



Lancashire Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS PART I

BOARD OF DIRECTORS PART I



1 October 2026



09:30 GMT+1 Europe/London



Lecture Hall, Education Centre 3, Chorley and South Ribble Hospital

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AGENDA

There will be a patient story from the Head of Charities presented to Board at 9.15am

REFERENCES

Only PDFs are attached

 0.0 Agenda - Board (part I) - 1 October 2026.pdf

Board of Directors

1 October 2026 | 9.15am | Lecture Hall, Education Centre 3,
Chorley and South Ribble Hospital

Agenda

At 09.15am, there will be a patient story from the Head of Charities

Items marked * have additional information in the Ancillary Pack

No	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	9:30 am	Verbal	Procedural	M Thomas
2.	Apologies for absence	9:32 am	Verbal	Procedural	M Thomas
3.	Declaration of interests	9:35 am	Verbal	Procedural	M Thomas
4.	Minutes of the meeting held on 6 August 2026 and Written Resolution 01.26	9:37 am	✓	Procedural	M Thomas
5.	Matters arising and action log update	9:40 am	✓	Procedural	M Thomas
6.	Chair's opening remarks and report	9:42 am	✓	Discussion	M Thomas
7.	Chief Executive's Report	9:45 am	✓	Discussion	S Nicholls
8.*	Board Assurance Framework	9:55 am	✓	Decision	H Ugradar
9. PERFORMANCE					
9.1	Integrated Performance Report as at August 2026 including Finance update and Single Improvement Plan	10:10 am	✓	Assurance	K Foster-Greenwood/ S Morrison/ N Pease/ C Carter
9.2*	Winter Plan 2026/27	10.50 am	✓	Decision	K Foster-Greenwood
10. PEOPLE & PARTNERSHIPS (WORKFORCE, EDUCATION AND RESEARCH)					
10.1	People & Partnerships Committee Chair's Report (including recommendations on reports below)	11.00 am	✓	Assurance	S Crean
*	a) Appraisal, Revalidation and Medical Governance (GMC) Annual Report		✓	Decision	
BREAK		11:20 am			
11. PATIENTS (SAFETY AND QUALITY)					
11.1	Safety and Quality Committee Chair's Report (including recommendations on reports below)	11:40 am	✓	Assurance	K Deeny
*	a) Perinatal Workforce Report		✓	Decision	
	b) Bi-Annual Adult & Children Safe Staffing Review		✓	Decision	
	c) Bi-Annual AHP Staffing Report		✓	Assurance	

No	Item	Time	Encl.	Purpose	Presenter
	d) Health and Safety Annual Report		✓	Assurance	
12. PRODUCTIVITY (FINANCE)					
12.1	Finance and Performance Committee Chair's Report <i>(including recommendations on reports below)</i>	11:55 am	✓	Assurance	K Deeny
*	a) EPRR Core Standards Annual Assurance		✓	Decision	
13. RISK, GOVERNANCE AND COMPLIANCE					
13.1	Audit Committee Chair's Report	12:05 pm	✓	Assurance	T Wheeler
13.2	Charitable Funds Committee Chair's Report	12:15 pm	✓	Assurance	T Ballard
14. ITEMS FOR INFORMATION * ancillary pack					
14.1	Data Quality Assurance Report		✓		
14.2	Corporate Calendar 2027-28		✓		
14.3	Maternity and Neonatal Services Baseline Assessment against the 10-Point Plan Inc Triage Benchmarking and MOSS		✓		
14.4	Date, time and venue of next meeting: <i>3 December 2026 at 9:15 am at Lecture Room 1, EC1, Royal Preston Hospital</i>	12:25 pm	Verbal	Information	M Thomas

1. CHAIR AND QUORUM

● Other

👤 M Thomas

🕒 9.30 am

Procedural Item

2. APOLOGIES FOR ABSENCE

● Other

● M Thomas

● 9.32 am

Procedural Item

3. DECLARATIONS OF INTEREST

● Other

● M Thomas

● 9.35 am

Procedural Item

4. MINUTES OF THE MEETING HELD ON 6 AUGUST 2026 AND WRITTEN RESOLUTION 01.26

● Other

● M Thomas

● 9.37 am

Procedural Item

REFERENCES

Only PDFs are attached



4.0 Minutes Board (Part I) - 6 August 2026.pdf



4.0 BoD WR01.26 Approval of maternity submission September 2026 Approved.pdf

Board of Directors

6 August 2026 | 9.15am

Lecture Room 1, Education Centre 1, Royal Preston Hospital

Part I

Present:

Prof. M Thomas	Chair
Dr T Ballard	Non-Executive Director
Mr C Carter	Chief Finance Officer
Prof. S Crean	Non-Executive Director
Prof. K Deeny	Non-Executive Director (<i>MSTeams</i>)
Mrs K Foster-Greenwood	Chief Operations Officer
Mr A Leather	Non-Executive Director
Prof. S Morrison	Chief Nursing Officer/Deputy Chief Executive Officer
Mr U Patel	Non-Executive Director
Prof. T Wheeler	Non-Executive Director

Apologies:

Mr S Canty, Prof. S Nicholls, Mr J Schorah

In attendance:

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

Presenters:

Ms E Ashton	Divisional Nursing & Midwifery Director (<i>minute 128/26</i>)
Ms J Connelly	Divisional Nursing Director, Neonatal (<i>minute 128/26</i>)
Ms L Murphy	Clinical Director, Obstetrics (<i>minute 128/26</i>)
Ms H Ugradar	Associate Director of Risk & Assurance (<i>minute 122/26</i>)

Governors observing:

L Bracewell, T Ramsay, G Robinson

Other Observers:

L Dickinson, Two members of the public

Presenters of the patient story:

Claire Jefferson	Head of service - Physical Health Psychology
Angela Waind	Consultant Counselling Psychologist Clinical Lead
Michelle Hayes	Deputy Divisional Director of Division of Clinical Services

Prior to the meeting the Board received the following presentation:

The Board was presented with 'Carol's story', which described the impact of an ovarian cancer diagnosis and the role of the Macmillan Psychological Health in Cancer Service in supporting holistic cancer care.

The story illustrated the psychological and emotional effects of diagnosis, including uncertainty, fear, loss of control, grief, changes to identity and the wider impact on family life. Through personalised therapy, timely intervention and continuity of care, Carol had been supported to manage distress, reconnect with what mattered most to her and make choices that were right for her family.

The Board heard that the service enabled psychological distress to be identified earlier and supported staff to have meaningful conversations with patients who may not otherwise disclose distress. Carol's involvement as an expert by experience had also contributed to service development and improvements for future patients.

The service impact had been demonstrated through completed therapy with 677 patients, almost 1,700 appointments, 168 urgent inpatient appointments and psychological skills training for 158 staff. Service user engagement, including events, focus groups and a dedicated panel, had helped ensure the service remained accessible, person-centred and informed by lived experience.

The Board considered the wider relevance of psychological support model beyond cancer care, including potential application across cardiac, respiratory, diabetes, MND and airways pathways. The importance of embedding psychological conversations throughout care pathways was emphasised, supported by staff training to recognise distress, normalise emotional wellbeing and maintain continuity of care.

The Board reflected on the need to evidence the case for sustainable funding beyond the initial Macmillan investment, including the potential system benefits of directing patients to the most appropriate support and reducing avoidable clinical demand. It was acknowledged that further business intelligence support would strengthen evaluation of system-wide impact and inform the case for change.

The discussion highlighted the need for a strategic approach to psychology provision across the organisation, including workforce development and divisional access to psychological expertise. The wider benefits for staff wellbeing were recognised, particularly for staff regularly exposed to death, mortality and distress.

Further reflection focused on the role of experts by experience in shaping services, the importance of capturing patient and carer insight during vulnerable periods, and the opportunity to share Carol's story more widely to support organisational learning. The partnership with Macmillan was recognised as a strong example of charitable funding, expertise and branding being integrated into healthcare delivery to improve access, engagement and equity. The Board gratefully acknowledged Carol's contribution to promoting the work of this service and supported further work to support strategy development, evaluation and consideration through the appropriate governance routes.

116/26 Chair and quorum

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

117/26 Declaration of interests

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

118/26 Minutes of the previous meeting

The minutes of the meeting held on 4 June 2026 were approved as a true and accurate record.

119/26 Matters arising and action log

All actions from previous meetings had been completed.

120/26 Chair's report

The Chair's report was received, which outlined the activities undertaken by the Chair during the previous two months in support of the Trust's governance, performance and wider partnership agenda. On behalf of the Board, appreciation was expressed to executive colleagues and wider teams for the sustained improvement in performance over the preceding six months, with particular recognition given to the traction achieved in planned care and wider access standards. The improvement trajectory was welcomed as evidence that recovery actions were having an impact.

It was recognised that significant challenges remained, including corridor care, urgent and emergency care pressures, community interface issues and financial recovery. The continued commitment required from colleagues across the organisation was acknowledged, with thanks extended to staff for their ongoing work during a challenging year.

121/26 Deputy Chief Executive's Report

The Board received the Deputy Chief Executive's Report which highlighted national, regional and local matters of interest since the previous meeting. The Board was updated on early engagement with the new Secretary of State for Health, whose stated priorities were described as aligned to the Trust's strategic risks, particularly in relation to prevention, early years, community services and the wider health and social care system. The constructive nature of the discussion was welcomed.

The Board was advised that national reports relating to maternity and neonatal services had been received since the previous meeting. The findings had reinforced the need for continued focus on the experience of women and families, while providing assurance that the Trust was focusing on the appropriate areas for improvement. Positive early feedback had also been received from the invited Maternity and Neonatal Intensive Support Team review, with recognition given to the active management of identified risks and the patient- and family-centred approach demonstrated by teams.

The Board was further advised that invited NHS England reviews had been undertaken across a number of services to test the reliability of the Trust's quality assurance arrangements. Feedback had indicated that the Trust's systems could be relied upon to identify areas requiring focus, while reinforcing the need to maintain momentum in urgent and emergency care improvement and to recognise the impact of those pressures on patients, families and staff.

Several positive achievements were highlighted, including national recognition for Specialty and Associate Specialist doctors, the appointment of a Trust medical leader to a national role, and the development of occupational therapy apprenticeship pathways to

address workforce gaps. The Board welcomed these examples as evidence of strong clinical leadership, workforce development and organisational progress.

In discussion, the Board reflected on the potential implications of the Government's emerging focus on prevention, early years and community-based care. It was confirmed that the Trust's strategy already identified children and young people as an area of focus, although further work was required to strengthen delivery, particularly in relation to urgent care attendances. The Board also welcomed recognition of the catering team's regional award, the contribution of corporate and support services to patient care, and the development of the Broadoaks child development facility as an example of the Trust's role as an anchor institution, partnership working and shared community benefit.

122/26 Board Assurance Framework

H Ugradar attended for this item.

The Board received an update regarding the Board Assurance Framework (BAF).

Following approval of the revised assurance committee structure in June 2026, the People and Partnerships Committee had been established, partially incorporating the remit of the former Workforce Committee together with the entire remit of the Education, Training and Research Committee. Relevant principal and operational high risks aligned to the People and Partnership objectives had been transferred to the Committee for oversight.

There were no operational high risks escalated to the Board from the 13 principal risks in the framework. One principal risk score had increased since the previous report, with PR13 relating to delivery of the planned reduction in whole-time equivalent workforce increasing from 16 to 20 following review of workforce reduction programme performance and its interdependency with delivery of the Trust's financial plan. All other principal risk scores had remained unchanged following executive and committee scrutiny.

It was reported that the Finance and Performance Committee had reviewed relevant principal risks in the context of recent performance improvements and had concluded that current scores remained appropriate, recognising that changes should be informed by a range of indicators, underlying risk drivers and evidence of sustained improvement over time.

The Board was also advised that the Audit Committee had approved an updated Risk Management Policy following implementation of the Ulysses Risk Management System and to support the revised Board Assurance Framework and committee oversight arrangements.

In discussion, the Board sought assurance on the conditions required for risk scores to reduce, particularly in the context of recent performance improvements. It was explained that statistical process control data and sustained delivery against trajectory would be monitored, with a potential reduction in relevant performance risk scores expected over the following three to six months, subject to continued improvement.

Assurance was also sought that risks transferred into the newly established People and Partnership Committee had been appropriately captured and would continue to be monitored. It was confirmed that relevant people and partnership risks had been aligned to the Committee and that high operational risks within its remit would be escalated through the established governance route.

The Board reflected on the Framework as a live strategic risk document and recognised that current scores had been reassessed during the Board's previous review, rather than being solely based on the original age of the risks. It was also recognised that some principal risks would require multi-year mitigation and should therefore be considered in the context of medium-term delivery plans and year-on-year progress.

Further discussion focused on the use of demographic and population health data to strengthen assurance in relation to health inequalities as aligned to Principal Risks 1. – Patient safety and experience within urgent and emergency pathway and 2. – People experiencing health inequalities. The Board was advised that data relating to urgent and emergency care and planned care had highlighted particular activity patterns in the most deprived communities, and that further work was being undertaken with partners to develop targeted interventions. Challenges remained in identifying some patient groups, including those with learning disabilities, serious mental illness and physical disabilities, and work was in progress to improve visibility of these cohorts. An update on targeted interventions and related data improvements was requested through the next health inequalities update. The Board took assurance that data quality and usability issues relating to health inequalities remained under close oversight through the Safety and Quality Committee, and that reporting would be aligned to the agreed timetable.

The Board also considered the risk profile associated with partnership working and integrated neighbourhood development. It was confirmed that further work was being progressed with system partners, including the Integrated Care Board, local government and the voluntary sector, to develop a more structured approach to partnership delivery. An update was expected to come through the relevant subcommittees prior to reporting back to the Board in December.

123/26 Integrated Performance Report inc. Finance Update and Single Improvement Plan

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

Patients - Positive performance was reported against mortality indicators, with satisfactory nursing and midwifery staffing maintained, although continued challenges in the midwifery support worker workforce were recognised and mitigations were in place. The Star accreditation programme continued to provide a key mechanism for identifying areas requiring further focus. An increase in complaints had been identified, largely associated with communication and flow-related issues, alongside concerns regarding pressure ulcer incidents. Additional specialist support had been brought in to strengthen the Trust's approach to patient and colleague experience, with early work undertaken through Board and Trust Management Board development sessions. Assurance was provided that this work was being used to reorientate the patient experience approach, particularly across inpatient pathways.

In discussion, the Board sought assurance regarding whether the increase in complaints might have been affected by the transition to the Ulysses system. It was confirmed that some data quality challenges remained and that a clearer position was expected by the end of September. However, communication had been confirmed as a key theme requiring continued focus. The Board also challenged the impact of flow on pressure ulcer incidents and sought greater clarity on when improvements should be expected. It was explained that national forecasting limitations made precise trajectories difficult, although work with the GIRFT (Getting It Right First Time) team and the frailty collaborative was being used to improve the evidence base. The Board recognised that pressure ulcers represented a significant patient harm and requested continued scrutiny through the Safety and Quality Committee, including focused assurance on frailty, length of stay and related pressure ulcer improvement work.

Performance - The Board was advised that the Trust had delivered a strong quarter one performance against constitutional standards. Urgent and emergency care four-hour performance had remained ahead of the operational standard for four consecutive

months, with June representing the strongest performance since July 2023. Twelve-hour performance had also improved and had been supported by implementation of the urgent and emergency care improvement plan, including the July launch of the extended emergency medicine assessment model (EEMAC), and development of the acute medical model, same day emergency care and frailty provision were in progress.

Referral to treatment performance had continued to improve, with reductions in overall waiting list size and waits over 52 weeks delivered ahead of operational targets. The 18-week position had improved but remained below the June target. Continued actions were being taken to improve productivity, reduce did-not-attend rates, increase internal and independent sector capacity and develop forecasting through the GIRFT programme. Cancer performance had improved across the latest validated position, with faster diagnosis and 62-day performance ahead of the Trust's May target and the 31-day standard just 0.5% below target, equating to 7 patients. Diagnostic performance had reached its highest level since March 2020, with continued focus on key modalities and a business case being prepared for echocardiography capacity.

The Board challenged how percentage variances translated into numbers of patients affected, particularly in relation to the cancer standard. It was agreed that future reporting should provide greater clarity on the patient impact of marginal performance variances. The Board also sought assurance on the risk associated with winter pressures and delayed transfers of care. It was confirmed that partnership work was progressing, including with local authority, community and voluntary sector colleagues, although residual system risk remained. The Board requested that further discussion be undertaken on partnership-related risks, the use of wider community and academic data, and the impact of partnership working on performance and patient experience, with reporting to be aligned through the relevant governance routes.

People - The Board was advised that continued focus had been placed on vacancy control, funded establishment, apprenticeship opportunities and whole-time equivalent reduction in support of the waste reduction programme. The vacancy control process had been revised to improve timeliness where posts were required, while also ensuring apprenticeship opportunities were considered as part of the Trust's social value approach. Sickness absence had increased slightly in-month but remained improved compared with the previous year. The proposed digital system for sickness reporting had progressed through executive review, with challenge regarding the level of investment effective use of resource. Alternative technological options were also being explored, including emerging systems using broader data sources and artificial intelligence, to ensure that the preferred approach remained appropriate and offered the best opportunity to support future workforce management across the Trust and wider NHS. The proposal would continue through appropriate Trust governance procedures.

Appraisal compliance had remained strong and had been fully compliant for more than three years.

Psychological support for staff was discussed, recognising the wider relevance of the earlier patient story and the potential benefit of closer alignment between occupational health psychology and clinical psychology. Assurance was provided that this was being explored, including opportunities for joint working, peer support and supervision. The Trust's full use of its apprenticeship levy was welcomed including its position as a registered apprenticeship provider, recognising the relevance of this to anchor institution responsibilities and future university status ambitions.

The Board challenged how staff experience, patient experience and communication themes were being triangulated for the non-clinical workforce, recognising that corporate and support roles were often key points of contact for patients and families. It was confirmed that this would be included in the development of the patient experience improvement plan following the specialist review which concludes in September, with a report expected through the relevant executive route. A Board workshop on the new staff standards was also proposed to support further consideration of staff experience and wellbeing.

Finance - The Board was advised that the Trust was on trajectory at month three, with a £13.6m deficit position including deficit support and delivery of £3.6m against the waste reduction programme. The current schemes delivered had achieved 6.3% of the required savings to date and opportunities for recurrent savings required further scrutiny and challenge. A full plan had been identified for the £60m waste reduction programme, with delivery risks monitored through divisional delivery groups. It was proposed that these groups be reconfigured into more frequent, shorter and more action-focused meetings to strengthen delivery oversight.

The Board was advised that pay expenditure remained a key area of focus. Whole-time equivalent staffing had reduced by 96 from month one, but this was below the planned trajectory of around 200, creating a risk to delivery of the financial plan. The Board challenged the pace of whole-time equivalent reduction and requested clearer projections and recovery actions, noting that slippage could not be allowed to accumulate into later months. It was emphasised that the financial recovery requirement was a collective Board responsibility and that stronger evidence would be required to demonstrate that actions were having the intended impact and assurance could be received.

Capital expenditure remained behind plan, although access to significant national capital funding was available and a structured and prioritised plan would be brought to the Finance and Performance Committee for consideration in August. Cash remained sufficient at month three; however, further measures would be required from September to avoid the need for emergency cash, with a potential requirement for emergency cash in October depending on delivery of the waste reduction programme and capital expenditure. Assurance was provided that supplier payment performance remained strong and that cash was not currently affecting payment practice, although this position would remain sensitive to financial recovery delivery and capital spending decisions.

124/26 Winter Planning 26/27 – Process and timescales

The Board was advised that winter planning for 2025/26 had been evaluated and had been considered through the Finance and Performance Committee. Planning for 2026/27 had commenced, with the required regional self-assessment due for submission by 26 August. The Board was further advised that the submission would be reviewed regionally, followed by attendance at the North West winter stress test event in September and formal submission of a Board assurance statement by 30 September.

The Board was advised that a more system-focused approach to winter preparedness was being developed, moving beyond traditional reliance on additional bed capacity. Work had commenced with voluntary, community, faith and social enterprise partners and system colleagues to consider alternative approaches to preventing avoidable emergency department attendances and admissions. It was recognised that additional capacity might still need to be considered as part of winter planning; however, the focus had shifted

towards prevention, demand management and more effective use of partnerships across the system.

It was confirmed that the full winter plan and supporting assurance would be submitted to the October Board meeting.

The Board RESOLVED to approve delegated authority to the Chair and CEO for formal sign-off of the 2026/27 Winter Plan for submission to NHSE by 30 September 2026.

125/26 Safety and Quality Committee Chair's Report

The Chair's report was received which summarised the points of alert, advisement and assurance for the Board. Digital risks and limitations themes had been identified and escalated for system-level review. Mitigation actions had been implemented due to increased pressure ulcer reporting. Pathology risks, including industrial action and suspended accreditation at a neighbouring Trust, were addressed through outsourcing. Substantial assurance on the Patient Safety Incident Response Framework was received, with further impact evaluation required. Progress in infection prevention was reported, although future risks from estate and operational pressures were highlighted. Healthcare Assistant workforce strengthening was advised, and data challenges for Health Inequalities reporting were monitored. Medical workforce issues in children's services were anticipated to be resolved by August, while the Urgent and Emergency Care Improvement Programme was formally governed and tracked.

A verbal update was given on matters from the July meeting for the Board's attention. Pressures had been identified within the cardiology pathway following triangulation of incident and complaints data. Action plans had been developed and were expected to be completed by 1 September, with ongoing assurance to be provided through the Patient Safety Incident Response Framework reporting route.

The Board was further advised that significant pressures remained within the obstetric workforce. Appropriate cover and mitigating actions were in place, supported by job planning review and workforce diagnostics; however, workforce fatigue and associated risks had been highlighted for continued oversight. The Board was advised that these matters would also be considered further through the maternity and neonatal services report.

The Committee had also received assurance regarding revised governance and assurance arrangements for pathology. Following due diligence, a discovery phase was underway to strengthen oversight and escalation, with detailed reports to be provided through the Committee, including clear ownership, actions and timescales, until the required level of assurance had been achieved.

126/26 Annual Safeguarding Report

The Annual Safeguarding report was presented for consideration and approval. The Safety and Quality Committee had endorsed the report at its meeting on 31 July 2026 (SQC Minute No.148/26 refers).

Assurance was sought regarding whether sufficient support was available from partner organisations in response to references within the report to children being cared for in

unsuitable hospital settings and increases in referrals relating to children, maternity and mental health.

The Board was advised that resource had improved compared with previous years, although further improvement was required, particularly in relation to the availability of timely crisis assessment and access to appropriate external placements. It was clarified that these issues were principally linked to external partner capacity and national placement constraints, rather than internal staffing alone.

It was agreed that operational matters relating to partner resource should continue to be progressed through executive and system routes. Assurance was provided that children were being kept safe through comprehensive risk assessments, care plans and additional staffing where required. The Board requested that the Safety and Quality Committee seek further assurance on whether the arrangements in place remained sufficient to maintain safety and deliver the required quality of care.

The Board RESOLVED to approve the Annual Safeguarding Report.

127/26 Annual Mortality, LEDER and PMRT Report

The Annual Mortality, LEDER and PMRT Report was presented and considered for approval, following assurance that the Safety and Quality Committee had duly scrutinised the content and endorsed the report at its meeting on 26 June 2026 (SQC Minute No.124/26 refers).

The Board RESOLVED to approve the Annual Mortality, LEDER and PMRT Report.

128/26 Maternity and Neonatal Services Report

E Ashton, J Connolly and L Murphy attended for this item.

The Maternity and Neonatal Services Report was received for assurance, following prior scrutiny by the Safety and Quality Committee. The Board was advised that the report format had been revised to align with the national maternity and neonatal Board reporting template, and that future reports would continue to follow this format. The Board was asked to confirm that it was assured in relation to the oversight and monitoring mechanisms used to assess safety and quality within maternity and neonatal services.

Assurance was received that five out of six MIS Year 8 standards were on track, with the Maternal Care bundle identified as at risk. Workforce pressures were highlighted, although safe staffing processes, escalation arrangements and recruitment actions were maintained. Strong compliance with mandatory training was reported, and governance processes for incident review, perinatal mortality, learning and family engagement were described. Operational pressures were noted in maternity assessment, elective caesarean pathways and neonatal services, though neonatal unit closures had reduced by June 2026. National maternity review recommendations were considered, local benchmarking was undertaken, and a MNIST review had occurred in July to support further improvement.

The Board recognised that recent national reports, including the Ockenden and Amos findings, required more than acknowledgement and should be used to identify relevant actions for the Trust, strengthen care and provide a clear governance record of the Trust's response. It was confirmed that maternity, neonatal and obstetric colleagues would

continue to attend Board discussions as a perinatal leadership team, in line with national expectations.

Assurance was provided that detailed scrutiny had been undertaken through the Safety and Quality Committee, supported by non-executive visits and ongoing engagement with services. Further non-executive assurance activity had been scheduled, including work aligned to cultural development and Freedom to Speak Up arrangements. The Board also received assurance that positive feedback had been received from the invited Maternity and Neonatal Intensive Support Team review, particularly in relation to family integrated care within neonatal services, including parental involvement in ward rounds and decision-making.

The Board sought assurance regarding implementation of Martha's Rule within maternity and neonatal services. It was reported that national work was underway, that the Trust had already partially implemented call for concern arrangements, and that further work would be undertaken to strengthen regular inpatient check-ins and develop more bespoke information for pregnant women, babies and families. Full implementation was expected to progress over the following three to four months, subject to national guidance.

Assurance was also sought regarding benchmarking against national recommendations and the extent to which external objectivity would inform the Trust's assessment of its position. It was confirmed that initial benchmarking would be undertaken internally against national requirements, with further national guidance expected in December. Assurance was also expected through continued regional oversight, peer networks, the awaited Maternity and Neonatal Intensive Support Team report, ICB and NHS England routes. The Board encouraged further external peer review where required to strengthen evidential assurance.

The Board was advised that workforce pressures within obstetrics remained significant, with reliance on agency staffing and additional hours being worked by existing colleagues. The current position was recognised as unsustainable, and the need for further recruitment and over-establishment to support safe and sustainable staffing was acknowledged. The Board confirmed that these concerns were being taken seriously and that further detail on the longer-term obstetric workforce plan would be brought through the appropriate governance route.

There was recognition from the Board that leadership provided by the perinatal leadership team during a period of significant national scrutiny and service pressure. The report was accepted for assurance, with continued oversight to be maintained through the Safety and Quality Committee and future Board reporting.

129/26 Board Assurance Statement: Nottingham Maternity Review; Response to Fuller Inquiry; and Human Tissue Authority Report

The Board Assurance Statement relating to the Trust's response to the Human Tissue Authority report and the learning arising from the Ockenden and Amos findings in relation to the dignified care of deceased babies was received. The Trust had reviewed its governance and accountability arrangements in response to the latest NHS England requirements and has confirmed that appropriate executive oversight, operational governance and accountability arrangements are in place. The report had been scrutinised and endorsed by the Safety and Quality Committee.

Assurance was provided that the pathway had been reviewed across relevant services, including mortuary, pathology, gynaecology and theatres. Executive visits to the Mortuary Department had been planned and undertaken, and further non-executive assurance activity had been scheduled. The Board was advised that teams had already reviewed the national findings and had taken steps to strengthen processes, with assurance also received that actions arising from the recent Human Tissue Authority inspection had met the required standards.

The Board sought assurance that the response extended beyond compliance with policies and procedures to include culture, behaviours, staff experience and the quality of interactions with bereaved families. It was confirmed that the Human Tissue Authority inspection had included staff interviews and that no concerns had been raised. It was also recognised that further assurance arrangements would be developed for the mortuary, reflecting the risks associated with small, specialist and isolated teams.

The meeting was advised that phase one actions were due for completion by December 2026, and that an additional report would be received by the Safety and Quality Committee in January 2027 to confirm completion, alongside the annual reporting cycle. Assurance was also provided that arrangements relating to termination of pregnancy pathways were subject to oversight, with a further report scheduled through the Committee.

The Board RESOLVED to approve the Board Assurance Statement for submission.

130/26 People and Partnerships Committee Chair's Report

The Chair's report was received. The Committee reported that assurance had been provided in relation to the Health and Wellbeing Strategy, with positive outcomes reflected through improvements in sickness absence, recognising that some short-term variation remained.

The Board was alerted to a high-scoring estates and facilities staffing risk, which remained above the acceptable risk level and was associated with the continued development and maturation of the OneLSC arrangements. Assurance was provided that an estates and facilities partnership had been established to strengthen the strategic client relationship, with agreed terms of reference and statutory compliance metrics being formalised. It was confirmed that this provided a mechanism for risks to be escalated and considered by relevant executives, although the underlying risk had not yet been resolved.

The Board was advised that mandatory and compliance training had been scrutinised by the Committee, including aseptic non-touch technique training and consultant access to face-to-face training. Assurance had been provided that compliance had reached the Trust threshold and that further work was being undertaken with relevant departments to maintain delivery.

In discussion, the transfer of risks into the newly established Committee was highlighted as an ongoing area requiring oversight. It was recognised that further meetings would support greater clarity on the full range of partnership-related risks within the Committee's remit.

131/26 Finance and Performance Committee Chair's Report

The Chair's report was received along with a verbal update from the July meeting. The Board was advised that the Committee had maintained continued focus on delivery of the waste reduction programme, with particular scrutiny applied to the requirement to convert in-year savings into recurrent, sustainable savings. Improvements in divisional focus and leadership were recognised, although the pace of delivery and level of control required to meet the financial recovery trajectory had been challenged, with limited assurance.

The Board was alerted to further key risks including the need for improved accountability and oversight arrangements of OneLSC, and the general finance position including Regional Provider Oversight Meeting outcomes related to persistent underperformance at divisional levels being identified. Strengthened accountability and governance arrangements were identified requirements in both areas.

The Board was advised that the Committee had undertaken detailed discussion regarding the methodology used to determine risk scores and the point at which changes should be made. Principal Risk 6, relating to access to urgent and emergency care, had been reviewed and retained at its current score, recognising that improvements had been delivered but that sustained performance would be required before any reduction could be supported.

The Committee had also considered more detailed analysis of workforce-related factors supporting the waste reduction programme, including vacancy levels, temporary staffing utilisation and workforce performance. Assurance was provided that a more comprehensive and joined up understanding of the workforce position was being developed to support delivery of the required whole-time equivalent reduction. The Committee had challenged the pace of progress and requested further detail on wider options available to maintain or recover delivery against the plan, recognising that financial recovery was a responsibility for the Board collectively.

132/26 Audit Committee Chair's report

The Audit Committee Chair's Report was received. The Board was advised that the Committee had maintained focus on continued vigilance, effective planning and reduction of unexpected issues within the audit programme. Assurance was provided that the number of exceptional matters had reduced significantly over the preceding 18 months, supported by strengthened financial oversight and continued focus on waste reduction and value for money.

133/26 Charitable Funds Committee Chair's Report

The Chair's report was received for assurance, with no points for alert or advisement. The Board was informed that there were no matters to alert or advise, and that fundraising activity continued to perform strongly across the Trust charity and associated appeals.

The Board received assurance that charitable funds were being actively used to support a range of projects and initiatives, with examples provided to demonstrate the impact of funds raised. It was recognised that legacy income remained inherently variable and was therefore subject to prudent forecasting.

134/26 Items for information

The following reports were received and noted for information:

- a) Quality Account
- b) North West Race Equity Assembly Annual Report 2025/26

135/26 The next meeting of the Board of Directors will be held on Thursday 1 October 2026 at 9:15am at Lecture Hall, EC3, Chorley and South Ribble Hospital.

The meeting closed at 12.17pm



Written Resolution 01/26

Maternity and Neonatal Services Baseline Assessment Submission

Pursuant to the Board of Directors' Standing Order 4.21, the following resolution is submitted for consideration.

BUSINESS TO BE CONSIDERED

Maternity and Neonatal 10 Point Plan Assurance Return

The Board is asked to consider and approve for submission to NHS England the Trust's Maternity and Neonatal Services Baseline Assessment against the 10-Point Plan, including the Maternity Specific Triage Benchmarking Audit.

NHS England has stipulated that the return must receive formal Trust Board approval prior to submission by 25 September 2026.

RESOLUTION

It is **RESOLVED** that the Maternity and Neonatal Services Baseline Assessment against the 10-Point Plan, including the Maternity Specific Triage Benchmarking Audit, as attached to this written resolution be approved for submission to NHSE.

Resolution issued: 23 September 2026

Long stop date for approval: 25 September 2026

Number required for assent: 7

Date resolution effective: 23.09.2026

Jennifer Foote
Director of Corporate Services

Name of Board Member:	Email approval/dissent received	Date
Uzair Patel	Approved	23.09.2026
Silas Nicholls	Approved	23.09.2026
Sarah Morrison	Approved	23.09.2026
John Schorah	Approved	23.09.2026
Tim Wheeler	Approved	23.09.2026
Craig Carter	Approved	23.09.2026
Mike Thomas	Approved	23.09.2026

5. MATTERS ARISING AND ACTION LOG UPDATE

● Other

👤 M Thomas

🕒 9.40 am

Procedural Item

REFERENCES

Only PDFs are attached



5.0 Action log - Board Pt I - 6 August 2026.pdf

Action log: Board of Directors (part I) – 1 October 2026

No Outstanding Actions

Completed Actions

No	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update
1.	-	06.08.2026	Patient Story: Letter of thanks and condolence to patient's family	DCEO	01.10.2026	Complete Update for 1 October 2026: Letter send to family.
2.	121/26	06.08.2026	DCEO report: Letter of congratulations to catering team for regional award.	DCEO	01.10.2026	Complete Update for 1 October 2026: Letter send via Estates team and acknowledgement received.
3.	123/26	06.08.2026	IPR People: Board Workshop on new staff standards, considering staff experience and wellbeing	CAT	01.10.2026	Complete Update for 1 October 2026: Added to programme suggestions for 2026/27.

ITEMS FOR FUTURE BUSINESS (for information)

<u>No</u>	<u>Min. ref.</u>	<u>Meeting date</u>	<u>Action and narrative</u>	<u>Owner</u>	<u>Deadline</u>	<u>Update</u>

6. CHAIR'S OPENING REMARKS AND REPORT

● Discussion Item

● M Thomas

● 9.42 am

REFERENCES

Only PDFs are attached

 6.0 Chair's Report Board Part I 1 October 2026 .pdf



Board of Directors Report

Meeting of the	Board of Directors		1 October 2026
	Part I	☒	Part II ☐
Title of Report	Chair’s Update Report		
Report Author	Katie Stanton, Business Manager, Corporate Affairs		
Lead Executive Director	Mike Thomas, Chair		
Recommendation/ Actions required	The Board of Directors is asked to receive the report and note the contents for information.		
	Decision ☐	Assurance ☐	Information ☒
Executive Summary	The purpose of this report is to provide a summary of work and activities undertaken during August and September 2026 by the Trust Chair.		
Link to Strategic Objectives 2026/27	Patients – deliver excellent care: Improve outcomes, reduce harm and deliver a positive patient experience.		☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.		☒
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.		☒
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.		☒
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.		☒

1. Introduction

This report provides an overview of the work and activities undertaken during August and September 2026 by the Trust Chair.

2. Chair Update's

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

Professor Anthony Rowbottom MBE

It was with great sadness that we learned of the recent passing of Professor Anthony Rowbottom following a short illness. On behalf of the Trust, I would like to extend sincere condolences to his family, friends and colleagues at this difficult time. Professor Rowbottom made a significant contribution to Lancashire Teaching Hospitals through his longstanding commitment to research,

innovation and clinical excellence, and his support for strengthening the Trust's partnerships with academic institutions. His contribution to patient care, education and the wider health community will be remembered with great respect and appreciation.

Edovation Limited

Following the news of Professor Rowbottom's passing, and to maintain continuity in the governance arrangements of Edovation Limited, of which he was a director, I exercised Chair's authority to appoint Jennifer Foote as a director.

Health Bill Progress

The Health Bill is expected to complete its parliamentary passage in the coming months, with the expectation of coming into law on 1 April 2027, and contains proposals that would remove the existing statutory requirements relating to NHS Foundation Trust Councils of Governors. Further guidance on implementation has not yet been issued. The Trust will continue to monitor developments and will consider the implications of the legislation once the final provisions and associated guidance have been confirmed.

NHS Oversight Framework outcome

Following a recent opportunity to reflect on the considerable progress made by the Trust over the past 12 months, our position within the NHS Oversight Framework has seen positive movement from Segment 4 to Segment 3, reflecting sustained improvements in both performance and financial metrics. I would like to acknowledge the commitment, professionalism and hard work of colleagues across the organisation that have contributed to this achievement.

3. Summary of Key Items from Board Part II meeting of 6th August 2026

The Board received updates on pathology services and on wider service planning matters. Assurance was also received in relation to maternity services, with continued oversight agreed through the appropriate governance routes.

The Board reviewed the Trust's financial position and the actions being taken to support delivery of the financial plan.

In addition, the Board approved financial delegations and a contract award relating to services delivered via a hosted service.

4. Chair's attendance at meetings

Details below are the meetings attended and activities undertaken during August and September 2026.

Date	Activity
August 2026	
4 th August	121 – Director of Corporate Affairs
4 th August	Lead Governor/Chair Liaison and Shared Briefing
4 th August	Introduction Meeting - Associate Director of Risk & Assurance
4 th August	121 – Managing Director, One LSC
6 th August	Board of Directors, LTH
11 th August	121 – Director of Communications and Engagement
11 th August	121 – Non-Executive Director

11 th August	121 – Business Manager, Corporate Affairs
11 th August	121 - Chief Transformation and Delivery Officer, LSC Provider Collaborative
11 th August	Health and Wellbeing Board Workshop
13 th August	121 – Chief Executive
13 th August	121 – Chair, LSC Integrated Care Board
13 th August	Chair's Discussion
13 th August	Board Development Session
18 th August	121 – Director of Public Health, Wellbeing & Communities
18 th August	121 – Managing Director, One LSC
20 th August	121 – Chief Executive
20 th August	LTH/ELHT – Chair/CEO's Meeting
26 th August	121 – Managing Director, LSC Provider Collaborative
25 th August	LTH Regional Provider Oversight Meeting
25 th August	Lead Governor/Chair Liaison and Shared Briefing
27 th August	121 – Director of Corporate Affairs
27 th August	121 – Business Manager, Corporate Affairs
27 th August	Board Workshop
27 th August	121 – Non-Executive Director
September 2026	
8 th September	121 – Non-Executive Director
8 th September	121 – Non-Executive Director
9 th September	Board to Board, NHSE
10 th September	121 – Director of Corporate Affairs
10 th September	Chair's Discussion
10 th September	Provider Collaborative Board Meeting
15 th September	121 – Non-Executive Director
15 th September	121 – Director of Corporate Affairs
15 th September	Monthly Non-Executive Directors Meeting
16 th September	LSC Non-Executive Director Forum
17 th September	121 – Chair, Northwest Ambulance Service
17 th September	121 – Chief Executive, St John's Hospice
22 nd September	121 – Director of Communications and Engagement
22 nd September	121 – Director of Corporate Affairs
22 nd September	Lead Governor/Chair Meeting
22 nd September	121 – Managing Director, LSC Provider Collaborative
26 th September	South Ribble Health Mela

5. Recommendations

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

7. CHIEF EXECUTIVE'S REPORT, INCLUDING THIRWALL REPORT

ACKNOWLEDGEMENT AND NEXT STEPS



Discussion Item



S Nicholls



9.45 am

REFERENCES

Only PDFs are attached



7.0 Chief Executive's Report to Board October 2026.pdf



Board of Directors' Report

Meeting of the	Board of Directors	1 October 2026	
	Part I ☒	Part II ☐	
Title of Report	Chief Executive's Report		
Report Author	Prepared by Naomi Duggan – Director of Communications and Engagement		
Lead Executive Director	Professor Silas Nicholls – Chief Executive		
Recommendation/ Actions required	The Board of Directors is asked to receive the report and note its contents for information.		
	Decision ☐	Assurance ☐	Information ☒
Executive Summary	The purpose of this report is to update the Trust Board on matters of interest since the previous meeting.		
Link to Strategic Objectives 2025/26	Patients – deliver excellent care: Improve outcomes, reduce harm and deliver a positive patient experience.		☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.		☒
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.		☒
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.		☒
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.		☒
Due Diligence	To give the Trust Board assurance, please complete the following:		
Committee Approval:	N/A	Date: N/A	
Operational Group Review:	N/A	Date: N/A	
Link to Board Assurance Framework:	N/A - Not aligned to a Principle Risk		
Appendices	N/A		

CHIEF EXECUTIVE'S REPORT

Improving patient flow and performance

Urgent and emergency care has been a major priority for us for some time. We know that when our Emergency Departments at Preston and Chorley become very busy, it affects the experience we can provide for patients and can impact quality of care. We have been particularly concerned about the experience of our frail older patients and those facing lengthy waits, who are often among the most vulnerable people using our services.

Over the last few months, a huge amount of work has taken place across our Emergency Departments and urgent care pathways focused on strengthening patient flow and ensuring people receive the right care, in the right place, at the right time.

A number of important developments have recently gone live. These include the opening of our Extended Emergency Medicine Ambulatory Care (EEMAC) unit, providing rapid assessment and turnaround for suitable patients, and the launch of our Medical Decisions Unit (MDU), creating additional capacity to support timely clinical decision-making and admissions management. Alongside these developments, teams have reviewed and strengthened pathways across the department, particularly for patients experiencing lengthy waits, while continuing to test and implement improvements for frail older patients using continuous improvement methods.

I'm pleased to say we're beginning to see the benefits of this work. Performance against the four-hour standard is now the best it has been in more than two years, and we've sustained that improvement over recent months. We have also seen a significant reduction in patients experiencing long waits, with overall long waits reducing by around 20% over the last three months. For frail older patients, waiting times in the department have reduced by 25%, helping to improve both their experience and outcomes. Importantly, we have also had a number of days where corridors have remained clear and demand has been managed more effectively.

Our frailty programme continues to go from strength to strength. We have successfully progressed from Phase 1 to Phase 2 of a national frailty initiative, recognising the quality of work already underway across our organisation. Building on this success, we are developing a business case for Board approval that would create an expanded frailty service both within the hospital and across community settings. This represents a significant investment and reflects our commitment to helping older people receive the right care earlier and closer to home wherever possible.

The innovation and leadership being demonstrated across our urgent and emergency care teams is particularly encouraging. Clinicians are increasingly challenging traditional pathways and developing new approaches that improve patient experience while supporting operational performance. This work is beginning to deliver measurable benefits and positions us well for further improvement over the coming months. I'd like to put on record my thanks to everyone involved across this piece of work on behalf of the wider Executive team.

NHS Oversight Framework

Twelve months ago, NHS England published Lancashire Teaching Hospitals' (LTH) segmentation and ranking in their new **NHS Oversight framework** (NOF), which set out how they would assess providers against a range of agreed metrics.

At the time, LTH ranked 127 / 134 in the acute and specialist provider league table. As a result, we were placed into segment 4 out of 4, which determined the level of response and potential intervention needed to improve our performance.

Now - a year on - and based on Quarter 1 data from 2026/27, I am delighted to confirm that our position has significantly improved to 109 / 134 and, for the first time, have been moved to segment 3. You can [access the NHS trust performance league tables process and results on the NHSE website here](#).

Our improvement journey remains a whole team effort and I would like to say a big thank you to colleagues for their hard work to date. I am confident that the proactive approach we are taking will lead to these improvements being sustained and I hope to confirm a further improved position in the Quarter 2 publication (late November).

Whilst our performance is improving, it's also worth acknowledging that patient experience remains a key priority. Over recent months, we have been working with Annie Lavery, the NHS's first Patient Experience Director, to better understand the experiences of people using our services and identify further opportunities for improvement. We'll be taking a more systematic approach to learning from patient feedback, addressing areas where we can do better, and sharing the excellent practice that happens across our wards and departments every day. The principle behind this work is simple: when we improve patient experience, we often improve staff experience too.

Thirlwall Inquiry

The final report of the Thirlwall Inquiry has now been published, examining the events at the Countess of Chester Hospital and the wider systems, governance and safeguarding arrangements that failed to protect babies and families. The report sets out recommendations intended to strengthen patient safety across the NHS.

Our thoughts remain with the babies and families affected by these devastating events. The report highlights serious failures in governance, leadership and safeguarding, and identifies missed opportunities to act on concerns raised by clinicians.

In response, the Government has announced a number of immediate actions, including:

- Stronger safeguarding measures across the NHS
- Tougher accountability arrangements for senior NHS managers
- Enhanced inspection and oversight arrangements
- Development of proposals for CCTV and "cot cams" in neonatal settings
- Further strengthening of processes for reviewing neonatal deaths
- Continued rollout of support for families affected by neonatal loss

Chief Nursing Officer for England, Duncan Burton, said the NHS must continue to learn from the findings, acknowledging the profound impact on affected families and the need for clear action to ensure the highest standards of safety and care. He also recognised that the report may be upsetting for colleagues, particularly those working in neonatal services or those with personal experience of neonatal care.

At Lancashire Teaching Hospitals, patient safety remains our highest priority. We are committed to fostering an open culture where colleagues feel able to speak up, raise concerns and contribute to continuous improvement. We will continue to review national guidance and recommendations arising from the Inquiry and incorporate relevant learning into our own services and practices.

Every day, our neonatal teams provide highly skilled and compassionate care to babies and families in some of the most difficult circumstances. We would like to thank you all for the care, kindness and professionalism you continue to show. Learning from this report is not about diminishing that commitment; it is about making sure everyone is supported to provide the safest possible care and that concerns are heard and acted on.

Read the Thirlwall Inquiry report: <https://thirlwall.public-inquiry.uk/the-report/>

Read the Government's response: <https://www.gov.uk/government/news/government-to-act-on-thirlwall-patient-safety-recommendations>

Building a better future for maternity and neonatal care – your voice

Your Voice is an NHS-wide opportunity for an open conversation to determine what happens next for all our maternity and neonatal services. The aim is for this to be the largest single conversation ever held about an NHS service, bringing together staff voices from across the country to help turn the **Independent**

National Maternity and Neonatal Investigation led by Baroness Amos into meaningful action for women, babies and families.

As such, we are encouraging midwives, neonatal nurses and staff on the wider maternity pathway to take part in the online conversation which is currently open and will inform the National Maternity and Neonatal Taskforce's action plan, so that future decisions are grounded in the realities of staff, services and families

Industrial action – blood sciences – East Lancashire

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

Unite the Union has notified us of its intention to undertake a fifth phase of industrial action, consisting of a further 20 days of strike action over four consecutive weeks. This additional action will follow the conclusion of the current phase and means strike action is now scheduled to continue until Friday 30 October 2026. The action will take place each week from 00:01 on Monday until 23:59 on Friday.

Having taken advice from NHS England and NHS Employers regarding the concerns raised about holiday pay calculations, Lancashire Teaching Hospitals NHS Foundation Trust remains confident that the national methodologies used to calculate holiday pay are correct and that there is no detriment to employees' pay. To satisfy ourselves that no local factors are creating pay detriment for Blood Sciences colleagues, we have reviewed sample pay calculations and undertaken further analysis of the rosters. Discussions with Unite continue as we seek to reach a resolution.

We recognise that the ongoing industrial action continues to present challenges for colleagues, services and patients. We respect the right of colleagues to participate in lawful industrial action and peaceful picketing. At the same time, our focus remains on maintaining safe, high-quality services for patients.

The withdrawal of previously agreed derogations on 6 August 2026 has had a significant impact on blood sciences services and continues to present challenges in maintaining the full range of testing normally available to patients. While urgent and clinically critical services continue to be prioritised, overall capacity remains significantly reduced.

We have implemented extensive contingency arrangements and are working closely with NHS partners and external providers to increase capacity safely and minimise disruption wherever possible. Patients requiring urgent and emergency care continue to be prioritised, alongside other clinically critical services.

We would like to thank colleagues who continue to work within our laboratory services in East Lancashire for their dedication, professionalism and commitment to supporting patients during this challenging period.

We encourage everyone to continue treating one another with kindness, professionalism and respect.

Super September - supporting more patients through increased elective activity

September marked a major organisational focus for us on increasing elective activity as part of our ongoing commitment to reducing waiting times and improving access to care. With an ambition for 70% of patients to be waiting less than 18 weeks for routine elective treatment by the end of the year, there was a renewed drive to maximise the capacity available across all services. Colleagues across the organisation were encouraged to explore opportunities for additional clinics, procedures, evening sessions, and weekend working where capacity allows.

While the focus was on "Super September", the challenge of reducing waiting lists extends well into the months ahead. A powerful example of what can be achieved is the significant turnaround in Endoscopy services, where sustained focus on capacity, productivity, workforce development and patient flow has resulted in performance improving from fewer than one in five patients being seen within six weeks to all patients being seen today for the first time in many years. Overall, the endoscopy waiting list has reduced

by around 70% over the last year and the programme is now being recognised nationally as an example of best practice.

This success demonstrates the impact of innovation, teamwork and a shared commitment to improving care. Building on this momentum, leaders are encouraged to support conversations within their services about how additional capacity can be created to help deliver more elective activity and further improve outcomes for patients waiting for care.

Flu Vaccination Campaign 2026

This year's flu vaccination campaign begins on 1 October and will run until the end of December.

Flu remains an unpredictable virus that can kill thousands of people. Last winter, in England flu caused around 3,800 deaths, but the disease burden and severity of the flu season varies. As recently as the 2024/25 season we saw around 9,700 deaths from flu. Last year, the flu vaccine prevented around 104,000 hospitalisations and 7,100 deaths.

Being healthy doesn't reduce your risk of getting flu or passing it on. You can have flu without any symptoms and pass it on to family, friends, colleagues, and patients, many of whom may be at increased risk from flu.

This year's campaign will be a time-limited campaign, and we are encouraging colleagues to get their jabs at the earliest opportunity. Flu vaccinations are available to all colleagues, including bank and agency workers, students/learners and volunteers and vaccinations are offered completely free of charge.

We will be kicking off this year's winter vaccinations campaign with two Vaxathon events at Preston and Chorley followed by drop in sessions and peer vaccinations available.

Annual Members' Meeting 2025/26

This year's Annual Members' Meeting 2025/2026 (AMM) will take place on Monday 5 October from 2pm – 4pm in the Sir Tom Finney Room at The County Ground, Thurston Road, Leyland, PR25 2LF.

The AMM gives members the chance to hear from our Executive Team as they present the 2025/26 Annual Report and Accounts.

The theme for this year's event is 'The NHS Left Shift: Moving Care Closer to Home and Reducing Time Spent Waiting'.

The session will be free to attend with free parking and refreshments also available. Those who wish to attend do not need to register their attendance in advance. Simply turn up on the day.

For more information, visit the AMM page on [our website](#). If you have any questions in advance of the meeting, please email corporateaffairs@lthtr.nhs.uk.

Trust wide successes and service developments



- **Doctor elected as next President of British Association of Spinal Surgeons**



These last two months have seen a number of outstanding achievements across clinical care, research, education, innovation and workforce development, demonstrating continued excellence and national recognition for services and colleagues.

A significant professional accolade was awarded to Dr Kaushik Ghosh, a leading spinal surgeon at the Trust, who has been elected as the next President of the British Association of Spine Surgeons, one of the most prestigious leadership roles in UK spinal surgery.

A long-standing member of BASS, Dr Ghosh was chosen by fellow members as President-Elect and will formally take up the position in 2027.

As President, Dr Ghosh will lead the organisation's Executive Committee, helping shape national policy, education and research programmes, while strengthening collaboration across the UK and internationally. His priorities include advancing spinal surgery education, developing guidance for complex procedures and supporting innovation, including navigation systems and robotic-assisted surgery.

Having worked at Lancashire Teaching Hospitals since 2005, Dr Ghosh has played a significant role in developing Preston into a nationally recognised spinal centre and training hub.



- **Steph Morrison recognised as Regional ESN Heroes award winner**



Recognition of individual excellence also came through Steph Morrison, Epilepsy Specialist Nurse, who has been recognised by Epilepsy Action as the Regional ESN Heroes Award Winner for the North West in its 2026 awards programme.

The award celebrates Epilepsy Specialist Nurses who have made a significant and lasting difference to the lives of people living with epilepsy and their families. Steph was selected following nominations from patients who highlighted her exceptional compassion, professionalism and unwavering commitment to those in her care. Feedback described her as “pure awesomeness”, praising her patience, understanding and willingness to go above and beyond, including undertaking home visits and providing consistent support during particularly challenging periods.



This external recognition reflects the outstanding quality of care delivered by our specialist nursing teams and demonstrates the profound impact they have on patient experience, wellbeing and clinical outcomes. Steph's dedication to supporting people with complex and often treatment-resistant epilepsy exemplifies our values of compassionate, person-centred care.

On behalf of the organisation, I would like to congratulate Steph on this well-deserved achievement. Her award is a testament not only to her individual commitment but also to the excellence of our specialist epilepsy services across the Trust.

- **Historic milestone for LTH cancer research**





Research and innovation have continued to advance with the launch of the OVACT study, the organisation's first Dose Escalation Phase 1 cancer trial through the Lancashire Clinical Research Facility (LCRF). This marks an important step in the development of the Trust's

early-phase research capability and reinforces our commitment to offering patients access to cutting-edge treatments and innovative research opportunities.



The OVACT study is a multi-centre clinical trial evaluating a novel mRNA cancer vaccine in patients with ovarian cancer. Led locally by Principal Investigator Dr Dennis Hadjiyiannakis, the study aims to assess the safety, tolerability and optimal dosing of the treatment while contributing to the development of new therapies for patients with limited treatment options.

The achievement reflects many months of planning, training and collaboration across research, clinical and operational teams to ensure the Trust was ready to safely deliver complex early-phase research. Demonstrating this readiness, a potential participant was contacted within just 25 minutes of the study opening.

The successful launch is a testament to the dedication and expertise of colleagues across the Research and Innovation team and represents a major step forward in positioning the Trust as a leading centre for innovative cancer research, bringing the latest advances in treatment closer to patients across Lancashire.

- **Undergraduate medical education celebration**



Education and leadership development remain key strengths. In July, the Trust hosted its annual Undergraduate Medical Education (UGME) Celebration Event, recognising the achievements, innovation and dedication of colleagues involved in undergraduate medical education during the 2025/26 academic year.

Led by Professor Madhavi Paladugu, the event brought together teams from across UGME to showcase successful initiatives, share learning and celebrate the collective contribution being made to the development of future doctors. A key theme of the event was the innovative use of technology to enhance teaching, learning and the overall educational experience for medical students.

Attendees highlighted a wide range of examples demonstrating educational excellence, collaborative work and creative approaches to supporting undergraduate training. The event also provided an opportunity for teams to learn from one another, share best practice and reflect on achievements over the past year.

- **Enhance Explore Programme showcases Foundation Doctors**



Foundation Doctors participating in the Enhance Explore Programme recently presented a range of quality improvement projects, many delivering measurable benefits in patient safety, clinical effectiveness and operational performance.

Built around the principles of the Lancashire Improvement Method (LIM), the programme combines leadership development with practical quality improvement projects aligned to Trust and system priorities.

Notable projects included work to improve timely corticosteroid administration for children presenting with acute asthma, enhance communication and task management within paediatric services, increase four-hour definitive outcomes in the Emergency Department, and strengthen utilisation of the Trust's Virtual Ward programme.

Several projects received external recognition, including national presentations and awards. Dr Zahra Al-Lawati's asthma improvement work was highly commended by the Royal College of Paediatrics and Child Health and was the only quality improvement project accepted for presentation at its national conference. A patient safety project led by Dr Francesca Beaumont and colleagues received first place at a national patient safety conference.

I was delighted to be present and able to praise the participants for their commitment to improving healthcare systems - outstanding clinicians look beyond individual patient encounters to drive broader organisational and population health improvements. The programme continues to provide a valuable platform for developing future clinical leaders while delivering tangible benefits for patients and services across the Trust.

- **Cancer Prehabilitation cycling challenge raises awareness and support**



In September, a team of approximately twenty colleagues from across Lancashire Teaching Hospitals successfully completed a 140-mile charity cycling challenge across Lancashire and Cumbria to raise awareness of cancer prehabilitation and support fundraising for Rosemere Cancer Centre.



Over two days, the team travelled between football clubs involved in the Lancashire and South Cumbria Cancer Alliance prehabilitation programme, beginning in Barrow and finishing at Burnley FC's Turf Moor. Along the route, colleagues highlighting the importance of the Versus Cancer prehabilitation sessions, which help patients improve their physical and emotional wellbeing before cancer treatment.

The challenge brought together staff from a wide range of specialties, including oncology, surgery, radiology, urology, gynaecology, rehabilitation and cancer services, demonstrating the Trust's multidisciplinary commitment to improving cancer outcomes. In addition to raising funds for Rosemere Cancer Centre, the event also showcased partnerships with the eight football club community organisations across Lancashire and South Cumbria, which provide locally accessible support programmes focused on exercise, nutrition and wellbeing. [You can read about the ride here](#), and on the [BBC website here](#).

- **Photobiomodulation Therapy introduced for head and neck cancer patients**



Rosemere Cancer Centre has begun offering photobiomodulation (PBM) therapy to all head and neck cancer patients following the charitable funding of a new PBM unit by Rosemere Cancer Foundation.

The £18,145 investment has enabled the Trust to become only the second centre in the North West, after The Christie, to provide the treatment in line with NICE recommendations.

PBM therapy uses low-level LED light delivered through a handheld "showerhead" device to prevent and treat oral mucositis, a common and often debilitating side effect of chemoradiotherapy. Oral mucositis can affect almost all patients receiving combined chemotherapy and radiotherapy for head and neck cancers, causing painful ulcers, inflammation, swallowing difficulties and, in some cases, interruptions to treatment.



The new technology offers a safe, non-invasive treatment with no known contraindications or side effects. Treatment takes approximately five minutes and, following initial training, patients can administer the therapy independently while attending appointments. The service is expected to benefit around 664 patients each year.

The project highlights the impact of charitable funding in bringing innovative treatments to patients and supporting our commitment to improving cancer care outcomes and patient experience. [Read more on the Rosemere website](#). Or on [Blog Preston](#) or the [Lancashire Telegraph](#).



- **Personal Health Record pilot supporting cancer patients**



Alongside this, a new digital Personal Health Record (PHR) platform, Patients Know Best (PKB), is being piloted at Rosemere Cancer Centre following a £64,470 investment from Rosemere Cancer Foundation. Integrated within the NHS App, the platform is designed to give cancer patients greater control over their care by providing secure, 24/7 access to diagnoses, test results, radiology reports, care plans and personalised support resources. The system enables patients to communicate directly with their Clinical Nurse Specialist and wider care team, including reporting treatment side effects, seeking advice and sharing photographs where appropriate. Patients can also choose to provide carers and family members with access to their records, helping to support shared decision-making and engagement with care.

The pilot aims to demonstrate benefits for both patients and healthcare teams by improving patient experience, increasing self-management and creating operational efficiencies. Potential benefits include reducing reliance on paper correspondence and streamlining communication processes. With approximately 300 new cancer diagnoses each month at the Trust, generating up to 28,800 follow-up appointments annually, the initiative has the potential to support more personalised and efficient care delivery.

Evaluation findings will inform decisions on future adoption across the wider region. [More details are available on Rosemere's website](#) - and in the [Lancashire Post](#).



- **Elective Surgical Hub Achieves National Reaccreditation**



National recognition was also secured for the Elective Surgical Hub at Chorley and South Ribble Hospital, which became one of the first services in England to achieve GIRFT reaccreditation. Having been the first Surgical Hub nationally to receive accreditation when the scheme was introduced, the Trust is now one of only four elective hubs in the country to secure reaccreditation, reflecting sustained excellence in the delivery of planned surgical care.

The reaccreditation followed a national review and site visit in June 2026, with assessors commending the hub's high-quality patient care, strong leadership, collaborative culture and commitment to continuous improvement. The review highlighted several areas of strength, including a highly engaged workforce, investment in elective capacity, strong theatre utilisation and significant improvements in day-case surgery rates, which increased from 77.1% to 83.1%.

Particular recognition was given to our elective paediatric surgery programme and the close partnership working between teams at Chorley and South Ribble Hospital and Royal Preston Hospital. Assessors also

praised the hub's clinical governance arrangements, workforce development programmes and established robotic surgery services across colorectal, upper GI, urology and gynaecology specialties.

While celebrating the achievement, the review identified opportunities for further improvement in pre-operative assessment, patient communications and theatre productivity. A Hub Optimisation Plan will now be developed to support the next phase of service enhancement and continued improvements in patient access, outcomes and elective recovery performance. [Read more on our website.](#)

- **Fifty years of service celebrated**



In July, Julie Riley, a Staff Nurse on Brindle Ward, celebrated a remarkable 50 years of service in the NHS. Julie began her healthcare career in 1976 as an auxiliary nurse at Heath Charnock Hospital, later working across Eaves Lane Hospital, Chorley and South Ribble Hospital, and several inpatient wards as services evolved. Her career took a remarkable turn when, in her early fifties, she was encouraged by her ward manager to undertake nurse training. Despite initial reservations about returning to education, Julie secured one of only six available training places and successfully qualified as a registered nurse.



Demonstrating exceptional commitment to lifelong learning, Julie went on to complete a nursing degree, becoming the first member of her family to attend university. She remains a strong advocate for continual development, reflecting that "you never stop learning." Over five decades, Julie has witnessed significant changes in healthcare delivery, technology and working practices. However, she believes the core value of compassion has remained constant throughout her career. [Read](#)

- **Theatres stalwart retires after more than 30 years of service**



A familiar face in Theatres has retired after more than 30 years of dedicated service. Medical Devices Support Worker, Mick Lowe, has spent 31 years at the Trust, following earlier service at Whittingham Hospital, where both his parents worked.

Mick joined Royal Preston Hospital when Whittingham closed, initially working as a porter supporting patient movement and theatre operations. He later managed Stores for around eight years before moving into a teaching role focused on health and safety and moving and handling. Over the years, Mick became a respected figure across theatres, delivering training in moving and handling, fire safety, medical gases, laser safety and general health and safety. His practical approach and wealth of experience helped generations of staff develop the skills and confidence needed to work safely. [Full story is on our website. It also appeared in the Lancashire Telegraph.](#)



- **Dr Riggs wins BBC Radio Lancashire's 'Make a Difference' award**



We are celebrating after therapy dog Dr Riggs won the Animal Award at the BBC Radio Lancashire Make a Difference Awards 2026, recognising the positive impact he and owner Linzi Bannister have on patients, visitors and staff at Chorley and South Ribble Hospital. Dr Riggs, a Sussex Spaniel and Pets as Therapy volunteer, was shortlisted from more than 1,000 nominations before going on to win the award. Nominated by our Volunteers Manager, Sarah Allen, the pair were recognised for their weekly visits to wards and departments including Leyland Ward, the Breast Care Unit and Rookwood A, where they provide comfort, companionship and emotional support to patients.

Linzi and Dr Riggs began volunteering following Linzi's own experience of receiving cancer treatment at the hospital. Since joining our volunteer team, they have become a valued presence, helping to reduce anxiety, lift spirits and support patient wellbeing. Their visits are particularly beneficial for patients awaiting appointments, those experiencing difficult news or those missing loved ones and pets while in hospital.

The award highlights the important contribution volunteers make to patient experience and wellbeing across the Trust. It also demonstrates the value of innovative, compassionate approaches that complement clinical care. Congratulations to Linzi and Dr Riggs on this well-deserved recognition and for the difference they continue to make for patients, colleagues and visitors every week. [Linzi and Dr Riggs' story is on our Trust website.](#)

1. RECOMMENDATIONS

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

8. * BOARD ASSURANCE FRAMEWORK

● Decision Item

● H Ugradar

● 9.55 am

REFERENCES

Only PDFs are attached



8.0 Board Assurance Framework Risk Summary Board Pt I October 2026.pdf



Board of Directors Report

Meeting of the	Board of Directors		1 October 2026	
	Part I	☒	Part II	☐
Title of Report	Board Assurance Framework (BAF) Report			
Report Author	Hajara Ugradar, Associate Director of Risk, Assurance and Corporate Affairs Emma Denfhy, Deputy Associate Director of Risk and Assurance			
Lead Executive Director	Executive Directors			
Recommendation / Actions required	The Board of Directors is asked to: Note and approve the updates to the BAF.			
	Decision	☒	Assurance	☐
			Information	☐
Executive Summary	This paper provides the Board of Directors with an update on the Board Assurance Framework (BAF) and the Principal Risks aligned to the 2026/27 Corporate Objectives. Principal Risks There are currently 13 Principal Risks within the BAF. Since the previous Board report, no Principal Risk scores have increased and all scores remain unchanged following ongoing Executive review and scrutiny through the relevant Committees of the Board. Full details of the Principal Risks are set out in Appendix 1. Although the risk score trajectories indicate that PR3 (Timely access to planned care), PR4 (Timely access to cancer care), PR6 (Timely access to diagnostic investigations) and PR13 (Delivery of the planned reduction in whole time equivalent workforce) had been expected to reduce at this stage of the year, the current scores have been maintained. This reflects previous Board discussion that risk scores should reflect the broader underlying risk position and be supported by evidence of sustained improvement over at least two quarters, rather than short-term improvement against individual indicators. Supporting performance reports demonstrate positive progress in a number of areas, including reductions in long waits for planned care and improvements in cancer and diagnostic performance trajectories. Some supporting indicators are subject to reporting and validation timeframes, meaning that the latest operational position may not yet be fully reflected in validated performance data. Further evidence of sustained improvement is therefore required before a reduction in these risk scores would be supported. PR9 (Failure to effectively manage staff absence and achieve Trust and National target rates) remains at a score of 12. The risk trajectory had anticipated a reduction in score by September 2026, with a target control date at the end of			

	September. Following the discontinuation of the Empactis pilot, the anticipated reduction has not been achieved. The risk trajectory and target control date will therefore be reviewed through the next People and Partnerships Committee cycle, taking account of the timescales required to approve, implement and embed a replacement digital absence management system. Following discussion at the Board of Directors in June 2026, further review has also been undertaken of PR1 (Patient safety and experience within the urgent and emergency care pathway). The title of the risk has been revised to include reference to eliminating corridor care, ensuring that the Principal Risk remains aligned to the Trust's operational improvement priorities and the focus of the transformation programme. Actions associated with PR1 have also been aligned to the Trust's Urgent and Emergency Care and Frailty Transformation Plan, strengthening the link between the Principal Risk, agreed transformation milestones and associated mitigating actions. The complementary Principal Risk relating to patient access, flow and performance continues to be managed separately through PR5 (Timely access to urgent and emergency care), with oversight through the Finance and Performance Committee. Review of Corporate Objectives and Principal Risks During October and November 2026, the 2026/27 Corporate Objectives will be reviewed through the relevant Committees of the Board alongside the Principal Risks aligned to each strategic objective. This will enable Committees to consider progress against delivery of the Corporate Objectives alongside the risks that may impact their achievement and provide scrutiny and challenge on whether the current Principal Risk profile remains appropriate. This will also include the review of partnership-related risks, following discussion at the Board of Directors in August 2026. A further update, including any recommended changes to the Principal Risk profile, will be provided to the Board at the next meeting. Strengthening alignment with the SIP There is also a plan to further strengthen the alignment between the BAF and delivery through the Single Improvement Plan (SIP). The proposed approach is to establish a clearer link between SIP delivery plans and Principal Risks, providing greater visibility of progress against key transformation and improvement programmes and how these contribute to the management and reduction of strategic risk. Operational Risks Whilst there are currently no operational high risks escalated to the Board through the BAF, the Safety and Quality Committee has reviewed an operational risk relating to ongoing disruption within pathology services; this remains subject to active management through established governance arrangements	
Link to Strategic Objectives 2026/2027	Patients – deliver excellent care: Improve outcomes, reduce harm and deliver a positive patient experience.	☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.	☒
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.	☒

	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.		☒
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.		☒
Committee Approval:	Committees of the Board	Date: August and September 2026	
Operational Group Review:	Board Workshop	Date: 3 rd March 2026	
Link to Board Assurance Framework:	All Principal Risks within the BAF		
Appendices	Appendix 1: Board Assurance Framework – 2026/27		

9.1 INTEGRATED PERFORMANCE REPORT AS AT AUGUST 2026 INCLUDING FINANCE UPDATE AND SINGLE IMPROVEMENT PLAN

● Other

👤 K Foster-Greenwood/S Morrison/N Pease/C Carter

🕒 10.10am

Item for assurance

REFERENCES

Only PDFs are attached

📄 9.1 IPR inc Finance and SIP Full Report Board Pt I October 2026.pdf



Board of Directors Report

Meeting of the	Board of Directors	1st October 2026	
	Part I ☒	Part II ☐	
Title of Report	Integrated Performance Report		
Report Author	Executive Directors		
Lead Executive Director	Katie Foster-Greenwood Chief Operating Officer		
Recommendation/ Actions required	The Board of Directors is asked to receive the integrated performance report, note the monitoring of the Single Improvement Plan delivery milestones is undertaken through the Finance and Performance committee and confirm it is assured of the Single Improvement Plan outcome metrics.		
	Decision ☐	Assurance ☒	Information ☐
Executive Summary	The purpose of the report is to present the Integrated Performance report to the Board of Directors with the position up to August 2026, unless date otherwise stated. The report provides the Single Improvement Plan, high level metrics, of which the outcomes have been scrutinised by each relevant committees of the Board. The outcome metrics are presented with a supporting summary, assurances provided and actions being taken to address the position where improvement is identified. The delivery milestones of the single Improvement plan are monitored through the Finance and Performance committee. The reporting around this continues to be refined with a plan to include milestone assurances in future IPR reporting. At the start of each priority section, a 3 A (Alert Advise and Assure) template is provided to guide the Board to areas of Alert Advise or Assure in line with the reporting approach adopted by the committees of the Board. The Chief Operating Officer will present the IPR with Executive Director presentation for each of the priorities.		
Link to Strategic Objectives 2025/26	Patients – deliver excellent care: Improve outcomes, reduce harm and deliver a positive patient experience.	☒	
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.	☒	

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

Integrated Performance Report

October 2026 Trust Board meeting with performance to August 2026



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SECTION

Key to KPI Variation and Assurance icons

How to read Statistical Process Control charts (SPC)

SPC KPI Metric Grid

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SIP delivery position

Appendix 1 – Assurance Reports

Key to Metric Variation, Assurance Icons & Dashboard Headers

Key to Metric Variance and Assurance Icons

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

Key to Metric SPC Chart and Variance and Assurance Icons

Mean
 Process Limit
 Improving special cause

Measure
 Concerning special cause
 Target

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

It's possible the target could be either passed or failed within the expected month to month variation of the measure

The target will be consistently failed within expected variation unless the process is changed

The target will be consistently passed within expected variation unless the process is changed

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

No signs of change over time evident in recent data

An example of concerning change is evident in the recent data

An example of positive change is evident in the recent data

Report heading explanation

The Assurance Icon indicates whether the metric is failing or passing the target, or is inconsistently passing and

A flag is generated for metrics that are calculated as requiring

The latest month target or threshold.

Data to the end of.

Metric Description	Assurance @ Mar-25	Variation to Latest Actual	Target				
			Concern	Mar-25	Latest Month Target	Latest Month Actual	Latest Month
Example Measure				100.00%	98.00%	95.00%	Jul-24

The name of the Metric

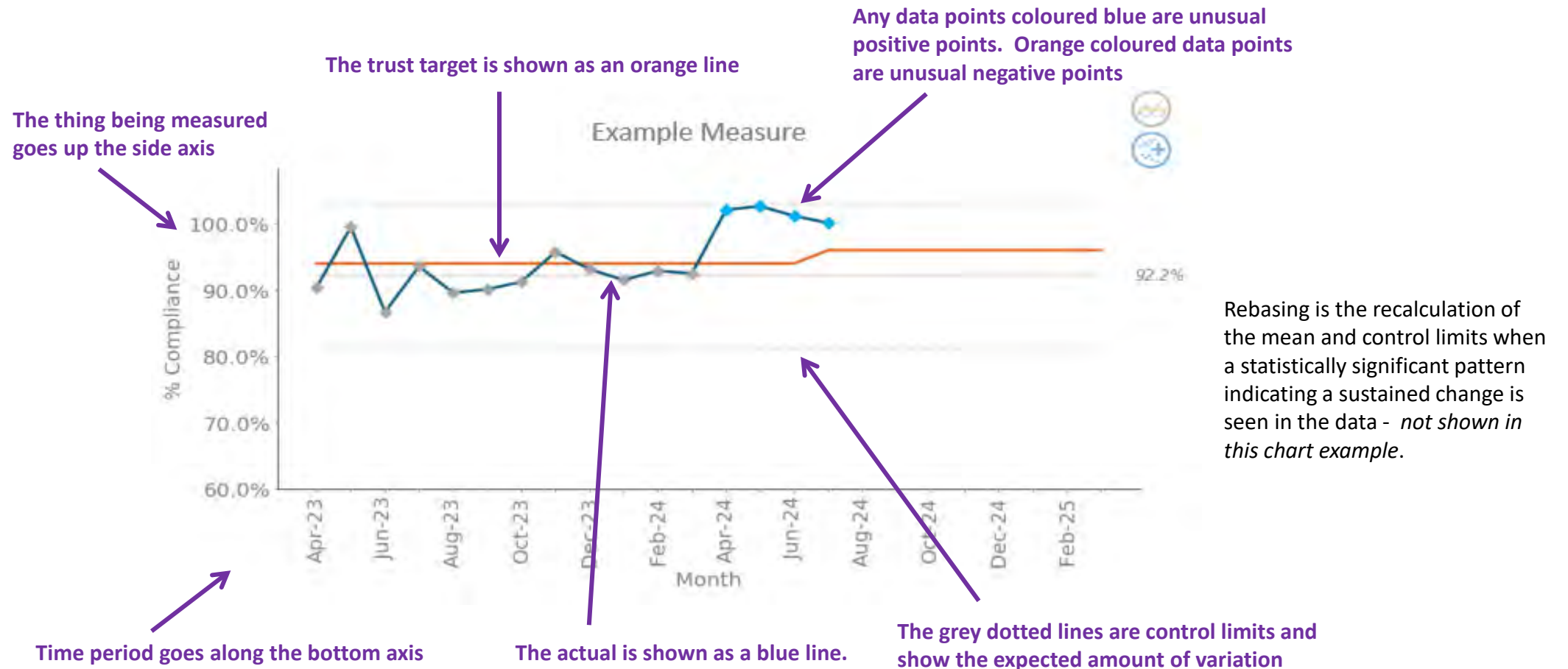
This shows whether there is a special or common cause variation of the metrics.

This March 2025 target

The current month actual performance.

How to read Statistical Process Control charts (SPC)

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





SPC KPI Metric Grid



Assurance Variation	Will consistently fail target within expected variation	Could both pass or fail target within expected variation	Will consistently pass target within expected variation
 Recent concerning pattern in the data	- Staff Survey: Recommend Trust as place to work		- Staffing Fill Rate - Registered Nurse - Staffing Fill Rate - Health Care Assistant
 Normal variation - no recent change	- Compliance with 15 minute ambulance turnaround time target - Compliance with 45 minute ambulance turnaround time target - Percentage of UEC (Type 1 & 3) patients seen within 4 hours - Average Number of boarded patients - Reduce not meeting criteria to reside - Staffing Fill Rate - Maternity Support Worker	- Staffing Fill Rate - Registered Midwife - Complaints per 1000 bed days - Perinatal - Number of Stillbirths - C. difficile performance against national trajectory Hospital Acquired cases (COHA & HOHA) - Bed occupancy % - 85% theatre utilisation - aggregate - Capped - Cancer Faster Diagnosis Performance - 31 Day Cancer Standard - Merged - Number of violence and aggression incidents toward staff	- STAR Accreditation all trust (Silver and Above)
 Recent positive pattern in the data	- Percentage of patients waiting less than 18 weeks - RTT - 52 week Waiters - Percentage of patients that receive a diagnostic test within six weeks - Cancer 62-day performance - Merged - Vacancies (% FTE) - Sickness Absence (%FTE)	- Pressure Ulcers per 1000 beds days (Category 2 and above) actions - Maximum wait of 12 hours as Total Time in Department - Turnover (%FTE)	

Non SPC Metrics flagged as a concern

Non SPC Metrics

Hospital Standardised Mortality Ratio	Lower Than Expected
Standardised Mortality Rate (All Diag	Lower Than Expected
Standardised Mortality Rate (Child <1	As Expected
Standardised Mortality Rate (Neonate	As Expected

Patients



Patients



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	Issue	Action
Alert Areas of concern or matters that need addressing urgently	1.a) Corridor Care remains high with 542 patients affected this in month in the Emergency Department. The improvement in 12 hour waits positively impacts the number of patients expereincing corridor care and a plan to eliminate by 31 March 2026 is in place. 1.b) Boarded Patients The average number of patients boarded patients per day has remained broadly unchanged with 27 patients per day affected by this.	1. Urgent & Emergency Care (UEC) pathway productivity: Continued focus on admission avoidance, length-of-stay reduction and improving frailty pathways. 2. Strengthened governance and oversight arrangements remain in place, including executive-led workstreams, weekly performance reporting and monitoring through the strategic oversight group and UEC improvement Board. 3. System-wide collaboration through the single improvement plan and Place-based UEC delivery structures continues to support coordinated action and address capacity constraints across the pathway. 4. The introduction of Extended Emergency Medicine Ambulatory Care (EEMAC) in July has successfully reduced patient numbers in corridors and waiting areas, supporting improved flow and patient experience. 5. The Medical Decisions Unit (MDU) opened in August 2026 to improve pathways of care. 6. A review of patient pathways across acute services is being undertaken to reduce duplication, streamline processes and support the delivery of more effective and efficient patient pathways. 7. System Single point of access event held 24.9.26 with the intention of improving accessiblity and avoiding hospital admissions. 8. Frailty ED, Community and Adult Social care huddles including post discharge frailty follow up and admission avoidance improvement programmes are currently demonstrating sustained week on week improvements in the length of time in ED for over 65 years.
Advise Areas of ongoing monitoring and any new developments	1.Maternity Support Worker/ Maternity Care Assistant fill rates - The overall maternity support worker fill rate is below the Trust target of 95% at 89.3%.	1. A successful recruitment campaign has concluded with new Maternity Support Workers (MSW) progressing through the Care Certificate and supernumerary period. Seven staff joined the numbers in January, with further starters scheduled through to May. This pipeline strengthens the establishment and will improve fill rates as onboarding completes. 2. Sickness continues to impact availability and is being managed in line with policy. 3. Recruitment and onboarding have taken longer than expected following changes within the recruitment team, and temporary bank staffing continues to be used to maintain safe staffing levels, a focus on decreasing reliance on temporary staff has commenced with recruitment team. 4. Shifts where increased risk is present are prioritised for the staffing that are available.
	2. Complaints - These remain within normal variation, however there has been a recent pattern of elocated activity for three data points, the most recent month demonstrates a return closer to the mean. Complaints continue to be predominantly driven by communication failures, delays in care and discharge processes. Patients consistently report frustration when expectations are not managed, information is inconsistent, or updates are not provided. Operational pressures, particularly waiting times, discharge complexity, corridor care and environmental challenges, remain significant contributors to dissatisfaction. Accessibility, cultural responsiveness and equitable communication also remain important themes for improvement.	1. Continue to deliver the actions outlined in the Single Improvement Plan. 2. Increase access to information regarding experience from patients with protected characteristics. 3. Development and delivery of preparing to be in hospital and preparing to go home to help manage expectations and work with families to be prepared to be cared for at home as soon as possible. 4. Continued focus on early resolution with departments and PALS. 5. Focus on use of PALS as early indictors to address concerns in areas and identify themes. 6. Estates and clinical partnership Board focused on improving the estate impact of experience. 7. Invited review from a patient experience specialist to support the development of a strengthened patient experience programme, draft report now received and will be shared in Safety and Quality committee in October 26 and reported to Board December 2026.
	3. Pressure Ulcers per 1000 bed days (Category 2 and above) - performance has remained above target since March 2025 until the last 3 months data points where there has been a significant improvement below the mean and below target. As this metric this has been an alert to Safety and Quality Committee in previous months this has now moved to advise until there is evidence that the improvement has been sustained.	1. Continued weekly harm review panel to focus on learning and improvements chaired by Deputy Chief Nursing Officer. 2. Ten-point improvement plan is in place and is being actively overseen for improvements. 3. Proactive Reduction of pressure ulcer rounds carried out by Tissue Viability Nurses are identifying early actions to take preventative actions whilst teaching and training colleagues in real time. 4. Equipment audit has been completed and minimum stock levels identified for each clinical area. Assurance of this is being monitored via Matrons daily checks and the plan is to become embedded within STAR assurance. 5. Divisional governance arrangements for review and validation of pressure ulcers have been reviewed and implemented 6. Refocus on fundamentals of care in ward and departments to reinforce good practice 7. All Matrons have received a letter to outline standards, expectations and to set their objective to reduce pressure ulcers 8. Pressure Ulcer Prevention training added to critical standards for STAR accreditation from October.
	4. Compliance with National Standards of Cleanliness - compliance with mandated cleaning frequencies remains at 90.6% for very high risk areas and at 68.65% compliance for high risk areas. Point of care inspection audits remain above target.	1.Recruitment to remaining 13.91WTE domestics is essential to be compliant with the national standards of cleanliness. This is a risk for delivery as recruitment is taking longer than turnover of staff in post. This continues to be escalated and tracked. 2.Following full service capacity appraisal, the service will step down NSoC across FR3, with resource redirected to FR1 and FR2 areas only. 3.The joint audit process is robust and focussing on the specific areas that need attention. 4.Positive working arrangements between clinical, estates and facilities staff are collaboratively overseeing this risk via partnership board.
	1. . Registered Nurse, Registered Midwife and Health Care Assistant fill rates - are achieving safe staffing levels.	1. Staffing levels consistently meet thresholds, supporting effective care delivery.
	2. STAR accreditation for all Trust.	1. Remains above target across the Trust, reflecting stabilisation following the introduction of critical standards. Continued focus on inpatient area and fundamental standards is critical in ensuring high quality outcomes are achieved for patients.
	3. Mortality - April data (Data is always a quater behind) Adult HSMR - Lower than expected, Adult SMR Adult - As expected SMR Child <1 day to 17 years - As expected SMR - Neonatal <1-28 days - As expected Still Birth rate - The 12-month local average mean still birth rate is 2.1 per 1000 (May 2025 to April 2026 excluding TOPFA) remains below the national average of 3.9 per 1000 births. 4. C.difficile rates - New tolerance for 2026/2027 has been agreed at 109 cases. Currently within trajectory.	1. Mortality actions continue as outlined in the biannual mortality plan. 1. The IPC Board Assurance Framework actions continue alongside the Infection Prevention and Control (IPC) improvement plan continue, the implementation of the cleaning standards is now in line with plan and appears to be underpinning improved performance.



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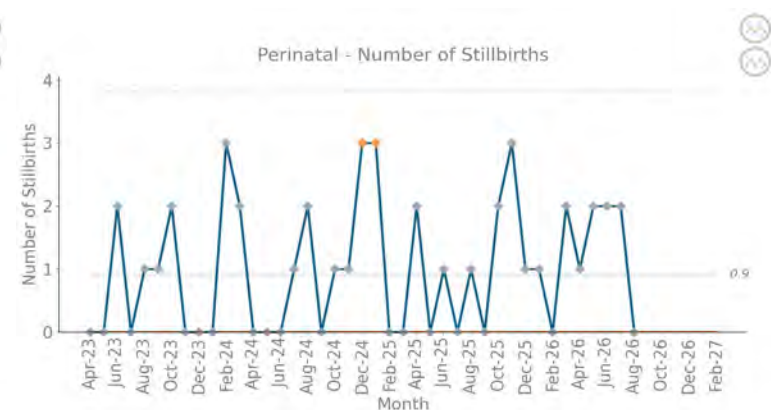
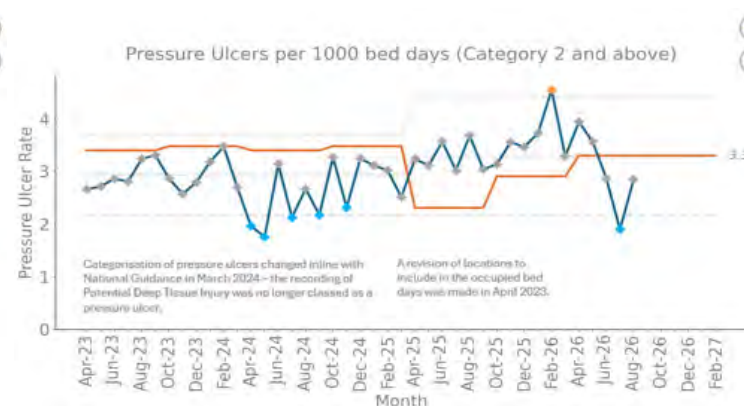
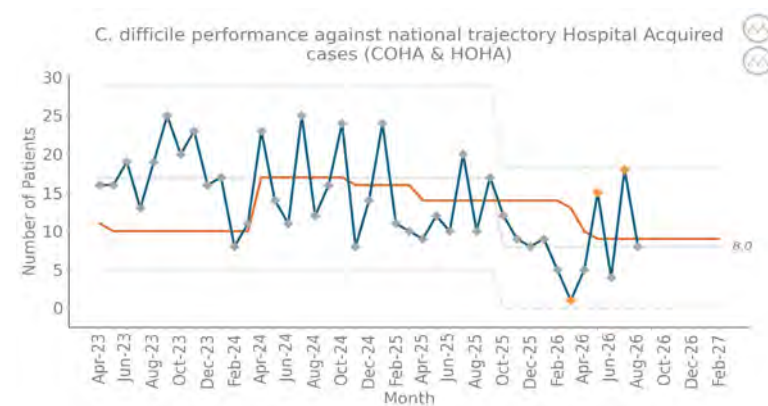
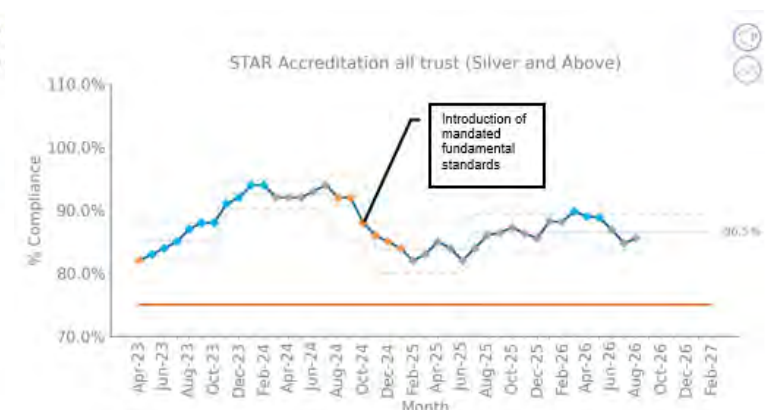
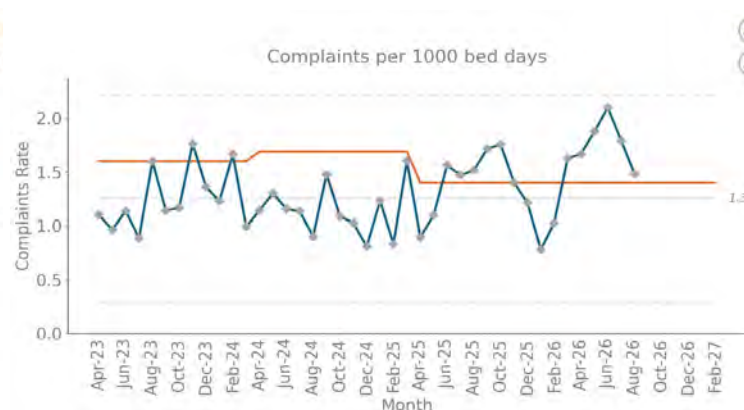
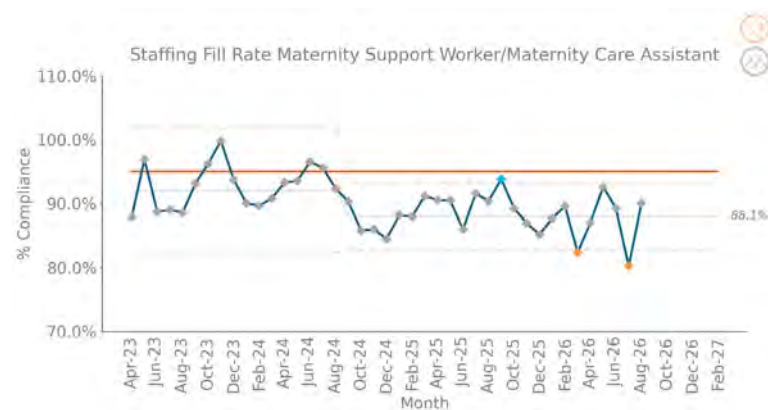
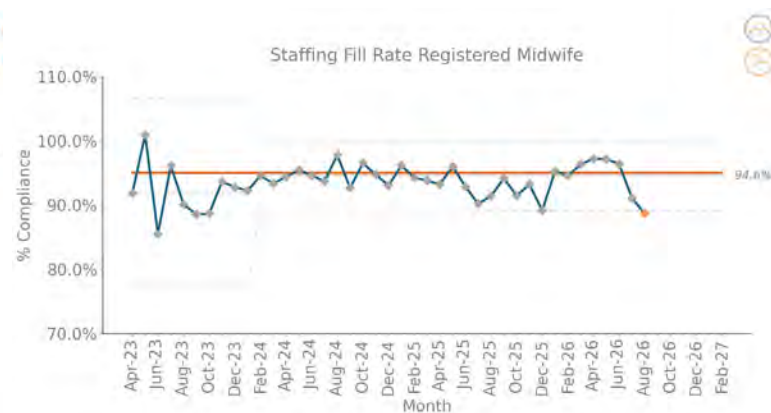
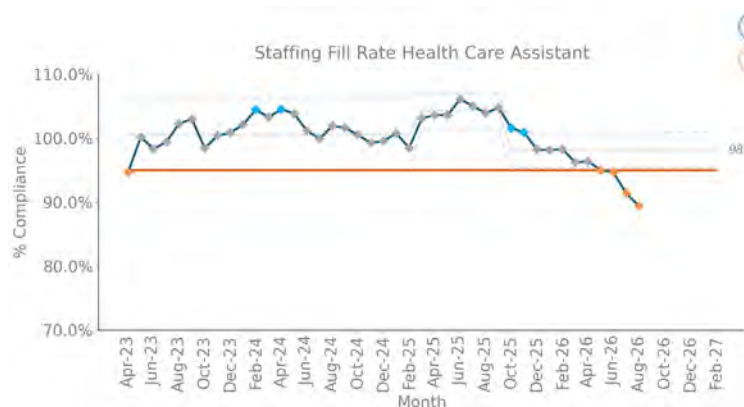
Patients

Metric Description		Assurance @ Mar-27	Variation to Latest Actual	Target			Latest Month Actual	Latest Month
				Concern	Mar-27	Latest Month Target		
Deliver Annual Safe Staffing Requirements	Staffing Fill Rate - Registered Nurse				95%	95%	94.41%	Aug-26
	Staffing Fill Rate - Health Care Assistant				95%	95%	89.46%	Aug-26
	Staffing Fill Rate - Registered Midwife				95%	95%	88.67%	Aug-26
	Staffing Fill Rate Maternity Support Worker/Maternity Care Assistant				95%	95%	90.04%	Aug-26
Patient Experience and Involvement	Complaints per 1000 bed days				1.40	1.40	1.48	Aug-26
	STAR Accreditation all trust (Silver and Above)				75.0%	75.0%	85.6%	Aug-26
C Difficile Improvement	C. difficile performance against national trajectory Hospital Acquired cases (COHA & HOHA)				9	9	8	Aug-26
Always Safety First	Hospital Standardised Mortality Ratio - Adult	Lower Than Expected					75.0	Apr-26
	Standardised Mortality Ratio - Relative Risk - All Diagnoses Adult	As Expected					88.4	Apr-26
	Standardised Mortality Ratio - Relative Risk - All Diagnoses Child (<1 day – 17 yrs)	As Expected					174.6	Apr-26
	Standardised Mortality Ratio - Relative Risk - All Diagnoses Neonates (<1-28 Days) <i>The updated TELSTRA model from November 2024 does not include still births</i>	As Expected					123.2	Apr-26
	Pressure Ulcers per 1000 bed days (Category 2 and above)				3.30	3.30	2.85	Aug-26
Maternity	Perinatal - Number of Stillbirths				0	0	0	Aug-26



Patients

Patients



Performance



Patients



Performance



People



Productivity



Partnerships



Performance



Alert, Advise, Assure Report

Category	Performance Driver	High Impact Actions	Performance Recovery
ALERT ⚠ Areas requiring urgent attention	• RTT 18 week performance - * Due to a National extension to the August 26 validation of performance the performance remains unvalidated. July 26 performance at 58.88% was a 0.16% improvement compared to June 26. However performance remains under the Operational Performance target. The number of follow ups >25% overdue has increased month on month since Oct 24. Capacity constraints are driving these increases however there is an opportunity to significantly demand manage via PIFU despite being close to rates. • Boarding & Days Kept Away from Home - DKAFH (%) has decreased by 0.4% in August 26.The position remains significantly above the operational plan target and is higher than August 25. Whilst the levels are within normal variation the data suggests a consistently failing target despite data to evidence the success of the strengths based work reducing demand. The numbers of patients cared for in boarder beds decreased in August 26 and escalation bed occupancy has significantly reduced since June.	• RTT - Additional capacity internal and external is being mobilised.A Super September initiative has commenced and early indications show increased booked activity. The Cardiology AI PIFU pilot is in development with clinical protocol testing underway with further scoping in Max Fax and Dermatology. • Boarding/DKAFH - Board and Ward round improvement work continues to progress and run alongside the EEMAC and MDU model of care improvements.	• RTT: An RTT forecasting methodology is being developed in conjunction with GIRFT. High level assessments project a return to operational standard performance for 18 weeks by the end of Q3. • UEC/Boarding: The anticipated 4 hour performance benefit of MDU is forecast to be between 1.2-1.4%. The anticipated 4 hour performance benefit of Frailty SDEC is forecast to be ~1.2%. Modelling of the impact on ED overcrowding and boarding will be reviewed at the end of Q2.
ADVISE 📅 Areas of ongoing monitoring	• UEC 4 Hour performance - The LTH operational performance target for August 26 re 4 hour performance was not achieved. Performance showed a decrease of -1.3% in August compared to July 26. August 26 performance decreased by 8 national ranking places. • UEC 12 hour + ED LOS - Aug 26 performance decreased slightly compared with July 26 at 11.29% and is below the Operational Improvement plan target of 11.7% for the fourth consecutive month. •Virtual Ward - occupancy remains below target and remains consistent with July performance (60.4% occupancy). •Cancer Performance (July) - 31 day performance is below target by 0.7%, this is being driver by high volumes of Dermatology referrals and delays within the pathology part of the pathway.	• UEC - Key actions being taken to improve the UEC model of care with a further embedding of EEMAC and MDU pathways. Further plans are in development to support NWAS direct pathways to EEMAC/MDU from early Oct 26. •VW - Medical posts have been recruited into the service to support an expanded utilisation - pre employment checks are underway. A review of wider VW staffing is underway to scope an increase in out of hospital capacity. •Cancer Performance - Key actions relating to the mobilisation of increased treatment and diagnostic capacity in July and August for Skin is being mobilised.	• UEC 12 Hour : The Trust is on trajectory to meet the operational performance targets. • Cancer: Performance forecasting suggests 62 Day cancer performance will meet operational standards by Nov 26, with 31 day performance achieving standard from July 26 onwards.
ASSURE ✓ Areas of positive assurance	• RTT Waiting List Reduction & 52 week performance - * Due to a National extension to the August 26 validation of performance, the performance remains unvalidated. The final position for July 26 shows that waiting list size is ahead of target. Finalised performance for August is not yet available due to an extended national deadline however the latest position re 52 week+ waits shows 365 patients on the waiting lists (ahead of target). Waiting list size in August is presently higher than July 26 however remains ahead of the operational target with further validation pending. • DM01 - Performance improved further in July 26 to 73.35% and is above the operations plan target of 70.2%. Significant improvement in over 6 week waiters in NOUS and Echo. July 26 performance is the highest performance noted at LTH for the past 4 years. • Cancer Performance (July) - FDS 62 day performance shows a further improved position (+1.3% versus June 26), and is only 0.1% under the July Trust operational performance plan. Trust performance is ranked 41st out of 117 providers for 62 day.		



Performance

Performance

Metric Description		Assurance @ Mar-27	Variation to Latest Actual	Target			Latest Month Actual	Latest Month
				Concern	Mar-27	Latest Month Target		
UEC In Flow	Compliance with 15 minute ambulance turnaround time target				66.30%	65.50%	28.86%	Aug-26
	Compliance with 45 minute ambulance turnaround time target				95.00%	91.20%	85.70%	Aug-26
	Percentage of UEC (Type 1 & 3) patients seen within 4 hours				82.00%	74.80%	72.56%	Aug-26
	Maximum wait of 12 hours as Total Time in Department (Type 1 and 2)				10.50%	11.65%	11.29%	Aug-26
UEC Flow	Bed occupancy %				94.00%	94.00%	93.77%	Aug-26
	Average Number of boarded patients				0	0	27	Aug-26
UEC Outflow	Reduce not meeting criteria to reside				5.00%	8.30%	11.49%	Aug-26
Elective (long waits)	Percentage of patients waiting less than 18 weeks				70.00%	63.20%	58.88%	Jul-26
	RTT - 52 week Waiters				0	1091	362	Jul-26
Elective (diagnostics)	Percentage of patients that receive a diagnostic test within six weeks				80.00%	70.20%	73.35%	Jul-26
Elective (theatre utilisation)	85% theatre utilisation - aggregate - Capped				85.00%	85.00%	83.71%	Aug-26
Elective (Cancer)	Cancer 62-day performance - Merged				80.30%	74.60%	75.00%	Jul-26
	Cancer Faster Diagnosis Performance				80.00%	80.00%	82.90%	Jul-26
	31 Day Cancer Standard - Merged				94.00%	94.10%	89.40%	Jul-26

Performance



People



Patients



Performance



People



Productivity



Partnerships

Alert, Advise, Assure Report: People

	Issue	Action
Alert Areas of concern or matters that need addressing urgently	Staff Engagement - Quarter 2 data set for the question "I would recommend my organisation as a place to work" has marginally increased since Q1 from 41% in Q1 to 43.7% in Q2. This remains below the target score of 60%. Whilst there is a marginal improvement, year on year trends typically see Q2 having slightly higher levels of engagement, this tends to correlate with moving out of winter and different patient pressures. We have in this quater seen a 2% increase in the item "I am enthusiastic about my job" and a similar 2% increase in "I look forward to going to work" when compared with Q1. Sickness - sickness absence remained high in M5. Although there was a small improvement in the long-term absence rate (4.43% compared to 4.62% in M4), this was offset by an increase in the short-term absence rate (1.88% compared to 1.75% in M4).	Staff Engagement - further implement and embed Staff Engagement Proposal and demonstrate / communicate visible action taken in response to colleague voice. To rescope the metrics used in Divisional Improvement Forums and accountability oversight frameworks to also include the item "Patient care is my organisations top priority", this would better align with the strategic programme of work we are taking around improving patient experience and real time reporting. Sickness - The business case for a Digital Sickness Absence system has been developed and is in the review and approval process. This is essential to provide full organisational oversight of sickness absence management, with the additional benefit of it being a tool to push out wellbeing advice and information to colleagues. The scale of the sickness absence caseload means that it is impractical to monitor policy compliance and maintain grip and control around absence management without a digital solution.
Advise Areas of ongoing monitoring and any new developments	Vacancy - Following the establishment review and vacancy removal exercise, the Trust vacancy rate has reduced to 5.46%, moving within target tolerance. Violence and Aggression - The number of reported violence and aggression incidents continues to fluctuate monthly, and increased in M5 (135 incidents, compared to 99 in M4). The highest number of incidents consistently occur in Emergency Department and other areas where the nature of the patient's condition makes them more prone to violent and aggressive behaviour.	Vacancy - Health Care Support Worker (HCSW) recruitment continues to address high level of vacancy in this area with Support to Nursing staff group as a whole carrying c 300 vacancies and HCSW being 230 WTE of these. We are starting to see HCSW commencing in post in M5 with 13 WTE new starters. However this is offset by a comparable number of leavers in month for M5. Despite this reported growth is up 10 WTE on M4 levels in part to due associated internal movements. We would expect c 60-70% of the pipeline offers converting to starts. Violence and Aggression - a Rapid Improvement Workshop was held in M4 with good multi-disciplinary engagement, and this generated new test of change ideas to supplement existing improvement work. A further workshop will be held in M6, which will focus mainly on the Zero Tolerance letter process.
Assure Areas of Assurance	Appraisal - Compliance remains above the 90% target for month 5. Core Skills and Mandatory Training - remains above the 90% compliance target for each metric at Trustwide level. Turnover remains consistently low for month 5 at 0.5%, of the voluntary leavers the reasons for leaving were promotion, improved work life balance, for health reasons or retirement. Vacancy - HCSW vacancies have reduced by c 50 WTE since M2 due to focused work on recruitment.	Appraisal - actions will focus on increasing use of objectives and personal development planning in appraisal, guidance is being developed to support appraisers to tailor their conversation based at the career and lifestage of appraisees, this now needs to be emedded in training and made available via the managers hub. Actions and communications to be developed to embed a positive performance management culture, with greater emphasis on giving and receiving feedback, having regular 1-1 conversations and regular review of objectives alongside day to day management of operational issues. Core Skills and Mandatory Training - actions focus on targeted support to increase compliance by professional group Turnover - The first draft of the New Starter Hub has also been completed, informed by feedback from the July Managers Update. The next stage will be to make necessary changes to induction and probation processes to be incorporated the purpose of this is to reduce turnover in colleagues with less than 1 years service.



Partnerships

People

Patients

Productivity

Performance

People

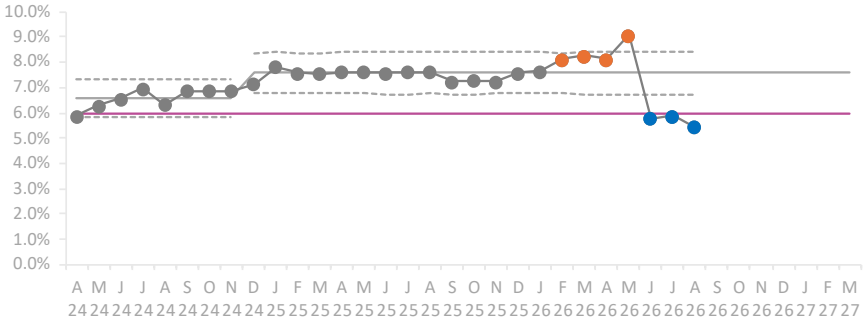
Metric Description		FY2627 Target Assurance	Latest Actual Variation	Target			Latest Actual	Latest Period
				Concern	FY2627	Latest Month Target		
People	Vacancies (% FTE) (source: General Ledger)				≤ 6%		5.46%	M05
	Turnover (% FTE) (annual assessment; ESR in-month reported)				≤ 10%		0.50%	M05
	Sickness Absence (% FTE) (annual assessment; in-month reported)				≤ 5.5%		6.29%	M05
	Number of violence and aggression incidents toward staff (annual assessment; in-month reported)				996		135	M05
	Core Skills Mandatory Training compliance (% modules) (module compliance reported)				100% of metrics at 90%		100.00%	M05
	Appraisal compliance (% HC)				≥ 90%		92.32%	M05
	Staff Survey: Recommend Trust as place to work (quarterly metric)				≥ 60%		43.70%	Q2



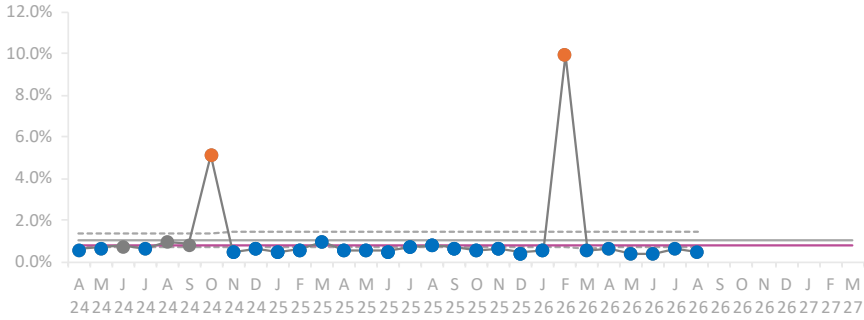
People

People

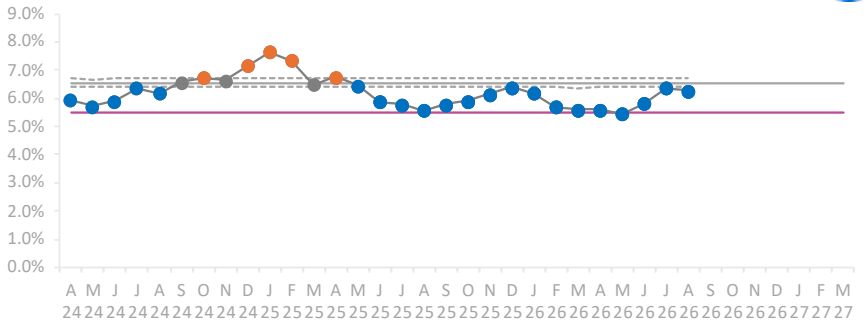
GL Vacancy Rate (% FTE)



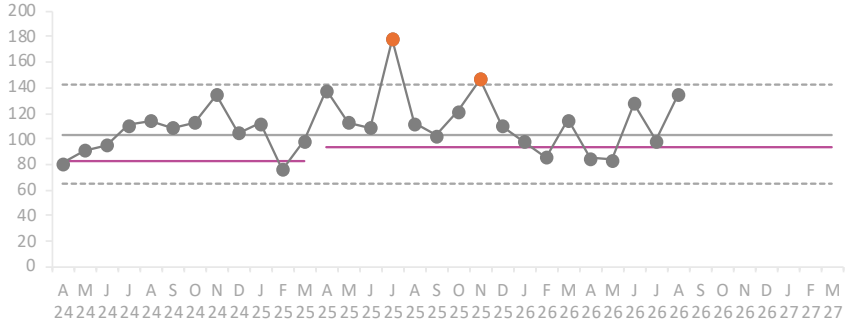
ESR Turnover (% FTE)



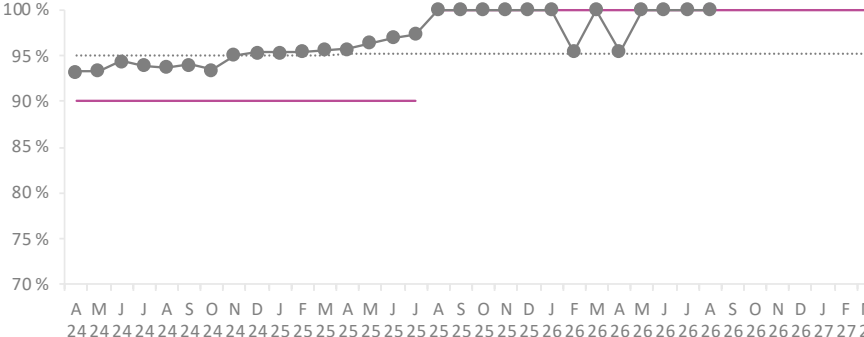
Overall Sickness (% FTE)



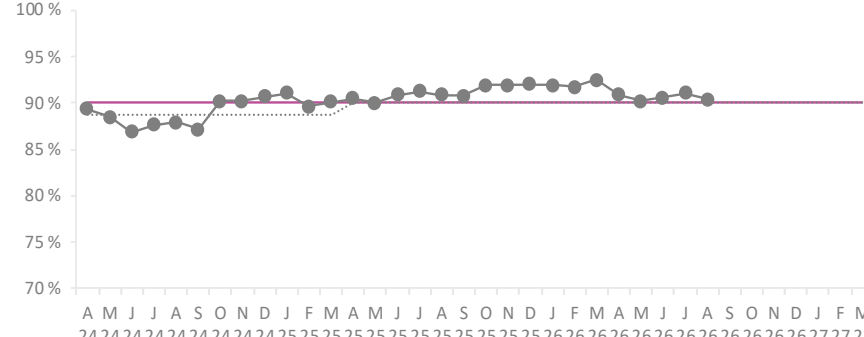
No. of Violence & Aggression Incidents Reported



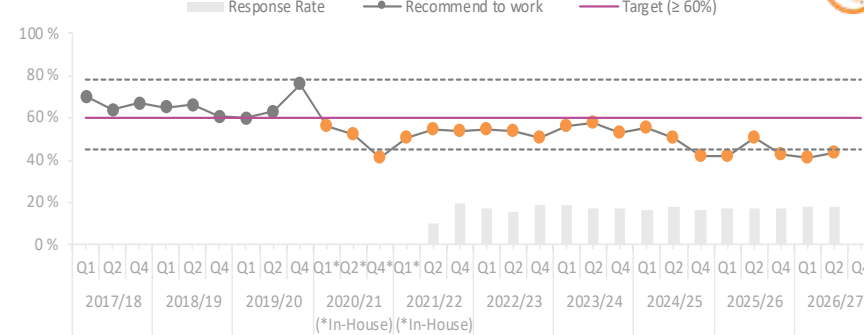
CSTF Compliance (% modules)



Appraisal Compliance (% HC)



NQPS % Recommend to Work



Productivity



Patients



Performance



People



Productivity



Partnerships

Executive Summary as at 31st August 2026			
	Issue	Action	Assurance
Alert Areas of concern or matters that need addressing urgently	Waste Reduction Programme		
	The Trust's 2026/27 waste reduction target is £60m, 5.7% of operating expenditure. Month 5 YTD WRP delivery is under-performing by £0.42m, however the NHSE Submitted Plan phasing is heavily weighted to later in the year. The in year Waste Reduction Programme has fully been identified at £60.0m with fully developed schemes to this value. Forecasting of WRP is assumed to be £60.0m best case, £41m likely case and £37m worst case. Confidence levels will continue to be reviewed at DDGs. Scheme development is continuing to ensure that any WRP plan slippage is mitigating.	The Trust has introduced a process to help mitigate the gap on WRP plan. This requests that Divisions review their recruitment pipeline to see what posts can be held to enable realignment to the expected WRP headcount reduction. The Trust has enhanced grip and control activities to mitigate slippage in schemes. For 2026/27 the Trust has implemented its Financial Sustainability Plan with areas aligned to Executive Leads, earlier planning and a focus on sustainable expenditure reduction rather than short term benefits. In September 2026 the Trust has implemented enhanced WRP assurance through the Financial Recovery Board.	Productivity board chaired by CFO External support for specific workstreams. Implementation of Financial Recovery Board, Divisional Delivery Groups and WRP Review meetings Embedding of PMO
	Cash Position		
	The Trust has been advised that Q2 DSF will be withheld by NHSE. Mitigations had been approved by the Trust Board, however the cash position was managed through working capital management which avoided the need to defer the September PDC dividend payment. Any slippage on WRP will mean revenue cash support may be required if the slippage exceeds the amounts that can be reasonably achieved through working capital management.	Application for capital cash support will be submitted to DHSC/NHSE as appropriate, after the mitigating actions have been implemented. Management of WRP to ensure where possible cash releasing efficiencies are implemented. Restriction of supplier payments in accordance with the priority list of suppliers. Utilisation of internal capital cash for revenue purposes as a short-term measure.	The cashflow forecast is updated daily and any emerging issues are escalated to the CFO. Monthly cashflow review by the CFO/ CEO
Advise Areas of ongoing monitoring and any new developments	Income and Expenditure		
	The Trust is reporting a £2.20m adverse position to plan to the end of August 2026. The Trust has a YTD £16.18m deficit against a £13.99m planned deficit (including DSF funding of £3.85m). DSF has not been received for M4 and M5 (£1.5m). Month 5 YTD WRP delivery is under-performing by £0.42m, however the NHSE Submitted Plan phasing is heavily weighted to later in the year. The forecast for 2026/27 has been developed based on non-receipt of DSF (best and likely cases include Q2-4 non-receipt, worst case includes further clawback of Q1), unmitigated Pathology industrial action costs as at month 5, further unmitigated Pathology industrial action costs (best and likely case includes £0.10m for M6, worst case includes a further £0.80m for M7-12) and a range associated with WRP delivery risk.	A re-set of the programme structure, governance and reporting for 2026/27 has taken place, including the introduction of the Productivity Board, Financial Recovery Board, DDGs and WRP Review meetings. Headcount reduction continues to be of significant focus with an additional 31.72WTE WRP delivered in M5 (106.29WTE YTD).	Grip and control Interventions and control measures are constantly being reviewed
Assure Areas of Assurance	Capital		
	Capital expenditure YTD is £4.04m below plan, with the slippage being mainly due to unforeseen site complications on the decarbonisation scheme. The contractor is confident the project will still deliver as per plan by the year-end. A positive response has been received from NHSE regarding capital bids against national allocations. To date we have received confirmation for £20.550m from NHSE. However work continues to ensure the remaining funding available to the trust is approved by NHSE.	The Trust is producing business cases for capital bids that have received approval to proceed to the next stage against the national allocations. Dialogue is ongoing with the regional NHSE team.	The capital plan will be updated as NHSE approvals are received. A system wide approach is being developed to support optimal use of national allocations.



Productivity

Productivity

Metric Description		Assurance @ Mar-27	Variation to Latest Actual	Concern	Target (£ 000's)		Latest YTD Actual (£ 000's)	Latest Month
					Mar-27	Latest YTD Target		
Productivity	I&E - Plan v Actual variance				0.0%	-13987	-16181	Aug-24
	WRP schemes delivery				60000	12025	11607	Aug-24

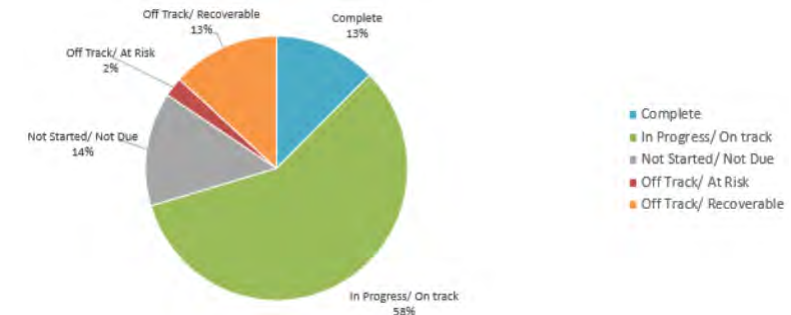


August-26 | Single Improvement Plan delivery position

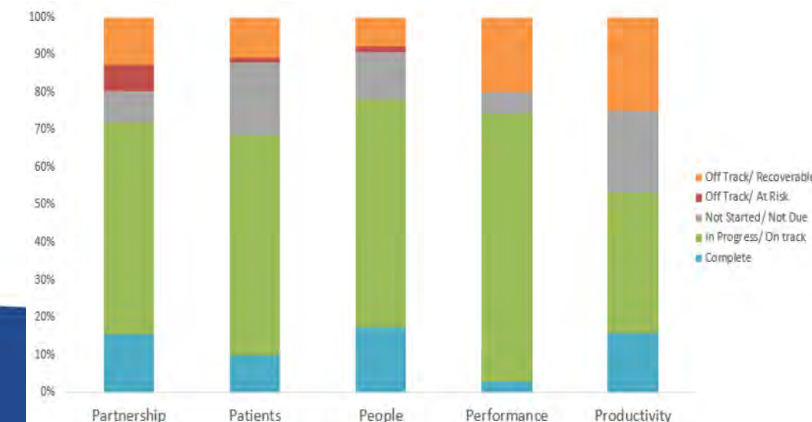
AAA	Issue	Action
Alert	Productivity: There are continued challenges in delivering the £60m plan but the Board is committed to achieving the plan and is proactively managing the risk. Performance: 18 week RTT performance remains off track however has seen improvement in July (Aug performance remains unvalidated). Days Kept Away from Home lost bed days remain high and above target. Partnerships: Digital and infrastructure outstanding funding, system and data sharing decisions are slowing delivery of several improvement programmes.	- CFO leading work to improve delivery forecast with CSIO driving delivery recovery actions. CEO mobilised Financial Recovery Board for fortnightly oversight of delivery focus and drive pace. Sprint approach being planned for joined up working across divisions to deliver against challenging transformational work. - COO leading work to increase capacity via a Super September initiative with ~30% increased activity identified to date. Actions underway to strengthen discharge and flow actions. - CSIO has implemented the Digital Oversight Committee for increased assurance on digital timeline and delivery. Ongoing work to recover digital delivery.
Advise	People: Sickness at 6.3%, support role vacancies and high temporary staffing continue to stretch teams. Performance: Diagnostic performance (DM01) has improved in Aug and is above target for the 3rd month – showing highest levels of performance since March 2020. 62 day cancer performance has improved in July 26. Patients: Experience and estates - emergency department feedback remains below target, and some safety, estates and staffing actions are receiving continued oversight.	- CPO plans in place to support the workforce pipeline, reduce sickness and progress the outstanding people and inclusion actions. - COO supporting close monitoring of productivity and performance re diagnostics and 31 day cancer at tumour group level. - CNO focus on patient feedback and resolve the outstanding estates funding and staffing decisions.
Assure	Performance: Reduction in long waits (52 week+) is showing a continued improvement and is ahead of target for the 7th month, similarly waiting lists size has continued to be ahead of plan for the 4th month and is ahead of target. Cancer performance re FDS is ahead of target for the 3rd month	Continued mobilization of additional capacity (internal and outsourcing), recruitment is ongoing into critical clinical roles.

Delivery movement is positive overall, with more milestones completed and fewer not yet started but a slight increase in delivery timeframe slippage although this is recoverable. Risks are actively discussed in each portfolio board to mitigate and control.

Overall delivery status – August-26



Delivery status by Portfolio – August-26



Integrated Performance Report

Appendix 1 – Assurance Reports

October 2026 Trust Board meeting with performance to August 2026



Patients



Performance



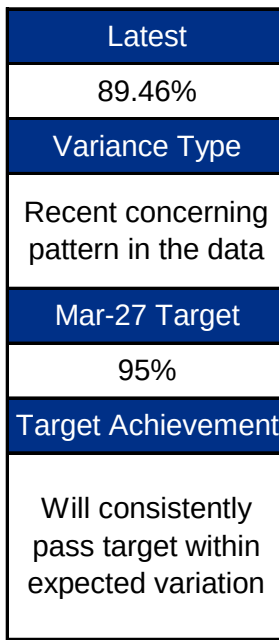
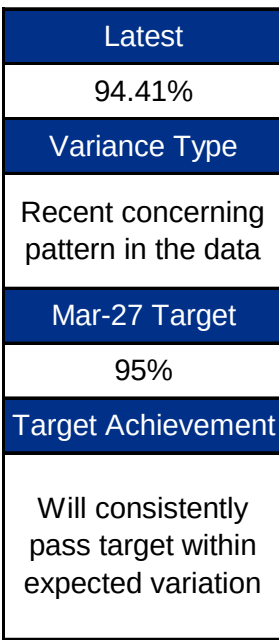
People



Productivity



Partnerships

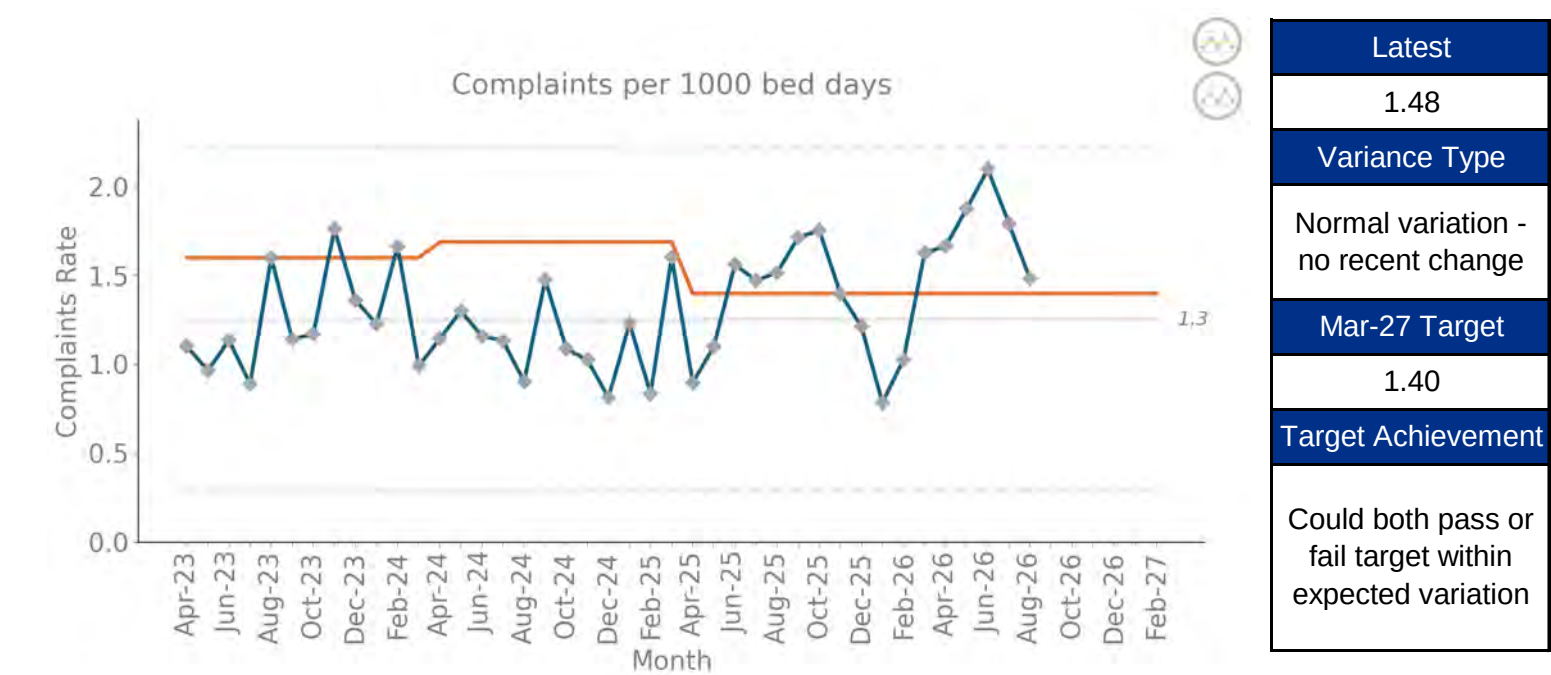


Metric	Summary	Action	Assurance
Staffing Fill Rate Registered Nurse	In August 2026, the Registered Nurse staffing fill rate was 94.41%, outside the Trust target range of 95–100%. CDH achieved 97.89%, RPH reported 93.91%, below target. Overall, safe staffing assurance is maintained through daily reviews, proactive deployment and established escalation processes. Performance continues to be monitored alongside patient acuity, quality indicators and red flag events, with targeted oversight at RPH to identify and mitigate emerging risks.	1. Twice daily nurse staffing meetings operate seven days a week, providing consistent oversight and timely management of safe staffing risks. 2. Established roster sign off processes are strengthened by weekly roster efficiency reviews, led by the Divisional Nurse Leaders since October 25, supporting effective workforce deployment and accountability.	1. All clinical areas continue to demonstrate stable staffing fill rates supporting assurance that safe staffing levels are being maintained. 2. Matron-led daily operational staffing meetings assess and respond to changes in pressure and demand, informed by patient acuity and dependency, red flags and professional judgement. 3. All agency shifts require approval and sign-off by the Chief Nursing Officer, providing senior oversight and control. 4. Biannual safe staffing reviews are undertaken in line with National Quality Board guidance, supporting evidence-based establishment planning.
Staffing Fill Rate Health Care Assistant	The Healthcare Assistant (HCA) fill rate continues to show a downward trend, reflecting high vacancy levels across inpatient wards. In August 2026, the overall fill rate was 89.46%—CDH 88.46% and RPH 89.66%—below the Trust target range of 95–100%. Temporary staffing and proactive workforce deployment continue to mitigate immediate risks and support safe care delivery. However, sustained vacancies and reliance on bank staffing remain workforce risks requiring close monitoring, targeted recruitment and continued oversight through established staffing escalation processes.	1. Twice-daily nurse staffing meetings operate seven days a week, providing consistent oversight and timely escalation of safe staffing risks. 2. A defined and advertised internal Band 2-to-Band 3 progression pathway supports workforce development and retention. 3. The centralised external recruitment campaign has recruited 102.59 WTE Band 2 and 68.91 WTE Band 3 Healthcare Assistants since May 2026, supporting vacancy reduction and workforce stability. The impact of this recruitment is not yet felt due to the time taken to progress through recruitment and induction, which can take circa 5-6 months. 4. Level 3 apprenticeship scheduled to commence September 26, level 2 apprenticeship interviewed with a planned commencement for October 26.	5. The weekly PSIRF Oversight Panel reviews incident harm levels, with findings triangulated through the quarterly serious incident and PSIRF report to identify trends and emerging risks. 6. Participation in the national Enhanced Therapeutic Observation and Care programme supports continuous improvement and the adoption of evidence-based practice 7. Additional duties follow a defined governance process, requiring approval from the Deputy or Divisional Nursing Director to maintain safety, effectiveness and appropriate oversight. 8. Delegated authority for bank approvals supports budget holders to secure timely staffing while operating within clear standards, targets and monitoring arrangements.

Patients - Deliver Annual Safe Staffing Requirements Assurance

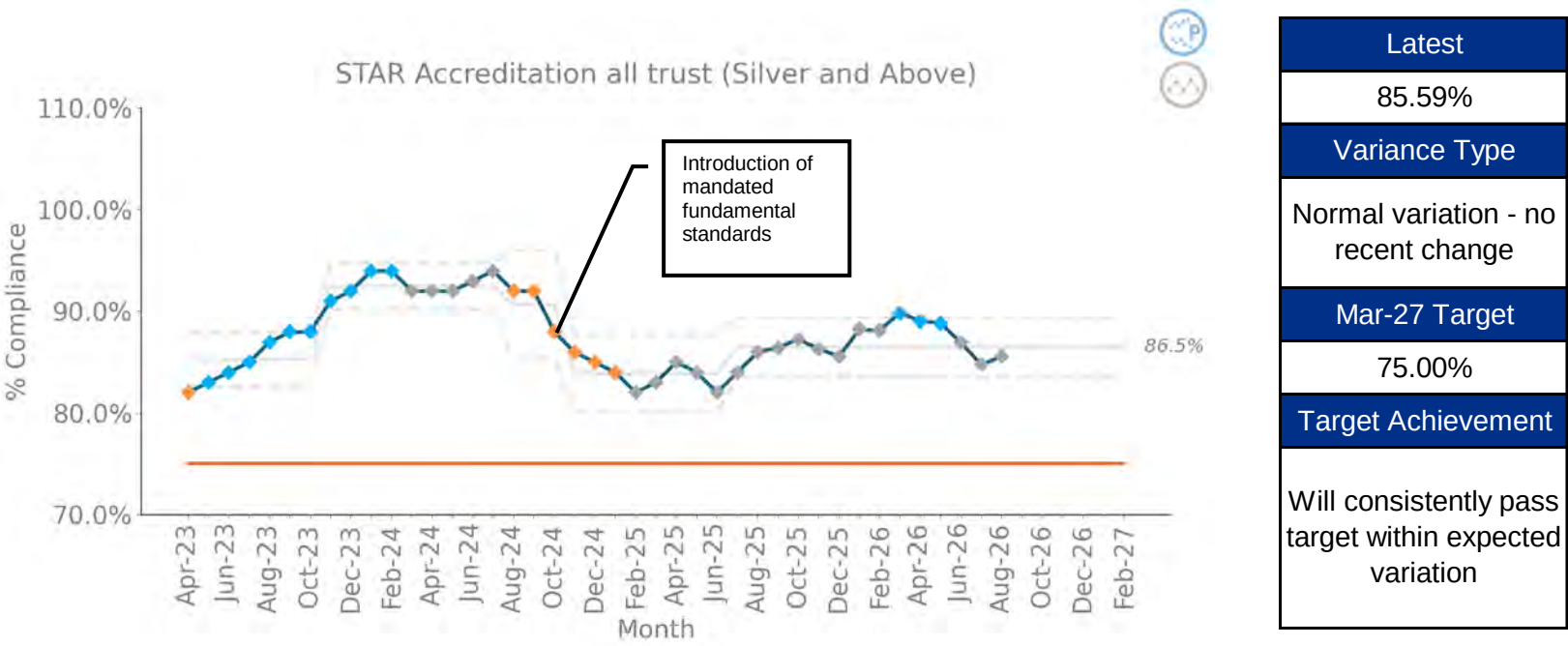


Patients - Complaints



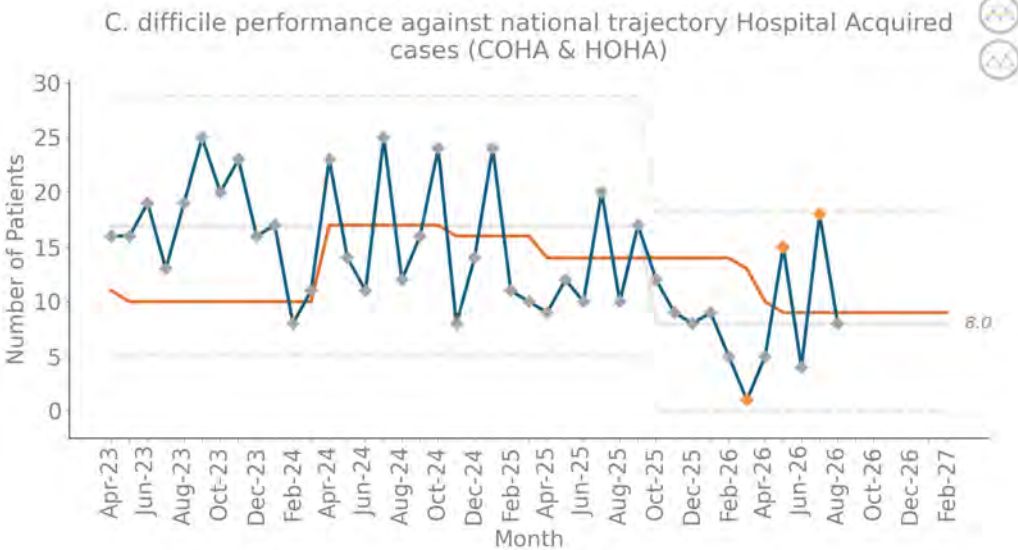
Metric	Summary	Action	Assurance
Complaints per 1000 bed days	Complaints per 1,000 bed days from April 2023 to early 2026, with performance fluctuating around a central baseline and a stepped trajectory line indicating expected or target levels.Overall, complaint rates have reduced this month from 1.79 in July to 1.48 in August. The Trust's Single Improvement Plan is guiding both immediate service improvements and longer-term system change to support sustained reduction.	- Continue to deliver the Single Improvement plan - Patients - Continue to deliver the Patient Safety Incident Response Framework with a focus on family liaison roles - Monitor actions in relation to National picker Surveys . - To deliver the PALS and local early resolution training. - Continue to progress the complaints review group using patient safety partners and governors - Where concerns have not been responded to locally escalatre to managers. - ELearning training for PALS concerns and a seperate package for Complaints Handling will be on training records within the next month.	- Annual patient experience reports to Safety and Quality committee. - Friends and family monthly reporting in place for all departments. - Inclusion of patient experience in STAR. - Chief Nursing Officer reviews all complaints and signs off responses. - Monitor picker survey action plans through Patient, Carer, Experience and Involvement Group. - Weekly meetings with the divisions to monitor progress and response times for concerns and complaints.

Patients - Quality Assurance STAR Accreditation



Metric	Summary	Action	Assurance
STAR Accreditation all trust (Silver and Above)	There are 118 clinical areas registered for the STAR Quality Assurance Framework. There are 101 areas rated green, 15 areas rated amber and 2 areas rated red. This results in 73 gold stars, 28 silver stars and 17 bronze stars. Of those 28 areas with silver stars, there are 6 who have achieved 3 consecutive silver stars and are awaiting gold panel approval. The Trust achieved 86% of areas rated silver and above and 62% of areas are rated gold for STAR accreditation visits. During August, there was 1 area who maintained a bronze star rating, 1 area reduced from silver to bronze, 2 areas reduced from gold to bronze, 1 area achieved their 3rd silver star and 2 areas achieved their first silver star, 1 area acheived a 2nd silver star and 5 areas maintained their gold star rating. Themes for improvement include recurring gaps in safety checks and equipment assurance, gaps in intentional rounding and incomplete skin assessment, risk assessments in particular weights and MUST as well as inconsistencies with fluid and food dietary charts. The Trust achieved 75% of Wards, ED and Theatres rated silver and above for the STAR accreditation visits.	- Standards which are not achieved require an improvement action which is monitored within the division through divisional assurance processes and via STAR monthly reviews and STAR accreditation visits. - The monthly STAR report includes trust wide and divisional STAR data and highlights good practice, areas for improvement and themes for learning, which is cascaded and discussed through the divisional Always Safety First meetings. The STAR report includes CQC (2023) learning and standards which continue to require improvement. - STAR monthly reports highlight those areas who are rated red or amber for STAR visits of less than 90% for STAR monthly. - There is clear direction that all bronze-rated areas have an action plan which is overseen by the Matron/Professional Lead, and divisional leads, all areas are required to be buddied with a gold-rated area and teams discuss their STAR improvement actions within team meetings.	- The STAR report is shared with the divisional leadership teams, good practice is shared and celebrated and that actions are developed where improvement is required. - Ward/department managers, matrons and professional leads provide assurance that actions are completed and monitored for effectiveness through the 1:1 with matrons and Divisional Nurse Directors. - The AMaT system supports with STAR audit data management and oversight and management of improvement actions. - There is a BI STAR page available to enable data triangulation. - STAR accreditation visits are scheduled depending on star rating, areas with a bronze star rating are reassessed within 2-3 months. (red every 2 months, amber every 3 months). Any area with a 15 steps result of C or below will receive a reassessment within one month. - Any immediate risks or serious concerns identified are addressed at the time and followed up to seek assurance that actions are in place.

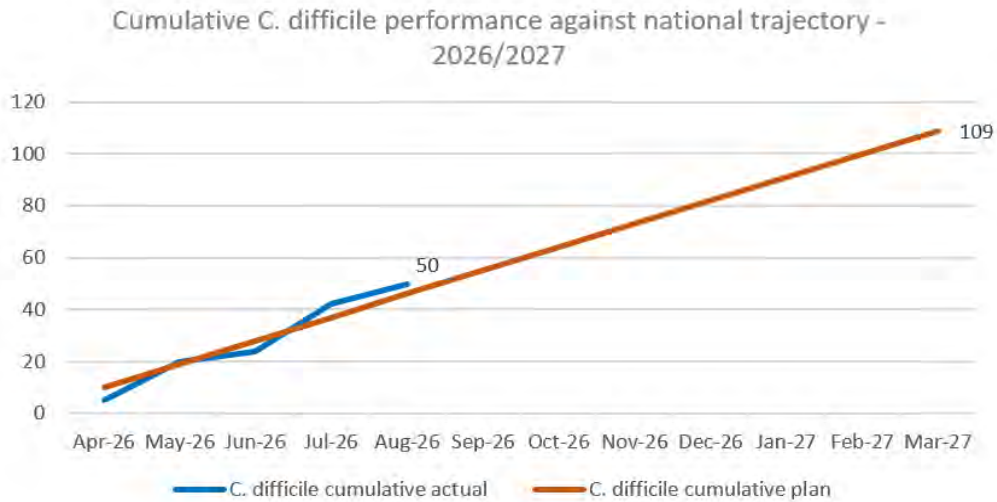
Patients - C Difficile Improvement Programme Assurance



Latest
8
Variance Type
Normal variation - no recent change
Mar-27 Target
9
Target Achievement
Could both pass or fail target within expected variation



Latest
90.60%
Variance Type
Normal variation - no recent change
Mar-27 Target
98.00%
Target Achievement
Will consistently fail target within expected variation



Latest
68.65%
Variance Type
Recent positive pattern in the data
Mar-27 Target
95.00%
Target Achievement
Will consistently fail target within expected variation

Metric	Summary	Action	Assurance
C. difficile performance against national trajectory Hospital acquired cases (COHA & HOHA)	During August 2026, 8 CDI cases were reported, bringing the 2026/27 year-to-date total to 50 against the Trust’s national objective of no more than 109 cases. . The CDI reduction programme and improvement plan remain subject to monthly oversight through the Infection Prevention and Control Committee and the Estates and Clinical Partnership Board. Compliance with the National Standards of Healthcare Cleanliness (2025) is monitored through the dashboard, alongside quality checks in areas not yet meeting required cleaning frequencies. Current cleaning-frequency compliance is 90.60% in Frequency 1 areas and 68.65% in Frequency 2 areas. Vacant domestic posts pose a risk to full compliance by the target date of September 2026 as vacancies have increased and recruitment is not keeping up with turnover of staff. Vacancies in month have increased to 13.91 WTE. This is being escalated through appropriate governance routes. The rise in CDI cases in Frequency 2 clinical areas require continued scrutiny and timely delivery of planned improvements.	1.Implementation of the approved business case to be compliant in high risk areas with National Standards of Healthcare Cleanliness (2025) - Trust vacancy sweep and subsequent vacancy freeze has led to a review of domestic capacity. Following full service capacity appraisal, the service will step down NSoC across FR3 - 6 categories, with resource redirected to FR1 and FR2 areas only. 2. Continued focus on IPC practice through STAR monthly and accreditation processes each month. 3. Continue to monitor key performance assurance indicators through Infection Prevention and Control committee each month.	1. IPC Board Assurance Framework reviewed through the Infection Prevention and Control Committee. 2. MIAA audit provides substantial assurance. 3. IPC dashboard and revalidation audits provide oversight of performance, compliance and emerging risks. 4. IPC risks and performance are reviewed through established Trust governance committees. 5. STAR incorporates IPC audits and cleaning-checklist compliance, 6. NHS England’s review provides external scrutiny and assurance regarding the Trust’s IPC arrangements and controls. 7. Antimicrobial stewardship is subject to established oversight and assurance reporting.



Patients

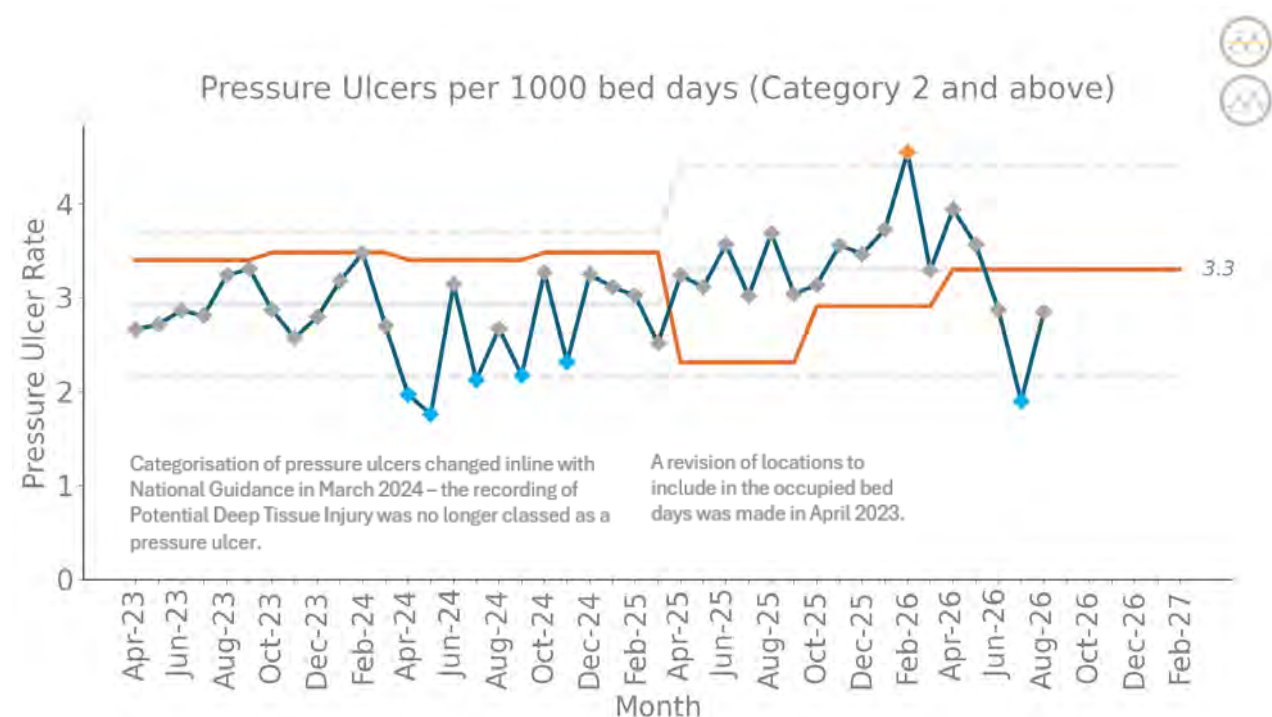
Performance

People

Productivity

Partnerships

Patients - Pressure Ulcers Assurance



Latest
2.85
Variance Type
Normal variation - no recent change
Mar-27 Target
3.30
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
Pressure Ulcers per 1000 bed days (Category 2 and above)	Pressure ulcers remain a key indicator of care quality and performance continues above the revised Trust threshold. A comprehensive improvement plan is in place focusing on prevention, consistent standards and strengthened review processes. Oversight has been enhanced through the Pressure Ulcer Panel, supporting cross-divisional learning, alongside pressure ulcer risk reduction rounds led by the tissue viability team, to provided proactive intervention, real-time feedback and education to ward teams. These measures strengthen oversight and support early intervention with a Trust focus on pressure ulcer prevention in line with the Trsut imprevemnt plan.	1. Monthly divisional review of pressure ulcer incidents, themes and trends through ASF meetings, translating learning into targeted actions to reduce harms. 2. Weekly Pressure Ulcer Review Panel to review harm, identify factors, and drive actions to prevent recurrence, with learning escalated through governance (from Nov 2025). 3. Proactive risk reduction rounds led by the tissue viability team, providing real-time support and challenge to improve prevention and reduce avoidable harm (from Mar 2026). 4. Delivery of an evidence-based improvement plan addressing key incident themes, with impact measured through reduced pressure ulcer incidence. 5. Strengthened data quality through housekeeping and reporting processes to ensure consistent, reliable data for monitoring trends and providing credible assurance.	1. Divisional Always Safety First Committees provide oversight of the pressure ulcer improvement plan and monitor progress against key actions. 2. Monthly monitoring of pressure ulcer incidence continues as a priority quality metric, with trends reviewed at divisional and Trust level. 3. STAR compliance for key questions 8d and 9c is monitored monthly as leading indicators of prevention practice. 4. Weekly Pressure Ulcer Panel, with a consolidated monthly learning report submitted to PSIRF Oversight. 5. Monthly oversight group for review and monitoring of actions from Pressure ulcer panel with division leadership representative.

Patients - Always Safety First Assurance - Mortality

Achievement	Position	Month
Lower Than Expected	75.0	April 2026
As Expected	88.4	April 2026
As Expected	174.6	April 2026
As Expected	123.2	April 2026

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

Source Data: Telstra (Dr Foster)

Metric	Summary	Action	Assurance
Hospital Standardised Mortality Ratio - Adult	HSMR is within Upper and Lower Control Limits and lower than expected when compared to peers.	- Continue with structured judgement review process. - Use mortality reviews to establish themes where care or experience could be improved. - Continue to work with the medical examiners office to review deaths in line with guidance. - Continue to use incident reporting processes where an incident occurs under Patient safety Incident Response Framework (PSIRF). - Continue to implement the 10 CNST safety actions for maternity and neonatal - Marthas rule (Call for Concern)implementation is underway. - Review the interface of Medical Examiner Reviews, Incident Reporting and Structured Judgement Reviews to ensure timely identification of harm level associated with patient deaths. - Identify top themes of learning from deaths and family feedback, identify existing relevant workstreams and develop maturity of learning framework including each theme. Project to be overseen by Mortality and End of Life Committee	- Mortality and End of Life committee chaired by Deputy Chief Medical Officer with responsibility for mortality. - Twice annual reports to safety and Quality committee. - Telstra system utilised to generate mortality data ensuring objective peer data is used to establish reported key performance indicator. - Speak Up arrangements are well established in the organisation. - Maternity Neonatal report provides assurance of compliance with Maternity neonate Safety Investigation branch for appropriate cases. - The Child Death Overview process ensures peer review takes place of all child deaths and is reported through the annual safeguarding report and the mortality reporting arrangements. - ED and maternity and neonatal safety forums in place with executive leads identified to encourage speak up in high risk areas. - Dr Foster (reverted back from TELSTRA) data will be used to review individual conditions which alert on the HSMR SHMI data. A narrative will be included in Mortality Reports to Safety and Quality Committee. - The Trust has been validated against all 10 CNST maternity and neonatal safety actions and is now progressing through the formal sign-off process. - Further Dr Foster training sessions will be provided for LTHTR in 2026 -2027.
Standardised Mortality Ratio - Relative Risk - All Diagnoses Adult	SMR is within Upper and Lower Control Limits and lower than expected when compared to peers.		
Standardised Mortality Ratio - Relative Risk - All Diagnoses Child (<1 day – 17 yrs)	SMR (Child <1 day -17 Years) (All Diagnoses) is within Upper and Lower Control Limits and within expected range compared to peer.		
Standardised Mortality Ratio - Relative Risk - All Diagnoses Neonates (<1-28 Days)	SMR (Neonatal <1 day -28 days) (All Diagnoses) is within Upper and Lower Control Limits and within expected range compared to peer.		



Patients

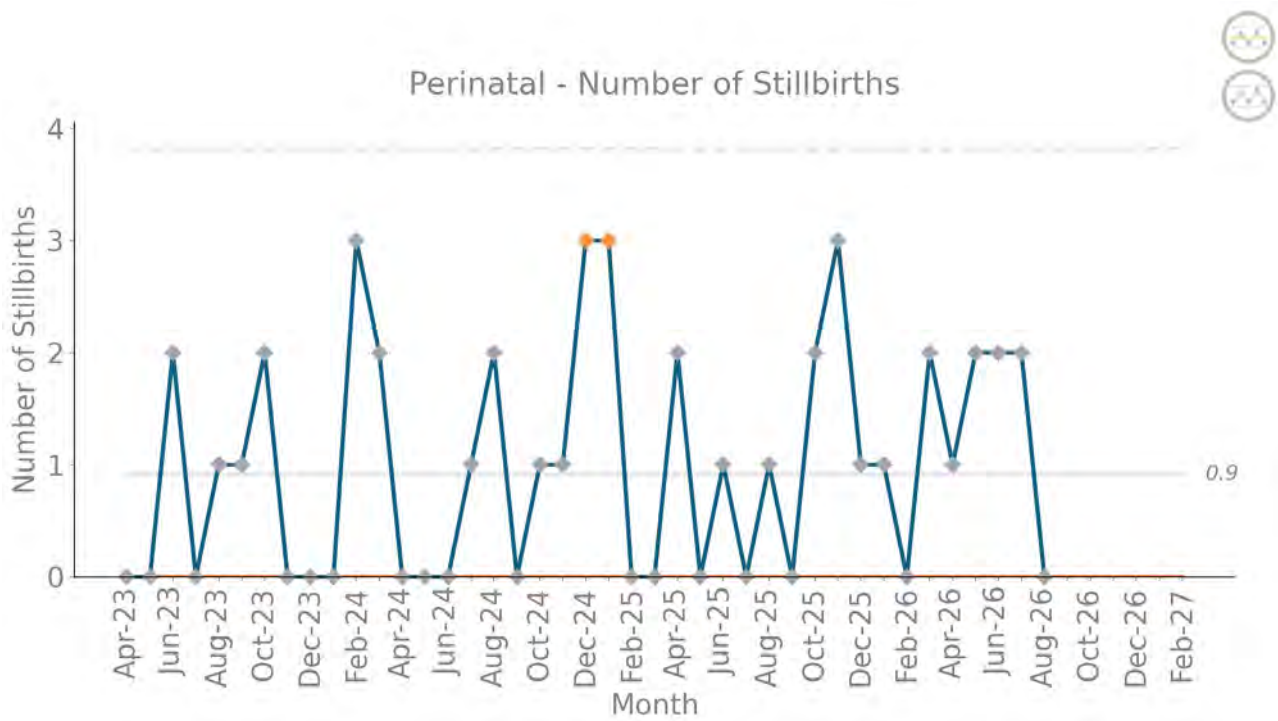
Performance

People

Productivity

Partnerships

Patients - Stillbirths Assurance

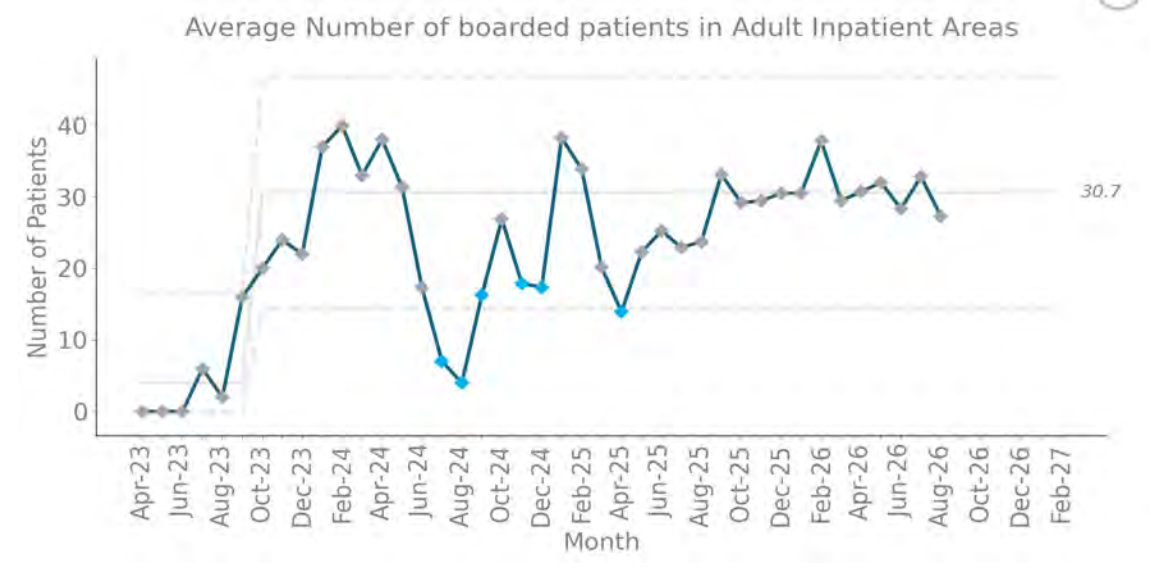
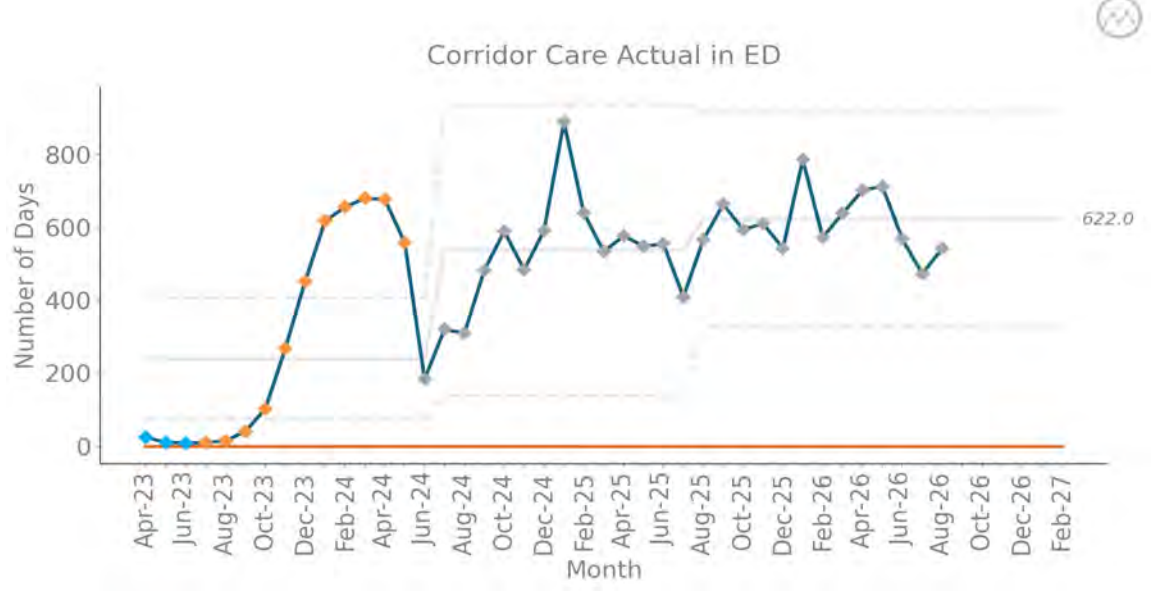
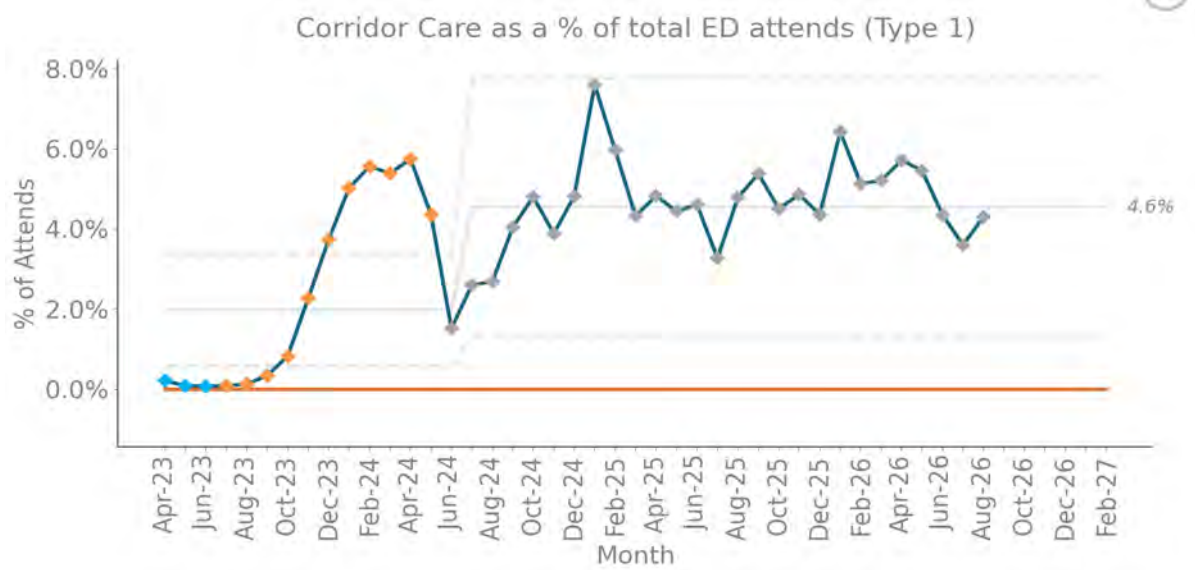
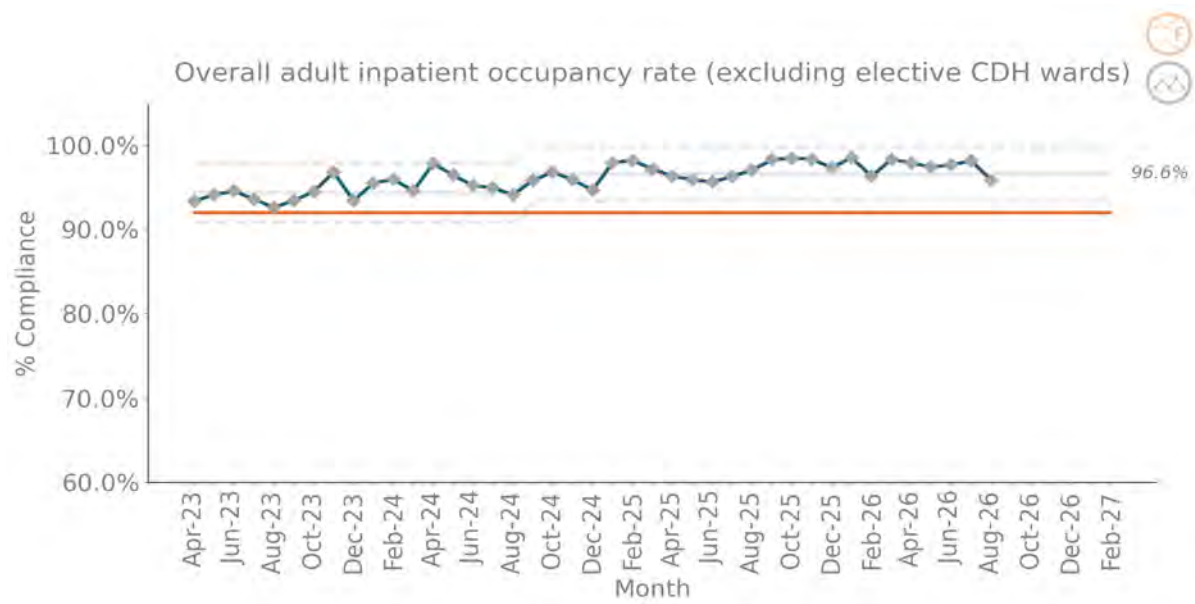


Latest
0
Variance Type
Normal variation - no recent change
Mar-27 Target
0
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
Perinatal - Number of Stillbirths	There were no stillbirths reported in August. The service continues to track the rates of stillbirth and review each case in line with national guidelines and reporting requirements. The 12-month local average mean still birth rate is 2.1 per 1000 (May 2025 to April 2026 excluding TOPFA) remains below the national average of 3.9 per 1000 births.	1. Implementation of the Maternity Incentive Scheme (MIS Year 8) safety standards. 2. Implementation of Single Improvement Plan (SIP) actions to improve outcomes for mothers, babies and families. 3. Report all cases via Submit a Perinatal Event Notification (SPEN) 4. Use National Maternity Dashboard analysis to review to provide peer comparison data for continuous improvement.	1. Perinatal Quality Surveillance dashboard analysis shared via the maternity and neonatal safety report (to Safety and Quality Committee). 2. Peer comparison data included within the reporting for oversight 3. National MBRRACE reporting provides overview of national themes to ensure learning is understood. 4. The Maternity Outcomes Signal System (MOSS) is now in place which provides real-time monitoring of key maternity outcome—such as term stillbirths, to detect early warning signals and prompt rapid intervention., there are no live signals at this time.

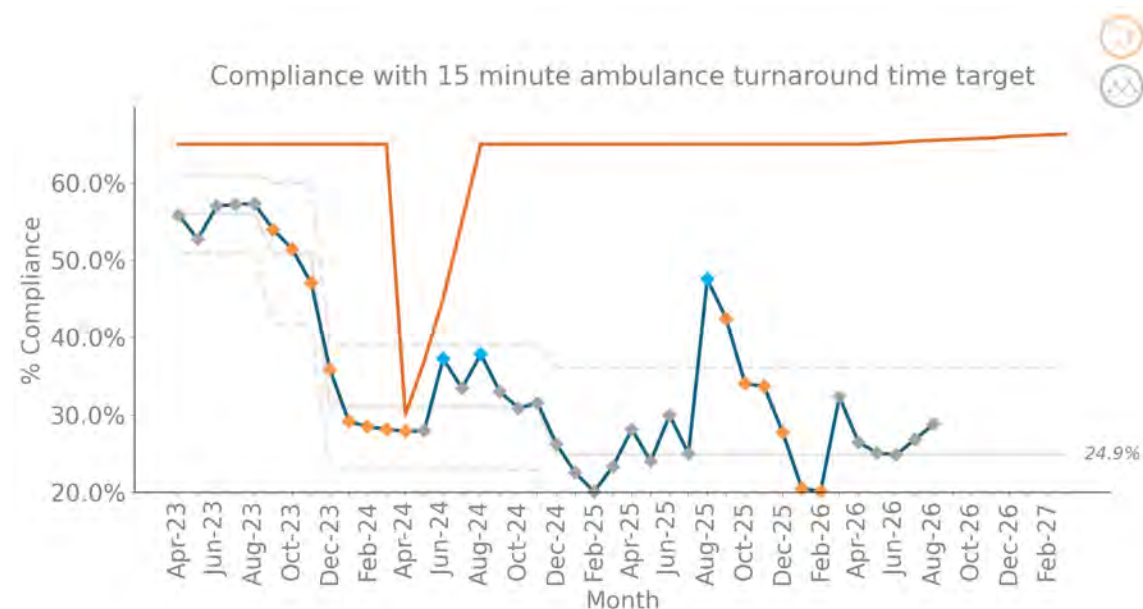


Patients - Corridor Care

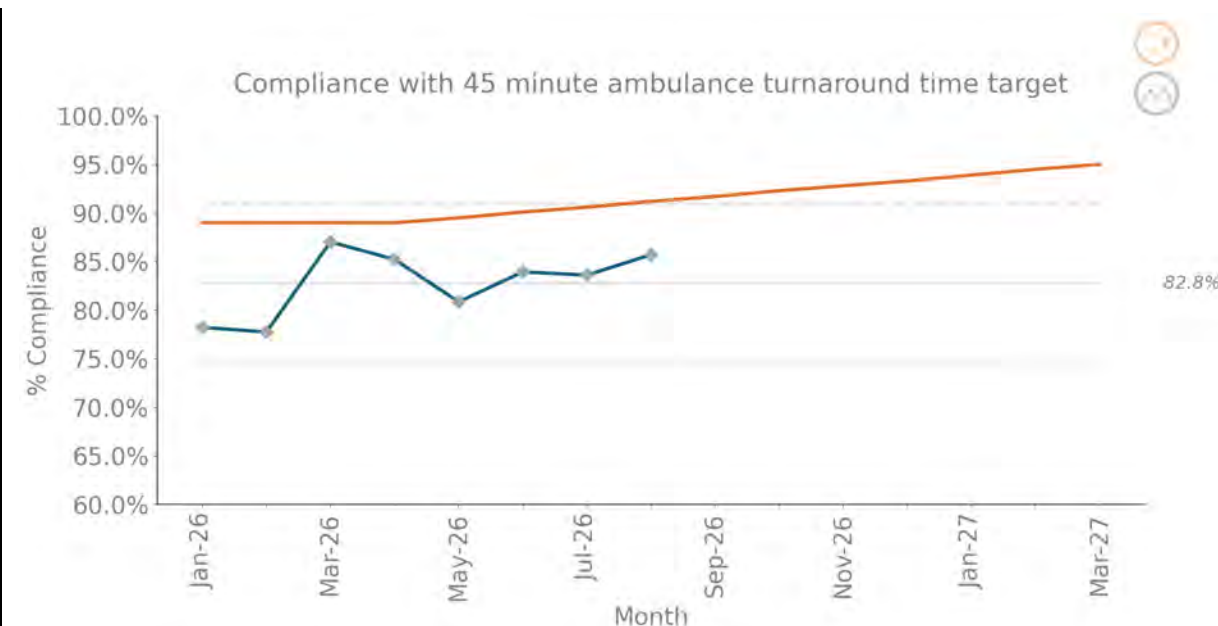


Metric	Summary	Action	Assurance
Overall adult inpatient occupancy rate (excluding elective CDH wards)	Adult inpatient occupancy remains above the Trust target at 95.9% against a target of 92%. SPC analysis demonstrates sustained common-cause variation with no recent improvement, indicating the Trust continues to operate at consistently high occupancy levels rather than experiencing a temporary increase in demand. Whilst occupancy has reduced from previous months, capacity pressures remain significant and continue to impact patient flow across the organisation. Ongoing work through the Urgent and Emergency Care Improvement Programme, including pathway redesign, admission avoidance initiatives and flow improvement schemes, continues to support reductions in avoidable occupancy and improve patient movement through the hospital. Occupancy, patient flow and discharge performance remain subject to enhanced operational oversight and system-wide monitoring through established governance arrangements.	1. Urgent & Emergency Care (UEC) pathway productivity: Continued focus on admission avoidance and length-of-stay reduction to release capacity and de-pressure occupancy. 2. Strengthened governance and oversight arrangements remain in place, including executive-led workstreams, weekly performance reporting, and monitoring through the Strategic Oversight Group and UEC Improvement Board. 3. System-wide collaboration through the Single Improvement Plan and Place-based UEC delivery structures continues to support coordinated action and address capacity constraints across the pathway. 4. The introduction of Extended Emergency Medicine Ambulatory Care (EEMAC) in July has successfully reduced patient numbers in corridors and waiting areas, supporting improved flow and patient experience. 5. The Medical Decisions Unit is planned to open in August 2026 to improve pathways of care. 6. A review of patient pathways across acute services is being undertaken to reduce duplication, streamline processes and support the delivery of more effective and efficient patient pathways.	1. The Improvement Plan is overseen by the Chief Operating Officer, providing executive sponsorship and alignment to the Trust's Single Improvement Plan 2. Fortnightly, executive-led workstream meetings review progress against agreed actions and unblock risks and issues. 3. Weekly performance reporting flows into the Strategic Oversight Group, with monthly reporting to the UEC Improvement Board. 4. Additional assurance is provided through the Single Improvement Plan Portfolio Board and the Place UEC Delivery Board (Lancashire & South Cumbria).

Performance - UEC Assurance



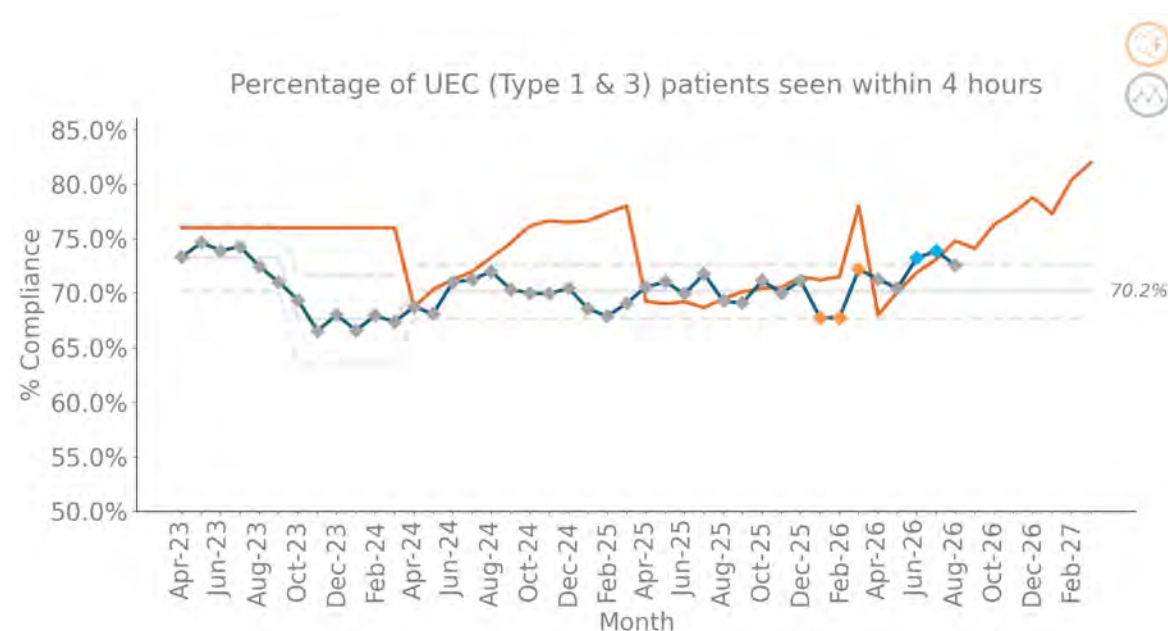
Latest
28.86%
Variance Type
Normal variation - no recent change
Mar 27 Target
66.3%
Target Achievement
Will consistently fail target within expected variation



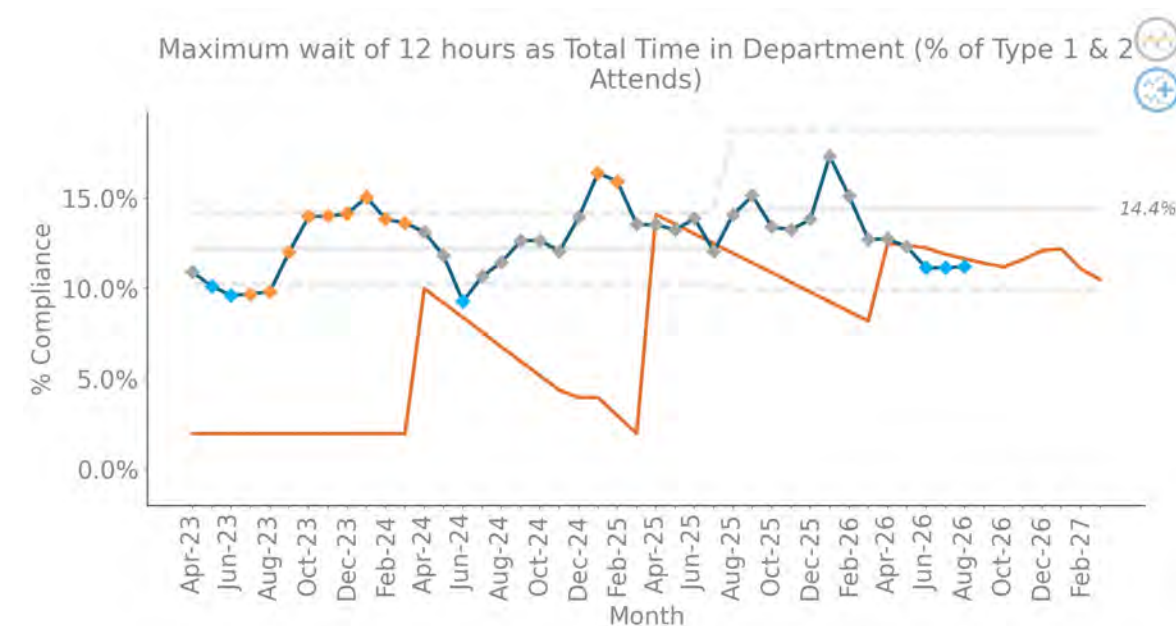
Latest
85.70%
Variance Type
Normal variation - no recent change
Mar 27 Target
95%
Target Achievement
Will consistently fail target within expected variation

Metric	Summary	Action	Assurance
Percentage of Ambulance Handovers within 15 minutes - Trust	In August 28.86% of patients were handed over from NWS within 15 minutes, an improvement of 2.04% compared to July. However the current position shows normal variation and will consistently fail the target within expected variation.	Improvement actions to support timely ambulance handover will be supported via the launch of the EEMAC, re-designed Acute Medical model and 24/7 SDEC which will commence at the end of July 26. Development of a multi agency Transfer of Care hub commenced on 18th May 26 with trusted assessor practices established which support step up admission into IMC will support delivery of a 1 day LOS reduction for DKAFH patients in pathways 1-3, thus reducing bed occupancy and aiding timely flow from ED. This alongside continued work on Ward and Board round processes and continued DKAFH improvement roll out will aim to see lost bed days for optimised patients reduced to within target by end March 27.	Comparison to both the national and regional performance positions for August 26 indicates that the Trust is below the national performance of 35.2% for 15 minute handovers and below the NW performance position of 31.7% of handovers within 15 minutes.
Percentage of Ambulance Handovers within 30 and 45 and 60 minutes - Trust	In August 74.25% of patients were handed over from NWS within 30 minutes, an improvement of 2.93% compared to July 26. Over 85.7% were handed over within 45 minutes, an improvement of 2.09% compared to July 26.		Comparison to both the national and regional performance positions for August 26 indicates that the Trust is below the national performance position of 75.2% for 30 minute handovers and below the NW performance position of 75.4%.

Performance - UEC Assurance



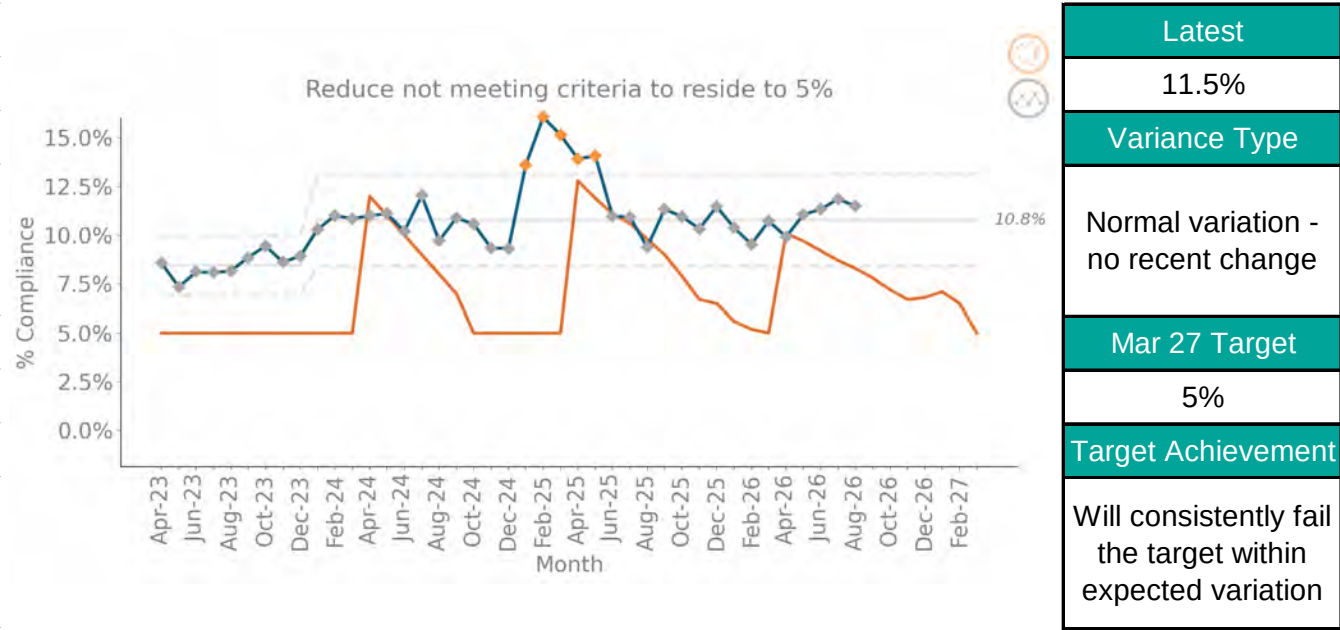
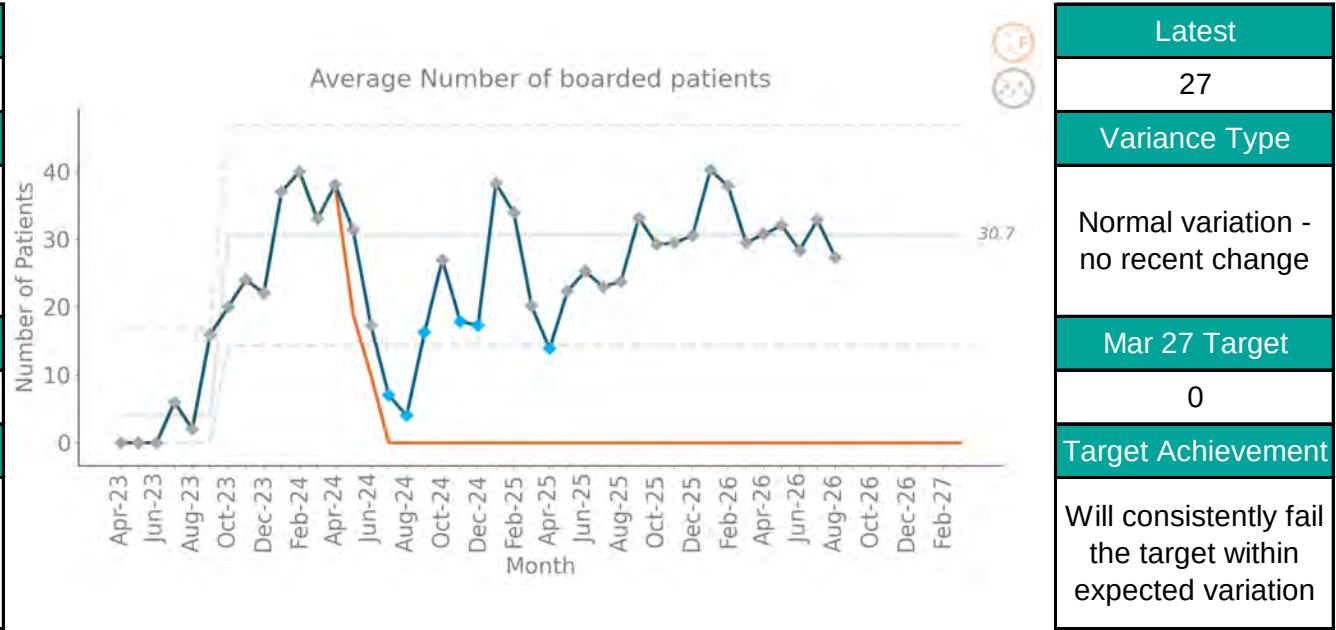
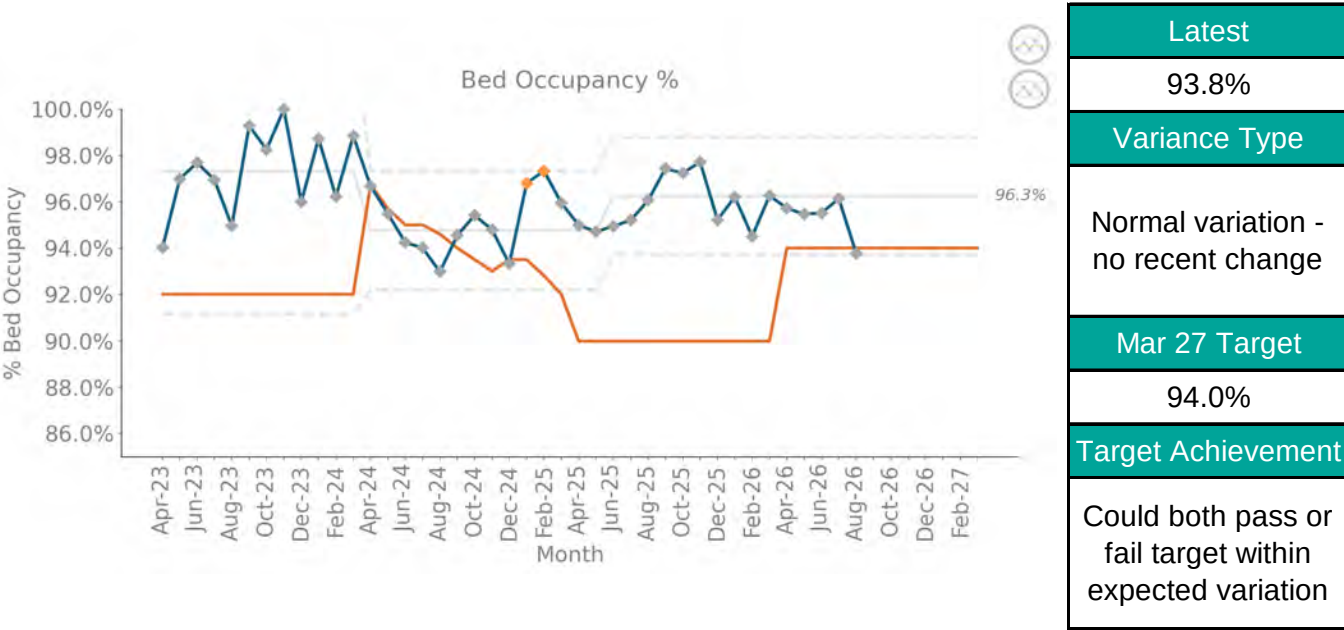
Latest
72.56%
Variance Type
Normal variation - no recent change
Mar 27 Target
82.00%
Target Achievement
Will consistently fail target within expected variation



Latest
11.29%
Variance Type
Recent positive pattern in the data
Mar 27 Target
8.20%
Target Achievement
Could both pass or fail target within expected variation

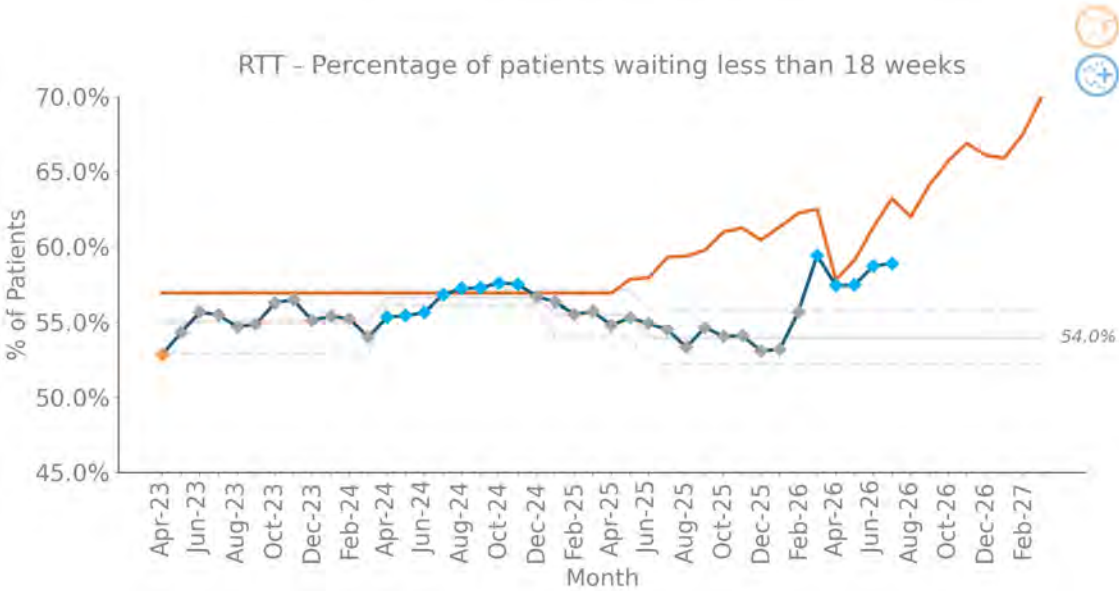
Metric	Summary	Action	Assurance
ED 4 Hour Performance - Trust	Performance against the national 4 hour access standard decreased in August 2026. Performance was 1.3% lower than July 26, and is lower than the Operational Plan target for July 26. August 26 experienced a lower daily attend level that July 26 of approximately 27 lower per day.	Progress continues with the Trusts UEC Transformation programme with key themes focusing on re-designed pathways Pre and Post hospital, the acute medical model of care, SDEC, Frailty and site escalation. An Extended Emergency Medicine Ambulatory Care facility was launched in July. Ther re-designed Acute Medical Model (MAC) will commence at the end of August 26 providing 24/7 SDEC provision and a Frailty SDEC service will be launched in Q2.	Comparison of 4 hour performance to the latest published national benchmarks indicates that the Trust is below the national average for August 26 of 75.0% and was ranked 73 out of 117 trusts nationally, a slight decrease of 8 places compared to July 26.
Maximum wait of 12 hours as Total Time in Department (% of Type 1 and 2 Attends)	The number of patients waiting over 12 hours (admitted and non-admitted Type 1 only) in ED for August 2026 increased slightly on July at 11.29%. The position shows normal variation and could both pass the year end target.	Work continues within the DKAFH programme. Multi-agency Transfer of Care hub commenced in May 26 with trusted assessor practices supporting step-up admission into IMC. Anticipated 1 days LOS reduction for DKAFH patients in pathways 1-3. Target: lost bed days for optimised patients reduced to target by end March 27.	The level of boarded patients decreased in August with an average of 27 patients per day. The volume of Days Kept Away from Home patients is far in excess of the target and above the August 25 position.

Performance - UEC Assurance

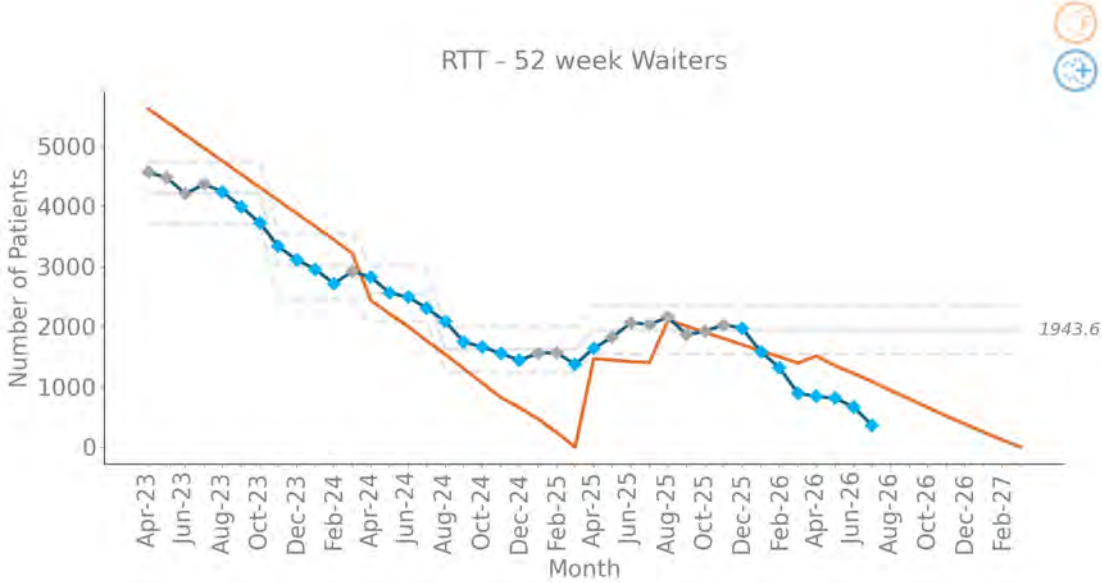


Metric	Summary	Action	Assurance
Bed occupancy %	The position shows an occupancy rate for August 26 of 93.8%, a decrease of 2.3% compared to July 26. The data shows normal variation and could both pass or fail the target within expected variation.	Bed occupancy remains significantly above target. Work continues linked to the DKAFH programme. A multi-agency Transfer of Care hub commenced on 18th May 26 with trusted assessor practices established to support step up admission into IMC. The anticipated impact is a 1 day LOS reduction for DKAFH patients in pathways 1-3. Continued work on Ward and Board round processes alongside DKAFH improvement roll out will aim to see lost bed days for optimised patients reduced to within target by end March 27.	Assurance via the Urgent Care Improvement Board and Urgent Care Improvement Plan
Average Number of Boarded Patients	On average 27 patients were boarded each day across both sites during August 26 with 837 associated bed days. This is a decrease compared with the July 26 position. These are predominantly medical patients requiring admission to an acute medical ward. The position shows normal variance and will consistently fail the target within expected variation.	A development of a multi-agency Transfer of Care hub commenced on 18th May 26 with trusted assessor practices established to support step up admission into IMC. The anticipated impact from the establishment of the Transfer of Care hub is a 1 day LOS reduction for DKAFH patients in pathways 1-3. This alongside continued work on Ward and Board round processes and continued DKAFH improvement roll out will aim to see lost bed days for optimised patients reduced to within target by end March 27.	Incident levels of harm are monitored on a monthly basis alongside patient feedback. UEC and In-patient survey feedback does reflect patient concerns regarding the practice of boarding. This is also reflected within the staff survey.
Reduce NMC2R to 5%	The number of patients in our hospitals that do not meet the nationally defined clinical criteria to reside for inpatient care in acute hospitals (NMC2R) decreased marginally in August (11.5% = daily average of 88 patients). Compared to the July position this is a decrease of 0.4%. The data shows normal variation and will consistently fail the target within expected variation.		Monitoring of NMC2R data is undertaken via the Central Lancs Urgent Care Delivery Board

Performance - Elective Care Assurance

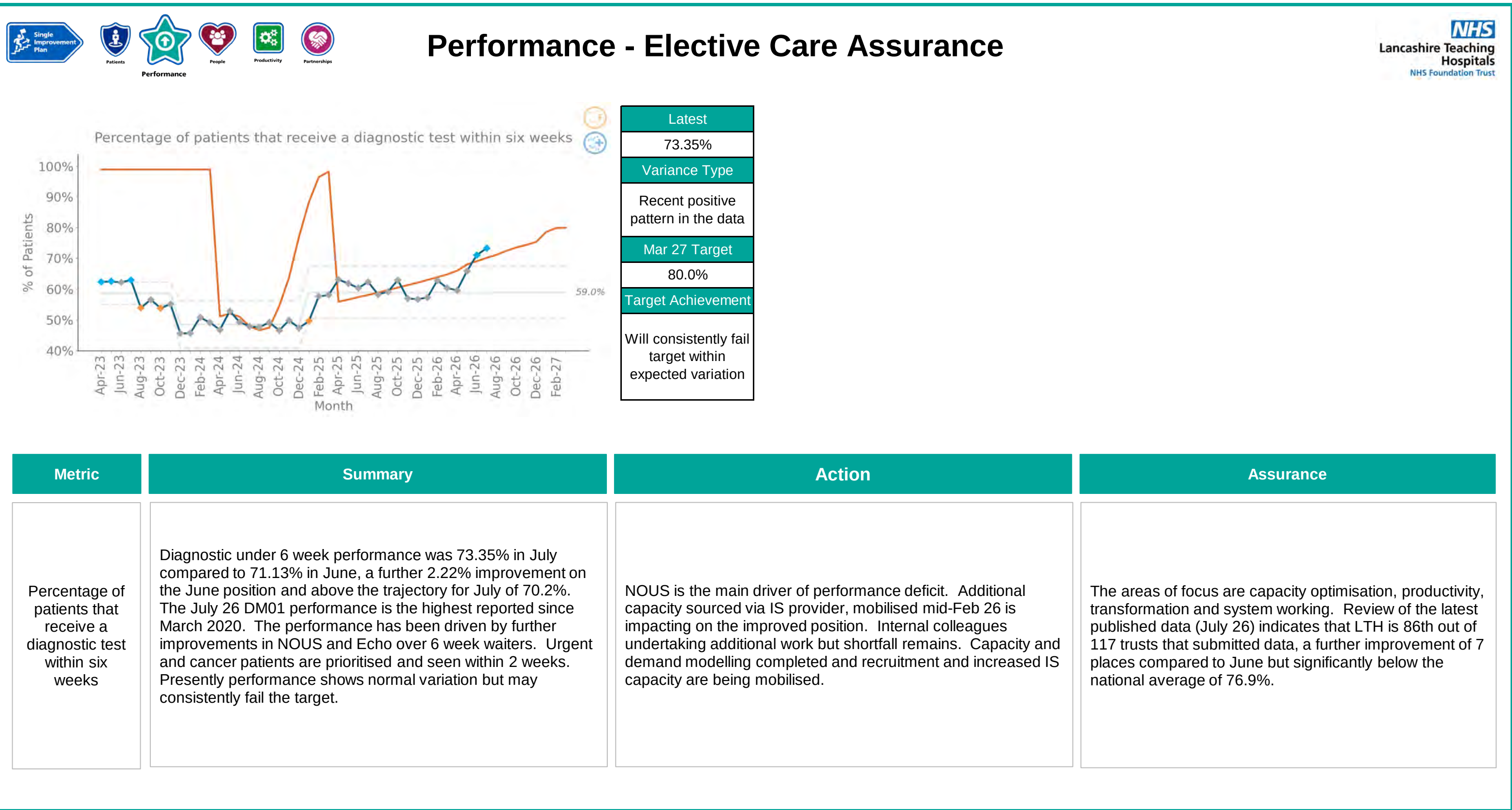


Latest
58.88%
Variance Type
Recent positive pattern in the data
Mar 27 Target
70.00%
Target Achievement
Will consistently fail target within expected variation

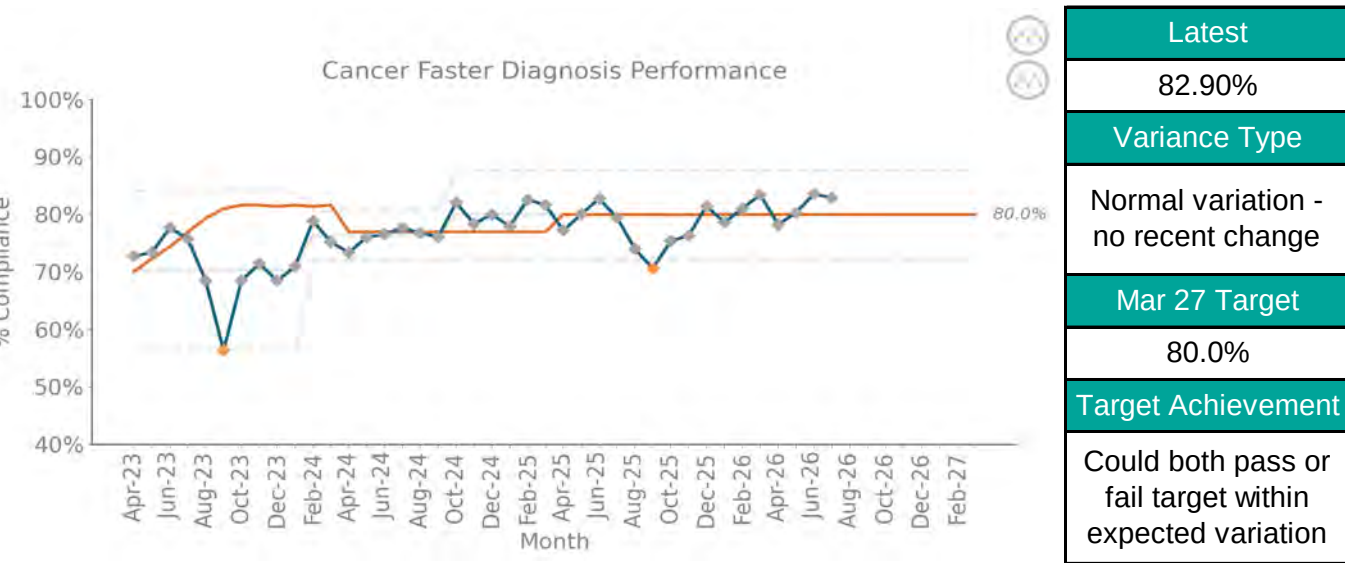
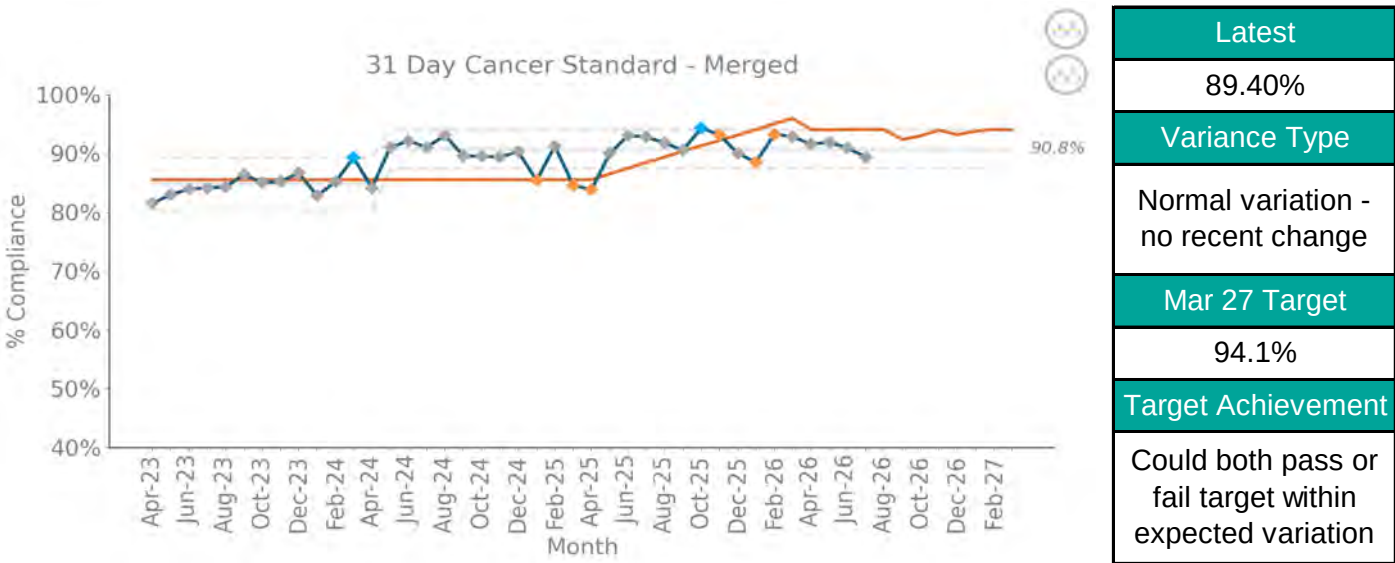
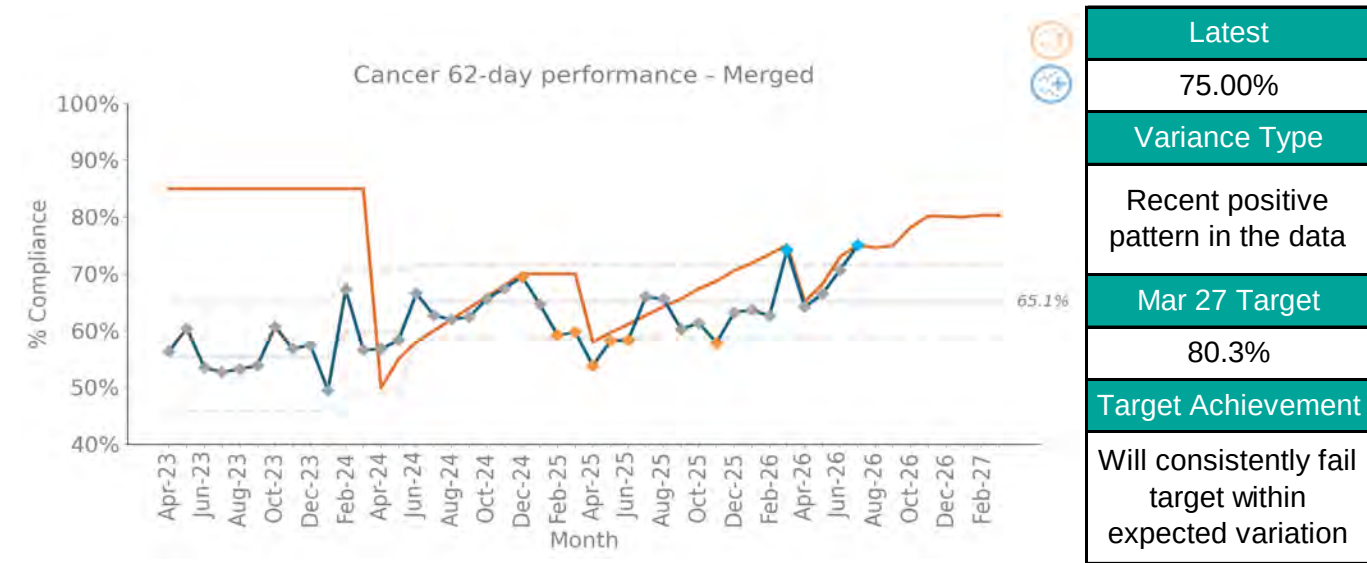


Latest
362
Variance Type
Recent positive pattern in the data
Mar 27 Target
0
Target Achievement
Will consistently fail target within expected variation

Metric	Summary	Action	Assurance
Percentage of patients waiting less than 18 weeks	The July 26 position of 58.88% is a 0.16% improvement compared to June 26. Analysis suggests a recent positive pattern in the data and that the target will be consistently failed. The Operational Plan 2026/27 year end target has been set at 70%. NATIONAL DEADLINES FOR AUGUST 26 HAVE BEEN EXTENDED. FINALISED DATA WILL NOT BE AVAILABLE UNTIL 23RD SEPTEMBER 2026	Ongoing work with digital partners to ensure capacity for ambitious PIFU rollout for constitutional standards and outpatient transformation. Additional activity mobilising via Independent Sector and WLIs. Internal business case undergoing Executive Check and Challenge. DNA rates reduced by a further 0.4%.	Comparison to the latest national performance position (June 26) indicates that the Trust is below the national position of 65.8% waiting under 18 weeks. The Trust is ranked 111 out of 118 trusts nationally for June 26 performance. July national performance is unavailable for this KPI at this time.
RTT - 52 week Waiters	The over 52 week waiter position in July was 362, a further decrease of -304 compared to the June position. Analysis suggests a recent positive pattern in the data and that the target may be consistently failed. NATIONAL DEADLINES FOR AUGUST 26 HAVE BEEN EXTENDED. FINALISED DATA WILL NOT BE AVAILABLE UNTIL 23RD SEPTEMBER 2026	Weekly 52 week breach reduction targets are in place for all specialties and is monitored at the weekly COO led Operations Board. Close monitoring of breach risks and capacity shortfalls are in place.	Local monitoring of all speciality RTT clock stop/performance is undertaken via the weekly Operational Board Comparison to the latest national performance position (July 26) indicates that the Trust at 0.6% in July was below the national picture of 1.5% waiting over 52 weeks. The Trust was ranked 34 out of 117 trusts that submitted data for July 26 performance.



Performance - Elective Care Assurance



Metric	Summary	Action	Assurance
62 Day Cancer Standard - Merged	Performance to the end of July shows a further improved position (+1.3% versus June 26), and is only 0.1% under the July Trust operational performance plan. Analysis shows normal variation in the data and will consistently fail the target within expected variation.		July 26 performance is above the latest national performance of 75% (July 26). The trust was ranked 41 out of 117 trusts for July performance, an improvement of 3 places.
31 Day Cancer Standard - Merged	Performance to the end of July 26 has fallen from June to 89.4% and is also below the monthly operational plan target of 94.1%. The performance is driven by high volumes of referrals within the Dermatology service and capacity constraints within pathology. Analysis shows a normal variation in the data and could both pass or fail the target within expected variation.	Whilst Cancer performance is improving there remains a close focus on individual tumour group improvement plans. Capacity and demand modelling has been completed for the majority of specialties. A Cancer dashboard is in development with the first 10 specialties now live and plans are in place to roll out for all tumour groups by the end of September which will provide live information to inform improvement plans. A Trust wild PTL weekly review has been implemented to track patient pathways. A Reducing Sleepless Nights campaign to provide a core focus on the waits patients experience whilst on a cancer pathway has been launched. Recruitment into key clinical vacancies has commenced with postholders due to commence in role starting 03/08/26.	31 day Decision to Treat performance a focus this year, with the requirement to reach 94% by the end of this year and then achieve 96% Operational standard in the following year. July 26 performance is below the latest national performance of 92.5% (July 26). The trust was ranked 100 out of 117 trusts for July performance, a drop of 28 places.
Cancer Faster Diagnosis Performance	Performance to the end of July 26 decreased by 0.8% versus June 26 but was above the monthly operational plan target of 80%. Analysis shows a recent concerning pattern in the data and could both pass or fail the target within expected variation.		Faster Diagnosis Standard July performance is 82.9% with the month on month target of 80% achieved. The Trust is currently ranked 36th out of 117 trusts.

Single Improvement Plan

Partnerships

People

Patients

Productivity

Performance

People - Workforce Assurance 1

Latest

5.46%

Variance Type

Recent concerning pattern in the data

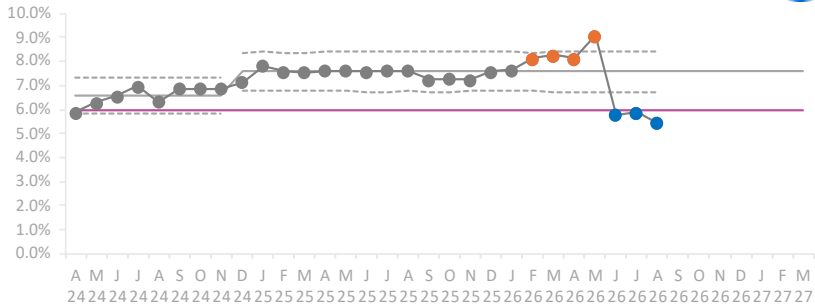
Mar 27 Target

≤ 6%

Target Achievement

Could both pass or fail target within expected variation

GL Vacancy Rate (% FTE)



Latest

0.50%

Variance Type

Normal variation - no recent change

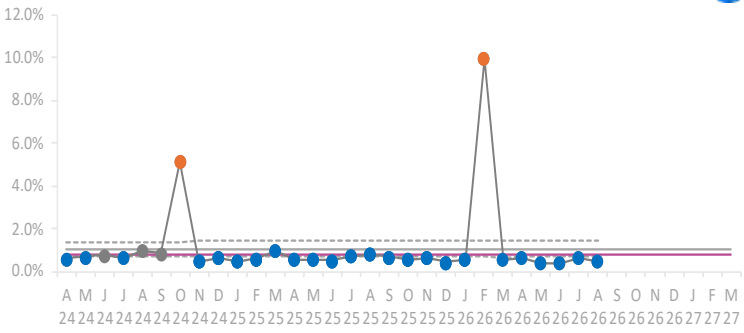
Mar 27 Target

≤ 10%

Target Achievement

Could both pass or fail target within expected variation

ESR Turnover (% FTE)



Latest

6.29%

Variance Type

Normal variation - no recent change

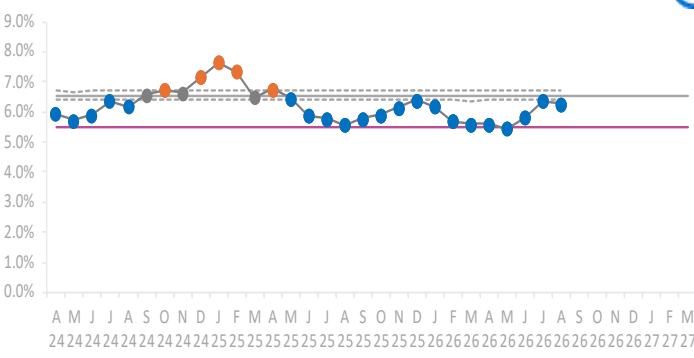
Mar 27 Target

≤ 5.5%

Target Achievement

Will consistently fail the target within expected variation

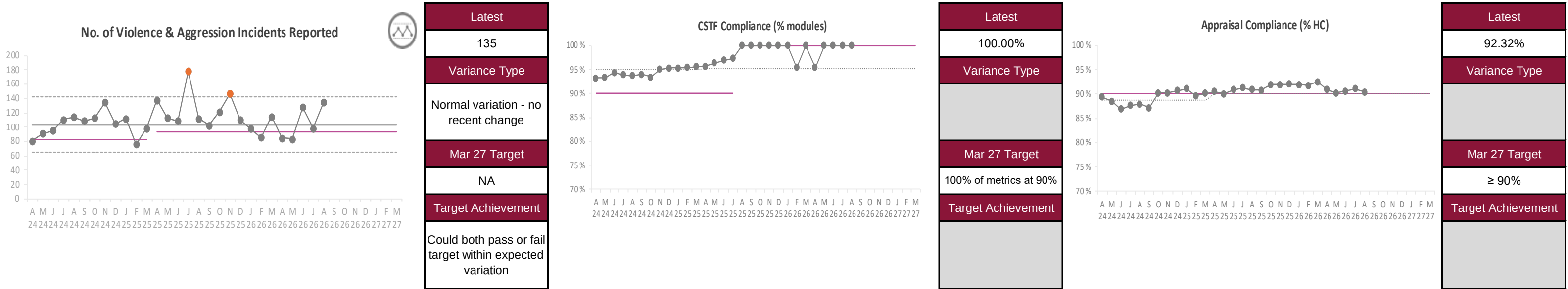
Overall Sickness (% FTE)



Metric	Summary	Action	Assurance
Vacancies (% FTE)	Following the establishment review and vacancy removal exercise, the Trust vacancy rate has reduced to 5.46% moving within target tolerance. However workforce supply challenges remain, particularly within Healthcare Support Worker and selected Medical and Dental groups. A significant recruitment pipeline remains in progress, including over 230 WTE HCSW vacancies currently under active recruitment.	Strategies to address Band 2/3 Healthcare Support Worker gaps have been developed jointly developed by nursing, education and workforce teams. Divisional Workforce Business Partners developing resourcing plans for hard to fill roles. Centralised recruitment underway.	Vacancy rate monitored through Board reporting, People and Performance Committee and Divisional Improvement Forums Safe staffing levels monitored daily in clinical areas. People Operations Group to include a focus on resourcing. EQIA process utilised to support vacancy control decision-making.
Turnover (% FTE)	M5 data for turnover is at 0.5% which is a further decrease than M4 at 0.64%, this remains below target.	The Annual Retention Report was recently presented at the People and Partnership Committee, it outlined the strategic programmes of work to tackle areas where turnover is higher. This includes focussing on what would support colleagues in early career to stay with us, identifying reasons for leaving by HCA colleagues and the fact that a significant proportion stay with us but as a bank worker and increasing our understanding of wider reasons for leaving by improving our data collection methodology.	Annual retention strategy update report provided to Workforce Committee in September 2026. Delivery of retention strategic action plan at corporate level, working with Divisions, Departments and Teams to support improvement in hot spot areas.
Sickness Absence (% FTE)	Sickness absence remained high in M5. Although there was a small improvement in the long-term absence rate (4.43% compared to 4.62% in M4), this was offset by an increase in the short-term absence rate (1.88% compared to 1.75% in M4).	The Workforce Business Partners are supporting managers to develop targeted action plans in 10 ward areas, although this work is currently behind plan due to gaps in the Workforce team. The business case for a Digital Sickness Absence system has been developed and is in the review and approval process. This is essential to provide full organisational oversight of sickness absence management, with the additional benefit of it being a tool to push out wellbeing advice and information to colleagues. All long-term sickness absence cases >6 months have recently been reviewed due to increasing numbers. There is evidence of slippage in policy milestones and management plans have therefore been refreshed.	'Failure to manage sickness absence management effectively' is a Principal Risk and subject to risk management review Annual Health and Wellbeing report, including a deep dive around sickness absence was presented to the July 2026 People & Partnerships Committee Waste Recovery Scheme around sickness absence reduction devolved to divisions and monitored through Divisional Delivery Group and Divisional Improvement Forums.

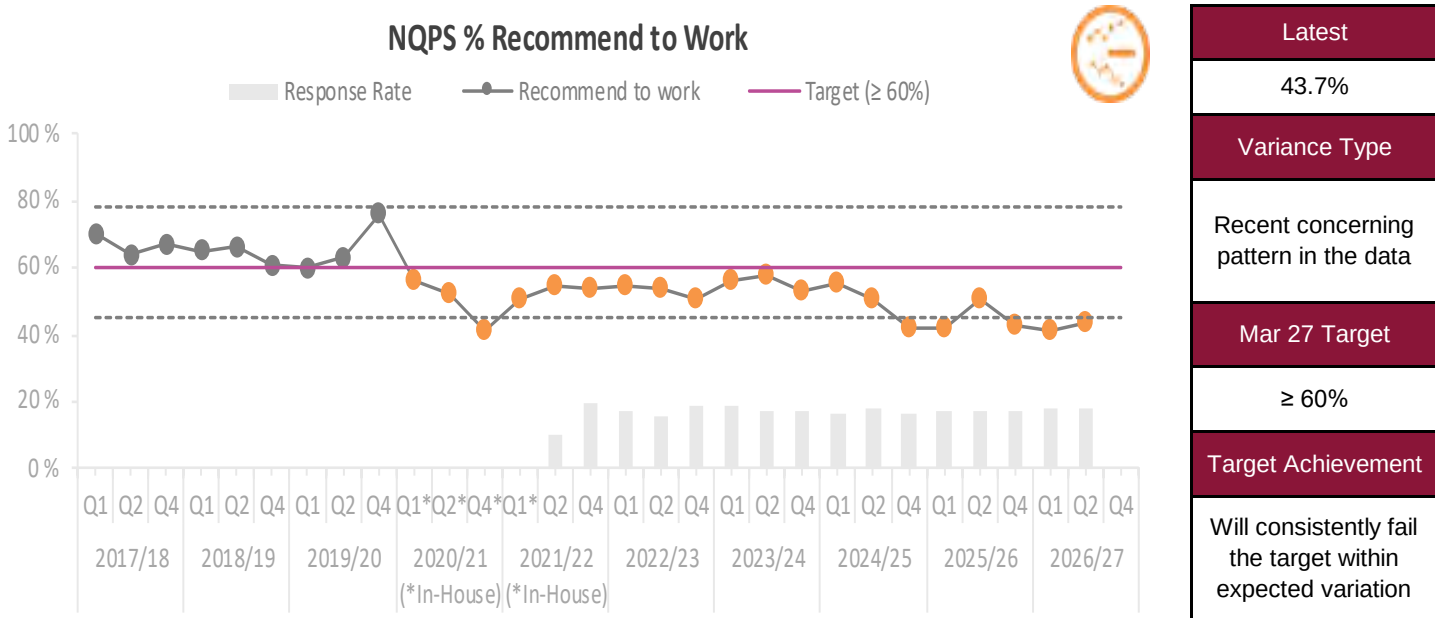
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People - Workforce Assurance 2



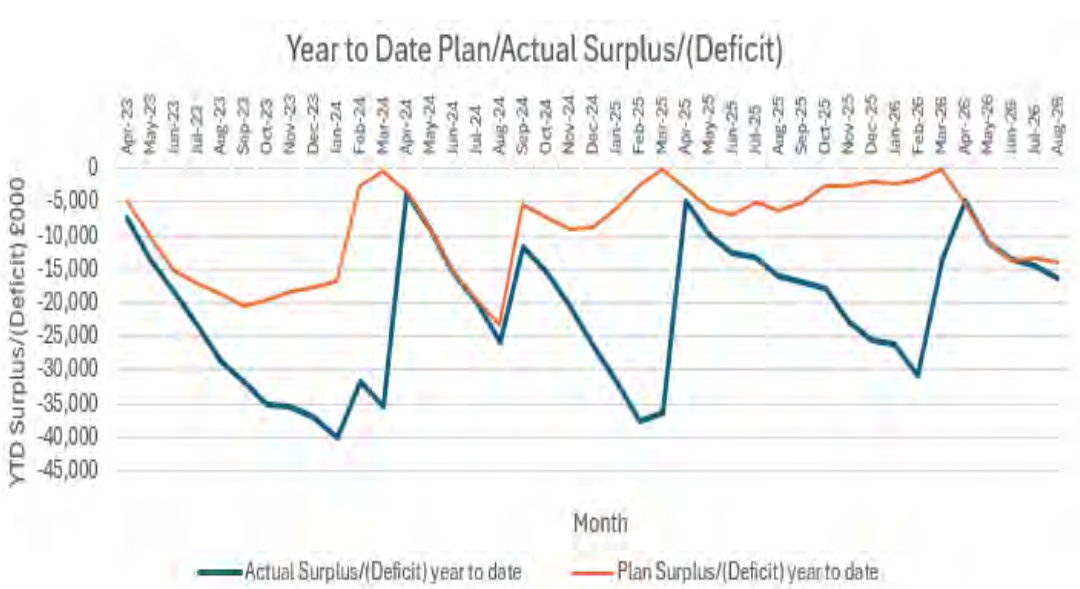
Metric	Summary	Action	Assurance
Number of violence and aggression incidents toward staff	The number of reported violence and aggression incidents continues to fluctuate monthly, and increased in M5 (135 incidents, compared to 99 in M4). The highest number of incidents consistently occur in Emergency Department and other areas where the nature of the patient's condition makes them more prone to violent and aggressive behaviour.	A Rapid Improvement Workshop was held in M4 with good multi-disciplinary engagement, and this generated new test of change ideas to supplement existing improvement work. A further workshop will be held in M6, which will focus mainly on the Zero Tolerance letter process. Targeted improvement work continues in Emergency Department including planned Estates developments to improve security.	Annual deep dive reports around incidents and actions to People and Partnerships Committee Incident data and reviewed through Health & Safety Governance Group
Core Skills Mandatory Training compliance (% modules)	Trust-wide compliance meets or exceeds the 90% threshold across all Core Skills and nationally mandated metrics, supported by established governance, reporting and escalation arrangements.	Divisional management teams are provided with both percentage compliance data and non-compliant staff numbers to support local accountability, prioritisation and escalation in accordance with the Mandatory Training Policy. For practical training requirements, session and assessment capacity is routinely reviewed, with targeted support implemented where additional capacity or improvement action is identified.	People and Partnerships Committee receives assurance on the Trust's governance, monitoring and escalation arrangements for statutory and mandatory training.
Appraisal compliance (% HC)	Appraisal compliance was 92.32% for M5, this has slightly increased from 91.1% in M4 and remains above the target of 90%.	To further progress the strategic actions in relation to appraisal, these include delivery of Objective Setting Masterclass training to teams with lowest scores on NHS Staff Survey items relating to appraisal. Embedding career based discussions in appraisal and publishing resources online. Refreshing templates based on NHS Managers Code and Standards and updated organisational values. The appraisal process has recently been audited, with final outcomes to be presented back to the Trust.	Annual Appraisal Update presented to Workforce Committee in May 2026. Divisional Performance metrics shared in Divisional Workforce Committees and Divisional Improvement Forums.

People - Workforce Assurance 3



Metric	Summary	Action	Assurance
Staff Survey: Recommend Trust as place to work	There have been no further changes to this metric, as it is a quarterly metric. Feedback from last report still stands which is - Quarter 2 data set for the question "I would recommend my organisation as a place to work" has marginally increased since Q1 from 41% in Q1 to 43.7% in Q2. This remains below the target score of 60%. Whilst there is a marginal improvement, year on year trends typically see Q2 having slightly higher levels of engagement, this tends to correlate with moving out of winter and different patient pressures. We have in this quater seen a 2% increase in the item "I am enthusiastic about my job" and a similar 2% increase in "I look forward to going to work" when compared with Q1.	A corporate-level action plan is being progressed and all Divisons have a staff survey action plan in place, with Divisions reviewing progress with the Staff Engagement Lead. Teams who are lower scoring have been contacted with the offer of targeted support. Work is now focussing on the next NHS Staff Survey round which will commence in October 2026.	Workforce Committee reports detailing the programme of work in response to NHS Staff Survey data and national benchmarking. Delivery of the corporate action plan progressed through collaboration with relevant teams and leads addressing priorities/themes. Divisional action plans are scheduled for monthly review through Divisional Workforce Committees - frequency and depth of reporting varies across Divisions. Enhanced team support activity is ongoing in targeted areas of concern, with progress tracked and reviewed through Organisational Development operational meetings

Productivity - Assurance



Latest YTD Actual (,000s)
-16,181
Latest YTD Target (,000s)
-13,987
Aug-26 Annual Target (,000s)
0



Latest YTD Actual (,000s)
11,607
Latest YTD Target (,000s)
12,025
Aug-26 Annual Target (,000s)
60,000

Metric	Summary	Action	Assurance
I&E - Plan v Actual variance	The Trust is reporting a £2.20m adverse position to plan to the end of August 2026. The Trust has a YTD £16.18m deficit against a £13.99m planned deficit (including DSF funding of £3.85m). DSF has not been received for M4 and M5 (£1.5m). Month 5 YTD WRP delivery is under-performing by £0.42m, however the NHSE Submitted Plan phasing is heavily weighted to later in the year. The forecast for 2026/27 has been developed based on non-receipt of DSF (best and likely cases include Q2-4 non-receipt, worst case includes further clawback of Q1), unmitigated Pathology industrial action costs as at month 5, further unmitigated Pathology industrial action costs (best and likely case includes £0.10m for M6, worst case includes a further £0.80m for M7-12) and a range associated with WRP delivery risk.	A re-set of the programme structure, governance and reporting for 2026/27 has taken place, including the introduction of the Productivity Board, Financial Recovery Board, DDGs and WRP Review meetings. Headcount reduction continues to be of significant focus with an additional 31.72WTE WRP delivered in M5 (106.29WTE YTD).	Grip and control Interventions and control measures are constantly being reviewed
WRP schemes delivery	The Trust's 2026/27 waste reduction target is £60m, 5.7% of operating expenditure. Month 5 YTD WRP delivery is under-performing by £0.42m, however the NHSE Submitted Plan phasing is heavily weighted to later in the year. The in year Waste Reduction Programme has fully been identified at £60.0m with fully developed schemes to this value. Forecasting of WRP is assumed to be £60.0m best case, £41m likely case and £37m worst case. Confidence levels will continue to be reviewed at DDGs. Scheme development is continuing to ensure that any WRP plan slippage is mitigating.	The Trust has introduced a process to help mitigate the gap on WRP plan. This requests that Divisions review their recruitment pipeline to see what posts can be held to enable realignment to the expected WRP headcount reduction. The Trust has enhanced grip and control activities to mitigate slippage in schemes. For 2026/27 the Trust has implemented its Financial Sustainability Plan with areas aligned to Executive Leads, earlier planning and a focus on sustainable expenditure reduction rather than short term benefits. In September 2026 the Trust has implemented enhanced WRP assurance through the Financial Recovery Board.	Productivity board chaired by CFO External support for specific workstreams. Implementation of Financial Recovery Board, Divisional Delivery Groups and WRP Review meetings Embedding of PMO

9.2 *WINTER PLAN 2026/27

● Decision Item

● K Foster-Greenwood

● 10.50 am

REFERENCES

Only PDFs are attached



9.2 Winter Surge Plan 26-27 Report Board October 2026.pdf



Board of Directors

Meeting of the	Board of Directors	1 October 2026
Title of Report	Winter Surge Planning Report 2026/27	
Report Author	L Walsh – Deputy Chief Operating Officer	
Lead Executive Director	Katie Foster-Greenwood, Chief Operating Officer	
Recommendation/ Actions required	The Trust Board is asked to note the contents of the report and approve the allocation of the 2026/27 Winter Planning budget to support Phase 1 mobilisation and continued development of Phase 2 system schemes.	
	Decision ☒	Assurance ☒ Information ☐
Executive Summary	This paper sets out the 2026/27 Winter Surge Plan for Lancashire Teaching Hospitals NHS Foundation Trust, describing the forecast increase in urgent and emergency care demand, the associated bed-capacity gap, the expected impact on emergency and elective performance if left unmitigated, and the proposed schemes to support delivery through winter. The modelling forecast is based on H1 2026/27 non-elective activity variances, an average length of stay of between 4.1 and 4.4 days, and a planning assumption of 95% occupancy. It indicates a monthly bed gap of between 10 and 73 beds across October 2026 to March 2027, with the greatest pressure in November. If unmitigated, this would lead to an estimated deterioration in four-hour emergency performance of between 0.7% and 5.0% during winter and would reduce inpatient capacity available for elective care, creating a further risk to referral to treatment recovery and planned care delivery. A total winter surge reserve of £800k has been identified. Phase 1 schemes requiring £335,064 of investment have been prioritised for mobilisation based on impact, cost and ease of implementation. Phase 2 schemes are being developed with system partners and will be funded from the remaining allocation, subject to approval. All schemes will be monitored monthly against mobilisation milestones and projected outcomes, with under-delivering schemes considered for disinvestment and reinvestment into alternatives.	
Link to Strategic Objectives 2026/27	Patients – deliver excellent care: Improve outcomes, reduce harm and deliver a positive patient experience.	☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.	☒
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.	☐
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.	☒

	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.	☐
Due Diligence	To give the Committee assurance, please complete the following:	
Operational Group Review:	Central Lancashire Urgent Care Delivery Board / Central Lancashire Operational Delivery Group	September 2026
Committee:	Finance and Performance Committee	September 2026
Link to Board Assurance Framework:	Principal Risk 1 (26/27) - Patient safety and experience within the urgent and emergency care pathway	
Appendices	Appendix 1 Winter Planning 2026/27 Board Assurance Statement	

1. Background / context

Lancashire Teaching Hospitals NHS Foundation Trust has been working with divisional and corporate colleagues to develop options to ensure the effective management of surge demand over the winter months. The 2026/27 budget setting process identified £800k to be held in reserve to support winter demand.

System-wide, divisional and corporate teams have identified schemes to address the bed and capacity deficits, focused on emergency department attendance avoidance, timely discharge home or to the appropriate place of care, length of stay reduction and admission avoidance.

2. Discussion

The non-elective admission plan has been used to calculate a forecast for the second half of 2026/27, based on the variance to plan identified in the first half of the year. Associated bed-day demand has been calculated using an average length of stay of between 4.1 and 4.4 days. A bed gap analysis has then been undertaken based on an assumed bed occupancy of 95%. This remains higher than the NHS England ambition of 92%, but reflects the requirement to balance winter resilience with delivery of the Financial Recovery Plan.

The analysis shows a forecast bed gap of between 10 and 73 beds between October 2026 and March 2027, with the greatest pressure in November. Based on year-to-date performance and the estimated deterioration associated with increased bed occupancy, the unmitigated bed deficit would result in a deterioration in four-hour emergency performance of between 0.7% and 5.0% over winter.

Scheme detail	Duration	Outcome	Cost
Additional paediatric medical capacity	5 months	Reduced waiting times within emergency department and paediatric assessment unit; four-hour breach prevention; increased timeliness of discharge and reduced length of stay.	£70,000
Increased discharge lounge capacity	5 months	Earlier admission to acute medical unit; reduced emergency department overcrowding; reduced 12-hour-plus length of stay.	£25,000
Emergency department transfer team	6 months	Reduced emergency department overcrowding and reduced ambulance handover breaches.	£35,000

Mental health weekend support	6 months	Reduced admissions, emergency department overcrowding, emergency department attendances and long waits for	£52,064
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		mental health transfer.	
High intensity user practitioner	6 months	Increased capacity to reduce emergency department attendance; reduced length of stay; increased admission avoidance; improved four-hour emergency department performance.	£35,000
Increased flu testing using point of care testing	6 months	Increased weekend discharge rate; reduced delayed discharge and length of stay; reduced flu transmission rates; increased site flow.	£85,000
Electronic prescribing	6 months	Reduced length of stay and increased bed capacity.	£33,000
Total			£335,064

Phase 1 schemes require £335,064 from the identified £800k winter surge budget. Phase 2 schemes, supported through system partners, are being scoped and will be considered through the Central Lancashire Operational Delivery Group in September 2026. Following approval, mobilisation will commence as soon as possible.

All schemes are approved based on projected outcomes which will be monitored monthly alongside mobilisation milestones. If any scheme fails to mobilise or under-delivers against outcomes, the Central Lancashire Urgent Care Delivery Board will recommend that funding is disinvested with one month's notice and reinvested in alternative schemes.

3. Financial implications

£800k has been identified in reserve to support winter demand. Phase 1 schemes require £335,064, leaving the remaining allocation available for Phase 2 schemes subject to approval through system governance. The allocation is lower than 2024/25 and remains consistent with 2025/26, creating a residual delivery risk if demand exceeds assumptions or if additional staffing or ward reconfiguration costs are required.

4. Legal implications

None identified within the paper.

5. Risks

The key risks are the reduced winter funding envelope compared with 2024/25; uncertainty around seasonal infection levels; potential constraints in securing temporary staffing; residual risk of boarding if demand cannot be fully mitigated; and possible cost implications if ward moves or reconfigurations are required. Mitigations include targeted winter schemes, monthly performance and mobilisation monitoring, potential disinvestment and reinvestment of under-delivering schemes, continued embedding of emergency care streaming and flow models, and delivery of the 2026/27 staff vaccination campaign.

6. Impact on stakeholders

The plan impacts patients, operational divisions, corporate teams, emergency and urgent care services, elective services, system partners and staff. The intended benefits are improved emergency department flow, admission avoidance, timely discharge, reduced length of stay, protection of elective capacity and improved resilience during periods of seasonal infection. Communication and mobilisation will be managed through divisional,

corporate and system governance routes, with Phase 2 schemes considered through the Central Lancashire Operational Delivery Group.

7. Recommendations

It is recommended that:

- I. The Committee notes the contents of the report and the risks associated with winter surge demand.
- II. The Committee approves the allocation of the 2026/27 Winter Planning budget to support Phase 1 mobilisation and continued development of Phase 2 system schemes.

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

10.1 *PEOPLE & PARTNERSHIPS COMMITTEE CHAIR'S REPORT

● Other

👤 S Crean

🕒 11.00 am

Item for assurance

Including recommendations on the following reports*:

a) a) Appraisal, Revalidation and Medical Governance (GMC) Annual Report

REFERENCES

Only PDFs are attached



10.1 PPC Chair's Report 8 Sept 26 - BoD 1 Oct 26.pdf



10.1a Appraisal, Revalidation and Medical Governance (GMC) Annual Report Summary Board Pt I Oct 2026.pdf

Strategic Risks

Trend

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



ALERT

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

- The Committee expressed concern regarding persistent OneLSC recruitment and estates-related risks, noting that despite mitigations and ongoing review, evidence of operational improvement remained limited.

ADVISE

Areas requiring on-
going monitoring;
Limited assurance
received.

- The Committee discussed workforce inequality and retention data, highlighting the need for improved workforce intelligence to understand the drivers behind pay gap metrics, retention challenges amongst early-career colleagues and the measurable impact of workforce improvement initiatives.

ASSURE

Assurance
received;
Matters of positive
note.

- The Committee received assurance regarding progress against the Education and Research & Innovation Single Improvement Plans, including strengthened governance arrangements, academic partnerships and continued progress towards University Hospital Status.

The Board of Directors is asked to:

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

Report	Meeting Date	Committee recommendation for Board
• Appraisal, Revalidation and Medical Governance Annual Report	8 Sept 2026	Endorsed



Board of Directors Report

Meeting of the	Board of Directors		01/10/2026
	Part I ☒	Part II ☐	
Title of Report	Appraisal, Revalidation and Medical Governance (GMC) Annual Report		
Report Author	Eric Mutema, Deputy Chief Medical Officer, Louisa Graham, Deputy Chief People Officer Laura Chapman, Head of Workforce Advice Debbie Kellett, Revalidation and Appraisal Manager Pauline North, Head of Medical Workforce		
Lead Executive Director	Steve Canty, Chief Medical Officer		
Recommendation/ Actions required	The Board of Directors is asked to approve the report.		
	Decision ☒	Assurance ☐	Information ☐
Executive Summary	This is a national submission and has to follow the template provided by NHS England North West and must be submitted to them by the 30th October 2026 with the signed statement of compliance. The purpose of this report is to set out the information that a designated body is expected to report upon, through their Higher-Level Responsible Officer (HLRO), to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards. The report provides assurance regarding the Trust's compliance with Responsible Officer Regulations and the effectiveness of appraisal, revalidation and medical professional standards arrangements during 2025/26.		
Link to Strategic Objectives 2026/27	Patients – deliver excellent care: Improve outcomes, reduce harm and deliver a positive patient experience.	☒	
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.	☒	
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.	☐	
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.	☐	
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.	☒	

Due Diligence	To give the Trust Board assurance, please complete the following:	
Committee Approval:	People and Performance Committee	September 2026
Operational Group Review:	Name of Operational Group:	Date:
Link to Board Assurance Framework:	N/A - No aligned to a Principle Risk	
Appendices	State whether there are any appendices and list them. For example: Appendix 1: 2025-26 Annual Submission	

1. Introduction

The report provides the Board of Directors with assurance regarding the Trusts compliance with Responsible Office Regulations, medical appraisal, revalidation and professional standards for doctors connected to Lancashire Teaching Hospitals NHS Foundation Trust in 2025/2026.

There are updates on the actions that were identified in last year's annual submission. The report also highlights emerging risks, and priorities for 2026/27 which include: - reviewing capacity and resilience, completing the appraisal policy review, strengthening governance processes, and implementing forthcoming GMC requirements for Physician Associates and Physician Associates in Anaesthesia.

2. Financial implications

None

3. Legal implications

The report supports the Trust's statutory obligations under the Medical Profession (Responsible Officers) Regulations 2010, GMC revalidation requirements and associated professional governance responsibilities.

4. Risks

The principal risk identified is the increasing demand on appraisal and revalidation processes without a corresponding increase in dedicated resource and maintaining sufficient numbers of Medical Appraisers.

5. Impact on stakeholders

Not applicable

6. Recommendations

It is recommended that:

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

BREAK

🕒 11.20 am

11. PATIENTS (SAFETY AND QUALITY)

11.1 *SAFETY AND QUALITY COMMITTEE CHAIR'S REPORT

Other

K Deeny

11.40am

Item for assurance

Including recommendations on the following reports*:

- a) Perinatal Workforce Report
- b) Bi-Annual Adult & Children Safe Staffing Review
- c) Bi-Annual AHP Staffing Report
- d) Health and Safety Annual Report

REFERENCES

Only PDFs are attached

-  11.1 SQC Chair's report 31 July 28 Aug 2026.pdf
-  11.1a Perinatal Workforce Report Summary Board Pt I October 2026.pdf
-  11.1b Bi-Annual Adult & Children Safe Staffing Review Summary Board Pt I October 2026.pdf
-  11.1c Bi-Annual AHP Staffing Report Summary Board Pt I October 2026.pdf
-  11.1d Health and Safety Report Summary Board Pt I October 2026.pdf

Chair's Report to Board			
Chair: Dr Karen Deeny	Committee:	Safety	& Quality
Committee			
Date(s): 31 July and 28 August 2026			

Strategic Risks	Trend
Patients - deliver excellent care	 15

ALERT

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

- Coroner's Ruling – Neglect 176666: The Committee recognised the significance of the case, the impact on the patient and family, and the extensive work undertaken in response. Significant organisational learning has been identified regarding safeguarding vulnerable patients, with workforce, leadership and governance actions implemented and HR processes completed where appropriate, Trust-wide learning shared, and consideration being given to independent audit of action implementation.

ADVISE

Areas requiring on-
going monitoring;
Limited assurance
received.

- The Harris Flex risk has now been formally reflected within the Strategic Risk Register. While the underlying issue had been recognised for some time, the Committee noted that the risk had not previously been fully articulated within the Trust's strategic risk framework and welcomed the strengthened oversight arrangements.
- Workforce productivity and efficiency continue to improve in nursing while maintaining a focus on patient safety. Benchmarking data demonstrated improved performance in care hours per patient day, with the Trust moving from the fourth to the third national quartile. Safety monitoring remains in place as per safe staffing arrangements. The Committee noted ongoing recruitment activity, monitoring of fill rates and the continued application of national workforce benchmarking evidence.
- The Trust received a significantly more challenging *Clostridioides difficile* objective of 109 cases for 2026/27, compared with 167 in the previous year, against which the Trust had reported 122 cases. The Committee noted this represented a substantial improvement challenge for the coming year. *Clostridioides difficile* cases exceeded the monthly tolerance during July. Infection Prevention and Control (IPC) Committee oversight remains in place; recognised seasonal factors, targeted infection control actions and monitoring through escalation mechanisms support expectations that performance will return to trajectory.
- Positive feedback was received following a recent external NHS England regulation mock inspection of Children's Services, Maternity, End of Life Care and Critical Care. The review highlighted strong cultures of openness, transparency and patient-centred care and provided assurance regarding the integrity of the Trust

STAR quality assurance framework. Ongoing improvement work within the Medicine Division and recent Maternity and Neonatal assurance visits were also noted. The Committee emphasised the importance of more proactively communicating positive outcomes and organisational improvements to staff and stakeholders.

- Significant progress had been demonstrated through the STAR programme, with substantial improvements in compliance across a number of divisions since the previous annual report. Targeted action plans remained in place for areas requiring further improvement, and the Committee considered the remaining objectives achievable with continued focused support.
- Recruitment to the Decontamination Lead post remained unsuccessful following previous recruitment rounds. There is ongoing Infection Prevention and Control (IPC) Committee oversight, with mitigations in place through regional decontamination leadership support, specialist oversight arrangements and continued monitoring of incidents and infection prevention risks.
- Pressure ulcer performance showed improvement, reaching the lowest level recorded since May 2024. The Committee advised continued monitoring to ensure improvements were sustained, supported by a 10-point improvement plan, enhanced governance, preventative ward rounds, intentional rounding audits and divisional oversight.
- National clinical audit findings have identified several areas requiring improvement and enhanced assurance arrangements. A risk-based approach to interim monitoring and local audit activity to be developed to ensure timely improvement ahead of future national audit reporting cycles.
- Strategic risk management arrangements continued to mature through the consolidation of duplicated divisional risks into organisation-wide programmes of work, improving oversight and focusing effort on delivery of mitigations and outcomes rather than maintenance of multiple risk registers.
- Pathology remains under enhanced regulatory and organisational oversight during the pathology network transition and period of industrial action. Strengthened governance arrangements, additional operational support, executive oversight, performance reporting and quality monitoring processes had been established to mitigate risks and support recovery.

ASSURE

Assurance received; Matters of positive note.

- The Committee received assurance regarding compliance with Maternity and Neonatal Safety Standards, supported by workforce diagnostics, phased recruitment plans and ongoing workforce reviews. Additional assurance was provided that neonatal staffing remained largely compliant with required standards, with clear plans in place to address remaining gaps. The perinatal leadership attended for these items.
- The Committee received assurance regarding Mortuary and Care After Death Services that no incidents of harm had been identified through incident reporting, assurance visits or external inspection activity. Additional assurance would be provided through executive and non-executive visits to the mortuary service. The Committee supported ongoing oversight through annual reporting, inclusion within the STAR assurance framework and consideration of future internal audit review.
- Patient Safety Incident Response Framework arrangements continued to mature, with strengthened system-wide learning, joint investigations and enhanced governance through the Always Safety First strategy and learning programmes.

- AHP workforce reporting provided assurance that safe staffing arrangements remained in place, with targeted action underway to address workforce pressures, recruitment challenges and productivity opportunities identified through benchmarking.
- The external Endoscopy review confirmed significant service improvement, recovery of performance standards and progress towards Joint Advisory Group (JAG) reaccreditation. Mitigations remained in place for outstanding actions, including pre-assessment provision and digital solutions, with sustained oversight through established governance arrangements.

The Board of Directors is asked to:

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

Report	Meeting Date	Committee recommendation for Board
a) Bi-Annual Adult & Children Safe Staffing Review	31 July 2026	The Committee confirmed its assurance in respect of the Nursing and Midwifery Workforce Review.
a) Bi-Annual AHP Staffing Report	28 Aug 2026	The Committee confirmed its assurance in respect of AHP safe staffing and supported the continued development of the digital AHP safe staffing dashboard.
b) Perinatal Workforce Report	25 Sept 2026	Verbal recommendation to be provided in the Board meeting.
c) Health and Safety Annual Report	25 Sept 2026	Verbal recommendation to be provided in the Board meeting.



Board of Directors

Meeting of the	Board of Directors	01 October 2026	
Title of Report	Perinatal Workforce Report		
Report Author	Emma Ashton – Divisional Midwifery & Nursing Director		
Lead Executive Director	Sarah Morrison – Chief Nursing Officer/Deputy Chief Executive Officer		
Recommendation/ Actions required	The Board of Directors are asked to: 1. Approve the Perinatal Workforce Report and associated action plans, noting its scrutiny and endorsement by the Safety and Quality Committee. 2. Note the gaps in provision, in line with standards for neonatal services, that require further consideration and a plan to address them. 3. Note the requirement to fund, as planned, year 2 of Birthrate Plus, and for this to be included as part of the budget-setting process. 4. Accept that, in line with NHS Improvement Workforce Safeguards guidance, the Chief Nursing Officer and Chief Medical Officer confirm that they are satisfied with the outcome of the annual safe staffing assessment and that, while risks remain that require active management, approved staffing levels, with the addition of the two additional obstetricians, are considered safe, effective and sustainable.		
	Decision ☒	Assurance ☐	Information ☐
Executive Summary	The Perinatal Workforce Report reviews the safety, sustainability and effectiveness of the maternity, obstetric, anaesthetic, neonatal and wider perinatal workforce at Lancashire Teaching Hospitals NHS Foundation Trust for the period March to August 2026. The review has been undertaken in line with National Quality Board (NQB) Safe Staffing Guidance and NHS Resolution Maternity Incentive Scheme (MIS) Year 8 requirements. The report concludes that maternity and perinatal services continue to provide safe care despite workforce and operational pressures. Strong governance arrangements, daily staffing oversight, robust escalation processes and high compliance with key safety standards provide assurance that risks are being appropriately managed. The Birthrate Plus® review undertaken in 2025 identified that the midwifery establishment was below recommended levels. The Trust Board approved a phased investment programme to increase midwifery staffing, with the majority of funding released during 2026/27. Midwifery fill rates remained generally high throughout the reporting period, although some deterioration was seen in July and August 2026 due to rising sickness absence. Sickness rates increased from 4.57% in May to 9.32% in July, reducing slightly to 8.28% in August. Staffing pressures are managed through redeployment, escalation processes and use of temporary staffing where required.		

	The Birthrate Plus Live Acuity Tool data demonstrates ongoing staffing pressures in Delivery Suite and both maternity wards. The majority of women requiring care on the Delivery Suite were classified within the highest acuity categories (Category IV and V), reflecting increased complexity and support needs. A review of maternity staffing models is underway to ensure workforce deployment better reflects demand and patient flow, with implementation expected to commence by December 2026. Performance against national maternity workforce safety standards remains strong, with one-to-one care in labour, supernumerary labour ward coordinator, obstetric consultant availability and obstetric anaesthetic cover all remaining compliant. The obstetric workforce remains under pressure because of consultant vacancies, long-term sickness absence, maternity leave and increased demand for both elective and emergency caesarean sections. The service is recruiting additional substantive consultants, expanding the resident doctor rota to establish a two-tier model, and working to separate the obstetric and gynaecology on-call rotas. In addition, the service is reviewing caesarean section capacity and demand, with findings to be presented to committee in due course. Neonatal medical staffing broadly meets BAPM standards, although workforce vacancies remain within Tier 1, Tier 2 and Advanced Neonatal Nurse Practitioner roles. The neonatal unit remains compliant with Tier 1 and Tier 2 rota requirements; however, consultant cover remains slightly below national standards, with a four-hour gap in resident consultant coverage during the week. Workforce reviews and action planning are underway to address remaining gaps. Review of neonatal nursing identified workforce risks, with a deficit of 2 WTE cot-side neonatal nurses against national workforce calculator recommendations. In addition, the review identified a requirement for an additional 5.51 WTE neonatal nurses to safely staff transitional care services. Shortages were also identified within specialist nursing, psychology, therapy and pharmacy services when benchmarked against BAPM and GIRFT recommendations. Psychology provision is not currently available against a recommended 1.7 WTE establishment, and a business case is being progressed to address this. Action plans are in place for each part of the workforce that does not fully comply with guidance, with evidence of actions being taken in response to multiple sources of intelligence. Following the publication of Ockenden, Amos and the Thirlwall Inquiry, further work is now required to plan the approach to neonatal staffing; therefore, no changes are requested as part of this review, recognising that the service is stable with no evidence of adverse outcomes for babies. The Safety and Quality Committee continues to receive monthly children and neonatal reports on service outcomes, staffing and standards to ensure suitable oversight is in place. Following publication of the National Maternity Triage Specification in July 2026, the maternity service has completed the national benchmarking audit exercise, which was presented to the Safety and Quality Committee in September 2026 prior to submission to NHS England by 25 September 2026. The report provides positive assurance regarding the safety and governance of perinatal staffing arrangements, supported by strong compliance with key maternity safety standards and ongoing investment in workforce expansion. However, neonatal nursing, specialist neonatal services, increasing patient acuity, induction of labour delays, workforce sickness and obstetric workforce sustainability remain the principal areas requiring continued oversight and focused action during 2026/27.	
Link to Strategic Objectives 2025/26	Patients – deliver excellent care: Improve outcomes, reduce harm and deliver a positive patient experience.	☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.	☒
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.	☒

	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.		☒
	Partnership – be fit for the future: Be an active system partner, leading to the delivery of the system clinical strategy, university hospital status, and fulfil our anchor and green plan ambitions.		☒
Due Diligence	To give the Trust Board assurance, please complete the following:		
Committee Review:	Safety and Quality	Date: September 2026	
Link to Board Assurance Framework:	PR1 – Patient Safety and Experience within the Urgent and Emergency Care Pathway PR2 – People Experiencing Health Inequalities PR7 – Experience of Under-Represented Staff Groups PR8 – Experience of Staff and Levels of Staff Satisfaction		
Appendices	Appendix Report 1 – Perinatal Workforce Report Appendix Report 2 - Maternity Safety & Quality Dashboard Appendix Report 3 – Obstetrics and Gynaecology Cultural Improvement Action Plan Appendix Report 4 – Maternity Workforce Action Plan Appendix Report 5 – Neonatal Action Plan		



Board of Directors

Meeting of the	Board of Directors		01 October 2026
Title of Report	Bi-annual Nursing and Midwifery Workforce Review		
Report Author	Catherine Gregory - Deputy Chief Nursing Officer, Nicola Ross – Head of Safe Staffing		
Lead Executive Director	Sarah Morrison Chief Nursing Officer		
Recommendation/ Actions required	The Board of Directors are asked to: approve the bi-annual staffing review to the Board, confirm it is satisfied of the assurances within the report.		
	Decision ☒	Assurance ☐	Information ☐
Executive Summary	This bi-annual review provides assurance that nursing and midwifery staffing establishments across the Trust remain safe, effective and sustainable. Whilst a number of workforce related risks have been identified, these are principally associated with workforce resilience and longer-term sustainability rather than immediate safety concerns and are being actively managed through established governance arrangements. The review has been undertaken in line with NHS Improvement workforce safeguards, National Quality Board guidance and NICE safe staffing principles. The review has been conducted as a desk top review by the Chief Nursing Officer (CNO). This has included the Deputy CNO, Matron for Patient Safety and Safe Staffing and involving each Divisional Nurse Director from the Clinical Divisions. The review has used triangulated staffing data alongside professional judgements, patient outcome and experience data and workforce data. The review concludes that staffing establishments remain safe and appropriate across all divisions. Workforce requirements have been assessed using recognised evidence-based methodologies, including the Safer Nursing Care Tool (SNCT), Birthrate Plus and relevant speciality-specific workforce standards. The review found no direct evidence that current vacancy levels are resulting in a deterioration in patient safety, patient experience or quality outcomes, albeit, there is an increase noted in pressure ulcers and complaints and it is likely the lack of substantive staff will be a feature of this hence the robust approach and firm strategy on the recruitment of substantive HCA positions. Safe fill rates continue to be maintained through established robust staffing escalation processes, flexible workforce deployment and effective divisional oversight.		

	Key risks identified relate to workforce sustainability and service resilience. These include Healthcare Support Worker vacancies, increasing patient acuity and dependency, patient flow pressures, specialist workforce shortages, leadership resilience, training capacity requirements, pharmacy support provision and cultural challenges within specific services. Findings at Divisional/Specialty level: Across Medicine and Surgery, staffing is sufficient to meet patient need. Some variances in SNCT requirements are evident in high-acuity areas, assessment units and services experiencing operational reconfiguration, increased dependency and patient flow pressures. Whilst these factors have reduced workforce resilience in some areas, triangulation confirms safe care is being maintained through established mitigation and escalation processes. In the Emergency Departments, SNCT variance is recognised and expected due to the limitations of the tool in reflecting prolonged length of stay, corridor care and boarding. Professional judgement, supported by operational data, confirms that safe care continues to be delivered, albeit within a highly pressurised environment. Within Diagnostic and Clinical Support (DCS) Division, Critical Care staffing was assessed as safe, supported by improving sickness absence trends, stable staffing performance and positive peer review findings. The principal risks identified relate to workforce sustainability, pharmacy provision, rehabilitation capacity and wider multidisciplinary team optimisation rather than immediate patient safety concerns. In Children's services, SNCT and professional judgement confirm safe staffing. Variance is minimal; however, workforce sustainability risks have been identified, particularly within neonatal services due to sickness levels and specialist staffing requirements. Within Women's services, staffing is considered safe when triangulated. Birthrate Plus and workforce data highlight ongoing gaps and pressure within the obstetric workforce, alongside leadership and cultural challenges. This division represents the highest risk, however there is no evidence of patient harm as a result of staffing. A plan to recruit to phase 1 of birthrate plus is being enacted and recruitment is expected to be complete by October 2026. Phase 2 of Birthrate plus investment will commence April 2027. Registered nurse vacancy rates continue to improve (circa 30 vacancies including maternity leave) however, workforce sustainability risks remain within support worker (circa 250WTE vacancies) and specialist staff groups. Divisional action plans have been developed to address identified risks and improvement opportunities. Progress is monitored through established governance arrangements. These actions include workforce planning, recruitment and retention initiatives, leadership development, pharmacy escalation arrangements, workforce redesign and service-specific quality improvement programmes.
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	Having reviewed the findings of this assessment, the Chief Nursing Officer is assured nursing and midwifery that staffing establishments remain safe, effective and sustainable. Identified risks are well understood, subject to mitigation and monitored through established governance structures to ensure continued delivery of high-quality patient care.	
Link to Strategic Objectives 2026/27 <i>(Please mark X against the strategic objective(s) applicable to this paper - this could be more than one)</i>	Patients – deliver excellent care: Improve outcomes, reduce harm and deliver a positive patient experience.	☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.	☒
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.	☒
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.	☒
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.	☐
Appendices	Appendix 1: Ancillary Pack – Full Report Appendix 2: Care Hours per Patient Day (CHPPD) Appendix 3: Safe Staffing Quality Assurance Dashboard Appendix 4: Acuity Levels calculated from the validated SNCT tool	



Safety and Quality Committee

Meeting of the	Board of Directors	01 October 2026	
Title of Report	Allied Health Professionals Bi-annual Safety & Quality Review		
Report Author	Claire Granato – Chief Allied Health Professional		
Lead Executive Director	Sarah Morrison – Chief Nursing Officer and Deputy Chief Executive		
Recommendation/ Actions required	The Board of Directors are asked to: I. Receive this report and confirm it is satisfied of the assurances for AHP safe staffing II. Support the continued development of the digital AHP safe staffing dashboard		
	Decision ☐	Assurance ☒	Information ☐
Executive Summary	This bi-annual review provides the Safety and Quality Committee with an assessment of safe staffing across all ten Allied Health Professional (AHP) groups at Lancashire Teaching Hospitals (LTH) for the period January to June 2026. In line with the National Quality Board and NHS Improvement Developing Workforce Safeguards guidance, the report triangulates workforce, quality and safety indicators to provide assurance of safe staffing in the absence of nationally mandated AHP staffing tools. Overall, the report provides assurance that AHP services have remained safe throughout the reporting period, with only one moderate and no severe harm incidents attributed to AHP workforce shortages and continued evidence of strong professional governance, workforce leadership and service quality. Training compliance remains high across most professional groups, 10 AHP departments currently hold Gold STAR accreditation, and four workforce risks have been sufficiently mitigated to be recommended for closure. Significant workforce challenges continue to affect a number of services. In 2026 the Trust implemented a vacancy sweep process across the organisation as part of the Workforce Reduction Plan (WRP) measures. This process resulted in vacant posts being removed from funded establishments. There is currently a reduction in funding for 45.47WTE across the AHP areas. This includes reductions in Diagnostic Radiography (10%) and Speech and Language Therapy (16%). While currently the risk to safe staffing is minimal. A clear understanding of the impact and actual establishment reductions will not be gained until the full review has taken place which is due to be completed by October with an update to the committee in the next bi-annual report.		

	Workforce pressures remain most evident within Diagnostic Radiography, Speech and Language Therapy, Occupational Therapy, Physiotherapy and Orthoptics, all of which are rated Amber within the AHP safe staffing dashboard. Key contributing factors include recruitment challenges, sickness absence, maternity leave, workforce shortages and capacity pressures. Diagnostic Radiography continues to hold the highest workforce-related risks, particularly within Ultrasound and Chorley services, although improvements have been seen in the Sonography workforce through reductions in maternity leave and sickness absence. The review identifies opportunities to strengthen investment in AHP services, particularly within Physiotherapy and Occupational Therapy, where national Model Health benchmarking suggests staffing levels are comparatively low relative to peer organisations. Given the Trust's specialist service profile, there may be opportunities to realise quality and productivity benefits through targeted workforce growth. The report concludes that AHP staffing remains safe overall, with effective mitigations in place for identified workforce risks. However, continued scrutiny is required regarding the impact of the vacancy sweep, workforce sustainability within Diagnostic Radiography and Speech and Language Therapy and sickness absence in a small number of services. The AHP workforce dashboard is under development, and a digital version is expected for the next report to the committee.	
Link to Strategic Objectives 2026/27	Patients – deliver excellent care: Improve outcomes, reduce harm and deliver a positive patient experience.	☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.	☒
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.	☒
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.	☒
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.	☐
Link to National Guidance and/or Framework:	NHS Improvement - Developing Workforce Safeguards (2018) National Quality Board Safe, Sustainable and Productive Staffing	
Committee Review	Safety and Quality Committee	August 2026
Appendices	Appendix 1: Ancillary Pack – Full Report Appendix 2: AHP Vacancy SPC Charts Appendix 3: Action Plan	



Board of Directors

Meeting of the	Board of Directors	01 October 2026	
	Part I ☒	Part II ☐	
Title of Report	Health and Safety Report		
Report Author	Emma Denfhy – Deputy Associate Director of Risk and Assurance Hajara Ugradar – Associate Director of Risk, Assurance, and Corporate Affairs		
Lead Executive Director	Sarah Morrison, Deputy Chief Executive/ Chief Nursing Officer		
Recommendation/ Actions required	The Board of Directors is asked to: Receive assurance on the progress made to strengthen health and safety governance arrangements, noting that the report has been scrutinised at Safety and Quality Committee and that further work remains required in relation to statutory compliance, estates-related risks and local risk assessment oversight.		
	Decision ☐	Assurance ☒	Information ☐
Executive Summary	This report provides an update to the Board of Directors on the Trust's health and safety governance arrangements, statutory compliance position, risk profile and key improvement priorities for the period November 2025 to August 2026 (covering the period since the last update to Safety and Quality Committee). The report has been scrutinised at Safety and Quality Committee and is presented to the Board for oversight and assurance, highlighting areas where governance and visibility have strengthened alongside areas where further work, investment and sustained oversight remain required. The Chief Nursing Officer is the lead executive for health and safety compliance and assurance, with the Chief People Officer retaining responsibility for the People function and the Chief Finance Officer retaining responsibility for estates and facilities. Since the previous update, the Trust has further strengthened its health and safety governance arrangements through monthly Health and Safety Governance Group (HSGG) meetings, improved reporting, enhanced scrutiny of statutory compliance, incident themes and risks, and clearer escalation routes into the Safety and Quality Committee and Trust Board. Substantial progress has been made against the 2025 Mersey Internal Audit Agency (MIAA) Health and Safety Governance recommendation, with evidence submitted to support closure of one remaining recommendation. Formal closure remains subject to MIAA review and confirmation. The report demonstrates that the Trust has improved visibility and grip of health and safety governance. However, this should be understood as strengthened oversight rather than full resolution of all underlying risks. The Trust continues to manage a complex health and safety risk profile, with key areas requiring sustained attention relating to ageing estate infrastructure, statutory compliance		

	within specific engineering disciplines, water safety, ventilation, electrical resilience, fire safety, workforce capacity, violence and aggression, environmental conditions, security arrangements and local risk assessment oversight. The Trust continues to monitor and manage compliance across key statutory areas. However, material challenges remain in relation to water safety, ventilation systems, low-voltage electrical infrastructure, fire safety and pressure systems and are subject to ongoing oversight. These issues are linked to ageing infrastructure, historical maintenance backlog, incomplete inspection programmes, assurance documentation gaps and workforce capacity constraints within operational estates services. Mitigation measures remain in place, with improvement activity overseen through Estates and Facilities governance arrangements and escalated through HSGG where required. As at the end of August 2026, there were 75 active risks aligned to HSGG. See Appendix 1 for more detail. From October 2026, HSGG will commence a structured review of the highest-scoring and longest-standing risks to support further challenge, escalation, risk reduction and clearer oversight of barriers to progress. Ward and departmental health and safety risk assessments are undertaken locally; however, the report identifies that corporate visibility of the quality, currency, review status and action tracking of these assessments is not yet consistent. Targeted deep-dive reviews have commenced in higher-risk and priority areas, and learning from these reviews will inform a phased, risk-based approach to strengthening local risk assessment oversight over the next 18 months. Incident, audit and inspection intelligence continues to provide an important source of assurance and organisational learning. During the reporting period, non-patient incident reporting highlighted recurring themes relating to workforce pressures, violence and aggression, estate-related issues, infection prevention compliance, digital system resilience and occupational safety. RIDDOR reporting arrangements remain in place, with reportable incidents investigated and learning progressed through relevant governance routes. Targeted safety communications are also being used to reinforce learning and safe practice, with the Health & Safety Bulletin providing practical guidance to staff on areas including sharps safety, clinical waste segregation, estates and incident reporting, and safe use of bariatric equipment. Audit, accreditation and external inspection activity has provided useful assurance that issues are being identified, escalated and acted upon, while also confirming areas where controls and monitoring require further strengthening. External inspections during the period included activity by the Health and Safety Executive, Lancashire Fire and Rescue Service, Environmental Health Services and Griffith & Armour. No enforcement or prohibition notices were issued during the reporting period although recommendations have been made in some areas. Work is underway to strengthen monitoring, tracking and reporting of fire action plans, with the proposed approach due to return to HSGG in November 2026. Health and safety training compliance remains strong across most core training areas, including Health, Safety and Welfare, Fire Safety, Infection Prevention and Control, Moving and Handling and Conflict Resolution. Display Screen Equipment (DSE) compliance remains below target and is a priority area for improvement. A small number of staff currently hold qualifications awarded by the National Examination Board in Occupational Safety and Health (NEBOSH) or have completed Institution of Occupational Safety and Health (IOSH) training providing some specialist health and safety expertise. To strengthen assurance and
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	sustainability, the Health and Safety Training Needs Analysis is being reviewed through the Single Improvement Plan. This will confirm competency requirements, current coverage and any specialist training gaps, informing a prioritised training plan by March 2027. Progress is being monitored through established SIP governance arrangements. The Health and Safety Team structure has been strengthened in response to resilience risks identified through the internal and MIAA review. Recruitment has been completed to key posts, with the full structure expected to be in place by December 2026. This additional capacity is an important enabler in moving from improved monitoring and coordination into more proactive audit, risk assessment support, action tracking, assurance testing and improvement activity across the organisation. The Board is asked to note the maturing health and safety governance arrangements, improved visibility of statutory compliance and risk, and clearer arrangements for escalation and oversight. However, the scale and complexity of the remaining work should not be underestimated. Key priorities to March 2027 include stabilising the estates and facilities workforce structure with OneLSC to enable focused delivery on key improvements, further strengthening performance indicators and dashboard reporting, progressing a phased programme of risk assessment and audit activity, reviewing longstanding and high-scoring risks, strengthening fire action plan monitoring, and improving Display Screen Equipment assessment compliance.	
Link to Strategic Objectives 2026/27	Patients – deliver excellent care: Improve outcomes, reduce harm and deliver a positive patient experience.	☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.	☐
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.	☒
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.	☐
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.	☒
Due Diligence	To give the Committee assurance, please complete the following:	
Committee Approval:	Name of Committee: Safety and Quality Committee	Date: 25 September 2026
Operational Group Review:	Health and Safety Governance Group Health and Safety Joint Staff Side Meeting	Date: 16 September 2026 23 September 2026
Link to Board Assurance Framework:	Principal Risk 12 (26/27) - Ability to access required Capital to support an ageing estate	
Appendices	Appendix One – Active Operational Risks Aligned to Health and Safety Governance Group. Appendix Two – Non-Patient Incident Profile for Reporting Period Appendix Three – Summary of External Inspections, Reviews and Accreditation Visits 01.11.2025 to 31.08.2026 Appendix Four – Targeted Health and Safety Bulletin	

12.1 *FINANCE AND PERFORMANCE COMMITTEE CHAIR'S REPORT

● Other

👤 K Deeny

🕒 11.55 am

Item for assurance

Including recommendations on the following reports*:

a) EPRR Core Standards Annual Assessment

REFERENCES

Only PDFs are attached

 12.1 FPC Chair's Report Jul Aug 26 - BoD 1 Oct 26.pdf

 12.1a EPRR Core Standards Annual Assurance Exec Summary Board Pt I Oct 2026.pdf

Strategic Risks

Trend

Deliver Value for Money – 20
Fit for the Future - 16



ALERT

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

- **WRP Delivery and Workforce Reduction** – concerns remained regarding delivery confidence and workforce reduction progress, with further assurance required on delivery of the full-year target.
- **Digital Dependencies** – delays to key digital programmes continued to impact delivery of planned transformation, workforce and productivity benefits.
- **Patient Flow and Days Kept Away from Home** – levels of patients remaining in hospital despite not meeting criteria to reside continued to place pressure on patient flow, capacity and delivery of improvement plans.
- **Cash Position and Financial Recovery** – concern remained regarding the ongoing reliance on WRP delivery to support financial recovery and cash sustainability.
- **DCS WRP Delivery** – confidence in delivery of the DCS contribution to the WRP remained limited, with reliance on complex transformational schemes.

ADVISE

Areas requiring on-
going monitoring;
Limited assurance
received.

- **Capital Programme Delivery and Estate Risk** – continued oversight was required to manage delivery risks associated with the capital programme and significant estate pressures.
- **Bed Configuration and Workforce Readiness** – further assurance was required regarding workforce readiness to support planned service redesign and bed reconfiguration.
- **Workforce Availability and Sickness** – sickness absence remained above trajectory, presenting a risk to workforce productivity and delivery of recovery plans.

ASSURE

Assurance
received;
Matters of positive
note.

- **Operational Performance Improvement** – continued improvement was reported across urgent and emergency care, diagnostics and cancer performance, with positive early impacts from patient flow initiatives.
- **Endoscopy Performance** – strong performance was maintained across endoscopy services, with achievements recognised as an example of best practice.
- **Strengthened Governance and Oversight** – assurance was received that governance and oversight arrangements supporting recovery, transformation and delivery continued to strengthen.
- **Procurement and Shared Services Performance** – assurance was received regarding continued improvements in procurement governance, contract management and utilisation of system-wide procurement arrangements.

The Board of Directors is asked to:

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

Report	Meeting Date	Committee recommendation for Board
a) EPRR Core Standards Annual Assurance	22.09.26	Endorsed



Board of Directors Report

Meeting of the	Board of Directors		1 October 2026	
	Part I	☒	Part II	☐
Title of Report	Emergency Preparedness, Resilience and Response (EPRR) Core Standards Annual Assurance 2026/27			
Report Author	Sam Hughes, Head of Emergency Preparedness, Resilience and Response			
Lead Executive Director	Katie Foster-Greenwood, Chief Operating Officer (Accountable Emergency Officer)			
Recommendation/ Actions required	I. The Board of Directors notes the outcome of the Trust's 2026/27 Emergency Preparedness, Resilience and Response Core Standards self-assessment and the assurance review undertaken with Lancashire and South Cumbria Integrated Care Board on 8 September 2026; takes assurance from the identified actions and timescales to address the ten standards assessed as Partially Compliant; and approves the Trust's overall Partially Compliant position and the EPRR Core Standards Annual Assurance 2026/27 for formal submission to Lancashire and South Cumbria Integrated Care Board. II. The Board of Directors confirms that the Trust will publicly state its emergency preparedness, resilience and response readiness and preparedness activities within its annual reporting arrangements, in accordance with Core Standard 35.			
	Decision	☒	Assurance	☒
Executive Summary	Information			
	☐			
Executive Summary	The purpose of this report is to present the Trust's annual self-assessment against the NHS England Emergency Preparedness, Resilience and Response (EPRR) Core Standards for 2026/27 and seek Board approval of the resulting assurance position. Following completion of the self-assessment and review and challenge with Lancashire and South Cumbria Integrated Care Board (ICB) on 8 September 2026, the Trust will report an overall Partially Compliant position. Of the 62 applicable standards, 52 are assessed as Fully Compliant, ten as Partially Compliant and none as Non-compliant. The ICB agreed the Trust's proposed position and the ten individual standards assessed as Partially Compliant. The areas of partial compliance relate to lockdown capability; EPRR training and responder competency; Business Continuity Plan review and exercising; the Data Security and Protection Toolkit; assurance of critical third-party providers; and chemical, biological, radiological and nuclear/HazMat equipment and training. Established arrangements remain in place across these areas, with actions and timescales identified to address the outstanding requirements. Progress will be monitored through the EPRR Committee and appropriate Trust governance arrangements.			

	The detailed Core Standards self-assessment and action plan, formal Statement of Compliance and EPRR Annual Report are provided within the ancillary pack. The Board is asked to take assurance from the assessment and associated improvement arrangements and approve the Trust's 2026/27 EPRR Core Standards annual assurance submission.	
Link to Strategic Objectives 2026/27	Patients – deliver excellent care: Improve outcomes, reduce harm and deliver a positive patient experience.	☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.	☐
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.	☐
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.	☐
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.	☒
Due Diligence	To give the Trust Board assurance, please complete the following:	
Committee Approval:	Name of Committee: Finance and Performance Committee	Date: 22.09.2026
Operational Group Review:	Name of Operational Group: Emergency Preparedness Resilience and Response Committee	Date: 17.07.2026
Link to Board Assurance Framework:	N/A - No aligned to a Principle Risk	
Appendices	Appendix 1: EPRR Core Standards Annual Self-Assessment and Action Plan 2026/27 Appendix 2: EPRR Statement of Compliance 2026/27 Appendix 3: EPRR Annual Report 2026	

1. Background / context or introduction

The NHS England Emergency Preparedness, Resilience and Response (EPRR) Core Standards provide a common framework through which NHS organisations assess and provide assurance regarding their preparedness to respond effectively to emergencies and disruptive events whilst maintaining services to patients.

Lancashire Teaching Hospitals NHS Foundation Trust is required to complete an annual self-assessment against the applicable Core Standards, supported by appropriate evidence and improvement actions where standards are not fully met. The Trust's 2026/27 self-assessment has been subject to review and challenge with Lancashire and South Cumbria Integrated Care Board (ICB) and has progressed through the Trust's internal governance arrangements prior to presentation to the Board for final approval.

2. Discussion

2.1 2026/27 Core Standards Assurance Position

The Trust has completed its annual self-assessment against the NHS England EPRR Core Standards for 2026/27 and will report an overall Partially Compliant position. Of the 62 applicable standards, 52 are assessed as Fully Compliant, ten as Partially Compliant and none as Non-compliant.

The ten standards assessed as Partially Compliant are:

CS17 – Lockdown; CS21 – Trained On-Call Staff; CS22 – EPRR Training; CS24 – Responder Training; CS47 – Business Continuity Plans; CS48 – Business Continuity Testing and Exercising; CS49 – Data Protection and Security Toolkit; CS53 – Assurance of Commissioned Providers/Suppliers; CS60 – Equipment and Supplies; and CS64 – Staff Training – Recognition and Decontamination.

The partial assessments reflect specific areas where further improvement, evidence or assurance is required rather than an absence of established arrangements. Actions, responsible leads and implementation timescales have been identified for each area and are detailed within **Appendix 1 – EPRR Core Standards Annual Self-Assessment and Action Plan 2026/27**. Progress will be monitored through the EPRR Committee and appropriate Trust governance arrangements.

2.2 ICB Assurance Review

The annual EPRR Core Standards assurance review with Lancashire and South Cumbria ICB took place on 8 September 2026. The review provided external challenge and validation of the Trust's self-assessment and supporting evidence. Following the review, the ICB agreed the Trust's proposed overall Partially Compliant position and the ten individual standards assessed as Partially Compliant. No standards are being reported as Non-compliant.

The formal Statement of Compliance is provided at **Appendix 2**, with wider assurance regarding EPRR activity, exercising, learning and improvement priorities during the reporting period provided through the **EPRR Annual Report at Appendix 3**.

2.3 Governance and Next Steps

The Core Standards self-assessment and associated improvement actions have been considered through the Trust's EPRR governance arrangements and presented to the Finance & Performance Committee on 22 September 2026. Subject to Board approval, the Trust's annual assurance return will be formally submitted to Lancashire and South Cumbria ICB.

Delivery of the identified improvement actions will continue to be monitored through the EPRR Committee, with appropriate escalation through Trust governance arrangements where required.

3. Financial implications

Delivery of the Core Standards improvement actions may have financial implications. In particular, replacement of the Trust's Powered Respirator Protective Suits, which begin to reach end of operational life from April 2027, will require investment. There may also be a significant financial requirement associated with improving electronic lockdown capability across the Royal Preston Hospital site, subject to completion of the current review of existing electronic and manual lockdown arrangements and identification of the required infrastructure improvements.

Further potential resource implications may arise from training, exercising and other improvement actions. These will be progressed through the appropriate Trust planning and governance routes as requirements, costs and implementation timescales are confirmed.

4. Legal implications

The Trust has statutory duties as a Category 1 responder under the Civil Contingencies Act 2004 to maintain appropriate emergency preparedness and business continuity arrangements. The NHS England EPRR Core Standards provide the framework through which the Trust demonstrates assurance against these requirements. No specific legal implications arise directly from this report; however, delivery of the identified improvement actions supports the Trust in meeting its statutory EPRR duties.

5. Risks

Failure to deliver the identified improvement actions may affect the Trust's ability to achieve full compliance with the NHS England EPRR Core Standards and could impact organisational preparedness and resilience.

Key areas requiring continued oversight include EPRR training compliance, business continuity assurance, lockdown capability, CBRN/HazMat preparedness and timely replacement of Powered Respirator Protective Suits. Actions and associated risks will continue to be monitored through the EPRR Committee and appropriate Trust governance arrangements.

6. Impact on stakeholders

The EPRR Core Standards assurance process supports the Trust's preparedness and resilience arrangements and therefore contributes to maintaining safe and effective services for patients, colleagues and partner organisations during emergencies and disruptive events.

Improvement actions will be progressed with the relevant operational, corporate and clinical services and, where appropriate, system partners. No specific communications plan is required in relation to the annual assurance submission; communications relating to individual improvement actions will be managed through the relevant workstreams where required.

7. Recommendations

- I. The Board of Directors notes the outcome of the Trust's 2026/27 Emergency Preparedness, Resilience and Response Core Standards self-assessment and the assurance review undertaken with Lancashire and South Cumbria Integrated Care Board on 8 September 2026; takes assurance from the identified actions and timescales to address the ten standards assessed as Partially Compliant; and approves the Trust's overall Partially Compliant position and the EPRR Core Standards Annual Assurance 2026/27 for formal submission to Lancashire and South Cumbria Integrated Care Board.
- II. The Board of Directors confirms that the Trust will publicly state its emergency preparedness, resilience and response readiness and preparedness activities within its annual reporting arrangements, in accordance with Core Standard 35.

13.1 AUDIT COMMITTEE CHAIR'S REPORT

● Other

● T Wheeler

● 12.05 pm

Item for assurance

REFERENCES

Only PDFs are attached



13.1 Audit Chair's Report 17 Sept 26 - Board October 2026.pdf

Chair's Report to Board	
Chair: Tim Wheeler	Committee: Audit
Date(s): 17 September 2026	

Strategic Risks	Trend
N/A	

ALERT

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

- **Outstanding Internal Audit Recommendations** - four recommendations from 2024/25 remained outstanding, relating to sickness absence, health and safety governance and mandatory training. Whilst assurance was received that these formed part of wider improvement programmes, the Committee sought continued scrutiny of revised implementation timescales and associated delivery risks.
- **Procedural Documents Compliance** - continued decline in procedural document compliance from 90% to approximately 85%, reflecting a significant backlog of overdue document reviews. The three-year review standard should be maintained; further action was required to address underlying causes rather than extending review periods

ADVISE

Areas requiring on-
going monitoring;
Limited assurance
received.

- The Committee advised that future **clinical audit reporting** should provide clearer risk-based assurance, including performance trajectories, trend analysis and triangulation of information between reporting cycles, to strengthen visibility of improvement and ongoing risk management.

ASSURE

Assurance
received;
Matters of positive
note.

- **Internal Audit Plan Delivery:** Progress against the Internal Audit Plan remained on track with no concerns identified regarding delivery of the future Head of Internal Audit Opinion.
- **Counter-Fraud Arrangements:** Counter-fraud activity remained effective, with no concerns identified in investigations activity and a programme of work in place to strengthen fraud risk assessment arrangements.
- **Final Audit Reports:** Substantial Assurance was received from both the Sepsis Data Quality Review and the C. difficile Review.
- **Salary Overpayments Controls:** Payroll controls remained effective, with no significant issues identified through audit testing and processes in place to recover overpayments.

- 
- **Cyber Security:** Independent testing and benchmarking provided assurance that cyber security controls remained robust and continued to evolve in response to emerging threats.

13.2 CHARITABLE FUNDS COMMITTEE CHAIR'S REPORT

● Other

👤 T Ballard

🕒 12.15 pm

Item for assurance

REFERENCES

Only PDFs are attached

📄 13.2 CFC Chair's report 15 Sept 2026.pdf

Chair's Report to Board			
Chair: Dr Tim Ballard	Committee:	Charitable	Funds
Date(s):15 September 2026			

Strategic Risks	trend	Items Recommended for approval
N/A		None

ALERT

Areas of concern;

- None

ADVISE

Areas requiring on-going monitoring;
Limited assurance received.

- None

ASSURE

Assurance received;
Matters of positive note.

- The Committee was assured that both the Hospital Charity and Rosemere Charity continued to perform strongly, with income ahead of target, expenditure remaining within planned levels, and overall financial performance positive.

Rosemere Charity

- Fundraising events and activity successes continued over the summer with significant amounts raised for RCF via events such as Classic Cars on Lytham Green (£45k), Brookfest Music Festival (£15k) and RCF's Cross Bay Walk (£23.5k). Individual sporting challenges continued to trend with participants taking part in a range of events from Iron Man to the City Preston Road Race, and Yorkshire 3 Peaks to the Great North Swim.
- The Rosemere Coffee Shop Limited had an excellent year of trading seeing profits grow to £45k, which will be donated to RCF.
- Funding supported a wide range of targeted enhancements to patient care and experience, including improvements to cancer patient environments such as waiting areas, research in partnership with local Universities and the Trusts own Centre for Health Research & Innovation

via a new Patient and Public Involvement, Engagement and Inclusion (PPIEP/EDI) Coordinator role.

- The Trust charities continue to collaborate by sharing resources, expertise and knowledge. They have partnered to organise a second global trek where participants will take on a Transylvanian Trek in Romania in September 2027.

Hospital's Charity/Baby Beat

- Fundraising events and activity have seen growth since the start of the current financial year, with a greater number of supporters organising events and taking on personal challenges to raise significant funds for various departments across the Trust including Maternity Services (via BB), Critical Care Unit and Children's Services.
 - Demand for funding continues with 64 funding applications being received in the current financial year, with 38 of those already approved supporting numerous areas with enhancements to patient comfort, experience and improved treatment outcomes through a number of initiatives ranging from £38.00 in value to £10k in value.
 - Baby Beat Limited via its shop in the Sharoe Green Unit continued its strong trading performance raising £32.3k in profit which will be donated to BB.
 - The Trust charities continue to collaborate by sharing resources, expertise and knowledge. They have partnered to organise a second global trek where participants will take on a Transylvanian Trek in Romania in September 2027.
-
- The Committee approved a Rosemere funding application to support a Patient and Public Involvement Coordinator role aimed at enhancing cancer research participation, improving patient experience and increasing diversity within research trials.
 - The Committee received assurance and approved the annual reports and accounts, approved the letters of representation and authorised submission to the Charity Commission upon completion of the audit process.

14. * ITEMS FOR INFORMATION

All items in ancillary pack

14.1 * DATA QUALITY ASSURANCE REPORT

● Information Item

Item for Decision and Information

14.2 * CORPORATE CALENDAR 2027-28

- Information Item

14.3 *MATERNITY SPECIFIC TRIAGE BENCHMARKING AUDIT

14.4 DATE, TIME AND VENUE OF NEXT MEETING

● Information Item

● M Thomas

● 12.25 pm

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

CLOSE