NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS PART I MEETING

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5 February 2026

09:15 GMT Europe/London

Lecture Room 1, Education Centre 1, Royal Preston Hospital

AGENDA

STAFF STORY PRESENTED BY THE PSYCHOLOGICAL & WELLBEING SERVICE

Information Item

09.15am

AGENDA

REFERENCES

Only PDFs are attached

0.0 - Agenda - Board (part I) - 5 February 2026 .pdf

Board of Directors

5 February 2026 | 9.15am | Lecture Room 1, Education Centre 1, Royal Preston Hospital

Agenda

At 09.15am, there will be a **staff story** presented by the Psychological & Wellbeing Service

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	9:30 am	Verbal	Information	M Thomas
2.	Apologies for absence	9:32 am	Verbal	Information	M Thomas
3.	Declaration of interests	9:35 am	Verbal	Information	M Thomas
4.	Minutes of the meeting held on 4 December 2025	9:37 am	✓	Decision	M Thomas
5.	Matters arising and action log update	9:40 am	✓	Decision	M Thomas
6.	Chair's opening remarks and report	9:42 am	✓	Information	M Thomas
7.	Chief Executive's report	9:45 am	✓	Information	S Nicholls
8.	Board Assurance Framework	10:00 am	✓	Decision	S Regan
9. PEOPLE (WORKFORCE, EDUCATION AND RESEARCH)					
9.1	Workforce Committee Chair's Report	10:15 am	✓	Assurance	A Leather
9.2*	Gender Pay Report	10:25am	✓	Decision	L Graham
9.3*	Equality, Diversity and Inclusion Annual Report	10:35am	✓	Decision	L Graham
9.4	Education, Training and Research Committee Chair's Report	10:45 am	✓	Assurance	S Crean
10. PERFORMANCE & PRODUCTIVITY (FINANCE)					
10.1	Integrated Performance Report as at February 2026 including Finance update and Single Improvement Plan (considered by appropriate Committees of the Board)	10:55 am	✓	Assurance	K Foster-Greenwood/ C Gregory/ N Pease/ C Carter
10.2	Finance and Performance Committee Chair's Report	11:35 am	✓	Assurance	J Schorah
BREAK		11:45 am			
11. PATIENTS (SAFETY AND QUALITY)					
11.1	Safety and Quality Committee Chair's Report	12 noon	✓	Assurance	K Deeny

№	Item	Time	Encl.	Purpose	Presenter
11.2*	Annual Adult Safe Staffing Report	12:10 pm	✓	Decision	C Gregory
11.3*	Maternity and Neonatal Service Update	12:20 pm	✓	Decision	E Ashton/E Romano
12.	**PARTNERSHIPS** (STRATEGY AND PLANNING)				
12.1	Corporate Objectives 2026/27	12:30 pm	✓	Decision	A Brotherton
13.	**RISK, GOVERNANCE AND COMPLIANCE**				
13.1*	2026/27 Plan and Board Assurance Statement	12:40 pm	✓	Decision	A Brotherton
13.2	Charitable Funds Committee Chair's Report	12:50 pm	✓	Assurance	T Ballard
13.3*	Review of Terms of Reference	12:55 pm	✓	Decision	J Foote
14.	**ITEMS FOR INFORMATION * ancillary pack**				
14.1*	Register of Interests		✓		
14.2	Date, time and venue of next meeting: *4 April 2026 at 9:15 am at Lecture Room 1, EC1, Royal Preston Hospital*	1:00 pm	Verbal	Information	M Thomas

* Full report in ancillary pack

1. CHAIR AND QUORUM

Information Item | M Thomas | 09.30am

2. APOLOGIES FOR ABSENCE

Information Item | M Thomas | 09.32am

3. DECLARATION OF INTERESTS

Information Item | M Thomas | 09.35am

4. MINUTES OF THE PREVIOUS MEETING HELD ON 4 DECEMBER 2025

Decision Item | M Thomas | 09.37am

REFERENCES

Only PDFs are attached

4.0 - Minutes - Board (Part I) - 4 December 2025 approved.pdf

Board of Directors

4 December 2025 | 9.15am
Lecture Room 1, Education Centre 1, Royal Preston Hospital

Part I

Present:

Professor M Thomas	Chair
Dr T Ballard	Non-Executive Director
Mr S Canty	Chief Medical Officer
Mr C Carter	Interim Chief Finance Officer
Dr K Deeny	Non-Executive Director *(via MS Teams)*
Ms K Foster-Greenwood	Chief Operating Officer
Mr A Leather	Non-Executive Director
Mrs S Morrison	Chief Nursing Officer/Deputy Chief Executive Officer
Professor S Nicholls	Chief Executive Officer
Mr J Schorah	Non-Executive Director
Professor T Wheeler	Non-Executive Director

Apologies: Prof S Crean, Mr U Patel

In attendance:

Professor A Brotherton	Chief Strategy and Improvement Officer
Mrs N Duggan	Director of Communication and Engagement
Mrs J Foote	Director of Corporate Affairs
Mrs K Lawrenson	Corporate Affairs Officer
Dr N Pease	Chief People Officer
Mr S Regan	Associate Director of Risk and Assurance
Mrs J Wiseman	Interim Business Manager *(minutes)*

Governors observing: Janet Miller, Carole Oldcorn, Lou Jackson and Frank Robinson *(via MS Teams)*

Observers: Annemarie Vicary, National Recovery Support Team, NHSE
Sarah Seaholme, National Recovery Support Team, NHSE
One member of the public

Presenters of the patient story: Deborah O'Mahoney, Divisional Nursing Director
Sarah McMullan, Matron

Prior to the meeting the Board received the following presentation: Patient Story, presented by the Division of Diagnostics and Clinical Support.

Gary and Kelly's Critical Care Journey
Gary, 33, was admitted after a severe road traffic collision. Initially taken to Royal Lancaster Infirmary due to helipad constraints, he was transferred to Royal Preston Hospital for emergency surgery. Gary sustained severe leg injuries that resulted in a through-knee amputation, bringing life-changing consequences for him and his family.

Sedation ended on 8 May and by 12 May Gary was ready for the major trauma ward but moved to Ward 16 due to bed shortages. During critical care, Gary experienced hallucinations and anxiety despite being CAM-negative. On 13 May, he self-discharged against advice while awaiting blood results; later tests showed low platelets. He returned five days later after Kelly, Gary's wife, called the ***Call for Concern*** *helpline, introduced in April 2024. On 20 May, Gary was readmitted to critical care with large bilateral pulmonary embolism. He described terrifying hallucinations and fear of death, which were eased by clear, reassuring communication from nursing staff. Addressing psychological needs alongside clinical care was vital. Kelly stayed by his side throughout, praising the critical care team but finding the ward environment stressful, with poor communication and confused patients increasing Gary's anxiety. Psychology support helped him cope with low mood and overwhelming emotions. Kelly felt empowered by the Call for Concern service, which prompted Gary's urgent readmission and provided reassurance.*

On 22 May, Gary stepped down to the major trauma ward with better support and communication. He was discharged home on 27 May. Both Gary and Kelly highlighted the importance of psychological care, clear updates and family involvement in recovery.

The Board acknowledged Gary's positive progress at home and his family's resilience, commending the support from clinical and psychological teams and the value of the Critical Care follow-up clinic. They reflected on the emotional impact for both patients and staff, highlighting the importance of access to psychological support, effective handovers and maintaining the correct care pathway. The Board recognised the need to improve awareness of escalation routes like Call for Concern, ensure smoother transitions to appropriate wards and enhance patient sleep and wellbeing. They expressed appreciation to Gary and Kelly for sharing their experience and commended the team's work noting how patient stories reinforce the real-life significance of their decisions and responsibilities.

215/25 Chair and quorum

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

The Board of Directors was informed that the meeting would be observed by representatives from the National Recovery Support Team.

216/25 Declaration of interests

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

217/25 Minutes of the previous meeting

The minutes of the meeting held on 2 October 2025 were approved as a true and accurate record subject to an amendment to minute no 188/25 regarding the accurate stating of financial information. It was agreed that the Chief Finance Officer would provide the correct information below for the enduring record:

Deliver Value for Money - By the end of August 2025, the Trust had faced significant financial pressures, with a deficit of £16 million against a planned deficit of £6.4 million, largely due to shortfalls in the Waste Reduction Programme and approximately £400,000 linked to industrial action earlier in the year. Year-to-date delivery amounted to £19.7 million, with £19.3 million being recurrent, indicating strong consistency in cost reduction. The current trajectory suggested an average monthly reduction of £1.6 million, although the target remained £5 million, underscoring the challenge ahead. Agency costs remained low at around 1% of overall pay costs, well below the national threshold of 3.2%. A consistent reduction in the normalised pay position was noted, with monthly expenditure decreasing from £49.3 million to £48.3 million, reflecting a £1 million average reduction. Slippage in pay reduction ambitions was evident, with only 132 of the planned 348 full-time equivalent reductions achieved. This contributed to a forecast outturn risk of £15–16 million. Divisional delivery groups had been established to review and mitigate these risks. As a result of ongoing financial and operational challenges, the Trust had been placed in Segment 5 of the NHS oversight framework, triggering intensive support through the provider improvement programme. Efforts to improve productivity included restructuring programme governance, and increased external support, with a focus on identifying further efficiency opportunities and strengthening project management capabilities.

218/25 Matters arising and action log

All actions from previous meetings had been completed.

219/25 Chair's report

The Chair's report provided an overview of activities and key developments during October and November 2025. The Board had received updates on the mid-year review with NHS England, progress on the New Hospital Programme land acquisition, and the Section 111 Notice regarding board leadership and financial improvement.

The Chair reflected on the current phase of organisational transformation, noting that the Board had worked together for under a year and was approaching the critical final quarter of the financial year. It was recognised that quarter four typically presented significant challenges for improvement, particularly regarding financial performance. The Board remained committed to achieving a balanced budget by April 2028, including addressing the underlying deficit and acknowledged ongoing pressures on the Waste Recovery Programme. Although a clear plan was in place and executives demonstrated a strong understanding of the challenges and data, performance indicators had not yet improved as anticipated.

The importance of maintaining a consistent approach, avoiding reactive changes to plans and learning from the experiences of other trusts was emphasised. It was agreed that performance would be reviewed at the end of quarter four, allowing sufficient time for growth and improvement to materialise. In addition, the importance of maintaining open communication with regional colleagues and providing regular updates was emphasised to ensure transparency and a shared understanding across all teams. The aspiration remained to achieve a 'good to outstanding' rating within five years. The Chair encouraged

the Board to engage in open discussions about difficult issues, ensuring that decisions were made with clear rationale and optimism, despite the challenging period.

220/25 Chief Executive's report

The Board received the Chief Executive's report, which provided updates on key developments since the last meeting. The Trust had managed the impact of national industrial action by resident doctors, maintained a focus on safe service delivery and continued preparations for winter pressures. Initiatives such as the reducing Days Kept Away from Home campaign had improved patient flow. The report highlighted service developments, including advances in robotic and colorectal surgery, national recognition in clinical research and strong results in the National Cancer Patient Experience Survey.

The Chief Executive reflected on the breadth of matters addressed in the report, highlighting ongoing efforts to manage the longstanding organisational deficit and its practical and strategic consequences. The Board was informed that, while progress had been made in reducing the underlying deficit, achieving the full savings target within the current year remained unlikely, necessitating careful trade-offs and decisions regarding capacity whilst prioritising patient safety, especially during the challenging winter period. The approach to performance improvement drew on lessons from previous years, with a shift towards sustainable solutions rather than short-term fixes and a focus on methodically reviewing demand, capacity and pathways for innovation.

The Board noted positive developments, including collaborative work with primary care partners to redesign pathways in urology and the use of robotics and artificial intelligence to validate waiting lists and improve administrative processes. The pressures on urgent and emergency care were acknowledged, particularly with the rising incidence of flu. Concerns centred on overcrowding and the added impact of industrial action, both of which created significant operational and financial challenges.

The Board discussed the forthcoming resident doctor strike, noting the significant impact on the wider healthcare system and requested assurance on how patient safety would be maintained. It was confirmed that well-established processes were in place, including gold command structures, daily planning meetings and an incident management team supported by tactical and strategic command, with reporting to regional colleagues. The Board was advised that an Industrial Action Planning Group continued to meet regularly, with measures evolving to maintain the highest possible level of activity during the critical period from 17 to 22 December. It was acknowledged that recent participation in industrial action had increased compared to previous strikes, but despite this, the organisation had successfully sustained a moderate level of planned activity.

The Board reflected on recent staff achievements, including the Recognising Excellence Awards held in Preston, which celebrated outstanding contributions across the organisation. The Board also acknowledged the Staff Memorial Service, where colleagues who had sadly passed away over the last 12 months whilst in service, were remembered. The Chief Executive emphasised the strong sense of community for people who had worked together for many years, often doing amazing things in difficult circumstances. The importance of nurturing this culture which remained central to the organisation's resilience and success, was acknowledged.

The ongoing work on the initiative for Days Kept Away from Home was acknowledged and colleagues were commended for effectively communicating the wider context of

hospital activity despite significant operational pressures. This included participation in the NHS Day coverage by BBC Radio Lancashire, where staff engaged enthusiastically to share both the challenges faced and the positive developments within the organisation.

It was noted that relationships with key partners, including local authorities, had strengthened significantly compared to the previous year, supported by ongoing engagement and collaborative work. This improvement had contributed to a reduction in delayed discharges although the target remained at 5%, so required further action. Within the Trust, positive progress was reported through cultural and programme changes aimed at reducing support requirements on discharge, resulting in shorter waits and an increase in the pathway for discharges. However, external pressures continued to impact performance, with approximately 75 beds occupied by patients medically fit for discharge. The Board was advised that urgent escalation meetings were scheduled with system leaders to agree practical actions to achieve the ambition of 35 additional discharges per day. The discussion also highlighted participation in a national improvement programme focused on frailty, bringing together partners across health and social care to address key priorities. It was acknowledged that traditional approaches to capacity, such as opening additional beds, were unsustainable and that work was underway to develop alternative models, including early intervention and community-based pathways. Budgetary pressures within local authorities were recognised as a risk and the organisation had provided input to consultations to mitigate potential impacts. The Board noted that while the target for achieving 5% delays for discharge was set for the end of March, current trends indicated this was a risk and progress updates would be provided through the Board assurance committees.

Congratulations were offered to the Chair who had been appointed as interim Chair of East Lancashire Hospital Trust, separate but in addition to his current post at Lancashire Teaching Hospitals Foundation Trust.

221/25 Board Assurance Framework

The Board received an update on the Board Assurance Framework, which set out the principal risks to delivery of the 2025/26 corporate objectives.

Since the last meeting, four principal risks had been recommended for control following reductions in score. Principal Risk 6 for timely access to diagnostics, saw its score decrease from 16 to 12, reflecting improvements in diagnostic performance, with recent data showing a 3.8% improvement in October compared to September, achieving 63.06% against a target of 65%. This position was reiterated, noting that the agreed operational target for diagnostic performance this year was 65%. While this was below the national ambition the Trust remained committed to its improvement trajectory, which had led to a reduction in the risk score and alignment with planned progress. It was emphasised that efforts were ongoing to exceed the 65% target wherever possible, although assurance to surpass this level had not yet been established. The improvement plans, including the sustainable solutions, capacity and demand programme, were actively being developed with diagnostic teams to inform future strategy. The Board acknowledged that the 65% target for March was a milestone rather than a final endpoint and that ongoing trajectory planning would guide further progress beyond the current financial year.

Principal Risk 7 related to the reliance on temporary medical workforce, was reduced from 16 to 12, following increased assurances about medical staffing and ongoing development of the 42-week productivity tool. Principal Risk 11 for compliance with core skills training

and appraisals, reduced from 9 to 6, as Trust-wide compliance with core skills training had been sustained since July, enabling closure of related Care Quality Commission (CQC) actions. Principal Risk 16 related to failure to progress the configuration of Trust services to enable delivery of the clinical strategy, reduced from 12 to 8 after approval of the long-term strategy, bringing the risk in line with the Board's level of tolerance.

Principal Risk 4 for the timely access to planned and cancer care, remained off trajectory for reduction despite improvements in treatment times. Progress was noted in reducing waiting times for both 52-week and 62-day treatment pathways. However, it was acknowledged that performance remained off trajectory for cancer care, with delays closely linked to poorer patient outcomes. The Board was informed that particular attention was being given to tumour sites with time-critical pathways, such as breast and skin, where targeted actions had led to some improvements. The more complex and time critical areas including brain, head and neck, national guidance varied. The Board welcomed the detailed approach to risk management and the ongoing commitment to protect patients most at risk. Implementing GIRFT (get it right first time) principles was expected to drive improvements in cancer performance. Best-time pathway approaches and national exemplars had been adopted to break down cancer pathways into detailed steps. Updates on GIRFT-related improvements and pathway metrics were scheduled for the next meetings of the Safety and Quality Committee and Finance and Performance Committee, with cross-referencing agreed to ensure there was comprehensive oversight.

Principal Risk 12 related to failure to meet financial plans, had been discussed at the Workforce Committee and Finance and Performance Committee, with challenges noted around workforce reduction and its impact on the Waste Reduction Programme. The Finance and Performance Committee requested a further report for its 23 December meeting.

Principal Risk 15 related to research capacity and capability, had its target date reset to February 2026 to allow further progress towards University Hospital status.

A concern was raised around Principal Risk 2, related to higher than trajectory rates of Clostridioides Difficile infection. It was noted that the Trust continued to track below the expected trajectory despite recent challenges, including a significant norovirus outbreak. Implementation of the national cleaning standards had now been completed in all very high-risk areas, with the remaining high-risk areas scheduled for rollout over the next five months, aiming for full compliance by 30 March 2026. Recruitment challenges were being actively managed to maintain progress. The Board was assured that joint monitoring activities involving estates, infection prevention and control and ward teams, were fostering a holistic approach to environmental management, which was expected to positively impact both patient and staff experience.

222/25 Integrated Performance Report as of November 2025

Patients - The Board noted that no alerts had been raised for the month. Fill rates for registered midwives and maternity support workers remained below target, as 20 new midwives were still completing induction and support worker recruitment was ongoing. Bank staff had been utilised to cover gaps, but some shifts could not be filled, which had been risk assessed. Complaints showed a five-month upward trend, mainly related to waiting times and care provision during waits, though overall numbers were lower than last year. Improvement actions were in place with an anticipated improvement expected by March 2026. Response compliance was confirmed as exceeding 90% with a thematic

analysis undertaken for the Annual Quality Account. Focused work had been undertaken on pressure ulcer management and reviewed equipment in emergency care pathways, with an Improvement Board established to spread best practice and address any lapses.

Staffing levels for registered nurses and healthcare assistants remained above target, partly due to additional staffing in emergency departments. The Board had corrected the establishment in Chorley Emergency Department to reduce reliance on temporary staff, expecting fill rates to drop as substantive staff replaced bank staff, generating savings. STAR accreditation had recovered following the implementation of mandatory standards and confidence in the fundamentals of care increased. All CQC “Must Do” actions had been delivered and mortality figures remained stable or lower than expected.

Performance - The Board reviewed key performance metrics, noting that urgent and emergency care type 1 metrics had improved and was above the operational plan for October, although pressures persisted due to flu and service demand. Type 3, urgent treatment performance deteriorated for the third consecutive month and remained below target. Detailed improvement plans had been requested from the service provider for tracking and reporting which were expected later in the day. Ambulance handover times worsened, directly linked to the Emergency Department overcrowding and high bed occupancy, with escalation protocols in place to intervene early.

The elective care waiting list size had reduced and was below the revised mid-year target for October, however the 18-week and 52-week wait performance declined and was off track for year-end objectives. Additional actions, including patient-initiated follow-ups and AI robotics pilot schemes, had been implemented to improve waiting list management and clock stops at the end of a patient’s treatment. Completion was anticipated by the end of December, enabling impact analysis to commence. The pilot for patient-initiated follow-up was highlighted as a significant innovation, being new across the NHS. Analysis results were expected for the next Improvement and Assurance Group meeting in December, with a report scheduled for presentation to the Finance and Performance Committee on 23 December. The Board noted the successful mobilisation of elective care recovery funding and zero 65-week waiters achieved for the first time.

Cancer performance showed improvement in 28-day and 62-day standards, though targets had not yet been met there were clear plans in place. Diagnostic performance exceeded the October ambition, supported by mutual aid and increased capacity, but workforce challenges in non-obstetric ultrasound remained a concern. The Board acknowledged ongoing system-wide collaboration to optimise capacity and provide mutual aid across providers.

People - The Board noted that whole time equivalent (WTE) reductions were being closely monitored, with a revised paper on staffing utilisation and run rates scheduled for the Finance and Performance Committee meeting on 23 December. Mitigations included vacancy management, rostering efficiencies and improved bank management processes. Violence and aggression incidents remained a focus, with new security measures introduced and peer learning undertaken. A significant reduction of incidents was reported in some divisions.

Sickness absence had risen slightly to 5.88%, however remained the lowest rate among Lancashire and South Cumbria providers. Appraisal compliance was above target, with ongoing efforts to improve the quality and effectiveness of appraisals through the Single Improvement Plan. Mandatory training and core skills compliance were maintained across

the organisation and included all clinical areas. The staff survey recently closed with a 44.8% response rate, 5.7% higher than last year, with increased participation across most divisions. Efforts were implemented to include staff without digital access. The survey results were expected in March 2026.

Productivity - The Board noted that as of October, the Trust reported a £17.7m deficit against a planned deficit of £2.5m, resulting in a variance of over £15m. The main factors driving this variance were under-delivery of the Waste Reduction Programme (WRP), industrial action cost pressures, operational pressures such as energy costs and high-intensity care. The WRP was £13.4m behind the original plan and around £6m behind the revised profile. It was noted that £26.6m had been delivered to date which was 44% of the target, of which £24m was recurrent. Agency spend remained below 1% of the pay bill and normalised pay run rates had decreased since April. Nevertheless, progress in reducing whole time equivalents had stalled. A weekly deep analysis was being undertaken to review sustainable reductions.

Deficit forecasts for the year ranged from an £8.8m best case scenario to a £31.2m worst case scenario, with WRP delivery, contractual risks and operational pressures as key influencing factors. Capital spend was £4.2m year-to-date against a plan of £7.5m. The Board was alerted to cash pressures, with a £10.5m request pending and notification that deficit support funding would be suspended for two months, creating a £5m impact. Updated financial information was expected within the next few days and the impact analysis would be completed within three to four working days to inform the January request. The Board noted a letter received placing a moratorium on the receipt of Deficit Support Funding. This would require the unplanned allocation of additional financial resource to service debt that would have been covered by the DSF. There was an expectation that DSF for the final quarter could be released in a single backdated tranche though this appeared to remain dependent upon performance against target.

The Board agreed that all plans should include clear date markers to enable assurance committees to carry out assurance work effectively. These signposts would confirm progress against commitments and highlight any delays or barriers. A question was asked how the Board would nurture organisational growth while meeting regulatory and performance standards. It was explained that mechanisms for sharing information included staff briefings, leadership sessions and weekly divisional improvement groups. A new approach to resource alignment and performance objectives was under development, with plans to present this at an executive development session in the new financial year.

The discussion then focused on the effective use of population health data to understand actions and their impact in greater detail. It was noted that the organisation served a diverse population and workforce and consideration was given to whether a population health lens was being applied effectively. Targeted use of population health data has been implemented in certain areas, such as reducing non-attendance rates and improving access for specific groups, including the prison population and individuals from minority ethnic backgrounds. However, this approach was not yet applied consistently across all services. Current priorities were centred on achieving fundamental performance and delivery standards, with plans to expand the use of population health data in the following year.

Examples were provided of how data had informed improvements in maternity services and had been used strategically for future service planning, including proposals for a

health hub in Preston. It was acknowledged that external funding would influence the timeline for establishing this hub. Broader application of population health data across all service areas remained a longer-term goal, requiring prioritisation and sequencing. The discussion also highlighted emerging work to apply population health insights to staff wellbeing, with the aim of preventing illness and addressing societal factors contributing to absence. This was seen as an opportunity to take prevention to the next level and inform future workforce strategies. A request was made for short-term assurance that population health considerations were being applied to urgent and emergency care challenges, alongside a medium-term plan to schedule an update for the Board on wider application. It was confirmed that work was ongoing across the whole system to embed population health principles. Several colleagues had completed the Population Health Academy Programme and a paper had been prepared following a review of the data. A follow-up call was scheduled with the wider team to progress planning and the approach was identified as a core element of next year's plan. A summary update was to be shared outside the meeting, with further discussions planned to ensure alignment. The Trust Health Improvement Plan had been published in December 2024. The first of two health inequalities improvement design events had taken place, where proposals were discussed on agreeing key priorities for the next 12 months and delivering them collaboratively.

223/25 Finance and Performance Committee Chair's Report inc. UEC Deep Dive

The Committee had acknowledged the need for in-depth debate and analysis, particularly around performance and referenced a recent comprehensive report on urgent and emergency care. The findings indicated that challenges were not solely due to increased activity but were significantly influenced by initial assessments and patient flow through emergency departments. Recommendations were made to focus on interventions likely to have the greatest impact.

There had been robust discussions regarding performance and financial position. It had been noted that while there had been some progress, the organisation remained some way off best-case financial forecast, largely due to slippage in new schemes and the removal of some financial efficiency schemes. The need for proactive operational and financial management had been emphasised, as any shortfall in programme delivery would exacerbate financial pressures. The Committee had also highlighted the importance of early planning and the lessons learned from the timing and implementation of major projects. The Board noted that the infrastructure had not been in place earlier in the year which included the Programme Management Office.

Assurance had been sought on workforce-related mitigations within the Waste Reduction Programme (WRP), as previous measures had not delivered the expected impact and the Committee was unable therefore to provide full assurance to the Board. It was agreed that a specific report on workforce plans and financial implications would be presented at the December meeting, with senior workforce leadership in attendance. The Committee maintained a commitment to seeking genuine assurance particularly in light of ongoing scrutiny and external assessments.

The financial position remained a concern, with the previous year's deficit and the risk of failing to deliver the WRP both impacting cash flow. The withdrawal of financial deficit support was noted to have direct cost implications, reinforcing the need for transparency and openness in reporting. .

224/25 Safety and Quality Committee Chair's Report

Two key alerts were brought to the Board's attention. The first related to urgent and emergency care that was discussed earlier, with performance oversight and scrutiny to be managed by the Finance and Performance Committee, while safety and quality aspects would remain under the Committee's remit. This approach was designed to ensure robust triangulation across committees and to avoid duplication of effort.

The second alert concerned potential delays in surgical pathways, attributed to challenges with the current tracking systems. The Committee highlighted the need for an effective system, noting that the existing electronic patient record (EPR) did not provide a sufficiently robust diagnostic tracking mechanism. Work was underway, including collaboration with the patient safety team and digital leads, to identify and implement digital solutions. A recent digital workshop had identified potential opportunities to improve performance tracking and reduce the risk of patient harm or delays. Incremental improvements were planned ahead of the transition to a new EPR system, with governance arrangements in place to ensure ongoing oversight. The Committee had agreed to receive monthly updates on progress in addressing these challenges.

The Committee had been assured by the immediate and short-term actions taken in response to a recent Never Event, confirming that close oversight would be maintained and a further report would be presented in January 2026. In relation to maternity theatre capacity and rising caesarean section rates, it was noted that this remained an unresolved issue, with escalation to the ICS Chief Nurse for further exploration. Monthly updates would continue through established reporting routes until a resolution was achieved.

The Committee advised that the Trust was on track to implement the Ulysses risk and incident management system in February 2026, which was expected to enhance visibility, tracking and reporting of incidents and themes. Assurance was provided that all Care Quality Commission (CQC) "must do" and "should do" actions had been completed.

225/25 Medium Term Planning Framework (2026/27 to 2028/29)

A summary of the Medium Term Planning Framework was presented, highlighting the transition to a multi-year approach, which was welcomed as it would support more effective planning. However, significant challenges were identified, particularly the misalignment between the level of activity required to improve performance and the funding available across the system. Capacity and demand work was underway, supported by external partners, with initial findings to be reported to the Executive Team. This work was being aligned with ongoing productivity analysis, which indicated a reduction in the productivity improvement opportunity from £99m at the start of the year to between £34m and £68m, depending on benchmarking data. It was noted that achieving the required productivity would necessitate reaching the top decile of performance across all specialties and that productivity improvements alone were unlikely to be sufficient.

The Board was informed that NHS England had requested the modelling of both a plan to meet constitutional standards and an affordable plan, with support offered by regional colleagues. The lack of growth funding this year and the likelihood of insufficient funding next year, were highlighted as significant constraints. Despite these challenges, the organisation remained committed to maximising delivery and pursuing further improvement opportunities, while recognising the plan would be particularly demanding.

Governance arrangements were outlined, with a requirement to submit five documents by 17 December 2025, including a Board Assurance Statement. As the work was ongoing, it was proposed and agreed that delegated authority be given to the Chair to sign off the assurance statement, with the report to be circulated to Board members for comment prior to submission.

It was further noted that the baseline for performance improvement assumed delivery of all operational targets set for the current year, with any shortfall adding to the improvement required in subsequent years. The planning guidance also reflected a shift towards individual organisational responsibility and accountability for financial control totals, alongside increased national efficiency expectations. The combined effect of a 2% cost efficiency requirement and a potential 2.5% income reduction was recognised as a material change in planning assumptions.

The Board discussed the need for clear oversight of the challenges and issues associated with implementing the required initiatives, including timescales and resource requirements. It was noted that planning updates would continue to be provided to the Finance and Performance Committee and that a Board workshop would be arranged to facilitate detailed discussion once further work had been completed. Risk tolerance and appetite would also form part of those discussions.

Reflections on the financial year emphasised the need for the organisation to stretch itself while remaining mindful of the national context and the importance of realistic planning. The Board recognised the significant capital investment required for the ageing estate and agreed that these considerations should be integrated into regional discussions to ensure a joined-up approach with system partners. It was acknowledged that there was a risk of focusing too narrowly on one set of requirements at the expense of others and that early, open discussions would be necessary to set realistic expectations and avoid overcommitment. The Board discussed the importance of finding the right balance between ambition and deliverability, both as a unitary board and in engagement with regulators and commissioners.

The ambition remained to also progress from good to outstanding, drawing lessons from peer organisations and model hospitals, particularly in the use of digital solutions and artificial intelligence. The Board noted that outstanding organisations maintained a culture of continuous improvement and challenge. The organisation had prioritised digital capability, with recent clinical engagement and external support informing future plans. Emerging themes included patient flow, timely discharge and the use of data and AI to address systemic challenges, with the aim of improving productivity, financial performance and patient outcomes.

The Board RESOLVED that the final sign-off of the Board Assurance Statement, following completion of the NHS Planning Framework be signed and approved by the Chair under delegated authority.

226/25 Workforce Committee Chair's Report

The Workforce Committee provided an update to the Board, focusing on whole time equivalent (WTE) performance, associated mitigations and the likelihood of not meeting year-end trajectories. This matter had been referred to the Finance and Performance Committee for further consideration, with a subsequent presentation planned. The Committee noted positive progress in managing long-term sickness absence and

improvements in appraisal and skills development, recognising the collective effort involved in achieving these outcomes.

Difficult discussions had taken place regarding vacancy control and its impact on gender equality and safety. The Committee continued to monitor these issues to ensure a balanced approach to finance, quality, and workforce resources across committees.

The Board discussed staff vaccination rates, reporting an internal uptake of 35.5% as of 19 November, with a system-wide rate of 46.3%. While improvements were noted, the Trust awaited final figures to assess performance against the stretch target set within the winter assurance framework. It was confirmed that mechanisms were in place to analyse outcomes and identify further improvements for the following year, with the organisation recognised regionally for its proactive approach to vaccination.

The Board discussed the ongoing challenge of productivity, particularly in the context of doing more with less and acknowledged that workload allocation and oversight would require further attention. These themes were linked to the medium-term plan and would remain a focus for future Committee discussions.

227/25 Education, Training and Research Committee Chair's Report

The Committee reported that the Trust's financial recovery programme and recruitment controls continued to constrain the expansion of educational and research initiatives.

Improvements in General Medical Council (GMC) survey results and the quality of undergraduate and postgraduate education were noted. However, the level of fatigue among resident doctors remained a concern. The Board was advised that a national ten-point plan to improve working lives was being implemented, with local action plans monitored through the Workforce Committee who agreed to provide a further update to the Board once final actions had been signed off. It had also been agreed that the Education, Training and Research Committee would be updated to ensure actions were closed and cross-referenced as appropriate.

228/25 GGI Report – Action Plan Against Recommendations and Final Form RSP Exit Criteria

The Board received a report comprising two parts. The first section confirmed the finalised RSP exit criteria, which had previously been considered at a special Board meeting in October and was now presented in completed format. The second section reflected on the Good Governance Institute (GGI) review report, which had been received by the Board in August. A workshop had been held in October with the GGI then drafting an action plan in response to the co-development work with board at the workshop. This action plan was presented for adoption and subject to approval, would be incorporated into the Programme Management Office oversight and monitored as part of the Single improvement Plan.

The Board RESOLVED to adopt the GGI Well-Led Review Action Plan within the Single Improvement Plan and acknowledged the Recovery Support Programme exit criteria in its final form.

229/25 Health and Safety Annual Report

The Safety and Quality Committee had endorsed the Health and Safety Report at its 28 November 2025 meeting *(minute ref 213/25).*

The Board noted significant improvements had been made over the past six months following the MIAA review, with five out of six actions now completed and the remaining action partially completed in line with the agreed timeline. Substantial risks associated with the ageing estate around health and safety continued to be managed, with enhanced leadership and engagement around these topics. The Board acknowledged the collaborative efforts that had resulted in greater visibility of risk prioritisation, which would support future capital investment decisions. While a strong presence of risk remained, encouraging signs of improvement were noted, underpinned by positive training performance and active incident reporting and investigation. There had been no enquiries from the Health and Safety Executive during the year. The increase in aggression and staff assault incidents over the past three years was highlighted, with ongoing work to address this trend.

The Board RESOLVED to approve the annual Health and Safety Report.

230/25 Items for information

The following reports were received and noted for information:

a) Maternity and Neonatal Services Update - The Safety and Quality Committee had endorsed the Maternity and Neonatal Service report at its 28 November 2025 meeting *(minute ref 207/25).* The Board's attention was drawn to a specific request to note the inclusion of the training action plan for the Maternity Incentive Scheme, year seven. Following scrutiny by the Safety and Quality Committee, the Board formally recorded its support for the actions required to achieve 90% compliance with PROMPT and fetal monitoring within six months of a trainee's commencement with the Trust

RSP colleagues were asked to provide feedback and acknowledged the considerable progress and the emergence of positive developments, despite improvements not always being immediately visible. The importance of maintaining focus and pace was emphasised, recognising that further challenges and difficult decisions lay ahead. The Board was encouraged to continue working collaboratively and to adhere to the agreed plans, particularly as the organisation approached the winter period. Reference was made to ongoing pressures, including bed occupancy and Emergency Department activity, with a patient story highlighting the significance of advocacy and the patient voice.

231/25 Date, time and venue of next meeting

The next meeting of the Board of Directors will be held on Thursday 5 February 2026 at 9:15am at Lecture Room 1, EC1, Royal Preston Hospital

The meeting closed at 12.30pm

5. MATTERS ARISING AND ACTION LOG UPDATE

Decision Item | M Thomas | 09.40am

REFERENCES

Only PDFs are attached

5.0 - Action log - Board (part I) - 4 December 2025.pdf

Action log: Board of Directors (part I) – 4 December 2025

No Outstanding Actions

ITEMS FOR FUTURE BUSINESS *(for information)*

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

COMPLETED ACTIONS *(for information)*

№	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update
1.	225/25	4 Dec 2025	**Medium Term Planning Framework –** ***a)*** Once finalised, the Board Assurance Statement will be circulated to Board members for comment before being approved by the Chair under delegated authority.	CS&IO	5 Feb 2026	**Completed** **Update for 5 Feb 2026:** Shared in Team Engine 18.12.2026
2.	222/25	4 Dec 2025	**Integrated Performance Report –** A summary update following the population health academy programme work to be provided to the Chair of Safety and Quality.	CS&IO	5 Feb 2026	**Completed** **Update for 5 Feb 2026:** Confirmation received that this was shared.

6. CHAIR'S OPENING REMARKS AND REPORT

Information Item | M Thomas | 09.42am

REFERENCES

Only PDFs are attached

6.0 - Chairs Report - Board of Directors - 5 February 2026.pdf

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Meeting of the	**Board of Directors**		**5th February 2026**
	Part I ☒		**Part II** ☐
Title of Report	**State the name of the report**		
Report Author	Rebecca Black, Executive Business Manager to CEO		
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 December and January by the Trust Chair.		
Link to Strategic Objectives 2025/26	**Patients – deliver excellent care:** Improve outcomes, reduce harm and deliver a positive patient experience.		☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.		☒
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.		☒
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.		☒
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.		☒

1. Introduction

The purpose of this report is to provide an overview of the work and activities undertaken during December 2025 and January 2026.

2. Discussion

During December 2025 and January 2026, I undertook a comprehensive programme of leadership, assurance, and system engagement activities. This included multiple Board and committee-related meetings, extensive 1:1 engagement with executive and non-executive leaders, participation in system-wide Improvement and Assurance Group sessions, collaboration with regional partners including NHSE and ICB leaders, and involvement in key development, performance, and governance discussions. I also engaged directly with stakeholders, staff, and partners to support strategic alignment, operational oversight, and improvement efforts across the Trust and wider system.

3. Lead Governor and Governor Departures

On behalf of the board, I would like to acknowledge the contributions made by three of our governors who have reached the end of their terms of office. Our Lead Governor, Janet Miller, alongside Margaret France who have both served nine years on the council, and Frank Robinson. All three have been diligent in representing our members and have given much of their time and commitment over the past years. Our thanks and appreciation to Janet, Margaret and Frank, we wish them well.

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

The Board held a constructive and robust discussion on the organisation's overall strategic position, including the ongoing focus on improving quality, performance, and financial sustainability. Members reaffirmed the importance of collective leadership and the need for transparency in decision-making as the Trust continues to navigate a challenging operational environment across the NHS.

There was a strong emphasis on:

- maintaining organisational discipline in the delivery of agreed plans
- supporting staff through sustained operational pressures
- ensuring the Trust remains aligned with national and regional expectations
- continuing to explore innovative opportunities, including digital and system-wide collaboration

Overall Strategic Position

The Board discussed the continued operational and financial pressures affecting the Trust and reaffirmed the importance of collective leadership, disciplined decision-making, and support for staff during a sustained period of demand.

Financial Outlook

The Board received an update on the Trust's year-end financial position and noted the challenges in meeting planned financial targets. Work continues across all divisions to improve productivity, strengthen delivery of savings plans, and collaborate with system partners to address the wider financial environment.

Committee Assurance

The Board received assurance reports from its committees, covering audit, safety and quality, finance and performance, workforce, and education. Committees continue to scrutinise key risks and monitor progress against improvement actions.

5. Chair's attendance at meetings

Details below are the meetings attended and activities undertaken during October and November 2025.

Date	Activity
December 2025	
2nd December	121 – Director of Communications and Engagement 121 – Director of Corporate Affairs 121 – Non-Executive Director
2nd December	Chief Executive and Director of Finance
2nd December	Board Development Session
2nd December	Chair and CEO – East Lancashire Teaching Hospital
3rd December	121 - A Vicary (RSP) NHSE 121 – E Woollett, Chair LSC ICB 121 – Non-Executive Director 121 – Director of Corporate Affairs 121 – Managing Director, 1LSC
4th December	Board of Directors
9th December	121 – Director of Corporate Affairs 121 – Director of Public Health
9th December	Volunteers Thank you Event
11th December	1LSC – IAG meeting
11th December	121 – Chief Executive
15th December	LTH – IAG meeting
16th December	Non-Executive Monthly Meeting
18th December	121 – Managing Director, LSC PCB 121 – Non-Executive Director 121 – Chief Executive

23rd December	121 – Director of Communications and Engagement 121 – Director of Corporate Affairs 121 – Non-Executive Director
23rd December	PWC/LTH/ELHT call
January 2026	
6th January	121 – Chief Strategy and Improvement Officer 121 – Director of Corporate Affairs 121 – A Brown, NHWE
6th January	Board Workshop
6th January	Special Board of Directors
8th January	121 – Associate Director of Governance and Risk
9th January	Stakeholders and MP meeting
12th January	1LSC – IAG meeting
13th January	LTH – IAG meeting
15th January	121 – Managing Director, LSC PCB 121 – Director of Communications and Engagement 121 – Chief Operating Officer 121 – Interim CEO, MBHT
15th January	LSC Provider Collaborative Board
19th January	NHSE meeting with CEO
20th January	Non-Executive Monthly Meeting
20th January	Council of Governors
20th January	121 – Chief Executive
22nd January	121 – Chief Medical Officer 121 – Associate Director – Governance and Risk Management
22nd January	Election Process Workshop
23rd January	Special Board of Directors
27th January	Meeting with Senior Asset and Property Manager/Deputy Director of Education

27th January	121 – Chief Strategy and Improvement Officer 121 – Non-Executive Director 121 – Director of Communications and Engagement
29th January	NW System Leaders
29th January	Non-Executive 360 Feedback Session
29th January	LTH IAG Pre-meeting

6. **Financial implications**
   None.

7. **Legal implications**
   None.

8. **Risks**
   None.

9. **Impact on stakeholders**
   Not applicable.

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

7. CHIEF EXECUTIVE'S REPORT

Information Item | S Nicholls | 09.45am

REFERENCES

Only PDFs are attached

7.0 - CEO Report to Board 29.01.2026.pdf

Board of Directors' Report

Meeting of the	Board of Directors		5 February 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		
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.		☒

CHIEF EXECUTIVE'S REPORT

Update on Operational Pressures

Between 8-9 and 27-28 January 2026 respectively, Lancashire Teaching Hospitals experienced periods of exceptional operational pressure, prompting the Trust to escalate to Operational Pressures Escalation Level 4 (OPEL 4).

This decision was taken following careful clinical and executive assessment and reflected the Trust's commitment to acting early where there is increased risk to patient safety and staff wellbeing.

I am pleased to report that, following intensive operational management and sustained efforts by staff across our hospitals and partner services, the Trust quickly managed to de-escalate to OPEL Level 3 at both Royal Preston Hospital and Chorley and South Ribble Hospital.

While this de-escalation may signal improved stability, the organisation continues to operate in a challenging and fragile environment, consistent with ongoing winter pressures across the NHS.

To maintain safety and resilience, a number of enhanced actions associated with OPEL Level 4 are, at times, retained as a precautionary measure. These actions are designed to ensure safe patient flow, support staff, and reduce the risk of further escalation should demand increase again.

Throughout both periods of escalation, essential services remained fully open, and patients requiring urgent care continued to be encouraged to seek help. The Trust also worked closely with system partners to reinforce clear public messaging about accessing health services appropriately, thereby helping to protect emergency care for those who need it most. and we thank our communities for their understanding and support in seeking appropriate alternatives to A&E.

I also want to place on record my gratitude to our colleagues, whose professionalism, flexibility, and dedication during this period was exceptional.

The Board continues to receive regular assurance on patient safety, workforce wellbeing, and operational performance, and remains confident that robust governance arrangements are in place to manage ongoing winter demand. The situation will continue to be closely monitored, and the Trust will take further action where necessary to safeguard high-quality care for our communities.

Ward Reconfiguration - Respiratory

Following a significant amount of due diligence and planning across multi-disciplinary teams, Ward 23's Respiratory unit and Ward 20's Respiratory Enhanced Care provision were recently relocated to Ward 19 at Royal Preston Hospital.

Ward 19, which was closed for some time to allow for extensive refurbishment and improvement works, is now known as the 'Respiratory Ward and Respiratory Support Unit (RSU)' and will provide an improved environment for patients and clinicians for the treatment of respiratory conditions.

A single, consolidated respiratory ward will also expand and share nursing skill sets across the service, improving workforce flexibility and ensuring staff can care for a wider range of respiratory needs when required.

As part of the move, the service will also see the establishment of a Respiratory Assessment Unit (RAU), which will aim to shift appropriate inpatient admissions to ambulatory care, reducing unnecessary hospital stays, complications associated with admission, and overall length of stay.

The creation of integrated pathways across the RAU and virtual ward will move care closer to home, improve patient experience and benefit early supported discharge and admission avoidance.

These works are aligned to our wider Reducing Days Kept Away from Home strategy to ensure patients receive the right care, at the right time, in the right place to reduce the overall length of stay.

A comprehensive staffing consultation and informing period took taken place with those in scope and, on behalf of the Executive Team, I would like to thank everyone for their co-operation, support and professionalism during this period.

Secretary of State visits Chorley & South Ribble Hospital

The Secretary of State for Health and Social Care, Wes Streeting, was joined by local MPs Sir Lindsay Hoyle (Chorley) and Paul Foster (South Ribble) for a visit to Chorley and South Ribble Hospital on Saturday 27 December.

Before a tour of the Emergency Department, the MPs met with Trust Chair, Mike Thomas, Chief Nursing Officer and Deputy Chief Executive, Sarah Morrison, Chief Medical Officer, Steve Canty and Consultant in Emergency Medicine, Nicola Fallon.

All three of our visitors were very appreciative of the work being carried out at both of our hospitals during the very busy winter period.

Pathology Single Service update

As you may recall from previous Board papers, on 28 July 2025 we started the TUPE information and consultation process for pathology colleagues across the system who will be moving to LTH.

To make sure everything goes smoothly, the transfer and launch of the new single pathology service will now happen on 1 April 2026 instead of 1 February as originally planned. This extra time helps us get everything right and aligns with the new financial year, making things simpler.

To support the establishment of the single service, Mr Steve Canty, our Chief Medical Officer has been appointed as the LTH Executive Lead for the Pathology Single Service.

For most colleagues, there will be no immediate changes to where or how they are working now. They will continue working in their current role, location, and team.

Later in 2026, we'll start transforming how we deliver pathology services. Our goals are:

- Better quality and consistency across the network
- Equity of access
- More efficient ways of working.

We'll use automation and digital technology to help make this happen. Any changes will be developed together with colleagues and staff side (trade union) representatives. Colleague input will be key throughout the process.

BMA Industrial action

I'd like to thank all colleagues who worked to keep our patients safe during the recent period of Resident Doctor industrial action between 7am on Wednesday 17 December to 7am on Monday 22 December.

As previously said, Lancashire Teaching Hospitals fully recognises and respects the rights of any of our colleagues to take lawful industrial action. During these strikes, our approach as a Trust was underpinned by compassion, professionalism, and a clear commitment to our organisational values.

Our primary operational focus was the maintenance of safe, life-critical services, particularly across urgent and emergency care pathways. In parallel, we took all reasonable steps to minimise disruption to other essential services, including elective care, cancer diagnostics, and treatment pathways. We looked to ensure as many services as possible continued to operate safely and encouraged patients who needed urgent medical care to continue to come forward as normal, especially in emergency and serious life-threatening cases. We asked patients to attend appointments as planned if we had not contacted them regarding the need to reschedule due to strike action, which was only enacted where it was necessary.

Comprehensive communications, including detailed FAQs, were issued in advance to our workforce to ensure clarity, consistency, and preparedness across services. A total of 23.91% of theatre lists were stood down at Chorley and 1.44% at Preston which accounted for 7.82% of our total activity.

Launch of 24/7 thrombectomy service for Lancashire and South Cumbria

Mechanical thrombectomy is a highly effective treatment for some cases of acute ischemic stroke caused by large vessel occlusion. Timely access to thrombectomy significantly improves patient outcomes, reducing long-term disability and mortality.

The regional thrombectomy service – provided by Lancashire Teaching Hospitals – expanded from five to seven days, as of 30 September 2023.

The service hours over seven days are currently between 8am and 10pm, receiving the last patient by 8pm.

A 24/7 service was commissioned by NHS Lancashire and South Cumbria Integrated Care Board (ICB) in 2024, but this has been delayed due to recruitment challenges.

Further to extensive planning and recruitment, we are pleased to update that the provision of mechanical thrombectomy services for Lancashire and South Cumbria expanded to a 24/7 service on Monday 2 February 2026.

NHS England Performance Update

New NHS England data (15 January 2026) showed significant progress on elective recovery despite record demand throughout 2025. In November, the national waiting list fell by over 86,000, reaching 7.31 million - the second largest monthly drop in 15 years outside the early pandemic period. This milestone comes one year after the launch of the Elective Reform Plan.

The reduction in waits was achieved during the NHS's busiest year on record, with 27.8 million A&E attendances and the highest ever number of ambulance incidents (9.31 million). December alone saw 2.33 million A&E attendances and more than 846,000 ambulance callouts.

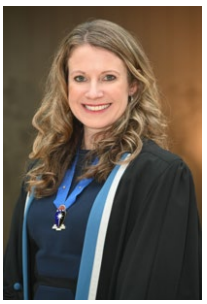
Winter pressures remain significant. Hospitals are managing high levels of flu and norovirus, with norovirus cases rising 57% week-on-week and bed occupancy at 94.1%.

Key operational improvements included expanded evening and weekend elective activity, additional community diagnostic capacity, and streamlined pathways such as "straight-to-test". In November, NHS staff delivered 2.45 million tests and checks, and the number of people waiting over 18 weeks fell compared with 2024. Cancer performance also improved, with 76.5% of patients receiving a diagnosis or all-clear within four weeks of urgent referral.

NHS leadership emphasises that, while progress is encouraging, the service remains under intense seasonal pressure and continues to ask the public to use urgent care services appropriately.

Trust wide successes and service developments

- **Consultant appointed Vice President of RCOG**



Consultant obstetrician Jenny Barber has been appointed as one of five new Vice Presidents of the Royal College of Obstetricians and Gynaecologists (RCOG), a nationally influential role in women's health.

Jenny, who joined Lancashire Teaching Hospitals in 2023, will serve a three-year term alongside her clinical duties, working two days per week for the RCOG. Her portfolio includes shaping national clinical guidelines, workforce models, safe staffing, and strengthening links between frontline practice and national policy.

She will also lead work to amplify women's and service-user voices, ensuring lived experience informs decision-making across maternity and gynaecology.

Jenny's appointment brings strategic benefits to LTH by enhancing the Trust's influence in national discussions and providing early insight into emerging standards. She draws on significant local experience in patient safety, governance, guideline development, and collaboration with the Maternity and Neonatal Voices Partnership. Read more on the Trust website.

- **Huw appointed as new Interim National Medical Examiner**

Congratulations to Dr Huw Twamley, who has been appointed as the interim National Medical Examiner for a 12-month term. Dr Twamley is well known to us at Lancashire Teaching Hospitals, having served as the Regional Medical Examiner for the North West, and he continues to work as a Consultant in Critical Care here.

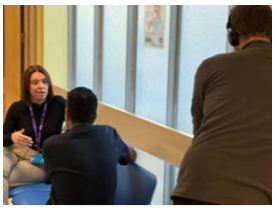
Alongside his clinical and regional leadership roles, he also holds an academic position at the University of Greater Manchester, where he is completing a PhD on the impact of the medical examiner system and teaches on the Masters in Coronial Law programme.

Huw he will provide national professional leadership for the medical examiner system across England and Wales - supporting examiners in strengthening patient safety, quality monitoring and public safeguarding.

A fantastic achievement for Dr Twamley and a proud moment for the Trust. Read more on our website.

- **Sky News visit Royal Preston to report on winter pressures and flu figures**

Sky News visited Royal Preston Hospital in early December for an extensive report on winter pressures and flu figures, taking in the Emergency Department and Ward 23, speaking to Dr Michael Stewart, Professor Mohammed Munavvar and Divisional Director for Medicine, Jo Taylor - pictured being interviewed by Health Correspondent Ashish Joshi about accessing the right care, and community services. Thanks to all for their time and cooperation.



You can watch the Sky News coverage here.

- **BBC North West Tonight visit RPH for NHS Day**

BBC North West Tonight visited Royal Preston Hospital in mid-January, as reporter Gill Dummigan recorded content for the latest BBC NHS Day on Thursday 22 January.

Gill interviewed Rachel Sansbury (Deputy Chief Nursing Officer), Rachel Smith (Specialist Physiotherapist), Professor Mohammed Munavvar (Consultant Chest Physician), Andy Curran (Pictured, Consultant in Emergency Medicine) and Naomi Tate (Discharge Lounge Manager), looking at delayed and complex discharges and what the Trust are doing to improve in this area – coincidentally in a week where Lancashire Teaching Hospitals ran a Multi-Agency Discharge Event (MADE) looking at the issue.

Thanks again to all involved and those who helped organise interviews. You can watch this back on BBC Radio Lancashire's Facebook.

- **LSC NHS Apprenticeship Awards success**

Lancashire Teaching Hospitals achieved strong recognition in the 2025 Lancashire & South Cumbria NHS Apprenticeship Awards, with 15 finalists across the organisation.

The Trust secured two award winners - Ava Bolton (Rising Star - T Level Award) and Lucy Wilson (Equality, Diversity & Inclusion Award) - alongside two highly commended entrants, Cameron West and Lewis Doherty. Lewis was notably shortlisted in three categories. Ava and Cameron are Runshaw College students who completed placements with LTH, while Lucy and Lewis joined the Trust as part of our first Healthcare Apprentices intake in September 2024. Both completed their Level 2 Healthcare Support Worker apprenticeship with Distinction, with Lewis progressing to Level 3.

Judges highlighted Ava's leadership, professionalism and outstanding performance in both academic and clinical settings and praised Lucy's exceptional contribution to inclusive practice within the Neuro Rehabilitation Unit, using her lived experience to positively influence team culture and patient care.

Physical trophy presentations will take place during National Apprenticeship Week in February. The full list of finalists is available here.

- **Angela bows out after half a century of care**

Angela Wilson, Staff Nurse in Outpatients at Chorley and South Ribble Hospital, retired towards the end of 2025 after an exceptional 50-year nursing career.

Angela began her general nursing training in November 1975 at Preston and Sharoe Green Hospitals. Aside from a short career break to raise her children, she worked continuously in nursing for five decades, demonstrating sustained commitment, resilience and adaptability. Her career spanned multiple organisations and regions, including Lancashire, Yorkshire and Scotland, before she returned to Lancashire and rejoined the Trust in 2000.

Within the Trust, Angela made long-standing contributions across several specialties, including Urology at Preston (Ward 15), Outpatients at Preston, and latterly Chorley, where she worked full-time from 2010. You can read Angela's story on our website. Thank you for your service Angela.

- **Making a difference through trauma-informed care**

At a Community of Practice meeting, colleagues heard from Eleanor Walker, High Intensity User Lead, on how trauma-informed care is improving outcomes for some of the Trust's most frequent Emergency Department (ED) attenders. This work forms part of the Health Improvement Plan and the wider health inequalities agenda, supporting individuals with complex emotional, social and psychological needs. Eleanor's role focuses on understanding the underlying drivers of high ED attendance, rather than treating attendance alone as a behavioural issue. Two patient case studies demonstrated how trauma, adverse childhood experiences and emotional distress significantly influence health behaviours — and how small, consistent, person-centred interventions can lead to sustained change.

One patient, previously attending ED almost daily, reduced attendance to near zero over two years following gradual confidence-building support and access to psychological therapies. Another case highlighted how trauma-informed language and staff awareness improved engagement and stability for a patient with long-term conditions.

While reductions in ED use are an outcome, the primary impact is improved wellbeing and more stable, less chaotic presentations. As a lone worker, Eleanor supports around 35 people annually through intensive, tailored support. The service demonstrates how trauma-informed approaches can improve patient experience, reduce inequalities and deliver meaningful, long-term system benefits.

- **First cohort graduate from Reducing Days Kept Away from Home Programme**

The Lancashire Improvement Method (LIM) Programme celebrated the graduation of its first cohort focused on Reducing Days Kept Away from Home in December, following eight months of targeted improvement work addressing patient deconditioning.

Multidisciplinary teams from Ward 14, Ward 16 and Major Trauma collaborated to improve patient outcomes and streamline discharge processes.

Senior leadership engagement was demonstrated at the graduation event, opened by the Chief Operating Officer Katie Foster-Greenwood and Deputy Chief Nursing Officer Rachel Sansbury, who recognised the teams' commitment and impact. Ward teams presented measurable improvements, particularly around board rounds, early mobilisation and embedding daily routines to maintain patient independence.

Key achievements included Ward 14 introducing structured daily routines to support patients sitting out for meals, resulting in 50% of eligible patients mobilising at lunchtime and a reduced reliance on residential rehabilitation beds. Ward 16 strengthened MDT working to promote independence despite environmental and cognitive challenges. Major Trauma increased early mobilisation within 24 hours of admission by 10%, reducing length of stay and pathway 2/3 discharges.

Overall, data shows fewer patients now require two staff for mobility, supporting safer, faster discharges, increased discharge home rates and improved patient experience. While the cohort has graduated, wards have committed to sustaining and spreading the improvements.

- **First Penicillin Allergy De-labelling at LTH**

In December, the Trust successfully completed its first penicillin allergy de-labelling following the launch of a new policy during World Antimicrobial Resistance Awareness Week. This milestone demonstrates the positive impact of the policy on patient care, antimicrobial stewardship, and service efficiency.

ENT surgeons Dr Shreya Reddy and Dr Sagar Mittal sought advice from the microbiology team when managing a complex deep-seated infection in a patient with a documented penicillin allergy. The reported allergy was a rash that had occurred many years previously, resulting in the patient being started on broad-spectrum, second-line intravenous antibiotics.

Following discussion with microbiology, Dr Reddy undertook a structured allergy assessment in line with the new guidance. This confirmed that an oral amoxicillin challenge was low risk. The patient successfully completed the challenge without adverse reaction, allowing the penicillin allergy label to be safely removed.

As a result, the patient was able to receive optimal first-line antibiotic therapy and was discharged on an Outpatient Parenteral Antibiotic Therapy (OPAT) regimen, avoiding a six-week inpatient stay.

Dr Reddy highlighted that the guidance and proforma were easy to use and emphasised the long-term benefits for patient outcomes and future treatment options. This case illustrated the clinical and operational value of penicillin allergy de-labelling at LTH.

- **Staff Memorial Service**

The annual Staff Memorial Service was held in a full chapel at Royal Preston Hospital in early December, as the Trust came together to honour and remember colleagues and friends we have lost over the past year.

Families and staff paid their respects during a moving and dignified service led by Lead Chaplain, Reverend Martin McDonald. Laura Mcmullan, Bereavement & Donor Support Assistant, and Imam Khalid each read poems before I had the honour of reading the names of those we have lost, as candles were lit in their memory.

After a short period of reflection and a minute's silence, Natalie Clough, Bereavement & Tissue Donation Service Lead, recited "The Hands of a Nurse" by Mark Darby and Reverend Simon Gilbertson read Flavia Weedn's poem "Some People". Imam Naeem followed with a poem in Arabic, with Chaplain Martin alternating in English. Throughout the service, Paramedic Rebecca Hunt sang beautifully, adding to the atmosphere of reflection and remembrance.

- **Early Pregnancy Loss Conference**

Towards the end of last year, the Trust hosted its inaugural Early Pregnancy Loss Conference at Kilhey Court, Standish.

Sponsored and funded by the national charity 4Louis, the event brought together healthcare professionals, patient partners and advocacy organisations to explore the clinical, emotional and pastoral aspects of early pregnancy loss.

The event placed bereaved parents at its centre, with three parent speakers contributing. Feedback was overwhelmingly positive, and the Trust is already considering plans to repeat the conference this year. You can read more on our website.

- **Volunteers enjoy Festive meal as special thank you**

Lancashire Teaching Hospitals' Charity funded festive lunches at Royal Preston and Chorley and South Ribble hospitals to thank the Trust's volunteer workforce for their outstanding contribution throughout the year.

Around 300 volunteers support services across the Trust, playing an essential role in enhancing patient and visitor experience and strengthening the hospital community.

Volunteers provide support across a wide range of areas, including welcoming patients and visitors, assisting in the Baby Beat shop and Rosemere Cancer Foundation Café, supporting Chaplaincy services, dedicating time to patients with dementia, and contributing to wellbeing initiatives such as the volunteer therapy dog programme. Their generosity, compassion and commitment continue to make a meaningful difference to both patients and staff.

Senior leaders, including Deputy Chief Executive and Chief Nursing Officer Sarah Morrison and other Executive colleagues, attended the lunches and personally thanked volunteers, reinforcing their importance as valued members of the Trust team.

- **Trust nurse invited to No.10 Christmas lunch**

Neurosurgery nurse Zoe Rufus (Ward 2C, Royal Preston Hospital) was invited to 10 Downing Street for a special Christmas lunch with the Prime Minister Keir Starmer, recognising her outstanding care for patients and exceptional fundraising work.

Zoe was the only NHS worker among 100 public sector guests from services including the fire, police and armed forces. Her fundraising efforts last year supported patients across Neurosurgery and Children's services, including Easter gifts, toiletries and over 600 Christmas presents for wards.

Zoe and her family were seated next to the Prime Minister, making the occasion a memorable acknowledgement of her dedication and contribution to patient experience.

- **Santa brings festive cheer to the Children's Ward**

Royal Preston Hospital welcomed an early visit from Santa Claus thanks to the Cisco Connected Santa programme, bringing festive cheer to children and families on the Children's Ward. Using Cisco's Webex video conferencing technology, Santa joined live from the North Pole, allowing young patients to share their Christmas wishes and enjoy a magical, interactive experience despite being in hospital.

The initiative combined high-quality virtual technology with in-person support from Cisco volunteers and hospital staff. Elves' workshops and a Christmas grotto were created within the hospital, while Santa was able to speak directly to children who were unable to leave their beds via iPads. The Cisco Connected Santa programme has been running for 17 years and supports hundreds of hospitalised children across the UK and Ireland each December, demonstrating the positive impact of technology-enabled partnerships on patient experience. You can read more on our website.

- **Green Prescribing in Radiotherapy**

Specialist Therapeutic Radiographer Katie Fisher has led an innovative green prescribing project at the Rosemere Cancer Centre, demonstrating how nature-based interventions can enhance cancer care.

Developed through her NIHR Applied Research Collaboration North West Coast (ARC NWC) RaCES internship, the project addresses the wellbeing needs of radiotherapy patients alongside clinical treatment. Rosemere treats 300 - 400 patients per month across seven linear accelerators, meaning staff have repeated contact with patients over several weeks.

"Green prescribing" is shown to reduce stress, tackle social isolation, and improve overall wellbeing during treatment. Working with partners, the project has introduced a suite of low-cost, practical initiatives. These include mapped walking routes around the hospital with QR-linked mindfulness content, seed swaps to encourage outdoor activity and social connection, nature imagery and window wraps in treatment areas, and information boards promoting local green spaces and community activities. You can read more on our website.

- **From China to Royal Preston Hospital – Dr Khan's inspirational journey**

When Dr Naveed Ullah Khan joined Lancashire Teaching Hospitals in October 2023 as a Senior Clinical Fellow in Neurology, it not only marked his first role in the NHS but the beginning of a remarkable period of professional and personal growth.

His journey from China to Preston took in exams, visa delays, research, teaching, and the daily realities of raising a child with severe autism, tied together by his resilience, modesty and determination.

You can read Dr Khan's full and inspirational story on our website.

1. RECOMMENDATIONS

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

8. BOARD ASSURANCE FRAMEWORK

Decision Item | S Regan | 10.00am

REFERENCES

Only PDFs are attached

8.0 - Board Assurance Framework - Final.pdf

Board of Directors Report

Meeting of the	Board of Directors	5th February 2026
	Part I ☒	**Part II** ☐
Title of Report	Board Assurance Framework (BAF) Report	
Report Author	Simon Regan, Associate Director of Risk & Assurance,	
Lead Executive Director	Executive Directors	
Recommendation / Actions required	The Board of Directors are asked to: • Note and approve the updates to the BAF. • Approve that Principal Risk 7 (2025/26) related to Reliance on temporary medical workforce can be controlled.	
	Decision ☒	**Assurance** ☐ / **Information** ☐
Executive Summary	This paper provides an update on the Board Assurance Framework (BAF), which contains the Principal Risks to the delivery of the 2025/26 Corporate Objectives. Updates since the last Board of Directors meeting: • In relation to Principal Risk 1 (2025/26) related to Patient experience within the urgent and emergency care pathway – the risk score has not progressed in line with the planned trajectory and the risk score is now off track. • Principal Risks 4 (Timely access to planned and cancer care) and 5 (Timely access to urgent and emergency care) linked to 'Performance' remain off track with the trajectory for a reduction in the risk scores and trajectories are under review. • For Principal Risk 6 (25/26) related to timely access to diagnostic investigations, the risk score was increased back to 16 from a score of 12 in December 2025 following a drop in diagnostic (DM01) performance in November 2025. As the score has been increased, the risk is now off track with the planned risk trajectory and this is being reviewed. • Principal Risks 12, 13 and 14 (25/26) linked to 'Productivity' continue to be reviewed month on month with a plan to review the trajectory accordingly, as and when assurance is obtained. • Principal Risk 8 (Experience of staff, with specific focus on under-represented staff groups) and Principal Risk 10 (Failure to effectively manage staff absence and achieve Trust and National target rates have not seen the reduction in the risk scores in line with their planned trajectory and are considered off track. The target control date for Principal Risk 10 has been changed to the end of March 2026 to support the improvements in controls and assurances.	

	• In relation to Principal Risk 2 (2025/26) related to Higher than trajectory rates of Clostridioides difficile (C.*difficile*) Infection – cases of C.*difficile* continue to track below trajectory and given the increased confidence that the Trust will remain below the planned trajectory, the score has been reduced from 16 to 12 in January 2026. Focus remains on cleaning standard implementation. • Principal Risk 7 (2025/26) related to Reliance on temporary medical workforce – the risk score has been reduced from 12 to 8. The risk score is now in line with its target score and it is therefore recommended that the Committee endorses the recommendation to the Board of Directors that this risk be considered reasonably 'controlled'. • There has been no further changes to Principal Risk scores since the last meeting of the Board of Directors. • There are currently no operational high risks of concern escalated to the Board within the BAF this month. • The Trust remains within segment five of the NHS Oversight Framework (NOF) and the Trust are part of the recovery support programme.		
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.		☒
Committee Approval:	Committees of the Board	**Date:** December 2025 & January 2026	
Operational Group Review:	Risk Management Group	**Date:** 16 December 2025	
Link to Board Assurance Framework:	All Principal Risks within the BAF		
Appendices	Appendix 1: Board Assurance Framework		

1. Background

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

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

2. Discussion

2.1 Board Assurance Framework

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

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

- In relation to Principal Risk 1 (2025/26) related to Patient experience within the urgent and emergency care pathway – the risk score remains off track with the planned reduction trajectory. Following analysis of the length of stay for patients in ED and the length of stay analysis that has been completed at specialty level, a decision to reconfigure the bed base is being progressed with an EQIA underway and consultation has commenced. The work has incurred some complexity and will be phased across Feb and March 2026. Draft plans for a new Mental Health Review Centre are progressing to a business case being submitted to NHS England for the release of capital.
- Principal Risks 4 (Timely access to planned and cancer care) and 5 (Timely access to urgent and emergency care) linked to 'Performance' remain off track with the trajectory for a reduction in the risk scores and trajectories are under review.
- For Principal Risk 6 (25/26) related to timely access to diagnostic investigations, the risk score was increased back to 16 from a score of 12 in December 2025 following a drop in DM01 performance in November 2025, linked to a dip in non-obstetric ultrasound. Workforce options to recruit and retain staff are being developed. As the score has been increased, the risk is now off track with the planned risk trajectory and this is being reviewed.
- Principal Risks 12, and 14 (25/26) linked to 'Productivity' continue to be reviewed month on month with a plan to review the trajectory accordingly, as and when assurance is obtained.
- For Principal Risk 13 (2025/26) related to the cash consequences of the Trust's underlying financial position, the formal request for £9.5 million in January 2026 was approved and has been received. Permission has been given by the Board of Directors to request a further £4 million in February 2026. A further driver to the cash requirement is as a result of the pause of deficit support funding in November and December 2025. The trajectory will continue to be reviewed month on month and adjusted accordingly should assurances be obtained.
- Principal Risk 8 (2025/26) related to Experience of staff, with specific focus on under-represented staff groups – the risk score has not been reduced in line with trajectory and is now considered off track. Staff Survey data will be reviewed to understand the impact of actions taken and the revised trajectory will be considered as a result.

- Principal Risk 10 related to Failure to effectively manage staff absence and achieve Trust and National target rates – the risk score has not been reduced in line with trajectory and the target control date has been extended to the end of March 2026. Whilst there have been improvements in absence rates compared to the last financial year, there have been delays in implementing the actions related to the digital absence management system, occupational therapist and the absence plan on a page.
- In relation to Principal Risk 2 (2025/26) related to Higher than trajectory rates of Clostridioides difficile (C.*difficile*) Infection – cases of C.*difficile* continue to track below trajectory and given the increased confidence that the Trust will remain below the planned trajectory, the score has been reduced from 16 to 12 in January 2026. Focus remains on cleaning standard implementation. The vacancy freeze has impacted on the ability to deliver on time. An assessment of the revised timeline is currently being undertaken and will be updated at the Safety & Quality Committee in February 2026.
- Principal Risk 7 (2025/26) related to Reliance on temporary medical workforce – the risk score has been reduced from 12 to 8 following improved assurances to Safety & Quality Committee in September 2025 in relation to medical staffing. In addition, the enhanced oversight of medical bank and agency usage has resulted in a reduction in variable pay. Development of the 42 week productivity tool continues with plans to test the first specialities in January 2026. The risk score is now in line with its target score and it is therefore recommended that the Board of Directors approve the recommendation that this risk be considered reasonably 'controlled'.

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

2.2 Operational High Risks for Escalation/De-escalation

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

3. Financial implications

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

4. Legal implications

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

5. Risks

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

6. Impact on stakeholders

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

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

7. Recommendations

7.1 It is recommended that the Board of Directors:

- Note and approve the updates to the BAF.
- Approve that Principal Risk 7 (2025/26) related to Reliance on temporary medical workforce can be controlled.

Lancashire Teaching Hospitals
NHS Foundation Trust

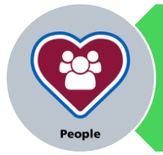
Board Assurance Framework

2025/26

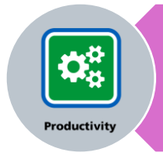
Board of Directors – February 2026

Patients – deliver excellent care

Performance – deliver timely, effective care



People – be a great place to work



Productivity – delivery value for money

Partnership – be fit for the future

Excellent care with compassion

Always Safety First

@LancsHospitals

How the Board Assurance Framework fits in

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

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

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

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

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

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

Understanding the Board Assurance Framework

Risk Rating Matrix (Likelihood x Consequence)

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

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

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

Our strategic approach at a glance

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

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

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

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

Lancashire & South Cumbria New Hospitals Programme

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

Enabling strategies

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

Single Improvement Plan

Partnerships | People | Patients | Productivity | Performance

Strategic Objectives

Patients – deliver excellent care

Improve outcomes, reduce harm and deliver a positive patient experience

Performance – deliver timely, effective care

Deliver agreed trajectories in clinical performance

People – be a great place to work

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

Productivity – deliver value for money

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

Partnership – be fit for the future

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

2025/26 Corporate Objectives

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

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

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

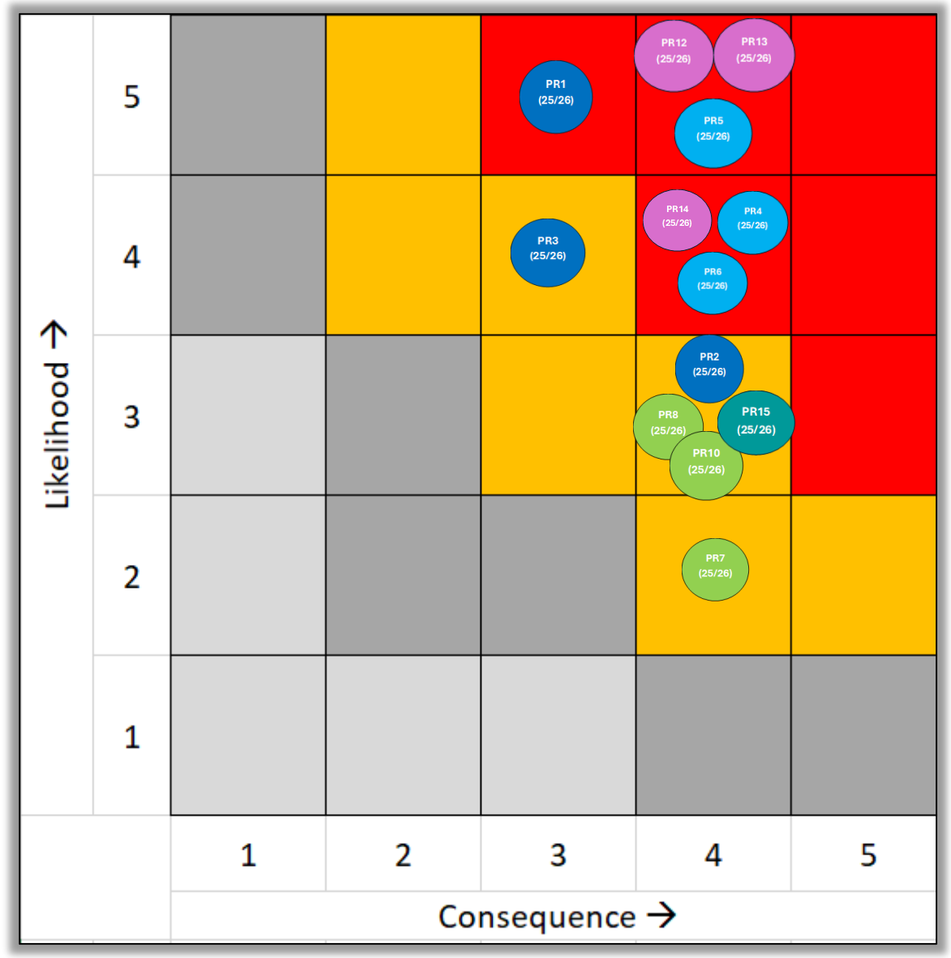
Productivity
- To provide value for money services by spending less, spending well and spending wisely
- To deliver sustained improvement evidenced through the single improvement plan
- Improve our underlying productivity and efficiency
- To develop a clinical services strategy for the organisation

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

Principal Risk Management

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

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



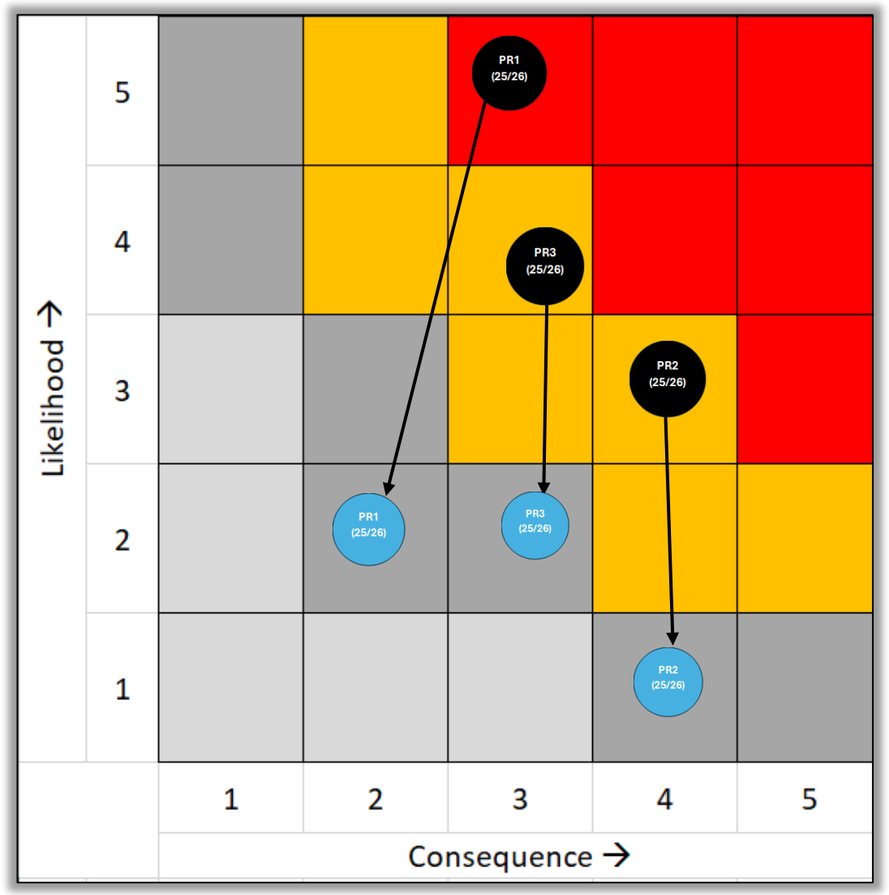
Key- Dark Blue = Patients, Light Blue = Performance, Green = People, Pink = Productivity, Turquoise - Partnership

Patients: Deliver excellent care

Monitored through Safety & Quality Committee

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

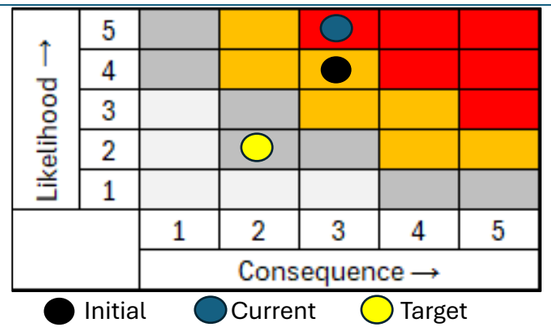
Ref.	Purpose of the objective	Scope and Focus of the Objective	Status
CO1	Improve outcomes and prevent harm	• Design a new medical model for UEC pathways. • Improvement to meet the average time to see a clinician in ED standard • Internal professional standards will be met by each specialty • Develop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



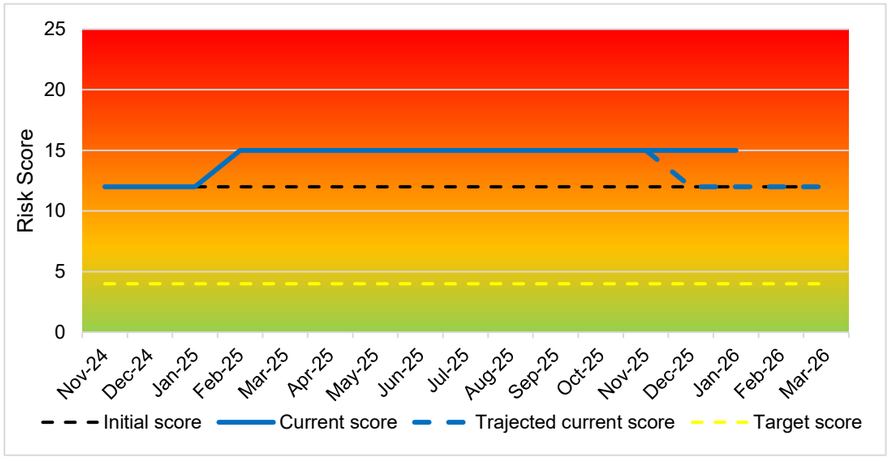
Heat map key: Black = current score, Blue = target score

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

Principal risk 1 (25/26) (ID 2102)	Risk Title:	Patient experience within the urgent and emergency care pathway		
	Risk Description:	There is a risk that patient experience within the urgent and emergency care pathway may be negatively impacted due to high service demand, long waiting times and overcrowding, affecting the ability to deliver care and communication in line with expectations. This could result in reduced patient satisfaction, increased complaints, poor staff experience, regulatory intervention, and potential reputational damage to the Trust.		
Committee	Safety & Quality	Risk Appetite and Tolerance	Cautious 1-6	
Director	Chief Nursing Officer	5Ts status	Treat	
Date risk opened	05/12/24	Date of last review	20/01/26	
		Target control date	31/07/26	



Risk Score Tracker



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

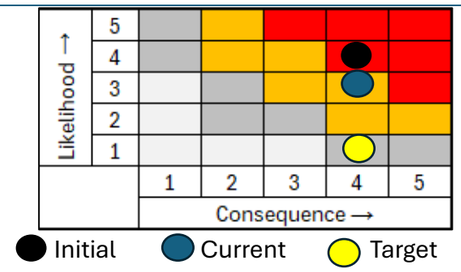
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Twice annual nurse staffing assessments. • Patient experience and Involvement Strategy. • Patient Experience & Involvement Group. • Single Improvement Plan related to patient experience. • National OPEL Framework. • L&SC daily Gold Command meetings. • Escalation Plan (including Full Capacity Protocol, Bed Escalation and Extreme Escalation). • Urgent & Emergency Care Delivery Board. • Urgent & Emergency Care Picker Survey Action Plan. • Discharge Improvement Plan.	• Community demand for primary and UEC services. • Community ability to increase the number of new patients being seen in 2 Hour Urgent care. • Alternatives to Emergency Care. • Ageing estate and environment. • Sub-optimal escalation areas. • Financial constraints. • Unpredictability of patient acuity. • Gap in the required number of beds. • Patients cared for outside of designated bed spaces.	<u>Level 1 Assurance</u> • Complaints and concerns – approx. less than 1% versus attendances. • ED dashboard provides monthly overview of safety, quality and performance metrics in ED. • Boarding position reported as part of the Safety & Quality dashboard with underpinning policy and procedure in place to ensure minimum care standards are met. • Improved position at CDH in relation to time to triage, average time to see a clinician. • STAR patient experience has some areas of positive performance. <u>Level 2 Assurance</u> • Patient Experience & Involvement Group reports to Safety & Quality Committee • Urgent and Emergency Care Picker Survey reported to Safety & Quality Committee. <u>Level 3 Assurance</u> • Friends & Family Test – some areas of positive assurance. • UEC survey reflecting outcomes 'about the same' as other Trusts	• Time to see a clinician at RPH consistently exceeds the 60 min average target. • Inpatient survey identified medicine at RPH most prevalent area of less positive experiences. • The CDH site UEC pathway is demonstrating increased occupancy levels leading to longer length of stay at the start of the pathway. Friends and Family Test – gaps related to communication, waiting times and overall experience.

Risk Treatment

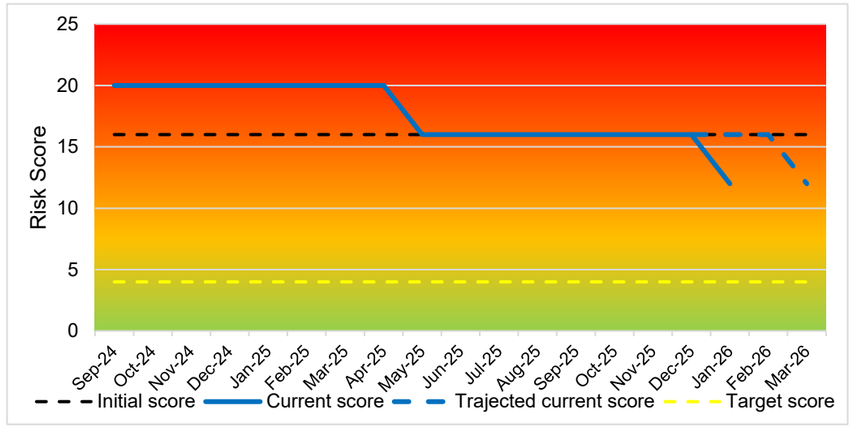
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action</u>
Assess the configuration of bed base to determine the most appropriate model for RPH ED.	S. Morrison	~~28.02.26~~ 31.03.26		Assess the configuration of bed base to determine the most appropriate model for RPH ED.
Increase capacity in 2 hour Urgent Care (care connexions).	S. Morrison	~~30.01.26~~ 31.03.26		Increase capacity in 2 hour Urgent Care (care connexions).
Work in partnership with LSCFT to develop a Mental health Review Centre adjacent to ED to reduce the length of time patients spend waiting with a mental health diagnosis in ED.	S. Morrison	30.09.26		Work in partnership with LSCFT to develop a Mental health Review Centre adjacent to ED to reduce the length of time patients spend waiting with a mental health diagnosis in ED.

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

Principal risk 2 (25/26) (ID 1157)	Risk Title:	Higher than trajectory rates of Clostridioides difficile (C.*difficile*) Infection		
	Risk Description:	There is a risk that there will be higher than trajectory rates of patients contracting C.*difficile* infection. The reasons for this are multifactorial and present a risk of increased mortality and morbidity, longer length of stay, poor patient experience, regulatory action, and reputational impact.		
Committee	Safety & Quality	Risk Appetite and Tolerance	Cautious 1-6	
Director	Chief Nursing Officer	5Ts status	Treat	
Date risk opened	09/06/21	Date of last review	20/01/26	
		Target control date	31/03/26	



Risk Score Tracker



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

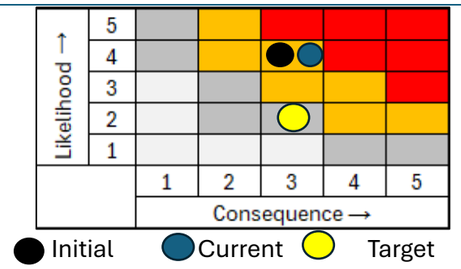
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Annual IPC Plan in place approved by IPCC and Trust Board. • IPC Policy in place. • Director for IPC and Matron for IPC in place. • Mandatory annual IPC e-learning core skills for all staff. • Antimicrobial pharmacist in post to drive improvements in antimicrobial usage and stewardship. • National cleaning standards in place on 15 wards, with remaining wards completing IPC audits and ward daily cleaning check lists. • Enhanced cleaning/fogging in place as required. • Sporicidal cleaning product (capable of killing C. difficile spores) is in place for general ward environmental cleaning • Ward whiteboard provides visibility of patients who present an infection risk to prompt timely action. • Isolation Room Dashboard ensures visibility of infection status in single rooms, ensuring rooms are used correctly and efficiently. • A rapid gastrointestinal test is available for exclusion of infection in diarrhoeal patients to aid rapid diagnosis. • Operational IPC meetings across Divisions. • Weekly virtual C.*difficile* ward round to support review and prevention, predominantly with relapses.	• Patient non-concordance with medical advice. • High prevalence nationally and community onset cases identified upon attendance at the hospital which creates an increased risk to others. • Non-adherence to antimicrobial guidelines in some cases. • Some staff demonstrate non-compliance with IPC advice and policy. • Isolation facilities insufficient to meet IPC needs across all infections, exacerbated by operational pressures in ED. • Ageing estate impacting upon IPC controls. • Lack of funding to support improvements to ageing estate. • A high number of blockages in the single stack sewage system leading to backflow of infectious waste into clinical areas. • A high frequency of macerator blockages and down-time leading to higher risk disposal methods of infectious waste • Lack of decant facilities to allow for thorough environmental decontamination. • Insufficient space for appropriate separation and storage of clean and dirty items on clinical areas • Funding for the implementation of the domestic services elements of the National Cleaning Standards 2021 is in place but being released in phases. There are 15 areas where this is implemented. • Delays in recruiting to domestic services vacancies due to vacancy controls in place.	<u>Level 1 Assurance</u> • IPC Dashboard triangulating process measures with outcome data. • Fogging compliance data available • Hospital acquired infection are reported on Datix. Themes and trends are monitored to identify learning. • Incident oversight in PSIRF triage meetings and regular MDT reviews under PSIRF for high prevalence wards. • For 2024/25, the final number of cases was below the trajectory by seven cases. • 2025/26 cases continue to track below trajectory. • IPC BAF report reviewed and shared at IPCC for assurance. • IPC monthly revalidation audits including hand hygiene, commodes, environmental checks and mattress checks. <u>Level 2 Assurance</u> • Monthly reporting into S&Q Committee, IPCC and Divisional IPC meetings, along with bi-monthly reporting into H&S Committee. <u>Level 3 Assurance</u> • Monthly IPC committee includes internal stakeholders and system partners from the ICB, UKHSA and LCC. • ICB & NHSE IPC Collaborative meetings. • NHS England / UKHSA external review in 2024.	• Inconsistent audits on National Cleaning Standards – not all areas compliant. • Trust / NHS England – UKHSA Review of wards that do not have national cleaning standards in place show that this gap could be contributing to an increase in infection rates.

Risk Treatment

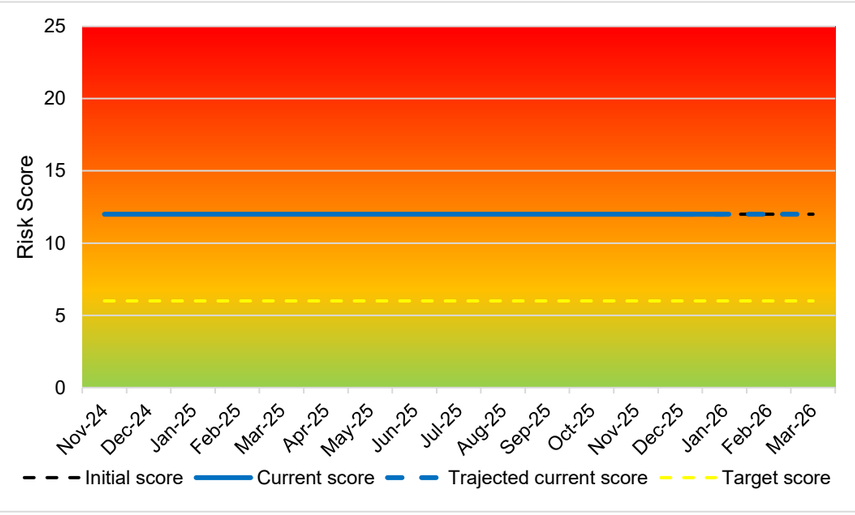
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Continue to implement the C.difficile improvement plan monitoring effectiveness through infection prevention and control committee	C. Gregory	31.03.26		Jan 26: The number of cases continues to track below trajectory. Focus continues on cleaning standard implementation, including training and assurance processes.
Implement the national cleaning standards phase 3 of 3.	C. Gregory/ J. Ashley	31.03.26		Jan 26: Full implementation planned for 31.03.26. The vacancy freeze has impacted on the ability to deliver on time. An assessment of the revised timeline is currently being undertaken and will be updated in the February 26 committee.

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

Principal risk 3 (25/26) (ID 2103)	Risk Title:	People experiencing Health inequalities	
	Risk Description:	There is a risk that the Trust will be unable to effectively address health inequalities because of disparities in access to healthcare services, social determinants of health (such as socioeconomic status, education, and housing conditions), commissioning arrangements, and unequal distribution of resources across communities. This could result in poorer health outcomes for disadvantaged groups, increased pressure on acute and emergency services, reduced patient satisfaction, potential reputational damage for the Trust, non-compliance with regulatory standards and missed opportunities for improving population health. The Trust is part of a wider system approach to health improvement and will work with partners to affect this, recognising the limitations of single services in affecting outcomes in a material way for people.	
Committee	Safety & Quality	Risk Appetite and Tolerance	Cautious 1-6
Director	Chief Nursing Officer	5Ts status	Treat
Date risk opened	05/12/24	Date of last review	20/01/26
		Target control date	31/03/27



Risk Score Tracker



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

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

Risk Treatment

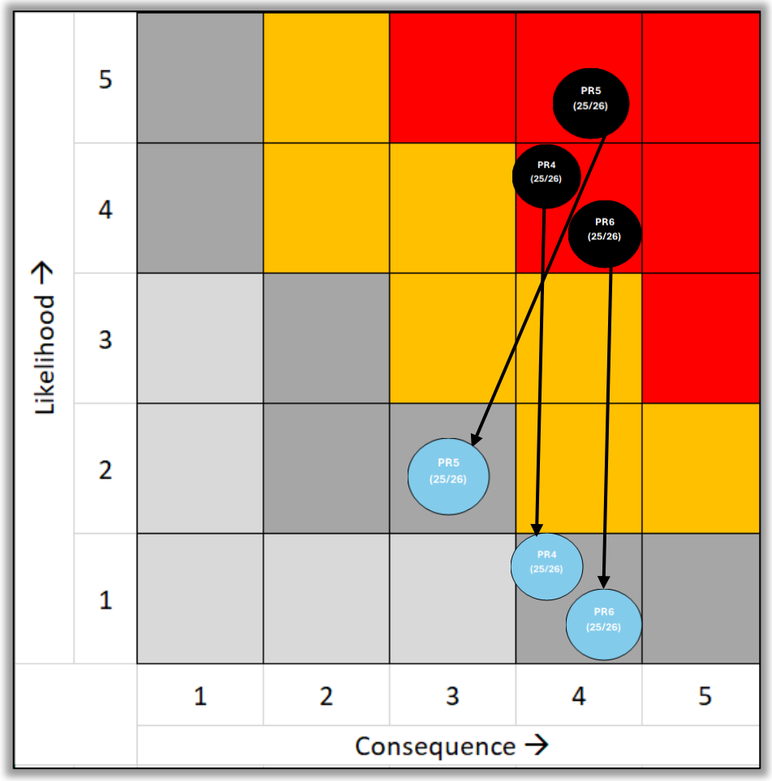
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Identify approach to driving health inequalities reduction through each portfolio of the single improvement plan	S. Morrison	~~31.12.25~~ 31.03.26		Jan 26: Part of planning for SIP 26 and has commenced.
Support case to approve the data sharing agreements between primary and secondary care.	A. Brotherton	~~31.12.25~~ 31.12.26		Jan 26: Awaiting outcome.
Delivery of the Trust's Health Improvement Plan through the three main strategic drivers 1. Awareness 2. Culture 3. Prevention	S. Morrison	31.03.26		Jan 26: Plan on a page approved through health inequalities group to enable communications plan to commence. The Safety and Quality committee will receive a twice yearly update on progress against the agreed actions within the health improvement plan evidencing the Trusts contribution towards this.

Performance: Deliver timely, effective care

Monitored through Finance & Performance Committee

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

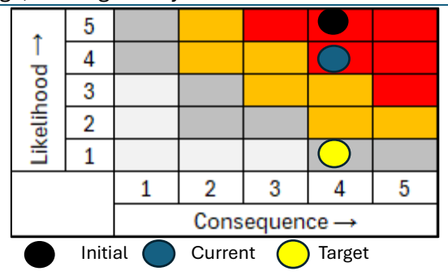
Ref.	Purpose of the objective	Scope and Focus of the Objective	Status
CO5	To minimise the risk of harm to patients through the continued delivery of our cancer recovery plan	• Delivery of more elective care to further improve performance against cancer waiting times standards. • Working in partnership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



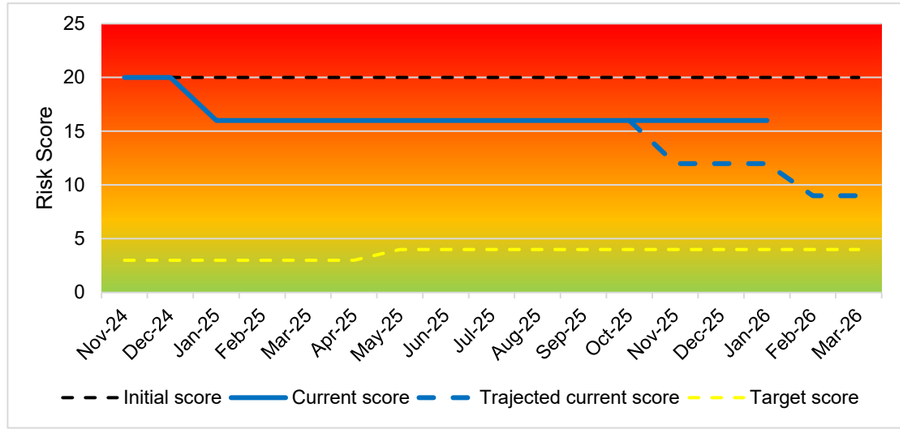
Heat map key: Black = current score, Blue = target score

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

Principal risk 4 (25/26) (ID 1125)	Risk Title:	Timely access to planned and cancer care	
	Risk Description:	There is a risk that there will be insufficient capacity to ensure timely access to planned and cancer care. This is because of backlogs that continue to be seen from the COVID period, surges in demand, shortfalls in capacity, the impact of industrial action, and financial restrictions limiting the ability to utilise external capacity. This could result in patient harms associated with a delay in timely access to planned and cancer care, poorer patient outcomes, inability to meet national constitutional standards, claims, poor patient experience, reputational damage, and regulatory action.	
Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious 1-6
Director	Chief Operating Officer	5Ts status	Treat
Date risk opened	19/05/21	Date of last review	12/01/26
		Target control date	31/03/26



Risk Score Tracker



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

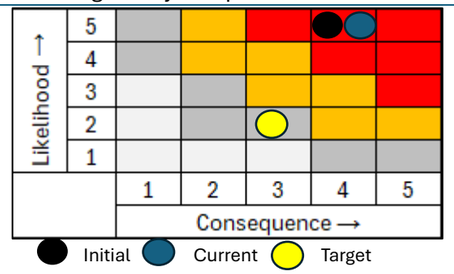
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• 25/26 Annual activity & Performance plans have been outlined to seek to deliver reduction in long waiting RTT targets. Plans include monthly trajectories and associated action plans. • Clear identification of clinical priorities via the use of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

Risk Treatment

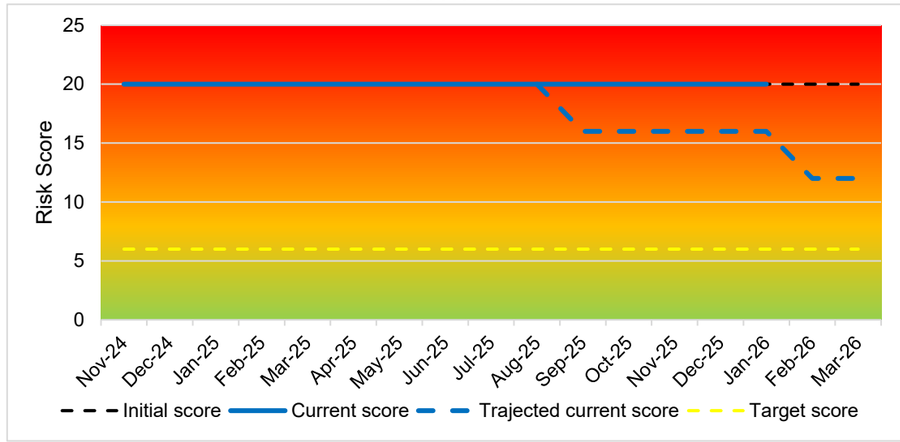
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Agree and implement L&SC validation policy	L. Walsh	31.12.25	12.01.26	Jan 26 : Ratification completed in other providers. All providers applying the same principles and approach.
Review of booking, scheduling and administrative resource benchmarking options	K. Foster-Greenwood	31.03.26		Jan 26 : Associate Director of Productivity post approved to lead the Admin & Clerical change programme. Awaiting advertising.
Capacity & Demand modelling to be undertaken for core specialities	K. Foster Greenwood	31.03.26		Jan 26: New action - 4 Specialities have had Exec Check & Challenge. Programme ongoing.
Scope options to provide interim A&C capacity to increase activity/booking and validation	K. Foster Greenwood	27.02.26		Jan 26: New action - External Bank A&C advert commenced. Scoping insourcing options to increase A&C capacity via external funding.

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

Principal risk 5 (25/26) (ID 2104)	Risk Title:	Timely access to urgent and emergency care	
	Risk Description:	There is a risk that patients may experience delays in timely access to urgent and emergency care because of high demand, insufficient out of hospital provision for patients who do not meet the criteria to reside in hospital, limited bed availability, workforce shortages, and delays in patient flow throughout the hospital and community. This could result in longer waiting times, compromised patient safety and experience, increased clinical risk, poorer health outcomes, and potential breaches of national performance targets, impacting the Trust's reputation and regulatory compliance.	
Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious 1-6
Director	Chief Operating Officer	5Ts status	Treat
Date risk opened	05/12/24	Date of last review	12/01/26
		Target control date	31/03/26



Risk Score Tracker



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

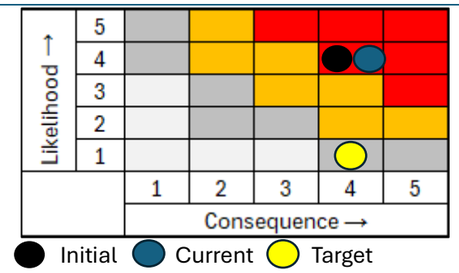
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Clinical triage processes are established. • OPEL and internal Site Pressure Score Framework and protocols are in place • L&SC daily Gold Command meetings. • Escalation and Surge Plans defined and in place. • Ambulatory and admission avoidance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

Risk Treatment

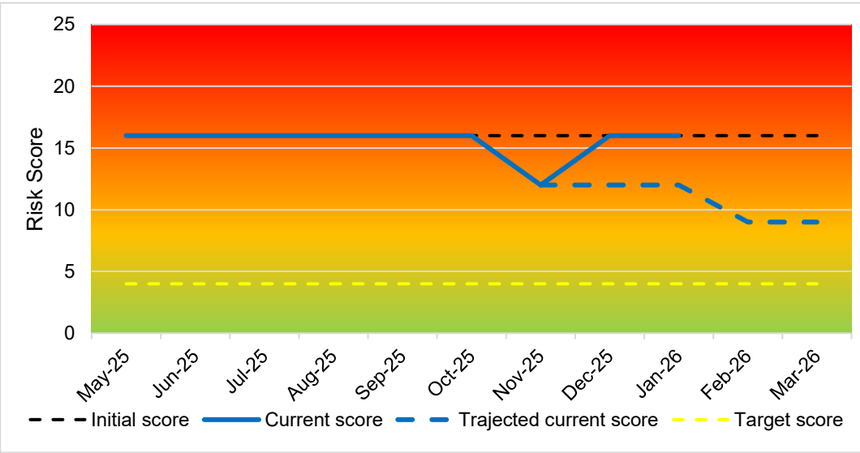
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Undertake the Emergency Care Intensive Support Team (ECIST) Capacity and Demand Model	D Bedford	31.12.25	31.12.25	Jan 26: ECIST have completed initial C&D work and are running a workshop on 21.01.26 with Clinicians and Divisions
Review of VW model and funding	L Walsh/C Gregory	31.12.25	23.12.25	Jan 26: Funding alignment within budgets completed & VW will be handed over to the Division of Medicine in January 2026
Review the Emergency Village Model of Care with ECIST support	D Bedford	31.03.26		Jan 26: ECIST confirmed Model of Care workshop to take place 21.01.26
Conclude and evaluate Ward & Board round standardisation	R Sansbury	31.03.26		Dec 25: Commenced a new improvement programme in September 25 to support colleagues to use improvement methodology to implement the ward and board round standards. An audit is currently underway to assess compliance with the key MDT Board round and ward round standards across the Trust with the aim of developing areas for improvement and then embedding into the safety triangulation accreditation review (STAR) programme for ongoing monitoring.
Increase Virtual Ward occupancy to minimum of 75% by March 2026.	L. Walsh	31.03.26		Jan 26: Dec 25 utilisation increased to 62.6%

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

Principal risk 6 (25/26) (ID 2188)	Risk Title:	Timely access to diagnostic investigations		
	Risk Description:	There is a risk of delays in the completion of diagnostic investigations linked to cancer and elective pathways of care due to high levels of demand, shortfalls in capacity, and financial restrictions limiting the ability to utilise external capacity. This could result in patient harms associated with a delay in timely diagnosis, poorer patient outcomes, inability to meet national constitutional standards, claims, poor patient experience, reputational damage, and regulatory action.		
Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious 1-6	
Director	Chief Operating Officer	5Ts status	Treat	
Date risk opened	03/06/25	Date of last review	12/01/26	
		Target Control date	31/03/26	



Risk Score Tracker



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

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

Risk Treatment

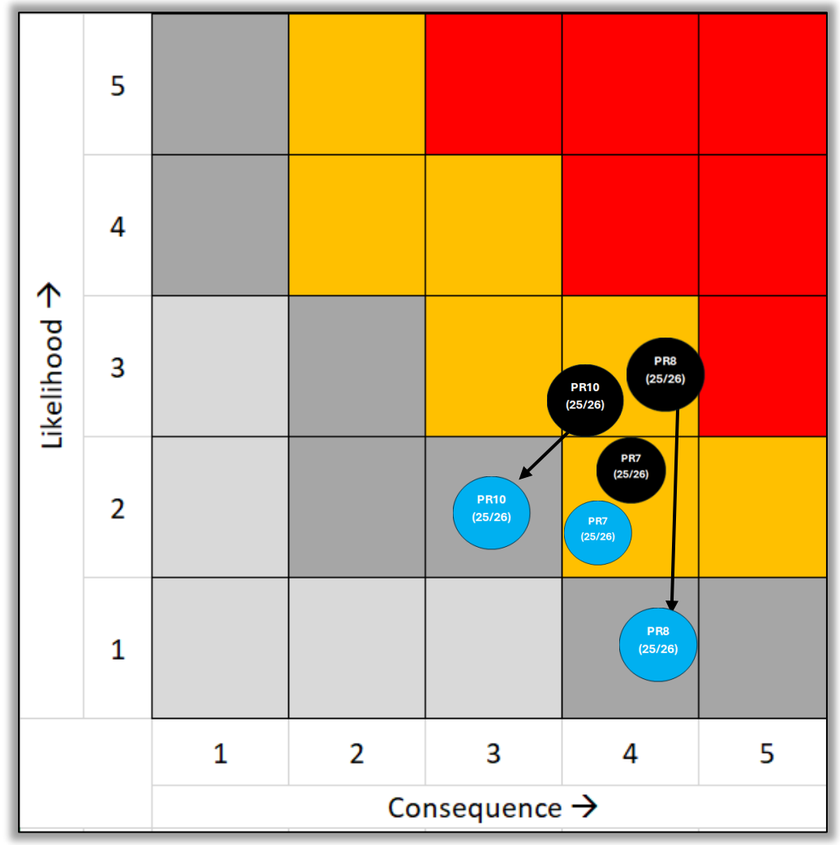
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Develop workforce offer to support recruiting and retaining non-obstetric ultra sonographers	D. O'Brien	31.01.26	12.01.26	Jan 26: Proposal drafted and shared with Execs.
Complete the build and mobilisation of additional endoscopy space	K. Foster-Greenwood	28.02.26		Jan 26: On track for February 2026
Recruit workforce in line with 5th room business case	D. O'Brien	28.02.26		Jan 26: Recruitment ongoing – 2 x B5s with unconditional offers (1 x start date Jan 26), 1 x HCA unconditional offer -started in post. 4 x B5s with conditional offers undertaking pre-employment checks. Target date updated to February 2026 to align to the endoscopy build.
Capacity & Demand analysis to be completed for key Diagnostic modalities	K. Foster Greenwood	31.03.26		Jan 26: New action - Modelling commenced.

People: Be a Great Place to Work

Monitored through Workforce Committee & Education, Training & Research Committee

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

Ref.	Purpose of the objective	Scope and Focus of the Objective	Status
CO9	To right size the workforce to support the delivery of safe, affordable and sustainable services, aligned with the Trust's strategy	• To deliver a workforce plan that responds to commissioning intentions and the communities we serve. • Achieve the headcount reduction needed to ensure successful delivery of the waste reduction workforce plan whilst maintaining safety.	Principal Risk 7 recommended as controlled
CO10	To strive to improve experience at work by actively listening to our people, and turning understanding into positive action	• To ensure staff choose to stay and work in Lancashire Teaching Hospitals and they are healthy at work. • Delivery of the People Plan. • To progress staff advocacy scores relating to provision of care. • To deliver the sexual safety charter within the organisation.	Risks identified
CO11	To be consciously inclusive in everything we do	• To ensure staff are equipped with the skills to create inclusive cultures that deliver inclusive care. • Deliver the Equality Diversity and Inclusion strategy. • To demonstrate we are an Anti-Racist Organisation.	Risks identified
CO12	To build a positive culture, demonstrating our values in action through increased colleague engagement across the organisation.	• Leaders at all levels recognise their contribution to creating a culture where colleagues feel, ○ Together we are one team ○ Together we can create your future ○ Together we make extraordinary things happen • We will all strive to demonstrate our 'shared responsibilities' in the way we interact with one another.	No risk identified
CO13	To develop leaders at every level of the organisation with the skills and behaviours that are able to provide compassionate leadership.	• To enhance the governance and leadership within the Board of Directors through the provision of a Board development programme. • To invest in the development of the senior leadership team within the organisation. • To support the development of leaders at department level through the delivery of leadership training and education.	Principal Risk 11 controlled December 2025

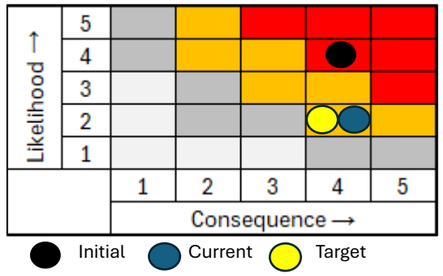


Heat map key: Black = current score, Blue = target score

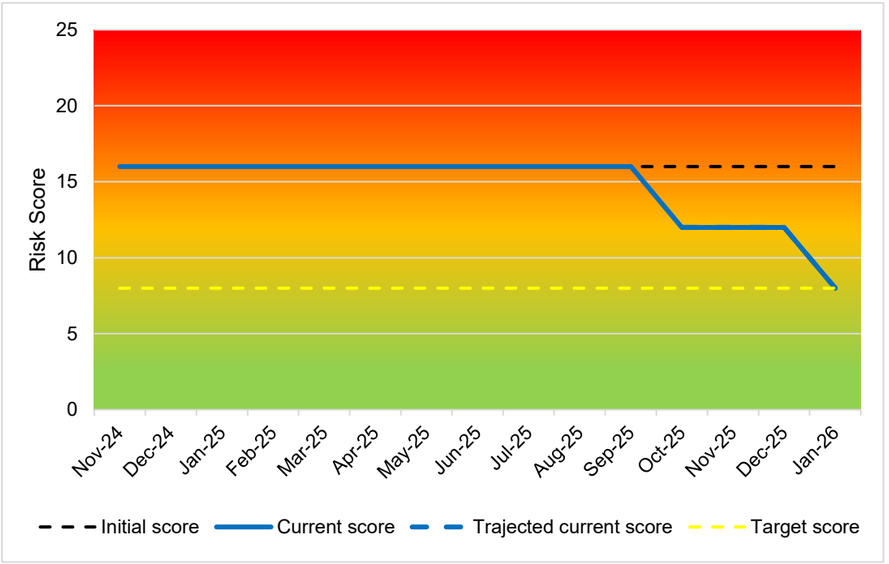
Strategic Objective: People	**Corporate Objective:** To right size the workforce to support the delivery of safe, affordable and sustainable services, aligned with the Trust's strategy	Overall Assurance Level	Medium

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

Committee	Workforce Committee	Risk Appetite and Tolerance	Open 4-8
Director	Chief Medical Officer	5Ts status	Treat
Date risk opened	05/12/2024	Date of last review	06/01/26
		Target control date	31/01/26



Risk Score Tracker



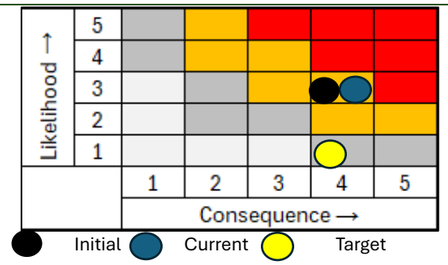
Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

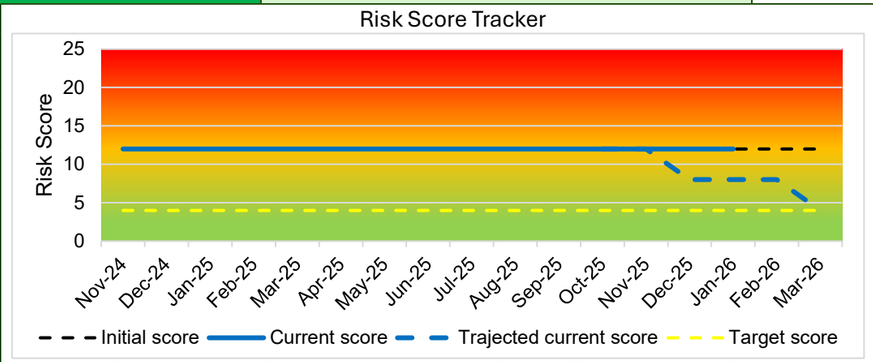
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Medical and Dental Job Planning Policy. • Medical Annual Leave policy in place. • Job plans in place for Consultants and Speciality Doctors. Agreed annually as a prospective plan. • Daily Management System in place to aid understanding of temporary workforce in a timely manner. • Processes for changes in job plans where this occurs in-year. • Healthroster system used to manage rotas. • Medical bank in place. • On-call system in place outside of normal working hours (built into job plans). • Non-medical roles for certain specialities to reduce the need for medical input (i.e. Advanced Nurse Practitioners, Consultant AHP roles, physician associates). • Enhanced grip and control measures for the use of temporary medical and agency staff.	• Inconsistent capacity and demand modelling across specialities. • Technical ability to monitor 42-week productivity against job plans.	<u>Level 1 Assurance</u> • Weekly Divisional Management Team review of medical variable spend. • Fortnightly review with Divisional Directors and Chief Medical Officer to monitor actions related to drivers of medical variable pay spend. • Monitoring of patients seen by a clinician following initial assessment. • Audit of Medical Review for outlying patients is high supporting completion of CQC action. • Utilisation of agency medical staff reported to Temporary Staffing & Rostering Group each month. • Reduced variable pay spend based on grip & control measures. <u>Level 2 Assurance</u> • Annual Job plan report to Workforce Committee. • Medical safe staffing report to Safety & Quality Committee. <u>Level 3 Assurance</u> [None detailed]	• Absence of robust 42-week monitoring of activity between Healthroster and L2P job plan software.

Risk Treatment				
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Development of 42-week productivity tool	M. Stewart	~~31.12.25~~ 31.01.26		Jan 26: Plan to review the first specialities in January 2026 to test the accuracy of the information.

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

Principal risk 8 (25/26) (ID 2110)	Risk Title:	Experience of staff, with specific focus on under-represented staff groups		
	Risk Description:	There is a risk that the Trust may not be considered a great place to work for colleagues or prospective employees across the Trust, including those in under-represented staff groups. This could result in negative experience for staff, adverse impact for colleagues with a protected characteristic, inability to retain a skilled and valued workforce, staff absence, regulatory intervention, and legal action.		
Committee	Workforce Committee	Risk Appetite and Tolerance	Open 4-8	
Director	Chief People Officer	5Ts status	Treat	
Date risk opened	05/12/2024	Date of last review	22/12/25	
		Target control date	31/03/26	





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

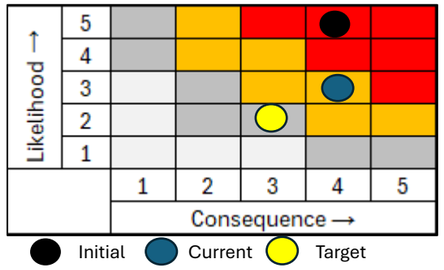
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Our People Plan • Action plan in response to NHS Staff Satisfaction Survey results. • Team Engagement and Development (TED) Tool and toolkit • Equality, Diversity and Inclusion Strategy & Policy. • Single Improvement Plan. • Equality, Diversity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

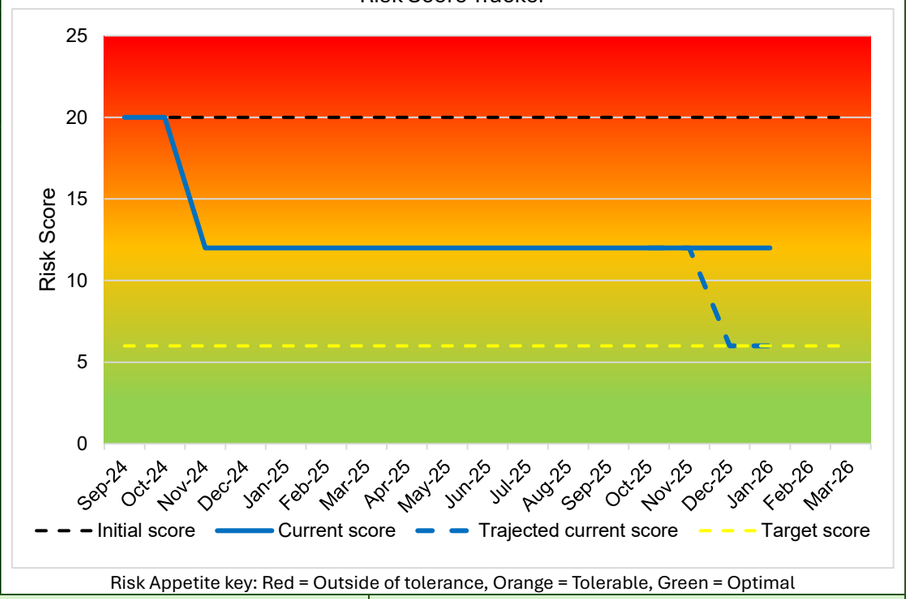
Risk Treatment

<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Work to be undertaken in conjunction with the Ethnicity forum to understand more about discrimination statistics	M Davis	~~31.12.25~~ 28.02.06		Jan 26: Session held as part of Black History Month in October, attended by CEO and other members of the Exec team. Repeated trust communications in respect of Zero Tolerance, updating Core Skills mandatory training content in response to letters received from NHSE in respect of AntiRacism/AntiSemitism. Trust Management Board presentation in November with a plan to undertake further development sessions throughout 2026. Work has been undertaken in the run up to the 2025 staff survey to encourage colleagues from minoritised groups to complete the staff survey. Survey data will be reviewed in January 2026 to see how the metric has changed, however there is an issue in securing colleague engagement across all the forums which impacts on our ability to further understand the experiences of minoritised groups.
Increasing the diversity of colleagues in band 8a and above as per WRES/WDES annual report	M. Davis	~~31.12.25~~ 28.02.06		Jan 26: Leadership offer continues to be promoted within the forums and as part of EDI marketplace events. Senior Recruitment was brought in-house and representatives from the Ethnicity Inclusion forum have been involved in the recruitment process for senior level posts. Further Talent Management work will be undertaken in 2026 with a focus on supporting minoritised groups. Workforce data will be reviewed as part of the WRES/WDES reporting process in May 2026. Figures will have changed as a result of fewer posts across the organisation, approx 10% lower than the previous year.
Work to be undertaken in conjunction with the Living with Disability forum to understand more about bullying and harassment	M Davis	30.01.26		Jan 26: The forum shared Trustwide communications throughout Disability History Month, however no colleagues attended the main event scheduled. The forum chair is meeting with Chief People Officer (Exec Sponsor for the forum) and the Head of Diversity & OD to discuss how to increase engagement. EDI team are working with Corporate Governance team to explore demographic data capture alongside risks which may help to understand this metric further/risk areas etc.
Increased use of TED	S. Kenny	31.03.26		Dec 25: Slight increase in use of TED. Update to be included in paper to Workforce Committee in January 2026.
Delivery of actions in NHS Staff Survey Action Plan	S. Kenny	31.03.26		Dec 25: Staff survey overview to be provided to Workforce Committee in January 2026 along with revised actions.

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

Principal risk 10 (25/26) (ID 499)	Risk Title:	Failure to effectively manage staff absence and achieve Trust and National target rates		
	Risk Description:	There is a risk that failure to effectively manage staff absence due to ineffective systems or processes, or managerial capability will compromise our ability to deliver safe staffing levels and continuity of care. It could also result in increased costs associated with temporary staffing, the Trust being unable to achieve Trust or National targets and could impact on staff morale.		
Committee	Workforce Committee	Risk Appetite and Tolerance	Open 4-8	
Director	Chief People Officer	5Ts status	Treat	
Date risk opened	10/02/14	Date of last review	31/12/25	
		Target control date	~~31/12/25~~ 31/03/26	





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

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

Risk Treatment

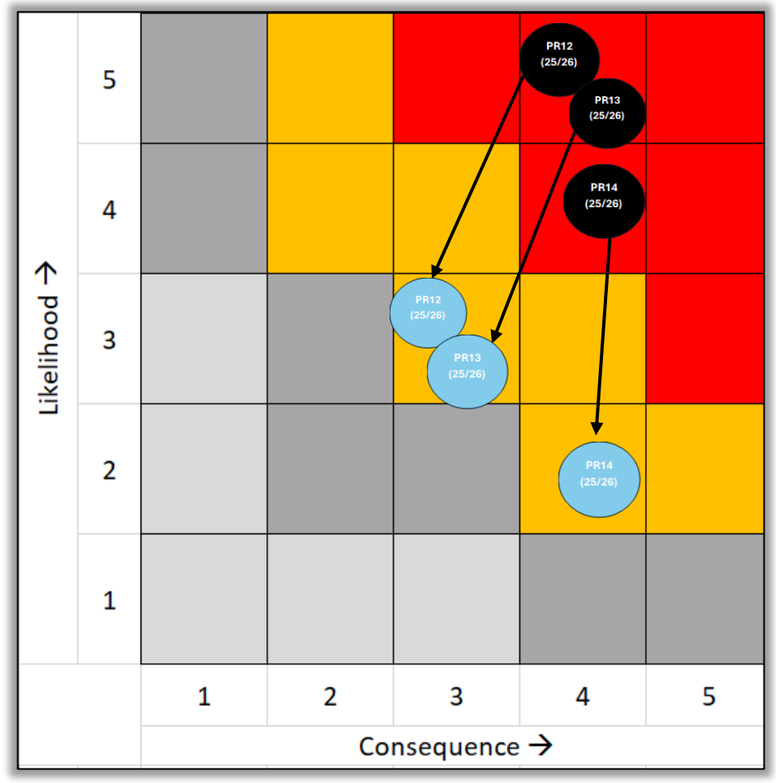
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Pilot Empactis as a digital absence management system	R. O'Brien	~~30.11.25~~ 30.01.26		Dec 25: Issues with the Electronic Staff Record and Single Sign On have now been resolved. User acceptance testing has commenced and roll out in first pilot area planned by the end of January 2026.
Introduce Occupational Therapist into Occupational Health model	R. O'Brien	~~31.12.25~~ 28.02.26		Dec 25: Work continuing to explore whether a) funding can be released from a skill mix review in Psychological Wellbeing service, or b) whether there is scope within the existing Occupational Health model to fund an OT post. Due date extended to accommodate ongoing work.
Deliver absence reduction 'plan on a page' against 4 key workstreams	R. O'Brien	~~31.12.25~~ 31.03.26		Dec 25: multiple actions completed and ongoing, including new ones identified through Rapid Improvement Events. A full evaluation will be undertaken at the end of the financial year. Capacity challenges are ongoing due to 2 gaps in the Workforce Advice team that we have been unable to fill to date.

Productivity: Deliver value for money

Monitored through Finance & Performance Committee

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

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

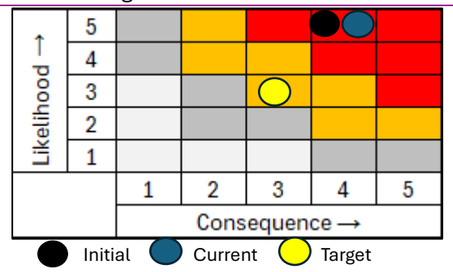


Heat map key: Black = current score, Blue = target score

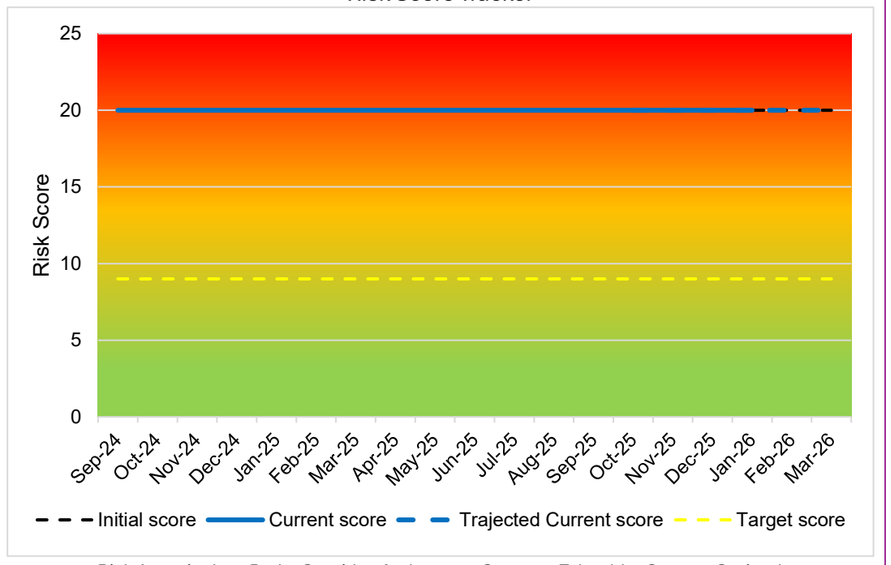
Strategic Objective: Productivity	**Corporate Objective:** Provide value for money services by spending less, spending well and spending wisely	Overall Assurance Level	Low

Principal risk 12 (25/26) (ID 1557)	Risk Title:	Failure to meet the financial plan in 2025/26	
	Risk Description:	There is a risk that the Trust may not deliver the financial plan for 2025/26. This is because of factors such as under-delivery of planned efficiency savings, inability to reduce some operational costs, rising operational demand, and insufficient external funding for some services. This could result in a significant financial deficit, reduced resources for patient care, challenges in maintaining service delivery, insufficient income to cover operational costs, inability to exit NHS Oversight Framework (NOF) segment 5, further regulatory intervention, impact on staff experience, and reputational damage.	

Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious 8-12
Director	Chief Finance Officer	5Ts status	Treat
Date risk opened	03/06/24	Date of last review	14/01/26
		Target control date	31/03/26



Risk Score Tracker



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

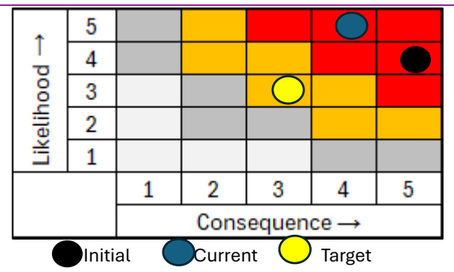
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Financial plan set at the start of the year - common assumptions and principles agreed collaboratively within the ICS. • Financial plan triangulated with activity and workforce plans. • The Standing Orders, Standing Financial Instructions and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

Risk Treatment

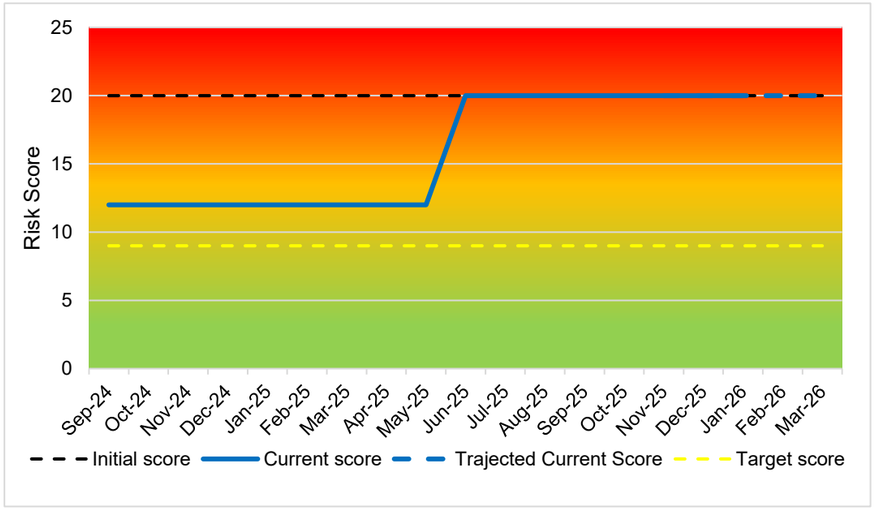
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Internal audit assessment of grip and control actions and Trust's current position	C. Carter	31.01.26	15.01.26	Jan 26: Grip and Control report to be presented at Audit Committee in January 2026. Actions being monitored through normal processes for Internal Audit.
External support obtained until end of financial year to further develop schemes and support programme management capacity	C. Carter	31.03.26		Dec 25: External support agreed until the end of the financial year to support the financial sustainability plan (FSP) and capacity & demand modelling, as well as a workforce analyst.

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

Principal risk 13 (25/26) (ID 802)	Risk Title:	Cash consequences of the Trust's underlying financial position	
	Risk Description:	There is a risk that the Trust may face cash flow challenges because of its underlying financial position, including recurring deficits, delayed delivery of financial recovery savings, or insufficient income to cover operational costs. This could result in a cash shortfall and therefore, an inability to meet financial obligations, impact on service delivery, delays in payments to suppliers, restricted investment in essential services and infrastructure, and potential further regulatory intervention or reputational damage.	
Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious 8-12
Director	Chief Finance Officer	5Ts status	Treat
Date risk opened	06/06/24	Date of last review	14/01/26
		Target control date	31/03/26



Risk Score Tracker



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

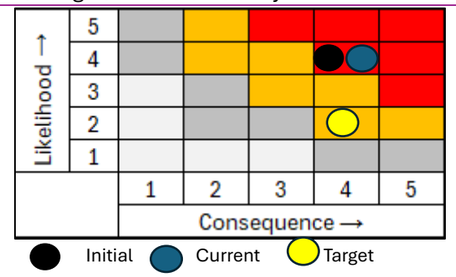
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Cash Management committee in place. • Annual cash plan in place. • Committee approved cash management policy on prioritisation of supplier payments. • Monthly cash flow forecasting. • Management of working capital balances. • Review of capital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

Risk Treatment

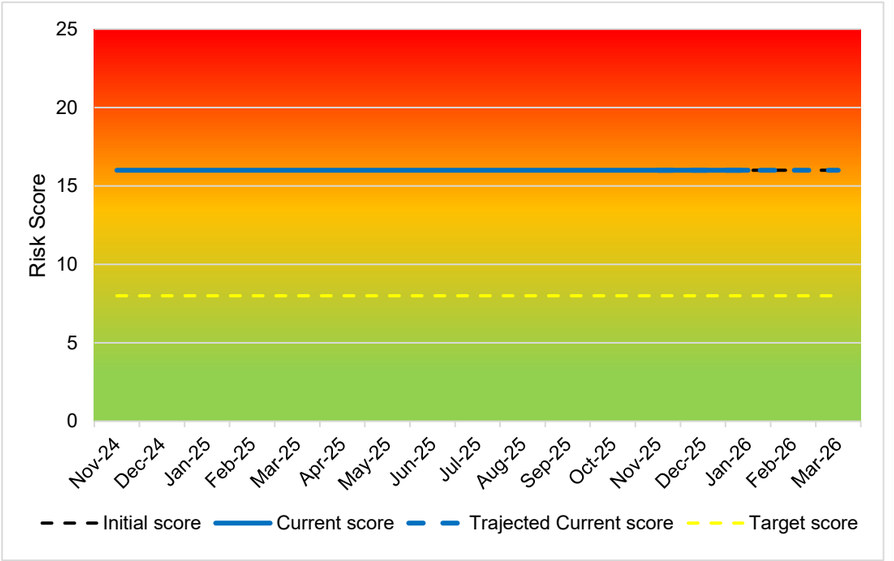
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Timely submissions to NHSE for cash support with Board of Director approval	C. McGourty	~~31.01.26~~ 28.02.26		Jan 26: The formal request for £9.5 million in January 2026 was approved and has been received. Permission has been given by the Board of Directors to request a further £4 million in February 2026. A further driver to the cash requirement is as a result of the pause of deficit support funding in November and December 2025.

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

Principal risk 14 (25/26) (ID 2106)	Risk Title:	Ability to access required Capital to support an ageing estate	
	Risk Description:	There is a risk that there may be insufficient internally generated capital to support all priority areas of the Trust's ageing estate. This is because of valuation decisions which determine capital funding allocations, the Trust's underlying financial position, competing priorities across the healthcare system, and delays in approvals for capital investment projects. This could result in an inability to progress critical infrastructure maintenance, inability to renew essential existing equipment, potentially impacting service delivery, patient safety, and long-term sustainability.	
Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious 8-12
Director	Chief Finance Officer	5Ts status	Treat
Date risk opened	05/12/24	Date of last review	14/01/26
		Target control date	31/03/26



Risk Score Tracker



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

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

Risk Treatment

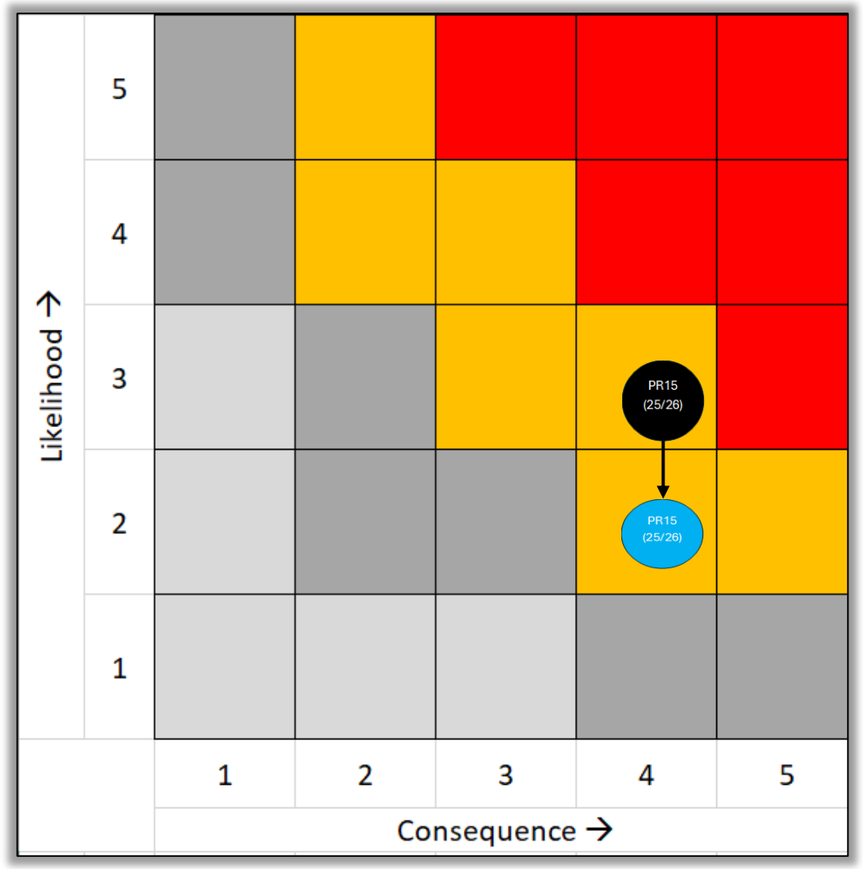
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Develop Estates Strategy	S. Ashworth	28.02.26		Dec 25: Draft Estates Strategy has now been completed and is being updated to align to the new Strategic Objectives (5Ps). The updated version will be reviewed at Trust Management Board for scrutiny and then Finance & Performance Committee.

Partnership: Be Fit for the Future

Monitored as indicated through the relevant Committee of the Board

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

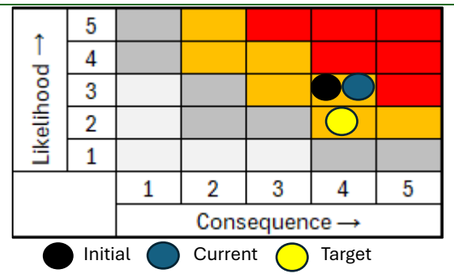
Ref.	Purpose of the objective	Scope and Focus of the Objective	Status
CO18	To develop and deliver our strategic plans to support the transitions outlined in the new NHS Plan:hospital to community; treatment to prevention; analogue to digital.	• Develop and launch the Trust strategy in collaboration with partners. • Develop the capital plans to support the transition. • Develop a digital programme to support the workforce reduction. • Communicate plans with internal and external stakeholders.	Principal Risk 16 controlled Dec 2025
CO19	Developing a sustainable future: to develop effective partnerships across L&SC which maximise population health and support services that are clinically and financially sustainable.	• Deliver plans for OneLSC and develop and implement agreed clinical service strategies/plans. • As an Anchor Institution, work with partners to improve population health, supporting development of a thriving local economy and reducing health inequalities. • Reduction in demand through development of Neighbourhood Health with specific focus on frailty and end of life management in central Lancashire.	Principal Risk 16 controlled Dec 2025
CO20	To make progress towards our ambition to be a University Teaching Hospital	• Work towards achieving University Hospital status • Continue to shape an education, learning and innovative culture	Risk identified
CO21	Working with partners, create a single pathology service	• To develop and implement the detailed plan for a single pathology service. • Work up the Capital Business Case for a single Pathology hub.	No risks identified



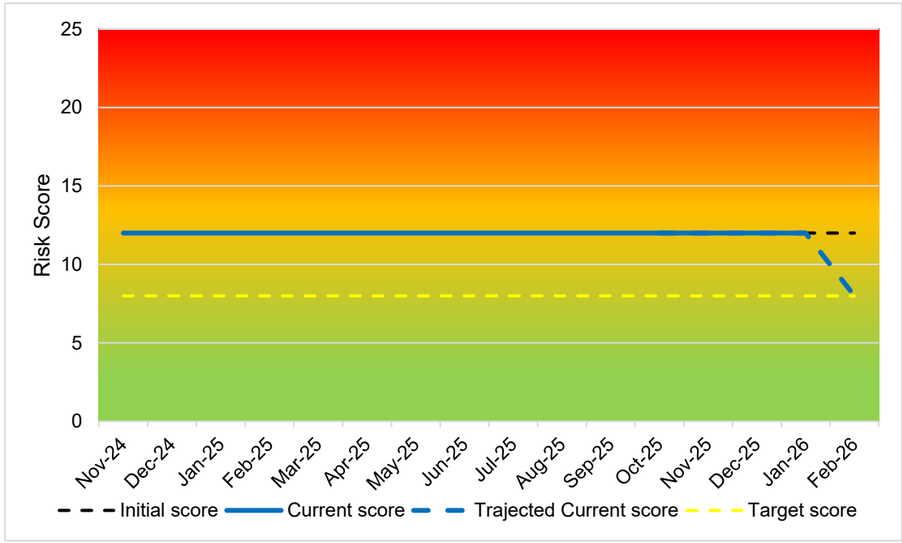
Heat map key: Black = current score, Blue = target score

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

Principal risk 15 (25/26) (ID 2113)	Risk Title:	Research capacity and capability to enable progress towards University Hospital status		
	Risk Description:	There is a risk that the research capacity and capability of the Trust may be insufficient to support the longer-term objectives of becoming a University Teaching Hospital. This is because of limitations of the Trust and potential partners in relation to funding, workforce constraints, lack of dedicated research time for clinical staff, lack of established clinical academics in L&SC and the need for an enhanced infrastructure to support research activities. This could result in missed opportunities for innovation and improvement in patient care, difficulty attracting and retaining talented research staff, an inability to advance the Trust's reputation as a leader in research and clinical excellence and the income generation associated with University Hospital opportunities.		
Committee	Education, Training & Research	Risk Appetite and Tolerance	Seek 9-12	
Director	Chief Strategy and Improvement Officer, and Chief Medical Officer	5Ts status	Treat	
Date risk opened	05/12/2024	Date of last review	27/01/26	
		Target control date	28/02/26	



Risk Score Tracker



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

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

Risk Treatment

<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Formulate a clear project plan to develop partnerships with potential University partners to explore UH status. This will include plans to engage the clinical teams in the specialities to support these to come to fruition.	P. Brown/ P. Martin-Hirsch/S. Canty	~~31.10.25~~ 28.02.26		Jan 26: The project plan and milestones will be developed ready to present to Education, Training and Research (ETR) Committee in February 2026.
Appointment of University of Lancashire joint posts to support the expansion of Undergraduate Medical placements at LTHTR	L. O'Brien	~~31.10.25~~ 31.12.25	31.12.25	Jan 26: Posts appointed to and start dates planned for early March 2026.
Have Research roles in place within 2 Divisions	P. Brown	~~01.12.25~~ 28.02.26		Jan 26: Appointments not yet agreed and awaiting discussion with new Chief Medical Officer. Due date extended pending a decision on next steps.

9. PEOPLE (WORKFORCE, EDUCATION AND RESEARCH)

9.1 WORKFORCE COMMITTEE CHAIR'S REPORT

Other | A Leather | 10.15am

Item for Assurance

REFERENCES

Only PDFs are attached

9.1 - Chairs Report - WFC - 13 Dec 25.pdf

Chair's Report to Board		
Chair: Adrian Leather	Workforce Committee	
Date(s): 13 January 2026	Agenda attached for information	✓

Strategic Risks	trend	Items Recommended for approval
People: Be a Great Place to Work – current score 12	→	• Gender Pay Gap Report • Annual Equality, Diversity and Inclusion Strategy Report

ALERT

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

- The Board should be alerted to emerging risks in estates and facilities, particularly regarding the implementation of national cleaning standards and the impact of vacancies on infection prevention and control.
- The Committee highlighted ongoing concerns about the reliability and consistency of workforce data, which impacts decision making.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- Principal Risk 7 (Temporary Medical Workforce): The risk is now recommended to be controlled, but the Committee recommends continued close monitoring for sustainability and early warning of any deterioration.
- The Board should be advised that significant headcount reductions are still required, and that service redesign or cessation options were being considered. The Committee will monitor directorate-level targets and delivery.
- Principal Risk 8 (Staff Experience): Staff experience risk remained off track, with a significant reduction in staff recommending the Trust as a place to work. The Committee advises the Board that this risk is not expected to improve in the short term due to ongoing organisational changes and national trends.

ASSURE

Assurance received; Matters of positive note.

- The Board should be assured of positive progress in areas such as vacancy control, reduction in variable pay, improved staff engagement in Estates and Facilities, and actions taken to address gaps in specialist nurse cover.

Workforce Committee

13 January 2026 | 1.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	a) Chair and quorum b) Temporary recording of meeting	1.00pm	Verbal	Information	A Leather
2.	Apologies for absence	1.01pm	Verbal	Information	A Leather
3.	Declaration of interests	1.02pm	Verbal	Information	A Leather
4.	Minutes of the previous meeting held on 11 November 2025	1.03pm	✓	Decision	A Leather
5.	Matters Arising and Action Log	1.05pm	✓	Decision	A Leather
6.	Strategic Risk Register	1.10pm	✓	Assurance	S Regan
7. PERFORMANCE					
7.1	People Accountability Oversight Framework	1.25pm	✓	Assurance	K Downey
7.2	Financial Recovery / Workforce Reduction Update	1.40pm	✓	Assurance	K Downey
8. TO ATTRACT, RECRUIT AND RESOURCE					
8.1	Fragile Services Update Report	1.55pm	✓	Assurance	K Downey
9. TO DELIVER A RESPONSIVE, FUTURE FOCUSSED AND ENABLING SERVICE					
9.1	Leng Review (resulting from AHP Staffing Report)	2.10pm	✓	Assurance	N Pease
BREAK		2.25pm			
10. TO BE INCLUSIVE AND SUPPORTIVE					
10.1	Annual Equality, Diversity and Inclusion Strategy Report	2.30pm	✓	Assurance	L Graham
11. TO ENGAGE, RETAIN, REWARD AND RECOGNISE					
11.1	Staff Survey Report and Action Plan (embargoed)	2.45pm	✓	Information and Assurance	L Graham
12. GOVERNANCE AND COMPLIANCE					

№	Item	Time	Encl.	Purpose	Presenter
12.1	Gap Reports: i) Gender ii) Ethnicity iii) Disability	3.00pm	✓	Decision	L Graham
12.2	Guardian of Safe Working Quarterly Report: Oct – Dec 2025	3.25pm	✓	Assurance	V Varughese
12.3	Strategic Risk Register Review	3.35pm	Verbal	Decision	A Leather
12.4	Items to alert, assure, advise to the board or items or referral to/from other committees	3.40pm	Verbal	Discussion	A Leather
12.5	Reflections on the meeting	3.45pm	Verbal	Discussion	A Leather
13.	ITEMS FOR INFORMATION				
13.1	Annual Partnership Update Report		✓		
13.2	Date, time, and venue of next meeting: *10 March 2026, 1.00pm via Microsoft Teams*	3.50pm	Verbal	Information	A Leather

9.2 GENDER PAY REPORT

Decision Item | L Graham | 10.25am

*Detailed report included in the separate ancillary pack

REFERENCES

Only PDFs are attached

9.2 - Board Combined Pay Gap Report 2026.pdf

Board of Directors

Meeting of the	**Board of Directors**		**Date of Meeting: 5th February 2026**
	Part I ☒		**Part II** ☐
Title of Report	**Combined Pay Gap Report (Gender, Ethnicity, Disability) 2025**		
Report Author	Gemma Aspinall, Diversity and Inclusion Practitioner		
Lead Executive Director	Neil Pease, Chief People Officer		
Recommendation/ Actions required	The Board of Directors is asked to: • Receive and note this Combined Pay Gap Report • Approve the report for publishing on our Trust website by 30 March 2026		
	Decision ☒	**Assurance** ☐	**Information** ☐
Executive Summary	The purpose of this document is to present the findings and recommended actions of our 2025 Combined Pay Gap report. The report presents a high-level overview of differences in average pay by the following characteristics: • Gender • Ethnicity • Disability status Our Trust is legally obliged to publish our gender pay gap information. Currently, there is no legal requirement to publish ethnicity or disability pay gap information, however our publication of these data sets supports expectations set out in the NHS Equality Diversity and Inclusion Improvement Plan. In summary, our combined pay gap reporting finds: • Our **median gender pay gap is 1.9% in favour of male colleagues**, which is a **decrease** from 3.2% in 2024. • Our **median ethnicity pay gap is 7.5% in favour of BME colleagues**, which is a **decrease** from 8.3% in 2024 • Our **median disability pay gap is 16.8% in favour of colleagues without a disability**. This is the first time our Trust has reported a disability pay gap, and while the data presents a stark pay gap, caution in interpreting this data is advised, due to known gaps in our workforce data; we are aware that the data around self-reporting of disability status on the NHS Electronic Staff Record may not be an accurate representation of our workforce		

	Our ability to take action regarding pay gaps is somewhat limited due to the need to interrogate the data further to understand it fully. Addressing pay gaps may also be impacted by NHS terms and conditions, occupational and sector segregation (i.e. roles that are dominated by one group over another), and other factors unique to our Trust, such as the geographical locations of our sites. This report details the findings of each pay gap report, and subsequent proposed actions. **It is recommended that the Board of Directors** • Receives and notes the report • Approve the report for publishing on our Trust internet site by 30th March 2025	
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:	Name of Committee: Workforce Committee	Date: 13th January 2026
Operational Group Review:	Name of Operational Group:	Date:
Link to Board Assurance Framework:	Principal Risk 8 (25/26) - Experience of staff, with specific focus on under-represented staff groups	
Appendices	Not Applicable	

9.3 EQUALITY, DIVERSITY AND INCLUSION ANNUAL REPORT

Decision Item | L Graham | 10.35am

*Detailed report included in the separate ancillary pack

REFERENCES

Only PDFs are attached

9.3 - Board EDI Annual Report 2025.pdf

Board of Directors

Meeting of the	**Board of Directors**		**5th February 2026**
	Part I ☒		**Part II** ☐
Title of Report	**Equality Diversity & Inclusion Annual Report 2025**		
Report Author	Mandy Davis, Head of Diversity & Organisational Development		
Lead Executive Director	Neil Pease, Chief People Officer		
Recommendation/ Actions required	The Board of Directors is asked to: approve the report for publishing on the Trust external internet pages.		
	Decision ☒	**Assurance** ☐	**Information** ☐
Executive Summary	The purpose of this report is to provide an annual update against the principles and aims of the Equality, Diversity and Inclusion (EDI) Strategy 2021 – 2026. This report forms part of our public sector duties as set out in the Public Sector Equality Duty and the Equality Act (2010). This report details the actions which have been completed in the last 12 months against the five principles set out in this strategy for our communities, patients and colleagues. The report highlights achievements delivered across the last 12 months, some of which are; • Proactive engagement with lesser-heard patient community groups leading to tangible changes in service provision • Improved accessibility to patient information through leaflets being produced in accessible formats, to the Trust website being adapted for screen readers • Increased workforce representation; ethnic minority representation increased to just over 30% (from 26.6%) whilst disability disclosure increased again to 6.7% (from 6.2%) with more colleagues completing Supporting Disability/Long Term conditions agreements. • Delivered Health Literacy training to over 100 leaders and introduced new e-learning modules in respect of Implicit Bias and Intercultural Communication. • Address local health disparities through initiatives such as targeted outreach, Post Partum Haemorrhage project and Healthier Wards. The report outlines the measurable impact and presents the current demographic information on our community and our workforce. It highlights our performance and current benchmarks reported in other mandated reports such as the Workforce Race Equality Standard,		

	Workforce Disability Equality Standard, National Staff Survey and Gender/Ethnicity/Disability Pay Gaps, alongside other intervention level evaluation measures where applicable. It describes the future focus to ensure we continue to deliver the strategic aims, which includes: • Refresh our organisational Values to make inclusive behaviours and actions more explicit. • Improved accessibility on Trust website with a focus on patient information • Continued work with faith communities to support improving experiences across faith groups • Explore adopting a Diversity & Inclusion champion role across the organisation to help with engagement and involvement, cascade and escalation of information etc. • Expand the Patient story Library - continue to grow the intranet-based patient story hub, making real-life experiences accessible to all staff for learning and service improvement. • Creating talent pathways for underrepresented groups including 'Rising Stars' and 'Future Stars' programmes plus a structured pathway for Consultant colleagues, ensuring colleagues from minority groups have adequate/specialised coaching support to support their career progression • Develop and implement Equality Representatives training for Recruiting Managers with a plan to then build into Core People Management Skills. • Continue to support 'representation' at Board level with training and development, use of Staff Stories illustrating different experiences and journeys and through sponsorship of staff Inclusion forums. • Deliver more experiential and inclusive training through Oliver McGowan training • Develop and promote resources like the Lancashire Health Hub to provide accessible, reliable health information for patients and communities. The Board of Directors are asked to approve the contents of the report for publishing externally on our internet pages.	
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:	Name of Committee: Workforce Committee	Date: 13th January 2026
Operational Group Review:	Name of Operational Group:	Date:
Link to Board Assurance Framework:	Principal Risk 3 (25/26) - People experiencing Health inequalities Principal Risk 8 (25/26) – Experience of staff, with specific focus on under-represented staff groups	
Appendices	State whether there are any appendices and list them.	

9.4 EDUCATION, TRAINING AND RESEARCH COMMITTEE CHAIR'S REPORT

Other | S Crean | 10.45am

Item for Assurance

REFERENCES

Only PDFs are attached

9.4 - Chairs Report ETR 9 Dec 2025.pdf

Chair's Report to Board		
Chair: Prof StJohn Crean	Education Training and Research Committee	
Date(s): 9 Dec 2025	Agendas attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	trend	Items Recommended for approval
People and Partnership	→ 12	**None.**

ALERT

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

- The Committee agreed that the organisation must take decisive action to address mandatory training non-compliance, particularly within hosted services, recognising the potential governance and safety risks posed by large numbers of untrained staff, although it was confirmed that no safety incidents had been linked to lack of mandatory training.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- The NIHR had introduced a 150-day target for commercial clinical trial set-up, which would be a key performance measure over the next two years. Failure to meet this standard poses significant financial and reputational implications for the organisation.
- Progress continued toward University Hospital status, with engagement from local universities, more grant applications, and a working group in place. Criteria changes expected in early 2026 would inform a revised plan. While academic requirements were not yet met, discussions with partners were positive and a phased delivery plan had been drafted. The Committee agreed not to draft a Department for Education letter applying to use "University" in the title; the priority remained on building research capability and meeting new criteria.
- The apprenticeship performance remained strong, with achievement rates above 85% and exceeding national averages, although a downward trend in programme uptake and levy expenditure posed risks. A full review of programme viability and alignment with workforce planning was planned for April 2026.

ASSURE

Assurance received; Matters of positive note.

- The Committee recommended approval to activate Edovation Ltd. as a subsidiary, enabling the TED Tool and Consultancy to operate as a commercial brand. The move was seen as a strategic opportunity to enhance commercial prospects, secure external funding, and support research and innovation.

- The research team achieved their seventh consecutive Gold Star Award for quality audits, placing the Trust among a select few nationally.

- Financial performance in research had been reported as positive, with underspend improving and recovery schemes on track, contributing to an overall swing of approximately £500,000 over the past two years, and successful commercial trial recruitment, supporting Trust priorities.

- The Red Rose Research event held in November had been highly successful. Presentations were of an excellent standard and there was consensus on advancing the clinical academic agenda across the system.

- The GMC survey results showed significant improvements, with several specialties commended by NHS England. Most external monitoring concerns had been resolved, leaving only one outstanding issue in acute internal medicine, with actions in progress.

Education, Training and Research Committee

9 December 2025 | 1.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	1.00pm	Verbal	Information	S Crean
2.	Apologies for absence	1.01pm	Verbal	Information	S Crean
3.	Declaration of interests	1.02pm	Verbal	Information	S Crean
4.	Minutes of the previous meeting held on 14 October 2025	1.03pm	✓	Decision	S Crean
5.	Matters arising and action log	1.05pm	✓	Decision	S Crean
6	Strategic Risk Register	1.10pm	✓	Assurance	S Regan
7.	PERFORMANCE				
7.1	R&I Update Report (inc. WRP)	1.20pm	✓	Assurance	P Brown
7.2	Core Skills Training Report	1.35pm	✓	Assurance	L O'Brien
7.3	Quality Assurance Report	1.50pm	✓	Assurance	L O'Brien
8.	STRATEGY AND PLANNING				
8.1	UHS Implementation Plan	2.05pm	✓	Assurance	L O'Brien / P Brown
8.2	Edovation Implementation Plan	2.20pm	✓	Assurance	L Graham
9.	GOVERNANCE AND COMPLIANCE				
9.1	Strategic Risk Register Review	2.35pm	Verbal	Decision	S Crean
9.2	Items to alert, assure, advise to the board or items or referral to/from other committees	2.45pm	Verbal	Information	S Crean
9.3	Reflections on the meeting	2.50pm	Verbal	Assurance	S Crean
10.	ITEMS FOR INFORMATION				

№	Item	Time	Encl.	Purpose	Presenter
10.1	Feeder Groups – Chair's Reports a) Education Finance & Performance Sub-Committee		✓		
10.2	Date, time, and venue of next meeting: *10 February 2026, 1pm, MS Teams*	3.00pm	Verbal	Information	S Crean

10. PERFORMANCE & PRODUCTIVITY (FINANCE)

10.1 INTEGRATED PERFORMANCE REPORT AS AT FEBRUARY 2026 INCLUDING FINANCE UPDATE AND SINGLE IMPROVEMENT PLAN

Other | Executive Team | 10.55am

Item for Assurance
K Foster-Greenwood
S Morrison
N Pease and
C Carter

REFERENCES

Only PDFs are attached

10.1 - Integrated Performance Report as at February 2026 including Finance update and Single Improvement Plan.pdf

Board of Directors Report

Meeting of the	**Board of Directors**		**5th February 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 December 2025, unless date otherwise stated. The report provides the Single Improvement Plan, high level metrics, of which the outcomes have been scrutinised by each relevant committees of the Board. The outcome metrics are presented with a supporting summary, assurances provided and actions being taken to address the position where improvement is identified. The delivery milestones of the single Improvement plan are monitored through the Finance and Performance committee. The reporting around this continues to be refined with a plan to include milestone assurances in future IPR reporting. At the start of each priority section, a 3 A (Alert Advise and Assure) template is provided to guide the Board to areas of Alert Advise or Assure in line with the reporting approach adopted by the committees of the Board. The Chief Operating Officer will present the IPR with Executive Director presentation for each of the priorities.		
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: October and November 2025
Appendices		

Board of Directors Report

Meeting of the	**Board of Directors**		**5th February 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 December 2025, unless date otherwise stated. The report provides the Single Improvement Plan, high level metrics, of which the outcomes have been scrutinised by each relevant committees of the Board. The outcome metrics are presented with a supporting summary, assurances provided and actions being taken to address the position where improvement is identified. The delivery milestones of the single Improvement plan are monitored through the Finance and Performance committee. The reporting around this continues to be refined with a plan to include milestone assurances in future IPR reporting. At the start of each priority section, a 3 A (Alert Advise and Assure) template is provided to guide the Board to areas of Alert Advise or Assure in line with the reporting approach adopted by the committees of the Board. The Chief Operating Officer will present the IPR with Executive Director presentation for each of the priorities.		
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.	☒
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	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: October and November 2025
Appendices		

The Best Version of Us
Our Culture Counts @LTH

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Integrated Performance Report

February 2026 Trust Board meeting with performance to December 2025


Patients


Performance


People


Productivity


Partnerships

Excellent care with compassion

Always Safety First

The Best Version of Us
Our Culture Counts @LTH

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Contents

Key to Metric Variation, Assurance Icons & Dashboard Headers

Lancashire Teaching Hospitals NHS Foundation Trust

Key to Metric Variance and Assurance Icons

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

Key to Metric SPC Chart and Variance and Assurance Icons

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

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

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

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

Report heading explanation

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

A flag is generated for metrics that are calculated as requring

The latest month target or threshold.

Data to the end of.

Metric Description	Assurance @ Mar-25	Variation to Latest Actual	Target Concern	Target 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.

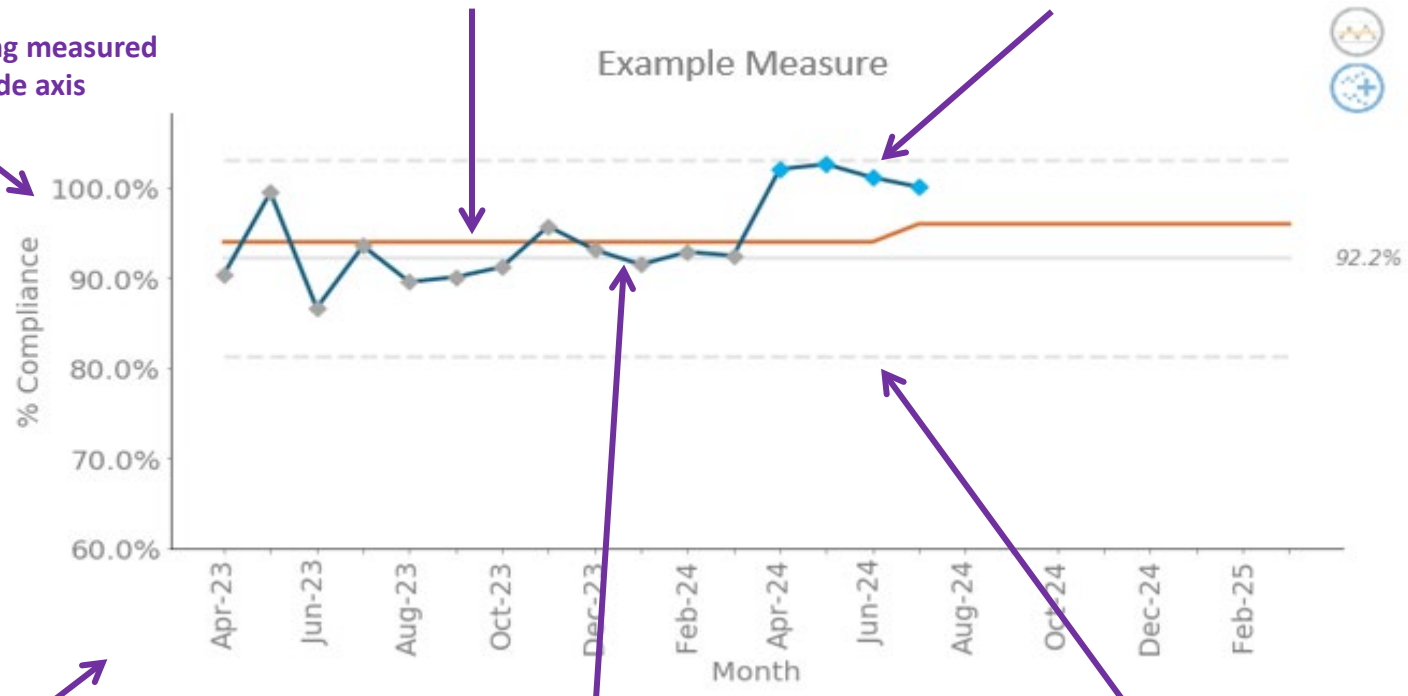
This March 2025 target

The current month actual performance.

How to read Statistical Process Control charts (SPC)

Lancashire Teaching Hospitals NHS Foundation Trust

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



The thing being measured goes up the side axis

The trust target is shown as an orange line

Any data points coloured blue are unusual positive points. Orange coloured data points are unusual negative points

Time period goes along the bottom axis

The actual is shown as a blue line.

The grey dotted lines are control limits and show the expected amount of variation

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

SPC KPI Metric Grid

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Variation \ Assurance	Will consistently fail target within expected variation	Could both pass or fail target within expected variation	Will consistently pass target within expected variation
Recent concerning pattern in the data	- Staff Survey: Recommend Trust as place to work - Vacancies (% FTE) - Percentage of patients waiting less than 18 weeks - 31 Day Cancer Standard	- Number of violence and aggression incidents toward staff - 85% theatre utilisation - aggregate - Capped	- Staffing Fill Rate - Health Care Assistant
Normal variation - no recent change	- Percentage of UEC (Type 1 & 3) patients seen within 4 hours - Maximum wait of 12 hours as Total Time in Department - Bed occupancy to 90% - Number of boarded patients - Reduce not meeting criteria to reside - Cancer 62-day performance - RTT - 52 week Waiters - Staffing Fill Rate - Maternity Support Worker	- Turnover (%FTE) - Sickness Absence (%FTE) - Staffing Fill Rate - Registered Midwife - Complaints per 1000 bed days - Pressure Ulcers per 1000 beds days (Category 2 and above) actions - Perinatal - Number of Stillbirths - Cancer Faster Diagnosis Performance - Percentage of patients that receive a diagnostic test within six weeks - Compliance with 60 minute ambulance turnaround time target	- Staffing Fill Rate - Registered Nurse - STAR Accreditation all trust (Silver and Above)
Recent positive pattern in the data	- RTT - 65 Week Waiters	- C. difficile performance against national trajectory - no more than 167 Hospital Acquired cases	

Non SPC Metrics flagged as a concern

I&E - Plan V Actual variance

WRP schemes delivery

Non SPC Metrics

Hospital Standardised Mortality Ratio (56 Basket – Adult)	Lower Than Expected
Standardised Mortality Rate (All Diagnoses – Adult)	Lower Than Expected
Standardised Mortality Rate (Child <1 day -17 Years) (All Diagnoses)	As Expected
Standardised Mortality Rate (Neonatal <1 day -28 days) (All Diagnoses)	As Expected
Maintain compliance with 10 Clinical Negligence Scheme for Trusts Safety	10/10 validated

People
Patients
Productivity
Performance

Patients


Single Improvement Plan
Patients
Performance
People
Productivity
Partnerships

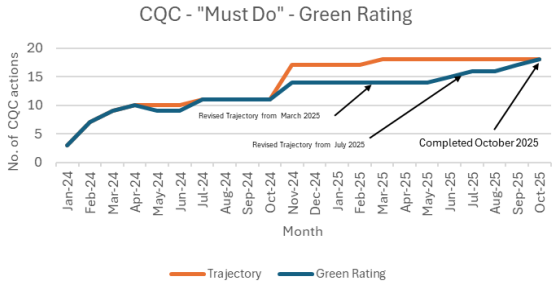
Executive Summary – Alert, Advise, Assure Report

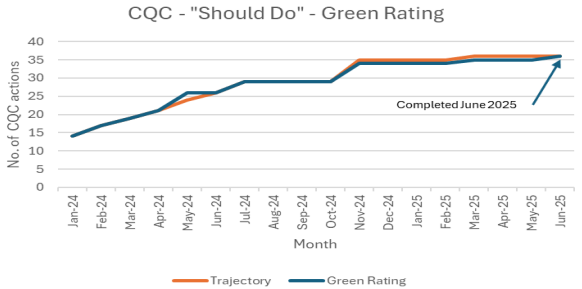
	Issue	Action
Alert Areas of concern or matters that need addressing urgently	None to alert for the month of December.	
Advise Areas of ongoing monitoring and any new developments	**1. Registered Midwife fill rates** - The overall midwifery fill rate is below the Trust target of 95% for December 2025 at 89.17%.	1. The vacancy for Registered Midwives is currently 4.61 WTE. People who had accepted posts have since given backword and there have been further leavers. Close monitoring of the midwifery establishment is ongoing with adverts going back out with plans to utilise the over offer. Bank and agency staff are being used to fill the gaps in the rota whilst the newly recruited Midwives are undertaking their preceptorship period.
	2. Staffing Fill Rate Maternity Support Worker - remains below 95% target at 85.22% with historical vacancies impacted fill rates.	2. There are currently 0.8 band 4 WTE MSW, 4.50 Band 3 MSW and 3.33 WRE Band 2 HCAs. However, a successful recruitment campaign has concluded and are currently awaiting confirmation of start dates.
	3. Complaints per 1000 bed days - The number of complaints per 1000 beds days continues to demonstrate a reduction when comparing to the previous year. It is noted that there were 5 months where complaints per 1000 days was above the mean, albeit within normal variation but the last 2 months have reduced in a downward trend .	3. The trend reflects an increased focus on achieving local resolution for patients and their families, enabling concerns to be addressed promptly and effectively at the point of care. Detailed work focused on managing extened waiting times and the fundementals of care is taking place with ward by ward friends and family performance used as a guide to understanding the impact of this.
	4. Pressure Ulcer incidence - The target line has been revised from April 2025 to reflect the average number of incidents from the previous year, rather than the three-year average used previously. Since this adjustment, the number of reported pressure ulcers has consistently exceeded the target.	4. Recognisning the increase in pressure ulcers has perisisted a pressure ulcer harms panel chaired by the Deputy CNO has been enacted as well as a revised systems focused pressure ulcer improvement plan including a review of equipment in the early part of the UEC pathway which is felt to be contributing toward pressure ulcer development.
Assure Areas of Assurance	**1. Compliance with National Standards of Cleanliness -** point of inspection audits for Very High- and High-Risk Areas are fully compliant at point of inspection where the cleaning standards have been implemented, confirming robust infection prevention and control measures.	1. Fully compliant at point of inspection, confirming robust infection prevention and control measures.
	2. Registered Nurse and Health Care Assistant fill rates - are consistently achieving safe staffing levels.	2. Staffing levels consistently meet thresholds, supporting effective care delivery.
	3. STAR accreditation for all Trust.	3. Remains above target across the Trust, reflecting stabilisation following the introduction of critical standards.
	4. **Friends and Family Test for adult day case, adult outpatient and neonatal**	4. Performance remains consistently above target and within normal variation, reflecting stable and positive patient experience.
	5. CQC Must do: By the end of October, the the "Must Do's" included in the 2023/2024 CQC Quality Improvement Plan were delivered.	5. CQC Quality Improvement Plan has been delivered.
	6. Mortality **Adult HSMR** - Lower than expected, **Adult SMR Adult** - Lower than expected **SMR Child <1 day to 17 years** - As expected **SMR - Neonatal <1-28 days** - As expected **Still Birth rate** - . The 12-month average mean (October 24- September 25) still birth rate is 2.6 per 1000 which remains below the national average of 3.9 per 1000.	6. Mortality actions continue as outlined in the biannual mortality plan.
	7. C.difficile rates - Currently remain within the national agreed trajectory.	7. The IPC Board Assurance Framework actions continue alongside the Cdifficile improvement plan continue, the implementation of the cleaning standards is now in line with plan and appears to be underpinning improved performance.

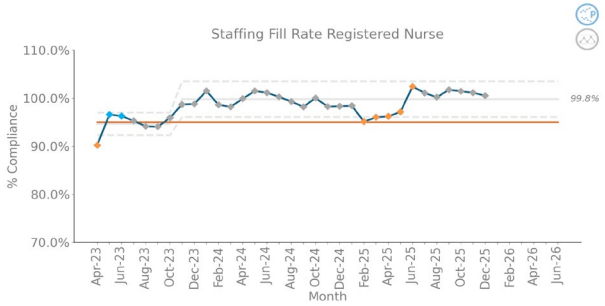
Patients

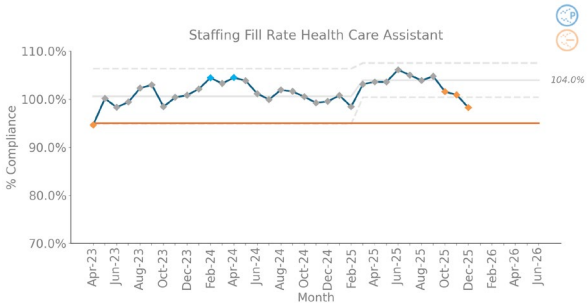
Metric Description		Assurance @ Mar-26	Variation to Latest Actual	Target			Latest Month Actual	Latest Month
				Concern	Mar-26	Latest Month Target		
CQC	CQC - "Must do" - Completed October 2025 (Number with Green rating)					18	18	Oct-25
	CQC - "Should do" - Completed June 2025 (Number with Green rating)					36	36	Jun-25
Deliver Annual Safe Staffing Requirements	Staffing Fill Rate - Registered Nurse	P			95%	95.0%	100.5%	Dec-25
	Staffing Fill Rate - Health Care Assistant	P			95%	95.0%	98.2%	Dec-25
	Staffing Fill Rate - Registered Midwife			⚑	95%	95.0%	89.2%	Dec-25
	Staffing Fill Rate - Maternity Support Worker	F		⚑	95%	95.0%	85.2%	Dec-25
Patient Experience and Involvement	Complaints per 1000 bed days			⚑	1.40	1.40	1.21	Dec-25
	STAR Accreditation all trust (Silver and Above)	P			75%	75.0%	85.6%	Dec-25
C Difficile Improvement	C. difficile performance against national trajectory - no more than 167 Hospital Acquired cases		+		13	14	8	Dec-25
Always Safety First	Hospital Standardised Mortality Ratio - Adult	Lower Than Expected					68.5	Aug-25
	Standardised Mortality Ratio - Relative Risk - All Diagnoses Adult	Lower Than Expected					69.2	Aug-25
	Standardised Mortality Ratio - Relative Risk - All Diagnoses Child (<1 day – 17 yrs)	As Expected					183.0	Aug-25
	Standardised Mortality Ratio - Relative Risk - All Diagnoses Neonates (<1-28 Days) *The updated TELSTRA model from November 2024 does not include still births*	As Expected					124.3	Aug-25
	Pressure Ulcers per 1000 bed days (Category 2 and above)				3.32	3.32	3.53	Dec-25
Maternity	Perinatal - Number of Stillbirths				0	0	1	Dec-25

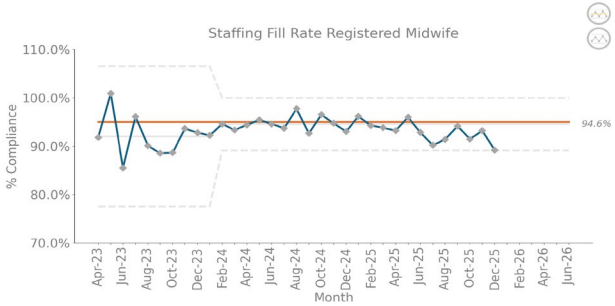
Patients

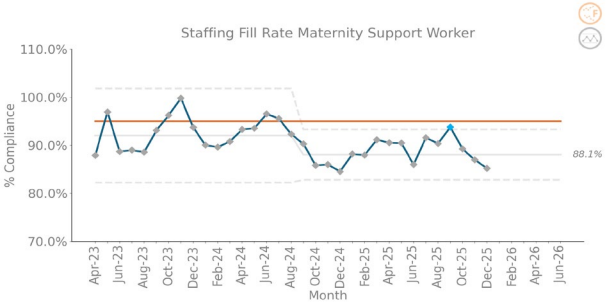

CQC - "Must Do" - Green Rating
No. of CQC actions
Revised Trajectory from March 2025
Revised Trajectory from July 2025
Completed October 2025
Month
Trajectory
Green Rating

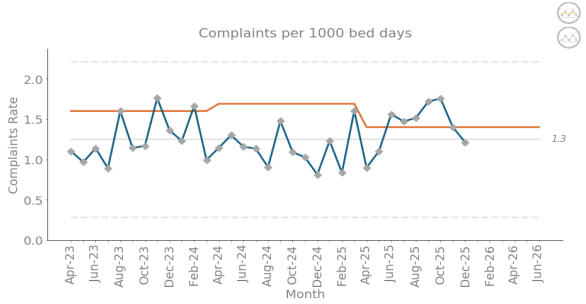

CQC - "Should Do" - Green Rating
No. of CQC actions
Completed June 2025
Month
Trajectory
Green Rating

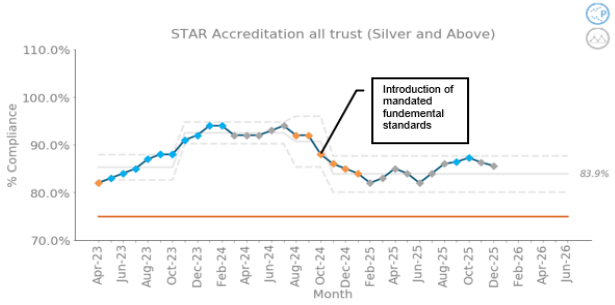

Staffing Fill Rate Registered Nurse
% Compliance
99.8%
Month

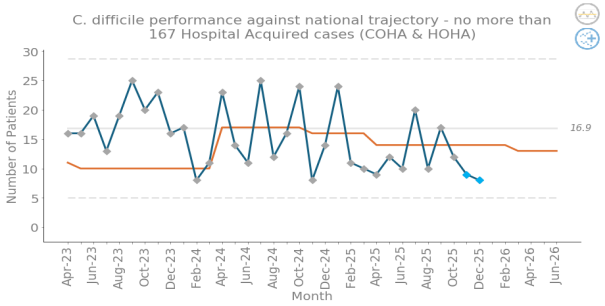

Staffing Fill Rate Health Care Assistant
% Compliance
104.0%
Month

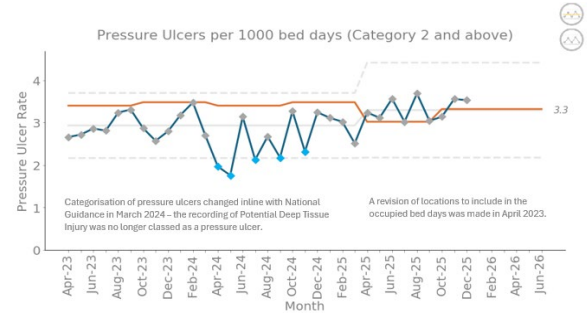

Staffing Fill Rate Registered Midwife
% Compliance
94.6%
Month

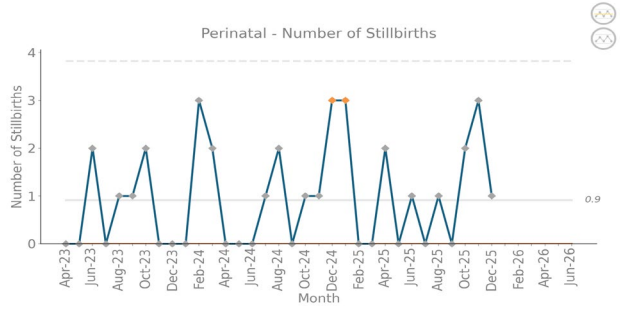

Staffing Fill Rate Maternity Support Worker
% Compliance
88.1%
Month


Complaints per 1000 bed days
Complaints Rate
1.3
Month


STAR Accreditation all trust (Silver and Above)
Introduction of mandated fundemental standards
% Compliance
83.9%
Month


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


Pressure Ulcers per 1000 bed days (Category 2 and above)
Pressure Ulcer Rate
3.3
Categorisation of pressure ulcers changed inline with National Guidance in March 2024 - the recording of Potential Deep Tissue Injury was no longer classed as a pressure ulcer.
A revision of locations to include in the occupied bed days was made in April 2023.
Month


Perinatal - Number of Stillbirths
Number of Stillbirths
0.9
Month

The Best Version of Us
Our Culture Counts @LTH

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Performance

Excellent care with compassion
Always Safety First

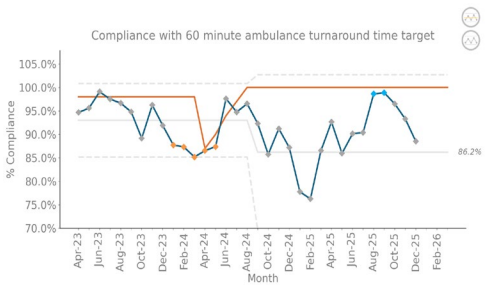
@LancsHospitals

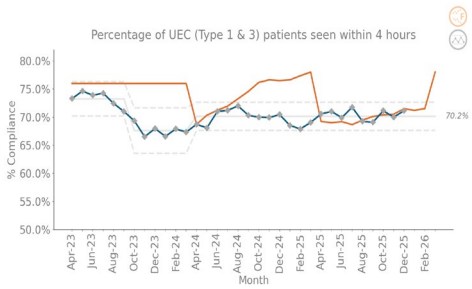
Alert Areas of concern or matters that need addressing urgently	• **RTT performance** - The number of follow ups >25% overdue has increased month on month since Oct 24. • **Diagnostic performance (DM01)** - performance has deteriorated by 0.3% in Dec 25 versus Nov 25. The significant deterioration continues within NOUS (-5.1%) and relates to capacity shortfalls due to leave and vacancies. • **Boarding** - Average of 30 patients boarded in December - a consistent position but remains very high and the number of escalation beds in use has increased month on month since July 25. • **Days Kept Away from Home** - (%) has increased in December - and remains significantly above the operational plan target and higher than the same period in Dec 24. Whilst the levels are within normal variation the data suggests a consistently failing target. • **4 hour performance** - Improvement in all types versus Nov 25 but below trajectory. Performance is below the National average of 74.2% (Nov 25) with LTH ranking 58/118. Performance is within normal variation and signals a consistently failing target position. • **Ambulance handover** performance deteriorated in all handover categories. LTH performance is below the national average for 15 min handover but consistent with the NW and is below the national average for 60 min handover..	• **RTT** - A key focus on validation of follow up waiting lists and an increase to PIFU is underway with good increases in PIFU rates noted (see Assure). Further plans to pilot PIFU by Default via AI robotics is in development with plans to pilot in Q4. H2 business case and RTF funding is being mobilised. Additional monies have been made available via NHSE to support 'sprint' to improve performance and additional capacity (WLI and IS) and traige/validation capacity is being secured. Mobilisation planned for Feb 26. • **DM01** - A proposal is being considered by Executives to support increased potential to recruit and retain sonography staff. In the short terms additional capacity is being sought via IS providers. Mutual Aid requests have been made however have not been secured. • **Boarding/Escalation Bed utilisation/DKAFH** - Work continues within the DKAFH programme. This is accompanied with the Home for Christmas campaign which commenced early Dec 25 and is a multi agency discharge initiative seeking to reduce bed occupancy. LCC have supported the addition of a social worker within ED from Jan 26 and a system wide improvement meeting has been requested for Jan to agree urgent additional remedial actions. • **4 hour performance** - Escalation discussions have taken place with all system partners to explore additional improvement initiatives to reduce the wait for assessment, discharge and improve flow. Various Type 3/Non admitted improvements have been enacted with weekly monitoring of progress underway and T3 performance has improved in Dec 25. Virtual ward occupancy increases are a key focus with improvements noted since Aug 25 however occupancy remains below target. CMO clinical engagement discussions are ongoing to support increased activity. Community deflections are being enacted via 2UCR and there have been month on month increases in activity since Sept 25. SDEC activity has increased throughout 2025 although remains below the stretch targets set. ECIST are supporting with a model of care re-design session in Jan 26 to ensure maximum utilisation of the available capacity • **Ambulance Handover performance-** Performance is linked to ED exit block and overcrowding. Significant work to reduce length of stay is underway as described above. Close adherence to the ambulance escalation policy is being maintained.
Advise Areas of ongoing monitoring and any new developments	• **RTT performance -** 18 week RTT performance has dipped slightly to 53.1% against a target of 60.5%. DNA rates have continued to reduce month on month since April 25 however remain above target. • **UEC -** The average wait to be seen time was maintained in December but remains above target. • **12 hour + ED LOS** - performance has deteriorated in December and remains above the Operational Improvement plan. • **Cancer performance** - Performance has improved (Dec 25 unvalidated) in 62 day and FDS standards however 62 day remains below trajectory. •**Virtual Ward** - occupancy remains below target however has improved compared to November 25. •**Theatre Utilisation** - saw a deterioration in December - key focus at CDH.	• **RTT** - See actions in Alerts section • Key actions being taken to improve **ambulance handover** performance include increasing 'Fit to Sit' practices, improve data capture with NWAS, increased flow out of ED via continuous flow 'cycles' every 30 mins to AMU. • A focus on reducing the **wait to be seen** time is central to the Divisional ED Improvement plan. The ECIST C&D modelling is underway and will inform the staffing levels by day of the week and hour of the day. • **12 hour + ED LOS & DKAFH** - ECIST teams have supported a Capacity & Demand analysis and a workshop to agree the future Emergency Village model of care is to take place in Jan 26. This will align the UEC resources to ensure a more timely assessment within ED and combined with DKAFH actions will seek to improve the exit block within ED which is driving the extend ED LOS. • **DM01** - Mutual aid has been secured for Echo (100 scans have taken place in Dec 25) and Cardiac CT (10 scans completed). Mobilisation of the 5th Endoscopy room is underway and will come on board at the end of 2025. Additional capital equipment is due to be operational at the end of 2025 which will also increase capacity. •**VW** - recruitment into Medical staffing is underway to support an expanded offer. Communications to all LTH and community teams to increase referrals has been shared. •**Theatre Utilisation**- a focus on reducing late starts and cancellations for equipment is ongoing and aligned to 6-4-2 protocols.
Assure Areas of Assurance	• **PIFU** - Rates have significantly increased since April 25 and are now at 5.01% in December which is above the March 26 target of 5%. • **65 Week RTT** - 0 breaches maintained in December 2025	

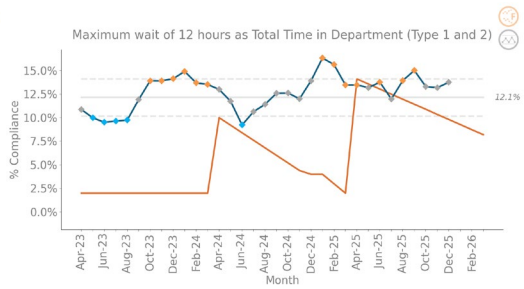
Performance

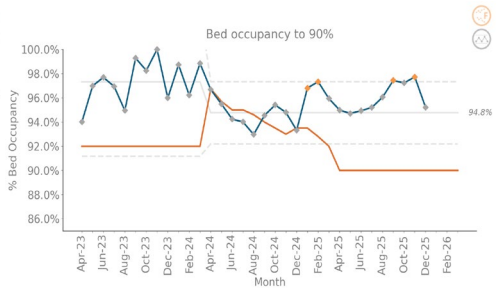
Metric Description		Assurance @ Mar-26	Variation to Latest Actual	Target Concern	Target Mar-26	Target Latest Month Target	Latest Month Actual	Latest Month
UEC In Flow	Compliance with 60 minute ambulance turnaround time target				100.00%	100.00%	88.51%	Dec-25
	Percentage of UEC (Type 1 & 3) patients seen within 4 hours				78.03%	71.50%	71.15%	Dec-25
	Maximum wait of 12 hours as Total Time in Department (Type 1 and 2)				8.20%	9.81%	13.75%	Dec-25
UEC Flow	Bed occupancy to 90%				90.00%	90.00%	95.22%	Dec-25
	Number of boarded patients				0	0	30	Dec-25
UEC Outflow	Reduce not meeting criteria to reside				5.00%	6.50%	11.46%	Dec-25
Elective (diagnostics)	Percentage of patients that receive a diagnostic test within six weeks				64.90%	62.20%	56.80%	Dec-25
Elective (long waits)	Percentage of patients waiting less than 18 weeks				62.50%	60.45%	53.10%	Dec-25
	RTT - 52 week Waiters				1395	1701	1977	Dec-25
	RTT - 65 Week Waiters				0	0	0	Dec-25
Elective (theatre utilisation)	85% theatre utilisation - aggregate - Capped				84.58%	84.58%	80.57%	Dec-25
Elective (Cancer) (unvalidated position, subject to change)	31 Day Cancer Standard				95.98%	93.14%	86.40%	Dec-25
	Cancer 62-day performance				75.10%	70.59%	62.37%	Dec-25
	Cancer Faster Diagnosis Performance				80.01%	80.00%	81.86%	Dec-25

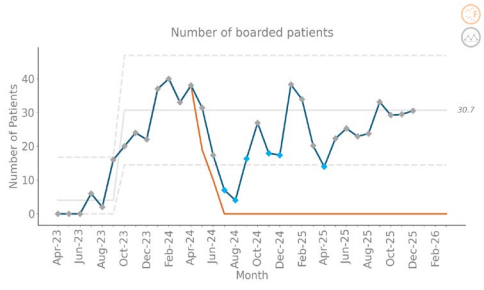
Performance

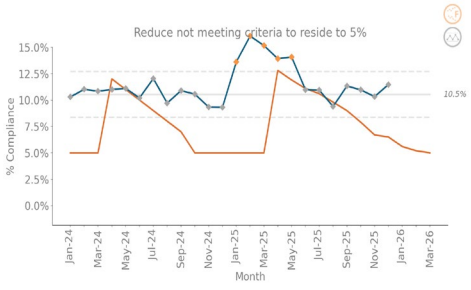


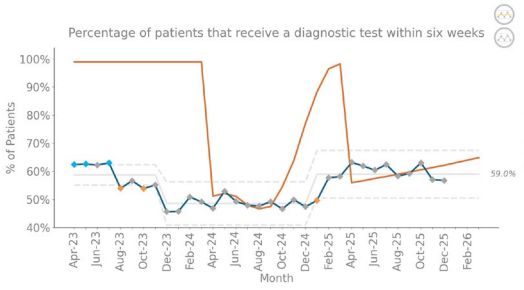


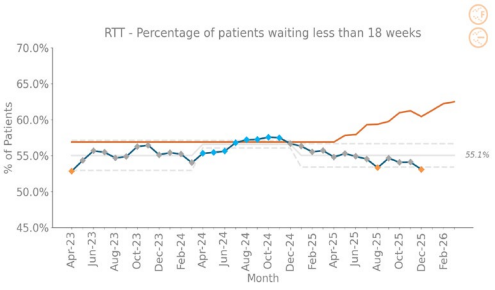


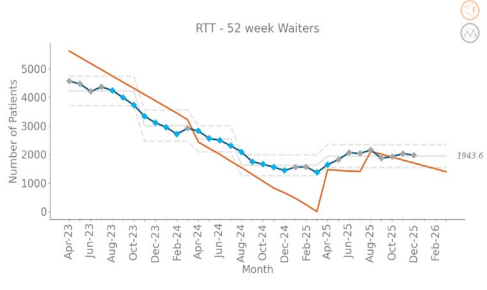


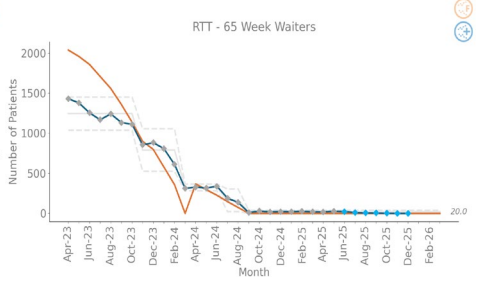


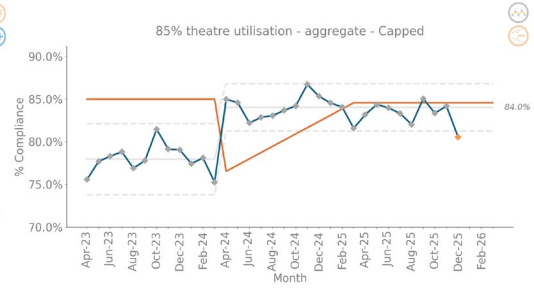


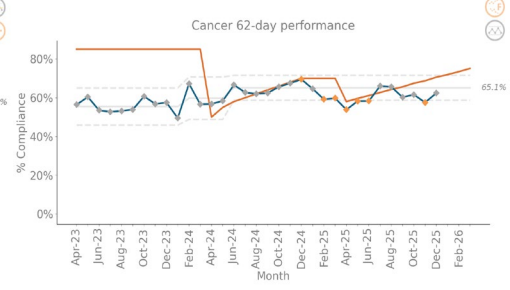


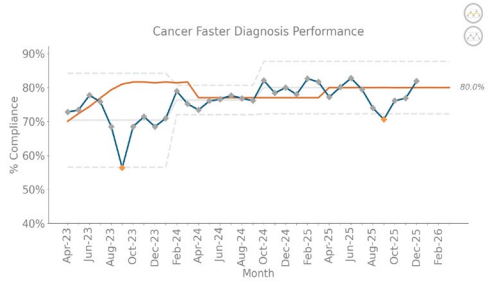


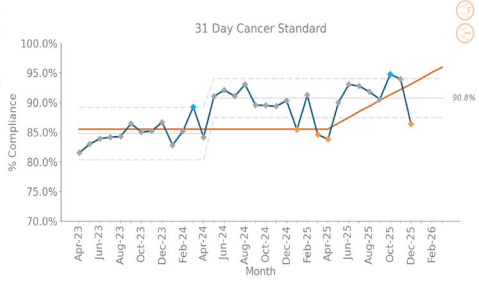












People


Single Improvement Plan
Patients
Performance
People
Productivity
Partnerships

Alert, Advise, Assure Report: People

	Issue	Action
Alert Areas of concern or matters that need addressing urgently		
Advise Areas of ongoing monitoring and any new developments	**Staff Engagement** - Increased use of TED, currently 44 TEDs to be completed before end of March to reach planned target. **Vacancy-** Vacancy rate remains high due to vacancy control measures. A new monthly cap of a total 20 posts maximum has been agreed to support financial recovery delivery targets.	**Staff Engagement** - Increase use of TED, with the 10years of TED celebration and communication campaign. Development of Corporate level action plan in response to 2025 NHS Staff Survey Results.
Assure Areas of Assurance	**Appraisal** - compliance is above target at 92.01%. **Turnover** - currently below expected at 0.50% in month. **Mandatory Training** - compliance is above target with 100% of metrics above 90%. **Sickness Absence**- The overall sickness absence rate increased to 6.38% in M09, as anticipated in line with seasonal trends. Both the short-term and long-term rates increased, although the overall rate is still 0.5% lower than the same period last year.	**Appraisal** - to bring about improvements in levels of compliance in Hosted Services and to implement further actions which will increase the use of Objectives and Personal Development Planning to support positive performance management and ensuring colleagues understand what is expected of them and are supported when completing their roles. **Turnover** - Refocus of retention strategic aims needed in order to support financial recovery whilst balancing service sustainability. **Mandatory Training** - as part of the next steps there will be an increased focus on Hosted Services, as well as SBU and CBU level compliance. **Sickness Absence-** The Workforce team are supporting divisional management teams to analyse the areas where sickness absence has increased in more detail. A second Rapid Improvement Event was held on 5 December, and through this further test of change ideas were generated, which will be further developed in M10. Empactis implementation is now in the user acceptance testing phase, with launch in the first pilot area anticipated in M10.

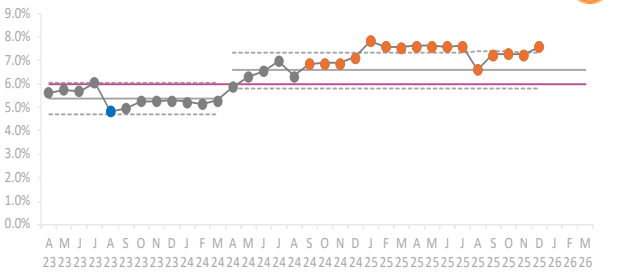
People

Metric Description		FY2526 Target Assurance	Latest Actual Variation	Target			Latest Actual	Latest Period
				Concern	FY2526	Latest Month Target		
People	Vacancies (% FTE) (source: General Ledger)				≤ 6%		7.59%	M09
	Turnover (% FTE) (National calculation annual assessment; ESR in-month reported)				≤ 10%		0.43%	M09
	Sickness Absence (% FTE) (annual assessment; in-month reported)				≤ 5.22%		6.38%	M09
	Number of violence and agression incidents toward staff (annual assessment; in-month reported)				996		110	M09
	Core Skills Mandatory Training compliance (% modules) (module compliance reported)				100% of metrics at 90%		100.00%	M09
	Appraisal compliance (% HC)				≥ 90%		92.01%	M09
	Staff Survey: Recommend Trust as place to work (quarterly metric)				≥ 60%		50.99%	Q2

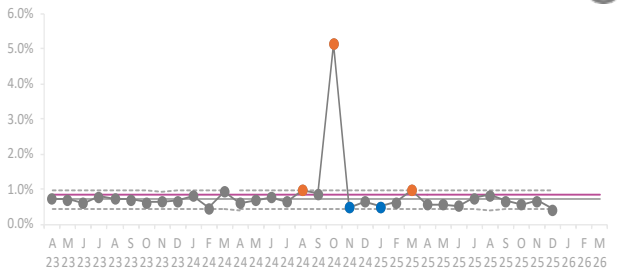
People

Lancashire Teaching Hospitals NHS Foundation Trust

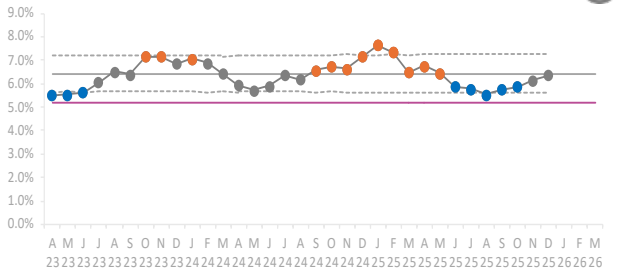
GL Vacancy Rate (% FTE)



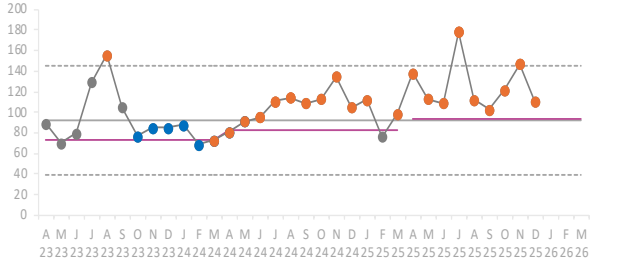
ESR Turnover (% FTE)



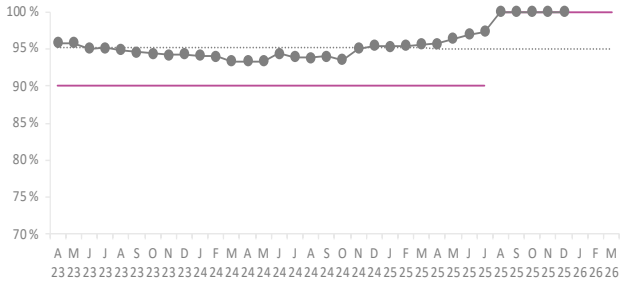
Overall Sickness (% FTE)



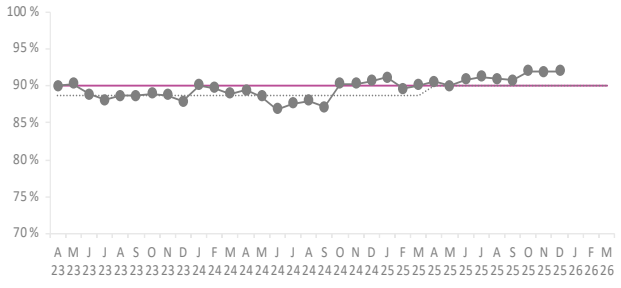
No. of Violence & Aggression Incidents Reported



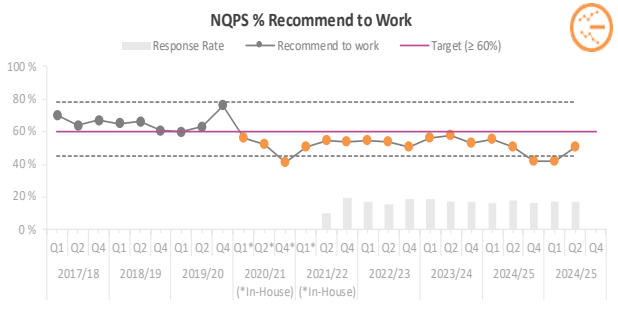
CSTF Compliance (% modules)



Appraisal Compliance (% HC)



NQPS % Recommend to Work



Productivity

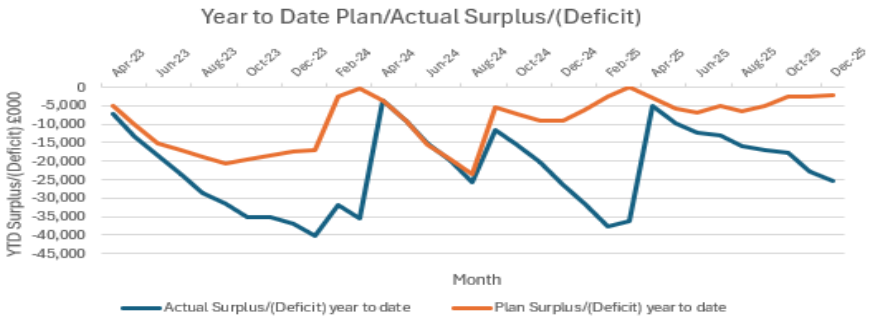
Alert, Advise, Assure Report

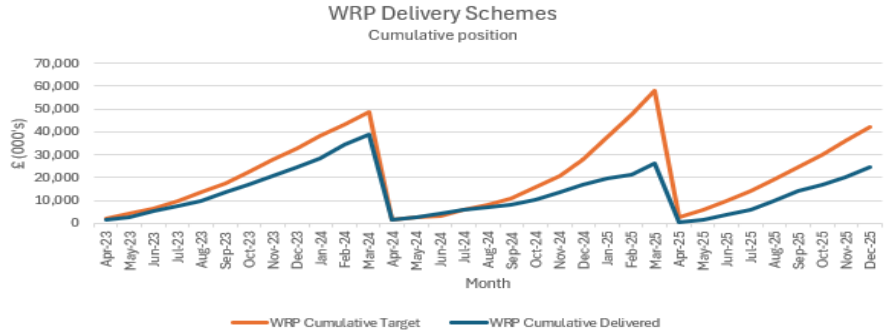
Lancashire Teaching Hospitals NHS Foundation Trust

	Issue	Action
Alert Areas of concern or matters that need addressing urgently	**Cash Position**	
	The Trust has received £22.5m cash support to date and an application for £9.5m of support in January has been submitted and approved by DHSC. The Board of Directors approved a further request for February for £4.0m and this has been submitted in accordance with NHSE timescales. The Board will be asked to approve a further application to the March cash support cycle and applications will be submitted accordingly. The Trust has been informed that the deficit support funding (DSF) of £2.5m per month may not be received in November to March. The revenue support application may not be approved by DHSC and the shortfall created by the DSF being withheld means the Trust will need to manage cash until the increased efficiencies come through in Q4.	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.
	Income and Expenditure	
	At the end of December 2025 the Trust has a deficit of £25.5m against a planned deficit of £2.1m. C9 The adverse variance to plan of £23.4m is as a consequence of the shortfall in delivery of the Waste Reduction Programme £17.7m, non receipt of deficit support funding for November and December of £5.0m and net operational pressures of £3.7m offset by funding for industrial action of £3m. At the time of setting the plan the Trust had not identified the full £60m programme and the unidentified element was included in the plan in 12ths in accordance with NHSE policy. The Trust has a rephased programme to resolve the shortfall in the final 6 months of the year. The Trust has had operational pressures of £3.7m that it has been unable to fully mitigated associated with; industrial action, patient acuity, junior doctor rotas, buildings dilapidations and maintenance of its energy system, these are largely considered non-recurrent. The Trust has operational pressures in: - the acute medical pathways reflected in overspends in medical and nursing pay budgets - sickness remains higher than in operational budgets resulting in nursing pay overspends	The Trust had a Turnaround Director to work with senior leaders to re-assess the current waste reduction programme position and deep dive into short, medium and long-term opportunities. A re-set of the programme structure, governance and reporting for 2025/26 has taken place. The Trust is working with the ICB on the urgent and emergency pathway system pressures which is one of the main operational pressures that the Trust faces. The system is now receiving enhanced support from NHSE as part of the provider improvement programme (formerly recovery support programme). A focus on grip and control activities continues. The Trust commissioned further external support for specific financial recovery plan workstreams and 2025/26 waste recovery programme development. Divisions will need to recover their financial performance by delivering improvements in their current run rates e.g. maximising grip around temporary pay, review of vacancies and continuing to mitigate shortfalls in the efficiency target as schemes move through development and implementation stages.
	Waste Reduction Programme	
	The Trust's 2025/26 waste reduction target is £60m, 7% of operating expenditure. At the end of December the Trust has delivered £30.9m of the £60m target (52%). The delivery in month was £4.0m against a plan of £5.9m. The Trust has identified schemes and opportunities to the value of £60m however the phasing is different to the financial plan with shortfalls in the first 6 months being offset with gains in the final 6 months of the year.	The Trust had a Turnaround Director to work with senior leaders to re-assess the current programme position and deep dive into short, medium and long-term opportunities. A re-set of the programme structure, governance and reporting has taken place for 2025/26. The Trust has additional external support to help with the delivery of the programme. The Trust is now embedding its own project management office structure to have a sustainable solution moving forward. The Trust is enhancing grip and control activities to mitigate slippage in specific schemes
Advise Areas of ongoing monitoring and any new developments	**Oversight Framework**	
	The Trust has received notification from the North West Region and is expecting a formal letter from NHSE that we have been put in Segment 5 of the new 2025/26 oversight framework. Segment 5 is where the organisation is one of the most challenged providers in the country, with low performance across a range of domains and low capability to improve or where the organisation is a challenged provider where NHS England has identified significant concerns. Segment 5 means the Trust will be subject to NHSE's most intensive support - the Provider Improvement Programme (PIP) - to ensure it meets improvement goals. Sustained improvement is required to leave the PIP.	The Lancashire and South Cumbria system is receiving nationally mandated support from PWC and the Trust is receiving support as part of the Provider Improvement Programme (previously Recovery Support Programme).
Assure Areas of Assurance	**Capital Position**	
	Capital expenditure in the year to date is below plan but plans are in place to deliver a forecast matching the available capital funding.	Continuing to closely monitor the capital schemes and submitting robust bids for funding in line with the opportunities that arise and associated deadlines.

Productivity

Metric Description		Assurance @ Mar-26	Variation to Latest Actual	Concern	Target (£ 000's) Mar-26	Latest YTD Target	Latest YTD Actual (£ 000's)	Latest Month
Productivity	I&E - Plan v Actual variance					-2133	-25529	Dec-25
	WRP schemes delivery				60000	42097	24373	Dec-25

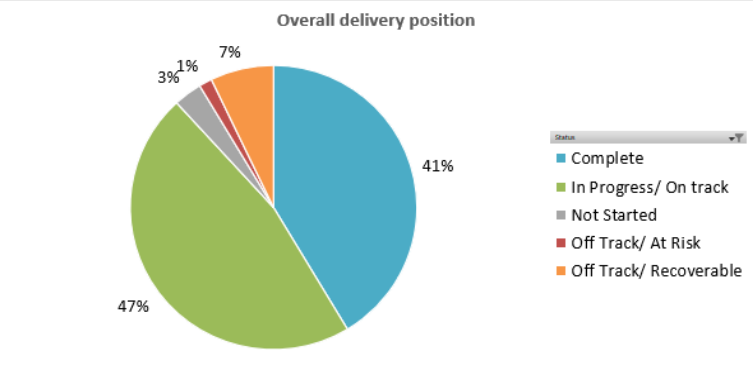


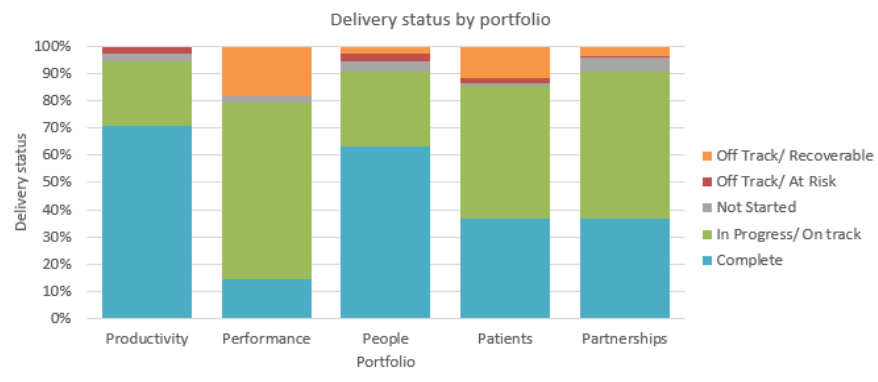


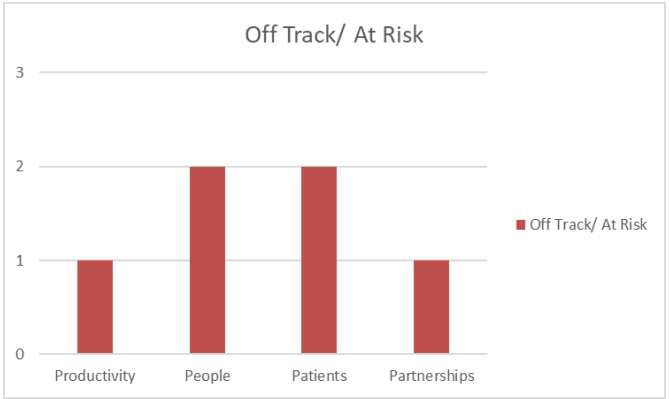
The Lancashire Teaching Hospitals **Single Improvement Plan** aims to improve patient care together.
The plan is based on what matters most to our patients, our colleagues, and our regulators, and it supports our overall goals. The SIP sets out a clear and simple way to improve how the Organisation works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

Lancashire Teaching Hospitals NHS Foundation Trust

December-25 | Single Improvement Plan delivery position







Status	Portfolio	Escalation	Key actions
Alert	PATIENTS	• Deterioration in patient experience metrics for urgent/emergency care, especially ED and adult inpatients. • Slippage in timeline for CYP improvement work due to medical staffing issues limiting capacity	• Map achievable trajectory for patient experience. Focus on minimising impact of flow through effective communications, review of comfort and approach to sleep and communications. Ward and board round to be used as a vehicle for improving patient clinician approach to care. • Discussion held with CMO for additional support required in paediatrics.
	PERFORMANCE	• RTT performance continue to be below target demonstrating a deteriorated position for 18 and 52 weeks • Overall DM01 performance deterioration to 57.06%, driven by NOUS • Number of boarded patients remain high and above target	• RTT funding secured to support reduction of 52 week by March-26 • Operational Performance Board now in place to closely monitor delivery plans and outcome metrics. • DKAFH programme rolled out to a further 16 wards
	PEOPLE	• Hosted services are a concern for both training and appraisal compliance. • Sickness absence management delayed due to technical issues with ESR and Empactis integration.	• Focussed support underway to bring areas into compliance. • Mitigations in progress - focussed work in divisions to support long term sickness absence management.
	PRODUCIVITY	• Financial recovery plan of £60m is at risk, with a risk mitigated position of £42.5m. • Cash risk escalated from significant to high	• CFO working through enhanced grip and control measures alongside mitigating under delivery of WRP • Prioritisation list enacted and Trust Board approval of up to £9.5m in January 2026.
Advise	PATIENTS	• National standards of cleanliness is delayed in year but expected to be compliant by end of March-26	• Oversight by CNO and Director of Estates and Facilities to ensure funding is available to recruit domestic staff. Positive feedback from ward managers to date on the impact of this in mobilised areas.
	PEOPLE	• Equality Diversity (EDI) and Inclusion actions being scoped in response to priority letter.	• EDI programme to be expanded to include scope of NHS England letter.
	PERFORMANCE	• Reduction of 133 lost bed days in November compared to October	• Critical focus remains on pathway zero and reducing delays
Assure	PATIENTS	• Full compliance with all year 7 10 CNST standards • C.*difficile* remains in trajectory	
	PERFORMANCE	• Cancer FDS performance has consistently met or exceeded trajectory and expected to meet 80% target by April-26	
	PEOPLE	• Compliance remains high, with all 33 metrics met for another month • Compliance with CQC "must do" actions for APLS training and moving/handling, leading to de-escalation of principal risk	

The Best Version of Us
Our Culture Counts @LTH

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Integrated Performance Report
Appendix 1 – Assurance Reports

February 2026 Trust Board meeting with performance to December 2025


Partnerships


People


Patients


Productivity

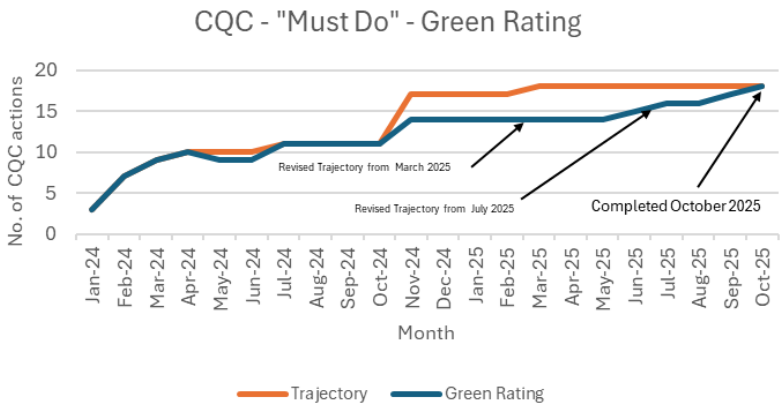

Performance

Excellent care with compassion

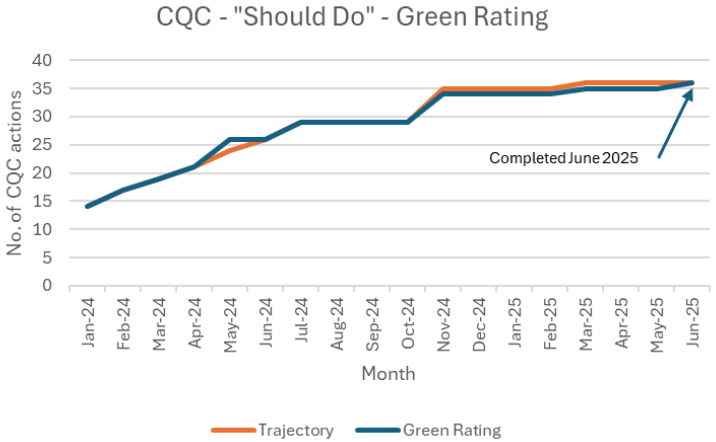
Always Safety First

@LancsHospitals

Patients - CQC Assurance



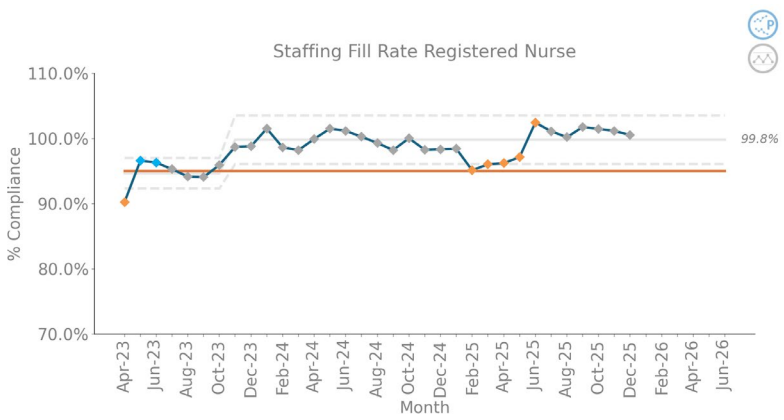
Latest
18
Month Target
18
Oct-25 Target
18



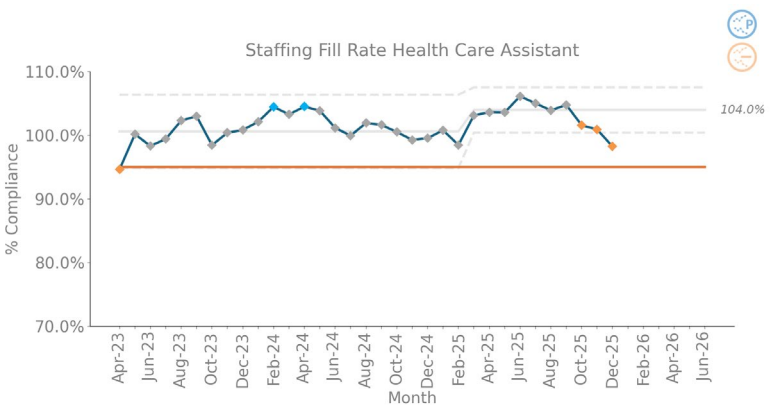
Latest
36
Month Target
36
June-25 Target
36

Metric	Summary	Action	Assurance
CQC - "Must do" (Number with Green rating)	1. At the end of October 2025, of the 'Must Do's' included in the 2023/2024 CQC Quality Improvement Plan (QIP), all 54 (100%) 'Must do' actions are delivered. 2. Training compliance for Urgent and Emergency Care (UEC) is reported combined for RPH and CDH. At the end of October 2025 training compliance for all staff within UEC was above the Trust target in all mandatory training metrics leading to the remaining 'Must Do' action being marked as delivered.	1. At the end of August 2025 the Trust shared communication with all staff regarding the changes to the Trust Code of Conduct and Disciplinary Procedure in relation to non-compliance with training requirements. It is expected that Divisions will enact the policy accordingly to ensure training compliance across all staff groups is maintained. 2. As the remaining 'Must Do' action in relation to mandatory training compliance for all staff in UEC has now delivered, the 2023/2024 CQC Quality Improvement Plan has been assessed as completed. 3. The monitoring of the must dos going forward will now cease.	1. From the 18 'Must Do' recommendations, all 18 'Must Do's' have been assessed as delivered at the end of October 2025. 2. There have been sustained positive improvements with overall training compliance across the organisation. At the end of October 2025 the Trust has maintained compliance above target for all Core Skills subjects for Medical and Dental, Nursing and Midwifery, and all other staff groups. This was also the case in the Urgent & Emergency Care team allowing the remaining action to be marked as delivered. 3. Training compliance will continue to be monitored through the Divisional Improvement Forums and reported to Workforce Committee as part of the People and Culture Accountability Framework.
CQC - "Should do" (Number with Green rating)	At the end of June 2025, of the 'Should Do's' included in the 2023/2024 CQC QIP, 100% were marked delivered.	1. There are no outstanding 'Should Do' actions. All 'should do actions were assessed as delivered at the end of June 2025. The position remains unchanged at the end of October 2025. 2. The monitoring of the must dos going forward will now cease.	From the 36 'Should Do' recommendations, 36 were assessed as delivered at the end of June 2025. The position remains unchanged at the end of October 2025.

Patients - Deliver Annual Safe Staffing Requirements Assurance



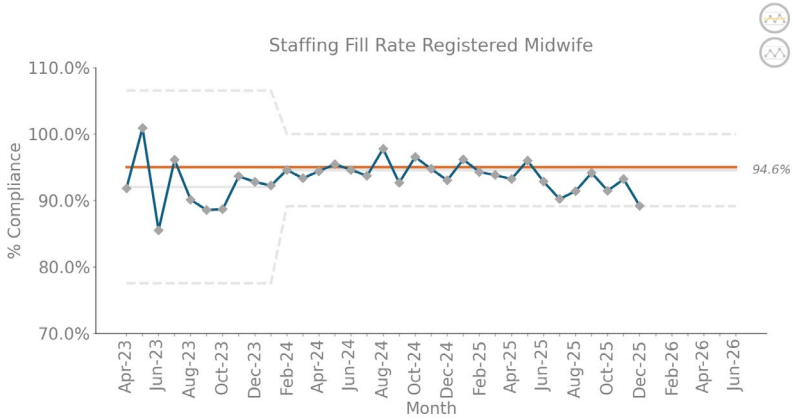
Latest
100.54%
Variance Type
Normal variation - no recent change
Mar-26 Target
95%
Target Achievement
Will consistently pass target within expected variation



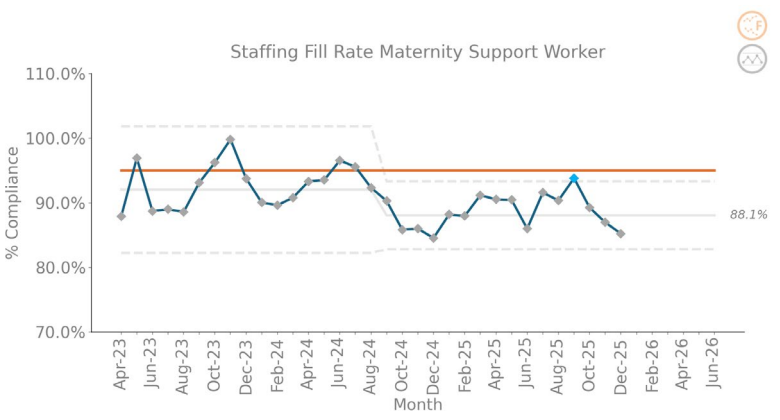
Latest
98.24%
Variance Type
Recent concerning pattern in the data
Mar-26 Target
95%
Target Achievement
Will consistently pass target within expected variation

Metric	Summary	Action	Assurance
Staffing Fill Rate Registered Nurse	The RN staffing fill rate for December was 100%. At site level, Chorley District Hospital (CDH) achieved a RN fill rate of 100%, while Royal Preston Hospital (RPH) reported a 101% RN fill rate. The implementation of strengthened controls for the approval processes for bank and agency is in place to ensure that as a Trust we are maximising the use of our resources while maintaining safety for our patients and staff. Redeployment of staff due to organisational change is being undertaken.	1. Twice daily nurse staffing meetins are in place 7 days a week for oversight of safe staffing 2. Roster sign off processes are in place and this has increased to weekly roster efficiency reviews which commenced by the Divisional Nurse Leaders in October 25. 3. There is a full review of all areas where fill rate is greater than 100% and actions are being taken, including redeployment of staff, where overestablishment is in place on a shift by shift basis. 4. Redeployment of staff into vacancies through organisational change and ward closures, ongoing into next year 2026.	1. All clinical areas are showing a stable fill rate position. 2. Daily operational staffing meetings led by matrons, assess and respond to changes in pressure and demand based on acuity and dependency, Red flags and professional judgement. 3. Approval and sign off of all agency shifts Chief Nursing Officer 4. Biannual safe staffing procedures are in place in line with National Quality Board guidance. 5. Weekly PSIRF oversight panel review incident harm levels, this is triangulated through a quarterly serious incident/PSIRF report. 6. Involvement in National Enhanced Theraputic Observation and Care (ETOC) improvement work. 7. Additional duties follow a clear governance process for request and approval by Deputy/ Divisional Nursing Director to maintain safety and efficacies.
Staffing Fill Rate Health Care Assistant	The HCA staffing fill rate for November was 98%. At site level, Chorley District Hospital (CDH) acheived a HCA fill rate of 97%, while Royal Preston Hospital (RPH) reported a 99% HCA fill rate. The need for bank support remains to ensure safety is maintained with HCA/MSW vacencies currently sat at 17% vacenciey rate for inpatient wards. Focus recrutment and retention plan is being developed to reduce reliance of temporary staffing to maintain safety.	1. Twice daily nurse staffing meetings are in place 7 days a week for oversight of safe staffing 2. Development of clear career pathways and recruitment routes into support worker roles through joint work between Recruitment, Education, and Safe Staffing, initial meeting planned for February 2026.	

Patients - Deliver Annual Safe Staffing Requirements Assurance



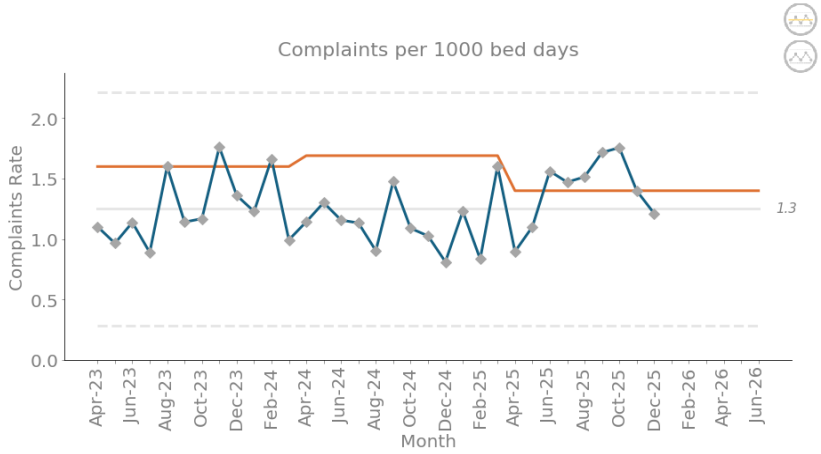
Latest
89.17%
Variance Type
Normal variation - no recent change
Mar-26 Target
95%
Target Achievement
Could both pass or fail target within expected variation



Latest
85.22%
Variance Type
Normal variation - no recent change
Mar-26 Target
95%
Target Achievement
Will consistently fail target within expected variation

Metric	Summary	Action	Assurance
Staffing Fill Rate Registered Midwife	The overall midwifery fill rate remains below the Trust target of 95% for December 2025. 19 midwives have been recruited, 12 are currently in their supernumery period with 8 due to complete buy the end of this month. A further 7 midwives were recruited in November and will commence in post between January and March. The current vacancy for Registered Midwives is being monitored closely with recruitment ongoing. Unfilled shifts continue to be sent to bank and agency to maintain safety. The next BirthRate plus assessment report for the service has been received and work is ongoing to prepare a report for consideration by the committee in February.	1. Weekly roster efficiency reviews as required to ensure appropriate use of bank and agency. 2. Monthly roster efficency meetings overseen by the deputy Divisonal Midwifery and Nursing Director 3. The service continues to recruit to turnover using over offer of 5 WTE.	1. Fill rates for Registered Midwives overall have been stable across day and night shift patterns. 2. The Safety and Quality committee review fill rate and minimum RM levels by area on a monthly basis. 3. Approval and sign off of all agency shifts undertaken by the Deputy/ Divisional Midwifery and Nursing Director. 4. Biannual safe staffing procedures are in place in line with National Quality Board guidance. 5. Weekly PSIRF oversight panel reviews incident harm levels, this is triangulated through a quarterly serious incident/PSIRF report. 6. Red-flag reporting is monitored to identify areas where additional input can be provided to manage the risk.
Staffing Fill Rate Maternity Support Worker	The overall Midwifery Support Worker fill rate is below the Trust target of 95% at 85.22% for December 2025. Short and long term sickness continues to affect the fill rate and this is being managed in line with the Trust Policy. The vacancy is being monitored and recent recruitment has ben successful. To maintain safe staffing levels, there continues to be a requirement to use bank to fill shifts. The recruitment and onboarding processes have been more protracted since changes to the recruitment team resulted in delays to staff progressing into posts following new appointment.	1. Weekly roster efficiency reviews are ongoing to ensure appropriate use of temporary staff. 2. Ongoing recruitment to fill all vacancies which are tracked using a local trajectory plan. 3. Sickness management procedures are reviewed by Workforce Business Partner to ensure appropriate management. 4. Band 2 MSW vacancies in maternity A,B and Delivery suite are being progressed through VCP or onboarding process.	1. The Safety and Quality committee review fill rate and minimum safe staffing levels by area on a monthly basis. 2.. Approval and oversight sight of rosters is undertaken by the Deputy/ Divisional Midwifery and Nursing Director. 3. Biannual safe staffing procedures are in place in line with National Quality Board guidance. 4.. Weekly PSIRF oversight panel reviews incident harm levels, this is triangulated through a quarterly serious incident/PSIRF report. 5. Red-flag reporting is monitored to identify areas where additional input can be provided to manage the risk.

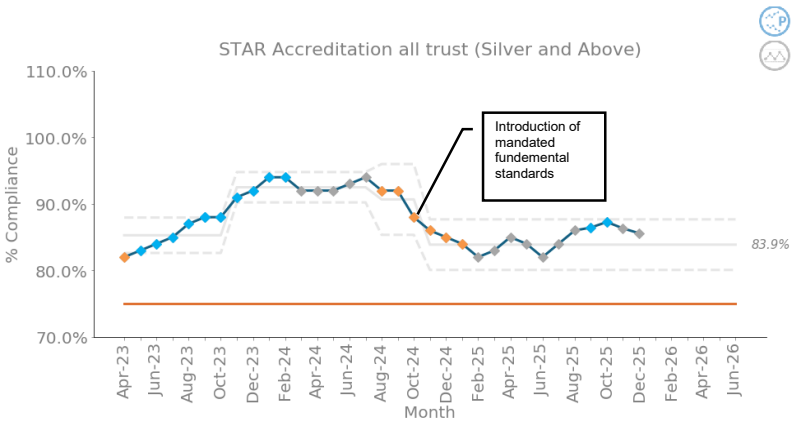
Patients - Complaints



Latest
1.76
Variance Type
Normal variation - no recent change
Mar-26 Target
1.40
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
Complaints per 1000 bed days	The number of complaints per 1000 beds days continues to demonstrate a reduction. The trend reflects an increased focus on achieving local resolution for patients and their families, enabling concerns to be addressed promptly and effectively at the point of care. It is noted that there has been 5 months where complaint per 1000 days is above the median line, albeit within normal variation, there has now been 2 months of downward trajectory. This is likely to be in part due to the number of complaints being received which has now become more manageable with the introduction of the patient form. Improving patient experience continues to be a central priority for the Trust. Targeted work is progressing through the Urgent and Emergency Care (UEC) improvement programme and the wider enhancements to inpatient pathways. Insight from the National Inpatient and Emergency Department surveys has highlighted specific areas requiring attention, and feedback from patients is shaping both immediate actions and longer-term improvements. Given the significant influence of the UEC pathway on the experience of patients, families and staff, it remains a core focus within the Trust's overall patient experience improvement plan. The main themes emerging from complaints continue to relate to communication, delays in treatment, delays in procedures, and delays in appointments. Delivery of the Trust's Single Improvement Plan remains closely aligned to the ongoing patient experience agenda. Work continues to progress against actions arising from national survey feedback across inpatient care, urgent and emergency care,	1. Continue to deliver the Patient Experience Improvement Plan via the Single Improvement Plan 2. Continue to deliver the Patient Safety Incident Response Framework with a focus on family liaison roles 3. Monitor actions in relation to National picker Surveys . 4. To deliver the PALS and local early resolution training. 5. Continue to progress the complaints review group using patient safety partners and governors 6. Where concerns have not been responded to locally escalate to managers.	1. Annual patient experience reports to Safety and Quality committee. 2. Friends and family monthly reporting in place for all departments. 3. Inclusion of patient experience in STAR. 4. Chief Nursing Officer reviews all complaints and signs off responses. 5. Monitor picker survey action plans through Patient, Carer, Experience and Involvement Group.

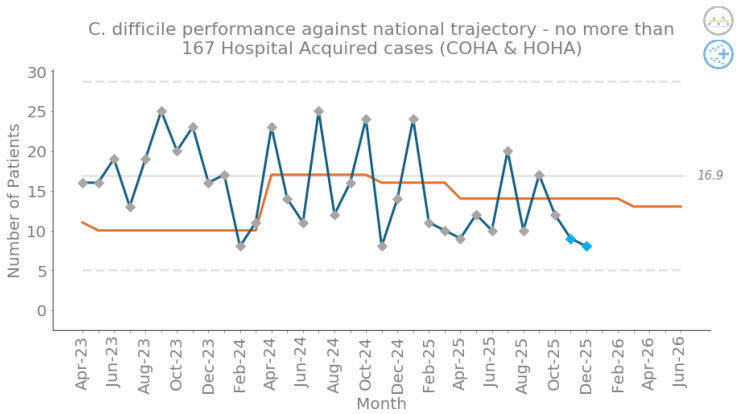
Patients - Quality Assurance STAR Accreditation



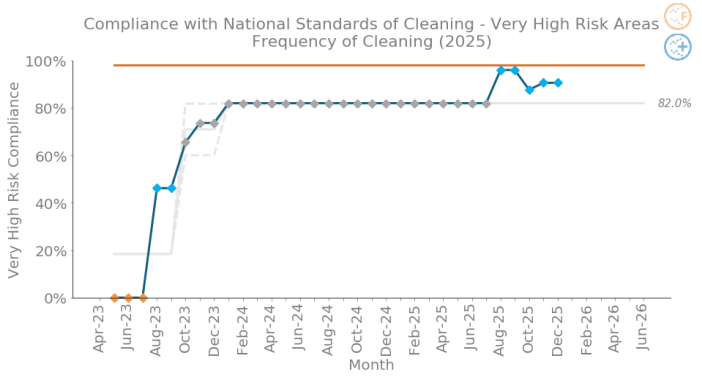
Latest
85.59%
Variance Type
Normal variation - no recent change
Mar-26 Target
75.00%
Target Achievement
Will consistently pass target within expected variation

Metric	Summary	Action	Assurance
STAR Accreditation all trust (Silver and Above)	There are 118 clinical areas registered for the STAR Quality Assurance Framework, of which all 118 have received STAR accreditation visits. There are 2 clinical areas with a red star rating, 15 areas with an amber rating and 101 areas rated green. This results in 17 bronze stars, 23 silver stars and 78 gold stars. There are 86% of areas rated silver or above. During December, there were 2 areas with a reduced STAR rating, 2 areas had an increase to silver and others maintained their star rating. One area had an decreased 15 steps rating from B to C and is due to be reassessed in January. Themes for improvement include the mandated 'critcal' standards of infection prevention and control, risk assessments, STAR audit action completion and mandatory training. Recurrent themes are included within the STAR report, theseinclude patient and staff experience, patient experience impacted upon by boarding and overcrowding, escalation of deteriorating patients, fluid balance management, assessment and delivery of enhanced therapeutic observations and care (ETOC). There are 75 % of wards, ED and theatres scoring silver and above for STAR accreditation visits.	1. Any standards which are not achieved require an improvement action which is monitored within division through divisional assurance processes and via STAR monthly reviews and STAR acreditation visits. 2. The monthly STAR report includes trustwide and divisional STAR data and highlights good practice, areas for improvement, themes for learning and an overarching STAR improvement action plan, which is cascaded and discussed through the divisional always safety first meetings. The STAR report includes CQC (2023) action plan standards which require improvement. 3. The STAR action plan has been updated to include recurrent themes and now included learning and actions from the Safety Visits undetaken by the senior leadership teams. 4. STAR monthly report updated to highlight those areas who are rated red or amber for STAR visits of less then 90% for STAR monthly reviews and includes areas ranking for their STAR performance. 5. A new STAR enhanced oversight panel commenced during October, involving 5 areas to drive action and support with STAR safety and quality actions.	1. 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. 2. Ward/department managers, matrons and professional leads provide assurance that actions are completed and monitored for effectiveness through the 1:1 with matrons and Divisional Nurse Directors. 3. The AMaT system supports with STAR audit data management and oversight and management of improvement actions. 4. There is a BI STAR page available to enable data triangulation. 5. STAR accreditation visits are scheduled depending on star rating, areas with a bronze star rating are reassessed within 2-3 months. (red every 2 months, amber every 3 months).

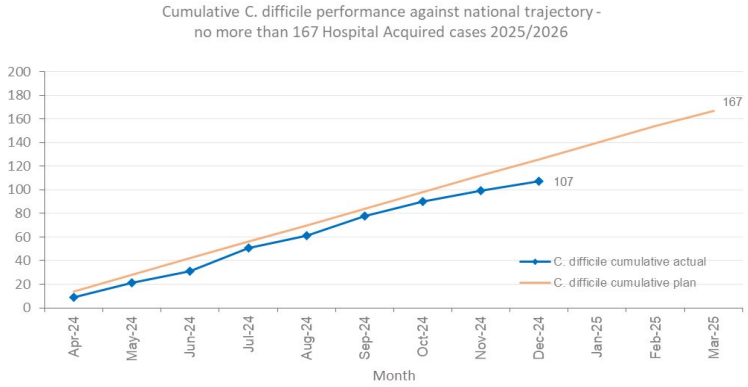
Patients - C Difficile Improvement Programme Assurance

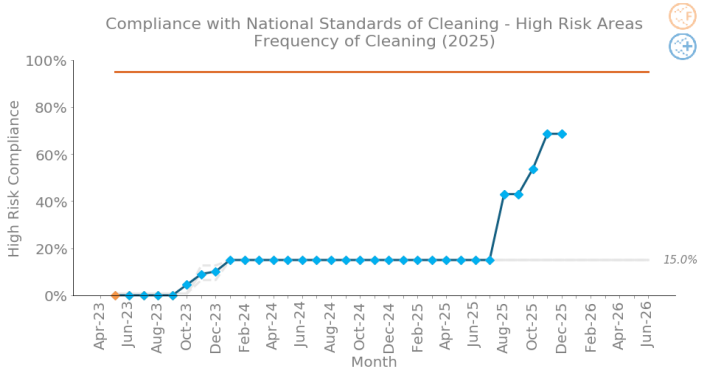


Latest
8
Variance Type
Recent positive pattern in the data
Mar-26 Target
13
Target Achievement
Could both pass or fail target within expected variation



Latest
90.60%
Variance Type
Recent positive pattern in the data
Mar-26 Target
98.00%
Target Achievement
Will consistently fail target within expected variation





Latest
68.64%
Variance Type
Recent positive pattern in the data
Mar-26 Target
95.00%
Target Achievement
Will consistently fail target within expected variation

Metric	Summary	Action	Assurance
C. difficile performance against national trajectory - no more than 167 Hospital Acquired cases	C.difficile is a recognised high risk for teh Trust. In December 2025 there were a total of 8 cases for the month, continuing the trend below the objective, with a total of 107 cases for 2025 / 2026 to date. The Trusts National objective for 2025/2026 is a total of 167 cases. The focused work on CDI reduction and the improvement plan continues to be monitored through the Infection Prevention and Control Committee each month and also the Estates, Facilities and Clinical Partnership Board. The National Standards of Healthcare Cleanliness (2025) for frequency of cleaning is now visible and monitored through the dashboard alongside the quality checks of those areas not yet achieving the frequency of cleaning standards. The joint efficacy audits commenced in November 2025.	1.Implementation of the approved business case to be compliant in high risk areas with National Standards of Healthcare Cleanliness (2025). 2. Continued focus on IPC 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 BAF report reviewed and shared at IPCC for assurance. 2. IPC Dashboard. 3. IPC monthly revalidation audits such as Hand Hygiene, Commodes, Environmental checks and Mattress checks. 4. Monthly reporting into S&Q, IPCC and Divisional IPC meetings, along with bi-monthly reporting into H&S Committee. 5. STAR encompasses IPC audits and cleaning checklist compliance, with all audit information available within AMAT. 6. NHS England review of IPC assurances. 7. Antimicrobial stewardship oversight and assurance reporting.

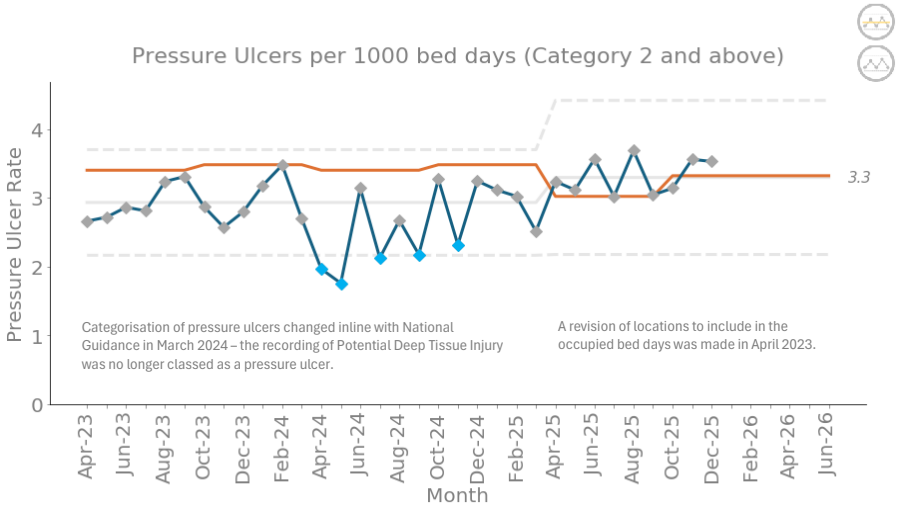
Patients - Always Safety First Assurance - Mortality

	Achievement	Position	Month
Hospital Standardised Mortality Ratio - Adult	Lower Than Expected	68.5	August 2025
Standardised Mortality Ratio - Relative Risk - All Diagnoses Adult	Lower Than Expected	69.2	August 2025
Standardised Mortality Ratio - Relative Risk - All Diagnoses Child (<1 day – 17 yrs)	As Expected	183.0	August 2025
Standardised Mortality Ratio - Relative Risk - All Diagnoses Neonates (<1-28 Days) *The updated TELSTRA model from November 2024 does not include still births*	As Expected	124.3	August 2025

Source Data: Telstra (Dr Foster)

Metric	Summary	Action	Assurance
Hospital Standardised Mortality Ratio - Adult	HSMR is within Upper and Lower Control Limits and within the expected range compared to peer.	1. Continue with structured judgement review process. 2. Use mortality reviews to establish themes where care or experience could be improved. 3. Continue to work with the medical examiners office to review deaths in line with guidance. 4. Continue to use incident reporting processes where an incident occurs under Patient safety Incident Response Framework (PSIRF). 5. Continue to implement the 10 CNST safety actions for maternity and neonatal 6. Marthas rule (Call for Concern)implementation is underway.	1. Mortality and End of Life committee chaired by Deputy Chief Medical Officer with responsibility for mortality. 2. Twice annual reports to safety and Quality committee. 3. Telstra system utilised to generate mortality data ensuring objective peer data is used to establish reported key performance indicator. 4. Speak Up arrangements are well established in the organisation. 5. Maternity Neonatal report provides assurance of compliance with Maternity neonate Safety Investigation branch for appropriate cases. 6. The Child Death Overview process ensures peer review takes place of all child deaths and is reported through the annual safeguarding report and the mortality reporting arrangements. 7. ED and maternity and neonatal safety forums in place with executive leads identified to encourage speak up in high risk areas. 8. 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. 9.The Trust has been validated against all 10 CNST maternity and neonatal safety actions and is now progressing through the formal sign-off process.
Standardised Mortality Ratio - Relative Risk - All Diagnoses Adult	SMR is within Upper and Lower Control Limits and within the expected range compared to peer.		
Standardised Mortality Ratio - Relative Risk - All Diagnoses Child (<1 day – 17 yrs)	SMR (Child <1 day -17 Years) (All Diagnoses) is within Upper and Lower Control Limits and within expected range compared to peer.		
Standardised Mortality Ratio - Relative Risk - All Diagnoses Neonates (<1-28 Days)	SMR (Neonatal <1 day -28 days) (All Diagnoses) is within Upper and Lower Control Limits and within expected range compared to peer.		

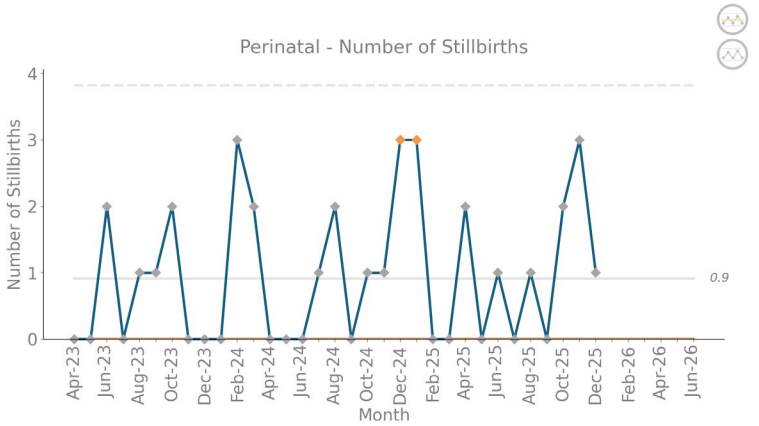
Patients - Pressure Ulcers Assurance



Latest
3.53
Variance Type
Normal variation - no recent change
Mar-26 Target
3.32
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
Pressure Ulcers per 1000 bed days (Category 2 and above)	Pressure ulcers are a recognised indicator of care quality. Since April 2025, the target line has been revised to reflect the previous year's average number of incidents. Since this adjustment, reported pressure ulcer numbers have consistently exceeded the target, with a notable increase in November 2025. Reducing pressure ulcer incidence remains a Trust-wide priority, supported by continued focus on preventative measures. A comprehensive improvement plan has been developed to drive key actions, uphold standards, and strengthen harm review processes. Additionally, the pressure ulcer and falls review process was updated in November 2025 to include a dedicated panel for cross-divisional learning, trend analysis, and sharing of key themes.	1. Continued focus on the Trust Operational Performance Single Improvement Plan aimed at reducing pressure ulcers by 1,000 bed days – commenced 2025 2. Review of all education and awareness programmes on pressure ulcer prevention across the Trust – expected completion by March 2026 3. Sharing of cross-divisional learning, key themes and trends at monthly divisional Always Safety-First meetings – commencing monthly from January 2026 4. Quarterly review of key themes and trends from high-incidence areas of pressure ulcers, with feedback provided at monthly ASF meetings and Pressure Ulcer Panel – from January 2026 5. Introduction of a Pressure Ulcer and Falls Review Panel to review harms, share learning, and identify themes and trends – commenced November 2025.	1. Always Safety First strategy reporting twice yearly to safety and quality committee. 2. Always Safety First committees at divisional level responsible for overseeing the implementation of the pressure ulcer improvement action plan. 3. Monitoring of pressure ulcer incidence monthly continues to be recognised as a priority metric. 4. Monitoring of the key questions 8d and 9c in STAR Monthly. 5. Severe harms to be presented at panel each month to review and share learning, good practice and actions with these actions monitored until closed

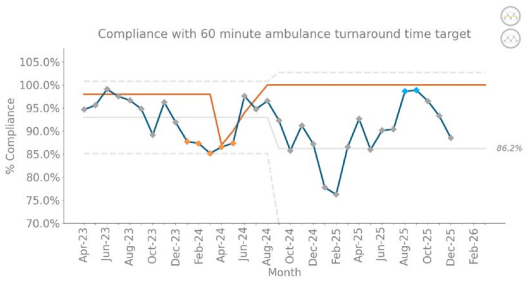
Patients - Stillbirths Assurance



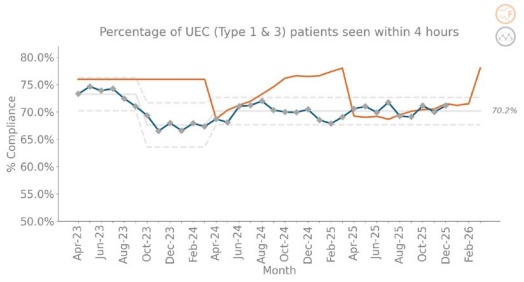
Latest
1
Variance Type
Normal variation - no recent change
Mar-26 Target
1
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
Perinatal - Number of Stillbirths	The service continues to track the rates of stillbirth and revew each case in line with nataional guidelines. There were no stillbirths in November 2025 and 1 in December 2025. This is within normal variation for the service. The 12-month average mean still birth rate is 2.6 per 1000 which remains below the national average of 3.9 per 1000.	1. Implementation of the 10 CNST maternity neonatal safety standards.	1. Monthly dashboard analysis shared via the maternity and neonatal safety report to safety and quality committee. 2. Peer comparison data included within the reporting 3. National MBRRACE reporting provides overview of national themes to ensure learning is understood. 4. ICB Local Maternity Neonatal System validation of CNST delivery of standards. 5. The Maternity Outcomes Signal System (MOSS) is now in place which provides real-time monitoring of key maternity outcomes—such as term stillbirths, to detect early warning signals and prompt rapid intervention

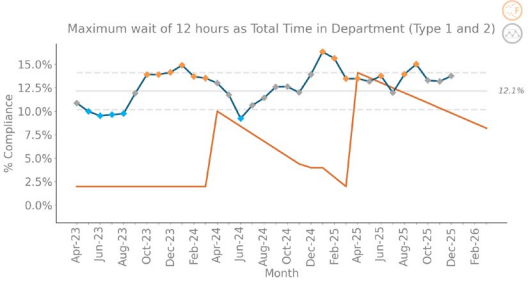
Performance - UEC Assurance



Latest
88.5%
Variance Type
Normal variation - no recent change
Mar-26 Target
100%
Target Achievement
Could both pass or fail target within expected variation



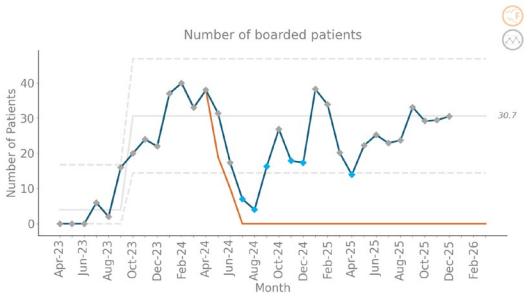
Latest
71.15%
Variance Type
Normal variation - no recent change
Mar-26 Target
78.02%
Target Achievement
Will consistently fail target within expected variation



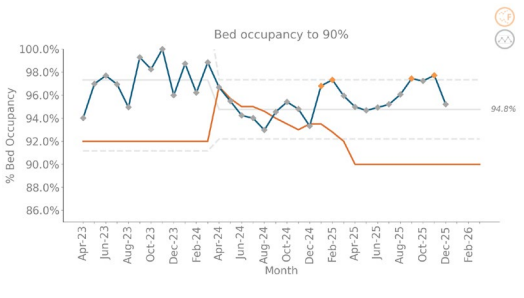
Latest
13.75%
Variance Type
Normal variation - no recent change
Mar-26 Target
8.20%
Target Achievement
Will consistently fail target within expected variation

Metric	Summary	Action	Assurance
Compliance with 60 minute ambulance turnaround time target	In December 392 patients waited between 30-60 minutes to be handed over from NWAS to the Trust, a rise of 37 from last month. 274 patients waited over 60 minute to be handed over from NWAS to the Trust in December 25, an increase of 117 compared to November. In December 88.5% of patients were handed over within 60 minutes, a deterioration compared to previous months.	Ambulance handover delays remain a high priority, and a local improvement collaborative is in place with key actions focusing on increasing NWAS to SDEC pathways. This accompanied with the improvement actions focusing on reducing LOS and DKAFH (NMC2R) which will reduce ED Overcrowding and support more timely handover and attendance and admission avoidance actions is aimed to see improvements.	Monitoring of ambulance demand is undertaken via the weekly Ambulance handover group. Comparison to both the national and regional performance positions for December 25 indicates that the Trust is below the national performance position of 92.3% for 60 minute handovers and below the NW performance position of 91.9%.
Percentage of UEC (Type 1 & 3) patients seen within 4 hours	Performance against the national 4 hour access standard improved in December 2025. The performance improvement was 1.2% compared to November. December experienced a slightly lower daily attend rate compared to November 25.	The UEC Improvement programme is focusing on measures to reduce the wait to be seen time, improving response times for patents referred to specialities and seeking to maximise referrals into SDEC. Targets have been set for each of these critical measures and is monitored via the UEC Improvement Board monthly. SDEC activity has deteriorated slightly in December to below the 40% target (-2.8%).	Improvements have been seen in SDEC activity throughout 2025, although not yet achieving the stretch target. Virtual ward occupancy has improved since Aug 25 but is not yet reaching target or showing an embedded improvement. Deflections into community services via 2UCR have increased month on month since Sept 25. Comparison of 4 hour performance to the latest published national benchmarks indicates that the Trust is below the national average for December 25 of 73.8% and was ranked 58 out of 118 trusts nationally.
Maximum of 12 Hours Total time in ED	The number of patients waiting over 12 hours (admitted and non-admitted Type 1 only) in ED increased in December to 13.75%, an increase of 0.58% compared to November. The position shows normal variation and will consistently fail the year end target.	The UEC improvement programme is focusing on reducing length of stay via improving board and ward round standards and driving down the days patients spend in hospital when they no longer require inpatient care.	Overall Bed Occupancy was at 95.2% with a range between 92% - 97% over the last 12 months. The level of boarded patients remained consistent in December with an average of 30 patients per day. The volume of Days Kept Away from Home patients is far in excess if the target ad markedly higher than the Dec 24 position versus Dec 25. Comparison within Model Health System indicates the Trust is above the provider median and within Quartile 3.

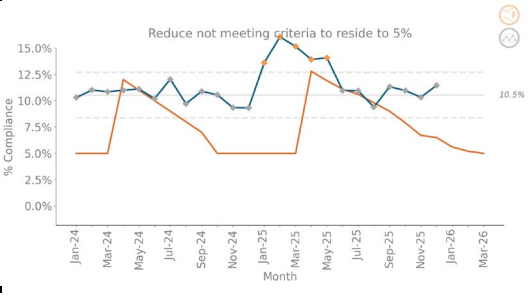
Performance - UEC Assurance



Latest
30
Variance Type
Normal variation - no recent change
Mar 26 Target
0
Target Achievement
Will consistently fail the target within expected variation



Latest
95.2%
Variance Type
Normal variation - no recent change
Mar 26 Target
90.0%
Target Achievement
Will consistently fail the target within expected variation

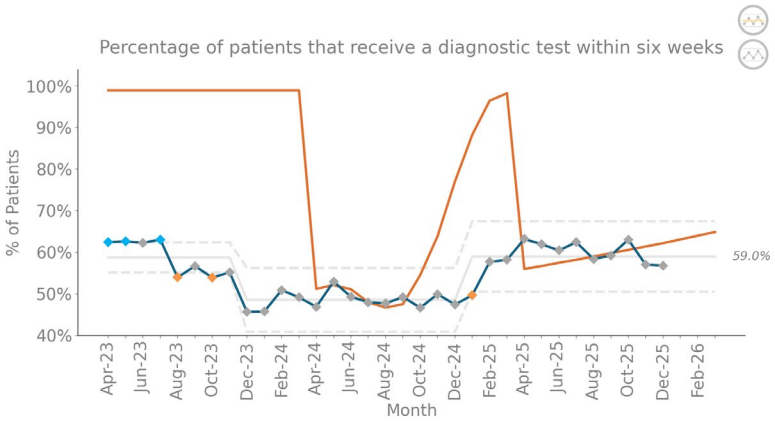


Latest
11.5%
Variance Type
Normal variation - no recent change
Mar 26 Target
5%
Target Achievement
Will consistently fail the target within expected variation

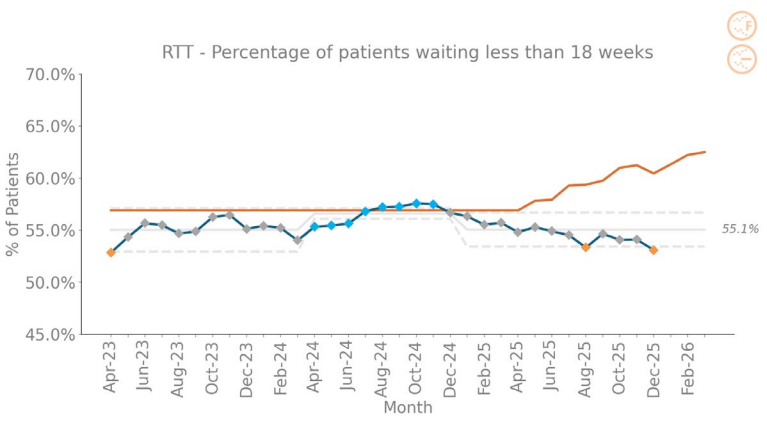
Metric	Summary	Action	Assurance
Number of Boarded Patients	On average 30 patients were boarded each day across both sites during December 25 with 899 associated bed days. This is consistent with the November 25 position. These are predominantly medical patients requiring admission to an acute medical ward. The position shows normal variance and will consistently fail the target within expected variation.	Key actions to reduce boarding and de-escalation bed use include actions to increase the use of the discharge lounge by providing capacity to 'pull' patients from wards, embedding effective Board and Ward round processes, expanding the use of virtual wards to support earlier discharge and an enhanced oversight of patients with a long length of stat and those classified as Days Kept Away from Home.	Incident levels of harm are monitored on a monthly basis alongside patient feedback. UEC and In-patient survey feedback does reflect patient concerns regarding the practice of boarding. This is also reflected within the staff survey.
Bed occupancy to 90%	The position shows an occupancy rate for December 25 of 95.2%, a drop of 1.8% compared to November 25. The data shows normal variation and will consistently fail the target.	A trust wide bed review is being undertaken to benchmark LOS against peers, assess any LOS reduction opportunities and materiality against the capacity reduction plans for the remainder of 25/26 and bed growth requirements for 26/27. Once complete agreement re bed changes in number and mix between G&A and DKAFH will be completed.	Assurance via the Urgent Care Improvement Board and Urgent Care Improvement Plan
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 (NMCTR) decreased in December (11.5% = daily average of 97 patients). Compared to the November position this is a decrease of 0.7%. The data shows normal variation.	The Days Kept Away from Home programme is a cornerstone of the length of stay reduction ambition within the trust. The programme has evidence that the DKAFH programme is effective in reducing the care demands (and corresponding discharge pathways) required on discharge, however, due to community capacity issues the benefit is not evident within a release of bed days. Given the performance position is one of consistently failing the target, a system wide escalation meeting has been requested to take place in Jan 26 to agree additional actions.	Monitoring of NMC2R data is undertaken via the Central Lancs Urgent Care Delivery Board

Performance - Elective Care Assurance

Lancashire Teaching Hospitals NHS Foundation Trust



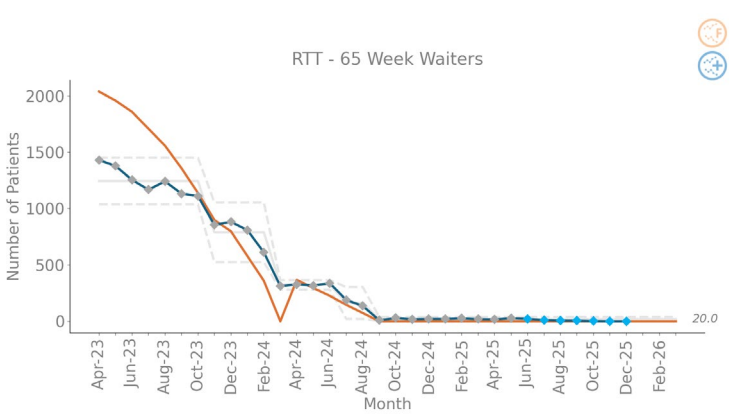
Latest
56.8%
Variance Type
Normal variation - no recent change
Mar 26 Target
65.0%
Target Achievement
Could both pass or fail target within expected variation



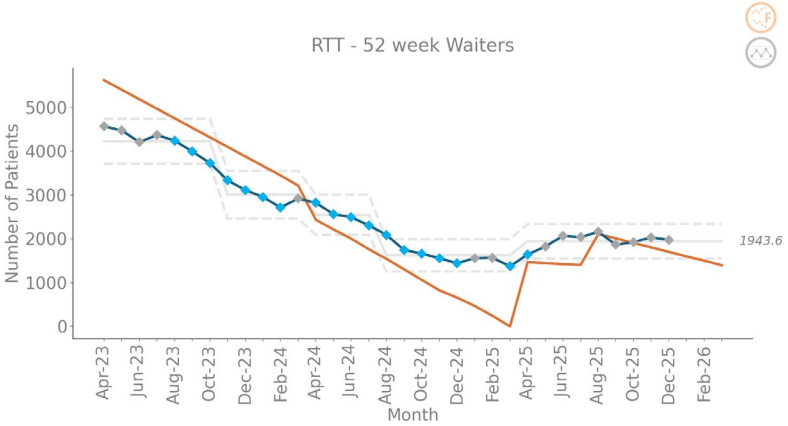
Latest
53.10%
Variance Type
Recent concerning pattern in the data
Mar 26 Target
62.50%
Target Achievement
Will consistently fail target within expected variation

Metric	Summary	Action	Assurance
Percentage of patients that receive a diagnostic test within six weeks	Diagnostics under 6 week performance was 56.8% in December compared to 57.1% in November, a 0.3% deterioration on the November position and below trajectory. The deterioration is predominantly driven by a rise in NOUS over 6 week waiters. Urgent and cancer patients are prioritised and seen within 2 weeks. Performance shows normal variation but may consistently fail the target.	The highest contributors of the backlog at modality level for the DM01 position are NOUS, endoscopy and echocardiography. Performance has improved in all modalities with the exception of NOUS which has significantly deteriorated as a result of increased workforce gaps. A proposal is being considered by Executives in Jan 26 to increase the recruitment and retention of sonographers and additional capacity is being scoped via IS providers.	The areas of focus are capacity optimisation, productivity, transformation and system working. Review of the latest published data (Nov 25) indicates that LTH is 112th out of 118 trusts that submitted data, the worst performing Trust in the ICB and significantly below the national average of 78.3%.
Percentage of patients waiting less than 18 weeks	The proportion of patients waiting less than 18 weeks on an RTT pathway has shown a consistent position throughout 2024/25. The Operational Plan 2025/26 year end target has been set at 65%. The December 25 position of 53.1% is 1% below the November performance. Analysis suggests a recent concerning pattern in the data and that the target will be consistently failed.	Performance is monitored at Divisional level via the weekly Operational Board where Issues and risks.	Comparison to the latest national performance position (Nov 25) indicates that the Trust is below the national position of 61.6% waiting under 18 weeks. The Trust is ranked 108 out of 118 trusts nationally for Nov.

Performance - Elective Care Assurance



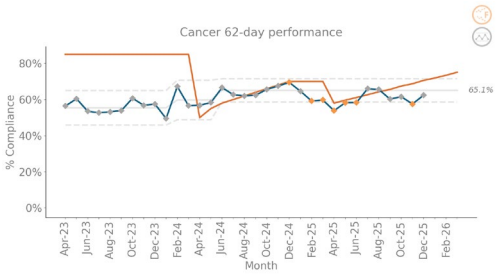
Latest
0
Variance Type
Recent positive pattern in the data
Mar 26 Target
0
Target Achievement
Will consistently fail the target within expected variation



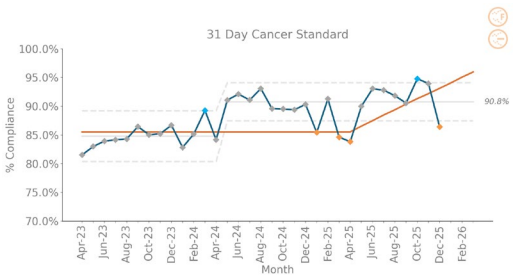
Latest
1977
Variance Type
Normal variation - no recent change
Mar 26 Target
1395
Target Achievement
Will consistently fail target within expected variation

Metric	Summary	Action	Assurance
RTT - 65 Week Waiters	The over 65 week waiters position has been maintained at 0 waiters at the end of December. There data shows a recent positive pattern in the data. Based on previous performance, the target is expected to be failed, however the position is expected to move to consistently pass the target next month if performance is maintained.	There is a process in place to ensure daily assurance of progress with >65 week waits prioritising and ensuring the sustained elimination of >78 week waits. Issues and risks are reviewed at the weekly Operational Board.	Monitoring of all premium cost activity is ongoing. Capacity & Demand modelling analysis is being concluded in line with the 25/26 annual planning process.
RTT - 52 week Waiters	The over 52 week waiter position in December was 1,977, a decrease of 56 compared to the November position. Analysis suggests normal variation in the data and that the target may be consistently failed. The proportion of patients on an RTT pathway waiting over 52 weeks was 3.1%, a slight decrease compared to November. The Operational Plan 2025/26 year end target has been set at 2.5%.	Capacity & Demand modelling is to be undertaken for all specialities and sub specialities. Focus on DNA reduction, PIFU and theatre utilisation is ongoing to maximise capacity.	Local monitoring of all speciality RTT clock stop/performance is undertaken via the weekly Operational Board. Comparison to the latest national performance position (Nov 25) indicates that the Trust is above the national picture which is 2.2% waiting over 52 weeks. The Trust is ranked 101 out of 118 trusts that submitted data for Nov 25.

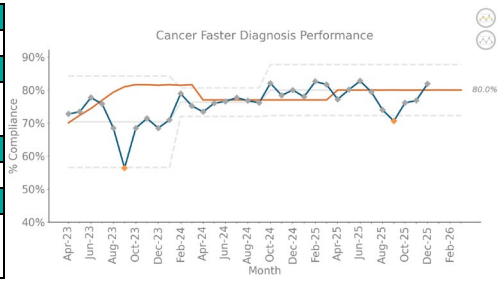
Performance - Elective Care Assurance



Latest
62.4%
Variance Type
Normal variation - no recent change
Mar 26 Target
75.1%
Target Achievement
Will consistently fail target within expected variation



Latest
86.4%
Variance Type
Recent concerning pattern in the data
Mar 26 Target
96.0%
Target Achievement
Will consistently fail target within expected variation

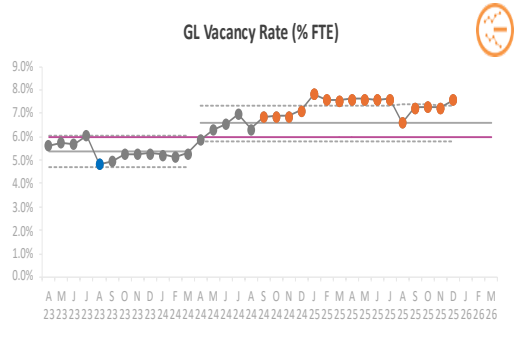


Latest
81.9%
Variance Type
Normal variation - no recent change
Mar 26 Target
80.0%
Target Achievement
Could both pass or fail target within expected variation

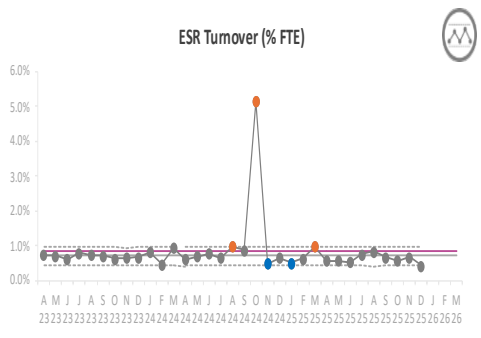
Metric	Summary	Action	Assurance
62 Day Cancer Standard	Performance to the end of December 25 (**currently unvalidated**) has improved compared to last month, but is below the monthly operational plan target of 70.6%. Analysis shows normal variation and will consistently fail the target.	Whilst Cancer performance is improving there are a small number of tumour groups with the greatest collective contribution to current performance challenges, these are Colorectal, Lung, Breast and Urology. All tumour sites have improvement plans to achieve performance targets.	The Trust is currently below the latest national average performance of 70.2% (Nov 25) and ranked 105 out of 188 Trusts nationally. Close monitoring of cancer PTLs are undertaken at the weekly Operational Board
31 Day Cancer Standard	Performance to the end of December 25 (**currently unvalidated**) is below last months position, and below the monthly operational plan target of 93.1%, and is expected to improve once validation is complete. Analysis shows a recent concerning pattern in the data and will consistently fail the target.		The Trust is currently below the latest national average performance of 91.7% (Nov 25). Close monitoring of cancer PTLs are undertaken at the weekly Operational Board
Cancer Faster Diagnosis Performance	Performance to the end of December 25 (**currently unvalidated**) is above last months position, and above the monthly operational plan target of 80%, and is expected to improve once validation is complete. Analysis shows normal variation and could consistently fail the target.		The Trust is currently above the latest national average performance of 76.5% (Nov 25) and ranked 67 out of 118 trusts nationally. Close monitoring of cancer PTLs are undertaken at the weekly Operational Board

People - Workforce Assurance 1

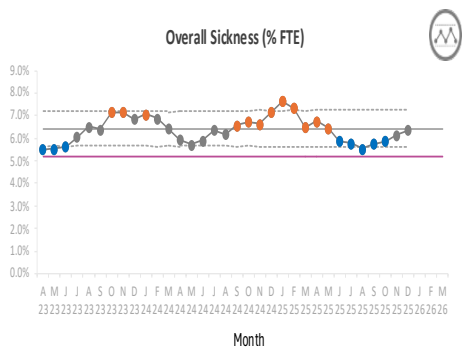
Lancashire Teaching Hospitals NHS Foundation Trust



Latest
7.59%
Variance Type
Recent concerning pattern in the data
Mar 26 Target
≤ 6%
Target Achievement
Will consistently fail the target within expected variation



Latest
0.43%
Variance Type
Normal variation - no recent change
Mar 26 Target
≤ 10%
Target Achievement
Could both pass or fail target within expected variation

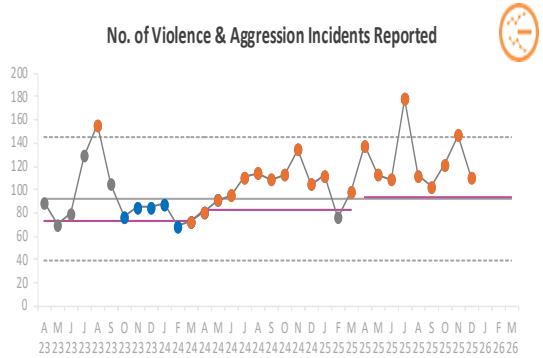


Latest
6.38%
Variance Type
Normal variation - no recent change
Mar 26 Target
≤ 5.22%
Target Achievement
Will consistently fail the target within expected variation

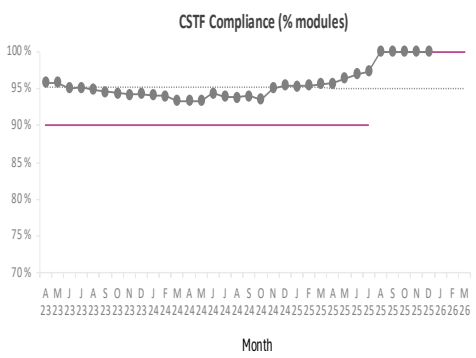
Metric	Summary	Action	Assurance
Vacancies (% FTE)	Vacancy rate remains high due to vacancy control measures. A new monthly cap of a total 20 posts maximum has been agreed to support financial recovery delivery targets.	Executive Team have reviewed all offer without a confirmed start date in support of financial recovery targets. Confirmed start dates will be approved accordingly. A vacancy cleanse is underway within Divisions to remove any non essential vacancies from establishment.	Vacancy rate monitored through Board reporting, Workforce Committee and Divisional Improvement Forums Safe staffing levels monitored daily in clinical areas New People Operations Group to include a focus on resourcing EQIA process utilised to support vacancy control decision -making
Turnover (% FTE)	Turnover has reduced slight to 0.43% in Month 9, which is line with seasonal variation norms and with no trends relating to staff group, or age group to note.	The NHSE Retention Self-Assessment is now complete, which has provided a degree of assurance regarding adequate focus and progress in relation to the 7 areas of the People Promise. Several areas have been highlighted as areas of excellence (Health & Wellbeing offer, Reward & Recognition (none financial) Team Working). Challenges are largely already known, with work already underway to address these. Those areas where plans where further consideration is required includes a flexible working dashboard, and consideration of / progression towards team rostering.	Annual retention strategy update report provided to Workforce Committee. Delivery of retention strategic action plan at corporate level, working with Divisions, Departments and Teams to support improvement in hot spot areas. 6 monthly retention updates provided to Divisions.
Sickness Absence (% FTE)	The overall sickness absence rate increased to 6.38% in M09, as anticipated in line with seasonal trends. Both the short-term and long-term rates increased, although the overall rate is still 0.5% lower than the same period last year.	The Workforce team are supporting divisional management teams to analyse the areas where sickness absence has increased in more detail. A second Rapid Improvement Event was held on 5 December, and through this further test of change ideas were generated, which will be further developed in M10. Empactis implementation is now in the user acceptance testing phase, with launch in the first pilot area anticipated in M10.	Twice yearly assurance reports to Workforce Committee Actions resulting from the MIAA Sickness Absence Management audit monitored through Audit Committee 'Failure to manage sickness absence management effectively' is a Principal Risk and subject to monthly risk management review Sickness monitored at divisional level through Divisional Improvement Forums.

People - Workforce Assurance 2

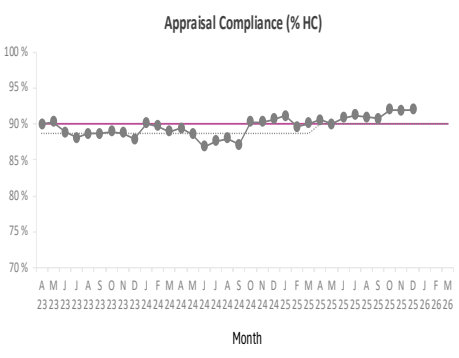
Lancashire Teaching Hospitals NHS Foundation Trust



Latest
110
Variance Type
Recent concerning pattern in the data
Mar 26 Target
NA
Target Achievement
Could both pass or fail target within expected variation



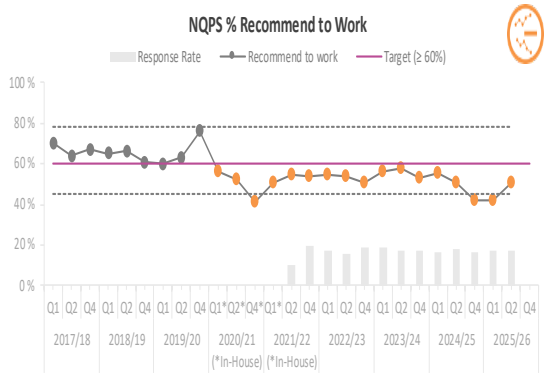
Latest
100.00%
Variance Type
Mar 26 Target
100% of metrics at 90%
Target Achievement



Latest
92.01%
Variance Type
Mar 26 Target
≥ 90%
Target Achievement

Metric	Summary	Action	Assurance
Number of violence and aggression incidents toward staff	Incidents decreased in M9. Monthly fluctuation is typical. It remains the case that most incidents occur in Emergency Department.	Implementation of the new Security system at Chorley commenced in M08. This is expected to be live by the end of the financial year. Additional camera outside the drugs room in ED, RPH installed. Changes to Violence Marker process being progressed through improvement work, with the aim of quicker application of flags, at source, to aid risk assessment.	Twice-yearly deep dive reports around incidents and actions to Workforce Committee Incident data reviewed through Health & Safety Governance Group
Core Skills Mandatory Training compliance (% modules)	Core Skills and Mandatory Training Compliance is above target with 100% of metrics above 90% for the 5th consecutive month.	Current focus of work is in relation to supportive actions to improve metrics in Hosted Services, as well as SBU and CBU level compliance. Role Specific training will be considered as part of the Education Single Improvement Plan for 2026/27.	Core Skills and Mandatory Training presented to Education, Training and Research Committee. Divisional Performance metrics shared in Divisional Workforce Committees and Divisional Improvement Forums on a monthly basis.
Appraisal compliance (% HC)	Appraisal compliance above target at 92%, a slight increase on M8. All professional groups are compliant with appraisal.	Appraisal single improvement plan programme of work continuing and has been refreshed following detailed analysis of appraisal evaluation feedback. All milestones are on track to deliver, the current focus of work is on enhancing appraisal quality, use of 360 degree feedback, rolling out objective setting masterclass training, training more medical appraisers and 360 degree feedback facilitators.	Annual Appraisal Update presented to Workforce Committee. Divisional Performance metrics shared in Divisional Workforce Committees and Divisional Improvement Forums on a monthly basis.

People - Workforce Assurance 3

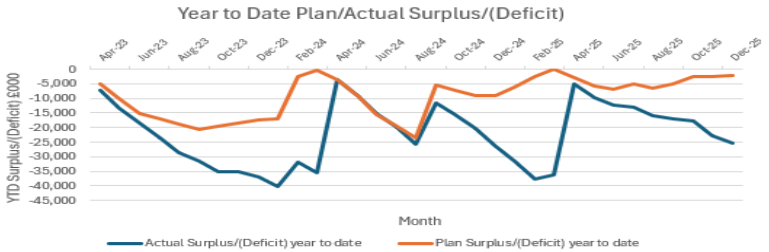


Latest
51.0%
Variance Type
Recent concerning pattern in the data
Mar 26 Target
≥ 60%
Target Achievement
Will consistently fail the target within expected variation

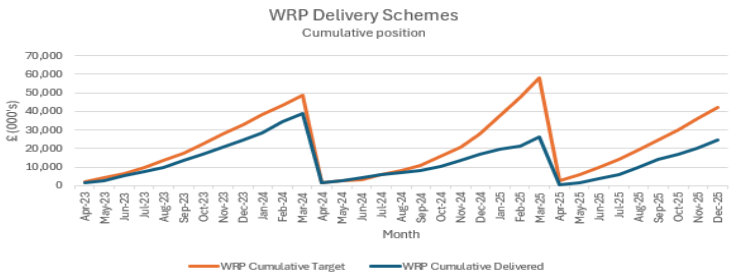
Metric	Summary	Action	Assurance
Staff Survey: Recommend Trust as place to work	**Please note: This is a quarterly metric; therefore, there is no update this month. The data remains unchanged**.	As described in the Single Improvement Plan programme of work for staff engagement, 45.1% of colleagues completed the NHS Staff Survey against the internal target of 50%. The 2025 Staff Survey results have now been received in Trust, analysis is underway and initial findings are due to be presented to Workforce Committee and Trust Management Board in January 2026. The Staff Engagement Proposal actions are underway with the first Executive Lead your voice event held on the 26th November, the Staff closed Facebook page due to launch now in the New Year, whilst is a slight delay from planned launch in December	Workforce Committee reports detailing the programme of work in response to NHS Staff Survey data and national benchmarking. Delivery of the Staff Engagement Proposal corporate action plan which is aligned to the Single Improvement Plan. 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

Lancashire Teaching Hospitals NHS Foundation Trust



Latest YTD Actual (,000s)
-25,529
Latest YTD Target (,000s)
-2,133
March 26 YTD Target (,000s)
-



Latest YTD Actual (,000s)
24,373
Latest YTD Target (,000s)
42,097
March 26 YTD Target (,000s)
60,000

Metric	Summary	Action	Assurance
I&E - Plan v Actual variance	At the end of December 2025 the Trust has a deficit of £25.5m against a planned deficit of £2.1m. C9 The adverse variance to plan of £23.4m is as a consequence of the shortfall in delivery of the Waste Reduction Programme £17.7m, non receipt of deficit support funding for November and December of £5.0m and net operational pressures of £3.7m offset by funding for industrial action of £3m. At the time of setting the plan the Trust had not identified the full £60m programme and the unidentified element was included in the plan in 12ths in accordance with NHSE policy. The Trust has a rephased programme to resolve the shortfall in the final 6 months of the year. The Trust has had operational pressures of £3.7m that it has been unable to fully mitigated associated with; industrial action, patient acuity, junior doctor rotas, buildings dilapidations and maintenance of its energy system, these are largely considered non-recurrent. The Trust has operational pressures in: - the acute medical pathways reflected in overspends in medical and nursing pay budgets - sickness remains higher than in operational budgets resulting in nursing pay overspends	The Trust had a Turnaround Director to work with senior leaders to re-assess the current waste reduction programme position and deep dive into short, medium and long-term opportunities. A re-set of the programme structure, governance and reporting for 2025/26 has taken place. The Trust is working with the ICB on the urgent and emergency pathway system pressures which is one of the main operational pressures that the Trust faces. The system is now receiving enhanced support from NHSE as part of the provider improvement programme (formerly recovery support programme). A focus on grip and control activities continues. The Trust commissioned further external support for specific financial recovery plan workstreams and 2025/26 waste recovery programme development. Divisions will need to recover their financial performance by delivering improvements in their current run rates e.g. maximising grip around temporary pay, review of vacancies and continuing to mitigate shortfalls in the efficiency target as schemes move through development and implementation stages.	Working with ICB on UEC Pathway Grip and control Interventions and control measures Mandated national support from PWC and the Provider Improvement Programme (formerly Recovery Support Programme)
WRP schemes delivery	'The Trust's 2025/26 waste reduction target is £60m, 7% of operating expenditure. At the end of December the Trust has delivered £30.9m of the £60m target (52%). The delivery in month was £4.0m against a plan of £5.9m. The Trust has identified schemes and opportunities to the value of £60m however the phasing is different to the financial plan with shortfalls in the first 6 months being offset with gains in the final 6 months of the year.	The Trust had a Turnaround Director to work with senior leaders to re-assess the current programme position and deep dive into short, medium and long-term opportunities. A re-set of the programme structure, governance and reporting has taken place for 2025/26. The Trust has additional external support to help with the delivery of the programme. The Trust is now embedding its own project management office structure to have a sustainable solution moving forward. The Trust is enhancing grip and control activities to mitigate slippage in specific schemes.	Waste reduction programme board chaired by CEO External support for specific workstreams. Implementation of Divisional Delivery Groups Embedding of PMO

10.2 FINANCE AND PERFORMANCE COMMITTEE CHAIR'S REPORT

Other | J Schorah | 11.35am

Item for Assurance

REFERENCES

Only PDFs are attached

10.2 - Chairs report - FPC - 25 Nov and 23 Dec 25 draft.pdf

Chair's Report to Board		
Chair: J Schorah	Committee: Finance and Performance Committee	
Date(s): 25 Nov & 23 Dec 2025	Agenda attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	Trend	Items Recommended for approval
Deliver Value for Money – 20 Fit for the Future - 15	⇨	None

ALERT

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

- **WRP:** The Trust had delivered WRP below the planned level year to date. Overall delivery had fallen significantly short of the annual target. Monthly performance had also been below expectations, resulting in a cumulative shortfall against the revised plan. The Committee reviewed the Month 8 position, alongside the detailed WRP/PMO update, and concluded that the Trust would not achieve the full WRP target by year end. The Trust had delivered £20.4m YTD against a planned £30.1m, with a revised forecast outturn of £41.8m compared to the £60.3m approved plan. This reflected a gap of £18.4m driven by a combination of delivery risks within key themes, particularly capacity reduction, procurement and digitally enabled outpatient schemes, operational pressures and industrial action costs.

- **Cash Position:** The Trust's cash balance continued to present a challenge, compounded by the withdrawal of national deficit support funding for Months 8 and 9. An application for additional cash support for January had been approved by NHS England and a further request for February and was awaiting approval. The Trust's cash balance at the end of October had been above plan due to restricted creditor payments. However, ongoing cashflow challenges had been anticipated, especially with the risk that national deficit support funding might not have been received from November to March. Applications for further cash support had been submitted, but approval was still pending.
- **Strategic Risk:** The Committee were alerted to the Principal Risks that remained off track. Furthermore, with the possible exception of Principle Risk 4 it was unlikely any of the Principal Risks would be controlled by the end of the current year. Principal Risk 4 related to timely access to planned and cancer care and Principal Risk 5, related to timely access to urgent and emergency care remain off trajectory. Principal Risk 6 related to timely access to diagnostic investigations, the risk score had increased back to 16 from a score of 12 following a review of the latest performance figures for November 2025 which showed a 6% drop in DM01 performance, linked to a dip in non-obstetric ultrasound. Workforce options to recruit and retain staff were being developed. As the score had been increased, the risk was now off track with the planned risk trajectory and this was under review.

- **Workforce WRP Financial Planning Mitigations:** The Committee raised concerns around the pace of

workforce related mitigations within WRP and agreed to receive a further update to provide assurance around the plan in place, at its January meeting.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- **Strategic Risks:** Overall, the strategic risk profile had remained static.
- **Divisional Update:** The Women and Children's Division continued to face similar challenges to other areas, though headcount performance was relatively stronger.
- **One LSC Procurement Update:** Improvements in governance and engagement were welcomed, but the need for proactive planning and horizon scanning was highlighted.
- **Urgent and Emergency Care Deep Dive:** The Committee acknowledged that UEC would remain a principal risk for the foreseeable future, even when performance improved incrementally. The Committee commended the comprehensive review and emphasised the need to prioritise actions with the greatest impact, focusing resources on fewer, high-value initiatives.
- **Planning Framework/ Planning Process 2026/27:** The Committee acknowledged the scale and complexity of the planning requirements, tight timescales and evolving guidance. Early work on next year's plan was noted, but significant risks remained around funding and performance expectations.
- **Strategic Risk Register:** The Committee reviewed the progress and scores of the Principal Risks. It was agreed that a review of the assurance levels would be undertaken to consider whether any Principal Risks should be downgraded from medium to low. One new operational risk had been graded as high risk related to insufficient theatre capacity across Obstetrics and Gynaecology, leading to delays in elective Caesarean Sections and Gynaecology.
- **Capital Funding:** Capital funding delays relating to orthodontics and mental health liaison schemes were noted; these were being managed through re-profiling into the next financial year in agreement with national teams.
- **PMO:** The Committee were advised that by the end of February the external resource would discontinue to leave a small substantive PMO team. Discussions on this were ongoing to ensure there would be a robust resource plan in the short and longer term.

ASSURE

Assurance received; Matters of positive notes

- **Strategic Risks:** The Committee were assured of the positive movement for Principal Risk 6 which related to timely access to diagnostics. There had been a decrease in score from 16 to 12 in November 2025 and was now a controlled risk. Improvements in DM01 performance continued in September and October 2025. Two operational risks had also reduced in score with one being moved to controlled and the other awaiting validation of being controlled.
- **PMO Reporting:** Positive progress was noted in the cadence and clarity of reporting, with improved visibility from PMO and Finance. Alignment of data between reports was emphasised as essential.

- **WRP:** WRP planning for 2026/7 had commenced, with a more systematic approach to organisational redesign, deeper service reviews and closer alignment with external advisory input.
- **Divisional Delivery Group Report for the DCS Division:** The Committee was assured on the Division's progress in demand management and WRP delivery, noting strong financial discipline, embedded accountability, strengthened clinical managerial ownership and robust monitoring through consolidated forums. The Division demonstrated proactive management of risks, expansion of schemes to maximise opportunities and sustained engagement in demand management processes, despite external dependencies impacting some areas.
- **Performance Assurance Progress Report:** The Committee acknowledged positive progress in several areas, including reductions in did not attend rates, growth in patient initiated follow-up and adherence to long wait elimination targets. Assurance was noted on the quality of the analysis and actions taken, though the overall performance position continued to require close oversight.

Finance and Performance Committee

25 November 2025 1.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	1.00pm	Verbal	Information	J Schorah
2.	Apologies for absence	1.01pm	Verbal	Information	J Schorah
3.	Declaration of interests	1.02pm	Verbal	Information	J Schorah
4.	Minutes of the previous meeting held on 21 October 2025	1.03pm	✓	Decision	J Schorah
5.	Matters arising and action log	1.05pm	✓	Decision	J Schorah
6.	Strategic Risk Register	1.10pm	✓	Decision	S Regan
7.	FINANCIAL PERFORMANCE				
7.1	M7 Finance Position and General Finance Update inc. IAG	1.20pm	✓	Assurance	C Carter
7.2	WRP & PMO Update	1.35pm	✓	Assurance	R Morgan-Evans
7.3	Turnaround Director and Divisional Delivery Group Report – WACs Division	1.50pm	✓	Assurance	K Pringle R Dineley
8.	OPERATIONAL PERFORMANCE				
8.1	Performance Assurance Progress Report inc. Tier 1 Update	2.00pm	✓	Assurance	K Foster-Greenwood
8.2	UEC Deep Dive	2.15pm	✓	Assurance	K Foster-Greenwood
8.3	One LSC Procurement update (incorporating supplier scores)	2.35pm	✓	Assurance	J Collins
9.	STRATEGY & PLANNING				
9.1	Annual Plan Road Map	2.50pm	✓	Assurance	I Ward
10.	GOVERNANCE AND COMPLIANCE				
10.1	Items to Alert, Advise or Assure the Board	3.05pm	Verbal	Information	J Schorah

№	Item	Time	Encl.	Purpose	Presenter
10.2	Reflections on the meeting	3.10pm	Verbal	Information	J Schorah
11.	ITEMS FOR INFORMATION				
11.1	Contract Performance		✓		
11.2	Single Improvement Plan		✓		
11.3	Chair's Reports/Minutes: (a) SIRO/AIO Working Group – no meeting until 27 Nov.		✓		
11.4	Grip and Control Action Plan		✓		
11.5	Date, time, and venue of next meeting: *23 December 2025, 1.00pm, Microsoft Teams*	3.15pm	Verbal	Information	J Schorah

Finance and Performance Committee

23 December 2025 1.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	1.00pm	Verbal	Information	J Schorah
2.	Apologies for absence	1.01pm	Verbal	Information	J Schorah
3.	Declaration of interests	1.02pm	Verbal	Information	J Schorah
4.	Minutes of the previous meeting held on 25 November 2025	1.03pm	✓	Decision	J Schorah
5.	**Matters arising** a) WFC Referral 115/25 **Action log**	1.05pm	✓	Decision	J Schorah
6.	Strategic Risk Register	1.10pm	✓	Decision	S Regan
7.	FINANCIAL PERFORMANCE				
7.1	M8 Finance Position and General Finance Update inc. IAG	1.20pm	✓	Assurance	C Carter
7.2	WRP and PMO Update	1.40pm	✓	Assurance	C Carter
7.3	Turnaround Director and Divisional Delivery Group Report – DCS Division	1.55pm	✓	Assurance	K Pringle D O'Brien
8.	OPERATIONAL PERFORMANCE				
8.1	Performance Assurance Progress Report inc. Tier 1 Update	2.10pm	✓	Assurance	K Foster-Greenwood
8.2	One LSC Procurement update (incorporating supplier scores)	2.25pm	✓	Assurance	J Collins
8.3	GIRFT Update	2.35pm	✓	Assurance	S Canty
9.	STRATEGY & PLANNING				
9.1	Single Improvement Plan (Performance and Productivity)	2.50pm	✓	Assurance	S Morrison
9.2	Planning Update	3.00pm	✓	Assurance	I Ward
9.3	Workforce WRP Financial Planning Mitigations	3.20pm	✓	Assurance	N Pease

№	Item	Time	Encl.	Purpose	Presenter
10.	GOVERNANCE AND COMPLIANCE				
10.1	Items to Alert, Advise or Assure the Board	3.50pm	Verbal	Information	J Schorah
10.2	Reflections on the meeting	3.55pm	Verbal	Information	J Schorah
11.	ITEMS FOR INFORMATION				
11.1	Contract Performance		✓		
11.2	LHS Ltd Update		✓		
11.3	Cyber Security Update		✓		
11.4	Corporate Services Benchmarking		✓		
11.5	Chair's Reports/Minutes: (a) Digital and Health Informatics Divisional Board (b) LHS Minutes (c) SIRO/AIO Working Group		✓		
11.6	Date, time, and venue of next meeting: *27 January 2026, 1.00pm, Microsoft Teams*	4.00pm	Verbal	Information	J Schorah

BREAK

11.45am

11. PATIENTS (SAFETY AND QUALITY)

11.1 SAFETY AND QUALITY COMMITTEE CHAIR'S REPORT

Other | K Deeny | 12.00pm

Item for Assurance

REFERENCES

Only PDFs are attached

11.1 - Chair's report - Safety and Quality Committee - 28 Nov 2025 & 2 Jan 2026.pdf

Chair's Report to Board		
Chair: Non-Executive Director Dr Karen Deeny	**Safety and Quality Committee**	
Date: 28 November 2025 & 2 January 2026	**Agenda attached for information**	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	Trend	Items Recommended for approval
Consistently Deliver Excellent Care	→	Annual Adult and Children Safe Staffing Report – 30 January meeting Maternity Safe Staffing Report – 30 January meeting

ALERT **Areas of concern; Matters requiring urgent attention; Insufficient assurance received.**	**Strategic Risk Register:** ○ UEC Risk - The Committee discussed the need for urgent actions to address pressures in urgent and emergency care. Stretch targets had been agreed with partners and a meeting of senior officers was scheduled to agree further measures. ○ It was noted that Principal Risk 1 related to Patient experience within the urgent and emergency care pathway was now off trajectory, with limited evidence of progress and the lack of movement raised concern that the Principal Risk would not be controlled as planned by the end of the financial year. This is linked to Principal Risk 5 - Timely access to urgent and emergency care, which is overseen by Finance and Performance Committee, and is also off trajectory. **Annual Health and Safety Review:** The Committee were assured of the progress made in regard to health and safety governance and assurance, whilst also noting the ongoing risks associated with in a number of areas and the need for continued diligence in this area and also the need for the capital plan allocation to reflect the prioritisation of actions in line with the risks present.
ADVISE **Areas requiring on-going monitoring; Limited assurance received.**	**Never Event:** The learning from the Angioplasty Never Event had been shared at the Lancashire and South Cumbria Shared Learning Forum at its meeting on 19 November 2025. **Maternity and Neonatal:** Rising demand for elective Caesarean Sections continued to place pressure on capacity, resulting in cancelled gynaecology cases and the need for additional out-of-hours sessions. Mitigation measures included weekly capacity reviews, governance oversight of the risk and an interim plan to improve theatre efficiency, with all-day lists scheduled from January aim to reduce the risk. **Quarterly PSIRF Update:** In October 2025, the Trust procured the Ulysses Risk Management system. Ulysses will replace the current DatixWeb Risk Management system with effect from the 1 February 2026. It was anticipated that the introduction of the Ulysses Risk Management System will significantly enhance the Trust's ability to track improvement actions. By integrating incident, risk and action planning modules, the system will provide greater visibility of progress and enable more robust reporting to the Safety and Quality Committee, ensuring assurance was strengthened and improvement work is demonstrably monitored.

	LSC Pathology Single Service: The Committee considered the EQIA associated with the transfer of the single pathology service acknowledging risks remained within the programme that would require continued work to mitigate. **Strategic Risk Register:** ○ Operational risk updates highlighted delays in surgical pathways due to inadequate tracking systems, with mitigations and governance oversight planned. The Committee noted that reliance on outdated EPR systems and whilst options were being explored to mitigate the risks the future EPR procurement should include the need to address this risk. ○ The Committee was informed of a case where the risks associated with water safety were highlighted. The detail of the case was shared with the Committee and the next steps defined. **Safety and Quality Dashboard:** ○ The Committee were informed that a review of the Friends and Family Test results in the emergency pathway had been undertaken. The overall score of 76.5% sat slightly below the national average of 77%, with internal targets currently set at 85%. Due to the challenging operational context, it was agreed that the internal target be aligned temporarily with the national average and then increased incrementally. ○ It was agreed that the Committee would recommend priority be given for a Board workshop to consolidate ideas around safe workforce reductions which would also triangulate the oversight across Finance & Performance, Workforce and Safety & Quality Committees, given the cross-cutting nature of the work. **Birth Rate Plus:** The Committee were informed that the Birth Rate Plus assessment was in its final stages and an update would be provided at the 30 January 2026 meeting. **Pressure Ulcers:** Pressure ulcers per 1,000 bed days increased, with a pronounced increase in November. A review panel has scrutinised all cases and refreshed improvement actions, with category 3 ulcers under further review by a panel. Increased incidence within the major trauma pathway and selected specialties were noted. Training compliance remained strong and existing actions were robust. A refreshed review was underway and updated risk assessment and care-planning tools were being finalised for completion in April 2026.
ASSURE **Assurance received; Matters of positive note.**	**The committee received assurance reports relating to:** Strategic Risk Report Safety and Quality Dashboard Maternity and Neonatal Report Children and Young People Report Health Inequalities Report Quarterly PSIRF Report Outsourced Contracts Update LSC Pathology Single Service – Schedule of progress against regulatory due diligence and EQIA Annual Health and Safety Review Mid-Year Medicines Governance Report **The reports provided an overview of areas of strength and areas that required continued focus.**

	Safety and Quality Dashboard: During October 2025 there were 12 cases of C.difficile, continuing the trend below the objective. The National objective set for the Trust for 2025/2026 was a total of 167 cases and the Trust had seen 90 cases to date. The focused work on C.difficile reduction and the improvement plan continued to be monitored through the Infection Prevention and Control Committee. **Safety and Quality Dashboard:** From the 18 'Must Do' recommendations included in the 2023/2024 CQC Quality Improvement Plan, all 18 'Must Do's' had been assessed as delivered at the end of October 2025. **Outsourced Contracts Update:** The Committee received the bi-annual update on outsourced clinical contracts, which provided assurance on performance monitoring and compliance. Regular meetings and reviews were confirmed, with quality and performance reports covering key indicators such as patient experience, complaints, incidents and clinical environment. **Angioplasty Never Event Update:** An update was provided on the Never Event involving interventional radiology and vascular surgery. Immediate actions had been taken, including adding integrity checks to interventional radiology count sheets and incorporating learning into local safety standards. A working group was established to map invasive procedures and validate checklists, with further work planned to strengthen compliance. **Annual Health and Safety Review:** The review provided assurance on strengthening governance arrangements, statutory compliance and progress following the MIAA review undertaken earlier in 2025. Significant improvements had been made, including strengthened governance structures, monthly health and safety governance meetings under revised terms of reference and reinstatement of key subgroup. **Children and Young People's Report:** The Committee was assured of the safe staffing, safety and quality of the Children and Young People services and the management and mitigation of identified risks. The significant pressures within the services was acknowledged by the Committee.

Safety and Quality Committee

28 November 2025 | 11.00am | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	11.00am	Verbal	Information	K Deeny
2.	Apologies for absence	11.01am	Verbal	Information	K Deeny
3.	Declaration of interests	11.02am	Verbal	Information	K Deeny
4.	Minutes of the previous meeting held on 31 October 2025	11.03am	✓	Decision	K Deeny
5.	Matters arising and action log	11.05am	✓	Decision	K Deeny
6.	Strategic Risk Register	11.10am	✓	Assurance	S Regan
7.	QUALITY AND PERFORMANCE				
7.1	Safety and Quality Dashboard	11.20am	✓	Assurance	C Gregory
7.2	Maternity and Neonatal Report	11.30am	✓	Assurance	E Ashton
7.3	Children and Young People Report	11.40am	✓	Assurance	S Morrison
7.4	Quarterly PSIRF Update	11.50am	✓	Assurance	H Ugradar
7.5	Outsourced Contracts Update	12.00pm	✓	Assurance	S Stow A Gammell
8.	GOVERNANCE AND COMPLIANCE				
8.1	LSC Pathology Single Service – Schedule of progress against regulatory due diligence and EQIA	12.10pm	✓	Assurance	A Rowbottom
8.2	Never Event – Radiology Datix ID 188329	12.20pm	✓	Assurance	H Ugradar
8.3	Annual Health and Safety Review	12.30pm	✓	Assurance	H Ugradar
8.4	Strategic risk register review	12.40pm	Verbal	Decision	K Deeny
8.5	Items to alert, advise or assure the Board.	12.45pm	Verbal	Information	K Deeny
8.6	Reflections on the meeting	12.50pm	Verbal	Assurance	K Deeny
9.	ITEMS FOR INFORMATION (matters to be raised by exception)				

№	Item	Time	Encl.	Purpose	Presenter
9.1	**Chairs' reports from feeder groups**: a) Infection, Prevention and Control Committee b) Safeguarding Board c) PSIRF Oversight Panel d) Medicines Governance Committee e) Patient Experience and Involvement f) Health Inequalities Group g) Health and Safety Governance		✓		
9.2	Date, time and venue of next meeting: *2 January 2026, 11.00am, Microsoft Teams*	12.55pm	Verbal	Information	K Deeny

Safety and Quality Committee

2 January 2026 | 11.00am | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	11.00am	Verbal	Information	K Deeny
2.	Apologies for absence	11.01am	Verbal	Information	K Deeny
3.	Declaration of interests	11.02am	Verbal	Information	K Deeny
4.	Minutes of the previous meeting held on 28 November 2025	11.03am	✓	Decision	K Deeny
5.	Matters arising and action log	11.05am	✓	Decision	K Deeny
6.	Strategic Risk Register	11.10am	✓	Assurance	S Regan
7.	QUALITY AND PERFORMANCE				
7.1	Safety and Quality Dashboard	11.20am	✓	Assurance	C Gregory
7.2	Children and Young People Report	11.30am	✓	Assurance	S Morrison
7.3	Mid-Year Medicines Governance Report	11.40am	✓	Assurance	G Price / E Barr
8.	GOVERNANCE AND COMPLIANCE				
8.1	Strategic risk register review	11.50am	Verbal	Decision	K Deeny
8.2	Items to alert, advise or assure the Board.	11.55am	Verbal	Information	K Deeny
8.3	Reflections on the meeting	12.00pm	Verbal	Assurance	K Deeny
9.	ITEMS FOR INFORMATION (matters to be raised by exception)				
9.1	**WFC Referral -** Financial Recovery /Workforce Recovery Programme (WRP) Update		✓		
9.2	**Terms of Reference:** a) Medicines Governance Committee b) Mortality and End of Life Care Committee				
9.3	**Chairs' reports from feeder groups**: a) Infection, Prevention and Control Committee b) Safeguarding Board c) PSIRF Oversight Panel		✓		

№	Item	Time	Encl.	Purpose	Presenter
	d) Medicines Governance Committee – not available e) Patient and Carer Experience and Involvement Group **f)** Health Inequalities Group **– no meeting** g) Health and Safety Governance h) End of Life Care Committee				
9.4	Date, time and venue of next meeting: *30 January 2026, 11.00am, Microsoft Teams*	12.05pm	Verbal	Information	K Deeny

11.2 ANNUAL ADULT SAFE STAFFING REPORT

Decision Item | S Morrison | 12.10pm

*Detailed report included in the separate ancillary pack

REFERENCES

Only PDFs are attached

11.2 - Annual Safe Staffing Review - Main Report.pdf

Board of Directors Report

Meeting of the	**Board of Directors**		**February 5th 2026**
	Part I ☒		**Part II** ☐
Title of Report	**Annual Safe Staffing Review - Nursing and Midwifery 2025/2026**		
Report Author	Catherine Gregory – Deputy Chief nursing Officer Nicola Ross – Matron for Patient Safety and Safe Staffing		
Lead Executive Director	Sarah Morrison - Chief Nursing Officer/Deputy Chief Executive		
Recommendation/ Actions required	The Board of Directors is asked to: Approve the Annual Safe Staffing Review and confirm that it is satisfied with the assurances provided within the report.		
	Decision ☒	**Assurance** ☐	**Information** ☐
Executive Summary	The Annual Safe Staffing Review for Nursing and Midwifery 2025/26 confirms that staffing levels across all divisions at Lancashire Teaching Hospitals NHS Foundation Trust remain safe, effective and sustainable. The review has been undertaken in accordance with National Quality Board guidance, NHS Improvement Workforce Safeguards, and relevant specialty-specific standards, using a triangulated approach that integrates Safer Nursing Care Tool (SNCT) data, professional judgement, and patient safety and quality metrics. The review covers inpatient wards, assessment areas, children's and neonatal services, maternity services, and critical care spanning the Medicine, Surgery, Women's and Children's, and Diagnostics and Clinical Support (DCS) divisions. Workforce modelling demonstrates that establishments broadly meet patient care needs, with targeted adjustments implemented to reflect changes in patient dependency and acuity, service reconfiguration, and operational pressures. Professional judgement remains a crucial component of the assessment, ensuring that staffing models are responsive to local context, seasonal variation, and evolving clinical demands. **Key Workforce Changes:** <u>Medicine Division</u> The findings of the safe staffing reviews give assurance that existing staffing levels and skill mix across medical inpatient wards are appropriate to meet service needs with the exception of the following:		

	Rookwood A (CDH) - In response to changes in patient dependency and workload priorities and to better balance workload across the 24-hour period, a test of change is underway to adjust the skill mix between day and night shifts. This involves increasing Band 3 staff over night with a corresponding reduction in Band 3 roles during the day, while maintaining safe and effective staffing. Ward 17 - A realignment of Band 2 and Band 3 roles alongside the removal of Band 4 posts has been implemented to strengthen Band 5 capacity during day shift, ensuring appropriate skill mix and professional oversight in line with patient need. Ward 24 (Gastroenterology) - The temporary RN Day shift uplift tested since the last review has been made permanent, within budget, with corresponding reductions to Band 2 and Band 4 shifts. Bleasdale Ward - The conversion of Band 3 to Band 4 on night shifts with continued interim Band 6 uplift to manage high acuity and leadership oversight. These skill mix changes have been made within budget. Medical Assessment Unit (Chorley) - Increased Fit to Sit capacity for patients awaiting assessment has been recognised and therefore it is proposed to convert 5.48 WTE from recurrent bank usage into substantive posts to reduce variable spend and improve sustainability. Acute Assessment Unit (AAU) - Due to recent specialty changes the review in this ward comprised of a desktop review to identify key learning for any ward reconfiguration process. This will be useful as further changes to ward reconfigurations are made, particularly with respect to the effect on staff morale and patient safety. <u>Emergency Department</u> A business case was approved at the Trust Management Board on 12th November 2025 to convert temporary staffing expenditure into substantive posts within the Emergency Department at Chorley and South Ribble Hospital. This change delivers a 5.5 WTE uplift in registered nurses and a 2.75 WTE uplift in health care assistants, strengthening the department's ability to provide safe and sustainable care. Further work is required to fully understand safe staffing requirements for the Emergency Department at Royal Preston Hospital, aligned to the urgent and emergency care workstreams currently in development. A proposal for a safe and effective staffing model for RPH ED will be presented as a separate paper. <u>Surgical Division</u> The findings of the safe staffing review confirms that staffing levels and skill mix review across surgical wards remain appropriate to meet service needs except for the Surgical Assessment Unit (SAU).

	Surgical Assessment Unit - agreed the introduction of a test of change converting one day RN shift to a twilight shift and an uplift in housekeeping hours to respond to evening demand patterns in line with other assessment areas. Surgical Enhanced Care provision has now been consolidated into Leyland Ward, improving efficiency, pathways and resilience. <u>Women's and Children's Division</u> Gynaecology - The safe staffing review confirms that current arrangements are appropriate to mee patient needs in the gynaecology ward. A staffing model adjustment has been agreed to manage additional triage support for the Gynaecology Assessment Area (GEPAU), this has been managed within existing budget. Paediatric services - Safe staffing has been maintained across Ward 8, PAU, day case and ED services, with seasonal variation and bed occupancy managed via professional judgement to ensure patient safety. The safe staffing review confirms that current staffing arrangements are appropriate to meet service needs. Neonatal Unit - Safe Staffing levels remain compliant with BAPM standards, and no structural changes have been made to the staffing model. Maternity - Services continue to operate in line with national guidance. The Birth Rate Plus assessment has been received and being considered and will be presented to S and Q Committee separately. <u>DCS Division</u> Critical Care Unit staffing adjusted following a successful test of removing one Band 5 RN from the rota. Safe staffing has been maintained in line with Guidelines for the Provision of Intensive Care Services (GPICS) standards through flexible deployment and ongoing acuity monitoring. **Workforce Risks and Mitigations** Across divisions, persistent challenges remain, including: • High demand for Enhanced Therapeutic Observation and Care (ETOC) in complex patient areas. • Ongoing HCA and support-worker vacancies affecting flexibility and resilience. • Above-target sickness levels linked to workload pressures. • Seasonal pressures and evening activity surges in assessment and surgical units. Mitigations include strengthened roster design, improved Safecare deployment, targeted recruitment, enhanced oversight via daily safe-staffing forums, and development of monthly HealthRoster good-practice monitoring.

	The Chief Nursing Officer and Chief Medical Officer confirm compliance with NICE safe staffing standards, NQB expectations, and NHS Improvement Workforce Safeguards. Triangulated analysis demonstrates that staffing models across all divisions continue to support safe, effective, and sustainable care for 2025/26.	
Link to Strategic Objectives 2025/26 ***(Please mark X against the strategic objective(s) applicable to this paper - this could be more than one)***	**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:	This report will be scrutinised at Safety and Quality Committee	Date: 30.01.26
Operational Group Review:	Name of Operational Group:	Date:
Link to Board Assurance Framework:	Principal Risk 1 (25/26) - Patient experience within the urgent and emergency care pathway	
Appendices	• Appendix 1 – Breakdown of Overall SNCT Data • Appendix 2 – CHPPD – Northwest Region & Peer Comparison • Appendix 3 – Safe Staffing Quality Assurance Dashboard (Adult inpatients) • Appendix 4 – Children's and Young People Dashboard • Appendix 5 – Structured Professional Judgment • Appendix 6 – Operational risks relating to staffing • Appendix 7 – Cost Centre WTE and Budget Summary by Division • Appendix 8 – Tariff Comparison	

11.3 MATERNITY AND NEONATAL SERVICE UPDATE

Decision Item | E Ashton / E Romano | 12.20pm

*Detailed report included in the separate ancillary pack

REFERENCES

Only PDFs are attached

11.3 - Maternity and Neonatal Safety Report February 2026.pdf

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Meeting of the	**Board of Directors**	**5 February 2026**
	Part I ☒	**Part II** ☐
Title of Report	**Maternity and Neonatal Services Safety Report**	
Report Author	J. Lambert – Deputy Midwifery & Nursing Director	
Lead Executive Director	Sarah Morrison – Chief Nursing Officer/Deputy Chief Executive Officer	
Recommendation/ Actions required	The Board of Directors is asked to: i. Receive the report, including the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) supplementary information pack and associated action plans which has been scrutinised by the Safety and Quality Committee at the end of MIS year 7. ii. Note the inclusion of the joint presentation and final position for the MIS Year 7 standards (see Appendix), confirming that the LMNS/ICB are satisfied with the evidence of compliance against all 10 standards. iii. Approve the instruction for the Trust Board to give permission to the Chief Executive Officer (CEO) to sign the Board declaration form prior to submission to NHS Resolution on the 3 March 2026. iv. Approve the instruction to share the Board declaration with the Accountable Officer (AO) for their Integrated Care Board (ICB) for sign off prior to submission to NHS Resolution on the 3 March 2026. v. Confirm it is assured of the oversight and monitoring mechanisms within maternity services.	
	Decision ☒	**Assurance** ☐ / **Information** ☐
Executive Summary	The purpose of this report is to provide the Board of Directors with an update in relation to maternity and Neonatal workforce, staffing, safety, quality, assurance and oversight programmes of work up to the end of December 2025. The report also details the final position at the end of the Year 7 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) reporting period. (1 December to 30 November 2025) Following validation by the Local Maternity and Neonatal System (LMNS) and Integrated Care Board (ICB), the service confirms that the Trust has met all 10 MIS safety standards, enabling submission of the Board Declaration to NHS Resolution by 3 March 2026. Robust oversight arrangements remain in place through the Trust Safety and Quality Committee, Perinatal Quality Surveillance framework and Board-level Safety Champions. The perinatal quality surveillance dashboard (PQSD) is included in Appendix 3. Overall clinical outcomes remain stable, with continued improvement in stillbirth rates, reducing to 2.3 per 1,000 births in 2025, including a significant reduction when excluding terminations for fetal anomaly.	

	Areas of exception include an increase in postpartum haemorrhage (PPH) since March 2025 and an increase in neonatal deaths in December 2025, related to highly complex, extreme pre-term cases. All relevant cases are subject to formal Perinatal Mortality Review, and targeted improvement actions are underway, including the establishment of a multiprofessional PPH task-and-finish group aligned to the new national Maternal Care Bundle. (MCB). The projected vacancy for registered midwives is 2.93 WTE (including maternity leave) by May 2026. This is a significantly improved position and includes the recruitment to Birthrate plus staffing increases. The vacancy continues to be tracked to ensure timely response to establishment gaps. Delays in the vacancy control, recruitment and onboarding have affected some areas of recruitment and where necessary escalation to the CNO is enacted. In the month of November and December 2025, compliance with BAPM nurse staffing ratios declined from 72.5% to 53% and 62.9% respectively. This deterioration was primarily driven by 34% staff unavailability (including 12% maternity leave and 10% sickness) alongside increased intensive care and high-dependency cot demand, requiring higher nurse-to-patient ratio's. There have been no adverse outcomes as a result of this. Work is underway to agree the approach to managing the maternity leave rates within neonatal services. For information, to address system-wide theatre capacity challenges, a Caesarean Section Summit is being convened by the ICB with Executives from each provider Trust in Lancashire and South Cumbria to agree the approach to managing this activity in future. This is in response to the rising Caesarean section rates nationally and at LTH, with elective procedures forming a significant proportion of births overall. Following the success of a 4-week pilot, a national maternity Daily Situation Report (SitRep) has been commenced. The purpose of the SitRep is to provide real-time oversight of safety and operational pressures, enabling early risk identification and rapid escalation as required. All maternity units are expected to submit data in relation to delays in induction, Caesarean Section and maternity and neonatal Diverts. The Maternity Care Bundle, launched in January 2026, sets out national best-practice standards across five critical clinical areas to reduce maternal mortality, serious illness, and health inequalities in England. This bundle promotes a whole-system, equity-focused approach, requiring collaboration across maternity, emergency, mental health, primary care, ambulance, and specialty services. The service has commenced work reviewing the new guidance and this will form part of the improvement work during the next year. Following the recent Prevention of Future Deaths report and regulatory notice issued to Manchester Foundation Trust after a maternal and neonatal death during a home birth, the maternity service is included in a regional rapid task and finish group (12-week duration) undertaking a comprehensive review of home birth provision. It is anticipated that this initial workstream will be used to inform a regional home birth charter. At this time there have been no immediate areas of concern identified for the home birthing service. The review into the culture across maternity and gynaecology services has concluded, and the report has been shared with the Divisional Senior Leadership Team. A series of feedback meetings facilitated by the Deputy Director of Workforce and Organisational Development (OD) are being arranged for colleagues who contributed to the review, with some already having taken place. Once these have concluded an action plan will be agreed and implemented with support from the OD team.

	Following the success of the Race and Health Observatory (RHO) work reducing disparity in outcomes for women of black or ethnic women who experience postpartum haemorrhage, representatives from the Lancashire Teaching hospitals are attending a national next steps for Maternity and Neonatal Health Equity, learning from the RHO Learning and Action Network Event. Members of the team are included in an expert panel to share best practice from the project. The work to progress the restorative courtyard for staff and services users in the Sharoe Green Unit is progressing well. This work is welcomed and may improve staff morale as they will have a quiet area to rest during breaks. ***For main report – see supplementary pack.***	
Link to Strategic Objectives 2025/26	**Patients – deliver excellent care:** Improve outcomes, reduce harm and deliver a positive patient experience.	☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.	☐
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.	☒
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.	☐
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.	☒
Due Diligence	To give the Trust Board assurance, please complete the following:	
Committee Approval:	Safety and Quality Committee	Date: 20 January 2026
Operational Group Review:	Maternity Safety and Quality Group	Date: January 2026
Link to Board Assurance Framework:	The report is linked to the BAF through planned and unplanned care risks, whilst a specific BAF risk is not identified at Board level, operational risks pertaining to Tier 2 rota provision, Caesarean section rates, safe staffing and culture are detailed within the risk register.	
Appendices	1. Clinical negligence scheme for trust information pack CNST year 7 2. Joint presentation detailing the final position with MIS year 7 maternity 3. Perinatal Quality Surveillance Supplementary Pack 4. Red Flags Data 5. Induction of Labour	

12. PARTNERSHIPS (STRATEGY AND PLANNING)

12.1 CORPORATE OBJECTIVES 2026/27

Decision Item | A Brotherton | 12.30pm

REFERENCES

Only PDFs are attached

12.1 - Corporate Objectives 2026 27.pdf

Board of Directors Report

Meeting of the	**Board of Directors**		
Part I ☒		**Part II** ☐	
Title of Report	**Corporate Objectives 2026/27**		
Report Author	A Brotherton/K Hudson		
Lead Executive Director	Ailsa Brotherton – Chief Strategy and Improvement Officer		
Recommendation/ Actions required	The Board of Directors is asked to: Note the work undertaken to develop the corporate objectives and approve them for adoption in 2026/27.		
	Decision ☒	**Assurance** ☐	**Information** ☐
Executive Summary	The purpose of this paper is to present to the Board of Directors the proposed corporate objectives for 2026/27. The Trust five-year strategy was approved in October 2025 setting out a series of tangible strategic objectives and incorporating the clinical service strategy. A workshop in January 2026 followed to prioritise and profile the themed objectives and the feedback received is incorporated into the paper. The corporate objectives for 2026/27 have been aligned to the 5Ps. This paper outlines the proposed high level corporate objectives with the detailed objectives outlined in the attached Appendix. These will be incorporated into objectives for members of the Executive team and used to inform the objective setting in appraisals for the senior leadership team and cascaded throughout the organisation. The objectives will be aligned to the organisation's risks and ambition for the delivery of the Single Improvement Plan.		
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.		☒

Link to Board Assurance Framework:	Linked to all principal risks
Appendices	Appendix 1: Corporate Objectives 2026/27

1. Background

Each year the Trust develops annual corporate objectives which are aligned to the strategic priorities and signed off by the Board. The Trust five-year strategy was approved in October 2025 setting out a series of tangible strategic objectives and incorporating the clinical service strategy. A workshop in January 2026 followed to prioritise and profile the themed objectives and the feedback received is incorporated into the paper.

2. Discussion

The Board Development Session was convened to build oversight, ownership, and accountability for these objectives, ensuring they are appropriately mapped across a three-year planning horizon linked to internal capacity and capabilities in teams and the emerging direction from system partners and collaborative work already underway.

The Trust Strategy is supported by six enabling strategies and a structured approach to risk management through the Board Assurance Framework (BAF). Corporate objectives are grouped under five strategic portfolios, Patients, People, Partnerships, Performance, and Productivity and aligned with national planning timelines. The session also sought to clarify dependencies, resource requirements, and escalation processes for risks that could impact delivery.
The proposed corporate objectives span multiple domains, including workforce development, financial sustainability, digital transformation, and service redesign. Year one priorities focus on foundational initiatives such as implementing telemedicine, improving urgent and emergency care pathways, and advancing integration with community services. Subsequent years will build on these foundations, introducing AI-enabled diagnostics, expanding continuity of care models, and embedding personalised care planning.

3. Financial implications

None related specifically to the setting of the corporate objectives, but the delivery of the objectives are fundamental to the Trust achieving the progress needed to achieve financial sustainability.

4. Legal implications

None

5. Risks

The risks relate to non-delivery and will be captured through the Board Assurance Framework and the risk registers.

6. Recommendations

It is recommended that:

I. The Board of Directors note the work undertaken to develop the corporate objectives and approve them for adoption in 2026/27

Appendix 1

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Corporate Objectives

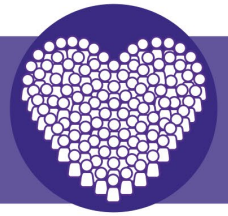
Excellent care with compassion

Always Safety First

@LancsHospitals

Our values and culture

We recognise that the programme of work needed in 2025/26 journey will be challenging so we must continue not to lose sight of our values:



Compassionate

A culture where we treat patients and colleagues with compassion, understanding and with kindness.

Collaborative

A culture where we recognise we are part of a bigger team, willing to work across boundaries to support others to achieve their aims.

Respectful

A culture where all roles or backgrounds are valued and equal, ideas are welcomed, we feel respected and supported.

Performance Focussed

A culture which is performance focussed, we strive to be the best. We are happy to be held and hold others to account in a positive, supportive manner, we are reflective and do not seek to blame.

Empowered

A culture where we are empowered and enabled to act to the full remit of our roles, we understand what we can do and feel able to act without permission.

Corporate Objectives

1. High Level Objectives

There are 5 of these aligned to the 5 P's summarising the detail of the corporate objectives. These will be used at Board level.

(Patients, Performance, People, Productivity, Partnerships)

2. Executive Objective

These explain the 5 high level objectives in detail providing executive leadership responsibility and what is expected operationally within each.

3. Cascade

The corporate objectives will be used to cascade into every leaders appraisal ensuring each leader understands their role in contributing towards achieving the objectives.

Corporate Objectives

1	Patients	Chief Medical Officer and Chief Nursing Officer
2	Performance	Chief Operating Officer
3	People	Chief People Officer
4	Productivity	Chief Finance Officer and Chief Strategy and Improvement Officer
5	Partnership	Trust Board

Corporate Objectives

Domain	Board Objective
Patients	Improve outcomes, reduce harm and deliver a positive patient experience.
Performance	Deliver agreed trajectories in clinical performance
People	Create an inclusive culture with leaders at every level leading colleague engagement.
Productivity	Deliver the agreed financial plan including waste reduction programme, maximising use of resources.
Partnership	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.

Patients

Single Improvement Plan

To improve patient care and experience, in particular Sepsis, Clostridium Difficile, risk assessment completion, medication safety, maternity, neonatal and childrens services whilst reducing health inequalities in our services.

Patients

Theme	Corporate Objective	**Scope and Focus of the Objective**	**How will we know if it has been achieved?**	**Exec Lead**	**Assurance Committee**
1.1 Women's health/ maternity/ Neonatal	Implement the national Maternity and Neonatal Improvement Plan	A commitment to delivering the national Maternity and Neonatal Improvement Plan, which sets out a comprehensive framework for enhancing the safety, quality, and equity of care for mothers and babies. This includes • strengthening clinical leadership, • improving workforce capacity • embedding evidence-based practices across maternity and neonatal services. Implementation will be supported by robust governance, continuous learning, and collaboration across the Integrated Care System to ensure consistent delivery and measurable improvements.	• Reduction in sepsis, improved thermal stability • MEWS/NEWTT2 implementation & compliance • Adoption of evidence-based interventions • Sustained reduction in term admissions to NICU • Sustained improvements in application of Sepsis 6, smoking cessation, diabetes management • Improved staffing metrics & safety culture survey scores	Chief Nursing Officer	Safety and Quality Committee
1.2 Long Term Conditions	Undertake a fundamental specialty redesign adopting the principles of the ten-year health plan	• Redesign of those specialties involved in long term care, guided by the principles of the ten-year health plan. • Rethinking how services are delivered, integrating care across settings, and aligning clinical pathways with population health priorities • Focus on prevention, early intervention, and multidisciplinary collaboration, ensuring that specialty services are more accessible and efficient.	• Reduction in emergency admissions for key LTC groups (e.g., COPD, heart failure, diabetes) • Reduction in avoidable 30-day readmissions • Improved LTC outcome metrics (e.g., HbA1c, spirometry stability, heart failure optimisation) • Reduced variation in outcomes between sites/services • % of LTC pathways aligned to evidence-based guidance and 10-year plan principles	Chief Nursing Officer	Safety and Quality Committee

Patients

Theme	Corporate Objective	**Scope and Focus of the Objective**	**How will we know if it has been achieved?**	**Exec Lead**	**Assurance Committee**
1.3 Specialist Services	Recognise the asset specialist services are to the organisation and the important role they play at LTH, delivering cutting edge care and being a catalyst for innovation and pioneering clinical practice	• Fostering clinical excellence. • Investing in specialist expertise • Ensuring that services are designed and delivered in a way that meets the diverse needs of the population. • Championing innovation and collaboration,	• we can reduce unwarranted variation in both access to care and patient outcomes, ensuring that every individual receives equitable, timely, and effective treatment regardless of geography or circumstance.	Chief Medical Officer	Safety and Quality Committee
1.4 Children and Young People	Design and deliver a children's and young people's plan to improve access to urgent and emergency care	• Design and implement a comprehensive Children's and Young People's Plan. This plan will be developed in collaboration with healthcare professionals, education providers, local authorities, and most importantly children, young people, and their families	• Identifying and addressing barriers to care • Streamlined referral pathways • Enhancing the capacity and responsiveness of urgent care services. • Creation of a more accessible, responsive, and inclusive urgent care system.	Chief Nursing Officer	Safety and Quality Committee

Performance

To increase productivity to improve waiting times for elective care, including waits for diagnostic services. To continue improvement of cancer performance to minimise the risk of harm. To develop and improve urgent and emergency care services working with our partners for improved whole system flow.

Performance

Theme	Corporate Objective	**Scope and Focus of the Objective**	**How will we know if it has been achieved?**	**Exec Lead**	**Assurance Committee**
2.1 Cancer	Improve patient experience through a focus on valuing patients' time by developing streamlined pathways and better communication, leading to the delivery of national standards for cancer	Redesigning care pathways to be more efficient, reducing unnecessary delays and handoffs. Improved communication, both between healthcare professionals and with patients, will ensure that individuals are well-informed, supported, and actively involved in their care journey. These efforts will help us	• Meet and exceed national cancer standards • Ensuring timely diagnosis, treatment, and follow-up • Fostering trust and confidence in our services.	Chief Operating Officer	Finance and Performance Committee
2.2 Urgent and Emergency Care	Improve patient experience and performance in Urgent and Emergency Care	• Co-design and standardise UEC pathways across providers to reduce duplication and improve consistency, working through the ICS urgent care networks • Streamline handoffs, improve communication, and reduce waiting • Explicitly targeting below-average UEC experience and long length of stay (LoS) for people presenting with mental health needs	• Achieve and sustain performance at or better than national average • Same Day Emergency Care (SDEC) utilisation: % of eligible patients managed via SDEC pathways • Reduction in serious incidents related to deterioration/escalation delays; timely delivery of sepsis bundles in urgent pathways • ED Friends & Family Test (FFT) positive score: Sustained improvement quarter-on-quarter	Chief Operating Officer	Finance and Performance Committee
2.3 Urgent and Emergency Care	Implement the strengths-based approach Days Kept Away from Home across all services	• Embedding a culture that values independence, supports recovery, and reduces unnecessary hospital admissions. • Fostering of multidisciplinary collaboration, enabling teams to work together to create care plans that are proactive, preventative, and tailored to each person's strengths and circumstances.	• Reduction in days kept away from home • Improvement in length of stay	Chief Operating Officer	Finance and Performance Committee

People

Single Improvement Plan

To improve colleague experience and create a positive organisational culture. Achieved by effective, supportive, inclusive and performance focussed line management. Aiming to reduce sickness absence, achieve compliance in appraisal and core skills, increase levels of team effectiveness and engagement, resulting in higher levels of colleague satisfaction and retention.

People

Theme	Corporate Objective	Scope and Focus of the Objective	How will we know if it has been achieved?	Exec Lead	Assurance Committee
3.1 Continuous Improvement, Education, Research and Innovation	Equipping all our colleagues, including the Board, with the improvement skills, knowledge and confidence to drive improvements within their teams and services	• Expanding the current programme to include giving teams an understanding of the population health position	• Increased % workforce training in improvement skills and methodology	Chief People Officer	Workforce Committee
3.2 People Plan	To attract, recruit and resource To be inclusive and supportive To be well led To deliver a responsive, future focused and enabling service To create a positive organisational culture To engage, retain, reward and recognise	• Deliver a programme of support for organisational equality, diversity and inclusion interventions • Delivering high quality leadership development • Supporting sickness absence management • Maintaining strategic workforce policy management • Providing workforce data and reporting • Facilitating improvements in team behaviours & organisational culture • Supporting training to minimise incidents of violence and aggression • Deliver a programme of work around retention and build on existing reward schemes	• Demonstrate maturing approach to EDI through improved Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) data. • Implement the health improvement plan and demonstrate improved outcomes for staff in minority groups. • To maintain an average or above position compared to peer for each people promise. • Improved staff advocacy score relating to a great place to be cared for • Reduction in the overall sickness rate • Colleague feedback and experience will exceed average people promise comparators. • An increase in colleagues who recommend LTH as a place to work • Reduction in the overall incidents of violence and aggression within the workplace	Chief People Officer	Workforce Committee

Productivity

To deliver the agreed Financial plan for the organisation, including the waste reduction programme, and support ongoing development of a full sustainability plan for the organisation.

Productivity

Theme	Corporate Objective	**Scope and Focus of the Objective**	**How will we know if it has been achieved?**	**Exec Lead**	**Assurance Committee**
4.1 Finance	Delivering waste reduction programmes without compromising quality or safety, including clinical pathway redesign, workforce optimisation, and digital innovation	• Delivery of agreed Waste Reduction Plan • Consistent compliance with EQIA associated governance to ensure patient care is maintained	• Teams delivering to the forecasted plans (within 1%) • Progress in the Improvement and Assurance group (IAG) exit criteria to progress towards exiting National Oversight Framework (NOF) 5	Chief Finance Officer	Finance and Performance Committee
4.2 Anchor Institute	Supporting Local Procurement	• To prioritise sourcing goods and services from local suppliers, contributing to the economic stability, wealth and growth of the region	• Number of active local suppliers used • Spend through collaborative arrangements (e.g., LPC) that includes explicit local social value or supplier development commitments	Chief Finance Officer	Finance and Performance Committee
4.3 Technology and Digital	Expansion of telemedicine and Remote Monitoring	• Expansion of our telemedicine services to provide remote consultations and monitoring, ensuring patients have access to care regardless of their location	• Increased ability to manage chronic conditions and reducing hospital admissions	Chief Strategy and Improvement Officer	Finance and Performance Committee
4.4 Technology and Digital	Implementation of Patient Engagement Tools	• Development of digital tools and platforms to enhance patient engagement, such as mobile apps for appointment scheduling, medication reminders, and health education	• Outpatient efficient metrics • Outpatient friends and family feedback metrics	Chief Strategy and Improvement Officer	Finance and Performance Committee
4.5 Technology and Digital	Expansion of the use of AI and Machine Learning	• Implementing AI and machine learning algorithms to enhance diagnostics, predict patient outcomes, and optimise treatment plans	• More accurate and timely care, reducing the burden on healthcare professionals and improving patient experiences	Chief Strategy and Improvement Officer	Finance and Performance Committee

Partnerships

To reduce and manage risks across the organisation, developing a learning and continuous improvement culture focused on working with partners to redesign and deliver our services to best meet the needs of our community.

Partnerships

Theme	Corporate Objective	**Scope and Focus of the Objective**	**How will we know if it has been achieved?**	**Exec Lead**	**Assurance Committee**
5.1 Overarching Objective	Being a collaborative system partner	• Working with partners across Lancashire and South Cumbria to prevent ill-health, reduce health inequalities and work across organisational boundaries to develop integrated services across primary, community, and secondary care	• Delivery of provider collaborative priority clinical transformation schemes • Delivery of phase two Pathology single service objectives	Chief Medical Officer	Trust Board
5.2 Diagnostics	Implement the Integrated Care System-wide diagnostics strategy, including unified PACS/RIS and cardiology systems	• Standardising Picture Archiving and Communication Systems (PACS), Radiology Information Systems (RIS), and cardiology platforms across organisations to ensure interoperability, reduce duplication, and improve the flow of information between providers	• More coordinated care pathways • Improved access to diagnostic results • Enhanced the ability to share expertise across sites	Chief Strategy and Improvement Officer	Finance and Performance Committee
5.3 Pathology	Implement a unified Laboratory Information System across the ICS	• To enhance diagnostic efficiency, data sharing, and clinical decision-making • Streamlining of laboratory workflows, reduced duplication, and enable real-time access to test results across multiple care settings	• Faster turnaround times • Improved accuracy • Better co-ordination between primary, secondary and community care providers	Chief Strategy and Improvement Officer	Finance and Performance Committee
5.4 Continuous Improvement, Education, Research and Innovation	Further developing our partnerships in Education	• Enhance the learning and development of our people and future healthcare professionals • Collaboration with leading universities, colleges, and training institutions placements, and research opportunities, ensuring that our people and students are equipped with the knowledge and skills needed to excel in their roles	• Provision of comprehensive educational opportunities fit for future healthcare education • Further development of a culture of continuous learning and innovation, ultimately improving patient care and outcomes	Chief People Officer	Education Training and Research Committee

Partnerships

Theme	Corporate Objective	**Scope and Focus of the Objective**	**How will we know if it has been achieved?**	**Exec Lead**	**Assurance Committee**
5.5 Continuous Improvement, Education, Research and Innovation	Improving research and innovation	• Investment in research initiatives and partnerships with leading academic institutions ensures that we stay at the forefront of advances in research • We will further build our partnerships with industry to optimise supporting commercial research	• Improvement in the offers our patients receive to access to the latest clinical trials and treatment.	Chief Medical Officer	Education Training and Research Committee
5.6 Community & Local Services	Horizontal integration with community services, providing comprehensive pathways for Central Lancashire working with primary and social care	• Develop comprehensive, joined-up pathways that span prevention, diagnosis, treatment, and ongoing support • Vertical integration to ensure that patients experience continuity across different levels of care, from community to hospital • Strengthened collaboration between services operating at the same level	• Reduction in health inequalities, through a reduction in gaps in access, outcomes and experience • Improved management of long-term conditions (reduced emergency attendance and unpanned admissions • Shift from reactive to preventative care	Chief Nursing Officer/Chief Medical Officer	Safety and Quality Committee

13. RISK, GOVERNANCE AND COMPLIANCE

13.1 2026/27 PLAN AND BOARD ASSURANCE STATEMENT ? APPROVAL PRIOR TO SUBMISSION

Decision Item | A Brotherton | 12.40pm

*Detailed report included in the separate ancillary pack

REFERENCES

Only PDFs are attached

13.1 - 2026.27 Plan and Board Assurance Statement.pdf

Board of Directors Report

Meeting of the	**Board of Directors**		**5th February 2026**
	Part I ☒		**Part II** ☐
Title of Report	**Medium Term Planning Update**		
Report Author	Ian Ward, Senior Associate Director of Strategic Planning		
Lead Executive Director	Ailsa Brotherton, Chief Strategy & Improvement Officer		
Recommendation/ Actions required	The Board of Directors are asked to: 1. **Note** the progress made in planning activity since mid-December 2. **Note** the key risks and financial uncertainties that remain as plans move toward the February submission. 3. **Support** continued executive-level oversight and disciplined decision-making to stabilise assumptions and reduce late changes. 4. **Endorse** escalation of contract and commissioning issues where risks to financial sustainability or deliverability are identified. 5. **Support** the extra-ordinary approval process for the final plan submission, five-year strategic narrative, and final triangulation.		
	Decision ☒	**Assurance** ☒	**Information** ☐
Executive Summary	The Trust has made strong progress since the mid-December draft submission, with Year 1 and 2 plans largely meeting constitutional standards (excluding A&E), staying within the revenue control limit, and incorporating significant workforce reductions. Work has since focused on strengthening triangulation, refining assumptions, evidencing assurance, and aligning contracting positions across system and Trust forums. January activity has prioritised reconciling activity, finance, and performance assumptions; embedding demand-management impacts within contract values; and addressing pricing inconsistencies. Executive planning huddles have continued to challenge deliverability and ensure mitigation plans are robust. Despite progress, key uncertainties remain - including specialised commissioning, funding gaps for constitutional standards, and confidence in activity growth - heightened by compressed timelines and late changes that constrain assurance.		

	The Board assurance process has been updated to reflect the current stage, with statements aligned to scoring criteria and recognising areas still maturing due to system dependencies and financial uncertainty. New statements have been added to ensure alignment with the financial plan and national expectations. Key risks continue to centre on deliverability, contract pricing, demand-management assumptions, and commissioning alignment, with implications for staff, system partners, and Board oversight as plans move toward final triangulation.		
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			
Committee Approval:	Finance & Performance Committee	25th November 2025:	
Link to Board Assurance Framework:	Choose an item		
Appendices	Appendix 1: Risk Log Appendix 2: Board Assurance Statements		

13.2 CHARITABLE FUNDS COMMITTEE CHAIR'S REPORT

Other | T Ballard | 12.50pm

Item for Assurance

REFERENCES

Only PDFs are attached

13.2 - Chairs report CFC 16 Dec 2025.pdf

Chair's Report to Board		
Chair: Tim Ballard	**Committee: Charitable Funds Committee**	
Date(s):16 December 2025	**Agenda attached for information**	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

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

ALERT

Areas of concern;

None

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- Ward 12 Day Room Funding Approval: The Committee approved the funding request for the Ward 12 day room refurbishment, noting concerns about high costs but confirming procurement followed due process. Assurance would be sought that all standing financial instructions (SFIs) were followed.
- Procurement and Value for Money: There was a discussion about ensuring competitive quotes for projects below the full tender threshold, with an action to review compliance with SFIs and report assurance to the Committee.

ASSURE

Assurance received; Matters of positive note.

- Angkor Wat Project Success: The Angkor Wat trek project was highlighted as a successful initiative with strong participation from colleagues within the Trust.

Charitable Funds Committee

16 December 2025 | 3.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	3.00pm	Verbal	Information	Chair
2.	Apologies for absence	3.01pm	Verbal	Information	Chair
3.	Declaration of interests	3.02pm	Verbal	Information	Chair
4.	Minutes of the previous meeting held on 16 September 2025	3.03pm	✓	Decision	Chair
5.	a) Action log & Matters Arising	3.04pm	✓	Decision	Chair
6.	STRATEGY AND PLANNING				
6.1	Hospitals' Charity update including Baby Beat	3.05pm	✓	Assurance	D Hill
6.2	Rosemere Charity update inc. requests for funding i) RCF Funding Approval Request RCF024-2526 – Ward 12 Day Room	3.15pm	✓	Decision	D Hill
7.	FINANCE AND PERFORMANCE				
7.1	Finance update including review of spending plan and balances	3.25pm	✓	Assurance	B Patel
7.2	Investments and Reserves Policy	3.35pm	✓	Assurance	B Patel
8.	GOVERNANCE AND COMPLIANCE				
8.1	Items to alert/advise/assure the Board	3.45pm	Verbal	Information	Chair
8.2	Reflections on the meeting	3.50pm	Verbal	Information	Chair
9.	ITEMS FOR INFORMATION				
9.1	Rosemere Management Committee Chair's report		✓		
	Date, time and venue of next meeting: *17 March 2026, 1.00pm, MS Teams*	3.55pm	Verbal	Information	Chair

13.3 REVIEW OF TERMS OF REFERENCE - CONTAINED IN THE ANCILLARY PACK

Decision Item | J Foote | 12.55pm

14. ITEMS FOR INFORMATION - CONTAINED IN THE ANCILLARY PACK

14.1 REGISTER OF INTERESTS

Information Item

*Detailed report included in the separate ancillary pack

14.2 DATE, TIME AND VENUE OF NEXT MEETING:

Information Item | M Thomas | 12.30pm

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