NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS PART I

BOARD OF DIRECTORS PART I

6 August 2026

09:15 GMT+1 Europe/London

Lecture Room 1, Education Centre 1, Royal Preston Hospital

AGENDA

- Agenda 1
  - 0.0 Agenda - Board (part I) - 6 August 2026 .pdf 2

1. Chair and quorum (9.30 am) 4
2. Apologies for absence (9.32 am) 5
3. Declarations of interest (9.35 am) 6
4. Minutes of the meeting held on 4 June 2026 (9.37 am) 7
   - 4.0 Minutes - Board (Part I) - 4 June 2026 APPROVED.pdf 8
5. Matters arising and action log update (9.40 am) 20
   - 5.0 Action log - Board (part I) - 4 June 2026.pdf 21
6. Chair's opening remarks and report (9.42 am) 22
   - 6.0 Chairs Report.pdf 23
7. Deputy Chief Executive's report (9.45 am) 27
   - 7.0 Deputy CEO Report to Board - 6 August 26 - final .pdf 28
8. Board Assurance Framework (9.55 am) 38
   - 8.0 BAF Risk Paper - August 2026 - Final.pdf 39
9. PERFORMANCE 68
   - 9.1 * Integrated Performance Report as at August 2026 (10.10 am) 69
     - 9.1 Integrated Performance Report as at 30 June 2026 - Executive Summary.pdf 70
   - 9.2 Winter planning 2026/27 - Process & timescales (11.10 am) 72
10. PATIENTS (SAFETY AND QUALITY) 73
    - 10.1 Safety and Quality Committee Chair's Report (11.20 am) 74
      - 10.1 SQC Chairs Report 29 May 26 June 2026.pdf 75
      - 10.1a - Annual Safeguarding Report August 2026 Executive Summary.pdf 82
      - 10.1b Annual Mortality Report - Executive Summary.pdf 85
    - 10.2* Maternity and Neonatal Services Report (11.30 am) 89
      - 10.2 Maternity & Neonatal Report - Executive Summary August 2026.pdf 90
    - 10.3*Board Assurance Statement: Nottingham Maternity Review; Response to the Fuller Inquiry; and Human Tissue Authority Report (11.40 am) 93
      - 10.3 Board Assurance Statement Nottingham Maternity Review; Response to the Fuller Inquiry; and Human Tissue Authority Report.pdf 94
- Break (11.50 am) 97

11. PEOPLE & PARTNERSHIPS (WORKFORCE, EDUCATION AND RESEARCH) 98

11.1 People & Partnerships Committee Chair's Report (12.00 pm) 99
11.1 PPC Chair's Report 15 July 2026 - BoD 6 Aug 26.pdf 100
12. PRODUCTIVITY (FINANCE) 104
12.1 Finance and Performance Committee Chair's Report (12.10 pm) 105
12.1 FPC Chair's Report 26 May 23 Jun 2026 - 06.08.26.pdf 106
13. RISk, GOVERNANCE AND COMPLIANCE 112
13.1 Audit Committee Chair's Report (12.20 pm) 113
13.1 - Audit Chair's Report 18 Jun 2026.pdf 114
13.2 Charitable Funds Committee Chair's Report (12.30 pm) 118
13.2 CFC Chairs Report 16 June 2026 - 06.08.26.pdf 119
14. * ITEMS FOR INFORMATION 121
14.1 * Quality Account 122
14.2 * North West Race Equity Assembly Annual Report 2025/26 123
14.3 Date, time and venue of next meeting (12.40 pm) 124
• CLOSE 125

AGENDA

There will be a patient story presented to Board at 9.15am

REFERENCES

Only PDFs are attached

0.0 Agenda - Board (part I) - 6 August 2026 .pdf

Board of Directors

6 August 2026 | 9.15am | Lecture Room 1, Education Centre 1, Royal Preston Hospital

Agenda

At 09.15am, there will be a **patient story**

Items marked * have additional information in the Ancillary Pack

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	9:30 am	Verbal	Information	M Thomas
2.	Apologies for absence	9:32 am	Verbal	Information	M Thomas
3.	Declaration of interests	9:35 am	Verbal	Information	M Thomas
4.	Minutes of the meeting held on 4 June 2026	9:37 am	✓	Decision	M Thomas
5.	Matters arising and action log update	9:40 am	✓	Decision	M Thomas
6.	Chair's opening remarks and report	9:42 am	✓	Information	M Thomas
7.	Deputy Chief Executive's report	9:45 am	✓	Information	S Morrison
8.	Board Assurance Framework	9:55 am	✓	Decision	H Ugradar
9. PERFORMANCE					
9.1*	Integrated Performance Report as at August 2026 including Finance update and Single Improvement Plan	10:10 am	✓	Assurance	K Foster-Greenwood/ S Morrison/ N Pease/ C Carter
9.2	Winter Planning 26/27 – Process and timescales	11:10 am	Verbal	Assurance	K Foster-Greenwood
10. PATIENTS (SAFETY AND QUALITY)					
10.1	Safety and Quality Committee Chair's Report *(including recommendations on reports below)*	11:20 am	✓	Assurance	K Deeny
*	a) Annual Safeguarding Report		✓	Decision	
	b) Annual mortality, LEDER and PMRT Report		✓	Decision	
10.2*	Maternity and Neonatal Services Report	11:30 am	✓	Assurance	Perinatal Leadership Team
10.3*	Board Assurance Statement: Nottingham Maternity Review; Response to the Fuller Inquiry; and Human Tissue Authority Report	11:40 am	✓	Decision	S Morrison
BREAK		11:50 am			
11. PEOPLE & PARTNERSHIPS (WORKFORCE, EDUCATION AND RESEARCH)					

№	Item	Time	Encl.	Purpose	Presenter
11.1	People & Partnerships Committee Chair's Report	12:00 pm	✓	Assurance	S Crean
12. PRODUCTIVITY (FINANCE)					
12.1	Finance and Performance Committee Chair's Report	12:10 pm	✓	Assurance	A Leather
13. RISK, GOVERNANCE AND COMPLIANCE					
13.1	Audit Committee Chair's Report	12:20 pm	✓	Assurance	T Wheeler
13.2	Charitable Funds Committee Chair's Report	12:30 pm	✓	Assurance	T Ballard
14. ITEMS FOR INFORMATION * ancillary pack					
14.1	Quality Account		✓		
14.2	North West Race Equity Assembly Annual Report 2025/26		✓		
14.3	Date, time and venue of next meeting: *1 October 2026 at 9:15 am at Lecture Room 1, EC1, Royal Preston Hospital*	12:40 pm	Verbal	Information	M Thomas

1. CHAIR AND QUORUM

Information Item | M Thomas | 9.30 am

2. APOLOGIES FOR ABSENCE

Information Item | M Thomas | 9.32 am

3. DECLARATIONS OF INTEREST

Information Item | M Thomas | 9.35 am

4. MINUTES OF THE MEETING HELD ON 4 JUNE 2026

Decision Item | M Thomas | 9.37 am

REFERENCES

Only PDFs are attached

4.0 Minutes - Board (Part I) - 4 June 2026 APPROVED.pdf

Board of Directors

4 June 2026 | 9.15am

Lecture Room 1, Education Centre 1, Royal Preston Hospital

Part I

Present:

Prof. M Thomas	Chair
Dr T Ballard	Non-Executive Director
Mr C Carter	Chief Finance Officer
Prof. S Crean	Non-Executive Director
Dr K Deeny	Non-Executive Director
Mrs K Foster-Greenwood	Chief Operations Officer
Mr A Leather	Non-Executive Director
Prof. S Morrison	Chief Nursing Officer/Deputy Chief Executive Officer
Prof. S Nicholls	Chief Executive Officer
Mr U Patel	Non-Executive Director
Mr J Schorah	Non-Executive Director

Apologies: Mr S Canty, Prof. T Wheeler

In attendance:

Prof. A Brotherton	Chief Strategy and Improvement Officer
Mrs N Compton	Corporate Affairs Officer
Mrs N Duggan	Director of Communication and Engagement
Mrs J Foote	Director of Corporate Affairs
Dr N Pease	Chief People Officer
Mrs K Stanton	Business Manager, Corporate Affairs *(minutes)*
Mr M Stewart	Deputy Chief Medical Officer

Presenters:

Dr D Cottle	Chief Clinical Information Officer *(minute 82/26)*
Ms K Hudson	Deputy Director of Strategy and Transformation *(minute 82/26)*
Ms E Ashton	Divisional Nursing & Midwifery Director *(minute 80/26)*
Mr P Moore	Interim Digital Director *(minute 82/26)*
Ms H Ugradar	Associate Director of Risk & Assurance *(minute 75/26)*

Governors observing: S Connell, L Jackson, I Linacre, T Lindsay, C Oldcorn, G Robinson

Other Observers: One member of the public

Presenters of the patient story:
Lorraine Azam – Stroke Consultant practitioner
Mr S Hill – Patient
Mrs F Hill - Relative
Jacqueline Murray – Deputy Divisional Nursing Director, Medicine
Steve Brown - Diagnostic Radiographer, Neurointerventional Radiology Lead

Prior to the meeting the Board received the following presentation: Mr Hill's Patient Story, presented by the Division of Medicine.

The Board received a patient story presentation from colleagues in the Thrombectomy and Stroke services regarding the experience of Mr S Hill, a patient who was admitted whilst experiencing a stroke.

Mr Hill, following early identification by family members of the F.A.S.T. (Face, Arm, Speech, Time to call) symptoms of Stroke, was quickly admitted by NWAS to Blackpool Victoria Hospital (BVH), where he received timely care, including consultation with the Tele Stroke service and administration of a blood thinner. Consultation across colleagues from BVH and Lancashire Teaching Hospitals (LTH) ensured that Mr Hill was appropriately transferred to LTH where he received a Thrombectomy to remove a blood clot in his brain just 16 minutes after colleagues first consulted to arrange the transfer of care. Mr Hill was held for monitoring and the following day received multi-disciplinary team care including assessment from physiotherapists, occupational therapists and speech and language therapists. During admission, Mr Hill was diagnosed with a previously unidentified condition of Atrial Fibrillation, for which he was then able to commence treatment to reduce risk of further strokes.

The importance of early identification and fast treatment was highlighted as essential better to understand patient outcomes, and Mr Hill's case demonstrated this success, including the benefit of LTH service provision across seven days.

The Board heard about the wrap around and follow-up care available to Mr Hill which included referral to the community Neuro Rehab Team and Occupational Therapy. Mr Hill's recovery journey would also include appointments in an outpatient clinic. Colleagues explained that the service has strong links with the Stroke Association which maintains presence on the ward.

Mr Hill presented his own experience of this journey, firstly acknowledging the help of all the NHS staff involved in his care, across the different hospitals and North West Ambulance service. Mr Hill described feeling seen, heard and cared for by the whole healthcare team and recognised the significant impact staff had on his positive outcome. The Board also heard Mrs Hill express her gratitude to staff and explain the impact the situation had on the wider family.

Mr and Mrs Hill were thanks by the Board for sharing their story and Mr Hill was wished a continued and successful recovery through his aftercare.

The Board reflected on Mr and Mrs Hill's experience and the long fight to host this life saving thrombectomy service for the area. There was consideration of how important post-operative care was to patients achieving maximum recovery and the Stroke service extended an invitation for the Board to visit the department opportunistically.

The Board learned that the Continuous Improvement team would identify key learning of the stroke pathway to capture and use best practice.

The rapid response of the North West Ambulance Service was considered highly effective in supporting Mr Hill's fast access to appropriate care, and it was agreed that a letter of recognition would be sent on behalf of the Board.

81/26 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.

82/26 Declaration of interests

There were no conflicts of interest declared by the Board in respect of the business to be transacted during the meeting.

83/26 Minutes of the previous meeting

The minutes of the meeting held on 2 April 2026 were approved as a true and accurate record.

84/26 Matters arising and action log

All actions from previous meetings had been completed.

85/26 Chair's report

The Chair's report was received, with recognition of the financial and performance challenges for the year ahead. Acknowledgement of improvements in cancer and referral to treatment performance was given as well as the continued importance of work towards a fully defined waste reduction plan. Reference was made to the impact that digital services could have to patients with awareness noted of further work for the Trust to do in this area.

The Board congratulated Non-Executive Director, Dr K Deeny, on being made a visiting Professor at the University of Cumbria.

86/26 Chief Executive's Report

The Board received the Chief Executive's Report.

Improvements in waiting times over the previous 12 months were noted, providing a stronger platform for the year ahead. Significant progress had been made in cancer performance, diagnostic waiting times and endoscopy, with sustained improvement attributed to focused improvement methodology, investment in facilities and workforce, and effective use of resources. The installation of a second linear accelerator was highlighted as a positive development to improve resilience, reduce waiting times and support timely cancer treatment.

The patient story was noted as a powerful reminder of the impact of services on patients and families. It was further noted that the latest national major trauma data indicated one of the strongest survivability performances in the country, reflecting sustained improvement over a number of years, although continued focus would be required.

The Board considered the positive news in the report, particularly around Trust colleagues and patient outcomes, and the value in communicating that across the community to grow confidence in people needing hospital care. Confirmation was given that there are ongoing programmes of local good news stories shared by the Trust, with an opportunity for colleagues and patients to share their contributions.

87/26 Board Assurance Framework

H Ugradar attended for this item.

The Board received an update regarding the Board Assurance Framework (BAF) which had been revised following approval of the 2026/27 Principal Risks and refined to align with the Trust's strategic objectives. A revised baseline had been established, with risk

scores reflecting the position at the start of the financial year and no material movement since approval. Key changes included the disaggregation of planned and cancer care risks into separate Principal Risks (PR3 – Timely access to planned care and PR4 – Timely access to cancer care), the division of workforce culture risks into two distinct risks PR7 – Experience of under-represented staff groups and PR8 – Experience of staff and levels of staff satisfaction), and the introduction of a new workforce reduction risk (PR13 – Delivery of the planned reduction in whole-time equivalent workforce.). Performance and financial risks remained high, consistent with the Trust's operational and financial position.

The Board challenged whether the risks associated with PR13 were sufficiently visible within the Board Assurance Framework, particularly in respect of service provision, patient safety, staff experience and public transparency. It was queried whether a separate or linked principal risk should be developed to demonstrate how the impact of workforce reduction on continued service delivery would be assessed.

The Board was advised that transformation, digital opportunities, revised commissioning arrangements and improved margin on activity were expected to support delivery, and that some workforce-related impacts were already being monitored through relevant principal risks, including indicators relating to morale, wellbeing, retention, culture, staff survey results, Freedom to Speak Up data and employee relations. However, concern remained that the risk should not be managed in the background and should be clearly visible to the Board and the public.

It was agreed that PR13 would be strengthened, including clearer description of the actions, controls and linked risks, and that related principal risks, including PR1 – Patient safety and experience within the urgent and emergency care pathway, would be reviewed as further urgent and emergency care transformation reporting and supporting metrics were received.

PR1 had been revised to make explicit reference to patient experience, alongside safety, and that this remained intrinsically linked to PR5 - Timely access to urgent and emergency care. The Board challenged whether PR1 should remain as a composite risk or be further disaggregated to provide clearer oversight of safety and experience.

It was confirmed that regular reporting on urgent and emergency care transformation would commence from June through the Safety and Quality Committee. This would inform a review of PR1 during quarter two, with clarity expected by the end of quarter two on whether the current composite format remained appropriate.

The Board also suggested the need for clearer measures of success, review triggers and timelines across principal risks, to enable more timely assessment of changing risk levels and support effective Board oversight.

The Board accepted the updates regarding the Board Assurance Framework.

88/26 Integrated Performance Report inc Finance Update and Single Improvement Plan

The Board received the Integrated Performance Report, including the finance update and Single Improvement Plan update as up to April 2026.

Patients - An increase in pressure ulcers was stated, linked primarily to pressures within the urgent and emergency care pathway and changes in the model of care, including patients remaining seated for longer periods. Mitigating actions were described, including weekly scrutiny of improvement actions, new seating in urgent care and further work within assessment areas, with improvement expected over the next two quarters.

Maternity support worker staffing challenges were highlighted, although recent appointments had reduced vacancies and improvement was anticipated. Positive progress was reported in relation to the STAR quality assurance programme and adherence to fundamental standards, with the recovery support team being used to test assurance in higher-risk areas not recently inspected by the CQC, including critical care, neonates and paediatrics.

Assurance was sought on the potential impact of industrial action on the Trust's performance improvement trajectory, recognising that patient safety had appropriately been prioritised. It was confirmed that industrial action presented a risk to delivery and had not been factored into the plan; however, the impact had been minimised where possible and would continue to be mitigated.

Performance - It was noted that year-end performance for 2025/26 had been finalised, with progress reported across planned care, cancer, diagnostics and urgent and emergency care. Referral to treatment performance had reached 59.4%, marginally below the 60% target, but representing a 5% improvement from the start of the year. The Trust had eradicated 65-week waits since November and reduced 52-week waits from over 2,100 patients to 894 by the end of March, exceeding the planned trajectory.

Continued focus was being placed on improving productivity, reducing DNA rates, increasing theatre utilisation towards 85%, expanding patient-initiated follow-up from 5% towards 20%, and reducing overdue follow-ups. Additional capacity was being mobilised where capacity gaps remain despite productivity improvements, these include waiting list initiatives, independent sector support and recruitment proposals.

Cancer performance had improved, with the faster diagnostic standard increasing by 2% and 62-day performance improving by over 18%, making the Trust the fifth most improved nationally and resulting in cancer tiering being stood down in quarter one. Diagnostic performance remained outwardly static, although underlying improvements, particularly in endoscopy, were continuing. Urgent and emergency care performance had also improved, with four-hour performance increasing by 4.5% and 12-hour performance by 2.5%; however, ongoing pressure remained. It was noted that an extended emergency department assessment service would be tested from July, with frailty same day emergency care planned for quarter two to reduce overcrowding and improve timely access.

Assurance was sought that key performance interventions, including PIFU, system flow and EEMAC, were evidence-based, quality assured and capable of delivering the required trajectory improvements. It was confirmed that established best practice, national models of care and GIRFT principles were being used, alongside more innovative digital approaches. Early testing of AI-supported waiting list validation had indicated potential to produce higher-yield clinical review lists, with governance and clinical protocols being developed with clinicians and learning being drawn from other Trusts.

Further assurance was sought on how the elimination of corridor care would be reflected within the Integrated Performance Report, given its significance as an indicator of patient experience, safety, performance and staff advocacy. It was confirmed that the revised national definition was being tracked through weekly executive reporting and would be incorporated into the IPR, supported by expected national comparative data.

There was an opportunity highlighted for ED colleagues to learn from an exemplar organisation, and this would inform local improvement work. The Board emphasised that corridor care should not be accepted as normal practice and that a zero-tolerance approach should be pursued wherever possible, recognising the disproportionate impact on older and more vulnerable patients and the links to wider frailty work.

People - It was reported that the sickness management system had not embedded as intended, and alternative platforms were being explored, including options linked to rostering systems and potential system-wide procurement. Sickness absence was reported at 5.57% against a 5.5% target, with the Trust remaining one of the stronger performers regionally.

A forensic review of vacancies was being undertaken to support delivery of safety targets and service redesign. Compliance with mandatory training and appraisal requirements was reported, and the anticipated introduction of a more nationally standardised approach to mandatory training was noted.

The Board was advised that executive discussions had commenced on the Trust's approach to information governance training, disciplinary interventions and duty of candour, in light of recent national events and the need to strengthen understanding of the impact of breaches on staff, patients and the public.

Assurance was sought on the timescale for replacement sickness management software and the wider benefits of digital plans for patients, workforce and finance. It was confirmed that a business case would be developed within three to six months, with system-wide options and implementation learning to be applied, and that a further update on digital priorities, timescales and impact would be provided.

Concern was expressed that system-level benefits of digital transformation were not yet sufficiently clear, particularly in relation to the impact on patients, staff, workforce requirements and financial planning. Further clarity was required on delivery timescales, funding, benefits realisation and workforce implications, including any training, development or workforce reduction requirements. It was agreed that the Partnership Care Board digital lead would be asked to consolidate the position and provide a clearer overview of the current programme of work, including how digital transformation was expected to translate into tangible benefits for patients and staff.

Finance - The 2026/27 financial plan had been submitted on a breakeven basis, dependent on delivery of a £60m waste reduction programme and receipt of £9.2m deficit support funding. It was noted that national deficit support had reduced significantly from the previous year, requiring delivery of the waste reduction programme to maintain financial balance.

Month one performance had delivered the planned £4.9m deficit and the £0.5m waste reduction target; however, this was noted to be a relatively low early target, with the required run rate increasing significantly later in the year. Approximately £43m of the £60m programme had been fully identified, with a further £3.5m expected to move into a fully planned position, leaving just under £10m still to be identified. The need to sustain the pace of delivery, progress transformational opportunities and work with commissioners on appropriate service funding was emphasised.

The cash position remained positive at £28m, equivalent to approximately 11–12 working days, although this was being monitored daily given planned repayments and capital creditor commitments. It was further noted that deficit support funding would be monitored quarterly and could be withheld if the Trust varied from plan, presenting a potential risk of up to £9.2m

The Board acknowledged the significant financial risk if the waste reduction programme and deficit support requirements were not delivered, including the potential loss of £9.2m deficit support and a materially increased underlying challenge for 2027/28. It was recognised that this could not be managed through recurrent savings alone and may require more fundamental service redesign, workforce changes and consideration of the future size and shape of the Trust.

Assurance was sought on whether unfunded services continued to be provided and whether service cessation may need to be considered. It was confirmed that the value was relatively small in the context of overall turnover and that the primary focus should remain on transformation, productivity, digital opportunities and improved income recovery. The Board identified the need to strengthen commercial thinking, reduce reliance on like-for-like workforce replacement, and develop risk mitigations for any service or workforce changes, recognising the potential impact on performance and patient care.

A suggestion was made for consideration to align relevant metrics to any parts of the Alert, Assure, Advise reports.

The Board received assurance that no unwarranted variations had been identified in the report.

89/26 Workforce Committee Chair's Report

The Chair's report was received and the Board considered the Workforce Committee's alert regarding increased reporting of bullying and harassment, with particular reference to the experience of staff from ethnic minority backgrounds and disabled staff. Assurance was provided that the issue had been reviewed through the Committee, supported by the Workforce Disability Equality Standard and Workforce Race Equality Standard reports. It was clarified that reported concerns related to both staff-on-staff and patient or public-related incidents. The Board was advised that relevant external professional guidance, including GMC guidance, may support further cross-professional learning and improvement.

It was RESOLVED that the following reports be approved:

i. **Workforce Disability Equality Standard (WDES) Return 2026** ***(WFC Minute No. 49/26 refers)***
ii. **Workforce Racial Equality Standard (WRES) Return 2026** ***(WFC Minute No. 49/26 refers)***
iii. **Freedom to Speak Up Report** ***(WFC Minute No. 47/26 refers)***
iv. **Social Value Strategy Annual Report** ***(WFC Minute No. 42/26 refers)***

90/26 Education, Training and Research Committee Chair's Report

The Chair's report was received, and the Board were alerted to recurrent mandatory training non-compliance, noting that compliance above 90% should not reduce focus on completion by all relevant staff, particularly where non-compliance could affect patient safety. Assurance was provided that stronger accountability measures had improved compliance above target, with enhanced reporting enabling areas of lower compliance, including paediatrics and subject-specific gaps such as blood culture training, to be identified and addressed.

The Board sought assurance on the Trust's ability to track role-specific essential training beyond the nationally mandated core skills framework, recognising its potential impact on safety and quality. Assurance was provided that this had been identified as a priority within the Always Safety First Strategy and Patient Safety Improvement Plan, with work underway to define training requirements on a risk-assessed basis. It was reported that priority roles and associated metrics would be identified within the next quarter, alongside a plan to demonstrate compliance before progressing to subsequent phases.

91/26 Safety and Quality Committee Chair's Report

The Chair's report was received with assurance given regarding the thrombectomy service, with continued committee oversight of any escalations that could compromise service delivery. Concern was raised regarding recurring digital interoperability, systems capability and associated risks identified across Safety and Quality, Finance and Performance and Workforce Committees. Assurance was provided that these concerns would be reviewed with relevant Committee Chairs, brought together through Trust Management Board, and reported back through the appropriate governance routes. It was noted that a Board workshop would support further consideration of system-level digital risks, target operating models were expected by the end of quarter two, and the EPR programme would be key to addressing current system limitations. A request was also made for a longitudinal trend of never events to support Board oversight.

It was RESOLVED that the following reports be approved:

i. **Infection Prevention and Control Annual report *(SQC Minute No. 98/26 refers)***
ii. **Patient Experience, Involvement and Engagement annual report *(SQC Minute No. 103/26 refers)***
iii. **PSIRF Annual Report 2025-26 *(SQC Minute No. 97/26 refers)***
iv. **Health Inequalities and Health Improvement Plan Annual Update *(SQC Minute No. 99/26 refers)***

92/26 Maternity and Neonatal Services Safety Report

E Ashton, Divisional Midwifery and Nursing Director, attended for this item

The Board received the content of the report which was aligned to the Perinatal Quality Surveillance Model (PQSM) and the updated Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) year 8 standards. Full compliance with the year 7 standards, which had been formally validated by NHS Resolution, was confirmed. Good progress was reported in transitioning to the revised year 8 framework, which placed

greater emphasis on Board oversight, the use of safety intelligence and targeted improvement across actions A–F.

The Board was assured by the Maternity and Neonatal Safety Report and the revised oversight arrangements for the Maternity Incentive Scheme, including removal of external validation, introduction of a midpoint review and the need for strengthened committee and Board assurance. The introduction of the Maternity Outcome Signal System was also reported.

Workforce challenges, particularly in maternity support roles, were discussed, with assurance provided that recruitment, apprenticeship routes, social value work and flexible retirement options were being used to support capacity. Postpartum haemorrhage rates were challenged, with assurance provided that multidisciplinary and thematic reviews, regional guidance, pharmacy support, training and continuous improvement testing were being progressed.

Assurance was also sought on staff experience within maternity services. It was recognised that the unit remained challenged by staffing pressures and wider national scrutiny, but that staff remained committed to safe, high-quality care. Ongoing culture work, staff engagement, unit visits, Safety Quad oversight including a Non-Executive Director representative, neonatal review processes and early escalation of significant events were noted as providing triangulated assurance.

It was RESOLVED that the:

i. **changes to the requirements commenced in year 8 MIS be approved;**
ii. **Assurance in respect of the oversight and monitoring mechanisms used to monitor safety and quality within maternity and neonatal services be recorded (SQC Minute No. 96/26 refers)**

93/26 Finance and Performance Committee Chair's Report

The Chair's report was received together with an additional update regarding progress against the Waste Reduction Programme. It was highlighted that, although the value of green-rated schemes was ahead of the same point in the previous year, progress had slowed and green-rated schemes did not equate to delivered savings. Month one financial position had been achieved, but not through delivery of the programme, and limited assurance was available at that stage regarding the trajectory for delivery. Concern was raised that key divisions which had under-delivered in the previous year were again behind plan, reinforcing the need for transformation, clear mitigations and strengthened oversight. The Board accepted the report and updates given.

94/26 LTH Digital Enabling Strategy

K Hudson, D Cottle and P Moore attended for this item

The Digital Enabling Strategy 2025–2030 set out a comprehensive framework for the use of digital technology to modernise service delivery and improve population health, aligned to national NHS reform and the Trust's strategic ambition. The strategy prioritised transformation across key areas of patient experience, operational performance, workforce capability and system partnerships, underpinned by the "5 Ps" model,

supported through enhanced digital access for patients, improved data utilisation and integrated systems, alongside investment in workforce development and collaborative working to enable more coordinated and preventative models of care. The strategy indicated that strong governance, cybersecurity and interoperability arrangements had been established to support safe and effective implementation.

The Board sought assurance that the patient perspective had been sufficiently reflected within the digital enabling strategy, particularly in relation to day-to-day patient experience, communication and the extent to which patient voice was influencing the direction of travel. It was suggested that the strategy represented a shift towards enabling patients to access and interact with their own information, including through the NHS App, patient portal and future digital communication routes. Assurance was provided that digital developments would be incremental and would include improved access to letters, two-way communication, patient-submitted information and a more effective digital front door to support clearer information and navigation for patients.

The Board also sought assurance on how staff experience would be considered, recognising that staff engagement and usability would be critical to successful implementation. It was reported that the current electronic patient record presented operational challenges and that feedback from staff would be used alongside preparedness work for a future system-wide EPR. A usability survey would be repeated and metrics were being developed to assess the reliability of core digital services and the practical impact on staff in clinical areas.

The Board recognised the importance of feedback loops across Finance and Performance, Safety and Quality and Workforce Committees, particularly in relation to implementation risks, clinical safety, digital exclusion and staff capability. Assurance was sought that university partners would be engaged to support digital skills development and that opportunities for self-booking, two-way communication and patient-submitted data would continue to be developed. Further assurance was sought that clear metrics would be established to evaluate impact, capacity and capability, with reporting through the Finance and Performance Committee. The Board was advised that clinical risks would be monitored, external learning would inform implementation, and some large-scale activity would be paced to support robust risk mitigation while maintaining delivery of the waste reduction programme.

The Board recognised that future engagement at a Workshop level would allow opportunity for deeper consideration at a strategic level.

It was RESOLVED to approve the Digital Enabling Strategy.

95/26 Audit Committee Chair's Report

The Chair's report was received was received with alerts, advisements and assurances outlined for the Board's information. The Board was advised that the Non-Executive Directors in Audit Committee had received a detailed overview of the 2025-26 annual accounts in readiness for final approval.

96/26 Recovery Support Programme Exit Criteria

Progress against the current Enforcement Undertakings and the Recovery Support Programme (RSP) exit criteria was presented, with supporting evidence as submitted to the Improvement Assurance Group in April 2026 detailed within the appended documentation.

Of the 31 undertakings, the majority had been achieved or were compliant, with a smaller number partially achieved or subsequently amended. It was highlighted that two financial undertakings relating to agreement of the 2025/26 Financial Plan and delivery of a consistent quarter-on-quarter run rate improvement had not been fully achieved. While overall financial run rate improvement had been delivered, variability across quarters had prevented full compliance with the requirement.

97/26 Assurance Committee Realignment Report

The report presented to Board explained that the 2026 Board effectiveness review had identified limitations within the existing committee structure, including duplication and gaps in assurance arising from an inability to effectively triangulate operational, financial and workforce performance.

In response, a revised committee model had been developed to improve accountability and strengthen oversight, with alignment to the five domains of the Single Improvement Plan providing a more integrated assurance framework. The proposed changes included the consolidation of workforce-related functions and enhanced oversight of workforce metrics within existing financial and performance structures, while maintaining current committee naming conventions. The model was set out as:

i. The re-alignment of assurance committees against the five domains of the SIP:

   Safety & Quality (SQC) with the Patient domain (with the retention of SQC as its name)
   Finance and Performance (FPC) with the Productivity and Performance domains (with the retention of FPC as its name)

   Workforce Committee and Education Training and Research Committee to be disestablished with a new People and Partnerships Committee established in their place, aligned to the domains of the same name;

ii. The Appointments, Remuneration & Terms of Employment to remain constituted on the same basis but renamed Remuneration Committee;

iii. the adoption of the updated Terms of Reference for all committees reflecting the re-alignment detailed in i. above;

iv. the adoption of the updated Cycles of Business for the newly aligned committees, recognising the need for further change as the new ways of working become embedded;

v. the revised committee membership, recognising that it remains within the authority of the Chair to amend this should the business of the Board require.

It was highlighted that the revised arrangements were expected to reduce duplication, strengthen assurance, and support more streamlined and strategic decision-making, with ongoing monitoring to address any emerging risks or gaps.

It was RESOLVED that the re-alignment of assurance committees as detailed above be approved.

98/26 Items for information

The following reports were received and noted for information:

a) Annual Fit and Proper Person Assessment – the Board was asked to note the completion and successful outcome of the Fit and Proper Person Annual Assessment for 2025-26 which forms part of the Trust's compliance with Regulation 5 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

99/26 The next meeting of the Board of Directors will be held on Thursday 6 August 2026 at 9:15am at Lecture Room 1, EC1, Royal Preston Hospital

The meeting closed at 12.20pm

5. MATTERS ARISING AND ACTION LOG UPDATE

Decision Item | M Thomas | 9.40 am

REFERENCES

Only PDFs are attached

5.0 Action log - Board (part I) - 4 June 2026.pdf

Action log: Board of Directors (part I) – 4 June 2026

No Outstanding Actions

Completed Actions

№	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update
1.	-	4 June 2026	**Patient Story** – Ask Comms team to invite Mr Hill's follow-up care and recovery to be tracked to improve wider F.A.S.T. awareness	CAT	6 Aug 2026	**COMPLETE** **Update 6.8.26:** Information passed to Comms team for consideration.
2.	-	4 June 2026	**Patient Story** – CI team capture key learning of stroke pathway	Chief Strategy and Improvement Officer	6 Aug 2026	**Completed** **Update 6.8.26:** Key learning captured in a case study and further work is underway now to share the work and approach with teams, including at an All Colleague briefing.
3.	88/26	4 June 2026	**IPR – People –** Ask PCB Digital Lead to consolidate the system position and provide a clearer overview of the current programme of work, including how digital transformation was expected to translate into tangible benefits for patients and staff.	CEO	6 Aug 2026	**Completed** **Update 6.8.26:** Ask made of the digital team and the digital team presented the vision and programme of work at a Board workshop on 30th July 2026, including the benefits for patients.
4.	-	4 June 2026	**Patient Story** – Write letter of recognition to NWAS for rapid response	CNO	6 Aug 2026	**Completed** **Update 6.8.26:** Sent on 14.07.2026

ITEMS FOR FUTURE BUSINESS *(for information)*

№	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update

6. CHAIR'S OPENING REMARKS AND REPORT

Information Item | M Thomas | 9.42 am

REFERENCES

Only PDFs are attached

6.0 Chairs Report.pdf

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Meeting of the	**Board of Directors**		**6th August 2026**
	Part I ☒		**Part II** ☐
Title of Report	**Chair's Update Report**		
Report Author	Rebecca Black, Executive Business Manager to Chair/Chief Executive		
Lead Executive Director	Mike Thomas, Chair		
Recommendation/ Actions required	The Board of Directors is asked to receive the report and note the contents for information.		
	Decision ☐	**Assurance** ☐	**Information** ☒
Executive Summary	The purpose of this report is to provide a summary of work and activities undertaken during June and July 2026 by the Trust Chair		
Link to Strategic Objectives 2025/26	**Patients – deliver excellent care:** Improve outcomes, reduce harm and deliver a positive patient experience.		☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.		☒
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.		☒
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.		☒
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.		☒

1. Introduction

The purpose of this report is to provide an overview of the work and activities undertaken during June and July 2026 by the Trust Chair.

2. Chair Update's

During June and July 2026, the Chair has been involved in a wide range of meetings and activities in support of the Trust's governance, performance and wider partnership agenda.

Volunteers Week

As part of the Volunteer's week I joined our Chief Executive I visited Baby Beat and met with Lucy Clarke and colleagues on the 4th June as well as volunteers Anne Costitch and Judith Carter on the information desk on the Preston site – both having been volunteers for 20+ years. What a lovely afternoon, a pleasure to meet them all and hear about their work for and in the Trust.

Health and Wellbeing Board – 9th June

CEO's and Chairs from LTH/ELHT/MBHT were invited to meet LCC Reform Members and their Chair of the HWB jointly with the ICB. We spent an evening in discussions regarding the future direction and strategy of the LCC HWB. All three trusts have been invited to have representatives on the LCC HWB. LCC will spend the summer having further discussions with other key NHS organisations and more detail regarding the HWB strategy will become available in due course.

Regional Chair, NHS England – 7th July

Kathy Cowell, Chair, NHSNW visited me and the CEO on 7th July 2026. Kathy very kindly gave us 3 hours of her time in which we had detailed discussions regarding Lancashire Teaching Hospital, Provider Collaborative, Lancashire and South Cumbria, NHSE and priority areas for action and improvements. We are very appreciative of Kathy's time, and for providing us with her perceptions and the next stage of regional developments.

3. Summary of Key Items from Board Part 2 meeting of 6th June 2026

The Board received and update on external review activity and the development of associated improvement plans, with emphasis placed on ensuring that any further actions were aligned to existing Trust improvement programmes and system-wide responsibilities.

The Board considered developments in relation to integrated community services and approved governance arrangements to support partnership working. It also received an update on the Trust's financial position, noting the continued requirement for strong financial grip, delivery of efficiency plans and sustained executive oversight. Governance arrangements for hosted services and transformation activity were reviewed and approved where required.

The Board approved a business case to support additional internal capacity for 2026/27, following scrutiny of the demand and capacity modelling, financial assumptions, mobilisation approach and delivery risks. A number of committee minutes and reports were also received for information. Matters considered were managed in accordance with the need to protect confidential, commercially sensitive, workforce-related and legally privileged information, while ensuring appropriate Board oversight and decision-making.

The Board held a Special Part II meeting in June to approve the Annual Report and Financial Accounts 2025-26 according to requirements following due scrutiny by the Audit Committee.

4. Chair's attendance at meetings

Details below are the meetings attended and activities undertaken during June and July 2026.

Date	Activity
June 2026	
2nd June	121 – Chief Executive
2nd June	121 – Non-Executive Director
2nd June	121 – Non-Executive Director
2nd June	121 – Director of Corporate Affairs
4th June	Board of Directors, LTH
4th June	Volunteers Week – Information Desk, RPH
9th June	121 – Director of Communications and Engagement
9th June	121 – Managing Director, LSC Provider Collaborative
9th June	Lead Governor/chair Liaison and shared briefings
9th June	Health and Wellbeing Board
9th June	Lead Governor Exit Interview
9th June	LSC Chairs meeting
9th June	Provider Collaborative Board
16th June	Senior Asset & Property Manager
16th June	121 – Managing Director, 1LSC
16th June	Introduction meeting - Associate Director of Quality and Governance
16th June	121 – Governor
16th June	Clinical Strategies Meeting
18th June	121 – LSC CEO
18th June	121 – Non-Executive Director
18th June	Board Development Session
23rd June	121 – Managing Director, LSC Provider Collaborative
23rd June	ELHT Regional Provider Oversight Meeting
23rd June	One LSC Regional Provider Oversight Meeting
24th June	LTH Regional Provider Oversight Meeting
25th June	Special Board of Directors
30th June	121 – Director of Communications & Engagement
30th June	Lead Governor/Chair meeting
30th June	121 – Non-Executive Director
30th June	Board pre-meeting
July 2026	
2nd July	121 – Non-Executive Director
2nd July	NW System Leaders

7th July	Regional Chair, NHS England
7th July	NHS Alliance
7th July	University of Lancashire
7th July	121 – Non-Executive Director
16th July	LTH/ELHT – Chair/CEO's meeting
16th July	Lead Governor/Chair Liaison and Shared Briefing
28th July	121 – Non-Executive Director
28th July	121 – Managing Director, Provider Collaborative
30th July	Board Workshop

4. **Financial implications**
   None

5. **Legal implications**
   None

6. **Risks**
   None

7. **Impact on stakeholders**
   None

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

7. DEPUTY CHIEF EXECUTIVE'S REPORT

Information Item | S Morrison | 9.45 am

REFERENCES

Only PDFs are attached

7.0 Deputy CEO Report to Board - 6 August 26 - final .pdf

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors' Report

Meeting of the	**Board of Directors**		6 August 2026
	Part I ☒		**Part II** ☐
Title of Report	Deputy Chief Executive's Report		
Report Author	Prepared by Naomi Duggan – Director of Communications and Engagement		
Lead Executive Director	Sarah Morrison Deputy Chief Executive and Chief Nursing Officer		
Recommendation/ Actions required	The Board of Directors is asked to receive the report and note its contents for information.		
	Decision ☐	**Assurance** ☐	**Information** ☒
Executive Summary	The purpose of this report is to update the Trust Board on matters of interest since the previous meeting.		
Link to Strategic Objectives 2026/27	**Patients – deliver excellent care:** Improve outcomes, reduce harm and deliver a positive patient experience.		☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.		☒
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.		☒
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.		☒
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.		☒
Due Diligence	To give the Trust Board assurance, please complete the following:		
Committee Approval:	N/A		Date: N/A
Operational Group Review:	N/A		Date: N/A
Link to Board Assurance Framework:	N/A - Not aligned to a Principle Risk		
Appendices	N/A		

DEPUTY CHIEF EXECUTIVE'S REPORT

Andy Burnham takes office as new Prime Minister

Andy Burnham became Prime Minister on 20 July 2026 following his election as Leader of the Labour Party after Keir Starmer's resignation. After being invited by King Charles III to form a government, Mr Burnham formally took office and became the UK's seventh Prime Minister in a decade. Prior to entering Downing Street, he served as Mayor of Greater Manchester and had previously held several Cabinet positions in earlier Labour governments.

Following his appointment, the new Prime Minister announced a new Cabinet and set out an agenda focused on economic growth, public service reform and greater regional empowerment. His administration has also indicated a renewed focus on areas including social care reform, housing, industrial strategy and the transfer of powers to local and regional authorities.

Yvette Cooper appointed as new Health Secretary

The Pontefract, Castleford and Knottingley MP was appointed Secretary of State for Health and Social Care on 20 July 2026 as part of Prime Minister Andy Burnham's first Cabinet. She succeeds James Murray, who had held the role since May 2026 and has previously served as Foreign Secretary and Home Secretary. Having been an MP since 1997, she also has prior experience in the Department of Health, having served as a health minister between 1999 and 2002. The wider ministerial team remains unchanged, with Stephen Kinnock and Karin Smyth continuing in their respective roles.

Following her appointment, Yvette Cooper MP stated that her priorities would include improving maternity services and progressing social care reform. Her appointment comes at a significant time for the NHS as the Government continues to address service pressures, workforce issues and long-term reform of health and care services.

Outcome of Lord Mann's review of antisemitism and other forms of racism in the NHS

Lord Mann was commissioned to lead an urgent review into how the NHS and its regulatory system recognises, reports, and tackles antisemitism and other forms of racism. The Government have accepted all recommendations for the Department of Health and Social Care and NHS England.

Reforms include delivering mandatory antisemitism training for NHS leaders and introducing clear national guidance on uniform and responding to racist behaviour, alongside a new set of Staff Standards, including one on tackling racism.

Lancashire Teaching Hospitals has a zero-tolerance approach to antisemitism, racism, or discrimination of any kind, and colleagues are urged to report incidents via managers or Freedom to Speak Up processes.

10 Point Action Plan for Maternity and Neonatal Services

NHS England has issued a 10 Point Action Plan for Maternity and Neonatal Services that all NHS Trusts and wider systems must prioritise over the next few months.

The urgent actions take into account the elements from Baroness Amos' independent National Investigation into Maternity and Neonatal Services and the Ockenden Review of Maternity and Neonatal Services at Nottingham University Hospitals Trust.

The action/improvement plan includes:

1. Listening to women and their families: Roll out of Martha's Rule across Maternity and Neonatal Services
2. Listening to women and their families using real time and transparently reported outcomes and experience and clinical audit data that are acted upon at Board-level

3. Establishing dual Board-level accountability between Medical Directors and Chief Nursing Officers for Maternity and Neonatal Care
4. To undertake an 'Amos into Action' staff listening exercise
5. To take measures to address inequalities in Maternity and Neonatal outcomes
6. To Ensure 24/7 safety and responsiveness of Maternity and Neonatal Services
7. Trusts to review their homebirth services
8. To respond to patient safety incidents, complaints and concerns with humanity, candour and a trauma-informed approach
9. To deliver safe and effective triage in Maternity Services
10. To implement post-death care standards

The outcomes of this work will be reported to NHS England as part of a national programme designed to strengthen safety, quality and experience for women, pregnant people, babies and families.

In a letter to NHS leaders, NHS England Chief Executive Sir Jim Mackey, described the publication of the report as "a turning point for Maternity and Neonatal Services" and called for collective action across the NHS to address failings and harm.

The national improvement programme will also support the work of the National Maternity and Neonatal Taskforce as it develops a wider National Action Plan due to be published later this year.

A significant early requirement for all NHS Trusts is to meet a set of new national Maternity triage principles and standards.

NHS Trusts now have three months to complete a Board-level audit of their Maternity Triage Services against the new national specification, identify any gaps and develop improvement plans. The outcomes of this audit must be submitted to NHS England and the Department of Health and Social Care.

Alongside the improvement plan, NHS England has also announced £10.6 million of national funding to support the recruitment of newly qualified midwives during 2026/27, helping to strengthen frontline Maternity Services and expand workforce capacity across the NHS.

Although the reviews did not focus on our hospitals, they and the subsequent NHS England 10 Point Plan, represent a further and important opportunity for all Maternity and Neonatal Services to reflect, learn and continue improving the care we provide to women, pregnant people, babies and families and we are committed to doing so.

Industrial action update – Blood Sciences (East Lancashire)

As lead provider for Pathology Services across Lancashire and South Cumbria, we are working closely with partners to manage industrial action affecting the Blood Sciences Departments at Royal Blackburn Teaching Hospital and Burnley General Teaching Hospital.

The Industrial action is impacting the processing of blood samples across East Lancashire, primarily affecting patients in areas such as Pendle, Hyndburn, Blackburn with Darwen, Burnley, Rossendale and parts of Ribble Valley.

Unite the Union began the industrial action on 15 June for a four week period, taking place each week from Monday at 00:01 until Friday at 23:59. A second phase of action began on 13 July running until 7 August in the same format. We have since been informed of the intention to carry out a third phase of industrial action, consisting of a further 20 days of strike between 10 August - 4 September 2026.

The industrial action is, at the time of writing, a Level 2 Critical Incident and extensive work is underway to reduce disruption and maintain services wherever possible.

We have gradually increased capacity and expanded the repertoire of tests available. Our priority is to restore blood testing capacity and the full range of tests to pre-industrial action levels as quickly and safely

as possible. Capacity is being increased in a phased way, with appropriate testing and assurance processes in place to ensure patient safety.

In the meantime, contingency plans remain in place across the health and care system to prioritise clinically urgent and priority routine testing, minimise delays for patients, and support clinical teams.

The dispute relates to the calculation of holiday pay. However, Agenda for Change contains nationally agreed provisions governing pay and annual leave calculations which are applied consistently across the NHS and are based on nationally agreed methodologies. Discussions are taking place at a national level involving NHS Employers, legal advisers and the Department of Health and Social Care to determine whether a national response is required. Until this guidance is received, we are unable to progress local resolution.

We encourage everyone to continue treating one another with compassion, professionalism and respect during this challenging period.

Industrial action update – British Medical Association

On 29 June, Resident doctors voted to accept an offer from the government, bringing an end to a period of industrial action that saw 21 days of strikes by the British Medical Association (BMA) resident doctors committee since July 2025.

The government will continue to engage closely with the BMA and other stakeholders to implement this deal and establish a new working relationship, to ensure the NHS remains a place where doctors can thrive and develop rewarding, long-term careers.

The conclusion of strikes by resident doctors will allow the NHS to focus on supporting patients and improving working conditions for all staff, rather than managing disruptive industrial action.

Meanwhile, on 6 July Consultants across England voted in favour of NHS strike action in the future over pay and pensions. In a ballot, 76% of the senior doctors who voted said they would be willing to take industrial action, meaning they now have a mandate for strike action over the next 12 months.

Trust wide successes and service developments



- **LTH named Hospital of the Year at NW HCA Awards**



It was great to see the LTH being named North West Hospital Caterers' Association Hospital of the Year, recognising the exceptional work of our catering teams at Royal Preston and Chorley and South Ribble hospitals.

The award highlights the department's achievements in improving patient experience, driving sustainability and investing in workforce development.

Key accomplishments include becoming the first NHS catering department in the country to achieve a Gold Award for food waste data reporting and securing a Bronze Food for Life Served Here Award for sourcing healthy, sustainable food. The team has

also secured funding through the Public Sector Decarbonisation Scheme, supporting the replacement of ageing fossil fuel systems and reducing the Trust's carbon footprint.

Despite operational and financial challenges, the team maintained high-quality services throughout the year, while investing in staff development through apprenticeships, leadership programmes and specialist training. The full story is on our website.

- **Consultant Recognised at Number 10 for NHS Contribution**

In July, Dr Avinash Jha, Consultant in Critical Care, represented us at a reception hosted at 10 Downing Street as part of the NHS's 78th birthday celebrations.

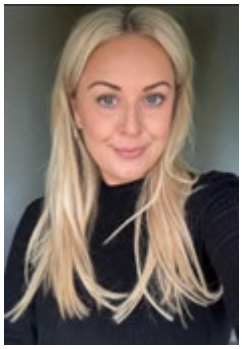


Dr Jha was one of just 80 NHS colleagues from across the country invited by former Prime Minister, Keir Starmer, in recognition of the outstanding contribution NHS staff make to patients, communities and healthcare services every day.

His invitation reflects both his personal achievements and the expertise within our critical care teams. In 2025, Dr Jha became the first Intensive Care Unit consultant in the UK to achieve certification from the European Society of NeuroSonology and Cerebral Hemodynamics (ESNCH). This prestigious qualification supports the advancement of bedside brain ultrasound in critical care, enabling faster diagnosis and contributing to improved patient outcomes.

National recognition of this kind highlights the calibre of staff working across our organisation and reinforces our reputation for clinical excellence, innovation and leadership. I would like to congratulate Dr Jha on this well-deserved recognition and thank him for his continued contribution to patient care and service development.

- **From studying psychology to helping raise £2 Million for NHS charities**



As Executive lead for our Charity I am particularly delighted to highlight the contribution of Rebecca Arestidou, Grant, Fundraising Impact and Project Officer for Lancashire Teaching Hospitals Charity, Baby Beat and Rosemere Cancer Foundation, whose work has helped secure more than £2 million in charitable funding for projects that support patient care, staff wellbeing and healthcare services across our organisation.

Over the past five years, Rebecca has successfully developed funding opportunities that have enabled a wide range of initiatives to progress, demonstrating the significant value that charitable income brings to the Trust and the communities we serve.

Rebecca's career journey also illustrates the benefits of attracting talented individuals from diverse backgrounds. Having originally studied psychology, she transitioned into fundraising during the Covid-19 pandemic and has used the skills gained through her academic and professional experience to build strong relationships with funders and secure investment for NHS services.

The £2 million secured to date represents a substantial contribution to improving patient experience, supporting our workforce and enabling service developments that might not otherwise have been possible. I would like to recognise Rebecca's outstanding contribution and thank the Charity teams for their continued success in attracting external funding and support for the Trust. Full details are on our website.

- **New play area improvements at Broadoaks**



I am delighted to see the completion of a significant new phase in the transformation of Broadoaks Child Development Centre in Leyland, with the opening of a fully accessible, purpose-built children's play area.

This development builds on a wider programme of investment over the past two years, including major roof replacement works and extensive internal refurbishment to address longstanding estate challenges and improve the environment for children, families and staff.

Delivered through a partnership between Lancashire Teaching Hospitals Charity and the Trevor Hemmings Foundation, the new play area has been designed to support both therapeutic play and clinical assessment. Features include sensory equipment, climbing structures, hopscotch markings and specialist safety surfacing, helping clinicians undertake physical and neurodevelopmental assessments in a welcoming and engaging environment. Full details are on our website.

- **Occupational Therapy Degree Apprenticeships**



Congratulations to Sophie McLean and Anthony Foye, who have become registered occupational therapists after completing a pioneering three-year apprenticeship programme. Both colleagues began their careers within LTH in support roles and progressed through a new apprenticeship pathway that enables staff to earn a degree while remaining in employment. The programme combines academic study with clinical practice and placements, creating an accessible route into registered professions for colleagues who may not have followed traditional educational pathways.

Their success demonstrates the value of apprenticeships in supporting workforce development, widening participation and retaining talented staff within the organisation. Both highlighted that the route enabled them to continue earning, maintain NHS service benefits and avoid the financial barriers often associated with full-time university study.

This is an excellent example of how innovative workforce pathways can support career progression, strengthen recruitment and retention, and help us develop the future clinical workforce from within our existing teams. You can read their story on the Trust website.

- **New EEMAC launches at Royal Preston**



Chief Executive, Silas Nicholls, was on hand to officially open the Extended Emergency Medicine Ambulatory Care (EEMAC) unit in June – a new service designed to improve the experience of patients attending the Emergency Department at Royal Preston Hospital.

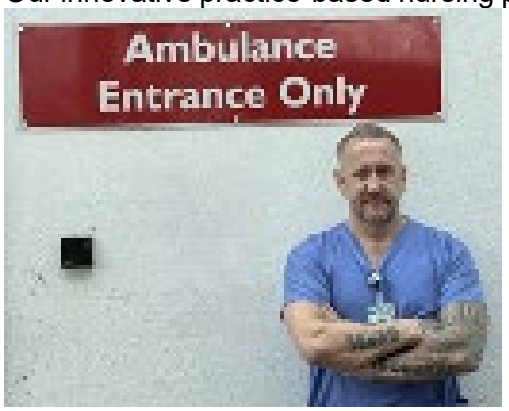
EEMAC is a newly recognised NHS model of care for patients who require more than four hours of assessment but do not need to be admitted to hospital. Located in the former Majors 4 area, EEMAC will provide a dedicated environment for adult patients aged 16 and over who present with an acute condition and are expected to be treated and discharged within 12 hours of arriving at hospital.

Managed by Emergency Medicine clinicians, the ambulatory care area will be open seven days a week from 8am until midnight. Patients will be referred directly to the unit by the Emergency Department team.

The introduction of EEMAC brings a number of benefits for patients, providing assessment and treatment in a quieter and more comfortable setting than the main Emergency Department, while still receiving care from Emergency Medicine specialists. The new model will also support national NHS emergency care waiting standards, and feedback has already been positive from patients.

- **Paul's journey into nursing through pioneering practice-based pathway**

Our innovative practice-based nursing pathway is helping people from non-traditional backgrounds access careers in healthcare, as demonstrated by newly qualified nurse Paul Tunstill.



Delivered by the University of Lancashire in partnership with Lancashire Teaching Hospitals, the BSc (Hons) Nursing with Registered Nurse (Adult) Practice Based Pathway combines academic learning with extensive hands-on clinical experience, allowing learners to apply classroom knowledge directly in practice throughout their training. The programme was introduced in 2023 to widen participation in nursing and address workforce challenges by creating a more flexible route into the profession. A key feature is its accessibility, with a Return to Study course supporting people who do not meet traditional university entry requirements.

Paul, a former Army serviceman, joined the pathway after being unable to access the traditional nursing degree route. He credits the programme with giving him an opportunity that might otherwise not have been available, particularly as someone entering higher education later in life. After qualifying as part of the first cohort, he secured a role in the Emergency Department at Royal Blackburn Hospital. Paul spoke to BBC Radio Lancashire's Graham Liver about his experience, and featured in the Burnley Express.

With 15 learners from the inaugural cohort now qualified, the programme is demonstrating how alternative training routes can attract talented individuals into nursing, diversify the workforce and help meet the future needs of the NHS. You can read Paul's story here.

- **30 years of service: Rob Hart's remarkable career**

Rob Hart recently marked 30 years of service with Lancashire Teaching Hospitals, with the consultant endoscopist recognised for a career defined by clinical expertise, innovation and dedication to patient care.



Joining the Trust as a consultant surgeon, Rob initially planned a career in orthopaedics before finding his passion in general surgery and, ultimately, endoscopy.

Over four decades in medicine, he has performed more than 22,000 colonoscopies and thousands of other endoscopic procedures, becoming one of the Trust's most experienced specialists. Since joining the national bowel cancer screening programme in 2008, he has taken particular pride in work that helps detect cancer early and save lives. He is also widely respected for managing complex referrals and challenging procedures.

Known for his commitment to continuous improvement, Rob believes healthcare must keep evolving to deliver the best outcomes for patients. Colleagues and patients also value his humour and ability to put people at ease during procedures. Rob's story is on our Trust website.

- **Prestigious National Leadership Appointment**



Congratulations to Nick Wood, our Consultant Gynaecological Oncologist, who has been appointed Vice President (President Elect) of the British Gynaecological Cancer Society (BGCS), a significant national leadership position within his specialty.

Under the Society's succession arrangements, Nick will automatically progress to the role of President in two years' time. This appointment recognises Nick's longstanding contribution to the BGCS and to improving care for women with gynaecological cancers. His previous work includes serving as Honorary Secretary, leading the development of research grant processes during the COVID-19 pandemic, and more recently working with NHS England Specialised Commissioning to develop service specifications for gynaecological cancer care.

Since joining the Trust, Nick has also played a leading role in major multicentre research studies focused on ovarian cancer outcomes, supported by our gynaecology research nursing teams. His appointment highlights the value of being a research-active organisation and demonstrates how investment in research infrastructure enables our clinicians to influence practice and policy at a national level.

This achievement further strengthens the Trust's reputation for clinical excellence, research and innovation, while supporting our ambition to expand clinical academic activity and progress our University Hospital aspirations.

- **Young people across Lancashire learn Knife Savers training**

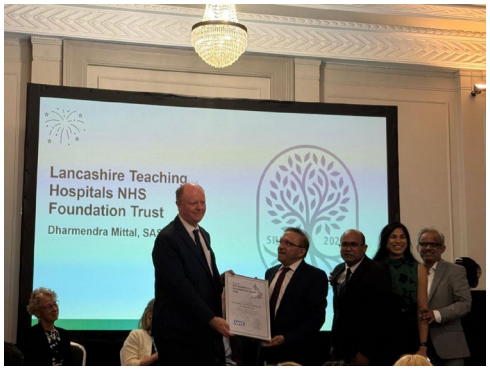


The Trust continued its commitment to community safety by supporting Knife Savers training for young people at Preston's Foxton Centre. The NHS-backed initiative equips participants with practical life-saving skills and raises awareness of the devastating impact of knife crime. Delivered by Emergency Department doctors, nurses and healthcare assistants, the training teaches young people how to respond to serious bleeding incidents, emphasising that a person can bleed to death in under five minutes and that immediate action can save lives. Hands-on sessions using realistic training models help build confidence and preparedness in emergency situations.

The latest event was attended by Lancashire Police and Crime Commissioner Clive Grunshaw, community leaders and BBC Radio Lancashire's Graham Liver. Knife crime remains a significant challenge, with 187 offences recorded in Preston between July 2025 and June 2026, including 51 involving victims under 25. More details are available on the Trust website.

- **Silver SEiD Award for Postgraduate Medical Education Team**

It was great to see our Postgraduate Medical Education team receive a national Silver SAS Excellence in Development (SEiD) Award, the highest level of recognition presented at the inaugural award ceremony in London. The award was presented by Professor Sir Chris Whitty and recognises organisations that demonstrate excellence in supporting Specialty, Associate Specialist and Specialist (SAS) doctors. The SEiD programme, developed by NHS England and key national partners, evaluates organisations against a range of criteria relating to professional development, wellbeing, career progression and workforce



support. The award recognises our commitment to creating an environment where SAS doctors are valued, supported and able to achieve their full potential.

This achievement reflects many years of work led by our SAS leadership and Medical Education teams, particularly Dharmendra Mittal, Mukta Vadhva, Vikas Kumar and Natalie Suffield, to drive cultural change and strengthen opportunities for this important part of our medical workforce. Recognition at a national level reinforces our reputation as an employer that invests in staff development, supports workforce retention and creates career progression opportunities, ultimately benefiting both patient care and service sustainability. The team is now working towards achieving Gold status in future assessments.

- **Conference highlights psychological support for people living with cancer**



Healthcare professionals, cancer patients and support organisations from across Lancashire and South Cumbria gathered in Crooklands to mark the first anniversary of the Macmillan Psychological Health in Cancer Service and highlight the importance of emotional wellbeing in cancer care. Hosted by Lancashire Teaching Hospitals, University Hospitals of Morecambe Bay and the Lancashire and South Cumbria Integrated Care Board, the service was established to ensure psychological support is recognised as a core part of cancer treatment. It provides specialist psychological assessments and evidence-based therapies for people living with cancer, supporting them from diagnosis through treatment and recovery.

Over its first year, the service has also worked closely with healthcare professionals, providing training, guidance and supervision to help integrate psychological care across cancer services and improve access to support for patients and families.

Supported by Macmillan Cancer Support, the service aims to build on its early success and continue expanding access to psychological support across Lancashire and South Cumbria. Read more on our website.

- **Trust-led course celebrates 20 years of training respiratory specialists**



We recently held the 20th British Thoracic Society (BTS) Interventional Bronchoscopy/Thoracoscopy Short Course, a nationally recognised programme that has trained more than 600 clinicians in advanced respiratory procedures since its launch.

Led by Respiratory Consultant Professor Mohammed Munavvar, the course was established following the introduction of endobronchial ultrasound (EBUS) at the Trust and remains the only BTS-accredited national course of its kind in the UK.

Held annually in Preston, the two-day programme attracts consultants and specialist registrars from across the UK and overseas, including delegates from Europe, Asia and the United States. The course combines expert lectures with practical workshops, giving participants hands-on experience with specialist equipment and simulation models.

The milestone also recognises the support of Rosemere Cancer Foundation, which helped establish the Trust's early EBUS service, laying the foundations for the course's long-term success and ongoing contribution to improving patient care. Full story is on our website.

1. RECOMMENDATIONS

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

8. BOARD ASSURANCE FRAMEWORK

Decision Item | H Ugradar | 9.55 am

REFERENCES

Only PDFs are attached

8.0 BAF Risk Paper - August 2026 - Final.pdf

Board of Directors Report

Meeting of the	Board of Directors		4th June 2026
	Part I ☒		**Part II** ☐
Title of Report	Board Assurance Framework (BAF) Report		
Report Author	Hajara Ugradar, Associate Director of Risk, Assurance and Corporate Affairs		
Lead Executive Director	Executive Directors		
Recommendation / Actions required	The Board of Directors are asked to: • Note and approve the updates to the BAF.		
	Decision ☒	**Assurance** ☐	**Information** ☐
Executive Summary	This paper provides an update on the Board Assurance Framework (BAF) following the review and approval of the Principal Risks aligned to the 2026/27 Corporate Objectives. Updates since the last Board of Directors meeting: • Following approval at the Board of Directors on 4 June 2026, the Trust's assurance committee structure has been re aligned to strengthen oversight and reduce duplication across key domains. The People and Partnerships Committee has been established, incorporating the remit of the former Workforce Committee and Education, Training and Research Committee. Principal Risks and operational high risks aligned to the People objective have transferred to the oversight of the People and Partnerships Committee. Whilst there are currently no Principal Risks aligned to the Partnership objective, operational high risks aligned to Partnerships have also transferred to the People and Partnerships Committee. • There are currently 13 Principal Risks within the BAF. • One Principal Risk score has increased since the previous Board report. PR13 (Delivery of the planned reduction in whole time equivalent workforce) increased from 16 to 20 following review of workforce reduction programme performance and its interdependency with delivery of the Trust's financial plan. All other Principal Risks remain unchanged following scrutiny by Executive Directors and Committees of the Board. • At its July 2026 meeting, the Finance and Performance Committee reviewed the current Principal Risks in the context of recent performance improvements. Whilst recognising positive progress in some areas, the Committee noted that Principal Risk scores should be informed by a range of indicators, consideration of the underlying drivers of risk and evidence that improvements are sustained over time. On this basis, the Committee		

	concluded that the current Principal Risk scores remain appropriate and no changes were recommended. • There are currently no operational high risks escalated to the Board through the BAF. • The Risk Management Policy has been updated following implementation of the Ulysses Risk Management System. Key changes include removal of Datix references, clarification of arrangements for superseded and merged risks, strengthened arrangements for cultural risks, clarification of accountability for services delivered on behalf of the Trust, and strengthened roles and responsibilities relating to health and safety and estates risk management. The Audit Committee approved the changes in June 2026 and noted that the policy would be updated to reflect the revised Board Committee structure. The updated policy supports the revised Board Assurance Framework and associated committee oversight arrangements.	
Link to Strategic Objectives 2026/2027	**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.	☒
Committee Approval:	Committees of the Board	**Date:** June and July 2026
Operational Group Review:	Board Workshop	**Date:** 3rd March 2026
Link to Board Assurance Framework:	All Principal Risks within the BAF	
Appendices	Appendix 1: Board Assurance Framework – 2026/27	

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 2026/27 Corporate Objectives.

2. Discussion

2.1 Current Board Assurance Framework

2.1.1 The BAF in Appendix 1 identifies the Principal Risks that threaten the delivery of the Corporate Objectives.

2.1.2 At the Board meeting on 2 April 2026, the Board approved the Principal Risks for 2026/27.

2.1.3 The BAF has since been refined to ensure full alignment with the Trust's strategic priorities, incorporating updates agreed through the March 2026 Board Workshop and Committees of the Board.

2.1.4 Following approval by the Board of Directors on 4 June 2026, the Trust's assurance committee structure has been realigned to strengthen oversight and reduce duplication across key domains. The People and Partnerships Committee has been established, incorporating the remit of the former Workforce Committee and Education, Training and Research Committee. All Principal Risks and operational high risks aligned to the People objective have transferred to the oversight of the People and Partnership Committee. Whilst there are currently no Principal Risks aligned to the Partnership objective, operational high risks aligned to the Partnerships objective have also transferred to the oversight of the People and Partnerships Committee.

2.1.5 The 2026/27 BAF continues to be reviewed through Committees of the Board, with Principal Risks aligned to Safety and Quality Committee, Finance and Performance Committee and People and Partnerships Committee.

2.1.6 The Principal Risks for 2026/27 are as follows:

Principal Risk Number	Principal Risk	Exec Lead	5Ps	Risk Appetite	Risk Tolerance	Current score	Direction of score since last meeting
PR1 (26/27)	Patient safety and experience within the urgent and emergency care pathway	CNO	Patients	Cautious	1-6	15	→
PR2 (26/27)	People experiencing Health inequalities	CNO	Patients	Cautious	1-6	12	→
PR3 (26/27)	Timely access to planned care	COO	Performance	Cautious	1-6	16	→
PR4 (26/27)	Timely access to cancer care	COO	Performance	Cautious	1-6	16	→

Principal Risk Number	Principal Risk	Exec Lead	5Ps	Risk Appetite	Risk Tolerance	Current score	Direction of score since last meeting
PR5 (26/27)	Timely access to urgent and emergency care	COO	Performance	Cautious	1-6	20	→
PR6 (26/27)	Timely access to diagnostic investigations	COO	Performance	Cautious	1-6	16	→
PR7 (26/27)	Experience of under-represented staff groups	CPO	People	Open	4-8	12	→
PR8 (26/27)	Experience of staff and levels of staff satisfaction	CPO	People	Open	4-8	12	→
PR9 (26/27)	Failure to effectively manage staff absence and achieve Trust and National target rates	CPO	People	Open	4-8	12	→
PR10 (26/27)	Delivery of the 2026/27 financial plan whilst reducing the size of the underlying financial deficit	CFO	Productivity	Open	8-12	20	→
PR11 (26/27)	Cash consequences of the Trust's underlying financial position	CFO	Productivity	Open	8-12	20	→
PR12 (26/27)	Ability to access required Capital to support an ageing estate	CFO	Productivity	Open	8-12	16	→
PR13 (26/27)	Delivery of the planned reduction in whole time equivalent workforce	CPO	Productivity	Open	8-12	20	↑

2.1.7 There has been one change in Principal Risk score since the last Board report. PR13 – Delivery of the planned reduction in whole time equivalent workforce increased from 16 to 20 following review by the Finance and Performance Committee. Month 2 workforce data demonstrated a material shortfall against the Workforce Reduction Programme trajectory and continued reliance on temporary staffing. The score was therefore increased to better reflect delivery risk and its interdependency with PR10 – Delivery of the Financial Plan. The score was reviewed and remained unchanged in July 2026.

2.1.8 Focused discussion has also taken place on specific risks, as detailed below:

- At its meeting on 12 May 2026, the Workforce Committee requested a review of PR7 – Experience of Under-represented Staff Groups, informed by NHS Staff Survey, WRES and WDES findings. The review identified a mixed position, with evidence of both improvement and deterioration across a number of indicators. These findings have been considered alongside the wider colleague experience data informing Principal Risk 8, which identified a number of common themes affecting the wider workforce, together with other sources of insight including application of Equality Impact Assessments, increased uptake of Supporting Disability and Long-Term Conditions agreements, continued positive reasonable adjustment outcomes, and benchmarking against peer organisations. On balance, whilst inequalities in experience remain in some areas, the overall evidence did not support an increase in the current risk score, and the current rating for PR7 remains unchanged.
- Following discussion at the Board of Directors in June 2026, the Safety and Quality Committee reviewed PR1 and remains supportive of a PR1 risk that explicitly reflects patient safety alongside patient experience within the urgent and emergency care pathway. The

complementary Principal Risk relating to access, flow and performance continues to be captured separately under PR5 and overseen by the Finance and Performance Committee.

- At its July 2026 meeting, the Finance and Performance Committee reviewed the current Principal Risks in the context of recent performance improvements. Whilst recognising positive progress across some areas, the Committee noted that Principal Risk scores should be informed by a range of indicators, consideration of the underlying drivers of risk and evidence that improvements are sustained over time. On this basis, the Committee concluded that the current Principal Risk scores remain appropriate and no changes were recommended.

2.1.9 All other Principal Risk scores remained unchanged during the reporting period following review by the relevant Executive Directors and Committees of the Board. Committee scrutiny continues to focus on delivery confidence, supporting metrics and evidence of sustained improvement when considering whether changes to Principal Risk scores are required.

2.2 Operational High Risks for Escalation/De-escalation

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

2.3 Risk Management

2.3.1 The Risk Management Policy has been updated following implementation of the Ulysses Risk Management System. Key changes include removal of Datix references, clarification of arrangements for superseded and merged risks, strengthened arrangements for cultural risks, clarification of accountability for services delivered on behalf of the Trust, and strengthened roles and responsibilities relating to health and safety and estates risk management. The Audit Committee approved the changes in June 2026 and noted that the policy would be updated to reflect the revised Board Committee structure. The updated policy supports the revised Board Assurance Framework and associated committee oversight arrangements.

3. Financial implications

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

4. Legal implications

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

5. Risks

5.1 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.

6. Impact on stakeholders

6.1 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.

6.2 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 Ulysses.

7. Recommendations

7.1 It is recommended that the Board of Directors:

- Note and approve the updates to the BAF.

Board Assurance Framework

2026/27

Board of Directors – August 2026

Patients – deliver excellent care

Performance – deliver timely, effective care

People – be a great place to work

Productivity – delivery value for money

Partnership – be fit for the future

How the Board Assurance Framework fits in



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



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



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



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



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



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

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

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

2026/27 Corporate Objectives

Patients
- Implement the national Maternity & Neonatal Improvement Plan, and Maternity Incentive Scheme
- Undertake a fundamental specialty redesign adopting the principles of the ten-year health plan. Priority areas year 1 are Frailty, COPD and Heart Failure
- Recognise the asset specialist services are, and the important role they play at LTH
- Design and deliver a children's & young people's plan to improve access to urgent & emergency care
- Improve outcomes and prevent harm
- Reduce occupancy across Urgent and Emergency Care pathways
- Reduction in Health Inequalities across core20plus5 for adults and children and frailty pathways

Performance
- Improve patient experience through a focus on valuing patients' time by developing streamlined pathways and better communication, leading to the delivery of national standards for cancer
- Improve patient experience and performance in Urgent and Emergency Care through the delivery of the 4 hour, 12 hour and ambulance handover standards
- Implement the strengths-based approach Days Kept Away from Home across all services
- RTT - Eliminate 52-week breaches and achieve compliance trajectories as agreed in the annual plan
- Diagnostics - Achievement of the 6 week diagnostic waiting times performance trajectories

People
- Equip all our colleagues, including the Board, with the improvement skills, knowledge and confidence to drive improvements within their teams and services
- Strengthen the confidence and capability of leaders
- Improve the experience of work of colleagues with protected characteristics
- Support the health, wellbeing, safety and attendance of our workforce
- Enhance colleague experience and levels of staff satisfaction

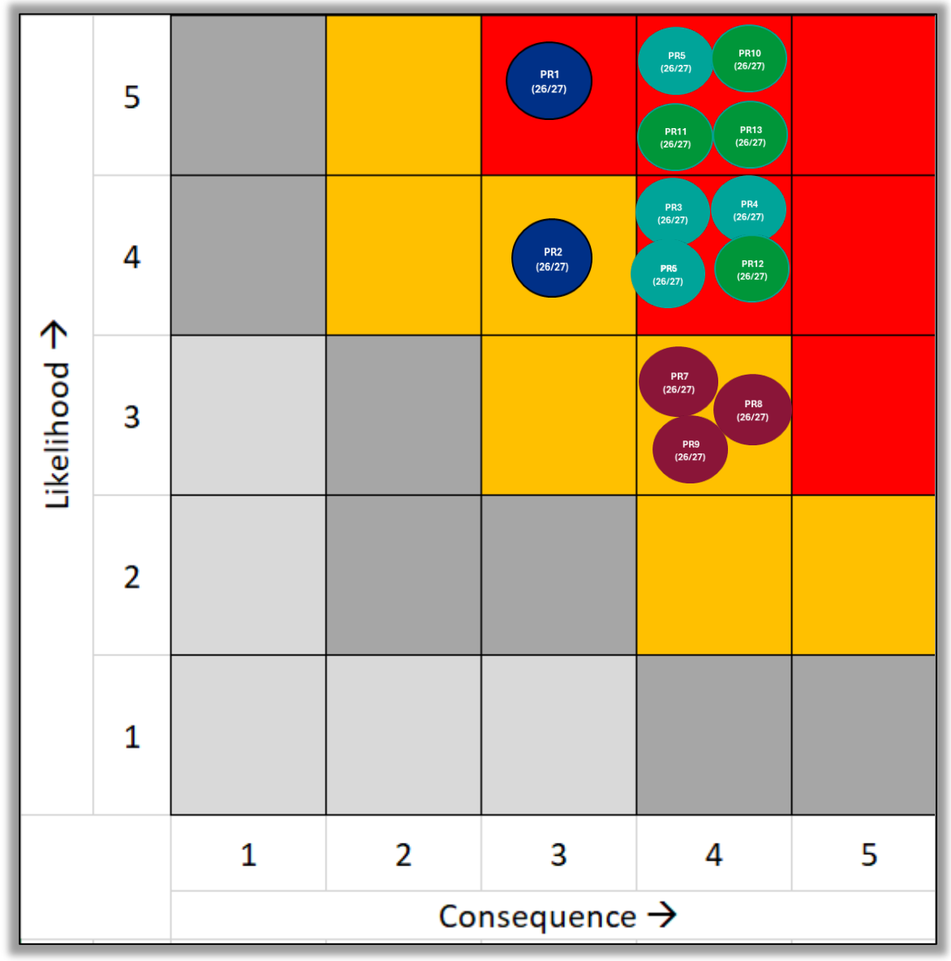
Productivity
- Deliver the waste reduction programme without compromising quality or safety, including clinical pathway redesign, workforce optimisation, and digital innovation
- Increase Local Procurement
- Expand use of telemedicine and Remote Monitoring
- Implement digital Patient Engagement Tools
- Expand the use of AI and Machine Learning

Partnership
- Be a collaborative system partner
- Implement the Integrated Care System-wide diagnostics strategy, including unified PACS/RIS and cardiology systems
- Implement a unified Laboratory Information System across the ICS
- Further develop our partnerships in Education
- Improve research and innovation
- Vertical integration with community services, providing comprehensive pathways for Central Lancashire working with primary and social care

Principal Risk Management

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

Ref	Principal Risk	Exec Lead	5Ps	Reporting Committee	Risk Appetite	Risk Tolerance	Current score	Direction of score since last report
PR1 (26/27)	Patient safety and experience within the urgent and emergency care pathway	CNO	Patients	SQC	Cautious	1-6	15	→
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PR12 (26/27)	Ability to access required Capital to support an ageing estate	CFO	Productivity	FPC	Open	8-12	16	→
PR13 (26/27)	Delivery of the planned reduction in whole time equivalent workforce	CPO	Productivity	FPC	Open	8-12	20	↑



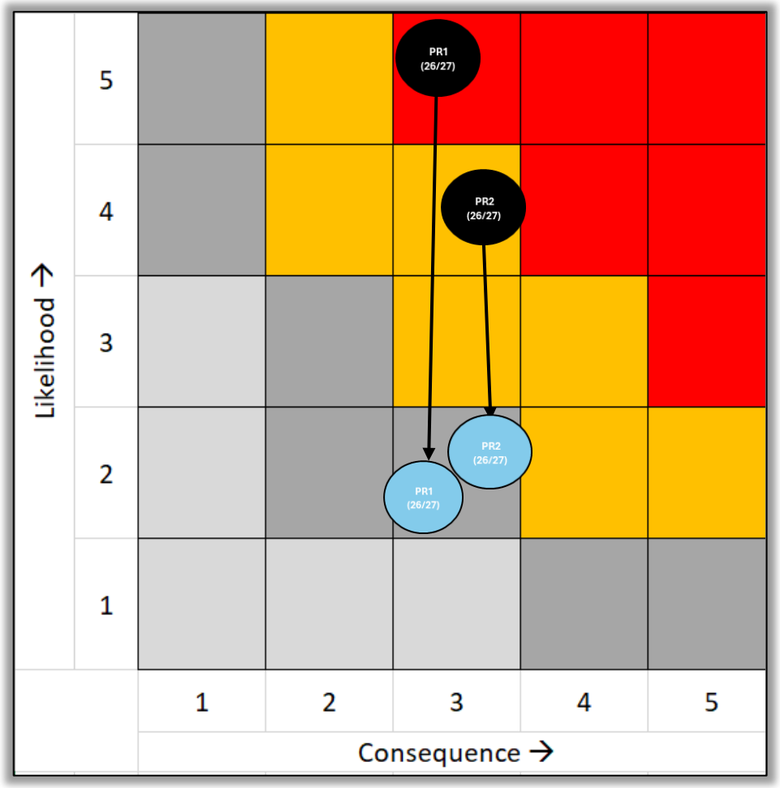
Key- Dark Blue = Patients, Turquoise = Performance, Red = People, Green = Productivity, Pink - Partnership

Patients: Deliver excellent care

Monitored through Safety & Quality Committee

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

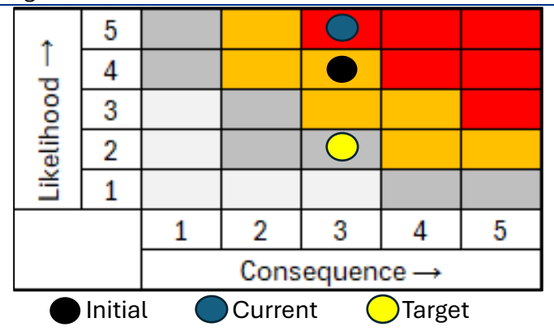
CO Ref.	Purpose of the objective	Scope and Focus of the Objective	How will we know if it has been achieved?	Status
1.1	Implement the national Maternity and Neonatal Improvement Plan and the Maternity Incentive Scheme	• Deliver the national Maternity and Neonatal Improvement Plan, which sets out a comprehensive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



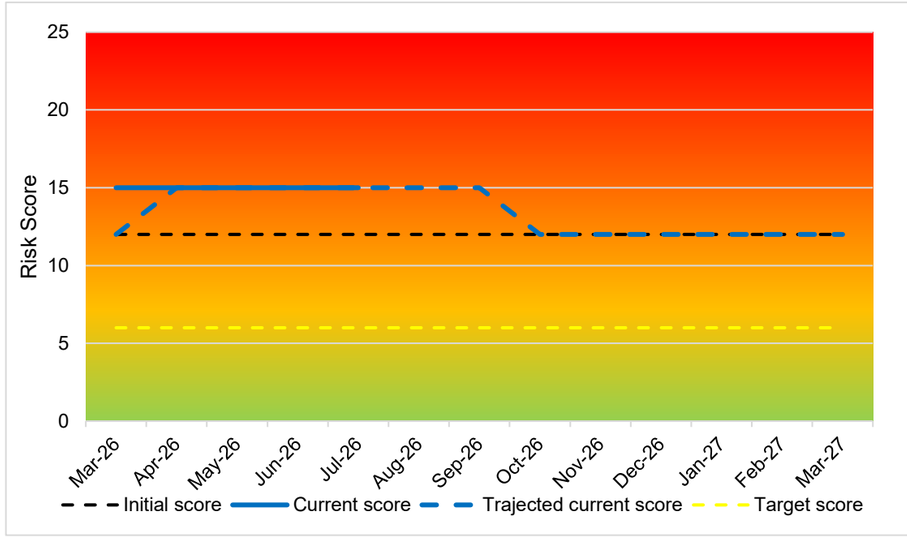
Heat map key: Black = current score, Blue = target score

Strategic Objective: Patients	Corporate Objective: Reduce occupancy across UEC pathways	Overall Assurance Level	Low

Principal risk 1 (26/27) (ID 2102)	Risk Title:	Patient safety and experience within the urgent and emergency care pathway	
	Risk Description:	There is a risk that patient safety and experience within the urgent and emergency care pathway may be negatively impacted due to consistently high service demand, delayed handover from ambulances, long waiting times and overcrowding, affecting the ability to deliver care and communication in line with expectations. This could result in increased patient safety incidents, reduced patient satisfaction, increased complaints, poor staff experience, regulatory intervention, and potential reputational damage to the Trust.	
Committee	Safety & Quality	Risk Appetite and Tolerance	Cautious 1-6
Director	Chief Nursing Officer	5Ts status	Treat
Date risk opened	05/12/24	Date of last review	21/07/26
		Target control date	31/03/27



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Trajectories and target reset for 26-27)

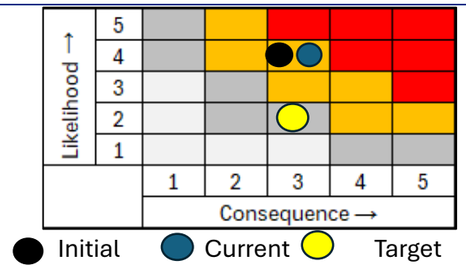
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Twice annual nurse staffing assessments. • Patient experience and Involvement plan. • Patient Experience & Involvement Group. • National OPEL Framework. • L&SC daily Gold Command meetings. • Escalation Plan (including Full Capacity Protocol, Bed Escalation and Extreme Escalation). • Urgent & Emergency Care Delivery Board. • Urgent & Emergency Care Picker Survey Action Plan. • Discharge Improvement Plan. • UEC Improvement Director in place.	• Community demand for primary and UEC services. • Community ability to increase the number of new patients being seen in 2 Hour Urgent care. • Alternatives to Emergency Care. • Ageing estate and environment. • Sub-optimal escalation areas. • Financial constraints. • Inpatient Picker survey identifies lower than expected experience outcomes. Gap in the required number of beds. • Patients cared for outside of designated bed spaces. • Not Meeting Criteria to reside >5% target.	<u>Level 1 Assurance</u> • Complaints and concerns – approx. less than 1% versus attendances. • Weekly PSIRF oversight panel reviewing incidents and emerging themes • Weekly and fortnightly forums with CNO/CMO/COO supporting escalation & speaking up culture. • Safety and Quality (S&Q) dashboard tracks S&Q metrics and includes the ED dashboard. • Boarding position monitored via S&Q dashboard, supported by policies to maintain care standards. • UEC performance indicators (triage and time to clinician), with improvements at CDH and stable position at RPH. • STAR patient experience and Friends & Family have some areas of positive performance. <u>Level 2 Assurance</u> • Patient Experience & Involvement Group reports, Picker Survey reports, Freedom to Speak Up Arrangements reported to Safety & Quality Committee. • Quarterly PSIRF report providing overview of significant incidents and trends, Bi annual mortality and medication safety reports to Safety and Quality Committee. • GMC resident doctor survey reported to People Committee. <u>Level 3 Assurance</u> • UEC survey reflecting outcomes 'about the same' as other Trusts	• Time to see a clinician at RPH consistently exceeds the 60 min average target. • Inpatient survey identified medicine at RPH most prevalent area of less positive experiences. • The CDH site UEC pathway is demonstrating increased occupancy levels leading to longer length of stay at the start of the pathway. • Friends and Family Test – gaps related to communication, waiting times and overall experience. • Summary Emergency Department Indicator Table (SEDIT) outcomes below peer

Risk Treatment

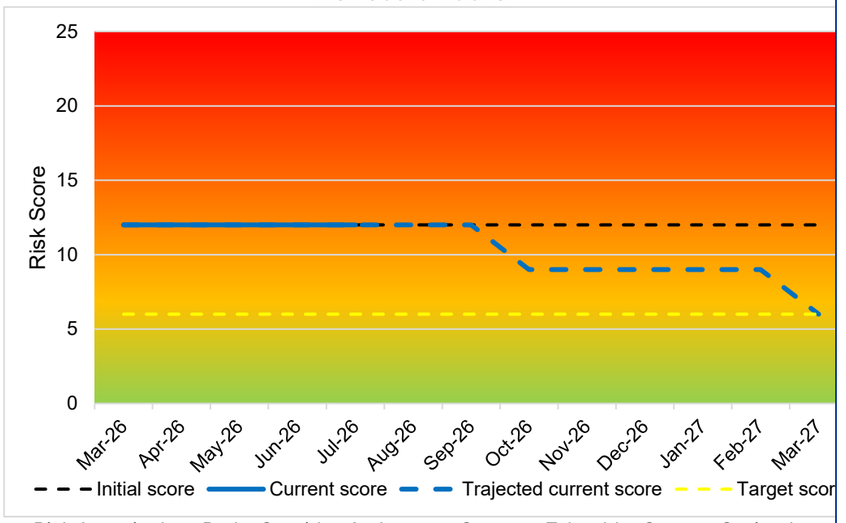
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Increase capacity in 2 hour Urgent Care (care connexions).	S. Morrison	~~31.03.26~~ ~~31.07.26~~ 30.09.26		July 26: Now a joint priority with LSCFT. MoU approved by both Boards (June 2026), with strengthened executive oversight including Lead Exec & UEC Improvement Director in-reach. Formal joint governance established, with Community Committee reporting to LSCFT Board from Sept 2026; Terms of Reference agreed and Lead NEDs confirmed for both organisations. The National Frailty Collaborative test of change for ED in-reach commenced on 19 July 2026. Milestones have therefore been revised to reflect the implementation timeline.
Develop Mental Health Review Centre (with LSCFT) adjacent to ED to reduce to reduce ED waits for mental health patients.	S. Morrison	30.09.26		July 2026: Plans have been approved and construction of the new unit is progressing as planned, with completion expected in July 2027. (NB: Last month incorrectly referenced deadline of July 2026; the agreed completion date has always been July 2027)
UEC Improvement Programme delivery	S. Canty	31.03.27		July 26: Extended Emergency Medicine Ambulatory Care (EEMAC) has been launched. Work is continuing to implement the Medical Ambulatory Care (MAC) model, 24/7 Same Day Emergency Care (SDEC) and Frailty SDEC as part of the wider Urgent and Emergency Care improvement programme. Delivery timescales continue to be reviewed to ensure plans remain achievable and aligned to operational capacity.
Patient Experience approach to inpatients and neonatal to be refreshed using Northumbria approach.	S. Morrison	01.07.26	15.8.26	July 26: Work commenced. Scoping and diagnostic underway. NMAHP session delivered circa 80 staff. Next steps TMB session 22.7.26. Board 13.8.26. Medical and Ops Groups Aug 26. Priority focus areas have been agreed as Medicine, ED and Neonatal Services. Lead in place and approach agreed in collaboration with customer care team.
Undertake Single Point of Access self-assessment with LSCFT team.	S. Morrison	01 10.26		July 26: Each organisation completed. Next steps to agree a whole-pathway improvement event to consolidate findings, agree a shared pathway approach and develop a system-wide improvement plan.

Strategic Objective: Patients	Corporate Objective: Reduction in Health Inequalities across core20plus5 for adults and children and frailty pathways	Overall Assurance Level	Medium

Principal risk 2 (26/27) (ID 2103)	Risk Title:	People experiencing Health inequalities	
	Risk 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	21/07/26
		Target control date	31/03/27



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Trajectories and target reset for 26-27)

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Lancashire & South Cumbria Integrated Care Partnership Health and Wellbeing Strategy. • LTH Health Improvement Plan, developed in conjunction with L&SC system partners. • Health Inequalities Group. Health Inequalities Patient Tracking List (PTL) Group. • Health literacy group relating to communication with patients. Specific improvement programmes for adults and children (e.g. High intensity user service, prisoner referral to treatment and ED navigator role in partnership with Lancashire Violence Reduction Network).	• Commissioning arrangements are led by the ICB. • The Trust has no Public Health Consultant. • Anchor institute plan is under review to link to other plans. • Anchor institute group to be established. • Absence of a defined approach to measuring and managing reduction in health inequalities	<u>Level 1 Assurance</u> • Oversight of Health Improvement Plan delivery through Health Inequalities Group <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. • Challenges in demonstrating the impact of actions on reducing health inequalities, pending further development of data and reporting.

Risk Treatment

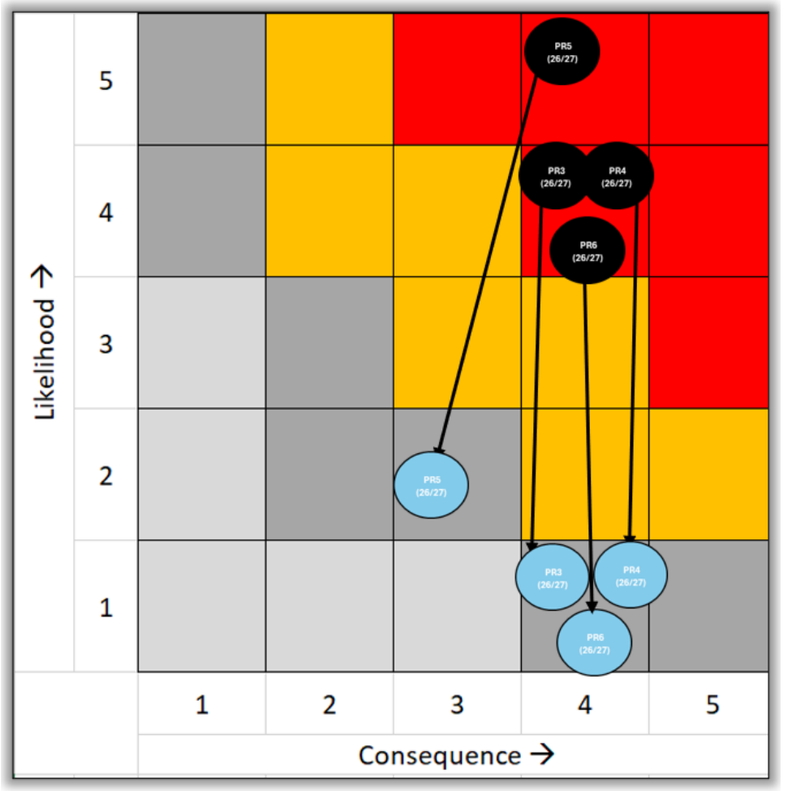
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Demonstrate progress in disaggregating data to enable understanding of health inequalities and facilitate different approaches to addressing these	R. Sansbury	30.06.26	31.05.26	June 26: Outline of work required prioritised in business intelligence programme of work, models of analysis discussed with CIO this month and example outline being explored. 6 month health inequality progress report prepared with additional data sets included demonstrating progress.
Establish an approach to routine access to health inequalities data.	A. Brotherton	31.10.26		July 2026: Board requirements have been reiterated. Progress remains dependent on the digital programme, with the CSIO progressing work through the One LSC programme.
Support case to approve the data sharing agreements between primary and secondary care.	A. Brotherton	31.12.26		July 2026: Progress remains dependent on the digital programme and agreement of primary and secondary care data-sharing arrangements. The CSIO is progressing this through the One LSC programme.

Performance: Deliver timely, effective care

Monitored through Finance & Performance Committee

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

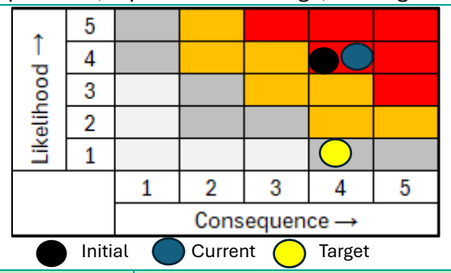
CO Ref.	Purpose of the objective	Scope and Focus of the Objective	How will we know if it has been achieved?	Status
2.1	Improve patient experience through a focus on valuing patients' time by developing streamlined pathways and better communication, leading to the delivery of national standards for cancer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



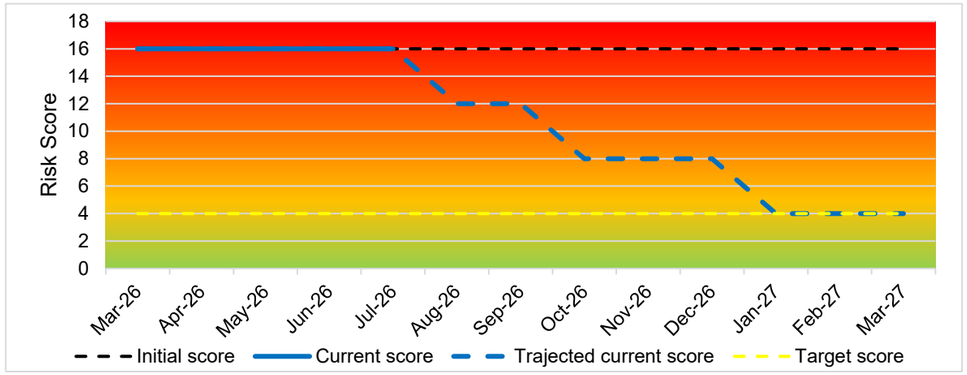
Heat map key: Black = current score, Blue = target score

Strategic Objective: Performance	Corporate Objective: RTT - Eliminate 52-week breaches and achieve compliance trajectories as agreed in the annual plan	Overall Assurance Level	Medium

Principal risk 3 (26/27) (ID 2314)	Risk Title:	Timely access to planned care	
	Risk Description:	There is a risk that there is insufficient capacity to deliver the required activity levels needed to achieve performance trajectories and deliver timely access to clinical assessment and treatment. Capacity constraints relate to insufficient workforce and/or physical estate shortfalls. Shortfalls in clinical capacity could result in patient harms associated with a delay in timely access to planned care, poorer patient outcomes, inability to meet national constitutional standards, claims, poor patient experience, reputational damage, and regulatory action.	
Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious 1-6
Director	Chief Operating Officer	5Ts status	Treat
Date risk opened	02/04/26	Date of last review	14/07/26
		Target control date	31/03/27



Risk Score Tracker



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

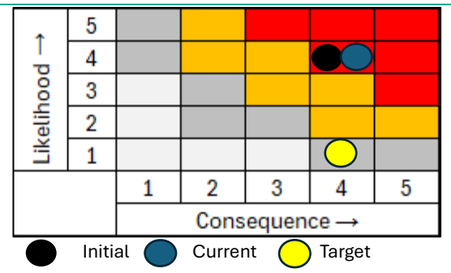
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• 26/27 Annual activity & Performance plans have been outlined to deliver reductions in long waiting RTT targets, waiting list reduction and improved 18 week compliance in line with agreed trajectories. Plans include monthly trajectories and associated action plans. • Clear identification of clinical priorities via the use of national clinical prioritisation codes. This enables the trust to understand the clinical priority (P2 – P6) of those patients to support scheduling the most clinically urgent. • PEP+ (Patient Engagement Portal) and AI functionality to support validation of the waiting list and digital letters to support the process. The frequency of validation is monitored via Divisional and organisational performance forums. • Weekly Operations Board in place to track performance and delivery of actions linked to improvement trajectories. • A report for P2 patients waiting over 5 weeks is in place for Divisions to plan their elective capacity. • 6-4-2 protocols in place to drive optimal use of theatre capacity. • Theatre efficiency programme in place, monitored through the Elective Transformation Programme and up to the Elective Transformation Board and some parts already implemented • Monitoring of benchmarking data via Model Hospital and GIRFT to drive productivity improvements. • Capacity & Demand modelling has been undertaken for key specialties. • Independent sector capacity is commissioned to support delivery of the required activity levels. • Pilot of AI Robotic (LLM) RTT validation underway with high success rates identified – being mobilised across full RTT PTL.	• Where specialties have a Capacity & Demand gap which cannot be mitigated via improved productivity, there is a need to resource additional capacity. • Restricted admin capacity to backfill short notice procedure cancellations. • Limited admin and clerical resource to support the 'double entry' required to accurately administrate the independent sector activity. • Limitations within the EPR (Flex Harris) system resulting in increased human administrative burden and increased risk of human error leading to data quality issues and potential patient treatment delays • Limited clinician appetite to deliver additional non-core activity required to deliver the required performance. • Independent sector (IS) capacity is insufficient to meet the requirements of the organisation or IS providers are unable or unwilling to support the case mix requested.	<u>Level 1 Assurance</u> • Live PTL performance report and Validation reports. <u>Level 2 Assurance</u> • Oversight in Divisional Improvement Forums, Operations Board and F&P Committee. • Benchmarking data analysis – model hospital, GIRFT, etc. <u>Level 3 Assurance</u> • Fortnightly tiering meetings in place to track progress. • Performance agenda established within IAGs	• Delays in concluding some harm reviews. • Data sets lack inequalities data visibility to assess the risk to poorer outcomes between patient groups on PTLs. • Limitations of EPR (Flex Harris) to link patient pathways which may result in ineffective performance management and reporting. • Lack of performance and productivity data visibility at speciality level

Risk Treatment

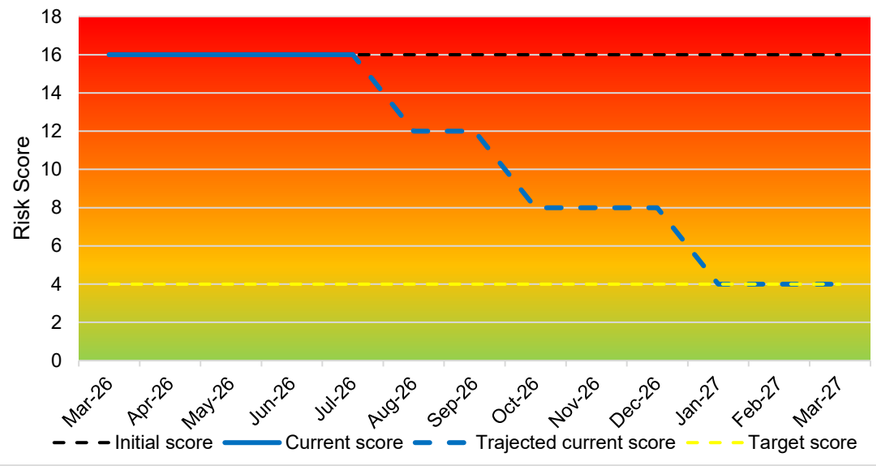
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Commission and mobilise additional Independent sector capacity	K Foster Greenwood	~~31.05.26~~ 31.07.26		July 26: Independent Sector capacity procurement is progressing and remains on track for mobilisation by the end of July 2026, supporting delivery of planned RTT activity trajectories.
Agree Phase 1 pilot AI PIFU specialties	K Foster Greenwood	31.05.26	31.05.26	June 26: AI PIFU Phase 1 pilot and rollout plan approved across 10 specialties. This completes the initial scoping phase. Next steps focus on finalising resource requirements and securing investment.
Commission business case development for key specialities based on the C&D outputs (25/26)	K Foster Greenwood	~~30.04.26~~ 30.06.26	04.06.26	June 26: Business case approved by Board of Directors.
Resource requirement to support 10 x AI PIFU roll out to be defined and investment secured.	K Foster Greenwood	31.07.26		July 26: NHS England funding was not approved. Following agreement with the ICB, the scope has been revised and implementation is now focused on delivery of three specialties per provider by September 2026, with the Trust aspiring to deliver four specialties where feasible.
Recruitment & mobilisation into Internal Capacity Business case	K Foster Greenwood	31.08.26		July 26: Internal capacity plans continue to be mobilised. Additional elective activity is being supported through waiting list initiatives to increase capacity and support delivery of RTT trajectories

Strategic Objective: Performance	Corporate Objective: Improve patient experience through a focus on valuing patients' time by developing streamlined pathways and better communication, leading to the delivery of national standards for cancer	Overall Assurance Level	Medium

Principal risk 4 (26/27) (ID 2315)	Risk Title:	Timely access to cancer care		
	Risk Description:	There is a risk that there will be insufficient capacity to ensure timely access to cancer care as a result of critical workforce or other capital resource gaps such as Diagnostic equipment. This could result in patient harms associated with a delay in timely access to cancer care, poorer patient outcomes, inability to meet national constitutional standards, claims, poor patient experience, reputational damage, and regulatory action.		
Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious 1-6	
Director	Chief Operating Officer	5Ts status	Treat	
Date risk opened	02/04/26	Date of last review	14/07/26	
		Target control date	31/03/27	



Risk Score Tracker



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

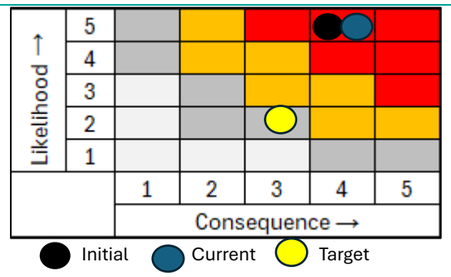
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Weekly monitoring of cancer patient tracking lists (PTLs) to reduce any delays with tumour specific action plans in place. • Weekly Operations Board established to track performance and delivery of actions linked to improvement trajectories. • 6-4-2 protocols in place to drive optimal use of theatre capacity. • Theatre efficiency programme in place, monitored through the Elective Transformation Programme and up to the Elective Transformation Board and some parts already implemented • Monitoring of benchmarking data via Model Hospital and GIRFT to drive productivity improvements.	• Where specialties have a Capacity & Demand gap which cannot be mitigated via improved productivity, there is a need to resource additional capacity. • Limited clinician appetite to deliver additional non-core activity required to deliver the required performance. • Inability to successfully recruit into nationally hard to recruit to posts e.g. Oncology • Restricted admin capacity to backfill short notice procedure cancellations. • Limitations within the EPR (Flex Harris) system resulting in increased human administrative burden and increased risk of human error leading to data quality issues and potential patient treatment delays • Lack of community capacity with the closure of Community Healthcare Hub and reduced capacity at Longridge resulting in high bed occupancy and increasing the risk of capacity related elective and cancer cancellations • RTF funding secured was at half the value of the submitted bid. • Limited digital and validation capacity to support the AI Robotic RTT validation pilot.	<u>Level 1 Assurance</u> • Live PTL performance report and Validation reports. • Harm reviews process in place for >104 day cancer pathway patients. <u>Level 2 Assurance</u> • Oversight in Divisional Improvement Forums, Operations Board and F&P Committee. • Benchmarking data analysis – model hospital, GIRFT, etc. <u>Level 3 Assurance</u> • Fortnightly tiering meetings in place to track progress • Performance agenda established within IAGs	• Delays in concluding some harm reviews. • Data sets lack inequalities data visibility to assess the risk to poorer outcomes between patient groups on PTLs. • Inability to assess the risk for patients on surveillance pathways. • Limitations of EPR (Flex Harris) to link patient pathways which may result in ineffective performance management and reporting. • Lack of performance and productivity data visibility at tumour group level

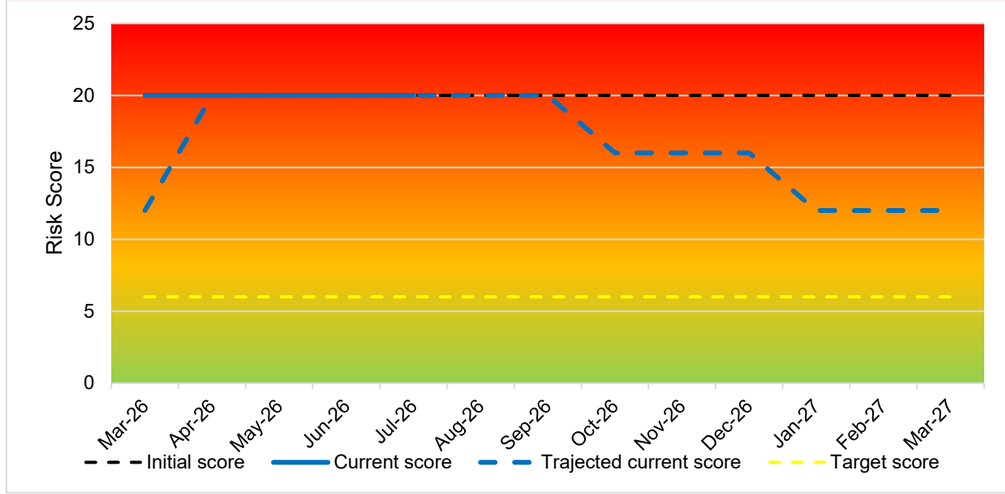
Risk Treatment

Action	Action Owner	Due Date	Done Date	Action Progress Update
Commission business case development for key specialities based on the C&D outputs	K Foster Greenwood	~~30.04.26~~ 30.06.26	04.06.26	June 26: Business case approved by Board of Directors.
Develop a Cancer productivity dashboard to monitor performance against best timed pathways to inform improvement plans and performance delivery.	K Foster Greenwood	~~30.06.26~~ 30.09.26		July 26: All tumour group roll out plan agreed with Digital colleagues. The Dashboard is progressing, with seven tumour group sections now live (Prostate, Skin, Breast, Bladder, Bladder Grade 1, Gynaecology and Gynaecology Ovarian). Further tumour groups will be added as required, with full rollout by September 2026.
Recruitment & mobilisation into Internal Capacity Business case	K Foster Greenwood	31.08.26		July 26: Internal capacity plans continue to be mobilised. Additional capacity is being supported through waiting list initiatives and targeted workforce deployment to improve access to cancer care and support achievement of performance trajectories.

Strategic Objective: Performance	Corporate Objective: Improve patient experience and performance in Urgent and Emergency Care through the delivery of the 4 hour, 12 hour and ambulance handover standards	Overall Assurance Level	Low
Risk Title:	Timely access to urgent and emergency care	Risk Score Tracker	

Principal risk 5 (26/27) (ID 2104)	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	14/07/26
		Target control date	31/03/27





Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Trajectory reset for 26/27)

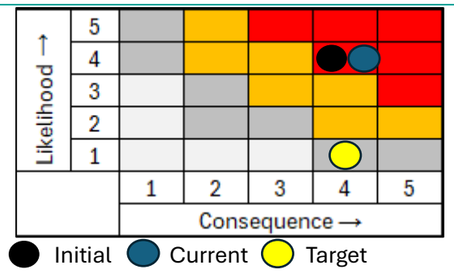
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Clinical triage processes are established. • OPEL and internal Site Pressure Score Framework and protocols are in place • L&SC daily Gold Command meetings. • Escalation and Surge Plans defined and in place. • Ambulatory and admission avoidance pathways established. • Same Day Emergency Care facilities in place. • Urgent care service provided by a third party co-located on both CDH and RPH sites. • Single Improvement Plan and Board established to track improvement delivery. • Central Lancs system wide UEC & Community Improvement Plan focusing on Hospital @ Home pathways and capacity and Days Kept Away from Home established. • Site Pressure Management processes, meetings and associated action cards established. • Clinical discharge team management of all patients classified as Days Kept Away from Home. • Virtual Ward capacity to support admission avoidance and early step down from hospital. • Care connections coordination function in place to link hospital and community provisions. • Continuous Flow Model is established to drive timely flow. • Ward & Board round process standardisation programme established. • 45 min Release to Rescue protocol implemented • Additional stretch targets agreed with system partners • UEC Programme Board Established and UEC Improvement Director in post • Extended Emergency Medicine Ambulatory Care in place	• Insufficient flow within the hospital bed base to prevent ED overcrowding. • Out of hospital provision is insufficient to meet the demand. • The environment and estate is sub-optimal.	<u>Level 1 Assurance</u> • ED Safety Surveillance dashboard monitors live metrics to assess risks of patient harm. <u>Level 2 Assurance</u> • Urgent & Emergency Care and Community Transformation Board provides monthly monitoring of all improvement actions across the system. • Emergency Department Dashboard to Safety & Quality Committee • Finance and Performance Committee. <u>Level 3 Assurance</u> • Fortnightly tiering meetings in place to track progress • Performance to be added to the IAG agenda from Jan 26.	• High bed occupancy levels (above 92%). • Time to triage and first senior review are not meeting Trust targets. • Performance for the 4 hour wait times and 12 hour total wait time in the department, are not meeting the Trust targets. • Ambulance turnaround times are not meeting the Trust targets.

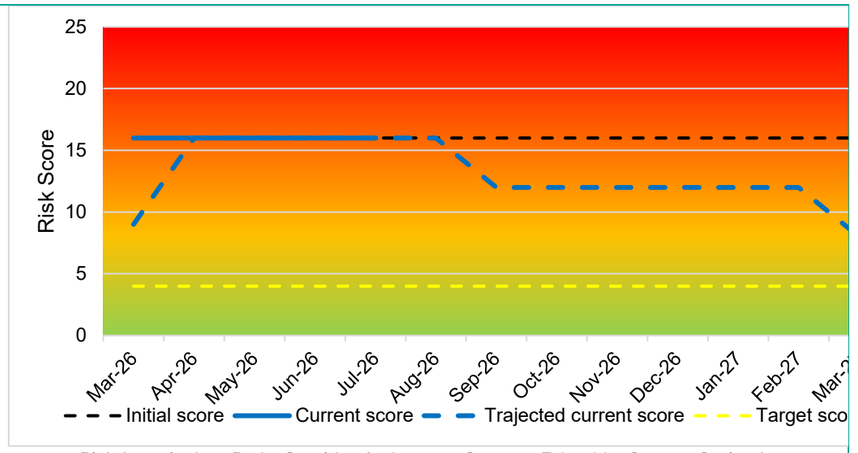
Risk Treatment

<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
UEC improvement programme	S Canty	31.08.26		July 26: Extended Emergency Medicine Ambulatory Care (EEMAC) has been launched. Work is continuing to implement the Medical Ambulatory Care (MAC) model, 24/7 Same Day Emergency Care (SDEC) and Frailty SDEC as part of the wider Urgent and Emergency Care improvement programme. Delivery timescales continue to be reviewed to ensure plans remain achievable and aligned to operational capacity.
Publication of a Standard Operating Procedure for MDT Board and Ward Rounds with aligned audit and training program	R Sansbury	~~30.06.26~~ 31.07.26		July 26: SOP undergoing final approval processes. Date extended to allow for final approval through the Trust's procedural document approval process.

Strategic Objective: Performance	Corporate Objective: Diagnostics - Achievement of the 6 week diagnostic waiting times performance trajectories	Overall Assurance Level	Medium
Risk Title:	Timely access to diagnostic investigations	Risk Score Tracker	

Principal risk 6 (26/27) (ID 2188)	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	14/07/26
		Target Control date	31/03/27





Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Trajectory reset for 2026/27)

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Diagnostic Improvement Group has been established to monitor progress of all improvement trajectories, support demand management, the use of technology and monitor productivity. • All Diagnostic modalities have undertaken a capacity and demand analysis and set improvement trajectories. • Clear identification of clinical priorities via the use of national clinical prioritisation codes. This enables the trust to understand the clinical priority using 'D codes' to support scheduling the most clinically urgent. • Diagnostic waiting validation processes are in place to ensure all capacity is effectively used. • Additional capacity has been commissioned within the 26/27 agreed MTP. • Weekly monitoring of cancer PTLs to reduce any delays is in place supported by a day zero PTL approach with tumour specific action plans in place. ICB support and performance monitoring re Cancer waiting times is delivered via the Tier 1 performance framework and meetings are held fortnightly. • Weekly Chief Operating Officer monitoring forum for core diagnostic modalities. • Weekly Performance Recovery Group established to monitor performance. • Mutual aid support enacted via neighbouring Trust for Echo • Additional capacity mobilised (non-recurrently) for Echo	• Lack of capacity to deliver comprehensive diagnostic waiting list validation. • Lack of triangulation between capacity and demand gaps, benchmarking data and job planning processes. • Physical estate and capital equipment constraints limit available capacity. • Limited influence re external (primary care) demand management.	<u>Level 1 Assurance</u> • Live PTL performance report. • Validation reports. • Datix incident reporting of any treatment delay related harms – review via SI/PSIRF processes with shared learning reports. • Benchmarking data – model hospital, GIRFT, etc <u>Level 2 Assurance.</u> • Oversight in Divisional Improvement Forums, Performance Review Group and F&P Committee. • Benchmarking data analysis – model hospital, GIRFT, etc. <u>Level 3 Assurance</u> • DM01 improvement plan and trajectory in place monitored through NHS England oversight arrangements.	• Data sets lack inequalities data visibility to assess the risk of poorer outcomes between patient groups on PTLs • Datix incident reporting to assess harms of treatment delays is retrospective

Risk Treatment

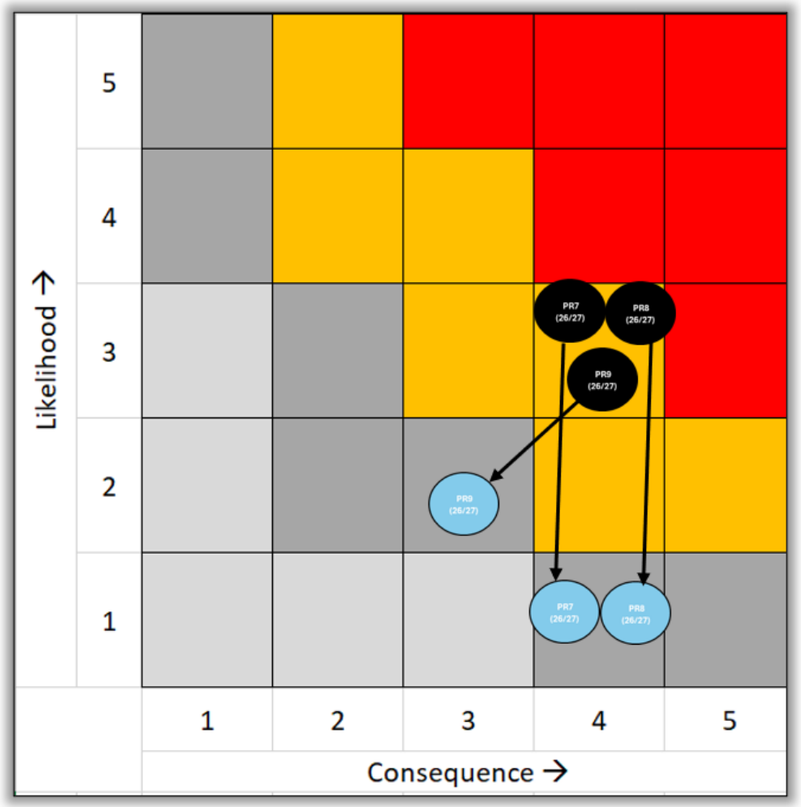
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Develop a Diagnostic productivity dashboard to monitor performance against best timed pathways to inform improvement plans and performance delivery.	K Foster Greenwood	~~30.06.26~~ 30.09.26		July 26: Action date delayed due to specialist resource gap – alternative resource options being scoped. Due date extended until end Sept 26.
Commission business case development for key specialities based on the C&D outputs	K Foster Greenwood	30.06.26	04.06.26	June 26: Business case approved by Board of Directors.
Recruitment & mobilisation into Internal Capacity Business case	K Foster Greenwood	31.08.26		July 26: Internal capacity plans continue to be mobilised. Additional diagnostic capacity is being secured through waiting list initiatives and other workforce measures to support delivery of diagnostic performance standards and reduce waiting times.

People: Be a Great Place to Work

Monitored through Workforce Committee & Education, Training & Research Committee

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

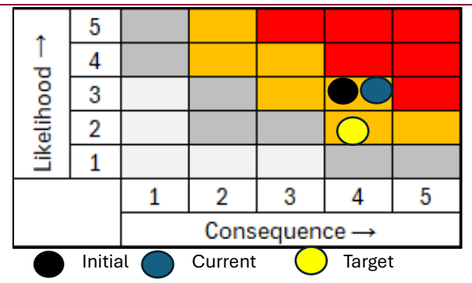
CO Ref.	Purpose of the objective	Scope and Focus of the Objective	How will we know if it has been achieved?	Status
3.1	Equip all our colleagues, including the Board, with the improvement skills, knowledge and confidence to drive improvements within their teams and services	• Expand the current programme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

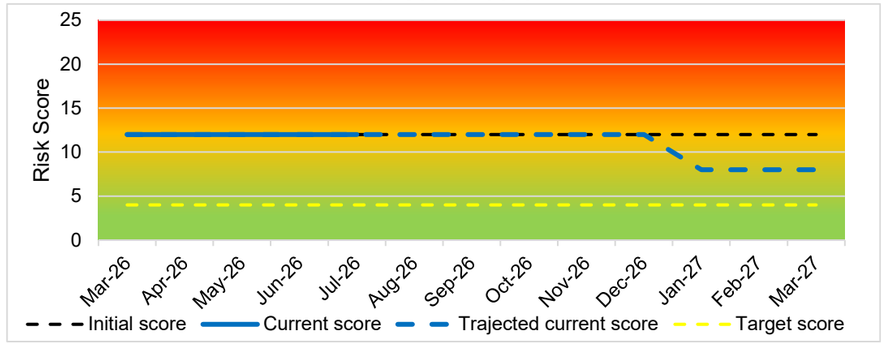


Heat map key: Black = current score, Blue = target score

Strategic Objective: People	Corporate Objective: Improve the experience of work of colleagues with protected characteristics	Overall Assurance Level	Medium

Principal risk 7 (26/27) (ID 2316)	Risk Title:	Experience of under-represented staff groups	
	Risk 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	People and Partnerships Committee	Risk Appetite and Tolerance	Open 4-8
Director	Chief People Officer	5Ts status	Treat
Date risk opened	02/04/26	Date of last review	06/07/26
		Target control date	31/03/27





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

- Our People Plan, Equality, Diversity and Inclusion (EDI) Policy and Strategy.
- Single Improvement Plan.
- EDI mandatory training.
- Supporting Disability in the Workplace policy and agreement.
- Trans and non-binary policy.
- Equality Impact Assessment policy and supporting toolkit.
- NHSE 8 High Impact Actions & NHS People Promise.
- NHS Staff Survey action plan.
- Culture programme, including Zero Tolerance campaigns.
- Freedom to Speak Up Policy, Process and Champions.
- Employee Relations policies and processes.
- Trust Values/Best Version of Us/Leadership in Lancs frameworks.
- Core People Management Skills programme.
- EDI resources/education/toolkits
- Staff ambassador forums for colleagues with protected characteristics (Ethnicity, Disability and Neurodiversity, LGBTQ+).
- Staff engagement offer
- Team Engagement and Development (TED) Tool and toolkit

Gaps in Controls

- No equivalent national Workforce Equality Standard for LGBTQ+ colleagues.
- ESR Declaration rates for colleagues with a long-term condition or disability.
- EQIA process/check and challenge in respect of EIA findings.
- Variable local application of inclusive management practices and management of poor behaviours
- Continue to await mandates and directives following the High Court ruling with regards to protected characteristics of sex.

Assurances

Level 1 Assurance

- EDI 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.

Level 2 Assurance

- L&SC ICS ED&I Group.
- EDI Strategy monitoring.
- Our People Plan Strategy Monitoring.
- Single Improvement Plan reporting.
- People and Partnerships Committee

Level 3 Assurance

- Internal Audit review of ED&I in 2023/24 – Substantial Assurance.
- WRES/WDES, EDS2022, North West Anti-Racist Framework and North West EDI Assurance processes.

Gaps in Assurances

- Challenges in ability to drill down into the NHS Staff Survey data from a minority group/divisional basis due to low numbers and confidentiality.
- Improvement opportunities identified through WRES (appointment from shortlisting, discrimination from managers, Board membership)
- Improvement opportunities identified through WDES (entering formal capability, experience of B&H or abuse, feeling valued).
- WRES and WDES reporting is available annually only.
- Variable Staff Survey response rates across protected characteristic groups.
- 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.
- Challenges in demonstrating reach, awareness and uptake of EDI support and communications across the workforce.

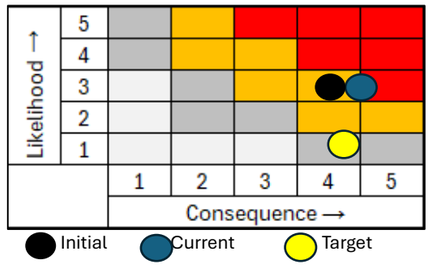
Risk Treatment

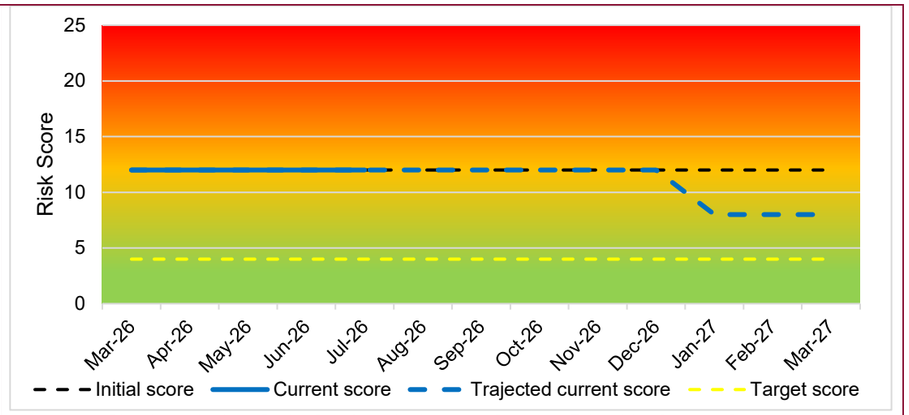
Action	Action Owner	Due Date	Done Date	Action Progress Update
Work to be undertaken in conjunction with the Ethnicity forum to understand more about discrimination statistics	M Davis	~~28.02.26~~ 30.09.26	30.06.26	July 26: Work completed through staff survey analysis, interviews, listening events and development of the Anti-Racist Framework programme. New action identified to represent next phase
Increasing the diversity of colleagues in band 8a and above as per WRES/WDES annual report	M. Davis	~~28.02.26~~ 31.05.26	31.05.26	July 26: Original action closed and replaced by a more specific Talent Management programme action.
Work to be undertaken in conjunction with the Living with Disability forum to understand more about bullying and harassment	M Davis	~~30.01.26~~ 31.05.26	31.05.26	July 26: Engagement and analysis work has improved understanding. Findings have informed targeted management and leadership interventions. Action complete and superseded by the manager skills and competence action.
Division Level Action Plans to be developed to improve areas of underperformance in relation to EDI	Divisional Directors	31.05.26	31.05.26	July 26: Action complete. Ongoing review arrangements established to monitor progress against divisional action plans.
Achieve Bronze Level of the Anti-Racist Framework to improve the experience of ethnic minority colleagues in relation to discrimination	M Davis	30.03.27		July 26: Steering group established and action plan agreed. Work underway to develop evidence and to convey our intention to become and anti-racist organisation
Implement a dedicated Talent Management programme for under-represented groups to increase diversity at Band 8a and above	M. Davis	31.01.27		July 26: Project to be progressed by the new Band 7 OD Practitioner, with implementation expected to commence in September 2026.
Increase managers' skills and competence to support colleagues with protected characteristics throughout the employee lifecycle	M. Davis	30.03.27		July 26: EDI content embedded within the Core People Management Skills programme. Inclusive leadership, compassionate conversations, disability awareness and cognitive bias interventions are being delivered or scheduled. Manager guidance and intranet resources have also been updated.

Strategic Objective: People	Corporate Objective: Enhance colleague experience and levels of staff satisfaction	Overall Assurance Level	Medium

	Risk Title:	Experience of staff and levels of staff satisfaction	Risk Score Tracker

Principal risk 8 (26/27) (ID 2317)	Risk Description:	There is a risk that the Trust may not be considered a great place to work for colleagues or prospective employees across the Trust. This could result in negative experience for staff, adverse impact for colleagues with a protected characteristic, inability to retain a skilled and valued workforce, staff absence, regulatory intervention, and legal action.	
Committee	People and Partnerships Committee	Risk Appetite and Tolerance	Open 4-8
Director	Chief People Officer	5Ts status	Treat
Date risk opened	02/04/26	Date of last review	06/07/26
		Target control date	31/03/27





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

- Our People Plan
- Action plan in response to NHS Staff Satisfaction Survey results.
- Team Engagement and Development (TED) Tool and toolkit to support team-level engagement and improvement
- Single Improvement Plan.
- Equality Impact Assessment policy.
- NHSE 8 High Impact (EDI) Actions & NHS People Promise.
- Culture programme, including Zero Tolerance campaigns.
- Freedom to Speak Up Policy, Process and Champions.
- Employee Relations policies and processes.
- Trust Values/Best Version of Us/Leadership in Lancs frameworks.
- Core People Management Skills programme.
- Leaders/All Colleague briefings
- Colleague engagement strategy and offer, including the Your Voice programme with structured leadership visibility
- Compassionate Performance Conversations Training & Team level civility workshops
- Use of Staff Survey data to support targeted bespoke OD support for lower performing teams

Gaps in Controls

- Variation in local leadership capability and application of people management practices.
- Capacity and time pressures on managers limiting their ability to consistently prioritise colleague engagement, people management and follow-through on actions.
- System-wide operational and financial pressures limiting improvement in day-to-day experience.
- Gap between staff feedback and visible action at team and divisional level.
- Inconsistent senior leader visibility and engagement with colleagues

Assurances

Level 1 Assurance

- NHS Staff Survey reports including year-on-year analysis, corporate action planning and evaluation of targeted OD and engagement support.
- Monthly reporting of TED participation and team-level engagement
- Quarterly National Quarterly Pulse Survey reporting.

Level 2 Assurance

- Our People Plan Strategy Monitoring.
- Single Improvement Plan reporting.
- People and Partnerships Committee oversight and challenge

Level 3 Assurance

- External benchmarking through NHS Staff Survey comparator analysis and Workforce Equality Standards (WRES/WDES) reporting.
- CQC inspection/Well-Led findings
- NHSE/National Provider Improvement Programme

Gaps in Assurances

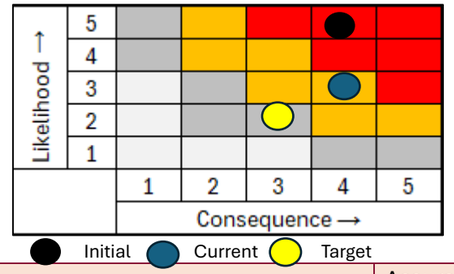
- Limited assurance that workforce initiatives and local actions are delivering measurable improvements in colleague experience and engagement.
- Variable National Quarterly Pulse Survey response rates, limiting confidence in real-time workforce insight.
- Limited availability of timely measures of colleague experience outside the annual NHS Staff Survey.
- Challenges in demonstrating the reach and effectiveness of organisational communication and engagement channels.

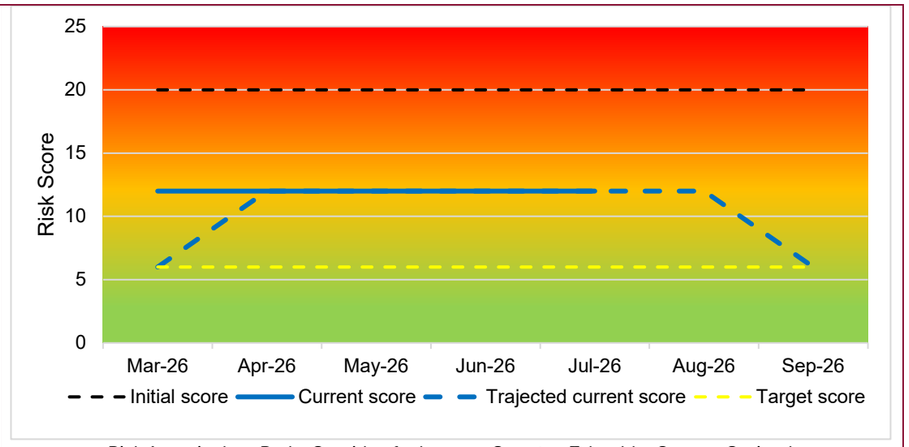
Risk Treatment

Action	Action Owner	Due Date	Done Date	Action Progress Update
Increase use of TED to support team-level engagement, involvement and local action planning	S. Kenny	~~31.03.26~~ 30.09.26		July 26: TED delivery has been strengthened through targeted coaching and revised training arrangements. Activity has increased compared with the same period in 2025/26, with further work planned to support priority teams identified through the NHS Staff Survey and promote wider uptake across the Trust.
Delivery of actions in NHS Staff Survey Action Plan for 2026/27	S. Kenny	31.03.27		July 26: Corporate and Divisional action plans have been agreed following review of NHS Staff Survey results. Monitoring arrangements are in place and targeted OD support has commenced for priority teams.
Strengthen senior leader visibility and engagement through structured programme of colleague engagement activity	S. Kenny	31.03.27		July 26: Your Voice events, recognition activity and local engagement continue to support senior leader visibility. A Listening into Action update has been shared with colleagues and planning is underway for future engagement activity and the Trust Values relaunch.
Strengthen managers' capability and confidence to hold compassionate, supportive and effective conversations throughout the employee lifecycle	S. Kenny	31.03.27		July 26: Delivery of the refreshed Leadership and Management Development Offer is underway. Core management, leadership, performance management and compassionate conversation programmes have been updated, with revised leadership frameworks due to launch in September 2026.

Strategic Objective: People	Corporate Objective: Support the health, wellbeing, safety and attendance of our workforce		Overall Assurance Level	Medium
	Risk Title:	Failure to effectively manage staff absence and achieve Trust and National target rates	Risk Score Tracker	

Principal risk 9 (26/27) (ID 499)	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	People and Partnerships 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	06/07/26
		Target control date	~~31/03/26~~ 30/09/26





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.	Level 1 Assurance • 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. Level 2 Assurance • People and Partnerships Committee. • Divisional Improvement Forums review absence levels. Level 3 Assurance [None detailed]	• Currently a manual process to monitor compliance with absence management policy and processes. • Inability to achieve the 4% target. • Internal audit of sickness absence management practices, (October 2024) provided limited assurance.

Risk Treatment

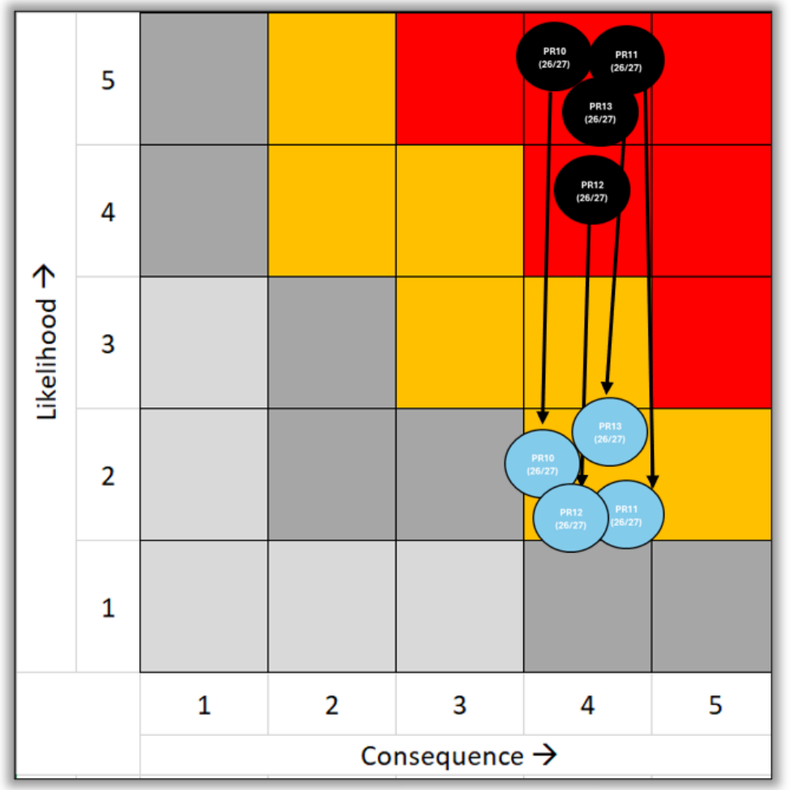
Action	Action Owner	Due Date	Done Date	Action Progress Update
Pilot Empactis as a digital absence management system	R. O'Brien	~~31.03.26~~ 31.07.26		July 26: The pilot has concluded and the contract ended with Empactis. A new product is currently being explored as outlined in the annual sickness absence and health and wellbeing report.
Introduce Occupational Therapist into Occupational Health model	R. O'Brien	~~31.03.26~~ 31.07.26		July 26: Continuing to work through financial position from Wellbeing Partners and changes due to TUPE in and out of services across LSC. Initial findings are there is no additional surplus to fund a post for 12-months, therefore wider options are being considered.
Deliver absence reduction 'plan on a page' against 4 key workstreams	R. O'Brien	~~31.03.26~~ 31.07.26	06.07.26	July 26: Full evaluation is included as part of agenda for July. The refreshed plan has been re-drafted for 2026/27 and included as part of this annual report.

Productivity: Deliver value for money

Monitored through Finance & Performance Committee

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

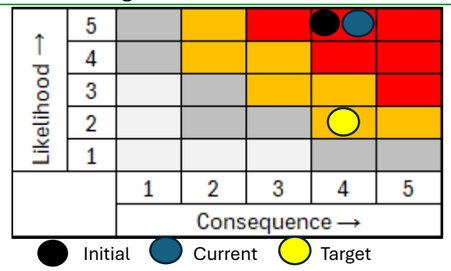
CO Ref.	Purpose of the objective	Scope and Focus of the Objective	How will we know if it has been achieved?	Status
4.1	Deliver the waste reduction programme without compromising quality or safety, including clinical pathway redesign, workforce optimisation, and digital innovation	• Delivery of agreed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

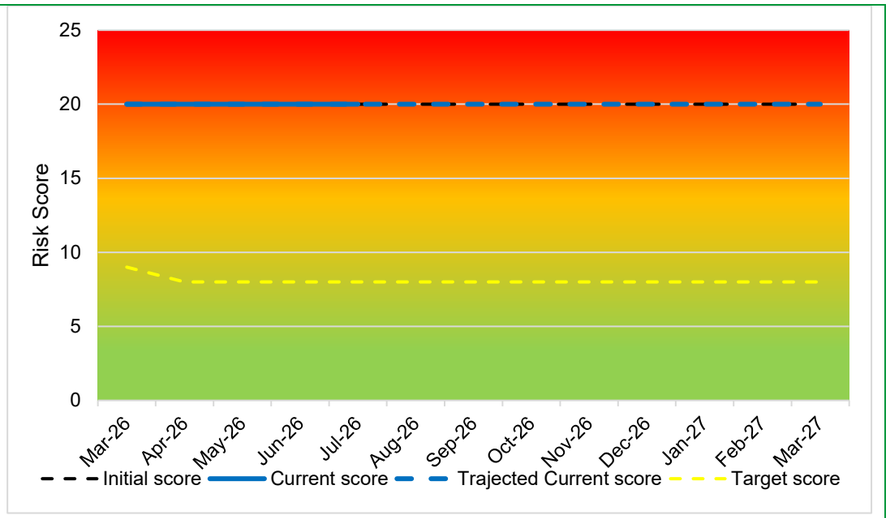


Heat map key: Black = current score, Blue = target score

Strategic Objective: Productivity	Corporate Objective: Deliver the waste reduction programme without compromising quality or safety, including clinical pathway redesign, workforce optimisation, and digital innovation		Overall Assurance Level	Low
Principal risk 10 (26/27)	Risk Title:	Delivery of the 2026/27 financial plan whilst reducing the size of the underlying financial deficit	Risk Score Tracker	
	Risk Description:	There is a risk that the Trust may not deliver the financial plan for 2026/27 and reduce the underlying deficit. This is because of factors such as under-delivery of planned efficiency savings, inability to reduce some operational costs, rising operational demand, and insufficient external funding for some services.		

(ID 1557)		This could result in a significant financial deficit, reduced resources for patient care, challenges in maintaining service delivery, insufficient income to cover operational costs, inability to exit NHS Oversight Framework (NOF) segment 5, further regulatory intervention, impact on staff experience, and reputational damage.	
Committee	Finance & Performance	Risk Appetite and Tolerance	Open 8-12
Director	Chief Finance Officer	5Ts status	Treat
Date risk opened	03/06/24	Date of last review	08/07/26
		Target control date	31/03/27





Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Trajectories and target reset for 26-27)

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Financial plan set at the start of the year - common assumptions and principles agreed collaboratively within the ICS. • Financial plan triangulated with activity and workforce plans. • The Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation are in place to support controlling expenditure. • Budgets set at the start of the financial year and agreed with budget holders, risks identified and rated to enable the Board of Directors to approve the budgets. • There are a suite of pay controls for filling vacancies and using agencies. • Processes are in place to ensure waste reduction programme (WRP) schemes that are delivered are transacted through the ledger. • There are a range of grip and control measures in place for managing discretionary expenditure. • There is a no PO no pay system in place for managing non pay expenditure. • Established Programme Management Office (PMO). • Action plan in place following MIAA Grip and Control Review. • Rebase of contract with commissioners to accommodate increasing demand and patient complexity.	• 2026/27 Waste Reduction Programme (WRP) not fully developed. • Unavoidable cost pressures (industrial action and price volatility)	<u>Level 1 Assurance</u> • Ledger reconciliations - on the integrity of the financial data. • Variance and trend analysis - on the integrity of the financial data. • Grip & Control measures reported to Trust Management Board. <u>Level 2 Assurance</u> • Risks identified monthly to Finance and Performance committee. • Internal Audit - on the integrity of financial systems and variable pay processes - through Audit Committee. • Trust assessment of action in response to independent assessment of Grip and Control report by MIAA to be reported to Finance and Performance Committee. • Financial plan monitored monthly to; budget holders, DIF, F&P committee, externally through provider finance returns (PFR) monthly returns and system improvement board assurance meetings. <u>Level 3 Assurance</u> • External Audit - on the financial accounts - through Audit Committee. • Collaborative working in ICS - integrity of financial data.	• Contracts not signed with commissioners, which creates uncertainty in relation to income. • Limitations and barriers work commissioned by the Recovery Support Programme (RSP) team not yet complete • Confidence in ability to deliver WRP plan

Risk Treatment

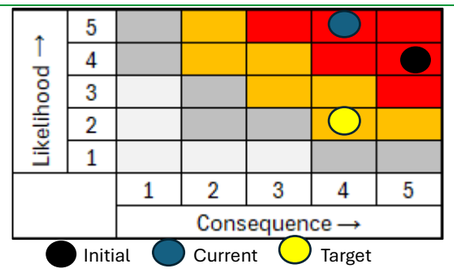
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Fully developed WRP for 2026/27 and reported to Finance & Performance Committee	C. Carter	~~30.04.26~~ 31.07.26		July 26: A fully developed plan is scheduled for consideration at the Regional Performance Oversight Meeting (RPOM) on 21 July 2026.
Contracts to be signed no later than the end of Q1 2026/2027	C. Carter	~~30.06.26-~~ 31.07.26		July 26: Financial elements of the contract have been agreed. Commissioners are finalising the remaining contractual documentation for Trust signature.
Final version of FSP to be taken to June Board	C. Carter	30.06.26	10.06.26	June 26: No major amendments since previous version and therefore decision taken not to take to June Board. Comms plan has been developed and will be implemented throughout the year.
Demonstrate progress with actions in delivery with WRP	C. Carter	31.03.27		July 26: A rapid review of all live vacancies has been completed, with recruitment activity reduced in line with the agreed headcount reduction targets within the Workforce Recovery Plan.

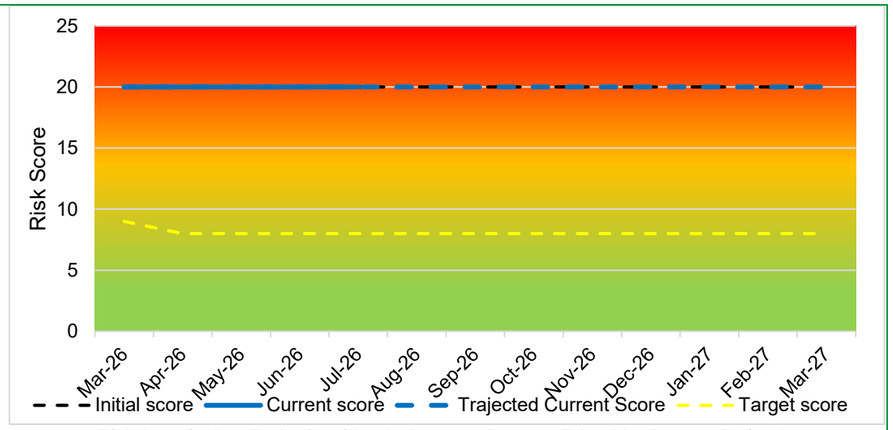
Strategic Objective: Productivity	Corporate Objective: Deliver the waste reduction programme without compromising quality or safety, including clinical pathway redesign, workforce optimisation, and digital innovation	Overall Assurance Level	Low

Principal risk 11 (26/27)	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.

Risk Score Tracker

(ID 802)		This could result in a cash shortfall and therefore, an inability to meet financial obligations, impact on service delivery, delays in payments to suppliers, restricted investment in essential services and infrastructure, and potential further regulatory intervention or reputational damage.	
Committee	Finance & Performance	Risk Appetite and Tolerance	Open 8-12
Director	Chief Finance Officer	5Ts status	Treat
Date risk opened	06/06/24	Date of last review	08/07/26
		Target control date	31/03/27





Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Trajectories and target reset for 26-27)

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Cash Management committee in place. • Annual cash plan in place. • Committee approved cash management policy on prioritisation of supplier payments. • Monthly cash flow forecasting. • Management of working capital balances. • Review of capital programme and timing of expenditure. • Engaging with affected suppliers. • Internal escalation process for urgent cash issues. • NHSE process for requesting cash support. • Additional NHSE process to draw down emergency cash if necessary. • Regular review of cash position and forecasts. • Financial services team resourced for cash management and forecasts. • Weekly system partners debtors update sent to CFO & DCFO • Prepayment arrangements in place for LTH hosted services	• Lack of full compliance with "No PO, No Purchase" arrangements • Access to cash support is subject to external approval. • 2026/27 Waste Reduction Programme (WRP) not fully developed.	<u>Level 1 Assurance</u> • Monitoring and reporting performance against 30-day deadline for payments. • Monthly Cash Review Group with CEO <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. • Confidence in ability to deliver WRP plan

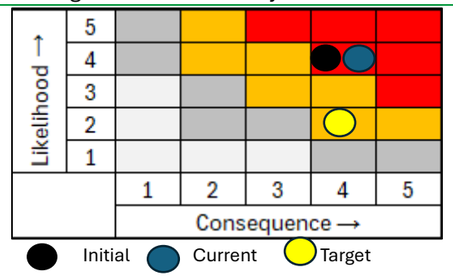
Risk Treatment

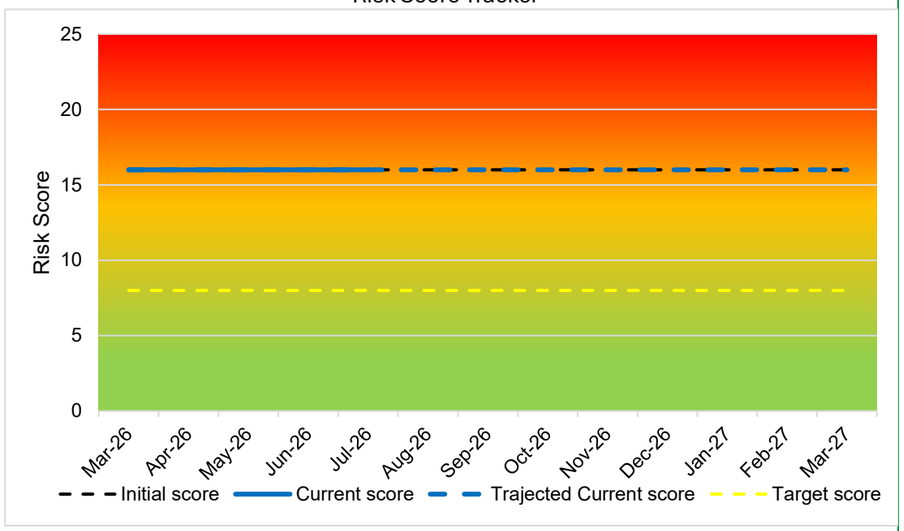
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Timely submissions to NHSE for cash support with Board of Director approval	C. Carter	~~30.04.26~~ 30.06.26	30.06.26	July 26: Cash support not currently required. All submissions remain up to date and the action has been completed and closed.
Strengthen system-wide cash management and financial resilience arrangements	C. Carter	31.03.27		July 26: System Deputy Directors of Finance are working collaboratively across partner organisations to identify and recover outstanding income and improve cash flow resilience. Ongoing mutual support arrangements remain in place to strengthen financial oversight and cash management.

Strategic Objective: Productivity	Corporate Objective: Deliver the waste reduction programme without compromising quality or safety, including clinical pathway redesign, workforce optimisation, and digital innovation	Overall Assurance Level	Medium

Principal risk 12 (26/27) (ID 2106)	Risk Title:	Ability to access required Capital to support an ageing estate	
	Risk Description:	There is a risk that there may be insufficient internally generated capital to support all priority areas of the Trust's ageing estate. This is because of valuation decisions which determine capital funding allocations, the Trust's underlying financial position, competing priorities across the healthcare system, and delays in approvals for capital investment projects. This could result in an inability to progress critical infrastructure maintenance, inability to renew essential existing equipment, potentially impacting service delivery, patient safety, and long-term sustainability.	

Committee	Finance & Performance	Risk Appetite and Tolerance	Open 8-12
Director	Chief Finance Officer	5Ts status	Treat
Date risk opened	05/12/24	Date of last review	08/07/26
		Target control date	31/03/27





Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Trajectories and target reset for 26-27)

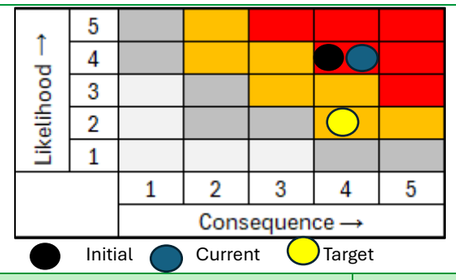
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Trust planning framework. • Capital Planning Forum review and determine risk-based approach and recommendations. • Capital Plan for 2026/27 agreed by Executive Team & Trust Board. • Backlog maintenance programme developed from 6 facet survey outcome, undertaken annually. • Medical Equipment Group with clinical input to support risk assessment and prioritisation. • IT provided with a budget from Capital Planning forum. • Contingency budget identified at the start of the financial year. • Emergency capital funding process for extreme situations. • Receipt of significant national capital funding • Standing financial instructions. • Standing Orders. • Scheme of Reservation and Delegation. • Estates Strategy. • External funding for key developments approved. • Estates and Facilities Partnership Board established	• Short timeframes for external bids alongside limited operational capacity reducing ability to fully cost proposals. • Impact of inflation in terms of project costs and timescales. • Ageing estate and inability to comply with latest statutory guidance.	<u>Level 1 Assurance</u> • Asset register in place to support oversight of medical equipment. • Tracking of project spend in Capital Planning Forum. <u>Level 2 Assurance</u> • Medical Device report to Safety & Quality Committee. • Capital update to Finance & Performance Committee. <u>Level 3 Assurance</u> • 6 facet survey and independent annual report which details the scope and level of the situation. • Estates Returns Information Collection (ERIC) returns to support benchmarking.	• Significant backlog maintenance. • Governance around contract change notices. • Data for ERIC returns is delayed in being released via Model Hospital (2 financial years behind).

Risk Treatment

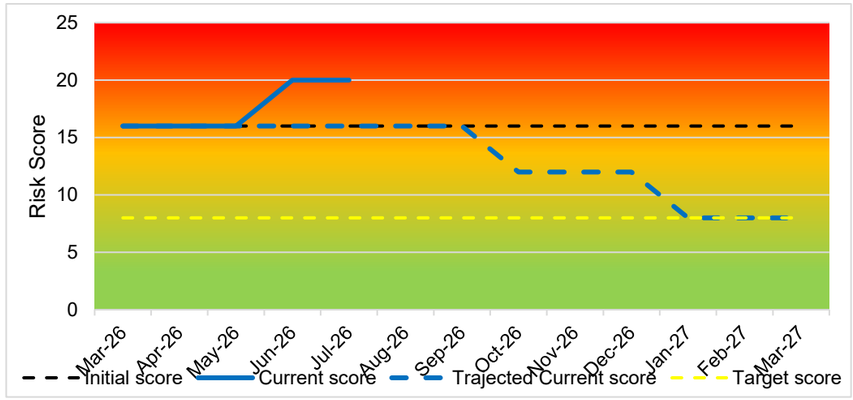
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Agree a fully worked up prioritised plan following confirmation all externally funded schemes	S. Ashworth	31.07.26		July 26: In progress

Strategic Objective: Productivity	Corporate Objective: Deliver the waste reduction programme without compromising quality or safety, including clinical pathway redesign, workforce optimisation, and digital innovation	Overall Assurance Level	Low

Principal risk 13 (26/27) (ID 2318)	Risk Title:	Delivery of the planned reduction in whole time equivalent workforce	
	Risk Description:	There is a risk that the Trust may not achieve the planned reduction in whole time equivalent (WTE) workforce for 2026/27. This is because of the requirement to increase performance, continued urgent and emergency care pressures and increasing patient acuity requiring workforce to be maintained or grow. This could result in an inability to achieve the waste reduction programme, inability to exit NHS Oversight Framework (NOF) segment 5 and further regulatory intervention.	
Committee	Finance & Performance	Risk Appetite and Tolerance	Open 8-12
Director	Chief People Officer	5Ts status	Treat
Date risk opened	02/04/26	Date of last review	21/07/26
		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)

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Trust planning framework. • Medium term planning submission to NHS England. • Workforce plan triangulated with activity and financial plans. • Recruitment controls in place, including Vacancy Control Panel and EQIA process to support workforce decisions. • Business Case Process to fully and accurately assess WTE impact for transformational schemes. • WTE assumptions validated through PID approval with senior workforce sign-off • WRP WTE changes transacted through the financial ledger, ensuring alignment between workforce delivery and financial reporting • Integrated governance and reporting framework in place, providing oversight of WTE performance through PMO, DDGs, FPC, Executive Team. • Real time Daily Management System (DMS) dashboards for review of premium WTE usage by area (WLI/EDP/Bank and Agency). • Daily variable pay control group to control use and associate rates. • Twice daily safe staffing oversight meetings	• Inability to fully develop and manage services within commissioned resources and in line with commissioning processes due to increasing demand, increased complexity and length of stay specifically patient Not Meeting Criteria to Reside (NMC2R) • Gap in funding for any MARS schemes to support reductions in the size of the workforce. • Operational pressures limiting management capacity to deliver schemes. • Activity plan demands driving requirement for additional WTE to support delivery. • Analyst capacity and skill in workforce information to provide level of assurance reporting required.	<u>Level 1 Assurance</u> • Grip & Control measures reported to Trust Management Board. <u>Level 2 Assurance</u> • Monthly NHSE Provider Workforce Returns (PWR) submission for monitoring of PWR effecting WTE delivery against plan. • Improvement and Assurance Group (IAG) and Waste Reduction Programme (WRP) Update to Workforce Committee. • PMO WRP reporting and WTE reporting into Finance and Performance Committee including WTE delivery and risk. <u>Level 3 Assurance</u> • [None]	• The planned reduction in whole time equivalent workforce was not met for 2025/26. • WTE identified with PIDs is reliant on delivery of schemes, some of which are considered high risk. • There are schemes that will result in an improved run rate, however, may not reduce WTE, the ability to explain and demonstrate this is critical. • Workforce information capability and capacity is limiting progress on reliability of analysis and reporting.

Risk Treatment

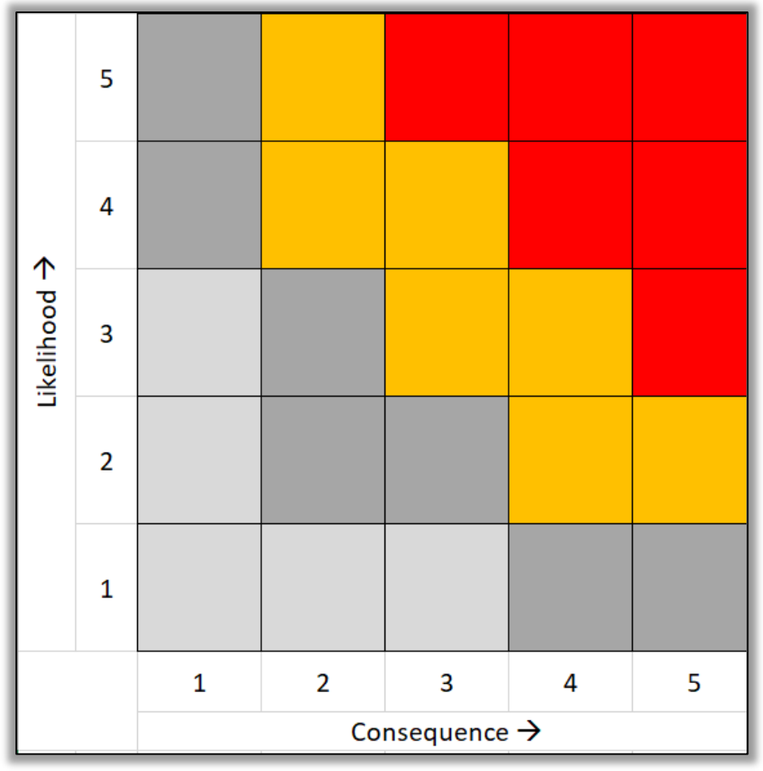
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Recruitment of additional workforce analyst to support financial recovery and planning.	K. Downey	31.07.26	16.07.26	July 26: Workforce analyst recruited and commenced in post on 16 July 2026.
Deliver workforce reductions through the Mutually Agreed Resignation Scheme (MARS) and other agreed workforce reduction measures.	N. Pease	30.09.26		July 26: A total of 14.05 WTE has been approved through the MARS scheme, with reductions being implemented on a phased basis. A further 0.4 WTE reduction is planned for Month 6. A MARS scheme will run each quarter going forward subject to the required national approvals and confirmation of scope.
Deliver an overall reduction of worked WTE whilst maintaining safety in each professional group as a result of recruiting to substantive positions, reducing sickness and increased grip and control of health roster.	S. Morrison / S. Canty	31.08.26		July 26: Reporting for each professional group will be available and presented in total worked to ensure oversight of total worked, this allows consideration of the positions held that in turn have led to continued variable pay use to maintain safety.
Implement and maintain vacancy pause/removal processes where planned workforce reduction schemes are not delivered, whilst maintaining safe staffing levels.	C. Carter	30.06.26	30.06.26	July 26: Initial implementation completed. The process will continue to be applied throughout 2026/27 to support delivery of workforce reduction targets.
Identify priority workforce transformation programmes and track through SIP.	N. Pease	31.08.26		July 26: New action identified with the intention to focus on areas of increased risk that provide an opportunity to improve outcomes and reduce costs.
Delivery the analogue to digital programme. a) PEP + b) Self check in c) Ambient Voice Technology	A. Brotherton	31.03.27		July 26: New action added to ensure oversight of schemes that will deliver headcount reductions. This is part of a priority focus for the next 10 years, with a digital strategy and annual delivery plans in place.
Delivery of premium staffing cost scheme.	N. Pease	30.10.26		July 26: New action added to reflect the WTE costs reduction programme.

Partnership: Be Fit for the Future

Monitored as indicated through the relevant Committee of the Board

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

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



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

9. PERFORMANCE

9.1 * INTEGRATED PERFORMANCE REPORT AS AT AUGUST 2026

Other | Executive Team | 10.10 am

Item for assurance

Including Finance update and Single Improvement Plan

REFERENCES

Only PDFs are attached

9.1 Integrated Performance Report as at 30 June 2026 - Executive Summary.pdf

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Meeting of the	**Board of Directors**		**6th August 2026**
	Part I ☒		**Part II** ☐
Title of Report	**Integrated Performance Report**		
Report Author	Executive Directors		
Lead Executive Director	Katie Foster-Greenwood Chief Operating Officer		
Recommendation/ Actions required	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.		
	Decision ☐	**Assurance** ☒	**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 June 2026, 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.		
Link to Strategic Objectives 2025/26	**Patients – deliver excellent care:** Improve outcomes, reduce harm and deliver a positive patient experience.		☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.		☒

	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.	☒
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.	☒
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.	☒
Due Diligence	Reported through Finance and Performance Committee, Workforce Committee, Safety and Quality Committee	
Committee Approval:	Trust sub committees	Date: May and June 2026
Appendices		

9.2 WINTER PLANNING 2026/27 - PROCESS & TIMESCALES

Other | K Foster-Greenwood | 11.10 am

Item for assurance
Verbal update

10. PATIENTS (SAFETY AND QUALITY)

10.1 SAFETY AND QUALITY COMMITTEE CHAIR'S REPORT

Other | K Deeny | 11.20 am

Item for assurance

Including recommendations on the following reports*:
a) Annual Safeguarding Report
b) Annual mortality, LEDER and PMRT Report

REFERENCES

Only PDFs are attached

- 10.1 SQC Chairs Report 29 May 26 June 2026.pdf
- 10.1a - Annual Safeguarding Report August 2026 Executive Summary.pdf
- 10.1b Annual Mortality Report - Executive Summary.pdf

Chair's Report to Board		
Chair: Dr Karen Deeny	**Committee: Safety & Quality Committee**	
Date(s): 29 May & 26 June 2026	**Agenda information attached for**	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	Trend
Patients - deliver excellent care	→ 15

ALERT

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

Digital limitations and risks are emerging as a recurring theme across multiple areas (e.g., EPR, Flex Harris, Wi-Fi, device access, interoperability). The Committee recommended the Board be alerted to the need for a more comprehensive, system-level view and escalation of digital risks.

The Committee draws the Board's attention to increased reporting of pressure ulcers. Mitigations include a comprehensive targeted action plan, strengthened Healthcare Assistant recruitment, specialist equipment procurement, and continued deep-dive analysis to understand and address root causes.

Pathology risks have been highlighted, including ongoing industrial action at East Lancashire NHS Trust and the temporary suspension of United Kingdom Accreditation Service (UKAS) accreditation at Royal Lancaster Infirmary. Actions include outsourcing of activity to mitigate risk.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

Substantial assurance has been received from Mersey Internal Audit Agency (MIAA) on the Patient Safety Incident Response Framework (PSIRF). Further work is needed to demonstrate impact and learning from incidents.

While significant progress has been made in Infection Prevention and Control (notably in the reduction of *Clostridioides difficile*), the Committee advises the Board to remain mindful of the challenging organisational context (including aging estate, operational and capacity pressures) which may impact future delivery.

Further work is required to strengthen the Healthcare Assistant workforce, prioritising substantive recruitment to improve care quality and reduce reliance on bank staff and dynamic staffing deployment reviews.

Challenges persist in availability of consistent and useable data for Health Inequalities and reporting continues to impact mitigation of Principal Risk 2. A resolution is not yet in place. This will be monitored through the Principal Risk 2.

Resolution of medical workforce challenges in children's services is anticipated by August. Existing staffing arrangements provide risk mitigation, and a revised paediatric medical model is being finalised within current resources

The Urgent and Emergency Care Improvement Programme is reporting quarterly to the Committee with a focus on progress and impact. A formal governance structure is now in place with defined improvement trajectories and balancing measures including re-admission rates.

Medical equipment requires explicit focus on the capital gap and associated risks, with improved tracking on the risk register.

ASSURE

Assurance received; Matters of positive note.

Allied Health Professional (AHP) productivity and workforce actions are underway to establish consistent key performance indicators (KPIs) across professions.

The Committee received assurance through reports covering quality, performance, governance and compliance, including the Safety and Quality Dashboard, Children and Young People Report, Urgent and Emergency Care Improvement Plan, Annual Mortality Report, Annual Medicines Governance Report, Medical Device Assurance Report and Annual Quality Account.

The Board of Directors is asked to:

1. Note the matters that the Committee wishes to Alert, Advise and Assure the Board.
2. Receive assurance and approve the following reports.

Report	Meeting Date	Committee recommendation for Board
a) Annual Mortality, LEDER and PMRT Report	26 June 2026	The Committee confirmed its assurance in respect of governance arrangements in place to review, report and learn from patient deaths and recommended the approval of the report by the Trust Board of Directors.
b) Annual Quality Account	26 June 2026	The Committee resolved that: i. the Quality Account be endorsed for the publication subject to the suggested amendments.

		ii. the same be submitted to the Trust Board of Directors for support post publication.
c) Annual Safeguarding Report	31 July 2026	The Committee confirmed its assurance in respect of the arrangements in place to safeguard patients and agreed to recommend approval of the report to the Board of Directors.
d) Mortuary Oversight, Care After Death and Response to NHS England Board Assurance Statement	31 July 2026	The Committee reviewed the Trust's response to the NHS England Mortuary Oversight Letter and associated Board Assurance Statement requirements and resolved to endorse the proposed action plan and recommend submission of the Board Assurance Statement to the Board of Directors for approval.

Safety and Quality Committee

29 May 2026 | 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 24 April 2026	11.03am	✓	Decision	K Deeny
5.	Matters arising and action log	11.05am	✓	Decision	K Deeny
6.	Strategic Risk Register	11.10am	✓	Assurance	H Ugradar
7.	QUALITY AND PERFORMANCE				
7.1	Safety and Quality Dashboard	11.20am	✓	Assurance	C Gregory
7.2	Maternity and Neonatal Report	11.30am	✓	Assurance	E Ashton / J Lambert
7.3	Annual PSIRF Report	11.40am	✓	Assurance	H Ugradar
7.4	Infection Prevention and Control Annual Plan Report	11.50am	✓	Assurance	D Orr
7.5	Health Inequalities Update	12.00pm	✓	Assurance	R Sansbury
7.6	Annual AHP Productivity and Quality Report	12.10pm	✓	Assurance	C Granato
7.7	Review of Cancelled Appointment Impact	12.20pm	✓	Assurance	J Howles
7.8	L&SC Pathology report on regulation actions and external review findings	12.30pm	✓	Assurance	A Rowbottom
8.	STRATEGY AND PLANNING				
8.1	Annual Patient Experience Report	12.40pm	✓	Assurance	C Gregory
9.	GOVERNANCE AND COMPLIANCE				
9.1	Strategic risk register review	12.50pm	Verbal	Discussion	K Deeny
9.2	Items to alert, advise or assure the Board	12.55pm	Verbal	Information	K Deeny

№	Item	Time	Encl.	Purpose	Presenter
9.3	Reflections on the meeting	1.00pm	Verbal	Assurance	K Deeny
10.	ITEMS FOR INFORMATION (matters to be raised by exception)				
10.1	Children & Young People Report		✓		
10.2	Sub-contract monitoring assurance report		✓		
10.3	Lancashire SEND system update		✓		
10.4	**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) Health and Safety Governance h) Mortality and End of Life Care Committee		✓		
10.5	Date, time and venue of next meeting: *26 June 2026, 11.00am, Microsoft Teams*	1.00pm	Verbal	Information	K Deeny

Safety and Quality Committee

26 June 2026 | 11.00am | Microsoft Teams

Agenda

Leads - please attend for Q&A of your report only, no overview presentation is required.

Items marked * have additional information in the Ancillary Pack

№	Item	Time	Encl.	Purpose	Lead
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 29 May 2026	11.03am	✓	Decision	K Deeny
5.	Action Log Matters Arising – cancer wait times	11.05am	✓	Decision	K Deeny
6.	Strategic Risk Register	11.10am	✓	Assurance	H Ugradar
7.	QUALITY AND PERFORMANCE				
7.1	Safety and Quality Dashboard	11.20am	✓	Assurance	R Sansbury
7.2*	Children and Young People Report	11.30am	✓	Assurance	S Morrison
7.3*	a) UEC Improvement Plan Update b) NHS England Standards for the First 72 Hours of Care	11.40am	✓	Assurance	S Canty M Stewart
7.4*	Annual Mortality, LEDER and PMRT Report	11.50am	✓	Assurance	K Davies
7.5*	Annual Safeguarding Report	12.00pm	✓	Assurance	R Sansbury
7.6*	Annual Medicines Governance Report	12.10pm	✓	Assurance	G Price
8.	GOVERNANCE AND COMPLIANCE				
8.1*	Medical Device Assurance Report	12.20pm	✓	Assurance	S Ashworth
8.2*	Annual Quality Account	12.30pm	✓	Assurance	H Ugradar
8.3	Strategic risk register review	12.40pm	Verbal	Discussion	K Deeny
8.4	Items to alert, advise or assure the Board	12.50pm	Verbal	Information	K Deeny

№	Item	Time	Encl.	Purpose	Lead
8.5	Reflections on the meeting	12.55pm	Verbal	Assurance	K Deeny
9.	ITEMS FOR INFORMATION (matters to be raised by exception) *Ancillary Pack				
9.1*	**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) Health and Safety Governance h) Mortality and End of Life Care Committee		✓		
9.2	Date, time and venue of next meeting: *31 July 2026, 11.00am, Microsoft Teams*	1.00pm	Verbal	Information	K Deeny

Board of Directors

Meeting of the	**Board of Directors**		**6 August 2026**
Title of Report	**Annual Safeguarding Report 2025/26**		
Report Author	Rich Wright- Head of Safeguarding		
Lead Executive Director	Sarah Morrison – Chief Nursing Officer and Deputy Chief Executive		
Recommendation/ Actions required	The Board of Directors are asked to i. Scrutinise the report and confirm that it is assured by the arrangements in place to safeguard patients, noting the considered review undertaken by Safety and Quality committee.		
	Decision ☐	**Assurance** ☒	**Information** ☐
Executive Summary	This report provides the Trust's annual safeguarding overview for 2025–26 and provides assurance to the Safety and Quality Committee that statutory, regulatory and contractual safeguarding responsibilities continue to be met for children, young people, adults at risk and vulnerable groups. It confirms compliance with key legislation and national guidance, including the Children Act, Care Act, Mental Capacity Act, Deprivation of Liberty Safeguards and the Mental Health Act, alongside delivery of NHS Standard Safeguarding Contract requirements and completion of the Provider Safeguarding Commissioning Assurance Toolkit (P-SCAT). During 2025/26, the Trust maintained effective safeguarding arrangements across adult, children and maternity services, with effective governance, statutory compliance, and multi-agency collaboration providing ongoing assurance to the Board. Oversight of Section 42 enquiries, safeguarding reviews, and partnership working with Lancashire County Council has supported continuous improvement and system learning. Key Achievements include: • Delivery of the Safeguarding Single Improvement Plan. Resulting in increased compliance with rapid tranquillisation safety, expansion of trauma-informed training and delivery of Enhanced Therapeutic Observation and Care in line with NHSE standards. • Positive feedback received from a focused CQC Mental Health Act (MHA) inspection which provided assurances that patients detained to the trust had received care according to the code of practice. • The Dementia, Learning Disabilities and Mental Health workstreams delivered improvements in workforce capability, person-centred care, and system integration,		

led through specialist input and targeted practice development, with key contributions to improvements in Enhanced Therapeutic Observations and Care (ETOC)

- Maternity services strengthened routine enquiry and domestic abuse identification processes, reinforcing compliance with national guidance and improving opportunities for disclosure and early intervention.
- Strong audit, quality assurance, and governance activity across safeguarding-related workstreams has supported sustained organisational learning, improved practice assurance and strengthened patient safety outcomes.
- Oliver McGowan Mandatory Training began a phased roll out in Autumn 2025, uptake and progression of this for trust staff has exceeded compliance trajectories and feedback from attendees positive.
- Feedback is being collated from vulnerable patient groups to support the patient voice being captured and to effect improvement and changes for patients with Mental Health, Learning Disabilities, Autism and Dementia.

Key challenges over 2025/26 have included:

- System pressure particularly relating to mental health capacity and the availability of appropriate placements for children and young people, which at times has required enhanced risk management within acute settings.
- Consistent application of Reasonable Adjustment Needs (RAN) remains an area for improvement.
- Full implementation of the Child Protection Information Sharing (CP-IS) system. There is continued reliance on the safeguarding team to mitigate risks while full roll out takes place.
- Ongoing need to strengthen staff confidence, professional curiosity, and consistent application of safeguarding, mental health and risk assessment processes across all clinical areas.

The Trust's approach continues to evolve beyond compliance, with a growing focus on continuous improvement, digital improvements, learning, and cultural development. This includes embedding trauma-informed practice, strengthening professional curiosity, and enhancing staff capability to respond effectively to complexity, risk, and health inequalities across all care settings. Actions related to the priorities identified for 2026/27 will be tracked and monitored via the safeguarding workplan and reported through the Safeguarding board.

Priorities for 2026/27 include:

- Delivery of the Safeguarding focused actions within the "Patients" and "Partnerships" sections of the Single Improvement Plan
- Progression of a capital funding bid for a dedicated Mental Health Assessment space adjacent to the Emergency Department.

	• Increased compliance with the use Reasonable Adjustment Digital Flag across all Trust services by September 2026, ensuring staff can consistently record, share, read, and update reasonable adjustment information within the National Care Records Service to improve accessibility, equity of care, and patient experience for disabled people. • Delivery of the Trust Dementia Plan aligned to the Lancashire and South Cumbria Integrated Care System Dementia Strategy. • Contribute to delivering on the Lancashire-wide Special Educational Needs and Disabilities (SEND) Priority Action Plan and strengthen oversight of children and young people at risk within hospital settings, through development of governance and assurance processes and improved uptake of training in relation to SEND basic awareness for clinical staff. • Continue to improve experiences and work in partnership to reduce delays for Children and Young People in unsuitable hospital settings. • Delivery of the Trust SEND improvement action plan. • Further develop the High Intensity User (HIU) programme to support vulnerable frequent attenders and reduce avoidable hospital attendance and length of stay.	
Link to Strategic Objectives 2025/26	**Patients – deliver excellent care:** Improve outcomes, reduce harm and deliver a positive patient experience.	☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.	☐
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.	☒
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.	☒
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.	☐
Due Diligence	To give the Committee assurance, please complete the following:	
Operational Group Review:	Safeguarding Board	Date: 26th May 2026
Link to Board Assurance Framework:	Principal Risk 3 (25/26) - People experiencing Health inequalities	
Appendices	Appendix 1-6 with included in main report.	

Board of Directors Report

Meeting of the	**Board of Directors**		**6th August 2026**
	Part I ☒		**Part II** ☐
Title of Report	**Annual Mortality, LEDER and PMRT Report**		
Report Author	Kathryn Flinn, Head of Inquest and Mortality		
Lead Executive Director	Steve Canty, Chief Medical Officer		
Recommendation/ Actions required	The Board of Directors is asked to: approve the report.		
	Decision ☐	**Assurance** ☒	**Information** ☐
Executive Summary	The purpose of this annual mortality report is to provide an update and assurance to the Board that the Trust has robust governance arrangements in place to review, report and learn from patient deaths. The report has been considered by the Safety and Quality Committee at its meeting in June 2026.		
Link to Strategic Objectives 2026/27	**Patients – deliver excellent care:** Improve outcomes, reduce harm and deliver a positive patient experience.		☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.		☒
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.		☐
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.		☐
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.		☐
Due Diligence	To give the Trust Board assurance, please complete the following:		
Committee Approval:	Safety and Quality Committee	26th June 2026	
Operational Group Review:	Mortality and End of Life Committee	8th June 2026	
Link to Board Assurance Framework:	Not applicable		
Appendices	Appendix 1: Mortality Benchmarking, Dr Foster report and Conditions with higher-than-expected mortality Appendix 2: Structured Judgement Reviews Appendix 3: Deaths subject to PSIRF Investigation		

	Appendix 4: Inquests and Coronial matters Appendix 5: Medical Examiners Service Appendix 6: Mortality Improvement Plan

1. Background

The Trust is committed to learning from internal and external information which describes and benchmarks the experience of patients at the end of their life, as well as that of their families and those close to them. By triangulating data from all of these sources, the aim is to improve experience for patients, relatives and staff in all aspects of care at the end of life and after death.

2. Discussion

Benchmarking

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

The Trust Summary Hospital Mortality Indicator (SHMI) for the data period is **96.27** and within expected range.

The SMR for children is **78.0** and within expected range**.** The 12-month SMR for neonatal deaths excluding stillbirths is **84.3** and also within expected range.
Stillbirth numbers are recorded by TELSTRA /Dr Foster as **7**.

Mortality Reviews including Coroner's cases

The Trust has completed SJRs (Structured Judgement Reviews) for 60% of deaths recorded during 2025 -2026.
Key themes of learning from SJRs have been presented, as well as the learning from LeDeR reviews, StEIS /PSIRF reported deaths and Inquests.

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

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

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

Two Regulation 28 reports and one letter of concern have been received.

Reviews were undertaken following concerns raised about mortality rates in patients with Clostridium Difficile and intracranial injuries. The reviews did not support the initial concerns and were related to data anomalies.

Medical Examiner Service

Medical Examiner review of cases remains consistently high, fulfilling the statutory duty, despite pressures within the service.

Improvement Work

Mortality Improvement work is progressing in relation to management of complex death cases (those which are the subject of Trust investigations, complaints and / or coroner referral) and thematic learning, with a focus on delayed recognition of the end of life within the Trust.

3. Financial implications

None

4. Legal implications

None

5. Risks

The Regulation 28 Reports issued represented a reputational risk to the Trust. This has been managed by comprehensive action plans which have been shared with and accepted by the coroner (with no requests for further assurance), the ICB, CQC and the patients' families.

6. Impact on stakeholders

Involvement in Inquests and other investigation processes following the death of a loved one has a significant impact on bereaved families and clinical teams. The Trust is committed to providing compassionate communication and support to bereaved families and colleagues at all touch points, and to providing the highest quality evidence to the coroner to enable the coroner and bereaved family to understand events leading to the death.

The Inquest and Mortality Team continue to provide individualised person-centred compassionate care and support to colleagues who find themselves in difficulty due to inquest involvement. The team work alongside colleagues from Clinical Psychology, Learner Support and senior and peer colleagues working with the witnesses involved.

The learning from multiple sources described in the report has been shared with clinical teams, and will benefit both patients and bereaved families going forwards.

7. Recommendations

It is recommended that the board endorse the report and confirm it is assured of the robust arrangements in place relating to the management of patient deaths.

10.2 * MATERNITY AND NEONATAL SERVICES REPORT

Other | Perinatal Leadership Team | 11.30 am

Item for assurance

REFERENCES

Only PDFs are attached

10.2 Maternity & Neonatal Report - Executive Summary August 2026.pdf

Board of Directors

Meeting of the	**Board of Directors**	**06 August 2026**	
Title of Report	**Maternity and Neonatal Services Safety Report**		
Report Author	Jo Lambert – Deputy Midwifery & Nursing Director		
Lead Executive Director	Sarah Morrison – Chief Nursing Officer/Deputy Chief Executive Officer		
Recommendation/ Actions required	The Board of Directors are asked to i. Receive and scrutinise the report, including the Clinical Negligence Scheme for Trusts (CNST) Year 8 Maternity Incentive Scheme (MIS) and separate Perinatal Quality Surveillance Dashboard ii. Confirm it is assured of the oversight and monitoring mechanisms used to monitor safety and quality within maternity and neonatal services. Noting the safety and quality committee have endorsed the report to Board.		
	Decision ☐	**Assurance** ☒	**Information** ☐
Executive Summary	This report provides the Board of Directors with an overview of maternity and neonatal safety, quality, workforce, governance and learning for Quarter 1 (April-June 2026) aligned to the requirements of the NHS Resolution Maternity Incentive Scheme (MIS) Year 8 and Perinatal Quality Surveillance Model (PQSM). In line with these standards and the updated expectations of MIS year 8, the format for reporting has been aligned with the nationally developed side set and this replaces the previous Maternity and Neonatal Safety report. This approach ensures greater focus on workforce, clinical standards, learning from events, culture, and the experiences of women and families, while enabling the Trust Safety and Quality Committee and Board of Directors to quickly understand key safety intelligence, clinical outcomes, and areas requiring action. The slide set has been structured to mirror the six Maternity Incentive Scheme (MIS) Year 8 Safety Standards, A-F Workforce and Capacity Training, Learning from Reviews and Investigations, Service User Voice, Equity, Care Bundles, Board Oversight, Governance, Culture and Leadership. This format provides a clear line of sight between clinical care and outcomes, enabling effective Board oversight and assurance. The Divisional Midwifery and Nursing Director will attend the Board of Directors alongside representatives from the wider perinatal team, including obstetric and neonatal Clinical Directors to ensure comprehensive multi-disciplinary input. The Perinatal Quality Dashboard has also been updated to align more closely with the format used by the committees of the Board which is presented as an accompanying slide set.		

	Overall, there is assurance that maternity and neonatal services continue to demonstrate a strong focus on safety, learning and continuous improvement, with 5/6 MIS Year 8 standards on track. The Maternal Care bundle (Standard E) remains the only standard currently rated as at risk due to the scale and complexity of the national implementation requirements and dependencies on wider system partners. Workforce remains the most significant operational challenge across maternity obstetrics and neonatal services, with teams experiencing pressures associated with vacancies, sickness absence, maternity leave and workforce availability. Safe staffing mechanisms are in place and have been maintained using redeployment between clinical areas, acuity measurement and escalation processes and proactive recruitment. Further workforce diagnostics and safe staffing reviews are planned to support work force sustainability. Training compliance provides strong assurance, with all eligible staff groups achieving more than the 90% MIS Year 8 requirement for maternity emergency skills, fetal monitoring and neonatal resuscitation training. Compliance levels of 98–100% across most professional groups, demonstrate the organisation's continued commitment to maintaining workforce competence and clinical safety. Perinatal mortality, incident investigation and thematic learning processes remain in place, with all eligible cases being reviewed through established perinatal Mortality Review Tool (PMRT) Maternity and Neonatal Safety Investigation MNSI) and Patient Safety investigation response Framework (PSIRF). In addition, strong governance arrangements, with learning focused on clinical escalation, communication, documentation, translation and interpretation services, sepsis recognition and risk assessment. There continues to be a strong commitment to family engagement, embedding learning into clinical practice, and targeted continuous improvement. Operational pressures are evident within maternity assessment suite (MAS) and elective caesarean pathways. During Q1, the neonatal unit experienced periods of both internal and external closure driven by workforce availability, increased acuity associated with intensive care and an increase in babies who require long period of intensive care. Internal closures had reduced to zero by June 2026 and British Association of Perinatal Medicine. (BAPM) compliance also improved to 90.1% indicating improved service resilience. Maternity Assessment Suite (Triage) activity also remained high, with over 3,100 attendances recorded during the quarter. In June 2026 there was one case of late maternal death which was outside of the reporting period and criteria for MNSI investigation. A detailed After-Action Review was undertaken, and no care concerns were identified. There were no MOSS critical alerts in Q1. The publication of both the Ockenden Report and the Amos National Maternity Review has reinforced the importance of safe, personalised and equitable maternity and neonatal care, strong clinical leadership, effective multidisciplinary working, and a culture that listens to women, families and staff. In addition to these two national reports the service has received a National 10-point plan with immediate actions and the new National Maternity Triage Framework specification. The service has undertaken an initial benchmarking review of the recommendations of these national documents and is actively progressing local actions where these are required, whilst awaiting further information, guidance and toolkits from the national team and publication of the national implementation and accountability framework. (See Slide 31). The maternity and neonatal teams remain committed to being an open, learning organisation that continuously seeks feedback, responds with robust governance candour and compassion, and works in partnership with women, families and staff to improve safety, experience and outcomes. As such the Maternity and Neonatal Improvement Support Team (MNIST) have been invited to undertake an review of services, perinatal culture and governance. The review will identify strengths, recognise good practice and highlight any areas of focus. This will take place from the 27 July 2026 and be concluded on the 30 July 2026. (Slide 33).

Link to Strategic Objectives 2025/26	**Patients – deliver excellent care:** Improve outcomes, reduce harm and deliver a positive patient experience.	☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.	☐
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.	☒
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.	☐
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.	☒
Due Diligence	To give the Trust Board assurance, please complete the following:	
Committee Approval:	Safety and Quality Committee	July 2026
Operational Group Review:	Maternity Safety and Quality Group	Date: July 2026
Link to Board Assurance Framework:	The report is linked to the BAF through planned and unplanned care risks, whilst a specific BAF risk is not identified at Board level, operational risks pertaining to Tier 2 rota provision, Caesarean section rates, safe staffing and culture are detailed within the risk register.	
Appendices	Ancillary Report 1 Maternity and Neonatal Board Report Slides Ancillary Report 2 Perinatal Quality Surveillance Dashboard Ancillary Report 3 Maternity and Neonatal Diagnostic Terms of Reference Ancillary Report 4 Maternity and Neonatal Diagnostic Colleague communication	

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

Decision Item | S Morrison | 11.40 am

REFERENCES

Only PDFs are attached

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

Board of Directors

Meeting of the	**Board of Directors**	**6 August 2026**
	Part 1 x	**Part 2**
Title of Report	**Mortuary Oversight, Care After Death and Response to NHS England Board Assurance Statement**	
Report Author	Hajara Ugradar, Associate Director of Risk, Assurance & Corporate Affairs Emma Denfhy, Deputy Associate Director of Risk & Assurance	
Lead Executive Director	Steve Canty, Chief Medical Officer and HTA Corporate Licence Holder	
Recommendation/ Actions required	The Board of Directors are asked to: I. Review the Trust's response to the NHS England Mortuary Oversight Letter and associated Board Assurance Statement requirements. II. Consider the current position against the NHS-relevant recommendations arising from the Fuller Inquiry. III. Endorse the proposed action plan to address any identified gaps and strengthen Board assurance arrangements relating to care after death. IV. Approve the submission of the Board Assurance Statement Noting the report and content have been scrutinised by the Safety and Quality Committee.	
	Decision ☒	**Assurance** ☐ / **Information** ☐
Executive Summary	On 26 June 2026, NHS England issued correspondence to all NHS provider trusts seeking renewed assurance regarding mortuary oversight, care after death, safeguarding arrangements and the implementation of recommendations arising from the Fuller Inquiry. Trusts that operate mortuary facilities, maintain storage areas for the deceased, or routinely provide care following death are required to submit a Board Assurance Statement by 31 July 2026. The Trust has reviewed its position against the NHS England requirements, including the Phase 1 and Phase 2 Fuller Inquiry recommendations. This has confirmed that established arrangements are in place for mortuary oversight, HTA compliance, physical and electronic security controls, operational monitoring, leadership accountability and escalation. The NHS England letter is provided at Appendix 1, the completed Board Assurance Statement is provided at Appendix 2, and the Fuller Inquiry Phase 1 Assurance and Phase 2 Action Plan documents are provided at Appendices 3 and 4. At the end of June 2026, 62% of Phase 2 actions were complete, 31% were ongoing and on track, and 7% were pended pending national updates. Remaining actions relate mainly to approved mortuary security enhancements and actions dependent on national guidance, with full completion planned by the end of December 2026.	

	Further assurance is provided through the Trust's HTA licensing arrangements. Royal Preston Hospital has held an HTA licence since 2007 and underwent its most recent inspection in September 2025. The inspection assessed all 72 HTA licensing standards and included a detailed review of governance, operational processes, traceability arrangements, staff training and the mortuary environment. No findings were identified relating to the care or management of deceased individuals. At the end of June 2026, 90% of the resulting improvement actions had been closed, with the remaining actions relating to the procurement and installation of mortuary equipment due for delivery in September 2026. The Trust has reviewed its governance and accountability arrangements in response to the latest NHS England requirements and has confirmed that appropriate executive oversight, operational governance and accountability arrangements are in place. The Mortuary Team structure chart, setting out key people, roles, responsibilities and reporting lines for mortuary services, associated body storage areas and care after death, is provided at Appendix 5. Oversight of mortuary services and post-death care is provided through established governance structures, with executive responsibilities for end-of-life care, HTA compliance, safeguarding, estates and security clearly defined. The Chief Nursing Officer/Deputy Chief Executive Officer visited the Mortuary on 8 July 2026 and the Histopathology service on 20 July 2026. The visits were supported by the Deputy Midwifery and Nursing Director, the Divisional Nursing Director for Diagnostics and Clinical Support Services, and the Associate Director for Risk, Assurance and Corporate Affairs. These visits, together with an independent NHS England Recovery Support Programme review undertaken as part of a wider mock CQC assessment also undertaken in July 2026, have provided positive assurance regarding professionalism, operational oversight and local controls, with no significant concerns identified. The Freedom to Speak Up Guardian met with the Mortuary Manager on 10 July 2026 and delivered a Freedom to Speak Up awareness session to the Mortuary team on 14 July 2026. Further Mortuary visits are planned by the Chief Medical Officer as HTA Corporate Licence Holder, with involvement from the Maternity Non-Executive Director Safety Champion/Freedom to Speak Up Non-Executive Director on 26 August 2026. In addition, the Trust Quality Assurance Team has been commissioned to develop a Safety Triangulation Accreditation Review (STAR) audit framework for mortuary services to ensure quality standards are regularly tested and assured. The framework will be informed by the findings of the Fuller Inquiry, HTA regulatory requirements and recommendations arising from the Nottingham and Ockenden reviews. The overarching NHS England Annex 1 action plan is provided at Appendix 6. While a small number of actions remain in progress, these are being managed through agreed delivery routes. This includes estates-related compliance assessments, actions awaiting further national guidance, and the approved mortuary security upgrade, for which the ordering process has progressed and confirmation of the priority installation date is awaited. No significant gaps in assurance have been identified. Going forward an annual report will be presented to the Safety and Quality Committee and Board of Directors in relation to mortuaries and body stores in line with the Phase 2 Fuller Recommendations.

Link to Strategic Objectives 2026/27	**Patients – deliver excellent care:** Improve outcomes, reduce harm and deliver a positive patient experience.	☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.	☐
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.	☐
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.	☐
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.	☐
Due Diligence	To give the Committee assurance, please complete the following:	
Committee Review:	Safety and Quality Committee	July 2026
Link to Board Assurance Framework:	Not applicable	
Appendices	Appendix 1: NHS England Letter – Nottingham Maternity Review Findings on Post-Death Care and Key Actions Required Following the Fuller Inquiry. Appendix 2: Completed Board Assurance Statement. Appendix 3: Fuller Inquiry Phase 1 Assurances. Appendix 4: Fuller Inquiry Phase 2 Action Plan. Appendix 5: Mortuary Team Structure Chart: Roles, Responsibilities and Reporting Lines. Appendix 6: NHS England Annex 1 Action Plan: Nottingham Maternity Review, Post-Death Care and Fuller Inquiry Requirements.	

BREAK

11.50 am

11. PEOPLE & PARTNERSHIPS (WORKFORCE, EDUCATION AND RESEARCH)

11.1 PEOPLE & PARTNERSHIPS COMMITTEE CHAIR'S REPORT

Other | S Crean | 12.00 pm

Item for assurance

REFERENCES

Only PDFs are attached

11.1 PPC Chair's Report 15 July 2026 - BoD 6 Aug 26.pdf

Chair's Report to Board of Directors		
Chair: StJohn Crean	Committee: People & Partnerships	
Date(s): 15 July 2026	Agenda attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	Trend
PR7 - Experience of Under-represented staff groups - 12 **PR8 - Experience of staff and levels of staff satisfaction - 12** **PR9 - Failure to effectively manage staff absence and achieve Trust and National target rates - 12**	⇨

ALERT

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

- A high-scoring Estates staffing risk (score 20) associated with the OneLSC partnership arrangements remains outside the Trust's risk appetite. The Committee was therefore only able to provide reasonable assurance and requested that this position be highlighted to the Board.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- The annualised sickness absence rate had reduced from 6.56% in 2024/25 to 6.02% in 2025/26, demonstrating positive progress, although further reductions were expected to become increasingly challenging. The Committee discussed how success was being measured through sickness absence trends, workforce wellbeing indicators and variable pay expenditure, and noted the need for continued focus on governance, oversight and targeted support in areas where absence levels remain of concern

ASSURE

Assurance received; Matters of positive note.

- The Health and Wellbeing Strategy was delivering positive outcomes, with sustained improvements in sickness absence and staff wellbeing measures; targeted interventions and monitoring arrangements were in place to support further improvement

The Board of Directors is asked to:

1. Note the matters that the Committee wishes to Alert, Advise and Assure the Board.
2. Receive assurance and approve the following reports

Report	Meeting Date	Committee recommendation for Board
a) None		

People & Partnerships Committee

15 July 2026 | 10.00 am | Microsoft Teams

Agenda

*Denotes inclusion of ancillary document in ancillary pack

№	Item	Time	Encl.	Purpose	Presenter
1.	a) Chair and quorum b) Temporary recording of meeting	10.00am	Verbal	Information	S Crean
2.	Apologies for absence	10.01pm	Verbal	Information	S Crean
3.	Declaration of interests	10.02am	Verbal	Information	S Crean
4.	Minutes/Action Logs Received of the final meetings of WFC & ETRC	10.03am	✓	Information	S Crean
5.	Matters arising and action log	10.05am	✓	Decision	S Crean
6. *	Strategic Risk Register	10.10am	✓	Assurance	H Ugradar
7. TRAINING & COMPLIANCE					
7.1 *	Workforce Compliance Metrics	10.20am	✓	Assurance	K Downey
7.2 *	Core Skills Training Report	10.30am	✓	Assurance	L O'Brien
8. STRATEGY & PLANNING					
8.1 *	SIP Education	10.40am	✓	Assurance	L O'Brien
8.2	SIP Research & Innovation	10.50am	✓	Assurance	P Brown
9. RECRUITMENT AND RESOURCE					
9.1 *	Annual Job Planning Report	11.00am	✓	Assurance	K Downey
10. FUTURE SERVICE					
10.1*	Annual Employee Relations Update and Equality Impact of Policies Report	11.10am	✓	Assurance	R O'Brien
11. INCLUSIVITY AND SUPPORT					
11.1*	Annual Health and Well-being Strategy Report	11.20am	✓	Assurance	R O'Brien
12. RISK					
12.1	Items to alert, assure, advise to the board or items of referral to other committees	11.30am	Verbal	Information	S Crean

№	Item	Time	Encl.	Purpose	Presenter
12.2	Reflections on Strategic Risks	11.35am	Verbal	Decision	S Crean
13.*	ITEMS FOR INFORMATION				
13.1	Staff Suspensions Report		✓		
13.2	Chairs' Reports from Feeder Groups/Workstreams a) Education Governance and Risk Sub-Committee b) Education Finance & Performance Sub-Committee		✓		
	Date, time, and venue of next meeting: *8 September 2026, 1.00pm via Microsoft Teams*	11.45am	Verbal	Information	S Crean

12. PRODUCTIVITY (FINANCE)

12.1 FINANCE AND PERFORMANCE COMMITTEE CHAIR'S REPORT

Other | A Leather | 12.10 pm

Item for assurance

REFERENCES

Only PDFs are attached

12.1 FPC Chair's Report 26 May 23 Jun 2026 - 06.08.26.pdf

Chair's Report to Board of Directors		
Chair: John Schorah	Committee: Finance & Performance	
Date(s): 26 May, 23 June	Agenda attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	Trend
Deliver Value for Money – 20 Fit for the Future - 16	⇧

ALERT

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

- **Financial Recovery, Workforce Reduction and Workforce Reduction Programme (WRP) Delivery:** There remains a material risk to delivery of the Trust's financial recovery plan, with workforce reductions, savings schemes and transformation programmes all progressing behind the pace required. Limited assurance is available that current interventions will deliver the required workforce and financial benefits, and there is an increasing risk that the Trust will not achieve its planned savings trajectory without more significant transformation and accelerated delivery of improvement schemes.
- **OneLSC Governance and Accountability:** Increasing concern was raised regarding lack of clarity on accountability, pace of delivery and ability to respond to Trust priorities, with risks identified around the current operating model not providing sufficient agility to deliver workforce interventions for groups transferred to OneLSC and transformation objectives, but it was reported arrangements were being developed to ensure continued visibility and assurance. .
- **M2 Finance Position and General Finance Update inc. RPOM:** Concerns raised regarding persistent underperformance at divisional level, which had been observed across more than one year. This indicates potential structural and cultural issues, with insufficient clarity regarding accountability for delivery. Strengthening accountability arrangements was identified as critical and remained a key risk area.
- **Divisional Delivery Group (DDG) Update Report – Medicine:** High risk of non-delivery, particularly given reliance on complex and high-risk schemes.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- **Green Plan:** Delivery is constrained by funding gaps, limited ownership in key areas and incomplete supply chain assurance.
- **DDaT / System Transformation:** Structural constraints and complexity are impacting pace of transformation, including challenges in evidencing system-wide benefit for shared EPR.

- **Rostering:** Development of new structures and roles were constrained by system level issues and dependency on OneLSC transformation timelines by early 2027 present a risk to sustaining improvements and delivering optimisation.
- **Strategic Risk Register:** Slippage against the capital programme requires active reprioritisation. While this presents an opportunity to redirect funding to support productivity and delivery, underspending against planned capital investment is not a positive position and requires closer oversight and planning.

ASSURE

Assurance received; Matters of positive note.

- **Single Improvement Plan:** Delivery at an early stage, with a small proportion of programmes off track and risks identified in key areas.
- **Cyber Security (DDaT):** Strong performance and high levels of compliance provided clear assurance on cyber controls.
- **Procurement:** Reduction in single tender waivers demonstrated strengthened governance and compliance.
- **Reporting:** Significant improvement in the quality of reporting across finance, workforce and performance, has enabled more targeted questioning and a better understanding of the underlying issues, providing stronger oversight.
- **WRP & Programme Management Office (PMO) Update:** Governance arrangements have strengthened, including the use of DDGs, enhanced PMO oversight and improved triangulation of information. These arrangements provide a clearer framework for monitoring delivery and holding divisions to account.
- **LHS Update:** Positive financial position of the Lancashire Hospitals Service, which has delivered a favourable outturn and is operating within its expected financial model, contributing positively to the Trust's overall position.

The Board of Directors is asked to:

1. Note the matters that the Committee wishes to Alert, Advise and Assure the Board.
2. Receive assurance and approve the following reports

Report	Meeting Date	Committee recommendation for Board
a) None		

Finance and Performance Committee

26 May 2026 1.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Lead
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 28 April 2026	1.03pm	✓	Decision	J Schorah
5.	Matters arising and action log	1.05pm	✓	Decision	J Schorah
6.	Strategic Risk Register (inc. review of Workforce Reduction Risk)	1.10pm	✓	Decision	H Ugradar
7.	OPERATIONAL PERFORMANCE				
7.1	Performance Assurance Progress Report (inc. clear focus on areas of underperformance).	1.20pm	✓	Assurance	K Foster-Greenwood
8.	FINANCIAL PERFORMANCE				
8.1	M1 Finance Position and General Finance Update inc. IAG	1.35pm	✓	Assurance	M Patel
8.2	Quarterly Grip and Control Update – (inc. definition & evidence of the organisational outcomes expected from controls).	1.50pm	✓	Assurance	M Patel
8.3	DDG Update Report - W&C	2.00pm	✓	Assurance	R Dineley
8.4	WRP and PMO Update	2.10pm	✓	Assurance	R Morgan-Evans
8.5	One LSC Procurement update (incorporating supplier scores)	2.20pm	✓	Assurance	J Collins
8.6	People Accountability Oversight Framework	2.30pm	✓	Assurance	N Pease
8.7	Financial Recovery / Workforce Reduction Update	2.40pm	✓	Assurance	N Pease
9.	STRATEGY & PLANNING				
9.1	SIP Update	2.50pm	✓	Assurance	R Morgan-Evans

№	Item	Time	Encl.	Purpose	Lead
9.2	Quarterly Green Plan Report	3.00pm	✓	Assurance	I Ward
9.3	LTH Digital Enabling Strategy	3.10pm	✓	Decision	K Hudson
9.4	LTH DDaT 6 monthly review	3.20pm	✓	Assurance	S Dobson
9.5	Health Roster Strategy Report	3.30pm	✓	Assurance	H Hall
10. RISK, GOVERNANCE AND COMPLIANCE					
10.1	Items to Alert, Advise or Assure the Board	3:40pm	Verbal	Information	J Schorah
10.2	Reflections on the meeting	3:50pm	Verbal	Information	J Schorah
11. ITEMS FOR INFORMATION (not for discussion unless raised in advance)					
11.1	Contract Performance		✓		
11.2	Capacity & Demand Output Log		✓		
11.3	EPRR Chair's Report		✓		
11.4	Date, time, and venue of next meeting: *23 June 2026, 1pm, Microsoft Teams*	4.00pm	Verbal	Information	J Schorah

Finance and Performance Committee

23 June 2026 1.00pm | Microsoft Teams

Agenda

(* denotes supplementary documents in ancillary pack)

№	Item	Time	Encl.	Purpose	Lead
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 26 May 2026	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	M2 Finance Position and General Finance Update inc. RPOM *	1.20pm	✓	Assurance	C Carter
7.2	Financial Recovery – Workforce Reduction *	1.30pm	✓	Assurance	N Pease
7.3	DDG Update Report - Medicine	1.40pm	✓	Assurance	Jo Taylor
7.4	WRP and PMO Update	1.50pm	✓	Assurance	R Morgan-Evans
8. OPERATIONAL PERFORMANCE					
8.1	Performance Assurance Progress Report *	2.00pm	✓	Assurance	K Foster-Greenwood
8.2	Model Service Programme & GIRFT Update	2.10pm	✓	Assurance	R Morgan-Evans
8.3	Workforce Productivity & Performance *	2.20pm	✓	Assurance	K Downey
9. STRATEGY & PLANNING					
9.1	SIP Update *	2.30pm	✓	Assurance	A Brotherton
9.2	LHS Ltd Update	2.40pm	✓	Assurance	G Price

№	Item	Time	Encl.	Purpose	Lead
10.	RISK, GOVERNANCE AND COMPLIANCE				
10.1	Items to Alert, Advise or Assure the Board	2.50pm	Verbal	Information	J Schorah
10.2	Reflections on the meeting	2.55pm	Verbal	Information	J Schorah
11.	ITEMS FOR INFORMATION * (not for discussion unless raised in advance)				
11.1	Contract Performance *		✓		
11.2	Cyber Security Update *		✓		
11.3	Chair's Reports: a) SIRO * b) Information Governance *		✓		
11.4	Date, time, and venue of next meeting: *28 July 2026, 1pm, Microsoft Teams*	3.00pm	Verbal	Information	J Schorah

13. RISK, GOVERNANCE AND COMPLIANCE

13.1 AUDIT COMMITTEE CHAIR'S REPORT

Other | T Wheeler | 12.20 pm

Item for assurance

REFERENCES

Only PDFs are attached

13.1 - Audit Chair's Report 18 Jun 2026.pdf

Chair's Report to Board		
Chair: Tim Wheeler	Committee: Audit	
Date(s): 18 June 2026	Agenda attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	Trend
N/A	

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

- **IG Annual Assurance Report (Compliance with DSPT)** The Trust's 'standards not met' position in the 25/26 DSPT submission, given the requirement for continued oversight of the associated improvement plan and system-wide digital dependencies.

ADVISE
Areas requiring on-going monitoring; Limited assurance received.

- **None**

ASSURE
Assurance received; Matters of positive note.

- **Internal Audit Opinion:** Substantial Assurance received from the Head of Internal Audit Opinion, confirming that the Trust's systems of internal control were well designed and operating effectively.
- **External Audit and Financial Statements:** The external audit was substantially complete, with no material misstatements identified and an unmodified audit opinion anticipated, supporting the integrity of the Annual Report and Accounts.
- **Counter-Fraud Arrangements:** Counter-fraud activity remained effective, with progress maintained; no concerns identified in investigation activity; and appropriate action taken to strengthen arrangements.
- **Governance and Compliance:** The Trust remained compliant with the Code of Governance, with no areas of non-compliance identified and appropriate oversight in place across governance arrangements.
- **Risk Management Framework:** The updated Risk Management Policy strengthened the Trust's risk management framework and supported effective identification and management of risk.

- **Annual Report and Accounts:** The annual report and accounts for the year 25/26 had been reviewed and recommended for final approval. They would be signed off electronically and submitted to NHS England.

The Board of Directors is asked to:

1. Note the matters that the Committee wishes to Alert, Advise and Assure the Board.
2. Receive assurance and approve the following reports

Report	Meeting Date	Committee recommendation for Board
a) Risk Management Policy Annual Update	18 June 2026	Approve

Audit Committee

18 June 2026 | 9.30am | Microsoft Teams

Agenda

***Full Report in ancillary pack**

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	9.30am	Verbal	Information	Chair
2.	Apologies for absence	9.31am	Verbal	Information	Chair
3.	Declaration of interests	9.32am	Verbal	Information	Chair
4.	Minutes of the previous meeting held on 16 April 2026	9.33am	✓	Decision	Chair
5.	Matters arising inc. Written Resolution 01.26 Action Log	9.35am	✓ ✓	Decision	Chair
6. INTERNAL AUDIT					
6.1*	Internal audit progress report (inc. update on progress against audits receiving limited assurance)	9.40am	✓	Assurance	MIAA
6.2*	Counter Fraud Progress Update (including previous investigations)	9.50am	✓	Assurance	MIAA
7. ANNUAL REPORT AND ACCOUNTS 2025-26					
7.1*	Head of Internal Audit Opinion 2025-26	10.00am	✓	Assurance	MIAA
7.2	(a) Draft ISA (UK&I) 260 (b) External Auditor's Annual report 2025-26 *(to be published alongside the Annual Report on the Trust's website*	10.10am	✓	Assurance	KPMG
7.3*	Draft Financial Accounts 2025-26 including: (a) List of movements from circulated annual accounts (b) Recommendation of final draft accounts to Board	10.20am	✓	Assurance	Assistant Director of Financial Services
7.4	Management representation letter: financial accounts 2025-26	10.30am	✓	Decision	KPMG
7.5*	Review of draft Annual Report, including the draft Annual Governance Statement (see pages 89 to 107 in A/R) and Recommendation of Approval thereof to the Board	10.35am	✓	Decision	Director of Corporate Affairs
8. GOVERNANCE & COMPLIANCE					

№	Item	Time	Encl.	Purpose	Presenter
8.1*	IG Annual Assurance Report (Compliance with DSPT)	10.45am	✓	Assurance	Director of Corporate Affairs
8.2*	Report on NHS FT Code of Governance compliance	10.55am	✓	Assurance	Director of Corporate Affairs
8.3*	Risk Management Policy 2026-27	11.05am	✓	Decision	Associate Director of Risk, Assurance & Corporate Affairs
8.4	Items to alert, assure and advise to Board or refer to other committees	11.15am	Verbal	Discussion	Chair
8.5	Reflections on the Meeting	11.20am	Verbal	Discussion	Chair
9. ITEMS FOR INFORMATION*					
9.1	Strategic Risk Report		✓		
9.2	Technical Update		✓		
9.3	Internal Audit Plan 2026-27 (final)		✓		
9.4	CIPFA EQA Results		✓		
9.5	Date, time and venue of next meeting: *17 September 2026, 10.30am, Microsoft Teams*	11.30am	Verbal	Information	Chair

13.2 CHARITABLE FUNDS COMMITTEE CHAIR'S REPORT

Other | T Ballard | 12.30 pm

Item for assurance

REFERENCES

Only PDFs are attached

13.2 CFC Chairs Report 16 June 2026 - 06.08.26.pdf

Chair's Report to Board		
Chair: Tim Ballard	**Committee: Charitable Funds Committee**	
Date(s):16 June 2026	**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.

- None

ASSURE

Assurance received; Matters of positive note.

- The Committee were assured by the investment report which confirmed strong portfolio performance, outperformance against benchmarks, and alignment with risk and ESG requirements.
- The Hospital's Charity and Rosemere Charity reports showed positive financial results, exceeding income targets, under budget on expenditure, and successful fundraising events.
- In terms of major fundraising events and activity, the Rosemere Charity saw particularly strong participation-driven events, including Walk in the Dark attracting over 600 participants and raising more than £60k, a sold-out Cross Bay Walk with over 300 places, and marathon activity generating around £20k from a small cohort of runners.
- Funding supported a wide range of targeted enhancements to patient care and experience, including improvements to cancer patient environments such as waiting areas, specialist seating, hydrotherapy equipment and ward facilities, as well as smaller-scale but high-impact items like patient comfort resources and translation tools.

Charitable Funds Committee

16 June 2026 | 1.00pm | Microsoft Teams

Agenda

*** Full report in ancillary pack**

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	1.00pm	Verbal	Information	Chair
2.	Apologies for absence	1.01pm	Verbal	Information	Chair
3.	Declaration of interests	1.02pm	Verbal	Information	Chair
4.	Minutes of the previous meeting held on 17 March 2026	1.03pm	✓	Decision	Chair
5.	Action log & Matters Arising	1.05pm	✓	Decision	Chair
6.	STRATEGY AND PLANNING				
6.1*	Hospitals' Charity update including Baby Beat	1.10pm	✓	Decision	D Hill
6.2*	Rosemere Charity update	1.25pm	✓	Information	D Hill
6.3*	Investment strategy and investment review including ESG annual performance report	1.40pm	✓	Assurance	M Trestini / B Patel
7.	FINANCE AND PERFORMANCE				
7.1*	Finance update including review of spending plan and balances	2.00pm	✓	Assurance	B Patel
8.	GOVERNANCE AND COMPLIANCE				
8.1	Items to alert/advise/assure the Board	2.20pm	Verbal	Information	Chair
8.2	Reflections on the meeting	2.25pm	Verbal	Information	Chair
9.	ITEMS FOR INFORMATION *ancillary pack				
9.1*	Rosemere Management Committee Chair's Report		✓		
9.2	Date, time and venue of next meeting: *15 September 2026, 1.00pm, MS Teams*	2.30pm	Verbal	Information	Chair

14. * ITEMS FOR INFORMATION

All items in ancillary pack

14.1 * QUALITY ACCOUNT

Decision Item

Item for Decision and Information

14.2 * NORTH WEST RACE EQUITY ASSEMBLY ANNUAL REPORT 2025/26

14.3 DATE, TIME AND VENUE OF NEXT MEETING

Information Item | M Thomas | 12.40 pm

1 October 2026 at 9:15 am at Lecture Room 1, EC1, Royal Preston Hospital

CLOSE