NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS MEETING

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4 December 2025

09:15 GMT Europe/London

Lecture Room 1, Education Centre 1, Royal Preston Hospital

AGENDA

PATIENT STORY FROM DIAGNOSTICS AND CLINICAL SUPPORT DIVISION

Information Item

09.15am

AGENDA

REFERENCES

Only PDFs are attached

0.0 - Agenda - Board (part I) - 4 December 25 (1).pdf

Board of Directors

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

Agenda

At 09.15am, there will be a **patient story from the DCS Division**

№	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 2 October 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. PERFORMANCE & PRODUCTIVITY					
9.1	Integrated Performance Report as at November 2025 including Finance update and Single Improvement Plan (considered by appropriate Committees of the Board)	10:15 am	✓	Assurance	K Foster-Greenwood/ S Morrison/ N Pease/ C Carter
9.2	Finance and Performance Committee Chair's Report inc. *UEC Deep Dive	10:45 am	✓	Assurance	J Schorah
10. PATIENTS (SAFETY AND QUALITY)					
10.1	Safety and Quality Committee Chair's Report	11:00 am	✓	Assurance	K Deeny
BREAK		11:10 am			
11. PARTNERSHIPS (STRATEGY AND PLANNING)					
11.1	Medium Term Planning Framework (2026/27 to 2028/29)	11:30 am	✓	Assurance	A Brotherton
12. PARTNERSHIPS (STRATEGY AND PLANNING)					
12.1	Workforce Committee Chair's Report	11:50 am	✓	Assurance	A Leather
12.2	Education, Training and Research Committee Chair's Report	12:00 pm	✓	Assurance	S Crean

№	Item	Time	Encl.	Purpose	Presenter
13.	**RISK, GOVERNANCE AND COMPLIANCE**				
13.1*	GGI Report – Action Plan Against Recommendations and Final Form RSP Exit Criteria	12:10 pm	✓	Decision	J Foote
13.2*	Health and Safety Annual Report	12:20 pm	✓	Assurance	S Morrison
14.	**ITEMS FOR INFORMATION * ancillary pack**				
14.1*	Maternity and Neonatal Services Update		✓		
14.2	Date, time and venue of next meeting: *5 February 2026 at 9:15 am at Lecture Room 1, EC1, Royal Preston Hospital*	12:30 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 2 OCTOBER 2025

Decision Item | M Thomas | 09.37am

REFERENCES

Only PDFs are attached

4.0 - Minutes - Board (Part I) - 2 October 25 - approved.pdf

Board of Directors

2 October 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
Prof S Crean	Non-Executive Director
Dr K Deeny	Non-Executive Director
Ms K Foster-Greenwood	Chief Operating Officer
Mrs S Morrison	Chief Nursing Officer/Deputy Chief Executive Officer
Mr J Schorah	Non-Executive Director
Professor T Wheeler	Non-Executive Director *(via MS Teams)*

Apologies: Mr S Nicholls, Mr A Leather and Mr U Patel

In attendance:

Mrs E Ashton	Divisional Midwifery and Nursing Director *(joined for minute 192/25)*
Mrs N Duggan	Director of Communication and Engagement
Mrs J Foote	Director of Corporate Affairs
Mrs K Hudson	Deputy Director of Strategy and Transformation
Mrs K Lawrenson	Corporate Affairs Officer *(minutes)*
Dr N Pease	Chief People Officer
Mrs M Przybysz	Executive Assistant
Mr S Regan	Associate Director of Risk and Assurance
Mr I Ward	Senior Associate Director for Strategic Planning

Apologies: Prof A Brotherton and Mr K Pringle

Governors observing: Sonia Connell, Janet Miller, Carole Oldcorn, Enid Povey, Graham Robinson

Observers: Annemarie Vicary, National Recovery Support Team, NHSE

Presenters of the patient story: Nicola Lowe, Joanne Connolly, Rachel Jackson

The Chair adjourned the meeting at 9:45am in order for the Board to receive the following presentation: Patient Story, Children and Young People and Neonates. The meeting reconvened thereafter.

The Board received a presentation from Nicola, a parent whose daughter Autumn was diagnosed with Type 1 Diabetes earlier this year. Autumn arrived at the emergency department in the early morning, where the triage nurse quickly identified diabetic ketoacidosis and initiated immediate care. Nicola described the professionalism and coordination of the medical team, which provided reassurance during a distressing time. Autumn was transferred to a high dependency unit, where staff communicated the treatment plan with compassion. Small gestures, such as a therapy dog visit, had a meaningful emotional impact. Nicola commended the care across departments, especially the paediatric diabetes team, and noted the smooth transition to community care. Autumn made a full recovery and expressed fondness for the hospital environment.

The Board reflected on the powerful account, emphasising the importance of communication in acute settings. Staff were praised for their clarity and empathy, which fostered trust and improved patient experience. Nicola's story illustrated how small acts and integrated care contributed to recovery. The Board also acknowledged the nomination of a youth worker for the Flying Star award, recognising her significant contribution to young patients with diabetes through non-clinical support. Her role, part of an NHS England-funded pilot, demonstrated the value of emotional and developmental engagement during the transition to adult services. The Board expressed appreciation for these efforts and extended best wishes for the awards event, and thanked Nicola for her moving contribution. It was proposed that a letter of thanks be sent from the Board to Nicola and those involved in Autumn's treatment. The Board reflected on the emotional impact of the case and its significance in illustrating the consequences of both successful and unsuccessful care. From a Safety and Quality Committee perspective, the story was recognised as a valuable lens through which to interpret data, particularly in relation to children's services, and was expected to influence future assurance practices.

176/25 Chair and quorum

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

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

177/25 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.

178/25 Minutes of the previous meeting

The minutes of the meeting held on 7 August 2025 were approved as a true and accurate record.

179/25 Matters arising and action log

The updated action log was received.

180/25 Chair's report

The report provided a summary of work and activities undertaken during August and September 2025 by the Trust Chair including a resumé of the items discussed in the Part II Board meeting on 7 August 2025.

The Chair acknowledged that the two most pressing challenges remained finance and performance, particularly the continual balance required in meeting financial targets whilst delivering on performance metrics. The Chair reflected that while regular performance tables were being produced, it was important to emphasise that the Board's primary responsibility was to improve the safety and quality of patient care. It was noted that any reputational benefits would naturally follow from improvements in care. The overarching goal remained to achieve and then progress from a CQC rating of 'good' to 'outstanding', necessitating a focused approach to addressing the ongoing issues of finance and performance.

181/25 Chief Executive's report

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

Board members, Governors, external stakeholders, and staff had received a comprehensive briefing regarding the Trust's position in the national league tables, which was acknowledged as disappointing. However, the focus remained firmly on patients and staff, with confidence expressed that the next quarter would show positive progress.

Following media attention on the US government's position related to paracetamol, the UK Medicines and Healthcare Products Regulatory agency (MHRA) confirmed its safety during pregnancy, and this reassurance was shared widely across communication platforms.

The annual flu vaccination programme had commenced successfully, with strong staff participation and engagement.

A welcome was extended to the new Chief Medical Officer, who had already made a positive impact.

The recent Annual Members Meeting, themed around health through activity, had over 40 attendees and featured interactive elements that reinforced health messages, supported by staff members from Active Lancashire. Appreciation was expressed to the Corporate Affairs Team and Governors for their contributions.

A letter from the NHS Northwest Black, Asian and Minority Ethnic Assembly had been received, prompting a reaffirmation of the Trust's commitment to anti-racism. The organisation continued to take visible and active steps to support minority ethnic colleagues and was preparing for an education process aligned with anti-racist standards later in the year.

182/25 Board Assurance Framework

The Board reviewed the Board Assurance Framework Risk Report, which outlined key risks to delivering the Trust's 2025/26 corporate objectives. The Trust remained in Segment Five of the NHS Oversight Framework and part of the Recovery Support Programme. Two principal risks saw score changes: the risk around resident doctors' experience was proposed for removal from the principal risk register due to improved assurance, including positive GMC survey results. The risk related to training compliance also decreased in score, though it remained under review pending October data. Principal Risk 2, concerning elevated C. difficile rates, was being addressed through phase two of national cleaning standards, with 50% completion targeted this month and full implementation by year-end. Principal Risk 5, regarding access to urgent and emergency care, remained off track despite improved bed occupancy. Overcrowding and boarding persisted, with mitigation efforts including expanded "days kept away from home" and increased community support. Winter planning and NHS England Northwest recovery transformation bids were linked to mitigation efforts, although the final decision was pending. Principal Risks 12, 13, and 14, focused on financial delivery, were expected to remain static through year-end. The cash position remained a concern due to unsupported NHS England requests. Capital trajectory changes would align with the estate strategy, and once the Trust Strategy was approved, that risk may be stepped down.

In response to a challenge from Board members on the mechanisms for change within the Board Assurance Framework, and the methodology available for in year change to deliver an agile framework that remained relevant, the Board was advised that the risk framework had been designed to identify principal risks to the delivery of the corporate objectives within the financial year. A workshop was scheduled annually at year-end to review in-year controls and assess emerging risks. It was acknowledged that while significant changes were uncommon, continuous monitoring was essential to identify any new principal risks. The Trust Strategy would guide future objectives, with ongoing evaluation of assurance levels to ensure alignment between strategy and risk management.

Assurance was provided regarding resident doctors' experience, with the highest GMC survey scores in four years. Improvements stemmed from cultural initiatives, enhanced oversight, and the creation of a working lives group for foundation doctors. Additional assurance was drawn from direct engagement with resident doctor forums and national guidance, including a ten-point expectation plan. The annual survey and qualitative feedback from listening events were acknowledged as valuable tools for ongoing assurance. Training compliance showed marked improvement, with structural changes and a zero-tolerance approach to persistent non-compliance. The Board endorsed this stance, highlighting its importance for patient safety.

Emergency care access remained a concern, with harm levels cited as 'stable' but ongoing issues in patient experience due to overcrowding and delays. Predictive modelling and winter planning were considered essential to mitigate future risks. The absence of recovery transformation funding was highlighted and discussed as a barrier to expanding same-day emergency care, with internal productivity improvements serving as partial mitigation.

The Board RESOLVED to approve the updates in the Board Assurance Framework and the step down of the Principal Risk related to suboptimal experience of resident doctors.

183/25 Trust Strategy

Following comprehensive reviews and workshops, the Trust Strategy 2025–2030 was submitted to the Board in its final version. Developed through extensive engagement with staff, patients, governors and partners, the strategy focused on five priorities: improving patient access and outcomes through technology, investing in staff development and culture, strengthening partnerships across health and social care, enhancing performance to meet and exceed national standards, and optimising resources for greater productivity. The strategy aligned with the new ten-year health plan for England and regional clinical priorities, emphasising shifts from hospital to community care, analogue to digital, and treatment to prevention.

The Board acknowledged the value of a simplified 'plan on a page' to support clarity across the organisation. Feedback had highlighted the need to focus on key priorities rather than every ambition. The strategy document was seen as a strong foundation for unifying the Trust, identifying year-one priorities and the importance of clearly communicating these to stakeholders. It was recognised as a central reference point for aligning business planning, financial strategy, and performance management, with appreciation expressed for its inclusive and representative nature. A key discussion point was ensuring staff engagement with the strategy and understanding their role in its delivery. It was emphasised that integration into the annual planning process would be essential, with speciality teams contributing to the development of objectives aligned with the strategy. The approach would prioritise financial sustainability and productivity within existing services. The Single Improvement Plan's year-one actions would be reviewed post-approval, and the strategy would be embedded across Committees, supported by divisional improvement forum reports.

The discussion reflected a shared ambition for improvement, particularly in the areas of cancer and diagnostics. Attention was drawn to the importance of identifying early indicators of progress, with a focus on metrics such as the 28-day Faster Diagnosis Standard, which had shown promising developments. However, it was acknowledged that assurance was still needed around the 62-day treatment standard, which remained a national priority and was of significant importance to patients and staff. Operational plans included clear performance trajectories, with the 62-day standard expected to be met by March. These plans would be updated as part of the new five-year framework.

The discussion highlighted the importance of partnerships, noting that while current collaborations were rightly focused on service delivery, community-based care, and reducing pressure on central services, there was a suggestion to broaden this scope to include political partnerships. Existing efforts such as monthly meetings with MPs, regular leader meetings, and participation in advisory groups were acknowledged, but it was suggested that a more structured update on external environment links and their strategic relevance could be useful, along with a review of group memberships to ensure appropriate representation, especially in light of the Trust's social value strategy.

The Board RESOLVED to approve the Trust Strategy for adoption and implementation.

184/25 Winter Plan

The Winter Plan was presented for consideration and approval. The Finance and Performance Committee had endorsed the report at its meeting on 23 September 2025 (FPC Minute No. 140/25 refers).

The Winter Surge Planning Report 2025/26 outlined how Lancashire Teaching Hospitals prepared to manage increased demand on urgent and emergency care services during the winter months. Data modelling predicted that, without intervention, winter pressures could result in a deterioration in performance of up to 4.5% and a bed deficit ranging from 9 to 69 beds, particularly in November 2025 and January 2026. To address this, the Trust had identified and funded a series of mitigation schemes, including additional paediatric medical capacity, increased discharge lounge capacity, an ED transfer team, extended same day emergency care provision, respiratory assessment provision, extra medical staffing for the Acute Medical Unit, and support for medical outliers. These schemes aimed to reduce emergency department attendances, admissions, bed occupancy and length of stay, while improving patient flow and discharge rates. The plan also included a focus on improving winter vaccination rates and outlined system-wide initiatives such as virtual wards and enhanced community services.

The Board was informed that the Board Assurance Statement required by NHSE had been endorsed by both the Chair and Chief Executive. It was noted that the statement included an Equality and Quality Impact Assessment (EQIA), as required, and provided assurances that key quality and risk elements were appropriately mitigated. These assurances covered scenarios involving baseline, moderate, and extreme winter pressures, including delivery of four-hour and twelve-hour targets, as well as referral-to-treatment standards and trajectories. The statement confirmed sufficient capacity to manage winter demands, particularly in elective and cancer care. It also referenced the Trust's reliance on the Recovery Transformation Fund and tiering status. In preparing the statement, discussions had taken place with colleagues across all provider Trusts in Lancashire and South Cumbria to ensure consistency, particularly with those in similar performance positions. Alignment with other provider Trusts in Lancashire and South Cumbria was confirmed, and the statement had been submitted by the 29 September deadline.

Attention was drawn to the winter vaccination campaign, with questions raised about the potential risks to the winter plan should staff uptake not improve. While the aspiration was to exceed last year's vaccination rates, the current planning assumptions were based on last year's figures. Broader pressures, including rising A&E attendances and respiratory infections, were also noted. The delayed decision on the Recovery Transformation Fund remained a concern, with mitigation plans in place should funding not be secured. The Board acknowledged that the fund was non-recurrent and would not resolve underlying performance issues. Strategic focus remained on developing community pathways to reduce admissions and length of stay, while managing risks associated with reduced bed capacity. The winter plan was seen as a consolidation of these efforts acknowledging the need for continued action during the period of increased pressure.

The Board RESOLVED to approve the Winter Plan, its contingent financial resource requirements and the Board Assurance Statement.

185/25 Finance and Performance Committee Chair's Report

The report as presented by the Chair of the Committee highlighted the ongoing financial and operational challenges facing the Trust, particularly the risk associated with limited cash availability due to stricter NHS England support and under-delivery of the Waste Reduction Programme (WRP). The report noted concerns about performance metrics, especially persistent long waits in elective care and referral to treatment, as well as issues in procurement processes and low capital expenditure due to cash constraints. Despite these challenges, the Committee had been assured by improvements in financial governance, pay and non-pay controls, and the positive impact of early winter planning. The establishment of a new Programme Management Office was underway to support delivery of the Single Improvement Plan and WRP, with interim resources mobilised to maintain momentum. The Committee had endorsed the Emergency Preparedness, Resilience and Response Core Standards and observed incremental progress in performance targets, while advising the Board of the critical time pressures and the need for ongoing monitoring and escalation of key risks.

At the end of August, cumulative year-to-date delivery stood at around 33% of the target. Performance metrics had not shown consistent improvement, and operational risks persisted despite some incremental gains. Progress had been made within the Single Improvement Plan (SIP), with many actions completed, but further work was needed to assess their impact. Future SIP planning would focus on benchmarking new initiatives.

The Board in peer-to-peer challenge discussed concerns around referral to treatment (RTT) performance and its implications for patient safety and quality. It was accepted that a clinical prioritisation process was in place, following Federation of Surgical Society Association guidelines, to categorise patients by urgency. Clinical validation and oversight were regularly conducted, with harm assessments applied. The debate highlighted the importance of triangulating patient experience, safety, and performance data. It was noted that while cancellations and delays were tracked, further assurance was needed to understand the implications for individual patients, particularly those experiencing repeated cancellations. It was suggested to develop a red flag system for patients affected by multiple cancellations which holds an inherent deterioration risk. The discussion concluded with a recommendation to produce a comprehensive assurance report to Safety and Quality Committee capturing the mitigations and risks discussed

186/25 Green Plan

The Green Plan was presented for consideration and approval. The Finance and Performance Committee had endorsed the report at its meeting on 23 September 2025 (FPC Minute No. 142/25 refers).

The Green Plan 2025–2028 set out Lancashire Teaching Hospitals NHS Foundation Trust’s strategic approach to environmental sustainability for the next three years. The plan, which aligned with national NHS net zero targets and statutory requirements, built on progress made since 2022 and identified ten key focus areas, including workforce and leadership, sustainable models of care, digital transformation, travel and transport, estates and facilities, medicines, procurement, food and nutrition, adaptation, and green space biodiversity. The plan aimed to support the Trust’s ambitions to deliver outstanding, sustainable healthcare and drive innovation while meeting national environmental standards.

The Board acknowledged the efforts of those involved in producing a complex and challenging document. The work was commended for its contribution to understanding key statutory obligations and aligning with governance requirements. It was confirmed that a permanent board-level Net Zero Lead had been appointed. The NED Champion for the Green Plan made observation regarding the organisation's role as an anchor institution, particularly in relation to sustainable prescribing practices and their long-term impact on healthcare and carbon footprint. The importance of initiating care appropriately and addressing health inequalities was emphasised.

The Board RESOLVED to approve the Green Plan for adoption and implementation.

187/25 Charitable Funds Committee Chair's Report

The Chair's Report noted adjustments to legacy income recognition practices to comply with auditor recommendations and charity SORP. The investments and reserves policy was reviewed and ratified, confirming continued compliance with best practice and ethical standards. The Committee had approved significant funding for the Baby Beat courtyard transformation and a cancer diagnostics research project, both of which were assessed for value for money and alignment with organisational strategy. Financially, combined charity funds increased by £238,000 over five months, with income and expenditure closely monitored; although legacy income was slightly behind plan, it was expected to meet targets by year-end.

The Board was advised of the accounting requirement to recognise legacy income once it is confirmed, even if the funds had not yet been received. Although this approach might appear counterintuitive, it was clarified as a standard rule based on commitment and assurance was provided that appropriate compliance measures were in place.

188/25 Integrated Performance Report as at September 2025

The Integrated Performance Report presented to the Board in October 2025 provided an overview of the Trust's performance up to August 2025, highlighting progress and ongoing challenges across people, patients, productivity, and performance.

Great Place to Work - The Trust had experienced a reduction in overall sickness absence rates for the fourth consecutive month, although short-term absence cases had trebled following the introduction of a new attendance management policy, and the Workforce Advice team's capacity remained challenged due to high levels of maternity leave. Vacancy rates had started to decrease as posts were released internally, but risks persisted around Healthcare Support Worker vacancies. Turnover had increased, with a significant proportion of staff leaving for further training, promotion, or relocation, and retention efforts were ongoing, including targeted support for specific age groups and teams.

Incidents of violence and aggression towards staff had peaked in July but subsequently declined, with improvement plans and national standards under review.

Appraisal compliance had remained above target, and mandatory training compliance had reached 100% across all metrics. Staff engagement, as measured by the quarterly survey, had shown a slight improvement but continued to fall below the national

average, prompting refreshed engagement initiatives and targeted interventions for lower-scoring teams. Overall, the Trust had maintained daily monitoring of safe staffing levels and continued to implement improvement actions in response to workforce challenges and survey feedback.

Consistently Deliver Excellent Care - During the reporting period, the Trust had observed an increase in complaints, particularly linked to delays in urgent and emergency care, diagnostic pathways, and communication, prompting targeted improvement plans and enhanced patient messaging.

Compliance with national standards of healthcare cleanliness had remained below target, although the implementation plan was progressing as scheduled. Pressure ulcers had shown a concerning spike in August, especially within urgent and emergency care, and improvement efforts were underway, including equipment reviews and staff training.

Staffing fill rates for maternity support workers had continued to fall short of the 95% target due to historical vacancies and sickness, but recruitment had concluded and further improvements were anticipated. The Trust had maintained safe nursing and midwifery staffing levels, with positive trends in recruitment and accreditation, and mortality and stillbirth rates had remained within or below expected ranges.

Overall, the Trust had continued to monitor and address patient experience, safety, and quality through focused action plans and regular Committee oversight.

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.

Operational Performance Summary – The Board was reminded that the Trust had been formally placed into Tier 1 for performance oversight relating to referral to treatment (RTT), cancer, and diagnostics, and Tier 2 for urgent and emergency care. Although the oversight meetings differed in designation, both were held fortnightly, ensuring consistent support. A recent change was noted in the centre's approach, with an increased focus on performance improvement. As a result, several providers, including the Trust, were expected to receive requests to submit formal reforecasts and

recovery plans due to deviation from original performance ambitions. There was also an indication that further stretching of targets might be required for the second half of the year, reinforcing the critical alignment between finance and performance functions.

During the reporting period, the Trust's performance had been challenged across several domains. Referral to treatment times had deteriorated, with breaches in both 52-week and 65-week waiting targets, particularly affecting specialties such as ENT, surgical dentistry, neurology, and colorectal surgery.

Four-hour emergency department performance had declined, and the number of boarded patients had remained static, reflecting ongoing capacity constraints.

Cancer pathway performance had stayed below target, although improvement plans were in place for the most affected tumour groups.

Ambulance handover times had improved, with a significant reduction in delays over 60 minutes, and triage times had decreased.

Despite these pressures, safe staffing levels for nursing and midwifery had been maintained, and compliance with mandatory training and appraisal targets had remained strong. The Trust had continued to monitor and address operational challenges through focused improvement plans, enhanced oversight, and targeted interventions.

Single Improvement Plan – The updated report included a dashboard summarising six SIP milestones and linked outcomes, with oversight provided by the Finance and Performance Committee. At the last Committee meeting, eight milestones were identified as off track and were subject to scrutiny. The Board was informed of efforts to enhance business intelligence capabilities, supported by NHS England's Recovery Support Team, with a focus on performance dashboards, pathway productivity, and broader organisational productivity and capacity. Improvements were noted in clinician appraisals, and patient experience and safety metrics were rated green, while productivity metrics were amber-green.

Board Discussion and Debate

The Board acknowledged a mixed performance, noting areas of strong progress alongside static or declining trends. The Trust had managed significant turnover challenges and had scheduled delivery later in the year to mitigate current shortfalls. A challenge was raised regarding the impact of short-term sickness on emergency care access and workforce strategy. Early identification of such sickness was recognised as a prompt to enable timely intervention and reduce progression to long-term absence, thereby improving operational performance. Progress on core skills training was welcomed, and the need to develop reporting mechanisms for role-specific essential training was identified as the next step following successful core training implementation.

Concerns were expressed regarding equitable access in referral to treatment (RTT) data across population groups. The Trust confirmed its ability to profile waiting lists by comorbidities and deprivation, and to triangulate this with DNA rates. Despite the data infrastructure supporting such analysis, operational pressures constrained the implementation of a fully stratified response. The importance of addressing health inequalities within the access policy was emphasised.

Further debate focused on performance data and productivity, with reference to the GIRFT metrics and benchmarking opportunities. It was agreed that timelines and trajectories for improvement should be brought to future Finance and Performance Committee meetings, with outputs from the capacity and demand modelling to inform job planning. The productivity programme remained ongoing, with outputs expected in the coming months.

Clarification was provided on fill rates exceeding 100%, attributed to unbudgeted emergency department capacity and enhanced therapeutic observation for high-risk patients. A national programme had facilitated a shift to evidence-based one-to-one care, reducing requests for additional support. The Trust continued collaboration with external partners to reduce patient length of stay, particularly for complex cases awaiting placement, with associated costs reaching £50,000 per month. Assurance was given that exceptional staffing requirements were not being absorbed into core budgets.

Maternity staffing was noted to be below target, with assurance sought that improvements were expected following birth rate plus appointments. Concerns were raised about staff survey results, particularly the low percentage recommending the Trust as a place to work. It was confirmed that the survey would launch imminently and that efforts had been made throughout the year to improve staff experience through practical measures and a new engagement strategy. Benchmarking indicated the Trust was slightly below peers, and a three-year improvement plan was in place.

A question was raised about the reduction in whole-time equivalents, with further clarification probed for in that the reduction was not due to redundancies but driven by turnover, reconfiguration, and reduced reliance on temporary staffing. The Trust had achieved a reduction of 132 against a target of 348, with further reductions planned. Slippage in delivery was linked to interdependencies such as estates and capital investment.

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

189/25 Workforce Committee Chair's Report

The Workforce Committee had reviewed strategic risks and noted a reduction in high-scoring risks, which was considered positive. Ongoing capacity limitations within the Workforce Team had affected data collection and analysis, particularly regarding violence and aggression trends. The Committee had spent some time understanding the dynamic between the Trust and One LSC regarding service delivery. Risks had been raised with the Head of People at One LSC and were being reviewed appropriately. The Committee had also discussed emerging risks in specialist skills within fragile services and expressed concern about high turnover rates, especially in the Estates team, with work-life balance cited as the most common reason for leaving. Assurance had been received regarding the scheduled launch of the Psychological Support Service in October, the robustness of the GMC revalidation and appraisal process, and the effectiveness of the workforce reduction plan. The Committee had acknowledged the positive cultural impact of onboarding and retention initiatives within the Women and Children's division, noting that these efforts had made a tangible difference. The Board were advised of the intention to address violence and aggression risks through the

Single Improvement Plan and a communications strategy, supported by project officer capacity and executive team backing.

An update was provided regarding ongoing discussions about changes to the future operating model of One LSC. It was noted that these developments might affect current hosting arrangements and that further information would be directed to the Workforce Committee once available.

190/25 GMC Revalidation Report

The GMC Revalidation Report was presented for consideration and approval. The Workforce Committee had endorsed the report at its meeting on 9 September 2025 (WFC Minute No. 100/25 refers).

The report covering the reporting period from April 2024 to March 2025 confirmed that the Trust completed appraisals for all eligible doctors, with 100% completion and a reduction in deferrals compared to the previous year. Key improvements included a refreshed medical appraisal policy, enhanced processes for transferring information between Responsible Officers, reinstatement of the appraisal quality assurance programme, and the embedding of Good Medical Practice 2024 in appraisals. The Trust also strengthened support for new doctors, increased the number of appraisers, and improved systems for managing concerns and promoting equality, diversity, and inclusion. Despite significant changes within the appraisal and revalidation team, the Trust maintained a continuous improvement philosophy and made notable progress in streamlining and enhancing its processes.

An observation was made regarding reference in the report to St Catherine's Hospice which should be recorded as St Catherine's University Hospice.

The Board RESOLVED to approve the report for submission to NHS England.

191/25 Safety and Quality Committee Chair's report

The Safety and Quality Committee report, as presented by the Committee Chair, alerted the Board to concerns about children being placed in unsuitable settings and emphasised the urgent need for systemic change, including plans to commission a joint health and social care residential facility in Lancashire. Ongoing monitoring had been advised for risks related to the Pharmacy Aseptic Service, Clostridium Difficile cases, patient boarding, and the implementation of cultural change in operational models. Assurance had been received on clinical prioritisation and harm mitigation for endoscopy, strengthened health and safety governance, and safe staffing across clinical groups. The Committee had also received positive assurance regarding maternity and neonatal care, compliance with Care Quality Commission recommendations, and the outcome of the CQC Radiotherapy Inspection, which was particularly pleasing in that it had resulted in zero recommendations. Reports on equality, quality impact, and incident management had demonstrated robust processes and ongoing improvements in safety, quality, and patient experience across the Trust.

Highlighting one of the issues raised by the Committee and while maintaining confidentiality, it was noted that some children were admitted due to clinical conditions, only for their social or home circumstances to later indicate that returning home would be unsafe or inappropriate. These cases subsequently required involvement from social

care services, where delays and systemic challenges were observed. Additional training and awareness were required for staff due to the complex and often challenging behaviours presented by some of these children. The discussion between board members highlighted that regulated activity was not being provided as the patients no longer required treatment, and the setting remained inappropriate for long-term care. This was acknowledged as a national problem, and there was an opportunity to influence broader systemic change. The Integrated Care Board and regional bodies were aware of the situation, which involved legal issues rooted in social care rather than hospital governance. Three programmes of work were underway, including addressing funding challenges for Monroe House, a transitional setting intended to support children before placement with families. Additionally, a system-wide review was planned to assess the allocation of resources for individuals with mental health diagnoses who did not require physical healthcare, with the aim of improving patient outcomes through more effective use of funding.

Two alerts were raised during the most recent Committee meeting. The first concerned a reported never event involving a retained balloon fragment in a patient following an angioplasty procedure. The fragment was identified via scan and successfully removed, with the patient recovering well. Discussions were ongoing with the Integrated Care Board regarding the classification of the event, and an independent radiology review had been commissioned to support this.

The second alert related to maternity theatre capacity, specifically the rising number of elective caesarean sections. Although a new theatre had been built, funding constraints had prevented full staffing and operationalisation. The Board was informed of potential impacts on urgent caesarean procedures and elective gynaecology services, though current mitigation measures were deemed effective. The issue was flagged for prioritisation in resource allocation discussions.

Additional updates included the development of a medical safe staffing report to complement existing nursing and midwifery reports, with attention to underrepresented staffing groups such as physician and anaesthetic assistants and healthcare scientists.

The Board was also advised of progress on Regulation 28, with the Committee having oversight of the response and timelines in place, and a further report scheduled for October.

192/25 Mid-year Maternity Service Safe Staffing Report

The Mid-year Maternity Service Safe Staffing Report was presented for consideration and approval. The Safety and Quality Committee had endorsed the report at its meeting on 26 September 2025 (SQC Minute No. 167/25 refers).

The report included updates from the perinatal quality surveillance dashboard and progress against the maternity incentive scheme, confirming compliance with safe staffing requirements across midwifery, obstetric, neonatal nursing and medical services. The obstetric consultant rota maintained a presence of 90 hours per week in line with national guidance. Middle grade rota pressures persisted, with only half of the requested training posts filled. Plans were underway to implement a two-tier rota and recruit SCF doctors to address gaps. The service achieved compliance with the 2022 Birthrate Plus assessment for midwifery staffing, with all vacant posts recruited and onboarding in progress. Monitoring of vacancies continued, aiming to reduce reliance on

bank and agency staff. A new Birthrate Plus assessment was ongoing, with results expected by the end of October. Sickness levels remained above target but were being actively managed under the new attendance policy. Since the last report, the service had diverted on 11 occasions due to staffing and acuity pressures, all in line with regional guidelines and without harm. With increased staffing, future diversions were expected to reduce. Ten active staffing-related risks were recorded, with scores between 10 and 20. Updates were also included on national oversight systems, including the Maternity Services Review and upcoming implementation of SPEN and MOSS systems. Patient experience and staff feedback were being reviewed, with a culture review underway and an action plan to follow. The Board concurred that, despite ongoing pressures, the service continued to operate responsibly, using robust oversight to mitigate risks and ensure safe care in line with national recommendations.

The NED Safety Champion for Maternity highlighted the importance of the Birthrate Plus assessment, reiterating its significance in linking safe staffing levels to positive outcomes during maternity and labour. The Board had previously approved the full Birthrate Plus recommendations, which had been viewed positively. It was noted that updated recommendations were expected in October, and the Board was advised to remain aware of their forthcoming release. Despite financial constraints, it was stressed that funding for safe staffing should remain a top priority.

The Board RESOLVED to approve the Maternity Safe Staffing Report.

193/25 Mortality Annual Report

The Mortality Annual Report was presented for consideration and approval. The Safety and Quality Committee had endorsed the report at its meeting on 27 June 2025 (SQC Minute No. 111/25 refers).

The Annual Mortality Report provided assurance to the Board of Directors that the Trust had maintained robust governance arrangements for reviewing, reporting, and learning from patient deaths. Mortality benchmarking demonstrated that the Trust's Hospital Standardised Mortality Ratio and Standardised Hospital Mortality Indicator were significantly lower than expected for the period, and the Standardised Mortality Ratios for children and neonates also remained within the expected range. The Trust had increased the proportion of deaths subject to Structured Judgement Reviews, and key themes from these reviews, as well as learning from inquests, LeDeR reviews, and patient safety incidents, had been presented. Six incidents had been reported as deaths likely due to problems in care, with two maternal deaths investigated and one Regulation 28 received. The Medical Examiner Service had continued to review cases at a consistently high rate despite statutory changes and service pressures.

Further assurance was noted in comparison to the report received the previous year. At that time, benchmarking had appeared lower due to coding issues related to palliative care. It was confirmed that this discrepancy had since been resolved, providing a more accurate and reliable view. The updated data was considered to offer increased assurance over the previous year's findings.

The Board confirmed it was assured of the Trust's arrangements for managing patient deaths and learning from them.

194/25 Mid-year Nurse Staffing Report

The Mid-year Maternity Service Safe Staffing Report was presented for consideration and approval. The Safety and Quality Committee had endorsed the report at its meeting on 25 July 2025 (SQC Minute No. 127/25 refers).

The mid-year staffing report was presented in accordance with National Quality Board guidance. This report covered all inpatient wards and confirmed that safe staffing establishments were in place to support safe care delivery. Progress had been made since the previous review, particularly in reducing vacancies. It was noted that while this reduction might prompt questions, it reflected improved productivity and the placement of substantive staff in appropriate roles. The transition from agency to bank staffing was highlighted as a positive development. Improvements were also observed in sickness absence and enhanced care delivery.

An update was provided to the Board regarding emergency department staffing. Although initial intentions were to enact changes through financial governance arrangements, a pause had been taken following further analysis of bed configuration and departmental size. This was to ensure patients received care in the most appropriate setting. Staffing rates remained aligned with escalated arrangements, ensuring no compromise to safety while a more informed decision was considered.

The Board RESOLVED to approve the Mid-year Nurse Staffing Report.

195/25 NHSE Provider Capability Self-Assessment

The Provider Capability Self-Assessment summarised the Trust's evaluation against NHS England's expectations across six domains: strategy, leadership and planning; quality of care; people and culture; access and delivery of services; productivity and value for money; and financial performance and oversight. Prior to consideration of the final form document at the meeting, board members had undertaken a workshop exercise on testing and challenging the details contained in the document. The report confirmed strong governance, a clear strategy aligned with national priorities, and robust quality assurance processes, with improvements in staff training, leadership, and patient safety. However, it was intended to report partial compliance in access and delivery of services, productivity, and financial performance. The Board considered this a sensible and prudent approach given that the Trust still had ongoing challenges in meeting performance targets, delivering efficiency improvements, and achieving financial sustainability. The Trust had implemented detailed improvement plans, strengthened financial controls, and engaged external support, but continued to face constraints due to limited funding and system-wide pressures.

A query was raised regarding the reassessment time frames. It was noted that updates were provided to the region on a six-monthly basis, with quarterly reviews conducted by the Board.

The Board RESOLVED to approve the self-assessment for submission.

196/25 Audit Committee Chair's Report

The Audit Committee had noted a significant downward trend in single tender waivers in procurement, reflecting improvement, but acknowledged that further work was needed to reach best practice and that this would remain a focus. The need for a more integrated view of divisional performance across risk, quality, and compliance metrics

was discussed. Assurance had been received regarding progress on the internal audit plan and risk management strategy, with key performance indicators above 90% and actions in place to address long-standing and operational high risks. The Committee had also received assurance on strong compliance with national clinical audit requirements and improvements in the management of procedural documents, with clear trajectories for ongoing compliance and transparency.

197/25 Items for information

The following reports were received and noted for information:

(a) Data Quality assurance report
(b) Social Value Strategy

198/25 Date, time and venue of next meeting

The next meeting of the Board of Directors will be held on Thursday 4 December 2025, 9:15am, Lecture Room 1, EC1, Royal Preston Hospital

The meeting closed at 12.40pm

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) - 2 October 25.pdf

Action log: Board of Directors (part I) – 2 October 2025

No Outstanding Actions

ITEMS FOR FUTURE BUSINESS *(for information)*

№	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update
1.	185/25	2 Oct 2025	***Repeated appointment cancellations – assurance report to SQC on patient impact*** It was noted that while cancellations and delays were tracked, further assurance was needed to understand the implications for individual patients, particularly those experiencing repeated cancellations. The discussion concluded with a recommendation to produce a comprehensive assurance report to Safety and Quality Committee capturing the mitigations and risks discussed	COO	4 Dec 2025	**Completed**– Added to the SQC Nov agenda.
2.	188/25	2 Oct 2025	***Integrated Performance Report -*** Further discussion focused on performance data and productivity, with reference to the GIRFT metrics and benchmarking opportunities. It was agreed that timelines and trajectories for improvement should be brought to future Finance and Performance Committee meetings, with outputs from the capacity and demand modelling to inform job planning	COO	4 Dec 2025	**Completed** – report included on cycle of business for FPC

COMPLETED ACTIONS *(for information)*

№	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update
1.	148/25	7 Aug 2025	***Board Assurance Framework -*** The Board agreed to maintain current risk scores but requested the BAF	ADoR&A	4 Dec 2025	**Completed** – Trajectories were added to Principal Risks from August 2025 at

№	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update
			include clearer timelines, trajectories and evidence to support future changes to be reviewed in late Autumn.			Committees of the Board and in the Board Assurance Framework as a whole in October 2025.
2.	N/A	2 Oct 2025	***Patient Story -*** A letter of thanks be sent to the staff involved in care, and patient's mum for allowing her story to be shared.	DoCA	ASAP	**Completed** **Update for 4 Dec 2025:** Letter issued.

6. CHAIR'S OPENING REMARKS AND REPORT

Information Item | M Thomas | 09.42am

REFERENCES

Only PDFs are attached

6.0 - Chair Board Report 041225.pdf

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Meeting of the	**Board of Directors**		**4th December 2025**
	Part I ☒		**Part II** ☐
Title of Report	**Chairs Update Report**		
Report Author	Rebecca Black, Executive Business Manager to CEO		
Lead Executive Director	Professor M 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 October and November 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 October and November 2025.

2. **Discussion**
   Mid-Year Review
   Myself and the Executive Team met with NHSE colleagues to provide an update on our current position and I am pleased to have received recognition from the NHSE in relation to how we continue to tackle the current pressures and are working closely with NHSE and ICB colleagues. There is a tremendous amount of work being undertaken and I would like to thank colleagues for their ongoing support to deliver on these challenges now and in the coming months.

   Walkabouts
   On the 21st October I visited a number of departments including the Discharge Lounge and the surgical Hub. My thanks go to the teams in this area for taking the time to talk to me when working in very busy environments. I was really proud of my nhs colleagues and the work that they are doing in all areas to ensure our patients receive the best possible care.

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

   1. New Hospital Site – Land Assembly
   - The Board discussed progress on acquiring land for the New Hospital Programme, emphasising the importance of securing the full site to support future development and public engagement.
   - The Board noted that the business case for the land acquisition is being finalised, with appropriate governance and oversight in place.
   - The Board delegated authority to the Chair and Chief Executive to approve the final business case submission, ensuring timely progress.

   2. Section 111 Notice
   - The Board considered the formal notice received from NHS England, which sets requirements for board leadership continuity and financial improvement.

4. **Chair's attendance at meetings**

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

Date	Activity
October 2025	
1st October	Board of Directors – GGI Well Led Review
1st October	A Vicary, NHSE
1st October	CMO
1st October	LSC ICB Chair
1st October	Non-Executive Director
2nd October	Board of Directors
9th October	LTH – Improvement and Assurance Group

14th October	Regional Workforce Strategic Assembly
14th October	Lancs Health & Wellbeing Board
15th October	CEO, UHMB
15th October	H Cross, PWC
15th October	Chief Strategy and Improvement Officer
15th October	Chairs, Deputy Chair, Lead Governor
15th October	N Everrett, Portering & Support Services Manager
15th October	LTH/UCLAN – strategic & operational links
21st October	Director of Communications & Engagement
21st October	Managing Director, LSC PCB
21st October	MIAA
21st October	Tour of Trust Departments, Royal Preston Hospital
21st October	Special Board
22nd October	Non-Executive Director
22nd October	Meeting re Mid-Year Review
22nd October	PCB meeting with Managing Director
23rd October	Non-Executive Director
23rd October	Director of Corporate Affairs
23rd October	Mid-Year Review
28th October	PCB Senior Leads Meeting
28th October	Chief Operating Officer
29th October	Chief Medical Officer
29th October	Deputy Director of Education
29th October	Chief Finance Officer, NHSE
30th October	Director of Corporate Affairs
30th October	Deputy Chief Executive
30th October	Council of Governors
November 2025	
4th November	Board of Directors Development Session
5th November	Chief Executive
5th November	Director of Corporate Affairs
6th November	Managing Director, 1LSC
6th November	Chief Finance Officer
11th November	Director of Communications & Engagement
11th November	Chief Strategy and Improvement Officer
11th November	Director of Corporate Affairs
11th November	LSC Chair
12th November	Mid Year Review
12th November	LSC Improvement & Assurance Group – 1LSC

13th November	LSC Improvement & Assurance Group – LTH
13th November	Chairs Discussion
13th November	Provider Collaboration board
25th November	Chief Strategy and Improvement Officer
25th November	Non-Executive Director
25th November	Director of Communications & Engagement
26th November	Chief Medical Officer
26th November	M Ellis, MP
26th November	A Vicary, NHSE
26th November	Regional Director, NHSE

5. **Financial implications**
   None.

6. **Legal implications**
7. None.

8. **Risks**
   No impact.

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.pdf

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors' Report

Meeting of the	Board of Directors		4 December 2025
	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

Industrial action

Resident doctors undertook national strike action from 14–19 November. During these strikes, our focus as a Trust was on ensuring as many services as possible continued to operate safely. We 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.

Whilst we always respect the right of our colleagues to strike, there is inevitably a negative impact on patients and colleagues due to additional delays, uncertainty and poorer outcomes for those who have to wait longer for procedures than they would normally have done. I'd therefore like to thank all colleagues who worked during the period of the Industrial Action and also all those who contributed to extensive planning required to maintain safe services.

NHS waiting list and winter pressures

In November, NHS England (NHSE) revealed that the NHS waiting list has fallen by 230,000 since July 2024, with September figures at 7.39 million (around 6.24 million patients), marking a slight month-on-month reduction of 15,845. Despite this progress, the health service was operating at unprecedented capacity ahead of winter, facing record A&E attendances and ambulance incidents. October saw 2.36 million A&E visits - 37,000 more than last year - and nearly 50,000 additional ambulance callouts (806,441 total). Encouragingly, ambulance response times for critical cases improved by almost 10 minutes compared to October 2024.

Preparations for winter have been more proactive than ever, with services stress-tested across three stages: preparation, staying ahead, and response. The NHS had delivered 14.4 million flu vaccinations as of November 13, exceeding last year's uptake by over 160,000. Primary care access is set to improve through a £1.1 billion investment in general practice - the largest increase in a decade.

However, significant challenges remain and five days of industrial action by resident doctors added strain to already stretched services.

Reducing Days Kept Away from Home

Between 20 – 26 October, colleagues at both our Royal Preston and Chorley sites ran a successful Reducing Days Kept Away from Home campaign aimed at decongesting our sites before the winter period.

Above all, we looked to enhance patient experience, reduce deconditioning, and embed sustainable improvements that support timely, person-centred care and efficient use of hospital capacity.

Ahead of the week, there were 108 patients across both sites who were medically fit for discharge but still occupying a clinical bed. This was contributing to a significant bottleneck at the front door as well as corridor care and boarding within our wards. Not only is this putting additional strain and pressure on colleagues, it is not providing our patients with the positive experience of our hospitals they deserve.

Despite the week presenting more admissions, the full multi-disciplinary team did an excellent job to expedite safe discharge with a focus on early planning and interventions as well as reducing avoidable delays, embedding effective board rounds and criteria led discharge. Between Monday-Friday, there was a total of 770 discharges with real success coming in driving down the number of bed days for our complex discharge patients. When the week began, there were 85 patients not meeting the criteria to reside with their collective bed days sitting at 479 and within three days this number was 78 patients with bed days at 298.

ITV Granada covered the week, visiting the Emergency Department, Ward 23, Discharge Lounge and Acute Assessment Unit (AAU). A big thank you to all colleagues who featured in interviews, including

Consultant in Emergency Medicine, Dr Michael Stewart; Consultant Chest Physician, Professor Mohammed Munavvar; Discharge Lounge Unit Manager, Naomi Tate; and Physiotherapist, Rebecca Sullivan.

A week long Multi-Agency Discharge Event (MADE), named “Home for Christmas” will begin week commencing 8 December with the aim of reducing bed occupancy levels to 85% ahead of the busy festive period.

Professor Mike Thomas appointed Interim Chair of East Lancashire Hospitals NHS Trust

On 11 November, we informed colleagues and partners that our Chair, Professor Mike Thomas, had been appointed as Interim Chair of East Lancashire Hospitals NHS Trust (ELHT) for a period of 18 months.

I would like to personally congratulate Mike on his appointment, which began at the start of December when their former Chair, Shazad Sarwar, came to the end of his tenure.

Mike will be undertaking his new position alongside his role as Chair of Lancashire Teaching Hospitals and it’s important to note that this is not a joint appointment and the governance of the two organisations will remain separate.

Mike is a former Non-Executive Director (NED) at ELHT, and in his role as Chair of the Lancashire and South Cumbria Provider Collaborative Board, he is familiar with the challenges and aspirations of the team there.

Maya Ellis MP visits Royal Preston Hospital

On 25 November we were pleased to welcome Maya Ellis MP to Royal Preston Hospital to meet with the Trust’s Executive Team and to have a tour of the site.

Maya visited our Emergency Department and Sharoe Green Maternity unit amongst other areas and met with a range of multi-disciplinary colleagues to learn about the great work that they do.

Important topics covered in the meeting with the Ribble Valley MP included the long term strategy for car parking at both our Chorley and Preston sites together with how we can better engage with our local communities, our approach to decongesting our sites and how we will be supporting Lancashire and South Cumbria NHS Foundation Trust by providing beds at our Fell View site to relocate a small cohort of patients who are currently being care for at Longridge Community Hospital with more information on this available here.

Flu vaccination urgency amid severe season warning

Top clinicians are warning of a potentially severe flu season, with hospital admissions for the H3N2 strain already rising earlier than usual. Infections have reached levels typically seen in December, prompting the NHS to launch an “SOS campaign” urging immediate vaccination uptake. Experts highlight that Australia recently experienced its worst flu season in seven years - a trend often mirrored in the UK. The dominant H3N2 strain has undergone seven mutations, reducing immunity from previous vaccinations and increasing risk for vulnerable groups.

The NHS made 2.4 million vaccination appointments available in mid-November, enough to cover a population the size of Greater Manchester. Last winter saw 7,500 flu-related excess deaths in the UK, including 53 children. With flu cases already triple last year’s levels, vaccination remains the most effective defence.

Thanks for the efforts of our own Vaxathon events, roving vaccinators and peer vaccinators, the Trust’s current level of staff vaccinations sits at 42.3% at the time of writing.

Trust wide successes and service developments

- **Sixth LSC Cancer Conference focuses on earlier diagnosis**

The sixth Lancashire and South Cumbria Cancer Conference in early October at Ribby Hall Village was hosted by the Cancer Education Hub in partnership with Rosemere Cancer Foundation.

A packed event brought together clinicians, patients, and community leaders to share best practice and innovation under the theme of earlier cancer diagnosis. Opening the conference, Katie Foster-Greenwood, our Chief Operating Officer, emphasised the life-saving impact of early detection and the need for continued collaboration across the region. Delegates heard powerful patient perspectives from advocates Nicola Nuttall and Brian Nolan, reinforcing the importance of listening and learning from lived experience.

The programme featured expert-led sessions on community engagement, screening initiatives, surgical advances, and emerging technologies such as AI in radiotherapy. Highlights included updates on lung cancer screening, robotic surgery, and prehabilitation in both clinical and community settings. Nicola Nuttall shared her daughter Laura's inspiring story and the work of the Be More Laura Foundation supporting brain cancer research.

Thanks to the Education Hub team for delivering an event that fosters knowledge-sharing and drives improvement in cancer care. Feedback from attendees was overwhelmingly positive, underlining the value of collaboration in achieving earlier diagnosis and better outcomes.

- **LTH leads robotic innovation in rectal cancer surgery**

The Trust is now the first centre in the region - and one of only seven nationally - to introduce robotic Transanal Minimally Invasive Surgery (TAMIS) for early-stage rectal cancer and complex polyps.

This advancement strengthens our position as a tertiary referral centre and reflects our commitment to innovation and patient-centred care. Robotic TAMIS offers significant benefits, including rectal preservation and reduced risk of permanent stoma, improving quality of life for patients. The procedure uses the Da Vinci surgical robot and a robotic motion table, both funded by Rosemere Cancer Foundation.

To date, four successful operations have been completed across Royal Preston and Chorley hospitals.

The motion table, a £300,000 investment from Rosemere, enables precise synchronisation between the robot and operating table, enhancing safety and outcomes. This technology supports a range of major robotic procedures and helps optimise theatre capacity.

Nationally, robotic surgery is a key NHS priority, with projections of 500,000 robot-assisted operations annually by 2035. Our adoption of robotic TAMIS aligns with this strategy and demonstrates how we are

delivering measurable benefits for patients. We extend our thanks to Rosemere for their support and to our colorectal team for pioneering this transformative approach to cancer care. Read more on our website.

- **World-first colorectal surgery gains global recognition**

Last June, a world-first surgical technique – Extra-Peritoneal Colorectal Surgery (EXPERTS) – developed exclusively by three of our consultant colorectal surgeons, Tarek Hany, Alka Jadav and Arnab Bhowmick, reached a major milestone, completing over 100 procedures. I'm pleased to see this innovative approach is attracting international interest, with leading surgeons from Europe and the United States visiting the Trust to observe and collaborate. Recently, Dr Antonio Caycedo-Marulanda from Orlando, Florida, travelled to Preston to see EXPERTS in action and was telementored by Mr Hany during his first case in the US.

EXPERTS avoids puncturing the peritoneum by accessing the bowel from beneath, and significantly improves patient safety and recovery, reduces complications, and eliminates the need for complex patient positioning.

This achievement demonstrates Lancashire Teaching Hospitals' leadership in surgical innovation and its commitment to improving outcomes for patients locally and internationally. Read more on our website.

- **National leadership in clinical research**

The Trust continues to demonstrate national leadership in clinical research through its NIHR Clinical Research Facility (CRF) and the influential role of Paul Brown, Deputy Director of Research & Innovation, who also serves as Director of the UK CRF Network. Since the last board meeting, Paul has addressed over 750 attendees at the UKCRF Network Conference in Birmingham. CRFs are specialist centres for high-risk, early-phase trials of new drugs, devices, and interventions. The Trust hosts one such facility, supported by five additional teams recruiting for later-phase studies, with oncology as the largest research area, alongside neuroscience and renal. The Trust is also advancing cancer vaccine trials.

Despite being smaller than many counterparts, Lancashire's CRF performs strongly and is recognised nationally. Under Paul's leadership, the UKCRF Network has secured over £3m in funding through to 2029, supporting operational development, trial triage, workforce training, and patient/public involvement, with a growing focus on diversity and inclusion.

Future research will increasingly move beyond hospitals into community settings. Lancashire is already exploring partnerships with local organisations to establish a regional hub for early-phase trials, ensuring the Trust remains at the forefront of innovation and patient-centred research. Read more on our website.

- **Trust celebrates excellence at 2025 Our People Awards**

It was a privilege to be present at our annual Our People Awards in October at the Imperial Banqueting Suite in Preston.

The event, presented by BBC Radio Lancashire's Graham Liver, honoured the compassion, dedication, and innovation of colleagues, and saw an impressive 499 nominations, with 31 finalists recognised across multiple categories celebrating excellence in patient care, innovation, and outstanding contributions in specialist areas.

Ten winners were announced alongside six recipients of new Special Recognition Awards, and the ceremony also marked significant milestones through the Long Service Awards, celebrating staff who have reached 20, 30, 40, or 50 year service milestones to the Trust - an enduring testament to commitment and care.

It was a fantastic opportunity to celebrate everything we do as an organisation, and highlighted the Trust's impact, with hundreds of thousands of patients treated annually, thousands of operations performed, and countless lives changed. Thanks to our sponsors Capsticks LLP, FWP Architects, and the Trust's TED Engagement Tool for supporting the event. Read more on our website.

- **"NHS Day" celebrated with live broadcast from RPH**

On 25 November colleagues at Royal Preston were delighted to welcome BBC Radio Lancashire's Graham Liver who broadcast his 6am – 10am morning show live from the discharge lounge.

"NHS Day", as it was labelled, was part of wider coverage across the North West spanning TV, radio, and online platforms, providing an insight into how NHS organisations are managing winter pressures and supporting patients during this challenging period.

There were a number of live guests from the Trust as well as those who pre-recorded interviews especially, and thanks go to Professor Mohammed Munavvar, Respiratory Consultant, Kelly Adams, Advanced Nurse Practitioner, Naomi Tate, Discharge Lounge Manager, Dr Michael Stewart, Consultant in Emergency Medicine, Sarah Morrison, Deputy Chief Executive and Chief Nursing Officer, Jo Connolly, Divisional Nursing Director – Children and Young People and Neonates, Dr Abhijit Das, Consultant Neurologist, Peter Beconsall, Ward 23 Volunteer, Nicola Fallon, Consultant in Emergency Medicine, Jodie Hamilton, Occupational Therapist and Charlotte Stewart, Specialist Physiotherapist. Thanks also goes to Dylan Grihault, Porter, Terry Lindsay, Pre Op Support Volunteer, Amara Ajaz, ED Volunteer, Gemma Aspinall, Diversity and Inclusion Practitioner, Reverend Martin McDonald, lead chaplain, and Joanne Cummings, Portering Services Manager for their involvement.

A big thank you to all colleagues involved.

- **Clinical Psychologist stood down from Jamaica deployment**

Following Hurricane Melissa's catastrophic impact on Jamaica at the end of October, Lancashire Teaching Hospitals' Principal Clinical Psychologist, Jay McNeil, was on standby to deploy with Serve On's international Urban Search and Rescue (USAR) team. The deployment aimed to assist in life-saving operations amid widespread devastation caused by the Category 5 storm. However, the situation evolved positively, with immediate rescue needs being met locally, with efforts shifting toward recovery and rebuilding. Jay and the team were stood down, and he said: "It's reassuring to see the resilience of Jamaica and regional support making a real difference. We remain ready to assist whenever needed."

Jay has been an active Serve On member since 2010, completing rigorous training and previously deploying to Türkiye after the 2023 earthquake. The USAR team trains monthly in London to maintain readiness for global disaster response, including collapsed structures and major floods.

Jay's expertise and commitment were highlighted in recent media coverage, including an interview on BBC Radio Manchester and a feature in the Lancashire Post.

- **Sophie and Sam share their story for Baby Loss Awareness Week**

The Trust marked Baby Loss Awareness Week by supporting national efforts to raise awareness and provide compassionate care for families affected by baby loss. ITV Granada Reports featured an interview with Claire Braithwaite, the Trust's Lead Bereavement Midwife, alongside parents Sophie and Sam Brown, who courageously shared their experience of losing their daughter, Rosie, at full term in January 2022. The Browns spoke about the deeply personal decisions they made in the days following Rosie's passing, including allowing her siblings to meet her, taking her home for a day, and going for a walk with her in a pram. These moments, supported by our specialist bereavement team, were vital in helping the family process grief and create lasting memories. Sam also highlighted the importance of fundraising for baby loss charities as part of Rosie's legacy.

By sharing their story, Sophie and Sam aimed to honour Rosie and help other families feel less alone. Their openness, combined with Claire's expert insight, underscores our commitment to compassionate bereavement care and its role in shaping national conversations around baby loss.

- **Joan celebrates an extraordinary milestone**

It was an inspiration to see Joan Guye, one of our post-transplant patients, reach a remarkable milestone in October. Joan has lived with a single transplanted kidney for 50 years - an achievement reached by only a handful of people worldwide. Joan marked her half-century with a celebration held at Royal Preston Hospital's Education Centre.

The average lifespan of a kidney transplant is 15–20 years for a deceased donor and 20–25 years for a live donor, making Joan's story a testament to the success of long-term care and the importance of organ donation. Originally transplanted under Manchester Royal Infirmary in 1975, Joan has since received ongoing care at Royal Preston Hospital. She expressed heartfelt gratitude to the medical teams who supported her journey.

The event reflected Joan's Dominican heritage, featuring themed decorations and even a parrot brought by Transplant Nurse Brian Vibert. Dr John Anderton, Consultant Renal Physician, praised Joan's commitment to her health, noting her kidney function remains among the best in clinic. Over five decades, Joan has seen approximately 35 different doctors, highlighting the continuity and quality of care provided by the Trust.

- **Black History Month celebration at Royal Preston Hospital**

The Trust marked Black History Month with a vibrant event at Royal Preston Hospital, celebrating Black heritage through storytelling, discussion, and cultural exchange. I was honoured to open the event, and highlight the diversity within the NHS, stressing the collective responsibility to challenge racism and foster inclusion. The event featured reflections from colleagues Michael Flome and Akinkunmi Omotoso (Core Therapies), who explored themes of identity, cultural pride, and resilience, sharing insights into West African heritage and their journeys within the NHS. Local chef Ibby recounted his migration from Sierra

Leone, while Wilhelmina Short, Emergency Department Staff Nurse, shared her inspiring story of overcoming adversity during Liberia's civil war and building a career with us.

Sarah Jules, Head of Operational Performance, contributed a video message underscoring the strength of diversity and authenticity in healthcare leadership. Attendees were encouraged to join staff inclusion forums to further embed these values.

The event also showcased the Embers of Care art project and concluded with traditional dishes from Uncleibby's Kitchen, funded by the Trust's new Colleague Lottery, reinforcing the celebration of culture and community.

- **Cancer Education Hub hosts head and neck clinical event**

The Cancer Education Hub, supported by Rosemere Cancer Foundation, recently hosted the Lancashire and South Cumbria Head and Neck Clinical Reference Group Education Event at Barton Manor Hotel.

The event brought together a multidisciplinary audience for expert-led sessions, networking, and collaborative learning. Sharan Jayaram, CRG Chair and Consultant ENT Surgeon at Lancashire Teaching Hospitals, opened the programme. Dr Remus-Mihai Seres (The Christie NHS Foundation Trust) delivered the first presentation on the evolving role of immunotherapy in head and neck cancers, exploring current applications and future potential. Consultant Plastic Surgeons Tarek Eldahshoury and Jeyaram Srinivasan (LTH) then discussed reconstructive surgery's critical role in complex cases, highlighting surgical techniques and multidisciplinary collaboration, before Dr Lip Wai Lee (The Christie) presented on proton beam therapy, covering evidence, trials, and implementation strategies.

The final session, led by Tomoko Lewis, Advanced Specialist Practitioner in Palliative Care (LTH), focused on supportive and palliative care, emphasising pain management and holistic patient support.

- **Trust excels in National Cancer Patient Experience Survey**

Once again we achieved outstanding results in the 2024 National Cancer Patient Experience Survey (CPES), maintaining an overall score of 9/10 for the fourth consecutive year – our best performance since the survey began in 2010. As the regional cancer centre, this reflects sustained excellence in patient care and experience.

The survey, conducted by Picker on behalf of NHS England, gathered feedback from 796 patients, achieving a 53% response rate, above the national average. Of the 61 questions, five scored above the expected range, with only two below. Tumour site teams performed strongly, with Brain scoring 9.4, and Colorectal, Head and Neck, and Prostate all above 9.

Key highlights include:

- 92% said the care team worked well together.
- 95% had a dedicated contact throughout treatment.
- 80% felt supported in overall health and wellbeing.
- 82% felt able to discuss worries during outpatient care.
- 90% received accessible support for managing side effects.

Lead Nurse Anne Tomlinson praised staff for their commitment to compassionate care and emphasised continuous improvement based on patient feedback.

- **Free festive Diwali meal is well received**

To celebrate Diwali on Monday 20 October, there was a free festive meal in Charters Restaurant at Royal Preston Hospital for 300 staff.

The festival of lights symbolises light over darkness, truth over ignorance and hope over despair, and the teamwork among staff was clearly visible on the day. The event would not have been possible but for kind contributions from the staff at LTHTR, who generously donated to celebrate, with thanks to Himanshu Singh, Shiva Tripathi, Manoj Khatri, Vikas Singh, Manish Gupta and Preeti Sood. Volunteers Poorna Veerappa, Manish Batra and Dharmendra Mittal also had a table offering information on the day.

- **Rachel wins Defence Inclusivity Award at Soldiering on Awards 2025**

Lt Col Rachel Diss, Occupational Therapist at Lancashire Teaching Hospitals and National Diversity and Inclusion Lead for the Army Cadet Force, won the prestigious Defence Inclusivity Award at the 2025 Soldiering On Awards. The ceremony, held in London, celebrated individuals and organisations making outstanding contributions to the Armed Forces community.

Rachel was recognised for her exceptional leadership in promoting diversity, equity, and inclusion across the UK Army Cadets. Her initiatives include leading cadet participation in the Pride in London parade, establishing diversity networks, embedding inclusive policies and training, and championing equality of opportunity for under-represented groups. Her work has empowered cadets and adult volunteers to feel valued and supported, fostering a culture of respect and authenticity. Read more on our website.

- **Remembrance Day service at RPH**

On 11 November, I and members of the Executive Board were proud to join staff and visitors in the chapel at Royal Preston Hospital for a poignant Remembrance Day service to honour those who served and sacrificed in times of war and conflict.

Marking 80 years since the end of the Second World War, the ceremony paid tribute to the fallen, the wounded, and all affected by war, while expressing hope for peace and reconciliation.

Stories from past conflicts highlighted courage and sacrifice, complemented by prayers for justice and peace.

Veteran Peter Beard, Senior Supply Chain Assistant and former Royal Army Medical Corps medic, laid the wreath. Peter served for 13 years, including tours in Kosovo, Bosnia, the Gulf, and Ireland, and shared reflections on the cost of service and the importance of remembrance.

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 Risk Paper - Dec 2025 - Final.pdf

Board of Directors Report

Meeting of the	Board of Directors	4th December 2025
	Part I ☒	**Part II** ☐
Title of Report	Board Assurance Framework (BAF) Report	
Report Author	Simon Regan, Associate Director of Risk & Assurance, Katy Clay, Head of Risk	
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 11 (Compliance with Core Skills Training & Appraisals Doctors) can be controlled • Approve that Principal Risk 16 (Failure to progress the configuration of Trust services to enable the delivery of the clinical strategy for LTHTR and L&SC) 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: • Principal Risk 4 (Timely access to planned and cancer care) - despite improvements seen in referral to treatment times (RTT) and 52 week targets, the Trust is if off trajectory with performance and therefore, the risk score trajectory for reduction has not been met and the score is now off track. • Principal Risk 5 (Timely access to urgent and emergency care) - there has been slippage in performance against targets and the risk remains off track with the planned reduction in risk score. • Principal Risk 6 (Timely access to diagnostics) and Principal Risk 7 (Reliance on temporary medical workforce) have both decreased in score from 16 to 12, in line with their planned trajectory. • Principal Risk 11 (Compliance with Core Skills Training & Appraisals) – the risk score has been reduced from 9 to 6 following Trust wide compliance achieved for all core skills training since July 2025 and closure of the training actions in CQC quality improvement plan. The risk score is now in line with its target score and it is therefore recommended that this risk is controlled. • Principal Risk 12 (Failure to meet the financial plan 2025/26) - discussion at Workforce Committee in November 2025 highlighted challenges around achieving the whole time equivalent (WTE) workforce reduction plan, which has an impact on the 2025/26 waste reduction programme (WRP). Workforce Committee have agreed to 'Alert' the Board of Directors on this matter in	

	December 2025. This has also since been discussed at Finance and Performance Committee in November 2025, with an update requested to the next Committee meeting. • For Principal Risk 15 (Research capacity and capability to enable progress towards University Hospital status) – the target date has been changed to February 2026 and the risk trajectory reset to allow for the establishment of a University Hospital Status working group and finalisation of the project plan. • For Principal Risk 16 (Failure to progress the configuration of Trust services to enable the delivery of the clinical strategy for LTHTR and L&SC) - the risk score has been reduced from 12 to 8 following the approval of the Trust's long term strategy. The risk score is now in line with its target score and it is therefore recommended that this risk is 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:** October & November 2025
Operational Group Review:	Risk Management Group	**Date:** 21 October 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:

- Principal Risk 1 (Patient experience within the urgent and emergency care pathway) – work continues to progress secondary care in-reach support, with Go To Doc now joining the weekly Urgent & Emergency Care huddle. However, this is not yet progressing in line with plan. Further discussions on how to enable this are taking place as part of the integrated leadership team.
- The discussion at Safety and Quality committee in October 2025 questioned the inclusion of inpatient experience into this risk and following review it has been determined the area of risk relates to Medicine and the UEC pathway and this is reflected in the title of the risk, however the actions and detail have been expanded to reflect this.
- The actions and risk have also been updated to reflect the current focus on the staffing and design of the front door model to ensure patients spend as little time as possible in the ED and where they do, the staffing appropriately reflects this to avoid the reliance on bank and agency. The case at Chorley District Hospital (CDH) has progressed in month with the aim of reducing temporary staff to a minimum.
- In relation to Principal Risk 2 (Higher than trajectory rates of clostridioides difficile (C.*difficile*) Infection) – 50% of areas have implemented the national standards of cleaning and cases of C.*difficile* continue to track below trajectory.
- Principal Risk 4 (Timely access to planned and cancer care) - despite improvements seen in referral to treatment times (RTT) and 52 week targets, the Trust is if off trajectory with performance. In addition, a mid-year review has highlighted the size of the waiting list as a priority moving forward. To address this, stretch agreements have been made with partners to reduce the gaps. However, the risk score trajectory for reduction has not been met and the score is now off track.
- Principal Risk 5 (Timely access to urgent and emergency care) - there has been slippage in performance against targets. This has been impacted by recent pressures in urgent and emergency care pathways and the risk remains off track with the planned reduction in risk score.
- Principal Risk 6 (Timely access to diagnostics) - there has been a decrease in score from 16 to 12 in November 2025. Improvements in DM01 performance continued in September and October 2025. Latest performance data shows that DM01 performance was 63.06% for October 2025 against a Trust target of 64.90%, which is a 3.81% improvement since September 2025.

As a result, progress has been made towards achieving the Corporate Objective 'To minimise the risk of harm to patients through the continued delivery of our DM01 recovery plan in line with trajectory', and the risk score has been reduced in line with the planned trajectory.

- Principal Risk 7 (Reliance on temporary medical workforce) – A report was provided to Safety & Quality Committee in September 2025 and given the increased assurances in this area, the current risk score has been reduced from 16 to 12. Further reviews of the score will be undertaken following an update on the progress of the development of the 42-week productivity tool.
- Principal Risk 9 (Sub-optimal experience of Resident Doctors) has been stepped down as a Principal Risk as agreed at the Board of Directors meeting in October 2025.
- Principal Risk 11 (Compliance with Core Skills Training & Appraisals) – The current score has been reduced from 9 to 6 following Trust wide compliance achieved for all core skills training since July 2025. Urgent & Emergency care failed to achieve the training in October 2025 (September data) as projected. This was achieved in November 2025 (October data) and supports closure of the CQC quality improvement plan. It is expected persistent non-compliance will continue to be dealt with in line with Trust policy to support ongoing compliance. The decrease in score now brings this risk in line with its target score and, as such it is recommended that this risk is now controlled.
- Principal Risk 12 (Failure to meet the financial plan 2025/26) - discussion at Workforce Committee in November 2025 highlighted challenges around achieving the whole time equivalent (WTE) workforce reduction plan, which has an impact on the 2025/26 waste reduction programme (WRP). Workforce Committee have agreed to 'Alert' the Board of Directors on this matter in December 2025. It is noted that neighbouring organisations are also facing similar challenges and the Chief People Officer is liaising with them to understand potential further steps for action. This has also since been discussed at Finance and Performance Committee in November 2025, with an update requested to the next Committee meeting.
- For Principal Risk 15 (Research capacity and capability to enable progress towards University Hospital status) – the target date has been changed to February 2026 and the risk trajectory reset to allow for the establishment of a University Hospital Status working group and finalisation of the project plan.
- For Principal Risk 16 (Failure to progress the configuration of Trust services to enable the delivery of the clinical strategy for LTHTR and L&SC) - the risk score has been reduced from 12 to 8 following the approval of the Trust's long term strategy at the Board of Directors meeting in October 2025. As the risk is now at the target score of 8, which is also within the Board's agreed Risk Tolerance, it is recommended that this risk is now controlled.

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

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 11 (Compliance with Core Skills Training & Appraisals Doctors) can be controlled.
- Approve that Principal Risk 16 (Failure to progress the configuration of Trust services to enable the delivery of the clinical strategy for LTHTR and L&SC) can be controlled.

Lancashire Teaching Hospitals
NHS Foundation Trust

Board Assurance Framework

2025/26

Board of Directors – December 2025

Patients – deliver excellent care

Performance – deliver timely, effective care

People – be a great place to work

Productivity – delivery value for money

Partnership – be fit for the future

How the Board Assurance Framework fits in

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

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

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

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

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

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

Understanding the Board Assurance Framework

Risk Rating Matrix (Likelihood x Consequence)

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

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

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

Our strategic approach at a glance

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

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

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

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

Lancashire & South Cumbria New Hospitals Programme

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

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

Single Improvement Plan

Partnerships | People | Patients | Productivity | Performance

Strategic Objectives

Patients – deliver excellent care
Improve outcomes, reduce harm and deliver a positive patient experience

Performance – deliver timely, effective care
Deliver agreed trajectories in clinical performance

People – be a great place to work
Create an inclusive culture with leaders at every level leading colleague engagement

Productivity – deliver value for money
Deliver the agreed financial plan including waste reduction programme, maximising use of resources

Partnership – be fit for the future
Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions

2025/26 Corporate Objectives

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

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

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

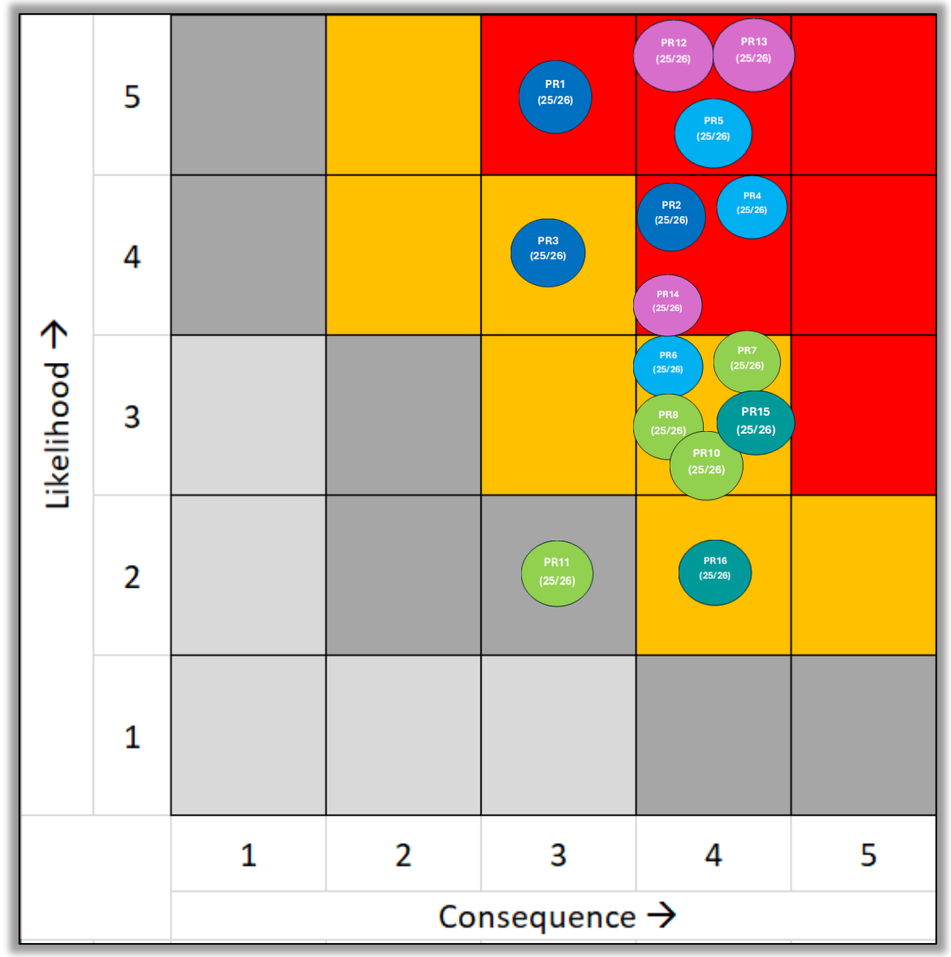
Productivity
- To provide value for money services by spending less, spending well and spending wisely
- To deliver sustained improvement evidenced through the single improvement plan
- Improve our underlying productivity and efficiency
- To develop a clinical services strategy for the organisation

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

Principal Risk Management

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

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



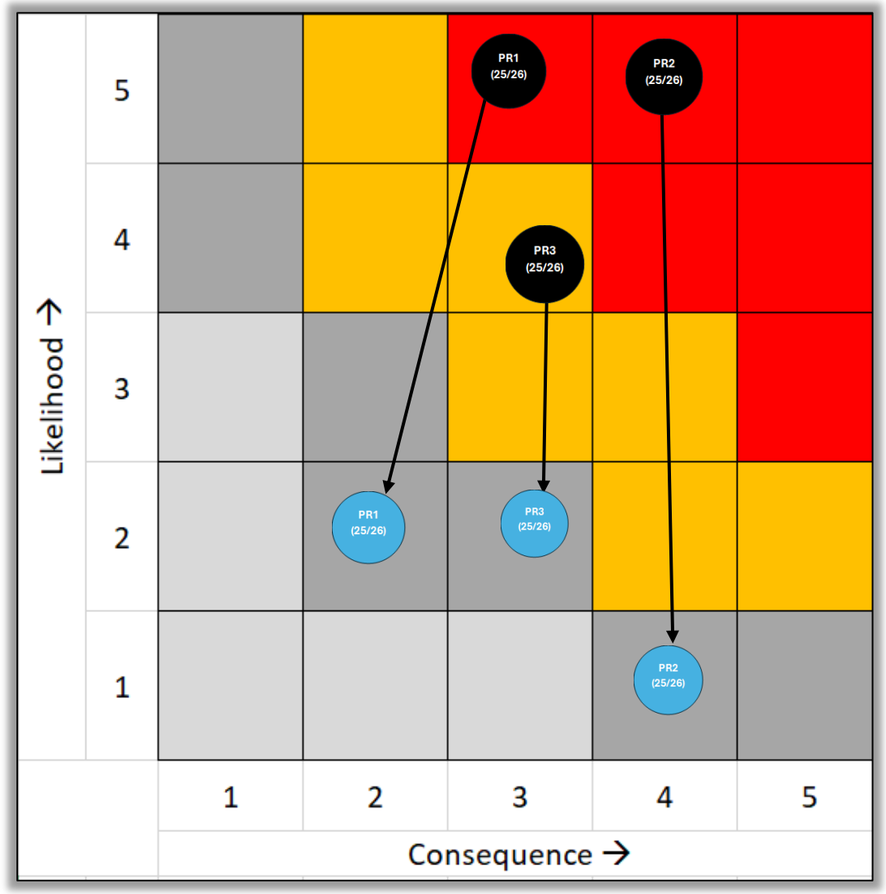
Key- Dark Blue = Patients, Light Blue = Performance, Green = People, Pink = Productivity, Turquoise - Partnership

Patients: Deliver excellent care

Monitored through Safety & Quality Committee

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

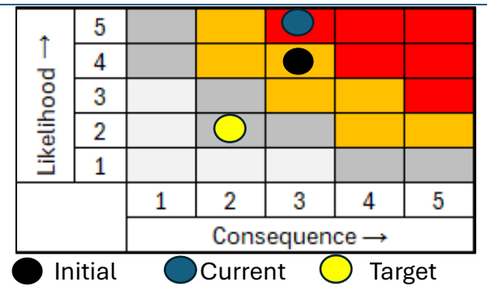
Ref.	Purpose of the objective	Scope and Focus of the Objective	Status
CO1	Improve outcomes and prevent harm	• Design a new medical model for UEC pathways. • Improvement to meet the average time to see a clinician in ED standard • Internal professional standards will be met by each specialty • Develop 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



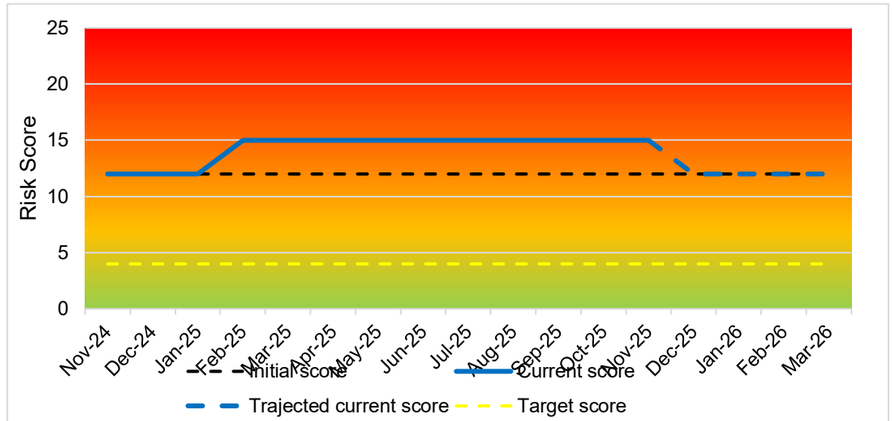
Heat map key: Black = current score, Blue = target score

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	14/11/25	
		Target control date	31/07/26	



Risk Score Tracker



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

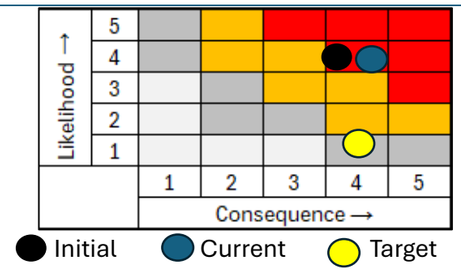
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Patient experience and Involvement Strategy. • Patient Experience & Involvement Group. • Single Improvement Plan related to patient experience. • National OPEL Framework. • L&SC daily Gold Command meetings. • Escalation Plan (including Full Capacity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

Risk Treatment

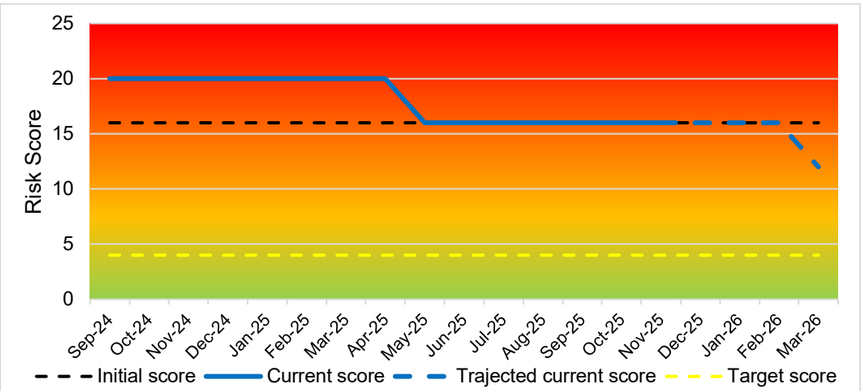
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Implement approach to days kept away from home to reduce length of stay that leads to prolonged waits in the ED.	K. Foster Greenwood	30.09.25	30.09.25	Oct 25 – Roll out continued and now in place for 16 wards
Develop tripartite plan with ICB and LCC to reduce number of patient spending time in hospital when no longer a requirement for their condition	S. Morrison	30.09.25	30.09.25	Oct 25 - Agreed to focus on 3 immediate actions. One is to place a social worker in the discharge and 2 hour response team. The second is to commission additional care hours for 2 hour urgent response. The third is to place a social worker with the admission avoidance team. Agreement to develop metrics to improve oversight of delays. Attendance at BCF Board now in place to enable influence of allocation of BCF. This work will continue to require focus and is part of the UEC performance improvement plan.
Increase capacity in care connexions	S. Morrison	~~30.11.25~~ 30.01.26		Nov 25: Go To Doc now joined weekly UEC improvement huddle, secondary care inreach support commenced. This is not yet progressing in line with plan. Further discussions on how to enable this are taking place as part of the integrated leadership team. Target date changed to reflect this.
Develop case to address staffing shortfalls leading to persistent variations in staffing in CDH ED.	S. Morrison	12.11.25	12.11.25	Nov 25: Case agreed leading to the conversion of persistent bank and agency to strengthen consistency of care and experience.
Assess the configuration of bed base to determine the most appropriate model for RPH ED.	S. Morrison	31.12.25		Nov 25: 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 project is underway to determine the most effective configuration to reduce the time patients spend waiting in ED.
Revaluate staffing model in ED RPH to reduce the use of bank and agency leading to improved consistency of care delivery in ED.	S. Morrison	31.12.25		Nov 25: Following the length of stay analysis and outcomes of a newly created capacity oversight group that is meeting on a twice weekly basis, a recommendation will be made that seeks to reduce the time patients spend in the ED.
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		Nov 25: Draft plans created for the new unit. Next stages include the submission of a business case prior to NHS England agreeing the release of capital.

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	14/11/25	
		Target control date	31/03/26	



Risk Score Tracker



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

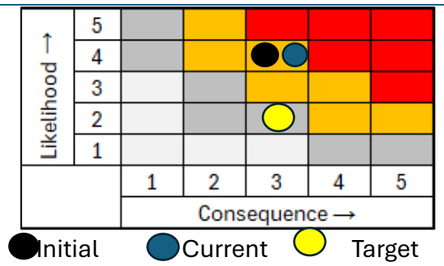
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Annual IPC Plan in place approved by IPCC and Trust Board. • IPC Policy in place. • Director for IPC and Matron for IPC in place. • Mandatory annual IPC e-learning core skills for all staff. • Antimicrobial pharmacist in post to drive improvements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

Risk Treatment

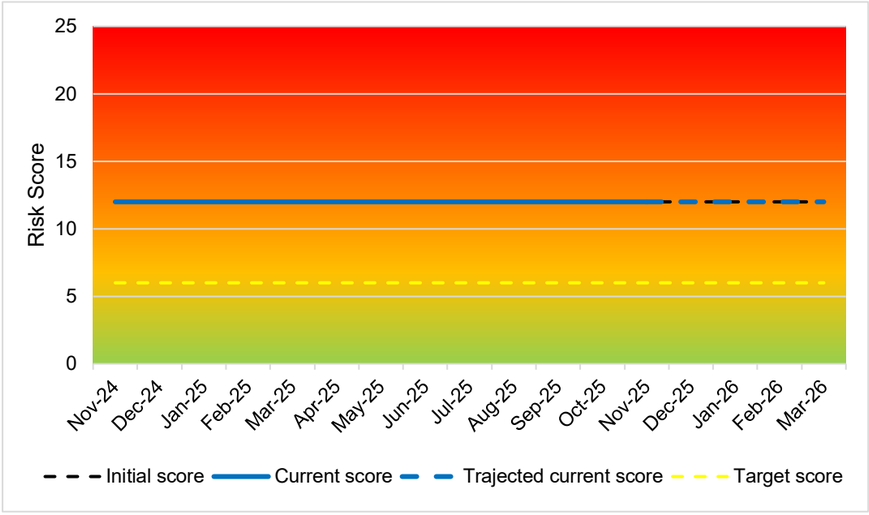
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Implement the national cleaning standards phase 2 of 3.	C. Gregory/ J. Ashley	31.10.25	24.10.25	Oct 25: 50% now in place and complete.
Continue to implement the C.difficile improvement plan monitoring effectiveness through infection prevention and control committee	C. Gregory	31.03.26		Nov 25: Annual objective for 2025/26 from the ICB. This equates to 167. Number of cases as at the end of October 2025 was 90. Outcomes are on track and 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		Nov 25: Compliance at 50%. Full implementation planned by 31.03.26.

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

Principal risk 3 (25/26) (ID 2103)	Risk Title:	People experiencing Health inequalities		
	Risk Description:	There is a risk that the Trust will be unable to effectively address health inequalities because of disparities in access to healthcare services, social determinants of health (such as socioeconomic status, education, and housing conditions), commissioning arrangements, and unequal distribution of resources across communities. This could result in poorer health outcomes for disadvantaged groups, increased pressure on acute and emergency services, reduced patient satisfaction, potential reputational damage for the Trust, non-compliance with regulatory standards and missed opportunities for improving population health. The Trust is part of a wider system approach to health improvement and will work with partners to affect this, recognising the limitations of single services in affecting outcomes in a material way for people.		
Committee	Safety & Quality	Risk Appetite and Tolerance	Cautious 1-6	
Director	Chief Nursing Officer	5Ts status	Treat	
Date risk opened	05/12/24	Date of last review	14/11/25	
		Target control date	31/03/27	



Risk Score Tracker



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

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

Risk Treatment

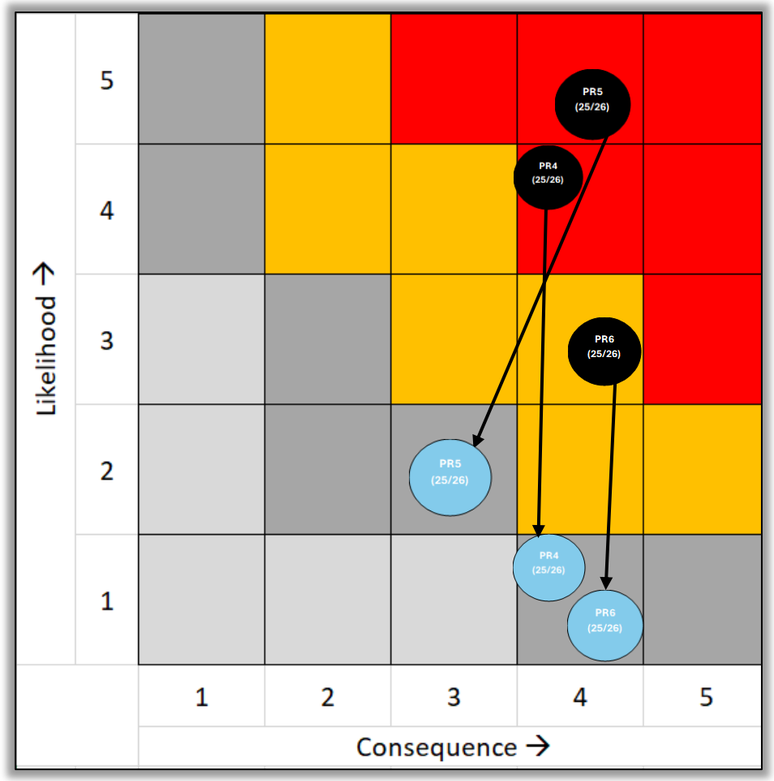
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Finalise Anchor Institute Plan, now named the Social Value Strategy	N. Pease	~~30.09.25~~ 30.11.25		Oct 25: The Social Value Strategy agreed at Board in August 2025. Anchor Institute Plan development underway and re-profiled for end of November.
Identify approach to driving health inequalities reduction through each portfolio of the single improvement plan	S. Morrison	31.12.25		Sept 25: Recruitment to PMO underway to provide SIP programme leadership and will support the development of this in H2.
Support case to approve the data sharing agreements between primary and secondary care.	~~S. Dobson~~ A. Brotherton	31.12.25		Nov 25: Executive Lead now Ailsa Brotherton for digital. The action reflects this but is a reflection of a OneLSC data sharing approach being negotiated with the ICB.
Delivery of the Trust's Health Improvement Plan through the three main strategic drivers 1. Awareness 2. Culture 3. Prevention	S. Morrison	31.03.26		Sept 2025: Plan on a page approved through health inequalities group to enable communications plan to commence. The Safety and Quality committee will receive a twice yearly update on progress against the agreed actions within the health improvement plan evidencing the Trusts contribution towards this.

Performance: Deliver timely, effective care

Monitored through Finance & Performance Committee

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

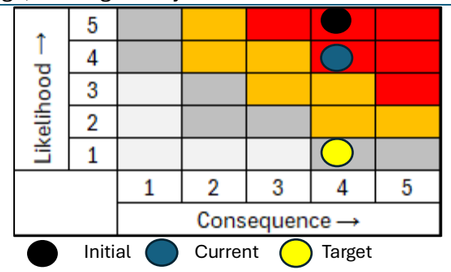
Ref.	Purpose of the objective	Scope and Focus of the Objective	Status
CO5	To minimise the risk of harm to patients through the continued delivery of our cancer recovery plan	• Delivery of more elective care to further improve performance against cancer waiting times standards. • Working in partnership 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



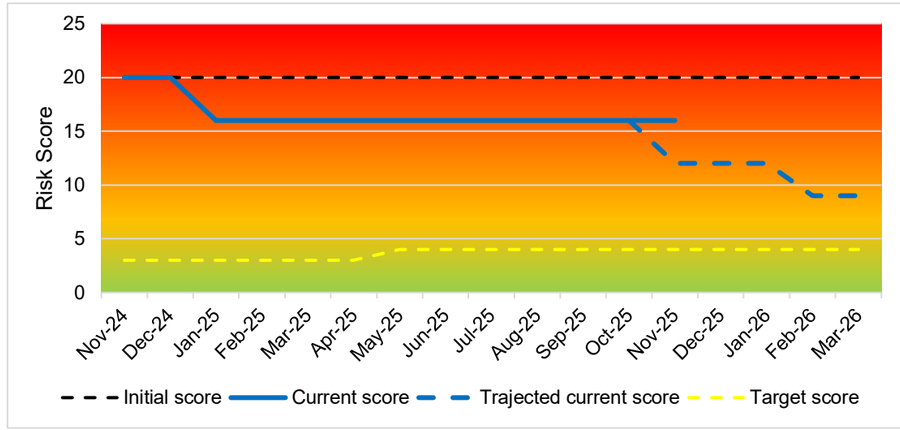
Heat map key: Black = current score, Blue = target score

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	05/11/25
		Target control date	31/03/26



Risk Score Tracker



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

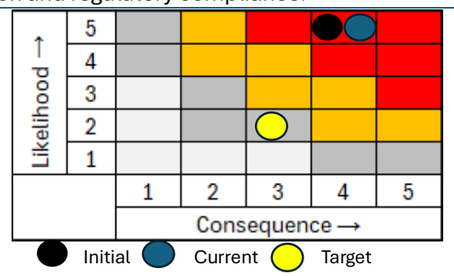
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• 25/26 Annual activity & Performance plans have been outlined to seek to deliver reduction in long waiting RTT targets. Plans include monthly trajectories and associated action plans. • Clear identification of clinical priorities via the use of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

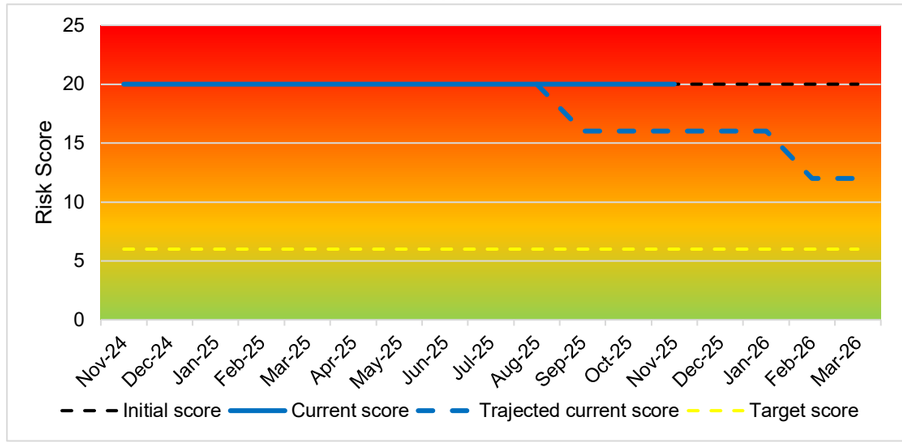
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Review of validation processes across L&SC to agree standardisation	L. Walsh	30.09.25	30.09.25	Oct 25: Validation policies have been reviewed across all L&SC providers and the L&SC Deputy COOs have drafted a standardised policy.
Mobilise schemes supported by non-recurrent Cancer alliance funds	K. Foster-Greenwood	31.10.25	31.10.25	Nov 25: Action completed
Mobilise commissioning of H2 business case for additional outsourced non recurrent capacity in key specialty areas.	K. Foster-Greenwood	~~31.10.25~~ 14.11.25		Nov 25 : Mobilisation has been delayed due to private provider site change and requirement for revised CQC registration. Mobilisation now forecast mid Nov 25.
Submit Recovery Transformation Fund bids to NHSE	K. Foster-Greenwood	01.11.25		Nov 25: Original bid rejected. Revised L&SC bid submitted – await response.
Agree and implement L&SC validation policy	L. Walsh	31.12.25		Nov 25: Alignment of policy completed. Governance ratification within provider Trusts underway.
Review of booking, scheduling and administrative resource benchmarking options	K. Foster-Greenwood	31.03.26		Aug 25: PWC partners have been scoping the transformation programme. There is also an ongoing review of the admin capacity vacancy factor for Administrative & Clerical reduction to 10%.

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

Principal risk 5 (25/26) (ID 2104)	Risk Title:	Timely access to urgent and emergency care	
	Risk Description:	There is a risk that patients may experience delays in timely access to urgent and emergency care because of high demand, insufficient out of hospital provision for patients who do not meet the criteria to reside in hospital, limited bed availability, workforce shortages, and delays in patient flow throughout the hospital and community. This could result in longer waiting times, compromised patient safety and experience, increased clinical risk, poorer health outcomes, and potential breaches of national performance targets, impacting the Trust's reputation and regulatory compliance.	
Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious 1-6
Director	Chief Operating Officer	5Ts status	Treat
Date risk opened	05/12/24	Date of last review	05/11/25
		Target control date	31/03/26



Risk Score Tracker



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

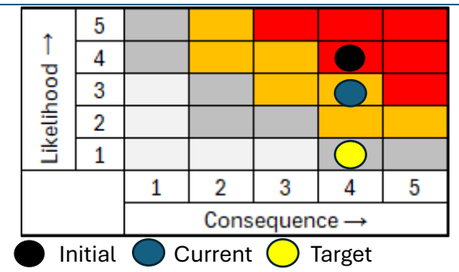
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Clinical triage processes are established. • OPEL and internal Site Pressure Score Framework and protocols are in place • L&SC daily Gold Command meetings. • Escalation and Surge Plans defined and in place. • Ambulatory and admission avoidance pathways established. • Same Day Emergency Care facilities in place. • Urgent care service provided by a third party co-located on both CDH and RPH sites. • Single Improvement Plan and Board established to track improvement delivery. • Central Lancs system wide UEC & Community Improvement Plan focusing on Hospital @ Home pathways and capacity and Days Kept Away from Home established. • Site Pressure Management processes, meetings and associated action cards established. • Clinical discharge team management of all patients classified as Days Kept Away from Home. • Virtual Ward capacity to support admission avoidance and early step down from hospital. • Care connections coordination function in place to link hospital and community provisions. • Continuous Flow Model is established to drive timely flow. • Ward & Board round process standardisation programme established. • 45 min Release to Rescue protocol implemented • 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

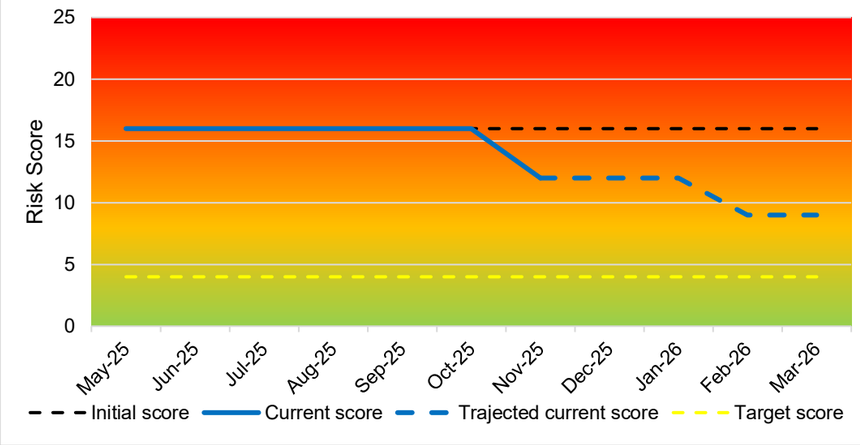
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Establish the See & Sort streaming provision	D. Bedford	31.10.25	31.10.25	Nov 25: Action completed
Undertake the Emergency Care Intensive Support Team (ECIST) Capacity and Demand Model	D Bedford	~~31.10.25~~ 30.11.25		Nov 25: ECIST work commenced. Deadline extended to end Nov 25
Review of VW model and funding	L Walsh/C Gregory	~~31.10.25~~ 31.12.25		Nov 25: Initial review of VW model completed and vacant posts aligned moved to VW budget. 2 x ACP posts remain in medicine which need to be moved across but dependent on other moves within medicine. Generalist model workshop planned for December 25.
Review the Emergency Village Model of Care with ECIST support	D Bedford	31.12.25		Nov 25: ECIST review commenced.
Conclude and evaluate Ward & Board round standardisation	R Sansbury	31.03.26		Apr 25: New action identified
Increase Virtual Ward occupancy to minimum of 75% by March 2026.	L. Walsh	31.03.26		Nov 25: Increased utilisation in VW during Oct, averaging 63% occupancy. Daily sitrep in place to drive increased activity via site team

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	05/11/25	
		Target Control date	31/03/26	



Risk Score Tracker



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

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

Risk Treatment

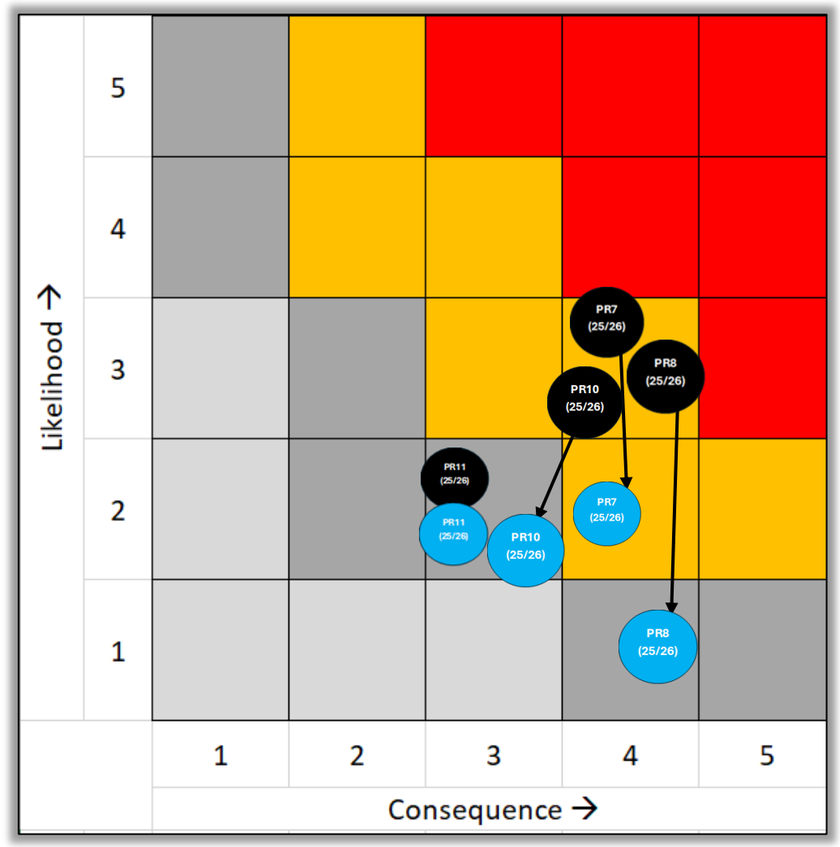
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Review internal demand utilisation benchmarking data and agree actions	K. Foster-Greenwood	31.10.25	31.10.25	Nov 25: Action completed. New action re establishing agreed demand reduction actions following data analysis.
Complete the build and mobilisation of additional endoscopy space	K. Foster-Greenwood	~~31.10.25~~ 28.02.26		Nov 25: Estates update suggests delayed until Feb 26
Mobilise commissioning of H2 non recurrent outsourcing business case	K. Foster-Greenwood	~~31.10.25~~ 14.11.25		Nov 25 : Mobilisation has been delayed due to private provider site change and requirement for revised CQC registration. Mobilisation now forecast mid Nov 25.
Review options to introduce Diagnostic utilisation into Control Room	K. Foster-Greenwood	15.11.25	15.11.25	Nov 25: Action completed.
Recruit workforce in line with 5th room business case	D. O'Brien	30.11.25		Sept 25: Recruitment ongoing
Establish internal demand management controls using the benchmarking data	D. O'Brien	31.12.25		Nov 25: New action identified

People: Be a Great Place to Work

Monitored through Workforce Committee & Education, Training & Research Committee

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

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

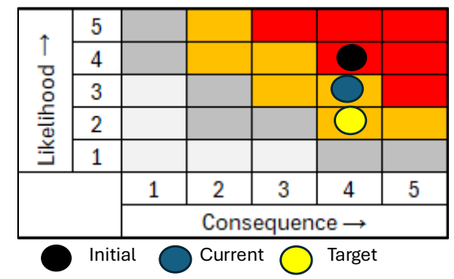


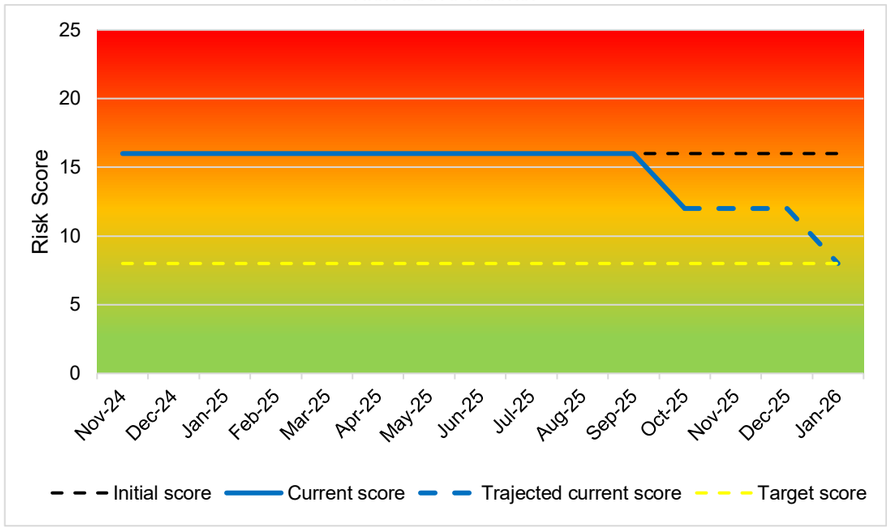
Heat map key: Black = current score, Blue = target score

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

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

Committee	Workforce Committee	Risk Appetite and Tolerance	Open 4-8
Director	Chief Medical Officer	5Ts status	Treat
Date risk opened	05/12/2024	Date of last review	23/10/25
		Target control date	31/01/26





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)

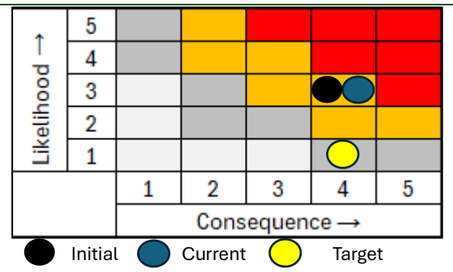
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Medical and Dental Job Planning Policy. • Medical Annual Leave policy in place. • Job plans in place for Consultants and Speciality Doctors. Agreed annually as a prospective plan. • Daily Management System in place to aid understanding of temporary workforce in a timely manner. • Processes for changes in job plans where this occurs in-year. • Healthroster system used to manage rotas. • Medical bank in place. • On-call system in place outside of normal working hours (built into job plans). • Non-medical roles for certain specialities to reduce the need for medical input (i.e. Advanced Nurse Practitioners, Consultant AHP roles, physician associates). • Enhanced grip and control measures for the use of temporary medical and agency staff.	• Inconsistent capacity and demand modelling across specialities. • Healthroster not fully aligned to job plans and when job plans are changed. • Operational capacity and technical ability to monitor 42-week productivity against job plans. • Vacancies in hard to recruit specialities can cause long gaps. • Understanding of speciality-by-speciality minimum safe staffing levels. • Sufficient resource to deliver transformational medical staffing projects. • Monitoring of actioning of Medical Annual Leave policy. • Retrospective additions of bank/agency shifts can be misleading for the Daily Management System	<u>Level 1 Assurance</u> • Monthly processes in place to review opportunities based on pay activity. • Monitoring of patients seen by a clinician within 14 hours of admission. • Monitoring of patients seen by a clinician following initial assessment. • Utilisation of agency medical staff reported to Temporary Staffing & Rostering Group each month. • Agency hours per month have halved in the period July 2024 – June 2025. <u>Level 2 Assurance</u> • Annual Job plan report to Workforce Committee. • Quarterly medical safe staffing report to Safety & Quality Committee. <u>Level 3 Assurance</u> [None detailed]	• Delays in patients accessing senior medical reviews consistently in all specialties • Inability to articulate the required medical staffing model. • Inability to report on safe staffing levels in relation to medical staffing in response to CQC must do • Absence of robust 42-week monitoring of activity between Healthroster and L2P job plan software. • Requirement to strengthen consistency between ledger and vacancies. • Reports do not readily differentiate short term bookings from long term agency/bank staff.

Risk Treatment

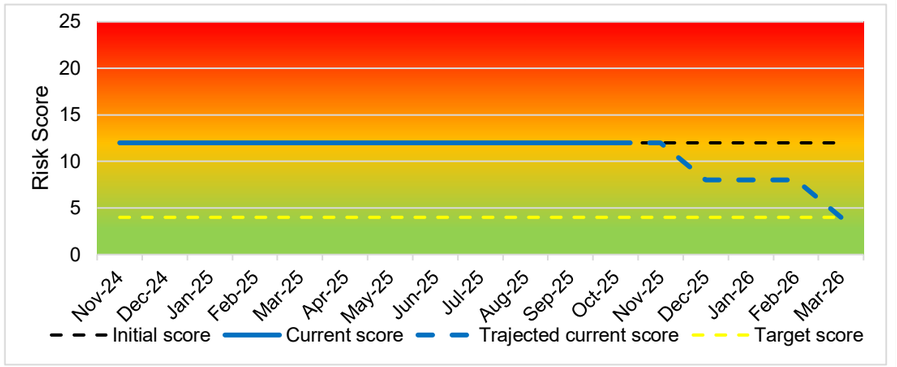
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Development of 42-week productivity tool	M. Stewart	~~30.09.25~~ 31.12.25		Oct 25: The work on aligning Healthroster with job plans is commencing, and the speciality-specific reconciliation will begin w/c 3rd November. Once the first few specialities are done, extracting the data and formally comparing delivered against planned can commence and building the tools that will be needed to give the forward assurance.

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	23/10/25
		Target control date	31/03/26



Risk Score Tracker



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

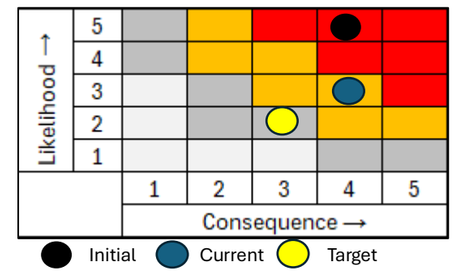
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Our People Plan • Corporate level action plan in response to NHS Staff Satisfaction Survey results. • Team Engagement and Development (TED) Tool and toolkit, supporting leaders to take local action to improve levels of engagement and satisfaction.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

Risk Treatment

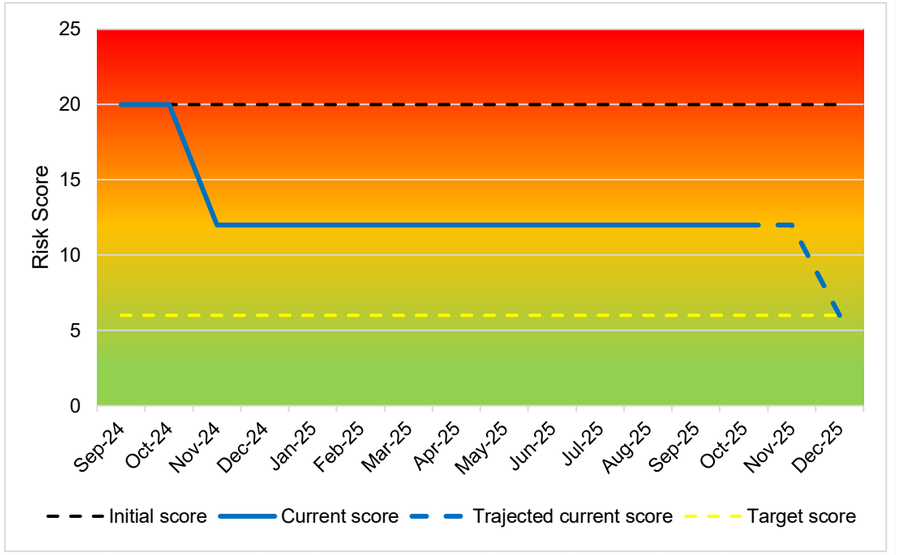
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Work to be undertaken in conjunction with the Living with Disability forum to understand more about bullying and harassment	M Davis	~~30.09.25~~ 30.01.26		Oct 25: Forum chairs have advised that Bullying & Harassment has been discussed in the forum; lived experiences have been captured and there are a number of colleagues who are being supported. The forum is wanting to undertake associated actions throughout Disability History Month (mid Nov-mid Dec) so results will be available Jan 2026. Due date amended to 30.01.26 to reflect that
Work to be undertaken in conjunction with the Ethnicity forum to understand more about discrimination statistics	M Davis	~~30.09.25~~ 31.12.25		Oct 25: WRES data presented to Ethnicity forum in September meeting. The Chief Executive has asked Head of Diversity & Organisational Development to present to Trust Management Board in November 2025. Discussions in the forum meeting about colleague experience in light of national discussions/actions in respect of St George's flag. Comms issued to advise colleagues of appropriate behaviours in work and to highlight that colleagues are to report instances of discriminatory behaviour. Due date amended to end of 2025 to account for additional actions required.
Increasing the diversity of colleagues in band 8a and above as per WRES/WDES annual report	M. Davis	31.12.25		Aug 25: Statistics regarding movement of non-clinical and clinical staff under BME, LTC and Disability categories in 2024/25 has been captured, with the acknowledgement that some movement is due to staff TUPEing out of the Trust into OneLSC. The Leadership & OD team are to review the Talent Management strategy and offer across the organisation before the end of 2025. Leadership development opportunities have been proactively shared with BME colleagues and colleagues with a LTC/Disability and this will continue.
Increased use of TED	S. Kenny	31.03.26		Oct 25: This is included within the revised Engagement Offer
Delivery of actions in NHS Staff Survey Action Plan	S. Kenny	31.03.26		Oct 25: This is included within the revised Engagement Offer

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	23/10/25	
		Target control date	31/12/25	



Risk Score Tracker



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

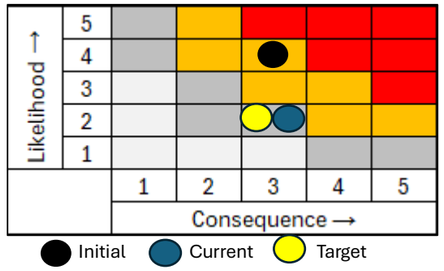
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Sickness Absence Policy in place. • Core People Management Skills training in place. • Monthly reports to Divisions - check & challenge. • Accountability Framework in place which has recently been refreshed. • Toolkits and templates for Managers. • "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

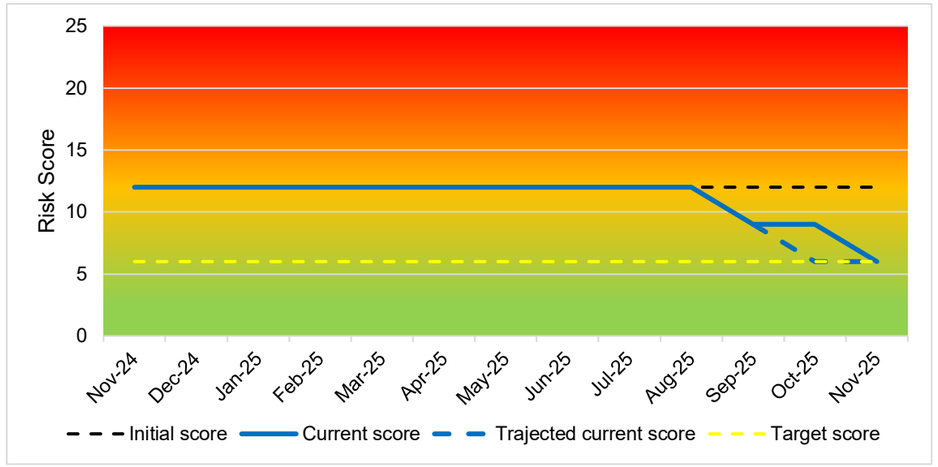
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Pilot Empactis as a digital absence management system	R. O'Brien	~~31.10.25~~ 30.11.25		Oct 25: Implementation timescale revised to the end of November 2025 due to difficulties with Electronic Staff Record interface which are still being resolved. User Acceptance Testing will commence early November 2025.
Introduce Occupational Therapist into Occupational Health model	R. O'Brien	~~31.10.25~~ 31.12.25		Oct 25: Funding for the OT post is not available. An investment case is being compiled and due date has been extended accordingly
Deliver absence reduction 'plan on a page' against 4 key workstreams	R. O'Brien	31.12.25		Oct 25: multiple actions are in progress. 2 new Workforce Advisers have commenced in post, plus 1 Workforce Officer is acting up to cover 1 Workforce Adviser maternity leave. There has therefore been an increase in advisory capacity, however there are still gaps. Recruitment to the 2nd Workforce Adviser maternity cover has been unsuccessful, and there are 2 Workforce Officer gaps due to acting up and long-term sickness. Occupational Health Physiotherapy is now fully established, enabling the progression of proactive actions to prevent and reduce musculoskeletal absence. A fixed term Psychologist is also now in post, although the benefit of this additional capacity is not currently being felt, as within the Psychological Wellbeing service, there are 3 colleagues absent due to long-term sickness.

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

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



Risk Score Tracker



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

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Core skills training framework (CSTF). • Training needs analysis. • Corporate Induction process. • Local Induction process. • Appraisal Policy. • Appraisal Policy for Medical and Dental colleagues. • Accountability Framework. • Self-service e-learning and appraisal platform. • Regular review of target audiences with Clinical Educators and Divisional leadership. • Training Compliance and Assurance Sub-Committee govern any proposed changes to Core Skills topics. • Monthly emails to staff to show compliance with training and appraisals and any areas that are due to expire. • Weekly reminder to staff who are out of date with Core Skills training. • 'Super red' tool produced to support the divisions in identifying staff who have more than 1 super red topic. • Monthly meetings take place between Training Performance and Compliance and Divisional Nursing Directors to review target audiences and complete approval for sign off of any changes. • Training reports map directly to CQC core services, by professional group. • Enhanced controls in place for staff who are persistently non-compliant with Core Skills training. This includes applying performance and disciplinary measures as required and has been endorsed by ETR Committee, and through the communications issued by the Executive Team.	• Nationally set Core Skills training framework.	<u>Level1 Assurance</u> • Training & Appraisal Compliance report - produced monthly and sent to divisional and corporate leaders. • Regular provisions and/or presentation of compliance including Core Skills training report to Divisional Workforce Committees. • Trust wide compliance achieved for all Core Skills, Mandatory training and appraisal for two consecutive months from July 2025. • Divisional compliance achieved for all Core Skills, Mandatory training and appraisal across all divisions and in areas identified as regulatory breaches by CQC. <u>Level 2 Assurance</u> • Reports to Training, Compliance and Assurance sub-committee. • Training and Appraisal reports to Divisional Improvement Forums. • Bi-monthly Education Training and Research committee reports to escalate gaps and assurances in plans to rectify. • Annual Appraisal Strategic Update report to Workforce Committee. <u>Level 3 Assurance</u> • Integrated Board Performance Report. • NHS Staff Survey Results	• [None]

Risk Treatment

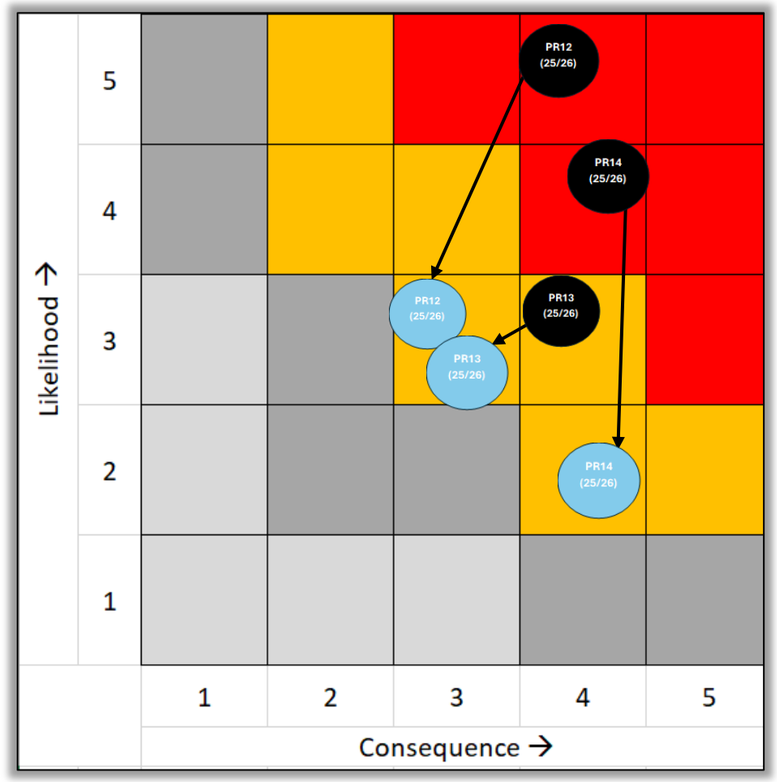
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Review one further month's data in October 2025 to obtain assurance that risk is controlled	L. O'Brien	~~15.10.25~~ 15.11.25	15.11.25	Nov 25: Trust wide compliance has been achieved for all core skills training since July 2025. Urgent & Emergency care failed to achieve the training in October 2025 (September data) as projected. This was achieved in November 2025 (October data) and supports closure of the CQC quality improvement plan. It is expected persistent non-compliance will continue to be dealt with in line with Trust policy to support ongoing compliance.

Productivity: Deliver value for money

Monitored through Finance & Performance Committee

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

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

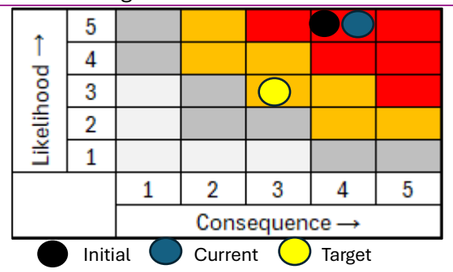


Heat map key: Black = current score, Blue = target score

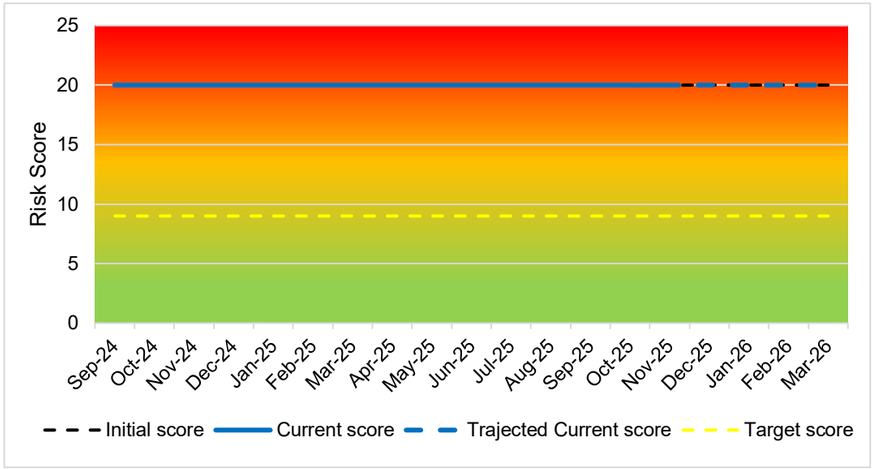
Strategic Objective: Productivity	**Corporate Objective:** Provide value for money services by spending less, spending well and spending wisely	Overall Assurance Level	Low

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

Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious 8-12
Director	Chief Finance Officer	5Ts status	Treat
Date risk opened	03/06/24	Date of last review	11/11/25
		Target control date	31/03/26



Risk Score Tracker



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

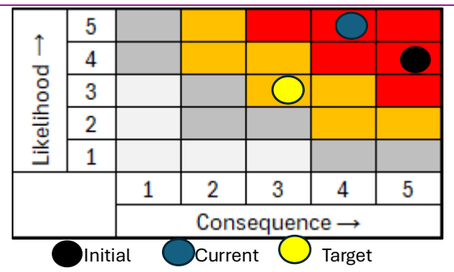
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Financial plan set at the start of the year - common assumptions and principles agreed collaboratively within the ICS. • Financial plan triangulated with activity and workforce plans. • The Standing Orders, Standing Financial Instructions and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

Risk Treatment

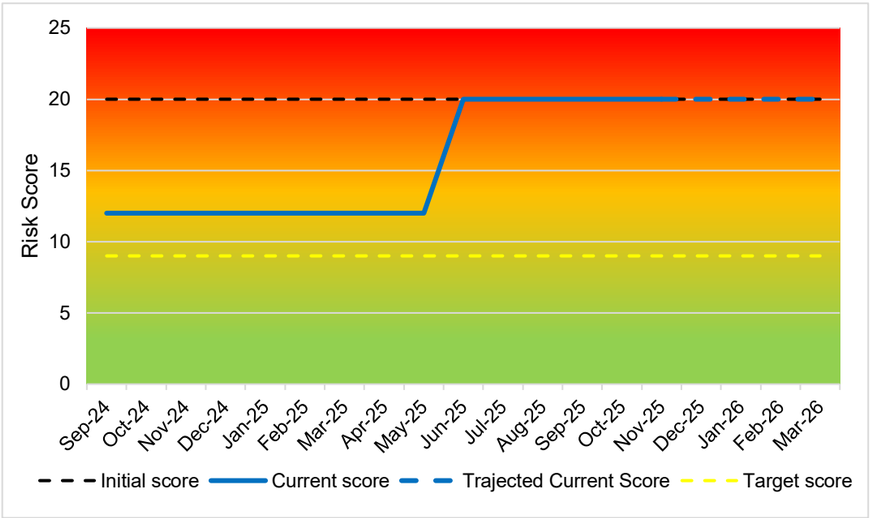
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Internal audit assessment of grip and control actions and Trust's current position	C. Carter	~~31.10.25~~ 31.01.26		Nov 25: Grip and Control report update prepared and shared with Trust Management Board 12.11.25. Quarterly assessment also scheduled into FPC cycle of business. Internal Audit report to be finalised with management responses by end Nov 2025 and will be reported back to Audit Committee in January 2026.
External support obtained until end of Quarter 1 to further develop schemes and support programme management capacity	C. Carter	31.12.25		Nov 25: Deputy Director of PMO has commenced in post. Further support has now been requested via RSP Team for further development of the Trust's Financial Stability Plan (FSP) in Quarter 4 25/26.

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	11/11/25
		Target control date	31/03/26



Risk Score Tracker



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

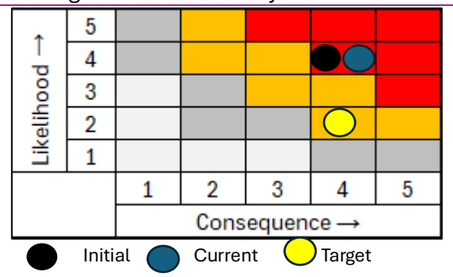
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Cash Management committee in place. • Annual cash plan in place. • Committee approved cash management policy on prioritisation of supplier payments. • Monthly cash flow forecasting. • Management of working capital balances. • Review of capital 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

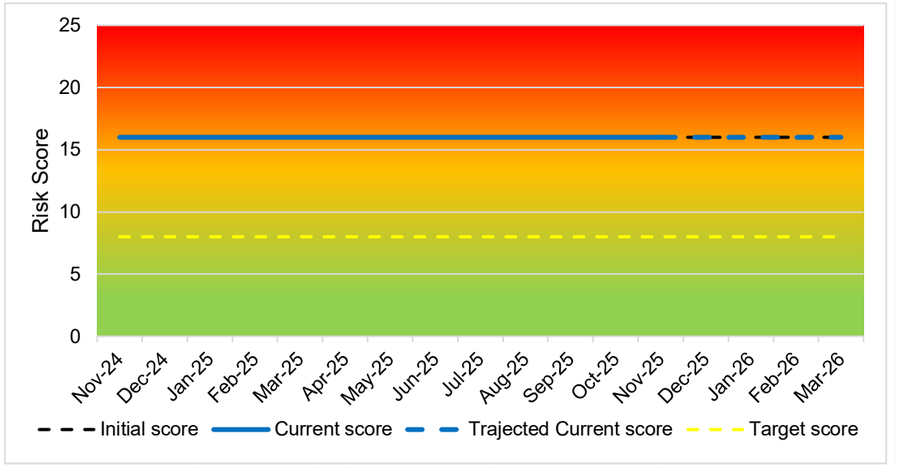
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Timely submissions to NHSE for cash support with Board of Director approval	C. McGourty	~~31.10.25~~ 31.12.25		Nov 25: Formal request to NHSE following Board approval for £10.5 million.

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	11/11/25	
		Target control date	31/03/26	



Risk Score Tracker



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

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

Risk Treatment

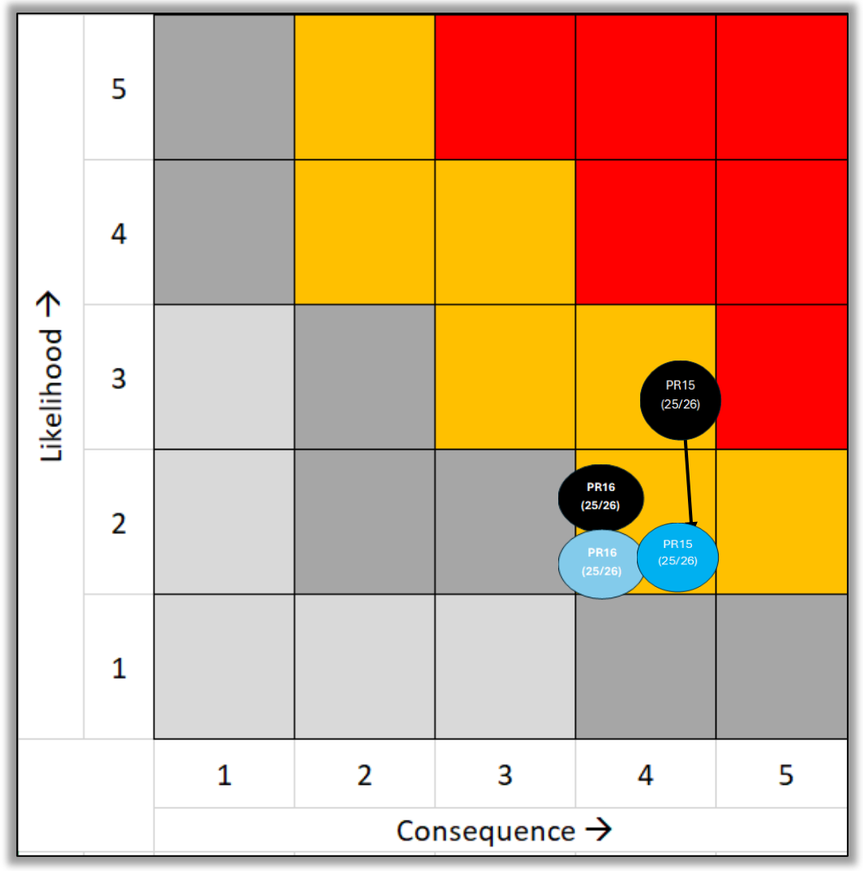
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Review approach to management and reporting of project spend at Capital Planning Forum	C. Carter	31.10.25	31.10.25	Nov 25: Trust has now developed a new overview report for Capital Group, summarising the whole programme with key forecast information included.
Develop Estates Strategy	S. Ashworth	~~30.11.25~~ 28.02.26		Nov 25: Draft Estates Strategy has now been completed and shared with senior Strategy Team prior to being taken through relevant governance processes for finalisation and publication.

Partnership: Be Fit for the Future

Monitored as indicated through the relevant Committee of the Board

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

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

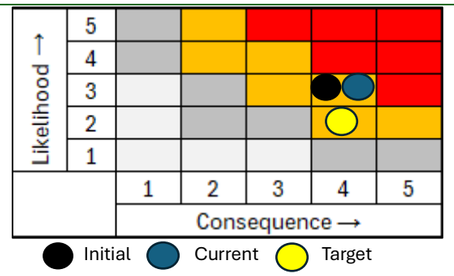


Heat map key: Black = current score, Blue = target score

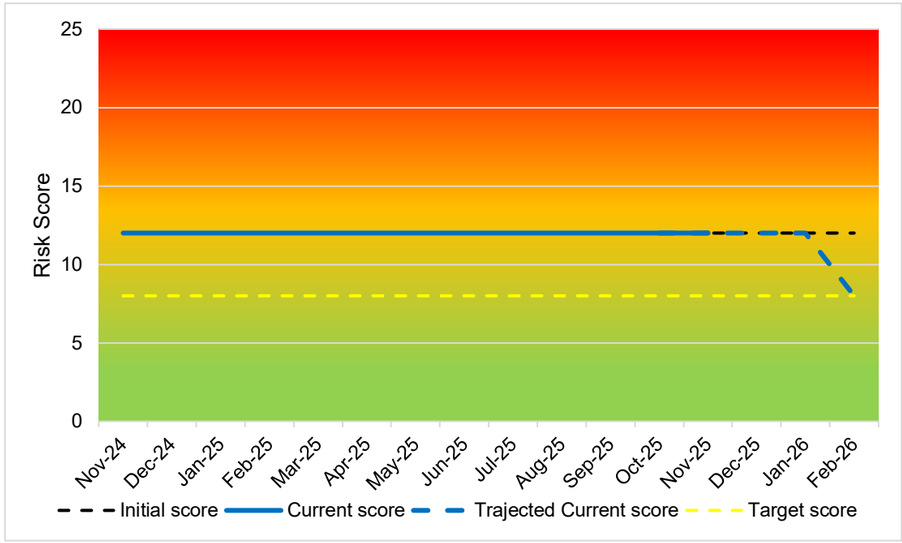
Strategic Objective: Partnership	**Corporate Objective:** To make progress towards our ambition to be a University Teaching Hospital	Overall Assurance Level	Medium

Principal risk 15 (25/26) (ID 2113)	Risk Title:	Research capacity and capability to enable progress towards University Hospital status	
	Risk Description:	There is a risk that the research capacity and capability of the Trust may be insufficient to support the longer-term objectives of becoming a University Teaching Hospital. This is because of limitations of the Trust and potential partners in relation to funding, workforce constraints, lack of dedicated research time for clinical staff, lack of established clinical academics in L&SC and the need for an enhanced infrastructure to support research activities. This could result in missed opportunities for innovation and improvement in patient care, difficulty attracting and retaining talented research staff, an inability to advance the Trust's reputation as a leader in research and clinical excellence and the income generation associated with University Hospital opportunities.	

Committee	Education, Training & Research	Risk Appetite and Tolerance	Seek 9-12
Director	Chief Strategy and Improvement Officer, and Chief Medical Officer	5Ts status	Treat
Date risk opened	05/12/2024	Date of last review	26/11/25
		Target control date	~~31/12/25~~ 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.

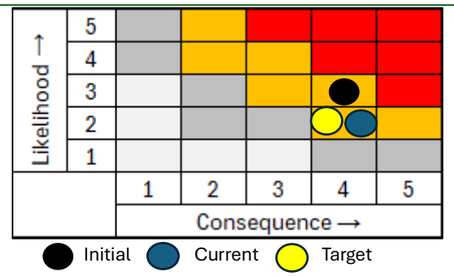
Risk Treatment

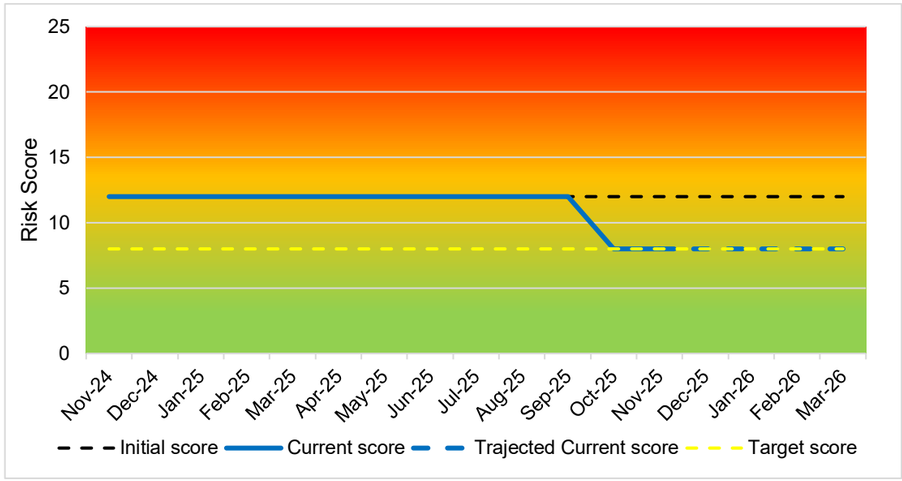
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Formulate a clear project plan to develop partnerships with potential University partners to explore UH status. This will include plans to engage the clinical teams in the specialities to support these to come to fruition.	P. Brown/ P. Martin-Hirsch/S. Canty	~~31.10.25~~ 28.02.26		Nov 25: A paper was presented to the executive team on 17th November 2025 with agreed recommendation to establish a University Hospital Status Working Group commencing January 2026. The project plan and milestones will be developed ready to present to Education, Training and Research (ETR) Committee in February 2025. Therefore, the action has been extended to end of February 2025.
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		Nov 25: Posts agreed through vacancy panel. Awaiting interviews in early December 2025 and therefore due date has been extended.
Have Research roles in place within 2 Divisions	P. Brown	~~01.12.25~~ 28.02.26		Nov 25: Appointments not yet agreed and will be discussed with new Chief Medical Officer. Due date extended pending a decision on next steps.

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

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

Committee	Finance & Performance	Risk Appetite and Tolerance	Seek 8-12
Director	Chief Strategy & Improvement Officer/Chief Medical Officer	5Ts status	Tolerate
Date risk opened	05/12/24	Date of last review	14/10/25
		Target control date	31/03/26





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

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Lancashire and South Cumbria (L&SC) Integrated Care System (ICS) joint NHS forward plan and Clinical Blueprint • Improvement & Assurance Group (IAG) in place and meeting monthly. • Three-year Single Improvement Plan • Trust strategy formally approved at board, October 2025 • Trust's Annual Corporate Objectives • Provider Collaborative Board Joint Committee (PCB JC) • Place based working • Trust development/integration plans with LSCFT • First Recovery Support Programme (RSP) has been held. The RSP Team are engaging in observing Board and Sub-Board Committee meetings and work is underway to develop the programme of work needed (which will be incorporated into SIP). • A Working Group is established to develop the Preston Health Hubs, in line with the NHS 10-year Plan published in July 2025, and Trust members are actively contributing.	• L&SC Clinical Blueprint has been developed but we are not yet at the stage where we have a detailed, agreed implementation plan. • Discussions with external partners regarding greater service/pathway integration still need further development and may be impacted by the discussions/plans with respect to the L&SC Clinical Blueprint. • Draft ICB Commissioning intentions have been shared but more discussion needed to agree the implications for the Trust. • System based working is still evolving/improving e.g. the PCB Governance reset is underway but has not been fully implemented and Place based working is still developing.	<u>Level 1 Assurance</u> • Trust Board workshops/seminars <u>Level 2 Assurance</u> • Finance & Performance Committee system updates • Trust Board discussions/papers <u>Level 3 Assurance</u> • ICB and Regional NHSE Improvement & Assurance Group (IAG). • Recovery Support Programme (RSP) /Provider Improvement Programme (PIP)	• [None].

Risk Treatment

<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Agree final Trust long term strategy	A. Brotherton	31.10.25	02.10.25	Oct 25: The Trust strategy has been updated based on feedback received, finalised, and presented to board on the 2nd October 2025.

9. PERFORMANCE AND PRODUCTIVITY

9.1 INTEGRATED PERFORMANCE REPORT

Other | Executive Team | 10.15am

including Finance update and Single Improvement Plan
Item for Assurance

REFERENCES

Only PDFs are attached

9.1 - Integrated Performance Report as at 31 October 2025.pdf

Board of Directors Report

Meeting of the	**Board of Directors**		**4th December 2025**
	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 October 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		

The Best Version of Us
Our Culture Counts @LTH

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Integrated Performance Report

December 2025 Trust Board meeting with performance to October 2025


Patients


Performance


People


Productivity


Partnerships

Excellent care with compassion

Always Safety First

@LancsHospitals

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.

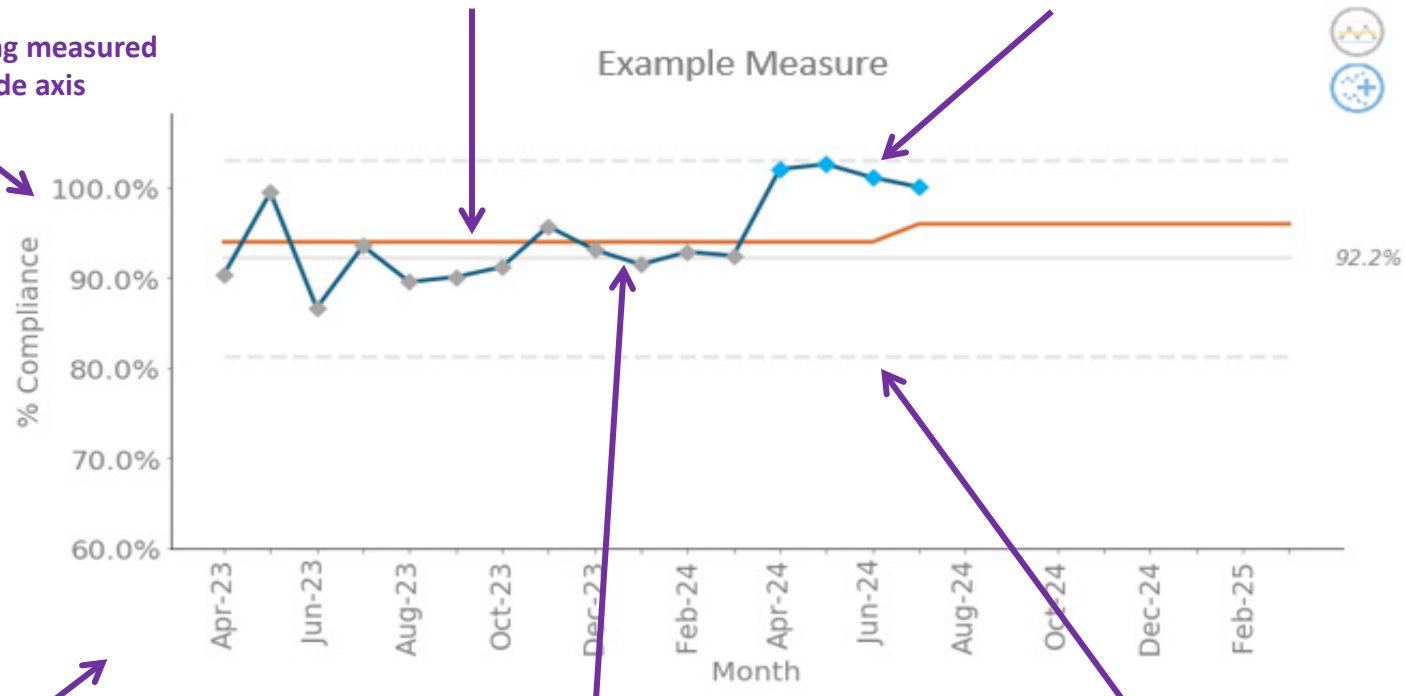
This March 2025 target

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

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) - Cancer 62-day performance		
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 - Compliance with 60 minute ambulance turnaround time target - Percentage of patients waiting less than 18 weeks - 31 Day Cancer Standard - Staffing Fill Rate - Maternity Support Worker	- Number of violence and aggression incidents toward staff - Turnover (%FTE) - Staffing Fill Rate - Registered Midwife - Complaints per 1000 bed days - C. difficile performance against national trajectory - no more than 167 Hospital Acquired cases - Pressure Ulcers per 1000 beds days (Category 2 and above) actions - Perinatal - Number of Stillbirths - 85% theatre utilisation - aggregate - Capped - Cancer Faster Diagnosis Performance - Percentage of patients that receive a diagnostic test within six weeks - RTT - 52 week Waiters	- Staffing Fill Rate - Registered Nurse
Recent positive pattern in the data	- RTT - 65 Week Waiters	- Sickness Absence (%FTE) - Maintain compliance with 10 Clinical Negligence Scheme for Trusts Safety - Staffing Fill Rate - Health Care Assistant	- STAR Accreditation all trust (Silver and Above)

Non SPC Metrics flagged as a concern

I&E - Plan V Actual variance

WRP schemes delivery

Non SPC Metrics

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

People
Patients
Productivity
Performance

The Best Version of Us
Our Culture Counts @LTH

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Patients

Excellent care with compassion

Always Safety First

@LancsHospitals

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 October 2025 and the breakdown for day and night fill is RM 97%-day, 82% night. **2. Staffing Fill Rate Maternity Support Worker -** remains below 95% target with historical vacancies impacted fill rates. **3. Complainst 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 5 months where complaints per 1000 days is above the median line, albeit within normal variation. **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.	1. The vacancy for registered midwives is currently 4.10 WTE and close monitoring of the midwifery establishment is ongoing with recruitment underway. 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. A successful recruitment campaign has concluded, with new starters commencing in October with allocated supernumerary time to achieve clinical competency sign-off 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 friedns and family performance used as a guide to understanding the impact of this. 4. Recognisning the increase in pressure ulcers has perisisted a pressure ulcer 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, confirming robust infection prevention and control measures. **2. Registered Nurse and Health Care Assistant fill rates -** are consistently achieving safe staffing levels. **3. STAR accreditation for all Trust.** 4. **Friends and Family Test for adult day case, adult outpatient and neonatal** **5. CQC Must do:** By the end of October, the outstanding action to be compliant in all manadatory training for all staff in UEC wasachieved meaning that all 54 of the "Must Do's" included in the 2023/2024 CQC Quality Improvement Plan were 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 2.8 per 1000 which remains below the national average of 3.9 per 1000. **7. C.difficile rates -** Currently remain within the national agreed trajectory.	1. Fully compliant at point of inspection, confirming robust infection prevention and control measures. 2. Staffing levels consistently meet thresholds, supporting effective care delivery. 3. Remains above target across the Trust, reflecting stabilisation following the introduction of critical standards. 4. Performance remains consistently above target and within normal variation, reflecting stable and positive patient experience. 5. CQC Quality Improvement Plan has been delivered. 6. Mortality actions continue as outlined in the biannual mortality plan. 7. The IPC Board Assurance Framework actions continue alongside the Cdifficile improvemnet plan continue, the implementation of the cleaning standards is now in line with plan and appears to be underpinning improved performance.

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

Patients

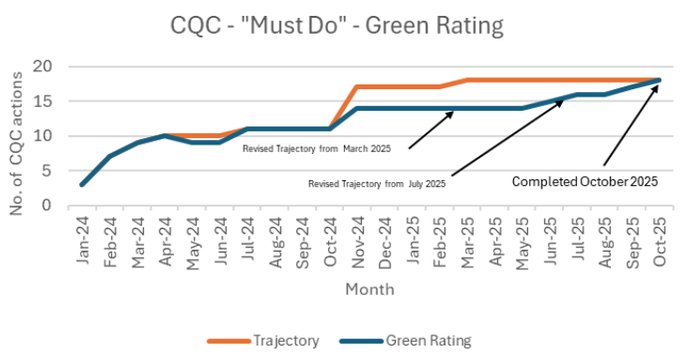
NHS Lancashire Teaching Hospitals NHS Foundation Trust

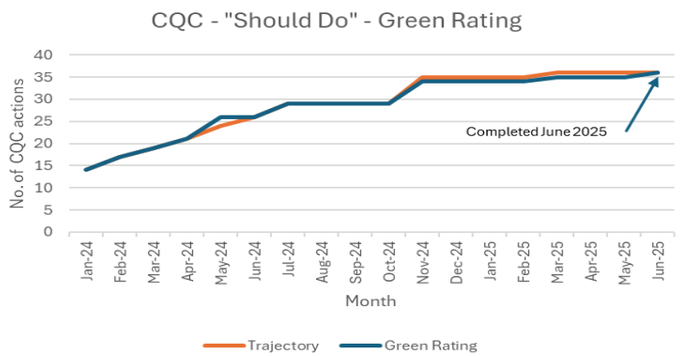
Metric Description		Assurance @ Mar-26	Variation to Latest Actual	Target			Latest Month Actual	Latest Month
				Concern	Mar-26	Latest Month Target		
CQC	CQC - "Must do" - Completed October 2025 (Number with Green rating)				18	18	18	Oct-25
	CQC - "Should do" - Completed June 2025 (Number with Green rating)					36	36	Jun-25
Deliver Annual Safe Staffing Requirements	Staffing Fill Rate - Registered Nurse				95%	95.0%	101.5%	Oct-25
	Staffing Fill Rate - Health Care Assistant				95%	95.0%	101.6%	Oct-25
	Staffing Fill Rate - Registered Midwife				95%	95.0%	91.5%	Oct-25
	Staffing Fill Rate - Maternity Support Worker				95%	95.0%	89.2%	Oct-25
Patient Experience and Involvement	Complaints per 1000 bed days				1.69	1.40	1.76	Oct-25
	STAR Accreditation all trust (Silver and Above)				75%	75.0%	87.3%	Oct-25
C Difficile Improvement	C. difficile performance against national trajectory - no more than 167 Hospital Acquired cases				16	14	12	Oct-25
Always Safety First	Hospital Standardised Mortality Ratio - Adult	Lower Than Expected					71.1	Jun-25
	Standardised Mortality Ratio - Relative Risk - All Diagnoses Adult	Lower Than Expected					68.3	Jun-25
	Standardised Mortality Ratio - Relative Risk - All Diagnoses Child (<1 day – 17 yrs)	As Expected					73.6	Jun-25
	Standardised Mortality Ratio - Relative Risk - All Diagnoses Neonates (<1-28 Days) *The updated TELSTRA model from November 2024 does not include still births*	As Expected					0.0	Jun-25
	Pressure Ulcers per 1000 bed days (Category 2 and above)				3.32	3.32	3.40	Oct-25
Maternity	Perinatal - Number of Stillbirths				0	0	2	Oct-25

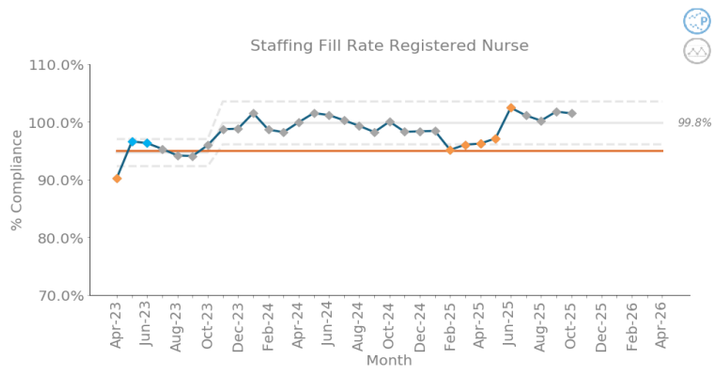
Single Improvement Plan | Patients | Performance | People | Productivity | Partnerships

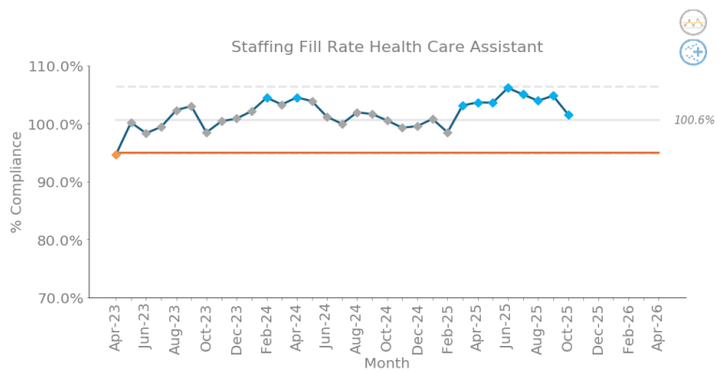
Patients

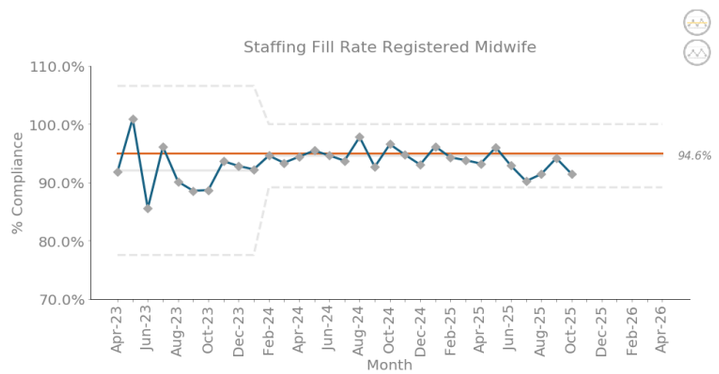
NHS Lancashire Teaching Hospitals NHS Foundation Trust

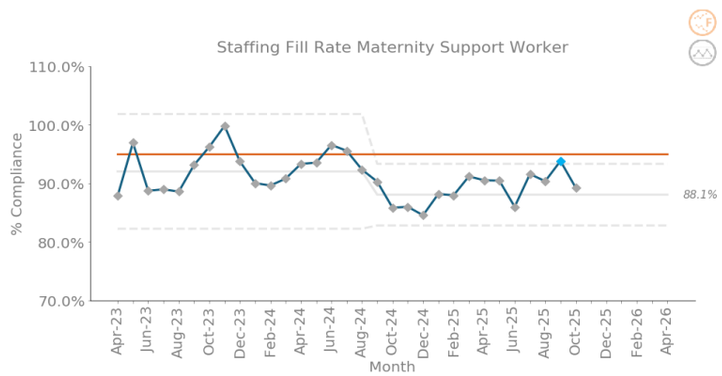


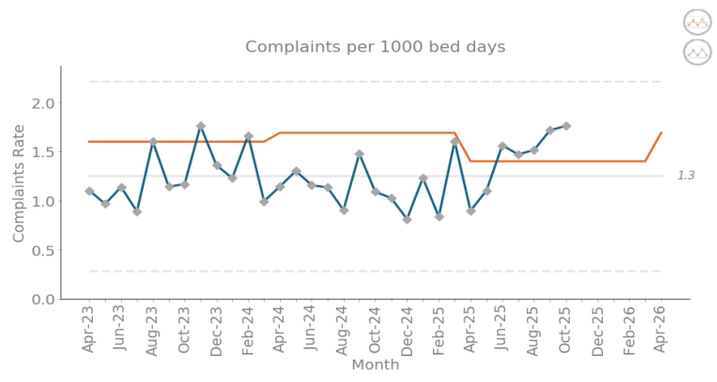


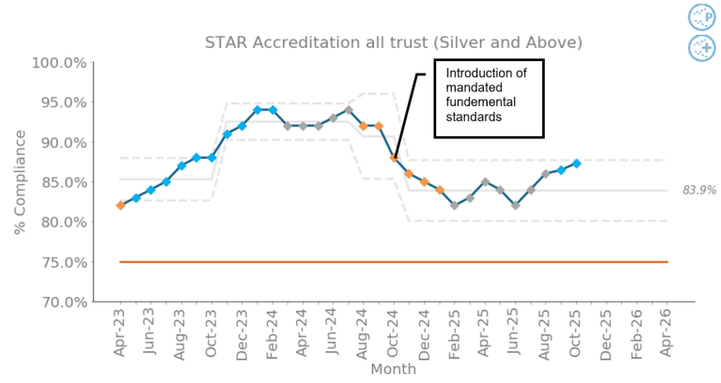


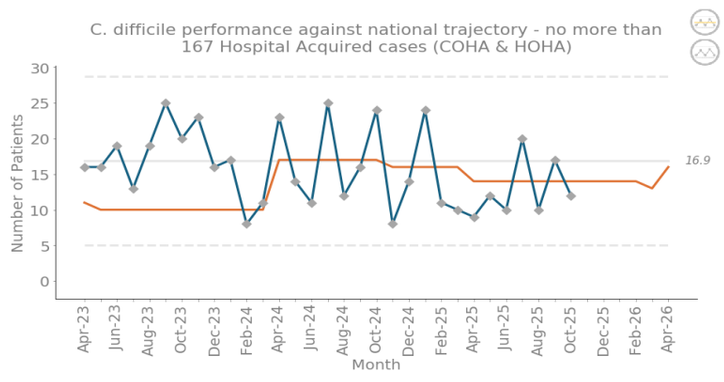


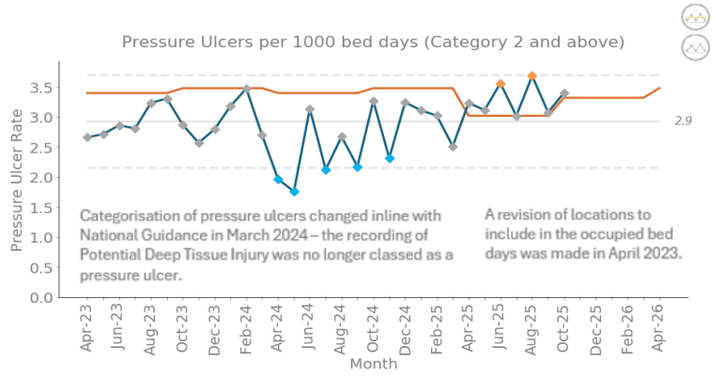


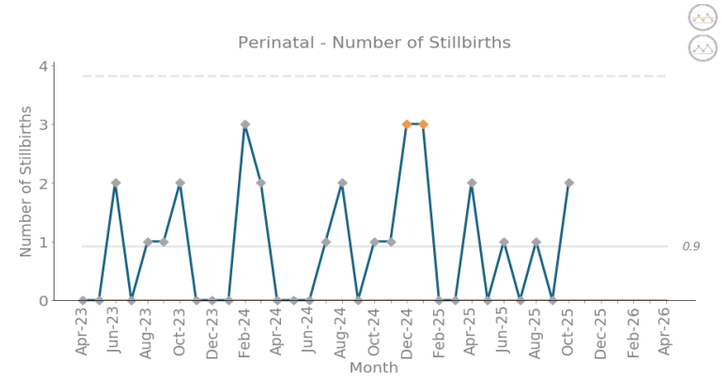












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Performance

Alert, Advise, Assure Report

	Issue	Action
Alert Areas of concern or matters that need addressing urgently	• **RTT performance** -Pressures remain in 52 weeks with the % of the waiting list being 52 weeks+ increasing in October 25. Similarly 18 week performance deteriorated in October achieving 54.1% versus a target of 61%. Improvements have been experienced in Neurology, Pain and Colorectal. Workforce gaps (clinical and administrative) and activity funding shortfalls continue to drive under performance. • **Boarding** - Average of 29 patients boarded in October - a reduced position but remains very high. • **4 hour performance** - Type 3 performance has deteriorated in October. • C**ancer performance -** both FDS and 62 day performance have deteriorated in October remains under below traget in September. This relates to a small number of tumour groups linked to workforce gaps.	• **RTT** - Recruitment to support increased validation has been approved, with additional hours supporting validation ongoing. AI validation pilots are underway to increase clock stops. A review of out of area demand is underway and will inform decisions to curtail activity as required. New models of care are being scoped in Pain and Neurology. The Board approved H2 Business case is being mobilised with capacity coming on line in Dec 25. • **DKAFH/Boarding** - Further roll out of the Lancs Improvement methodology and DKAFH cultural change programme to maximise the benefits and LOS reductions has commenced across a further 16 wards. • **4 hour performance** - A Type 3 performance improvement plan as been requested from GTD. Additionally key actions are in place to reduce non admitted breaches by reducing the wait for first clinical assessment, increasing deflections into community services, VW and SDEC. Admitted performance focus centres around improving bed flow via DKAFH and Ward/Board Round standard implementation. • **Cancer performance** - recruitment of substantive and Locum Cons staffing in breast is underway with the first post holder in post mid Nov 25 and subsequent due to be in post by Dec 25, Colorectal, Lung and Urology- capacity is being increased via Clinical specialists, improved working with Endoscopy and additional EBUS capacity. FDS actions relate to workforce gaps in Dermatology. Recruitment has been concluded and performance is recovering.
Advise Areas of ongoing monitoring and any new developments	• **RTT performance - 65 weeks -** a very small numbers of breaches remain in ENT and relate to complexity and patient choice. • **Ambulance handover** performance (15/30 and 60 mins) - performance has deteriorated in October 25 against all standards. • **12 hour + ED LOS** - performance has deteriorated in October and is above the Operational Improvement plan. • **Days Kept Away from Home** patient (%) has slightly decreased in October bu remains above the operational target. • **Diagnostic performance** (DM01) improved in October by 3.83% and is above the operational performance target but remains considerably below national average. •**Virtual Ward** occupancy remains below target however has improved by 0% utilisation versus Sept (+45 patients). •**Theatre Utilisation** saw a deteriorated position in October - key focus at CDH.	• 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** - Key focused action re Continuous flow and DKAFH are ongoing with a roll out of the DKAFH work underway with a further 16 wards. • **DM01** - Mutual aid has been secured for Echo (100 scans to take 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	• **ED Triage** times have remained consistent. • **Non Elective Length of stay** (10.2 days Sept 25 - Model Hospital) is below that of peer averages and Q2.	

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

Performance

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Metric Description		Assurance @ Mar-26	Variation to Latest Actual	Target Concern	Target Mar-26	Target Latest Month Target	Latest Month Actual	Latest Month
UEC In Flow	Compliance with 60 minute ambulance turnaround time target				100.00%	100.00%	96.51%	Oct-25
	Percentage of UEC (Type 1 & 3) patients seen within 4 hours				78.03%	70.43%	71.16%	Oct-25
	Maximum wait of 12 hours as Total Time in Department (Type 1 and 2)				8.20%	10.89%	13.29%	Oct-25
UEC Flow	Bed occupancy to 90%				90.00%	90.00%	97.23%	Oct-25
	Number of boarded patients				0	0	29	Oct-25
UEC Outflow/Community Collaborative	Reduce not meeting criteria to reside				5.00%	7.90%	10.96%	Oct-25
Elective (diagnostics)	Percentage of patients that receive a diagnostic test within six weeks				64.90%	60.60%	63.06%	Oct-25
Elective (long waits)	Percentage of patients waiting less than 18 weeks				62.50%	61.00%	54.07%	Oct-25
	RTT - 52 week Waiters				1395	1905	1926	Oct-25
	RTT - 65 Week Waiters				0	0	2	Oct-25
Elective (theatre utilisation)	85% theatre utilisation - aggregate - Capped				84.58%	84.58%	83.36%	Oct-25
Elective (Cancer)	31 Day Cancer Standard				95.98%	91.34%	90.76%	Oct-25
	Cancer 62-day performance				75.10%	67.44%	55.41%	Oct-25
	Cancer Faster Diagnosis Performance				80.01%	79.98%	76.97%	Oct-25

Unvalidated position, subject to change

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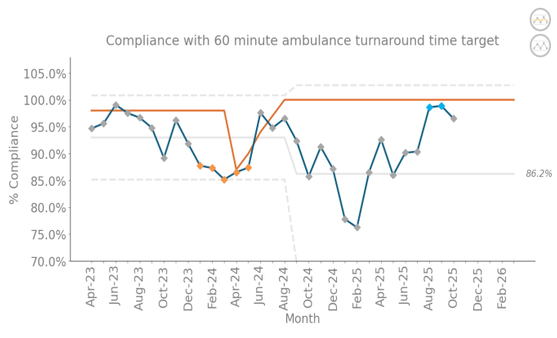
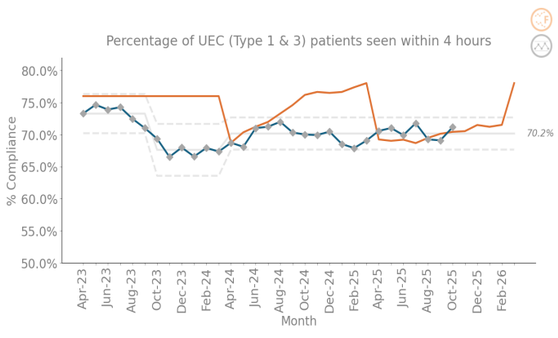
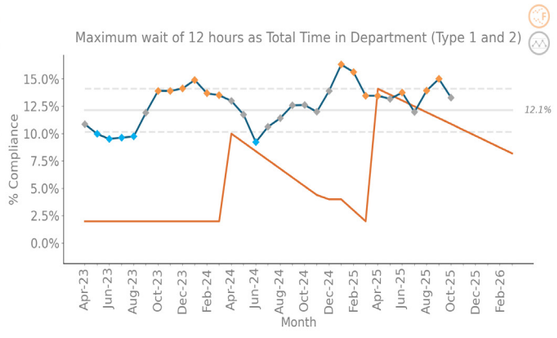
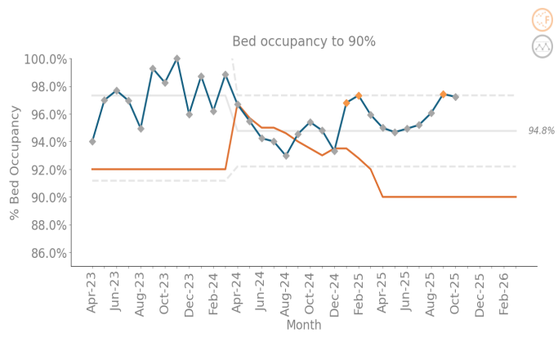
Performance

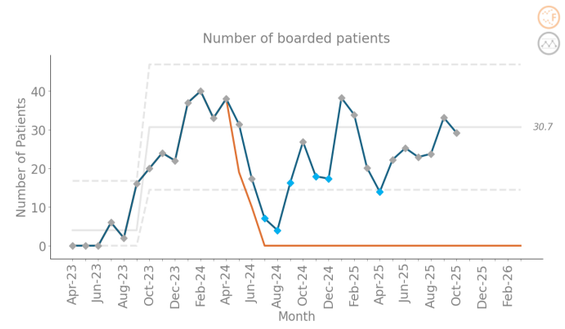
NHS Lancashire Teaching Hospitals NHS Foundation Trust

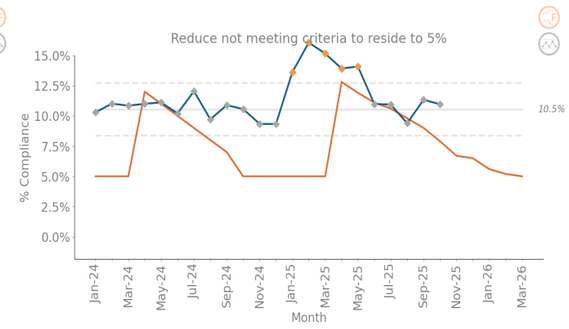


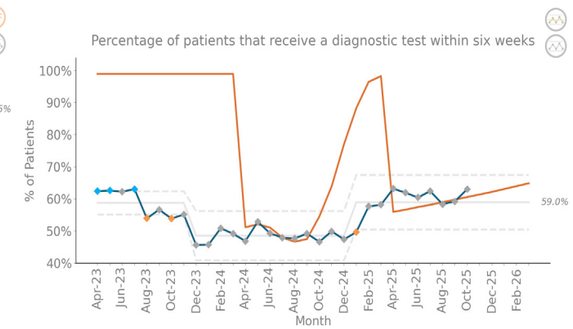


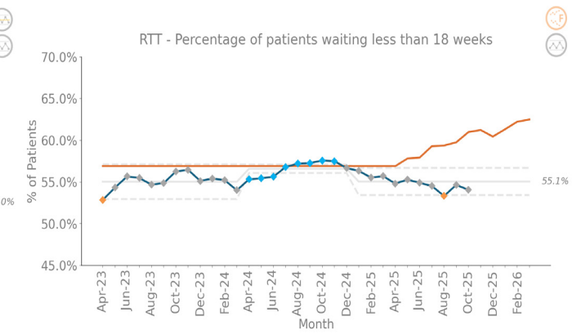


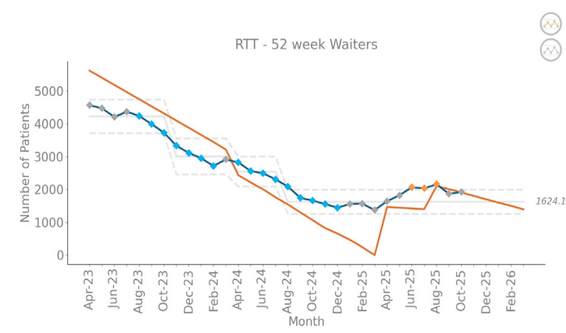


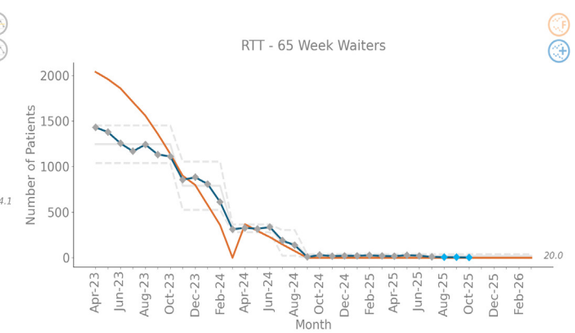


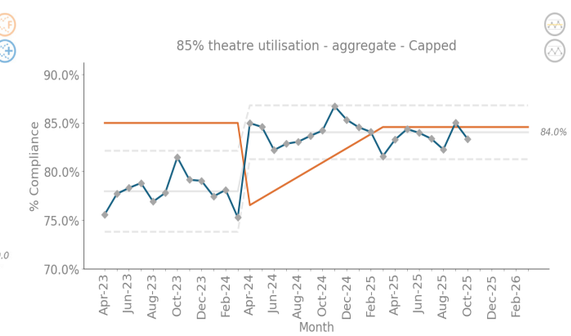


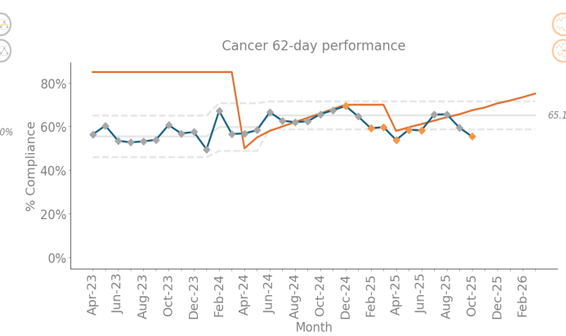


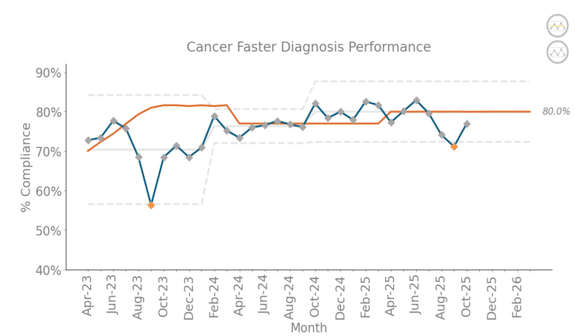


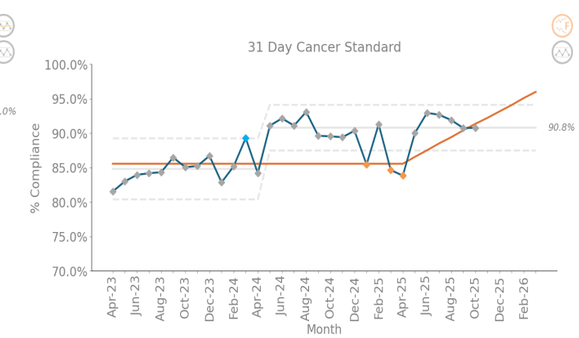












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People

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Alert, Advise, Assure Report

NHS Lancashire Teaching Hospitals NHS Foundation Trust

	Issue	Action
Alert Areas of concern or matters that need addressing urgently	WTE numbers are currently not reducing in line with Trust operational plans and require additional intervention to reduce WTE numbers by M12. Flu vaccination uptake amongst the workforce remains low compared to pre-Covid levels, although is already 5% higher than the final reported uptake for 2024/25.	Additional Vacancy Controls in place to limit externally advertised posts to 20 per month to control WTE growth. Focused WRP WTE reduction plans in place to reduce bank WTE usage between M8-M12, including additional nurse rostering controls. Flu vaccinations will continue to be offered until at least mid-December, with mobile vaccination teans operating across shift patterns, visiting all wards and departments.
Advise Areas of ongoing monitoring and any new developments	Violence and aggression inidents increased slightly in M7 compared to M6. It remains the case that the majority of incidents occur in Emergency Department.	Improvement work around restraint and violence markers is being progressed by the Mental Health and Violence Prevention and Reduction Big Rooms. The new security system has now been implemented on the Chorley site.
Assure Areas of Assurance	Although sickness absence increased slightly in M7, the overall absence rate was >0.8% lower than the same period last year, and there has been a further reduction in long-term sickness absence. The absence rate for M7 was also the lowest of the 5 provider Trusts in Lancashire and South Cumbria. Appraisal remains above target. Post appraisal evaluation demonstrates a positive experience of appraisal by the 300 colleagues who have completed the survey in last 6 months. Turnover remains below target and has reduced further in October to 0.55% (from 0.86% in September). All divisions have achieved 90% compliance for all Core Skills and Mandatory Training metrics	The sickness absence reduction plan continues to be progressed, including a further Rapid Improvement Workshop with divisional teams on 5 December. To refocus the Single Improvement Action plan towards improving quality of appraisal and using full scope of appraisal as a performance management tool by increasing use of objectives and development planning. For retention - actions include benchmarking levels of retirement in the region, increasing use of probationary process and developing actions following the self assessment against the NHSE retention tool.

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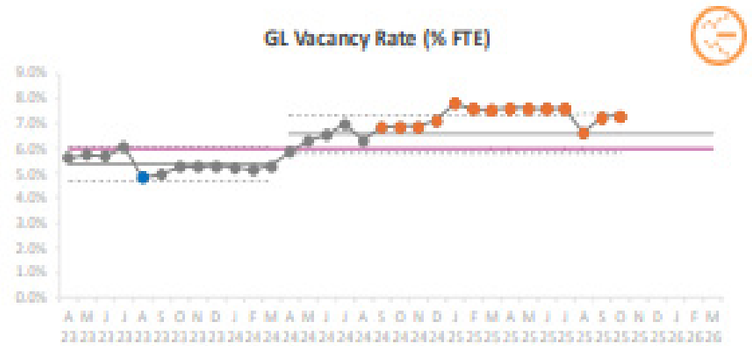
People

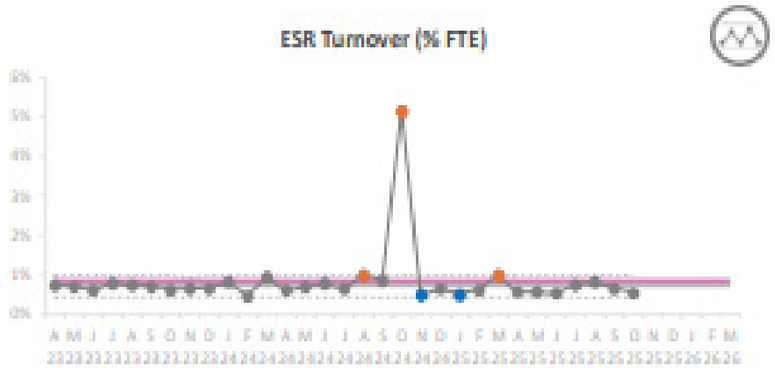
NHS Lancashire Teaching Hospitals NHS Foundation Trust

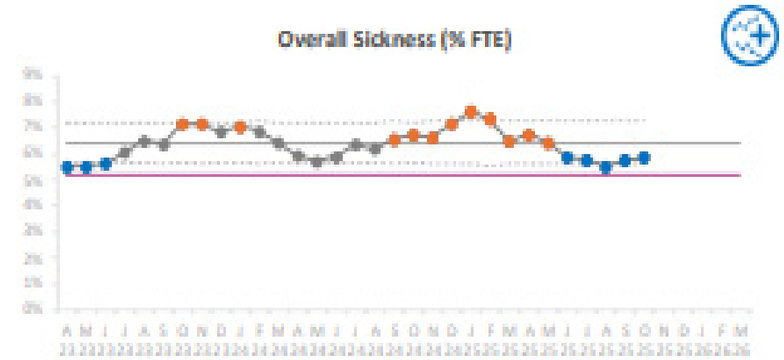
Metric Description		FY2526 Target Assurance	Latest Actual Variation	Target			Latest Actual	Latest Period
				Concern	FY2526	Latest Month Target		
People	Vacancies (% FTE) (source: General Ledger)	F	−	⚑	≤ 6%		7.30%	M07
	Turnover (% FTE) (annual assessment; ESR in-month reported)			⚑	≤ 10%		0.55%	M07
	Sickness Absence (% FTE) (annual assessment; in-month reported)		+		≤ 5.22%		5.88%	M07
	Number of violence and aggression incidents toward staff (annual assessment; in-month reported)			⚑	996		122	M07
	Core Skills Mandatory Training compliance (% modules) (module compliance reported)				100% of metrics at 90%		100%	M07
	Appraisal compliance (% HC)				≥ 90%		91.94%	M07
	Staff Survey: Recommend Trust as place to work (quarterly metric)	F	−	⚑	≥ 60%		50.99%	Q2

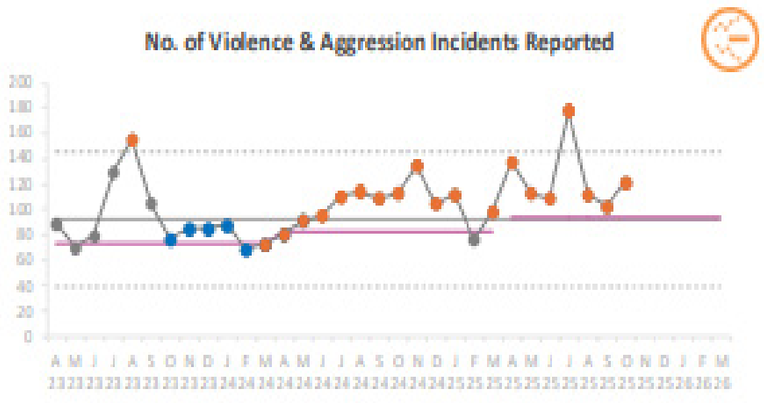
People

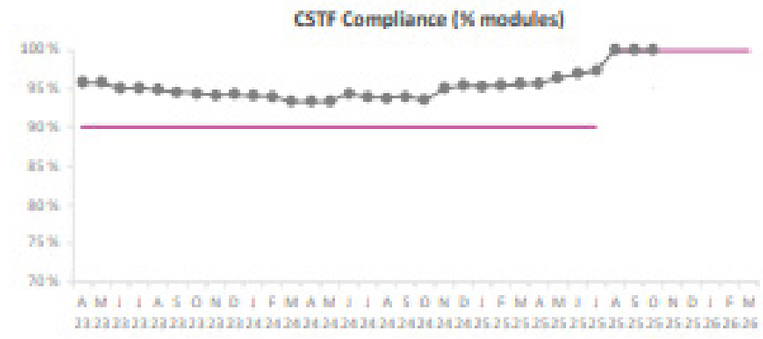
Lancashire Teaching Hospitals NHS Foundation Trust

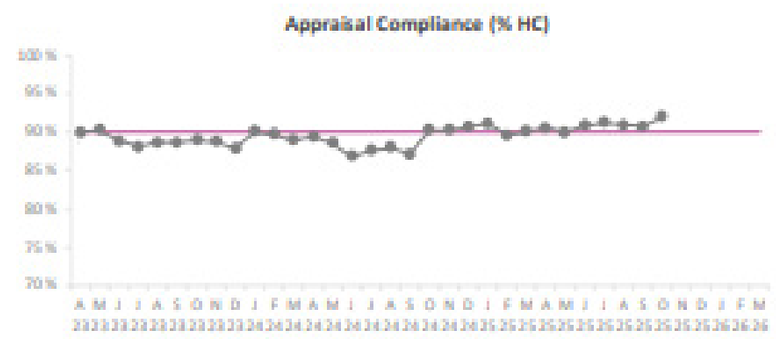


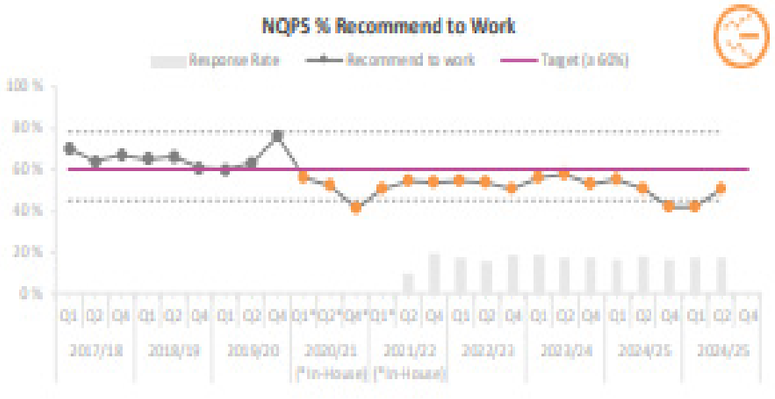












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NHS Foundation Trust

Productivity

Excellent care with compassion

Always Safety First

@LancsHospitals

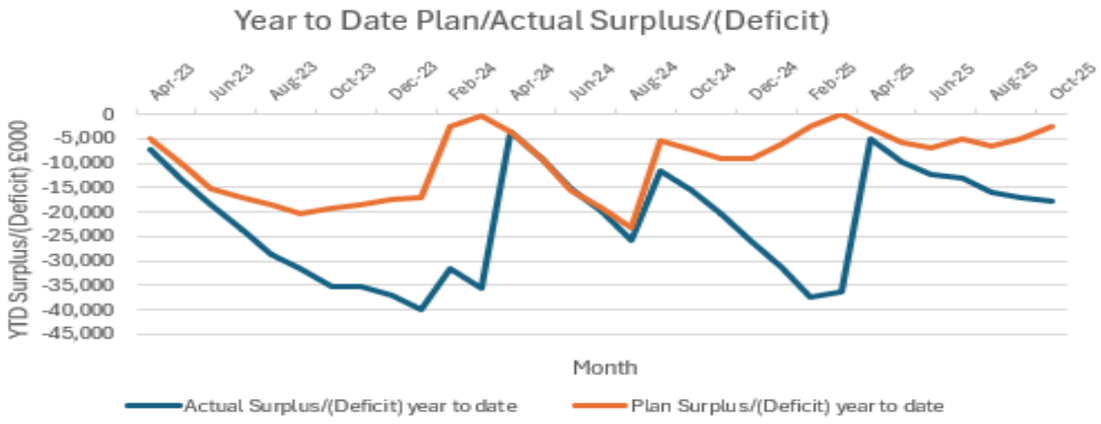
Alert, Advise, Assure Report

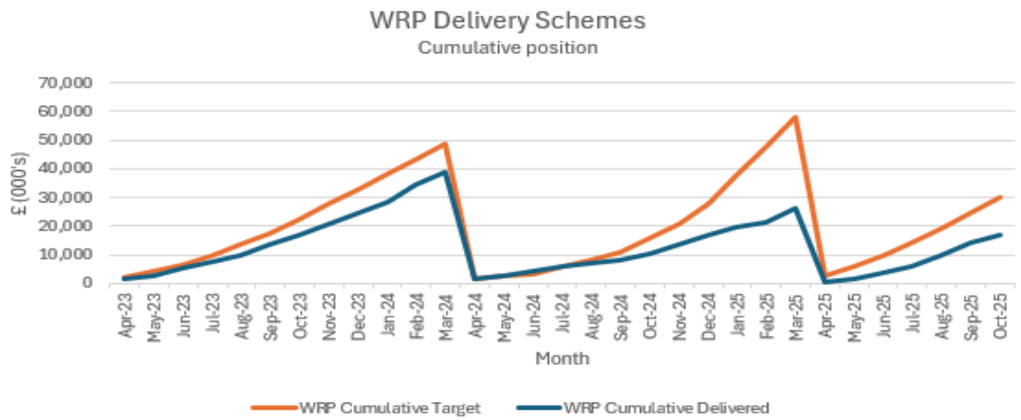
Lancashire Teaching Hospitals NHS Foundation Trust

	Issue	Action
Alert Areas of concern or matters that need addressing urgently	**Cash Position**	
	The Trust has received £12m cash support to date, £3.6m in September and £8.4m in October. The receipt in October means the payments that had previously been cancelled have now been paid. The Board of Directors have approved a further request in December for £10.5m and an application has been submitted accordingly. However, 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 Q3 and 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 capital cash for revenue purposes as a short-term measure.
	Income and Expenditure	
	At the end of October 2025 the Trust has a deficit of £17.7m against a planned deficit of £2.5m. The adverse variance to plan of £15.2m is as a consequence of the shortfall in delivery of the Waste Reduction Programme (£13.4m) and operational pressures of £1.8m. 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 £18m that it has been unable to mitigated associated with; industrial action, patient acuity, buildings dilapidations and maintenance of its energy system, these are unusual expenditures and are 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 has a Turnaround Director to work with senior leaders to re-assess the current waste reduction programme position and deep dive into short, medium and long-term opportunities. A re-set of the programme structure, governance and reporting for 2025/26 has taken place. The Trust is working with the ICB on the urgent and emergency pathway system pressures which is one of the main operational pressures that the Trust faces. The system is now receiving enhanced support from NHSE as part of the provider improvement programme (formerly recovery support programme). A focus on grip and control activities continues. The Trust has commissioned further external support to support specific financial recovery plan workstreams and 2025/26 waste recovery programme development. Divisions will need to recover their financial performance by delivering improvements in their current run rates e.g. maximising grip around temporary pay, review of vacancies and continuing to mitigate shortfalls in the efficiency target as schemes move through development and implementation stages.
	Waste Reduction Programme	
	The Trust's 2025/26 waste reduction target is £60m, 7% of operating expenditure. At the end of October the Trust has delivered £26.6m of the £60m target (44%). The delivery in month was £3.0m 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 has a Turnaround Director to work with senior leaders to re-assess the current programme position and deep dive into short, medium and long-term opportunities. A re-set of the programme structure, governance and reporting has taken place for 2025/26. The Trust has additional external support to help with the delivery of the programme. The Trust is building up its own project management office structure to have a sustainable solution moving forward. 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	Target (£ 000's) Concern	Mar-26	Latest YTD Target	Latest YTD Actual (£ 000's)	Latest Month
Productivity	I&E - Plan v Actual variance					-2506	-17712	Oct-25
	WRP schemes delivery				60000	30287	16912	Oct-25

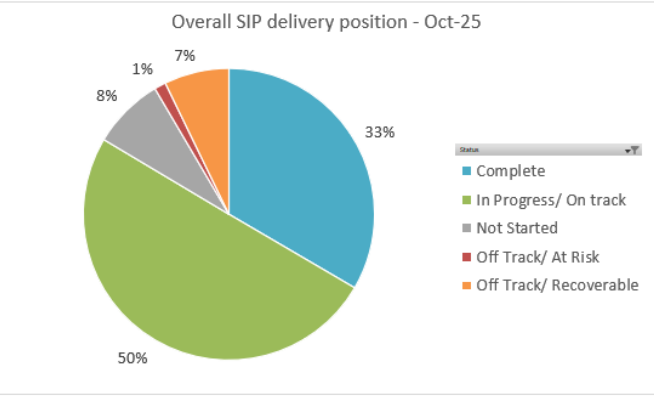


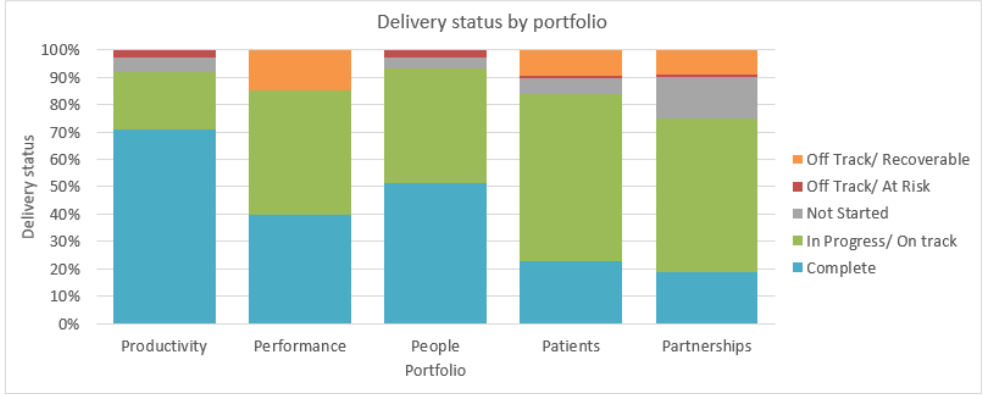


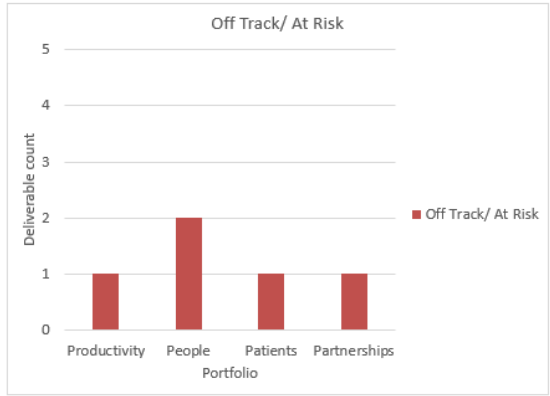
The Lancashire Teaching Hospitals **Single Improvement Plan** aims to improve patient care together.
The plan is based on what matters most to our patients, our colleagues, and our regulators, and it supports our overall goals. The SIP sets out a clear and simple way to improve how the Organisation works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

October-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.	• 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.
	PERFORMANCE	• Outpatient follow-up backlogs growing, super validation is reliant upon variable pay however 145 WTE vacancies across the clinical divisions within A&C staff areas this is proving difficult to maintain. • Cancer 62-day performance under target due to Breast workforce gaps • Ambulance handover delays worsened and boarded patients in corridor care above target. • DKAFH levels remain static and very high with extended delays associated with capacity shortfalls in LCC for triage.	• Tier 1 performance improvement plans developed across Cancer, UEC, RTT and Diagnostics. • Operational Performance Board now in place to closely monitor delivery plans and outcome metrics. • Breast workforce recruitment underway with first postholder in place
	PEOPLE	• Core skills compliance issues in advanced paediatric life support and moving/handling in urgent care. • Sickness absence management delayed due to technical issues with ESR and Empactis integration.	• Focussed support underway to bring areas into compliance. Overall compliance now achieved. • 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 £45m. • Mitigating actions in place but not sufficient for a fully balanced plan.	• CFO working through enhanced grip and control measures alongside mitigating under delivery of WRP. • CEO providing scheme level check and challenge regarding delivery.
	PARTNERSHIPS	• Corporate policy compliance position below target.	• Escalation through Corporate Divisional Improvement forum to department leads - updates required.
Advise	PATIENTS	• Health Inequalities dashboard development not progressing due to BI capacity.	• Escalated to OneLSC Chief Improvement Officer for BI resource to be aligned. • Opportunity to replicate approach UHMB have in place identified. Resource to deliver not yet identified.
	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.
	PARTNERSHIPS	• Partnership Board – Several programmes flagged as requiring updates against agreed milestones	• Deputy CEO followed up with programme leads , request made to complete by 30 November to facilitate assessment of risk and facilitate delivery.
Assure	PEOPLE	• Appraisal compliance is now at 92%, medical appraisal has improved to over 90%. • Mandatory training compliant.	• Policy change regarding appraiser and appraisee responsibilities in undertaking appraisal to be made once mandatory training policy changes tested and embedded.
	PARTNERSHIPS	• Cleaning standards on track for compliance 31 March 2026 in line with plan.	• Phase 3 of implementation has commenced alongside joint monitoring aspect with regards to cleaning standards. Positive feedback from ward managers to date on the impact of this.

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Integrated Performance Report
Appendix 1 – Assurance Reports

December 2025 Trust Board meeting with performance to October 2025


Partnerships


People


Patients


Productivity


Performance

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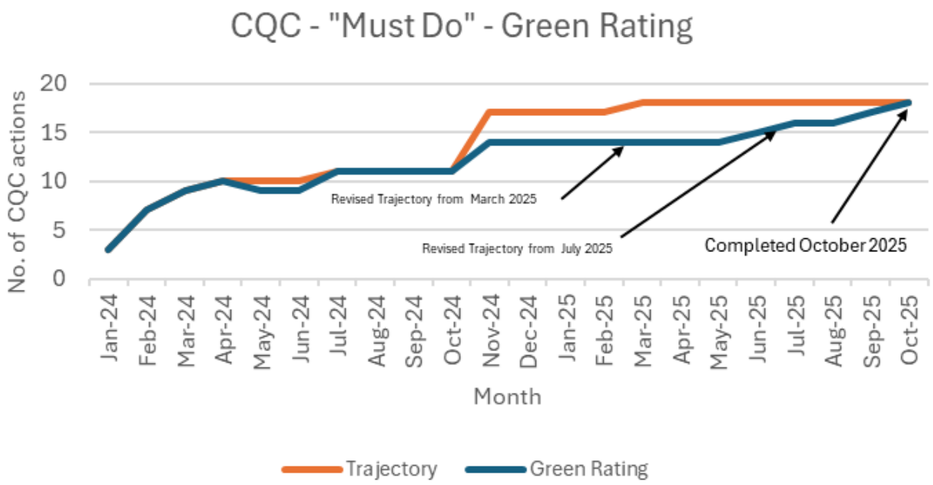
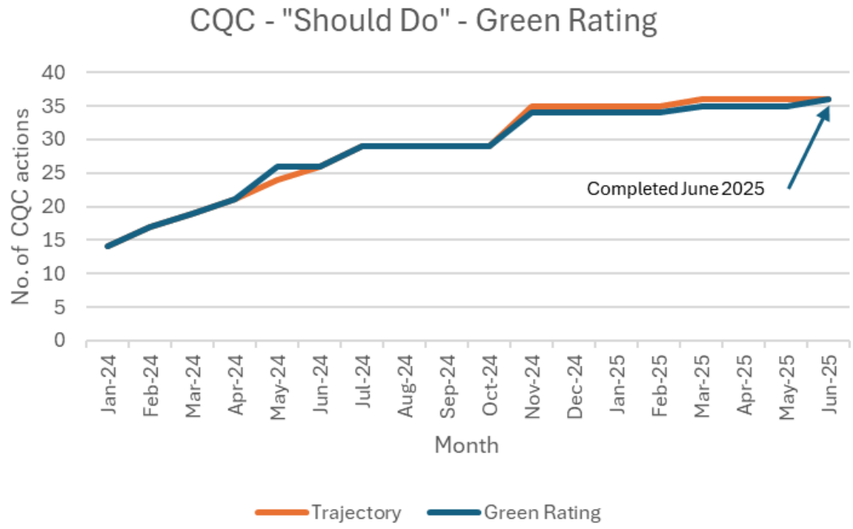
Patients - CQC Assurance

Lancashire Teaching Hospitals NHS Foundation Trust



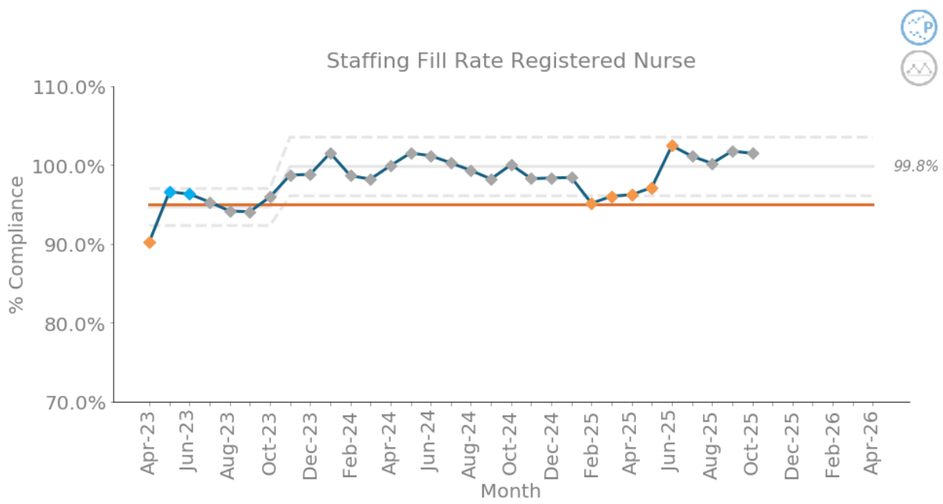
Latest
18
Month Target
18
Oct-25 Target
18



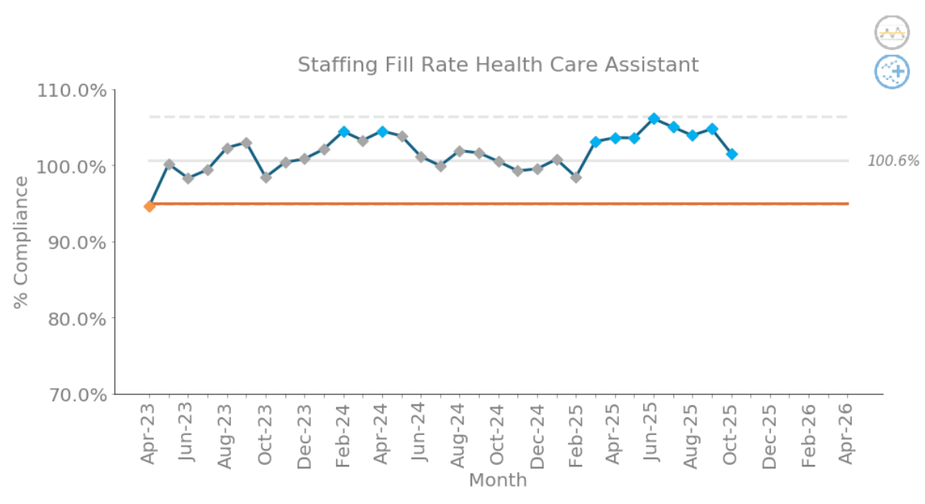
Latest
36
Month Target
36
June-25 Target
36

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
101.47%
Variance Type
Normal variation - no recent change
Mar-26 Target
95%
Target Achievement
Will consistently pass target within expected variation

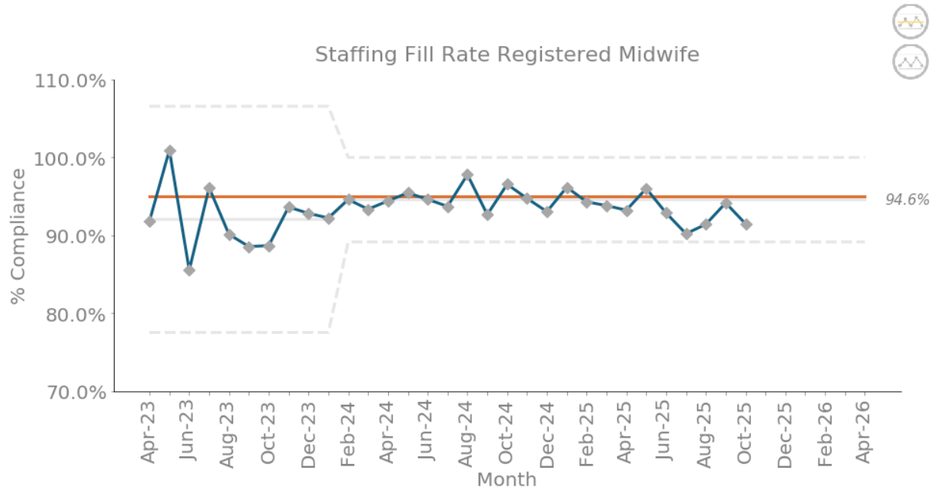


Latest
101.57%
Variance Type
Recent positive pattern in the data
Mar-26 Target
95%
Target Achievement
Could both pass or fail target within expected variation

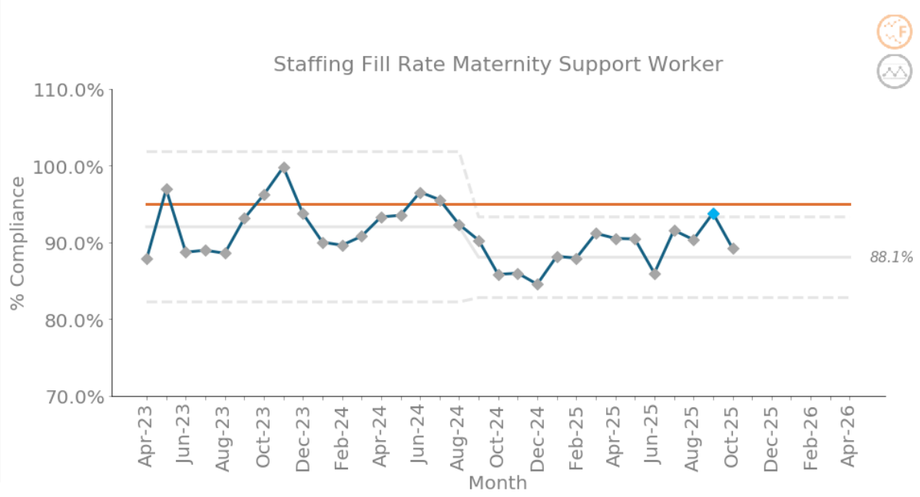
Metric	Summary	Action	Assurance
Staffing Fill Rate Registered Nurse	The RN staffing fill rate for inpatient wards in October was 102%. At site level, Chorley District Hospital (CDH) achieved a RN fill rate of 100%, while Royal Preston Hospital (RPH) reported a 102% RN fill rate. The implementation of 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 have 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 being taken including redeployment of staff where overestablishment is in place on a shift by shift basis.	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 inpatient wards in October was 102%. At site level, Chorley District Hospital (CDH) acheived a HCA fill rate of 101%, while Royal Preston Hospital (RPH) reported a 102% HCA fill rate. The need for bank support remains to ensure safety is maintained. The implementation of strengthened approval processes for bank is in place to ensure that as a Trust we are maximising the use of our resources while maintaining safety for our patients and staff.	1. Weekly roster efficiency reviews undertaken by the Divisional Nurse Leaders as an interim measure following the introduction of strengthened approval processes for bank use, commenced October 25. 2. A review of Band 2 and Band 3 roles is being undertaken inline with national role guidance, due to be complete end of November. 3. Redeployment of staff into vacancies through organisational change and ward closures, ongoing into next year 2026 4.Divisional Nurse Leaders began integrating ward-level fill-rate data in September 2025 to understand the drivers and safety requirements behind wards operating above 100% fill	

Patients - Deliver Annual Safe Staffing Requirements Assurance

Lancashire Teaching Hospitals NHS Foundation Trust



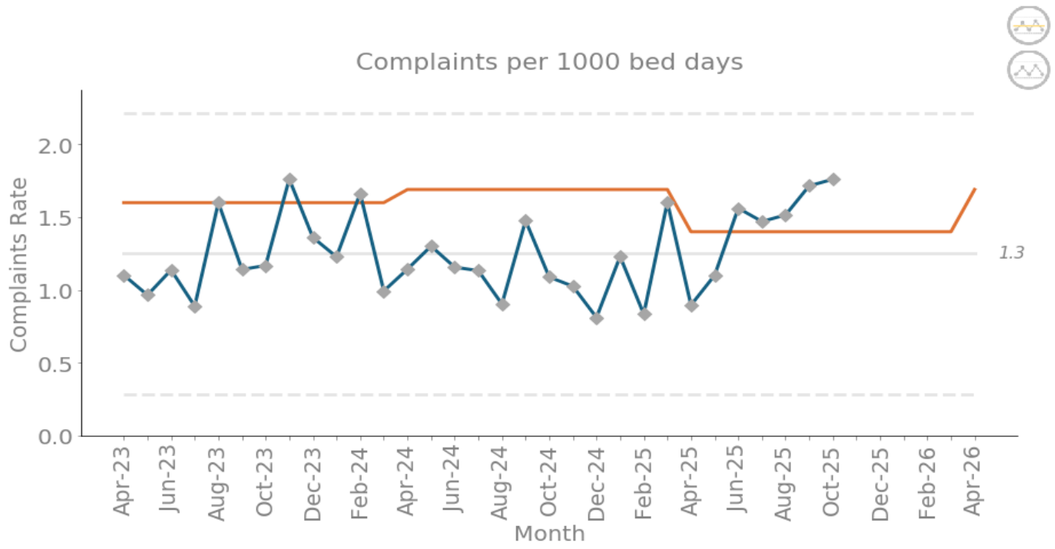
Latest
91.48%
Variance Type
Normal variation - no recent change
Mar-26 Target
95%
Target Achievement
Could both pass or fail target within expected variation



Latest
89.24%
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 is below the Trust target of 95% for October 2025 and the breakdown for day and night fill is RM 97%-day, 82% night. The vacancy for registered midwives is currently 4.10 WTE and close monitoring of the midwifery establishment is ongoing considering new starters, leavers and maternity leave variation. Unfilled shifts continue to be sent to bank and agency and high use areas and spend continue to be associated with Delivery Suite, Maternity A and B and Maternity Assessment Suite. The next BirthRate plus assessment for the service is on track and the final draft is being prepared for consideration and scrutiny by the Divisonal Midwifery and Nursing Director and Chief Nursing Officer.	1. Weeklyroster efficiency reviews as required to ensure appropriate use of bank and agency commenced October 25. 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. Interviews planned for November 2025 . Shortlisted 15 candidates.	1. Fill rates for registered midwives overall have been stable across day and night shift patterns. 2. The Safety and Quality committee review fill rate and minimum RM levels by area on a monthly basis. 3. Approval and sign off of all agency shifts undertaken by the Deputy/ Divisional Midwifery and Nursing Director. 4. Biannual safe staffing procedures are in place in line with National Quality Board guidance. 5. Weekly PSIRF oversight panel reviews incident harm levels, this is triagulated througha quarterley serious incident/PSIRF report. 6. Redflag reporting is monitored to identify areas where additional input can be provided to manage the risk.
Staffing Fill Rate Maternity Support Worker	The overall midwifery support worker fill rate is below the Trust target of 95% at 89% for October 2025 and the breakdown for day and night fill is 83% day and 94% night). Continuing long term sickness affecting fill is being managed in line with the Trust Policy . To maintain safe staffing levels, there continues to be a requirement to use bank to backfill shifts. The recruitment and onboarding processes have been more retracted since changes to the recruitment team have resulted in delays to staff progressing into posts following new appointment .	1. Weekly roster efficiency reviews to ensure appropriate use of bank. 2. Ongoing recruitment to fill all vacancies which are tracked using a local trajectory. 3. Sickness management procedures reviewed by Workforce BP to ensure appropriate management. 4. Band 2 MSW vacancies in maternity A,B and Delivery suite being progressed through recruitment.	1. The Safety and Quality committee review fill rate and minimum safe staffing levels by area on a monthly basis. 2.. Approval and oversight sight of rosters is undertaken by the Deputy/ Divisional Midwifery and Nursing Director. 3. Biannual safe staffing procedures are in place in line with National Quality Board guidance. 4.. Weekly PSIRF oversight panel reviews incident harm levels, this is triagulated througha quarterley serious incident/PSIRF report. 5. Redflag reporting is monitored to identify areas where additional input can be provided to manage the risk.

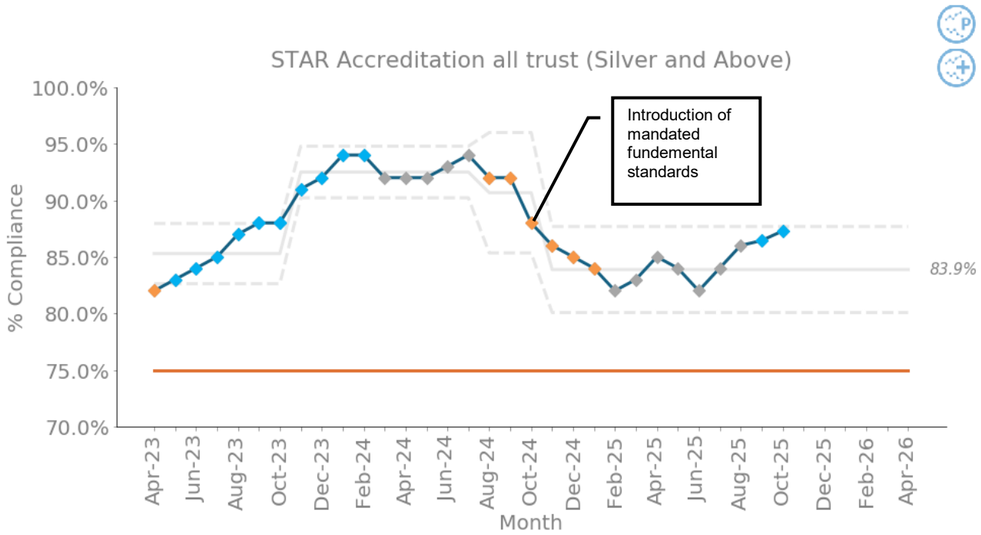
Patients - Complaints



Latest
1.76
Variance Type
Normal variation - no recent change
Mar-26 Target
1.69
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 5 months where complaint per 1000 days is above the median line., albeit within normal variation. Improving patient experience remains a key focus. Targeted efforts are underway as part of the Urgent and Emergency Care (UEC) improvement plans and enhancements to inpatient pathways. Insight from the national inpatient and ED surveys have provided specific areas of focus and feedback from patients, informing immediate and longer-term actions. It is acknowledged that the UEC pathway has significant impact on the overall experience of patients, families and staff and as such remains a key priority within the Trusts patient experience improvement plan. The top themes from complaints relate to communication, delays in treatment, delays in procedures and delays in appointments. The continued focus on delivery of the trust Single Improvement incorporates the ongoing patient experience plan. The continued delivery of actions in response to feedback within the national inpatient survey, urgent emergency care, cancer care and maternity.	1. Continue to deliver the Patient Experience 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 escalatre 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

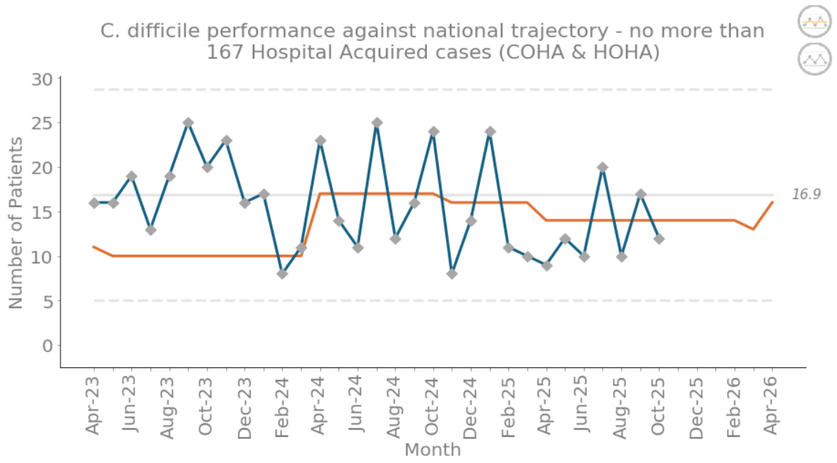


Latest
87.28%
Variance Type
Recent positive pattern in the data
Mar-26 Target
75.00%
Target Achievement
Will consistently pass target within expected variation

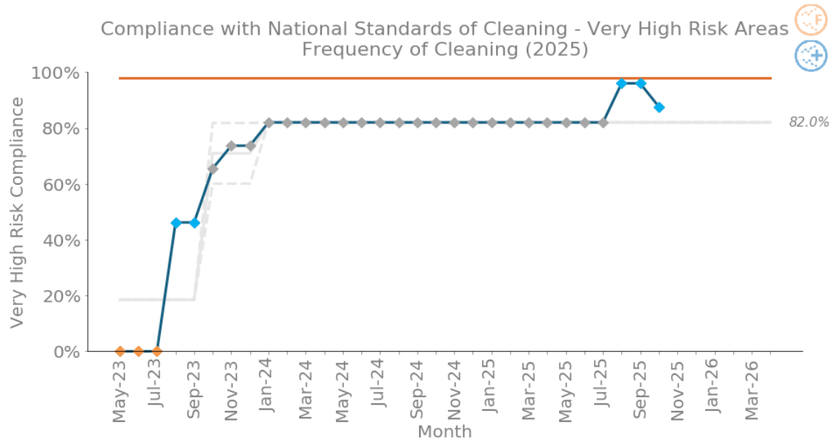
Metric	Summary	Action	Assurance
STAR Accreditation all trust (Silver and Above)	There are 118 clinical areas registered for the STAR Quality Assurance Framework, of which all 118 have received STAR accreditation visits. There is one clinical areas with a red star rating, 14 areas with an amber rating and 103 areas rated green. This results in 15 bronze stars, 21 (of which onw has 3 consecutive silver stars) and 82 gold stars. There are 87% of areas rated silver or above. During October, there were no areaa with a reduced STAR rating, one area had an increase to silver and others maintained their star rating. One area had an decreased 15 steps rating from A to B, the others maintained their current rating. 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 action plan, these 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 78 % of wards, ED and theatres scoring silver and above for STAR accreditation visits.	1. Any standards which are not achieved require an improvement action which is monitored within division through divisional assurance porcesses and via STAR monthly reviews and STAR acreditation visits. 2. The monthly STAR report includes trustwide and divisional STAR data and highlights good practice, areas for improvement, themes for learning and an overarching STAR improvement action plan, which is cascaded and discussed through the divisional always safety first meetings, the always safety first learning and improvement group and estates and facilities partnership board. The STAR report includes CQC (2023) action plan standards. 3. The STAR action plan has been updated to include recurrent themes and now included learning and actions from the Safety Visits undetaken by the senior leadership teams. 4. Monthly meetings with DND, Matron & Ward/Department lead with 3 area's currently scoring a bronze rating with a supportive improvement action plan in place. Review of overdue actions tracked through 1-1's. 5. STAR monthly report updated to highlight those areas who are rated red or amber for STAR visits of less then 90% for STAR monthly reviews and includes areas ranking for their STAR performance. 6. A new STAR enhanced oversight panel commenced during October, involving 4 areas to drive action and support with STAR safety and quality actions.	1. The STAR report is shared within the divisional leadership teams, good practice is shared and celebrated and that actions are developed where improvement is required. 2. Ward/department managers, matrons and professional leads provide assurance that actions are completed and monitored for effectiveness through the 1:1 with matrons and Divisional Nurse Directors. 3. The AMaT system supports with STAR audit data management and oversight and management of improvement actions. 4. There is a BI STAR page available to enable data triangulation. 5. STAR accreditation visits are scheduled depending on star rating, areas with a bronze star rating are reassessed within 2-3 months. (red every 2 months, amber every 3 months).

Patients - C Difficile Improvement Programme Assurance

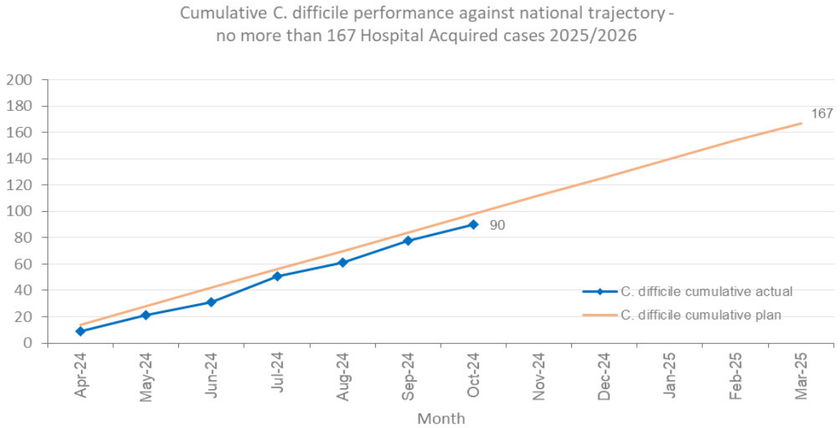
Lancashire Teaching Hospitals NHS Foundation Trust

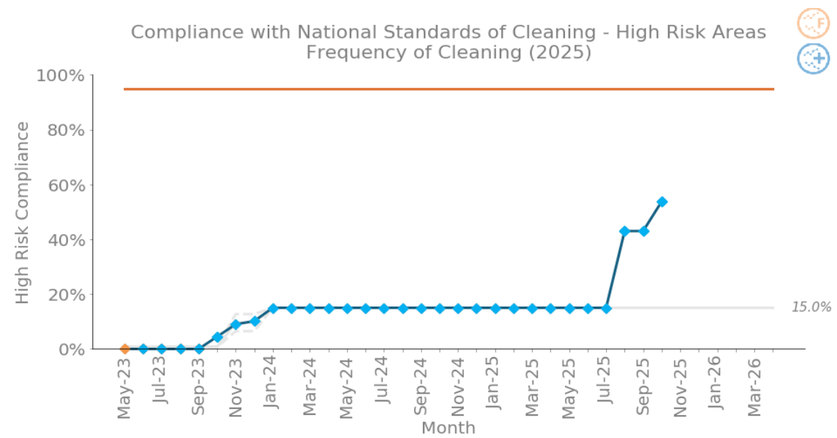


Latest
12
Variance Type
Normal variation - no recent change
Mar-26 Target
13
Target Achievement
Could both pass or fail target within expected variation



Latest
87.67%
Variance Type
Recent positive pattern in the data
Mar-26 Target
98.00%
Target Achievement
Will consistently fail target within expected variation





Latest
53.75%
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 199 Hospital Acquired cases	C.difficile is a recognised as a principal risk for the organisation. During October 2025 there were 12 cases for the month, continuing the trend below the objective, with a total of 90 cases for 2025 / 2026 to date. The National objective set for the Trust 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 and 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. Current compliance 72% for frequency 1 areas, 38% for FR 2 area with Phase 2 implementation commenced in October. The joint monitoring/efficacy audits are due to commence in November 2025.	1.Phased implementation of the approved business case to be compliant in high risk areas with National Standards of Healthcare Cleanliness (2025) by the end January 2026 is underway and demonstrating good progress. In October 2025 an additional 16 areas have been included and a further 15 are planned for November with teh remaining 30 clinical areas to be included before the end of January. 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

Patients | Performance | People | Productivity | Partnerships

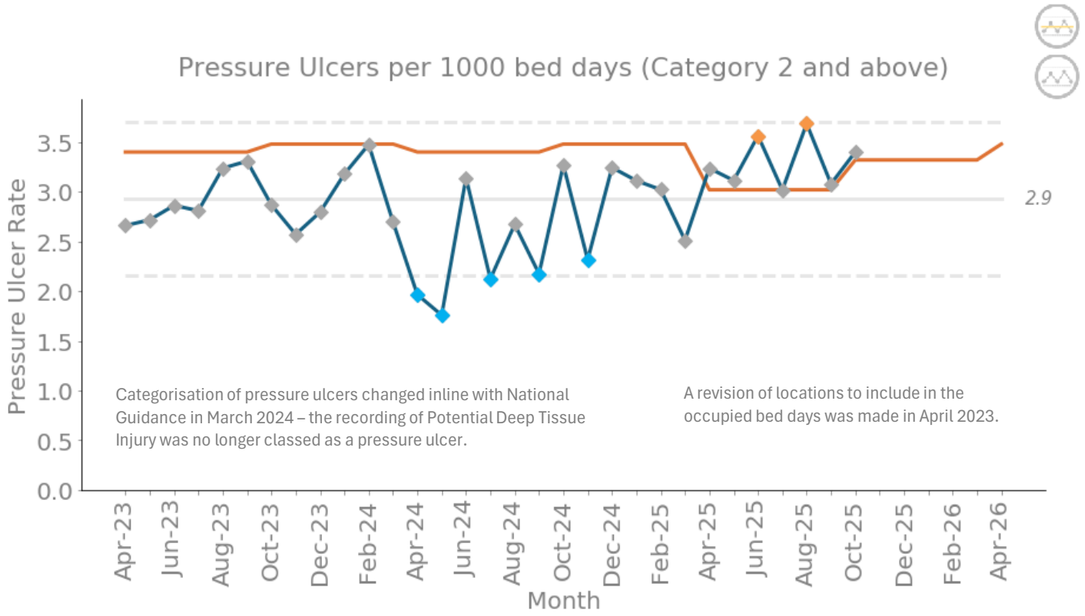
Lancashire Teaching Hospitals NHS Foundation Trust

	Achievement	Position	Month
Hospital Standardised Mortality Ratio - Adult	Lower Than Expected	71.1	June 2025
Standardised Mortality Ratio - Relative Risk - All Diagnoses Adult	Lower Than Expected	68.3	June 2025
Standardised Mortality Ratio - Relative Risk - All Diagnoses Child (<1 day – 17 yrs)	As Expected	73.6	June 2025
Standardised Mortality Ratio - Relative Risk - All Diagnoses Neonates (<1-28 Days) *The updated TELSTRA model from November 2024 does not include still births*	As Expected	0.0	June 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.
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.		

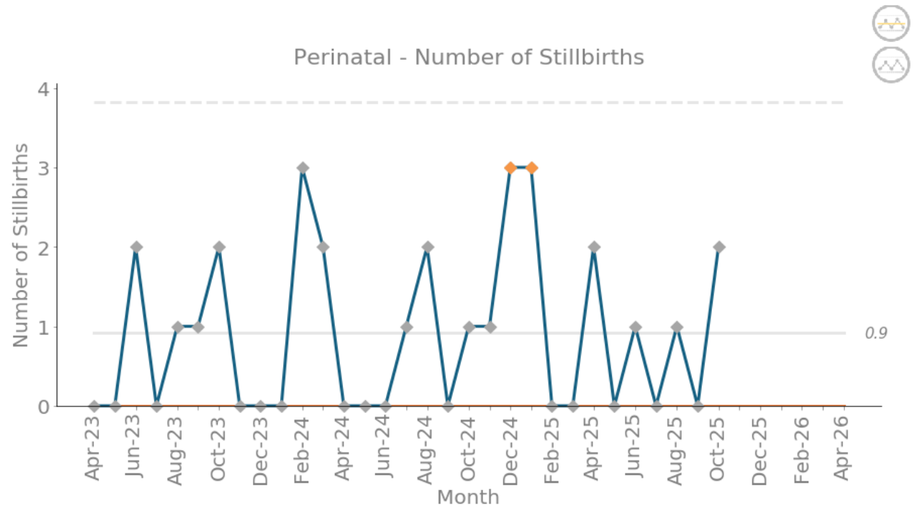
Patients - Pressure Ulcers Assurance



Latest
3.40
Variance Type
Normal variation - no recent change
Mar-26 Target
3.48
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 recognised as an indicator of care quality. The target line has been revised from April 2025 to reflect the average number of incidents from the previous year, rather than the three-year average used previously. Since this adjustment, the number of reported pressure ulcers has consistently exceeded the target. Device-related pressure ulcers continue to fluctuate, Wards with high device usage are undertaking focused improvement work around device management. Reducing the incidence of pressure ulcers remains a Trust-wide priority, with ongoing emphasis on preventative care interventions. A pressure ulcer improvement has been development to support key action, standards and drive further improvements, The pressure ulcer review process has been updated and introduced from November 2025	1. Creation of an organisational pressure ulcer improvement action plan lead by the Deputy Chief Nursing Officer 2. Introduction of a review panel to review severe harms in pressure ulcer starting in November 2025, with a Charis report going to PSIRF oversight panel. 3. Continued focus on Operational Performance Single Improvement plan. 4. STAR quality assurance fundamental standards include intentional rounding which is linked to pressure relief interventions. 5. Education and awareness of pressure ulcer prevention is provided throughout the Trust. 6. Sharing of cross divisional learning key themes and trends at monthly divisional always safety-first meetings, 7. Quarterly review of key themes and trends from high incidents areas of pressure ulcers presented at Always Safety First Learning and Improvement group.	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

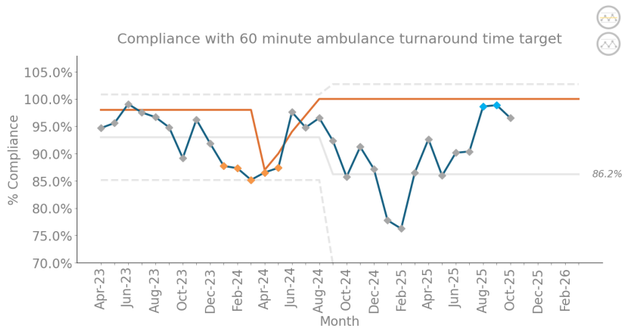


Latest
2
Variance Type
Normal variation - no recent change
Mar-26 Target
1
Target Achievement
Could both pass or fail target within expected variation

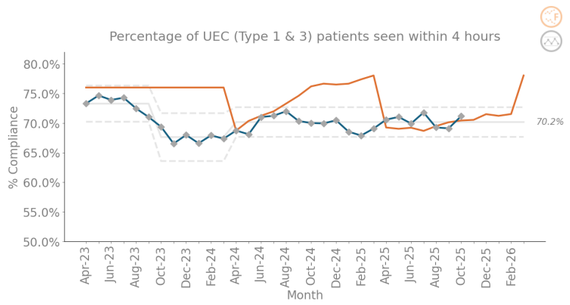
Metric	Summary	Action	Assurance
Perinatal - Number of Stillbirths	The service continues to track the rates of stillbirth and revew each case in line with nataional guidelines. There were no stillbirths in September 2025 and 2 in October 2025. This is within normal variation for the service. The 12-month average mean (October 24- September 25) still birth rate is 2.8 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 expected to be implemented at the end of November 2025. The system will provide real-time monitoring of key maternity outcomes—such as term stillbirths, to detect early warning signals and prompt rapid intervention

Performance - UEC Assurance

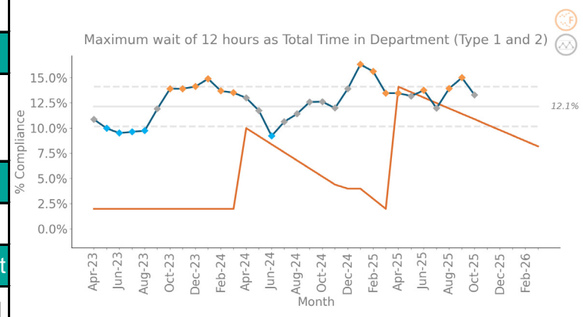
Lancashire Teaching Hospitals NHS Foundation Trust



Latest
96.5%
Variance Type
Normal variation - no recent change
Mar-26 Target
100%
Target Achievement
Could both pass or fail target within expected variation



Latest
71.16%
Variance Type
Normal variation - no recent change
Mar-26 Target
78.02%
Target Achievement
Will consistently fail target within expected variation

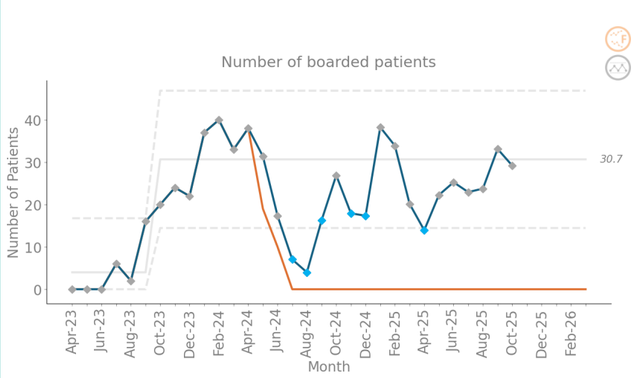


Latest
13.29%
Variance Type
Normal variation - no recent change
Mar-26 Target
8.20%
Target Achievement
Will consistently fail target within expected variation

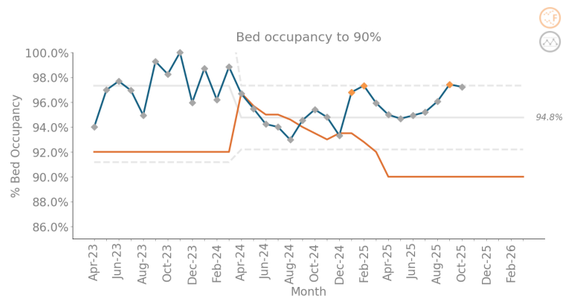
Metric	Summary	Action	Assurance
Compliance with 60 minute ambulance turnaround time target	In October 25 520 patients waited between 30-60 minutes to be handed over from NWAS to the Trust, an increase of 248 from last month. 87 patients waited over 60 minute to be handed over from NWAS to the Trust in October 25, an increase of 61 compared to September. For the fifth consecutive month over 90% of patients were handed over within 60 minutes, a slight deterioration of 2.1% compared to September 25.	Ambulance handover delays remain a high priority, and a local improvement collaborative is in place with key actions focusing on increasing NWAS to SDEC pathways. This accompanied with the improvement actions focusing on reducing LOS and NMC2R which will reduce ED Overcrowding and support more timely handover and attendance and admission avoidance actions is aimed to see improvements.	Monitoring of ambulance demand is undertaken via the weekly Ambulance handover group. Comparison to both the national and regional performance positions for September 25 indicates that the Trust is above the national performance position of 92.4% for 60 minute handovers and above the NW performance position of 96.0%.
Percentage of UEC (Type 1 & 3) patients seen within 4 hours	Performance against the national 4 hour access standard improved in October 2025. The performance improvement was 2.1% compared to September. October experienced a higher daily attend rate than September 25, experiencing 24 more attends per day than the previous month.	The UEC Improvement programme is focusing on measures to reduce the wait to be seen time, improving response times for patents referred to specialities and seeking to maximise referrals into SDEC. Targets have been set for each of these critical measures and is monitored via the UEC Improvement Board monthly. SDEC activity has been improved in October to above the 40% target (+0.74%).	The average time to triage in October increased slightly to 17 minutes with time to treatment also increasing slightly to 167 minutes. This follows a significant decrease in both waits in August. Comparison of 4 hour performance to the latest published national benchmarks indicates that the Trust is below the national average for October 25 of 74.1% and was ranked 61st 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) in ED decreased in October to 13.29%, a decrease of 1.71% compared to September. 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 97.4% with a range between 92% - 97% over the last 12 months. The level of boarded patients decreased in October with an average of 29 patients per day. Comparison within Model Health System indicates the Trust is above the provider median and within Quartile 3.

Performance - UEC Assurance

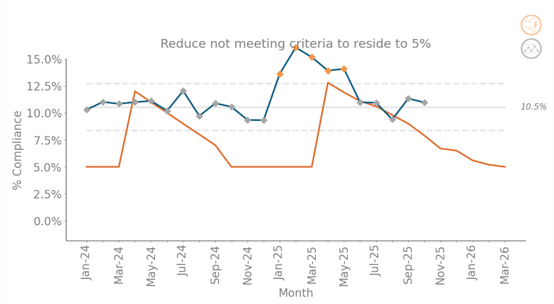
Lancashire Teaching Hospitals NHS Foundation Trust



Latest
29
Variance Type
Normal variation - no recent change
Mar 26 Target
0
Target Achievement
Will consistently fail the target within expected variation



Latest
97.2%
Variance Type
Normal variation - no recent change
Mar 26 Target
90.0%
Target Achievement
Will consistently fail the target within expected variation

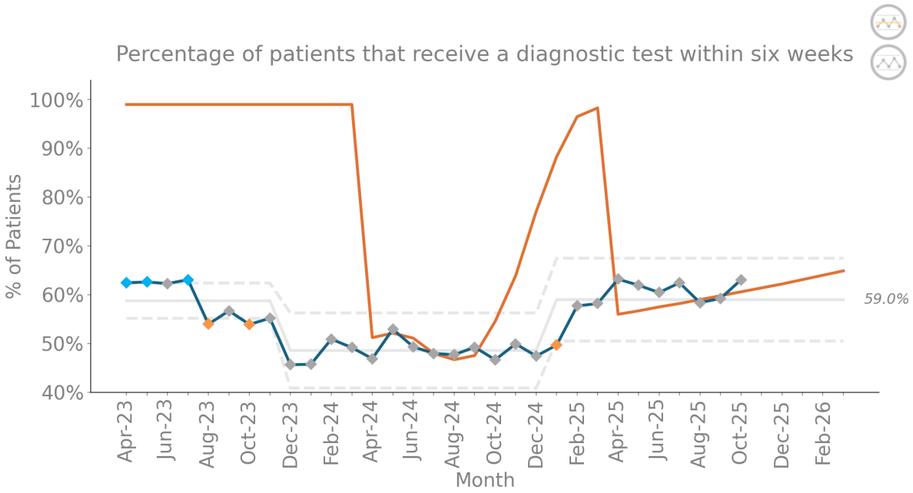


Latest
11.0%
Variance Type
Normal variation - no recent change
Mar 26 Target
5%
Target Achievement
Will consistently fail the target within expected variation

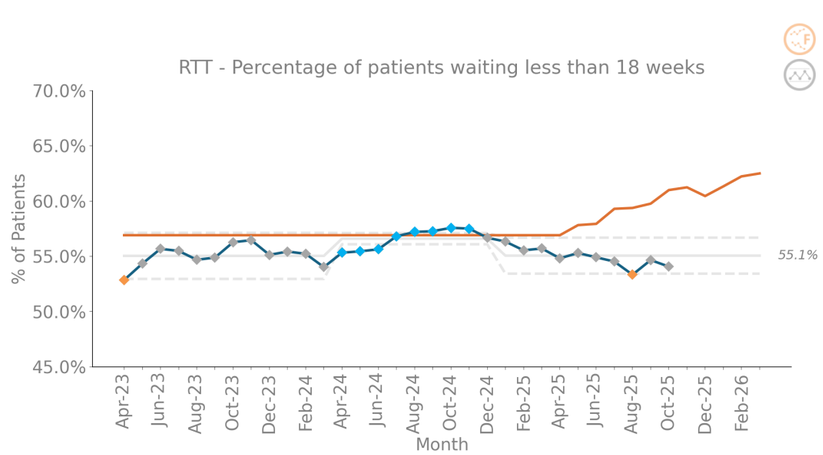
Metric	Summary	Action	Assurance
Number of Boarded Patients	On average 29 patients were boarded each day across both sites during October 25 with 905 associated bed days. This is decrease of 4 compared to the September 25 position. These are predominantly medical patients requiring admission to an acute medical ward. The position shows normal variance and will consistently fail the target within expected variation.	A focus on maximising use of the discharge lounge to reduce the need for boarding. The Medical Division has re-introduced Continuous Flow Model WC 17th March 2025.	Incident levels of harm are monitored on a monthly basis alongside patient feedback. UEC and In-patient survey feedback does reflect patient concerns regarding the practice of boarding. This is also reflected within the staff survey.
Bed Occupancy	The position shows an occupancy rate for October 25 of 97.2%, a drop of 0.2% compared to September 25. The data shows normal variation and will consistently fail the target.	The 24/25 UEC Improvement plan continue to be tracked against its ambitions to reduce avoidable admissions and reduce LOS. A significant change to the 25/26 UEC plan has been proposed and supported by the L&SC ICB and Central Lancashire UEC Delivery Board. Plans to further scope and mobilise the 25/26 programme is underway at pace. LTH has closed a 24 bedded ward in line with its Financial Recovery Plan at the end of Feb 25.	Assurance via the Urgent Care Improvement Board and Urgent Care Improvement Plan
Reduce NMC2R	The number of patients in our hospitals that do not meet the nationally defined clinical criteria to reside for inpatient care in acute hospitals (NMCTR) decreased in October (11.0% = daily average of 92 patients). Compared to the September position this is a decrease of 0.3%. The data shows normal variance.	The Days Kept Away from Home programme is a cornerstone of the length of stay reduction ambition within the trust. The programme seeks to significantly reduce the number and days patients spend away from home without clinical rationale. Initial monitoring of DKAFH metrics is showing reduction in care requirements on discharge and therefore a reduction in lost bed days whilst NMC2R.	Monitoring of NMC2R data is undertaken via the Central Lancs Urgent Care Delivery Board

Performance - Elective Care Assurance

Lancashire Teaching Hospitals NHS Foundation Trust



Latest
63.1%
Variance Type
Normal variation - no recent change
Mar 26 Target
65.0%
Target Achievement
Could both pass or fail target within expected variation



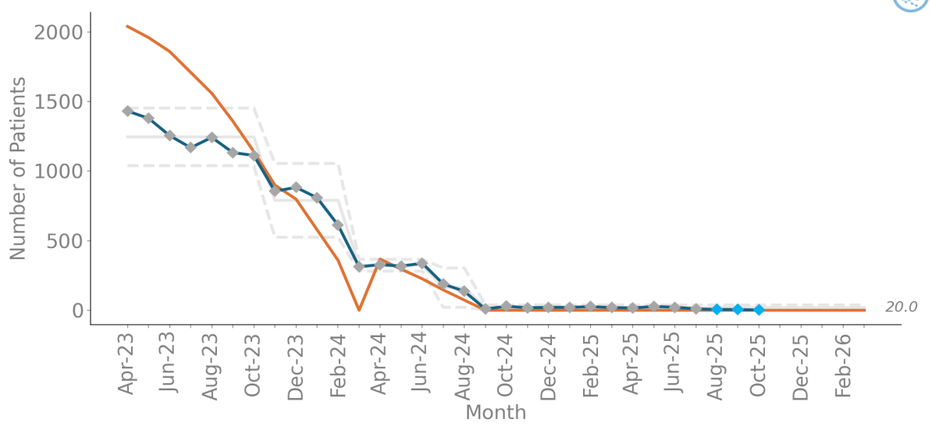
Latest
54.07%
Variance Type
Normal variation - no recent change
Mar 26 Target
62.50%
Target Achievement
Will consistently fail target within expected variation

Metric	Summary	Action	Assurance
Percentage of patients that receive a diagnostic test within six weeks	Diagnostics under 6 week performance was 63.1% in October compared to 59.3% in September, a 3.8% improvement on the September position and above trajectory. 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. Mutual aid has been requested for echocardiology. A rapid improvement week has been held WC 13/01/25 to support productivity improvements and reduce process barriers to support improved utilisation of the available endoscopy capacity. Actions and progress are being tracked weekly in a COO led PTL management meeting and monthly within the Diagnostic Improvement Group. Performance improvements have been achieved in CT, Audiology, Neurophysiology, sleep studies and scopes.	The areas of focus are capacity optimisation, productivity, transformation and system working. Review of the latest published data (Sept 25) indicates that LTH is 109th out of 118 trusts that submitted data, the worst performing Trust in the ICB and significantly below the national average of 77.5%.
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 October 25 position of 54.07% shows a position consistent with September, following a period of deteriorating performance. Analysis suggests normal variation in the data and that the target may be consistently failed.	Performance is monitored at Divisional level via the Elective Performance Review Group where Issues and risks.	Comparison to the latest national performance position (Sep 25) indicates that the Trust is below the national position of 61.8% waiting under 18 weeks. The Trust is ranked 105 out of 118 trusts nationally for Sept.

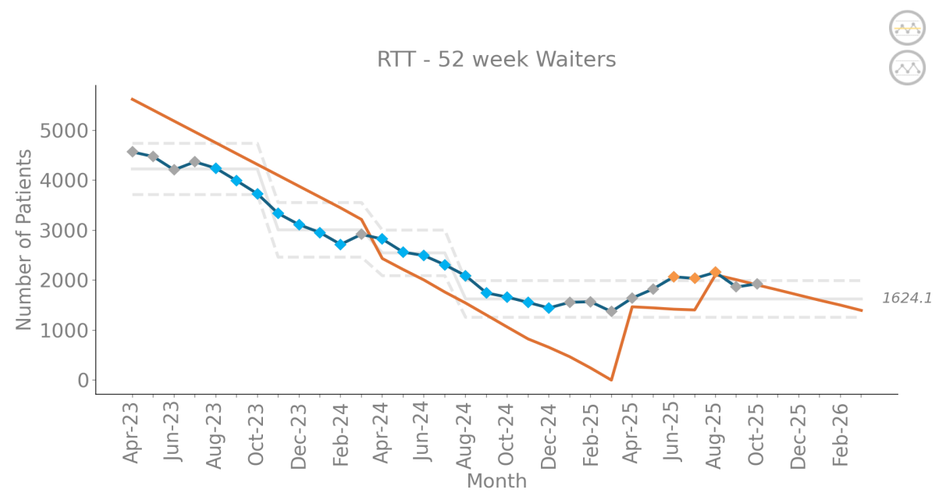
Performance - Elective Care Assurance

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

NHS Lancashire Teaching Hospitals NHS Foundation Trust



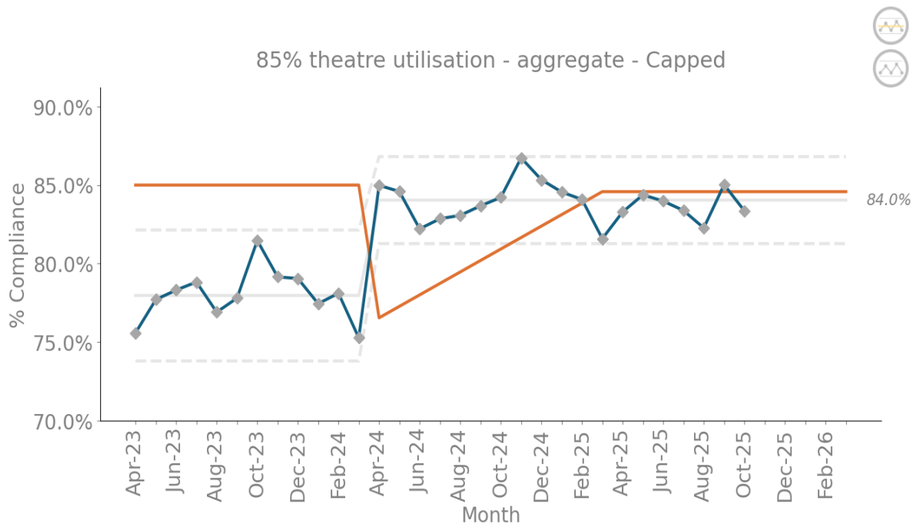
Latest
2
Variance Type
Recent positive pattern in the data
Mar 26 Target
0
Target Achievement
Will consistently fail the target within expected variation



Latest
1926
Variance Type
Normal variation - no recent change
Mar 26 Target
1395
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
RTT - 65 Week Waiters	The over 65 week waiters position decreased further in October to 2 from 5 in September 25. Breaches were all experienced within ENT, due to capacity shortfalls, equipment issues and on the day patient cancellations. There data shows normal variation, however analysis would suggest that the target may be consistently failed.	There is a process in place to ensure daily assurance of progress with >65 week waits prioritising and ensuring the sustained elimination of >78 week waits. Issues and risks are reviewed at the Elective Performance Review Group.	Monitoring of all premium cost activity is ongoing. Capacity & Demand modelling analysis is being concluded in line with the 25/26 annual planning process. Comparison to the latest NW region position indicates that the Trust is currently 12th out of all acute and specialist trusts and 6th out of acute Trusts in terms of the number in the 65 week waiter cohort.
RTT - 52 week Waiters	The over 52 week waiter position in October was 1,926, a slight increase of 62 compared to the September 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 2.99%, consistent with the September position.	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 (Sep 25) indicates that the Trust is above the national picture which is 2.4% waiting over 52 weeks. The Trust is ranked 79 out of 118 trusts that submitted data for Sept 25.

Performance - Theatre Utilisation



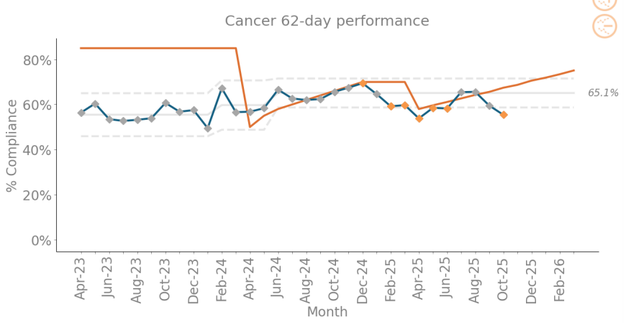
Latest
83.4%
Variance Type
Normal variation - no recent change
Mar 26 Target
84.6%
Target Achievement
Could both pass or fail target within expected variation

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

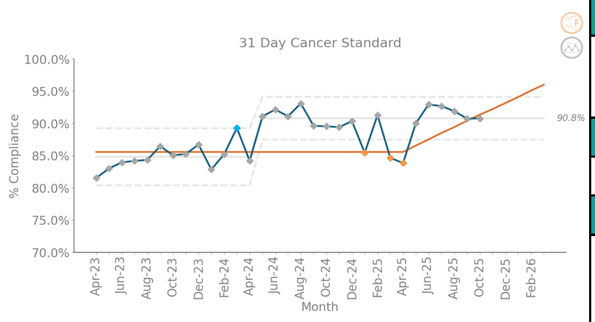
Performance - Cancer Assurance

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

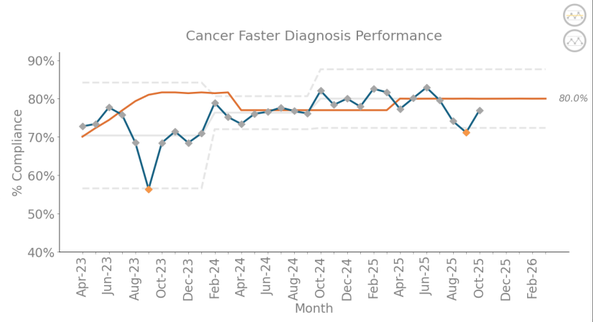
NHS Lancashire Teaching Hospitals NHS Foundation Trust



Latest
55.4%
Variance Type
Recent concerning pattern in the data
Mar 26 Target
75.1%
Target Achievement
Will consistently fail target within expected variation



Latest
90.8%
Variance Type
Normal variation - no recent change
Mar 26 Target
96.0%
Target Achievement
Will consistently fail target within expected variation



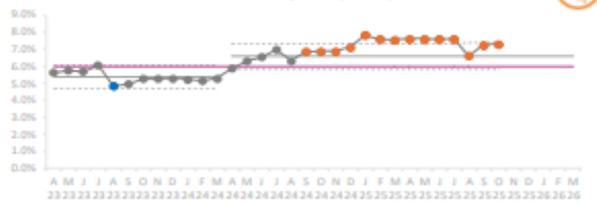
Latest
77.0%
Variance Type
Normal variation - no recent change
Mar 26 Target
80.0%
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
62 Day Cancer Standard	Performance to the end of October 25 (currently unvalidated) is below last month, and below the monthly operational plan target of 67.4%. Analysis shows a recent concerning pattern in the data and will consistently fail the target.	Whilst Cancer performance is improving there are a small number of tumour groups with the greatest collective contribution to current performance challenges, these are Colorectal, Lung, Breast and Urology. All tumour sites have improvement plans to achieve performance targets.	The Trust is currently below the latest national average performance of 67.9% (Sept 25) and ranked 95 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 October 25 (currently unvalidated and expected to meet the target) is slightly below last months position, and below the monthly operational plan target of 91.3%, and is expected to improve once validation is complete. Analysis shows normal variation and will consistently fail the target.		The Trust is currently below the latest national average performance of 91.3% (Sept 25). Close monitoring of cancer PTLs are undertaken at the weekly Operational Board
Cancer Faster Diagnosis Performance	Performance to the end of October 25 (currently unvalidated) is above last months position, and below the monthly operational plan target of 80%, and is expected to improve once validation is complete. Analysis shows normal variation and will consistently fail the target.		The Trust is currently above the latest national average performance of 73.9% (Sept 25) and ranked 83 out of 118 trusts nationally. Close monitoring of cancer PTLs are undertaken at the weekly Operational Board

People - Workforce Assurance 1

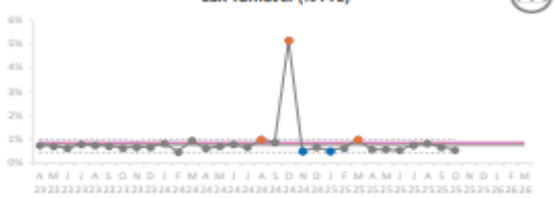
NHS Lancashire Teaching Hospitals NHS Foundation Trust

GL Vacancy Rate (% FTE)



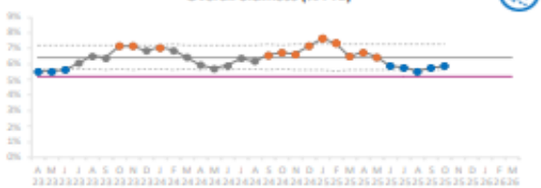
Latest
7.30%
Variance Type
Recent concerning pattern in the data
Mar 26 Target
≤ 6%
Target Achievement
Could both pass or fail target within expected variation

ESR Turnover (% FTE)



Latest
0.55%
Variance Type
Normal variation - no recent change
Mar 26 Target
≤ 10%
Target Achievement
Could both pass or fail target within expected variation

Overall Sickness (% FTE)

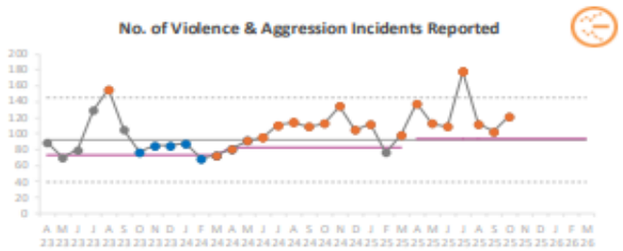


Latest
5.88%
Variance Type
Normal variation - no recent change
Mar 26 Target
≤ 5.22%
Target Achievement
Will consistently fail the target within expected variation

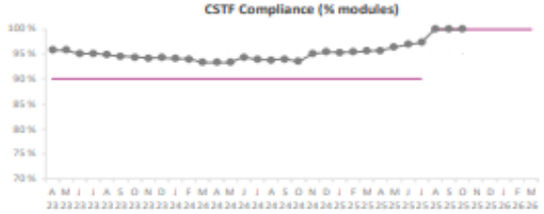
Metric	Summary	Action	Assurance
Vacancies (% FTE)	Vacancy rate remains high due to vacancy control measures. Additional vacancy control measures have been introduced this month to support financial recovery delivery by M12.	Divisional management teams continue to review vacancies at Divisional Vacancy Control Panels. New Vacancy Control terms of reference are being developed to support enhanced financial recovery with weekly limits set across the Trust for numbers of external vacancies that will be released to control WTE growth.	Vacancy rate continues to monitored through Board reporting, Workforce Committee and Divisional Improvement Forums Safe staffing levels monitored daily in clinical areas The Workforce and OD SIP Board monitors and delivery and actions in relation to vacancy control measures. EQIA process utilised to support vacancy control decision-making and associated safe staffing risks.
Turnover (% FTE)	Turnover has continue to reduce to 0.55% in Month 7, compared with 0.86% in September.	Undertake a review into levels of retirement and how this benchmarks across regional and national trends. Implement actions following the NHSE Retention Self Assessment based on gaps founds. Further embed the probationalry proces and move to monitoring complaince against the prcess.	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)	Sickness absence increased slightly in M7, although long-term absence has continued to reduce. The overall absence rate is running >0.8% lower than the same period last year, and benchmarks favourably when compared to the other provider Trusts in Lancashire and South Cumbria.	Further Rapid Improvement Event with divisional management teams on 5 December. Empactis implementation in pilot areas - anticipated to be live early in the New Year. Flu vaccination campaign commenced on 1st October. Uptake remains significantly lower than pre-Covid, although to date is already >5% higher than last year's final position.	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 Fortnightly sickness absence task and finish group in place to monitor actions of the sickness absence reduction plan

People - Workforce Assurance 2

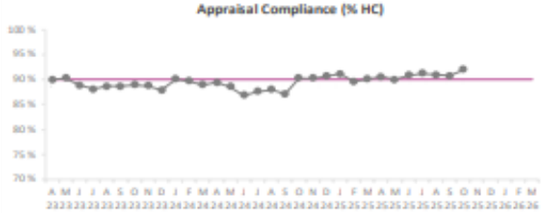
Lancashire Teaching Hospitals NHS Foundation Trust



Latest
122
Variance Type
Normal variation - no recent change
Mar 26 Target
NA
Target Achievement
Could both pass or fail target within expected variation



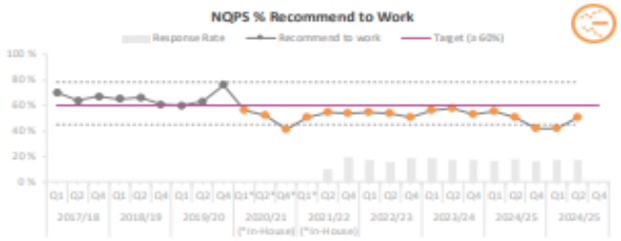
Latest
100.00%
Variance Type
Mar 26 Target
100% of metrics at 90%
Target Achievement



Latest
91.94%
Variance Type
Mar 26 Target
≥ 90%
Target Achievement

Metric	Summary	Action	Assurance
Number of violence and aggression incidents toward staff	Incidents increased slightly in M7, compared to M6. It remains the case that the majority of incidents occur in Emergency Department.	The Mental Health and Violence Prevention and Reduction Big Rooms are progressing improvement work related to restraint and violence markers. New security system implemented at Chorley.	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)	Overall Trustwide Core Skills and Mandatory training compliance is 100%.	Divisions to continue enhanced scrutiny of Core Skills and Mandatory Training to ensure sustained compliance for all metrics	All divisions have achieved 90% compliance for all Core Skills and Mandatory Training.
Appraisal compliance (% HC)	Appraisal complaince above target at 91.94%, 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 and changing how medical appraisal compliance is recorded.	Annual Appraisal Update presented to Workforce Committee in May 2025. Divisional Performance metrics shared in Divisional Workforce Committees and Divisional Improvement Forums.

People - Workforce Assurance 3



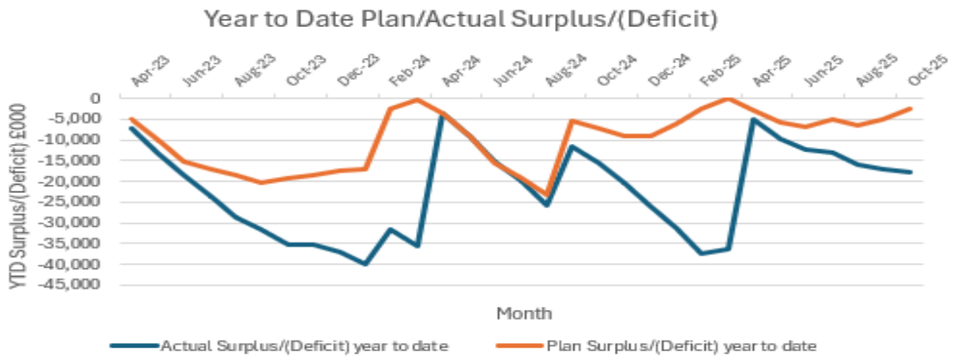
Latest
51.0%
Variance Type
Recent concerning pattern in the data
Mar 26 Target
≥ 60%
Target Achievement
Will consistently fail the target within expected variation

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.**	As described in the Single Improvement Plan programme of work for staff engagement, the NHS Staff Survey is currently live till the end of Novemeber, at the time of writing this update completion rate is at 41% against the internal target of 50%. The Staff Engagement Proposal actions are underway with the first Executive Lead your voice event being held on the 26th November, the Staff closed Facebook page due to launch in December, the profession specific recognition and engagement days have been identified for the next 12 months, with relevant leads being contacted to provide support for interactive conversations to take place and a listening in action approach applied to address suggested areas for improvement.	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.

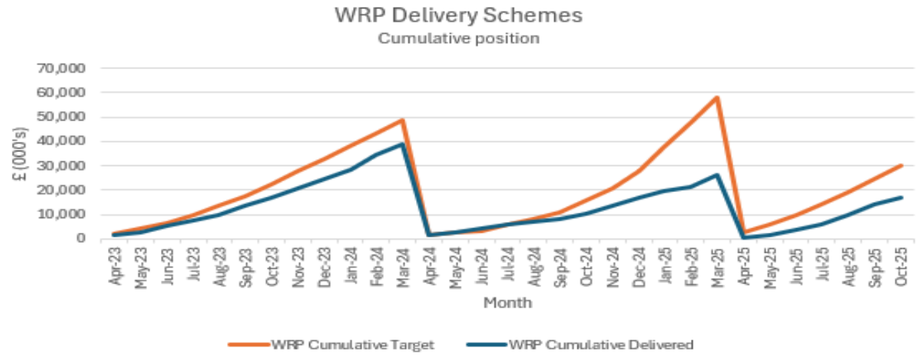
Productivity - Assurance

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

NHS Lancashire Teaching Hospitals NHS Foundation Trust



Latest YTD Actual (,000s)
-17,712
Latest YTD Target (,000s)
-2,506
March 26 YTD Target (,000s)
-



Latest YTD Actual (,000s)
16,912
Latest YTD Target (,000s)
30,287
March 26 YTD Target (,000s)
60,000

Metric	Summary	Action	Assurance
I&E - Plan v Actual variance	At the end of October 2025 the Trust has a deficit of £17.7m against a planned deficit of £2.5m. The adverse variance to plan of £15.2m is as a consequence of the shortfall in delivery of the Waste Reduction Programme (£13.4m) and operational pressures of £1.8m. 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 £18m that it has been unable to mitigated associated with; industrial action, patient acuity, buildings dilapidations and maintenance of its energy system, these are unusual expenditures and are 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 has a Turnaround Director to work with senior leaders to re-assess the current waste reduction programme position and deep dive into short, medium and long-term opportunities. A re-set of the programme structure, governance and reporting for 2025/26 has taken place. The Trust is working with the ICB on the urgent and emergency pathway system pressures which is one of the main operational pressures that the Trust faces. The system is now receiving enhanced support from NHSE as part of the provider improvement programme (formerly recovery support programme). A focus on grip and control activities continues. The Trust has commissioned further external support to support specific financial recovery plan workstreams and 2025/26 waste recovery programme development. Divisions will need to recover their financial performance by delivering improvements in their current run rates e.g. maximising grip around temporary pay, review of vacancies and continuing to mitigate shortfalls in the efficiency target as schemes move through development and implementation stages.	Turnaround Director Working with ICB on UEC Pathway Grip and control Interventions and control measures Mandated national support from PWC and the Provider Improvement Programme (formerly Recovery Support Programme)
WRP schemes delivery	'The Trust's 2025/26 waste reduction target is £60m, 7% of operating expenditure. At the end of October the Trust has delivered £26.6m of the £60m target (44%). The delivery in month was £3.0m 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 has a Turnaround Director to work with senior leaders to re-assess the current programme position and deep dive into short, medium and long-term opportunities. A re-set of the programme structure, governance and reporting has taken place for 2025/26. The Trust has additional external support to help with the delivery of the programme. The Trust is building up its own project management office structure to have a sustainable solution moving forward. The Trust is enhancing grip and control activities to mitigate slippage in specific schemes.	Turnaround Director Waste reduction programme board chaired by CEO External support for specific workstreams. Implementation of Divisional Delivery Groups Implementation of PMO

9.2 FINANCE AND PERFORMANCE COMMITTEE CHAIR'S REPORT

Other | J Schorah | 10.45am

*Inc UEC Deep Dive report included in the separate ancillary pack
Item for Assurance

REFERENCES

Only PDFs are attached

9.2 - Chairs report - FPC - 23 Sept and 21 Oct 25.pdf

Chair's Report to Board		
Chair: J Schorah	Committee: Finance and Performance Committee	
Date(s): 23 Sept & 31 Oct 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	⇨	• **The Urgent and Emergency Care Deep Dive Report was reviewed by the Committee at the 25 November meeting and is included in the ancillary pack.**

ALERT

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

- **Urgent alert from 25 November meeting -** The Committee expressed concern about the lack of assurance on workforce-related mitigations within the WRP, noting that previous measures such as enhanced scrutiny and PMO support had not delivered the expected impact. It was agreed that a specific report on workforce plans and financial implications would be presented at the next meeting, with senior workforce leadership in attendance to provide assurance.
- **Strategic Risk:** The risk linked to urgent and emergency care (PR5) remained off track. While there had been progress in reducing bed days for the 'days kept away from home' cohort, total lost bed days still exceeded targets, leading to ED overcrowding and ongoing boarding issues.
- **Finance Position:** The Committee noted that while there had been progress, there were risks in the delivery of the WRP. The Committee stressed the need for close oversight of the cash position, noting that programme delivery is increasingly constrained by cash pressures. Any delivery shortfall would worsen financial strain, reinforcing the importance of proactive operational and financial management.
- **Performance Assurance Report**: As noted in the Advise section of this report there is progress on various targets however, RTT and 18-week wait performance remain challenged, with a small number of residual 65 week breaches in ENT and Surgical Dentistry due to case complexity and patient choice. 52-week+ breach numbers are below trajectory across several key specialties driven by capacity constraints. Overall, 18-week performance continues to decline due to limited capacity and funding. Boarding figures held steady in August, averaging 23 patients. UEC 4-hour performance worsened in August across All Types and Type 1, falling below plan. Cancer 62-day performance remains below target (58.51% in May), impacted by capacity issues in a few tumour groups.
- **M6 Finance**: The Trust was now trending towards the worst-case financial forecast due to slippage in new schemes and the removal of the VAT/Estates transformation scheme from the mid-case projection. While this reflected variance to plan, the Committee acknowledged that the Trust was making meaningful progress against a challenging target, including nearing full-year delivery levels and achieving a £1.7 million monthly reduction in operational expenditure.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- **Single Improvement Plan:** It was noted that while SIP delivery actions were progressing to plan, there remained a question as to whether these actions were effectively impacting the intended outcomes. The organisation's entry into the Performance Improvement Programme (PIP) triggered a review of the SIP, with a focus on key areas identified by the RSP team. Risks were noted around expanding the SIP scope beyond current capacity and timelines. Delivery plans were being adjusted to align with PIP priorities. The Committee was advised that failure to deliver the SIP could impact the Trust's 2025/26 waste reduction and financial improvement targets.
- **Performance Assurance Report:** Ambulance handover performance improved in August but remained below national and Trust targets for 15, 30, and 60-minute benchmarks. Initial clinical assessment times also improved but still exceed targets, although they outperform national and regional averages. 12-hour+ ED stays worsened but remain within the Operational Improvement Plan. Patients within the Days kept away from home cohort decreased for the third month and were below target, while lost bed days rose above target. Diagnostic performance (DM01) exceeded targets in July but fell 41% in August across modalities, now below target and national average. Virtual ward occupancy remained below target.
- **M6 Finance -** The Committee requested an update in November regarding the tighter recruitment thresholds, including pausing recruitment in specific areas based on real-time data from the daily management system. These measures were confirmed to be ready for immediate implementation upon approval.
- **SIP Update -** Slippage in delivery was acknowledged, but assurance was given that catch-up was underway, supported by new PMO appointments and executive oversight. The permanent PMO lead had recently joined the Trust, and it was agreed that they would be introduced to Non-Executive Directors and attend future workshops before formally joining committee meetings in the new year.
- **Annual Plan, Forward Plan and 3 Year Trajectory** - The importance of early engagement in planning was emphasised, particularly in relation to capacity, demand and affordability at system level.
- **Performance Assurance Progress Report** - The Committee expressed appreciation for the progress made in improving long-standing performance metrics. September data showed positive movement in planned care, with a 1.4% improvement in 18-week referral-to-treatment performance. Additionally, 52-week breaches had reduced to 2.9%, approaching the internal aspiration of 2.5%. A further reduction in 65-week breaches was also noted, with the ambition to eliminate these entirely. Cancer performance showed improvement, with 62-day metrics exceeding target for a second consecutive month.

ASSURE

Assurance received; Matters of positive notes

- **Strategic Risk:** The Committee was advised that one operational risk which was high scoring has been assessed as having reduced below a score of 15 in the last review – ID 1808: risk of delay to patient pathways due to inability to deliver and fully utilise core sessions in Endoscopy.

- **WRP & WTE Reduction:** The Committee received assurance that agency staffing levels remained within acceptable parameters. It was agreed that further detail on pay would be brought to the next meeting to support continued oversight and strategic planning.
- **Performance Assurance Report:** ED triage times have improved, now falling below the target threshold. Compliance with the Cancer Faster Diagnostic Standard continues to exceed the target level.
- **Strategic Risk:** The Committee expressed support for the recommendation to move Principal Risk 16 to a score of 8, noting it as positive progress. This related to the failure to progress the configuration of Trust services to support the Clinical Strategy for Lancashire Teaching Hospitals and Lancashire and South Cumbria.

Finance and Performance Committee

23 September 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 26 August 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	M5 Finance Position and General Finance Update	1.20pm	✓	Assurance	C Carter
7.2	Divisional Delivery Group Report – Medicine Division	1.40pm	✓	Assurance	D Bedford
8.	STRATEGY & PLANNING				
8.1	Planning Controls Update inc. SIP & external dependencies	1.55pm	✓	Assurance	K Marshall
8.2	Annual Plan, Forward Plan and 3 Year Trajectory	2.05pm	✓	Assurance	A Ryan
8.3	Planning Framework / Business Planning Process 2026/27	2.15pm	✓	Assurance	A Ryan
9.	OPERATIONAL PERFORMANCE				
9.1	Performance Assurance Progress Report	2.25pm	✓	Assurance	K Foster-Greenwood
9.2	Winter Plan	2.40pm	✓	Decision	K Foster-Greenwood
10.	GOVERNANCE AND COMPLIANCE				
10.1	NWSDE and AGem Contract	2.55pm	✓	Assurance	S Dobson
10.2	Green Plan	3.05pm	✓	Decision	T Summersgill

№	Item	Time	Encl.	Purpose	Presenter
10.3	Items to Alert, Advise or Assure the Board	3.20pm	Verbal	Information	J Schorah
10.4	Reflections on the meeting	3.25pm	Verbal	Information	J Schorah
11.	ITEMS FOR INFORMATION				
11.1	Contract Performance		✓		
11.2	Costing, costing transformation and patient-level costing (Q4 24/25) (in line with the national timetable)		✓		
11.3	Chair's Reports/Minutes: (a) Information Governance and Records Committee		✓		
11.4	Date, time, and venue of next meeting: *21 October 2025, 1.00pm, Microsoft Teams*	3.30pm	Verbal	Discussion	J Schorah

Finance and Performance Committee

21 October 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 23 September 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	M6 Finance Position and General Finance Update	1.20pm	✓	Assurance	C Carter
7.2	Turnaround Director and Divisional Delivery Group Report – Surgery Division	1.35pm	✓	Assurance	K Pringle L Wilkinson
8.	STRATEGY & PLANNING				
8.1	Planning Controls Update inc. SIP & external dependencies	1.55pm	✓	Assurance	A Brotherton
8.2	Annual Plan, Forward Plan and 3 Year Trajectory	2.10pm	✓	Assurance	I Ward
8.3	Pathology Service Transfer Due Diligence	2.25pm	✓	Assurance	A Rowbottom
9.	OPERATIONAL PERFORMANCE				
9.1	Performance Assurance Progress Report	2.40pm	✓	Assurance	K Foster-Greenwood
9.2	Industrial Action Impact Report	2.55pm	✓	Assurance	K Foster-Greenwood
9.3	One LSC Procurement update (incorporating supplier scores)	3.10pm	not received	Assurance	J Collins
10.	GOVERNANCE AND COMPLIANCE				

№	Item	Time	Encl.	Purpose	Presenter
10.1	Items to Alert, Advise or Assure the Board	3.20pm	Verbal	Information	J Schorah
10.2	Reflections on the meeting	3.25pm	Verbal	Information	J Schorah
11.	ITEMS FOR INFORMATION				
11.1	Contract Performance		✓		
11.2	Trading Accounts (inc. Deficit Protocol Controls)		✓		
11.3	Chair's Reports/Minutes: (a) EPRR Committee (b) ELFS Management Board (c) LHS Minutes		✓		
11.4	Date, time, and venue of next meeting: *25 November 2025, 1.00pm, Microsoft Teams*	3.30pm	Verbal	Information	J Schorah

10. PATIENTS (SAFETY AND QUALITY)

10.1 SAFETY AND QUALITY COMMITTEE CHAIR'S REPORT

Other | K Deeny | 11.00am

Item for assurance

REFERENCES

Only PDFs are attached

10.1 - Chair's report - Safety and Quality Committee - 26 Sept & 31 Oct 2025.pdf

Chair's Report to Board		
Chair: Non-Executive Director Dr Karen Deeny	**Safety and Quality Committee**	
Date: 26 September & 31 October 2025	**Agenda attached for information**	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	Trend	Items Recommended for approval
Consistently Deliver Excellent Care	→	**None**

ALERT **Areas of concern; Matters requiring urgent attention; Insufficient assurance received.**	None to report
ADVISE **Areas requiring on-going monitoring; Limited assurance received.**	**VTE:** A multi-professional Venous Thrombus Embolism Improvement Group had been established and meeting weekly. Initial findings indicated data flow issues linked to documentation changes. Specialty-level data had been shared and expectations reinforced through governance forums. **Pressure Ulcers**: While performance remained within expected levels of variation, an increase in device related incidents highlighted the need for continued vigilance and targeted intervention. Assurance was provided through ongoing monitoring, and focused improvement actions aligned to the "Always Safety First" strategy. **Birth Rate Plus:** The current Birth Rate Plus assessment was ongoing with a report anticipated by the end of October 2025. **Children and Young People:** The Committee acknowledged the improvement in patient experience within the Children and Young People services, noting a reduction in complaints and an increase in compliments. This was recognised as a reflection of sustained efforts over the past 18 months to enhance service quality and responsiveness. **Never Event:** The Committee received an update on the Interventional Radiology incident where a balloon fragment had been retained in the patient during a planned angioplasty and later removed following scan identification. The patient was informed and had recovered well. This has been confirmed as a Never Event with actions were underway. The Committee requested assurance on progress and a report would be presented in early January to provide assurance of delivery. **Children's Ward 8:** The Committee highlighted the importance of cross-referencing workforce strategies for retaining younger staff with the Workforce Committee. **Monroe House:** Monroe House had opened, providing a new facility for young people with dysregulated behaviour; this was seen as a significant step forward.

	Thrombectomy 24/7 Service Provision: The Committee noted the increased level of confidence to meet the February implementation date for the full service provision. **2024 Picker National Inpatient Survey:** Following the outcomes of the survey, an action plan had been developed in response to the findings and themes in order to improve the patient experience and involvement strategy.
ASSURE **Assurance received; Matters of positive note.**	**The committee received assurance reports relating to:** Strategic Risk Report Safety and Quality Dashboard Mid-year Maternity Safe Staffing Report Children and Young People Report Health Inequalities Report Inspection of Radiopharmacy Services by the Specialist Pharmacy Services (SPS) Quality Assurance Bi-annual Sepsis Report CQC Quarterly Update Thrombectomy Regulation 28 – Action Plan Update National Inpatient Survey 2024 National Cancer Patient Experience Survey 2024 C. Difficile Mortality Report Equality & Quality Impact Assessment Report Regulation 28 – Datix ID 181528 Infected Pacemaker Wound Central Alert system Assurance Report **The reports provided an overview of areas of strength and areas that required continued focus.** **Health Inequalities:** The Committee was assured in respect of the progress of the Health Improvement Plan since publication in December 2024, whilst noting the resource challenges to deliver all ambitions of the plan. **Sepsis:** Sepsis treatment compliance continued to improve, with Emergency Department rates rising to 86% and inpatient adult compliance maintained at 81%. Mortality rates remained below national averages. Mandatory training and blood culture competencies exceeded 90%. **Safe Staffing**: Staffing levels within maternity services remained aligned with national guidance, including recommendations from BAPM, RCOG and Birthrate Plus, ensuring safe care delivery in accordance with NICE standards. Nurse safe staffing levels are demonstrating a positive position. **Strategic Risk Register:** The Committee was assured of the progress updates and specific action plans for each of the principal risks aligned to the Committee. **Safety and Quality Dashboard:** The dashboard provided assurance of the safe staffing levels and improvement trajectory for Clostridioides Difficile infection rates.

	National Cancer Patient Experience Survey 2024: The report for Lancashire Teaching Hospitals (published July 2025) showed strong cancer patient experience with an overall average patient rating of 9.0/10. This score had been sustained for four years and was above national average. **Central Alert System Assurance Report:** All alerts received by the organisation had been responded to within required deadlines, demonstrating compliance and commitment to patient safety.

Safety and Quality Committee

26 September 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 29 August 2025	11.03am	✓	Decision	K Deeny
5.	Matters arising and action log	11.05am	✓	Decision	K Deeny
6.	Strategic Risk Register	11.10am	✓	Assurance	E Holden
7.	QUALITY AND PERFORMANCE				
7.1	Safety and Quality Dashboard	11.20am	✓	Assurance	C Gregory
7.2	Mid-year Maternity Safe Staffing Report	11.30am	✓	Assurance	E Ashton
7.3	Children and Young People Report	11.40am	✓	Assurance	C Gregory
7.4	Health Improvement Plan	11.50am	✓	Assurance	R Sansbury
7.5	Medical Staffing Report	12.00pm	✓	Assurance	M Stewart
7.6	Inspection of Radiopharmacy Services by the Specialist Pharmacy Services (SPS) Quality Assurance	12.10pm	✓	Assurance	G Price
7.7	Bi-annual Sepsis Report	12.20pm	✓	Assurance	C Roberts
8.	GOVERNANCE AND COMPLIANCE				
8.1	Strategic risk register review	12.30pm	Verbal	Decision	K Deeny
8.2	Items to alert, advise or assure the Board.	12.35pm	Verbal	Information	K Deeny
8.3	Reflections on the meeting	12.40pm	Verbal	Assurance	K Deeny
9.	ITEMS FOR INFORMATION (matters to be raised by exception)				
9.1	**Chairs' reports from feeder groups**: a) Infection, Prevention and Control Committee		✓		

№	Item	Time	Encl.	Purpose	Presenter
	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: *31 October 2025, 11.00am, Microsoft Teams*	12.45pm	Verbal	Information	K Deeny

Safety and Quality Committee

31 October 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 26 September 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	CQC Quarterly Update	11.40am	✓	Assurance	S Regan
7.4	Thrombectomy Regulation 28 – Action Plan Update	11.50am	✓	Assurance	D O'Brien
7.5	National Inpatient Survey 2024	12.00pm	✓	Assurance	S Morrison
7.6	National Cancer Patient Experience Survey 2024	12.10pm	✓	Assurance	A Tomlinson
7.7	C. Difficile Mortality Report	12.20pm	✓	Assurance	C Gregory
8.	GOVERNANCE AND COMPLIANCE				
8.1	Equality & Quality Impact Assessment Report	12.30pm	✓	Assurance	S Morrison
8.2	Regulation 28 – Datix ID 181528 Infected Pacemaker Wound	12.40pm	✓	Assurance	S Canty
8.3	Central Alert system Assurance Report	12.50pm	✓	Assurance	H Ugradar
8.4	Strategic risk register review	1.00pm	Verbal	Decision	K Deeny
8.5	Items to alert, advise or assure the Board.	1.05pm	Verbal	Information	K Deeny

№	Item	Time	Encl.	Purpose	Presenter
8.6	Reflections on the meeting	1.08pm	Verbal	Assurance	K Deeny
9.	ITEMS FOR INFORMATION (matters to be raised by exception)				
9.1	**Chairs' reports from feeder groups**: a) Infection, Prevention and Control Committee b) Safeguarding Board c) PSIRF Oversight Panel d) Medicines Governance Committee e) Patient Experience and Involvement f) Health Inequalities Group g) Mortality and End of Life Care Committee h) Health and Safety Governance		✓		
9.2	Date, time and venue of next meeting: *28 November 2025, 11.00am, Microsoft Teams*	1.10pm	Verbal	Information	K Deeny

BREAK

11.10am

11. PARTNERSHIPS (STRATEGY AND PLANNING)

11.1 MEDIUM TERM PLANNING FRAMEWORK (2026/27 TO 2028/29)

Other | A Brotherton | 11.30am

Item for assurance

REFERENCES

Only PDFs are attached

11.1 - Medium Term Planning Framework - Planning Update Dec 25.pdf

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Meeting of the	**Board of Directors**	**4th December 2025**	
	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: • Note the contents of this paper and support the planning activities required. • Actively engage in supporting with oversight and constructively challenging assumptions to ensure that plans developed give the assurance they are evidence-based, realistic, and aligned with our purpose and wider system strategy. • Support delegation of plan sign-off to EMT given the time constraints around draft submission on 17 December 2025. (Submission to region required on 16 December 2025)		
	Decision ☒	**Assurance** ☒	**Information** ☐
Executive Summary	This report updates the Board on the new NHS Planning Framework, which now requires a five-year strategic plan and three-year financial, workforce, and performance submissions. The process involves two key submission stages and sets ambitious national targets for access, efficiency, and workforce, with each organisation now responsible for achieving breakeven independently. Planning is progressing in two phases: groundwork and operational readiness. Most groundwork is complete, with ongoing work on demand, capacity, and workforce planning. The Board must provide assurance at both draft and final stages, confirming plans are realistic, deliverable, and aligned with national priorities. Key risks include tighter financial controls, challenging performance targets, workforce shortages, and compressed timelines.		
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: Board Assurance Framework Appendix 2: High-Level Timeline Appendix 3: Risk Log	

1. Introduction

1.1. The purpose of this paper is to provide the Trusts Board of Directors with an update on the NHS Planning Framework, updated publications and guidance and to provide assurance of the progress made within the organisation.

2. Discussion

2.1. A revised NHS Planning Framework (v2.0) was published on 24th October 2025, building and further refining on previous guidance, over the last few weeks a significant amount of guidance, technical definitions and supporting information has been published (over 50 documents in total). The key headline measures are described in the relevant sub-sections below.

2.2. Medium-Term Planning Framework and Strategy headlines

2.2.1. The most recent version confirms a shift toward a 5-year strategic plan, underpinned by a 3-year numerical returns covering finance, workforce and performance trajectories for the period 2026-27 through to 2028-29.

2.2.2. A two-stage submission process is confirmed where the 3-year numerical plans are submitted first (mid-December 2025), followed later by the full submission (early-Feb 2026), including the updated numerical plans, 5-year narrative plan, triangulation and integration along with board assurance statements.

2.2.3. Revised Targets have been introduced to outline the expectations of year 1 and confirming the expectation of year 3, these are summarised in Table 1 - national targets below:

Table 1 - national targets

Indicator	26/27 Target	27/28	28/29 Target
18 weeks	**Min 7% improvement, or 65%** (whichever is greater) *69.5% based on 25/26 M12 plan*	**81%**	**92%**
FDS	Maintain **80%**	**80%**	**80%**
31d	**94%** by Mar 27	**95%**	**96%**
62d	**80%** by Mar 27	**82.50%**	**85%**
DM01	Min 3% improvement or **80%** (whichever is greater)	90%	**99%**
4hr A&E	Maintain or improve to **82%** by Mar 27	83.50%	**85%**
12hr A&E	Improvement in % compared to 25/26	Year on Year improvement	Year on Year improvement
community health 18w	**78%**	**79%**	**80%**
Bank & Agency	30% reduction in agency 10% year on year bank	25% reduction in agency 10% year on year bank	25% reduction in agency 10% year on year bank

2.2.4. The target baselines for Referral to Treatment (18 weeks RTT) have been confirmed as being the Mar 26 position submitted in 2025/26 planning round. This presents a particular challenge for LTHTR as the performance submission made last year was conditional upon receiving the appropriate funding and growth, this did not happen.

2.2.5. Providers are required to submit detailed 3-year workforce plans as part of their planning submissions, covering numbers, roles, and skills needed to deliver service shifts and productivity targets, these should include detail of reducing sickness absence rates, reduction of expensive temporary arrangements.

2.2.6. We are required to implement reforms to consultant job planning, ensuring 95% of medical job plans are signed off annually, with robust monitoring and assurance systems in place by 2027/28, and multiprofessional job planning in place by 2028/29.

2.3. Revenue Finance and Contracting Guidance

2.3.1. Revenue Finance & Contracting Guidance introduces some major shifts in financial governance and planning expectations.

2.3.2. The previous 'system breakeven duty' is removed from 1 April 2026, where all ICBs and NHS Trusts are now required to maintain a breakeven financial position as individual bodies in each financial year.

2.3.3. Phasing Out Deficit Support Funding (DSF) - Non-recurrent DSF will be provided where an organisation has a deficit plan limit, allowing it to submit a breakeven plan. However, all ICBs and NHS trusts are expected to move to breakeven without deficit support funding by the end of the planning horizon. The Trusts own plans will move to breakeven position by the end of year 2, as detailed in previous papers and outlined in the Financial Sustainability Plan.

2.3.4. Linked to the point above organisations in receipt of DSF are required to report their financial position both including and excluding DSF in public board reports.

2.3.5. Efficiency Mandates mean that plans must incorporate the delivery of a sustained 2% year-on-year improvement in productivity as a minimum requirement, with Trust boards required to confirm that all productivity opportunities have been fully considered and reflected in plans as part of the assurance process.

2.3.6. ICB funding distribution is undergoing reform to target convergence toward fair shares and incorporate core growth assumptions moving toward target distribution over the planning horizon.

2.3.7. Major changes to the financial framework and payment scheme are introduced, setting out the 3-year revenue and 4-year capital spending review settlement, the disaggregation of block contracts, a proposed change to the way Urgent & Emergency Care is funded through a marginal rate approach, comprising a fixed element and a 20% variable payment, along with the introduction of more Best Practice Tariffs (BPT) to further incentivise the left-shift agenda.

2.3.8. ICB recurrent baseline allocations will be adjusted to include elective recovery funding distributed on a target basis, with additional non-recurrent funding provided from 2026/27 to 2028/29 to support meeting constitutional standards for elective care. This funding aims to improve elective and diagnostic activity performance, including the 18-week referral-to-treatment and 6-week diagnostic waiting time standards.

2.3.9. The Cost Uplift Factor (CUF) for planning purposes is summarised below in Table 2 - Net Uplift

Table 2 - Net Uplift

Cost	Estimate	Cost Weight	Weighted Estimate
Pay	2.10%	71.31%	1.50%
Drugs	0.58%	2.37%	0.01%
Capital	1.66%	4.44%	0.07%
Other	2.20%	19.66%	0.43%
Unallocated CNST	0.52%	2.22%	0.01%
Total Cost Uplift Factor (CUF)			2.03%
Efficiency Factor			-2.00%
Net Uplift			0.03%

- **Estimate**: The expected inflation rate for a specific cost category (e.g., pay, drugs, capital).
- **Cost Weight**: The proportion of total NHS spend that the category represents.

- **Weighted Estimate**: The category's inflation impact after applying its weight, contributing to the total CUF.

2.3.10. For years 2 and 3, the Total CUF is equal to the efficiency factor so there is 0% growth, Consumer Price Index (CPI) is expected to be around 2.0% for each of the 3 years in the planning horizon.

2.3.11. Maximising productivity and efficiency will therefore be essential to address the ongoing disparity between NHS funding uplift and cost increases aligned with CPI (See Figure 1 - inflation comparison). Although the gap is smaller than in previous years, robust mitigation plans remain necessary.

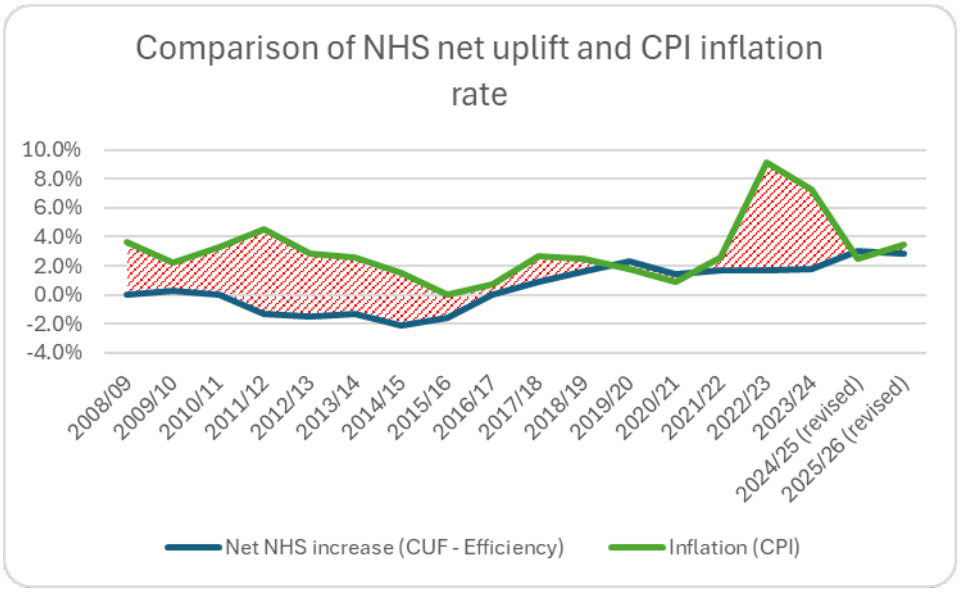


Figure 1 - inflation comparison

2.3.12. The chart above can be simplified to say that £1 in 2008/09, in NHS terms is now worth £1.10 and in RPI terms is worth £1.64 in 2025/26. The net funding for the next three years for NHS will be 0% with RPI forecasts around 3.5% in year 1 and 2.5% from year two and three.

2.3.13. Mandatory Contract Sign-Off - fully populated contracts using the NHS Standard Contract must be completed and signed by 31 March 2026. Failure to agree aligned plans and contracts locally will be viewed as a failure of leadership, resulting in NHS England rejecting plan submissions.

2.3.14. The expectations in guidance require us to deliver step-change improvements in access, quality, and productivity while operating within increasingly tight financial constraints and with the removal of system-level financial flexibility (i.e. breakeven required at organisational level, not system level). This invariably creates a tension between ambition and deliverability, especially where historic deficits or underlying demand pressures exist.

2.3.15. This tension if further compounded with an expectation of delivering productivity gains while reducing reliance on temporary staffing is extremely challenging in the context of ongoing workforce shortages, rising demand, and the need to maintain quality and safety, coupled with the adoption of new payment models that may shift financial risks may lead to us

becoming exposed to financial instability if activity or case mix changes faster than funding flows, especially with proposals around removal of block contracts.

2.3.16. Boards must provide assurance that they have oversight of the plans that include finance, activity, performance, and workforce data over a three-year horizon, with more detailed assurance statements and triangulation sign-off that plans are deliverable for the final submission. The compressed timetable for December submissions creates a risk of incomplete assurance and limited time for robust challenge and validation.

2.4. Board Assurance Process

2.4.1. The planning guidance requires Boards to provide formal assurance at two key stages of the planning cycle:

a) Draft Submission – 17 December 2025
- Focus on process assurance: confirming that the organisation has followed the required planning steps, engaged stakeholders, and applied governance principles.
- Board must review and approve the initial integrated plan and associated impact assessments.

b) Final Submission – 12 February 2026
- Focus on full endorsement: confirming that the final plans are deliverable, triangulated, and aligned with national priorities.
- Board must confirm that governance, prioritisation, and risk mitigation processes have been applied consistently.

2.4.2. This assurance is being undertaken via a maturity assessment of a range of board assurance statements (attached at Appendix 1) which are required to be signed off by the Chief Executive Officer and Chair, covering the following areas:

a) **Foundational activities**: acknowledgement and confirmation that the key planning actions outlined in the planning framework as part of Phase 1 have been conducted and reviewed
b) **Governance and leadership**: confirmation that appropriate decision-making structures are in place as well as key input and sponsorship at a senior and clinical level
c) **Plan development**: to provide assurance that plans have been developed in line with the standards outlined in the Medium Term Planning Framework, have been co-produced, are evidence based and align with national ambitions.

2.4.3. Each of the assurance statements must be assed for maturity using the following criteria:

i. **Embedded [Full Assurance]**: The action is fully integrated into normal operations. It is standardised, sustainable, and reinforced by policy, leadership, systems and culture. Continuous Improvement is an established norm, and outcomes are consistently positive.
ii. **Maturing**: The action is becoming routine. There are documented processes, growing staff awareness, and increasing consistency across teams. Evaluation and improvement mechanisms may be in place but are not yet fully optimised.
iii. **Developing**: Steps have been taken to introduce and implement this action. There may be informal processes, or isolated examples of good practice, but they lack consistency, coordination, or broad awareness.

iv. **Not Embedded [No Assurance]**: There is little to no evidence that this action has started. If it has, it's ad=hoc, inconsistent, or heavily reliant on individuals rather than being supported by systems and structures.

2.4.4. If board selects a maturity assessment of 2 to 4 for any statement, then supporting commentary must be provided, including a description of any exceptions that organisations wish to be noted. These statements and supporting narrative will form part of the submission required.

2.4.5. Acknowledging that confidence in the plans will be dynamic and evolve over the planning cycle, The first part of assurance and associated statements are based upon engagement in the process, whereas the final assurance will provide formal confirmation that:

- All considerations around **finance, workforce, activity, and quality of care** have been addressed.
- Plans are **deliverable, triangulated, and aligned with national priorities**.
- Governance, prioritisation, and risk mitigation processes have been applied consistently.

2.5. Current Progress

2.5.1. The planning cycle is segmented into two distinct phases as indicated in table 3 below:

Table 3 - Planning Phases

Phase:	Key Activities:
Phase 1 (Analysis, governance and redesign groundwork)	• Review and refresh clinical service strategies (e.g., elective recovery, urgent & emergency care) • Establish governance and leadership for planning at provider level • Conduct demand and capacity analysis for inpatient, outpatient, theatres • Identify fragile services and initiate pathway redesign • Assess workforce gaps and productivity opportunities • Complete financial baseline and cost driver analysis • Benchmark performance and identify variation in length of stay, readmissions, theatre utilisation • Engage with place-based priorities and JSNA for acute services
Phase 2 (Operational readiness, assurance and implementation)	• Finalise activity plans for elective, urgent, diagnostics, and cancer pathways • Triangulate finance, workforce, and activity for operational delivery • Confirm prioritisation principles for service changes and investments • Complete Board Assurance Statement for provider • Submit full planning templates and commentary to ICB/NHS England • Implement agreed productivity actions (e.g., theatre efficiency, discharge processes) • Prepare for performance monitoring and reporting against national targets

2.5.2. Phase 1 is largely complete, with Capacity & Demand work ongoing with support from the Intensive Support Team and PwC, Phase 2 activities are now well underway, a detailed project plan has been developed for tracking progress against key tasks and milestones. A high-level summary plan is included at Appendix 2. A risk log has also been created, there

is further work required to standardise this with the trusts adopted risk nomenclature and is included at Appendix 3: Risk Log

2.5.3. Workforce planning is progressing to plan with close working with the Finance team to ensure consistency in end of year positions and Financial Sustainability Plans. Detailed workforce changes arising from activity and performance consequences are embryonic at this stage and are expected to start crystalising when clarity begins to form around the point on the continuum between aspirational performance improvement and financial affordability.

2.5.4. Initial baseline financial submissions have been made to establish the baseline year end position with further iterations of plan being developed from this point.

2.5.5. Specialty-level engagement has been a major focus, with divisional / specialty meetings underway the first phase of face-to-face meetings has concluded, with second phase of meeting completing in the last two weeks of November, where teams are expected to present back their plans ahead of seeking divisional triumvirate and then executive lead sign off.

2.5.6. Capacity and demand work is ongoing supported by both NHSE Intensive Support Team (IST) and PricewaterhouseCoopers (PwC) once complete this will form a significant step in understanding the gap analysis between our own capacity compared to that needed to achieve the ambitious performance improvements.

2.5.7. Triangulation and reconciliation work is ongoing to align activity, workforce, and financial assumptions. Governance arrangements remain robust, with weekly meetings taking place with planning leads across the various disciplines and Executive oversight and attendance every other week.

2.5.8. System-wide discussions are taking place given the significant risk around affordability, control totals and the level of performance improvement that is being requested, system leaders are seeking a joint meeting with Regional colleagues who are driving for performance, and ICB colleagues who are balancing the books.

2.5.9. The System Planning Group continues to work with the ICB to elicit the underpinning detail behind the high-level commissioning intentions that were shared at the end of September, it is however unlikely that we will be in receipt of this information in time for inclusion in draft plan submission for 17th December.

2.5.10. Given the significant timescale constraints, the Board of Directors are asked to delegate approval of the draft operational plan submissions including assurance sign-off to EMT.

3. Financial Implications

3.1. Details Whilst there are no direct financial implications arising from this paper; it notes the proposed financial direction and recently published guidance and highlights that provider organisations are now in receipt of the control totals they must operate within.

4. Legal Implications

4.1. There are no direct legal implications arising within this paper.

5. Risks

5.1. This paper highlights the risks listed below:

i. Loss of system-level financial flexibility increases pressure on organisational breakeven.
ii. The level of performance improvement required is not likely to be met with associated increase in revenue funding.
iii. Achieving productivity gains while reducing temporary staffing is challenging amid workforce shortages and rising demand.
iv. Delays in receiving necessary detail around Commissioning Intentions means they cannot be assessed and included in draft submissions.
v. Compressed planning timetable risks incomplete assurance and limited validation.
vi. That board will be asked to assure final plans that do not meet all the national requirements.

6. Impact on stakeholders

6.1. The following impacts are identified:

i. Board and Executive Leadership will face increased responsibility for ensuring the organisation achieves breakeven at an individual level. They must provide robust assurance that integrated plans covering finance, workforce and performance are deliverable, while managing heightened financial risk under new payment models.

ii. Deeper engagement will be needed with clinical divisions and specialty teams, to produce final detailed activity, performance, workforce plans aligned with financial assumptions.

iii. ICB must adapt to changes in funding distribution and guidance around commissioning activity to delivery performance, and ensure commissioning intentions are communicated promptly to providers, reducing uncertainty during the planning cycle.

iv. Regional and ICB teams must be aligned to balance performance improvement with affordability.

7. Recommendations

7.1. The Board of Directors are asked to:

i. Note the contents of this paper and support the planning activities required.

ii. Actively engage in supporting with oversight and constructively challenging assumptions to ensure that plans developed give the assurance they are evidence-based, realistic, and aligned with our purpose and wider system strategy.

iii. Support delegation of plan sign-off to EMT given the time constraints around draft submission on 17 December 2025. (Submission to region required on 16 December 2025)

Provider Board assurance statements – first submission

Assurance Statement	Maturity Assessment 1-4
1. The board has reviewed the outputs from the foundational work undertaken as part of phase one of planning. This includes reviewing demand and capacity analysis.	
2. The board can confirm strong clinical leadership is involved in the development of plans.	
3. The board can confirm processes are in place to take into consideration the assessment of population needs, underserved communities and inequalities when developing plans.	
4. Robust quality and equality impact assessments (QEIA) are underway or are planned to be undertaken and reviewed by the board to inform development of the organisation's plan.	
5. The board is playing an active role in setting direction, reviewing drafts, and constructively challenging assumptions during the plan's development.	
6. The board is confident that there is a data-driven and clinically-led continuous improvement approach in place. The organisation has a systematic approach to building improvement capacity and capability.	
7. The board confirms that the organisation has established structures to work effectively with commissioners and system partners, ensuring that system working is constructive and efficient.	
8. The board can confirm that the plan is evidence-based, robust and deliverable. The board is content that the phasing of the plan across three years is realistic.	
9.The board can confirm that plans have been triangulated across finance, workforce and performance, ensuring each element of the plan reinforces the others, making the plan internally consistent.	
10. The board can guarantee that the organisation is fully considering and reflecting productivity opportunities in plans. This should include those identified in national data packs as well as any local opportunities to improve productivity.	
11. The board can confirm that the organisation has a robust approach to risk management in place including the ability to demonstrate a comprehensive understanding of financial risk and an agreed approach to managing and mitigating risks in year.	
12. The board can confirm work is underway to ensure contract values used in planning submissions are aligned across (commissioner and provider) activity and financial plans.	
13. The board can confirm that there is an effective process in place to manage the sign-off of contracts.	
14. The board can confirm that there is a timetable in place to ensure that the board will be updated on the sign-off of contracts and any delays to signing contracts will be reviewed by the board.	
15. The board can confirm the impact of the 10 Year Health Plan on the workforce is being considered in the development of plans. This includes the impact of productivity gains and how staff are deployed including the three shifts - from hospital to community, from analogue to digital, from sickness to prevention.	
16. **(Ambulance Trusts)** The board, supported by the lead ambulance commissioner, can confirm that there is alignment of hospital handover trajectories in both ambulance and acute trust plans within their footprint.	

Appendix 2: High-Level Timeline

Timetable to Review of Trusts Annual Business Planning Process

18/11/2025

ID	Task	Complete %	Q1			Q2			Q3			Q4		
			Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
			M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
1.0	**Revised planning process agreed**													
1.1	Undertake comprehensive review of existing tools and models (including lesson learned feedback)	100%												
1.2	System Planning Improvement Event	100%												
1.3	Map out timeline for further development of process and tools	100%												
1.4	Undertake model / tool refinements	100%												
1.5	Test models with selected stakeholders	100%												
1.6	Discuss & agree system colleagues changes & improvements	100%												
1.7	Communication of revisions to relevent teams	100%												
1.8	Undertake refresh of key data lines on quarterly basis to compare plans to forecasts	100%												
1.9	Issue to Teams	100%												
2.0	**25/26 planning Meetings**													
2.1	Session 1 - Launch (Virtual)	100%												
2.2	Session 2 - Initial Division / Speciality Plan (Face to Face)	100%												
2.3	Session 3 - Pre Draft Submission (Face to Face)	17%												
2.4	Session 3 - Divisional Sign-off	0%												
2.5	Session 4 - Divisional Check & Challenge (Face to Face)	0%												
2.6	Session 3 - Divisional Sign-off	0%												
3.0	**Plan Work up**													
3.1	Capacity & Demand / Model Service Review	35%												
3.2	Activity Planning	35%												
3.3	Commissioning Intentions Shared	100%												
3.4	Commissioning Intention Detail Numericals Shared	0%												
3.5	Business Case identification and workup	25%												
3.6	Waste Reduction Plan development	20%												
3.7	Financial Plan	35%												
3.8	Workforce Plan	35%												
4.0	**26/26 Governance**													
4.1	Assessment of outputs & triangulation	10%												
4.2	Triumvirate sign-of plans	0%												
4.3	**Director Sign-off final plans**	0%												
4.4	**Board Sign-off of final plan**	0%												
4.5														
5.0	**Submissions**													
5.1	Initial Draft to PCB / ICB	0%												
5.2	Draft Submission (17/12)	0%												
5.3	Final Draft to PCB/ICB	0%												
5.4	Final Submission (05/02)	0%												
5.5														
5.6														

Appendix 3: Risk Log

Operational & Contract Planning

Tue, 18 Nov 2025
Version:

Minimum	Low	Moderate	High	Extreme
Accept	Mitigate / Transfer		Eliminate	

Ref	Risk Description	Owner	Date Raised	Assessment				Mitigation action	Action Completed Date	Risk status (Planned, Active, Closed)
				Probability (1 = v. unlikely, 5 = v. likely)	Impact (1 = v. low 5 = v. high)	Risk Score (1 = v. low, 25 = v. high)	Risk Profile			
1	Performance ambition exceeds available funding resource (early indication suggest cost of improvement over three year horizon at £63.5m)	ICB/Trust		5	4	20	Extreme	consider planning scenarios (Affordable performance, and cost of hitting standards) - appropriate escalation through EMT and Board.		
2	Commissioning Intentions detail not available in sufficient time to factor into draft planning submissions	ICB		4	2	8	Low	The PSC supporting ICB on 10 priorities intentions.		
3	Supporting guidance not published in sufficient time to inform draft plan	National		3	3	9	Moderate	Plan on what is known and document assumptions and risks		
4	Capacity & Demand not completed for initial draft plan submission	Trust		3	2	6	Low	Assessment of volume of activity to achieve standards		
5	Insufficient time and resource to adequately prepare robust returns for draft submission following change to planning horizon (3 year plans)	Trust		3	3	9	Moderate	Document shortfalls and explain in narrative.		
6						0	--			
7						0	--			
8						0	--			
9						0	--			
10						0	--			
11						0	--			
12						0	--			
13						0	--			
14						0	--			
15						0	--			

	Impact	Negligable	Minor	Moderate	Significant	Severe
Probability		1	2	3	4	5
(81-100)%	5	5	10	15	20	25
(61-80)%	4	4	8	12	16	20
(41-60)%	3	3	6	9	12	15
(21-40)%	2	2	4	6	8	10
(1-20)%	1	1	2	3	4	5

12. PEOPLE (WORKFORCE, EDUCATION AND RESEARCH)

12.1 WORKFORCE COMMITTEE CHAIR'S REPORT

Other | A Leather | 11.50am

Item for assurance

REFERENCES

Only PDFs are attached

12.1 - WFC Chairs Report 11 Nov.pdf

Chair's Report to Board		
Chair: Adrian Leather	Workforce Committee	
Date(s): 11 November 2025	Agenda attached for information	✓

Strategic Risks	trend	Items Recommended for approval
People: Be a Great Place to Work – current score 12	→	

ALERT

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

- The Committee noted uncertainty in achieving projected risk score reductions for PR10 (sickness absence management) and that the risk may not reduce as anticipated due to external factors and winter pressures. The Board should be alerted to these uncertainties and the need for realistic expectations.

  The Committee would also recommend a Board-level discussion on risk appetite and tolerance in light of organisational priorities, while recognising significant improvements achieved in long-term sickness absence and workforce resilience.

- The Committee reflected on assurances received regarding achieving the WTE workforce reduction and meeting the 2025–26 Workforce Reduction Plan targets. It was agreed that, given current performance, these targets remained highly challenging. Following further discussion, it was concluded that the risk in this area had increased and confidence in mitigation actions to recover the position was low.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- The Committee agreed to advise the Board on recognising available tools such a TED programme to support delivery through the workforce and alignment with oversight framework requirements.

  A Board workshop was suggested to better understand and promote the contribution of people-focused programmes (e.g., TED, engagement, recognition) to strategic delivery and oversight framework.

ASSURE

Assurance received;

- The Committee was assured of the progress of the enhanced leadership and management development offer, with increased uptake and impact on operational activities and culture.

Matters of positive note.

Workforce Committee

11 November 2025 | 1.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	a) Chair and quorum b) Temporary recording of meeting	1.00pm	Verbal	Information	A Leather
2.	Apologies for absence	1.01pm	Verbal	Information	A Leather
3.	Declaration of interests	1.02pm	Verbal	Information	A Leather
4.	Minutes of the previous meeting held on 9 September 2025.	1.03pm	✓	Decision	A Leather
5.	Matters arising and action log	1.05pm	✓	Decision	A Leather
6.	Strategic Risk Register	1.10pm	✓	Assurance	S Regan
7. PERFORMANCE					
7.1	People Accountability Oversight Framework	1.15pm	✓	Assurance	K Downey
7.2	Financial Recovery / Workforce Reduction Update	1.25pm	✓	Assurance	K Downey
8. TO ATTRACT, RECRUIT AND RESOURCE					
8.1	Recruitment Strategy Report	1.35pm	✓	Assurance	K Downey
9. TO DELIVER A RESPONSIVE, FUTURE FOCUSSED AND ENABLING SERVICE					
9.1	Annual Medical Employee Relation Cases	1.45pm	✓	Assurance	R O'Brien
10. TO BE WELL LED					
10.1	Annual Leadership and Management Development Strategy Report	1.55pm	✓	Assurance	L Graham
11. TO CREATE A POSITIVE ORGANISATIONAL CULTURE					
11.1	Biannual Freedom to Speak Up Report	2.05pm	✓	Assurance	L Graham
12. TO ENGAGE, RETAIN, REWARD AND RECOGNISE					
12.1	Engagement and Recognition Strategic Aim Update Report	2.15pm	✓	Assurance	L Graham
13. GOVERNANCE AND COMPLIANCE					

№	Item	Time	Encl.	Purpose	Presenter
13.1	Guardian of Safe Working Quarterly Report inc. April to June report	2.25pm	✓	Assurance	V Varughese
13.2	Staff Suspensions Report	2.35pm	✓	Assurance	N Pease
13.3	Strategic Risk Register Review	2.40pm	Verbal	Decision	A Leather
13.4	Items to alert, assure, advise to the board or items or referral to/from other committees	2.45pm	Verbal	Information	A Leather
13.5	Reflections on the meeting	2.50pm	Verbal	Assurance	A Leather
14.	ITEMS FOR INFORMATION				
14.1	Chairs' Reports from Feeder Groups/Workstreams a) Temporary Staffing Group		✓		
14.2	Date, time, and venue of next meeting: *13 January 2026, 1.00pm via Microsoft Teams*	2.50pm	Verbal	Information	A Leather

12.2 EDUCATION, TRAINING AND RESEARCH COMMITTEE CHAIR'S REPORT

Other | S Crean | 12.00pm

Item for Assurance

REFERENCES

Only PDFs are attached

12.2 - ETR Chairs Report 14 Oct.pdf

Chair's Report to Board		
Chair: Prof StJohn Crean	Education Training and Research Committee	
Date(s): 14 Oct 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 Trust's financial recovery programme and recruitment controls impact the ability to expand educational and research initiatives. The Board should be alerted to these constraints and their potential effect on service delivery and compliance.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- The Committee discussed strategies to achieve University Hospital status, including exploring a direct approach to the Department for Education for use of the title, while committing to meet full criteria over time. The Board should be advised of ongoing engagement with NHS Providers and the need for stakeholder support.
- Improvements in GMC survey results and undergraduate/postgraduate education quality were reported, but high levels of emotional exhaustion and burnout among resident doctors remained a concern. The Board should be advised that a 10-point national plan was being implemented, with local action plans monitored via the Workforce Committee.

ASSURE

Assurance received; Matters of positive note.

- The Trust was on track to deliver both Tier 1 and Tier 2 Oliver McGowan mandatory training by the national deadline, using an external provider for Tier 2. The Committee was assured that a compliant plan was in place and reported nationally.
- The Knowledge and Library Services achieved exemplary status in NHS England accreditation, with ongoing digital access improvements and plans to integrate evidence tools into the electronic patient record. The Committee was assured of continued innovation and attention to future workforce needs.

Education, Training and Research Committee

14 October 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 12 August 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.	STRATEGY AND PLANNING				
7.1	Research and Innovation Annual Report Strategy Update (full report)	1.20pm	✓	Information	P Brown
7.2	University Hospital Status Update	1.35pm	✓	Assurance	P Brown
7.3	KLS (Knowledge and Library Services) Annual report	1.45pm	✓	Assurance	S Corrin
8.	PERFORMANCE				
8.1	Core Skills Training Report	2.00pm	✓	Assurance	L O'Brien
8.2	Quality Assurance Report	2.15pm	✓	Assurance	L O'Brien
8.3	NHSE 2025 Annual Self-Assessment for Placement Providers	2.30pm	✓	Decision	L O'Brien
9.	GOVERNANCE AND COMPLIANCE				
9.1	Strategic Risk Register Review	2.45pm	Verbal	Decision	S Crean
9.2	Items to alert, assure, advise to the board or items or referral to/from other committees	2.50pm	Verbal	Information	S Crean
9.3	Reflections on the meeting	2.55pm	Verbal	Assurance	S Crean

№	Item	Time	Encl.	Purpose	Presenter
10.	ITEMS FOR INFORMATION				
10.1	Feeder Groups – Chair's Reports a) Training Compliance & Assurance Committee b) Education Finance and Performance c) Research and Innovation		✓		
10.2	Date, time, and venue of next meeting: *9 December 2025, 1pm, MS Teams*	3.00pm	Verbal	Information	S Crean

13. RISK, GOVERNANCE AND COMPLIANCE

13.1 *GGI REPORT ? ACTION PLAN AGAINST RECOMMENDATIONS AND FINAL FORM RSP EXIT CRITERIA

Decision Item | J Foote | 12.10pm

*Detailed report included in the separate ancillary pack

REFERENCES

Only PDFs are attached

13.1 - BoD GGI action plan and RSP exit criteria 04.12.25.pdf

Board of Directors Report

Meeting of the Board of Directors	**4 December 2025**		
Part I ☒		**Part II** ☐	
Title of Report	**GGI Review Action Plan and RSP Exit Criteria**		
Report Author	Jennifer Foote, Director of Corporate Affairs		
Lead Executive Director	Jennifer Foote, Director of Corporate Affairs		
Recommendation/ Actions required	The Board is asked to approve that: 1. The action plan to address the recommendations as set out in the GGI well led review of August 2025 be adopted and subsumed within the Single Improvement Plan. 2. The Recovery Support Programme exit criteria be acknowledged in final form.		
	Decision ☒	**Assurance** ☐	**Information** ☐
Executive Summary	It is a CQC requirement for NHS Trusts to undertake a periodic independent review of its leadership function (well-led), ordinarily on a three-year cycle. This was last undertaken by the Trust in 2022. In order to assess the improvement trend from that review and to understand the impact of measures taken as a result of that review, GGI were commissioned to undertake the work. In addition, the Trust is currently receiving support from NHSE as a result of the receipt of additional licence undertakings for finance and governance. As part of the Recovery Support Programme, NHSE agreed to consider the outcome of the GGI as part of its wider review. The GGI report in full is produced again as an appendix in the ancillary pack of papers for this meeting. The action plan to address the recommendations is included as Appendix 1 to this report. The RSP exit criteria were considered initially in the special part II Board held in October and are reproduced here as part of the ancillary pack to recognise them in final form. In order for the Board to be fully sighted on the completion of the actions these will be subsumed into the relevant parts of the Single Improvement Plan. Oversight of completion will then fall within the PMO and SIP Oversight Board.		
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 Review:	Board Workshop 1 October 2025	
Previously considered	Board of Directors 7 August 2025	
Operational Group Review:	EMT	Date: 17 November 2025
Link to Board Assurance Framework:	Principal Risk 12 (25/26) - Failure to meet the financial plan 2025/26	
Appendices	Appendix 1: GGI Review Action Plan Appendix 2: GGI Review Report (in ancillary pack) Appendix 3: RSP Exit Criteria (in ancillary pack)	

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Improvement Plan following the Good Governance Improvement (GGI) Well Led review – 2025/26

Lead:	Sarah Morrison/Jennifer Foote
Position:	Deputy Chief Executive/Director of Corporate Affairs

Status Key	
1	Not complete / not expected to meet timescales me
2	Actions on track to achieve deadlines
3	All actions complete.
4	All actions completed and evidence provided

Version	Date
1.0	31/10/2025

Ref	Recommendation	Key Actions	Lead	Deadline for action	Progress Update	Current Status (1 2 3 4)
Quality Statement 1 – Shared Direction and Culture						
R1	Single Improvement Plan (SIP) to be widely understood by workforce and guides their work	1.1 - Single Improvement Plan boards to be updated.	Director Communications & Chief Strategy & Improvement Officer	Complete	• Single Improvement Plan boards have been updated and included in STAT audits	4
		1.2 – SIP and 5Ps (Patients, People, Performance, Productivity and Partnerships) to be included in communications with staff.	Chief Strategy & Improvement Officer/Director of Communications & Engagement	Complete	• SIP features prominently as part of workforce communications • 5Ps are repeatedly communicated in executive vlogs	4
		1.3 - Ensure team and individual objectives are aligned to the SIP through performance management and appraisal processes	Chief Operating Officer, Chief People Officer	March 2026	• Appraisal documentation updated to reflect the 5Ps • Corporate objectives in place aligned to the 5Ps • Development of corporate objectives will commence December 25 with a plan to cascade through organisation for start of new financial year	2
		1.4 - Confirm staff awareness of the SIP as part of the Safety Triangulation Accreditation Review (STAR) process	Chief Nursing Officer /Deputy Chief Executive Officer	March 26	• Build into STAR the inclusion of SIP Boards and the contribution of the department towards the SIP	2

Ref	Recommendation	Key Actions	Lead	Deadline for action	Progress Update	Current Status (1 2 3 4)
		1.5 - Board members to test awareness of the SIP as part of Board Visibility Programme	Non-executives	March 26	• To be included in Board walk round conversations	2
R2	Staff understand the importance of securing the Trust's finances and how the Trust is doing that	2.1 - Regular messages reinforced by Chair and Chief Executive	Director of Communications & Engagement	Complete	• Finance features as part of communications • Finance position is communicated to staff in executive vlogs	4
		2.2 - Promote opportunities for staff to suggest their own ideas for efficiency savings and highlight where these have been adopted successfully	Chief Finance Officer	March 26	• Various rotes to participate in idea generations in place	2
		2.3 - Communicate to staff the longer-term plan for financial sustainability and stability beyond the current financial year	Chief Finance Officer, Director of Communications & Engagement	January 26	• Planning for the development has commenced with 2 board development sessions completed to date. Expertise through PWC has been secured to develop the FSP. Once complete this will be shared as part of the 5P approach	2
R3	Staff understand how the Trust ensures the quality of services at a time of financial pressure	3.1 - Corporate communications re: Single Improvement Plan	Chief Strategy & Improvement Officer/Director of Communications & Engagement	Complete	• SIP features prominently as part of workforce communications. • Further work underway to plan the promotion of SIP through social media, internal TV and estate	2
		3.2 - EQuality Impact Assessment (EQIA) process embedded	Chief Nursing Officer / Deputy Chief Executive Officer	Complete	• EQIA Process in use across the Trust and reported to Safety & Quality Committee. Quarterly reports to Safety and Quality	4
		3.3 - Focus on quality clearly articulated in Board meetings	Chair	Complete	• Patient impact considered in all agenda items. • Patient story at each Board meeting.	4
		3.4 - Continue to communicate and explain EQIA process to staff at all levels	Chief Nursing Officer / Deputy Chief	April 26	• EQIA processes are in place and built into the systems surrounding both Waste Reduction Schemes and	4

Ref	Recommendation	Key Actions	Lead	Deadline for action	Progress Update	Current Status 1 2 3 4
			Executive Officer & Chief Medical Officer		change programmes as well as vacancy control processes	
		3.5 - Communicate outcomes of STAR accreditation process, highlighting teams and departments that have maintained and improved high levels of quality	Chief Nursing Officer / Deputy Chief Executive Officer, Director of Communications & Engagement	April 26	• Approach to celebrating STAR outcomes has been reviewed and changed to share each gold as part of the weekly NMAHPS leaders forum. Further consideration underway with wider communications/engagement plan	2
R4	Staff feel supported at times of operational and workload pressures	4.1 – Continue to focus on health and wellbeing agenda	Chief People Officer	Complete	• Regular communications with staff on wellbeing offer in place. • Development of staff gyms on each site underway	4
		4.2 - Signposting of support services, e.g. Occupational Health, Employee Assistance Programme	Chief People Officer	Complete	• Regular communications with staff on support services available.	4
		4.3 – Continue with the organisational culture plan for the organisation.	Chief People Officer	April 26	• Engagement plan has been refreshed and now includes Trust wide events with Executive team to focus on advocacy in wave 1 to understand the areas that matter most to colleagues to ensure support is targeted appropriately • The People plan is reported to workforce committee where progress is tracked • Targeted work to develop leaders to understand what makes a difference and how to support during times of pressure •	2

Ref	Recommendation	Key Actions	Lead	Deadline for action	Progress Update	Current Status (1 2 3 4)
		4.4 - Actively promote the Trust's existing wellbeing offer for staff and monitor uptake of these services	Chief People Officer	Completed	• Continued advertisement through monthly health and well being communications and through the interactions as part of sickness policy	4
		4.5 - Explore additional ways to show appreciation and recognition for staff, both formal and informal	Chief People Officer	April 26	• Engagement plan revisited and in progress • Person, team and department of the month in place and being utilised • Staff lottery commenced and being used to fund reward and recognition	2
Quality Statement 2 – Capable, compassionate and inclusive leadership						
R5	Consistency of leadership at board level	5.1 - Fully established, substantive executive team in place	Chief Executive	Complete	• Permanent Executive Team in place	4
		5.2 - Ongoing programme of board and executive development	Chief Executive / Director of Corporate Affairs	Complete	• Funding for board development agreed with Recovery Support Programme. • Board workshops and development programmes in place.	4
		5.3 – Utilise the talent matrix in place to determine development needs of the sub board and divisional leadership team	Chief People Officer	Complete	• Rising stars identified through appraisals • Trust Management Board development programme in place • Triumvirate development to be explored as part of the next phase including considering shadow Board plan for 26/27	2
		5.4 – Development plan underway for Trust Management Board	Chief Executive, Chief Operating Officer and other executives	Complete	• Funding in place, programme due to be finalised.	3

Ref	Recommendation	Key Actions	Lead	Deadline for action	Progress Update	Current Status (1 2 3 4)
		5.5 - Pursue extension of terms of office for non-executives who were initially appointed for one year	Chair, Director of Corporate Affairs	Complete	• Plan for extensions in place.	4
R6	Board member visibility and recognition among staff	6.1 - Non-executive directors aligned to specific divisions to build relationships and insights into services	Non-executives	Complete	• Non-executive buddy arrangements in place with divisions	4
		6.2 – Executive Vlogs to communicate with staff in place.	Director of Communications & Engagement	Complete	• Executive Vlogs produced regularly	4
		6.3 – Produce occasional vlogs/written for non-executive directors, similar to those done by executives	Director of Communications & Engagement / Board of Directors	April 26	• This will be worked into the programme of VLOGs	2
		6.4 – Enhance arrangements for non-executive safety visits, including a process to 'close the loop' on any issues identified during the visits	Director of Corporate Affairs	April 26	• Discussion regarding the approach to this to be held as part of a future Board development session	2
		6.5 - Design and print/produce digital 'poster boards' with pictures of the board members and display around trust premises	Director of Communications & Engagement	April 26	• Included in the communication plan	2
		6.6 - Make greater use of corporate induction to introduce executives to new staff and set the tone for the organisation	Chief People Officer	April 26	• The approach to this is being explored	2
R7	Board & executive development – focus on unitary board and working together	7.1 – Develop a Board development programme	Chair / Director of Corporate Affairs	Complete	• Board development programme in place	4
		7.2 - Consider 'board to board' or executive-to-executive meetings with partners such as East Lancs NHS Trust, the Integrated Care Board and Lancs County Council	Chair, Chief Executive, Director of Corporate Affairs	April 26	• The approach to this is being explored	2

Ref	Recommendation	Key Actions	Lead	Deadline for action	Progress Update	Current Status (1 2 3 4)
R8	Widespread participation in professional & leadership development among staff	8.1 - Further develop the trust's approach to talent management	Chief People Officer	June 26	• The approach to this is being revisited and presented to TMB in March 26	2
		8.2 - Undertake a high-level review to identify the extent of any obstacles to staff participating in professional development activities	Chief People Officer	April 26	• The approach to this is being explored	2
		8.3 - Scope opportunities to work more closely with local universities to support the trust's professional and leadership development programmes	Chief People Officer	June 26	• Longstanding relationships with HIEI and further education establishments	4
Quality Statement 3 – Freedom to Speak Up						
R9	Freedom to Speak Up (FTSU) service actively promoted to staff, and new Guardian widely recognised across the trust	9.1 - Identify teams / departments which do not engage with the guardian service in order to understand why this may be	Chief People Officer	June 26	• Freedom to Speak service has been stabilised and expanded • The work to understand low contacts will commence in January 26	2
R10	Guardian widely recognised across the trust	10.1 - FTSU promoted in induction, corporate comms, social media and through staff side	Chief People Officer	Complete	• FTSU is regularly promoted across the Trust in communications with staff through various routes	4
		10.2 - Include greater focus on FTSU as part of the safety visits to wards and departments	Chief Nursing Officer / Deputy Chief Executive Officer	February 26	• Focus on speaking up as part of the safety visits	2
R11	Changes made as a result of speaking up can be seen and are known by staff	11.1 – Ensure changes as a result of freedom to speak up are monitored for learning	Chief People Officer	Complete	• Report to workforce committee highlights examples of changes – 'You said, we did'	4
		11.2 - Provide detailed feedback to individuals who raise concerns	Chief People Officer	Complete	• Guardian provides detailed feedback to individuals who raise concerns	2

Ref	Recommendation	Key Actions	Lead	Deadline for action	Progress Update	Current Status (1 2 3 4)
		11.3 - Undertake an analysis of the impact of the guardian service in terms of changes that have resulted from raising concerns, patient safety and staff experience	Chief People Officer	April 26	• To be captured in the annual F2SU report	2
		11.4 - Publicise examples of changes from FTSU cases through corporate communications such as executive vlogs	Chief People Officer & Director of Communications & Engagement	March 26	• This work will commence in January 2026	2
R12	Regular, in-depth engagement between Guardian, CEO, Chair, Non-executive Champion and the wider board	12.1 - Programme regular diarised meetings for the new guardian with the Chair, CEO and NED champion	Chair, Chief Executive	February 26	• Dates scheduled to cokmmence January 2026	2
Quality Statement 4 – Workplace equality, diversity and inclusion						
R13	Enhanced representation of diversity in leadership and management roles	13.1 - Improve data visibility re: leadership roles and career progression	Chief People Officer	March 26	• WRES and WDES annual reports on cycle of business for workforce committee • To be built into the talent management programme	2
R14	Communications around Equality, Diversity and Inclusion (EDI) that explain the context, what the Trust is doing and what it has achieved	14.1 – Enhance staff and Board understanding of EDI experiences	Chief People Officer	Complete	• Staff stories at Board relating to equality, diversity and inclusion • EDI included as part of corporate induction to the trust • EDI covered as part of Trust board development work • Ongoing work to include regular content within Trust internal communications about the work done in this area	4
R15	Effective governance of EDI work through the EDI Strategy Group	15.1 - EDI strategy group to complete self-assessment of the group's effectiveness alongside the next scheduled review of its terms of reference	Chief People Officer	June 26	• This is part of the EDI plan.	2

Ref	Recommendation	Key Actions	Lead	Deadline for action	Progress Update	Current Status (1 2 3 4)
		15.2 - Workforce committee to scrutinise chair's reports from the EDI group	Chief People Officer	February 26	• EDI group chairs report now on cycle of business for workforce committee.	4
R16	Consistency of experience of staff with protected characteristics across divisions and services	16.1 – Promote networks amongst colleagues with protected characteristics	Chief People Officer	Complete	• Staff networks established and meeting regularly • Protected time guaranteed for network chairs • Networks have executive director sponsors	4
		16.2 - Review forthcoming national staff survey results and resulting Workforce Race Equality Standards (WRES) / Workforce Disability Equality Standards (WDES) data in detail, alongside soft intelligence from across the trust	Chief People Officer	Complete	• Considered by Workforce Committee and Trust Management Board	4
Quality Statement 5 – Governance, management and sustainability						
R17	Role of Education, Training and Research (ETR) Committee determined in relation to Workforce Committee	17.1 - Committee meetings re-phased from bi-monthly to quarterly	Director of Corporate Affairs	Complete	• Revised for 2026/27 corporate calendar	4
		17.2 - Review terms of reference and cycles of business of the workforce and ETR committees	Director of Corporate Affairs	June 26	• Scheduled for review.	2
R18	More concise and user-friendly, assurance-based reporting to board and committees	18.1 - Condense the papers for the Board of Directors meeting	Director of Corporate Affairs	Complete	• Board papers which have already been discussed elsewhere moved to an ancillary pack, condensing the agenda of the Board of Directors	4
		18.2 – Strengthen assurance from sub-committees to reduce Board time and duplication	Chair / Director of Corporate Affairs	Complete	• Greater emphasis on the role of sub-committees providing assurance to the Board, reducing pressure on board agendas.	4

Ref	Recommendation	Key Actions	Lead	Deadline for action	Progress Update	Current Status (1 2 3 4)
		18.3 – Introduce new Committee and Board templates aligned to NHS Providers best practice	Director of Corporate Affairs	Complete	• In place and due to be used from Board in December 2025.	3
		18.4 - Arrange training in writing for assurance, targeted to those who produce papers for the board or its committees	Director of Corporate Affairs	April 26	• This will be arranged as part of the senior leadership team development plan.	2
		18.5 - Chairs to reinforce clear expectations for how reports are written and presented in meetings, including rejecting papers which do not meet the criteria	Chair and Committee chairs	January 26	• This will be reinforced through Committees.	2
		18.6 - Consider applying a word count or page limit to reports for the board and committees	Director of Corporate Affairs	January 26	• This will be considered.	2
R19	Stronger relationship with Council of Governors with healthy balance of collaboration & challenge	19.1 - In anticipation of future elections and turnover of members, plan induction process so that roles and responsibilities are clear from the outset	Director of Corporate Affairs	Complete	• In place for future elections and appointments	4
		19.2 - Consider ongoing development work, such as seminars or workshops, for the Council of Governors	Director of Corporate Affairs	Complete	• In place and ongoing	4
		19.3 - Await further national guidance about the future of the foundation trust governor role in the light of the NHS Ten Year Plan and assess its implications for the trust	Director of Corporate Affairs	TBC	• Awaiting date so Trust's response can be finalised.	2
R20	Engaged, informed and growing Foundation Trust membership	20.1 - Promote the role of governors to the membership in advance of future elections, to attract a wide range of prospective candidates	Director of Corporate Affairs	March 26	• This will be included in the communications plan.	2

Ref	Recommendation	Key Actions	Lead	Deadline for action	Progress Update	Current Status (1 2 3 4)
		20.2 - Promote opportunities for members to support other trust activities such as the work of the hospital charity	Director of Corporate Affairs, Director of Comms and Engagement	March 26	• The approach to this will be considered in the next quarter.	2
		20.3 - Ensure that communications directed to foundation trust members describe and explain the changes taking place in the organisation	Director of Corporate Affairs, Director of Comms and Engagement	Complete	• In place and ongoing	4
Quality Statement 6 – Partnerships and communities						
R21	Stakeholder mapping in place, with understanding of how best to engage with each partner	21.1 - Health improvement plan to be developed	Chief Nursing Officer / Deputy Chief Executive Officer & Chief Medical Officer	Complete	• Three-year health improvement plan developed with input from Lancashire County Council, aligned to ICP principles	4
		21.2 - Link the key elements of the health improvement plan to the workstreams of the SIP	Chief Strategy & Improvement Officer	April 26	• The inclusion of this in each SIP will be prepared as the SIP is prepared for 2026/27.	2
		21.3 - Strengthen executive-level relationships with Lancashire County Council (LCC) through more face-to-face time, e.g. a board-to-board session and / or three-way meeting with the Chief Operating Officer, Chief Nurse and LCC Director of Adult Services	Chief Executive	April 26	• Positive relationships forged by Chair and CEO with partners since coming into post • Participation in health scrutiny panel	2
		21.4 - Produce stakeholder map for the trust, with input from the board through a seminar / board development session	Chief Strategy & Improvement Officer/Director of Communications and Engagement.	April 26	• This will commence in January 2026.	2
R22	Strong, collaborative working relationship with LSC Integrated	22.1 - Prioritise engagement with newly-appointed ICB Chief	Chief Executive	November 26	• CEO relationship established and work commenced.	4

Ref	Recommendation	Key Actions	Lead	Deadline for action	Progress Update	Current Status (1 2 3 4)
	Care Board (ICB) through period of change	Executive to agree best ways of working together				
		22.2 - Focus on the relationship re: commissioning of specialist services, to embed a more robust approach to contracting and strategic planning	Chief Finance Officer	February 26	• The CFO will lead the contract meetings with specialist commissioning to ensure the structure and outputs are maximised.	2
R23	Service reconfiguration proceeds to schedule with demonstrable positive impacts for LTHTR and the whole system	23.1 - Work with the ICB to define the next steps in response to the Clinical Services Reconfiguration report	Chief Executive	January 26	• This work is progressing.	2
		23.2 - Work with the ICB regarding optimal location of services across the system	Chief Executive	March 26	• This work is progressing.	2
		23.3 - Build on the Chief Executive's role as lead CEO for the Provider Collaborative Board Joint Committee (PCBJC)	Chief Executive	Complete	• This will be ongoing	4
Quality Statement 7 – Learning, improvement and innovation						
R24	Patient safety strategy widely communicated and understood, and guides work of teams	24.1 - Launch new Always Safety First strategy, supported by high profile corporate communications to raise awareness of the new approach	Chief Nursing Officer / Deputy Chief Executive, Chief Medical Officer, Director of Communications & Engagement	March 26	• Consultation has commenced.	2
		24.2 - Deliver enhanced PSIRF training incorporating psychological safety and human factors principles to build confidence and a systems-thinking approach."	Chief Nursing Officer / Deputy Chief Executive, Chief Medical Officer	September 2026	• Scoping for this has commenced. This is a long term development project and is underpinned by safety training within the Trusts target audience in line with PSIRF guidance.	2

Ref	Recommendation	Key Actions	Lead	Deadline for action	Progress Update	Current Status (1 2 3 4)
R25	Support for staff involved in patient safety incidents	25.1 - Include staff support within training and development for managers, by providing and sharing positive examples of how staff can be supported following an incident – 'what good looks like'	Chief Nursing Officer / Deputy Chief Executive, Chief People Officer	March 26	• The focus will be on facilitating after incident reviews and creating a psychologically safe environment. Standards and a training package are in development.	2
		25.2 - Adopt and implement NHS England's 'Being Fair' tool as part of the trust's patient safety and HR processes, ensuring alignment with PSIRF and the new leadership framework.	Chief Nursing Officer / Deputy Chief Executive, Chief People Officer	March 26	• Tool circulated and approach to this under discussion to ensure it is implemented in a meaningful way.	2
		25.3 - Monitor provision of feedback to people who have reported incidents and ensure improvement in areas where feedback is lacking	Chief Nursing Officer / Deputy Chief Executive, Chief Medical Officer	June 26	• This will form part of the new Always Safety First strategy.	2
R26	Lancashire Improvement Methodology is embedded and benefits can be quantified and demonstrated	26.1 – Develop new Trust improvement approach	Chief Strategy & Improvement Officer	Complete	• New Lancashire Improvement Methodology developed and adopted in 2025	4
		26.2 - Produce rebranded templates and materials aligned to the Lancashire Improvement Methodology	Chief Strategy & Improvement Officer	April 26	• Work is underway	2
		26.3 - Include participation in improvement programmes within divisional / team / individual objectives as part of objective setting for the year ahead, and reach out to teams which are harder to engage with the QI agenda	Chief Strategy & Improvement Officer	April 26	• This will be considered as part of the corporate objective setting exercise.	2
		26.4 - Highlight and celebrate examples of recent successful quality improvement projects with	Chief Strategy & Improvement Officer/Chief Nursing Officer	February 26	• Group established to organise the approach to sharing and inspiring positive improvement work.	2

Ref	Recommendation	Key Actions	Lead	Deadline for action	Progress Update	Current Status (1 2 3 4)
		an emphasis on the difference they have made				
		26.5 - Improve staff skills for analysing, presenting and interpreting data for quality improvement purposes	Chief Strategy & Improvement Officer	April 26	• This is ongoing as part of the improvement method training.	4
Quality Statement 8 – Environmental sustainability						
R27	Staff awareness of the new Green Plan and how they can contribute	27.1 - Finalise Green plan	Chief Finance Officer	Complete	• Green plan approved at Board in October 2025.	4
		27.2 - Link the key elements of the green plan to the workstreams of the SIP	Chief Finance Officer	April 26	• This will form part of preparing the SIP for 2026/27.	2
R28	Existing environmental measures and successes publicised inside and outside the trust	28.1 - Share information about new and ongoing initiatives, e.g. installation of solar panels, large sewer plan, through regular trust communications, team brief sessions etc.	Chief Finance Officer/Director of Communications and Engagement.	January 26	• Communications approach to include green contributions and successes	2
R29	Sustainable procurement through OneLSC	29.1 - Explore with OneLSC how scoring criteria can encourage selection of more environmentally friendly options, including use of more locally based suppliers where appropriate	Chief Finance Officer	February 26	• This will be explored as part of the procurement group.	2
		29.2 - Explore the costs and benefits of more environmentally sustainable procurement	Chief Finance Officer	February 26	• This will be explored as part of the procurement group.	2

13.2 *HEALTH AND SAFETY ANNUAL REPORT

Other | S Morrison | 12.20pm

Item for assurance
*Detailed report included in the separate ancillary pack

REFERENCES

Only PDFs are attached

13.2 - Health and Safety Report November SQC 2025 Final Board Executive Summary.pdf

Board of Directors

Meeting of the	**Board of Directors**		**4 December 2025**
	Part I ☒		**Part II** ☐
Title of Report	**Health and Safety Report**		
Report Author	Maureen Cowburn, Health and Safety Manager Hajara Ugradar, Associate Director of Safety and Learning		
Lead Executive Director	Sarah Morrison, Deputy Chief Executive / Chief Nursing Officer		
Recommendation/ Actions required	The Board of Directors is asked: • Receive the report for assurance noting the scrutiny of the report that has taken place through the Safety and Quality committee who has confirmed it is assured of the progress on Health and Safety governance improvements and progress against MIAA recommendations, whilst noting the ongoing operational challenges during the improvement phase.		
	Decision ☐	**Assurance** ☒	**Information** ☐
Executive Summary	**This report provides assurance to the Board of Directors on the Trust's health and safety governance arrangements, statutory compliance, and progress following the Mersey Internal Audit Agency (MIAA) Limited Assurance review earlier this year. It also reaffirms the Trust's commitment to maintaining a safe and healthy environment for colleagues, patients, and visitors, promoting a culture of safety, compliance, and continuous improvement across all services.** Significant improvements have been made to governance structures, with the Health and Safety Governance Group (HSGG) operating under revised Terms of Reference and a strengthened Cycle of Business. Monthly meetings, enhanced representation, and improved escalation to the Executive Management Team have increased visibility of risks and actions. A number of subgroups have been reinstated, and new groups such as the Fire Safety Group have been established to provide focused oversight of high-risk areas. Collaborative working between the Corporate Governance Team, Estates and Facilities and Workforce Colleagues has strengthened assurance mechanisms and improved statutory compliance reporting.		

	Progress against the MIAA recommendations is strong, with five of six actions completed. The remaining action, implementation of the Health and Safety dashboard and KPI reporting is partially complete and dependent on the new Ulysses system. Interim assurance is provided through manual reporting and SMART principles embedded in governance papers. Statutory compliance is being overseen in key domains including fire safety, water safety, asbestos management, medical gases, waste, and security, supported by audits, external inspections, and specialist oversight with the development of a new Estates and Facilities Statutory Compliance Tracker. However, residual risks remain in relation to ageing estate infrastructure, fire dampers, and water safety, which require continued capital investment and monitoring. Team resilience has improved through interim appointments and the transfer of the Physical Risk Manager into the governance team, reducing reliance on single-person roles. A sustainable structure is planned for 2026. The Workplace Risk Assessment Procedure is being refreshed to strengthen consistency and visibility across the organisation, supported by plans for risk assessment training and a central repository to improve assurance and audit capability. Incident reporting and investigation processes remain strong, with oversight of RIDDOR compliance and no requests for further action from the Health and Safety Executive. Slips, trips, and falls continue to be the most reported RIDDOR category, and sharps injuries persist due to container design issues. While violence and aggression incidents have reduced overall, assaults on staff have doubled over the past three years, requiring ongoing mitigation through security enhancements and multidisciplinary safety planning. Training compliance remains consistently high, with core skills above 90% and targeted improvements underway for specialist roles such as fire wardens and moving and handling trainers. Partnership working has been strengthened through the reset of the Health and Safety Joint Consultative Committee, ensuring meaningful staff-side engagement and improved consultation processes. Whilst significant progress has been made in strengthening health and safety governance and statutory compliance, a substantial amount of work remains underway. Between now and March 2026, work will continue to strengthen governance and capability, including development of the Health and Safety dashboard. At the same time, intelligence from statutory compliance trackers, self-assessments, and governance escalations will be consolidated and triangulated with risks on the Trust's risk register. This will provide a comprehensive and current view of health and safety risks, enabling prioritisation of actions and clarity on areas where targeted investment is required. These priorities will further inform the Health and Safety and associated workstreams of the Single Improvement Plan to ensure alignment and accountability.

	From April 2026, the Health and Safety workplan for 2026/27 will move further into delivery, addressing the highest-risk areas identified during this consolidation phase. This will include progressing estates compliance improvements, implementing specialist training programmes, completing governance enhancements, and embedding cultural and behavioural change initiatives. This phased approach ensures improvement activity is evidence-based, resource-focused, and capable of delivering sustained assurance across the organisation.		
Link to Strategic Objectives 2025/26	**Patients – deliver excellent care:** Improve outcomes, reduce harm and deliver a positive patient experience.		☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.		☐
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.		☒
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.		☒
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.		☒
Due Diligence	To give the Committee assurance, please complete the following:		
Committee Review:	Safety and Quality Committee	28 November 2025	
Operational Group Review:	Health and Safety Governance Group	Monthly meetings	
Link to Board Assurance Framework:	Principal Risk 14 (25/26) - Ability to access required Capital to support an ageing estate		
Appendices	State whether there are any appendices and list them. For example: Appendix A: MIAA Action Tracker Appendix B: Health and Safety Profile for Specific Areas Appendix C: Key Improvement Areas		

14. ITEMS FOR INFORMATION - CONTAINED IN THE ANCILLARY PACK

14.1 *MATERNITY AND NEONATAL SERVICES UPDATE

Information Item

contained in the ancillary pack

REFERENCES

Only PDFs are attached

14.1 - Maternity Neonatal Report - Executive Summary BOD December 2025.pdf

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Meeting of the	**Board of Directors**	**4 December 2025**
	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 CNST Maternity Incentive Scheme (MIS) supplementary information pack and associated action plans for oversight and assurance noting the report has been scrutinised by the Safety and Quality committee. ii. Note the inclusion of the training action plan for MIS year 7 and record in the Board minutes that it is supportive of the action plan for achievement of 90%, based on the scrutiny at safety and Quality committee. iii. 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 Safety and Quality Committee with an update in relation to workforce, staffing, safety, quality, assurance and oversight programmes of work including the Clinical Negligence for Trust (CNST) Maternity Incentive Scheme (MIS) for the year 7 reporting period. (1 December 2024 to 30 November 2025). The report covers the period up to the end of October 2025. To date the service remains on track to deliver 9/10 MIS standards, with one standard (MIS standard 8) requiring an action plan for improvement in relation to the training compliance of 90% for medical trainees for PROMPT and fetal monitoring. For the service to declare compliance with standard, the Board of Directors must acknowledge the action plan to achieve 90% and agree the trajectory to meet the requirements and note this in the formal minutes. The perinatal quality surveillance dashboard (PQSD) is included in Appendix 2. The model provides a structure for reporting and escalating emerging quality and safety risks. Areas of increased pressure continue to be evident in the unvalidated red flag reporting related to delay in assessment by an obstetrician, within 30 minutes in maternity triage and this continues to be the highest reporting category. Delay in induction of labour continues to second highest reporting category. In the month of October 2025, the escalation policy was utilised on one occasion in response to acuity and staffing levels to maintain safety of the maternity service. The divert lasted for a duration for 12 hours and a total of 7 women were affected. All cases were telephone triaged prior to being asked to attend an alternative provider and required antenatal assessment. No harm has been associated with transfers out.	

	The vacancy for registered midwives is currently 4.10 WTE and the service continues to use the over offer to recruit to turnover. Close monitoring of the establishment is ongoing and fill rates are tracked (RM 97%-day, 82% night) and Maternity Support Workers (MSW) (83% day and 94% night). All posts midwifery and support workers are going through recruitment processes. The lower-than-expected fill rates for maternity support workers are attributed to long term sickness absence and vacancy which is going through control processes. For information, the safety and Quality committee is informed that the portal Submit a Perinatal Event Notification (SPEN) has been implemented on the 3 November 2025. Designed to streamline reporting of perinatal and maternal events, it replaces multiple existing systems (NHS Resolution's Early Notification Scheme, MNSI, MBRRACE-UK and Child Death Overview Panels CDOPs) with a single-entry point for notifications. In addition, the Maternity Outcomes Signal System (MOSS) is also anticipated to commence at the end of November 2025. This is a real time safety monitoring mechanism which supports early detection and response to adverse intrapartum events. Intended to be a soft signal, the system will alert the maternity and neonatal service of intrapartum events of term stillbirth and neonatal death within 28 days, allowing for early action and response. Over time the system will also monitor brain injury (HIE grade 2or 3). The safety and quality committee will be updated in due course on the specification and operating procedures. 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 undertaking a comprehensive review of home birth provision. ***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: 28 November 2025
Operational Group Review:	Maternity Safety and Quality Group	Date: November 2025
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, C 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. Perinatal Quality Surveillance Supplementary Pack 3. Red Flags Data 4. Induction of labour update.	

14.2 DATE, TIME AND VENUE OF NEXT MEETING:

Information Item | M Thomas | 12.30pm

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