Single Improvement Plan

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Lancashire Teaching Hospitals NHS Foundation Trust

ANNUAL REPORT AND ACCOUNTS 2025–26

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Lancashire Teaching Hospitals NHS Foundation Trust

Annual Report and Accounts 2025–26

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

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www.lancsteachinghospitals.nhs.uk

CHAIR'S AND CHIEF EXECUTIVE'S WELCOME

Dear Stakeholder,

We are pleased to present the Annual Report and Accounts for Lancashire Teaching Hospitals NHS Foundation Trust for 2025–26.

We begin by expressing our sincere thanks to all our colleagues. Over the past year, they have once again demonstrated exceptional commitment, resilience and professionalism in the face of ongoing challenges. We have continued to operate within an increasingly complex and demanding environment, shaped by sustained operational pressures, rising demand for services, workforce challenges, industrial action and financial constraints across the NHS. Despite these pressures, our teams have remained focused on delivering high-quality compassionate care and improving outcomes for the communities we serve.

We are proud of the meaningful progress made against our strategic priorities this year. Through collaboration, innovation and a shared sense of purpose, we have continued to advance our vision of working together to improve both the health and wealth of our population.

At the heart of our work is our commitment to improving outcomes, experience and access for patients. During 2025–26, we have delivered tangible improvements across a number of key performance areas. Notably, we successfully eradicated the backlog of patients waiting more than 65 weeks for treatment and continued to reduce the number waiting over 52 weeks – marking significant progress in our elective care recovery.

We have also strengthened delivery across cancer pathways, achieving improved performance against key standards, while further enhancing access to diagnostic services. These achievements reflect the sustained efforts of our teams to redesign pathways, increase productivity and deliver care more efficiently, ensuring patients receive timely, high-quality care.

We recognise that challenges remain. Demand across urgent and emergency care continues to place pressure on flow and performance, while diagnostic capacity remains constrained. Tackling these pressures, further reducing waiting times and ensuring timely access to care will remain key priorities for the year ahead.

Alongside our focus on operational delivery, we have continued to invest in innovation, service transformation and infrastructure. This year has seen significant developments that strengthen our role as a regional centre for specialist care. These include the introduction of a 24/7 mechanical thrombectomy service, providing life-saving stroke treatment to patients across Lancashire and South Cumbria, and the installation of a new state-of-the-art linear accelerator at the Rosemere Cancer Centre, enhancing our cancer treatment capability.

We have also continued to expand our use of robotic-assisted surgery, reaching the milestone of 1,000 robotic prostatectomies and introducing new colorectal surgery techniques. This has been complemented by sustained investment in our infrastructure, including a refurbished helipad and completion of the final land acquisition on the proposed site for the replacement of Royal Preston Hospital. Together, these developments demonstrate how we are harnessing innovation, research and advanced technologies to improve clinical outcomes and patient experience, while reinforcing our role as a leading provider of specialist services across our integrated care system.

Our people are at the heart of everything we achieve. We are committed to creating an environment in which colleagues feel valued, supported and empowered to deliver the highest standards of care.

Over the past year, we have continued to invest in education and training, expanding opportunities for professional development and strengthening leadership across the organisation. We have also maintained a strong focus on equality, diversity and inclusion, alongside supporting the health and wellbeing of our staff, recognising the pressures many continue to face.

We remain committed to embedding a positive, inclusive and compassionate culture across our organisation – one in which our values are evident in how we work with one another, and in the care we provide to patients and communities.

Improving quality and safety continues to be central to our work. During 2025–26, we have made further progress in embedding our continuous improvement approach through the adoption of the Lancashire Improvement Method, supporting teams to improve patient pathways, reduce variation and deliver better outcomes. We have also launched our Always Safety First strategy, reinforcing our commitment to patient safety, learning and continuous improvement, supported by strengthened governance, improved data and increased engagement with patients and staff.

Collaboration with partners remains essential to delivering sustainable healthcare. We continue to work closely with our partners across the Lancashire and South Cumbria Integrated Care System to improve population health, reduce inequalities and deliver more integrated and coordinated care. Our relationships with other NHS organisations, local authorities, universities and the voluntary, community, faith and social enterprise sector are critical in helping us redesign services and ensure patients receive care in the most appropriate setting.

As 2025–26 drew to a close, we were ready to launch the Lancashire and South Cumbria Pathology Service, helping to strengthen and modernise diagnostic services for local patients. From 1 April 2026 pathology services across the system came together as one service, led by LTH. This change brought together staff and expertise from Blackpool Teaching Hospitals NHS Foundation Trust, East Lancashire Hospitals NHS Trust, University Hospitals of Morecambe Bay NHS Foundation Trust, and LTH into a single coordinated network.

As an anchor institution, we are committed to supporting the wider health and wellbeing of our communities, contributing to social and economic development and addressing the broader determinants of health.

Like many NHS organisations, we continue to face significant financial challenges. During 2025–26, we made progress in improving our financial position, reducing our underlying deficit and delivering substantial savings, although further work is required to achieve long-term sustainability. Our focus remains on improving productivity, reducing waste and ensuring that we make the best possible use of the resources available to us, underpinned by strong governance, transparency and accountability. Our Green Plan ensures that we also continue to proactively consider sustainability in its wider sense.

Looking ahead, we are clear about our priorities. We will continue to focus on improving access to care, reducing waiting times, strengthening urgent and emergency care services, delivering our financial recovery plans, addressing health inequalities and investing in our workforce, infrastructure and digital transformation.

We continue to prepare for the opportunities presented by the New Hospital Programme. In March 2026, we were pleased to complete the purchase of the final section of land on the proposed site for the replacement of Royal Preston Hospital, marking a significant milestone and enabling future public consultation on the preferred site. No final decisions have yet been made and will be subject to full public consultation at a later date, alongside the necessary national and local approvals. We remain open to alternative site suggestions, which would be considered through the same comprehensive review process. Current national timelines indicate that construction of a replacement Royal Preston Hospital is expected to begin between 2037 and 2039.

Our five year strategy, outlining our longer term aspirations and our three year Single Improvement Plan (SIP) detailing the five key areas of focused work that will help us achieve this under the categories of Patients; Performance; People; Productivity and Partners are available on the Our strategies section of our website.

Finally, and perhaps most importantly, we would like to extend our heartfelt thanks to everyone who has supported the Trust over the past year. This includes Dr Gerry Skailes, who retired from her Board position as Chief Medical Officer in November 2025 after a long and distinguished NHS career. We also want to reiterate the hard work of all our colleagues, who continually go the extra mile; our patients and carers, for their trust and feedback; and our partners and governors, for their continued support and collaboration. We'd like to give a special thank you to all those who have supported and fundraised for our charities, allowing extra funding to be spent on things that enhance patient experience. Together, we will continue to build on our progress and deliver high-quality, sustainable care and specialist care for all the communities we serve, within Lancashire and Cumbria and beyond.

Finally, a huge thank you must go out to our local communities, who have once again shown remarkable support for our hospitals and our charities. Listening to patients, families and carers both when things do not go well, as well as when they do, helps us shape our services of the future. We are extremely appreciative of all those who have taken the time to give us their feedback – please continue to do so, it really does help to shape the way that we work on your behalf.

Professor Mike Thomas
Chief Executive
25 June 2026

Professor Silas Nicholls
Chief Executive
25 June 2026

Lancashire Teaching Hospitals NHS Foundation Trust

PERFORMANCE REPORT 2025–26

OVERVIEW OF PERFORMANCE

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

This report is prepared in accordance with sections 414A, 414C and 414D of the Companies Act 2006 (as inserted/amended by the Companies Act 2006 except for sections 414A(5) and (6) and 414D(2) which are not relevant. For the purposes of this report, we have treated ourselves as a quoted company. Additional information on our forward plans is available in our operational plan on our website. Information on any mandatory disclosures included within this report is provided on pages 83–86.

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

Who we are

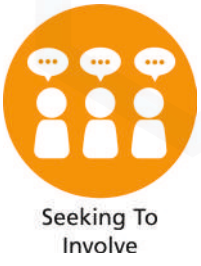
Lancashire Teaching Hospitals NHS Foundation Trust was established on 1 April 2005 as a public benefit corporation authorised under the Health and Social Care (Community Health and Standards) Act 2003. We are registered with the Care Quality Commission (CQC) without conditions to provide the following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

- Diagnostic and screening services
- Maternity and midwifery services
- Surgical procedures
- Termination of pregnancies
- Treatment of disease, disorder or injury
- Management of supply of blood and blood-derived products
- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Vaccination hub satellite service
- Accommodation for persons who require nursing or personal care

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

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

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



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

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

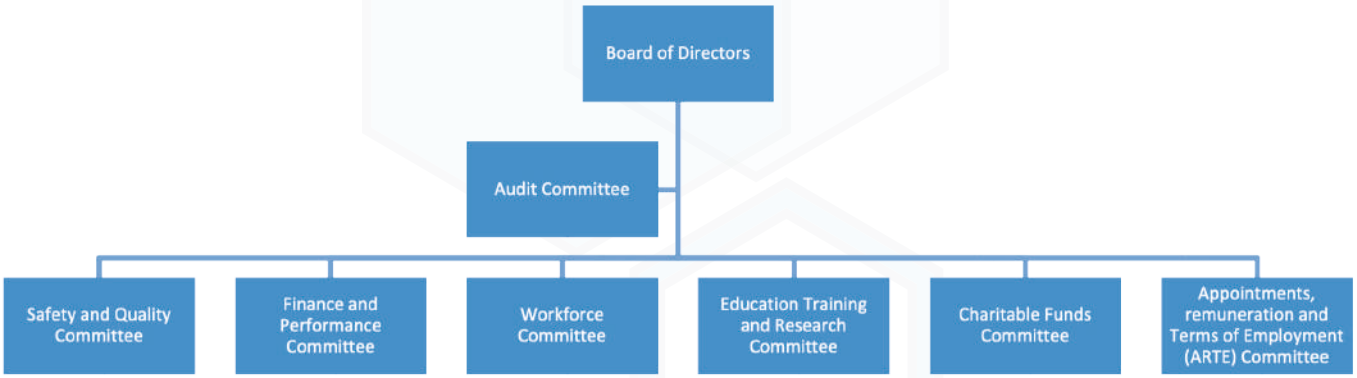
- Adult Allergy and Clinical Immunology
- Cancer (including radiotherapy, drug therapies and cancer surgery)
- Disablement services such as artificial limbs and wheelchairs
- Major Trauma
- Neurosciences including neurosurgery and neurology (brain surgery and nervous system diseases)
- Renal (kidney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

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

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

How we are run

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



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

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

Strategic Aims and Ambitions

Our aim is to become a leading accountable healthcare organisation within the Lancashire and South Cumbria system. In doing so, we will develop an affordable and sustainable model of healthcare for our organisation and the local population.

The strategic priorities as part of this focus on:

- Our role as the provider of specialist services for the population of Lancashire and South Cumbria and a provider of local services for the population of Central Lancashire.
- Our role as a centre for Continuous Improvement, Education and Research and Innovation
- Our role as an Anchor Institution – where social value and sustainability is aligned to the health and wealth of our population

The strategy provides a blueprint for the roles we aim to play as an organisation within our system and outlines our vision for our sites and the redesign of our clinical services in line with the national Fit for the Future 10 Year Health Plan for England . It has been developed through engagement and listening sessions with our people, our patients and local population and our partners who have all shared their vision and ambitions for the future with us.

We extend our sincere thanks to them.

Our Trust strategy sets out the context for our organisation, and outlines how we will develop services fit for the future by focusing on our five Ps:

Patients

We will improve access, patient experience, safety, quality of care and outcomes by leveraging advanced technologies and developments in science.

Performance

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

People

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

Partnerships

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

Productivity

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

Our principal issues and risks

The Trust continues to identify potential risks to achieving its strategic objectives as part of established organisational governance processes. The Board Assurance Framework (BAF) is the principal mechanism used to identify and monitor the most significant risks facing the Trust, together with the actions in place to mitigate them.

The BAF is underpinned by the Principal Risk Register, which captures those risks that may threaten the achievement of the Trust's strategic and corporate objectives. It also incorporates high-scoring risks from the Operational Risk Register that are escalated through Committees of the Board. These risks originate from divisional and corporate risk registers and may impact the day-to-day operation of the organisation. This approach enables the Board of Directors to assess whether there are appropriate and effective controls in place to support delivery of the Trust's strategic objectives.

In 2025–26, there were 16 Principal Risks overseen by the Board of Directors and its Committees. Of these, five risks were moved to 'controlled' status and one was stepped down for ongoing management through operational governance arrangements.

During 2025–26, Committees of the Board continued to oversee all operational risks scoring 15 or above relevant to the Strategic Objectives aligned to the Committee. There were no operational high risks of concern escalated to the Board of Directors in the BAF during 2025–26.

In March 2026, the Board of Directors held a Board Workshop to review the Corporate Objectives and to identify potential Principal Risks for 2026–27. The outcomes from the Board Workshop were reported to the Board of Directors meeting in April 2026 for approval.

A detailed update on the Trust's principal risks and issues is included as part of the Annual Governance Statement.

Our performance

Operational performance

The Operational Performance programme focused on improving productivity and improving service delivery leading to improved outcomes for our patients. Key achievements include:

Long waiters

The year concluded with 894 patients on the planned care waiting list having waited 52 weeks or more. This constituted 1.4% of the total waiting list and performance was better than the agreed NHS England target of 2.5% by the end of March 2026.

Referral to treatment

In March 2026, the Trust's RTT 18-week performance was recorded at 59.4%, representing an improvement of 4.6 percentage points compared with the start of the year in April 2025.

Cancer waiting times

In March 2026, 62-day cancer performance exceeded the 75% target, with performance delivered at 76.6%. This represented an improvement of over 23% compared with the start of the financial year in April 2025, meaning that the Trust achieved the fifth largest improvement nationally. Performance against the Faster Diagnosis Standard (28 days) also improved by 5.7% compared with the start of the year, with 83.5% achieved in March 2026 against a target of 80%.

Diagnostic 6 week standard

Despite good improvement across a number of diagnostic modalities, performance remained challenged throughout the year, finishing just short of the 65% target in March 2026 at 60.45%. However, significant reductions were achieved in the number of longest waiting patients (-87%).

UEC 4 & 12 hour standard

Performance has remained strained within the UEC pathway however year end performance has exceeded that of March 25 (69.1%) with performance achieved being recorded at 71.8% in March 26. 12 hour performance has marginally reduced by year end with performance at 12.7% versus 13.3% in March 25.

Performance analysis

Core Standards	2024–25	2025–26	Current Period	Comparison
A&E - 4 hour standard	69.8	70.1	% - Cumulative to end Mar 2026	Improved
Cancer - 2 week rule (all referrals)	87.1	86.7	% - Cumulative to end Mar 2026	Deteriorated
Cancer - 2 week rule - referrals with breast symptoms	76.3	82.0	% - Cumulative to end Mar 2026	Improved
Cancer - 31 day target	89.4	91.8	% - Cumulative to end Mar 2026	Improved
Cancer - 31 day target - subsequent treatment – surgery	66.3	68.4	% - Cumulative to end Mar 2026	Improved
Cancer - 31 day target - subsequent treatment – drug	98.3	98.7	% - Cumulative to end Mar 2026	Improved
Cancer - 31 day target - subsequent treatment -radiotherapy	93.7	93.2	% - Cumulative to end Mar 2026	Deteriorated
Cancer - 62 day target	62.7	63.3	% - Cumulative to end Mar 2026	Improved
Cancer - 62 day target - referrals from nss (summary)	36.0	25.0	% - Cumulative to end Mar 2026	Deteriorated
28 Day faster diagnosis standard – compliance	77.8	78.6	% - Cumulative to end Mar 2026	Improved
MRSA	0	0	% - Cumulative to end Mar 2026	Maintained
C.Difficile infections	192	122	% - Cumulative to end Feb 2026	Improved
18 Weeks - referral to treatment - % of incomplete pathways < 18 weeks	56.4	54.8	% - Cumulative to end Mar 2026	Deteriorated
18 Weeks - referral to treatment -number of incomplete pathways > 104 weeks	0.0	0.0	End Mar 2026 census position	Maintained
18 Weeks - referral to treatment -number of incomplete pathways > 78 weeks	0.0	0.0	End Mar 2026 census position	Maintained
18 Weeks - referral to treatment -number of incomplete pathways > 65 weeks	19.0	0.0	End Mar 2026 census position	Improved
18 Weeks - referral to treatment -number of incomplete pathways > 52 weeks	1372.0	896.0	End Mar 2026 census position	Improved
% of patients waiting over 6 weeks for a diagnostic test	49.9	39.7	% - Cumulative to end Mar 2026	Improved

Emergency Preparedness, Resilience and Response

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

Health inequalities

Lancashire Teaching Hospitals published a "Health Improvement plan: A plan to reduce health inequalities 2024 – 2026" in December 2024. The plan was developed through an extensive consultation exercise to ensure appropriate engagement with key internal and external stakeholders across organisations. The plan reflects the shared ambition of our partners and aligns to the local priorities of both the Integrated Care Partnership, Integrated Care Board and Lancashire County Council as well as the more recently published NHS 10-year plan.

Understanding population health needs

The local Plus 5 groups for Lancashire and South Cumbria for adults are:

- **Maternity** - continuity of care for women from Black, Asian and minority ethnic communities and the most deprived groups
- **Severe mental illness** – annual physical health checks
- **Chronic respiratory disease** – increasing vaccination rates
- **Early cancer diagnosis** – aim for 75% of cases diagnosed at stage 1 or 2 by 2028
- **Hypertension case finding** – optimal management including lipid management

The local Plus 5 groups for Lancashire and South Cumbria for Children and Young People (CYP) are:

- **Asthma** – reduce reliance of reliever medication
- **Diabetes** – increase real time continuous monitoring and increase use of insulin pumps
- **Epilepsy** – increase assess in the first year of diagnosis for those with a learning disability or autism
- **Oral health** – address the backlog of tooth extractions in under 10yrs
- **Mental health** – improve access rates for CYP

Analysis of the Annual Health Inequalities Dataset (2024–25) shows:

Elective children's care:
- Small increase in children from the most deprived areas accessing elective inpatient care compared to the previous 12 months. Alongside this there has been a 4% reduction in the number of children not being brought for outpatient appointments indicating the continued work on supporting children to access care

Elective adult care:
- Stable access across deprivation groups. However there has been a 52% increase in women from the most deprived areas receiving inpatient elective care over the last five years compared to pre-pandemic levels

Emergency children's care:
- There are proportionally higher levels of attendance among children from Asian/Asian British communities living in more deprived areas of Preston.

Gender variation:
- Higher proportion of boys than girls accessing emergency care across all groups.

Improving data quality, collection and analysis

The Single Improvement Plan outlines the commitment to provide useable data related to health inequalities with the capability of being interrogated at neighbourhood level by the areas within the NHSE measurement framework for health inequalities.

Understanding healthcare access, experience and outcomes

The Trust provides a High Intensity User (HIU) programme that focuses on providing person centred trauma informed care for the people most frequently attending the Emergency Department (ED). Over the last 12 months the HIU programme has seen all people using the service reduce attendance at ED by 20%. With some patients having had a 100% reduction.

Elective waiting list tracking continues to focus on population groups. A specific cohort being prisoners; aiming to reduce waits for prisoners who have a longer length of wait than other patient cohorts. Data analysis in 2025 shows continued reduction in waiting times for prisoners over the last 6 months with the longest wait now at 65 weeks.

Using information to take action on health inequalities

The Tobacco and Alcohol Care Team (TACT) have seen 4-week quit rate increase (patients agreeing to continue with stop smoking support) increase by average 75 patients per month with nicotine replacement prescription increasing and a decrease of 30-day readmission. Data analysis shows that for the last 12 months over 97% of patients meeting the criteria on alcohol assessment were referred for advice or intervention by TACT.

The Trust Child Excessive Weight service saw 86 patients with 48 booked into Q2. Excellent patient feedback continues to be received regarding this service and its positive impact on families.

Getting it Right First Time (GiRFT) improvement work is underway for children with diabetes. This has resulted in 219 out of 221 children using Continuous Glucose Monitoring (99% of clinical caseload).

The Trust has been focusing on reducing post-partum haemorrhage (PPH) for women from minority ethnic groups. This effort has resulted in a nationally recognised improvement, with a 3% reduction in PPH and improved patient experience.

Publishing information on health inequalities

The Safety and Quality Committee receives a bi-annual report on progress against the Trust Health Improvement Plan. The Board of Directors receives and annual report on progress of the delivery of the Health Improvement Plan.

The priority actions for the 2026–27 are:

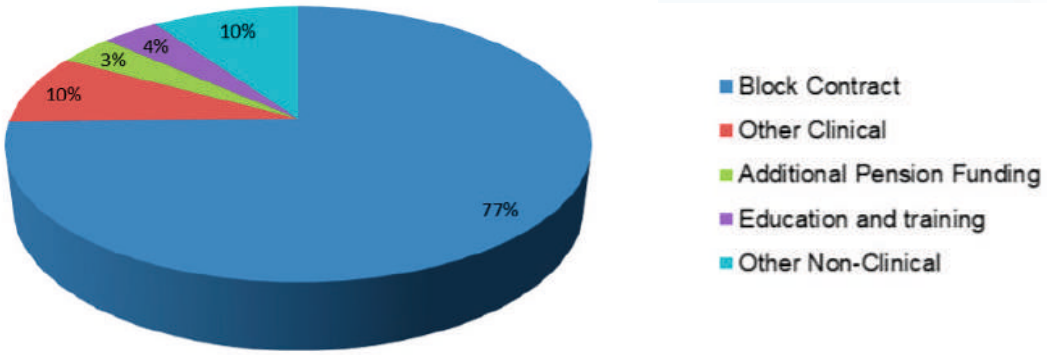
1. Strengthening trauma informed person-centred care through expanding the HIU approach
2. Provision of all patient information in inclusive multiple language and "easy read" formats while increasing the access to immediate real time translation through digital technology
3. Improved access to outpatient, elective and cancer care for the most deprived communities through data dashboards at neighbourhood level that allow speciality teams to focus actions with those communities
4. Continuing to use digital technology to increase access with a continued focus on reducing digital exclusion
5. Improved digital integration and "Shared Care Record" utilisation to ensure that information already recorded about people in one system can be used to inform care
6. Deepening community participation and co production by strengthening the approach to business case and service development with a requirement to include population health data analysis and the how inequalities will be addressed
7. Continuing to embed the use of the Reasonable Adjustment Needs Digital flag Sept 2026

Our finances

Income generation

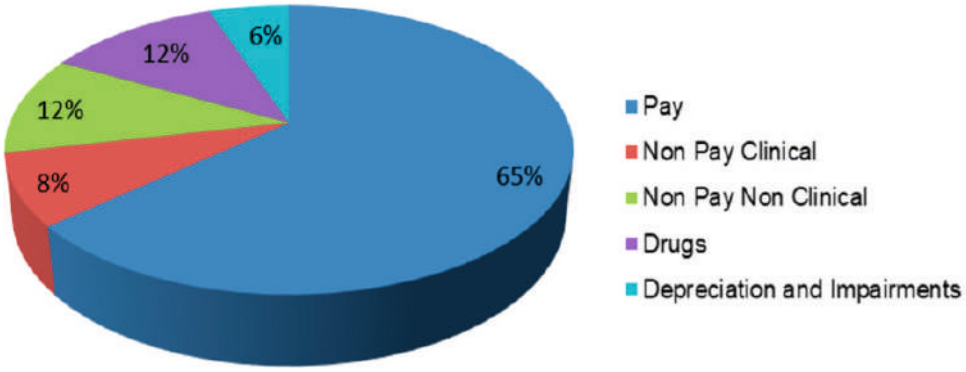
During 2025–26 the Trust generated income from patient care, including through a block contract of £816m (2024–25: £780m), an increase of 5% from 2024–25. This included £30.0m of deficit support funding (2024–25 £21.9m). The Trust achieved £37.5m of its £60.0m savings target and mitigated some of the shortfall through one off technical benefits and additional income

A further £127m (2024–25: £87m) was generated from other income sources which includes training levies, research funding, car parking, catering and retail outlets and from providing services to other organisations. The significant increase in income is primarily the full year effect of the additional contracts awarded to the subsidiary by the other Trusts within our system.



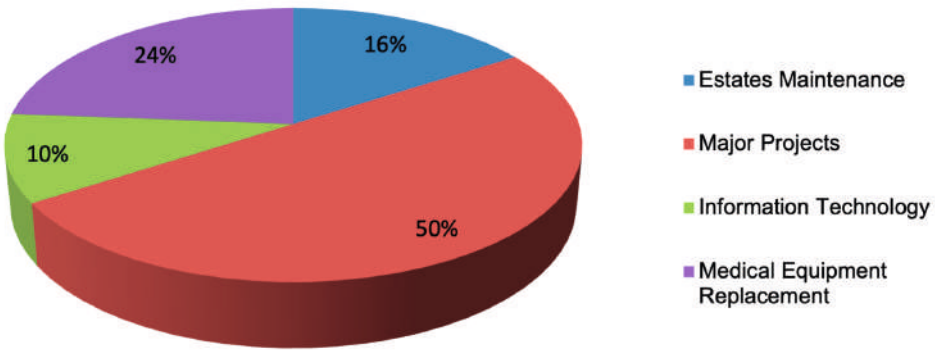
Expenditure

Operating expenditure for the year was £970m (2024–25: £916m), the graph below shows the main categories of expenditure at the Trust. The main reason for the rise in costs can be attributed to pay awards, inflationary cost increases, and restoration of elective and outpatient activity. The Trust delivered £37.5m savings against a financial recovery target of £60m.



Capital investment

In 2025–26 £59m excluding leases (2024–25: £59m) was invested in the Trust's capital programme to maintain and improve the asset base of the Trust as illustrated in the chart below. Major projects in year included the purchase of land (£19m) for the New Hospital Project, and £4m on ward and theatre refurbishments as part of a cyclical programme. £14m was spent on new and replacement medical equipment, £9m was spent addressing estates backlog maintenance issues, and £6m was spent on IT renewals.



Better Payment Practice Code (BPPC)

We aim to treat all suppliers ethically and to comply with the BPPC target, which states that we should aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. For 2025–26 we paid 77% (2024–25 81%) of invoices to this timescale.

	NHS		Non-NHS		Total	
	No.	**Value £'000**	**No.**	**Value £'000**	**No.**	**Value £'000**
Invoices paid within 30 days	2,214	141,755	87,802	377,207	90,016	518,962
Invoices not paid within 30 days	582	30,287	25,754	53,484	26,336	83,771
Total Invoices	**2,796**	**172,042**	**113,556**	**430,691**	**116,352**	**602,733**
BPPC %	79	82	77	88	77	86
Total amount of any liability to pay interest						***2***

Reconciliation of underlying trading position for year ending 31 March 2026

The Trust delivered an accounting deficit for the year of £36.5m (2024–25: £57.7m). After adjustment for accounting movements relating to impairment charges and income and expenditure for donated assets, the Trust delivered a revised trading deficit of £13.7m (2024–25: £36.2m). .

		Group	
		2025–26	**2024–25**
		£000	**£000**
Deficit for the year		(36,460)	(57,712)
Add back I&E impairments		24,436	21,491
Remove net donated income		(1,631)	(24)
Revised trading surplus / (deficit)		**(13,655)**	**(36,245)**

Forward look

The operational and financial planning process for 2026–27 has been developed in line with the expectations set out in the national planning guidance. The key focus of the guidance is to:

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

The key requirements of the national guidance include the following:

- Improve RTT performance to 70% ≤18 weeks by March 2027, with further recovery to 81% by March 2028 and 92% by March 2029
- Reduce the total RTT waiting list from ~53k (Mar-27) to ~44k (Mar-28) and ~32.5k (Mar-29)
- Deliver and sustain 80% compliance with the 28-day Faster Diagnosis Standard across the plan period
- Improve 62-day cancer treatment performance to ~80% by March 2027, 82.5% by March 2028, and 85% by March 2029
- Achieve 94% compliance with the 31-day cancer treatment standard by March 2027, rising to 96% by March 2028 and sustained thereafter
- Improve DM01 performance (those patients waiting less than 6 weeks for diagnostic test or procedure) to 80% by March 2027, increasing to 90% in 2027–28 and 99% by the end of 2028–29
- Improve A&E 4-hour performance to 82% by March 2027, rising to ~83–85% in 2027–28 and ~85%+ in 2028–29
- Reduce 12-hour A&E breaches year-on-year, from ~21.6k (2026–27) to ~19.1k (2027–28) and ~18.6k (2028–29)
- Reduce ambulance handover delays, including average handover time and the proportion exceeding 15 and 45 minutes
- Deliver a £9.2m deficit in 2026–27 in line with control totals and DSF conditions, and return to break-even from 2027–28 onwards
- Fully develop and deliver £60m of CIP in 2026–27, addressing under-development and pace of delivery
- Deliver sustained productivity improvements (~2% per annum), including reduced reliance on temporary staffing
- Urgently sign all outstanding commissioner contracts to mitigate material financial risk
- Maintain strong Board ownership and oversight of plan delivery, with grip on risks and trajectory slippage
- Demonstrate how plans actively reduce health inequalities in access, experience and outcomes
- Align service delivery with the three NHS strategic shifts (prevention, community, digital)
- Deliver Green Plan and sustainability commitments, embedding them in governance and decision-making

The Trust's financial plan for 2026–27 has been developed taking into account the national planning guidance, However the plan is not without significant risk. As part of agreeing the Lancashire and South Cumbria Integrated Care System (L&SC ICS) overall plan, deficit support funding of £9m has been agreed. However, given the underlying deficit and the year-on-year local efficiency requirement there is still a requirement to deliver a "Waste Reduction Programme" of £60m to break even.

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

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

Lancashire Hospital Services (LHS) Ltd

LHS Ltd is a wholly owned subsidiary company delivering outpatient pharmacy services for the trust. The transfer of the management and running of community pharmacies previously operated by Lloyds Pharmacies to LHS Ltd went live in February 2025. This involved the onboarding of six new pharmacy sites which are being operated on behalf of three hospital trusts: East Lancashire Hospital Trust, University Hospitals of Morecambe Bay NHS Foundation Trust and Blackpool Teaching Hospitals NHS Foundation Trust, (the Participating Trusts). The financial principles agreed to with all parties relating to this transaction provide LHS Ltd and the trust with a level of protection relating to any potential financial downsides with the option to review and amend dispensing charges to each of the parties should there be evidence that these are not covering all associated costs. The Board of Directors of the company has representation for all trusts involved in receiving the services provided by the company.

LHS has delivered in excess of expectation for 2025–26. The forecast was a small surplus of £166k and the actual results show a surplus of £360k, which the Board will consider as part of a re-investment in services for the future.

Going concern

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

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

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

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

The Trust remains in a deficit position and will need to work with its partners across the local healthcare system, provider collaborative board and the ICB to achieve efficiencies, and maximise the use of its assets to achieve a sustainable financial balance.

Being a good corporate citizen

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

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

Social, community and human rights

The Trust in late 2025, refreshed its Social Value strategy which sets out our aim to improve the lives of our communities and colleagues through our role as an anchor institution. To achieve our ambition, the strategy outlines how we will put social value at the forefront of decision making through:

To deliver progress a comprehensive action plan has been developed which describes the programmes of work we will take, some of the actions include:

- Understanding the socioeconomic background of our workforce, enabling us as an organisation to develop targeted actions which enable colleagues to reach their full potential.
- Provision of a range of widening participation programmes to support disadvantaged members of our community to access work and experience in a healthcare setting.
- Develop careers support to enable colleagues to navigate their next steps to progress their futures.
- Deliver targeted development programmes for colleagues with protected characteristics to ensure we have proportional representation across all levels and professions.
- Work in partnership with local schools and colleagues to encourage students into healthcare careers.
- Provide health and wellbeing support to colleagues with protected characteristics or experience social deprivation

The Modern Slavery Act 2015

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

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

Counter-fraud

We have a policy in respect of countering fraud and corruption which includes contact details of the national helpline and a local independent counter fraud officer. The Trust has an accredited anti-fraud specialist provided by Mersey Internal Audit Agency (MIAA) and they deliver the service in line with NHS Counter Fraud Authority's standards. During 2025 the Trust has ensured it is compliant with the requirements of the Economic Crime and Corporate Transparency Act 2023 and the new corporate offence of failure to prevent fraud.

Health and safety performance

Health and safety

The Trust is committed to safeguarding the health, safety and welfare of all employees, patients, visitors and others who may be affected by its activities. This commitment is guided by health and safety legislation, including the Health and Safety at Work etc. Act 1974 and supporting regulations, which provide the framework for managing workplace health and safety risks. The Trust's approach focuses on clear leadership and accountability, access to competent professional advice, effective governance arrangements and continual learning to support safe environments and practices.

Leadership, accountability and governance

Accountability for health and safety sits with the Chief Executive Officer and the Board of Directors, with executive oversight provided by the Deputy Chief Executive Officer/Chief Nursing Officer. A Health and Safety Governance Group meets monthly and provides structured oversight of key health and safety risks. Clear escalation routes are in place to support timely consideration of emerging risks at executive and Board level where required.

The Trust is supported by a Health and Safety Team, including two Health and Safety Managers who act as competent persons in line with regulatory expectations. Working collaboratively with responsible officers, subject matter experts and service teams, they provide professional advice and guidance to support risk assessment, safe systems of work and local management of health and safety risks.

Where appropriate, specialist expertise is accessed through collaborative system arrangements to support resilience and assurance in more complex or higher risk areas.

Estates and system working

In March 2026, Estates and Facilities services moved into One LSC, a shared operating model across Lancashire and South Cumbria hosted by East Lancashire Hospitals NHS Trust. Statutory responsibilities under the Health and Safety at Work Act 1974 remain with Lancashire Teaching Hospitals NHS Foundation Trust in relation to its undertaking and the control of its premises. Governance arrangements are in place to support effective collaboration, oversight of estates related health and safety risks, and access to appropriate specialist and technical expertise as the new model embeds.

Taskforce on Financial Climate Related Disclosures (TFCD)

The Trust reports against the Task Force on Climate-related Financial Disclosures (TCFD) framework, following HM Treasury's phased public-sector requirements and NHS England's sustainability reporting guidance. Disclosures are provided on a comply or explain basis in line with the Department of Health and Social Care Group Accounting Manual 2025–26. A refreshed three year Green Plan was published in July 2025, across ten areas of focus, reporting progress via the quarterly submissions to the Greener NHS reporting system and annual Estate Return Information Collection (ERIC) return.

Governance and accountability

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

To drive operational delivery of the Green Plan, a clear governance structure is in place which consists of assigned subject leads across the ten areas of focus. There is a green plan lead within the planning team, who co-ordinates implementation, reporting and escalation of the plan, with senior support from the dedicated board level senior responsible officer. The green plan lead attends quarterly meetings with the Lancashire and

South Cumbria Integrated Care Board to update on progress of the Trust plan, providing regional alignment and an opportunity to escalate concerns, along with obtaining updates from the regional lead to disseminate locally to the area leads. A monthly sustainability working group and quarterly leads meeting are chaired by the Green Plan Lead. These monitor actions, risks and mitigations to provide updates quarterly, bi-annually and annually to the Finance and Performance Committee through to the Trust Board of Directors.

Each of the leads are responsible for working towards the net zero goals set out in the Green Plan, aligning with national guidance.

The ten areas of focus are;

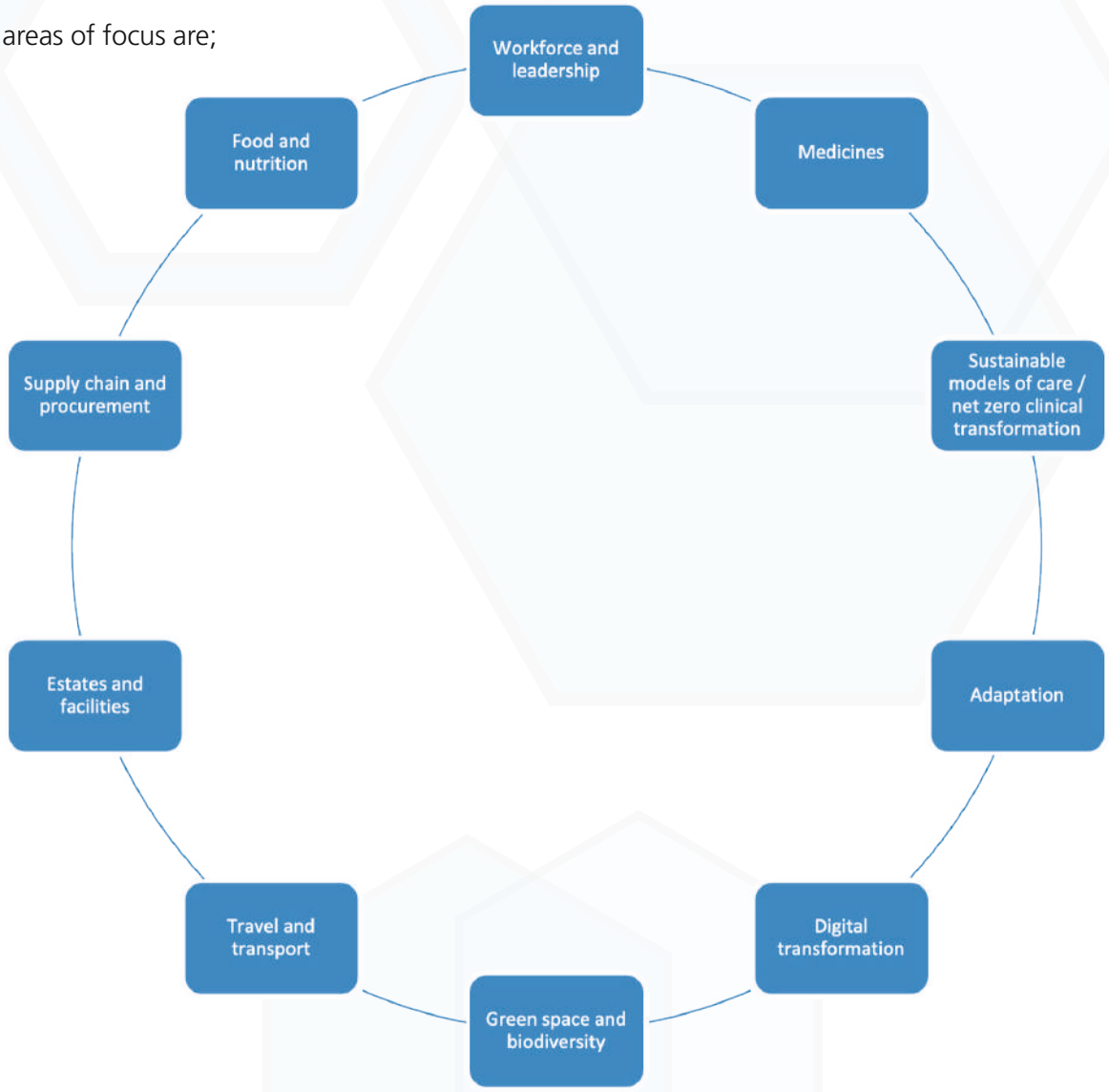


Figure 1: Overall percentage breakdown of progress on year 1 actions

Risk management

Lancashire Teaching Hospitals was announced as one of the NHS Trusts on the New Hospitals Programme in 2021. Since then, significant delays to the original timescales have been advised with further delays expected until at least 2037–2039.

The Trust acknowledges the requirement to complete the NHS Climate Change Risk Assessment tool (NHS CCRA) to assist with identification of risks specifically relating to the effects of climate change, to enable a longer-term Adaptation plan to be developed. The Trust identifies climate-related risks and opportunities across areas of the Green Plan domains, suggesting the following potential risks in the short, medium and long term.

Short term risks (1–3 years):

◊ Extreme heat and cold events impacting operating theatres, wards and digital infrastructure

◊ Travel and transport disruption affecting staff and patient flow

◊ Waste and water system pressures

◊ Increased emergency demand linked to climate related illness

Medium term risks (3–10 years):

◊ Increasing energy costs and constraints

◊ More frequent adverse weather affecting infrastructure resilience

◊ Regulatory tightening around carbon, procurement and estate decarbonisation

Long term risks (10+ years):

◊ Sustained pressure on estate condition and suitability

◊ Increasing chronic disease burden linked to climate impacts

◊ Need for systemic adaptation across care pathways

Opportunities include energy cost reduction, digital first care models, active travel uptake, transition to low carbon clinical practices, biodiversity improvements and strengthened partnership working with local health systems.

Managing climate related risks

As part of the NHSE Emergency Preparedness, Resilience and Response (EPRR) Core Standards compliance https://www.england.nhs.uk/ourwork/eprr/ the Trust has an Adverse Weather and Health Plan that is activated during periods of extreme weather. Beyond the Adverse Weather and Health Plan, there are local business continuity plans (BCPs) in place across divisions. These plans require services to identify mitigations to ensure critical activities are maintained during challenges such as staff shortages, surges in service demand, or loss of utilities/IT.

Integration with overall risk management

Climate risks are embedded within the Trust's organisational risk framework:

- Included within corporate risk registers
- Reflected in business case assessments and procurement requirements
- Incorporated into investment decisions, including estate decarbonisation and energy efficiency works

This approach ensures climate risk is considered alongside traditional operational, financial and clinical risks.

Metrics and targets

In line with NHS guidance, LTHTR does not report Scope 1–3 emissions under TCFD, as these are calculated nationally by Greener NHS.

The Trust reports annually on:

- Energy consumption and carbon emissions, provided via the Greener NHS Dashboard
- Overheating and flooding incidents, recorded through ERIC and internal systems
- Waste and water metrics from national datasets
- Progress against the Green Plan actions are tracked through the monthly working group

Targets are aligned to national programmes and the Green Plan. These include:

- Compliance with the Health and Care Act 2022 sustainability duties
- Achievement of national Net Zero targets (2040 direct emissions, 2045 indirect)
- Delivery of estate decarbonisation programmes (e.g. LED upgrades, heat decarbonisation projects)
- Clinical transformation targets to reduce high-impact gases (e.g. elimination of desflurane already achieved, work underway on nitrous oxide reduction)
- Biodiversity and green space enhancements
- Travel plan implementation and modal shift targets

Performance is reviewed quarterly and annually, with adjustments made through the governance structure where required.

Reporting data

	Annual carbon emissions (tCO2e)				
	2020-21	2021-22	2022-23	2023-24	2024-25
Gas	18,723	18,325	18,240	18,483	18,716
Waste	2,170	2,278	2,224	2,157	2,047
Electricity	1,769	2,563	1,820	1,985	2,005
Water and Sewerage	223	89	91	91	80
Oil	73	56	64	47	36
Coal	0	0			
Hot water and steam	0	0	0	0	0
Grand Total	22,958	23,311	22,440	22,763	22,885

Figure 2: Source - Greener NHS Dashboard 2024–25 (refreshed 14th January 2026) Lancashire Teaching Hospital demonstrating annual carbon emissions produced from the energy and water consumed during the last 5 years

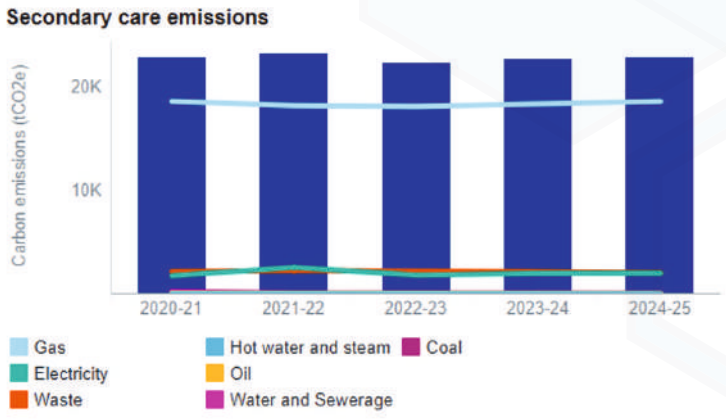
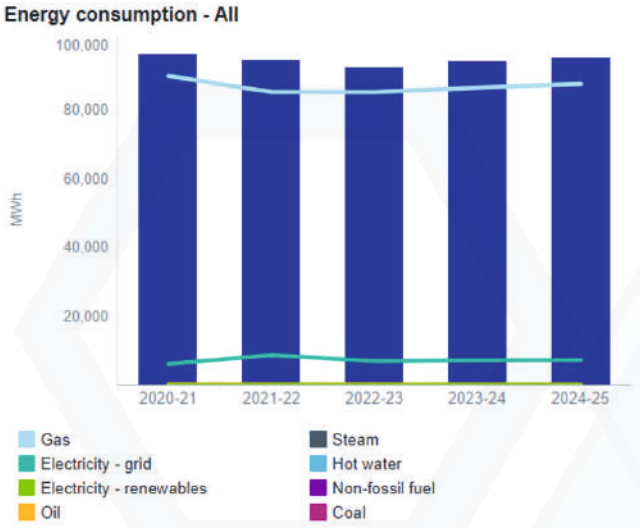
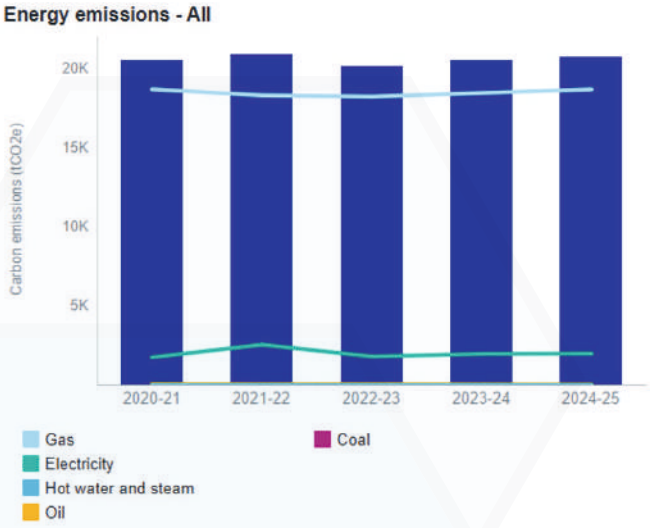


Figure 3: Source Greener NHS Dashboard 2024–25 (refreshed 14th January 2026) Lancashire Teaching Hospital showing the same data as figure 2 in bar chart format





Annual energy consumption (MWh)					
	2020-21	2021-22	2022-23	2023-24	2024-25
Gas	90,109	85,425	85,379	86,718	87,824
Electricity - grid	6,141	8,799	6,960	7,221	7,287
Electricity - renewables	0	0	0	0	0
Oil	228	171	195	143	111
Steam	0	0	0	0	0
Hot water	0	0	0	0	0
Non-fossil fuel	0	0	0	0	0
Coal	0	0			
Grand Total	96,478	94,396	92,535	94,082	95,222

Annual carbon emissions (tCO2e)					
	2020-21	2021-22	2022-23	2023-24	2024-25
Gas	18,723	18,325	18,240	18,483	18,716
Electricity	1,769	2,563	1,820	1,985	2,005
Oil	73	56	64	47	36
Coal	0	0			
Hot water and steam	0	0	0	0	0
Grand Total	20,565	20,944	20,125	20,515	20,758

Figure 4: Source - Greener NHS Dashboard 2024–25 (refreshed 14th January 2026) Lancashire Teaching Hospital demonstrates energy consumption during the last 5 years

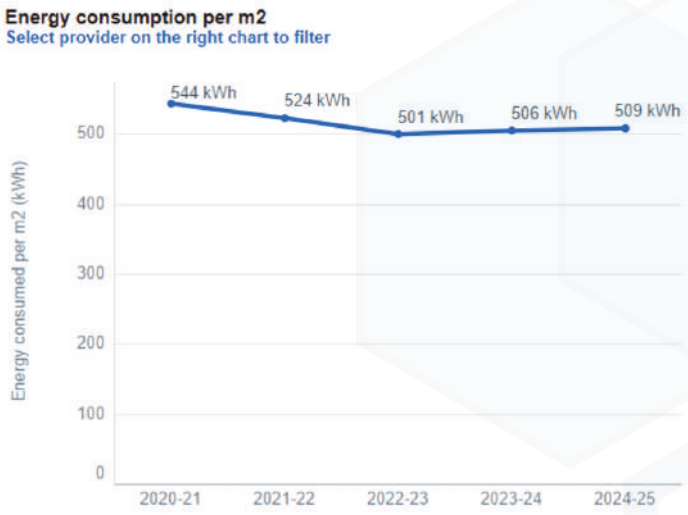


Figure 5: Source - Greener NHS Dashboard 2024–25 (refreshed 14th January 2026) Lancashire Teaching Hospital demonstrates energy consumption per m2 increasing since 2022–23

Anaesthetic and medical gases are responsible for around 2% of all NHS emissions and 5% of emissions from acute care, according to the Delivering a net zero National Health Service (July 2022 report). Desflaurane is no longer used at Lancashire Teaching Hospitals. Further work has commenced to asses how nitrous oxide waste can also be reduced across the sites.

Some of the key headlines regarding our Green Plan achievements during 2025 include:

- A clinical lead has been identified to support with net zero clinical transformation
- A dedicated travel co-ordinator post has been recruited to which will oversee the implementation of the travel plan
- Funding was obtained to continue with the upgrade of LED lighting at Royal Preston Hospital
- Work commenced to decarbonise the estate at Royal Preston Hospital with planning work started in April 2025
- 160 tree whips planted at the Chorley and South Ribble District General Hospital in 2025

Prohibition or enforcement notices

Revised enforcement undertakings issued to the Trust in February 2025 continued to be in place throughout the year. In November 2025, an additional licence condition pursuant to s. 111of the Health and Social Care Act 2012 was imposed in relation to additional governance arrangements. For details of the enforcement undertakings and the Trust's progress against them please see the Annual Governance Statement.

Overseas operations

The Trust does not have any subsidiaries overseas.

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

Professor Silas Nicholls
Chief Executive
25 June 2026

Lancashire Teaching Hospitals NHS Foundation Trust

ACCOUNTABILITY REPORT 2025–26

DIRECTORS' REPORT

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

This Directors' report is prepared in accordance with:

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

Our Board of Directors

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

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

Non-Executive Directors as at 31 March 2026

Professor Mike Thomas, (Chair) (I)

Appointment: 1 January 2025 to 31 December 2027

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

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

Dr Tim Ballard, Non-Executive Director (I)

Appointment: 1 October 2023 to 30 September 2026

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

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

Tim is the Board-level Ockenden Maternity Safety Champion

Professor StJohn Crean (I)

Appointment: 4 March 2025 – 3 March 2028

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

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

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

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

Dr Karen Deeny, Non-Executive Director (I)

Appointment: 1 March 2025 – 28 February 2028

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

In 2026 the Council of Governors extended her initial one year term to the standard three years.

Karen is Chair of the Safety and Quality Committee.

Adrian Leather, Non-Executive Director (I)

Appointment: 1 March 2025 – 28 February 2028

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

In 2026 the Council of Governors extended his initial one year term to the standard three years.

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

Uzair Patel, Non-Executive Director (I)

Appointment: 2 July 2024 – 1 July 2027

Uzair moved from a position of Associate Non-Executive Director to Non-Executive Director in July 2024.

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

Uzair is chair of Lancashire Hospital Services Ltd, a wholly owned subsidiary of the Trust.

John Schorah, Non-Executive Director (I)

Appointment: 1 March 2025 – 28 February 2026

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

In 2026 the Council of Governors extended his initial one year term to the standard three years.

John is the Chair of the Finance and Performance Committee

Professor Tim Wheeler, Non-Executive Director (I)

Appointment: 1 April 2025 – 31 March 2028

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

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

In 2026 the Council of Governors extended his initial one year term to the standard three years.

Tim is Chair of the Audit Committee.

Executive Directors

Professor Silas Nicholls, Chief Executive

Permanent post – appointment from 8 January 2024

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

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

In addition to his Chief Executive role, Silas is the Chair of the North West Leadership Academy. In January 2024 he was awarded the title of Professor of Leadership and Healthcare Management – Institute of Medicine, University of Bolton.

Silas currently acts as Lead CEO for the Lancashire and South Cumbria Provider Collaboration Board and is a member of the Board of the ICB as the representative for acute providers.

Sarah Morrison, Chief Nursing Officer and DCEO

Permanent post – appointment from 1 August 2019

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

Sarah is also Deputy Chief Executive Officer.

Katie Foster-Greenwood, Chief Operating Officer

Permanent post – appointment from 12 August 2024

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

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

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

Mr Steve Canty, Chief Medical Officer

Permanent post – appointment from 1 October 2025

Mr Steve Canty graduated from University of St Andrews and University of Manchester. He completed post graduate training across the North West and was appointed as a Consultant Trauma & Orthopaedic Surgeon with a special interest in Knee Surgery at Lancashire Teaching Hospitals in 2008. He has had an increasing senior portfolio of leadership roles within the Trust and North West region since 2012. He has held posts as the Chair Lancashire and South Cumbria Trauma & Orthopaedic and MSK Network, Medical Lead Lancashire and South Cumbria New Hospital Programme, North West Clinical Senate Council member, GIRFT North West Regional Clinical Specialty Lead for Orthopaedics and MSK, Medical Lead LTH Health Inequalities Group, and recently Interim Deputy Chief Medical Officer Professional Standards Portfolio.

Steve was appointed as full-time Chief Medical Officer at Lancashire Teaching Hospitals from October 2025 and continues to work at LTH as a Consultant Orthopaedic Surgeon undertaking clinics and theatre sessions.

He is also the Caldicott Guardian.

Craig Carter, Interim Chief Finance Officer

Interim post – appointment from 1 May 2025

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

Executive Directors (non-voting)

Professor Ailsa Brotherton, Chief Strategy and Improvement Officer

Permanent post – appointment from 1 December 2017

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

Naomi Duggan, Director of Communications and Engagement

Permanent post – appointment from 1 April 2020

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

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

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

Jennifer Foote MBE, Director of Corporate Affairs

Permanent post – appointment from 1 July 2022

As Director of Corporate Affairs Jennifer acts as Company Secretary to the Board of Directors and Council. Jennifer is appointed Senior Information Risk Owner (SIRO) for the Trust. Jennifer joined the Trust in July 2022 and has extensive experience of corporate governance across the public sector, including working as part of a national team for improvement in governance in FE institutions and as a National Leader of Governance in the Department for Education.

Jennifer also acts in the capacity of Secretary of the Provider Collaborative Board Joint Committee.

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

Dr Neil Pease, Chief People Officer

Permanent post – appointment from 1 December 2023

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

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

In addition to his role at the Trust, Neil has also served as interim CPO for East Lancashire Hospitals Trust.

Board members whose term of office ended during 2025–26

Gerry Skailes, Chief Medical Officer

Permanent post – appointment from 1 March 2018 until 30 September 2025

Gerry graduated from Guys Hospital in London and spent the early years of her medical training in London and the South Coast before moving to the Christie Hospital to undertake specialist training in Clinical Oncology. She was appointed as a Consultant at Royal Preston Hospital in 1997 with an interest in treating lung and gynaecological cancers. She has held a number of leadership roles within the Trust and North West region including Clinical Lead for the Lancashire and South Cumbria Cancer Alliance and Deputy Medical Director of the Trust. Gerry continues to work as a Consultant in Oncology undertaking a weekly acute oncology ward round and is actively involved in a number of the ICP and ICS Committees. Gerry was appointed as the Trust's full-time Medical Director from March 2018 until her retirement on 30 September 2025.

David Stonehouse, Interim Chief Finance Officer

Interim Post – 2 September 2024 – 30 April 2025

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

Appointment and removal of Non-Executive Directors

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

Division of responsibilities

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

Review of effectiveness

All Non-Executive Directors completed satisfactory individual appraisals of their performance for 2025–26 in March and April 2026. This was reported through to Council in April 2026. Executive Directors undertook parallel reviews, reported through to the Appointments, Remuneration and Terms of Employment (ARTE) Committee. In February 2026 the Board undertook a self-assessment review (including a committee effectiveness review) and reported its assurance that the board had undertaken its responsibilities diligently and effectively to the Trust Board meeting held on 2 April 2026.

Declaration of interests

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

Independence of Directors

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

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

Board assurance committees

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

Audit Committee

The role of the Audit Committee is to provide independent assurance to the board on the effectiveness of the governance processes, risk management systems and internal controls on which the board places reliance for achieving its corporate objectives and in meeting its fiduciary responsibilities. It is authorised by the board to investigate any activity within its terms of reference and to seek any information it requires from staff. For 2025–26 internal audit services were undertaken by MIAA. External audit services for the year were provided by KPMG. Further details are included in the Annual Governance Statement.

Five meetings of the committee were held in 2025–26.

Audit Committee attendance

Audit Committee attendance summary from 1 April 2025 to 28 February 2026 (no meetings of the committee were held in March 2026)

Name of Committee member	A	B	Percentage of meetings attended (%)
Dr Karen Deeny	4	5	80
Adrian Leather	1	1	100
John Schorah	5	5	100
Tim Wheeler	5	5	100
Uzair Patel	2	2	100

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

Safety and Quality Committee

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

Safety and Quality Committee attendance

Name of Committee member	A	B	Percentage of meetings attended (%)
Dr Tim Ballard	11	12	91
Dr K Deeny	12	12	100
John Schorah	9	12	75
Sarah Morrison	9	12	75
Steve Canty	4	6	66
Dr G Skailes	5	6	83

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

Finance and Performance Committee

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

Finance and Performance Committee Attendance

Name of Committee member	A	B	Percentage of meetings attended (%)
Adrian Leather	8	12	66
Uzair Patel	8	12	66
John Schorah	11	12	91
Dr Tim Ballard	1	1	100
Katie Foster-Greenwood	11	12	91
Craig Carter	10	11	90
David Stonehouse	1	1	100

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

Workforce Committee

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

Workforce Committee attendance

Name of Committee member	A	B	Percentage of meetings attended (%)
Prof. StJohn Crean	2	6	33
Dr Karen Deeny	6	6	100
Adrian Leather	6	6	100
Sarah Morrison	5	6	83
Dr Neil Pease	5	6	83

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

Education, Training and Research Committee

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

Education Training and Research Committee attendance

Name of Committee member	A	B	Percentage of meetings attended (%)
Dr Tim Ballard	4	6	67
Prof. StJohn Crean	4	6	67
Adrian Leather	2	6	33
Mr Steve Canty	2	2	100
Dr Ailsa Brotherton	2	2	100
Dr Neil Pease	3	6	50

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

Nominations Committee and ARTE Committee attendance statistics may be found on pages 64 and 65.

Board meeting attendance summary 2025–26

MEMBERS	3/4/2025	3/6/2025	7/8/2025	2/10/2025	4/12/2025	5/2/2026	A	B	Percentage Attended
VOTING NON-EXECUTIVE DIRECTORS									
Mike Thomas	P	P	P	P	P	P	6	6	100
Dr Tim Ballard	P	P	P	P	P	P	6	6	100
Prof. StJohn Crean	P	Ab	Ab	P	Ab	P	3	6	50
Dr Karen Deeny	P	P	P	P	P	P	6	6	100
Adrian Leather	P	Ab	P	Ab	P	P	4	6	67
Uzair Patel	P	P	P	Ab	Ab	P	4	6	67
John Schorah	P	P	Ab	P	P	P	5	6	83
Tim Wheeler	P	P	P	P	P	P	6	6	100
VOTING EXECUTIVE DIRECTORS									
Dr G Skailes	P	Ab	P				2	3	67
Prof. Silas Nicholls	P	P	P	Ab	P	P	5	6	83
Sarah Morrison	P	Ab	P	P	P	Ab	4	6	67
Katie Foster-Greenwood	P	P	P	P	P	P	6	6	100
Mr Steve Canty				P	P	P	3	3	100
Mr D Stonehouse	P						1	1	100
Craig Carter		P	P	P	P	P	5	5	100
NON-VOTING EXECUTIVE DIRECTORS									
Dr Ailsa Brotherton	P	P	P	Ab	P	P	5	6	83
Jennifer Foote	P	P	P	P	P	P	6	6	100
Naomi Duggan	Ab	Ab	P	P	P	P	4	6	67
Dr Neil Pease	Ab	P	P	P	P	P	5	6	83

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

Political donations

The Trust has neither made nor received any political donations during 2025–26.

Directors' declaration

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

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

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

COUNCIL OF GOVERNORS' REPORT

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

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

At the end of 2025–26, the Council comprised 28 governor seats, of which: 18 are elected governors who represent the public constituency; five are elected governors who represent the staff constituencies; one is appointed by our University partnership organisations (University of Central Lancashire, Lancaster University and University of Manchester); and four are appointed by local authorities (being Lancashire County Council, Preston City Council, Chorley Council and South Ribble Borough Council).

Elections

The governor election process takes place between January and March each year, and governors generally serve a three-year term of office, beginning in April. At the end of March 2026, there were seven vacancies in the public constituency and three vacancies in the staff categories of Doctors and Dentists, Non-Clinical and Unregistered Healthcare and Support Workers. On 23 March 2026 it was announced that all positions had been filled on either a contested or uncontested basis.

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

Council of Governors' subgroups

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

Understanding the views of Governors and Members

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

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

- Governor attendance at public Board meetings (in the capacity of observer) is encouraged and governor attendance is recorded within the Board minutes. For 2025–26 meetings of Council were held on site at both Royal Preston Hospital and Chorley and South Ribble District Hospital, with an option to join remotely.
- There is Non-Executive Director representation at each of the governor subgroups.
- It is an expectation that the non-executive directors who chair the Board assurance committees attend Council of Governors' meetings in order to be held directly to account for the Board oversight of the performance of the Trust.

- As part of the Trust's forward planning process, the Board and the Council of Governors had opportunities to work together to understand the strategic priorities of the Trust and the challenges that needed to be addressed.
- Information flows through a variety of events, including system-wide initiatives, consultation on Trust strategic plans, and a range of working groups on patient-specific topics such as car parking and patient letters.
- Opportunities for visits to clinical areas and departments across the Trust which this year have included Catering, Pharmacy and Emergency departments as well as the Lancashire Elective Surgery Hub and Day of Surgery Admission Unit at Royal Preston Hospital.

Board and Council engagement

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

To help governors fulfil their important role of holding the Board to account, governors receive updates on progress against the Trust's Strategy and Single Improvement Plan at their quarterly Council of Governors' meetings. Regular briefings are provided to governors on topical issues. In line with good practice, there is a policy on engagement between the Board and Council. The Chair also meets individually with the lead governor on a regular basis. The lead governor role (with a remit as set out in the Code of Governance) during 2025–26 was held by public governor Janet Miller.

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

Appointment of external auditors

At its meeting in October 2025, in accordance with its duties and responsibilities, Council reappointed KPMG as external auditors for the next 3 years.

Declaration of interests

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

Attendance summary

There were four formal Council meetings during 2025–26, which were quarterly meetings scheduled for April, July and October 2025 and January 2026.

The table below shows governors' attendance at Council meetings in 2025–26:

Name of governor	Term of office	No. of terms	Type of governor	A	B	Percentage of meetings attended (%)
Pav Akhtar	1.04.2024 -31.03.2027	3rd term	Public	3	4	75
Takhsin Akhtar	01.04.2025–31.03.2028	3rd term	Public	2	4	50
George Bailey	01.04.2025-31.03.2028	1st term	Public	3	4	75
Alistair Bradley	01.04.2024–31.05.2025	9th term	Appointed: Chorley Council	0	1	0
Sheila Brennan	01.04.2025–31.03.2028	2nd term	Public	4	4	100
Darrell Brooks	01.04.2025–31.03.2028	1st term	Public	4	4	100
Paul Brooks**	01.04.2025-31.10.25	1st term	Public	1	2	50
Michelle Brown	24.7.2025-23.7.2026	1st term	Appointed: Chorley Council	3	3	100
Sonia Connell	01.04.2025-31.03.2028	1st term	Staff: Nurses and Midwives	4	4	100
Philip Curwen	01.04.2024 – 31.03.2027	1st term	Public	3	4	75
Dr Margaret France	01.04.2017–31.03.2026	3rd term	Public	2	4	50
Graham Fullarton	01.04.2023–31.03.2026	1st term	Public	2	4	50
Lucienne Jackson	13.02.2025–31.05.2026	2nd term	Appointed: South Ribble Borough Council	2	4	50
Angela Kos	01.04.2024–31.03.2027	1st term	Public	4	4	100
Daniel Matchett	30.10.2025–31.05.26	1st term	Appointed: Lancashire County Council	0	1	0
Janet Miller	01.04.2017–31.03.2026	3rd term	Public	4	4	100
Carole Oldcorn	01.04.2025–31.03.2028	1st term	Public	4	4	100
Eddie Pope**	10.06.2024-05.05.2025	6th term	Appointed: Lancashire County Council	0	1	0
Enid Povey	01.04.2025–31.03.2028	1st term	Public	4	4	100
Christine Pownall**	01.04.2024–29.07.2025	1st term	Public	2	2	100
Lesley Purcell**	01.04.2024–01.04.25	1st term	Staff: non-clinical support	0	0	N/A

Name of governor	Term of office	No. of terms	Type of governor	A	B	Percentage of meetings attended (%)
Tom Ramsay	01.04.2024–31.03.2027	1st term	Staff: other health professionals and healthcare scientists	2	4	50
Frank Robinson	01.04.2023–31.03.2026	3rd term	Public	4	4	100
Graham Robinson	01.04.2024–31.03.2027	1st term	Public	4	4	100
Suleman Sarwar	1.05.2025–31.05.2026	4th term	Appointed: Preston City Council	2	4	50
Teik Chooi Oh**	01.04.2024–11.11.25	1st term	Staff: doctors and dentists	0	3	0
Tim Young	01.04.2025–31.03.2028	1st term	Public	3	4	75
Feixia Yu**	01.04.2023–30.04.2025	1st term	Public	0	1	0

A = Meetings attended | B = Maximum number of meetings the governor could have attended
*** Term of office ended due to resignation in 2025–26*

Director attendance at Council of Governors' meetings

The following Directors attended Council meetings during 2025–26:

Non-Executive Directors:
- Michael Thomas, Chair
- Tim Ballard, Non-Executive Director
- StJohn Crean, Non-Executive Director
- Karen Deeney, Non-Executive Director
- Adrian Leather, Non-Executive Director
- Uzair Patel, Non-Executive Director
- John Schorah, Non-Executive Director
- Tim Wheeler, Non-Executive Director

Executive Directors:
- Ailsa Brotherton, Director of Innovation, Research and Improvement
- Steve Canty, Chief Medical Officer
- Jennifer Foote, Director of Corporate Affairs
- Katie Foster-Greenwood, Chief Operating Officer
- Sarah Morrison, Chief Nursing Officer
- Silas Nicholls, Chief Executive
- Neil Pease, Chief People Officer

Governor training and development

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

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

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

During 2025–26, our governors have participated in joint Board and Council sessions and governor workshops which included the following topics:

- A presentation for 2025–26 Operational Planning
- A presentation on NHS Finance and Planning
- A presentation on NHS Impact: Improving Patient Care Together
- A presentation and consultation on the 5 Year Strategic Plan
- A workshop on the Safety Triangulation Accreditation System (STAR) quality assurance framework
- A workshop on the Council Effectiveness Review and Key Performance Indicators
- A presentation and consultation on Equality, Diversity and Inclusion within the NHS
- A presentation and consultation on Quality and Safety within the NHS

Expenses claimed by Governors

Whilst governors do not receive payment for their work with us, we have a policy of reimbursing any necessary expenditure. During 2025–26 £941.60 of expenses were claimed by our governors.

	2024–25	2025–26
Number of governors in office during the year	23	28
Total number claiming expenses:	1	4
Aggregate sum of expenses (£00s):	£51.30	941.60

Contacting your Governors

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

MEMBERSHIP REPORT

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

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

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

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

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

Our membership

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

Constituency	Members as at 31.03.25	Members as at 31.03.26
Public	8,913	8,753
Staff	9,413	9,413
Total Membership	18,326	18,166

Source: Civica Membership Database

During 2025–26 regular data cleansing was carried out to ensure that records continue to be as accurate as possible.

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

The Health and Care Act 2022 recognised that NHS Foundation Trusts now operate within the new system way of working. The Council of Governors is assessing how it will discharge its wider duty to consider the Board's performance in part of the Trust's contribution to system-wide plans and their delivery, and its openness to collaboration with other partners, including with other providers through Provider Collaboratives. In holding Non-Executive Directors to account for the performance of the Board, the Council of Governors now considers whether the interests of the public at large have been factored into Board decision-making and be assured of the Board's performance in the context of the system as a whole, and as part of the wider provision of health and social care.

Review of 2025–26

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

The Trust hosted its Annual Members' Meeting on 25 September 2025. The event provided an opportunity for patients, staff members and the public to find out about what had been happening at Royal Preston Hospital and Chorley and South Ribble Hospital and gave a detailed update on the progress and innovations the Trust had made during the last year. The AMM was hosted by the Chair, Mike Thomas who presented an overview of achievements and performance during 2024–25, a summary of the Trust's strategy was presented by Prof Ailsa Brotherton (Chief Strategy and Improvement Officer), and a summary of the Annual Reports and Accounts was presented by Craig Carter (Interim Chief Finance Officer). The AMM also provided an opportunity for governors to explain the work undertaken over the last 12 months and how the Council, Non-Executive Directors and Board worked together in the interests of the needs of the local population. To that end, an informative presentation was delivered by Public Governor Graham Robinson. The AMM received keynote speeches from Gregg Stevenson MBE (World and European Champion and Paralympic Gold Medallist), and Susan Saul (Macmillan Clinical Lead Physiotherapist – Prehabilitation) who discussed cancer prehabilitation, a multi-modal intervention aimed at optimising physical, nutritional, and psychological status to enhance treatment readiness and recovery.

The event was kindly supported and partnered by the Active Lancashire team were also on-site providing attendees with the opportunity to take part in fitness activities in keeping with the theme of the event.

In total 49 people attended the AMM, which was held at an external venue The County Ground, Thurston Road, Leyland.

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

Assessment of the membership and ensuring representativeness

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

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

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

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

Members can contact the Corporate Affairs Office via:
Website: https://www.lancsteachinghospitals.nhs.uk/get-involved
Email: corporateaffairs@lthtr.nhs.uk

QUALITY IMPROVEMENT

Major service developments

Despite ongoing operational and financial pressures across the Lancashire and South Cumbria healthcare system - including a sustained winter demand and the effects of industrial action – 2025–26 saw a number of significant service developments at the Trust.

These developments will not only improve patient experience but strengthen clinical outcomes, reduce pressures on emergency and elective pathways, and enhance capacity across our sites.

These achievements reflect the dedication and resilience of our colleagues and partners, who continue to drive innovation and improvement for the communities we serve.

Highlights from the year include:

Launch of 24/7 Thrombectomy Service for Lancashire and South Cumbria

As of 2 February 2026, Royal Preston Hospital (RPH) can now provide a full 24/7 mechanical thrombectomy service, delivering round-the-clock, life-saving treatment for stroke patients across Lancashire and South Cumbria.

Stroke remains a leading cause of death and disability. For the 10 – 15% of ischemic stroke patients who can benefit from a thrombectomy this can significantly improve survival and reduce long-term disability for those that are.

Mechanical thrombectomy is one of the most effective treatments for acute ischaemic stroke, where every minute is critical to prevent irreversible brain damage. Becoming a 24/7 centre ensures faster decision-making, quicker transfers and timely treatment for eligible patients, improving outcomes across the region.

Lancashire Teaching Hospitals (LTH) is one of three specialist centres commissioned in the North West to deliver this service. Following extensive planning and recruitment, the expansion to a full 24/7 model strengthens the Trust's position as a major regional hub for advanced stroke care and reflects its commitment to providing high-quality, specialist treatment close to home for the communities it serves.

New land for proposed site for replacement for RPH secured

In March 2026, we completed the purchase of the final section of land on the proposed site for the replacement for RPH.

The land at Lancashire Central, adjacent to the planned commercial site, has been purchased from strategic partner, Lancashire County Council, as part of the national New Hospital Programme.

The purchase completes the land assembly of the acres required to build a replacement for RPH and enables future public consultation on the proposed new hospital site.

RPH unveils refurbished helipad after £720,000 HELP Appeal upgrade

RPH was pleased to see a thorough refurbishment of its helipad following a £720,000 upgrade funded entirely by the HELP Appeal – the UK's only charity dedicated to supporting NHS helipad infrastructure. The donation is the largest single charitable gift in the Trust's history.

The project has modernised the helipad to meet current safety and aviation standards. Improvements include a new landing pad, upgraded lighting, enhanced safety fencing and barriers, improved signage, updated aviation control systems, better drainage and a live on-site weather station. These enhancements will increase safety, reliability and efficiency for critical air ambulance transfers.

Trust begins its Medicine reconfiguration programme

In January 2026, we began our medicine reconfiguration work in line with the Trust's new Days Kept Away from Home (DKAFH) initiative which helps to cohort patients who are fit for discharge to free up speciality beds across our wards and patient improve flow.

At any given time, there are around 90 patients within our hospitals who are medically fit for discharge but still occupy a clinical bed. This is contributing to a significant bottleneck at the front door as well as corridor care and boarding within our wards.

By expanding a dedicated area for patients who do not meet the criteria to reside, it allows for specialist teams to provide a more focussed approach on reducing the length of stay associated with this patient group.

Lancashire and South Cumbria Pathology Service

Following significant preparatory work across 2025–26, a single Lancashire and South Cumbria Pathology Network will be provided by Lancashire Teaching Hospitals Trust from 1 April 2026. This will bring together Pathology colleagues from Blackpool Teaching Hospitals, East Lancashire Hospitals, and University Hospitals of Morecambe Bay to join the Trust as we aim to come together as one single pathology team and service for our healthcare system.

Performing our 1,000th robotic-assisted prostatectomy

We reached a major milestone in April 2025 after completing our 1,000th robotic-assisted prostatectomy using the advanced da Vinci Xi system at Chorley and South Ribble Hospital. This achievement reflected the Trust's long-standing commitment to pioneering robotic surgery for patients with urological cancers.

The system enables highly precise, minimally invasive surgery through tiny incisions, improving patient outcomes such as reduced pain, quicker recovery, shorter hospital stays, and better long-term continence and sexual function.

Cutting-edge cancer treatment boost with new radiotherapy machine

We significantly enhanced our cancer services in 2025 with the introduction of a new state-of-the-art linear accelerator (LINAC) at the Rosemere Cancer Centre, funded through a share of a £70m government investment. The Trust was one of three in the North West selected to receive the advanced radiotherapy equipment as part of the national Plan for Change to modernise cancer treatment.

The new LINAC will replace ageing machinery, improving reliability and reducing the number of cancelled appointments caused by equipment failures - an issue estimated to affect up to 13,000 appointments nationally.

For Lancashire and South Cumbria, the investment will expand access to advanced techniques such as Stereotactic Ablative Radiotherapy (SABR), enabling highly targeted treatment that minimises damage to healthy tissue and improves outcomes.

Pioneering new robotic rectal cancer surgery in the region

We became the first centre in the region - and one of only seven in the UK - to introduce robotic TAMIS (Transanal Minimally Invasive Surgery), a pioneering technique for treating early rectal cancer and complex polyps.

The innovation strengthens the Trust's long-established Early Rectal Cancer service and reflects our commitment to investing in advanced technology that improves outcomes for patients across Lancashire and South Cumbria. Robotic TAMIS uses the Da Vinci surgical robot and a specialist robotic motion table, both funded by Rosemere Cancer Foundation, to remove cancers and large polyps while preserving normal bowel function and reducing the likelihood of permanent stoma formation.

Introducing robotic TAMIS at Chorley and South Ribble Hospital helps optimise theatre capacity and ensures timely access to care. As a tertiary referral centre for early rectal cancer, the Trust is now able to offer more precise, minimally invasive treatment that avoids major surgery and improves patient experience and recovery.

Continuous Improvement

During 2025–26, the Continuous Improvement (CI) programme supported delivery of safer, more reliable and person-centred care through the Trust wide adoption of the Lancashire Improvement Method (LIM) as the single framework for improvement. LIM has enabled teams to better understand patient pathways, reduce unwarranted variation and codesign changes that improve outcomes and experience.

At the frontline, coached improvement through the Microsystem Coaching Academy (MCA) and its transition into the Local Level Improvement Programme (LIP) supported ward and service teams to improve reliability of care, reduce delays and prevent avoidable harm. The Days Kept Away from Home (DKAFH) improvement programme has developed a strengths based focus on maintaining patient independence, reducing deconditioning and supporting timely discharge.

At pathway level, multidisciplinary Big Rooms continued to improve coordination and flow across complex pathways including stroke, cancer and mental health, contributing to safer transitions of care and improved patient experience.

The CI team alongside our clinical teams have taken part in national improvement collaboratives, including thrombolysis and improving maternity care and this work has been presented at national and international conferences. Improvements have also been made to our safety surveillance system which enables our clinical teams to have oversight of key patient safety metrics.

Always Safety First

Developed through extensive engagement with colleagues, patients, communities and partners, the Always Safety First strategy reflects insight from frontline teams, patient experience, incidents and wider safety intelligence. It aligns with national direction including the NHS Patient Safety Strategy, the Patient Safety Commissioner Principles, the Patient Safety Incident Response Framework (PSIRF), the Patient Safety Health Inequalities Reduction Framework, the NHS Digital Clinical Safety Strategy, and strengthened CQC expectations.

Our 2026–27 priorities represent the first year of delivery and set out the specific areas where we will focus our improvement efforts to deliver safer, more reliable care.

Research participation in clinical research

During 2025–26 the Centre for Health Research & Innovation has continued to focus on streamlining its research portfolio, along with increasing the number of commercial research studies that we participate in to redress the balance in line with national guidance and targets, notably new metrics to hasten study set-up to 150 days. Overall, we have recruited 1262 patients across research studies covering a whole range of therapeutic areas, and research types, including early phase experimental commercial funded research studies to qualitative academic studies, in collaboration with our university partners. This includes 1002 into National Institute of Health and Care Research (NIHR) portfolio studies, of which 60 patients into commercially funded studies. There are 287 active studies of which 145 are open to recruitment. We remain steady with between 20 and 27 commercial studies open to recruitment and an increase to 32% (26% 2024–25) of our portfolio now commercial at any one time which has helped achieve financial balance.

PATIENT EXPERIENCE

The Trust's Single Improvement Plan 2025–26 highlights the importance of actively listening to and responding to patient experiences. The plan was shaped through engagement with patients, relatives, carers, colleagues, governors, and partner organisations, ensuring a collaborative focus on improving the quality of patient care.

The plan has 5 key objectives:

- Improve the outcome of the inpatient survey
- Develop a reliable method of stakeholder engagement
- Reduce the number of complaints per 1000 bed days
- Increase the ability to hear feedback from protected minority groups
- Increase the volunteering workforce available at LTH

This work will focus on improving the experience of our patients and their families, measured through Patient Experience Surveys. It aimed to improve staff satisfaction, monitored through Staff Survey results and the monthly Staff Pulse Survey. In addition, there was an increased focus on engaging a wider range of stakeholders, including protected minority groups, through targeted engagement events.

Complaints and concerns

During 2025–26 the Trust received 329 formal complaints, an increase of 4 from 2024–25. The complaints performance has been monitored through the year and patients receiving response within 35 or 60 days has risen from last year with the average for the year at 81%.

Comparator data for Complaints 2022 to 2025

Year	Complaints received	Increase/reduction
2023–24	355	-132
2024–25	325	-30
2025–26	329	+4

Source: LTHTR Ulysses

The increase represents a percentage of 1.23%. The trend in the ratio of complaints to patient contacts over the past three years is detailed in the table below:

Of the 329 complaints received between April 2025 to March 2026, 289 (88%) related to care or services provided at the Royal Preston Hospital (RPH), 40 (12%) to care or services provided at Chorley and South Ribble Hospital (CDH). There were no cases which were deemed to be outside of the 12 months' timescale set out under the NHS Complaints Procedure

Number of complaints by division – April 2025 to March 2026

Division	Number (%)	Division	Number (%)
Medicine	120 (36%)	Women and Children's Services	54 (16%)
Surgery	127 (39%)	Diagnostics and Clinical Support	21 (6%)
Estates and Facilities	3 (0.5%)	Corporate Services	4 (1.5%)

Source: LTHTR Ulysses

Trend of ratio of complaints per patient contact 2022 to 2026

Year	No of complaints	Total episodes (inpatient/ outpatient)	Ratio of complaints to patient contacts
2022–23	487	849,328	1:1,744
2023–24	355	882,589	1:2,486
2024–25	325	917,962	1:2,825
2025–26	329	952,167	1:2,896

Source: LTHTR Ulysses

During this financial year there were 253 cases closed. The outcome of these can be broken down into the following outcomes 14 (5.5%) of the complaints were upheld. 154 (60%) were partly upheld and 72 (28%) were not upheld. 15 (6.5%) cases were rejected due to them following other processes and not the complaints process.

The NHS Complaints Regulations determine that all complaints should be acknowledged within three working days of receipt. In the current reporting period, 94% of complainants received an acknowledgement within that timescale where complaints were received into the Patient Experience and PALS team.

Second letters may be received because of dissatisfaction with the initial response or as a result of the complainant having unanswered questions. During the period between April 2025 and March 2026 we received nine second letters.

During the period 1st April 2025 to 31st March 2026 253 complaints were closed. 81% of complaints received in 2025–26 were closed within the 35-day or 60-day timescale. This is reported to Safety & Quality Committee

Top 3 themes from complaints by division:

Division	Themes
Diagnostic and Clinical Support	1. Treatment/procedure 2. Clinical Assessment 3. Diagnostics
Women and Children	1. Treatment/procedure 2. Communication 3. Staff Treatment, procedure. Staff Behaviour/Diagnosis/Clinical Assessment
Medicine	1. Appointments 2. Communication 3. Treatment/procedure
Surgery	1. Treatment/procedure 2. Communication 3. Appointments

The Parliamentary Health Service Ombudsman (PHSO)

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

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

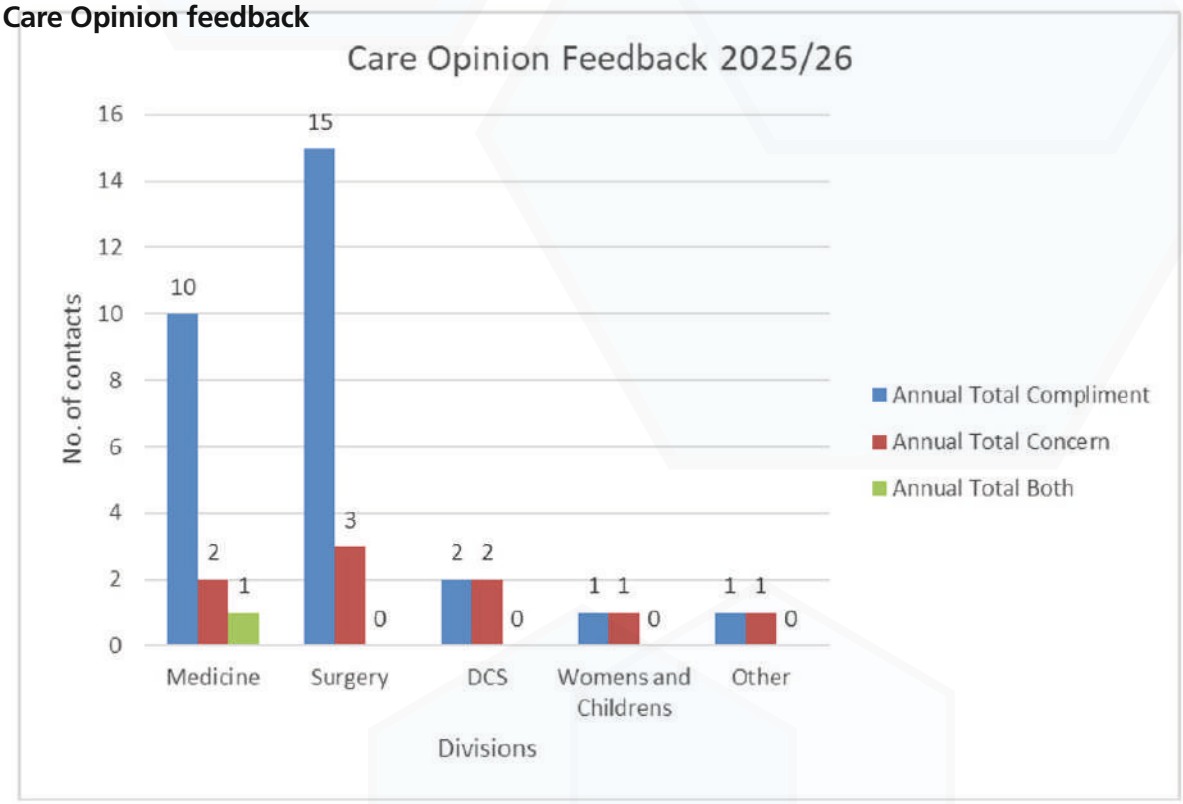
Compliments

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

Care Opinion website

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

Care Opinion feedback

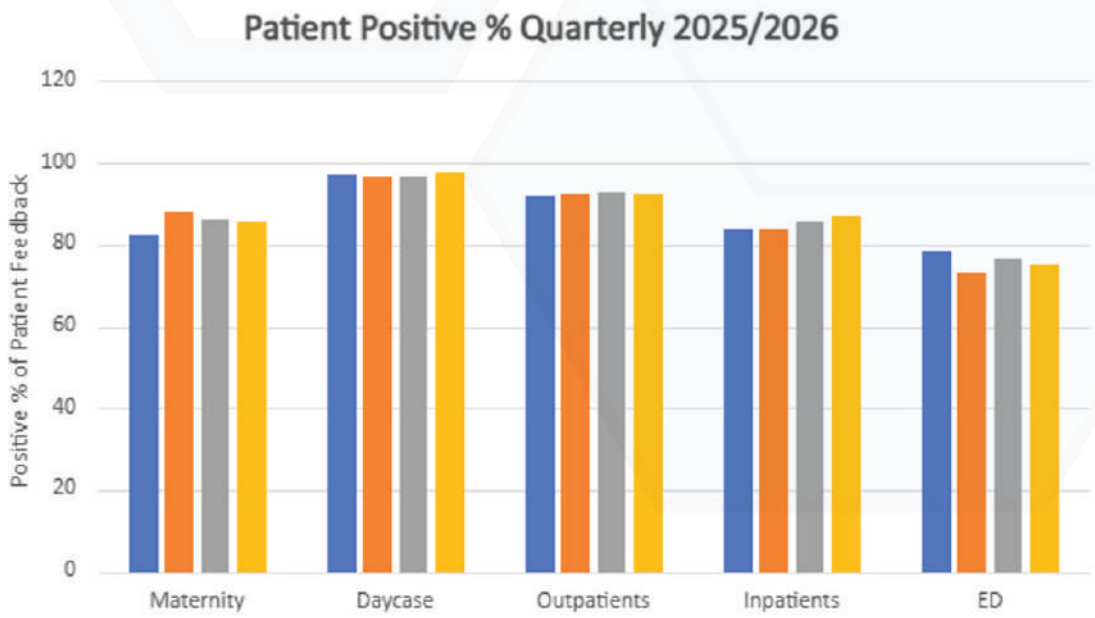


Friends and Family feedback

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

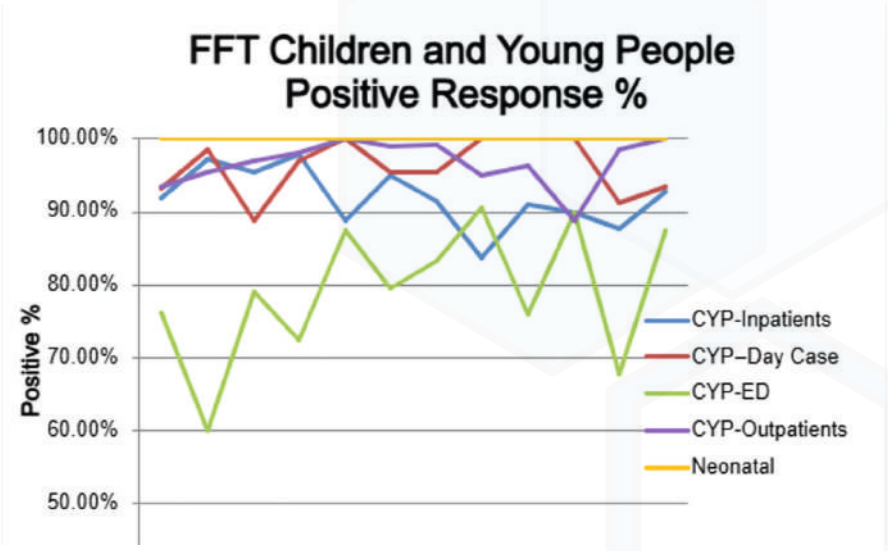
- Maternity
- Day Case
- Outpatients
- Inpatients
- Emergency Department

Percentage of positive responses Friends and Family by Division



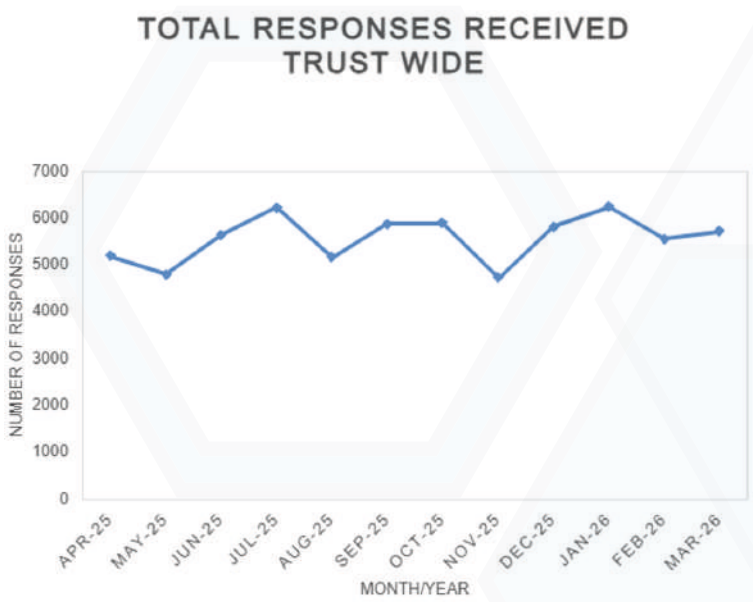
Source: FFT data CIVICA

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



Friends and Family % Response

Source: FFT data CIVICA



Friends and Family response rate

Expanding the methods used to collect feedback is important if we are to understand what matters to patients. The response rate is an area we set out to improve, and the data below demonstrates this has been achieved with a total of 3,555 more valuable pieces of feedback than what was collected in 2024–25.

Year	QR codes/ online surveys	Paper surveys	Telephone surveys	SMS text surveys	Total
2023–2024	3,016	10,944	2,112	46,471	62,543
2024–2025	973	13,661	910	49,936	65,480
2025–2026	1,217	15,587	404	51,827	69,035

In the year 2025–26 there has been a positive increase in the response rates overall of 5.43% on the previous year. Increases have been realised with paper surveys, online surveys and SMS text surveys. There has been a reduction in the telephone surveys which in part may be due to an increase in SMS text surveys, online surveys and paper preferences for service users. Staff are actively encouraging patients to complete the FFT before leaving the hospital, which in turn supports the increase in paper survey completion.

National Patient Survey results

Maternity Survey 2025

The survey was carried out, inviting responses from mothers who received care during April and July 2025. Compared to the 2024 survey, Lancashire Teaching Hospitals has significantly improved in 4 areas, and there are no areas identified as significantly worse.

Mothers reported very positive experiences, with 98% rating their overall care positively, 97% feeling treated with respect and dignity during labour and birth, 98% expressing confidence and trust in staff, and 98% feeling involved in decisions about their care during labour and birth.

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

Inpatient Survey 2024

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

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

Children and Young People's Survey 2024

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

Due to the change in sample period, data collection period, methodology and content the survey is not comparable to previous years. Based on the Care Quality Commission (CQC) we cannot compare the 2020 survey with the information in the 2024 survey due to the significant changes, most ratings were 'About the Same' compared to other Trusts.

Patient Experience and Involvement Service

Over the past year, we have strengthened our approach to understanding and engagement with patients and carers from diverse backgrounds, including individuals with protected characteristics and communities disproportionately affected by health inequalities. This has enabled us to maintain a clear focus while deepening our insight into their experiences and needs.

Inclusion and accessibility

Effective communication remains central to how we engage with our communities. To ensure our services are accessible to all, we have established a comprehensive communication framework designed to minimise barriers and support inclusive access.

Our translation and interpretation services offer a full 24 hour, seven day a week service for individuals who do not speak English. Language interpreters can be accessed on demand or pre booked for video consultations, available via an App, PC, or Trust mobile. Face to face interpretation continues to be provided for complex clinical discussions/procedures or sensitive conversations, with telephone interpretation also available when appropriate.

Our Deaf community continues to have access to a 24 hour, seven days a week British Sign Language (BSL) interpretation service. This includes video based support as an interim option, complimenting the preferred provision of face to face interpreters.

In recent years, we have strengthened this offer by providing staff and volunteers with an optional Deaf Awareness course. We are now progressing plans to introduce this as mandatory e learning to ensure all staff have a strong understanding of Deaf culture and communication needs.

Community involvement

Placing the voices of our patients and communities at the centre of decision making and service development remains fundamental to our approach. By involving people directly in shaping services, we help ensure that communities feel confident in accessing the support available to them and are empowered to manage their own health.

Our commitment to reducing health inequalities also extends beyond our clinical settings. Teams have continued to work within local communities, showcasing available services, increasing awareness, and providing education to help remove barriers to access. Data indicates that these targeted actions have contributed to a measurable increase in the uptake of our screening services.

The Trust has participated in a series of new initiatives aimed at addressing health inequalities across local communities. The meetings focus on local authority wards, and are chaired by Preston City Council, bringing together representatives from a wide range of organisations, including the Integrated Care Board (ICB), Lancashire and South Cumbria NHS Foundation Trust (LSCFT), St Catherine's Hospice, Preston North End, Places for People, Preston Muslim Forum, Age UK, and Lancashire County Council.

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

Improvements

The continued use of our reasonable adjustment flagging system has supported staff with a clear and efficient method for documenting the individual needs of our community. Our Volunteer Hospital Guide Service continues to play a valuable role in this regard, enabling patients to book support in advance and reduce anxiety associated with navigating our busy hospital sites.

The Trust's ongoing participation in the Sunflower Lanyard Hidden Disabilities Scheme remains well received, with more than 3,500 lanyards distributed to patients to date, alongside dedicated wristbands for our children's services.

A key focus this year has been proactive engagement with lesser heard groups. Feedback and personal stories have informed service developments such as:

- Installation of Qibla Muslim directional arrows in wards
- Use of photographs on catering menus to reduce communication barriers
- Improvements to Trust signage
- Addition of family rooms on wards
- Provision of pillows in ED waiting areas to improve comfort
- Recruitment of additional volunteer hospital guides

Our new Stoma friendly public toilet facilities have now been completed, and work is underway to introduce non gendered facilities for both staff and patients. In addition, Qibla signage has been installed across ward areas to support our Muslim communities, and new family rooms have been created to provide quiet, reflective spaces when needed.

The Patient Voice

A number of well established forums across the Trust provide patients with a platform to share their lived experiences, raise concerns, and influence improvements. This ongoing dialogue ensures that services remain responsive, inclusive and aligned with the needs of those we serve.

Forums include:

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

Patient Safety Partners

In December 2025 the Trust welcomed three new Patient Safety Partners, marking a significant strengthening of its commitment to robust safety governance, a transparent learning culture, and meaningful patient and carer involvement. The partners bring lived experience and an independent perspective that compliment clinical and operational expertise, ensuring that the patient and carer voice is consistently represented in decision-making. The partners attend identified committees and contribute to discussions on quality, risk, and improvement priorities. Their role includes supporting safety-improvement projects, reviewing data to highlight themes and learning opportunities and offering constructive challenge to ensure that care remains safe, equitable, and patient-centred. Working to a clear action plan, they are helping embed a culture in which patients, carers, and staff collaborate to shape safer services and strengthen organisational accountability.

Volunteers

Our volunteers provide a vital service to our Trust, generously dedicating their time to support our patients, families, visitors and staff. Whether motivated by a personal connection to our hospitals or a desire to develop new professional skills, every volunteers is highly valued. Currently we have around 330 volunteers.

Since 2024, we have been reporting volunteer activity data to NHS England, including both the number of active volunteers and the hours they contribute to our Trust. Our year to date total now stands at **9,846 recorded hours**. Importantly, this figure reflects the contributions of only **30% of our active volunteer workforce**, indicating that the true scale of volunteer impact is significantly higher than current reporting captures.

Examples of the Volunteer roles and activities undertaken during 2025–26

Stakeholder relations

Over the last few years in Lancashire and South Cumbria, a number of organisations have been working in a more collaborative way to develop integrated care. This includes NHS organisations, local authorities, the voluntary, community, faith and social enterprise (VCFSE) sector, hospices and local universities. We have already made great progress in improving the way our services work together and how we work as a partnership. In 2025–26, there have been many examples of collaborative work across the local health and care system against a number of key priorities including, but not exclusive to, urgent and emergency care, discharge and elective care recovery and financial recovery, amongst others. Examples of key stakeholder relations are set out below.

Integrated Care Board in Lancashire and South Cumbria

The Trust is part of the Lancashire and South Cumbria Integrated Care System (ICS). The role of the ICS has been focused on joining up health and care services, improving people's health and wellbeing, and to make sure everyone has the same access to services and gets the same outcomes from treatment.

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

The work of the ICS is directed by the Integrated Care Board (ICB). Working collaboratively with the Provider Trusts, the ICB has played a key role in 2025–26 on improving the financial recovery and leading the development of the clinical service redesign across the system.

Lancashire Place

The vision of Lancashire Place has focused on 'Living Better Lives in Lancashire', with the ambition to help the citizens of Lancashire to live longer, healthier, and happier lives. This will be achieved in partnership with the Lancashire and South Cumbria ICB and the provider trusts by improving health and care services through integrated working and addressing health and wellbeing inequality across the Lancashire Place. Priorities for 2025–26 included the development of integrated neighbourhood teams and improving urgent and emergency care pathways. Teams across Lancashire Place are participating in the national Frailty Collaborative which is focused on redesigning the clinical model of care for individuals living with frailty to provide care closer to home, reducing length of stay in hospital and improving discharge through testing of frailty attuned care bundles.

Lancashire and South Cumbria Provider Collaborative (PCB)

The five NHS Trusts in Lancashire and South Cumbria formed a Provider Collaborative in 2021 with the aim of better supporting patient care, creating a great place to work and reducing duplication to ensure the very best value for taxpayers' money. Trusts include Blackpool Teaching Hospitals NHS Foundation Trust, East Lancashire Hospitals NHS Trust, Lancashire and South Cumbria NHS Foundation Trust, Lancashire Teaching Hospitals NHS Foundation Trust and University Hospitals of Morecambe Bay NHS Foundation Trust. Each Trust Board has formally approved constituting the provider collaborative as a joint committee under s.65Z6 of the National Health Act 2006 with delegated functions and recognises its share of assets, liabilities, revenue and expenditure, associated with the operations of the collaborative, in the relative accounts.

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

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

The cost contribution from LTH to the PCB for 2025–26 was £630k.

One LSC

One Lancashire and South Cumbria (One LSC) brings together a number of central services from the five NHS trusts which make up the health system's Provider Collaborative. One LSC is a shared venture – all five Trusts have joint shared ownership – with East Lancashire Hospitals NHS Trust (ELHT) the host organisation employing One LSC colleagues on behalf of the other Trusts. The purpose of One LSC is to drive collaboration in corporate services to improve service quality, increase resilience and improve cost efficiency, ultimately to support better patient care. Colleagues from functions including HR, Finance, Digital, Estates and Facilities, and Procurement transferred to One LSC in November 2024, with Estates and Facilities colleagues from LTH transferring on 1 March 2026.

One LSC's development continues with the transformation of services planned to enable the realisation of benefits through the optimisation of shared central services.

Local networks

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

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

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

National networks

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

Many colleagues also hold professorships with academic institutions including the Chief Executive, Silas Nicholls, who is a Professor of Leadership and Healthcare Management – Institute of eMedicine, at University of Greater Manchester.

We also have a number of colleagues across the Trust who hold prestigious national positions, some examples are:

- Consultant in Critical Care Medicine and Anaesthesia, Professor Shondipon Lahais the president of the Intensive Care Society UK
- Advanced Critical Care Practitioner, Lisa Halsall, has been elected to chair the Advanced Practitioner in Critical Care Professional Affairs Group of Intensive Care Society UK.
- Consultant in Critical Care Dr Huw Twamley was appointed as the interim National Medical Examiner (NME) for England and Wales.
- Donna Peat, Advanced Clinical Practitioner in Respiratory Medicine, has also been appointed as the Asthma + Lung UK Champion for the Lancashire and South Cumbria Integrated Care Board (ICB).

REMUNERATION REPORT

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

- Sections 420 to 422 of the Companies Act 2006 (section 420(2) and (3), section 421(3) and (4) and section 422 (2) and (3) do not apply to NHS Foundation Trusts
- Regulation 11 and Parts 3 and 5 of Schedule 8 of the Large and Medium-sized Companies and Groups (Accounts and Reports) Regulations 2008 (SI 2008/410) ("the Regulations")
- Parts 2 and 4 of Schedule 8 of the Regulations as adopted by NHSI in the reporting manual
- Elements of the NHS Foundation Trust Code of Governance.

Remuneration Committees

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

Nominations Committee

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

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

The composition of the Committee during 2025–26 is detailed in the attendance summary below.

Nominations Committee attendance summary

Name of Committee member	A	B	Percentage of meetings attended (%)
Mike Thomas, Chair	1	1	100
Alistair Bradley, Appointed Governor	1	1	100
Janet Miller, Public Governor	1	1	100
Substitutes:			
Tom Ramsay, Staff Governor	1	1	100

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

Work of the Committee

The Committee met once in April 2025 to consider the outcome of the NED appraisals for 2024–25 as undertaken by the Chair.

The Committee reviewed the process of appointment of the Senior Independent Director.

Appointments, Remuneration and Terms of Employment (ARTE) Committee

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

In 2025 the Trust appointed Craig Carter, Interim CFO to the substantive position (with a start date to be confirmed). This followed immediately on from the wider unsuccessful recruitment exercise for the post undertaken in October 2024 and as such attracted no further cost implications for external agencies. The recruitment to the Chief Medical Officer in 2025 was undertaken with in-house support with no cost implications for external agency spend.

ARTE Committee attendance summary

Name of Committee member	A	B	Percentage of meetings attended (%)
Prof. Mike Thomas	4	4	100
Dr Tim Ballard	2	4	50
Prof StJohn Crean	2	4	50
Dr Karen Deeny	1	4	25
Adrian Leather	2	4	50
Uzair Patel	3	4	75
John Schorah	4	4	100
Prof. Tim Wheeler	2	4	50

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

Work of the Committee

During 2025–26, the Committee met on four occasions. The Committee meetings involved a range of business in line with its terms of reference which enabled it to:

- Receive feedback on the outcome of the Executive Directors' appraisals.
- Receive assurance on the re-alignment of Executive Director portfolios in response to additional work being undertaken at a system level, with the PCB or with other trusts
- Approve the substantive appointment of the Chief Finance Officer following an interim arrangement.
- Approve the appointment of the Chief Medical Officer

Annual Statement on remuneration

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

All Very Senior Manager (VSM) remuneration is considered in line with our VSM pay policy and the NHS Very Senior Manager Pay Framework (May 2025). As a Trust in National Oversight Framework 5, no inflationary uplift was made for any individual who has been in a VSM post with the trust for more than two years.

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

SENIOR MANAGERS' REMUNERATION POLICY

As detailed in the Chair's statement above, the remuneration policy is designed to attract and retain talented individuals to deliver the Trust's objectives at the most senior level, with a recognition that the policy has to take account of the pressures on public sector finances. This report outlines the approach adopted by the ARTE Committee when setting the remuneration of the Executive Directors and the other Executives who have authority or responsibility for directing or controlling the major activities of the organisation.

The following posts have been designated as fitting this criterion by the ARTE Committee and are collectively referred to as the senior Executives within this report:

Executive Directors

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

Other Executives

- Chief People Officer
- Director of Communications and Engagement
- Chief Strategy and Improvement Officer
- Director of Corporate Affairs

Details on membership of the ARTE Committee and individual attendance can be found on page 65 of this report.

Our policy on Executive pay

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

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

The remuneration package for senior Executives comprises:

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

The remuneration package for Non-Executive Directors comprises:

Salary:	As determined by the Council of Governors and reviewed in line with the national guidance on remuneration of Non-Executive Directors. Current rates are: • £13,000 p.a. for Non-Executive Directors • £6,500 p.a. for Associate Non-Executive Directors (none currently) • £2,000 p.a. as additional responsibility payment payable to the Vice Chair, Senior Independent Director and Ockenden Champion • £55,000 p.a. for the Chair (with effect from 1 December 2025 this dropped to £45k p.a. to reflect the additional responsibilities undertaken by the post holder for the separate role of chair of East Lancashire Teaching Hospitals carrying a total remuneration of £90k p.a.)
Additional benefits:	• Gym membership discounts with NHS identification • Access to NHS staff benefits offered by retailers • Onsite therapies at discounted rates • Salary sacrifice schemes

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

Our Non-Executive Directors are requested to provide three months' notice in the event that they wish to resign before their term of office comes to an end. They are not entitled to any compensation for early termination. During the year no Executive Director, Non-Executive Director or Very Senior Manager received a payment for loss of office.

Annual report on remuneration

Business expenses

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

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

	2025–26	2024–25
Total number of Directors who served during the year:	19	28
Number of Directors receiving expenses:	6	6
Aggregate sum of expenses paid to Directors (£00s):	£2,669	£779

Salary and pension contributions of all Directors and senior Executives

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

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

Remuneration Report 2025–26

		2024–25				2025–26			
Name	**Title**	**Salary and Fees** (bands of £5,000)	**Expense Payments** (taxable) (to the nearest £100)	**All pension related benefits** (bands of £2,500)	**TOTAL of all items** (bands of £5,000)	**Salary and Fees** (bands of £5,000)	**Expense Payments** (taxable) (to the nearest £100)	**All pension related benefits** (bands of £2,500)	**TOTAL of all items** (bands of £5,000)
		£'000	**£**	**£'000**	**£'000**	**£'000**	**£**	**£'000**	**£'000**
Silas Nicholls (1)	Chief Executive Officer	260–265	1,300	0	260–265	270–275	2,000	0	270–275
Sarah Morrison (2)	Chief Nursing Officer / Interim Deputy Chief Executive Officer from 1 October 2024	160–165	1,100	12.5–15.0	175–180	185–190	1,700	55.0–57.5	245–250
Katie Foster-Greenwood	Chief Operating Officer from 12 August 2024	90–95	3,600	62.5–65.0	155–160	150–155	6,900	140.0–142.5	300–305
Emma Ince	Interim Chief Operating Officer from 10 June to 29 August 2024	30–35	1,000	0	30–35	0	0	0	0
Imran Devji	Interim Chief Operating Officer to 9 June 2024	25–30	0	10.0–12.5	40–45	0	0	0	0
Craig Carter	Interim Chief Finance Officer from 1 May 2025	0	0	0	0	170–175	0	62.5–65.0	235–240
David Stonehouse	Interim Chief Finance Officer from 2 September 2024 to 30 April 2025	100–105	0	0	100–105	15–20	0	0	15–20
Jonathan Wood	Chief Finance Officer / Deputy Chief Executive to 1 September 2024	80–85	500	0	80–85	0	0	0	0
Steve Canty	Chief Medical Officer from 1 October 2025	0	0	0	0	100–105	0	135.0–137.5	240–245

		2024–25				2025–26			
Geraldine Skailes	Chief Medical Officer to 30 September 2025	225–230	800	20.0–22.5	250–255	115–120	0	75.0–77.5	190–195
Ailsa Brotherton	Director of Continuous Improvement and Transformation	140–145	0	105.0–107.5	245–250	145–150	0	80.0–82.5	225–230
Jennifer Foote (3)	Director of Corporate Affairs (SIRO)	120–125	0	30.0–32.5	150–155	145–150	0	32.5–35.0	180–185
Naomi Duggan	Director of Communications and Engagement	130–135	0	25.0–27.5	155–160	135–140	0	50.0–52.5	185–190
Neil Pease (4)	Chief People Officer (joint post with ELHT from 01/05/2025)	150–155	0	0	150–155	95–100	0	0	95–100
Stephen Dobson	Chief Information Officer to 30 June 2024	40–45	0	7.5–10.0	50–55	0	0	0	0
Gary Doherty	Director of Strategy and Planning to 7 January 2025	115–120	0	0	115–120	0	0	0	0
Angela Mulholland-Wells	Operational Director of Finance to 6 October 2024	65–70	0	45.0–47.5	110–115	0	0	0	0
Mike Thomas (5)	Chair from 1 January 2025	10–15	0	0	10–15	50–55	0	0	50–55
Peter White	Chair to 31 December 2024	40–45	0	0	40–45	0	0	0	0
Adrian Leather	Vice / ChairNon-Executive Director from 1 March 2025	0–5	0	0	0–5	10–15	0	0	10–15
Paul O'Neill	Vice Chair / Non-Executive Director to 2 March 2025	10–15	0	0	10–15	0	0	0	0
Tim Watkinson	Senior Independent Director to 31 March 2025	15–20	0	0	15–20	0	0	0	0
Karen Deeny	Non-Executive Director from 1 March 2025	0–5	0	0	0–5	10–15	0	0	10–15
Tim Ballard	Non-Executive Director	10–15	0	0	10–15	10–15	0	0	10–15
StJohn Crean (6)	Non-Executive Director from 3 March 2025	0–5	0	0	0–5	10–15	0	0	10–15
John Schorah	Non-Executive Director from 1 March 2025	0–5	0	0	0–5	10–15	0	0	10–15

		2024–25				2025–26			
Tim Wheeler	Non-Executive Director from 1 April 2025	0	0	0	0	10–15	0	0	10–15
Victoria Crorken	Non-Executive Director to 7 February 2025	10–15	0	0	10–15	0	0	0	0
Kate Smyth	Non-Executive Director to 28 February 2025	10–15	0	0	10–15	0	0	0	0
Jim Whitaker	Non-Executive Director to 1 July 2024	0–5	0	0	0–5	0	0	0	0
Tricia Whiteside	Non-Executive Director to 28 February 2025	10–15	0	0	10–15	0	0	0	0
Uzair Patel	Non-Executive Director from 2 July 2024	5–10	0	0	5–10	10–15	0	0	10–15
Uzair Patel	Associate Non-Executive Director from 1 October 2023 to 1 July 2024	0–5	0	0	0–5	0	0	0	0
Michael Wearden	Associate Non-Executive Director to 9 June 2024	0–5	0	0	0–5	0	0	0	0
Peter Wilson (7)	Associate Non-Executive Director to 15 June 2024	0–5	0	0	0–5	0	0	0	0
Jonathan Wood (8)	Managing Director of Lancashire & South Cumbria Provider Collaborative from 2 September 2024	105–110	700	0	105–110	185–190	1,800	7.5–10.0	195–200

Notes:

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

Non Executive Directors do not receive any pensionable remuneration.

(1) Pay for 2025/26 includes additional pay (£8.5k) for additional roles taken on in year: Lead CEO for the Lancashire and South Cumbria Provider Collaborative Board (PCB) and Lead CEO for the Lancashire and South Cumbria Integrated Care Board (ICB).

(2) Pay for 2025/26 includes backdated additional responsibility remuneration (£8k) for appointment to Deputy Chief Executive Officer from December 2024.

(3) Pay for 2025/26 includes backdated additional responsibility remuneration (£8k) for being appointed as the Trust's Senior Information Risk Owner (SIRO) from October 2024.

(4) From the 14th May the Chief People Officer post was shared with East Lancashire Hospital Trust (ELHT). The amount shown in the table above is the Trust's share of their remuneration. Total remuneration £175,000-£180,000.

(5) From the 15th December the Chair was appointed as Interim Chair for East Lancashire Hospital Trust whilst continuing as Chair of the Trust. The amount shown in the table above is the Trust's share of their remuneration with ELHT being recharged for their share of the remuneration. Total remuneration £65,000-£70,000.

(6) The amount disclosed is the amount recharged by the University of Central Lancashire for this post.

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

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

Pension benefit

	2025–26							
Name	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2026 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2026 (bands of £5,000) £000	Cash Equivalent Transfer Value at 1 April 2025 £000	Real increase in Cash Equivalent Transfer Value (CETV) £000	Cash Equivalent Transfer Value at 31 March 2025 £000	Employer's contribution to stakeholder pension £000
Silas Nicholls Chief Executive Officer (1)	0	0	0	0	0	0	0	0
Sarah Morrison Deputy Chief Executive / Chief Nursing Officer	2.5–5.0	0.0–2.5	45–50	110–115	874	48	957	0
Katie Foster-Greenwood Chief Operating Officer	5.0–7.5	12.5–15.0	50–55	125–130	952	141	1,128	0
Craig Carter Chief Finance Officer	2.5–5.0	2.5–5.0	45–50	105–110	777	52	865	0
Geraldine Skailes Chief Medical Officer (2)	2.5–5.0	0	15–20	0	212	65	295	0
Steve Canty Chief Medical Officer	5.0–7.5	12.5–15.0	75–80	190–195	1,380	143	1,718	0
Neil Pease Chief People Officer (3)	0	0	0	0	0	0	0	0
Ailsa Brotherton Director of Continuous Improvement and Transformation	2.5–5.0	0	85–90	0	1,392	87	1,521	0
Naomi Duggan Director of Communications and Engagement	2.5–5.0	0	35–40	0	537	47	610	0
Jennifer Foote Director of Corporate Affairs (SIRO)	0.0–2.5	0	5–10	0	104	26	149	0
Jonathan Wood Managing Director of the Lancashire & South Cumbria Provider Collaborative	0.0–2.5	0	80–85	200–205	1,845	23	1,921	0

Notes:

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

(2) Geraldine Skailes retired and took their pension in September 2025.

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

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

Fair pay disclosure

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

The banded remuneration of the highest-paid director in Lancashire Teaching Hospitals NHS Foundation Trust in the financial year 2025–26 was £270,000 - £275,000 (2024–25, £260,000 - £265,000). This is a change between years of 3.8% (2024–25, 4.0%). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

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

Pay ratio information

	2025–26			2024–25		
	25th percentile	Median	75th percentile	25th percentile	Median	75th percentile
Total remuneration (£)	26,598	37,796	50,273	25,674	33,796	47,037
Salary component of total remuneration (£)	26,598	37,796	50,273	25,674	33,796	47,037
Pay ratio information	10.2	7.2	5.4	10.2	7.8	5.6

In 2025–26, 9 employees (2024–25, 14) received remuneration in excess of the highest-paid director and remuneration ranged from £10 to £376,714 (2024–25, £10 to £382,269).

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

The average percentage change from the previous financial year for salaries and allowances (based on total for all employees on an annualised basis, divided by full time equivalent number of employees; (both excluding the highest paid director) for employees of the Trust as a whole is 3.4% (2024–25, 3.4%). On the same basis, the average percentage change from the previous financial year for performance pay and bonuses payable due to clinical excellence award payments is down 4.3% (2024–25 down 38.6%).

The Group Accounting Manual requires temporary agency staff to be included within the above median pay disclosures. Temporary agency staff costs equated to £3.97m in the year (2024–25, £10.1m). We have included information from our main agency staffing provider to calculate a meaningful annualised cost per temporary staff member for 2025–26 that is consistent with the information was included in the prior year calculation.

Non-executive directors (NEDs) are outside the scope of fair pay disclosures and have been excluded from the calculation for 2025–26. The prior year disclosure does include NEDs and has not been restated to exclude them as it is considered negligible to the total remuneration cost.

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

Professor Silas Nicholls
Chief Executive
25 June 2026

STAFF REPORT

Our people

As at 31 March 2026, we employed 8,230 substantive members of staff. This number is broken down as shown in the below table; note that some staff hold roles that fall under different staff groups, thus the figures in the below table do not sum to the stated distinct headcount.

Staff Group	Headcount
Additional Clinical Services	1,833
Additional Professional, Scientific and Technical	242
Administrative and Clerical (inc. NEDs)	1,269
Allied Health Professionals	730
Estates and Ancillary	10
Healthcare Scientists	287
Medical and Dental (excl. Lead Employer Doctors)	962
Nursing and Midwifery Registered	2,897

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

	2025–26 HC	% of Total HC	2024–25 HC	% of Total HC	2023–24 HC	% of Total HC
Age (years)						
Under 20	405	4.9%	367	3.9%	63	0.6 %
20 - 29	909	11.0%	1,222	12.9%	1,849	17.9 %
30 - 39	2,426	29.5%	2,584	27.4%	2,800	27.1 %
40 - 49	2,017	24.5%	2,207	23.4%	2,332	22.6 %
50 - 59	1,650	20.0%	1,972	20.9%	2,143	20.8 %
60 - 69	772	9.4%	1,019	10.8%	1,071	10.4 %
70 and over	51	0.6%	66	0.7%	65	0.6 %
Ethnicity						
BAME: Asian	1,882	22.9%	2,114	22.4%	2,167	21.0 %
BAME: Black	350	4.3%	363	3.8%	361	3.5 %
BAME: Mixed	133	1.6%	153	1.6%	158	1.5 %
BAME: Other	154	1.9%	153	1.6%	152	1.5 %
White: Other	211	2.6%	289	3.1%	313	3.0 %
White: UK & ROI	5,429	66.0%	6,253	66.3%	7,043	68.2 %
Not Stated	71	0.9%	112	1.2%	129	1.2 %
	2025–26 HC	% of Total HC	2024–25 HC	% of Total HC	2023–24 HC	% of Total HC
Legal Sex						
Male	1,670	20.3%	2,230	23.6%	2,473	24.0 %
Female	6,560	79.7%	7,207	76.4%	7,850	76.0 %
Recorded Disability	575	7.0%	585	6.2%	567	5.5 %

As at 31 March 2026, the gender split of our Board of Directors (including Non-Executive Directors) was ten male and six female. The gender split of our senior executives, as defined by the Appointment, Remuneration and Terms of Employment Committee, was three male and five female, with an average age of 54 years.

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

Attendance management

Sickness absence data is reported on a calendar year basis (January to December 2025):

Figures Converted by Department of Health to Best Estimates of Required Data Items:	
Average FTE 2025	8,577
Adjusted FTE days lost (to Cabinet Office definitions)	120,736
Average sick days per FTE	14.1
Statistics published by NHS Digital from ESR Data Warehouse:	
FTE days available	3,120,357
FTE days recorded sickness absence	195,190

Source: NHS Digital - Sickness Absence and Publication - based on data from the ESR Data Warehouse
Period covered: 01 January 2025 to 31 December 2025

The 12-month average sickness absence rate for the period 1 January to 31 December 2025 was 6.34%; an improvement compared to 6.47% in the previous year. The proportional split of this between short-term sickness (less than 28 days) and long-term sickness (28 days or more) was different to the previous year, with a greater proportion of sickness absence categorised as long-term. The annualised short-term absence rate was 2.09% compared to 2.36% in 2024 and the long-term absence rate was 4.26% compared to 4.11% in 2024.

Mental health continues to be the top reason for working days lost due to sickness absence, equating to 28.8% of the overall sickness absence rate in 2025. Back and other musculoskeletal reasons collectively equated to 15%. Consequently, our health and wellbeing strategy proactively focused on interventions to support psychological wellbeing and musculoskeletal health. Over 150 Mental Health First Aiders were trained throughout the year, and 10 'Wellbeing Cafes' were facilitated. The Occupational Health Physiotherapist service was strengthened during the year, with the appointment of a second substantive Physiotherapist; and service developments have progressed, including a telephone triage clinic.

Flu vaccination uptake significantly increased in our winter 2025 campaign, with 46.5% of colleagues that deliver direct patient care receiving the flu jab, compared to 32.4% in 2024. This may have been a contributing factor towards a much lower sickness absence rate during the winter months than the previous year.

The wellbeing of our workforce is a key organisational priority, and in addition to health and wellbeing interventions, a range of steps have been taken to equip managers to support colleagues and manage sickness absence. This includes launch of a new Attendance Management policy, toolkit resources and a comprehensive educational programme. Priorities for the next year will focus on more bespoke work with teams, rehabilitation pathways following long-term sickness and continuing to evolve our wellbeing approach, in particular to address health inequalities within the workforce.

Equality, Diversity and Inclusion

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

The greatest representation of minority ethnic colleagues in non-clinical roles are in band 2 and below (below band 1 tend to be apprentices). Across the remaining bands ethnic minority colleagues are underrepresented across all other non-clinical bands when compared against the overall non-clinical ethnic minority workforce (19.4%). Representation at band 3 (15.1%) and at 8d (11.1%) are the closest remaining bands to the 19.4% overall representation figure for the non-clinical workforce. A key aspect to note is the reduction in overall workforce numbers from 2024 (10,323) to 2025 (9,471), most of which have been seen across the non-clinical workforce.

From a clinical workforce perspective, the highest percentage of minority ethnic colleagues can be found in band 5 roles (49%). With the exception of band 2 and band 5 clinical roles, minority ethnic colleagues are underrepresented in all other bands when compared against the overall clinical minority ethnic workforce (29.4%). Representation at band 6, band 7 and band 8a have all increased on the previous year.

From a medical and dental workforce perspective, the highest percentage of minority ethnic colleagues can be found in trainee roles (72.3%). There has been an increase in minority ethnic representation at Consultant level (52.7% to 53.5%) and at Senior Medical Manager level (42.2% to 46.6%) from the previous year.

The percentage of colleagues who have disclosed a disability/long-term condition (LTC) in our Electronic Staff Record (ESR) dropped slightly from the previous year with 5.9% (down from 6.1%) of our non-clinical workforce recording they have a disability/LTC and 5.7% (down from 5.8%) of our clinical workforce.

There is a fairly even representation of colleagues with a disability/LTC across most bands in non-clinical roles with band 2 (5.7%), band 7 (5.7%) and band 8c (5.6%) . Representation at band 6 level is significantly lower at 2.6% and there continues to be no representation at bands 8d or 9. Significant over-representation can be seen at VSM level with 14.3% of non-clinical colleagues declaring a disability or long-term condition. A similar picture can be seen when reviewing representation of colleagues with a disability/LTC across clinical roles; bands 5, 7 and 8c fall slightly below the 5.7% overall Trust representation figure, with significantly less representation at band 8b (1.6%) and no representation at band 8d or band 9. Again, significant over-representation can be seen at VSM level with 50% of clinical colleagues declaring a disability or long-term condition.

Our WDES staff survey data also told us 79% of colleagues who have a disability or LTC say the organisation has made reasonable/adequate adjustments to enable them to carry out their work. This is above the national average for this measure (74%) and is an improvement on the previous year's result (78%). There has been a continued improvement in the proportion of colleagues with a disability/LTC who report feeling under pressure to come into work when not feeling well enough (-1.6%). This is also better than the national average (80% vs 78%). Over the past 12 months we have continued to promote the adoption of a compassionate approach to colleagues with a disability/LTC – this work will continue through both through the delivery of actions associated with our Equality, Diversity & Inclusion strategy in addition to educational programmes, such as our Managers Update sessions and our Core People Management Skills programme for line managers.

Occupational Health

As in previous years, in 2025–26 there were three services making up our Occupational Health offer for our workforce:

1. Services related to pre-employment screening, management referrals, immunisations, health surveillance and support for needle-stick injuries were provided by Wellbeing Partners (our joint venture with Wigan, Wrightington and Leigh NHS Foundation Trust).
2. The Occupational Health Physiotherapy service is delivered in-house with professional leadership from our Core Therapies team. The service exists to provide rapid access assessment and treatment for colleagues suffering from musculoskeletal injuries or conditions.
3. Psychological Wellbeing services are also provided in-house by our team of Clinical Psychologists, Cognitive Behavioural Therapists, Counsellors, and Psychological Wellbeing Practitioners. .

Staff engagement and consultation

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

As part of our strategic aim to be a great place to work, our annual programme of work includes measuring, understanding and taking action to deliver improvements in staff engagement, satisfaction and overall experience of work. This is delivered through a range of methods below includes some examples of the ways we engage and listen to colleagues throughout the colleague lifecycle:

- Onboarding and welcome
- Survey opportunities
- Internal opportunities to engage
- Trust engagement opportunities
- Team level engagement

TED Tool (Team Engagement and Development)

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

NHS staff survey

The response rate to the 2025–26 survey among Trust staff was 45.1% (4,271 colleagues engaged) which shows an increase in comparison to 2024–25 which was 39% (3,994 colleagues engaged).

Indicators ('People Promise' elements and themes)	2025–26		2024–25		2023–24	
	Trust score	Benchmarking group score	Trust score	Benchmarking group score	Trust score	Benchmarking group score
People Promise:						
We are compassionate and inclusive	**7.12**	7.28	**7.15**	7.21	**7.30**	7.24
We are recognised and rewarded	**5.83**	5.87	**5.90**	5.92	**6.06**	5.94
We each have a voice that counts	**6.51**	6.60	**6.60**	6.67	**6.77**	6.70
We are safe and healthy	**6.04**	6.07	**6.03**	6.09	**6.25**	6.08
We are always learning	**5.54**	5.57	**5.53**	5.64	**5.66**	5.62
We work flexibly	**6.19**	6.22	**6.18**	6.24	**6.42**	6.20
We are a team	**6.71**	6.75	**6.75**	6.74	**6.86**	6.75
Staff engagement	**6.49**	6.74	**6.63**	6.84	**6.91**	6.91
Morale	**5.68**	5.84	**5.72**	5.93	**6.02**	5.90

The 2025 results indicate relative stabilisation following a period of decline. While the Trust now sits slightly below the national average across several People Promise themes including Staff Engagement, Morale, We Are Always Learning, We Are Safe and Healthy and We Each Have a Voice That Counts.

The Trust achieved a response rate of 45.1%, which remains 1.9% below the national benchmark but represents a significant improvement from 39% in the previous year (a 6.1 percentage point increase year on year).

This improvement is likely attributable to a more structured and coordinated survey approach, including a comprehensive communications and launch pack, clearer and consistent Trust-wide messaging, targeted engagement activity.

Priorities and targeted actions

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

1. **Colleague Health and Wellbeing**

   Strengthen awareness and address the level of burn out and wellbeing concerns reported to targeted teams and exploring how our corporate offer can further support improvements.

2. **Colleague Sexual Safety:**

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

3. **Colleague Health, Safety & Physical Violence:**

   Address experiences of personal safety by further embedding our Zero Tolerance approach to support colleagues to feel safe at work.

4. **Raising Concerns:**

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

5. **Recognition:**

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

6. **Equality, Diversity & Inclusion (EDI):**

   Understand how experience varies across different protected characteristic groups/sub groups and take actions to understand how to close the gaps.

7. **Advocacy in Patient Care and Place to Work:**

   Address the different perceptions around quality of care and the declining advocacy scores to find ways to support and increase feelings of trust and engagement with the organisation and pride in patient care.

8. **Support and Development for Managers:**

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

9. **Bespoke OD Team Development Work:**

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

10. **Response Rates:**

    Continue to improve response rates and take action to ensure stronger representation in colleague feedback and reaching national benchmark target.

Monitoring performance and tracking impact

Regular monitoring and internal reporting takes place within the Organisational Development Team, monthly Divisional Workforce Committees, Monthly Single Improvement Plan reports and annually to our Trust Workforce Committee and Board. Progress is tracked through analysing results of our engagement surveys, retention data, and wider colleague feedback.

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

Learning and development 2025–26

Overview

During 2025–26, the Trust continued to strengthen its role as a major regional provider of education and training, supporting the development of a skilled, compassionate, and future-ready workforce. Education is a critical enabler of the Trust's strategic ambitions - improving quality and safety, enhancing workforce capability, and securing the long term sustainability of clinical services.

Mandatory and core skills training

The Trust sustained strong performance in Mandatory and Core Skills training, maintaining compliance above the required threshold for all nationally mandated subjects. Strengthened governance arrangements ensured training requirements remained current, evidence based, and aligned to national standards. This sustained compliance provides assurance that colleagues have the fundamental knowledge and skills required to work safely and effectively.

Developing the future workforce

The Trust continued to be a key clinical education provider across the North West, supporting large numbers of nursing, midwifery and allied health professional students, as well as medical undergraduates and trainees. Placement capacity remained strong, supported by close partnership working with regional universities and further education institutions.

The Practice Based Pathway for Nursing continued to expand, offering a distinctive hospital based training model that blends academic study with hands on clinical experience. This pathway strengthens the local supply of newly qualified nurses and reinforces the Trust's commitment to innovative approaches to workforce development.

Medical education has expanded, with the Trust delivering full undergraduate curricula for partner medical schools and enhancing postgraduate support, induction and supervision arrangements. The Trust remained one of the highest performing organisations in the region for national training compliance for rotational doctors. Focus on learner wellbeing, pastoral support and transition to practice continued to be integral to the Trust's medical education offer.

The Trust strengthened its Advanced Practice education framework during 2025–26, creating clearer development pathways, more consistent supervision and improved support for clinicians progressing into advanced roles.

Strengthening clinical education and skills

During 2025–26, the Trust strengthened the way it supports staff to maintain and develop clinical skills by bringing all education functions together into a single, coordinated framework. This approach provides clearer leadership, stronger governance, and a more consistent standard of training across the organisation. It ensures that education activity is aligned to areas of highest clinical risk and supports the delivery of safe and effective care.

A unified clinical education function has enabled the Trust to improve how it monitors workforce capability, how it prioritises skills development, and how it supports colleagues as they join the organisation or move into new roles. This has strengthened confidence that staff have the competencies required for the environments in which they work.

Apprenticeships and widening participation

Apprenticeships remained a vital route into employment and progression. The Trust expanded its apprenticeship portfolio across clinical and non clinical areas, strengthening the supply of Health Care Support Workers, Senior Health Care Support Workers and Learning and Skills Mentors. Achievement rates remained strong, and the Trust was recognised within regional apprenticeship awards.

Widening participation activity continued to support the Trust's role as an anchor institution. Through targeted community partnerships, employability programmes and work experience opportunities, the Trust enabled young people, career changers and under represented groups to access NHS careers. These programmes contribute to long term workforce sustainability and support broader social value commitments.

Support for staff – involvement/education

This year saw the Involvement Services establish a link with our apprenticeship programme and now contribute to sessions delivered by educators training Level 3 Senior Healthcare Support Worker apprentices.

This initiative aims to ensure that staff are comprehensively equipped with the knowledge and skills necessary to provide inclusive, patient-centred care. By embedding these elements into apprenticeship training, we aim to foster a workforce that is informed, empathetic, and responsive to the diverse needs of our patient population. It is hoped by educating and supporting the staff in this way they will have the knowledge and support they need to make for a better patient experience.

Education governance and quality

Education governance remained focused on quality, assurance and continuous improvement. The Trust strengthened its evaluation and feedback mechanisms, enabling more robust understanding of learner experience across professions and settings. Engagement in national and regional forums such as the GMC National Training Survey and the Safe Learning Environment Charter reinforced the Trust's commitment to high quality learning environments and positive education cultures.

Staff Costs

			2025–26	2024–25
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	441,441	32,659	474,100	462,024
Social security costs	52,906	3,913	56,819	46,226
Apprenticeship levy	2,192	162	2,354	2,307
Employer's contributions to NHS pension scheme	77,366	5,722	83,088	80,549
Pension cost – other	142	-	142	130
Temporary staff	-	3,973	3,973	10,106
Total gross staff costs	**574,047**	**46,429**	**620,476**	**601,342**
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	**574,047**	**46,429**	**620,476**	**601,342**
Of which				
Costs capitalised as part of assets	1,755	245	**2,000**	3,101

Average number of employees (WTE basis)

			2025–26	2024–25
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	1,121	98	**1,219**	1,207
Ambulance staff	-	-	**-**	-
Administration and estates	2,191	64	**2,255**	2,374
Healthcare assistants and other support staff	1,664	304	**1,969**	2,170
Nursing, midwifery and health visiting staff	2,610	177	**2,787**	2,885
Nursing, midwifery and health visiting learners	-	-	**-**	-
Scientific, therapeutic and technical staff	836	14	**850**	823
Healthcare science staff	276	8	**284**	273
Social care staff	-	-	**-**	-
Other	28	-	**28**	31
Total average numbers	**8,726**	**665**	**9,391**	**9,764**
Of which:				
Number of employees (WTE) engaged on capital projects	25	1	**26**	52

Off-payroll arrangements

None for 2024–25. None for 2025–26

Staff exit packages

	2025–26			2024–25		
Exit packages cost band including any special payment element	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**
<£10,000	5	53	**58**	1	52	**53**
£10,000 - £25,000	4	4	**8**	1	6	**7**
£25,001 - £50,000	3	2	**5**	2	3	**5**
£50,001 - £100,000	2	-	**2**	-	-	**-**
£100,001 - £150,000	1	-	**1**	-	-	**-**
£150,001 - £200,000	1	-	**1**	-	-	**-**
>£200,000	-	-	**-**	-	-	**-**
Total number of exit packages by type	16	59	**75**	4	61	**65**
Total resource cost	£605,000	£308,000	**£913,000**	£105,000	£411,000	**£516,000**

Exit packages: non-compulsory departure payments

	2025–26		2024–25	
	Payments agreed	**Total value of agreements**	**Payments agreed**	**Total value of agreements**
	Number	**£000**	**Number**	**£000**
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations contractual costs	2	79	10	172
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	57	229	51	239
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**59**	**308**	**61**	**411**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	-	-	-	-

Value of special severance payments approved by NHS Improvement

No special severance payments were submitted to NHSE for approval in 2025–26.

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

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

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

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

Comply or explain

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

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

Mandatory disclosures

Code ref.	Summary of requirement	See page(s):
A.2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	13–14 62–63
A.2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce	13 62–63 73–80
A.2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements	13 62–63

Code ref.	Summary of requirement	See page(s):
B.2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: • has been an employee of the trust within the last two years • has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme • has close family ties with any of the trust's advisers, directors or senior employees • holds cross-directorships or has significant links with other directors through involvement with other companies or bodies • has served on the trust board for more than six years from the date of their first appointment • is an appointed representative of the trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.	32–34
B.2.13	The annual report should give the number of times the board and its committees met, and individual director attendance.	39–41 64–65
B.2.17	For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors.	43–47
C.2.5	If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.	87
C.2.8	The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.	38 64
C.4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience	32–37
C.4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.	100
C.4.13	The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served • the gender balance of senior management and their direct reports	64 73–75
C.5.15	Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	43–47

Code ref.	Summary of requirement	See page(s):
D.2.4	The annual report should include: • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed • an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans • where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	39 104–105
D.2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy	88
D.2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	89–106
D.2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	89–106
D.2.9	The annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare.	22 92–108
E.2.3	Where a trust releases an executive director, eg to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	N/A
Appendix B, para 2.3 (not in Schedule A)	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	43–47
Appendix B, para 2.14 (not in Schedule A)	The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS foundation trust's website and in the annual report.	43–47
Appendix B, para 2.15 (not in Schedule A)	The board of directors should state in the annual report the steps it has taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, eg through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations	43–47
FT ARM Annex 7 to chapter 2	**The Task force on climate-related financial disclosures (TFCD)** NHS Foundation Trusts are required to follow the 'task force on climate-related financial disclosure' requirements on a comply or explain basis. Entities should disclose how they identify, assess and manage climate related risks as part of the risk management pillar. Metrics and targets used in assessment and management of climate issues should also be disclosed.	25–30
FT ARM S. 2.23	information on the trust's work to tackle health inequalities, including the extent to which the trust has exercised its functions consistent with NHS England's statement under section 13SA(1) of the NHS Act 2006 on how NHS bodies should exercise their powers to collect, analyse and publish information related to health inequalities	17–18

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

Other disclosures in the public interest

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

Summary of disclosure	See page(s):
Actions taken to maintain or develop the provision of information to, and consultation with, employees.	75–80
The foundation trust's policies in relation to disabled employees and equal opportunities.	75–78
Information on health and safety performance and occupational health.	25 74–76
Information on policies and procedures with respect to countering fraud and corruption.	24
Statement describing the better payment practice code, or any other policy adopted on payment of suppliers, performance achieved and any interest paid under the Late Payment of Commercial Debts (Interest) Act 1998.	20
Details of any consultations completed in the previous year, consultations in progress at the date of the report, or consultations planned for the coming year.	43–44 62–63
Consultation with local groups and organisations, including the overview and scrutiny committees of local authorities covering the membership areas.	59–61
Any other public and patient involvement activities.	56–59
The number of and average additional pension liabilities for, individuals who retired early on ill-health grounds during the year.	Note 8.1 To the accounts
Detailed disclosures in relation to "other income" where "other income" in the notes to the accounts is significant.	Note 3 Note 3.1 To the accounts
A statement that the NHS Foundation Trust has complied with the cost allocation and charging guidance issued by HM Treasury.	22
Sickness absence data.	74
Details of serious incidents involving data loss or confidentiality breach.	103–104

Voluntary disclosures

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

Summary of disclosure	See page(s):
Sustainability / environmental reporting	25–30
Equality reporting	75–78
Slavery and human trafficking statement (Modern Slavery Act 2015)	24

NHS OVERSIGHT FRAMEWORK

The new NHS Oversight Framework 2025–26 describes a consistent and transparent approach to assessing NHS trusts and foundation trusts, ensuring public accountability for performance and providing a foundation for how NHS England works with systems and providers to support improvement. The framework is supported by a focused set of national priorities, including those set out in the planning guidance for 2025–26, aiming to strengthen local autonomy. These are presented alongside wider contextual metrics that reflect medium-term goals in areas such as inequalities and outcomes. The contextual metrics do not constitute part of the score but will inform how NHS England responds to segmentation.

The NHS priorities and operational planning guidance 2025–26 made it clear that achieving a financial reset this year is a priority. It set the expectation that every provider must deliver a balanced net system financial position in collaboration with its system partners. The approach of NHS England will mean that unless providers are delivering a surplus or breakeven position, their segmentation will be limited to no better than 3. Entry into segment 5 will be reserved for the most challenged organisations that require the most support to improve.

Segmentation

The continuing challenges faced by the Trust in respect of finance and performance led to a decision by NHSE to move the Trust into segment 5 for 2025–26. As a result the Trust received support from the National Recovery Support Programme (RSP) throughout the year. In October 2025 a decision was taken by NHS England to impose an Additional Licence Condition pursuant to Section 111 of the Health and Social Care Act 2012 – 'Additional governance arrangements'. This was out in place to ensure that the newly appointed board would remain in place to give a degree of stability in leadership as the Trust improved and moved on from segment 5 and the RSP.

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

STATEMENT OF ACCOUNTING OFFICER'S RESPONSIBILITIES

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

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

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

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

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

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

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

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

Professor Silas Nicholls
Chief Executive
25 June 2026

ANNUAL GOVERNANCE STATEMENT 2025–26

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Lancashire Teaching Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Lancashire Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2026 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Leadership and accountability

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

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

Accountability arrangements for risk management in 2025–26:

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

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

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

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

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

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

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

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

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

(j) The Nominated Individual with the Care Quality Commission (CQC) is the Chief Nursing Officer/Deputy Chief Executive.

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

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

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

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

Training and learning

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

This included face to face Risk Management Workshops and an e-learning package, which has now been rolled out across the Trust.

The Trust has transitioned to a new Risk Management System (Ulysses) in this financial year. Additional training has been provided to support its use and will continue to be provided before access is granted to relevant modules.

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

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

During 2025–26, a risk workshop took place to provide training for Executive and Non-Executive Directors. As part of the session, the risk appetite and tolerances were reviewed and subsequently approved by the Board of Directors.

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

The risk and control framework

The management of risk

Risk management is a fundamental part of operational working and service delivery. It is the responsibility of all employees and requires commitment and collaboration of both clinical and non-clinical staff.

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

(a) A Risk Management Strategy 2024–27, approved by the Board of Directors in February 2024;

(b) The Trust's Risk Management Policy;

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

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

(e) Organisational risk management structures;

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

(g) Incident reporting;

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

(i) The Board Assurance Framework.

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

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

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

Risk Management strategy

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

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

- The Trust procured a new Risk Management System in 2025–26, which went live on 28th January 2026 across the Trust.
- A reduction of 20 high risks in year 2 of the strategy, which exceeds the Year 2 goal by 7. This is the second year running this target has been exceeded and represents an overall reduction from January 2024 to January 2026 of 41 high risks, which exceeds the three year target at the inception of the strategy (planned to reduce by ~39). The total number of risks have reduced and those in each of the significant, moderate and low categories have all reduced, supporting the effective prioritisation of risks for the Trust.
- Long standing risks (risks active for 5 years or more) have been reduced by 55 in-year, which exceeds the strategy target of 15% (circa 11).
- Implementation of an E-Learning Risk Management Training package.

The Risk Management Policy

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

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

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

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

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

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

The Board Assurance Framework (BAF) is the principal mechanism used to identify and monitor the most significant risks facing the Trust, together with the actions in place to mitigate them.

The BAF is underpinned by the Principal Risk Register, which captures those risks that may threaten the achievement of the Trust's strategic and corporate objectives. It also incorporates high-scoring risks from the Operational Risk Register that are escalated through Committees of the Board. These risks originate from divisional and corporate risk registers and may impact the day-to-day operation of the organisation. This approach enables the Board of Directors to assess whether there are appropriate and effective controls in place to support delivery of the Trust's strategic objectives.

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

All operational risks are categorised in line with the Trust's strategic objectives that they predominantly impact upon. Any high scoring operational risks (scoring 15+) are also presented to Committees of the Board to which the strategic objectives are aligned, at each meeting.

At the end of 2025–26, the risk profile of the Trust shows improvement with 418 overall risks in March 2025 compared to 351 in March 2026 and 72 high risks in March 2025 compared to 53 in March 2026. High risk themes continue to be reflective of the following:

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

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

- Delivery of Year 2 of the Risk Management Strategy 2024–27.
- The Risk Management Policy, which is available to all staff through the Trust's intranet.
- Effective use of the Principal, and operational risk registers at both divisional and corporate level, and the BAF.
- Risk Management Group, chaired by the Chief Executive, which is responsible for the Risk Management arrangements across the Trust. The Group supports enriched discussion regarding risk management, risk themes and trends and has become the conduit for wider cross-organisational discussion and learning regarding risk escalation and collaborative response.
- Risk Management training has continued in the form of Workshops. Positive feedback received from those attending the sessions.
- A Risk Management E-Learning Package has been rolled out in line with the Training Needs Analysis.
- Compliance with the mechanisms for the reporting of all accidents and incidents using an online incident reporting system.
- Ensuring that there is a robust process in place to escalate all risks with a rating of 15+ to Committees of the Board, and the Board, if required.

- Embedding the use of dashboards, including themes, risk appetite, heat-maps, trajectory of risk and qualitative narrative on actions and mitigations.
- Automated governance dashboards for each division, providing easy access and removing the need for manual creation of dashboards. These are monitored as part of the accountability framework in divisional improvement forums, with a specific risk section.
- Strengthening of divisional accountability processes through Divisional Boards and the Accountability Framework through challenging performance of risk at Clinical Business Unit and Speciality Business Unit level.
- Continued training at all levels of the organisation in line with the National Patient Safety Strategy.
- Continuing to embed the Patient Safety Incident Response Framework (PSIRF).
- Actively monitoring PSIRF implementation at the Safety and Quality Committee on a quarterly basis, and the Board annually.
- Engaging with the Board of Directors using risk information to drive the Board workshop agenda.
- Using outcomes from complaints, incidents, claims, Safety Triangulation Accreditation Review (STAR) visits and internal and external reviews, to mitigate future risks and aggregating these to identify Trust-wide risks.
- Connecting performance across the Trust at Board, Committee, Divisional and Speciality level using integrated performance reports which provides Ward to Board reporting that includes a range of metrics in relation to quality, operations, finance and workforce.
- Creating an open and accountable reporting culture whereby staff are encouraged to identify and report risk issues.
- Risks within Committee papers are connected to strategic risks within the BAF.
- 'Freedom to Speak Up Guardian' and champions in place for staff to raise concerns. The team are promoted within the Trust and any concerns are triangulated with other processes for management, improvement and shared learning.
- Use of an equality impact assessment policy which links to the planning framework and outlines the requirements of divisional management and Board members in assessing and monitoring the impact of service changes.

Risk Appetite

The Trust's Risk Appetite Statement and tolerance levels were reviewed and discussed at a workshop with the Board of Directors in May 2025, and approved at the Board of Directors in June 2025, with no changes from the updated Risk Appetite and tolerances approved in December 2024.

In March 2026, the Board of Directors discussed the potential to change the Risk Appetite for the 'Productivity' Strategic Objective from 'Cautious' to 'Open' and this change was proposed to the Board of Directors meeting on 2nd April 2026 along with an updated Risk Appetite Statement.

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

The Risk Appetite Statement set by the Board for 2025–26 was:

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

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

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

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

Quality governance

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

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

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

Safety, quality and patient experience

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

- A Patient Experience and Involvement Strategy 2022–25, which sets out the approach to involving patients, service users and their carers.
- A Risk Management Strategy 2024–27, which sets out the approach to improving Risk Maturity in the organisation.
- Utilising the Patient Safety Incident Response Framework (PSIRF) to investigate and learn from incidents.
- Patient Safety Partners are actively embedded in the organisation and provide the voice of the patient during meetings and activities of the Trust.
- A Safety and Quality Committee which meets monthly and is chaired by a Non-Executive Director.
- Publication of an Annual Quality Account (Report) as a separate document to the Annual Report.
- Arrangements and monitoring processes to ensure ongoing compliance with National Institute for Health and Care Excellence (NICE) guidance and service accreditation standards.
- A Deputy Chief Medical Officer who is the Trust Lead for mortality and reports regularly to the Safety and Quality Committee in respect of mortality.
- Safety Triangulation Accreditation Review (STAR) Quality Assurance Framework is operated in all clinical departments and monitored by the Safety & Quality Committee.

- Patient Safety Leadership Visits began in early 2024, with participation from the Senior Nursing, Midwifery, AHP, and Clinical Governance Leadership Teams. These visits are a critical component of the Trust's approach to ensuring the quality and safety of care. Conducted monthly, they focus on pre-identified topics or issues. Senior leaders visit various wards and departments to observe, identify good practice, and highlight areas for improvement. The aim is to enhance the STAR quality assurance process, provide additional assurance, drive improvements, increase visibility, and model behaviours for addressing challenging themes identified through the STAR process or other insights and intelligence.
- A Board Safety and Experience Programme is in place to maintain Board visibility and contact with staff delivering services.
- A safe staffing dashboard is in place to monitor nurse staffing levels across all wards and departments and a monthly staffing report is presented to the Safety and Quality Committee through the mandated safe staffing report. This is triangulated with incidents, patient experience (friends and family test) for maternity services, children and neonatal services and adult inpatients, including the Emergency Department.
- The Trust routinely considers and acts upon the recommendations of national quality benchmarking exercises, e.g. national patient surveys and other national publications, such as reports from the Health Services Safety Investigations Body (HSSIB) and the Maternity and Newborn Safety Investigations (MNSI) programme.
- The Trust acts upon patient feedback from complaints and concerns and from feedback from Patient and Public Involvement representatives, such as Healthwatch and Trust governors.
- Patient and staff stories are presented to the Trust Board and actions and lessons learned are widely shared.
- There is a process for the management of all patient safety and medical device alerts, prescribing and drug alerts, field safety notices, estates and facilities alerts, service disruption alerts and all alerts that arise as a result of actions identified by NHS England, or other national bodies are acted upon.
- Where appropriate, risk alerts are made to partner organisations in line with statutory responsibilities, such as for safeguarding purposes.
- Operational and quality breaches are discussed at the relevant operational and governance forums and Integrated Care Board (ICB) meetings with remedial action plans enacted.

Patient Safety Incident Response Framework

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

A PSIRF policy and the Trust's Patient Safety Incident Response plan were developed and revised governance processes were implemented to support the transition. Since adopting PSIRF, the Trust has reviewed incident response activity and the learning generated, which has informed the development of new patient safety improvement priorities for 2026–27 and the Trust's Always Safety First Strategy 2026–30. Progress with implementation of PSIRF is monitored by the Safety and Quality Committee.

Clinical effectiveness

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

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

Capacity and flow

The NHS continues to face sustained and significant operational pressures in 2025–26. Lancashire Teaching Hospitals NHS Foundation Trust, in common with other NHS Trusts nationally, remains challenged by high levels of non elective demand, ongoing workforce pressures and constraints in community and social care capacity, which impact on the ability to discharge patients in a timely way. As a result, performance against a number of national emergency and elective access standards continues to be under pressure, with periods of heightened operational risk experienced during the year.

High levels of bed occupancy have persisted, largely driven by delays in discharge and increased acuity and complexity of patients admitted. In response, the Trust has continued to embed and strengthen its Continuous Flow Model, supporting earlier discharge in the day.

During 2025–26, the Trust is working closely with system partners through the Central Lancashire improvement programme to further enhance discharge flow, reduce deconditioning and improve patient outcomes. This includes a strengthened focus on strengths based approaches to discharge planning, closer integration with community services and further standardisation of ward level processes.

Key actions progressed during the year include:

- Increased activity in Q4 to improve performance and reduce overall waiting list size
- Continued implementation and refinement of the revised Acute Medicine model of care
- Further expansion of Virtual Ward provision, including Frailty, Respiratory and Acute Medicine pathways
- Increased utilisation and standardisation of Same Day Emergency Care pathways
- Ongoing review and strengthening of internal escalation and operational management arrangements
- Continued embedding of the Continuous Flow Model
- Standardisation and consistent application of Ward and Board round processes.

Safety Triangulation Accreditation Review (STAR) Quality Assurance Framework

The Trust ensures assurance of delivery of CQC standards and recommendations through the Trust's Safety Triangulation Accreditation Review (STAR) Quality Assurance Framework which provides evidence of the standard of care delivery, including what works well and where further improvements are required through:

- STAR Monthly reviews – 17 audit questions are undertaken by the Matron or Professional Leads; peer reviewed for each area.
- STAR Accreditation Visits – an in-depth unannounced CQC-style audit is undertaken by the Quality Assurance Team with support from staff, governors and volunteers from across the Trust. Follow up to the visits is risk stratified depending on the outcome of the previous review.
- Ward/Clinical Department to Board reporting arrangements on STAR outcomes.

Data quality and security

The Trust has a clear focus on data quality. Performance information is triangulated with other known information to identify any areas of weakness and where data requires further exploration, specific reviews are undertaken. The Trust is regularly audited on data quality and in the last year has been audited by MIAA on C Difficile and Sepsis. The Trust is also audited each year for its data security and prevention tool kit submissions which includes both security and data quality components.

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

The Trust has a risk, scoring 20, related to the potential for a cyber-attack. The risk is reviewed and updated monthly as controls are continuously improved to counter increasing threats. The Trust continues to meet NHSE alerts and submitted 'approaching standards' for the 2024–25 data security and protection toolkit assessment.

Principal risks

The Trust has in place a Board Assurance Framework (BAF), which is designed to provide a structure and process to enable the Trust to identify those strategic and operational risks that may compromise the achievement of the Trust's high level strategic objectives, known as the '5Ps' (Patients, Performance, People, Productivity, Partnership).

The BAF is underpinned by the Principal Risk Register, which captures those risks that may threaten the achievement of the Trust's strategic and corporate objectives. It also incorporates high-scoring risks from the Operational Risk Register that are escalated through Committees of the Board. These risks originate from divisional and corporate risk registers and may impact the day-to-day operation of the organisation. Principal risks and any operational high risks of concern form the Board Assurance Framework. This approach enables the Board of Directors to assess whether there are appropriate and effective controls in place to support delivery of the Trust's strategic objectives.

The BAF was reviewed in a Board workshop in May 2025 and the Principal Risks for 2025–26 were approved by the Board of Directors in June 2025, made up of 16 Principal Risks, which were considered risks to the delivery of the Trust's Corporate Objectives. These included some that had continued from 2024–25 and new Principal Risks. An overview of the 2025–26 Principal Risks and their status at the end of March 2026 are included below (PR numbers are refreshed each year):

Ref	Principal Risk	Exec Lead	5Ps	Reporting Committee	Risk Appetite	Risk Tolerance	Score at 31.03.26
PR1 (25–26)	Patient experience within the urgent and emergency care pathway	CNO	Patients	SQC	Cautious	1–6	15
PR2 (25–26)	Higher than trajectory rates of clostridioides difficile (C.difficile) Infection	CNO	Patients	Recommended as Controlled – March 2026			
PR3 (25–26)	People experiencing Health inequalities	CNO	Patients	SQC	Cautious	1–6	12
PR4 (25–26)	Timely access to planned and cancer care	COO	Performance	FPC	Cautious	1–6	16
PR5 (25–26)	Timely access to urgent and emergency care	COO	Performance	FPC	Cautious	1–6	20
PR6 (25–26)	Timely access to diagnostic investigations	COO	Performance	FPC	Cautious	1–6	16

Ref	Principal Risk	Exec Lead	5Ps	Reporting Committee	Risk Appetite	Risk Tolerance	Score at 31.03.26
PR7 (25–26)	Reliance on temporary medical workforce	CMO	People	Controlled - February 2026			
PR8 (25–26)	Experience of under-represented staff groups	CPO	People	WFC	Open	4–8	12
PR9 (25–26)	Sub-optimal experience of Resident Doctors	CPO	People	Stepped down from Principal Risk Status October 2025			
PR10 (25–26)	Failure to effectively manage staff absence and achieve Trust and National target rates	CPO	People	WFC	Open	4–8	12
PR11 (25–26)	Compliance with Core Skills Training & Appraisals	CPO	People	Controlled - December 2025			
PR12 (25–26)	Failure to meet the financial plan 2025/26	CFO	Productivity	FPC	Cautious	8–12	20
PR13 (25–26)	Cash consequences of the Trust's underlying financial position	CFO	Productivity	FPC	Cautious	8–12	20
PR14 (25–26)	Ability to access required Capital to support an ageing estate	CFO	Productivity	FPC	Cautious	8–12	16
PR15 (25–26)	Research capacity and capability to enable progress towards University Hospital status	CSIO& CMO	Partnership	Recommended as Controlled – March 2026			
PR16 (25–26)	Failure to progress the configuration of Trust services to enable the delivery of the clinical strategy for LTHTR and L&SC	CSIO& CMO	Partnership	Controlled - December 2025			

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

In 2025–26, three Principal Risks (PR7, PR11, PR16) were mitigated as far as possible and supported the achievement of the corporate objectives, and as a result, the risks were considered reasonably controlled. An additional two risks (PR2 and PR15) were recommended as controlled at the end of March 2026 for consideration in the April 2026 Board of Directors meeting. One Principal Risk (PR9) was stepped down from Principal Risk status in October 2025 to become an operational risk following positive assurances received at the Education, Training and Research Committee, pending completion of the remaining action.

A Board Workshop was undertaken in March 2026 to review the BAF and potential Principal Risks for 2026–27 following the approval of the corporate objectives for 2026–27. Proposals were made to the Board of Directors in April 2026.

Operational High Risks escalated to Board:

Operational High Risks escalated to Board:

During 2025–26, Committees of the Board continued to oversee all operational risks scoring 15 or above relevant to the Strategic Objectives aligned to the Committee. There were no operational high risks of concern escalated to the Board of Directors in the BAF during 2025–26.

During the year, the Internal Audit review of the Trust's assurance framework and supporting processes noted:

- The BAF is structured to meet NHS requirements.
- The governance and assurance structure was defined, and it aligns to the NHS England's well-led assurance framework.
- There was clear ownership of the AF by the Board and Audit Committee, which seemed to have robust processes to identify emerging risks and capture them within the AF.
- The organisation considers risk appetite regularly and the risk appetite is used to inform the management of the BAF.
- The BAF is visibly used by the organisation.
- The BAF clearly reflects the risks discussed by the Board.

Well-Led

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

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

Although all core services across the Royal Preston and Chorley sites were rated as 'good' for Well Led, the overall Well Led rating for the Trust declined from 'good' to 'requires improvement'. A quality improvement plan was developed in response to the inspection, which was monitored by the Safety & Quality Committee, and has been completed in 2025–26. The inspection, and outcome is covered in more detail under the Care Quality Commission section of the Annual Governance Statement.

The Trust commissioned a developmental well-led review in 2025–26, which was led by Good Governance Improvement (GGI). The review was generally positive but identified 29 recommendations where the Trust may be able to improve arrangements. The Trust's response was formulated into an action plan, which was adopted by the Board of Directors in December 2025 and monitored through the Trust's Single Improvement Plan (SIP).

Effectiveness of governance and risk maturity

The effectiveness of the Trust's governance structures continued to be internally tested during 2025–26 via the process of internal and external audit, inspections, national audits and national staff surveys.

As indicated, the Trust commissioned a developmental well-led review in 2025–26, which was undertaken by GGI. As part of the review, the Trust's Governance and Risk Management processes were assessed and found to be positive.

In addition, Mersey Internal Audit Agency (MIAA) undertook a review of the Risk Management (Core Controls) at the Trust in 2025–26 as part of the Internal Audit plan and this received Substantial Assurance. The Assurance Framework review for 2025–26 was also positive about the arrangements at the Trust.

Head of internal audit opinion 2025–26

The overall opinion for the period 1 April 2025 to 31 March 2026 provides substantial Assurance that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

Compliance with the NHS Foundation Trust licence condition 4 (ft governance)

The Board undertakes a review of its effectiveness annually. It has not identified any principal risks to compliance with provider licence condition FT4. This condition covers the effectiveness of governance structures, the responsibilities of Directors and Committees, the reporting lines and accountabilities between the Board, its Committees and the Executive team. The structures and reporting frameworks in place have allowed it to discharge its responsibilities throughout the year during a period of change in the positions of both Chair and Chief Executive Officer.

The Board is satisfied with the timeliness and accuracy of information to assess risks to compliance with the Foundation Trust's licence and the degree of rigour of oversight it has over performance.

Workforce

The workforce plan is aligned to national workforce policy and the priorities of the NHS 10-year plan, system planning assumptions and the Trust's financial recovery trajectory. It reflects delivery of quality and performance improvement, productivity gains and reduction in reliance on temporary staffing, while maintaining safe staffing levels and clinical resilience.

The plan assumes a progressive reduction in overall whole time equivalent (WTE) reduction over the five-year period, driven by service review, productivity improvement and more effective deployment of staff. This includes a reduction in bank and agency expenditure, improved alignment of job plans to medical rostering to increase productivity and standardisation of clinical activity.

Care Quality Commission

There have been no overall inspections of the Trust in 2025–26 by the Care Quality Commission (CQC). However, the CQC attended to conduct two focussed reviews in 2025–26:

- The Trust Radiotherapy department was inspected by CQC in July 2025 to assess compliance with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). The inspection was positive about the arrangements in place within the department and there were no actions identified to improve practice or enforcement.
- The Trust was visited by CQC on 8th and 9th September 2025 to conduct an announced short notice review as part of the CQC's planned Mental Health Act (MHA) monitoring visits. The purpose of the visit to Royal Preston Hospital and Chorley and South Ribble Hospital was to monitor the use of the MHA and assess compliance with the MHA Code of Practice in acute hospital settings. Overall, the findings of the monitoring visit were positive and CQC concluded that the Trust was meeting the needs of patients detained under the Mental Health Act. The CQC identified one concern regarding the length of time patients are delayed in the acute hospital setting awaiting inpatient mental health care. This is a shared challenge with the neighbouring Mental Health Trust and action plans were submitted by both organisations to demonstrate the commitment to addressing the delays. This will be monitored via the Safety & Quality Committee.

The Trust continues to hold engagement meetings with CQC as part of the required monitoring arrangements.

The Trust completed the remaining actions from the CQC inspection in 2023, in this financial year and the action plan was closed.

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

Declarations of interest

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

NHS Pension scheme

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

Equality and diversity legislation

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

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

Greener NHS programme

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

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

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

- Trust-wide commitment to the adoption of a Single Improvement Plan approach, which has involved undertaking extensive staff engagement to identify priorities for improvement and is informing the development of a system wide Continuous Improvement Strategy for the whole health economy;
- Approval of the annual budget by the Board;
- Monthly Finance and Performance Committee meetings to ensure Directors meet their respective financial targets reporting to the Board;
- Monthly Divisional Improvement Forums attended by members of the Executive Team to ensure that Divisions meet the required level of performance for key areas including financial targets;
- Full implementation of the Investigation & Intervention improvement actions around Grip and Control, including development of a weekly temporary pay tracker for banks usage at ward level.
- Refreshed the governance structure for the Waste Reduction Programme with the programme board chaired by the CEO and all programmes having an Executive Director sponsor
- Appointment of a Turnaround Director to further enhance the above and support development of the forward savings programme with the development of the Project Management Office
- With the additional temporary support of advisors building an approach to service reviews using SLR and other benchmark data from NHSE to identify saving opportunities
- In combination with the above support savings programme development through "rapid improvement weeks" which facilitates operation team members coming together to identify efficiencies through service redesign

- Actively engaging in the One LSC finance programme to develop best in class processes within the finance function which will be mobilised in 2025–26. Impact in 2024–25 being a consistent approach to planning assumptions in quarter four for the new financial year across the Lancashire and South Cumbria System focused on exit run-rate as the start point for planning assumptions
- The Trust continues to have in place a 'Quality Impact Assessment' and robust governance systems that require clinical approval of all cost improvement programme schemes that have a clinical impact.

The Trust is continuing to implement the recommendation of reviews undertaken during 2024–25 to deliver sustainable benefits.

Financial sustainability

During the 2025–26 financial year the Trust delivered a deficit of £13.7m, this is inclusive of £30.0m of central deficit support funding.

The underlying deficit of the Trust, and funding reductions due to the Lancashire & South Cumbria Health System being above its fair share funding alongside local cost pressures resulted in the Trusts annual efficiency requirement being significantly in excess of the national headline efficiency target of 2.0% with the Trust setting a savings target of £60m (6.9%).

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

Trust clinical strategy

The Trust Clinical Strategy is incorporated into the recently published Trust Strategy and aligns with the national priorities with a strong focus on integrated care, preventative health and innovation. The service developments and transformation are developed in collaboration with Integrated Care System colleagues and system partners following the governance processes outlined in the Lancashire and South Cumbria Integrated Care Board service change policy.

Information governance

The confidentiality and security of information regarding patients, staff and the Trust is maintained through governance and control policies, all of which support current legislation and is reviewed on a regular basis. Any incident involving a breach of personal data is handled under the Trust's risk and control framework, graded and the more serious incidents are reported to the Department of Health and Social Care and the Information Commissioner's Office (ICO) where appropriate.

For the reporting period 2025–26, the Trust experienced 3 externally reportable data breaches. Two of these incidents, the ICO confirmed that no further action was required. Of the other incident, the Trust is currently awaiting a response from the ICO. Full investigations have been conducted for all incidents and root cause analysis completed.

As part of our annual assessment, the Data Security Protection Toolkit (DPST) is reviewed annually and updated to ensure Trust standards are aligned with statutory obligations. In September 2024, the DSPT adopted the National Cyber Security Centre's Cyber Assessment Framework (CAF) as the basis for cyber security and information governance assurance.

The DSPT now includes expanded requirements compared to the previous year and is structured around 47 contributing outcomes, each supported by indicators of good practice

The status for the 2024–25 DSPT is 'approaching standards' as 6 Outcomes did not meet the expected achievement level. An improvement plan is in place, and this has been agreed with NHSE, with regular updates provided.

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

Data quality and governance

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

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

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

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

Review of effectiveness

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

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

- The Assurance Framework and the monthly performance reports, which provides evidence that the effectiveness of the controls in place to manage the risks to the organisation achieving its principal objectives, have been reviewed.
- All relevant Committees have a clear timetable of meetings, cycles of business and a clear reporting structure to allow issues to be raised.

- The Board undertakes bi-monthly reviews of the BAF, and the Committees of the Board at each meeting undertake detailed scrutiny of assurance received or gaps identified in relation to risks assigned to that particular Committee.

Financial reporting

The external audit plan for 2025–26 highlighted as significant audit opinion risks:

(i) Management override of controls

(ii) Fraud risk from expenditure recognition.

The Audit Committee has considered the appropriateness of the accounts being prepared on a going concern basis and drawn on the views of management and the external auditors to support the conclusion that it is appropriate for the accounts to be prepared on this basis. (Taken from KPMG Draft Report to Audit Committee April 2026).

Overall assurances on integrated governance, risk management and internal control

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

Audits undertaken as part of 2024–25 Plan and reported in 2025–26	Assurance Level
Data Quality Review – Waiting List Management	Moderate
Mandatory Training	Substantial
Patient Safety and Incident Response Framework	Substantial
Renal IT Infrastructure Management	Moderate
Health and Safety Governance Review	Limited
Audits undertaken as part of 2025–26 Plan	**Assurance Level**
Board Assurance Framework	N/A Advisory
Risk management – Core Controls	Substantial
Conflicts of Interest	Substantial
Key Financial Controls	Substantial
Continuous Flow – Policy and Compliance	Substantial
Grip & Control Governance	Moderate
Grip & Control Implementation	Substantial
Resuscitation Service	Substantial
ESR/Payroll	Substantial
Data Security and Protection Toolkit	Overall Assurance Rating – High Risk; Veracity of the organisation's self-assessment - High Confidence

The Director of Internal Audit has provided an overall opinion of Substantial Assurance based on the work of internal audit during 2025–26. (From Draft report presented to Audit Comm April 2026).

Compliance

Following a recommendation from the North West NHS England (NHSE) regional team, it was agreed that Lancashire Teaching Hospitals NHS Foundation Trust would be placed into NHS Oversight Framework (NOF) segment 5 from February 2025. This would enable to Trust to receive support from the National Recovery Support Programme (RSP). Additionally, the North West Regional Support Group determined that the Trust's current Undertakings should be revised in the form of a Variation to Enforcement Undertakings to reflect the Trust's current financial position and to emphasise the actions required to improve this position.

A decision was also taken by NHS England, in October 2025 to impose a Notice of Intent to impose an Additional Licence Condition pursuant to Section 111 of the Health and Social Care Act 2012 – 'Additional governance arrangements'. This was to ensure that the newly appointed board remained

Existing Quality Undertakings remain unchanged.

Conclusion

In conclusion, my review confirms that Lancashire Teaching Hospitals NHS Foundation Trust has an adequate system of internal control and that there have been no significant control issues at the Trust in 2025–26. Where control issues have been identified, action has been taken or action/ improvement plans are in place to address such issues.

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

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

Professor Silas Nicholls
Chief Executive
25 June 2026

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

Professor Silas Nicholls
Chief Executive
25 June 2026

Lancashire Teaching Hospitals NHS Foundation Trust

FINANCIAL REVIEW 2025–26

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

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Lancashire Teaching Hospitals NHS Foundation Trust ("the Trust") for the year ended 31 March 2026 which comprise the Consolidated Statement of Comprehensive Income, Group and Trust Statements of Financial Position, Group and Trust Statements of Changes in Equity and Group and Trust Statements of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Group and the Trust as at 31 March 2026 and of the Group's and the Trust's income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State in February 2026 as being relevant to NHS Foundation Trusts and included in the Department of Health and Social Care Group Accounting Manual 2025/26; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

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

Going concern

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

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

Our conclusions based on this work:

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

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

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

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

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

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

As required by auditing standards and taking into account possible pressures to meet delegated targets/ other reasons specific to this audit, we performed procedures to address the risk of management override of controls in particular the risk that Group management may be in a position to make inappropriate accounting entries. On this audit we did not identify a fraud risk related to revenue recognition due to the block nature of the majority of the funding provided to the Group during the year. There are some areas of income with variable payment mechanisms, however this is limited to elective inpatient activity, and we consider the level of revenue affected at year end to be insignificant. Therefore the uncertainty associated with this variable income stream does not lead to a significant risk that revenue is materially misstated. We therefore assessed that there was limited opportunity for the Group and the Trust to manipulate the income that was reported

As the Trust and system is set a financial performance target by NHSE there is a risk that non-pay expenditure, excluding depreciation, may be manipulated in order to report that the control total has been met. The setting of a planned outturn target can create an incentive for management to understate the level of non-pay expenditure compared to that which has been incurred. We have therefore recognised a fraud risk related to expenditure recognition, particularly in relation to completeness of manual year-end accruals This is in line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom.

We also performed procedures including:

- Identifying journal entries and other adjustment to test based on risk criteria and comparing the identified entries to supporting documentation. These included journal entries with unusual characteristics compared to the total journal population
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.
- Inspecting a sample of relevant non-pay expenditure and related bank transactions, which occurred in the period post 31 March 2026, in order to determine whether relevant expenditure has been recognised completely in the correct accounting period.
- Performing a year-on-year comparison of a sample of the largest accruals in the prior year and current year and challenging management where the movement is not in line with our understanding of the entity.

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

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

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

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

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

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

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

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

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

Other information in the Annual Report

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

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

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

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the NHS Foundation Trust Annual Reporting Manual 2025/26.

Accounting Officer's and Audit Committee's responsibilities

As explained more fully in the statement set out on page 88, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Group's and the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the Group and the Trust or dissolve the Group and the Trust without the transfer of their services to another public sector entity.

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

Auditor's responsibilities

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

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

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

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

Significant weakness - Financial sustainability

We have identified a significant weakness in the Trust's arrangements for financial sustainability relating to the monitoring and risk assessment of the Trust's waste recovery plan (WRP).

This matter was reported in the prior year. In the current year, the Trust agreed a WRP of £60.0m for 2025/26 and break-even outturn position. In January 2026, the Trust was reporting a year-to-date deficit of £26.1m, primarily attributable to under-delivery of the WRP. In agreement with NHSE, the Trust submitted a revised forecast outturn deficit of £9.2m, predicated on realising £8.6m of savings from estates transformation and receipt of £30m of deficit support funding (DSF).

The final year-end outturn was a £13.6m deficit, which reflected full receipt of £30m DSF but £22.5m under delivery of the WRP. The gap was mitigated through additional income.

In response to the recommendation identified in the prior year, the Trust has strengthened its governance arrangements in relation to the WRP, but it is acknowledged there is still significant work to undertake to get back to a financially sustainable footing. Overall delivery of the WRP improved, but there was still a significant gap from the £60m target. We also note that the trust's underlying deficit was much improved on 24/25 at £51.7m compared to £90m in the prior year.

As a result, we consider the significant weakness in the Trust's arrangements for financial sustainability relating to the monitoring and risk assessment of its WRP programme during the year remains in place.

Recommendation

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

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

As explained more fully in the statement set out on page 88, the Accounting Officer is responsible for ensuring that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

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

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

Statutory reporting matters

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

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

We have nothing to report in these respects.

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

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

DELAY IN CERTIFICATION OF COMPLETION OF THE AUDIT

As at the date of this audit report, we are unable to confirm that we have completed our work in respect of the trust accounts consolidation pack of the Trust for the year ended 31 March 2026 because we have not received confirmation from the NAO that the NAO's audit of the Department of Health and Social Care accounts is complete.

Until we have completed this work, we are unable to certify that we have completed the audit of Lancashire Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2026 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the NAO Code of Audit Practice.

Debra Chamberlain

for and on behalf of KPMG LLP

Chartered Accountants

1 St Peter's Square

Manchester

M2 3DE

26 June 2026

Lancashire Teaching Hospitals NHS Foundation Trust

Annual accounts for the year ended 31 March 2026

Foreword to the accounts

Lancashire Teaching Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2026, have been prepared by Lancashire Teaching Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed ……

Name **Silas Nicholls**
Job title **Chief Executive**
Date **25 June 2026**

Consolidated Statement of Comprehensive Income

		Group	
		2025/26	2024/25
	Note	£000	£000
Operating income from patient care activities	2	815,843	779,547
Other operating income	3	127,625	86,960
Operating expenses	6,8	(970,172)	(916,028)
Operating surplus/(deficit) from continuing operations		**(26,704)**	**(49,521)**
Finance income	10	1,504	2,568
Finance expenses	11	(893)	(1,222)
PDC dividends payable		(10,294)	(9,528)
Net finance costs		**(9,683)**	**(8,182)**
Other gains / (losses)	12	(60)	(9)
Corporation tax expense		(14)	-
Surplus / (deficit) for the year from continuing operations		**(36,461)**	**(57,712)**
Surplus / (deficit) for the year		**(36,461)**	**(57,712)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	1,105	(3,660)
Revaluations		474	421
Total other comprehensive income for the period		**1,579**	**(3,239)**
Total comprehensive income / (expense) for the period		**(34,882)**	**(60,951)**
Surplus/ (deficit) for the period attributable to:			
Lancashire Teaching Hospitals NHS Foundation Trust		(36,461)	(57,712)
Total		**(36,461)**	**(57,712)**
Total comprehensive income/ (expense) for the period attributable to:			
Lancashire Teaching Hospitals NHS Foundation Trust		(34,882)	(60,951)
Total		**(34,882)**	**(60,951)**

Statements of Financial Position

		Group		Trust	
		31 March 2026	31 March 2025	31 March 2026	31 March 2025
	Note	£000	£000	£000	£000
Non-current assets					
Intangible assets	14	2,048	3,339	2,048	3,339
Property, plant and equipment	15	367,239	353,660	367,239	353,658
Right of use assets	17	22,321	27,886	22,321	27,886
Receivables	19	6,599	6,503	8,099	8,003
Total non-current assets		**398,207**	**391,388**	**399,707**	**392,886**
Current assets					
Inventories	18	18,006	17,926	14,974	15,274
Receivables	19	52,240	41,070	50,611	39,899
Cash and cash equivalents	20	29,852	8,253	28,276	7,505
Total current assets		**100,098**	**67,249**	**93,861**	**62,678**
Current liabilities					
Trade and other payables	21	(100,807)	(94,310)	(96,112)	(91,237)
Borrowings	23	(10,280)	(10,198)	(10,280)	(10,198)
Provisions	24	(300)	(339)	(300)	(339)
Other liabilities	22	(6,386)	(7,123)	(6,386)	(7,123)
Total current liabilities		**(117,773)**	**(111,970)**	**(113,078)**	**(108,897)**
Total assets less current liabilities		**380,532**	**346,667**	**380,490**	**346,667**
Non-current liabilities					
Borrowings	23	(15,320)	(24,935)	(15,320)	(24,935)
Provisions	24	(3,570)	(2,736)	(3,570)	(2,736)
Other liabilities	22	-	(2,085)	-	(2,085)
Total non-current liabilities		**(18,890)**	**(29,756)**	**(18,890)**	**(29,756)**
Total assets employed		**361,642**	**316,911**	**361,600**	**316,911**
Financed by					
Public dividend capital		751,814	672,201	751,814	672,201
Revaluation reserve		36,888	36,459	36,888	36,459
Income and expenditure reserve		(427,060)	(391,749)	(427,102)	(391,749)
Total taxpayers' equity		**361,642**	**316,911**	**361,600**	**316,911**

The notes on pages 121 to 154 form part of these accounts.

Name **Silas Nicholls**
Position **Chief Executive**
Date **25 June 2026**

Consolidated Statement of Changes in Equity for the year ended 31 March 2026

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2025 - brought forward	**672,201**	**36,459**	**(391,749)**	**316,911**
Surplus/(deficit) for the year	-	-	(36,461)	**(36,461)**
Other transfers between reserves	-	(1,150)	1,150	**-**
Impairments	-	1,105	-	**1,105**
Revaluations	-	474	-	**474**
Public dividend capital received	79,613	-	-	**79,613**
Public dividend capital repaid	-	-	-	**-**
Taxpayers' and others' equity at 31 March 2026	**751,814**	**36,888**	**(427,060)**	**361,642**

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

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

Trust	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2025 - brought forward	**672,201**	**36,459**	**(391,749)**	**316,911**
Surplus/(deficit) for the year	-	-	(36,503)	**(36,503)**
Other transfers between reserves	-	(1,150)	1,150	**-**
Impairments	-	1,105	-	**1,105**
Revaluations	-	474	-	**474**
Public dividend capital received	79,613	-	-	**79,613**
Public dividend capital repaid	-	-	-	**-**
Taxpayers' and others' equity at 31 March 2026	**751,814**	**36,888**	**(427,102)**	**361,600**

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

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

Statements of Cash Flows

		Group		Trust	
		2025/26	2024/25	2025/26	2024/25
	Note	£000	£000	£000	£000
Cash flows from operating activities					
Operating surplus / (deficit)		(26,704)	(49,521)	(27,063)	(49,521)
Non-cash income and expense:					
Depreciation and amortisation	6.1	30,500	33,031	30,498	33,029
Net impairments	7	24,436	21,491	24,436	21,491
Income recognised in respect of capital donations	3	(2,455)	(849)	(2,455)	(849)
(Increase) / decrease in receivables and other assets		(12,551)	422	(12,024)	1,456
(Increase) / decrease in inventories		(80)	(1,123)	300	577
Increase / (decrease) in payables and other liabilities		2,627	13,332	1,253	11,072
Increase / (decrease) in provisions		(799)	(434)	(799)	(434)
Net cash flows from / (used in) operating activities		**14,974**	**16,349**	**14,146**	**16,821**
Cash flows from investing activities					
Interest received	10	1,504	2,568	1,504	2,568
Purchase of intangible assets		(5,130)	(6,015)	(5,130)	(6,015)
Purchase of PPE and investment property		(51,700)	(54,666)	(51,700)	(54,666)
Receipt of cash donations to purchase assets		2,373	849	2,373	849
Net cash flows from / (used in) investing activities		**(52,953)**	**(57,264)**	**(52,953)**	**(57,264)**
Cash flows from financing activities					
Public dividend capital received		79,613	37,776	79,613	37,776
Public dividend capital repaid		-	(1,200)	-	(1,200)
Movement on loans from DHSC		(363)	(1,108)	(363)	(1,108)
Movement on other loans		(76)	(76)	(76)	(76)
Capital element of lease liability repayments		(9,811)	(9,961)	(9,811)	(9,961)
Interest on loans		(50)	(64)	(50)	(64)
Other interest		(2)	(66)	(2)	(66)
Interest paid on lease liability repayments		(784)	(1,041)	(784)	(1,041)
PDC dividend (paid) / refunded		(8,949)	(11,125)	(8,949)	(11,125)
Net cash flows from / (used in) financing activities		**59,578**	**13,135**	**59,578**	**13,135**
Increase / (decrease) in cash and cash equivalents		**21,599**	**(27,780)**	**20,771**	**(27,308)**
Cash and cash equivalents at 1 April - brought forward		**8,253**	**36,033**	**7,505**	**34,813**
Cash and cash equivalents transferred under absorption accounting		-	-		
Cash and cash equivalents at 31 March	20	**29,852**	**8,253**	**28,276**	**7,505**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2025/26 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

Note 1.2 Going concern

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

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

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

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

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

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

Note 1.3 Consolidation

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

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

The Trust is sole owner of Lancashire Hospitals Services Limited, a company dispensing prescription drugs to Trust patients, and since 1st February the patients of the other acute NHS trusts within Lancashire and South Cumbria. The company has traded throughout the 2025/26 financial year. As sole owner, the company constitutes a subsidiary of the Trust and the financial results of the company through the financial year have been consolidated with the Trust to form the Group. The Trust is also the sole owner of Edovation Limited which has not been consolidated due to it being a dormant company.

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

Note 1.3 Consolidation (Continued)
Joint operations are arrangements in which the trust has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. One LSC was created by the four provider Trusts in the Lancashire and South Cumbria system and each Trust transferred some corporate and support service functions into One LSC with effect from 1st November 2024. One LSC was assessed against the relevant accounting standards and the conclusion was that it was a joint operation and continued to be a joint operation throughout 2025/26. As a joint operation the trust has included within its financial statements its share of the assets, liabilities, income and expenses.

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

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

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

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

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

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

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

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

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

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

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

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

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

Note 1.6 Other forms of income

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

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

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

Note 1.7 Expenditure on employee benefits
Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is not recognised in the financial statements as the value is considered to be immaterial.

Pension costs

NHS Pension Scheme
Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

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

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

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

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

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

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

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

Note 1.8 Expenditure on other goods and services

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

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

Note 1.9 Insurance contracts (Trust as the insurer)

An insurance contract is a contract under which the Trust has accepted significant pre-existing insurance risk from the policyholder by agreeing to compensate the policyholder if a specified uncertain future event adversely affects the policyholder.

IFRS 17 is effective from 2025/26 for the insurer accounting for such contracts. The standard is applied retrospectively with a transition date of 1 April 2024, restating prior periods. The Trust has determined that it does have any contracts to which IFRS 17 is applicable and therefore no accounting adjustments or restatements have been necessary.

Note 1.10 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised where:

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

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

Subsequent expenditure

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

Measurement
Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.
Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current value in existing use is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis.

Note 1.10 Property, plant and equipment (continued)

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

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

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

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as ‘held for sale’ cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised. Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

Note 1.10 Property, plant and equipment (continued)

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Buildings, excluding dwellings	12	80
Plant & machinery	5	15
Transport equipment	7	7
Information technology	3	15
Furniture & fittings	7	10

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.11 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the trust's business or arise from contractual or other legal rights. Intangible assets are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the Trust intends to complete the asset and sell or use it
- the Trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, e.g., the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset where it meets recognition criteria.

Note 1.11 Intangible assets (continued)

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Prior to 1 April 2025, intangible assets were held under a revaluation approach reflecting current value in existing use. Revaluation gains and losses and impairments were treated in the same manner as for property, plant and equipment. On 1 April 2025, the carrying value of these assets was carried forward as 'deemed cost' and any related revaluation surpluses in the revaluation reserve were transferred to the I&E reserve.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Impairments

Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value an impairment is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	**Max life Years**
Information technology	3	5
Software licences	1	10
Licences & trademarks	2	2

Note 1.12 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method except for drugs inventories which are measured using the weighted average cost method.

Note 1.13 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

Note 1.14 Financial assets and financial liabilities

Recognition
Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Classification and measurement
Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost
Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets
For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition
Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.15 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.16 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2026:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
Very long-term	Exceeding 40 years	5.07%	4.55%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2026:

	Inflation rate	Prior year rate
Year 1	2.5%	2.60%
Year 2	2.0%	2.30%
Into perpetuity	2.0%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at Note 24.1 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.17 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 25 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 25.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.18 Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.19 Value added tax
Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.20 Corporation tax
The Trust is a health service body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for HM Treasury to disapply the exemption in relation to specified activities of a Foundation Trust (S519A(3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the scope of corporation tax in respect of activities which are not related to, or ancillary to, the provision of healthcare.

Note 1.21 Climate change levy
Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.22 Foreign exchange
The functional and presentational currency of the trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• monetary items are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.23 Third party assets
Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.24 Losses and special payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.25 Transfers of functions to / from other NHS bodies / local government bodies
For functions that have been transferred to the trust from another NHS / local government body, the transaction is accounted for as a transfer by absorption. The assets and liabilities transferred are recognised in the accounts using the book value as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain / loss corresponding to the net assets / liabilities transferred is recognised within income / expenses, but not within operating activities.

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the trust has transferred to another NHS / local government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss / gain corresponding to the net assets/ liabilities transferred is recognised within expenses / income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve. Adjustments to align the acquired function to the trust's accounting policies are applied after initial recognition and are adjusted directly in taxpayers' equity.

Note 1.26 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2025/26.

Note 1.27 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards to be applied in 2025/26:

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard has been adopted by the UK Endorsement Board to be effective for accounting periods beginning on or after 1 January 2027. The Standard has not yet been adopted by the FReM and early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

Changes to valuation of property, plant and equipment (PPE) assets – The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE and right of use assets currently subject to revaluation have a total book value of £288m as at 31 March 2026.

The current accounting policy for property assets measures the cost of replacing the service potential using a 'modern equivalent asset'. This policy is not changing. In deriving the modern equivalent asset, the Trust and its valuers currently adopt an 'alternative site' assumption for all of its specialised buildings, meaning the replaced service potential may be in a different location. The option of using this assumption is being withdrawn for NHS bodies from 1 April 2028. Therefore the hypothetical modern equivalent asset will change to be located on current sites in asset valuations from 2028/29. Assets valued on an alternative site basis have a total book value of £288m at 31 March 2026. The impact of applying the changes in future periods cannot be quantified but is expected to be material.

Note 1.28 Critical judgements in applying accounting policies

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Note 1.29 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

The revaluations of hospitals have been carried out by Cushman & Wakefield, a property services firm whose valuers are registered with the Royal Institution of Chartered Surveyors (RICS), the regulatory body for the valuation services industry. Cushman & Wakefield provided a full valuation of land and property as at 31st March 2024, and have provided a desktop valuation of these assets as at 31 March 2026 using the modern equivalent asset (MEA) approach. This approach assumes that the asset would have been replaced with a modern equivalent, not a building of identical design, with the same operational value as the existing asset. The modern equivalent may well be smaller that the existing asset, for example, due to technological advances in plant and machinery or reduced operational use. The application and assessment of the valuation has been informed by Trust management in respect of the estimated requirements of a modern equivalent hospital. Estimation uncertainty within the revaluation is primarily driven by the following key assumptions:

• Selection of individual Building Cost Information Services (BCIS) values for each individual building component from within a published range, reflecting the condition and specifications of the actual component.
• The application of a ‘location factor’ adjustment to the overall BCIS index movement to reflect specific local factors relating to the cost of construction.
• The application of physical obsolescence adjustments to the valuation of individual buildings to reflect the building’s age and condition, and application of functional obsolescence adjustments to reflect the extent to which a modern equivalent asset would be configured in a more efficient manner and over a reduced gross internal area.

It is impracticable to disclose the extent of the possible effects of an assumption or another source of estimation uncertainty at the end of the reporting period. Outcomes within the next financial year that are different from the assumption around the valuation of our land or PPE could require a material adjustment to the carrying amount of the asset recorded in note 15.

Note 2 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.5

Note 2.1 Income from patient care activities (by nature)	2025/26 £000	2024/25 £000
Acute services		
Income from commissioners under API contracts - variable element*	190,295	174,822
Income from commissioners under API contracts - fixed element*	517,368	489,412
High cost drugs income from commissioners	61,075	60,687
Other NHS clinical income	9,818	16,463
All services		
Private patient income	250	1,239
National pay award central funding***		1,635
Additional pension contribution central funding**	33,751	31,999
Other clinical income	3,286	3,290
	815,843	**779,547**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 NHS Payment Scheme documentation.

https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 for implementing the backdated element of pay awards where government offers were finalised after the end of the 2023/24 financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

Note 2.2 Income from patient care activities (by source)	2025/26 £000	2024/25 £000
Income from patient care activities received from:		
NHS England	117,396	116,691
Integrated care boards	693,384	656,930
Department of Health and Social Care	4	6
Other NHS providers	588	533
NHS other	225	-
Local authorities	217	903
Non-NHS: private patients	250	1,239
Non-NHS: overseas patients (chargeable to patient)	332	76
Injury cost recovery scheme	3,069	2,882
Non NHS: other	378	287
Total income from activities	**815,843**	**779,547**
Of which:		
Related to continuing operations	815,843	779,547
Related to discontinued operations	-	-

Note 2.3 Overseas visitors (relating to patients charged directly by the provider)

	2025/26	2024/25
	£000	£000
Income recognised this year	332	76
Cash payments received in-year	42	66
Amounts added to provision for impairment of receivables	280	114
Amounts written off in-year	244	202

The above note relates to the treatment of overseas visitors charges directly by the Trust in accordance with Guidance on implementing the overseas regulations 2015 issued by the Department of Health and Social Care.

Amounts written off in-year 2025/26: 9 customers (2024/25 6 customers)

Note 3 Other operating income (Group)

	2025/26			2024/25		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	5,524	-	**5,524**	4,031	-	**4,031**
Education and training	34,122	1,353	**35,475**	31,778	1,014	**32,792**
Non-patient care services to other bodies	25,548		**25,548**	22,611		**22,611**
Receipt of capital grants and donations and peppercorn leases		2,455	**2,455**		849	**849**
Revenue from operating leases		2,058	**2,058**		2,131	**2,131**
Other income	56,565	-	**56,565**	24,546	-	**24,546**
Total other operating income	**121,759**	**5,866**	**127,625**	**82,966**	**3,994**	**86,960**
Of which:						
Related to continuing operations			127,625			86,960
Related to discontinued operations			-			-

Note 3.1 Breakdown of Other income recognised in 'Other Operating Income

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Car Parking income	4,000	3,263	4,000	3,263
Catering	2,380	2,157	2,380	2,157
Pharmacy sales	2,347	2,752	2,357	2,752
Staff accommodation rental	476	456	476	456
Non-clinical services recharged to other bodies	32	36	32	36
Clinical excellence awards	200	525	200	525
Other income generation schemes (recognised under IFRS 15)*	47,130	15,357	9,941	9,939
Total Other Income	**56,565**	**24,546**	**19,386**	**19,128**

*Charges for discretionary services and sales of goods.

Note 4.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2025/26	2024/25
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	7,589	4,039
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	2,657	23

Note 4.2 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2026 £000	31 March 2025 £000
within one year	6,386	7,123
after one year, not later than five years	-	2,085
Total revenue allocated to remaining performance obligations	**6,386**	**9,208**

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from
(i) contracts with an expected duration of one year or less and
(ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 4.3 Income from activities arising from commissioner requested services

The trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2025/26	2024/25
	£000	£000
Income from services designated as commissioner requested services	810,780	773,621
Income from services not designated as commissioner requested services		
Total	**810,780**	**773,621**

Note 4.4 Fees and charges (Group)

The following disclosure is of income from charges to service users where the full cost of providing that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

	2025/26	2024/25
	£000	£000
Income	57,995	25,432
Full cost	(55,172)	(22,286)
Surplus / (deficit)	**2,823**	**3,146**

The income and expenditure in the above note includes East Lancashire Financial Services (ELFS) Business Services. ELFS provides financial services and systems to a number of other NHS clients. ELFS income for the year was £13.36m (2024/25: £13.13m) and ELFS expenditure for the year was £13.08m (2024/25: £12.70m).

Note 5 Operating leases - Lancashire Teaching Hospitals NHS Foundation Trust as lessor

This note discloses income generated in operating lease agreements where Lancashire Teaching Hospitals NHS Foundation Trust is the lessor. These leases relate to parts of the Trust buildings which are occupied by third parties to, for example, use as retail outlets.

Note 5.1 Operating leases income (Group)

	2025/26	2024/25
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	1,975	1,986
Variable lease receipts / contingent rents	83	145
Total in-year operating lease income	**2,058**	**2,131**

Note 5.2 Future lease receipts (Group)

	31 March 2026	31 March 2025
	£000	£000
Future minimum lease receipts due in:		
- not later than one year	1,687	1,823
- later than one year and not later than two years	1,687	1,823
- later than two years and not later than three years	1,687	1,287
- later than three years and not later than four years	1,687	1,287
- later than four years and not later than five years	1,665	1,287
- later than five years	2,282	1,848
Total	**10,695**	**9,355**

Note 6.1 Operating expenses (Group)

	Group		Trust	
	2025/26 £000	2024/25 £000	2025/26 £000	2024/25 £000
Staff and executive directors costs *	617,894	598,197	614,683	596,841
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	114,581	85,288	80,457	80,014
Supplies and services - clinical (excluding drugs costs)	77,462	75,885	77,462	75,885
Premises	36,421	36,721	37,332	36,805
Depreciation on property, plant and equipment	28,666	31,203	28,664	31,201
Net impairments	24,436	21,491	24,436	21,491
Clinical negligence	22,089	19,764	22,089	19,764
Purchase of healthcare from non-NHS and non-DHSC bodies	15,786	16,953	15,786	16,953
Supplies and services - general	14,297	11,357	14,237	12,620
Establishment	5,240	5,272	5,151	5,239
Education and training	3,797	3,183	3,781	3,178
Consultancy costs	350	-	350	-
Transport (including patient travel)	1,936	3,346	1,852	3,330
Amortisation on intangible assets	1,834	1,828	1,834	1,828
Expenditure on short term leases	1,205	1,231	1,205	1,231
Insurance (as a policy holder)	924	913	885	898
Other	676	721	666	715
Expenditure on low value leases	671	806	671	806
Redundancy	582	44	582	44
Car parking & security	531	31	531	31
Inventories written down	407	313	95	313
Legal fees	331	414	331	386
Audit services **	282	257	242	227
Research and development	266	269	266	269
Internal audit costs	201	248	201	248
Remuneration of non-executive directors	185	177	185	177
Losses, ex gratia & special payments	108	11	108	11
Change in provisions discount rate(s)	8	(45)	8	(45)
Hospitality	-	7	-	7
Movement in credit loss allowance: contract receivables / contract assets	(247)	381	(247)	381
Increase/(decrease) in other provisions	(747)	(238)	(747)	(238)
Total	**970,172**	**916,028**	**933,096**	**# 910,610**
Of which:				
Related to continuing operations	970,172	916,028	-	916,028
Related to discontinued operations	-	-	-	-

* One LSC is deemed to be jointly controlled and therefore the Trust share of costs which are £21.055m for 2025/26 (£7.499m for 2024/25) have been included within staff costs.

** Total audit services for 2025/26 are £229k plus £12k for overruns relating to 2024/25. Both figures are exclusive of VAT and relate solely to statutory external audit work.

Note 6.2 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £2,000k (2024/25: £2,000k).

Note 7 Impairment of assets (Group)

	2025/26 £000	2024/25 £000
Net impairments charged to operating surplus / deficit resulting from:		
Abandonment of assets in course of construction	-	3,127
Changes in market price	24,436	18,364
Total net impairments charged to operating surplus / deficit	**24,436**	**21,491**
Impairments charged to the revaluation reserve	(1,105)	3,660
Total net impairments	**23,331**	**25,151**

Note 8 Employee benefits (Group)

	2025/26 Total £000	2024/25 Total £000
Salaries and wages	474,100	462,024
Social security costs	56,819	46,226
Apprenticeship levy	2,354	2,307
Employer's contributions to NHS pensions	83,088	80,549
Pension cost - other	142	130
Temporary staff (including agency)	3,973	10,106
Total gross staff costs	**620,476**	**601,342**
Recoveries in respect of seconded staff	-	-
Total staff costs	**620,476**	**601,342**
Of which		
Costs capitalised as part of assets	2,000	3,101

Note 8.1 Retirements due to ill-health (Group)

During 2025/26 there were 10 early retirements from the trust agreed on the grounds of ill-health (6 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £815k (£1,146k in 2024/25).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2023, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

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

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

Note 10 Finance income (Group)

Finance income represents interest received on assets and investments in the period.

	2025/26	2024/25
	£000	£000
Interest on bank accounts	1,504	2,568
Total finance income	**1,504**	**2,568**

Note 11.1 Finance expenditure (Group)

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2025/26	2024/25
	£000	£000
Interest expense:		
Interest on loans from the Department of Health and Social Care	30	43
Interest on other loans	18	18
Interest on lease obligations	784	1,041
Interest on late payment of commercial debt	2	66
Total interest expense	**834**	**1,168**
Unwinding of discount on provisions	59	54
Total finance costs	**893**	**1,222**

Note 11.2 The late payment of commercial debts (interest) Act 1998

	2025/26	2024/25
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	2	66

Note 12 Other gains / (losses) (Group)

	2025/26	2024/25
	£000	£000
Gains on disposal of assets	-	10
Losses on disposal of assets	(60)	(19)
Total gains / (losses) on disposal of assets	**(60)**	**(9)**

Note 13 Trust income statement and statement of comprehensive income

In accordance with Section 408 of the Companies Act 2006, the trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The trust's deficit for the period was £36.5 million (2024/25: deficit £57.7 million). The trust's total comprehensive income/(expense) for the period was (£34.9m million) (2024/25: (£61.0 million)).

Note 14.1 Intangible assets - 2025/26

Group	Software licences	Licences & trademarks	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Cost at 1 April 2025 - brought forward *	**12,834**	**13**	**1,011**	**-**	**13,858**
Additions	1,379	-	1,900	1,851	**5,130**
Disposals / derecognition	(1,791)	-	-	-	**(1,791)**
Cost at 31 March 2026	**12,422**	**13**	**2,911**	**1,851**	**17,197**
Amortisation at 1 April 2025 - brought forward	**10,486**	**13**	**20**	**-**	**10,519**
Provided during the year	1,471	-	363	-	**1,834**
Impairments	208	-	2,528	1,851	**4,587**
Disposals / derecognition	(1,791)	-	-	-	**(1,791)**
Amortisation at 31 March 2026	**10,374**	**13**	**2,911**	**1,851**	**15,149**
Net book value at 31 March 2026	**2,048**	**-**	**0**	**-**	**2,048**
Net book value at 1 April 2025	**2,348**	**-**	**991**	**-**	**3,339**

* From 1 April 2025, the option to apply the revaluation model in IAS 38 to intangible assets has been withdrawn prospectively. Where assets were previously revalued, the carrying value at the transition date was carried forward as 'deemed cost'.

Note 14.2 Intangible assets - 2024/25

Group	Software licences	Licences & trademarks	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**15,358**	**13**	**2,378**	**1,548**	**19,297**
Additions	493	-	687	4,835	**6,015**
Impairments	-	-	-	-	**-**
Revaluations	(3,017)	-	(2,054)	(6,383)	**(11,454)**
Reclassifications	-	-	-	-	**-**
Valuation / gross cost at 31 March 2025	**12,834**	**13**	**1,011**	**-**	**13,858**
Amortisation at 1 April 2024 - brought forward	**9,521**	**13**	**507**	**-**	**10,041**
Provided during the year	1,511	-	317	-	**1,828**
Impairments	2,472	-	1,249	6,383	**10,104**
Revaluations	(3,017)	-	(2,054)	(6,383)	**(11,454)**
Reclassifications	(1)	-	1	-	**-**
Amortisation at 31 March 2025	**10,486**	**13**	**20**	**-**	**10,519**
Net book value at 31 March 2025	**2,348**	**-**	**991**	**-**	**3,339**
Net book value at 1 April 2024	**5,837**	**-**	**1,871**	**1,548**	**9,256**

Note 15.1 Property, plant and equipment - 2025/26

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2025 - brought forward	**32,400**	**245,353**	**9,542**	**111,158**	**112**	**30,277**	**442**	**429,284**
Additions	18,932	14,401	4,022	13,178	-	2,223	-	**52,756**
Impairments	(8,776)	(1,119)	-	-	-	-	-	**(9,895)**
Reversals of impairments	210	2,224	-	-	-	-	-	**2,434**
Revaluations	20	(17,099)	(400)	-	-	(1,885)	(172)	**(19,536)**
Reclassifications	-	9,127	(9,127)	1	1	(2)	-	**-**
Disposals / derecognition	-	-	-	(466)	-	(1,147)	(9)	**(1,622)**
Valuation/gross cost at 31 March 2026	**42,786**	**252,887**	**4,037**	**123,871**	**113**	**29,466**	**261**	**453,421**
Accumulated depreciation at 1 April 2025 - brought forward	**-**	**1,408**	**-**	**54,264**	**90**	**19,726**	**136**	**75,624**
Provided during the year	-	7,493	-	10,036	5	3,272	41	**20,847**
Impairments	-	11,736	400	-	-	504	77	**12,717**
Reversals of impairments	-	(1,434)	-	-	-	-	-	**(1,434)**
Revaluations	-	(17,552)	(400)	-	-	(1,886)	(172)	**(20,010)**
Reclassifications	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	(406)	-	(1,147)	(9)	**(1,562)**
Accumulated depreciation at 31 March 2026	**-**	**1,651**	**-**	**63,894**	**95**	**20,469**	**73**	**86,182**
Net book value at 31 March 2026	**42,786**	**251,236**	**4,037**	**59,977**	**18**	**8,997**	**188**	**367,239**
Net book value at 1 April 2025	**32,400**	**243,945**	**9,542**	**56,894**	**22**	**10,551**	**306**	**353,660**

Note 15.2 Property, plant and equipment - 2024/25

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**17,150**	**254,209**	**4,086**	**107,977**	**112**	**29,436**	**371**	**413,341**
Additions	18,000	7,144	9,282	3,502	-	841	71	**38,840**
Impairments	(3,050)	(4,909)	(3,827)	-	-	-	-	**(11,786)**
Reversals of impairments	300	949	-	-	-	-	-	**1,249**
Revaluations	-	(7,157)	-	-	-	-	-	**(7,157)**
Reclassifications	-	-	1	(1)	-	-	-	**-**
Disposals / derecognition	-	(4,883)	-	(320)	-	-	-	**(5,203)**
Valuation/gross cost at 31 March 2025	**32,400**	**245,353**	**9,542**	**111,158**	**112**	**30,277**	**442**	**429,284**
Accumulated depreciation at 1 April 2024 - brought forward	**-**	**6,152**	**-**	**45,048**	**85**	**16,128**	**92**	**67,505**
Provided during the year	-	7,658	-	9,517	5	3,598	44	**20,822**
Impairments	-	7,222	-	-	-	-	-	**7,222**
Reversals of impairments	-	(7,163)	-	-	-	-	-	**(7,163)**
Revaluations	-	(7,578)	-	-	-	-	-	**(7,578)**
Reclassifications	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	(4,883)	-	(301)	-	-	-	**(5,184)**
Accumulated depreciation at 31 March 2025	**-**	**1,408**	**-**	**54,264**	**90**	**19,726**	**136**	**75,624**
Net book value at 31 March 2025	**32,400**	**243,945**	**9,542**	**56,894**	**22**	**10,551**	**306**	**353,660**
Net book value at 1 April 2024	**17,150**	**248,057**	**4,086**	**62,929**	**27**	**13,308**	**279**	**345,836**

The Trust position differs from the group position by an insignificant amount and therefore a separate note is not included in these accounts. The subsidiary assets (fixtures & fittings) had a gross cost of £8k, accumulated depreciation of £6k at 31st March 2025 and a further £2k provided during 2025-26, giving a net book value of £nil at 31st March 2026.

Note 15.3 Property, plant and equipment financing - 31 March 2026

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	42,786	248,701	2,687	56,919	18	8,987	182	**360,280**
Owned - donated/granted	-	2,535	1,350	3,058	-	10	6	**6,959**
NBV total at 31 March 2026	**42,786**	**251,236**	**4,037**	**59,977**	**18**	**8,997**	**188**	**367,239**

Note 15.4 Property, plant and equipment financing - 31 March 2025

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	32,400	242,015	9,542	53,400	22	10,551	299	**348,229**
Owned - donated/granted	-	1,930	-	3,494	-	-	7	**5,431**
NBV total at 31 March 2025	**32,400**	**243,945**	**9,542**	**56,894**	**22**	**10,551**	**306**	**353,660**

Note 15.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2026

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	92	4,994	-	-	-	-	-	**5,086**
Not subject to an operating lease	42,694	246,242	4,037	59,977	18	8,997	188	**362,153**
NBV total at 31 March 2026	**42,786**	**251,236**	**4,037**	**59,977**	**18**	**8,997**	**188**	**367,239**

Note 15.6 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2025

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	88	4,970	-	-	-	-	-	**5,058**
Not subject to an operating lease	32,312	238,975	9,542	56,894	22	10,551	306	**348,602**
NBV total at 31 March 2025	**32,400**	**243,945**	**9,542**	**56,894**	**22**	**10,551**	**306**	**353,660**

Note 16 Donations of property, plant and equipment

In 2025/26, the Trust received medical equipment and funding for estates work totalling £388k (2024/25: £849k) from the non-consolidated charity. A further donation of £717k was received from The HELP Appeal (County Air Ambulance Trust) to renew the helipad at the Royal Preston Hospital site.

Note 17 Leases - Lancashire Teaching Hospitals NHS Foundation Trust as a lessee

The Trust leases many assets including land and buildings, vehicles, machinery, equipment, and IT. This note details information about leases for which the Trust is a lessee.

Land & Buildings leases

The Trust leases clinical space within other NHS sites which are owned by NHS Property Services or other NHS Foundation Trusts. These leases run for 5 to 12 years and amounts payable under the leases are revised annually using inflation factors as set out in NHS Planning guidance issued by NHSE.

The Trust also has two leases with commercial landlords; one for Preston Business Centre and one for Finney House. The lease for Preston Business Centre is for 10 years and commenced on 1st December 2021. The amount payable under this lease is revised at five yearly intervals as per the clauses in the lease. The lease for Finney House commenced on the 15th November 2023 for a 5 year term. The lease terms provide for an annual rental review each April using the consumer price index from the preceding February.

The Trust leases some of it's premises under operating leases (see note 5.1)

Some leases contain extension options exercisable by the Trust in accordance with the lease terms. The Trust seeks to include extension options in new leases to provide operational flexibility. The extension options are exercisable only by the Trust and not by the lessors. The Trust assesses at lease commencement whether it is reasonably certain to exercise the extension options. It reassesses whether it is reasonably certain to exercise options if there is a significant event or significant change in circumstances within it's control.

Other leases

The Trust leases vehicles and equipment, with terms between 1 to 8 years. In some cases the Trust has options to purchase the assets at the end of the contract term; in other cases the Trust is obliged to return the items to the lessor or negotiate a secondary lease. Neither are considered to be obligations and therefore the Trust is not estimating liabilities beyond the original lease terms.

Note 17.1 Right of use assets - 2025/26

Group	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2025 - brought forward	**20,074**	**22,862**	**231**	**6**	**43,173**	**1,039**
Additions	651	8	60	-	**719**	-
Movements in provisions for restoration / removal costs	1,535	-	-	-	**1,535**	-
Disposals / derecognition	(17)	(127)	(141)	(6)	**(291)**	(17)
Valuation/gross cost at 31 March 2026	**22,243**	**22,743**	**150**	**-**	**45,136**	**1,022**
Accumulated depreciation at 1 April 2025 - brought forward	**8,293**	**6,854**	**134**	**6**	**15,287**	**110**
Provided during the year	3,017	4,725	77	-	**7,819**	102
Disposals / derecognition	(17)	(127)	(141)	(6)	**(291)**	(17)
Accumulated depreciation at 31 March 2026	**11,293**	**11,452**	**70**	**-**	**22,815**	**195**
Net book value at 31 March 2026	**10,950**	**11,291**	**80**	**-**	**22,321**	**827**
Net book value at 1 April 2025	**11,781**	**16,008**	**97**	**-**	**27,886**	**929**

Net book value of right of use assets leased from other NHS providers	-
Net book value of right of use assets leased from other DHSC group bodies	827

Note 17.2 Right of use assets - 2024/25

Group	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**29,542**	**11,732**	**250**	**6**	**41,530**	**816**
Additions	356	13,355	24	-	**13,735**	223
Remeasurements of the lease liability	293	-	-	-	**293**	-
Revaluations	(9,625)	-	-	-	**(9,625)**	-
Reclassifications	-	(1)	1	-	**-**	-
Disposals / derecognition	(492)	(2,224)	(44)	-	**(2,760)**	-
Valuation/gross cost at 31 March 2025	**20,074**	**22,862**	**231**	**6**	**43,173**	**1,039**
Accumulated depreciation at 1 April 2024 - brought forward	**8,701**	**3,119**	**100**	**4**	**11,924**	**8**
Provided during the year	5,258	5,043	78	2	**10,381**	102
Impairments	4,451	-	-	-	**4,451**	-
Revaluations	(9,625)	-	-	-	**(9,625)**	-
Disposals / derecognition	(492)	(1,308)	(44)	-	**(1,844)**	-
Accumulated depreciation at 31 March 2025	**8,293**	**6,854**	**134**	**6**	**15,287**	**110**
Net book value at 31 March 2025	**11,781**	**16,008**	**97**	**-**	**27,886**	**929**
Net book value at 1 April 2024	**20,841**	**8,613**	**150**	**2**	**29,606**	**808**

Net book value of right of use assets leased from other NHS providers	-
Net book value of right of use assets leased from other DHSC group bodies	929

Note 17.3 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 23.

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Carrying value at 1 April	**33,021**	**29,880**	**33,021**	29,880
Lease additions	719	13,735	719	13,735
Lease liability remeasurements	-	293	-	293
Interest charge arising in year	784	1,041	784	1,041
Early terminations	-	(926)	-	(926)
Lease payments (cash outflows)	(10,595)	(11,002)	(10,595)	(11,002)
Carrying value at 31 March	**23,929**	**33,021**	**23,929**	**33,021**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 6.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

The Trust does not sub lease any right of use assets so the value included within revenue from operating leases in note 3 all relates to Trust owned property that is leased.

Note 17.4 Maturity analysis of future lease payments at 31 March 2026

	Group		Trust	
	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2026	31 March 2026	31 March 2026	31 March 2026
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	10,609	124	10,609	124
- later than one year and not later than five years;	11,343	398	11,343	398
- later than five years.	3,124	595	3,124	595
Total gross future lease payments	**25,076**	**1,117**	**25,076**	**1,117**
Finance charges allocated to future periods	(1,147)	(255)	- 1,147	(255)
Net lease liabilities at 31 March 2026	**23,929**	**862**	**23,929**	**862**
Of which:				
Leased from other NHS providers		-		-
Leased from other DHSC group bodies		862		862

Note 17.5 Maturity analysis of future lease payments at 31 March 2025

	Group		Trust	
	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2025	31 March 2025	31 March 2025	31 March 2025
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	10,521	129	10,521	129
- later than one year and not later than five years;	19,809	448	19,809	448
- later than five years.	4,530	669	4,530	669
Total gross future lease payments	**34,860**	**1,246**	**34,860**	**1,246**
Finance charges allocated to future periods	(1,839)	(297)	- 1,839	(297)
Net finance lease liabilities at 31 March 2025	**33,021**	**949**	**33,021**	**949**
Of which:				
Leased from other NHS providers		-		-
Leased from other DHSC group bodies		949		949

Note 18 Inventories

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Drugs	6,411	6,514	3,379	3,862
Consumables	11,401	11,222	11,401	11,222
Energy	193	176	193	176
Other	1	14	1	14
Total inventories	**18,006**	**17,926**	**14,974**	**15,274**
of which:				
Held at fair value less costs to sell	-	-		

Inventories recognised in expenses for the year were £142,945k (2024/25: £114,699k). Write-down of inventories recognised as expenses for the year were £407k (2024/25: £313k).

Note 19.1 Receivables

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Current				
Contract receivables	38,679	29,013	37,951	29,628
Allowance for impaired contract receivables / assets	(1,064)	(1,712)	(1,064)	(1,712)
Prepayments (non-PFI)	9,900	5,793	9,872	5,764
Operating lease receivables	440	189	440	189
PDC dividend receivable	-	1,285	-	1,285
VAT receivable	1,568	3,547	646	1,739
Other receivables	2,717	2,955	2,766	3,006
Total current receivables	**52,240**	**41,070**	**50,611**	**39,899**
Non-current				
Contract receivables	6,563	6,254	6,563	6,254
Allowance for impaired contract receivables / assets	(742)	(644)	(742)	(644)
Other receivables	778	893	2,278	2,393
Total non-current receivables	**6,599**	**6,503**	**8,099**	**8,003**
Of which receivable from NHS and DHSC group bodies:				
Current	27,848	21,083	27,848	21,083
Non-current	778	893	778	893

Note 19.2 Allowances for credit losses - 2025/26

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Allowances as at 1 Apr 2025	**2,356**	**2,248**	**2,356**	**2,248**
New allowances arising	586	783	586	783
Changes in existing allowances	104	(12)	104	(12)
Reversals of allowances	(937)	(390)	(937)	(390)
Utilisation of allowances (write offs)	(303)	(273)	(303)	(273)
Allowances as at 31 Mar 2026	**1,806**	**2,356**	**1,806**	**2,356**

Note 20 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
At 1 April	**8,253**	**36,033**	**7,505**	**34,813**
Net change in year	21,599	(27,780)	21,599	(27,308)
At 31 March	**29,852**	**8,253**	**29,104**	**7,505**
Broken down into:				
Cash at commercial banks and in hand	1,596	773	20	25
Cash with the Government Banking Service	28,256	7,480	28,256	7,480
Total cash and cash equivalents as in SoFP	**29,852**	**8,253**	**28,276**	**7,505**
Total cash and cash equivalents as in SoCF	**29,852**	**8,253**	**28,276**	**7,505**

Note 20.1 Third party assets held by the trust

Lancashire Teaching Hospitals NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	Group and Trust	
	31 March 2026	31 March 2025
	£000	£000
Bank balances	8	8
Total third party assets	**8**	**8**

Note 21 Trade and other payables

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Current				
Trade payables	31,247	28,140	27,243	25,288
Capital payables	22,071	21,097	22,071	21,097
Accruals	26,065	25,630	25,515	25,630
Social security costs	5,860	5,369	5,860	5,347
Other taxes payable	6,515	5,988	6,440	5,969
PDC dividend payable	60	-	60	-
Pension contributions payable	6,467	6,526	6,457	6,518
Other payables	2,522	1,560	2,466	1,388
Total current trade and other payables	**100,807**	**94,310**	**96,112**	**91,237**
Of which payables from NHS and DHSC group bodies:				
Current	18,968	11,766	18,967	8,693
Non-current	-	-	-	-

Note 22 Other liabilities

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Current				
Deferred income: contract liabilities	6,386	7,123	6,386	7,123
Total other current liabilities	**6,386**	**7,123**	**6,386**	**7,123**
Non-current				
Other deferred income	-	2,085	-	2,085
Total other non-current liabilities	**-**	**2,085**	**-**	**2,085**

Note 23 Borrowings

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Current				
Loans from DHSC	103	368	103	368
Other loans	79	79	79	79
Lease liabilities	10,098	9,751	10,098	9,751
Total current borrowings	**10,280**	**10,198**	**10,280**	**10,198**
Non-current				
Loans from DHSC	1,300	1,400	1,300	1,400
Other loans	189	265	189	265
Lease liabilities	13,831	23,270	13,831	23,270
Total non-current borrowings	**15,320**	**24,935**	**15,320**	**24,935**

Note 23.1 Reconciliation of liabilities arising from financing activities (Group)

Group - 2025/26	Loans from DHSC	Other loans	Lease liabilities	Total
	£000	£000	£000	£000
Carrying value at 1 April 2025	**1,768**	**344**	**33,021**	**35,133**
Cash movements:				
Financing cash flows - payments and receipts of principal	(363)	(76)	(9,811)	**(10,250)**
Financing cash flows - payments of interest	(32)	(18)	(784)	**(834)**
Non-cash movements:				
Additions	-	-	719	**719**
Lease liability remeasurements	-	-	-	**-**
Application of effective interest rate	30	18	784	**832**
Early terminations	-	-	-	**-**
Carrying value at 31 March 2026	**1,403**	**268**	**23,929**	**25,600**

Group - 2024/25	Loans from DHSC	Other loans	Lease liabilities	Total
	£000	£000	£000	£000
Carrying value at 1 April 2024	**2,879**	**420**	**29,880**	**33,179**
Cash movements:				
Financing cash flows - payments and receipts of principal	(1,108)	(76)	(9,961)	**(11,145)**
Financing cash flows - payments of interest	(46)	(18)	(1,041)	**(1,105)**
Non-cash movements:				
Additions	-	-	13,735	**13,735**
Lease liability remeasurements	-	-	293	**293**
Application of effective interest rate	43	18	1,041	**1,102**
Early terminations	-	-	(926)	**(926)**
Carrying value at 31 March 2025	**1,768**	**344**	**33,021**	**35,133**

Note 24 Provisions for liabilities and charges analysis (Group)

Group	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2025	**1,103**	**218**	**1,754**	**3,075**
Change in the discount rate	8	-	(64)	**(56)**
Arising during the year	21	107	1,821	**1,949**
Utilised during the year	(96)	(107)	(33)	**(236)**
Reversed unused	-	(44)	(929)	**(973)**
Unwinding of discount	30	-	81	**111**
At 31 March 2026	**1,066**	**174**	**2,630**	**3,870**
Expected timing of cash flows:				
- not later than one year;	93	174	33	**300**
- later than one year and not later than five years;	347	-	543	**890**
- later than five years.	626	-	2,054	**2,680**
Total	**1,066**	**174**	**2,630**	**3,870**

Permanent injury benefits

Payments are made on a quarterly basis to the NHS Pension Scheme and NHS Injury Benefit Scheme respectively.

Note 24 Provisions for liabilities and charges analysis (continued)

Legal claims

Legal claims provisions relate to employer and public liability claims.

Clinician's pension tax

Clinicians who were members of the NHS Pensions Scheme and who as a result of work undertaken in the tax year (2019/20) face a tax charge in respect of growth of their NHS pension benefits above their pensions savings annual allowance threshold will be able to have this charge paid by the NHS Pension Scheme.

Dilapidation provisions

The Trust has created a provision for the reinstatement of leased properties (dilapidations). Payments will be made as and when leases expire and agreements are reached with Landlords.

Note 24.1 Clinical negligence liabilities

At 31 March 2026, £303,404k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Lancashire Teaching Hospitals NHS Foundation Trust (31 March 2025: £307,404k).

Note 25 Contingent assets and liabilities

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Value of contingent liabilities				
NHS Resolution legal claims	(59)	(94)	(59)	(94)
Other	-	(640)	-	(640)
Gross value of contingent liabilities	**(59)**	**(734)**	**(59)**	**(734)**
Amounts recoverable against liabilities	-	2,560		
Net value of contingent liabilities	**(59)**	**1,826**	**(59)**	**(734)**
Net value of contingent assets	**-**	**1,920**		

Northumbria Healthcare NHS Foundation Trust appealed the VAT treatment of income earned from car parking by NHS Trusts. HMRC rejected the Trust's claim and both the First-Tier Tribunal (Tax Chamber) and the Upper Tribunal (Tax & Chancery Chamber) dismissed the Trust's appeal. The Court of Appeal allowed the Trust's appeal.

The Northumbria Healthcare NHS Foundation Trust was the lead case, and a number of NHS Foundation Trusts, including this Trust, had submitted claims on the same basis as the lead case. At the 31st March 2025 HMRC's appeal to the Supreme Court was pending and consequently the Trust recognised a contingent asset of £2.560m being the amount of VAT that was potentially recoverable, along with a contingent liability of £0.640m being the fee that would become payable to the Trusts VAT advisors who had led on the appeal on behalf of the Trust.

During 2025/26 HMRCs appeal was heard by the Supreme Court and the Court ruled in favour of HMRC. As a consequence the contingent asset and liability have both been removed.

Note 26 Contractual capital commitments

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Property, plant and equipment	16,520	-	16,520	-
Total	**16,520**	**-**	**16,520**	**-**

The contractual capital commitments represent the value of works committed to on projects that were work in progress at the 31st March. There were no contractual capital commitments at 31 March 2025. The contractual capital commitment at 31 March 2026 relates to the remaining value of works on a decarbonisation scheme. This scheme funded through Public Sector Decarbonisation Scheme (PSDS) grants which will be received as expenditure occurs.

Note 27 Financial instruments

Note 27.1 Financial risk management

International Financial Reporting Standard 9 requires disclosure of the role which Financial Instruments have had during the period in creating or changing the risks which a body faces in undertaking its activities. Because of the continuing service provider relationship which the Trust has with its Commissioners, and the way in which those Commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also, Financial Instruments play a much more limited role in creating or changing risk for the Trust than would be typical of listed companies, to which these standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and Financial Assets and Liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's Treasury Management operations are carried out by the Finance Department, within parameters defined formally within the Trust's Standing Financial Instructions, and policies agreed by the Board of Directors. The Trust's treasury activities are also subject to review by Internal Audit.

Liquidity Risk

Net operating costs of the Trust are funded under annual Service Agreements with NHS Commissioners, which are financed from resources voted annually by Parliament. While the Trust is in deficit it is accessing working capital support by means of PDC through DHSC. The Trust largely finances its capital expenditure from internally generated cash, and funds made available by the DHSC. Additional funding by way of loans has been arranged with the Foundation Trust Financing Facility to support major capital developments. The Trust is, therefore, exposed to liquidity risks from the loan funding - however these risks are approved, and comply with Monitor's Risk Assessment Framework.

Currency Risk

The Trust is a domestic organisation with the overwhelming majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations, and therefore has low exposure to currency rate fluctuations..

Interest Rate Risk

100% of the Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. The Trust is not, therefore, exposed to significant interest rate risk.

Credit Risk

The majority of the Trust's Income comes from contracts with other public sector bodies, and therefore the Trust has low exposure to credit risk. The maximum exposure as at 31st March is within Receivables from customers, as disclosed in the Trade and Other Receivables note to these Accounts.

Note 27.2 Carrying values of financial assets

	Group		Trust	
Carrying values of financial assets as at 31 March 2026	**Held at amortised cost**	**Total book value**	**Held at amortised cost**	**Total book value**
	£000	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	47,371	**47,371**	48,192	47,371
Cash and cash equivalents	29,852	**29,852**	28,276	29,852
Total at 31 March 2026	**77,223**	**77,223**	**76,468**	**77,223**

	Group		Trust	
Carrying values of financial assets as at 31 March 2025	**Held at amortised cost**	**Total book value**	**Held at amortised cost**	**Total book value**
	£000	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	36,944	**36,944**	39,111	39,111
Cash and cash equivalents	8,253	**8,253**	7,505	7,505
Total at 31 March 2025	**45,197**	**45,197**	**46,616**	**46,616**

Note 27.3 Carrying values of financial liabilities

	Group		Trust	
Carrying values of financial liabilities as at 31 March 2026	**Held at amortised cost**	**Total book value**	**Held at amortised cost**	**Total book value**
	£000	**£000**	**£000**	**£000**
Loans from the Department of Health and Social Care	1,403	**1,403**	1,403	**1,403**
Obligations under leases	23,929	**23,929**	23,929	**23,929**
Other borrowings	268	**268**	268	**268**
Trade and other payables excluding non financial liabilities	81,841	**81,841**	85,899	**85,899**
Total at 31 March 2026	**107,441**	**107,441**	**111,499**	**111,499**

	Group		Trust	
Carrying values of financial liabilities as at 31 March 2025	**Held at amortised cost**	**Total book value**	**Held at amortised cost**	**Total book value**
	£000	**£000**	**£000**	**£000**
Loans from the Department of Health and Social Care	1,768	**1,768**	1,768	**1,768**
Obligations under leases	33,021	**33,021**	33,021	**33,021**
Other borrowings	344	**344**	344	**344**
Trade and other payables excluding non financial liabilities	76,426	**76,426**	73,401	**73,401**
Total at 31 March 2025	**111,559**	**111,559**	**108,534**	**108,534**

Note 27.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	Group		Trust	
	31 March 2026	**31 March 2025**	**31 March 2026**	**31 March 2025**
	£000	**£000**	**£000**	**£000**
In one year or less	92,671	87,435	96,729	84,410
In more than one year but not more than five years	12,144	20,636	12,144	20,636
In more than five years	4,112	5,638	4,112	5,638
Total	**108,927**	**113,709**	**112,985**	**110,684**

Note 28 Losses and special payments

	2025/26		2024/25	
Group and trust	**Total number of cases**	**Total value of cases**	**Total number of cases**	**Total value of cases**
	Number	**£000**	**Number**	**£000**
Losses				
Cash losses	6	-	2	-
Fruitless payments and constructive losses	1	84	-	-
Bad debts and claims abandoned	867	336	1,024	245
Stores losses and damage to property	6	407	3	313
Total losses	**880**	**827**	**1,029**	**558**
Special payments				
Compensation under court order or legally binding arbitration award	3	6	4	4
Ex-gratia payments	29	146	29	94
Total special payments	**32**	**152**	**33**	**98**
Total losses and special payments	**912**	**979**	**1,062**	**656**

Note 29 Related parties

Lancashire Teaching Hospitals NHS Foundation Trust is a public interest body, a Department of Health and Social Care (parent of the group) Group body, authorised by NHS Improvement, the Independent Regulator for NHS Foundation Trusts. During the year none of the Board members or members of key management staff or parties related to them has undertaken any material transactions with Lancashire Teaching Hospitals NHS Foundation Trust.

The Board of Directors, or close family members of the same, who have interests in or hold positions with organisations with which the Trust has had transactions during the year, are listed below:

	Income	Expenditure	Receivable	Payable	Relationship
	£000	£000	£000	£000	
NHS Lancashire and South Cumbria ICB	679,799	214	7,127	3,463	Executive Director
NHS England	114,518	3,990	2,613	6,187	Chair
East Lancashire Hospitals NHS Trust	18,332	3,777	5,847	4,379	Chair Corporate Director
University Hospitals of Morecambe Bay NHS Foundation Trust	13,707	1,015	1,464	2,040	Non-Executive Director
Care Quality Commission	-	435	-	-	Non-Executive Director
University of Lancashire	774	238	533	6	Non-Executive Director Corporate Director
St Catherine's Hospice	7	7	41	-	Executive Director
Weightmans Solicitors LLP	-	146	-	-	Non-Executive Director Executive Director
Electricity North West Ltd	-	7	-	-	Non-Executive Director

The Trust previously established a wholly owned subsidiary, Lancashire Hospitals Services Ltd. Lancashire Hospitals Services Ltd took over the outpatient pharmacies across the Trust on 1 October 2018. With effect from the 1 February 2025 the subsidiary also took over the outpatient pharmacies at East Lancashire Hospitals NHS Trust, University Hospitals of Morecambe Bay NHS Foundation Trust and Blackpool Teaching Hospitals NHS Foundation Trust. Being wholly owned and controlled by the Trust, the Trust has prepared its financial statements on a Group basis, consolidating the results of Lancashire Hospitals Services Ltd.

The Trust is Corporate Trustee of two charities which means that the Trust has control over the charities. Both Charities are registered with the Charity Commission and produce a set of annual accounts and an annual report (separate to that of the NHS Foundation Trust) These documents will be available by December 2026, on request from the Finance Department of the Trust. Details of the charities and of material transactions between them and the Trust are detailed below.

Charity	Registered Number	Donations received	Receivable	Payable
		£000	£000	£000
Lancashire Teaching Hospitals Charity	1051194	11	80	0
The Rosemere Cancer Foundation	1131583	295	121	0

Note 30 Events after the reporting date

The Boards of Lancashire Teaching Hospitals NHS Foundation Trust (LTH), East Lancashire Hospitals NHS Trust (ELHT), Blackpool Teaching Hospitals NHS Foundation Trust (BTH), and University Hospitals of Morecambe Bay NHS Foundation Trust (UHMB) have agreed that with effect from the 1st April 2026 the Pathology Services provided by each Trust transferred to LTH to create a Pathology Single Service. LTH manages the Pathology Single Service and charges the other three trusts for the services as a contracted service.

The transfer will take place in two phases. In phase one, which happened on 1st April 2026, the staff engaged in delivering pathology services transferred to LTH under the Transfer of Undertakings (Protection of Employment) regulations, and LTH became responsible for those staff and associated non-pay costs. It is estimated that phase one transfer will increase income and expenditure in 2026/27 by c£68m. Non-current assets such as property and plant and machinery will transfer in phase two. The date for phase two has not been agreed.

The values of assets (other than phase 2 assets), liabilities and reserves to be transferred are under negotiation but are not considered to be material. The transfers will be accounted for as transfers by absorption. From the 1st April 2026 the income, expenditure, assets and liabilities arising from the trading activities of the Pathology Single Service will be reported within the future annual accounts of LTH.

One LSC has been accounted for as a joint operation within these financial statements (see note 3). There are developments taking place from 1st April 2026 which will move One LSC from a joint operation to an entity that is solely controlled by ELHT, and this will change the accounting treatment accordingly from that date. The value of services received from One LSC will be reported as a contracted service in expenditure in future accounting periods.

If you have any queries regarding this report, or wish to make contact with any of the Directors or Governors, please contact:

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For more information about Lancashire Teaching Hospitals NHS Foundation Trust see:

www.lancsteachinghospitals.nhs.uk

@lancshospitals

lancshospitals

Auditor's Annual Report 2025/26

Lancashire Teaching Hospitals NHS Foundation Trust

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26 June 2026

Contents

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This report is addressed to Lancashire Hospitals NHS Foundation Trust (the Trust), as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state, those matters we are required to state to them in an auditors' annual report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Lancashire Teaching Hospitals NHS Foundation Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

We take no responsibility to any member of staff acting in their individual capacities, or to third parties.

External auditors do not act as a substitute for the audited body's own responsibility for putting in place proper arrangements to ensure that public business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively.

01 Executive Summary

Executive Summary

Purpose of the Auditor's Annual Report

This Auditor's Annual Report provides a summary of the findings and key issues arising from our 2025-26 audit of Lancashire Teaching Hospitals NHS Foundation Trust (the 'Trust'). This report has been prepared in line with the requirements set out in the Code of Audit Practice published by the National Audit Office and is required to be published by the Trust alongside the annual report and accounts.

Our responsibilities

The statutory responsibilities and powers of appointed auditors are set out in the Local Audit and Accountability Act 2014. In line with this we provide conclusions on the following matters:

Accounts - We provide an opinion as to whether the accounts give a true and fair view of the financial position of the Group and the Trust and of their income and expenditure during the year. We confirm whether the accounts have been prepared in line with the Group Accounting Manual prepared by the Department of Health and Social Care (DHSC).

Annual report - We assess whether the annual report is consistent with our knowledge of the Trust. We perform testing of certain figures labelled in the remuneration report.

Value for money - We assess the arrangements in place for securing economy, efficiency and effectiveness (value for money) in the Trust's use of resources and provide a summary of our findings in the commentary in this report. We are required to report if we have identified any significant weaknesses as a result of this work.

Other reporting - We may issue other reports where we determine that this is necessary in the public interest under the Local Audit and Accountability Act.

Findings

We have set out below a summary of the conclusions that we provided in respect of our responsibilities.

Accounts	We issued an unqualified opinion on the Consolidated Trust's accounts on the 26 June 2026. This means that we believe the accounts give a true and fair view of the financial performance and position of the Group and the Trust. We have provided further details of the key risks we identified and our response on page 7-8.
Annual report	We did not identify any significant inconsistencies between the content of the annual report and our knowledge of the Trust. We confirmed that the annual report has been prepared in line with the NHS Group Accounting Manual (GAM) and the Foundation Trust Annual Reporting Manual (the ARM).
Value for money	We are required to report if we identify any matters that indicate the Trust does not have sufficient arrangements to achieve value for money. No new significant weaknesses have been identified in 2025/26. However, in the prior year we identified a significant weakness relating to financial sustainability and this remains in 2025/26. We have provided further detail on page 10. We have followed up on the significant weakness identified in the prior year on page 22.
Other reporting	We did not consider it necessary to issue any other reports in the public interest.

02
Audit of the Financial Statements

Audit of the financial statements

KPMG provides an independent opinion on whether the Trust's financial statements:

- Give a true and fair view of the state of the Trust's affairs as at 31 March 2026 and of its income and expenditure for the year then ended;
- Have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State in February 2026 as being relevant to NHS Foundation Trusts and included in the Department of Health and Social Care Group Accounting Manual 2025/26; and
- Have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

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

Audit opinion on the financial statements

We have issued an unqualified opinion on the Trust's financial statements on 26 June 2026.

The full opinion is included in the Trust's Consolidated Annual Report and Accounts for 2025/26 which can be obtained from the Trust's website.

Further information on our audit of the financial statements is set out overleaf.

Audit of the financial statements

The table below summarises the key risks that we identified to our audit opinion as part of our risk assessment and how we responded to these through our audit.

Significant risk - Fraud risk from expenditure recognition - completeness	Procedures undertaken	Findings
Risk: ***Liabilities for purchases of goods or services are recorded inappropriately when they are not recorded, the entity has a present obligation that is not accounted for in the correct financial year, or the expenditure recognised is not complete.*** As the Trust and system is set a financial performance target by NHSE there is a risk that non-pay expenditure, excluding depreciation, may be manipulated to report that the control total has been met. The setting of a planned outturn target can create an incentive for management to understate the level of non-pay expenditure compared to that which has been incurred. At the end of February 2026, the Trust had a deficit of £30.8m against a planned deficit of £1.5m. The adverse variance to plan of £29.3m is mainly as a consequence of the shortfall in delivery of the Waste Reduction Programme £20.0m and non-receipt of deficit support funding for November to February of £10.0m. At M10, the trust had agreed a revised deficit forecast of £9.2m by 31 March 2026. We have considered the most likely way to achieve the revised deficit target would be through the omission of year end manual accruals (both NHS and non-NHS), pushing expenditure into future periods to mitigate financial pressures that exist in the period to 31 March 2026.	• We have evaluated the design and implementation of controls to provide assurance over the completeness of accruals. • We have inspected a sample of invoices of expenditure, in the period before 31 March 2026 and in two month following 31 March 2026, to determine whether expenditure has been recognised in the correct accounting period; • We have performed a year-on-year comparison of a sample of the largest accruals in the prior year and current year and challenged management where the movement is not in line with our understanding of the entity. • We inspected a sample of cash expenditure recorded in the bank statement post year end and reviewed associated evidence, including invoice where applicable, to test for unrecorded liabilities. • We have inspected journals posted as part of the year end close procedures that increase the level of expenditure recorded in order to critically assess whether there was an appropriate basis for posting the journal and the value can be agreed to supporting evidence;	We completed the procedures as described and we did not identify any material misstatements relating to this area. Management's established control process to review aged accruals on a monthly basis is not designed at the required level of precision to address the risk over completeness of accruals. As such we deem the control ineffective. .

Audit of the financial statements

The table below summarises the key risks that we identified to our audit opinion as part of our risk assessment and how we responded to these through our audit.

Significant risk – Management override of controls	Procedures undertaken	Findings
Fraud risk related to unpredictable way management override of controls may occur Professional standards require us to communicate the fraud risk from management override of controls as significant. Management is in a unique position to perpetrate fraud because of their ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively. We have not identified any specific additional risks of management override relating to this audit.	• Assessed accounting estimates for bias by evaluating whether judgements and decisions in making accounting estimates, even if individually reasonable, indicated a possible bias. • In line with our methodology, evaluated the design and implementation of controls over journal entries and post closing adjustments. • Assessed the appropriateness of changes compared to the prior year to the methods and underlying assumptions used to prepare accounting estimates. • Assessed the business rationale and the appropriateness of the accounting for significant transactions that are outside the Trust's normal course of business or are otherwise unusual. • Identified journal entries and other adjustments with characteristics that make them susceptible to fraud using KPMG Clara Journal Entry Analysis and performed procedures to test the appropriateness of these entries and adjustments.	We completed the procedures as described and we did not identify any material misstatements relating to this area. Through our evaluation of the design and implementation of controls around journal entries, whilst it does demonstrate segregation of duties, it does not meet the management review control criteria as stipulated by auditing standards and is not consistently applied across those who can post journal entries. For example, we identified that the ledger system does permit ELFS (shared service provider) members to self-approve journals. Whilst there are mitigations in place that reduces the risk over management override, such as the nature of the journals posted by ELFS, we deem design of the control to be ineffective. Whilst we are not raising a formal control observation in this regard, and the Trust considers its existing controls to be proportionate to address the associated risk, as management override of control is a significant risk we are required to bring this matter to your attention.

03 Value for Money

Value for Money

Introduction

We are required to consider whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources or 'value for money'. We consider whether there are sufficient arrangements in place for the Trust for the following criteria, as defined by the National Audit Office (NAO) in their Code of Audit Practice:

- Financial sustainability: How the Trust plans and manages its resources to ensure it can continue to deliver its services.
- Governance: How the Trust ensures that it makes informed decisions and properly manages its risks.
- Improving economy, efficiency and effectiveness: How the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

Approach

We undertake risk assessment procedures in order to assess whether there are any risks that value for money is not being achieved. This is prepared by considering the findings from other regulators and auditors, records from the organisation and performing procedures to assess the design of key systems at the organisation that give assurance over value for money.

Where a significant risk is identified we perform further procedures in order to consider whether there are significant weaknesses in the processes in place to achieve value for money.

We are required to report a summary of the work undertaken and the conclusions reached against each of the aforementioned reporting criteria in this Auditor's Annual Report. We do this as part of our commentary on VFM arrangements over the following pages.

We also make recommendations where we identify weaknesses in arrangements or other matters that require attention from the Trust.

Summary of findings

	Financial sustainability	Governance	Improving economy, efficiency and effectiveness
Commentary page reference	12-15	16-18	19-20
Identified risk of significant weakness?	Yes (pg 21)	No	No
Actual significant weakness identified/Ongoing significant weakness?	Yes	No	No
2024-25 Findings	Significant weakness in arrangements identified	No significant weakness identified	Risk of significant weakness noted but did not materialise into significant weakness
Direction of travel	⇔	⇔	⇔

Significant weaknesses followed up from the prior year

A significant weakness surrounding financial sustainability was identified in the previous year and remains in the current year. In line with guidance, we have not raised a new recommendation this year but have followed up the progress in implementing the recommendation previously raised, see page 22.

Value for Money

NATIONAL CONTEXT

In July 2025 the Department of Health and Social Care published the 10 year plan for the NHS. This sets the strategic direction that is planned to be taken for the health service, with a focus built around three key shifts:

- From hospital to community;
- From analogue to digital; and
- From sickness to prevention.

A number of structural changes are planned to support the implementation of the strategy between 2025 and 2027, with NHS England taking greater responsibility for the management of financial performance of providers within the sector and a reduced role for managing finances at an integrated care system level.

It is anticipated that all provider trusts will become foundation trusts and a scheme to pilot 'advanced' foundation trusts was launched during the year, with greater freedoms available for the management of finances as well as the leadership for accountable health organisations available to those providers in the highest performing segment of NHS England's oversight framework.

While revised structures were implemented there continued to be a focus on improving performance in key operational areas, including reducing referral to treatment backlogs and ambulance waiting times. Nationally the proportion of elective patients waiting less than 18 weeks improved from 60% to 65% during 2025-26, though 1.3% of patients continued to wait over 52 weeks to commence treatment. Eliminating long waiters forms a key part of the priorities for the NHS in the year and moving into 2026-27.

Nationally ambulance response times also improved and reduced to the lowest level since 2021 for category 2 response times, reflecting serious but not life-threatening conditions that require ambulance support. The target for this standard remains 18 minutes, which has not been met since 2021.

LOCAL CONTEXT

Lancashire Teaching Hospitals NHS Foundation Trust is a large acute Trust providing district general hospital services to over 395,000 people in Chorley, Preston and South Ribble and specialist care to 1.8m people across Lancashire and South Cumbria. The Trust provides care across four facilities in Preston and Chorley. It is part of the Lancashire and South Cumbria Integrated Care System (ICS).

In April 2025, the Trust's Board submitted a break-even plan underpinned by a recurrent waste reduction programme (WRP) of £60m and non-recurrent deficit support funding of £30m. At the year end, the Trust achieved a deficit of £13.6m against a break-even plan, however, the Trust had agreed a revised deficit target in February 2026 of £9.2m.

The main driver for the overspend was pay (£24.8m), primarily where the Trust has not realised savings under its WRP pay schemes (£21.6m). Overall, the Trust delivered cost improvement savings totalling £37.5m, this was still £22.5m short of the original WRP target (£60m) for the year. £24m of the savings was delivered recurrently with the full year impact of this being £38m.

Whilst WRP delivery continues to be challenging for the Trust, there has been a strengthening in arrangements during the year and a reduction in the underlying deficit.

The Trust invested £59m in capital during 2025-26, including a £19m purchase of land as part of the New Hospital Programme and £14m of medical equipment.

Operationally there was some improvement in performance against core indicators, however, the Trust is still underperforming against the A&E 4 hours standard, Emergency Department length of stay over 12 hours and ambulance handover target. The Trust did see improvement in the 18-week referral to treatment target - the number of incomplete pathways greater than 65 weeks, and some of the cancer indicators.

Financial Sustainability

How the Trust plans and manages its resources to ensure it can continue to deliver its services.

We have considered the following in our work:

- How the Trust ensures that it identifies all the significant financial pressures that are relevant to its short and medium-term plans and builds these into them;
- How the Trust plans to bridge its funding gaps and identifies achievable savings;
- How the Trust plans finances to support the sustainable delivery of services in accordance with strategic and statutory priorities;
- How the Trust ensures that its financial plan is consistent with other plans such as workforce, capital, investment, and other operational planning which may include working with other local public bodies as part of a wider system; and
- How the Trust identifies and manages risks to financial resilience, e.g. unplanned changes in demand, including challenge of the assumptions underlying its plans

Financial Plan 2025-26

The financial plan for 2025-26 was created in accordance with NHS planning guidelines, in addition to ICS-wide principles. We saw evidence of appropriate review and approval by budget holders through to challenge and final approval by the Board of Directors. We are satisfied that the plan has been developed to ensure consistency between workforce and operational plans.

The Trust submitted a final 2025-26 break-even financial plan to NHSE at the end of April 2025. The plan was reliant on a recurrent waste reduction programme (WRP) of £60m and non-recurrent deficit support funding of £30m. The Board received a presentation on the key facets of the plan and how it linked with national priorities and the priority workstreams set out by the ICB. The exit run rate for 2024-25 reported in the 2025-26 financial plan was a deficit of £65.8m. The initial draft plan in early April 2025 reported a planned deficit of £5m, however in the final submission to NHSE at the end of April 2025 this was revised to a break-even plan. The £5m improvement was bridged by £1.2m of recurrent income, £3.1m of non-recurrent income and £0.7m slippage in local cost pressures. The underlying position at plan was a £90.0m deficit, comprising £30.0m non-recurrent Deficit Support Funding (DSF) and £60.0m plan for WRP delivery.

The 2025-26 break-even plan was agreed assuming high risk mitigations could be delivered in year alongside the WRP target of £60m. The WRP had £30.8m of identified schemes at various levels of maturity and ongoing activities to identify new schemes and mature current identified schemes. In addition, the Trust had included an additional £21.2m of unidentified waste reduction schemes in the financial plan which was in line with the targets set for divisions for year 2 of the 3-year financial sustainability plan 2026-2027. The remaining £8m target had been included in the financial plan in order to help bridge the gap in likely deficit support funding.

Similar to 2024-25, it was acknowledged taking costs out of the system requires a coordinated system-wide response, and through the Emergency, Elective and Outpatients Transformation Boards, significant pieces of long-term work were underway to redesign services to reduce the recurrent costs of delivery across the system. In view of the long-term nature of many of the identified solutions, achievement of an in-year WRP target of this magnitude was subject to considerable risk.

There was clear reporting to both Board and Finance and Performance Committee (FPC) in the period leading up to finalisation of the plan, including articulation of the inherent financial sustainability risks in terms of delivery of the financial plan and wider operational pressures such as high bed occupancy, delivery of RTT and diagnostics and A&E performance.

Financial Monitoring and Performance 2025-26

We are satisfied that, throughout 2025-26, the Trust's budget monitoring arrangements and associated committee oversight were effective in identifying and analysing financial pressures that could pose a risk to delivery of the financial plan. Our review of relevant Board and Finance and Performance Committee (FPC) sub-committee minutes indicate that both financial and operational performance were subject to appropriate scrutiny and challenge, including assessing and managing financial risks.

Financial Sustainability

In respect of the process for monitoring against budgets, financial forecasts are based on the run rate plus known impacts as discussed in budget holder meetings. We have examined examples of the Trust's Divisional Improvement Forums that are held with each division to review scorecard reporting including key performance indicators (KPIs) across each of the Trust-wide strategic ambitions. Additionally, the finance team has regular monthly budget holder meetings to discuss financial performance, concerns and pressures impacting the specific budgets. We reviewed examples of budget holder meeting logs confirming that budget monitoring is consistent across the trust.

Financial Outturn 2025-26

In January 2026, the Trust was reporting a year-to-date deficit of £26.1m, primarily attributable to under-delivery of the WRP, the non-receipt of £7.5m of DSF, and operational pressures of £4.3m, partially offset by £3.0m of industrial action funding and other non-recurrent flexibilities. In agreement with NHSE, the trust then submitted a revised forecast outturn deficit of £9.2m, predicated on realising £8.6m of savings from estates transformation and receipt of the full £30m of DSF. The Trust had delivered £30.0m of its waste reduction programme, representing an adverse variance of £18.0m against plan as at month 10, with a best-case forecast delivery of £50.4m for the full year WRP.

The final year-end outturn was a £13.6m deficit, which reflected full receipt of £30m DSF but £22.5m under delivery of the WRP. The gap was mitigated through additional income.

Waste Recovery Programme

Efficiency scheme development is an integral part of the annual planning round, with generation of schemes starting in Q3 or earlier depending on the nature of the scheme. All schemes are included on the tracker even where schemes do not have a financial value. There are several stages of governance, starting with identification and approval at divisional level, through to Divisional Improvement Forum and then onto the relevant sub-committee and Waste Recovery Board (WRB).

When a potential opportunity is identified the scheme will go through several stages before it is finally approved by the executive team. Firstly, it will be discussed and considered within the divisions' own governance structure. Once approved at Divisional board, it will then be discussed in the Divisional Improvement Forum with the Executives, where it will then receive further approval/ support and be submitted to all relevant committees for a final validation based upon its impact, and it's QIA risk scoring. We observed examples of this process through our risk assessment.

Key financial and performance metrics:	2025-26	2024-25
Planned surplus/(deficit)	£0.0m	£2.6m
Actual surplus/(deficit)	(13.6m)	(£36.2m)
Planned CIP as a % of spend	6%	7%
- Recurrent	£60m	£58m
- Non-recurrent	£0m	£0m
Actual CIP as a % of spend	4%	2.8%
- Recurrent	£24m	£18m
- Non-recurrent	£13m	£8m
Year-end cash position	£29.8m	£8.2m

Financial Sustainability

How the Trust plans and manages its resources to ensure it can continue to deliver its services.

We have considered the following in our work:

- How the Trust ensures that it identifies all the significant financial pressures that are relevant to its short and medium-term plans and builds these into them;
- How the Trust plans to bridge its funding gaps and identifies achievable savings;
- How the Trust plans finances to support the sustainable delivery of services in accordance with strategic and statutory priorities;
- How the Trust ensures that its financial plan is consistent with other plans such as workforce, capital, investment, and other operational planning which may include working with other local public bodies as part of a wider system; and
- How the Trust identifies and manages risks to financial resilience, e.g. unplanned changes in demand, including challenge of the assumptions underlying its plans

In response to the external reviews, an external firm were contracted to provide additional PMO support to help manage the WRP programme during 25-26. The external firm, alongside a turnaround director, supported the Trust with developing the 2025/26 WRP, including PMO support (whilst the internal PMO structure was put in place). They supported with governance relating to WRP such as associated tracking of schemes and actions, reporting and supporting with the preparation for monthly IAG meetings. The PMO structure that was put in place during 2025/26 has now been fully recruited to and has become fully operational since the year end.

Delivery of WRP YTD at Month 2 2025/26 was £1.5m, resulting in a negative YTD variance to plan of £4.4m. The Trust had identified all £60.0m, however, £17.8m of it was at hopper (outline plan) stage and £12.5m high or medium risk. This was clearly reported to FPC and Board. Comparatively, at month 2 2026/27 the trust have delivered their WRP to plan with £8.9m of schemes hopper and £8.5m high and medium risk.

Waste Recovery Programme monitoring

Waste Recovery Programme Boards (WRPB) chaired by either the CEO, CFO or other appropriate executive, have met every other week during the financial year. WRPB track the development of WRP plans and in year monitoring against these plans including identification of mitigation or supporting colleagues with the delivery of schemes. More detailed Divisional Delivery Groups (DDGs) have taken place every other week chaired by either the CFO or Turnaround Director to support divisions with their efficiency programme with clear actions developed with regards to delivery.

The WRPB and DDG monitors performance against efficiency plans both for divisional plans and divisional cross cutting projects. Any variance against plan is discussed and appropriately challenged, with actions recorded for mitigations should they be needed. SROs are aware of the need to bring mitigations where schemes are not delivering as per the original plan.

We reviewed a number of WRPB and DDG meetings packs during the year to assess the level of detail and actions identified in these forums. Action notes are taken but no minutes specifically, so it was not possible to assess the level of challenge. However, escalation was clearly evident with actions identified at DDG, reported to WRPB and subsequently highlighted through the monthly finance reports presented to FPC.

The level of risk associated with each of the schemes has been transparently reported throughout the year, and the WRP forecast delivery for the year fluctuated between £44m-£48m which was broadly in line with outturn delivery £37.5m (an under-delivery of £22.5m), £24m of which was recurrent (£38m full year impact of recurrent schemes). This was an improvement on the prior year where overall achievement was £26m, £18m of which was recurrent.

In 2025-26, ongoing financial and operational challenges resulted in the Trust being placed in Segment 5 of the NHS Oversight Framework, triggering enhanced support through NHS England's Provider Improvement Programme. This has included consultancy support in the form of grip and control interventions to support productivity improvements. We have considered the implications of this from both a financial sustainability and governance perspective.

Financial Sustainability

How the Trust plans and manages its resources to ensure it can continue to deliver its services.

We have considered the following in our work:

- How the Trust ensures that it identifies all the significant financial pressures that are relevant to its short and medium-term plans and builds these into them;
- How the Trust plans to bridge its funding gaps and identifies achievable savings;
- How the Trust plans finances to support the sustainable delivery of services in accordance with strategic and statutory priorities;
- How the Trust ensures that its financial plan is consistent with other plans such as workforce, capital, investment, and other operational planning which may include working with other local public bodies as part of a wider system; and
- How the Trust identifies and manages risks to financial resilience, e.g. unplanned changes in demand, including challenge of the assumptions underlying its plans

Financial planning 2026-27 and beyond

As at the end of February 2026, the underlying deficit based on the exit run rate was £51.7m, an improvement of £38.3m from 2025/26 planning underlying deficit (£90m).

We reviewed the 2026-27 Planning Framework/Planning Process Report submitted to the February 2026 FPC meeting, which summarises the initial financial plan for the Trust for 2026-27, the drivers of the gap and the measures necessary to address the position. We were satisfied that this paper detailed key themes from the NHS Operational Planning Guidance published in December 2025, the Trust's financial position, and subsequently how the Trust plans to address the financial gap to ensure that it can deliver high quality care.

In line with NHS England 2026–29 Planning Framework, the trust also submitted a five-year strategic plan supported by a three-year numerical return. The submission reflected updated national guidance, system assumptions and strengthened triangulation across finance, workforce and performance, with Board oversight and assurance provided as part of the final return.

The final revenue budget proposal for 26-27 was a break-even budget reliant on a recurrent Waste Reduction Plan (WRP) of £60m and non-recurrent deficit support funding of £9.2m, presented to FPC in March 2026 and recommended to Board for approval. The current underlying deficit based on the exit run rate was £51.7m (£90.0m prior year). The plan included risks identified of £36m mainly associated with the significant WRP target required to deliver the plan and the potential cost of implementing the transformation that will be required in services.

There was clear reporting to both Board and FPC in the period leading up to finalisation of the plan, including articulation of the inherent financial sustainability risks in terms of delivery of the financial plan and wider operational pressures such as high bed occupancy, delivery of RTT and diagnostics and A&E performance.

Conclusion

Despite realising a deficit in 25/26, the trust's underlying deficit is much improved on 24-25 at £51.7m compared to £90m in the prior year. In response to the recommendation identified in the prior year, the trust has strengthened its governance arrangements in relation to the WRP, but acknowledge there is still significant work to undertake to get back to a financially sustainable footing. Overall delivery of the WRP improved but there was still a significant gap from the £60m target.

Appropriate arrangements have been put in place to respond to the actions identified through the external reviews in the prior year, and similarly governance arrangements continued to be strengthened on the back of internal audit's recommendations following its Grip and Control review in January 2026.

We therefore do not consider there to be a significant weakness in arrangements relating to financial sustainability but will continue to monitor the effectiveness of identification and monitoring of the WRP plans into 26/27.

Governance

How the Trust ensures that it makes informed decisions and properly manages its risks.

We have considered the following in our work:

- how the Trust monitors and assesses risk and how the body gains assurance over the effective operation of internal controls, including arrangements to prevent and detect fraud;
- how the Trust ensures effective processes and systems are in place to ensure budgetary control; to communicate relevant, accurate and timely management information (including non-financial information where appropriate); supports its statutory financial reporting requirements; and ensures corrective action is taken where needed, including in relation to significant partnerships;
- how the Trust ensures it makes properly informed decisions, supported by appropriate evidence and allowing for challenge and transparency; and
- how the body monitors and ensures appropriate standards, such as meeting legislative/regulatory requirements and standards in terms of management or Board members' behaviour

Risk Management

The Board Assurance Framework (BAF) is the foundation of the Trust's risk management arrangements. We have reviewed the BAF at various points throughout the year and are satisfied that strategic risks are appropriately captured, regularly reviewed, and subject to effective discussion and challenge at Trust Board meetings. The Trust applies its risk assessment criteria, as set out in the Risk Management Policy, consistently across all risks to ensure a standardised approach. We have inspected the Corporate Risk Register and note that this gives sufficient coverage of ongoing risks, demonstrating that the Trust has appropriate processes for monitoring the implementation and effectiveness of actions to address identified risks.

A Risk Management Group (RMG) chaired by the CEO was introduced at the Trust in March 2024. The RMG meets monthly and provides an update on the current position around high risks in the organisation. In addition to this, divisions and corporate departments present a quarterly in-depth overview, which includes all risks, irrespective of the score.

The Trust transferred risk management system from Datix to Ulysses on 28 January 2026. Risks surrounding the implementation were discussed in detail at RMG meetings prior to implementation Training requirements for usage of the system were put in place and testing of the system's functionality was carried out to ensure a smooth transition.

Effective decision making

A number of significant decisions requiring Board approval were taken during the year, including the approval of the Trust as lead provider for a single pathology service across Lancashire and South Cumbria. This will bring together pathology services from Blackpool Teaching Hospitals NHS FT (BTH), East Lancashire Hospitals NHS Trust (ELHT) and University Hospitals Morecambe Bay NHS Foundation Trust (UHMB) and the Trust into one service from 1 April 2026.

The service reorganisation was first presented to FPC in August 2024 as a solution to transform pathology services into a unified system in Lancashire and South Cumbria as mandated by the Lancashire and South Cumbria Integrated Care Board (LSC ICB) and the Provider Collaborative Board (PCB). Financial implications and risks of the programme's implementation were clearly communicated to the FPC and the Board in August and October 2025 respectively where there was appropriate challenge and scrutiny of the decision. Following these communications, implementing a centralised facility for pathology services was the preferred option, with the Trust as the host. In November 2025, the single service was endorsed by both the PCB and the ICB.

We have reviewed FPC and Board minutes and papers throughout the financial year. We are satisfied that there is sufficient ability for committee and Board members to take informed decisions based upon the detail provided in the attached papers. These papers also demonstrate that with respect to financial risks reported and recommendations made, there are detailed discussions occurring to challenge and analyse the information presented.

Governance

Responding to external reviews

In 2024-25, a number of external reviews were undertaken at the Trust after being placed in Segment 4 of the National oversight Framework (subsequently escalated to Segment 5). This included a system wide review of grip and control measures for pay and non-pay expenditure. In response to all external reviews, an overarching action plan was developed in March 2025.

In an update to the Trust Management Board in November 2025, of the 110 actions, 87% were deemed to have adequate controls in place with no further action. Of the remaining 14 actions, 11 had subsequent actions and a further 3 were stood down as irrelevant by the Trust.

In January 2026, Mersey Internal Audit Agency (MIAA) completed an independent internal audit of the Trust's response to the Grip & Control recommendations. The audit concluded that the Trust had developed a detailed action plan accurately reflecting the review findings and that evidence was in place to demonstrate completion of the majority of actions reviewed, resulting in substantial assurance over implementation of pay-related controls.

MIAA also assessed governance arrangements for oversight and escalation of the action plan, identifying opportunities to strengthen triangulation and monitoring across forums, and provided moderate assurance in this area. This review confirmed that the Trust had made meaningful progress in delivering the recommendations, though further embedding of governance arrangements was required to ensure sustained and consistent control across the wider programme.

In a report to Audit Committee in April 2026, all actions in response to the MIAA review were closed. With regard to the Grip & Control action plan, the Trust undertook intensive activities to update the action plan with 11 outstanding actions identified where further strengthening or assurance was required.

	2026	2025
Control deficiencies reported in the Annual Governance Statement	None	None
Head of Internal Audit Opinion	Substantial Assurance	Substantial Assurance
Oversight Framework segmentation	5	4
Care Quality Commission rating	Requires improvement	Requires improvement

Governance

How the Trust ensures that it makes informed decisions and properly manages its risks.

We have considered the following in our work:

- how the Trust monitors and assesses risk and how the body gains assurance over the effective operation of internal controls, including arrangements to prevent and detect fraud;
- how the Trust ensures effective processes and systems are in place to ensure budgetary control; to communicate relevant, accurate and timely management information (including non-financial information where appropriate); supports its statutory financial reporting requirements; and ensures corrective action is taken where needed, including in relation to significant partnerships;
- how the Trust ensures it makes properly informed decisions, supported by appropriate evidence and allowing for challenge and transparency; and
- how the body monitors and ensures appropriate standards, such as meeting legislative/regulatory requirements and standards in terms of management or Board members' behaviour

Compliance with laws and regulations

Through our review of the Standing Financial Instructions (SFIs) we are satisfied that there are detailed roles, responsibilities and delegation to the various committees, and that this gives an appropriate escalation framework for making key decisions.

The Trust has a Local Counter Fraud Specialist who undertakes anti-fraud activities throughout the year and reports into the Audit Committee. Other key arrangements designed to detect fraud such as Whistleblowing Policy, Freedom to Speak Up and associated governance features are well embedded within the organisation.

Reviews for compliance with the staff code of conduct, laws & regulations and the Trust's constitution is completed via the Audit Committee, Board meetings and other governance structures as identified through our testing. Through the Trust intranet site, weekly Chief Executive briefing and daily updates the Trust sets out any updates on the wider system and internal changes. A Code of Conduct policy is in place to ensure compliance with expected standards of behaviour, including recording of interests, gifts and hospitality.

Conclusion

We have not identified any significant weakness in arrangements relating to governance.

Improving economy, efficiency and effectiveness

How the Trust uses information about its costs and performance to improve the way it manages and delivers its services

We have considered the following in our work:

- how financial and performance information has been used to assess performance to identify areas for improvement;
- how the Trust ensures effective processes and systems are in place in order to develop their cost saving efficiency saving program;
- how the Trust evaluates the services it provides to assess performance and identify areas for improvement;
- how the Trust ensures it delivers its role within significant partnerships and engages with stakeholders it has identified, in order to assess whether it is meeting its objectives; and
- where the Trust commissions or procures services, how it assesses whether it is realising the expected benefits.

Non-financial performance monitoring

Non-financial performance is scrutinised regularly by the Executive Team with specific follow up of non-compliant metrics and associated recovery plans. Non-financial performance is formally reported and scrutinised monthly via the Integrated Performance Report to the Board, as well as detailed reports on Finance, Workforce and Safety & Quality (SQC) being presented to each meeting of the respective Board sub-Committees. We have reviewed examples and evidence of this in action and consider arrangements to be appropriate.

In respect of benchmarking, the Trust's costing team provides regular Service Line reporting (SLR) reports that are used for internal purposes, reflecting the contribution of each specialty to the Trust's overall financial position. These are reported directly to the Trust's Finance and Performance Committee (FPC) bi-annually. We have inspected the report submitted to the September 2025 meeting. Within this report high level analytics are provided on the Trust's largest loss-making service lines, including key drivers and the reasons for any movements versus the previously reported period. We saw evidence of effective review and challenge of this report in the FPC minutes.

As part of the bi-annual SLR update, service line surpluses/deficits are analysed versus National Cost Collection Indices. Any 'bottom quadrant' service lines (those reporting service line deficits as well as high national cost collection indices) are highlighted for service line reviews.

Procurement

Following transition of the Lancashire Procurement Cluster (LPC) to Procurement and Supply Chain of One LSC, the Trust has implemented a standard assurance and performance report with the key objective of informing and giving insight to FPC. The report provides an overview of CIP delivery, ongoing work for single quote waivers, as well as reporting procurement performance benchmarked against national and local metrics.

We have reviewed the single tender waiver report submitted to the Audit Committee on 15 January 2026, which included a summary of waivers from 1st September to 31st December 2025. A total of 4 waivers were appropriately approved during this period.

This represents a significant improvement compared to the 36 waivers approved during the same period in 2024/25, with a total value of £4,307,003. This report informs that the reduction in the number of waivers follows from the successful implementation of the new single quote waiver process.

Additionally, we examined a Procurement & Logistic Service Performance report submitted to the FPC in February 2026, which provided an update on the waste reductions and financial improvement status for month 10. The report shows savings of £2.1m had been achieved to date which an overall target for 2025/26 of £2.7m.

Improving economy, efficiency and effectiveness

How the Trust uses information about its costs and performance to improve the way it manages and delivers its services

We have considered the following in our work:

- how financial and performance information has been used to assess performance to identify areas for improvement;
- how the Trust ensures effective processes and systems are in place in order to develop their cost saving efficiency saving program;
- how the Trust evaluates the services it provides to assess performance and identify areas for improvement;
- how the Trust ensures it delivers its role within significant partnerships and engages with stakeholders it has identified, in order to assess whether it is meeting its objectives; and
- where the Trust commissions or procures services, how it assesses whether it is realising the expected benefits.

Contract Management

We are satisfied there is an appropriate framework for monitoring of the performance of subcontractors proportional to the scale of the contract (e.g. a whole clinical service versus a single specialty).

We inspected the bi-annual Outsourced Material Clinical Sub-Contracts Performance Monitoring Update submitted to the SQC meeting in November 2025. The report informed that two issues were identified with suppliers that they were seeking to address. In reviewing the report, we also examined the reporting of detailed KPI dashboards to the SQC in relation to these two sub-contracts in place as well as qualitative information on the identified issues. We are satisfied with the governance processes in place to manage material sub-contracts given the detailed level of monitoring taking place at the committee level.

The Procurement & Logistic Service Performance report also confirmed the number of active contracts maintained by the LPC and how many are up for renewal in the current financial year. The procurement performance metrics have been fully adopted and embedded during 2025-26 and are now reported monthly. Adoption of these standards is designed to provide assurance and ensure the service provided is in line with national benchmarks.

CQC

Following publication of the last CQC report in November 2023, management had developed a CQC Action Plan which the Trust has continued to monitor throughout the year. The must-do actions are central to the Single Improvement Plan across multiple domains including Well-Led, Safety and Quality and People & Culture. The latest version of the action plan confirmed all Must-Do actions were assessed as delivered by the end of October 2025.

Partnership arrangements

The Trust works closely with the other providers within the Lancashire and South Cumbria (L&SC) system through a prominent role on the Provider Collaborative Board, with the Trust's Chief Executive (CE) being the lead CE for the Provider Collaborative among numerous other Board-level links with both the providers in L&SC and the ICB.

The Trust interacts with the ICB on a regular basis both in terms of providing accountability for in-year performance but also with respect to strategic planning for 2025-26 and beyond. The Trust is taking a lead role on numerous projects aimed at increasing collaboration and therefore removing costs from the L&SC system, for example as the Lead Provider for the Pathology shared service.

Conclusion

We have not identified any significant weakness in arrangements relating to improving economy, efficiency and effectiveness.

Significant Value for Money Risk

1 Waste Recovery Programme arrangements

Risk that value for money arrangements may contain a significant weakness linked to financial sustainability.

Significant Value for Money Risk

Description

The Board approved the 2025-26 break-even plan in April 2025 assuming high risk mitigations could be delivered in year alongside the Waste Reduction Programme (WRP) target of £60m. The WRP had £30.8m of identified schemes at various levels of maturity and £21.2m of unidentified schemes. Similarly, the £9.2m deficit plan agreed for 2026-27 in February 2026, is underpinned by a £60m WRP. As at 17th February 2026, £34m of schemes had been identified on the 2026-27 WRP tracker, with £26m unidentified.

There is a risk that unidentified savings in financial planning could substantially threaten the delivery of the plan.

Our response

Response

- We will review the appropriateness of the assumptions used to form the financial plan for 2025/26 and 2026/27 and verify if there has been sufficient challenge by those charged with governance via scrutiny of Board and Committee minutes.
- We will review the arrangements in place to support the identification and delivery of the WRP
- We will assess how developed the efficiency plans were, the level of identified versus unidentified savings and whether the arrangements in place are conducive to informed decision making.
- We will consider the arrangements in place for the implementation of actions from the various system reviews carried out in 24-25, following up the recommendation identified in response to the significant weakness identified in the prior year.

Our findings

Findings

- Appropriate arrangements were in place for the development and approval of the financial plans in 25/26 and for 26/27.
- The Trust has strengthened its governance arrangements in relation to the identification and delivery of WRP but there remains a high level of risk, with individual schemes at varying levels of maturity.
- The Trust has been transparent when reporting WRP development and delivery throughout the year.
- Appropriate arrangements have been put in place to respond to the actions identified through the external reviews in the prior year,

Conclusion

We have not identified a new significant weakness in arrangements in the current year, however the previous significant weakness remains open. The Trust acknowledges there is still significant work to undertake to get back to a financially sustainable footing.

Prior year findings

Significant weaknesses followed up from the prior year

In our annual auditor's report for the financial year 2024-25 we reported that the Trust had a significant weakness in arrangements over financial sustainability surrounding the strength of the cost improvement programme risk assessment and delivery. As required by the Code of Audit Practice we have revisited this issue and set out in the table below an update in regards to the arrangements in this area.

#	Recommendation	Management Response	Current status
1	**Strengthening CIP risk assessment and delivery** The Trust has recently strengthened its governance arrangements in relation to cost control and efficiency with the support of external consultants to ensure Executive Directors and divisional leaders are in control of and accountable for Waste Recovery Plan (WRP) schemes identified in the 2025-26 plan. Given the challenge of the WRP (£60m) to be delivered in 2025-26 and the delivery achieved in 2024-25 we recommend management continue to strengthen and sustain the arrangements in place that enable a robust level of challenge and risk assessment of WRP plans. Management should ensure that the risk assessment of those plans is sufficiently prudent to ensure that financial forecasts do not deteriorate unexpectedly due to either their delayed delivery or the value of the efficiency not being as high as predicted. In turn this should enable risks to delivery are appropriately managed and escalated to ensure full visibility to the Board of Directors throughout the year. Financial outturn figures can also be more reliable when being shared with external regulators and partners	The Trust has adopted the definition of risk categories and percentages that were agreed within the One LSC collaboration and is using the standard guidance and documentation that supports services in developing each scheme. The Trust has a bi-weekly waste recovery board led by the CEO and separately executive led 'buddy' meetings for the divisions. The system currently has PWC as part of the external regulation requirements. PWC have been reviewing individual scheme documentation to confirm that the Trust's risk assessment of the scheme is robust or they have recommended changes to the categorisation. The Trust aims for a tracker over £60m to allow for a reduction in value as schemes progress through the development gateways with; divisional deep dive workshops, One LSC and system workshops, review of national benchmarking opportunities e.g. GIRFT and model health system and enhanced PMO support using modelling tools to draw on available data sources including costing, activity and workforce information to identify further opportunities.	Despite realising a deficit in 25/26, the Trust's underlying deficit is much improved on 24-25 at £51.7m compared to £65.8m in the prior year. In response to the recommendation identified in the prior year, the trust has strengthened its governance arrangements in relation to the WRP, but acknowledge there is still significant work to undertake to get back to a financially sustainable footing. Overall delivery of the WRP improved, however there was still a significant gap from the £60m target. Appropriate arrangements have been put in place to respond to the actions identified through the external reviews in the prior year, and similarly governance arrangements continued to be strengthened on the back of internal audit's recommendations following its Grip and Control review in January 2026. We therefore consider the weakness remains in place until arrangements are further developed and embedded to achieve a sustainable financial position.

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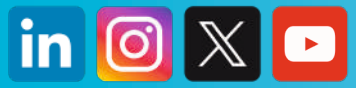

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