NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS MEETING

BOARD OF DIRECTORS MEETING

2 October 2025

09:15 GMT+1 Europe/London

Lecture Room 1, Education Centre 1, Royal Preston Hospital

AGENDA

- Patient Story from Children and Young People and Neonates (09.15am) 1
- Agenda 2

0.0 - Agenda - Board (part I) - 2 October 25 .pdf 3

1. Chair and quorum (09.30am) 5
2. Apologies for absence (09.31am) 6
3. Declaration of interests (09.32am) 7
4. Minutes of the previous meeting held on 7 August 2025 (09.33am) 8

4.0 - Minutes - Board (Part I) - 7 August 25 - Approved.pdf 9

5. Matters arising and action log update (09.34am) 21

5.0 - Action log - Board (part I) - 7 August 25.pdf 22

6. Chair's opening remarks and report (09.35am) 24

6.0 - Chairs Report - 021025.pdf 25

7. Chief Executive's Report (09.40am) 30

7.0 - CEO Report.pdf 31

8. Board Assurance Framework (09.50am) 45

8.0 - BAF Risk Paper - Oct 2025 - Final.pdf 46

9. FIT FOR THE FUTURE (STRATEGY AND PLANNING) 78

9.1 *Trust Strategy (10.00am) 79

9.1 - Strategy Covering Paper Final docx.pdf 80

9.2 *Winter Plan (10.10am) 84

9.2 - Winter Plan Cover Paper.pdf 85

10. DELIVER VALUE FOR MONEY (FINANCE AND PERFORMANCE) 91

10.1 Finance and Performance Committee Chair's Report (10.20am) 92

10.1 - Chair's report - FPC - 22 July 26 August 25.pdf 93

10.2 *Green Plan (10.30am) 99

10.2 - Green Plan 2025-2028.pdf 100

10.3 Charitable Funds Committee Chair's Report (10.35am) 102

10.3 - Chairs Report CFC 16 Sept.pdf 103

10.4 Integrated Performance Report (10.40am) 105

10.4 - Integrated Performance Report as at 31 August 2025.pdf 106

- Break (11.20am) 149

11. GREAT PLACE TO WORK (WORKFORCE, EDUCATION AND RESEARCH) 150

11.1 Workforce Committee Chair's Report (11.35am) 151
11.1 - Chairs Report WFC 9 Sept.pdf 152
11.2*GMC Revalidation Report (Medical Appraisal Report) (11.45am) 156
11.2 - NW FQAI Annual Medical Appraisal and Revalidation Report Exec Summary.pdf 157
12. CONSISTENTLY DELIVER EXCELLENT CARE (SAFETY AND QUALITY) 159
12.1 Safety and Quality Committee Chair's Report (11.55am) 160
12.1 - Chair's report - Safety and Quality Committee - 25 July 2025 & 29 August.pdf 161
12.2*Mid-year - Maternity Service Safe Staffing Report (12.05pm) 168
12.2 - Maternity Service Safe Staffing Report.pdf 169
12.3*Mortality Annual Report (12.10pm) 172
12.3 - Annual mortality report 24-25 Final for submission to Board v1.pdf 173
12.4*Mid-year Nurse Staffing Report (12.15pm) 175
12.4 - Mid-year Nurse Staffing Report.pdf 176
13. RISK, GOVERNANCE AND COMPLIANCE 180
13.1 NHSE Provider Capability Self-Assessment (12.20pm) 181
13.1 - NHSE Provider Capability Self-Assessment.pdf 182
13.2 Audit Committee Chair's Report (12.30pm) 199
13.2 - Chairs Report Audit 24 Sept.pdf 200
14. ITEMS FOR INFORMATION - contained in the ancillary pack 203
14.1*Data Quality Assurance Report 204
14.2*Social Value Strategy 205
14.3 Date, time and venue of next meeting: (12.30pm) 206

PATIENT STORY FROM CHILDREN AND YOUNG PEOPLE AND NEONATES

Information Item

09.15am

AGENDA

REFERENCES

Only PDFs are attached

0.0 - Agenda - Board (part I) - 2 October 25 .pdf

Board of Directors

2 October 2025 | 9.15am | Lecture Room 1, Education Centre 1, Royal Preston Hospital

Agenda

At 09.15am, there will be a **patient story from Children and Young People and Neonates**

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	9:30am	Verbal	Information	M Thomas
2.	Apologies for absence	9:31am	Verbal	Information	M Thomas
3.	Declaration of interests	9:32am	Verbal	Information	M Thomas
4.	Minutes of the meeting held on 7 August 2025	9:33am	✓	Decision	M Thomas
5.	Matters arising and action log update	9:34am	✓	Decision	M Thomas
6.	Chair's opening remarks and report	9:35am	✓	Information	M Thomas
7.	Chief Executive's report	9:40am	✓	Information	S Morrison
8.	Board Assurance Framework	9:50am	✓	Decision	S Regan
9. FIT FOR THE FUTURE (STRATEGY AND PLANNING)					
9.1*	Trust Strategy	10.00am	✓	Decision	K Hudson
9.2*	Winter Plan	10:10am	✓	Decision	K Foster-Greenwood
10. DELIVER VALUE FOR MONEY (FINANCE AND PERFORMANCE)					
10.1	Finance and Performance Committee Chair's Report - *following report recommended for approval confirmation*	10:20am	✓	Assurance	J Schorah
10.2*	Green Plan	10.30am	✓	Decision	I Ward
10.3	Charitable Funds Committee Chair's Report	10:35am	✓	Assurance	U Patel
10.4	Integrated Performance Report as at September 2025 including Finance update and Single Improvement Plan (considered by appropriate Committees of the Board)	10:40am	✓	Assurance	K Foster-Greenwood/ S Morrison/ N Pease/ C Carter
BREAK		11:20am			
11. GREAT PLACE TO WORK (WORKFORCE, EDUCATION AND RESEARCH)					
11.1	Workforce Committee Chair's Report - *following report recommended for approval confirmation*	11:35am	✓	Assurance	K Deeny

№	Item	Time	Encl.	Purpose	Presenter
11.2*	GMC Revalidation Report (Medical Appraisal Report)	11:45am	✓	Decision	S Canty
12.	**CONSISTENTLY DELIVER EXCELLENT CARE** (SAFETY AND QUALITY)				
12.1	Safety and Quality Committee Chair's Report – *following three reports are also recommended for approval confirmation*	11:55am	✓	Assurance	K Deeny
12.2*	Mid-year - Maternity Service Safe Staffing Report	12.05pm	✓	Decision	S Morrison
12.3*	Mortality annual report	12:10pm	✓	Decision	S Canty
12.4*	Mid-year Nurse Staffing Report	12:15pm	✓	Decision	S Morrison
13.	**RISK, GOVERNANCE AND COMPLIANCE**				
13.1	NHSE Provider Capability Self-Assessment	12:20pm	✓	Decision	S Morrison
13.2	Audit Committee Chair's Report	12:30pm	✓	Assurance	T Wheeler
14.	**ITEMS FOR INFORMATION * ancillary pack**				
14.1	Data quality assurance report		✓		
14.2	Social Value Strategy		✓		
14.3	Date, time and venue of next meeting: *4 December 2025 at 9:15 am at Lecture Room 1, EC1, Royal Preston Hospital*		Verbal	Information	M Thomas

* Full Report in ancillary pack

1. CHAIR AND QUORUM

Information Item | M Thomas | 09.30am

2. APOLOGIES FOR ABSENCE

Information Item | M Thomas | 09.31am

3. DECLARATION OF INTERESTS

Information Item | M Thomas | 09.32am

4. MINUTES OF THE PREVIOUS MEETING HELD ON 7 AUGUST 2025

Decision Item | M Thomas | 09.33am

REFERENCES

Only PDFs are attached

4.0 - Minutes - Board (Part I) - 7 August 25 - Approved.pdf

Board of Directors

7 August 2025 | 9.15am

Lecture Room 1, Educations Centre 1, Royal Preston Hospital

Part I

Present:

Professor M Thomas	Chair
Dr T Ballard	Non-Executive Director
Mr C Carter	Interim Chief Finance Officer
Dr K Deeny	Non-Executive Director
Ms K Foster-Greenwood	Chief Operating Officer
Mr A Leather	Non-Executive Director
Mrs S Morrison	Chief Nursing Officer/Deputy Chief Executive Officer
Professor S Nicholls	Chief Executive Officer
Mr U Patel	Non-Executive Director
Dr G Skailes	Chief Medical Officer
Professor T Wheeler	Non-Executive Director

Apologies: Mr J Schorah, Prof S Crean

In attendance:

Mrs A Brotherton	Chief Strategy and Improvement Officer
Mrs N Duggan	Director of Communication and Engagement
Mrs J Foote	Director of Corporate Affairs
Dr N Pease	Chief People Officer
Mr S Regan	Associate Director of Risk and Assurance
Mrs K Lawrenson	Corporate Affairs Officer
Mrs J Wiseman	Interim Business Manager, Corporate Affairs *(minutes)*
Ms E Ashton	Divisional Nursing & Midwifery Director (Item **/25)

Governors observing: Frank Robinson, Sonia Connell, Janet Miller, Carole Oldcorn, George Bailey, Graham Robinson

Observers: Annemarie Vicary, National Recovery Support Team, NHSE

Presenters of the patient story: Hazel Wright, Dr Muna Parajuli, Dr Thomas Thorp

Prior to the meeting the Board received the following presentation: Patient Story, Medical Division.

The Board received a patient story presentation illustrating the care journey of an elderly patient, Stephanie, through the Trust's frailty pathway. Stephanie had significant health conditions and was supported at home by her husband. Following two falls in quick succession, she was assessed in the Emergency Department and transferred to the Acute Frailty Assessment Unit. Although advanced care planning was discussed, Stephanie and her family were not ready to proceed at that time. She was discharged with telephone follow-up service by the frailty nurses and a package of care to help twice daily.

Post-discharge, concerns were raised, and a frailty outreach visit was arranged. Following clinical assessment, Stephanie was stepped up to the Virtual Frailty Ward. The Multidisciplinary Team reviewed her case and arranged further investigations, which indicated that Stephanie was approaching the end of life.

The Virtual Frailty Ward team facilitated Stephanie's wish to remain at home. This included anticipatory care planning by two senior Geriatricians, prescribing end-of-life medications, and arranging urgent occupational therapy input and equipment. Stephanie died peacefully at home at the end of June 2025, surrounded by her family. Stephanie's husband Colin provided feedback – "Thank you for the excellent care you gave to my wife, I am forever grateful. Enabling her to stay at home was so important to Stephanie and her family and you made this happen. I am happy for you to share her story so this can continue for other patients".

The Board acknowledged the compassionate and patient-centred approach demonstrated by the frailty team. The story highlighted the importance of proactive end-of-life care planning and the value of enabling patients to remain in their preferred place of care. The Board expressed condolences to Stephanie's family and agreed to send a letter of thanks for allowing her story to be shared.

141/25 Retirement of the Chief Medical Officer

The CEO informed the Board that this would be the last formal Board meeting for Dr Gerry Skailes in her role as Chief Medical Officer. The Board acknowledged Gerry's long service, dedication and commitment to the Trust, recognising also her service to the improvement of medical care in the system. On behalf of the Board the Chair wished her all good wishes for her retirement.

142/25 Chair and quorum

Having noted that due notice of the meeting had been given to each member and that a quorum was present the meeting was declared duly convened and constituted.

The Board of Directors were informed that the meeting would be observed by a representative from the National Recovery Support Team.

143/25 Declaration of interests

Non-Executive Dr T Ballard declared an interest in that he was a CQC National GP Advisor. The interest was noted with no requirement to leave the meeting.

144/25 Minutes of the previous meeting

The minutes of the meeting held on 3 June 2025 were approved as a true and accurate record.

145/25 Matters arising and action log

The updated action log was received.

146/25 Chair's report

The report provided a summary of work and activities undertaken during June and July 2025 by the Trust Chair including a resumé of the items discussed in the part II Board meeting on 3 June 2025.

147/25 Chief Executive's report

The report provided an overview on matters of interest since the previous meeting. In addition, the Chief Executive highlighted some key points.

It was confirmed that following the retirement of the current Chief Medical Officer at the end of September, Dr Steve Canty (currently Divisional Medical Director for Surgery at the Trust) would assume the role.

The Board was updated on the recent industrial action involving resident doctors. Appreciation was expressed to colleagues who remained in work during this period. While efforts had been made to minimise disruption, the action had impacted patient care and service delivery. Further information regarding operational and performance impact would be presented to the Finance and Performance Committee, with subsequent dissemination to relevant committees upon finalisation.

148/25 Board Assurance Framework

The Well Led Framework by NHS England and the Care Quality Commission (CQC) required Boards of all provider organisations to ensure there was an effective and comprehensive process in place to identify, understand, monitor and address current and future risks. This included a Board Assurance Framework (BAF) which provided a structure and process to enable organisations to identify those strategic and operational risks that may compromise the achievement of the Trust's objectives.

The Board received an update on the Board Assurance Framework (BAF). One risk score had increased since the previous meeting, Principal Risk 13, relating to the cash consequences of the Trust's financial position, which rose from 12 to 20. This was due to the absence of confirmed support from NHS England and the forecasted cash shortfall anticipated from September. Following the approval of the application for cash support on 1 July 2025 at the Special Board of Directors meeting *(minute ref 139/25),* guidance had been received from NHS England and a response had been submitted. A cash management group had been established to monitor and escalate issues as needed, reporting into the Finance and Performance Committee.

Progress was noted on Principal Risk 12 concerning delivery of the financial plan, with Waste Reduction Programme schemes underway. Principal Risk 7 related to temporary medical workforce was discussed, with improvements observed in sickness absence

and significant reduction in agency reliance. Workforce was developing a strategy around staff engagement and a reduction in sickness absence has been noted for three consecutive months, standing at a rate of 5.8%. Shared learning and ideas with East Lancashire Hospitals had been beneficial to both Trusts.

Principal Risk 2, concerning the Clostridium Difficile infection rate, was noted to be performing below the expected trajectory. It was agreed that the situation should continue to be monitored closely, and any consideration of a risk score reduction would be deferred until the end of 2025 to ensure that the improvement was sustained.

The Board agreed to maintain current risk scores but requested the BAF include clearer timelines, trajectories and evidence to support future changes to be reviewed in late Autumn. Consideration of the forthcoming league tables would be required to triangulate with performance data to achieve consistent goals. The Board emphasised the importance of triangulating assurance across committees and maintaining clarity between operational risks and strategic assurance.

The Board RESOLVED to approve the updates in the Board Assurance Framework.

149/25 Safety and Quality Committee Chair's Report

The Board received a verbal update from the Chair of the Safety and Quality Committee covering key priorities from the July meeting, supplementing the written report covering the May and June meetings. Two previously reported never events were noted, including a fourth never event in ophthalmology within 18 months. Enhanced oversight was initiated, including an internal forensic review with the inclusion of Integrated Care Board colleagues, and an external review scheduled for September 2025. The Committee had acknowledged the rigour and commitment of staff in addressing the root causes collaboratively. An update was provided on the Regulation 28 Notification regarding the thrombectomy services, with a formal response submitted in July.

Improvements in Tier 2 maternity staffing were noted, contributing to enhanced safety outcomes and financial efficiencies. The STAR quality assurance programme continued to show progress, with performance improvements expected by August. The Committee had acknowledged that STAR was not directly aligned with Waste Reduction Programme metrics and had requested data for any correlation between staffing and underperformance. An explanation of the STAR quality assurance programme was provided as a risk-stratified accreditation visit programme undertaken by peer auditors with a comprehensive reflection of regulatory inspection standards. As part of the quality assurance mechanism, departments were required to achieve the fundamental standards before progressing to a green rating.

Continuous flow and boarding initiatives had been discussed at the June meeting, with early feedback from staff indicating limited impact. A six-month review was planned, with interim escalation routes in place. At the July meeting the endoscopy waiting times were reviewed and the Committee was assured by mitigation plans addressing clinical harm. Performance aspects were referred to the Finance and Performance Committee.

The Committee endorsed the Trust's proactive response to the NHS England's National Maternity and Neonatal Review. While not named in the review, the Trust was preparing a culture review led by the Deputy Chief People Officer. Focused work on health

inequalities and harm reporting would continue with triangulation across subcommittees with a shared commitment to avoid duplication and maintain focus.

The Committee received the Medical Safe Staffing report and agreed to receive a follow-up report in September, which would include the progress on risk mitigation and CQC feedback. This would support the development of robust assurance for medical staffing.

150/25 Quality Account

With reference to Minute No. 106/25, the Quality Account was presented in final form for approval.

The Board RESOLVED to approve the Quality Account for 2024/25.

151/25 Annual Safeguarding Report

The Annual Safeguarding report was presented for consideration and approval. The Safety and Quality Committee had endorsed the report at its meeting on 27 June 2025 (SQC Minute No.112/25 refers).

Two recommendations had been requested for future iterations: the inclusion of timelines and trajectories to strengthen assurance, and clearer cross-referencing with the national review around mental health and learning disabilities. The Board welcomed the adoption of a reform-based approach and acknowledged its contribution to improving patient experience and addressing behavioural challenges. It was agreed that safeguarding matters with workforce implications would be considered for future scrutiny by the Workforce Committee.

The Board RESOLVED to approve the Annual Safeguarding Report.

152/25 Maternity and Neonatal Services Report

The report provided an update report in relation to workforce, staffing and safety, quality, assurance and oversight programmes of work including the Clinical Negligence for Trust (CNST) Maternity Incentive Scheme (MIS) for the year 7 reporting period. (1 December 2024 to 30 November 2025). The report had been scrutinised by the Safety and Quality Committee (SQC Minute No. 90/25 refers) and aligned with the site visits conducted by the Non-Executive Director Maternity and Neonatal Champion.

Key challenges were noted in maternity triage and induction of labour, where delays impacted patient experience. No harm events had been reported, and improvement work was underway. Staffing pressures led to two service diverts affecting eight women, all of whom returned safely to the service. Recruitment was ongoing to fill 17.85 midwife vacancies, with anticipated onboarding within 12 weeks. Obstetric staffing improvements were expected by October.

The Board was informed of a forthcoming national review of maternity services, with ten trusts expected to be selected. While the Trust had not received any indication of inclusion, mechanisms were in place to absorb learning from the review. A national oversight signalling system was expected in November to support early identification of concerns. The Board supported a future development session to review national

maternity oversight frameworks and their local implications. Assurance was provided that learning from national reviews would be actively incorporated into local practice.

The Board discussed the importance of culture and its link to staffing and safety. A rigorous review of culture and leadership within maternity services was underway. The contribution of midwife support workers was highlighted, noting the need to prioritise their recruitment and well-being in workforce planning. It was suggested that liaison could be undertaken with Nottingham University Hospital to gather feedback on learning outcomes from an independent review.

A discussion was held around the increased demand for Caesarean sections. It was explained that this was attributed to a rise in women having induction of labour, driven by national initiatives such as the Saving Babies' Lives programme, which had introduced stricter clinical guidelines. It was noted that initiating one intervention often led to further interventions, including Caesarean sections. Additionally, some individuals who began induction had then opted to discontinue the process, resulting in unplanned Caesarean section. It was anticipated that this upward trend would continue until it eventually plateaued, although the timeline for this remained uncertain.

The Board confirmed its assurance of the Trust's progress and oversight in relation to workforce, staffing, safety, quality, and the CNST Maternity Incentive Scheme (MIS) for Year 7.

153/25 Winter Planning - Lesson Learned and Planning 25/26

The Board received an update on the outcomes and learning from the 2024/25 winter planning period that had been scrutinised by the Finance and Performance Committee (FPC Minute No. 110/25 refers).

A series of targeted schemes had been implemented focusing on attendance and admission avoidance, Emergency Department (ED) responsiveness, and discharge flow. These interventions led to a 1.7% improvement in four-hour performance compared to the previous winter, with reduced average boarding levels. However, ambulance handovers and delayed discharges remained areas of concern. Key learning included the need for earlier mobilisation of winter planning schemes, the impact of workforce stretch when opening additional beds, and the importance of maintaining ring-fenced areas such as discharge lounges.

Emphasis was placed on the importance of achieving improvements over the summer and autumn period. A reduction in attendances of approximately 5% was observed during the previous winter, which was attributed in part to efforts focused on reducing demand in the ED. Notably, this was the first winter in several years where additional winter ward capacity had not been opened, a decision taken to avoid further strain on staffing. While there was recognition of areas requiring improvement, early signs of improvements were acknowledged. Planning for the upcoming winter had already commenced, with oversight by the Finance and Performance Committee. The Board noted that a formal assurance statement would be required once the locality and ICB plans were finalised.

Challenges were raised regarding the granularity of data available to assess population health characteristics and their influence on winter pressures, recognising that further work to improve analytics would be an ongoing iterative process.

154/25 Workforce Committee Chair's report

The Chair's report from the Workforce Committee provided an overview of items discussed at the meetings on 8 July 2025 based on the 3As methodology (Alert, Advise, Assure) including, where appropriate, items recommended for approval by the Board.

Concerns had been raised regarding the current capacity of the workforce team, which was noted as a limiting factor in progressing organisational transformation at the desired pace.

Positive developments were highlighted to the Board, including sustained improvement in sickness absence rates, now consistently below 6%, and significant progress in addressing non-compliance with mandatory training. These improvements were recognised as essential to strengthening leadership, staff engagement and retention. The Committee had also noted improvements in appraisal completion rates and welcomed the advancement of the health and well-being strategy. The importance of aligning workforce activity with organisational priorities and staff engagement were noted.

155/25 Guardian of Safe Working Report

The Board received the Guardian of Safe Working report, covering the period from January to December 2024. The report had been reviewed by the Workforce Committee (WC Minute No. 82/25 refers), with no items escalated.

The report reviewed exception reporting, safe staffing levels, junior doctor and clinical fellows' welfare across the Trust. Exception reports had increased to 670 in 2024, up from 520 in 2023, with 34 immediate safety concerns (ISCs) reported, an increase of 16 against the previous year. A concern around the increase was raised and it was explained that contributing factors had been identified and addressed, resulting in a reduction in reports this year. The Local Negotiating Committee now had doctor representation that helped to identify concerns. The majority of exception reports originated from foundation year one doctors, particularly in the early months of their placements. In response to a query, the Board was informed of ongoing work to improve the working lives of doctors, including targeted interventions in areas such as medicine and surgery. Monthly safety visits included areas that had been highlighted and had led to changes in practice, such as improved night cover arrangements, with positive feedback received from junior staff.

The Board noted the retirement of the current Guardian of Safe Working and was advised of their commitment to the role whilst working as a Consultant Paediatrician. The Board asked that a letter of appreciation be sent to Dr Kendall. Recruitment for a successor was underway.

156/25 Social Value Strategy

The Board received the Social Value Strategy, that had been reviewed by the Workforce Committee (WC Minute No. 79/25 refers). The strategy aimed to strengthen the organisation's role as an anchor institution, with a focus on supporting local communities through responsible use of resources, inclusive employment practices and estate

utilisation. The strategy was informed by partner engagement and a literature review. This included a delivery framework to guide impact measurement and improvement.

The Board noted alignment with the Trust's strategic mission to improve the health and wealth of the local population and integration with broader priorities such as health inequalities, workforce development and the green plan. Btu queried further on the planned methodology to ensure that the oversight towards outcomes were monitored and met. It was confirmed that the strategy would be overseen by the Workforce Committee, with regular updates and an annual report to the Board. The strategy remained iterative, with future revisions expected to align with the NHS 10-year plan and other national developments. The importance of embedding social value across all organisational activities was emphasised.

The Board discussed opportunities to share the strategy with regional and national partners to support system-wide sustainability across the services of Lancashire and Sout Cumbria.

The work that had been undertaken to improve access to careers in medicine within the communities served was probed for further detail, particularly to understand the approach for young people who had not previously considered such pathways. It was explained that the approach extended beyond academic preparation, involving advocacy with educational institutions regarding entry requirements and work experience opportunities.

The Board RESOLVED to note the progress and supported the continued development of the Social Value Strategy.

157/25 Education, Training and Research Committee Chair's report

The Chair's report from the Education, Training and Research Committee provided an overview of items discussed at the meeting on 10 June 2025. The Board were informed that the Committee had focused on mandatory training compliance, particularly among medical and dental staff. Improvements were noted, with full compliance achieved across all core skills, including levels three and four resuscitation training. The Board acknowledged this as a significant achievement and recognised the link between training compliance and quality of care. The Board noted that persistent non-compliance may lead to disciplinary action. Concerns were raised about sustaining compliance long-term, and it was explained that enhanced reporting and a graduated escalation process were now in place to support ongoing adherence.

The Committee had also discussed the experience of resident doctors, with ongoing work to improve working conditions. Positive developments were reported in collaboration with academic partners, including joint appointments that supported the Trust's aspiration to achieve university hospital status. Progress in research was highlighted, with growth in research portfolios and strengthened partnerships.

158/25 Integrated Performance Report as of the end of April 2025

The Board received the latest iteration of the Integrated Performance Report (IPR), which had been refined in response to previous feedback to improve clarity and effectiveness. The revised format aimed to support better understanding of current performance and enable focused attention on priority areas for organisational

improvement. The report provided the Single Improvement Plan, high level metrics, of which the outcomes had been scrutinised by each relevant subcommittees of the Board. The outcome metrics were presented with a supporting summary, assurances provided and actions being taken to address the position where improvement was identified.

Great Place to Work - Improvements in mandatory training compliance were noted, supported by enhanced reporting and weekly executive review. Cross-organisational collaboration was highlighted as a positive influence on workforce initiatives. The Board was informed of ongoing work to improve reporting on violence and aggression against staff, with efforts underway to adopt best practice with other trusts in the system. Concerns were raised about violence and aggression, particularly in specialist units such as neurorehabilitation. The Board was assured that national enhanced care models were being adopted and that incident patterns were being assessed across peer providers.

Preparations for the upcoming staff survey were discussed, alongside continued focus with staff engagement. Appraisal rates had exceeded 95%, which was recognised as a contributor to performance and staff development.

Consistently Deliver Excellent Care - It was confirmed that all the Care Quality Commission (CQC) “should do” actions had been completed, with three “must do” actions outstanding relating to medical staff training in the Emergency Department. The Board sought confirmation on compliance with outstanding CQC “must do” actions. It was confirmed that trust-level compliance had been achieved, with department-level data expected for August reporting.

Midwifery support worker fill rates remained below funded levels, attributed to sickness and other career progression opportunities. Work was ongoing to address these challenges. Overall staffing fill rates remained positive. Mortality rates were reported as stable and below national average, with assurance provided through deep-dive reviews.

Progress in STAR accreditation was noted, with improvements in critical standards. The importance of maintaining rigour in assessments to ensure confidence in reported outcomes was highlighted.

The Trust had recorded its highest number of compliments in a single month, with over 1,000 logged, particularly within the Women’s and Children’s division. This was linked to ongoing reward and recognition initiatives, culminating in the annual People Awards.

Deliver Value for Money - The Board received an update on the financial position as at Month 3. The Trust reported a deficit of £12.5million against a planned deficit of £7million, primarily due to underperformance in the Waste Reduction Programme (WRP). While the original plan targeted £9.4million savings in quarter 1, £3.6million was achieved. However, this aligned with the revised WRP profile, indicating delivery against the updated plan.

The Board was informed that over £60million in WRP schemes had now been identified, with more than £50million either delivered or fully developed. Divisional delivery groups had been established to monitor progress and assess delivery risk, chaired by the Turnaround Director and attended by executive and divisional leadership colleagues.

Capital expenditure was reported at £802,000 against a planned £972,000 for quarter 1, with deliberate restraint due to the current cash position. The Board noted that a formal cash request had been submitted to NHS England and that capital spend, WRP delivery, and cash flow would require close monitoring.

In relation to the Waste Reduction Programme, the Board asked when benefits would be realised. It was confirmed that delivery would begin to exceed original targets from Month 7 onwards, with a step-up in Month 4. The Board emphasised the importance of maintaining control as winter pressures approached and noted the link to cash flow requirements.

Operational Performance Summary - The Board received the operational performance report and was informed that the Trust would re-enter NHS England's Tier 1 support programme, with a focus on planned care, including referral to treatment (RTT), cancer and diagnostics. This would involve fortnightly meetings with the regional team to review improvement plans and receive guidance. The Board discussed the implications of re-entering Tier 1 oversight and stressed the need to learn from previous cycles to ensure sustainable improvement.

Ambulance handover performance was highlighted as a key area of improvement. Since the implementation of the national 45-minute release to rescue target on 1 August, no breaches had occurred, indicating early success. The Board noted the importance of sustaining this progress, given its impact on patient safety and staff morale.

RTT and diagnostic performance remained under pressure, with workforce gaps and administrative constraints contributing to delays. Targeted recruitment and vacancy management were underway to support improvement. Cancer performance showed improvement in faster diagnosis and 31-day standards, and although improved, the 62-day performance remained below target. Forecasts for achieving the 62-day cancer standard were set for October, while diagnostics performance was anticipated to reach 65% by April 2026 with further planning required to address growth gaps in the next annual cycle. It was noted that oversight of these targets would be with the Finance and Performance Committee.

The Board was updated on the "days kept away from home" initiative, with early signs of improvement from cohort wards and joint triage work with Lancashire County Council. These efforts aimed to reduce unnecessary hospital stays and improve discharge pathways.

A question was asked whether divisional teams received performance data in a similar format, and it was confirmed that divisional scorecards aligned with the accountability framework and were under review.

Assurance was sought on the sustainability of improvements in diagnostics, particularly regarding the use of temporary staffing. It was confirmed that a refreshed capacity and demand analysis was underway, with benchmarking to identify productivity opportunities and residual gaps. Mutual aid modelling across the system was being reviewed, starting with Echocardiology.

The importance of coordinated planning across the system and national efforts to reassess resource distribution was noted. It was agreed that sustained improvement

would be essential to progress from turnaround status to a high-performing specialist provider.

The Board confirmed it was assured in respect of the actions being taken to improve performance.

159/25 Finance and Performance Committee Chair's report

The Chair's report from the Finance and Performance Committee provided an overview of items discussed at the meetings on 27 May and 24 June 2025 based on the 3As methodology (Alert, Advise, Assure).

The Committee had focused on the interdependencies between the recovery plan and operational performance, acknowledging that while the financial plan remained affordable, achieving the next steps of improvement remained challenging. Assurance had been provided around improved grip and control, with evidence of behavioural change across teams. This included increased vacancy control panel (VCP) rejections, proactive vacancy management, and enhanced scrutiny of productivity and delivery options. Safe staffing remained a priority, with executive triangulation introduced to ensure decisions around vacancy rejections were balanced against service delivery needs. Daily and weekly reviews were enabling responsive adjustments where concerns were escalated. Assurance was noted that, while the process required careful navigation, robust mechanisms were in place to monitor and respond to emerging risks.

160/25 Audit Committee Chair's Report

The Chair's report from the Audit Committee provided an overview of items discussed at the meeting on 24 June 2025 based on the 3As methodology (Alert, Advise, Assure).

Limited assurance was noted in relation to the health and safety review, with ongoing initiatives across the organisation aimed at addressing identified issues. The Committee continued to monitor progress and coordinate with other subcommittees to ensure resolution.

Financial sustainability remained a key focus, with some positive developments such as the reduction in sickness absence contributing to cost mitigation. Issues had been identified regarding prescription charging and derogations from financial regulations, particularly within estates and facilities. These were under active review, with no confirmed financial loss but potential risk noted.

The Committee had highlighted the importance of data quality, noting that while decision-making data was generally sound, improvements in timeliness were needed in some areas. The Board was encouraged to consider functional needs and internal workforce dynamics to ensure optimal resource utilisation.

161/25 Charitable Funds Committee Chair's report

The Chair's report from the Charitable Funds Committee and provided an overview of items discussed at the meeting on 17 June 2025 based on the 3As methodology (Alert, Advise, Assure). No items were escalated.

Recent funding approvals included accommodation support for families attending the oncology unit and upgrades to staff areas within the chemotherapy unit at Chorley

District Hospital. These initiatives were noted as having a positive impact on patient and staff experience.

The Board was informed that the overall charitable funds, including Baby Beat and Rosemere funds, remained in a strong financial position. A presentation from the Trust's investment administrator had confirmed continued confidence in the management of charitable assets.

162/25 EPRR Core Standards Assurance

The Board received the Emergency Preparedness Resilience Response (EPRR) assurance report, following scrutiny by the Finance and Performance Committee (FPC Minute No. 111/25 refers).

The Trust's self-assessment against national core standards had resulted in a proposed rating of substantial compliance. Of the 62 standards, 58 were fully met and four were partially met, primarily due to resource constraints. Recruitment to address these gaps was underway, with completion expected in October. Two policies related to warning and informing were pending publication. The Data Security and Protection Toolkit submission had been assessed as "approaching compliance". Business continuity protocols, particularly around supplies, were highlighted as a system-wide issue being addressed collaboratively across the Integrated Care Board.

The Board confirmed it was assured of the Trust's emergency preparedness and formally acknowledged the submission of Substantial Compliance for the 2025-2026 EPRR Core Standards.

163/25 Items for information

The following reports were received and noted for information:

(a) AHP Safe Staffing Report

164/25 Date, time and venue of next meeting

The next meeting of the Board of Directors will be held on Thursday 2 October 2025, 9:15am, Lecture Room 1, EC1, Royal Preston Hospital

The meeting closed at 12.45pm

5. MATTERS ARISING AND ACTION LOG UPDATE

Decision Item | M Thomas | 09.34am

REFERENCES

Only PDFs are attached

5.0 - Action log - Board (part I) - 7 August 25.pdf

Action log: Board of Directors (part I) – 7 August 2025

Outstanding Actions

№	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update
1.	148/25	7 Aug 2025	***Board Assurance Framework -*** The Board agreed to maintain current risk scores but requested the BAF include clearer timelines, trajectories and evidence to support future changes to be reviewed in late Autumn.	ADoR&A	4 Dec 2025	

COMPLETED ACTIONS *(for information)*

№	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update
1.	n/a	7 Aug 2025	**Patient Story** – A letter of thanks be sent to the patient's family for allowing her story to be shared.	DoCA	ASAP	**Completed** **Update for 2 Oct 2025** - Letter drafted and posted 12 Aug.
2.	147/25	7 Aug 2025	**CEO Update -** Further information regarding operational and performance impact following industrial action to be presented to the Finance and Performance Committee, with subsequent dissemination to relevant committees upon finalisation.	COO CFO	2 Oct 2025	**Completed** **Update for 2 Oct 2025** – Added to the FPC Oct agenda.
4.	152/25	7 Aug 2025	***Maternity and Neonatal Services Report –*** A future Board development session to include a review of the national maternity oversight framework anticipated at the end of 2025.	DoCA	2 Oct 2025	**Completed** **Update for 2 Oct 2025** - detail logged in the board development work plan.
5.	155/25	7 Aug 2025	***Guardian of Safe Working*** - The Board noted the retirement of the current Guardian of Safe Working and	DoCA	2 Oct 2025	**Completed** **Update for 2 Oct 2025:** Letter drafted and sent.

№	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update
			asked that a letter of appreciation be sent to Dr Kendall.			

6. CHAIR'S OPENING REMARKS AND REPORT

Information Item | M Thomas | 09.35am

REFERENCES

Only PDFs are attached

6.0 - Chairs Report - 021025.pdf

Board of Directors Report

Chair's Report			
Report to:	Board Of Directors – Part 1	**Date:**	02.10.25
Report of:	Chair	**Prepared by:**	Mike Thomas, Chair
Part I	√	**Part II**	

Purpose of Report					
For assurance	☐	**For decision**	☐	**For information**	☒

Executive Summary:

The purpose of this report is to provide a summary of work and activities undertaken during August and September by the Trust Chair.

It is recommended that the Board receives the report and notes the contents for information.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive health innovation through world class education, teaching and research	☒	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

Chair's Report

1. Introduction

The purpose of this report is to provide an overview of the work and activities undertaken during August and September 2025.

Walkabout Education and Training

On 30th July, I conducted a visit to the Education and Training department, during which I had the opportunity to meet with Lauren O'Brien, Deputy Director of Education, and her colleagues. The visit was both informative and encouraging, and I was impressed by the high levels of enthusiasm, professionalism, and expertise demonstrated by the team. This reflects positively on the quality of work currently being delivered within the department.

Population of Health

I continue to participate in meetings with colleagues from the Trust and the wider Lancashire and South Cumbria system. The approach remains comprehensive, with a clear emphasis on prevention, early intervention, and the reduction of health inequalities. There is a sustained focus on the delivery of integrated care and on the advancement of preventative strategies, which are viewed as central components of the region's long-term vision for health and care services.

Community of Practice Event

On 5th September, I attended the Community of Practice forum, which has been established to promote collaboration, innovation, and continuous improvement across the organisation. Led bimonthly by C Gregory, Deputy Chief Nurse, each session is structured around a designated theme relevant to service delivery and professional development. The forum provides a valuable platform for discussion on best practice, incident learning, and in-depth exploration of priority areas.

The session I attended focused on the Days Kept Away from Home Initiative, designed to empower patients in actively managing their health and well-being. This initiative aims to shift the focus of care towards patients' strengths and capabilities, rather than solely their medical conditions. The discussion underscored that successful implementation relies on the commitment and understanding of all staff, working collaboratively with patients, families, and carers to ensure shared ownership of objectives and outcomes.

2. Chair's Update – Summary of Key Items from Private Board

Preston Youth Strategy 2025–2035

- The Board received the Preston Youth Strategy, developed in collaboration with partner agencies and over 1,400 young people.
- The importance of aligning Trust priorities with the Youth Strategy was acknowledged, especially regarding children and young people's services.
- The Board discussed the need for streamlined protocols to review and respond to external strategies and noted upcoming local government reforms.

Finance and Performance

- The Board received an update on financial performance at Q1, noting improved confidence in scheme identification and delivery.
- Divisional delivery groups were supporting risk identification and improved forecasting.
- The Waste Reduction Programme is achieving a recurrent savings rate of 80–85%, with robust Equality and Quality Impact Assessment processes in place.
- The Board emphasised the importance of maintaining the pace of improvement and planning for the next financial year.

Well-Led Review (GGI)

- The Board received the initial findings of the Well-Led Review, highlighting strengths in governance, risk management, and patient safety.
- Recommendations included improving communication of the Single Improvement Plan, increasing Board visibility, and promoting staff well-being resources.

Risk Management

- The process for managing restricted risks was explained, with assurance provided on governance arrangements.

Business Case Approval

- The Board approved the business case for the Endoscopy 5th Room, which will repatriate outsourced activity, improve productivity, and support accreditation requirements.

3. Chair's attendance at meetings

Details below are the meetings attended and activities undertaken during August and September 2025.

Date	Activity
August 2025	
6th	1:1 A Vicary, NHSE
6th	1:1 Director of Corporate Affairs
6th	1:1 Lead CEO, Provider Collaborative
6th	1:1 Director of Communications & Engagement
7th	LTH Board of Directors
13th	1:1 Chief Strategy and Information Officer
14th	Provider Collaborative Board
14th	1:1 Lead CEO, Provider Collaborative
26th	1:1 Non Executive Director
26th	1:1 Deputy Director of Education
28th	Mtg with Non-Executive Director and Lead Governor
28th	Engagement Session, NHSE
28th	1:1 Divisional Director, Surgery
26th	1:1 Lead CEO, Provider Collaborative
September 2025	
2nd	Board Workshop
3rd	1:1 Head of Patient Experience
4th	Chief Executive, NHSE
4th	Leadership Academy
5th	Community of Practice Event
9th	IAG Mtg, County Hall
10th	1:1 Director of Corporate Affairs
10th	Provider Collaborative Colleague Briefing
10th	MIAA meeting
11th	1:1 A Vicary, NHSE
11th	Provider Collaborative Board
11th	Focus Meeting
16th	1:1 Non-Executive Director
16th	Non-Executive Director Meeting
18th	ARTE Committee
23rd	Chairs and MD for Provider Collaborative

24th	1:1 Director of Corporate Affairs
24th	1:1 Deputy Director of Education
24th	1:1 Lead Governor
24th	COG Development Meeting
25th	1:1 Director of Communications and Engagement
25th	Annual Members Meeting
25th	ARTE Committee

4. Financial implications

There are no financial implications associated with the recommendations in this report.

5. Legal implications

There are no legal implications associated with the recommendations in this report.

6. Risks

There are no risks associated with the recommendations in this report.

7. Impact on stakeholders

There is no impact on stakeholders associated with the recommendations in this report.

8. Recommendations

It is recommended that the Board received the report and notes the contents for information.

7. CHIEF EXECUTIVE'S REPORT

Information Item | S Morrison | 09.40am

REFERENCES

Only PDFs are attached

7.0 - CEO Report.pdf

Board of Directors' Report

Chief Executive's Report			
Report to:	Board of Directors	**Date:**	2 October 2025
Report of:	Chief Executive	**Prepared by:**	N Duggan
Part I	✓	**Part II**	

Purpose of Report					
For assurance	☐	**For decision**	☐	**For information**	☒

Executive Summary:

The purpose of this report is to update the Trust Board on matters of interest since the previous meeting.

The Board is requested to receive the report and note its contents for information.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive health innovation through world class education, teaching and research	☒	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

Not applicable

CHIEF EXECUTIVE'S REPORT

NHS League Tables published

On Tuesday 9th September, the Secretary of State for Health and Social Care, Wes Streeting, announced Lancashire Teaching Hospitals' segmentation and ranking as part of NHS England's new NHS Oversight framework (NOF).

The new NOF sets out how NHSE will assess providers and Integrated Care Boards (ICBs), alongside a range of agreed metrics, promoting improvement whilst also identifying which organisations need support. This is intended to both strengthen board assurance and help regional oversight teams take a view of boards' grip and awareness of the challenges their organisations face and their track record of addressing them.

The results confirm that LTH ranks 127/134 in the acute and specialist provider league table. You can access the NHS trust performance league tables process and results on the NHSE website here. We have also been notified that we are in a new segment five, created for those currently in the Recovery Support Programme, but the league tables do not reflect this at this stage.

Both the segmentation and ranking are primarily a reflection of our long-standing financial deficit and our strategic decision to prioritise financial recovery efforts in 2025/26.

We understand that this ranking will be of concern, but we remain committed to delivering excellent care with compassion and wanted to provide some additional context surrounding the results.

Segmentation

Earlier this year the Trust was placed into segment four of the NHS Oversight Framework and, along with two other local Trusts and the ICB, was enrolled into the Recovery Support Programme.

The new NHS Oversight Framework 2025/26, however, introduces an additional fifth level to help those organisations which need support the most. You can read more about the new framework on the NHS England website here.

All providers currently in the Recovery Support Programme (RSP) have been placed in segment five by default.

As such, we will continue to be supported by NHS England's (NHSE) most intensive scrutiny and performance management. The new metrics will allow for more targeted help for Trusts, and we welcome the support being provided by NHSE and other partners to help us focus on the areas we must improve.

We'd like to make it clear that the segmentation under the new framework is not directly comparable to our previous position – there are different metrics involved, and this does not mean the Trust's performance has deteriorated. Neither has our ability to deliver the highest quality care to those who need it.

League table ranking

The Trust finances play a significant part in our league ranking but we have also been gradually recovering from a range of performance challenges.

Work and improvement measures we are currently undertaking include:

- Prioritising delivering improvements in the key metrics that form the league table, with initiatives including targeted interventions to address the root causes of absenteeism, complemented by a comprehensive wellbeing offer to provide enhanced support for colleagues.
- Programmes of work underway through our Single Improvement Plan (SIP) to improve patient safety and staff engagement. Please note it will take some months before this work is reflected in the published league tables, as the metrics for these relate either to CQC inspections (CQC ratings are used to allocate a score) or are annually published surveys.

- Streamlining our operational processes, implementing advanced technologies to improve patient care and service delivery, and investing in staff training and development.
- A commitment to continuous improvement and we are confident that these initiatives will lead to significant advancements in our performance metrics over time. Katie-Foster Greenwood, our Chief Operating Officer is developing a further Performance Improvement Plan, which will be reported to our Finance and Performance Committee and to Trust Board.

Our improvement journey so far has been a whole team effort from colleagues across the Trust. I would like to say a big thank you to colleagues for their hard work to date, it is greatly appreciated.

As a senior leadership team, we are confident that the proactive approach we are taking together as a Trust will lead to the improvements needed and that we will see an improved position in the Quarter 2 publication (late November).

We do not underestimate the task at hand and hugely value the continued support of our colleagues and communities as we navigate the current challenges, focusing on making these important improvements and on what matters most to our patients.

Martha's Rule rolled out to all acute hospitals

Martha Mills died in 2021 aged 13 after developing sepsis in hospital, where she had been admitted with a pancreatic injury after falling off her bike. Martha's family's concerns about her deteriorating condition were not responded to, and in 2023 a coroner ruled that Martha would probably have survived had she been moved to intensive care earlier.

This led to the creation of Martha's Rule, a scheme which allows patients and families to seek a second opinion if they feel their condition, or the condition of a loved one, is deteriorating and they are not being listened to.

As outlined in May 2024, Royal Preston and Chorley and South Ribble Hospitals were among 143 hospital sites to test and roll out Martha's Rule in its first year, and the NHS has now announced that this is now available in every acute hospital in England, with new data showing hundreds of patients have benefitted from potentially life-saving changes to their care thanks to the scheme.

Between September 2024 and June 2025, there were 4,906 calls made nationally to Martha's Rule helplines to escalate concerns about care – leading to 241 potentially life-saving interventions being triggered.

The positive results from the first year have led the NHS to expand its use to an additional 67 sites – meaning all 210 acute inpatient sites in England now offer the service.

NHS kicks off winter vaccine rollout

The NHS has launched its winter vaccination campaign, starting with flu jabs for millions of children and pregnant women. This rollout aims to protect vulnerable groups ahead of the colder months, when viruses spread more easily. To increase accessibility, vaccine teams are offering family-friendly drop-in clinics, and for the first time, some school immunisation teams will provide flu vaccines to 2- to 3-year-olds in nurseries. All children aged two to 16, as well as those aged six months to 18 in clinical risk groups, are eligible for the flu vaccine.

Most school-aged children will receive their flu shots at school, while younger children or those who miss their scheduled sessions can get vaccinated at GP practices or community clinics. Pregnant women are encouraged to speak with their maternity teams or visit their GP or local pharmacy to receive the jab. In addition, the NHS National Booking System is now open for eligible individuals to schedule both flu and COVID-19 vaccinations, with appointments available from 1 October.

Last winter, the flu vaccine helped prevent around 100,000 hospitalisations in England, yet flu-related admissions still placed significant pressure on NHS services, with over 300,000 hospital bed days recorded. To ensure timely

protection, the NHS is sending out millions of invitations this month, although eligible individuals are urged not to wait and can book their appointments via the NHS website, app, or by calling 119.

The Trust's official flu campaign began on 1 October with all colleagues, volunteers and learners eligible to receive the vaccine, free of charge. The vaccination team are offering a combination of pre-planned drop-in sessions (promoted two weeks in advance) and the Flu Fighter team will be set up in specified areas, at set times, for colleagues to visit and access their vaccines. We are also offering roving vaccination in clinical and ward areas.

Medicines and Healthcare products Regulatory Agency (MHRA) confirms paracetamol during pregnancy remains safe

Following the announcement by US President Donald Trump (Monday 22 September 2025) that US physicians will soon be advised not to prescribe paracetamol (known as Tylenol in the US) to pregnant women, the MHRA have confirmed that taking paracetamol during pregnancy remains safe and there is no evidence it causes autism in children.

Dr Alison Cave, Chief Safety Officer at the MHRA, said: "Patient safety is our top priority. There is no evidence that taking paracetamol during pregnancy causes autism in children.

"Paracetamol remains the recommended pain relief option for pregnant women when used as directed. Pregnant women should continue to follow existing NHS guidance and speak to their healthcare professional if they have questions about any medication during pregnancy. Untreated pain and fever can pose risks to the unborn baby, so it is important to manage these symptoms with the recommended treatment.

"Our advice on medicines in pregnancy is based on rigorous assessment of the best available scientific evidence. Any new evidence that could affect our recommendations would be carefully evaluated by our independent scientific experts.

"We continuously monitor the safety of all medicines, including those used during pregnancy, through robust monitoring and surveillance. We encourage anyone to report any suspected side effects to us via the Yellow Card scheme."

Silas Nicholls appointed as new Lead Chief Executive of Lancashire and South Cumbria Provider Collaborative

At the start of September, I was honoured to be appointed as the Lead Chief Executive of the Lancashire and South Cumbria Provider Collaborative (PCB). This followed the recent announcement that Aaron Cummins has been appointed as the Chief Executive of NHS Lancashire and South Cumbria Integrated Care Board from November 2025. Just to be clear I be undertaking this new role alongside my position of Chief Executive at LTH.

My priority will be to build on the strong foundations already in place – deepening partnerships and exploring new opportunities to co-design meaningful solutions with colleagues, patients, and the public.

I would also like to recognise Aaron Cummins for his exceptional leadership. He has brought providers together with integrity and determination, and I am committed to continuing that legacy. I look forward to working closely with Aaron as he transitions into his new role leading the Integrated Care Board this Autumn.

Welcome to our New Chief Medical Officer

At our last Board meeting we said a fond farewell to our Chief Medical Officer Dr Gerry Skailes who retired from the Trust at the end of September following an exemplary career and nearly 28 years of service at our hospitals. There have of course been many leaving events and speeches in Gerry's honour which were very well deserved and she will be much missed.

I am delighted that Gerry's successor, Mr Steve Canty, has now formally taken up his post as our new Chief Medical Officer and I extend a warm welcome to him at his first Board meeting in this capacity.

Annual Members' Meeting 2024/25

Thank you to everyone who attended the Annual Members' Meeting on Thursday 25th September at the Lancashire Football Association.

The AMM gave members and the general public the chance to hear from the Trust's Executive Team and Chair as they presented the 2024/25 Annual Report and Accounts. This year's theme was 'Health through activity' and featured representatives from Active Lancashire who supported this year's event.

There was also keynote speeches from Physiotherapist, Susan Saul on the cancer prehab partnership between the local NHS and English Football League (EFL) and a presentation from Paralympic Gold Medallist, Gregg Stevenson, on his journey to Paralympic gold after after losing his legs to an IED blast while on patrol in Helmand Province in 2009.

Remaining True to our Values

I am the Executive sponsor for our Ethnicity Inclusion Forum and last week I heard first hand from colleagues about how worried some of them, their families and our patients are, in respect of the recent rise in hostility towards people from ethnic minorities, immigrants and different religions which have culminated in demonstrations and marches leading to extensive and high profile media and social media coverage. Whilst we do not appear to have had any specific incidents of racism within our Trust in recent weeks relating to this activity, we can never be complacent.

I have therefore asked our Director of Communications and Engagement Naomi Duggan to work with representatives from the Ethnicity Forum including our Equality and Diversity lead and Organisational Development teams to ensure that our longstanding commitment to diversity and inclusion remains highly visible across the Trust.

Whilst we have an embedded zero tolerance approach to racism and discrimination whether from patients, visitors, or staff, we continue to reinforce this throughout all our communications and engagement channels and our comprehensive work on developing a positive culture throughout our organisation. Colleagues from our Ethnicity Forum help us to shape our messages and share their stories both via the forum and through individual sessions and meetings.

Through the work we do on Workplace Race Equality Standards (WRES), we know that white applicants are 1.5 times more likely to be appointed from shortlisting than Black Asian and Ethnic Minority (BAME) colleagues. BAME colleagues have also reported through the staff survey that they are 2.3 times more likely to experience discrimination from their manager or their colleagues. Representation of BAME colleagues in senior, VSM or voting Board members of the Board also needs to be improved. We have listened; a range of actions have already been completed, including a full review of our recruitment processes, which are regularly reviewed through our Single Improvement Plan, our Risk Management processes but also discussed at our People Committee with an annual update to Board. There is undoubtedly more to do.

Last year around 20% of BAME colleagues completed the staff survey, that means we are only hearing from 1 in 5. This year we really want to stress the importance of our BAME colleagues completing the national Staff Survey, so we have data which we can be more confident in, which more clearly represents the voice and the views of BAME colleagues across our organisation. This ensures we understand how colleagues are experiencing working within our Trust, we can focus on the areas that matter, see where disparities exist, and we can take appropriate action.

We continue to embed anti-racism through our active bystander training, and our inclusive leadership development programmes. We are about to embark on setting up an Anti-racist working group to help us look at progressing through the levels of the North West Anti-Racism Framework - any colleagues who might be

interested in supporting this work are asked to email Gemma Aspinall, our Diversity & Inclusion Practitioner. Within our regular engagement forums our senior leaders continue to acknowledge the importance of treating everyone with respect and living our values, whilst ensuring colleagues are aware of how they can raise concerns via their line managers and our Freedom to Speak up processes.

At the end of my report I have attached as an appendix a letter we have recently received from the NHS North West Black, Asian and Minority Ethnic Assembly. This includes a Call to Action, and I hope that this update has provided assurance that our Trust is already well underway with the activities suggested but we remain committed to involving colleagues and responding to suggestions as to how we can further strengthen our approach.

Trust wide successes and service developments

- **New Green Plan for 2025-28 launched**

It was great to see the launch our new Green Plan for 2025-2028, which builds on our first Green Plan, from 2022. Our new Green Plan was officially launched at Royal Preston Hospital, as our Sustainability Team were joined by Chief People Officer, Dr Neil Pease and Director of Corporate Affairs, Jennifer Foote, who popped along to Charters Restaurant to show their support.

The Green Plan 2025-28 sets out how the Trust will deliver its environmental and sustainability plans over the next three years with the support of colleagues and the communities we serve. It also celebrates the excellent progress that has been made in embedding sustainability within our working practices. The Green Plan highlights working practices that promote greater sustainability and efficiency right across our organisation, from transport and energy to utilities and waste, as part of the work we do as a large local employer and anchor institution in Lancashire and South Cumbria.

The Green Plan is also aligned to our Single Improvement Plan, which sets out the strategic ambitions of the organisation. Long term, our Green Plan is intended to ensure that sustainability is at the centre of all decision-making and is incorporated into every department, service and policy strategy.

- **Gemma's MS journey and passion for care**

It has been wonderful to witness how Gemma Devine, a Healthcare Assistant at Chorley Hospital, is turning her personal journey with multiple sclerosis (MS) into a source of inspiration for others.

Diagnosed after six years of uncertainty and debilitating symptoms that began at age 18, Gemma faced immense physical and emotional challenges, with her condition leaving her unable to perform basic tasks, resulting in lasting consequences like tooth loss and hair removal, which she described as “the most dehumanizing, devastating and humiliating moment of my life.”

Now thriving on Rookwood A, a dementia-friendly ward, recently passed her Band 3 Apprenticeship, and has gleaned the confidence to not only make a spotlight presentation on the All Colleague Briefing, but also tell her story on the Trust website, in the Lancashire Post and Blog Preston, as well as speaking to That’s TV Lancashire. Gemma said “The Trust has shaped me as a person, definitely. If I can teach myself how to walk again, I can get through anything. I feel so confident and empowered, that all of these things are coming to me and I think I've manifested it. 2025 is Gemma's year for sure!”

Gemma’s positivity radiates through her work and interactions, and her smile has become a bridge to connect with dementia patients, helping to build trust and comfort.

- **Exciting step forward for Gemma after Clinical Research Investment Scheme award**

Gemma Owens, Consultant Gynaecological Oncology Surgeon and Research Lead for Gynaecology at the Trust, has been awarded a place on the NIHR Manchester Biomedical Research Centre (BRC) Clinical Research Investment Scheme (CRIS). This prestigious award supports promising NHS consultants in developing as independent clinical researchers and marks a major milestone in both Gemma’s academic career and the Trust’s ambition to become a university hospital. Over the next two years, Gemma will lead a pilot study investigating non-invasive diagnostic methods for womb cancer, supported by collaborators in Manchester and locally.

The project aims to address the burden of invasive procedures currently used to diagnose womb cancer, such as transvaginal ultrasounds, hysteroscopies, and biopsies, which are often distressing and unnecessary for the majority of women. The project tackles a real clinical challenge – how we diagnose womb cancer in a way that’s effective but also less invasive for women. Her study will explore the use of infrared biospectroscopy to analyse urine and vaginal fluid samples, potentially paving the way for a simple, affordable point-of-care test.

Gemma’s success is supported by the mentorship of Pierre Martin-Hirsch, Director of Research and Innovation, whose leadership helped secure the Trust’s partnership with the Manchester BRC. Through the CRIS scheme, Gemma will gain access to mentorship, training, and a wider academic network. Her long-term goal is to build an independent research portfolio and secure a joint clinical-academic appointment, helping to advance both her career and the Trust’s research profile.

- **Sonia opens Sepsis Awareness Month with Radio Lancashire slot**

Sonia Connell, the Trust's Lead Sepsis Nurse, marked the beginning of Sepsis Awareness Month in September with a slot on Graham Liver's Breakfast Show on BBC Radio Lancashire.

You can listen back here between 7:50:32 and 7:54:50. Sonia also delivered the spotlight presentation at the August All Colleague Team Briefing.

The Lancashire Post also featured Sonia here on Sepsis Awareness Month, a cause very dear to her heart: “As Sepsis Lead Nurse, I am extremely passionate about raising the awareness of sepsis, and in providing support to sepsis survivors. Last year we tragically lost our mum Joan to sepsis. This experience was incredibly painful but has made me more determined to raise awareness of this silent killer.”

Sonia is also a finalist in the 'Making a Difference' Award category at the Trust's Our People Awards this month.

- **Trust helping fast-track patients with head and neck cancer into cancer vaccine trial**

In August, it was announced that the Trust’s Lancashire Clinical Research Facility is one of 15 NHS sites fast-tracking patients with advanced head and neck cancers into a pioneering cancer vaccine trial.

The trial, part of the NHS Cancer Vaccine Launch Pad, uses mRNA technology to help the immune system target and destroy cancer cells containing HPV proteins. Despite progress in treating early-stage HPV-positive tumours, around 25% of patients still relapse within two years. The Trust is working with BioNTech to identify eligible patients for the AHEAD-MERIT trial (BNT113-01), with one patient already enrolled.

Dr Dennis Hadjiyiannakis, Consultant Clinical Oncologist and Medical Director of the NIHR Lancashire Clinical Research Facility, described the vaccine as potentially “game-changing” for patients facing difficult diagnoses, offering hope for improved survival and quality of life.

This is the third cancer vaccine trial supported by the NHS Cancer Vaccine Launch Pad, which aims to connect thousands of patients with cutting-edge immunotherapy research. Lancashire Teaching Hospitals continues to actively support this initiative, helping accelerate cancer research and expand access to innovative treatments.

- **Consultant leads study which could save the NHS millions in treatment costs**

Dr Abhijit Das, Consultant Neurologist at the Trust and Honorary Associate Professor at the University of Lancashire, has led a groundbreaking study revealing a biological link between Functional Neurological Disorder (FND) and Chronic Pain (CP).

Published in *BMJ Neurology Open*, the research is the first to comprehensively analyse brain imaging data from over 2,500 global patient studies, identifying shared abnormalities in key brain networks responsible for cognitive and emotional processing. FND and CP are among the most common neurological conditions in the UK, yet often under-recognised.

FND affects around 9% of NHS neurology inpatients and 16% of outpatients annually, while chronic pain impacts up to half of UK adults, with eight million experiencing pain severe enough to disrupt daily life. The study highlights overlapping brain mechanisms — including the default mode, sensorimotor, and salience networks — that may explain the connection between these conditions.

This discovery opens the door to integrated treatment approaches that could target both conditions simultaneously, such as neuromodulation, neurofeedback, or clinical hypnosis. By streamlining therapies and

improving outcomes, the findings have the potential to save the NHS millions in treatment costs while offering more effective care for patients.

- **Dr White appointed as an Editorial Fellow at BMJ Practical Neurology**

Also in the field of Neurology, Dr Laura White, ST5 Neurology Registrar at Royal Preston Hospital and NIHR Academic Clinical Lecturer at Lancaster Medical School, has been appointed as an Editorial Fellow at *BMJ Practical Neurology*. This prestigious role offers her the opportunity to contribute to a leading clinical journal that focuses on practical, evidence-based guidance for neurologists in everyday practice.

Unlike traditional academic journals, *BMJ Practical Neurology* prioritises accessible content that supports clinicians in diagnosing and managing neurological conditions. As part of the editorial team, Dr White will participate in regular meetings to help shape journal priorities, uphold editorial standards, and support the peer review process, gaining valuable insight into medical publishing.

Her appointment not only highlights her expertise and leadership in the field but also enhances the Trust's reputation within the international clinical research community.

- **Miracle to milestones - how Oluchi became 'Support Worker of the Year'**

Oluchi Okoroafor, a Senior Healthcare Assistant at the Trust and postgraduate nursing student, has been named Health Support Worker of the Year at the Black Healthcare Awards.

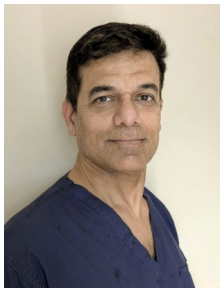
Overwhelmed with emotion, Oluchi dropped to her knees in tears as she accepted the award, a moment made even more powerful by the personal challenges she had recently faced - including her daughter Miracle being on life support the same day she learned she was shortlisted.

Thankfully, Miracle recovered, and Oluchi's resilience and dedication continued to shine. Despite the adversity, Oluchi has excelled academically, earning distinctions in all her modules and recognition for her clinical placements. She was also shortlisted for two Student Nursing Times Awards, including the Mary Seacole Award for Outstanding Contributions to Diversity and Inclusion. Her commitment to supporting others stood out to judges, particularly her role in founding the SWAB (Student-Led Wellbeing and Academic Buddying) project, which helps international students adjust to the UK's education system.

Oluchi's story has inspired others, including a former nurse who returned to the profession after reading about her achievements. With a new role secured in respiratory care and an invitation to a reception at the House of Lords, her journey from media studies in Nigeria to nursing in the UK is a testament to perseverance and purpose. "This award is not just for me," she says. "It's for every student, every parent, everyone who feels like giving up. You can achieve anything."

- **Congratulations to Arun Cardozo**

Arun Cardozo, Consultant ENT Surgeon, was honoured with the prestigious Best Consultant Tutor award at the University of Manchester Medical School's annual Student Led Teaching Awards for 2024-2025.



Mr Cardozo is the Year 4 ENT Clinical Placement Supervisor for the speciality week, and was recognised for his outstanding dedication and excellence in teaching. Each year, the MBChB Student Programme Representatives organise the Student Led Teaching Awards, inviting medical students from the University of Manchester to nominate staff members who have demonstrated exceptional teaching skills or provided outstanding support.

Mr Cardozo's commitment and impact earned him the top award in the Best Tutor category, and Professor Madhavi Paladugu, Hospital Dean at LTHTR, congratulated him and his team on this well-deserved recognition, and emphasised that it truly reflects his steadfast dedication to education and the wider ENT team's commitment to integrate medical students within the ENT department at LTHTR.

- **Psychological Health in Cancer Team guest on Radio Lancashire**

Louisa Swift, Macmillan Project Manager and Dr Alice Trailer (Clinical Psychologist) from the Trust's Psychological Health in Cancer Team, were guests of Nishma Hindocha on BBC Radio Lancashire recently (listen here from 16:10:05 - 16:16:35), talking about the new Psychological Health in Cancer service, a pilot funded by Macmillan Cancer Support via Lancashire Teaching Hospitals NHS Foundation Trust.

The segment was also promoting the 'Living well with and beyond Cancer day' that took place on 10 September, at Furness Rugby Club, Barrow–in–Furness, which was open to anyone living with and beyond cancer, as well as family members, friends, and carers.

These days will be running regularly across the year throughout Lancashire and South Cumbria.

- **Early Pregnancy Loss Memorial Service**

There was a deeply moving and well-attended Early Pregnancy Loss Memorial Service in the chapel at Royal Preston Hospital, hosted by the Trust and led by Specialist Nurse Kirstie Russell. Families from near and far, including mums, dads, grandparents, and others gathered to honour and remember the lives lost in early pregnancy. Some attendees travelled significant distances to be part of the service, a testament to the importance and impact of this invaluable offering.

The atmosphere was one of reflection, compassion, and shared support, with many expressing gratitude for the space to grieve and connect. Kirstie, who leads the Trust's Early Pregnancy Loss Service, continues to provide dedicated and ongoing support to those affected, ensuring that no one walks this journey alone.

- **Recognisiing colleagues following their retirements**

After 21 years with the Trust, Consultant Lead Orthotist Gordon Steel recently retired, leaving behind a legacy of innovation, compassion, and excellence in patient care. His career in orthotics began in 1979 and spanned the UK, from the south west to Carlisle. A celebration at the Specialist Mobility Rehabilitation Centre marked his retirement, attended by colleagues, friends, and family. Gordon's passion for science and mechanics led him to orthotics, and he witnessed the evolution of materials from metal and leather to carbon fibre and 3D printing, even designing a custom 3D-printed arm for a patient who wanted to fly a light aircraft.

Gill Nixon (nee Jones) has taken a well-deserved retirement after dedicating her working life of 45 years to the NHS, commencing her career as a nurse student at Preston back in September 1980, before qualifying in 1983. Gill accepted her first staff nurse role aged 21, within surgery and then in 1985 she became a staff nurse on our intensive care unit (ICU). Gill has had a long and full career specialising in critical care and pain management. After a period at other Trusts, Gill returned to Royal Preston in January 1988 and concluded her time at the Trust as a Senior Clinical Nurse Specialist, helping lead and set up the inpatient pain service.

After nearly 30 years of service, Martin Myers MBE has retired from his role as Consultant Clinical Biochemist and Laboratory Director for Clinical Biochemistry at the Trust. Martin's career has been marked by transformative contributions to pathology services, both locally and nationally. With a PhD in Chemical Pathology and a Fellowship from the Royal College of Pathologists, he joined the Trust in 1996 with a vision to modernise the pathology department. His leadership during the COVID-19 pandemic was pivotal, helping implement rapid diagnostic testing and advising NHS Supplies to equip hospitals with essential blood gas analysers.

Martin held several senior roles at the Trust, including Associate Medical Director and Clinical Director, and played a key role in developing clinical pathways that reshaped pathology services. Nationally, he served as Co-Clinical Lead for NHS England's GIRFT Pathology Programme and chaired the MHRA IVD Expert Advisory Group. Martin's achievements earned him an MBE, the NHS Lifetime Achievement Award, and recognition as one of the world's leading pathologists.

1. RECOMMENDATIONS

i. It is recommended that the Board receive the report and note its contents for information.

To: Chairs, Chief Executives and Chief People Officers
North West NHS Trusts and
Integrated Care Boards
And North West Black, Asian and Minority Ethnic Assembly

Louise Shepherd
North West Region
4th Floor
3 Piccadilly Place
Manchester
M1 3BN

louise.shepherd17@nhs.net

23 September 2025

Dear Colleagues

Standing Together Against Racism and Supporting Our Workforce

Across the UK, we are witnessing an unsettling rise in nationalist sentiment and anti-immigrant, Islamophobic marches. These developments are having a profound impact on Black, Asian and Minority Ethnic and Muslim communities, including many of our colleagues and their families. While such hostility may be most visible on our streets and in our media, it inevitably reverberates inside our organisations, affecting the wellbeing, sense of belonging, experience and safety of our staff.

As leaders within the NHS, we have a responsibility to act decisively. Our values compel us to demonstrate and grow a culture of zero tolerance to racism in all its forms, to support colleagues who are affected, and to champion a culture where diversity is celebrated and protected.

We ask you to consider the following immediate actions:

- **Zero tolerance:** Reaffirm that racism and discrimination will not be tolerated within your organisations, whether from patients, visitors, or staff. Ensure policies are visible, enforced, and driven by senior leadership.
- **Support Black, Asian and Minority Ethnic staff networks:** Resource and empower your networks to provide peer support, shape local action, and advise on organisational priorities. Create opportunities for staff to share their experiences, whether through listening sessions, reflective practice groups, or facilitated forums. Respond effectively and quickly, to build confidence and safety amongst colleagues.
- **Visible leadership:** Senior leaders should speak out against racism, demonstrate allyship, and ensure colleagues feel seen, heard, and supported.

- **Education and training:** Continue to embed anti-racism through active bystander training, and inclusive leadership development.
- **Workplace Race Equality Standards:** Ensure effective plans to address any disparities, with particular focus on improving recruitment outcomes and reducing and preventing incidents of racial Harassment, Bullying and Abuse.

Examples of Anti-racist Action and Good Practice

Across the North West, colleagues are already modelling powerful responses to racism and celebrating the richness of our workforce:

- **Mid Cheshire Hospitals NHS Foundation Trust** recently held their annual *Connecting Cultures* event, which received coverage from BBC Radio Stoke and BBC News. The celebration showcased the diverse heritage of staff through food, music, and cultural performances. Staff spoke openly about the Trust's zero tolerance stance on racism and the protection and support they feel in their workplace. Nurse Korina Sibanda, for example, described feeling "protected as an international nurse," even amid wider hostility.
- **Greater Manchester Mental Health NHS Foundation Trust** has been internationally recognised, winning the *Johnathan MacLennan Award* for its *Race Ethnicity and Cultural Heritage (REACH) Community of Practice*. This initiative is pioneering anti-racism through Quality Improvement, tackling daily racial abuse in clinical settings, implementing sanctions against perpetrators, and fostering safe spaces and active bystander training for staff.
- **Naomi McVey**, Regional Head of Allied and Medical Associate Professions, has been shortlisted for *Ally of the Year* at the 2025 Black, Asian and Minority Ethnic Health & Care Awards, recognising her outstanding commitment to equity, inclusion, and support for colleagues across the sector.

These examples highlight what can be achieved when Trusts act decisively, invest in their people, and lead with courage.

A Call to Action

We invite you to:

1. Share with us the steps your Trust is taking to support colleagues and stand against racism during this period of heightened hostility.
2. Publicly reaffirm your commitment to anti-racism with staff and communities.
3. Build on the good practice already happening across the region to ensure consistency, resilience, and solidarity.

The NHS is built on the dedication of people from all backgrounds. In standing firm against racism, we not only protect our colleagues but also strengthen our service to patients and

communities. We believe we should all be unapologetically anti-racist and steadfast in the face of challenges to our diverse communities.

Thank you for your leadership and your ongoing commitment to making our NHS a safe, inclusive and anti-racist place to work.

Yours faithfully,

Evelyn Asante-Mensah OBE
Chair, Pennine Care Foundation Trust
And North West, Black Asian and Minority Ethnic Assembly

Louise Shepherd CBE
Regional Director (North West)

On behalf of the NHS North West Black, Asian and Minority Ethnic Assembly

8. BOARD ASSURANCE FRAMEWORK

Decision Item | S Regan | 09.50am

REFERENCES

Only PDFs are attached

8.0 - BAF Risk Paper - Oct 2025 - Final.pdf

Board of Directors Report

Board Assurance Framework (BAF) Risk Report

Report to:	Board of Directors	**Date:**	2 October 2025
Report of:	Associate Director of Risk & Assurance	**Prepared by:**	K Clay
Part I	✓	**Part II**	

Purpose of Report					
For assurance	☐	**For decision**	☒	**For information**	☐

Executive Summary:

The Well Led Framework by NHS England and the Care Quality Commission (CQC) requires Boards of all provider organisations to ensure there is an effective and comprehensive process in place to identify, understand, monitor and address current and future risks. This includes a Board Assurance Framework (BAF) which provides a structure and process to enable organisations to identify those strategic and operational risks that may compromise the achievement of the Trust's objectives.

This paper provides an update on the BAF following the review and approval of the Principal Risks to the delivery of the 2025/26 Corporate Objectives.

Principal Risks

The BAF in Appendix 1 identifies the Principal Risks that threaten the delivery of the Corporate Objectives. Due to scheduling of committees, the Principal Risks detailed in Appendix 1 are those that have been presented to Committees of the Board, or reviewed in preparation for the next Committee at the time of writing this paper.

Since the last meeting, there are two Principal Risks that have changed in score:

- Principal Risk 9 (Suboptimal Experience of Resident Doctors) – The score of the risk has been reduced from 12 to 9 following the work undertaken and increased assurances from the GMC National Training Survey. The Education, Training and Research Committee agreed in August 2025 that a proposal would be made to the Board of Directors for the risk to be stepped down as a Principal Risk to be managed operationally until completion of the remaining actions.
- Principal Risk 11 (Compliance with Core Skills Training & Appraisals) – The current score has been reduced from 12 to 9 following consistent improvement in Trust wide compliance statistics and progress towards completion of actions from the 2023 CQC inspection. The target date for risk control has been extended to mid-October 2025 to allow for the review of one further month's training information, with the expectation that compliance will be achieved and that the risk can be reasonably controlled.

Other updates since the last Board of Directors meeting include:

- Trajectories have been added to each Principal Risk as requested at the last Board of Directors meeting in August 2025.
- In relation to Principal Risk 2 (Higher than trajectory rates of clostridioides difficile (C.*difficile*) Infection) – The implementation of National Cleaning Standards Phase 2 is progressing with delivery of 50% to be implemented by October 2025.

- In relation to Principal Risk 3 (People experiencing Health inequalities) – Work to develop the Anchor Institute Plan progresses, which will support the Trust's commitment to delivering wider social value and strengthening its role as an anchor institution within the local community. The Chief Medical Officer for the ICS has written to GPs to make data sharing request and a follow up meeting is scheduled for September 2025.
- Principal Risk 5 (Timely access to urgent and emergency care) - the risk is now considered off track with trajectory as whilst we are seeing improvements in percentage of beds occupied by patients in the days kept away from home (DKAFH) cohort, the lost number of bed days continues to be above target and this is driving increased Emergency Department (ED) overcrowding and leading to continued boarding. The Emergency Care Intensive Support Team (ECIST) are commencing work with the Trust and will be assisting with ED capacity and demand modelling, and clinical leadership to further develop the Acute Medical Unit (AMU) and same day emergency care (SDEC) models of care. In addition, DKAFH is being rolled out to 16 further wards from this month and there are further actions to increase the number of ED attendances and admissions that are supported by community services. The winter plan and overcrowding mitigations are linked to the outcome of the NHS England North West recovery transformation bids, for which a decision is outstanding.
- Principal Risk 7 (Reliance on temporary medical workforce) – there has been progress following the development of an assurance report provided to Safety & Quality Committee in June 2025, which was due to be re-presented in September 2025. Resource for a 6 month internal secondment has been identified to support the development of the 42 week productivity tool. Following review of the trajectories, it is anticipated that further assurance updates to Safety & Quality Committee, and progression of the 42 week productivity tool will support a reduction, and potential control of this Principal Risk. The target control date has been extended to end of January 2026 as a result
- Principal Risk 12 (Failure to meet the financial plan 2025/26) - the trajectory has been reviewed by the Chief Finance Officer and reset to continue at a 20 until there is confidence in the delivery risks for the Waste Reduction Programme (WRP). The trajectory will be reviewed month on month and adjusted accordingly as and when assurance is obtained.
- For Principal Risk 13 (Cash consequences of the Trust's underlying financial position) - the target control date has been extended to 31st March 2026. In addition, the trajectory has been reviewed by the Chief Finance Officer and reset to continue at a 20 recognising the Trust's cash request was not met in full and further requests need to be made for support from NHS England. The trajectory will be reviewed month on month and adjusted accordingly as and when assurance is obtained.
- For Principal Risk 14 (Ability to access required Capital to support an ageing estate) - the trajectory has been reviewed by the Chief Finance Officer and reset to continue at 16 with a view to amending in future months following development and implementation of the Estates strategy.
- It is anticipated that Principal Risk 16 (Failure to progress the configuration of Trust services to enable the delivery of the clinical strategy for LTHTR and L&SC) will be controlled upon approval of the Trust strategy.

There has been no further changes to risk scores since the last meeting of the Board. The Trust is now within segment five of the NHS Oversight Framework (NOF) and the Trust are part of the recovery support programme

Operational High Risks for Escalation/De-escalation

There are currently no operational high risks of concern escalated to the Board within the BAF this month.

It is recommended that Board of Directors:

- Note and approve the updates to the BAF.
- Approve the step down of Principal Risk 9 (Suboptimal Experience of Resident Doctors) from Principal Risk status to be managed as an operational risk until completion of the remaining actions.

Appendix 1 – Board Assurance Framework			
Trust Strategic Aims and Ambitions supported by this Paper:			
Aims		**Ambitions**	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive health innovation through world class education, teaching and research	☒	Deliver Value for Money	☒
		Fit For The Future	☒
Previous consideration			
Committees of the Board in line with cycles of business			

1. Background

1.1 The Well Led Framework by NHS England and the Care Quality Commission (CQC) requires Boards of all provider organisations to ensure there is an effective and comprehensive process in place to identify, understand, monitor and address current and future risks. This includes a Board Assurance Framework (BAF) which provides a structure and process to enable organisations to identify those strategic and operational risks that may compromise the achievement of the Trust's objectives.

1.2 This paper provides the Board of Directors with an update on the BAF following the review and approval of the Principal Risks to the delivery of the 2025/26 Corporate Objectives.

2. Board Assurance Framework

2.1 The BAF in Appendix 1 identifies the Principal Risks that threaten the delivery of the corporate objectives.

2.2 It should be noted due to scheduling of Committees, the Principal Risks detailed in Appendix 1 are those that have been presented to Committees of the Board or reviewed in preparation for the next Committee at the time of writing this paper.

2.3 Since the last meeting, there are two Principal Risks that have changed in score:

- Principal Risk 9 (Suboptimal Experience of Resident Doctors) – The score of the risk has been reduced from 12 to 9 following the work undertaken and increased assurances from the GMC National Training Survey. The Education, Training and Research Committee agreed in August 2025 that a proposal would be made to the Board of Directors for the risk to be stepped down as a Principal Risk to be managed operationally until completion of the remaining actions.
- Principal Risk 11 (Compliance with Core Skills Training & Appraisals) – The current score has been reduced from 12 to 9 following consistent improvement in Trust wide compliance statistics and progress towards completion of actions from the 2023 CQC inspection. The target date for risk control has been extended to mid-October 2025 to allow for the review of one further month's training information, with the expectation that compliance will be achieved and that the risk can be reasonably controlled.

2.4 Other updates since the last Board of Directors meeting include:

- Trajectories have been added to each Principal Risk as requested at the last Board of Directors meeting in August 2025.
- Principal Risk 1 (Patient experience within the urgent and emergency care pathway) – the implementation of a new approach around "days kept away from home" is progressing positively, with 2 wards now in place with training commenced and a further 16 wards progressing in line with the plan. A new action has been identified to document the ongoing work between the Trust, Integrated Care Board (ICB) and Lancashire County Council (LCC) to develop a tripartite Not Meeting Criteria to Reside (NMC2R) Plan.
- In relation to Principal Risk 2 (Higher than trajectory rates of clostridioides difficile (C.*difficile*) Infection) – The implementation of National Cleaning Standards Phase 2 is progressing with delivery of 50% to be implemented by October 2025.
- In relation to Principal Risk 3 (People experiencing Health inequalities) – Work to develop the Anchor Institute Plan progresses, which will support the Trust's commitment to delivering wider social value and strengthening its role as an anchor institution within the local community. The Chief Medical Officer for the ICS has written to GPs to make data sharing request and a follow up meeting is scheduled for September 2025.

- Principal Risk 5 (Timely access to urgent and emergency care) - the risk is now considered off track with trajectory as, whilst we are seeing improvements in percentage of beds occupied by patients in the days kept away from home (DKAHF) cohort, the lost number of bed days continues to be above target and this is driving increased Emergency Department (ED) overcrowding and leading to continued boarding. The Emergency Care Intensive Support Team (ECIST) are commencing work with the Trust and will be assisting with ED capacity and demand modelling, and clinical leadership to further develop the Acute Medical Unit (AMU) and same day emergency care (SDEC) models of care. In addition, DKAHF is being rolled out to 16 further wards from this month and there are further actions to increase the number of ED attendances and admissions that are supported by community services. The winter plan and overcrowding mitigations are linked to the outcome of the NHS England North West recovery transformation bids, for which a decision is outstanding. Divisions are scoping further remedial actions and depending on those a further review of waste reduction programme (WRP) schemes may be needed
- Principal Risk 7 (Reliance on temporary medical workforce) – there has been progress following the development of an assurance report provided to Safety & Quality Committee in June 2025, which was due to be re-presented in September 2025. Resource for a 6 month internal secondment has been identified to support the development of the 42 week productivity tool. Following review of the trajectories, it is anticipated that further assurance updates to Safety & Quality Committee, and progression of the 42 week productivity tool will support a reduction, and potential control of this Principal Risk. The target control date has been extended to end of January 2026 as a result
- Principal Risk 12 (Failure to meet the financial plan 2025/26) - the trajectory has been reviewed by the Chief Finance Officer and reset to continue at a 20 until there is confidence in the delivery risks for the Waste Reduction Programme (WRP). The trajectory will be reviewed month on month and adjusted accordingly as and when assurance is obtained.
- For Principal Risk 13 (Cash consequences of the Trust's underlying financial position) - the target control date has been extended to 31st March 2026. In addition, the trajectory has been reviewed by the Chief Finance Officer and reset to continue at a 20 recognising the Trust's cash request was not met in full and further requests need to be made for support from NHS England. The trajectory will be reviewed month on month and adjusted accordingly as and when assurance is obtained.
- For Principal Risk 14 (Ability to access required Capital to support an ageing estate) - the trajectory has been reviewed by the Chief Finance Officer and reset to continue at 16 with a view to amending in future months following development and implementation of the Estates strategy.
- It is anticipated that Principal Risk 16 (Failure to progress the configuration of Trust services to enable the delivery of the clinical strategy for LTHTR and L&SC) will be controlled upon approval of the Trust strategy.

2.5 There has been no further changes to risk scores since the last meeting of the Board. The Trust is now within segment five of the NHS Oversight Framework (NOF) and the Trust are part of the recovery support programme

3. Operational High Risks for Escalation/De-escalation

3.1 There are currently no operational high risks escalated to the Board within the BAF this month.

4. Financial implications

4.1 Any financial implications are captured within the Risk Register records and managed accordingly.

5. Legal implications

5.1 Any legal implications are captured within the Risk Register records and managed accordingly.

6. Risks

6.1 The paper identifies Principal and Operational Risks that may compromise the achievement of the Trust's high level Strategic Objectives and therefore, the entirety of the paper is risk focused.

7. Impact on stakeholders

7.1 A robust and well managed BAF reduces the negative impact on patients and staff and the reputation of the organisation. Its purpose is to mitigate and reduce, as far as is reasonably practicable, the level of risk to that identified in the Trust risk appetite statement.

7.2 All risks can impact upon patient experience, staff experience, the Integrated Care System and cross divisional work. This is captured within individual risk register entries on Datix.

8. Recommendations

8.1 It is recommended that Board of Directors:

i. Note and approve the updates to the BAF.

ii. Approve the step down of Principal Risk 9 (Suboptimal Experience of Resident Doctors) from Principal Risk status to be managed as an operational risk until completion of the remaining actions.

Lancashire Teaching Hospitals
NHS Foundation Trust

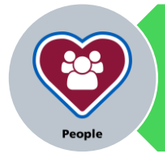
Board Assurance Framework

2025/26

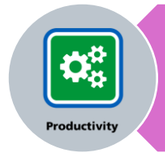
Board of Directors – October 2025

Patients – deliver excellent care

Performance – deliver timely, effective care



People – be a great place to work



Productivity – delivery value for money

Partnership – be fit for the future

Excellent care with compassion

Always Safety First

@LancsHospitals

How the Board Assurance Framework fits in

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

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

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

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

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

Reporting: To make the Board Assurance Framework as easy to read as possible, we use visual scales based on a traffic light system to highlight overall assurance. Red indicates items with low assurance, amber shows items with medium assurance and green shows items with high assurance. It is recognised that elements of this document may not support accessibility standards, but this can be re-produced in an accessible form if required. Should this be required, please contact company.secretary@lthtr.nhs.uk.

Understanding the Board Assurance Framework

Risk Rating Matrix (Likelihood x Consequence)

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

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

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

Our strategic approach at a glance

Our vision
- Working together to improve the health and wealth of the population we serve

Our purpose
- To provide the best specialist and local health and care services

Our values
- Caring & Compassionate
- Building Team Spirit
- Seeking to Involve
- Recognising Individuality
- Taking Personal Responsibility

Strategic priorities
- Advanced Diagnostics
- Anchor Institution
- New Models of Care & Population Health
- Pioneering Specialist Services
- Stronger links with Academic Partners

Lancashire & South Cumbria New Hospitals Programme

Strategic framework
- **The 5 Ps**
- **P**atients
- **P**eople
- **P**artnership
- **P**roductivity
- **P**erformance

Enabling strategies

Always Safety First • Digital • Estates & Facilities • Finance • Workforce

Single Improvement Plan

Partnerships | People | Patients | Productivity | Performance

Strategic Objectives

Patients – deliver excellent care

Improve outcomes, reduce harm and deliver a positive patient experience

Performance – deliver timely, effective care

Deliver agreed trajectories in clinical performance

People – be a great place to work

Create an inclusive culture with leaders at every level leading colleague engagement

Productivity – deliver value for money

Deliver the agreed financial plan including waste reduction programme, maximising use of resources

Partnership – be fit for the future

Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions

2025/26 Corporate Objectives

Patients
- Improve outcomes and prevent harm
- Deliver a positive patient experience
- Develop new ways of working across the system that lead to more effective patient interventions and pathways.
- To deliver good tertiary services to the population of Lancashire and South Cumbria and District General Hospital Services to the population of Central Lancashire

Performance
- To minimise the risk of harm to patients through the continued delivery of our cancer recovery plan
- To minimise the risk of harm to patients through the delivery of our elective recovery plan
- To improve the responsiveness of urgent and emergency care
- To minimise the risk of harm to patients through the continued delivery of our DM01 recovery plan in line with trajectory

People
- To right size the workforce to support the delivery of safe, affordable and sustainable services, aligned with the Trust's strategy
- To strive to improve experience at work by actively listening to our people, and turning understanding into positive action
- To be consciously inclusive in everything we do.
- To build a positive culture, demonstrating our values in action through increased colleague engagement across the organisation.
- To develop leaders at every level of the organisation with the skills and behaviours that are able to provide compassionate leadership.

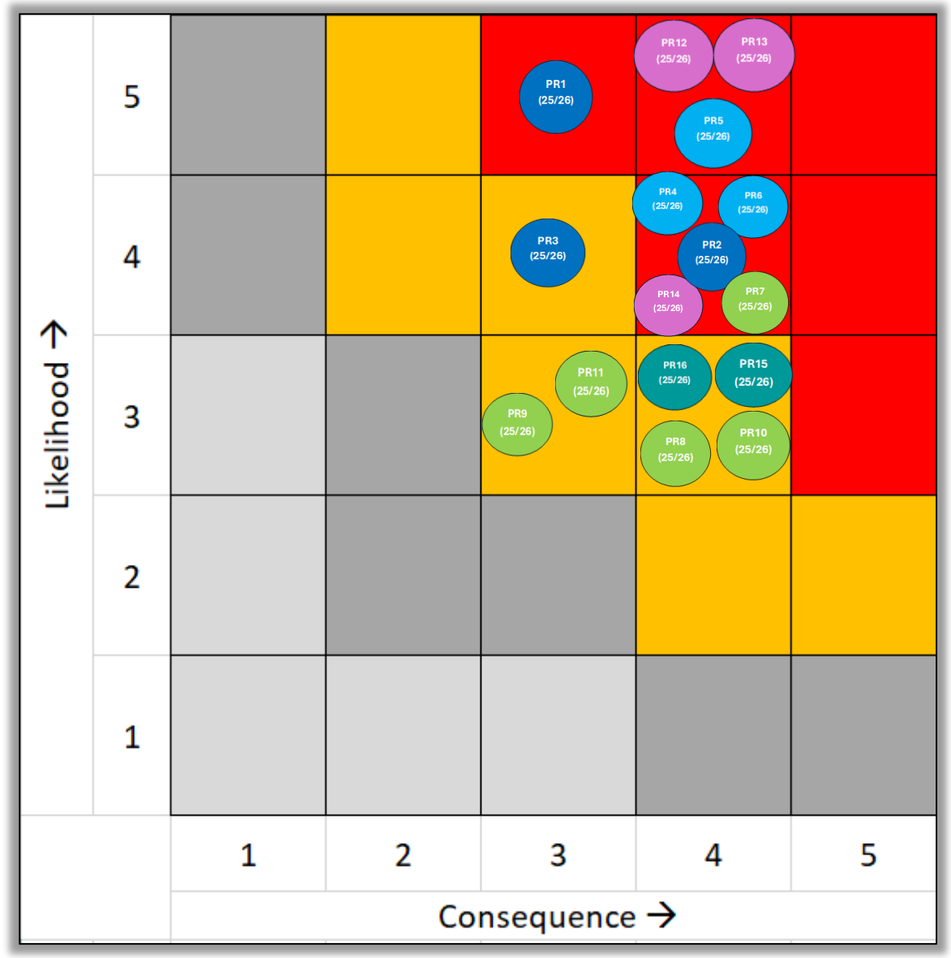
Productivity
- To provide value for money services by spending less, spending well and spending wisely
- To deliver sustained improvement evidenced through the single improvement plan
- Improve our underlying productivity and efficiency
- To develop a clinical services strategy for the organisation

Partnership
- To develop and deliver our strategic plans to support the transitions outlined in the new NHS Plan:hospital to community; treatment to prevention; analogue to digital.
- Developing a sustainable future: to develop effective partnerships across L&SC which maximise population health and support services that are clinically and financially sustainable.
- To make progress towards our ambition to be a University Teaching Hospital
- Working with partners, create a single pathology service

Principal Risk Management

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

Ref	Principal Risk	Exec Lead	5Ps	Reporting Committee	Risk Appetite	Risk Tolerance	Current score	Direction of score since last report
PR1 (25/26)	Patient experience within the urgent and emergency care pathway	CNO	Patients	SQC	Cautious	1-6	15	→
PR2 (25/26)	Higher than trajectory rates of clostridioides difficile (C.*difficile*) Infection	CNO	Patients	SQC	Cautious	1-6	16	→
PR3 (25/26)	People experiencing Health inequalities	CNO	Patients	SQC	Cautious	1-6	12	→
PR4 (25/26)	Timely access to planned and cancer care	COO	Performance	FPC	Cautious	1-6	16	→
PR5 (25/26)	Timely access to urgent and emergency care	COO	Performance	FPC	Cautious	1-6	20	→
PR6 (25/26)	Timely access to diagnostic investigations	COO	Performance	FPC	Cautious	1-6	16	→
PR7 (25/26)	Reliance on temporary medical workforce	CMO	People	WFC	Open	4-8	16	→
PR8 (25/26)	Experience of staff, with specific focus on under-represented staff groups	CPO	People	WFC	Open	4-8	12	→
PR9 (25/26)	Sub-optimal experience of Resident Doctors	CPO	People	ETR	Open	4-8	9	↓
PR10 (25/26)	Failure to effectively manage staff absence and achieve Trust and National target rates	CPO	People	WFC	Open	4-8	12	→
PR11 (25/26)	Compliance with Core Skills Training & Appraisals	CPO	People	ETR	Open	4-8	9	↓
PR12 (25/26)	Failure to meet the financial plan 2025/26	CFO	Productivity	FPC	Cautious	8-12	20	→
PR13 (25/26)	Cash consequences of the Trust's underlying financial position	CFO	Productivity	FPC	Cautious	8-12	20	→
PR14 (25/26)	Ability to access required Capital to support an ageing estate	CFO	Productivity	FPC	Cautious	8-12	16	→
PR15 (25/26)	Research capacity and capability to enable progress towards University Hospital status	CSIO & CMO	Partnership	ETR	Seek	8-12	12	→
PR16 (25/26)	Failure to progress the configuration of Trust services to enable the delivery of the clinical strategy for LTHTR and L&SC	CSIO& CMO	Partnership	FPC	Seek	8-12	12	→



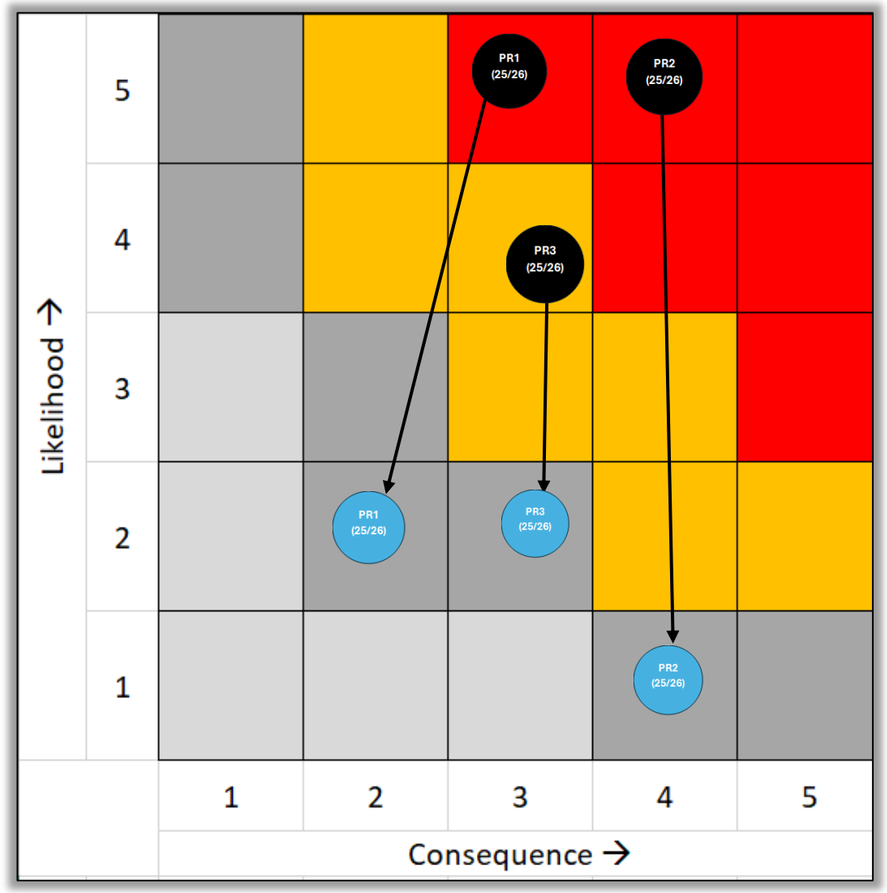
Key- Dark Blue = Patients, Light Blue = Performance, Green = People, Pink = Productivity, Turquoise - Partnership

Patients: Deliver excellent care

Monitored through Safety & Quality Committee

The following 2025/26 corporate objectives are aligned to the **Patients** strategic objective:

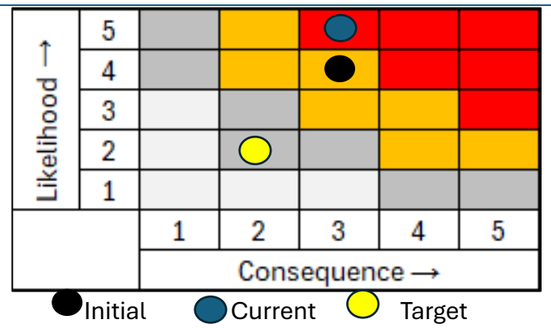
Ref.	Purpose of the objective	Scope and Focus of the Objective	Status
CO1	Improve outcomes and prevent harm	• Design a new medical model for UEC pathways. • Improvement to meet the average time to see a clinician in ED standard • Internal professional standards will be met by each specialty • Develop approach to medical staffing assurance. • Deliver medicines safety and optimisation programme • Lead delivery of CQC action plan • Continued implementation of PSIRF & demonstrate maturity in the approach to learning. • Implement the Always Safety First and learning strategy 2025-2028 • Deliver agreed C.difficile improvement actions • Deliver 10 CNST maternity neonatal safety actions • Deliver annual safe staffing requirements • Deliver the Health Improvement Plan: Our plan to reduce health inequalities	Risk identified
CO2	Deliver a positive patient experience	• Improve the experience of inpatients, improve position in ED and children and maintain positive position in cancer and maternity surveys • Implements a change in culture in UEC pathways focussing on preventing deconditioning and reducing 'days kept away from home' and in elective services ' days worrying'.	Risk identified
CO3	To develop new ways of working across the system that lead to more effective patient interventions and pathways.	To deliver more services to patients outside of hospital: • Lead the approach to community transformation • Develop & deliver the community transformation plan • Establish new ways of working with primary care to promote partnership approach to transformation • Clinically lead the transformation of patient pathways	Risk identified
CO4	To deliver good tertiary services to the population of Lancashire and South Cumbria and District General Hospital Services to the population of Central Lancashire	• Progress the Integrated Care Board and Provider Collaborative Board clinical services programme for vascular, urology, haematology and head and neck. • Progress in tertiary services peer review compliance. • Develop an approach to frailty and end of life care that meets the needs of the local population.	Risk identified



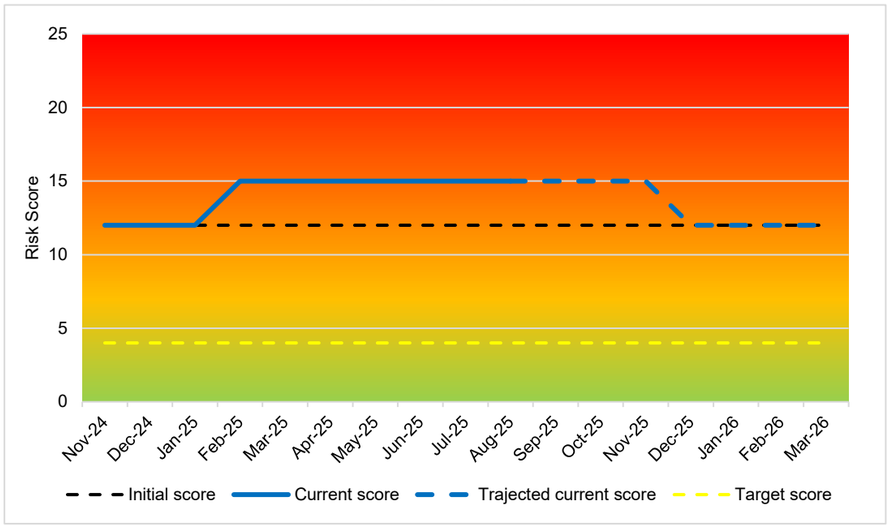
Heat map key: Black = current score, Blue = target score

Strategic Objective: Patients	**Corporate Objective:** Deliver a positive patient experience	Overall Assurance Level	Medium

Principal risk 1 (25/26) (ID 2102)	Risk Title:	Patient experience within the urgent and emergency care pathway		
	Risk Description:	There is a risk that patient experience within the urgent and emergency care pathway may be negatively impacted due to high service demand, long waiting times and overcrowding, affecting the ability to deliver care and communication in line with expectations. This could result in reduced patient satisfaction, increased complaints, poor staff experience, regulatory intervention, and potential reputational damage to the Trust.		
Committee	Safety & Quality	Risk Appetite and Tolerance	Cautious 1-6	
Director	Chief Nursing Officer	5Ts status	Treat	
Date risk opened	05/12/24	Date of last review	07/09/25	
		Target control date	31/07/26	



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

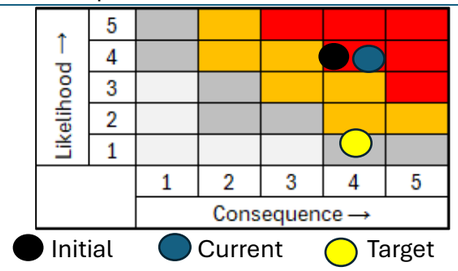
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Patient experience and Involvement Strategy. • Patient Experience & Involvement Group. • Single Improvement Plan related to patient experience. • National OPEL Framework. • L&SC daily Gold Command meetings. • Escalation Plan (including Full Capacity Protocol, Bed Escalation and Extreme Escalation). • Urgent & Emergency Care Delivery Board. • Urgent & Emergency Care Picker Survey Action Plan. • Discharge Improvement Plan.	• Community demand for primary and UEC services. • Alternatives to Emergency Care. • Ageing estate and environment. • Sub-optimal escalation areas. • Being cared for in areas that are waiting areas / not traditional bed spaces. • Financial constraints. • Unpredictability of patient acuity. • Gap in the required number of beds. • Patients cared for outside of designated bed spaces.	<u>Level 1 Assurance</u> • Complaints and concerns – approx. less than 1% versus attendances. • ED dashboard provides monthly overview of safety, quality and performance metrics in ED. • Improved position at CDH in relation to time to triage, average time to see a clinician. • STAR patient experience has some areas of positive performance. <u>Level 2 Assurance</u> • Patient Experience & Involvement Group reports to Safety & Quality Committee • Urgent and Emergency Care Picker Survey reported to Safety & Quality Committee. <u>Level 3 Assurance</u> • Friends & Family Test – some areas of positive assurance.	• Time to see a clinician at RPH consistently exceeds the 60 min average target. • Urgent and Emergency Care Picker Survey identified areas for improvement. • Friends and Family Test – gaps related to communication, waiting times and overall experience.

Risk Treatment

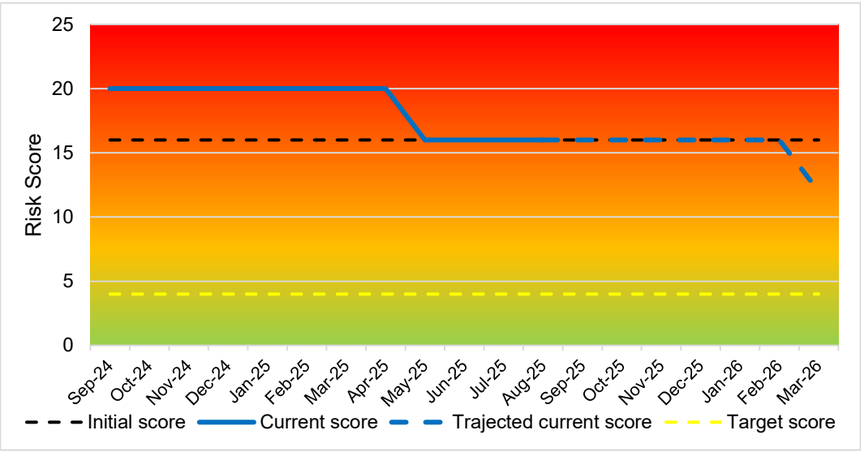
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Delivery of Urgent & Emergency Care Picker Survey Action Plan	A. Booth	31.08.25	31.08.25	Aug 25 – UEC plan finalised and will now proceed and be monitored through the Single Improvement Plan and progress reported through the bi annual patient experience report to Safety and Quality Committee.
Implement approach to days kept away from home to reduce length of stay that leads to prolonged waits in the ED.	K. Foster Greenwood	30.09.25		Sept 25 –Progressing positively. 2 wards now in place with training commenced for a further 16 wards progressing in line with the plan.
Increase capacity in care connexions	S. Morrison	31.10.25		Sept 25 – Go To Doc now joined weekly UEC improvement huddle, secondary care inreach support commenced. This is expected to take until 30 November 25 to see the benefits of this.
Develop tripartite plan with ICB and LCC to reduce number of patient spending time in hospital when no longer a requirement for their condition	S. Morrison	30.09.25		Sept 25 – New action identified. Tripartite Not Meeting Criteria to Reside Plan in development with ICB and LCC.

Strategic Objective: Patients	**Corporate Objective:** Improve outcomes and prevent harm	Overall Assurance Level	Medium

Principal risk 2 (25/26) (ID 1157)	Risk Title:	Higher than trajectory rates of Clostridioides difficile (C.*difficile*) Infection	
	Risk Description:	There is a risk that there will be higher than trajectory rates of patients contracting C.*difficile* infection. The reasons for this are multifactorial and present a risk of increased mortality and morbidity, longer length of stay, poor patient experience, regulatory action, and reputational impact.	
Committee	Safety & Quality	Risk Appetite and Tolerance	Cautious 1-6
Director	Chief Nursing Officer	5Ts status	Treat
Date risk opened	09/06/21	Date of last review	07/09/25
		Target control date	31/03/26



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal

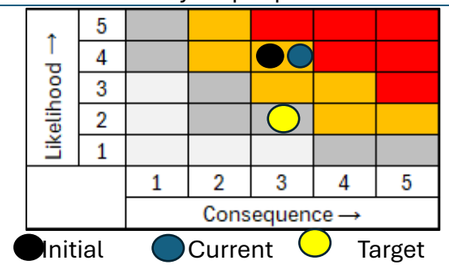
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Annual IPC Plan in place approved by IPCC and Trust Board. • IPC Policy in place. • Director for IPC and Matron for IPC in place. • Mandatory annual IPC e-learning core skills for all staff. • Antimicrobial pharmacist in post to drive improvements in antimicrobial usage and stewardship. • National cleaning standards in place on 15 wards, with remaining wards completing IPC audits and ward daily cleaning check lists. • Enhanced cleaning/fogging in place as required. • Sporicidal cleaning product (capable of killing C. difficile spores) is in place for general ward environmental cleaning • Ward whiteboard provides visibility of patients who present an infection risk to prompt timely action. • Isolation Room Dashboard ensures visibility of infection status in single rooms, ensuring rooms are used correctly and efficiently. • A rapid gastrointestinal test is available for exclusion of infection in diarrhoeal patients to aid rapid diagnosis. • Operational IPC meetings across Divisions. • Weekly virtual C.*difficile* ward round to support review and prevention, predominantly with relapses.	• Patient non-concordance with medical advice. • High prevalence nationally and community onset cases identified upon attendance at the hospital which creates an increased risk to others. • Non-adherence to antimicrobial guidelines in some cases. • Some staff demonstrate non-compliance with IPC advice and policy. • Isolation facilities insufficient to meet IPC needs across all infections, exacerbated by operational pressures in ED. • Ageing estate impacting upon IPC controls. • Lack of funding to support improvements to ageing estate. • A high number of blockages in the single stack sewage system leading to backflow of infectious waste into clinical areas. • A high frequency of macerator blockages and down-time leading to higher risk disposal methods of infectious waste • Lack of decant facilities to allow for thorough environmental decontamination. • Insufficient space for appropriate separation and storage of clean and dirty items on clinical areas • Funding for the implementation of the domestic services elements of the National Cleaning Standards 2021 is in place but being released in phases. There are 15 areas where this is implemented. • Delays in recruiting to domestic services vacancies due to vacancy controls in place.	<u>Level 1 Assurance</u> • IPC Dashboard triangulating process measures with outcome data. • Fogging compliance data available • Hospital acquired infection are reported on Datix. Themes and trends are monitored to identify learning. • Incident oversight in PSIRF triage meetings and regular MDT reviews under PSIRF for high prevalence wards. • For 2024/25, the final number of cases was below the trajectory by seven cases. • IPC BAF report reviewed and shared at IPCC for assurance. • IPC monthly revalidation audits including hand hygiene, commodes, environmental checks and mattress checks. <u>Level 2 Assurance</u> • Monthly reporting into S&Q Committee, IPCC and Divisional IPC meetings, along with bi-monthly reporting into H&S Committee. <u>Level 3 Assurance</u> • Monthly IPC committee includes internal stakeholders and system partners from the ICB, UKHSA and LCC. • ICB & NHSE IPC Collaborative meetings. • NHS England / UKHSA external review in 2024.	• Inconsistent audits on National Cleaning Standards – 15 wards compliant. • Trust / NHS England – UKHSA Review of wards that do not have national cleaning standards in place show that this gap could be contributing to an increase in infection rates.

Risk Treatment

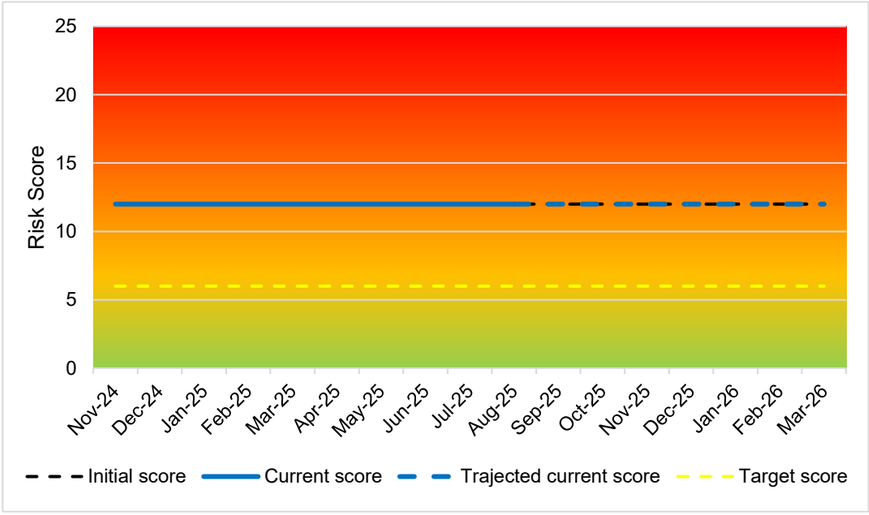
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Implement the national cleaning standards phase 2 of 3.	C. Gregory/ J. Ashley	31.10.25		Sept 25: Phased implementation progressing with delivery of 50% to be implemented by October 2025.
Continue to implement the C.difficile improvement plan monitoring effectiveness through infection prevention and control committee	C. Gregory	31.03.26		Sept 25: Annual objective for 2025/26 from the ICB. This equates to 167. Number of cases as at the end of August 2025 was 61. Focus continues on cleaning standard implementation, including training and assurance processes.
Implement the national cleaning standards phase 3 of 3.	C. Gregory/ J. Ashley	31.03.26		Sept 25: Full implementation planned by 31.03.26

Strategic Objective: Patients	**Corporate Objective:** Develop new ways of working across the system that lead to more effective patient interventions and pathways	Overall Assurance Level	Medium

Principal risk 3 (25/26) (ID 2103)	Risk Title:	People experiencing Health inequalities		
	Risk Description:	There is a risk that the Trust will be unable to effectively address health inequalities because of disparities in access to healthcare services, social determinants of health (such as socioeconomic status, education, and housing conditions), commissioning arrangements, and unequal distribution of resources across communities. This could result in poorer health outcomes for disadvantaged groups, increased pressure on acute and emergency services, reduced patient satisfaction, potential reputational damage for the Trust, non-compliance with regulatory standards and missed opportunities for improving population health. The Trust is part of a wider system approach to health improvement and will work with partners to affect this, recognising the limitations of single services in affecting outcomes in a material way for people.		
Committee	Safety & Quality	Risk Appetite and Tolerance	Cautious 1-6	
Director	Chief Nursing Officer	5Ts status	Treat	
Date risk opened	05/12/24	Date of last review	07/09/25	
		Target control date	31/03/27	



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)
***Trajectory for current score is for a decrease to 9 in March 2027**

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Lancashire & South Cumbria Integrated Care Partnership Health and Wellbeing Strategy. • LTH Health Improvement Plan, developed in conjunction with L&SC system partners. • Health Inequalities Group. • Health Inequalities Patient Tracking List (PTL) Group. • Health literacy group relating to communication with patients. • Specific improvement programmes for adults and children (e.g. High intensity user service, prisoner referral to treatment and ED navigator role in partnership with Lancashire Violence Reduction Network).	• Commissioning arrangements are led by the ICB. • The Trust has no Public Health Consultant. • Anchor institute plan is under review to link to other plans. • Anchor institute group to be established.	<u>Level 1 Assurance</u> [None detailed] <u>Level 2 Assurance</u> • Monthly chairs reporting to Safety & Quality Committee • Bi-annual update on Health inequalities to Safety & Quality Committee. <u>Level 3 Assurance</u> • Annual compliance NHS statement on information on Health Inequalities – data does not suggest there are barriers for patients from areas of lower deprivation to accessing elective care services. • Quarterly Report to ICB on Health Inequalities.	• Annual compliance NHS statement on information on Health Inequalities – challenges around the completeness and accuracy of ethnicity data captured, with around 7% of patient's ethnicity either unknown or not stated for Central Lancashire. • Inability to access primary care data that would allow improved data quality on high risk groups such as patients with a learning disability, serious mental health and/or physical disability.

Risk Treatment

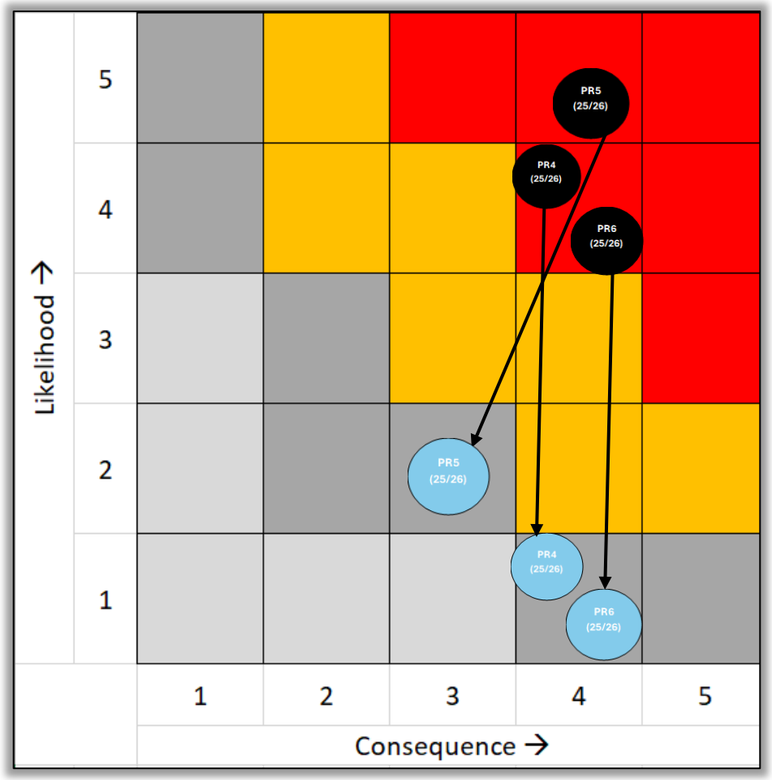
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Finalise Anchor Institute Plan	N. Pease	30.09.25		Sept 25: The Social Value Strategy agreed at Board in August 2025. Anchor Institute Plan development underway.
Identify approach to driving health inequalities reduction through each portfolio of the single improvement plan	S. Morrison	~~31.08.25~~ 31.12.25		Sept 25: Delivery date extended due to prioritisation of Waste Reduction Focus of the SIP. Recruitment to PMO underway to provide SIP programme leadership and will support the development of this in H2.
Support case to approve the data sharing agreements between primary and secondary care.	S. Dobson	31.12.25		Sept 2025: Chief Medical Officer ICS written to GPs to make data sharing request. Follow up planned for September 25.
Delivery of the Trust's Health Improvement Plan through the three main strategic drivers 1. Awareness 2. Culture 3. Prevention	S. Morrison	31.03.26		Sept 2025: Plan on a page approved through health inequalities group to enable communications plan to commence. The Safety and Quality committee will receive a twice yearly update on progress against the agreed actions within the health improvement plan evidencing the Trusts contribution towards this. Next update due September 2025.

Performance: Deliver timely, effective care

Monitored through Finance & Performance Committee

The following 2025/26 corporate objectives are aligned to the **Performance** strategic objective:

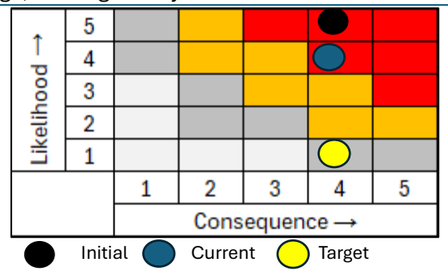
Ref.	Purpose of the objective	Scope and Focus of the Objective	Status
CO5	To minimise the risk of harm to patients through the continued delivery of our cancer recovery plan	• Delivery of more elective care to further improve performance against cancer waiting times standards. • Working in partnership with providers across L&SC to maximise our collective assets and ensure equity of access. • Work with locality partners to manage demand effectively. • Deliver specialty and divisional improvement trajectory.	Risk identified
CO6	To minimise the risk of harm to patients through the delivery of our elective recovery plan	• Delivery of more elective care to improve performance against elective waiting times standards. • Working in partnership with providers across L&SC to maximise our collective assets and ensure equity of access. • Work with locality partners to manage demand effectively. • Deliver specialty and divisional improvement trajectory.	Risk identified
CO7	To improve the responsiveness of urgent and emergency care	• Working with partners, we will continue reforms to urgent and emergency care to deliver safe, high-quality care. • Specific focus on preventing inappropriate attendance at Eds. • The ED and assessment units will be designed to deliver timely assessment, treatment and discharge. • Same Day Emergency Care and virtual wards will increase in use.	Risk identified
CO8	To minimise the risk of harm to patients through the continued delivery of our DM01 recovery plan in line with trajectory	• Delivery of the plan to improve diagnostic performance. • Working in partnership with providers across L&SC to maximise our collective assets and ensure equity of access. • Work with locality partners to manage access to diagnostics and improvement collaboratively, learning from Cheshire and Merseyside. • Deliver specialty and divisional improvement trajectory.	Risk identified



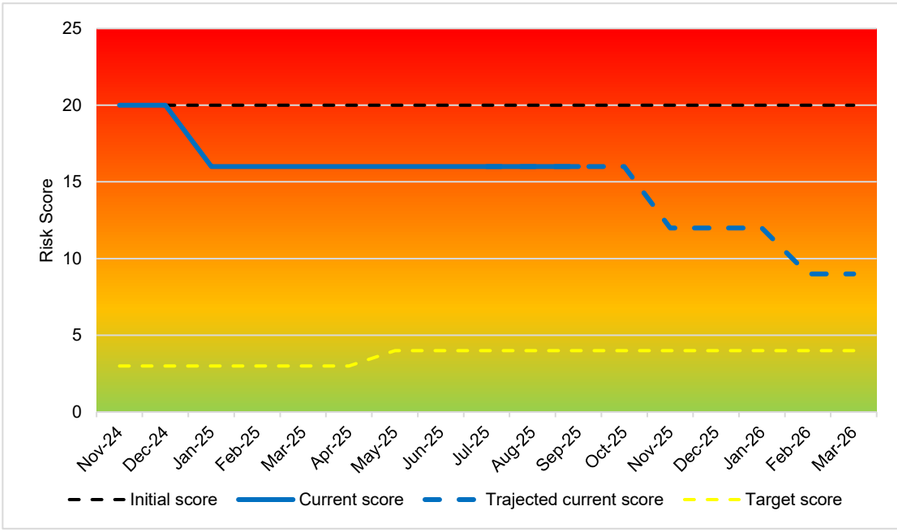
Heat map key: Black = current score, Blue = target score

Strategic Objective: Performance	**Corporate Objective:** Minimise the risk of harm to patients through the delivery of our cancer/elective recovery plan	Overall Assurance Level	Medium

Principal risk 4 (25/26) (ID 1125)	Risk Title:	Timely access to planned and cancer care	
	Risk Description:	There is a risk that there will be insufficient capacity to ensure timely access to planned and cancer care. This is because of backlogs that continue to be seen from the COVID period, surges in demand, shortfalls in capacity, the impact of industrial action, and financial restrictions limiting the ability to utilise external capacity. This could result in patient harms associated with a delay in timely access to planned and cancer care, poorer patient outcomes, inability to meet national constitutional standards, claims, poor patient experience, reputational damage, and regulatory action.	
Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious 1-6
Director	Chief Operating Officer	5Ts status	Treat
Date risk opened	19/05/21	Date of last review	15/09/25
		Target control date	31/03/26



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal

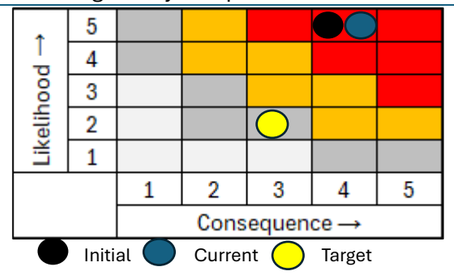
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• 25/26 Annual activity & Performance plans have been outlined to seek to deliver reduction in long waiting RTT targets. Plans include monthly trajectories and associated action plans. • Clear identification of clinical priorities via the use of national clinical prioritisation codes. This enables the trust to understand the clinical priority (P2 – P6) of those patients to support scheduling the most clinically urgent. • PEP+ (Patient Engagement Portal) and AI functionality to support validation of the waiting list and digital letters to support the process. The frequency of validation is monitored via Divisional and organisational performance forums. • Weekly monitoring of cancer patient tracking lists (PTLs) to reduce any delays with tumour specific action plans in place. • Weekly Performance Recovery Group established to track performance and delivery of actions linked to improvement trajectories. • A report for P2 patients waiting over 5 weeks is in place for Divisions to plan their elective capacity. • 6-4-2 protocols in place to drive optimal use of theatre capacity. • Forecasting of potential breaches for Divisions to proactively focus on patients for review and listing, focusing on month-end 52 week+ risks as part of the performance recovery group. • Theatre efficiency programme in place, monitored through the Elective Transformation Programme and up to the Elective Transformation Board and some parts already implemented • Monitoring of benchmarking data via Model Hospital and GIRFT to drive productivity improvements.	• Lack of triangulation between capacity and demand gaps, benchmarking data and job planning processes • Inability to fully validate waiting lists regularly due to digital and workforce shortfalls. • Lack of standardised SOPs for validation. • Shortfalls in funding to support the required capacity to deliver the elective restoration plan (ERF cap). • National pension rules for clinicians means there is limited appetite for working additional hours. • Restricted admin capacity to backfill short notice procedure cancellations. • Limitations within the EPR (Flex Harris) system resulting in increased human administrative burden and increased risk of human error leading to data quality issues and potential patient treatment delays • Lack of community capacity with the closure of Community Healthcare Hub and reduced capacity at Longridge resulting in high bed occupancy and increasing the risk of capacity related elective and cancer cancellations	<u>Level 1 Assurance</u> • Live PTL performance report and Validation reports. • Harm reviews process in place for >65 week and cancer pathway patients. <u>Level 2 Assurance</u> • Oversight in Divisional Improvement Forums, Performance Review Group and F&P Committee. • Benchmarking data analysis – model hospital, GIRFT, etc. <u>Level 3 Assurance</u> • DMO1 improvement plan and trajectory in place monitored through NHS England oversight arrangements.	• Delays in concluding some harm reviews. • Data sets lack inequalities data visibility to assess the risk to poorer outcomes between patient groups on PTLs. • Inability to assess the risk for patients on surveillance pathways. • Limitations of EPR (Flex Harris) to link patient pathways which may result in ineffective performance management and reporting.

Risk Treatment

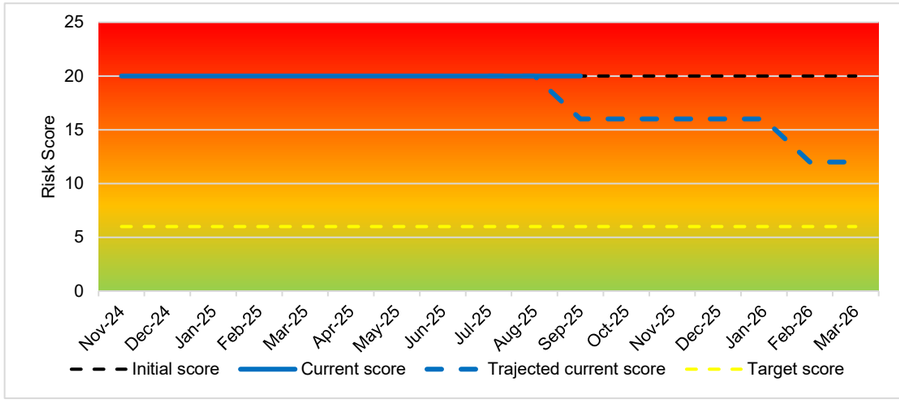
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Submit Recovery Transformation Fund bids to NHSE	K. Foster-Greenwood	~~01.09.25~~ 01.10.25		Sept 25: Awaiting feedback from NHS England
Review of validation processes across L&SC to agree standardisation	L. Walsh	30.09.25		Sept 25: Validation policies have been reviewed across all L&SC providers and the L&SC Deputy COOs are working together to draft a standardised policy. Target completion extended to September 2025. This work is progressing and on track for completion at the end of September.
Review of booking, scheduling and administrative resource benchmarking options	K. Foster-Greenwood	31.03.26		Aug 25: PWC partners have been scoping the transformation programme. Updates anticipated by end Aug 25. There is also an ongoing review of the admin capacity vacancy factor for Administrative & Clerical reduction to 10%.

Strategic Objective: Performance	**Corporate Objective:** Improve the responsiveness of urgent and emergency care	Overall Assurance Level	Low

Principal risk 5 (25/26) (ID 2104)	Risk Title:	Timely access to urgent and emergency care	
	Risk Description:	There is a risk that patients may experience delays in timely access to urgent and emergency care because of high demand, insufficient out of hospital provision for patients who do not meet the criteria to reside in hospital, limited bed availability, workforce shortages, and delays in patient flow throughout the hospital and community. This could result in longer waiting times, compromised patient safety and experience, increased clinical risk, poorer health outcomes, and potential breaches of national performance targets, impacting the Trust's reputation and regulatory compliance.	
Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious 1-6
Director	Chief Operating Officer	5Ts status	Treat
Date risk opened	05/12/24	Date of last review	15/09/25
		Target control date	31/03/26



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

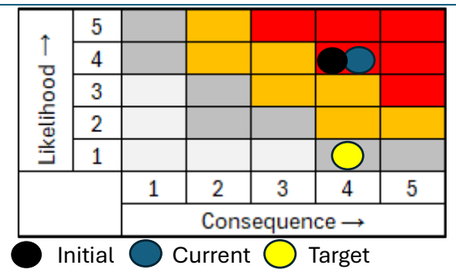
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Clinical triage processes are established. • OPEL and internal Site Pressure Score Framework and protocols are in place • L&SC daily Gold Command meetings. • Escalation and Surge Plans defined and in place. • Ambulatory and admission avoidance pathways established. • Same Day Emergency Care facilities in place. • Urgent care service provided by a third party co-located on both CDH and RPH sites. • Single Improvement Plan and Board established to track improvement delivery. • Central Lancs system wide UEC & Community Improvement Plan focusing on Hospital @ Home pathways and capacity and Days Kept Away from Home established. • Site Pressure Management processes, meetings and associated action cards established. • Clinical discharge team management of all patients classified as Days Kept Away from Home. • Virtual Ward capacity to support admission avoidance and early step down from hospital. • Care connections coordination function in place to link hospital and community provisions. • Continuous Flow Model is established to drive timely flow. • Ward & Board round process standardisation programme established. • 45 min Release to Rescue protocol implemented	• Insufficient flow within the hospital bed base to prevent ED overcrowding. • Out of hospital provision is insufficient to meet the demand. • The environment and estate is sub-optimal.	<u>Level 1 Assurance</u> • ED Safety Surveillance dashboard monitors live metrics to assess risks of patient harm. <u>Level 2 Assurance</u> • Urgent & Emergency Care and Community Transformation Board provides monthly monitoring of all improvement actions across the system. • Emergency Department Dashboard to Safety & Quality Committee • Finance and Performance Committee. <u>Level 3 Assurance</u> [None detailed]	• High bed occupancy levels (above 92%). • Time to triage and first senior review are not meeting Trust targets. • Performance for the 4 hour wait times and 12 hour total wait time in the department, are not meeting the Trust targets. • Ambulance turnaround times are not meeting the Trust targets.

Risk Treatment

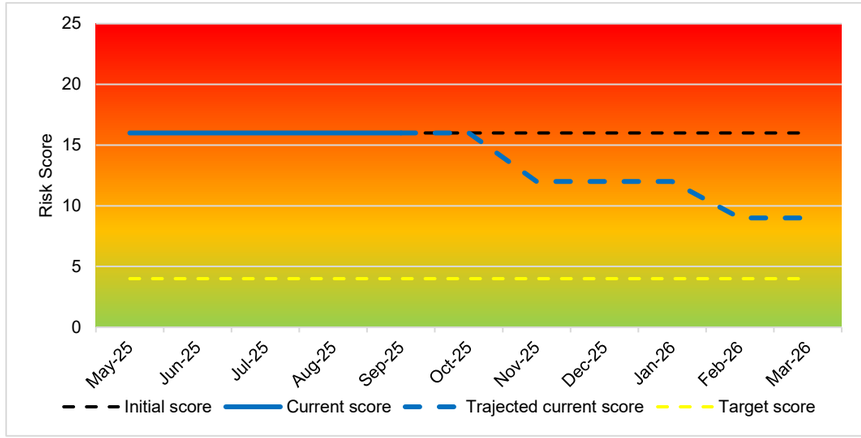
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Support the mobilisation of the NWAS "45 minute release to rescue" protocol	K. Foster-Greenwood	01.08.25	01.08.25	Aug 25: protocol now implemented and being supported by LTHTR
Implement a triage process with LCC to reduce delays and support timely decision making	L. Walsh	30.08.25	01.08.25	Aug 25: triage process now implemented
Mobile Site Pressures Meeting re-set	K. Foster-Greenwood	11.08.25	11.08.25	Aug 25: New action identified and completed.
Surge planning to be concluded re Winter period 25/26	K. Foster-Greenwood	01.09.25	01.09.25	Sept 25: Completed.
Development of virtual ward step up model	L. Walsh	01.09.25	01.09.25	Sept 25: The VW team are now co-located with the 2UCR team and managing patients across both functions without the need for referrals etc. The Step-up model is being rolled out and once a number of SOPs have been approved it is anticipated that there will be an increase in activity from the community into virtual ward.
Consider expanding the "Days Kept Away From Home Programme"	K. Foster-Greenwood	30.09.25	01.09.25	Sept 25: 16 further wards identified for roll out of the DKAFH principles – commenced.
Review options to pilot the roll out of the Continuous Flow Model at weekends	K. Foster-Greenwood	30.09.25	01.09.25	Sept 25: Weekend roll out of CFM now taking place as boarding allows.
Conclude and evaluate Ward & Board round standardisation	R Sansbury	31.03.26		Apr 25: New action identified
Increase Virtual Ward occupancy to minimum of 75% by March 2026.	L. Walsh	31.03.26		Sep 25: New action identified
Undertake the Emergency Care Intensive Support Team (ECIST) Capacity and Demand Model	D Bedford	31.10.25		Sep 25: New action identified

Strategic Objective: Performance	**Corporate Objective:** To minimise the risk of harm to patients through the continued delivery of our DM01 recovery plan in line with trajectory	Overall Assurance Level	Medium

Principal risk 6 (25/26) (ID 2188)	Risk Title:	Timely access to diagnostic investigations		
	Risk Description:	There is a risk of delays in the completion of diagnostic investigations linked to cancer and elective pathways of care due to high levels of demand, shortfalls in capacity, and financial restrictions limiting the ability to utilise external capacity. This could result in patient harms associated with a delay in timely diagnosis, poorer patient outcomes, inability to meet national constitutional standards, claims, poor patient experience, reputational damage, and regulatory action.		
Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious 1-6	
Director	Chief Operating Officer	5Ts status	Treat	
Date risk opened	03/06/25	Date of last review	15/09/25	
		Target Control date	31/03/26	



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Diagnostic Improvement Group has been established to monitor progress of all improvement trajectories, support demand management, the use of technology and monitor productivity. • All Diagnostic modalities have undertaken a capacity and demand analysis and set improvement trajectories. • Clear identification of clinical priorities via the use of national clinical prioritisation codes. This enables the trust to understand the clinical priority using 'D codes' to support scheduling the most clinically urgent. • Diagnostic waiting validation processes are in place to ensure all capacity is effectively used. • Additional capacity has been commissioned for M1-6 25/26. • Weekly monitoring of cancer PTLs to reduce any delays is in place supported by a day zero PTL approach with tumour specific action plans in place. ICB support and performance monitoring re Cancer waiting times is delivered via the Tier 1 performance framework and meetings are held fortnightly. • Weekly Chief Operating Officer monitoring forum for core diagnostic modalities. • Weekly Performance Recovery Group established to monitor performance.	• Lack of capacity to deliver comprehensive diagnostic waiting list validation. • Funding to support additional capacity ceases in M6 25/26. • Lack of triangulation between capacity and demand gaps, benchmarking data and job planning processes. • Physical estate and capital equipment constraints limit available capacity. • Limited influence re external (primary care) demand management.	<u>Level 1 Assurance</u> • Live PTL performance report. • Validation reports. • Datix incident reporting of any treatment delay related harms – review via SI/PSIRF processes with shared learning reports. • Benchmarking data – model hospital, GIRFT, etc <u>Level 2 Assurance.</u> • Oversight in Divisional Improvement Forums, Performance Review Group and F&P Committee. • Benchmarking data analysis – model hospital, GIRFT, etc. <u>Level 3 Assurance</u> • DM01 improvement plan and trajectory in place monitored through NHS England oversight arrangements.	• Data sets lack inequalities data visibility to assess the risk of poorer outcomes between patient groups on PTLs • Datix incident reporting to assess harms of treatment delays is retrospective

Risk Treatment

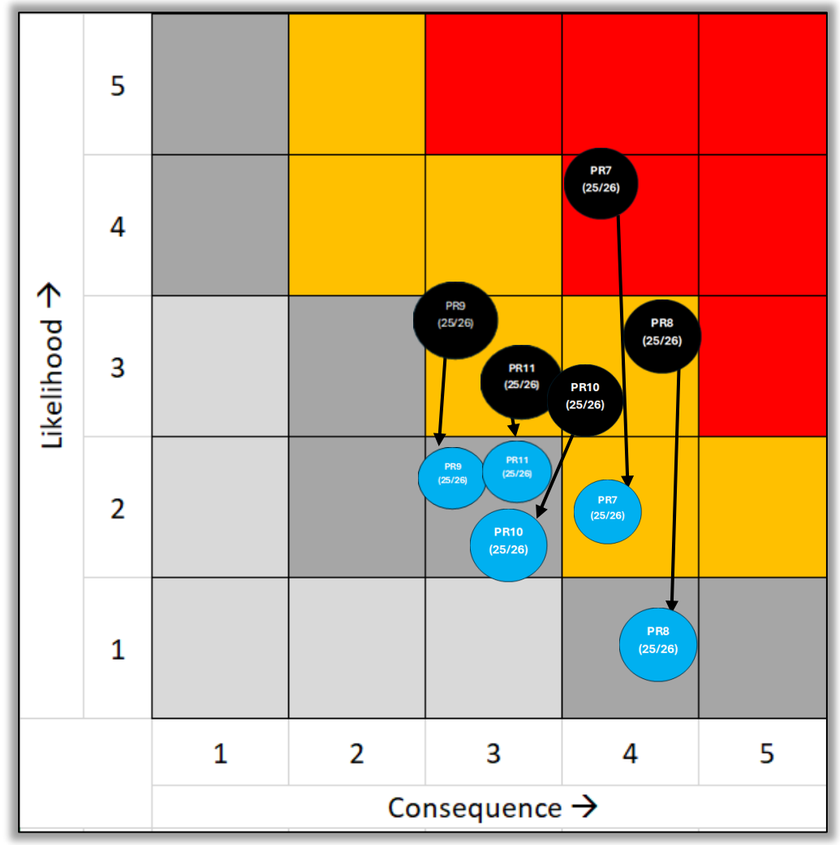
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Review options to increase capacity via skill mix changes for Urological diagnostic tests	K. Foster-Greenwood	~~31.07.25~~ 30.08.25	01.09.25	Sept 25: Options scoped. Plans in place to support recovery of the DM01 target for Urological tests by end March 26.
NHSE Cardiac Improvement Programme review to support improvements	K. Foster-Greenwood	31.08.25	04.09.25	Sept 25: Report shared and undertaking factual accuracy checking. Improvement plans developed and being tracked via Diagnostic Improvement Group
Scope mutual aid and outsourcing options across L&SC	K. Foster-Greenwood	31.08.25	08.08.25	Aug 25: Mutual aid model completed for Echo.
Review internal demand utilisation benchmarking data and agree actions	K. Foster-Greenwood	~~30.09.25~~ 31.10.25		Sept: 25: Data has been shared to divisions by DCS, CRG discussion led by Deputy CMO required. Agreed in DDG an approach and CMO support required to expedite. Extended delivery date due to clinical availability.
Review options to introduce Diagnostic utilisation into Control Room	K. Foster-Greenwood	~~31.08.25~~ 30.09.25		Sept 25: Delay in rolling out diagnostic utilisation into the control room as MR is currently transitioning from paper to digital referrals. Working with the imaging team to incorporate NOUS into the control room from w/c 29/09. Once the other modalities are using digital referrals they will be managed within the control room function.
Complete the build and mobilisation of additional endoscopy space	K. Foster-Greenwood	31.10.25		Sept 25: Latest build completion timescales anticipated handover Nov 25.
Recruit workforce in line with 5th room business case	D. O'Brien	30.11.25		Sept 25: Recruitment ongoing

People: Be a Great Place to Work

Monitored through Workforce Committee & Education, Training & Research Committee

The following 2025/26 corporate objectives are aligned to the **People** strategic objective:

Ref.	Purpose of the objective	Scope and Focus of the Objective	Status
CO9	To right size the workforce to support the delivery of safe, affordable and sustainable services, aligned with the Trust's strategy	• To deliver a workforce plan that responds to commissioning intentions and the communities we serve. • Achieve the headcount reduction needed to ensure successful delivery of the waste reduction workforce plan whilst maintaining safety.	Risks identified
CO10	To strive to improve experience at work by actively listening to our people, and turning understanding into positive action	• To ensure staff choose to stay and work in Lancashire Teaching Hospitals and they are healthy at work. • Delivery of the People Plan. • To progress staff advocacy scores relating to provision of care. • To deliver the sexual safety charter within the organisation.	Risks identified
CO11	To be consciously inclusive in everything we do	• To ensure staff are equipped with the skills to create inclusive cultures that deliver inclusive care. • Deliver the Equality Diversity and Inclusion strategy. • To demonstrate we are an Anti-Racist Organisation.	Risks identified
CO12	To build a positive culture, demonstrating our values in action through increased colleague engagement across the organisation.	• Leaders at all levels recognise their contribution to creating a culture where colleagues feel, ○ Together we are one team ○ Together we can create your future ○ Together we make extraordinary things happen • We will all strive to demonstrate our 'shared responsibilities' in the way we interact with one another.	No risk identified
CO13	To develop leaders at every level of the organisation with the skills and behaviours that are able to provide compassionate leadership.	• To enhance the governance and leadership within the Board of Directors through the provision of a Board development programme. • To invest in the development of the senior leadership team within the organisation. • To support the development of leaders at department level through the delivery of leadership training and education.	Risks identified

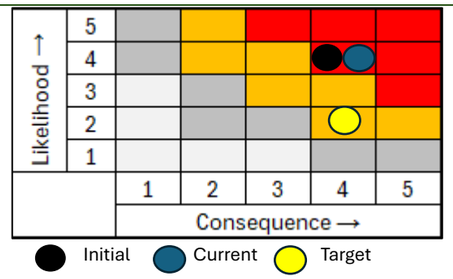


Heat map key: Black = current score, Blue = target score

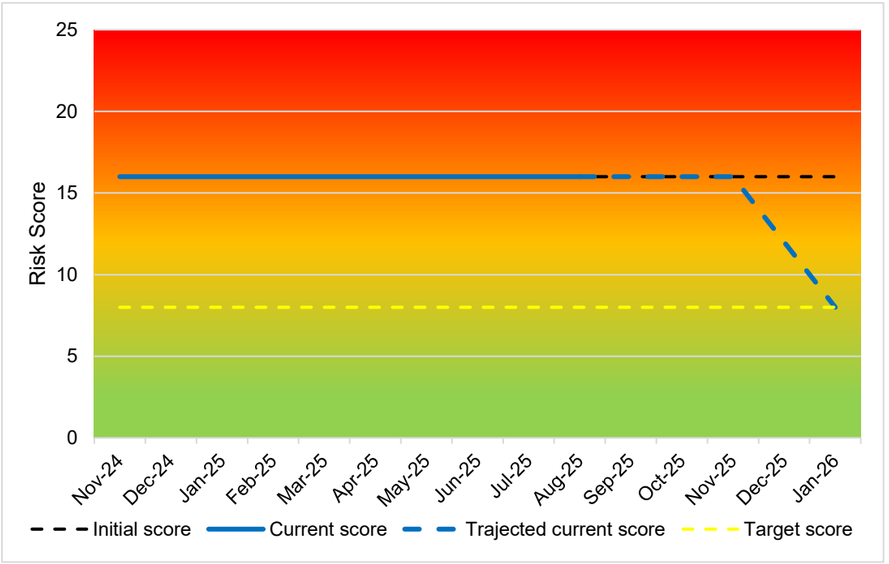
Strategic Objective: People	**Corporate Objective:** To right size the workforce to support the delivery of safe, affordable and sustainable services, aligned with the Trust's strategy	Overall Assurance Level	Medium

Principal risk 7 (25/26) (ID 2105)	Risk Title:	Reliance on temporary medical workforce	
	Risk Description:	There is a risk that there may be insufficient numbers of medical staff across the Trust. This is due to increasing capacity and demand, and an inability to recruit to vacancies in some specialities. This could result in a reliance on temporary medical staff, lack of continuity of care, patients not receiving treatment in a timely way, poor outcomes, patient harm, lack of detailed organisational knowledge of processes, poor patient and staff experience, staff working extra hours and an impact on wellbeing, financial impact of enhanced payment rates, regulatory enforcement, legal action and reputational impact.	

Committee	Workforce Committee	Risk Appetite and Tolerance	Open 4-8
Director	Chief Medical Officer	5Ts status	Treat
Date risk opened	05/12/2024	Date of last review	12/08/25
		Target control date	~~31/12/25~~ 31/01/26



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

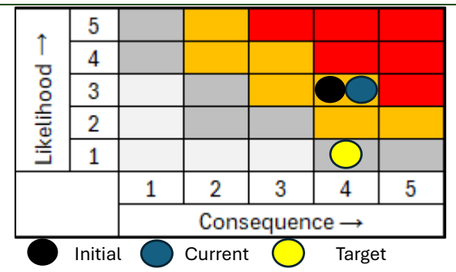
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Medical and Dental Job Planning Policy. • Medical Annual Leave policy in place. • Job plans in place for Consultants and Speciality Doctors. Agreed annually as a prospective plan. • Daily Management System in place to aid understanding of temporary workforce in a timely manner. • Processes for changes in job plans where this occurs in-year. • Healthroster system used to manage rotas. • Medical bank in place. • On-call system in place outside of normal working hours (built into job plans). • Non-medical roles for certain specialities to reduce the need for medical input (i.e. Advanced Nurse Practitioners, Consultant AHP roles, physician associates). • Enhanced grip and control measures for the use of temporary medical and agency staff.	• Inconsistent capacity and demand modelling across specialities. • Healthroster not fully aligned to job plans and when job plans are changed. • Operational capacity and technical ability to monitor 42-week productivity against job plans. • Vacancies in hard to recruit specialities can cause long gaps. • Understanding of speciality-by-speciality minimum safe staffing levels. • Sufficient resource to deliver transformational medical staffing projects. • Monitoring of actioning of Medical Annual Leave policy. • Retrospective additions of bank/agency shifts can be misleading for the Daily Management System	<u>Level 1 Assurance</u> • Monthly processes in place to review opportunities based on pay activity. • Monitoring of patients seen by a clinician within 14 hours of admission. • Monitoring of patients seen by a clinician following initial assessment. • Utilisation of agency medical staff reported to Temporary Staffing & Rostering Group each month. <u>Level 2 Assurance</u> • Annual Job plan report to Workforce Committee. • Quarterly medical safe staffing report to Safety & Quality Committee. <u>Level 3 Assurance</u> [None detailed]	• Delays in patients accessing senior medical reviews consistently in all specialties • Inability to articulate the required medical staffing model. • Inability to report on safe staffing levels in relation to medical staffing in response to CQC must do • Absence of robust 42-week monitoring of activity between Healthroster and L2P job plan software. • Requirement to strengthen consistency between ledger and vacancies. • Reports do not readily differentiate short term bookings from long term agency/bank staff.

Risk Treatment

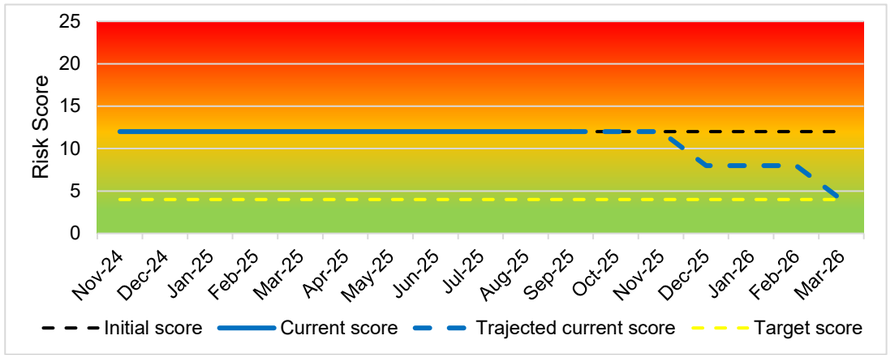
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Development of 42-week productivity tool	M. Stewart	~~31.07.25~~ 30.09.25		Aug 2025: Funding identified to support a 6 month post to support the development of the 42-week productivity tool and recommendation has been made that this will be an internal secondment with backfill for the individual's existing duties. Vacancy has been taken through Vacancy Control Panel and there is a confirmed start date of 15th September 2025.

Strategic Objective: People	**Corporate Objective:** To be consciously inclusive in everything we do	Overall Assurance Level	Medium

Principal risk 8 (25/26) (ID 2110)	Risk Title:	Experience of staff, with specific focus on under-represented staff groups	
	Risk Description:	There is a risk that the Trust may not be considered a great place to work for colleagues or prospective employees across the Trust, including those in under-represented staff groups. This could result in negative experience for staff, adverse impact for colleagues with a protected characteristic, inability to retain a skilled and valued workforce, staff absence, regulatory intervention, and legal action.	
Committee	Workforce Committee	Risk Appetite and Tolerance	Open 4-8
Director	Chief People Officer	5Ts status	Treat
Date risk opened	05/12/2024	Date of last review	12/08/25
		Target control date	31/03/26



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

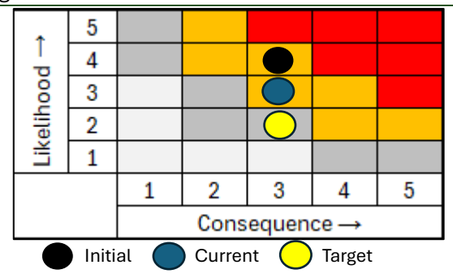
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Our People Plan • Corporate level action plan in response to NHS Staff Satisfaction Survey results. • Team Engagement and Development (TED) Tool and toolkit, supporting leaders to take local action to improve levels of engagement and satisfaction. • Equality, Diversity and Inclusion Policy. • Equality, Diversity and Inclusion Strategy. • Single Improvement Plan. • Equality, Diversity and Inclusion mandatory training. • Supporting Disability in the Workplace policy and agreement. • Trans and non-binary policy. • Equality Impact Assessment policy. • NHSE 8 High Impact Actions. • NHS People Promise. • Culture programme, including Zero Tolerance campaigns. • Freedom to Speak Up Policy, Process and Champions. • Employee Relations policies and processes. • Trust Values/Best Version of Us/Leadership in Lancs frameworks. • Core People Management Skills programme. • EDI resources/education/toolkits • Leaders/All Colleague briefings • Staff ambassador forums for colleagues with protected characteristics.	• No equivalent national Workforce Equality Standard for LGBTQ+ colleagues. • ESR Declaration rates for colleagues with a long-term condition or disability. • EQIA process/lack of challenge in respect of EIA findings. • Gaps in localised application of inclusive management practices and in addressing poor behaviours which are not inclusive. • Awaiting mandates and directives following the High Court ruling with regards to protected characteristics of sex in April 2025.	<u>Level 1 Assurance</u> • Equality Diversity and Inclusion Annual Report • Suite of NHS Staff Survey reports and corporate level action plan. • Monthly reporting of participation with TED Tool. • Quarterly reporting of National Quarterly Pulse data. <u>Level 2 Assurance</u> • L&SC ICS ED&I Group. • Equality, Diversity and Inclusion Strategy monitoring. • Our People Plan Strategy Monitoring. • Single Improvement Plan reporting. • Workforce Committee. <u>Level 3 Assurance</u> • Internal Audit review of ED&I in 2023/24 – Substantial Assurance. • Some positive areas identified in the Workforce Race Equality Standards (WRES). • Some positive areas identified in the Workforce Disability Equality Standards (WDES). • North West Anti-Racist Framework. • EDS2022 • North West ED&I Assurance template	• Challenges in ability to drill down into the NHS Staff Satisfaction Survey data from a minority group/divisional basis due to low numbers and confidentiality. • Areas for improvement identified in the Workforce Race Equality Standards (WRES). • Areas for improvement identified in the Workforce Disability Equality Standards (WDES). • WRES/WDES report only completed on an annual basis • Ability to take meaningful actions which impact the Gender Pay Gap with Agenda for Change (AfC) • Ability to measure progress in Divisions and Departments with regard to actions taken to address lower levels of staff satisfaction and engagement. • Ability to drive up completion of the National Quarterly Pulse, to enable reporting to be more representative of the workforce.

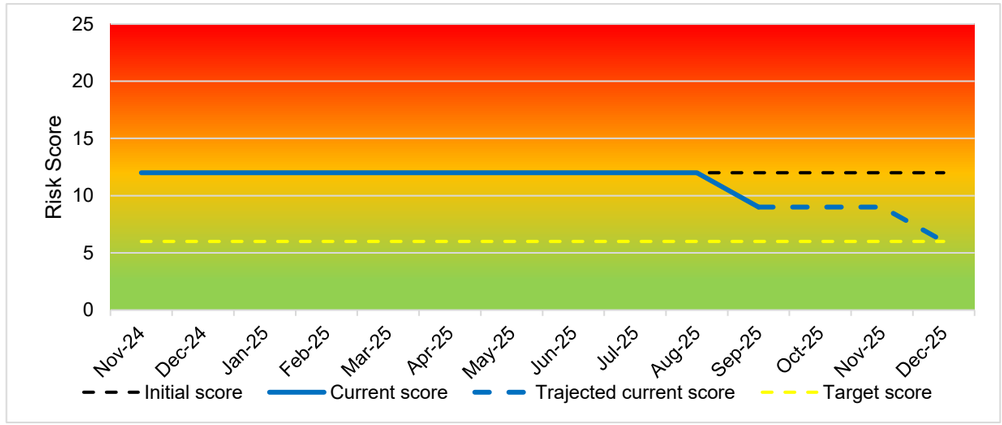
Risk Treatment

<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Development of a refreshed colleague engagement offer	S. Kenny	31.07.25	31.07.25	Aug 25: Development completed
Work to be undertaken in conjunction with the Living with Disability forum to understand more about bullying and harassment	M Davis	~~31.07.25~~ 30.09.25		Aug 25: Forum Chairs have been briefed on the results of the Staff Survey and WDES metrics, especially in respect of Bullying & Harassment. Chairs are covering in next forum meeting - action due date extended to September to allow for colleague feedback. Work has been ongoing across the organisation to support culture (Compassionate Conversations) and presentation at Leader briefing in respect of Kindness and Compassion too which will influence this area
Work to be undertaken in conjunction with the Ethnicity forum to understand more about discrimination statistics	M Davis	~~31.07.25~~ 30.09.25		Aug 25: Forum chairs have been briefed on the results of the staff survey and the metric in respect of discrimination - they will be discussing in the next Inclusion forum meeting. Due date moved to end of September to allow for meeting to take place/feedback etc.
Increasing the diversity of colleagues in band 8a and above as per WRES/WDES annual report	M. Davis	~~31.07.25~~ 31.12.25		Aug 25: Statistics regarding movement of non-clinical and clinical staff under BME, LTC and Disability categories in 2024/25 has been captured, with the acknowledgement that some movement is due to staff TUPEing out of the Trust into OneLSC. The Leadership & OD team are to review the Talent Management strategy and offer across the organisation before the end of 2025. Leadership development opportunities have been proactively shared with BME colleagues and colleagues with a LTC/Disability and this will continue.
Increased use of TED	S. Kenny	31.03.26		Aug 25: Improvement seen in the usage of TED over the course of the year and to be monitored for sustained usage.
Delivery of actions in NHS Staff Survey Action Plan	S. Kenny	31.03.26		Aug 25: Work remains ongoing with communications issued Trustwide around what has been achieved so far within the plan.

Strategic Objective: People	**Corporate Objective:** To strive to improve experience at work by actively listening to our people, and turning understanding into positive action	Overall Assurance Level	Medium

Principal risk 9 (25/26) (ID 2111)	Risk Title:	Sub-optimal experience of Resident Doctors		
	Risk Description:	There is a risk that resident doctors experience of working at the Trust may not always be positive. This is because of operational pressures and working practices. This could result in poor staff experience, grievances, absence, a reduced level of medical staff, inability to recruit, patient safety incidents, regulatory intervention and reputational damage.		
Committee	Education, Training and Research Committee	Risk Appetite and Tolerance	Open 4-8	
Director	Chief People Officer	5Ts status	Treat	
Date risk opened	05/12/2024	Date of last review	18/09/25	
		Target control date	31/12/25	





Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

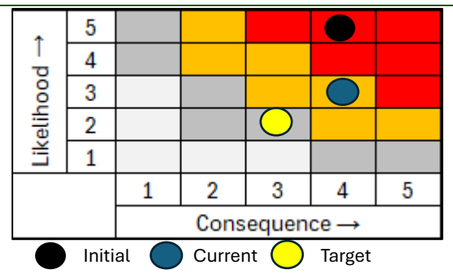
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Workforce and OD Strategy. • Education and Training Strategy. • Divisional education contracts. • NHS Education Contract. • Medical Workforce team.	• National requirement to take an NHS Staff Survey approach to the GMC National Training Survey. • StatMand training currently under national review for all staff groups including resident doctors. • Requirement to work with Lead Employer who holds employment responsibilities for resident doctors. • Time restriction of Lead Medical Education officer to progress the resident doctor agenda.	<u>Level 1 Assurance</u> • Resident doctor forum. • Divisional Workforce Committee. • Raising Concerns Group. • Enhancing Doctors Working Lives Action and Assurance Group. <u>Level 2 Assurance</u> • Education, Training and Research Committee. • Workforce Committee. <u>Level 3 Assurance</u> • NHSE Monitoring the Learning Environment quarterly meetings. • GMC National Training Survey (NTS). • National Education and Training Survey. • Annual Internal Placement Experience. • De-escalation of concerns monitored via NHSE Intensive Support Framework (category ISF 1). • GMC National Training Survey 2025 results indicate that Trust performance has improved in 17 out of 18 themes when compared with 2024 data. • 9 out of 18 themes are now above the national average. • Overall satisfaction is above the National Average for the first time in over four years having increased (+5.83%) to 78.56%	• A number of areas of Post Graduate Medical Education are currently being monitored within the NHSE Intensive Support Framework, these include: 1) Senior Support for Foundation Doctors and Acting Beyond Competencies at CDH (ISF 1) 2) Efficient handover with clear allocation of roles (ISF 1) 3) GMC NTS 2024 Results showed Neurology RPH, Radiology RPH, Clinical Oncology RPH and Obstetrics and Gynaecology RPH in ISF 1.

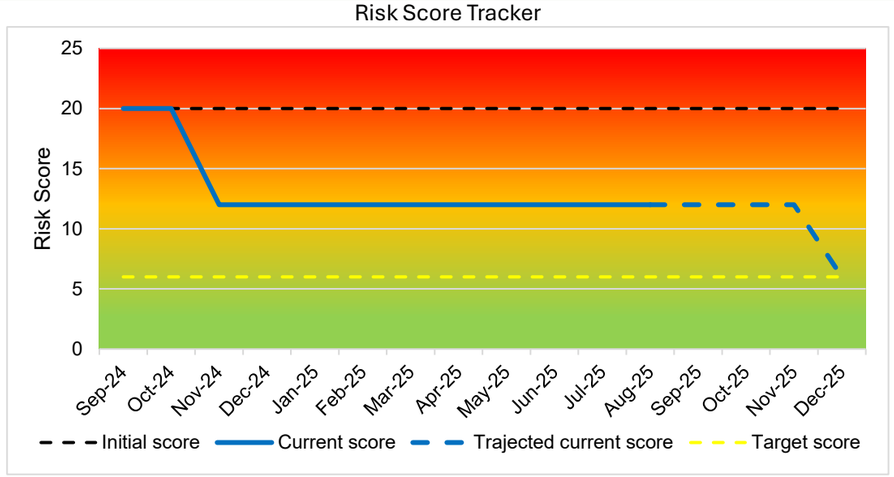
Risk Treatment

<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Receipt and review of GMC Survey results to understand assurance around controls in place – expected end of July 2025	L. O'Brien	31.08.25	31.08.25	Sept 25: Results presented to Education, Training and Research (ETR) Committee in August 2025
GMC Survey results to be reported to Enhancing Doctors Working Lives Action and Assurance Group to enable triangulation of themes	L O'Brien	31.08.25	31.08.25	Sept 25: GMC included for discussion at Enhancing Doctor's Working Lives (EDWL) group and ETR Committee
Implement education portfolio changes to provide dedicated support to Medical Education	L. O'Brien	30.09.25	18.09.25	Sept 25: Band 8b Education lead portfolio expanded to include Medical Education, Advanced Practice, and other Medical Associate Professions – this will provide senior oversight of Medical Education portfolio.
NHS Staff Survey level of analysis and corporate level action plan for GMC survey to be presented to ETR in October	L O'Brien	31.10.25		Sept 25: To be presented at ETR in October 2025.
Review Education and Training Strategy	L. O'Brien	31.12.25		Jul 25: An annual strategy update will be presented to ETR in August 2025. Delays in the publication of the Trust Strategy , as well as the publishing of a 10-year plan from NHSE will impact on future Trust Education and Training Strategy. Due date extended.

Strategic Objective: People	**Corporate Objective:** To ensure we improve colleagues wellbeing and experience at work by actively listening to our people, and turning understanding into positive action	Overall Assurance Level	Medium

Principal risk 10 (25/26) (ID 499)	Risk Title:	Failure to effectively manage staff absence and achieve Trust and National target rates		
	Risk Description:	There is a risk that failure to effectively manage staff absence due to ineffective systems or processes, or managerial capability will compromise our ability to deliver safe staffing levels and continuity of care. It could also result in increased costs associated with temporary staffing, the Trust being unable to achieve Trust or National targets and could impact on staff morale.		
Committee	Workforce Committee	Risk Appetite and Tolerance	Open 4-8	
Director	Chief People Officer	5Ts status	Treat	
Date risk opened	10/02/14	Date of last review	12/08/25	
		Target control date	31/12/25	





Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal

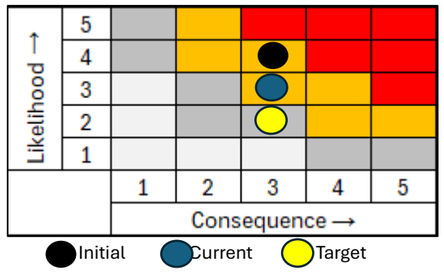
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Sickness Absence Policy in place. • Core People Management Skills training in place. • Monthly reports to Divisions - check & challenge. • Accountability Framework in place which has recently been refreshed. • Toolkits and templates for Managers. • "What Good Looks Like" for Managers. • Live data & reports in Health Roster. • Workforce Advisor Support in place (although at an insufficient level) • Health & Wellbeing Strategy in place. • Workforce & Organisational Development Strategy in place. • Operational processes in place Divisionally to look at staffing levels. • Dashboards in rosters to see safe staffing levels. • Rostering guidance and support in place.	• Gaps in localised management practices. • Lack of one complete absence record affecting ability to demonstrate policy compliance. • Insufficient capacity within the Workforce team to support absence management as proactively as possible. • Lack of localised risk assessments/stress risk assessments/moving & handling risk assessments. • Lack of triangulated data to support prediction/notice of warning signs for sickness absence. • Insufficient capacity within the psychological wellbeing service. • Development of mechanisms to prevent additional work/shifts which are counterintuitive to sickness absence position.	<u>Level 1 Assurance</u> • Divisional Workforce Committees. • Sickness absence reports are produced on a monthly basis which enables trend analysis of absence rates at cost centre level. These are reported through divisional workforce committees. • The Workforce team have undertaken local audits of absence management practice e.g. Return To Work Interview compliance. <u>Level 2 Assurance</u> • Workforce Committee. • Divisional Improvement Forums review absence levels. <u>Level 3 Assurance</u> [None detailed]	• Currently a manual process to monitor compliance with absence management policy and processes. • Inability to achieve the 4% target. • Internal audit of sickness absence management practices, (October 2024) provided limited assurance.

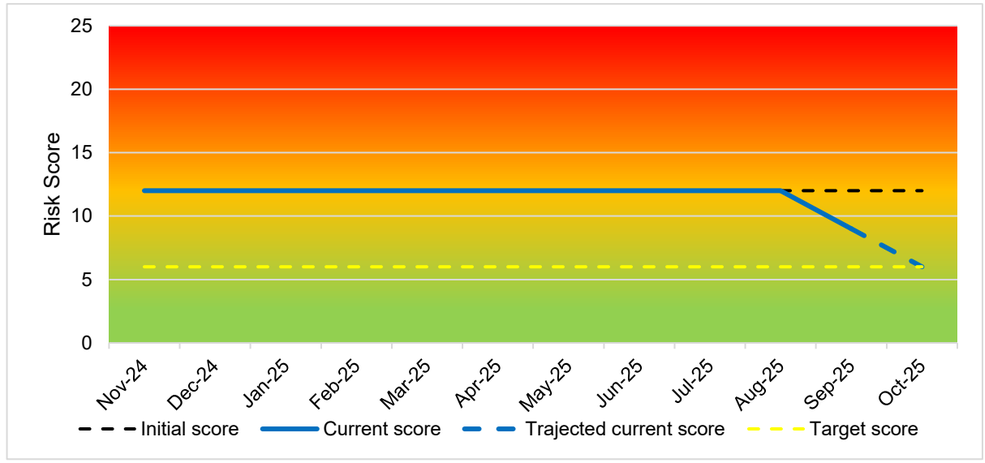
Risk Treatment

Action	Action Owner	Due Date	Done Date	Action Progress Update
Launch Rapid Access policy for expediting staff treatment	R. O'Brien	31.07.25	31.07.25	Aug 25: Policy ratified in July 2025. Action completed
Introduce restrictions on additional hours following sickness	R. O'Brien	31.07.25	31.07.25	Aug 25: Restrictions implemented and communications circulated across the Trust
Benchmarking of absence reduction practice	R. O'Brien	31.08.25	29.08.25	Aug 25: Colleagues from NHS England who are leading on sickness absence reduction have reviewed our strategies and advised on any gaps when benchmarked to best practice in other organisations. The report from NHS England has been received and is now being worked through in regard to any action plan required in response.
Pilot Empactis as a digital absence management system	R. O'Brien	~~31.08.25~~ 30.09.25		Aug 25: Further delays to implementation experienced due to delays with the requisition to pay for the ESR interface. The latest predicted implementation date is end of September 2025, due date extended accordingly.
Introduce Occupational Therapist into Occupational Health model	R. O'Brien	30.09.25		Aug 2025: Funding for the OT post is not available. An investment case is being compiled.
Deliver absence reduction 'plan on a page' against 4 key workstreams	R. O'Brien	31.12.25		June 2025: All actions continue to be progressed, however we are experience significant staffing pressures in the Workforce Advice team which is hindering pace. 2 new Workforce Advisers are at pre-employment stage, and we are seeking approval to recruit a further 2 to cover maternity gaps. Recruitment to the additional Psychologist post is live and 2 Occupational Health Physiotherapists have also been appointed, the first commencing on 30th June.

Strategic Objective: People	**Corporate Objective:** To develop leaders at every level of the organisation with the skills and behaviours that are able to provide compassionate leadership.	Overall Assurance Level	Medium

Principal risk 11 (25/26) (ID 2041)	Risk Title:	Compliance with Core Skills Training & Appraisals		
	Risk Description:	There is a risk that staff may not have received the core skills training required for their role or had an appraisal in the Trust-defined timeframes. This is due to unavailability of staff, time and capacity. This could result in staff not having up to date competencies, patient safety incidents, poor patient experience, poor staff experience, regulatory action, claims and complaints.		
Committee	Education, Training & Research Committee	Risk Appetite and Tolerance	Open 4-8	
Director	Chief People Officer	5Ts status	Treat	
Date risk opened	05/12/2024	Date of last review	18/09/25	
		Target control date	~~30/09/25~~ 15/10/25	





Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Core skills training framework (CSTF). • Training needs analysis. • Corporate Induction process. • Local Induction process. • Appraisal Policy. • Appraisal Policy for Medical and Dental colleagues. • Accountability Framework. • Self-service e-learning and appraisal platform. • Regular review of target audiences with Clinical Educators and Divisional leadership. • Training Compliance and Assurance Sub-Committee govern any proposed changes to Core Skills topics. • Monthly emails to staff to show compliance with training and appraisals and any areas that are due to expire. • Weekly reminder to staff who are out of date with Core Skills training. • 'Super red' tool produced to support the divisions in identifying staff who have more than 1 super red topic. • Monthly meetings take place between Training Performance and Compliance and Divisional Nursing Directors to review target audiences and complete approval for sign off of any changes. • Training reports map directly to CQC core services, by professional group.	• Gaps in localised application of appraisal policy and processes. • Nationally set Core Skills training framework. • National review of Core Skills Training Framework (CSTF), which is reviewing statutory and mandatory training across all Trusts, with a plan to produce a national StatMand framework in 2025. This could increase / change the requirements for delivery of training nationally and the governance processes.	<u>Level1 Assurance</u> • Training & Appraisal Compliance report - produced monthly and sent to divisional and corporate leaders. • Regular provisions and/or presentation of compliance including Core Skills training report to Divisional Workforce Committees. • Trust wide compliance achieved for all Core Skills, Mandatory training and appraisal for two consecutive months (July and August 25) • Divisional compliance achieved for all Core Skills, Mandatory training and appraisal in Corporate Services, DCS, Estates and Facilities, Surgery and Women & Children's • <u>Level 2 Assurance</u> • Reports to Training, Compliance and Assurance sub-committee. • Training and Appraisal reports to Divisional Improvement Forums. • Bi-monthly Education Training and Research committee reports to escalate gaps and assurances in plans to rectify. • Annual Appraisal Strategic Update report to Workforce Committee. <u>Level 3 Assurance</u> • Integrated Board Performance Report. • NHS Staff Survey Results	• The Trust has not yet achieved compliance in all Core Skills and mandatory training for all professional groups and all CBUs

Risk Treatment

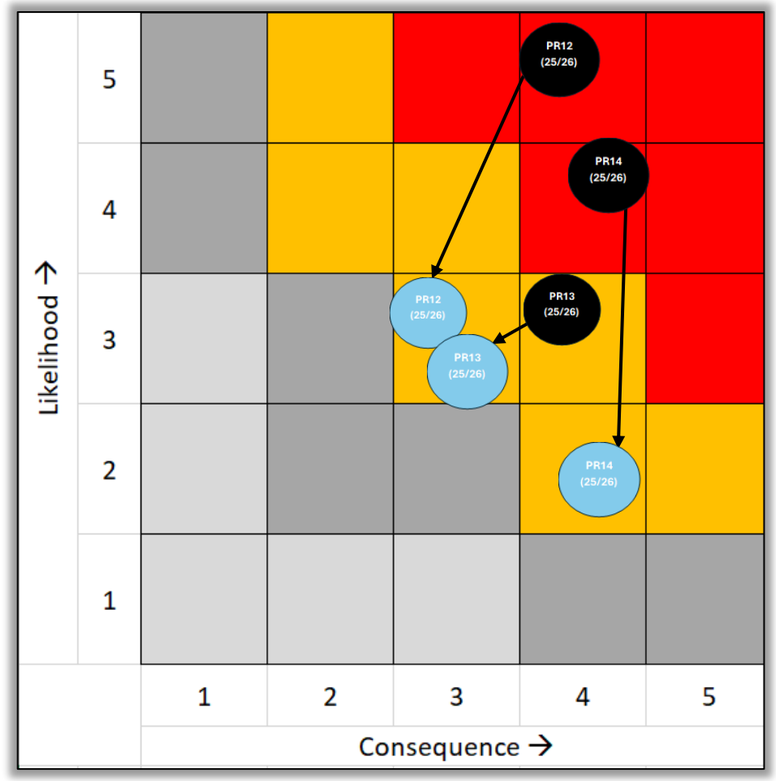
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Reviewing processes including guidance provided on how to complete appraisals, reviewing appraisal forms, monitoring and QA processes and developing intranet information hub.	L. Graham	30.09.25	18.09.25	Sept 25: All action detailed has been taken. More detailed reporting into Divisional Workforce Committees remains an ongoing action due to resourcing issues, however this is reported into SIP and is not impacting on the compliance levels.
Review Mandatory Training Policy	L. O'Brien	30.09.25	18.09.25	Sept25: Policy ratified and available on Heritage
Review one further month's data in October 2025 to obtain assurance that risk is controlled	L. O'Brien	15.10.25		

Productivity: Deliver value for money

Monitored through Finance & Performance Committee

The following 2025/26 corporate objectives are aligned to the **Productivity** strategic objective

Ref.	Purpose of the objective	Scope and Focus of the Objective	Status
CO14	To provide value for money services by spending less, spending well and spending wisely	• To evidence improved value for money and delivery of the financial recovery programme • To design services that are affordable and deliver within the budget. • Commit to make the best use of finance and colleague contribution.	Risks identified
CO15	To deliver sustained improvement evidenced through the single improvement plan	• To deliver against the plan and demonstrate improved outcomes for the organisation • Launch the Lancs Improvement Method	No risk identified
CO16	Improve our underlying productivity and efficiency	• To maximise our productivity through the deliver of the Waste Reduction Programme, Single Improvement Plan and other transformation plans	No risk identified
CO17	To develop a clinical services strategy for the organisation	• To develop safe, innovative, sustainable and affordable clinical models for the future	No risk identified

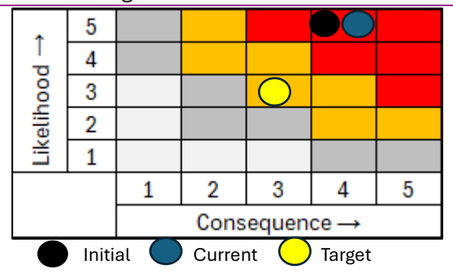


Heat map key: Black = current score, Blue = target score

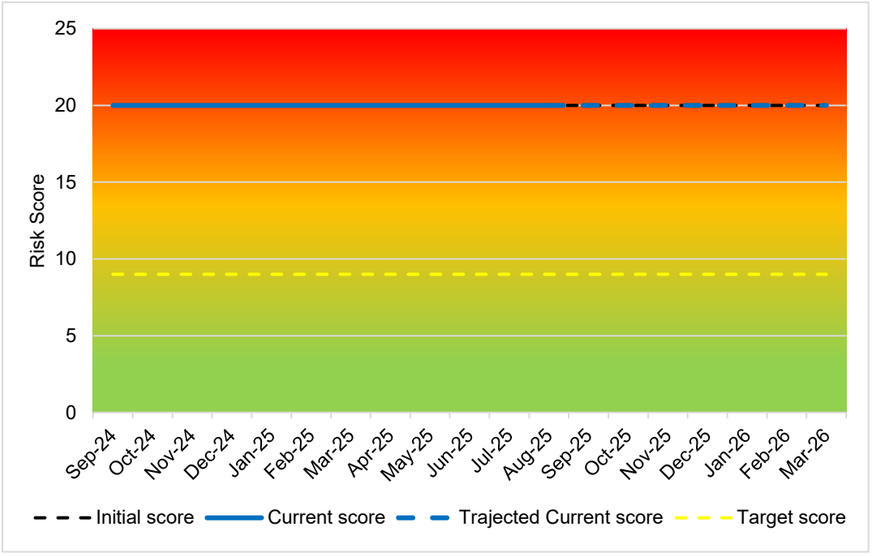
Strategic Objective: Productivity	**Corporate Objective:** Provide value for money services by spending less, spending well and spending wisely	Overall Assurance Level	Low

Principal risk 12 (25/26) (ID 1557)	Risk Title:	Failure to meet the financial plan in 2025/26	
	Risk Description:	There is a risk that the Trust may not deliver the financial plan for 2025/26. This is because of factors such as under-delivery of planned efficiency savings, inability to reduce some operational costs, rising operational demand, and insufficient external funding for some services. This could result in a significant financial deficit, reduced resources for patient care, challenges in maintaining service delivery, insufficient income to cover operational costs, inability to exit NHS Oversight Framework (NOF) level 4, further regulatory intervention, impact on staff experience, and reputational damage.	

Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious 8-12
Director	Chief Finance Officer	5Ts status	Treat
Date risk opened	03/06/24	Date of last review	10/09/25
		Target control date	31/03/26



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

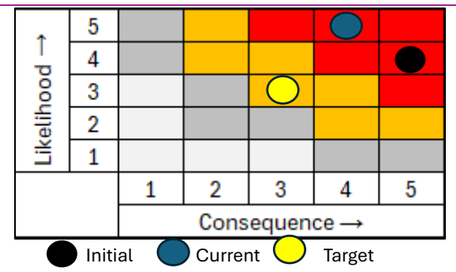
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Financial plan set at the start of the year - common assumptions and principles agreed collaboratively within the ICS. • Financial plan triangulated with activity and workforce plans. • The Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation are in place to support controlling expenditure. • Budgets set at the start of the financial year and agreed with budget holders, risks identified and rated to enable the Board of Directors to approve the budgets. • There are a suite of pay controls for filling vacancies and using agencies. • WRP schemes fully developed for 2025/26 (£60.3 million) • Processes are in place to ensure waste reduction programme (WRP) schemes that are delivered are transacted through the ledger. • There are a range of grip and control measures in place for managing discretionary expenditure. • There is a no PO no pay system in place for managing non pay expenditure.	• Inability to fully develop and manage services within commissioned resources and in line with commissioning processes due to increasing demand and evolving complexity of patient needs. • The savings programme alongside additional control measures is not delivering the required level of financial improvement. NHSE are supportive of using additional advisory support to maximise delivery in the current financial year and develop plans for 25/26. • PMO to support the divisions to deliver the WRP is being finalised with external support. • Operational pressures limiting management capacity.	<u>Level 1 Assurance</u> • Ledger reconciliations - on the integrity of the financial data. • Variance and trend analysis - on the integrity of the financial data. <u>Level 2 Assurance</u> • Risks identified monthly to Finance and Performance committee. • Internal Audit - on the integrity of financial systems - through Audit Committee. <u>Level 3 Assurance</u> • Financial plan monitored monthly to; budget holders, DIF, F&P committee, externally through provider finance returns (PFR) monthly returns and system improvement board assurance meetings. • External Audit - on the financial accounts - through Audit Committee. • Collaborative working in ICS - integrity of financial data.	• The Trust did not deliver the identified financial plan for 2024/25. The deterioration of forecast in-year resulted the Trust being escalated to national oversight framework (NOF) level 4 and being enrolled in the recovery support programme (RSP). (Trust is now in Segment 5 of the national framework). • Assessment of the Trust's actions in response to External support grip and control review require external assessment to confirm completion. • External financial governance review identified some areas to strengthen. • WRP schemes, whilst fully developed, have risks to delivery.

Risk Treatment

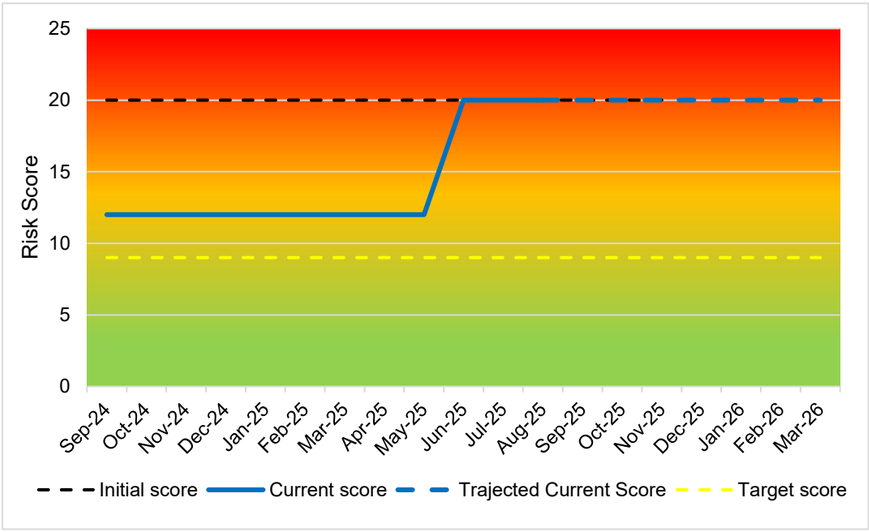
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Internal audit assessment of grip and control actions and Trust's current position	C. Carter	30.09.25		Sept 25: Internal audit progressing with Grip & Control assessment and still on track for a completed report by the end of September 2025.
External support obtained until end of Quarter 1 to further develop schemes and support programme management capacity	C. Carter	~~31.08.25~~ 31.12.25		Sept 25: RSP support confirmed and in place as of 1st September 2025. Additional external support expected will continue until mid-November 2025 (pending final approval from NHSE) and substantive Deputy Director of PMO starts 1st October 2025.

Strategic Objective: Productivity	**Corporate Objective:** To provide value for money services by spending less, spending well and spending wisely	Overall Assurance Level	Low

Principal risk 13 (25/26) (ID 802)	Risk Title:	Cash consequences of the Trust's underlying financial position	
	Risk Description:	There is a risk that the Trust may face cash flow challenges because of its underlying financial position, including recurring deficits, delayed delivery of financial recovery savings, or insufficient income to cover operational costs. This could result in a cash shortfall and therefore, an inability to meet financial obligations, impact on service delivery, delays in payments to suppliers, restricted investment in essential services and infrastructure, and potential further regulatory intervention or reputational damage.	
Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious 8-12
Director	Chief Finance Officer	5Ts status	Treat
Date risk opened	06/06/24	Date of last review	10/09/25
		Target control date	~~30/11/25~~ 31/03/26



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal

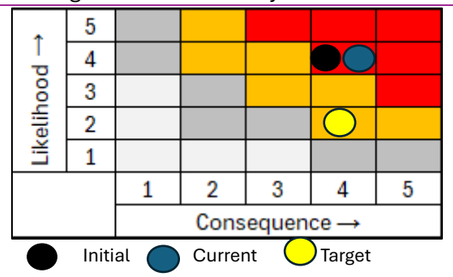
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Cash Management committee in place. • Annual cash plan in place. • Committee approved cash management policy on prioritisation of supplier payments. • Monthly cash flow forecasting. • Management of working capital balances. • Review of capital programme and timing of expenditure. • Engaging with affected suppliers. • Internal escalation process for urgent cash issues. • NHSE process for requesting cash support. • Additional NHSE process to draw down emergency cash if necessary. • Regular review of cash position and forecasts. • Financial services team resourced for cash management and forecasts.	• Levels of understanding of the cash consequences of not using the established ordering processes. • Access to cash support is subject to external approval.	<u>Level 1 Assurance</u> • Monitoring and reporting performance against 30-day deadline for payments. <u>Level 2 Assurance</u> • Internal Audit reporting through Audit Committee. • Monthly reporting of position including KPIs to Finance & Performance Committee. <u>Level 3 Assurance</u> [None detailed]	• Forecasting generally highlights potential shortfalls in cash availability. However, some invoices can be delayed in being received. • Drop in performance against 30-day deadline for payments.

Risk Treatment

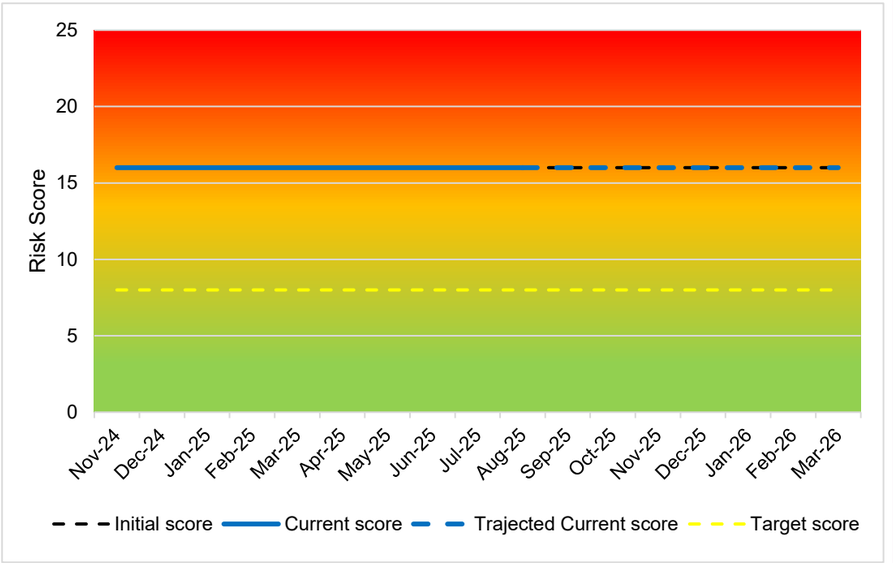
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Timely submissions to NHSE for cash support with Board of Director approval	C. McGourty	~~30.11.25~~ 31.10.25		Sept 25: The Trust requested £12 million for September 25 cash position and received £3.6 million. Mitigating actions were taken to offset risk in September 2025 and the Trust re-applied for cash of £8.4 million in October 2025 (signed off by CEO and Chair of the Trust).

Strategic Objective: Productivity	**Corporate Objective:** To provide value for money services by spending less, spending well and spending wisely	Overall Assurance Level	Medium

Principal risk 14 (25/26) (ID 2106)	Risk Title:	Ability to access required Capital to support an ageing estate		
	Risk Description:	There is a risk that there may be insufficient internally generated capital to support all priority areas of the Trust's ageing estate. This is because of valuation decisions which determine capital funding allocations, the Trust's underlying financial position, competing priorities across the healthcare system, and delays in approvals for capital investment projects. This could result in an inability to progress critical infrastructure maintenance, inability to renew essential existing equipment, potentially impacting service delivery, patient safety, and long-term sustainability.		
Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious 8-12	
Director	Chief Finance Officer	5Ts status	Treat	
Date risk opened	05/12/24	Date of last review	10/09/25	
		Target control date	31/03/26	



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Trust planning framework. • A balanced Capital Plan for 2025/26 has been agreed. • Capital Planning Forum review and determine risk-based approach and recommendations. • Capital Plan agreed by Executive Team & Trust Board. • Backlog maintenance programme developed from 6 facet survey outcome, undertaken annually. • Medical Equipment Group with clinical input to support risk assessment and prioritisation. • IT provided with a budget from Capital Planning forum. • Contingency budget identified at the start of the financial year. • Emergency capital funding process for extreme situations. • Identification of national funding 'bid opportunities'. • Standing financial instructions. • Standing Orders. • Scheme of Reservation and Delegation.	• Externally set capital allocation. • External capital bid opportunities have short timeframes and ability to fully cost this is limited by operational capacity. • Impact of inflation in terms of project costs and timescales. • Ageing estate and inability to comply with latest statutory guidance. • Estates Strategy not finalised. • Approach to IT allocations requires review. • Inability to replace medical equipment as required.	<u>Level 1 Assurance</u> • Asset register in place to support oversight of medical equipment. <u>Level 2 Assurance</u> • Medical Device report to Safety & Quality Committee. • Capital update to Finance & Performance Committee. <u>Level 3 Assurance</u> • 6 facet survey and independent annual report which details the scope and level of the situation. • Estates Returns Information Collection (ERIC) returns to support benchmarking.	• Significant backlog maintenance. • Tracking of project overruns and underspend. • Governance around contract change notices. • Data for ERIC returns is delayed in being released via Model Hospital (2 financial years behind).

Risk Treatment

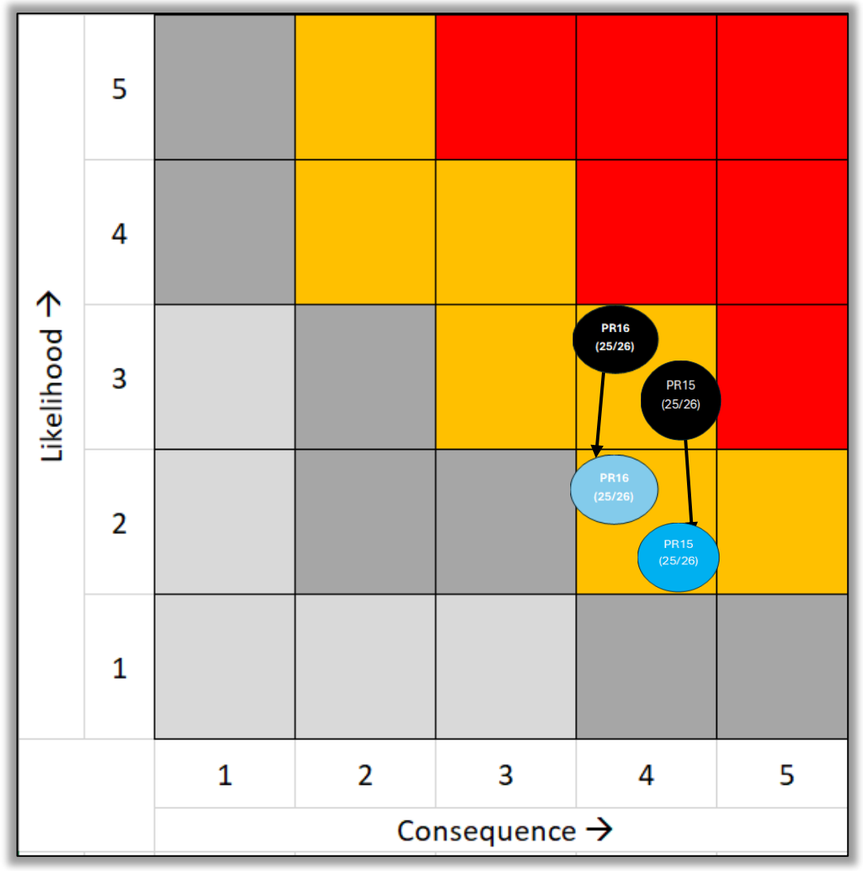
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Review approach to management and reporting of project spend at Capital Planning Forum	C. Carter	~~31.07.25~~ 31.10.25		Aug 25: Template being produced for project updates and meeting structure being revised. Extended to allow for implementation with teams to be able to update templates and report in. Planned this will commence by October 2025.
Develop Estates Strategy	~~C. Howell~~ S. Ashworth	30.11.25		Aug 25: Action owner amended. Draft strategy is now complete and is out for feedback and formatting ahead of being shared for approval.

Partnership: Be Fit for the Future

Monitored as indicated through the relevant Committee of the Board

The following 2025/26 corporate objectives are aligned to the **Partnership** strategic objective:

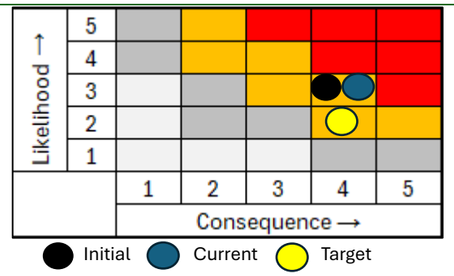
Ref.	Purpose of the objective	Scope and Focus of the Objective	Status
CO18	To develop and deliver our strategic plans to support the transitions outlined in the new NHS Plan:hospital to community; treatment to prevention; analogue to digital.	• Develop and launch the Trust strategy in collaboration with partners. • Develop the capital plans to support the transition. • Develop a digital programme to support the workforce reduction. • Communicate plans with internal and external stakeholders.	No risks identified
CO19	Developing a sustainable future: to develop effective partnerships across L&SC which maximise population health and support services that are clinically and financially sustainable.	• Deliver plans for OneLSC and develop and implement agreed clinical service strategies/plans. • As an Anchor Institution, work with partners to improve population health, supporting development of a thriving local economy and reducing health inequalities. • Reduction in demand through development of Neighbourhood Health with specific focus on frailty and end of life management in central Lancashire.	Risk identified
CO20	To make progress towards our ambition to be a University Teaching Hospital	• Work towards achieving University Hospital status • Continue to shape an education, learning and innovative culture	Risk identified
CO21	Working with partners, create a single pathology service	• To develop and implement the detailed plan for a single pathology service. • Work up the Capital Business Case for a single Pathology hub.	No risks identified



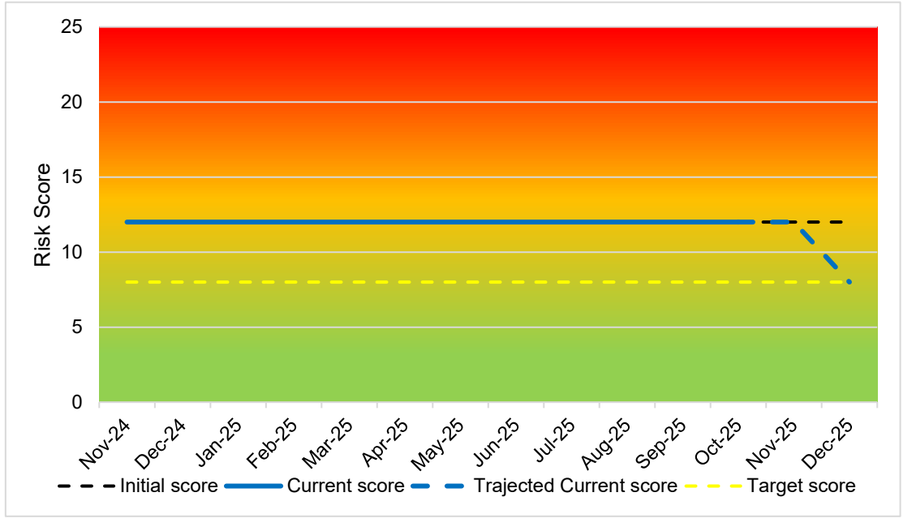
Heat map key: Black = current score, Blue = target score

Strategic Objective: Partnership	**Corporate Objective**: To make progress towards our ambition to be a University Teaching Hospital	Overall Assurance Level	Medium

Principal risk 15 (25/26) (ID 2113)	Risk Title:	Research capacity and capability to enable progress towards University Hospital status		
	Risk Description:	There is a risk that the research capacity and capability of the Trust may be insufficient to support the longer-term objectives of becoming a University Teaching Hospital. This is because of limitations of the Trust and potential partners in relation to funding, workforce constraints, lack of dedicated research time for clinical staff, lack of established clinical academics in L&SC and the need for an enhanced infrastructure to support research activities. This could result in missed opportunities for innovation and improvement in patient care, difficulty attracting and retaining talented research staff, an inability to advance the Trust's reputation as a leader in research and clinical excellence and the income generation associated with University Hospital opportunities.		
Committee	Education, Training & Research	Risk Appetite and Tolerance	Seek 9-12	
Director	Chief Strategy and Improvement Officer, and Chief Medical Officer	5Ts status	Treat	
Date risk opened	05/12/2024	Date of last review	03/09/25	
		Target control date	31/12/25	



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Fixed National Institute of Health & Care Research (NIHR) Income. • Research & Innovation Strategy (2022-25). • Some protected job-planned time for clinical research activity. • Quarterly Research Collaborative meetings with the 2 main LSC universities to develop research opportunities. • Some joint appointments with university partners.	• Historical and current overspend of research budget. • Funding available to increase capacity and capability. • Ability to engage medical colleagues in in different academic specialities to support advances in research in those areas. • Strategy and appetite of universities to invest in clinical or other academic roles to be based at the Trust.	<u>Level 1 Assurance</u> [None detailed] <u>Level 2 Assurance</u> • Bi-annual Research & Innovation Strategy update. • Research & Innovation Committee. • Education, Training & Research Committee. <u>Level 3 Assurance</u> • Integral role in ICS R&I Collaborative.	• Income generation plan for financial recovery plan is behind trajectory. • Initial project plan to develop partnerships not currently agreed and therefore progress is not able to be reported to R&I Committee and ETR Committee. • Universities are experiencing similar budget constraints and so may lack ability to invest in these areas.

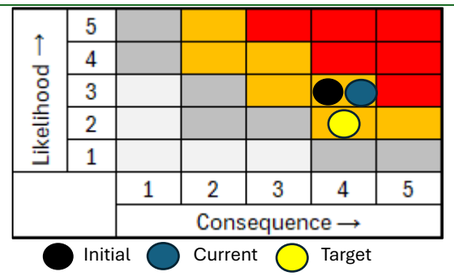
Risk Treatment

<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Formulate a clear project plan to develop partnerships with potential University partners to explore UH status. This will include plans to engage the clinical teams in the specialities to support these to come to fruition.	P. Brown/ P. Martin-Hirsch/S. Canty ~~C. Skailes~~	~~31.08.25~~ 31.10.25		Sept 25: Second project meeting has been held with the addition of Deputy Director of Education and 3 x Divisional Medical Directors for Medicine, Surgery and Women's & Children's Services. Set actions revolve around a) further discussions with UoM and b) The UHA and any possibility of a 3rd University partner.
Appointment of University of Lancashire joint posts to support the expansion of Undergraduate Medical placements at LTHTR	L. O'Brien	~~30.09.25~~ 31.10.25		Sep 25: Posts confirmed through Vacancy Control Panel and expected to be advertised internally before the end of the month. Due date extended to allow for advertisement and recruitment to be completed.
Have Research roles in place within 2 Divisions	P. Brown	~~01.10.25~~ 01.12.25		Sept 25: Research & Innovation has begun a restructure to allow greater flexibility in clinical teams and in which divisional alignment is central, initially to Medicine and Surgery – this is yet to be confirmed. Further work is required with Workforce colleagues thus the change to due date to 01/12/25, by which time it should be confirmed if it is realistic for some or all Divisions to appoint a lead on one PA with sufficient time for the new CMO to review.

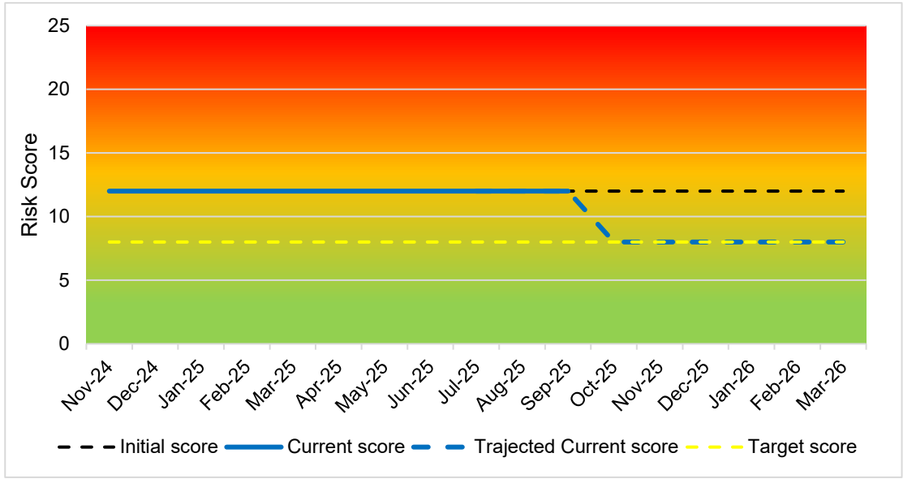
Strategic Objective: Partnership	**Corporate Objective**: Developing a sustainable future: to develop effective partnerships across L&SC which maximise population health and support services that are clinically and financially sustainable.	Overall Assurance Level	Medium

Principal risk 16 (25/26) (ID 2107)	Risk Title:	Failure to progress the configuration of Trust services to enable the delivery of the clinical strategy for LTHTR and L&SC
	Risk Description:	There is a risk that the configuration of services and implementation of the long term strategy for the Trust may be hindered because of lack of alignment with system partners, clear commissioning intentions, insufficient clarity/strength within our processes for system governance/change, resource limitations, and potential resistance to change. This could result in delays in achieving the objectives, fragmented service delivery, reduced quality of patient care, increased costs and inefficiencies across the healthcare system, and failure to improve health outcomes for the population.

Committee	Finance & Performance	Risk Appetite and Tolerance	Seek 9-12
Director	Chief Strategy & Improvement Officer/Chief Medical Officer	5Ts status	Treat
Date risk opened	05/12/24	Date of last review	16/09/25
		Target control date	31/03/26



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Lancashire and South Cumbria (L&SC) Integrated Care System (ICS) joint NHS forward plan and Clinical Blueprint • Improvement & Assurance Group (IAG) in place and meeting monthly. • Three-year Single Improvement Plan • Trust's Annual Corporate Objectives • Provider Collaborative Board Joint Committee (PCB JC) • Place based working • Trust development/integration plans with LSCFT • First Recovery Support Programme (RSP) has been held. The RSP Team are engaging in observing Board and Sub-Board Committee meetings and work is underway to develop the programme of work needed (which will be incorporated into SIP). • A Working Group is established to develop the Preston Health Hubs, in line with the NHS 10-year Plan published in July 2025, and Trust members are actively contributing.	• L&SC Clinical Blueprint has been developed but we are not yet at the stage where we have a detailed, agreed implementation plan. • Discussions with external partners regarding greater service/pathway integration still need further development and may be impacted by the discussions/plans with respect to the L&SC Clinical Blueprint. • Trust long term strategy not yet finalised, but the aim is to present to October 2025 Board now the NHS 10-year Plan has been published in July 2025. • Draft ICB Commissioning intentions have been shared but more discussion needed to agree the implications for the Trust. • System based working is still evolving/improving e.g. the PCB Governance reset is underway but has not been fully implemented and Place based working is still developing.	<u>Level 1 Assurance</u> • Trust Board workshops/seminars <u>Level 2 Assurance</u> • Finance & Performance Committee system updates • Trust Board discussions/papers <u>Level 3 Assurance</u> • ICB and Regional NHSE Improvement & Assurance Group (IAG). • Recovery Support Programme (RSP) /Provider Improvement Programme (PIP)	• Finalised Trust long term strategy

Risk Treatment

<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Agree final Trust long term strategy	A. Brotherton	31.10.25		Sep 25: Further work has been undertaken on the draft Trust Strategy and is due to be presented at a joint Board and Governors Workshop on 23rd September 2025. Following this, any updates will be made and the Strategy presented to Board for approval in October 2025.

9. FIT FOR THE FUTURE (STRATEGY AND PLANNING)

9.1 *TRUST STRATEGY

Decision Item | K Hudson | 10.00am

*Exec summary only as part of board papers pack. Detailed report to be included in a separate ancillary pack

REFERENCES

Only PDFs are attached

9.1 - Strategy Covering Paper Final docx.pdf

Board of Directors

Trust Strategy 2025-30			
Report to:	Board of Directors	**Date:**	2nd October 2025
Report of:	Chief Strategy and Improvement Officer	**Prepared by:**	A. Brotherton and K. Hudson

Purpose of Report					
For assurance		**For decision**	☒	**For information**	

Executive Summary

The Trust Strategy 2025-2030 (Appendix 1) outlines our vision to become a leading Accountable Healthcare Organisation within the Lancashire and South Cumbria system. This strategy aims to develop an affordable and sustainable model of healthcare for our organisation and the local population. It has been developed through extensive engagement with our people, patients, governors and partners. The strategy focuses on the Trusts five key priorities:

Patients: we will improve access, patient experience, safety, quality of care and outcomes by leveraging advanced technologies and developments in science

People: we will invest in the development of our colleagues to be the best version of us; our culture counts.

Partnerships: We will strengthen collaborations with local health and social care providers and the Voluntary Community, Faith and Social Enterprise sector to integrate care services to ensure seamless and coordinated patient care. We will also strengthen our partnerships with local universities, building our research to improve patient outcomes.

Performance: we will implement performance improvement programmes to monitor and enhance the quality of care provided, ensuring that we work towards meeting and then exceeding national standards.

Productivity: we will focus on optimising our resources and reducing inefficiencies within our healthcare system to improve infrastructure and patient experience and outcomes.

This paper provides an overview of the strategy, its context, main content sections, and requests approval from the Board.

How the strategy was developed.

The Trust Strategy development began with a Board workshop discussion focused on our strategic vision. This was followed by a series of listening events held with colleagues across the Trust and listening events held with partners and groups across our system. The first draft was then developed and presented to a Board workshop in Autumn 2024. A decision was taken to delay finalising the strategy until our new Chair was appointed and the ten-year health plan for England was published as the Board recognised the importance of aligning our vision and strategy to the new ten-year health plan. The strategy has been updated to align to the new ten-year health plan and the vision for the Lancashire and South Cumbria system. The Trust Strategy has also been discussed in a joint Board and Governor workshop, held on 23rd September 2025.

Recommendation

The Board of Directors are asked to:

i. Discuss and approve the Trust Strategy for adoption and implementation through the Single Improvement Plan as the vehicle for delivery.

Trust Strategic Aims and Ambitions supported by this Paper:			
Aims		**Ambitions**	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high-quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive health innovation through world-class education, teaching, and research	☒	Deliver Value for Money	☒
		Fit For The Future	☒

1. Background

Our Changing Context

The development of this strategy has been informed by significant shifts in the healthcare landscape, including changes to the NHS infrastructure, the Fit for the Future ten-year health plan for England, the Clinical Vision for Lancashire and South Cumbria, an increased focus on reducing health inequalities and the changing demographics of our local population. These factors have been incorporated into our planning to ensure an affordable and sustainable model for the future.

2. Discussion

The Trust Strategy development began with a Board workshop discussion focused on our strategic vision. This was followed by a series of listening events held with colleagues across the Trust and listening events held with partners and groups across our system. The first draft was then developed and presented to a Board workshop in Autumn 2024. A decision was taken to delay finalising the strategy until our new Chair was appointed and the ten-year health plan for England was published as the Board recognised the importance of aligning our vision and strategy to the new ten-year health plan. Following publication of the ten-year health plan in July 2025, the strategy has been updated to align to the new ten-year health plan and the vision for the Lancashire and South Cumbria system. The Trust Strategy has also been discussed in a joint Board and Governor workshop, held on 23rd September 2025.

Our Ambition and Role

Our ambition is to become an Accountable Healthcare Organisation within Lancashire and South Cumbria, delivering an affordable and sustainable model for the future. We aim to be the provider of specialist services for the population of Lancashire and South Cumbria and a provider of local services for the population of Central Lancashire. Additionally, we strive to be a centre for Continuous Improvement, Education, and Research and Innovation, and an Anchor Institution committed to improving the health and wellbeing of the population we serve.

Our Services

Our vision for clinical services over the next five years aligns with the Integrated Care System transformation road map and clinical blueprint and priorities. We aim to seize opportunities provided by new technologies, medicines, and innovations to deliver better care for all our patients. We will work with partners to make three significant shifts in how we work and deliver care: from hospital to community, from analogue to digital, and from sickness to prevention. Our focus areas include:

- ***Cancer:*** Enhancing early detection, treatment, and survivorship programmes.
- ***Children and Young People***: Generating the right start in life for future health and well-being by providing comprehensive care that addresses physical, mental, and social health.
- ***Community Services:*** Developing integrated community-based care to reduce hospital admissions and support patients in their homes.
- ***Local Services:*** Ensuring accessible and high-quality care for the local population.
- ***Long Term Conditions:*** Driving pro-active condition management through integrated care pathways and innovation for chronic conditions such as diabetes and cardiovascular diseases.
- ***Diagnostic and Clinical Support Services***: Delivering timely access, leveraging advanced diagnostic tools and technologies to improve accuracy and efficiency.
- ***Pathology:*** Modernising pathology services to support timely and precise diagnostics.
- ***Specialised Services:*** Offering specialised treatments and services for complex health needs.
- ***Urgent and Emergency Care:*** Improving patient experience, responsiveness and admission avoidance for urgent and emergency pathways.
- ***Women's Health, Maternity, and Neonates:*** Providing high quality, comprehensive care for women and newborns, focusing on maternal health and neonatal outcomes.

Delivering Our Strategy

Our commitment through this strategy is to ensure science and technology are central to the reinvention of the NHS. We aim to offer instant access to advice and appointments, moving towards a service that predicts and prevents ill health rather than simply diagnosing and treating it. We will design our services based on the core principles and values of the NHS, enhanced by the expertise of a wider network of technology, life sciences, local government, civil society, and third-sector organisations. Our goal is to improve the health of our local population and narrow health inequalities. The strategy will be delivered through the Trust's Single Improvement Plan with key objectives being annually.

The Trust Strategy 2025-2030 is a comprehensive plan that addresses the current and future needs of our organisation and the local population. By focusing on our five key priorities, we aim to deliver high-quality, sustainable healthcare services. The approval of this strategy by the Board is crucial for its successful implementation and the achievement of our vision.

3. Financial implications

Any financial implications associated with the delivery of this strategy will be considered as part of the business planning and budget setting process annually.

4. Legal implications

None

5. Risks

The risks are associated with non-approval and non-delivery of the Strategy. Delays in approval will impact on the Trust's Provider Capability Assessment as having a Trust Strategy is a core element under the Strategy and Leadership section of the self-assessment framework. However, if the strategy requires further work, the Provider self-assessment could be updated ahead of the submission to NHS England.

The risks of non-delivery relate to the recovery of the Trust's financial position and recovery of key performance metrics. These will be fully managed and mitigated through the Trust's Single Improvement Plan.

6. Impact on stakeholders

It is anticipated that this strategy will have a positive impact on our system partners as we increase our commitment to partnership working and implementation of the shifts from hospital to community, analogue to digital and treatment to prevention. We will work with system partners to develop robust implementation plans to undertake this work collaboratively.

7. Recommendations

It is recommended that:

i. Discuss and approve the Trust Strategy for adoption and implementation through the Single Improvement Plan as the vehicle for delivery.

9.2 *WINTER PLAN

Decision Item | K Foster-Greenwood | 10.10am

*Exec summary only as part of board papers pack. Detailed report to be included in a separate ancillary pack

REFERENCES

Only PDFs are attached

9.2 - Winter Plan Cover Paper.pdf

Board of Directors Report

Winter Surge Planning Report 2025/26			
Report to:	Board of Directors	**Date:**	02.10.2025
Report of:	Chief Operating Officer	**Prepared by:**	K Foster-Greenwood
Part I	X	**Part II**	

Purpose of Report					
For assurance	☒	**For decision**	☒	**For information**	☐

Executive Summary:

The Winter Planning Paper 25/26 outlines Lancashire Teaching Hospitals plans to ensure the Trust has sufficient capacity to meet the anticipated winter surge in demand on its Urgent & Emergency Care system. The paper outlines the data modelling which depicts an increased demand and the associated bed requirements and performance impact if unmitigated.

Data modelling suggest that the 'unmitigated' impact of winter surges in demand would likely be a deterioration of between 0.5-4.5%with an increased bed demand of between 9-69 beds. (Ranges are based on demand by month with the largest increases in demand predicted to be in November 25 an Jan 26.

The plan describes several mitigation schemes aimed at reducing ED attendances, admissions, bed occupancy/LOS and improving patient discharge flow. Schemes have been assessed against their impact on the aforementioned aims, cost and ease of mobilisation.

All schemes will be monitored monthly and any scheme which fails to mobilise or deliver the required outcomes will be considered for cessation and investment will be directed to alternative schemes.

Funding of £800K was identified to support surge management in 2025/26. The following schemes have been identified as being of the highest impact and are recommended as Phase 1 schemes to be mobilised in September, these include:

- Additional Paediatric medical capacity: Outcomes – reduced waiting times within ED and PAU, 4 hour breach prevention, increased timeliness of discharge/reduced LOS
- Increased discharge lounge capacity: Outcomes – Earlier admission to AMU, ED overcrowding reduction, reduced 12 hour+ LOS
- ED Transfer Team: Outcomes: Reduced ED overcrowding, reduce ambulance handover breaches
- Extended SDEC provision: Outcomes – reduced admissions, reduced ED overcrowding, reduced ED attendances, improved 4 hour ED performance
- Respiratory Assessment Provision: Outcomes: - increased capacity to reduced ED overcrowding, reduced LOS, increased admission avoidance, improved 4 hour ED performance
- Additional medical staffing support to AMU (Evenings and weekends): Outcomes – increased weekend discharge rate, reduced evening overcrowding in ED, reduced LOS.
- Medical outlier medical support: Outcomes – Reduced LOS for outlying patients, increased bed

capacity, reduced 12 hour+ED LOS.

Despite these programmes, the variation in demand will fluctuate and modelling is unable to predict aspects e.g seasonal infections which many increase pressure in services. The 25/26 surge plan seeks to provide additional capacity within affordable budgets to mitigate the forecast pressure and prevent the ED performance consequence by providing alternatives to admission or schemes which will reduce length of stay.

The Phase 1 schemes do not include plans to open additional in-patient non elective beds however a Phase 2 scheme has been prepared and costed to support the mobilisation of additional beds should this be required. Funding to support Phase 2 would need to be sourced from slippage or cessation of Phase 1 schemes or be supported by additional winter funding.

It is recommended that:

I. Board of Directors note the contents of the report and the continued actions relating to mitigating demand schemes.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☐
To drive health innovation through world class education, teaching and research	☐	Deliver Value for Money	☒
		Fit For The Future	☐

Previous consideration

Finance and Performance Committee

1. Background

Lancashire Teaching Hospitals NHS Foundation Trust (LTH) has been working with Divisional and corporate colleagues to develop options to ensure the effective management of surge demand over the winter months.

LTH budget setting identified £800K to be held in reserves to support winter demand. Divisional and corporate teams have identified schemes to address the identified bed and capacity deficits with initiatives supporting the following key area:

1) ED attendance avoidance
2) ED Breach/over-crowding avoidance
3) Length of Stay (LOS) reduction
4) Admission avoidance

2. Assessment – Bed deficit and impact on 4 hour performance

The data in table 1 has utilised the Non-Elective (NEL) admission plan and an associated bed day demand has been identified assuming an average length of stay (ALOS) of 4.5 days with an additional 0.5 day LOS added to support an increased acuity of patients.

A bed gap has been highlighted based on a bed occupancy of 95%. It is acknowledged that this is higher than the NHSE ambition of 92% and whilst all UEC improvement ambitions continue to aim to achieve 92% bed occupancy, it will not be possible to deliver this in Q4 25/26 due to the requirement to deliver the Financial Recovery Plan (FRP).

Table 1 – Non Elective Operational Plan

NEL Operational Plan Delivery Oct-Mar 2025/26
Bed Requirements Oct-Mar 2025/26
ALOS Current 2025/26 - 4.5 Days plus 0.5 day increase for winter

	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Total NEL Operational Plan	4,724	4,827	4,763	4,796	4,305	4,620
NEL ALOS 2024/25 (specific PODs)	5.0	5.0	5.0	5.0	5.0	5.0
Bed Day Requirement	23,620	24,135	23,815	23,980	21,525	23,100
Bed Requirement	**762**	**805**	**768**	**774**	**769**	**745**
Current Core Beds	774	774	774	774	774	774
% Occupancy	98%	104%	99%	100%	99%	96%
Target % Occupancy	95%	95%	95%	95%	95%	95%
Var	3%	9%	4%	5%	4%	1%
Bed requirement to deliver 95% occupancy	**801**	**843**	**807**	**812**	**807**	**783**
95% Variance to Current Beds	**27**	**69**	**33**	**38**	**33**	**9**
Potential Performance deterioration	**71.50%**	**69.70%**	**73.40%**	**74.10%**	**75.80%**	**78.50%**
% Performance Deterioration	**-1.5%**	**-4.5%**	**-2.0%**	**-2.5%**	**-2.0%**	**-0.5%**

The table above shows the current and unmitigated bed deficit. It suggests that the bed gap, assuming a 95% bed occupancy is between 9 and 69 beds, based on variations in demand month on month.

Based on this bed gap, an assessment of ED performance has been included in the data set linked to performance year to date and deteriorations in bed occupancy per 0.5%. The unmitigated bed deficit would result in a performance deterioration of between -0.5% to -4.5% over the course of winter.

To address this gap and the associated risks to patient safety and organisational performance, the following mitigating schemes have been developed.

3. Mitigations to address the identified bed gap

Scheme Detail	Duration	Outcome	Cost
Additional Paediatric medical capacity	5 months	Reduced waiting times within ED and PAU 4 hour breach prevention Increased timeliness of discharge/reduced LOS	**£133,064**
Increased discharge lounge capacity	5 months	Earlier admission to AMU ED overcrowding reduction Reduced 12 hour+ LOS	**£57,037**
ED transfer Team	5 months	Reduced ED overcrowding Reduce ambulance handover breaches	**£24,945**
Extended SDEC provision	6 months	Reduced admissions Reduced ED overcrowding Reduced ED attendances Improved 4 hour ED performance	**£60,565**
Respiratory Assessment provision	5 months	Increased capacity to reduced ED overcrowding Reduced LOS Increased admission avoidance Improved 4 hour ED performance	**£97,690**
Additional Medical Staffing AMU	5 months	Increased weekend discharge rate Reduced evening overcrowding in ED Reduced LOS.	**£90,007**
Medical Outlier Team	4 months	Reduced LOS for outlying patients Increased bed capacity Reduced 12 hour+ED LOS.	**£115,600**
Additional winter bed capacity	6 weeks	Reduce 12 hour+ ED LOS Reduce ED overcrowding	**£179,000**
Total			**£804,638**

LTH schemes identified above require investment of £804,638 from the identified £800K winter surge budget. Whilst the allocation is over budget, a decision re the mobilisation of additional beds will be made in January 26 and at this point, schemes will be terminated to ensure costs remain within the allotted £800K budget.

All local internal schemes will be approved on a 1 month notice basis, whereby should they fail to mobilise or not deliver the intended outcomes, schemes will be terminated and monies re-invested into alternative schemes.

4. Seasonal Influences

In addition to seasonal increases in unplanned care demand, the risk of winter respiratory infections on staffing capacity is also a key consideration.

Winter Vaccination Campaign 2025/26

- There is a focus to significantly improve the vaccination rates achieved in 2024/25 which were disappointing. Seasonal training for vaccinators is already live and a staffing plan to support vaccination capacity is underway.
- Vaccination delivery will be through a combination of planned pop up stands/sessions and roving teams throughout all areas of the Trust over an extended day.
- Promotion of sessions will be focused in high footfall areas to increase awareness of sessions.

- Specific departmental visits will be scheduled for larger departments.

5. System Wide Surge schemes

Within L&SC a UEC Capacity Investment Programme supported the mobilisation of additional schemes to support the management of increased demand. The schemes which would provide additional resource to Central Lancashire include:

Initiative / Scheme	Duration	Description	Go-live Date/Timescale for Implementation
Therapy (Chorley District Hospital	12 Months	Therapy admission avoidance service at Chorley District Hospital.	1 April 2025 – 31 March 2026
Hospice at Home	12 Months	St Catherines Hospice - provide hands-on personal care, psychological support for patients and their families.	1 April 2025 – 31 March 2026
Care Connexion	12 Months	Expansion of single point of access/care navigation/transfer of care hub for Central Lancashire.	1 April 2025 – 31 March 2026
Virtual Wards	12 Months	Allow patients to get hospital-level care at home safely and in familiar surroundings, helping speed up their recovery whilst freeing up hospitals beds for patients that need them most.	1 April 2025 – 31 March 2026
Long Term Conditions - Local Enhanced Service	12 Months	To ensure those patients with an existing diagnosis of COPD and asthma who are at highest risk of worsening respiratory health and most likely to exacerbate are identified and offered a Holistic Health Assessment to ensure their respiratory care is optimal.	1 April 2025 – 31 March 2026

6. Risks to the delivery of the winter surge plan

Financial Recovery Plan (FRP) associated risk: Whilst a budget of £800K was set aside to support the management of surge winter demand on the organisation, this is a reduced allocation versus the previous year. Additionally the 25/26 Waste reduction programme seeks to reduce community and general and acute beds by 164 thus reducing the capacity to support additional winter demand.

Seasonal Infections: The data utilised in the modelling has not considered any exceptional impacts of a significant seasonal infection.
Mobilisation risks: Availability of temporary staffing to support surge schemes may be constrained and given the current financial constraints, approval to recruit to additional temporary staff may not be reached. Any additional staffing secured would result in increases in variable pay spend during the winter period.

Boarding: Whilst surge demand mitigation schemes have been outlined above, there remains a risk that demand is not able to be fully mitigated and this may, for patient safety reasons, result in the need to board

patients into non core bed spaces. To prevent this, a further expansion of the Daysk Kept Away from Home programme and a further roll out of the Continuous Flow Model at weekends is planned.
Further ward moves: The additional winter bed capacity scheme described above is costed on the use of a current shared space. Should there be any further ward reconfigurations, this may impact on the associated costs outlined.

7. Recommendations

It is recommended that:

I. Board of Directors note the contents of the report.
II. Board of Directors approve the allocation of 25/26 Winter Planning budget.

10. DELIVER VALUE FOR MONEY (FINANCE AND PERFORMANCE)

10.1 FINANCE AND PERFORMANCE COMMITTEE CHAIR'S REPORT

Other | J Schorah | 10.20am

Item for assurance

REFERENCES

Only PDFs are attached

10.1 - Chair's report - FPC - 22 July 26 August 25.pdf

Chair's Report to Board		
Chair: J Schorah	Committee: Finance and Performance Committee	
Date(s): 22 July & 26 August 2025	Agenda attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	Trend	Items Recommended for approval
Deliver Value for Money – 20 Fit for the Future - 15	⇨	EPRR Core Standards 2025-26

ALERT

Areas of concern; Matters requiring urgent attention; Insufficient assurance received.

- The cash consequences of the Trust's underlying financial position remained at 20 in recognition of the stricter approach to cash support from NHS England and the profile of the current waste reduction plan (WRP). This was an increased risk that there will be limited cash availability from August 2025, should the Trust's request for cash support not be met.
- Progress on the Waste Recovery Programme was acknowledged; however, delivery remained below target, with only £2.4m million achieved in July against a target of £4.9 million. The Trust has delivered £6m YTD of the WRP as at the end of July a negative variance of £8.4m to plan. For the year delivery is at £14.5m 24% of the £60m annual target. Current delivery forecast at the August meeting was £42.3m in year 2025/26 whilst the total value of the Programme remains £60.3 million. There is a RAG adjusted shortfall of £18m, £6.9m of which relates to schemes not "Green". The £11.3m balance reflects current delivery risk. The Committee agreed that the Board should be alerted to the critical time pressures for programme delivery. Furthermore, the delivery risk of the WRP is not a standalone item but much linked to the cash risk that remains a standing alert.
- There is a risk of decreased performance metrics due to the continued disparity between the level of activity the Trust was being asked to deliver and the funding being received to support it. All productivity savings were currently being directed into the Waste Reduction Programme (WRP).
- Referral to Treatment (RTT) performance remained a significant concern, with persistent long waits and ongoing access challenges. The Trust continued to experience delays in elective care pathways, with increasing numbers of patients waiting beyond acceptable timeframes. Contributing factors included capacity shortfalls, operational pressures, and service-specific constraints. Without targeted intervention, this remained a risk of sustained non-compliance with national RTT standards and further impact on patient experience and outcomes.
- Concerns were raised regarding procurement processes, specifically delays in VAT submissions and ambiguity around contract ownership. In response, a dedicated project manager has been appointed and a user group was being established to oversee progress. To support transparency and accountability, access to advisory documentation was also being granted.
- Capital expenditure remained low due to cash constraints, with only £1.1million spent against a planned

£2.5million by the end of month four. The Trust continued to manage risks related to estates and facilities delays. A cash request of £12million had been submitted to NHS England, with a meeting scheduled for 3rd September to discuss the matter.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- The Committee advises the Board that while there was assurance around the planning and identification of schemes within the Waste Reduction Programme (WRP), the actual delivery risk associated with these schemes remained under active review.
- The Single Improvement Plan showed a positive trajectory with a shift from 'off track' to 'in progress' and 'complete' statuses, a number of milestones remained at risk or not yet started. This warrants continued assurance monitoring and early escalation to the Board to ensure sustained delivery momentum.
- In May 2025, a team restructure and consultation were undertaken to establish a new Programme Management Office (PMO). Recruitment to the required roles within the new structure was ongoing, with the aim of creating a robust function to support delivery of the Single Improvement Plan, including the Waste Reduction Programme. Interim resources were mobilised in Quarter 2 with support from NHS England to maintain momentum during the transition.
- Principle risk scores remained static with no improvement , two new operational risks had been graded as high and 1 existing operational risk had an increased score now ranking it as high.

ASSURE

Assurance received; Matters of positive notes

- The Committee was assured that significant progress had been made in strengthening grip and control across the Trust, with robust improvements in pay and non-pay controls, workforce processes, and financial governance, all of which were now underpinning delivery of the 2025/26 Waste Reduction Programme.
- The learning from the Winter Plan 2024-25 review provided assurance that early planning and targeted schemes helped mitigate the impact of winter pressures. While challenges remained, improvements in key areas would be adopted within the approach for the winter planning process for 2025-26.
- The Committee endorsed the Emergency Preparedness, Resilience and Response (EPRR) Core Standards Annual Assurance for 2025-2026 and confirmed it was assured of the substantial compliance with the EPRR Core Standards.
- The Committee received the July update on the Single Improvement Plan. It was confirmed that no milestones were currently at risk and forecast delivery remained on track for 2025/26. All overdue milestones were in progress and a positive shift in milestone delivery had been observed during quarter one.
- There continued to be incremental progress regarding a number of performance targets and trends.

Finance and Performance Committee

22 July 2025 1.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	1.00pm	Verbal	Information	J Schorah
2.	Apologies for absence	1.01pm	Verbal	Information	J Schorah
3.	Declaration of interests	1.02pm	Verbal	Information	J Schorah
4.	Minutes of the previous meeting held on 24 June 2025	1.03pm	✓	Decision	J Schorah
5.	Matters arising and action log	1.05pm	✓	Decision	J Schorah
6.	Strategic Risk Register	1.10pm	✓	Decision	S Regan
7. FINANCIAL PERFORMANCE					
7.1	M3 Finance Position and General Finance Update	1.20pm	✓	Assurance	C Carter
7.2	Grip and Control	1.35pm	✓	Assurance	C Carter
8. STRATEGY & PLANNING					
8.1	Planning Controls inc. SIP progress & external dependencies	1.50pm	✓	Assurance	A Brotherton
9. OPERATIONAL PERFORMANCE					
9.1	Performance Assurance Progress Report	2.05pm	✓	Assurance	K Foster-Greenwood
9.2	Winter Plan	2.20pm	✓	Assurance	K Foster-Greenwood
10. GOVERNANCE AND COMPLIANCE					
10.1	EPRR Core Standards	2.30pm	✓	Decision	K Foster-Greenwood
10.2	Items to Alert, Advise or Assure the Board	2.40pm	Verbal	Information	J Schorah
10.3	Reflections on the meeting	2.45pm	Verbal	Information	J Schorah
11. ITEMS FOR INFORMATION					

№	Item	Time	Encl.	Purpose	Presenter
11.1	Contract Performance		✓		
11.2	Trading Accounts (inc. Deficit Protocol Controls)		✓		
11.3	Chair's Reports/Minutes: (a) (EPRR) Committee **– not received** (b) ELFS Management Board Minutes **– not received** (c) LHS Minutes		✓		
11.4	Date, time, and venue of next meeting: *26 August 2025, 1.00pm, Microsoft Teams*	2.50pm	Verbal	Discussion	J Schorah

Finance and Performance Committee

26 August 2025 1.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	1.00pm	Verbal	Information	J Schorah
2.	Apologies for absence	1.01pm	Verbal	Information	J Schorah
3.	Declaration of interests	1.02pm	Verbal	Information	J Schorah
4.	Minutes of the previous meeting held on 22 July 2025	1.03pm	✓	Decision	J Schorah
5.	Matters arising and action log	1.05pm	✓	Decision	J Schorah
6.	Strategic Risk Register	1.10pm	✓	Decision	H Ugradar
7. FINANCIAL PERFORMANCE					
7.1	M4 Finance Position and General Finance Update	1.20pm	✓	Assurance	C Carter
7.2	Divisional Delivery Groups update – *including latest view on Risk adjusted forecast*	1.35pm	✓	Assurance	K Pringle
8. STRATEGY & PLANNING					
8.1	Planning Controls inc. SIP progress & external dependencies	1.50pm	✓	Assurance	A Brotherton
8.2	Recovery Support Group Exit Criteria	2.15pm	✓	Decision	S Morrison
8.3	LHS Ltd Chairs Report	2.40pm	✓	Assurance	U Patel G Price
9. OPERATIONAL PERFORMANCE					
9.1	Performance Assurance Progress Report	2.50pm	✓	Assurance	K Foster-Greenwood
10. GOVERNANCE AND COMPLIANCE					
10.1	Items to Alert, Advise or Assure the Board	3.10pm	Verbal	Information	J Schorah
10.2	Reflections on the meeting	3.15pm	Verbal	Information	J Schorah
11. ITEMS FOR INFORMATION					

№	Item	Time	Encl.	Purpose	Presenter
11.1	Contract Performance		✓		
11.2	Lancashire Procurement Collaborative update (incorporating supplier scores) – **report not received**		✓		
11.3	Chair's Reports/Minutes: (a) Senior Information Risk Owner/Asset Information Owner Working Group **– no meeting.** (b) Digital and Health Informatics Divisional Board – **report not received.** (c) EPRR Committee		✓ ✓ ✓ ✓		
11.4	Date, time, and venue of next meeting: *23 September 2025, 1.00pm, Microsoft Teams*	3.20pm	Verbal	Discussion	J Schorah

10.2 *GREEN PLAN

Decision Item | I Ward | 10.30am

*Exec summary only as part of board papers pack. Detailed report to be included in a separate ancillary pack

REFERENCES

Only PDFs are attached

10.2 - Green Plan 2025-2028.pdf

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board Committee Report

Green Plan 2025-2028			
Report to:	Trust Board	**Date:**	2nd October 2025
Report of:	Craig Carter – Chief Finance Officer	**Prepared by:**	T Summersgill
Part I	☑	**Part II**	

Purpose of Report					
For assurance	☐	**For decision**	☒	**For information**	☐

Executive Summary:

The purpose of this report is to present the Lancashire Teaching Hospitals NHS Foundation Trust Green Plan 2025–2028 for approval. The Green Plan was approved through the Finance and Performance Committee in May 2025, with the final version including graphics approved through FPC on 23rd September 2025. The plan was published in July 2025 as per national guidance.

The Green Plan outlines the Trust's strategic approach to environmental sustainability over the next three years, aligning with national NHS net zero targets and statutory requirements. It builds on progress made since 2022 and identifies ten key focus areas, including workforce and leadership, sustainable models of care, digital transformation, travel and transport, estates and facilities, medicines, procurement, food and nutrition, adaptation, and green space biodiversity.

The full report is included in the ancillary pack.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive health innovation through world class education, teaching and research	☒	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

The Green Plan has been approved through the Finance and Performance Committee 27th May 2025 and subsequently the final version with graphics added, was approved through FPC on 23rd September, published in line with national guidance on 29th July 2025.

10.3 CHARITABLE FUNDS COMMITTEE CHAIR'S REPORT

Other | U Patel | 10.35am

Item for assurance

REFERENCES

Only PDFs are attached

10.3 - Chairs Report CFC 16 Sept.pdf

Chair's Report to Board		
Chair: Uzair Patel	**Committee: Charitable Funds Committee**	
Date(s):16 Sept 2025	**Agenda information attached for**	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	trend	Items Recommended for approval
N/A		**None**

ALERT

Areas of concern;

None

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- **Audit and Accounting Compliance:** Adjustments have been made to legacy income recognition practices to comply with auditor recommendations and charity SORP, with full documentation included in the auditor's management letter.

ASSURE

Assurance received; Matters of positive note.

- **Investment Policy Review:** The investments and reserves policy was reviewed and ratified, confirming continued compliance with best practice and ethical investment standards.
- **Charity Project Approvals:** The Committee approved significant funding for the Baby Beat courtyard transformation and a research project related to cancer diagnostics, both following thorough review and assurance of value for money and alignment with organisational strategy.
- **Financial Health:** Combined charity funds increased by £238,000 in five months, with income and expenditure closely monitored. Legacy income was slightly behind plan but expected to meet targets by year-end.

Charitable Funds Committee

16 September 2025 | 2.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	2.00pm	Verbal	Information	Chair
2.	Apologies for absence	2.01pm	Verbal	Information	Chair
3.	Declaration of interests	2.02pm	Verbal	Information	Chair
4.	Minutes of the previous meeting held on 17 June 2025	2.03pm	✓	Decision	Chair
5.	a) Action log & Matters Arising	2.04pm	✓	Decision	Chair
6.	STRATEGY AND PLANNING				
6.1	Hospitals' Charity update including Baby Beat inc. requests for funding a) LTHC Funding Approval Request - CF0050_25	2.05pm	✓	Decision	D Hill
6.2	Rosemere Charity update inc. requests for funding a) RCF Funding Approval Request - RCF008-25/26	2.15pm	✓	Decision	D Hill
7.	FINANCE AND PERFORMANCE				
7.1	Finance update including review of spending plan and balances	2.25pm	✓	Assurance	B Patel
8.	GOVERNANCE AND COMPLIANCE				
8.1	Charities annual report and accounts	2.35pm	✓	Decision	B Patel / D Hill
8.2	Investment Policy & Allocation of Gains and Losses	2.45pm	✓	Decision	B Patel / D Hill
8.3	Items to alert/advise/assure the Board	2.55pm	Verbal	Information	Chair
8.4	Reflections on the meeting	3.00pm	Verbal	Information	Chair
9.	ITEMS FOR INFORMATION				
9.1	Rosemere Management Committee Chair's report		✓		
	Date, time and venue of next meeting: *9 December 2025, 10.30am, MS Teams*	3.00pm	Verbal	Information	Chair

10.4 INTEGRATED PERFORMANCE REPORT

Other | Executive Team | 10.40am

including Finance update and Single Improvement Plan
Item for assurance

REFERENCES

Only PDFs are attached

10.4 - Integrated Performance Report as at 31 August 2025.pdf

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Integrated Performance Report						
Report to:	Board of Directors		**Date:**	2nd October 2025		
Report of:	Executive Team		**Prepared by:**	Executive Directors		
Part I	✓		**Part II**			
Purpose of Report						
For assurance	☒	**For decision**	☐	**For information**	☐	

Executive Summary:

The purpose of the report is to present the Integrated Performance report to the Board of Directors with the position up to August 2025, unless date otherwise stated.

The report provides the Single Improvement Plan, high level metrics, of which the outcomes have been scrutinised by each relevant committees of the Board. The outcome metrics are presented with a supporting summary, assurances provided and actions being taken to address the position where improvement is identified.

The delivery milestones of the single Improvement plan are monitored through the Finance and Performance committee. The reporting around this continues to be refined with a plan to include milestone assurances in future IPR reporting.

At the start of each priority section, a 3 A (Alert Advise and Assure) template is provided to guide the Board to areas of Alert Advise or Assure in line with the reporting approach adopted by the committees of the Board.

The Chief Operating Officer will present the IPR with Executive Director presentation for each of the priorities.

The Board of Directors is asked to receive the integrated performance report, note the monitoring of the Single Improvement Plan delivery milestones is undertaken through the Finance and Performance committee and confirm it is assured of the Single Improvement Plan outcome metrics.

Aims		Ambitions	
To offer excellent health care and treatment to our local communities	☒	Consistently Deliver Excellent Care	☒
To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive innovation through world-class education, teaching, and research	☐	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

Finance and Performance Committee, Workforce Committee, Safety and Quality Committee

The Best Version of Us
Our Culture Counts @LTH

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Integrated Performance Report

October 2025 Trust Board meeting with performance to August 2025


Partnerships


People


Patients


Productivity


Performance

Excellent care with compassion

Always Safety First

The Best Version of Us
Our Culture Counts @LTH

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Contents

SECTION	PAGE
Key to KPI Variation and Assurance icons	2
How to read Statistical Process Control charts (SPC)	3
SPC KPI Metric Grid	4
People	05 - 08
Patients	09 - 11
Productivity	12 - 15
Performance	16 - 19
Appendix 1 – Assurance Reports	20 - 39

Key to Metric Variation, Assurance Icons & Dashboard Headers

Lancashire Teaching Hospitals NHS Foundation Trust

Key to Metric Variance and Assurance Icons

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

Key to Metric SPC Chart and Variance and Assurance Icons

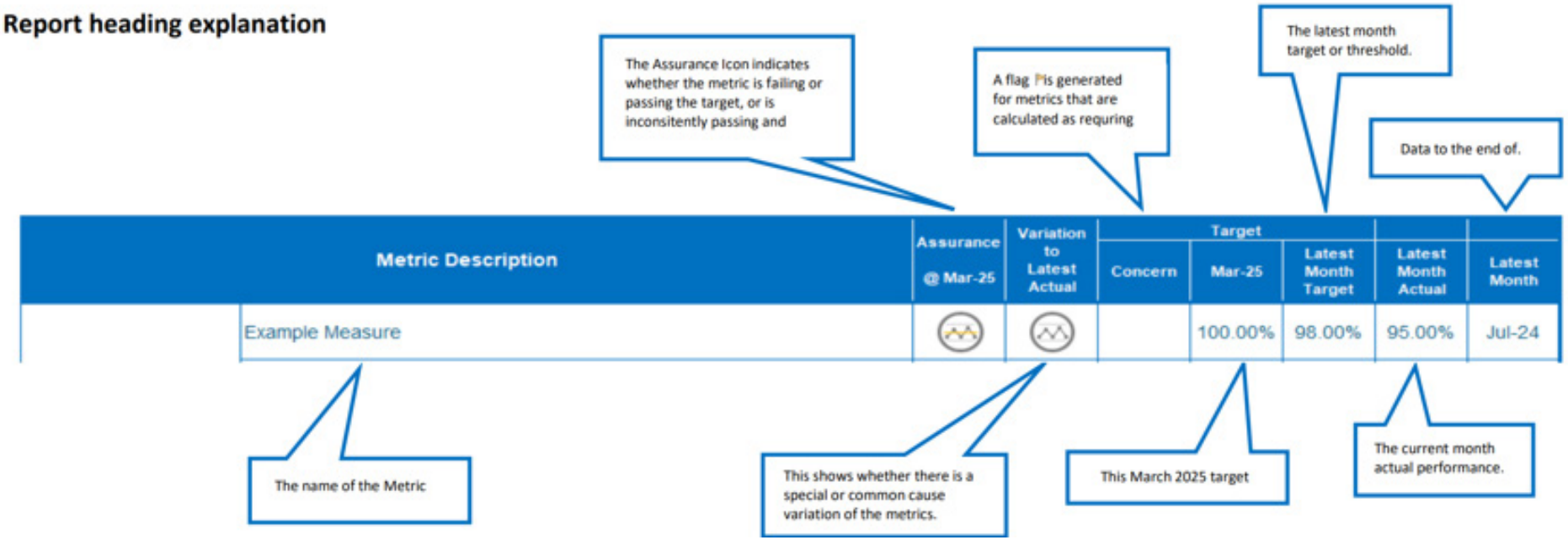
Assurance Icons – How likely are we to hit the set target in future?

It's possible the target could be either passed or failed within the expected month to month variation of the measure	*The target will be consistently failed within expected variation unless the process is changed*	*The target will be consistently passed within expected variation unless the process is changed*

Variation Icons – Is the measure showing signs of change over time?

No signs of change over time evident in recent data	*An example of concerning change is evident in the recent data*	*An example of positive change is evident in the recent data*

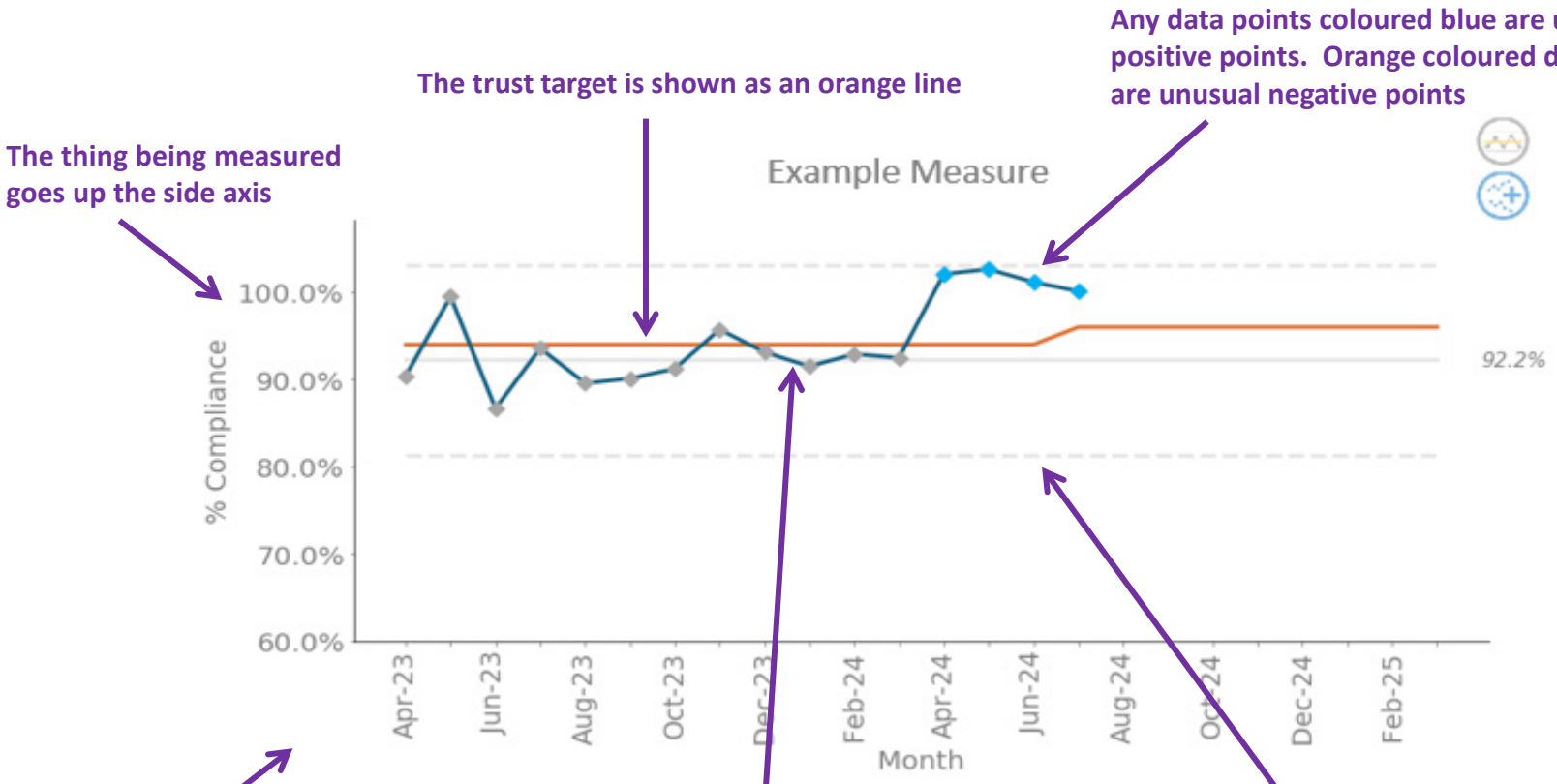
Report heading explanation



How to read Statistical Process Control charts (SPC)

Lancashire Teaching Hospitals NHS Foundation Trust

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



Rebasing is the recalculation of the mean and control limits when a statistically significant pattern indicating a sustained change is seen in the data - *not shown in this chart example*.

SPC KPI Metric Grid

Lancashire Teaching Hospitals NHS Foundation Trust

Variation \ Assurance	Will consistently fail target within expected variation	Could both pass or fail target within expected variation	Will consistently pass target within expected variation
Recent concerning pattern in the data	- Staff Survey: Recommend Trust as place to work - Percentage of patients waiting less than 18 weeks - 31 Day Cancer Standard	- Vacancies (% FTE) - RTT - 52 week Waiters	
Normal variation - no recent change	- Percentage of UEC (Type 1 & 3) patients seen within 4 hours - Maximum wait of 12 hours as Total Time in Department - Bed occupancy to 90% - Number of boarded patients - Reduce not meeting criteria to reside - RTT - 65 Week Waiters - Cancer 62-day performance	- Number of violence and aggression incidents toward staff - Turnover (%FTE) - Staffing Fill Rate - Health Care Assistant - Staffing Fill Rate - Registered Midwife - Complaints per 1000 bed days C. difficile performance against national trajectory - no more than 167 Hospital Acquired cases - Pressure Ulcers per 1000 beds days (Category 2 and above) actions - Perinatal - Number of Stillbirths - 85% theatre utilisation - aggregate - Capped - Cancer Faster Diagnosis Performance	- Staffing Fill Rate - Registered Nurse - STAR Accreditation all trust (Silver and Above)
Recent positive pattern in the data	- Percentage of patients that receive a diagnostic test within six weeks	- Sickness Absence (%FTE) - Maintain compliance with 10 Clinical Negligence Scheme for Trusts Safety	

Non SPC Metrics flagged as a concern

I&E - Plan V Actual variance

WRP schemes delivery

Non SPC Metrics

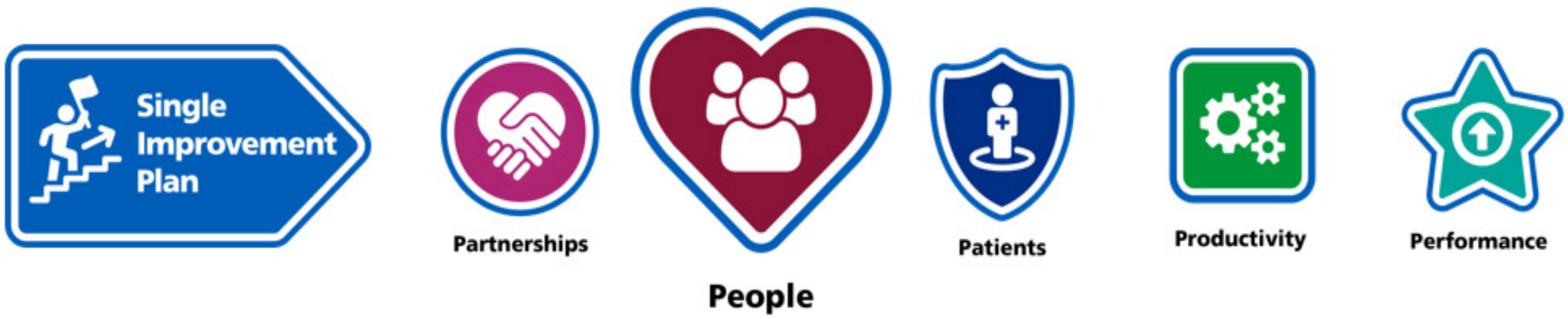
Hospital Standardised Mortality Ratio (56 Basket – Adult)	Lower Than Expected
Standardised Mortality Rate (All Diagnoses – Adult)	Lower Than Expected
Standardised Mortality Rate (Child <1 day -17 Years) (All Diagnoses)	As Expected
Standardised Mortality Rate (Neonatal <1 day -28 days) (All Diagnoses)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

People
Patients
Productivity
Performance

The Best Version of Us
Our Culture Counts @LTH

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

People



Excellent care with compassion

Always Safety First

@LancsHospitals

Alert, Advise, Assure Report

Lancashire Teaching Hospitals NHS Foundation Trust

	Issue	Action
Alert Areas of concern or matters that need addressing urgently	**Sickness Absence Management** - Case numbers for short term absence have trebled following the introduction of the new attendance management policy. Capacity remains challenged within the Workforce Advice team, due to high levels of maternity leave. **Staff Survey** - Despite reaching out on several occasions to lower performing teams with an offer of support, a proportion of these teams have not responded. **Violence and Aggression**- incidents remain high but there has been a significant reduction since peak reported in July.	**Sickness Absence Management** - Request to VCP to appoint 2 fixed term Band 5 Workforce Advisers has been approved to cover maternity leave and support sickness absence agenda. **Staff Survey**- Currently engaging with 18 lower scoring teams, oversight delivered through Divisional Workforce Committees via Senior Divisional Leads/ Workforce BPs and OD leads. Trust Level Action Plan circulated and 'You said we did' weekly communications rolling out ahead of NSS25 with full communication plan developed to support response rates and engagement.
Advise Areas of ongoing monitoring and any new developments	**Violence and Aggression** - rates remain but seen reduction since July. **Staff Survey-**National Quarterly Pulse Survey indicated a small improvement in levels of engagement for this quarter, however still below the national average.	**Violence and Aggression** - Deep dive report on reduction plans has been submitted to workforce committee and Trust Management Board. Planning to move work undertaken by Big Room into Rapid Improvement Event Format. Self assessment against new national Violence , Prevention and Reduction Standard will be reviewed further and improvement plan developed. **Staff Survey**- Refreshed colleague engagement offer developed, includes a tiered approach to providing engagement opportunities, with 3 new interventions, executive lead your voice sessions, using the professional recognition days to hear from all colleagues and targeted board visits to areas which have high or low advocacy scores.
Assure Areas of Assurance	**Vacancy Management** - Vacancy control processes remain in place to support financial recovery, with majority of roles being advertised internally first. **Sickness Absence Managemen**t - Overall sickness absence rate has improved for 4th consecutive month standing at 5.56%. **Appraisal** - Appraisal compliance currently above 90% at 91.2%. **Mandatory Training**- all areas met new target of 100% completion at 90% or above.	**Appraisal**- Communications around non compliance interventions completed. **Vacancy**- internal only vacancy page created on intranet and continually communicated through all available channels. **Sickness absence** plan continues to be progress including actions from rapid improvement event held in July.

People

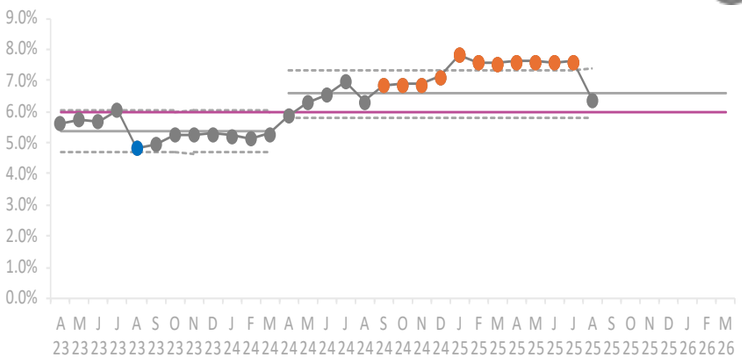
Lancashire Teaching Hospitals NHS Foundation Trust

Metric Description		FY2526 Target Assurance	Latest Actual Variation	Target			Latest Actual	Latest Period
				Concern	FY2526	Latest Month Target		
People	Vacancies (% FTE) (source: General Ledger)				≤ 6%		6.39%	M05
	Turnover (% FTE) (annual assessment; ESR in-month reported)				≤ 10%		0.82%	M05
	Sickness Absence (% FTE) (annual assessment; in-month reported)				≤ 5.22%		5.56%	M05
	Number of violence and aggression incidents toward staff (annual assessment; in-month reported)				996		178	M05
	Core Skills Mandatory Training compliance (% modules) (module compliance reported)				100% of metrics at 90%		100%	M05
	Appraisal compliance (% HC)				≥ 90%		91.24%	M05
	Staff Survey: Recommend Trust as place to work (quarterly metric)				≥ 60%		42.30%	Q1

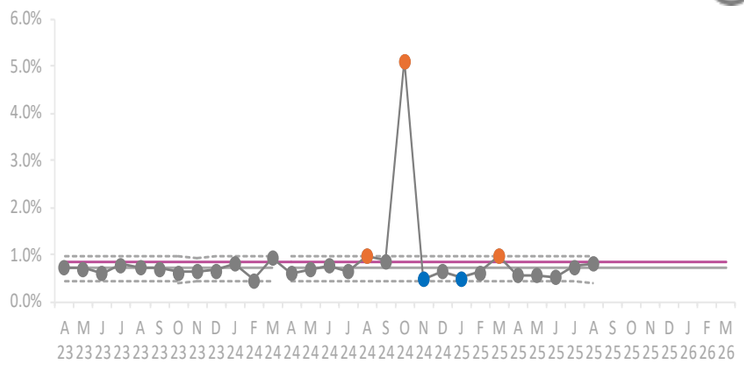
People

Lancashire Teaching Hospitals NHS Foundation Trust

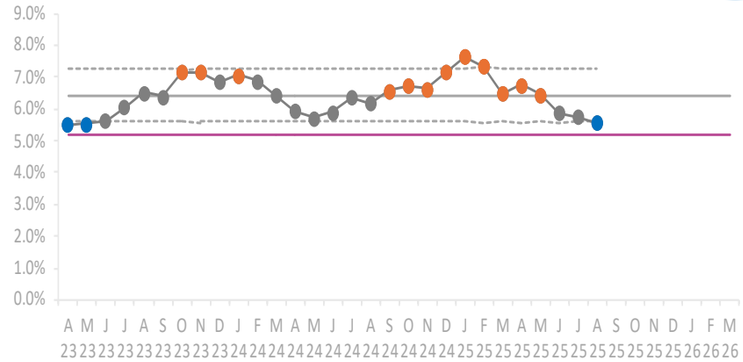
GL Vacancy Rate (% FTE)



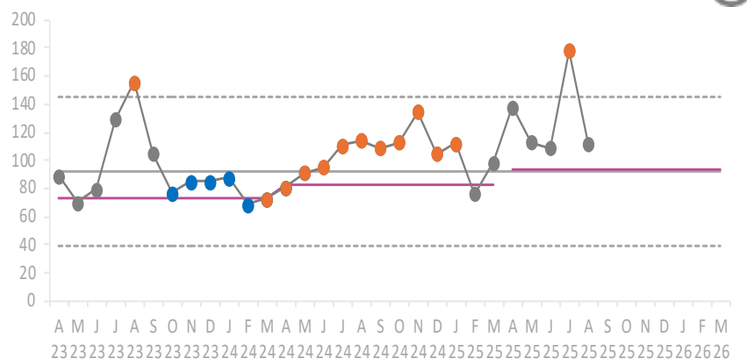
ESR Turnover (% FTE)



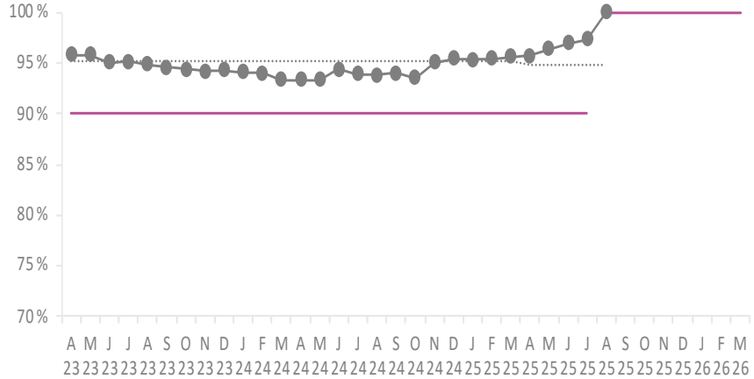
Overall Sickness (% FTE)



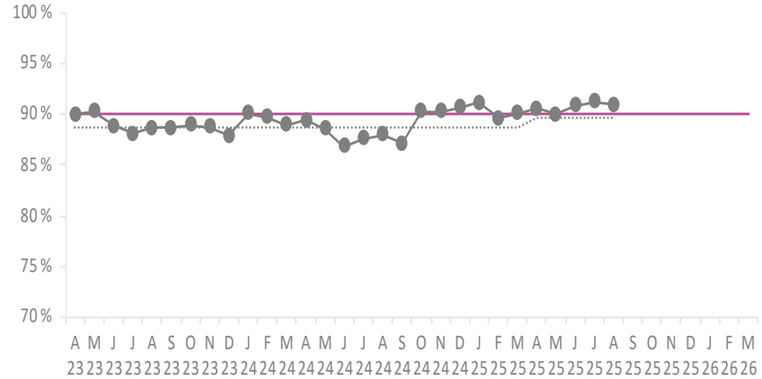
No. of Violence & Aggression Incidents Reported



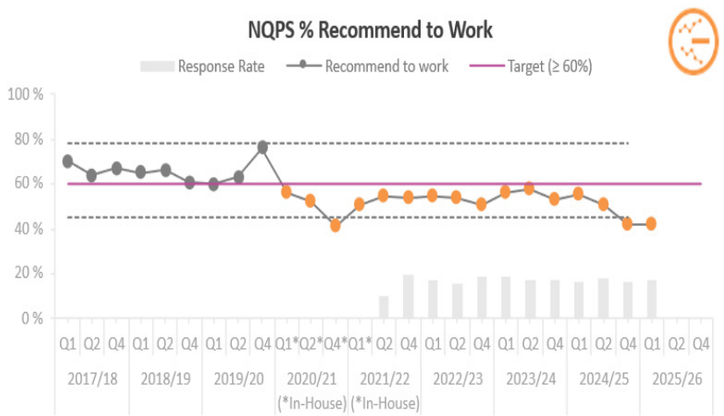
CSTF Compliance (% modules)



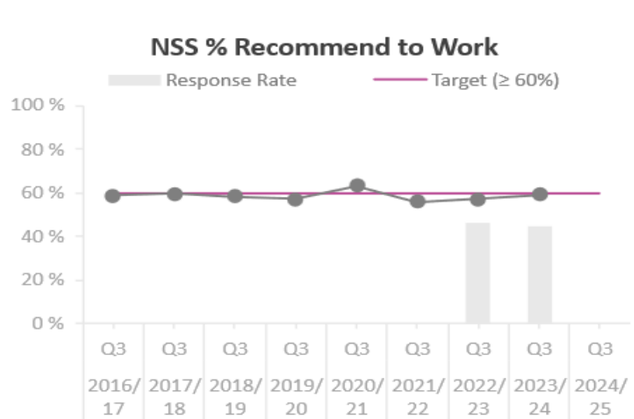
Appraisal Compliance (% HC)



NQPS % Recommend to Work



NSS % Recommend to Work



The Best Version of Us
Our Culture Counts @LTH

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Patients

Excellent care with compassion

Always Safety First

@LancsHospitals

Alert, Advise, Assure Report

Lancashire Teaching Hospitals NHS Foundation Trust

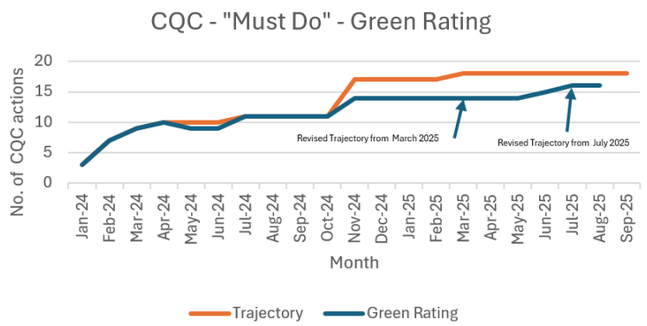
	Issue	Action
Alert Areas of concern or matters that need addressing urgently	**1. Complaints** : Increase in complaints for the previous quarter linked to delays in Urgent and Emergency Care and diagnostic pathway and communication.	1. The SIP in September focused on strengthening the assurance regarding progress on the improvement plans for UEC and inpatients. 2. The Patient expereince group is exploring how messaging could be provided to patients to ensure an accurate understanding of their position on the waiting list is understood. 3. Tier 1 for diagnostocs and Tier 2 for urgent and emergency care improvement plans are in place and monitored through Tiering arrangements. 4. Team Engagement work continues to focus on values, behaviours, civility and positive communication methods.
Advise Areas of ongoing monitoring and any new developments	**1. C.difficile:** Compliance with National Standards of Healthcare Cleanliness compliance with mandated cleaning frequencies remains below standard with the implementation plan on track with delivery plan by the March 2026. **2. Pressure Ulcers**: There has been one astonomical data point in August with increases noted in the Urgent and Emergency Care Pathway. **3. Staffing Fill Rate Maternity Support Worker:** remains below 95% target with historical vacancies and sickness impacted fill rates. **4. CQC must do delivery**: The two remaining must dos are on track to complete in month. The final position will be provided at the October Safety and Quality committe.	1. A phased implementation plan is underway following Board-approved investment, with a target of 50% compliance by October 2025. 2. Pressure ulcer improvement plan continues with a review of prevention equipment in UEC pathways underway and training on the strengths based 'Days kept away from home' approach. 3.Nights shifts are prioritised due to risk. Recruitment has now concluded. Sickness management is line with requirements. This is expected to improve within the next quarter.
Assure Areas of Assurance	1. **Staffing fill rates:** The rates are demonstrating a positive trend providing assurance of safe Nursing and Midwifery levels. Recruitment to the final Birthrate plus Midwives is now complete and they will join the service from October to Dec 25. **2. STAR accreditation:** The Trust remains above target, demonstrating three consectuve months of improvement following the introduction of critical standards. **3. Mortality and still birth:** Rates remain within or below expected range.	

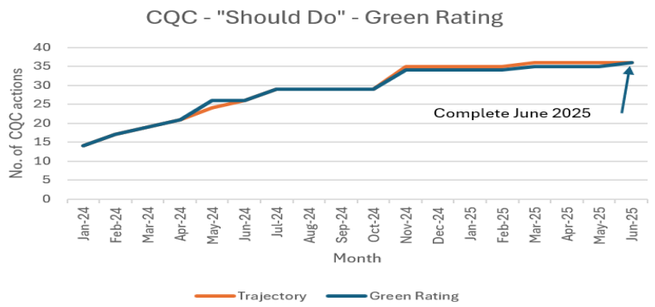
Patients

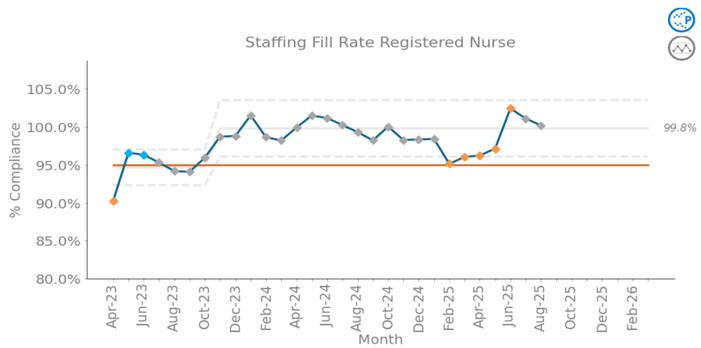
Lancashire Teaching Hospitals NHS Foundation Trust

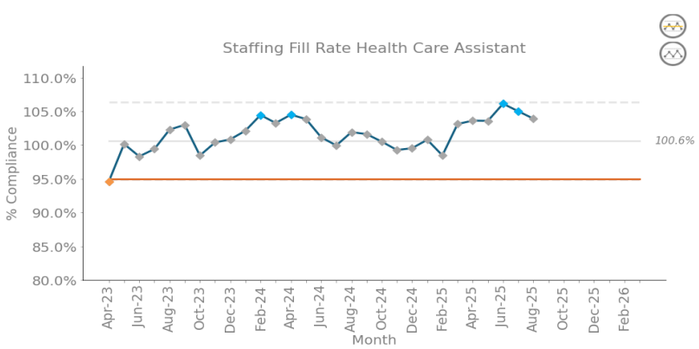
Metric Description		Assurance @ Mar-26	Variation to Latest Actual	Target			Latest Month Actual	Latest Month
				Concern	Mar-26	Latest Month Target		
CQC	CQC - "Must do" (Number with Green rating)				18	16	16	Aug-25
	CQC - "Should do" (Number with Green rating) - Completed June 2025				36	36	36	Jun-25
Deliver Annual Safe Staffing Requirements	Staffing Fill Rate - Registered Nurse				95%	95.0%	102.4%	Aug-25
	Staffing Fill Rate - Health Care Assistant				95%	95.0%	106.1%	Aug-25
	Staffing Fill Rate - Registered Midwife				95%	95.0%	92.9%	Aug-25
	Staffing Fill Rate - Maternity Support Worker				95%	95.0%	86.0%	Aug-25
Patient Experience and Involvement	Complaints per 1000 bed days				1.40	1.40	1.56	Aug-25
	STAR Accreditation all trust (Silver and Above)				75%	75.0%	82.0%	Aug-25
C Difficile Improvement	C. difficile performance against national trajectory - no more than 167 Hospital Acquired cases				13	14	10	Aug-25
Always Safety First	Hospital Standardised Mortality Ratio - Adult	Lower Than Expected					63.9	Apr-25
	Standardised Mortality Ratio - Relative Risk - All Diagnoses Adult	Lower Than Expected					62.8	Apr-25
	Standardised Mortality Ratio - Relative Risk - All Diagnoses Child (<1 day – 17 yrs)	As Expected					0.0	Apr-25
	Standardised Mortality Ratio - Relative Risk - All Diagnoses Neonates (<1-28 Days) *The updated TELSTRA model from November 2024 does not include still births*	As Expected					0.0	Apr-25
	Pressure Ulcers per 1000 bed days (Category 2 and above)				3.32	3.02	4.34	Aug-25
Maternity	Perinatal - Number of Stillbirths				0	0	1	Aug-25

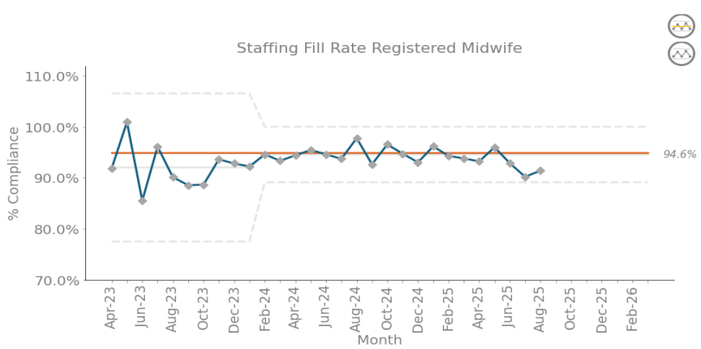
Patients

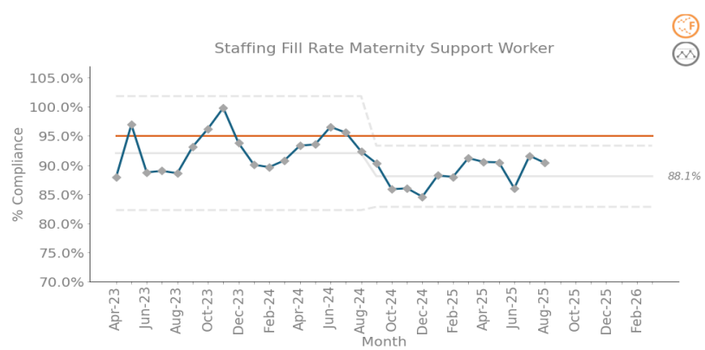

CQC - "Must Do" - Green Rating
No. of CQC actions
Revised Trajectory from March 2025
Revised Trajectory from July 2025
Month
Trajectory
Green Rating

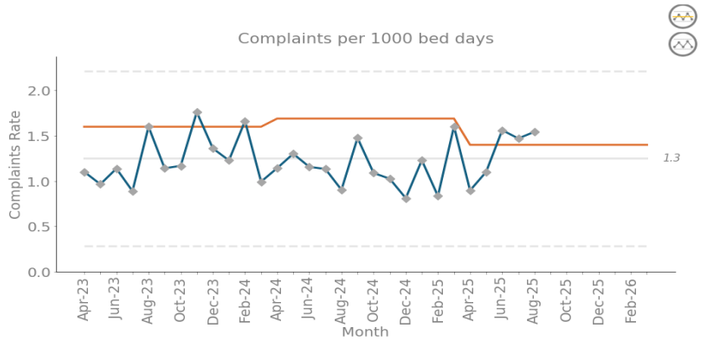

CQC - "Should Do" - Green Rating
No. of CQC actions
Complete June 2025
Month
Trajectory
Green Rating

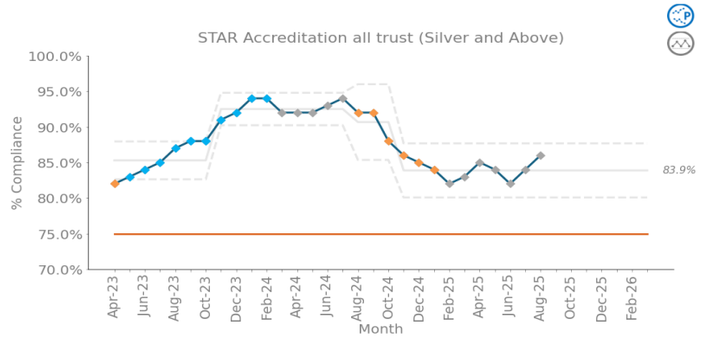

Staffing Fill Rate Registered Nurse
% Compliance
99.8%
Month

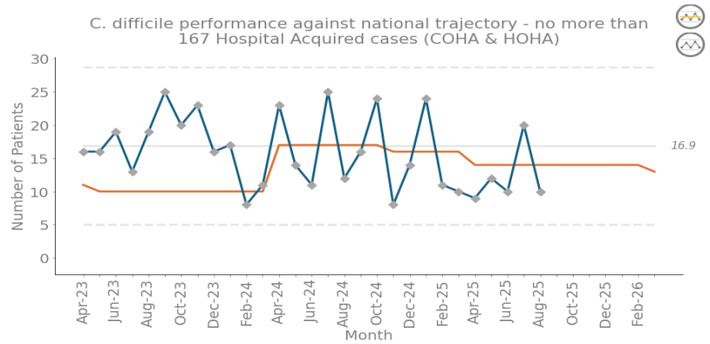

Staffing Fill Rate Health Care Assistant
% Compliance
100.6%
Month

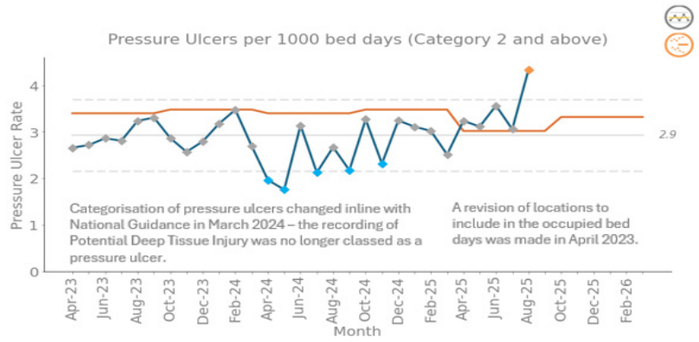

Staffing Fill Rate Registered Midwife
% Compliance
94.6%
Month

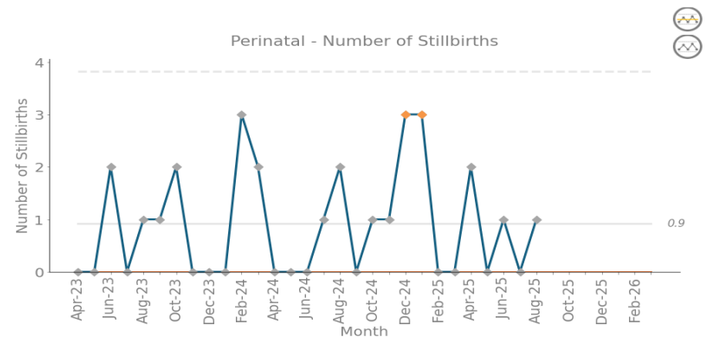

Staffing Fill Rate Maternity Support Worker
% Compliance
88.1%
Month


Complaints per 1000 bed days
Complaints Rate
1.3
Month

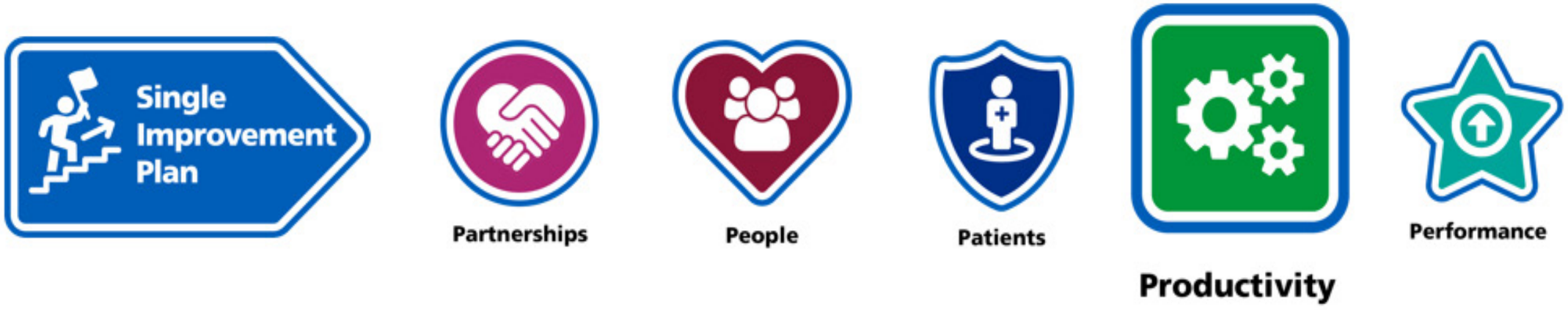

STAR Accreditation all trust (Silver and Above)
% Compliance
83.9%
Month


C. difficile performance against national trajectory - no more than 167 Hospital Acquired cases (COHA & HOHA)
Number of Patients
16.9
Month


Pressure Ulcers per 1000 bed days (Category 2 and above)
Pressure Ulcer Rate
2.9
Categorisation of pressure ulcers changed inline with National Guidance in March 2024 – the recording of Potential Deep Tissue Injury was no longer classed as a pressure ulcer.
A revision of locations to include in the occupied bed days was made in April 2023.
Month


Perinatal - Number of Stillbirths
Number of Stillbirths
0.9
Month

Productivity



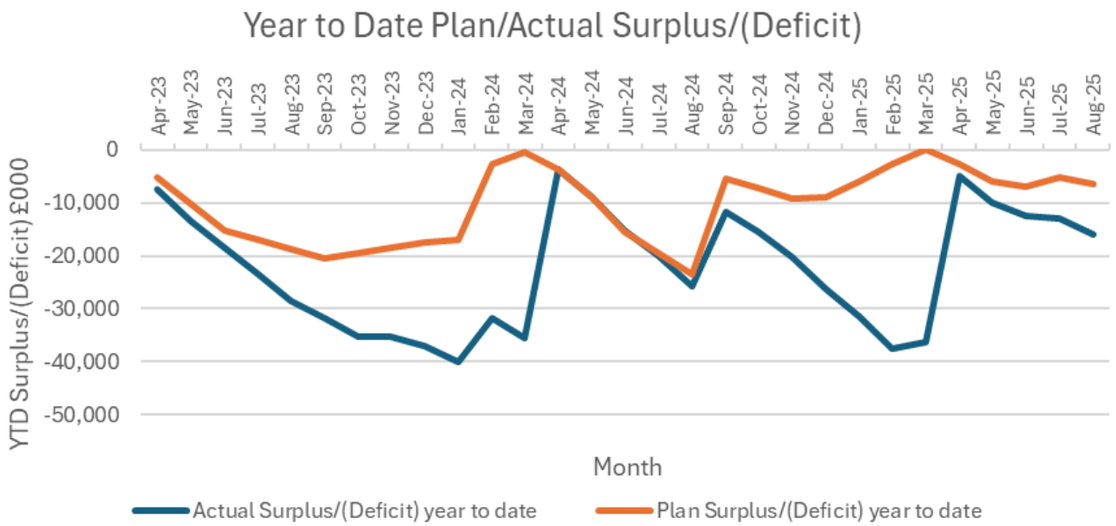
Alert, Advise, Assure Report

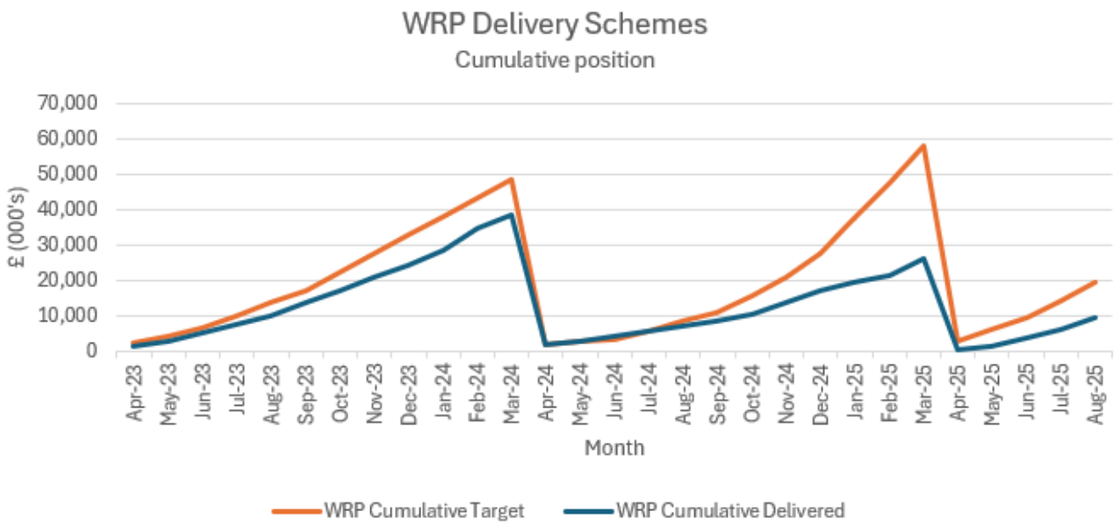
Lancashire Teaching Hospitals NHS Foundation Trust

	Issue	Action
Alert Areas of concern or matters that need addressing urgently	**Cash Position**	
	The Trust requested £12m cash support for September 2025 and DHSC approved just £3.566m. An application for £8.434m in October has been submitted but it should be noted however that it is highly unlikely that revenue support will be approved by DHSC and the Trust will need to manage cash until the increased efficiencies come through in Q3 and Q4. This has meant that payments due for the PDC dividend, NHS LA payment, and Roche managed service contract which were all due for payment in September have had to be cancelled.	Management of WRP top ensure where possible cash releasing efficiencies are implemented. Restriction of supplier payments in accordance with the priority list of suppliers. Utilisation of capital cash for revenue purposes as a short-term measure.
Advise Areas of ongoing monitoring and any new developments	**Income and Expenditure**	
	The Trust submitted the final financial plan to NHSE at the end of April. For 2025/26 the Trust has a break-even plan which is reliant on a recurrent waste reduction programme of £60m and non-recurrent deficit support funding of £30m. At the end of August 2025 the Trust has a deficit of £16.0m against a planned deficit of £6.4m. The adverse variance to plan of £9.6m is as a consequence of the shortfall in delivery of the Waste Reduction Programme. At the time of setting the plan the Trust had not identified the full £60m programme and the unidentified element was included in the plan in 12ths in accordance with NHSE policy. The shortfall in efficiency programme to the end of August was 9.6m. In month 4 the Trust also had additional costs of £0.4m associated with industrial action. The Trust has operational pressures in: - the acute medical pathways reflected in overspends in medical and nursing pay budgets - sickness remains higher than in operational budgets resulting in nursing pay overspends	The Trust has a Turnaround Director to work with senior leaders to re-assess the current waste reduction programme position and deep dive into short, medium and long-term opportunities. A re-set of the programme structure, governance and reporting for 2025/26 has taken place. The Trust is working with the ICB on the urgent and emergency pathway system pressures which is one of the main operational pressures that the Trust faces. The system is now receiving enhanced support from NHSE as part of the provider improvement programme (formerly recovery support programme). A focus on grip and control activities continues. The Trust has commissioned further external support to support specific financial recovery plan workstreams and 2025/26 waste recovery programme development. Divisions will need to recover their financial performance by delivering improvements in their current run rates e.g. maximising grip around temporary pay, review of vacancies and continuing to mitigate shortfalls in the efficiency target as schemes move through development and implementation stages.
	Waste Reduction Programme	
	The Trust's 2025/26 waste reduction target is £60m, 7% of operating expenditure. At the end of August the Trust has delivered £19.7m of the £60m target (33%). The delivery in month was £3.6m against a plan of £4.8m. The Trust has identified schemes and opportunities to the value of £60m however the phasing is different to the financial plan with shortfalls in the first 6 months being offset with gains in the final 6months of the year.	The Trust has a Turnaround Director to work with senior leaders to re-assess the current programme position and deep dive into short, medium and long-term opportunities. A re-set of the programme structure, governance and reporting has taken place for 2025/26. The Trust has additional external support to help with the delivery of the programme. The Trust is building up its own project management office structure to have a sustainable solution moving forward.
	Oversight Framework	
	The Trust has received notification from the North West Region and is expecting a formal letter from NHSE that we have been put in Segment 5 of the new 2025/26 oversight framework. Segment 5 is where the the organisation is one of the most challenged providers in the country, with low performance across a range of domains and low capability to improve or where the organisation is a challenged provider where NHS England has identified significant concerns. Segment 5 means the Trust will be subject to NHSE's most intensive support - the Provider Improvement Programme (PIP) - to ensure it meets improvement goals. Sustained improvement is required to leave the PIP.	The Lancashire and South Cumbria system is receiving nationally mandated support from PWC and the Trust is receiving support as part of the Provider Improvement Programme (previously Recovery Support Programme).
Assure Areas of Assurance	**Capital Position**	
	Capital expenditure in the year to date is below plan but plans are in place to deliver a forecast matching the available capital funding.	Continuing to closely monitor the capital schemes and submitting robust bids for funding in line with the opportunities that arise and associated deadlines.

Productivity

Metric Description		Assurance @ Mar-26	Variation to Latest Actual	Target (£ 000's) Concern	Mar-26	Latest YTD Target	Latest YTD Actual (£ 000's)	Latest Month
Productivity	I&E - Plan v Actual variance					-6437	-16056	Aug-25
	WRP schemes delivery				60000	19231	9634	Aug-25

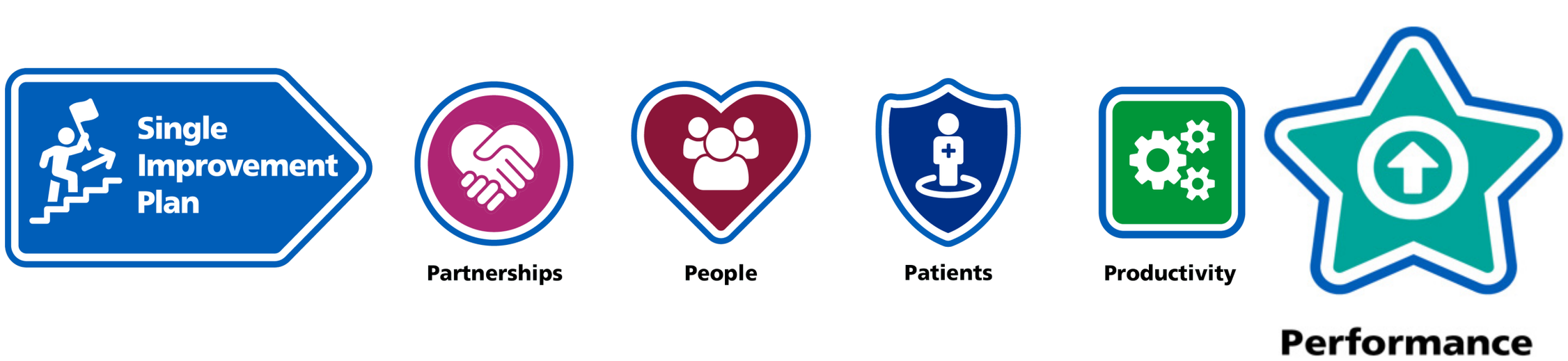




The Best Version of Us
Our Culture Counts @LTH

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Performance



Excellent care with compassion

Always Safety First

@LancsHospitals

Alert, Advise, Assure Report

	Issue	Action
Alert Areas of concern or matters that need addressing urgently	• **RTT performance** - 65 weeks - small numbers of breaches remain in ENT and Surgical dentistry and relate to complexity and patient choice. 52 week+ breaches continue to grow with key speciality pressures inc ENT, Surgical Dentistry, Neurology , Plastics, Vascular, Pain, and Colorectal and relate to capacity constraints. 18 week performance continues to deteriorate due to capacity and activity funding constraints. • **Boarding** - Average of 23 patients boarded in August - a static position • **4 hour performance** within UEC has deteriorated in August 25 in All types and Type 1 categories and is below the operational plan. • **62 day cancer performance** remains under target (58.5% May - validated) and relates to capacity in a small number of tumour groups	• **RTT** - administrative and clerical vacancies are being released to recruitment to support increased validation, recruitment into vacancies are underway in relevant specialities with requests for mutual aid ongoing. A review of out of area demand is underway and will inform decisions to curtail activity as required. New models of care are being scoped in Pain and Neurology. Additional capacity • **DKAFH/Boarding** - Further roll out of the Lancs Improvement methodology and DKAFH cultural change programme to maximise the benefits and LOS reductions has commenced across a further 16 wards. • **4 hour performance** - key actions are to reduce non admitted breaches by reducing the wait for first clinical assessment, increasing deflections into community services, VW and SDEC. Admitted performance focus centres around improving bed flow via DKAFH and Ward/Board Round standard implementation. • **62 day cancer** actions centre around Breast - recruitment of substantive and Locum Cons staffing due to be in post by Dec 25, Colorectal, Lung and Urology- increased capacity via Clinical specialists, improved working with Endoscopy and additional EBUS capacity.
Advise Areas of ongoing monitoring and any new developments	• **Ambulance handover** performance (15/30 and 60 mins) - whilst marked improvements have been noted in August in all handover areas, performance remains below the national and Trust targets for 25/26. • The **waiting time for first clinical assessment** has improved in August but remains above target, although this is higher than the national and L&SC levels. • **12 hour + ED LOS** - performance has deteriorated in August but remains under the Operational Improvement plan. • **Days Kept Away from Home** patient (%) have reduced for the 3rd months and are below the operational target however the number of lost bed days has increased this month and are higher than target. • **Diagnostic performance** (DM01) improved in July 25 and was above the operational target for the month but remains below the national average. The position deteriorated in August by 4% across a range of modalities and remains under the monthly target. •**Virtual Ward** occupancy remains below target. •Theatre Utilisation saw a deteriorated position in August.	• Key actions being taken to improve **ambulance handover** performance include increasing 'Fit to Sit' practices, improve data capture with NWAS, increased flow out of ED via continuous flow 'cycles' every 30 mins to AMU. 45 minute release to rescue commenced 1st Aug 25 and actions have seen a considerable reduction in over 60 min waits. Aug 25 saw 31 x over 60 min handover delays versus 381 in July 25. • A focus on reducing the **wait to be seen** time is central to the Divisional ED Improvement plan. The ECIST C&D modelling will be commenced in September to inform optimal rota patterns to aid timely assessment. • **12 hour + ED LOS & DKAFH** - Key focused action re Continuous flow and DKAFH are ongoing with a roll out of the DKAFH work underway with a further 16 wards. • **DM01** - Mutual aid continues to be requested for Echo, NOUS and Cardiac CT with options being scoped to provide additional outsourced capacity. Mobilisation of the 5th Endoscopy room is underway and will come on board at the end of 2025. Additional capital equipment is due to be operational at the end of 2025 which will also increase capacity. •**VW** - recruitment into Medical staffing is underway to support an expanded offer. Communications to all LTH and community teams to increase referrals is underway. •**Theatre Utilisation**- a focus on reducing late starts and cancellations for equipment is ongoing and aligned to 6-4-2 protocols.
Assure Areas of Assurance	• **ED Triage** times have reduced to below target in August. • **Cancer Faster Diagnostic standard** compliance remains above target	

Performance

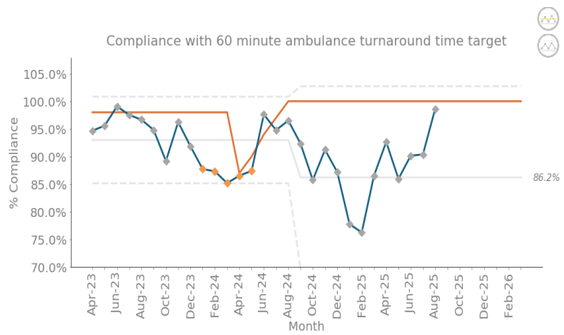
Lancashire Teaching Hospitals NHS Foundation Trust

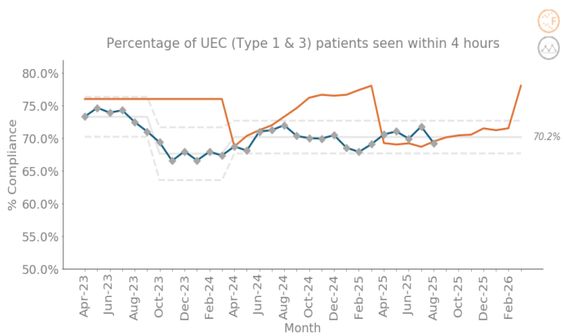
Metric Description		Assurance @ Mar-26	Variation to Latest Actual	Target Concern	Target Mar-26	Target Latest Month Target	Latest Month Actual	Latest Month
UEC In Flow	Compliance with 60 minute ambulance turnaround time target				100.00%	100.00%	98.62%	Aug-25
	Percentage of UEC (Type 1 & 3) patients seen within 4 hours				78.03%	69.49%	69.26%	Aug-25
	Maximum wait of 12 hours as Total Time in Department				8.20%	11.95%	11.24%	Aug-25
UEC Flow	Bed occupancy to 90%				90.00%	90.00%	96.05%	Aug-25
	Number of boarded patients				0	0	23	Aug-25
UEC Outflow/Community Collaborative	Reduce not meeting criteria to reside to 5				5.00%	9.80%	9.39%	Aug-25
Elective (diagnostics)	Percentage of patients that receive a diagnostic test within six weeks				65.00%	59.00%	58.38%	Aug-25
Elective (long waits)	Percentage of patients waiting less than 18 weeks				64.80%	59.38%	53.34%	Aug-25
	RTT - 52 week Waiters				1395	2107	2158	Aug-25
	RTT - 65 Week Waiters				0	0	6	Aug-25
Elective (theatre utilisation)	85% theatre utilisation - aggregate - Capped				84.58%	84.58%	82.40%	Aug-25
Elective (Cancer)	31 Day Cancer Standard				95.98%	89.40%	87.05%	Aug-25
	Cancer 62-day performance				75.10%	64.26%	63.45%	Aug-25
	Cancer Faster Diagnosis Performance				80.01%	79.99%	74.60%	Aug-25

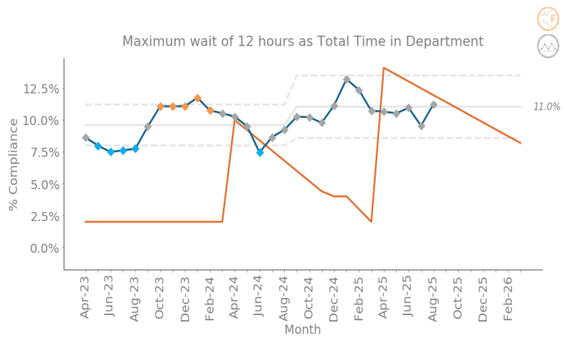
Unvalidated position, subject to change

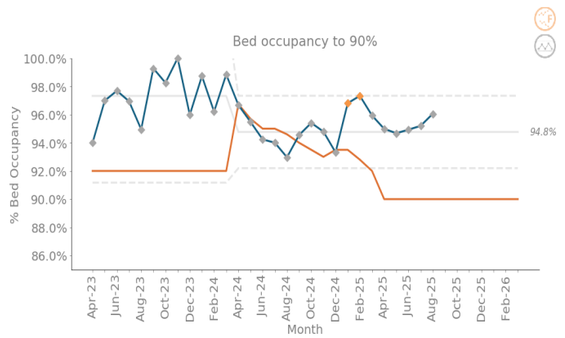
Performance

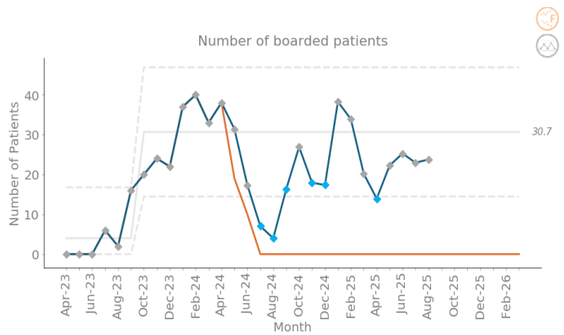
Lancashire Teaching Hospitals NHS Foundation Trust

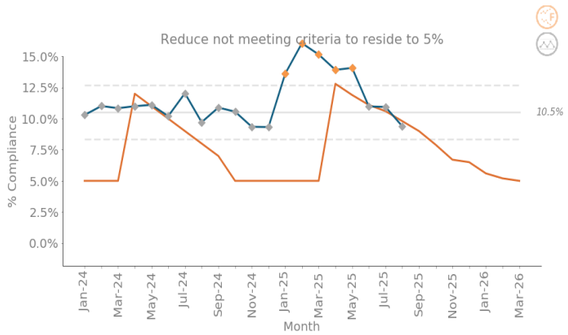


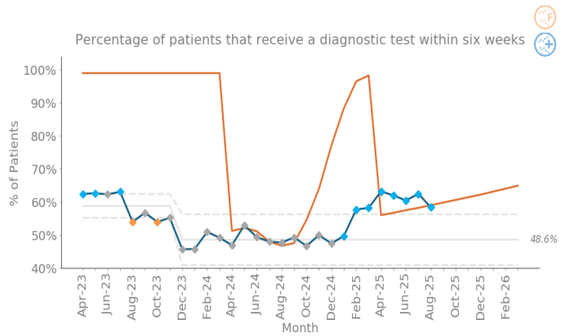


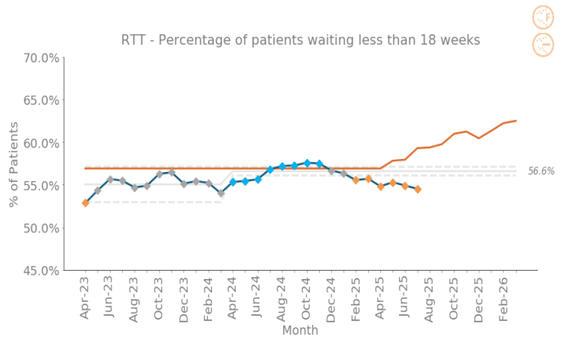


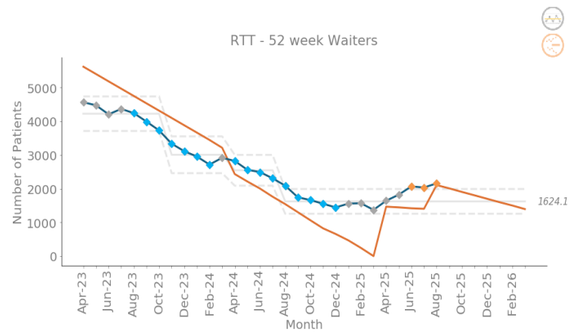


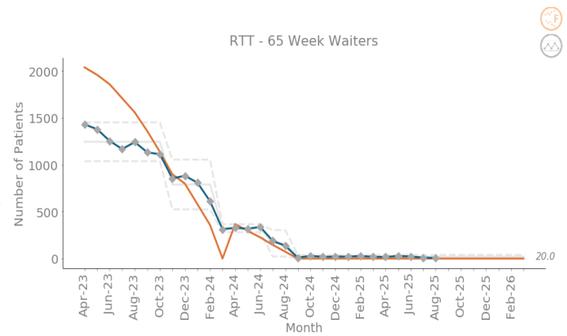


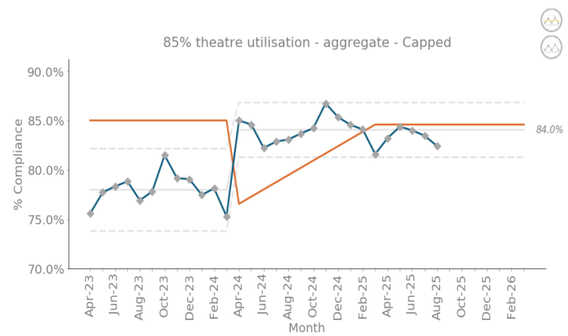


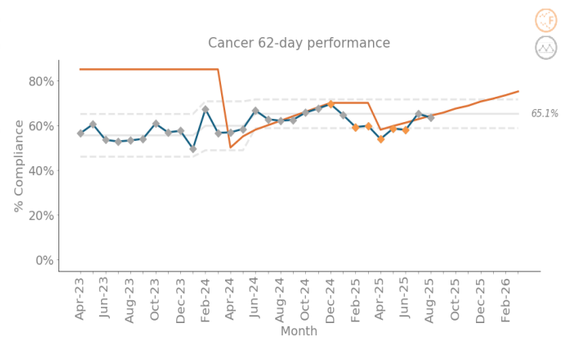


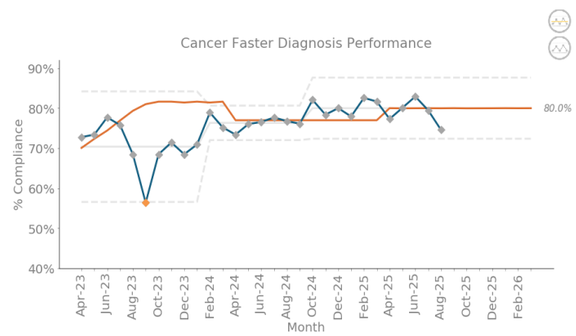


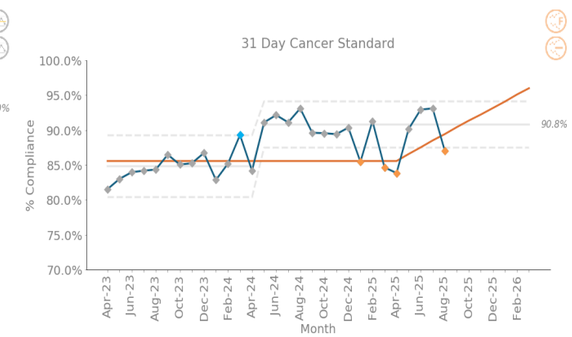










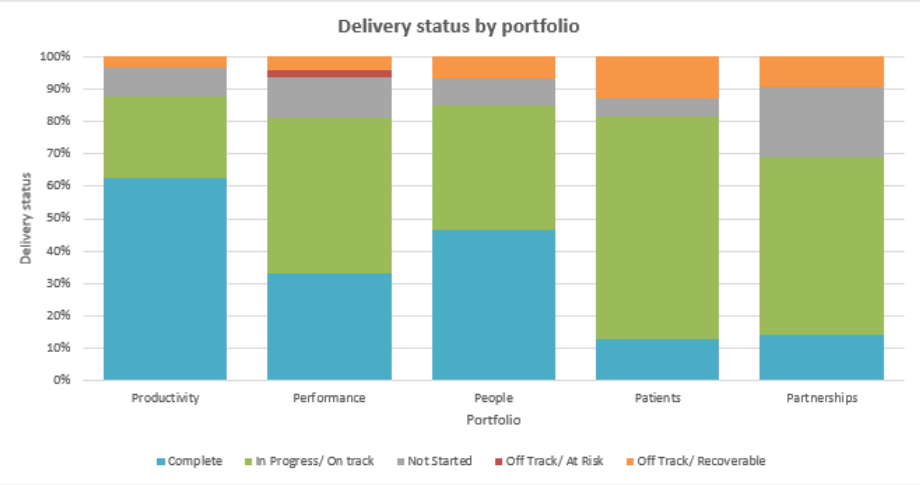


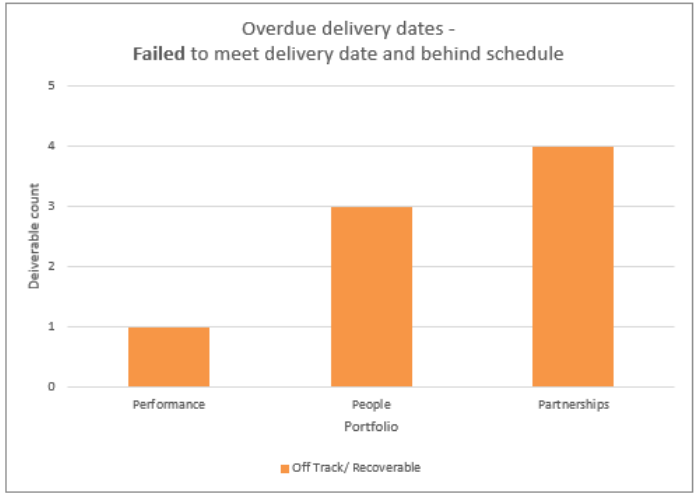
Single Improvement Plan

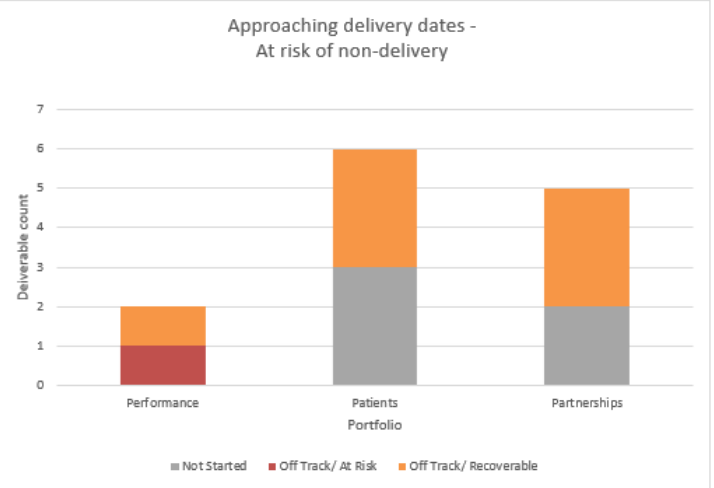
The Lancashire Teaching Hospitals **Single Improvement Plan** aims to improve patient care together. The plan is based on what matters most to our patients, our colleagues, and our regulators, and it supports our overall goals. The SIP sets out a clear and simple way to improve how the organisation works across 5 core portfolios, the **5 P's**.

NHS Lancashire Teaching Hospitals NHS Foundation Trust

August-25 | Single Improvement Plan Delivery position







Status	Escalation	Key actions
Alert	• Lack of progress on Information Intelligence programme development and Digital delivery to support waste recovery programme schemes. • Off track cash position, September cash request was not approved in full	• Planned digital workshop at the end September-25 to support development of strategic direction with senior leaders, supported by Price Waterhouse Cooper (PWC). • NHS Recovery Support Team resource for business intelligence support. • The Trust will enact its prioritisation list and request the balance in October. Financial sustainability plan being developed with PWC team.
Advise	• 8 milestones failed to meet delivery date and are behind schedule across Performance, People and Partnerships portfolios. 13 milestones approaching delivery date and off track or at risk across Performance, Patients and Partnerships portfolios. • NHS Recovery Support Team feedback on a need to mature governance for the SIP and embedding into organisational business • Amber/red NHS Oversight Framework rating for access to services rating	• Horizon scanning for upcoming risks and focus into each portfolio delivery group on impact on delayed delivery, plans to remain agile to adapt as required to deliver required outcomes. • Planned change for SIP oversight through Trust Management Board for broader visibility and planned review and refresh of each portfolio delivery governance and Senior Responsible Officer oversight. • Tier 1 performance improvement plan being developed
Assure	• Improvement to medical clinician appraisals has improved to 82% • Green NHS Oversight Framework rating for patient experience and safety metrics • Amber/Green NHS Oversight Framework rating for productivity metrics.	

The Best Version of Us
Our Culture Counts @LTH

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Integrated Performance Report
Appendix 1 – Assurance Reports

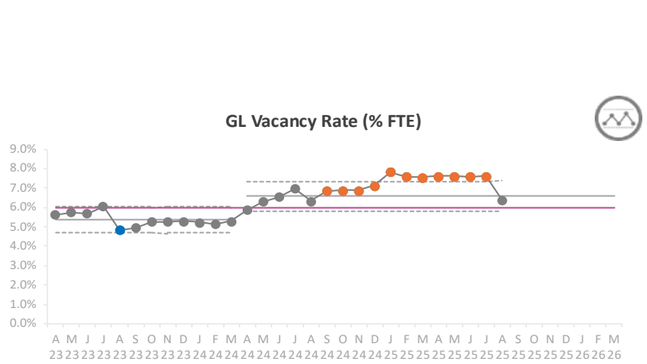
October 2025 Trust Board meeting with performance to August 2025

Excellent care with compassion

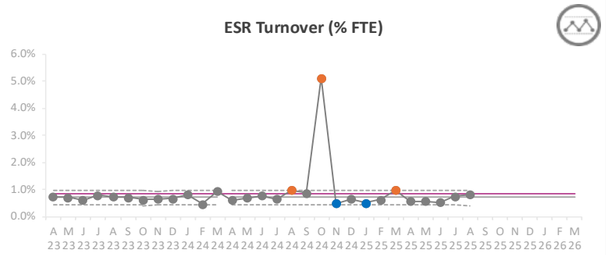
Always Safety First

People - Workforce Assurance 1

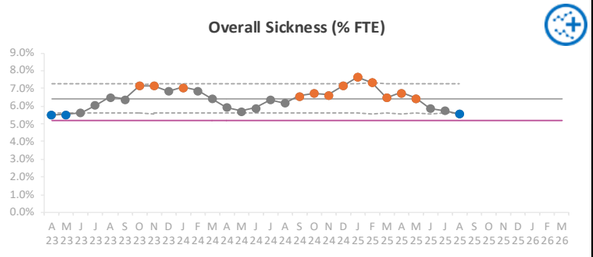
Lancashire Teaching Hospitals NHS Foundation Trust



Latest
6.39%
Variance Type
Recent concerning pattern in the data
Mar 26 Target
≤ 6%
Target Achievement
Could both pass or fail target within expected variation



Latest
0.82%
Variance Type
Normal variation - no recent change
Mar 26 Target
≤ 10%
Target Achievement
Could both pass or fail target within expected variation



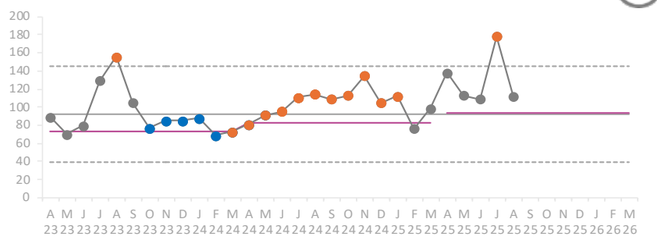
Latest
5.56%
Variance Type
Normal variation - no recent change
Mar 26 Target
≤ 5.22%
Target Achievement
Will consistently fail the target within expected variation

Metric	Summary	Action	Assurance
Vacancies (% FTE)	Vacancy rate remains high due to vacancy control measures, however this is starting to reduce as some posts are released internally only first and externally. We still have risks around our HCSW vacancies with the current vacancy rate at c 15%.	Strategies to address Band 3 Healthcare Support Worker gaps being jointly developed by nursing, education and workforce teams ncy control process updated to include defined times for holding posts for redeployment and internal/external advertising.	Vacancy rate monitored through Board reporting, Workforce Committee and Divisional Improvement Forums Safe staffing levels monitored daily in clinical areas New People Operations Group to include a focus on resourcing EQIA process utilised to support vacancy control decision-making
Turnover (% FTE)	The in month turnover was 1.47% this is above target and reflects a further increase in turnover for the last 2 consecutive months. On analysis of the 138 people who left the Trust 46% were for voluntary reasons, with the 3 highest reasons for leaving being 31% leaving to undertake further training and education, 23% for promotion and 15% for relocation. 27% of leavers were due to ends of fixed term contract and was therefore anticiapted turnover.	To explore team level retention data to trianguate to other sources of evidence to understand if teams require support to improve colleagues experience of work and career development planning. Review of national trends around retirement and apply analysis to Trust workforce model to determine what actions need to be taken. To undertake analysis of reasons for leaving in 25-29 age group and further embed stay conversation approach.	Annual Workforce Committee Report on Retention was presented at Workforce Committee in September. Undertaking the National Self Assessment for retention in November.
Sickness Absence (% FTE)	Sickness absence has reduced for the 4th consecutive month now standing at 5.56%.Case numbers for short term absence have trebled following the introduction of the new attendance management policy. Capacity remains challenged within the Workforce Advice team, due to high levels of maternity leave	Recruitment has started for 2 x B5 Workforce Advisors to cover maternity gaps in the team.Sickness absence plan continues to be progress including actions from rapid improvement event held in July.	A report was submitted to July workforce committee on sickness absence for assurance.

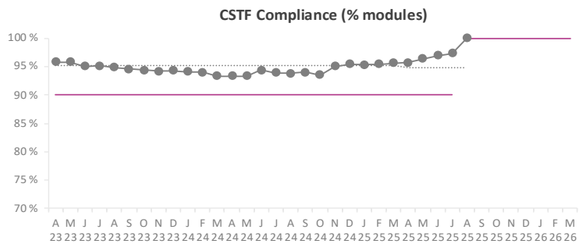
People - Workforce Assurance 2

Single Improvement Plan | Partnerships | People | Patients | Productivity | Performance

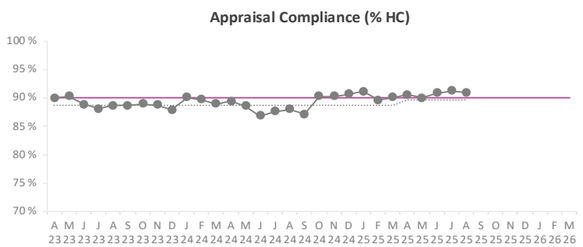
Lancashire Teaching Hospitals NHS Foundation Trust



Latest
178
Variance Type
Normal variation - no recent change
Mar 26 Target
NA
Target Achievement
Could both pass or fail target within expected variation



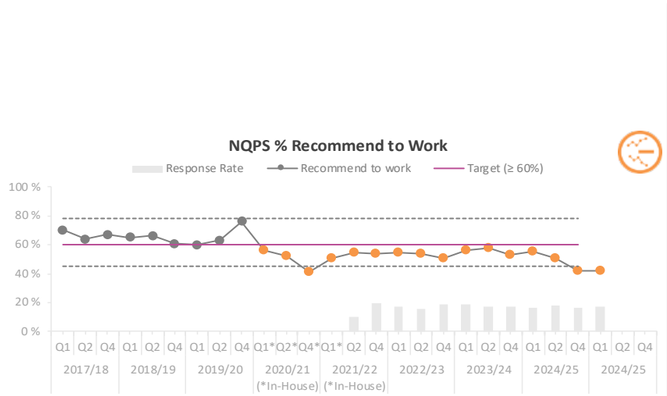
Latest
100.00%
Variance Type
Mar 26 Target
100% of metrics at 90%
Target Achievement



Latest
91.24%
Variance Type
Mar 26 Target
≥ 90%
Target Achievement

Metric	Summary	Action	Assurance
Number of violence and aggression incidents toward staff	Following a peak in July, V&A incidents after started to reduce.	Self assessment against new national Violence , Prevention and Reduction Standard will be reviewed further and improvement plan developed. Planning to move work undetaken by Big Room into Rapid Improvement Event Format.	Deep dive report on reduction plans has been submitted to workforce committee and Trust Management Board.
Core Skills Mandatory Training compliance (% modules)	Overall Trustwide Core Skills and Mandatory training compliance is 100% with all metrics now achieving the 90% target	Targeted intervention and focus has taken place for Resuscitation training, including a review of the Training Needs Analysis. Training provision has been increased and there is enhanced levels of scrutiny and reporting at divisional and professional level.	High levels of engagement at divisional level and targeted intervention is positively impacting compliance figures with all divisions demonstrating compliance in August.
Appraisal compliance (% HC)	Appraisal compliance was 91.24% in August which is above the target of 90%. The staff group with the lowest compliance is Medical and Dental at 82%, this is the last month of their appraisal window.	All Divisions and Department have received Appraisal compliance data via Workforce Business Partner and Education Compliance Teams, asking to develop plans to achieve 90%. Medical and Dental staff have been contacted about non compliance and asking for appraisals to be completed before the end of the window.	Annual Appraisal Update presented to Workforce Committee in May 2025. Divisional performance metrics shared in Divisional Workforce Committees and Divisional Improvement Forums.

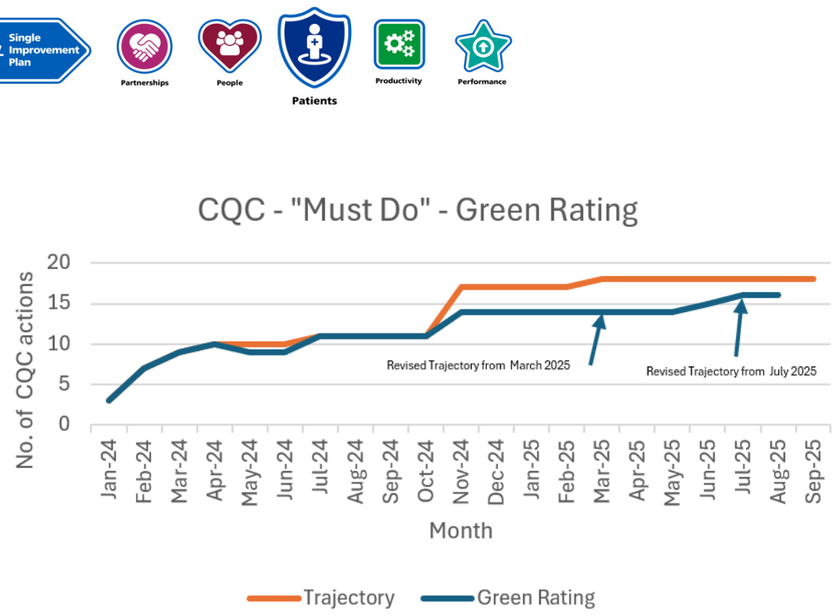
People - Workforce Assurance 3



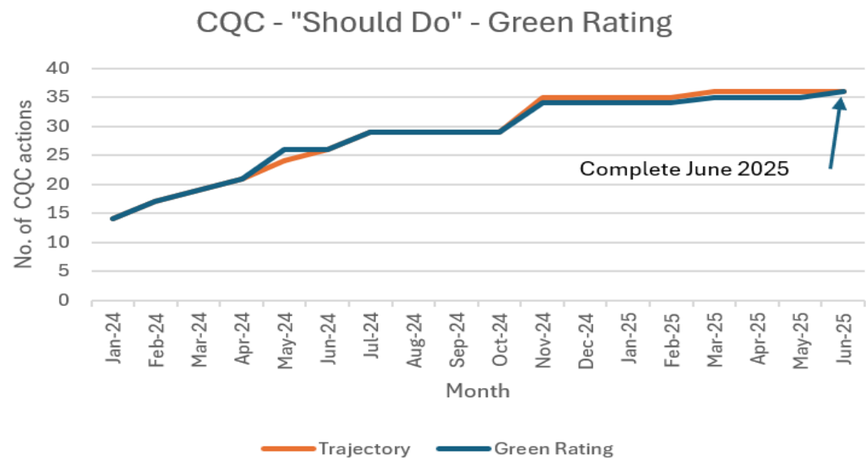
Latest
42.3%
Variance Type
Recent concerning pattern in the data
Mar 26 Target
≥ 60%
Target Achievement
Will consistently fail the target within expected variation

Metric	Summary	Action	Assurance
Staff Survey: Recommend Trust as place to work	**Please note: This is a quarterly metric; the data used for this update is from the June data set.** August: National Quarterly Pulse Survey indicated a small improvement in levels of engagement for this quater, however still below the national average. For the staff engagement question, relating to recommending the organisation as a place of work, we have seen a very small increase in this quater to 42.3% however this remains below the national average. For the question seeking colleagues views if they would recommend the organisaiton to friends and family to receive care this has remained static this quater at 49.1%.	Refreshed and tiered colleague engagement offer developed and approved via executive team members, includes a tiered approach to providing engagement opportunities, with 3 new interventions, executive lead your voice sessions, using the professional recognition days to hear from all colleagues and targeted board visits to areas which have high or low advocacy scores. Currently engaging with 18 lower scoring teams – oversight delivered through Divisional Workforce Committees via Senior Divisional Leads/ Workforce BPs and OD leads. Trust Level Action Plan circulated and 'You said we did' weekly communiations rolling out ahead of NSS25 with full communication plan developed to support response rates and engagement.	Workforce Committee reports detailing the programme of work in response to NHS Staff Survey data and national benchmarking. Delivery of the corporate action plan progressed through collaboration with relevant teams and leads addressing priorities/themes. Divisional action plans are scheduled for monthly review through Divisional Workforce Committees - frequency and depth of reporting varies across Divisions. Enhanced team support activity is ongoing in targeted areas of concern, with progress tracked and reviewed through Organisational Development operational meetings.

Patients - CQC Assurance



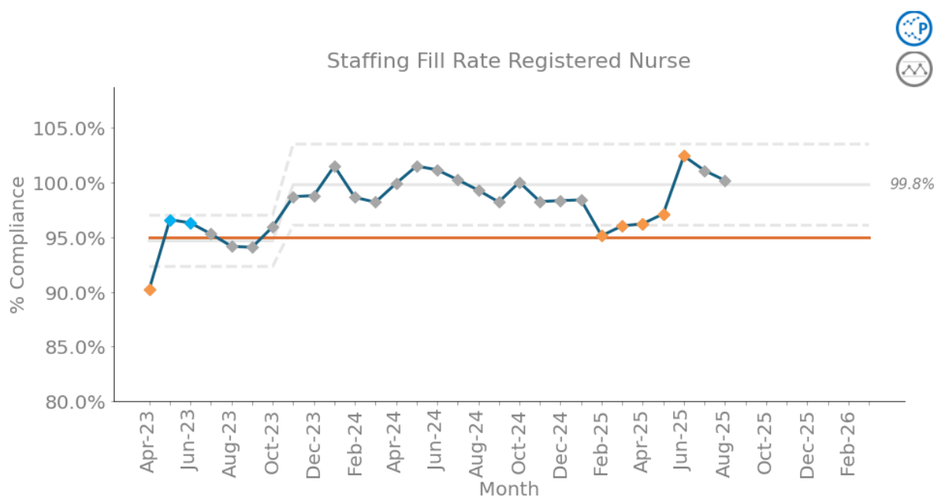
Latest
16
Month Target
16
Sept-25 Target
18



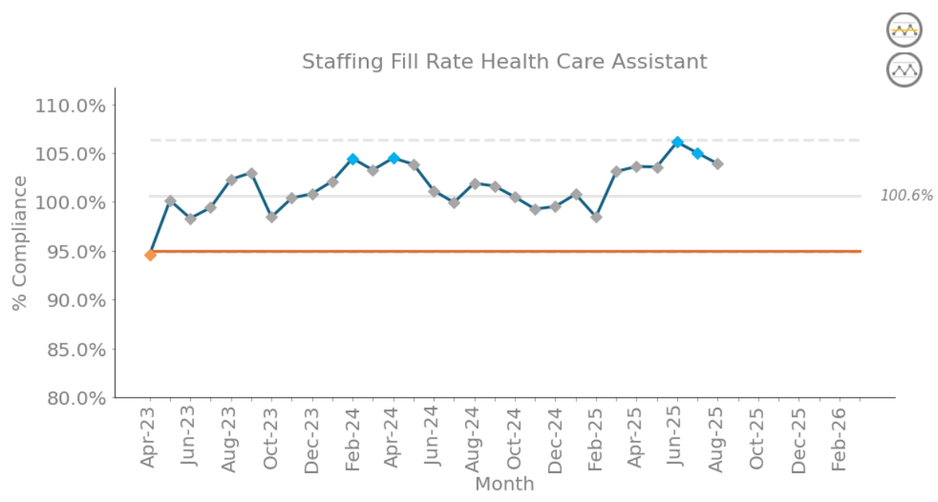
Latest
36
Month Target
36
June-25 Target
36

Metric	Summary	Action	Assurance
CQC - "Must do" (Number with Green rating)	1. At the end of August 2025, of the 'Must Do's' included in the 2023/2024 CQC Quality Improvement Plan (QIP), 52 (96%) of Must do actions are delivered. 2 (4%) actions remain 'amber-green'. 2. In relation to the two remaining 'Must Do' actions associated with training - two must do actions failed to meet the target set to be compliant by 31 July 2025 and the trajectory was re-based to the end of September 2025. This is in relation to training for Medical and Dental staff in urgent and emergency care (UEC). At the end of August 2025, both actions remain undelivered, however, improved performance continues to be observed. It is also acknowledged that medical training compliance in UEC has been impacted in August 2025 due to trained staff leaving the department. At the end of August 2025, Medical staff in UEC were compliant in 18 out of 19 training metrics and nursing staff were compliant in 19 out of 20 training metrics. Non-compliance was demonstrated in Advanced Paediatric Life Support (APLS) for medics (86%) and Moving and Handling Level 2 training for Nursing Staff (89%), other staff (73%).	1. Rates of appraisal and training: Compliance continues to be monitored monthly. 2. The trajectory for delivery of these two 'must do' actions was re-based to the end of September 2025 (data available October) to allow for the new approach to take effect. 3. Decision enacted August 2025 to initiate disciplinary action for persistent non-compliance. 4. APLS is a Resuscitation Council UK externally facilitated course. There are no APLS courses planned in September 2025, therefore alternative training is being facilitated for non-compliant staff.	1. From the 18 'Must Do' recommendations, 16 have been assessed as delivered and the themes of the 2 outstanding 'Must Do' recommendations are related to staff training compliance in urgent and emergency care. 2. There has been positive improvements with overall training compliance across the organisation. The Trust are above the target for all Core Skills subjects. 3. The Trust has recently shared communication with all staff regarding the upcoming changes to the Trust Code of Conduct and Disciplinary Procedure in relation to non-compliance with training requirements. It is anticipated that the decision to treat persistent non-compliance with training as a disciplinary matter, will support improved training compliance. 4. Nurse training compliance remains 90% or above for all resuscitation training metrics and sepsis training at the end of August 2025.
CQC - "Should do" (Number with Green rating)	At the end of August 2025, of the 'Should Do's' included in the 2023/2024 CQC QIP, 100% of should do actions remain delivered.	1. There are no outstanding 'Should Do' actions. All 'should do actions were assessed as delivered at the end of June 2025. The position remains unchanged at the end of August 2025.	From the 36 'Should Do' recommendations, 36 remain delivered at the end of August 2025.

Patients - Deliver Annual Safe Staffing Requirements Assurance



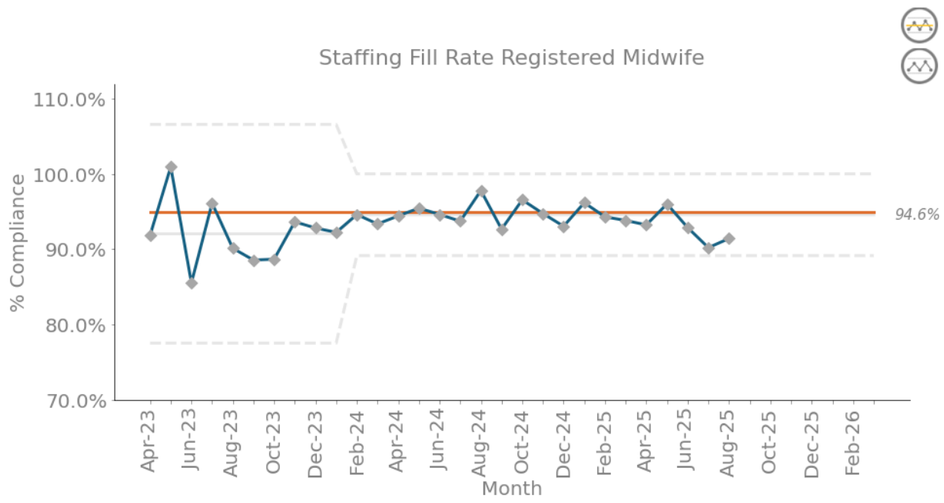
Latest
100.20%
Variance Type
Normal variation - no recent change
Mar-26 Target
95%
Target Achievement
Will consistently pass target within expected variation



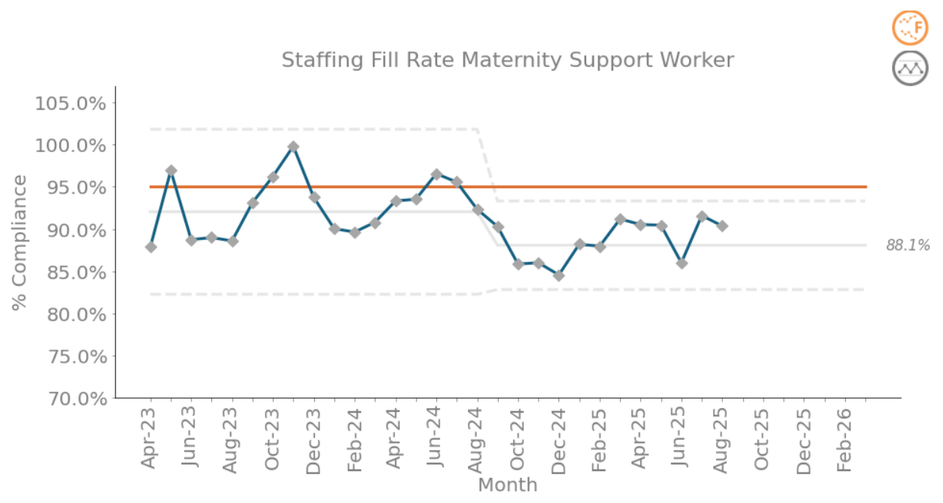
Latest
103.92%
Variance Type
Could both pass or fail target within expected variation
Mar-26 Target
95%
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
Staffing Fill Rate Registered Nurse	The RN staffing fill rate for inpatient wards in August was 100%. At site level, Chorley District Hospital (CDH) achieved a RN fill rate of 101%, while Royal Preston Hospital (RPH) reported a 100% RN fill rate. The need for bank support remains to ensure safety is maintained, with a limited number of areas still requiring agency support. The implementation of strengthened approval processes for bank and agency is in place to ensure that as a Trust we are maximising the use of our resourced while maintaining safety for our patients and staff. Redeployment of staff due to organisational change is being undertaken.	1. Ward managers work clinically as part of the clinical establishment with Matrons, if required, to support patient care. 2. Weekly roster efficiency reviews undertaken by the Divisional Nurse Leaders 3. Redeployment of staff into vacancies through organisational change and ward closers.	1. All clinical areas are showing a stable fill rate position. 2. Daily operational staffing meetings led by matrons, assess and respond to changes in pressure and demand based on acuity and dependency, Red flags and professional judgement. 3. Approval and sign off of all agency shifts undertaken by the Deputy/ Divisional Nursing Director. 4. Biannual safe staffing procedures are in place in line with National Quality Board guidance. 5. Weekly PSIRF oversight panel reviews incident harm levels, this is triangulated through a quarterly serious incident/PSIRF report. 6. Involvement in National Enhanced Theraputic Observation and Care (ETOC) improvement work.
Staffing Fill Rate Health Care Assistant	The HCA staffing fill rate for inpatient wards in August was 104%. At site level, Chorley District Hospital (CDH) scheived a HCA fill rate of 103%, while Royal Preston Hospital (RPH) reported a 104% HCA fill rate. The need for bank support remains to ensure safety is maintained. The implementation of strengthened approval processes for bank is in place to ensure that as a Trust we are maximising the use of our resourced while maintaining safety for our patients and staff	1. Weekly roster efficiency reviews undertaken by the Divisional Nurse Leaders as an interim measure following the introduction of strengthened approval processes for bank use. 2. A review of Band 2 and Band 3 roles is being undertaken inline with national role guidance. 3. Introduction of apprentiships into vacancies has commenced in the inpatient wards. 4. Redeployment of staff into vacancies through organisational change and ward closers.	

Patients - Deliver Annual Safe Staffing Requirements Assurance



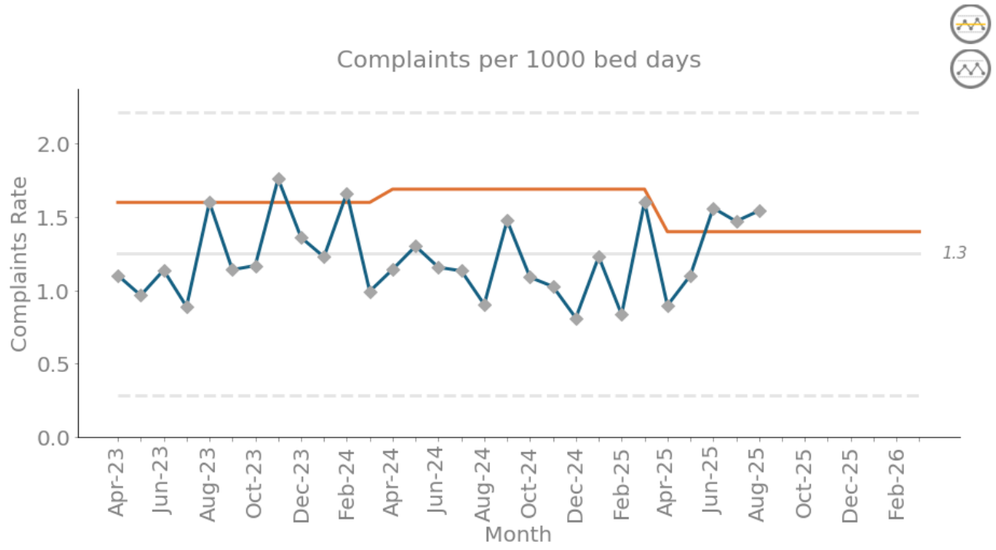
Latest
91.42%
Variance Type
Normal variation - no recent change
Mar-26 Target
95%
Target Achievement
Could both pass or fail target within expected variation



Latest
90.36%
Variance Type
Normal variation - no recent change
Mar-26 Target
95%
Target Achievement
Will consistently fail target within expected variation

Metric	Summary	Action	Assurance
Staffing Fill Rate Registered Midwife	The fill rates for Registered Midwives in August 2025 demonstrate a slight increase to 91.42%, t this is within normal variation. Recruitment to the midwifery vacancy has been completed and all posts have been offered and accepted. It is anticipated that the new starters will comence in post over the next 3 months as they enter the register or complete their notice periods. Current vacancies continue to result in bank and agency spend associated with Delivery Suite, Maternity A and B and Maternity Assessment Suite. The next BirthRate plus assessment for the service has commenced and is on track.	1. Daily Safety Huddles led by matrons respond to changes in pressure and demand based on acuity to move staff around the service as required. 2. Ward managers work clinically in addition to the 80/20 split when required during periods of high activity or reduced staffing. 3. Specialist midwives asked to provide additional clinical sessions at times of high acuity 4. Weekly roster efficiency reviews to ensure appropriate use of bank and agency.	1. Fill rates for registered midwives overall have been stable across day and night shift patterns. 2. The Safety and Quality committee review fill rate and minimum RM levels by area on a monthly basis. 3. Approval and sign off of all agency shifts undertaken by the Deputy/ Divisional Midwifery and Nursing Director. 4. Biannual safe staffing procedures are in place in line with National Quality Board guidance. 5. Weekly PSIRF oversight panel reviews incident harm levels, this is triagulated througha quarterley serious incident/PSIRF report. 6. Redflag reporting is monitored to identify areas where additional input can be provided to manage the risk.
Staffing Fill Rate Maternity Support Worker	Fill rates for MSW's is below target. Continuing long term sickness on maternity A and community services is being managed in line with the Trust Policy. However, to maintain safe staffing levels, there continues to be a requirement to use bank to backfill shifts. The implementation of the strengthened approval and oversight processes for bank approval continues to be utilised to ensure that the service is maximising efficient use of resources whilst continuing to prioritise safe care. Recruitement to vacancy is ongoing.	1. Daily Safety Huddles led by matrons who respond to changes in pressure and demand based on acuity to move staff around the service as required. 2. Weekly roster efficiency reviews to ensure appropriate use of bank. 3. Ongoing recruitment to fill all vacancies which are tracked using a local trajectory 4. Sickness management procedures reviewed by Workforce BP to ensure appropriate management. 5. Night shifts are prioritsed to ensure periods when less additional support can be accessed are staffed appropriately.	1. The Safety and Quality committee review fill rate and minimum safe staffing levels by area on a monthly basis. 2.. Approval and oversight sight of rosters is undertaken by the Deputy/ Divisional Midwifery and Nursing Director. 3. Biannual safe staffing procedures are in place in line with National Quality Board guidance. 4.. Weekly PSIRF oversight panel reviews incident harm levels, this is triagulated througha quarterley serious incident/PSIRF report. 5. Redflag reporting is monitored to identify areas where additional input can be provided to manage the risk.

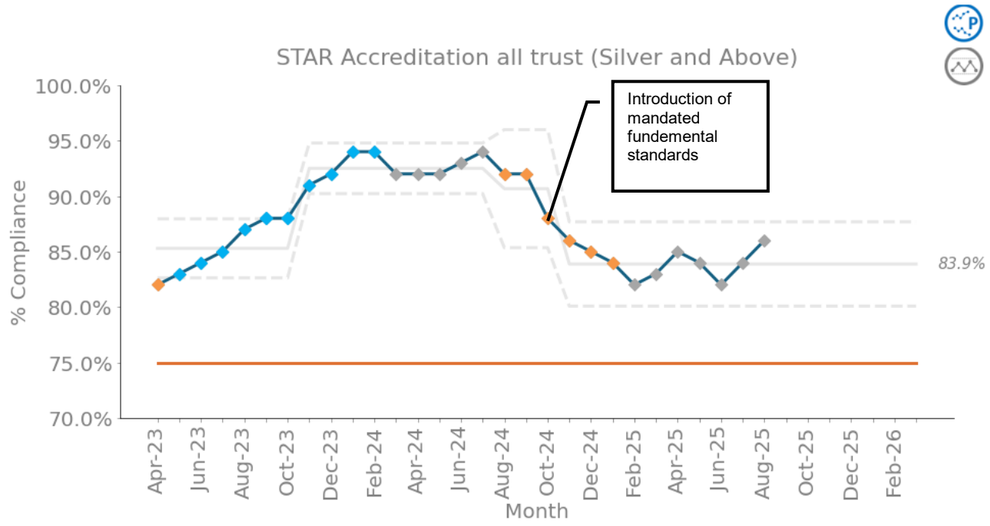
Patients - Patient Experience and Involvement Assurance



Latest
1.54
Variance Type
Normal variation - no recent change
Mar-26 Target
1.40
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
Complaints per 1000 bed days	Whilst, overall the number of complaints per 1000 beds days has demonstrated a sustained reduction. The previous quarter has resulted in higher than target numbers of complaints. This is as a result of complaint increases in the Emergency and diagnostic pathway predminantly related to waiting times and communication. Targeted efforts continue as part of the Urgent and Emergency Care (UEC) improvement plans and enhancements to inpatient pathways. Insight from the national inpatient and ED surveys have provided specific areas of focus and feedback from patients, informing immediate and longer-term actions. It is acknowledged that the UEC pathway has significant impact on the overall experience of patients, families and staff and as such remains a key priority within the Trusts patient experience improvement plan. The top themes from complaints relate to communication, delays in treatment, delays in procedures and delays in appointments.	1. Continue to deliver the Patient Experience Plans focusing on UEC and inpatients as areas that require improvement. Specifically actions in addition to the UEC operational improvement plan in this quater include; an increase in volunteers, facilities to provide support i to patients, information on waiting times and patient information on TV screens and commencement of about me boards. 2. Continue to deliver the Patient Safety Incident Response Framework with a focus on family liaison roles 3. Monitor actions agreed in relation to National Picker Surveys . 4. To deliver the PALS and local early resolution training. 5. Continue to progress the complaints review group using patient safety partners and governors 6. The SIP in September focused on strengthening the assurance regarding progress on the improvement plans for UEC and inpatients. An issue with the friends and family system has affected the ability to evalusate if efforts to date have had the desired impact on topics important to patients. THe Associate Director of patient exepereince and quality has been tasked with producing a mechanism of assurance in this area fo rthe October Patient SIP.	1. Annual patient experience reports to Safety and Quality committee. 2. Friends and family monthly reporting in place for all departments. 3. Inclusion of patient experience in STAR. 4. Chief Nursing Officer reviews all complaints and signs off responses. 5. Monitor picker survey action plans through Patient, Carer, Experience and Involvement Group.

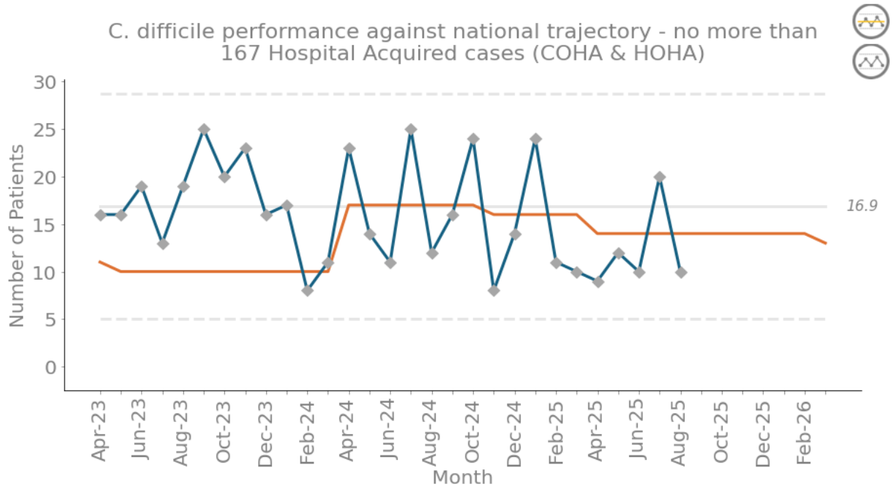
Patients - Quality Assurance STAR Accreditation



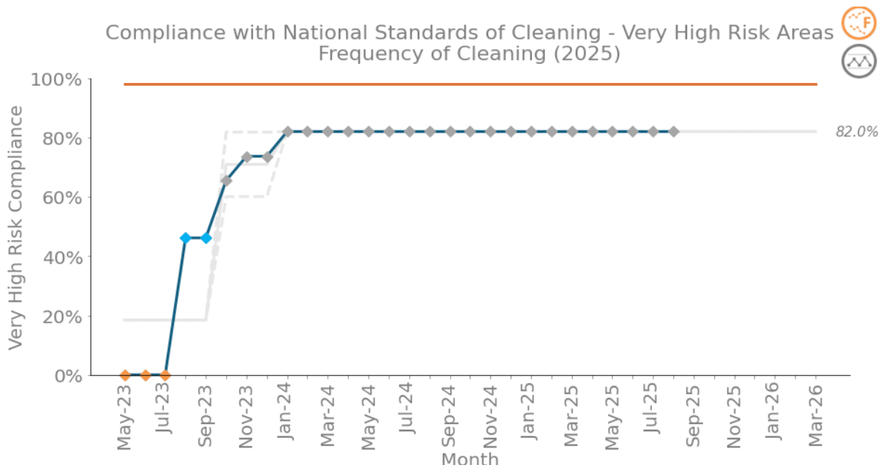
Latest
86.00%
Variance Type
Normal variation - no recent change
Mar-26 Target
75.00%
Target Achievement
Will consistently pass target within expected variation

Metric	Summary	Action	Assurance
STAR Accreditation all trust (Silver and Above)	There are 118 clinical areas registered for the STAR Quality Assurance Framework, of which all 118 have received STAR accreditation visits. There is one clinical areas with a red star rating, 15 areas with an amber rating and 102 areas rated green. This results in 16 bronze stars, 23 silver stars (of which 4 have acheived 3 consecutive silver stars and are awaiting the gold approval panel) and 79 gold stars. There are 86% of areas rated silver or above. During August, further evidence of improvement following the issuance of mandated fundemental standards in October 2024 leading to a decline in performance. There was one area with a reduced STAR rating, 3 areas had an increase to silver and others maintained their star rating. Three areas had an increased 15 steps rating from B to A, the others maintained their current rating. Themes for improvement include environmental and estate issues, infection prevention and control concerns. Recurrent themes included within the STAR action plan include patient and staff experience continue to impacted upon by boarding and overcrowding, escalation of deteriorating patients, fluid balance management, risk assessments, assessment and delivery of enhanced therapeutic observations and care (ETOC), mandatory training and IPC key standards. There are 78 % of wards, ED and theatres scoring silver and above for STAR accreditation visits.	1. Any standards which are not achieved require an improvement action which is monitored within division through divisional assurance porcesses and via STAR monthly reviews and STAR acreditation visits. 2. The monthly STAR report includes trustwide and divisional STAR data and highlights good practice, areas for improvement, themes for learning and an overarching STAR improvement action plan, which is cascaded and discussed through the divisional always safety first meetings, the always safety first learning and improvement group and estates and facilities partnership board. The STAR report includes CQC (2023) action plan standards. 3. The STAR action plan has been updated to include recurrent themes and now included learning and actions from the Safety Visits undetaken by the senior leadership teams. 4. Monthly meetings with DND, Matron & Ward/Department lead with 3 area's currently scoring a bronze rating with a supportive improvement action plan in place. Review of overdue actions tracked through 1-1's. 5. STAR monthly report updated to highlight those areas who are rated red or amber for STAR visits of less then 90% for STAR monthly reviews and includes areas ranking for their STAR performance. 6. Deep dive on monthly assurance requested for October 2025 NMAHPs board.	1. The STAR report is shared within the divisional leadership teams, good practice is shared and celebrated and that actions are developed where improvement is required. 2. Ward/department managers, matrons and professional leads provide assurance that actions are completed and monitored for effectiveness through the 1:1 with matrons and Divisional Nurse Directors. 3. The AMaT system supports with STAR audit data management and oversight and management of improvement actions. 4. There is a BI STAR page available to enable data triangulation. 5. STAR accreditation visits are scheduled depending on star rating, areas with a bronze star rating are reassessed within 3 months. 6. Proposal to NMAHP Board to drive improvements in standards including enhanced oversight and support with high quality improvement actions accepted.

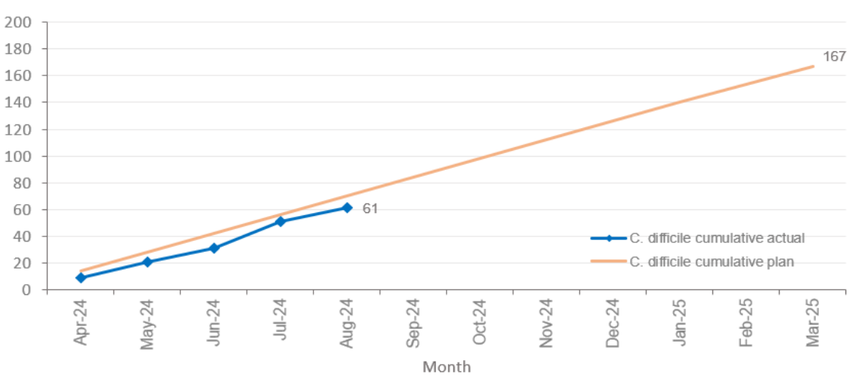
Patients - C Difficile Improvement Programme Assurance

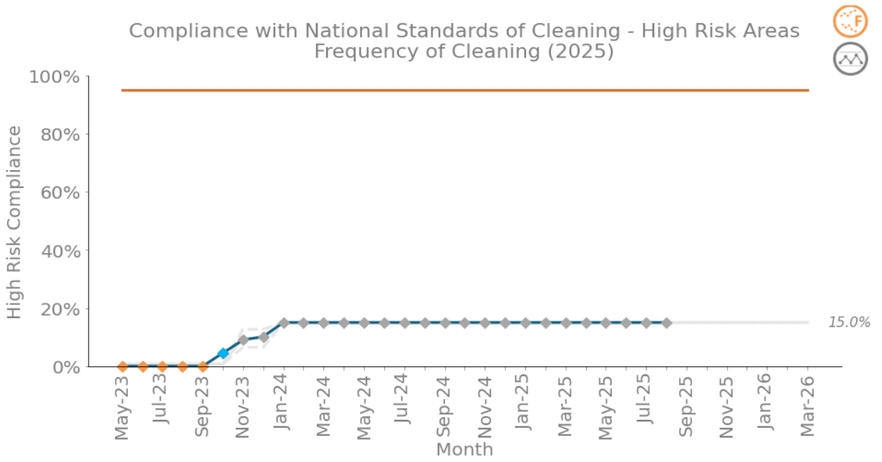


Latest
10
Variance Type
Normal variation - no recent change
Mar-26 Target
13
Target Achievement
Could both pass or fail target within expected variation



Latest
82.00%
Variance Type
Normal variation - no recent change
Mar-26 Target
98%
Target Achievement
Will consistently fail target within expected variation





Latest
15.00%
Variance Type
Normal variation - no recent change
Mar-26 Target
95%
Target Achievement
Will consistently fail target within expected variation

Metric	Summary	Action	Assurance
C. difficile performance against national trajectory - no more than 199 Hospital Acquired cases	The increase in C.difficile is a recognised high risk and forms part of the principle risks for the organisation. During August 2025 there were 10 cases for the month, continuing the trend below the objective, with a total of 61cases for 2025 / 2026 to date. The Trusts National objective for 2025/2026 is a total of 167 cases The focused work on CDI reduction and the improvement plan continues to be monitored through the Infection Prevention and Control Committee and also the Estates and Clinical Partnership Board. The National Standards of Healthcare Cleanliness (2025) for frequency of cleaning is now visible and monitored through the dashboard alongside the quality checks of those areas not yet achieving the frequency of cleaning standards. Current compliance 72% for frequency 1 areas, 38% for FR 2 area with Phase 2 implementation aimed for October.	1. Implementation of the approved business case to be compliant in high risk areas with National Standards of Healthcare Cleanliness (2025). 2. Continued focus on IPC in practice through STAR monthly and accreditation processes. 3. Continue to monitor key performance assurance indicators through Infection Prevention and Control committee.	1. IPC BAF report reviewed and shared at IPCC for assurance. 2. IPC Dashboard. 3. IPC monthly revalidation audits such as Hand Hygiene, Commodes, Environmental checks and Mattress checks. 4. Monthly reporting into S&Q, IPCC and Divisional IPC meetings, along with bi-monthly reporting into H&S Committee. 5. STAR encompasses IPC audits and cleaning checklist compliance, with all audit information available within AMAT. 6. NHS England review of IPC assurances.

Patients - Always Safety First Assurance

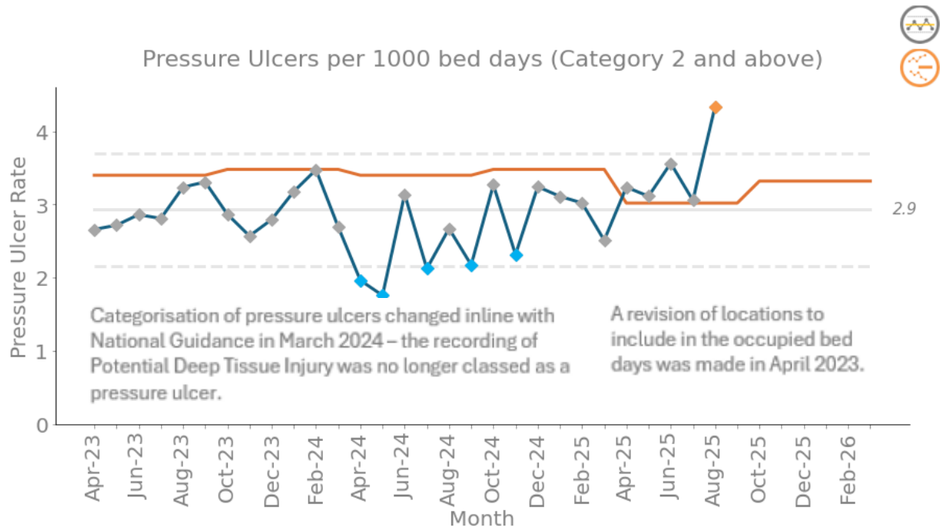
Lancashire Teaching Hospitals NHS Foundation Trust

	Achievement	Position	Month
Hospital Standardised Mortality Ratio - Adult	Lower Than Expected	63.9	April 2025
Standardised Mortality Ratio - Relative Risk - All Diagnoses Adult	Lower Than Expected	62.8	April 2025
Standardised Mortality Ratio - Relative Risk - All Diagnoses Child (<1 day – 17 yrs)	As Expected	0.0	April 2025
Standardised Mortality Ratio - Relative Risk - All Diagnoses Neonates (<1-28 Days) *The updated TELSTRA model from November 2024 does not include still births*	As Expected	0.0	April 2025

Source Data: Telstra (Dr Foster)

Metric	Summary	Action	Assurance
Hospital Standardised Mortality Ratio - Adult	HSMR is within Upper and Lower Control Limits and within the expected range compared to peer.	1. Continue with structured judgement review process. 2. Use mortality reviews to establish themes where care or experience could be improved. 3. Continue to work with the medical examiners office to review deaths in line with guidance. 4. Continue to use incident reporting processes where an incident occurs under Patient safety Incident Response Framework (PSIRF). 5. Continue to implement the 10 CNST safety actions for maternity and neonatal 6. Marthas rule (Call for Concern)implementation is underway.	1. Mortality and End of Life committee chaired by Deputy Chief Medical Officer with responsibility for mortality. 2. Twice annual reports to safety and Quality committee. 3. Telstra system utilised to generate mortality data ensuring objective peer data is used to establish reported key performance indicator. 4. Speak Up arrangements are well established in the organisation. 5. Maternity Neonatal report provides assurance of compliance with Maternity neonate Safety Investigation branch for appropriate cases. 6. The Child Death Overview process ensures peer review takes place of all child deaths and is reported through the annual safeguarding report and the mortality reporting arrangements. 7. ED and maternity and neonatal safety forums in place with executive leads identified to encourage speak up in high risk areas.
Standardised Mortality Ratio - Relative Risk - All Diagnoses Adult	SMR is within Upper and Lower Control Limits and within the expected range compared to peer.		
Standardised Mortality Ratio - Relative Risk - All Diagnoses Child (<1 day – 17 yrs)	SMR (Child <1 day -17 Years) (All Diagnoses) is within Upper and Lower Control Limits and within expected range compared to peer.		
Standardised Mortality Ratio - Relative Risk - All Diagnoses Neonates (<1-28 Days)	SMR (Neonatal <1 day -28 days) (All Diagnoses) is within Upper and Lower Control Limits and within expected range compared to peer.		

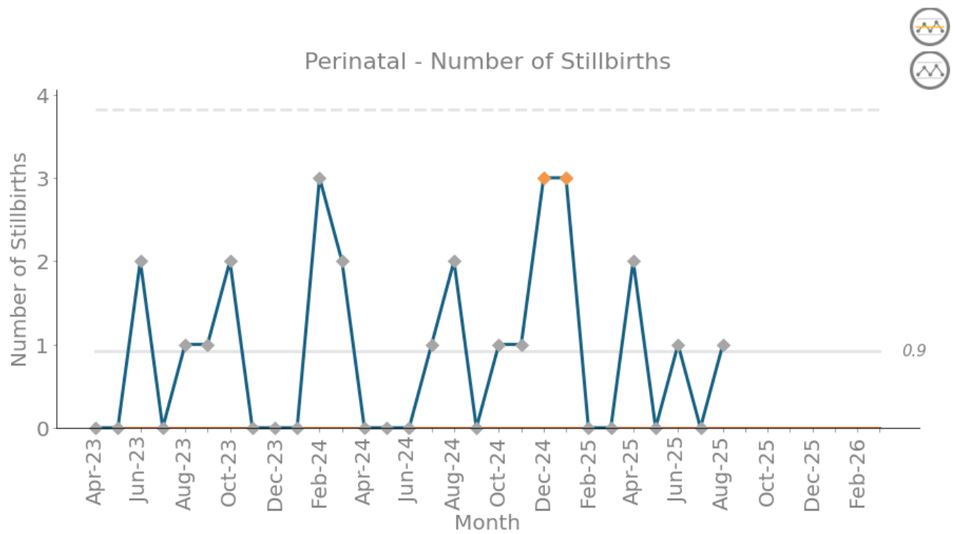
Patients - Always Safety First Assurance



Latest
4.34
Variance Type
Recent concerning pattern in the data
Mar-26 Target
3.32
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
Pressure Ulcers per 1000 bed days (Category 2 and above)	Pressure ulcers continue to be recognised as an indicator of care quality. The target line has been revised from April 2025 to reflect the average number of incidents from the previous year, rather than the three-year average used previously. The rate is stable and has, until the previous month remained within upper and lower control limits. August has shown an astronomical data point. There is a correlation noted with the length of time patients are waiting in the emergency pathway. Alongside the continued work on the UEC pathway the safety team are reviewing the equipment in use and the days kept away from home strengths based approcah is focused is aimed at reducing deconditioning in patients that lead to the development of pressure ulcers.	1. Delivery of an organisational pressure ulcer improvement action plan lead by the Deputy Chief Nursing Officer 2. Continued focus on Operational Performance Single Improvement plan. 3. STAR quality assurance fundamental standards includes intentional rounding which is linked to pressure relief interventions. 4. Education and awareness of pressure ulcer prevention is provided throughout the Trust. 5. Sharing of cross divisional learning key themes and trends at monthly divisional always safety-first meetings, 6. Quarterly review of key themes and trends from the pressure ulcer review tool completed on Datix at Alays Safety First Learning and Improvement group. 7. Test of change completed to implement strengths based approach 'Days Kept Away from Home' in 2 areas completed and will beocme normal practice. 8. Roll out of strengths based education to 16 wards by 31 October 2025. 9. Rereview of pressure ulcer preventing equipment in the emergency pathway.	1. Always Safety First strategy reporting twice yearly to safety and quality committee. 2. Always Safety First committees at divisional level responsible for overseeing the implementation of the pressure ulcer improvement action plan. 3. Monitoring of pressure ulcer incidence monthly continues to be recognised as a priority metric. 4. Monitoring of the key questions 8d and 9c in STAR Monthly.

Patients - Maternity Assurance

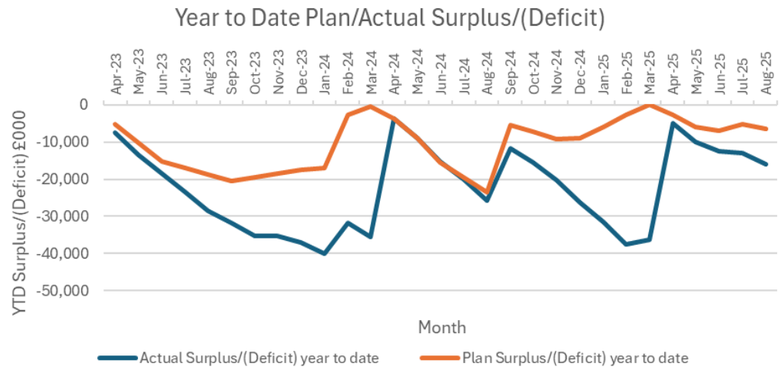


Latest
1
Variance Type
Normal variation - no recent change
Mar-26 Target
1
Target Achievement
Could both pass or fail target within expected variation

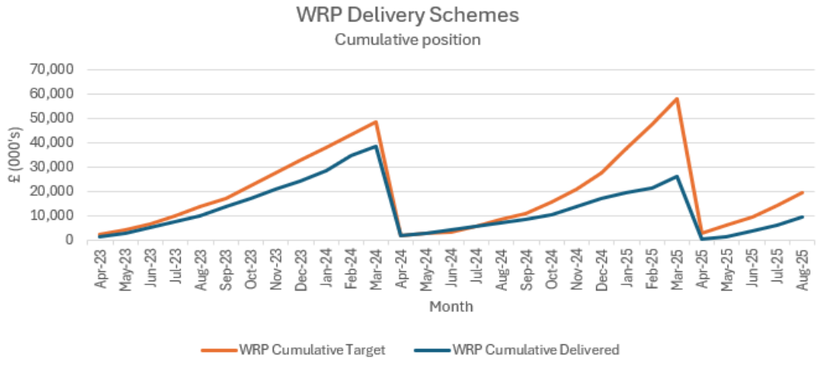
Metric	Summary	Action	Assurance
Perinatal - Number of Stillbirths	The service continues to track the rates of stillbirth and revew each case in line with nataional guidelines. There was one stillbirth in August and the rate was 2.8 per 1000. This is within normal variation for the service. The 12-month average mean (August 24-July 25) still birth rate is 3.0 per 1000 which remains below the national average of 3.9 per 1000.	1. Implementation of the 10 CNST maternity neonatal safety standards.	1. Monthly dashboard analysis shared via the maternity and neonatal safety report to safety and quality committee. 2. Peer comparison data included within the reporting 3. National MBRRACE reporting provides overview of national themes to ensure learning is understood nationally. 4. ICB Local Maternity Neonatal System validation of CNST delivery of standards.

Productivity - Assurance

Lancashire Teaching Hospitals NHS Foundation Trust



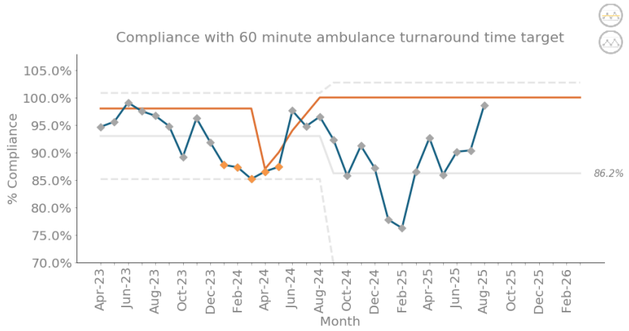
Latest YTD Actual (,000s)
-16,056
Latest YTD Target (,000s)
-6,437
March 26 YTD Target (,000s)
-



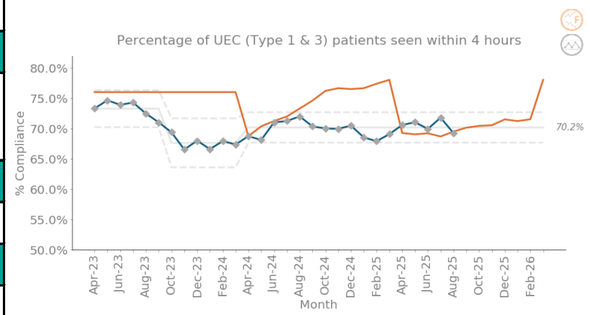
Latest YTD Actual (,000s)
9,634
Latest YTD Target (,000s)
19,231
March 26 YTD Target (,000s)
60,000

Metric	Summary	Action	Assurance
I&E - Plan v Actual variance	The Trust submitted the final financial plan to NHSE at the end of April. For 2025/26 the Trust has a break-even plan which is reliant on a recurrent waste reduction programme of £60m and non-recurrent deficit support funding of £30m. At the end of August 2025 the Trust has a deficit of £16.0m against a planned deficit of £6.4m. The adverse variance to plan of £9.6m is as a consequence of the shortfall in delivery of the Waste Reduction Programme. At the time of setting the plan the Trust had not identified the full £60m programme and the unidentified element was included in the plan in 12ths in accordance with NHSE policy. The shortfall in efficiency programme to the end of August was 9.6m. In month 4 the Trust also had additional costs of £0.4m associated with industrial action. The Trust has operational pressures in: - the acute medical pathways reflected in overspends in medical and nursing pay budgets - sickness remains higher than in operational budgets resulting in nursing pay overspends	The Trust has a Turnaround Director to work with senior leaders to re-assess the current waste reduction programme position and deep dive into short, medium and long-term opportunities. A re-set of the programme structure, governance and reporting for 2025/26 has taken place. The Trust is working with the ICB on the urgent and emergency pathway system pressures which is one of the main operational pressures that the Trust faces. The system is now receiving enhanced support from NHSE as part of the provider improvement programme (formerly recovery support programme). A focus on grip and control activities continues. The Trust has commissioned further external support to support specific financial recovery plan workstreams and 2025/26 waste recovery programme development. Divisions will need to recover their financial performance by delivering improvements in their current run rates e.g. maximising grip around temporary pay, review of vacancies and continuing to mitigate shortfalls in the efficiency target as schemes move through development and implementation stages.	Turnaround Director Working with ICB on UEC Pathway Grip and control Interventions and control measures Mandated national support from PWC and the Provider Improvement Programme (formerly Recovery Support Programme)
WRP schemes delivery	'The Trust's 2025/26 waste reduction target is £60m, 7% of operating expenditure. At the end of August the Trust has delivered £19.7m of the £60m target (33%). The delivery in month was £3.6m against a plan of £4.8m. The Trust has identified schemes and opportunities to the value of £60m however the phasing is different to the financial plan with shortfalls in the first 6 months being offset with gains in the final 6months of the year.	The Trust has a Turnaround Director to work with senior leaders to re-assess the current programme position and deep dive into short, medium and long-term opportunities. A re-set of the programme structure, governance and reporting has taken place for 2025/26. The Trust has additional external support to help with the delivery of the programme. The Trust is building up its own project management office structure to have a sustainable solution moving forward.	Turnaround Director Waste reduction programme board chaired by CEO External support for specific workstreams. Implementation of Divisional Delivery Groups Implementation of PMO

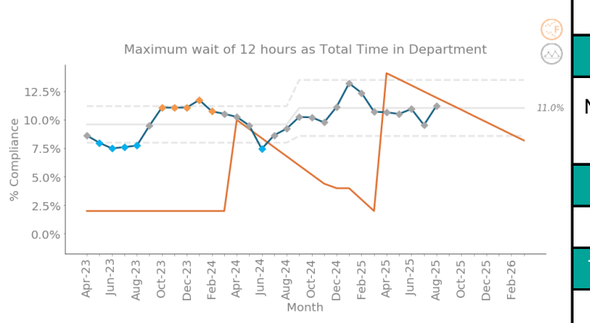
Performance - UEC Assurance



Latest
98.6%
Variance Type
Normal variation - no recent change
Mar-26 Target
100%
Target Achievement
Could both pass or fail target within expected variation



Latest
69.26%
Variance Type
Normal variation - no recent change
Mar-26 Target
78.02%
Target Achievement
Will consistently fail target within expected variation

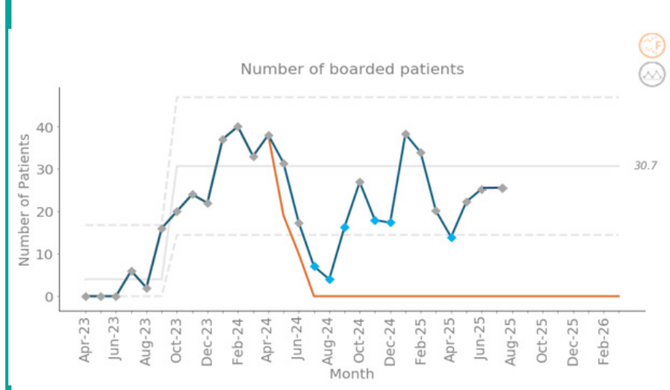


Latest
11.24%
Variance Type
Normal variation - no recent change
Mar-26 Target
8.20%
Target Achievement
Will consistently fail target within expected variation

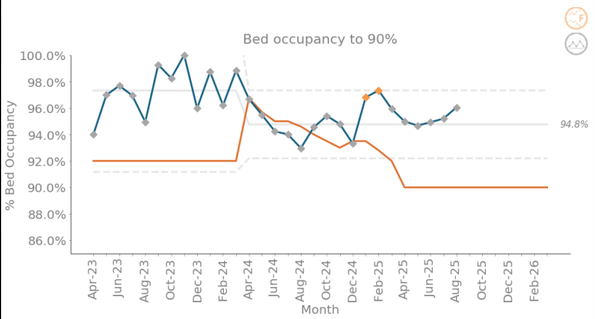
Metric	Summary	Action	Assurance
Compliance with 60 minute ambulance turnaround time target	In August 25 248 patients waited between 30-60 minutes to be handed over from NWAS to the Trust, a significant decrease of 231 from last month. 31 patients waited over 60 minute to be handed over from NWAS to the Trust in August 25, a further significant decrease of 190 compared to July. For the third consecutive month over 90% of patients were handed over within 60 minutes, a significant improvement of 8.2% compared to July 25.	Ambulance handover delays remain a high priority, and a local improvement collaborative is in place with key actions focusing on increasing NWAS to SDEC pathways. This accompanied with the improvement actions focusing on reducing LOS and NMC2R which will reduce ED Overcrowding and support more timely handover and attendance and admission avoidance actions is aimed to see improvements.	Monitoring of ambulance demand is undertaken via the weekly Ambulance handover group. Comparison to both the national and regional performance positions for August 25 indicates that the Trust is above the national performance position of 94.2% for 60 minute handovers and above the NW performance position of 97.2%.
Percentage of UEC (Type 1 & 3) patients seen within 4 hours	Performance against the national 4 hour access standard deteriorated in August 2025. The performance deterioration was 2.5% compared to July. August experienced a lower daily attend rate than July 25.	The UEC Improvement programme is focusing on measures to reduce the wait to be seen time, improving response times for patents referred to specialities and seeking to maximise referrals into SDEC. Targets have been set for each of these critical measures and is monitored via the UEC Improvement Board monthly. SDEC activity has been deteriorated in August to marginally below the 40% target (-0.4%).	The average time to triage in August decreased significantly to 13 minutes with time to treatment also decreasing significantly to 146 minutes. Comparison of 4 hour performance to the latest published national benchmarks indicates that the Trust is below the national average for August 25 of 75.9% and was ranked 14th out of Trusts in the NW Region for August 25.
Maximum of 12 Hours Total time in ED	The number of patients waiting over 12 hours (admitted and non-admitted) in ED increased in August to 11.24%, an increase of 1.7% compared to July. This follows a period of sustained and improving performance to Jul 25. The position shows normal variation and will consistently fail the year end target.	The UEC improvement programme is focusing on reducing length of stay via improving board and ward round standards and driving down the days patients spend in hospital when they no longer require inpatient care.	Overall Bed Occupancy was at 93.1% with a range between 92% - 97% over the last 12 months. The level of boarded patients remained static in August with an average of 23 patients per day. Comparison within Model Health System indicates the Trust is above the provider median and within Quartile 3.

Performance - UEC Assurance

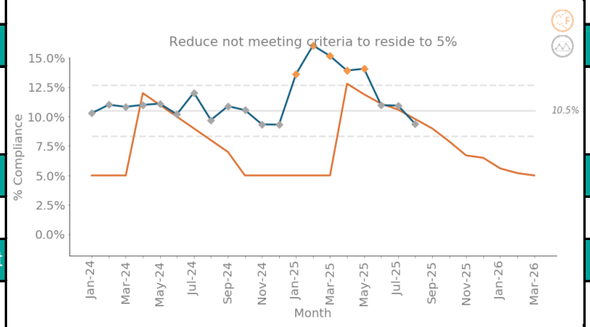
Lancashire Teaching Hospitals NHS Foundation Trust



Latest
23
Variance Type
Normal variation - no recent change
Mar 26 Target
0
Target Achievement
Will consistently fail the target within expected variation



Latest
96.1%
Variance Type
Normal variation - no recent change
Mar 26 Target
90.0%
Target Achievement
Will consistently fail the target within expected variation

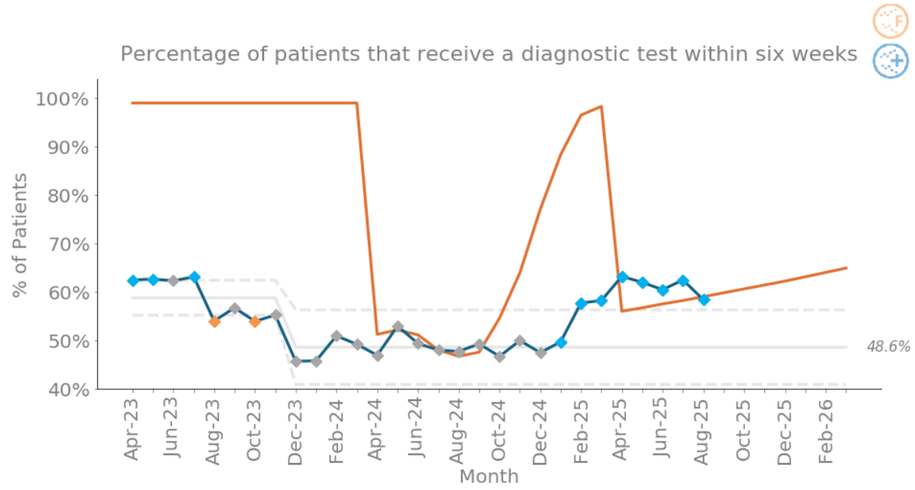


Latest
9.4%
Variance Type
Normal variation - no recent change
Mar 26 Target
5%
Target Achievement
Will consistently fail the target within expected variation

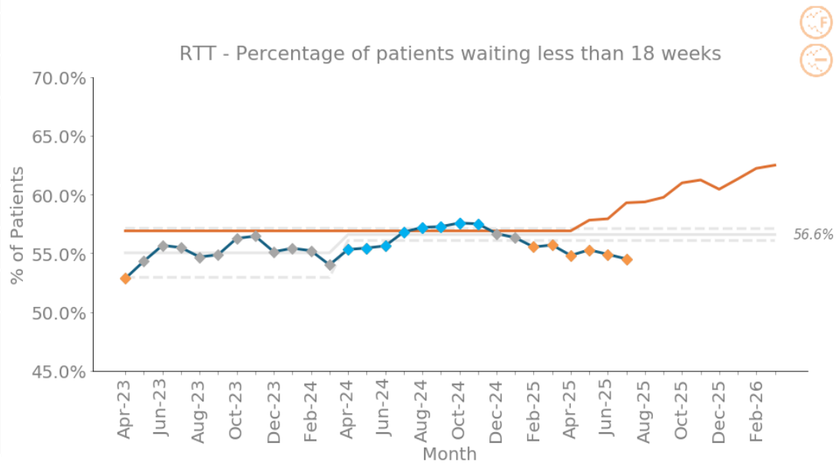
Metric	Summary	Action	Assurance
Number of Boarded Patients	On average 23 patients were boarded each day across both sites during August with 713 associated bed days. This is consistent with the July 25 position. These are predominantly medical patients requiring admission to an acute medical ward. The position shows normal variance and will consistently fail the target within expected variation.	A focus on maximising use of the discharge lounge to reduce the need for boarding. The Medical Division has re-introduced Continuous Flow Model WC 17th March 2025.	Incident levels of harm are monitored on a monthly basis alongside patient feedback. UEC and In-patient survey feedback does reflect patient concerns regarding the practice of boarding. This is also reflected within the staff survey.
Bed Occupancy	The position shows an occupancy rate for August 25 of 96.1%, a rise of 3% compared to July 25. The data shows normal variation and will consistently fail the target.	The 24/25 UEC Improvement plan continue to be tracked against its ambitions to reduce avoidable admissions and reduce LOS. A significant change to the 25/26 UEC plan has been proposed and supported by the L&SC ICB and Central Lancashire UEC Delivery Board. Plans to further scope and mobilise the 25/26 programme is underway at pace. LTH has closed a 24 bedded ward in line with its Financial Recovery Plan at the end of Feb 25.	Assurance via the Urgent Care Improvement Board and Urgent Care Improvement Plan
Reduce NMC2R	The number of patients in our hospitals that do not meet the nationally defined clinical criteria to reside for inpatient care in acute hospitals (NMCTR) decreased further in August (9.4% = daily average of 81 patients). Compared to the July position this is a decrease of 1.1%. The data shows normal variance.	The Days Kept Away from Home programme is a cornerstone of the length of stay reduction ambition within the trust. The programme seeks to significantly reduce the number and days patients spend away from home without clinical rationale. Initial monitoring of DKAFH metrics is showing reduction in care requirements on discharge and therefore a reduction in lost bed days whilst NMC2R.	Monitoring of NMC2R data is undertaken via the Central Lancs Urgent Care Delivery Board

Performance - Elective Care Assurance

Lancashire Teaching Hospitals NHS Foundation Trust



Latest
58.4%
Variance Type
Recent positive pattern in the data
Mar 26 Target
65.0%
Target Achievement
Will consistently fail the target within expected variation

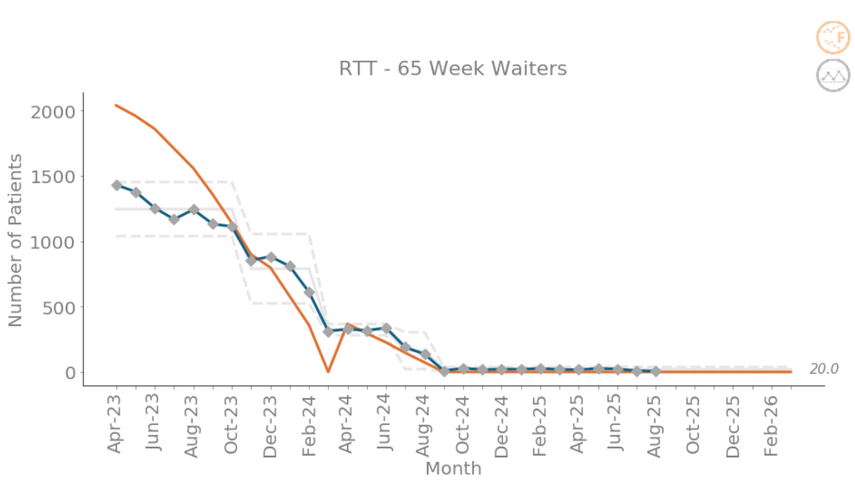


Latest
53.34%
Variance Type
Recent concerning pattern in the data
Mar 26 Target
62.50%
Target Achievement
Will consistently fail target within expected variation

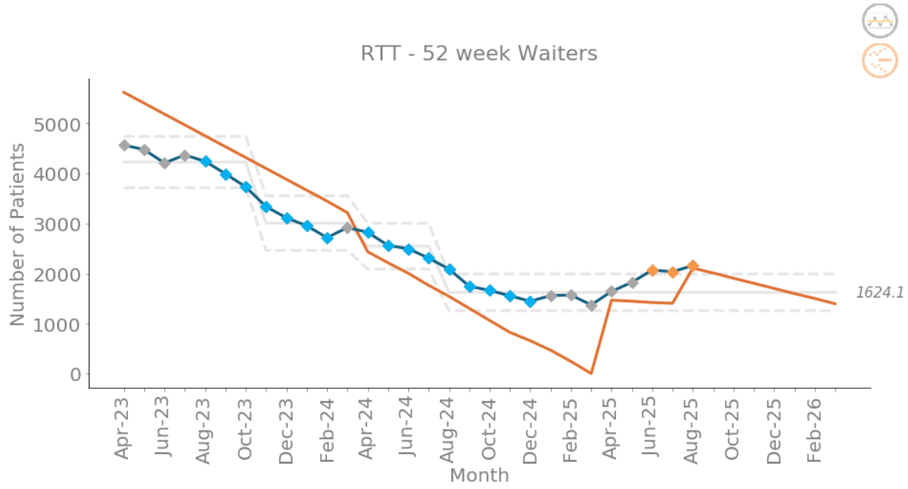
Metric	Summary	Action	Assurance
Percentage of patients that receive a diagnostic test within six weeks	Diagnostics under 6 week performance was 58.4% in August compared to 62.5% in July, a 4.1% deterioration on the July position and below trajectory. Urgent and cancer patients are prioritised and seen within 2 weeks. Performance shows a recent positive pattern in the data but may consistently fail the target.	The highest contributors of the backlog at modality level for the DM01 position are NOUS, endoscopy and echocardiography. Mutual aid has been requested for echocardiology. A rapid improvement week has been held WC 13/01/25 to support productivity improvements and reduce process barriers to support improved utilisation of the available endoscopy capacity. Actions and progress are being tracked weekly in a COO led PTL management meeting and monthly within the Diagnostic Improvement Group. Performance improvements have been achieved in CT, Audiology, Neurophysiology, sleep studies and scopes.	The areas of focus are capacity optimisation, productivity, transformation and system working. Review of the latest published data (July 25) indicates that LTH is 107th out of 117 trusts that submitted data, the worst performing Trust in the ICB and significantly below the national average of 78.1%.
Percentage of patients waiting less than 18 weeks	The proportion of patients waiting less than 18 weeks on an RTT pathway has shown a consistent position throughout 2024/25. The Operational Plan 2025/26 year end target has been set at 65%. The August 25 position of 53.34% shows a slight deterioration compared to July 25 Analysis suggests recent concerning pattern in the data and that the target may be consistently failed.	Performance is monitored at Divisional level via the Elective Performance Review Group where Issues and risks.	Comparison to the latest national performance position (July 25) indicates that the Trust is below the national position of 61.4% waiting under 18 weeks. The Trust is ranked 104 out of 118 trusts that submitted data.

Performance - Elective Care Assurance

Lancashire Teaching Hospitals NHS Foundation Trust



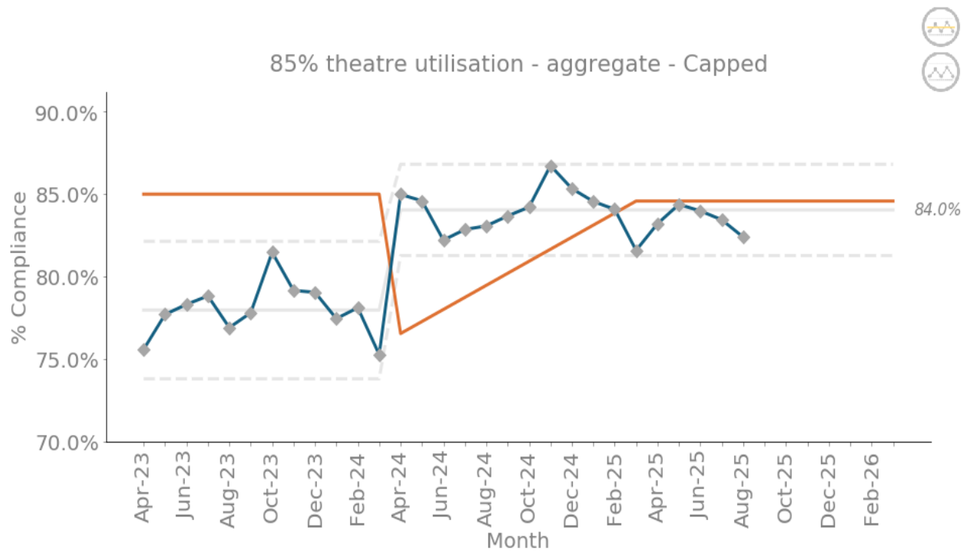
Latest
6
Variance Type
Normal variation - no recent change
Mar 26 Target
0
Target Achievement
Will consistently fail the target within expected variation



Latest
2158
Variance Type
Recent concerning pattern in the data
Mar 26 Target
1395
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
RTT - 65 Week Waiters	The over 65 week waiters position decreased further in August to 6 from 10 in July 25. Breaches are due to capacity shortfalls, equipment issues and on the day patient cancellations. There data shows normal variation, however analysis would suggest that the target may be consistently failed.	There is a process in place to ensure daily assurance of progress with >65 week waits prioritising and ensuring the sustained elimination of >78 week waits. Issues and risks are reviewed at the Elective Performance Review Group.	Monitoring of all premium cost activity is ongoing. Capacity & Demand modelling analysis is being concluded in line with the 25/26 annual planning process. Comparison to the latest NW region position indicates that the Trust is currently 12th out of all acute and specialist trusts and 6th out of acute Trusts in terms of the number in the 65 week waiter cohort.
RTT - 52 week Waiters	The proportion of patients on an RTT pathway waiting over 52 weeks was 3.3%, a slight increase of 0.15% compared to July. The Operational Plan 2025/26 year end target has been set at 2.5%.	Capacity & Demand modelling is to be undertaken for all specialities and sub specialities. Focus on DNA reduction, PIFU and theatre utilisation is ongoing to maximise capacity.	Comparison to the latest national performance position (July 25) indicates that the Trust is above the national picture which is 2.6% waiting over 52 weeks. The Trust is ranked 85 out of 118 trusts that submitted data.

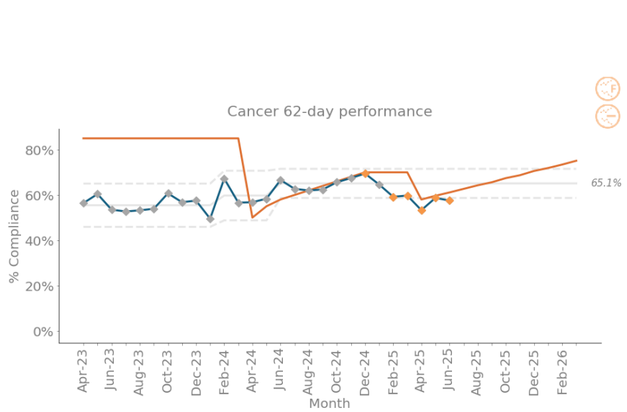
Performance - Theatre Utilisation



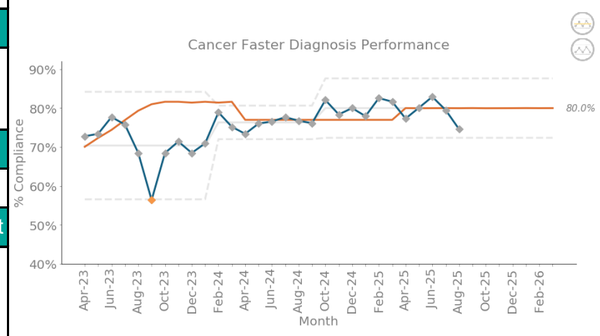
Latest
82.4%
Variance Type
Normal variation - no recent change
Mar 26 Target
84.6%
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
85% theatre utilisation - aggregate - Capped	Performance throughout 24/25 has been positive with regards theatre utilisation however a deterioration has been noted in 2025/26 due to pressures within the HSDU provision.	An assessment of process within HSDU has been undertaken by the Continuous Improvement team with benchmarking via other similar units. Further improvement plans are in development with close monitoring of performance metrics.	Improvements in theatre utilisation are monitored through the Divisional Improvement Forums with a focus on capped and uncapped utilisation rates, levels of cancellations, late starts and early finishes. Theatre data is also submitted to Model Health for national analysis.

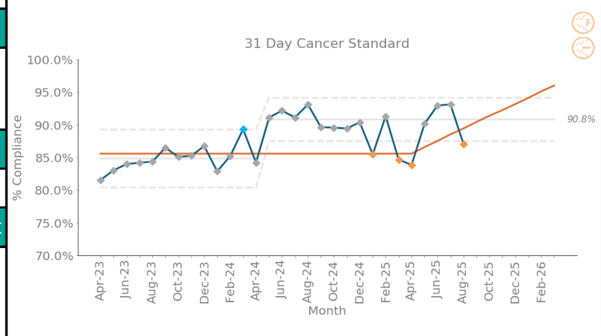
Performance - Cancer Assurance



Latest
63.5%
Variance Type
Normal variation - no recent change
Mar 26 Target
75.1%
Target Achievement
Will consistently fail target within expected variation



Latest
74.6%
Variance Type
Normal variation - no recent change
Mar 26 Target
80%
Target Achievement
Could both pass or fail target within expected variation



Latest
87.1%
Variance Type
Normal variation - no recent change
Mar 26 Target
96.0%
Target Achievement
Will consistently fail target within expected variation

Metric	Summary	Action	Assurance
Cancer 62-day performance	Performance to the end of August 25 (currently unvalidated and expected to meet the target) is below last month, and marginally below the monthly operational plan target of 64.3%, however is expected to achieve the target once validation is complete. Analysis shows normal variation in the data and will consistently fail the target.	Whilst Cancer performance is improving there are a small number of tumour groups with the greatest collective contribution to current performance challenges, these are Colorectal, Lung and Urology. All tumour sites have improvement plans to achieve performance targets.	The Trust is currently below the latest national average performance of 69.2% (July 25). Close monitoring of cancer PTLs are undertaken at fortnightly Performance Recovery Group
Cancer Faster Diagnosis Performance	Performance to the end of August 25 (**currently unvalidated**) is below last month, and below the monthly operational plan target of 80%. Analysis shows normal variation in the data and could both pass and fail the target.		The Trust is currently below the latest national average performance of 76.6% (July 25). Close monitoring of cancer PTLs are undertaken at fortnightly Performance Recovery Group
31 Day Cancer Standard	Performance to the end of August 25 (currently unvalidated and expected to meet the target) is below last months position, and below the monthly operational plan target of 89.4%, and is expected to improve once validation is complete. Analysis shows normal variation in the data and will consistently fail the target.		The Trust is currently below the latest national average performance of 92.4% (July 25). Close monitoring of cancer PTLs are undertaken at fortnightly Performance Recovery Group

BREAK

11.20am

11. GREAT PLACE TO WORK (WORKFORCE, EDUCATION AND RESEARCH)

11.1 WORKFORCE COMMITTEE CHAIR'S REPORT

Other | K Deeny | 11.35am

Item for assurance

REFERENCES

Only PDFs are attached

11.1 - Chairs Report WFC 9 Sept.pdf

Chair's Report to Board		
Chair: Adrian Leather	**Workforce Committee**	
Date(s): 9 September 2025	**Agenda attached for information**	✓

Strategic Risks	trend	Items Recommended for approval
People: Be a Great Place to Work – current score 16	→	**GMC Revalidation Report (Medical Appraisal Report)**

ALERT

Areas of concern; Matters requiring urgent attention; Insufficient assurance received.

- **Workforce Team Capacity:** Ongoing capacity limitations were impacting the collection and analysis of data, particularly concerning violence and aggression trends, which had implications for providing assurance to the Committee.

  The Committee discussed the dynamic between the Trust and One LSC regarding service delivery and the need for board-level escalation. Risks had been raised with the Head of People at One LSC and were being reviewed by CSEC (Central Services Executive Committee) to authorise recruitment.

- **Fragile Services:** The Committee noted emerging risks in short, medium, and long-term specialist skills within fragile services.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- **Strategic Risk Register:** The Committee noted a reduction in the number of high-scoring risks from 10 to 8, which was considered a positive development.
- **Violence and Aggression Strategy:** It was agreed that the Board would be advised of the risks identified in the report and the intention to address them through the Single Improvement Plan and communications plan, supported by project officer capacity and executive team backing.
- **Workforce Trends:** Concerns were expressed regarding the most common reason for leaving being work-life balance with Estates team showing high turnover.

ASSURE

Assurance received; Matters of positive note.

- **Psychological Support Service:** Assurance was provided that the service was scheduled to come on stream in October, despite concerns about delay.
- **Workforce Reduction Plan:** Confidence was expressed in the actions and mitigations in place to deliver the workforce reduction profile as planned.
- **GMC Revalidation:** Assurance was provided on the successful completion of appraisals and the robustness of the revalidation process.
- **Onboarding and Retention:** The Committee acknowledged the positive cultural impact within the Women and Children's division, noting that the work undertaken had made a tangible difference.

Workforce Committee

9 September 2025 | 1.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	a) Chair and quorum b) Temporary recording of meeting	1.00pm	Verbal	Information	A Leather
2.	Apologies for absence	1.01pm	Verbal	Information	A Leather
3.	Declaration of interests	1.02pm	Verbal	Information	A Leather
4.	Minutes of the previous meeting held on 8 July 2025.	1.03pm	✓	Decision	A Leather
5.	Matters arising and action log	1.05pm	✓	Decision	A Leather
6.	Strategic Risk Register	1.10pm	✓	Assurance	S Regan
7. PERFORMANCE					
7.1	People Accountability Oversight Framework	1.15pm	✓	Assurance	K Downey
7.2	Financial Recovery / Workforce Reduction Update	1.35pm	✓	Assurance	K Downey
8. TO DELIVER A RESPONSIVE, FUTURE FOCUSSED AND ENABLING SERVICE					
8.1	Fragile Services Report	1.45pm	✓	Assurance	K Downey
9. TO BE INCLUSIVE AND SUPPORTIVE					
9.1	Annual Violence and Aggression Report	1.55pm	✓	Assurance	R O'Brien
10. TO BE WELL LED					
10.1	GMC Revalidation (Medical Appraisal) Report	2.10pm	✓	Assurance	G Skailes
11. TO ENGAGE, RETAIN, REWARD AND RECOGNISE					
11.1	Annual Onboarding and Retention Strategy Report	2.15pm	✓	Assurance	L Graham
12. GOVERNANCE AND COMPLIANCE					
12.1	Strategic Risk Register Review	2.25pm	Verbal	Decision	A Leather

№	Item	Time	Encl.	Purpose	Presenter
12.2	Items to alert, assure, advise to the board or items or referral to/from other committees	2.40pm	Verbal	Information	A Leather
12.3	Reflections on the meeting	2.45pm	Verbal	Assurance	A Leather
13.	ITEMS FOR INFORMATION				
13.1	Chairs' Reports from Feeder Groups/Workstreams a) Temporary Staffing Group		✓		
13.2	Date, time, and venue of next meeting: *11 November 2025, 1.00pm via Microsoft Teams*	2.50pm	Verbal	Information	A Leather

11.2 *GMC REVALIDATION REPORT (MEDICAL APPRAISAL REPORT)

Decision Item | S Canty | 11.45am

*Exec summary only as part of board papers pack. Detailed report to be included in a separate ancillary pack

REFERENCES

Only PDFs are attached

11.2 - NW FQAI Annual Medical Appraisal and Revalidation Report Exec Summary.pdf

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

2024-2025 Annual Submission to NHS England Northwest: Framework for Quality Assurance and Improvement

Report to:	Board of Directors	**Date:**	2 October 2025
Report of:	Chief Medical Officer	**Prepared by:**	D Kellett and L Eccles

Purpose of Report					
For assurance	☐	**For decision**	☒	**For information**	☐

Executive Summary:

This is a national submission and has to follow the template provided by NHS England North West and must be submitted to them by the 31st October 2025 with the signed statement of compliance.

This purpose of this report is to set out the information and metrics that a designated body is expected to report upwards, through their Higher-Level Responsible Officer (HLRO), to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

On the last day of the reporting period the number of doctors with a prescribed connection was 821. 779 of these were due an appraisal in the reporting period and 100% of these were completed. There were 34 doctors who were “approved missed” due to reasons of long-term sickness, career break and parental leave. There were 8 doctors who were not due an appraisal in the reporting period.

The total number of revalidation recommendations submitted to the General Medical Council (GMC) was 178, out of these there were 153 positive recommendations and no late recommendations. There were 25 deferrals and no non-engagers. The number of deferrals was roughly equivalent in number to the 2023-24 year, however as there were more recommendations submitted during this reporting period therefore the percentage of deferrals has reduced from 18% to 14%. Of the 25 deferred, all were due to insufficient evidence. 8 of these were due to interrupted practice such as long-term sickness, maternity leave or periods of no employment meaning there was insufficient appraisal evidence and/or 360 feedback.

An update on all actions identified in last year’s annual submission has been undertaken and is detailed within the report, these include the review and update of the medical appraisal policy, streamlining of process to transfer information between Responsible Officers for doctors joining and leaving the Trust, reinstatement of the appraisal quality assurance programme and embedding Good Medical Practice 2024 in appraisal. In addition ensuring 360 feedback is started 2 years prior to revalidation and constant monitoring of this has been implemented to ensure deferrals for this reason are reduced.

Further actions for the next year have been identified and include inclusion of Physician Assistants (PAs) and Physician Assistants in Anaesthesia (PAAs) in the medical appraisal process, peer review in 2026, review of

bank workers and consideration regarding setting a minimum clinical activity standard to enable the Chief Medical Officer to act as Responsible Officer on behalf of the Trust as a Designated Body.

It is recommended that:

I. The board review this report for assurance.
II. The CEO signs the statement of compliance (section 4), this document to be returned to NHS England.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☐	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☐	Great Place To Work	☐
To drive health innovation through world class education, teaching and research	☒	Deliver Value for Money	☐
		Fit For The Future	☒

Previous consideration

12. CONSISTENTLY DELIVER EXCELLENT CARE (SAFETY AND QUALITY)

12.1 SAFETY AND QUALITY COMMITTEE CHAIR'S REPORT

Other | K Deeny | 11.55am

Item for assurance

REFERENCES

Only PDFs are attached

12.1 - Chair's report - Safety and Quality Committee - 25 July 2025 & 29 August.pdf

Chair's Report to Board		
Chair: Non-Executive Director Dr Karen Deeny	Safety and Quality Committee	
Date: 25 July & 29 August 2025	Agenda attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	Trend	Items Recommended for approval
Consistently Deliver Excellent Care	→	• The Mid-Year Nursing and Midwifery Workforce Review Report were recommended for Board approval at the July Committee meeting. • The Annual Mortality Report was recommended for Board approval at the June Committee meeting

ALERT **Areas of concern; Matters requiring urgent attention; Insufficient assurance received.**	**Children in unsuitable settings: The Committee agreed to alert the Board to concerns regarding children being placed in unsuitable settings and the urgent need to explore opportunities for systemic change in collaboration with external partners. The Committee was informed of plans to strengthen internal and partner processes to support improved management of the circumstances when they occurred. The Committee was also made aware of a plan to commission a joint health and social care residential setting to reduce the number of children placed in unsuitable settings in Lancashire. The commissioning of this remains to be finalised between LCC and the ICB.**
ADVISE **Areas requiring on-going monitoring; Limited assurance received.**	**The Pharmacy Aseptic Service risk score had increased. The current temporary facility was ageing, not fully compliant with national standards and required refurbishment by 2027, Capital funding remained unsecured; a gap analysis had been completed, and discussions were ongoing within the capital planning forum and across the system with other organisations in similar positions.** **As of 30th June 2025, a total of 31 Clostridium Difficile cases had been reported. Given the national objective for 2025/2026 was a total of 167 cases the Trust was currently within trajectory as June's data had continued the positive trend and sustained monthly reduction since February 2025.** **The Committee discussed concerns around the boarding of patients and the impact on both the patient experience and staff. It was acknowledged that cultural change and operational adjustments to the continuous flow model would take time to embed.** **The Committee endorsed the Trust's proactive response to NHS England's national maternity and neonatal review. While not named in the review, the Trust was progressing a culture review led by the Deputy Chief People Officer. Focused work on health inequalities and harm reporting would continue.**

	Assurance was received on clinical prioritisation and harm mitigation for Endoscopy. Performance and capacity actions remained ongoing, with an update expected in August. Oversight of the recovery plan and business case would be reported through to the Finance & Performance Committee. **Following the MIAA audit outcome, the Health and Safety Governance meetings had moved to a monthly schedule. Work was progressing towards a strengthened team structure to support the health and safety function. The health and safety programme had been incorporated into the single improvement plan to enhance its impact.** **Principal Risk target review: Further consideration would be given to the target risk score for patient experience within the Emergency Department with a recommendation to be provided for Board discussion as part of the risk report for next Board.** **High Temperature impact: The Committee noted that heat-related pressures experienced by colleagues and patients during the summer months. Progress against these would be monitored through Estates and Emergency Preparedness Resilience and Response processes and reported to the Finance and Performance Committee. Further consideration however, would be given to Trust-wide effects.** **Safe Staffing: The need for a broader review of clinical groups not currently captured in safe staffing reports was discussed by the Committee. It was agreed further consideration would be given to physician and anaesthetic assistants, healthcare scientists and psychologists as part of safe staffing reports.** **Regulation 28 – mechanical thrombectomy: The Committee discussed the response to the coroner regarding the regulation 28 issuance. A further update was scheduled for October to ensure the plan associated with this would be enacted in line with expectations.**
ASSURE **Assurance received; Matters of positive note.**	**The committee received assurance reports relating to:** **Strategic Risk Report** **Mid-year Adult and Children Safe Staffing Report** **Maternity and Neonatal Report inclusive of NHSE request of Boards Maternity and Neonatal Care** **CQC Quarterly Update** **Annual Mortality Report** **Clinical Harm Report – Endoscopy Assurance** **Annual Quality Account** **Medical Device Assurance Report** **Annual STAR Report** **Equality & Quality Impact Assessment Report**

	Quarterly PSIRF Update **Clinical Audit and Outcome Report** **Annual Pathology Report** **Annual AHP Staffing Report** **Annual Civil Claims Report** **CQC Radiotherapy Inspection Report** **The reports provided an overview of areas of strength and areas that required continued focus.** **The Children and Young People report provided the Committee with clear visibility on the care provision for children and young people within the organisation.** **The Committee endorsed the mid-year adult and children safe staffing review and supported the proposed staffing model changes from a patient safety perspective, which were subject to financial approval.** **The Maternity and Neonatal Report provided assurances of the safety and quality standards within the maternity service.** **Of the 54 Care Quality Commission recommendations, 51 have been delivered, with the remaining three training-related actions on track for completion by end of July. Core mandatory training is meeting trajectory, with full compliance confirmation expected in early August. Notable improvements included fluid balance documentation and compliance with medical outlier reviews, both supported by audits.** **The Medical Device Assurance Report, the Quality Account and the Annual STAR Quality Assurance report were scrutinised by the Committee that confirmed it was assured of the robust processes within the organisation.** **CQC Radiotherapy: The CQC Radiotherapy Inspection Report confirmed an outcome of zero recommendations following the inspection. This was noted as an exceptional achievement for the Trust, reflecting the high standards of leadership and operational delivery within the radiotherapy service. The inspection, which involved detailed scrutiny due to the nature of radiation services, demonstrated full compliance and excellence across all areas assessed.** **PSIRF quarterly report: The Committee received the PSIRF quarterly report noting the continued approach to strengthening PSIRF principals across the organisation including the overall improvement in duty of candour compliance and the continued focus on the management of incidents.**

Safety and Quality Committee

25 July 2025 | 11.00am | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	11.00am	Verbal	Information	K Deeny
2.	Apologies for absence	11.01am	Verbal	Information	K Deeny
3.	Declaration of interests	11.02am	Verbal	Information	K Deeny
4.	Minutes of the previous meeting held on 27 June 2025	11.03am	✓	Decision	K Deeny
5.	Matters arising and action log	11.05am	✓	Decision	K Deeny
6.	Strategic Risk Register	11.10am	✓	Assurance	S Regan
7.	QUALITY AND PERFORMANCE				
7.1	Safety and Quality Dashboard	11.20am	✓	Assurance	C Gregory
7.2	Mid-year Adult and Children Safe Staffing Report	11.30am	✓	Assurance	C Gregory
7.3	Maternity and Neonatal Report inclusive of NHSE request of Boards Maternity and Neonatal Care	11.40am	✓	Assurance	E Ashton
7.4	CQC Quarterly Update	11.50am	✓	Assurance	S Regan
7.5	Clinical Harm Report – Endoscopy Assurance	12.00pm	✓	Assurance	D O'Mahoney
7.6	Annual Quality Account	12.10pm	✓	Decision	S Morrison
7.7	Medical Device Assurance Report	12.20pm	✓	Assurance	S Morrison
7.8	Annual STAR Report	12.30pm	✓	Assurance	C Gregory
8.	GOVERNANCE AND COMPLIANCE				
8.1	Equality & Quality Impact Assessment Report	12.40pm	✓	Assurance	S Morrison
8.2	Strategic risk register review	12.50pm	Verbal	Decision	K Deeny
8.3	Items to alert, advise or assure the Board.	12.55pm	Verbal	Information	K Deeny
8.4	Reflections on the meeting	1.00pm	Verbal	Assurance	K Deeny

№	Item	Time	Encl.	Purpose	Presenter
9.	ITEMS FOR INFORMATION (matters to be raised by exception)				
9.1	**Chairs' reports from feeder groups**: a) Infection, Prevention and Control Committee b) Safeguarding Board c) PSIRF Oversight Group d) Medicines Governance Committee e) Patient Experience and Involvement f) Health Inequalities Group – not received g) Health and Safety Governance		✓		
9.2	Board Briefing – CQC Planned Engagement visit		✓		
9.3	Date, time and venue of next meeting: *29 August 2025, 11.00am, Microsoft Teams*	1.05pm	Verbal	Information	K Deeny

Safety and Quality Committee

29 August 2025 | 11.00am | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	11.00am	Verbal	Information	K Deeny
2.	Apologies for absence	11.01am	Verbal	Information	K Deeny
3.	Declaration of interests	11.02am	Verbal	Information	K Deeny
4.	Minutes of the previous meeting held on 25 July 2025	11.03am	✓	Decision	K Deeny
5.	Matters arising and action log	11.05am	✓	Decision	K Deeny
6.	Strategic Risk Register	11.10am	✓	Assurance	E Holden
7.	QUALITY AND PERFORMANCE				
7.1	Safety and Quality Dashboard	11.20am	✓	Assurance	C Gregory
7.2	Children and Young People Report	11.30am	✓	Assurance	S Morrison
7.3	Quarterly PSIRF Update	11.40am	✓	Assurance	H Ugradar
7.4	Clinical Audit and Outcome Report	11.50pm	✓	Assurance	H Ugradar
7.5	Annual Pathology Report	12.00pm	✓	Assurance	D O'Brien
7.6	Annual AHP Staffing Report	12.10pm	✓	Assurance	C Granato
8.	GOVERNANCE AND COMPLIANCE				
8.1	Regulation 28 – Response to Coroner	12.20pm	✓	Assurance	D O'Brien
8.2	Annual Civil Claims Report	12.30pm	✓	Assurance	S Kukadia-Fielding
8.3	CQC Radiotherapy Inspection Report	12.45pm	✓	Assurance	S Morrison
8.4	Strategic risk register review	12.55pm	Verbal	Decision	K Deeny
8.5	Items to alert, advise or assure the Board.	1.00pm	Verbal	Information	K Deeny
8.6	Reflections on the meeting	1.05pm	Verbal	Assurance	K Deeny

№	Item	Time	Encl.	Purpose	Presenter
9.	ITEMS FOR INFORMATION (matters to be raised by exception)				
9.1	Board Briefing – CQC Mental Health Act Visit		✓		
9.2	**Terms of Reference:** **a)** Infection, Prevention and Control Committee **b)** Safeguarding Board **c)** PSIRF Oversight Panel		✓		
9.3	**Chairs' reports from feeder groups**: a) Infection, Prevention and Control Committee b) Safeguarding Board c) PSIRF Oversight Panel d) Medicines Governance Committee e) Patient Experience and Involvement f) Health Inequalities Group g) Mortality and End of Life Care Committee h) Health and Safety Governance – no meeting		✓		
9.4	Date, time and venue of next meeting: *26 September 2025, 11.00am, Microsoft Teams*	1.10pm	Verbal	Information	K Deeny

12.2 *MID-YEAR - MATERNITY SERVICE SAFE STAFFING REPORT

Decision Item | S Morrison | 12.05pm

REFERENCES

Only PDFs are attached

12.2 - Maternity Service Safe Staffing Report.pdf

Board of Directors Report

Maternity Service Safe Staffing Report			
Report to:	Board of Directors	**Date:**	02.10.2025
Report of:	Chief Nursing Officer	**Prepared by:**	Jo Lambert
Part I		**Part II**	*x*

Purpose of Report					
For assurance	☐	**For decision**	☒	**For information**	☐

Executive Summary:

The purpose of this report is to present the second maternity service safe staffing review for 2025 for approval following scrutiny by the Safety and Quality Committee.

It provides assurance that maternity services continue to operate in alignment with national standards for safe, effective, and sustainable staffing. (National Quality Board NQB)

The review outlines the findings from the latest staffing review of workforce metrics and combines workforce data with clinical outcomes and patient experience to assess the impact of staffing on safety and quality. The Perinatal Quality Surveillance Dashboard (PQSD Appendix 1) triangulates workforce data, patient experience, and clinical effectiveness indicators, providing a framework for assurance. Additionally, Appendix 2 is included to detail the progress against 9/10 Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) national priorities.

Staffing requirements continue to be informed by Birth Rate Plus (BR+) midwifery acuity tool, supplemented by professional judgment. The BR+ assessment conducted at the end of 2022 identified a required uplift of 29.7 WTE (midwives and postnatal support workers), which has been addressed through the 2024/25 financial planning, enabling the service to declare compliance (Appendix 3,4 & 5). The scheduled three-yearly BR+ review is currently underway, and its findings will be shared once they have been validated by the Chief Nursing Officer and the Divisional Midwifery and Nursing Director.

This report also includes a summary of obstetric, neonatal nursing, and neonatal medical staffing, recognising the critical interdependencies across the multidisciplinary team and their impact on maternal and neonatal outcomes.

The midwifery vacancy is 18.25 WTE which includes vacancy, maternity leave and the over offer which enables the service to recruit to turnover. All the vacancies have now been recruited, and onboarding is in progress. It is anticipated that graduated starts will commence from September 2025. The service is monitoring vacancies and drop off rates and any further vacancy will be expedited through vacancy control processes.

The current level of midwifery continuity of carer (MCoC) is being delivered safely without compromising one-to-one care in labour. Work is progressing to build the blocks to establish an enhanced team, with a focus on families in decile 1 and women from Black, Asian, and minority ethnic backgrounds. This will take a phased approach to final implementation and initially focus on antenatal and postnatal continuity.

Training compliance for PROMPT, fetal monitoring is below 90% for the first time in the year 7 MIS reporting period. This is because of the new trainee rotation. A recovery plan is in place to address non-compliance, with an associated action plan and this will enable the service to declare compliance with standard 8 of MIS. (Appendix 6)

Analysis of the Perinatal Quality Surveillance Dashboard highlights areas of pressure, particularly red flags associated with midwifery and obstetric staffing. Delays in induction and triage remain the most frequently reported concerns and actions are ongoing to mitigate the risks including the implementation of the tier 2 rota an the improvement project focused on Induction of Labour. (Appendix 9).

As discussed in previous iterations of this report, the rising demand for caesarean sections continues to exceed current capacity. While the service can accommodate 12 uncomplicated elective procedures per week, capacity analysis indicates a need for 17 theatre slots. The business case is progressing to support the 4th theatre. This is a priority workstream requiring approval.

Since the last safe staffing report, in April 2025, the service has diverted on 11 occasions. The time frames for divert ranged between 4 and 24 hours. and was associated with unit acuity and established vacancy. This represents a new and rising trend in the data and confirms that previous actions taken to support the workforce and invest in midwifery staffing and the tier 2 model is timely and warranted.

Following the letter issued by NHS England, Sir Jim Mackey and Duncan Burton in June 2025 which informed Trusts that the national maternity and neonatal investigation would be undertaken, Baroness Valerie Amos has confirmed that 14 hospital trusts will be included in the rapid, independent, national investigation into maternity and neonatal services. The maternity service confirms that it is not included in this cohort, however progress with the investigation will be observed closely so that any more immediate learning is actioned.

During this reporting period, there have been no whistleblowing enquiries related to staffing levels. One Freedom to Speak Up (FTSU) case was raised. Work to address culture concerns around behaviour, communication, and team dynamics is ongoing lead by the organisational development team and a draft report expected by the end of September 2025. Following this a culture improvement plan will be implemented, informed by the SCORE culture survey (Appendix 7 and 8) and the outcome of the culture review.

Despite the challenges noted, the service remains relatively stable and is working responsively. The staffing establishments informed by BR+ and recommended by the Divisional Midwifery and Nursing Director and the Chief Nursing Officer meet the requirements of the NICE Safe Staffing Guidelines (2014) and the National Quality Board's guidance (2016).

***The full report is included in the Ancillary Pack.**

RECOMMENDATION

It is recommended the Board of Directors

i. Approve the safe staffing report, noting endorsement by the Safety and Quality committee.
ii. Note that the 3 yearly Birth Rate plus re- assessment is ongoing.
iii. Scrutinise the Perinatal Quality Surveillance Dashboard and CNST information and confirm it is assured of the outcomes presented.
iv. Acknowledge the requirement to address the current capacity gap for Caesarean section and support progression of addressing case to open the new 4th theatre through the Trust business case process.

Appendices

To support this paper, more detailed information is provided in the appendices. Further information on any of the topics covered is available on request.

Appendix 1 Perinatal Quality Surveillance Dashboard
Appendix 2 Clinical Negligence for Trust Maternity Incentive Scheme summary
Appendix 3 Birth Rate Plus summary 2022
Appendix 4 Breakdown of Specialist Midwife Portfolio
Appendix 5 Leadership Structure
Appendix 6 Training Action Plan
Appendix 7 SCORE Action plan
Appendix 8 Workforce Plan 2025
Appendix 9 Red Flag Data

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive health innovation through world class education, teaching and research	☐	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

None

12.3 *MORTALITY ANNUAL REPORT

Decision Item | S Canty | 12.10pm

REFERENCES

Only PDFs are attached

12.3 - Annual mortality report 24-25 Final for submission to Board v1.pdf

Board of Directors Report

Annual Mortality Report 2024-2025			
Report to:	Board of Directors	**Date:**	2 October 2025
Report of:	Chief Medical Officer	**Prepared by:**	K Flinn G Clarke

Purpose of Report					
For assurance		**For decision**	x	**For information**	

Executive Summary:

The purpose of this annual mortality report is to provide an update and assurance to the Board of Directors that the Trust has robust governance arrangements in place to review, report and learn from patient deaths. The report has been considered by the Mortality and End of life Committee at its meeting in June 2025.
This report presents a range of information and benchmarking data to provide assurance to the Board in the following areas:

- Mortality benchmarking – Hospital Standardised Mortality Ratio (HSMR) and Standardised Hospital Mortality Indicator (SHMI)
- Adult Structured Judgement Reviews (SJR) Mortality Reviews & Learning
- Learning from Inquests
- Update to TELSTRA (Dr Foster) methodology changes
- Inquest learning and feedback
- Learning Disabilities Deaths, Reviews & Learning (LeDeR)
- Mental Health deaths reviews and learning
- Strategic Executive Information System (StEIS) /Patient Safety Incident Response Framework (PSIIRF) and Maternity and Newborn Safety Investigations (MNSI) Deaths & Learning
- Perinatal, Neonatal & Child Deaths
- Medical Examiner Service Activity
- Mortality Improvement Plans

This annual mortality report presents mortality benchmarking, demonstrating that the Trust **HSMR** of **75.2** and SMR of **74.0** are significantly lower than expected for the 12-month period of December 2023 / November 2024. The Trust **SHMI** for the data period is **92.19** and within expected range.

The **SMR for children** is **88.9** and within expected range**.** The 12-month SMR for neonatal deaths excluding stillbirths is **92.4** and within expected range.

The Trust completed SJRs (Structured Judgement Reviews) for 58% of deaths during 2024 -2025. This is an increase on the 54% reported in the Bi- Annual report 2024-25.
Key themes of learning from SJRs have been presented, as well as the learning from LeDeR reviews, StEIS /PSIRF reported deaths and Inquests.

Six incidents were reported onto StEIS under the category of “death likely due to problems in care” during the reporting period under PSIRF framework, with a further 2 maternal deaths investigated by MNSI.

One Regulation 28 has been received.

Medical Examiner review of cases remains consistently high despite statutory changes and pressures within the service.

It is recommended that the Board of Directors confirm it is assured of the robust arrangements in place relating to the management of patient deaths.
The full report is in the ancillary pack.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☐
To drive health innovation through world class education, teaching and research	☐	Deliver Value for Money	☐
		Fit For The Future	☐

Previous consideration

None

12.4 *MID-YEAR NURSE STAFFING REPORT

Decision Item | S Morrison | 12.15pm

REFERENCES

Only PDFs are attached

12.4 - Mid-year Nurse Staffing Report.pdf

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Bi-annual Nursing and Midwifery Workforce Review							
Report to:	Board of Directors			**Date:**	02.10.2025		
Report of:	Chief Nursing Officer			**Prepared by:**	C Gregory, N Ross		
Part I	*x*			**Part II**			
Purpose of Report							
For assurance	☐	**For decision**	**x**		**For information**		☐

Executive Summary:

The purpose of this report is to detail the findings of the Lancashire Teaching Hospitals NHS Foundation Trust 2025 bi-annual nurse safe staffing review following scrutiny by the Safety and Quality.

The report provides assurance to the Board of Directors that safe staffing levels have been set within the services. The report triangulates workforce information with safety metrics, patient experience and clinical effectiveness indicators (Appendix 1).

The report fulfils the requirement outlined in the Developing Workforce Safeguards (NHS Improvement, 2018), National Quality Board (NQB, 2016) staffing guidance, supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time and uses further sector specific evidence-based improvement resources published by NHS Improvement.

The report provides an updated position on the themes requiring improvement that arose from the annual report 2024/2025 which were:

1. Healthcare Assistant vacancies – Currently 135WTE in May 2025 compared to 165 in November 2024.
2. Sickness absence rate - small reduction equating to 6.68% in May 2025.
3. Roster key performance indicators monitored via the Daily Management System (DMS) - initial launch February 2025 and further launch June 2025 after further refinement
4. Enhanced therapeutic Observations and Care (ETOC) - The Trust has subsequently been selected to participate in Cohort 2 of the NHS England Enhanced Therapeutic Observations and Care Collaborative which is currently under way and training has been rolled out during June 2025.

This six- month review has been conducted using a desktop methodology as per Trust policy and it applies a triangulated approach looking at workforce and patient outcome and experience data to assess staffing across all four clinical divisions: Surgery, Medicine, Women's and Children's and Diagnostic and Clinical Support (DCS) encompassing admission and assessment units, as well as inpatient areas for, neonates and children

and young people and inpatient areas. It draws on outcome metrics for both patients and staff from a three-month period (January 2025 – March 2025) combined with Safer Nursing Care Tool (SNCT) validated data and a professional judgment as recommended by the NHS Improvement- Developing Workforce Safeguards (2018).

The Safer Nursing Care Tool is a NICE endorsed acuity and dependency Tool which has been developed by the Shelford Group chief nurses' sub-group as an innovative and evidence-based decision support tool to help Chief Nursing Officers and Board of Directors within acute NHS hospitals measure patient acuity and / or dependency to inform and approve safe staffing for nurses.

The findings of the review have been validated as being appropriate through the application of the professional judgement by the Divisional Nurse Director and/or the Divisional Nursing and Midwifery Director for each clinical division.

Outcome of the review

The outcome of the six-month review found that the SNCT data, triangulated with the professional judgment and patient and staff outcome metrics provided assurance that existing staffing levels and skill-mix are appropriate to meet the service's needs and patient demand for the following areas:

- Paediatric Ward
- Neonatal Unit
- Gynaecology Ward
- Includes all Surgical wards and Assessment Areas
- Critical Care Unit
- Paediatric Emergency Department
- Includes all Medical Wards and Assessment Areas with the exception of the Emergency Departments (EDs) which is addressed separately with recommendations made within the report.

Emergency Department and Urgent and Emergency Care Pathway

The outcome of the desk-top review for both Royal Preston Hospital (RPH) and Chorley District Hospital (CDH) highlighted some data changes that needed to be explored further including a significant increase in the SNCT staffing requirements for the CDH ED and high occupancy levels in the ED at RPH that prompted a deeper analysis and review. The STAR outcomes for both departments have failed to achive a green star except on 2 occasions since 2017 with RPH ED never having met the required standard. ED CDH CQC safe rating deteriorated from Good at the last inspection and RPH have a sustained requires improvement position for its CQC rating.

The current SNCT does not account for patients delayed in the ED for over 12 hours resulting in incomplete data for workforce planning. While NHS England is developing a new SNCT tool tailored to ED settings, a release date is yet to be confirmed. Until then, professional judgement, supported by triangulated data sources, remains essential to determine appropriate staffing levels. The continued reliance on ED boarding capacity, despite efforts to reduce avoidable admissions, significantly impacts nursing requirements and highlights the need for flexible and responsive staffing approaches.

ED CDH

The ED department at CDH has on average 2250 attendees a month, with seasonal fluctuations noted to be

minimal. However, the time a patient is being cared for within the ED department has significantly changed. Since September 2024 the number of patients spending more than 12 hours within the department has increased from an average of 4.7% to an average of 11.5%. In June 2025 ED remained open on 29 out of 30 nights beyond the 22.00 commissioned closing time due to insufficient beds on the Medical Assessment Unit to accept patients who needed admission.

During the first SNCT audit in March 2024, when staffing levels were deemed sufficient to meet patient needs, sickness absence was 6.97%. In contrast, during periods of higher acuity that exceeded baseline staffing levels in the subsequent audits of June 2024 and January 2025. Sickness rates rose significantly to 15.85% and 13.58% respectively. There has also been a correlation of patient safety incident increases, whilst harm levels has remained stable, this should be treated with caution given the corresponding sickness, occupancy and time spent in the ED.

The report proposes a revised staffing model at CDH to take into account the fluctuating demand over the opening hours of the service and supports a staggered start and finish time, while ensuring appropriate staffing levels to meet the demand of the service and maintain safety. The proposal is based on a safety and quality evaluation and will now follow financial governance processes for approval.

The staffing recommendation for CDH ED is to convert 5.5WTE bank spend into substantive establishment creating a £12k saving against current spend.

ED RPH

The ED at RPH continues to have high volumes of patients awaiting inpatient beds, with an average of 40-50 patients daily spending extended periods of time waiting for beds. Despite best efforts, the utilisation of boarding (cared for on a trolly outside of a recognised bed space) capacity within ED remains consistent and the data presented in this report demonstrates 30% of patients are delayed in RPH ED over 12 hours, with some delayed up to 72 hours whose care needs and dependency are not captured in the SNCT data. The analysis of attendances and the professional judgement has been critical to fully appraise the staffing requirements.

The report proposes a revised staffing model at RPH ED increases the registered staffing numbers to 24 registered nurses Sunday to Tuesday and 22 Registered nurses Wednesday to Saturday which reflects peak occupancy trends in patients and would facilitate the removal of agency currently in place, whilst also reducing the number of bank shifts to respond to periods of high occupancy and/or surge. As CDH ED, the proposal is based on a safety and quality evaluation and will now follow financial governance processes for approval.

The staffing recommendation for RPH ED is to convert 15.75 WTE bank and agency spend into substantive establishment creating a £215k saving against current spend.

This proposal seeks to ensure the right number of staff with the right skills in the right times within the EDs moving away from a long standing reliance on bank and agency aiming to improve the outcomes for staff and patients. This is in line with the Royal College of Emergency Medicine (RCEM) best practice guidelines for a safe level of temporary staffing support for an ED.

In line with the recommendation from NHS Improvement Workforce Safeguards (2018) guidance, the Chief Nursing Officer confirms the outcome of the six-month review will deliver safe, effective and sustainable staffing levels for the organisation and meet the requirements of the NICE Safe Staffing Guidelines (2014) and the National Quality Board (NQB) Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time (2016) for all areas with the exception of the ED department at RPH and CDH and

proposes that the revised model of nursing is accepted (subject to financial and governance processes), to meet safe staffing requirements.

***The full report is included in the Ancillary Pack.**

It is recommended that the Board of Directors:

i. Approve the bi-annual staffing review, noting the endorsement by the Safety and Quality Committee.
ii. Note that in line with the recommendation from NHS Improvement Workforce Safeguards (2018) guidance, the Chief Nursing Officer confirms the outcome of the six-month review will deliver safe, effective and sustainable staffing levels for the organisation and meet the requirements of the NICE Safe Staffing Guidelines (2014) and the National Quality Board (NQB) Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time (2016).
iii. Note the decision to advance the ED staffing proposal is paused until the medicine divisional team define the service changes taking place around the urgent and emergency care pathway. Bank remains in place during this time to maintain safe staffing. This will be concluded by 31 October 2025.

Appendix 1 – Triangulated patient and workforce outcomes
Appendix 2 – CHPPD
Appendix 3 – Example Professional Judgment template

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	x	Consistently Deliver Excellent Care	x
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	x	Great Place To Work	x
To drive health innovation through world class education, teaching and research		Deliver Value for Money	x
		Fit For The Future	x

Previous consideration

None

13. RISK, GOVERNANCE AND COMPLIANCE

13.1 NHSE PROVIDER CAPABILITY SELF-ASSESSMENT

Decision Item | S Morrison | 12.20pm

REFERENCES

Only PDFs are attached

13.1 - NHSE Provider Capability Self-Assessment.pdf

Board of Directors

Provider Capability Self-assessment			
Report to:	Board of Directors	**Date:**	2nd October 2025
Report of:	Chief Nursing Officer and Deputy Chief Executive	**Prepared by:**	A.Brotherton and S. Morrison

Purpose of Report					
For assurance		**For decision**	☒	**For information**	

Executive Summary

As part of the new NHS Oversight Framework (NOF), NHS England will now commence assessing NHS trusts' capability. To facilitate this, each Trust has been asked to complete a self-assessment using a standard template with supporting evidence. NHS England will use the results of the self-assessment alongside the providers' NOF segments to judge what actions or support are appropriate with each Trust.

NHS boards have been asked to assess their organisation's capability against a range of expectations across six areas which have been derived from 'The insightful provider board'. These are:

- strategy, leadership and planning
- quality of care
- people and culture
- access and delivery of services
- productivity and value for money
- financial performance and oversight

The purpose of this paper is to summarise the self-assessment that has been undertaken in the six domains outlined in the self-assessment. The completed self-assessment is outlined in Appendix 1. A list of the proposed supporting evidence is outlined in Appendix 2.

Recommendation

The Board of Directors are asked to;

(i) Review and discuss the completed self-assessment and proposed supporting evidence and advise of any changes required following a critical discussion

(ii) Approve the self-assessment (subject to any proposed changes being incorporated) for submission to NHS England by the deadline of 22nd October 2025.

Trust Strategic Aims and Ambitions supported by this Paper:			
Aims		**Ambitions**	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high-quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive health innovation through world-class education, teaching, and research	☒	Deliver Value for Money	☒
		Fit For The Future	☒
Previous consideration			

1. Context

As part of the NHS Oversight Framework (NOF), NHS England will assess NHS trusts'* capability, using this alongside providers' NOF segments to judge what actions or support are appropriate at each trust. As a key element of this, NHS boards will be asked to assess their organisation's capability against a range of expectations across 6 areas derived from 'The insightful provider board', namely:

- strategy, leadership and planning
- quality of care
- people and culture
- access and delivery of services
- productivity and value for money
- financial performance and oversight

The purpose of the self-assessment is to strengthen board assurance and help the NHS England oversight teams take a view of our trust capability based on the Boards' awareness of the challenges the organisation faces and actions to address these challenges. This will help to ensure that the Board's attention is on a set of key expectations related to our core functions as well as encourage an open culture of 'no surprises' between the trust and the oversight teams.

The NHS England regional team will then use the assessment and supporting evidence, along with other information, to derive a view of the organisation's capability.

2. Discussion

The self-assessment

The process set out by NHS England aims to ensure that completion of the self-assessment is not a 'tick box' exercise. As outlined above, the purpose is to promote self-awareness and transparency at NHS trust boards regarding their organisation's capabilities, strengths, weaknesses and the challenges they face. It also aims provides a consistent framework for regional oversight teams to engage with NHS trusts, identify key risks and, over time, assess management's track record in delivering performance and/or identifying and addressing issues to ensure strong, sustainable organisations able to deal with challenges as they emerge. Trusts have been given eight weeks to carry out the self-assessment and return it to the NHS England regional team.

The NHS England guidance specifies that where Boards already conduct effectiveness reviews, they should consider the degree to which these overlap with this self-assessment. In addition, and to avoid duplication, relevant evidence gathered to support NHS trusts' annual governance statements can also support the self-assessment.

3. The Self-Assessment Key Lines of Enquiry

NHS England provide a number of key lines of enquiry for each domain which are intended to aid the completion of the self-assessment. These have informed the completion of the self-assessment. The detailed KloEs are outlined in Appendix 3.

Details of the guidance for completion can be found on the National Oversight Framework section on the NHS England website:
https://www.england.nhs.uk/long-read/assessing-provider-capability-guidance-for-nhs-trust-boards/

4. Process of completion

The self-assessment has been completed by the Executive team and considered by the Non-Executive Directors ahead of a wider Board discussion. The contents of the self-assessment will be considered as part of the Good Governance Improvement group developmental review (2025) Board development session held on 1 October 2025. Given this is the first submission of this self-assessment, it is difficult

to determine the correct level of supporting evidence to submit. When this is submitted to the regional team, it will be made clear that the Trust is willing to submit further evidence if more detail is required in any domain.

5. Summary of the capability assessment cycle

NHS England has set out the assessment cycle, this is summarised in Figure 1.

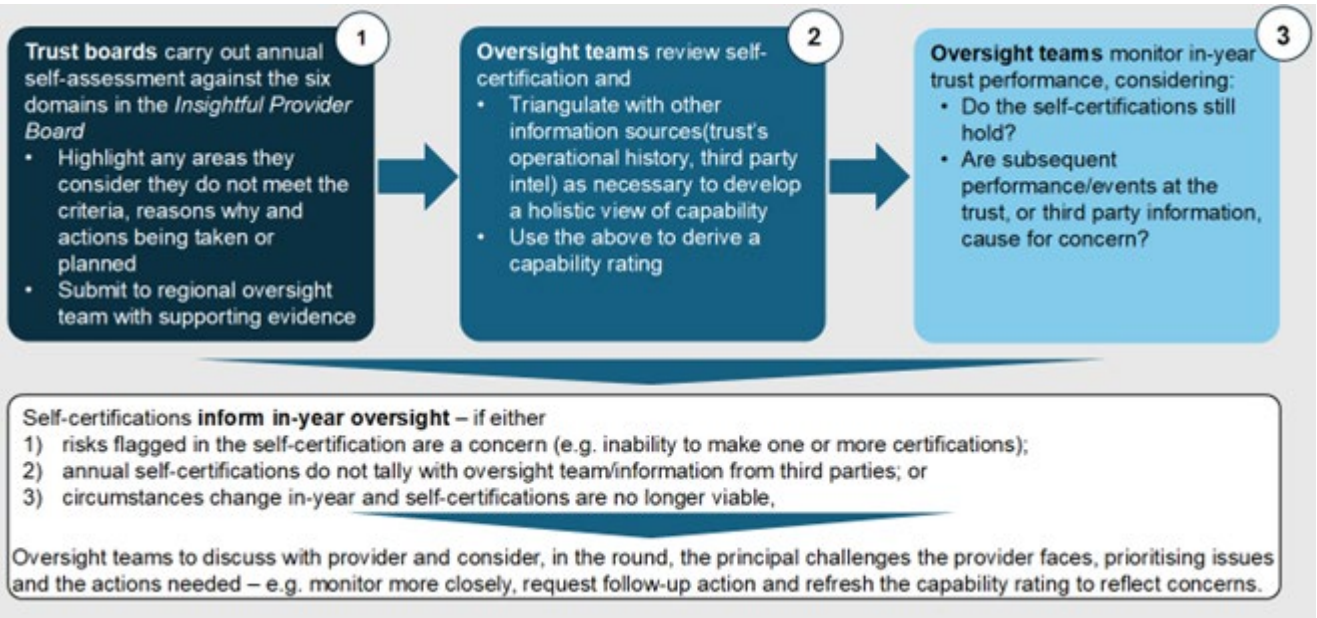


Figure 1: Assessment Cyle summary

Source: https://www.england.nhs.uk/long-read/assessing-provider-capability-guidance-for-nhs-trust-boards/

6. Selecting the level of compliance

In addition to completing each section of the self-assessment tool and providing supporting evidence, the Board is required to select for each domain the level of compliance achieved with the three options being 'confirmed', 'partially confirmed' or 'not met'.

NHS England recognise that the board may not be able to make a positive self-assessment either because it considers the risks in a specific area are too great or its organisation is already manifestly failing in a specific area (for example, delivering on access targets). In these situations, boards are asked to explain:

- the reasons why a positive self-assessment cannot be made against specific criteria and the extent to which these have been outside the trust's control to address (for example, industrial action, system-wide factors)
- how long the reasons have persisted
- a summary of any mitigating actions the trust has taken or is taking
- if not already shared with oversight teams, a high-level description of trust plans to address the issue, how long this is likely to take and KPIs or other information the trust will use to assess progress

Oversight teams will use this information to form their view of the overall capability of the trust and tailor their oversight relationship with it.

The areas where the self-assessment has identified partially confirmed are outlined below with the rationale as to why a positive self-assessment cannot be made, how long the reason has persisted, a summary of mitigating actions being taken and reference to the Trust plan to address the issue.

4. Access and delivery of services

Rationale: *The Trust is in Tier 1 for RTT, Cancer and DM01 and Tier 2 for Urgent and Emergency care.*
How long has this persisted? *This is the second year of this Tiering position. The mitigating actions are contained within the action plans submitted to NHS England.*
Plan: *The Trust is mobilising internal grip and control and productivity actions to improve the position however, the Trust requires financial support to fund activity growth and recover the current performance position. This has been outlined as part of the Tiering discussions with NHS England and with the ICB.*

5. Productivity and value for money
Rationale: *At the start of the financial year 25/26 the opportunity identified was £98.3m.*
How long has this persisted? *The opportunity to improve productivity has persisted for more than 2 years. The Trust has worked with PWC to identify the opportunities across each specialty for productivity and efficiency improvement using the Model Health System data and the Carter data. The first wave of work has been completed which has resulted in improvement. The benchmarking exercise has been repeated by PWC in Sept 2025, the initial analysis has shown the Trust against peers has a further £34.2m to £68.5m of opportunity to be validated. (This now requires further validation). The Trust is rated amber green currently for productivity.*
Plan: *The Trust is focused on developing a suite of measures that will build on existing productivity measurement approaches in theatre and health roster and allow closer monitoring and scrutiny of productivity in outpatients and 42 productive weeks for job planned colleagues across the organisation.*

6. Financial performance and oversight
Rationale: *The Trust is in NOF 5. The Trust has a robust financial governance framework, having had an external review of the previous arrangements from Ernst Young and having had support from PwC and the Trust's turnaround director to strengthen the financial governance framework. The Trust has appropriate contract management arrangements in place. As part of our work with PwC, the Recovery Support Programme team and the Improvement and Assurance Group, the Trust has a strengthened programme of work focused on financial controls. The internal audit programme for 24/25 included an internal audit of key financial processing controls which concluded a substantial assurance opinion. Continuous audits of the Trust's financial controls have been put into place, this year with PwC and a repeat audit is being concluded by MIAA focussed on grip and control.*
How long has this persisted? *The financial performance and oversight improvement requirement was highlighted in 2024/25 and the trust placed into the Recovery Support Programme and more recently into NOF 5.*
Plan: *The Trust continues to report to the Improvement and Assurance (IAG) on the progress against the financial plan.*

7. Material in-year changes

The Board must also be aware of material in-year changes which may impact on the self-assessment. In addition to the annual self-assessment, NHS England advise in the guidance that if the board becomes aware in-year of a significant change to its ability to meet any of the self-assessment criteria it should inform the oversight team along with the actions it is taking to address the issue.

The assessment has not identified any additional significant in year change to make NHS England aware of outside the known and understood risks associated with finance and performance.

8. Third-party information

As set out in the NHS Oversight Framework, third-party information relating to the organisation's governance and risk profile, staff morale and quality of care provided may inform NHS England's view of NHS trust capability. The Board are asked to note that NHS England expect that where trusts receive information that impacts on their self-assessment they should share this with NHS England.

Relevant third parties include:

- **other bodies with regulatory responsibilities**, where concerns can reflect weaknesses in internal governance and systems of internal control and oversight – including the Information Commissioner, Human Tissue Agency and NHS Blood and Transplant
- **professional representative bodies,** reflecting issues with working conditions, staff morale, operating culture and safety – including the General Medical Council, Nursing and Midwifery Council and Royal Colleges
- **patients and the public,** reflecting issues in areas such as patient experience and culture via groups like Healthwatch
- **staff information,** reflecting issues in internal culture and inability to speak up, for example via staff survey or whistleblowers
- **integrated care board partners,** covering areas like the trust's willingness to collaborate and deliver shared goals
- **other NHS England teams,** reflecting knowledge from central programmes like quality, cyber assurance or digital maturity
- **relevant oversight groups,** including joint strategic oversight groups (JSOG) and system and regional quality groups
- **other sources** as relevant to the NHS trust, including coroners, Parliamentary Health Service Ombudsman, local government and Social Care Ombudsman, Ofsted, the trust's internal and external auditors and even the police

9. Next Steps after submission

Following submission of the self-assessment, the NHS England regional oversight teams will review the trust's submitted self-assessment and consider the statements and evidence. Using a range of considerations, including the historical track record of the trust, its recent regulatory history and any relevant third-party information, the oversight team will decide the trust's capability rating and share this with the Trust, including the rationale for the rating. There are four possible ratings: green; amber-green; amber-red and red. The ratings are summarised in Appendix 4.

10. Financial implications

The financial implications associated with the areas of partial compliance are outlined as part of the programs of work.

11. Legal implications

The Trust's license is currently subject to regulatory undertakings.

12. Risks

The risks are outlined within the Board Assurance Framework.

13. Impact on stakeholders

The ability to meet the constitutional standards is impacting the experience and outcomes for the wider community. This is being mitigated as part of the wider single improvement plan, however, whilst the Trust is on its improvement journey there will continue to be an impact on wider community and health and social care system stakeholders.

14. Recommendations

The Board of Directors are asked to;

I. Review and discuss the completed self-assessment and proposed supporting evidence and advise of any changes required following a critical discussion
II. Approve the self-assessment (subject to any proposed changes being incorporated) for submission to NHS England by the deadline of 22nd October 2025.

Appendix 1

Completed Self-assessment template

Appendix 2

Supporting Evidence for each domain

Strategy, leadership and planning

- Trust strategy
- Digital Plan
- Clinical system reconfiguration recommendations
- License conditions letter
- Exit criteria
- Portfolio summary and covering paper
- Accountability Framework
- The GGI review (July 2025) report
- Board Succession plan
- Summary of the Strasys review
- Joint work plan for the Strategy leads
- Self-assessment against the 6 domains in insightful provider board

Quality of care

- STAR Quality assurance policy
- Freedom to speak up Board report
- Core skills report (ETR)
- Mat neo CNST report for last year
- Corporate objectives (Board paper)
- Annual nurse and midwifery staffing reports
- Patient Experience report
- Health improvement plan
- Morality report
- Single Improvement Plan
- Risk Management Policy
- ToR of the Risk Management Committee
- Equality Quality Impact Assessment (EQIA)

People and culture

- Education and Training Strategy Annual Report 2024/25
- Leadership in Lancs Framework
- Magnet4Europe
- Staff survey report
- Leadership and OD report
- Statutory and mandatory training policy

Access and delivery of services

- Performance Improvement Plans (Tier 1 and 2 submissions)
- Health Improvement Plan
- Health Inequality data submission

Productivity and value for money

- Productivity opportunity (Steve Stow) and the FSP

- DMS Change package and powerpoint slide pack

Financial performance and oversight

- Draft Financial Sustainability plan.
- Days Kept Away From Home presentation
- MIAA Grip and Control Audit
- Waste Reduction Programme papers

Appendix 3: The key lines of Enquiry in each domain

The self-assessment
Below are the indicative examples of the evidence boards should use or lines of enquiry they might consider taking to assess whether they can positively self-certify against each criterion. These should not be seen as exhaustive as Trusts are expected to have developed specific approaches to gain assurance in particular areas.

I. Strategy, leadership and planning

Self-assessment criteria	Indicative evidence or lines of enquiry
1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners.	• Are the trust's financial plans linked to and consistent with those of its commissioning integrated care board (ICB) or ICBs, in particular regarding capital expenditure? • Are the trust's digital plans linked to and consistent with those of local and national partners as necessary? • Do plans reflect and leverage the trust's distinct strengths and position in its local healthcare economy? • Are plans for transformation aligned to wider system strategy and responsive to key strategic priorities agreed at system level?
2. The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHS England.	• Is the trust currently complying with the conditions of its licence? • Is the trust meeting requirements placed on it by regulatory instruments – for example, discretionary requirements and statutory undertakings – or is it co-operating with the requirements of the national Performance Improvement Programme (PIP)?
3. The board has the skills, capacity and experience to lead the organisation.	• Are all board positions filled and, if not, are there plans in place to address vacancies? • What proportion of board members are in interim/acting roles? • Is an appropriate board succession plan in place? • Are there clear accountabilities and responsibilities for all areas of operations including quality, delivering access standards, operational planning and finance?
4. The trust is working effectively and collaboratively with its system partners and NHS trust collaborative for the overall good of the system(s) and population served.	• Is the trust contributing to and benefiting from its NHS trust collaborative? • Does the board regularly meet system partners, and does it consider there is an open and transparent review of challenges across the system? • Can the board evidence that it is making a positive impact on the wider system, not just the organisation itself – for example, in terms of sharing resources and supporting wider service reconfiguration and shifts to community care where appropriate and agreed?

II. Quality of care

Self-assessment criteria	Indicative evidence or lines of enquiry
5. Having had regard to relevant NHS England	• The trust can demonstrate and assure itself that internal procedures: o ensure required standards are achieved (internal and external)

guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	○ investigate and develop strategies to address substandard performance ○ plan and manage continuous improvement ○ identify, share and ensure delivery of best practice ○ identify and manage risks to quality of care • There is board-level engagement on improving quality of care across the organisation. • Board considers both quantitative and qualitative information, and directors regularly visit points of care to get views of staff and patients. • Board assesses whether resources are being channelled effectively to provide care and whether packages of care can be better provided in the community. • Board looks at learning and insight from quality issues elsewhere in the NHS and can in good faith assure that its trust's internal governance arrangements are robust. • Board is satisfied that current staff training and appraisals regarding patient safety and quality foster a culture of continuous improvement.
6. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board.	• Does the board triangulate qualitative and quantitative information, including comparative benchmarks, to assure itself that it has a comprehensive picture of patient experience? • Does the board consider variation in experience for those with protected characteristics and patterns of actual and expected access from the trust's communities? • Is the board satisfied that it receives timely information on quality that is focused on the right matters? • Does the board consider volume and patterns of patient feedback, such as the Friends and Family Test or other real-time measures, and explore whether staff effectively respond to this? • How does the organisation involve service users in quality assessment and improvement and how is this reflected in governance? • Is the board satisfied it is equipped with the right skills and experience to oversee all elements of quality and address any concerns? • Is the board satisfied that the trust has a clear system to both receive complaints from patients and escalate serious and/or re-occurring complaints to the relevant executive decision-makers?

III. People and culture

Self-assessment criteria	**Indicative evidence or lines of enquiry**
7. Staff feedback is used to improve the quality of care provided by the trust.	• Does the board look at the diversity of its staff and staff experience survey data across different teams (including trainees) to identify where there is scope for improvement? • Does the board engage with staff forums to continually consider how care can be improved? • Can the board evidence action taken in response to staff feedback?
8. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels.	• Does the trust regularly review skills at all levels across the organisation? • Does the board see and, if necessary, act on levels of compliance with mandatory training?
9. Staff can express concerns in an open and constructive environment.	• Does the board engage effectively with information received via Freedom To Speak Up (FTSU) channels, using it to improve quality of care and staff experience?

	• Are all complaints treated as serious and do complex complaints receive senior oversight and attention, including executive level intervention when required? • Is there a clear and streamlined FTSU process for staff and are FTSU concerns visibly addressed, providing assurance to any others with similar concerns? • Is there a safe reporting culture throughout the organisation? How does the board know? • Is the trust an outlier on staff surveys across peers?

IV. Access and delivery of services

Self-assessment criteria	Indicative evidence or lines of enquiry
10. Plans are in place to improve performance against the relevant access and waiting times standards.	• Is the trust meeting those national standards in the NHS planning guidance that are relevant to it? If not, is the trust taking all possible steps towards meeting them, involving system partners as necessary? • Where waiting time standards are not being met or will not be met in the financial year, is the board aware of the factors behind this? Is there a plan to deliver improvement?
11. The trust can identify and address inequalities in access/waiting times to NHS services across its patients.	• The board can track and minimise any unwarranted variations in access to and delivery of services across the trust's patients/population and plans to address variation are in place.
12. Appropriate population health targets have been agreed with the integrated care board.	• Is there a clear link between specific population health measures and the internal operations of the trust? • Do teams across the trust understand how their work is improving the wider health and wellbeing of people across the system?

V. Productivity and value for money

Self-assessment criteria	Indicative evidence or lines of enquiry

13. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant.	• Board uses all available and relevant benchmarking data, as updated from time to time by NHS England, to:
	  ○ review its performance against peers
	  ○ identify and understand any unwarranted variations
	  ○ put programmes in place to reduce unwarranted negative variation.
	• The trust's track record of delivery of planned productivity rates.

VI. Financial performance and oversight

Self-assessment criteria	Indicative evidence or lines of enquiry
14. The trust has a robust financial governance framework and appropriate contract management arrangements.	• Trust has a work programme of sufficient breadth and depth for internal audit in relation to financial systems and processes, and to ensure the reliability of performance data. • Have there been any contract disputes over the past 12 months and, if so, have these been addressed? • [Potentially more appropriate for acute trusts] Are the trust's staffing and financial systems aligned and show a consistent story regarding operational costs and activity carried out? Has the trust had to rely on more agency/bank staff than planned?
15. Financial risk is managed effectively and financial considerations (for example,	• Does the board stress-test the impact of financial efficiency plans on resources available to underpin quality of care? • Are there sufficient safeguards in place to monitor the impact of

efficiency programmes) do not adversely affect patient care and outcomes.	financial efficiency plans on, for example, quality of care, access and staff wellbeing? • Does the board track performance against planned surplus/deficit and where performance is lagging it understands the underlying drivers?
16. The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn.	• Is the board contributing to system-wide discussions on allocation of resources? • Does the trust's financial plan align with those of its partner organisations and the joint forward plan for the system? • Would system partners agree the trust is doing all it can to balance its local/organisational priorities with system priorities for the overall benefit of the wider population and the local NHS?

Appendix 4: Summary of the Risk ratings

Rating: Green: High confidence in management.

Indicative criteria

- No concerns evident from the self-assessment or subsequent performance.
- No concerns arising from third-party information.
- High confidence in the trust's ability to deliver on its priorities based on track record over past 12–24 months.

Rating: Amber–green: Some concerns or areas that need addressing

Indicative criteria

- After discussion with the trust, some concerns emerging across more than 1 domain, but these as yet are not affecting quality of care, delivery of core services, finance or the wider reputation of the NHS.
- Trust has prepared plan(s) to address any problems with associated timeframe for delivery
- Historical issues/track record mean NHS England does not (yet) have full confidence in the board.

Rating: Amber–red: Material issue needs addressing or failure to address major issues over time.

Indicative criteria

- Issues with self-assessment or subsequent issues across multiple domains.
- Failure to deliver on agreed plans to address a material issue.
- Potentially in breach of licence.

Rating: Red: Significant concerns arising from poor delivery, governance and other issues.

Indicative criteria

- Material or long-running concerns at the organisation that management has been unable to grip.
- NHS trust in breach of licence or likely to be.

Provider Capability - Self-Assessment Template

	The Board is satisfied that…		*(Mitigating/contextual factors where boards cannot confirm or where further information is helpful)*
Strategy, leadership and planning	• The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners • The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE • The board has the skills, capacity and experience to lead the organisation • The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served	**Confirmed**	***Introduction:*** *The Trust Board has undertaken a comprehensive improvement programme over the last year since the new Chair and CEO joined the organisation. At around the time the new CEO was appointed NHS England requested a review of financial governance (undertaken by Ernest Young) and in line with NHS England guidance, the Trust was due to complete its well led developmental review and commissioned the Good Governance Improvement group to undertake this to inform its development programme of work. The Board recognised the need to create the Project Management Office governance arrangements to underpin the delivery of a high risk financial programme of work. To ensure the capability and capacity was created within the organisation PWC were engaged along with an internal Turnaround Director to reduce the risk of failure. This has progressed in line with plan and continues to be a key focus, ensuring there is a sustainable approach for the future.* ***1. Strategy:*** *The Trust has recently developed its strategy for 2025-30 following the arrival of the new Chair. This is planned for approval on 2 October 2025 Board of Directors. It was developed in partnership with colleagues in a number of listening events and system partners. It is fully aligned to the NHS England 10 year plan, summarising the financial challenges, outlines our ambition to become an accountable care organisation, makes a commitment to optimise the hospitals sites aligned to productivity and efficiencies and outlines the priority areas for our core clinical services, patients and colleagues. This has been developed alongside the Trusts financial sustainability plan which has been supported by PWC recognising the scale of the savings required. The strategy reflects the following; the strategic framework, alignment to the fit for the future NHS 10 year health plan, our commitment to become an accountable healthcare organisation, becoming a well led organisation, governance arrangements, achieving financial sustainability, our role as a provider of specialist and local care, our role as an anchor institution, our people and workforce, continuous improvement education and research, our commitment to population health, our approach to technology and digital and our operating model. The services that are in line with the system clinical priorities are contained within the strategy alongside details of how the strategy will be delivered. The Trust has recently held a digital workshop facilitated by PWC to understand excellence from a digital perspective and an implementation plan is under development aligning to national and local priorities.* *The Trust Strategy will be delivered through the Single Improvement Plan (SIP), each portfolio of the SIP is aligned to the 5 priorities of the organisation, referred to as the 5P's, Patients, Performance, People, Productivity, Partnerships and monitored through the Finance and Performance Committee and to the Board through the Integrated Performance report.* ***2. Licence Conditions*** *: The Trust is currently complying with conditions on the licence. The Trust is engaging fully with the Recovery Support Programme (RSP) which has now the transitioned to the National Performance Improvement Programme (NPIP). The Trust Board is fully committed to making the required improvements at pace and is working with the support of the NPIP team to secure the additional capacity required for the priority programmes of work. This includes: Improving the capability and capacity of the PMO; Workforce data analyst; demand and capacity modelling; support from ECIST, SIP governance, Board and senior leadership development. The trust has engaged with a programme of support through PWC and employed a Turnaround Director recognising the significant savings required across the organisation to ensure there is the capacity to undertake the work at the pace required. The Trusts revised exit criteria was considered by the Finance and Performance committee on the 26 August and confirmation provided to NHS England this was accepted. This has replaced the previous exit criteria that were in place.* ***3. Board of Directors:*** *The Trust has a full complement of non-executive directors, 5 of which were appointed in early 2025 and are all substantiv e appointments. The Board has made 2 new Executive Director appointments, and an interim Chief Financial Officer appointment and the CEO has reorganised the portfolio of the Executive team to ensure there are clear accountabili ties and responsibilities for all areas of operations including quality, delivery access standards, operational planning and finance. To ensure this is embedded the Trust has implemented a new accountability framework which was highlighted as an example of good practice in the developmental well led review undertake by the Good Governance Improvement organisation in July 2025. The Trust has commenced a Board development programme to support the Board developing and working as a unitary Board and there is a Board succession plan in place with an Annual Executive succession assessment undertaken.* ***4. System Leadership:*** *The Trust Chair is the chair of the Provider Collaborative Board. The Trust CEO has recently been appointed as the lead CEO of th e PCB and as the acute Trust representative on the ICB. The Board is acutely aware of the demand on leadership time to enable the system working but also appreciates that improvements will not be delivered without a whole system approach. The Board is closely monitoring the key metrics and performance indicators. The CEO has recently appointed a new deputy CEO, which is the Chief Nursing Officer and the CNO has robust deputy arrangements. The Trust is a fully active member of the PCB meeting monthly with a supporting governance infrastructure in place to facilitate a collaborative approach to system challenges, mutual aid to improve overall system performance. The ICB CEO also attends the PCB to ensure whole system working. There is joint working across each Executive portfolio. The Trust does consider there is an open and transparent review of challenges across the system. The review undertaken by Strasys and an experienced medical leader is supporting the clinical leaders to develop a plan for clinical redesign.* *The Provider Improvement Directors meet regularly and have delivered a number of improvement programmes for example Engineering Better care programme on Frailty. More recently the teams are aligning programmes of work to the financial priorities and are working together to share best practice in reducing costs e.g. trauma and orthopaedics and the newly designed daily Management System to reduce variable pay, which we are sharing with 15 organisations as part of the NHS Impact improvement organisation.* *The Trust has provided mutual aid to system partners to address system fragility and have recently made a joint appointment to the Chief People Officer for East Lancashire. This has enabled sharing of learning across both organisations; examples include the work to reduce sickness at LTH now being shared with ELHT and improving processes for people and recruitment. Teams are now working together to address the clinical reconfiguration to advance vascular reconfiguration as a first priority. The Trust is engaging in a system wide review of community services and has also agreed to be the lead provider for pathology.*
Quality of care	• Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients • Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	**Confirmed**	***1. Patient Safety Information and Analysis:*** *The Trust has an internal quality assurance programme in place called STAR. STAR includes the CQC Key Lines of Enquiry and includes monthly peer monitoring alongside a risk stratified accreditation process. Results are reported from ward to board disaggregated by risk to demonstrate outcomes in out patient and inpatient areas. The system mandates a number of fundamental elemts of care and the reporting of these are presented to safety and quality committee on a monthly basis. The standards were developed in response to areas that required improvement from the previous years results and correlated with areas that required improvement as identified in the CQC inspection. The scope of the audits include staff and patient feedback, environment and documentation. There are 14 different groups of accreditations audits to reflects the range of needs across the various clinical departments. Departments who achieve 3 consecutive green (90% or above) rated accreditation outcomes are awarded a gold star as part of celebration events on a quarterly basis. The Board is involved in the celebration of achieving gold status. Wards and departments are required to evidence improvement work and peer support as part of the Gold accreditation and then share learning with ward and departments as part of the chief nurse weekly Nursing, Midwifery & AHP leaders forum. There is a STAR quality assurance policy in place that outlines the arrangements to respond to areas where improvement is required and enhanced monitoring arrangements are in place when risks are identified. A monthly STAR report is produced with learning themed following analysis of the results across the organisation, this is used to motivate and inspire improvement work. The Trust has a continuous improvement team in place that supports focused work in line with the Always Safety First strategy, the strategy that aligns to the national safety strategy. Improvement work has focused to date on fluid balance, VTE, intentional rounding, sepsis, induction of labour, triage and medication safety. The outcome of the STAR monthly and accreditation is contained within the Divisional Improvement Forums which are part of the Trust Accountability Framework.* *Each Board member is aligned to a division within the organisation, there are monthly safety walk rounds focused on themes arising from patient safety incidents in which Board members are involved in. There is a monthly Emergency Department (chaired by the CNO) and Maternity and neonatal safety forum (Chaired by CNO and includes the Board MatNeo NED) recognising the risks within these services. There is a patient story at the start of each Board meeting and a patient experience bi annual report that provides progress against the patient experience plan for the organisation. This includes qualitative and quantitative information.* *The organisation has commenced a programme of work for Urgent and Emergency Care focused on reducing the days kept away from home. The strengths based approach is aimed at valuing patients time and includes a number of training and equipment interventions delivered in partnership with the local authority to reduce the impact of deconditioning whilst in hospital and to reduce length of stay in hospital. The UEC plan has 2 core components, these are days kept away from home and 2 hour response. There is a lead executive for each programme of work.* *The Good Governance Improvement organisation undertook a developmental well led review in July 2025. The outcome of this provided assurance to the board that there was appropriate governance and risk processes within the organisation. The organisation has consistently achieved the 10 Mat neo safety standards for the previous 6 years. The evidence submission for these standards is independently appraised and approved by the ICB.* *The organisation has completed reviews following national case reviews including the Manchester Mental Health Trust and the Fuller report. The Board has remained compliant with requests from NHS England including the use of the Infection, prevention and Control Board Assurance Framework and more recently the maternity neonatal request of Boards.* *The Organisation is fully compliant with appraisal and core skills at 90% or above.* *There is an Equality Quality Impact Assessment policy and process in place aligned to the delivery of Waste Reduction Programmes (WRP) and major changes. There is a quarterly review and assurance report presented to the Safety and Quality committee. A sample of the EQIAs have been tested as part of the NPIP process and has met the required standard. There is evidence of scheme rejection as part of the EQIA process.* *The Trust has a set of Corporate objectives that includes objectives aligned to the 5P's. Patients, Performance, People, Productivity and Partnership focused on improvement. The Trust has a well established improvement offer. There is a Chief Strategy and Improvement Officer with a team of improvement experts who have used the NHS Impact framework to ensure a robust improvement methodology is adopted at System (macro), Pathway (meson), local ward and department (micro) level. In line with best practice guidance the trust has four improvement experts (trained to either MSc in improvement or IHI improvement advisors), 80 internal quality experts (as defined by NHS improvement report 2017). The trust has had 2 continuous improvement strategies and this year has developed a single improvement plan aligned to the priorities and objectives of the organisation.* ***2. Systems to monitor and relay concerns to Board:*** *There is a twice annual Freedom to speak up report that is scrutinised by the Board of Directors. This is informed by a bi monthly Freedom to speak up triangulation meeting which considers Datix, F2SU concerns, student, staff and patient feedback. Speak up arrangements are encouraged as part of STAR accreditation and monthly safety visits are designed for small numbers of people to go into areas that are aimed at encouraging staff to speak up. There are staff side arrangements in place and presence at various forums across the organisation to ensure staff voices are heard. There are arrangements in place for team leaders to utilise the Team Engagement Tool (TED) which includes exploring speaking up and raising concerns. Staff survey results are analysed based on feedback and targeted culture work undertaken in areas where results indicate closed cultures or leadership improvements are required. The outcomes of this work is reported to workforce committee.* *The Safety and Quality committee receive bi annual nurse, midwifery and AHP safe staffing and mortality reports that triangulate information relating to staff and patient experience and outcomes against safe staffing levels and fill rate. The further development of an approach to medical staffing is underway but currently includes the Guardian of Safe working report and GMC survey results alongside exception reports. This information is also triangulated against outcomes measures as part of the safe staffing reviews. The Chief Nursing Officer meets with matrons, ward/department managers and educators weekly and the Chief Medical Officer meets with Clinical Directors fortnightly ensuring a space to connect and encourage speaking up and sharing of concerns and risks to take a shared approach to addressing any areas highlighted.* *Patient experience surveys are compared against national organisations. The trust currently compared favourably for cancer and maternity , at peer average for inpatient and children and less favourably for UEC. Action plans are in place to continue to focus on feedback provided through STAR visits, incidents, complaints , concerns and friends and family surveys. The trust has a health Improvement plan, designed to systematically address areas that will continue towards the system approach to reducing health inequalities. The trust undertakes the mandated analysis of UEC and elective admissions in adults and children annually to identify any themes that may lead to preventable inequalities. Individual patient interviews are undertaken with patients who have protected characteristics. This year a new approach to learning disability and mental health patients has resulted in more focused feedback from patients within these pathways. A youth worker on the children's ward is focused on collecting feedback from children presenting with mental health disturbances.* *Structured Judgement reviews take place for all patients who die in hospital with a diagnosed serious mental health illness or learning disability. the PSIRF considers the impact of protected characteristics on patient safety incidents and learning incorporates consideration of factors likely to have influenced the outcomes for patients and families. The Board has a comprehensive Safety and quality committee agenda that is holistic in its approach and has demonstrated the appetite to increase frequency of data where assurances are not sufficient or where the risk is deemed high. The safety and quality committee receives monthly information on the number of complaints and bi annual themed analysis of complaint and friends and family information. This information is scrutinised as part of STAR quality assurance processes and within division governance arrangements.*
People and Culture	• Staff feedback is used to improve the quality of care provided by the trust • Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels • Staff can express concerns in an open and constructive environment	**Confirmed**	*1.* ***Staff feedback*** *is used in a number of ways to improve the quality of care provided at the trust. The staff survey feedback, quarterly pulse surveys, STAR staff and patient feedback, feedback from patient safety walk rounds, leadership forums, student feedback, improvement forums continue to be used to prioritise the areas that have been taken forward as part of the Always Safety First Strategy and wider improvement work across the organisation. As part of a European research study Magnet4Europe staff were surveyed over the period of the study and reported safety as an organisational priority within the top quartile of providers. Sickness is a priority improvement area across the organisation, with a number of actions demonstrating early delivery and a commitment for continued focus. The staff survey results in 2024/25 demonstrated a correlating reduction in people promise scores aligned to the significant financial pressures of the organisation. Prior to this there had been a year on year improvement in all people promise areas with above average performance in 2024/25.* ***2. Education and Training:*** *Over the past year significant progress has been made across all key areas of education and training with notable developments in compliance, clinical skills student support, governance and workforce development. (see education training strategy annual report). The Trust monitors compliance on a monthly basis and reports to Board through the Education, Training and Research committee and is fully compliant (>90%) with all core skills and appraisal, compliance has been strengthened recently with the introduction of additional processes to ensure compliance is achieved and maintained across the workforce. The trusts provides training for every level of the organisation in the areas of clinical skills required to deliver reliable care. there are a number of widening participation career pathways available with robust use of the apprenticeship offer up to and including Masters level apprenticeships. NHS England are working with the trust to explore the development of a Centre for Modern healthcare Education. There is a robust leadership development designed to underpin the vision and leadership direction. The Framework focuses on maximising performance and potential and builds on the Trust values. It captures and describes the attributes, behaviours and outcomes, which support people managers and leaders in improving their performance now and in the future, which will in turn improve the performance of our organisation. NMAHP Continuing Professional Development funds are ringfenced to ensure adequate access to training is achieved. An annual training needs analysis is undertaken with close partnership working in place with local Higher Education Institutions to ensure value and quality for money is achieved. The Board is assured through the appropriate use of funds through a report to Education Training Research committee alongside reporting to NHS England.* ***3. Staff expressing concerns:*** *There is a twice annual Freedom to speak up report that is scrutinised by the Board of Directors. The purpose of this assurance report is to detail the volume of concerns raised over the last 6 months broken down by Division, Team, professional group and location of concerns. The themes and trends of concerns are also analysed alongside the number of cases closed and volume of anonymous reporting. The report presents assurance against the strategic level actions being taken in response to the concerns. The report triangulates concerns with colleagues perceptions as provided in the relevant NHS Staff Survey questions. The Raising Concerns Group is a subgroup of Workforce Committee, meeting bimonthly, this meeting is chaired by the Chief People Officer and the Non-Executive Director with responsibility for FTSU in attendance, alongside colleagues from Governance, Patient Experience, EDI, Workforce, Organisational Development, Senior Medical Leaders and Education. The purpose of the group is to review themes and trends in relation to FTSU concerns and triangulate this with other sources of evidence this can include grievances, culture work, EDI Ambassador Forum Feedback, Datix, Ward Accreditation outcomes, patient experience themes from patient satisfaction surveys and complaints, resident doctor surveys etc. The group discusses the proposed actions and next steps for escalating the risk to relevant team or meeting for further intervention and oversight. There is a mature and comprehensive culture risk process in the Trust, which sets out how cultural concerns can be identified, categorised and responded to. All culture risks have executive and Board level oversight. The Divisions meet on a monthly basis with the Executive Team to review any active culture risks, review progress, any further supportive intervention required and impact on improvement. There is a review process of all Trust culture risks in Workforce Committee, where appropriate in Safety and Quality Committee and also Board.* *There is a clear process for colleagues to raise concerns, individuals can make direct contact with the Guardian, the FTSU Champions, via an anonymous Datix form and through a QR code to an online form if IT access is an issue. All concerns are acknowledge and colleagues have the chance to discuss concerns should they wish with the Guardian. The individual is consulted with before a case is closed to ensure they are satisfied appropriate action has been taken. 3 months post the case being closed, the individual is contacted for their feedback on the service and if improvements in the workplace have been sustained.* *The NHS Staff Survey Data for 2024 found that in response to the question "Feel safe to speak up about anything that concerns me in this organisation" the Trust average was 58.5% which is below the national average of 60.5%., For the item "Feel organisation would address any concerns I raise" the Trust average was 44.2% against a national average of 48.0%. For both questions 2024 was the first year of decline after 3 years of steady improvement, a comprehensive action plan is being delivered to address this. There is evidence that staff raise concerns through a number of routes and this has lead to the required response and intervention. The focus on speaking up and the methods to do so remain a clear focus of the quality assurance accreditation visits, safety walk rounds, communications and interactions with teams.* *More broadly with regard to other NHS Staff Survey items relating to other areas of concern such as bullying and harassment and clinical concerns the Trust sat broadly in line with the national average as displayed below:* *-"Last experience of physical violence reported" Trust average 72.5% which is above the national average of 71.4%* *-"Last experience of bullying, harassment or abuse reported" Trust average 52.6% which is slightly above the national average of 52.5%* *-"Encouraged to report errors, near misses & incidents" Trust average of 86.0% is same as national average* *-"Would feel secure raising concerns about unsafe clinical practise" Trust average 70.1% which is slightly above the national average of 70.0%* *-"Would feel confident that organisation would address concerns about unsafe clinical practice" Trust average 53.2% which is below the national average of 55.1%*

Access and delivery of services	• Plans are in place to improve performance against the relevant access and waiting times standards • The trust can identify and address inequalities in access/waiting times to NHS services across its patients • Appropriate population health targets have been agreed with the ICB	**Partially confirmed**	***1. Performance Improvement:*** *The Trust is in Tier 1 for RTT, Cancer and DM01 and Tier 2 for UEC. The Trust performs positively for the cancer faster Diagnostic standards. The Trust has received no funding for growth in 2025/26 and although has been asked to deliver activity without additional funding this is limiting the ability to deliver the targets. The Board was pleased the work delivered this year has resulted in an amber green rating for productivity. There are 4 plans that have been developed that aim to improve performance, the outcome of which are monitored by the Finance and Performance Committee.* *The trust has detailed speciality/service level performance improvement plans in place focussing on RTT, Cancer, Diagnostics and UEC performance.* *The Trust Board requires additional resource to deliver this. A bid to receive Regional Transformation Funds was submitted, the success of this will determine the ability to improve and mitigate the impact of winter.* *The Board has undertaken a winter plan self assessment that will be discussed at the October 2025 Board highlighting the risks associated with not receiving the Regional Transformation Fund.* *Weekly Performance Recovery meetings are in place and chaired by the COO or Deputy COO to track delivery of improvement plans and performance. The COO reports progress to the CEO on a weekly basis through the improvement walk the wall exercise ensuring the executive team are involved in supporting recovery in this area.* *The Trust is supported within the Tiering framework by NHSE colleagues who review progress and barriers to delivery on a fortnightly basis.* *The quarterly PSIRF report identifies any patients that incur harm as a result of delays and enables a thematic approach to be taken where necessary. For example, current endoscopy times and risk requires waiting list validation and clinical triage to ensure high risk patients are identified and appropriately accessing treatment. The risks associated with DM01, Cancer and UEC are principal risks on the Board Assurance Framework.* *The Trust recognises the importance of a robust approach to demand and capacity analysis to maximise performance improvement. Support has been secured through NPIP for the Intensive Support Team to support the development of skills capability within operational teams.* ***2. Health Inequalities and alignment to system targets*** *: The Trust has a health improvement plan developed in partnership with the Director of Public Health aligned to the Integrated Care Partnership priorities and is compliant with publishing data for adults and children in planned and urgent care that identifies inequalities by deprivation, ethnicity and gender. Its use is evolving within the organisation and provides assurance to the Safety and Quality committee twice annually on the progress made against the plan. The trust has worked with the system to create a proposal describing the collaborative work required to reduce health inequalities. Work is also underway which the Trust has facilitated to co-design with partners a model for large scale change ensuring the intelligent use of data, optimising digital and technology, clinical leadership to redesign pathways of care and aligning the improvement approach at system level to NHS Impact. The trust has minimise the number of patients waiting longer than 65 weeks and where a learning disability or serious mental illness is recognised a clinical triage takes place to ensure risks are minimised for this group of patients recognising the additional risks present. There is a limiting factor post Covid where primary care data is no longer shared with the Trust and therefore this approach has now ceased. The Trust is also leading work with North East and North Cumbria team and the healthcare improvement team in Scotland to explore how to best design, deliver and sustain improvement at system level as part of a Health foundation grant which is being evaluated by Professor Nicola Burgess.* *Education regarding reducing health inequalities is a core primary driver of the health improvement plan.* ***The rationale for the assessment score:*** *Rationale: The Trust is in Tier 1 for RTT, Cancer and DM01 and Tier 2 for Urgent and Emergency care.* *How long has this persisted? This is the second year of this Tiering position. The mitigating actions are contained within the action plans submitted to NHS England.* *Plan: The Trust is mobilising internal grip and control and productivity actions to improve the position however, the Trust requires financial support to fund activity growth and recover the current performance position. This has been outlined as part of the Tiering discussions with NHS England and with the ICB.*
Productivity and value for money	• Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	**Partially confirmed**	***1. Productivity*** *The Trust has worked with PWC to identify the opportunities across each specialty for productivity and efficiency improvement using the Model Health System (MHS) data and the carer data. the first wave of work has been completed which has resulted in improvement. The benchmarking exercise has been repeated by PWC in Sept 2025, the initial analysis has shown the Trust against peers has a further £34.2m to £68.5m of opportunity to be validated. At the start of the financial year 25/26 the opportunity identified was £98.3m. (This now requires further validation)* *The Trust has an Outpatient Programme Board and a Theatre Efficiency Group that use MHS benchmarking data to develop focused improvement plans. The outcomes of this are reported to Finance and performance committee. The outpatient Board has a comprehensive programme to deliver improvements in Patient Initiated Follow up (PIFU) PET plus leading to improved performance and experience for patients. The work is also focussed on reducing waiting list initiatives, Did Not Attends (DNA's) and increase clinic utilisation. A reception self check in business case is in development which will further improve productivity in outpatients and further accelerate the productivity in outpatients.* *The Trust has an ambition to develop a digital strategy that will create a digital patient portal to access all services, this would significantly reduce the workforce WTE required to manage the outpatient booking process and would enable significant improvements in performance but does require financial investment.* *The trust recognises further focused work on the measurement of wider productivity within the organisation will identify future benefits and is developing an approach that will enable specialty level understanding of agreed metrics.* *The Trust has developed a business intelligence daily management system triangulating roster metrics and use with financial outputs to drive efficient use of the workforce in all areas. This system is in place for all healthrosters in all departments of the Trust. The reporting enables a clear line of sight to track and monitor compliance with agreed approaches to headroom, additional staffing, sickness and roster management and is supported by weekly oversight through the CEO walk the wall review.* *The Trust has a service review programme in place that utilises methodology recommended through the Improvement and Assurance group. This utilises the latest data from MHS, and in addition has a GIRFT steering group that is linked to the Single Improvement Plan Oversight Group.* *The opportunity analysis provided by NHS England was utilised at the start of 2024/25 to identify the services with the greatest opportunity and these services have taken part on the first wave of the service reviews. the team are working with PWC to refine the approach to service reviews to maximise delivery of improvements through the adoption of digital. The next wave of service reviews is planned and will continue to be tracked through the PMO and WRP.* *The Trust has launched a 'Days Kept Away from Home' strengths based approach focused on reducing deconditioning and optimising length of stay for patients whilst improving outcomes, the development of an approach in partnership with Lancashire County Council has led to the implementation of a proportionate care model of care and assessment that aims to reduce overall reliance on long term health and care needs.* *The Trust has an electronic job plan system in place, 85% of job plans have now progressed through a strengthened process led by the Deputy Chief Medical Officer. There is a WRP programme in the plan to further enhance this work to realise the benefits from a 42 productive week programme of work.* *Chorley is a GIRFT accredited hub for adult and children elective surgical care.* *Sickness has limited some of the progress within GIRFT portfolio, this has now been addressed and structures put in place to ensure PMO leadership for GIRFT within each division. The Deputy CMO chairs a newly formed GIRFT programme Board.* *The Trust is rated amber green currently for productivity.* ***The rationale for the assessment score:*** *Rationale: At the start of the financial year 25/26 the opportunity identified was £98.3m.* *How long has this persisted? The opportunity to improve productivity has persisted for more than 2 years. The Trust has worked with PWC to identify the opportunities across each specialty for productivity and efficiency improvement using the Model Health System data and the Carter data. The first wave of work has been completed which has resulted in improvement. The benchmarking exercise has been repeated by PWC in Sept 2025, the initial analysis has shown the Trust against peers has a further £34.2m to £68.5m of opportunity to be validated. (This now requires further validation). The Trust is rated amber green currently for productivity.* *Plan: The Trust is focused on developing a suite of measures that will build on existing productivity measurement approaches in theatre and health roster and allow closer monitoring and scrutiny of productivity in outpatients and 42 productive weeks for job planned colleagues across the organisation.*
Financial performance and oversight	• The trust has a robust financial governance framework and appropriate contract management arrangements • Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes • The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	**Partially confirmed**	***1. Financial governance oversight:*** *The Trust has a robust financial governance framework, having had an external review of the previous arrangements from Ernst Young and having had support from PwC and the Trust's turnaround director to strengthen the financial governance framework. The Trust has appropriate contract management arrangements in place.* ***2. Financial Risk:*** *As part of our work with PwC, the Recovery Support Programme team and the Improvement and Assurance Group, the Trust has a strengthened programme of work focused on financial controls. The internal audit programme for 24/25 included an internal audit of key financial processing controls which concluded a substantial assurance opinion. Continuous audits of the Trust's financial controls have been put into place, this year with PwC and a repeat audit is being concluded by MIAA focussed on grip and control. The Trust has included waiting list management data quality as part of the internal audit in 2024/25 and in 2025/26 there is a financial governance internal audit scheduled to take place and a data quality audit.* ***3. Contract Disputes:*** *There have been no formal contractual disputes in the last 12 months.* ***4. System Working:*** *Lancashire and South Cumbria PCB host a clinical reconfiguration programme developed as part of a wider system analysis of the most effective delivery of clinical services. The programmes planned for 2025/26 are on track for delivery.* *The Trust has taken a standardised approach to people arrangements with the aim of ensuring value for money and positive people experiences across the ICS.* *The Trust has designed, tested and embedded a new Daily Management system to track the variable pay and unavailability of staff and has aligned this to the financial costs. This has been shared across the system and wider NHS as part of NHS Impact.* ***The rationale for the assessment score:*** *Rationale: The Trust is in NOF 5. The Trust has a robust financial governance framework, having had an external review of the previous arrangements from Ernst Young and having had support from PwC and the Trust's turnaround director to strengthen the financial governance framework. The Trust has appropriate contract management arrangements in place. As part of our work with PwC, the Recovery Support Programme team and the Improvement and Assurance Group, the Trust has a strengthened programme of work focused on financial controls. The internal audit programme for 24/25 included an internal audit of key financial processing controls which concluded a substantial assurance opinion. Continuous audits of the Trust's financial controls have been put into place, this year with PwC and a repeat audit is being concluded by MIAA focussed on grip and control.* *How long has this persisted? The financial performance and oversight improvement requirement was highlighted in 2024/25 and the trust placed into the Recovery Support Programme and more recently into NOF 5.* *Plan: The Trust continues to report to the Improvement and Assurance (IAG) on the progress against the financial plan.*
	In addition, the board confirms that it has not received any relevant third-party information contradicting or undermining the information underpinning the disclosures above.	**Confirmed**	*The Board confirms this.*

Signed on behalf of the board of directors

Name

Date

13.2 AUDIT COMMITTEE CHAIR'S REPORT

Other | T Wheeler | 12.30pm

Item for assurance

REFERENCES

Only PDFs are attached

13.2 - Chairs Report Audit 24 Sept.pdf

Chair's Report to Board		
Chair: T Wheeler	**Committee: Audit**	
Date(s): 24 September 2025	**Agenda attached for information**	✓

Strategic Risks	trend	Items Recommended for approval
N/A		**N/A**

ALERT **Areas of concern; Matters requiring urgent attention; Insufficient assurance received.**	• None
ADVISE **Areas requiring on-going monitoring; Limited assurance received.**	• Procurement: There is a significant downward trend in single tender waivers, showing improvement, but further work is needed to reach best practice levels. The Board should be advised that this remains a focus area, with ongoing efforts to minimise waivers and strengthen controls. • Triangulation of divisional performance: The Committee discussed the need for a more integrated view of divisional performance across risk, quality, and compliance metrics.
ASSURE **Assurance received; Matters of positive note.**	• Internal audit and risk management: Progress is being made on the internal audit plan and risk management strategy, with KPIs above 90% and actions in place to address long-standing and operational high risks. • Clinical audit and procedural documents: Strong compliance with national clinical audit requirements and a more rigorous, transparent process for procedural document management are in place, with ongoing improvements and clear trajectories for compliance.

Audit Committee

24 September 2025 | 10.00am-12.20pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	10.30am	Verbal	Information	Chair
2.	Apologies for absence	10.31am	Verbal	Information	Chair
3.	Declaration of interests	10.32am	Verbal	Information	Chair
4.	Minutes of the previous meeting held on 24 June 2025	10.33am	✓	Decision	Chair
5.	Matters arising and action log	10.35am	✓	Decision	Chair
6. INTERNAL AUDIT					
6.1	Internal audit progress report (inc. update on progress against audits receiving limited assurance)	10.40am	✓	Assurance	MIAA
6.2	Combined Internal Audit and Anti-Fraud follow-up summary report	10.50am	✓	Assurance	MIAA
6.3	Counter Fraud Progress Update	11.00am	✓	Assurance	MIAA
7. GOVERNANCE & COMPLIANCE					
7.1	Bi-Annual Risk Management Strategy	11.10am	✓	Assurance	Associate Director of Risk & Assurance
7.2	RSP Support Funding Update	11.20am	verbal	Information	Interim Chief Finance Officer
7.3	Procurement Update & Single Tender Waiver Report	11:25am	✓	Assurance and Approval	Associate Director of Procurement
7.4	Losses and Special Payments Report	11.35am	✓	Decision	Assistant Director of Financial Services
7.5	Cyber Security	11.45am	✓	Assurance	Chief Information Officer
7.6	Clinical Audit Programme Update	11.55am	✓	Assurance	Associate Director of Safety and Learning

№	Item	Time	Encl.	Purpose	Presenter
7.7	Procedural Documents Update	12.05pm	✓	Assurance	Associate Director of Safety and Learning
7.8	Items to alert, assure and advise to Board or refer to other committees	12.10pm	Verbal	Discussion	Chair
7.9	L & SC Audit Chairs' Briefing	12.15pm	Verbal	Information	Chair
8. ITEMS FOR INFORMATION					
8.1	Civil Claims annual report		✓		
8.2	Strategic Risk Report		✓		
8.3	MIAA NHSCFA Feedback report		✓		
8.4	MIAA FTPFO – AC progress paper		✓		
8.5	Date, time and venue of next meeting: *15 January 2026, 10.30am, Microsoft Teams*	12.20pm	Verbal	Information	Chair

14. ITEMS FOR INFORMATION - CONTAINED IN THE ANCILLARY PACK

14.1 *DATA QUALITY ASSURANCE REPORT

Information Item

contained in the ancillary pack

14.2 *SOCIAL VALUE STRATEGY

Information Item

contained in the ancillary pack

14.3 DATE, TIME AND VENUE OF NEXT MEETING:

Information Item | M Thomas | 12.30pm

4 December 2025 at 9:15am at Lecture Room 1, EC1, Royal Preston Hospital