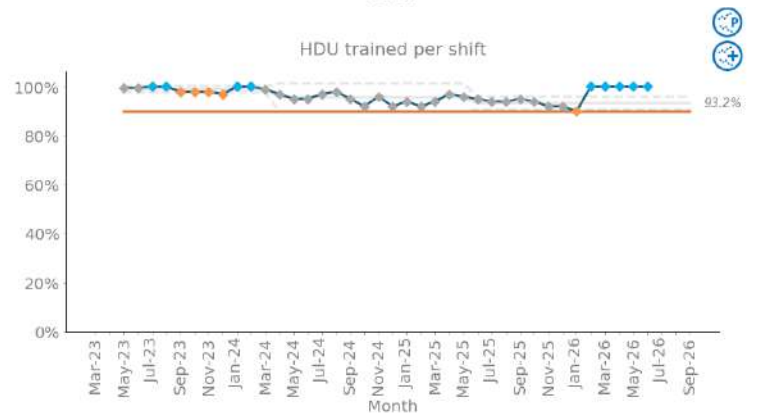
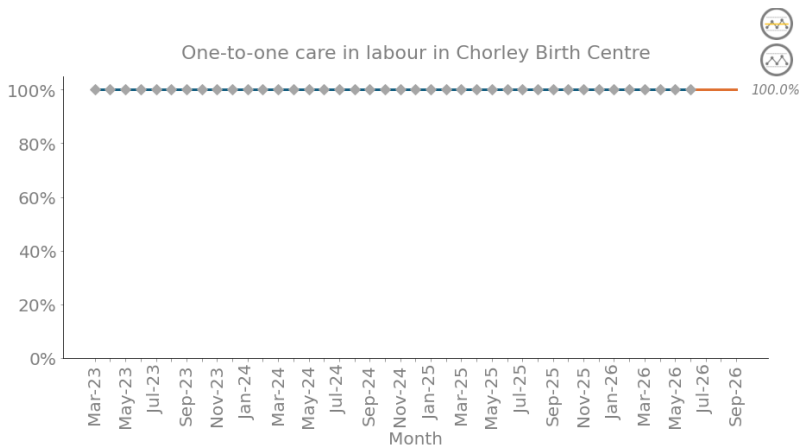
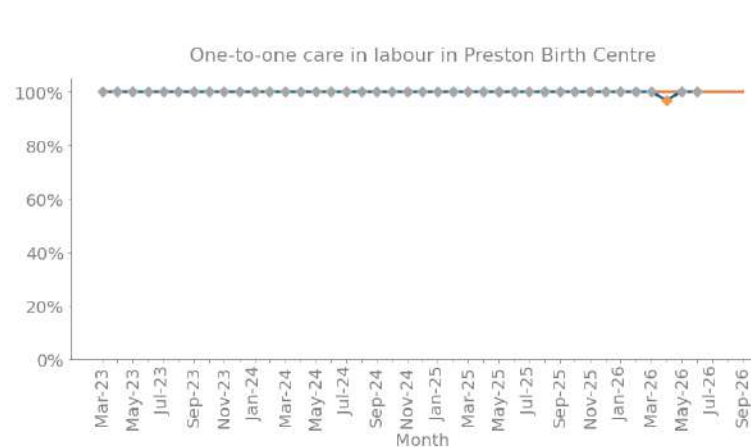
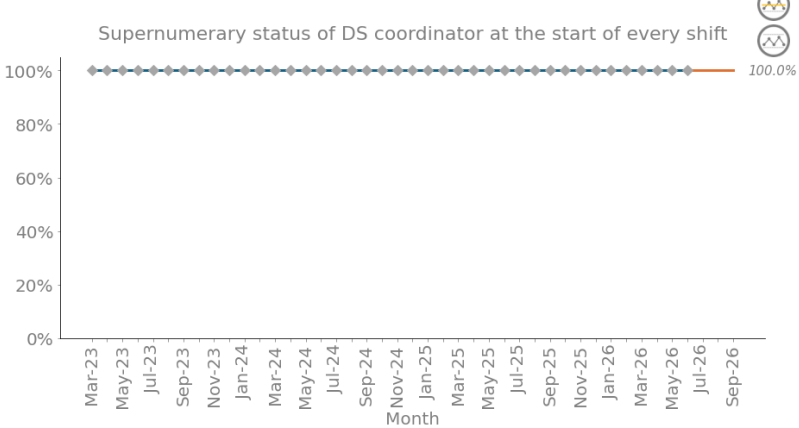
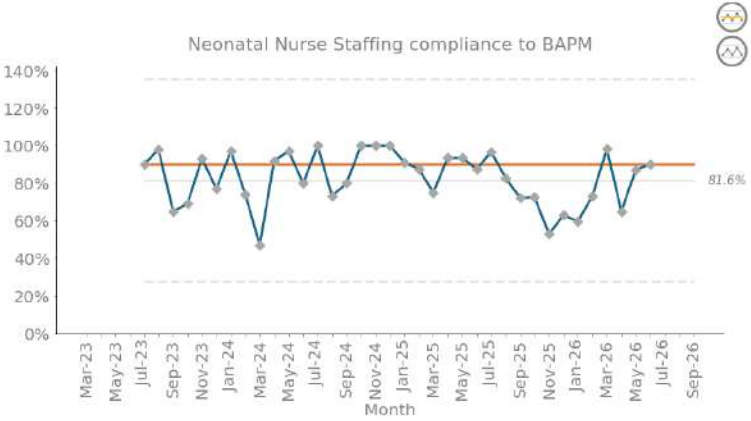
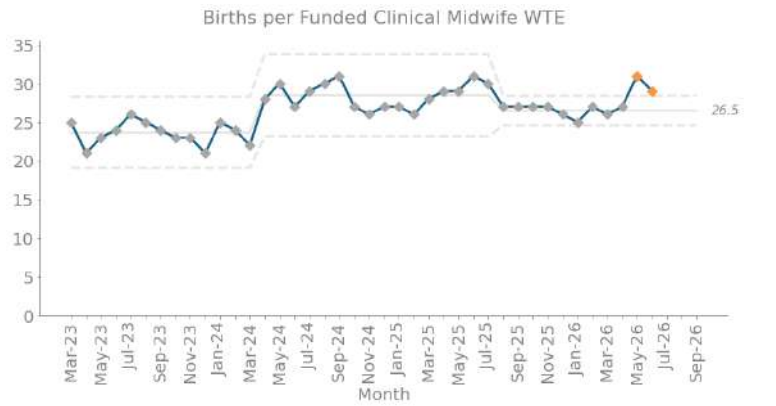
Assurance Report – Sickness



Latest
4.3%
Variance Type
Recent positive pattern in the data
Target
5.2% (Trust)
Target achievement
Could both pass or fail target within expected variation

Metric	Summary	Actions	Assurance
Sickness	Performance relating to sickness absence continues to demonstrate a positive and sustained improvement across maternity services. SPC analysis shows a sustained downward trend in sickness absence from October 2025 onwards, with both March 2026 and May 2026 demonstrating results below the expected limits of variation, indicating special cause improvement rather than normal fluctuation. Notably, the May 2026 position represents the lowest recorded level of sickness absence since 2023/24. This sustained reduction provides assurance that workforce attendance is improving, contributing to greater staffing stability, resilience and workforce capacity across maternity services. any impact on quality, safety and clinical outcomes.	- Monthly workforce assurance meetings will continue to provide oversight of workforce performance, staffing risks and delivery of workforce improvement plans. - Targeted workforce reviews will be undertaken in areas demonstrating elevated sickness absence or sustained long-term absence to identify contributory factors, support staff wellbeing and implement appropriate interventions. - Continue monitoring sickness absence trends alongside staffing, quality and operational performance metrics to assess the impact of workforce attendance on service resilience. - Continue implementation of health, wellbeing and attendance support initiatives to sustain improvements in workforce attendance and reduce the likelihood of future increases in sickness absence	- SPC analysis demonstrates a sustained improvement in sickness absence performance since October 2025, with recent results indicating a reduction beyond that expected through normal variation. - Sickness absence data is monitored alongside staffing, patient safety, quality and operational performance indicators to provide assurance regarding the impact of workforce attendance on service delivery. - Established workforce planning, escalation and wellbeing processes remain in place to support staff attendance, maintain safe staffing levels and mitigate risks associated with workforce pressures.

Dashboard 3 – Graphs Normal variation and on/around target

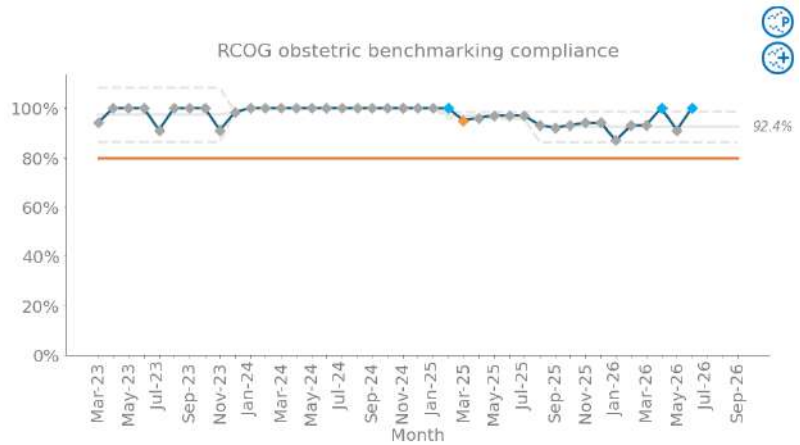


Dashboard 4 – Obstetric Medical Staffing

Metric Description		Assurance	Variation	Target			Latest actual month	Latest month
				Concern	Latest month	Target rationale		
Obstetric Medical Staffing	Number of Consultant hours on obstetric unit			No Target Set			90	Jun-26
	RCOG obstetric benchmarking compliance				80.0%	(MIS Year 7)	100.0%	Jun-26
	24-hour acute obstetric medical staffing fill rate				100.0%	Local	100.0%	Jun-26



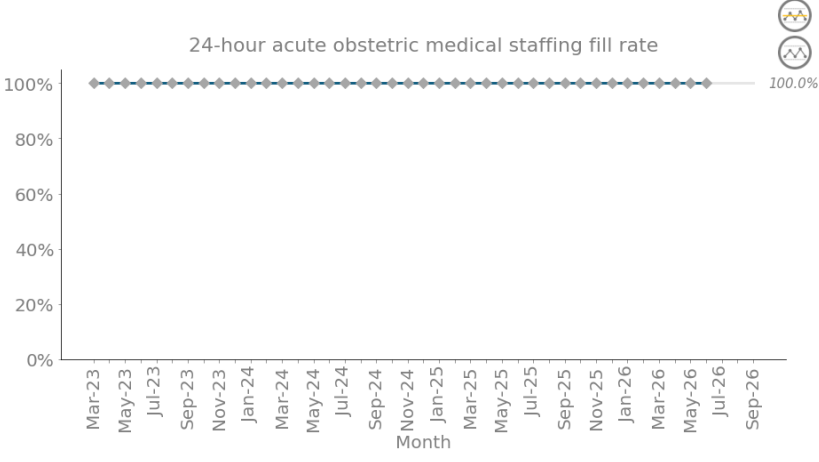
Assurance Report – RCOG Compliance



Latest
100.0%
Variance Type
Recent positive pattern in the data
Target
80.0% (MIS Year 7)
Target achievement
Will consistently pass target within expected variation

Metric	Summary	Actions	Assurance
RCOG consultant attendance obstetric benchmarking compliance	Consultant attendance is monitored in line with Royal College of Obstetricians and Gynaecologists (RCOG) workforce standards and forms part of the assurance framework supporting Maternity Incentive Scheme (MIS) Year 8 requirements relating to workforce, capacity and the delivery of safe clinical care. SPC analysis demonstrates that two of the three most recent data points are higher than expected variation, indicating improved compliance with consultant attendance standards. This provides assurance that timely senior obstetric review is being achieved for women requiring specialist assessment and intervention and reflects a strengthening position in relation to workforce compliance and clinical oversight. Although MIS Year 8 standards no longer specify a single national percentage threshold for consultant attendance, organisations are required to demonstrate compliance with RCOG workforce standards and provide evidence of effective monitoring, governance oversight and assurance arrangements relating to consultant attendance in the clinical scenarios identified within the RCOG workforce guidance. A local target of 80% has been applied	1. Continue to monitor consultant attendance against RCOG workforce standards through established performance and governance arrangements. 2. Review areas of non-compliance or variation to identify contributory factors and implement targeted improvement actions where required. 3. Continue workforce planning and recruitment initiatives to support sustainable consultant workforce capacity and resilience. 4. Utilise consultant attendance data to inform service improvement, workforce planning and compliance with Maternity Incentive Scheme requirements	1. Consultant attendance is routinely monitored through established maternity governance and performance reporting arrangements in line with RCOG workforce standards. 2. Recent SPC analysis demonstrates improved compliance with consultant attendance requirements, providing assurance that women are receiving timely access to senior obstetric review when required. 3. Performance is reviewed as part of the organisation's Maternity Incentive Scheme assurance framework, supporting oversight of workforce capacity, clinical safety and quality of care.

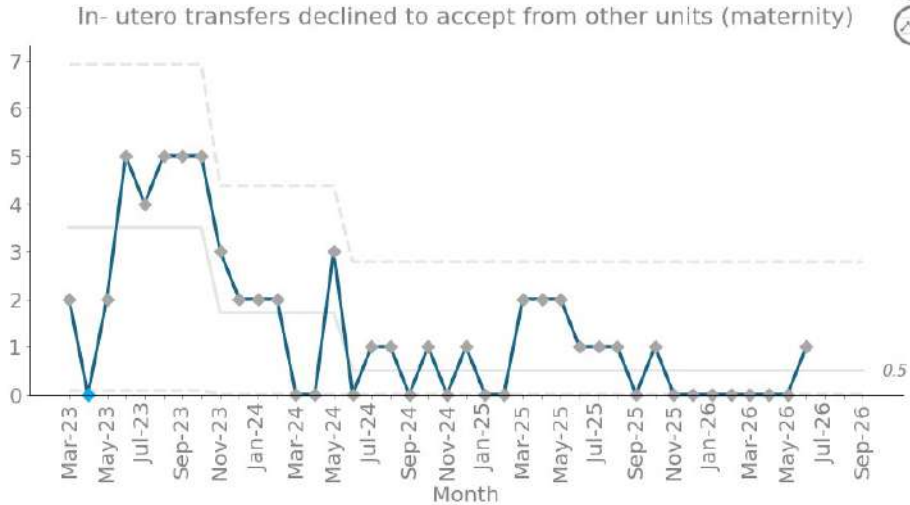
Dashboard 4 - GraphsNormal variation and on/around target



Dashboard 5 – Clinical Escalation

Metric Description		Assurance	Variation	Target			Latest actual month	Latest month
				Concern	Latest month	Target rationale		
Clinical Escalation	Maternity Diverts				No Target Set		1	Jun-26
	Number of times home birth service stood down				No Target Set		0	Jun-26
	Women who transfer to an alternative provider during induction of labour				No Target Set		0	Jun-26
	In- utero transfers declined to accept from other units (maternity)				No Target Set		1	Jun-26
	In- utero transfers declined to accept from other units (NICU)				No Target Set		1	Jun-26
	In- utero transfers from LTHTR to another Trust due to NICU closure (Antenatal)				No Target Set		0	Jun-26
	NICU Closure				No Target Set		0	Jun-26
	Delay in inductions				No Target Set		39	Jun-26
	Elective sections stood down				No Target Set		3	Jun-26

Assurance Report – Transfers Declined



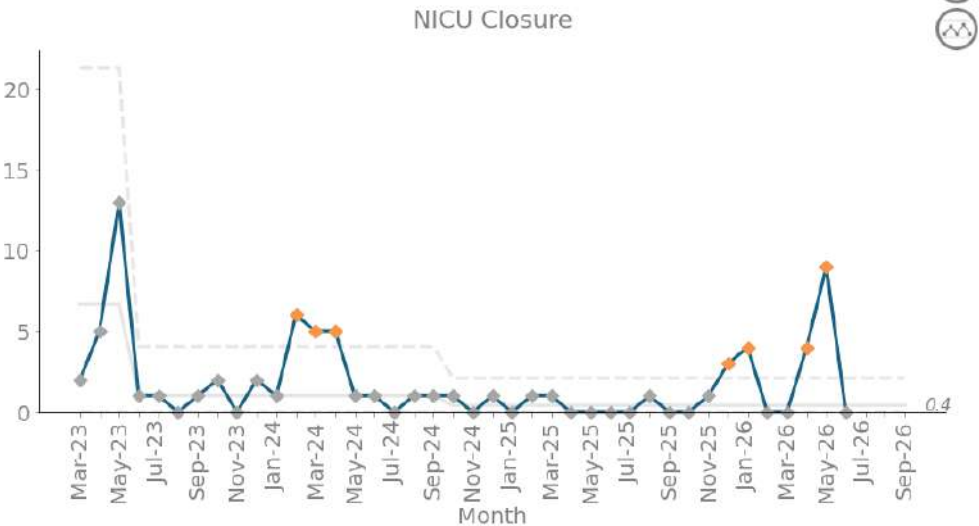
Latest
1
Variance Type
Normal Variation – no recent change
Target
No Target Set
Target achievement
No Target Set



Latest
1
Variance Type
Recent concerning pattern in the data
Target
No Target Set
Target achievement
No Target Set

Metric	Summary	Actions	Assurance
In –utero transfers declined to accept from other units (NICU)	Performance relating to in-utero transfers declined by Neonatal Unit (NCU) from other units continues to be monitored through established operational and governance arrangements. SPC analysis demonstrates higher values for NICU in May 2026 and June 2026, indicating potential variation from expected performance. This increase is attributable to a combination of workforce and capacity pressures, including periods of elevated sickness absence, staff vacancies and short-term staff unavailability, which impacted available nursing capacity within the neonatal unit. In addition, increased demand from babies requiring prolonged intensive care reduced cot availability and limited the unit's ability to safely accept external transfers. Whilst this variation is noted, assurance is provided that decisions to decline transfers were made through established operational and clinical management processes, with patient safety, safe staffing and the maintenance of safe standards of care remaining the primary considerations	- Continue daily review of neonatal cot capacity, workforce availability and service demand to support timely decision-making regarding transfer requests. - Continue recruitment and retention initiatives to address workforce vacancies and improve staffing resilience within neonatal services. - Utilise escalation processes and workforce management arrangements to mitigate the impact of sickness absence and short-term staffing pressures. - Continue biannual safe staffing reviews with the Chief Nursing Officer aligned to National Quality Board (NQB) requirements.	- All decisions to decline transfers are made through established clinical and operational management processes, with patient safety and safe staffing remaining the overriding considerations. - Transfer activity, cot capacity, workforce availability and demand are routinely reviewed through neonatal operational network and governance arrangements to provide oversight of service resilience and risk. - Workforce metrics, including vacancies and sickness absence, are monitored alongside neonatal activity and capacity data to understand factors influencing transfer acceptance.

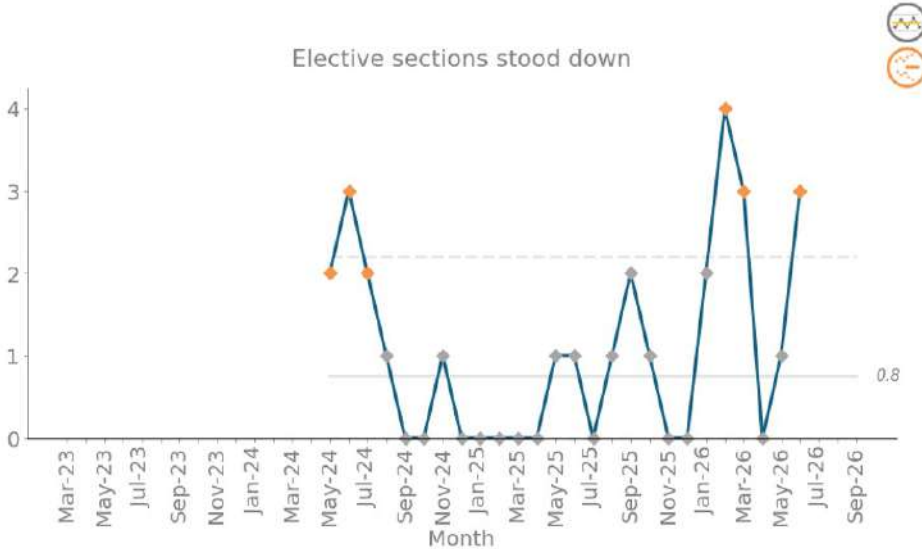
Assurance Report – NICU Closure



Latest
0
Variance Type
Normal Variation – no recent change
Target
No Target Set
Target achievement
No Target Set

Metric	Summary	Actions	Assurance
NICU Closure	Performance relating to NICU closures continues to be monitored through established neonatal governance and capacity management arrangements. SPC analysis demonstrates a higher value in May 2026, reflecting increased capacity pressures associated with neonatal nursing workforce availability, a higher number of multiple births and increased demand from babies requiring prolonged intensive care. Whilst both internal and external closures were elevated during the quarter, internal closures reduced to zero by June 2026, with BAPM compliance improving to 90.1%. This improvement is most likely linked to a change in acuity or complexity.	- Continue to monitor sickness absence with fortnightly workforce meetings. - Continue to recruit to maternity leave. - Redeploy staff from the Paediatric ward to support safe staffing. - Put unfilled shifts out to bank and agency to support safe staffing	- NICU closure activity, neonatal capacity and workforce availability continue to be monitored through established operational, performance and governance arrangements. - The reduction in internal closures to zero by June 2026, alongside improved BAPM compliance of 90.1%, provides assurance that actions taken to address workforce and capacity pressures have improved service resilience. - Local performance will continue to be reviewed alongside regional and national benchmarking information where available to identify variation, support learning and evaluate the effectiveness of improvement initiatives.

Assurance Report – Elective sections stood down

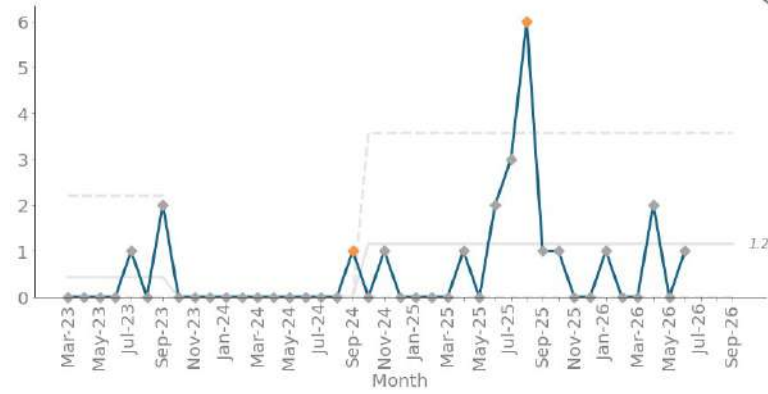


Latest
3
Variance Type
Recent concerning pattern in the data
Target
No Target Set
Target achievement
No Target Set

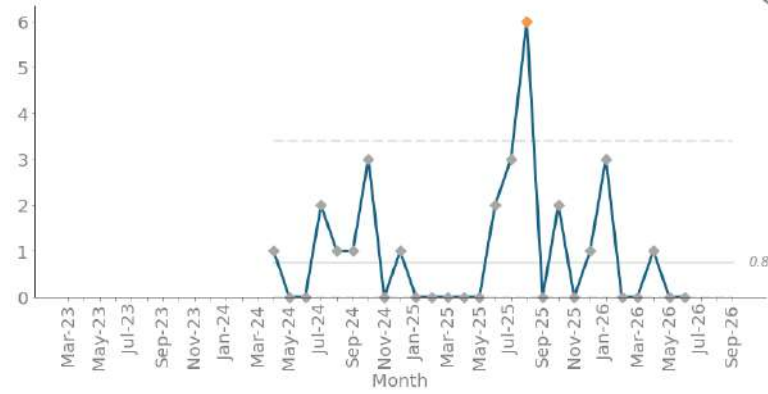
Metric	Summary	Actions	Assurance
Elective sections stood down	Performance relating to elective caesarean sections being stood down continues to be monitored through established operational and governance arrangements. The SPC chart demonstrates increased variation over the last four months, with February 2026, March 2026 and June 2026 showing higher than expected numbers when compared with historical performance. This variation reflects increasing caesarean section demand and the ongoing capacity pressures within maternity theatres and highlights the need to optimise elective theatre utilisation. A comprehensive capacity and demand review is currently underway to better understand activity levels, utilisation patterns and opportunities for improvement. In parallel, actions are being implemented to strengthen booking and scheduling processes, ensuring theatre allocation is aligned more effectively with case complexity and anticipated procedure duration. Further assurance is provided through the planned opening of a fourth theatre within the Sharoe Green Unit, which is expected to improve capacity, patient flow and overall operational resilience.	- Weekly multidisciplinary theatre scheduling meetings will continue to optimise elective caesarean section capacity, improve theatre utilisation and support a reduction in procedure stand downs. - A revised booking and scheduling approach is being implemented within antenatal clinic services to align theatre allocation more effectively with the complexity and anticipated duration of individual cases. - The OG4 mobilisation programme will continue to be progressed through fortnightly meetings to ensure operational, workforce and quality requirements are delivered in preparation for service expansion. - Final approval of the theatre floor plan signaling operational readiness. - A dedicated workforce plan is being developed alongside the mobilisation programme to ensure appropriate staffing arrangements are in place for the expanded service. - Mitigating actions will continue to be explored in relation to emerging staffing gaps within the surgery theatre team, recognising the potential impact on planned implementation timelines. - Progress towards opening the fourth theatre will continue to be monitored, with the anticipated go-live date currently expected in early November 2026	- Weekly multidisciplinary oversight provides assurance that theatre capacity, scheduling challenges and operational risks are reviewed and managed proactively. - Capacity and demand analysis is being undertaken to inform future planning and ensure theatre resources are utilised effectively. - The planned opening of a fourth theatre within the Sharoe Green Unit provides assurance that a longer-term solution is being implemented to improve capacity, resilience and operational flow.

Dashboard 5 – Graphs Normal variation and on/around target

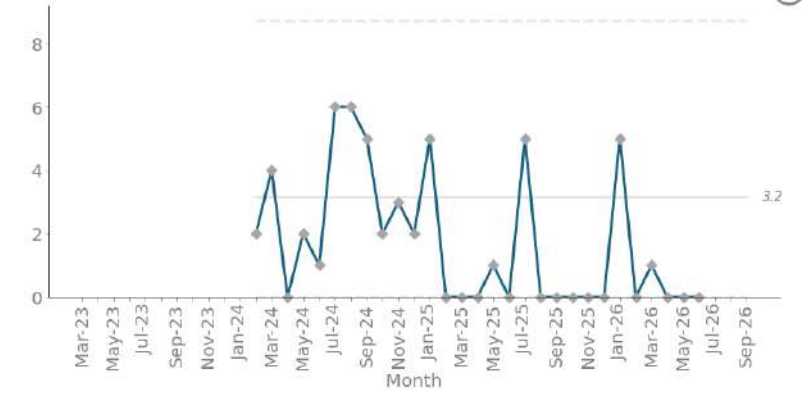
Maternity Diverts



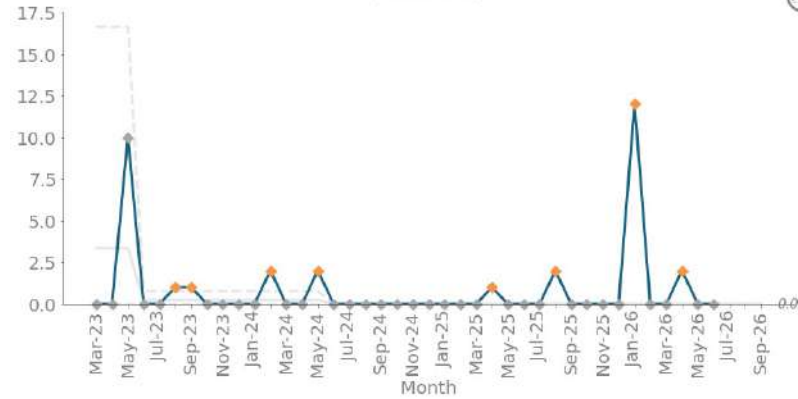
Number of times home birth service stood down



Women who transfer to an alternative provider during induction of labour



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



Delay in inductions



Maternity and Neonatal Improvement Support Team (MNIST) Diagnostic Review Lancashire Teaching Hospitals NHS Foundation Trust Terms of Reference

Background

Following discussions held between members of the Trust Executive Team and the Regional Chief Midwife it was agreed that a diagnostic visit be undertaken by the MNIST Team to review the maternity and neonatal services at Lancashire Teaching Hospitals.

Purpose

The purpose of the diagnostic visit is to provide an independent external review of maternity and neonatal services at Lancashire Teaching Hospitals NHS Foundation Trust ensuring a robust governance framework underpins the review

This review will be undertaken by National Maternity Improvement Advisors, Midwifery, Obstetric, and Neonatal together with a national Service User Representative and may include other national leads and colleagues.

The team will be on site from 27th July 2026 13.00 hrs to 30th July 2026 13.00 hrs, with high level feedback being provided at the end of the visit and a report thereafter.

Methodology

The team will gain as much intelligence by reviewing systems and processes around workforce, efficiency, safety, effectiveness, and experience. Governance processes and oversight together with culture will be explored throughout the review

Information will be gathered via both virtual and face to face meetings. This will be a combination of one-to-one meetings, with key members of the MDT and executive teams, focus groups with staff, attendance at scheduled meetings during the review period, reviewing requested documents and walk abouts within the clinical areas.

Team Members

The following will be part of the review team:

- Midwifery Maternity Improvement Advisors
- Obstetric Maternity Improvement Advisor
- Neonatal Improvement Advisors
- National Quality Improvement Lead
- National Service User Representative

Not all members of the team will be present throughout the visit; we will confirm in advance on what days which members of the team will be present. The Lead Improvement Advisor will be present throughout.

Format of the Visit

On 27th July at 13.00 hrs the visiting team will meet with the senior perinatal leadership team and executive body and will outline the diagnostic process. The Trust is asked to provide a short presentation about their perinatal service, the improvement journey to date inclusive of both successes and challenges, and any areas identified internally that would require additional support.

Documents

The visiting team will ask for some documents prior to the visit and when on site to support and triangulate findings.

External Stakeholders

The team will also meet with the MNSI, NHSR leads for the region and the Neonatal ODN.

Meetings / 1:1s

The team will request to meet with the following members of staff during the time that they are on site, however, it is appreciated that not all members of staff will be available during this time and where it is not possible, virtual meetings may be scheduled following the review to ensure additional or missing information is gleaned. Focus groups will also be requested with staff and invites to scheduled meetings as appropriate. A list of meetings and 1:1's, will need to be coordinated by the Trust as follows:

1:1s –

- Director of Midwifery
- Clinical Director (Obstetrics)
- Clinical Director (Neonates)
- Divisional Director of Ops
- Chief Nurse
- Chief Executive
- Chief Medical Director
- General Manager
- Clinical Lead (Obstetrics)
- Clinical Lead (Neonates)
- Head of Midwifery
- Head of Neonatal Nursing
- HR lead for Division
- Board Safety Champion and NED Safety Champion
- MNVP chair/s
- EDI Lead
- Consultant Midwife / Midwives
- Labour Ward Clinical Lead & Matron for Labour Ward

Focus Groups -

- Perinatal Leadership Team Meeting
- Anaesthetic Leads
- Consultant Body (Neonates)
- Consultant Body (Obstetrics)
- Resident Doctors (Obstetrics)
- Resident Doctors (Neonates)
- Staff Focus Group – both hospital and community
- Student Midwives focus group
- Practice development Team
- Matrons (Neonates)
- Matrons (Maternity)
- Ward Managers

- Governance Lead Midwife and Team to include Obstetric Lead for Governance
- Neonatal Governance Resource (medical & nursing)
- AHPs (neonates)
- Specialist Midwives
- Bereavement lead / team
- FTSU guardian
- Safeguarding Lead Midwife
- Screening lead
- PMA's
- Quality Improvement team

Meetings -

Meetings and focus groups can run concurrently as the team will be allocated accordingly, with an ask that comfort breaks and lunch breaks are factored into the schedule. If the Trust can also provide a list of the departmental meetings whilst on site, these will also be attended where able.

Escalation

Any significant or immediate safety concerns identified whilst on site will be escalated to the Director of Midwifery / Chief Nurse / Clinical Director should they arise throughout the period of the review. Contact details of a lead point of contact for the Diagnostic Review will be shared ahead of the scheduled visits and will be revisited at point of arrival.

Administration

Administration support will be provided by the Trust to develop the daily agenda prior to the visit and throughout the review period. The schedule must be received by the Lead Maternity Improvement Advisor at least one week before the visit.

ID / security badges will need to be provided to the team at the start of the visit and will be handed back at the end.

Feedback

High level feedback will be provided in the form of a presentation at the end of the visit on 30th July 2026 at 12.00pm, we request the meeting to be set up by the Trust with invitation to the regional team.

Reporting

A completed diagnostic report will be provided within 4 weeks of the review.

Evaluation

The Trust will be requested to complete an evaluation form following the diagnostic review and following the completion of the report.

Follow Up Meeting

A follow up meeting will be held with the Lead Maternity Improvement Advisor and the Director of Midwifery and Clinical Director to review the report for factual accuracy.

Team Requirements for the Visit

- A room that the team can base themselves in throughout the time they are on site.
- ID badges with relevant access to maternity and neonatal services.
- Programme of meetings / focus groups scheduled by Trust
- Teams channel for shared documents.
- Refreshments where possible.
- Car parking allocated for team that will be driving

DRAFT



Patient



Performance



People



Productivity



Partnerships

Maintaining and continually improving Maternity and Neonatal safety remains our highest priority

Dear Colleagues

As part of our commitment to delivering safe, compassionate and high-quality care for women, babies and families, we have invited the NHS England Maternity and Neonatal Improvement Support Team (MNIST) to undertake an external review of our services.

The review will take place from **27 July 2026** and will run for **four days**.

The review team will provide an independent perspective on our services, helping us identify strengths, recognise good practice, and highlight opportunities to further enhance the care we provide.

The review forms part of wider work taking place to understand and respond to concerns that have been raised relating to culture, governance and professional relationships within the service. We recognise that positive working relationships, a strong culture and effective governance are fundamental to maternity and neonatal safety, and we are committed to ensuring that any issues are understood and addressed appropriately.

During the review, colleagues will be invited to participate in interviews, meetings or discussions with the review team present in the clinical area. We encourage colleagues to engage openly and honestly, as staff experiences and perspectives are an important part of the review process.

We appreciate that external reviews can sometimes create uncertainty. We want to reassure colleagues that this review has been proactively commissioned by us to support learning, improvement and the continued development of our services. Our focus remains on providing the best possible care for women, babies and families.

At the same time, we want to recognise that there are truly amazing things happening every day across our maternity and neonatal services, and the review team want to hear about this. Colleagues consistently demonstrate compassion, professionalism, expertise and dedication in the care they provide every day. We recognise how hard our teams work, often in challenging circumstances, and we want to be clear that this review does not diminish the enormous contribution that staff make each and every day.

We have the utmost respect for the commitment shown by our colleagues and remain confident in, and trusting of the work that you do as a team. The care, support and expertise you provide are valued, appreciated and fundamental to the success of our services.

We also want to reassure colleagues that speaking up remains an essential part of maintaining safe services. Creating an environment where concerns can be raised confidently and addressed appropriately is central to patient safety, continuous improvement and a positive workplace culture. Thank you for your continued professionalism, resilience and commitment to the women, babies and families who rely on our services.

If you feel you want to talk to anyone about this or are worried in anyway, please contact the divisional management team who will be happy to provide any further information. We hope this is a positive experience for the service.

We have attached some information from MNIST team for your information.

Kind regards



Sarah Morrison
Chief Nursing Officer



Steve Canty
Chief Medical Officer

Diagnostic Visit

**National Maternity and Neonatal Improvement Advisors from NHS England's Maternity and Neonatal Improvement Support Team will be visiting the Trust on
27th to 30th JULY 2026**

The team will be visiting all areas and there will be focus groups to enable staff to talk to the team and share successes and challenges.

If you would like to speak to the team separately, or feel you need longer with them please contact the lead for the diagnostic:

sarah.latham11@nhs.net

The aim of the visit is supportive to enable advice and solutions to be provided to the senior midwifery, obstetric, neonatal and executive teams along with the sharing and learning of good practice identified within other units.

We look forward to meeting you all



To share your feedback about how the diagnostic went after the visit takes place, please scan the QR code above.

Frequently Asked Questions (FAQ)

What is the Maternity and Neonatal Improvement Support Team (MatNeolST)?

The MatNeolST is a national team that provides bespoke and focused improvement support to maternity and neonatal services.

Is the diagnostic visit an inspection?

No, the aim of the visit is supportive, to enable advice and solutions to be provided to the senior midwifery, obstetric, neonatal and executive teams along with the sharing and learning of good practice identified within other units.

What if I'm not in work or I am unavailable when the Maternity and Neonatal Improvement Advisors are on site?

The MatNeolST want to meet as many staff as possible to help us understand the Trust's services. If you want to share your thoughts and experiences but are not in work or are unavailable whilst MIAs are on site, please contact the lead for the visit to speak to the team separately.

When will we receive feedback from the diagnostic visit?

The MatNeolST will provide high-level feedback to the Perinatal Leadership Team and Executive Team at the end of the visit. A comprehensive diagnostic report will be shared with the Perinatal Leadership Team and Executive Team within 2 – 4 weeks.

10.3 BOARD ASSURANCE STATEMENT: NOTTINGHAM MATERNITY REVIEW; RESPONSE TO THE FULLER INQUIRY; AND HUMAN TISSUE AUTHORITY REPORT

● Decision Item

REFERENCES

Only PDFs are attached

-  10.3 Board Assurance Statement Nottingham Maternity Review; Response to the Fuller Inquiry; and Human Tissue Authori.pdf

Meeting of the	Board of Directors	6 August 2026	
	Part 1 x	Part 2	
Title of Report	Mortuary Oversight, Care After Death and Response to NHS England Board Assurance Statement		
Report Author	Hajara Ugradar, Associate Director of Risk, Assurance & Corporate Affairs Emma Denfhy, Deputy Associate Director of Risk & Assurance		
Lead Executive Director	Steve Canty, Chief Medical Officer and HTA Corporate Licence Holder		
Recommendation/ Actions required	The Board of Directors are asked to: I. Review the Trust's response to the NHS England Mortuary Oversight Letter and associated Board Assurance Statement requirements. II. Consider the current position against the NHS-relevant recommendations arising from the Fuller Inquiry. III. Endorse the proposed action plan to address any identified gaps and strengthen Board assurance arrangements relating to care after death. IV. Approve the submission of the Board Assurance Statement Noting the report and content have been scrutinised by the Safety and Quality Committee.		
	Decision ☒	Assurance ☐	Information ☐

1. Background

- 1.1 On 26 June 2026 NHS England wrote to all NHS provider trusts requesting renewed assurance relating to mortuary oversight, care after death, safeguarding arrangements and implementation of recommendations arising from the Fuller Inquiry.
- 1.2 The request was issued following the publication of Donna Ockenden's Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust on 24 June 2026, alongside the Human Tissue Authority's findings relating to Nottingham University Hospitals and the continuing implementation of recommendations arising from the Fuller Inquiry. The letter asks Trust Boards to formally review and confirm local oversight arrangements for the dignity, security and safeguarding of deceased people, rather than introducing a new standalone requirement.
- 1.3 The letter requires all NHS provider trusts that have a mortuary, related storage area for the deceased, or routinely care for people after death, to complete and return the Board Assurance Statement by 31 July 2026.

2. Discussion

Trust Response to the Fuller Inquiry

- 2.1 The Fuller Inquiry Phase 1 Report was published on 28 November 2023. The report was the first phase of the Independent Inquiry into the issues raised by the David Fuller case and focused specifically on

how Fuller was able to commit offences in the mortuaries of Maidstone and Tunbridge Wells NHS Trust without detection.

- 2.2 While the Fuller Inquiry Phase 1 made recommendations primarily for Maidstone and Tunbridge Wells NHS Trust and related local organisations, in 2024 the Trust undertook a detailed review of the recommendations and performed a gap analysis to identify any potential learning from the Inquiry.
- 2.3 The Phase 1 review concluded that the Trust met the recommendations applicable to Lancashire Teaching Hospitals NHS Foundation Trust and identified appropriate governance, security, access control, Human Tissue Authority (HTA) oversight, and internal and external reporting mechanisms. Assurances were reported to the Safety & Quality Committee and are provided at Appendix 3.
- 2.4 The Fuller Inquiry Phase 2 Report, which was the final report of the Independent Inquiry into the issues raised by the David Fuller case, was published on 15 July 2025 by the Department of Health and Social Care.
- 2.5 The report considered whether procedures and practices across hospitals and other settings adequately safeguard the security and dignity of deceased people, and it made 75 recommendations, including 29 recommendations that are immediately relevant to the NHS.
- 2.6 Following publication of the Phase 2 Report, the Trust commissioned Marlowe Fire & Security Specialists to undertake a specialist strategic review of the systems in place to protect deceased people in January 2026. The findings have informed the Fuller Inquiry Phase 2 action plan and associated consideration of mortuary security enhancements.
- 2.7 Marlowe Fire & Security has submitted a proposal to provide a comprehensive security upgrade for the mortuary at Royal Preston Hospital. The proposal includes new CCTV (Closed Circuit Television) coverage, enhanced access control systems, audio/video intercoms, personnel tracking functionality and installation of a safety fence. The solution is intended to improve security, staff safety, access management and operational oversight. The requirement for the mortuary security upgrade has been approved by the Chair of the Capital Planning Forum and the Deputy Chief Financial Officer. The ordering process has been progressed, and confirmation of the priority installation date is awaited.
- 2.8 In response to the Fuller Inquiry Phase 2 Report recommendations, a detailed action plan was developed. The action plan contains 29 individual actions derived from 21 NHS-relevant recommendations. Of these, three recommendations have been stood down as they relate to national actions rather than Trust actions.
- 2.9 At the end of June 2026, 62% of actions within the Fuller Inquiry Phase 2 action plan had been marked as completed, 31% were ongoing and remain on track to deliver within trajectory, and 7% had been pending pending the release of national updates. The remaining actions are focused on strengthening existing arrangements, including implementation of approved security enhancements and completion of actions dependent on national guidance. The action plan is provided in Appendix 4 for oversight by the Committee and is set for completion by the end of December 2026.

Human Tissue Authority (HTA) Inspections

- 2.10 Royal Preston Hospital has been licensed by the Human Tissue Authority (HTA) since 2007. The most recent HTA inspection was performed in September 2025 and was the fourth inspection of the establishment.

- 2.11 During the 2025 inspection, all 72 HTA licensing standards were assessed. The inspection included a review of the establishment's governance documentation relating to licensed activities. This included policies and procedural documents relating to licensed activities, cleaning records for the mortuary, equipment servicing records, audits, risk assessments, meeting minutes, reported incidents, and training records for mortuary staff, porters and consent seekers.
- 2.12 The inspection included a visual assessment of the establishment, including the post-mortem (PM) room, body storage areas, Computerised Tomography (CT) scanning area and viewing room. The inspection team observed the processes for admission and release of bodies within the mortuary.
- 2.13 Audits were conducted onsite of five bodies from refrigerated storage and one body in long-term storage. Identification details on bodies were cross-checked against the information recorded in the register, associated paperwork and electronic records. Audits of traceability were also conducted for tissue blocks and slides from six PM cases, including audits of the consent documentation for the retention of these tissues.
- 2.14 HTA also interviewed staff as part of the inspection process. Discussions were held with staff including the Designated Individual (DI), Senior Anatomical Pathology Technologist (APT), APT, Pathologist, porters, staff in the histology department and consent seekers for PM examinations.
- 2.15 A paper was presented to the Committee at the end of January 2026 summarising the inspection findings and the actions to be taken by the Trust in response to the inspection. No findings related to the care of the deceased.
- 2.16 At the end of June 2026, good progress had been made with the action plan, with 90% of actions closed by HTA following the provision of supporting evidence. The remaining actions relate to the procurement and installation of equipment within the Mortuary and are due to be delivered in September 2026. Updates on progress with completion of the action plan are provided to the Committee quarterly through the Regulatory Update Report.

Trust Response to the Nottingham Maternity Review Findings on Post-Death Care and Key Actions Required Following the Fuller Inquiry.

- 2.17 The current NHS England Board Assurance Statement requires Trusts to review their local position and assure themselves that all deceased people cared for in NHS settings are treated with respect, dignity, security and compassion.
- 2.18 Boards are required to confirm that roles and responsibilities across teams involved in post-death care, including estates, safeguarding, pathology, bereavement, mortuary and corporate services, are clearly defined, understood and regularly tested. In addition, Executive Leadership arrangements must be reviewed to ensure there is appropriate oversight of safeguarding responsibilities relating to people after death.
- 2.19 A structure chart for the Mortuary Team and key roles and responsibilities is provided at Appendix 5. This sets out the key people, roles and reporting lines involved in the oversight and delivery of mortuary services, associated body storage areas and care after death, including operational, professional and executive accountability arrangements.

- 2.20 In response to the NHS England correspondence, assurance activities have commenced. A review of the Fuller Inquiry Phase 2 action plan has been performed, and all ongoing actions remain on track to deliver within trajectory. Progress with the action plan demonstrates that there is a robust framework of physical and electronic security controls, supported by routine monitoring and audit activity within the Mortuary environment. Appropriate leadership arrangements are established, with clearly identified operational and executive accountability. Clear accountability and escalation processes are also in place. The ongoing actions are largely enhancements to existing arrangements rather than fundamental control gaps.
- 2.21 The Trust has established governance arrangements to ensure effective oversight of the Mortuary, associated storage areas and all locations where deceased individuals are cared for. The Trust's Deceased Operations Group, chaired by the HTA Designated Individual, provides operational oversight. This group reports to the End-of-Life Care Group, chaired by the Deputy Chief Medical Officer, which in turn reports to the Committee.
- 2.22 The Freedom to Speak Up Guardian met with the Mortuary Manager on 10 July 2026 and delivered a Freedom to Speak Up awareness session to the Mortuary team on 14 July 2026. This was intended to strengthen staff awareness of speaking up arrangements and support colleagues to feel confident in raising concerns where appropriate.
- 2.23 Executive oversight of arrangements relating to deceased patients, including safeguarding responsibilities after death, is established within the Trust's governance framework. The Chief Medical Officer was formally appointed as the HTA Corporate Licence Holder on 29 September 2025. Executive accountability for end-of-life care, HTA compliance, safeguarding, estates and security is clearly defined within the Trust's Listed Regulatory Roles document, which is reviewed and updated annually.
- 2.24 The Chief Nursing Officer visited the Mortuary on 8 July 2026 and the Histopathology service on 20 July 2026. The visits were supported by the Deputy Midwifery and Nursing Director, the Divisional Nursing Director for the Division of Diagnostics and Clinical Support Services (DCS), and the Associate Director for Risk, Assurance and Corporate Affairs. The visits provided positive assurance regarding the professionalism, commitment and operational oversight of teams involved in care after death. Staff were engaged, knowledgeable and able to describe the controls in place to support safe, dignified and compliant practice. No significant concerns were identified. Further Mortuary visits are planned by the Chief Medical Officer as the HTA Corporate Licence Holder in August 2026 and will include participation from the Maternity Non-Executive Director Safety Champion/Freedom to Speak Up Non-Executive Director.
- 2.25 In parallel, NHS England Recovery Support Programme (RSP) colleagues continue to work in partnership with the organisation to provide independent challenge, support and assurance. Throughout July 2026, NHS England Recovery Support colleagues have undertaken a series of focused reviews, including Neonatal Intensive Care, Maternity Services and End-of-Life Care Services, and a Mortuary visit is planned. The reviews are intended to provide an additional source of external assurance and support the identification of opportunities for further improvement. Feedback received to date has been reassuring and positive, with no concerns identified regarding quality of care, patient safety, regulatory compliance or security arrangements.
- 2.26 In addition, the Trust Quality Assurance Team has been commissioned to develop a Safety Triangulation Accreditation Review (STAR) audit framework for mortuary services to ensure quality standards are regularly tested and assured. The framework will be informed by the findings of the

Fuller Inquiry, HTA regulatory requirements and recommendations arising from the Nottingham and Ockenden reviews.

2.27 An action plan has been developed summarising the requirements set out in Annex 1 of the NHS England letter. The overarching action plan is provided in Appendix 6. Outstanding actions include confirmation from Estates and Facilities regarding compliance with the NHS Premises Assurance Model (PAM) and Health Building Note (HBN) 16-01 standards. Agreed delivery timelines are in place for all estates-related actions, and the Board will be asked to review and approve the PAM submission prior to the national submission deadline of 8 September 2026. Five actions remain pending publication of further national guidance. Progress against the Annex 1 action plan will be reported to the Committee through the quarterly Regulatory Update Report.

2.28 Going forward an annual report will also be presented to the Safety and Quality Committee and Board of Directors in relation to mortuaries and body stores in line with the Phase 2 Fuller Recommendations.

3. Financial implications

3.1 The requirement for the mortuary security upgrade, including enhancements to CCTV, access control and site safety arrangements, has been approved by the Chair of the Capital Planning Forum and the Deputy Chief Financial Officer. The ordering process has been progressed, and confirmation of the priority installation date is awaited. The associated costs are being managed through the Trust's established estates and capital governance processes.

4. Legal implications

4.1 The Trust must provide a completed Board Assurance Statement to NHS England by 31 July 2026. Failure to demonstrate appropriate oversight and compliance with applicable national requirements could result in external scrutiny or regulatory challenge.

5. Risks

5.1 Failure to maintain effective oversight of mortuary services, body storage areas and care after death could result in reputational damage, regulatory scrutiny, Human Tissue Authority concerns, impacts on patient, family and public confidence, and failure to comply with national expectations regarding dignity and care of the deceased. Mitigating actions include completion of the Board Assurance Statement, implementation of the action plan, continued executive oversight and ongoing assurance reporting.

6. Impact on stakeholders

6.1 The paper impacts bereaved families, mortuary services, pathology services, Estates and Facilities, safeguarding teams, clinical services, Trust Board members, the Human Tissue Authority and NHS England. Communication will be undertaken through existing governance arrangements and relevant operational groups. Actions arising from the review will be communicated to relevant service leads and incorporated into governance reporting structures.

7. Recommendations

The Board of Directors are asked to:

- I. Review the Trust's response to the NHS England Mortuary Oversight Letter and associated Board Assurance Statement requirements.
- II. Consider the current position against the NHS-relevant recommendations arising from the Fuller Inquiry.
- III. Endorse the proposed action plan to address any identified gaps and strengthen Board assurance arrangements relating to care after death.
- IV. Approve the submission of the Board Assurance Statement

Noting the report and content have been scrutinised by the Safety and Quality Committee.

To: NHS trusts and integrated care boards:

- chief executives
- chief operating officers
- chief nursing officers
- chairs
- medical directors
- clinical directors
- estates and facilities leads

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

26 June 2026

cc. NHSE regional teams:

- regional directors
- chief nursing officers
- medical directors
- estates and facilities leads
- communications leads

Dear colleagues,

Nottingham maternity review findings on post-death care and key actions required following the Fuller inquiry

The NHS holds a special responsibility for the care of patients from birth, throughout their lives and in death. At every stage, we must deliver care with dignity, respect and compassion.

When dignity after death is not preserved, the NHS betrays the trust that is placed in it and not only fails those that have died, but also their loved ones, adding to their grief and harm. As leaders, we must ensure this never happens by putting in place the right support and oversight, so that all staff working in the NHS consistently uphold dignity and care.

The further instances of unacceptable care of the deceased, amongst the many distressing findings of Donna Ockenden's [Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust \(NUH\)](#), are shocking. We must

remember that this is not the first time that unacceptable care and poor oversight of mortuaries have been uncovered, and there is already a clear set of actions to strengthen and improve this area of care. The findings of Donna Ockenden's report should be considered alongside the Phase 2 report of the independent inquiry into the heinous crimes of David Fuller, [published in July 2025](#). The report made 75 recommendations to strengthen the protection, security and dignity of people after death, including 29 that are immediately relevant to the NHS.

In response to Donna Ockenden's review and the Human Tissue Authority's (HTA) recent report on NUH, the Government has announced that the HTA is taking immediate action with a new requirement for mortuaries to review HTA reportable incident (HTARI) internal records from 2015-2026. This audit will ensure that all reportable incidents during this period have been logged with the HTA, and that any missing incidents are reported retrospectively. A Regulatory update will be issued by the HTA in July setting out the parameters, timeframe, process and deadlines for the evidential compliance audit. The HTA will report findings to the Secretary of State in October.

We know that the NHS has been working hard to meet the recommendations following the independent inquiry into the actions of David Fuller. However, in light of these further terrible findings, we are asking you not only to ensure compliance, but that you are rigorously reviewing your mortuary departments on a regular basis. To do this, ask yourselves the question 'what do you really know about the culture of your services, and the values and behaviours of your staff?'.

No system or process can totally mitigate malign or malicious intent. However, every Board member and senior leader involved in the care of the deceased should read these reports and ask themselves if this could be happening in their organisation. They should explore this by visiting services, listening to staff, encouraging concerns to be raised and acted on, and asking themselves whether the care provided would be good enough for their own loved ones. Boards are responsible for maintaining clear oversight of mortuaries, related storage areas and any other areas where people who have died are cared for, and for ensuring dignity, security and post-death care are central to local planning, governance and delivery.

To support this oversight, **Annex 1** summarises the guidance and support NHS boards should consider, and **Annex 2** maps the NHS-focused Fuller Inquiry recommendations to this guidance.

Trusts are asked to cascade this letter to relevant teams, including estates, safeguarding, pathology, bereavement, mortuary, corporate services, and your Freedom to Speak Up Guardians. Issues requiring support or escalation should be raised through regional teams.

Every Board should continue to review its local position and assure itself that all deceased people cared for in NHS settings are treated with the respect, dignity, security and compassion they deserve. This goes beyond compliance; it is fundamental to compassionate care.

On the basis that all NHS providers may be involved in caring for people after they die, we need assurance that each Board has robustly tested its position. **All NHS Provider Trusts that have a mortuary, related storage area for the deceased, or routinely care for people after death, are asked to complete and return the Board Assurance Statement provided at Annex 3 by 31 July 2026.**

For NHS trust chief executives, medical directors and chief nurses, there will be a chance to discuss this and broader issues in maternity and neonatal care when we come together in London on Tuesday 30 June.

Thank you for all you have already done in response to the Fuller recommendations to date. However, there is still more work to do. We owe it to those who have died, and to their families and loved ones to ensure the findings of the Donna Ockenden review, the HTA report on NUH, and the Fuller Inquiry recommendations lead to meaningful and lasting change.

Yours sincerely,



Duncan Burton

Chief Nursing Officer for England



Sarah-Jane Marsh

NHS England Chief Operating Officer

Annex 1 - Summary of national updates made or planned in response to the Fuller Inquiry

1. NHS Premises Assurance Model (PAM) (15 April 2026)

[The NHS Premises Assurance Model \(PAM\)](#) supports boards, directors of finance and estates and clinical leaders to make more informed decisions about the development of their estates and facilities services and provides assurances that the estate is safe, efficient, effective and of high quality. The NHS Standard Contract requires providers to comply with the PAM. A new set of high-level self-assessment questions reflecting relevant recommendations made by the Fuller Inquiry has now been incorporated into the latest version of the PAM. The submission window for the NHS runs from 8 May 2026 to 8 September 2026.

For assurance by trust boards: Trusts should assure themselves against the latest version of the PAM self-assessment questions.

2. Health Building Note 16-01: Facilities for mortuaries, including body stores and post-mortem services (May 2023)

Health building notes (HBNs) give best practice guidance on the design and planning of new healthcare buildings and on the adaptation or extension of existing facilities. [Health Building Note 16-01: Facilities for mortuaries, including body stores and post-mortem services](#) was updated in 2023, to enhance levels of security, access and CCTV, however we will be providing further update during 2026 to provide additional guidance to NHS trusts on recommendations raised by the Fuller Inquiry.

For assurance by trust boards: Trusts should consider best practice guidance set out in the HBN for ongoing planning.

3. Insightful provider board guide (November 2024)

Trusts are reminded that the [insightful provider board guide](#) is intended to help boards to identify the information they need and the cultures, behaviours and governance required to ensure that information is used effectively. This guidance already references mortuary practices but will be updated later in 2026 and will incorporate relevant content to reflect Fuller findings and recommendations. It should be read alongside the [Code of governance for NHS provider trusts](#) (March 2026) and [Guidance on good governance and collaboration](#) (April 2023).

For assurance by trust boards: Trust boards should use the guidance provided to reflect and consider whether the leadership, culture, systems and processes they have in place are using information in the best way to lead their organisations effectively in respect of matters relating to mortuaries and body stores.

4. Assessing provider capability: guidance for NHS Trust Boards (August 2025)

[Assessing provider capability: guidance for NHS trust boards](#) provides a self-assessment framework to strengthen boards' governance and assurance. These self-assessments are used by regional oversight teams along with their own views and information held by 3rd-party bodies (including the Human Tissue Authority) to take a view of management, governance and grip. This guidance is also due to be updated later in 2026.

For assurance by trust boards: As per [Insightful provider board guide](#) (see entry 3).

5. Advanced Foundation Trust Programme (12 November 2025)

For existing NHS foundation trusts and NHS trusts who wish to become advanced foundation trusts, the [Advanced Foundation Trust Programme](#) requires evidence that trusts applying for advanced foundation trust status have considered relevant insights and learning from inquiry recommendations and have implemented them or are in the process of implementing them (question 2, advanced foundation trust criteria – quality governance arrangements are effective in practice).

For assurance by trust boards: As per [Insightful provider board guide](#) (see entry 3).

6. NHS Safeguarding accountability and assurance framework (April 2026)

The [NHS Safeguarding Accountability and Assurance Framework](#) (SAAF) sets out the safeguarding roles and responsibilities of all individuals working in providers of NHS-funded care settings and NHS commissioning organisations. This includes requirements for an executive lead for safeguarding. In April 2026, the SAAF was updated to include reference to the deceased. Trusts should also note this addition will require a supporting reference to be made in the annual report about

safeguarding children, adults and children in care. This must be submitted to the trust board.

NHS England is also updating related training to include reference to the deceased. These updates will be made during 2026.

For assurance by trust boards: Providers must demonstrate that these updates to safeguarding are embedded at every level in their organisation, with effective governance processes evident. Providers must assure themselves, the regulators, and their commissioners that safeguarding arrangements are robust and are working.

In line with updates to the SAAF, executive leadership should now include oversight of arrangements for the deceased. Trust boards are encouraged to consider their local arrangements accordingly. Executive leadership for safeguarding, estates and related security matters may vary according to local arrangements (for example, operating via a dual accountability between the executive lead for statutory safeguarding and the executive lead for estates) and trust boards should ensure this is clearly articulated.

Local take-up of safeguarding training and resources requires ongoing assurance by trusts.

7. Related Third Party Guidance

HTA Guidance

The Human Tissue Authority (HTA) [Codes of Practice](#) provide practical guidance to professionals carrying out activities within the scope of the HTA's remit, which includes licensed mortuary facilities in the NHS estate. This includes detail on the required appointment of a Designated Individual. The Human Tissue Authority have additionally published [good practice guidance for those responsible for the dignity and care of the deceased](#). This is voluntary guidance and applicable to all settings, including unlicensed body stores.

Hospice UK Guidance

[Hospice UK](#) have several resources to support clinical and non-clinical staff in a hospice role. Their [Care After Death](#) guidance provides a comprehensive guide for all staff who are responsible for the care of a deceased adult.

Annex 2 – NHS specific Fuller Inquiry report recommendations and supporting guidance. Please refer to annex 1 for additional context on supporting guidance.

Recommendations 1 to 9 (relevant to security, CCTV, access and audit)

The full text of these recommendations can be found in the [Phase 2 Report](#) (pp.264-265).

Supporting guidance

NHS Premises Assurance Model (see entry 1 in Annex 1).

Health Building Note 16-01: Facilities for mortuaries, including body stores and post-mortem services (see entry 2 in Annex 1).

Other third-party guidance: Human Tissue Authority code of practice and Human Tissue Authority voluntary guidance (see entry 7 in Annex 1).

Recommendations 10, 11, and 12 (relevant to the role of the Designated Individual)

The full text of these recommendations can be found in the [Phase 2 Report](#) (p.265).

Supporting guidance

Third party guidance: Human Tissue Authority guidance, including the role of the Designated Individual (see entry 7 in Annex 1).

Recommendations 13 and 14 (relevant to the role of the Mortuary Manager)

The full text of these recommendations can be found in the [Phase 2 Report](#) (pp.265-266).

Supporting guidance

Local HR policies and resource allocations.

Recommendations 15, 16, 17 and 18 (relevant to the board assurance and reporting)

The full text of these recommendations can be found in the [Phase 2 Report](#) (pp.265-266).

Supporting guidance

The Insightful provider board guide (see entry 3 in Annex 1).

Assessing provider capability: guidance for NHS trust boards and third-party information (see entry 4 in Annex 1).

Advanced Foundation Trust Programme (see entry 5 in Annex 1).

Recommendations 19, 20 and 21 (relevant to safeguarding)

The full text of these recommendations can be found in the [Phase 2 Report](#) (pp.266-267).

Supporting guidance

NHS Safeguarding Accountability and Assurance Framework (see entry 6 in Annex 1).

Recommendations 24 and 25 (relevant to medical education settings)

The full text of these recommendations can be found in the [Phase 2 Report](#) (pp.267-268).

Supporting guidance

Where relevant to the NHS, these actions have been reflected in the NHS Premises Assurance Model (see entry 1 in Annex 1)

Recommendation 27 (relevant to hospice settings)

The full text of this recommendation can be found in the [Phase 2 Report](#) (p.268).

Supporting guidance

NHS trusts directly providing a hospice service that includes provision for either a mortuary or body store should be aware of wider updates, as set out in **annex 1**. Other related third-party guidance has also been updated in line with inquiry findings: Hospice UK guidance (Care After Death) and Best practice guidance from the Human Tissue Authority (see entry 7 in Annex 1).

Recommendations 30 to 33 (relevant to ambulance policies and data)

The full text of these recommendations can be found in the [Phase 2 Report](#) (p.269).

Supporting guidance

The government's interim update sets out what action should be taken. A further update is expected in summer 2026.

In addition to the Government's interim update, ambulance trusts are individually responsible for introducing operational policies as described in the recommendation, and for ongoing monitoring of their use. Boards should assess compliance against these recommendations.

Annex 3 – Board Assurance Statement for NHS Provider Trusts. Please return this assurance statement to the NHS England Inquiry Team by **31 July 2026** to: england.nhsinquiryteam@nhs.net

Assurance statement	Confirmed (yes/no)	Additional comments or qualifications (optional)
The roles and responsibilities between the relevant teams responsible for mortuary care, including estates, safeguarding, pathology, bereavement, mortuary and corporate services, are clear, understood and are tested on a regular basis.	Yes	
The Board has undertaken a review of progress against the 29 recommendations immediately relevant to the NHS as made by the Fuller Inquiry. Where the Trust is not fully meeting a specific recommendation, a time-limited action plan is in place to close any gaps.	Yes	Fuller phase 2 action plan in place with ongoing monitoring arrangements defined and timebound.
In line with updates to the NHS Safeguarding Accountability and Assurance Framework, executive leadership has been reviewed with clear oversight of arrangements for the safeguarding of people after they die.	Yes	

Assurance statement	Confirmed (yes/no)	Additional comments or qualifications (optional)
The Board can assure itself the organisation has a plan in place to ensure the effective oversight of matters relating to mortuaries, related storage areas (or wider facilities) where the deceased are cared for, including the correct information and governance arrangements. If it cannot, it has identified the actions necessary to address this and a plan is in place to implement them as a matter of urgency.	Yes	Appropriate governance structures in place to ensure effective oversight of matters relating to mortuaries, related to storage areas where the deceased are cared for.
For all issues related to estates, there is an agreed timeline in place to undertake a self-assessment against the latest version of the NHS Premises Assurance Model and submit data within the current window (closing 8 September 2026), ensuring that your plan includes PAM sign-off from your Board prior to submission.	Yes	Nottingham and Fuller Inquiry Annex 1 letter action plan in place with ongoing monitoring arrangements defined and timebound.

Trust Name	Trust CEO/AO name	Date	Trust Chair name	Date
Lancashire Teaching Hospitals NHS Foundation Trust	Professor Silas Nicholls	31.07.2026	Professor Mike Thomas	31.07.2026



Board of Directors Report

Fuller Inquiry – Phase 1 Recommendations

Report to:	Board of Directors	Date:	6 June 2024
Report of:	Chief Medical Officer	Prepared by:	R Dineley
Part I	✓	Part II	

Purpose of Report

For assurance	☒	For decision	☐	For information	☐

Executive Summary:

David Fuller's dreadful crimes at Maidstone and Tunbridge Wells NHS Trust are deeply shocking and have had a significant impact on many people.

The purpose of this paper is to consider the recommendations from the Independent Inquiry into the issues raised by the David Fuller case and to provide assurance to the Board of Directors that the operational procedures of the mortuary and body stores at both Preston and Chorley Hospital sites comply with the Human Tissue Authority's (HTA) standards and guidance.

The Fuller Inquiry involves two phases. Phase 1 examined what happened at Maidstone and Tunbridge Wells NHS Trust with the subsequent report being published in November 2023 with 17 recommendations made specifically to Maidstone and Tunbridge Wells NHS Trust. However, the Trust have reflected on these to consider its current position against the recommendations, in the interest of learning and improvement.

Phase 2 of the inquiry is underway and will consider the broader national picture, to understand the procedures and practices across the country that are in place to protect the deceased person. The Trust will respond to any requests to support Phase 2 as needed.

In March 2023 the Trust were inspected by the HTA and the findings were reported to the Safety and Quality Committee in May 2023. All findings have since been closed by the HTA.

It is recommended that Board of Directors:

- I. Note the findings from Phase 1 of the Fuller Inquiry.
- II. Confirm they are assured of the processes in place to protect the safety and dignity of the deceased person.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims	Ambitions		
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒

To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☐	Great Place To Work	☐
To drive health innovation through world class education, teaching and research	☐	Deliver Value for Money	☐
		Fit For The Future	☐
Previous consideration			
Safety and Quality Committee – May 2024			

1. Background

- 1.1 David Fuller's dreadful crimes at Maidstone and Tunbridge Wells NHS Trust are deeply shocking and have had a significant impact on many people.
- 1.2 The Fuller Inquiry involves two phases. Phase 1 examined what happened at Maidstone and Tunbridge Wells NHS Trust with the [subsequent report being published in November 2023](#) with 17 recommendations made.
- 1.3 The purpose of this paper is to consider the recommendations from Phase 1 of the Independent Inquiry into the issues raised by the David Fuller case and to provide assurance to the Board of Directors that the operational procedures of the mortuary and body stores at both Preston and Chorley Hospital sites comply with the Human Tissue Authority's (HTA) standards and guidance.
- 1.4 The Human Tissue Authority's (HTA) regulatory remit is defined in the Human Tissue Act 2004. The HTA regulates the Post-Mortem sector.
- 1.5 The HTA is the regulator that sets licencing standards for mortuaries where post-mortem examinations are carried out, including those aspects of security relevant to their remit.
- 1.6 Establishments licensed in the Post-Mortem sector are required to notify the HTA of serious incidents and near-miss incidents that may affect the dignity of the deceased person, and damage public confidence. Incidents that are required to be reported to the HTA are termed 'HTA Reportable Incidents' (HTARIs).
- 1.7 In March 2023 the Trust was inspected by the HTA with all findings being subsequently closed and a report was provided to Safety & Quality Committee, a sub-committee of the Board of Directors, in May 2023.
- 1.8 Phase 2 of the inquiry is underway and will consider the broader national picture, to understand the procedures and practices across the country that are in place to protect the deceased person. The Trust will respond to any requests to support Phase 2 as needed.

2. Phase 1 Fuller Report Recommendations

- 2.1 In November 2023 the Phase 1 report from the Fuller inquiry was published and 17 recommendations were made specifically to Maidstone and Tunbridge Wells NHS Trust. However, the Trust have reflected on these to consider its current position against the recommendations, in the interest of learning and improvement.
- 2.2 A summary of the Trust's assessment of the position against the recommendations can be seen in Table 1.

Table 1 – Overview of the Trust's position against the recommendations from Phase 1 of the Fuller inquiry

Recommendations from Phase 1 of the Fuller Inquiry	Recommendations considered applicable solely to the Trust	Trust considers that it complies with recommendations in full	Trust considers that further work is required to meet the recommendations
17	16	16	0

- 2.3 Recommendation 12 relates to the Local Authority and the Trust are unable to comment on behalf of external partners. However, the Trust are supportive of the Local Authority undertaking any checks to

assure themselves of the safety and dignity of the deceased person, should this be required. The Trust are reviewing ancillary services, which may interact with a deceased person where contracts exist, as part of reflecting on this recommendation holistically.

- 2.4 A more detailed update on the Trust's position against the 17 recommendations from Phase 1 of the Fuller Inquiry Report is included in Table 2.

Table 2 – Detailed overview of the Trust's position against each of the recommendations from Phase 1 of the Fuller inquiry

Recommendation 1

Maidstone and Tunbridge Wells NHS Trust must ensure that non-mortuary staff and contractors, including maintenance staff employed by the Trust's external facilities management provider, are always accompanied by another staff member when they visit the mortuary. For example, maintenance staff should undertake tasks in the mortuary in pairs.

Assurance Statement

The Trust considers that it complies with this recommendation in full on the following basis:

- The Trust mortuary is accessible with a swipe card and digit lock code during working hours. Staff or other visitors without access must ring the doorbell to gain access to the mortuary. Out of hours a key and the alarm code are also required.
- Only anatomical pathology technicians (APTs), Porters, Security and bereavement team have swipe access to the mortuary and only these staffing groups can gain access out of hours.
- Porters require access out of hours, to transfer a deceased person from the wards to the mortuary and to accept a deceased person from the community who need to be transferred to the mortuary by funeral directors. When porters bring a deceased person from the wards they are in pairs. Porters are allocated jobs via an electronic system that the Trust use to allocate tasks called smart page. This has an audit trail and allows visibility of which porters are dealing with a task, such as transferring a deceased person to the mortuary.
- The Bereavement team require access out of hours to perform eye retrievals. They require a porter to remove the deceased person from the fridge and to cross check the identity. Porters will leave the bereavement nurse alone in the mortuary until the deceased person needs returning to the fridge. The bereavement team must sign in and out of the mortuary and this access will also be seen on the swipe card access system and the CCTV.
- Security may need to gain access to the mortuary in case of an emergency. However, these cases are rare and the on-call APT must be contacted to notify them and the APT will attend the site. Any access by Security can be identified by swipe card access and CCTV review.
- All non-mortuary staff that require access to the mortuary when the APTs are not in, must complete an e-learning training package. This is reviewed by the Designated Individual (DI) bi-annually to check compliance. Any staff who are not complying with this requirement will have their swipe access removed from the mortuary. The training package includes the use of trolleys, security, Human Tissue Authority (HTA), HTA reportable incidents (HTARis) and how to report and incident.
- All maintenance and external contractors that enter the mortuary are supervised by the APTs. They cannot access the mortuary in or out of hours without an APT, as they do not have swipe access or the codes for the digit locks, or the alarm.
- Compliance with swipe access is audited monthly against the CCTV. Currently 7 days are picked at random. However, from June 2024, daily auditing will be undertaken. Any variation from expected practice is reported as an incident via the trust datix system and escalated to the Divisional Safety and Quality Committee.
- The same applies to the mortuary at Chorley District Hospital (CDH). The only difference between the

sites is that CDH does not receive a deceased person from the community and that the Chorley mortuary is also accessed via swipe access and a key, which is kept in a key safe with a lock.

Recommendation 2

Maidstone and Tunbridge Wells NHS Trust must assure itself that all regulatory requirements and standards relating to the mortuary are met and that the practice of leaving deceased people out of mortuary fridges overnight, or while maintenance is undertaken, does not happen.

Assurance Statement

The Trust considers that it complies with this recommendation in full on the following basis:

- It is against the Trust's standard practice to leave a deceased person out of the fridge overnight or while maintenance is being undertaken and it has never been known or identified to have happened previously at the Trust.
- This practice is also against HTA standards, and the Trust consider that this is not respectful to a deceased person or their families and loved ones.
- A deceased person is only removed from fridges for certain reasons, e.g. for a viewing or a post mortem (PM) and this will happen just before the viewing, or the PM.
- The deceased person is returned to the fridge as soon as the viewing or PM is completed.
- CCTV monitors the fridge room, so it can be seen when a deceased person is removed and returned to the fridges.
- When the department is locked up every night the APTs will lock all PM rooms, so if there was an instance whereby someone was left out this would be seen at this time. Offices are locked and the viewing room is checked every night before the APTs leave.
- There is no PM room at Chorley and when a viewing has taken place, the deceased person is returned to the fridge as soon as the viewing has ended. CCTV captures all viewings.

Recommendation 3

Maidstone and Tunbridge Wells NHS Trust must assure itself that it is compliant with its own current policy on criminal record checks and re-checks for staff. The Trust should ensure that staff who are employed by its facilities management provider or other contractors are subject to the same requirements.

Assurance Statement

The Trust considers that it complies with this recommendation in full on the following basis:

- The Trust is compliant with its own current policy on criminal records checks.
- The level of Disclosure and Barring Service (DBS) checks undertaken for Trust staff has been determined using DBS guidance on role eligibility.
- All maintenance and external contractors that enter the mortuary are supervised by the APTs. They cannot access the mortuary in or out of hours without an APT, as they do not have swipe access or the codes for the digit locks, or the alarm.

It is noted that the Inquiry will consider the wider issue of the use and effectiveness of criminal record checks for employment that involves access to the deceased person in Phase 2 of its work.

Recommendation 4

Maidstone and Tunbridge Wells NHS Trust must assure itself that its Mortuary Managers are suitably qualified and have relevant anatomical pathology technologist experience. The Mortuary Manager should have a clear line of accountability within the Trust's management structure and must be adequately managed and supported.

Assurance Statement

The Trust considers that it complies with this recommendation in full on the following basis:

- The Mortuary Designated Individual (DI) is the Head Biomedical Scientist (BMS) who works in Cellular Pathology.
- The Senior APT is the Mortuary Manager (from herein referred to as the Mortuary Manager) who runs the mortuary day-to-day, and is a qualified member of staff with a certificate and diploma in Anatomical pathology, foundation degree (level 5) in mortuary science, Leadership management course (ILM3), appraisal training and adult post mortem consent training and other internal courses.
- The Senior APT has regular meetings with the DI for the HTA Post-Mortem sector.
- Both attend the departmental meeting and Deceased Operational Group meeting which reports into the Mortality End of life Committee (MEOL) which subsequently reports into Safety and Quality Committee, a sub-committee of the Board of Directors. Any incidents are reported on Datix and escalated through to Divisional Safety and Quality Committee which is a sub-Committee of the Divisional Board which reports into the Divisional Improvement Forum (DIF) meeting, which is Chaired by members of the Executive Team and this reports into Committees of the Board by exception, providing appropriate opportunities for escalation to the Board of Directors, if this was required.
- As well as the Designated Individual for the Mortuary, there are a number of Persons Designate who, although they do not have statutory duties, support compliance with HTA requirements. Persons Designate at the Trust include staff from the Mortuary, Gynaecology, Bereavement Team and Diagnostics Clinical Business manager.

Recommendation 5

The role of Mortuary Manager at Maidstone and Tunbridge Wells NHS Trust should be protected as a full-time dedicated role, in recognition of the fact that this is a complex regulated service, based across two sites, that requires the appropriate level of management attention.

Assurance Statement

The Trust considers that it complies with this recommendation in full on the following basis:

- The Mortuary Manager has a full-time dedicated role overseeing the mortuary on the Preston and Chorley sites.
- The Mortuary Manager has regular meetings with her line manager (who is also the Designated Individual with the Human Tissue Authority (HTA), providing appropriate routes to raise any issues or concerns.
- The Mortuary Manager is subject to the Trust's appraisal process.

Recommendation 6

Maidstone and Tunbridge Wells NHS Trust must review its policies to ensure that only those with appropriate and legitimate access can enter the mortuary.

Assurance Statement

The Trust considers that it complies with this recommendation in full on the following basis:

- The mortuaries at both sites are classed as restricted areas, the swipe access list to the mortuary is controlled by the mortuary staff, who review any requests for staff to be added and decide whether this is needed.
- The full swipe access list for both mortuaries is audited every three months by mortuary staff, and anyone that doesn't require access will be removed by either the mortuary or security staff
- Internal mortuary entrances on both sites can only be accessed by staff with swipe card access; at Preston this is also accompanied by a digi-lock and a key, that only appropriate staff have access to, at Chorley there is also a key required but no digi-lock.
- At Preston, any keys to the mortuary that are in circulation are controlled by mortuary, portering, bereavement and security staff.
- The allocation of the 9 mortuary keys at Preston is: 5 APTs keys, 1 Security key, 1 Bereavement staff key and 2 Porters keys.
- At Chorley, the key to access the fridge room is secured in a lock box with a code within the mortuary, which only appropriate staff have access to. Portering staff also have access to 1 key for the fridge room at Chorley.
- Any external entrances to the mortuaries, such as the Funeral Director's entrance are secured by a roller shutter door, which can only be operated from inside and is policed by mortuary staff and the porters to allow non-trust staff to enter.
- When the mortuary at Preston is closed, an alarm is set which covers all areas, and can only be set and silenced by staff with access to the code, this includes mortuary, portering, security and bereavement staff.
- The alarm is triggered upon entering the mortuary, and if not silenced, will send an alert to the switchboard to contact the security team to investigate the matter.
- Any sensitive areas within the mortuary that only require APT access (such as the offices) are also secured by separate keys when the mortuary is closing and being secured, which only mortuary staff have access to (5 keys for every staff member).
- The post-mortem room is locked from the inside when the mortuary is closed, and can only be accessed by APTs.
- Any staff in addition to those mentioned above, such as estates staff, external contractors, funeral directors or NHS Blood and Transplant (NHS BT) are constantly supervised when in the mortuary by mortuary staff or portering staff.
- All non-mortuary staff are required to complete an online e-learning course before being granted access to the mortuary, this covers HTA, HTA reportable incidents and how to report them, moving and handling in the mortuary, and wellbeing.
- All of these details described above can also be found within the Mortuary Security Standard Operating Procedure (SOP) (SP-620) internally.

Recommendation 7

Maidstone and Tunbridge Wells NHS Trust must audit implementation of any resulting new policy and must regularly monitor access to restricted areas, including the mortuary, by all staff and contractors.

Assurance Statement

The Trust considers that it complies with this recommendation in full on the following basis:

- Mortuary access is by swipe access and digit code lock during working hours at RPH and swipe access and key at CDH.
- The mortuaries at both sites are classed as restricted areas, the swipe access list to the mortuary is controlled by the mortuary staff, who review any requests for staff to be added and decide whether this is needed.
- Swipe access lists are reviewed quarterly ensuring only those requiring access are granted it and those who have left the Trust have been removed.

- Although some groups of staff have swipe access during working hours, access out of hours also requires a digit code, alarm code or key locker code, and access to these are restricted. For example, Pathologists have swipe access 9-5 Monday to Friday but have no access to keys or alarm codes, so can only access the mortuary when an APT is present.
- The Trust have CCTV which monitors access to the mortuaries and the body storage areas at both Preston and Chorley mortuaries which is regularly audited on a monthly basis by selecting 7 random days.
- From June 2024 a trial of daily auditing will be undertaken at Preston to ensure it is more robust. Similarly at Chorley, an audit will be conducted when staff visit on a Tuesday and a Thursday but the audit will be undertaken against CCTV for every day.
- When auditing the swipe access and CCTV are cross checked to review staff access for those days and the reasons behind doing so.

Recommendation 8

Maidstone and Tunbridge Wells NHS Trust should treat security as a corporate not a local departmental responsibility.

Assurance Statement

The Trust considers that it complies with this recommendation in full on the following basis:

- The Chief Medical Officer and Deputy Chief Nurse have visited the mortuary at Preston and reviewed security arrangements in place. There are also plans to do the same at Chorley.
- The mortuaries at both sites are classed as restricted areas, the swipe access list to the mortuary is controlled by the mortuary staff, who review any requests for staff to be added and decide whether this is needed.
- The mortuary staff are able to see the swipe access system to monitor staff entering and leaving the mortuary 24/7.
- The Trust supported the extension of CCTV at both Preston & Chorley mortuaries to enhance security.
- Some staff members are restricted to just during the day and others can be removed by the mortuary if they should not have access.
- Mortuary security incidents are escalated through the division of Diagnostic and Clinical Support Services, which has a reporting route through to Safety and Quality Committee, and ultimately, the Board of Directors. This includes the reporting and escalation of any Human Tissue Authority Reportable Incidents (HTARIs), as required.

Recommendation 9

Maidstone and Tunbridge Wells NHS Trust must install CCTV cameras in the mortuary, including the post-mortem room, to monitor the security of the deceased and safeguard their privacy and dignity.

Assurance Statement

The Trust considers that it complies with this recommendation in full on the following basis:

- CCTV is installed covering all access points to the Mortuaries and body stores at Preston and Chorley.
- There is no CCTV in the post mortem room at Preston. However, the doors to the post mortem (PM) room are covered by a camera. At Maidstone and Tunbridge Wells NHS Trust the setup was different in that the back of fridges containing a deceased person could be accessed from the PM room and were not covered by CCTV. This is not the case at Lancashire Teaching Hospitals as fridges cannot be accessed from the PM room, meaning any removal of a deceased person would be visible on CCTV in the process of moving to the PM room. The Trust considers this sufficient so as to not

impact on the privacy and dignity of a deceased person during a post mortem.

- There is no post mortem room at Chorley and all areas are covered by CCTV.
- There is usually always at least 1 APT and 1 pathologist present in the PM room during a post mortem, unless it is an out of hours home office post mortem where the pathologist has finished the post mortem and left the lone APT to finish reconstructing and cleaning.
- There are 8 CCTV cameras at Preston and 5 cameras at Chorley.
- The retention period for CCTV images at Preston is 5 months but is only 30 days at Chorley. This still allows sufficient time to complete the audits as they are carried out monthly. This is due to change to an audit of activity on every day across both sites, as indicated in recommendation 7.

Recommendation 10

Maidstone and Tunbridge Wells NHS Trust must ensure that footage from the CCTV is reviewed on a regular basis by appropriately trained staff and examined in conjunction with swipe card data to identify trends that might be of concern.

Assurance Statement

The Trust considers that it complies with this recommendation in full on the following basis:

- An audit of CCTV is examined in conjunction with the swipe access on a regular basis and recorded on the Trust's quality management system.
- From June 2024 the mortuary will undertake a trial to change this to a daily audit so every day will be checked.
- Swipe access lists are reviewed quarterly ensuring only those requiring access are granted it and those who have left the Trust have been removed.
- Any CCTV incidents are raised at the Divisional Safety and Quality meeting, which can escalate through the Trust's governance structure to the Board of Directors if required, as referred to in the response to recommendation 4.

Recommendation 11

Maidstone and Tunbridge Wells NHS Trust must proactively share Human Tissue Authority reports with organisations that rely on Human Tissue Authority licensing for assurance of the service provided by the mortuary.

Assurance Statement

The Trust considers that it complies with this recommendation in full on the following basis:

- The Trust considers Human Tissue Authority (HTA) inspection reports at the Trust's Safety & Quality Committee, a sub-committee of the Board of Directors. Representatives from the Integrated Care Board (ICB) are invited to, and attend the Safety and Quality Committee, and also receive the papers, which includes the outcomes of any inspections that occur.
- The Trust has a Quality Review Meeting (QRM) with the ICB where quality is routinely monitored, and any issues, including the outcome of inspections are discussed as required.
- The Local Authority attend the Trust's Deceased Operational Group meeting where HTA inspection outcomes are discussed and can request further information as needed.
- As with any inspection, the Trust's HTA inspection reports can be accessed on the HTA website should external partners wish to access this at any time.

It is noted that the Inquiry will consider the current legislation and system of regulation and oversight of mortuaries, the legislation in relation to safeguarding with regard to the deceased, and the responsibilities of the various regulators charged with ensuring the security and dignity of the deceased in more detail in Phase 2 of its work.

Recommendation 12

Kent County Council and East Sussex County Council should examine their contractual arrangements with Maidstone and Tunbridge Wells NHS Trust to ensure that they are effective in protecting the safety and dignity of the deceased.

Assurance Statement

The Trust are unable to comment on behalf of external partners. However, the Trust are supportive of the Local Authority undertaking any checks to assure themselves of the safety and dignity of the deceased person, should this be required. To note:

- The Trust has a Service Level Agreement (SLA) with Lancashire County Council (LCC) and the coroner, and representatives of both attend both the Deceased Operational Group and the Post Mortem Computerised Tomography (PMCT) meetings to gain assurance that the trust is effective in protecting the safety and dignity of the deceased person.
- The PMCT meeting reports to the Deceased Operational Group meeting and in turn reports to Mortality and End of Life Care Committee, which reports into Safety and Quality Committee, a sub-committee of the Board of Directors, therefore any issues raised can be escalated.
- The Trust are reviewing ancillary services, which may interact with a deceased person where contracts exist, as part of reflecting on this recommendation holistically.

It is noted that the Inquiry intends to consider the role and responsibilities of local authorities in respect of the provision of mortuary services in Phase 2 of its work.

Recommendation 13

We have illustrated throughout this Report how Maidstone and Tunbridge Wells NHS Trust relied on reassurance rather than assurance in monitoring its processes. The Board must review its governance structures and function in light of this.

Assurance Statement

The Trust considers that it complies with this recommendation in full on the following basis:

- Governance in relation to the mortuary is escalated through the division of Diagnostic and Clinical Support Services, which has a reporting route through to Safety and Quality Committee, and ultimately, the Board of Directors. This includes the reporting and escalation of any Human Tissue Authority Reportable Incidents (HTARIs), as required.
- The Trust has a Deceased Operational Group in place, which is chaired by the Designated Individual. This reports to the Mortality and End of Life Care Committee, chaired by a Deputy Chief Medical Officer, which in turn reports to the Safety and Quality Committee, which is a sub-committee of, and reports to the Board of Directors.
- The Trust had a HTA inspection in March 2023. The outcome and corrective and preventative actions were reported to the Safety and Quality Committee on behalf of the Board of Directors, in sufficient detail and supported the Designated Individual to ensure the requirements of the HTA were met.
- As part of the Annual reporting cycle for Safety and Quality Committee, there is an Annual Pathology Report provided, which includes Mortuary updates as required.

Recommendation 14

Maidstone and Tunbridge Wells NHS Trust Board must have greater oversight of licensed activity in the mortuary. It must ensure that the Designated Individual is actively involved in reporting to the Board and is supported in this.

Assurance Statement

The Trust considers that it complies with this recommendation in full on the following basis:

- HTA inspection outcomes and any corrective and preventative actions are reported to the Safety and Quality Committee, a sub-committee of the Board of Directors.
- As part of the Annual reporting cycle for Safety and Quality Committee, there is an Annual Pathology Report provided, which includes Mortuary updates as required.
- The Trust's HTA Designated Individual (DI) has several routes available to report to the Board of Directors:
 - Via normal line management arrangements within the Division of Diagnostic and Clinical Support Services (DCS).
 - The Trust has a Deceased Operational Group in place, which is chaired by the DI. This reports to the Mortality and End of Life Care Group, chaired by a Deputy Chief Medical Officer, which in turn reports to the Safety and Quality Committee, which reports to the Board of Directors.
 - The Mortuary is part of the division of Diagnostic and Clinical Support Services, which has a reporting route through to Safety and Quality Committee, and ultimately, the Board of Directors. This includes the reporting and escalation of any Human Tissue Authority Reportable Incidents (HTARIs), as required.
 - The DI has direct access to the Trust's Chief Medical Officer, who is a member of the Board of Directors, and they can escalate any matters as required.

Recommendation 15

Maidstone and Tunbridge Wells NHS Trust should treat compliance with Human Tissue Authority standards as a statutory responsibility for the Trust, notwithstanding the fact that the formal responsibility under the Human Tissue Act 2004 rests with the Designated Individual. The Act will be subject to review in Phase 2 of the Inquiry's work.

Assurance Statement

The Trust considers that it complies with this recommendation in full on the following basis:

- HTA inspections, outcomes and any corrective and preventative actions are overseen at a Corporate and Divisional level, and reported to the Safety and Quality Committee, a sub-committee of the Board of Directors.
- As part of the Annual reporting cycle for Safety and Quality Committee, there is an Annual Pathology Report provided, which includes Mortuary updates as required.
- The DI has direct access to the Trust's Chief Medical Officer, who is a member of the Board of Directors, and they can escalate any matters as required.
- Support is available to the Designated Individual to meet the HTA standards, as required.

Recommendation 16

The Chief Nurse should be made explicitly responsible for assuring the Maidstone and Tunbridge Wells NHS Trust Board that mortuary management is delivered in such a way that it protects the security and dignity of the deceased.

Assurance Statement

The Trust considers that it complies with this recommendation in full on the following basis:

- The Chief Medical Officer is responsible for assuring the Board of Directors in relation to the security and dignity of the deceased person.
- The DI has direct access to the Trust's Chief Medical Officer, who is a member of the Board of Directors, and they can escalate any matters as required.
- The Chief Nursing Officer is responsible for Clinical Governance and works together with the Chief Medical Officer to ensure the necessary assurances are received at the Safety and Quality Committee on behalf of the Board of Directors.
- The Chief Medical Officer and Deputy Chief Nurse have visited the Mortuary at Preston and reviewed security arrangements in place.

Recommendation 17

Maidstone and Tunbridge Wells NHS Trust must treat the deceased with the same due regard to dignity and safeguarding as it does its other patients.

Assurance Statement

The Trust considers that it complies with this recommendation in full on the following basis:

- Policies, processes and procedures to safeguard the deceased person are continually reviewed and monitored, and organisational support has been provided where required to improve the arrangements.
- Any Human Tissue Authority Reportable Incidents (HTARIs) are appropriately reported and investigated with the aim of learning and improvement.
- The Mortuary Manager audits security arrangements to ensure the dignity and safeguarding of deceased person(s).

3. Conclusion

- 3.1 Following review of the Phase 1 Fuller recommendations made in relation to Maidstone and Tunbridge Wells NHS Trust, the Trust considers that the operational procedures for the mortuaries and body stores at both hospital sites are in accordance with the recommendations.
- 3.2 As indicated, the Trust are unable to respond to recommendation 12 on behalf of external partners. However, the Trust are reviewing ancillary services, which may interact with a deceased person where contracts exist, as part of reflecting on this recommendation holistically

4. Financial implications

- 4.1 There are no financial implications in relation to this report.

5. Legal implications

- 5.1 The Trust are appropriately licensed and regulated by the Human Tissue Authority (HTA) in relation to practices within the mortuary.
- 5.2 Any identified deficiencies in adherence to regulations could result in regulatory or legal action.

6. Risks

- 6.1 This paper considers risks to security within the mortuary alongside the controls and assurances in place.

7. Impact on stakeholders

- 7.1 Any identified deficiencies in caring for the deceased person and impacting their safety and dignity could have a significant impact on relatives and family members, as identified in Phase 1 of the Fuller Inquiry.

8. Recommendation

8.1 It is recommended that Board of Directors:

- I. Note the findings from Phase 1 of the Fuller Inquiry.
- II. Confirm they are assured of the processes in place to protect the safety and dignity of the deceased person.

Action Plan – Fuller Inquiry Phase 2 Action Plan (NHS Hospital Recommendations)

Status Key	
1	Not complete
2	Actions on track to deliver within timescale
3	All actions complete but awaiting evidence
4	All actions completed and good supporting evidence provided

Version	Updated by	Date
1.1	E.Denfhy, Deputy Associate Director for Risk and Assurance	22.07.2026

Ref	Area of Concern	Key Actions	Lead	Deadline for action	Progress	Current Status
						1 2 3 4
1.	All NHS trusts with mortuaries and/or body stores should commission a specialist strategic review of the systems in place to protect deceased people, which should include a detailed risk assessment of the potential breaches of security that could occur. The review should include an assessment of: - The systems in place to identify any unauthorised access to the facility; - The strength and effectiveness of barriers to prevent unauthorised access to the facilities; - The systems in place to identify any access to deceased people for unauthorised purposes; and - How CCTV is used, including its monitoring and any audits undertaken.	Commission a specialist strategic review of the systems in place to protect deceased people.	Designated Individual Mortuary manager	Completed	21.07.2026 – A specialist review of mortuary security was completed by Marlow Fire and Security specialists in January 2026. A report has been provided following the review with recommendations made in relation to an installation proposal. The self-assessment documentation has been submitted to NHS England detailing the work recommendations and associated costs arising from the specialist review performed by Marlow Fire and Security. Action completed.	4
		Review recommendations arising from the specialist strategic review of the systems in place to protect deceased people and agree how to proceed with the works suggested.	HTA Corporate License Holder Chief Finance Officer	31.12.2026	22.07.2026 – The requirement for the mortuary security upgrade has been approved by the Chair of the Capital Planning Forum and the Deputy Chief Financial Officer. The ordering process has been progressed, and confirmation of the priority installation date is awaited	3
2.	All NHS trusts should install CCTV inside the mortuary, with cameras facing all doors and access points, the reception area and the doors of body fridges, while maintaining the security and dignity of deceased people by implementing the appropriate safeguards. Where double-ended fridges also open into the post-mortem room, NHS trusts should install CCTV cameras inside the post-mortem room that focus on the doors to the fridges.	Installation of CCTV inside the mortuary.	Designated Individual Mortuary manager	Completed	21.07.2026 – CCTV is installed inside the mortuary, and all exits are covered. Action completed.	4

Ref	Area of Concern	Key Actions	Lead	Deadline for action	Progress	Current Status			
						1	2	3	4
3.	All NHS trusts should routinely audit the access data of all facilities used to store deceased people.	Conduct audit in accordance with the audit schedule.	Mortuary manager	Completed	21.07.2026 – Access is audited weekly of the previous 7 days. Action completed.				4
4.	The practice of using shared electronic swipe cards for specific staff groups should cease immediately.	Audit access to the mortuary to provide assurance that the practice of sharing electronic swipe cards has ceased.	Mortuary manager	Completed	21.07.2026 - Electronic swipe cards not shared – Mortuary swipe access audit undertaken weekly and any incidents reported and investigated. Any audit findings escalated to the Division of Diagnostics and Clinical Support Services (DCS) Safety and Quality meeting.				4
5.	All NHS trusts should consider putting in place systemic operational barriers that prevent the security and dignity of deceased people being compromised. An example of this would be implementation of a rule that prevents electronic devices such as phones or cameras being taken into a mortuary, other than for approved reasons.	Develop a Standard Operating Procedure (SOP) which describes the processes to prevent the security and dignity of deceased people being compromised, and details situations where staff would be permitted to bring devices, such as phones, into the mortuary, e.g. police.	Designated Individual Mortuary manager	31.12.2026	21.07.2026 - Those viewing bodies are not allowed to take photos. Updated guidance is awaited from HTA, and the Trust will update the existing security SOP once published.				3
6.	All NHS trusts should take every breach of security in a mortuary or body store extremely seriously. Each security incident should be reviewed by a security expert who is able to identify any systemic security issues associated with the incident. A detailed action plan should be developed for each security breach, no matter how minor trusts regard such breaches to be. All security breaches occurring in mortuaries should be incorporated into security reports provided to trust boards or relevant subcommittees, in line with security breaches in other vulnerable areas.	Implement process for internal and external reporting of incidents.	Designated Individual Mortuary manager	Completed	21.07.2026 - Incidents reported internally via Ulysses and external as HTARI. Action completed.				4
		Ulysses notification rules to be built to notify security or mortuary-related security incidents to ensure review by the security team.	Deputy Associate Director of Risk and Assurance	31.07.2026	21.07.2026 – Notification rule to be built and communicated to the teams at the July 2026 Safeguarding Board update.				3
		Mortuary security incidents to be added to the monthly security update to safeguarding board.	Trust lead for Security	31.08.2026	21.07.2026 – To be incorporated from 01.08.2026.				3
7.	The NHS should ensure that the security standards required for body stores are the same as those required for facilities licensed by the Human Tissue Authority.	Publish updated national standards.	NHS England	Not a Trust action.	21.07.2026 – Not a Trust action, action stood down from Trust action plan.				Stood Down not a Trust action
8.	All NHS trusts should consider the installation of 'swipe to exit' for mortuary facilities. This would allow trusts to monitor and audit entry and exit, as well as time spent in the mortuary.	Consider the installation of "swipe to exit" for mortuary facilities.	Designated Individual Mortuary manager	Completed	21.07.2026 - Swipe to exit not in place; however, access is audited.				4
9.	All NHS trusts should monitor the number of staff with access to the mortuary or body store and keep this under routine review.	Audit the number of staff with access to the mortuary or body store.	Designated Individual	Completed	21.07.2026 - Regular audit and cleansing of staff with access to the mortuary – frequency every 6 months. Action completed				4

Ref	Area of Concern	Key Actions	Lead	Deadline for action	Progress	Current Status			
						1	2	3	4
			Mortuary manager						
		Audit Cycle detailing the frequency of Audit.	Designated Individual Mortuary manager	Completed	21.07.2026 - Regular audit and cleansing of staff with access to the mortuary – frequency every 6 months. Action completed				4
10.	NHS trusts should ensure that Designated Individuals (DI) have enough time and resources to fulfil their responsibilities, including time for learning and development.	Designated Individual (DI) in post and recognised in role as being the responsible DI.	Divisional Director DCS	Completed	21.07.2026 – DI in post. The role is undertaken within the current Clinical Business Manager (CBM) role. Action completed.				4
11.	NHS trusts should ensure that senior managers, including the Chief Executive, have a clear understanding of the role of the Designated Individual, their lines of accountability, and the individual legal responsibility associated with being a Designated Individual.	The Designated Individual (DI) should be included in the Trust's Regulatory and Lead Roles document which is updated annually and approved by Trust management board.	Deputy Associate Director for Risk and Assurance	Completed	21.07.2026 – The roles and responsibilities of the DI are detailed within the Trust's Regulatory and Lead Roles document, which is updated annually and approved by Trust Management Board. Next due for review in January 2027.				4
12.	NHS trusts should ensure that Designated Individuals (DI) attend the correct governance forums. This would allow them to escalate issues and risks, as well as reporting upwards when required.	DI attendance at appropriate governance meetings which allow for escalation to Committee and the Board of Directors when required.	Designated Individual	Completed	21.07.2026 – The Designated Individual attends DCS Safety and Quality, chairs the Postmortem CT Group, and chairs the Deceased Operational Group, which escalates into the Mortality and End of Life Care Committee, ensuring that there are appropriate routes for escalation if required. Action completed.				4
13.	A professional background in the field of mortuary services should be made a prerequisite for the post of Mortuary Manager.	Role specific training requirement for the appointed Mortuary Manager.	Mortuary manager	Completed	21.07.2026 - Mortuary Manager is Senior Anatomical Pathology Technician. Action completed.				4
14.	NHS trusts should assure themselves that the Mortuary Manager has adequate resources and support to perform their role effectively, including meeting any reporting requirements.	Consider protected time for the Mortuary Manager.	Designated Individual	31.08.2026	21.07.2026 – The Mortuary Manager role is undertaken alongside clinical responsibilities. Current arrangements are being reviewed by the Divisional Nursing Director for DCS to ensure there is sufficient capacity, support and protected time, where required, to fulfil mortuary management responsibilities and associated reporting requirements.				3
15.	All NHS trusts should establish a routine reporting system for matters relating to mortuaries and body stores. This reporting system should include the presentation of a formal report, by the accountable executive director, to the trust board on a routine basis. The accountable executive director should	Establish a routine governance reporting system for matters relating to mortuaries and body stores.	Designated Individual	Completed	21.07.2026 – The Trust has established governance arrangements to ensure effective oversight of the mortuary, associated storage areas and all locations where deceased individuals are cared for. The Trust's Deceased Operations Group, chaired by the HTA Designated Individual, provides operational				4

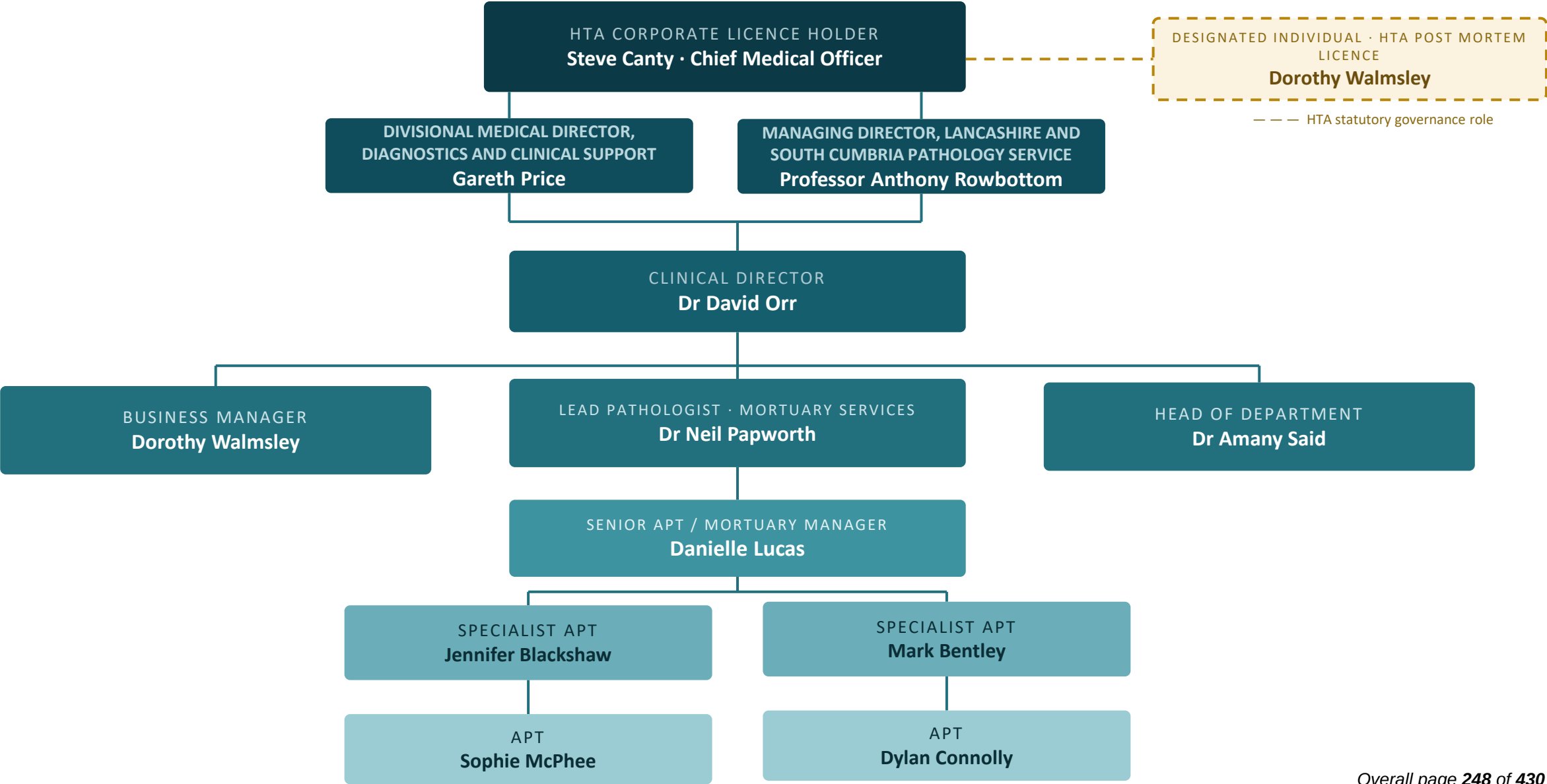
Ref	Area of Concern	Key Actions	Lead	Deadline for action	Progress	Current Status			
						1	2	3	4
	prepare and present to the Trust board a formal annual report, similar to the annual safeguarding report. The report should include: - Staffing matters; - Security incidents; - All serious incidents; - Human Tissue Authority reports (where applicable); and - All security audits, including audits of access and any access breaches.				oversight. This group reports to the End of Life Care Group, chaired by the Deputy Chief Medical Officer, which in turn reports to the Safety and Quality Committee, a Committee of the Board.				
		Annual Mortuary report to be presented at Safety and Quality Committee to include the following: - Staffing matters; - Security incidents; - All serious incidents; - Human Tissue Authority reports (where applicable); - All security audits, including audits of access and any access breaches.	Designated Individual	31.10.2026	21.07.2026 – The Corporate Affairs team is reviewing committee and Board reporting arrangements to ensure the Annual Mortuary Report is scheduled through the appropriate governance route, including consideration by the Safety and Quality Committee prior to onward reporting to Board.	3			
		Annual Mortuary report to be presented to the Board of Directors by the Executive Lead.	Chief Medical Officer	30.11.2026	21.07.2026 – Comprehensive report included on agenda for August 2026. The Corporate Affairs team is reviewing committee and Board reporting arrangements to ensure the Annual Mortuary Report is scheduled through the appropriate governance route, including consideration by the Safety and Quality Committee prior to onward reporting to Board.	3			
16.	Trust boards should assure themselves that the recommendations in this Report have been implemented	Completion of the Board Assurance Statement for NHS provider trusts, which confirms review of the Fuller report recommendations, to be returned to the NHS England Inquiry Team by 31 July 2026.	Board of Directors	31.07.2026	21.07.2026 – Board assurance statement to be completed and submitted following presentation to July 2026 Safety and Quality Committee.	3			
17.	Trust boards should ensure that these recommendations and governance arrangements are applied to any temporary facilities used by trusts for the storage and care of deceased people.	Governance arrangements to be detailed for temporary storage facilities.	Designated Individual Mortuary manager	30.11.2026	21.07.2026 – Trust does not have any temporary storage facilities. Action Stood down.	Action Stood Down			
18.	Trust boards should take note of the fact that mortuary services are subject to statutory regulation and should be treated with equivalent regard to other regulated activities within trust governance arrangements.	Role of the Designated Individual and the Corporate License Holder to be detailed in the Trust's Regulatory and Lead Roles document which is updated annually and approved by Trust Management Board.	Deputy Associate Director of Risk and Assurance	Completed	21.07.2026 - The roles and responsibilities of the DI and the Corporate Licence Holder are detailed within the Trust's Regulatory and Lead Roles document which is updated annually and approved by Trust Management Board. Next due for review in January 2027.	4			

Ref	Area of Concern	Key Actions	Lead	Deadline for action	Progress	Current Status			
						1	2	3	4
		Reporting of Human Tissue Authority (HTA) Inspection findings to Safety and Quality Committee.	Associate Director of Risk and Assurance	Completed	21.07.2026 – Last HTA inspection September 2025. A paper was presented to the Safety and Quality Committee at the end of January 2026 summarising the reporting findings and the actions to be taken by the Trust in response to the inspection. No findings related to the care of the deceased. At the end of June 2026 good progress has been made to date with the action plan with 90% of actions being closed by HTA following the provision of supporting evidence.	4			
		Monitoring of HTA Inspection action plans by Safety and Quality Committee.	Associate Director of Risk and Assurance	Completed	21.07.2026 – Progress with the completion of HTA action plans is monitored by the Safety and Quality Committee through the quarterly regulatory update report.	4			
19.	NHS trust boards should ensure that the security and dignity of deceased people are included in safeguarding training, policies and assurance.	Safeguarding training compliance monitored monthly via the Safeguarding Board. Areas of non-compliance should be escalated via the Chair's triple A report.	Deputy Nursing Director with responsibility for Safeguarding	Completed	17.07.2026 – There is a comprehensive programme of staff safeguarding training in place in accordance with the requirements of the NHS Safeguarding Accountability and Assurance Framework (SAAF). Safeguarding training compliance is reported monthly into Trust safeguarding board ensuring ongoing oversight of compliance. Divisional performance is also overseen monthly via the Divisional Improvement Forums.	4			
		Trust safeguarding training materials to be updated in reference to the deceased following the release of the national update.	Head of Safeguarding	31.12.2026	17.07.2026 – Action pended subject to the release of the updated national guidance.	Pending release of updated national guidance			
		Mortuary security incidents to be added to the monthly security update to safeguarding board.	Trust lead for Security	31.08.2026	21.07.2026 – To be incorporated from 01.08.2026.	3			
		Annual safeguarding report to board to be updated to include the recommendations in relation to the deceased in accordance with the updated SAAF guidance.	Head of safeguarding	30.05.2027	17.07.2026 – Action pended subject to the release of the updated national guidance.	Pending release of updated national guidance			
		Mortuary security policy in place	Designated Individual Mortuary manager	Completed	21.07.2026 – The mortuary has a security policy in place which is subject to audit. Action completed.	4			
20.	The remit of the Chief Nurse in NHS trusts should explicitly include executive	Executive responsibility for safeguarding, estates and related security matters to be	Deputy Associate	Completed	17.07.2026 – Executive accountability for end-of-life care, HTA compliance, safeguarding, estates	4			

Ref	Area of Concern	Key Actions	Lead	Deadline for action	Progress	Current Status
						1 2 3 4
	responsibility for safeguarding the security and dignity of deceased people in NHS mortuaries and body stores.	articulated in the Trust's Regulatory Roles Document which is updated annually and presented to Trust Management Board.	Director for Risk and Assurance		and security is clearly defined within the Trust's Listed Regulatory Roles document, which is reviewed and updated annually. The Chief Nursing Officer is the Executive with responsibility for safeguarding and end-of-life care.	
21.	NHS England should formally incorporate the safeguarding of deceased people into its safeguarding framework for NHS trusts.	NHS England to update the NHS Safeguarding Accountability and Assurance Framework (SAAF) to include the safeguarding of deceased people.	NHS England	Not a Trust action.	21.07.2026 – Not a Trust action, action stood down from Trust action plan.	Stood Down not a Trust action
Action Plan sign-off by: S. Canty, Chief Medical Officer Date:22.07.26						

Mortuary Lines of Responsibility

Human Tissue Authority — Governance & Operational Reporting Structure



Action Plan – Nottingham Maternity Review Findings on Post-Death Care and Key Actions Required Following the Fuller Inquiry.

Status Key	
1	Not complete
2	Actions on track to deliver within timescale
3	All actions complete but awaiting evidence
4	All actions completed and good supporting evidence provided

Version	Updated by	Date
1.1	E. Denfhy, Deputy Associate Director of Risk and Assurance	17.07.2026

Ref	Area of Concern	Key Actions	Lead	Deadline for action	Progress	Current Status
						1 2 3 4
1.	NHS Premises Assurance Model (PAM). The NHS Standard Contract requires providers to comply with the PAM. A new set of high-level self-assessment questions reflecting relevant recommendations made by the Fuller Inquiry has now been incorporated into the latest version of the PAM. The submission window for the NHS runs from 8 May 2026 to 8 September 2026. Trusts should assure themselves against the latest version of the PAM self-assessment questions.	Completion of the PAM self-assessment.	Director of Estates and Facilities	08.09.2026	17.07.2026 – Confirmation requested regarding submission of the PAM.	2
		Board Approval of the PAM prior to submission by 08.09.2026.	Board of Directors	08.09.2026	17.07.2026 – Confirmation requested regarding submission of the PAM.	2
2.	Health Building Note (HBN) 16-01: Facilities for mortuaries, including body stores and post-mortem services. HBN 16-01 will be updated in 2026 to provide additional guidance to NHS trusts on recommendations raised by the Fuller Inquiry. Trusts should consider best practice guidance set out in the HBN for ongoing planning.	Confirmation regarding compliance with current mortuary facility guidance.	Director of Estates and Facilities	31.07.2026	17.07.2026 – Confirmation requested regarding current mortuary facility guidance.	2
		Following publication of updated guidance, compliance report to be provided to Safety and Quality Committee.	Director of Estates and Facilities	31.12.2026	17.07.2026 – Action pended subject to the release of the updated national guidance.	Pending release of updated national guidance

Ref	Area of Concern	Key Actions	Lead	Deadline for action	Progress	Current Status
						1 2 3 4
3.	Insightful provider board guide. The guidance will be updated later in 2026 and will incorporate relevant content to reflect Fuller findings and recommendations. Trust boards should use the guidance provided to reflect and consider whether the leadership, culture, systems and processes they have in place are using information in the best way to lead their organisations effectively in respect of matters relating to mortuaries and body stores.	Completion of the updated self-assessment framework.	Director for Corporate Affairs	31.12.2026	17.07.2026 – Action pended subject to the release of the updated national guidance.	Pending release of updated national guidance
4.	Assessing provider capability: guidance for NHS Trust Boards. The self-assessments contained within the assessing provider capability: guidance for NHS Trust Boards are used by regional oversight teams along with their own views and information held by 3rd-party bodies (including the Human Tissue Authority) to take a view of management, governance and grip. This guidance is also due to be updated later in 2026	Completion of the updated self-assessment framework.	Director for Corporate Affairs	31.12.2026	17.07.2026 – Action pended subject to the release of the updated national guidance.	Pending release of updated national guidance
5.	Advanced Foundation Trust Programme For existing NHS foundation trusts and NHS trusts who wish to become advanced foundation trusts, the programme requires evidence that Trusts applying for advanced foundation Trust status have considered relevant insights and learning from inquiry recommendations and have implemented them or are in the process of implementing them.	Clarification of the organisational position on Advanced Foundation Trust status.	Associate Director of Risk, Assurance, and Corporate Affairs	31.12.2026	17.07.2026 – Ongoing.	2
6.	NHS Safeguarding Accountability and Assurance framework (SAAF) In April 2026, the SAAF was updated to include reference to the deceased. Trusts should also note this addition will require a supporting reference to be made in the annual report about safeguarding children, adults and children in care. This must be submitted to the Trust board. NHS England is also updating related training to include reference to the deceased. These updates will be made during 2026.	Executive leadership should now include oversight of arrangements for the deceased.	Chief Medical Officer	Completed	26.09.2025 The Chief Medical Officer was confirmed as the HTA Corporate Licence Holder by HTA on 29.09.2025.	4
		Executive responsibility for safeguarding, estates and related security matters to be articulated in the Trust's Regulatory Roles Document which is updated annually and presented to Trust Management Board.	Deputy Associate Director for Risk and Assurance	Completed	17.07.2026 – Executive responsibility for safeguarding, estates and related security matters is detailed within the Trust's Regulatory and Lead Roles document, which is updated annually and approved by Trust Management Board. The next review is due in January 2027.	4

Ref	Area of Concern	Key Actions	Lead	Deadline for action	Progress	Current Status
						1234
		Safeguarding training compliance monitored monthly via the Safeguarding Board. Areas of non-compliance should be escalated via the Chair's triple A report.	Deputy Nursing Director with responsibility for Safeguarding	Completed	17.07.2026 – Safeguarding training compliance is reported monthly to the Trust Safeguarding Board, ensuring ongoing oversight of compliance. Divisional performance is also overseen monthly via the Divisional Improvement Forums.	4
		Trust safeguarding training materials to be updated following the release of the national update.	Head of Safeguarding	31.12.2026	17.07.2026 – Action pended subject to the release of the updated national guidance.	Pending release of updated national guidance
		Annual safeguarding report to the Board to be updated to include the recommendations in relation to the deceased, in accordance with the updated SAAF guidance.	Head of safeguarding	30.05.2027	17.07.2026 – Action pended subject to the release of the updated national guidance.	Pending release of updated national guidance
Action Plan sign-off by:		S.Canty, Chief Medical Officer			Date:22.07.26	

14. ITEMS FOR INFORMATION

14.1 QUALITY ACCOUNT

● Decision Item

Item for information and decision

REFERENCES

Only PDFs are attached



14.1 Quality Account.pdf



Board of Directors

Meeting of the	Board of Directors		6 th August 2026
Title of Report	Quality Account 2025/26		
Report Author	Lisa Elliott, Associate Director of Safety and Learning Michelle Durkin, Deputy Associate Director of Safety and Learning		
Lead Executive Director	Sarah Morrison, Chief Nursing Officer		
Recommendation/ Actions required	The Board of Directors is asked to: 1. Approve the 2025/26 Quality Account for publication, noting the endorsement from the Safety and Quality Committee. 2. Review and accept the Easy Read version, which will be published on the Trust’s website.		
	Decision ☒	Assurance ☐	Information ☐
Executive Summary	The 2025–26 Quality Account describes a year of important progress and continued challenge for Lancashire Teaching Hospitals NHS Foundation Trust. The Trust has strengthened its strategic focus through the Single Improvement Plan, continued to embed patient safety and learning through the Patient Safety Incident Response Framework, and developed the next Always Safety First: Safety and Learning Strategy. Improvements have been made in planned care, cancer performance, diagnostics, staff training, appraisal compliance, research activity, patient experience and financial delivery. At the same time, the report is clear that there is more to do. Urgent and emergency care, patient flow, diagnostic access, infection prevention, workforce confidence, reducing avoidable harm, and reducing variation in patient experience remain key areas for continued focus in 2026–27. The Trust plans to use the next year to consolidate improvement, strengthen governance and assurance, and ensure that progress is visible, measurable and sustained. Highlights from 2025–26 • Clearer strategic direction: Publication of the Trust Strategy and enabling strategies with continued delivery through the Single Improvement Plan, organised around patients, performance, people, productivity and partnerships. • Safety and learning: Continued embedding of the Patient Safety Incident Response Framework, development of the updated Always Safety First: Safety and Learning Strategy, and STAR accreditation achieved in 89% of assessed areas. • Patient outcomes and experience: Maternity services met all ten Maternity Incentive Scheme standards and improved their national survey		

	ranking, with strong feedback on respect, dignity, confidence and involvement in care. • Access and planned care: The 65-week elective backlog was eliminated, 52-week waits reduced, cancer performance improved against the 62-day and 28-day standards, and diagnostic longest waits reduced. • People and culture: Core skills training and appraisal compliance remained above target, sickness absence improved compared with previous periods, and retention remained stable. Staff survey showed improvements in the majority of areas compared to last year with the exception of advocacy scores for staff and patients, these are the priority for the organisation. • Continuous improvement: More than 900 staff completed improvement training, with improvement programmes supporting safer care, better flow, reduced variation and productivity benefits. • Financial and productivity progress: The year-end financial position was better than planned, supported by savings delivery, external support and the development of a three-year financial sustainability plan. • Research and innovation: Research activity continued to grow, with increased commercial study activity, major funding secured, continued BioNTech partnership work and investment in research infrastructure. Areas to focus on in 2026–27 • Urgent and emergency care: Improve flow, reduce crowding, reduce long waits, improve ambulance handover performance and strengthen patient experience in urgent pathways. • Reducing harm and variation: Focus on falls, pressure ulcers, medicines safety, infection prevention and control, deterioration, sepsis, maternity and neonatal safety, and learning from mortality reviews. • Planned care, diagnostics and cancer: Sustain progress on long waits, improve referral to treatment performance, strengthen diagnostic access and continue to improve cancer pathway timeliness. • Patient experience and involvement: Improve communication at key points in the patient journey, especially admission, delays, discharge and transitions of care; strengthen involvement of families and seldom-heard communities. • Staff confidence and wellbeing: Respond to staff survey findings, improve advocacy score for staff and patients, improve engagement, reduce violence and aggression, support attendance and strengthen leadership, team culture and psychological safety. • Health inequalities and social value: Develop better use of data to understand inequalities, improve access for deprived and under-represented communities, and align delivery with the Health Improvement Plan and Social Value Strategy. • Financial sustainability and productivity: Deliver the financial sustainability plan, strengthen waste reduction, improve grip and control, and ensure productivity improvements support quality and patient safety. • Governance, risk and assurance: Continue to strengthen risk management, data quality, information governance and Board assurance so that improvement work is measurable, transparent and sustained.	
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:	
Operational Group Review:	Safety and Quality Committee	Date: 26 th June 2026
Link to Board Assurance Framework:	Principal Risk 1 (26/27) - Patient safety and experience within the urgent and emergency care pathway Principle Risk 2 (26/27) People experiencing Health Inequalities Principle Risk 3 (26/27) Timely access to planned care Principle Risk 4 (26/27) Timely access to cancer care Principle Risk 5 (26/27) Timely access to urgent and emergency care Principle Risk 6 ((26/27) Timely access to diagnostic investigations Principle Risk 7 (26/27) Experience of under-represented staff groups Principle Risk 8 (26/27) Experience of staff and levels of staff satisfaction	
Appendices	Appendix 1: Quality Account Appendix 2: Quality Account easy read version	



Lancashire Teaching Hospitals NHS Foundation Trust

Quality Account 2025/2026



Quality Account 2025-26

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PART 1 – Chief Executive’s Statement

1.1 Chief Executive’s Statement



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

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

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

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

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

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

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

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

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

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



Professor Silas Nichols

Chief Executive Officer

PART 2 – Priorities for Improvement

2.1 Strategic Overview

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

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

2.1.2 Our Strategy

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

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

Figure 1 Our Trust Strategy 2025–2030



2.1.3 Governance of the strategy

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

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

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

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

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

Board Committees provide oversight of each area of the SIP:

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

2.2 Use of Symbols in the Quality Account 2025–26

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

2.2.1 Symbols aligned to the SIP

Figure 2 Symbols aligned to the SIP

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



Patients



Performance



People



Productivity



Partnerships

2.2.2 Measuring success

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

Table 1 The symbols used to represent levels of achievement

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

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

2.3 Key Achievements from 2025-26

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

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



2.3.1 Partnerships

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

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

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



2.3.2 People

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

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



2.3.3 Patients

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

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

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

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

Table 2 Summary of Key Performance Indicator comparable data

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

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



2.3.4 Productivity

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

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

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



2.3.5 Operational Performance

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

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

2.3.6 Forward plan for 2026-27

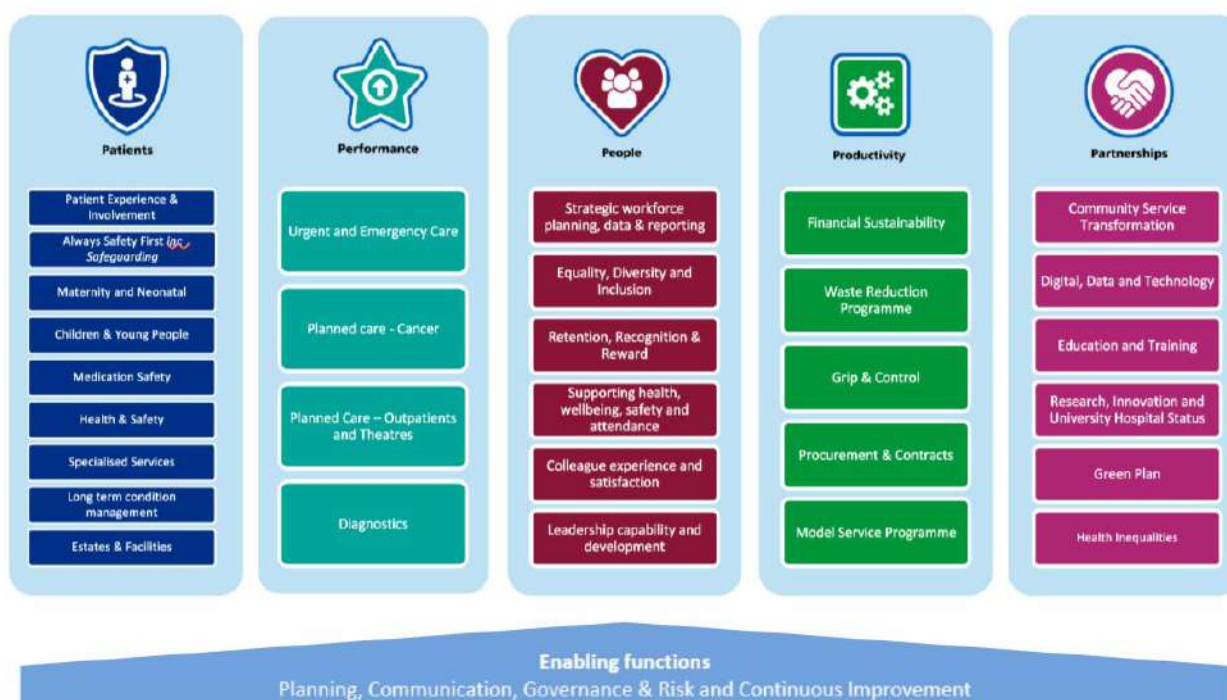
Progress made in 2025–26 provides a strong foundation for continued improvement. The focus on performance, financial stability, and service delivery will continue into 2026–27.

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

Figure 3 SIP Strategic Framework



Figure 4 SIP Scope 2026-27





2.4 Continuous Improvement

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

Improving care for patients

Improvements were delivered at both team and pathway level:

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

Delivering timely and effective care

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

Supporting our people

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

Improving productivity and value

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

Working in partnership

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

Looking ahead

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



2.5 Always Safety First (ASF)

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

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

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

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

2026–27 priorities

Safer culture

Focus on strengthening openness, learning and leadership:

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

Safer system

Strengthening the systems that support safe care:

- Improved digital systems, including the Electronic Patient Record

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

Safer patients

Reducing harm and improving safety outcomes:

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

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



2.6 Risk Management

2.6 Risk Management

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

2.6.1 Risk Management and Risk Maturity

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

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

2.6.2 Risk Management Strategy

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

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

2.6.3 Risk Management Policy & Board Assurance Framework (BAF)

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

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

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

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

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

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

2.6.4 Risk Appetite and Tolerance

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

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

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

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

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

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

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

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

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

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

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

2.6.5 Our principal risks and issues

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

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

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

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

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

Table 6: Principal Risks in 2025/26:

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

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

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

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

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

2.6.6 Operational High Risks escalated to Board:

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

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

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

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

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

2.7 Statements of Assurance from the Board

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

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

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

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



2.8 Participation in Clinical Audits

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

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

The Trust did not participate in four national audits:

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

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

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

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

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

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

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

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

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

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

Table 8: National Audits and Confidential Enquiries – Planned Actions

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

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

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

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

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

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

Table 9: Local Clinical Audits and Resulting Actions

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

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

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



2.9 Clinical Research

2.9.1 Participation in Clinical Research

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

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

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

2.9.2 Trust Achievements in Research

Key achievements during 2025–26 include:

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

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

2.9.3 Research Governance

During 2025–26:

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

2.9.4 Workforce

Investment in the research workforce continued:

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

2.9.5 Studies, Trials and Research

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

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

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

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



2.10 Registration with the Care Quality Commission

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

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

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

2.10.1 CQC Finney House

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

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

2.10.2 Trust Inspections 2025-26

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

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

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

The Trust continues regular engagement meetings with the CQC.

2.10.3 CQC Inspection 2023

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

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

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

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

Figure 5 provides a summary of these ratings.

Figure 5: CQC Trust wide rating

Safe	Requires improvement	●
Effective	Requires improvement	●
Caring	Good	●
Responsive	Requires improvement	●
Well-led	Requires improvement	●
Use of resources	Requires improvement	●

2.10.4 CQC Inspection Outcomes and Quality Improvement Plan

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

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

2.10.5 Recognition of Good Practice

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

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



2.11 Quality of Data

2.11.1 Information Governance

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

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

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

2.11.2 Data Quality

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

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

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

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

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

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

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

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

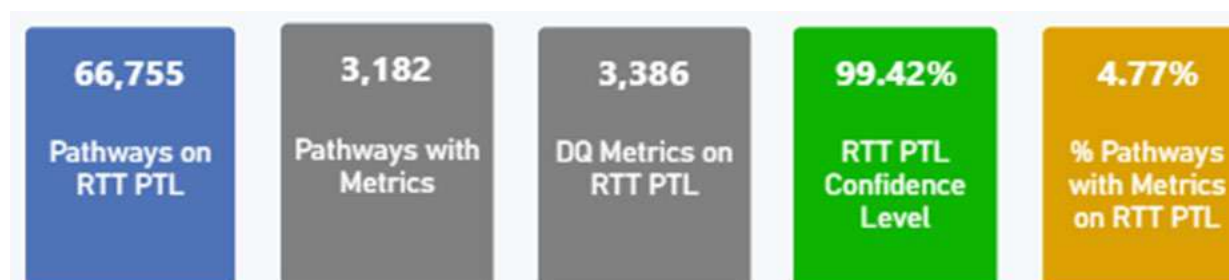
Table 10: NHS Digital Data Quality

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

Data source NHS Data Quality Maturity Index

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

Figure 6: National Waiting List Data



LUNA National Data Quality Solution

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

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



2.12 Information Governance

2.12.1 Confidentiality and Information Security

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

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

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

2.12.2 Data Security and Protection Toolkit (DSPT)

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

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

2.12.3 Information Risk Management

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

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

2.12.4 Governance Structure

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

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

2.12.5 Information Governance Management Framework

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



2.13 Adult Mortality Reviews

2.13.1 Overview of Mortality Governance

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

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

The Medical Examiner Service provides additional independent review.

2.13.2 Structured Judgement Reviews (SJRs)

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

By March 2026:

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

Thirteen cases were referred to the Coroner:

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

2.13.3 Deaths Due to Problems in Care

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

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

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

2.13.4 Learning from Structured Judgement Reviews

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

Areas of strong practice included:

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

Areas identified for further focus included:

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

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

2.14 Reporting Core Indicators

2.14.1 Overview

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

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

2.14.2 Operational Pressures and System Challenges

Key factors affecting performance included:

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

2.14.3 System-Wide Transformation Initiatives

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

- Expansion of virtual wards, supporting care closer to home

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

2.14.4 Performance Highlights and Areas for Improvement

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

Urgent and Emergency Care (UEC):

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

Planned care:

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

Cancer performance:

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

Diagnostics:

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

2.14.5 Summary of Performance against Core Indicators

Table 11: Core Standards 2025-2026

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

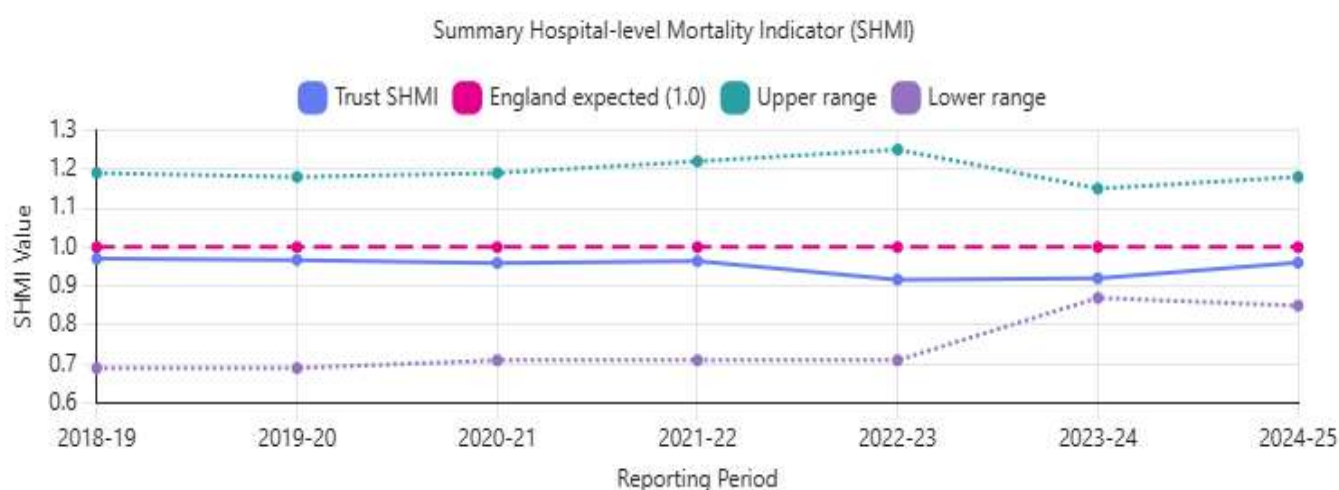
2.14.6 NHS Digital Data and Performance Indicators

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

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

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

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

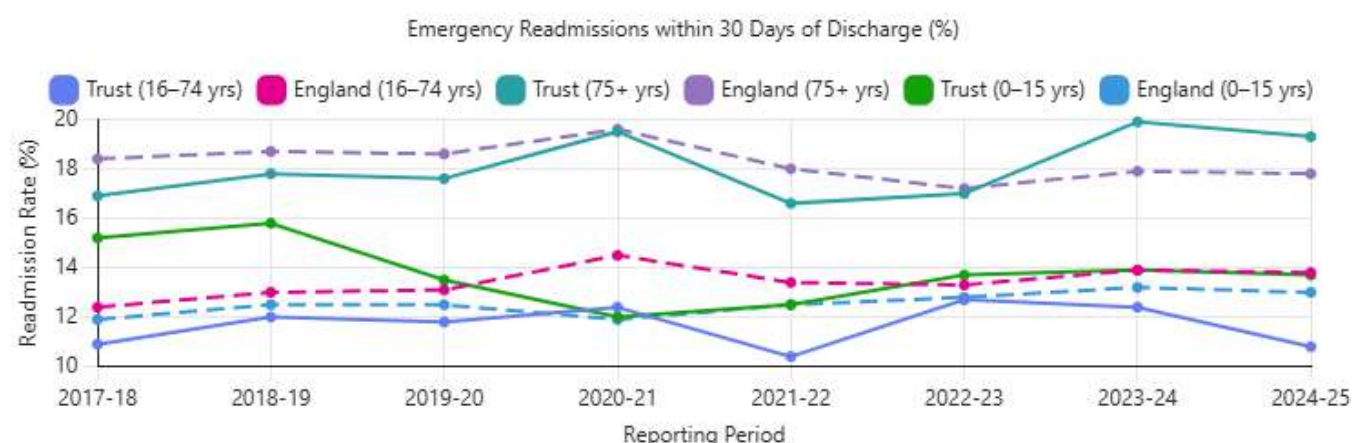


The Summary Hospital-level Mortality Indicator (SHMI) compares the number of deaths recorded with the number expected, where a score of 1 represents the national average.

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

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

Figure 8: Emergency Readmissions within 30 Days of Discharge



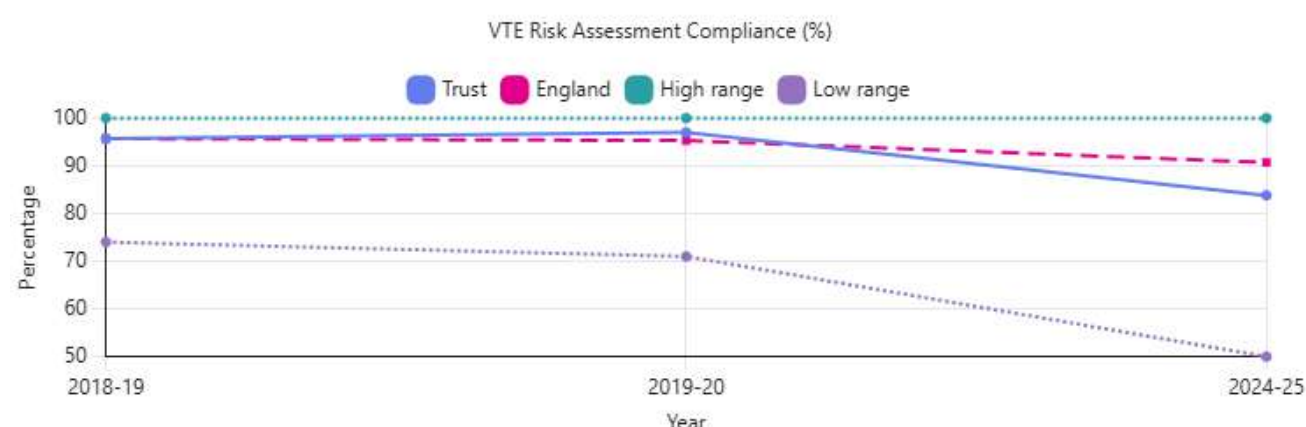
Emergency readmissions within 30 days of discharge are an important measure of how well care and discharge planning meet patient's needs.

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

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

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

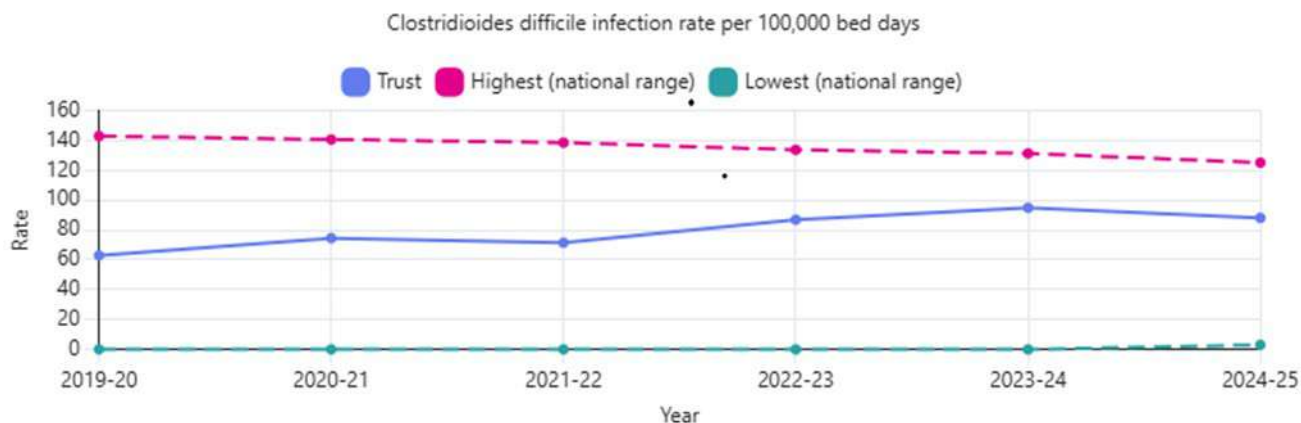
Figure 9: Venous Thromboembolism (VTE) Risk Assessment * most current data



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

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

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

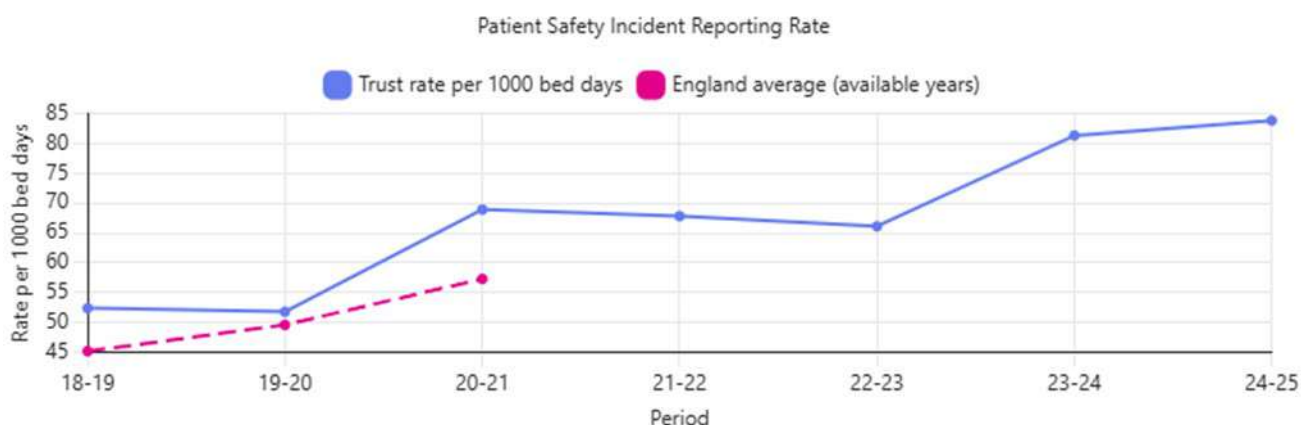


The Trust's rate of Clostridioides difficile (C. difficile) infection has varied over time, rising from 62.9 per 100,000 bed days in 2019–20 to 94.8 in 2023–24, before reducing to 88 in 2024–25.

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

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

Figure 11: Patient Safety Incidents * most current data



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

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

Summary for NHS Digital Data and Performance Indicators

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

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

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



2.15 Patient experience performance indicator

2.15.1 Adult Inpatient Survey 2024

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

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

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

Overall Patient Experience – Historical and External Comparison

Table 12: Adult inpatient survey Questions 46- 48

Overall Adult Inpatient Survey 2024

Historical

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

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

2.15.2 Commitment to Continuous Improvement

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

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

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



2.16 Staff experience performance indicator

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

A key question asks:

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

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

Table 13: Staff Recommendation as a Provider of Care LTH

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

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

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

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



2.17 Freedom to Speak Up

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

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

2.17.1 Service Delivery

Staff are supported to speak up through:

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

Overview of FTSU Activity and Trends in 2025

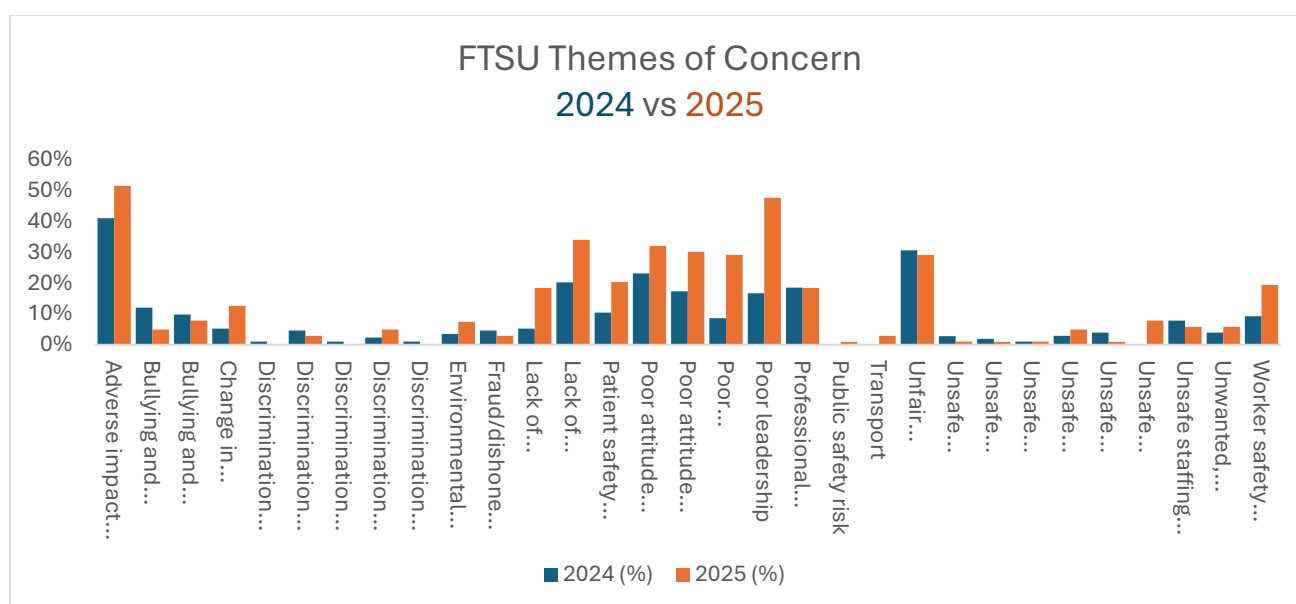
- 103 concerns raised (reduced from 160 in 2024)
- 23.4% raised anonymously (increase from the previous year)
- Most concerns raised by registered nurses, healthcare assistants and administrative staff

Staff survey results for 2025 show:

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

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

Figure 12: FTSU Themes of Concerns



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

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

2.17.2 Key Priorities

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

Strengthening visibility and trust

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

Developing the FTSU Champion network

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

Creating a positive speaking up culture

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

- Support leaders to encourage open conversations

Understanding staff experience

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

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

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

PART 3 - Review of Quality Performance

3.1 Review of Quality Performance - Patient Safety



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

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

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

Key areas of focus within the programme are outlined below:

Table 14: Key areas of focus within the ASF programme

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

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

3.1.1 The Patient Safety Incident Response Framework (PSIRF)



Patient Safety Incident Response Framework (PSIRF)

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

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

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

Refreshed PSIRF Policy and Plan

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

Key local priorities are:

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

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

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

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

Patient and Family Engagement and Compassionate Involvement

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

Patients and families are offered opportunities to:

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

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

Key developments include:

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

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

Priorities for 2026-27

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

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

3.1.2 Safety Triangulation Accreditation Review (STAR)



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

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

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

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

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

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

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

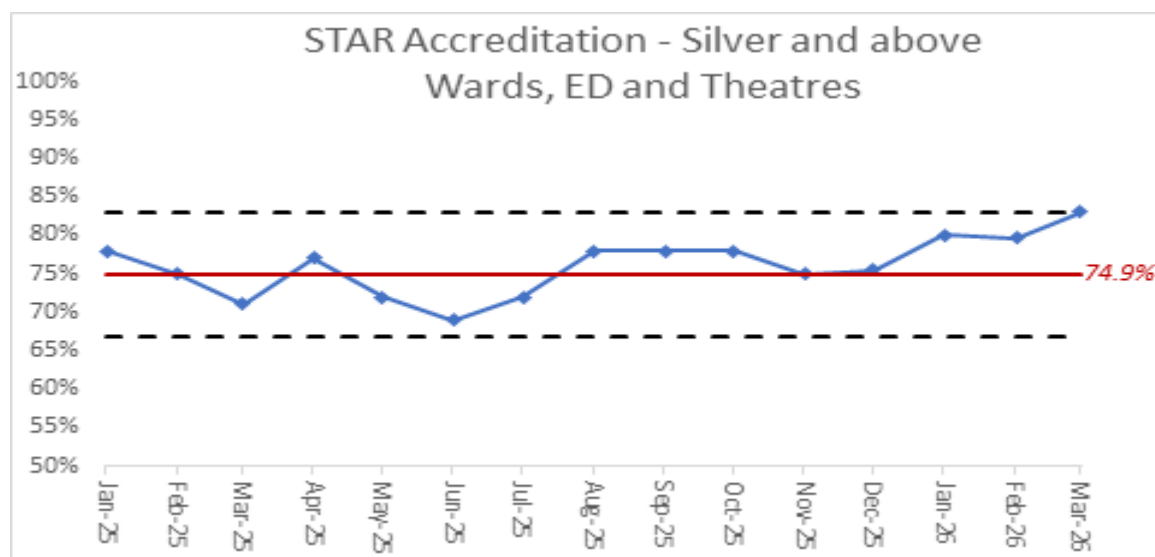
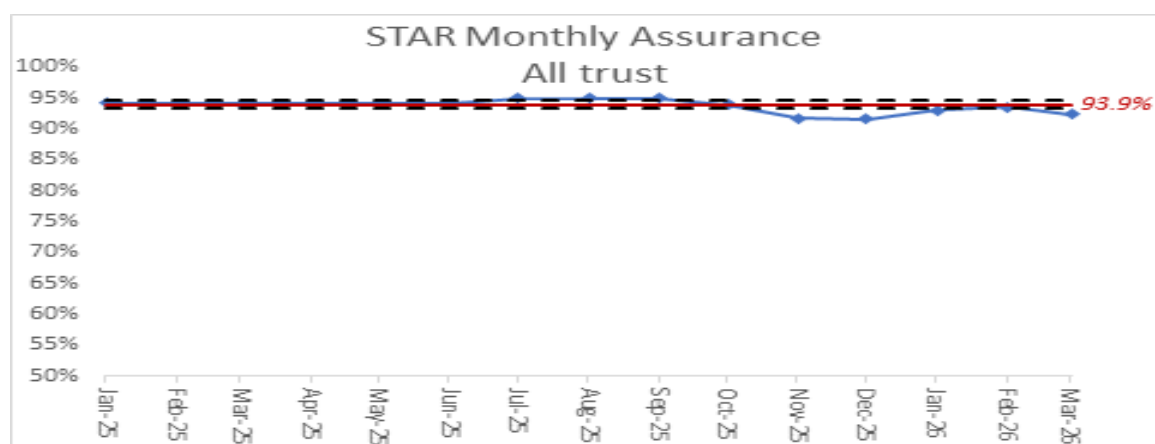
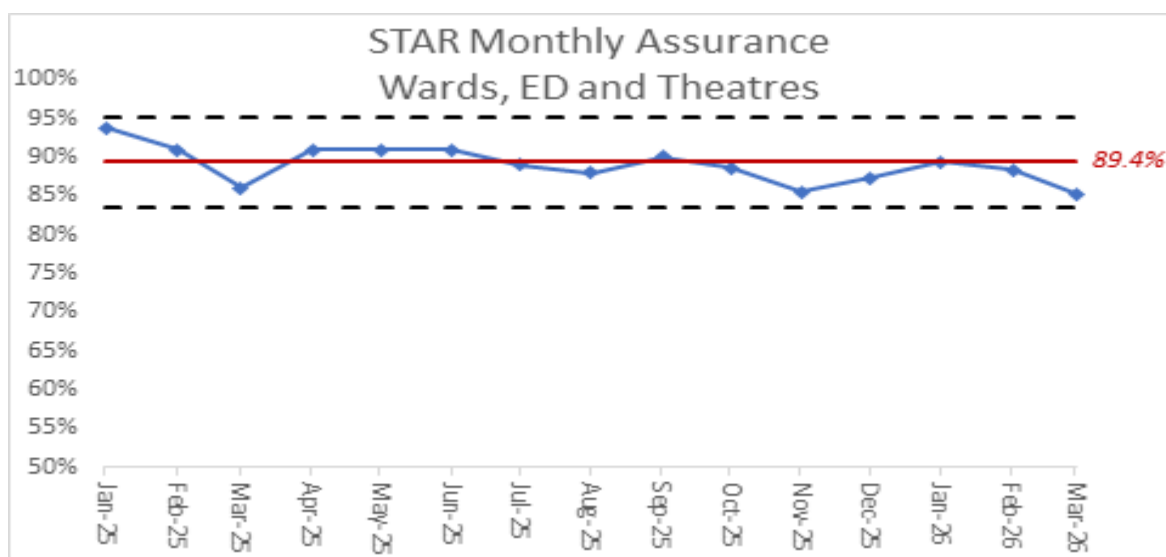


Figure 14: STAR Monthly Review Trust-wide Compliance and STAR Monthly for Wards, ED and Theatres by Month





3.1.3 Falls Prevention

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

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

Figure 15: Falls Data 2025–26

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

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

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



Source: LTHTR Datix data

3.1.3.1 Falls Risk Management and Governance

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

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

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

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

3.1.4 Safeguarding (including Maternity, Children and Adults)



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

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

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

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

3.1.4.2 Safeguarding Activity

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

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

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

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

3.1.4.3 Externally commissioned services

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

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

Table 15: Safeguarding Teams externally funded specialist roles

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

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

3.1.4.4 Maternity Safeguarding Activity

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

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

3.1.4.4.1 Key Activities and Achievements

Key developments during the year include:

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

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

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

3.1.4.5 Children and Young People

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

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

3.1.4.5.1 Summary of Safeguarding Activities

Strengthening partnership working

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

Improving response to child sexual harm

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

Child Protection Information Sharing (CP-IS)

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

Supporting children in care

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

Professional challenge and escalation

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

Strengthening safeguarding practice

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

Emergency Department Navigator

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

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

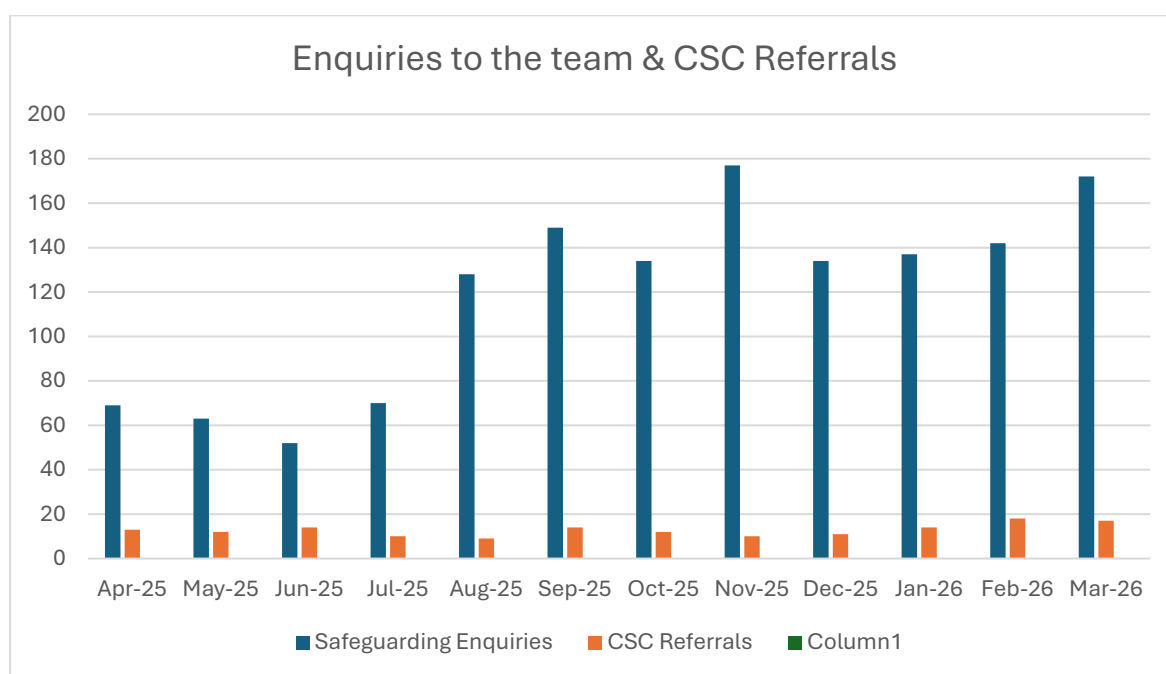
3.1.4.5.2 Child Safeguarding Training mandatory Compliance

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

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

3.1.4.5.3 Social care referrals

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



Source: LTHTR Datix/Ulysses data

3.1.4.5.4 Children's Social Care Referrals

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

3.1.4.5.5 Child Deaths

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

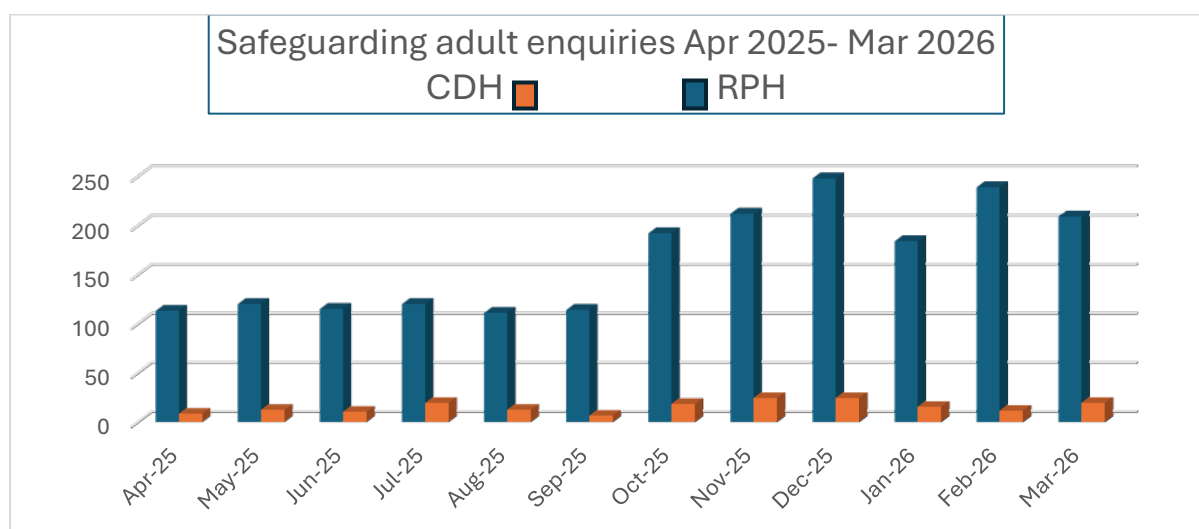
Child Mortality Review Meetings continue to be chaired by the Named Doctor for Children's Safeguarding, providing clinical leadership and professional oversight. Meetings are formally recorded, with agreed actions monitored through the Women's and Children's governance structure to ensure clear accountability,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

3.1.4.6 Safeguarding Adult Activity

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

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

Figure 18: Safeguarding Adult enquiries



Source: LTHTR Datix/Ulysses data

3.1.4.6.1 Section 42 enquiries

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

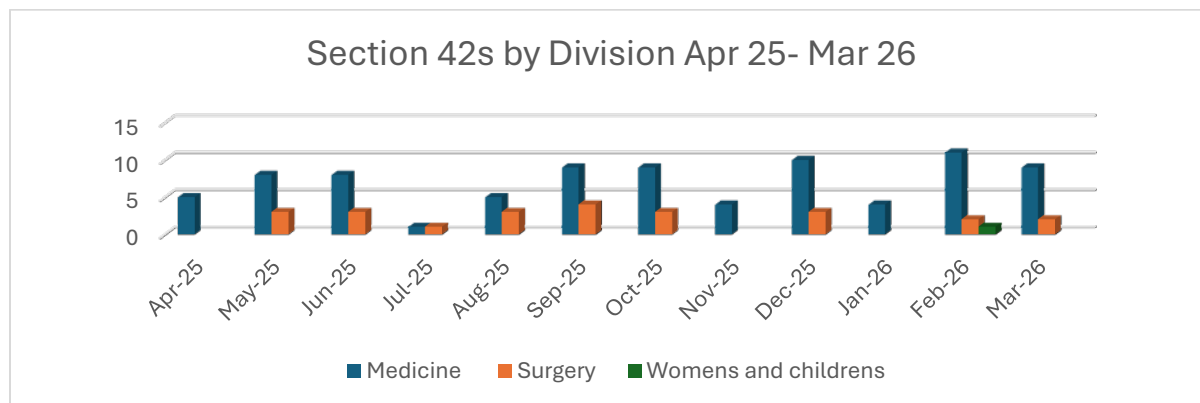
The Trust has clear processes to respond to these enquiries. Adult Safeguarding Practitioners lead internal reviews and act as the link with the Local Authority.

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

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

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

Figure 19: Section 42 by Division

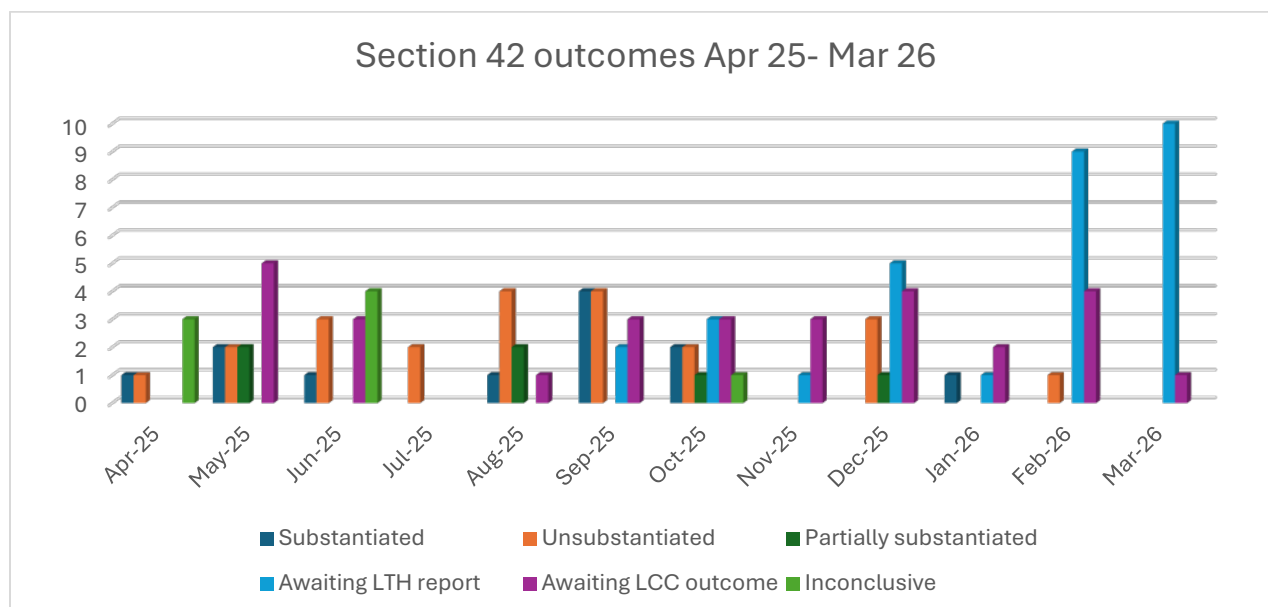


Source: LTHTR Datix/Ulysses data

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

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

Figure 20: Section 42 by outcomes



Source: LTHTR Datix/Ulysses data

3.1.4.6.2 Adult safeguarding training & PREVENT

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

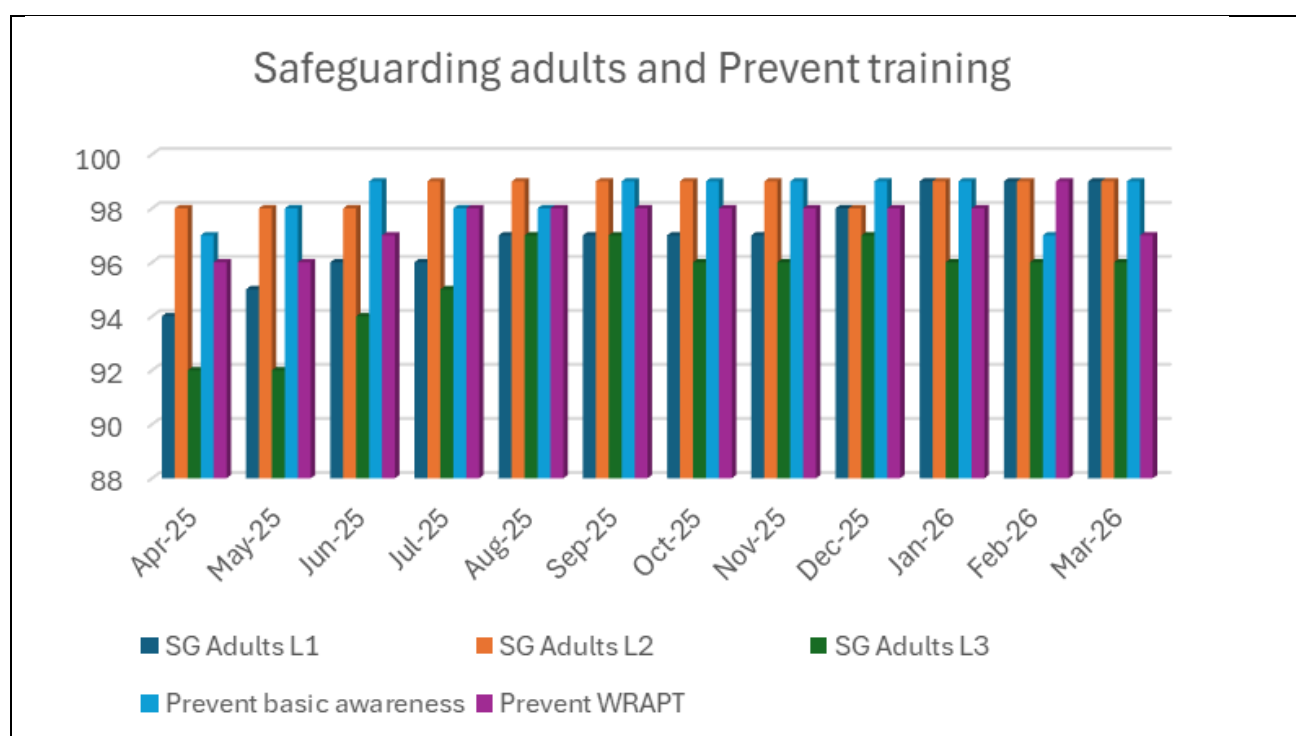
The Trust continues to work with regional and national partners to identify and respond to risks linked to radicalisation and exploitation.

In the past year:

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

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

Figure 21: Safeguarding and Prevent Training



Source: LTHTR Datix/Ulysses data

3.1.4.6.3 Managing Allegations Persons in Position of Trust (PiPoT)

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

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

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

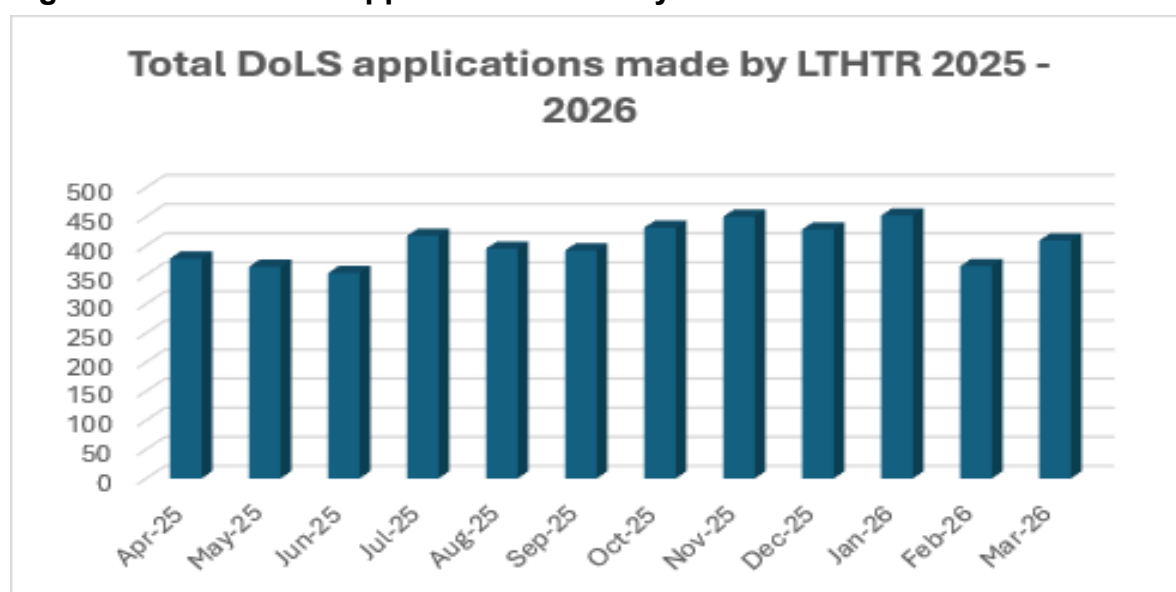
The Trust uses an electronic system to support the Mental Capacity Act and Deprivation of Liberty Safeguards processes, helping ensure decisions are lawful, consistent and centred on the patient.

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

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

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

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



Source: LTHTR Datix/Ulysses data

3.1.4.6.5 Safeguarding Supervision

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

3.1.4.6.6 Mental Health, Learning Disabilities, Autism and Dementia

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

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

Safeguarding Single Improvement Plan (SIP):

Work has focused on improving care for patients with mental health needs, learning disabilities and autism. This includes reducing restrictive practices, improving de-escalation and supporting staff to manage complex needs.

Training and workforce development:

Progress includes:

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

Patient and family engagement:

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

Data, governance and assurance:

Improved oversight includes:

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

Wider improvement work:

Key developments include:

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

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



3.1.5 Incidents

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

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

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

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

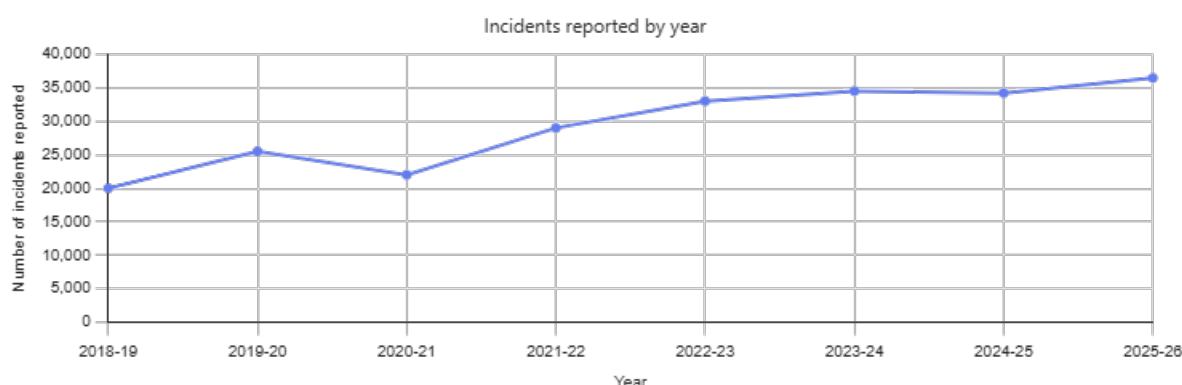
Table 16: Level of Harm Related to Incidents 2025-26

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

Source: LTHTR Datix data

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

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



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



3.1.6 Never Events

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

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

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

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

Table 17: Never events incidence April 2025 to March 2026

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

3.1.7 Duty of Candour



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

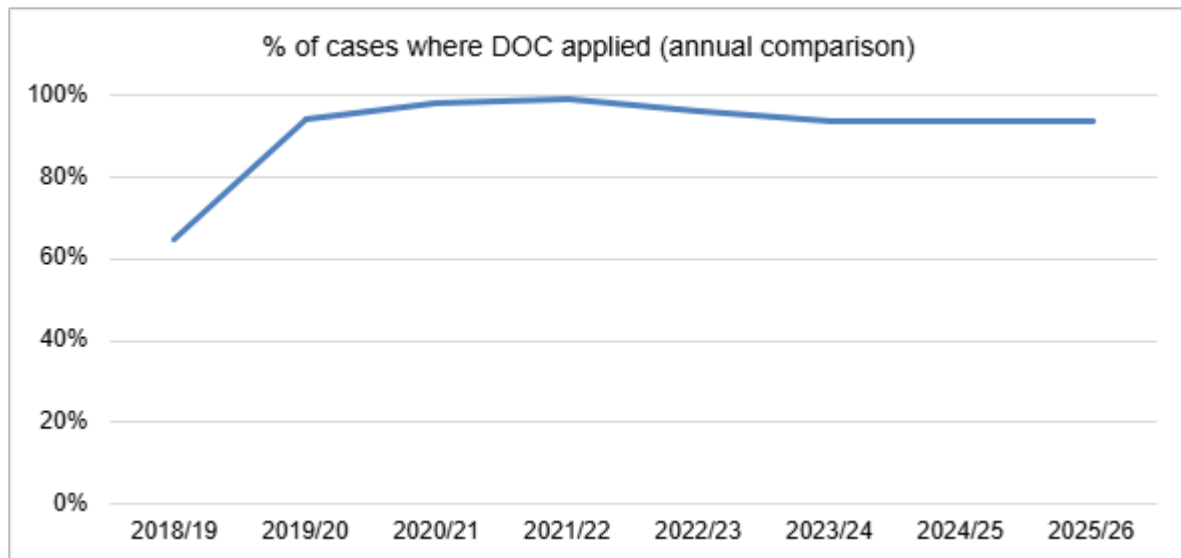
In 2025–26, **552 cases** met the criteria for Duty of Candour, an **11% reduction** from the previous year:

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

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

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

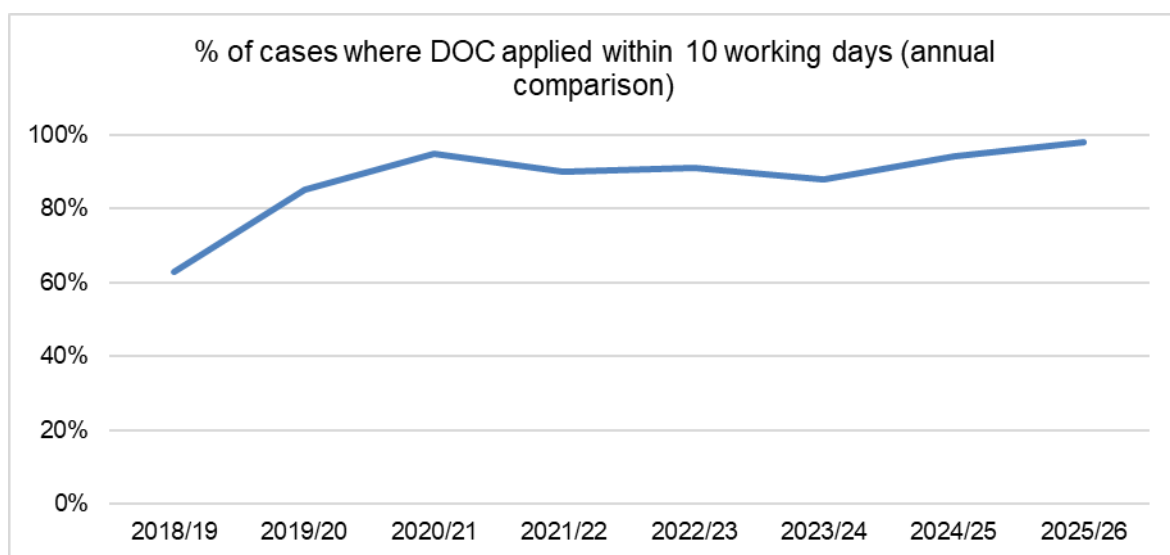
Figure 24: Percentage of Cases with Duty of Candour Applied (Annual Comparison)



Source: LTHTR Ulysses data

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

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



Source: LTHTR Ulysses data

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

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

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

3.2 Review of Quality Performance - Effective Care

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

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

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

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



3.2.1 Getting It Right First Time (GIRFT)

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

Central oversight

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

GIRFT Steering Group

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

Ten specialty deep dive sessions

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

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

Table 18: Key GIRFT Activities in 2025–26

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

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

3.2.2 Tissue Viability - Pressure Ulcer Incidence and Prevention



3.2.2.1 Pressure Ulcer Incidence

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

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

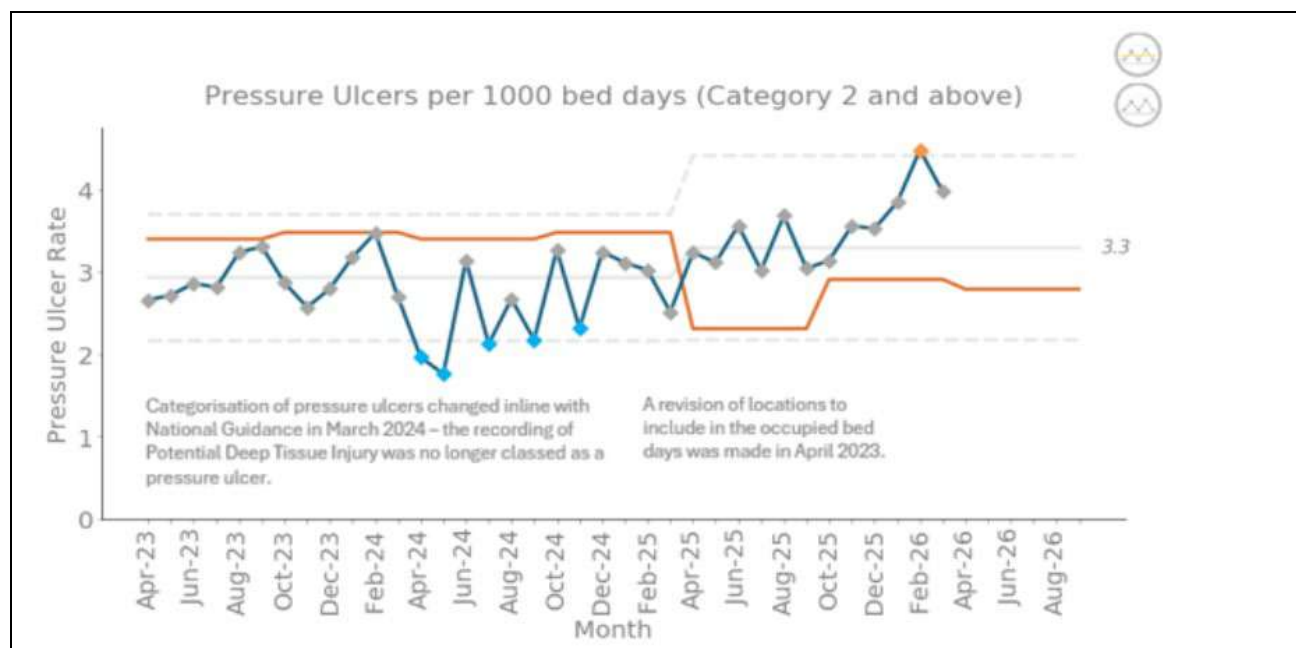
- Increasing patient frailty and complexity
- Longer stays in the Emergency Department
- More patients being cared for in temporary ward areas
- Delays in discharge for patients waiting for community support or placements

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

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

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

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



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

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

3.2.2.2 Pressure Ulcer Improvement Plan

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

Learning from Incidents

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

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

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

Education and Training

Ongoing training supports staff to prevent pressure ulcers, including:

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

Strengthened Governance

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

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

Clinical Practice and Equipment

Improvements in care and equipment include:

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



3.2.3 Nutrition for Effective Patient Care

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

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

3.2.3.1 Nutritional Screening

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

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

Compliance is monitored through the STAR quality assurance system.



3.2.4 Medication and Incident Monitoring

3.2.4.1 Medicines Safety

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

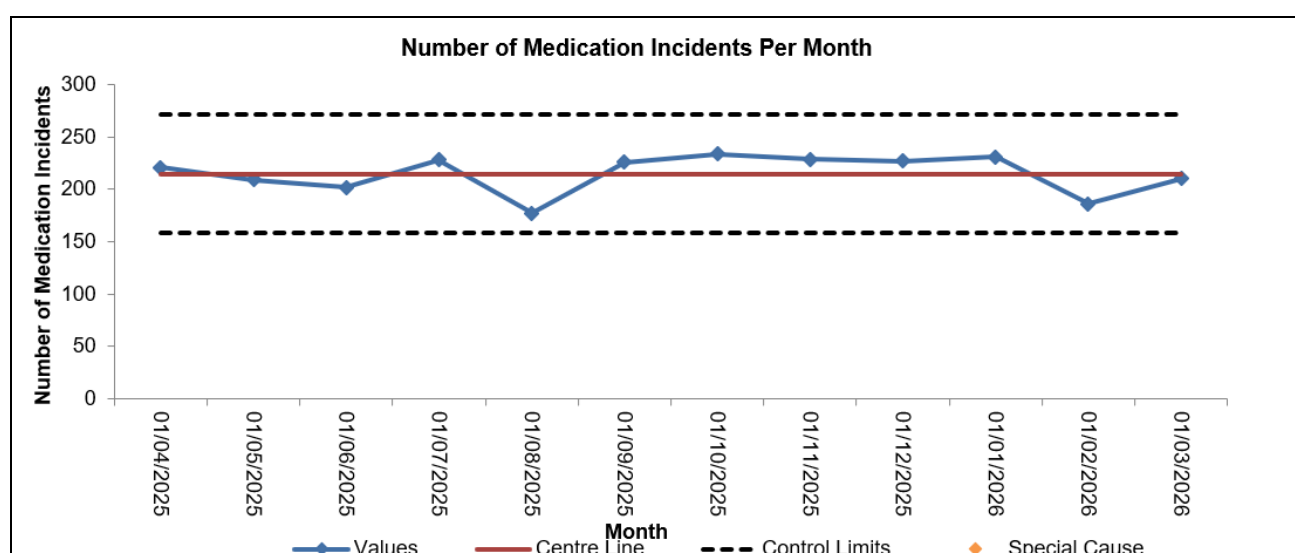
The Medication Safety team promotes a culture of incident reporting in line with the Patient Safety Incident Response Framework (PSIRF). Reporting is supported through the Ulysses system, introduced in February 2026.

Between April 2025 and March 2026:

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

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

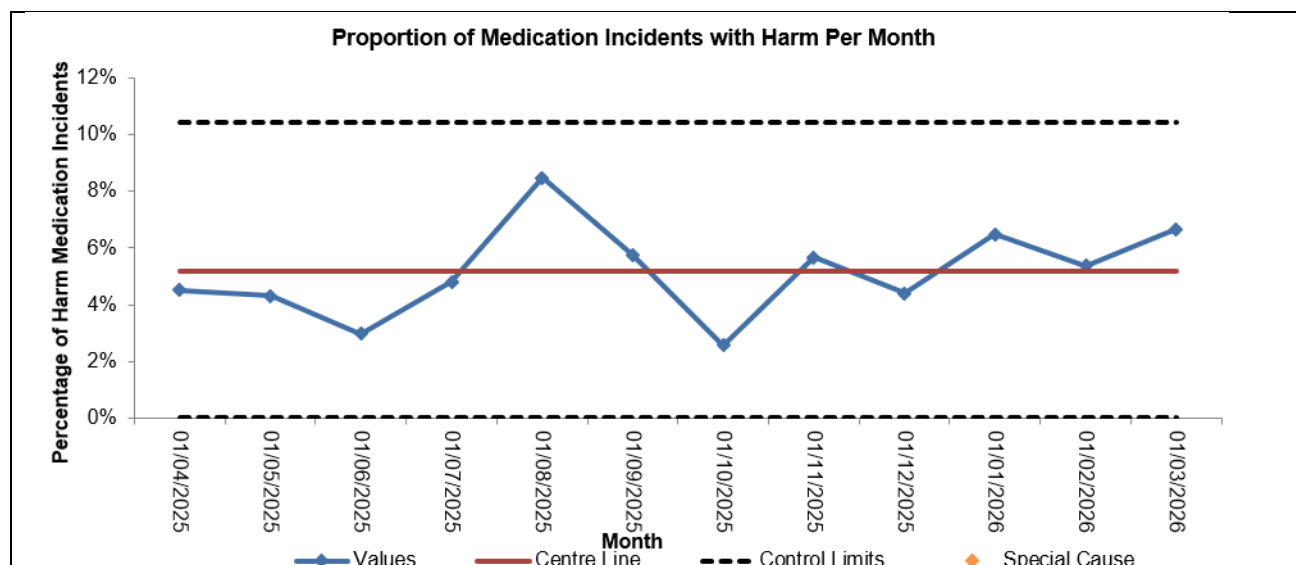
Figure 27: Number of medication incidents per month



Source: LTHTR data

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

Figure 28: Proportion of medication incident with harm per month



Source: LTHTR data

3.2.4.2 Medication Safety Governance and Proactive Monitoring

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

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

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

3.2.4.3 Clinical Pharmacy Service

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

Recent work to better match capacity and demand has included:

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

4. Verification of other medicines

3.2.4.4 Discharge

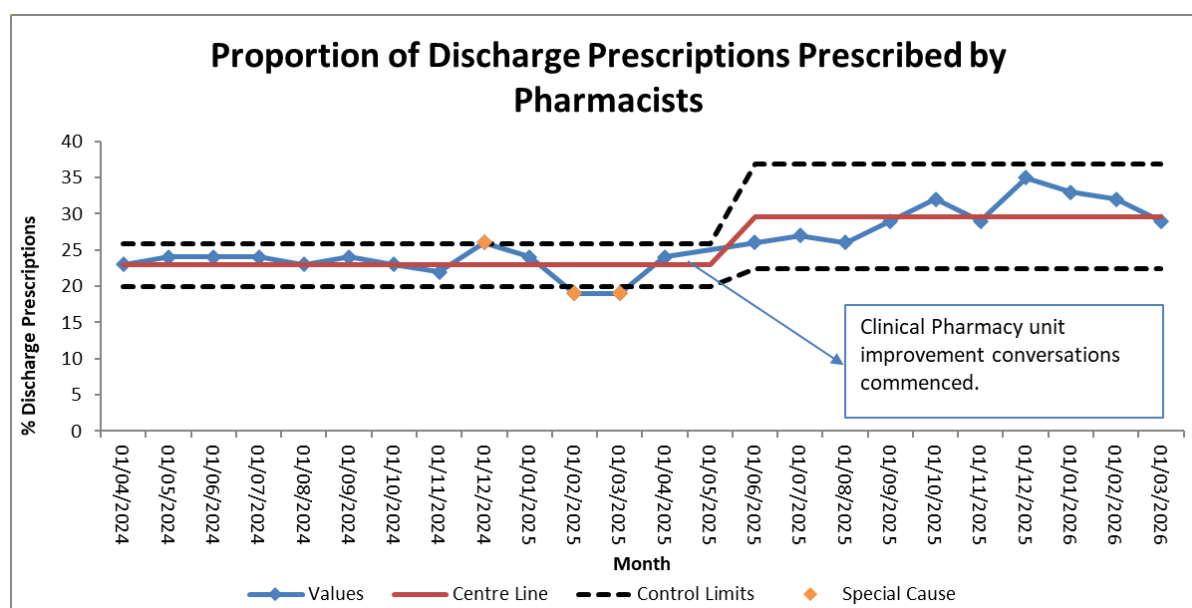
Discharge medicines remain a priority, supporting timely patient discharge and improving flow through the hospital.

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

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

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

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



Source: LTHTTR.data

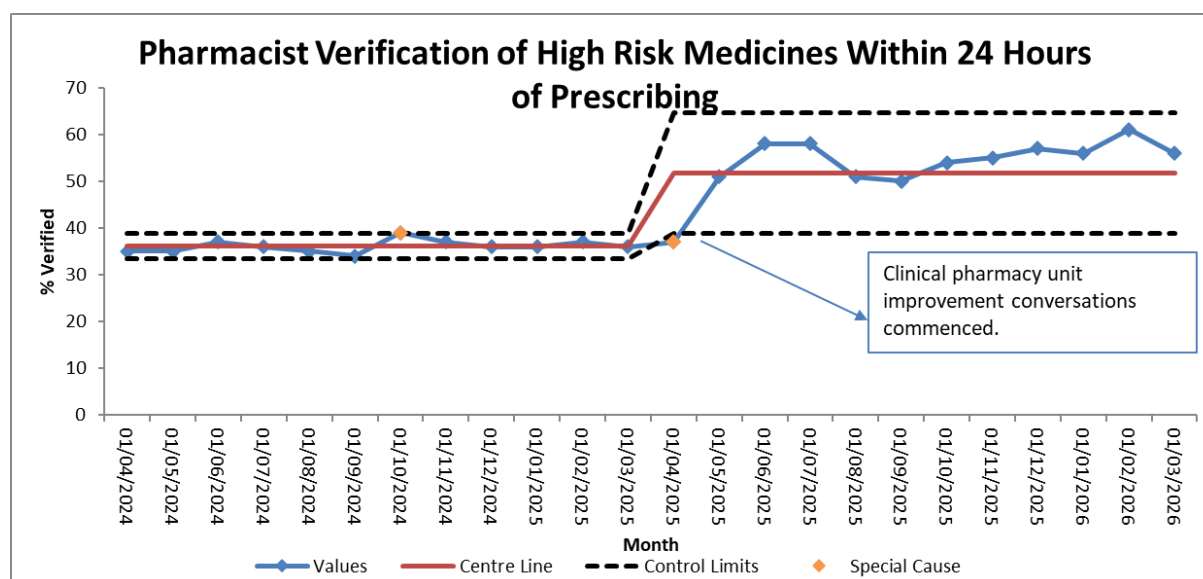
3.2.4.5 High risk medicines

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

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

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

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



Source: LTHTR data

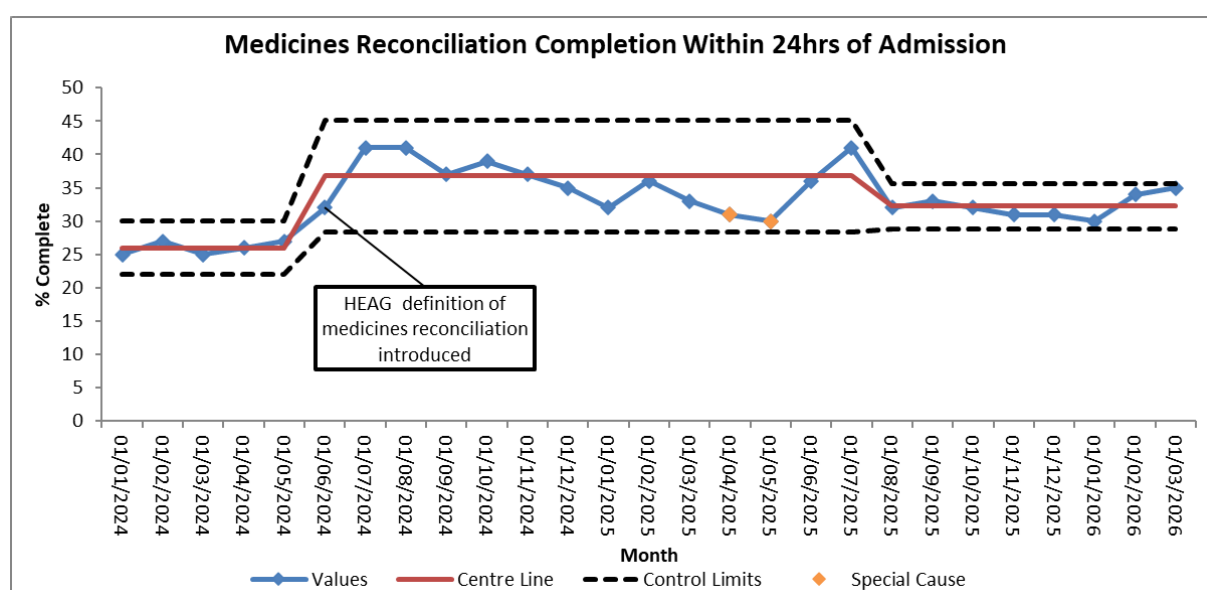
3.2.4.6 Medicines reconciliation

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

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

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

Figure 31: Medicines Reconciliation Within 24hr of Admission



Source: LTHTR data

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

Within existing resources, improvements continue, supported by:

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

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

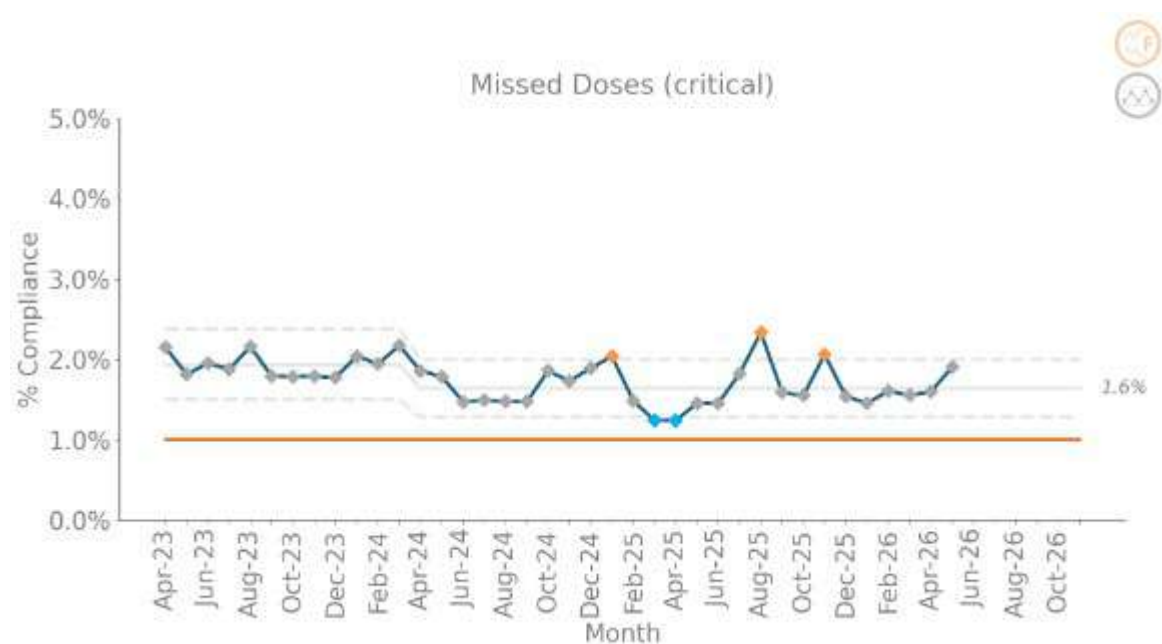
3.2.4.7 Medication Administration

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

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

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

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



Source: LTHTR data

3.2.4.5 Antimicrobial Stewardship

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

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

These audits review:

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

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

Table 19: Antimicrobial Stewardship Point Prevalence Audit Results

	N° of patients on antibiotics	N° of antibiotic prescriptions audited	% Documented Indication on the Prescription	% Compliance with Guidelines	% Compliance with Guidelines or Recommended by Microbiology	% Compliance with documented review within 72hrs
Trust Wide Q4 2025-26	404	561	90%↓	83%↓	86%↓	92%↓
Trust Wide Q3 2025-26	359	482	93%↓	90%↔	92%↔	96%↑
Trust Wide Q2 2025-26	333	446	96%↑	90%↔	92%↑	90%↑
Trust Wide Q1 2025-26	313	410	94%↑	90%↔	91%↔	53%↓

Source: LTHTR data

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

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

Further improvements during the year include:

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

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



3.2.5 Infection Prevention and Control (IPC)

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

Key Achievements

During 2025–26, progress included:

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

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

Areas for focus

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

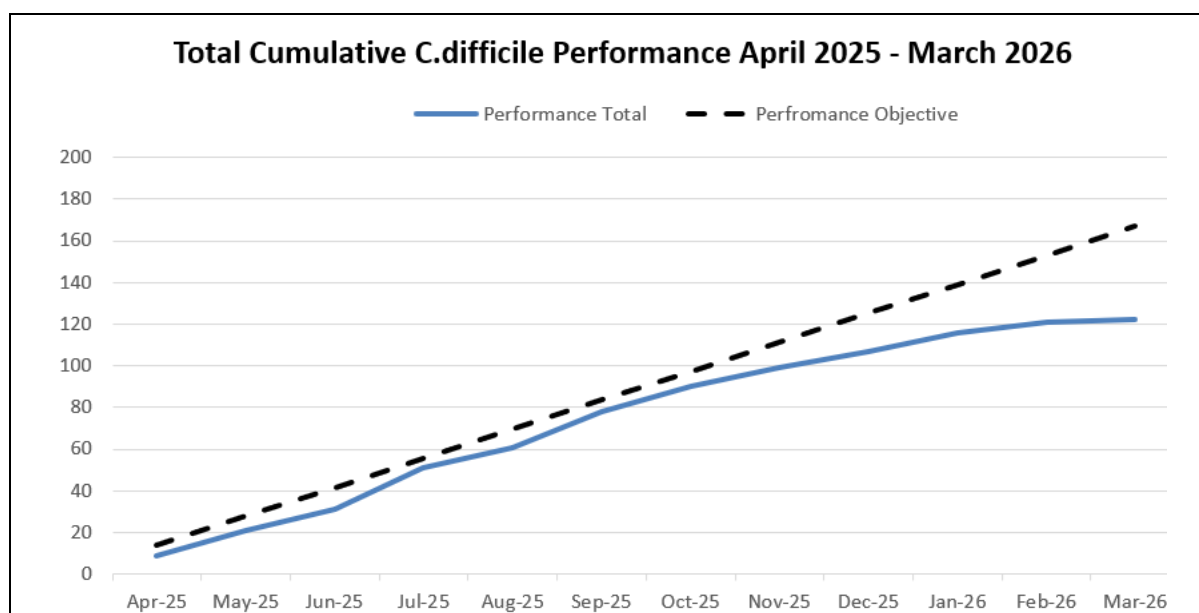
3.2.5.1 *Clostridioides difficile* (*C.difficile*)

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

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

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

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



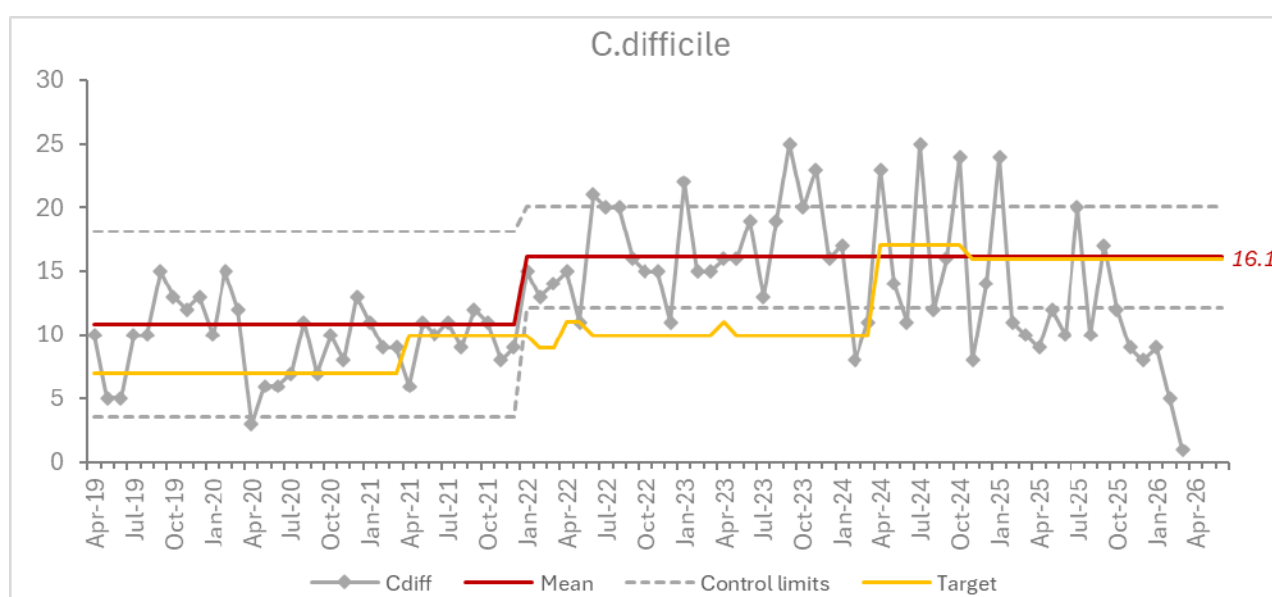
Source: LTHTR.data

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

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

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

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



Source: LTHTR.data

The National and Regional picture

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

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

Key developments during 2025-26

National standards of cleanliness

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

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

C. difficile testing

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

Digital dashboard

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

National surveillance programme

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

Significant challenges and opportunities for 2026-27

Estates and infrastructure

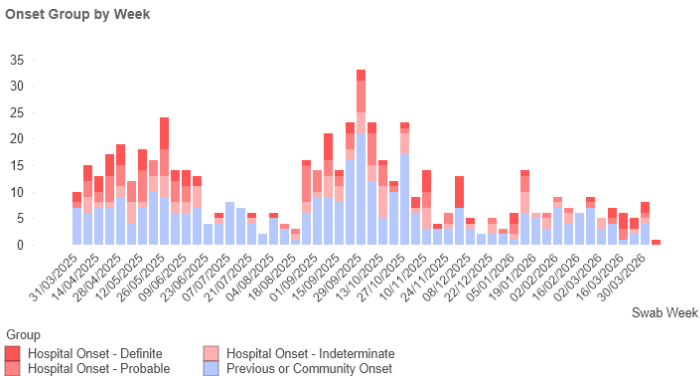
Ageing buildings and limited single-room capacity continue to present challenges. Issues with drainage systems and infrastructure remain under review, with plans for improvement.

Capacity pressures

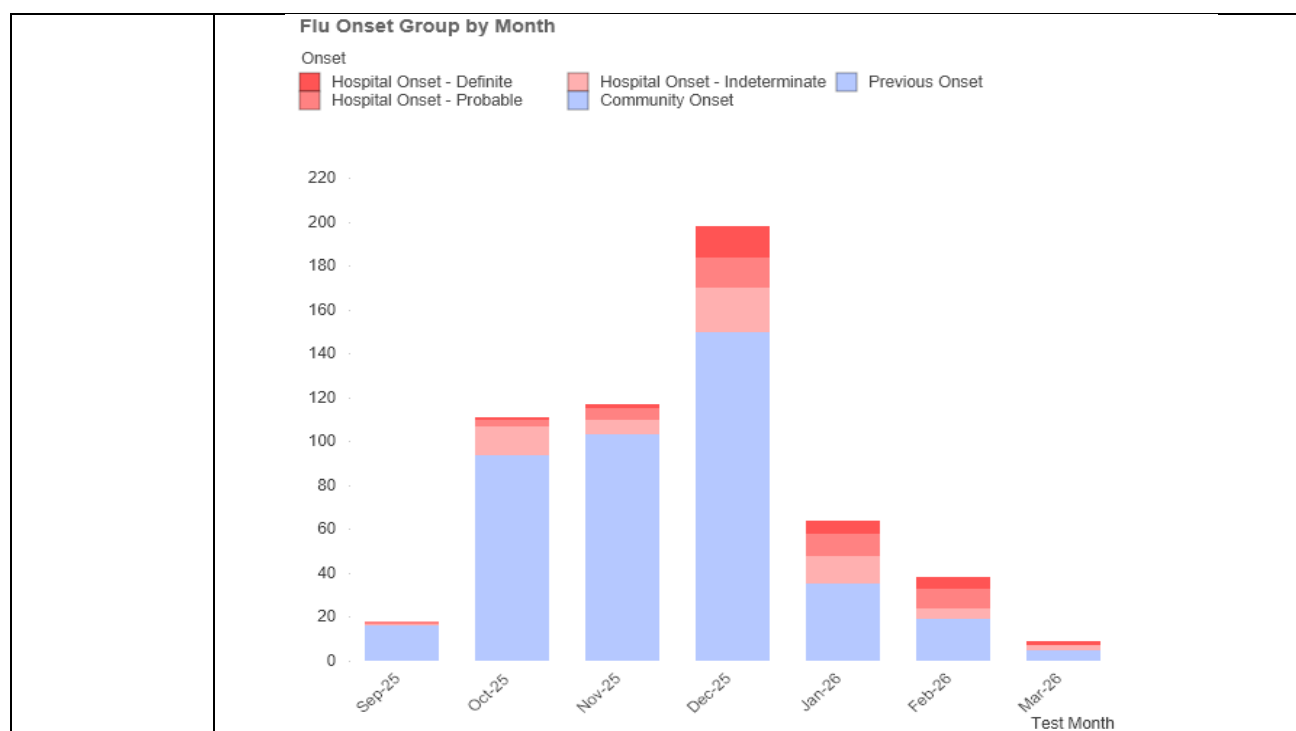
Ongoing pressure on emergency and inpatient services, including patient boarding, increases the risk of infection. Improving patient flow and ensuring appropriate facilities remain key priorities.

3.2.5.2 Infection Prevention and Control Performance against other organisms of concern

Table 20: Trust performance related to other organisms of concern

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

	Source: LTHTR data The 2025/2026 Objective for <i>Pseudomonas aeruginosa</i> Bacteraemia Hospital Associated Infections was 13. LTHTR ended the year with a Total of 14 Hospital Associated <i>Pseudomonas aeruginosa</i> Bacteraemia cases for 2025/2026, this is 1 case over the objective. The 2025/2026 objective for <i>Klebsiella</i> species bloodstream Hospital Associated Infections was 26. The Trust ended the year with a Total of 38 Hospital Associated <i>Klebsiella</i> species cases for the year 2025/2026, this is 12 cases above the objective.
3.2.5.2.4 Norovirus	The year 2025/2026 saw 25 Confirmed Norovirus Outbreaks (4 outbreaks less than in 2024/25). This matched the current National picture with increased spread of new variant of Norovirus (GII.17) to a more susceptible population that had not been exposed to such viruses during the COVID-19 Pandemic. Figure 37: Number of confirmed positive Norovirus Patients April 2025 – March 2026 (excluding patients identified in outbreaks that are likely Norovirus positive but not tested) Source: LTHTR data
3.2.5.2.5 Influenza	The Influenza season at LTHTR began in September 2025 and peaked earlier in the winter than in previous years in line with national trends. In December 2025 there were concerns about the potential of an exceptionally severe winter season, due to the emergence of new circulating influenza strains. As a precautionary step, in late December 2025 and early January 2026 universal mask wearing was implemented on admission areas. However, LTHTR remained within expected seasonable patterns, and this was withdrawn. Figure 38: Influenza cases in the 2025/26 season. Source: LTHTR data



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

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



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

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

Table 21: Understanding Key Mortality Indicators

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

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

3.2.6.1 Mortality Surveillance

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

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

Figure 39: SHMI Peer Comparison Funnel Plot

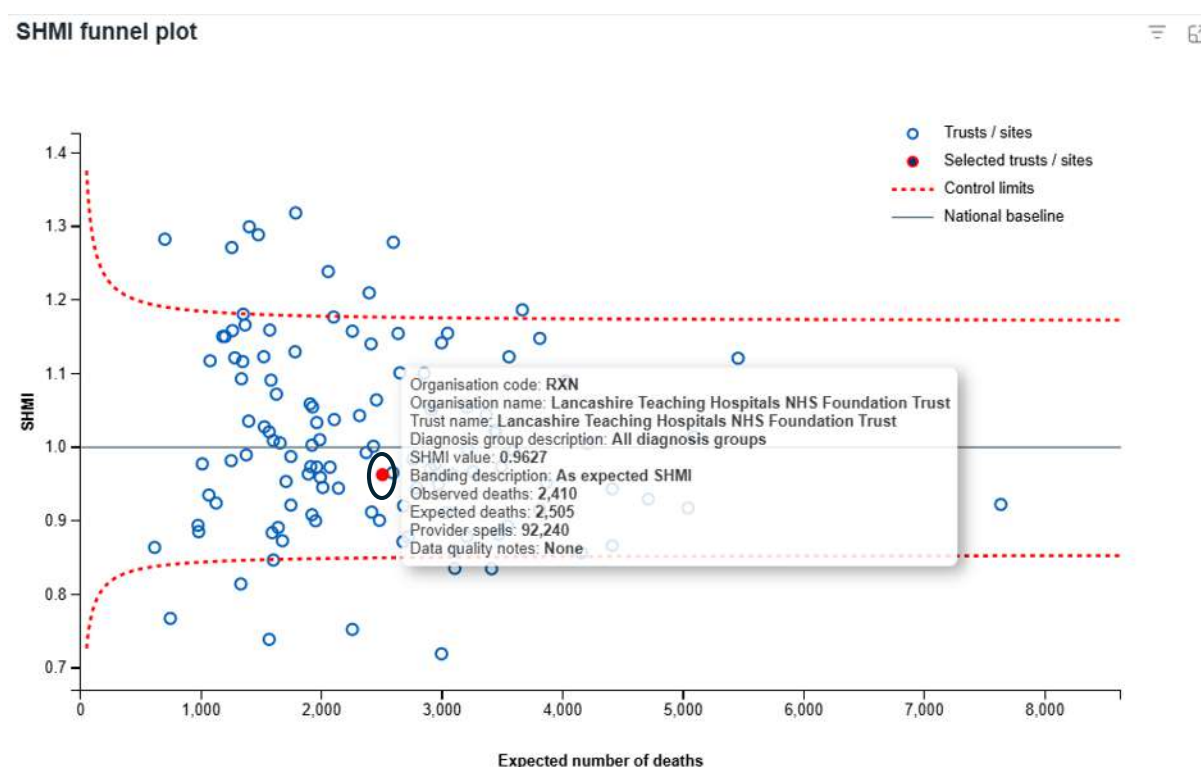


Figure 40: Monthly HSMR Trend

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

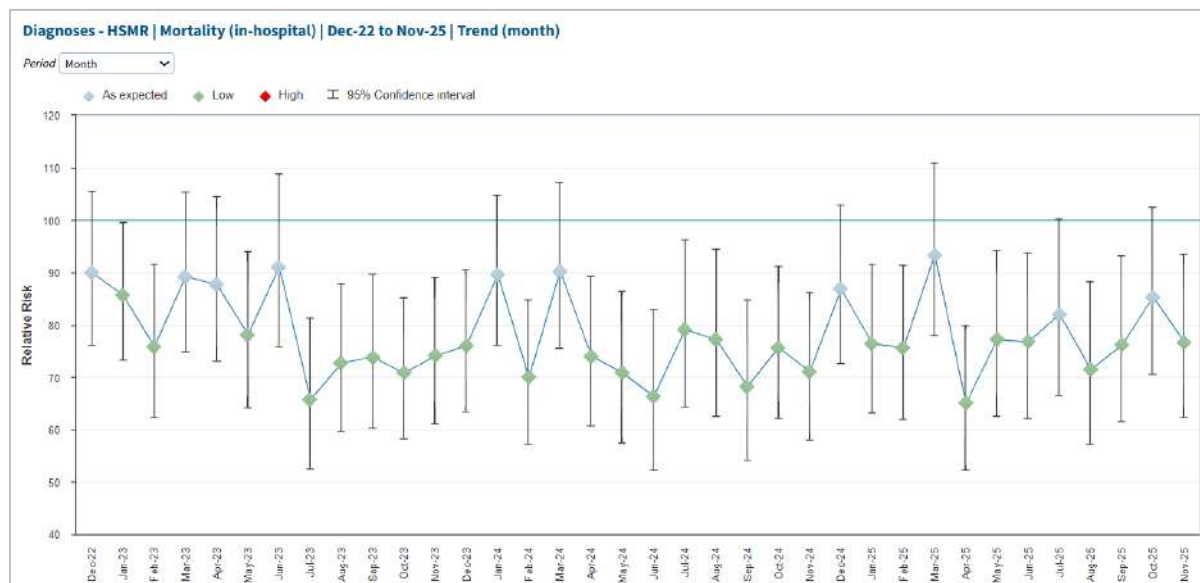


Figure 41: Rolling 12-month HSMR Trend

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

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

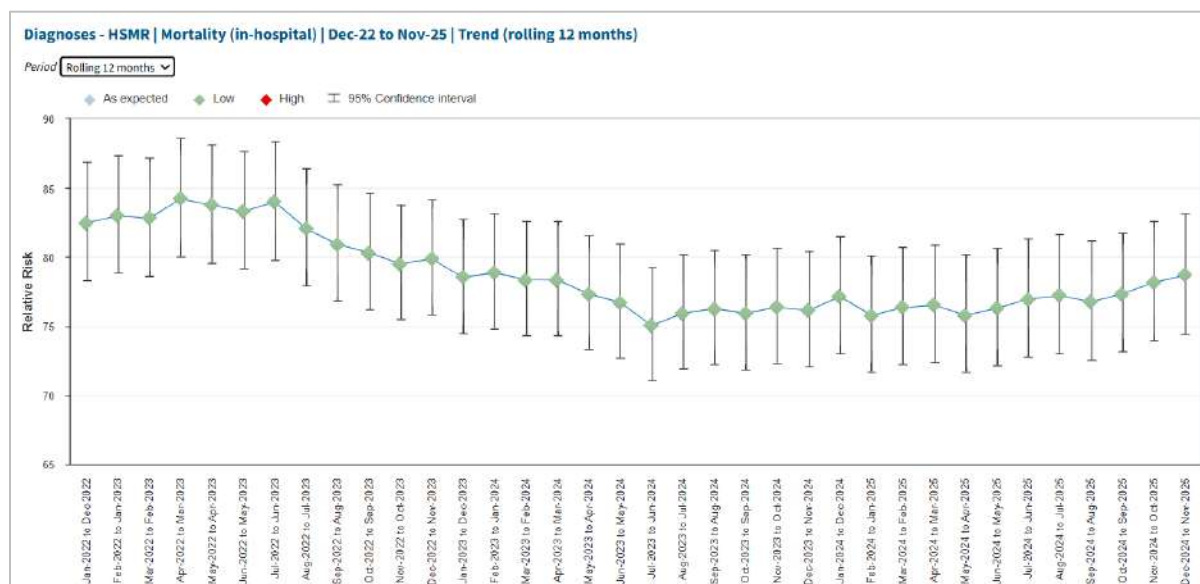


Figure 42: HSMR Regional Peer Comparison

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

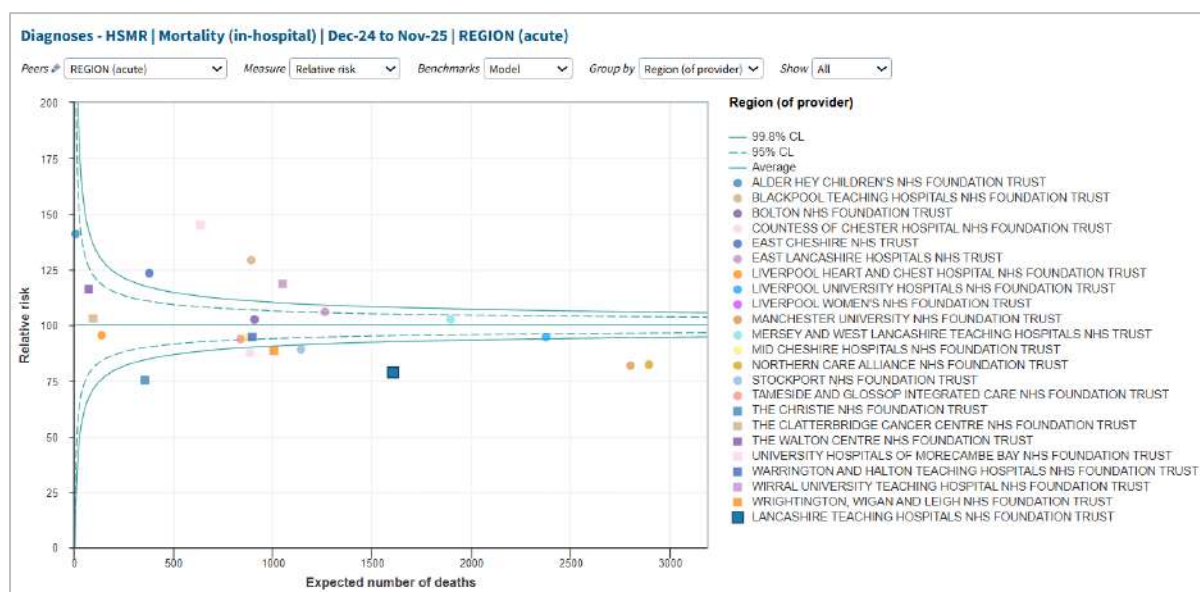
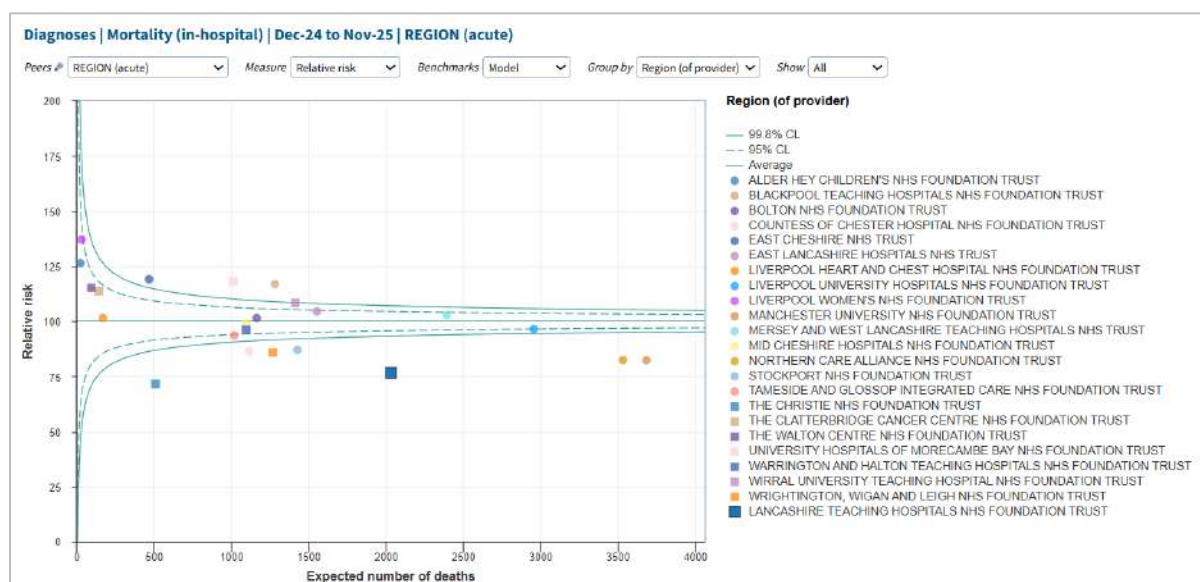


Figure 43: SMR Regional Acute Trust Benchmark December 2024 – November 2025

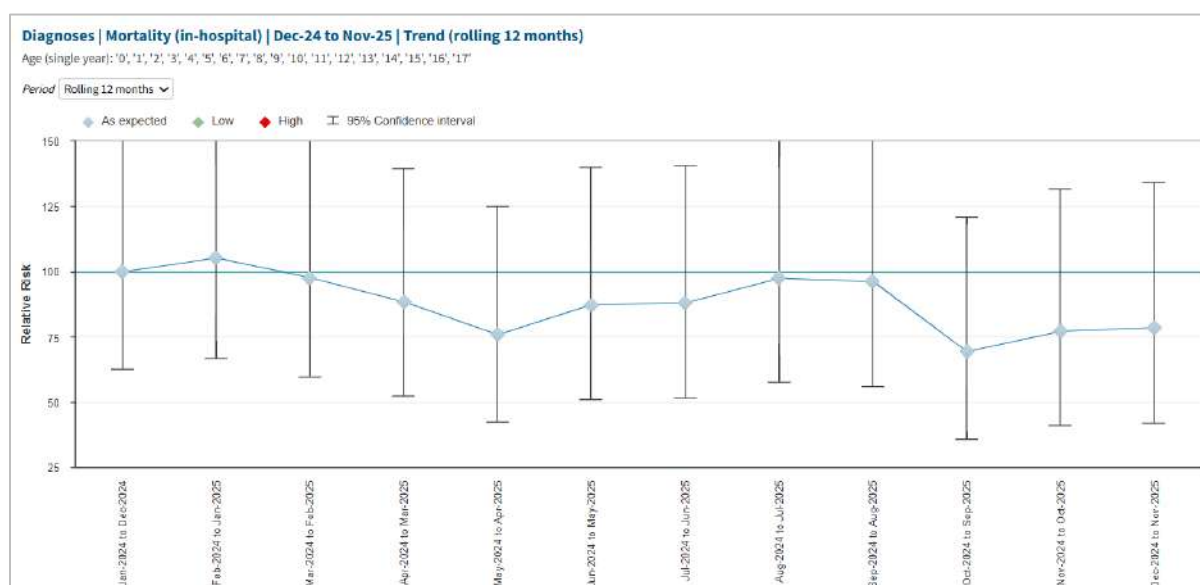
The Standardised Mortality Ratio (SMR) for all diagnoses was **76.6**, indicating mortality lower than expected. This is shown in the figure below, demonstrating performance compared to regional acute trusts.



3.2.6.2 Child Deaths

Figure 44: SMR for Children

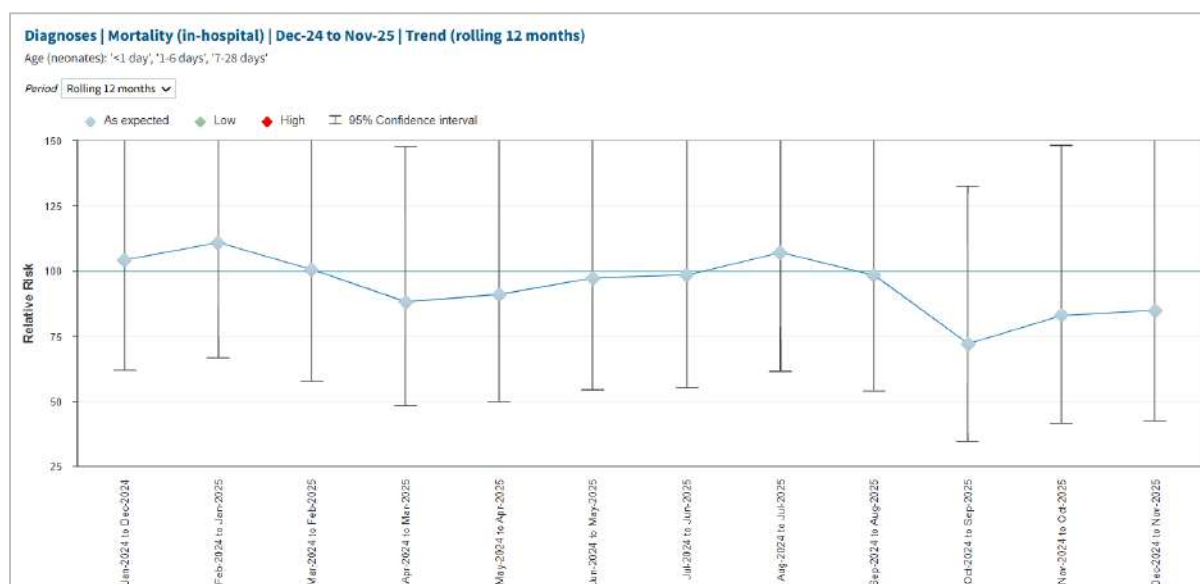
Child SMR (0–17 years): 78.4 – within expected range



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

Figure 45: SMR for Neonatal Deaths

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



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

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

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

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

3.2.6.3 Perinatal Mortality & Perinatal Mortality Review Tool

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

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

Between April 2025 and March 2026:

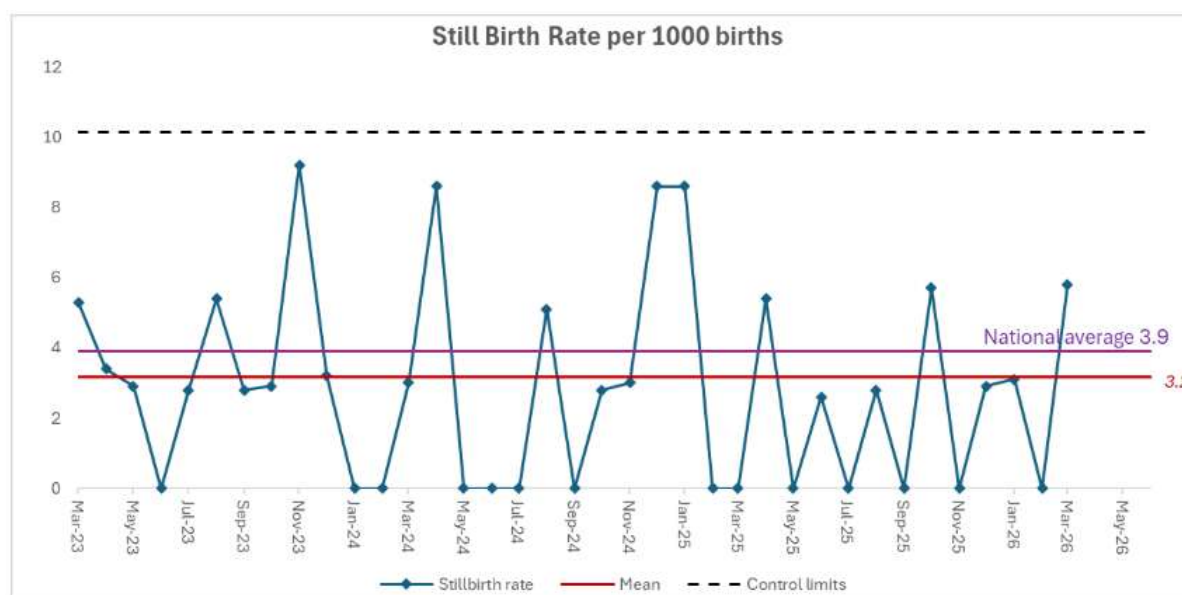
- 25 cases were reported to MBRRACE-UK
- 20 cases met the criteria for full review

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

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

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

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



3.2.6.4 Medical Examiner Service

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

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

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

The review process includes:

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

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

Table 22: Medical Examiner Service Performance 2025-26 data

Total Figures for April 2025 – March 2026

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

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

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

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

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

Key themes identified included:

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

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

3.2.6.5 Learning from Corners Regulation 28 Report

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

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

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

Key actions included:

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

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

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

3.3 Review of Quality Performance – Experience of Care

3.3.1 Patient Experience Performance Report 2025-26



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

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

Key objectives include:

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

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

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



3.3.2 Complaints and Concerns

3.3.2.1 Complaints

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

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

Table 23: Comparator data for Complaints 2023 to 2026

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

Source: LTHTR.Datix-Ulysses

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

Of the complaints received:

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

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

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

Source: LTHTR.Datix-Ulysses

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

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

Source: LTHTR.Datix-Ulysses

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

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

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

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

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

In addition, the Patient Experience and PALS Team managed:

- 1,654 concerns
- 4,739 enquiries

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

Table 26: Top 3 themes from complaints by division

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



3.3.3 The Parliamentary Health Service Ombudsman (PHSO)

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

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

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

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



3.3.4 Compliments

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

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

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

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



3.3.5 Friends and Family Feedback (FFT)

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

The Trust reports FFT feedback across the following areas:

- Maternity

- Day case
- Outpatients
- Inpatients
- Emergency Department

3.3.5.1 Children and Young People (CYP) Feedback

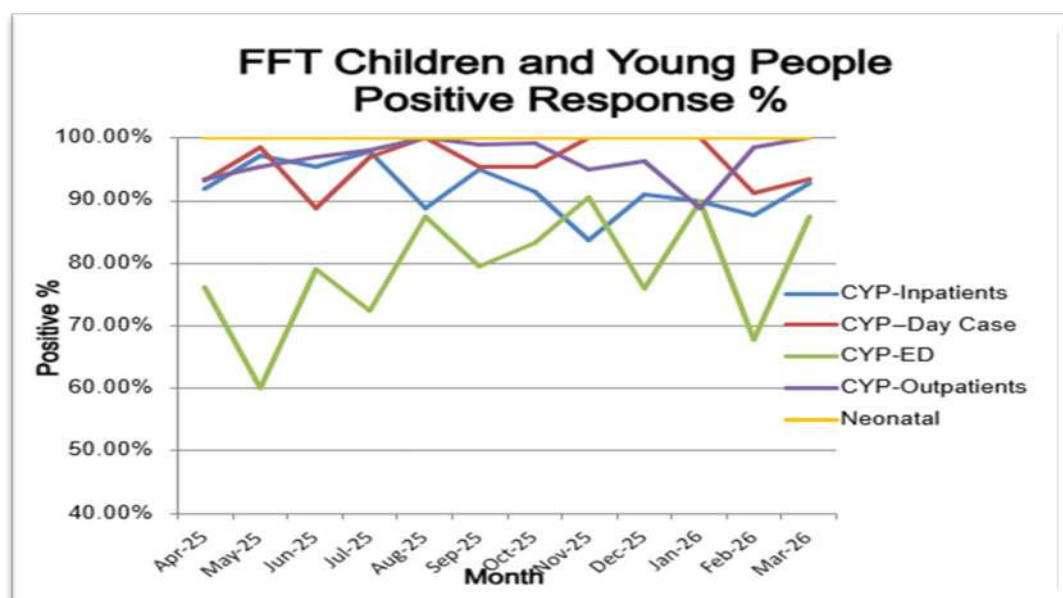
Although not a national requirement, the Trust also collects feedback from Children and Young People to ensure their experiences are understood.

Feedback shows variation across services:

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

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

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



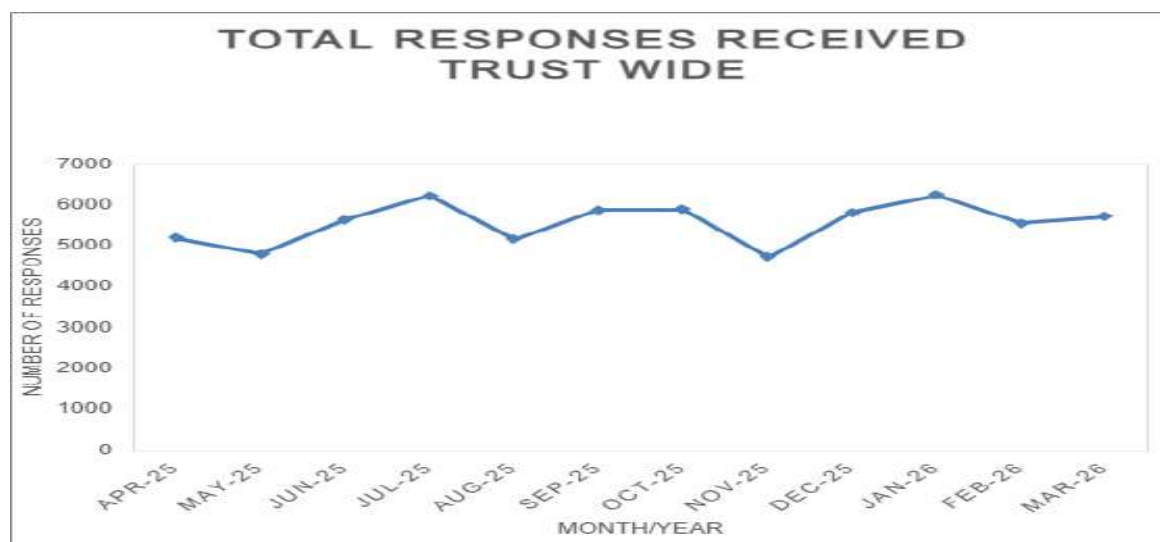
.....Source: FFT.data.CIVICA

3.3.5.2 Response Rates and Collection Methods

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

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

Figure 48: Friends and Family % Response



.....Source: FFT.data.CIVICA

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

Table 27: FFT response rates

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

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

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

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

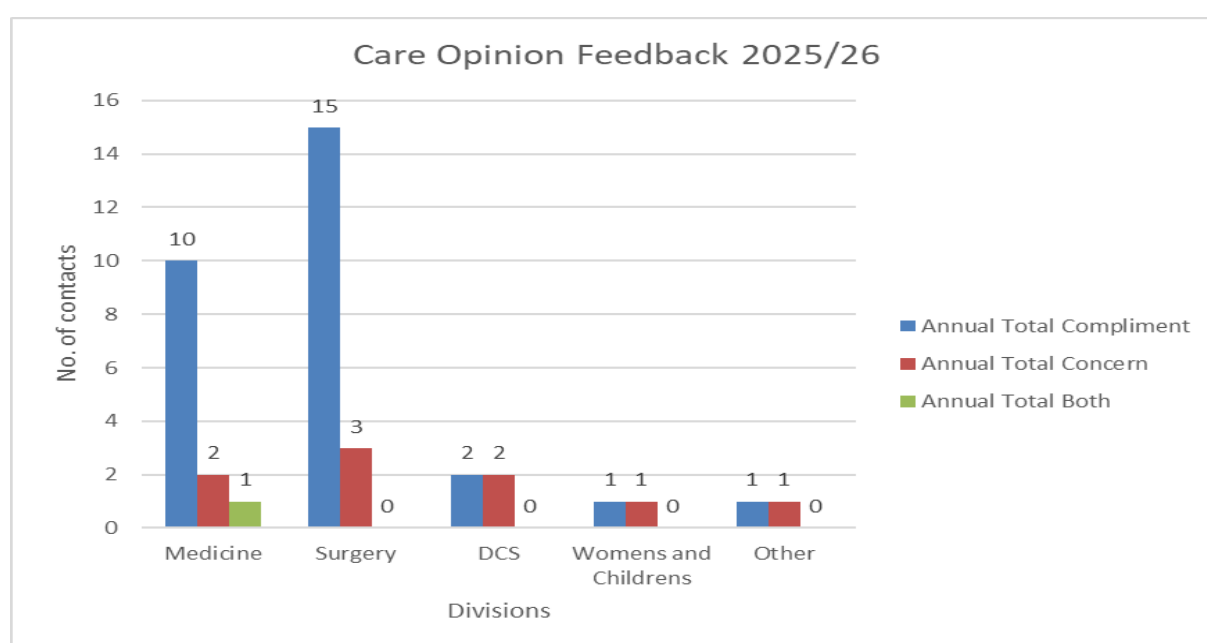
3.3.5 Care Opinion Website

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

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

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

Figure 49: Care Opinion feedback



3.3.6 National Patient Survey Results

Maternity Survey 2025

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

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

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

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

Inpatient Survey 2024

The survey included patients treated between January and April 2024:

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

Of the 63 questions, 45 were comparable with 2023:

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

Compared with other trusts:

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

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

Children and Young People's Survey 2024

The survey included patients treated between March and May 2024:

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

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

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

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

4. Major Service Developments and Improvements



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

Key developments

24/7 Thrombectomy Service

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

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

More details are [available on the Trust website](#)

New hospital site progress

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

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

The full story is [available on the Trust website](#).



Helipad refurbishment

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

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



Medicine reconfiguration programme

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

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

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

Pathology Service transformation

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

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

Robotic surgery milestone

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

The full story is [available on the Trust website](#).



New radiotherapy equipment

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

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

The full story is [available on the Trust website](#).



Dialysis service development

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

The full story is [available on the Trust website](#).



Robotic rectal cancer surgery

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

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

The full story is [available on the Trust website](#).



4.1 Staff Survey and Recommendation of Our Care

4.1.1 NHS Staff Survey 2024-25

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

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

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

4.1.2 Survey Results and Benchmarking

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.1.3 Staff Engagement Results

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

Table 30: 2025 Staff Engagement Question Breakdown

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

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

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

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

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

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

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

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

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

4.1.4 Next steps and future priorities

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

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

4.1.5 Priorities and targeted actions

Key areas of focus include:

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

Examples of work delivered in 2025-26:

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

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

4.1.6 Monitoring Performance and Tracking Impact

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

Performance is reviewed through:

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

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

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

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

4.2 Medical and Dental Workforce Rota Gaps



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

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

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

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

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

Table 31: Medical and Dental Vacancies

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

Grade	Funded WTE	Filled WTE	Vacant WTE	Vacancy Rate
FY1	68.60	68.00	0.60	0.41%
FY2	44.00	40.90	3.10	7.05%
ST1-2	120.00	108.06	11.94	9.95%
ST3+	144.56	175.12	N/A	N/A
Junior Clinical Fellow	85.81	89.62	N/A	N/A
Senior Clinical Fellow	123.34	106.48	18.86	13.67%
SAS	94.86	92.75	2.11	2.22%
Consultant	520.72	480.27	40.45	7.77%
Total	1,201.29	1,161.80	39.49	3.29%

.....Source: LTHTR data Feb. 868 General ledger.

4.3 Consultant Vacancy Rates



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

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

To manage these pressures, the Trust continues to:

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

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

4.4 Core Skills Training



4.3 Core Skills Training

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

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

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

Further detail is provided in Table 32.

Table 32: Core Skills training metrics

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

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

4.5 Quality Assurance

4.5.1 Overview and Assurance Statement

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

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

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

4.5.2 Governance and Oversight

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

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

4.5.3 Governor Engagement and Assurance

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

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

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

Annex 1 : Statements from external stakeholders

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

Our ref: QA2025-26 SD 001



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22nd June 2026

Professor Silas Nichols
Lancashire Teaching Hospital NHS Trust

Dear Silas

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

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

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

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

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

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

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

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

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

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

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

delivering sustained reductions in delays and improvements in operational performance.

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

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

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

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

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

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

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

The ICB will continue to seek assurance that:

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

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

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

Yours sincerely

Claire Lewis

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

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



Healthwatch response to Lancashire Teaching Hospitals NHS Foundation Trust

2025–26 Quality Account

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

Patient engagement and experience

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

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

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

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

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

Patient safety

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

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

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

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

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

However, there are areas where risks remain, including:

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

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

Staff experience and safety culture

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

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

In summary

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

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

Healthwatch would therefore encourage the Trust to prioritise:

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

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

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

Kind regards,

Kate Rees

Assistant Head of Service for Healthwatch in Lancashire and Cumbria

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

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

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

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

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

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

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

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

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

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

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

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

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

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust annual reporting manual 2025-26 and supporting guidance.
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
 - Board minutes and papers for the period April 2025 to March 2026.
 - Papers relating to quality reported to the Board over the period April 2025 to March 2026.
 - Feedback from Integrated Care Board 22nd June 2026
 - Feedback from Healthwatch 29th June 2026
 - Feedback from Overview and Scrutiny Committee 18th June 2026
 - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 is incorporated in the Annual Patient Experience Report 2025-26.
 - The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered.
 - The performance information reported in the Quality Report is reliable and accurate.
 - There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review by MIAA to confirm that they are working effectively in practice.
 - The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
 - The Quality Report has been prepared in accordance with NHSI's Quality Account manual and supporting guidance as well as the standards to support data quality for the preparation of the Quality Report.
 - The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

A handwritten signature in cursive script, appearing to read "Mike Thomas".

Professor Mike Thomas Chair

Date: 30 June 2026

A stylized, abstract handwritten signature consisting of several loops and a long horizontal stroke.

Silas Nicholls Chief Executive

Date: 30 June 2026

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Appendix 3 - Glossary of Abbreviations

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

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

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

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

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

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

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

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

Quality Account Report 2025-2026

Easy Read

Lancashire Teaching Hospital NHS Trust



About Us



We are Lancashire Teaching Hospitals Foundation Trust.

We run Royal Preston and Chorley and South Ribble Hospital.

We work with patients, families, staff and partner organisations.

We want to provide safe, kind and effective care.

Our Quality Account



Our Quality Account is a report about the quality of NHS care.

Every NHS Trust writes a Quality Account every year.

The report looks back at what we did 2025-2026. It also looks forward to what we want to improve in 2026-2027.

Our Trust Strategy



Our strategy says what is most important to us.

It helps us plan how to improve services.

We want care to be safe, effective and centred on patients.

We want to improve health and wellbeing for local people.

Our Priorities



Patients – improve safety, quality, access and experience.

Performance – reduce waits and meet national standards.

People - support and develop our staff.

Productivity – use money and resources wisely.

Partnerships – work with other organisations.

What went well in 2025-2026



We removed the backlog of patients waiting more than 65 weeks for planned treatment.

Cancer services improved, more patients received faster diagnosis and treatment.

Staff training and appraisals stayed strong. Staff turnover improved.

Keeping patients safe



Patient safety is one of our highest priorities.

We continue to learn from incidents, complaints and patient feedback.

Maternity services met all 10 national safety standards.

What this means for patients:

We are working to reduce harm and make care safer.

Always Safety First



Always Safety First is our safety and learning strategy.

It supports a safer culture where people can speak up and learn.

It also supports safer systems, better digital tools and better risk management.

Infection prevention



We worked hard to reduce infections in hospital.

C difficile cases reduced from 192 to 122.



We continued work on cleaning, hand hygiene and safe use of antibiotics

What this means for patients: Fewer people became unwell because of this infection.

Waiting times and emergency care

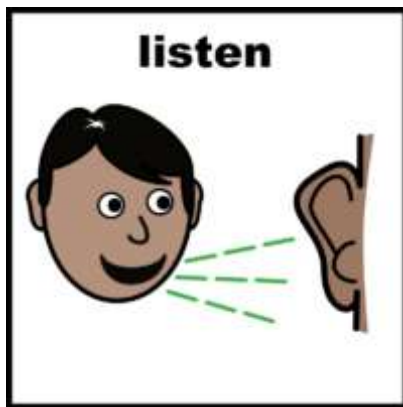


We improved some waiting times for planned care and cancer care.

Urgent and emergency care is still under pressure.

Some patients still wait too long in the Emergency Department.

Listening to patients



We listen to patients, families and carers.

We received 8,230 compliments and thank you messages.

We received 329 formal complaints.

We use complaints to help us improve.

Friends and Family Test



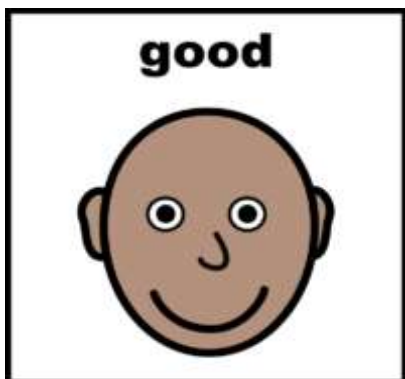
The Friends and Family Test asks people what they think about our services.

More than 69,000 responses were received in 2025-2026.

This feedback helps teams to make changes to improve care.

Feedback from our patients

Positive feedback:



Staff were kind and caring.

People felt treated with dignity.

Some services received very positive comments.

Things to improve:



Waiting times.

Communication.

Discharge information.

Ward environments.

Compliments and complaints



Compliments help us understand what good care looks like.



Complaints help us understand what we could do better.

81% of complaints were answered within agreed timescales.

Supporting our staff

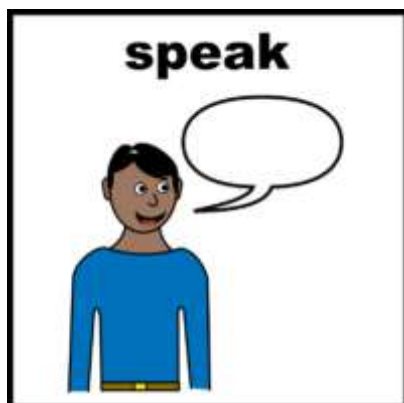


Our staff are important to safe and kind care.

Core skills training compliance was above 95%

We are working to improve staff wellbeing, morale and confidence.

Freedom to speak up



Freedom to speak up helps staff raise concerns safely.

The Trust has Freedom to Speak Up Guardians and Champions.

We want staff to feel listened to and supported.

Research



Research helps us to find better treatments and improve care.

1,262 patients took part in research studies.

Research also helped us bring new treatments and new ideas to patients.

Clinical audits



Clinical audits check whether care is being provided in the right way.

We took part in 92% of the national audits we were eligible for.

Actions from audits are monitored so learning can lead to improvement.

New service and improvements



A 24 hour Thrombectomy service was introduced for stroke patients.

Land was purchased for a proposed replacement Royal Preston Hospital.

Robotic surgery and radiotherapy equipment continued to develop.

What we need to do better



- Improve urgent and emergency care.
- Improve patient flow and reduce delays in leaving hospital.
- Reduce pressure ulcers.
- Improve staff experience and confidence.

Our plans for 2026-2027



- Create a safer culture where people feel able to speak up.
- Improve digital systems and safety processes.
- Reduce fails, pressure ulcers and infection.
- Improve medicines safety.

Working with partners



- We work with NHS organisations, councils, universities and community groups.
- We also work closely with the Care Quality Commission or CQC for short.
- Working together helps us improve health and care across Lancashire and South Cumbria.



Useful Words



Quality Account - a report about the quality of NHS care.



Patient Safety - work to stop people being harmed.



Complaint - when someone tells us they are unhappy with care.



Research - studies to help improve treatments and services.



C difficile - an infection in the bowel that can make people unwell.

Thank you



Thank you to patients, families and carers.

Thank you to volunteers, staff and partner organisations.

Your feedback helps us to improve care every day.

Please ask a member of staff if you would like help in understanding this information.

This information can be made available in large print, audio, Braille and in other languages.

We would like to thank Leeds and York Partnership Trust for the use of images from their learning disability service.

<https://www.learningdisabilityservice-leeds.nhs.uk/easy-on-the-i/>

14.2 NORTH WEST RACE EQUITY ASSEMBLY ANNUAL REPORT 2025/26

● Information Item

REFERENCES

Only PDFs are attached

 14.2 NHS North West Race Equity Assembly Annual Report 25.26 - Full Report Ancillary 06.08.26.pdf



NHS NORTH WEST
Race Equity Assembly

**NHS North West
Race Equity Assembly**

Annual Report 2025-2026

NHS

England
North West

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A new name for the Assembly

Effective April 2026, the NHS North West Race Equity Assembly (formerly the NHS North West Black, Asian and Minority Ethnic Assembly) has a new name that better aligns our identity with our strategic mission. While the term 'BAME' is well-used and recognised, there are instances where the acronym might obscure the distinct, diverse experiences of the individual communities it represents. By moving to 'Race Equity' the Assembly shifts towards a more granular, outcome-focused approach. This change, driven by member feedback, emphasises a commitment to tackling specific health inequalities and systemic racism with greater clarity and visibility.

Welcome

Introducing our annual report 2025–2026.

When the Covid-19 pandemic exposed deep-rooted health inequalities in racialised communities, the NHS North West Race Equity Assembly (previously known as the NHS North West Black, Asian and Minority Ethnic Assembly) was formed as part of a regional leadership response to bring about long-term, meaningful system change on anti-racism and health inequalities.

Six years on, we continue to challenge racism and inequality in all forms. We work collaboratively to advance equality, diversity and inclusion across NHS organisations, offering practical support through our Anti-racist Framework.

We're proud of the progress we've made, the partnerships we've built and the impact we're seeing. And as we look ahead, we remain focused on creating a fairer, unapologetically anti-racist and more inclusive healthcare system for everyone.

Read on to learn more about our work and the difference it's making.



Thoughts from our Co-chairs

What began as an urgent effort to understand and address the disproportionate impact of the Covid-19 virus on minoritised communities has become a broad and dynamic movement for change.

The NHS North West Race Equity Assembly brought together leaders to place race equity as a central priority for the health and care system in our region.



Evelyn Asante-Mensah OBE
Independent Co-chair, NHS North West
Race Equity Assembly

Several years on, our mission remains as urgent as ever. Workforce inequalities persist, including barriers to career progression, bullying and harassment, and under-representation in senior leadership. The unacceptable reality is that many Black, Asian and Minority Ethnic colleagues experience overt racism while performing their roles.

This continues alongside the longstanding poor health outcomes affecting minoritised communities. There are concerning disparities in maternal and neonatal outcomes, mental health access and patient experience that underscore the ongoing need for systemic change.

The Assembly has moved seamlessly from discussion to action, with 48% of committed NHS Trusts achieving Anti-racist Framework (ARF) Bronze-level recognition. This is a vital foundational step to address racial inequalities.

However, the progress made is set against a challenging wider context. Recent increases in racism and racial tensions across the UK, and globally, highlight the difficult environment in which racialised colleagues continue to work and live.

Our vision remains unchanged: to advocate for minoritised communities, support the NHS in the North West to become unapologetically anti-racist, and work collectively to ensure equity in health, care, and opportunity for all.

Thoughts from our Co-chairs

The NHS is undergoing huge change, and this presents a significant opportunity to ensure that anti-racism is at the forefront of our strategic commissioning, workforce planning and organisational priorities.

Over the past year, the NHS North West Race Equity Assembly has made significant strides in embedding anti-racist principles into our healthcare systems. Our role is to ensure the voices of staff and communities are heard, valued, and acted upon.



Louise Shepherd CBE
Co-chair, NHS North West Race Equity Assembly
Regional Director, NHS England - North West

Following the leadership of Richard Barker, I have been proud to step up to co-chair and support this vital platform for Black, Asian and Minority Ethnic leaders to share their experiences, shape discussions, and influence how we deliver care and support to our workforce across the North West.

It has been particularly heartening to see our Anti-racist Framework (ARF) being adopted by multiple Integrated Care Boards and Trusts, with many achieving Bronze-level recognition.

Yet, despite this forward momentum, evidence shows us that we still have a very long way to go to reduce the inequalities faced due to interpersonal and systemic racism across the NHS.

Workforce inequalities and health disparities affecting minoritised communities remain pressing, and we must strive for collective action across the whole North West system to turn ambition into meaningful, tangible action.

Meet our Steering Group Chair

In a diverse and interconnected world when inclusion is truly embedded, it becomes part of how an organisation thinks, leads and delivers. It strengthens the connections between people, lifts morale and creates the conditions for lasting, meaningful progress.

These are the principles that guide the NHS North West Race Equity Assembly's work, and, as Chair of the Steering Group, my focus is on ensuring that our strategic oversight translates into meaningful impact.



Sharmila Kar

Joint Director Equality and Engagement,
NHS GM Integrated Care (Manchester
Locality)/Manchester City Council
NHS North West Race Equity Assembly
Steering Group Chair

Over the past year, I have been proud to see the Assembly continue to grow as a distinct and influential part of the regional NHS landscape, providing a platform for racialised leaders to shape discussions and influence change across workforce and patient-facing priorities.

We have successfully leveraged the power of both the steering group and our membership to guide NHS organisations in embedding anti-racism.

With continued support for the adoption of the Anti-racist Framework and encouraging collaboration across Trusts and Integrated Care Boards, we can ensure that organisations are not only implementing the basics but also embedding anti-racism into leadership, commissioning and workforce strategies.

I am proud of what the Assembly has achieved so far, and I am excited about the opportunity to strengthen its strategic influence further.

Our work is about turning ambition into tangible change: addressing racial inequalities, ensuring inclusion is woven through the fabric of organisations and systems, and making a real difference for staff, patients and communities.

Racism and discrimination remain deeply ingrained within the social, political and economic fabric of our society, and their effects continue to be felt by staff and communities across the NHS.

If we are to dismantle structures that are systematically racist, the work starts with us - with those who hold influence and drive strategy. Race equality matters, and the Assembly provides a vital vehicle for collective leadership to make it happen.

Meet our Director

Having joined the Assembly in January 2025, I've been fully focused on building on the strong foundations set by brilliant colleagues Sharmila Kar, Antemeka Cobin-Wilson and Harvi Higgins who have moved on to new roles.

We've recruited a new team (more from them on the next page!) and, in the context of a changing NHS, we've focused on maintaining momentum and impact on race equity.



Ayo Barley

Director, NHS North West Race Equity Assembly

Our priority remains embedding the Anti-racist Framework, with a focus on continuous improvement. This includes commissioning an independent evaluation of its impact to understand what is working well and where more attention is needed.

We've also explored opportunities to work in partnership with organisations like the NHS North West Leadership Academy to embed anti-racism as widely as possible across our systems and strengthen the competencies of our system leaders.

I have connected with colleagues across the North West who share a commitment to advancing racial equality. Together, we have explored areas where our impact can be strengthened, and identified where further progress is required.

We remain committed to anti-racism principles that challenge the status quo and take meaningful action to dismantle the structures and systems that perpetuate disparities across our communities.

On behalf of the Assembly, I would like to take the opportunity to extend our sincere thanks to Raj Jain, former Assembly Steering Group Chair, who stepped down from his role in October 2025, alongside his tenure as Chair of NHS Cheshire and Merseyside ICB. We recognise and deeply appreciate his dedicated service and lasting contribution to advancing race equity within the NHS.

I would also like to extend my thanks to our Co-chairs, Steering Group Chair, the steering group and our members for their ongoing support, guidance and championing of our agenda. Their leadership and dedication continue to drive the Assembly's influence and help shape a more inclusive and equitable NHS.

As we finalise and share plans for 2026-2027, I'm feeling energised by the collective challenge ahead and would urge all leaders to join us. By working collaboratively, we can continue to embed anti-racism across the NHS in the North West and ensure real, tangible improvements for both staff and the communities we serve.

Meet the Assembly team



Sonia Sarah

Programmes and Partnerships Manager

Reducing inequalities by being boldly and unapologetically anti-racist is at the heart of the

NHS North West Race Equity Assembly's ethos, core values and vision. We want to collaboratively level the playing field and deliver an equitable world for all.

I joined the Assembly in November on secondment from Bradford Teaching Hospitals NHS Foundation Trust, bringing with me 20 years' experience in equality, diversity and inclusion, anti-racism and social justice work.

My background has helped me effectively lead on the Anti-racist Framework programme (ARF) and I am heartened that we've received a record level of interest from new Trusts and NHS organisations who want to get on board.

This collective commitment drives our mission forward, ensuring that systemic change is not just a goal, but a reality. I have valued the opportunities to develop partnerships and contribute to new programme initiatives, and it has been particularly rewarding to help establish consistent standards and foster a sense of shared accountability across organisations.

Representing the Assembly as a strong advocate for collaboration and inclusive workplaces has been a real highlight, alongside supporting tangible progress towards fairer working environments and improved experiences for both staff and the communities they serve.

Together, we are helping to ensure that every voice is heard, valued and amplified.



Saraj Mohammed

Membership and Business Support Officer

Joining the Assembly as Membership and Business Support Officer is both a professional

opportunity and a personal responsibility. Early on, I supported the Anti-racist Framework Discovery Event with the North West Leadership Academy. Key takeaways were the need for spaces where honesty is welcomed and leaders engage with equity-driven change. Infrastructure and values must work hand in hand.

I particularly enjoy supporting Assembly and Steering Group meetings, facilitating the Anti-racist Framework, and compiling purposeful member communications. Stepping into this role has shown me that leadership is not always visible - it's often about enabling others to lead well and ensuring this impact is felt by all.

Our mission in action

The NHS North West Race Equity Assembly is defined by a singular, unwavering stance: we are unapologetically anti-racist.

Our mission is not merely to acknowledge the existence of racial bias, but to dismantle the systems that allow it to persist. We exist to move beyond the rhetoric of 'inclusion' and into the active work of challenging discrimination of every kind.

Our work is rooted in the belief that passive observation is a form of complicity. Consequently, the Assembly has evolved into a strategic, independent and authoritative voice committed to transforming the NHS into an environment where fairness is the default and systemic racism is eradicated through decisive, high-level action.

However, we are clear that we are not the default delivery body for anti-racism work that individual NHS organisations must lead themselves. Instead, our refreshed mandate reaffirms our role in shaping policy, building capability and holding the system to account as a key feature of regional performance management and oversight.

By amplifying the voices of the marginalised and forcing a confrontation with longstanding inequalities, we are leading a bold agenda for structural change.

In the following pages, we invite you to explore how our steering group members are bringing this mission to life with real-world impact. These examples of our mission in action demonstrate our ongoing push for an NHS that is truly equitable, just and free from discrimination.



Tackling racism and discrimination – a regional perspective



Abid Dar

Regional Head of Inclusion and Engagement (Retention and Experience)
Joint Lead - People and Culture Directorate, NHS England - North West

As lead on regional EDI and retention strategies, I've realised that racism evolves, is fluid, it shapeshifts and is chameleonic and evasive. It has morphed and evolved to include nationalism, antisemitism, Islamophobia, anti-migrant sentiment and beyond. It's easier to see and harder to catch. Social media has allowed it to deepen its presence and impact and spiral out of control.

Here in the North West, we are consciously and actively lifting the lid on poor practices, behaviours and actions around racism and discrimination. NHS England is setting the EDI-mandated standards and strong expectations, while enabling meaningful partnerships with Trusts and providers.

We follow policies and guidance that give us useful direction in tackling racism and discrimination in all forms.

Our Leadership Equality Assurance Framework (LEAF) gives us a strengths-based, peer-led platform to understand our regional performance, celebrate success and identify the needs we can support. Within this, areas of sexual safety, recruitment, violence prevention reduction and harassment are all covered.

Our Staff Survey, EDI Improvement Plan, Workforce Race Equality Standards, Ethnicity Pay Gap and reducing Health Inequalities requirements all identify key challenges and set the benchmark for measured anti-racism progress.

From Spring 2026, the new NHSE Staff Standards will drive further improvements with its overt 'Tackling Racism' requirements. And at the same time a new Regional Blueprint will oversee and drive anti-racism improvements.

How pharmacy is embedding inclusion and anti-racism

Pharmacy professionals across the North West have been embedding inclusion – including anti-racism – in a practical, evidence-informed and sustainable way.

The North West Inclusive Pharmacy Practice (IPP) Toolkit was launched in May 2025, offering a practical resource designed to support pharmacy teams to embed inclusive and anti-racist practices within everyday clinical care, workforce development and leadership.



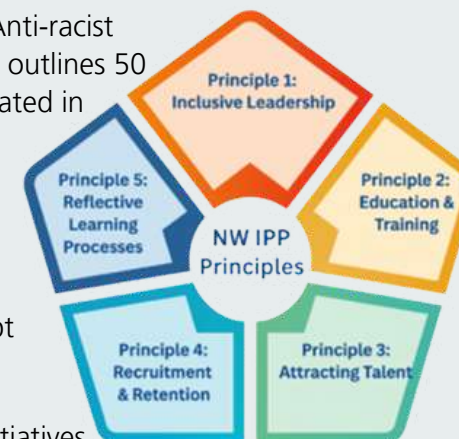
Dr Devina Halsall
Deputy Chief Pharmacist (Controlled
Drugs Accountable Officer), NHS
England - North West



Sadie Pinkney
Lecturer in Pharmacy Practice,
University of Liverpool

Aligned to both the NHS North West Race Equity Assembly Anti-racist Framework and pharmacy professional standards, the toolkit outlines 50 recommended initiatives across five core principles demonstrated in the graphic (right).

The toolkit also includes a progress tracker and executive summary enabling organisations to self-assess, identify gaps and prioritise actions for implementation. Each initiative is accompanied by a suggested timeline, with flexibility to adapt to local organisational context.



Following consultation and early implementation, 41 new initiatives were implemented across 18 NHS Trusts within the first months of publication. Examples include rota scheduling that accommodates religious observances, introduction of inclusive recruitment checklists and the delivery of education and training on cultural competence (ranging from undergraduate learners to senior leaders).

Regional and national engagement has been strengthened through the NW IPP Steering Group, which plays a central role in producing, reviewing and sustaining the toolkit. The group consists of 18 members, representing hospital, community, primary care, academia and commissioning. In addition, a national IPP roundtable was held at Clinical Pharmacy Congress North, which brought together key stakeholders to share learning and explore opportunities for wider adoption of anti-racism and inclusive practice.

Ongoing evaluation will assess implementation and impact as adoption increases across systems. This includes understanding how the toolkit contributes to improved workforce inclusivity, psychological safety and equitable career progression, as well as its role in supporting more culturally responsive, person-centred care and reducing health inequalities for patients.



Active anti-racism at work



Naveed Sharif

Associate Director of Culture and Inclusion, NHS Lancashire and South Cumbria Integrated Care Board
National NHS Muslim Network Chair

As a commissioning NHS organisation, Lancashire and South Cumbria ICB explicitly recognises that racism - structural, institutional, or interpersonal - profoundly harms staff wellbeing, patient safety and population health.

In alignment with the NHS Constitution and Equality Act 2010, we are committed to becoming an actively anti-racist organisation.

This work is embedded in our governance and strategy to ensure substantive improvement over symbolic change. A board-level executive lead holds formal accountability, providing regular progress reports to maintain transparency.

We rigorously review Workforce Race Equality Standard (WRES) data to inform targeted action plans addressing disparities in recruitment, promotion and disciplinary processes. By strengthening inclusive recruitment and succession planning, we are actively diversifying senior leadership and enhancing oversight of equity-related risks.

Our pursuit of Bronze status within the Anti-racist Framework reinforces that safe services depend on a workforce that feels valued. We have strengthened Freedom to Speak Up processes and confidential reporting to ensure concerns are raised without fear. We continuously monitor disciplinary data to address disproportionality, ensuring staff feel heard and confident that action follows feedback.

Positive staff survey results and improved morale contribute to workforce stability and retention - essential components of safe, effective and well-led services. By embedding equity into every level of leadership, we provide responsive care for our entire community while fostering an environment of continuous reflection and measurable progress.

"By embedding equity into every level of leadership, we provide responsive care for our entire community while fostering an environment of continuous reflection and measurable progress."



Public Health leadership in the Assembly

As North West Director of Healthcare Public Health I have had the privilege of embedding the Assembly's core values into my role.

Over the past year, my primary focus has been supporting the development of the North West's anti-racist public health collaborative, an initiative backed by all 24 Directors of Public Health across the region.



Dr Gunjit Bandesha

Director of Healthcare Public Health,
NHS England - North West

A significant milestone was the successful conference held in Preston in May 2025, which framed racism as a structural determinant of health and forged vital links between the Assembly and the wider workforce. This work continues through the creation of an anti-racism consensus statement and a clear definition of 'what good looks like' to improve outcomes for the North West's global majority population.

Accurate ethnicity data is equally fundamental to addressing health inequalities. Throughout 2025–2026, the North West Public Health Directorate led national and regional efforts to improve ethnicity recording, including hosting national webinars and aligning activity with NHS England's improvement plan. Our analysis revealed significant performance inconsistencies across providers; consequently, with executive agreement, we are now embedding ethnicity recording as a core element of assurance, commissioning and oversight.

Finally, we recognise that building an anti-racist movement requires intentional, systematic learning. We invited Keisha Thompson from the Legacies of Enslavement programme to deliver an intensive two-day training session for all public health staff.

This challenging programme deepened our understanding of health inequalities, leading to the development of a cultural competency toolkit to ensure this learning informs our everyday practice.

ICB perspectives

From intention to measurable change

NHS Greater Manchester Integrated Care Board



Majid Hussain

Director of Equality and Inclusion, NHS Greater Manchester Integrated Care Board

This year, Greater Manchester moved from intention to measurable change in tackling systemic racism.

Responding to a call by Mayor Andy Burnham, the Integrated Care Partnership (ICP) launched a region-wide anti-racist campaign to protect staff, promote allyship and strengthen leadership accountability.

Key strategic pillars were introduced, including enhanced reporting in the form of a dedicated Datix Reporting Pathway for hate incidents. This structured approach allows the system to track trends and coordinate with Greater Manchester Police to improve safety and prevention.

We also have a quarterly Leadership for Inclusion programme that equips NHS leaders with practical tools to challenge bias and foster psychological safety, directly informed by diverse lived experiences.

Tackling racism is essential for safe, equitable healthcare. By addressing structural barriers, we ensure services are inclusive and responsive to those most affected by inequality. Our zero-tolerance approach is reinforced by public leadership, stronger partnerships and improved reporting.

In its commissioning role, ICB drives system-wide change, ensuring contracts and performance frameworks promote equity and culturally responsive care. Embedding these practices builds trust with patients and strengthens accountability.

This work also transforms the staff experience. Creating psychologically safe environments improves engagement, morale and retention. By integrating anti-racist principles across leadership, commissioning and service delivery, we ensure sustainable, fair and high-quality care for everyone in Greater Manchester.





Firmly committing to anti-racism

NHS Lancashire and South Cumbria Integrated Care Board



Aisha Chaudhary

Director of Culture and Inclusion, NHS Lancashire and South Cumbria Integrated Care Board

Lancashire and South Cumbria Integrated Care Board remains firmly committed to advancing anti-

racism across our health and care system. Our belief is that tackling racism is fundamental to creating a culture where colleagues from Black, Asian and Minority Ethnic backgrounds feel valued, safe and able to thrive.

We also believe that a firm anti-racist stance, and action, is critical to our wider ambition to reduce health inequalities across the North West, where many communities continue to experience poorer health outcomes and barriers to accessing services. Listening to lived experience and acting on it must remain central to how we lead change.

"Listening to lived experience and acting on it must remain central to how we lead change."

The Assembly plays an important role in driving this agenda forward. By bringing together staff voices, system partners and community insight, it helps challenge inequity in the workplace while strengthening our collective efforts to improve outcomes for the communities we serve.

Building stronger relationships with local partners and communities is essential if we are to create inclusive services, improve experiences of care, and foster greater trust.

"Building stronger relationships with local partners and communities is essential if we are to create inclusive services, improve experiences of care, and foster greater trust."

Anti-racism is therefore not a standalone initiative, but a core part of building a fairer, more inclusive health and care system across our region.

Advancing anti-racism

NHS Cheshire and Merseyside Integrated Care Board



Thomasina Afful

Associate Director Equality, Diversity and Inclusion, NHS Cheshire and Merseyside Integrated Care Board

NHS Cheshire and Merseyside Integrated Care Board remains firmly committed to implementing the principles and priorities of the NHS North West Race Equity Assembly, recognising its vital role in driving meaningful and sustained progress on race equality across the system.

Despite significant systemwide challenges over the past 12 months, which have necessitated a refocusing of organisational priorities, tangible progress to advance race equality outcomes has been achieved.

This includes, but is not limited to, seven provider Trusts (circa 50%) across our system achieving Anti-racist Framework Bronze recognition and now actively working towards securing Silver. This represents a clear commitment from provider leadership to embed anti-racist practice, accountability and cultural change across NHS organisations.

In addition, the ICB collaborated with the Liverpool City Region Race Equality Hub,

GraceHolla Ltd and the NHS North West Leadership Academy to deliver a targeted leadership shadowing programme, supporting 50 ethnically diverse aspiring leaders to access structured career development opportunities. Participants were paired with 50 senior leaders drawn from across public, education, private and charitable sector organisations, strengthening cross-sector learning, visibility and progression pathways.

While recognising that considerable challenges remain, these achievements reflect the ICB's continued commitment to anti-racism as a core enabler of improved organisational culture, leadership and system performance. It's also central to building trust with our diverse communities and partners, enabling more effective engagement, co-production and service design that better reflect local needs. These are two reasons why NHS Cheshire and Merseyside ICB remain committed to this work and to working in partnership with the Assembly, regional colleagues and system partners to accelerate progress towards racial equity and inclusive organisational cultures across the North West.



Anti-racist Framework

In June 2023, our Anti-racist Framework was re-launched. Designed to enable effective challenge of racism and discrimination in the NHS, the framework takes individuals and organisations through a learning journey that begins at fear of change right through to the growth zone.

The framework is underpinned by:

- The principles of prioritising anti-racism
- Understanding lived experience
- Growing inclusive leaders
- Acting to tackle inequalities
- Reviewing and reflecting on progress.

It also sets out actions that can be used to embed anti-racist practices organisation-wide.



Three levels of achievement

The framework is organised into three levels of achievement: Bronze, Silver and Gold. Each level builds on the next, encouraging incremental changes and consistent actions towards eliminating racial discrimination within organisations.



Signifies that an organisation has taken initial steps towards becoming an intentionally anti-racist organisation. These deliverables are those that embed structures and accountability for the delivery of racial equity in an organisation.



Shows that organisations have embedded structures to ensure commitment and accountability towards achieving anti-racism and have also developed actions to nurture and empower Black, Asian and Minority Ethnic talent, encourage culture change and improve data collection, quality and reporting.



Organisations can demonstrate that anti-racism has been embedded at all levels, with diverse representation at the most senior levels and parity in staff experience, as well as ensuring anti-racism is seen as being everyone's business through performance and engagement.



Expansion of the Anti-racist Framework

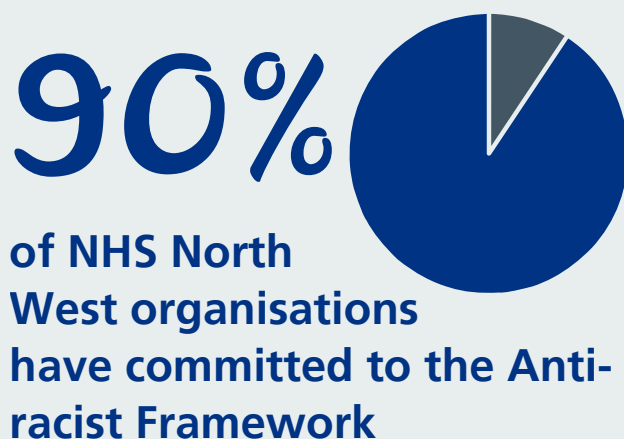
To date, over 90% of NHS Trusts in the North West have committed to the Anti-racist Framework and are at various stages in their journey to achieving Bronze recognition. The region's three Integrated Care Boards - Greater Manchester, Lancashire and South Cumbria, and Cheshire and Merseyside - are implementing the framework, as well as the NHS England - North West region.



Nearly half (48%) of the committed NHS organisations across the North West region have been formally awarded Anti-racist Framework (ARF) Bronze recognition and have sent a clear signal of intent to challenge racism and discrimination within their organisations.

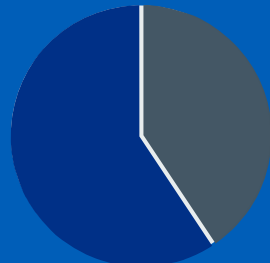
This momentum is set to accelerate as we enter Spring 2026 with a record number of organisations interested in gaining Bronze recognition.

Later this year, we will launch a roadmap of readiness for Silver ARF Expressions of Interest. This preparatory phase will pave the way for a formal Spring 2027 launch of Silver status, providing a clear trajectory for organisations to move beyond foundational commitment toward advanced, sustained impact.



So far

48%



**have achieved
Bronze
recognition**

NHS North West Trusts committed to the Anti-racist Framework

NHS North West Region

- North West Ambulance Service NHS Trust

NHS Cheshire and Merseyside ICB

- Alder Hey Children's NHS Foundation Trust
- Clatterbridge Cancer Centre NHS Foundation Trust
- Countess of Chester Hospital NHS Foundation Trust
- Cheshire and Wirral Partnership NHS Foundation Trust
- East Cheshire NHS Trust
- University Hospitals of Liverpool Group formerly:
 - Liverpool University Hospitals NHS Foundation Trust
 - Liverpool Women's NHS Foundation Trust
 - Liverpool Heart and Chest Hospital NHS Foundation Trust
- North Cheshire and Mersey NHS Foundation Trust (formerly Warrington and Halton and Bridgewater NHS FTs)
- Mid Cheshire Hospitals NHS Foundation Trust
- Mersey and West Lancashire Teaching Hospitals NHS Trust
- Wirral Community Health and Care NHS Foundation Trust

- Wirral University Teaching Hospital NHS Foundation Trust
- North Cheshire and Mersey NHS Foundation Trust

NHS Greater Manchester ICB

- Northern Care Alliance NHS Foundation Trust
- Stockport NHS Foundation Trust
- Tameside and Glossop Integrated Care NHS Foundation Trust
- The Christie NHS Foundation Trust
- Wrightington, Wigan and Leigh NHS Foundation Trust
- Pennine Care NHS Foundation Trust
- Bolton NHS Foundation Trust
- Manchester University NHS Foundation Trust
- Greater Manchester Mental Health NHS Foundation Trust

NHS Lancashire and South Cumbria ICB

- Blackpool Teaching Hospital NHS Foundation Trust
- East Lancashire Hospitals NHS Trust

- Lancashire and South Cumbria NHS Foundation Trust
- Lancashire Teaching Hospitals NHS Foundation Trust
- University Hospitals of Morecambe Bay NHS Foundation Trust



Anti-racism in action

Using the ARF as a foundation for consistency

Liverpool Women's NHS Foundation Trust

The Anti-racist Framework (ARF) provides vital clarity on what 'good' looks like: robust board-level oversight, transparent progress measures and high levels of scrutiny. This ensures that commitments translate into meaningful change for both staff and patients.



Lisa Shoko

Equality, Diversity, Inclusion and Anti-Racism Programme Lead, Liverpool Women's NHS Foundation Trust

At Liverpool Women's University Hospital, we introduced an Anti-Racism Hub prior to the Framework's release. The Framework provided a directive and aspirational lever that gave our existing work greater structure and legitimacy. Crucially, it recognises that there is no single prescribed methodology; organisations can demonstrate anti-racism through various approaches, provided they are well-led, rigorously assessed and built on the right principles.

By aligning our Hub with wider architecture, we challenged the assumption that equity work is unquantifiable. Our approach is deliberately tied to good governance, evidence systems and workforce metrics. This model was recognised as best practice by the Equality and Human Rights Commission and has led to commissioned regional work addressing disproportionate referrals to the Nursing and Midwifery Council.

The Framework offers a necessary shared baseline. If standardised nationally, it could become a powerful instrument for ensuring anti-racism is systematic and embedded rather than episodic. A workforce that feels safe and fairly treated is better placed to deliver the equitable care patients deserve.

Ultimately, the Framework demonstrates that anti-racism is a core component of workforce integrity. As a foundation for consistency, it ensures that the standards we apply to anti-racism match the quality of care we aim to provide.

Building an anti-racist future

Mersey and West Lancashire Teaching Hospitals NHS Trust

Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) has used its journey to Anti-racist Framework Bronze recognition to transform culture, and ensure dignity, fairness and safety for every patient and staff member.

The Trust has embedded anti-racism into the core of its clinical and operational functions, marking a pivotal shift from policy to tangible systemic change.



Key milestones toward building an anti-racist future include:

- Workforce empowerment: Band 5 BAME Nurse and Midwife Career Progression Workshops have yielded immediate results. Following sessions, six colleagues from ethnic minority backgrounds successfully secured promotions (five to Band 6 and one to Band 7) directly addressing historical disparities in career advancement.
- Clinical equity: In November 2025, MWL launched the Maternity Triage Passport. This initiative provides an alternative pathway for women facing language barriers, allowing them to bypass phone-based triage and access life-saving care directly.
- Development of an Inclusive Language Guide to promote respectful, accurate and inclusive communication across MWL.
- Cultural accountability: The formal launch of the Trust's Anti-Racism Statement - developed via roundtable consultations with the BAME Staff Network and patients - sets a clear standard for behaviour and strategic direction.

Impact is being sustained through an Equality and Health Inequalities Council, ensuring high-level oversight. With the implementation of the Saving Lives, Improving Mothers' Care bundle and ongoing 'active bystander' training, MWL is not just reacting to discrimination but proactively dismantling it.

"This achievement reflects the dedication of colleagues who drive systemic change. It strengthens our resolve to ensure dignity and fairness are embedded in everything we do."

MWL Senior Leadership

Through these targeted actions, MWL is creating a more compassionate environment, earning the trust of its diverse community, and setting a regional benchmark for inclusive healthcare.

"Self-confident to apply for another role" - feedback from Band 5 career progression workshop participant.

Accelerating equity

Wrightington, Wigan and Leigh NHS Foundation Trust

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (WWL) is using the Anti-racist Framework to embed fairness and equity into its foundational DNA.

Driven by Workforce Race Equality Standard (WRES) data and the lived experiences of 'Global Majority' colleagues, the Trust adopted the Anti-racist Framework to dismantle systemic barriers and meet the needs of its local population.

WWL has moved beyond passive inclusion towards active anti-racism by synchronising leadership accountability with frontline empowerment.

Anti-racism is now a governance priority, with a dedicated EDI Strategy Group chaired by the CEO. This ensures that the Anti-Racist Strategy 2025 and Zero-Tolerance Policy are not just documents, but enforced standards of conduct.

Through the Passport to Progression and Global Majority Nursing Fellowships, the Trust has provided equity-focused support that has already resulted in successful Band 7 appointments for underrepresented staff, directly improving representation in senior clinical roles.

The Trust's Health Outreach and Inclusion Service has successfully reduced health inequalities for asylum seekers and vulnerable groups by improving GP registration rates and screening uptake, ensuring equitable access to care for the most marginalised.

The Global Majority Forum has become a primary engine for change, providing leaders with deep insights into institutional barriers. By reshaping reporting processes and cultural norms based on this feedback, WWL is building a sustainable foundation where every colleague and patient is treated with unwavering dignity.

"Our Board is unequivocal in its commitment to being an actively anti-racist organisation. Anti-racism is intentionally embedded into our leadership, culture, and governance."

Professor Dame Robina Shah,
Trust Chair

Through these integrated actions, WWL is demonstrating that purposeful, structured anti-racism is essential for both workforce wellbeing and clinical excellence.

Reaching out - our work in South Yorkshire

In 2025–2026 we successfully piloted offering the Anti-racist Framework to South Yorkshire Trusts as part of our commitment to knowledge exchange and influencing others.

Challenging bias

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Doncaster and Bassetlaw Teaching Hospitals (DBTH) NHS Foundation Trust is successfully transitioning from intention to active anti-racism by engaging with the NHS North West Race Equity Assembly Anti-racist Framework (ARF).

Recognising the profound link between systemic racism, health inequalities and staff experience, DBTH sought a rigorous, evidence-based mechanism to challenge institutional biases.

Building on its 2021 RACE Code accreditation and subsequent EDI Improvement Plans, the Trust adopted the Anti-racist Framework to ensure deep accountability and sustainable cultural transformation.

DBTH has successfully integrated targeted anti-racist actions into its overarching strategy, aligning directly with the NHS High Impact Actions. This involved launching focused workstreams on inclusive recruitment, career progression and board-level development, alongside reciprocal mentoring programmes that bridge the gap between frontline staff and senior leaders.

These initiatives have secured ARF Bronze recognition, positioning DBTH as a leader within the South Yorkshire system.

The impact is evident in the establishment of a 'shared language' across the Trust, which has facilitated honest, vital conversations about race and privilege. Early indicators show improved staff survey scores regarding belonging and fairness, alongside strengthened governance.

As leadership affirms, becoming an actively anti-racist organisation is fundamental to creating a culture where staff feel safe and valued. Through activating the Anti-racist Framework, DBTH has successfully turned an institutional commitment into tangible action for the benefit of both its workforce and the diverse communities it serves.

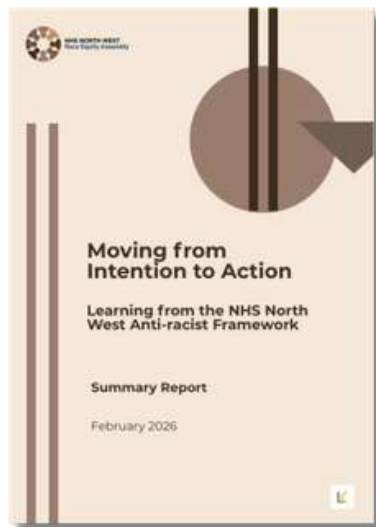


Continuous improvement

Listening and learning – NHS North West’s commitment to systemic change

Over the past year, the North West region has deepened its commitment to systemic change. To measure progress, an independent evaluation carried out by Liberating Knowledge captured insights from a survey of 274 staff and a specialist focus group.

The review highlighted that while the Anti-racist Framework provides essential structure and legitimacy, awareness remains uneven. It's high among senior leaders but lower on the frontline.



Front cover of the Liberating Knowledge review.

Critical challenges persist, including:

- Limited staff confidence in reporting mechanisms
- Gaps in organisational capability to respond to racial harm
- Barriers such as competing priorities and inconsistent leadership accountability.

However, where the Framework is fully embraced, it acts as a vital bridge between intent and action. But the evaluation also found that driving change often falls on individuals without sufficient authority, highlighting a need for dedicated roles and resourced staff networks.

To ensure anti-racism remains core organisational business, our focus shifts to:

- Refining the Framework: Simplifying submissions and clarifying expectations
- Expanding capability: Strengthening regional peer networks and providing practical tools for frontline staff
- Data-driven progress: Improving evaluation metrics to help organisations track and demonstrate real-world impact.

We recognise the growth of the Framework and are committed to making improvements to ensure it remains a tool that leads to meaningful change in tackling racism across our system.

**See page 32 for details of our plans to continually improve the Anti-racist Framework*

Read the full summary report [here](#)

Advocacy in action

Amplifying voices and driving change

For Black, Asian and Minority Ethnic communities across the North West, advocacy is not an abstract principle. It's a necessity for ensuring that lived experience shapes decision-making and that health systems are held accountable for equitable outcomes.

Over the past year, the NHS North West Race Equity Assembly has acted as a powerful collective voice during a period of heightened anti-immigrant sentiment and widening inequalities.

Through sustained engagement with Integrated Care Boards (ICBs) and NHS Trusts, our advocacy has extended beyond simply raising concerns to influencing tangible, systemic change.

Why advocacy matters

Structural inequality within health and care systems is widespread, appearing in disparities in access, experience and representation. For many communities, trust in institutions has been eroded by experiences of discrimination and biases.

Without this sustained challenge, inequities risk becoming invisible, but with it, systems are pushed to reflect and reform. Our advocacy is grounded in frontline insight, which is elevated strategically to senior leaders through formal correspondence.





Our advocacy in practice

Part of our advocacy work focused on the impact of hostile public discourse on the psychological safety of Black, Asian and Minority Ethnic staff and patients. Rather than asking for statements, we invited Trusts to demonstrate intentional anti-racist action.

This has spearheaded detailed work with specific Trusts to examine workforce data and review governance. Through these actions, we have secured substantive responses from leaders, established direct dialogue with decision-makers and embedded our Anti-racist Framework as a tool for improvement.

Impact and influence

By speaking with a unified voice, the NHS North West Race Equity Assembly has reinforced that our diverse communities are key stakeholders in shaping an equitable future for the North West. Our collective leadership has moved the conversation from intent to measurable practice, ensuring that race equity remains a priority at the highest levels of the system.

Looking ahead

We will continue to amplify lived experience, challenge systems and work alongside leaders committed to meaningful change. For every marginalised community across the region – and beyond - our advocacy will ensure voices are heard and continue to bring about much-needed change.

Our partnerships

Racism is not always conscious, explicit or readily visible; it's often systemic and structural, embedded in the policies, practices and beliefs that shape our organisational cultures. Therefore, to address it requires a coordinated, system-wide response to tackle the inequalities that persist across the NHS.

Over the past 12 months, we have strengthened partnerships with like-minded organisations to amplify our collective impact and drive meaningful change.

A key milestone in 2025–2026 has been the establishment of our strategic partnership with the NHS North West Leadership Academy. Read on to find out more about progress to date and priorities for the year ahead.



Strengthening inclusive North West leadership

Our strategic partnership with the North West Race Equity Assembly continues to be one of the most purposeful and intentional collaborations in our regional leadership work.



Lorna Krisson
Senior System Lead,
NHS North West
Leadership Academy



Dr Frances Dodd
Head of the
NHS North West
Leadership Academy

Together, we are committed to strengthening an inclusive North West leadership community where race equity, compassion and belonging thrive. Our partnership vision and ambition is clear – we strive to educate, advocate and take joint action to eliminate racism.

The partnership supports the alignment of strategic drivers, with the aim of catalysing regional goals and collective impact on anti-racism and leadership development.

Over the last year, our work together has expanded significantly. Collaborative initiatives include:

- The **formation of a working group**, with representatives from the Assembly Steering Group, NHS England North West and NHS North West Leadership Academy (NHS NWLA) to bring together joint expertise, identify regional priorities and critical allyship. The group co-created a strategic vision and partnership agreement to actively promote and champion collective ways of working. The working group has been instrumental in shaping conversations about representation, capability building and equity of opportunity within leadership pathways.

- Co-produced **joint events and thought-leadership** such as a [podcast on anti-racist leadership practice](#); a [virtual masterclass on Powerful Allyship](#); and Ayo Barley, Director of the NW Race Equity Assembly, contributed as a panel member at the NHS NWLA's annual Festival of Leadership conference that celebrates progress, connects leaders and inspires action towards a shared vision for inclusive, compassionate and system-wide leadership.
- **Sharing and maximising resources** based on our individual organisation's established positions, joint communications channels, and capturing best practice.

Looking ahead, our collaboration will continue to focus on building leadership capability that reflects the rich diversity of the North West. Together, we will further enhance leadership development approaches in real-world insight, challenge structural barriers and co-design opportunities that respond directly to the needs and experiences of diverse communities.

Read on to find out about the NHS NWLA and NHS North West Race Equity Assembly's commitments for the next 12 months.

Our commitment for the next 12 months includes:

- Jointly hosting a regional conference on Driving Race Equity – strategies for anti-racism health and care systems.
- Exploring tailored anti-racist board development and regional anti-racism advocacy.
- Capitalising on opportunities to shape the North West system where diversity is not just acknowledged, but actively valued in decision-making and leadership practice.

Through the Assembly's guidance, we are also committed to enhancing our internal practice on anti-racism and will be seeking Anti-racist Framework Bronze accreditation during 2026-2027.

We are really proud of what we have achieved together so far – and we are even more excited for what we will continue to achieve as collaborative partners.



Festival of Leadership Panel, October 2025



NHS NWLA Anti-racist Framework discovery session, Feb 2026



Left to right: Ayo Barley, Sally Senior, Lorna Krisson, Evelyn Asante-Mensah, October 2025



Ayo Barley and Lorna Krisson in the Leadership Live studio, October 2025

Recognition and awards

'Unsung hero' Evelyn celebrates



In the past year we celebrated our co-chair Evelyn Asante-Mensah OBE winning an Unsung Heroes Award from the Advancing Ethnic Minority Women into Leadership Roles within Health and Social Care network.

Evelyn's tireless advocacy, principled leadership and commitment to social and racial justice have opened doors for colleagues, amplified minoritised voices and supported the underserved. She tirelessly continues to mentor, listen and uplift others.

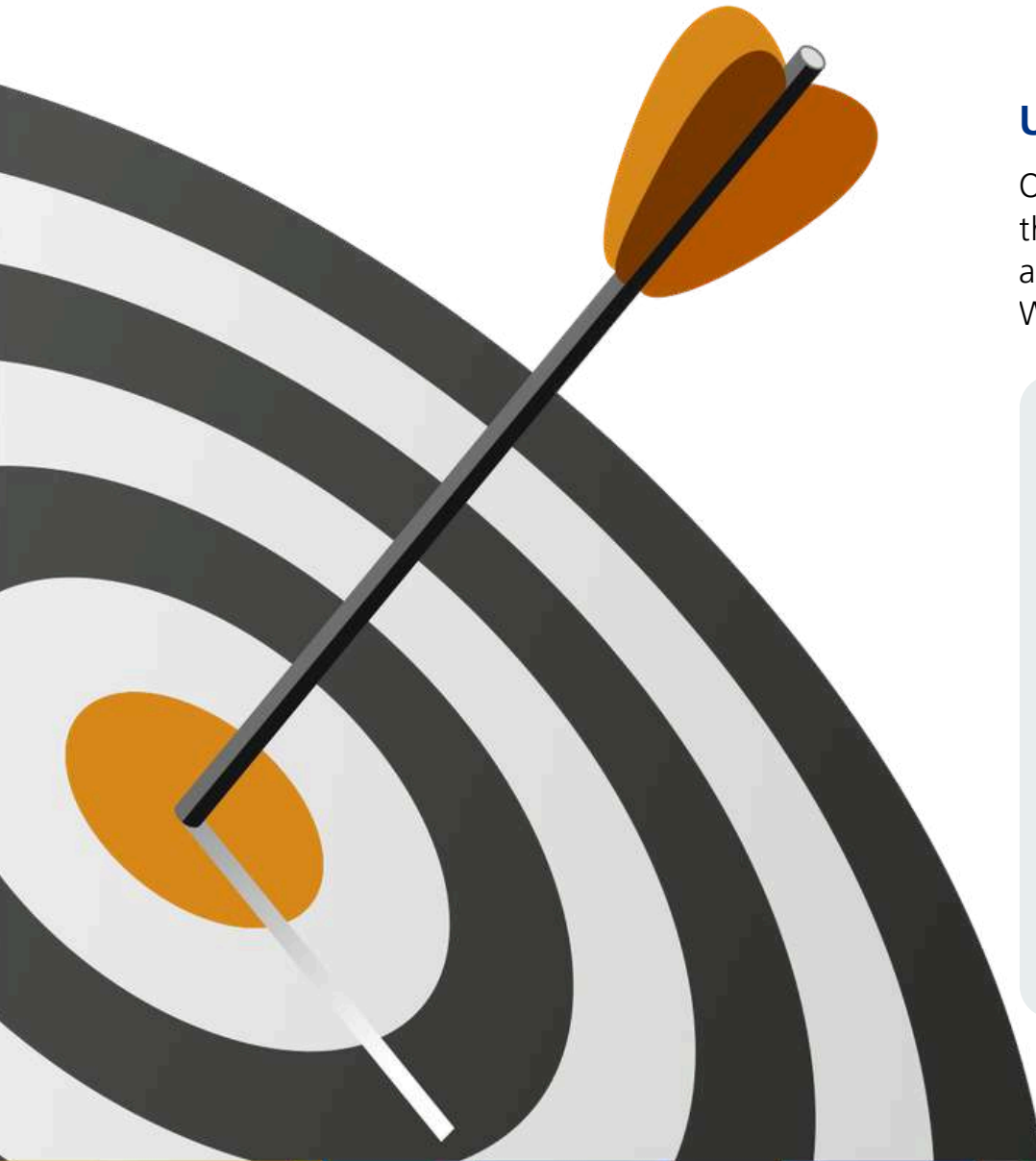
Angela Assor, event organiser and host endorsing the award, said: "We celebrate Evelyn Asante-Mensah for her dedication, achievements and the inspiration she brings to those around her. Her journey is a testament to what is possible through hard work, courage and purpose."

Anti-racist Initiative Award 2025

The NHS North West Race Equity Assembly was highly commended in the Caribbean and African Health Network (CAHN) Annual Black History Month Gala Anti-Racist Initiative Award 2025.

The commendation recognises the Assembly's ongoing work to challenge and eliminate racism across systems and institutions, and its continued leadership in advancing anti-racist practice.





Looking ahead

Using five strategic pillars to strengthen our position

Our ambition for 2026-2027 is to embed the Assembly's refreshed role through delivery of its five strategic pillars, strengthening its position as a strategic advisory, advocacy and influencing body across the North West NHS system.

We will:

- Further embed advocacy, influence and performance oversight to hold organisations to account and inform system action
- Improve the Anti-racist Framework to assess organisational maturity and drive continuous improvement
- Grow our membership to broaden influence and ensure diverse voices shape system priorities
- Develop an Innovation Hub to share effective evidence-based approaches to tackling race inequality
- Offer anti-racist education to build board-level leadership capability, confidence and meaningful accountability.

Join our mission

We invite you to join us in advancing race equity in the NHS.

The NHS North West Race Equity Assembly welcomes ongoing engagement from NHS leaders of all backgrounds who are committed to advancing race equity across our healthcare system. We encourage individuals and organisations to connect with and support the Assembly's work as it continues to evolve.

We remain committed to sharing insight, resources and learning to support leaders, staff networks and those with responsibility for anti-racism and equality, diversity and inclusion, helping to build capability and strengthen impact across the region.

Further information about the Assembly's work, priorities and supporting resources is [available through our webpages](#).



Email: england.nwraceequity_assembly@nhs.net

Website: www.england.nhs.uk/north-west/nhs-north-west-race-equity-assembly