NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS PART I

BOARD OF DIRECTORS PART I

2 April 2026

09:15 GMT+1 Europe/London

Royal Preston Hospital, Education Centre1, Lecture Room 1

Patient Story 09:15 - 09:30am

AGENDA

AGENDA

Items marked * have full content in the Ancillary pack

REFERENCES

Only PDFs are attached

Agenda - Board (part I) - 2 April 2026 .pdf

Board of Directors

2 April 2026 | 9.15am | Lecture Room 1, Education Centre 1, Royal Preston Hospital

Agenda

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

№	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 5 February 2026	9:37 am	✓	Decision	M Thomas
5.	Matters arising and action log update	9:40 am	✓	Decision	M Thomas
6.	Chair's opening remarks and report	9:42 am	✓	Information	M Thomas
7.	Chief Executive's report	9:45 am	✓	Information	S Morrison
8.*	Board Assurance Framework	9:55 am	✓	Decision	S Regan
9. PATIENTS (SAFETY AND QUALITY)					
9.1	Safety and Quality Committee Chair's Report	10:05 am	✓	Assurance	T Ballard
9.2*	CQC Mental Health Act Focused Visit Report	10:15 am	✓	Assurance	S Regan
9.3*	Always Safety First Strategy	10:20 am	✓	Decision	S Morrison
9.4*	Maternity Annual Safe Staffing Report	10:25 am	✓	Decision	E Ashton
10. PERFORMANCE & PRODUCTIVITY (FINANCE)					
10.1	Integrated Performance Report as at February 2026 including Finance update and Single Improvement Plan	10:30 am	✓	Assurance	K Foster-Greenwood/ S Morrison/ N Pease/ C Carter
BREAK		10:55am			
10.2	Finance and Performance Committee Chair's Report	11:10 am	✓	Assurance	J Schorah
10.3*	Green Plan – Annual Report	11:20 am	✓	Assurance	I Ward
11. PEOPLE (WORKFORCE, EDUCATION AND RESEARCH)					

№	Item	Time	Encl.	Purpose	Presenter
11.1	Workforce Committee Chair's Report	11:30 am	✓	Assurance	A Leather
11.2*	National Staff Survey Benchmark Report	11:40 am	✓	Decision	N Pease
11.3	Education, Training and Research Committee Chair's Report	11:55 pm	✓	Assurance	S Crean
12.	**PARTNERSHIPS** (STRATEGY AND PLANNING)				
12.1*	Estates Strategy	12:05 pm	✓	Decision	K Hudson
13.	**RISK, GOVERNANCE AND COMPLIANCE**				
13.1	Charitable Funds committee Chair's Report	12:15 pm	✓	Assurance	T Ballard
13.2	Board Self-Assessment and Committee Effectiveness Review 2025/26	12:25 pm	✓	Decision	J Foote
13.3	Appointment of Directors & Authorised Signatories– LHS Ltd/Hospital Charities Investment Fund	12:30 pm	✓	Decision	J Foote
14.	**ITEMS FOR INFORMATION * ancillary pack**				
14.1	Audit Committee Chair's Report (verbal update given at previous meeting)		✓		
14.2	Data Quality Assurance Report		✓		
14.3	Use of Common Seal		✓		
14.4	Governor Election Report		✓		
14.5	Cycle of Business 2026/27		✓		
14.6	Date, time and venue of next meeting: *4 June 2026 at 9:15 am at Lecture Room 1, EC1, Royal Preston Hospital*	12:40 pm	Verbal	Information	M Thomas

* Full report in ancillary pack

1. CHAIR AND QUORUM

Information Item | Chair | 09:30 am

2. APOLOGIES FOR ABSENCE

Information Item | Chair | 09:32 am

3. DECLARATIONS OF INTEREST

Information Item | Chair | 09:35 am

4. MINUTES OF MEETING HELD ON 5 FEBRUARY 2026

Decision Item | Chair | 09:37 am

REFERENCES

Only PDFs are attached

4.0 - Minutes - Board (Part I) - 5 February 2026 - approved.pdf

Board of Directors

5 February 2026 | 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
Professor S Crean	Non-Executive Director
Dr K Deeny	Non-Executive Director *(via MS Teams)*
Ms K Foster-Greenwood	Chief Operating Officer
Mr A Leather	Non-Executive Director
Mr U Patel	Non-Executive Director
Professor S Nicholls	Chief Executive Officer
Mr J Schorah	Non-Executive Director
Professor T Wheeler	Non-Executive Director *(via MS Teams)*

Apologies: Mrs S Morrison

In attendance:

Professor A Brotherton	Chief Strategy and Improvement Officer
Mrs N Duggan	Director of Communication and Engagement
Mrs J Foote	Director of Corporate Affairs
Mrs L Graham	Deputy Chief People Officer *(minute 12 - 13/26)*
Mrs C Gregory	Deputy Chief Nursing Officer
Mrs K Lawrenson	Corporate Affairs Officer
Dr N Pease	Chief People Officer
Mr S Regan	Associate Director of Risk and Assurance *(minute 10/26)*
Mrs J Wiseman	Interim Business Manager *(minutes)*

Governors observing: Janet Miller, Margaret France, Lou Jackson, Graham Robinson and Frank Robinson *(via MS Teams)*

Observers: Annemarie Vicary, National Recovery Support Team, NHSE
Jo Burrows, National Recovery Support Team, NHSE *(via MS Teams)*

Presenters of the staff story: Jane Crowther, Advanced Clinical Practitioner
Ruth Lawrence, Senior Cognitive Behavioural Therapist
Rachel O'Brien, Associate Director of Workforce

Prior to the meeting the Board received the following presentation: Staff Story, presented by the Psychological & Wellbeing Service.

The Board heard a staff member's account describing her long-term experiences of psychological ill-health and the support provided by the Trust's Psychological Wellbeing Service. The staff member had faced significant mental health challenges over time, including periods of hospital care and support from crisis services. Earlier therapy accessed externally had been inconsistent and largely ineffective due to long waits and limited continuity.

The colleague was first referred to the Trust's internal psychology service following a diagnosis of a bipolar disorder. They emphasised the importance of remaining in work and noted that early assessments had raised concerns that a return might not be possible. However, structured psychological support enabled them to stabilise their wellbeing and return to work later that year. Continued access to follow-up sessions and clear workplace adjustments under their existing supportive framework were described as essential to their sustained progress.

In 2023 they self-referred back to the service due to escalating anxiety linked to academic and professional pressures. Continuity with the same therapist was a key factor in their decision to wait for treatment. Significant improvements were noticed both personally and by colleagues. Deep gratitude was expressed to the entire Psychological Wellbeing team. It was emphasised that the service had been lifechanging, enabling continued engagement in work, professional growth, and career advancement.

The Board thanked colleagues for presenting the story and acknowledged the personal courage involved in sharing such experiences. The importance of managers understanding available wellbeing offers and developing psychologically informed leadership skills, was emphasised. The Board was informed that wellbeing formed a core component of people management training, with dedicated modules focused on how managers could support colleagues and signpost them to appropriate services. It was noted that the organisation had also developed psychological first aid and deescalation skills within management training, aiming to create a more psychologically informed culture across teams.

The Board reflected on the need for continued organisational focus and awareness on staff psychological health, recognising the significant impact this had on workforce stability, sickness absence and organisational culture. The Board agreed that a letter of thanks would be sent to the staff member who shared her story and to the colleagues involved.

4/26 Chair and quorum

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

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

5/26 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.

6/26 Minutes of the previous meeting

The minutes of the meeting held on 4 December 2025 were approved as a true and accurate record.

7/26 Matters arising and action log

All actions from previous meetings had been completed.

8/26 Chair's report

The Chair provided an overview of recent activity and reflected on the significant operational pressures experienced over the winter period. It was noted that the Trust continued to face sustained demand, with concurrent circulation of flu, Covid-19 and other respiratory viruses contributing to an exceptionally challenging two months. For the first time, all four acute trusts in the system were simultaneously operating at OPEL 4, resulting in an inability to divert patients across sites and placing considerable strain on services. The Chair expressed appreciation to clinical and support staff across the Trust and the wider system for their resilience, professionalism and commitment to maintaining safe care despite these pressures.

The Chair emphasised that, alongside managing winter demand, the Trust continued to progress its operational and financial priorities, including yearend planning, the medium-term plan and ongoing performance improvement work. The need to maintain focus on delivering agreed targets, strengthening financial discipline and advancing improvement initiatives was reiterated. Assurance was offered that robust oversight arrangements remained in place and that the agenda for the meeting would provide further updates across these areas. end planning, the medium-term plan and ongoing performance improvement work. The need to maintain focus on delivering agreed targets, strengthening financial discipline and advancing improvement initiatives was reiterated. Assurance was offered that robust oversight arrangements remained in place and that the agenda for the meeting would provide further updates across these areas. -end planning, the medium-term plan and ongoing performance improvement work. The need to maintain focus on delivering agreed targets, strengthening financial discipline and advancing improvement initiatives was reiterated. Assurance was offered that robust oversight arrangements remained in place and that the agenda for the meeting would provide further updates across these areas.

9/26 Chief Executive's report

The Chief Executive provided an update on key operational issues and wider system pressures. The Board was informed that, despite intense pressure across all acute trusts in the system, colleagues had worked with professionalism and resilience to maintain patient safety and essential services. Early de-escalation from OPEL 4 had been achieved through sustained operational management, though the wider environment remained fragile and consistent with ongoing winter challenges. Escalation was achieved through sustained operational management, though the wider environment remained fragile and consistent with ongoing winter challenges.-escalation was achieved through sustained operational management, though the wider environment remained fragile and consistent with ongoing winter challenges.

The Chief Executive highlighted the need to review and strengthen medical staffing models, including a shift away from incremental change in urgent care pathways towards more fundamental redesign. This would include optimising same day emergency care, ensuring consultant workforce models were fit for purpose and improving integration with community and primary care services. Related objectives had been set for senior leaders and further updates would be brought to the Board as work progressed. Internally, the Trust continued work to re-balance bed capacity, particularly across medical and respiratory pathways, supported by a recent multi-disciplinary planning exercise. -day emergency care, ensuring consultant workforce models were fit for purpose and improving integration with community and primary care services. Related objectives had been set for senior leaders and further updates would be brought to the Board as work progressed.

Preparations were nearing completion for the launch of the single pathology service, with the transfer scheduled for 1 April 2026. The Board noted that this would mark the start of a wider transformation programme. The Chief Executive formally recorded thanks to Professor Anthony Rowbottom and the Pathology Team for their significant contribution throughout the transition process.

The Board was pleased to note the launch of the 24/7 mechanical thrombectomy service, which had already treated its first out of hours patient. The service was expected to deliver substantial improvements in patient safety and outcomes. It was noted that the Safety and Quality Committee had requested a quarterly progress report to monitor service provision, with any urgent concerns to be escalated between reporting cycles.

A question was raised about how learning from the implementation of the winter plan would be captured. It was confirmed that future plans would undergo scrutiny by the relevant committees and the Board, with actions developed as a result. Earlier planning had been crucial in mobilising staff. It was noted that there continued to be challenges in identifying sufficient staff who could be released at short notice, which had limited the full mobilisation of some services. It was reported that planning assumptions had considered a likely winter scenario ranging from a mild seasonal period to a significant spike in infections. Resources had initially been allocated to support this range, but these had to be reprioritised as the winter period proved more severe than expected, particularly in relation to flu and respiratory illness. The flu surge had occurred earlier than anticipated and the team had been able to respond quickly however demand had remained higher for longer than planned. As a result, the bed base had been expanded and maintained beyond the original timeframe, requiring reductions in other areas of expenditure. It was noted that winter performance, while still not at the required level, had been better than the previous year and continued an improving trend. -prioritised as the winter period proved more severe than expected, particularly in relation to flu and respiratory illness. The flu surge occurred earlier than anticipated and the team had been able to respond quickly

An overview was also provided on the impact of recent industrial action, including mitigations to protect urgent and cancer services and the learning that would be incorporated into future planning.

10/26 Board Assurance Framework

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

It was noted that two principal risks had reduced in score since the previous meeting and one had increased. The report highlighted that risks relating to patient experience within the urgent and emergency care pathway and timely access to urgent and emergency care remained off track. The risk relating to timely access to planned and cancer care also remained off trajectory and would be explored further in the performance section of the Integrated Performance Report. It was confirmed that the diagnostic investigations risk had increased in response to a decline in performance, driven primarily by obstetric ultrasound pressures.

An update was provided on financial risks, including confirmation that external financial support had been approved in January and that an additional request would be submitted in February. The Board also noted issues arising from the temporary pause in deficit support funding and the resulting impact on the cash position. The staff experience risk, with a particular focus on under-represented groups, remained off track pending further analysis of the Staff Survey once embargoed data was released.

The Board received an update on Principal Risk 10, noting that although staff absenteeism had improved compared with the previous year, delays in implementing the digital absence management system, the introduction of the occupational therapist role and elements of the absence reduction plan meant that the target control date had been reprofiled to the end of March to allow completion of the required actions and to provide the additional assurance needed by the organisation.

There had been positive movement in Principal Risk 2, relating to Clostridioides Difficile, with performance continuing to track below the tolerance level and sufficient confidence to reduce the likelihood score from 16 to 12. In addition, the Board was informed that Principal Risk 7, relating to reliance on the temporary medical workforce, had reduced from 12 to 8 following strengthened assurance received through relevant committees and the risk was now in line with its target score and recommended for consideration as reasonably controlled. There were no operational high-risk items escalated to the Board during the period and no further changes were reported to the remaining principal risk items escalated to the Board during the period and no further changes were reported to the remaining principal risks.

Board members asked for assurance that the highest-risk and most clinically urgent diagnostic cases continued to be prioritised appropriately. It was confirmed that risk stratification processes were in place and that clinical teams were validating long waiters, with significant progress made in endoscopy supported by national bodies. Further detail was provided on the outcomes of recent safety assessments, including the proportions of patients who were recategorised, expedited, or identified as no longer requiring diagnostic investigations. The Board directed that the Safety and Quality Committee should receive a breakdown of the diagnostic data as part of the next report to the Committee.

A question was raised regarding two week wait referrals that did not subsequently result in a cancer diagnosis, querying whether analysis of these patterns could support earlier decision making in primary care. The Board discussed the potential for identifying themes, geographical variation and opportunities to reduce inappropriate referrals while ensuring timely diagnosis for patients at risk. It was agreed that the Lancashire and South Cumbria Cancer Improvement Board would be the appropriate forum for progressing this work, with outcomes to be fed back to the Board through the Safety and Quality Committee. The Board discussed the potential for identifying themes, geographical variation and

opportunities to reduce inappropriate referrals while ensuring timely diagnosis for patients at risk.

The Board sought assurance that discussions relating to diagnostic risk did not alter the overall BAF scoring. Confirmation was provided that the scores remained consistent with the reported position and highlighted the forthcoming Board workshop planned for March, which would include forward looking risk assessment for 2026/27. A challenge was raised regarding the risk relating to health inequalities, noting that despite its strategic importance and national emphasis on demand management, the risk score and mitigations had not changed since 2024. The Board requested further work in this area be incorporated into the upcoming workshop. It was noted that related work through the Safety and Quality Committee, including the annual health inequalities report, could support refinement of this risk and greater clarity over actions, influence and system level constraints.

The Board noted interest in benchmarking the Trust's approach to risk scoring against regional peers to understand variations in methodology and risk appetite. It was agreed that this would be explored through future joint Executive to Executive sessions with regional partners.

The Board also reviewed progress relating to the Staff Survey. Members noted embargo restrictions but emphasised the importance of timely internal review to inform planning. The Executive team outlined how existing staff engagement findings were already informing strategic priorities, including concerns around urgent and emergency care pressures.

The Board RESOLVED to approve the updates to the Board Assurance Framework and for Principal Risk 7 related to the reliance on temporary medical workforce, to be controlled.

11/26 Workforce Committee Chair's Report

The Workforce Committee Chair's report was presented. The Committee had discussed emerging risks relating to fragile services, particularly within Estates and Facilities. Specific concerns were raised regarding capacity pressures in essential support areas, including the hospital sterilisation and decontamination service and catering, where current workforce gaps were creating short term operational challenges. The Board was advised that while longer term plans were in place, immediate mitigation remained necessary and work was underway to clarify short, medium and long term actions. The Board noted that the Committee continued to monitor Principal Risk 7 following its recommendation for control, recognising the need for sustained oversight to ensure the improved position was maintained.

The Committee also highlighted the growing fragility within certain clinical and entry level roles, including no obstetric ultrasound and sonography and emphasised the importance of strengthening recruitment pipelines through partnerships with educational institutions and local communities. The discussion linked this to the organisation's social value commitments, noting increased staff engagement within Estates and Facilities and improved staff survey response rates as indicators of positive cultural development. It was noted that the Workforce Committee would continue to monitor the fragile services. A proposal was made to strengthen Board oversight of fragile services by bringing together the workforce, finance, performance and quality dimensions of fragility into a single,

consolidated assurance view. It was agreed that this proposal would be explored further potentially through a Board development session.

The Board explored opportunities to integrate workforce planning with digital and AI enabled transformation, noting that technology could support both efficiency and alternative workforce models. Members raised the need for assurance on the financial, regulatory and workforce implications of AI adoption, highlighting concerns around potential overreliance on emerging digital solutions and the requirement to demonstrate a clear return on investment. It was confirmed that a structured organisational programme was being developed to support the transition from analogue to digital processes, while ensuring alignment across clinical, corporate and administrative services. The Board also noted the potential future impacts of technological change on role design, skill mix and workforce sustainability with the need to manage these sensitively

12/26 Gender Pay Report

The Board received the report which had been endorsed by the Workforce Committee (Minute No 12/26). The report brought together the annual gender pay gap findings and for the first time, the ethnicity and disability pay gap analyses. The Board noted that publication of the gender pay gap was a legal requirement, while publication of ethnicity and disability pay gaps aligned with national NHS expectations and the organisation's wider commitment to equality, diversity and inclusion.

The Board was informed that the median gender pay gap had reduced to 1.9% in favour of male colleagues, now below the threshold for mandatory corrective action. The ethnicity pay gap showed that colleagues from ethnic minority backgrounds earned £1.07 for every £1.00 earned by white colleagues, attributed in part to higher representation in upper middle quartiles. The disability pay gap was reported at 16.8% in favour of nondisabled colleagues; it was noted that only 6% of staff had self-declared a disability, compared with an estimated actual figure of 20–25% and therefore caution was advised in interpreting the data. The Board further noted that addressing gaps required more sophisticated analysis, including intersectional breakdowns and more robust data completeness, which were currently constrained by workforce information capacity.

It was highlighted that while the reduction in pay gaps was positive, the Trust required clearer long-term targets and a consolidated, more ambitious action plan. Capacity limitations within the workforce information function continued to inhibit deeper analysis. Board members sought assurance regarding regional benchmarking, the structural barriers facing disabled colleagues and delays to external workplace adjustments. It was confirmed that broader comparative data would be explored as part of the next stage of analysis. Improved visibility of disability related needs supported by increased completion of supporting disability agreements and embedding EDI in appraisal and performance processes was expected to strengthen understanding and inform future actions.

A discussion was held around the position relating to the disability pay gap and the wider experiences of disabled colleagues. Members noted that delays in accessing workplace adjustments and barriers to career progression may be contributing to disparities in pay and representation. It was acknowledged that the challenges faced by disabled colleagues were complex and multifactorial and that this group continued to report poorer workplace experiences than other minority groups. The Board was informed that there had been a significant increase in the number of supporting disability agreements in place, and that embedding equality, diversity and inclusion discussions within appraisal, people

management processes and routine managerial conversations was helping to improve visibility of colleagues requiring support, including carers. The Board emphasised the importance of strengthening engagement with staff networks to understand the lived experience of disabled colleagues and to ensure that improvement actions were shaped by those insights. It was noted that the forthcoming EDI strategy would include a renewed focus on minority group talent management, with dedicated workstreams across all protected characteristics. The Board discussed wider practical issues affecting disabled colleagues, noting reports of significant national delays in access to work assessments for workplace adaptations. It was noted that recent organisational focus on sickness management had correlated with an increase in carers' leave requests, suggesting that some colleagues might have previously relied on sickness absence due to insufficient flexibility. It was agreed that this remained an important area for ongoing attention within the workforce and EDI programmes.

The Board RESOLVED to approve the Gender Pay Report for publishing on the Trust website by 30 March 2026.

13/26 Equality, Diversity and Inclusion Annual Report

The Board received the Equality, Diversity and Inclusion (EDI) Annual Report for 2025, which formed part of the Trust's statutory responsibilities under the Public Sector Equality Duty and the Equality Act 2010. The report had been endorsed by the Workforce Committee (Minute No 12/26). The Board noted that the report summarised progress against the five principles of the EDI Strategy 2021-2026 and demonstrated continued maturity in the Trust's approach over recent years. The report highlighted achievements across the previous 12 months, including strengthened engagement with lesser heard community groups, improvements in accessibility of patient information, increased workforce representation among ethnic minority and disabled colleagues, expanded health literacy and bias awareness education for leaders and targeted initiatives to reduce health disparities.

The report outlined future areas of focus, including refreshing organisational values to strengthen expectations of inclusive behaviours, further improvements to accessible information, enhanced partnership working with faith communities, proposals to explore a Diversity and Inclusion Champion role, development of talent pipelines for under-represented groups, and expanded experiential inclusion training.

The Workforce Committee chair confirmed that the report had undergone detailed scrutiny, with particular emphasis on ensuring stronger communication of findings and actions at divisional level and on alignment with Principal Risk 3 (health inequalities) and Principal Risk 8 (staff experience). The Committee also emphasised the need to reinforce leadership visibility, strengthen use of tools such as TED and support ongoing social value commitments. The Board agreed that while significant progress had been delivered since the introduction of the five year strategy, this remained a developmental journey requiring continued focus.

The Board RESOLVED to approve the Equality, Diversity and Inclusion Annual Report for publishing on the Trust website.

14/26 Education, Training and Research Committee Chair's Report

The Board received the report from the Education, Training and Research Committee. The report highlighted ongoing concerns regarding mandatory training compliance, in particular with hosted services, noting that despite no safety incidents being linked to non-compliance, the governance and workforce risks required continued attention. Assurance was provided that further work was underway and that the issue would return to the Committee for an updated review.

The Board noted the positive and sustained appetite across the organisation for education, training and research, despite wider system challenges. The Committee highlighted progress in strengthening research capability, including improvements in the set-up and initiation of commercial clinical trials and the financial benefits derived from commercial research activity. The Committee also reported continued development in the Trust's journey toward University Hospital status, acknowledging local benchmarking activity and the organisation's commitment to meeting the revised national criteria, which placed greater emphasis on multi-professional education and commercial research growth.

Strong apprenticeship performance was commended, with the Board recognising the complexity of supporting apprentices who balanced training with clinical and operational duties. The Committee had also welcomed discussions on activating the Trust's commercial education arm, reflecting opportunities for knowledge exchange, innovation and income generation. The Board further noted positive developments showcased at the recent regional research event and the improvements reported in national GMC training survey results, demonstrating marked progress in specialty areas and reaffirming the Trust's educational standing.

The Board discussed the importance of lifelong learning as a core component of retention, professional development and the Trust's social value mission. Members also noted the challenges associated with achieving full mandatory training compliance and the impact this can have on quality and workforce assurance. Clarification was provided on processes relating to professional revalidation requirements across clinical professions being part of the appraisal process.

15/26 Integrated Performance Report as of December 2025

Patients - The Board received an update on maternity and patient experience indicators. Registered midwife fill rates remained below the Trust target at 89.17% in December with midwifery support worker fill rates also below target at 85.22%. Recruitment was ongoing, with recent starters completing supernumerary periods and further posts being progressed. Temporary staffing continued to be used on a shift-by-shift basis to maintain safety. Registered nurse and healthcare assistant fill rates met safe staffing thresholds and remained stable. The number of complaints per 1,000 bed days showed a recent downward trend, with work focused on early resolution, communication during delays and cancelled appointments. Pressure ulcer incidence remained above the revised target and a harms panel and improvement actions, including equipment checks early in the UEC pathway had been implemented. C.difficile performance stayed within the national tolerance level, supported by progress on National Standards of Healthcare Cleanliness and joint efficacy audits.

Performance - The Board noted that urgent and emergency care metrics remained off track on several measures despite some incremental improvement. Four-hour access performance improved slightly to 71.15% in December with 60-minute ambulance handover compliance falling to 88.5% and it was reported that there were 251 forty-five minute handover breaches in December. A systemwide extraordinary meeting had agreed immediate actions as part of the capacity and demand work and would be tracked through the Central Lancashire Delivery Group. The Board explored whether additional communication should occur with system or ICB partners where ambulance handover delays risked approaching unsafe thresholds. It was acknowledged that communication and escalation already occur, but system partners were often affected simultaneously. The Board sought clarification on communication with patients experiencing very long waits or corridor care. It was confirmed that teams had spoken directly with patients to explain delays, actions being taken and the fact that this was not considered acceptable or normal practice. Similar communication took place with ambulance crews, who were equally affected. A question was raised about whether safety was impacted when neighbouring trusts temporarily closed wards or services and patients were transferred. It was confirmed that whole system surge pressures generally result in all organisations being constrained simultaneously and cross boundary transfers were therefore rare in routine pressure situations. The Board received assurance that when transfers did occur, oversight of safety was maintained.

The Board noted several positive developments within urgent and emergency care despite the continued operational pressures. Activity through the two hour urgent community response service continued to increase, and virtual ward utilisation had also increased month on month, reaching approximately 80% in January, representing a significant improvement and demonstrating strengthened community based alternatives to admission. The Board was informed that capacity and demand modelling for the Emergency Department had been completed with support from relevant national teams and redesign work was progressing. A high-level scope and proposal for a revised model of care was due to be considered by the Executive Management Team, with mobilisation planned during February. Additional transformation resource would be aligned to this programme to accelerate delivery. Questions were also raised about the “leftshift” ambitions and whether the Trust’s urgent and emergency care transformation linked effectively into primary care, community services and prevention. It was confirmed that this work was underway, forming part of a whole system approach. However, releasing capacity in primary care through prevention was a longer-term endeavour and historically depended on significant transformation funding that was no longer available at scale. Members discussed front door streaming, triage and earlier intervention by clinically appropriate staff to prevent unnecessary Emergency Department attendance or admission. Plans to enhance front door leadership capacity, including recruitment of a senior clinical lead with a primary care background, were noted.-hour urgent community response service continued to grow and virtual ward utilisation had increased month on month, reaching approximately 80% in January, representing a significant improvement and demonstrating strengthened community-based alternatives to admission.-level scope and proposal for a revised model of care was due to be considered by the Executive Management Team, with mobilisation planned during February. Additional transformation resource would be aligned to this programme to accelerate delivery.

In planned care, the Board heard that although the number of 52 week breaches had reduced and the percentage waiting less than 18 weeks had improved slightly in December, performance remained significantly below national standards. Mitigating actions included intensive validation activity, both human and AI enabled, strengthened

demand management processes and rapid mobilisation of NHS England sprint funded additional activity for the remainder of the financial year. Six high-risk specialties had entered the detailed capacity and demand programme, with outputs due by the end of March to inform sustainable recovery plans.

Indicative assessments suggested the potential for a 3% improvement in 18week RTT performance, a 1% improvement in 52week waits and a reduction of approximately 4,000 patients from the waiting list, though it was acknowledged that these improvements were not sufficient alone to restore compliance. The Board noted that modelling remained subject to confirmation of outputs from the AI pilot, currently in testing, and from next year's agreed activity plan. Positively, the Trust continued to maintain zero 65 week waiters, and DNA rates were continuing to fall, although not yet at the desired level.

The Board also discussed diagnostic performance, noting that December's position had stabilised compared with November, although DM01 performance remained below plan at 56.8%. Additional capacity for the remainder of 2025/26 had been sourced and a strengthened recruitment and retention proposal for sonography was being finalised for the Executive Management Team consideration. In relation to endoscopy, the Board noted that while waiting list size had reduced significantly, this was not yet reflected in overall DM01 performance due to the backlog profile. Further capacity and demand modelling across key modalities would be completed by March.

An update was provided on cancer performance, which, although still below operational targets, was marginally above the recovery trajectory, with continued progress expected. The Board acknowledged the extensive transformation work across urgent care, planned care and diagnostics, recognising the challenge of delivering performance improvement while operating within significant financial and workforce constraints. The Board noted the Executive Team's commitment to maximising all available opportunities to deliver sustainable recovery.

Questions focused on DNAs, cancelled appointments and administrative processes, including whether reductions in administrative workforce were sustainable. The Board was advised that DNA rates were improving due to reminders and early interventions; however, the current EPR and administrative workflows were driving inefficiencies, repeated rescheduling and patient confusion. A largescale transformation of clinical and nonclinical administrative processes was required. The Executive Team was defining the resource requirement for this work, noting that meaningful redesign could not be delivered without dedicated capacity. Members stressed that although the Board remained committed to headcount control, there might be cases where targeted investment was required to deliver transformation and secure return on investment. The Executive Management Team confirmed that proposals, including potential use of external digital funding, would come through EMT before returning to Board.

The Board also discussed the challenge of achieving national performance standards, referencing weekly benchmarking reports showing fluctuating performance. Executives advised that sustainable improvement required transformation rather than short-term fixes. A clearer set of central performance metrics and expected trajectories would be presented to the Improvement & Assurance Group in early March, before coming to the Board on 2 April 2026.

People - The Board received an update on the People metrics. The Committee noted the increasing emphasis on the Team Engagement and Development (TED) tool, which underpinned a significant proportion of the Trust's organisational development approach. Divisions and departments were being encouraged to increase their use of TED to support cultural improvement.

The Board was advised that the vacancy rate had risen to just over 7%, which was expected given the Trust's strengthened vacancy control measures. Rather than automatically recruiting to posts as they became vacant, divisions were being asked to consider alternative workforce models, skill mix and service redesign before proceeding. control measures.

The Board noted the positive position regarding mandatory training and appraisal, with both remaining above target for several consecutive months. Core Skills training was at 100% compliance across all metrics, although hotspot areas particularly in hosted services still required targeted support. A concern was raised about essential role specific training, noting that many national serious incidents had been associated not with failures in core mandatory training, but with gaps in job specific competencies. The Board queried when reporting on job specific training would begin and which governance route it would follow. It was agreed to review current processes, ensure a register of recommendations existed and confirm the appropriate committee oversight

On sickness absence, the Board acknowledged that overall sickness had likely peaked for the winter period. A number of divisions were however reporting a shift towards increasing long-term sickness. The team was therefore undertaking division by division case review sessions, a process previously shown to be effective in reducing long term absence and rebalancing the ratio towards short-term sickness.

Productivity - The Board reviewed the financial position. At the end of December, the Trust reported a £25.5m deficit against a planned £2.1m deficit (adverse variance £23.4m), driven predominantly by Waste Reduction Programme (WRP) under delivery, nonreceipt of deficit support funding in November and December along with net operational pressures, partly offset by industrial action funding. The Board noted that the Trust was finalising its forecast outturn, with the current estimated range indicating a deficit of around £17.8m. This figure included WRP under delivery of approximately £18m, contractual and technical pressures of around £3m and interest charges linked to cash borrowing. System level discussions were underway regarding potential beneficial adjustments linked to the Estates Transformation work.

The Board also received assurance that although the Trust remained in a challenging position, several positive financial indicators were evident. The Trust's underlying pay position had improved, with normalised pay expenditure reducing from £50.5m to £48.1m per month. Whole-time equivalent staffing had reduced by 117 WTE in Month 9 and by more than 500 WTE across the past 14 months on a sustainable and safe basis.

On capital, the Board noted that the Trust had an annual programme of £40.2m, with a current forecast of £35.2m, leaving a variance of £5m. The shortfall was primarily due to delays in two nationally supported schemes for mental health liaison and orthodontics. Work was underway with national teams to explore re-phasing or alternative arrangements and a mitigation proposal would go through the Finance & Performance Committee.

The Board also discussed the Trust's cash position. The Trust had received £9.5m in cash support for January. A further £4m request for February had been declined due to the receipt of £3m in industrial action funding, which offset the need for that drawdown.

Clarification was sought around the relationship between the WRP and the Trust's in year deficit. It was explained that the organisation lost approximately a quarter of the delivery period at the start of the financial year while establishing programme architecture. Two major areas of WRP slippage were programmes of work for the estates optimisation and ward reconfiguration which were delayed due to complexity, system interdependencies and winter capacity decisions made for safety. The recovery plans had since been independently scrutinised by the system Turnaround Director, with increasing confidence in deliverability. The yearend challenges were exacerbated by the March yearend constraint imposed nationally, despite the Trust working to a three-year recovery programme.

The Board confirmed its assurance in respect of the Single Improvement Plan outcome metrics.

16/26 Finance and Performance Committee Chair's Report

In relation to performance, the Committee had continued to seek assurance that year end trajectories for the principal risks, particularly cancer remained achievable. While there had been some positive developments, including reductions in DNA rates and improvements against certain long wait targets, overall assurance remained limited. The Board was reminded that operational pressures and demand increases continued to impact delivery.

On finance, the Board was informed that the reported forecast carried material risk and was not yet secure. The Committee emphasised that significant work remained and confirmed that this would be scrutinised again at the next meeting. The Board heard that workforce performance remained an area of heightened scrutiny. The Committee had noted that the planned reduction in WTE had not been achieved, notwithstanding the complex and multifactorial reasons explained by the workforce team. The Committee had therefore requested continued monthly reporting to ensure progress.

Recent deep dive activity was also reported, including a review of additional payments for medical staff, with a further update scheduled for Q1 and a review of the emerging model service review framework, intended to strengthen productivity and benchmarking approaches. The Committee reiterated that the organisation would not materially change on 1 April and that plans must be ready for implementation from the start of Q1 to avoid the delays experienced in the previous year. The Board supported this message, noting the need for transformation initiatives to proceed at pace.

During discussion, it was highlighted that improved triangulation between finance, performance and workforce data including the attendance of the Chief People Officer at the Finance and Performance Committee was valued. The Board acknowledged the need for clearer, more consistent workforce data, particularly regarding WTE reductions. It was noted that discrepancies between data sources had already been identified and that action was being taken to address this.

17/26 Safety and Quality Committee Chair's Report

An update was provided on the outpatient tracking and scheduling alert raised at the previous Board meeting, with confirmation that a working group had now been established to consolidate divisional risks into a single organisational entry. Initial analytics had been provided by the business intelligence team. The Committee had emphasised the need for regular oversight, clear progress updates and defined timeframes through the Waiting List Safety Group and would continue to monitor progress monthly until the issue was stabilised and resolved.

The Board was informed of two new alerts from the 30 January meeting. The first related to a recently declared Never Event in Interventional Radiology. The Board noted that the initial briefing had already been shared and that no new learning had emerged at that stage. Environmental walkarounds with patient safety partners were planned and Non-Executive Directors had confirmed their continued support to participate, as they had during previous Never Event reviews. Ongoing updates would be received as actions and learning developed.

The second alert concerned preliminary feedback from a paediatric trauma unit peer review, which had identified immediate risks in the paediatric CT imaging pathway and resuscitation room availability. Work was underway to understand the findings fully and a plan would be brought to the Committee's February meeting for further scrutiny.

The Board was advised that maternity theatre capacity would be considered later in the meeting under a separate agenda item. The Committee had also received a positive update on the recent Mental Health Act inspection, which had confirmed strong compliance, positive patient experience and effective systems. Minor discharge related issues were already being addressed, with actions to be monitored through established governance routes.

The Board discussed the improvement in Mental Health Act compliance and agreed that the Safety and Quality Committee would consider the report at its February meeting and provide formal written acknowledgement to the relevant teams.

18/26 Annual Adult Safe Staffing Report

The Board received the Annual Adult Safe Staffing Report, which had been endorsed at the Safety and Quality Committee (Minute No 19/26). The Board was informed that the review had been conducted through the established triangulated method, incorporating validated workforce data, professional judgement and analysis of safety, quality and workforce metrics. The review was aligned with National Quality Board guidance and NHS Improvement Workforce Safeguards. It was highlighted that this assessment reflected safe staffing levels within the current clinical configuration and that staffing establishments would be revisited as part of forthcoming clinical pathway changes and bed reconfigurations associated with the Waste Reduction Programme. Any changes would be subject to Equality and Quality Impact Assessment.

It was noted that the workforce modelling confirmed that the current establishment broadly met patient care needs, with targeted adjustments identified within budget where required to respond to patient acuity, service reconfiguration and operational pressures. External compliance requirements including compliance with British Association of Perinatal Medicine (BAPM) and Guidelines for the Provision of Intensive Care Services

(GPICS) and other specialty specific standards, had also been considered.-specific standards

The Board was advised of several ongoing risks, including the Trust's participation in the national pilot for enhanced observation of care and outstanding recruitment to healthcare assistant posts, which continued to drive bank spend. Mitigations included strengthened roster design, improved deployment through Safe Care, targeted recruitment, daily safe staffing oversight and enhanced healthcare assurance processes.

The Board received assurance that, overall, safe staffing standards continued to be met. The Chief Nursing Officer and Chief Medical Officer had confirmed full compliance with NICE Workforce Standards, NQB expectations and NHS Improvement Workforce Safeguards. Evidence demonstrated that staffing models across divisions continued to support safe, effective and sustainable care for 2025–2026.

The Board RESOLVED to approve the 2025/26 Annual Adult Safe Staffing Report.

19/26 Maternity and Neonatal Service Report

The Board received the maternity and neonatal update along with the final position for Year 7 of the CNST Maternity Incentive Scheme, noting that it had already been endorsed by the Safety and Quality Committee (minute No 20/26).

The Board was informed that, following validation by the Local Maternity and Neonatal System, the Trust had met all 10 CNST safety actions for the relevant period from 1 December 2024 to 30 November 2025. On the basis of this external validation, the Board was asked to approve delegated authority for the Chief Executive Officer to sign the required declaration for submission to NHS Resolution by 3 March 2026.

The Board was updated on key quality indicators. The maternity SPC dashboard continued to show broadly stable outcomes, including sustained improvement in stillbirth rates. Two areas requiring ongoing focus were highlighted. The incidents of Postpartum Haemorrhage (PPH) had seen an increase since March 2025. A deep dive investigation, together with a multiprofessional rapid task and finish group, was underway. These actions aligned with the forthcoming national maternity care bundle. The Board discussed the increase in PPH and received further assurance that the rise did not reflect deterioration in the improvements made for ethnic minority women. It was noted that improvements previously achieved for women from ethnic minority backgrounds reducing the disparity to 9% had been maintained. An unexpected rise in Neonatal deaths had been identified in December cases linked to extreme prematurity and case complexity. All cases were undergoing full perinatal mortality review, with findings to inform continuous learning and service improvement.

An update was provided on the workforce, noting continued progress in reducing midwifery vacancies, with projections indicating a vacancy level of approximately 2.93 WTE by May. Recruitment delays had occurred, but overall workforce stability was improving. The Birthrate Plus assessment confirmed the need for an uplift in staffing due to increased acuity and complexity. Further details and funding proposals would be taken to the Safety and Quality Committee at its February meeting.

The Board also noted a reduction in BAPM nurse standard compliance in November and December due to staffing unavailability linked to maternity leave and sickness. It was confirmed that no adverse outcomes had resulted and that mitigations were in place.

Further updates included the rise in Caesarean Section rates. An ICB led summit had been convened to establish a systemwide response to rising rates. Following a regional Prevention of Future Deaths report affecting another trust, the Home Birth Service was participating in a regional review to inform a new home birth charter. No issues of concern had been identified locally. A wider point was raised regarding the need for consistent Trustwide oversight of Prevention of Future Deaths reports in connection to home births, with the Safety and Quality Committee confirming that this broader lens was being embedded into the governance framework. The Maternity and Gynaecology culture review had concluded, with feedback sessions underway and an Organisational Development supported action plan being developed. led summit had been convened to establish a systemwide response to rising rates.

The Trust had recently contributed to an expert panel on national maternity and neonatal equality work, reflecting external recognition of local improvement work. The Board also commended the team for achieving full CNST compliance ahead of national deadlines, noting the significant work required.

The Board RESOLVED to:

1. **approve the Maternity and Neonatal Service Report and confirmed it was assured of the effective management of risks through robust governance processes.**
2. **approve delegated authority for the Chief Executive Officer to sign the required declaration for submission to NHS Resolution by 3 March 2026.**

20/26 Corporate Objectives 2026/27

The Board received the updated Corporate Objectives, noting that the objectives had been developed iteratively through the forward planning workshop and had been refined to reflect Board feedback.

A question was raised regarding accountability, with the Board seeking clarity on how delivery against the objectives, particularly financial performance and delivery of forecasted plans would operate in practice. It was confirmed that accountability would sit with the Chief Finance Officer as the first accountable officer and with Executive Directors collectively. The Board was advised that the objectives would form the basis for setting Executive Director objectives for the coming year and would then cascade to divisional and team level objectives supported by learning frameworks and strengthened governance. The Board noted that divisional delivery groups would form a key part of the accountability infrastructure and that the Waste Reduction Programme and budget delivery would be closely aligned to this framework. A suggestion was raised regarding appraisal cascades, with the Board suggesting that corporate objectives should be reflected not only in leadership appraisals but throughout the wider workforce to ensure organisational alignment.

The Board agreed to amend the wording in the values and culture section to reflect a positive commitment, replacing “continue not to lose sight of our values” with “continue to

hold firm to our values". A further amendment was agreed to change reference to clinical performance to include financial performance.

The Board RESOLVED to approve the Corporate Objectives for adoption in 2026/27 subject to the agreed amendments.

21/26 2026/27 Plan and Board Assurance Statement

The Board received an update on the 2026/27 planning process and noted that work had progressed in line with national requirements, including assessment of the financial opportunities outlined in the NHS England planning pack. The Board was informed that the indicative opportunities included £9.1m in elective care, £9.3m in outpatients, and £67.2m across urgent and emergency care. The Board acknowledged that not all of this opportunity was realistically deliverable, but these figures formed the national baseline used for planning.

The Board noted that significant work had taken place to mitigate the planning gap, including the productivity and pathway redesign initiatives described earlier in the meeting. The Board was reminded that draft submissions were due to the ICS on 12 February, and that further work would continue up to that deadline due to the complexity of the multi-year planning templates. Given the timing of the Board meeting, members were asked to delegate authority to the Chair and Chief Executive to sign off the Board Assurance Statement ahead of formal submission. It was confirmed that the final assurance documentation would be circulated to all members following completion. The Board also discussed the importance of triangulation across workforce and finance assessing the deliverability of the plan. It was noted that many of the productivity opportunities that would ordinarily support the plan had already been utilised to address the affordability challenge, limiting the remaining available scope.

In response to a query, the Board was assured that the plan would be submitted with explicit risk statements for each area where compliance could not be guaranteed, ensuring transparency with the ICS and regional team. The Board also noted the update that the Improvement and Assurance Group had recognised the affordability constraints and the need for a system-wide response to support urgent and emergency care improvements. Further clarity was expected in March once contract negotiations were more advanced.

The Board RESOLVED to delegate authority to the Chair and Chief Executive to sign off the Board Assurance Statement ahead of formal submission.

22/26 Charitable Funds Committee Chair's Report

The Committee chair reported that both the main charity and the Rosemere Cancer Foundation continued to perform strongly, with healthy financial positions and sustained fundraising activity. The only area noted as slightly off-track related to legacies, which by nature remained unpredictable given the reliance on external bequests.

The Board was advised that the most significant item funded since the previous Board meeting was a substantial investment for Ward 12. The Committee had initially requested that the proposal be strengthened and made more ambitious and following its resubmission had reviewed the revised bid. The process highlighted the Committee's earlier request to ensure that all bids were appropriately scoped and that internal

contracting approaches were scrutinised for value. It was confirmed that the expenditure fell clearly within the charitable purposes of the charity.

23/26 Review of Terms of Reference

The Board received an update regarding the review of the revision of assurance committee Terms of Reference following an action from an internal audit. It was noted that the internal audit had recommended the inclusion of an additional statement within the terms of reference for both the Safety and Quality and the Education, Training and Research Committees under the list of duties: "Consider the control and mitigation of strategic and operational high risks related to the business of the committee and provide assurance to the Board that such risks are being effectively controlled and managed as part of the Board Assurance Framework".

The Board RESOLVED to approve the additional wording to the Terms of Reference of the Safety and Quality and Education, Training and Research Committees.

24/26 Items for information

The following reports were received and noted for information:

a) Register of Interests

RSP colleagues were asked to provide feedback and acknowledged there had been a marked increase in discussion focused on the learning, triangulation of information and the use of national benchmarks. This was viewed as a positive development compared to earlier observations. It was further noted that the Board was demonstrating an appropriate balance between managing current financial and performance pressures and maintaining a forward-looking focus on longer-term strategic ambitions, including research, education and the future hospital programme. The Board was commended for not becoming solely absorbed by immediate challenges. The strength of triangulation evident in the meeting and the integration of multiple data sources into Board deliberations was highlighted. The prominent positioning of the Board Assurance Framework at the start of the agenda was welcomed, noting that this set a clear tone for discussions on strategic risk. The accompanying paper was also described as high quality. The Board was informed that, to ensure objectivity across the system, members of the RSP team were observing different trusts' Board meetings. The presence of both observers formed part of a coordinated approach to providing constructive feedback and supporting system improvement. The Board was commended for not becoming solely absorbed by immediate challenges.

25/26 Date, time and venue of next meeting

The next meeting of the Board of Directors will be held on Thursday 2 April 2026 at 9:15am at Lecture Room 1, EC1, Royal Preston Hospital

The meeting closed at 1.00pm

5. MATTERS ARISING AND ACTION LOG UPDATE

Decision Item | Chair | 09:40 am

REFERENCES

Only PDFs are attached

5.0 - Action log - Board (part I) - 5 February 2026.pdf

Action log: Board of Directors (part I) – 5 February 2026

No Outstanding Actions

COMPLETED ACTIONS *(for information)*

№	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update
1.		5 Feb 2026	**Staff Story –** A letter to be sent to staff member and supporting colleagues for sharing their story and to the psychological service colleagues acknowledging the provision.	CAT	2 Apr 2026	**Completed** **Update for 2 Apr 2026:** Letters approved by Chair and circulated.
2.	23/26	5 Feb 2026	**ToR Revision –** ETR and SQC ToR to be updated to include the revised wording approved by BoD	CAT	2 Apr 2026	**Completed** **Update for 2 Apr 2026** – ToR have been updated.
3.	11/26	5 Feb 2026	**WFC chairs Report -** A proposal was made to strengthen Board oversight of fragile services by bringing together the workforce, finance, performance and quality dimensions of fragility into a single, consolidated assurance view. It was agreed that this proposal would be explored further outside the meeting, potentially through a Board development session.	D of CA	2 Apr 2026	**Completed** **Update for 2 April 2026:** Added to workplan for workshops in 2026/27.
4.	20/26	5 Feb 2026	**Corporate Objectives -** The Board agreed to amend the wording in the values and culture section to reflect a positive commitment, replacing “continue not to lose sight of our values” with “continue to hold firm to our values”. A further amendment was agreed to change reference to clinical performance to include financial performance.	CS&IO	2 Apr 2026	**Completed** **Update for 2 April 2026:** The updated corporate objectives are appended to the BAF.
5.	10/26	5 Feb 2026	**BAF –**	CMO	2 Apr 2026	**Completed** **Update for 2 April 2026:**

№	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update
			a) The Safety and Quality Committee requested that the diagnostic data breakdown including proportions of patients re-categorised, expedited or found to no longer require diagnostics be included in the next report. **b)** Analyse patterns in two-week wait referrals that do not result in a cancer diagnosis, identifying themes, geographical variation, and opportunities to reduce inappropriate referrals, via the Lancashire and South Cumbria Cancer Improvement Board, and report outcomes back to the Board through the relevant committee. **c)** Include further analysis of diagnostic risk scoring and health inequalities—drawing on Safety & Quality Committee work—within the March Board workshop to support refinement of 2026/27 risks. **d)** The Board noted interest in benchmarking the Trust's approach to risk scoring against regional peers to understand variations in methodology and risk appetite. It was agreed that this would be explored through future joint Executive to Executive sessions with regional partners.	COO AD of R&A	2 Apr 2026 2 Apr 2026	a) Feedback from the Board is noted and whilst it is not immediately able to be actioned routinely, consideration of how this can be done to drive productivity changes will be incorporated into the operational discussions for this area of improvement. b) Feedback on the areas where there are opportunities to influence/change referral patterns that do not result in cancer outcomes continue to be part of the cancer board programmes of work. The outcomes of this work will be shared as they become available. c) Principal Risks and Corporate Objectives were reviewed at the Board Workshop on 3rd March 2026 and proposals for 2026/27 are included in the Board Assurance Framework paper. d) The Executive to Executive sessions are being arranged.
6.	15/26	5 Feb 2026	**IPR – People -** It was agreed to review current processes for job-specific training, ensure a register of recommendations existed and confirm the appropriate committee oversight.	CPO	2 Apr 2026	**Completed** **Update for 2 Apr 2026:** This is included within section 2.2 and appendix 2 of the Core Skills and Medical Devices report that will be presented to ETR Committee on 31st March (agenda item 7.1)

ITEMS FOR FUTURE BUSINESS *(for information)*

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

6. CHAIR'S OPENING REMARKS AND REPORT

Information Item | Chair | 09:42 am

REFERENCES

Only PDFs are attached

6.0 Chair's Report April 26 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**	**2nd April 2026**	
	Part I ☒	**Part II** ☐	
Title of Report	**Chair's Update Report**		
Report Author	Rebecca Black, Executive Business Manager to CEO		
Lead Executive Director	Mike Thomas, Chair		
Recommendation/ Actions required	The Board of Directors is asked to receive the report and note the contents for information.		
	Decision ☐	**Assurance** ☐	**Information** ☒
Executive Summary	The purpose of this report is to provide a summary of work and activities undertaken during February and March 2026 by the Trust Chair.		
Link to Strategic Objectives 2025/26	**Patients – deliver excellent care:** Improve outcomes, reduce harm and deliver a positive patient experience.		☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.		☒
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.		☒
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.		☒
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.		☒

1. **Introduction**

The purpose of this report is to provide an overview of the work and activities undertaken during February and March 2026.

2. Throughout February and early March, I have been heavily engaged in a wide range of executive and system-level responsibilities, including preparations for multiple MTP (Medium Term Plan) discussions with NHSE, coordinating briefing materials, aligning with colleagues across the Lancashire and South Cumbria system, and planning for these sessions. I have also contributed to governance work around the Board development**,** Board self-assessment, and financial planning, including updates on forecast changes and operational pressures.

I have also been involved in operational and collaborative matters: arranging meetings with regional and national partners, responding to service issues (including patient care queries and corridor care discussions), supporting leadership development initiatives, and maintaining close communication with Trust executives and external stakeholders.

Finally, I would like to acknowledge the significant hard work, commitment, and resilience demonstrated by the Executive Team and their departments over recent months. The scale and complexity of the ongoing Improvement & Assurance Group (IAG) work, the sustained navigation of financial pressures, and the considerable challenges related to headcount and workforce constraints have required exceptional leadership, collaboration, and focus. Despite these pressures, colleagues have continued to drive improvements, provide thoughtful strategic input, and maintain momentum across multiple critical workstreams. Their dedication is deeply appreciated and instrumental in supporting the organisation through this demanding period.

3. **Chair's Update – Summary of Key Items from Board Part II meeting of 5th February 2026**

The Board met on 5 February 2026 to discuss several strategic and operational matters relating to the Trust's ongoing development, financial sustainability, and service improvement programmes.

The Board received a broad organisational update from the Executive Team, which covered progress on major programmes of work including estates development, digital transformation, and system-level collaboration. The discussion highlighted continuing positive engagement with national partners on long-term infrastructure planning and future service models.

A financial overview was presented, confirming that the Trust continues to work within a challenging financial environment. The Board reviewed the current position and the steps being taken to improve financial resilience, including strengthened planning arrangements and continued focus on delivering agreed efficiency programmes. Assurance was received that the Trust is maintaining strong governance and oversight of its financial commitments.

The Board also considered updates on several major strategic programmes. This included the ongoing development of the Trust's long-term sustainability plan, progress in regional estates optimisation work, and the advancement of key business cases supporting improvements to patient pathways, service capacity, and digital capability.

Important operational and quality matters were noted, including updates on risk management processes and assurance mechanisms supporting clinical quality, workforce, and safety. Where external reviews or improvement activity were underway, the Board confirmed that appropriate governance, oversight and support were in place.

The meeting concluded with receipt of routine reports from Board committees, reaffirming the Trust's commitment to transparency, effective governance, and delivery of high-quality patient care

4. Chair's attendance at meetings

Details below are the meetings attended and activities undertaken during February and March 2026.

Date	Activity
February 2026	
2nd February	Pre Meetings for LTH and 1LSC Improvement & Assurance Group (IAG)
3rd February	LTH Improvement & Assurance Group (IAG) – PWC/NHSE/ICB
3rd February	121 – Director of Corporate Services
3rd February	121 – A Brown, NHSE
3rd February	1LSC Improvement & Assurance Group (IAG) – PWC/NHSE/ICB
4th February	SUMS Annual Conference (London)
5th February	LTH Board of Directors
5th February	121 – Director of Communications & Engagement
17th February	121 – Chief Strategy and Improvement Officer
17th February	121 – Non-Executive Director
17th February	Non-Executive 360 Feedback Session
17th February	121 – A Brown, NHSE
17th February	Non-Executive Monthly Meeting
19th February	121 – Chief People Officer
19th February	121 – Lead Governor and Non-Executive Director
19th February	121- Managing Director, LSC Provider Collaborative
19th February	121 – Business Manager, Corporate Affairs
19th February	Board Development Session
24th February	121 – Director of Communications & Engagement
24th February	121 – Deputy Director of Education
24th February	121 – Non-Executive Director
26th February	Corridor Care Summit
27th February	Executive Leadership MTP Discussion – LSC Provider Collaborative
27th February	Executive Leadership MTP Discussion – Lancashire Teaching Hospital
March 2026	
3rd March	121 – Director of Corporate Services
3rd March	Non-Executive Director Appraisal
3rd March	Special Board of Directors Meeting
3rd March	Board Workshop
4th March	LTH Improvement & Assurance Group (IAG) – PWC/NHSE/ICB
4TH March	1LSC Improvement & Assurance Group (IAG) – PWC/NHSE/ICB

10th March	121 - Chair, LSC Integrated Care Board
10th March	121 – LTH Chief Executive
10th March	Non-Executive Appraisal
12th March	Lancashire Leaders' meeting
12th March	Trust Chairs meeting
12th March	Provider Collaboration Board meeting
17th March	121 – Director of Communications & Engagement
17th March	Strategic Workforce Assembly
17th March	121 – Director of Corporate Services
17th March	121 – Chief Medical Officer
17th March	Non-Executive Directors meeting
19th March	121 – Deputy Director of Education
19th March	Non-Executive Director Appraisal
19th March	121 – Managing Director, LSC Provider Collaborative
19th March	Non-Executive Director Appraisal

5. **Financial implications**
   None.

6. **Legal implications**
   None.

7. **Risks**
   None.

8. **Impact on stakeholders**
9. 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 Morrison | 09:45 am

REFERENCES

Only PDFs are attached

7.0 Chief Executive's Report to Board - April 2026.pdf

Board of Directors' Report

Meeting of the	Board of Directors		2 April 2026
	Part I ☒		**Part II** ☐
Title of Report	Chief Executive's Report		
Report Author	Prepared by Naomi Duggan – Director of Communications and Engagement		
Lead Executive Director	Professor Silas Nicholls – Chief Executive		
Recommendation/ Actions required	The Board of Directors is asked to receive the report and note its contents for information.		
	Decision ☐	**Assurance** ☐	**Information** ☒
Executive Summary	The purpose of this report is to update the Trust Board on matters of interest since the previous meeting.		
Link to Strategic Objectives 2025/26	**Patients – deliver excellent care:** Improve outcomes, reduce harm and deliver a positive patient experience.		☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.		☒
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.		☒
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.		☒
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.		☒

CHIEF EXECUTIVE'S REPORT

Finance and improvement update

As the Trust approaches the end of the 2025/26 financial year, significant progress has been made in strengthening our financial position. We have improved our underlying deficit by over £14m against a baseline deficit of £65.7m - the largest improvement achieved in the past six years.

Work continues to ensure strong momentum into 2026/27 and to support delivery of the Trust's plan to break even by March 2028. Preparations for next year include advancing a full pipeline of cost-saving schemes to ensure early impact.

We have also received confirmation that Lancashire Teaching Hospitals, alongside eight other Trusts, will transition from the NHS England Recovery Support Programme (RSP) into the new National Provider Improvement Programme (NPIP) from April 2026. NPIP will run for approximately six to nine months and supports organisations through five phases - mobilise, assess, plan, support and transition - focusing on strengthening the conditions and capacity required for sustainable improvement. Further updates will follow as the programme progresses.

Due to being in the RSP, this places the Trust in segment 5 of the National Oversight Framework (NOF). As such. we were recently ranked 129/134 in the acute and specialist provider league tables following quarter three's publication on the Model Health System on 18 March - a slight improvement on quarter two data.

Transfer of LTH Estates and Facilities into One LSC

On 1 March 2026, our Lancashire Teaching Hospitals' estates and facilities (E&F) colleagues transferred into One LSC, joining colleagues from Blackpool Teaching Hospitals NHS Foundation Trust (BTH) and University Hospitals of Morecambe Bay NHS Foundation Trust who transferred to lead provider East Lancashire Hospitals NHS Trust (ELHT) in November 2024.

This move brought all acute Trusts into one joined up E&F service, helping to standardise best practice, increase resilience and support a more strategic approach to managing estates across the region.

Although employed by ELHT, our E&F colleagues remain a very big part of the LTH family in their day-to-day roles and I would like to acknowledge the professionalism of all colleagues and leaders during this process along with our staff side colleagues who have been very busy supporting a number of key change programmes across our hospitals and the wider system

Medicine reconfiguration update

A number of changes have now been made to the reconfiguration of beds within the medicine division in support of our Days Kept Away from Home (DKAFH) initiative which helps to cohort patients who are fit for discharge to free up speciality beds across our wards and improve flow.

At any given time, there are around 90 patients within our hospitals who are medically fit for discharge but still occupy a clinical bed. This is contributing to a significant bottleneck at the front door as well as corridor care and boarding within our wards. The changes have allowed us to expand the dedicated area for these patients, as well as allowing specialist teams to provide a more focussed approach on reducing the length of stay associated with this patient group.

In addition, freeing up more speciality beds across the RPH site will also facilitate the early movement of Emergency Department patients into an appropriate ward setting. Moving patients directly into ward environments ensures they receive the right care, from the right teams, in the right setting, while reducing crowding within ED and supporting improved flow through the hospital.

Welcoming Improvement Director, Caroline VanLuttmer

This year the NHS as whole is being asked to increase our focus on performance. We're delighted that Caroline VanLuttmer – a highly experienced Improvement Director – is temporarily joining us to provide expert support to the delivery of urgent care transformation across the organisation, including working with our system partners.

Caroline will be collaborating with the Executive team and the Medicine Divisional Management team on this important agenda.

Governor Elections 2026

Voting for the election to the Council of Governors opened on 25 February 2026.

In the staff constituency, elections took place in the 'Unregistered Healthcare and Support Workers', 'Doctors and Dentists' and 'Non-Clinical' categories. In the public constituency there were seven places available, with 12 candidates running for election. Online voting for the election to the Council of Governors closed on Friday 20 March 2026 and the declaration of results were published on Monday 23 March 2026.

Confirmation of the results is below:

Public: re-elected

- Graham Fullarton

Public: newly elected

- Christine Turner
- Linda Bracewell
- Susan Bailey
- Ian Facer
- Zulekha Mushtaq
- Terry Lindsay

Staff: newly elected

- George-Adrian Rata (Doctors and Dentists)
- Ian Linacre (Non-Clinical)
- Sheila Beale (Unregistered Healthcare and Support Workers)

The terms for all of the above Governors will run until 31 March 2029.

I would also like to put on record my sincere thanks to outgoing public Governors Janet Miller, Margaret France and Frank Robinson who have each recently completed their terms at the Trust.

Trust wide successes and service developments

- **Urology pilot new 'one-stop' clinic for patients with urinary symptoms**

Our Urology team have launched a new one-stop clinic designed to significantly reduce waiting times and the number of appointments for patients experiencing problems passing urine, most commonly due to an enlarged prostate.

Based in Cuerden Outpatients at Chorley and South Ribble Hospital, the pilot clinic will run every other Tuesday for eight weeks. It introduces a single point of access model that allows patients to have all the necessary assessments and investigations completed in one visit.

Currently, patients are often required to attend multiple appointments before a treatment plan can be agreed. Under the new model, patients will complete questionnaires and a bladder diary before attending.

On the day, they will have a flow test, see a doctor for assessment, and, where needed, have further investigations, all in a single appointment. Many patients will be able to leave with a treatment plan or prescription the same day.

If successful, the team hopes to expand the model to support prostate cancer patients ahead of radiotherapy treatment and, in time, enable GPs to book directly into the clinic.

This work supports our wider ambition to develop more single point of access services that improve patient experience and reduce delays in care.

- **Sir Lindsay Hoyle plants ceremonial tree at Chorley and South Ribble Hospital**

Rt Hon Sir Lindsay Hoyle MP to Chorley and South Ribble Hospital was recently invited to plant a ceremonial tree to celebrate and highlight the range of work being done to by the Trust to support biodiversity and green space on our hospital sites.

This is part of the delivery of our Green Plan (2025-2028), including the planting of new trees provided by NHS Forests.

In attendance were Deputy Chief Executive and Chief Nurse Sarah Morrison, Planning Officer Tracey Calvey, who supports with the Green Plan for the Trust, Non-executive Directors Tim Ballard, Tim Wheeler and Uzair Patel, Building Manager Gary Wilkes and Shaun Ashworth, Interim Director of Estates and Facilities, Adam Sharples, Head of Communications and Chris Boden Communications Officer.

Sir Lindsay was also given a tour of the memorial garden to showcase some of the grounds work completed to date.

- **Celebrating 10 Years of the NIHR Lancashire Clinical Research Facility**

As the NIHR Lancashire Clinical Research Facility marks its ten-year anniversary, we are proud to reflect on a decade of growth, innovation, and impact in early phase clinical research.

Since opening, we have significantly expanded our early phase portfolio, progressing from no early phase activity to establishing a strong, diverse programme of studies across multiple specialties. This includes advancing into cutting edge areas such as advanced therapies, GMO studies, gene therapy trials and cancer vaccines. Our team has grown in both size and expertise. We have invested heavily in comprehensive clinical training to continually enhance the skills required to deliver a high quality, safe, and responsive research service.

Throughout the decade, we have collaborated with a wide range of industry partners, achieving notable milestones including:

- The First global and first UK participant enrolments
- Achieving top recruiting centre status across several national studies
- The development of England's first strategic contract with BioNTech, which has strengthened our commercial portfolio and is establishing standardised processes to support innovative trial delivery across Lancashire & South Cumbria
- Working closely with other National Institute for Health Research (NIHR) infrastructure, including the Manchester Biomedical Research Centre (MBRC) and the NIHR BioResource, to support investigator led studies and broaden research opportunities.

A standout accomplishment has been the successful delivery of the PERSICA first in human trial (the LCRF/LSC's first early phase trial) which has since been published in The Lancet's eClinicalMedicine (https://doi.org/10.1016/j.eclinm.2026.103764) with positive patient outcomes. This achievement highlights our capability to deliver complex, high impact early phase trials to the highest standards.

Together, these achievements reflect a decade of commitment to advancing research, improving patient outcomes, and positioning the NIHR Lancashire CRF as a leading centre for early phase and innovative clinical trials.

- **Nurse call bell replacement works**

With the original nurse call system reaching the end of its operational life, a Nurse Call System upgrade began in October 2025.

All existing nurse call bells are being replaced with new, fully compatible units, designed to integrate with the upgraded infrastructure. The new nurse call bells provide patients with a reliable and immediate method of alerting nursing staff when assistance is required, which integrates with the central nurse call panel and offers enhanced reliability and reduced system downtime. Replacing the nurse call bells as part of the wider system upgrade ensures long-term sustainability, improved reliability, and enhanced patient safety.

Defibrillator standardisation improving response times and patient outcomes

We have successfully standardised all clinical areas onto the ZOLL R Series Plus defibrillators, replacing three legacy models and reducing complexity for colleagues who require life-support training.

Early results show clear improvements in cardiac arrest response:

- Earlier delivery of shocks, with ward teams now defibrillating before the Resuscitation Service arrives.
- Pre- and post-shock pauses reduced from ~25 seconds to 12–15 seconds through See-Thru CPR visual guidance.
- Increased ROSC rates, linked to faster intervention and improved CPR quality.

The Resuscitation Service worked with ZOLL's Clinical Implementation team to train 25 theatre "Super Users" and deliver on-ward refresher sessions, ensuring high staff confidence across all roles.

The new devices power on in AED mode with clear prompts, while ALS providers can switch to manual mode instantly. Real-time CPR feedback is further strengthening performance and supporting effective debriefing.

Data from RescueNet CaseReview continues to be used to embed best practice and enhance team responses Trust-wide.

- **LSC NHS Apprenticeship Awards are presented**

We were delighted to have 15 finalists in the 2025 Lancashire & South Cumbria NHS Apprenticeship Awards, along with two award winners - Ava Bolton (Rising Star - T Level Award) and Lucy Wilson (Equality, Diversity & Inclusion Award).

We also had two highly commended entrants, Cameron West and Lewis Doherty. Lewis was notably shortlisted in three categories. Ava and Cameron are Runshaw College students who completed placements with LTH, while Lucy and Lewis joined the Trust as part of our first Healthcare Apprentices intake in September 2024. Both completed their Level 2 Healthcare Support Worker apprenticeship with Distinction, with Lewis progressing to Level 3.

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

Awards were presented to colleagues during National Apprenticeship Week in February.

- **Bishop of Burnley praises chaplaincy team during visit to Royal Preston Hospital**

The Bishop of Burnley, Rt Rev Dr Joe Kennedy, visited Royal Preston Hospital in February, reflecting on the vital role of chaplaincy teams and sharing how his own recent experience as a patient deepened his appreciation for those who offer spiritual care on the wards. Bishop Joe has spent much of his ministry travelling across Lancashire, visiting churches, schools and chaplaincies to see "what God is doing in that place," something he describes as one of the greatest joys of his role.

During his visit to Royal Preston Hospital, Bishop Joe said he was struck by the depth of commitment shown by the chaplaincy team, who he met in the chapel and Muslim prayer room, while he also went out within the hospital to the Emergency Department and Critical Care Unit.

Read more about Biship Joe's visit on our website.

- **Noeleen retires after 50 years in nursing**

After an extraordinary 50-year career in nursing, Noeleen Griggs has officially hung up her uniform.

However, her legacy continues with daughter and granddaughter Anneen and Amelia Carlisle following in her footsteps.

Trust Operational Officer, Anneen, herself has three decades of service, while Amelia is a Sister / Charge Nurse on the Surgical Assessment Unit, having qualified in 2019. Surrounded by colleagues, friends, and family in the conservatory on Ward 2b at Royal Preston Hospital, Noeleen marked her retirement with laughter, memories, and a few happy tears. Anneen spoke on behalf of her siblings Justine, Kate, James, and daughter Amelia, sharing a heartfelt tribute to her mum. Noeleen, from Fulwood, started her training in 1971, at the old Royal Infirmary in Preston, completing placements at Sharoe Green and later spending time at Deepdale Hospital.

Noeleen is looking forward to more time with her devoted husband, Alan, while she has 13 grandchildren and two great-grandchildren to keep her busy – and a long-awaited trip to Florence planned for May. Read more about Noeleen's service on our website.

- **Royal Preston Hospital unveils newly-refurbished helipad**

Royal Preston Hospital officially reopened its fully refurbished helipad in February, following the completion of a major upgrade programme made possible by a £720,000 donation from the HELP Appeal - the country's only charity dedicated to funding NHS hospital helipads.

The grant, the largest single charitable donation in the Trust's history, has enabled the hospital to replace and modernise its entire helipad infrastructure to meet current safety and legislative standards.

Mark Bishop from the Trust Estates Department, in conjunction with FWP Architects and main contractor Carefoot, successfully delivered the project, which introduces a range of modern upgrades designed to enhance both safety and operational efficiency. Key improvements include a brand-new, state-of-the-art landing pad, upgraded Heli lighting, new safety fencing and barriers, enhanced signage, modernised aviation control systems, improved drainage and the installation of an on-site live weather station.

These enhancements will significantly improve safety, reliability, and efficiency for critical air ambulance transfers. The new safety barriers on internal hospital roads and enhanced fencing around the helipad will ensure vehicles - and particularly pedestrians - are kept at a safe distance during helicopter arrivals and take-offs, helping to prevent disruption and avoid delays.

With its latest donation, the HELP Appeal has now donated £875,000 to the helipad facilities at the Royal Preston Hospital since the charity was set up in 2009. The full story is on our website.

- **Quick thinking 12-year-old hailed a hero after helping mum at Royal Preston Hospital**

A 12-year-old girl was praised as a “remarkable" young hero by staff at Lancashire Teaching Hospitals after she came to her mum's aid when she suddenly collapsed during an appointment. Helen Whaite, of Leyland, was at Royal Preston Hospital for her daughter Alex's neurology appointment when Alex, who herself has epilepsy, noticed something was wrong shortly after her mum returned to the waiting area after going to the toilet. Within seconds, her mum Helen became unresponsive - and Alex didn’t hesitate.

She tapped her mum on the shoulder, called out for help when she received no response, and stayed right by her side, preventing her from injuring herself while alerting staff.

Hospital colleagues rushed to help, but later said it was Alex’s calmness and quick judgement that stood out.

Helen remembers very little of what happened - but was later told about how her daughter stopped her from hitting nearby furniture as she fell unwell.

Alex was then looked after on the Children's Ward while mum was treated, getting the chance to use the play area, and to recognise her bravery, the Trust arranged a surprise presentation for her - celebrating her courage and presence of mind.

Roald Dahl's Marvellous Children's Charity also gave her a goody bag, including a resilience certificate designed to celebrate bravery. Thankfully, Alex’s mum has since made a good recovery. The full story is on our website.

- **Sixth annual Ramadan Challenge is a huge success**

The sixth annual Ramadan Challenge for Rosemere Cancer Foundation proved a huge success.

Around 100 colleagues, including Chief Executive Silas Nicholls, Deputy Chief Executive Sarah Morrison, Chief Strategy and Improvement Officer Ailsa Brotherton and Director of Communication and Engagement Naomi Duggan, attended the Iftar - the fast-breaking evening meal of Muslims in Ramadan - in Charters Restaurant at Royal Preston Hospital, as well as representatives of the local community. And the event, to raise funds for Rosemere, had raised a fabulous total of £1,600 at the time of writing - up £400 from last year and only previously topped in 2024.

Thanks again go to Respiratory Consultant Professor Mohammed Munavvar, supported by the chaplaincy team and staff from various departments, for organising the event.

Our Endoscopy team at Chorley and South Ribble Hospital also came together for a meaningful and uplifting Iftar – with initiative creating a wonderful moment of togetherness and reflection, while also raising around £350 for Rosemere Cancer Foundation.

- **Angkor Wat Trek to Cambodia**

A huge thank you to our amazing colleagues who took on a multi-day trek to Angkor Wat in Cambodia last November to raise crucial funds for our hospital charities - Lancashire Teaching Hospitals Charity, Baby Beat, and Rosemere Cancer Foundation.

Our fabulous Trust colleagues who took part in the trek (as part of a 27-strong team of charity supporters) helped raise an incredible total of £43,572.16! Their adventure began with a 13-hour flight from Gatwick to Siem Reap in Cambodia.

After a night's rest in a hotel, they then set out on a five-day camping expedition to the UNESCO World Heritage site of Angkor Wat, the 12th century Buddhist temple complex considered the Eighth Wonder of the World. Over the week, the team walked up to 25km a day, all in support of the work that our charity teams do for the benefit of our patients.

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 | 09:55 am

REFERENCES

Only PDFs are attached

8.0 Board Assurance Framework Board Report April 26.pdf

Board of Directors Report

Meeting of the	Board of Directors	2nd April 2026
	Part I ☒	**Part II** ☐
Title of Report	Board Assurance Framework (BAF) Report	
Report Author	Simon Regan, Associate Director of Risk & Assurance,	
Lead Executive Director	Executive Directors	
Recommendation / Actions required	The Board of Directors are asked to: • Note and approve the updates to the BAF. • Approve that Principal Risk 2 (2025/26) related to Higher than trajectory rates of Clostridioides difficile (C.*difficile*) Infection be moved to 'Controlled' status. • Note the final Corporate Objectives for 2026/27 included at Appendix 2. • Note and approve the newly identified Principal Risks for 2026/27 in Appendix 3. • Note and approve the Risk Appetite, Risk Tolerance and Revised Risk Appetite Statement.	
	Decision ☒	**Assurance** ☐ / **Information** ☐
Executive Summary	This paper provides an update on the Board Assurance Framework (BAF), which contains the Principal Risks to the delivery of the 2025/26 Corporate Objectives. Updates since the last Board of Directors meeting: • In relation to Principal Risk 2 (2025/26) related to Higher than trajectory rates of Clostridioides difficile (C.*difficile*) Infection – cases of C.*difficile* continue to track below trajectory and given the increased confidence and assurance that the Trust will remain below the planned trajectory at the end of this month, the score has been further reduced from 8 to 4, which is the target score. As the risk is now at the target score of 4, which is also within the Board's agreed Risk Tolerance, it is recommended that this Principal Risk be moved to 'Controlled' status. • In relation to Principal Risk 15 (2025/26) related to Research capacity and capability to enable progress towards University Hospital status – following presentation of the University Hospital Status plan and joint appointments being made, the Education, Training and Research Committee considered that progress has been made towards the Trust's ambition to be a University Hospital in line with the 2025/26 Corporate Objective. The risk has been reduced to 8, which is the target score, and is also within the Board's agreed Risk Tolerance and as a result, it is recommended that this Principal Risk be moved to 'Controlled' status.	

	• Principal Risks 4, 5 and 6 (25/26) linked to 'Performance' remain off track with the trajectory for a reduction in the risk scores. Proposals for 2026/27 are included in the paper. • Principal Risk 12 (25/26) related to the failure to meet the financial plan 2025/26 – the Trust will not meet its 2025/26 financial plan and this risk has now been realised. The risk has been updated to reflect the revised 2026/27 risk. • For Principal Risk 13 (25/26) related to the cash consequences of the Trust's underlying financial position, the Trust has now received its request in full inclusive of Deficit Support Funding. The risk has been updated to reflect the revised 2026/27 risk. • There have been no changes to any other scores since the last meeting and focus has turned to 2026/27 following the development of the new Corporate Objectives. • 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, which is due to transition to the National Provider Improvement Programme (NPIP). **Review of Corporate Objectives for 2026/27** The Corporate Objectives for 2026/27 were considered by the Board of Directors in February 2026. Following review and feedback from the Board, some amendments have been made and the final version of the Corporate Objectives for 2026/27 is included at Appendix 2. The Principal Risks are under review alongside the objectives. Potential new risks or revisions to the Board Assurance Framework and Principal Risks aligned to Committees of the Board were discussed at a Board Workshop on 3 March 2026. Changes were proposed in relation to: • Principal Risk 1 (Patient experience within the urgent and emergency care pathway), which is proposed to include the safety aspects of this risk in relation to ambulance handovers and Summary Emergency Department Indicator Table (SEDIT). The proposed updates have been included in Appendix 1. • Principal Risk 3 (People experiencing Health Inequalities), which is proposed to focus on assessment and projects for 26/27 in line with the Corporate Objective. The proposed updates have been included in Appendix 1. • Principal Risk 4 (Timely access to planned and cancer care), which is proposed to be split into two Principal Risks to reflect that cancer and planned care performance carry separate risks. The updated proposed new risks are included at Appendix 3. • Principal Risk 8 (Experience of staff, with specific focus on under-represented staff groups), which related to splitting the wider culture risk and the risk to the experience of under-represented staff groups, therefore creating two risks. The draft proposed risks have been developed for consideration of approval by the Board of Directors and are included in Appendix 3. • In addition to the updates to existing Principal Risks, a potential new Principal Risk was discussed and has been developed for consideration of approval for consideration of approval for inclusion in the 2026/27 Board Assurance Framework, which relates to 'Delivery of the planned reduction

	in whole time equivalent workforce' and this is proposed to be monitored at Finance & Performance Committee. A draft of the proposed risk can be found in Appendix 3. The remaining risks are planned to be retained/refreshed for 26/27 and updates have been made to existing risks for Committees of the Board in March 2026, and the updated versions are reflected in Appendix 1. **Operational High Risks for Escalation/De-escalation** There are currently no operational high risks of concern escalated to the Board within the BAF this month. **Review of Risk Appetite and Tolerance for 2026/27** The Risk Appetite and Tolerances were set by the Board of Directors in June 2025. A review of this is undertaken at least annually, and there was a planned review of this in a Board Workshop on 3 March 2026. Changes were proposed in relation to the Risk Appetite for the 'Productivity' strategic objective from 'Cautious' to 'Open'. It is recommended the Board consider and approve the proposed changes to the Risk Appetite and the updated Risk Appetite Statement.	
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:** February and March 2026
Operational Group Review:	Board Workshop	**Date:** 3rd March 2026
Link to Board Assurance Framework:	All Principal Risks within the BAF	
Appendices	Appendix 1: Board Assurance Framework – 2025/26 Appendix 2 – 2026/27 Corporate Objectives – Final. Appendix 3 – Draft new Principal Risks for 2026/27. Appendix 4 – Risk Appetite scale and matrix. Appendix 5 – Comparison of the Trust's current and proposed Risk Appetite and rationale Appendix 6 – Comparison of the Trust's current and proposed Risk Tolerance and rationale.	

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.

1.3 The paper also includes an update on 2026/27 following the approval of new Corporate Objectives and a review of the Risk Appetite, Tolerances and the Risk Appetite Statement.

2. Discussion

2.1 Current Board Assurance Framework

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

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

- In relation to Principal Risk 2 (2025/26) related to Higher than trajectory rates of Clostridioides difficile (C.*difficile*) Infection – cases of C.*difficile* continue to track below trajectory and given the increased confidence and assurance that the Trust will remain below the planned trajectory at the end of this month, the score has been further reduced from 8 to 4, which is the target score. As the risk is now at the target score of 4, which is also within the Board's agreed Risk Tolerance, it is recommended that this Principal Risk be moved to 'Controlled' status.
- At the Safety & Quality Committee meeting in February 2026, it was reported that vacancy freeze procedures had delayed cleaning standards implementation, which is an outstanding action in Principal Risk 2. As noted in the same meeting, the delivery of cleaning standards is not solely staffing related and other components are progressing well and as such, the delayed recruitment should not prevent the risk from being controlled. Infection rates and actions to improve them will continue to be reported to the Safety & Quality Committee as usual and therefore, any concerns about the ability to meet infection trajectories in 2026/27 could lead to the development of a new Principal Risk, if required.
- In relation to Principal Risk 15 (2025/26) related to Research capacity and capability to enable progress towards University Hospital status – following presentation of the University Hospital Status plan and joint appointments being made, the Education, Training and Research Committee considered that progress has been made towards the Trust's ambition to be a University Hospital in line with the 2025/26 Corporate Objective. The risk has been reduced to 8, which is the target score, and is also within the Board's agreed Risk Tolerance and as a result, it is recommended that this Principal Risk be moved to 'Controlled' status. There is one remaining action outstanding. However, this should not prevent the risk being controlled and the action will be monitored through the University Hospital Status Working Group.
- Principal Risk 4 (25/26) related to timely access to planned and cancer care, Principal Risk 5 (25/26) related to timely access to urgent and emergency care, and Principal Risk 6 (25/26) related to timely access to diagnostic investigations remain off track. Proposals for 2026/27 are

included later in the report. There are however improvements evident in the February data regarding 18 week Referral to Treatment, 52-week long waits and Diagnostic performance (DM01), which if continued in March 2026 may result in the risk scores reducing.

- Principal Risk 8 (2025/26) related to Experience of staff, with specific focus on under-represented staff groups – the risk score has not been reduced in line with trajectory and is now considered off track. A review of staff survey data and resultant actions was provided to the Workforce Committee in March 2026.
- Principal Risk 10 related to Failure to effectively manage staff absence and achieve Trust and National target rates – the risk score has not been reduced in line with trajectory and the risk score is now off track. Whilst there have been improvements in absence rates compared to the last financial year, there have been delays in implementing the actions related to a digital absence management system, occupational therapist and the absence plan on a page.
- Principal Risk 12 (25/26) related to the failure to meet the financial plan 2025/26 – the Trust will not meet its 2025/26 financial plan and this risk has now been realised. The risk has been updated to reflect the revised 2026/27 risk.
- For Principal Risk 13 (2025/26) related to the cash consequences of the Trust's underlying financial position, the £4 million cash support requested in February 2026 was rejected. However, £3 million was received for support with industrial action costs and the Trust was able to manage the difference of £1 million for February 2026. A further request for up to £15 million was approved by the Board of Directors in February 2026 (£12.5 million of this is driven by the suspension of deficit support funding since October 2025). The Trust has now received its request in full inclusive of Deficit Support Funding. The risk has been updated to reflect the revised 2026/27 risk.

2.1.3 There have been no changes to any other scores since the last meeting and focus has turned to 2026/27 following the development of new Corporate Objectives.

2.1.4 The Trust remains in segment five of the NHS Oversight Framework (NOF) and the Trust is enrolled in the recovery support programme, which is due to transition to the National Provider Improvement Programme (NPIP) from April 2026.

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. Review of Corporate Objectives for 2026/27

3.1 The Corporate Objectives for 2026/27 were considered by the Board of Directors in February 2026. Following review and feedback from the Board, some amendments have been made and the final version of the Corporate Objectives for 2026/27 is included at Appendix 2. The Principal Risks are under review alongside the Corporate Objectives.

3.2 Any potential new risks or revisions to the Board Assurance Framework and Principal Risks aligned to Committees of the Board were discussed at a Board Workshop on 3 March 2026. Changes were proposed in relation to:

- Principal Risk 1 (Patient experience within the urgent and emergency care pathway), which is proposed to include the safety aspects of this risk in relation to ambulance handovers and Summary Emergency Department Indicator Table (SEDIT). The proposed updates have been included in Appendix 1.

- Principal Risk 3 (People experiencing Health Inequalities), which is proposed to focus on assessment and projects for 26/27 in line with the Corporate Objective. The proposed updates have been included in Appendix 1.
- Principal Risk 4 (Timely access to planned and cancer care), which is proposed to be split into two Principal Risks to reflect that cancer and planned care performance carry separate risks. The updated proposed new risks are included at Appendix 3.
- Principal Risk 8 (Experience of staff, with specific focus on under-represented staff groups), which related to splitting the wider culture risk and the risk to the experience of under-represented staff groups, therefore creating two risks. The draft proposed risks have been developed for consideration of approval by the Board of Directors and are included in Appendix 3.
- In addition to the updates to existing Principal Risks, a potential new Principal Risk was discussed and has been developed for consideration of approval, which relates to 'Delivery of the planned reduction in whole time equivalent workforce' and this is proposed to be monitored at Finance & Performance Committee. A draft of the proposed risk can be found in Appendix 3.

3.3 The remaining risks are planned to be retained/refreshed for 26/27 and updates have been made to existing risks for Committees of the Board in March 2026, and the updated versions are reflected in Appendix 1 .

3.4 Following Board consideration of the proposals, the numbering of the Principal Risks will be refreshed and updated to reflect the 2026/27 financial year.

4. Review of Risk Appetite and Tolerance for 2026/27

4.1 The Risk Appetite and Tolerances were set by the Board of Directors in June 2025. A review of this is undertaken at least annually, and there was a planned review of this in a Board Workshop on 3 March 2026.

4.2 Changes were proposed in relation to the Risk Appetite for the 'Productivity' strategic objective and it is recommended that the Board of Directors consider changing the Risk Appetite from ' Cautious' to 'Open'. A copy of the Risk Appetite scale and risk matrix used is included at Appendix 4.

4.3 A detailed comparison of the Trust's current Risk Appetite and rationale, and the proposed Risk Tolerance and rationale are included at Appendix 5 and 6 respectively.

4.4 The proposed Risk Appetite and Tolerances aligned to the Strategic Objectives, identified as the '5 Ps' with rationale are shown in Table 1 and Table 2 for consideration of adoption by the Board of Directors

Table 1 – Summarises the Trust's Strategic Objectives and their proposed risk appetite

Strategic Objectives (the 5 Ps)	**Current Risk Appetite**	**Rationale**
Patients Deliver excellent care	Cautious	Providing safe and effective care for patients is paramount and so we have a low tolerance of risks which would adversely affect the quality and safety of clinical care. The Trust recognises that there may be an adverse impact on other Strategic Objectives but we prefer safe delivery options for patients with a low degree of residual risk, and we aim to work to regulatory standards.
Performance Deliver timely, effective care		
People To be a great place to work	Open	We are willing to accept some risk where there is a potential to improve recruitment, retention and employees' personal development.
Productivity Deliver value for money	Open	We are willing to accept quantifiable and well-controlled financial risk where there are tangible benefits and opportunities to restore financial balance, e.g. invest to save programmes.
Partnership To be fit for the future	Seek	We are willing to consider all possible solutions to providing sustainable healthcare for local communities, while maintaining a low tolerance for risks to quality or patient safety.

Table 2 – Summarises the Trust's Strategic Objectives and their proposed risk tolerances

Strategic Objectives (the 5 Ps)	**Risk Tolerance**	**Rationale**
Patients Deliver excellent care	1-6	We are not willing to tolerate moderate (or worse) harm, however there will always remain a small possibility of adverse outcomes despite the fullest range of safety measures being put in place.
Performance Deliver timely, effective care		
People To be a great place to work	4-8	Whilst recognising that the need to meet unprecedented demand for services and to make significant changes will impact on our workforce, the safety and wellbeing of staff is a priority, and we are guided by our shared values.
Productivity Deliver value for money	8-12	Acute trusts face considerable financial and operational changes which are heavily influenced by external factors outside of our direct control. Transformational changes needed to meet this challenge inevitably carry a degree of risk.
Partnership To be fit for the future	8-12	To transform our services, develop our infrastructure and mature system leadership arrangements we will need to consider all possible solutions to drive innovation and therefore tolerate some degree of risk.

4.5 In light of the proposed changes, an updated risk appetite statement is included below and it is recommended that the Board of Directors adopt this.

> Providing safe and effective care for patients is paramount and so we have a low tolerance of risks which would adversely affect the quality and safety of clinical care. However, to **deliver excellent care for Patients,** our **Performance** needs to support the delivery of **timely, effective care** and we recognise that, in pursuit of these overriding objectives, we may need to take other types of risk which impact on different organisational objectives. Overall, our risk appetite in relation to **Patients** and **Performance** is cautious – we prefer safe delivery options with a low degree of residual risk, and we work to regulatory standards.
>
> We have an open appetite for those risks which we need to take in pursuit of our commitment to being **a Great Place to Work for our People.** By being open to risk, we mean that we are willing to consider all potential delivery options which provide an acceptable level of reward to our organisation, its staff and those who it serves. We tolerate some risk in relation to this aim when making changes intended to benefit patients and services. However, in recognising the need for a strong and committed workforce with the right skills and knowledge, this tolerance does not extend to risks which compromise the safety of our **People**, or undermine our Trust values.
>
> We also have an open appetite for risk in relation to our strategic objective in relation to **Productivity, to Deliver Value for Money**. However, we are also committed to work within our statutory financial duties, regulatory undertakings, and our own financial procedures which exist to ensure probity and economy in the Trust's use of public funds.
>
> We seek to be **Fit for the Future** through our commitment to working in **Partnership** with organisations in the local health and social care system to make current services sustainable and develop new ones. In pursuit of these aims, we will, where necessary, seek risk - meaning that we are eager to be innovative and will seek options offering higher rewards and benefits, recognising the inherent business risks.

4.6 Upon finalising the Board Risk Appetite, Tolerance and Risk Appetite Statement, the Strategic Decision Support tool will be updated and cascaded through the organisation to support colleagues in the application of this in practice, and when making decisions.

5. Financial implications

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

6. Legal implications

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

7. Risks

7.1 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.

8. Impact on stakeholders

8.1 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.

8.2 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.

9. Recommendations

9.1 It is recommended that the Board of Directors:

- Note and approve the updates to the BAF.
- Approve that Principal Risk 2 (2025/26) related to Higher than trajectory rates of Clostridioides difficile (C.*difficile*) Infection be moved to 'Controlled' status.
- Note the final Corporate Objectives for 2026/27 included at Appendix 2.
- Note and approve the newly identified Principal Risks for 2026/27 in Appendix 3.
- Note and approve the Risk Appetite, Risk Tolerance and Revised Risk Appetite Statement.

9. PATIENTS (SAFETY AND QUALITY)

9.1 SAFETY AND QUALITY COMMITTEE CHAIR'S REPORT

Other | T Ballard | 10:05 am

Item for assurance

REFERENCES

Only PDFs are attached

9.1 - Chair's report - Safety and Quality Committee - 30 Jan & 27 Feb 2026.pdf

Chair's Report to Board		
Chair: Non-Executive Director Dr Karen Deeny	**Safety and Quality Committee**	
Date: 30 January & 27 February 2026	**Agenda attached for information**	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	Trend	Items Recommended for approval
Consistently Deliver Excellent Care	→	MHA Monitoring Report – 27 February Always Safety First Strategy – 27 March

ALERT **Areas of concern; Matters requiring urgent attention; Insufficient assurance received.**	**Paediatric Trauma Unit Peer Review:** The Committee received an initial update of the review, noting early verbal and preliminary written feedback. The review had identified one immediate risk around the Paediatric CT Imaging Pathways and a concern regarding the need for a dedicated Paediatric Resuscitation Room. **Board Briefing:** An update was provided on a recently declared Never Event in Interventional Radiology. No new learning had been identified beyond the findings previously reported to Board and further environmental walkthroughs with patient safety partners were planned. Findings will be reported to the PSIRF Oversight Panel and updates to the Committee will be presented in the quarterly reports.
ADVISE **Areas requiring on-going monitoring; Limited assurance received.**	**STAR Accreditation Monthly Assurance:** Divisional action plans were in place and were subject to governance oversight to ensure delivery and sustained performance improvement. In addition, a new STAR Safety and Quality Enhanced Oversight Panel had commenced in October, providing strengthened scrutiny and support to accelerate progress against outcomes where sustained delivery remained more challenging. **Outpatient tracking and scheduling:** The Committee received an update on work to consolidate risks associated with outpatient tracking and scheduling. A working group had been arranged to review available data and to align divisional risks into a single, organisation-wide entry, supported by initial analytics from Business Intelligence. **Surgical Tracking:** The Committee noted that the issue had been captured within both the risk register update and the Patient Safety Incident Response Framework (PSIRF) update. It was agreed that further updates on timeframes and progress of the Waiting List Safety Group, including BI data support would be provided through the quarterly PSIRF report. **Annual Maternity and Neonatal Safe Staffing Report:** the Committee endorsed the Birthrate Plus findings and supported the progression of the proposed workforce investment plan to ensure national requirements were met and a safe and sustainable maternity service was provided, noting that this was subject to further Trust financial approval processes. **HTA Inspection:** A delay in replacing a post-mortem table reflected capital prioritisation and was a recognised risk. While the service remained compliant with licensing regulations, this would remain under monitoring by the Committee until fully resolved, with particular focus on identifying any emerging patterns of delay, which would be escalated to the Finance and Performance Committee as required.

	Strategic Risk Register: An increase in one risk relating to the Outpatient Speech and Language Therapy Feeding Service reflected wider concerns associated with under-commissioned services. Work was underway to consolidate similar risks to identify common causes, with oversight through the Risk Management Group and structured engagement with the Integrated Care Board. **Principal Risks:** The Committee discussed the need for further work that was required to refine principal risk definitions to ensure there was clarity of ownership, controllability and alignment with available mitigation levers. The planned Board workshop was supported as a key mechanism to refocus assurance on risks within organisational influence, with a more disciplined approach to escalation of system-wide dependencies. **Pathology in Lancashire and South Cumbria:** Discussion highlighted the importance of maintaining clear oversight of regulatory actions, external review findings and quality management system issues arising from the pathology transfer.
ASSURE **Assurance received; Matters of positive note.**	**Equality and Quality Impact Assessment Report:** The Committee was assured that EQIAs continue to be applied consistently and at scale during significant workforce and financial recovery activity, with both internal and external reviews confirming the robustness of the process. Minor improvements had been identified and are now being embedded into future programme mobilisation. **Annual Safe Staffing Review:** The Committee was assured that safe staffing was being maintained, supported by data-driven reviews and targeted staffing adjustments that strengthened effectiveness and efficiency across services. **Maternity and Neonatal Report:** The Committee received the report which summarised workforce, quality and assurance activity and confirmed full compliance with all ten standards of the CNST Maternity Incentive Scheme for year seven. This compliance had been validated by the Local Maternity and Neonatal System and the ICB. **Thrombectomy Regulation 28 Update:** The Committee was assured of strong progress with the 24/7 Thrombectomy service now live and remaining Regulation 28 requirements being monitored. Outstanding mutual aid arrangements are due to progress through regional discussions. **Bi-Annual Mortality, LEDER and PMRT Report:** Strong mortality performance continued, supported by robust review processes, positive external indicators and ongoing progress against the mortality improvement plan, with no emerging thematic concerns. **Clostridioides difficile:** Assurance was provided around the principal risk relating to Clostridioides Difficile reflecting sustained improvement in performance and increased confidence in the effectiveness of current controls. The risk score was reduced from 12 to 8 in February 2026 and would continue to be monitored to ensure performance remained under the agreed level of tolerance. **Allied Health Professionals Report:** The Bi-annual AHP Safe Staffing Report provided strengthened assurance through the introduction of a structured, RAG-rated dashboard across ten professional groups. This enhanced approach aligned with national guidance and mirrored nursing safe staffing methodology, improving consistency and comparability of assurance. **Patient Safety Incident Response Framework:** The quarterly Patient Safety Incident Response Framework (PSIRF) update provided strengthened assurance following the MIAA review, with expanded coverage across incident investigation,

	training, performance and health inequalities. Benchmarking indicated the Trust was within the top decile nationally for incident reporting, reflecting a mature patient safety reporting culture. **CQC Mental Health Act Monitoring Report:** The CQC Mental Health Act monitoring visit provided positive assurance, with no concerns identified regarding compliance with the Mental Health Act or Code of Practice. A single system-wide issue relating to delays in access to inpatient mental health services was noted and was being addressed collaboratively, with actions monitored through quarterly regulatory assurance updates.

Safety and Quality Committee

30 January 2026 | 11.00am | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	11.00am	Verbal	Information	K Deeny
2.	Apologies for absence	11.01am	Verbal	Information	K Deeny
3.	Declaration of interests	11.02am	Verbal	Information	K Deeny
4.	Minutes of the previous meeting held on 2 January 2026	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	Annual Adult and Children Safe Staffing Report	11.30am	✓	Assurance	C Gregory
7.3	Maternity and Neonatal Report	11.40am	✓	Assurance	E Ashton
7.4	Thrombectomy Regulation 28 Update	11.50am	✓	Assurance	S Canty
7.5	Bi-Annual Mortality, LEDER and PMRT Report	12.00pm	✓	Assurance	S Canty
7.6	HTA Inspection	12.10pm	✓	Assurance	D O'Mahoney
7.7	Paediatric Trauma Unit Peer Review	12.20pm	✓	Assurance	S Canty
8.	GOVERNANCE AND COMPLIANCE				
8.1	Equality and Quality Impact Assessment Report	12.30pm	✓	Assurance	C Gregory
8.2	Mid-Year Medical Device Assurance Report	12.40pm	✓	Assurance	S Ashworth
8.3	Strategic risk register review	12.50pm	Verbal	Decision	K Deeny
8.4	Items to alert, advise or assure the Board.	12.55pm	Verbal	Information	K Deeny

№	Item	Time	Encl.	Purpose	Presenter
8.5	Reflections on the meeting	12.58pm	Verbal	Assurance	K Deeny
9.	ITEMS FOR INFORMATION (matters to be raised by exception)				
9.1	**Terms of Reference:** **a)** Patient Experience and Improvement Group		✓		
9.2	Board Briefing – 215558 – Never Event		✓		
9.3	**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 – No Meeting f) Health Inequalities Group g) Health and Safety Governance		✓		
9.4	Date, time and venue of next meeting: *27 February 2026, 11.00am, Microsoft Teams*	1.00pm	Verbal	Information	K Deeny

Safety and Quality Committee

27 February 2026 | 11.00am | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	11.00am	Verbal	Information	K Deeny
2.	Apologies for absence	11.01am	Verbal	Information	K Deeny
3.	Declaration of interests	11.02am	Verbal	Information	K Deeny
4.	Minutes of the previous meeting held on 30 January 2026	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	Annual Maternity and Neonatal Safe Staffing Report	11.30am	✓	Assurance	J Lambert
7.3	Children and Young People Report	11.40am	✓	Assurance	S Morrison
7.4	Quarterly PSIRF Update	11.50am	✓	Assurance	H Ugradar
7.5	Pathology in Lancashire and South Cumbria	12.00pm	✓	Assurance	A Rowbottom
7.6	Mid-Year AHP Staffing Report	12.10pm	✓	Assurance	C Granato
8.	GOVERNANCE AND COMPLIANCE				
8.1	CQC Mental Health Act Monitoring Report	12.20pm	✓	Assurance	R Sansbury
8.2	Strategic risk register review	12.30pm	Verbal	Decision	K Deeny
8.3	Items to alert, advise or assure the Board	12.35pm	Verbal	Information	K Deeny
8.4	Reflections on the meeting	12.45pm	Verbal	Assurance	K Deeny
9.	ITEMS FOR INFORMATION (matters to be raised by exception)				

№	Item	Time	Encl.	Purpose	Presenter
9.1	**Chairs' reports from feeder groups**: a) Infection, Prevention and Control Committee b) Safeguarding Board c) PSIRF Oversight Panel d) Medicines Governance Committee e) Patient Experience and Involvement f) Health Inequalities Group g) Health and Safety Governance h) Mortality and End of Life Care Committee		✓		
9.3	Date, time and venue of next meeting: *27 March 2026, 11.00am, Microsoft Teams*	12.55pm	Verbal	Information	K Deeny

9.2 CQC MENTAL HEALTH ACT FOCUSED VISIT REPORT *

Other | S Regan | 10:15 am

Item for assurance

REFERENCES

Only PDFs are attached

9.2 CQC Mental Health Act Focused Visit Report Board Summary.pdf

Board of Directors Report

Meeting of the	**Board of Directors**	**2nd April 2026**
	Part I ☒	**Part II** ☐
Title of Report	**Care Quality Commission Mental Health Act Monitoring Visit Report**	
Report Author	Rachel Sansbury - Deputy Chief Nursing Officer	
Lead Executive Director	Sarah Morrison - Chief Nursing Officer/ Deputy Chief Executive	
Recommendation/ Actions required	The Board of Directors is asked to: Discuss and note the positive content of the report and the response to the findings of the report.	
	Decision ☐	**Assurance** ☒ / **Information** ☐

Executive Summary

The purpose of this paper is to provide the Board of Directors with a summary of the findings of the Care Quality Commission's (CQC) focused visit on the Mental Health Act (MHA) 1983 and compliance with the MHA Code of Practice. The visit to Lancashire Teaching Hospitals NHS Foundation Trust took place on 8th and 9th September. The report has been considered by the Safety and Quality committee.

The CQC shared the findings of their visit with the Trust on 20th January 2026. The CQC conduct regular MHA monitoring visits to Trusts where people are detained under the MHA. This was the first visit of this type for the Trust. The visit is not a formal inspection and so there are no overall ratings.

Areas visited

The visit focused specifically on how the Trust works within the MHA Code of Practice and so visits took place to areas where patients were detained under the MHA. The areas visited were:

- Ward 18 and Barton ward at Royal Preston Hospital who both had patients detained under section 3 of the MHA
- Rookwood B at Chorley and South Ribble Hospital who had a patient detained under section 2 of the MHA
- Brindle ward at Chorley and South Ribble Hospital where a patient had recently been discharged following being detained under section 2 of the MHA

The visit included:

- A review of the facilities available to patients with mental health needs
- Speaking with patients, families and carers

	• Speaking with staff across the wards where patients were detained • Review of patient records, including detention documentation, care plans, capacity assessments, daily notes, risk assessments and ward round notes • Interviews with the Deputy Director for Governance and Assurance, the Lead Nurse for Mental Health and Learning Disabilities, the Mental Health Liaison Team Service Manager, 2 Matrons and the Deputy Chief Nursing Officer. • A review of a portfolio of evidence provided by the Trust **Findings** Feedback from the visit overall was positive with no concerns identified from the CQC about how the Trust complies with its responsibilities under the MHA. Feedback from the families and carers of patients detained under the MHA was good with the report noting that, staff "went the extra mile to do their best", even though their loved one was not in a setting appropriate to meet their mental health needs. Partnership working with Lancashire and South Cumbria NHS Foundation Trust (LSCFT) as the mental health provider was noted to be positive. The review of the documentation of detained patients demonstrated compliance with the MHA and the Code of Practice. However, CQC identified concern about the length of time patients waited in the acute Trust, once they no longer had any medical needs to transfer to an inpatient mental health setting. The report findings were shared with LSCFT who provided a formal response to be shared with both the CQC and the Trust (appendix 3). The Trust submitted a provider action statement to the CQC on 9th February (appendix 2) that included the formal response from LSCFT. Table 1 provides a summary of the concerns and actions taken. Progress against the delivery of the actions will be included in the quarterly regulatory assurance report provided to the Safety and Quality Committee.	
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	February 2026
Operational Group Review:	Mental Health Interface Meeting	Date: 18/02/26
Link to Board Assurance Framework:	Principal Risk 1 (25/26) - Patient experience within the urgent and emergency care pathway	
Appendices	Appendix 1 – CQC Mental Health Act Monitoring Visit Report for Lancashire Teaching Hospitals NHS Trust Appendix 2 – Lancashire Teaching Hospitals NHS Trust Provider Action Statement Appendix 3 – Lancashire and South Cumbria NHS Foundation Trust Provider Action Statement	

9.3 ALWAYS SAFETY FIRST STRATEGY *

Decision Item | S Morrison | 10:20 am

REFERENCES

Only PDFs are attached

9.3 Always Safety First Safety and Learning Board Report.pdf

Board of Directors Report

Meeting of the	**Board of Directors**	**2nd April 2026**
	Part I ☒	**Part II** ☐
Title of Report	**Always Safety First: Safety and Learning Strategy (2026-2030)**	
Report Author	H Ugradar, Associate Director of Safety and Learning C Gregory, Deputy Chief Nursing Officer S Morrison, Deputy Chief Executive and Chief Nursing Officer	
Lead Executive Director	S Morrison, Deputy Chief Executive and Chief Nursing Officer	
Recommendation/ Actions required	The Board of Directors are asked to approve the new Always Safety First: Safety and Learning Strategy 2026-2030 noting the Safety and Quality committee have endorsed the approval and scrutinised the strategy. The Safety and Quality Committee will receive bi-annual updates on the outcomes and progress of the strategy.	
	Decision ☒	**Assurance** ☐ / **Information** ☐
Executive Summary	The inaugural Always Safety First Strategy (2021–2024) established a shared language for safety, strengthened patient involvement, introduced Safety-II principles and laid the foundations for improved governance, surveillance and learning systems whilst demonstrating improved outcomes in some metrics. It helped create the basis for a more open and learning-focused culture but recognised that there is more to do. As part of developing the new strategy, we reflected on what has worked well and on the lessons we have learned. This includes the need for greater consistency, stronger digital support, deeper improvement capability and more reliable systems across all services. This new strategy builds directly on those insights, strengthening what works and addressing where further progress is required whilst having a greater emphasis on learning. This strategy also represents an important shift. Alongside strengthening safety processes and systems, we are placing a renewed emphasis on people, the behaviours, relationships and conditions that enable colleagues to speak up, feel safe, and learn together. A supportive, psychologically safe culture is essential for learning and improvement. We are therefore moving from a strategy that focused primarily on safety systems to one that explicitly integrates safety and learning, recognising that how we learn how we understand, share and act on insight is central to delivering safer care. Developed through extensive engagement with colleagues, patients, communities and partners, the strategy reflects insight from frontline teams, patient experience, incidents and wider safety intelligence. It aligns with national direction including	

	the NHS Patient Safety Strategy, the Patient Safety Commissioner Principles, the Patient Safety Incident Response Framework (PSIRF), the Patient Safety Health Inequalities Reduction Framework, the NHS Digital Clinical Safety Strategy, and strengthened CQC expectations. As an enabling strategy, the Always Safety First: Safety and Learning strategy sets out the context for our organisation and describes the conditions we will create to embed safety into everyday practice aligning with our strategic framework. The strategy will be delivered through the patient pillar of the Single Improvement Plan, with defined outcome measures for years 1, 2 and 3. This approach will enable early identification of any components that are not on track, allowing timely escalation for additional support or adjustment of approach. It aligns with our continuous improvement methodology of planning, doing, studying and acting, with a focus on sustaining improvements and sharing learning. Progress updates will be provided to the Safety and Quality Committee on a six-monthly basis.		
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	27 March 2026	
Operational Group Review:	Trust Management Board Senior Leadership Team	11th March 2026 27th February 2026	
Link to Board Assurance Framework:	Principal Risk 1 (25/26) - Patient experience within the urgent and emergency care pathway		
Appendices	Appendix 1: Always Safety First: Safety and Learning Strategy 2026-2030		

9.4 MATERNITY ANNUAL SAFE STAFFING REPORT *

Decision Item | E Ashton | 10:25 am

REFERENCES

Only PDFs are attached

9.4 Maternity Annual Safe Staffing Report Board Summary.pdf

Board of Directors Report

Meeting of the	**Board of Directors**	**Date of Meeting:** 2nd April 2026
	Part I ☒	**Part II** ☐
Title of Report	**Maternity Annual Safe Staffing 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 Birthrate Plus® findings and approve the progression of the risk mitigated workforce investment plan to ensure national requirements are met and a safe and sustainable maternity service is provided, whilst managing the material investment required over a 2 year phased plan. ii. Scrutinise the Perinatal Quality Surveillance Dashboard and confirm it is assured of the outcomes presented	
	Decision ☒	**Assurance** ☐ / **Information** ☐
Executive Summary	The purpose of this report is to present the first maternity safe staffing review for 2026. The report has been scrutinized by the safety and quality committee who endorse the recommendations made within the report. It provides assurance that maternity services continue to operate in alignment with national standards for safe, effective, and sustainable staffing (National Quality Board NQB). This report presents the findings from the latest Birthrate Plus® (BR+) assessment, undertaken to ensure that maternity services have the right number of staff with the appropriate skills to deliver safe, effective, and high-quality care. Workforce metrics, clinical outcomes, and patient-experience data have been triangulated through the Perinatal Quality Surveillance Dashboard (PQSD), providing a robust framework for oversight and assurance (Appendix 1). The report also summarises the current obstetric, neonatal nursing, and neonatal medical staffing position, recognising the critical interdependencies across the multidisciplinary team and their collective impact on perinatal outcomes.	

Birthrate Plus® continues to underpin midwifery staffing requirements, supported by professional judgement in line with national standards. The most recent assessment (April–December 2025) undertaken, reviewed and validated by the Chief Nursing Officer and the Divisional Midwifery and Nursing Director, has identified that an uplift of 15.25 WTE Band 6 and Band 8a midwives, is required to meet nationally recognised maternity safe-staffing standards.

Following on from the Trust Safe staffing reviews further investment is also required to uplift Band 2 Midwifery support on one of the maternity wards to enable 24/7 provision. The total amount of investment required is £1,057,646.
Addressing these gaps is critical to fulfilling the requirements of the Three-Year Delivery Plan for Maternity and Neonatal Services, enabling continued compliance with CNST safety standards. A two-year implementation plan is proposed to strengthen clinical, specialist and governance capacity, reduce reliance on temporary staffing, and ensure that required investment is achievable within tight financial planning constraints.

The midwifery workforce position throughout 2025/26 to date has improved and continues to demonstrate a positive upward trajectory. Current vacancies are 2 WTE inclusive of vacancies and maternity leave. This reflects the impact of sustained and effective recruitment strategies (recruiting to turn over and funding maternity leave). While some delays in recruitment and onboarding have been experienced, these have not materially impacted overall on workforce stability.

Midwifery Continuity of Carer (MCoC) is currently being delivered safely, with no adverse impact on the service's ability to maintain one-to-one intrapartum care. Work is progressing to establish the foundations for expanding enhanced continuity models, prioritising families living in deprivation decile 1 and women from Black, Asian and minority ethnic backgrounds, in line with national equity priorities. Recruitment is underway for an externally funded Continuity Lead Midwife and a Maternity Support Worker, who will provide dedicated oversight of continuity models, evaluate current provision, and support the development of future teams aligned to the evolving workforce specification and national expectations.

Analysis of the Perinatal Quality Surveillance Dashboard highlights areas of pressure, particularly red flags associated with midwifery and obstetric staffing. Delays in induction of labour and review in triage remain the most frequently reported escalations.

Since the last safe-staffing report in October 2025, the number of maternity unit diverts has reduced and is now within expected operational ranges. Over the past three months, there has been only one divert, which was due to neonatal capacity constraints and the inability to accept transfers, rather than midwifery workforce or maternity capacity issues. Neonatal diverts have however increased in quarter 3 and into quarter 4 because of high acuity requirement for intensive care cots and unavailability.

During this reporting period, there have been no whistleblowing enquiries related to staffing levels. Across the division there were 3 Freedom to Speak Up (FTSU) raised, associated with maternity and obstetrics.

In summary, the service remains stable and is responding effectively to operational pressures. The staffing establishment shortfall of 15.25 WTE identified through Birthrate Plus® and endorsed by the Divisional Midwifery and Nursing Director and the Chief Nursing Officer require approval following discussion at the safety and Quality committee.

	The cost to implement this is £1,057,646. This is a budget pressure to the Trust. To mitigate both the financial and safety risk a phased approach to this is set out within the paper that would see a 2 year phasing approach adopting, in line with the approach of previous years with priority safety areas identified in year 1 (26/27).	
Link to Strategic Objectives 2025/26	**Patients – deliver excellent care:** Improve outcomes, reduce harm and deliver a positive patient experience.	☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.	☐
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.	☒
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.	☐
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.	☒
Due Diligence	To give the Trust Board assurance, please complete the following:	
Committee Approval:	**Safety & Quality Committee**	Date: February 2026
Operational Group Review:	**NA**	
Link to Board Assurance Framework:	The report is linked to the BAF through planned and unplanned care risks, whilst a specific BAF risk is not identified at Board level, operational risks pertaining to Tier 2 rota provision, Caesarean section rates, safe staffing and culture are detailed within the risk register.	
Appendices	Appendix 1 – Perinatal quality surveillance dashboard Appendix 2 – Clinical negligence for Trust Maternity Incentive Scheme Summary Appendix 3 – Birthrate plus report Appendix 4 – Leadership structure Appendix 5 – Workforce action plan Appendix 6 – Red flags	

10. PERFORMANCE & PRODUCTIVITY (FINANCE)

10.1 INTEGRATED PERFORMANCE REPORT AS AT APRIL 2026 INCLUDING FINANCE UPDATES AND SINGLE IMPROVEMENT PLAN *

Other | K Foster-Greenwood/S Morrison/N Pease/C Carter | 10:30 am

Item for assurance

REFERENCES

Only PDFs are attached

10.1 Integrated Performance Report as at 28 February 2026.pdf

Board of Directors Report

Meeting of the	**Board of Directors**		**2nd April 2026**
	Part I ☒		**Part II** ☐
Title of Report	**Integrated Performance Report**		
Report Author	Executive Directors		
Lead Executive Director	Katie Foster-Greenwood Chief Operating Officer		
Recommendation/ Actions required	The Board of Directors is asked to receive the integrated performance report, note the monitoring of the Single Improvement Plan delivery milestones is undertaken through the Finance and Performance committee and confirm it is assured of the Single Improvement Plan outcome metrics.		
	Decision ☐	**Assurance** ☒	**Information** ☐
Executive Summary	The purpose of the report is to present the Integrated Performance report to the Board of Directors with the position up to February 2026, unless date otherwise stated. The report provides the Single Improvement Plan, high level metrics, of which the outcomes have been scrutinised by each relevant committees of the Board. The outcome metrics are presented with a supporting summary, assurances provided and actions being taken to address the position where improvement is identified. The delivery milestones of the single Improvement plan are monitored through the Finance and Performance committee. The reporting around this continues to be refined with a plan to include milestone assurances in future IPR reporting. At the start of each priority section, a 3 A (Alert Advise and Assure) template is provided to guide the Board to areas of Alert Advise or Assure in line with the reporting approach adopted by the committees of the Board. The Chief Operating Officer will present the IPR with Executive Director presentation for each of the priorities.		
Link to Strategic Objectives 2025/26	**Patients – deliver excellent care:** Improve outcomes, reduce harm and deliver a positive patient experience.		☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.		☒

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

The Best Version of Us
Our Culture Counts @LTH

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Integrated Performance Report

April 2026 Trust Board meeting with performance to February 2026


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

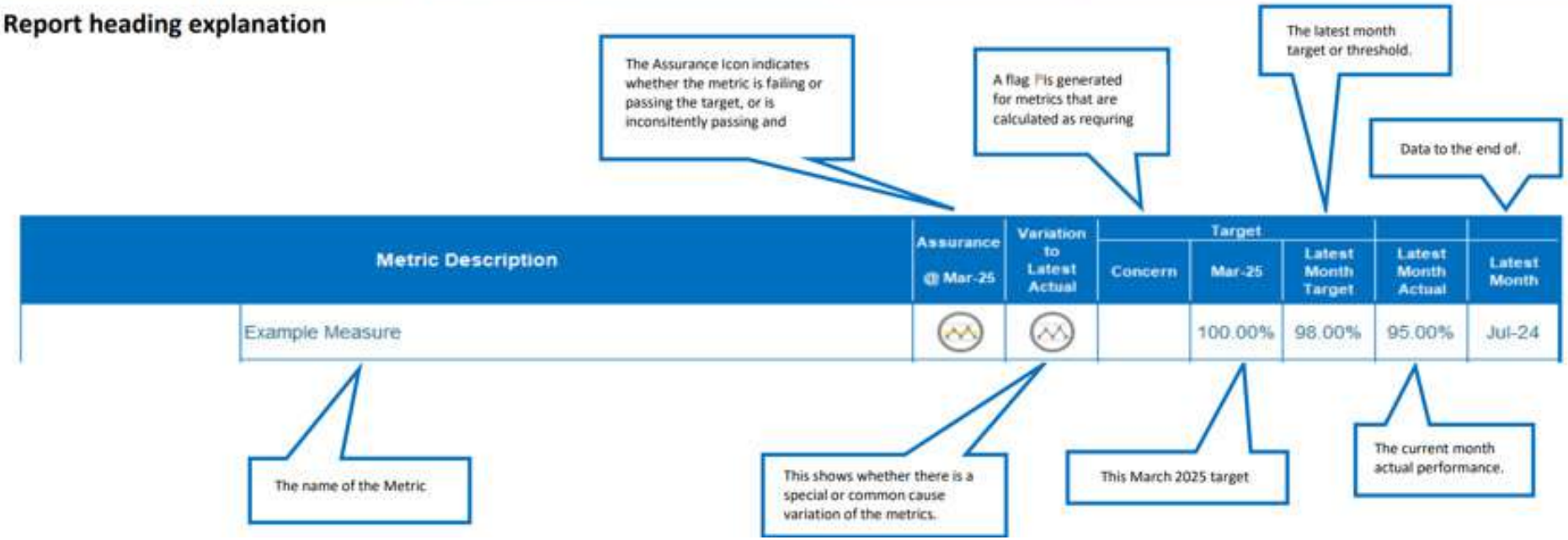
Assurance Icons – How likely are we to hit the set target in future?

- 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



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	- Vacancies (% FTE) - Staff Survey: Recommend Trust as place to work - Percentage of UEC (Type 1 & 3) patients seen within 4 hours - Maximum wait of 12 hours as Total Time in Department - Cancer 62-day performance	- Turnover (%FTE) - 85% theatre utilisation - aggregate - Capped	- Staffing Fill Rate - Health Care Assistant
Normal variation - no recent change	- Bed occupancy to 90% - Number of boarded patients - Reduce not meeting criteria to reside - 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 - Staffing Fill Rate - Registered Midwife - Complaints per 1000 bed days - Pressure Ulcers per 1000 beds days (Category 2 and above) actions - Perinatal - Number of Stillbirths - Cancer Faster Diagnosis Performance - Percentage of patients that receive a diagnostic test within six weeks - Compliance with 60 minute ambulance turnaround time target	- Staffing Fill Rate - Registered Nurse
Recent positive pattern in the data	- RTT - 65 Week Waiters - RTT - 52 week Waiters	- Sickness Absence (%FTE) - C. difficile performance against national trajectory - no more than 167 Hospital Acquired cases	- 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
Maintain compliance with 10 Clinical Negligence Scheme for Trusts Safety	10/10 validated

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	**1. Pressure Ulcers per 1000 bed days (Category 2 and above) -** recent concerning pattern over the last 4 months. This is linked to the long waiting times in the UEC pathway, increased use of waiting areas in assessment units and the effectiveness of pressure relieving interventions.	1. A comprehensive pressure ulcer improvement programme is in place, supported by the Trust wide Pressure Ulcer Review Panel that was established in November 2025, providing consistent monthly oversight, robust investigation and shared learning across divisions. Monthly Always Safety First meetings and quarterly thematic reviews further strengthen cross divisional learning and ensure timely action in high incidence areas. 2. Proactive safety walk arounds by the Tissue Viability Team, are commencing April 2026, which will enhance real time assurance and support early identification of risks, ensuring sustained improvement in pressure ulcer prevention and patient outcomes. 3. A review of the seating provision in waiting areas is underway with the intention of purchasing improved specification seating. 4. Continued focus on quality of the interventions focused on reducing pressure damage through STAR and matron assurance processes.
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% at 89%.	1. A successful recruitment campaign has concluded, with new Maternity Support Workers (MSW) progressing through the Care Certificate and supernumerary period. Seven staff joined the numbers in January, with further starters scheduled through to May. This pipeline strengthens the establishment and will improve fill rates as onboarding completes. 2. Sickness continues to impact availability and is being managed in line with policy. 3. Recruitment and onboarding have taken longer than expected following changes within the recruitment team, and temporary bank staffing continues to be used to maintain safe staffing levels, a focus on decreasing reliance on temporary staff has commenced with recruitment team. 4. Shifts where increased risk is present are prioritised for the staffing that are available.
	2. Complaints - consistent performance within normal variation, themes include waiting times in the UEC pathway, boarding and delays in appointments. The focus on improving the UEC inpatient experience remains the key priority area of focus.	1. Continue to deliver the actions outlined in the Single Improvement Plan. 2. Increase access to information regarding experience from patients with protected characteristics. 3. Development and delivery of preparing to be in hospital and preparing to go home to help manage expectations and work with families to be prepared to be cared for at home as soon as possible. 4. Continued focus on early resolution with departments and PALS. 5. Focus on use of PALS as early indictors to address concerns in areas and identify themes. 6. Estates and clinical partnership Board focused on improving the estate impact of experience.
Assure Areas of Assurance	**1. Compliance with National Standards of Cleanliness -** point of inspection audits for Very High- and High-Risk Areas are fully compliant at point of inspection where the cleaning standards have been implemented, confirming robust infection prevention and control measures.	1. Fully compliant at point of inspection, confirming robust infection prevention and control measures.
	2. Registered Nurse and Health Care Assistant fill rates - are consistently achieving safe staffing levels.	2. Staffing levels consistently meet thresholds, supporting effective care delivery.
	3. STAR accreditation for all Trust.	3. Remains above target across the Trust, reflecting stabilisation following the introduction of critical standards. Continued focus on inpatient area and fundamental standards is critical in ensuring high quality outcomes are achieved for patients.
	4. CQC Must do: By the end of October, the "Must Do's" included in the 2023/2024 CQC Quality Improvement Plan were delivered. **5. 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 updated local stillbirth rate between March 2025 and February 2026 was 1.9 per 1000 births which is below the national average of 3.9 per 1000. **6. C.difficile rates -** Currently remain within the national agreed trajectory.	4. CQC Quality Improvement Plan has been delivered. 5. Mortality actions continue as outlined in the biannual mortality plan. 6. The IPC Board Assurance Framework actions continue alongside the C.difficile improvement plan continue, the implementation of the cleaning standards is now in line with plan and appears to be underpinning improved performance.

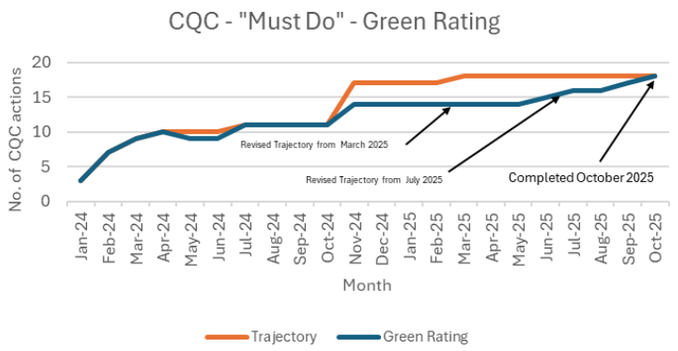
Patients

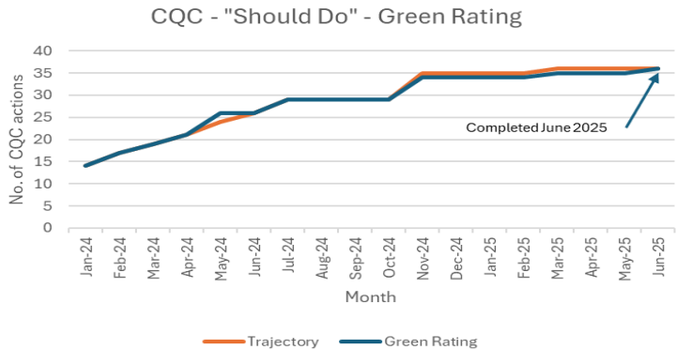
Metric Description		Assurance @ Mar-26	Variation to Latest Actual	Target			Latest Month Actual	Latest Month
				Concern	Mar-26	Latest Month Target		
CQC	CQC - "Must do" - Completed October 2025 (Number with Green rating)					18	18	Oct-25
	CQC - "Should do" - Completed June 2025 (Number with Green rating)					36	36	Jun-25
Deliver Annual Safe Staffing Requirements	Staffing Fill Rate - Registered Nurse				95%	95.0%	99.7%	Feb-26
	Staffing Fill Rate - Health Care Assistant				95%	95.0%	98.3%	Feb-26
	Staffing Fill Rate - Registered Midwife				95%	95.0%	94.6%	Feb-26
	Staffing Fill Rate - Maternity Support Worker				95%	95.0%	89.6%	Feb-26
Patient Experience and Involvement	Complaints per 1000 bed days				1.40	1.40	1.03	Feb-26
	STAR Accreditation all trust (Silver and Above)				75%	75.0%	88.1%	Feb-26
C Difficile Improvement	C. difficile performance against national trajectory - no more than 167 Hospital Acquired cases				13	13	5	Feb-26
Always Safety First	Hospital Standardised Mortality Ratio - Adult	Lower Than Expected					82.2	Oct-25
	Standardised Mortality Ratio - Relative Risk - All Diagnoses Adult	Lower Than Expected					73.7	Oct-25
	Standardised Mortality Ratio - Relative Risk - All Diagnoses Child (<1 day – 17 yrs)	As Expected					120.6	Oct-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					213.3	Oct-25
	Pressure Ulcers per 1000 bed days (Category 2 and above)				2.79	2.91	4.36	Feb-26
Maternity	Perinatal - Number of Stillbirths				0	0	0	Feb-26

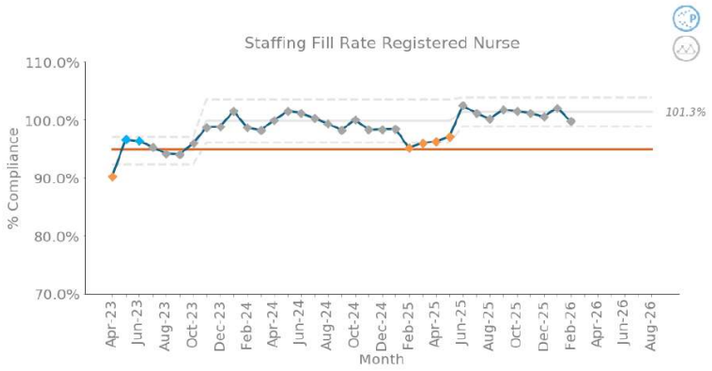
Single Improvement Plan | Patients | Performance | People | Productivity | Partnerships

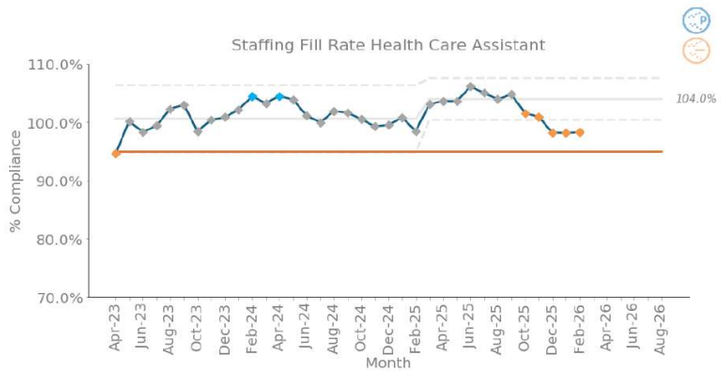
Patients

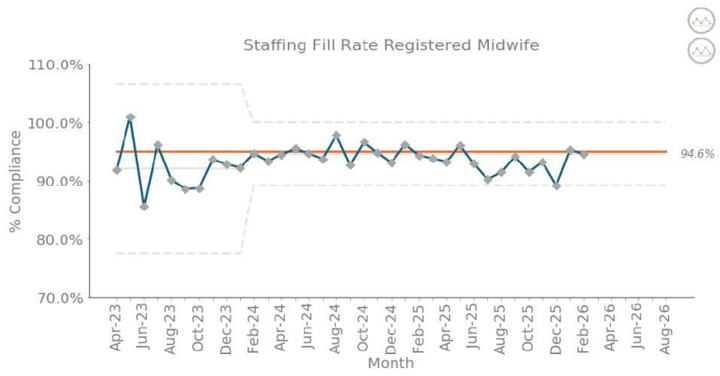
NHS Lancashire Teaching Hospitals NHS Foundation Trust

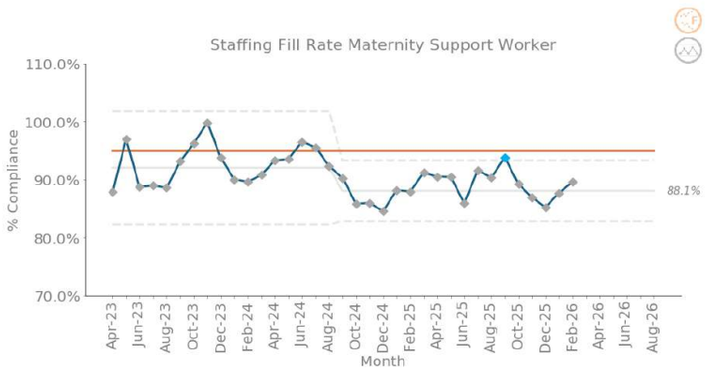


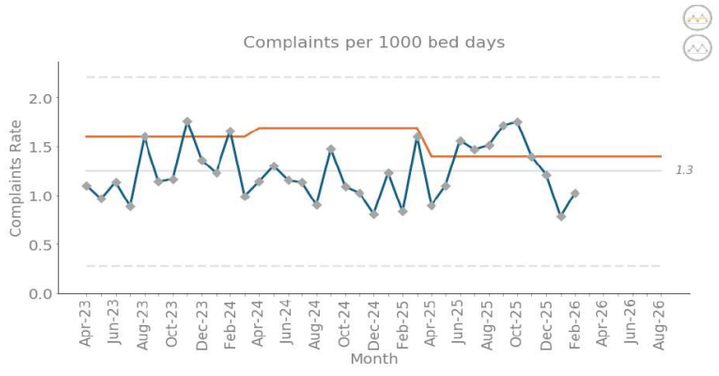


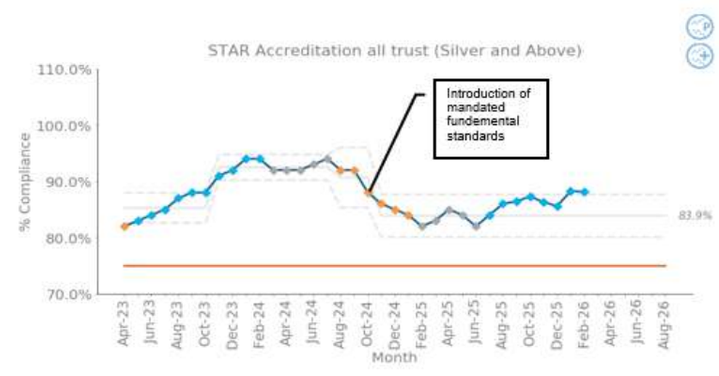


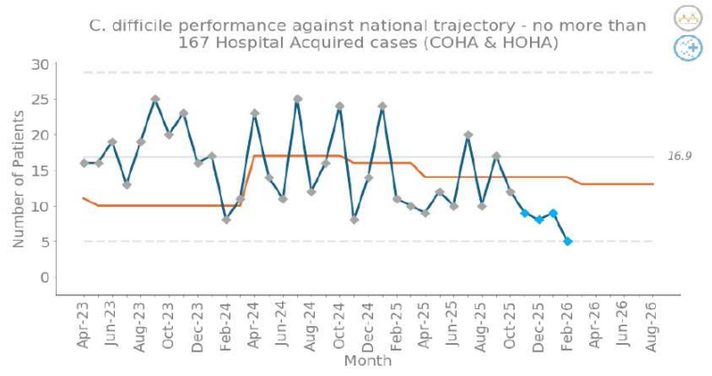


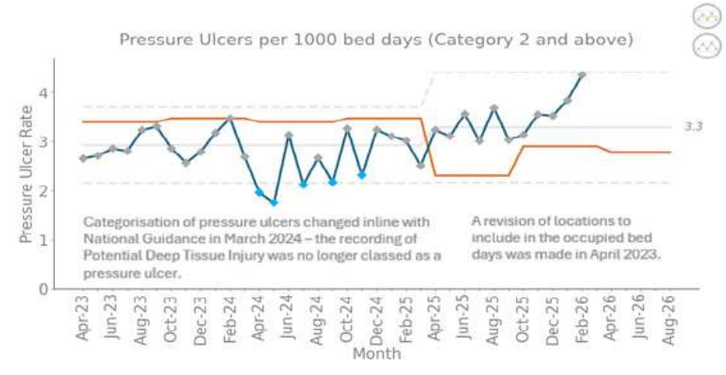


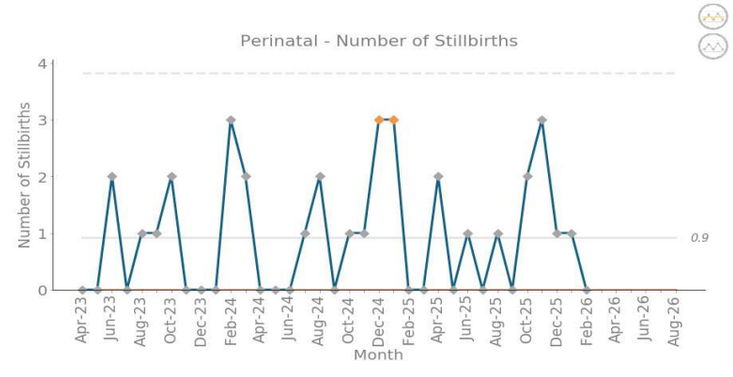












The Best Version of Us
Our Culture Counts @LTH

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Performance

Excellent care with compassion

Always Safety First

@LancsHospitals

Alert, Advise, Assure Report

Alert Areas of concern or matters that need addressing urgently	• **RTT performance** - The number of follow ups >25% overdue has increased month on month since Oct 24. Capacity constraints are driving these increases however there is an opportunity to significantly demand manage via PIFU despite being close to rates. Waiting list size has increased by 1.2% in Feb 26 versus Jan 26 due to administrative focus on mobilising additional 'sprint funded' activity. • **Boarding** - Average of 38 patients boarded in February 26 - a drop compared to previous months and remains very high. The number of escalation beds in use had increased month on month since July 25, however reduced slightly in February. • **Days Kept Away from Home** - (%) has decreased in February 26. The position remains significantly above the operational plan target but lower than the same period in Feb 25. Whilst the levels are within normal variation the data suggests a consistently failing target despite data to evidence the success of the strengths based work reducing demand. This is as a result of ever increasing system wide demand on services within LCC. • **4 hour performance** - Improvement in Type 1 performance, however Type 3 deteriorated in Feb 26 and is below trajectory. Performance is below the national average of 74.1% (Feb 26) with LTH ranking 80/118. Performance is within normal variation and signals a consistently failing target position. • **Ambulance handover performance** -performance maintained in 15 and 60 minute handovers in February 26. LTH performance is below the national and NW average for both 15 and 60 min handover. Drivers of UEC performance deficit relate to overcrowding preventing timely intimal assessment and ED exit block due to very high bed occupancy levels linked to DKAfH.	• **RTT** - A key focus on validation of follow up waiting lists and an increase to PIFU is underway. Good increases have been noted overall in 25/26 however there have been reductions noted in Dec/Jan with improvement returned in Feb. Further plans to pilot PIFU by Default via AI robotics is in development with a pilot within Cardiology planned for Feb 26, however due to capacity constraints within the Data Science team this has been delayed until April 26. H2 business case and RTF/Sprint funding is being mobilised which is providing additional clinical capacity, validation and triage capacity. Waiting list size will reduce in Q1 following the conclusion of 'sprint funded' activities. • **Boarding/Escalation Bed utilisation/DKAFH** - Work continues within the DKAFH programme and whilst there is positive evidence of demand management activity resulting from the strengths based approach, this is being off set by LCC capacity pressures. An ICB wide escalation meeting was held in March and actions have been allocated to colleagues within LCC to agree the domiciliary care hours shortfalls. • **4 hour performance** - The UEC re-design programme has commenced with CMO leadership to re-design the clinical Emergency Model of Care. A revised vision has been drafted and support from a UEC Improvement Director has commenced in the organisation in March 2026. The Medicine team have also been piloting test of change within the March 26 national EUC sprint with national models of Extended Emergency Medicine Ambulatory Care and broadened SDEC criteria. The evaluation of these tests of change will inform the future Model of Care re-design. • **Ambulance Handover performance**- Performance is linked to ED exit block and overcrowding. Significant work to reduce length of stay is underway as described above. Close adherence to the ambulance escalation policy is being maintained.
Advise Areas of ongoing monitoring and any new developments	• **RTT performance -** 18 week RTT performance improved to 55.7%, (an improvement of 2.5% versus Jan 26) however remains below the operational target. DNA rates have continued to reduce month on month since April 25 however remain above target. • **DM01 -** Performance has improved in February 26 to 62.94%, (a 5.6% improvement compared to Jan 26 yet remains below the operational performance target • **UEC -** The average wait to be seen time deteriorated in February 26 and remains above target. • **12 hour + ED LOS** - performance has improved in February 26 but remains above the Operational Improvement plan. • **Cancer performance** - Performance has deteriorated (Feb 26 unvalidated) in 62 day. 28 day is above target however 31 day remains below trajectory but shows improved performance. •**Virtual Ward** - occupancy remains below target however and has deteriorated slightly compared to January 26. •**Theatre Utilisation** - remained consistent in February 26 - key focus at CDH.	• **RTT** - See actions in Alerts section • **DM01** - Additional capacity has been sourced via an IS provider and has been mobilised mid Feb 26. A short, medium and long term workforce proposal has been approved and is being mobilised with short term additional capacity due to come on line in early May 26. Following completion of the capacity and demand modelling a resource case is anticipated to be developed for key modalities. • **UEC** - Key actions being taken to improve ambulance handover performance include increasing 'Fit to Sit' practices, improve data capture with NWAS, increased flow out of ED via continuous flow 'cycles' every 30 mins to AMU. • A focus on reducing the wait to be seen time is central to the Divisional ED Improvement plan. The ECIST C&D modelling is underway and will inform the staffing levels by day of the week and hour of the day. • **12 hour + ED LOS & DKAFH** - ECIST teams have supported a Capacity & Demand analysis and a workshop to agree the future Emergency Village model of care is to take place in Jan 26. This will align the UEC resources to ensure a more timely assessment within ED and combined with DKAFH actions will seek to improve the exit block within ED which is driving the extend ED LOS. •**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	• **65 Week RTT** - 0 breaches maintained in February 2026. • **52 Week RTT** - significant improvement in both the actual and % over 52 weeks in February 2026.	

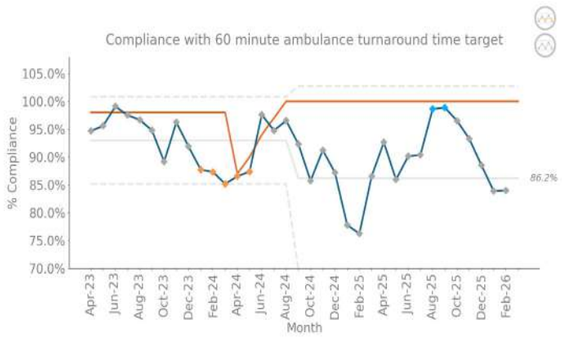
Performance

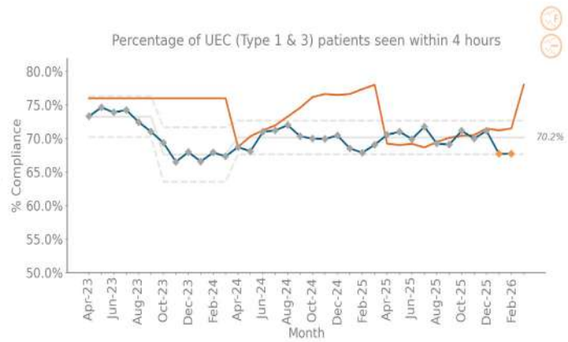
Lancashire Teaching Hospitals NHS Foundation Trust

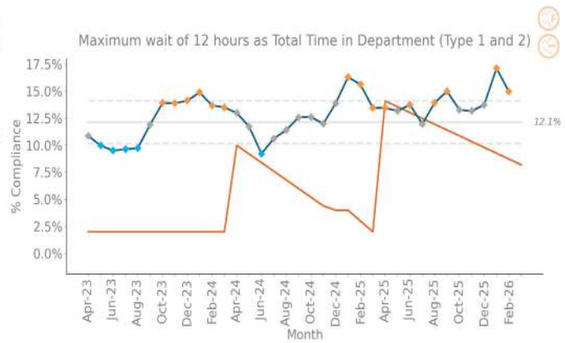
Metric Description		Assurance @ Mar-26	Variation to Latest Actual	Target Concern	Target Mar-26	Target Latest Month Target	Latest Month Actual	Latest Month
UEC In Flow	Compliance with 60 minute ambulance turnaround time target				100.00%	100.00%	83.99%	Feb-26
	Percentage of UEC (Type 1 & 3) patients seen within 4 hours				78.03%	71.52%	67.74%	Feb-26
	Maximum wait of 12 hours as Total Time in Department (Type 1 and 2)				8.20%	8.73%	14.97%	Feb-26
UEC Flow	Bed occupancy to 90%				90.00%	90.00%	94.50%	Feb-26
	Number of boarded patients				0	0	38	Feb-26
UEC Outflow	Reduce not meeting criteria to reside				5.00%	5.20%	9.53%	Feb-26
Elective (diagnostics)	Percentage of patients that receive a diagnostic test within six weeks				64.90%	64.00%	62.94%	Feb-26
Elective (long waits)	Percentage of patients waiting less than 18 weeks				62.50%	62.23%	55.70%	Feb-26
	RTT - 52 week Waiters				1395	1501	1321	Feb-26
	RTT - 65 Week Waiters				0	0	0	Feb-26
Elective (theatre utilisation)	85% theatre utilisation - aggregate - Capped				84.58%	84.58%	81.37%	Feb-26
Elective (Cancer) (unvalidated position, subject to change)	31 Day Cancer Standard				95.98%	95.08%	89.27%	Feb-26
	Cancer 62-day performance				75.10%	73.42%	57.07%	Feb-26
	Cancer Faster Diagnosis Performance				80.01%	80.00%	81.12%	Feb-26

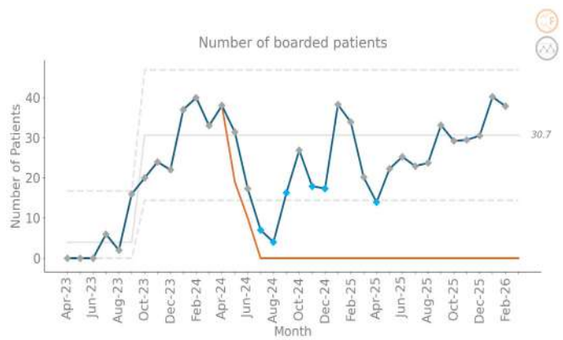
Performance

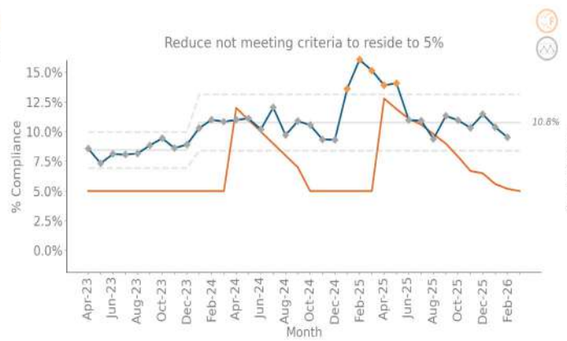
Lancashire Teaching Hospitals NHS Foundation Trust

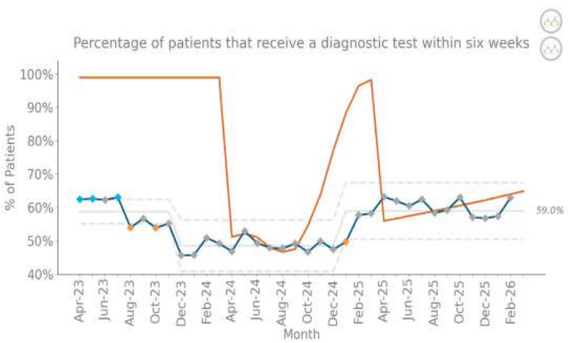


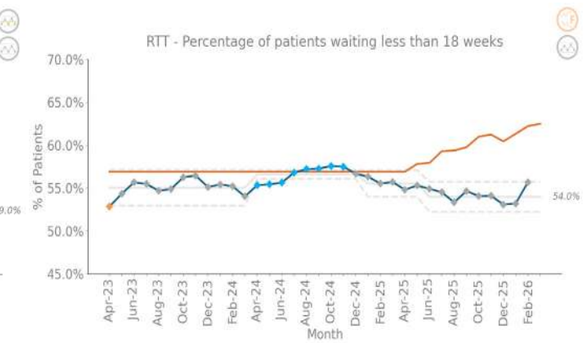


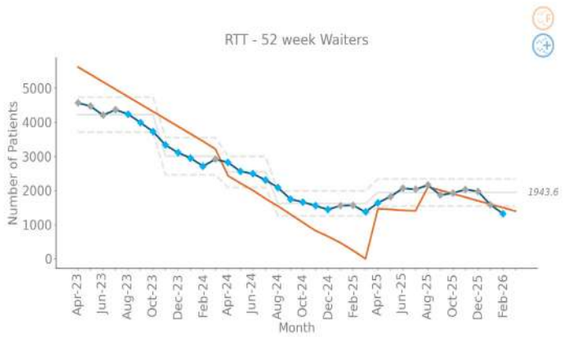


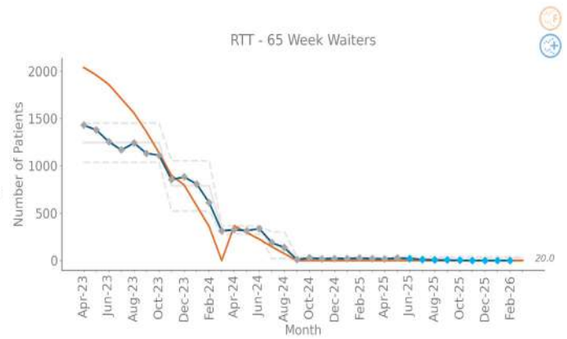


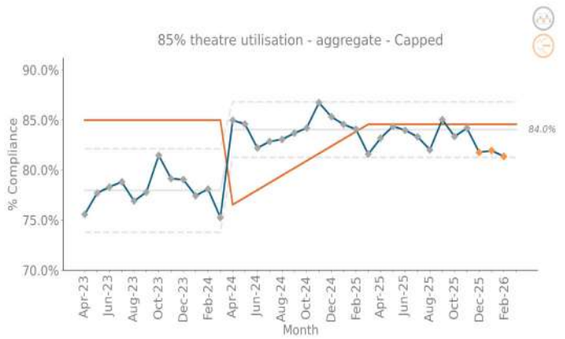


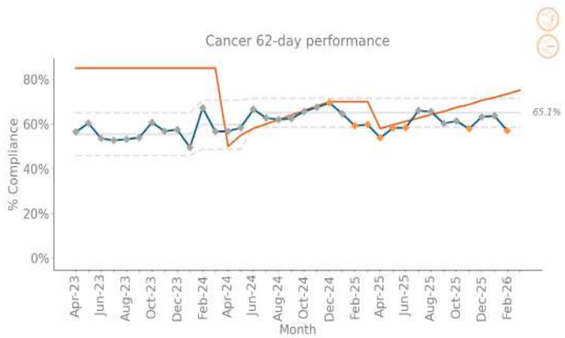


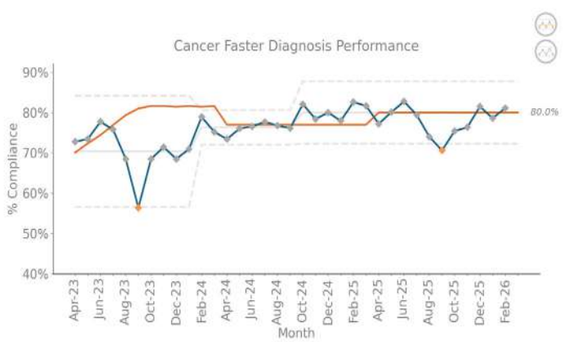


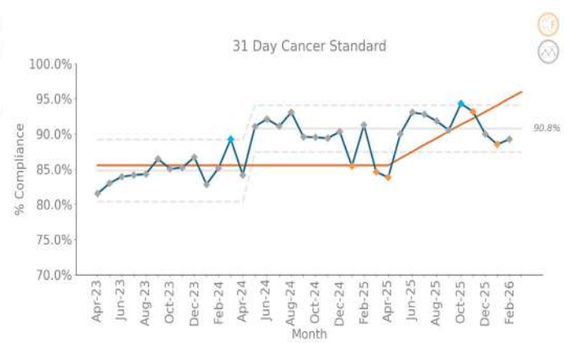












The Best Version of Us
Our Culture Counts @LTH

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

People

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

Lancashire Teaching Hospitals NHS Foundation Trust

Alert, Advise, Assure Report: People

	Issue	Action
Alert Areas of concern or matters that need addressing urgently	**Staff Engagement** - levels of advocacy with regards to recommending the organisation as a place to work and be cared for has further declined	**Staff Engagement** - further implement and embed Staff Engagement Proposal and demonstrate / communicate visible action taken in response to colleague voice. Organisation wide and divisional level action plan in development, alongside divisional level EDI staff survey analysis to support identification of inclusion specific actions for each Division.
Advise Areas of ongoing monitoring and any new developments	**Vacancy** - Vacancy rate remains high due to vacancy control measures, and current cap on 20 WTE approvals per month at Vacancy Control Panel. **Sickness** - At 5.71% the M11 sickness absence rate was significantly lower than the same period last year (7.47%) and the progress made in mitigating absence levels over the winter months, keeps us on track to achieve a reduction in the annualised rate of approximately 0.5% for 2025/26. The digital sickness absence system (Empactis) is now live in four areas, with further roll-outs during April.	**Vacancy**- The Finance team are undertaking an establishment cleanse vacancy review within Divisions over the next month. This is being undertaken as part of financial recovery actions. Whilst this exercise will not reduce WTE in post it will provide greater control on any future growth. Once transacted this could reduce the Trust vacancy rate for future months. Likely to impact by M1 26/27.
Assure Areas of Assurance	**Appraisal** compliance remains above the 90% target. **Core Skills and Mandatory Training** remains above the 90% compliance target for each metric at Trustwide level. **Turnover** remains consistently low for month 11, once peak of TUPE of F&E is excluded from the data. Actual turnover M11 including (766.24 WTE leavers from F&E) was 9.92%. Excluding this TUPE we remain at 0.55%.	**Appraisal** - actions will focus on increasing use of objectives and personal development planning in appraisal, guideance is being developed to support appraisers to tailor their conversation based at the career and lifestage of appraisees. **Core Skills and Mandatory Training** - actions focus on targeted support to increase compliance in Hosted Services **Turnover** - to refresh strategic actions relating to turnover, which will include generational differences and needs from the workplace.

People

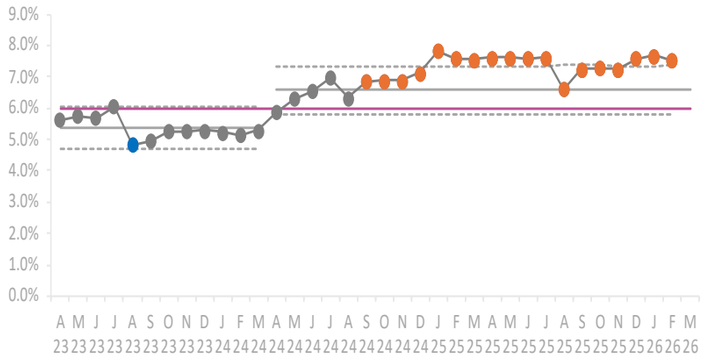
Metric Description		FY2526 Target Assurance	Latest Actual Variation	Target			Latest Actual	Latest Period
				Concern	FY2526	Latest Month Target		
People	Vacancies (% FTE) (source: General Ledger)				≤ 6%		7.53%	M11
	Turnover (% FTE) (annual assessment; ESR in-month reported)				≤ 10%		9.92%	M11
	Sickness Absence (% FTE) (annual assessment; in-month reported)				≤ 5.22%		5.71%	M11
	Number of violence and aggression incidents toward staff (annual assessment; in-month reported)				996		86	M11
	Core Skills Mandatory Training compliance (% modules) (module compliance reported)				100% of metrics at 90%		95.45%	M11
	Appraisal compliance (% HC)				≥ 90%		91.91%	M11
	Staff Survey: Recommend Trust as place to work (quarterly metric)				≥ 60%		42.54%	Q4

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

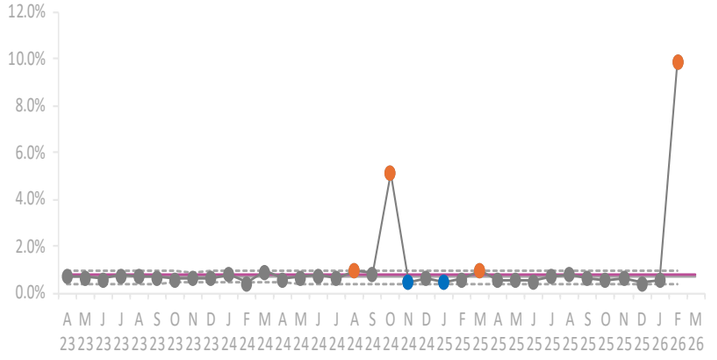
People

Lancashire Teaching Hospitals NHS Foundation Trust

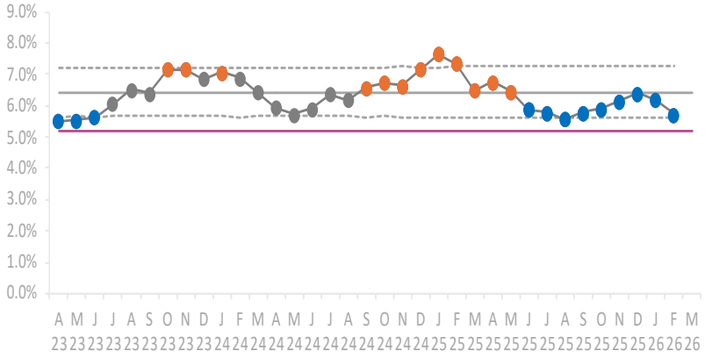
GL Vacancy Rate (% FTE)



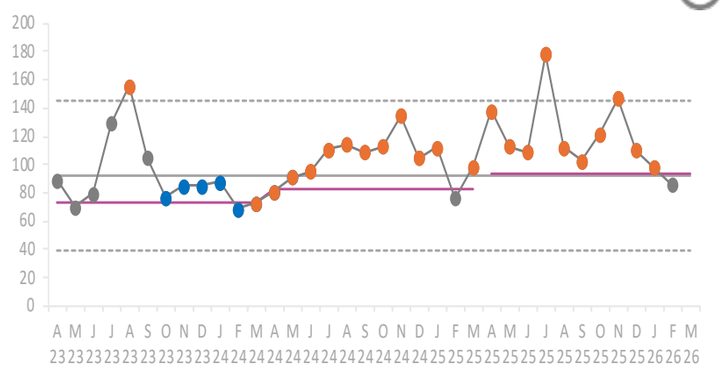
ESR Turnover (% FTE)



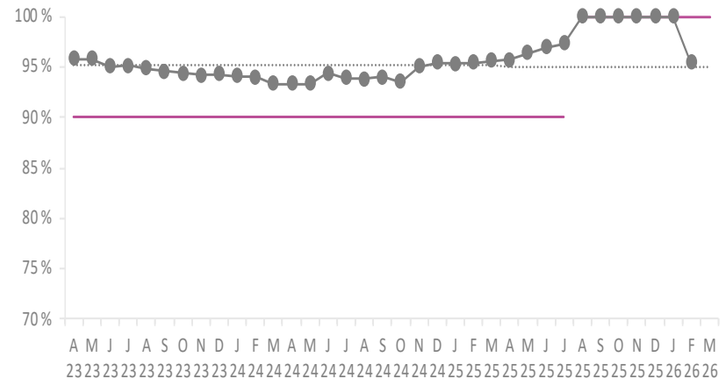
Overall Sickness (% FTE)



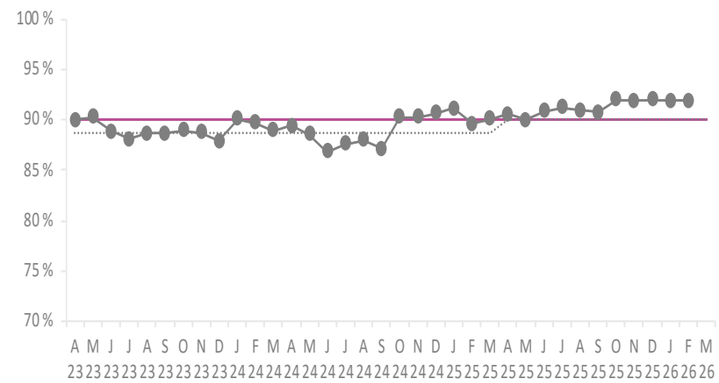
No. of Violence & Aggression Incidents Reported



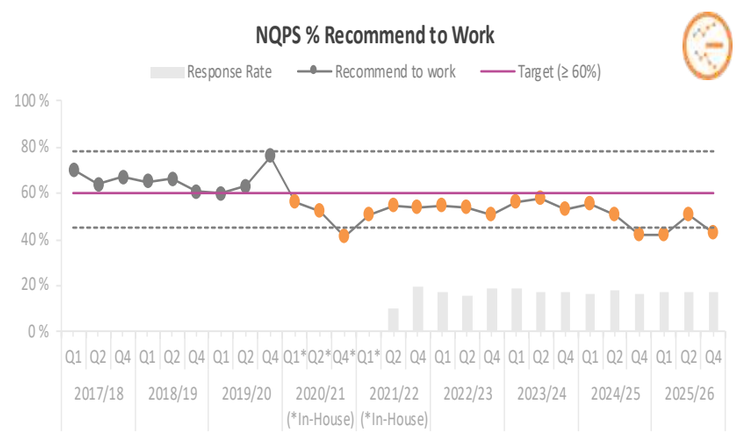
CSTF Compliance (% modules)



Appraisal Compliance (% HC)



NQPS % Recommend to Work



The Best Version of Us
Our Culture Counts @LTH

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Productivity

Excellent care with compassion

Always Safety First

@LancsHospitals

Alert, Advise, Assure Report

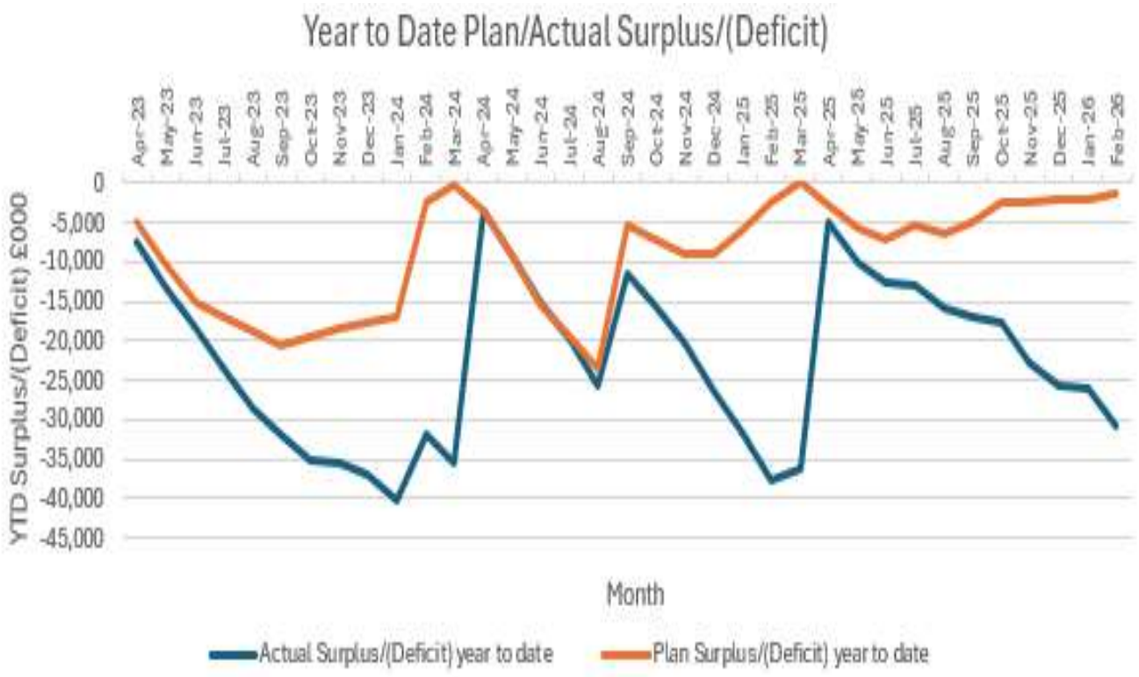
Lancashire Teaching Hospitals NHS Foundation Trust

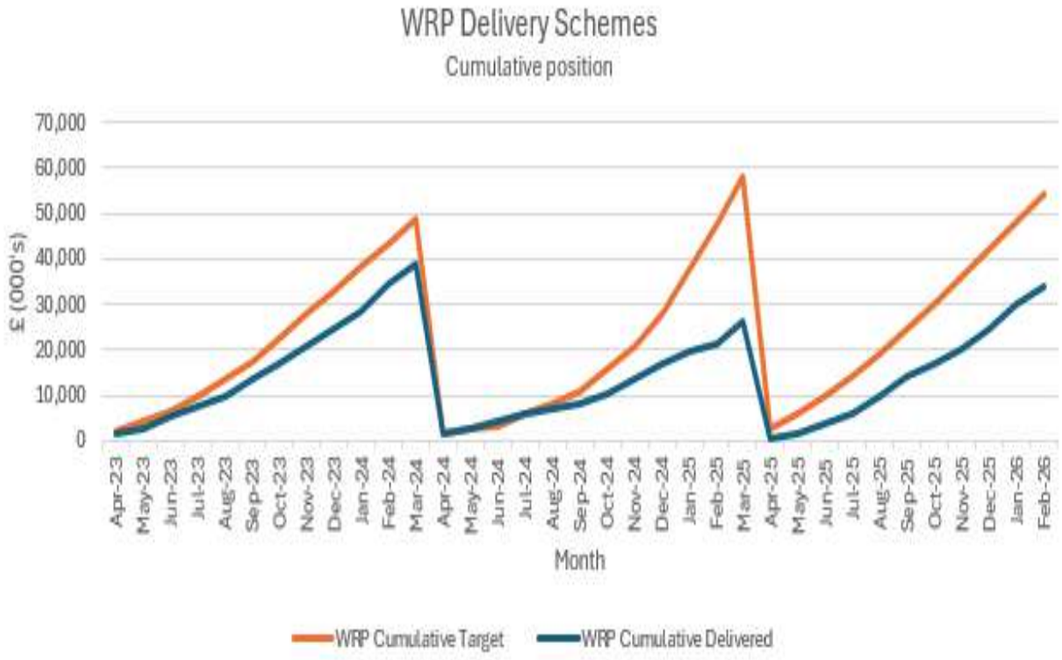
	Issue	Action
Alert Areas of concern or matters that need addressing urgently	**Cash Position**	
	The Trust has received £32.0m cash support to date and a further £10m (of the £15m requested) has been approved for March. The Trust expects to receive some or all of the deficit support funding (DSF) which had been withheld November and February. We are seeking confirmation as to how much will be paid in March. The 2025/26 forecast out-turn is being achieved with a shortfall in WRP, and with the use of non-cash releasing measures. This means that the Trust will continue to have a shortfall in cash which will need to be managed until the increased efficiencies come through.	Management of WRP to ensure where possible cash releasing efficiencies are implemented. Restriction of supplier payments in accordance with the priority list of suppliers. Utilisation of internal capital cash for revenue purposes as a short-term measure.
	Income and Expenditure	
	At the end of February 2026 the Trust has a deficit of £30.8m against a planned deficit of £1.5m. The adverse variance to plan of £29.3m is mainly as a consequence of the shortfall in delivery of the Waste Reduction Programme £20.0m and non receipt of deficit support funding for November to February of £10.0m. The Trust has had operational pressures associated with; industrial action, patient acuity, junior doctor rotas, buildings dilapidations and maintenance of its energy system, these are largely considered non-recurrent and have been fully mitigated with industrial action funding and non-recurrent technical items. The Trust has operational pressures in: - the acute medical pathways reflected in overspends in medical and nursing pay budgets - sickness remains higher than in operational budgets resulting in nursing pay overspends	The Trust had a Turnaround Director to work with senior leaders to re-assess the current waste reduction programme position and deep dive into short, medium and long-term opportunities. A re-set of the programme structure, governance and reporting for 2025/26 has taken place. The Trust is working with the ICB on the urgent and emergency pathway system pressures which is one of the main operational pressures that the Trust faces. The system is now receiving enhanced support from NHSE as part of the provider improvement programme (formerly recovery support programme). A focus on grip and control activities continues. The Trust commissioned further external support for specific financial recovery plan workstreams and 2025/26 waste recovery programme development. Divisions will need to recover their financial performance by delivering improvements in their current run rates e.g. maximising grip around temporary pay, review of vacancies and continuing to mitigate shortfalls in the efficiency target if slippage in schemes continues. The Trust supports divisions through regular divisional review groups that enable escalation to the Executive if there are barriers to delivery.
	Waste Reduction Programme	
	The Trust's 2025/26 waste reduction target is £60m, 7% of operating expenditure. At the end of January the Trust has delivered £34.8m of the £60m target (58%). The delivery in month was £5.7m against a plan of £6.0m. The Trust has identified schemes and opportunities to the value of £60m however the phasing is different to the financial plan with shortfalls in the first 6 months being offset with gains in the final 6 months of the year.	The Trust had a Turnaround Director to work with senior leaders to re-assess the current programme position and deep dive into short, medium and long-term opportunities. A re-set of the programme structure, governance and reporting has taken place for 2025/26. The Trust has additional external support to help with the delivery of the programme. The Trust is now embedding its own project management office structure to have a sustainable solution moving forward. The Trust is enhancing grip and control activities to mitigate slippage in specific schemes
Advise Areas of ongoing monitoring and any new developments	**Oversight Framework**	
	The Trust is 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

Lancashire Teaching Hospitals NHS Foundation Trust

Metric Description		Assurance @ Mar-26	Variation to Latest Actual	Concern	Target (£ 000's) Mar-26	Latest YTD Target	Latest YTD Actual (£ 000's)	Latest Month
Productivity	I&E - Plan v Actual variance					-1530	-30863	Feb-26
	WRP schemes delivery				60000	54018	34017	Feb-26

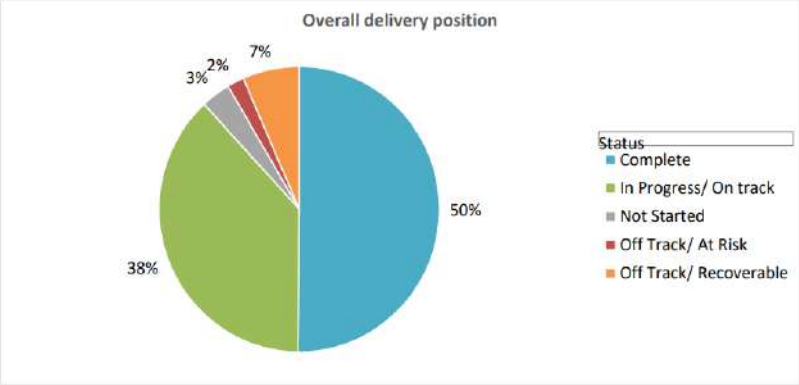


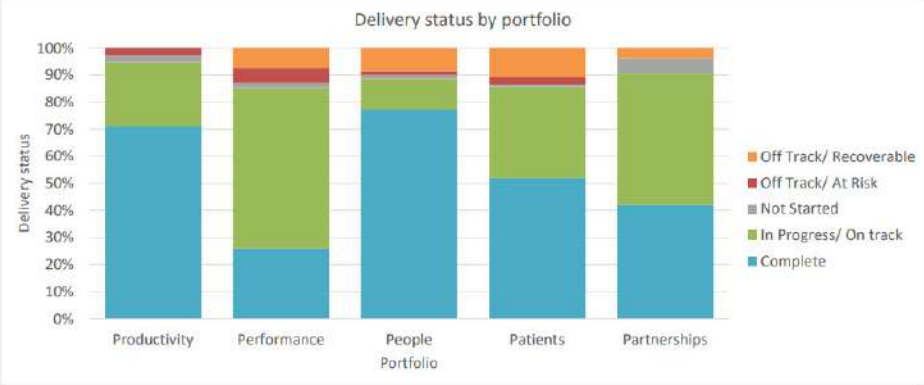


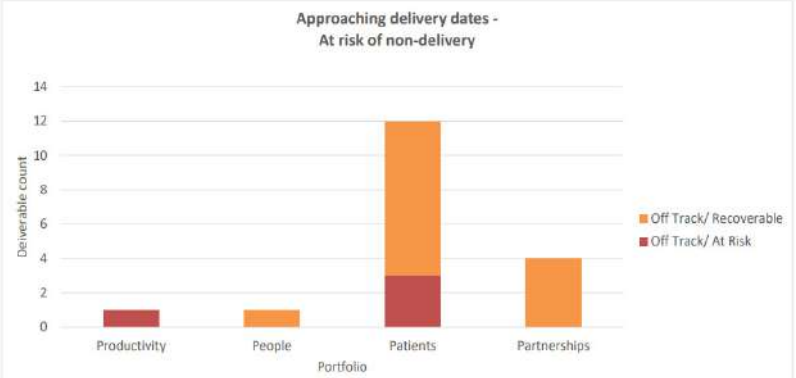
The Lancashire Teaching Hospitals **Single Improvement Plan** aims to improve patient care together.
The plan is based on what matters most to our patients, our colleagues, and our regulators, and it supports our overall goals. The SIP sets out a clear and simple way to improve how the Organisation works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

February-26 | 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. • Continued slippage in timeline for CYP improvement work due to medical staffing issues limiting capacity.	• Focus on minimising impact of flow through effective communications, review of comfort and sleep. • Discussion held with CMO for additional support required in paediatrics.
	PERFORMANCE	• RTT performance continue to be below target but slight improvement in last period. • Overall DM01 performance below target but slight improvement since last period 57.38%, driven by NOUS. • Number of boarded patients remain high and above target, 4hr performance deterioration against target.	• RTT funding secured to mobilise additional capacity and additional validation and triage. • NOUS over offer recruitment to be considered by Execs. • Urgent meeting with GtD/ICB and NHSE to agree remedial actions at front door.
	PEOPLE	• Sickness absence management Empactis remains challenging with numerous delays. • Report of racism and discrimination remain persistent with little movement in metrics.	• Consideration of alternate solutions and mitigating actions to sickness management. • Current capacity in EDI constrained, consider capacity and priorities across OD team to support.
	PRODUCIVITY	• 25/26 financial recovery plan of £60m is at risk, with a risk mitigated position of £42.5m.	• CFO working through enhanced grip and control measures alongside mitigating under delivery of WRP, Focus on robust development of 26/27 plans.
Advise	PATIENTS	• Neonatal nursing staffing challenges affecting capacity and compliance over the last 3 months.	• Escalated through safe staffing reports, impact on transfers and transitional care capacity
	PEOPLE	• Upcoming national leadership and appraisal requirements may significantly increase workload.	• Potential realignment of objectives, training and systems to be considered.
	PERFORMANCE	• Shortfall in ECHO capacity.	• Additional non-recurrent capacity via mutual aid from ELHT arranged for ECHO.
	PARTNERSHIPS	• Community partnership agreement delayed.	• Shift to April-26 but being broadened to cover all interfaces.
Assure	PATIENTS	• Rapid tranquilisation and restraint audit compliance improve to 93% direct link to actions taken in safeguarding SIP. • Positive progress in smoking/alcohol intervention metrics, VTE compliance and Registered Nurse fill rates.	
	PERFORMANCE	• Cancer FDS performance has consistently met or exceeded trajectory and expected to meet 80% target by April-26. • Zero 65 week wait maintained.	
	PEOPLE	• Core skill and appraisal compliance remains high above 90%. • Sickness winter absence levels significantly lower compared to previous years. • Retention remains strong, early leavers reduced compared to previous years.	

The Best Version of Us
Our Culture Counts @LTH

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

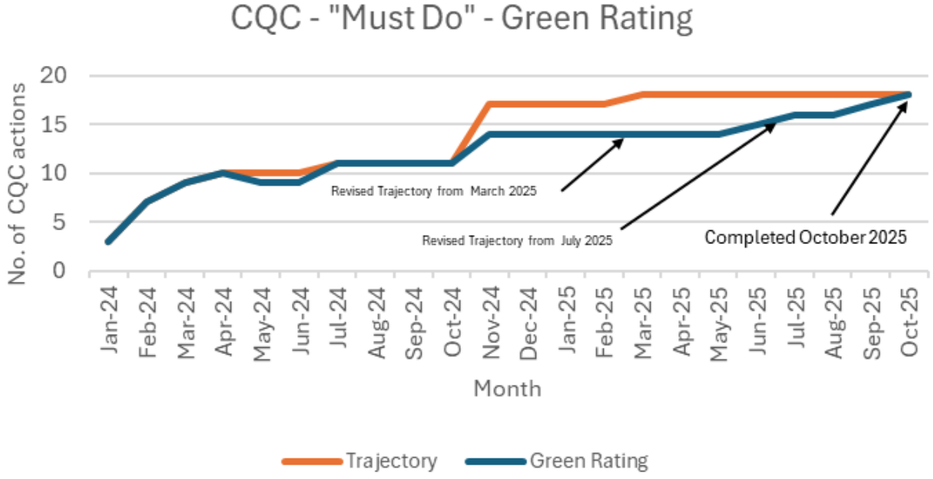
Integrated Performance Report
Appendix 1 – Assurance Reports

April 2026 Trust Board meeting with performance to February 2026

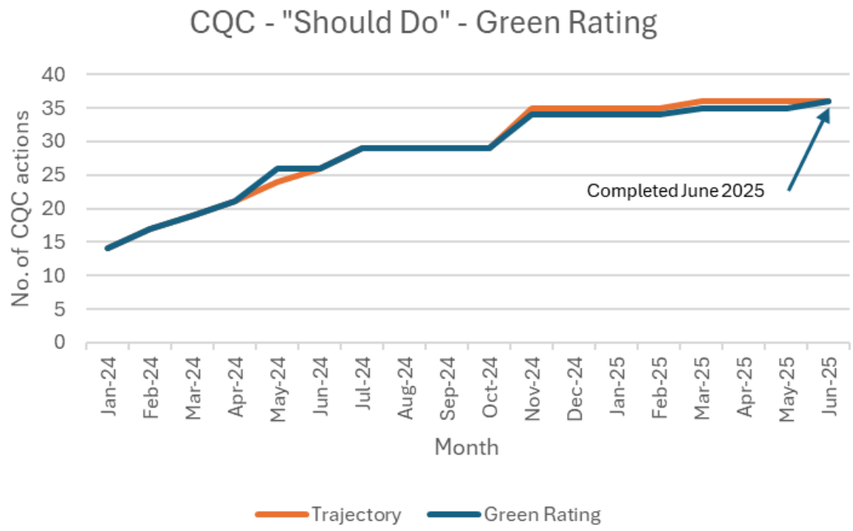
Excellent care with compassion

Always Safety First

Patients - CQC Assurance



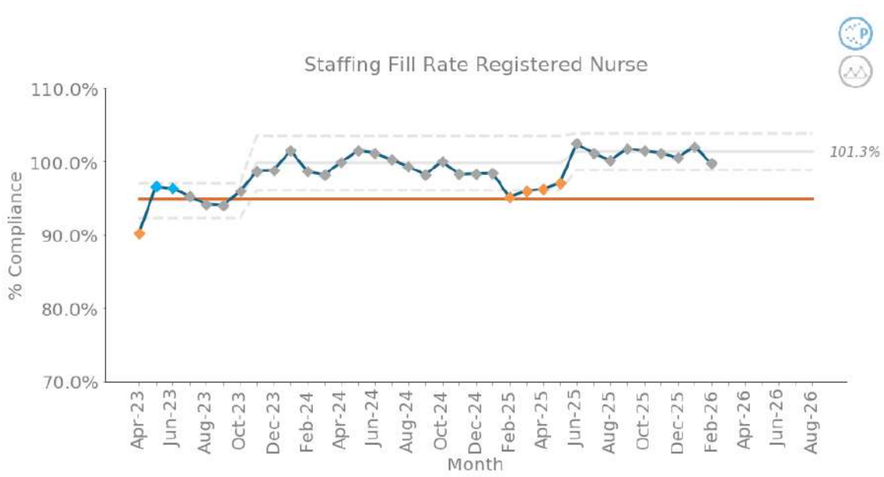
Latest
18
Month Target
18
Oct-25 Target
18



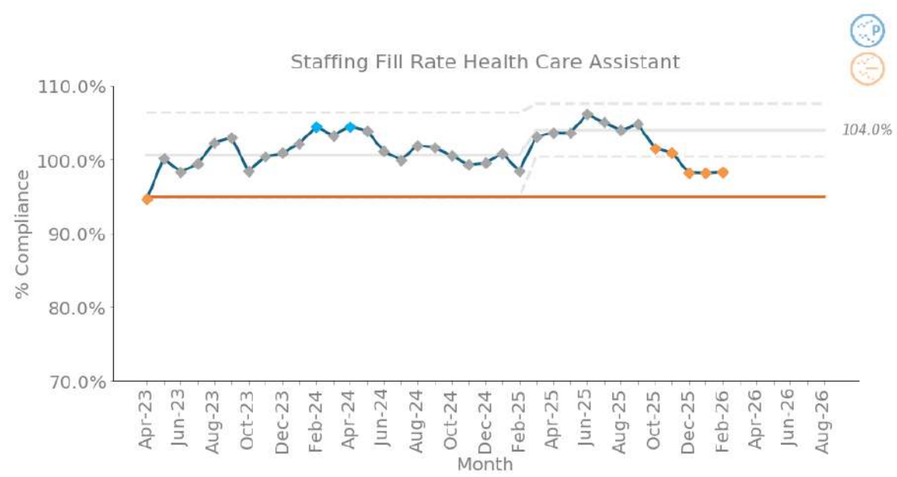
Latest
36
Month Target
36
June-25 Target
36

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

Patients - Deliver Annual Safe Staffing Requirements Assurance



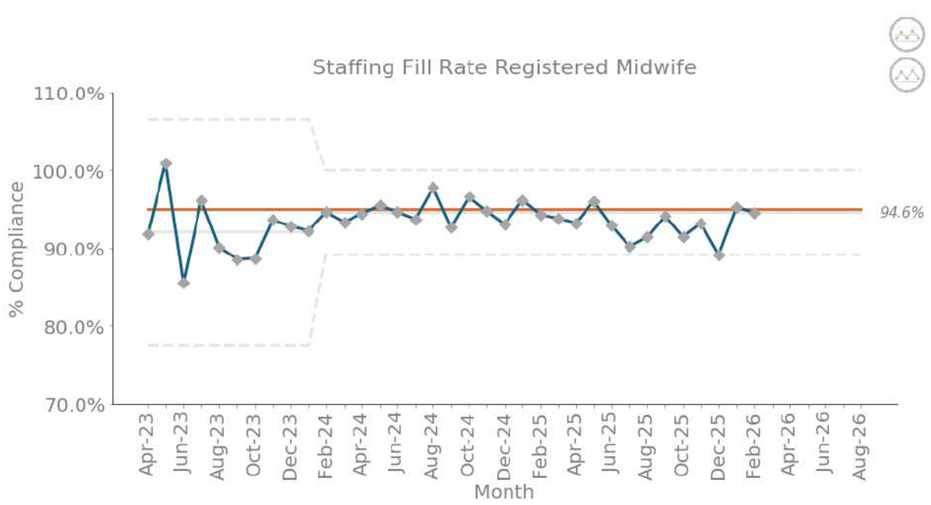
Latest
99.74%
Variance Type
Normal variation - no recent change
Mar-26 Target
95%
Target Achievement
Will consistently pass target within expected variation



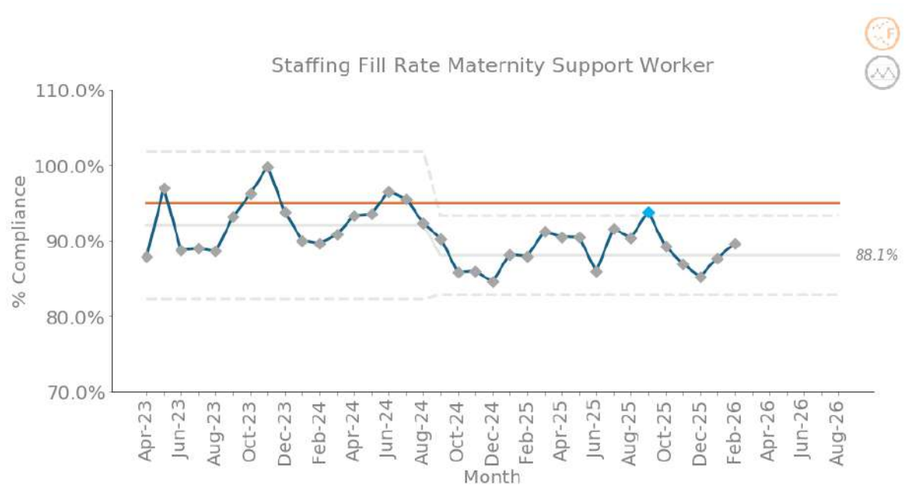
Latest
98.29%
Variance Type
Recent concerning pattern in the data
Mar-26 Target
95%
Target Achievement
Will consistently pass target within expected variation

Metric	Summary	Action	Assurance
Staffing Fill Rate Registered Nurse	The RN staffing fill rate for February 2026 was 99%. At site level, Chorley District Hospital (CDH) achieved a 100% RN fill rate and Royal Preston Hospital (RPH) achieved 99%. Strengthened controls for bank and agency approval remain in place to ensure effective use of resources while maintaining patient and staff safety. Redeployment of staff linked to organisational change continues within the Division of Medicine and is being monitored to ensure safe staffing levels are maintained.	1. Twice daily nurse staffing meetings 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 . 4. Redeployment of staff into vacancies through organisational change and ward closures, ongoing into February 2026.	1. All clinical areas are showing a stable fill rate position. 2. Daily operational staffing meetings led by matrons to 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 by Chief Nursing Officer 4. Biannual safe staffing procedures are in place in line with National Quality Board guidance. 5. Weekly PSIRF oversight panel reviews incident harm levels, this is triangulated through a quarterly serious incident/PSIRF report. 6. Involvement in National Enhanced Therapeutic 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 February was 98%. At site level, Chorley District Hospital (CDH) achieved a 94% fill rate, while Royal Preston Hospital (RPH) achieved 99%. Bank support continues to be required to maintain safety, as HCA/MSW vacancies remain high at 17% across inpatient wards. A focused recruitment and retention plan is in place to reduce reliance on temporary staffing and strengthen workforce stability.	1. Twice daily nurse staffing meetings are in place 7 days a week for oversight of safe staffing. 2. Internal Band 2–Band 3 progression route is defined and advertised, with the first cohort scheduled to begin in April 2026. 3. Centralised external recruitment campaign is in development and planned to go live in April 2026.	

Patients - Deliver Annual Safe Staffing Requirements Assurance



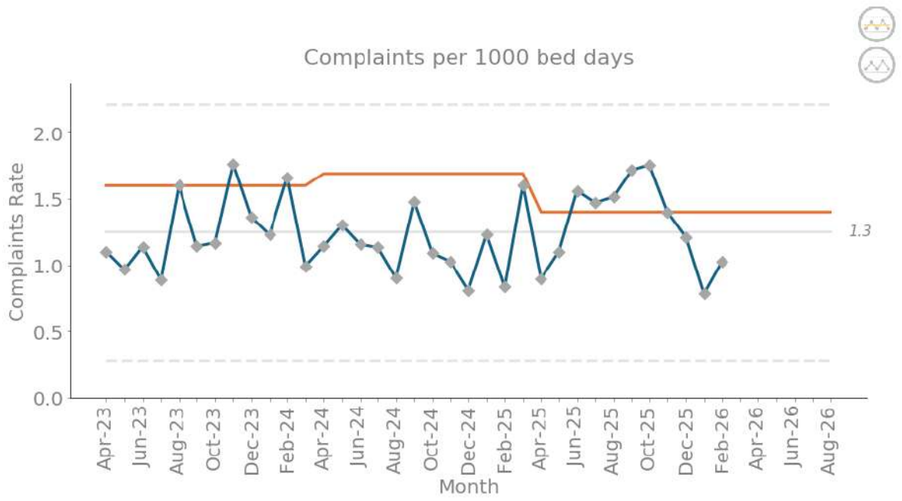
Latest
94.56%
Variance Type
Normal variation - no recent change
Mar-26 Target
95%
Target Achievement
Could both pass or fail target within expected variation



Latest
89.57%
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 94.56% which is just below the Trust target of 95% in February 2026. This demonstrates a relatively stable but improved position following the successful recruitment of midwives at the end of last year. 3 midwives are currently in their supernumerary period and the 7 midwives that were recruited in November are currently onboarding. The current vacancy for Registered Midwives is being monitored closely with further recruitment pending. Unfilled shifts continue to be sent to bank and agency to maintain safety. The most recent Birthrate plus assessment report for the service was presented to Safety and Quality committee in February and will be taken to Trust Board in April for consideration of funding.	1. Weekly roster efficiency reviews as required to ensure appropriate use of bank and agency. 2. Monthly roster efficiency meetings overseen by the deputy Divisional Midwifery and Nursing Director 3. The service continues to recruit to turnover using over offer of 5 WTE.	1. Fill rates for Registered Midwives overall have been stable across day and night shift patterns. 2. The Safety and Quality committee review fill rate and minimum RM levels by area on a monthly basis. 3. Approval and sign off of all agency shifts undertaken by the Deputy/ Divisional Midwifery and Nursing Director. 4. Biannual safe staffing procedures are in place in line with National Quality Board guidance. 5. Weekly PSIRF oversight panel reviews incident harm levels, this is triangulated through a quarterly serious incident/PSIRF report. 6. Red-flag reporting is monitored to identify areas where additional input can be provided to manage the risk.
Staffing Fill Rate Maternity Support Worker	The overall Midwifery Support Worker fill rate remains below the Trust target of 95% at 89.57% for February 2026, which is a slight improvement from the previous 3 months. Short and long term sickness continues to affect the fill rate and this is being managed in line with the Trust Policy. The vacancy is being monitored and recent recruitment has ben successful and onboarding is in progress. The recruitment and onboarding processes have been more protracted since changes to the recruitment team resulted in delays to staff progressing into posts following new appointment. To maintain safe staffing levels, there continues to be a requirement to use bank to fill shifts.	1. Weekly roster efficiency reviews are ongoing to ensure appropriate use of temporary staff. 2. Ongoing recruitment to fill all vacancies which are tracked using a local trajectory plan. 3. Sickness management procedures are reviewed by Workforce Business Partner to ensure appropriate management. 4. Band 2 MSW vacancies in maternity A,B and Delivery suite are being progressed through VCP or onboarding process.	1. The Safety and Quality committee review fill rate and minimum safe staffing levels by area on a monthly basis. 2.. Approval and oversight sight of rosters is undertaken by the Deputy/ Divisional Midwifery and Nursing Director. 3. Biannual safe staffing procedures are in place in line with National Quality Board guidance. 4.. Weekly PSIRF oversight panel reviews incident harm levels, this is triangulated through a quarterly serious incident/PSIRF report. 5. Red-flag reporting is monitored to identify areas where additional input can be provided to manage the risk.

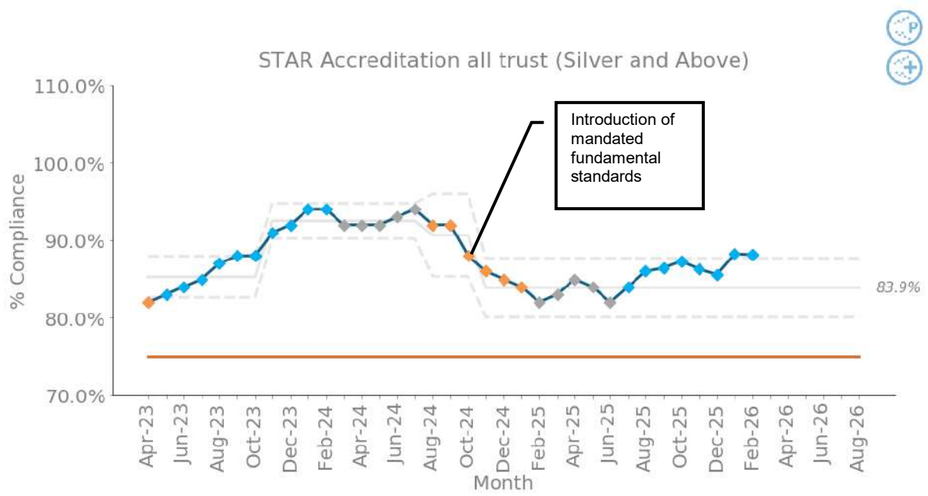
Patients - Complaints



Latest
1.03
Variance Type
Normal variation - no recent change
Mar-26 Target
1.40
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
Complaints per 1000 bed days	The rate of complaints per 1,000 bed days continues to indicate steady system performance, reflecting improvements in early resolution and more timely responses at the point of care. Patient experience remains a core organisational priority, with targeted actions progressing through the Urgent and Emergency Care (UEC) improvement programme and ongoing work to strengthen inpatient pathways. Insights from both the national inpatient and ED surveys continue to shape short-term service adjustments as well as longer-term strategic improvements. A recent increase in monthly complaints may be linked to reduced follow-up after initial PALS contact, with some cases escalating where ward-level responses have not been provided in a timely way. The most frequent themes remain communication and delays related to treatment, procedures, and appointments. Delivery of the Trust's Single Improvement Plan continues, alongside the development of the 26/27 plans, which incorporate actions arising from national survey findings and wider improvement programmes across UEC, cancer services, and maternity. From an SPC perspective, the complaints rate is stable, predictable, and statistically in control, but it is not showing signs of improvement. The organisation is consistently achieving the level of performance that the current processes are capable of delivering. Any meaningful reduction in complaints will therefore require intentional changes to those underlying processes rather than reactions to individual monthly fluctuations.	1. Continue to deliver the Patient Experience Improvement Plan via the Single Improvement Plan 2. Continue to deliver the Patient Safety Incident Response Framework with a focus on family liaison roles 3. Monitor actions in relation to National picker Surveys . 4. To deliver the PALS and local early resolution training. 5. Continue to progress the complaints review group using patient safety partners and governors 6. Where concerns have not been responded to locally escalate to managers.	1. Annual patient experience reports to Safety and Quality committee. 2. Friends and family monthly reporting in place for all departments. 3. Inclusion of patient experience in STAR. 4. Chief Nursing Officer reviews all complaints and signs off responses. 5. Monitor picker survey action plans through Patient, Carer, Experience and Involvement Group.

Patients - Quality Assurance STAR Accreditation

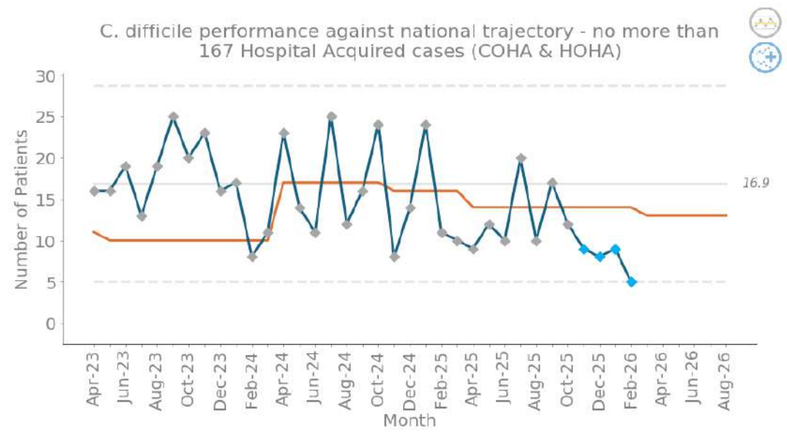


Latest
88.14%
Variance Type
Recent positive pattern in the data
Mar-26 Target
75.00%
Target Achievement
Will consistently pass target within expected variation

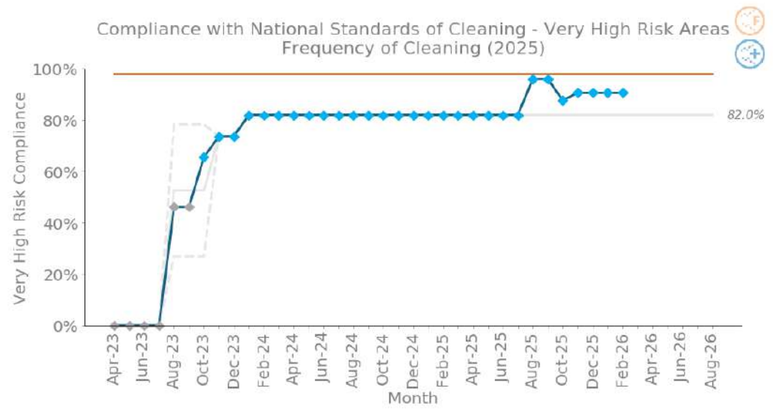
Metric	Summary	Action	Assurance
STAR Accreditation all trust (Silver and Above)	There are 118 clinical areas registered for the STAR Quality Assurance Framework, of which 117 have received STAR accreditation visits, with one new area (Respiratory Ward & Respiratory Support Unit) scheduled their visit during March. There is one clinical area with a red star rating, 12 areas with an amber rating and 104 areas rated green. This results in 13 bronze stars, 29 silver stars and 75 gold stars. There are 88% of areas rated silver or above. During February, there was one area with a reduced STAR rating, 2 areas had an increase to silver and others maintained their star rating. Themes for improvement include the mandated 'critical' standards of infection prevention and control, risk assessments, STAR audit action completion and mandatory training. Recurrent themes are included within the STAR report, these include 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). A bespoke assurance assessment of the boarding standards was presented to the NMAHP Board during February. There are 79 % of wards, ED and theatres scoring silver and above for STAR accreditation visits.	1. Any standards which are not achieved require an improvement action which is monitored within division through divisional assurance processes and via STAR monthly reviews and STAR accreditation visits. 2. The monthly STAR report includes trustwide and divisional STAR data and highlights good practice, areas for improvement, themes for learning and an overarching STAR improvement action plan, which is cascaded and discussed through the divisional always safety first meetings. The STAR report includes CQC (2023) action plan standards which require improvement. 3. The STAR action plan has been updated to include recurrent themes and now included learning and actions from the Safety Visits undertaken by the senior leadership teams. 4. STAR monthly report updated to highlight those areas who are rated red or amber for STAR visits of less then 90% for STAR monthly reviews and includes areas ranking for their STAR performance. 5. The STAR enhanced oversight panel involves 5 areas to drive action and support with STAR safety and quality actions.	1. The STAR report is shared with the divisional leadership teams, good practice is shared and celebrated and that actions are developed where improvement is required. 2. Ward/department managers, matrons and professional leads provide assurance that actions are completed and monitored for effectiveness through the 1:1 with matrons and Divisional Nurse Directors. 3. The AMaT system supports with STAR audit data management and oversight and management of improvement actions. 4. There is a BI STAR page available to enable data triangulation. 5. STAR accreditation visits are scheduled depending on star rating, areas with a bronze star rating are reassessed within 2-3 months. (red every 2 months, amber every 3 months).

Patients - C Difficile Improvement Programme Assurance

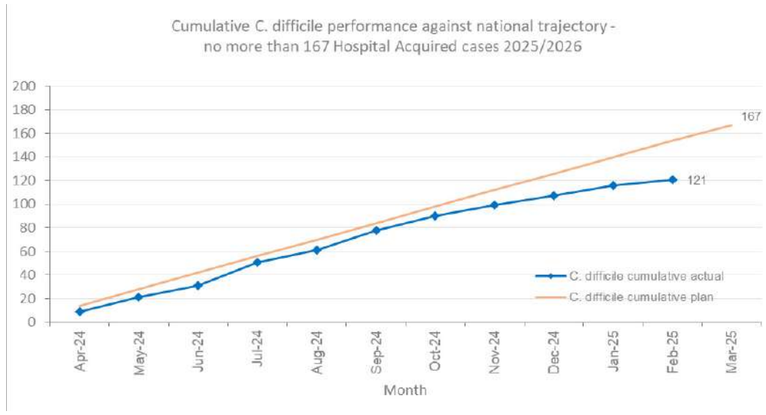
Patients

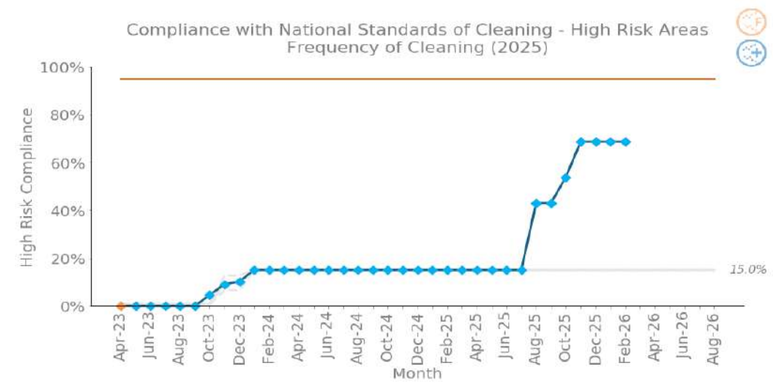


Latest
5
Variance Type
Recent positive pattern in the data
Mar-26 Target
13
Target Achievement
Could both pass or fail target within expected variation



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

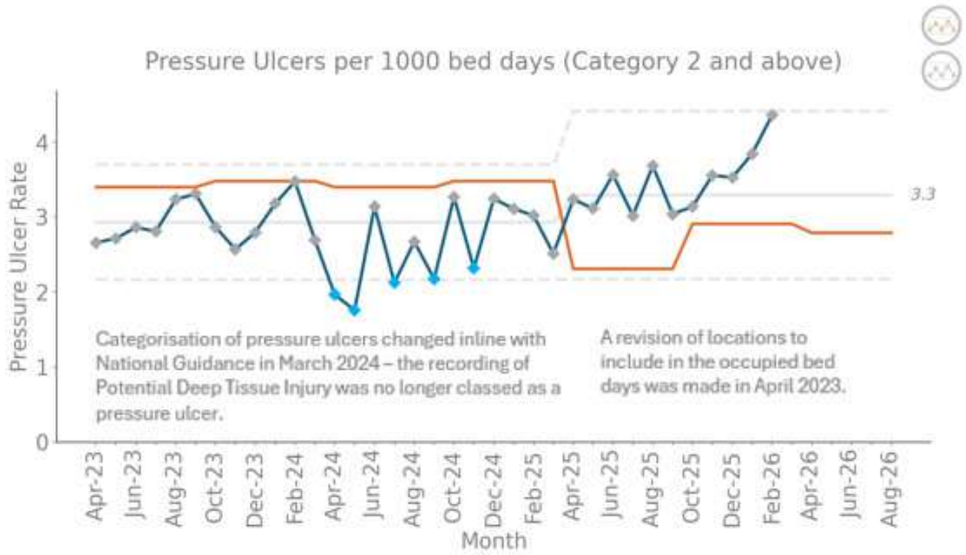




Latest
68.64%
Variance Type
Recent positive pattern in the data
Mar-26 Target
95.00%
Target Achievement
Will consistently fail target within expected variation

Metric	Summary	Action	Assurance
C. difficile performance against national trajectory - no more than 167 Hospital Acquired cases	The increase in C.difficile is a recognised high risk and forms part of the principal risks for the organisation. During February 2026 there were a total of 5 cases for the month, continuing the trend below the objective, with a total of 121 cases for 2025 / 2026 to date. The Trusts National objective for 2025/2026 is a total of 167 cases The focused work on CDI reduction and the improvement plan continues to be monitored through the Infection Prevention and Control Committee each month and also the Estates 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 2025.	1.Implementation of the approved business case to be compliant in high risk areas with National Standards of Healthcare Cleanliness (2025). 2. Continued focus on IPC practice through STAR monthly and accreditation processes each month. 3. Continue to monitor key performance assurance indicators through Infection Prevention and Control committee each month.	1. IPC BAF report reviewed and shared at IPCC for assurance. 2. IPC Dashboard. 3. IPC monthly revalidation audits such as Hand Hygiene, Commodes, Environmental checks and Mattress checks. 4. Monthly reporting into S&Q, IPCC and Divisional IPC meetings, along with bi-monthly reporting into H&S Committee. 5. STAR encompasses IPC audits and cleaning checklist compliance, with all audit information available within AMAT. 6. NHS England review of IPC assurances. 7. Antimicrobial stewardship oversight and assurance reporting.

Patients - Pressure Ulcers Assurance



Latest
4.36
Variance Type
Normal variation - no recent change
Mar-26 Target
2.79
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 continue to serve as a key indicator of care quality. Since the revision of the Trust target in April 2025, incident numbers have remained above the expected threshold. Due to the ongoing transition to a new incident reporting system, February data may be subject to retrospective amendment following full validation. Reducing pressure ulcers remains a Trust priority and is supported by a comprehensive improvement plan focused on prevention, consistent standards, and strengthened review processes. To enhance learning and oversight, a dedicated Pressure Ulcer and Falls Panel was introduced in November 2025, providing a forum for cross-divisional learning and the sharing of emerging themes.	1. Monthly sharing of cross-divisional learning, key themes and trends through Always Safety-First (ASF) meetings (from January 2026). 2.Quarterly thematic review of high-incidence pressure-ulcer areas, with findings fed back into monthly ASF meetings to ensure responsive action. 3.Pressure Ulcer and Falls Review Panel to review harms, identify themes and trends, and generate actions to improve practice (commenced November 2025). 4.Pressure ulcer safety walk-arounds by the Tissue Viability Team, shifting to a proactive assurance model (commencing April 2026).	1. Divisional Always Safety First Committees provide oversight of the pressure ulcer improvement plan and monitor progress against key actions. 2. Monthly monitoring of pressure ulcer incidence continues as a priority quality metric, with trends reviewed at divisional and Trust level. 3. STAR compliance for key questions 8d and 9c is monitored monthly as leading indicators of prevention practice. 4. Weekly Pressure Ulcer and Falls Panel, with a consolidated monthly learning report submitted to PSIRF Oversight.

Patients - Always Safety First Assurance - Mortality

Patients

Lancashire Teaching Hospitals NHS Foundation Trust

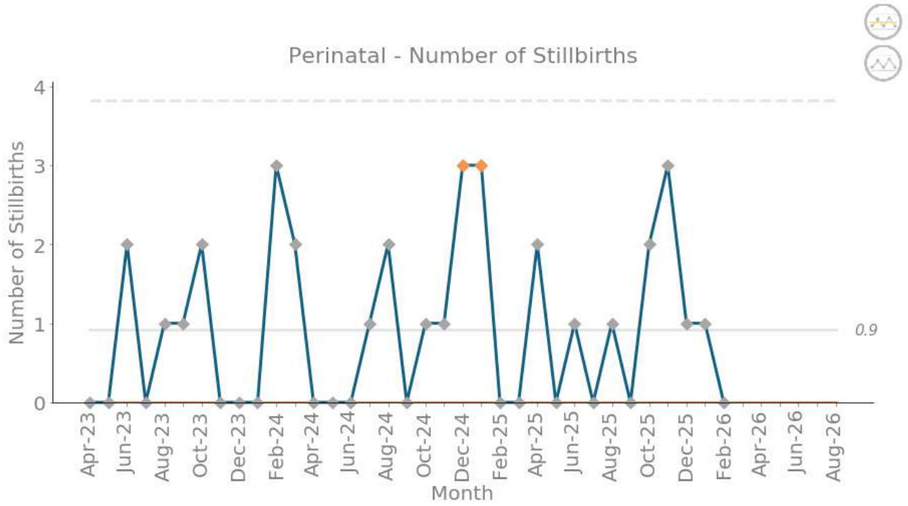
	Achievement	Position	Month
Hospital Standardised Mortality Ratio - Adult	Lower Than Expected	82.2	October 2025
Standardised Mortality Ratio - Relative Risk - All Diagnoses Adult	Lower Than Expected	73.7	October 2025
Standardised Mortality Ratio - Relative Risk - All Diagnoses Child (<1 day – 17 yrs)	As Expected	120.6	October 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	213.3	October 2025

Source Data: Telstra (Dr Foster)

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

Patients - Stillbirths Assurance

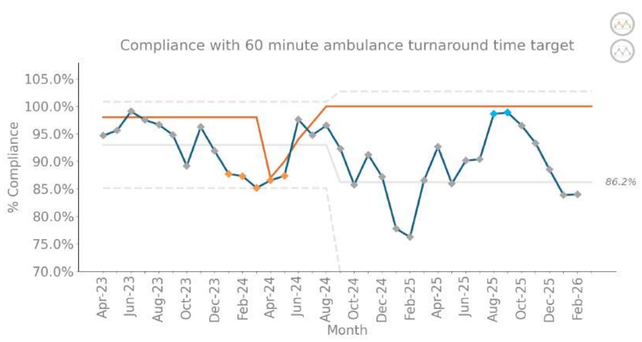
Patients



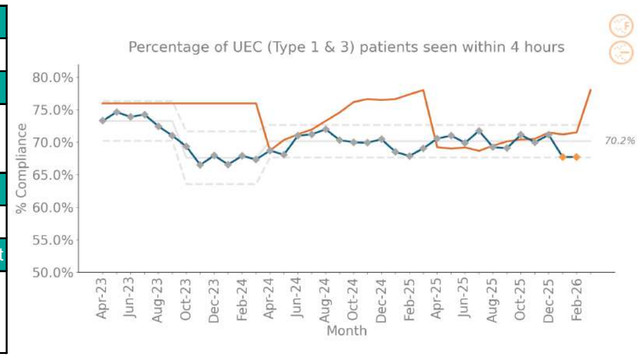
Latest
0
Variance Type
Normal variation - no recent change
Mar-26 Target
0
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
Perinatal - Number of Stillbirths	The service continues to track the rates of stillbirth and review each case in line with national guidelines. There was one stillbirths in January 2025 and no stillbirths in February 2025. Performance is in line within normal variation for the service. The 12-month local average mean still birth rate is currently 1.9 per 1000 (March 2025 to February 2026 inclusive) which remains below the national average of 3.9 per 1000 births.	1. Implementation of the 10 CNST maternity neonatal safety standards. 2. Implementation of Single Improvement Plan (SIP) actions to improved outcomes for mothers, babies and families.	1. Perinatal Quality Surveillance dashboard analysis shared via the maternity and neonatal safety report to safety and quality committee. 2. Peer comparison data included within the reporting for oversight 3. National MBRRACE reporting provides overview of national themes to ensure learning is understood. 4. ICB Local Maternity Neonatal System validation of CNST delivery of standards. 5. The Maternity Outcomes Signal System (MOSS) is now in place which provides real-time monitoring of key maternity outcome—such as term stillbirths, to detect early warning signals and prompt rapid intervention

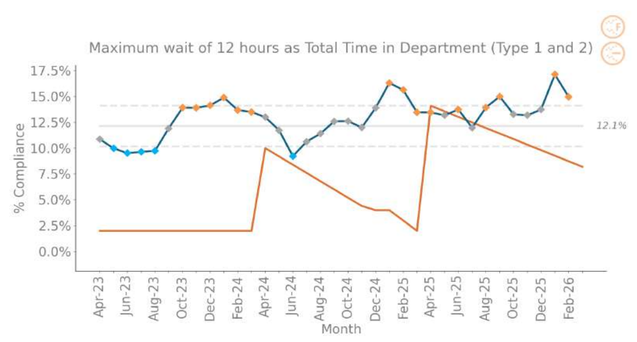
Performance - UEC Assurance



Latest
84.0%
Variance Type
Normal variation - no recent change
Mar-26 Target
100%
Target Achievement
Could both pass or fail target within expected variation



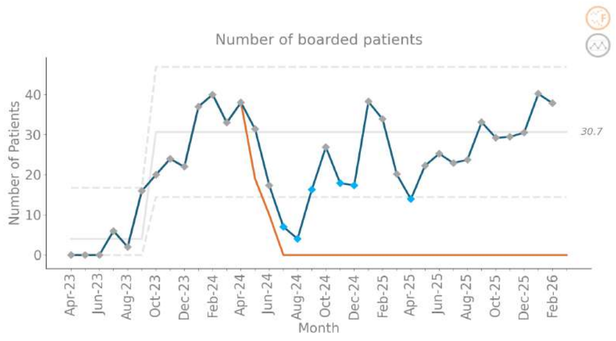
Latest
67.74%
Variance Type
Recent concerning pattern in the data
Mar-26 Target
78.02%
Target Achievement
Will consistently fail target within expected variation



Latest
14.97%
Variance Type
Recent concerning pattern in the data
Mar-26 Target
8.20%
Target Achievement
Will consistently fail target within expected variation

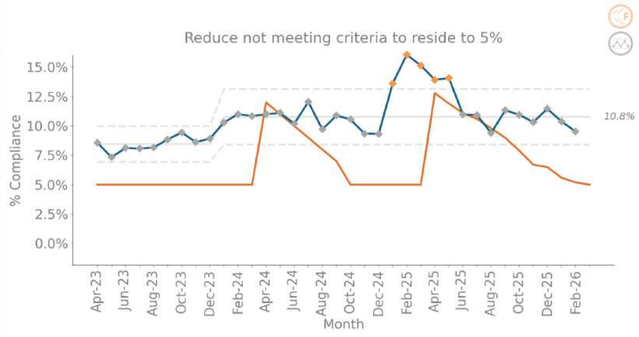
Metric	Summary	Action	Assurance
Compliance with 60 minute ambulance turnaround time target	In February 452 patients waited between 30-60 minutes to be handed over from NWAS to the Trust, a rise of 4 from last month. 352 patients waited over 60 minute to be handed over from NWAS to the Trust in February, a decrease of 26 compared to December. In February 84% of patients were handed over within 60 minutes, n improvement compared to previous months.	Ambulance handover delays remain a high priority, and a local improvement collaborative is in place with key actions focusing on increasing NWAS to SDEC pathways. This accompanied with the improvement actions focusing on reducing LOS and DKAFH (NMC2R) which will reduce ED Overcrowding and support more timely handover and attendance and admission avoidance actions is aimed to see improvements.	Monitoring of ambulance demand is undertaken via the weekly Ambulance handover group. Comparison to both the national and regional performance positions for January 26 indicates that the Trust is below the national performance position of 88.3% for 60 minute handovers and below the NW performance position of 87%.
Percentage of UEC (Type 1 & 3) patients seen within 4 hours	Performance against the national 4 hour access standard improved in February 2026. The performance improvement was 0.01%% compared to January. February experienced a daily attend rate consistent with January 26.	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 remained consistent at slightly above the 40% target (+0.48%).	Improvements have been seen in SDEC activity throughout 2025, although not yet achieving the stretch target. Virtual ward occupancy has improved since Aug 25 but is not yet reaching target or showing an embedded improvement. Deflections into community services via 2UCR have increased month on month since Sept 25. Comparison of 4 hour performance to the latest published national benchmarks indicates that the Trust is below the national average for February 26 of 74.1% and was ranked 80 out of 118 trusts nationally.
Maximum of 12 Hours Total time in ED	The number of patients waiting over 12 hours (admitted and non-admitted Type 1 only) in ED decreased in February to 14.96%, a decrease of 2.16% compared to January. The position shows a recent concerning pattern in the data 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 94.5% with a range between 92% - 97% over the last 12 months. The level of boarded patients decreased in February with an average of 38 patients per day. The volume of Days Kept Away from Home patients is far in excess of the target and slightly lower than the Feb 25 position versus Feb 26. Comparison within Model Health System indicates the Trust is above the provider median and within Quartile 3.

Performance - UEC Assurance



Latest
38
Variance Type
Normal variation - no recent change
Mar 26 Target
0
Target Achievement
Will consistently fail the target within expected variation

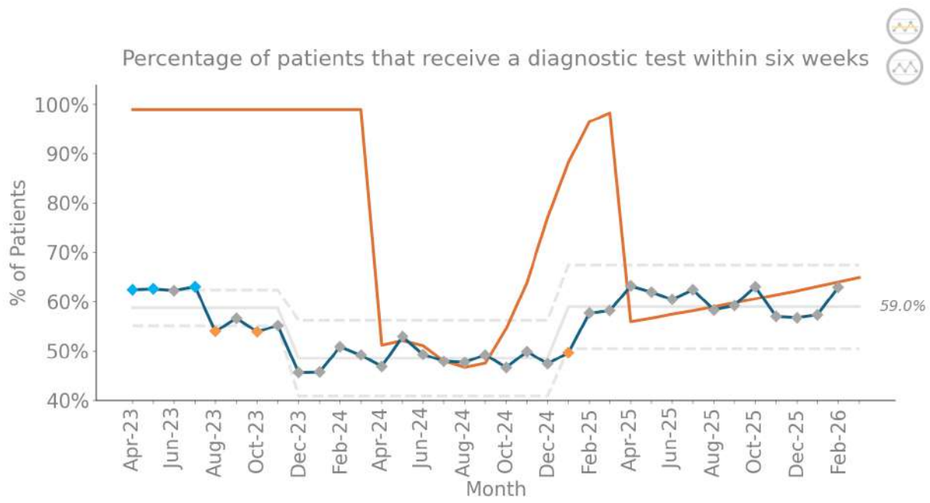
Latest
94.5%
Variance Type
Normal variation - no recent change
Mar 26 Target
90.0%
Target Achievement
Will consistently fail the target within expected variation



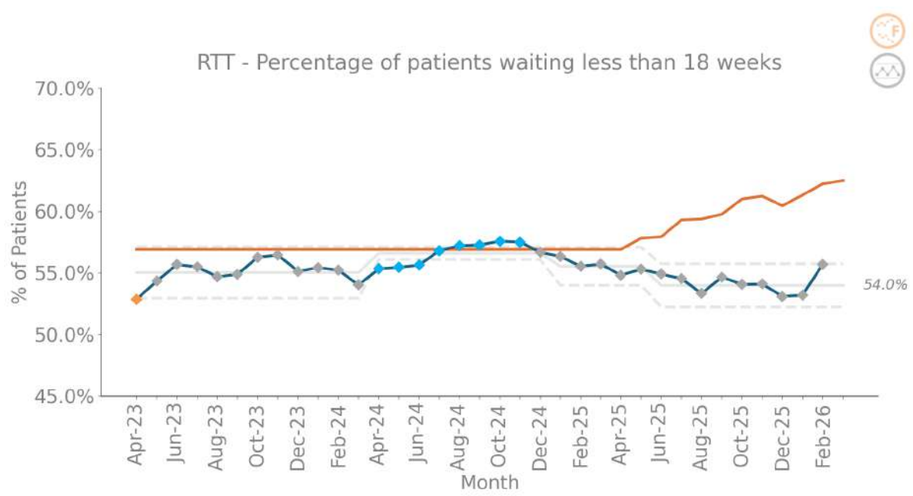
Latest
9.5%
Variance Type
Normal variation - no recent change
Mar 26 Target
5%
Target Achievement
Will consistently fail the target within expected variation

Metric	Summary	Action	Assurance
Number of Boarded Patients	On average 38 patients were boarded each day across both sites during February 26 with 1012 associated bed days. This is a rise compared with the December 25 position. These are predominantly medical patients requiring admission to an acute medical ward. The position shows normal variance and will consistently fail the target within expected variation.	Key actions to reduce boarding and de-escalation bed use include actions to increase the use of the discharge lounge by providing capacity to 'pull' patients from wards, embedding effective Board and Ward round processes, expanding the use of virtual wards to support earlier discharge and an enhanced oversight of patients with a long length of stat and those classified as Days Kept Away from Home.	Incident levels of harm are monitored on a monthly basis alongside patient feedback. UEC and In-patient survey feedback does reflect patient concerns regarding the practice of boarding. This is also reflected within the staff survey.
Bed occupancy to 90%	The position shows an occupancy rate for February of 94.5%, a drop of 1.7% compared to January 26. The data shows normal variation and will consistently fail the target.	A trust wide bed review is being undertaken to benchmark LOS against peers, assess any LOS reduction opportunities and materiality against the capacity reduction plans for the remainder of 25/26 and bed growth requirements for 26/27. Once complete agreement re bed changes in number and mix between G&A and DKAFH will be completed.	Assurance via the Urgent Care Improvement Board and Urgent Care Improvement Plan
Reduce NMC2R to 5%	The number of patients in our hospitals that do not meet the nationally defined clinical criteria to reside for inpatient care in acute hospitals (NMCTR) decreased in February (9.5% = daily average of 77 patients). Compared to the January position this is a further decrease of 0.9%. The data shows normal variation.	The Days Kept Away from Home programme is a cornerstone of the length of stay reduction ambition within the trust. The programme has evidence that the DKAFH programme is effective in reducing the care demands (and corresponding discharge pathways) required on discharge, however, due to community capacity issues the benefit is not evident within a release of bed days. An ICB wide escalation meeting was held in March and actions have been allocated to colleagues within LCC.	Monitoring of NMC2R data is undertaken via the Central Lancs Urgent Care Delivery Board

Performance - Elective Care Assurance



Latest
62.9%
Variance Type
Normal variation - no recent change
Mar 26 Target
65.0%
Target Achievement
Could both pass or fail target within expected variation

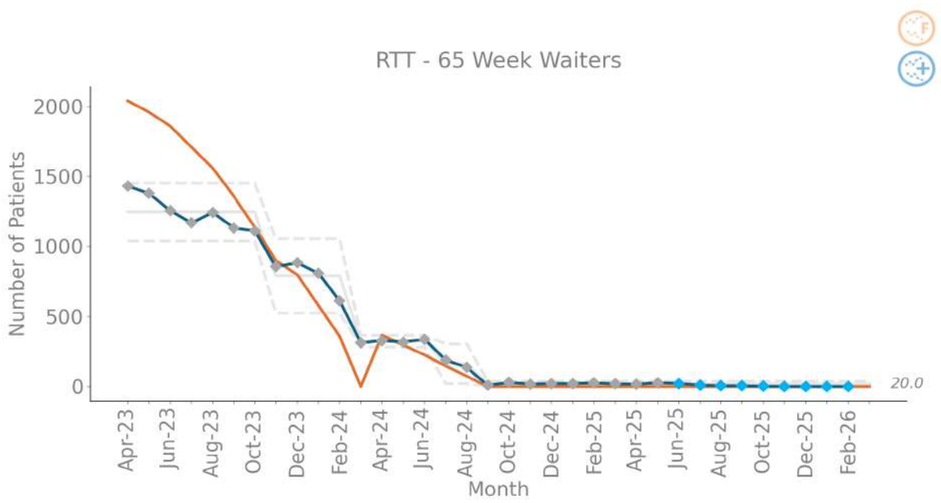


Latest
55.70%
Variance Type
Normal variation - no recent change
Mar 26 Target
62.50%
Target Achievement
Will consistently fail target within expected variation

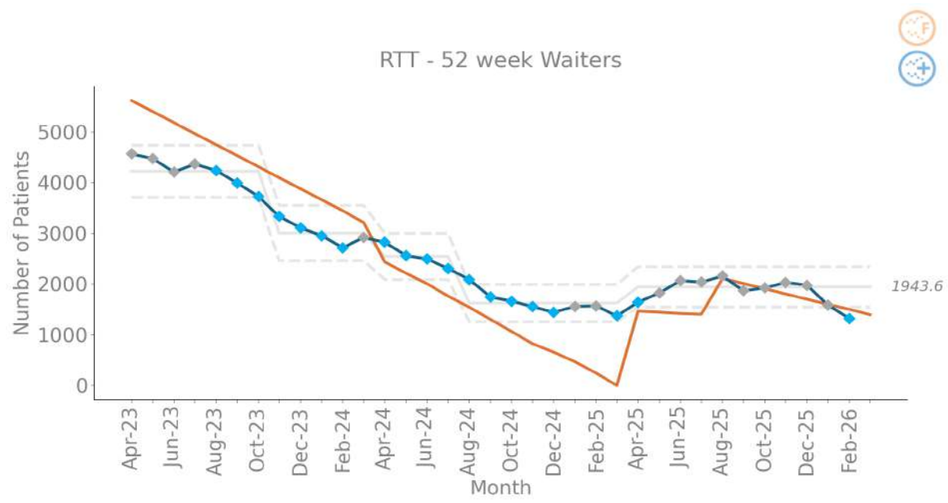
Metric	Summary	Action	Assurance
Percentage of patients that receive a diagnostic test within six weeks	Diagnostics under 6 week performance was 62.94% in February compared to 57.4% in January, a 5.6% improvement on the January position and below trajectory. Improvements have been driven by a reduction in NOUS, MRI, Scopes over 6 week waiters. Urgent and cancer patients are prioritised and seen within 2 weeks. Performance shows normal variation but may consistently fail the target.	The highest contributors of the backlog at modality level for the DM01 position are NOUS, endoscopy and echocardiography. Performance has improved in all modalities with the exception of NOUS which has significantly deteriorated as a result of increased workforce gaps. A short, medium and long term workforce proposal has been approved and is being mobilised with short term additional capacity due to come on line in early May 26.	The areas of focus are capacity optimisation, productivity, transformation and system working. Review of the latest published data (Jan 26) indicates that LTH is 106th out of 118 trusts that submitted data, the worst performing Trust in the ICB and significantly below the national average of 75.3%.
Percentage of patients waiting less than 18 weeks	The proportion of patients waiting less than 18 weeks on an RTT pathway has shown a consistent position throughout 2024/25. The Operational Plan 2025/26 year end target has been set at 65%. The February 26 position of 55.7% is 2.5% above the January performance. Analysis suggests a recent concerning pattern in the data and that the target will be consistently failed.	Performance is monitored at Divisional level via the weekly Operational Board where Issues and risks.	Comparison to the latest national performance position (Jan 26) indicates that the Trust is below the national position of 61.4% waiting under 18 weeks. The Trust is ranked 111 out of 118 trusts nationally for Jan 26.

Performance - Elective Care Assurance

Lancashire Teaching Hospitals NHS Foundation Trust



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

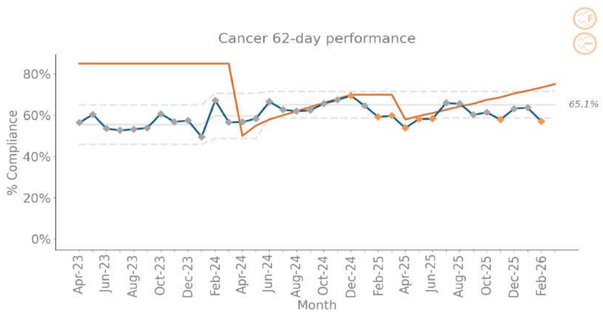


Latest
1321
Variance Type
Recent positive pattern in the data
Mar 26 Target
1395
Target Achievement
Will consistently fail target within expected variation

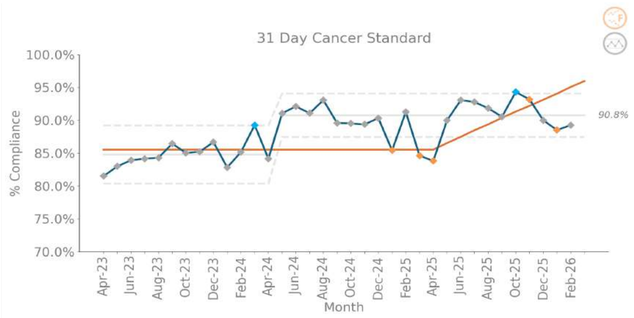
Metric	Summary	Action	Assurance
RTT - 65 Week Waiters	The over 65 week waiters position has been maintained at 0 waiters at the end of February 26. There data shows a recent positive pattern in the data.	There is a process in place to ensure daily assurance of progress with >65 week waits prioritising and ensuring the sustained elimination of >78 week waits. Issues and risks are reviewed at the weekly Operational Board.	Monitoring of all premium cost activity is ongoing. Capacity & Demand modelling analysis is being concluded in line with the 25/26 annual planning process.
RTT - 52 week Waiters	The over 52 week waiter position in February was 1,321, a further significant decrease of -263 compared to the January position. Analysis suggests normal variation in the data and that the target may be consistently failed.	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 (Jan 26) indicates that the Trust is above the national picture which is 1.9% waiting over 52 weeks. The Trust is ranked 96 out of 118 trusts that submitted data for Jan 26.

Performance - Elective Care Assurance

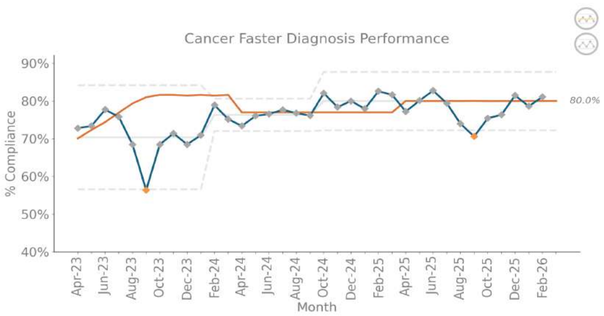
Lancashire Teaching Hospitals NHS Foundation Trust



Latest
57.1%
Variance Type
Recent concerning pattern in the data
Mar 26 Target
75.1%
Target Achievement
Will consistently fail target within expected variation



Latest
89.3%
Variance Type
Normal variation - no recent change
Mar 26 Target
96.0%
Target Achievement
Will consistently fail target within expected variation



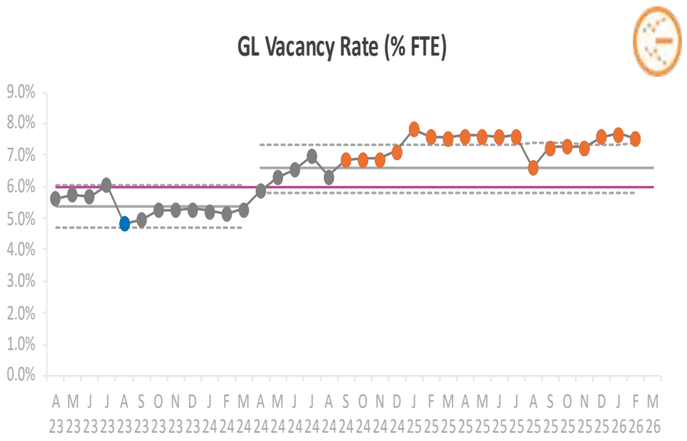
Latest
81.1%
Variance Type
Normal variation - no recent change
Mar 26 Target
80.0%
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
62 Day Cancer Standard	Performance to the end of February 26 (**currently unvalidated**) has deteriorated compared to last month, and is below the monthly operational plan target of 73.4%. 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 71.9% (Jan 26) and ranked 78 out of 119 Trusts nationally. Close monitoring of cancer PTLs are undertaken at the weekly Operational Board
31 Day Cancer Standard	Performance to the end of February 26 (**currently unvalidated**) is above last months position, but below the monthly operational plan target of 95.1%, and is expected to improve once validation is complete. Analysis shows normal variation and will consistently fail the target.		The Trust is currently just below the latest national average performance of 89.8% (Jan 26). Close monitoring of cancer PTLs are undertaken at the weekly Operational Board
Cancer Faster Diagnosis Performance	Performance to the end of February 26 (**currently unvalidated**) is above last months position, and above the monthly operational plan target of 80%, and is expected to improve once validation is complete. Analysis shows normal variation and could both pass or fail the target within expected variation.		The Trust is currently above the latest national average performance of 77.4% (Jan 26) and ranked 32 out of 119 trusts nationally. Close monitoring of cancer PTLs are undertaken at the weekly Operational Board

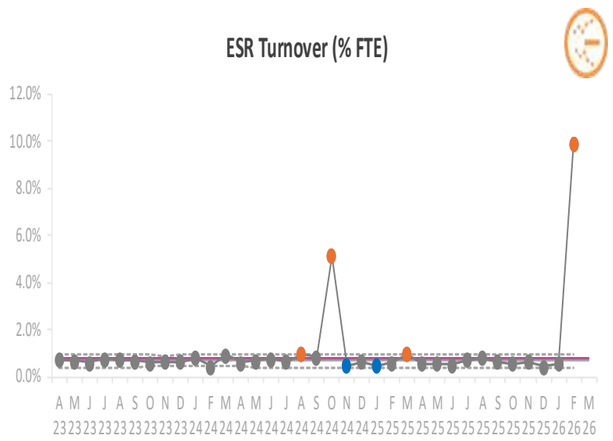
People - Workforce Assurance 1

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

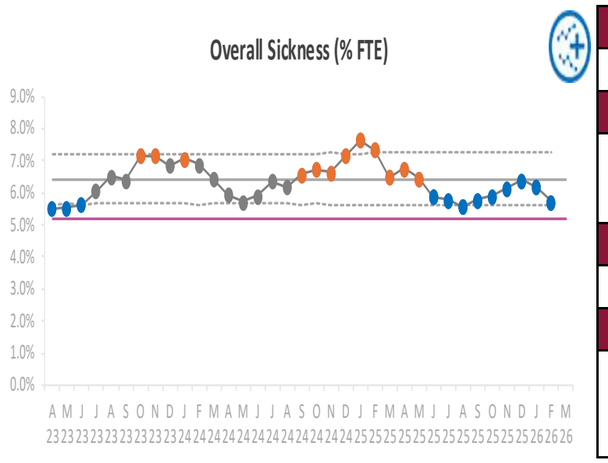
NHS Lancashire Teaching Hospitals NHS Foundation Trust



Latest
7.53%
Variance Type
Recent concerning pattern in the data
Mar 26 Target
≤ 6%
Target Achievement
Could both pass or fail target within expected variation



Latest
9.92%
Variance Type
Normal variation - no recent change
Mar 26 Target
≤ 10%
Target Achievement
Could both pass or fail target within expected variation



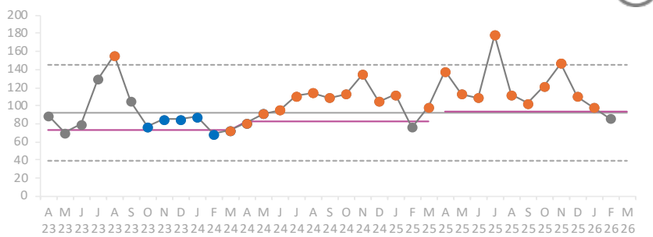
Latest
5.71%
Variance Type
Normal variation - no recent change
Mar 26 Target
≤ 5.22%
Target Achievement
Will consistently fail the target within expected variation

Metric	Summary	Action	Assurance
Vacancies (% FTE)	Vacancy rate remains high due to vacancy control measures, however over 100 wte posts have been filled through redeployment in the last month, and a number of essential posts have been released for external advert	Divisional management teams reviewing all long-standing vacancies enabling cleansing of establishments Strategies to address Band 3 Healthcare Support Worker gaps being jointly developed by nursing, education and workforce teams Vacancy control process updated to include defined times for holding posts for redeployment and internal/external advertising All posts currently held for redeployment under review	Vacancy rate monitored through Board reporting, Workforce Committee and Divisional Improvement Forums Safe staffing levels monitored daily in clinical areas New People Operations Group to include a focus on resourcing EQIA process utilised to support vacancy control decision-making
Turnover (% FTE)	Turnover remains consistently low for month 11.	Turnover - to refresh strategic actions relating to turnover, which will include generational differences and needs from the workplace.	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.
Sickness Absence (% FTE)	Sickness absence increased in M1, following a reduction over the preceding 2 months. Long-term absence continues to account for over two-thirds of the overall absence rate and is therefore the primary focus. Approximately 30% of all sickness absence us due to mental health.	New Attendance Management policy published 12 May and launch event held for managers Procurement of digital absence management system has advanced enabling implementation planning to commence in detail To support colleague wellbeing, new restrictions around working additional hours following sickness absence will be introduced in June Occupational Health physiotherapy gaps soon to be resolved following successful recruitment of 1 post-holder with a 2nd post due to be offered Agreement to recruit a further fixed term psychologist to address capacity gaps and enable proactive work to be progressed	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 Paper to May TMB outlined actions completed, ongoing or newly developed

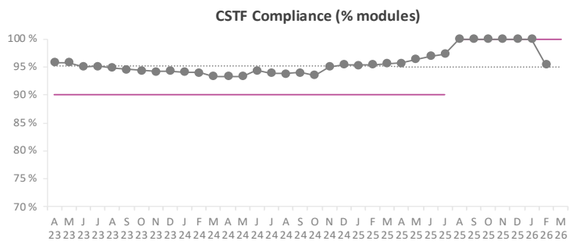
People - Workforce Assurance 2

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

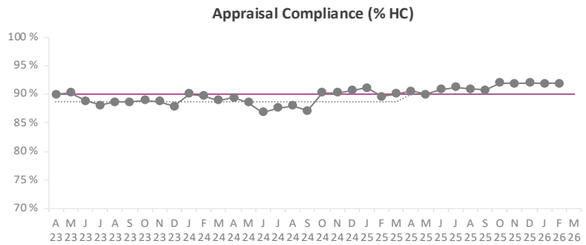
NHS Lancashire Teaching Hospitals NHS Foundation Trust



Latest
86
Variance Type
Normal variation - no recent change
Mar 26 Target
NA
Target Achievement
Could both pass or fail target within expected variation



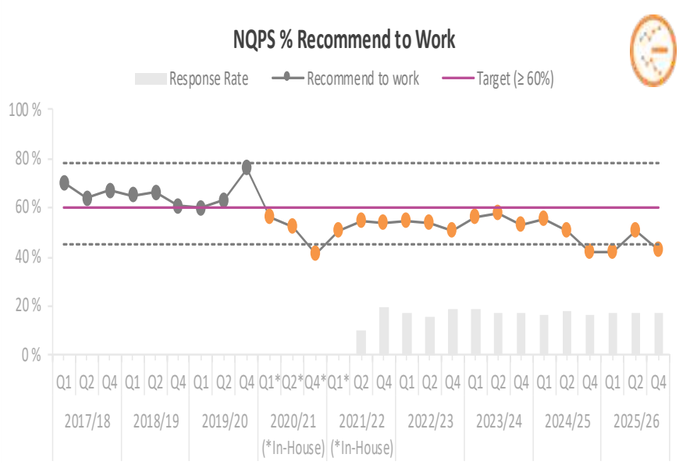
Latest
95.45%
Variance Type
Mar 26 Target
100% of metrics at 90%
Target Achievement



Latest
91.91%
Variance Type
Mar 26 Target
≥ 90%
Target Achievement

Metric	Summary	Action	Assurance
Number of violence and aggression incidents toward staff	January and February's data is now in the graph (BM)	Monthly meetings established for Emergency Department with clinical, security and workforce representatives to review actions and learning from recent incidents Security presence increased in ED with the aim of 24/7 cover, and an assessment of all other security measures underway Liaison between Resilience leads and police recently strengthened Violence and aggression risk assessment for wards/departments reviewed by Big Room and will be relaunched in June Violence marker process being reviewed through the Big Room with Safeguarding involvement, with a particular process on how accessible information is to the clinical teams	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 95.45%	Targeted intervention and focus has taken place at SBU and CBU level to ensure that all metrics are compliant by professional group.	High levels of engagement at divisional level and targeted intervention continues to positively impact compliance figures
Appraisal compliance (% HC)	Appraisal compliance remains above the 90% target.	Actions will focus on increasing use of objectives and personal development planning in appraisal, guidance is being developed to support appraisers to tailor their conversation based at the career and lifestage of appraisees.	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
42.5%
Variance Type
Recent concerning pattern in the data
Mar 26 Target
≥ 60%
Target Achievement
Will consistently fail the target within expected variation

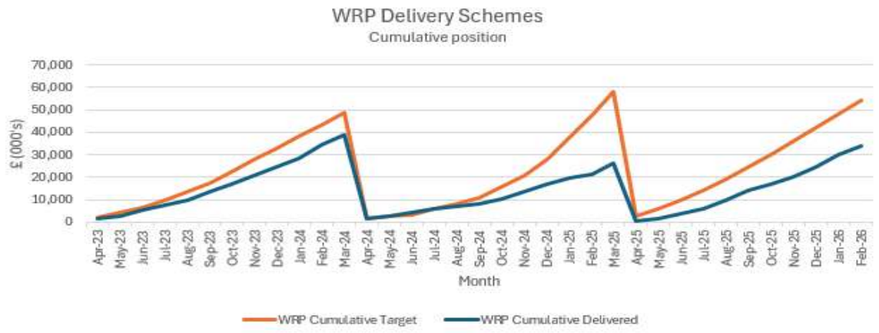
Metric	Summary	Action	Assurance
Staff Survey: Recommend Trust as place to work	Levels of advocacy with regards to recommending the organisation as a place to work and be cared for has further declined in Q4, this is reflective of the score and national benchmarking received as part of the NHS Staff Survey Results.	A Colleague Voice event was dedicated to exploring reasons for decline in advocacy, with actions underway. Future actions include to further implement and embed Staff Engagement Proposal and demonstrate / communicate visible action taken in response to colleague voice. Develop and implement an organisation wide and divisional level action plans in response to NHS Staff Survey results, alongside producing divisional level EDI staff survey analysis to support identification of inclusion specific actions for each Division.	Workforce Committee reports detailing the programme of work in response to NHS Staff Survey data and national benchmarking. Delivery of the corporate action plan progressed through collaboration with relevant teams and leads addressing priorities/themes. Divisional action plans are scheduled for monthly review through Divisional Workforce Committees - frequency and depth of reporting varies across Divisions. Enhanced team support activity is ongoing in targeted areas of concern, with progress tracked and reviewed through Organisational Development operational meetings.

Productivity - Assurance

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

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Latest YTD Actual (,000s)
-30,863
Latest YTD Target (,000s)
-1,530
March 26 YTD Target (,000s)
-



Latest YTD Actual (,000s)
34,017
Latest YTD Target (,000s)
54,018
March 26 YTD Target (,000s)
60,000

Metric	Summary	Action	Assurance
I&E - Plan v Actual variance	At the end of February 2026 the Trust has a deficit of £30.8m against a planned deficit of £1.5m. The adverse variance to plan of £29.3m is mainly as a consequence of the shortfall in delivery of the Waste Reduction Programme £20.0m and non receipt of deficit support funding for November to February of £10.0m. The Trust has had operational pressures associated with; industrial action, patient acuity, junior doctor rotas, buildings dilapidations and maintenance of its energy system, these are largely considered non-recurrent and have been fully mitigated with industrial action funding and non-recurrent technical items. The Trust has operational pressures in: - the acute medical pathways reflected in overspends in medical and nursing pay budgets - sickness remains higher than in operational budgets resulting in nursing pay overspends	The Trust had a Turnaround Director to work with senior leaders to re-assess the current waste reduction programme position and deep dive into short, medium and long-term opportunities. A re-set of the programme structure, governance and reporting for 2025/26 has taken place. The Trust is working with the ICB on the urgent and emergency pathway system pressures which is one of the main operational pressures that the Trust faces. The system is now receiving enhanced support from NHSE as part of the provider improvement programme (formerly recovery support programme). A focus on grip and control activities continues. The Trust commissioned further external support for specific financial recovery plan workstreams and 2025/26 waste recovery programme development. Divisions will need to recover their financial performance by delivering improvements in their current run rates e.g. maximising grip around temporary pay, review of vacancies and continuing to mitigate shortfalls in the efficiency target if slippage in schemes continues. The Trust supports divisions through regular divisional review groups that enable escalation to the Executive if there are barriers to delivery.	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 February the Trust has delivered £36.4m of the £60m target (61%). The delivery in month was £4.0m against a plan of £6.0m.	The Trust had a Turnaround Director to work with senior leaders to re-assess the current programme position and deep dive into short, medium and long-term opportunities. A re-set of the programme structure, governance and reporting has taken place for 2025/26. The Trust has additional external support to help with the delivery of the programme. The Trust is now embedding its own project management office structure to have a sustainable solution moving forward. The Trust is enhancing grip and control activities to mitigate slippage in specific schemes.	Waste reduction programme board chaired by CEO External support for specific workstreams. Implementation of Divisional Delivery Groups Embedding of PMO

BREAK

10:55 am

10.2 FINANCE AND PERFORMANCE COMMITTEE CHAIR'S REPORT

Other | J Schorah | 11:10 am

Item for assurance

REFERENCES

Only PDFs are attached

10.2 - FPC Chairs Report 27 Jan 24 Feb.pdf

Chair's Report to Board		
Chair: J Schorah	Committee: Finance and Performance Committee	
Date(s): 27 January & 24 February 2026	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 - 16	⇨	None

ALERT

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

- The Committee re-visited its previous assessment that none of the Principal Risks were expected to be controlled by year-end, with the possible exception of cancer performance, and agreed that this alert to Board should remain unchanged, noting that there had been no movement in operational risks. The Committee continues to alert that the financial risk position remains stagnant. The Committee also stressed the importance of recognising that deficit support funding was not guaranteed, with failure to deliver the required programme position likely to affect eligibility and subsequent cash consequences.

- Significant pressures across urgent and elective care had been highlighted, including worsening ambulance handover delays, ongoing failure of the 4-hour and 12-hour emergency standards, and prolonged waits for senior clinical assessment. High bed occupancy, continued boarding, and large numbers of patients not meeting criteria to reside reflect sustained flow challenges. Elective care performance remained off-trajectory, with low RTT 18-week compliance, high numbers of 52-week waiters, deteriorating diagnostic performance, and a growing backlog of overdue follow-ups. Cancer standards also continue to underperform, particularly in colorectal, lung, breast and urology pathways, indicating system-wide issues impacting timely care.
  Performance pressures in February remained significant across several areas. Overdue RTT follow-ups continue to rise month-on-month due to limited capacity, and diagnostic performance was affected by deteriorating NOUS results linked to workforce gaps. Patient flow pressures were evident, with high levels of boarding and escalation bed use, and Days Kept Away from Home remained markedly above target. Emergency care performance continued to decline, with 4-hour performance below national averages and ambulance handovers worsening across all categories, driven largely by overcrowding and exit block.

- It was confirmed that the mid-case forecast included an unresolved financial risk of approximately £6 million, and that although several mitigation routes were available, including non-recurrent flexibilities, a potential settlement with the commissioner, and detailed review of accruals, the risk had not yet been fully covered. It was re-affirmed that cash remained a critical challenge requiring close oversight. The Board

should be alerted that the recurrent programme delivery targets were not guaranteed, and that achieving the required exit position would depend on both run-rate improvements and revisiting non-recurrent items.

- Single Improvement Plan: The Committee noted that progress had been hindered by limited medical leadership capacity required for the review of the children's urgent care pathway. Implementation of the digital sickness-absence management system had been delayed, with the pilot rescheduled for January. Further slippage had also occurred against the financial waste-reduction programme target; and there were continued challenges in urgent and emergency care linked to shortages in domiciliary care. Staffing constraints were also affecting virtual ward delivery and adherence to national cleaning standards for managing C. difficile. Ongoing boarding in wards continued to negatively affect patient experience.

- While further progress on WRP was expected in the coming weeks, the Committee agreed that of the £42 million identified to date, less than £1 million had reached green status, with the remainder spread across amber and red stages and this represented a significant alert for the Board given the remaining timeframe and the inherent risk within the schemes.

- The Committee agreed that while a compliant and triangulated 2026–29 Planning Framework had been produced, delivery represented a significant organisational risk.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- Performance Assurance Progress: It was acknowledged that, despite ongoing challenges, some improvement had been achieved compared with the previous year and that this should be recognised. It was also observed that operational teams were making sustained efforts to drive progress, despite the constraints. It was noted there had been incremental improvement on planned care. Performance remained broadly in line with the position forecast at the start of the year, with ongoing acknowledgement that urgent and emergency care, waiting list size and 18-week performance would not be achieved, while confidence remained in meeting the 52-week standard.

- Headcount Reduction: Clarity was still required regarding the expected performance trajectory, with recognition that historical challenges meant there were continued risks to achieving the targeted figures within the remaining three month period. The Committee noted that improvements in agency, bank and wider workforce measures were visible but not progressing at the pace required.

- It was acknowledged that there continued to be a slower pace of delivery in some areas of the Single Improvement Plan.

- The cash position and March cash request was directly dependent on the receipt of deficit support funding, however it was uncertain whether this was contingent on achieving or formally signing up to the forecast.

- LHS Consolidation: The subsidiary's expansion created technical reporting fluctuations, prompting a pause in consolidation until year end, with future monthly consolidation required but no change to the underlying financial position.

- WRP / PMO risks include limited capacity to develop and approve schemes, difficulties in achieving headcount reduction, PMO constraints, and the £50.4 million in-year target depends on securing the estates transformation scheme.

- The latest One LSC Procurement Update indicates that the target of £2.7 million for the year appears to be on track.

ASSURE

Assurance received; Matters of positive notes

- Assurance was provided that the organisation expected to deliver its capital position by year-end. The Committee received assurance that capital expenditure was on track with no internal cash escalations anticipated, and that national schemes not deliverable in-year would either be handed back or reprofiled, with system-wide impacts to be considered where relevant.

- The Committee remained broadly comfortable with 2026/27 planning timelines but emphasised the need to avoid complacency.

- Headcount Reduction: Key interventions appeared to be taking effect, providing a degree of assurance around current progress.

- Medical Staffing Additional Payments: Assurance had been gained that actions were being taken and progress was under way. System changes were due shortly, and it was suggested that monitoring should continue for the remainder of the quarter to understand the impact of those changes.

- Procurement Controls: Operational KPIs and contract management are robust, with ongoing improvements in reporting and oversight.

Finance and Performance Committee

27 January 2026 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 December 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. PERFORMANCE					
7.1	Performance Assurance Progress Report	1.20pm	✓	Assurance	K Foster-Greenwood
7.2	Length of Stay Analysis Report	1.35pm	✓	Assurance	K Foster-Greenwood
7.3	One LSC Procurement update (incorporating supplier scores)	1.50pm	No paper received	Assurance	J Collins
8. PRODUCTIVITY					
8.1	M9 Finance Position and General Finance Update inc. IAG	2.00pm	✓	Assurance	C Carter
8.2	Model Service Approach	2.20pm	✓	Assurance	C Carter
8.3	WRP and PMO Update	2.35pm	✓	Assurance	R Morgan-Evans
8.4	Workforce Reduction Progress Report	2.50pm	✓	Assurance	N Pease
8.5	Medical Staffing Additional Payments	3.00pm	✓	Assurance	S Canty
9. PARTNERSHIPS					
9.1	Planning Controls Update including SIP & External Dependencies	3.10pm	✓	Assurance	A Brotherton

№	Item	Time	Encl.	Purpose	Presenter
9.2*	Annual Plan, Forward Plan and 5 year financial and operational plan (including submission update)	3.20pm	✓	Assurance	A Brotherton
9.3*	Single Pathology Service – Legal Document Review	3.30pm	✓	Assurance	J Foote
10.	RISK, GOVERNANCE AND COMPLIANCE				
10.1	Items to Alert, Advise or Assure the Board	3.40pm	Verbal	Information	J Schorah
10.2	Reflections on the meeting	3.45pm	Verbal	Information	J Schorah
11.	ITEMS FOR INFORMATION *Ancillary Pack				
11.1	Contract Performance		✓		
11.2	Trading Accounts (inc. deficit protocol controls)		✓		
11.3	Chair's Reports/Minutes: (a) Emergency Preparedness, Resilience and Response (EPRR) Committee (b) ELFS Management Board Minutes		✓		
11.4	Date, time, and venue of next meeting: *24 February 2026, 1.00pm, Microsoft Teams*	3.50pm	Verbal	Information	J Schorah

Finance and Performance Committee

24 February 2026 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 27 January 2026	1.03pm	✓	Decision	J Schorah
5.	Matters arising: WFC Referral Nov 2025 and Action Log	1.05pm	✓	Decision	J Schorah
6.	Strategic Risk Register	1.10pm	✓	Decision	S Regan
7. FINANCIAL PERFORMANCE					
7.1	M10 Finance Position and General Finance Update inc. IAG	1.20pm	✓	Assurance	C Carter
7.2	Quarterly Grip and Control Update	1.40pm	✓	Assurance	C Carter
7.3	LHS Ltd Consolidation	1.50pm	✓	Information	C Carter
7.4	WRP and PMO Update	2.00pm	✓	Assurance	R Morgan-Evans
7.5	One LSC Procurement update (incorporating supplier scores)	2.15pm	✓	Assurance	J Collins
8. OPERATIONAL PERFORMANCE					
8.1	Performance Assurance Progress Report	2.30pm	✓	Assurance	K Foster-Greenwood
9. STRATEGY & PLANNING					
9.1	SIP Update	2.50pm	✓	Assurance	A Brotherton
9.2	Annual Plan, Forward Plan and 5 year financial and operational plan (including submission update)	3.10pm	✓	Assurance	A Brotherton
9.3	Annual Green Plan Report	3.35pm	✓	Assurance	N Pease

№	Item	Time	Encl.	Purpose	Presenter
9.4	Pathology in Lancashire and South Cumbria	3.45pm	✓	Assurance	A Rowbottom
10.	RISK, GOVERNANCE AND COMPLIANCE				
10.1	Items to Alert, Advise or Assure the Board	3.55pm	Verbal	Information	J Schorah
10.2	Reflections on the meeting	3.58pm	Verbal	Information	J Schorah
11.	ITEMS FOR INFORMATION				
11.1	Contract Performance		✓		
11.2	Feeder Group Terms of Reference: (a) Emergency Preparedness, Resilience and Response (EPRR) Committee (b) ELFS Management Board – no meeting		✓		
11.3	Chair's Reports/Minutes: (a) Senior Information Risk Owner/Asset Information Owner Working Group (b) LHS Minutes		✓		
11.4	Date, time, and venue of next meeting: *24 March 2026, 9.30am, Microsoft Teams*	4.00pm	Verbal	Information	J Schorah

10.3 GREEN PLAN ANNUAL REPORT *

Other | I Ward | 11:20 am

Item for assurance

REFERENCES

Only PDFs are attached

10.3 Green Plan Annual Report Apr 26.pdf.pdf

Board of Directors Report

Meeting of the	**Board of Directors**		**2nd April 2026**
	Part I ☒		**Part II** ☐
Title of Report	**Green Plan Annual Update**		
Report Author	Tina Summersgill, Planning Manager		
Lead Executive Director	Craig Carter, Chief Finance Officer		
Recommendation/ Actions required	The Board of Directors is asked to: 1. Note the position of progress and delays in year 1 of the Green Plan 2. Support recommendations to ensure compliance with the plan.		
	Decision ☐	**Assurance** ☒	**Information** ☒
Executive Summary	This paper provides an update on Lancashire Teaching Hospitals' progress in delivering the Trust Green Plan (2025–2028) during year one aligned with national NHS sustainability requirements. The Trust submitted the Q3 Greener NHS Data Collection on 22 January 2026, confirming continued governance arrangements, with a Board-level net zero lead and a published Green Plan in place. Progress is evident across several domains; however, key escalations require Board oversight. These include potential nitrous oxide wastage due to ageing anaesthetic infrastructure, absence of a plan for transitioning the Trust fleet to zero-emission vehicles by 2027, and limitations in the staff salary sacrifice scheme that currently does not exclusively restrict to zero-emission options only. Additionally, gaps remain in evidence of supply chain compliance with NHS net-zero tendering requirements. A lack of assigned leadership for the Adaptation workstream has delayed development of a climate adaptation plan, despite national expectations. Work is underway with regional colleagues to support this, but internal leadership remains a gap. Energy and carbon data for 2024–25 show increased emissions (21,862 tCO2e), driven by estate expansion and rising utility usage. The Trust currently consumes no renewable electricity and performs poorly compared with peers on greener energy utilisation. Clinical waste emissions (scope 3) remain significantly higher than regional and national averages, highlighting a pressing area for improvement.		

	Progress against Year 1 Green Plan milestones is mixed: while promoting training, digital transformation efforts, sustainable care models, and Public Sector Decarbonisation Scheme (PSDS) funded decarbonisation planning have commenced, several actions (e.g. waste strategy, EPMA rollout, travel plan updates) remain outstanding. **Key risks** Key risks relate to fleet transition funding, unsuccessful capital bids for decarbonisation schemes, and the absence of a dedicated sustainability budget - now formally captured as a corporate risk. Additional assurance gaps exist within procurement and medicines workstreams.	
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:	Finance & Performance Committee	Date: 24th February 2026
Operational Group Review:	Sustainability Leads Meeting	Date: 18th February 2026
Link to Board Assurance Framework:	Choose an item	
Appendices	Appendix 1 - NHS Greener Data Submission January 2026 Appendix 2 - Green Plan Action Tracker	

11. PEOPLE (WORKFORCE, EDUCATION AND RESEARCH)

11.1 WORKFORCE COMMITTEE CHAIR'S REPORT

Other | A Leather | 11:30 am

Item for assurance

REFERENCES

Only PDFs are attached

11.1 Workforce Committee Chair's report - 10 March 2026 (1).pdf

Chair's Report to Board		
Chair: Adrian Leather	**Workforce Committee**	
Date(s): 10 March 2026	**Agenda attached for information**	✓

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

ALERT

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

- The Board should be alerted that significant challenges had been experienced implementing the Empactis digital sickness absence system with procurement, IT and governance processes, and concerns had been raised about similar issues affecting other digital systems, resulting in a deteriorating trajectory for this critical workforce risk.
- The Committee noted the scale of ongoing organisational change and agreed this warranted escalation to the Board as a live issue affecting morale, capacity and the organisation's ability to support teams through sustained change.
- **Workforce Information Risk:** It was agreed that Risk ID 2137, Capacity in the Workforce Information Team remained appropriately scored at 16.

  The Committee raised concern about the fragility of workforce informatics capacity, noting that while data quality remained sound, limited analytical support was constraining the Trust's ability to meet increasing reporting and assurance requirements. This was impacting both Board level oversight and operational teams' understanding of workforce flows and demand. Requests for workforce information continued to rise at a time when system level capability remained insufficient, and the Committee agreed that further investment in skills and capacity would be essential to meet future organisational needs.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- The Committee supported celebration of staff survey improvements alongside targeted interventions, however should highlight persistent themes around morale and feeling heard to the Board, given the wider organisational pressures.
- The Committee noted that AI and AVT are being cited as fulfilling service gaps in administrative capacity, without assurance that these solutions are operationally viable.

ASSURE

Assurance received;
Matters of positive note.

- The Committee was assured that fragile services had been identified and protected in future workforce plans, with ongoing monitoring.

- The Committee can assure the Board of progress and future actions on NHS England Sexual Safety Charter, including consistent standards for One LSC staff and support for victims.

11.2 NATIONAL STAFF SURVEY BENCHMARK REPORT *

Decision Item | N Pease | 11:40 am

REFERENCES

Only PDFs are attached

11.2 National Staff Survey Benchmark Board Report April 2026.pdf

Board of Directors Report

Meeting of the	**Board of Directors**		**Date of Meeting 2nd April 2026**
	Part I ☒		**Part II** ☐
Title of Report	**National Staff survey Benchmark**		
Report Author	Samantha Kenny – Head of Organisational Development Programmes		
Lead Executive Director	Neil Pease – Chief People Officer		
Recommendation/ Actions required	The Board of Directors is asked to: receive the NHS Staff Survey Results and note the approach to addressing areas of improvement		
	Decision ☐	**Assurance** ☒	**Information** ☐
Executive Summary	This report presents the Trust's 2025 NHS Staff Survey results in comparison with national benchmarks and previous years, alongside analysis of colleague feedback and recommended areas for organisational focus. Following three years of year-on-year improvement between 2022 and 2023, the Trust experienced a decline in results in 2024, broadly reflecting the increasing financial, operational and workforce pressures being experienced across the NHS. The 2025 results indicate relative stabilisation following this period of decline. While the Trust now sits slightly below the national average across several People Promise themes including Staff Engagement, Morale, We Are Always Learning, We Are Safe and Healthy and We Each Have a Voice That Counts. The overall gap to the national benchmark remains relatively small. Areas such as recognition and reward, flexible working and inclusion remain broadly aligned with national averages, and team working continues to perform comparatively strongly. Although it is disappointing to see results remain below the national benchmark after previous improvement, the overall pattern is not unexpected given the sustained pressures facing colleagues and services. Importantly, the data does not show a sharp deterioration from the previous year. Instead, the results suggest relative steadiness across most measures, with the most notable changes seen within Staff Engagement and perceptions of colleague voice and influence.		

	It is also notable that team cohesion, compassion and local leadership relationships remain relatively stable. This indicates that colleagues continue to demonstrate strong professional commitment and support for one another despite challenging circumstances. It is therefore likely that initiatives implemented in recent years including the TED programme, leadership and people management development, increased focus on recognition, flexible working and wellbeing support, may be helping to mitigate some of the wider pressures experienced across the organisation. The report provides detailed analysis at Trust, Divisional and team level, alongside insights from free-text comments provided by colleagues. The qualitative feedback highlights several recurring themes including leadership visibility, staffing and operational pressures, patient advocacy and safety, wellbeing and morale. While many colleagues continue to express pride in their teams and the care they provide, there is a clear signal that sustained pressures are influencing perceptions of organisational support, voice and recognition. Based on the findings, this report proposes a number of priority areas for action, including strengthening colleague voice and influence, addressing perceptions of safety and speaking up, supporting teams experiencing sustained pressure, reinforcing leadership visibility and engagement, and continuing to develop approaches that support colleagues to feel valued and recognised. The report concludes with recommended corporate priorities for action and is aligned with existing 'Your Voice' programme setting out how improvements will be driven through both organisational and team-level interventions. Divisional Workforce Committees will be supported to review their local results and identify priority areas for action, with the Organisational Development team providing targeted support to teams requiring additional intervention.	
Link to Strategic Objectives 2025/26	**Patients – deliver excellent care:** Improve outcomes, reduce harm and deliver a positive patient experience.	☐
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.	☐
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.	☒
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.	☐
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.	☐
Due Diligence	To give the Trust Board assurance, please complete the following:	
Committee Approval:	Name of Committee: Workforce Committee	Date: 10th March 2026

Operational Group Review:	Name of Operational Group: Trust Management Board	Date: 11th March
Link to Board Assurance Framework:	Principal Risk 8 (25/26) - Experience of staff, with specific focus on under-represented staff groups Select correct Principal Risk from the drop down	
Appendices	State whether there are any appendices and list them. For example: Appendix 1: 2025 Staff Survey Benchmark Report Appendix 2: Team Results Manager Dashboard Appendix 3: RAG Staff Survey Data by locality	

INTRODUCTION

This report builds on the paper submitted in the January 2025 Workforce Committee report, (and details the national benchmarking for our National Staff Survey results, which will be publicly available as of the 12th March 2025 when the embargo has been lifted. It also includes the analysis of the free text comments, themes identified and the key priority areas for action.

The report highlights at a Divisional Level the teams with the lowest satisfaction and may require supportive intervention and the recommended next steps.

Finally, the report includes a suggested priorities and areas of focus for the next 12 months. Many of these actions and areas are a continuation or next phases following work already completed.

OUR PERFORMANCE AGAINST THE NATIONAL BENCHMARK

Appendix 1 provides the full organisational breakdown against national benchmarks for Acute and Acute/Community Trusts. Of the 121 organisations within our benchmarking group, the mean response rate was 47%. LTH achieved a response rate of 45.1%, which remains 1.9% below the benchmark but represents a significant improvement from 39% in the previous year (a 6.1 percentage point increase year on year).

As outlined in the previous Workforce Committee report, this improvement is likely attributable to a more structured and coordinated survey approach, including comprehensive communications and launch pack, clearer and consistent Trust-wide messaging, targeted engagement activity. The campaign deliberately combined realism about organisational pressures with recognition of high-quality care and teamwork, reinforcing the value placed on colleague voice and participation.

Given the continued gap to the national benchmark and the strong correlation between response rates, engagement, and advocacy measures, it is recommended that improving and sustaining response rates remains a priority within the 2026 Staff Survey cycle (September–November 2026) with increased visible leadership involvement.

Graph 1 details the Trust's 2025 results (navy blue) against the national average for Acute and Acute/Community Trusts (benchmark). The Trust's results sit below the national average across all nine People Promise elements and themes; however, the differences are relatively small in scale, ranging from -0.03 to -0.25 points.

The areas showing greater variation from the national average are those linked to engagement, morale and feeling heard, rather than perceptions of teamworking or day-to-day experience. The smallest variances are within We are safe and healthy (-0.03), We are always learning (-0.03), We are recognised and rewarded (-0.04), We work flexibly (-0.03), and We are a team (-0.04), indicating close alignment with the national position in these areas.

The largest gaps are within Staff Engagement (-0.25), Morale (-0.16), and We each have a voice that counts (-0.09). While modest in absolute terms, these measures are strategically significant given their association with advocacy, retention and discretionary effort. With the gaps more pronounced in areas connected to voice and morale, this suggests colleagues may be experiencing reduced influence or agency within the wider organisational context.

The lower score in **Staff Engagement** is of particular note, as this theme incorporates advocacy of care and reflects colleagues' confidence in recommending the Trust as a place to receive treatment.

Given the continued financial challenges, increasing pressures and ongoing operational demands placed on teams, these results are not unexpected. Importantly, the 2025 data does not reflect a sharp deterioration from the previous year. Rather, it suggests steadiness at a level slightly below the national mean, indicating stabilisation rather than continued downward movement.

Despite these pressures, scores relating to team cohesion and compassionate practice remain relatively stable. This indicates that colleagues continue to demonstrate commitment to their roles and to one another, even within highly pressured circumstances. It also suggests that interventions implemented over recent years (including TED, Leadership and People Management development, and enhanced focus on recognition and wellbeing) may be helping to mitigate some of the impact, acting as a buffer against wider organisational challenges.

While this does not remove the need for further action, it indicates that our strategic focus remains appropriately directed and should be reinforced rather than fundamentally redirected.

TRUST PERFORMANCE AGAINST PREVIOUS YEARS

Table 1 provides a comparison of Trust results across the People Promise elements and themes from 2022 to 2025.

Key observations include:

- As previously reported, following steady improvement between 2022 and 2023 (where most measures demonstrated upward movement) 2024 represented a notable shift, with declines observed across all nine People Promise elements and themes which aligned with a period of significant operational and financial pressure across the organisation.
- As noted above, the 2025 results show a different pattern. Rather than continued widespread decline, the data suggests relative stabilisation across the majority of measures. Seven of the nine elements show minimal year-on-year movement (ranging between +0.01 and -0.04), indicating steadiness rather than further deterioration. We are safe and healthy, We are always learning, and We work flexibly show marginal improvement (+0.01), while We are compassionate and inclusive, We are a team, and Morale remain broadly stable.
- As described in the benchmark analysis above two areas demonstrate more notable movement. We each have a voice that counts has reduced by -0.09, and Staff Engagement has reduced by -0.14. The decline in Staff Engagement is the most pronounced shift this year and continues the downward trajectory from the 2023 high point (6.91). Given that Staff Engagement incorporates motivation, involvement and advocacy, this remains a key indicator requiring focused attention.
- Importantly, the scale of change between 2024 and 2025 is significantly smaller than seen between 2023 and 2024. This suggests that while overall scores remain below their 2023 peak, the rate of decline has slowed, and in several areas performance has stabilised.
- In summary, the trajectory across the four-year period shows three phases: improvement (2022–2023), systemic decline (2023–2024), and relative steadiness (2024–2025). The strategic priority now is to protect this stability while addressing the underlying drivers of engagement, voice and morale, to prevent further drift and support gradual recovery.

Trust performance against National Benchmark ‘best’

Table 2 shows the gap between the Trust’s results and the national benchmark ‘Best’.

Key insights include:

- In 2022 and 2023, gaps were positive (+0.3 to +0.5), indicating relative alignment with or outperformance of some national leaders.
- In 2024 this position shifted, when the gap moved from positive to negative across all elements. This represented a marked change in position relative to the top-performing Trusts and coincided with increased operational, financial and system pressures.
- The 2025 data indicates that this gap has widened further across most measures. While the movement year-on-year is incremental rather than dramatic, the distance to the highest-performing Trusts remains material.
- The largest gaps are within Staff Engagement (-0.87) and Morale (-0.74), followed by We are always learning (-0.67) and We each have a voice that counts (-0.61).
- Although the gaps are narrower within We are a team (-0.43) and We are compassionate and inclusive (-0.59), they remain below the benchmark ‘Best’ and have not reduced year-on-year. This suggests that while team-level resilience remains comparatively stronger, it has not been sufficient to close the performance distance to the highest-performing organisations.
- This widening gap is not solely a reflection of current morale, but has longer-term cultural implications. Where colleagues feel constrained by external pressures or reduced agency, sustaining a culture of empowerment and shared leadership becomes more challenging.
- If unaddressed, there is a risk that disengagement becomes embedded, making recovery slower and further widening the gap between our current position and our ambition to be a highly engaged, high-performing Trust.

GRAPH 1 – 2025 Staff Survey Results with National Benchmark for All People Promise Elements

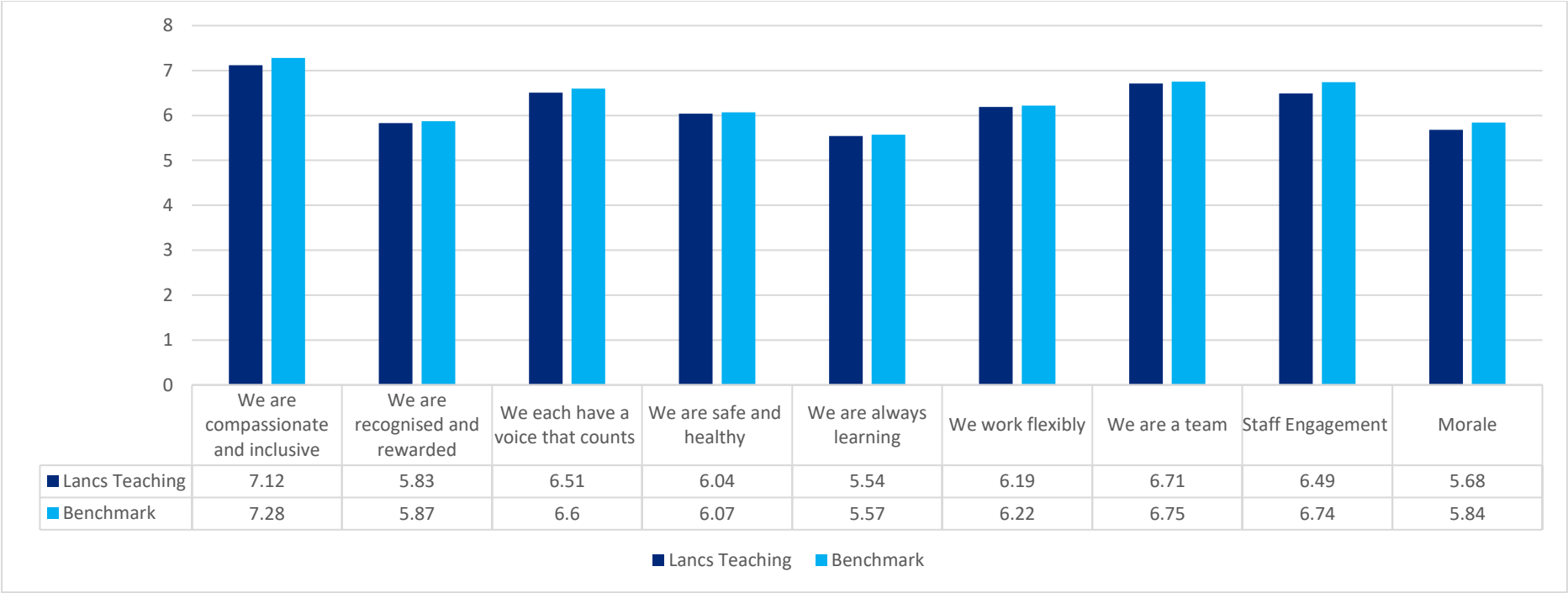


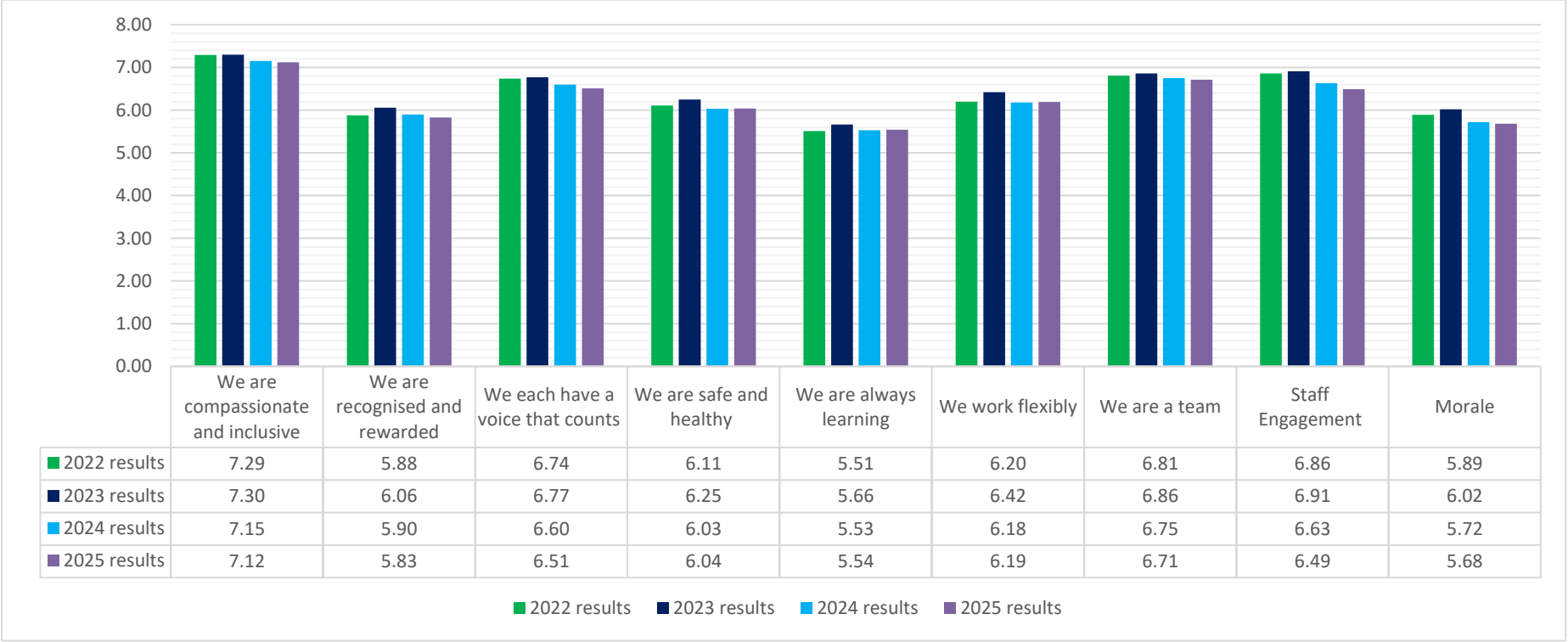
TABLE 1 – People Promise Results Comparison 2022 – 2025

People Promise Measures	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
2022 results	7.29	5.88	6.74	6.11	5.51	6.20	6.81	6.86	5.89
2023 results	7.30	6.06	6.77	6.25	5.66	6.42	6.86	6.91	6.02
2024 results	7.15	5.90	6.60	6.03	5.53	6.18	6.75	6.63	5.72
2025 results	**7.12**	**5.83**	**6.51**	**6.04**	**5.54**	**6.19**	**6.71**	**6.49**	**5.68**
Change 2024 v 2025	-0.03	-0.07	-0.09	0.01	0.01	0.01	-0.04	-0.14	-0.04

TABLE 2 - People Promise Gap Analysis between 'Best' and Trust 2022 - 2024

People Promise Measures	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Gap between LTH and Best 2022	0.4	0.5	0.4	0.3	0.4	0.4	0.3	0.4	0.4
Gap between LTH and Best 2023	0.42	0.31	0.39	0.33	0.41	0.44	0.33	0.41	0.50
Gap between LTH and Best 2024	-0.54	-0.40	-0.54	-0.50	-0.56	-0.68	-0.37	-0.76	-0.66
Gap between LTH and Best 2025	-0.59	-0.51	-0.61	-0.54	-0.67	-0.55	-0.43	-0.87	-0.74

GRAPH 2 - People Promise Measure Results - 2022-2025



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
2022 results	7.29	5.88	6.74	6.11	5.51	6.20	6.81	6.86	5.89
2023 results	7.30	6.06	6.77	6.25	5.66	6.42	6.86	6.91	6.02
2024 results	7.15	5.90	6.60	6.03	5.53	6.18	6.75	6.63	5.72
2025 results	7.12	5.83	6.51	6.04	5.54	6.19	6.71	6.49	5.68

SUB SCORES AND QUESTION ANALYSIS IDENTIFYING ITEMS FOR IMPROVEMENT IN 2025

Last year, the Organisational Development team improved the way we present the Staff Survey data to enable leaders and managers to better understand and engage with their results. We prepare data at Trust, Divisional, Department (SBU) and Team level in a user-friendly way and bring together previous data sets showing the changes to enable comparison and quicker analysis.

This year we have added additional insights to the Manager Dashboard to allow managers to see 'at a glance' their Top 5 highest scoring and lowest scoring questions, see which questions have shown biggest improvements and biggest decline in comparison to their previous years. The '**Team Level Results - Managers Dashboard**' has been provided in Appendix 2.

When reviewing individual questions at Trust level, across 99 comparable items, year-on-year changes range from -4.3% to +3.6%, with the majority reflecting small decreases between 0% and -2%.

Of the 99 questions:

- 12 show improvement year-on-year
- 27 remain broadly stable (within a +/-0.5% range)
- 60 show a reduction compared to 2024

Appendix 3 includes the standard Picker RAG-rated results for reference.

Table 3 below looks at both the questions which have shown a decline and presents these alongside the different facets called sub scores which make up each of the People Promise Elements. Where a question has declined, national benchmark comparison has also been included.

The purpose of this table is to help enable us, at an organisational level, to determine what actions we need to take to bring about improvements.

TABLE 3 – SUB SCORE ANALYSIS

SUB SCORE	COMPARISON TO NATIONAL AVERAGE	QUESTION ANALYSIS *Subtheme questions showing comparison changes in percentage points to the previous year, with the national benchmark (NA) included for reference.*
PROMISE ELEMENT 1 – WE ARE COMPASSIONATE AND INCLUSIVE		
Compassionate Culture	Below National Average (-0.56)	Sub-theme question above NA • I feel that my role makes a difference to patients / service users. +0.49 These sub-theme questions are below NA • Care of patients/service users is organisation's top priority -3.6% • Organisation acts on concerns raised by patients/service users -2.8% • Would recommend organisation as place to work -4.3% • If friend/relative needed treatment would be happy with standard of care provided by organisation -3.7%
Compassionate Leadership	Broadly aligned with national average (within ±0.05)	These sub-theme questions are below NA • My immediate manager works together with me to come to an understanding of problems -1.4 • My immediate manager is interested in listening to me when I describe challenges I face -1.5 • Immediate manager cares about my concerns -1.5% • My immediate manager takes effective action to help me with any problems I face -0.7%
Diversity and Equality	Above National Average	Sub-theme question above NA • Organisation acts fairly: career progression +0.08 • Last 12 months have you personally experienced discrimination at work from patients/public -0.86 • Last 12 months have you personally experienced discrimination at work from manager /colleague -0.07 This sub-theme question is below NA • Feel organisation respects individual differences -1.1%
Inclusion	Slightly below national average (0.06–0.15 difference)	These sub-theme questions are below NA • I feel valued by my team -2.5 • I feel a strong personal attachment to my team -2.35 • Colleagues are understanding and kind to one another –2.3% • Colleagues are polite and treat each other with respect -2.08%
PROMISE ELEMENT 2 – WE ARE RECOGNISED AND REWARDED		
Recognised and rewarded	Broadly aligned with national average (within ±0.05)	Sub-theme question above NA • Satisfied with recognition for good work -3.1% • My immediate manager values my work -0.5% These sub-theme questions are below NA • Satisfied with extent organisation values my work -1.9% • Satisfied with level of pay +0.3 • Colleagues show appreciation to one another -2.4%

PROMISE ELEMENT 3 – WE EACH HAVE A VOICE THAT COUNTS		
Autonomy and control	On National Average	Sub-theme questions above NA • I always know what my work responsibilities are +0.7 • Feel trusted to do my job -0.5% • Opportunities to show initiative frequently in my role -1.0% • Able to make suggestions to improve the work of my team/dept -0.9% • Involved in deciding changes that affect my work -2.2% These sub-theme questions are below NA • Able to make improvements happen in my area of work -1.7% • Have a choice in deciding how to do my work -1.25%
Raising concerns	Below National Average (-0.21)	These sub-theme questions are below NA • I would feel secure raising concerns about unsafe clinical practice. -3.4% • Would feel confident that org would address concerns about unsafe clinical practice -2.7% • Feel safe to speak up about anything that concerns me in this organisation -2.9% • Feel organisation would address any concerns I raised -1.8%
PROMISE ELEMENT 4 – WE ARE SAFE AND HEALTHY		
Health and safety climate	Below National Average (-0.16)	Sub-theme questions above NA • Have realistic time pressures – No change • Organisation takes positive action on health and well-being -1.2% • Last experience of physical violence reported +1.4% These sub-theme questions are below NA • Able to meet conflicting demands on my time at work +1.3% • Have adequate materials, supplies and equipment to do my work +0.3% • Enough staff at organisation to do my job properly +0.2% • Last experience of physical violence reported +1.4% • Last experienced harassment, bullying or abuse at work, reported? +0.8%
Burnout	On National Average	This sub-theme question is above NA • Never/rarely lack energy for family and friends +1.2% These sub-theme questions are below NA • Never/rarely find work emotionally exhausting -2.4% • Never/rarely feel burnt out because of work -2.6% • Never/rarely frustrated by work -0.8% • Never/rarely exhausted by the thought of another day/shift at work -2.1% • Never/rarely worn out at the end of work -1.7% • Never/rarely feel every working hour is tiring -2.0%
Negative experiences	Above National Average	All these sub-theme questions are on or above NA • In last 12 months, have not felt unwell due to work related stress +0.5% • In last 3 months, have not come to work when not feeling well enough to perform duties +0.5% • Not experienced physical violence from colleagues -0.1% • Not experienced harassment, bullying or abuse at work from patients/public -0.8% • Not experienced harassment, bullying or abuse at work from managers -0.01% • Not experienced harassment, bullying or abuse at work from colleagues +1.3% • Experienced at least one incident of unwanted behaviour of a sexual nature from patients/public? +0.4% • I can eat nutritious and affordable food while I am working -0.6%

		These sub-theme questions are below NA • Not experienced physical violence from patients/public -1.1% • Not experienced physical violence from managers -0.1% • Experienced at least one incident of unwanted behaviour of a sexual nature from staff? +0.5 Not comparable – Above NA • In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work
PROMISE ELEMENT 5 – WE ARE ALWAYS LEARNING		
Development	Slightly below national average (0.06–0.15 difference)	These sub-theme questions are below NA • This organisation offers me challenging work -2.6% • There are opportunities for me to develop my career in this organisation -3.6% • Have opportunities to improve my knowledge and skills -3.2% • Feel supported to develop my potential -2.8% • Able to access the right learning and development opportunities when I need to – 1.0% • I am able to access clinical supervision opportunities when I need to -0.6%
Appraisals	On National Average	This sub-theme questions are above NA • Have you had an appraisal in last 12 months? These sub-theme questions are below NA • Appraisal helped me improve how I do my job -1.2% • Appraisal helped me agree clear objectives for my work -2.8% • Appraisal left me feeling organisation values my work -2.0%
PROMISE ELEMENT 6 – WE WORK FLEXIBLY		
Support for work-life balance	On National Average	This sub-theme questions are on or above NA • Organisation is committed to helping balance work and home life +0.1% • Achieve a good balance between work and home life +0.6% • Can approach immediate manager to talk openly about flexible working +1.6%
Flexible working	Broadly aligned with national average (within ±0.05)	• Satisfied with opportunities for flexible working patterns +0.5%
PROMISE ELEMENT 7 – WE ARE A TEAM		
Team working	Broadly aligned with national average (within ±0.05)	These sub-theme questions are on or above NA • The team has a set of shared objectives -0.2% • Team members often meet to discuss the team's effectiveness +1.0% • Team members understand each other's roles -0.5% These sub-theme questions are below NA • I receive the respect I deserve from my colleagues at work -1.2% • I enjoy working with the colleagues in my team -1.4% • Team has enough freedom in how to do its work -0.9% • Team deals with disagreements constructively -1.2% • Teams within the organisation work well together to achieve objectives -1.1%

Line management	Broadly aligned with national average (within ±0.05)	This sub-theme questions are on or above NA • Immediate manager encourages me at work -1.0% • Immediate manager gives clear feedback on my work -0.8% • Immediate manager takes a positive interest in my health & well-being -0.9% These sub-theme questions are below NA • Immediate manager asks for my opinion before making decisions that affect my work – No change
STAFF ENGAGEMENT		
Motivation	Broadly aligned with national average (within ±0.05)	• Time often/always passes quickly when I am working -0.9% (Above NA) These sub-theme questions are below NA • Often/always look forward to going to work -2.2% • Often/always enthusiastic about my job -2.8%
Involvement	Broadly aligned with national average (within ±0.05)	These sub-theme questions are above NA • Opportunities to show initiative frequently in my role -1.0% • Able to make suggestions to improve the work of my team/dept -0.9% This sub-theme question is below NA • Able to make improvements happen in my area of work -1.7%
Advocacy	Below National Average (-0.75)	All these subtheme questions show a more significant gap compared to NA this year • Care of patients/service users is organisation's top priority -3.6% • Would recommend organisation as place to work -4.3% • If friend/relative needed treatment would be happy with standard of care provided by org -3.7%
MORALE		
Thinking about leaving	Below National Average (-0.24)	These sub-theme questions are below NA • I don't often think about leaving this organisation -2.0% • I am unlikely to look for a job at a new organisation in the next 12 months -0.8% • I am not planning on leaving this organisation -1.8%
Work pressure	Below National Average (-0.26)	These sub-theme questions are below NA • Able to meet conflicting demands on my time at work +1.3% • Have adequate materials, supplies and equipment to do my work +0.3% • Enough staff at organisation to do my job properly +0.2%
Stressors	Broadly aligned with national average (within ±0.05)	These sub-theme questions are on or above NA • Always know what my work responsibilities are +0.2% • Involved in deciding changes that affect my work -2.2% • Have a choice in deciding how to do my work -1.3% • Immediate manager encourages me at work -1.0% These sub-theme questions are below NA • Have unrealistic time pressures - no change • Relationships at work are strained -2.5% • Receive the respect I deserve from my colleagues at work -1.2%

FREE TEXT COMMENTS AND THEMES

Colleagues who completed the National Staff Survey were invited to provide any additional comments about working in this organisation, using a free-text answer option. This year, a total of 975 free-text responses were recorded from 4,271 total survey responses, meaning 23% of respondents provided a comment. This represents an increase compared with 22% in 2024 and reflects continued engagement from colleagues in sharing more detailed feedback.

Overall Sentiment

Each comment was themed to identify the overall sentiment and tone within the narrative.

It is important to note that because a single comment can contain mixed sentiment, totals exceed 100% of comments. Table 4 presents the distribution of sentiment across this year's comments, alongside a comparison with 2024. Negative volume has grown year-on-year and remains the dominant tone however there are small upticks in positive and neutral.

TABLE 4 – Free text comments overview of sentiment and tone

Overall sentiment and tone	Frequency count 2025	Frequency count 2024
Positive	**145**	137
Negative	**836**	782
Neutral	**68**	41

Comments were analysed further. Table 5 shows the high-level themes and table 6 gives a breakdown of the high-level themes split into sub themes. The sub themes have been ordered by highest count to help give an indication of where improvements are required to enhance levels of satisfaction and engagement.

TABLE 5 – High Level Themes Frequency Count

High Level Theme	Frequency Count 2025	Frequency Count 2024
Staff Engagement / Morale / Hygiene Factors (Carparking, IT, Estate, Catering)	**586**	631
Health, Safety and Wellbeing/Flexible Working	**581**	289
Culture / Leadership/ Inclusion	**495**	434
Team Working (including Staffing/ Resources)	**428**	433
Development/Career	**109**	95

TABLE 6 – Sub Theme Frequency Count

High Level Theme	Sub Theme	Frequency Count 2025	Frequency Count 2024
Culture / Leadership/ Inclusion	**Leadership/Line manager**	**264**	211
Team Working	**Resources & Staffing**	**229**	180
Health, Safety and Wellbeing/Flexible working	**Advocacy/Patient Safety**	**215**	62
Health, Safety and Wellbeing/Flexible working	**Health & Wellbeing/Policies**	**158**	33
Staff engagement / Morale / Hygiene Factors (Carparking, IT, Estate, Catering)	**Motivation/Morale**	**116**	50
Health, Safety and Wellbeing/Flexible working	**Workload/work pressures**	**112**	50
Staff engagement / Morale / Hygiene Factors (Carparking, IT, Estate, Catering)	**Recognition / Valued**	**110**	49
Team Working	**Team working**	**108**	76
Team Working	**Communication**	**79**	34
Culture / Leadership/ Inclusion	**Culture**	**73**	57
Staff engagement / Morale / Hygiene Factors (Carparking, IT, Estate, Catering)	**Pay**	**65**	47
Staff engagement / Morale / Hygiene Factors (Carparking, IT, Estate, Catering)	**Thinking about leaving**	**61**	37
Culture / Leadership/ Inclusion	**Raising concerns**	**58**	35
Staff engagement / Morale / Hygiene Factors (Carparking, IT, Estate, Catering)	**Stress/Anxiety**	**57**	27
Health, Safety and Wellbeing/Flexible working	**Burnout**	**55**	20
Development/Career	**Progression**	**54**	46
Culture / Leadership/ Inclusion	**D+E**	**46**	33
Development/Career	**Development**	**46**	35
Staff engagement / Morale / Hygiene Factors (Carparking, IT, Estate, Catering)	**Car Parking**	**43**	57
Staff engagement / Morale / Hygiene Factors (Carparking, IT, Estate, Catering)	**Estate**	**41**	New theme
Staff engagement / Morale / Hygiene Factors (Carparking, IT, Estate, Catering)	**Involvement**	**41**	24
Culture / Leadership/ Inclusion	**Personal Safety i.e. Bullying/ Harassment/Violence/Aggression**	**35**	28
Health, Safety and Wellbeing/Flexible working	**Flexible/Agile Working**	**29**	26
Culture / Leadership/ Inclusion	**Inclusion**	**19**	15
Staff engagement / Morale / Hygiene Factors (Carparking, IT, Estate, Catering)	**Health/Safety**	**17**	3
Staff engagement / Morale / Hygiene Factors (Carparking, IT, Estate, Catering)	**Recruitment Processes**	**13**	11
Team Working	**Autonomy & Control**	**12**	0
Staff engagement / Morale / Hygiene Factors (Carparking, IT, Estate, Catering)	**IT**	**12**	New theme
Health, Safety and Wellbeing/Flexible working	**Work-Life Balance**	**12**	18
Staff engagement / Morale / Hygiene Factors (Carparking, IT, Estate, Catering)	**Catering**	**10**	9
Development/Career	**Appraisals**	**9**	3

Free Text Comments - Qualitative Analysis

The qualitative data provides important context to the quantitative results outlined earlier in this report. While overall score movements at Trust level are relatively modest, the free text comments demonstrate a more pronounced and emotionally charged narrative around leadership, staffing, safety, and organisational direction.

The analysis identifies five dominant themes in the 2025 free text comments: Leadership / Line Manager, Resources & Staffing, Advocacy / Patient Safety, Health & Wellbeing / Policies and Motivation / Morale.

Although several themes interrelate, the first three in particular show strong cross-linkage and form a consistent narrative pattern which appears from interpretation of the comments to relate across all staff groups, roles and departments.

THEME – Leadership and Line Management (264 comments)

Leadership remains the most frequently referenced theme within the qualitative data this year.

There is a clear distinction in the narrative between experiences of immediate line management and perceptions of organisational-level leadership. Many colleagues describe supportive relationships with their direct managers, particularly in relation to wellbeing and day-to-day operational support. However, comments indicate a recurring perception of distance between strategic decision-making and frontline operational realities. Across divisions, colleagues describe a desire for:

- Greater visibility of senior leaders within clinical and operational environments
- Clearer line of sight between financial decisions and their impact on patient care
- Stronger opportunities to influence decisions that directly affect their teams

Several comments reference a perception of a “top-heavy” structure, particularly in the context of staffing pressures. These perceptions are often linked to wider concerns about fairness and prioritisation rather than leadership capability.

Colleagues also describe occasions where consultation processes did not feel fully translated into action, contributing to reduced confidence that their voice influences outcomes. While not universal, this theme is sufficiently consistent to suggest it reflects a broader perception rather than isolated feedback.

Illustrative comments include:

- *“There is a real disconnect between what actually happens day to day and what senior teams think happens.”*
- *“I feel supported by my immediate management structure… it is the wider management structure that I struggle with.”*
- *“We would welcome more opportunities for senior leaders to see firsthand the pressures experienced on wards.”*

Analysis:

The strength and consistency of this theme suggests that engagement at Trust level is influenced not simply by communication frequency, but by perceived influence, visibility and organisational fairness. This aligns with lower scores in voice and advocacy-related survey measures and may represent an area where targeted action could positively influence overall engagement.

THEME – Resources and Staffing (229 comments)

Concerns regarding staffing levels and resourcing remain one of the most prominent themes within the qualitative data and are closely interlinked with perceptions of patient safety, morale and organisational prioritisation.

Colleagues across areas describe sustained staffing pressures, including vacant posts, increased redeployment, delays in recruitment processes, and reduced administrative support. There are also recurring references to equipment availability, estate issues, and infrastructure challenges impacting day-to-day efficiency.

Many comments acknowledge the wider financial context facing the NHS; however, the operational impact of cost control measures is frequently described as increasing workload and reducing capacity to deliver care in the way colleagues would wish. There is also a perception in some areas that the distribution of financial constraint is uneven, contributing to feelings of inequity between roles, departments or sites.

Illustrative comments include:

- *"We are constantly working on skeleton staff… staff are working beyond their capacity and are not able to provide the care that they want to."*
- *"We do not have enough equipment and resources… this adds to work pressures and impacts on patient care."*
- *"Vacancy approved but take months to advertise, leaving teams stretched in the meantime."*

Analysis:

This theme reflects not only operational challenge but also symbolic interpretation. Staffing levels are frequently viewed as an indicator of organisational priority, and therefore strongly influence morale, advocacy and engagement.

THEME – Advocacy and Patient Safety (215 comments)

Advocacy and patient safety are strongly represented within this year's qualitative responses and are closely linked to the Resources and Leadership themes.

Colleagues describe concern that current operational pressures, including staffing constraints and use of border beds, may impact the quality and dignity of care. While many express continued pride in their professional standards and commitment to patients, there is evidence of moral tension where colleagues feel unable to consistently deliver care at the level they expect of themselves.

There are also references to discharge processes, patient flow pressures, and perceived prioritisation of efficiency metrics, which some colleagues feel can conflict with clinical judgement. Importantly, these concerns appear rooted in professional values rather than disengagement. Many comments combine criticism with clear expressions of loyalty to patients and teams.

Illustrative comments include:

- *"Border beds are unsafe and undignified for patients."*
- *"We are trying our best with less staff, but it does not always feel safe."*
- *"I love my patients, but it is hard to give the level of care they deserve under current pressures."*

Analysis:

This theme aligns closely with the decline in Staff Engagement, particularly as this incorporates measures of advocacy. Perceptions of patient safety and care standards seen in the free text reflect the deterioration seen in the question 'would recommend care' and is strategically significant because it extends beyond patient experience into employer reputation.

In many sectors, belief in the organisation's core product or service underpins employee advocacy. Within healthcare, where professional identity is closely aligned to quality of care, this relationship is particularly strong. Where colleagues feel unable to confidently recommend the Trust as a place to receive treatment, this may also influence their willingness to recommend it as a place to work, with potential implications for retention and attraction.

THEME – Health & Wellbeing / Policies (158 comments)

Health and wellbeing concerns remain significant within the qualitative data and are frequently associated with workload pressures and policy implementation. A notable proportion of comments reference the revised sickness absence policy. While the policy intent may be understood, colleagues describe anxiety around trigger points and concern about attending work while unwell. This suggests the policy carries emotional as well as procedural impact.

Burnout, exhaustion and sustained pressure are recurring in the comments. Although positive feedback is provided regarding specific wellbeing services, colleagues frequently report difficulty accessing support due to workload or shift patterns.

The theme also links with perceptions of fairness, particularly in relation to flexible working, family responsibilities and return-to-work processes.

Illustrative comments include:

- *"The changes to the sickness policy have made it difficult to take time off when unwell."*
- *"Staff are exhausted and feel unable to access wellbeing support due to workload."*
- *"We feel expected to give more and more despite being short staffed."*

Analysis:

Health and wellbeing comments appear to reflect ongoing pressure rather than a single reaction to one issue. The tone suggests sustained fatigue across teams rather than isolated frustration.

Feedback about sickness policy and flexible working is often less about the detail of the policy itself and more about how it feels in practice. For some colleagues, these policies influence whether they feel trusted, treated fairly and valued.

There are also signs that this pressure may be affecting behaviour, for example colleagues coming to work when unwell or feeling hesitant to raise concerns. Over time, this can have implications for both staff wellbeing and patient care.

Importantly, many colleagues remain deeply committed to their roles and to patient care. However, some comments suggest a shift from feeling proud to feeling worn down. This highlights the importance of ensuring policies are implemented with clarity, fairness and visible support.

THEME – Motivation and Morale (116 comments)

Comments about morale present a mixed picture. Many colleagues still speak positively about their immediate teams and take pride in the work they do. However, there is a noticeable theme of fatigue and frustration, and a sense that optimism has reduced compared to previous years.

Several comments appear from long-serving staff describe feeling that the organisation has changed over time, particularly in relation to financial pressures and how decisions are experienced locally.

There are references to people considering leaving, most commonly linked to workload, pay, lack of progression and feeling they have little influence over decisions that affect them.

It is important to note that morale concerns appear to be driven more by wider organisational pressures than by breakdown within teams. In many areas, team relationships remain strong despite the broader challenges.

Illustrative comments include:

- *"I used to be proud to say I worked here… now it feels different."*
- *"Staff are worn out and morale is low."*
- *"I love my team and my patients, but the wider pressures are difficult."*

Analysis:

Morale appears to be shaped more by ongoing operational pressures than by any single change. The consistency of comments about workload, staffing gaps, recruitment freezes and being expected to "do more with less" reflects comments running through the feedback around feeling valued.

It's clear that 'feeling valued' does not relate primarily to recognition schemes or reward initiatives. Instead, colleagues describe feeling less valued when staffing levels are stretched, when vacancies remain unfilled, when policies feel rigid, or when changes are implemented without visible involvement or explanation.

While many colleagues remain committed to their roles and teams, the persistence of these themes indicates a risk of longer-term disengagement if fairness, transparency and visible progress are not clearly demonstrated.

Summary

Across the dominant themes, a consistent pattern emerges. Team-level commitment and professional pride remain strong; however, there is a perception gap at organisational level relating to visibility, influence, fairness and prioritisation.

The qualitative data suggests that colleagues continue to care deeply about patient care and organisational success but sustained financial and operational pressures are shaping how decisions are experienced on the ground. Addressing these perceptions will be critical in strengthening trust, advocacy and engagement moving forward.

Based on the findings from the free-text comments and question data, clear priorities have emerged for us as a Trust. The next step is to develop and agree on both Divisional and Corporate-level action

plans to address priority areas for improvement and continue enhancing staff satisfaction, morale, and overall engagement.

DIVISIONAL & TEAM LEVEL FINDINGS

This section further enhances the high-level information provided in the January 2025 Workforce Committee. Divisional Workforce Committees have been provided with their data set, guidance around the next steps and opportunity to discuss further and identify action and where Organisational Development (OD) support to be prioritised.

Out of the 245 teams eligible for a report, 157 teams will receive a team report, and 88 teams (36%) will not receive a report. This is because there is a minimum threshold of 10 responses to enable the report to be available. This shows an improvement on last year where we saw 110 teams not receive a report (41%).

Reviewing Team Support Progress from 2024

Following the 2024 Staff Survey results, a cohort of teams was identified for enhanced support and targeted development. The purpose of this approach was to enable the Organisational Development team to proactively engage with those teams demonstrating lower scores, offering tailored interventions and support. By doing so, we aim to drive organisation-wide improvements in staff experience and satisfaction across all nine People Promise elements and ultimately help teams strengthen their overall working environment.

This year's analysis goes beyond headline scores. Rather than simply noting movement in engagement, we have reviewed patterns across the full range of drivers to understand where change is broad and embedded, where it is mixed, and where there are signs of sustained decline.

Teams demonstrating broad-based improvement

A number of teams show a clear and consistent improvement pattern across several themes — typically including teamworking, line management, engagement, morale and recognition moving in the same direction.

The strongest "all-round" improvement profiles include:

438 03 Main X-Ray (CDH) (T36314)

Significant gains in teamworking (+0.98), line management (+1.65), engagement (+0.67), morale (+0.78) and recognition (+1.00), alongside improvement in work pressure and stressors. This represents a strong culture and workload improvement pattern.

438 04 Plastics Ward 4 (RPH) (T35726)

Continued strengthening across team (+1.05), involvement (+1.41), engagement (+0.98), morale (+0.42) and recognition (+0.62). This is an example of a high-performing team consolidating and building further.

438 14 ENT DoSA & Day Case Ward (RPH) (T35174)

Improvement across teamworking (+1.64), engagement (+0.45), morale (+0.94), work pressure (+1.47) and recognition (+1.19). The combined uplift across culture and workload drivers is particularly notable.

438 15 Hospital Capacity Management Team (T35444)

Broad improvement across team, line management (+1.46), engagement (+0.35), morale (+0.57) and recognition (+0.78), indicating a strengthening leadership and team environment.

Further positive movement is also evident in:

- 438 01 Anaesthetics Pre-Op (RPH) (T35315)
- 438 08 Gynaecology Outpatients (RPH) (T36018)
- 438 08 Specialist Midwives (T36006)
- 438 25 Medical Engineering (T36830)
- 438 11 RTT Validation & Assurance Team (T37416)
- 438 06 Surgery Divisional Management Team (T35123)

Across these teams, improvement is not isolated to one indicator. Gains in line management and teamworking are typically accompanied by improved motivation and involvement, leading to stronger engagement and morale outcomes. Recognition scores have also increased in most of these teams, reinforcing the link between feeling valued and overall experience.

Teams showing stability with mixed movement

A smaller group of teams remain broadly stable year-on-year, with limited movement in headline engagement and morale scores, or improvement in one theme offset by decline in another.

These include:

- 438 01 Theatres – Scrub (CDH) (T35324)
- 438 17 Emergency Department (RPH) (T35502)
- 438 02 Ribblesdale Ward (T35905)
- 438 01 Anaesthetics Medical (T35301)
- 438 12 Haematology Main Dept (T36201)

In these teams, results suggest a holding position rather than clear upward or downward trajectory. For example, some have improved line management or teamworking scores, but this has not yet translated into stronger engagement or morale. Others show stable engagement but declining advocacy or involvement.

This pattern indicates that while deterioration is not evident, there remains opportunity to strengthen the underlying drivers that convert stability into improvement.

Teams demonstrating further decline

A number of teams show consistent downward movement across several themes. In these teams, reductions in teamworking and line management are typically accompanied by falls in motivation, involvement and recognition, alongside worsening intention to leave.

The most significant decline profiles include:

438 77 ELFS Payroll (TE2001)

Engagement (-0.87), morale (-1.08), team (-1.24), line management (-1.53), recognition (-1.21) and a significant increase in intention to leave (-2.14). This represents the most pronounced deterioration in the cohort.

438 06 Urology Ward 10 (RPH) (T35005)

Broad decline across engagement (-0.89), morale (-1.23), recognition (-1.05) and intention to leave (-1.57).

438 06 Surgical Assessment Unit (SAU) (RPH) (T35022)

Reductions across engagement (-0.86), morale (-1.00), involvement (-1.35), work pressure (-1.08) and recognition (-0.80).

Others include:

- 438 14 Audiology (T35170)
- 438 12 Clinical Biochemistry (T36224)
- 438 01 Gynaecology Theatres – Scrub (RPH) (T36017)
- 438 01 Gynaecology Theatres – Anaesthetics (RPH) (T36030)
- 438 22 Clinical Audit (T36507)

Across these teams, the pattern is consistent rather than isolated. Decline in foundational culture measures (teamworking and line management) appears to cascade into reduced engagement and morale, often alongside increased intention to leave and lower recognition.

Common drivers emerging across the dataset

Three consistent drivers are evident across the full range of teams:

1. **Motivation and involvement are the strongest predictors of engagement movement.** Where motivation and involvement improve (e.g. Main X-Ray, Plastics Ward 4, ENT DoSA), engagement increases. Where they decline (e.g. Urology Ward 10, SAU, ELFS Payroll), engagement consistently falls.
2. **Morale tracks workload experience and recognition.** Improvements in work pressure and stressors, alongside stronger recognition scores, are closely linked to rising morale (e.g. Medical Engineering, ENT DoSA, Hospital Capacity Management). Conversely, where recognition falls sharply, morale tends to follow.
3. **Teamworking and line management act as the foundation layer.** Where both improve together, broader outcomes strengthen. Where both decline, deterioration is rarely confined to one area. This reinforces the importance of visible leadership, clarity, and team cohesion as central levers for improvement.

Overall, this year's analysis provides a more understanding than the previous year's headline-only review. It enables clearer identification of where improvement is embedded, where stability requires further focus, and where targeted support is required to prevent further decline and mitigate retention risk.

2025 Team Level Results Analysis

This year's team analysis has been undertaken across all teams with valid 2025 Staff Survey data. The review focuses on four core People Promise outcome measures which provide a balanced view of culture, engagement and team working risk:

- Overall "We are recognised and rewarded"
- Overall "We are a team"
- Overall Staff Engagement
- Overall Morale

Each team has been reviewed against:

1. **Trust 2025 averages**
    - Recognition: 5.79
    - We are a team: 6.69
    - Engagement: 6.48
    - Morale: 5.66

2. **Direction of travel from 2024 to 2025, identifying significant declines (≥ -0.5) across the four headline measures.**

Rather than producing a single "low performing" list, this year's analysis introduces a tiered model. This allows us to distinguish between immediate priority teams, those showing early signs of vulnerability, and high-performing teams from whom we may be able to learn.

The 2025 analysis demonstrates that performance is not evenly distributed across the organisation. There is:

- A small but important group requiring immediate targeted support
- A broader preventative cohort
- A strong group of high-performing teams whose practice can inform improvement elsewhere

This approach represents a more detailed analysis than previous years, moving beyond headline engagement scores to consider both position and trajectory.

Tier 1 – Priority OD support

These teams are:

- Below Trust average across all four headline measures
  AND

- Showing significant decline in two or more areas

This combination indicates structural culture risk rather than isolated score fluctuation.

Tier 1 teams

- 438 01 Theatres – Scrub (RPH) (T35302)
- 438 03 Radiology Nursing (T36306)
- 438 06 Surgical Assessment Unit (SAU) (RPH)
- 438 06 Urology Ward 10 (RPH)

- 438 08 Midwifery Integrated Services
- 438 10 Neonatal Unit (RPH)
- 438 10 Paediatrics Assessment Unit
- 438 11 Call Centre
- 438 14 ENT Ward 3 (RPH)
- 438 16 Renal Management
- 438 27 Student, Trainee & Placement Support
- 438 77 ELFS Payroll (TE2001)
- 438 05 Respiratory Ward 23
- 438 08 W&C Divisional Management Team

Across these teams, low recognition, weakened team climate, reduced engagement and declining morale are occurring together. When low scores and decline appear together across measures, it indicates broader cultural strain rather than isolated movement in one area and therefore priority for Divisional and OD support.

Tier 2 – Watch / preventative cohort

These teams are:

- Below Trust average in two to three measures
  OR
- Showing early signs of decline in one or more measures

They are not showing the deterioration seen in Tier 1, but without intervention may decline further.

Across this group we typically see:

- Reasonable team climate but softer morale
- Good engagement but emerging recognition issues
- Strong team working but rising work pressure
- Stable performance but one or two measures slipping

This group would benefit from support with interventions likely to be lighter-touch and locally led, with targeted support where required.

- 438 01 Anaesthetics Medical (T35301)
- 438 01 Anaesthetics Pre-Op (RPH) (T35315)
- 438 01 Gynaecology Theatres – Anaesthetics (RPH) (T36030)
- 438 01 Gynaecology Theatres – Scrub (RPH) (T36017)
- 438 01 Theatres – Scrub (CDH) (T35324)
- 438 02 Ribblesdale Ward (T35905)
- 438 03 Main X-Ray (CDH) (T36314)
- 438 04 Plastics Ward 4 (RPH) (T35726)
- 438 05 Elderly Rookwood A (CDH) (T35435)
- 438 06 Surgery Divisional Management Team (T35123)
- 438 06 Surgical Ward (CDH) (T35020)
- 438 07 Neurology Management (T35763)
- 438 08 Gynaecology Outpatients (RPH) (T36018)

- 438 08 Specialist Midwives (T36006)
- 438 09 Orthopaedics Fracture Clinic (RPH) (T35111)
- 438 09 Orthopaedics Ward 14 (RPH) (T35102)
- 438 11 RTT Validation & Assurance Team (T37416)
- 438 12 Clinical Biochemistry (T36224)
- 438 12 Haematology Main Dept (T36201)
- 438 14 Audiology (T35170)
- 438 14 ENT DoSA & Day Case Ward (RPH) (T35174)
- 438 15 Hospital Capacity Management Team (T35444)
- 438 17 Emergency Department (RPH) (T35502)
- 438 17 Paediatric Emergency Department (RPH) (T35578)
- 438 18 MAU (CDH) (T35437)
- 438 22 Clinical Audit (T36507)
- 438 25 Medical Engineering (T36830)
- 438 25 Portering (RPH) (T36820)
- 438 27 Clinical Education (T37018)
- 438 27 Research CHRI Cancer (T36660)

Tier 3 – Positive / higher performing teams

These teams are above Trust average across all four headline measures. A total of 53 teams meet this threshold. Examples include:

- 438 30 Trust HQ
- 438 16 Westmorland Renal Centre (WGH)
- 438 06 Stoma Care Specialist Nurses
- 438 14 Oral Outpatients (RPH)
- 438 11 Clinical Investigation Unit (CDH)
- 438 02 Oncology Outpatients
- 438 11 Outpatients (CDH)
- 438 22 Safeguarding
- 438 06 Rawcliffe Surgical Day Case Unit (CDH)
- Pharmacy Tech & Commissioning
- Pharmacy Medicines Safety
- 438 01 Critical Care Medical
- 438 01 Critical Care Outreach
- 438 02 Chemotherapy Day Case Unit (RPH)
- 438 02 Oncology Medical

These teams demonstrate strong culture foundations, positive team climate and healthier morale profiles. They provide valuable opportunities for learning and sharing any effective local practice.

Next steps

The next phase of work will:

- Work with Workforce colleagues to review sickness absence data alongside these team to triangulate further and adjust priorities where needed.

- Work with the STAR audit team to cross-reference clinical performance data where applicable, ensuring alignment between staff experience and service quality indicators

This integrated approach will strengthen our understanding of where cultural, workforce and clinical performance indicators intersect and allow more targeted, proportionate support.

Working with Divisional Workforce Committee, we will:

- Agree the priority teams for supportive intervention by Organisational Development.
- Make initial contact with the team leaders to contract and agree the appropriate support and OD interventions
- Continue to communicate and provide progress updates with Divisional leadership teams
- Support Divisions to identify and agree their own Staff Survey plans for action aligned to their Divisional People Plans.
- Celebrate and communicate with higher performing and improver teams from the staff survey results to engage and continue to learn management practices and activities these leaders undertake as part of an exercise to capture and share best practice across the Trust.
- Further work will be undertaken as part of the corporate level action plan to review the teams who have not reached the reporting threshold to understand if other data sets could provide insight as to if these teams are cause for concern. We will also prepare a targeted communication with the managers of these teams to feedback on their response rate and encourage improvement for the 2026 survey.

Further data analysis to support divisions

Following discussion at January's Workforce Committee an action was taken to provide Divisions with a more detailed breakdown of their Staff Survey results alongside EDI data. The intention is not simply to share additional information, but to enable Divisional teams to reflect on what this means for their local workforce and consider targeted actions where required.

To support this, additional reporting has been requested from our external provider, Picker.

Workforce profile by division

Each Division will receive an updated Workforce Profile so that they are clear on:

- The composition of their workforce
- Representation across bands, professional groups, age
- Representation across ethnicity, disability and gender

This ensures discussions about experience are grounded in an understanding of who makes up the workforce locally.

The following reports will be provided to enable more focused local conversations:

Division & Ethnicity: This will show how colleagues from ethnic minority backgrounds feel at Divisional level, with comparison to the previous year. This supports Divisions to understand whether experiences differ across ethnic groups and whether local action is required.

Division, Ethnicity & Band: This will allow us to explore how colleagues from ethnic minority backgrounds experience work at different bands within each Division. This helps identify whether experience varies by seniority or role level.

Division & Disability: This will show how colleagues who identify as having a disability feel at Divisional level, with year-on-year comparison. This supports understanding of accessibility, inclusion and reasonable adjustment culture locally.

Division, Disability & Band: This will explore how colleagues with a disability experience work at different bands within Divisions.

(*Note: In some areas numbers may be too small to report robustly.*)

Staff Grouping at Divisional Level (2023, 2024, 2025): This will enable Divisions to compare experience across staff groups within their own area. For example:

- How do nurses in Medicine feel compared to nurses in Surgery?
- Do administrative colleagues experience work differently to clinical colleagues within the same Division?
- Are there differences between AHPs, medical staff and support staff locally?

This supports more targeted action rather than assuming a single Divisional narrative.

Additional areas being explored

At Divisional level we are also exploring experience across gender and employee group. This will allow Divisions to consider whether experience differs meaningfully across these groups and where focused leadership attention may be required. This represents a continued shift towards more mature use of staff survey data - moving beyond overall scores and towards understanding lived experience across different groups within Divisions.

SUMMARY AND CORPORATE LEVEL ACTION PLAN

The 2025 Staff Survey results demonstrate relative stabilisation following the more significant decline observed between 2023 and 2024. However, the data also confirms that performance remains below national averages across all People Promise elements, with the most material gaps in:

- Staff Engagement (-0.14 year-on-year; -0.87 gap to national ‘Best’)
- Advocacy (-0.75 below national average)
- Morale and intention to leave (-0.24 below national average)
- Confidence in raising concerns (-3.4% below national average on security raising unsafe practice)

Of 99 comparable questions, 60 have reduced year-on-year. While many movements are modest in scale, the direction of travel is consistent. Qualitative feedback (975 comments) reinforces this pattern. The dominant themes are:

- Leadership visibility and influence
- Staffing and operational pressure
- Advocacy and patient safety
- Sustained wellbeing strain
- Morale and feeling valued

Across the dataset, team-level commitment remains comparatively strong. The emerging risk is not collapse of culture at team level, but erosion of organisational trust, influence and advocacy if sustained pressures are not visibly addressed.

In response, the Corporate Action Plan will focus on six priority areas.

1. Strengthen organisational voice and influence

Decline in “We each have a voice that counts” and raising concerns measures indicates a need to reinforce colleague influence and confidence. The Your Voice programme will remain the primary Trust-wide engagement mechanism. Recommended corporate focus:

- Continue and formally embed the *Your Voice* programme as the central Trust-level engagement mechanism.
- Publish a quarterly “You Said – We Are Doing” summary demonstrating visible action against both Staff Survey and Your Voice feedback.
- Introduce structured follow-up loops for major change programmes, ensuring colleagues receive feedback on how their input influenced decisions.
- Strengthen executive visibility through structured back-to-the-floor engagement aligned to high-pressure services.

2. Protect patient advocacy and professional pride

Advocacy scores have shown the most significant deterioration. Declines in recommending the organisation as a place to work (-4.3%) and confidence in care standards (-3.7%) are strategically significant and 215 qualitative comments referenced patient safety. Recommended corporate focus:

- Clearer communication linking financial decisions to patient safety mitigation
- Triangulation of staff experience with clinical quality indicators
- Reinforcement of Zero Tolerance and Speak Up mechanisms
- Take all opportunities to discuss with staff and embed a narrative reconnecting professional pride to organisational direction

Restoring confidence in care standards is critical not only for engagement, but for reputation, recruitment and retention.

3. Address the Impact of Staffing and Operational Pressure

Staffing and workload remain the most consistently referenced qualitative themes. While financial and workforce constraints remain real, the recommended corporate focus:

- Clear communication regarding workforce plans, headcount reductions and vacancy controls
- Clear communication of recruitment timelines and prioritisation
- Targeted support to the highest-risk teams identified in Tier 1

The objective is to stabilise burnout, workload and morale indicators within the next survey cycle.

4. Reframe “Feeling Valued” as a Systemic Experience

Survey and qualitative findings indicate that “feeling valued” is less associated with reward initiatives and more with:

- Staffing sufficiency
- Fairness and proportionality in policy implementation
- Involvement in decision-making
- Visible leadership presence

This suggests that organisational actions intended to recognise or reward colleagues will have limited impact if wider operational pressures remain unaddressed. Corporate focus will therefore prioritise improving clarity, transparency and engagement around organisational decisions, ensuring that both large-scale change and local operational adjustments are communicated effectively and discussed with those affected where possible.

This will be supported by continued investment in leadership and people management development to strengthen the quality of conversations, engagement and decision-making at local level. alongside continued investment in leadership and people management development.

5. Targeted Team-Level Intervention

A tiered analysis model has identified teams below Trust average across four core measures and declining along with those high performing. It is recommended that Organisational Development Team work to.

- Prioritise Tier 1 teams for structured OD intervention
- Integrate Staff Survey, sickness and clinical performance data for more precise targeting
- Capture and share learning from Tier 3 high-performing teams
- Progress will be measured through movement in engagement, morale and recognition measures in 2026.

6. Sustain and Improve Response Rates

Response rate has improved to 45.1% but remains below the 47% national benchmark.

Given the correlation between response rate and engagement indicators, increasing participation will be a priority for the 2026 survey cycle. Recommended corporate focus includes

- Increased visible executive sponsorship of 2026 survey cycle
- Continue to provide Divisions and Managers with targeted response-rate dashboards and targeted communications
- Engage teams below reporting threshold with bespoke communication and face to face team visits

Integration with the Your Voice Programme

Alongside other forums and networks the *Your Voice* programme and associated action plan remains a primary delivery mechanism for our corporate level actions. The Staff Survey Corporate Action Plan must:

- Be aligned and reference the existing five ‘Your Voice’ themes
- Avoid duplication of initiatives
- Continue to use ‘Your Voice’ sessions to discuss further and co-design with staff
- Ensure dynamic updating of actions as further feedback emerges

This ensures the Staff Survey does not operate as a standalone annual response, but as part of an ongoing engagement cycle.

CONCLUSION

The 2025 results reflect stabilisation following systemic pressure, continued team-level resilience and an emerging strain in organisational-level trust and advocacy.

The key objective for 2026 is therefore to protect stability, rebuild organisational trust, reinforce professional pride and target areas of sustained strain.

FINANCIAL IMPLICATIONS

Research shows that organisations with higher staff satisfaction and engagement tend to achieve stronger financial performance. Enhancing the overall staff experience - particularly in areas of concern - is critical for maintaining operational effectiveness and long-term sustainability.

Evidence from the NHS Staff Survey and national workforce research consistently demonstrates a strong relationship between staff engagement, patient experience, safety outcomes and organisational performance.

A decline in engagement, morale, and advocacy, alongside increasing apathy, can have significant financial consequences for the Trust, including:

- **Productivity Loss and Reduced Efficiency -** Disengaged employees are less motivated to contribute beyond their basic duties, leading to inefficiencies, reduced work quality, and slower processes. This not only impacts service delivery but also increases operational costs.

- **Increased Turnover and Associated Costs -** Low morale and dissatisfaction often lead to higher turnover, resulting in:
    - Increased need for recruitment, onboarding, and training expenses
    - A heavier workload for remaining staff, increasing burnout risks
    - Loss of institutional knowledge and expertise, reducing overall effectiveness
    - Delays in service delivery due to unfilled vacancies

- **Rising Absence and Presenteeism Costs –** Disengaged employees are more likely to take increased sick leave, adding pressure on remaining staff and overall raising costs associated with sickness absence or temporary staffing. Presenteeism may also increase, reducing productivity, increasing the likelihood of mistakes and posing potential safety risks in healthcare settings.

- **Retention Costs -** If retention rates decline and absence increases, the organisation may need to revert to more costly agency use. This not only inflates workforce expenditure but also disrupts team cohesion and service continuity.

- **Increased Regulatory and Compliance Risks** - Lower engagement levels are associated with reduced adherence to best practice, increased risk of error, and weaker safety culture.. Poor engagement levels in healthcare settings may negatively affect CQC ratings, potentially leading to funding reductions and loss of public trust.

- **Decline in Innovation and Problem-Solving -** Highly engaged teams contribute ideas that drive efficiency and cost-saving initiatives. When apathy rises, fewer employees participate in innovation, limiting opportunities for service improvement and financial sustainability.

- **Reputational Damage and Recruitment Challenges -** A decline in advocacy can damage the organisation's external reputation, making it harder to attract top talent in the future and potential to increase recruitment costs. A poor workplace reputation can also impact external partnerships, funding opportunities, and contract renewals (e.g. Education and Placements)

- **Negative Impact on Patient and Service User Outcomes -** Disengagement among frontline staff can directly affect patient experience, safety, and overall service quality. This may result in an increase in complaints, litigation, and financial settlements. Declining service standards can also reduce patient or client satisfaction scores, impacting future funding and contractual performance measures.

- **Leadership and Management Time Costs -** A disengaged workforce demands more management attention, requiring additional interventions such as staff engagement programs, grievance resolutions, and cultural development work. Team Leaders may be forced to divert time and resources away from strategic priorities to address morale and retention challenges.

- **Further Investment -** Recurring themes in staff feedback emphasise the urgent need for greater investment in resources, equipment, supplies, and infrastructure to enable colleagues to perform their roles effectively. Addressing these issues and improving staff satisfaction will require significant investment but could support productivity improvements, workforce sustainability, and lead to long-term organisational success and financial sustainability.

RISKS

As outlined in this report, several emerging themes and trends pose potential risks at both the organisational and divisional levels, including those highlighted in the financial implications. These risks include:

- **Increased Turnover and Vacancy Pressures**: Rising levels of burnout, work-related pressures, and concerns over pay may increase the intention to leave, exacerbating already high vacancy rates. This would place additional strain on remaining colleagues and impact service delivery.
- **Team Leader/Manager Capacity and Commitment to Engagement**: The ability of managers to implement initiatives such as TED, hold meaningful engagement conversations, and support colleague satisfaction may be compromised due to workload pressures and resource limitations. Given that direct line managers have the most significant impact on colleague engagement, this could hinder the achievement of key outcome measures.
- **Leadership Development Participation**: Operational demands and competing priorities may affect leaders' and managers' ability to attend or fully engage in development programmes, reducing their effectiveness in improving workforce culture and performance.
- **Application of Learning in the Workplace**: Cultural barriers, a lack of accountability, and an underappreciation of leadership responsibilities may prevent managers from applying newly acquired skills, knowledge, and behaviours. This limits the impact of leadership development efforts on organisational performance.
- **Resource Constraints vs. Demand**: A real and perceived lack of resources in patient-facing roles is contributing to dissatisfaction among colleagues. Addressing this challenge goes beyond the remit of the Workforce and Organisational Development (OD) department and

will require a coordinated response at Trust, local health economy, and potentially national/government levels to drive system-wide change.

- **Capacity Constraints in Organisational Development**: The demand for team support from the Organisational Development function is significant and growing. Managing team turnaround efforts while simultaneously delivering on commitments within Our People Plan 2023-2026 will place considerable pressure on OD resources.
- **Failure to Progress Actions**: Inability to demonstrate visible progress against our corporate level action plan may result in deepening the level of disengagement and dissatisfaction. This could lead to the organisation failing to improve and meet the national averages in next 2025 Staff Survey.

IMPACT ON STAKEHOLDERS

The primary stakeholders are our colleagues, having a highly engaged, satisfied, rewarded and motivated colleagues enables the organisation to achieve its vision. It is well publicised that highly engaged teams are more innovative, resilient, productive and able to deliver compassionate care.

As a large employer we are duty bound to continue to invest in the staff satisfaction and levels of colleague engagement, not only for our current workforce, but also for our future workforce who will want to join an organisation with a positive reputation.

RECOMMENDATIONS

The Board of Directors is asked to: receive the NHS Staff Survey Results and note the approach to addressing areas of improvement.

APPENDIX 1 – 2025 STAFF SURVEY NATIONAL BENCHMARK REPORT

Separate document included in the pack.

APPENDIX 2 – 2025 STAFF SURVEY RESULTS TEAM LEVEL - MANAGERS DASHBOARD

Separate document included in the pack.

APPENDIX 3 - STAFF SURVEY RAG REPORT

Separate document included in the pack.

11.3 EDUCATION, TRAINING AND RESEARCH COMMITTEE CHAIR'S REPORT

Other | S Crean | 11:55 pm

Item for assurance

REFERENCES

Only PDFs are attached

11.3 - ETR Chairs Report 10 Feb.pdf

Chair's Report to Board		
Chair: Prof StJohn Crean	Education Training and Research Committee	
Date(s): 10 February 2026	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.

- None

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- The Committee downgraded the University Hospital status risk (PR15) from 12 to 8, noting progress however, the Board should be advised that the risk score was reduced because the risk of not having a clear plan had decreased, not because the end goal had been achieved.
- Plans and partnerships were advancing with regards to obtaining University Hospital status, however the Board should be advised that the criteria for status was changing, and full details were not yet available.
- Hosted services mandatory training remained sub-optimal, and the Board should be advised that compliance was under scrutiny and would continue to be monitored by the Committee.

ASSURE

Assurance received; Matters of positive note.

- The NIHR feedback was positive, with all amber-rated issues addressed. The Board should be assured of the facility's quality and its role in supporting University Hospital status.

Education, Training and Research Committee

10 February 2026 | 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 9 December 2025	1.03pm	✓	Decision	S Crean
5.	Matters arising and action log	1.05pm	✓	Decision	S Crean
6	Strategic Risk Register	1.10pm	✓	Assurance	S Regan
7.	PERFORMANCE				
7.1	Core Skills Training Report	1.20pm	✓	Assurance	L O'Brien
7.2	Enhance Explore Foundation Programme	1.40pm	✓	Assurance	S Clough
8.	STRATEGY AND PLANNING				
8.1	University Hospital Status Update	2.00pm	✓	Assurance	P Brown
9.	GOVERNANCE AND COMPLIANCE				
9.1	NIHR CRF annual report and feedback	2.15pm	✓	Information	P Brown
9.2	Strategic Risk Register Review	2.30pm	Verbal	Decision	S Crean
9.3	Items to alert, assure, advise to the board or items or referral to/from other committees	2.40pm	Verbal	Information	S Crean
9.4	Reflections on the meeting	2.45pm	Verbal	Assurance	S Crean
10.	ITEMS FOR INFORMATION				
10.1	Review of Cycle of Business		✓		

№	Item	Time	Encl.	Purpose	Presenter
10.2	Feeder Groups – Chair's Reports a) Education Finance and Performance Sub-Committee b) Education Governance and Risk Sub-Committee c) Research and Innovation Sub-Committee		✓		
10.3	Date, time, and venue of next meeting: *7 April 2026, 1pm, MS Teams*	2.50pm	Verbal	Information	S Crean

12. PARTNERSHIPS (STRATEGY AND PLANNING)

12.1 ESTATES STRATEGY *

Decision Item | K Hudson | 12:05 pm

REFERENCES

Only PDFs are attached

12.1 Estates Strategy Board Cover Report 2nd April 2026.pdf

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Meeting of the	**Board of Directors**		**2nd April 2026**
	Part I ☒		**Part II** ☐
Title of Report	**Estates & Facilities Enabling Strategy 2025–2030**		
Report Author	Shaun Ashworth One LSC -Interim Director Estates & Facilities		
Lead Executive Director	Craig Carter Chief Finance Officer		
Recommendation/ Actions required	The Board of Directors is asked to: Approve the Estates & Facilities Enabling Strategy.		
	Decision ☒	**Assurance** ☐	**Information** ☐
Executive Summary	This paper sets out the key deliverables of the Estates & Facilities Enabling Strategy 2025–2030, aligned to the Trust's five strategic pillars (Patients, People, Performance, Productivity, Partnerships). The Strategy responds to an ageing estate, significant backlog maintenance (£66.2m), and service pressures across Royal Preston, Chorley, and community sites, while preparing for the long-term transition to the New Hospital Programme (NHP). The deliverables below constitute the multi-year estates roadmap that will be overseen through the Single Improvement Plan (SIP) governance structure and aligned to annual corporate objectives.		
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:	Finance and Performance Committee	Date: 24th March 2026	
Operational Group Review:	Capital Planning Forum	Date: 11th March 2026	

Link to Board Assurance Framework:	Principal Risk 1 (25/26) - Patient experience within the urgent and emergency care pathway
Appendices	State whether there are any appendices and list them. For example: Appendix 1: Estates & Facilities Enabling Strategy 2025–2030

1. Background

Lancashire Teaching Hospitals NHS Foundation Trust is entering a period of significant operational and strategic challenge, driven by rising service demand, an ageing estate, and the need to transform models of care across Lancashire and South Cumbria. The Estates & Facilities Enabling Strategy 2025–2030 sets out the Trust's response to these pressures and describes how the physical infrastructure will support delivery of the organisation's overarching five-year vision.

The Strategy has been developed against a backdrop of major national change, including the Fit for the Future 10-Year Health Plan for England, reform of NHS England functions, and the evolution of Integrated Care Boards into more commissioning-focused organisations. These system shifts, combined with the Lancashire and South Cumbria clinical blueprint which identifies Lancashire Teaching Hospitals as the specialist centre for the region underscore the importance of an estate capable of supporting both specialist and local services.

The Trust's estate faces substantial pressures. Much of the critical infrastructure, particularly at Royal Preston Hospital, is approaching the end of its economic life, with £66.2m in backlog maintenance and increasing difficulty meeting modern clinical, safety, and compliance standards. Both main hospital sites are operating at full capacity, with constrained space, ageing utility systems, and limited ability to accommodate the technological and digital advancements required for contemporary healthcare delivery. These conditions, along with limited capital availability and the delayed New Hospital Programme now anticipated in the 2040s, highlight the urgent need for targeted investment and strategic prioritisation.

At the same time, the Trust is committed to transforming care delivery in line with national and regional ambitions: shifting activity from hospital to community, leveraging digital innovation, addressing health inequalities, and strengthening the role of the organisation as an anchor institution. The Estates & Facilities Enabling Strategy provides a framework for supporting these ambitions by ensuring that the Trust's estate is safe, compliant, resilient, sustainable, and aligned to future models of care.

This Board Paper summarises the key deliverables from the Strategy through the lens of the Trust's 5Ps Patients, Performance, People, Productivity, and Partnerships and sets out the required actions over the next five years to maintain essential services while enabling transformation.

2. Key Deliverables Over Time (2025–2030) Aligned to the 5Ps

A. PATIENTS

Objective: Improve patient access, safety, experience, and outcomes through modern, compliant, patient-centred estates.

Key Deliverables (2025–2030)

1. Infrastructure Renewal Programme – Royal Preston Hospital

    Major replacement and upgrade of plumbing, heating, ventilation, and drainage to prevent critical system failure over the next 20 years.

    Priority focus on areas essential for infection control, emergency and assessment pathways.

2. Infection Prevention & Control (IPC)–Driven Refurbishment Programme

    Systematic refurbishment of clinical areas using IPC-compliant materials and layouts.

    Improved ventilation, surfaces, and spatial design to reduce hospital-acquired infections.

3. Accessibility Improvements Across All Sites

    Whole-site accessibility upgrades: signage, pathways, seating, waiting areas, parking, and disability access improvements.

    Dementia-friendly enhancements to address low PLACE scores in this domain.

4. Improved Patient Flow & Space Optimisation

    Reconfiguring patient routes on acute sites to reduce congestion.

    Expanding community-based diagnostics and outpatient pathways to reduce acute pressures.

B. PERFORMANCE

Objective: Improve elective throughput, diagnostics, cancer performance, and urgent & emergency care capacity.

Key Deliverables (2025–2030)

1. Estate Rationalisation & Consolidation to Enable Clinical Transformation

    Utilisation audits to identify underused, fragmented or functionally inadequate space.

    Reallocation of capacity to high-impact services aligned to clinical priorities.

2. Technology-Ready Infrastructure

    Electrical upgrades to meet HBN requirements (particularly where current provision restricts modern medical equipment use).

Digital and AI-ready diagnostic and theatre environments.

3. Theatre, Intervention & Procedure Suite Modernisation

Targeted reliability programme for theatres and interventional radiology to minimise downtime and cancellations.

4. Community Diagnostics Expansion

Continued development of Preston Healthport CDC to bolster diagnostics, endoscopy, and physiological science capacity.

C. PEOPLE

Objective: Create modern, healthy, flexible working environments that attract, retain, and empower staff.

Key Deliverables (2025–2030)

1. Workforce-Led Estates Planning
   Collaborative design of clinical and non-clinical spaces that support new flexible and hybrid ways of working.

2. Modern Fit-for-Purpose Workspaces

Reconfiguration of outdated areas to support multidisciplinary working, education, and clinical skills development.

Improved ventilation, heating, and welfare facilities to address existing deficits.

3. Staff Wellbeing Improvements

Investment in staff break areas, rest facilities, and supporting estates.

Exploration of staff accommodation options with local partners.

D. PRODUCTIVITY

Objective: Reduce costs, backlog maintenance, carbon footprint, and deliver efficiencies to support the Trust's financial plan.

Key Deliverables (2025–2030)

1. Net Zero Carbon Programme – Trust-Wide

Energy and water efficiency schemes across all sites.

Sustainable design standards integrated into all capital projects.

2. Major Backlog Maintenance Reduction Plan

Targeted investment prioritised by risk, clinical impact, and statutory compliance.

3. Rationalisation & Reallocation of Space

Consolidation of support services into centralised accommodation (e.g., One LSC model at Preston Business Centre).

Reduction in duplication of estate functions and operational costs.

E. PARTNERSHIPS

Objective: Strengthen collaboration across the ICS, local authorities, universities, and community partners.

Key Deliverables (2025–2030)

1. Delivery of the Lancashire & South Cumbria Clinical Blueprint

    Joint development and delivery of the proposed Preston Neighbourhood Health Centre and other community hubs.

2. Integrated Service Models on Shared Sites

    Strengthening co-located services (e.g., Chorley Birth Centre, mental health partners, community teams).

3. Continued Joint Working with the New Hospital Programme

    Pre-construction planning and enabling works to support future transition.

4. Partnerships for Staff Accommodation and Education Facilities

    Engagement with local authorities and FE/HE institutions to expand training and living accommodation.

3. Timeline Summary (2025–2030)

2025–2026 (Foundation Years)

- Space utilisation audits completed; prioritised estates plan established
- Launch of infrastructure renewal programme at RPH
- First wave of IPC-driven refurbishments
- Staff welfare improvements initiated
- CDC expansion phase 2 planning

2026–2028 (Acceleration Phase)

- Major utility and engineering system upgrades
- New flexible and hybrid workplace environments delivered
- Chorley Hospital elective and outpatient enhancements
- Community-based diagnostic hubs expanded
- Backlog maintenance reduction milestones achieved

- Net Zero carbon interventions implemented at scale

2028–2030 (Transformation & NHP Alignment)

- Estate rationalisation programme completed
- Multi-site resilience improvements for urgent/emergency care
- New partnership-driven facilities (e.g., Preston Neighbourhood Health Centre) operational
- Estates-enabled delivery of SIP outcomes across the 5Ps
- Completion of enabling works for RPH NHP transition

4. Governance

Delivery will be monitored through:

- Single Improvement Plan (SIP) – aligned to the 5Ps, led by responsible Executive Directors.
- Board Assurance Framework (BAF) – strategic risk oversight.
- Finance & Performance Committee – overarching responsibility for SIP delivery.
- Safety & Quality, Workforce, and Partnership Boards – domain-specific oversight.

5. Recommendations

The Board is asked to:

1. Approve the Estates & Facilities Strategy and Key Deliverables Plan 2025–2030.
2. Endorse the alignment of these deliverables with the Trust's 5Ps strategic framework.
3. Note the governance arrangements through SIP, BAF, and Board Committees.

13. RISK, GOVERNANCE AND COMPLIANCE

13.1 CHARITABLE FUNDS COMMITTEE CHAIRS REPORT

Other | T Ballard | 12:15 pm

Item for assurance

REFERENCES

Only PDFs are attached

13.1 Charitable Funds Committee Chairs Report 17 March.pdf

Chair's Report to Board			
Chair: Tim Ballard	**Committee: Charitable Committee**	**Funds**	
Date(s):17 March 2026	**Agenda information**	**attached for**	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

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

ALERT

Areas of concern;

- None

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- None

ASSURE

Assurance received; Matters of positive note.

- It was suggested to encourage team-building and fundraising initiatives using the charity as a focus, especially for teams facing challenges.
- Suggestion was made for strategic involvement of the charity lead in planning meetings for the £50 million ward block renovation, ensuring clear boundaries between charity-funded and business-as-usual items.
- The Committee approved five Rosemere Charity grant applications during the meeting. These included a research grant for the OPALLR project at East Lancashire Hospitals Trust, a grant for Semi-Rigid Olympus Thoracoscopes at University Hospitals Morecambe Bay, funding for a SPY-PHI portable handheld imaging system for the plastics department, new furniture for the radiotherapy department, and an Ultrasound Bronchoscope to enhance lung cancer diagnostics.

Charitable Funds Committee

17 March 2026 | 1.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	1.00pm	Verbal	Information	Chair
2.	Apologies for absence	1.01pm	Verbal	Information	Chair
3.	Declaration of interests	1.02pm	Verbal	Information	Chair
4.	Minutes of the previous meeting held on 16 December 2025	1.03pm	✓	Decision	Chair
5.	a) Action log & Matters Arising	1.05pm	✓	Decision	Chair
6.	STRATEGY AND PLANNING				
6.1	Hospitals' Charity update including Annual Work Plan and Baby Beat, approval of annual budgets, approval of updated Trust Charitable Guidance policy and approval of Charity Gifts in Kinds policy.	1.10pm	✓	Decision	D Hill
6.2	Rosemere Charity update including Annual Work Plan, approval of annual budgets and inc. requests for funding a) RCF009-25/26 – OPALLR Research - £75,362 b) RCF033-25/26 – SPY-PHI (SPY Portable Handheld Imaging System) for LTHTR - £119,731.25 c) RCF036-25/26 – New furniture for Radiotherapy Department - £38,100 d) RCF038-25/26 - Olympus BF-UCP190F Linear Ultrasound Bronchoscope for LTHTR - £72,965 e) RCF037-25/26 - Four Semi Rigid Olympus Thoracoscopes for UHMB - £ 152,464.60	1.30pm	✓	Decision	D Hill
7.	FINANCE AND PERFORMANCE				
7.1	Finance update including review of spending plan and balances	2.00pm	✓	Assurance	S McGrath
8.	GOVERNANCE AND COMPLIANCE				
8.1	Items to alert/advise/assure the Board	2.20pm	Verbal	Information	Chair
8.2	Reflections on the meeting	2.25pm	Verbal	Information	Chair
9.	ITEMS FOR INFORMATION				

№	Item	Time	Encl.	Purpose	Presenter
9.1	Review annual Cycle of Business		✓		
9.2	Rosemere Management Committee Chair's Report		✓		
9.3	Date, time and venue of next meeting: *16 June 2026, 1.00pm, MS Teams*	2.30pm	Verbal	Information	Chair

13.2 BOARD SELF-ASSESSMENT AND COMMITTEE EFFECTIVENESS REVIEW 2025/26

Decision Item | J Foote | 12:25 pm

REFERENCES

Only PDFs are attached

13.2 Board Self-Assessment & Committee Effectiveness Review 2025-26 April 26.pdf

Board of Directors Report

Meeting of the	**Board of Directors**		**2 April 2026**
	Part I ☒		**Part II** ☐
Title of Report	**Board and Committee Self-Assessment 2026/26**		
Report Author	Jennifer Foote, Director of Corporate Affairs		
Lead Executive Director	Jennifer Foote, Director of Corporate Affairs		
Recommendation/ Actions required	The Board of Directors is asked to approve the attached self-assessment and associated actions for improvement during 2026/27.		
	Decision ☒	**Assurance** ☐	**Information** ☐
Executive Summary	The Board is required to comment on its effectiveness and the effectiveness of its committees as part of the Annual Report. In prior years this was undertaken separately for each board and committee. However, in order to deliver an integrated view in a timely way a workshop was held on 19 February 2026. This focussed on how the members of the board and the associated assurance committees had collectively undertaken their role during the year 2025/26 to reach a conclusion sufficient to support the statement made in the Annual Report. The Board recognised that it was compliant in its discharge of its responsibilities and that this was the same conclusion for its assurance committees. However, the Board has also set out a series of actions designed to move its corporate governance practices from compliance to excellence during the course of 2026/27.		
Link to Strategic Objectives 2025/26	**Patients – deliver excellent care:** Improve outcomes, reduce harm and deliver a positive patient experience.		☐
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.		☐
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.		☐
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.		☐
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.		☒

Lancashire Teaching Hospitals

Board self-assessment against the NHSE Insightful Board Methodology (6 Domains)- 19 February 2026

Discussion covered	What we do well	What we need to improve	Action	By when
1. Governance				
Are there rigorous skills-based recruitment and appointment processes for non-executives, and are these independent?	Yes, this is in place and articulated in the Constitution	Whilst we are content that we are demonstrating compliance in governance we aspire to demonstrate excellence in governance and will continue to seek ways to improve both our approach and implementation of process through benchmarking against best practice.	Seek opportunities to benchmark against good practice	September 2026
Does the size of the board, the committee structures and processes reflect the size, services and complexity of the organisation?	Yes, this is reviewed regularly. ETR committee reflects the specific requirements of a Teaching Trust There is a good level of trust across the Board, allowing members to undertake individual duties without requiring additional approval of the wider Board. Though still new and developing, this is an example of a high functioning Board.		Approach governance across providers within the system to achieve a consistent approach	February 2027
Are there regular performance reviews of the board and its individual members?	Yes, annually both as a board and through individual appraisals		Seek opportunities to benchmark against good practice	February 2027
Are the roles and responsibilities of the Senior Independent Director clear and agreed by the board (as set out in the Code of governance)?	Yes, this follows code requirements		Explore specific training opportunities to evidence continuous development	February 2027
Does the board receive the right information, presented in the right way and at the right time?	Yes, agenda are determined against a pre-agreed cycle of business with meetings planned to allow for a timely flow of information.		Roll out of the current ancillary pack methodology used for Board meetings to all assurance committees	April 2026

Are there robust internal controls across the trust to support organisation-wide transparency and accountability?	Yes, an approved Accountability Framework is in place		This will be reviewed annually as part of the COB	April 2026
Are the right structures in place to escalate information through the organisation from the point of care to the board?	Yes, via the Accountability Framework, BAF, Divisional Improvement Forums, Your voice events and safety visits.		Safety Visits invite extended to wider Divisional management Teams to increase Board exposure and working relationships.	February 2026
Is the board able to hear patients, service users and staff voices in an authentic way as part of its leadership role?	Yes, through patient and staff stories. Also, all Board members are encouraged to take part in both planned visits and individual visits to triangulate information received in reports		Summary of learning from patient stories to be developed as part of 26/27 patient experience workplan.	June 2026
2. Transparency and Candour				
The Care Quality Commission's 'Regulation 20: Duty of Candour' is a statutory duty to be open and transparent with people receiving care.	Evidenced open learning and reporting through Datix/Ulysses system. Compliance with duty of candour part of committee cycle of business.	The new Ulysses system will be monitored to ensure that this continues to be effective Understand mor ethe inclusion of incidents that may not be subject to duty of candour and the potential over reporting that may take place and the unintended impact this may have.	Explore the inclusion of incidents and understand if over reporting is taking place, whilst in principle this is not a negative area, it may be causing more concern that necessary and needs to be understood further.	June 2026
Boards must develop and foster a safe reporting culture so that staff, service users and family members feel able to report incidents or concerns and have assurance these will be listened to and acted on.	NEDs invite and voluntarily receive direct reports of incidents and issues, noting that these matters were already known through appropriate reporting channels. Staff openly share information directly with directors when visited (and as this has already been reported nothing is heard for the first time through these channels) Reporting levels in the organisation are in the top quartile of the country.	Whilst we are content this happens in practice we need to be assured the importance of this is revisited through communication and interventions and then test this as part of Board visibility.	Continue to roll out the 'Your voice' engagement approach focused on listening to encourage speaking up and demonstrate the benefit of this.	August 2026

	Renewed focus and increased resource in speak up arrangements.			
Creating a feedback loop is essential for a transparent culture. The board should ensure that staff, patients and service users are told about what is happening or has happened as a result of their feedback. The board should ensure that staff, patients and service users are told about what is happening and has happened as a result of their feedback	Patient and staff stories are a standing item in Board meetings, with acknowledgement sent back to the relevant party. Complaints provide feedback to patients on actions being taken as a result of feedback. This is triangulated with the quality assurance team focus and priorities developed into the always safety first strategy due for Board approval in April. The revised engagement approach is focused on listening and feedback with dedicated actions in place to theme areas of importance.	'Impact' reporting to reflect on staff and patient stories could be improved.	Refer to 2021 NICE guidelines Sections 1-8 for 'checklist' approach.	June 2026
3. Problem Solving				

Well-led, successful boards should be scrutinising the information and data presented to them. “Problem-sensing involves actively seeking out weaknesses in systems relating to quality and safety, typically using multiple techniques and sources of organisational intelligence. [This includes] forms of organisational intelligence that offer challenge, disrupting any incipient risk of complacency…As with the collection of “harder” data, though, it is important not to mistake activity for action. Simply undertaking listening activities or unannounced visits is no substitute for the hard work of analysing and responding to the issues they unearth. The willingness of those at the “sharp end” [frontline] to speak and of those at the “blunt end” (senior leadership) to listen exist in a reciprocal relationship.”	Over the year there is evidence that the Board has moved forward significantly from simply identifying a problem to now considering “how do we work collaboratively to solve the problem”. Opportunities to triangulate with staff directly are well used without this turning into a ‘champion’ or ‘siloed’ culture. The chair and other NEDs are very visible at both hospital sites.	Business Intelligence and WTE data measurement discrepancies could be improved to support confidence and assurance. Tension in holding current known problems and actively pursuing new problems. The upcoming development session will support this work.	Board Development ‘deep dive’ session exclusively about problem Solving, specifically thinking about looking ahead.	April 2026
4. Culture [The Board agreed to view culture in terms of ‘behaviour and standards’ to improve measurability]				
Does the board role-model a culture of open and curious challenge?	Wide mutual recognition of support and openness across Executive and Non-Executive Directors. Acknowledge strong leadership of the Chair. As a new board members have quickly gelled as a team to work together to drive challenge and question as a means to an end rather than an end in itself.	More efficient ways of working could allow for the Board to find time for the reflection needed to shift the effectiveness of the Board.	Behaviour and Standards to be the subject of a future board development deep dive Board development session will continue to be designed to focus on areas that will continue to develop this practice within the Board.	October 2026 ongoing
Does the board understand when to seek external review and independent input?	Yes, Multiple reviews undertaken during 25/26 recognising that the membership of the Trust board had materially changed in a very short space of time. This allowed for an evidenced based ‘baseline’ from which to	In addition to understanding where the issues lie there is a need to value and celebrating achievements, and to look at how this can be done without being an empty gesture.	Engage with outstanding Trusts that sit similarly within the system to gain further learning around a ‘look up and look out’ approach.	September 2026

	undertake future self-assessments and confirm (GGI review and RSP oversight) that the Board had no material deficiencies of practice. There is also evidence of external input in clinical areas of concern when required demonstrating an open attitude toward this.		Consider opportunities to seek external views on areas of challenge.	
Is most of the discussion at the public board, and with clear justification for any items discussed in private?	Yes. FoIA exemption used to guide PII designation			
Are issues appropriately escalated from executives and is information presented transparently?	The Board recognises the constructive relationship between Non-Executive and Executive Directors. Both the Accountability Framework and the Board Assurance Framework allow for a consistent approach.	Need to be clear that escalation does not become mere duplication of discussion.	Benchmark this against Trusts who have acknowledge standards of best practice.	September 2026
Does the board balance operational performance with people performance at all levels of the organisation?	The discrete focus allowed by Workforce and FPC ensures that both aspects receive appropriate scrutiny and oversight. The new Integrated Performance Report introduced during 2025 also ensures that operational performance and people performance are given equitable treatment whilst at the same time allowing for correlation on trends an issues between the two. External feedback confirms the IPR is in line with best practice through the making data count team NHSEngland.	Business Intelligence to be developed further to allow for a timely representation and links between the two. Talent management and performance management to be a key focus for Workforce committee during 2026/27	Ensure talent management and performance management are covered as deep dives by Workforce Cttee during 2026/27 Expand corporate objective roll out to front line staff in a standardised way for 26/27.	February 2027 April 2026
Do all board members undertake 360-degree feedback?	External input as a NOF 5 Trust in addition to internal feedback. Governor feedback an essential standard part of NED appraisal.	Need to evolve into a consistent defined process across both NEDS and Execs	Include 360 degree feedback in a wider format that currently available for board member appraisals	April 2027
Does the board proactively seek views, listen to them and demonstrably follow-	Yes. Department visits," Your Voice".	Need to develop this so that it is embedded within	Benchmark this against Trusts who have	September 2026

up, and promote the value of a 'speaking up' culture?	Consistent approach to learning rather than blame. Recent session on Being fair demonstrated openness to the approach and built into the Always Safety First strategy. Speak up and lessons learned is an area of focus for development as part of staff survey.	standard practice, without losing the impact of such a dialogue	acknowledge standards of best practice. Evidence of the strengthened approach to learning from speaking up and incidents through Always Safety First strategy.	October 2026
Is Freedom to Speak Up (FTSU) information discussed at the board and is it considered alongside other sources of information on organisational culture?	Yes, regular reports are within both the Board and committee cycle of business NED and Speak up Guardian meetings in place as well as speak up arrangements being identified as benefitting from being enhanced in safety and quality as well as workforce committee.	As above. The Board sees it as imperative that it remains with open access for this type of issue to ensure that its focus on financial sustainability is not at the cost of patient care and safety.	Behaviour and Standards to be the subject of a future board development deep dive Update cycle of business in safety and quality in line with workforce to reflect safety focussed speak up triangulated report.	October 2026 April 26
5. Using Information				
Be timely, reflecting the most recent data available	Reports planned in line with agreed cycle of business, accepting that there is always a lag due to publishing in advance. Integrated Performance Report now in use – both in depth and high level data. Easy to use and transparent, allowing the Board to identify trends. External feedback confirms the IPR is in line with best practice through the making data count team NHSEngland.	Understand both historical data and timely data for pro-active problem solving and improvements.	Explore the use of access to dashboards for all board members	September 2026
Cover both improvement – using statistical methods to track trends over time, looking at variation and not just	The Board has used training given during the year e.g. 'Plot the Dots' statistical data session	Could use Population Health data in a more meaningful way. Dashboard needed.	Explore the use of access to dashboards for all board members	September 2026

comparing against targets at a point in time; and assurance – looking at whether standards are being met and comparing performance against relevant historical trust data or external benchmarks	to challenge and interrogate data more effectively , this has been tested again in Quarter 3 and evaluated positively. Ongoing focus on improvement 'what by when' articulation present in discussions.			
Be valid and subject to review – are the measures fit for purpose?	New IPR allowed for a better focus of discussion at board meetings – with the opportunity to track independencies and challenges on correlation of issues.	Use of a well-informed dashboard would improve review process further	Annual review of measures to take place following corporate objective and BAF Board development sessions completed in March 2026.	April 2026
Allow for deep dives to understand care quality and performance	Focus of necessity this year has been on finance and performance whilst continuing to receive assurance on progress on safety and quality. It is recognised there are some areas that require further focus, reflected in the new principal risks including UEC occupancy and its impact on safety and experience, health inequalities and their impact on patients and the wider system.	Desire to increase focus on care quality and performance in Board workshops	Future Board Development session planned	Added to workshop programme for 2026/27
6. Committees – agreed that all assurance committees had undertaken their role effectively during 2025/26				
Committee Effectiveness during 2025/26: - Finance and Performance (FPC)	Effective more from operational detail. Clear understanding across the committee of FPC needs, with ongoing improvement demonstrated. Desire to be more specific on what by when for operational improvements.	Reporting on headcount into FPC and Workforce committees could be made more consistent and based on a set of pre agreed metrics Create more opportunity to focus on performance	Continue to finesse the approach to WTE data in FPC Improvement Director to support UEC programme recognising capacity to deliver scope of improvements and dedicated time required to do this has presented a challenge this year.	ongoing

- Safety and Quality Committee (SQC)	This board is effective with room to develop towards excellence. Agenda planning ensures effective meetings and ensures necessary assurance reporting is available. There is appropriate clinical representation amongst the members, supporting effective discussion. The committee invites report authors to present, which supports engagement and effective discussion. Issues open to escalation in and out of committee as required. Clear intention and culture of the committee to drive positive improvement in contract to negative blame. Evidence of learning from national cases to inform assurance activity and improvement work.	There could be improved consideration around Triangulation with Workforce and FPC could be systemised. Learn from other national Regulation 28 notices for learning and improvement. workforce safety.	Explore approaches to learning from patient experiences and how this is used to promote positive practice and learning. Broaden approach to national learning as part of the Always Safety First strategy.	September 2026 September 2026
- Audit	Effectively prioritise key areas, with improvement towards targets being achieved. Quality of timely papers has improved, including executive summaries, with detail now in appendices. Meetings keep to time with affective chairing, whilst maintaining robust but succinct discussion. Reduction in single quote waivers tolerance noted.	Maintain vigilance around fraud and safeguarding.		

	Quality of internal audit reports and executive presence has strengthened assurances in 25/26.			
- Workforce	Committee demonstrates confidence in the People team. There have been considerable achievements through the productivity of the committee e.g. effective work around core skills, appraisals and psychological safety. Examples of strong team working and co-creation of initiatives e.g. Driving performance improvement through policy changes and consideration of how to develop this further. Effective triangulation across committees e.g. SQC and FPT. Established thresholds and trajectories. Forward looking around areas such as future skills, fragile services and oversight. Effectively use 3As to escalate issues to Board. Effective frequency of meetings for meaningful data reporting and actions which allows productive deeper dive into data sets. Committee demonstrates curiosity.	Opportunity to have a sharper line of sight between committee and the workforce, which is already being given consideration. Need to improve Workforce data analysis and understanding. Better recognise consistently performing areas of workforce, in readiness look at committee level initiatives for improvement. Build on previous successful working to identify further opportunities for supporting managers to drive performance improvements across teams.	Consider the configuration of finance and WTE work to ensure areas identified from improvement through IAG are addressed systematically.	May 2026

	The committee actively welcome voice of subject matter experts, which adds value to the issues and discussions.			
- Education Training and Research Committee (ETR)	Recognise a journey of improvement. Core skills topic progressed effectively in year. Effective challenging of information reported; looking for the 'why' as well as 'what' behind issues. People representation and insight gives greater assurance to the committee with strong engagement from Executive team. Active challenging of repeated risks. Committee effectively recognise and celebrate successful working such as recent direct acknowledgement of the research community. Focus on life long learning. Commitment to working towards University Hospital status by proactively considering practical requirements.	Improve opportunities and engagement around wider learning – looking ahead to desired improvements. Create focus on role specific high risk skills. Create more forward thinking committee change. Consider impact of organisational policies and the opportunity to shape these to drive improved performance and outcomes.	Include policy opportunity to single improvement plan in 26/27.	April 2026
- Appointments, Remunerations, Terms of Establishment Committee (ARTE)	Discharged duties effectively. Appointment in year of new Chief Finance Officer an example of matters addressed this year.			
- Charitable Fund Committee (CFC)	Discharge duties effectively.		.	

	Good engagement around Rosemere Trust. Ensure management of funds towards non-NHS services. The committee ensures all members have a clear understanding of appropriate use of funds through effective challenge and management of issues.			
Is the role of each board committee clear, including what areas and organisational risks it covers and how it reports into the board?	Yes, Terms of reference and Cycles of Business are all clear, up to date and effective. The Board Assurance Framework provides a clear articulation of how the principal risks of the Trust are managed. Positive feedback from NHSEngland on the live use of the BAF.	Retrospective more than future planning is a consequence of system and Trust pressures.	Recognising that the role of the assurance committee generally is to provide retrospective assurance to the board so that it can look forward, it would be helpful to explore how committees could also develop a forward-thinking perspective. Find out where this might be adopted with a view to sharing best practice.	September 2026
Are there areas and functions of your trust's operations that require specific governance groups	Yes, as a Teaching Trust the Trust opts to also establish an Education, Training and Research Committee. A review was undertaken in 2024 to assess whether this committee could be merged with Workforce but the decision was made to retain the discrete focus.	Previously explored when and if committees could be set up differently and concluded the current arrangement remains optimum for now whilst agreeing that the Board should remain open to doing things differently if a more effective and efficient way of working is identified	Seek opportunities to benchmark against good practice	February 2027

Having considered the matters above the board and its assurance committees separately concluded that regulatory and compliance responsibilities had been discharged effectively during the year 2025/26

13.3 APPOINTMENT OF DIRECTORS AND AUTHORISED SIGNATORIES - LHS LTD/HOSPITAL CHARITIES INVESTMENT FUNDS

Decision Item | J Foote | 12:30 pm

REFERENCES

Only PDFs are attached

13.3 Appointment of Directors & Authorised Signatories? LHS LtdHospital Charities Investment Fund 02.04.26.pdf

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Meeting of the	**Board of Directors**		**2 April 2026**
	Part I ☒		**Part II** ☐
Title of Report	**Appointment of Directors & Authorised Signatories– LHS Ltd/Hospital Charities Investment Fund**		
Report Author	Jennifer Foote, Director of Corporate Affairs		
Lead Executive Director	Jennifer Foote, Director of Corporate Affairs		
Recommendation/ Actions required	The Board of Directors is asked to consider: 1. the request of LHS Ltd and if so minded appoint Paul Jones (UHMB) and Silas Nicholls (Lead CEO, PCB JC) as directors of the board of LHS Ltd. 2. The appointment of the following as authorised signatories to the Brewin Dolphin charity investment fund: Sarah Morrison Craig Carter Jennifer Foote		
	Decision ☒	**Assurance** ☐	**Information** ☐
Executive Summary	This report comprises two parts both relating to the appointment of individuals to positions with either a wholly owned subsidiary or relating to the investment of hospital charity funds. **Part One – LHS Ltd Appointment of Directors** LHS Ltd is a wholly owned subsidiary of the Trust. The company currently holds a number of outpatient pharmacy contracts for delivery to the four acute trusts in the Lancashire and South Cumbria system. The Board of directors of the subsidiary comprises nominated representatives from partner trusts. The nominated member for UHMB resigned in February. At its meeting on 20 March, the LHS Ltd Board considered the nomination of Paul Jones as the replacement director for UHMB. Paul currently serves as Company Secretary of the Trust Board at UHMB. In addition, the company Board considered a proposal to appoint the Lead CEO of the PCB JC as a director to allow for input and oversight by the provider collaborative. The Articles of Association allow for both appointments to be made but as a reserved matter by the Trust Board at LTH.		

	Part Two – Brewin Dolphin Investment Fund The authorised signatories with Brewin Dolphin are out of date and need to be updated as soon as possible. Brewin Dolphin will only accept instructions from authorised signatories in respect of the following: • Authorisation to buy or sell investments • Approve changes to the investment portfolio • Instruct transfers or withdrawals • Approve updates to account details • Confirm changes to risk appetite, mandates, or investment policies The Trust Board of Directors is the corporate trustee for the hospital charities that use Brewin Dolphin the manage their investment funds. It is therefore recommended that the signatories should be updated to the those executive directors with a link to the operation and oversight of the charities.	
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.	☒

14. ITEMS FOR INFORMATION *ANCILLARY PACK

14.1 Audit Committee Chair's Report (verbal update given at previous meeting)
14.2 Data Quality Assurance Report
14.3 Use of Common Seal
14.4 Governor Election Report
14.5 Cycle of Business 2026/27

DATE, TIME AND VENUE OF NEXT MEETING:

Other | M Thomas | 12:40 pm

4 June 2026 at 09:15 am at Lecture Room 1, EC1, Royal Preston Hospital