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NHS Foundation Trust

Lancashire Teaching Hospitals NHS Foundation Trust

ANNUAL REPORT AND ACCOUNTS 2024–25

Excellent care with compassion

Always Safety First

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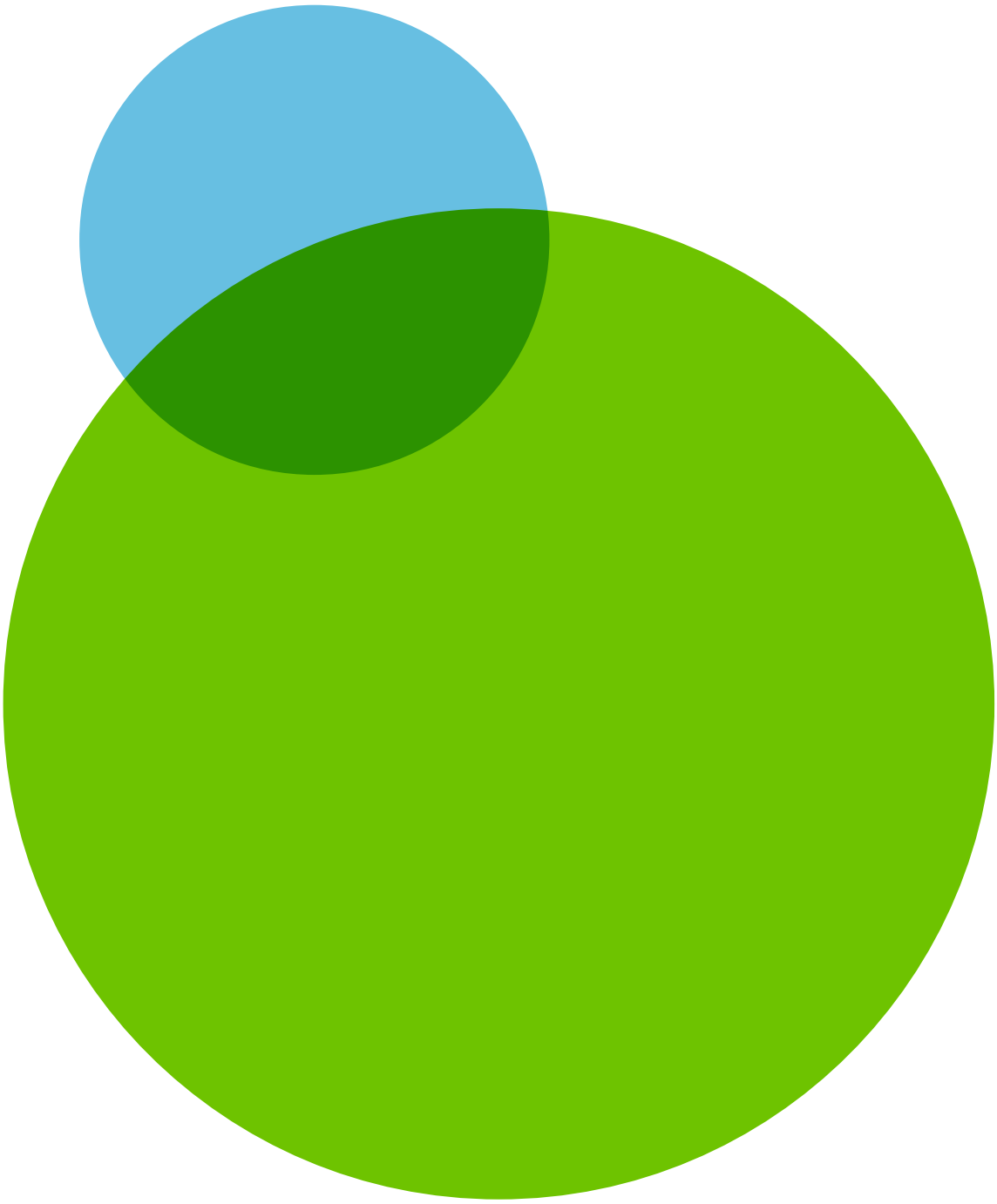
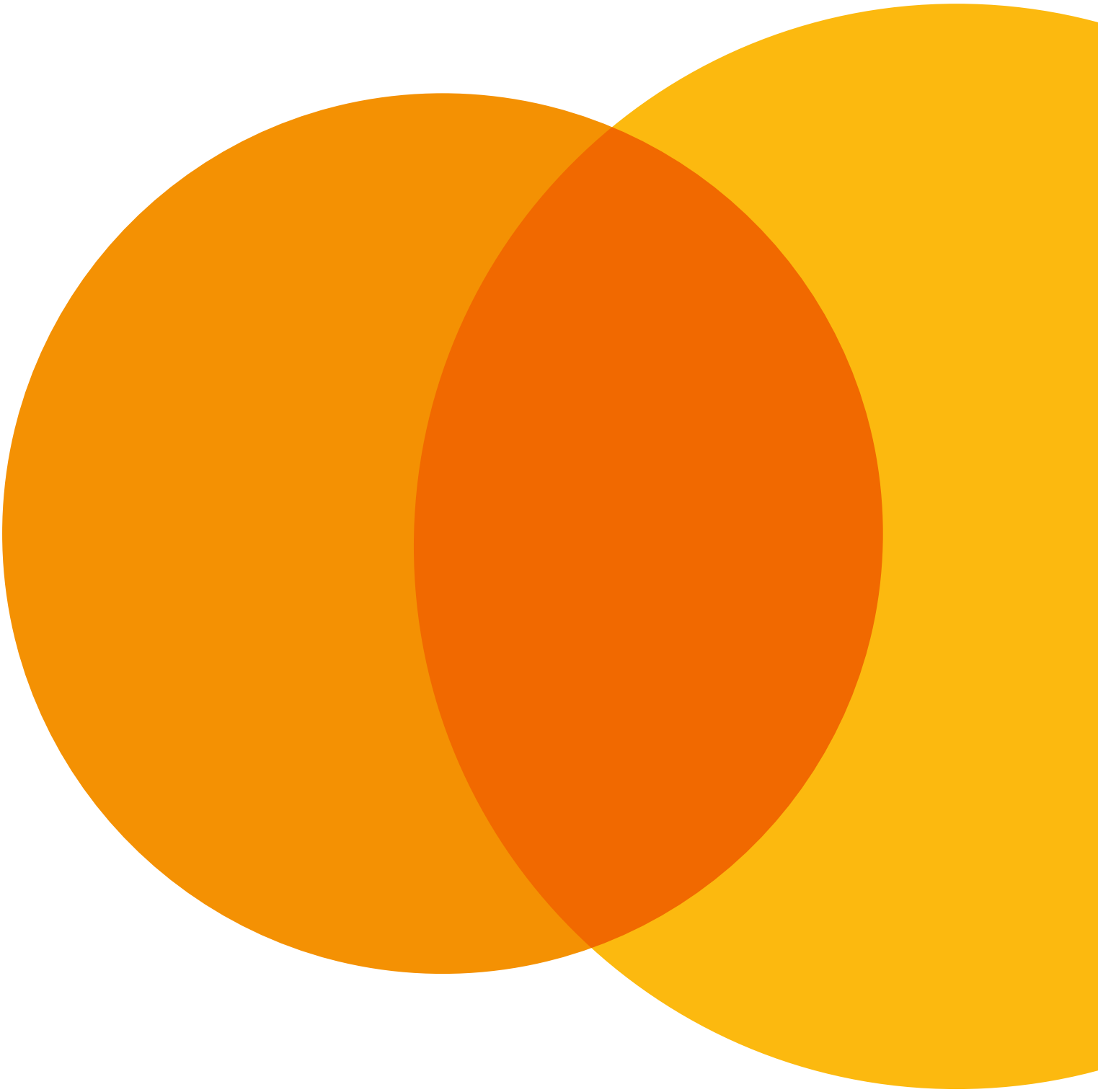
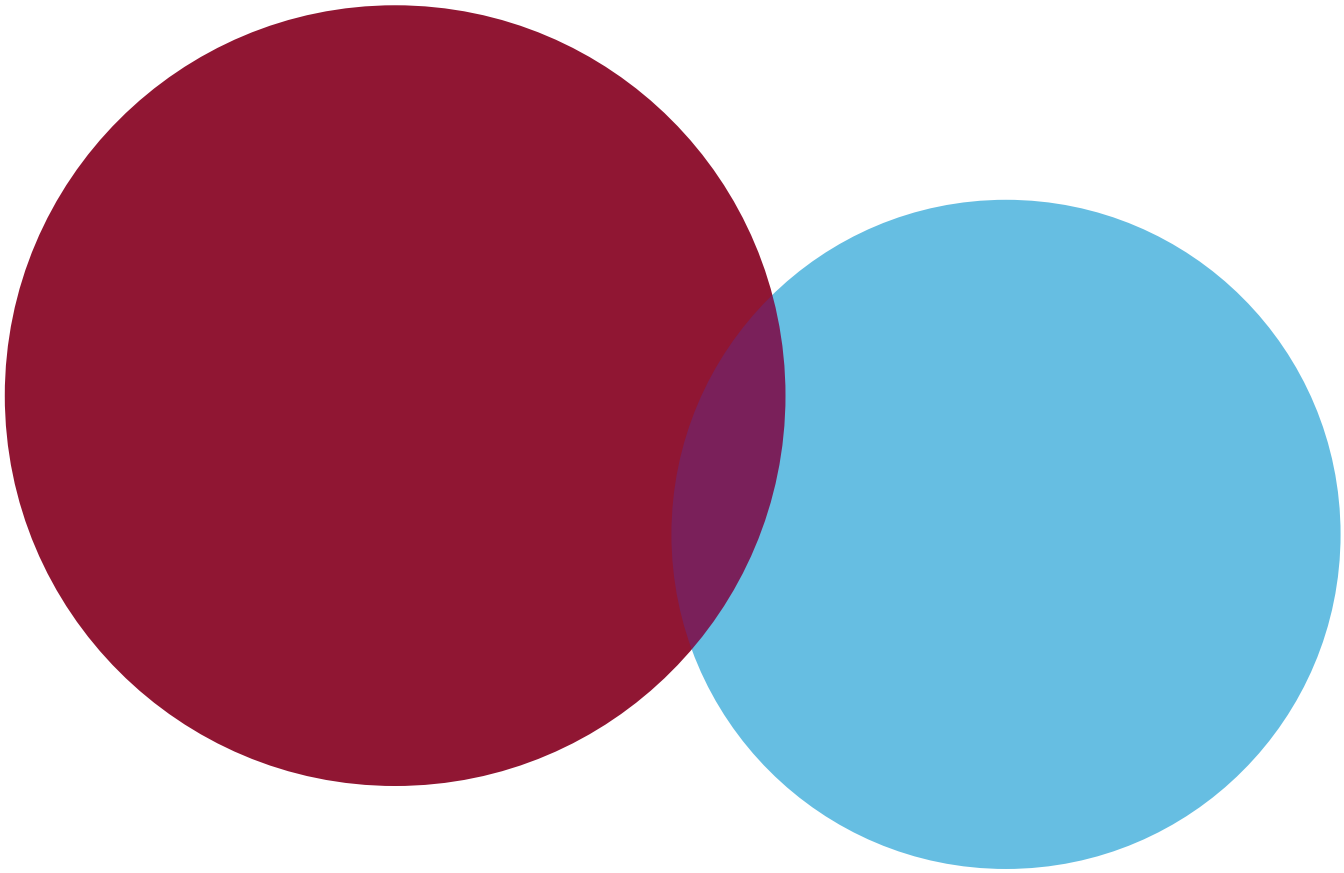


Lancashire Teaching Hospitals NHS Foundation Trust

Annual Report and Accounts 2024–25

Presented to Parliament pursuant to schedule 7, paragraph 25(4) (a) of the National Health Service Act 2006





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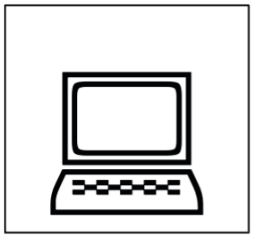

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CHAIR'S AND CHIEF EXECUTIVE'S WELCOME

Dear Stakeholder,

Having joined the Trust in January 2024 and January 2025 as Chief Executive and Chair respectively, we are proud of the services that Lancashire Teaching Hospitals delivers for the people of Lancashire and South Cumbria. We are pleased to share our Annual Report and Accounts 2024/25, which showcases many positive aspects of our work, whilst highlighting the areas we need to improve upon to provide the excellent care we aspire to.

We must begin with a sincere thank you to everyone who has contributed to the achievements, targets and developments described in this report. This includes the work of former Chair, Peter White, who retired as Chair of the Trust in December 2024, and other Board members who stood down in 2024/25.

Year-on-year, our colleagues work tremendously hard against a backdrop of increasing service demand and challenging financial savings targets. They continue to go the extra mile for each other and our patients, for which we are truly grateful. We would also like to acknowledge the important work of our volunteers and council of governors, who devote many hours of their own time without expecting any reward or recognition. Their contribution significantly strengthens our Trust.

Finally, a heartfelt thank you must go out to our local communities, who have once again shown remarkable support for our hospitals and our charities. Listening to patients, families and carers both when things do not go well, as well as when they do, helps us shape our services of the future. We are extremely appreciative of all those who have taken the time to give us their feedback.

It has been a challenging year for the health and care system locally and for the Trust, in terms of pressures on services, patient flow, and finances. We have continued to face increased demand and shortfalls in capacity in urgent and emergency care, resulting in longer waiting times for patients due to high bed occupancy. We experienced a highly pressured Winter period due to the prevalence of flu, Covid, norovirus and measles cases locally. Surges in planned care demand combined with capacity issues have also resulted in extended waiting times for treatment.

Performance across both urgent and emergency care and elective care has been impacted by operational pressures, with increased bed occupancy levels leading to times where patients have needed to be cared for in corridors, increased length of stay, increased numbers of patients who do not meet the criteria to reside, and periods of industrial action.

The financial impact of industrial action lessened significantly in 2024/25, with the Government announcing in July 2024 that the 2024–25 pay rise would be awarded to Agenda for Change staff in England in line with NHS Pay Review Body recommendations. Consultants accepted a pay offer from government in April 2024, specialty and specialist doctors in June 2024 and resident doctors in September 2024.

The Trust continues to face challenges in reducing the significant backlog of patients awaiting diagnostic testing, which has had a negative impact on overall diagnostic performance this year. However, with targeted support from NHS England, we have made measurable progress in key areas, including referral to treatment, cancer pathways, and diagnostic performance. As a result of sustained improvements, in the final quarter of 2024/25 we stepped down from the enhanced monitoring and support framework.

At Lancashire Teaching Hospitals, the cost of delivering our services and delivering patient care has continued to be greater than the income received, resulting in a significant gap in our finances. This year we have been under intense scrutiny from regulators both as a Trust and as a system. Whilst the Trust has ended the year in a position that NHS England (NHSE) and NHS Lancashire and South Cumbria Integrated Care Board (ICB) are satisfied with, there is still a long way to go.

Following the change in government in 2024, a review of the national New Hospital Programme was commissioned. The outcome of the review (published in January 2025) shows an ongoing commitment to delivering two brand-new hospitals on two new sites to replace Royal Preston Hospital and University Hospitals of Morecambe Bay NHS Foundation Trust's Royal Lancaster Infirmary, however the timescales for delivering these two hospitals are now delayed. Construction work on a replacement Royal Preston Hospital is expected to start between 2037 and 2039, with construction work on a replacement Royal Lancaster Infirmary expected to start between 2035 and 2038.

Although we are disappointed about the delayed plans for a new Royal Preston Hospital, we welcome the Government's commitment to delivering the hospital albeit over a longer than anticipated timeframe. We will continue to work closely with all our partners and stakeholders to ensure that the need for new facilities remains high on everybody's agenda so that our communities can continue to access high quality and specialist care in an environment that truly suits their needs.

Celebrating successes is important to us and throughout the year we have been pleased to acknowledge the many achievements of our colleagues and departments. The Trust has continued to implement important service developments, ranging from the introduction of new cutting-edge technology and pioneering new surgical procedures to the opening of new facilities. This has benefited both patients and colleagues, as well as helping to alleviate pressure and improve flow across our sites. These achievements reflect the determination of our dedicated colleagues and key partners, who have stayed focused on enhancing our services for the communities we support.

Education and training continue to be key enablers to delivering safe and effective patient care. The Trust provides clinical skills training, placement support, professional development, and apprenticeships and widening participation, amongst other areas. This is complemented by the introduction of enhanced technology resources and innovative projects, such as the new practice-based pathway into nursing. The Trust has continued to maintain its long-standing relationships with higher education partners, which for many years has seen medical, nursing, and wider multidisciplinary clinicians progress academically within the Trust and wider healthcare system.

In 2024/25, our Centre for Health Research and Innovation streamlined its research portfolio and expanded its involvement in commercial studies to align with national targets. The Trust is lucky to have colleagues dedicated to research across a range of clinical disciplines spanning diverse therapeutic areas and research types, from early-phase commercial trials to academic qualitative studies.

The Trust has developed a three-year Green Plan in response to national NHS net zero ambitions, focusing on reducing emissions. Achievements in this area have included implementing a prescription tracker to reduce double prescribing and loss of medication, recycling old robots as new pharmacy robots have been installed, reducing printing, removing single use plastics from catering outlets, planting trees and hedges, and installing new more energy efficient LED (Light Emitting Diode) lighting.

Our health and care system continues to work together in collaboration and an innovative example of this is One Lancashire and South Cumbria (One LSC) which brings together a number of central services from the five NHS trusts which make up the health system's Provider Collaborative. The aim is to use our collective resources to improve service quality, increase resilience and improve cost efficiency, ultimately to support better patient care. In November 2024, colleagues from functions including people services, finance, digital, data and technology, and procurement and logistics transferred to One LSC and its development continues with the planned transformation of services to enable the realisation of One LSC's full benefits.

Similarly, a great deal of collaborative work has taken place across the Lancashire and South Cumbria healthcare system to develop a future model for outpatient dispensing services. In February 2025 it was confirmed that Lancashire Hospital Service (LHS), a subsidiary owned by Lancashire Teaching Hospitals, will provide acute Trusts with a long-term opportunity to develop and enhance dispensing services together for the benefit of our local communities while ensuring NHS money is spent in the most cost-effective way.

Throughout 2024/25, work has been progressing on a business case to support the Pathology Service to establish a clinical model and delivery framework that will support the formation of a single service. The establishment of a unified pathology service presents an opportunity to consolidate operations, enhance service delivery and address future challenges effectively whilst maintaining high-quality patient care. In 2024/25, governance approval was secured for the transition to a Lancashire and South Cumbria (LSC) Pathology Single Service with our Trust recently selected as the host trust for this.

We have ambitious targets and ongoing challenges to tackle as a Trust and a health and care system. In 2025/26, in line with national planning guidance, our focus will be on reducing the time people wait for elective care; improving A&E waiting times and ambulance response times; driving the reform that will support delivery of our immediate priorities and ensure the NHS is fit for the future; living within the budget allocated, reducing waste and improving productivity; and maintaining our collective focus on the overall quality and safety of our services.

We have a target to save around £60million in 2025/26 to bring us back into financial balance, with the majority of the savings opportunities already identified. We must now turn our attention and focus on the delivery of those plans to help give our regulators confidence that we can achieve the required deficit reduction during the course of 2025/26. We are working closely together as a healthcare system and with the full involvement of our staff side colleagues to ensure that changes do not compromise patient safety, and that colleagues are kept updated and treated fairly.

Thank you once again to our communities, partners and key stakeholders for your ongoing support of your local NHS. Please do continue to get involved – we hugely value your involvement.

Professor Mike Thomas
Chair
26 June 2025

Professor Silas Nicholls
Chief Executive
26 June 2025

Lancashire Teaching Hospitals NHS Foundation Trust

PERFORMANCE REPORT 2024–25

OVERVIEW OF PERFORMANCE

The purpose of this report is to inform the users of the Trust of its performance and to help them assess how the Directors have performed in promoting the success of the Trust.

This report is prepared in accordance with sections 414A, 414C and 414D of the Companies Act 2006 (as inserted/amended by the Companies Act 2006 except for sections 414A(5) and (6) and 414D(2) which are not relevant. For the purposes of this report, we have treated ourselves as a quoted company. Additional information on our forward plans is available in our operational plan on our website. Information on any mandatory disclosures included within this report is provided on pages 86 to 89.

The accounts contained within this report have been prepared under a direction issued by NHS England (NHSE) under the National Health Service (NHS) Act 2006.

Who we are

Lancashire Teaching Hospitals NHS Foundation Trust was established on 1 April 2005 as a public benefit corporation authorised under the Health and Social Care (Community Health and Standards) Act 2003. We are registered with the Care Quality Commission (CQC) without conditions to provide the following regulated activities:

- diagnostic and screening services
- maternity and midwifery services
- surgical procedures
- termination of pregnancies
- treatment of disease, disorder or injury
- management of supply of blood and blood-derived products
- assessment or medical treatment for persons detained under the Mental Health Act 1983
- vaccination hub satellite service
- accommodation for persons who require nursing or personal care

We are a large acute Trust providing district general hospital services to over 395,000 people in Chorley, Preston and South Ribble and specialist care to 1.8m people across Lancashire and South Cumbria.

We are a values-driven organisation. Our values were designed by our staff and patients and are embedded in the way we work on a day-to-day basis:

- **Caring and compassionate**: We treat everyone with dignity and respect, doing everything we can to show we care.
- **Recognising individuality**: We respect, value, and respond to every person's individual needs.
- **Seeking to involve**: We will always involve you in making decisions about your care and treatment and are always open and honest.
- **Team working**: We work together as one team, and involve patients, families, and other services, to provide the best care possible.
- **Taking personal responsibility**: We each take personal responsibility to give the highest standards of care and deliver a service we can always be proud of.

We believe that to provide the best care, we need continually to improve the way in which we provide services. If we are to be the best, we need continually to seek improvement and embrace change, empowering our teams to develop ideas and drive them forward. We have adopted a Continuous Improvement approach and developed a strategy to support this.

As well as providing healthcare for our local patients, we are proud to be the regional centre for a range of specialist services. These services include:

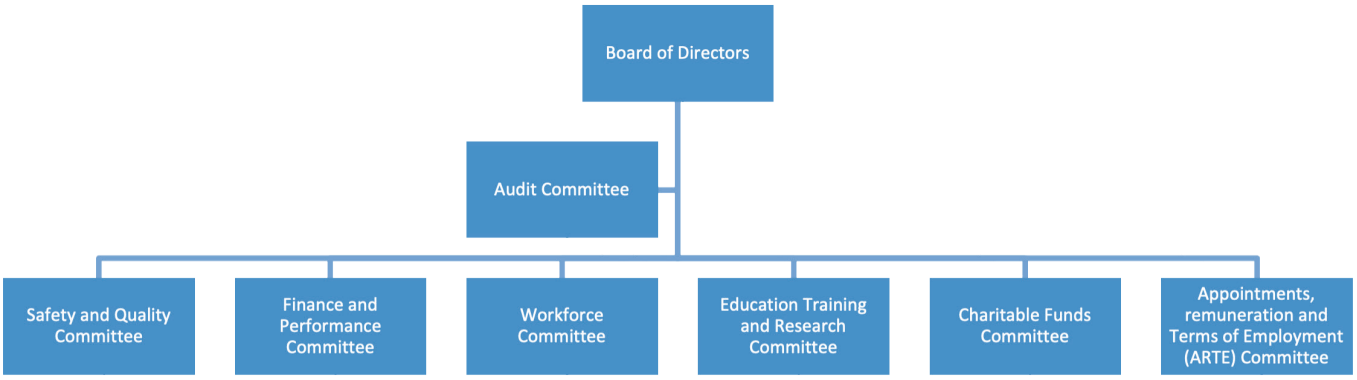
- Adult Allergy and Clinical Immunology
- Cancer (including radiotherapy, drug therapies and cancer surgery)
- Disablement services such as artificial limbs and wheelchairs
- Major Trauma
- Neurosciences including neurosurgery and neurology (brain surgery and nervous system diseases)
- Renal (kidney diseases)
- Specialist vascular surgery

Our portfolio of services will continue to develop as the strategy for the provision of services across our region is developed, but the delivery of specialist services will remain at the heart of our purpose and the decisions we take in our day-to-day activities will be taken in the context of ensuring we remain as the Lancashire and South Cumbria Integrated Care System (ICS) specialist hospital.

When we were established in 2005, we were the first Trust in the county to be awarded 'teaching hospitals' status. We believe that developing the workforce of the future is central to delivering high quality healthcare into the future. We are a local leader in respect of our education, training, and research and as the only National Institute for Health and Care Research (NIHR) Clinical Research Facility in Lancashire and South Cumbria, and a leading provider of undergraduate education, we will continue to drive forward the ambitions described in our education and research strategies.

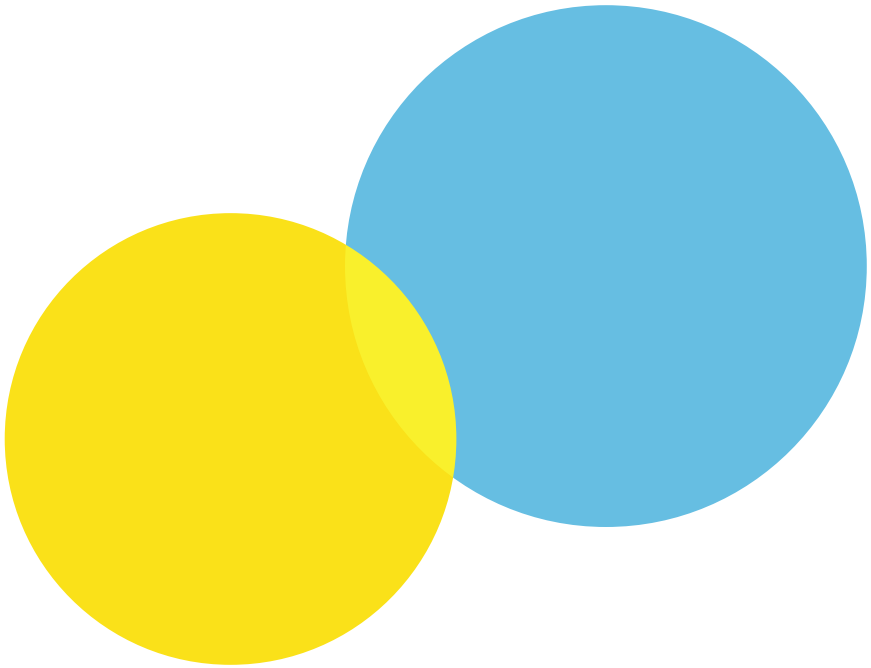
How we are run

The Board of Directors is responsible for the overall leadership and strategic direction of the organisation. The board operates a committee structure, with each committee responsible for seeking assurance on matters within its purview. The established committee structure and a summary of their roles is set out below:



Audit Committee	Safety and Quality Committee	Finance and Performance Committee	Workforce Committee
Responsible for oversight of the financial reporting process, obtaining assurance around the systems of internal control, internal audit, counter-fraud and other corporate governance matters	Responsible for seeking assurance on and having oversight of the quality and safety elements of the business and reviewing high level risks allocated to the strategic objective of patients	Responsible for seeking assurance on and having oversight of the people elements of the business and reviewing high level risks allocated to the strategic objective of people	Responsible for seeking assurance on and having oversight of the people elements of the business and reviewing high level risks allocated to the strategic objective of people

ARTE Committee	Charitable Funds Committee	Education, Training and Research Committee
A statutory committee, responsible for determining the remuneration, allowances and other terms and conditions of the executive directors	Responsible for oversight and distribution of the charitable funds held by the Trust as corporate trustee.	Responsible for oversight of our research activities and seeking assurance around delivery education and research and part of our wider ambition to become a university teaching hospital



Strategic Aims and Ambitions

Our Context

Our mission is to always provide excellent care with compassion to our local communities. Our colleagues strive to ensure that every patient receives the highest quality of service. The Trust also aims to be a great place to work, fostering an environment where colleagues feel valued and supported and to delivering value for money, ensuring that our resources are used efficiently and effectively. The Trust is also focused on being fit for the future, continuously improving and adapting to meet the evolving needs of our community.

Providing district general hospital services to over 385,000 people in Preston, Chorley and the South Ribble areas, the Trust aims to provide a range of the highest standard of specialised services to over 1.7m patients across Lancashire and South Cumbria. Services are delivered from two main hospital sites; Chorley and South Ribble Hospital and Royal Preston Hospital, with other services delivered through our community-based sites; The Specialist Mobility and Rehabilitation Centre, Preston Healthport Community Diagnostic Centre and Broadoaks Child Development Centre, along with several services and clinics delivered from a wide range of smaller community-based facilities.

Our dedication to driving innovation through world-class education, teaching, and research is unwavering. These strategic aims are the foundation upon which we build our services and initiatives.

Our Values

Our values underpin everything we do. We are caring and compassionate, treating everyone with dignity and respect. We recognise individuality, valuing and responding to each person's unique needs. We seek to involve our patients in making decisions about their care and treatment, and we are always open and honest. We work together as one team, involving patients, families, and other services to provide the best care possible. Each of us takes personal responsibility to give the highest standards of care and deliver a service we can always be proud of.

Our Strategy

The success of our organisation is founded on having a clear strategy. This is delivered through the "Single Improvement Plan" which outlines our commitments, delivery promises, and identifies the things we will achieve both now and in the future.

Our Strategy is founded on four ambitions:

1. **Consistently Deliver Excellent Care**: We aim to improve outcomes and reduce harm, striving to achieve a CQC rating of good. Priorities include reducing pressure ulcers, maintaining compliance with maternity safety actions, and improve A&E waiting times.
2. **A Great Place to Work**: We aim to promote health and wellbeing, reduce sickness absence, value each other, reduce discrimination, and improve staff engagement and training.
3. **Deliver Value for Money**: We aim to agree revenue and capital financial plans, deliver cost improvement targets, achieve bed occupancy rates, and ensure efficient use of resources.
4. **Fit for the Future**: We aim to deliver outstanding and sustainable healthcare, drive health innovation, transform outpatient and elective care, and collaborate with system partners.

Communicating Our Plan

The Single Improvement Plan is how we will deliver our wider strategy. Ensuring that everyone understands their role in helping us deliver our goals is key. Team objectives are translated into individual objectives through the appraisal process, creating a strategic link between individual, team, and organisational objectives.

Monitoring Progress

The Board of Directors provides a framework of good governance to enhance the care and wellbeing of our patients and staff. Metrics within the Integrated Performance Report for the Board of Directors are aligned to the Single Improvement Plan outcomes, providing details of performance against agreed KPIs. The Trust has developed and implemented a new Accountability Framework.

The priority for 2025/26 is to develop a new medium-term strategy which is fully aligned to the ICB strategy and priorities.

Integrated Care Board in Lancashire and South Cumbria

The Trust is part of the Lancashire and South Cumbria Integrated Care System (ICS). The role of the ICS is to join up health and care services, improve people's health and wellbeing, and to make sure everyone has the same access to services and gets the same outcomes from treatment. The ICS also has the duty to monitor and manage how money is spent and make sure health services work well and are of high quality.

Lancashire and South Cumbria ICS has a clear vision outlining a strong community focus working in harmony with a high performing hospital system. To achieve this the Lancashire and South Cumbria ICS supports multi-professional teams across health and social care working within agreed protocols and pathways and within aligned financial incentives to deliver clear and mutually agreed goals and targets for the benefit of local communities.

The work of the ICS is directed by the Integrated Care Board (ICB). Since July 2022 NHS Lancashire and South Cumbria Integrated Care Board (ICB) has held responsibility for planning NHS services, including primary care, community pharmacy and those previously planned by Clinical Commissioning Groups (CCGs). The ICB works closely with the Provider Collaborative Board to co-design and oversee the transformation of services.

Lancashire Place

Lancashire Place has a large population spread across a large geographical footprint. Due to its size, it is divided into three sub-localities: North, Central and East Lancashire. The area of Central and West Lancashire covers the main district general hospital services delivered by Lancashire Teaching Hospitals covering the areas of Chorley, Preston, and South Ribble (as well as West Lancashire).

The vision of Lancashire Place is 'Living Better Lives in Lancashire', with the ambition to help the citizens of Lancashire to live longer, healthier, and happier lives. This will be achieved in partnership with the Lancashire and South Cumbria ICB and the five provider trusts by improving health and care services through integration and addressing health and wellbeing inequality across the Lancashire Place.

Priorities for 2024/25 were linked to the wider Transforming Care in the Community Programme, development of integrated neighbourhood teams and improving urgent and emergency care pathways. Teams across Lancashire Place are participating in the regional Learning and Improvement Networks for Urgent and Emergency Care and Elective care which is part of the national NHS IMPACT programme to bring teams together to scale up best practice and share the best of the NHS with the rest of the NHS.

Our principal issues and risks

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

In 2024 a review of the Board Assurance Framework was undertaken with a recommendation to change from a strategic risk approach to a principal risk approach. Details of our principal risks and issues are outlined in detail as part of the Annual Governance Statement.

Our performance

Lancashire Teaching Hospitals NHS Foundation Trust performance is measured against a range of patient safety, access and experience indicators identified in the NHS compliance framework and the acute services contract.

The NHS continued to face significant challenges in the delivery of its constitutional standards in 2024–25. Whole health economy system pressures, in response to increased demand and shortfalls in capacity, resulted in longer waiting times for Urgent and Emergency Care (UEC), due to high bed occupancy and surges in planned care demand coupled with capacity shortfalls similarly resulted in extended waiting times for treatment.

Performance across both UEC and Elective Care has been impacted upon by operational pressures, including the impact of periods of industrial action, an increase in bed occupancy levels resulting in times when patients have needed to be cared for in non-designated bed spaces, an increased length of stay and increased numbers of patients who do not meet the criteria to reside (NMCTR). In addition to this, we have been unable to reduce the significant backlog of patients requiring diagnostic testing which has impacted negatively on overall diagnostic performance. However, the Trust has been supported by colleagues within NHS England to ensure improvements in Referral to Treatment (RTT), cancer and diagnostic performance and in the last quarter of 24/25 LTH has now stepped down from this enhanced level of monitoring and support given the improvements seen within these areas of performance.

In 2024–25, the Trust continued to take a lead role in bringing together operational delivery of key transformational work streams identified and prioritised by all system partners: the development of Virtual Wards implementing point of care testing, increasing utilisation; and working with Lancashire & South Cumbria NHS Foundation Trust (LSCFT) to progress a single point of access for all community and hospital avoidance schemes bringing together 2-hour Crisis Response, Virtual Ward, Same Day Emergency Care (SDEC) and wider community services to support people to stay safe at home.

Urgent and Emergency Care

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

In 2024–25 we have;

- Established an Acute Assessment Unit to reduce time spent in the Emergency Department ahead of the delivery of increased Medical Assessment Unit capacity.
- Expanded the Virtual Ward bed base to include Frailty, Respiratory and Acute Medicine; successfully implementing remote monitoring for virtual ward patients.
- Enhanced our internal escalation measures, including the implementation of a site pressure score and robust actions in relation to the management of whole hospital flow.
- Expanded SDEC pathways and admission avoidance therapy provision.
- Developed revised ward and board round standards and rolled out Continuous Flow.

Elective

Lancashire Teaching Hospitals began the 2024–25 fiscal year facing significant pressures in managing elective care in part due to the impact of industrial action and backlog recovery of the previous year. The overarching priority for 2024–25 was to address the long waits and recover the backlog position for elective procedures.

Key Achievements in 2024–25:

Elimination of Longest Waits: we successfully eliminated waits of over 78 weeks for elective care. This was a significant improvement from the 181 cases recorded in 2023–24 reducing to a zero position in 2024- 25.

Reduction of Backlog: we continued our efforts to reduce the backlog of patients waiting over 65 weeks for elective care. The backlog was reduced from 1531 cases in 2023–24 to 19 in 2024–25. The number of patients waiting above 52 weeks has significantly reduced from 4944 cases in 2023–24 to 1505 in 2024–25.

These achievements reflect our commitment to improving patient care and reducing waiting times. We will continue to prioritise the recovery of our core services and strive to enhance the overall patient experience in the coming years.

Diagnostics

Diagnostic performance has remained a challenge throughout 2024–25. Performance against the Diagnostic access standard (DM01) has remained significantly under trajectory despite incremental improvement in Q3 & Q4 achieving 8.4% improvement in DM01 performance from September 2024 to February 2025. Diagnostic performance challenges are driven by the backlog of patients requiring a diagnostic test in addition to increasing demand, workforce constraints with the availability of appropriately trained staff, which is reflected nationally, and equipment and space constraints. To address this challenge, our diagnostic services developed a workforce strategy to attract and retain specialised diagnostic staff alongside several training programmes.

In 2024–25 we have:

- Implemented an automated validation process which has reduced our waiting lists by circa 4%.
- Established a diagnostic performance meeting with a focus on backlog reduction/elimination.
- Established a diagnostic improvement group with a focus on capacity optimisation, productivity and transformation.
- Implemented a revised access policy to support how we manage our demand.
- Refined clinical triage process across Echocardiography in line with National Standards resulting in a rejection rate of 5%.

Cancer

Significant progress has been made with both cancer 62-day performance and performance against the 28-day faster diagnosis standard (FDS). This was achieved by building on the work implemented in 2023–24 to reduce backlogs.

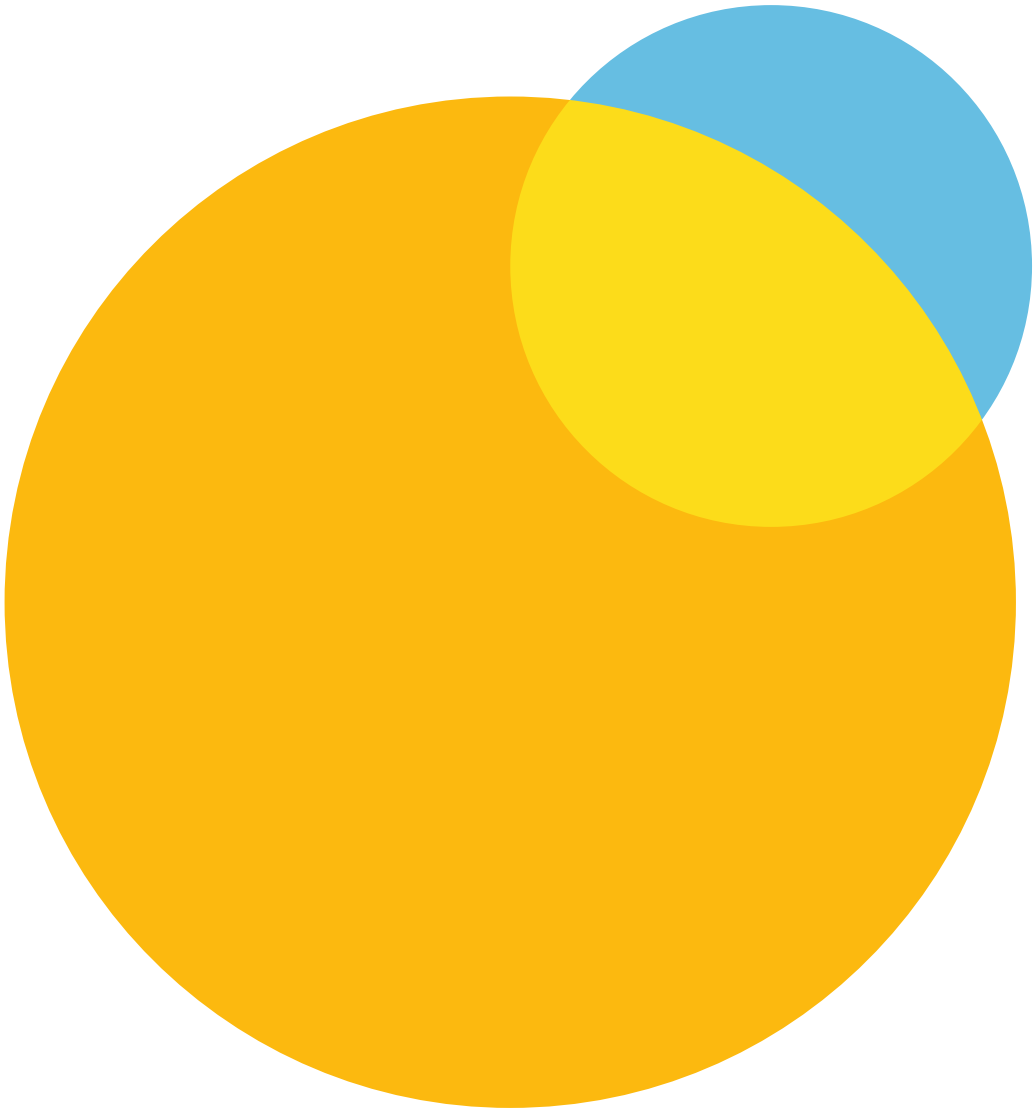
In 2024/25 we have;

- Exceeded the 28-day faster diagnosis standard of 77% by March 2025 achieving 81.2% for the month of March and 77.8% for 24–25. This means that more of our patients have received early confirmation of a cancer or non-cancer diagnosis.
- Improved our cancer 62-day performance from 56% to 62% which means that more patients have received their first treatment for cancer within 62 days.
- Streamlined colorectal faster diagnosis pathways and successfully increased 28 days FDS compliance from 36.5% in Jan 2024 to 73% in March 2025.
- Increased productivity in gynaecology pathways, enabling patients to be triaged faster.
- Implemented a post menstrual bleed pathway which has enabled patients to access scanning which provides treatment and reassurance to our patients earlier. This has improved the patient experience and enabled us to manage patients on appropriate non-cancer pathways.
- Excelled in the National Cancer Patient Experience Survey, maintaining an overall Patient Experience score of 9/10 for the third year running, with no scores below the national average.
- Enhanced utilisation of digital systems by using an image platform for triage of suspected skin cancer. Patients can attend local skin hubs for image capture rather than attending the hospital on multiple occasions.

- Facilitated 24 community events to improve cancer awareness and address health inequalities; this supports us to achieve earlier diagnosis of cancer.

EPRR

The Trust remains committed to ensuring robust Emergency Preparedness, Resilience, and Response (EPRR) arrangements in accordance with NHS England's Core Standards. Over the past year, we have undertaken a programme of training, exercises, and business continuity planning to enhance our preparedness for a wide range of incidents, ensuring the safety of patients, staff, and services. Our readiness activities are continuously reviewed and refined to maintain compliance with regulatory requirements and best practice guidance.



Performance analysis

The summary position detailing performance in 2024–25 is shown in the table below:

ANNUAL REPORT 2024–25

KPIs 2024–25 COMPARED TO 2023–24

Indicator	2023–24	2024–25	Current Period	Comparison
A&E - 4 hour standard	70.4	69.8	% - Cumulative to end Mar 2025	Deteriorated
Cancer - 2 week rule (All Referrals) - New method	83.5	87.1	% - Cumulative to end Mar 2025	Improved
Cancer - 2 week rule - Referrals with breast symptoms	91.0	76.3	% - Cumulative to end Mar 2025	Deteriorated
Cancer - 31 day target	84.4	89.3	% - Cumulative to end Mar 2025	Improved
Cancer - 31 Day Target - Subsequent treatment – Surgery	58.2	66.2	% - Cumulative to end Mar 2025	Improved
Cancer - 31 Day Target - Subsequent treatment – Drug	98.4	98.2	% - Cumulative to end Mar 2025	Deteriorated
Cancer - 31 Day Target - Subsequent treatment – Radiotherapy	87.1	93.8	% - Cumulative to end Mar 2025	Improved
Cancer - 62 day Target	56.0	62.4	% - Cumulative to end Mar 2025	Improved
Cancer - 62 Day Target - Referrals from NSS (Summary)	29.9	35.6	% - Cumulative to end Mar 2025	Improved
28 day faster diagnosis standard – compliance	71.5	77.8	% - Cumulative to end Mar 2025	Improved
MRSA	0	0	% - Cumulative to end Mar 2025	Maintained
C.difficile Infections	203	182	% - Cumulative to end Mar 2025	Improved
18 weeks - Referral to Treatment - % of Incomplete Pathways < 18 Weeks	55.0	56.5	% - Cumulative to end Mar 2025	Improved
18 weeks - Referral to Treatment -Number of Incomplete Pathways > 104 Weeks	0.0	0.0	End March 2025 census position	Maintained
18 weeks - Referral to Treatment -Number of Incomplete Pathways > 78 Weeks	11.0	0.0	End March 2025 census position	Improved
18 weeks - Referral to Treatment -Number of Incomplete Pathways > 65 Weeks	312.0	19.0	End March 2025 census position	Improved
18 weeks - Referral to Treatment -Number of Incomplete Pathways > 52 Weeks	2918.0	1567.0	End March 2025 census position	Improved
% of patients waiting over 6 weeks for a diagnostic test	45.6	50.5	% - Cumulative to end Mar 2025	Deteriorated

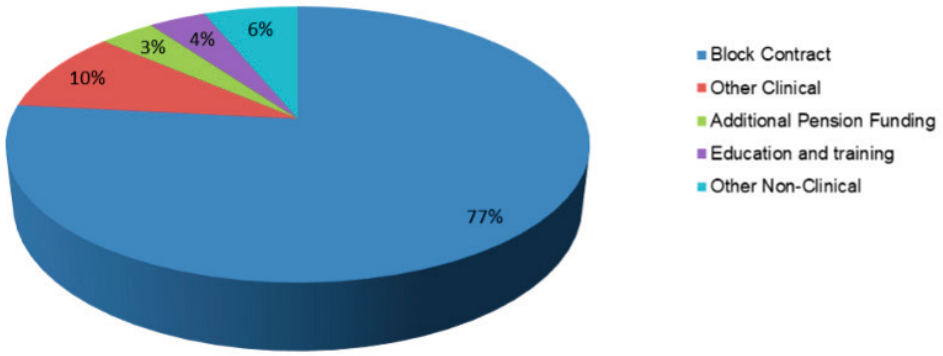
Our finances

Income Generation

During 2024/25 the Trust generated income from patient care, including through a block contract of £780m (2023/24: £731m), an increase of 6% from 2023/24. This included £21.9m of deficit support funding (2023/24 £23.9m).

A further £87m (2023/24: £79m) was generated from other income sources which includes training levies, research funding, car parking, catering and retail outlets and from providing services to other organisations.

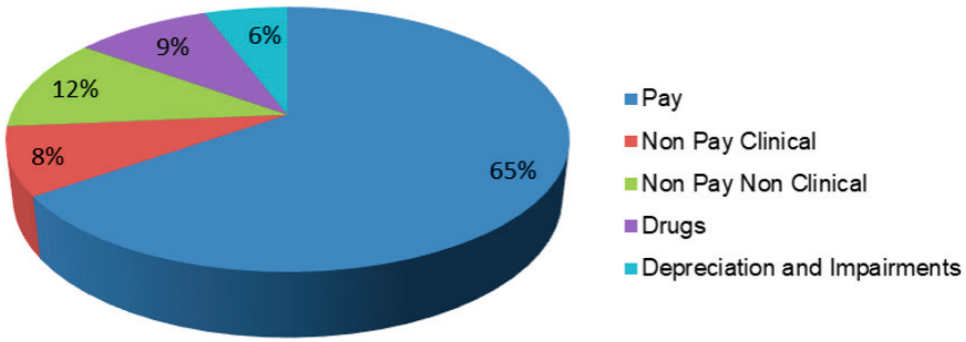
Income Analysis



Expenditure

Operating expenditure for the year was £916m (2023/24: £868m), the graph below shows the main categories of expenditure at the Trust. The main reason for the rise in costs can be attributed to pay awards, inflationary cost increases, and restoration of elective and outpatient activity. The Trust delivered £26.1m savings against a financial recovery target of £58m.

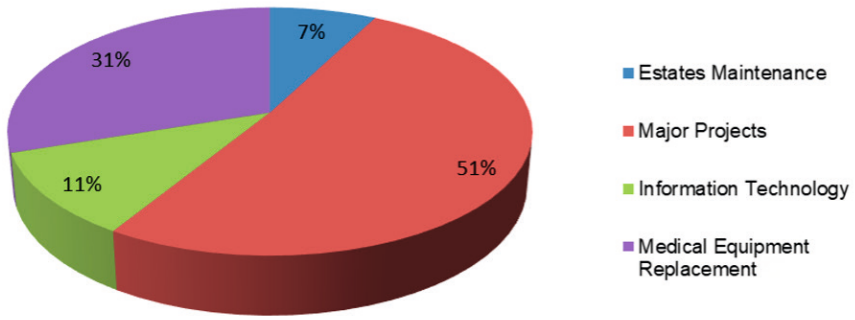
Expenditure



Capital Investment

In 2024/25 £44m excluding leases (2023/24: £57m) was invested in the Trust's capital programme to maintain and improve the asset base of the Trust as illustrated in the chart below. Major projects in year included the purchase of land for the New Hospital project (18m), and the new DOSA/SAU facility. £19m was spent through purchase and lease on new and replacement medical equipment, as a combination of outright purchases and lease agreements.

Capital Expenditure



Better Payment Practice Code (BPPC)

We aim to treat all suppliers ethically and to comply with the BPPC target, which states that we should aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. For 2024/25 we paid 81% (2023/24 74%) of invoices to this timescale.

	NHS		Non-NHS		Total	
	No.	**Value £'000**	**No.**	**Value £'000**	**No.**	**Value £'000**
Invoices paid within 30 days	2,225	168,590	92,712	329,036	94,937	497,626
Invoices not paid within 30 days	873	30,375	21,108	57,464	21,981	87,839
Total Invoices	**3,098**	**198,965**	**113,820**	**386,500**	**116,918**	**585,465**
BPPC %	72	85	82	85	81	85
Total amount of any liability to pay interest						66

Reconciliation of underlying trading position for year ending 31 March 2025

The Trust delivered an accounting deficit for the year of £57.7m (2023/24: £67.9m). After adjustment for accounting movements relating to impairment charges and income and expenditure for donated assets, the Trust delivered a revised trading deficit of £36.2m (2023/24: £35.6m).

		Group	
		2024/25	**2023/24**
		£000	**£000**
Deficit for the year		(57,712)	(67,924)
Add back I&E impairments		21,491	31,889
Remove net donated income		(24)	374
Remove DHSC centrally procured inventories (donated)		0	94
Revised trading surplus / (deficit)		**(36,245)**	**(35,567)**

Forward Look

The operational and financial planning process for 2025/26 has been developed in line with the expectations set out in the national planning guidance. The key focus of the guidance is to:

1. Reduce the time people wait for elective care,
2. Improve A&E waiting times and ambulance response times
3. Drive the reform that will support delivery of our immediate priorities and ensure the NHS is fit for the future
4. Live within the budget allocated, reducing waste and improving productivity.
5. Maintain our collective focus on the overall quality and safety of our services.

The key requirements of the national guidance include the following:

- Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement.
- Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement.
- Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026.
- Improve performance against the headline 62-day cancer standard to 75% by March 2026.
- Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026
- Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026 and a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25.
- Deliver a balanced net system financial position for 2025/26.
- Reduce agency expenditure as far as possible, with a minimum 30% reduction on current spending across all systems.
- Close the activity/ WTE gap against pre-Covid levels (adjusted for case mix)
- Improve safety in maternity and neonatal services, delivering the key actions of the of the 'Three-year delivery plan'.
- Reduce inequalities in line with the Core20PLUS5 approach for adults and children and young people

In addition to these measures NHSE North West regional team have requested a +15% improvement in performance to the proportion of patients waiting less than 6 weeks for a diagnostic test (DM01) to 65%.

The Trust's financial plan for 2025/26 has been developed taking into account the national planning guidance, However the plan is not without significant risk. As part of agreeing the Lancashire and South Cumbria Integrated Care System (L&SC ICS) overall plan, deficit support funding of £30m has been agreed. Given the underlying deficit and the year-on-year local efficiency requirement there is still a requirement to deliver a "Waste Reduction Programme" of £60m to breakeven.

To support delivery of this ambitious financial recovery programme the Trust has dedicated programme management support including a Programme Management Office and a Turnaround Director. Schemes are monitored and reported on a weekly and monthly basis through the Trust's governance process.

The Trust continues to work in partnership within the Integrated Care System and with neighbouring Trusts via the Provider Collaborative

Lancashire Hospital Services (LHS) Ltd

LHS Ltd is a wholly owned subsidiary company delivering outpatient pharmacy services for the trust. The transfer of the management and running of community pharmacies previously operated by Lloyds Pharmacies to LHS Ltd went live in February 2025. This involved the onboarding of six new pharmacy sites which are being operated on behalf of three hospital trusts: East Lancashire Hospital Trust, University Hospitals

of Morecambe Bay NHS Foundation Trust and Blackpool Teaching Hospitals NHS Foundation Trust, (the Participating Trusts). The financial modelling relating to this transaction indicates that the effect on LHS will be positive in year 1. The monthly Profit Before Taxation (PBT) is expected to increase from the average normalised position of £11k per month for April 2024 – Jan 2025, to a position of an average PBT of £14k per month in the financial year 2025/26.

The financial principles agreed to with all parties relating to this transaction provide LHS Ltd and the trust with a level of protection relating to any potential financial downsides with the option to review and amend dispensing charges to each of the parties should there be evidence that these are not covering all associated costs.

Going concern

These accounts have been prepared on a going concern basis which the directors believe to be appropriate for the following reasons.

The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Guidance from the Department of Health and Social care indicates that all NHS bodies will be considered to be going concerns unless there are ongoing discussions at department level regarding the winding up of the activity of the organisation. There are no such conversations regarding this Trust and as such it is regarded as a going concern with indicative deficit support funding already in place for 2025/26.

Based on these indications the directors believe that it remains appropriate to prepare the accounts on a going concern basis.

Taskforce on Financial Climate Related Disclosures (TFCD)

In October 2020, 'Delivering a net zero National Health Service' was published, highlighting the consequences of climate change, leading to major disease such as cardiac problems, asthma and cancer. The Trust has developed a three year Green Plan to focus on reducing emissions across twelve key areas of focus, reporting progress via the quarterly submissions to the Greener NHS reporting system and annual Estate Return Information Collection (ERIC) return.

Governance and accountability

The Green Plan is a living document outlining how we will fulfil our responsibility as an anchor institution and mitigate our impact on climate change. It is aligned to the national guidance and standards, with a more detailed framework and action plan defining what will be achieved and by when.

To ensure delivery of the Green Plan, a clear governance structure is in place which consists of appointed subject leads for each of the twelve areas of focus. There is a green plan lead within the planning team, who co-ordinates the progress of the plan, with senior support from the dedicated board level executive. The green plan lead attends quarterly meetings with the Lancashire and South Cumbria Integrated Care Board (ICB) to update on progress of the Trust plan, escalate concerns, along with obtaining updates from the regional lead to disseminate locally to the area leads. The green plan lead chairs a monthly sustainability working group meeting with the area leads to provide updates and progress of actions and aims, these are updated on a tracker and form part of the annual update via the Finance and Performance Committee through to the Trust Board. Any issues or concerns raised at the working group meetings are escalated to the executive board member, who provides support and oversight of the Green Plan.

Each of the leads are responsible for working towards the net zero goals, aligning with national guidance. The twelve areas of focus are

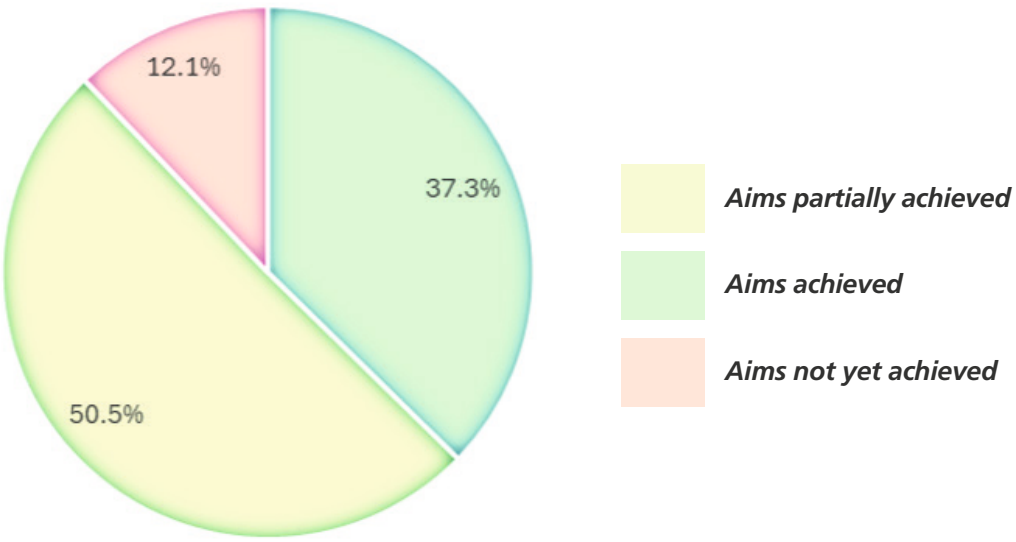


Figure 1: Overall RAG percentage breakdown of aims achieved

Risk Management

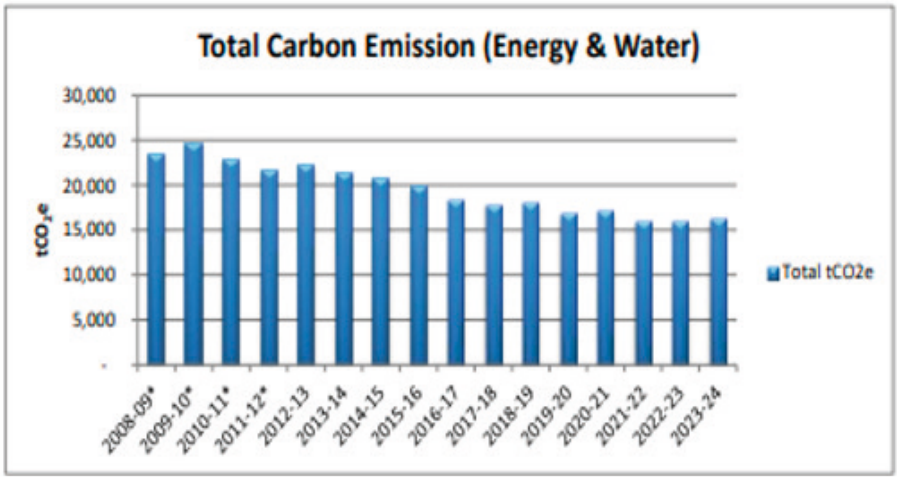
Each of the area leads is responsible for raising and managing climate related risks relevant to their area of focus. These are recorded as per the Trust Risk Management Policy onto the Datix database. There are currently 12 active risks on the risk register relating to estate and/or digital which are aligned to the green plan and/or sustainability theme.

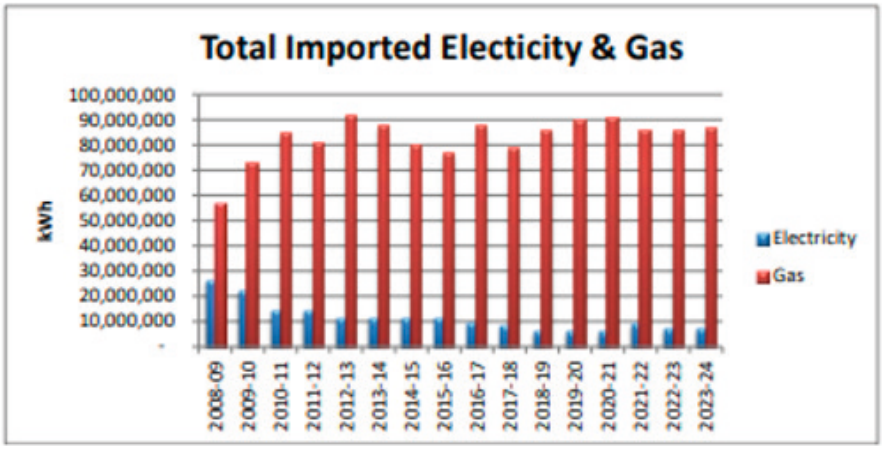
Reporting

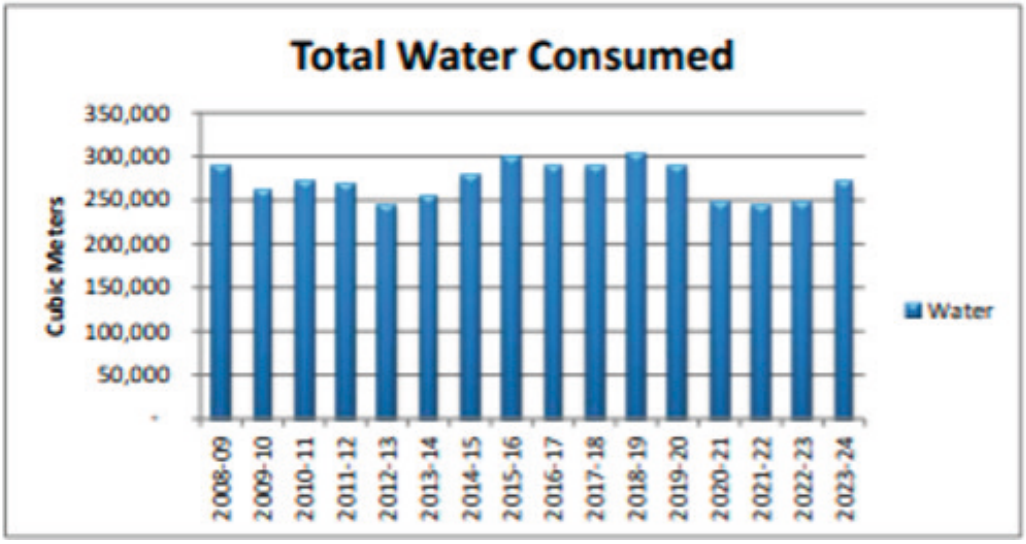
The latest data published for 2023–24 is illustrated below, detailing the consumption and emissions relating to building energy, waste and water. This is data that is sumbittmed and extracted via the ERIC annual reporting return completed by the Trust. The previous SDAT return has been replaced by the quarterly submission to the NHS greener data collection and is accessed thorugh the NHS Greener dashboard.

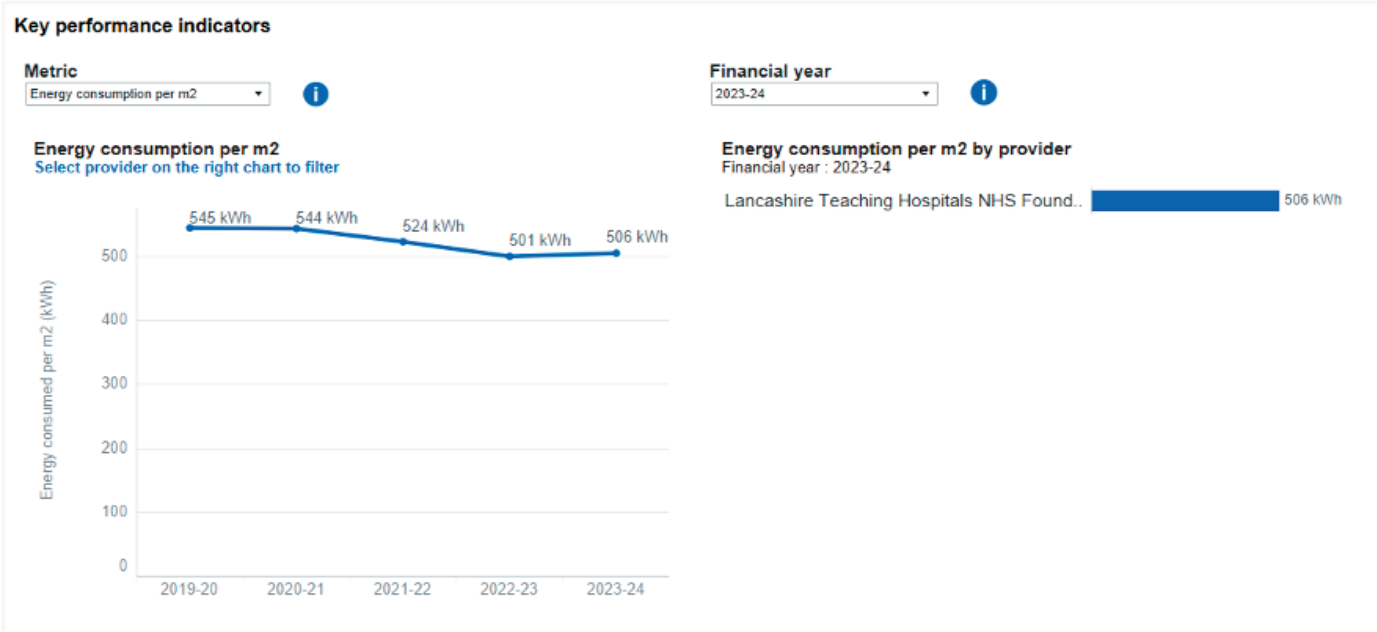
Reporting mechanisms are:

Annual carbon emissions (tCO2e)					
	2019-20	2020-21	2021-22	2022-23	2023-24
Gas	18,548	18,723	18,325	18,240	18,483
Electricity	1,965	1,769	2,563	1,820	1,985
Waste	895	1,085	1,139	1,112	1,079
Water and Sewerage	262	223	89	91	91
Data covers consumption and carbon equivalent emissions related to building energy, waste and water consumption. **Sources:** Estates Return Information (ERIC). All carbon equivalent emissions are in tonnes (tCO2e) rounded to the nearest whole number. When filtering by trust, some values for emissions may be present as 0 due to this rounding. Refreshed: **28 January 2025**					
Hot water and steam	0	0	0	0	0
Grand Total	21,739	21,873	22,172	21,327	21,684









- Quarterly submission to Greener NHS data collection is used to measure our progress on sustainability and to inform annual plans
- ERIC (Estates Return Information Collection) – this is a mandatory data collection for all NHS trusts, required by the Department of Health
- The Greener NHS Dashboard is used as the source of data to measure our performance and benchmark against our peers
- Trust sustainability report – there is a requirement for sustainability to be reported annually to the Board and publish this as part of our annual report. This report will include;

  ◊ narrative updates on progress to date and key achievements

  ◊ delivery of key milestones and risks to future delivery

  ◊ quantitative assessment of progress against defined targets
- Transport return
- Annual sustainability staff survey

Source : Lancashire Teaching Hospital ERIC submission 2023/24

Anaesthetic and medical gases are responsible for around 2% of all NHS emissions and 5% of emissions from acute care, according to the Delivering a net zero National Health Service (July 2022 report). The use of Desflaurane has a global warming potential 2500 times greater than carbon dioxide, this is no longer used at Lancashire Teaching Hospitals.

Progress on other domains within the current Green Plan are progressed with a financially prudent approach, utilising grant and other funding as appropriate.

Some of the key headlines regarding our Green Plan achievments include:

- Implementation of a prescription tracker to reduce double prescribing, reducing loss of medication therefore reducing waste
- Two new Pharmacy robots for Chorley and Preston installed allowing old robots to be recycled rather than sent to landfill
- 9 out of 12 months data has shown a reduction in printing compared to the previous year
- Agreements in place for Free and discounted use of public transport
- Funding bid successful for 20 walking leaders to be trained
- Successful funding bid enabled installation of LED lighting at the Chorley site
- Further funding bid approved for 2025 to continue with the upgrade of LED lighting at the Preston site
- Funding bid submitted for heat decarbonisation to reduce steam output
- 30 small trees and 40 hedge row whips planted at the Chorley site
- Engagement events held with Love to Cycle and Lancashire County Council to promote outdoor walking routes/space
- Single use plastics removed from front of house catering outlets
- The catering team achieved the Bronze status aware from the SOIL Association
- Cool sticks implementation within Pharmacy for Critical Care and Theatres to reduce the usage of Ethyl Chloride spray, resulting in both a cost saving and environmental saving
- Re-upholstering of public area furniture resulting in a saving of £5000

The Trust is currently developing the next iteration of the Green Plan in line with the refreshed statutory guidance, with the plan expected to be published by the end of July 2025. Progress continues to be reported on a quarterly basis via the Greener NHS Data Collection and the annual ERIC returns, with Board updates provided annually.

Social, community and human rights

The Apprenticeships and Widening Participation team is dedicated to fostering careers and generating employment opportunities within the local community. They collaborate with a range of organisations, including the Integrated Care Board, local colleges, Department of Work and Pensions, Princes Trust, Lancashire County Council, children in care, charities, and business networking groups. The table below provides a brief overview of the range of programmes we provide and the outcomes for 2024–25.

Programme	Description	Outcomes 2024–25
Pre-Employment Programme	8-week programme to support long-term unemployed people within our community back into employment.	20 participants 16 completed 15 employed with the Trust
Reboot	Targeted at 'job ready' candidates providing a 4-week programme to equip participants with knowledge, skills and enhanced understanding combined with direct observation in the workplace setting for their preferred role or career.	22 participants 16 completed 8 employed within the Trust
Ready, Steady, Apply	A three-day classroom-based programme to support candidates who struggle with the application process. The programme offers guidance and interview tips, guaranteeing candidates an interview upon successful completion.	4 participants 2 completed 1 employed within the Trust 1 employed in the voluntary sector
Preston Widening Access Programme	Disadvantaged students who aspire for a career in Medicine are provided with support to help them gain knowledge and experience to assist with their application for a place to study at Manchester University. This programme is in its tenth year.	25 participants 20 guaranteed interviews Outcomes to be confirmed in 2025
Work Familiarisation Programme	A six-week programme for students with learning difficulties and disabilities to gain an insight into the world of work. Following completion, participants can opt to take part in more formal work experience opportunities. To date, approximately 1000 learners have completed it.	41participants 41 completions
Work Experience Placements	Offers placement opportunities to individuals of all ages from across the region to gain first-hand insight into clinical (learners aged 16 and over) and non-clinical roles (learners aged 14–15) across the Trust.	Clinical (16 yrs +) 569 Applications 400 Placements offered 319 Placements attended Non-Clinical (14–15): 81 Applications 36 Placements Offered 31 Placements Attended
Supporting Careers	Virtual and face to face clinics helping school and college students to gain interview skills, application form writing skills and advice on career pathways at local high schools and colleges.	21 events held over several days
Careers Events	These events are held at various colleges, high schools and within our very own LIFE centre to promote healthcare professions.	1017 learners attended LTH careers events The team attended 40 events across the region

Being a Good Corporate Citizen

At Lancashire Teaching Hospitals NHS Foundation Trust, we are committed to being a responsible and proactive corporate citizen. This commitment is reflected in how we care for our patients, support our colleagues, reduce our environmental impact, and strengthen our local communities. The Trust is committed to working collaboratively with local partners to maximise the opportunities to support local businesses and to create opportunities for our local population through widening participation.

The Trust remains focused on transparency and sustainability, delivering value not only to the NHS but also to the communities that we serve.

The Modern Slavery Act 2015

The Trust has zero tolerance to slavery and human trafficking and is committed to ensuring that there is no modern slavery or human trafficking in our supply chains or in any part of our service. The Trust is fully aware of the responsibilities it bears towards patients, employees and the local community and, as such, we have a strict set of ethical values that we use as guidance with regard to our commercial activities. We therefore expect that all suppliers to the Trust adhere to the same ethical principles. The summary below sets out the steps the Trust takes to ensure that slavery and human trafficking is not taking place in our supply chains or in any part of our service:

- **Assessing risk related to human trafficking and forced labour associated with our supply base**: we do this by supply chain mapping and developing risk ratings on labour practices of our suppliers to understand which markets are most vulnerable to slavery risk.
- **Developing a Supplier Code of Conduct**: we will issue our Supplier Code of Conduct to our existing key suppliers as well as those that are in a market perceived to be of a higher risk (for example, catering, cleaning, clothing and construction). The Supplier Code of Conduct will also be included within our tendering process. We will request confirmation from all our existing and new suppliers that they are compliant with our Supplier Code of Conduct.
- **Monitoring supplier compliance with the Act**: we will request confirmation from our key suppliers that they are compliant with the Act.
- **Training and provision of advice and support for our staff**: we are further developing our advice and training about slavery and human trafficking for Trust staff through our Safeguarding Team to increase awareness of the issues and how staff should tackle them.
- **Monitoring contracts**: we continually review the employment or human rights contract clauses in supplier contracts.
- **Addressing non-compliance**: we will assess any instances of non-compliance with the Act on a case-by-case basis and will then tailor remedial action appropriately.

Counter-Fraud

We have a policy in respect of countering fraud and corruption which includes contact details of the national helpline and a local independent counter fraud officer. The Trust has an accredited anti-fraud specialist provided by Mersey Internal Audit Agency (MIAA) and they deliver the service in line with NHS Counter Fraud Authority's standards.

Health and safety performance

The Trust's policy is to safeguard the health and safety of all its employees, patients, visitors, and anyone who may be affected by Trust activities by ensuring the Trust is compliant with the Health and Safety at Work Act (1974). This is the primary legislation covering occupational health and safety in the United Kingdom (UK) and defines the fundamental structure and authority for the regulation and enforcement of workplace health, safety, and welfare in the UK.

The overall responsibility for leading and implementing health and safety arrangements rests with the Chief Executive and the Board of Directors. The Board fulfils its obligations through the designated Director responsible for health and safety, the Chief Nursing Officer. The Director of Estates and Facilities has management responsibility for physical health and safety and the Associate Director of Safety and Learning for delivering health and safety governance.

The Trust has an appointed Health and Safety Manager who is the designated Trust competent person with the necessary qualifications as defined in the requirements of the Management of Health and Safety at Work Regulations. They have the significant remit to review and manage health and safety governance operationally across the hospital sites. The Health and Safety Manager is supported by subject matter experts within the Trust and through responsible officers whose role it is to co-ordinate and lead health and safety within their own area or service. These roles are supported with a programme of training to further upskill the Trust in health and safety management.

Prohibition or enforcement notices

On the 4 February 2025 the Trust were notified of revised enforcement undertakings which were formally accepted by the Trust on 19 February 2025. For details of the enforcement undertakings and the Trust's progress made against them, please see the Annual Governance Statement.

Overseas operations

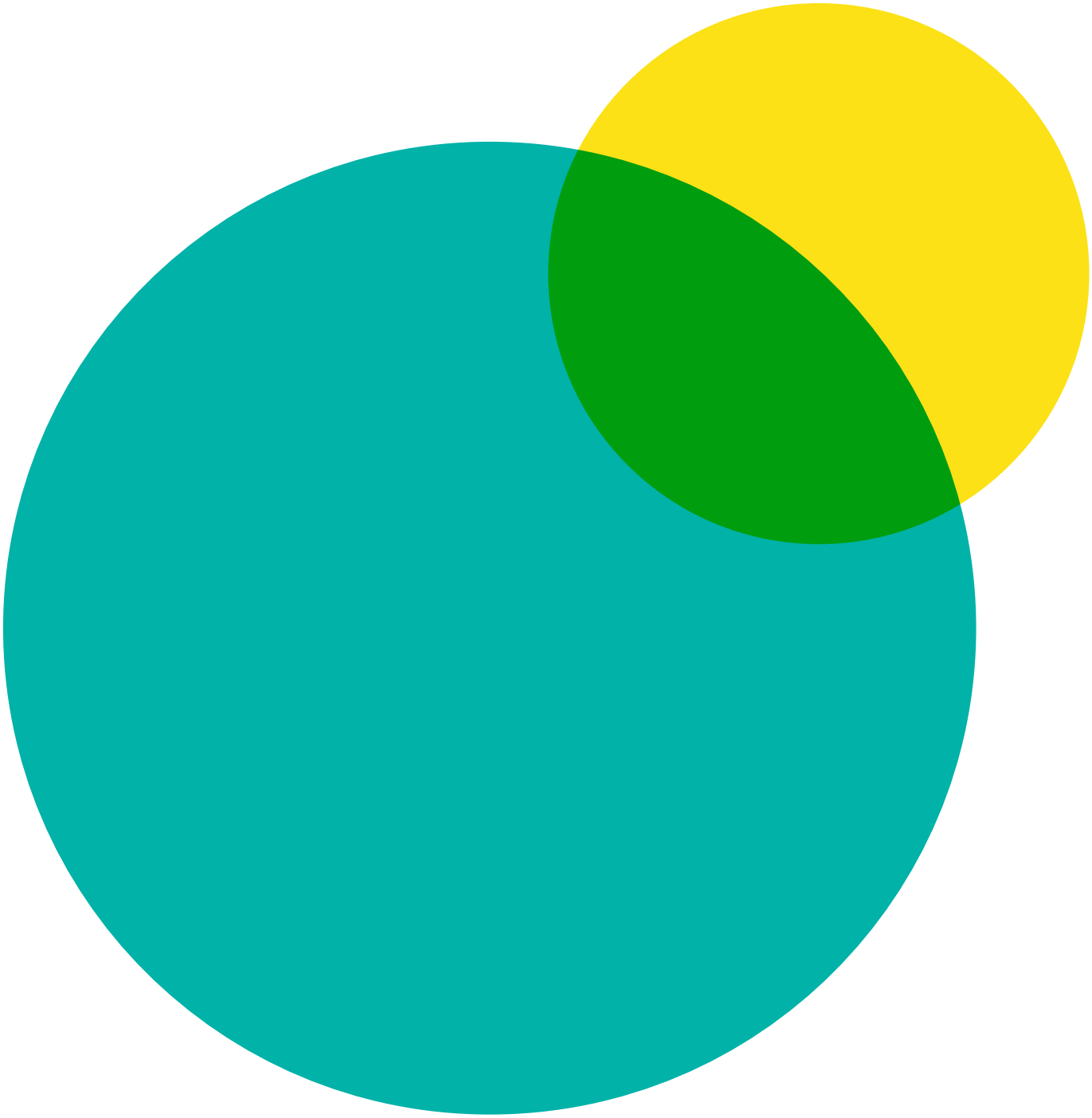
The Trust does not have any subsidiaries overseas.

This Performance Report is signed on behalf of the Board of Directors by:

Professor Silas Nicholls
Chief Executive
26 June 2025

Lancashire Teaching Hospitals NHS Foundation Trust

ACCOUNTABILITY REPORT 2024–25



DIRECTORS' REPORT

The Directors present their annual report on the activities of Lancashire Teaching Hospitals NHS Foundation Trust.

This Directors' report is prepared in accordance with:

- sections 415, 416 and 418 of the Companies Act 2006 (section 415(4) and (5) and sections 418(5) and (6) do not apply to NHS Foundation Trusts) as inserted by SI 2013 (1970)
- Regulation 10 and Schedule 7 to the Large and Medium-sized Companies and Groups (Accounts and Reports) Regulations 2008. All the requirements of schedule 7 applicable to the Trust are disclosed within the report
- additional disclosures required by the Treasury's Financial Reporting Manual
- additional disclosures required by NHSE in its Annual Reporting Manual

Our Board of Directors

Our Board of Directors is a unitary Board with a number of Directors having a medical, nursing or other health professional background. The Non-Executive Directors have wide-ranging expertise and experience, with backgrounds in finance, law, quality and service improvement, health and social care, risk, governance and regulation, and higher education. The Board is balanced and complete in its composition, and appropriate to the requirements of the organisation. The respective roles and responsibilities of Board and Council, the types of decisions made, and matters reserved or delegated are set out in the constitution and standing orders of the Board.

Please note that (I) indicates that the Non-Executive Director is considered independent.

Non-Executive Directors as at 31 March 2025

Professor Mike Thomas, (Chair) (I)

Appointment: 1 January 2025 to 31 December 2027

Professor Mike Thomas took up the role of Chair of the Trust Board at Lancashire Teaching Hospitals NHS Foundation Trust in January 2025. As well as this, he also continues to serve as the Chair of the Lancashire and South Cumbria Provider Collaborative Board.

Mike has worked in academia and the health sector for nearly 40-years in a variety of senior academic roles, including Vice-Chancellor, also holding various professional chairs across four universities. Prior to entering academia, he served in the Royal Navy, working for five years in HM Submarines before employment in the engineering sector and then qualifying as a mental health nurse and later a psychological therapist. He remains research active and a practising clinical psychotherapist. For many years he carried out clinical research to enhance mental health support for individuals who experience severe and enduring eating disorders whilst, simultaneously, over the last fifteen years he has been working with research colleagues across the UK investigating issues that impact on compassionate leadership in both the public and private sectors. He has written three books and numerous articles and chapters on these two subjects.

Dr Tim Ballard, Non-Executive Director (I)

Appointment: 1 October 2023 to 30 September 2026

Tim was born and brought up in Lancashire and after qualifying in medicine he went into general practice in 1988. He was a GP trainer for about 25 years and was an Examiner for 21 years for the membership examination of the Royal College of GPs (RCGP) and for a period led the Simulated Surgery module assessing the consultation skills of doctors. Tim was a nationally elected member of Council at the RCGP for 12 years and served as Vice Chair at the RCGP from 2013 to 2016.

Since 2016 Tim has been a National Clinical Advisor at the Care Quality Commission (CQC) giving clinical advice to the commission around the areas of general practice, independent primary care, online and digital health, as well as supporting CQC inspections. Tim is a keen advocate for environmental sustainability especially as it relates to healthcare.

Tim is the Board-level Ockenden Maternity Safety Champion.

Professor StJohn Crean (I)

Appointment: 4 March 2025 – 3 March 2028

Professor Crean also serves the University of Central Lancashire as Pro Vice-Chancellor (Research and Enterprise) and previously held the roles of Executive Dean of the Faculty of Clinical and Biomedical Sciences, Director of Dental Research and Knowledge Transfer, and Dean of the School of Postgraduate Medical and Dental Education.

Beyond the University, StJohn is an Honorary Consultant at Blackpool Victoria Hospitals Trust and the University of Morecambe Bay Hospitals Foundation Trust. He is currently the Robert Bradlaw advisor in the Faculty of Dental Surgery at the Royal College of Surgeons of England, and Editor-in-Chief of the Faculty Dental Journal (FDJ). In addition, he holds the posts of President of the Northwest Branch of the British Dental Association and Chairman of the Fylde Section.

His research interests include the safe management of medicalised patients in dentistry and the role of oral bacteria in systemic disease, with a focus on neurodegenerative conditions such as Alzheimer's disease.

StJohn is Chair of the Education, Training and Research Committee.

Dr Karen Deeny, Non-Executive Director (I)

Appointment: 1 March 2025 – 28 February 2026

Karen started her career as a speech and language therapist and has over 40 years' experience across health, social care and education organisations and systems locally, regionally and nationally. Her work as a clinician, senior leader, researcher and author has been driven by an enduring passion for working with and learning from patients and staff to improve people's experiences and outcomes of care. Karen has completed the NHS Top Leaders programme, holds a PhD in healthcare improvement and is an Institute of Leadership and Management qualified executive coach and mentor. She now works independently supporting a range of statutory, voluntary and charitable organisations with their assurance and improvement programmes.

Karen is Chair of the Safety and Quality Committee.

Adrian Leather, Non-Executive Director (I)

Appointment: 1 March 2025 – 28 February 2026

Adrian is the CEO of Active Lancashire and has worked in Lancashire for over 20 years, focusing his energy on making Lancashire a healthier and more equitable place. Adrian's background is in community development and criminal justice. However, his passion is in collaborating with other organisations to help them be more successful and innovative.

Adrian is Chair of the Workforce Committee and Vice Chair of the Board of Directors.

Uzair Patel, Non-Executive Director (I)

Appointment: 2 July 2024 – 1 July 2027

Uzair moved from a position of Associate Non-Executive Director to Non-Executive Director following the end of term of office of Jim Whitaker in July 2024.

Uzair is a Chartered Accountant and senior finance professional with deep and wide-ranging experience across global banking in a range of technical and commercially focused roles. He is a board member of Torus Foundation supporting communities in Liverpool and the surrounding areas. He was previously a board member at the national domestic-violence and abuse charity, Safe Lives, as well as Chair of Audit and Risk at King's College London Students' Union. He was co-creator of the award-winning #ThisIsMe mental-health campaign at Barclays and across the City of London in partnership with the Lord Mayor of London. He read Biomedical Sciences at King's College London with a focus on neuroscience and pharmacology.

John Schorah, Non-Executive Director (I)

Appointment: 1 March 2025 – 28 February 2026

John is an accomplished legal professional with extensive experience in strategic transformation, mergers and acquisitions, and corporate governance. John became Weightmans' Managing Partner in 2013 and was re-elected for the second time in 2018 until 2023. During his time on Weightmans' board, John has overseen the firm's acquisitions, opening of new offices, overhauled the partnership remuneration structure and seen the firm's overall revenues rise from £43.8m in 2007 to £100m.

John is the Chair of the Finance and Performance Committee.

Tim Watkinson, Non-Executive Director (I)

Appointment: 1 April 2016 to 31 March 2025

Tim is a qualified accountant with over 25 years' experience in senior audit positions in the public sector. He was previously the Group Chief Internal Auditor for the Ministry of Justice and prior to that was a District Auditor with the Audit Commission, including terms of office in Lancashire County Council, Preston City Council and Chorley Borough Council. Tim has led national teams and taken a lead role for the Audit Commission in the development of methodology for improving the performance of local authorities. Tim has experience of working in major accountancy firms providing audit and consultancy services to the public sector including the NHS. He has also been employed as an accountant and a Chief Internal Auditor within the NHS.

Tim was appointed as the Senior Independent Director (SID) on 20 September 2022. He continued as the Chair of the Trust's Audit Committee up to 31 March 2025. He is also the Non-Executive Board lead for Freedom to Speak Up and a member of the Rosemere Management Committee. Outside the Trust, Tim is an independent member of the UK Statistics Authority's Audit and Risk Assurance Committee.

Professor Tim Wheeler, Non-Executive Director (I)

Appointment: 1 April 2025 – 31 March 2026

Tim is a highly accomplished professional with extensive experience in leadership roles across various sectors, including public, charitable, and commercial environments. Tim had a proven track record of managing large organisations, ensuring financial solvency, and delivering strategic plans. Tim was appointed the Vice-Chancellor of the University of Chester in 2005, from which he retired in 2020. He was educated at the University College of North Wales, Bangor. During his career, he has held posts at universities in England, Ireland and Scotland, and a period as a Senior Visiting Research Scholar at St John's College, Oxford.

Much of his work has involved academic and industrial consultancies, in addition to experience in Europe, America, China and Australia. He has published over 120 articles, books and research reports in a diverse range of areas including dyslexia, psychopharmacology, communications and safety. He has been a school governor and FE corporation governor for over 30 years. He is a Deputy Lieutenant for Cheshire and is actively involved with Chester Cathedral as a Lay Canon. He is a freeman of the Cities of London and Chester.

Tim succeeded Tim Watkinson as Chair of the Audit Committee from 1 April 2025.

Executive Directors

Professor Silas Nicholls, Chief Executive

Permanent post – appointment from 8 January 2024

Silas is an experienced Chief Executive and NHS leader who began his NHS career as a graduate management trainee. He has since held a wide range of general management posts, including commissioning roles in health authorities, management of community services and extensive hospital management experience.

Silas has held a number of Chief Executive posts since 2016 and joined Lancashire Teaching Hospitals in January 2024.

In addition to his Chief Executive role, Silas is the Chair of the North West Leadership Academy.

In January 2024 he was awarded the title of Professor of Leadership and Healthcare Management – Institute of Medicine, University of Bolton.

Sarah Morrison (formerly Cullen), Chief Nursing Officer

Permanent post – appointment from 1 August 2019

Sarah is a Registered Nurse with experience in a variety of nursing and operational roles in a broad range of specialties. Sarah spent 18 years of her career at University Hospitals of Morecambe Bay and joined Lancashire Teaching Hospitals in 2017 as the Deputy Nursing, Midwifery and AHP Director becoming the Executive Nursing, Midwifery and AHP Director in 2019. Sarah is the Executive lead with responsibility for the hospital charity, clinical governance, maternity, children and safeguarding. She is also a trustee of the post graduate education charity. Sarah is also Deputy Chief Executive Officer.

Katie Foster-Greenwood, Chief Operating Officer

Permanent post – appointment from 12 August 2024

Katie joined Lancashire Teaching Hospitals in August 2024 having previously been Chief Operating Officer at Salford Care Organisation which is part of the Northern Care Alliance NHS Foundation Trust (since June 2019). Katie was also the Greater Manchester Chief Operating Officer Lead for Urgent & Emergency Care supporting the development of an Integrated Care Board co-ordination hub.

Katie started in the NHS in 1996 as an ED registered nurse and then moved into operations management working within the Greater Manchester system in both provider, commissioning, and private healthcare organisations.

Katie has led large scale adult community service re-design and transformation and has a breadth of experience working alongside and managing adult social care services.

Gerry Skailes, Chief Medical Officer

Permanent post – appointment from 1 March 2018

Gerry graduated from Guys Hospital in London and spent the early years of her medical training in London and the South Coast before moving to the Christie Hospital to undertake specialist training in Clinical Oncology. She was appointed as a Consultant at Royal Preston Hospital in 1997 with an interest in treating lung and gynaecological cancers. She has held a number of leadership roles within the Trust and North West region including Clinical Lead for the Lancashire and South Cumbria Cancer Alliance and Deputy Medical Director of the Trust. Gerry continues to work as a Consultant in Oncology undertaking a weekly acute oncology ward round and is actively involved in a number of the ICP and ICS Committees. Gerry was appointed as the Trust's full-time Medical Director from March 2018 and is also our Caldicott Guardian.

David Stonehouse, Interim Chief Finance Officer

Interim Post – 2 September 2024 – 30 April 2025

David has over 20 years' experience as a Finance Director, most recently in the role of Interim Finance Director at Manchester University NHS Foundation Trust. He has also worked at a variety of other NHS Trusts, including Dartford and Gravesham NHS Trust, The Hillingdon Hospitals Foundation Trust, Barnet, Enfield and Haringey Mental Health NHS Trust and The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust.

Craig Carter, Interim Chief Finance Officer

Interim post 1 May 2025 -

Craig joined the NHS as a national finance management trainee in 2003 and has over 20 years of experience working in senior roles across various operational and corporate finance functions in several large acute Trusts including Manchester Foundation Trust, Royal Liverpool University Hospital, Aintree University Hospital and Northern Care Alliance, and in commissioning across Chorley and Preston. He has recently been involved in some major locality integration work regarding financial flows and development of locality plans for elective recovery.

Executive Directors (non-voting)

Ailsa Brotherton, Director of Continuous Improvement and Transformation

Permanent post – appointment from 1 December 2017

Ailsa joined the Trust in 2017 from Manchester Foundation Trust where she was the Director of Transformation for the Single Hospital Programme. Prior to this Ailsa was the Clinical Quality Director for the North of England with the Trust Development Authority/NHSI. She has also held a post-doctoral senior research fellow post, has a master's in Leadership (Quality Improvement) from Ashridge Business School and is a Health Foundation Generation Q Fellow. Ailsa has extensive experience of designing and delivering quality improvement and large-scale change programmes. Ailsa holds an honorary professorship in the School of Health and Wellbeing at the University of Central Lancashire and is working with our academic partners to ensure all our improvement programmes are evidence based and evaluated Ailsa is member of the national Improvement Directors' network, as well as a registered dietitian.

Naomi Duggan, Director of Communications and Engagement

Permanent post – appointment from 1 April 2020

Naomi joined the Trust in April 2020 having previously undertaken a similar role at University Hospitals of North Midlands from October 2015 where she was a member of the Board and Executive team. Prior to this, Naomi has held senior communications and engagement roles at Tameside and Glossop Primary Care Trust, Oldham Metropolitan Borough Council and within private sector retail.

Naomi has run her own consultancy business and after her first degree she started her career as a Management trainee on the Blue Chip British Coal Corporation graduate scheme. Naomi has worked on a number of transformational projects for the NHS including Better Care Together in Morecambe Bay and Healthier Together in Greater Manchester, as well as controversial retail schemes which needed positive engagement to win the hearts and minds of a range of key stakeholders in order to secure planning permission and political and community support.

A graduate of Leeds University, Naomi has an MBA from Leeds University Business School, a Postgraduate certificate in Marketing from Sheffield Business School and the Chartered Institute of Marketing Diploma. She is also a member of the Chartered Institute of Public Relations.

Jennifer Foote MBE, Director of Corporate Affairs

Permanent post – appointment from 1 July 2022

As Director of Corporate Affairs Jennifer also acts as Company Secretary to the Board of Directors and Council. Jennifer also acts as SIRO for the Trust.

Jennifer joined the Trust in July 2022 and has extensive experience of corporate governance across the public sector, including working as part of the Further Education Commissioner's Team in the Department of Education as a National Leader of Governance.

Jennifer was awarded the MBE in 2017 for services to governance.

Neil Pease, Chief People Officer

Permanent post – appointment from 1 December 2023

Neil brings over 25 years of NHS experience, transitioning to Lancashire Teaching Hospitals after serving nearly four years at Nottingham University Hospitals NHS Trust as Executive People Director and Chief People Officer. Before that, he held executive roles at University Hospitals of Derby and Burton NHS Foundation Trust and Northern Lincolnshire and Goole Hospitals NHS Foundation Trust.

With a degree in Sports Medicine from Glasgow University, Neil shifted his focus to education and organisational development, pioneering clinical simulation in palliative care education. His journey includes roles at NHS Hull and a stint as Director of Strategic Development at Hull Kingston Rovers Rugby League Club. He holds a Professional Doctorate from Sheffield Hallam University in organisational development and anthropology.

Board members whose term of office ended during 2024–25

The following Board members stepped down during 2024–25:

Non-Executive Directors

Peter White (Chair)	1 August 2023 to 31 July 2026 (resigned 31 December 2024)
Victoria Crorken	24 January 2022 to 23 January 2026 (resigned 7 February 2025)
Paul O'Neill	4 March 2019 to 3 March 2025
Kate Smyth	4 February 2019 to 4 June 2025 (resigned 28 February 2025)
Jim Whitaker	3 July 2017 to 1 July 2024
Tricia Whiteside	9 September 2019 to 8 September 2025 (resigned 28 February 2025)

Associate Non-Executive Directors

Michael Wearden, Associate Non-Executive Director	10 June 2022 to 9 June 2024
Peter Wilson, Associate Non-Executive Director	16 June 2022 to 15 June 2024

Executive Directors

Imran Devji, Interim Chief Operating Officer	1 October 2023 to 9 June 2024
Stephen Dobson, Chief Information Officer	1 April 2020 to 1 July 2024
Gary Doherty, Director of Strategy	30 January 2022 to 5 January 2025
Emma Ince, Interim Chief Operating Officer	10 June 2024 to 11 August 2024
Jonathan Wood, Chief Finance Officer	1 August 2019 to 1 September 2025

Appointment and removal of Non-Executive Directors

Appointment and, if appropriate, removal of Non-Executive Directors is the responsibility of the Council of Governors. When appointments are required to be made, usually for a three-year term, the Trust Nominations Committee oversees the process and makes recommendations to the Council as to appointments. The procedure for removal of the Chair and other Non-Executive Directors is laid out in our Constitution which is available on our website or on request from the Company Secretary.

In March 2025 Council was required to make a number of new appointments to non-executive director positions. Following the appointment of Mike Thomas as Chair, Council agreed to derogate from the standing process for the recruitment and appointment of non-executive directors to allow for four new appointments to be made for a period of one year as part of the Trust approach to transformation and change.

Division of responsibilities

There is a clear division of responsibilities between the Chair and the Chief Executive. The Chair ensures the Board has a strategy which delivers a service that meets the expectations of the communities we serve, and that the organisation has an Executive team with the ability to deliver the strategy. The Chair facilitates the contribution of the Non-Executive Directors and their constructive relationships with the Executive Directors. The Chief Executive is responsible for leadership of the Executive team, for implementing our strategy and delivering our overall objectives, and for ensuring that we have appropriate risk management systems in place.

Review of Effectiveness

All Non-Executive Directors completed satisfactory individual appraisals of their performance for 2024–25 in March and April 2025. This was reported through to Council in April 2025. Executive Directors undertook parallel reviews, reported through to the Appointments, Remuneration and Terms of Employment (ARTE) Committee.

Declaration of interests

All Directors have a responsibility to declare relevant interests, as defined within our Constitution. These declarations are made to the Company Secretary, reported formally to the Board, and entered into a register which is available to the public. The register is also published on our website and a copy is available on request from the Company Secretary.

Independence of Directors

The role of Non-Executive Directors is to bring strong, independent oversight to the Board and all Non-Executive Directors are currently considered to be independent. The Board is made up of a majority of independent Non-Executive Directors who have the skills to challenge management objectively. There is also a strong belief in the importance of ensuring continuity of corporate knowledge, whilst developing and supporting new skills and experience brought to the Board by new Non-Executive Directors.

Decisions on reappointments of Non-Executive Directors are made by the Council of Governors. A reappointment of a Non-Executive Director is not ordinarily undertaken beyond six years unless there is an explicit requirement of the Trust that can only be addressed by the individual remaining in post. The maximum term of office is nine years in aggregate, in line with the Trust's Constitution.

Board Assurance Committees

In order to ensure that committees are able to remain quorate and discharge their responsibilities in a timely manner, the Standing Orders of the Board allow for alternate members to attend. The attendance listed below are for the permanent members of each committee.

Audit Committee

The role of the Audit Committee is to provide independent assurance to the board on the effectiveness of the governance processes, risk management systems and internal controls on which the board places reliance for achieving its corporate objectives and in meeting its fiduciary responsibilities. It is authorised by the board to investigate any activity within its terms of reference and to seek any information it requires from staff. For 2024–25 internal audit services were undertaken by MIAA. External audit services for the year were provided by KPMG. Further details are included in the Annual Governance Statement.

Four meetings of the committee were held in 2024/25.

Audit Committee Attendance

Audit Committee attendance summary from 1 April 2024 to 28 February 2025 (no meetings of the committee were held in March 2025)

Name of Committee member	A	B	Percentage of meetings attended (%)
Tim Watkinson (Committee Chair)	4	4	100
Victoria Crorken	4	4	100
Uzair Patel	2	2	100
Kate Smyth	4	3	75
Tricia Whiteside	4	3	75

A = Maximum number of meetings the member could have attended | B = Meetings attended.

Safety and Quality Committee

The role of the Safety and Quality Committee is to promote and lead a safety and quality strategy that continues to improve and maintain an 'Always Safety First' culture in which staff are supported and empowered to improve services and care. The Committee monitors the performance delivery of the Trust-wide safety and quality metrics and provides the Board of Directors with assurance on the effectiveness of the safety and quality performance management framework, and patient experience and outcomes of care.

Safety and Quality Committee Attendance

Name of Committee member	A	B	Percentage of meetings attended (%)
Ms K Smyth - Chair Non-Executive Director	11	10	91
Dr K Deeny – Chair (wef 1 March 2025) Non-Executive Director	1	1	100
Dr T Ballard Non-Executive Director	12	12	100
Ms K Foster-Greenwood Chief Operating Officer	7	4	57
Ms S Morrison Chief Nursing, Midwifery and AHP Officer	12	10	83
Professor P O'Neill Non-Executive Director	11	7	64
Mr J Schorah Non-Executive Director	1	1	100
Dr G Skailes Chief Medical Officer	12	10	83

A = Maximum number of meetings the member could have attended | B = Meetings attended.

Finance and Performance Committee

The role of the Finance and Performance Committee is to obtain assurance on behalf of the Board in respect of operational performance, financial performance and planning processes, in particular that the Trust's financial and operational plans are viable and that relevant risks have been identified and mitigated.

Finance and Performance Committee Attendance

Name of Committee member	A	B	Percentage of meetings attended (%)
Mrs T Whiteside (Chair) Non-Executive Director	11	9	82
Mr I Devji Interim Chief Operating Officer	2	2	100
Ms K Foster-Greenwood Chief Operating Officer	8	5	62
Mr Adrian Leather Non-Executive Director	1	1	100
Mr U Patel Non-Executive Director	9	5	56
Mr John Schorah (Chair wef 1 March 2025) Non-Executive Director	1	1	100
Mr D Stonehouse Interim Chief Finance Officer	7	7	100
Mr T Watkinson Non-Executive Director	12	11	92
Mr J Whitaker Non-Executive Director	3	1	33
Mr J Wood Chief Finance Officer/ Deputy Chief Executive Officer	5	5	100

A = Maximum number of meetings the member could have attended | B = Meetings attended.

Workforce Committee

The role of the Workforce Committee is to oversee the development and implementation of the workforce and organisational development strategy for the organisation, and provide assurance to the Board on the development, implementation and review of the Trust's workforce and organisational development strategy and workforce plan in order to support service improvement and to meet the needs of patients, staff, regulators and commissioners.

Workforce Committee Attendance

Name of Committee member	A	B	Percentage of meetings attended (%)
Mr J Whitaker (Chair) Non-Executive Director	1	1	100
Prof. StJohn Crean Non-Executive Director	1	1	100
Mrs V Crorken (Chair wef June 2024) Non-Executive Director	5	3	60
Mr Adrian Leather (Chair wef March 2025) Non-Executive Director	1	1	100
Ms S Morrison Chief Nursing Officer	6	4	66
Mr U Patel Non-Executive Director	4	4	100
Dr N Pease Chief People Officer	1	1	100

Name of Committee member	A	B	Percentage of meetings attended (%)
Ms K Smyth Non-Executive Director	5	5	100
Mr D Stonehouse Interim Chief Finance Officer	3	2	66
Mr J Wood Deputy Chief Executive & Chief Finance Officer	1	1	100

A = Maximum number of meetings the member could have attended | B = Meetings attended.

Education, Training and Research Committee

The role of the Education, Training and Research Committee is to provide strategic direction and board assurance in relation to education, training, research and innovation activity. To give consideration to the strategic direction and funding plans for the Trust in relation to research, education and training and to consider proposals on all research and development activity in the Trust in addition to receiving quality assurance reports from external as they relate to education, training and research.

Education Training and Research Committee Attendance

The Committee did not meet during March 2025.

Name of Committee member	A	B	Percentage of meetings attended (%)
Professor P O'Neill (Chair) Interim Chair	5	5	100
Dr T Ballard Non-Executive Director	4	2	50
Mrs V Crorken Non-Executive Director	1	1	100
Ms S Morrison Chief Nursing Officer	5	4	80
Ms K Smyth Non-Executive Director	5	5	100

A = Maximum number of meetings the member could have attended | B = Meetings attended.

Nominations Committee and ARTE Committee attendance statistics may be found on pages 63 and 64.

Board meeting attendance summary 2024–25

PRESENT	04/04/2024	06/06/2024	01/08/2024	03/10/2024	05/12/2024	06/02/2025	A	B	Percentage of meetings attended
VOTING NON-EXECUTIVE DIRECTORS									
Mike Thomas						P	1	1	100%
Peter White	P	P	P	P	P		5	5	100%
Tim Ballard	P	P	P	P	P	P	6	6	100%
Victoria Crorken	P	P	P	P	P		5	5	100%
Paul O'Neill	P	A	P	P	A	P	6	4	67%
Uzair Patel	P	P	P	A	A	P	6	4	67%
Kate Smyth	P	P	P	A	P	P	6	5	83%
Tim Watkinson	P	P	P	P	P	P	6	6	100%
Jim Whitaker	P	P					2	2	100%
Tricia Whiteside	P	P	P	Ab	P	P	6	5	83%
VOTING EXECUTIVE DIRECTORS									
Katie Foster-Greenwood				P	P	P	3	3	100%
Sarah Morrison	P	Ab	P	P	P	P	6	5	83%
Silas Nicholls	P	P	P	P	P	P	6	6	100%
Gerry Skailes	P	P	P	P	P	Ab	6	5	83%
David Stonehouse				P	P	P	3	3	100%
Jonathan Wood	P	P	P				3	3	100%
NON-VOTING ASSOCIATE NON-EXECUTIVE DIRECTORS									
Michael Wearden	P	Ab					2	1	50%
Peter Wilson	Ab	Ab					2	0	0%
NON-VOTING EXECUTIVE DIRECTORS									
Ailsa Brotherton	P	Ab	P	P	Ab	P	6	4	67%
Imran Devji	P	P					2	2	100%
Gary Doherty	P	P	Ab	P	P		5	4	80%
Naomi Duggan	P	P	P	P	P	P	6	6	100%
Neil Pease	P	Ab	P	P	P	P	6	5	83%

P = Present | Ab = Absent | A = Maximum number of meetings the Director could have attended | B = Meetings attended.

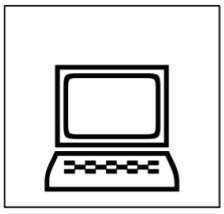
Political donations

The Trust has neither made nor received any political donations during 2024–25.

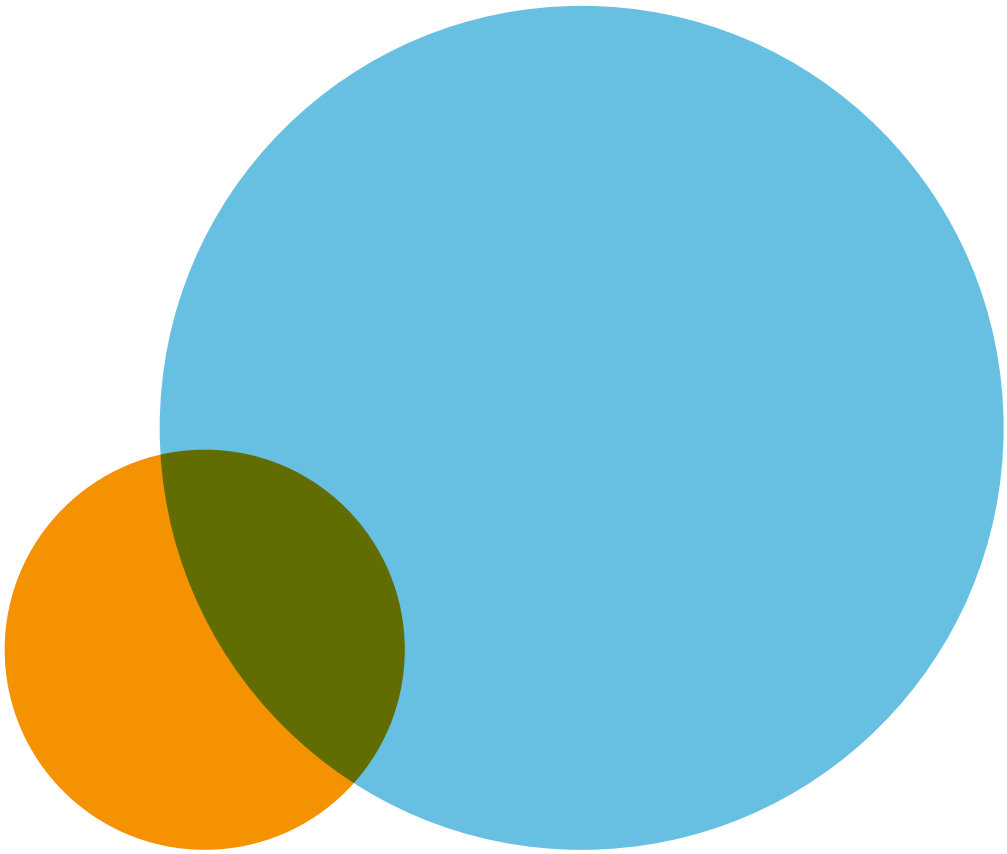
Directors' declaration

All directors have confirmed that, so far as they are aware, there is no relevant audit information of which the auditor is not aware and that they have taken all steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the NHS Foundation Trust's auditor is aware of that information. All directors understand that it is their responsibility to prepare the annual report and accounts, and that they consider the annual report and accounts, taken as a whole, to be fair, balanced and understandable, and to provide the information necessary for patients, regulators and other stakeholders to assess the performance of Lancashire Teaching Hospitals NHS Foundation Trust, including our business model and strategy.

If you would like to make contact with a director, please contact the Company Secretary by email: company.secretary@lthtr.nhs.uk



Also available on our website:
Register of directors' interests
Director biographies
Statement on the division of responsibilities between Chair and Chief Executive



COUNCIL OF GOVERNORS' REPORT

The Council of Governors comprises elected and appointed governors who represent the interests of the members and the wider public. It also has an important role in holding Non-Executive Directors of the Board to account.

The Council of Governors has an essential function in influencing how the Trust develops its services to meet the needs of patients, members, and the wider community in the best way possible. The Council needs to be assured the Trust Board has considered the consequences of decisions on other partners within their system, and the impact on the public at large.

At the end of 2024–25, the Council comprised 28 governor seats, of which: 18 are elected governors who represent the public constituency; five are elected governors who represent the staff constituencies; one is appointed by our University partnership organisations (University of Central Lancashire, Lancaster University and University of Manchester); and four are appointed by local authorities (being Lancashire County Council, Preston City Council, Chorley Council and South Ribble Borough Council).

Elections

The governor election process takes place between January and March each year, and governors generally serve a three-year term of office, beginning in April. At the end of March 2025, there were eight vacancies in the public constituency and two vacancies in the staff categories of nurses and midwives and unregistered healthcare and support workers (due to a combination on in year resignations and end of term of office). On 21 March 2025 it was announced that eight public governors and a staff governor for nurses and midwives had been elected to their respective constituencies. No candidate had come forward for the unregistered healthcare and support worker vacancy meaning 27 of the 28 governor seats were filled.

Ahead of this year's election process, various governor recruitment activities were undertaken to promote the role of the governor, including, issuing dedicated pre-election mailing to all members; advertising governor vacancies within the 'Trust Matters' magazine and advertising on media screens at both hospital sites; two pre-election workshops were held with Directors of Corporate Affairs to encourage members to stand for election; and social media was used to highlight the election opportunities.

Council of Governors' Subgroups

Two governor subgroups are in place to consider specific issues in more detail than is possible at formal Council meetings. The subgroups focus on care and safety, and membership/public engagement. Both the subgroups have clear terms of reference and report their activities to formal Council of Governors' meetings. Each subgroup may also have a Non-Executive Director in attendance. In addition, the Council nominates governors as members of the Trust Nominations Committee.

Understanding the views of Governors and Members

Directors develop an understanding of the views of governors and members about the organisation through attendance at the Annual Members' Meeting, Council of Governors' meetings and workshops, linkages with the Council subgroups and an annual interactive forward planning session with the Board each year.

During the year we continued to focus on maintaining an effective relationship between the Board and governors through a number of ways, including the following:

- Governor attendance at public Board meetings (in the capacity of observer) is encouraged and governor attendance is recorded within the Board minutes. For 2024/25 meetings of Council reverted to fully in person and were held both at Royal Preston Hospital and Chorley and South Ribble District Hospital.
- There is Non-Executive Director representation at each of the governor subgroups.

- It is an expectation that the non-executive directors who chair the Board assurance committees attend Council of Governors' meetings in order to be held directly to account for the Board oversight of the performance of the Trust.
- As part of the Trust's forward planning process, the Board and the Council of Governors had opportunities to work together to understand the strategic priorities of the Trust and the challenges that needed to be addressed.
- Information flows through a variety of events, including system-wide initiatives, consultation on Trust strategic plans, and a range of working groups on patient-specific topics such as car parking and patient letters.
- Opportunities for visits to clinical areas and departments across the Trust which this year have included the Immersive Suite, the Discharge Lounge and the Acute Medical Unit.

Board and Council engagement

The Trust Chair leads both the Board of Directors and the Council of Governors and, as such, is an important link between the two bodies. There are a range of other ways in which the two bodies work together, including joint Board and Council development sessions and written communications. In the event of any misunderstanding or disagreement, the Standing Orders for the Board set out a clear and unambiguous process for the resolution of disputes between Board and Council.

To help governors fulfil their important role of holding the Board to account, governors receive updates on progress against the Trust's Strategy and Single Improvement Plan at their quarterly Council of Governors' meetings. Regular briefings are provided to governors on topical issues. In line with good practice, there is a policy on engagement between the Board and Council. The Chair also meets individually with the lead governor on a regular basis. The lead governor role (with a remit as set out in the Code of Governance) during 2024–25 was held by public governor Janet Miller.

The importance of joint working between the Board and the Council is acknowledged by the members of both bodies, who are committed to building on the progress that they have made in this area. The benefits of sharing good practice across NHS organisations is recognised and governors benefit from networks with colleagues in other Foundation Trusts in the Northwest as well as involvement in events arranged by organisations such as NHS Providers and MIAA.

Following a review of Council commissioned in 2023, a joint task and finish group was established to translate the recommendations into actions which were implemented during 2024–25.

Declaration of interests

All governors have a responsibility to declare relevant interests as defined in our Constitution. These declarations are made to the Company Secretary and are subsequently reported to the Council and entered into a register. The register is published on our website or is available on request from the Company Secretary.

Attendance summary

There were four formal Council meetings during 2024–25, which were quarterly meetings scheduled for April, July and November 2024 and January 2025. In addition, two special meetings of Council were convened in February 2025 for the appointment of new non-executive directors.

The table below shows governors' attendance at Council meetings in 2024–25:

Name of governor	Term of office	No. of terms	Type of governor	A	B	Percentage of meetings attended (%)
Will Adams**	21.05.24-13.02.2025	2nd annual term	Appointed: South Ribble Borough Council	4	1	25
Pav Akhtar	1.04.2023 -31.03.2026	3rd term	Public	4	2	50
Takhsin Akhtar	01.04.2025–31.03.2028	3rd term	Public	4	2	50
Liz Bamber**	01.04.2024 – 22.09.2024	1st term	Public	3	2	67
David Blanchflower**	01.04.2023-31.03.2025	1st term	Public	4	3	75
Alistair Bradley	01.04.2024–31.05.2025	9th annual term	Appointed: Chorley Borough Council	4	3	75
Sheila Brennan	01.04.2025–31.03.2028	2nd term	Public	4	3	75
Carole Cochrane**	01.04.2024-16.01.2024	1st term	Public	3	2	67
Philip Curwen*	01.04.2024 – 31.03.2027	1st term	Public	4	1*	25
Steven Doran**	01.04.2023–15.10.2024	1st term	Staff: Nurses and midwives	2	1	50
Dr Margaret France	01.04.2017–31.03.2026	3rd term	Public	4	2	50
Graham Fullarton	01.04.2023–31.03.2026	1st term	Public	4	4	100
Nigel Garratt**	23.04.2024-01.04.2025	1st term	Appointed: UCLan	3	2	67
Christopher Heap**	01.04.2024 – 09.10.2024	1st term	Staff: unregistered healthcare and support workers	3	1	33
Steve Heywood	01.04.2022-31.03.2025	3rd term	Public	4	4	100
Lucienne Jackson^	13.02.2025–12.02.2026	1st annual term	Appointed: South Ribble Borough Council	n/a	n/a	n/a
Angela Kos	01.04.2024–31.03.2027	1st term	Public	4	4	100
Janet Miller	01.04.2017–31.03.2026	3rd term	Public	4	4	100
Eddie Pope	01.04.2024-31.03.2025	6th annual term	Appointed: Lancashire County Council	4	2	50

Name of governor	Term of office	No. of terms	Type of governor	A	B	Percentage of meetings attended (%)
Christine Pownall	01.04.2024–31.03.2027	1st term	Public	4	4	100
Lesley Purcell	01.04.2024–31.03.2027	1st term	Staff: non-clinical support	3	3	100
Tom Ramsay	01.04.2024–31.03.2027	1st term	Staff: other health professionals and healthcare scientists	4	3	75
Frank Robinson	01.04.2023–31.03.2026	3rd term	Public	4	4	100
Graham Robinson	01.04.2024–31.03.2027	1st term	Public	4	4	100
Suleman Sarwar	1.04.2024–31.03.2025	3rd annual term	Appointed: Preston City Council	4	2	50
Mike Simpson**	01.04.2022–31.03.2025	2nd term	Public	4	3	75
Teik Chooi Oh	01.04.2024–31.03.2027	1st term	Staff: doctors and dentists	4	2	50
Louise Tudor**	01.04.2024-02.12.2024	1st term	Public	3	2	67
Feixia Yu	01.04.2023–31.03.2026	1st term	Public	4	1	25

A = Maximum number of meetings the governor could have attended | B = Meetings attended
** Dispensation from Chair for approved leave of absence.*
*** Term of office ended due to resignation in 2024–25*
^ Appointed in February 2025 therefore no meetings attended

Director attendance at Council of Governors' meetings

The following Directors attended Council meetings during 2024–25:

Non-Executive Directors:

- Peter White, Chair
- Michael Thomas, Chair
- Tim Ballard, Non-Executive Director
- Victoria Crorken, Non-Executive Director
- Paul O'Neill, Non-Executive Director
- Kate Smyth, Non-Executive Director
- Tim Watkinson, Non-Executive Director
- Michael Wearden, Associate Non-Executive Director
- Tricia Whiteside, Non-Executive Director

Executive Directors:

- Ailsa Brotherton, Director of Innovation, Research and Improvement
- Imran Devji, Interim Chief Operating Officer
- Gary Doherty, Director of Strategy and Planning
- Jennifer Foote, Director of Corporate Affairs
- Sarah Morrison, Chief Nursing Officer

- Silas Nicholls, Chief Executive
- Neil Pease, Chief People Officer
- Jonathan Wood, Chief Finance Officer/Deputy Chief Executive

Governor training and development

The importance of providing effective training and development opportunities for our governors is understood and is achieved in a number of ways.

On appointment, governors receive formal induction training to enable them to understand the context in which they are carrying out their role, including information on their statutory duties, as well as practical information such as the various subgroups available to them. The induction covers areas such as the local and national context, the role of regulatory bodies, the Foundation Trust provider licence, as well as practical details such as the calendar of meetings and the ways in which they will be expected to contribute in formal and subgroup meetings. Emphasis is placed on the respective roles of the Board and the Council of Governors. Induction is a continuous, tailored process, with skills and knowledge being identified and developed at an early stage.

A number of governor training sessions or workshops are held each year that form a key part of the governor development process, the topics of which are largely governor-led. The opportunity is also taken at workshops for updates on operational performance, communications with the regulator and topical issues affecting the Trust.

During 2024–25, our governors have participated in joint Board and Council sessions and governor workshops which included the following topics:

- A presentation and consultation on the development of a clinical strategy
- An externally facilitated workshop on appreciative enquiry
- A workshop facilitated by NHS Providers on member and public engagement
- A joint workshop with the Board facilitated by NHS Providers on accountability and the board/governor relationship
- A presentation on the development of the Trust Estates Strategy
- A presentation on new ways of working – One LSC
- A presentation on apprenticeships
- A workshop on managing complaints
- A presentation on Artificial Intelligence – a vision for the system
- Two consultation groups on the Always Safety First strategy

Expenses claimed by Governors

Whilst governors do not receive payment for their work with us, we have a policy of reimbursing any necessary expenditure. During 2024–25 £51.30 of expenses were claimed by our governors.

	2023–24	2024–25
Number of governors in office during the year	22	23
Total number claiming expenses:	4	1
Aggregate sum of expenses (£00s):	£611	£51.30

Contacting your Governors

If you wish to contact a governor then please email: corporateaffairs@lthtr.nhs.uk

MEMBERSHIP REPORT

Membership is free and aims to give local people and staff a greater influence on the provision and development of our services.

Public membership is open to members of the public aged 16 or over who live in our membership area which comprises all of the component electoral wards in the following Local Authority areas:

Blackburn with Darwen	Blackpool	Bolton
Bury	Cheshire East	Cheshire West
Cumberland	Halton	Knowsley
Liverpool	Lancashire	Manchester
Oldham	Rochdale	Salford
Sefton	St Helens	Stockport
Tameside	Trafford	Warrington
Wigan	Wirral	Westmorland and Furness

Eligible staff members automatically become Foundation Trust members unless they choose to opt out. Staff eligible for Foundation Trust membership are those who either:

- hold a permanent contract of employment with us;
- are contracted to work for a period of 12 months or longer or have held a series of temporary contracts adding up to more than 12 months; or
- are employed by the private sector or other partners (for example local Government or other NHS Trusts) and work at the Trust on a permanent basis or fixed-term contract of 12 months or more.

Our membership

The membership constituency for Lancashire Teaching Hospitals NHS Foundation Trust encompasses a wide and diverse geographical area, including the metropolitan areas of Liverpool and Manchester and the rural areas of north Lancashire and Cumbria.

Constituency	Members as at 31.03.24	Members as at 31.03.25
Public	9,147	8,913
Staff	10,252	9,413
Total Membership	19,399	18,326

Source: Civica Membership Database

During 2024–25 regular data cleansing was carried out to ensure that records continue to be as accurate as possible.

The membership database has continued to be updated with many members confirming their preference for receiving information from the Trust by email. This helps with more effective and efficient engagement with members as well as reducing expenditure on printing and postage costs.

The Health and Care Act 2022 recognised that NHS Foundation Trusts now operate within the new system way of working. The Council of Governors is assessing how it will discharge its wider duty to consider the Board's performance in part of the Trust's contribution to system-wide plans and their delivery, and its openness to collaboration with other partners, including with other providers through Provider Collaboratives.

In holding Non-Executive Directors to account for the performance of the Board, the Council of Governors now considers whether the interests of the public at large have been factored into Board decision-making and be assured of the Board's performance in the context of the system as a whole, and as part of the wider provision of health and social care.

Review of 2024–25

Trust Matters, our members' magazine, is produced twice a year providing up-to-date information to members regarding the Trust's service developments and delivery against strategic priorities. The magazine also includes a dedicated section in which governors are able to inform members of the various ways in which they represent them and report back to members on how they have helped influence decision-making and service development from their views and feedback.

The Trust hosted its Annual Members' Meeting on 26 September 2024. The event provided an opportunity for patients, staff members and the public to find out about what had been happening at Royal Preston Hospital and Chorley and South Ribble Hospital and gave a detailed update on the progress and innovations the Trust had made during the last year. At the meeting, Chief Officers shared a review of the organisation's 2023–24 annual report and accounts and an outline of the plans for 2024–25 and beyond. This was followed by presentations relating to Health Inequalities and the adoption of the Core 20 +5 plan to address these issues. The presentation was given by the Chief Nurse with members of staff attending with demonstrations and information on a range of associated Trust services.

The Annual Members' Meeting was held in person at the Lancashire Conservation Studios, Preston. The number of people attending in person was 58.

In partnership with the Communications and Engagement Team, social media has continued to prove a useful tool throughout the year to promote Trust events, elections to the Council of Governors and to provide information to the public, members, and staff.

Assessment of the membership and ensuring representativeness

As a Foundation Trust, we are required to have a membership strategy in place, together with a clear work plan for its implementation. The three-year Membership Strategy (2025–28) was approved in January 2025 by the Council of Governors and the Trust Board.

Our vision for our membership is to have an informed, engaged and involved membership who are able to fully represent the needs and experiences of our community by actively participating in influencing and shaping how our services are provided both now and in the future.

We aim to have a Council of Governors elected from and by the membership which is effective in representing the membership and supporting the Board in formulating strategy, shaping culture and ensuring accountability.

Further details and a copy of our three-year Membership Strategy can be found on the Trust website.

Members can contact the Corporate Affairs Office via:

Website: https://www.lancsteachinghospitals.nhs.uk/get-involved

Email: corporateaffairs@lthtr.nhs.uk

QUALITY IMPROVEMENT

Below highlights some of the key developments made by the Trust to improve service quality and an overview of the Trust's arrangements in place to govern service quality. Additional information on quality is available in our 2024–25 Quality Account which will be available on the Trust website at the end of June 2025 and within our Annual Governance Statement.

Continuous Improvement

The main focus for the Continuous Improvement (CI) team in 2024/2025 has been to support the delivery of the Single Improvement Plan and in the latter part of the year this has included supporting the delivery of the Trust's financial recovery programme. As part of this work the team has worked with colleagues to design and test a new systematic approach to improvement, taking the learning from Leeds Teaching Hospitals. The CI team, in collaboration with divisions and corporate teams, has developed the 'Lancashire Improvement Method,' a holistic approach to organisational change. Key highlights include the delivery of Rapid Improvement Workshops (RIWs) to identify and deliver savings opportunities.

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

Always Safety First

The Always Safety First Strategy is the Trust's response to the National Patient Safety Strategy, facilitating improvement in safety metrics across the organisation. We are in year three of the strategy this year. The Board continues to recognise the benefits of embedding a culture of continuous improvement across our organisation, supporting staff to design, test, embed and sustain changes that benefit patients and the local population. This is reliant on building capacity and capability lead improvement. Always Safety First is based on proactive regular review of our safety metrics and safety intelligence to inform our priorities, improvement co-designed with our staff and patients, shared governance, collaborative working across divisions and clinical specialties, and learning to improve.

Research participation in clinical research

During 2024–25, the Centre for Health Research & Innovation has focused on streamlining its research portfolio, along with increasing the number of commercial research studies that we participate in to redress the balance in line with national guidance and targets. Overall, we have recruited 1684 patients across 84 research studies covering a whole range of therapeutic areas, and research types, including early phase experimental commercial funded research studies to qualitative academic studies, in collaboration with our university partners. This includes 596 into National Institute of Health and Care Research (NIHR) portfolio studies, of which 61 patients into commercially funded studies. We remain steady with between 15 and 25 commercial studies open to recruitment and approximately 23% of our portfolio now commercial at any one time. This has increased from 13% this time last year. Overall, we have had a significant increase in recruitment to all commercial studies with around 500 in year.

We have reviewed and granted local confirmation of capacity and capability, opening 53 new research studies during this year.

PATIENT EXPERIENCE

The Patient Experience and Involvement strategy emphasises the importance of listening to and acting on patient experiences. This involves genuinely understanding the experiences of patients and families, whether positive or negative, and using these insights to drive improvements. We engaged patients, relatives, carers, colleagues, governors, and partner organisations in shaping the strategy's actions. The strategy is divided into 3 sections:

1. **Insight**: Enhancing our understanding of patient experience and involvement by gathering insights from various sources.
2. **Involvement**: Providing patients, colleagues, and partners with the skills and opportunities to improve patient experience across the entire system.
3. **Improvement**: Designing and supporting improvement programs that deliver effective and sustainable change.

The strategy aims to engage our patients and communities in co-producing and delivering services collaboratively as equal partners. In year three, the final year of the strategy has built on the solid foundations established in the previous two years and further elevated the prominence of the patient voice.

Complaints and Concerns

During 2024/2025 the Trust received 325 formal complaints, a decrease of 30 from 2023/2024. The complaints performance has been monitored through the year and patients receiving response within 35 or 60 days has risen from last year with the average for the year at 82%.

Comparator data for Complaints 2022 to 2025

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

Source: LTHTR Datix

The trend in the ratio of complaints to patient contacts over the past three years is detailed in the table below. Of the 325 complaints received between April 2024 to March 2025, 257 (79%) related to care or services provided at the Royal Preston Hospital (RPH), 60 (18%) to care or services provided at Chorley and South Ribble Hospital (CDH), 1 (1%) to care or services provided by Preston Business Centre, and 7 (2%) to care and services provided at Finney House Community Healthcare Hub. There were no cases which were deemed to be outside of the 12 months' timescale set out under the NHS Complaints Procedure.

Number of Complaints by Division – April 2024 to March 2025

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

Source: LTHTR Datix

Trend of ratio of complaints per patient contact 2021 to 2025

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

Source: LTHTR Datix

During this financial year there were 307 cases due to be closed. The outcome of these can be broken down into the following outcomes 17 (6%) of the complaints had been upheld. 178 (58%) were partly upheld and 102 (33%) were not upheld. 10 (3%) cases currently remain open at the end of the year.

The NHS Complaints Regulations determine that all complaints should be acknowledged within three working days of receipt. In the current reporting period, 98% of complainants received an acknowledgement within that timescale where complaints were received into the Patient Experience and PALS team.

Second letters may be received because of dissatisfaction with the initial response or as a result of the complainant having unanswered questions. During the period between April 2024 and March 2025 we received 16 second letters.

During the period 1st April 2024 to 31st March 2025 332 complaints were closed. 82% of complaints received in 2024/25 were closed within the 35-day or 60-day timescale. This is reported to Safety & Quality Committee monthly.

Top 3 themes from complaints by division:

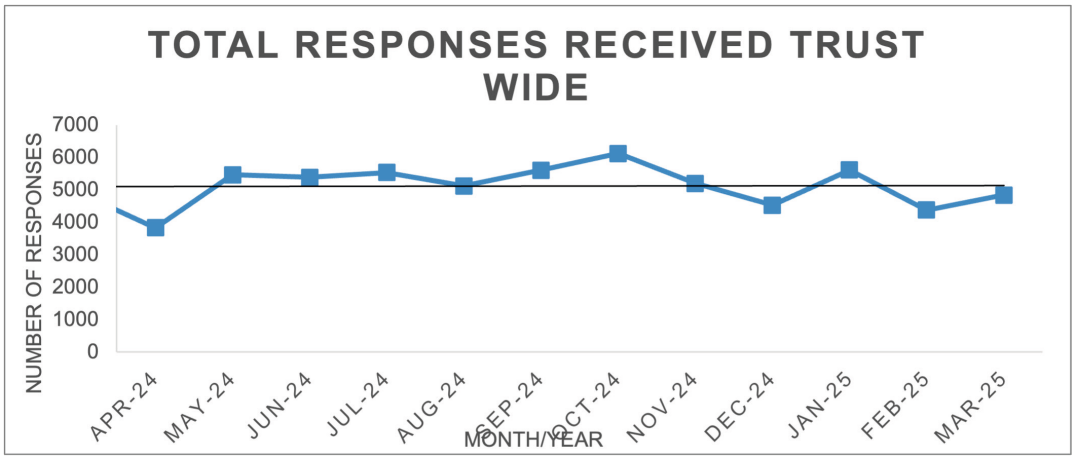
Division	Themes
Diagnostic and Clinical Support	Communication Treatment/procedure Nursing care
Women and Children	Communication Treatment/procedure Nursing care
Medicine	Communication Treatment/procedure Nursing care
Surgery	Treatment/procedure Communication Staff behaviour or attitude

The Parliamentary Health Service Ombudsman (PHSO)

Complainants have the right to request that the Parliamentary and Health Services Ombudsman (PHSO) undertakes an independent review into their complaint in instances where local resolution has not been achieved. Between the period 1st April 2024 to 31st March 2025 there were 4 cases referred to the PHSO; 3 are ongoing; and 1 was partly upheld.

During this period, the PHSO sent final reports for 6 cases which were opened prior to April 2024 and the outcome of these were that 3 were not upheld, 2 were partly upheld, and 1 was upheld. There is one further case referred to the PHSO prior to April 2024, which is still under investigation by the PHSO, and a final decision is yet to be reached.

Compliments



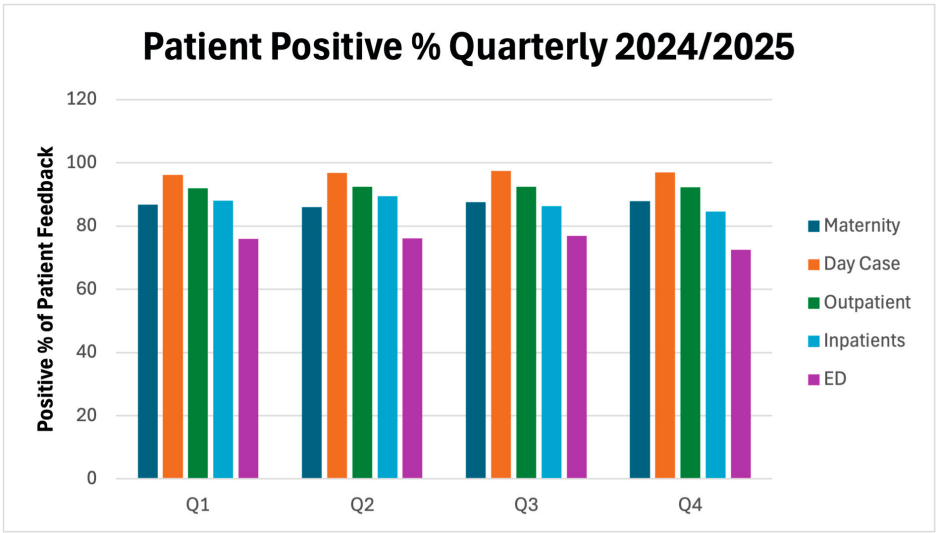
The Trust receives formal and informal compliments from patients and their families in relation to their experience of care. During 2024/25 a total of 6,831 compliments and thank you cards were received by wards, departments and through the Chief Executive's Office. There has been a 76% increase in the number of compliments received this year. Departments are being encouraged to actively log compliments on the Datix system. This provides teams with the opportunity to celebrate success locally and as part of their wider teams and divisions. The results from divisional compliments are now published monthly in the Trust Communications and discussed as part of divisional meetings.

Friends and Family Feedback

The Friends and Family Test (FFT) is used as a national measure to identify whether patients would or would not recommend the services of our hospitals to their friends and family. The national requirement is to report on the following areas:

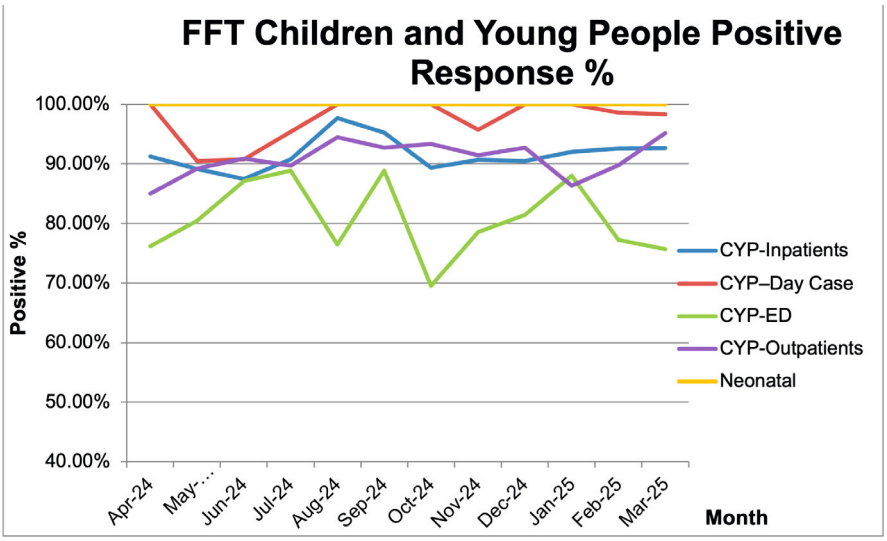
- Maternity
- Day Case
- Outpatients
- Inpatients
- Emergency Department

Percentage of positive responses Friends and Family by Division



Source: FFT data CIVICA

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



Friends and Family % Response

Source: FFT data CIVICA

Friends and Family response rate

Expanding the methods used to collect feedback is important if we are to understand what matters to patients. The response rate is an area we set out to improve and the data below demonstrates this has been achieved with a total of 2,937 more valuable pieces of feedback than what was collected in 2023/24.

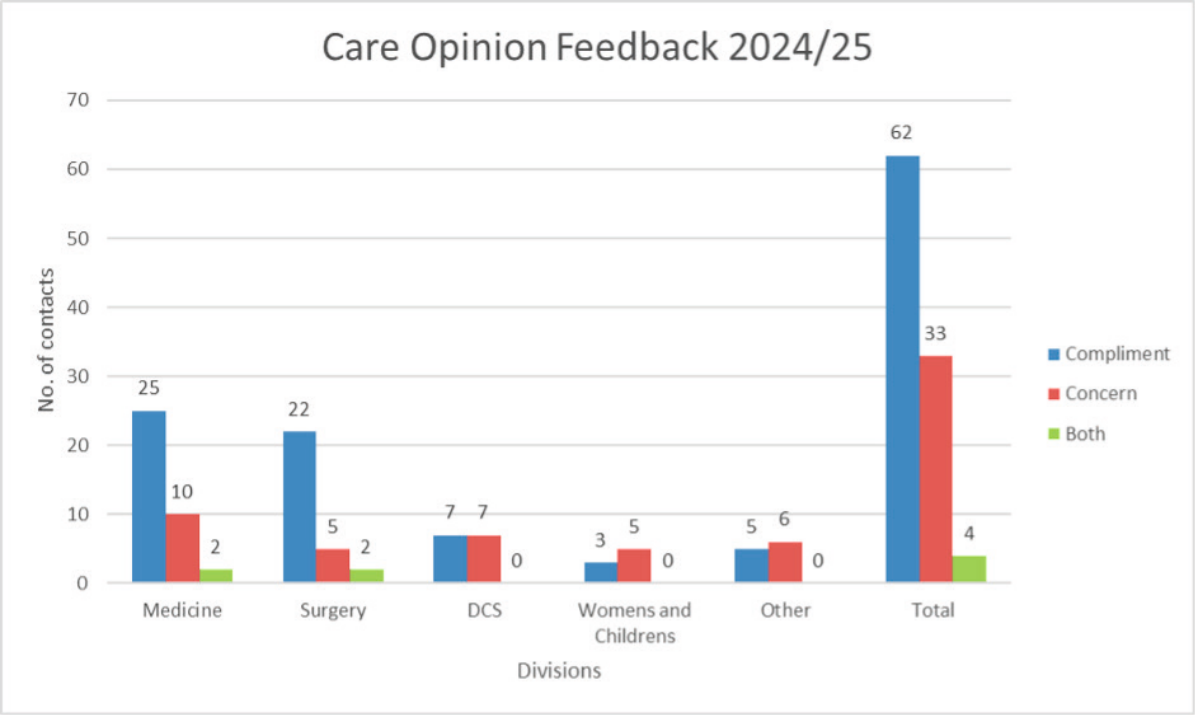
Year	QR codes/ online surveys	Paper surveys	Telephone surveys	SMS text surveys	Total
2022–2023	2,905	6,788	4,421	37,070	51,184
2023–2024	3,016	10,944	2,112	46,471	62,543
2024–2025	973	13,661	910	49,936	65,480

In the year 2024–2025 there has been a positive increase in the response rates overall of 4.69% on the previous year. Increases have been realised with paper surveys and SMS text surveys. There has been a reduction in the telephone surveys and online surveys which in part may be due to an increase in SMS text surveys and paper preferences for service users. Staff are actively encouraging patients to complete the FFT before leaving the hospital, which in turn supports the increase in paper survey completion.

Care Opinion Website

During the past financial year there have been a total of 198 reviews posted on the Care Opinion website relating to care and treatment at Lancashire Teaching Hospitals NHS Foundation Trust. These have consisted of 124 compliments and 66 concerns and 8 that have provided both concerns and compliments.

Care Opinion feedback



National Patient Survey Results

Maternity Survey 2024

The Maternity survey was based on a sample of inpatients during April and July 2024. A total of 324 patients from Lancashire Teaching Hospitals were randomly selected to take part in the survey. 318 patients were eligible for the survey, of which 103 returned a completed questionnaire, giving a response rate of 32%. This is a 7% decrease on the 2023 survey. The average response rate for the 56 'Picker' trusts in 2024 was 39%.

Urgent and Emergency Care Survey 2024

The survey was based on a sample of inpatients during April and July 2024. A total of 1250 patients from Lancashire Teaching Hospitals were randomly selected to take part in the survey. 1195 patients were eligible for the survey, of which 363 returned a completed questionnaire, giving a response rate of 30%. This is a 5% increase on the 2022 survey. The average response rate for the 64 'Picker' trusts in 2024 was 30%.

Inpatient Survey 2023

The survey was based on a sample of inpatients during July and November 2023. A total of 1250 patients from Lancashire Teaching Hospitals were randomly selected to take part in the survey. 1176 patients were eligible for the survey, of which 470 returned a completed questionnaire, giving a response rate of 40%. This is a 2% increase on the 2022 survey. The average response rate for the 64 'Picker' trusts in 2023 was 43%.

Patient Experience and Involvement Service

We are in the final year of our Patient Experience and Involvement Strategy 2022–2025. During the last 3 years we have committed to learn and develop with the involvement of our communities and their lived experiences.

Inclusion and accessibility

With a growing diverse local community, in this year we have updated our language services to ensure communication is more accessible for staff. Language video call services are now available on any iPad and Trust mobile via an appropriate link. Every member of staff has access 24 hours a day, 7 days a week, and communication can easily be made using these tools with no need for booking in advance. Our British Sign Language service is also available via video calls and is used as an in-between service in conjunction with the preferred option of face-to-face interpreters. Our patient information is available in every format including paper, easy read, photo books, digital with speak and translate, Braille on request, and video BSL sign format for our Deaf community.

A focus on our Trust website has also changed the way we display our information so that it is screen reader user friendly. Collaborative working has been key in producing these benefits with learning taken from our stakeholders along with our patients and carers and our long-standing Patient Information Group who advise on the clarity and easy understanding of our information.

Experience tells us that, for patients in hospital, they or their family members or carers, can identify the early subtle signs of deterioration often before hospital staff, due to familiarity and awareness of the individual's normal health and behaviours. This year we have instigated 'Call 4 Concern'. This enables patients and their relatives to call for help or advice when they are concerned about a patient's condition, and where they feel that their concern is not being heard by the ward team. It also empowers patients and relatives with the opportunity to request a second opinion and raise awareness of any deterioration.

Community Involvement

Putting the voice of our patients and communities at the centre of decision making and developing services ensures that these communities use the services in place to support their own health. Several forums are well established within the Trust, so patients have a platform to share their lived experiences and voice their concerns.

Our commitment has also seen our clinical services going into our local communities and demonstrating services available to them, providing knowledge and learning to ensure any barriers are broken down and help drive down any health inequalities. Data has proven that these actions have resulted in a higher uptake in our screening services.

Internal led and joint external forums bring together co-working with the patient voice at the heart of developing services. Forums include:

Cancer Patient Forum	SMRC Joint User Forum
Endometriosis UK Lancashire	The Youth Forum
Patient Information Group	Maternity Voices Partnership
Specialist Mobility Rehabilitation Centre (SMRC) Mobility Matters Forum Patient Research Group	Critical Care Ex Patients & Relatives Support Group
Preston Dystonia and Migraine Group	Lancashire Learning Disability and Autism Partnership
The Renal Working Group	V. I. (Visual Impairment) Forum
The Sepsis Patient Support Group	Patient and Carers Experience and Involvement Group
Cancer information Group	

Improvements

Our 'Hospital Guide Service' has gone from strength to strength this year and has seen an increase in our volunteer recruitment. This service has provided a huge benefit to many with the stress relief and enhanced positive experience with a simple added small service. Our hospital guides also stay with people in waiting areas and provide that emotional comfort for people who are alone.

As part of our commitment to our Patient Experience Strategy, we have enhanced our volunteer training providing support on; 'Sighted Guiding' from Guide Dogs UK and 'Deaf Awareness and Basic BSL'. The hospital guide service also now offers patients the opportunity to book a guide in advance, creating a better patient experience and a stress-free visit.

Hidden Disabilities – Improvements

The use of the reasonable adjustment system has allowed staff a simple way to document the needs of our community. Updates to this have recently included an adaption of our 'Registered Assistance Dogs Policy' to include Owner Trained Assistance Dogs which are now covered by the same legalities as Registered dogs.

Continuation of the Trust's membership in the Sunflower Lanyard Hidden Disabilities Scheme is still on going with over 3000 lanyards given to patients who have required them, along with wristbands for our children's service.

This year also saw the introduction of stoma friendly public toilets across both sites, with a campaign ran by Colostomy UK making accessible toilets 'stoma friendly' across Royal Preston and Chorley and South Ribble Hospitals, thanks to funding from Rosemere Cancer Foundation. This has been a welcomed introduction by both patients and staff at the Trust.

Patient Stories

Patient and family stories are shared with colleagues to ensure the patient and family experiences are fully understood through sharing their experiences and influencing more positive experiences in the future. We often receive feedback that compliments staff and services which we now share with all so we can celebrate the good and inspire others to do to the same.

Patient Champions

We continue to build relationships, share knowledge and ideas with our patient champions, who are based in every unit and ward. The champions have empowered other colleagues by driving forward our support services and ensuring their areas are up to date with all resources, activities and information.

Patient Safety Partners

Our Patient Safety Partners are another way in which we engage with our communities. They are committed to being the voice of our patients, carers and families and ensure that patient safety is at the forefront of all we do. Their engagement with patients and feedback to our services ensures we maintain and improve clinical care and safety in all our processes and policies.

Equality, Diversity and Inclusion

To support our vision of providing Excellent Care with Compassion, we have an Equality, Diversity and Inclusion (EDI) Strategy 2021–26. The aspiration behind the strategy is to "be consciously inclusive in everything we do for our colleagues and communities". Through this we commit to treating everyone we meet; patients, their families, carers, colleagues, temporary workers, volunteers and colleagues from other organisations with dignity, respect, kindness and understanding.

The strategy outlines a set of five principles which aim to provide a framework of ideas and options to create systematic changes, these are:

1. Demonstrating collective commitment to equality, diversity and inclusion

2. Being evidence-led and transparent

3. Recognising the importance of lived experiences

4. Being representative of our community

5. Bringing about change through education and development

Volunteers

Our volunteers provide a huge service to the Trust, giving up their time to provide support to our patients, families, visitors and staff. Many of our volunteers support us because of a personal connection to our hospitals or because they want to give something back. For others, it's an opportunity to develop new skills, knowledge and experience to support their employability prospects. Whatever their reason, we truly value the role they play and the contribution they make.

We have grown our volunteer workforce to circa 320 volunteers now registered and actively volunteering with us. We also work with third party organisations such as Baby Beat, Macmillan, Rosemere Cancer Centre, NCT (National Childbirth Trust) and soon to be the Stroke Association so our wards, departments and patients receive such a lot of support.

We have started to record the number of volunteering hours that volunteers contribute to the Trust each month. This is part of the NHS England Volunteer Data Collection that takes place each quarter. Since the count started in November 2024, volunteers have logged 4,150 hours.

In January 2024 we recruited a new Volunteer Manager following the retirement of the previous incumbent. She has continued to build on the strong foundations as well as bring new processes and innovation to our Volunteer Service.

We have identified a number of priorities for the next 12 months – underpinning all of them is to continue to support our existing volunteers, provide opportunities to develop them, raise the profile of our volunteer service and to encourage more volunteering roles across our hospitals by engaging with our staff members.

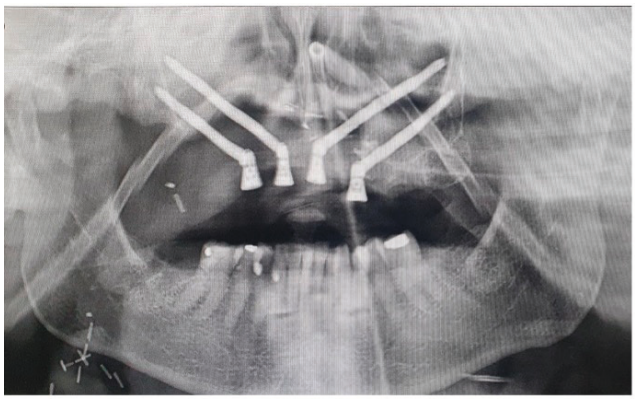
Major Service Developments

The Lancashire and South Cumbria healthcare system has experienced significant challenges during 2024/25 due to sustained operational and financial pressures, however the Trust has continued to implement a number of important service developments. These developments, which range from introducing cutting-edge technology to the opening of new facilities, have benefited both patients and colleagues as well as helping to alleviate pressure and improve flow across our sites.

These achievements reflect the determination of our hardworking colleagues and dedicated key partners, who have stayed focused on enhancing our services for the communities we support. The major developments during the past year are outlined below:

Lancashire and South Cumbria first for Maxillofacial and Restorative Teams

In July, a maxillofacial cancer patient was given a second chance at life after Lancashire Teaching Hospitals successfully performed the region's first-ever ZIP flap procedure, which reconstructs 80% of a patient's jaw. The 12-hour surgery involved taking away 80% of the patient's upper jaw and then reconstructing it with a Zygomatic Implant Perforated Flap. The Restorative team then fixed the dentures into the implants, which will greatly improve the patient's quality of life.



Had the patient not undergone the surgery, his Maxillary cancer would have spread and was life-threatening.

Neurosurgery department performs its first ever spinal surgery with 3D technology

In a significant leap forward in precision and patient safety, the Trust's Neurosurgery department successfully performed its first complex spinal surgery utilising intraoperative 3D CT and navigation technology. This state-of-the-art technique involves the use of Stryker's AIRO TruCT - an intraoperative 3D CT scanner – which allows surgeons to obtain high-resolution, real-time images of the spine during surgery.

This enables the surgical team to visualise the intricate structures of the spine with unprecedented clarity and accuracy. Combined with advanced navigation systems, surgeons can precisely plan and execute the surgery, reducing the risk of complications and improving outcomes.

Expansion of Maternal Medicine Centre service

A dedicated clinic for the management of pregnant and newly birthed women and birthing people with hypertension, pre-eclampsia and eclampsia opened in August as part of Lancashire Teaching Hospitals' maternal medicine centre.

The Lancashire Antenatal Pre-eclampsia and Hypertension Clinic, or LeAPH for short, was developed by Dr Emma Ingram, lead Obstetric Consultant for hypertension, and Sr Lisa Cook, Specialist Midwife for Maternal Medicine, and runs on Wednesday mornings in the Trust's Antenatal clinic.

The Maternal Medicine Centre was established in October 2023 following the Independent Review of maternity services in the Ockenden Report. The new centre made the Trust the third centre in the region to offer enhanced maternity services, along with Liverpool and Manchester.

New Acute Medical Assessment Unit expands capacity

Lancashire Teaching Hospitals opened a new Acute Medical Assessment Unit (AMU) at Royal Preston Hospital in September, to improve patient experience and help take pressure off the Emergency Department.

This newly refurbished unit replaced the Medical Assessment Unit (MAU) on ward 19, as the team and patients moved to the AMU on Wards 5. Patients who would normally be admitted to MAU are now admitted onto the new AMU, which comprises of 24 beds spaces, two assessment bays and 10 side rooms.

Having the additional space within the assessment bays allows the acute team to pull patients directly from the Emergency Department, to improve patient experience, length of stay, admission avoidance and performance within the Emergency Department. The new unit supports the implementation of new acute pathways and works to ensure that patients are seen by the right team in the right place.

Trust expands Endoscopy service as Sherwood Endoscopy Unit opens

In September, the Trust expanded their Endoscopy service with the opening of the Sherwood Endoscopy Unit. The unit, located at the front of Royal Preston Hospital, added another two endoscopy rooms to the service, resulting in an initial expansion to five rooms. Within the unit, the Trust will complete a range of endoscopic procedures including gastroscopy, colonoscopy and flexible sigmoidoscopy in two fully equipped endoscopy rooms, with state-of-the-art facilities.

Paediatric Surgical Hub recognised for enhancing children's surgical care

The Trust's Paediatric Elective Surgical Hub was accredited as part of a Getting It Right First Time (GIRFT) quality improvement scheme in September, recognising clinical and operational enhancements to children's surgical care.

The accreditation of the hub, which is based at Chorley and South Ribble Hospital, came after the Trust's Elective Surgical Hub was one of the first eight sites to be recognised when the scheme was piloted in early 2023. The accreditation provides recognition that Hubs work to a defined set of clinical and operational standards and is part of the national plan to increase capacity for elective care, with more dedicated operating theatres and beds.

The service is specific to certain specialties including dental and facial surgery, ophthalmology, plastic surgery and ear, nose and throat procedures.

Trust opens 'gold-standard' regional Mohs surgery service for skin cancer patients

Lancashire Teaching Hospitals' plastic surgery department opened the first service in the region – and one of only a small number nationwide - offering the 'gold-standard' Mohs Micrographic Surgery and Plastic.

Surgical Reconstruction for NHS skin cancer patients.

Based at Chorley and South Ribble Hospital, the service offers patients with high-risk skin cancers in high-risk locations - such as the face, nose, ears, eyes and mouth - treatment with real-time histological analysis of the tumour and reconstruction of the wound, all in one sitting.

The Trust have been working towards making the service available for around a decade, and feedback from patients and staff has been extremely positive. The service is provided by consultant plastic surgeons and is supported by a team of specialist pathologists, technicians, nurses, and theatre staff.

Community Diagnostic Centre opens

As of January 2025, the Preston Healthport Community Diagnostic Centre (CDC) was opened to make it quicker and easier for patients to access life-saving diagnostic tests.

The CDC, located in Fulwood, will deliver thousands of extra lifesaving tests, checks and scans in the heart of the community, ensuring that patients across Lancashire and South Cumbria can get quicker diagnoses, care and treatment.

The Preston Healthport CDC is the result of joint working between Lancashire Teaching Hospitals, Lancashire and South Cumbria ICB, NHS England and NHS Property Services.

Stakeholder Relations

Over the last few years in Lancashire and South Cumbria, a number of organisations have been working in a more collaborative way to develop integrated care. This includes NHS organisations, local authorities, the voluntary, community, faith and social enterprise (VCFSE) sector, hospices and local universities.

We have already made great progress in improving the way our services work together and how we work as a partnership. Joining up health and care is nothing new – we have been working towards this for some years, and we want to build on this excellent work.

By working together more effectively we will make a real difference to the lives of people and their families by supporting better health, improving health and care services and reducing health inequalities.

In 2024/25, there have been many examples of collaborative work across the local health and care system against a number of key priorities including, but not exclusive to, urgent and emergency care, discharge and elective care recovery and financial recovery, amongst others.

Examples of key stakeholder relations are set out below:

NHS Lancashire and South Cumbria Integrated Care Board (ICB)

NHS Lancashire and South Cumbria ICB is a statutory NHS organisation, which is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in our geographical area. The ICB's role is to join up health and care services, improve people's health and wellbeing, and make sure everyone has the same access to services and gets the same outcomes from treatment. They also oversee how money is spent and make sure health services are working well and are of high quality.

The Trust works collaboratively with the ICB as part of the wider Lancashire and South Cumbria Integrated Care Partnership (ICP) which is a statutory committee jointly formed between the ICB and all upper-tier local authorities that fall within the ICS area. The ICP brings together a broad alliance of partners concerned with improving the care, health, and wellbeing of the population.

Further information about the ICB, including their successes and challenges in 2024/25 is available on their website: www.lancashireandsouthcumbria.icb.nhs.uk/AnnualReports

Lancashire and South Cumbria Provider Collaborative

The five NHS Trusts in Lancashire and South Cumbria formed a Provider Collaborative in 2021 with the aim of better supporting patient care, creating a great place to work and reducing duplication to ensure the very best value for taxpayers' money.

Trusts include Blackpool Teaching Hospitals NHS Foundation Trust, East Lancashire Hospitals NHS Trust, Lancashire and South Cumbria NHS Foundation Trust, Lancashire Teaching Hospitals NHS Foundation Trust and University Hospitals of Morecambe Bay NHS Foundation Trust.

Each Trust Board has formally approved constituting the provider collaborative as a joint committee under s.65Z6 of the National Health Act 2006 with delegated functions and recognises its share of assets, liabilities, revenue and expenditure, associated with the operations of the collaborative, in the relative accounts.

As a joint committee, the provider collaborative aims to enable greater collaboration between the Trusts to:

- Improve the pace of decision making to enable better patient outcomes and quality of patient care
- Provide NHS Lancashire and South Cumbria Integrated Care Board (the ICB), NHS England, local authorities and the wider ICS with a single, collective view of the Trusts on proposals for service change
- Develop, implement, manage and oversee shared clinical, corporate and other services on behalf of the Trusts across Lancashire and South Cumbria as delegated to them including the associated operating delivery and governance models which they may agree to adapt, and
- Support financial stability and sustainability through reduced duplication and a better use of existing resources

The cost for 2024/25 was £2.25m shared across each member organisation.

One LSC

One Lancashire and South Cumbria (One LSC) brings together a number of central services from the five NHS trusts which make up the health system's Provider Collaborative.

One LSC is a shared venture – all five Trusts have joint shared ownership – with East Lancashire Hospitals NHS Trust (ELHT) the host organisation employing One LSC colleagues on behalf of the other Trusts.

The purpose of One LSC is to drive collaboration in corporate services to improve service quality, increase resilience and improve cost efficiency, ultimately to support better patient care.

Colleagues from functions including People's Service, Finance, Digital, Data and Technology and Procurement and Logistics transferred to One LSC in November 2024.

One LSC's development continues with the transformation of services planned to enable the realisation of One LSC's full benefits.

New Hospitals Programme

In January 2025, the Secretary of State for Health and Social Care made a statement on the outcome of the Government's review into the national New Hospital Programme.

The outcome of the review shows an ongoing commitment to delivering two brand-new hospitals on two new sites to replace Royal Preston Hospital (Lancashire Teaching Hospitals NHS Foundation Trust) and Royal Lancaster Infirmary (University Hospitals of Morecambe Bay NHS Foundation Trust), which will create better outcomes for patients and staff across Lancashire and South Cumbria. However, the timescales for delivering these two hospitals are now delayed, with construction expected to begin between 2035 and 2039.

Under a revised delivery timetable:

- Construction work on a replacement Royal Lancaster Infirmary is expected to start between 2035 and 2038
- Construction work on a replacement Royal Preston Hospital is expected to start between 2037 and 2039.

In December 2024, proposed sites were announced for the two brand new hospitals, with the land acquisition process supported by the national New Hospital Programme. A comprehensive series of public and colleague engagement events and a survey were announced to gather feedback and insights on the proposed sites but this work was suspended until further notice.

Lancashire and South Cumbria Pathology Service

Four acute hospital Trusts currently deliver pathology services in Lancashire and South Cumbria through eight sites in the five areas that make up the ICS footprint: Morecambe Bay, Fylde Coast, West Lancashire, Central Lancashire and Pennine Lancashire. This results in duplication, as well as variance in how pathology services are delivered in terms of cost, workforce and estate utilisation.

Approximately 40 million tests are processed each year by circa 800 members of specialist and expert staff for a population of nearly 1.8 million people and 238 GP practices. Growth in the demand for health and care services and long-term conditions has put a strain on health and care services and collaboration is fundamental to responding to these pressures to ensure the best use of the public purse, to eliminate duplication and create economies of scale.

Throughout 2024/25, work has been progressing on a business case to support the Pathology Service to establish a clinical model and delivery framework that will support the formation of a single service. It describes network priorities that will deliver transformation and ensure that by 2025 the service is operating as an NHSE defined mature network. The establishment of a unified pathology service presents an opportunity to consolidate operations, enhance service delivery and address future challenges effectively whilst maintaining high-quality patient care.

In 2024/25, governance approval was secured for the transition to a Lancashire and South Cumbria (LSC) Pathology Single Service, and a comprehensive Transition, Transfer, and Transform (TTT) plan was developed. Detailed engagement with pathology colleagues and other key stakeholders will take place during 2025/2026 to implement these plans.

Local Networks

The Trust continues to support equality, diversity, and inclusion across its workforce with established Inclusion Ambassador Forums, including Living with Disabilities Forum, LGBTQ+ Forum, and Ethnicity Forum.

The Forums help provide a voice, give support, are a place for colleagues to raise issues, review policies and procedures, provide ideas and educate colleagues to truly embrace and celebrate difference. The Forums have Board-level sponsors and help promote Lancashire Teaching Hospitals as an inclusive employer.

We understand that it is important that our patients, their loved ones, and the local population are involved in decision-making about the care and services that we provide. The Patient and Carers Experience and Involvement Group (previously called the Patient Experience and Involvement Group) provides a platform for staff to engage and consult with patients and the public to identify their needs. A number of local community groups are welcomed to the group including Deafway, n-Compass, Alzheimer's Society, Healthwatch, AccessAble and others. The Trust has several service-user groups and forums covering all different aspects of patient care, for example our Cancer Patient and Carers forum, which was established in 2021.

National Networks

Executive team members have maintained their memberships in professional networks throughout the year to ensure partnership working at a national level. This has enabled shared learning nationally to implement best practice and innovation within the Trust for the benefit of our local population.

In January 2025, Professor Mike Thomas became Chair of Lancashire Teaching Hospitals. He is also Chair of Making Space, a national mental health charity and co-founded the College for Military Veterans and the Emergency Services.

Mike's appointment was followed by the welcoming of a number of new Non-Executive Directors in March 2025, who also bring with them a wealth of experience in local and national networks. Their experience compliments a range of national positions also held by Executive Directors whose biographies can be found on the Trust website at

www.lancsteachinghospitals.nhs.uk/board-of-directors

Outside of Executive Team colleagues, the Trust also has a plethora of clinicians who hold senior positions on a national level. An example is Critical Care Consultant, Professor Shondipon Laha, who in December 2024 was named the new president of the Intensive Care Society (ICS) on a two-year term, becoming only the second person of Asian origin to hold the prestigious title. More information about colleagues who have gained national positions is available on the Trust website's latest news at www.lancsteachinghospitals.nhs.uk/news

REMUNERATION REPORT

The NHS Foundation Trust annual reporting manual requires NHS Foundation Trusts to prepare a remuneration report in their annual report and accounts. The reporting manual and NHSI requires that this remuneration report complies with:

Sections 420 to 422 of the Companies Act 2006 (section 420(2) and (3), section 421(3) and (4) and section 422 (2) and (3) do not apply to NHS Foundation Trusts

Regulation 11 and Parts 3 and 5 of Schedule 8 of the Large and Medium-sized Companies and Groups (Accounts and Reports) Regulations 2008 (SI 2008/410) ("the Regulations")

Parts 2 and 4 of Schedule 8 of the Regulations as adopted by NHSI in the reporting manual

Elements of the NHS Foundation Trust Code of Governance.

REMUNERATION COMMITTEES

There are two Committees which deal with the appointment, remuneration and other terms of employment of our directors. The Nominations Committee, a Committee of the Trust, is concerned with the Chair and other Non-Executive Directors. The ARTE Committee, as a Committee of the Board, deals with the pay and conditions of senior Executives.

Nominations Committee

The Committee comprises the Chair (except where there is a conflict of interest in relation to the Chair's role, when the Vice Chair or Senior Independent Director will attend), two public governors, one staff governor, and one appointed governor. The members have a nominated deputy who attends in their place if they are unable to attend. The Company Secretary advises the Committee as appropriate, and the Chief Executive is invited to attend all meetings. The Terms of Reference of the Committee are publicly available on application.

The Council of Governors appoint the members of the Nominations Committee for a two-year period and elections are held to replace any Committee member who ceases to be a governor following the annual governor elections or retirement of a governor in-year.

The composition of the Committee during 2024–25 is detailed in the attendance summary below.

Nominations Committee attendance summary

Name of Committee member	A	B	Percentage of meetings attended (%)
Peter White, Chair	2	2	100%
Mike Thomas, Chair	3	3	100%
Professor Paul O'Neill	1	1	100%
Tim Watkinson, Senior Independent Director	3	3	100%
Alistair Bradley, Appointed Governor	7	6	86%
Steven Doran, Staff Governor	3	1	33%
Steve Heywood, Public Governor	7	6	86%
Janet Miller, Public Governor	7	7	100%
Substitutes:			
Tom Ramsay, Staff Governor	4	2	50%

A = Maximum number of meetings the member could have attended | B = Meetings attended.

Work of the Committee

During 2024–25, the Committee met on seven occasions which enabled it to:

- Receive feedback on the outcome of the Chair's appraisal for 2020–24.
- Receive feedback on the outcome of the Non-Executive Directors' appraisals for 2023–24.
- Consider and recommend to the Council of Governors the appointment of Chair from January 2025.
- Receive, consider, and recommend to the Council of Governors re-appointment of two Non-Executive Directors whose terms of office were due to come to an end during 2024–25.
- Receive, consider and recommend to the Council of Governors the appointment of a new University nominated Non-Executive Director
- Consideration and recommendation to the Council of Governors the Non-Executive Director appointments made following an agreed process by Council in February 2025.

The search for the chair appointments during the year (which was an open advertisement process) was supported externally. The external firm (Peridot) that supported this appointment was engaged following a competitive process at a cost of £10,000. Additional appointments made during the year were supported internally at no additional cost.

Notwithstanding the direction received by Council for the appointments undertaken in February 2025, the Committee was committed to ensuring that vacancies during the year reached the widest possible audience, and that the selection process reflected the high standards of the Trust's approach to equality, diversity and inclusion.

Appointments, Remuneration and Terms of Employment (ARTE) Committee

All Non-Executive Directors are members of the Committee. The Chief Executive and Chief People Officer are normally in attendance at meetings of the Committee, except when their positions are being discussed. The Director of Corporate Affairs as Company Secretary also attends meetings as appropriate to provide advice and expertise and the Committee has the option to seek further professional advice as required.

During 2024–25 the Committee was supported by Gatenby Sanderson in the recruitment search for the Chief Operating Officer at a total cost of £27,318.

In addition, an unsuccessful recruitment search for the position of Chief Finance Officer was undertaken in October 2024 and was support by Seymour John at a cost of £31,350.

ARTE Committee attendance summary

Name of Committee member	A	B	Percentage of meetings attended (%)
Peter White	4	2	50%
Tim Ballard	4	4	100%
Victoria Crorken	4	3	75%
Paul O'Neill	4	3	75%
Uzair Patel	2	2	100%
Kate Smyth	4	4	100%
Tim Watkinson	4	4	100%
Jim Whitaker	2	1	50%
Tricia Whiteside	4	3	75%

A = Maximum number of meetings the member could have attended | B = Meetings attended.

Work of the Committee

During 2024–25, the Committee met on four occasions. The Committee meetings involved a range of business in line with its terms of reference which enabled it to:

- Consider and approve the plan for recruitment of the substantive Chief Operating Officer.
- Receive feedback on the outcome of the Executive Directors' appraisals.
- Re-align the Executive Director portfolios in response to a reduction in the number of executive directors at the Trust
- Consider and approve the interim arrangements for the Chief Finance Officer and agree the plan to recruit to the substantive post.

Mike Thomas took over the chair from Peter White on 1 January 2025. No meetings were held during the final quarter of the year.

ANNUAL STATEMENT ON REMUNERATION

At Lancashire Teaching Hospitals, we understand that our Executive remuneration policy is key to attracting and retaining talented individuals to deliver our business plan, whilst at the same time recognising the constraints that public sector budgetary measures bring.

In line with the Trust's agreed policy, the pay award for VSM posts was made in line with the recommendation of the Senior Salary Review Board in its annual report on Senior Salaries 2024.

Mike Thomas
Chair of the Appointments, Remuneration and Terms of Employment Committee

SENIOR MANAGERS' REMUNERATION POLICY

As detailed in the Chair's statement above, the remuneration policy is designed to attract and retain talented individuals to deliver the Trust's objectives at the most senior level, with a recognition that the policy has to take account of the pressures on public sector finances.

This report outlines the approach adopted by the ARTE Committee when setting the remuneration of the Executive Directors and the other Executives who have authority or responsibility for directing or controlling the major activities of the organisation. The following posts have been designated as fitting this criterion by the ARTE Committee and are collectively referred to as the senior Executives within this report:

Executive Directors

- Chief Executive
- Chief Finance Officer
- Chief Nursing Officer
- Chief Medical Officer
- Chief Operating Officer

Other Executives

- Chief People Officer
- Director of Communications and Engagement
- Director of Continuous Improvement
- Director of Strategy and Planning (up to 5 January 2025)
- Chief Information Officer (up to 30 June 2024)
- Director of Corporate Affairs

Details on membership of the ARTE Committee and individual attendance can be found on page 64 of this report.

Our policy on Executive pay

Our policy on the remuneration of senior Executives is set out in a policy document approved by the ARTE Committee. When setting levels of remuneration, the Committee considers the remuneration policies and practices applicable to our other employees, along with any guidance received from the sector regulator and the Department of Health and Social Care. In addition, the Committee considers the need to ensure good use of public funds and delivering value for money. The maximum of any component of senior managers' remuneration is determined by the ARTE Committee.

Each year, the Chief Executive undertakes appraisals for each of the senior Executives, and the Chair undertakes the Chief Executive's appraisal. The results of these appraisals are presented to the ARTE Committee, and they are used to inform the Committee's discussions. The Committee considers matters holistically when considering Executive remuneration, such as the individual Executive's performance, the collective performance of the Executive Team and the performance of the organisation as a whole.

The remuneration package for senior Executives comprises:

Salary:	As determined by the ARTE Committee and reviewed annually.
Senior Executives do not receive any additional benefits that are not provided to staff as part of the standard Agenda for Change contract arrangements. No senior Executives have tailored arrangements outside of those described above.	

The remuneration package for Non-Executive Directors comprises:

Salary:	As determined by the Council of Governors and reviewed in line with the national guidance on remuneration of Non-Executive Directors. Current rates are: • £13,000 p.a. for Non-Executive Directors • £6,500 p.a. for Associate Non-Executive Directors (none currently) • £2,000 p.a. as additional responsibility payment payable to the Vice Chair, Senior Independent Director and Ockenden Champion • £55,000 p.a. for the Chair
Additional benefits:	• Gym membership discounts with NHS identification • Access to NHS staff benefits offered by retailers • Onsite therapies at discounted rates • Salary sacrifice schemes

There is no provision for bonuses to be paid to any senior manager within the Trust.

All senior Executives are employed on contracts with a six-month notice period. In the event that the contract is terminated without the Executive receiving full notice, compensation is limited to the payment of salary for the contractual notice period. No additional provision is made within the contracts for compensation for early termination and there is no provision for any additional benefit, over and above standard NHS pension arrangements, in the event of early retirement. In line with all other employees, senior Executives may have access to mutually agreed resignation schemes (MARS) where these have been authorised.

Our Non-Executive Directors are requested to provide three months' notice in the event that they wish to resign before their term of office comes to an end. They are not entitled to any compensation for early termination.

During the year no Executive Director, Non-Executive Director or Very Senior Manager received a payment for loss of office.

ANNUAL REPORT ON REMUNERATION

Business expenses

As with all staff, we reimburse the business expenses of Non-Executive Directors and senior Executives that are necessarily incurred during the course of their employment, including sundry expenses such as car parking and transport costs such as rail fares.

The expenses paid to Directors (both Executive and Non-Executive) during the year were:

	2023–24	2024–25
Total number of Directors who served during the year:	23	28
Number of Directors receiving expenses:	5	6
Aggregate sum of expenses paid to Directors (£00s):	£1,837	£779

Salary and pension contributions of all Directors and senior Executives

Information on the salary and pension contributions of all Directors and senior Executives is provided in the tables on the following pages. The information in these tables, and in the remainder of this remuneration report, has been subject to audit by KPMG LLP. Additional information is available in the notes to the accounts.

Each of the Chief Executive's, the Chief Finance Officer's and the Chief Medical Officer's salary is above £150,000 per annum but within or below the national average, when benchmarking against other Trusts. In order to ensure the level of remuneration paid by the Trust is reasonable, on an annual basis we carry out a rigorous process of benchmarking against all other Trusts (including Trusts with comparable income, with comparable headcount, by Trust type and by region). We also take into account the individual Executive's performance, the collective performance of the Executive Team and the performance of the organisation as a whole. Furthermore, we consider the remuneration policies and practices applicable to our other employees, along with any guidance received from the sector regulator and the Department of Health and Social Care. Taking such factors into account, the ARTE Committee considers the remuneration for the Chief Executive, the Chief Finance Officer and the Chief Medical Officer to be reasonable.

Remuneration Report 2024–25

		2023/24				2024/25			
Name	**Title**	**Salary and Fees** (bands of £5,000)	**Expense Payments** (taxable) (to the nearest £100)	**All pension related benefits** (bands of £2,500)	**TOTAL of all items** (bands of £5,000)	**Salary and Fees** (bands of £5,000)	**Expense Payments** (taxable) (to the nearest £100)	**All pension related benefits** (bands of £2,500)	**TOTAL of all items** (bands of £5,000)
		£'000	**£**	**£'000**	**£'000**	**£'000**	**£**	**£'000**	**£'000**
Silas Nicholls	Chief Executive Officer from 8 January 2024	55–60	300	0	55–60	260–265	1,300	0	260–265
Faith Button	Interim Chief Executive Officer from 1 October 2023 to 7th January 2024	65–70	0	35.0–37.5	105–110	0	0	0	0
Kevin McGee	Chief Executive Officer left 30 September 2023	150–155	0	0	150–155	0	0	0	0
Katie Foster-Greenwood	Chief Operating Officer from 12 August 2024	0	0	0	0	90–95	3,600	62.5–65.0	155–160
Emma Ince	Interim Chief Operating Officer from 10 June to 29 August 2024	0	0	0	0	30–35	1,000	0	30–35
Imran Devji	Interim Chief Operating Officer to 9 June 2024	70–75	0	77.5–80.0	150–155	25–30	0	10.0–12.5	40–45
Faith Button	Chief Operating Officer (Interim CEO as above) left 16 February 2024	105–110	0	80.0–82.5	185–190	0	0	0	0
David Stonehouse	Interim Chief Finance Officer from 2 September 2024	0	0	0	0	100–105	0	0	100–105

		2023/24				2024/25			
Jonathan Wood	Chief Finance Officer / Deputy Chief Executive to 1 September 2024	185–190	1,200	0	185–190	80–85	500	0	80–85
Geraldine Skailes	Chief Medical Officer Retired on 2 November 2024 and returned 4 November 2024	215–220	1,200	0	220–225	225–230	700	20.0–22.5	250–255
Sarah Morrison	Chief Nursing Officer / Interim Deputy Chief Executive Officer from 1 October 2024	150–155	4,800	2.5–5.0	160–165	160–165	1,100	12.5–15.0	175–180
Neil Pease	Chief People Officer from 1 December 2023	45–50	0	0	45–50	150–155	0	0	150–155
Nicki Latham	Interim Chief People Officer from 1 June to 30th November 2023	70–75	0	0	70–75	0	0	0	0
Karen Swindley	Chief People Officer left 31 May 2023	20–25	0	0	20–25	0	0	0	0
Stephen Dobson	Chief Information Officer to 30 June 2024	120–125	0	10.0–12.5	130–135	40–45	0	7.5–10.0	50–55
Ailsa Brotherton	Director of Continuous Improvement and Transformation	120–125	0	0	120–125	140–145	0	105.0–107.5	245–250
Gary Doherty	Director of Strategy and Planning to 7 January 2025	145–150	0	0	145–150	115–120	0	0	115–120
Naomi Duggan	Director of Communications and Engagement	120–125	0	0	120–125	130–135	0	25.0–27.5	155–160
Jennifer Foote	Director of Corporate Affairs (SIRO) Role was previously Company Secretary	115–120	0	27.5–30.0	140–145	120–125	0	30.0–32.5	150–155
Angela Mulholland-Wells	Operational Director of Finance to 6 October 2024	125–130	0	30.0–32.5	160–165	65–70	0	45.0–47.5	110–115
Mike Thomas	Chair from 1 January 2025	0	0	0	0	10–15	0	0	10–15

		2023/24				2024/25			
Peter White	Chair to 31 December 2024	35–40	0	0	35–40	40–45	0	0	40–45
Adrian Leather	Vice / ChairNon-Executive Director from 1 March 2025	0	0	0	0	0–5	0	0	0–5
Paul O'Neill	Vice Chair / Non-Executive Director to 2 March 2025	25–30	0	0	25–30	10–15	0	0	10–15
Tim Watkinson	Senior Independent Director to 31 March 2025	15–20	0	0	15–20	15–20	0	0	15–20
Tim Ballard	Non-Executive Director from 1 October 2023	5–10	0	0	5–10	10–15	0	0	10–15
Victoria Crorken	Non-Executive Director to 7 February 2025	10–15	0	0	10–15	10–15	0	0	10–15
Kate Smyth	Non-Executive Director to 28 February 2025	10–15	0	0	10–15	10–15	0	0	10–15
Jim Whitaker	Non-Executive Director to 1 July 2024	10–15	0	0	10–15	0–5	0	0	0–5
Tricia Whiteside	Non-Executive Director to 28 February 2025	10–15	0	0	10–15	10–15	0	0	10–15
Uzair Patel	Non-Executive Director from 2 July 2024	0	0	0	0	5–10	0	0	5–10
Uzair Patel	Associate Non-Executive Director from 1 October 2023 to 1 July 2024	0–5	0	0	0–5	0–5	0	0	0–5
Michael Wearden	Associate Non-Executive Director to 9 June 2024	5–10	0	0	5–10	0–5	0	0	0–5
Peter Wilson (1)	Associate Non-Executive Director to 15 June 2024	5–10	0	0	5–10	0–5	0	0	0–5
Karen Deeny	Non-Executive Director from 1 March 2025	0	0	0	0	0–5	0	0	0–5
John Schorah	Non-Executive Director from 1 March 2025	0	0	0	0	0–5	0	0	0–5

		2023/24				2024/25			
StJohn Crean	Non-Executive Director from 3 March 2025	0	0	0	0	0–5	0	0	0–5
Jonathan Wood (2)	Managing Director of Lancashire & South Cumbria Provider Collaborative from 2 September 2024	0	0	0	0	105–110	700	0	105–110

Notes:

All members have been in post for the whole year unless otherwise stated.

Non-Executive Directors do not receive any pensionable remuneration.

(1) Peter Wilson chose not to accept remuneration for his role. The amount disclosed is the amounts that would have been received.

(3) The post of Managing Director of Lancashire & South Cumbria Provider Collaborative (PCB) is not a member of the LTH Board. Lancashire Teaching Hospitals NHS Foundation Trust (LTH) host the PCB that is working on new ways of collaborative working across the five Provider NHS Trusts within the region and has the ability to influence decisions of these Trusts.

Pension benefit

Name	Real increase in pension at pension age (bands of £2,500) £000							
	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2025 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000) £000 Cash Equivalent Transfer Value at 1 April 2024 £000	Real increase in Cash Equivalent Transfer Value (CETV) £000	Cash Equivalent Transfer Value at 31 March 2025 £000	Employer's contribution to stakeholder pension £000
Silas Nicholls Chief Executive Officer (1)	0	0	0	0	0	0	0	0
Katie Foster-Greenwood Chief Operating Officer	2.5–5.0	5.0–7.5	40–45	110–115	785	62	952	0
Emma Ince Interim Chief Operating Officer (2)	0.0–2.5	0	15–20	0	184	0	216	0
Imran Devji Interim Chief Operating Officer	0.0–2.5	0.0–2.5	60–65	65–70	928	9	1,054	0
Sarah Morrison Deputy Chief Executive / Chief Nursing Officer	0.0–2.5	0	45–50	105–110	794	8	874	0
David Stonehouse Interim Chief Finance Officer (3)	0	0	0	0	0	0	0	0

Name	Real increase in pension at pension age (bands of £2,500) £000							
Geraldine Skailes Chief Medical Officer (4)	0.0–2.5	0	10–15	0	131	18	212	0
Gary Doherty Director of Strategy and Planning (5)	0	0	60–65	180–185	1,731	27	1,891	0
Stephen Dobson Chief Information Officer	0.0–2.5	0	35–40	0	517	9	609	0
Neil Pease Chief People Officer (6)	0	0	0	0	0	0	0	0
Ailsa Brotherton Director of Continuous Improvement and Transformation	5.0–7.5	0	80–85	0	1,188	106	1,392	0
Naomi Duggan Director of Communications and Engagement	0.0–2.5	0	30–35	0	466	24	537	0
Jennifer Foote Director of Corporate Affairs (SIRO)	0.0–2.5	0	5–10	0	62	23	104	0
Angela Mulholland-Wells Operational Director of Finance	0.0–2.5	0	5–10	0	78	29	122	0
Jonathan Wood Managing Director of the Lancashire & South Cumbria Provider Collaborative	0.0–2.5	0	75–80	200–205	1,728	0	1,845	0

Notes:

(1) Silas Nicholls has chosen not to be covered by the NHS pension arrangements during the reporting year having opted out of the scheme.

(2) David Stonehouse has chosen not to be covered by the NHS pension arrangements during the reporting year having opted out of the scheme.

(3) Geraldine Skailes retired and took her pension in November 2024 then chose to opt back into the NHS pension scheme under a new membership when returning in the same month.

(4) Gary Doherty opted back into the NHS pension scheme in September 2024 after having opted out since October 2017; pension entitlement has only been provided up to the 7th January 2025.

(5) Neil Pease chose not to be covered by the NHS pension arrangements during the reporting year, having opted out of the scheme in November 2018.

(6) Jonathan Wood's entitlement includes his Chief Finance Officer role and his current role as Managing Director of the Lancashire & South Cumbria Provider Collaborative.

Fair pay disclosure

NHS Foundation Trusts are required to disclose the relationship between the remuneration of the highest-paid director in our organisation against the 25th percentile, median and 75th percentile of total remuneration of our organisation's workforce.

The banded remuneration of the highest-paid director in Lancashire Teaching Hospitals NHS Foundation Trust in the financial year 2024–25 was £260,000 - £265,000 (2023–24, £250,000 - £255,000). This is a change between years of 4.0% (2023–24, -7.3%). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Set out below, the total remuneration of the employee at the 25th percentile, median and 75th percentile, is further broken down to disclose the salary component. The pay ratio shows the relationship between the remuneration of the highest paid director in Lancashire Teaching Hospitals NHS Foundation Trust against each percentile of the remuneration of the organisation's workforce.

Pay ratio information

	2024/25			2023/24		
	25th percentile	Median	75th percentile	25th percentile	Median	75th percentile
Total remuneration (£)	25,674	33,796	47,037	24,745	32,865	45,496
Salary component of total remuneration (£)	25,674	33,796	47,037	24,745	32,865	45,496
Pay ratio information	10.2	7.8	5.6	10.2	7.7	5.5

In 2024–25, 14 (2023–24, 12) employees received remuneration in excess of the highest-paid director in 2024–25. Remuneration ranged from £10 to £382,269 (2023–24, £25 to £316,652).

Total remuneration includes salary and non-consolidated performance-related pay for all staff, including those that transferred to East Lancashire Hospitals Trust as part of One LSC. It does not include employer pension contributions and the cash equivalent transfer value of pensions, severance payments or benefits in kind. The benefit in kind pay information was not available during the preparation of the annual report disclosures but it considered to be negligible to the total remuneration cost.

The average percentage change from the previous financial year for salaries and allowances (based on total for all employees on an annualised basis, divided by full time equivalent number of employees; (both excluding the highest paid director) for employees of the Trust as a whole is 3.4% (2023–24, 5.4%). On the same basis, the average percentage change from the previous financial year for performance pay and bonuses payable due to clinical excellence award payments is down 38.6% (2023–24 up 44.0%).

The Group Accounting Manual requires temporary agency staff to be included within the above median pay disclosures. Temporary agency staff costs equated to £10.1m in the year (2023–24, £20.6m). We have included information from our main agency staffing provider that amounts to £2.99m to calculate a meaningful annualised cost per temporary staff member for 2024–25 that is consistent with the information was included in the prior year calculation.

This Remuneration Report is signed on behalf of the Board of Directors by:

Professor Silas Nicholls
Chief Executive
26 June 2025

STAFF REPORT

Our people

As at 31 March 2025, we employed 9,437 substantive members of staff. This number is broken down as shown in the below table; note that some staff hold roles that fall under different staff groups, thus the figures in the below table do not sum to the stated distinct headcount.

Staff Group	Headcount
Additional Clinical Services	2,066
Additional Professional, Scientific and Technical	236
Administrative and Clerical (incl. NEDs)	1,395
Allied Health Professionals	723
Estates and Ancillary	875
Healthcare Scientists	291
Medical and Dental (excl. Lead Employer Doctors)	902
Nursing and Midwifery Registered	2,954

A comparison of our workforce over the past three financial years is provided in the table below, and our staff turnover can be accessed via the information published by NHS Digital at the following link: NHS workforce statistics - NHS Digital.

	2024–25 HC	% of Total HC	2023–24 HC	% of Total HC	2022–23 HC	% of Total HC
Age (years)						
Under 20	367	3.9%	63	0.6 %	74	0.7 %
20 - 29	1,222	12.9%	1,849	17.9 %	1,853	18.6 %
30 - 39	2,584	27.4%	2,800	27.1 %	2,713	27.2 %
40 - 49	2,207	23.4%	2,332	22.6 %	2,176	21.8 %
50 - 59	1,972	20.9%	2,143	20.8 %	2,140	21.5 %
60 - 69	1,019	10.8%	1,071	10.4 %	961	9.6 %
70 and over	66	0.7%	65	0.6 %	57	0.6 %
Ethnicity						
BAME: Asian	2,114	22.4%	2,167	21.0 %	1,964	19.7 %
BAME: Black	363	3.8%	361	3.5 %	334	3.3 %
BAME: Mixed	153	1.6%	158	1.5 %	157	1.6 %
BAME: Other	153	1.6%	152	1.5 %	156	1.6 %
White: Other	289	3.1%	313	3.0 %	294	2.9 %
White: UK & ROI	6,253	66.3%	7,043	68.2 %	6,935	69.5 %
Not Stated	112	1.2%	129	1.2 %	134	1.3 %
	2024–25 HC	% of Total HC	2023–24 HC	% of Total HC	2022–23 HC	% of Total HC
Legal Sex						
Male	2,230	23.6%	2,473	24.0 %	2,309	23.2 %
Female	7,207	76.4%	7,850	76.0 %	7,665	76.8 %
Recorded Disability	585	6.2%	567	5.5 %	477	4.8 %

As at 31 March 2025, the gender split of our Board of Directors (including Non-Executive Directors) was ten male and six female. The gender split of our senior executives, as defined by the Appointment, Remuneration and Terms of Employment Committee, was three male and six female, with an average age of 55 years.

The Trust is required to publish the ethnic diversity of its board and senior managers in its annual Workforce Race Equality Standard report, in which indicator nine assesses how far the board reflects the ethnic diversity of the Trust's workforce. In addition, we publish our gender pay gap report annually. Both can be accessed via the Trust website.

Attendance management

Sickness absence data is reported on a calendar year basis (January to December 2024):

Figures Converted by Department of Health to Best Estimates of Required Data Items:	
Average FTE 2024	9,564
Adjusted FTE days lost (to Cabinet Office definitions)	132,307
Average sick days per FTE	13.8
Statistics published by NHS Digital from ESR Data Warehouse:	
FTE days available	3,532,327
FTE days recorded sickness absence	217,948

Source: NHS Digital - Sickness Absence and Publication - based on data from the ESR Data Warehouse
Period covered: 01 January 2024 to 31 December 2024

The 12-month average sickness absence rate for the period 01 January to 31 December 2024 was 6.47%; a deterioration compared to 6.30% in the previous year. The proportional split of this between short-term sickness (less than 28 days) and long-term sickness (28 days or more) was generally consistent with the previous year. The annualised short-term absence rate was 2.36% compared to 2.30% in 2023 and the long-term absence rate was 4.11% compared to 4.00% in 2023.

Mental health remains the top reason for working days lost due to sickness absence with an occurrence of 29.5% among all sickness absence episodes, with the annualised rate increasing from 1.62% to 1.91%. Our psychological wellbeing service for colleagues continues to work proactively to support colleagues, although demand for services has increased with an impact on waiting times. The team are leading on the development of a number of on-line resources on behalf of Lancashire and South Cumbria and these include individual and team stress risk assessment tools, an incident support toolkit and psychological skills for managers e-learning. These are designed to promote early intervention and develop manager capability in supporting mental health in the workplace. Mental Health First Aider training has also been re-launched during the year.

Flu and COVID-19 vaccination uptake was disappointing in our 2024/5 campaign, with only 32.3% of colleagues that deliver direct patient care receiving the flu jab and 14.4% accepting the COVID-19 booster. Vaccination uptake has deteriorated significantly post-pandemic, and this reflects a downward national trend amongst frontline healthcare workers. A full evaluation has been undertaken, with key priorities ahead of the 2025/26 campaign including the establishment of a peer vaccinator network and exploring ways in which we can more effectively capture data around colleagues vaccinated elsewhere.

Our health and wellbeing strategy is holistic and aligned with other organisational strategies, including Equality, Diversity and Inclusion, Social Value and Sustainability. Over the last year we have partnered with local organisations to deliver health checks for colleagues, weight management programmes and obtain grant funding to train walk leaders. Priorities for the next 12-months include an increased focus on preventing musculoskeletal injury at work, developing a rehabilitation pathway for colleagues returning from long-term sickness absence and using charitable funding for further break space refurbishment.

Equality, Diversity and Inclusion

Through completion of our Workforce Race Equality System (WRES) and Workforce Disability Equality System (WDES) reporting, we review of our workforce profile by minority group and pay band so we can understand where colleagues may be experiencing barriers to career progression.

The greatest representation of minority ethnic colleagues in non-clinical roles are in band 2 and below (below band 1 tend to be apprentices). With the exception of colleagues in band 2 or below, ethnic minority colleagues are underrepresented across all other non-clinical bands when compared against the overall non-clinical ethnic minority workforce (18.9%). Representation at band 3 (16.4%) and at 8c (13.8%) are slightly under 18.9% overall representation figure for the non-clinical workforce.

From a clinical workforce perspective, the highest percentage of minority ethnic colleagues can be found in band 5 roles (49.5%). With the exception of apprentices and band 5 clinical roles, minority ethnic colleagues are underrepresented in all other bands when compared against the overall clinical minority ethnic workforce (27.3%). Representation at band 2 (26.3%) is slightly under the 27.3% overall representation figure for the clinical workforce.

From a medical and dental workforce perspective, the highest percentage of minority ethnic colleagues can be found in trainee roles (76.7%). Minority ethnic colleagues are underrepresented at Consultant level and above, when compared against the overall medical and dental minority ethnic workforce.

The work we have undertaken to promote inclusion across our organisation, including a "Share not Declare" ethos has seen a continued increase in the percentage of colleagues who have disclosed a disability/long-term condition (LTC) in our Electronic Staff Record (ESR).

In addition to the levels of representation across our workforce, our 2024 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) staff survey data tells us that:

- 51% of minority ethnic colleagues believe our organisation provides equal opportunities for career progression and promotion (an increase of 1.1% on the previous year) compared to 60% of white colleagues (a decrease from 62% the previous year).
- 54% of colleagues with a long-term condition (LTC) or disability believe our organisation provides equal opportunity for career progression or promotion (same as the previous year) versus 59% of colleagues without a LTC/disability (a decrease from 61% the previous year).

Our WDES staff survey data also told us 79.1% of colleagues who have a disability or LTC say the organisation has made reasonable/adequate adjustments to enable them to carry out their work. This is above the national average for this measure (74%) and is an improvement on the previous year's result (78.3%). There has been a continued improvement in the proportion of colleagues with a disability/LTC who report feeling under pressure to come into work when not feeling well enough (-1.6%). This is also better than the national average (80% vs 78%). Over the past 12 months we have continued to promote the adoption of a compassionate approach to colleagues with a disability/LTC – this work will continue through both through the delivery of actions associated with our Equality, Diversity & Inclusion strategy in addition to educational programmes, such as our Core People Management Skills programme for line managers.

Occupational Health

As in previous years, in 2024–25 there were three services making up our Occupational Health offer for our workforce:

1. The service related to pre-employment screening, management referrals, immunisations, health surveillance and support for needle-stick injuries continues to be provided by Wellbeing Partners (our Occupational Health joint venture with Wrightington, Wigan and Leigh NHS Foundation Trust).
2. The Physiotherapy service is delivered in-house with professional leadership from our Core Therapies Team. The service exists to provide rapid access assessment and treatment for colleagues suffering from musculoskeletal injuries or conditions.
3. Psychological wellbeing services are also provided in-house by our team of clinical psychologists, cognitive behavioural therapists, counsellors, and psychological wellbeing practitioners. The service has been the subject of national case studies of best practice, and we continue to see positive outcome data with colleagues experiencing reductions in measures of anxiety, depression, and burnout post-therapy.

Priorities for 2025/26 include reducing waiting times and exploring new support pathways, including for colleagues rehabilitating from long-term sickness absence and to support neuro-diversity.

Staff engagement and consultation

Staff experience and engagement is at the heart of what creates and supports a positive organisational culture. Our aim is to create a positive experience of work for all our colleagues, where they feel engaged with their role, their team, and our vision as a Trust.

As part of our strategic aim to be a great place to work, our annual programme of work includes measuring, understanding and taking action to deliver improvements in staff engagement, satisfaction and overall experience of work. This is delivered through a range of methods below:

- Onboarding & Welcome
- Survey Opportunities
- Internal Opportunities to engage
- Trust Engagement Opportunities
- Team Level Engagement

TED Tool (Team Engagement and Development)

The internal TED tool has been used across the organisation for the last over eight years and is designed to be used by team leaders to enable them to have a conversation about their teams' level of effectiveness and engagement. It supports team and individual engagement by providing staff with the opportunity to share their feedback and collectively identify solutions as part of the team development action plan.

NHS staff survey

The response rate to the 2024/25 survey among Trust staff was 39% (3,994 colleagues engaged) which shows a decline in comparison to 2023/24 which was 45% (4,539 colleagues engaged).

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

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	**7.15**	7.21	**7.30**	7.24	**7.29**	7.18
We are recognised and rewarded	**5.90**	5.92	**6.06**	5.94	**5.88**	5.72
We each have a voice that counts	**6.60**	6.67	**6.77**	6.70	**6.74**	6.65
We are safe and healthy	**6.03**	6.09	**6.25**	6.08	**6.11**	5.88
We are always learning	**5.53**	5.64	**5.66**	5.62	**5.51**	5.35
We work flexibly	**6.18**	6.24	**6.42**	6.20	**6.20**	6.00
We are a team	**6.75**	6.74	**6.86**	6.75	**6.81**	6.64
Staff engagement	**6.63**	6.84	**6.91**	6.91	**6.86**	6.80
Morale	**5.72**	5.93	**6.02**	5.90	**5.89**	5.68

The 2024/25 survey results show a shift in trend after several years of steady improvement with the Trust consistently meeting or exceeding national benchmarks.

Despite an increased level of communication and engagement before and during the fieldwork, the completion rate of the survey has declined in comparison to previous year and is below the national average of 49%.

There has been an overall decline across the survey questions and people promise indicator scores. Indicator themes falling below the benchmark average include: Staff Engagement, Morale, 'We are always learning', 'We are safe and healthy', 'We each have a voice that counts'.

We have maintained a position close to the national average in 'We are recognised and rewarded', 'We work flexibly' and 'We are compassionate and inclusive' and we remain above the national average for 'We are a team'. The success in this area is strongly linked to the continued use of TED (Team Engagement and Development Tool) and our continued focus on team development.

Whilst the results in the survey are challenging to read, they provide a snapshot of the current working environment at the Trust and reflect the impact and challenges of our local context, the significant amount of change and level of uncertainty staff are experiencing, alongside the wider national context.

Priorities and targeted actions

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

1. Colleague Wellbeing & Flexible Working:

Strengthen awareness and understanding of flexible working and address the level of burn out and wellbeing concerns reported exploring how our corporate offer can further support improvements.

2. Colleague Sexual Safety:

Continue to implement and embed the NHS' Sexual Safety Charter to address experiences seen through the new questions focused on unwanted sexual behaviour.

3. Colleague Health, Safety & Physical Violence:

Address experiences of personal safety i.e. discrimination, bullying, harassment, aggression by further embedding our Zero Tolerance approach to support colleagues to feel safe at work.

4. Raising Concerns:

Address the decline in colleagues reporting confidence in raising concerns (now below national average).

5. Recognition:

Continuing to develop and embed our offer to support all colleagues to feel rewarded and recognised and further improve scores linked to team level appreciation.

6. Equality, Diversity & Inclusion (EDI):

Understand how experience varies across different protected characteristic groups/subgroups and take actions to understand how to close the gaps. Improve team-level appreciation scores.

7. Advocacy in Patient Care and Place to Work:

Address the different perceptions around quality of care and the declining advocacy scores (largely driven by driven by perceptions that financial pressures are prioritised over patient care) to find ways to support and increase feelings of trust, engagement, and pride in patient care.

8. Support and Development for Managers:

Address overall declines across the survey questions and improve the individual colleague experience by focusing on engaging People Managers and colleague conversations.

9. Bespoke OD Team Development Work:

Address and prioritise bespoke development, targeting teams with lower staff survey results to help improve and support more positive team cultures.

10. Response Rates:

Address the decrease in this year's response rates and take action to ensure stronger representation in colleague feedback and reaching national benchmark target.

Monitoring Performance and Tracking Impact

Regular monitoring and internal reporting takes place within the Organisational Development Team, monthly Divisional Workforce Committees, Monthly Single Improvement Plan reports and annually to our Trust Workforce Committee and Board. Progress is tracked through analysing results of our engagement surveys, retention data, and wider colleague feedback. This includes evaluating the impact of interventions and actions taken at all levels (organisation, divisional, team), understanding trends over time in our engagement data and to inform proposals for future workstreams to target further areas for improvement.

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

Learning and Development

This section provides a summary overview of learning, development, education, and training activity delivered during 2024–25.

Training and Compliance

Mandatory training is a key enabler to delivering safe and effective patient care, reducing organisational risk, and ensuring a safe working environment. Of the training subjects which are nationally mandated, either through the national Core Skills Training Framework or other relevant legislation, the Trust is currently (as of March 2025) demonstrating target compliance (90% for all subjects) in 27 out of 31 subjects. This is an improvement from the year-end position reported in 2023–24.

The Trust has implemented a new reporting matrix which significantly enhances the Trust's ability to view mandatory training compliance not only at an individual and Trust wide level as before but also at Division, Clinical Business Unit, Specialty Business Unit and Department level as well as by professional group. This has resulted in achieved and sustained compliance in 3 key metrics in the Trust since November 2024 (Moving and Handling Level 2, Patient Safety Access to Practice, Resus Level 1 – Non-Clinical).

Mask fit testing (booking and recording) has been digitalised this year reducing the administrative burden on many staff groups who would previously have administrated the process. In addition, an online Display Screen Equipment (DSE) assessment has been developed to enable staff to self-assess with support of DSE assessors when required.

Medical Device and Clinical Competencies

Overall Medical Device compliance across the Trust exceeds the target at 92% with Trust wide compliance increasing 7% in the last 12 months. All divisions are achieving the 90% compliance target. A new project commenced in 24/25 to review and risk assess all clinical competencies utilised in the Trust, with the plan to have all clinical competencies electronic to ensure robust monitoring and analysis of competence in the divisions.

Clinical Skills Education

The Clinical Skills Education Team supports the Trust to meet its legal obligation of ensuring our staff and students have the right knowledge, experience and skills to deliver safe, effective and compassionate care for our patients. The past 12 months has seen the implementation of a wider range of technology enhanced learning resources to enrich the learning experience of our staff and meet a wider range of learning styles.

The team have increased skills teaching provision throughout the trust. A bespoke Critical Care Communications session was developed, involving a range of specialist services to make the scenarios as realistic as possible and engage the staff and develop their skills.

New developments have included developing a multi-professional preceptorship programme for newly qualified nurses and AHPs and implementing outreach days visiting preceptees in their clinical areas to provide pastoral support.

The team provide all the practical clinical skills and Communication & Ethics teaching for the year 3- 5 medical students and run the 22 mock and 36 full Objective Structured Clinical Exams (OSCE) for medical students. This year has seen the introduction of new ultrasound-guided cannulation sessions and production of 3 new skills films.

Patients as Educators provide a vital contribution in the teaching sessions, providing high-quality learning experiences for the medical students by enabling them to hear the patient's personal experience of managing their conditions on a day-to-day basis and allows them to practice essential communication skills alongside skills acquisition.

Student, Trainee and Placement Support (STAPS)

Over the past year, the STAPS team has made significant strides in supporting medical professionals' development and facilitating educational placements across various healthcare sectors. They organised numerous courses and induction sessions for doctors, coordinated teaching sessions, and reviewed trainee portfolios. The team received awards for their contributions to education and maintained high training compliance standards. They introduced new programmes to address workforce gaps and expanded training opportunities. Additionally, they placed a wide range of students in various disciplines and delivered CPD sessions to enhance clinical skills. Collaboration with universities and departments has strengthened educational partnerships, and the Learner Support Team provided comprehensive academic and pastoral support, including mental health first aid training and new initiatives to promote student well-being.

Professional Education Development

In partnership with University of Central Lancashire, the new Practice-Based Pathway into Nursing continues to grow from strength to strength with 126 students enrolled onto the programme. This programme is an innovative approach to delivering a hospital-based pathway for the BSc Hons Pre-Registration Nursing (Adult) Programme and is based on additionality, thus offering additional pre-registration nursing students and growth in future registered nurse workforce supply.

The Registered Nurse Degree Apprenticeship, delivered in partnership with Northumbria University, has concluded the funding was previously received from Health Education England to support this initiative. Since programme commencement in September 2020 a total of 84 participants have been recruited, as of March 2025 all of them have successfully graduated. Opportunities to secure additional funding are being pursued with the aim of integrating this model of training with the Practice-Based Pathway.

Apprenticeships and Widening Participation

Apprenticeships continue to be a government priority and offer structured learning pathways towards meaningful employment. During 2024–25, the Trust has delivered a range of apprenticeships targeted towards workforce supply and skills gaps, and outcomes include:

- 19 Level 2 Healthcare Support Worker
- 52 Level 3 Senior Healthcare Support Worker
- 62 Level 4 Learning and Skills Mentor
- 2.3% new staff recruitments as apprentices
- 28 outsourced apprenticeships across clinical and non-clinical pathways
- 81.3% Qualification & Achievement Rate against a target of 62%

The Trust had 20 employees shortlisted across nine categories for the annual Lancashire & South Cumbria NHS Health & Social Care Apprenticeship Awards in June 2024. The event saw an LTH employee win in one category and four others recognised as Highly Commended runners-up in other categories.

This year, the Trust welcomed 38 T Level students. T levels are Level 3 classroom-based technical programmes that equip students with the skills, knowledge and behaviours needed to progress into skilled employment. The Trust has commenced industry placements in clinical and non-clinical services and is growing its offer aligned to demand from our local partner colleges.

Advanced Practice Education

Advanced Practice (AP) continues to go from strength to strength, with 116 ACPs and 21 Non-Medical Consultants in the Trust. The AP Leadership Team have organised and continue to develop a rolling educational programme and events inhouse, across the ICS and North-west region. This education component consists of monthly lunch time learning sessions and quarterly CPD events. Forums to support AP, Consultant level practice and Research. Pastoral support and Health & Wellbeing is a priority for all trainees this is facilitated via monthly support sessions and tripartite performance review meetings with the University, AP Leadership team and trainees. The Trust also offer a buddy system, linking up trainees with experienced qualified APs for extra support and guidance.

			2024/25	2023/24
	Permanent	Other	Total	Total
	£0	£0	£0	£0
Salaries and wages	426,119	35,905	462,024	424,123
Social security costs	42,634	3,592	46,226	46,270
Apprenticeship levy	2,128	179	2,307	2,140
Employer's contributions to NHS pensions	74,289	6,260	80,549	66,944
Pension cost – other	120	10	130	154
Other post-employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	-	-	-	-
Temporary staff	-	10,106	10,106	20,642
NHS charitable funds staff	-	-	-	-
Total gross staff costs	545,290	56,052	601,342	560,273
Recoveries in respect of seconded staff	-			
Total staff costs	545,290	56,052	601,342	560,273
Of which				
Costs capitalised as part of assets	2,686	415	3,101	2,894

Consultancy costs	
2024/25	**2023/24**
£0	£0
0	0

Average number of employees (WTE basis)

			2024/25	2023/24
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	1080	127	1,207	1,126
Ambulance staff	-	-	-	-
Administration and estates	2295	79	2,374	1,646
Healthcare assistants and other support staff	1807	364	2,170	3,255
Nursing, midwifery and health visiting staff	2678	208	2,885	2,942
Nursing, midwifery and health visiting learners	-	-	-	-
Scientific, therapeutic and technical staff	808	15	823	806
Healthcare science staff	264	9	273	258
Social care staff	-	-	-	-
Other	31	-	31	32
Total average numbers	8,963	801	9,764	10,065
Of which:				
Number of employees (WTE) engaged on capital projects	49	3	52	51

In 2024/25 a classification change of other clinical support staff was required; these staff numbers are now reported in Administration and estates. To aid comparison, the number of staff affected by this change that are disclosed in 2024/25 as administration and estates is 952.

Pensions/retirement benefits and senior employees' remuneration

Accounting policies for pensions and other retirement policies and details of senior employees' remuneration are set out in the notes to the accounts and on pages 67 to 72 of this report.

Off-payroll arrangements

None for 2024/25

Staff exit packages

	2024/25	2023/24				
Exit packages cost band including any special payment element	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**
<£10,000	1	52	53	3	1	4
£10,000 - £25,000	1	6	7	1		1
£25,001 - £50,000	2	3	5	-	-	-
£50,001 - £100,000	-	-	-	-	-	-
£100,001 - £150,000	-	-	-	-	-	-
£150,001 - £200,000	-	-	-	-	-	-
>£200,000	-	-	-	-	-	-
Total number of exit packages by type	4	61	65	4	1	5
Total resource cost	**£105,000**	**£411,000**	**£516,000**	**£29,000**	**£8,000**	**£37,000**

Exit packages: non-compulsory departure payments

	2024/25	2023/24		
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	**£000**	**Number**	**£000**
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations contractual costs	10	172	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	51	239	1	8
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	61	411	1	8
Of which:			-	-
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary			-	-

Value of special severance payments approved by NHS Improvement

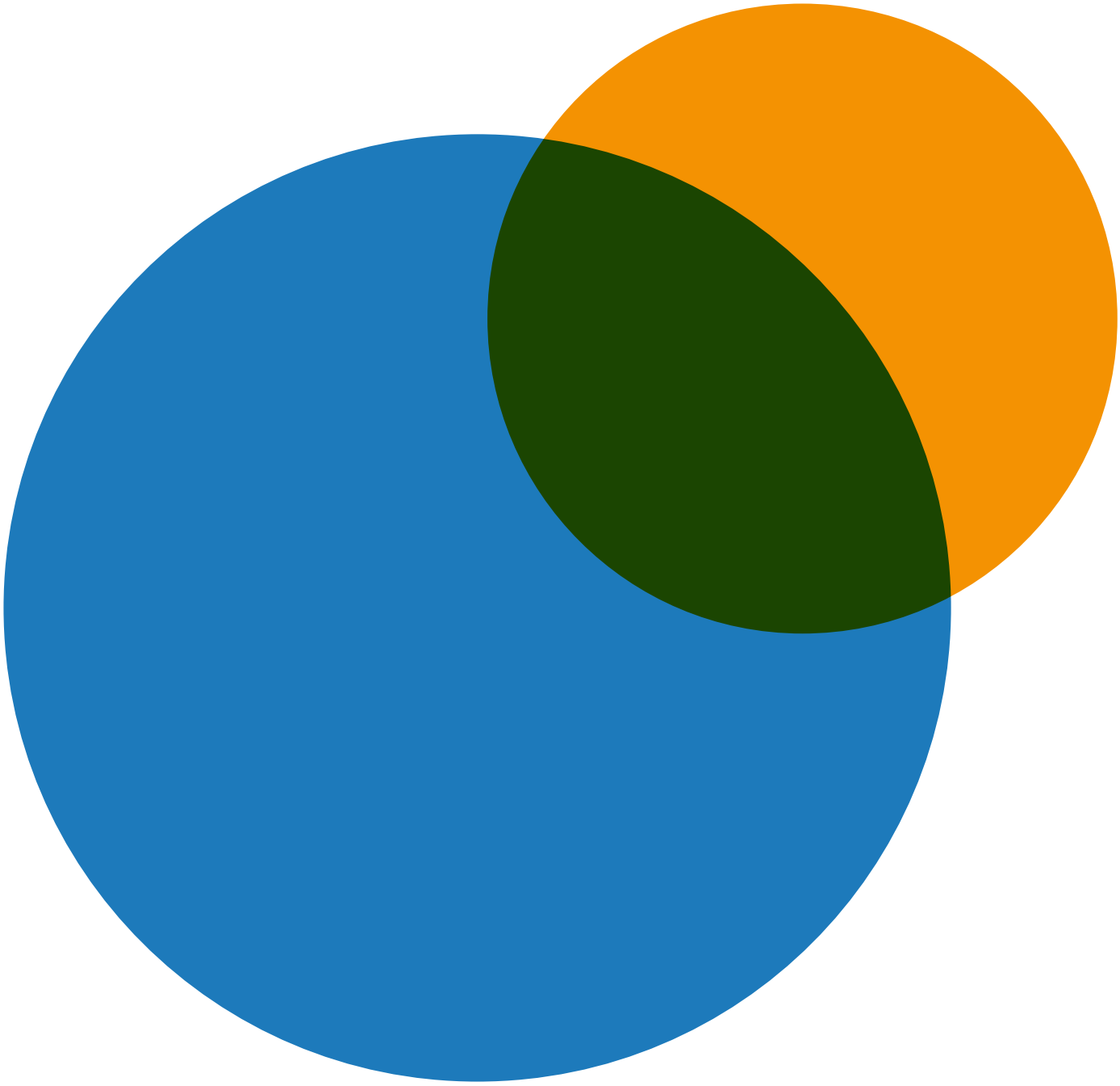
No special severance payments were submitted to NHSI for approval in 2024/25.

Facilities and Time Off for Union Representatives

The 2024–25 collation and reporting of facilities and time off for union representatives falls outside of the timing of this report. Based on 2023–24 however the organisation had a headcount of 51 local trade union representatives, equating to 44.84 whole-time equivalents. Two of these were seconded into our Partnership team for 100% of working hours. Of the remaining representatives:

- There were no representatives who had between 51% and 99% of their working hours as facilities time
- 25 representatives had between 1% and 50% of their working hours as facilities time
- 24 representatives had 0% of their working time as facilities time

The hours spent totalled 3,544.9 and of these 47.9 hours were for paid trade union duties. The total cost of facility time was £81,641.70, representing 0.01% of the pay bill.



DISCLOSURES SET OUT IN THE CODE OF GOVERNANCE FOR NHS PROVIDER TRUSTS

The purpose of the code of governance is to assist NHS Foundation Trust Boards in improving their governance practices by bringing together the best practice of public and private sector corporate governance. The code is issued as best practice advice but requires a number of disclosures to be made within the annual report.

The code of governance for NHS provider trusts contains guidance on good corporate governance. NHSE, as the healthcare sector regulator, is keen to ensure that NHS Foundation Trusts have the autonomy and flexibility to ensure their structures and processes work well for their individual organisations, whilst making sure they meet overall requirements. For this reason, the code is designed around a 'comply or explain' approach.

The new code has been in place since 1 April 2023 and sets out a common overarching framework for the corporate governance of NHS providers (being NHS trusts and NHS foundation trusts), reflecting developments in UK corporate governance and the development of integrated care systems. The Trust is committed to the principles of the Code, which is supported by its robust internal governance arrangements, meets the statutory disclosure requirements in this annual report and also adheres to all other 'comply or explain' requirements.

Comply or explain

NHSE recognises that departure from the specific provisions of the code may be justified in particular circumstances, and reasons for non-compliance with the code should be explained. This 'comply or explain' approach has been in successful operation for many years in the private sector and within the NHS Foundation Trust sector. In providing an explanation for non-compliance, NHS Foundation Trusts are encouraged to demonstrate how its actual practices are consistent with the principle to which the particular provision relates.

Whilst the majority of disclosures are made on a 'comply or explain' basis, there are other disclosures and statements (which we have termed 'mandatory disclosures' in this report) that we are required to make, even where we are fully compliant with the provision.

Mandatory disclosures

Code ref.	Summary of requirement	See page(s):
A.2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	13 - 14
A.2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce	13–14, 62–63
A.2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements	13–14, 62–63

Code ref.	Summary of requirement	See page(s):
B.2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: • has been an employee of the trust within the last two years • has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme • has close family ties with any of the trust's advisers, directors or senior employees • holds cross-directorships or has significant links with other directors through involvement with other companies or bodies • has served on the trust board for more than six years from the date of their first appointment • is an appointed representative of the trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.	31–33
B.2.13	The annual report should give the number of times the board and its committees met, and individual director attendance.	38–41
B.2.17	For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors.	43–47
C.2.5	If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.	66
C.2.8	The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.	65–66
C.4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience	31–36
C.4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.	N/A
C.4.13	The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served • the gender balance of senior management and their direct reports	65–66 77–78
C.5.15	Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	43–44

Code ref.	Summary of requirement	See page(s):
D.2.4	The annual report should include: • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed • an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans • where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	38,110
D.2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy	93
D.2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report	94–110
D.2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report	94–110
D.2.9	The annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare.	94–110
E.2.3	Where a trust releases an executive director, eg to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	N/A
Appendix B, para 2.3 (not in Schedule A)	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	43–47
Appendix B, para 2.14 (not in Schedule A)	The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS foundation trust's website and in the annual report	43–47
Appendix B, para 2.15 (not in Schedule A)	The board of directors should state in the annual report the steps it has taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, eg through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations	43–47
FT ARM Annex 7 to chapter 2	The Task force on climate-related financial disclosures (TFCD) NHS Foundation Trusts are required to follow the 'task force on climate-related financial disclosure' requirements on a comply or explain basis. Entities should disclose how they identify, assess and manage climate related risks as part of the risk management pillar. Metrics and targets used in assessment and management of climate issues should also be disclosed.	23–27

'FT ARM' indicates that the disclosure is required by the NHS Foundation Trust Annual Reporting Manual rather than the code of governance.

Other disclosures in the public interest

NHS Foundation Trusts are public benefit corporations and it is considered to be best practice for the annual report to include 'public interest disclosures' on the Foundation Trust's activities and policies in the areas set out below.

Summary of disclosure	See page(s):
Actions taken to maintain or develop the provision of information to, and consultation with, employees.	79–81
The foundation trust's policies in relation to disabled employees and equal opportunities.	78–79
Information on health and safety performance and occupational health.	77, 79
Information on policies and procedures with respect to countering fraud and corruption.	28
Statement describing the better payment practice code, or any other policy adopted on payment of suppliers, performance achieved and any interest paid under the Late Payment of Commercial Debts (Interest) Act 1998.	20
Details of any consultations completed in the previous year, consultations in progress at the date of the report, or consultations planned for the coming year.	43–44, 62–63
Consultation with local groups and organisations, including the overview and scrutiny committees of local authorities covering the membership areas.	62–63
Any other public and patient involvement activities.	56
The number of and average additional pension liabilities for, individuals who retired early on ill-health grounds during the year.	Note 5.2 to the accounts
Detailed disclosures in relation to "other income" where "other income" in the notes to the accounts is significant.	Note 2.5 to the accounts
A statement that the NHS Foundation Trust has complied with the cost allocation and charging guidance issued by HM Treasury.	21
Sickness absence data.	77
Details of serious incidents involving data loss or confidentiality breach.	108–109

Voluntary disclosures

We have also included a number of 'voluntary disclosures' (as defined by the Foundation Trust annual reporting manual) in this report. These can be found as follows:

Summary of disclosure	See page(s):
Sustainability / environmental reporting	23–27
Equality reporting	78–79
Slavery and human trafficking statement (Modern Slavery Act 2015)	28

NHS OVERSIGHT FRAMEWORK

NHS England's NHS Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. NHS organisations are allocated to one of four 'segments'.

A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). A segment does not determine specific support requirements. By default, all NHS organisations are allocated to segment 2 unless the criteria for moving into another segment are met. These criteria have two components:

(a) objective and measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics (the themes are: quality of care; access and outcomes; people; preventing ill-health and reducing inequalities; leadership and capability; finance and use of resources; local strategic priorities)

(b) additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity.

An NHS Foundation Trust will be in segment 3 or 4 only where it has been found to be in breach or suspected breach of its licence conditions.

Segmentation

The deteriorating financial position the trust led to a decision by NHSE to move the Trust from Segment 3 to segment 4 (for finance only) in February 2025 and this remains the Trust's position as at 31 March 2025. As a result the Trust will receive support from the National Recovery Support Programme (RSP). Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website: https://www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/. At the same time a decision was taken by NHS England to issue a Notice of Intent to impose an Additional Licence Condition pursuant to Section 111 of the Health and Social Care Act 2012 – 'Additional governance arrangements'.

The Trust fully recognises the need to improve its financial situation and return to full compliance with its licence conditions. To do this the trust has engaged closely with NHSE and intends to make full use of the support offered through the Recovery Support Programme (RSP). Internally the Trust operates a detailed Waste Recovery Programme designed to deliver on efficiency initiatives through all areas of the Trust and is independently advised on this by PwC, and with internal advice provided by a specialist Turnaround Director. The financial recovery and associated improvements in service efficiency is monitored by the Board of Directors through the Trust Single Improvement Plan. Externally the Trust is held to account for the delivery of its financial improvement through the Improvement and Assurance Group operated by PwC on behalf of NHSE North West Region.

In maintaining focus on the above the Trust is cognisant of its overriding duty of care to deliver patient safety and maintain its segment 3 status for quality.

STATEMENT OF ACCOUNTING OFFICER'S RESPONSIBILITIES

Statement of the Chief Executive's responsibilities as the accounting officer of Lancashire Teaching Hospitals NHS Foundation Trust.

The NHS Act 2006 states that the Chief Executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHSE.

NHS England has given Accounts Directions which require Lancashire Teaching Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Lancashire Teaching Hospitals NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHSE including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance;
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy; and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the Foundation Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Professor Silas Nicholls
Chief Executive
26 June 2025

ANNUAL GOVERNANCE STATEMENT 2024–25

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Lancashire Teaching Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Lancashire Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2025 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Leadership and accountability

The Chief Executive has overall responsibility for ensuring that effective risk management systems are in place within the Trust, for meeting all statutory requirements, and for adhering to guidance issued by NHS Improvement and other regulatory bodies in respect of risk and governance. The Chief Executive ensures the work of the Committees of the Board, is reviewed by the Board of Directors.

The Trust has the capacity to handle risk through delegated responsibilities in place as defined in the Scheme of Reservation and Delegation of Powers, and the Risk Management Policy, both of which are approved by the Board of Directors. The Policy outlines the Trust's approach to risk, accountability arrangements and the risk management process including identification, analysis, evaluation and approval of the risk appetite and tolerance.

Accountability arrangements for risk management in 2024–25:

the Board of Directors has overall responsibility for ensuring robust systems of internal control, encouraging a culture of risk management, routinely considering risks and defining its appetite for risk;

(a) Committees of the Board scrutinise those risks that fall within their terms of reference on behalf of the Board of Directors, recommending new or revised risks to the Board as appropriate;

(b) the Audit Committee on behalf of the Board of Directors ensures that the Trust's risk management systems and processes are robust;

(c) the Risk Management Group started in March 2024, Chaired by the Chief Executive, and this meeting is now responsible for the Risk Management arrangements across the Trust, which includes reviewing risks relevant to its remit and advising all Committees of the Board on potential/existing strategically significant risks, as well as liaising with the Divisional Boards and Groups to ensure the consistency of risk reporting and also overseeing the Trust's Risk Register;

(d) the Chief Executive, as the Trust's Accountable Officer, has overall responsibility for the risk management processes, the Risk Management Strategy 2024–27, and the Risk Management Policy;

(e) the Chief Nursing Officer/Deputy Chief Executive and Chief Medical Officer, supported by the Associate Director of Risk and Assurance, Associate Director of Safety and Learning, Deputy Chief Nursing Officer(s), Deputy Chief Medical Officer (s), and Director of Corporate Affairs, advise the Trust Board on all matters relating to governance, risk and quality;

(f) each member of the Executive Team has responsibility for the identification and management of risks within their executive portfolios;

(g) the Executive Chief Finance Officer has responsibility for ensuring that the Trust has sound financial arrangements that are controlled and monitored through financial regulations and policies;

(h) the Deputy Chief Information Officer is responsible for ensuring that there are mechanisms in place for assuring the quality and accuracy of the performance data which informs reporting; and

(i) the Nominated Individual with the Care Quality Commission (CQC) is the Chief Nursing Officer.

The Board Assurance Framework and Risk Register have been regularly scrutinised and reviewed through the Trust's governance structure and have been subject to internal and external reviews. The Trust's strategic intentions, policies, procedures, and supporting documentation are openly accessible via the intranet for all staff to reference.

The existing organisational management structure and Risk Management Policy illustrates the Trust's commitment to effective governance and quality governance, including risk management processes.

There is a central risk management team and a centralised health and safety team, supported by divisional governance and risk teams, led by a Lead Clinical Governance and Risk Manager in each division.

As Accounting Officer, I have overall accountability for risk management within the Trust, however the Risk Management Policy describes the responsibility of every member of staff to recognise, respond to, report, record and reduce risks while they are undertaking work for the Trust.

Training and learning

Following approval of the Risk Management Strategy 2024–27, the training needs analysis (TNA) was refreshed and training identified for colleagues across the organisation in relation to Risk Management.

Training has commenced in the form of face to face Risk Management Workshops and an e-learning package has been developed, which is due to be rolled out. Deep dive training has also been provided to Divisional Governance teams in this financial year to support individual and collective deep dives of risks. System training is provided for colleagues through the Datix training programme which is available to all staff.

Mandatory training for all staff reflects essential training needs, and includes an update on risk management processes for topical areas such as health and safety, fire safety, infection prevention and control, safeguarding children and vulnerable adults, patient safety for all staff, information governance, moving and handling, conflict resolution, fraud and bribery in the NHS, and equality, diversity and human rights.

Training for individual roles continues to be identified by managers and agreed with staff through personal development plans.

During 2024–25, a risk workshop took place to provide training for Executive and Non-Executive Directors. As part of the session, the risk appetite and tolerances were reviewed and subsequently approved by the Board of Directors.

Monitoring of training compliance and escalation arrangements are in place via the Education, Training and Research Committee, and the Divisional Improvement Forums to ensure that the Trust maintains good performance and can ensure targeted action in respect of areas or staff groups where performance is not at the required level. Where performance is below expected levels, the Trust Executive Team oversees tailored support for the Divisions and Corporate Teams in line with the Accountability Framework to underpin sustainable improvement and delivery of plans, objectives and required outcomes.

Trust policies are available on the Trust's intranet and staff are encouraged to participate in the consultation of new and updated policies, such as the Risk Management Policy.

As a learning organisation, the Trust takes an Always Safety First approach and has a strategy which seeks to ensure good practice is identified and shared via corporate and divisional governance arrangements using multiple mediums, learning from mortality reviews, complaints, incidents and claims to reduce the risk of

repeated issues. The Board of Directors receives assurances from the Safety and Quality Committee relating to the management of all serious untoward incidents, including Never Events.

The risk and control framework

The management of risk

Risk management is a fundamental part of operational working and service delivery. As set out in the Risk Management Policy, it is the responsibility of all employees and requires commitment and collaboration of both clinical and non-clinical staff.

The development of effective risk management across the organisation is underpinned by clear processes and procedures which include:

(a) a Risk Management Strategy 2024–27;

(b) the Trust's Risk Management Policy;

(c) training for colleagues in the correct application of the policy;

(d) the organisational process for risk identification and analysis;

(e) organisational risk management structures;

(f) the development and application of risk registers within the organisation;

(g) incident reporting;

(h) the accountability and responsibility arrangements for risk management; and

(i) the Board Assurance Framework.

Throughout the reporting period the Safety and Quality Committee, Finance and Performance Committee, Workforce Committee and Education, Training and Research Committee were the Committees of the Board charged with scrutinising the arrangements in place for specific areas of risk. They are supported by a number of operational groups, including, but not limited to:

- Trust Management Board
- Risk Management Group
- Divisional Management Groups
- Health and Safety Governance Group
- Infection Prevention and Control Committee
- Medicines Governance Committee
- Patient Experience and Involvement Group
- Safeguarding Board
- Mortality and End of Life Group
- Patient Safety Incident Response Framework (PSIRF) Oversight Panel
- Capital Planning Forum
- Information Governance Forum
- Emergency Preparedness, Resilience and Response Group
- Always Safety First Learning and Improvement
- Raising Concerns Group

These arrangements are supported by the work of the Audit Committee which receives assurances on the effectiveness of the risk management framework annually through the Head of Internal Audit Opinion. This is based on an Internal Audit Programme which tests key aspects of the Trust's governance arrangements through a series of risk-based reviews undertaken throughout the year, which are also reported to the Audit Committee.

Risk Management Strategy

In pursuit of excellence in its risk management arrangements, the Trust developed a new Risk Management Strategy 2024–27, which has been in place since February 2024.

Good progress has been made in the first year of the strategy with positive steps taken across all areas. Some key areas of improvement this year include:

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

The Risk Management Policy

The Trust's Risk Management Policy provides a framework for managing risk within the Trust and outlines the objectives and structures in place to support the management of risk across the organisation.

The policy defines risk in the context of clinical, health and safety, organisational, business, information, financial or environmental risk and also provides a definition of risk management. It details the Trust's approach to:

- the provision of high-quality services to the public in ways aimed at securing the best outcome for all involved. To this end, the Trust ensures that appropriate measures are in place to reduce or minimise risks to everyone for whom we have a responsibility;
- the implementation of policies and training to ensure that all appropriate staff are competent to identify risks, are aware of the steps needed to address them and have authority to act;
- management action to assess all identified risks and the steps needed to minimise them. This comprises continuous evaluation, monitoring and reassessment of these risks and the resultant actions required;
- the designation of Executive leads with responsibility for implementation of the policy and the execution of risk management through operational groups and monitoring committees;
- action plans to maintain compliance with regulatory standards, which contribute to the delivery of the risk control framework; and
- the process by which risks are evaluated and controlled throughout the organisation. In support of the Risk Management Policy, a range of supplementary policies exist that provide clear guidance for staff on how to deal with concerns, complaints, claims, accidents and incidents on behalf of patients, visitors or themselves.

To ensure consistency, risks are systematically identified using a standardised approach. The potential consequence and likelihood of the risk occurring are scored and the sum of these scores determines the level in the organisation at which the risk is reported and monitored to ensure effective mitigation. Risk control measures are identified and implemented to reduce the potential for harm. A target risk score is created and monitored through the risk management process. In recognition that a risk may not be eliminated, this score must be set at the lowest tolerable level.

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

The Risk Management Group oversees Risk Management arrangements within the Trust and this is chaired by the Chief Executive. The group has a cycle of business and this includes consideration of Divisional / Departmental reports on a cyclical basis to allow oversight, monitoring and escalation of risk areas. The Risk Management Group is able to escalate operational risks of concern to the appropriate Committee of the Board for further consideration when required and the Committee in turn is able to choose to escalate an operational risk of concern to the Board of Directors for oversight.

The Trust has in place a Board Assurance Framework (BAF), which is designed to provide a structure and process to enable the Trust to identify those strategic and operational risks that may compromise the achievement of the Trust's high level strategic objectives. In December 2024, the Board Assurance Framework was revised to a Principal Risk approach. Principal Risks are risks to the delivery of the Trust's corporate objectives, which are considered most likely to materialize, and those which are likely to have the greatest adverse impact on delivery. Corporate objectives are set annually by the Board of Directors and any risks to delivery have the potential to affect the ability to deliver the overall strategic objectives of the Trust.

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

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

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

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

There is a continued focus on risk maturity and this is being achieved through the continued embedding of risk management within the Trust by various means, including:

- Delivery of Year 1 of the Risk Management Strategy 2024–27.
- The Risk Management Policy, which is available to all staff through the Trust's intranet.
- Effective use of the Principal, and operational risk registers at both divisional and corporate level, and the BAF.
- Operation of the Risk Management Group chaired by the Chief Executive.
- Risk Management training rolled out in the form of Workshops. Positive feedback received from those attending the sessions.
- Compliance with the mechanisms for the reporting of all accidents and incidents using an online incident reporting system.
- Ensuring that there is a robust process in place to escalate all risks with a rating of 15+ to Committees of the Board and the Board, if required.

- Embedding the use of dashboards, including themes, risk appetite, heat-maps, trajectory of risk and qualitative narrative on actions and mitigations.
- Strengthening of divisional accountability processes through Divisional Boards and the Accountability Framework through challenging performance of risk at Clinical Business Unit and Speciality Business Unit level.
- Continued training at all levels of the organisation in line with the National Patient Safety Strategy.
- Actively monitoring PSIRF implementation at the Safety and Quality Committee on a quarterly basis, and the Board annually.
- Engaging with the Board of Directors using risk information to drive the Board workshop agenda.
- Using outcomes from complaints, incidents, claims, Safety Triangulation Accreditation Review (STAR) visits and internal and external reviews, to mitigate future risks and aggregating these to identify Trust-wide risks.
- Creating an open and accountable reporting culture whereby staff are encouraged to identify and report risk issues.
- Risks within Committee papers are connected to strategic risks within the BAF.
- 'Freedom to Speak Up Guardian' and champions in place for staff to raise concerns. The team are promoted within the Trust and any concerns are triangulated with other processes for management, improvement and shared learning.
- Use of an equality impact assessment policy which links to the planning framework and outlines the requirements of divisional management and Board members in assessing and monitoring the impact of service changes.

Risk Appetite

The Trust's Risk Appetite Statement and tolerance levels were reviewed and approved at the Board of Directors in June 2024, with no changes from the previous year.

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

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

The revised Risk Appetite Statement adopted by the Board of Directors from 5 December 2024 is:

Providing safe and effective care for patients is paramount and so we have a low tolerance of risks which would adversely affect the quality and safety of clinical care. However, to deliver excellent care for Patients, our Performance needs to support the delivery of timely, effective care and we recognise that, in pursuit of these overriding objectives, we may need to take other types of risk which impact on different organisational objectives. Overall, our risk appetite in relation to Patients and Performance is cautious – we prefer safe delivery options with a low degree of residual risk, and we work to regulatory standards.

We have an open appetite for those risks which we need to take in pursuit of our commitment to being a Great Place to Work for our People. By being open to risk, we mean that we are willing to consider all potential delivery options which provide an acceptable level of reward to our organisation, its staff and those who it serves. We tolerate some risk in relation to this aim when making changes intended to benefit patients and services. However, in recognising the need for a strong and committed workforce with the right skills and knowledge, this tolerance does not extend to risks which compromise the safety of our People, or undermine our Trust values.

We also have an open appetite for risk in relation to our strategic objective in relation to Productivity, to Deliver Value for Money. However, we are also committed to work within our statutory financial duties, regulatory undertakings, and our own financial procedures which exist to ensure probity and economy in the Trust's use of public funds.

We seek to be Fit for the Future through our commitment to working in Partnership with organisations in the local health and social care system to make current services sustainable and develop new ones. In pursuit of these aims, we will, where necessary, seek risk - meaning that we are eager to be innovative and will seek options offering higher rewards and benefits, recognising the inherent business risks.

Quality Governance

The Trust has strong quality governance arrangements in place, which are overseen by the Safety and Quality Committee, a Committee of the Board. There is a thorough cycle of business in place to ensure assurance is received about safety, patient experience and effectiveness.

A suite of quality metrics are provided in a Safety & Quality Dashboard on a monthly basis to the Safety and Quality Committee to track performance, which support the Committee in understanding areas to focus attention. This is replicated in other Committees of the Board where integrated performance report metrics are aligned to the relevant Committee. The Board of Directors also receive an Integrated Performance Report with a full range of metrics included to track performance.

This approach is replicated at divisional level with a detailed set of key performance indicators produced for divisions. These are considered as part of Divisional Improvement Forums (DIFs) which are chaired by a member of the Executive Team as part of the Accountability Framework.

Safety, Quality and Patient Experience

The Trust has in place a range of mechanisms for managing and monitoring risks in respect of safety and quality including:

- An Always Safety First Strategy which concluded in 2024, with a revised version in development.
- A Patient Experience and Involvement Strategy 2022–2025, which sets out the approach to involving patients, service users and their carers.
- Utilising the Patient Safety Incident Response Framework (PSIRF) to investigate and learn from incidents.
- Three Patient Safety Partners are actively embedded in the organisation and provide the voice of the patient during meetings and activities of the Trust.
- A Safety and Quality Committee which meets monthly and is chaired by a Non-Executive Director.
- Publication of an Annual Quality Account (Report) as a separate document to the Annual Report.
- Arrangements and monitoring processes to ensure ongoing compliance with National Institute for Health and Care Excellence (NICE) guidance and service accreditation standards.
- A Deputy Chief Medical Officer who is the Trust Lead for mortality and reports regularly to the Safety and Quality Committee in respect of mortality.
- Safety Triangulation Accreditation Review (STAR) Quality Assurance Framework is operated in all clinical departments.
- Patient Safety Leadership Visits began in early 2024, with participation from the Senior Nursing, Midwifery, AHP, and Clinical Governance Leadership Teams. These visits are a critical component of our organisation's approach to ensuring the quality and safety of care. Conducted monthly, they focus on pre-identified topics or issues. Senior leaders visit various wards and departments to observe, identify good practice, and highlight areas for improvement. The aim is to enhance the STAR quality assurance process, provide additional assurance, drive improvements, increase visibility, and model behaviors for addressing challenging themes identified through the STAR process or other insights and intelligence.
- A Board Safety and Experience Programme is in place to maintain Board visibility and contact with staff delivering services.
- A safe staffing dashboard is in place to monitor nurse staffing levels across all wards and departments and a monthly staffing report is presented to the Safety and Quality Committee through the mandated safe staffing report. This is triangulated with incidents, patient experience (friends and family test) for maternity services, children and neonatal services and adult inpatients, including the Emergency Department.

- The Trust routinely considers and acts upon the recommendations of national quality benchmarking exercises, e.g. national patient surveys and other national publications, such as reports from the Health Services Safety Investigations Body (HSSIB) and the Maternity and Newborn Safety Investigations (MNSI) programme.
- The Trust acts upon patient feedback from complaints and concerns and from feedback from Patient and Public Involvement representatives, such as Healthwatch and Trust governors.
- Patient and staff stories are presented to the Trust Board and actions and lessons learned are widely shared.
- There is a process for the management of all patient safety and medical device alerts, prescribing and drug alerts, field safety notices, estates and facilities alerts, service disruption alerts and all alerts that arise as a result of actions identified by NHS Improvement, or other national bodies are acted upon.
- Where appropriate, risk alerts are made to partner organisations in line with statutory responsibilities, such as for safeguarding purposes.
- Operational and quality breaches are discussed at the relevant operational and governance forums and Integrated Care Board (ICB) meetings with remedial action plans enacted.

Patient Safety Incident Response Framework

In line with the requirements of the National Patient Safety Strategy, the Trust has transitioned from the Serious Incident Framework to the Patient Safety Incident Response Framework (PSIRF).

A PSIRF policy and the Trust's Patient Safety Incident Response plan were developed and revised governance processes were implemented to support the transition. The Trust is currently reviewing the activity and learning since the implementation of PSIRF to determine if any new priorities should be adopted. Progress with implementation of PSIRF is monitored by the Safety and Quality Committee.

Clinical Effectiveness

With respect to clinical audit, the Trust has an annual clinical audit and effectiveness plan that is developed and agreed for the forthcoming year, which incorporates national mandatory audits , corporate audits, audits associated with Trust-wide priorities including those linked to the national and locally agreed PSIRF priorities, audits of national policies and guidelines, as well as other audits commissioned specifically in response to areas of identified risk and concern. The Chief Medical Officer has an identified Deputy Chief Medical Officer who is the Trust Lead for Clinical Audit and Effectiveness.

The Audit Committee and the Safety and Quality Committee both receive clinical audit and effectiveness reports to provide assurance that the Trust has effective controls in place and is responsive to areas of concern, which may have been highlighted through the audit process, as well as audit outcomes which demonstrates best practice against defined standards. The clinical audit and effectiveness reports also provide evidence that health professionals are providing care that is both evidence-based and up to date.

Capacity and Flow

The NHS continued to be faced with significant pressures in 2024–25 and like all other NHS Trusts across the country Lancashire Teaching Hospitals remained challenged by non-elective demand for services and shortfalls in community capacity to allow timely discharge. As a result, performance across the board, both emergency and elective continued to be impacted with operational pressures experienced through the year resulting in non-compliance in relation to a number of key standards.

As a result of barriers to timely discharge, high levels of bed occupancy were noted. Mitigating actions included the roll out of a 'Continuous Flow Model' which has driven discharge earlier in the day, greater utilisation of the discharge lounge and reduced the dependence on the use of escalation beds. Additionally, there has been a focus on increasing pathways away from the Emergency Department through virtual ward and Same Day Emergency Care, for example. A system-wide Central Lancashire improvement plan for 25/26 has been developed and will seek to significantly expand the 'Hospital@Home' provision and focus on improved discharge flow via the development of strengths based approaches, reducing deconditioning and improving discharge processes.

During 2024/5 the Trust put in place a range of measures:

- Mobilised a revised Acute Medicine model of care
- Increased the Virtual Ward utilisation for Frailty, Respiratory and Acute Medicine.
- Increased Same Day Emergency Care pathways and utilisation
- Revised the internal escalation management processes
- Mobilised a Continuous Flow Model
- Revised and mobilised a standard Ward & Board round process

Safety Triangulation Accreditation Review (STAR) Quality Assurance Framework

The Trust ensures assurance of delivery of CQC standards and recommendations through the Trust's Safety Triangulation Accreditation Review (STAR) Quality Assurance Framework which provides evidence of the standard of care delivery, including what works well and where further improvements are required through STAR Monthly reviews, STAR Accreditation Visits and Ward/Clinical Department to Board reporting arrangements on STAR outcomes. Governors are also included in our risk management approach through inclusion in the STAR initiative.

Data Quality and Security

The Trust has a clear focus on data quality. Performance information is triangulated with other known information to identify any areas of weakness and where data requires further exploration, specific reviews are undertaken. The Trust is regularly audited on data quality and in the last few years has been audited on referral to treatment waiting lists and its data quality framework and clinical coding quality. The Trust is also audited each year for its data security and prevention tool kit submissions which includes both security and data quality components.

The Trust is also monitored monthly through the national data quality maturity index which looks at the quality of both the commissioning data sets and Waiting List National Minimum Dataset submissions.

The Trust has a risk, scoring 15, related to the potential for a cyber-attack. The risk is reviewed and updated monthly as controls are continuously improved to counter increasing threats. The Trust continues to meet NHSE alerts and received substantial assurance for its most recent Data Security and Prevention Tool Kit assessment.

Principal risks

The most significant risks that threaten the achievement of the Trust's aims and ambitions are identified within the Board Assurance Framework (BAF), alongside controls and assurances which describe how the Trust manages and mitigates these risks.

The BAF is the mechanism by which the Trust evaluates the risks that could impact on the achievement of the Trust's strategic objectives.

A review of the Board Assurance Framework was undertaken during the year, with the new framework formally adopted in December 2024. This concluded that the Trust should change from a strategic risk approach to a principal risk approach. This had the potential to improve risk prioritisation linked to the delivery of the annually developed corporate objectives, which are designed to support delivery of the overall strategic objectives of the organisation.

Strategic Risks April – December 2024

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

Principal Risks December 2024 onwards

Ref	Principal Risk	Exec Lead	5Ps	Reporting Committee	Risk Appetite	Risk Tolerance	Score at 31.03.25
PR1 (24/25)	Patient experience within the urgent and emergency care pathway	CNO	Patients	SQC	Cautious	1–6	15
PR2 (24/25)	Higher than trajectory rates of clostridioides difficile (C.difficile) Infection	CNO	Patients	SQC	Cautious	1–6	20
PR3 (24/25)	People experiencing Health inequalities	CNO	Patients	SQC	Cautious	1–6	12
PR4 (24/25)	Timely access to planned and cancer care	COO	Performance	FPC	Cautious	1–6	16
PR5 (24/25)	Timely access to urgent and emergency care	COO	Performance	FPC	Cautious	1–6	20
PR6 (24/25)	Reliance on temporary medical workforce	CMO	People	WFC	Open	4–8	16
PR7 (24/25)	Experience of under-represented staff groups	CPO	People	WFC	Open	4–8	12

Ref	Principal Risk	Exec Lead	5Ps	Reporting Committee	Risk Appetite	Risk Tolerance	Score at 31.03.25
PR8 (24/25)	Sub-optimal experience of Resident Doctors	CPO	People	ETR	Open	4–8	12
PR9 (24/25)	Failure to effectively manage staff absence and achieve Trust and National target rates	CPO	People	WFC	Open	4–8	12
PR10 (24/25)	Compliance with Core Skills Training & Appraisals	CPO	People	ETR	Open	4–8	12
PR11 (24/25)	Failure to meet the financial plan 2024/25	CFO	Productivity	FPC	Open	8–12	20
PR12 (24/25)	Cash consequences of the Trust's underlying financial position	CFO	Productivity	FPC	Open	8–12	12
PR13 (24/25)	Ability to access required Capital	CFO	Productivity	FPC	Open	8–12	16
PR14 (24/25)	Readiness for the New Hospital Programme	CFO	Partnership	NHP	Seek	8–12	4
PR15 (24/25)	Research capacity and capability to enable progress towards University Hospital status	DIRI & CMO	Partnership	ETR	Seek	8–12	12
PR16 (24/25)	Implementing the long term strategy for the Trust	DIRI & CMO	Partnership	FPC	Seek	8–12	12

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

Principal Risk 14 is now considered controlled in that the delayed timescales to the New Hospitals Programme meant there was limited risk to the delivery of the associated Corporate Objective.

Operational High Risks escalated to Board:

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

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

- Principal Risk 1 – Patient experience within the urgent and emergency care pathway.
- Principal Risk 5 - Timely access to urgent and emergency care.

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

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

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

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

Well-Led

The Trust, as a whole, reviews its own leadership and governance arrangements periodically, in line with the requirements of NHS Improvement that providers carry out developmental reviews.

Following the Care Quality Commission (CQC) Well Led inspection in 2019, the Trust developed a Well Led and Governance Maturity Plan to drive improvement in the Well Led domain of the organisation and this incorporated recommendations from a review undertaken of the divisional governance arrangements by the Quality Governance Lead from the Nursing Directorate at NHSE/I which identified the Trust as an exemplar organisation in October 2020, a Risk Maturity Self-Assessment tool supported by Mersey Internal Audit Agency (MIAA), and a MIAA developmental Well Led review in February 2021. In addition, two external consultants were engaged from July 2021 to November 2022. Firstly, an external leadership consultant undertook a series of development sessions with the Board. Secondly, the Trust commissioned a Risk and Assurance review by an external provider from February 2022 to November 2022.

The Trust was inspected by CQC between May 2023 and July 2023, which incorporated a Well Led inspection, and the subsequent publication of the report in November 2023.

Although all core services across the Royal Preston and Chorley sites were rated as good for Well Led, the overall Well Led rating for the Trust declined from good to requires improvement. A quality improvement plan was developed in response to the inspection, which is being monitored by the Safety & Quality Committee.

The Trust plans to undertake a Well Led Development review in 2025/26.

Effectiveness of Governance and Risk Maturity

The effectiveness of the Trust's governance structures continued to be internally tested during 2024–25 via the process of internal and external audit, inspections, national audits and national staff surveys.

The Trust undertook an internal self-assessment of Risk Maturity at Division / Department and Trust level in 2024–25. The outcome was positive and identified some areas of further development to support the Trust Risk Management Strategy 2024 – 27 aim to reach the highest levels of Risk Maturity across the Trust.

Workforce

To ensure that short, medium, and long-term workforce strategies and staffing systems are in place, the Trust has an annual workforce plan in place aligned to the operational planning cycle with a focus on resourcing strategies to fill long-term or hard to fill workforce gaps.

This is reviewed and approved by the Finance and Performance Committee, Workforce Committee, signed off by the Executive team and commended to the Board. The workforce plan takes into account changes to services, investment and cost improvement plans, recruitment issues, turnover, and predictive workforce supply. It also considers external factors that may influence services, including commissioning strategies, service transformations, nursing acuity reviews and local workforce challenges such as gaps in establishment, retention issues, roles which are difficult to fill, new roles, training opportunities and apprenticeships. Workforce growth is included in plan where this has been fully financially approved. However, ultimately the workforce plan must produce a deliverable plan within the approved financial envelope.

To balance workforce supply and demand, workforce plans and regular skills gap analysis have taken place to inform localised or profession-specific recruitment and retention plans. These plans detail the programme of activity to reduce gaps through proactive campaigns around hard to fill posts.

Actions have also been identified to look at opportunities to work across the ICS to support workforce supply.

Recruitment trajectories are monitored and reviewed by the Workforce Committee for key staff groups such as nurses and healthcare support workers. There continues to be a focus on reducing premium spend, filling hard to fill medical posts and health care support worker recruitment.

Care Quality Commission

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

The Trust has completed the majority of actions following the CQC inspection undertaken in 2023, with 6 of the 54 outstanding and progress is monitored by Safety and Quality Committee and the Board of Directors.

The Foundation Trust is fully compliant with the registration requirements of the CQC.

Declarations of Interest

The foundation trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff, as defined by the Trust's Policy TP-200 Code of Business Conduct, within the past twelve months and as required by the 'Managing Conflicts of Interest in the NHS guidance.

NHS Pension scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Equality and Diversity Legislation

Control measures are in place to ensure that all the organisation's obligations under equality and diversity legislation are complied with.

As required through the NHS Standard Contract the Trust completes and publishes compliance against the Workforce Race Equality Standard process and the Workforce Disability Equality Standard.

Greener NHS Programme

The foundation trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

We have continued to develop our systems and processes to help us deliver an improvement in the financial performance, including:

- Trust-wide commitment to the adoption of a Single Improvement Plan approach, which has involved undertaking extensive staff engagement to identify priorities for improvement and is informing the development of a system wide Continuous Improvement Strategy for the whole health economy;
- approval of the annual budget by the Board;
- monthly Finance and Performance Committee meetings to ensure Directors meet their respective financial targets reporting to the Board;
- monthly Divisional Improvement Forums attended by members of the Executive Team to ensure that Divisions meet the required level of performance for key areas including financial targets;
- full implementation of the Investigation and Intervention improvement actions around Grip and Control, including development of a weekly temporary pay tracker for banks usage at ward level.
- Refreshed the governance structure for the Waste Reduction Programme with the programme board chaired by the CEO and all programmes having an Executive Director sponsor
- appointment of a Turnaround Director to further enhance the above and support development of the forward savings programme with the development of the Project Management Office
- with the additional temporary support of advisors building an approach to service reviews using SLR and other benchmark data from NHSE to identify saving opportunities
- in combination with the above support savings programme development through "rapid improvement weeks" which facilitates operation team members coming together to identify efficiencies through service redesign
- actively engaging in the One LSC finance programme to develop best in class processes within the finance function which will be mobilised in 2025/26. Impact in 2024/25 being a consistent approach to planning assumptions in quarter four for the new financial year across the Lancs and South Cumbria System focused on exit run-rate as the start point for planning assumptions
- the Trust continues to have in place a 'Quality Impact Assessment' and robust governance systems that require clinical approval of all cost improvement programme schemes that have a clinical impact.

In addition, the Trust has worked with a number of independent organisations during the year on financial recovery and sustainability. These reviews were undertaken by

- Ernst & Young
- Simon Worthington
- PA Consulting
- PWC

Financial Sustainability

During the 2024/25 financial year the Trust delivered a deficit of £36.3m, this is inclusive of £21.9m of central deficit support funding.

The underlying deficit of the Trust, local year on year pressures and funding reductions due to The Lancashire & South Cumbria Health System being above its fair share funding resulted in the Trust's annual efficiency requirement being significantly in excess of the national headline efficiency target of 1.1% with the Trust setting a savings target of £58m (6.9%).

The Trust underdelivered on its savings target by £26.4m and shortfalls in planned income for frailty and intermediate care account for a further £5.5m of the shortfall with the balance driven by operational pressures including those arising from volume growth where income is fixed e.g. renal services and pathology.

The ramp up in the Trusts savings target increased materially from the second half of the financial year, which is when the Trust started to deviate materially from plan. This resulted in escalation actions with NHS England in the autumn and the revised undertakings agreed in February 2025.

Trust Clinical Strategy

The Integrated Care System has developed a clinical blueprint which outlines the key principles for service development and redesign. The Trust has a Clinical Strategy which has driven the clinical service developments in year. The Trust also has a health inequalities action plan which has been designed in collaboration with system partners to focus on reducing health inequalities across our local population. In line with the national priorities to move from analogue to digital, treatment to prevention and hospital to community, our strategy has been refocused to deliver the national priorities.

Information Governance

The confidentiality and security of information regarding patients, staff and the Trust is maintained through governance and control policies, all of which support current legislation and is reviewed on a regular basis. Personal information is, increasingly, held electronically within secure IT systems. It is inevitable that in a complex NHS organisation a small number of data security incidents occur. The Trust is diligent in its reporting and investigation of such incidents, in line with statutory, regulatory, and best practice obligations. Any incident involving a breach of personal data is handled under the Trust's risk and control framework, graded and the more serious incidents are reported to the Department of Health and Social Care and the Information Commissioner's Office (ICO) where appropriate.

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

As part of our annual assessment, the Data Security Protection Toolkit (DPST) is reviewed annually and updated to ensure Trust standards are aligned with statutory obligations. The status for the 2023–24 DSPT is 'standard met'. Progress on this year's DSPT submission has been impacted by the change in approach and reporting framework. A delay in the DSPT supporting guidance documentation being issued together with an earlier baseline submission deadline complicated the completion of the toolkit. For 2024–25 the Trust has therefore taken a prudent approach with an assessment of 'standards not met' together with the commitment to develop and implement an improvement plan to achieve full compliance.

The Trust has established a dedicated information risk framework with Information Asset Owners throughout the organisation which is embedded with responsibilities in ensuring information assets are handled and managed appropriately. There are robust and effective systems, procedures, and practices to identify, manage and control information risks. Alongside training and awareness, incident management is part of the risk management framework and is a mechanism for the immediate reporting and investigation of actual or suspected information security breaches and potential vulnerabilities or weaknesses within the organisation. This will ensure compliance in line with the UK General Data Protection Regulations and the Data Protection Act 2018.

Although the Board of Directors is ultimately responsible for information governance it has delegated responsibility to the Information Governance Records Committee which is accountable to the Finance and Performance Committee. The Information Governance Committee is chaired by the Chief Medical Officer who is also the Caldicott Guardian. The Board appointed Senior Information Risk Owner is the Director of Corporate Affairs.

The Information Governance Management Framework brings together all the statutory requirements, standards, and best practice and in conjunction with the Information Governance Policy, is used to drive continuous improvement in information governance across the organisation. The development of the Information Governance Management Framework is informed by the results from DSPT assessment and by participation in the Information Governance Assurance Framework.

Data quality and governance

The Trust has a clear focus on data quality and good quality information is vital to enable individual staff and the organisation to evidence they are delivering high quality care.

A Data Quality Assurance team, via the Trust's Data Quality Policy and Framework, continuously monitors data looking for, correcting, and feeding back to divisional teams for improved data capture on areas such as:

- Outpatient appointments
- Inpatient/Outpatient commissioning services
- GP information
- Patient demographic data (addresses, date of birth, etc.)
- NHS numbers
- Visits
- Discharge dates
- Length of stay information
- Duplicates

In addition, a separate team validates waiting lists to ensure future events are correctly associated with their original referrals. This involves a combination of algorithmic and human validation with further checks on data consistency performed by the national team as data is submitted. Validated data is updated onto the Trust's electronic patient record.

An external data quality audit in 2023 looking at clinical coding identified areas of focus for ED treatment and investigation code and outpatient procedure code reporting with a recognition that coding in admitted patient care is low risk and supported by good processes. As a result, significant work was undertaken through 2024/25 working with clinical divisions to reconcile activity across clinical systems to improve clinical capture of information, and where possible to automate information capture into the trust EPR. This has improved data quality, activity capture and income generation.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and Safety and Quality Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The process that has been applied in maintaining and reviewing the effectiveness of the system of internal control, includes:

- The Assurance Framework and the monthly performance reports, which provides evidence that the effectiveness of the controls in place to manage the risks to the organisation achieving its principal objectives, have been reviewed.
- All relevant Committees have a clear timetable of meetings, cycles of business and a clear reporting structure to allow issues to be raised.
- The Board undertakes bi-monthly reviews of the BAF, and the Committees of the Board at each meeting undertake detailed scrutiny of assurance received or gaps identified in relation to risks assigned to that particular Committee.

Financial Reporting

The external audit plan for 2024–25 highlighted as significant audit opinion risks:

(i) management override of controls

(ii) fraud risk from expenditure recognition

The Audit Committee has considered the appropriateness of the accounts being prepared on a going concern basis and drawn on the views of management and the external auditors to support the conclusion that it is appropriate for the accounts to be prepared on this basis.

Overall assurances on integrated governance, risk management and internal control

With respect to the internal audit reports issued this year, the table below confirms the assurance levels provided for the work carried out by the internal auditors:

Audits undertaken as part of 2023/24 plan and reported in 2024/25	Assurance Level
Duty of Candour	Moderate
Key Financial Transactional Controls	Moderate
Mortality	Substantial
Risk Management Review	High
Data Quality – Patient Initiated Follow Up (PIFU)	Moderate
Mental Health Assessment and Rapid Tranquillisation	Substantial
IT Business Continuity and Disaster Recovery	Substantial
Data Security and Protection Toolkit	Substantial
Audits undertaken as part of 2024/25 plan	**Assurance Level**
Fit and Proper Persons	Substantial
Sickness Absence Management	Limited
Risk Management Core Controls	Substantial
Key Financial Processing Controls	Substantial
Discharges (no criteria to reside)	Moderate
Medical Job Planning	Substantial
Maternity Triage	Substantial
Data Quality, Waiting List Management (Diagnostics)	Moderate
Mandatory Training	Substantial
Patient Safety Incident Response Framework	Substantial
Health & Safety Governance	Limited
Board Assurance Framework	N/A - advisory
Contingency Insourcing	N/A advisory

The Director of Internal Audit has provided an overall opinion of Substantial Assurance based on the work of internal audit during 2024–25.

Compliance

Following a recommendation from the North West NHS England (NHSE) regional team, it was agreed that Lancashire Teaching Hospitals NHS Foundation Trust would be placed into NHS Oversight Framework (NOF) segment 4 from February 2025. This would enable to Trust to receive support from the National Recovery Support Programme (RSP). Additionally, the North West Regional Support Group determined that the Trust's current Undertakings should be revised in the form of a Variation to Enforcement Undertakings to reflect the Trust's current financial position and to emphasise the actions required to improve this position.

A decision was also taken by NHS England, as a result of the NOF 4 placement, to issue a Notice of Intent to impose an Additional Licence Condition pursuant to Section 111 of the Health and Social Care Act 2012 – 'Additional governance arrangements'.

Existing Quality Undertakings remain unchanged.

Conclusion

In conclusion, my review confirms that Lancashire Teaching Hospitals NHS Foundation Trust has an adequate system of internal control and that there have been no significant control issues at the Trust in 2024–25. Where control issues have been identified, action has been taken or action/ improvement plans are in place to address such issues.

The Trust Board recognises the challenges that the Trust faces to make the necessary service improvements and achieve financial sustainability which will require both a continuous focus by the Trust and a collaborative approach for solutions across the health system. The challenges the Board has focused on to deliver the Trust's aims and ambitions are robustly articulated in the strategic risk register that underpins the BAF in line with the Risk Management Policy.

This Annual Governance Statement is signed on behalf of the Board of Directors by

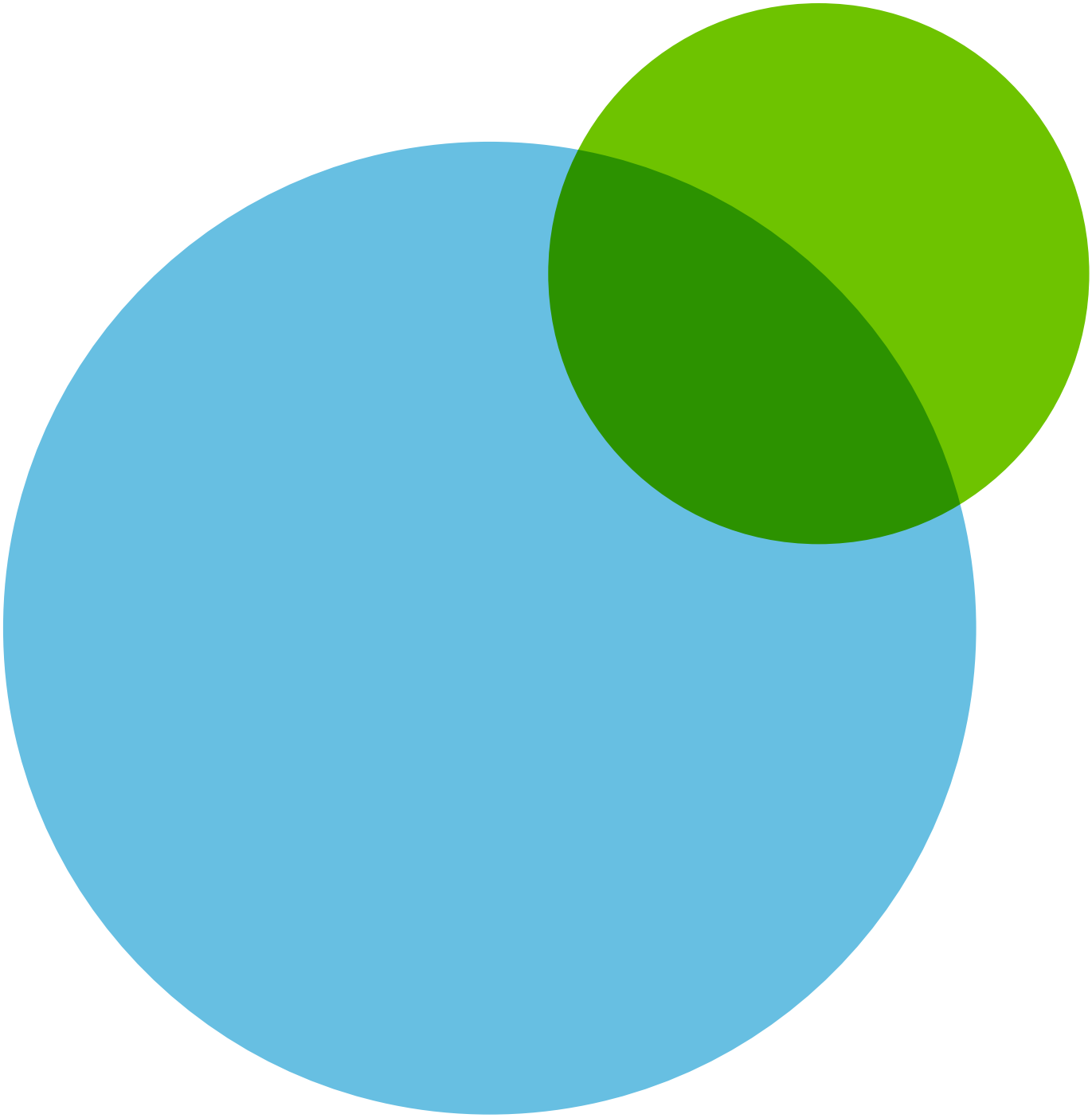
Professor Silas Nicholls
Chief Executive
26 June 2025

This Accountability Report is signed on behalf of the Board of Directors by

Professor Silas Nicholls
Chief Executive
26 June 2025

Lancashire Teaching Hospitals NHS Foundation Trust

FINANCIAL REVIEW 2024–25



INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Lancashire Teaching Hospitals NHS Foundation Trust ("the Trust") for the year ended 31 March 2025 which comprise the Consolidated Statement of Comprehensive Income, Group and Trust Statements of Financial Position, Group and Trust Statements of Changes in Equity and Group and Trust Statements of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Group and the Trust as at 31 March 2025 and of the Group's income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State in February 2025 as being relevant to NHS Foundation Trusts and included in the Department of Health and Social Care Group Accounting Manual 2024/25; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Group in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Accounting Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to either cease the Group and the Trust's services or dissolve the Group and the Trust without the transfer of their services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over their ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accounting Officer's conclusions, we considered the inherent risks associated with the continuity of services provided by the Group and the Trust over the going concern period.

Our conclusions based on this work:

- we consider that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified and concur with the Accounting Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Group's and the Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the Group and the Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to dete*ct*

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the Group's high-level policies and procedures to prevent and detect fraud including the internal audit function, and the Group's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected, or alleged fraud.
- Assessing the incentives for management to manipulate reported financial performance because of the need to achieve financial performance targets delegated to the Group by NHS England
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reading the Group's accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, and taking into account possible pressures to meet delegated targets, we performed procedures to address the risk of management override of controls in particular the risk that Group management may be in a position to make inappropriate accounting entries. On this audit we did not identify a fraud risk related to revenue recognition due to the block nature of the funding provided to the Group during the year. We therefore assessed that there was limited opportunity for the Group and the Trust to manipulate the income that was reported.

The setting of a financial performance target can create an incentive for management to understate the level of non-pay expenditure compared to that which has been incurred. We have therefore recognised a fraud risk related to expenditure recognition, particularly in relation to completeness of year-end accruals This is in line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom.

We also performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included entries made to unrelated accounts linked to the recognition of expenditure, self-approved journals and other unusual journal characteristics.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.
- Performing a search for unrecorded liabilities after year-end to identify any potential missed liabilities by inspecting bank statements and for selected items, assessing whether the liability was recognised in the appropriate period by comparison to supporting documentation

Identifying and responding to risks of material misstatement related to compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the Accounting Officer and other management (as required by auditing standards), and discussed with the Accounting Officer and other management the policies and procedures regarding compliance with laws and regulations.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

Firstly, the Group is subject to laws and regulations that directly affect the financial statements, including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Secondly, the Group is subject to many other laws and regulations where the consequences of non-compliance could have a material effect on amounts or disclosures in the financial statements, for instance through the imposition of fines or litigation. We identified the following areas as those most likely to have such an effect: health and safety, data protection laws, anti-bribery, employment law, recognising the nature of the Group's and the Trust's activities. Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the Accounting Officer and other management and inspection of regulatory and legal correspondence, if any. Therefore, if a breach of operational regulations is not disclosed to us or evident from relevant correspondence, an audit will not detect that breach.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Accounting Officer is responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the NHS Foundation Trust Annual Reporting Manual 2024/25.

Accounting Officer's and Audit Committee's responsibilities

As explained more fully in the statement set out on page 91 the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Group's and the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the Group and the Trust or dissolve the Group and the Trust without the transfer of their services to another public sector entity.

The Audit Committee is responsible for overseeing the Trust's financial reporting process.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

Except for the matter explained below, we have nothing to report in this respect.

Significant weakness - Financial sustainability

The Trust agreed a financial recovery plan (FRP) of £58.0m for 2024/25. In early October 2024, the Trust reported being £1.2m behind the FRP plan (to date) but by mid-October the Trust had informed NHS England that the Trust was now forecasting a £31.9m gap on the forecast FRP delivery. The Trust's final FRP savings delivered were £26.1m.

The projected full-year underperformance in the delivery of cost improvement plans (CIPs), that form part of the FRP, was not reported to the Finance and Performance Committee and Trust Board until October. The level of accountability at divisional level was also not sufficient to ensure there was effective monitoring and risk assessment of the delivery of the CIPs.

As a result, we have identified a significant weakness in the Trust's arrangements for financial sustainability relating to the monitoring and risk assessment of CIPs during the year.

Recommendation

We recommend the Trust strengthen and sustain the arrangements in place to enable a robust level of challenge and risk assessment of cost improvement plans. The Trust should ensure that the risk assessment of those plans is sufficiently prudent to ensure that financial forecasts do not deteriorate unexpectedly due to either their delayed delivery or the value of the efficiency not being as high as predicted. In turn this should ensure that the risks to delivery are appropriately managed and escalated to enable full visibility to the Board of Directors throughout the year.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 91 the Accounting Officer is responsible for ensuring that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Under Section 62(1) and paragraph 1(d) of Schedule 10 of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We are also not required to satisfy ourselves that the Trust has achieved value for money during the year.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- we issue a report in the public interest under paragraph 3 of Schedule 10 of the National Health Service Act 2006; or
- we make a referral to the Regulator under paragraph 6 of Schedule 10 of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure which is unlawful, or is about to take, or has taken, a course of action which, if pursued to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

DELAY IN CERTIFICATION OF COMPLETION OF THE AUDIT

As at the date of this audit report, we are unable to confirm that we have completed our work in respect of the trust accounts consolidation pack of the Trust for the year ended 31 March 2025 because we have not received confirmation from the NAO that the NAO's audit of the Department of Health and Social Care accounts is complete.

Until we have completed this work, we are unable to certify that we have completed the audit of Lancashire Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2025 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the NAO Code of Audit Practice.

Timothy Cutler

for and on behalf of KPMG LLP

Chartered Accountants

1 St Peter's Square

Manchester

M2 3AE

30 June 2025

Lancashire Teaching Hospitals NHS Foundation Trust

Annual accounts for the year ended 31 March 2025

Foreword to the accounts

Lancashire Teaching Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2025, have been prepared by Lancashire Teaching Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed

Name **Silas Nicholls**
Job title **Chief Executive**
Date **26 June 2025**

Consolidated Statement of Comprehensive Income

		Group	
		2024/25	2023/24
	Note	£000	£000
Operating income from patient care activities	2	779,547	731,222
Other operating income	3	86,960	78,722
Operating expenses	6,8	(916,028)	(868,082)
Operating surplus/(deficit) from continuing operations		**(49,521)**	**(58,138)**
Finance income	10	2,568	1,707
Finance expenses	11	(1,222)	(653)
PDC dividends payable		(9,528)	(10,805)
Net finance costs		**(8,182)**	**(9,751)**
Other gains / (losses)	12	(9)	(35)
Surplus / (deficit) for the year from continuing operations		**(57,712)**	**(67,924)**
Surplus / (deficit) for the year		**(57,712)**	**(67,924)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(3,660)	(3,000)
Revaluations		421	4,118
Total comprehensive income / (expense) for the period		**(60,951)**	**(66,806)**
Surplus/ (deficit) for the period attributable to:			
Lancashire Teaching Hospitals NHS Foundation Trust		(57,712)	(67,924)
TOTAL		**(57,712)**	**(67,924)**
Total comprehensive income/ (expense) for the period attributable to:			
Lancashire Teaching Hospitals NHS Foundation Trust		(60,951)	(66,806)
TOTAL		**(60,951)**	**(66,806)**

Statements of Financial Position

		Group		Trust	
		31 March 2025	31 March 2024	31 March 2025	31 March 2024
	Note	£000	£000	£000	£000
Non-current assets					
Intangible assets	14	3,339	9,256	3,339	9,256
Property, plant and equipment	15	353,660	345,836	353,658	345,832
Right of use assets	17	27,886	29,606	27,886	29,606
Receivables	19	6,503	7,032	8,003	8,532
Total non-current assets		**391,388**	**391,730**	**392,886**	**393,226**
Current assets					
Inventories	18	17,926	16,803	15,274	15,851
Receivables	19	41,070	39,678	39,899	39,541
Cash and cash equivalents	20	8,253	36,033	7,505	34,813
Total current assets		**67,249**	**92,514**	**62,678**	**90,205**
Current liabilities					
Trade and other payables	21	(94,310)	(99,490)	(91,237)	(98,677)
Borrowings	23	(10,198)	(8,158)	(10,198)	(8,158)
Provisions	24	(339)	(327)	(339)	(327)
Other liabilities	22	(7,123)	(5,587)	(7,123)	(5,587)
Total current liabilities		**(111,970)**	**(113,562)**	**(108,897)**	**(112,749)**
Total assets less current liabilities		**346,667**	**370,682**	**346,667**	**370,682**
Non-current liabilities					
Borrowings	23	(24,935)	(25,021)	(24,935)	(25,021)
Provisions	24	(2,736)	(3,128)	(2,736)	(3,128)
Other liabilities	22	(2,085)	(1,247)	(2,085)	(1,247)
Total non-current liabilities		**(29,756)**	**(29,396)**	**(29,756)**	**(29,396)**
Total assets employed		**316,911**	**341,286**	**316,911**	**341,286**
Financed by					
Public dividend capital		672,201	635,625	672,201	635,625
Revaluation reserve		36,459	40,979	36,459	40,979
Income and expenditure reserve		(391,749)	(335,318)	(391,749)	(335,318)
Total taxpayers' equity		**316,911**	**341,286**	**316,911**	**341,286**

The notes on pages 123 to 155 form part of these accounts.

Name **Silas Nicholls**
Position **Chief Executive**
Date **26 June 2025**

Consolidated Statement of Changes in Equity for the year ended 31 March 2025

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2024 - brought forward	**635,625**	**40,979**	**(335,318)**	**341,286**
Surplus/(deficit) for the year	-	-	(57,712)	**(57,712)**
Other transfers between reserves	-	(1,281)	1,281	**-**
Impairments	-	(3,660)	-	**(3,660)**
Revaluations	-	421	-	**421**
Public dividend capital received	37,776	-	-	**37,776**
Public dividend capital repaid	(1,200)	-	-	**(1,200)**
Taxpayers' and others' equity at 31 March 2025	**672,201**	**36,459**	**(391,749)**	**316,911**

Consolidated Statement of Changes in Equity for the year ended 31 March 2024

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2023 - brought forward	**541,952**	**41,019**	**(268,552)**	**314,419**
Surplus/(deficit) for the year	-	-	(67,924)	**(67,924)**
Other transfers between reserves	-	(1,158)	1,158	**-**
Impairments	-	(3,000)	-	**(3,000)**
Revaluations	-	4,118	-	**4,118**
Public dividend capital received	108,295	-	-	**108,295**
Public dividend capital repaid	(14,622)	-	-	**(14,622)**
Taxpayers' and others' equity at 31 March 2024	**635,625**	**40,979**	**(335,318)**	**341,286**

Trust	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2024 - brought forward	**635,625**	**40,979**	**(335,318)**	**341,286**
Surplus/(deficit) for the year	-	-	(57,712)	**(57,712)**
Other transfers between reserves	-	(1,281)	1,281	**-**
Impairments	-	(3,660)	-	**(3,660)**
Revaluations	-	421	-	**421**
Public dividend capital received	37,776	-	-	**37,776**
Public dividend capital repaid	(1,200)	-	-	**(1,200)**
Taxpayers' and others' equity at 31 March 2025	**672,201**	**36,459**	**(391,749)**	**316,911**

Consolidated Statement of Changes in Equity for the year ended 31 March 2024

Trust	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2023 - brought forward	**541,952**	**41,019**	**(268,552)**	**314,419**
Surplus/(deficit) for the year	-	-	(67,924)	**(67,924)**
Other transfers between reserves	-	(1,158)	1,158	**-**
Impairments	-	(3,000)	-	**(3,000)**
Revaluations	-	4,118	-	**4,118**
Public dividend capital received	108,295	-	-	**108,295**
Public dividend capital repaid	(14,622)	-	-	**(14,622)**
Taxpayers' and others' equity at 31 March 2024	**635,625**	**40,979**	**(335,318)**	**341,286**

Statements of Cash Flows

	Note	Group 2024/25 £000	Group 2023/24 £000	Trust 2024/25 £000	Trust 2023/24 £000
Cash flows from operating activities					
Operating surplus / (deficit)		(49,521)	(58,138)	(49,521)	(58,138)
Non-cash income and expense:					
Depreciation and amortisation	6.1	33,031	34,607	33,029	34,605
Net impairments	7	21,491	31,889	21,491	31,889
Income recognised in respect of capital donations	3	(849)	(457)	(849)	(457)
(Increase) / decrease in receivables and other assets		422	9,575	1,456	9,872
(Increase) / decrease in inventories		(1,123)	(2,084)	577	(2,182)
Increase / (decrease) in payables and other liabilities		13,332	(17,045)	11,072	(18,089)
Increase / (decrease) in provisions		(434)	(456)	(434)	(456)
Movements in charitable fund working capital		-	-	-	-
Tax (paid) / received		-	-	-	-
Operating cash flows from discontinued operations		-	-	-	-
Other movements in operating cash flows		-	-	-	-
Net cash flows from / (used in) operating activities		**16,349**	**(2,109)**	**16,821**	**(2,956)**
Cash flows from investing activities					
Interest received		2,568	1,707	2,568	1,707
Purchase of intangible assets		(6,015)	(3,386)	(6,015)	(3,386)
Purchase of PPE and investment property		(54,666)	(44,048)	(54,666)	(44,048)
Sales of PPE and investment property		-	90	-	90
Receipt of cash donations to purchase assets		849	457	849	457
Net cash flows from / (used in) investing activities		**(57,264)**	**(45,180)**	**(57,264)**	**(45,180)**
Cash flows from financing activities					
Public dividend capital received		37,776	108,295	37,776	108,295
Public dividend capital repaid		(1,200)	(14,622)	(1,200)	(14,622)
Movement on loans from DHSC		(1,108)	(1,575)	(1,108)	(1,575)
Movement on other loans		(76)	(75)	(76)	(75)
Capital element of lease liability repayments		(9,961)	(12,306)	(9,961)	(12,306)
Interest on loans		(64)	(92)	(64)	(92)
Other interest		(66)	(3)	(66)	(3)
Interest paid on lease liability repayments		(1,041)	(533)	(1,041)	(533)
PDC dividend (paid) / refunded		(11,125)	(10,269)	(11,125)	(10,269)
Net cash flows from / (used in) financing activities		**13,135**	**68,820**	**13,135**	**68,820**
Increase / (decrease) in cash and cash equivalents		**(27,780)**	**21,531**	**(27,308)**	**20,684**
Cash and cash equivalents at 1 April - brought forward		**36,033**	**14,502**	**34,813**	**14,129**
Cash and cash equivalents transferred under absorption accounting		-	-	-	-
Cash and cash equivalents at 31 March	20	**8,253**	**36,033**	**7,505**	**34,813**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2024/25 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis which the directors believe to be appropriate for the following reasons.

The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Guidance from the Department of Health and Social Care indicates that all NHS bodies will be considered to be going concerns unless there are ongoing discussions at department level regarding the winding up of the activity of the organisation. The Trust has not been informed by NHS England that there is any prospect of its dissolution within the next twelve months and it anticipates the continuation of the provision of services in the foreseeable future as evidenced by the inclusion of financial provision for those services in published documents and contracts for services with commissioners.

It is clear that the Trust remains in a deficit position and will need to work with its partners across the local healthcare system to achieve efficiencies, maximise the use of its assets and sustainable financial balance. The Trust will work with NHS England and its stakeholders to achieve this objective.

In addition to the matters referred to above, the Trust has not been informed by NHS England and NHS Improvement that there is any prospect of its dissolution within the next twelve months and it anticipates the continuation of the provision of services in the foreseeable future as evidenced by the inclusion of financial provision for those services in published documents and contracts for services with commissioners.

Based on these indications the directors believe that it remains appropriate to prepare the accounts on a going concern basis.

Note 1.3 Consolidation

Subsidiary entities are those over which the trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines.

The Trust is corporate trustee of the Lancashire Teaching Hospitals NHS Foundation Trust Charity and the Rosemere Cancer Foundation Charity. The Trust has assessed its relationship to the charitable funds and determined them to be subsidiaries because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable funds and the ability to affect those returns and other benefits through its power over the funds. However the combined charitable funds are not material to the Trust and therefore consolidation is not required.

The Trust is sole owner of Lancashire Hospitals Services Limited, a company dispensing prescription drugs to Trust patients. The company has traded throughout the 2024/25 financial year. As sole owner, the company constitutes a subsidiary of the Trust and the financial results of the company through the financial year have been consolidated with the Trust to form the Group. The Trust is also the sole owner of Edovation Limited which has not been consolidated due to it being a dormant company.

The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year.

Note 1.3 Consolidation (Continued)
Joint operations are arrangements in which the trust has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. One LSC was created by the four provider Trusts in the Lancashire and South Cumbria system and each Trust transferred some corporate and support service functions into One LSC with effect from 1st November 2024. One LSC was assessed against the relevant accounting standards and the conclusion was that it was a joint operation. As a joint operation the trust has included within its financial statements its share of the assets, liabilities, income and expenses.

Note 1.4 Segmental Reporting
An operating segment is a component of the Trust that engages in activities from which it may earn revenues and incur expenses, including revenues and expenses that relate to transactions with any of the Trust's other components.

The chief operating decision maker for the Trust is the Board of Directors. The Board receives the monthly financial reports for the whole Trust and subsidiary information relating to income and divisional expenses. The board makes decisions based on the effect on the monthly financial statements.

The single segment of Healthcare has therefore been identified consistent with the core principle of IFRS 8 which is to enable users of the financial statements to evaluate the nature and financial effects of business activities and economic environments.

Note 1.5 Revenue from contracts with customers
Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts
The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

High costs drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual usage or at a fixed baseline in addition to the price of the related service.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for CQUIN and BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. Trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the trust contributes to system performance and therefore the availability of funding to the trust's commissioners.

Note 1.5 Revenue from contracts with customers (continued)

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.6 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Other income

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract. Other income includes income from car parking and catering which is recognised at the point of receipt of cash consideration.

Note 1.7 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is not recognised in the financial statements as the value is considered to be immaterial.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years".
An outline of these follows:

Pension costs (continued)

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.8 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

In 2024/2025 the Trust revised the expenditure accounting policy for expenditure accruals. The revised policy is that individual items valued at less than £5,000 and/or relating to period more than 3 months (previously 6 months) in the past are not accrued. There are limited exceptions to this policy which can be approved by management.

Note 1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g., plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Note 1.9 Property, plant and equipment (continued)
Measurement

Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. The modern equivalent may be smaller than the existing asset, for example, due to technological advances in plant and machinery or reduced operational use. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as ‘held for sale’ cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

Impairments
In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised. Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life	**Max life**
	Years	**Years**
Buildings, excluding dwellings	1	80
Plant & machinery	5	15
Transport equipment	7	7
Information technology	3	15
Furniture & fittings	7	10

Note 1.10 Intangible assets (continued)
Software

Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset where it meets recognition criteria.

Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets
Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Information technology	5	10
Software licences	2	10
Licences & trademarks	2	2

Note 1.11 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method except for drugs inventories which are measured using the weighted average cost method.

Between 2020/21 and 2023/24 the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department. Distribution of inventories by the Department ceased in March 2024, and the value of inventories held at that date was deemed to be immaterial and was expensed to the Statement of Comprehensive Income in full in 2023/24.

Note 1.12 Cash and cash equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

Note 1.13 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.14 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2025:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	4.03%	4.26%
Medium-term	After 5 years up to 10 years	4.07%	4.03%
Long-term	After 10 years up to 40 years	4.81%	4.72%
Very long-term	Exceeding 40 years	4.55%	4.40%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2025:

	Inflation rate	Prior year rate
Year 1	2.60%	3.60%
Year 2	2.30%	1.80%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.40% in real terms (prior year: 2.45%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at Note 24.1 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 25 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 25, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.18 Value added tax
Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.19 Corporation tax
The Trust is a health service body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for HM Treasury to disapply the exemption in relation to specified activities of a Foundation Trust (S519A(3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the scope of corporation tax in respect of activities which are not related to, or ancillary to, the provision of healthcare.

Note 1.20 Climate change levy
Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.21 Foreign exchange
The functional and presentational currency of the trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• monetary items are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.22 Third party assets
Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.23 Losses and special payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.24 Transfers of functions to / from other NHS bodies / local government bodies
For functions that have been transferred to the trust from another NHS / local government body, the transaction is accounted for as a transfer by absorption. The assets and liabilities transferred are recognised in the accounts using the book value as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain / loss corresponding to the net assets / liabilities transferred is recognised within income / expenses, but not within operating activities.

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the trust has transferred to another NHS / local government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss / gain corresponding to the net assets/ liabilities transferred is recognised within expenses / income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve. Adjustments to align the acquired function to the trust's accounting policies are applied after initial recognition and are adjusted directly in taxpayers' equity.

Note 1.25 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2024/25.

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted
The DHSC GAM does not require the following IFRS Standards to be applied in 2024/25:

IFRS 17 Insurance Contracts – The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 has been adopted by the FReM from 1 April 2025. Adoption of the Standard for NHS bodies will therefore be in 2025/26. The Standard revises the accounting for insurance contracts for the issuers of insurance. Application of this standard from 2025/26 is not expected to have a material impact on the financial statements.

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted (continued)
Changes to non-investment asset valuation – Following a thematic review of non-current asset valuations for financial reporting in the public sector, HM Treasury has made a number of changes to valuation frequency, valuation methodology and classification which are effective in the public sector from 1 April 2025 with a 5 year transition period. NHS bodies are adopting these changes to an alternative timeline.

Changes to subsequent measurement of intangible assets and PPE classification / terminology to be implemented for NHS bodies from 1 April 2025:
• Withdrawal of the revaluation model for intangible assets. Carrying values of existing intangible assets measured under a previous revaluation will be taken forward as deemed historic cost.
• Removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity.
These changes are not expected to have a material impact on these financial statements.

Changes to valuation cycles and methodology to be implemented for NHS bodies in later periods:
• A mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years.
• Removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern equivalent asset basis. The approach for land has not yet been finalised by HM Treasury.

The impact of applying these changes in future periods has not yet been assessed but is expected to have a material impact upon PPE measurement in future periods.

Note 1.27 Critical judgements in applying accounting policies
In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Note 1.28 Sources of estimation uncertainty
The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

The revaluations of hospitals have been carried out by Cushman & Wakefield, a property services firm whose valuers are registered with the Royal Institution of Chartered Surveyors (RICS), the regulatory body for the valuation services industry. Cushman & Wakefield provided a full valuation of land and property as at 31st March 2024, and have provided a desktop valuation of these assets as at 31 March 2025 using the modern equivalent asset (MEA) approach. This approach assumes that the asset would have been replaced with a modern equivalent, not a building of identical design, with the same operational value as the existing asset. The modern equivalent may well be smaller that the existing asset, for example, due to technological advances in plant and machinery or reduced operational use. The application and assessment of the valuation has been informed by Trust management in respect of the estimated requirements of a modern equivalent hospital. Estimation uncertainty within the revaluation is primarily driven by the following key assumptions:

• Selection of individual Building Cost Information Services (BCIS) values for each individual building component from within a published range, reflecting the condition and specifications of the actual component.
• The application of a ‘location factor’ adjustment to the overall BCIS index movement to reflect specific local factors relating to the cost of construction.
• The application of physical obsolescence adjustments to the valuation of individual buildings to reflect the building’s age and condition, and application of functional obsolescence adjustments to reflect the extent to which a modern equivalent asset would be configured in a more efficient manner and over a reduced gross internal area.

It is impracticable to disclose the extent of the possible effects of an assumption or another source of estimation uncertainty at the end of the reporting period. Outcomes within the next financial year that are different from the assumption around the valuation of our land or PPE could require a material adjustment to the carrying amount of the asset recorded in note 15

Note 2 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.5

Note 2.1 Income from patient care activities (by nature)	2024/25 £000	2023/24 £000
Acute services		
Income from commissioners under API contracts - variable element*	174,822	154,515
Income from commissioners under API contracts - fixed element*	489,412	489,290
High cost drugs income from commissioners	60,687	59,730
Other NHS clinical income	16,463	1,717
All services		
Private patient income	1,239	1,122
National pay award central funding***	1,635	371
Additional pension contribution central funding**	31,999	20,392
Other clinical income	3,290	4,085
Total income from activities	**779,547**	**731,222**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2023/25 NHS Payment Scheme documentation.

https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%, 2023/24: 20.6%) and related NHS England funding (9.4%, 2023/24: 6.3%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 and 2023/24 for implementing the backdated element of pay awards where government offers were finalised after the end of the financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

Note 2.2 Income from patient care activities (by source)	2024/25 £000	2023/24 £000
Income from patient care activities received from:		
NHS England	116,691	244,183
Integrated care boards	656,930	481,319
Department of Health and Social Care	6	18
Other NHS providers	533	235
NHS other	-	86
Local authorities	903	745
Non-NHS: private patients	1,239	968
Non-NHS: overseas patients (chargeable to patient)	76	69
Injury cost recovery scheme	2,882	3,340
Non NHS: other	287	259
Total income from activities	**779,547**	**731,222**
Of which:		
Related to continuing operations	779,547	731,222
Related to discontinued operations	-	-

Note 2.3 Overseas visitors (relating to patients charged directly by the provider)

	2024/25	2023/24
	£000	£000
Income recognised this year	76	69
Cash payments received in-year	66	39
Amounts added to provision for impairment of receivables	114	204
Amounts written off in-year	202	257

The above note relates to the treatment of overseas visitors charges directly by the Trust in accordance with Guidance on implementing the overseas regulations 2015 issued by the Department of Health and Social Care.

Amounts written off in-year 2024/25: 6 customers (2023/24 73 customers)

Note 3 Other operating income (Group)

	2024/25			2023/24		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	4,031	-	**4,031**	3,652	-	**3,652**
Education and training	31,778	1,014	**32,792**	29,796	1,996	**31,792**
Non-patient care services to other bodies	22,611	-	**22,611**	20,619	-	**20,619**
Receipt of capital grants and donations and peppercorn leases	-	849	**849**	-	457	**457**
Charitable and other contributions to expenditure	-	-	**-**	-	141	**141**
Revenue from operating leases	-	2,131	**2,131**	-	1,944	**1,944**
Other income	24,546	-	**24,546**	20,117	-	**20,117**
Total other operating income	**82,966**	**3,994**	**86,960**	**74,184**	**4,538**	**78,722**
Of which:						
Related to continuing operations			86,960			78,722
Related to discontinued operations			-			-

Note 3.1 Breakdown of Other income recognised in 'Other Operating Income' (Group)

	2024/25	2023/24
	£000	£000
Car Parking income	3,263	2,977
Catering	2,157	1,974
Pharmacy sales	2,752	2,765
Staff accommodation rental	456	409
Non-clinical services recharged to other bodies	36	130
Clinical excellence awards	525	476
Other income generation schemes (recognised under IFRS 15)*	15,357	11,386
Total Other Income	**24,546**	**20,117**

*Charges for discretionary services and sales of goods.

Note 4.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2024/25	2023/24
	£000	£000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	4,039	5,013
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	23	634

Note 4.2 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	2025	2024
	£000	£000
within one year	7,123	5,587
after one year, not later than five years	2,085	1,247
after five years	-	-
Total revenue allocated to remaining performance obligations	**9,208**	**6,834**

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure.
Revenue from
(i) contracts with an expected duration of one year or less and
(ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 4.3 Income from activities arising from commissioner requested services

The trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2024/25	2023/24
	£000	£000
Income from services designated as commissioner requested services	773,621	725,502
Income from services not designated as commissioner requested services	-	-
Total	**773,621**	**725,502**

Note 4.4 Fees and charges (Group)

The following disclosure is of income from charges to service users where the full cost of providing that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

	2024/25	2023/24
	£000	£000
Income	25,432	15,519
Full cost	(22,286)	(14,095)
Surplus / (deficit)	**3,146**	**1,424**

Note 5 Operating leases - Lancashire Teaching Hospitals NHS Foundation Trust as lessor

This note discloses income generated in operating lease agreements where Lancashire Teaching Hospitals NHS Foundation Trust is the lessor. These leases relate to parts of the Trust buildings which are occupied by third parties to (for example) use as retail outlets.

Note 5.1 Operating leases income (Group)

	2024/25	2023/24
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	1,986	1,829
Variable lease receipts / contingent rents	145	115
Total in-year operating lease income	**2,131**	**1,944**

Note 5.2 Future lease receipts (Group)

	31 March 2025	31 March 2024
	£000	£000
Future minimum lease receipts due in:		
- not later than one year	1,823	1,575
- later than one year and not later than two years	1,823	972
- later than two years and not later than three years	1,287	972
- later than three years and not later than four years	1,287	972
- later than four years and not later than five years	1,287	972
- later than five years	1,848	1,454
Total	**9,355**	**6,917**

Note 6.1 Operating expenses

	Group		Trust	
	2024/25	2023/24	2024/25	2023/24
	£000	£000	£000	£000
Staff and executive directors costs	598,197	557,350	596,841	556,278
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	85,288	75,060	80,014	75,032
Supplies and services - clinical (excluding drugs costs)	75,885	59,449	75,885	59,449
Premises	36,721	43,305	36,805	44,554
Depreciation on property, plant and equipment	31,203	32,243	31,201	32,241
Net impairments	21,491	31,889	21,491	31,889
Clinical negligence	19,764	18,927	19,764	18,927
Purchase of healthcare from non-NHS and non-DHSC bodies	16,953	16,115	16,953	16,115
Supplies and services - general	11,357	13,431	12,620	13,414
Establishment	5,272	5,030	5,239	5,030
Transport (including patient travel)	3,346	3,111	3,330	3,099
Education and training	3,183	4,382	3,178	4,382
Amortisation on intangible assets	1,828	2,364	1,828	2,364
Expenditure on short term leases	1,231	1,293	1,231	1,293
Insurance	913	862	898	852
Expenditure on low value leases	806	800	806	800
Other	721	702	715	662
Legal fees	414	444	386	431
Movement in credit loss allowance: contract receivables / contract assets	381	90	381	90
Fees payable to the external auditor				
Audit services *	257	232	227	215
other auditor remuneration (external auditor only)	-	-	-	-
Internal audit costs	248	243	248	243
Inventories written down	313	218	313	180
Research and development	269	141	269	141
Remuneration of non-executive directors	177	173	177	173
Redundancy	44	29	44	29
Car parking & security	31	-	31	-
Losses, ex gratia & special payments	11	11	11	11
Hospitality	7	-	7	-
Purchase of healthcare from NHS and DHSC bodies	-	149	-	149
Change in provisions discount rate(s)	(45)	(66)	(45)	(66)
Increase/(decrease) in other provisions	(238)	105	(238)	105
Total	**916,028**	**868,082**	**910,610**	**868,082**
Of which:				
Related to continuing operations	916,028	868,082		
Related to discontinued operations	-	-		

* Total audit services for 2024/25 are £219k (excluding VAT) which relate solely to statutory external audit. No additional work has been undertaken.

Note 6.2 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £2 million (2023/24: £2 million).

Note 7 Impairment of assets (Group)

	2024/25	2023/24
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Abandonment of assets in course of construction	3,127	-
Changes in market price	18,364	31,889
Total net impairments charged to operating surplus / deficit	**21,491**	**31,889**
Impairments charged to the revaluation reserve	3,660	3,000
Total net impairments	**25,151**	**34,889**

Note 8 Employee benefits (Group)

	2024/25 Total £000	2023/24 Total £000
Salaries and wages	462,024	424,448
Social security costs	46,226	45,945
Apprenticeship levy	2,307	2,140
Employer's contributions to NHS pensions	80,549	66,944
Pension cost - other	130	154
Temporary staff (including agency)	10,106	20,642
Total gross staff costs	**601,342**	**560,273**
Recoveries in respect of seconded staff	-	-
Total staff costs	**601,342**	**560,273**
Of which		
Costs capitalised as part of assets	3,101	2,894

Note 8.1 Retirements due to ill-health (Group)

During 2024/25 there were 6 early retirements from the trust agreed on the grounds of ill-health (14 in the year ended 31 March 2024). The estimated additional pension liabilities of these ill-health retirements is £1,146k (£2,063k in 2023/24).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2024, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 at 23.7% of pensionable pay (previously 20.6%). The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

Note 10 Finance income (Group)

Finance income represents interest received on assets and investments in the period.

	2024/25	2023/24
	£000	£000
Interest on bank accounts	2,568	1,707
Total finance income	**2,568**	**1,707**

Note 11.1 Finance expenditure (Group)

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2024/25	2023/24
	£000	£000
Interest expense:		
Interest on loans from the Department of Health and Social Care	43	72
Interest on other loans	18	18
Interest on lease obligations	1,041	533
Interest on late payment of commercial debt	66	3
Total interest expense	**1,168**	**626**
Unwinding of discount on provisions	54	27
Total finance costs	**1,222**	**653**

Note 11.2 The late payment of commercial debts (interest) Act 1998 (Group)

	2024/25	2023/24
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	66	4
Compensation paid to cover debt recovery costs under this legislation	-	3

Note 12 Other gains / (losses) (Group)

	2024/25	2023/24
	£000	£000
Gains on disposal of assets	10	-
Losses on disposal of assets	(19)	(35)
Total gains / (losses) on disposal of assets	**(9)**	**(35)**

Note 13 Trust income statement and statement of comprehensive income

In accordance with Section 408 of the Companies Act 2006, the trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The trust's deficit for the period was £57.7 million (2023/24: £67.9 million). The trust's total comprehensive expense for the period was £61.0 million (2023/24: £66.8 million).

Note 14.1 Intangible assets - 2024/25

Group	Software licences	Licences & trademarks	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**15,358**	**13**	**2,378**	**1,548**	**19,297**
Additions	493	-	687	4,835	**6,015**
Impairments	-	-	-	-	**-**
Revaluations	(3,017)	-	(2,054)	(6,383)	**(11,454)**
Reclassifications	-	-	-	-	**-**
Valuation / gross cost at 31 March 2025	**12,834**	**13**	**1,011**	**-**	**13,858**
Amortisation at 1 April 2024 - brought forward	**9,521**	**13**	**507**	**-**	**10,041**
Provided during the year	1,511	-	317	-	**1,828**
Impairments	2,472	-	1,249	6,383	**10,104**
Revaluations	(3,017)	-	(2,054)	(6,383)	**(11,454)**
Reclassifications	(1)	-	1	-	**-**
Amortisation at 31 March 2025	**10,486**	**13**	**20**	**-**	**10,519**
Net book value at 31 March 2025	**2,348**	**-**	**991**	**-**	**3,339**
Net book value at 1 April 2024	**5,837**	**-**	**1,871**	**1,548**	**9,256**

Note 14.2 Intangible assets - 2023/24

Group	Software licences	Licences & trademarks	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - as previously stated	**13,366**	**13**	**1,815**	**3,910**	**19,104**
Additions	1,992	-	813	581	**3,386**
Impairments	-	-	(250)	(2,943)	**(3,193)**
Reclassifications	-	-	-	-	**-**
Valuation / gross cost at 31 March 2024	**15,358**	**13**	**2,378**	**1,548**	**19,297**
Amortisation at 1 April 2023 - as previously stated	**7,432**	**13**	**243**	**-**	**7,688**
Provided during the year	2,088	-	276	-	**2,364**
Impairments	-	-	(11)	-	**(11)**
Reclassifications	1	-	(1)	-	**0**
Amortisation at 31 March 2024	**9,521**	**13**	**507**	**-**	**10,041**
Net book value at 31 March 2024	**5,837**	**-**	**1,871**	**1,548**	**9,256**
Net book value at 1 April 2023	**5,934**	**-**	**1,572**	**3,910**	**11,416**

Note 15.1 Property, plant and equipment - 2024/25

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2024 - brought forward	**17,150**	**254,209**	**4,086**	**107,977**	**112**	**29,436**	**371**	**413,341**
Additions	18,000	7,144	9,282	3,502	-	841	71	**38,840**
Impairments	(3,050)	(4,909)	(3,827)	-	-	-	-	**(11,786)**
Reversals of impairments	300	949	-	-	-	-	-	**1,249**
Revaluations	-	(7,157)	-	-	-	-	-	**(7,157)**
Reclassifications	-	-	1	(1)	-	-	-	**-**
Disposals / derecognition	-	(4,883)	-	(320)	-	-	-	**(5,203)**
Valuation/gross cost at 31 March 2025	**32,400**	**245,353**	**9,542**	**111,158**	**112**	**30,277**	**442**	**429,284**
Accumulated depreciation at 1 April 2024 - brought forward	**-**	**6,152**	**-**	**45,048**	**85**	**16,128**	**92**	**67,505**
Provided during the year	-	7,658	-	9,517	5	3,598	44	**20,822**
Impairments	-	7,222	-	-	-	-	-	**7,222**
Reversals of impairments	-	(7,163)	-	-	-	-	-	**(7,163)**
Revaluations	-	(7,578)	-	-	-	-	-	**(7,578)**
Reclassifications	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	(4,883)	-	(301)	-	-	-	**(5,184)**
Accumulated depreciation at 31 March 2025	**-**	**1,408**	**-**	**54,264**	**90**	**19,726**	**136**	**75,624**
Net book value at 31 March 2025	**32,400**	**243,945**	**9,542**	**56,894**	**22**	**10,551**	**306**	**353,660**
Net book value at 1 April 2024	**17,150**	**248,057**	**4,086**	**62,929**	**27**	**13,308**	**279**	**345,836**

Note 15.2 Property, plant and equipment - 2023/24

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - as previously stated	**16,952**	**245,284**	**12,786**	**88,047**	**88**	**26,669**	**252**	**390,078**
Additions	-	26,020	3,219	21,008	24	3,868	119	**54,258**
Impairments	-	(1,084)	(4,883)	-	-	-	-	**(5,967)**
Reversals of impairments	198	2,771	-	-	-	-	-	**2,969**
Revaluations	-	(25,785)	-	-	-	(1,100)	-	**(26,885)**
Reclassifications	-	7,003	(7,036)	34	-	(1)	-	**-**
Disposals / derecognition	-	-	-	(1,112)	-	-	-	**(1,112)**
Valuation/gross cost at 31 March 2024	**17,150**	**254,209**	**4,086**	**107,977**	**112**	**29,436**	**371**	**413,341**
Accumulated depreciation at 1 April 2023 - as previously stated	**-**	**1,234**	**-**	**37,251**	**73**	**12,372**	**60**	**50,990**
Provided during the year	-	6,622	-	8,785	12	4,344	32	**19,795**
Impairments	-	36,349	(14)	-	-	512	-	**36,847**
Reversals of impairments	-	(8,138)	-	-	-	-	-	**(8,138)**
Revaluations	-	(29,903)	-	-	-	(1,100)	-	**(31,003)**
Reclassifications	-	(12)	14	(2)	-	-	-	**-**
Disposals / derecognition	-	-	-	(986)	-	-	-	**(986)**
Accumulated depreciation at 31 March 2024	**-**	**6,152**	**-**	**45,048**	**85**	**16,128**	**92**	**67,505**
Net book value at 31 March 2024	**17,150**	**248,057**	**4,086**	**62,929**	**27**	**13,308**	**279**	**345,836**
Net book value at 1 April 2023	**16,952**	**244,050**	**12,786**	**50,796**	**15**	**14,297**	**192**	**339,088**

The Trust position differs from the group position by an insignificant amount and therefore a separate note is not included in these accounts. The subsidiary assets (fixtures & fittings) had a gross cost of £8k, accumulated depreciation of £4k at 31st March 2024 and a further £2k provided during 2024-25, giving a net book value of £2k at 31st March 2025.

Note 15.3 Property, plant and equipment financing - 31 March 2025

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	32,400	242,015	9,542	53,400	22	10,551	299	**348,229**
Owned - donated/granted	-	1,930	-	3,494	-	-	7	**5,431**
NBV total at 31 March 2025	**32,400**	**243,945**	**9,542**	**56,894**	**22**	**10,551**	**306**	**353,660**

Note 15.4 Property, plant and equipment financing - 31 March 2024

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	17,150	246,179	4,086	59,570	27	13,202	271	**340,485**
Owned - donated/granted	-	1,878	-	3,359	-	106	8	**5,351**
NBV total at 31 March 2024	**17,150**	**248,057**	**4,086**	**62,929**	**27**	**13,308**	**279**	**345,836**

Note 15.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2025

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	88	4,970	-	-	-	-	-	**5,058**
Not subject to an operating lease	32,312	238,975	9,542	56,894	22	10,551	306	**348,602**
NBV total at 31 March 2025	**32,400**	**243,945**	**9,542**	**56,894**	**22**	**10,551**	**306**	**353,660**

Note 15.6 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2024

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	88	4,004	-	-	-	-	-	**4,092**
Not subject to an operating lease	17,062	244,053	4,086	62,929	27	13,308	279	**341,744**
NBV total at 31 March 2024	**17,150**	**248,057**	**4,086**	**62,929**	**27**	**13,308**	**279**	**345,836**

Note 16 Donations of property, plant and equipment

In 2024/25, the Trust received medical equipment donations totalling £849k (2023/24: £475k) from the non-consolidated charity.

Note 17 Leases - Lancashire Teaching Hospitals NHS Foundation Trust as a lessee

The Trust leases many assets including land and buildings, vehicles, machinery, equipment, and IT. This note details information about leases for which the Trust is a lessee.

Land & Buildings leases

The Trust leases clinical space within other NHS sites which are owned by NHS Property Services or other NHS Foundation Trusts. These leases run for 5 to 12 years and amounts payable under the leases are revised annually using inflation factors as set out in NHS Planning guidance issued by NHSE.

The Trust also has two leases with commercial landlords; one for Preston Business Centre and one for Finney House. The lease for Preston Business Centre is for 10 years and commenced on 1st December 2021. The amount payable under this lease is revised at five yearly intervals as per the clauses in the lease. The lease for Finney House commenced on the 15th November 2023 for a 5 year term. The lease terms provide for an annual rental review each April using the consumer price index from the preceding February.

The Trust leases some of it's premises under operating leases (see note 5.1)

Some leases contain extension options exercisable by the Trust in accordance with the lease terms. The Trust seeks to include extension options in new leases to provide operational flexibility. The extension options are exercisable only by the Trust and not by the lessors. The Trust assesses at lease commencement whether it is reasonably certain to exercise the extension options. It reassesses whether it is reasonably certain to exercise options if there is a significant event or significant change in circumstances within it's control.

Other leases

The Trust leases vehicles and equipment, with terms between 1 to 8 years. In some cases the Trust has options to purchase the assets at the end of the contract term; in other cases the Trust is obliged to return the items to the lessor or negotiate a secondary lease. Neither are considered to be obligations and therefore the Trust is not estimating liabilities beyond the original lease terms.

Note 17.1 Right of use assets - 2024/25

Group	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2024 - brought forward	**29,542**	**11,732**	**250**	**6**	**-**	**41,530**	**816**
Transfers by absorption	-	-	-	-	-	**-**	-
Additions	356	13,355	24	-	-	**13,735**	223
Remeasurements of the lease liability	293	-	-	-	-	**293**	-
Revaluations	(9,625)	-	-	-	-	**(9,625)**	-
Reclassifications	-	(1)	1	-	-	**-**	-
Disposals / derecognition	(492)	(2,224)	(44)	-	-	**(2,760)**	-
Valuation/gross cost at 31 March 2025	**20,074**	**22,862**	**231**	**6**	**-**	**43,173**	**1,039**
Accumulated depreciation at 1 April 2024 - brought forward	**8,701**	**3,119**	**100**	**4**	**-**	**11,924**	**8**
Provided during the year	5,258	5,043	78	2	-	**10,381**	102
Impairments	4,451	-	-	-	-	**4,451**	-
Revaluations	(9,625)	-	-	-	-	**(9,625)**	-
Disposals / derecognition	(492)	(1,308)	(44)	-	-	**(1,844)**	-
Accumulated depreciation at 31 March 2025	**8,293**	**6,854**	**134**	**6**	**-**	**15,287**	**110**
Net book value at 31 March 2025	**11,781**	**16,008**	**97**	**-**	**-**	**27,886**	**929**
Net book value at 1 April 2024	**20,841**	**8,613**	**150**	**2**	**-**	**29,606**	**808**

Net book value of right of use assets leased from other NHS providers	-
Net book value of right of use assets leased from other DHSC group bodies	929

Note 17.2 Right of use assets - 2023/24

Group	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2023 - brought forward	**30,161**	**19,516**	**260**	**6**	**21**	**49,964**	**8,570**
Transfers by absorption	458	-	-	-	-	**458**	-
Additions	800	1,160	65	-	-	**2,025**	800
Remeasurements of the lease liability	647	-	-	-	-	**647**	(6,827)
Reclassifications	(2,346)	2,346	-	-	-	**-**	(1,667)
Disposals / derecognition	(178)	(11,290)	(75)	-	(21)	**(11,564)**	(60)
Valuation/gross cost at 31 March 2024	**29,542**	**11,732**	**250**	**6**	**-**	**41,530**	**816**
Accumulated depreciation at 1 April 2023 - brought forward	**3,808**	**6,999**	**70**	**2**	**10**	**10,889**	**1,733**
Transfers by absorption	-	-	-	-	-	**-**	-
Provided during the year	5,071	7,294	70	2	11	**12,448**	34
Reclassifications	-	-	-	-	-	**-**	(1,699)
Disposals / derecognition	(178)	(11,174)	(40)	-	(21)	**(11,413)**	(60)
Accumulated depreciation at 31 March 2024	**8,701**	**3,119**	**100**	**4**	**-**	**11,924**	**8**
Net book value at 31 March 2024	**20,841**	**8,613**	**150**	**2**	**-**	**29,606**	**808**
Net book value at 1 April 2023	**26,353**	**12,517**	**190**	**4**	**11**	**39,075**	**6,837**

Net book value of right of use assets leased from other NHS providers	-
Net book value of right of use assets leased from other DHSC group bodies	808

Note 17.3 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 23.

	Group		Trust	
	2024/25	2023/24	2024/25	2023/24
	£000	£000	£000	£000
Carrying value at 1 April	**29,880**	**39,225**	**29,880**	39,225
Transfers by absorption	-	441	-	441
Lease additions	13,735	2,025	13,735	2,025
Lease liability remeasurements	293	647	293	647
Interest charge arising in year	1,041	532	1,041	532
Early terminations	(926)	(151)	(926)	(151)
Lease payments (cash outflows)	(11,002)	(12,839)	(11,002)	(12,839)
Carrying value at 31 March	**33,021**	**29,880**	**33,021**	**29,880**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 6.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

The Trust does not sub lease any right of use assets so the value included within revenue from operating leases in note 3 all relates to Trust owned property that is leased.

Note 17.4 Maturity analysis of future lease payments at 31 March 2025

	Group		Trust	
	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2025	31 March 2025	31 March 2025	31 March 2025
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	10,521	129	10,521	129
- later than one year and not later than five years;	19,809	448	19,809	448
- later than five years.	4,530	669	4,530	669
Total gross future lease payments	**34,860**	**1,246**	**34,860**	**1,246**
Finance charges allocated to future periods	(1,839)	(297)	(1,839)	(297)
Net lease liabilities at 31 March 2025	**33,021**	**949**	**33,021**	**949**
Of which:				
Leased from other NHS providers		-		-
Leased from other DHSC group bodies		949		949

Note 17.5 Maturity analysis of future lease payments at 31 March 2024

	Group		Trust	
	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2024	31 March 2024	31 March 2024	31 March 2024
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	7,426	78	7,426	78
- later than one year and not later than five years;	17,914	302	17,914	302
- later than five years.	6,017	743	6,017	743
Total gross future lease payments	**31,357**	**1,123**	**31,357**	**1,123**
Finance charges allocated to future periods	(1,477)	(315)	(1,477)	(315)
Net finance lease liabilities at 31 March 2024	**29,880**	**808**	**29,880**	**808**
Of which:				
Leased from other NHS providers		-		-
Leased from other DHSC group bodies		808		808

Note 18 Inventories

	Group		Trust	
	31 March 2025 £000	31 March 2024 £000	31 March 2025 £000	31 March 2024 £000
Drugs	6,514	5,692	3,862	4,740
Consumables	11,222	10,935	11,222	10,935
Energy	176	162	176	162
Other	14	14	14	14
Total inventories	**17,926**	**16,803**	**15,274**	**15,851**
of which:				
Held at fair value less costs to sell	-	-		

Inventories recognised in expenses for the year were £114,699k (2023/24: £82,557k). Write-down of inventories recognised as expenses for the year were £313k (2023/24: £218k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2023/24 the Trust received £141k of items purchased by DHSC. Distribution of inventory by the Department ceased in March 2024.

In 2023/24 the Trust, on the grounds of materiality, excluded donated PPE from inventories. Instead the deemed cost of these inventories was charged directly to expenditure on receipt with the corresponding benefit recognised in income.

Note 19.1 Receivables

	Group		Trust	
	31 March 2025	31 March 2024	31 March 2025	31 March 2024
	£000	£000	£000	£000
Current				
Contract receivables	29,013	28,962	29,628	29,007
Allowance for impaired contract receivables / assets	(1,712)	(1,532)	(1,712)	(1,532)
Prepayments (non-PFI)	5,793	5,521	5,764	5,511
Operating lease receivables	189	126	189	126
PDC dividend receivable	1,285	-	1,285	-
VAT receivable	3,547	2,669	1,739	2,448
Other receivables	2,955	3,932	3,006	3,981
Total current receivables	**41,070**	**39,678**	**39,899**	**39,541**
Non-current				
Contract receivables	6,254	6,879	6,254	6,879
Allowance for impaired contract receivables / assets	(644)	(716)	(644)	(716)
Other receivables	893	869	2,393	2,369
Total non-current receivables	**6,503**	**7,032**	**8,003**	**8,532**
Of which receivable from NHS and DHSC group bodies:				
Current	21,083	20,893	21,083	20,678
Non-current	893	869	893	869

Note 19.2 Allowances for credit losses

	Group		Trust	
	31 March 2025	31 March 2024	31 March 2025	31 March 2024
	£000	£000	£000	£000
Allowances as at 1 Apr	**2,248**	**2,383**	**2,248**	**2,383**
New allowances arising	783	933	**783**	**933**
Changes in existing allowances	(12)	(5)	**(12)**	**(5)**
Reversals of allowances	(390)	(838)	**(390)**	**(838)**
Utilisation of allowances (write offs)	(273)	(225)	**(273)**	**(225)**
Allowances as at 31 Mar	**2,356**	**2,248**	**2,356**	**2,248**

Note 20 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2024/25	2023/24	2024/25	2023/24
	£000	£000	£000	£000
At 1 April	**36,033**	**14,502**	**34,813**	**14,129**
Net change in year	(27,780)	21,531	(27,308)	20,684
At 31 March	**8,253**	**36,033**	**7,505**	**34,813**
Broken down into:				
Cash at commercial banks and in hand	773	1,241	25	21
Cash with the Government Banking Service	7,480	34,792	7,480	34,792
Total cash and cash equivalents as in SoFP	**8,253**	**36,033**	**7,505**	**34,813**
Total cash and cash equivalents as in SoCF	**8,253**	**36,033**	**7,505**	**34,813**

Note 20.1 Third party assets held by the trust

Lancashire Teaching Hospitals NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	Group and Trust	
	31 March 2025	31 March 2024
	£000	£000
Bank balances	8	7
Monies on deposit	-	-
Total third party assets	**8**	**7**

Note 21 Trade and other payables

	Group		Trust	
	31 March 2025 £000	31 March 2024 £000	31 March 2025 £000	31 March 2024 £000
Current				
Trade payables	28,140	19,367	25,288	18,325
Capital payables	21,097	36,923	21,097	36,923
Accruals	25,630	23,309	25,630	23,558
Social security costs	5,369	5,604	5,347	5,595
Other taxes payable	5,988	6,489	5,969	6,481
PDC dividend payable	-	312	-	312
Pension contributions payable	6,526	6,380	6,518	6,380
Other payables	1,560	1,106	1,388	1,103
Total current trade and other payables	**94,310**	**99,490**	**91,237**	**98,677**
Of which payables from NHS and DHSC group bodies:				
Current	11,766	10,847	8,693	10,034
Non-current	-	-	-	-

Note 22 Other liabilities

	Group		Trust	
	31 March 2025 £000	31 March 2024 £000	31 March 2025 £000	31 March 2024 £000
Current				
Deferred income: contract liabilities	7,123	5,587	7,123	5,587
Total other current liabilities	**7,123**	**5,587**	**7,123**	**5,587**
Non-current				
Deferred income: contract liabilities	-	-	-	-
Other deferred income	2,085	1,247	2,085	1,247
Total other non-current liabilities	**2,085**	**1,247**	**2,085**	**1,247**

Cancer Alliance funding has been received by the Trust to support staff posts over a 2 year period. A proportion that represents funding for the second year is deferred as non-current and the remainder is included in the current balance.

Note 23 Borrowings

	Group		Trust	
	31 March 2025 £000	31 March 2024 £000	31 March 2025 £000	31 March 2024 £000
Current				
Loans from DHSC	368	1,116	368	1,116
Other loans	79	79	79	79
Lease liabilities	9,751	6,963	9,751	6,963
Total current borrowings	**10,198**	**8,158**	**10,198**	**8,158**
Non-current				
Loans from DHSC	1,400	1,763	1,400	1,763
Other loans	265	341	265	341
Lease liabilities	23,270	22,917	23,270	22,917
Total non-current borrowings	**24,935**	**25,021**	**24,935**	**25,021**

Note 23.1 Reconciliation of liabilities arising from financing activities (Group)

Group - 2024/25	Loans from DHSC	Other loans	Lease liabilities	Total
	£000	£000	£000	£000
Carrying value at 1 April 2024	**2,879**	**420**	**29,880**	**33,179**
Cash movements:				
Financing cash flows - payments and receipts of principal	(1,108)	(76)	(9,961)	**(11,145)**
Financing cash flows - payments of interest	(46)	(18)	(1,041)	**(1,105)**
Non-cash movements:				
Transfers by absorption	-	-	-	**-**
Additions	-	-	13,735	**13,735**
Lease liability remeasurements	-	-	293	**293**
Application of effective interest rate	43	18	1,041	**1,102**
Early terminations	-	-	(926)	**(926)**
Carrying value at 31 March 2025	**1,768**	**344**	**33,021**	**35,133**

Group - 2023/24	Loans from DHSC	Other loans	Lease liabilities	Total
	£000	£000	£000	£000
Carrying value at 1 April 2023	**4,456**	**495**	**39,225**	**44,176**
Cash movements:				
Financing cash flows - payments and receipts of principal	(1,575)	(75)	(12,306)	**(13,956)**
Financing cash flows - payments of interest	(74)	(18)	(533)	**(625)**
Non-cash movements:				
Transfers by absorption	-	-	441	**441**
Additions	-	-	2,025	**2,025**
Lease liability remeasurements	-	-	647	**647**
Application of effective interest rate	72	18	532	**622**
Early terminations	-	-	(151)	**(151)**
Carrying value at 31 March 2024	**2,879**	**420**	**29,880**	**33,179**

Note 24 Provisions for liabilities and charges analysis

Group	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2024	**1,265**	**193**	**1,997**	**3,455**
Change in the discount rate	(43)	-	(10)	**(53)**
Arising during the year	171	105	29	**305**
Utilised during the year	(96)	(80)	(41)	**(217)**
Reversed unused	(216)	-	(298)	**(514)**
Unwinding of discount	22	-	77	**99**
At 31 March 2025	**1,103**	**218**	**1,754**	**3,075**
Expected timing of cash flows:				
- not later than one year;	92	218	29	**339**
- later than one year and not later than five years;	347	-	122	**469**
- later than five years.	664	-	1,603	**2,267**
Total	**1,103**	**218**	**1,754**	**3,075**

Permanent injury benefits

Payments are made on a quarterly basis to the NHS Pension Scheme and NHS Injury Benefit Scheme respectively.

Note 24 Provisions for liabilities and charges analysis (continued)

Legal claims

Legal claims provisions relate to employer and public liability claims.

Clincians pension tax

Clinicians who were members of the NHS Pensions Scheme and who as a result of work undertaken in the tax year (2019/20) face a tax charge in respect of growth of their NHS pension benefits above their pensions savings annual allowance threshold will be able to have this charge paid by the NHS Pension Scheme.

Dilapidation provisions

The Trust has created a provision for the reinstatement of leased properties (dilapidations). Payments will be made as and when leases expire and agreements are reached with Landlords.

Note 24.1 Clinical negligence liabilities

At 31 March 2025, £307,404k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Lancashire Teaching Hospitals NHS Foundation Trust (31 March 2024: £301,867k).

Note 25 Contingent assets and liabilities

	Group		Trust	
	31 March 2025 £000	31 March 2024 £000	31 March 2025 £000	31 March 2024 £000
Value of contingent liabilities				
NHS Resolution legal claims	(94)	(109)	(94)	(109)
Other	(640)	-	(640)	-
Gross value of contingent liabilities	**(734)**	**(109)**	**(734)**	**(109)**
Amounts recoverable against liabilities	2,560	-	2,560	-
Net value of contingent assets	**1,920**	**-**	**1,920**	**-**

Northumbria Healthcare NHS Foundation Trust appealed the VAT treatment of income earned from car parking by NHS Trusts. HMRC rejected the Trust's claim and both the First-Tier Tribunal (Tax Chamber) and the Upper Tribunal (Tax & Chancery Chamber) dismissed the Trust's appeal. The Court of Appeal allowed the Trust's appeal. HMRC now appeals to the Supreme Court.

The Northumbria Healthcare NHS Foundation Trust is the lead case, and a number of NHS Foundation Trusts, including this Trust, have submitted claims on the same basis as the lead case. If HMRC's appeal to the Supreme Court is rejected the decision will be final and all Trusts that have submitted claims on the same basis as the lead case will be entitled to a refund of overpaid VAT and statutory interest.

In the event of a favourable outcome it has been estimated that the amount of VAT and interest due to this Trust is £2.560m. A total of £0.640m would be due to the Trusts VAT advisors who have led on the appeal on behalf of the Trust. Therefore the Trust is reporting a net contingent asset of £1.920m.

Note 26 Contractual capital commitments

	31 March 2025 £000	31 March 2024 £000	31 March 2025 £000	31 March 2024 £000
Property, plant and equipment	-	5,832	-	5,832
Total	**-**	**5,832**	**-**	**5,832**

The contractual capital commitments represent the value of works committed to on projects that were work in progress at the 31st March. There were no contractual capital commitments at 31 March 2025.

Note 27 Financial instruments

Note 27.1 Financial risk management

International Financial Reporting Standard 9 requires disclosure of the role which Financial Instruments have had during the period in creating or changing the risks which a body faces in undertaking its activities. Because of the continuing service provider relationship which the Trust has with its Commissioners, and the way in which those Commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also, Financial Instruments play a much more limited role in creating or changing risk for the Trust than would be typical of listed companies, to which these standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and Financial Assets and Liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's Treasury Management operations are carried out by the Finance Department, within parameters defined formally within the Trust's Standing Financial Instructions, and policies agreed by the Board of Directors. The Trust's treasury activities are also subject to review by Internal Audit.

Liquidity Risk
Net operating costs of the Trust are funded under annual Service Agreements with NHS Commissioners, which are financed from resources voted annually by Parliament. While the Trust is in deficit it is accessing working capital support by means of PDC through DHSC. The Trust largely finances its capital expenditure from internally generated cash, and funds made available by the DHSC. Additional funding by way of loans has been arranged with the Foundation Trust Financing Facility to support major capital developments. The Trust is, therefore, exposed to liquidity risks from the loan funding - however these risks are approved, and comply with Monitor's Risk Assessment Framework.

Currency Risk
The Trust is a domestic organisation with the overwhelming majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations, and therefore has low exposure to currency rate fluctuations..

Interest Rate Risk
100% of the Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. The Trust is not, therefore, exposed to significant interest rate risk.

Credit Risk
The majority of the Trust's Income comes from contracts with other public sector bodies, and therefore the Trust has low exposure to credit risk. The maximum exposure as at 31 March 2023 is within Receivables from customers, as disclosed in the Trade and Other Receivables note to these Accounts.

Note 27.2 Carrying values of financial assets

	Group		Trust	
Carrying values of financial assets as at 31 March 2025	**Held at amortised cost**	**Total book value**	**Held at amortised cost**	**Total book value**
	£000	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	36,944	**36,944**	39,111	**39,111**
Cash and cash equivalents	8,253	**8,253**	7,505	**7,505**
Total at 31 March 2025	**45,197**	**45,197**	**46,616**	**46,616**

	Group		Trust	
Carrying values of financial assets as at 31 March 2024	**Held at amortised cost**	**Total book value**	**Held at amortised cost**	**Total book value**
	£000	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	38,520	**38,520**	40,115	**40,115**
Cash and cash equivalents	36,033	**36,033**	34,813	**34,813**
Total at 31 March 2024	**74,553**	**74,553**	**74,928**	**74,928**

Note 27.3 Carrying values of financial liabilities (Group)

	Group		Trust	
Carrying values of financial liabilities as at 31 March 2025	**Held at amortised cost**	**Total book value**	**Held at amortised cost**	**Total book value**
	£000	**£000**	**£000**	**£000**
Loans from the Department of Health and Social Care	1,768	**1,768**	1,768	**1,768**
Obligations under leases	33,021	**33,021**	33,021	**33,021**
Other borrowings	344	**344**	344	**344**
Trade and other payables excluding non financial liabilities	76,426	**76,426**	73,401	**73,401**
Total at 31 March 2025	**111,559**	**111,559**	**108,534**	**108,534**

	Group		Trust	
Carrying values of financial liabilities as at 31 March 2024	**Held at amortised cost**	**Total book value**	**Held at amortised cost**	**Total book value**
	£000	**£000**	**£000**	**£000**
Loans from the Department of Health and Social Care	2,879	**2,879**	2,879	**2,879**
Obligations under leases	29,880	**29,880**	29,880	**29,880**
Other borrowings	420	**420**	420	**420**
Trade and other payables excluding non financial liabilities	79,586	**79,586**	78,793	**78,793**
Total at 31 March 2024	**112,765**	**112,765**	**111,972**	**111,972**

Note 27.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	Group		Trust	
	2025	**2024**	**2025**	**2024**
	£000	**£000**	**£000**	**£000**
In one year or less	87,435	88,258	84,410	87,465
In more than one year but not more than five years	20,636	19,061	20,636	19,061
In more than five years	5,638	7,318	5,638	7,318
Total	**113,709**	**114,637**	**110,684**	**113,844**

Note 28 Losses and special payments

	2024/25		2023/24	
Group and trust	**Total number of cases**	**Total value of cases**	**Total number of cases**	**Total value of cases**
	Number	**£000**	**Number**	**£000**
Losses				
Cash losses	2	-	4	-
Fruitless payments and constructive losses	-	-	1	17
Bad debts and claims abandoned	1,024	245	918	403
Stores losses and damage to property	3	313	3	218
Total losses	**1,029**	**558**	**926**	**638**
Special payments				
Compensation under court order or legally binding arbitration award	4	4	1	-
Extra-contractual payments	-	-	-	-
Ex-gratia payments	29	94	49	149
Special severance payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**33**	**98**	**50**	**149**
Total losses and special payments	**1,062**	**656**	**976**	**787**

Note 29 Related parties

Lancashire Teaching Hospitals NHS Foundation Trust is a public interest body, a Department of Health and Social Care (parent of the group) Group body, authorised by NHS Improvement, the Independent Regulator for NHS Foundation Trusts. During the year none of the Board members or members of key management staff or parties related to them has undertaken any material transactions with Lancashire Teaching Hospitals NHS Foundation Trust.

The Board of Directors, or close family members of the same, who have interests in or hold positions with organisations with which the Trust has had transactions during the year, are listed below:

	Income	Expenditure	Receivable	Payable	Relationship
	£000	£000	£000	£000	
Lancashire and South Cumbria ICB	648,446	41	4,750	2,388	Non-Executive Directors
NHS England	112,983	1,834	2,329	4,540	Chair Corporate Director
East Lancashire Hospitals NHS Trust	6,537	3,829	3,038	2,320	Non-Executive Director
University Hospitals of Morecambe Bay NHS Foundation Trust	4,443	1,006	1,899	2,138	Non-Executive Director
University of Central Lancashire	565	296	41	60	Non-Executive Director Executive Director Corporate Director
North West Ambulance Service NHS Trust	389	268	49	43	Chair Non-Executive Director Executive Director
University of Manchester	361	290	99	18	Non-Executive Director Corporate Director
St Catherine's Hospice	121	4	32	1	Executive Director
University of Bolton	99	27	-	2	Executive Director
Care Quality Commission	-	435	-	-	Non-Executive Director
Weightmans Solicitors LLP	-	150	-	43	Non-Executive Director Executive Director

The Trust previously established a wholly owned subsidiary, Lancashire Hospitals Services Ltd. Lancashire Hospitals Services Ltd took over the outpatient pharmacies across the Trust on 1 October 2018. With effect from the 1 February 2025 the subsidiary also took over the outpatient pharmacies across East Lancashire Hospitals NHS Trust, University Hospitals of Morecambe Bay NHS Foundation Trust and Blackpool Teaching Hospitals NHS Foundation Trust. Being wholly owned and controlled by the Trust, the Trust has prepared its financial statements on a Group basis, consolidating the results of Lancashire Hospitals Services Ltd.

The Trust is Corporate Trustee of two charities which means that the Trust has control over the charities. Both Charities are registered with the Charity Commission and produce a set of annual accounts and an annual report (separate to that of the NHS Foundation Trust) These documents will be available in December 2025, on request from the Finance Department of the Trust. Details of the charities and of material transactions between them and the Trust are detailed below.

Charity	Registered Number	Donations received	Receivable	Payable
		£000	£000	£000
Lancashire Teaching Hospitals Charity	1051194	59	100	0
The Rosemere Cancer Foundation	1131583	790	77	0

Note 30 Transfers by absorption

A transfer of East Lancashire Financial Services (ELFS) from Northern Care Alliance NHS Foundation Trust (NCA) to Lancashire Teaching Hospitals NHS Foundation Trust (LTH) took place on the 1st June 2023. This transfer was transacted as a transfer by absorption by the two Trusts; LTH as the receiving entity and NCA as the divesting entity. The total assets transferred were equal to the liabilities transferred giving a nil impact upon the SOCI. There were no such transfers during 2024/25.

	2024/25	2023/24
	£000	£000
Inward transfers Northern Care Alliance NHS Foundation T		
Right of Use Assets	-	458
Receivables	-	2,286
Payables	-	(1,003)
Other Liabilities	-	(1,300)
Borrowings (Right of Use Assets lease liability)	-	(441)
Net transfers - recognised in the SOCI as a loss due to transfers by ab	**-**	**-**

If you have any queries regarding this report, or wish to make contact with any of the Directors or Governors, please contact:

Company Secretary
Lancashire Teaching Hospitals NHS Foundation Trust
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PR2 9HT

T: **01772 522010**
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For more information about Lancashire Teaching Hospitals NHS Foundation Trust see:

www.lancsteachinghospitals.nhs.uk

@lancshospitals

lancshospitals

KPMG

Auditor's Annual Report 2024/25

Lancashire Teaching Hospitals NHS Foundation Trust

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30 June 2025

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This report is addressed to Lancashire Teaching Hospitals NHS Foundation Trust (the Trust) as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state, those matters we are required to state to them in an auditors' annual report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than Lancashire Teaching Hospitals NHS Foundation Trust , as a body, for our audit work, for this report, or for the opinions we have formed.

We take no responsibility to any member of staff acting in their individual capacities, or to third parties.

External auditors do not act as a substitute for the audited body's own responsibility for putting in place proper arrangements to ensure that public business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively.

01 Executive Summary

Executive Summary

Purpose of the Auditor's Annual Report

This Auditor's Annual Report provides a summary of the findings and key issues arising from our 2024-25 audit of Lancashire Teaching Hospitals NHS Foundation Trust (the 'Trust'). This report has been prepared in line with the requirements set out in the Code of Audit Practice published by the National Audit Office and is required to be published by the Trust alongside the annual report and accounts.

Our responsibilities

The statutory responsibilities and powers of appointed auditors are set out in the Local Audit and Accountability Act 2014. In line with this we provide conclusions on the following matters:

Accounts - We provide an opinion as to whether the accounts give a true and fair view of the financial position of the Trust and of its income and expenditure during the year. We confirm whether the accounts have been prepared in line with the Group Accounting Manual prepared by the Department of Health and Social Care (DHSC).

Annual report - We assess whether the annual report is consistent with our knowledge of the Trust. We perform testing of certain figures labelled in the remuneration report.

Value for money - We assess the arrangements in place for securing economy, efficiency and effectiveness (value for money) in the Trust's use of resources and provide a summary of our findings in the commentary in this report. We are required to report if we have identified any significant weaknesses as a result of this work.

Other reporting - We may issue other reports where we determine that this is necessary in the public interest under the Local Audit and Accountability Act.

Findings

We have set out below a summary of the conclusions that we provided in respect of out;

Accounts	We issued an unqualified opinion on the Trust's accounts on 30 June 2025. This means that we believe the accounts give a true and fair view of the financial performance and position of the Trust. We have provided further details of the key risks we identified and our response on page 5.
Annual report	We did not identify any significant inconsistencies between the content of the annual report and our knowledge of the Trust. We confirmed that the annual report has been prepared in line with the NHS Group Accounting Manual (GAM) and the Foundation Trust Annual Reporting Manual (the ARM).
Value for money	We are required to report if we identify any matters that indicate the Trust does not have sufficient arrangements to achieve value for money. We identified one significant weakness relating to risk assessment and delivery of CIP schemes. We have provided further detail on page 10.
Other reporting	We did not consider it necessary to issue any other reports in the public interest.

02
Audit of the Financial Statements

Audit of the financial statements

KPMG provides an independent opinion on whether the Trust's financial statements:

- Give a true and fair view of the state of the Trust's affairs as at 31 March 2025 and of its income and expenditure for the year then ended;
- Have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State in February 2025 as being relevant to NHS Foundation Trusts and included in the Department of Health and Social Care Group Accounting Manual 2024/25; and
- Have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Audit opinion on the financial statements

We have issued an unqualified opinion on the Trust's financial statements before 30 June 2025.

The full opinion is included in the Trust's Annual Report and Accounts for 2024/25 which can be obtained from the Trust's website.

Further information on our audit of the financial statements is set out overleaf.

Audit of the financial statements

The table below summarises the key risks that we identified to our audit opinion as part of our risk assessment and how we responded to these through our audit.

Risk	Procedures undertaken	Findings
Risk: Liabilities and related expenditure for purchase of goods or services are not completely or recorded in the correct accounting period As the Trust and system is set a financial performance target by NHS England there is a risk that non-pay expenditure, excluding depreciation, may be manipulated to report that the control total has been met. The setting of a control total can create an incentive for management to understate the level of non-pay expenditure compared to that which has been incurred. In addition, the trust introduced new accounting policies in 23/24 whereby they no longer accrue for items less than £5k or greater than 3 months old. They also adopted the position to not accrue for specific manual accruals they deem to be immaterial , for example holiday pay accrual. We consider this manipulation would be most likely to occur through understating year-end manual accruals, for example to push back expenditure to 2025/26 to mitigate financial pressures.	– We evaluated the design and implementation of controls to ensure the completeness of accruals. – We inspected a sample of cash expenditure recorded in the bank statement in the post balance sheet and reviewed associated evidence including invoice where applicable to test for unrecorded liabilities. – We inspected journals posted as part of the year end close procedures that decrease the level of expenditure recorded in order to critically assess whether there was an appropriate basis for posting the journal and the value can be agreed to supporting evidence; – We performed a year-on-year comparison of the accruals made in the prior year and current year and challenged management where the movement was not in line with our understanding of the entity. – We performed retrospective review of prior year accruals in order to assess the completeness with which accruals had been recorded at 31 March 2024 and based our expectation for accruals in current year	We did not identify any material misstatements relating to this risk – Management have updated their accruals policy further in 2024-25 to not accrue for items less than £5k or greater than 3 months old. We have considered the impact of this through our testing and whilst we have not been able to quantify the value of ‘unaccrued’ expenditure, through our understanding of monthly review of accruals process (and the prior year error - £1m) we are satisfied this can never have a material impact. – Similarly, last year we reported an audit difference for Holiday pay accrual and Time off in Lieu. Management have quantified the impact and the accrual value has actually reduced in line with our expectation based on the Trust’s annual leave policy. The year-on-year impact that would be posted to the statement of comprehensive income is less than our triviality threshold so has not been reported in the summary of audit misstatements. The same principle applies to the time off in lieu accrual. – Overall, whilst accruals may be understated it is not to a degree which would impact our true and fair opinion..

Audit of the financial statements

The table below summarises the key risks that we identified to our audit opinion as part of our risk assessment and how we responded to these through our audit.

Risk	Procedures undertaken	Findings
Management override of controls Professional standards require us to communicate the fraud risk from management override of controls as significant. Management is in a unique position to perpetrate fraud because of their ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively.	– Assessed accounting estimates for biases by evaluating whether judgements and decisions in making accounting estimates, even if individually reasonable, indicate a possible bias. – In line with our methodology, evaluated the design and implementation of controls over journal entries and post-closing adjustments. – Assessed the appropriateness of changes, compared to the prior year, to the methods and underlying assumptions used to prepare accounting estimates. – Assessed the business rationale and the appropriateness of the accounting for significant transactions that are outside the Trust's normal course of business or are otherwise unusual. – Identified journal entries and other adjustments with characteristics that indicate that they may be inappropriate or unauthorised and therefore may have been used to manipulate the financial statements (which we refer to as 'high-risk journals and other adjustments') and perform procedures to test the appropriateness of these entries and adjustments. – We tested the completeness of the related parties identified and assess whether relevant transaction had been appropriately disclosed within the financial statements.	In light of the fact no automated controls exist that we can place reliance on to mitigate the risk of management override, we have assessed the design and implementation of manual controls. Management's journal control, whilst it does demonstrate a degree of segregation of duties, it does not meet the management review control criteria as stipulated by auditing standards. As such we deem the control ineffective. Whilst we are not raising a formal control observation in this regard, and the Trust considers its existing controls to be proportionate to address the associated risk, as journals are associated with a significant risk we are required to bring this matter to your attention. We identified 10 journal entries and other adjustments meeting our high-risk criteria – our examination did not identify unauthorised, unsupported or inappropriate entries. We evaluated accounting estimates, including the consideration of the valuation of land and buildings, and did not identify any indicators of management bias. Our procedures did not identify any significant unusual transactions.

03 Value for Money

Value for Money

Introduction

We are required to consider whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources or 'value for money'. We consider whether there are sufficient arrangements in place for the Trust for the following criteria, as defined by the National Audit Office (NAO) in their Code of Audit Practice:

- Financial sustainability: How the Trust plans and manages its resources to ensure it can continue to deliver its services.
- Governance: How the Trust ensures that it makes informed decisions and properly manages its risks.
- Improving economy, efficiency and effectiveness: How the Trust uses information about its costs and performance to improve the way it manages and delivers its services

Approach

We undertake risk assessment procedures in order to assess whether there are any risks that value for money is not being achieved. This is prepared by considering the findings from other regulators and auditors, records from the organisation and performing procedures to assess the design of key systems at the organisation that give assurance over value for money.

Where a significant risk is identified we perform further procedures in order to consider whether there are significant weaknesses in the processes in place to achieve value for money.

We are required to report a summary of the work undertaken and the conclusions reached against each of the aforementioned reporting criteria in this Auditor's Annual Report. We do this as part of our commentary on VFM arrangements over the following pages.

We also make recommendations where we identify weaknesses in arrangements or other matters that require attention from the Trust.

Summary of findings

	Financial sustainability	Governance	Improving economy, efficiency and effectiveness
Commentary page reference	13-16	17-18	19-21
Identified risks of significant weakness?	Yes	No	Yes
Actual significant weakness identified?	Yes	No	No
2023-24 Findings	No significant weakness identified	No significant weakness identified	No significant weakness identified
Direction of travel	⇧	⇔	⇔

Value for Money

NATIONAL CONTEXT

Following the general election in July 2024 the Labour government commissioned reviews in order to determine the causes of challenges within the sector and where priorities were for improvement. A 10 year plan is currently being developed to set out the strategy for transforming health care services in the future.

Operational performance across the sector has continued to be significantly below constitutional standards, continuing a trend that began during the Covid-19 pandemic. In March 2025 25% of patients attending A&E waited more than the four hour target and 60% of patients awaiting planned care had a wait of more than 18 weeks. While mental health performance improved year on year in a number of areas the backlog for treatment nationally has grown by a further 11% year on year, with 1.7 million referred patients awaiting their second contact.

During the year a revised timetable was announced for the New Hospital Programme, the national capital project to build 40 new hospitals. For a number of hospitals this has meant delays to the timetable for their construction deferred to the 2030s.

Financial performance

Local NHS systems continued to face challenging financial targets in 2024-25. Budgets across the 42 integrated care systems in England had a combined £500m deficit compared to the funding that was available at the beginning of 2024-25. By February 2025 (the latest national data available when this report was drafted) the forecast performance of all systems was a £604m overspend against the agreed figures.

Each year NHS entities are delegated efficiency targets through funding allocations and contracting guidance. Across England there was a £539m shortfall in the identified efficiencies compared to those required based on the agreed levels of funding delegated to systems.

Structures

Significant changes to the structure of the health system have been announced, to be implemented between 2025 and 2027. ICBs have been set running cost targets, with many expected to pursue mergers or large restructurings in order to achieve these. Providers are expected to reverse 50% of their corporate cost growth since Covid-19. During 2025-26 all NHS entities will therefore need to reassess their structures, which can impact on management bandwidth, stability of controls and morale.

LOCAL CONTEXT

Lancashire Teaching Hospitals NHS Foundation Trust is a large acute Trust providing district general hospital services to over 395,000 people in Chorley, Preston and South Ribble and specialist care to 1.8m people across Lancashire and South Cumbria. The Trust provides care across four facilities in Preston and Chorley

The Trust is part of the Lancashire and South Cumbria Integrated Care System (ICS).

The Trust Board's initial planned deficit for 2024/25 of £24.3m was not accepted by NHSE, and it was revised to a £21.9m deficit. At month six, the Trust received £21.9m of deficit funding, on a non-recurrent basis, to a enable a revised break-even budget.

The Trust continued to face increasing pressure from unfunded emergency beds, driven by the number of patients not meeting the criteria to reside remaining high throughout the year.

At the year end, the Trust achieved a deficit of £36.2m against a revised break-even plan. The Trust delivered cost improvement plans totalling £26.1m of savings which was £31.9m short of the original Financial Recovery Programme FRP//WRP target (£58m) for the year.

One LSC, a shared collaboration service, went live on 1 November 2024 with 400 WTE LTH staff transferring to its host, East Lancashire Hospitals NHS Trust (ELHT). We are satisfied there has been appropriate challenge and scrutiny at Board level over the transfer. The challenge now will be maintaining the necessary level of assurances over its operating effectiveness and the delivering the savings as intended.

The Trust submitted the draft annual financial plan to NHS England on 27 March 2025 which included £60.0m of Waste Reduction & Financial Improvement Programme (WRP) schemes to deliver a £5.0m deficit at the end of March 2026. This was subsequently updated to a break-even plan following increased income from commissioners and slippage on the timing of local cost pressures. The plan is reliant on a recurrent waste reduction (WRP) target of £60m and non-recurrent deficit support funding of £30m.

Financial Sustainability

How the Trust plans and manages its resources to ensure it can continue to deliver its services.

We have considered the following in our work:

- How the Trust ensures that it identifies all the significant financial pressures that are relevant to its short and medium-term plans and builds these into them;
- How the Trust plans to bridge its funding gaps and identifies achievable savings;
- How the Trust plans finances to support the sustainable delivery of services in accordance with strategic and statutory priorities;
- How the Trust ensures that its financial plan is consistent with other plans such as workforce, capital, investment, and other operational planning which may include working with other local public bodies as part of a wider system; and
- How the Trust identifies and manages risks to financial resilience, e.g. unplanned changes in demand, including challenge of the assumptions underlying its plans

Financial plan 2024-25

The financial plan for 24/25 was created in accordance with NHS planning guidelines, in addition to ICS-wide principles. We saw appropriate review and approval from budget holders through to the Board of Directors. The proposed deficit plan of £24.3m for 2024/25 was approved by the Board on the 4th April 2024, after receiving a presentation on the key aspects of the plan and how it linked with national priorities and the priority workstreams set out by the ICB.

The exit run rate for 2023-24 reported by providers in the ICS was a deficit of £276m against an initial deficit plan of £80m.The Integrated Care Board were aiming for organisations to plan on a combined deficit of c£190m for 24-25. The Trust Board's initial planned deficit of £24.3m was not accepted by NHSE, and it was revised to a £21.9m deficit. At month six, the Trust received £21.9m of deficit funding, on a non-recurrent basis, to a enable a revised break-even budget for 24-25.

The deficit target was agreed assuming high risk mitigations could be delivered in year alongside a financial improvement plan of £58.0m, comprising core cost improvement of £41.4m, income/productivity of £8.3m and place-based optimisation/risk management of £8.3m. Similar to 23-24, it was acknowledged taking costs out of the system would require a coordinated system-wide response. Significant pieces of long-term work were underway, through the Emergency, Elective and Outpatients Transformation Boards, to redesign services to reduce the recurrent costs of delivery across the system.

There was clear reporting to both Board and Finance and Performance Committee (FPC), at that time and in the period leading up to finalisation of the plan. Equally, there was documented discussion at the June 2024 Board of Directors meeting, about accepting the proposed changes to the plan particularly with regard to elements outside of the trust's control or influence.

At the time of agreeing the revised plan total in June 2024, the trust had identified £49.2m of schemes for 24/25, however only £12.5m of schemes were rated green or amber with any confidence of delivery. £20m (41%) were considered high risk and £16.6m (34%) described as 'hopper' (outline plan)

Through our review of Board minutes between April and June it was evident that the Directors had voiced concerns that it would be challenging to sign up to these plans without some form of mitigation articulated and in place. FPC also expressed concerns about meeting the CIP targets and the risk of having unrealistic financial plans. It called for more detailed and realistic planning, as the current plans seemed overly ambitious and not achievable.

Financial Sustainability

Financial Monitoring and Performance 2024-25

We are satisfied that throughout 24/25 the budget monitoring process and associated committee scrutiny was sufficient to identify and analyse pressures that could present risks to the Trust in achieving the financial plan. Additionally, through our review of relevant Board and FPC sub-committee meeting minutes we found that financial and operational performance was appropriately challenged.

FPC received the month 5 finance report on 24th September 2024. Per the report, the Trust was £2m adverse to plan (in month), resulting in the Trust being £2.5m adverse for the year. The report stated that this was due to the increased cost for industrial action. In total, the report stated that £1.6m of the variance is influenced or due to external factors. It was noted that the trust remained £36m off its Financial Recovery Plan (FRP or CIP) target even with the anticipated funding adjustments. However, in October 2024 the CEO sent a letter to NHSE informing them that the trust was now forecasting a likely deficit of £52.9m, £31.9m off plan. The Trust's forecast financial deficit for the year had materially increased between 30 August and 15 October 2024.

The Trust commissioned an external review of financial governance including a review of the reasons and contributing factors to the Trust's financial deterioration in the current financial year and quality of governance processes underpinning financial management and reporting. In the report the following points were noted:

- The Trust agreed to a 2024/25 control total that required savings well beyond previous achievements. The savings requirements were profiled to be delivered in the second half of the year (87% in H2). Therefore, up to Month 4, the Trust was able to report that it was on plan despite the underlying deficit increasing. There were no fully worked up plans for the delivery of savings by 1 April 2024, and it was noted that major savings schemes were never translated to savings targets for Divisions to own.
- The Board and Committees had taken re-assurance from the progress reported against the headline Financial Plan and from the reports on the Financial Recovery Programme. However, the risk-ratings allocated to FRP schemes were optimistic in quantum and timing of recurrent savings and did not provide explicit ratings on the likelihood of schemes to deliver their intended targets in year.
- Once the size of the potential deviation to plan became apparent during Month 6, the Trust was unable to initiate the rapid actions required to mitigate this.

In addition, the NHSE Investigation and & Intervention (I&I) lead attended the Trust on the 31st of October and 1st November prompted by the deterioration in the reported financial forecast at month 6. A report was presented to FPC on 24th November 2025 proposing immediate actions to support mitigating risks highlighted in the financial risk assessment. Actions included: a Rapid Process Improvement Week to reduce variable pay across selected departments, a vacancy freeze, strengthening the existing FRP, technical review of the balance sheet and increasing capacity and capability.

The report suggested, based on a review of the information gathered, that unless significant action was taken, the forecast deficit was more likely to be £65.9m with potential for it to be as bad as £77.2m.

Governance arrangements

Divisional progress is monitored through the Divisional Improvement Forums and the progress of the transformational programmes is monitored through the Transformation and Recovery Board and reported to Board through FPC. We have reviewed the terms of reference for the FPC, the Transformation and Recovery Board and Divisional Improvement Forums, as well as minutes throughout the year and note that there is adequate reporting of the actual and forecast financial impact of the efficiency schemes in place, along with detail of the relevant financial RAG ratings. There was limited documented evidence of challenge at a divisional level.

Financial Sustainability

The external review did acknowledge governance processes and controls over the FRP were implemented by the Turnaround Director once they arrived during April 2024. However, further PMO capacity was required and the current structures and processes in place did not drive clear accountability for delivery of outcomes and improvements. In addition, the "Matrix" structure of the FRP programme did not clearly allocate accountabilities for delivering the FRP – for example, there are major multi-million Trust-wide schemes with ownership at Executive level that required significant Divisional support to be delivered.

The report also notes at the start of the financial year, controls over key areas of expenditure e.g. Single Tender Waivers, Limited Liability Partnerships (LLPs) for Medical Staff contracting to undertake elective work for the Trust and Variable pay spend controls were not robust and work was still needed to embed them. FPC had raised concerns in 24/25 on financial control weaknesses resulting in excess expenditure and the lack of detailed plans to remediate control weaknesses. Response to these concerns were addressed through the enhanced grip and control measures implemented during the year.

Grip and control

LTH was placed into Segment 4 of the NHS Oversight Framework in January 2025, on account of the growth in financial deficit that it had seen in recent years. This triggered the Trust's inclusion in the National Recovery Support Programme. A system wide review was undertaken by external consultants to review grip and control measures for pay and non-pay. The subsequent report acknowledged that the Trust had recently enhanced its pay expenditure control environment, which has resulted in measurable improvements such as reduction in overtime by 65% since April 2024, and agency use by 50%. In addition, the approvals process for pay expenditure is strong and, of the panels observed during the review, check and challenge of resourcing requests is robust.

The Trust had enhanced its non-pay controls environment in January 2025, operating a non-pay panel twice weekly, chaired by the CFO. All non-pay spend (except drugs) is reviewed by the panel prior to approval. The report notes the improved controls had resulted in visible improvements in some discretionary spend, such as a 40% reduction in purchase requisitions and an increase in compliance from 5% to 41% in relation to the "No PO No Pay" policy. However, not all areas were producing observable improvements, e.g. discretionary areas such as equipment purchases, travel and printing.

The Trust is also required to undertake self-assessment of compliance to both the HFMA Getting the Basics Right checklist and the NHSE Grip and Control Checklist which is one of the requirements of the National Operating Framework for providers. These checklists were amalgamated with 313 controls contained in the combined checklist.

In Q2 the Trust was requested to provide formal response to 47 of the controls which would then be audited by an independent firm to assess the strength of the response and assurance of controls, with resulting recommendations where appropriate.

The firm undertook a detailed review of 26 of the 47 submitted responses and concluded:

- Control in place and evidenced as working – 8
- Control in place but should be strengthened – 15
- Control not in place and needs to be actioned – 3

A report was shared with FPC on 22 October 2024 providing an update on the controls and an associated action plan. In January 2025, an update to the action plan was provided summarising that all actions were complete apart from one. In response to all the previous and ongoing external reviews, an action plan was developed in March 2025 containing 141 actions. No summary was presented of the progress against the action plan at the March 25 FPC meeting. As at June 2025, 88 have either been fully or partially actioned or are ongoing, 9 have been reviewed but not implemented and 44 are to be implemented.

Financial Sustainability

Cost Improvement Programme (CIP)

Efficiency Boards were introduced in Q4 (2023/24) which have enabled Divisions to present proposed plans to an Executive led Board to summarise progress of plan identification and delivery, including risks to achieving the plans.

By July 2024, the Trust had identified £57.1m of the financial recovery programme, which was slightly behind the FRP timetable. Of the £57.1m identified, £5.5m were in delivery, £32.3m were in sign off and £19.1m were ideas being progressed. There was therefore £0.9m to be identified. However, the majority of schemes were allocated for delivery in the final quarter of the year.

On the 3rd October they received an update that the Trust was £1.2m off track on the FRP plan. The Board confirmed it was assured in respect of action being taken to improve performance. Indeed, the Month 7 Finance Report also included information on the FRP, reporting that to date £10.3m had been delivered, with an adverse variance of £5.5m. This had worsened to £7.1m by month 8 and £10.7m by month 9. The Trust adjusted its previous re-forecast of £39.1m delivery by year-end to a probable case of £26.1m - £31.9m adverse variance from FRP target. The month 12 finance report confirmed that the trust had delivered £26.1m of savings.

The minutes note the Board reflected on whether action could have been instigated sooner in response to the indicative adverse warnings. Further discussion took place on how to manage the ambition to fix significant legacy underlying problems in a timely and sustainable manner. Meetings had been arranged with the Executive Directors to discuss the financial trajectory and the speed of delivery of their plans. Some further significantly material steps had been taken with a total job freeze for clinical and non-clinical staff which is in line with the NHSE recommendation.

The failure to deliver CIP plans adds to the underlying financial deficit position currently carried by the Trust.

Despite this we have seen regular monthly monitoring of CIP performance against targets at an individual scheme level and Trust level through FPC and to the Board, with more detailed monitoring taking place via Divisional Improvement Forums and at the Budget Holder level through monthly meetings. There is evidence that Quality Impact Assessments are completed for approved efficiency schemes. There was limited documented evidence of challenge at a divisional level and budget holder meetings.

Key financial and performance metrics:	2024-25	2023-24
Planned surplus/(deficit)	£2.6m	(0.4m)
Actual surplus/(deficit)	(£36.2m)	(£35.6m)
Planned CIP as a % of spend	7%	5.5%
- Recurrent	£58m	£48.5m
- Non-recurrent	£0m	£0m
Actual CIP as a % of spend	2.8%	4.5%
- Recurrent	£18m	£32.3
- Non-recurrent	£8m	£6.4m
Year-end cash position	£8.2m	£36m

Financial Sustainability

Cost Improvement Programme (CIP) 2025/26

In response to the external reviews, an external firm were contracted to provide additional PMO support to help manage the CIP programme during 24-25. For 25-26, that responsibility has now moved to a different firm.

The Trust submitted the draft annual financial plan to NHS England on 27 March 2025 which included £60.0m of Waste Reduction & Financial Improvement Programme (WRP) schemes to deliver a £5.0m deficit at the end of March 2026. This was subsequently updated to a break-even plan following increased income from commissioners and slippage on the timing of local cost pressures. The plan is reliant on a recurrent waste reduction (WRP) target of £60m and non-recurrent deficit support funding of £30m.

Delivery of WRP YTD at Month 2 is reported to be £1.5m, resulting in a negative YTD variance to plan of £4.4m. The Trust has identified all £60.0m, however, £17.8m is hopper (outline plan) and £12.5m is medium or high risk. Waste Recovery Boards, chaired by the CEO, have replaced Efficiency Boards and meet fortnightly to monitor the implementation of schemes and allow Executive level challenge of progress.

The Trust has continued to develop the WRP including moving schemes through gateways to improve the governance & financial risk rating. Further work continues to identify schemes including divisional deep dive workshops (supported by the external firm), One LSC and system workshops, bi-weekly Waste Recovery Boards led by the CEO and SRO executive led ‘buddy’ meetings.

Conclusion

Through our review of minutes and the output of the external reviews there is evidence of good practice with respect to pay and non-pay controls which has resulted in some positive outcomes such as a reduction in agency and overtime spend.

However, the Trust agreed a FRP plan of £58m at the start of the year and only delivered £26.1m. Although positions were reported to FPC and Trust Board, the underlying position was not reported clearly until month 6 and therefore could have impacted on the decision-making and the assurance taken by the Board, negating the impact of the adequate challenge posed by Board members. The level of accountability at divisional level was not sufficient enough to ensure the effective monitoring and delivery of CIPs.

The Trust has invested significantly in WRP and PMO support through external firms and this is reflected in the high level of CIP identified by June 2025. However, our assessment is there is a significant weakness in arrangements relating to monitoring and risk assessment of CIPs during the year.

Governance

How the Trust ensures that it makes informed decisions and properly manages its risks.

We have considered the following in our work:

- how the Trust monitors and assesses risk and how the body gains assurance over the effective operation of internal controls, including arrangements to prevent and detect fraud;
- how the Trust ensures effective processes and systems are in place to ensure budgetary control; to communicate relevant, accurate and timely management information (including non-financial information where appropriate); supports its statutory financial reporting requirements; and ensures corrective action is taken where needed, including in relation to significant partnerships;
- how the Trust ensures it makes properly informed decisions, supported by appropriate evidence and allowing for challenge and transparency; and
- how the body monitors and ensures appropriate standards, such as meeting legislative/regulatory requirements and standards in terms of management or Board members' behaviour

Risk Management

The key element of the risk management process at the Trust is embodied in the Board Assurance Framework (BAF). We have reviewed the BAF at various stages throughout the year to ensure that strategic risks are appropriately included and we are satisfied that these risks are regularly discussed and challenged at Trust board meetings.

The Trust's risk assessment criteria, outlined in the Risk Management policy, are used to assess all risks to ensure a consistent methodology is used. We have inspected the Corporate Risk Register and note that this gives strong coverages of ongoing risks, showing that the Trust has appropriate processes for monitoring the implementation and effectiveness of actions to address identified risks.

During the last visit in 2023, the CQC had been complementary about the risk processes in place at the trust, noting the trust had processes to escalate relevant risks and they observed sufficient challenge of the key areas of risk at the Board meeting they observed.

A Risk Management Group (RMG) chaired by the CEO was introduced into the Trust in March 2024. The RMG meets monthly and provides an update on the current position around High risks in the organisation. In addition to this divisions and corporate departments present a quarterly in-depth overview, which includes all risks, irrespective of the score.

Decision making

Approval of key decisions and Business cases are required to follow the Trust governance process and scheme of delegation including approval by divisional leadership and Trust's Strategic Planning Group following challenge before being presented to Trust executive team or Trust Board depending on size, scale and materiality of the ask against assigned authority limits.

A number of key decisions have taken place during the year requiring Board sign off – including the incorporation of One LSC and the subsequent transfer of 400 Whole time equivalents (WTE) LTH staff on the 1 November 2024. One LSC is a collaborative central service developed in partnership by the five Trusts in Lancashire and South Cumbria (LSC) and Integrated Care Board ICB). East Lancashire Hospitals NHS Trust (ELHT) was appointed as the One LSC host organisation in September 2023, meaning that colleagues joining One LSC will be employed by ELHT on behalf of all five Trusts.

There have been a number of presentations to Board of Directors since the start of 2023-24 articulating a compelling financial case for change including £70m in recurring savings across the system by the end of 2026/27. In February 2024, an update was provided on the proposals with challenge from the Board regarding the level of risk with the proposals.

Following questions from the initial report to Board in February 2024, a series of FAQs was compiled to provide assurances over the concerns raised. The paper noted the programme has monitored risks monthly and the risk approach is being matured into a BAF, with the support of their internal auditors.

Governance

On 1 August 2024 the Board approved and agreed to enter into the Strategic Collaboration Agreement (SCA) as the enabling document for the delivery of shared services through a collectively directed and owned model ahead of commencement on 1 November 2024. Whilst we are satisfied there has been appropriate challenge and scrutiny at Board level of the move to One LSC, a high-level review of the shared service was carried out by an external consultant in April 2025 and highlighted there had been challenges with integration, with fragmented operations and processes, inconsistent service scope and decision-making delays. The challenge now will how the LTH Board can continue to be assured over One LSC's operating effectiveness and transformation.

Our commentary on the review and approval of the 2024-25 financial plan is included on page 13. In respect of the process for monitoring against budgets, financial forecasts are based on the run rate plus known impacts as discussed in budget holder meetings. We have reviewed FPC and Board minutes as well as the attached papers throughout the financial year. We are satisfied that there is sufficient information to enable committee and Board members to take informed decisions. These papers also demonstrate that with respect to financial risks reported and recommendations made, there are detailed discussions occurring to challenge and analyse the information presented.

Compliance with laws and regulations

Through our review of the Standing Financial Instructions (SFIs) we are satisfied that these detail the roles, responsibilities and delegation of the various committees, and that this gives an appropriate escalation framework for making key decisions. The Trust has a Local Counter Fraud Specialist who undertakes anti-fraud activities throughout the year and reports into the Audit Committee. Other key arrangements designed to detect fraud such as Whistleblowing Policy, Freedom to Speak Up and associated governance features are well embedded within the organisation. Reviews for compliance with the staff code of conduct, laws & regulations and the Trust's constitution is completed via the Audit Committee, Board meetings and other governance structures as identified through our testing. We have made one low-priority recommendation on Page regarding the fact that the Standards of Business Conduct and Recruitment & Selection Policies are now beyond their target review dates and should be refreshed.

CQC

Following publication of the last CQC report on 24 November 2023, management had developed a CQC Action Plan which the trust has continued to monitor throughout the year. The must-do actions are central to the Single Improvement Plan across multiple domains including Well-Led, Safety and Quality and People & Culture. The latest version of the action plan confirmed all Must-Do actions were either complete or on-track to deliver within timescale.

	2025	2024
Control deficiencies reported in the Annual Governance Statement	None	None
Head of Internal Audit Opinion	Substantial	Substantial
Oversight Framework segmentation	4	3
Care Quality Commission rating	Requires improvement	Requires improvement

Improving economy, efficiency and effectiveness

How the Trust uses information about its costs and performance to improve the way it manages and delivers its services

We have considered the following in our work:

- how financial and performance information has been used to assess performance to identify areas for improvement;
- how the Trust ensures effective processes and systems are in place in order to develop their cost saving efficiency saving program;
- how the Trust evaluates the services it provides to assess performance and identify areas for improvement;
- how the Trust ensures it delivers its role within significant partnerships and engages with stakeholders it has identified, in order to assess whether it is meeting its objectives; and
- where the Trust commissions or procures services, how it assesses whether it is realising the expected benefits.

Finance and Performance Information

We have considered the review of financial information in early slides. Non-financial performance is scrutinised regularly by the Executive Team with specific follow up of non-compliant metrics and associated recovery plans. Non-financial performance is formally reported and scrutinised via the Integrated Performance Report to the Board monthly, as well as detailed reports on Finance, Workforce, Safety & Quality being presented to each meeting of the respective Board sub-Committees. We have reviewed examples and evidence of this in action and consider it to be appropriate.

In terms of developing and assessing plans relating to major decisions, we have reviewed the activity of the Finance function regarding the preparation of business cases and are satisfied that there is a standard business case template and guidance being utilised. The Trust has the required number of staff trained to NHS Better Business Cases training standards, and business case guidance and templates include the need to have strategic, management, economic and financial relevance. Quality / Equality Impact Assessment is required for all business cases.

Contract Management

We are satisfied there is an appropriate framework for monitoring of the performance of subcontractors depending on the scale of the contract (e.g. a whole clinical service versus a single specialty). However, following the findings above we will explore in more detail what monitoring systems and processes are in place around contract renewal.

Partnership

The Trust works closely with the other providers within the Lancashire and South Cumbria (L&SC) system through a prominent role on the Provider Collaborative Board (PCB). The PCB is Chaired by LTH's Chair (Mike Thomas) with the remainder of the Board made up of Chairs and Chief Executives of all the provider trusts in L&SC. The PCB is the vehicle which allows the Trusts to make joint decisions to benefit patients and communities across the system.

The Trust interfaces with the ICB on a regular basis both in terms of providing accountability for in-year performance but also with respect to strategic planning for 2024/25 and beyond. The Trust is taking a lead role on numerous projects aimed at increasing collaboration and therefore removing costs from the L&SC system, for example as the Lead Provider for the Pathology Collaborative.

The Trust has undertaken a number of initiatives during the year to redesign services and ease pressure on the urgent and emergency care system locally. During the Covid-19 pandemic the Trust's capacity expanded, with the support of non-recurrent resource. However, the challenge is now to remove that additional capacity given that the funding for it is no longer available.

Improving economy, efficiency and effectiveness

Procurement

The Trust's internal auditors completed a review of Insourcing arrangements during the year concluding that there is an inadequate system of internal controls and a weakness with the operating effectiveness of controls is in place. It is defined as the employment of a third-party organisation to perform medical services and procedures on trust premises.

The Trust's engagement with LLPs (to deliver insourcing services) was primarily driven by the need to enhance service delivery and manage waiting lists effectively, however, as these arrangements evolved, several concerns emerged regarding the procurement processes employed.

The report stated:

- The Trust have no policies, procedures or guidance covering insourcing arrangements, this has led to an inconsistency in processes being followed, staff being unaware of their roles and responsibilities, incorrect processes and documentation being completed and consistent contract monitoring not taking place.
- The Trust and Lancashire Procurement Cluster (LPC) are currently taking a reactive approach to contract management rather than a proactive approach to prevent issues arising.
- The Trust and LPC did not have all the appropriate evidence expected for the insourcing contracts arrangements that were in place, including; contract documents, approvals, declarations of interests, insurance details and evidence of contract monitoring.
- Staff who are involved in insourcing, from an operational aspect, have not had any appropriate training to ensure that they understand the process and what is expected of them.

Despite these findings, which amounted to £3.5m of costs to the trust in 24-25, several contracts have been exited, and the Trust now has full oversight of the remaining contracts. In response, the trust must continue to ensure all agreements comply with NHS Standards. One action that has been implemented for example, is the development of a procurement SOP which reflects national policies, Trust SFIs and delegated authority limits.

Following discussion with management about the arrangements in place for procurement more generally, it was evident there were some limitations in the shared service model operated by the Lancashire Procurement Cluster, in terms of the level of support and oversight they provided across the trust. We met with an independent procurement consultant, employed by the Trust, who stressed there were gaps in knowledge and understanding which had led to a high number of waivers, inefficient use of catalogues and last-minute interventions for contract renewal.

A SOP was developed to provide guidance on the process to follow when purchasing goods and supplies, and the ongoing responsibilities to manage and publish supplier performance. In addition, following the transition of the LPC to Procurement and Supply Chain of One LSC, the interim CFO proposed (from November 2024) LTH implement a standard assurance and performance report with the key objectives to inform and give sight to Finance and Performance Committee colleagues, an overview of CIP delivery, ongoing work for single quote waivers, as well as reporting procurement performance benchmarked against national and local metrics.

Improving economy, efficiency and effectiveness

References were also made in the external reviews to this issue. For example, one of the external firms appointed to support financial improvement identified procurement as an area for significant improvement. The move to One LSC has not yet resulted in visible improvements to controls, such as a single location for contract information. This increases the risk of non-compliance which could potentially impact value for money. There was also a £4m CIP objective for 24/25.

As at November 24, there were 83 schemes identified with CIP forecast of £3.5m annualised (of which £2.5m in year). Delivery to date was £2.4m annualised (£2m in year). Part of One LSC role is to develop the efficiency and effectiveness of the procurement function across the system for providers.

We have also seen evidence of the assurance and performance report being presented at FPC which is a marked improvement compared to the previous level of assurance.

Conclusion

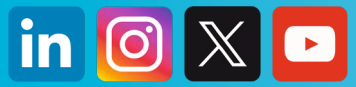
We are satisfied the findings of the insourcing review and overall arrangement for the procurement function is not indicative of a significant weakness. Management have responded quickly to the findings of the Insourcing review, and we do not believe limitations in the overarching procurement process could lead to significant financial loss. Equally, management has taken appropriate action to secure improvements where recommendations have been identified.

Recommendations

We raised the following recommendations in response to significant weaknesses identified in our value for money procedures.

#	Recommendation	Management Response
1	**Strengthening CIP risk assessment and delivery** The Trust has recently strengthened its governance arrangements in relation to cost control and efficiency with the support of external consultants to ensure Executive Directors and divisional leaders are in control of and accountable for Waste Recovery Plan (WRP) schemes identified in the 2025-26 plan. Given the challenge of the WRP (£60m) to be delivered in 2025-26 and the delivery achieved in 2024-25 we recommend management continue to strengthen and sustain the arrangements in place that enable a robust level of challenge and risk assessment of WRP plans. Management should ensure that the risk assessment of those plans is sufficiently prudent to ensure that financial forecasts do not deteriorate unexpectedly due to either their delayed delivery or the value of the efficiency not being as high as predicted. In turn this should enable risks to delivery are appropriately managed and escalated to ensure full visibility to the Board of Directors throughout the year. Financial outturn figures can also be more reliable when being shared with external regulators and partners	The Trust has adopted the definition of risk categories and percentages that were agreed within the One LSC collaboration and is using the standard guidance and documentation that supports services in developing each scheme. The Trust has a bi-weekly waste recovery board led by the CEO and separately executive led 'buddy' meetings for the divisions. The system currently has PWC as part of the external regulation requirements. PWC have been reviewing individual scheme documentation to confirm that the Trust's risk assessment of the scheme is robust or they have recommended changes to the categorisation. The Trust aims for a tracker over £60m to allow for a reduction in value as schemes progress through the development gateways with; divisional deep dive workshops, One LSC and system workshops, review of national benchmarking opportunities e.g. GIRFT and model health system and enhanced PMO support using modelling tools to draw on available data sources including costing, activity and workforce information to identify further opportunities.

KPMG



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