





Lancashire Teaching Hospitals  
NHS Foundation Trust

# COUNCIL OF GOVERNORS

# COUNCIL OF GOVERNORS

 23 April 2026

 13:00 GMT+1 Europe/London

 Seminar Room A, Chorley and South Ribble Hospital

## AGENDA

|   |     |
|---|-----|
| • 0.0 Agenda .....  | 1   |
| 0.0 Agenda (PI) - Council of Governors - 23 April 2026 .pdf .....   | 2   |
| 1. Chair and Quorum (1:00 pm) .....   | 4   |
| 2. Apologies for absence (1:01 pm) .....  | 5   |
| 3. Declarations of Interest (1:02 pm) .....   | 6   |
| 4. Minutes of the previous meeting held on 20 January 2026 (1:03 pm).....   | 7   |
| 4.0 Minutes - 20 January 2026 Council of Governors (part I) approved.pdf.....   | 8   |
| 5. Matters arising and action log (1:04 pm) .....   | 17  |
| 5. Action log (part I) - Council of Governors - 20 January 2026 (1).pdf .....   | 18  |
| 6. Chairman and Chief Executive's opening remarks (1:05 pm).....  | 19  |
| 7. PRODUCTIVITY AND PERFORMANCE .....   | 20  |
| 7.1 Board Committee Chairs' Reports including Integrated Performance Report Summary (1:15 pm)   | 21  |
| 7.1 - Committee Chairs Report Council April 2026.pdf.....   | 22  |
| 7.2 Update for Care and Safety Subgroup (1:45 pm) .....   | 68  |
| 7.3 Update from Membership Subgroup (1:55 pm).....  | 69  |
| 7.4 Membership Subgroup Terms of Reference (2:05 pm).....   | 70  |
| 7.4 Membership Subgroup Terms of Reference.pdf.....   | 71  |
| 8. GOVERNANCE AND COMPLIANCE .....  | 74  |
| 8.1 Outcome of Non-Executive Director Appraisals and Re-Appointment of Dr T Ballard for Second<br>Term - Report of the Nominations Committee (2:10 pm)..... | 75  |
| 8.1 Outcome of Non-Executive Director Appraisals and Re-appointment of Dr T Ballard for Second<br>Term April 2026 (1).pdf .....                             | 76  |
| 8.2 Quality Account 2026/27: Engagement on Safer Priorities (2:20 pm).....  | 78  |
| 8.3 Council Effectiveness Self-Assessment (2:30 pm) .....   | 79  |
| 8.3 CoG Board Effectiveness Self Assessment April 2026.pdf .....  | 80  |
| 8.4 Governor Elections 2026 (2:40 pm) .....   | 90  |
| 8.4 Governor Elections 2026.pdf .....   | 91  |
| 9. ITEMS FOR INFORMATION .....  | 97  |
| 9.1 - Governor Opportunities and Activities Report - Feb 26 - April 26.pdf.....   | 98  |
| 9.2 - Governor Issues Report.pdf .....  | 100 |
| 9.3 Appointment of Lead Governor April 2026 (1).pdf.....  | 101 |
| 9.4 Governor Register of Interests 2026-27 April 26.pdf.....  | 103 |

|  |     |
|--|-----|
| 9.5 COG SIP Update Apr-26.pdf .....                                      | 107 |
| 9.6 Corporate Objectives 2026-27 April 2026.pdf.....                     | 113 |
| 9.7a Minutes Care and Safety Subgroup 12 Jan & 19 Mar 2026.pdf.....      | 136 |
| 9.7b - Minutes - Membership Subgroup - 3 February 2026 approved.pdf..... | 148 |
| • Date, time and venue of next meeting (2:45 pm).....                    | 151 |

## 0.0 AGENDA

### REFERENCES

Only PDFs are attached



0.0 Agenda (PI) - Council of Governors - 23 April 2026 .pdf

# Council of Governors

23 April 2026 | 1.00pm

Seminar Room A, Chorley & South Ribble Hospital

## Agenda

| No  | Item  | Time   | Encl.        | Purpose     | Presenter               |
|---|---|--------|--------------|-------------|-------------------------|
| 1.  | Chair and quorum  | 1.00pm | Verbal       | Information | M Thomas                |
| 2.  | Apologies for absence   | 1.01pm | Verbal       | Information | M Thomas                |
| 3.  | Declaration of interests  | 1.02pm | Verbal       | Information | M Thomas                |
| 4.  | Minutes of the previous meetings held on 20 January 2026  | 1.03pm | ✓            | Decision    | M Thomas                |
| 5.  | Matters arising and action log  | 1.04pm | ✓            | Information | M Thomas                |
| 6.  | Chairman and Chief Executive's opening remarks  | 1.05pm | Verbal       | Information | M Thomas/<br>S Nicholls |
| <b>7. PRODUCTIVITY AND PERFORMANCE</b>          |   |        |              |             |                         |
| 7.1   | Board Committee Chairs' Reports, including Integrated Performance Report Summary  | 1.15pm | ✓            | Assurance   | Non-Executive Directors |
| 7.2   | Update from Care and Safety Subgroup  | 1:45pm | Verbal       | Information | G Robinson              |
| 7.3   | Update from Membership Subgroup   | 1:55pm | Verbal       | Information | S Brennan               |
| 7.4   | Membership Subgroup Terms of Reference  | 2:05pm | ✓            | Decision    | J Foote                 |
| <b>8. GOVERNANCE AND COMPLIANCE</b>             |   |        |              |             |                         |
| 8.1   | Outcome of Non-Executive Director Appraisals and Re-appointment of Dr T Ballard for Second Term – Report of the Nominations Committee | 2:10pm | ✓            | Assurance   | M Thomas                |
| 8.2   | Quality Account 2026/27: Engagement on Safety Priorities  | 2:20pm | Presentation | Information | S Morrison              |
| 8.3   | Council Effectiveness Self -Assessment  | 2:30pm | ✓            | Decision    | J Foote                 |
| 8.4   | Governor Elections 2026   | 2.40pm | ✓            | Information | J Foote                 |
| <b>9. ITEMS FOR INFORMATION (taken as read)</b> |   |        |              |             |                         |
| 9.1   | Governor opportunities summary  |        | ✓            |             |                         |

| <b>No</b> | <b>Item</b>   | <b>Time</b> | <b>Encl.</b> | <b>Purpose</b> | <b>Presenter</b> |
|-----------|---|-------------|--------------|----------------|------------------|
| 9.2       | Governor issues report  |             | ✓            |                |                  |
| 9.3       | Appointment of Lead Governor  |             | ✓            |                |                  |
| 9.4       | Register of Interests   |             | ✓            |                |                  |
| 9.5       | Single Improvement Plan   |             | ✓            |                |                  |
| 9.6       | Corporate Objectives 2026/27  |             | ✓            |                |                  |
| 9.7       | Minutes of Governor Subgroups:<br>(a) Care and Safety Subgroup – 12 Jan & 19 Mar 2026<br>(b) Membership Subgroup – 3 Feb 2026     |             | ✓            |                |                  |
| 9.8       | Date, time and venue of next meeting:<br><i>23 July 2026, 10.00am, Lecture Room 1, Education Centre 1, Royal Preston Hospital</i> | 2:45pm      | Verbal       | Information    | M Thomas         |

## 1. CHAIR AND QUORUM

● Information Item

👤 M Thomas

🕒 1:00 pm

## 2. APOLOGIES FOR ABSENCE

● Information Item

👤 M Thomas

🕒 1:01 pm

### 3. DECLARATIONS OF INTEREST

● Information Item

👤 M Thomas

🕒 1:02 pm

## 4. MINUTES OF THE PREVIOUS MEETING HELD ON 20 JANUARY 2026

● Decision Item

👤 M Thomas

🕒 1:03 pm

---

### REFERENCES

Only PDFs are attached



4.0 Minutes - 20 January 2026 Council of Governors (part I) approved.pdf

# Council of Governors

## Public Meeting

20 January 2026 | 1.00pm

Lecture Room 1, Education Centre 1, Royal Preston Hospital

### Present:

|                 |  |
|-----------------|--|
| Mike Thomas     | Chair                                      |
| Pav Akhtar      | Public Governor ( <i>via MS Teams</i> )    |
| Takhsin Akhtar  | Public Governor ( <i>via MS Teams</i> )    |
| George Bailey   | Public Governor                            |
| Sheila Brennan  | Public Governor                            |
| Darrell Brooks  | Public Governor ( <i>via MS Teams</i> )    |
| Michelle Brown  | Appointed Governor ( <i>via MS Teams</i> ) |
| Sonia Connell   | Staff Governor                             |
| Philip Curwen   | Public Governor                            |
| Margaret France | Public Governor                            |
| Angela Kos      | Public Governor ( <i>via MS Teams</i> )    |
| Janet Miller    | Public Governor                            |
| Carole Oldcorn  | Public Governor                            |
| Enid Povey      | Public Governor                            |
| Tom Ramsay      | Staff Governor                             |
| Frank Robinson  | Public Governor                            |
| Graham Robinson | Public Governor                            |
| Tim Young       | Public Governor                            |

### Apologies:

Graham Fullarton, Lou Jackson, Daniel Matchett, Suleman Sarwar

### In attendance:

|                    |  |
|--------------------|--|
| Tim Ballard        | Non-Executive Director ( <i>via MS Teams</i> )                 |
| Steve Canty        | Chief Medical Officer ( <i>attended for minute 6/26</i> )      |
| Karen Lawrenson    | Corporate Affairs Officer                                      |
| Karen Deeny        | Non-Executive Director ( <i>via MS Teams</i> )                 |
| Jennifer Foote MBE | Director of Corporate Affairs                                  |
| Silas Nicholls     | Chief Executive  |
| Uzair Patel        | Non-Executive Director ( <i>via MS Teams</i> )                 |
| John Schorah       | Non-Executive Director ( <i>via MS Teams</i> )                 |
| Tim Wheeler        | Non-Executive Director ( <i>via MS Teams</i> )                 |
| Jo Wiseman         | Interim Business Manager, Corporate Affairs ( <i>minutes</i> ) |

### Apologies:

StJohn Crean, Adrian Leather

### Report Presenters:

Professor Anthony Rowbottom, Managing Director – Pathology Collaborative (*minute 6/26*)

**1/26 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.

**2/26 Declaration of interests**

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

**3/26 Minutes of the previous meeting**

It was agreed that the minutes of the meeting held on 30 October 2025 were approved as a true and accurate record.

**4/26 Matters arising and action log**

A copy of the action log had been circulated, and it was noted that there were no outstanding actions.

Action 79/25, previously completed, was agreed to be re-opened to follow up on the Director of Communications' email sent on 6 November 2025. This involved contacting the recruitment team to ensure governors were included in future career events.

On behalf of the Council of Governors the Chair recognised that Margaret France, Janet Miller and Frank Robinson were attending their final meeting and recorded the appreciation of the Trust for their significant contributions, commitment and public service over many years. Additional comments highlighted the extensive experience and dedication these members had brought to the Council and the wider community.

**5/26 Chair and Chief Executive's opening remarks**

An update was provided by the Chief Executive, giving a detailed overview of operational and financial challenges during the winter period. The Council was informed that the organisation had experienced significant seasonal pressures, with increased flu and Covid admissions leading to a brief escalation to the highest internal pressure level. Despite these conditions, the organisation had maintained ambulance turnaround times and continued to move patients safely through the system, although it was acknowledged that crowding in urgent care areas had at times affected patient experience. Work was ongoing to strengthen internal patient flow, including making better use of recent investments in assessment units and updated estate facilities. Gratitude was expressed for the dedicated efforts of colleagues throughout the organisation during the recent period when the Trust was escalated to OPEL level 4.

The financial position was outlined, noting that while in year pressures remained considerable, planning for the next financial cycle had begun earlier than in previous years, enabling more robust development of savings plans. The Council heard that there was still a significant gap between projected funding requirements and the likely allocation from system partners, with work progressing on -demand management pathways and on revising contractual -risk sharing arrangements. Encouragingly, all financial scenarios

indicated- a reduction in the underlying deficit for the first time in several years. Capital planning discussions had also progressed, with early indications of substantial investment being made available to address longstanding estate issues, including infrastructure deficiencies and ward environment improvements.

The new single pathology service was on schedule to go live on 1 April 2026, marking the culmination of a longstanding strategic objective and forming the foundation for significant future modernisation. Progress was also being made on the planned transfer of vascular services, with financial and -due diligence processes completed and outstanding clinical adjacency issues close to resolution. The transfer, expected in the new financial year-, was viewed as vital to strengthening the major trauma centre and supporting complex maternity and obstetric work undertaken on behalf of the wider region.

A recent visit by the Secretary of State for Health and Social Care and local MPs to one of the Trust's sites was noted as positive engagement and an opportunity to highlight priority areas for development.

The Council received an update on forthcoming capital investment and wider strategic developments. It was reported that NHS England had given an early indication that the Trust would receive funding for essential work on the main accommodation block over the next 12 to 18 months. The funding would allow the organisation to address critical problems such as drainage and sewage systems, which had been contributing to infection control challenges and would enable phased refurbishment of ward environments to improve lighting, ventilation, circulation space and overall conditions for patients, visitors and staff. Reference was made to recent refurbishment work in newer clinical areas, where improvements made by estates teams had already demonstrated the positive impact of modernised facilities.

The Council was also informed that the Trust had been approached by the New Hospital Programme to accelerate the planned purchase of a second parcel of land required for future development. An initial meeting with national bodies had been positive, with further scrutiny scheduled at an upcoming Treasury Committee. The Trust had proposed an additional, innovative step to bring forward enabling works, which would include the installation of new road junctions required to connect the site to local and motorway networks. If approved, tendering for this work could begin within the year and the initial work commencing in 2027 and completing in 2028.

During discussion, the Council sought clarification on the apparent difference between the optimistic financial position presented and the more challenging outlook reflected in other reports. It was explained that, while immediate in year pressures remained significant, -long term planning scenarios all demonstrated a meaningful reduction in the underlying deficit for the first time in several years. This improvement reflected sustained work to address historical financial challenges, although regulators continued to focus heavily on maximising -in year- performance. Although external experts reviewed the robust plans, they were not implemented early enough in 2025, resulting in a deficit for the next financial year.

Further questions were raised regarding whether the capital allocation would be sufficient to maintain a safe and effective estate until new hospital plans progressed, with the response noting that although the investment would address key risks, additional funding would still be required. Work was ongoing to explore solutions such as partnership models for car-parking infrastructure and to develop wider estate plans, including proposals for

an urgent care led- community health hub to mitigate the impact of future site reconfiguration.

## 6/26 Lancashire and South Cumbria Pathology Single Service

*Professor Anthony Rowbottom attended for this item.*

The Council received an update on the transition to a single, Lancashire and South Cumbria pathology service hosted by the Trust. It was reported that the consolidation aimed to improve quality, reduce duplication and strengthen long term clinical and financial sustainability. The Council noted that legal work and staff consultation were well advanced, with the service scheduled to transfer on 1 April 2026. Due diligence was progressing across ten domains, identifying several risks particularly within workforce, finance and procurement, although mitigating actions were in place and most areas were expected to improve before transfer. The Council further noted that regulatory compliance, governance structures and operational arrangements would sit under the Trust's existing frameworks, ensuring consistent standards across all sites. Engagement with staff and system partners was ongoing through a structured communications plan.

The rationale for establishing a single service was described, with the main expected benefits including increased productivity, improved cost efficiency, strengthened workforce resilience and greater opportunities for automation and standardisation across previously separate laboratories.

It was emphasised that the transfer would not result in immediate structural changes, with staffing, management arrangements and working practices remaining stable on day one to ensure continuity and minimise operational impact. During the next year, further work would be undertaken to design the future operating model and to realise the full benefits of consolidation. The update also noted that the network had been engaging closely with staff representatives and unions, whose ongoing involvement had helped shape a realistic and safe transition timeline, including the decision to defer the transfer date to ensure readiness.

The Council was advised that workforce shortages within pathology remained a significant national issue and that the intention was to use the new service to strengthen workforce capacity rather than reduce it, through modernised roles, improved automation and more efficient processes. Risks associated with the transition had been identified, including the potential for industrial relations challenges, although it was reported that staff-side engagement had been consistently constructive. The Council noted that the establishment of the single service was expected to support longer term strategic objectives, including future hospital planning and that a further update would be provided later in the year once the service had moved into its implementation phase and early benefits could be demonstrated.

The Council acknowledged positive feedback from Non-Executive Directors, who stated that ongoing communication with the pathology programme lead had given them a clear understanding of new risks, operational challenges, and project developments. It was confirmed that these meetings, held outside the routine committee structure, had offered substantial assurance that the programme was advancing appropriately and that issues were being identified and managed in a transparent and timely manner. The Council was advised that this ongoing dialogue had strengthened confidence in the governance and implementation of the new pathology service.

*The Chief Medical Officer and Managing Director of the Pathology Collaborative left the meeting.*

## **7/26 Board Committee Chairs' Reports**

The Non-Executive Directors provided an overview of the areas of focus for their respective assurance committee.

### **a) Education, Training and Research Committee:**

The Council received an update on the work of the Education, Training and Research Committee, which had met twice since the previous Council meeting. The Council was informed that core skills training compliance had reached 90% or above across all areas, which was highlighted as a significant improvement and a result of strong collaboration across committees. It was also reported that feedback from the GMC survey indicated improved experience for trainee doctors. The Committee continued to maintain a long-term ambition for the Trust to become a University Hospital and members stressed the importance of sustaining this strategic focus despite financial pressures. Financial performance relating to research activity had improved, becoming more self-sustaining than in previous years. Positive progress in apprenticeships was noted, including developments that supported internal career pathways. Some areas of concern were highlighted, particularly training related to advanced life support and paediatric sepsis, although it was confirmed that these areas were being closely monitored with cross-committee oversight.

### **b) Charitable Funds Committee**

The Council was informed that charitable income continued to perform strongly, with the Trust's charity exceeding budget expectations and demonstrating sustained growth. The Committee reported a strong financial position. Legacy income had reduced; however, it was noted that accounting rules required income to be recognised once assured, even if probate caused delays in receiving funds. A significant recent investment related to improvements on Ward 12, enabling private and appropriate spaces for sensitive discussions with patients and families. The Rosemere Cancer Foundation also reported significant income, supported by fundraising events and service developments. The Committee provided assurance of stable financial performance, responsible governance, and continued support for projects benefitting patients and families.

### **c) Safety and Quality Committee:**

The Committee continued to closely monitor three significant risks. The first concerned maternity theatre capacity for both planned and emergency procedures. Funding decisions were expected by the end of January; however, even if approved, operational improvements would not be realised until April. In the interim, medical job planning had been revised to enable full day caesarean section lists, with the aim of reducing out of hours procedures. This issue would continue to be reviewed monthly until resolved.

The second key risk related to sustained pressures in urgent and emergency care. It was described that performance in the emergency pathway was exceptionally difficult to shift, despite improvements elsewhere in the patient flow pathway. The Committee continued to scrutinise this monthly and had asked operational leads to explore all potential solutions,

including learning from other organisations. The third area of concern involved surgical scheduling and tracking, where processes needed strengthening to ensure timely care and to prevent patients being missed or delayed. The Committee was working jointly with the Finance and Performance Committee to oversee improvements.

Safe staffing levels remained stable in adult inpatient areas and cleanliness compliance was improving, despite ongoing estates challenges. Rates of *C. difficile* infections continued to remain below tolerance levels. Children and young people's services were reported to be maintaining safe services despite seasonal pressures, with particular focus on improvements in transitional care pathways. A small number of specialist placements had been supported through a newly opened external service, which had eased some pressure but did not fully resolve the wider system issue.

The Committee had also reviewed the quality and safety of outsourced clinical contracts and remained assured on all areas, with no financial penalties required. Health and safety governance had strengthened significantly, with improved structures, monitoring and alignment to the Trust's improvement plan.

Clarity was sought to understand the risks associated from vacancy levels, headcount reductions and potential impact on patient safety. The Council was advised that vacancies did not automatically equate to posts needing to be filled, as some were already identified for removal. All proposed reductions were subject to formal review to ensure of no impact on safety. Examples of illustrating the complexity of workforce decisions were provided and the principle that reductions would never compromise patient care was reiterated.

**d) Finance and Performance Committee (FPC):**

The Council heard from the Finance and Performance Committee chair who explained that although the Trust had made progress compared with the previous financial year, there continued to be significant challenges in delivering the planned £60m savings target for the current year. Two key factors were identified as affecting progress: in year planning delays, workforce reductions not materialising at the required pace and risks associated with major estates reorganisation linked to efficiency savings. It was noted that some of these issues were largely outside the Trust's control, although the impact on the deficit had been considerable. Clarification was provided that progress and challenge were not contradictory; while long term improvements were evident, in year pressures and operational constraints meant the Trust would not meet all financial expectations by yearend. The Trust continued to face financial challenges, with deficits above plan and slower than expected delivery of the Waste Reduction Programme due to industrial action, operational pressures and reduced external support funding.

Patient safety, performance standards, and national expectations remain essential, regardless of financial pressures. Performance risks were highlighted as persistent and although improvements were anticipated in some areas, particularly cancer services. Most key indicators were not expected to return to target by the end of the financial year. Planning for 2026/27 remained complex, with risks relating to workforce capacity, income and deliverability of required trajectories.

A question was raised about whether next year's financial plans incorporated the current year's shortfall. It was confirmed that they did, with planning assumptions aligned to an anticipated run rate deficit. Assurance was sought on whether the Trust Board was cognisant of the need to ensure that performance improvements would track financial

improvements, noting that many indicators had remained challenging for several years. The response confirmed that while plans were in place, most key risks would not be controlled by year end and performance recovery would depend heavily on next year's execution. In addition, weekly and national scrutiny of performance continued and planning for the coming year required the Trust to either meet or justify exceptions to national standards.

**e) Workforce Committee:**

The Committee had noted a considerable reduction in the use of temporary medical staff, which was welcomed. The main challenge remained reducing whole-time equivalent numbers, which formed a critical part of the Trust's financial savings plan. A detailed trajectory and delivery plan had been requested jointly with the Finance and Performance Committee, recognising that this would remain a significant challenge for the organisation. The Committee stressed the importance of ensuring that no workforce reduction compromised patient safety. All proposals continued to undergo formal equality and quality impact assessments led by clinical executives, with rejected proposals returned to divisions where safety could not be assured. Work was underway to strengthen the visibility of workforce issues from division to board, ensuring clearer line of sight and improved accountability.

A question was raised about sickness absence levels within the workforce. The meeting was informed that sickness absence had been reducing and that targeted work to manage both long term and short term absence had contributed positively. Council was asked to note that the actual sickness absence figures as reported to Board in the Integrated Performance Report were submitted as part of the papers to Council.

A further question was raised about violence and aggression in emergency care and if additional funding for security had been approved. Training improvements had been implemented and the Committees continued to triangulate safety data and revisit decisions if any concerns were to emerge. It was explained that incidents of violence and aggression occurred in areas not typically associated with public disorder, such as postoperative wards and critical care, often involving confused or vulnerable patients. A zero tolerance approach remained in place for deliberate violence or verbal abuse.

**f) Audit Committee:**

An update from the Audit Committee reported that several internal audit reviews had been completed, including those relating to resuscitation, conflicts of interest and medical systems. No significant concerns had been identified. The Trust remained compliant with counter fraud requirements and continued to monitor national best practice, including financial reporting changes and estate related funding considerations. Work was ongoing with external auditors to ensure appropriate governance around the procurement of land for the new hospital, which involved a sole provider. Wider external recommendations and national guidance continued to be incorporated into Trust processes.

*The Chief Executive left the meeting.*

**8/26 Update from Chairs of Subgroups**

The Chairs of the Care and Safety and Membership Subgroups summarised the topics discussed at recent meetings and the following points were noted:

a) *Care and Safety Subgroup*

The subgroup provided an update on recent activity. Since the previous meeting, two meetings had taken place in November and January. An update was given by Estates and Facilities colleagues, who outlined progress on several projects, including ongoing planning work, essential infrastructure maintenance including the nurse call system replacements, roof and flooring repairs and the installation of new security cameras. It was reported that planning work was underway to secure funding the multi-storey car parks at Chorley due to deterioration of the existing decked facility. The subgroup was subsequently informed that a recent structural inspection had concluded that a key administrative building was not fit for purpose in the medium to long term.

An update on patient experience and involvement confirmed that a number of patient leaflets had been revised or withdrawn following updated clinical guidance. The Carers' Charter and associated informational materials had also been refreshed and work had commenced to review the visiting hours policy. Training needs relating to deaf cultural awareness had been identified, with discussions ongoing about incorporating this into mandatory training. Clarification was provided regarding support available to the deaf community, including contracted services and video support options.

Assurance had been sought regarding the accessibility of outpatient appointment letters. It was confirmed that contract discussions were progressing to ensure alternative formats could be made available, including large print, audio and translated versions. The subgroup also received an update on community engagement activity undertaken through local health inequality initiatives organised alongside partner organisations. Governors had recently undertaken visits to clinical services, including urgent care and surgical hubs.

b) *Membership Subgroup*

An update was provided that informed that since the previous Council of Governors meeting, the subgroup had reviewed its terms of reference. The subgroup reported a 15% decline in public membership since 2021, despite an increase in the local catchment population over the same period. It was also noted that membership was not representative of the local non-white population. To address this, the subgroup intended to seek guidance and pursue additional community engagement activities to increase membership diversity. The subgroup advised that a request for a dedicated social media account had been declined, meaning members would continue using personal accounts to promote elections and membership, which had limited the visibility of current election information. Benchmarking with other trusts indicated that wider promotion across sites included brochures and banners which could be beneficial, particularly where these emphasised the reasons for becoming a member rather than the mechanics of the process. This would be added to the subgroup agenda for forthcoming meetings. The subgroup also recognised the imminent loss of several longstanding governors and planned to capture their knowledge to support succession planning.

**9/26 Approval of Subgroup's Terms of Reference**

The Council received the revised Terms of Reference for the Care and Safety Subgroup, which had undergone a full review by subgroup members. The Council noted that the Terms of Reference clarified the Subgroup's responsibilities, membership arrangements,

meeting conduct, reporting routes and the protocol for Governor visits to clinical and nonclinical areas.

**The Council RESOLVED to approve the Care and Safety Subgroup Terms of Reference.**

**10/26 Governor Elections 2026**

An update on the process for elections for 2026 was submitted for information. The meeting was reminded that the process was now live and therefore discussion needed to avoid any reference to individual cases or specifics. Timelines, information and planned workshops were all progressing as scheduled. A concern was raised about the visibility of election messaging. Although the report stated that information was being shared on the Trust website, media screens and social media channels, it was noted that media screens did not appear to be operational and that no election related content was present on the Trust's Facebook or X accounts. It was agreed to provide this feedback to the relevant communications lead.

**11/26 Items for information**

The following reports had been circulated with the agenda for information:

- (i) Governor Opportunities Summary
- (ii) Governor Issues Report
- (iii) Single Improvement Plan
- (iv) Minutes of Governor Subgroups:
  - Care and Safety Subgroup – 15 Sept and 13 Nov 2025
  - Membership Subgroup – 3 Oct and 5 Dec 2025
  - Chairs, Deputy Chairs and Lead Governor – 6 Jan 2026

**12/26 Date, time and venue of next meeting**

The next meeting of the Council of Governors will be held on 23 April 2026 at 1.00pm in Seminar Room A, Education Centre 3, Chorley District Hospital

**13/26 Discussion on how the meeting in public has been conducted**

The Council reflected that the meeting held in public had been conducted appropriately and that all agenda items had been fully covered.

**14/26 Resolution to exclude press and public**

**It was RESOLVED that the press and public be excluded from the meeting.**

*The meeting concluded at 2.44pm*

## 5. MATTERS ARISING AND ACTION LOG

● Information Item

👤 M Thomas

🕒 1:04 pm

---

### REFERENCES

Only PDFs are attached

 5. Action log (part I) - Council of Governors - 20 January 2026 (1).pdf

## Action log: Council of Governors (part I) – 20 January 2026

### There Are No Outstanding Actions

#### COMPLETED ACTIONS (for information)

| No | Min. ref. | Meeting date | Action and narrative  | Owner                             | Deadline   | Update  |
|----|-----------|--------------|---|-----------------------------------|------------|---|
| 1. | 80/25     | 30 Oct 2025  | <i>Membership Subgroup Update:</i><br>Council discussed options to strengthen engagement and agreed that communications support could be sought from existing governor resources. It was agreed that the proposal would be passed to the relevant team, and discussions would take place to progress this initiative. | Director of Communications        | Ongoing    | <b>Complete</b><br><b>Update on 17 April 2026: Response from DoC:</b> Given the national direction of travel for the role of governors and membership and ongoing Trust pressures and priorities it would not be the best use of resources to focus on growing the membership. However the current approach to keeping the membership and our wider internal and external stakeholders informed about Trust activities will continue, and the governors ongoing commitment to being involved with engagement both internally and externally are very much appreciated.<br><b>Update on 20 Jan 2026:</b> In progress |
| 2. | 4/26      | 20 Jan 2026  | <i>Action Log</i> – A follow up email to the one circulated on 6 Nov would be sent to the Recruitment Manager and CPO to request that governors be involved in future career events.  | Director of Communications        | 9 Apr 2026 | <b>Complete</b><br><b>Update 17 April 2026: Response from DoC</b> The recruitment team are aware that governors would like to be invited to future career events and have been asked to let Corporate Affairs know of anything appropriate. It should be noted that the team are very small and given the WRP programme that activity is very targeted – so the Trust will not necessarily be attending all the events it might have done in the past.<br><b>Update on 16 April 2026:</b> Further email has been circulated and response to be received.  |
| 3. | 10/26     | 20 Jan 2026  | <i>Governor Elections 2026</i> – A request be made of the Communications team for the election messaging to be visible on social media and internal media screens.  | CAT<br>Director of Communications | 9 Apr 2026 | <b>Complete</b><br><b>Update on 16 April 2026:</b> An email had been sent to the Communications team prior to elections asking for this to be actioned.   |

## 6. CHAIRMAN AND CHIEF EXECUTIVE'S OPENING REMARKS

● Information Item

👤 M Thomas / S Nicholls

🕒 1:05 pm

## 7. PRODUCTIVITY AND PERFORMANCE

## 7.1 BOARD COMMITTEE CHAIRS' REPORTS INCLUDING INTEGRATED PERFORMANCE REPORT SUMMARY

Other

Non-Executive Directors

1:15 pm

Item for Assurance

---

### REFERENCES

Only PDFs are attached

 7.1 - Committee Chairs Report Council April 2026.pdf



# Council of Governors Report

|   |   |   |  |
|---|---|---|--|
| <b>Meeting of the</b>                       | <b>Council of Governors</b>   | <b>23 April 2026</b>                                    |  |
|   | <b>Part I</b> <input checked="" type="checkbox"/>   | <b>Part II</b> <input type="checkbox"/>                 |  |
| <b>Title of Report</b>                      | <b>Board Committee Chairs' Reports</b>  |   |  |
| <b>Recommendation/ Actions required</b>     | To receive the report and consider the assurance available from this performance assurance report.  |   |  |
|   | <b>Decision</b><br><input type="checkbox"/>   | <b>Assurance</b><br><input checked="" type="checkbox"/> | <b>Information</b><br><input type="checkbox"/> |
| <b>Executive Summary</b>                    | <p>Council has a statutory responsibility to hold the Board of Directors to account, via the Non-Executive Directors (NEDs), for the performance of the Trust.</p> <p>This report requires all assurance committee chairs to present to Council. This allows for a greater degree of understanding of the work of Non-Executive Directors committees. The detail contained in the report is not a definitive list of all matters considered, but an assurance provided by the Chairs as NEDs on what they consider to be the matters currently of importance. Sometimes an item may also appear on the agenda for Council as a substantive item (e.g. the Single Improvement Plan). Where this occurs the Committee Chairs will contribute to the debate at that point, rather than duplicating the matter in their own report.</p> <p>To provide the Council of Governors with assurance that the Board of Directors is ensuring the effective, efficient, and economic provision of services.</p> |   |  |
| <b>Link to Strategic Objectives 2025/26</b> | <b>Patients – deliver excellent care:</b> Improve outcomes, reduce harm and deliver a positive patient experience.  | <input checked="" type="checkbox"/>                     |  |
|   | <b>Performance – deliver timely, effective care:</b> Deliver agreed trajectories in clinical performance.   | <input checked="" type="checkbox"/>                     |  |
|   | <b>People – be a great place to work:</b> Create an inclusive culture with leaders at every level leading colleague engagement.   | <input checked="" type="checkbox"/>                     |  |
|   | <b>Productivity – deliver value for money:</b> Deliver the agreed financial plan including waste reduction programme, maximising use of resources.  | <input checked="" type="checkbox"/>                     |  |
|   | <b>Partnership – be fit for the future:</b> 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.  | <input checked="" type="checkbox"/>                     |  |

## Introduction

The NHS Act (2006), as amended, places a duty on the Council of Governors to hold the Board of Directors to account, via the Non-Executive Directors (NEDs), for the performance of the Trust.

## Non-Executive Director Assurance

The Board of Directors has in place a Board Assurance Framework (BAF) in which it identifies the key risks to the Trust meeting its strategic objectives.

The oversight and scrutiny of the risks to achieving the strategic objectives, are delegated to Committees of the Board for scrutiny and to gain assurance that the risks are being addressed.

## Update from Committee Chairs

This report will continue to ensure that governors are provided with updates from any meetings that have taken place since the last Council meeting.

The narrative below provides an analysis from each of the Trust Committees and sets out the assurance that each Committee of the Board is able to provide to the Council of Governors.

### Education, Training and Research Committee

*Chair: StJohn Crean*

#### NED Analysis:

The Education, Training and Research Committee met on 10 February and 31 March 2026 and reviewed assurance across education, training, research and innovation, with particular focus on regulatory compliance and progress towards University Hospital status. Sustained Trust-wide compliance with core skills and mandatory training above the 90% target was reported, providing high-level assurance, although the Committee remained concerned about ongoing non-compliance within specific services and professional groups, particularly medical and dental staff, and emphasised the need for stronger escalation, accountability and embedding compliance as routine practice. Learner experience showed the first sustained improvement for several years, with national survey results improving across most themes, while further work was required to address variation, facilities issues and cultural concerns.

Assurance was provided on apprenticeships, which continued to perform well and support workforce development, alongside recognition of apprenticeship levy underspend and the need for better alignment with workforce planning. The Committee noted significant improvement in the financial position of Research and Innovation, with delivery of savings, a return to surplus and growth in income-generating activity supporting future ambitions. Good progress was reported on University Hospital status, with strengthened governance, partnerships and planning leading to a reduction in the associated principal risk score, reflecting reduced risk from lack of a clear plan, while noting that national criteria remained subject to change. The Committee endorsed the Education and Research Single Improvement Plans, recognising them as coherent, strategic frameworks aligning education, research and improvement to patient safety, workforce capability and the Trust's wider strategic objectives, while stressing the importance of translating ambition into consistent frontline delivery.

## **Charitable Funds Committee**

**Chair: Tim Ballard**

### **NED Analysis:**

The Charitable Funds Committee met on 17 March 2026. The Hospitals' Charity update reported strong performance, with income exceeding plan, expenditure remaining below budget, and sustained fundraising success despite wider reductions in charitable giving. Governance arrangements had been strengthened through updated Charitable Guidance and a new Gifts in Kind Policy, both of which were approved, alongside the 2026/27 annual plans and budgets. The Committee acknowledged the embedding of revised legacy-income accounting and discussed the role of charitable activity in supporting staff wellbeing and major capital developments, noting the importance of clear separation between charitable enhancements and core Trust funding.

The Rosemere Charity update confirmed continued strong performance, with over £1m raised year-to-date and expenditure under budget. A programme of fundraising and charitable investment across research, equipment and clinical environments was noted, and five funding applications were approved, subject to confirmation of specific assurance on radiotherapy seating. The Committee welcomed the equitable distribution of proposed benefits and discussed engagement with partner Trusts.

The finance update reported a combined charitable fund balance of £3.456m, driven by net income and investment gains, with available funds increasing after commitments.

## **Safety and Quality Committee**

**Chair: Karen Deeny**

### **NED Analysis:**

The Safety and Quality Committee held four meetings between January and March 2026 and reviewed assurance regarding patient safety, quality, workforce safety and regulatory compliance. The Committee maintained oversight of principal risks relating to patients' experiences within the urgent and emergency care pathway, healthcare associated infection and people experiencing health inequalities. Sustained improvement was noted in *Clostridioides difficile* performance which supported movement of this risk to controlled status. Pressures in urgent and emergency care, including boarding and corridor care, remained significant and off trajectory. Assurance was consistently received on safe staffing across adult, maternity, neonatal and children's services; this was frequently accompanied by recognition of high operational pressures, workforce vacancies and some reliance on temporary staffing, particularly within maternity, neonates and healthcare support worker roles.

The Committee scrutinised a wide range of safety intelligence including mortality, incidents, medicines management, sepsis, clinical audit and patient experience. Strong assurance was evidenced in mortality data and in a mature reporting culture and active learning through Patient Safety Incident Reporting Framework (PSIRF). Areas for continued focus include compliance in adult sepsis processes and data quality challenges linked to business intelligence capacity. Significant external and regulatory assurance was noted, including full compliance with the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme standards, positive feedback from a CQC Mental Health Act monitoring visit, progress on actions following a Human Tissue Authority (HTA) inspection, and the successful introduction of a 24/7 thrombectomy service following Regulation 28 requirements. The Committee endorsed the new Always Safety First Safety and Learning Strategy and supported continued joint oversight with other committees

on bed configuration, workforce recovery and system pressures. The need to connect strong governance and assurance with sustainable frontline improvements and to keep the Board sighted on areas of material risk and emerging concern continues to be emphasised.

### **Finance and Performance Committee**

**Chair: John Schorah**

#### **NED Analysis:**

The Finance and Performance Committee met in January, February and March 2026 and reviewed the Trust's financial position, operational performance and delivery of recovery plans. This was against a backdrop of sustained system pressure and challenging targets. Throughout the period, principal risks relating to urgent and emergency care, planned care, diagnostics and overall financial sustainability remained off trajectory, with limited movement in risk scores, prompting concern about the pace of improvement and the realism of delivery expectations. The Committee repeatedly highlighted high bed occupancy, boarding, poor ambulance handover performance and rising overdue follow-ups contributing to underperformance, while recognising incremental improvement in some elective, diagnostic and cancer metrics. Financially, the Trust continued to forecast an in-year deficit but showed improvement on 24/25. The results are dependent on non-recurrent mitigations, deficit support funding and system-level solutions. Progress against the Waste Reduction Programme was noted but remained insufficient to close the underlying gap completely, with workforce reduction, variable pay control and transformational schemes identified as critical but challenging levers, requiring sustained effort over multiple years.

The Committee scrutinised planning assumptions for 2026/27 and beyond, including the Medium-Term Plan, budget setting and workforce trajectories, noting that plans were triangulated and compliant but carried material delivery risk, particularly in relation to the scale of required savings, headcount reduction and physical capacity constraints. Stronger grip and control arrangements, improved governance, clearer divisional accountability and enhanced programme management were welcomed, alongside the development of longer-term approaches such as model service reviews and estates strategy. The Committee provided assurance to the Board where appropriate, including on capital delivery, procurement controls and elements of performance recovery, but consistently advised the Board of the need for transparency about risk, dependency on external funding and system partners, and the importance of avoiding over-commitment to plans that could not be credibly delivered.

### **Workforce Committee**

**Chair: Adrian Leather**

#### **NED Analysis:**

The Workforce Committee met on 13 January and 10 March 2026 and reviewed assurance on workforce capacity, staff experience, workforce risks and delivery of workforce elements of the financial recovery programme. Key principal risks relating to staff experience, staff absence and workforce information capacity remained off trajectory, reflecting sustained operational pressure, major organisational change and delays in implementing enabling digital systems, particularly the sickness absence system. Assurance was provided that reliance on temporary medical staffing had reduced and was considered controlled, subject to continued close monitoring. Workforce reductions continued through vacancy restraint and reduced variable pay, although whole-time equivalents remained above plan and further significant reductions were required over the next three years, creating ongoing risk to capacity, morale and sustainability. Staff survey findings showed stabilisation following earlier decline but highlighted persistent

concerns around workload, leadership visibility and morale, which the Committee agreed were unlikely to improve in the short term. The Committee was assured of progress on sexual safety, equality, diversity and inclusion, and identification of fragile services, but raised concern about the fragility of workforce information and informatics capacity, agreeing this significantly constrained assurance and required escalation to the Board.

## **Audit Committee**

***Chair: Tim Wheeler***

### **NED Analysis:**

The Audit Committee was duly convened on 29 January 2026. Internal audit reports were considered, with substantial assurance provided on resuscitation and conflicts of interest, and moderate assurance on grip and control and renal IT. Key actions focused on strengthening training assurance, monitoring declarations, embedding a coordinated pay-control action plan, and addressing a high-risk issue relating to clinical documentation stored outside core systems, with no patient safety risks identified. Progress against the internal audit plan and follow-up actions remained positive, supporting delivery of a robust year-end opinion. The counter-fraud update reported continued progress on prevention activity and policy updates, with further work required to refresh the fraud risk assessment and address HR-related investigation themes, particularly around sickness absence and secondary employment.

The Committee received enhanced assurance from the first consolidated report on external reviews, noting no significant risks requiring escalation. Losses and special payments were reviewed, with agreement to benchmark performance against peers, and procurement updates confirmed a significant reduction in single tender waivers, with further improvement work planned. Year-end accounting proposals, external audit risks, and estates accounting treatment were considered and approved where required. Updates on data security compliance and Recovery Support Programme funding confirmed delivery remained on track.

## Appendix 1 – Governor Dashboard



# Integrated Performance Report

April 2026 Trust Board meeting with performance to February 2026



Patients



Performance



People



Productivity



Partnerships

## Contents

| <b>SECTION</b>                                       | <b>PAGE</b> |
|--|-------------|
| Key to KPI Variation and Assurance icons             | 2           |
| How to read Statistical Process Control charts (SPC) | 3           |
| SPC KPI Metric Grid                                  | 4           |
| People   | 05 - 08     |
| Patients   | 09 - 11     |
| Productivity   | 12 - 15     |
| Performance  | 16 - 19     |
| Appendix 1 – Assurance Reports                       | 20 - 39     |

# Key to Metric Variation, Assurance Icons & Dashboard Headers

## Key to Metric Variance and Assurance Icons

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

## Key to Metric SPC Chart and Variance and Assurance Icons

Mean  
 Process Limit  
 Improving special cause  
 Measure  
 Concerning special cause  
 Target

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

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

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

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

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

*No signs of change over time evident in recent data*

*An example of concerning change is evident in the recent data*

*An example of positive change is evident in the recent data*

## Report heading explanation

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

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

A flag P is generated for metrics that are calculated as requiring

The latest month target or threshold.

Data to the end of.

The name of the Metric

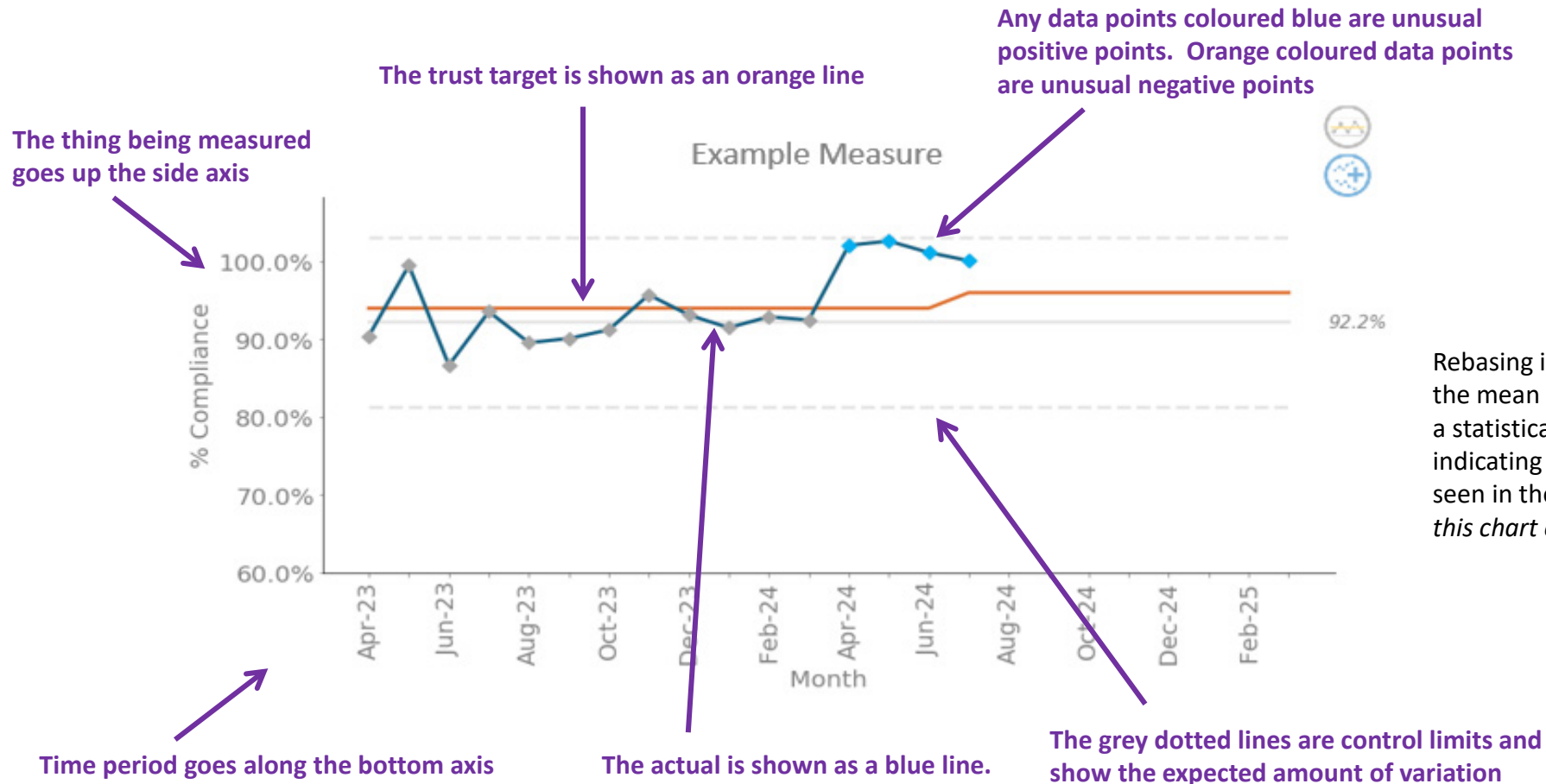
This shows whether there is a special or common cause variation of the metrics.

This March 2025 target

The current month actual performance.

# How to read Statistical Process Control charts (SPC)

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



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

| Variation                             | Assurance<br>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 | <ul style="list-style-type: none"> <li>- Vacancies (% FTE)</li> <li>- Staff Survey: Recommend Trust as place to work</li> <li>- Percentage of UEC (Type 1 &amp; 3) patients seen within 4 hours</li> <li>- Maximum wait of 12 hours as Total Time in Department</li> <li>- Cancer 62-day performance</li> </ul>         | <ul style="list-style-type: none"> <li>- Turnover (%FTE)</li> <li>- 85% theatre utilisation - aggregate - Capped</li> </ul>  | <ul style="list-style-type: none"> <li>- Staffing Fill Rate - Health Care Assistant</li> </ul>      |
| Normal variation - no recent change   | <ul style="list-style-type: none"> <li>- Bed occupancy to 90%</li> <li>- Number of boarded patients</li> <li>- Reduce not meeting criteria to reside</li> <li>- Percentage of patients waiting less than 18 weeks</li> <li>- 31 Day Cancer Standard</li> <li>- Staffing Fill Rate - Maternity Support Worker</li> </ul> | <ul style="list-style-type: none"> <li>- Number of violence and aggression incidents toward staff</li> <li>- Staffing Fill Rate - Registered Midwife</li> <li>- Complaints per 1000 bed days</li> <li>- Pressure Ulcers per 1000 beds days (Category 2 and above) actions</li> <li>- Perinatal - Number of Stillbirths</li> <li>- Cancer Faster Diagnosis Performance</li> <li>- Percentage of patients that receive a diagnostic test within six weeks</li> <li>- Compliance with 60 minute ambulance turnaround time target</li> </ul> | <ul style="list-style-type: none"> <li>- Staffing Fill Rate - Registered Nurse</li> </ul>           |
| Recent positive pattern in the data   | <ul style="list-style-type: none"> <li>- RTT - 65 Week Waiters</li> <li>- RTT - 52 week Waiters</li> </ul>  | <ul style="list-style-type: none"> <li>- Sickness Absence (%FTE)</li> <li>- C. difficile performance against national trajectory - no more than 167 Hospital Acquired cases</li> </ul>   | <ul style="list-style-type: none"> <li>- STAR Accreditation all trust (Silver and Above)</li> </ul> |

### 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     |

# Patients



**Patients**



**Performance**



**People**



**Productivity**



**Partnerships**



# Executive Summary – Alert, Advise, Assure Report

|   | Issue  | Action  |
|---|--|---|
| <b>Alert</b><br>Areas of concern or matters that need addressing urgently | <b>1. Pressure Ulcers per 1000 bed days (Category 2 and above)</b> - 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.  | <ol style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>3. A review of the seating provision in waiting areas is underway with the intention of purchasing improved specification seating.</li> <li>4. Continued focus on quality of the interventions focused on reducing pressure damage through STAR and matron assurance processes.</li> </ol>   |
| <b>Advise</b><br>Areas of ongoing monitoring and any new developments     | <b>1. Registered Midwife fill rates</b> - The overall midwifery fill rate is below the Trust target of 95% at 89%.<br><br><b>2. Complaints</b> - 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.   | <ol style="list-style-type: none"> <li>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.</li> <li>2. Sickness continues to impact availability and is being managed in line with policy.</li> <li>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.</li> <li>4. Shifts where increased risk is present are prioritised for the staffing that are available.</li> </ol><br><ol style="list-style-type: none"> <li>1. Continue to deliver the actions outlined in the Single Improvement Plan.</li> <li>2. Increase access to information regarding experience from patients with protected characteristics.</li> <li>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.</li> <li>4. Continued focus on early resolution with departments and PALS.</li> <li>5. Focus on use of PALS as early indicators to address concerns in areas and identify themes.</li> <li>6. Estates and clinical partnership Board focused on improving the estate impact of experience.</li> </ol> |
| <b>Assure</b><br>Areas of Assurance                                       | <b>1. Compliance with National Standards of Cleanliness</b> - 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.<br><br><b>2. Registered Nurse and Health Care Assistant fill rates</b> - are consistently achieving safe staffing levels.<br><br><b>3. STAR accreditation for all Trust.</b><br><br><b>4. CQC Must do:</b> By the end of October, the "Must Do's" included in the 2023/2024 CQC Quality Improvement Plan were delivered.<br><br><b>5. Mortality</b><br><b>Adult HSMR</b> - Lower than expected,<br><b>Adult SMR Adult</b> - Lower than expected<br><b>SMR Child &lt;1 day to 17 years</b> - As expected<br><b>SMR - Neonatal &lt;1-28 days</b> - As expected<br><b>Still Birth rate</b> - 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.<br><br><b>6. C.difficile rates</b> - Currently remain within the national agreed trajectory. | <ol style="list-style-type: none"> <li>1. Fully compliant at point of inspection, confirming robust infection prevention and control measures.</li> <li>2. Staffing levels consistently meet thresholds, supporting effective care delivery.</li> <li>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.</li> <li>4. CQC Quality Improvement Plan has been delivered.</li> <li>5. Mortality actions continue as outlined in the biannual mortality plan.</li> <li>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.</li> </ol>   |



Patients

# Patients



Lancashire Teaching Hospitals  
NHS Foundation Trust

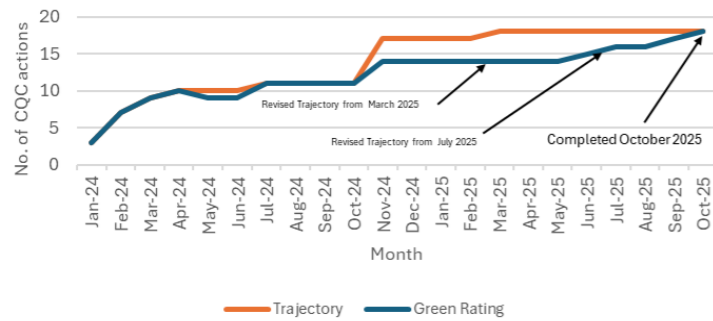
| Metric Description                        |   | Assurance<br>@ Mar-26 | Variation<br>to<br>Latest<br>Actual | Target  |        |                           | Latest<br>Month<br>Actual | Latest<br>Month |
|---|---|-----------------------|-------------------------------------|---------|--------|---------------------------|---------------------------|-----------------|
|   |   |                       |                                     | Concern | Mar-26 | Latest<br>Month<br>Target |                           |                 |
| CQC                                       | CQC - "Must do" - Completed October 2025<br>(Number with Green rating)  |                       |                                     |         |        | 18                        | 18                        | Oct-25          |
|   | CQC - "Should do" - Completed June 2025<br>(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)<br><i>The updated TELSTRA model from November 2024 does not include still births</i> | 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          |



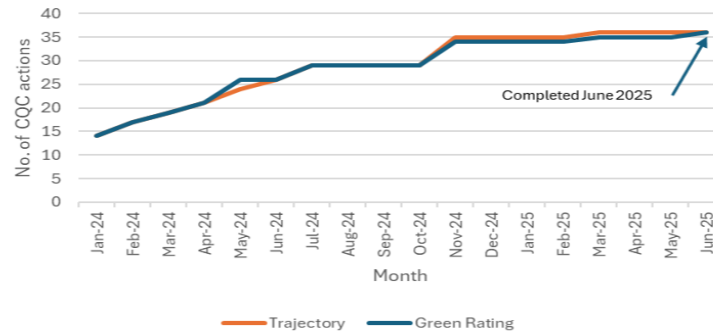
Patients

# Patients

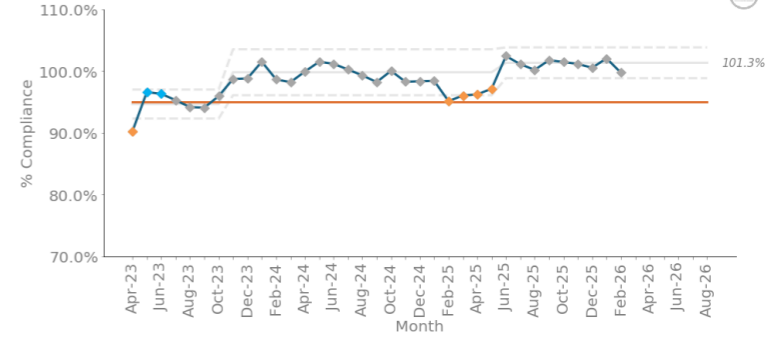
### CQC - "Must Do" - Green Rating



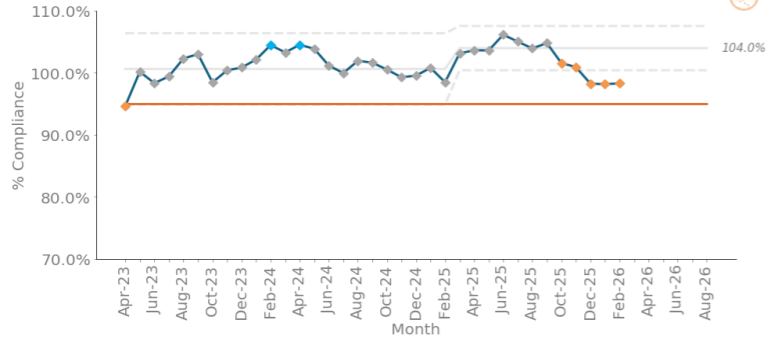
### CQC - "Should Do" - Green Rating



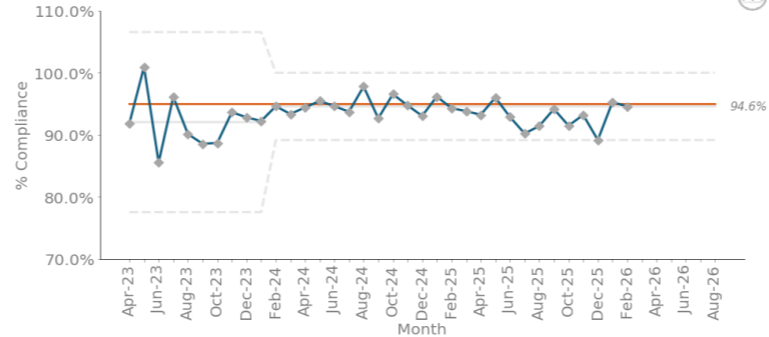
### Staffing Fill Rate Registered Nurse



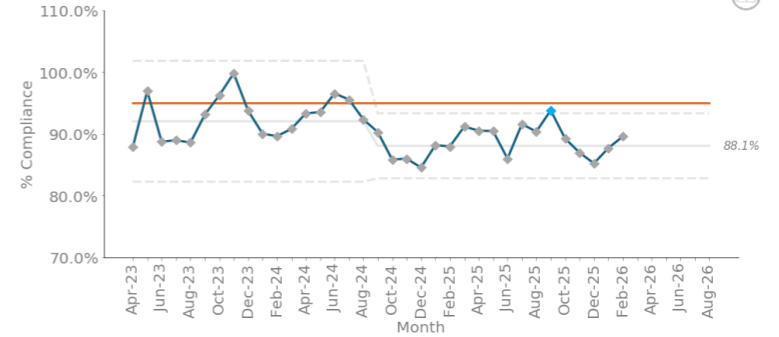
### Staffing Fill Rate Health Care Assistant



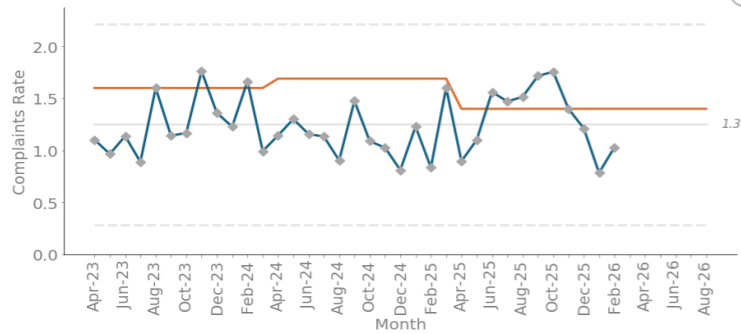
### Staffing Fill Rate Registered Midwife



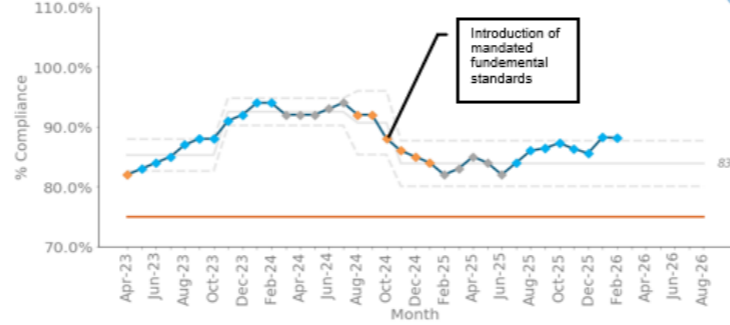
### Staffing Fill Rate Maternity Support Worker



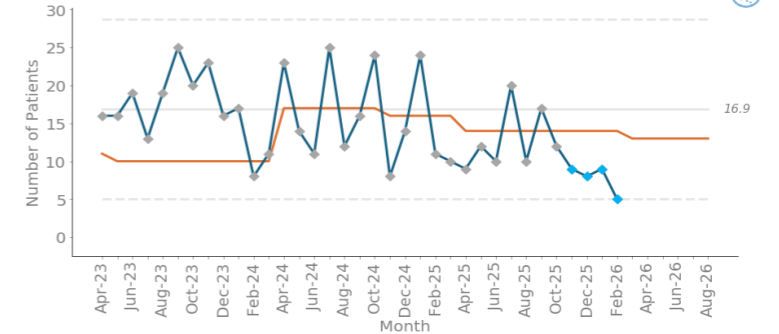
### Complaints per 1000 bed days



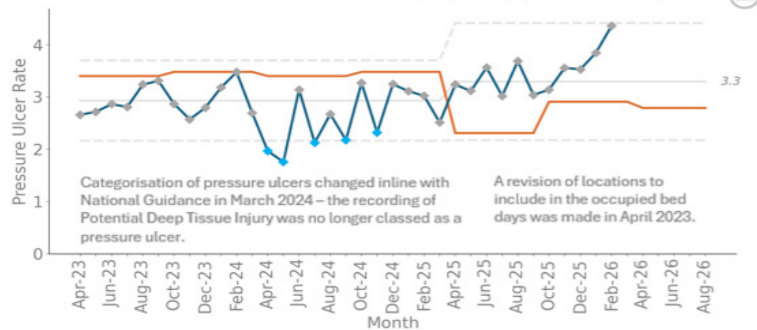
### STAR Accreditation all trust (Silver and Above)



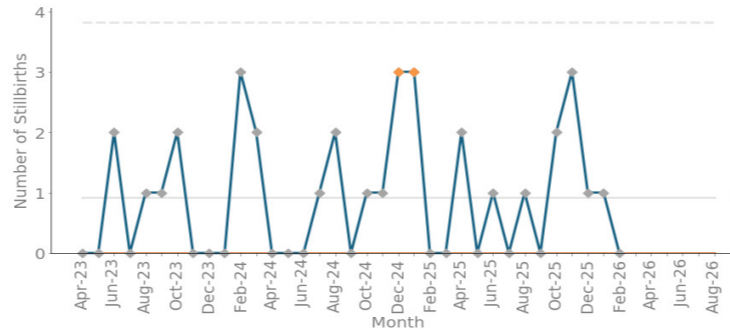
### C. difficile performance against national trajectory - no more than 167 Hospital Acquired cases (COHA & HOHA)



### Pressure Ulcers per 1000 bed days (Category 2 and above)



### Perinatal - Number of Stillbirths



# Performance



**Patients**



**Performance**



**People**



**Productivity**



**Partnerships**





## Alert, Advise, Assure Report

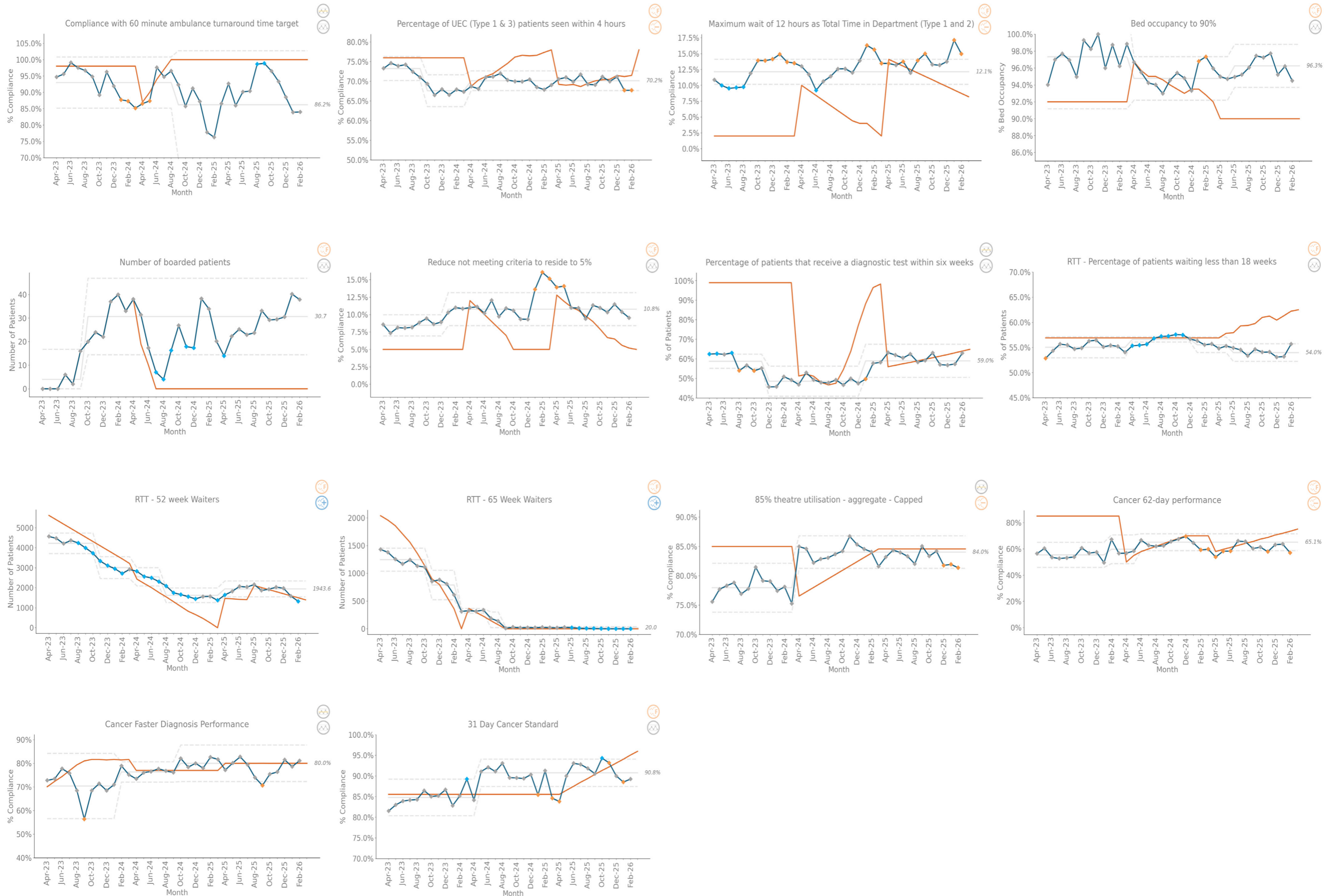
|   |  |   |
|---|--|---|
| <p><b>Alert</b><br/>Areas of concern or matters that need addressing urgently</p> | <ul style="list-style-type: none"> <li>• <b>RTT performance</b> - The number of follow ups &gt;25% overdue has increased month on month since Oct 24. Capacity constraints are driving these 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.</li> <li>• <b>Boarding</b> - 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.</li> <li>• <b>Days Kept Away from Home</b> - (%) 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.</li> <li>• <b>4 hour performance</b> - 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.</li> <li>• <b>Ambulance handover performance</b> -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.</li> </ul> | <ul style="list-style-type: none"> <li>• <b>RTT</b> - 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.</li> <li>• <b>Boarding/Escalation Bed utilisation/DKAFH</b> - 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.</li> <li>• <b>4 hour performance</b> - 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.</li> <li>• <b>Ambulance Handover performance</b>- 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.</li> </ul> |
| <p><b>Advise</b><br/>Areas of ongoing monitoring and any new developments</p>     | <ul style="list-style-type: none"> <li>• <b>RTT performance</b> - 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.</li> <li>• <b>DM01</b> - Performance has improved in February 26 to 62.94%, (a 5.6% improvement compared to Jan 26 yet remains below the operational performance target</li> <li>• <b>UEC</b> - The average wait to be seen time deteriorated in February 26 and remains above target.</li> <li>• <b>12 hour + ED LOS</b> - performance has improved in February 26 but remains above the Operational Improvement plan.</li> <li>• <b>Cancer performance</b> - Performance has deteriorated (Feb 26 unvalidated) in 62 day. 28 day is above target however 31 day remains below trajectory but shows improved performance.</li> <li>• <b>Virtual Ward</b> - occupancy remains below target however and has deteriorated slightly compared to January 26.</li> <li>• <b>Theatre Utilisation</b> - remained consistent in February 26 - key focus at CDH.</li> </ul>   | <ul style="list-style-type: none"> <li>• <b>RTT</b> - See actions in Alerts section</li> <li>• <b>DM01</b> - 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.</li> <li>• <b>UEC</b> - 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.</li> <li>• A focus on reducing the wait to be seen time is central to the Divisional ED Improvement plan. The ECIST C&amp;D modelling is underway and will inform the staffing levels by day of the week and hour of the day.</li> <li>• <b>12 hour + ED LOS &amp; DKAFH</b> - ECIST teams have supported a Capacity &amp; 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.</li> <li>• <b>VW</b> - recruitment into Medical staffing is underway to support an expanded offer. Communications to all LTH and community teams to increase referrals has been shared.</li> <li>• <b>Theatre Utilisation</b>- a focus on reducing late starts and cancellations for equipment is ongoing and aligned to 6-4-2 protocols.</li> </ul>  |
| <p><b>Assure</b><br/>Areas of Assurance</p>                                       | <ul style="list-style-type: none"> <li>• <b>65 Week RTT</b> - 0 breaches maintained in February 2026.</li> <li>• <b>52 Week RTT</b> - significant improvement in both the actual and % over 52 weeks in February 2026.</li> </ul>  |   |



# Performance

| Metric Description  |  | Assurance | Variation to Latest Actual | Concern | Target  |                     | Latest Month Actual | Latest Month |
|---|--|-----------|----------------------------|---------|---------|---------------------|---------------------|--------------|
|   |  | @ Mar-26  |                            |         | Mar-26  | Latest Month Target |                     |              |
| 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)<br><small>(unvalidated position, subject to change)</small> | 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



# People



**Patients**



**Performance**



**People**



**Productivity**



**Partnerships**





People

# Alert, Advise, Assure Report: People

|   | Issue   | Action  |
|---|---|---|
| <p><b>Alert</b><br/>Areas of concern or matters that need addressing urgently</p> | <p><b>Staff Engagement</b> - levels of advocacy with regards to recommending the organisation as a place to work and be cared for has further declined</p>  | <p><b>Staff Engagement</b> - 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.</p>  |
| <p><b>Advise</b><br/>Areas of ongoing monitoring and any new developments</p>     | <p><b>Vacancy</b> - Vacancy rate remains high due to vacancy control measures, and current cap on 20 WTE approvals per month at Vacancy Control Panel.<br/><b>Sickness</b> - 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.</p> | <p><b>Vacancy</b>- 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.</p>  |
| <p><b>Assure</b><br/>Areas of Assurance</p>                                       | <p><b>Appraisal</b> compliance remains above the 90% target.<br/><b>Core Skills and Mandatory Training</b> remains above the 90% compliance target for each metric at Trustwide level.<br/><b>Turnover</b> remains consistently low for month 11, once peak of TUPE of F&amp;E is excluded from the data. Actual turnover M11 including (766.24 WTE leavers from F&amp;E) was 9.92%. Excluding this TUPE we remain at 0.55%.</p>  | <p><b>Appraisal</b> - 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.<br/><b>Core Skills and Mandatory Training</b> - actions focus on targeted support to increase compliance in Hosted Services<br/><b>Turnover</b> - to refresh strategic actions relating to turnover, which will include generational differences and needs from the workplace.</p> |



People

# People

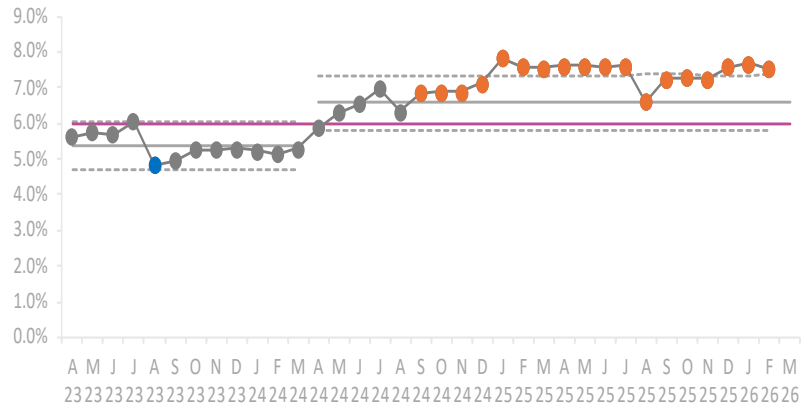
| Metric Description   | FY2526 Target Assurance | Latest Actual Variation | Target  |                        |                     | Latest Actual | Latest Period |
|--|-------------------------|-------------------------|---------|------------------------|---------------------|---------------|---------------|
|  |                         |                         | Concern | FY2526                 | Latest Month Target |               |               |
| Vacancies (% FTE)<br>(source: General Ledger)  |                         |                         |         | ≤ 6%                   |                     | 7.53%         | M11           |
| Turnover (% FTE)<br>(annual assessment; ESR in-month reported)                                     |                         |                         |         | ≤ 10%                  |                     | 9.92%         | M11           |
| Sickness Absence (% FTE)<br>(annual assessment; in-month reported)                                 |                         |                         |         | ≤ 5.22%                |                     | 5.71%         | M11           |
| Number of violence and aggression incidents toward staff<br>(annual assessment; in-month reported) |                         |                         |         | 996                    |                     | 86            | M11           |
| Core Skills Mandatory Training compliance (% modules)<br>(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<br>(quarterly metric)                               |                         |                         |         | ≥ 60%                  |                     | 42.54%        | Q4            |



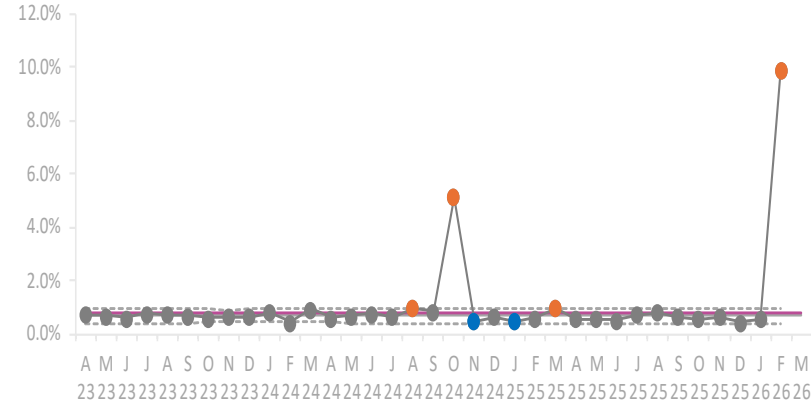
People

# People

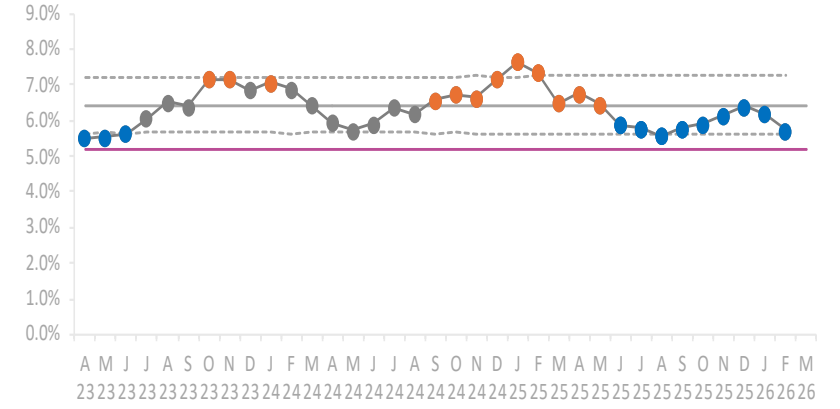
### GL Vacancy Rate (% FTE)



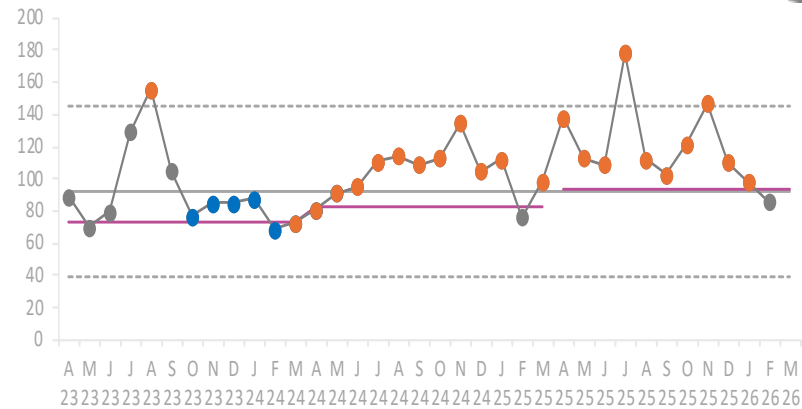
### ESR Turnover (% FTE)



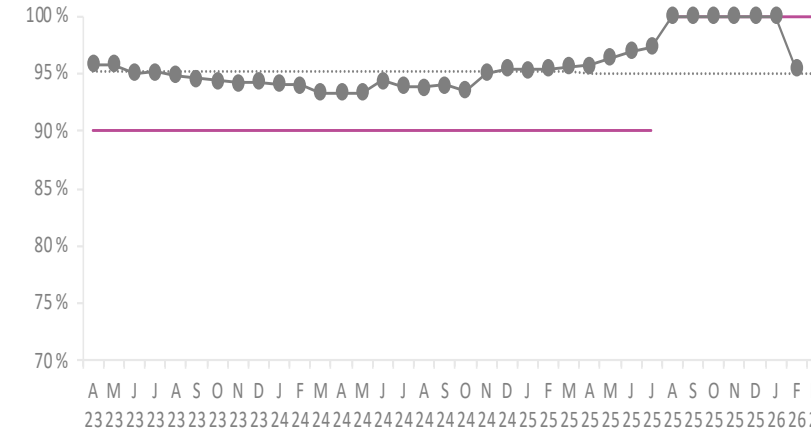
### Overall Sickness (% FTE)



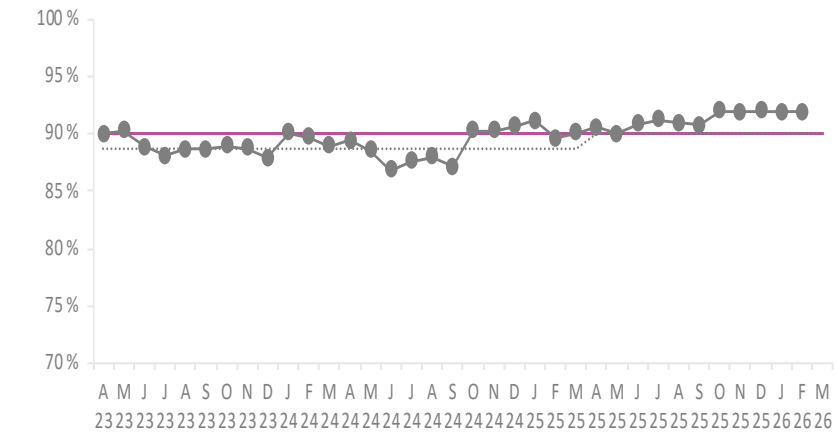
### No. of Violence & Aggression Incidents Reported



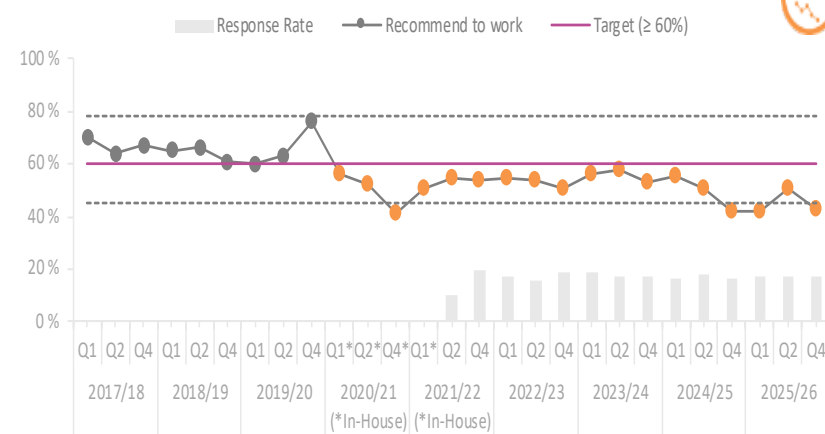
### CSTF Compliance (% modules)



### Appraisal Compliance (% HC)



### NQPS % Recommend to Work



# Productivity



**Patients**



**Performance**



**People**



**Productivity**



**Partnerships**



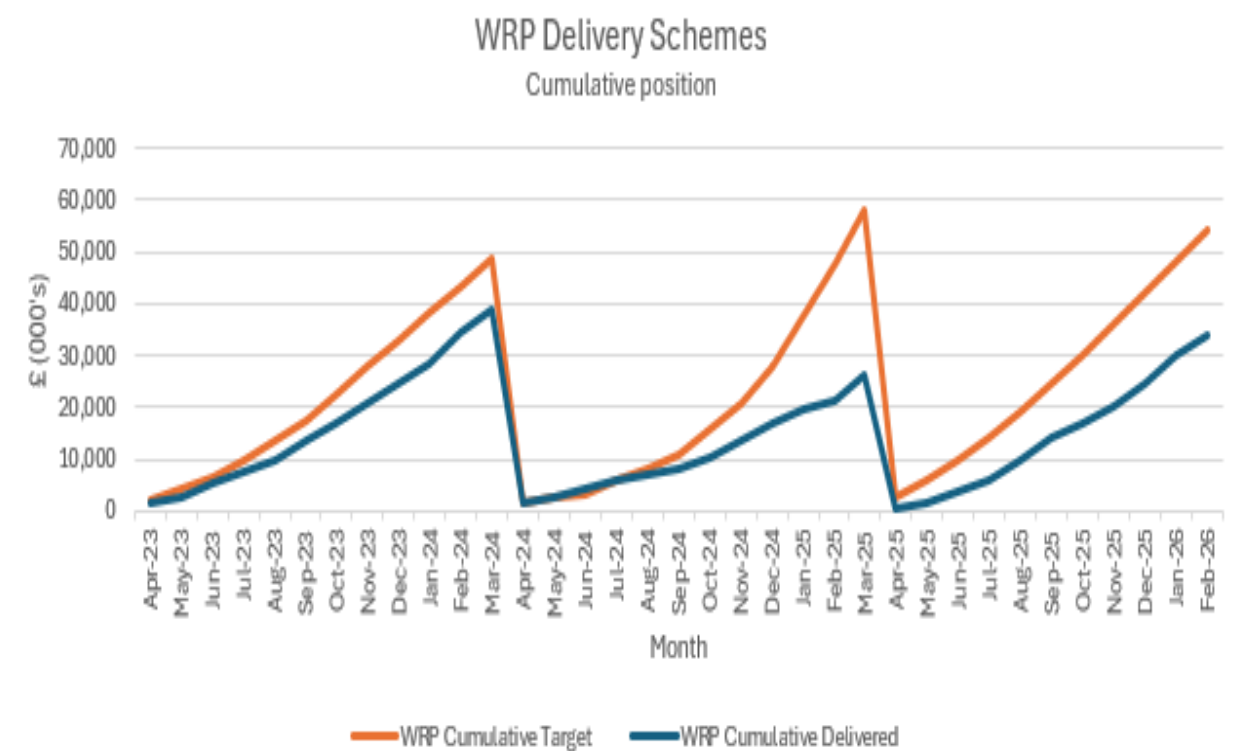
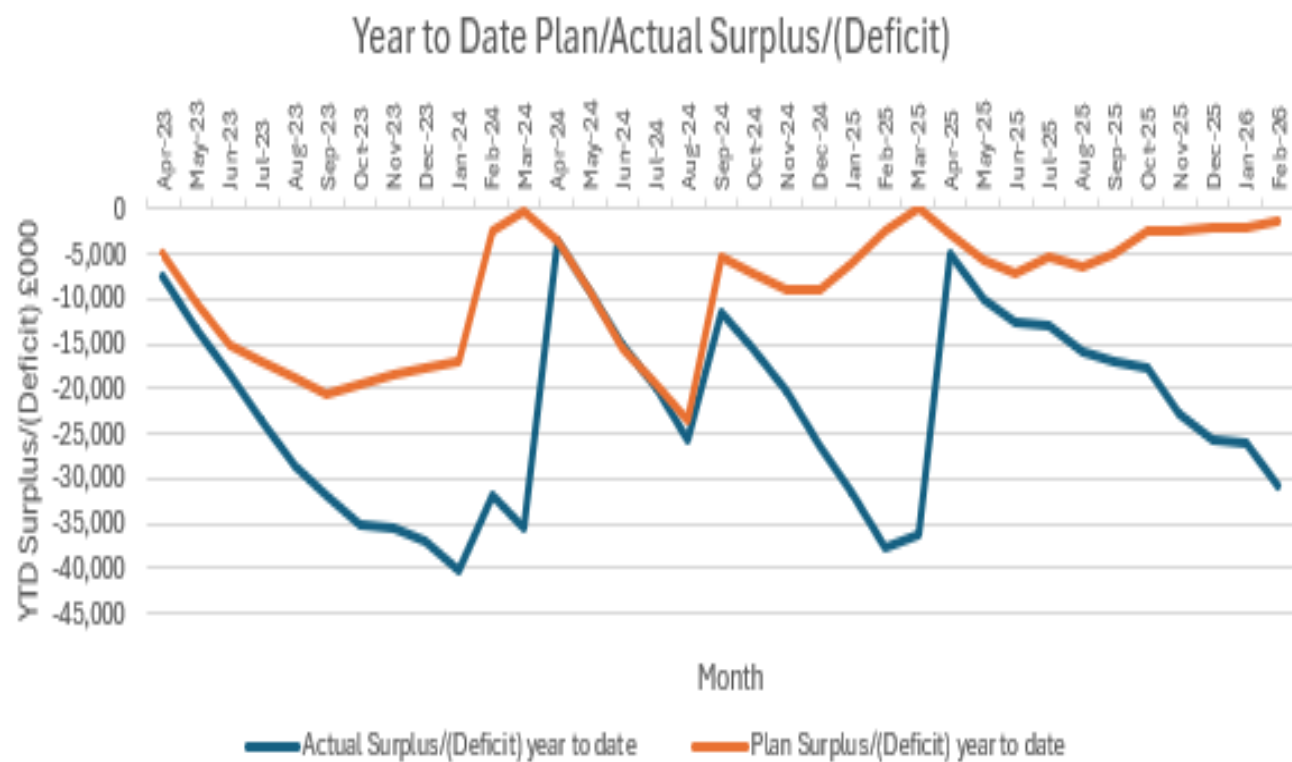
# Alert, Advise, Assure Report

|   | Issue   | Action  |
|---|---|---|
| <p><b>Alert</b><br/>Areas of concern or matters that need addressing urgently</p> | <b>Cash Position</b>  |   |
|   | <p>The Trust has received £32.0m cash support to date and a further £10m (of the £15m requested) has been approved for March.</p> <p>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.</p> <p>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.</p>   | <p>Management of WRP to ensure where possible cash releasing efficiencies are implemented.</p> <p>Restriction of supplier payments in accordance with the priority list of suppliers.</p> <p>Utilisation of internal capital cash for revenue purposes as a short-term measure.</p>   |
|   | <b>Income and Expenditure</b>   |   |
| <p><b>Alert</b><br/>Areas of concern or matters that need addressing urgently</p> | <p>At the end of February 2026 the Trust has a deficit of £30.8m against a planned deficit of £1.5m.</p> <p>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.</p> <p>The Trust has operational pressures in:</p> <ul style="list-style-type: none"> <li>- the acute medical pathways reflected in overspends in medical and nursing pay budgets</li> <li>- sickness remains higher than in operational budgets resulting in nursing pay overspends</li> </ul> | <p>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.</p> <p>A re-set of the programme structure, governance and reporting for 2025/26 has taken place.</p> <p>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.</p> <p>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.</p> <p>The Trust commissioned further external support for specific financial recovery plan workstreams and 2025/26 waste recovery programme development.</p> <p>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.</p> |
|   | <b>Waste Reduction Programme</b>  |   |
| <p><b>Alert</b><br/>Areas of concern or matters that need addressing urgently</p> | <p>The Trust's 2025/26 waste reduction target is £60m, 7% of operating expenditure.</p> <p>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.</p>  | <p>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.</p> <p>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.</p> <p>The Trust is enhancing grip and control activities to mitigate slippage in specific schemes</p>   |
|   | <b>Oversight Framework</b>  |   |
| <p><b>Advise</b><br/>Areas of ongoing monitoring and any new developments</p>     | <p>The Trust is in Segment 5 of the new 2025/26 oversight framework.</p> <p>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.</p> <p>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.</p>   | <p>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).</p>  |
|   | <b>Capital Position</b>   |   |
| <p><b>Assure</b><br/>Areas of Assurance</p>                                       | <p>Capital expenditure in the year to date is below plan but plans are in place to deliver a forecast matching the available capital funding.</p>   | <p>Continuing to closely monitor the capital schemes and submitting robust bids for funding in line with the opportunities that arise and associated deadlines.</p>   |

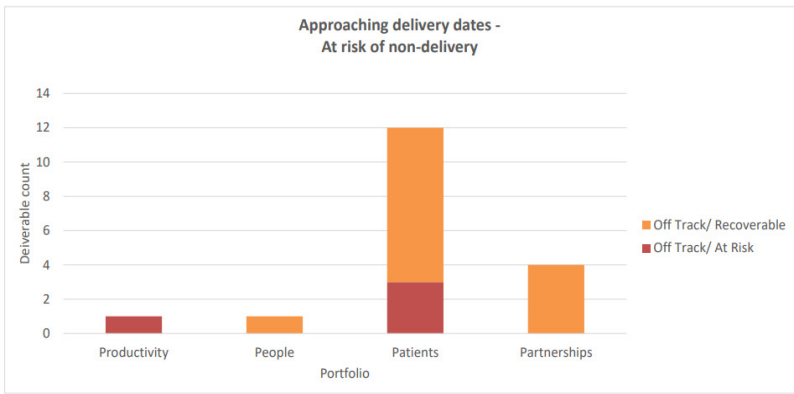
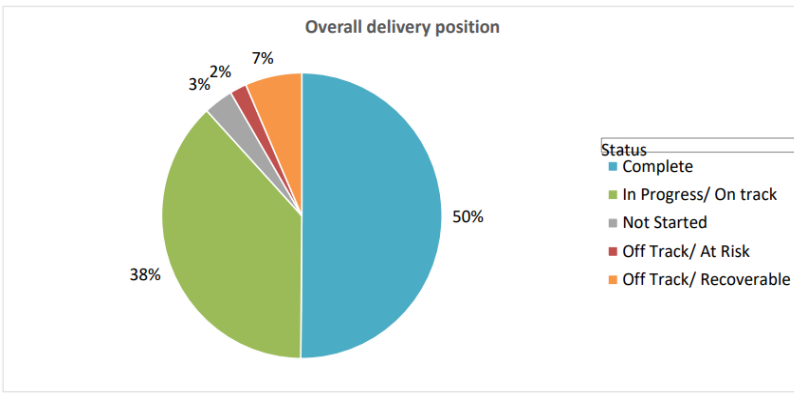


# Productivity

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



February-26 | Single Improvement Plan delivery position



| Status | Portfolio    | Escalation   | Key actions  |
|--------|--------------|--|--|
| Alert  | PATIENTS     | <ul style="list-style-type: none"> <li>Deterioration in patient experience metrics for urgent/emergency care, especially ED and adult inpatients.</li> <li>Continued slippage in timeline for CYP improvement work due to medical staffing issues limiting capacity.</li> </ul>  | <ul style="list-style-type: none"> <li>Focus on minimising impact of flow through effective communications, review of comfort and sleep.</li> <li>Discussion held with CMO for additional support required in paediatrics.</li> </ul>  |
|        | PERFORMANCE  | <ul style="list-style-type: none"> <li>RTT performance continue to be below target but slight improvement in last period.</li> <li>Overall DM01 performance below target but slight improvement since last period 57.38%, driven by NOUS.</li> <li>Number of boarded patients remain high and above target, 4hr performance deterioration against target.</li> </ul> | <ul style="list-style-type: none"> <li>RTT funding secured to mobilise additional capacity and additional validation and triage.</li> <li>NOUS over offer recruitment to be considered by Execs.</li> <li>Urgent meeting with GtD/ICB and NHSE to agree remedial actions at front door.</li> </ul> |
|        | PEOPLE       | <ul style="list-style-type: none"> <li>Sickness absence management Empactis remains challenging with numerous delays.</li> <li>Report of racism and discrimination remain persistent with little movement in metrics.</li> </ul>   | <ul style="list-style-type: none"> <li>Consideration of alternate solutions and mitigating actions to sickness management.</li> <li>Current capacity in EDI constrained, consider capacity and priorities across OD team to support.</li> </ul>  |
|        | PRODUCTIVITY | <ul style="list-style-type: none"> <li>25/26 financial recovery plan of £60m is at risk, with a risk mitigated position of £42.5m.</li> </ul>  | <ul style="list-style-type: none"> <li>CFO working through enhanced grip and control measures alongside mitigating under delivery of WRP, Focus on robust development of 26/27 plans.</li> </ul>   |
| Advise | PATIENTS     | <ul style="list-style-type: none"> <li>Neonatal nursing staffing challenges affecting capacity and compliance over the last 3 months.</li> </ul>   | <ul style="list-style-type: none"> <li>Escalated through safe staffing reports, impact on transfers and transitional care capacity</li> </ul>  |
|        | PEOPLE       | <ul style="list-style-type: none"> <li>Upcoming national leadership and appraisal requirements may significantly increase workload.</li> </ul>   | <ul style="list-style-type: none"> <li>Potential realignment of objectives, training and systems to be considered.</li> </ul>  |
|        | PERFORMANCE  | <ul style="list-style-type: none"> <li>Shortfall in ECHO capacity.</li> </ul>  | <ul style="list-style-type: none"> <li>Additional non-recurrent capacity via mutual aid from ELHT arranged for ECHO.</li> </ul>  |
|        | PARTNERSHIPS | <ul style="list-style-type: none"> <li>Community partnership agreement delayed.</li> </ul>   | <ul style="list-style-type: none"> <li>Shift to April-26 but being broadened to cover all interfaces.</li> </ul>   |
| Assure | PATIENTS     | <ul style="list-style-type: none"> <li>Rapid tranquilisation and restraint audit compliance improve to 93% direct link to actions taken in safeguarding SIP.</li> <li>Positive progress in smoking/alcohol intervention metrics, VTE compliance and Registered Nurse fill rates.</li> </ul>  |  |
|        | PERFORMANCE  | <ul style="list-style-type: none"> <li>Cancer FDS performance has consistently met or exceeded trajectory and expected to meet 80% target by April-26.</li> <li>Zero 65 week wait maintained.</li> </ul>   |  |
|        | PEOPLE       | <ul style="list-style-type: none"> <li>Core skill and appraisal compliance remains high above 90%.</li> <li>Sickness winter absence levels significantly lower compared to previous years.</li> <li>Retention remains strong, early leavers reduced compared to previous years.</li> </ul>   |  |

# Integrated Performance Report Appendix 1 – Assurance Reports

April 2026 Trust Board meeting with performance to February 2026



Partnerships



People



Patients



Productivity

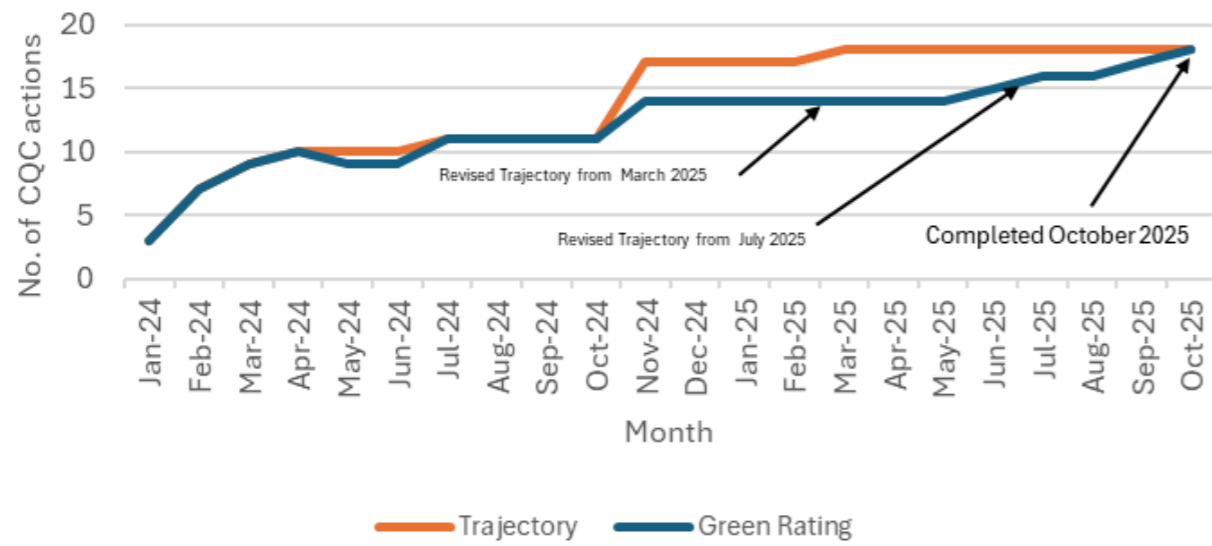


Performance



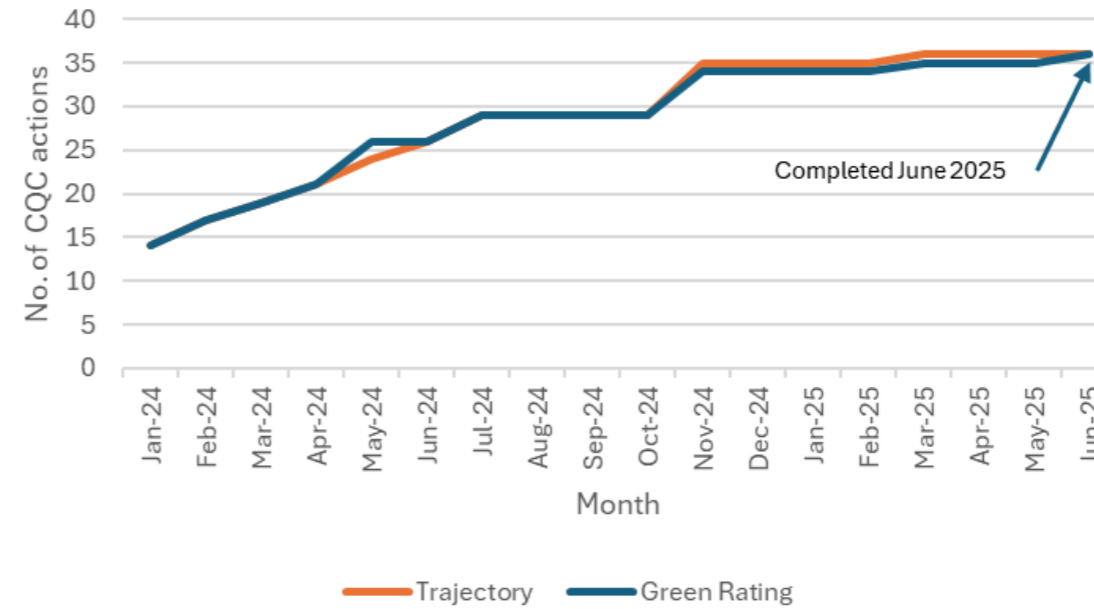
# Patients - CQC Assurance

### CQC - "Must Do" - Green Rating



|               |
|---------------|
| Latest        |
| 18            |
| Month Target  |
| 18            |
| Oct-25 Target |
| 18            |

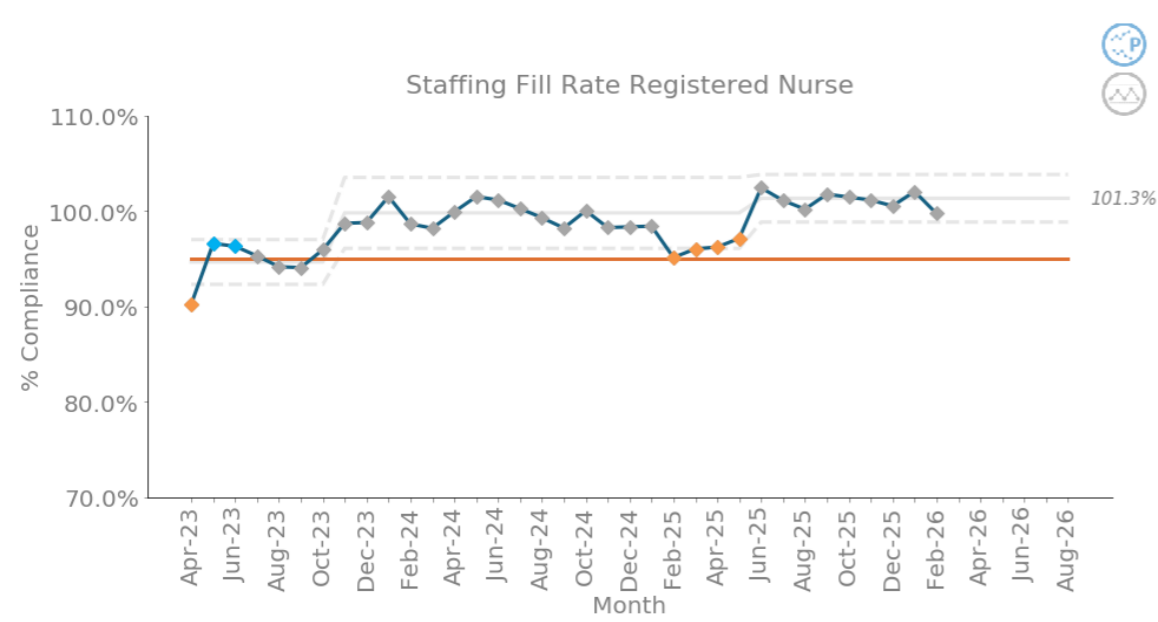
### CQC - "Should Do" - Green Rating



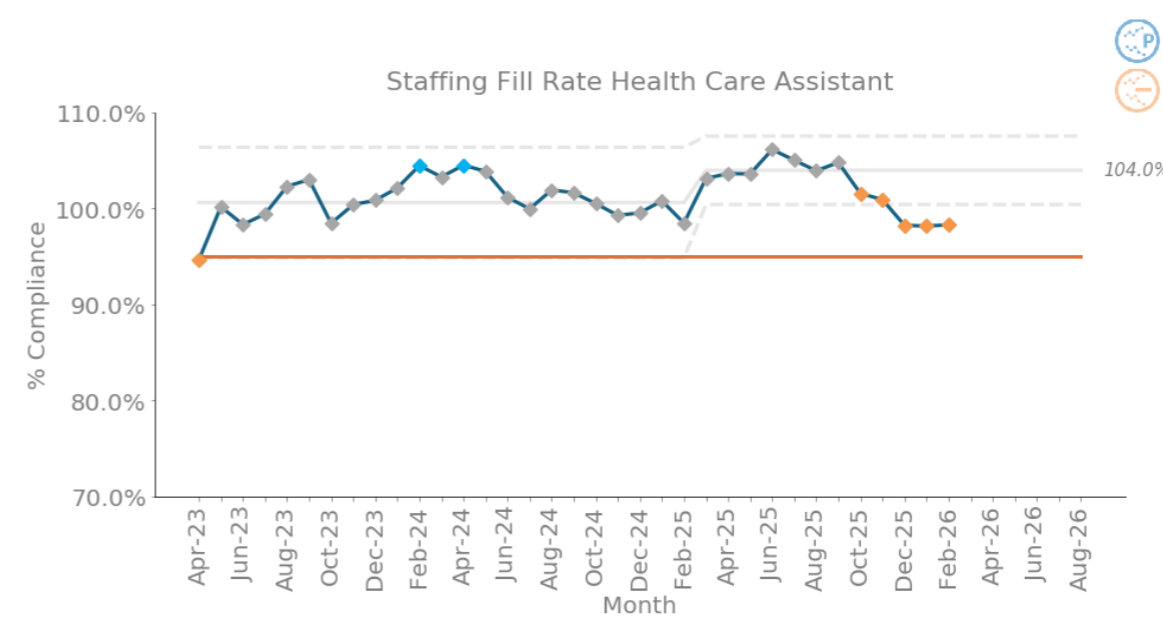
|                |
|----------------|
| Latest         |
| 36             |
| Month Target   |
| 36             |
| June-25 Target |
| 36             |

| Metric                                       | Summary  | Action  | Assurance   |
|--|--|---|---|
| CQC - "Must do" (Number with Green rating)   | <ol style="list-style-type: none"> <li>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.</li> <li>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.</li> </ol> | <ol style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>The monitoring of the must dos going forward will now cease.</li> </ol> | <ol style="list-style-type: none"> <li>From the 18 'Must Do' recommendations, all 18 'Must Do's' have been assessed as delivered at the end of October 2025.</li> <li>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 &amp; Emergency Care team allowing the remaining action to be marked as delivered.</li> <li>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.</li> </ol> |
| CQC - "Should do" (Number with Green rating) | <p>At the end of June 2025, of the 'Should Do's' included in the 2023/2024 CQC QIP, 100% were marked delivered.</p>  | <ol style="list-style-type: none"> <li>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.</li> <li>The monitoring of the must dos going forward will now cease.</li> </ol>  | <p>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.</p>   |

# 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 |

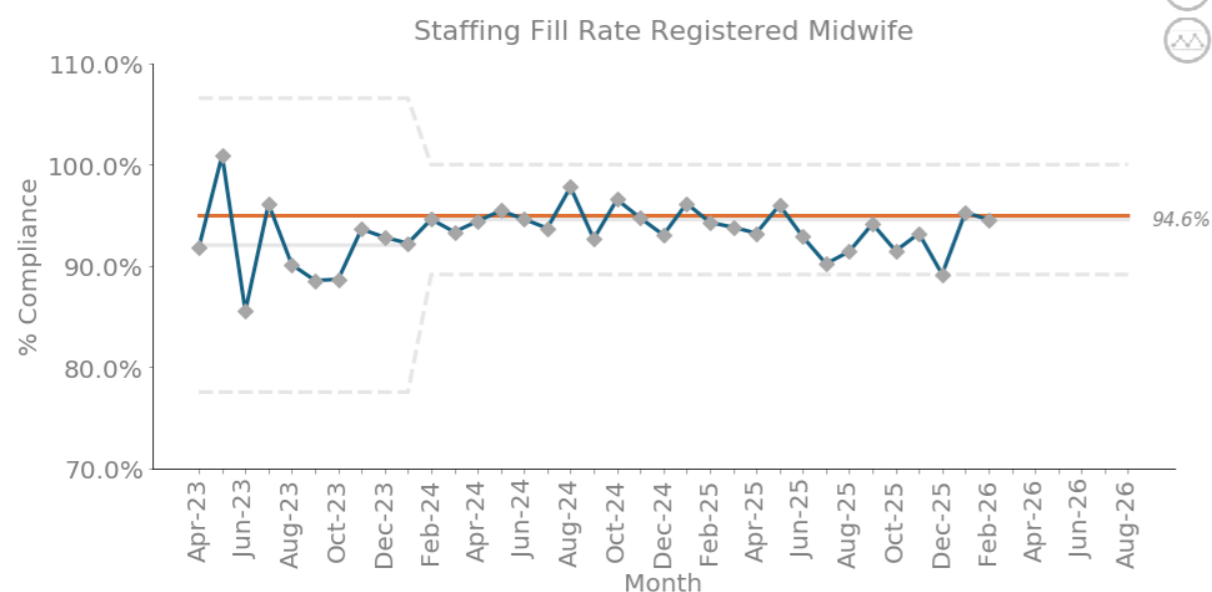


|   |
|---|
| Latest  |
| 98.29%  |
| Variance Type   |
| Recent concerning pattern in the data                   |
| Mar-26 Target   |
| 95%   |
| Target Achievement                                      |
| Will consistently pass target within expected variation |

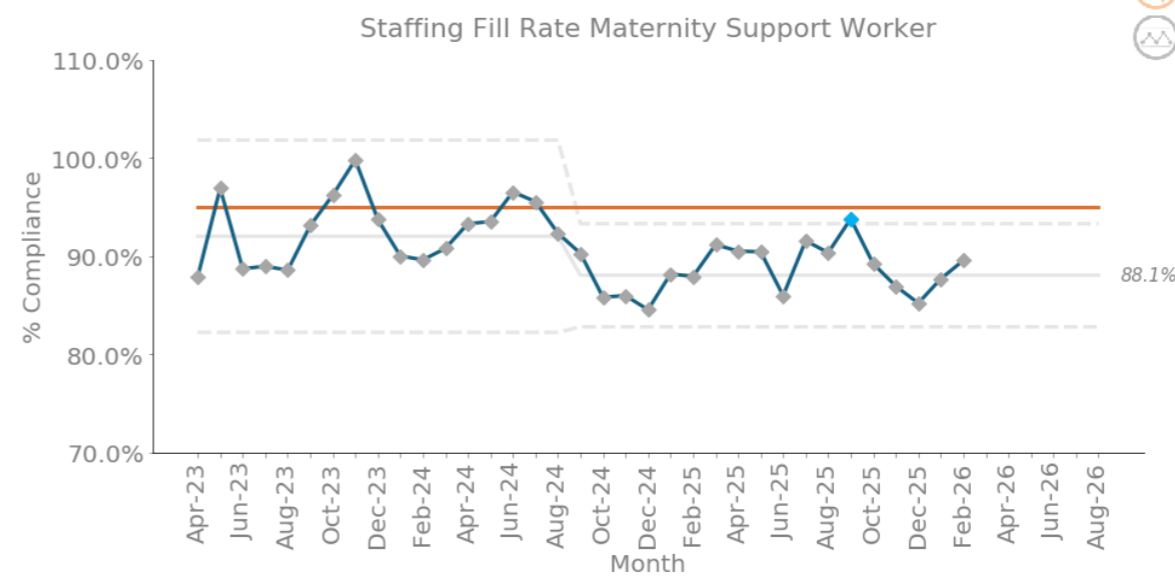
| Metric                                   | Summary   | Action   | Assurance  |
|--|---|--|--|
| Staffing Fill Rate Registered Nurse      | The RN staffing fill rate for February 2026 was 99%. At site level, Chorley District Hospital (CDH) achieved a 100% RN fill rate and Royal Preston Hospital (RPH) 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. | <ol style="list-style-type: none"> <li>Twice daily nurse staffing meetings are in place 7 days a week for oversight of safe staffing.</li> <li>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.</li> <li>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 .</li> <li>Redeployment of staff into vacancies through organisational change and ward closures, ongoing into February 2026.</li> </ol> | <ol style="list-style-type: none"> <li>All clinical areas are showing a stable fill rate position.</li> <li>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.</li> <li>Approval and sign off of all agency shifts by Chief Nursing Officer</li> <li>Biannual safe staffing procedures are in place in line with National Quality Board guidance.</li> <li>Weekly PSIRF oversight panel reviews incident harm levels, this is triangulated through a quarterly serious incident/PSIRF report.</li> <li>Involvement in National Enhanced Therapeutic Observation and Care (ETOC) improvement work.</li> <li>Additional duties follow a clear governance process for request and approval by Deputy/ Divisional Nursing Director to maintain safety and efficacies.</li> </ol> |
| 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.  | <ol style="list-style-type: none"> <li>Twice daily nurse staffing meetings are in place 7 days a week for oversight of safe staffing.</li> <li>Internal Band 2–Band 3 progression route is defined and advertised, with the first cohort scheduled to begin in April 2026.</li> <li>Centralised external recruitment campaign is in development and planned to go live in April 2026.</li> </ol>   |  |



# Patients - Deliver Annual Safe Staffing Requirements Assurance



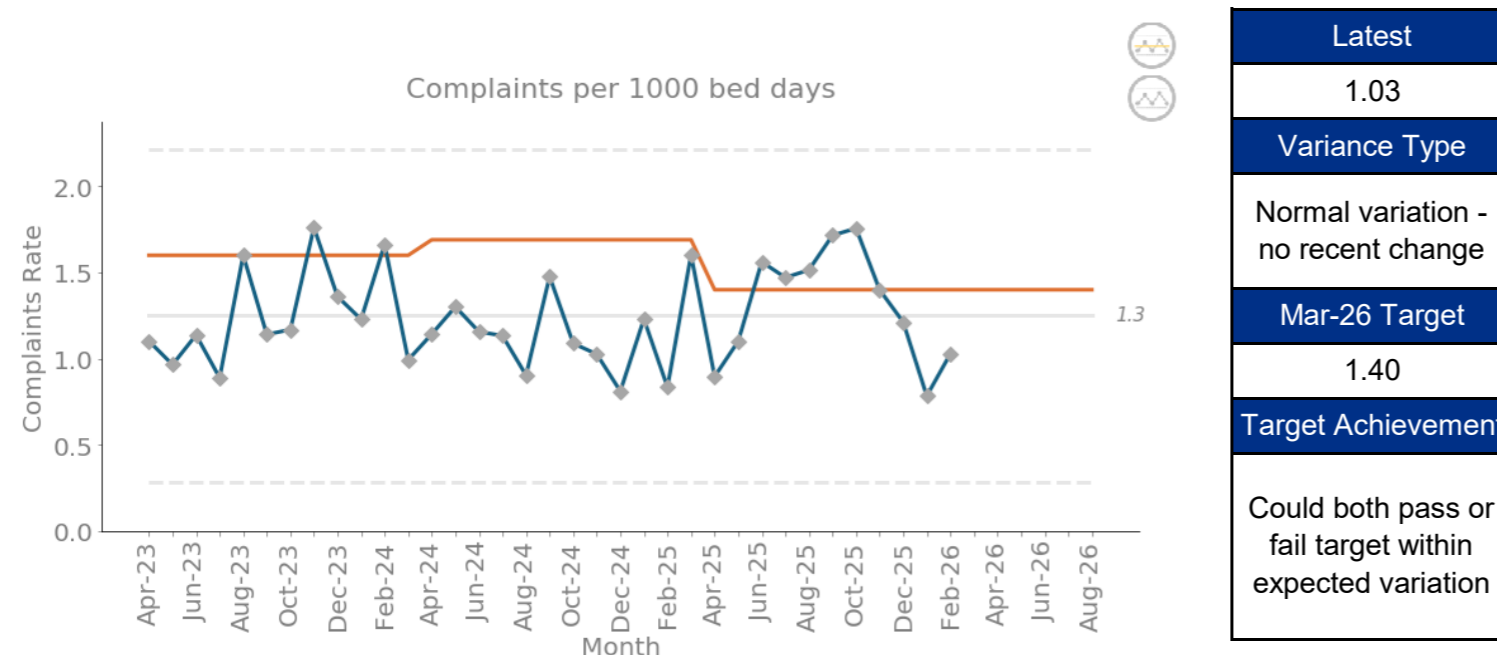
|  |
|--|
| Latest   |
| 94.56%   |
| Variance Type  |
| Normal variation - no recent change                      |
| Mar-26 Target  |
| 95%  |
| Target Achievement                                       |
| Could both pass or fail target within expected variation |



|   |
|---|
| 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. | <ol style="list-style-type: none"> <li>Weekly roster efficiency reviews as required to ensure appropriate use of bank and agency.</li> <li>Monthly roster efficiency meetings overseen by the deputy Divisional Midwifery and Nursing Director</li> <li>The service continues to recruit to turnover using over offer of 5 WTE.</li> </ol>  | <ol style="list-style-type: none"> <li>Fill rates for Registered Midwives overall have been stable across day and night shift patterns.</li> <li>The Safety and Quality committee review fill rate and minimum RM levels by area on a monthly basis.</li> <li>Approval and sign off of all agency shifts undertaken by the Deputy/ Divisional Midwifery and Nursing Director.</li> <li>Biannual safe staffing procedures are in place in line with National Quality Board guidance.</li> <li>Weekly PSIRF oversight panel reviews incident harm levels, this is triangulated through a quarterly serious incident/PSIRF report.</li> <li>Red-flag reporting is monitored to identify areas where additional input can be provided to manage the risk.</li> </ol> |
| 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 been 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.  | <ol style="list-style-type: none"> <li>Weekly roster efficiency reviews are ongoing to ensure appropriate use of temporary staff.</li> <li>Ongoing recruitment to fill all vacancies which are tracked using a local trajectory plan.</li> <li>Sickness management procedures are reviewed by Workforce Business Partner to ensure appropriate management.</li> <li>Band 2 MSW vacancies in maternity A,B and Delivery suite are being progressed through VCP or onboarding process.</li> </ol> | <ol style="list-style-type: none"> <li>The Safety and Quality committee review fill rate and minimum safe staffing levels by area on a monthly basis.</li> <li>Approval and oversight sight of rosters is undertaken by the Deputy/ Divisional Midwifery and Nursing Director.</li> <li>Biannual safe staffing procedures are in place in line with National Quality Board guidance.</li> <li>Weekly PSIRF oversight panel reviews incident harm levels, this is triangulated through a quarterly serious incident/PSIRF report.</li> <li>Red-flag reporting is monitored to identify areas where additional input can be provided to manage the risk.</li> </ol>  |

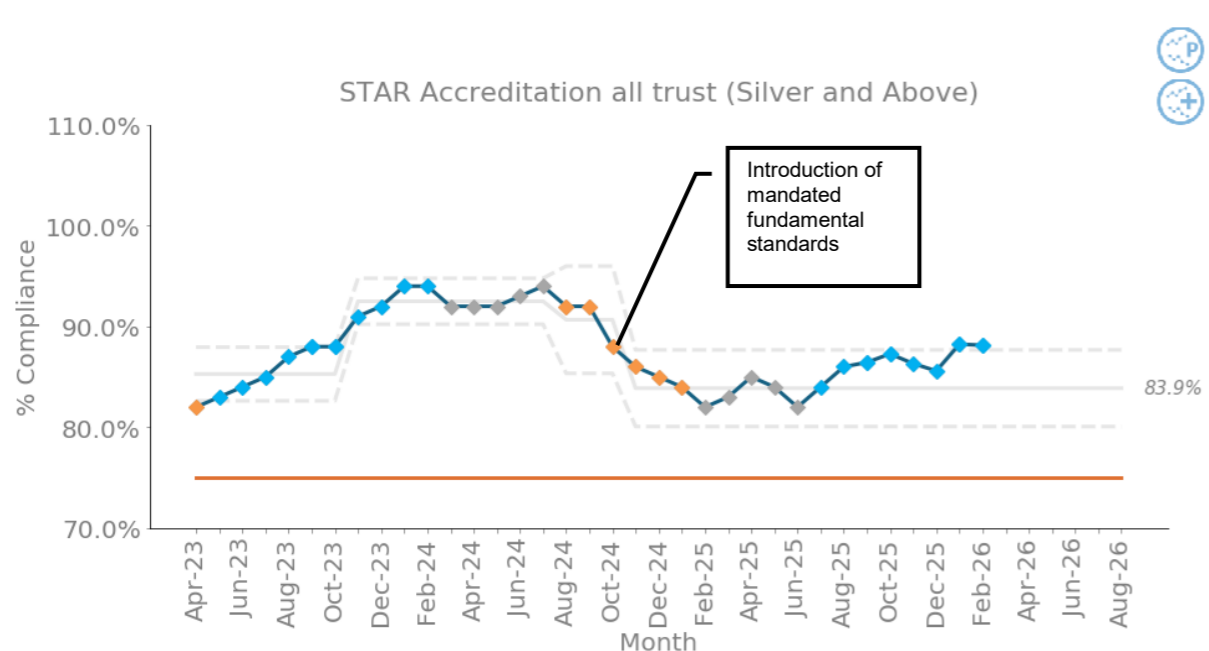
# Patients - Complaints



| Metric                       | Summary   | Action  | Assurance  |
|------------------------------|---|---|--|
| Complaints per 1000 bed days | <p>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.</p> <p>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.</p> <p>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.</p> | <ol style="list-style-type: none"> <li>1. Continue to deliver the Patient Experience Improvement Plan via the Single Improvement Plan</li> <li>2. Continue to deliver the Patient Safety Incident Response Framework with a focus on family liaison roles</li> <li>3. Monitor actions in relation to National picker Surveys .</li> <li>4. To deliver the PALS and local early resolution training.</li> <li>5. Continue to progress the complaints review group using patient safety partners and governors</li> <li>6. Where concerns have not been responded to locally escalate to managers.</li> </ol> | <ol style="list-style-type: none"> <li>1. Annual patient experience reports to Safety and Quality committee.</li> <li>2. Friends and family monthly reporting in place for all departments.</li> <li>3. Inclusion of patient experience in STAR.</li> <li>4. Chief Nursing Officer reviews all complaints and signs off responses.</li> <li>5. Monitor picker survey action plans through Patient, Carer, Experience and Involvement Group.</li> </ol> |



# Patients - Quality Assurance STAR Accreditation

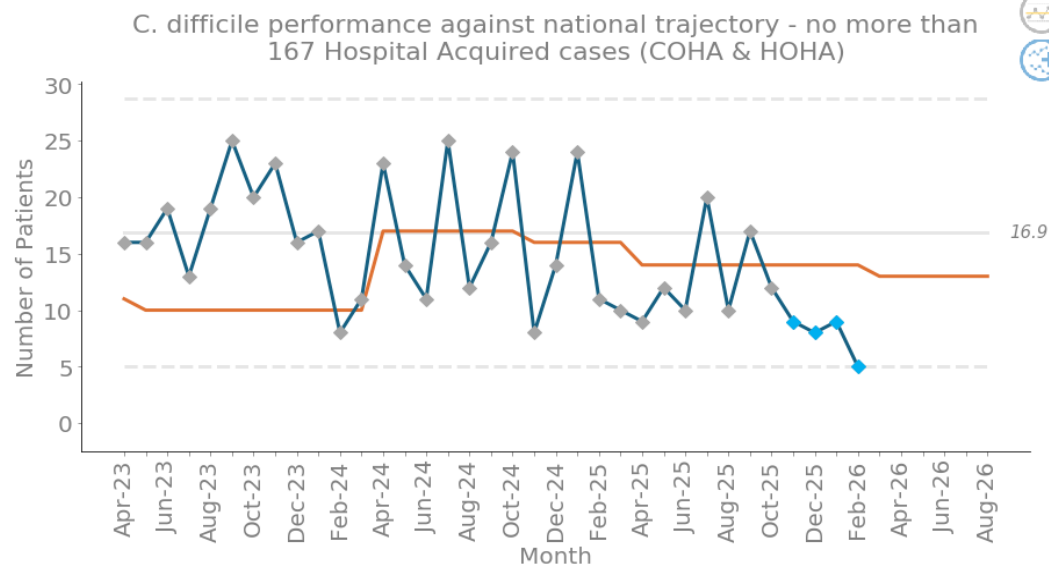


|   |
|---|
| Latest  |
| 88.14%  |
| Variance Type   |
| Recent positive pattern in the data                     |
| Mar-26 Target   |
| 75.00%  |
| Target Achievement                                      |
| Will consistently pass target within expected variation |

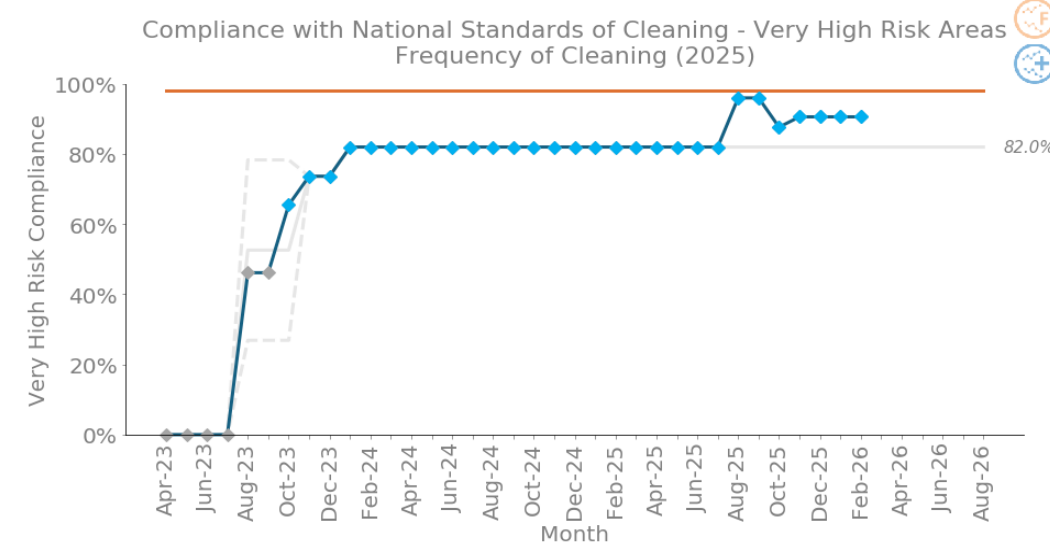
| Metric  | Summary   | Action   | Assurance   |
|---|---|--|---|
| STAR Accreditation all trust (Silver and Above) | <p>There are 118 clinical areas registered for the STAR Quality Assurance Framework, of which 117 have received STAR accreditation visits, with one new area (Respiratory Ward &amp; Respiratory 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.</p> <p>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.</p> <p>There are 79 % of wards, ED and theatres scoring silver and above for STAR accreditation visits.</p> | <ol style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>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.</li> <li>STAR monthly report updated to highlight those areas who are rated red or amber for STAR visits of less than 90% for STAR monthly reviews and includes areas ranking for their STAR performance.</li> <li>The STAR enhanced oversight panel involves 5 areas to drive action and support with STAR safety and quality actions.</li> </ol> | <ol style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>The AMaT system supports with STAR audit data management and oversight and management of improvement actions.</li> <li>There is a BI STAR page available to enable data triangulation.</li> <li>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).</li> </ol> |



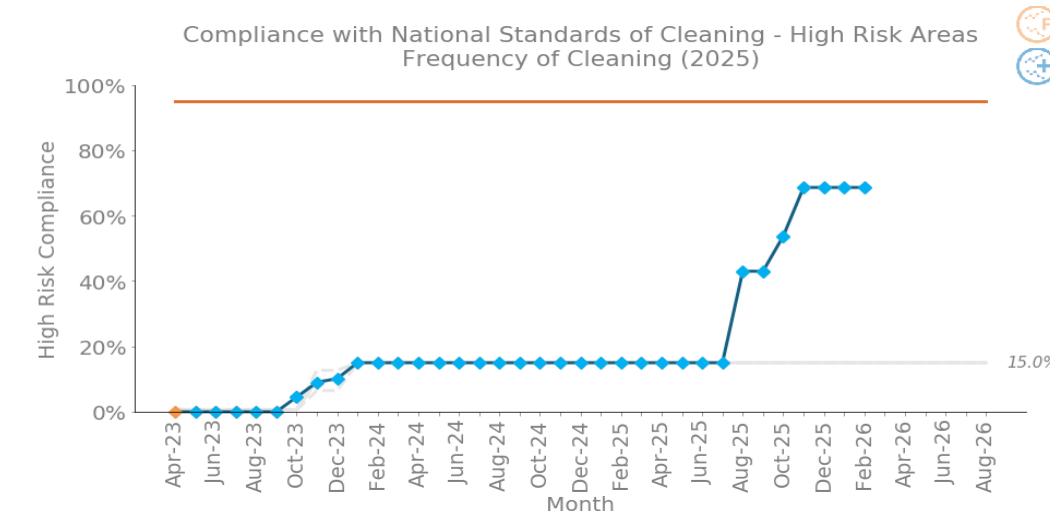
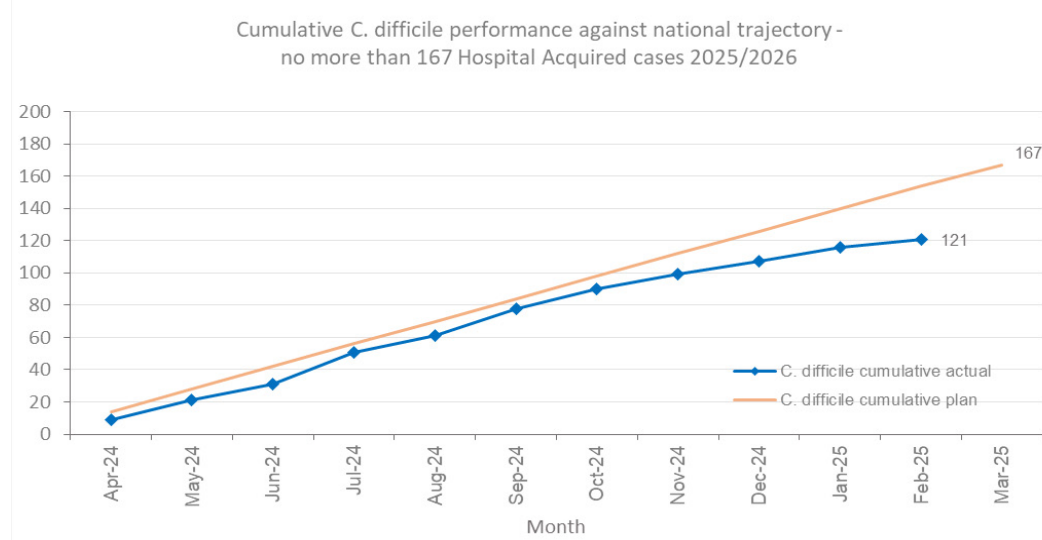
# Patients - C Difficile Improvement Programme Assurance



|  |
|--|
| 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 |



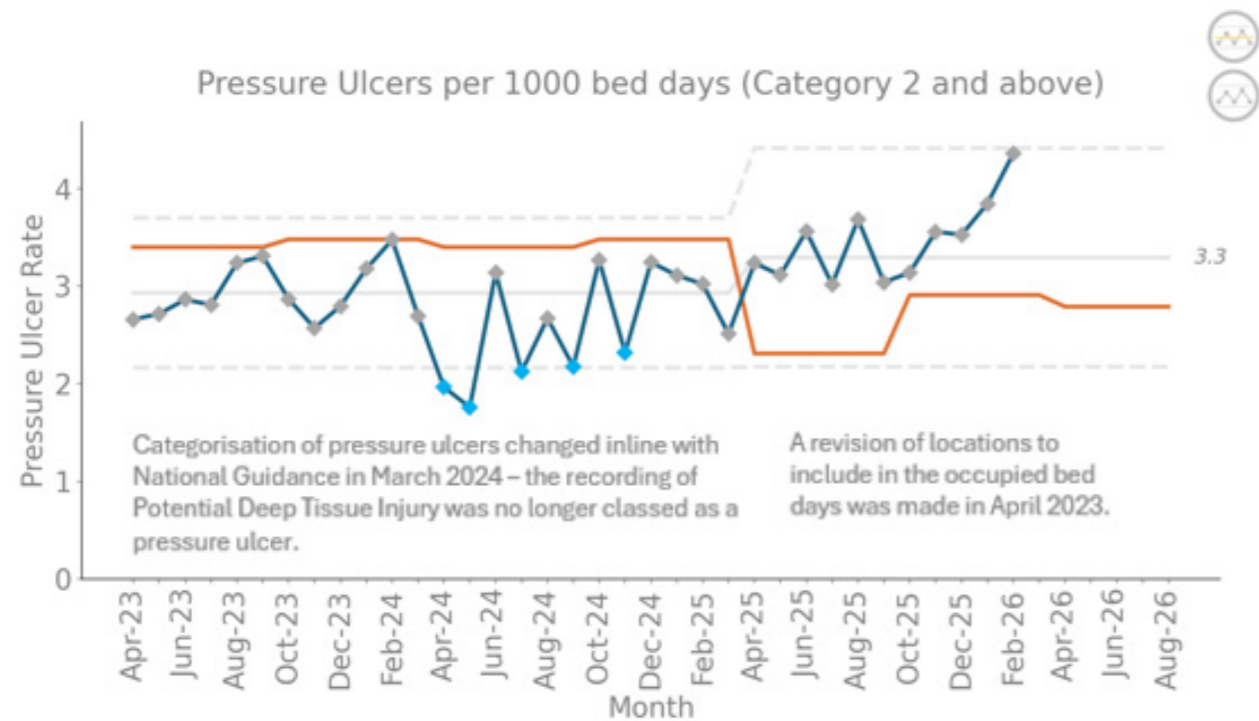
|   |
|---|
| Latest  |
| 68.64%  |
| Variance Type   |
| Recent positive pattern in the data                     |
| Mar-26 Target   |
| 95.00%  |
| Target Achievement                                      |
| Will consistently fail target within expected variation |

| 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<br>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. | <ol style="list-style-type: none"> <li>1.Implementation of the approved business case to be compliant in high risk areas with National Standards of Healthcare Cleanliness (2025).</li> <li>2. Continued focus on IPC practice through STAR monthly and accreditation processes each month.</li> <li>3. Continue to monitor key performance assurance indicators through Infection Prevention and Control committee each month.</li> </ol> | <ol style="list-style-type: none"> <li>1. IPC BAF report reviewed and shared at IPCC for assurance.</li> <li>2. IPC Dashboard.</li> <li>3. IPC monthly revalidation audits such as Hand Hygiene, Commodes, Environmental checks and Mattress checks.</li> <li>4. Monthly reporting into S&amp;Q, IPCC and Divisional IPC meetings, along with bi-monthly reporting into H&amp;S Committee.</li> <li>5. STAR encompasses IPC audits and cleaning checklist compliance, with all audit information available within AMAT.</li> <li>6. NHS England review of IPC assurances.</li> <li>7. Antimicrobial stewardship oversight and assurance reporting.</li> </ol> |



Patients

# 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. | <ol style="list-style-type: none"> <li>1. Monthly sharing of cross-divisional learning, key themes and trends through Always Safety-First (ASF) meetings (from January 2026).</li> <li>2. Quarterly thematic review of high-incidence pressure-ulcer areas, with findings fed back into monthly ASF meetings to ensure responsive action.</li> <li>3. Pressure Ulcer and Falls Review Panel to review harms, identify themes and trends, and generate actions to improve practice (commenced November 2025).</li> <li>4. Pressure ulcer safety walk-arounds by the Tissue Viability Team, shifting to a proactive assurance model (commencing April 2026).</li> </ol> | <ol style="list-style-type: none"> <li>1. Divisional Always Safety First Committees provide oversight of the pressure ulcer improvement plan and monitor progress against key actions.</li> <li>2. Monthly monitoring of pressure ulcer incidence continues as a priority quality metric, with trends reviewed at divisional and Trust level.</li> <li>3. STAR compliance for key questions 8d and 9c is monitored monthly as leading indicators of prevention practice.</li> <li>4. Weekly Pressure Ulcer and Falls Panel, with a consolidated monthly learning report submitted to PSIRF Oversight.</li> </ol> |



## Patients - Always Safety First Assurance - Mortality

|   | 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)<br><i>The updated TELSTRA model from November 2024 does not include still births</i> | As Expected         | 213.3    | October 2025 |

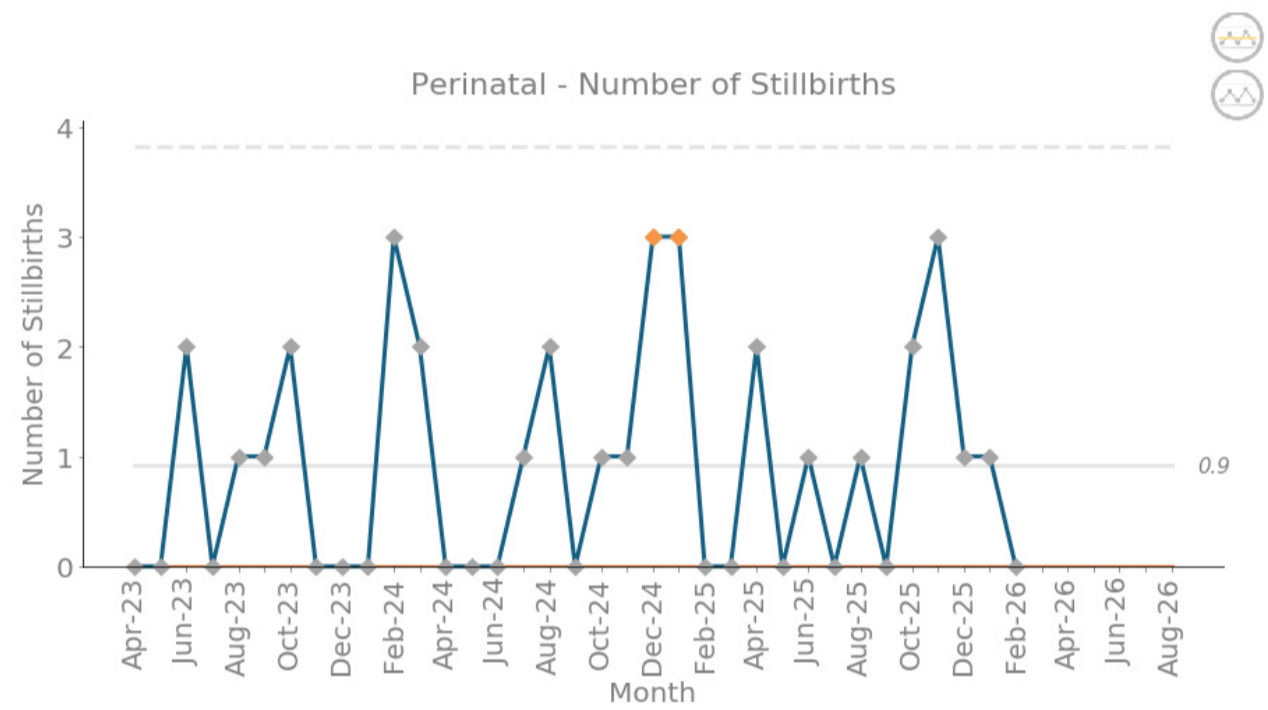
Source Data: Telstra (Dr Foster)

| 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.                                       |  |  |
| Standardised Mortality Ratio - Relative Risk - All Diagnoses Adult                   | SMR is within Upper and Lower Control Limits and lower than expected when compared to peers.  | <ol style="list-style-type: none"> <li>Continue with structured judgement review process.</li> <li>Use mortality reviews to establish themes where care or experience could be improved.</li> <li>Continue to work with the medical examiners office to review deaths in line with guidance.</li> <li>Continue to use incident reporting processes where an incident occurs under Patient safety Incident Response Framework (PSIRF).</li> <li>Continue to implement the 10 CNST safety actions for maternity and neonatal</li> <li>Marthas rule (Call for Concern) implementation is underway.</li> </ol> | <ol style="list-style-type: none"> <li>Mortality and End of Life committee chaired by Deputy Chief Medical Officer with responsibility for mortality.</li> <li>Twice annual reports to safety and Quality committee.</li> <li>Telstra system utilised to generate mortality data ensuring objective peer data is used to establish reported key performance indicator.</li> <li>Speak Up arrangements are well established in the organisation.</li> <li>Maternity Neonatal report provides assurance of compliance with Maternity neonate Safety Investigation branch for appropriate cases.</li> <li>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.</li> <li>ED and maternity and neonatal safety forums in place with executive leads identified to encourage speak up in high risk areas.</li> <li>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.</li> <li>The Trust has been validated against all 10 CNST maternity and neonatal safety actions and is now progressing through the formal sign-off process.</li> </ol> |
| 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

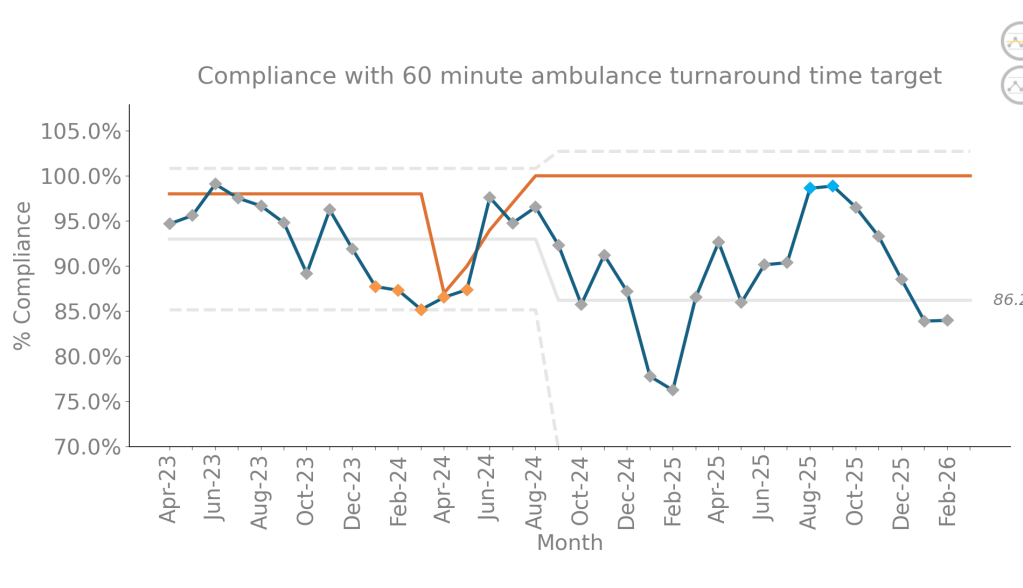
## Patients - Stillbirths Assurance



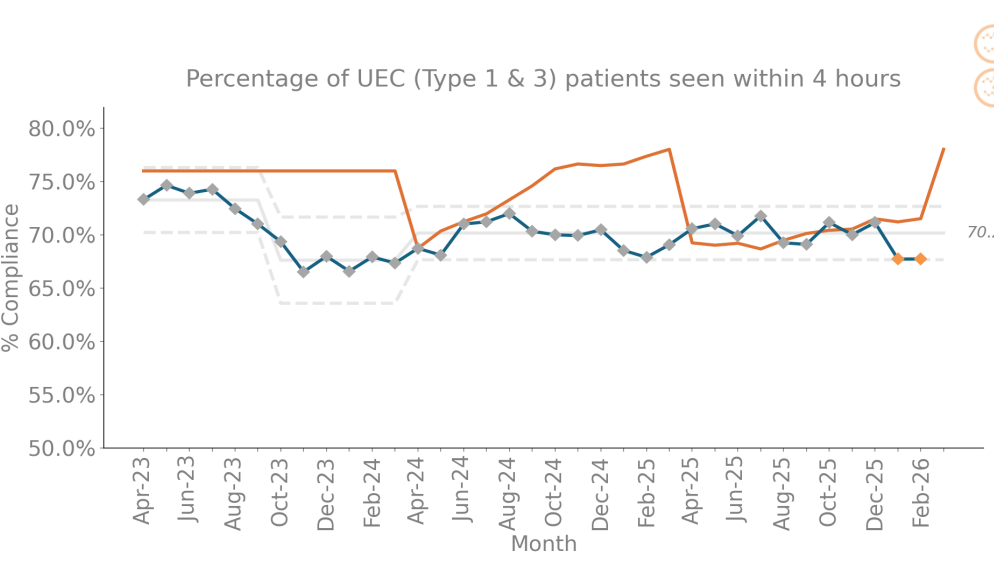
|                    |  |
|--------------------|--|
| Latest             | 0  |
| Variance Type      | Normal variation - no recent change                      |
| Mar-26 Target      | 0  |
| Target Achievement | Could both pass or fail target within expected variation |

| 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. | <ol style="list-style-type: none"> <li>Implementation of the 10 CNST maternity neonatal safety standards.</li> <li>Implementation of Single Improvement Plan (SIP) actions to improved outcomes for mothers, babies and families.</li> </ol> | <ol style="list-style-type: none"> <li>Perinatal Quality Surveillance dashboard analysis shared via the maternity and neonatal safety report to safety and quality committee.</li> <li>Peer comparison data included within the reporting for oversight</li> <li>National MBRRACE reporting provides overview of national themes to ensure learning is understood.</li> <li>ICB Local Maternity Neonatal System validation of CNST delivery of standards.</li> <li>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</li> </ol> |

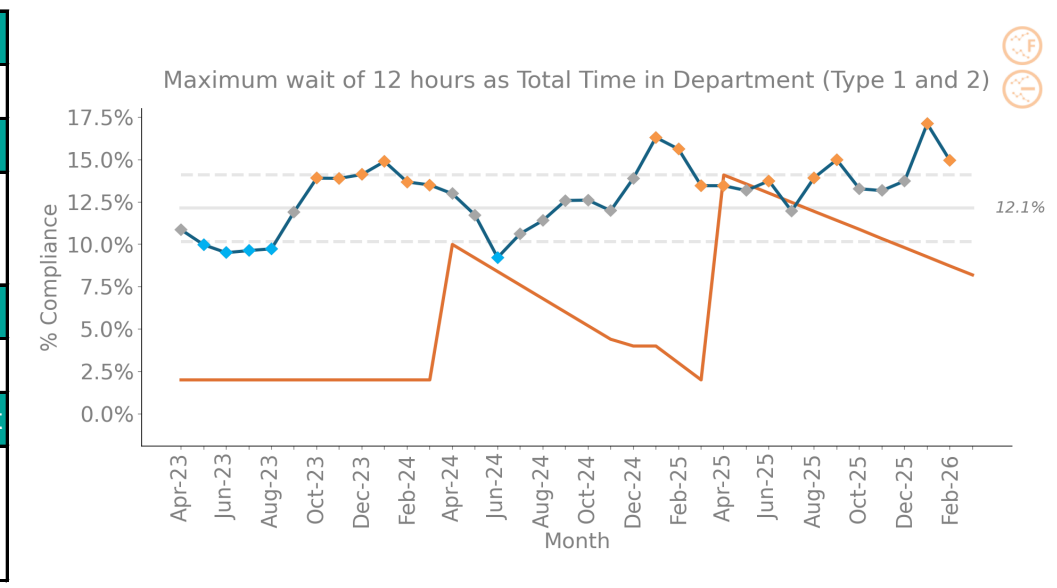
# Performance - UEC Assurance



|  |
|--|
| 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 |



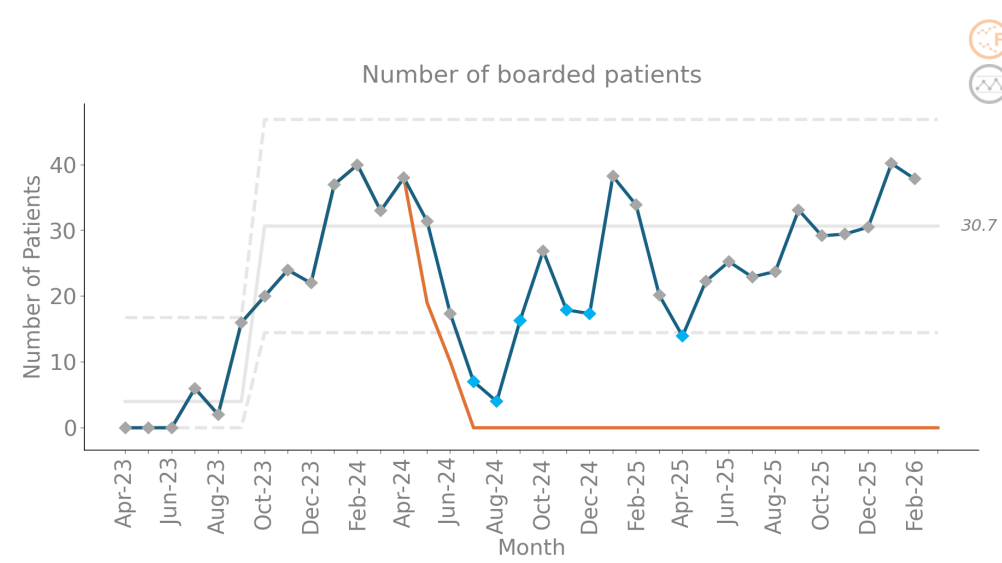
|   |
|---|
| Latest  |
| 67.74%  |
| Variance Type   |
| Recent concerning pattern in the data                   |
| Mar-26 Target   |
| 78.02%  |
| Target Achievement                                      |
| Will consistently fail target within expected variation |



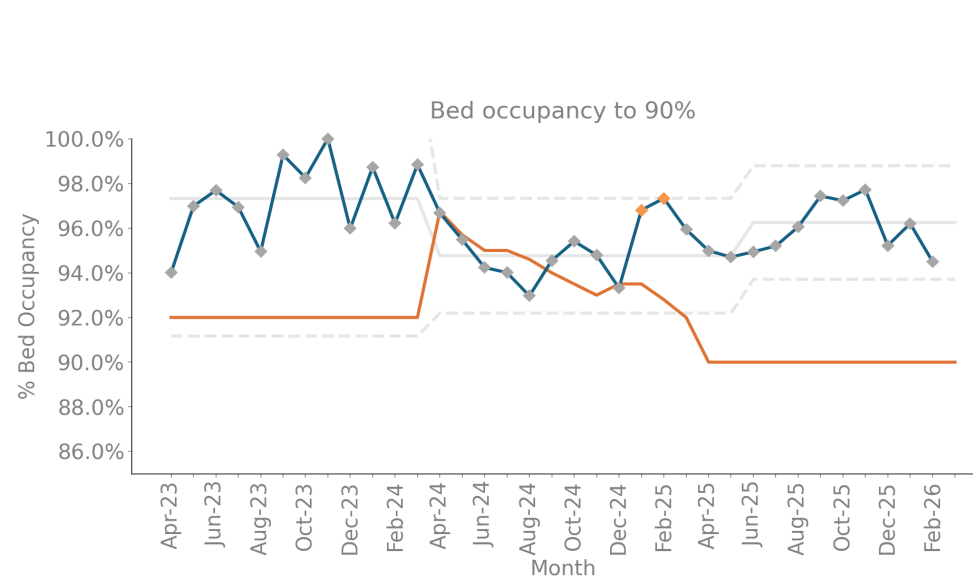
|   |
|---|
| Latest  |
| 14.97%  |
| Variance Type   |
| Recent concerning pattern in the data                   |
| Mar-26 Target   |
| 8.20%   |
| Target Achievement                                      |
| Will consistently fail target within expected variation |

| 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 NWS to the Trust, a rise of 4 from last month. 352 patients waited over 60 minutes to be handed over from NWS to the Trust in February, a decrease of 26 compared to December. In February 84% of patients were handed over within 60 minutes, an 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 NWS 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 patients 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.  |

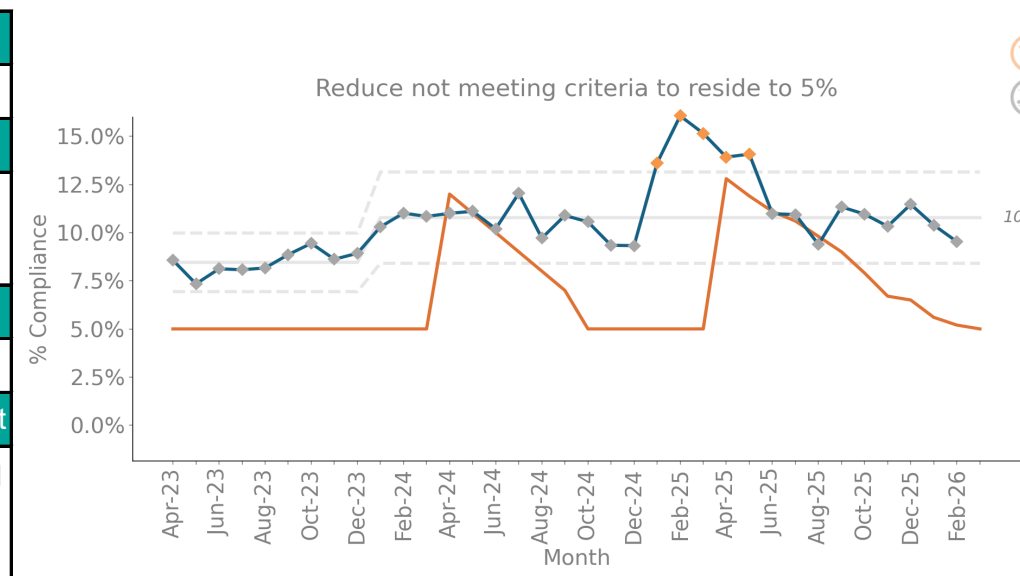
# Performance - UEC Assurance



|   |
|---|
| 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 |

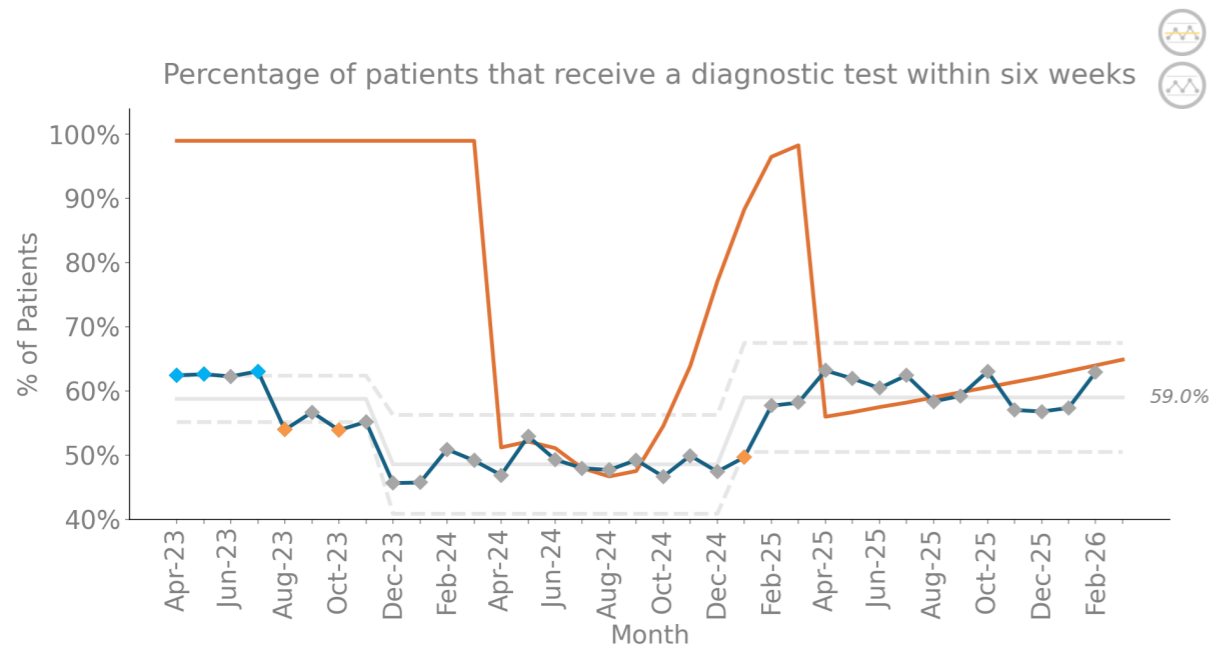


|   |
|---|
| Latest  |
| 9.5%  |
| Variance Type   |
| Normal variation - no recent change                         |
| Mar 26 Target   |
| 5%  |
| Target Achievement  |
| Will consistently fail the target within expected variation |

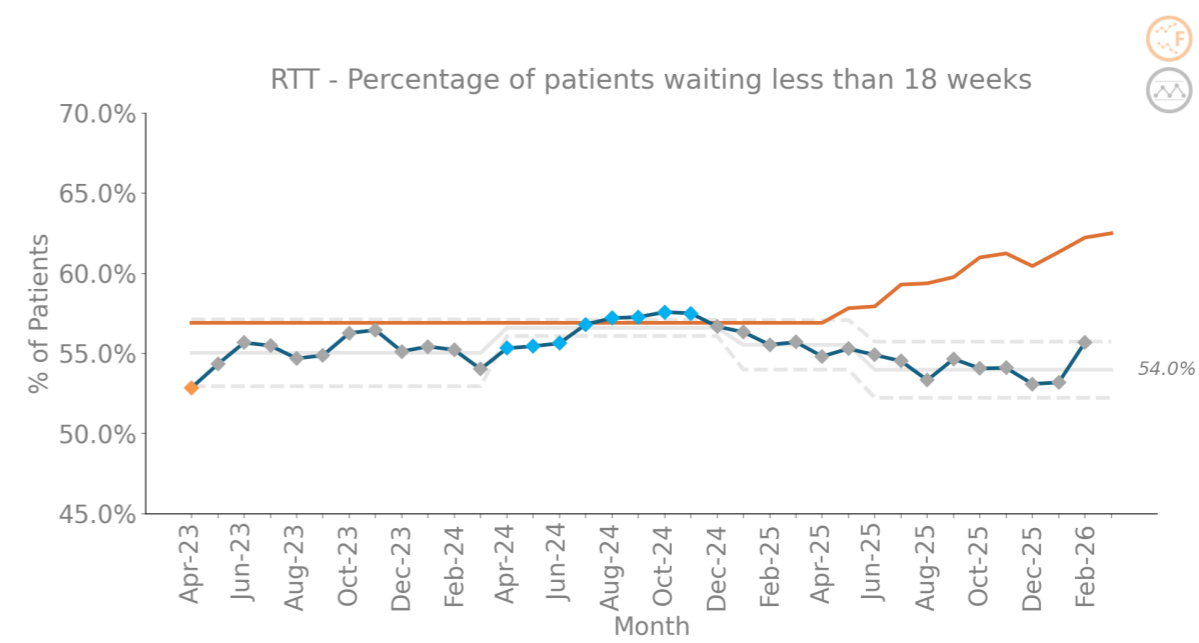
| Metric                     | Summary  | Action   | Assurance   |
|----------------------------|--|--|---|
| Number of Boarded Patients | On average 38 patients were boarded each day across both sites during February 26 with 1012 associated bed days. This is a rise compared with the December 25 position. 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 stay 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 |

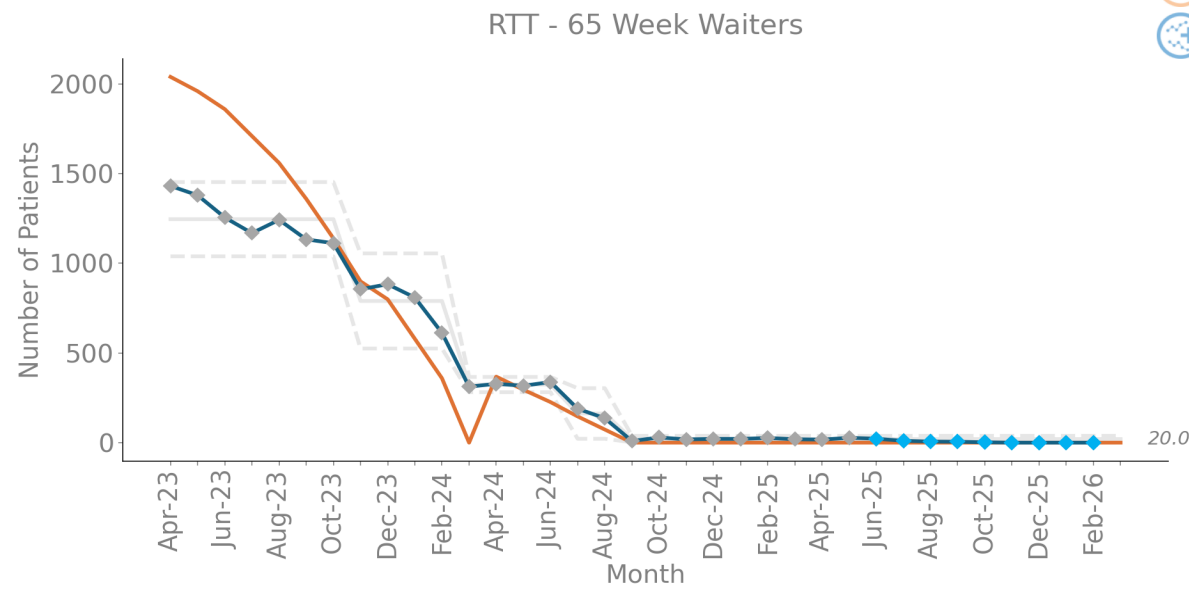


|   |
|---|
| Latest  |
| 55.70%  |
| Variance Type   |
| Normal variation - no recent change                     |
| Mar 26 Target   |
| 62.50%  |
| Target Achievement                                      |
| Will consistently fail target within expected variation |

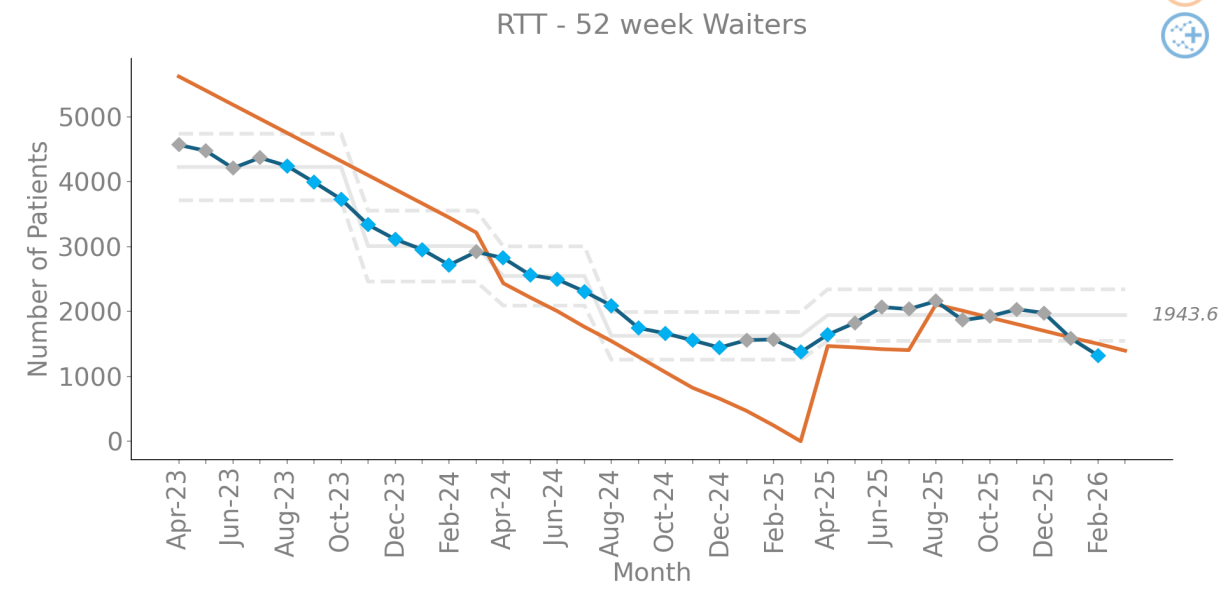
| Metric   | Summary  | Action   | Assurance   |
|--|--|--|---|
| Percentage of patients that receive a diagnostic test within six weeks | Diagnostics under 6 week performance was 62.94% in February compared to 57.4% in January, a 5.6% improvement on the January position and below trajectory. Improvements 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%.<br><br>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



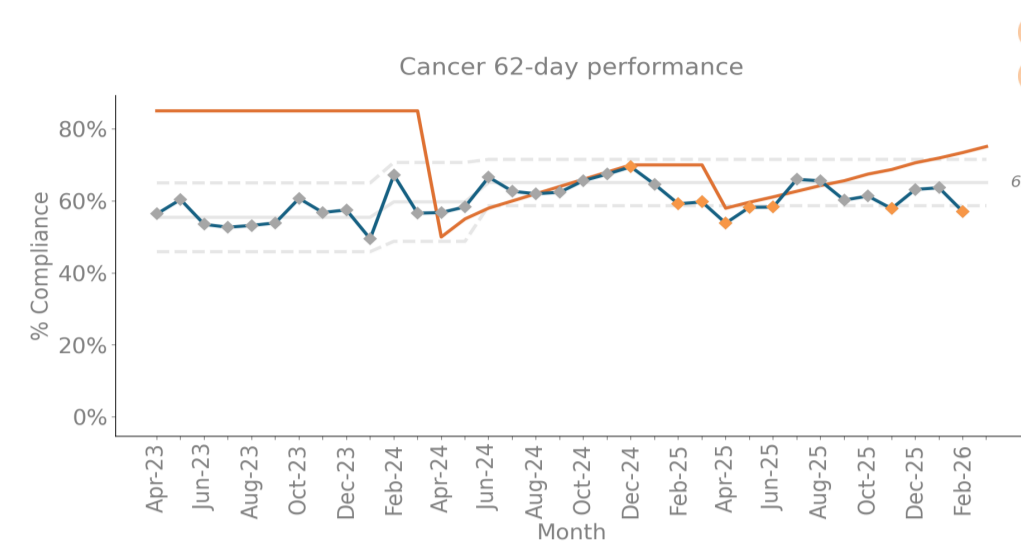
|   |
|---|
| Latest  |
| 0   |
| Variance Type   |
| Recent positive pattern in the data                         |
| Mar 26 Target   |
| 0   |
| Target Achievement  |
| Will consistently fail the target within expected variation |



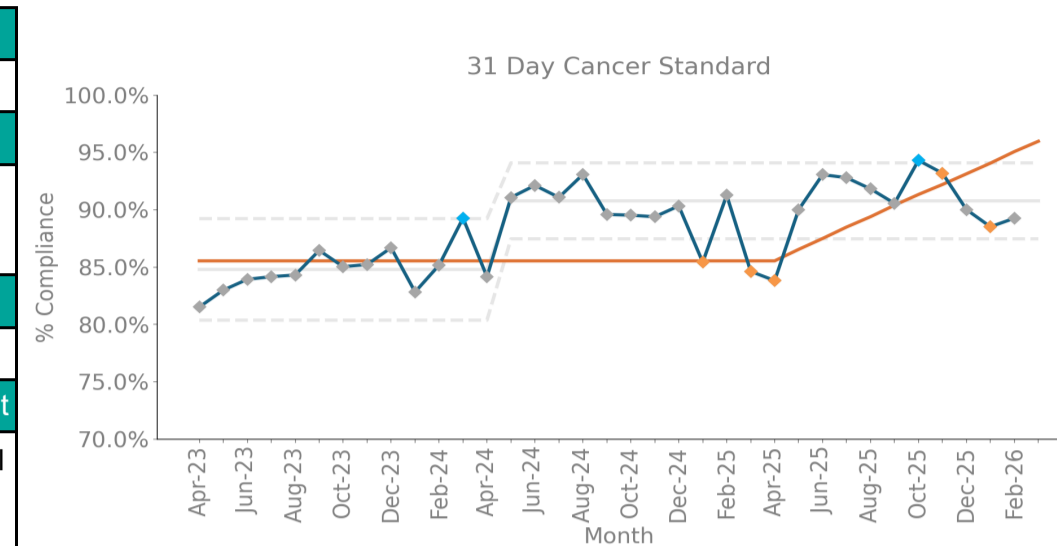
|   |
|---|
| Latest  |
| 1321  |
| Variance Type   |
| Recent positive pattern in the data                     |
| Mar 26 Target   |
| 1395  |
| Target Achievement                                      |
| Will consistently fail target within expected variation |

| 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.<br><br>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.<br><br>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. |

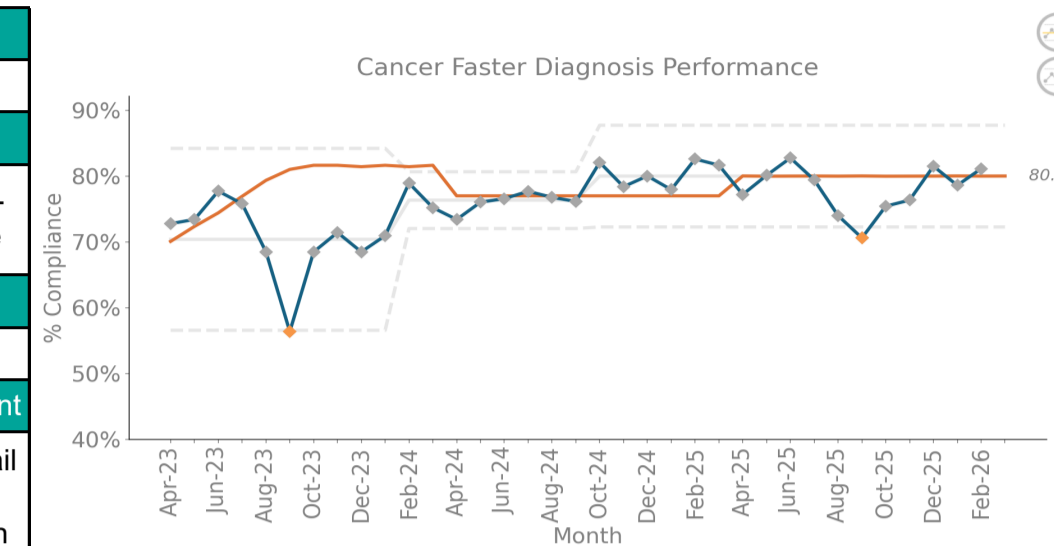
# Performance - Elective Care Assurance



|   |
|---|
| 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   |
| 95.1%   |
| 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 ( <b>currently unvalidated</b> ) 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.  |   | 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 ( <b>currently unvalidated</b> ) 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.                          | 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 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 ( <b>currently unvalidated</b> ) 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 |

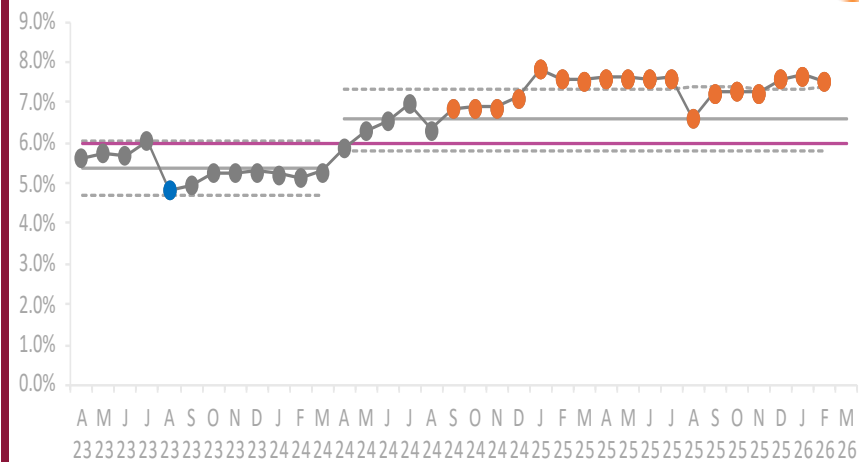


People

# People - Workforce Assurance 1

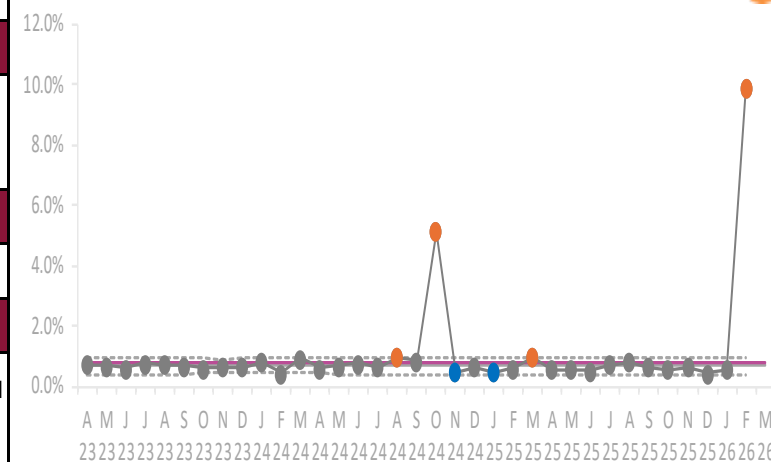


### GL Vacancy Rate (% FTE)



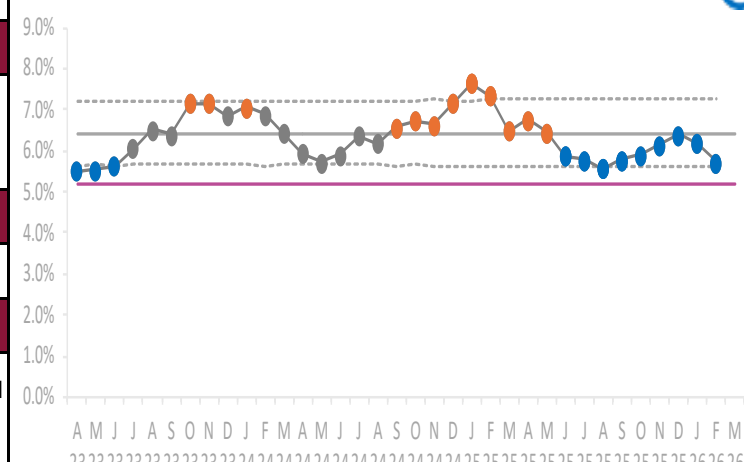
|                    |  |
|--------------------|--|
| Latest             | 7.53%  |
| Variance Type      | Recent concerning pattern in the data                    |
| Mar 26 Target      | ≤ 6%   |
| Target Achievement | Could both pass or fail target within expected variation |

### ESR Turnover (% FTE)



|                    |  |
|--------------------|--|
| 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 |

### Overall Sickness (% FTE)



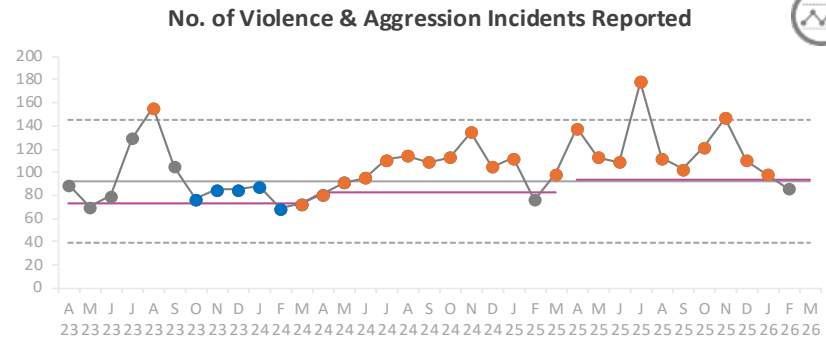
|                    |   |
|--------------------|---|
| Latest             | 5.71%   |
| Variance Type      | Normal variation - no recent change                         |
| Mar 26 Target      | ≤ 5.22%   |
| Target Achievement | Will consistently fail the target within expected variation |

| 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<br>Strategies to address Band 3 Healthcare Support Worker gaps being jointly developed by nursing, education and workforce teams<br>Vacancy control process updated to include defined times for holding posts for redeployment and internal/external advertising<br>All posts currently held for redeployment under review   | Vacancy rate monitored through Board reporting, Workforce Committee and Divisional Improvement Forums<br>Safe staffing levels monitored daily in clinical areas<br>New People Operations Group to include a focus on resourcing<br>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.<br>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<br>Procurement of digital absence management system has advanced enabling implementation planning to commence in detail<br>To support colleague wellbeing, new restrictions around working additional hours following sickness absence will be introduced in June<br>Occupational Health physiotherapy gaps soon to be resolved following successful recruitment of 1 post-holder with a 2nd post due to be offered<br>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<br>Actions resulting from the MIAA Sickness Absence Management audit monitored through Audit Committee<br>'Failure to manage sickness absence management effectively' is a Principal Risk and subject to monthly risk management review<br>Fortnightly sickness absence task and finish group in place to monitor actions of the sickness absence reduction plan<br>Paper to May TMB outlined actions completed, ongoing or newly developed |

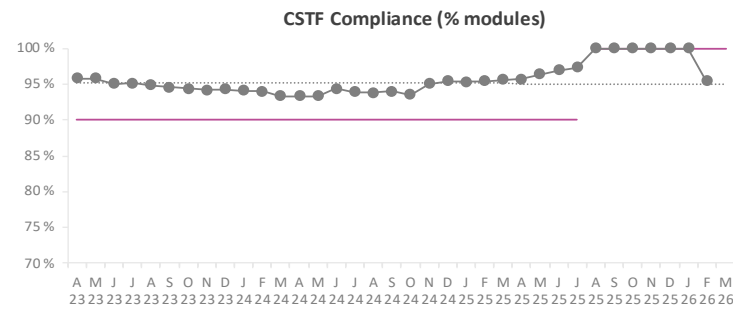


People

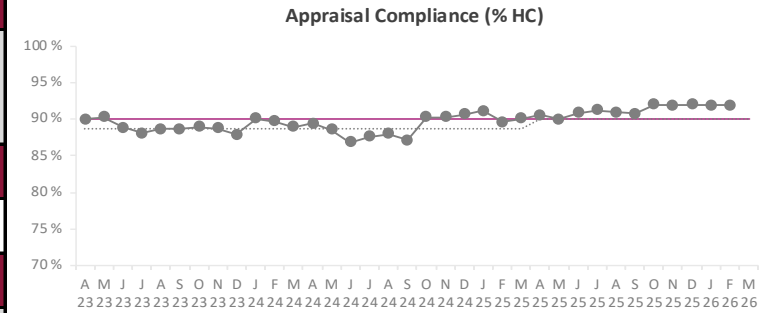
# People - Workforce Assurance 2



|  |
|--|
| 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 |
|                    |

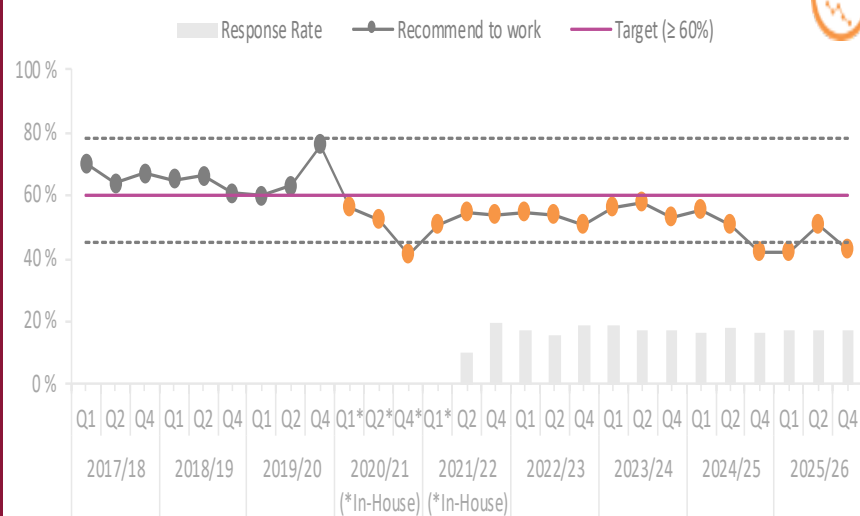
| Metric   | Summary   | Action   | Assurance  |
|--|---|--|--|
| Number of violence and aggression incidents toward staff | January and February's data is now in the graph (BM)                      | Monthly meetings established for Emergency Department with clinical, security and workforce representatives to review actions and learning from recent incidents<br>Security presence increased in ED with the aim of 24/7 cover, and an assessment of all other security measures underway<br>Liaison between Resilience leads and police recently strengthened<br>Violence and aggression risk assessment for wards/departments reviewed by Big Room and will be relaunched in June<br>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<br>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.<br>Divisional Performance metrics shared in Divisional Workforce Committees and Divisional Improvement Forums. |



People

# People - Workforce Assurance 3

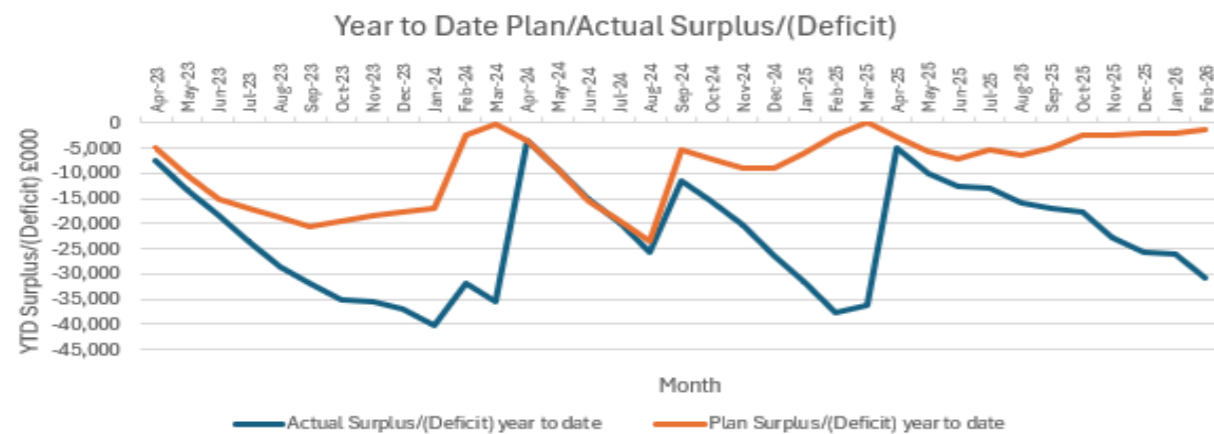
### NQPS % Recommend to Work



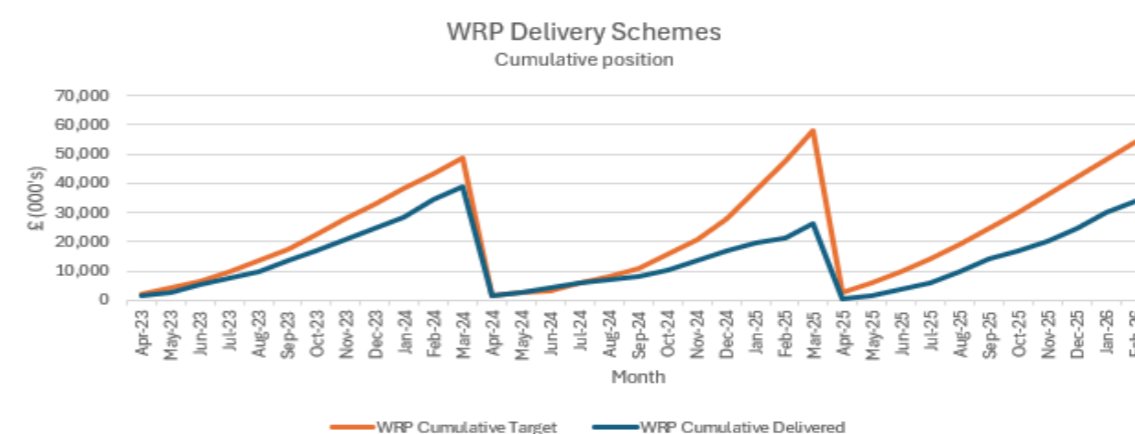
|   |
|---|
| Latest  |
| 42.5%   |
| Variance Type   |
| Recent concerning pattern in the data                       |
| Mar 26 Target   |
| ≥ 60%   |
| Target Achievement  |
| Will consistently fail the target within expected variation |

| 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. | <p>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.</p> <p>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.</p> | <p>Workforce Committee reports detailing the programme of work in response to NHS Staff Survey data and national benchmarking.</p> <p>Delivery of the corporate action plan progressed through collaboration with relevant teams and leads addressing priorities/themes.</p> <p>Divisional action plans are scheduled for monthly review through Divisional Workforce Committees - frequency and depth of reporting varies across Divisions.</p> <p>Enhanced team support activity is ongoing in targeted areas of concern, with progress tracked and reviewed through Organisational Development operational meetings.</p> |

# Productivity - Assurance



|                             |
|-----------------------------|
| 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 | <p>At the end of February 2026 the Trust has a deficit of £30.8m against a planned deficit of £1.5m.</p> <p>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.</p> <p>The Trust has operational pressures in:</p> <ul style="list-style-type: none"> <li>- the acute medical pathways reflected in overspends in medical and nursing pay budgets</li> <li>- sickness remains higher than in operational budgets resulting in nursing pay overspends</li> </ul> | <p>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.</p> <p>A re-set of the programme structure, governance and reporting for 2025/26 has taken place.</p> <p>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.</p> <p>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.</p> <p>The Trust commissioned further external support for specific financial recovery plan workstreams and 2025/26 waste recovery programme development.</p> <p>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.</p> | <p>Working with ICB on UEC Pathway</p> <p>Grip and control Interventions and control measures</p> <p>Mandated national support from PWC and the Provider Improvement Programme (formerly Recovery Support Programme)</p> |
| WRP schemes delivery         | <p>'The Trust's 2025/26 waste reduction target is £60m, 7% of operating expenditure.</p> <p>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.</p>  | <p>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.</p> <p>The Trust has additional external support to help with the delivery of the programme.</p> <p>The Trust is now embedding its own project management office structure to have a sustainable solution moving forward.</p> <p>The Trust is enhancing grip and control activities to mitigate slippage in specific schemes.</p>   | <p>Waste reduction programme board chaired by CEO</p> <p>External support for specific workstreams.</p> <p>Implementation of Divisional Delivery Groups</p> <p>Embedding of PMO</p>                                      |

## 7.2 UPDATE FOR CARE AND SAFETY SUBGROUP

● Information Item

👤 G Robinson

🕒 1:45 pm

## 7.3 UPDATE FROM MEMBERSHIP SUBGROUP

● Information Item

👤 S Brennan

🕒 1:55 pm

## 7.4 MEMBERSHIP SUBGROUP TERMS OF REFERENCE

● Decision Item

👤 J Foote

🕒 2:05 pm

---

### REFERENCES

Only PDFs are attached

 7.4 Membership Subgroup Terms of Reference.pdf



# Council of Governors

|   |  |  |
|---|--|--|
| <b>Meeting of the</b>   | <b>Council of Governors</b>  | <b>23 April 2026</b>                         |
| <b>Title of Report</b>  | <b>Membership Subgroup Terms of Reference</b>  |  |
| <b>Report Author</b>  | Katie Stanton, Business Manager, Corporate Affairs   |  |
| <b>Lead Executive Director</b>  | Jennifer Foote, Director of Corporate Affairs  |  |
| <b>Recommendation/<br/>Actions required</b>   | It is recommended that the Council of Governors approve the Membership Subgroup Terms of Reference.  |  |
|   | <b>Decision</b><br><input checked="" type="checkbox"/>   | <b>Assurance</b><br><input type="checkbox"/> |
| <b>Executive Summary</b>  | The purpose of this report is to provide the Council of Governors with the Terms of Reference for the Membership Subgroup.   |  |
|   | The Terms of Reference have undergone a comprehensive review by subgroup members and all proposed amendments are presented in Appendix 1, where changes have been clearly highlighted for ease of reference. |  |
| <b>Link to Strategic Objectives 2025/26</b><br><br><i>(Please mark X against the strategic objective(s) applicable to this paper - this could be more than one)</i> | <b>Patients – deliver excellent care:</b> Improve outcomes, reduce harm and deliver a positive patient experience.   | <input checked="" type="checkbox"/>          |
|   | <b>Performance – deliver timely, effective care:</b> Deliver agreed trajectories in clinical performance.  | <input type="checkbox"/>                     |
|   | <b>People – be a great place to work:</b> Create an inclusive culture with leaders at every level leading colleague engagement.  | <input checked="" type="checkbox"/>          |
|   | <b>Productivity – deliver value for money:</b> Deliver the agreed financial plan including waste reduction programme, maximising use of resources.   | <input type="checkbox"/>                     |
|   | <b>Partnership – be fit for the future:</b> 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. | <input checked="" type="checkbox"/>          |
| <b>Appendices</b>   | State whether there are any appendices and list them. For example:<br>Appendix 1: Membership Terms of Reference – with track changes   |  |

---

---

## TEMPORARY TERMS OF REFERENCE

---

---

### 1. CONSTITUTION

- 1.1 ~~These Terms of Reference reflect the scope and remit of the Membership and Public Engagement Sub Group for the period 14 April – 31 July 2024 or until such time as the Council decides on the form and function of the sub group in the light recommendations arising from the Task and Finish sub group on Governance and clarification of the Trust's strategy on Membership and Public Engagement. These interim Terms of Reference reflect the scope and remit of the Membership and Public Engagement Sub Group for the period 31 July 2024 – 31 July 2026 pending the publication of the Trusts Engagement strategy.~~

### 2. PURPOSE

- 2.1 To support the discharge of the responsibility of Council to engage with the public and provide the view of the public at large on matters relating to the work of the Trust. This will include actively planning how governors may participate in external events, forward planning for maintaining a calendar of events; other matters that may arise from time to time in connection with the duty public engagement and considered relevant by the sub group.

### 3. COMPOSITION AND CONDUCT OF THE SUBGROUP

- 3.1 Any governor may join the Sub Group upon notification to the Corporate Affairs Team. The quorum shall be three governors (including either the chair or deputy chair).
- 3.2 The members of the Subgroup shall elect from amongst themselves a Chair and Deputy Chair of the Subgroup. Once elected by the Subgroup, the term of the Chair and Deputy Chair (as appropriate) shall be for the initial period of the temporary constitution of the sub group. A governor may not put themselves forward as Chair if they are also the chair of another sub-group.
- 3.3 If the Chair is not present at a meeting, it is expected that the Deputy Chair shall chair the relevant meeting.
- 3.4 Election of the Chair and Deputy Chair shall be completed by way of a secret ballot. Only those substantive members of the Subgroup are entitled to cast a vote and a vote shall be passed by a simple majority of those members present and voting. In the event of a tied decision, the decision shall be put to a Council meeting for consideration.
- 3.5 **Notice of meetings.** Before each meeting, a notice specifying the business proposed to be transacted (agenda) and the minutes of the previous meetings (if appropriate) shall be sent by electronic mail to the usual place of business, designated e-mail address or residence of all governors, so as to be available at least three clear days before the meeting.
- 3.6 **Frequency of meetings.** The Subgroup shall meet as set out in the calendar of meetings for the Membership Sub Group for ~~2024/25~~, 2024/26. However, the Chair may call a meeting at any time provided that notice of the meeting is given as specified in s.3.5 above.

- 3.7 Any member of the Subgroup who wishes to add an item to the agenda should agree this with the Chair of the Subgroup.
- 3.8 **Minutes.** The minutes of meetings shall be formally recorded and submitted for agreement at the next meeting of the Subgroup.

## 8. GOVERNANCE AND COMPLIANCE

## 8.1 OUTCOME OF NON-EXECUTIVE DIRECTOR APPRAISALS AND RE-APPOINTMENT OF DR T BALLARD FOR SECOND TERM - REPORT OF THE NOMINATIONS COMMITTEE

● Other

👤 M Thomas

🕒 2:10 pm

Item for Assurance

---

### REFERENCES

Only PDFs are attached



8.1 Outcome of Non-Executive Director Appraisals and Re-appointment of Dr T Ballard for Second Term April 2026 (1).pdf



# Council of Governors Report

|   |  |   |  |
|---|--|---|--|
| <b>Meeting of the</b>                       | <b>Council of Governors</b>  |   | <b>23 April 2026</b>                           |
|   | <b>Part I</b> <input checked="" type="checkbox"/>  | <b>Part II</b> <input type="checkbox"/>                 |  |
| <b>Title of Report</b>                      | Outcome of Non-Executive Director Appraisals and Re-appointment of Dr T Ballard for Second Term  |   |  |
| <b>Report Of</b>                            | Nominations Committee  |   |  |
| <b>Recommendation/ Actions required</b>     | It is recommended that the Council approves the recommendations of the Nominations Committee to  |   |  |
|   | <ol style="list-style-type: none"> <li>1. re-appointment Dr Tim Ballard for a second term of office for three years from 1 October 2026;</li> <li>2. notes the satisfactory completion of the non-executive director appraisals for 2025/2026.</li> </ol>  |   |  |
|   | <b>Decision</b><br><input checked="" type="checkbox"/>   | <b>Assurance</b><br><input checked="" type="checkbox"/> | <b>Information</b><br><input type="checkbox"/> |
| <b>Executive Summary</b>                    | <p><b>Re-Appointment of NED</b><br/>Under Schedule 7, paragraph 17(1) of the National Health Service Act 2006, it is for the Council of Governors at a general meeting to appoint, re-appoint or remove the Non-Executive Directors. The purpose of this report is to provide information for the Nominations Committee to consider re-appointment of Dr T Ballard whose term of office is due to expire on 30 September 2026.</p> <p><b>Completion of NED appraisals 2025/26</b><br/>The Chair undertook appraisals with the Non-Executive Directors and Associate Non-Executive Directors for the year 2025/26. In addition the Chair was appraised by Karen Deeney as Senior Independent Director (SID). Karen in turn was appraised by Adrian Leather as Vice-Chair to ensure a separation of consideration.</p> |   |  |
| <b>Link to Strategic Objectives 2025/26</b> | <b>Patients – deliver excellent care:</b> Improve outcomes, reduce harm and deliver a positive patient experience.   | <input checked="" type="checkbox"/>                     |  |
|   | <b>Performance – deliver timely, effective care:</b> Deliver agreed trajectories in clinical performance.  | <input checked="" type="checkbox"/>                     |  |
|   | <b>People – be a great place to work:</b> Create an inclusive culture with leaders at every level leading colleague engagement.  | <input checked="" type="checkbox"/>                     |  |
|   | <b>Productivity – deliver value for money:</b> Deliver the agreed financial plan including waste reduction programme, maximising use of resources.   | <input checked="" type="checkbox"/>                     |  |
|   | <b>Partnership – be fit for the future:</b> 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.   | <input checked="" type="checkbox"/>                     |  |

## Re-Appointment of NED

Under Schedule 7, paragraph 17(1) of the National Health Service Act 2006, it is for the Council of Governors at a general meeting to appoint, re-appoint or remove the Non-Executive Directors. The purpose of this report is to provide information for the Nominations Committee to consider re-appointment of Dr Tim Ballard whose first term of office is due to expire on 30 September 2026. In line with the Trust's Constitution (paragraph 12.14), any re-appointment of a Non-Executive Director by the Council of Governors for a second term may be undertaken without the need to revert to open process as long as a satisfactory appraisal has been carried out in accordance with procedures which the Board of Directors have approved. Discussions have been held with Dr Ballard who has confirmed his intention to serve for a further term, as determined by the Trust Constitution and subject to approval by the Council of Governors. This was considered by the Nominations Committee at its meeting on 14 April and the recommendation for Council to approve a second term was made.

## NED Appraisals

All non-executive directors undertake an annual appraisal to assess their performance during the prior year in order for Council to have assurance that they continue to be fit for the role during the coming year. This is undertaken using the NHSE framework for NED appraisals and is reported through to NHS Region once acknowledged as completed by Council. Objectives are individually set using the guidance as detailed in 'the Insightful Board' and taking into account the Corporate Objectives for the year and any other roles carried out by the individual as part of their NED role. Council itself does not undertake the appraisal, it confirms (via the Nominations Committee) that the appraisals have been undertaken and that a satisfactory outcome has been achieved. Details of objectives are personal data and are not therefore published.

Details of the appraisals are set out as follows:

| Name                           | Date of Appraisal | Outcome                | Notes   |
|--------------------------------|-------------------|------------------------|---|
| <b>Chair</b><br>Mike Thomas    | 19 March 2026     | Satisfactory Appraisal | documents completed and objectives set for 2026/27. |
| <b>Non-Executive Directors</b> |                   |                        |   |
| Tim Ballard                    | 3 March 2026      | Satisfactory Appraisal | documents completed and objectives set for 2026/27. |
| StJohn Crean                   | 31 March 2026     | Satisfactory Appraisal | documents completed and objectives set for 2026/27. |
| Karen Deeney                   | 19 March 2026     | Satisfactory Appraisal | documents completed and objectives set for 2026/27. |
| Adrian Leather                 | 19 March 2026     | Satisfactory Appraisal | documents completed and objectives set for 2026/27. |
| Uzair Patel                    | 10 March 2026     | Satisfactory Appraisal | documents completed and objectives set for 2026/27. |
| John Schorah                   | 2 April 2026      | Satisfactory Appraisal | documents completed and objectives set for 2026/27. |
| Tim Wheeler                    | 31 March 2026     | Satisfactory Appraisal | documents completed and objectives set for 2026/27. |

## 8.2 QUALITY ACCOUNT 2026/27: ENGAGEMENT ON SAFER PRIORITIES

● Information Item

👤 S Morrison

🕒 2:20 pm

## 8.3 COUNCIL EFFECTIVENESS SELF-ASSESSMENT

● Decision Item

● J Foote

● 2:30 pm

---

### REFERENCES

Only PDFs are attached

 8.3 CoG Board Effectiveness Self Assessment April 2026.pdf



# Council of Governors

|   |   |  |
|---|---|--|
| <b>Meeting of the</b>                       | <b>Council of Governors</b>   | <b>23 April 2026</b>                         |
| <b>Title of Report</b>                      | <b>Council Effectiveness Self -Assessment</b>   |  |
| <b>Report Author</b>                        | Katie Stanton, Business Manager in Corporate Affairs  |  |
| <b>Lead Executive Director</b>              | Jennifer Foote, Director of Corporate Affairs   |  |
| <b>Recommendation/ Actions required</b>     | The Council is asked to: endorse the proposed Key Performance Indicators for 2026/27 as a measure of effectiveness.   |  |
|   | <b>Decision</b><br><input checked="" type="checkbox"/>  | <b>Assurance</b><br><input type="checkbox"/> |
| <b>Executive Summary</b>                    | The Council met on 9 April 2026 to review performance against the Council Key Performance Indicators (KPIs) for 2025/26 and to agree the proposed KPIs for 2026/27. The proposed indicators reflect the Council's responsibilities and current priorities and are used as a measure of the Council's effectiveness in discharging its duties. |  |
|   | The Council as asked to consider and approve the new KPIs put forward.  |  |
| <b>Link to Strategic Objectives 2025/26</b> | <b>Patients – deliver excellent care:</b> Improve outcomes, reduce harm and deliver a positive patient experience.  | <input checked="" type="checkbox"/>          |
|   | <b>Performance – deliver timely, effective care:</b> Deliver agreed trajectories in clinical performance.   | <input type="checkbox"/>                     |
|   | <b>People – be a great place to work:</b> Create an inclusive culture with leaders at every level leading colleague engagement.   | <input checked="" type="checkbox"/>          |
|   | <b>Productivity – deliver value for money:</b> Deliver the agreed financial plan including waste reduction programme, maximising use of resources.  | <input type="checkbox"/>                     |
|   | <b>Partnership – be fit for the future:</b> 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.  | <input checked="" type="checkbox"/>          |
| <b>Due Diligence</b>                        | To give the Committee assurance, please complete the following:   |  |
| <b>Operational Group Review:</b>            | Governor Training Attendees   | Date: 9 April 2026                           |
| <b>Appendices</b>                           | State whether there are any appendices and list them. For example:<br>Appendix 1 Proposed KPIs for 2026/27.<br>Appendix 2 sets out the 2025/26 indicators, related activity and survey results.   |  |

## **1. Background / context or introduction**

The session was convened to review and reflect on a set of key performance indicators (KPIs) for the Council of Governors as set for 2025/26 and to establish a set to adopt for the 2026/27 year. These KPIs were intended to measure the Council's effectiveness across core areas of governance and engagement. Once finalised, the proposed KPIs for 2026/27 would be compiled into a formal report for submission and approval at the Council of Governors meeting scheduled for 23 April 2026.

The Governors were presented with the Key Performance Indicators and yearly performance for each indicator as well as in year survey results and free text comments received with the surveys, which were conducted October 2025 and March 2026.

## **2. Financial implications**

None

## **3. Legal implications**

None

## **4. Risks**

None

## **5. Impact on stakeholders**

None

## **6. Recommendations**

It is recommended that:

- I. Th Council approve the 2026/27 KPIs put forward

## Appendix 1

### Council of Governor Key Performance Indicators 2026/27

| KPI Area                                | Indicator   | Target / Threshold   |
|---|---|--|
| Governor Attendance and Quoracy         | Attendance at Subgroup meetings                     | 75% of subgroup membership   |
|   | Attendance at Council of Governors meetings         | 90% of all governors   |
| Governor Induction                      | Completion of induction for new governors           | 100% within two months   |
| Governor Retention                      | Number of resignations (excluding term completions) | Trigger review if more than 6 resignations (April–March)   |
| Engagement with Non-Executive Directors | Observe a Board of Directors meetings               | At least 1 per year  |
|   | Hybrid governor and NED meetings held at both sites | 4 per year to be held  |
|   | Confidence survey on holding NEDs to account        | Conducted March 2027<br>*revised question  |
| Governor Engagement                     | Development of Engagement Plan                      | Schedule for in year Development Session   |
|   | Governor attendance at AMM                          | 50% of Governors to attend   |
| Training                                | Training sessions attended                          | At least 3 per governor per year of a minimum of 5 held events (inc STAR, PLACE and department visits) |

## **Appendix 2**

### **Council of Governor Key Performance Indicators and Outcomes 2025/26**

| KPI Area                                      | Indicator  | Target / Threshold                | Notes  |
|---|--|-----------------------------------|--|
| <p><b>Governor Attendance and Quoracy</b></p> | <p>Attendance at Subgroup meetings</p>             | <p>75% of subgroup membership</p> | <p>Across 5 Membership Subgroup meetings held in 2025/26, attendance by current Governor members (excluding non-Governor attendees) equated to an overall attendance rate of 60%.</p> <p>Across 6 Care and Safety Subgroup meetings held during 2025/26, attendance by current Governor members (excluding non-Governor attendees) equated to an overall attendance rate of 77.8%.</p> |
|   | <p>Attendance at Council of Governors meetings</p> | <p>90% of all governors</p>       | <p>20 Jan 2026 attendance 81.8%. This is the only CoG meeting held since the KPI was agreed, with previous meetings 2025/26 ranging 66.7% to 75% attendance</p>  |
|   | <p>Attendance at Annual Members' Meeting</p>       |                                   | <p>9 Governors were in attendance at the AMM 2025/26</p>   |

| KPI Area                  | Indicator   | Target / Threshold                                       | Notes   |
|---------------------------|---|--|---|
| <b>Governor Induction</b> | Completion of induction for new governors           | 100% within two months                                   | 100% achieved   |
| <b>Governor Retention</b> | Number of resignations (excluding term completions) | Trigger review if more than 6 resignations (April–March) | 7 resignations 2025-26. Note 3 were appointed from partnering organisations and left their employment, forcing resignation.   |
| <b>Training</b>           | Training sessions attended                          | At least 5 per governor per year                         | 4 of 5 planned CoG training sessions in 2025/26 occurred, 3 of which have attendance data recorded. 15% of governors still in post as of 31 March 2026 had attended all 3 sessions held and 10% had not attend any sessions held. |

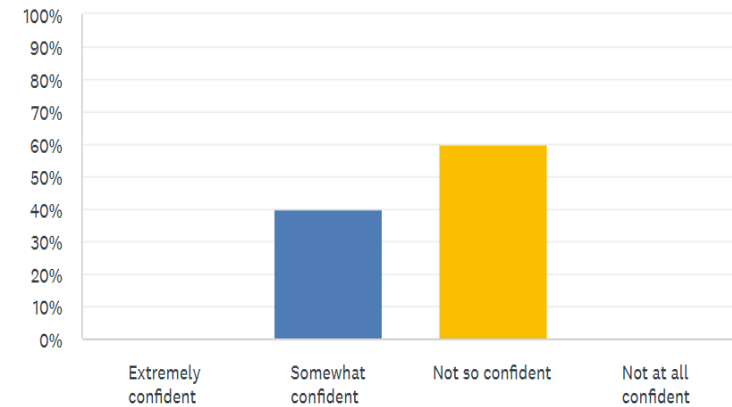
| KPI Area                                       | Indicator   | Target / Threshold   | Notes   |
|--|---|--|---|
| <b>Engagement with Non-Executive Directors</b> | Observe a Board of Directors meetings               | At least 1 per year  | During 2025/26, 13 of the Trust's 27 Governors (48.1%) observed at least one meeting of the Board of Directors. Of the 20 Governors still in post at the end of 2025/26, 55% had observed at least one meeting. |
|  | Hybrid governor and NED meetings held at both sites | 4 per year (2025/26 had only 2 sessions scheduled. 23 April & 23 Sept) | 8 Governors still in post as of 31 March 2026 (40%) had attended both Joint Board and Council development sessions held during 2025/26. 5 Governors (25%) had attended neither session.                         |
|  | Confidence survey on holding NEDs to account        | Conducted now and again in April                                       | Follow-up questions if confidence does not improve  |
| <b>Governor Engagement</b>                     | Development of Engagement Plan                      | By April 2026  | None evidenced  |

## Survey Monkey Results as of 20 October 2025

- Being a newbie it is getting to know the NEDs and the processes and systems in place which is improving month on month  
22/10/2025 11:45 [View respondent's answers](#) [Add tags](#) ▼
- The amount of time spent with the NEDs outside of formal meetings  
17/10/2025 11:14 [View respondent's answers](#) [Add tags](#) ▼
- No contact with NEDs. Questioning of any data/report is after it is completed and feels like horse has bolted.  
16/10/2025 16:27 [View respondent's answers](#) [Add tags](#) ▼
- I don't think our words or actions seem to matter  
16/10/2025 15:14 [View respondent's answers](#) [Add tags](#) ▼
- No real personal contact. Navigation via the board papers is difficult because of the volume. Personally I have never met some of the NEDs which makes forming relationships difficult and getting an understanding of everyone's point of view.  
16/10/2025 14:48 [View respondent's answers](#) [Add tags](#) ▼

How confident do you feel in your ability to hold Non-Executive Directors (NEDs) to account in your governor role?

Answered: 10 Skipped: 0



✓ We only have sight of their interaction with Board Members in a very formal public meeting . It would be better to have access to Committee meetings to measure their input into decision making processes . As Governors we are all wanting to see the Trust thrive and I see no reason why we cannot be trusted with a deeper level of involvement - in an observer role . When we get close to a problem the usual response is that we are not there to get involved with operational issues. That leads to a a feeling of being sidelined

16/10/2025 09:31

[View respondent's answers](#) [Add tags ▼](#)

✓ My experience in being held to account from my professional background helps my to hold NEDs to account at LTH. Knowledge of LTH as an organisation is still a learning curve for me.

16/10/2025 06:26

[View respondent's answers](#) [Add tags ▼](#)

✓ Past Failure to do has not been analyzed

15/10/2025 18:17

[View respondent's answers](#) [Add tags ▼](#)

✓ I have only been a public governor for six months and I am not familiar with the system. Apart from that I only know three of the NEDs

15/10/2025 15:36

[View respondent's answers](#) [Add tags ▼](#)

✓ Very little contact

15/10/2025 15:10

[View respondent's answers](#) [Add tags ▼](#)

# Survey Monkey Results as of 7 April 2026

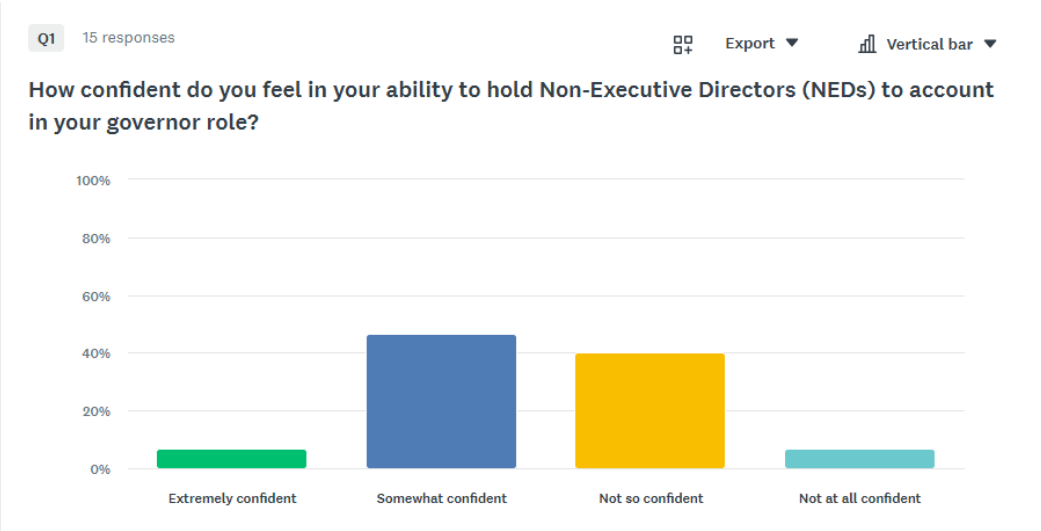
- 07/04/2026 19:58 [View full response](#) [Add tags](#)

A total lack of training!

31/03/2026 15:37 [View full response](#) [Add tags](#)
- Previous experience helps with this
- Seeing the NEDs in action during meetings and visits (these hospital visits still need to be more frequent)
- Not enough contact between the NEDs and the COG.

07/04/2026 19:58 [View full response](#) [Add tags](#)
- The NEDs do produce helpful reports and expose themselves to questioning at CoG and CaSs. The predilection for attending those meetings remotely and the reluctance to attend site visits or otherwise meet with Governors does however impact our effectiveness.

06/04/2026 17:01 [View full response](#) [Add tags](#)



## 8.4 GOVERNOR ELECTIONS 2026


● Information Item

● J Foote

● 2:40 pm

### REFERENCES

Only PDFs are attached

 8.4 Governor Elections 2026.pdf



# Council of Governors

|   |  |  |   |
|---|--|--|---|
| <b>Meeting of the</b>                       | Council of Governors   | 23 April 2026                                |   |
|   | <b>Part I</b> <input checked="" type="checkbox"/>  | <b>Part II</b> <input type="checkbox"/>      |   |
| <b>Title of Report</b>                      | <b>Governor Elections 2026</b>   |  |   |
| <b>Report Author</b>                        | Katie Stanton, Business Manager, Corporate Affairs   |  |   |
| <b>Lead Executive Director</b>              | Jennifer Foote, Director of Corporate Affairs  |  |   |
| <b>Recommendation/ Actions required</b>     | It is recommended that the Board of Directors receive the report and note the contents for information.  |  |   |
|   | <b>Decision</b><br><input type="checkbox"/>  | <b>Assurance</b><br><input type="checkbox"/> | <b>Information</b><br><input checked="" type="checkbox"/> |
| <b>Executive Summary</b>                    | <p>The purpose of this report is to confirm the results of the 2026 elections to the Council of Governors. The Governor election process is an annual process carried out in line with the Trust’s Constitutional requirements and in accordance with Model Election Rules as published by NHS Providers. The election was conducted by Electoral Reform Services who acted as Returning Officer on behalf of the Trust.</p> <p>For the 2026 Governor election, there were seven vacancies in the public constituency and three vacancies in the staff categories of Doctors and Dentists, Non-Clinical and Unregistered Healthcare and Support Workers. Voting closed on 20 March 2026 with results declared on 23 March 2026, included in the report for information. A copy of the Report of Voting and Uncontested Report from the Returning Officer are attached which includes the list of candidates elected and a breakdown of voting.</p> <p>It is recommended that the Council of Governors receive the report and the results of the 2026 Governor election for information.</p> <p>Appendix 1: Report of Voting and Uncontested Report</p> |  |   |
| <b>Link to Strategic Objectives 2025/26</b> | <b>Patients – deliver excellent care:</b> Improve outcomes, reduce harm and deliver a positive patient experience.   | <input checked="" type="checkbox"/>          |   |
|   | <b>Performance – deliver timely, effective care:</b> Deliver agreed trajectories in clinical performance.  | <input checked="" type="checkbox"/>          |   |
|   | <b>People – be a great place to work:</b> Create an inclusive culture with leaders at every level leading colleague engagement.  | <input checked="" type="checkbox"/>          |   |

|  |  |                                     |
|--|--|-------------------------------------|
|  | <b>Productivity – deliver value for money:</b> Deliver the agreed financial plan including waste reduction programme, maximising use of resources.   | <input checked="" type="checkbox"/> |
|  | <b>Partnership – be fit for the future:</b> 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. | <input checked="" type="checkbox"/> |

## 1. Introduction

The Governor election process is an annual process carried out in line with the Trust's Constitutional requirements and in accordance with Model Election Rules as published by NHS Providers. The election was conducted by Electoral Reform Services who acted as Returning Officer on behalf of the Trust.

For the 2026 Governor election, there were seven vacancies in the public constituency and three vacancies in the staff categories of Doctors and Dentists, Non-Clinical and Unregistered Healthcare and Support Workers. Voting closed on 20 March 2026 with results declared on 23 March 2026, included in the report for information. A copy of the Report of Voting and Uncontested Report from the Returning Officer are attached which includes the list of candidates elected and a breakdown of voting.

The first Council of Governors meeting is held on 23 April 2026 and induction for new Governors has commenced. One governor has been re-elected for the period 1 April 2026 to 31 March 2029.

### Outcome of the 2026 Election to the Council of Governors

The outcome of the 2026 Governor election is confirmed as follows:

#### CONTEST: PUBLIC

The election was conducted using the single transferable vote electoral system and the following candidates were selected (in order of election):

Graham Fullarton (re-elected)  
Christine Turner  
Linda Bracewell  
Susan Bailey  
Ian Facer  
Zulekha Mushtaq  
Terry Lindsay

#### UNCONTESTED: STAFF

George-Adrian Rata (Doctors and Dentists)  
Ian Linacre (Non-Clinical)

#### ELECTED: STAFF

Sheila Beale (Unregistered Healthcare and Support Workers)

## 2. Financial implications

There are no financial implications associated with the recommendations in this report.

### **3. Legal implications**

The election process has been conducted in line with the Trust's Constitution and the Model Election Rules published by NHS Providers.

### **4. Risks**

There are no risks associated with the recommendations in this report.

### **5. Impact on stakeholders**

Stakeholders will be advised of the outcomes of the elections.

### **6. Recommendations**

It is recommended that the Council of Governors receive the report and the results of the 2026 Governor election for information.

## LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST

### ELECTION TO THE COUNCIL OF GOVERNORS

CLOSE OF VOTING: 5PM ON 20 MARCH 2026

#### CONTEST: Public

*The election was conducted using the single transferable vote electoral system.*

*The following candidates were elected (in order of election):*

| ELECTED           |  |  |
|-------------------|--|--|
| TURNER, Christine |  |  |
| BRACEWELL, Linda  |  |  |
| BAILEY, Susan     |  |  |
| FACER, Ian        |  |  |
| FULLARTON, Graham |  |  |
| MUSHTAQ, Zulekha  |  |  |
| LINDSAY, Terry    |  |  |

|  |     |       |
|--|-----|-------|
| Number of eligible voters                  |     | 8,782 |
| Votes cast online:                         | 277 |       |
| Votes cast by post:                        | 278 |       |
| Total number of votes cast:                |     | 555   |
| Turnout:                                   |     | 6.3%  |
| Number of votes found to be invalid:       |     | 9     |
| Total number of valid votes to be counted: |     | 546   |

#### CONTEST: Staff: Unregistered Healthcare and Support Workers

*The election was conducted using the single transferable vote electoral system.*

*The following candidate was elected:*

| ELECTED       |  |  |
|---------------|--|--|
| BEALE, Sheila |  |  |

|  |    |       |
|--|----|-------|
| Number of eligible voters                  |    | 2,086 |
| Votes cast online:                         | 97 |       |
| Total number of votes cast:                |    | 97    |
| Turnout:                                   |    | 4.7%  |
| Number of votes found to be invalid:       |    | 0     |
| Total number of valid votes to be counted: |    | 97    |



The result sheets for the election forms the Appendix to this report. They detail:-

- the quota required for election
- each candidate's voting figures, and
- the stages at which the successful candidates were elected.

Civica Election Services can confirm that, as far as reasonably practicable, every person whose name appeared on the electoral roll supplied to us for the purpose of the election:-

a) was sent the details of the election and

b) if they chose to participate in the election, had their vote fairly and accurately recorded

The elections were conducted in accordance with the rules and constitutional arrangements as set out previously by the Trust, and CES is satisfied that these were in accordance with accepted good electoral practice.

All voting material will be stored for 12 months.

**Ciara Hutchinson**  
**Returning Officer**  
**On behalf of Lancashire Teaching Hospitals NHS Foundation Trust**

## LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST

### ELECTION TO THE COUNCIL OF GOVERNORS

**CLOSE OF NOMINATIONS: 5PM ON 3 FEBRUARY 2026**

Further to the deadline for nominations for the above election, the following constituencies are uncontested:

| <b>STAFF: DOCTORS AND DENTISTS<br/>1 TO ELECT</b>                        |
|--|
| The following candidate was elected unopposed:<br><br>George-Adrian Rata |

| <b>STAFF: NON-CLINICAL<br/>1 TO ELECT</b>                         |
|---|
| The following candidate was elected unopposed:<br><br>Ian Linacre |

**Ciara Hutchinson**  
**Returning Officer**  
**On behalf of Lancashire Teaching Hospitals NHS Foundation Trust**

## 9. ITEMS FOR INFORMATION

### ● Information Item

(taken as read)

9.1 Governor Opportunities Summary

9.2 Governor Issues Report

9.3 Appointment of Lead Governor

9.4 Register of Interests

9.5 Single Improvement Plan

9.6 Corporate Objectives 2026/27

9.7 Minutes of Governor Subgroups:


(a) Care and Safety Subgroup ? 12 Jan & 19 Mar 2026


(b) Membership Subgroup ? 3 Feb 2026


---


## REFERENCES

Only PDFs are attached

 9.1 - Governor Opportunities and Activities Report - Feb 26 - April 26.pdf

 9.2 - Governor Issues Report.pdf


 9.3 Appointment of Lead Governor April 2026 (1).pdf

 9.4 Governor Register of Interests 2026-27 April 26.pdf

 9.5 COG SIP Update Apr-26.pdf

 9.6 Corporate Objectives 2026-27 April 2026.pdf

 9.7a Minutes Care and Safety Subgroup 12 Jan & 19 Mar 2026.pdf

 9.7b - Minutes - Membership Subgroup - 3 February 2026 approved.pdf



# Council of Governors Report

|   |  |  |   |
|---|--|--|---|
| <b>Meeting of the</b>                       | <b>Council of Governors</b>  | <b>23 April 2026</b>                         |   |
|   | <b>Part I</b> <input checked="" type="checkbox"/>  | <b>Part II</b> <input type="checkbox"/>      |   |
| <b>Title of Report</b>                      | <b>Governor Opportunities and Activities – January 2026 to April 2026</b>  |  |   |
| <b>Report Author</b>                        | Jennifer Foote, Director of Corporate Affairs  |  |   |
| <b>Recommendation/ Actions required</b>     | It is recommended that the Council of Governors receive the report and note the contents for information.  |  |   |
|   | <b>Decision</b><br><input type="checkbox"/>  | <b>Assurance</b><br><input type="checkbox"/> | <b>Information</b><br><input checked="" type="checkbox"/> |
| <b>Executive Summary</b>                    | <p>The purpose of this report is to update the Council of Governors on the opportunities, events and activities governors have been involved in during January to April 2026.</p> <p>The governor role is to represent the interests of Foundation Trust members, the public and the organisations the appointed governors represent. The events and engagement opportunities that Governors have been involved in are recorded in the report and attached as appendix 1.</p> <p>It should also be noted that several governors also undertake voluntary roles across both our hospital sites.</p> |  |   |
| <b>Link to Strategic Objectives 2025/26</b> | <b>Patients – deliver excellent care:</b> Improve outcomes, reduce harm and deliver a positive patient experience.   | <input checked="" type="checkbox"/>          |   |
|   | <b>Performance – deliver timely, effective care:</b> Deliver agreed trajectories in clinical performance.  | <input checked="" type="checkbox"/>          |   |
|   | <b>People – be a great place to work:</b> Create an inclusive culture with leaders at every level leading colleague engagement.  | <input checked="" type="checkbox"/>          |   |
|   | <b>Productivity – deliver value for money:</b> Deliver the agreed financial plan including waste reduction programme, maximising use of resources.   | <input checked="" type="checkbox"/>          |   |
|   | <b>Partnership – be fit for the future:</b> 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.   | <input checked="" type="checkbox"/>          |   |
| <b>Appendices</b>                           | State whether there are any appendices and list them. For example:<br>Appendix 1: Governor Activities Report   |  |   |

## Appendix 1

There are a number of regular activities which Governors could be involved in including:

### **STAR celebration events**

Held three times per year, teams present the peer support activity in which they have been involved as part of the STAR accreditation framework as well as celebrating achievements.

### **PLACE (Patient Led Assessment of the Care Environment)**

The national programme usually takes place annually at each of our hospital sites (Chorley and South Ribble and Royal Preston Hospital). It is an opportunity for Governors to engage with patients and training is provided by the Trust.

The list below does not include scheduled meetings of Council and workshops.

| <b>EVENT: excluding scheduled meetings and workshops</b>     | <b>DATE: 2 January 2026 to 1 April 2026</b> |
|--|---|
| Council of Governors Meeting                                 | 20 January 2026                             |
| Patient and Carers Experience and Involvement Group (P&CEIG) | 27 January 2026                             |
| Carers Forum   | 28 January 2026                             |
| Joint Governor and NED Visit to MAU Chorley                  | 4 February 2026                             |
| Board of Directors Meeting                                   | 5 February 2026                             |
| Joint Governor and NED Visit to MAU Chorley                  | 10 February 2026                            |
| Patient and Carers Experience and Involvement Group (P&CEIG) | 24 February 2026                            |
| Carers Forum   | 25 February 2026                            |
| Mini Health Mela, Preston                                    | 7 March 2026                                |
| Carers Forum   | 25 March 2026                               |
| Patient and Carers Experience and Involvement Group (P&CEIG) | 31 March 2026                               |
|  |   |
|  |   |
|  |   |



# Council of Governors Report

|   |   |  |   |
|---|---|--|---|
| <b>Meeting of the</b>                       | <b>Council of Governors</b>   | <b>23 April 2026</b>                         |   |
|   | <b>Part I</b> <input checked="" type="checkbox"/>   | <b>Part II</b> <input type="checkbox"/>      |   |
| <b>Title of Report</b>                      | <b>Governor Issues Report</b>   |  |   |
| <b>Report Author</b>                        | Jennifer Foote, Director of Corporate Affairs   |  |   |
| <b>Recommendation/<br/>Actions required</b> | It is recommended that the Council receives the report and notes the contents for information.  |  |   |
|   | <b>Decision</b><br><input type="checkbox"/>   | <b>Assurance</b><br><input type="checkbox"/> | <b>Information</b><br><input checked="" type="checkbox"/> |
| <b>Executive Summary</b>                    | <p>The purpose of this report is to provide visibility of the issues and concerns raised by Governors for information.</p> <p>The agreed process for Governors to raise issues and concerns is through the Corporate Affairs Team (CorporateAffairs@lthtr.nhs.uk). These are then passed to the appropriate manager for investigation and response. A response is then provided to the Governor who raised the issue, with a summary submitted to Council as part of this report.</p> <p>During the period January 2026 to April 2026, one issue had been raised regarding discarded items around Royal Preston Hospital that needed to be removed. The estates team addressed the issues, and 9 February 2026, all items had been removed.</p> |  |   |
| <b>Link to Strategic Objectives 2025/26</b> | <b>Patients – deliver excellent care:</b> Improve outcomes, reduce harm and deliver a positive patient experience.  | <input checked="" type="checkbox"/>          |   |
|   | <b>Performance – deliver timely, effective care:</b> Deliver agreed trajectories in clinical performance.   | <input checked="" type="checkbox"/>          |   |
|   | <b>People – be a great place to work:</b> Create an inclusive culture with leaders at every level leading colleague engagement.   | <input checked="" type="checkbox"/>          |   |
|   | <b>Productivity – deliver value for money:</b> Deliver the agreed financial plan including waste reduction programme, maximising use of resources.  | <input checked="" type="checkbox"/>          |   |
|   | <b>Partnership – be fit for the future:</b> 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.  | <input checked="" type="checkbox"/>          |   |



# Council of Governors

|   |   |   |
|---|---|---|
| <b>Meeting of the</b>                       | <b>Council of Governors</b>   | <b>23 April 2026</b>  |
| <b>Title of Report</b>                      | <b>Appointment of Lead Governor</b>   |   |
| <b>Report Author</b>                        | Katie Stanton, Business Manager, Corporate Affairs  |   |
| <b>Lead Executive Director</b>              | Jennifer Foote, Director of Corporate Affairs   |   |
| <b>Recommendation/<br/>Actions required</b> | <b>The Council is asked to note the outcome of the Lead Governor ballot appointing Graham Robinson as Lead Governor for the next 12 months up to and including 31 March 2027.</b>   |   |
|   | <b>Decision</b><br><input type="checkbox"/>   | <b>Assurance</b><br><input type="checkbox"/>  |
| <b>Executive Summary</b>                    | <p>In line with the NHS Foundation Trust Code of Governance, Councils of Governors is recommended to appoint a governor to act as a Lead Governor. The role of Lead Governor at the Trust is restricted to the scope as outlined in the code of Governance. The purpose of this report is to confirm the results of the recent virtual ballot for the Lead Governor role for the 12-month period up to and including 31 March 2027.</p> <p>The term of office of the Lead Governor expired on 31 March 2026, and to ensure the annual appointment was made as soon as possible following the 2026 Governor Election, governors supported the proposal to hold a virtual ballot. The process adopted mirrored that undertaken in previous years, whereby governors with at least 12 months in office were invited to express an interest in the Lead Governor role. Two expressions of interest were received and the outcome of the virtual ballot resulted in a majority for Mr Graham Robinson.</p> |   |
|   | <b>Link to Strategic Objectives 2025/26</b>   | <p><b>Patients – deliver excellent care:</b> Improve outcomes, reduce harm and deliver a positive patient experience. <input checked="" type="checkbox"/></p> <p><b>Performance – deliver timely, effective care:</b> Deliver agreed trajectories in clinical performance. <input checked="" type="checkbox"/></p> <p><b>People – be a great place to work:</b> Create an inclusive culture with leaders at every level leading colleague engagement. <input checked="" type="checkbox"/></p> <p><b>Productivity – deliver value for money:</b> Deliver the agreed financial plan including waste reduction programme, maximising use of resources. <input checked="" type="checkbox"/></p> <p><b>Partnership – be fit for the future:</b> 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. <input checked="" type="checkbox"/></p> |

## **1. Context**

In line with the NHS Foundation Trust Code of Governance, Councils of Governors is recommended to appoint a governor to act as a Lead Governor. The role of Lead Governor at the Trust is restricted to the scope as outlined in the code of Governance. The purpose of this report is to confirm the results of the recent virtual ballot for the Lead Governor role for the 12-month period up to and including 31 March 2027.

## **2. Discussion**

The term of office of the Lead Governor expired on 31 March 2026, and to ensure the annual appointment was made as soon as possible following the 2026 Governor Election, governors supported the proposal to hold a virtual ballot. The process adopted mirrored that undertaken in previous years, whereby governors with at least 12 months in office were invited to express an interest in the Lead Governor role. Two expressions of interest were received by the closing date of 30<sup>th</sup> March. A total of 10 votes were recorded via virtual ballot by the closing date of 7<sup>th</sup> April 2026 and the outcome resulted in a majority for Mr Graham Robinson.

## **3. Financial implications**

None

## **4. Legal implications**

None

## **5. Risks**

None

## **6. Impact on stakeholders**

None

## **7. Recommendations**

The Council is asked to note the outcome of the Lead Governor ballot appointing Graham Robinson as Lead Governor for the next 12 months up to and including 31 March 2027.



# Council of Governors

|   |  |  |
|---|--|--|
| <b>Meeting of the</b>                       | <b>Council of Governors</b>  | <b>23 April 2026</b>                         |
| <b>Title of Report</b>                      | <b>Register of Interest 2026/27</b>  |  |
| <b>Report Author</b>                        | Katie Stanton, Business Manager, Corporate Affairs   |  |
| <b>Lead Executive Director</b>              | Jennifer Foote, Director of Corporate Affairs  |  |
| <b>Recommendation/ Actions required</b>     | The Council is asked to note the requirement to ensure individual interests are kept up to date at all times.  |  |
|   | <b>Decision</b><br><input type="checkbox"/>  | <b>Assurance</b><br><input type="checkbox"/> |
| <b>Executive Summary</b>                    | In line with the Trust’s Constitution (section 11, sub-section 11.38 to 11.41) there is a requirement for Governors to declare any material interests that would impact on their role as a Governor or member of the Council of Governors. |  |
|   | It is the responsibility of every Governor to ensure any changes to their interests are notified to the Office of the Company Secretary at the time of the change to their interests so the central register can be updated.               |  |
|   | The purpose of this report is to present information to the Council on the declared interests of each Governor as at 1 April 2026. The register of interests is included as appendix 1.  |  |
|   | It is recommended that the Council receive the report for information and note the requirement to ensure any changes are notified to the Office of the Company Secretary at the time of the change.  |  |
|   |  |  |
| <b>Link to Strategic Objectives 2025/26</b> | <b>Patients – deliver excellent care:</b> Improve outcomes, reduce harm and deliver a positive patient experience.   | <input type="checkbox"/>                     |
|   | <b>Performance – deliver timely, effective care:</b> Deliver agreed trajectories in clinical performance.  | <input type="checkbox"/>                     |
|   | <b>People – be a great place to work:</b> Create an inclusive culture with leaders at every level leading colleague engagement.  | <input checked="" type="checkbox"/>          |
|   | <b>Productivity – deliver value for money:</b> Deliver the agreed financial plan including waste reduction programme, maximising use of resources.   | <input type="checkbox"/>                     |
|   | <b>Partnership – be fit for the future:</b> 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.                               | <input type="checkbox"/>                     |
| <b>Link to Board Assurance Framework:</b>   | Principal Risk 1 (25/26) - Patient experience within the urgent and emergency care pathway <b>Select correct Principal Risk from the drop down</b>   |  |

|                   |   |
|-------------------|---|
| <b>Appendices</b> | State whether there are any appendices and list them. For example:<br>Appendix 1: Register of Interests of Council of Governors |
|-------------------|---|

## 1. Context

In line with the Trust's Constitution (section 11, sub-sections 11.38 to 11.41) there is a requirement for Governors to declare any material interests that would impact on their role as a Governor or member of the Council of Governors.

It is the responsibility of every Governor to ensure any changes to their interests are notified to the Office of the Company Secretary at the time of the change to their interests so the central register can be updated.

## 2. Discussion

None

## 3. Financial implications

None

## 4. Legal implications

Section 11 (sub-sections 11.38 to 11.41) of the Trust's Constitution have been reproduced below:

### *Disclosure of interests*

*11.38 A governor shall declare any pecuniary or other interests in accordance with the requirements set out in the Council of Governors' standing orders.*

*11.39 The Council of Governors has adopted its own standing orders for its practice and procedure, in particular for its procedure at meetings.*

### *Declaration*

*11.40 A public governor may not vote at a meeting of the Council of Governors, following their election or re-election, unless, before attending the meeting, they have made a declaration in the form specified by the Company Secretary of the particulars of their qualification to vote as a member of the Trust and that they are not prevented from being a governor.*

*11.41 A public governor shall be deemed to have confirmed the declaration upon attending each subsequent meeting of the Council of Governors.*

## 5. Risks

There are no risks associated with the recommendations in the report.

## 6. Impact on stakeholders

There are no stakeholder impacts associated with the recommendations in the report.

## 7. Recommendations

It is recommended that the Council receive the report for information and note the requirement to ensure any changes are notified to the Office of the Company Secretary at the time of the change.

## Appendix 1

## Council of Governors

### Register of Interests as at 1 April 2026



Lancashire Teaching  
Hospitals

NHS Foundation Trust

| Name             | Position  | Declared Interest   |
|------------------|---|---|
| Pav Akhtar       | Public Governor   | <ul style="list-style-type: none"> <li>Member of Lancashire Teaching Hospitals NHS FT</li> <li>Related to T Akhtar (Public Governor) at Lancashire Teaching Hospitals NHS FT</li> <li>Chief Diversity and Inclusion Officer, NHS Blood and Transplant</li> <li>Non-Executive Director of Healthwatch England</li> <li>Member of Unison</li> <li>Member of the Labour Party</li> <li>Councillor at Preston City Council</li> <li>National Advisor to the CQC on equalities and good governance, which includes supporting CQC inspections</li> </ul> |
| Takhsin Akhtar   | Public Governor   | <ul style="list-style-type: none"> <li>No declaration received</li> </ul>   |
| George Bailey    | Public Governor   | <ul style="list-style-type: none"> <li>No disclosable interests</li> </ul>  |
| Susan Bailey     | Public Governor   | <ul style="list-style-type: none"> <li>No disclosable interests</li> </ul>  |
| Sheila Beale     | Staff Governor (representing Unregistered Healthcare and Support Workers) | <ul style="list-style-type: none"> <li>No disclosable interests</li> </ul>  |
| Linda Bracewell  | Public Governor   | <ul style="list-style-type: none"> <li>No disclosable interests</li> </ul>  |
| Sheila Brennan   | Public Governor   | <ul style="list-style-type: none"> <li>No disclosable interests</li> </ul>  |
| Darrell Brooks   | Public Governor   | <ul style="list-style-type: none"> <li>No disclosable interests</li> </ul>  |
| Michelle Brown   | Appointed Governor (representing Chorley Council)                         | <ul style="list-style-type: none"> <li>Elected Member of Chorley Council</li> </ul>   |
| Sonia Connell    | Staff Governor (representing nurses and midwives)                         | <ul style="list-style-type: none"> <li>No disclosable interests</li> </ul>  |
| Philip Curwen    | Public Governor   | <ul style="list-style-type: none"> <li>No declaration received</li> </ul>   |
| Ian Facer        | Public Governor   | <ul style="list-style-type: none"> <li>General Optical Services Contractor</li> </ul>   |
| Graham Fullarton | Public Governor   | <ul style="list-style-type: none"> <li>No disclosable interests</li> </ul>  |
| Lou Jackson      | Appointed Governor (representing South Ribble Borough Council)            | <ul style="list-style-type: none"> <li>Elected Member of South Ribble Borough Council</li> <li>Member of the Labour Party</li> <li>LCC Adult Health Scrutiny Committee</li> <li>South Ribble Borough Council Standard Committee</li> <li>SRBC Council of Governors Scrutiny Committee</li> </ul>  |
| Angela Kos       | Public Governor   | <ul style="list-style-type: none"> <li>Progress Housing Group, Lancashire Enterprise Business Park, Leyland PR26 6TZ – Independent Member of the Group Audit &amp; Risk Committee and Shadow Non-Executive Director of the Board.</li> </ul>  |

|                    |  |  |
|--------------------|--|--|
| Ian Linacre        | Staff Governor (representing non-clinical)   | <ul style="list-style-type: none"> <li>No disclosable interests</li> </ul>   |
| Terry Lindsay      | Public Governor  | <ul style="list-style-type: none"> <li>Employed by Manchester City Council</li> </ul>  |
| Daniel Matchett    | Appointed Governor (representing Lancashire County Council)                        | <ul style="list-style-type: none"> <li>Registered Mental Health Nurse with NMC</li> <li>Member of the Free Speech Union</li> <li>Member of Workers for England Union</li> <li>Member of Reform UK</li> <li>Chair of Reform UK Rossendale &amp; Darwen</li> <li>Chair of the Lancashire Health &amp; Wellbeing Board</li> <li>Elected county councillor</li> <li>Cabinet Member for Health &amp; Wellbeing at LCC</li> <li>Company Director – Lucinda Claude Ltd – Used for freelance nursing assessments</li> <li>Company Director – Neuro Wellbeing Ltd – Joint venture with other RMNs that is now in the process of being struck off due to other commitments. (Waiting on HMRC to update)</li> </ul> |
| Zulekha Mushtaq    | Public Governor  | <ul style="list-style-type: none"> <li>No disclosable interests</li> </ul>   |
| Carole Oldcorn     | Public Governor  | <ul style="list-style-type: none"> <li>No disclosable interests</li> </ul>   |
| Enid Povey         | Public Governor  | <ul style="list-style-type: none"> <li>Volunteer at Lancashire Teaching Hospitals NHS Foundation Trust</li> <li>Member of the ICB Citizen Panel</li> </ul>   |
| Tom Ramsay         | Staff Governor (representing Other Health Professionals and Healthcare Scientists) | <ul style="list-style-type: none"> <li>Spouse is a Physiotherapist at Lancashire Teaching Hospitals NHS Foundation Trust</li> <li>Private Practice (Mint Rehab) providing private orthotics/orthoses</li> <li>Director of Mint Holmes – property letting to private renting tenants</li> </ul>   |
| George-Adrian Rata | Staff Governor (representing Doctors and Dentists)                                 | <ul style="list-style-type: none"> <li>No disclosable interests</li> </ul>   |
| Graham Robinson    | Public Governor  | <ul style="list-style-type: none"> <li>Trustee of Citizens Advice Lancashire West</li> </ul>   |
| Suleman Sarwar     | Appointed Governor (representing Preston City Council)                             | <ul style="list-style-type: none"> <li>Member of the Labour Party and the Co-operative Party</li> <li>Preston City Labour Councillor</li> <li>Cabinet Member for Climate Change at Preston City Council</li> <li>Member of UNISON</li> </ul>   |
| Christine Turner   | Public Governor  | <ul style="list-style-type: none"> <li>Member of the Conservative Party</li> <li>Euxton Parish Councillor</li> </ul>   |
| Tim Young          | Public Governor  | <ul style="list-style-type: none"> <li>No disclosable interests</li> </ul>   |



# Council of Governors

|   |   |   |
|---|---|---|
| <b>Meeting of the</b>                       | <b>Council of governors</b>   | <b>23/04/26</b>   |
| <b>Title of Report</b>                      | <b>SIP Update February 2026</b>   |   |
| <b>Report Author</b>                        | K Marshall, Head of Programme Management Office   |   |
| <b>Lead Executive Director</b>              | A Brotherton, Chief Strategy and Improvement Officer  |   |
| <b>Recommendation/ Actions required</b>     | The Council of Governors are asked to:<br>I. Note the delivery position of the SIP for February 2026 and key areas at risk of non-delivery in-year.   |   |
|   | <b>Decision</b><br><input type="checkbox"/>   | <b>Assurance</b><br><input checked="" type="checkbox"/> |
| <b>Executive Summary</b>                    | <p>The purpose of this paper is to provide an overview of delivery progress and outcomes of the Single Improvement Plan (SIP) during February 2026. Since the last reporting period, there has been a 5% positive movement and increased milestone completion. However, several areas remain challenging to deliver, including digital sickness absence management system (Empactis) and review of Children’s urgent and emergency care pathway. Delivery of the Trust’s waste reduction target remains at risk of not being delivered in-year. Since the last reporting period, metrics showing a recent concerning pattern include cancer 62-day performance and 4-hour waits in ED. Sustained positive change can be seen in a reduction of <i>c.difficile</i> cases and 65-week waiters, in line with trajectory.</p> <p>The Trust Strategy provides the overarching direction and priorities for the SIP for 2026/27. An outline plan was agreed by the Trust Management Board in February 2026. There is considerable work to fully develop the Waste Reduction Programme (WRP) plan for 2026/27, which is the organisational priority during February and March. The SIP will be finalised during April and shared with the Committee in the next forum.</p> |   |
| <b>Link to Strategic Objectives 2025/26</b> | <b>Patients – deliver excellent care:</b> Improve outcomes, reduce harm and deliver a positive patient experience.  | <input checked="" type="checkbox"/>                     |
|   | <b>Performance – deliver timely, effective care:</b> Deliver agreed trajectories in clinical performance.   | <input checked="" type="checkbox"/>                     |
|   | <b>People – be a great place to work:</b> Create an inclusive culture with leaders at every level leading colleague engagement.   | <input checked="" type="checkbox"/>                     |
|   | <b>Productivity – deliver value for money:</b> Deliver the agreed financial plan including waste reduction programme, maximising use of resources.  | <input checked="" type="checkbox"/>                     |
|   | <b>Partnership – be fit for the future:</b> 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.  | <input checked="" type="checkbox"/>                     |
| <b>Operational Group Review:</b>            | Single Improvement Plan Oversight Board   | Date: 11/02/26  |
| <b>Link to Board Assurance Framework:</b>   | The Single Improvement Plan is an organisational-level plan aligned to all corporate objectives and principal risks.  |   |
| <b>Appendices</b>                           | No appendices included  |   |

## 1. Background

In April 2024, Lancashire Teaching Hospitals developed and implemented a Single Improvement Plan (SIP) with the aim to align and focus improvement efforts across the Organisation in a 3-year strategic plan. For 2025/26 plans include a focus on areas of continued challenge to deliver outcome improvement alongside financial improvement.

## 2. Discussion

### 2.1 Delivery overview

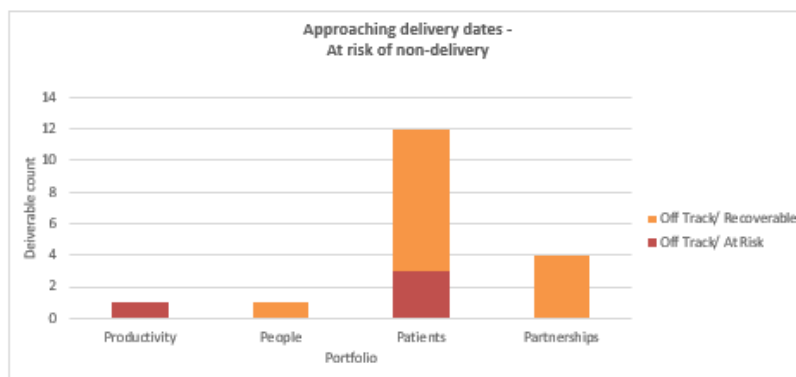
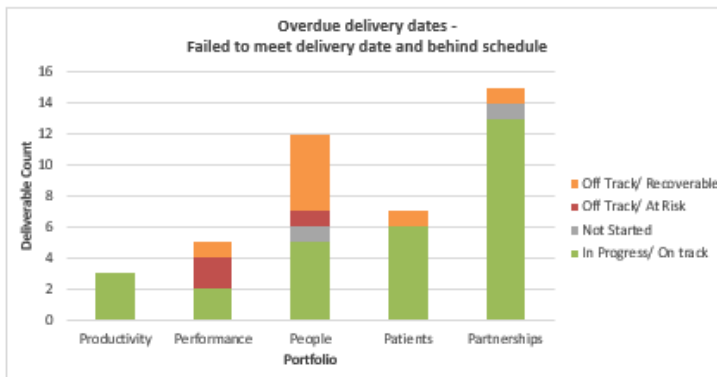
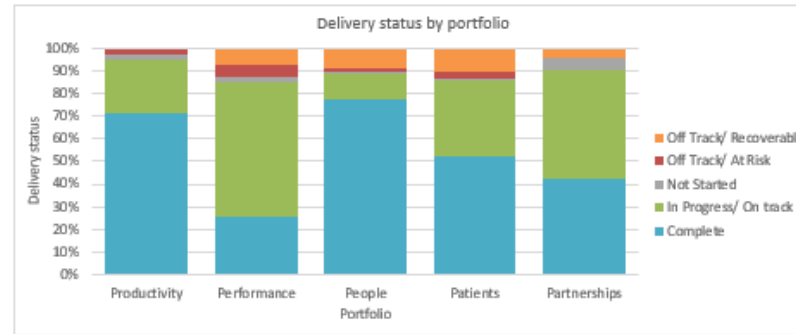
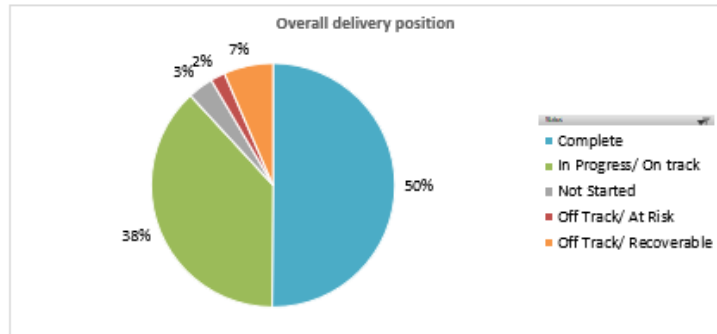
Since the last reporting period, there has been a 5% positive movement and increased milestone completion. However, there continue to be several areas of delay and challenge, including the implementation of the digital sickness absence management system and the Children's urgent and emergency care pathway review. Delivery of the Trust's waste reduction target remains at risk of not being delivered in-year. Delivery is monitored through each portfolio and escalated to the SIP Oversight Board. Some areas have overdue milestones with work underway to reduce slippage by implementing mitigations or re-prioritising workplans in line with current capacity. The Committee is asked to note the impact on SIP delivery of the decision to delay recruitment to vacant posts to maximise headcount reduction. The SIP Delivery Dashboard below (Figure 1) shows the delivery summary by portfolio and areas of concern.

Areas that remain at risk of not delivering in-year are summarised below. Several of these have been in at risk status for several months indicating further intervention is required or that the target date or deliverable is not achievable. These are under review by portfolio SRO and programme lead.

| At Risk      |                                 |  |                       |   |          |
|--------------|---------------------------------|--|-----------------------|---|----------|
| Portfolio    | Programme                       | Deliverable  | Status                | Comments/update   | Due date |
| People       | Sickness Management             | Implement digital sickness absence management system   | Off Track/<br>At Risk | Implementation plan in progress. Difficulties with the interface between ESR and Empactis and enablement of single sign on access have created further delays (although now resolved). System is now in user testing phase with launch with first pilot areas during February. Challenge with supplier and poor engagement creating further delays. | Jan-26   |
| Patients     | Children & Young People         | Review children's urgent care pathways - front door triage and discharge models  | Off Track/<br>At Risk | The new Trust strategy identifies CYP UEC as a priority. There is a CMO action to review the current approach and formalise leadership and reporting metrics  | Mar-26   |
| Patients     | Critical Care and Enhanced Care | Sepsis 6 delivered within 1 hours for NEWS>7 within ED & IP areas<br><br>Snr review compliance within NEWS timeframe   | Off Track/<br>At Risk | Targeting senior review blood culture and antibiotic delivery<br><br>Thematic review being undertaken and targets agreed for 26/27  | Mar-26   |
| Performance  | UEC                             | Wait to be seen - reduce the waiting time for first assessment<br><br>Ambulance handover reduction in 45 mins breaches | Off Track/<br>At Risk | Wait to be seen times continue to be in excess of target. UEC re-design programme commissioned and will review C&D data to assess opportunities to re-align ED medical shifts to reduce waiting times.  | Feb-26   |
| Productivity | Financial Recovery              | £60m schemes delivered by end Mar  | Off Track/<br>At Risk | Actions are being monitored through DDGs to recover the position as much as possible. Mitigations are being developed for programme slippage through non-recurrent flexibilities.   | Mar-26   |

Table 1. Milestones at risk

Reporting Period: Feb-26



**Movement since last period**

A further 5% increase in complete actions since last reporting period

No movement since last period for areas flagged as overdue and off track.

Focus on areas overdue and flagged as off track for areas of concern to be reviewed.

7 key actions flagged as at risk across portfolios

Figure 1. SIP delivery dashboard February-26

Key points include

- Further 5% increase in milestone completion
- Continued limited capacity in some teams due to current vacancy control measures reducing capacity and slowing pace of delivery completion, several workplans re-prioritised in line with capacity.
- Several key areas continue to flag as at risk of delivery in-year as noted in Table 1 above and are being reviewed by programme leads and SROs for 26/27 plans.

## 2.2 SIP outcomes

Detailed metrics are monitored through each SIP portfolio as shown in the Integrated Performance Report as reported to committees of the Board. A summary of key performance indicator matrix in table 2 shows the position of key metrics and any correlation between performance of metrics across portfolios. Since last reporting period areas showing a recent concern pattern in key outcomes data include performance targets cancer 62-day performance and 4 hour waits in ED. A sustained positive change can be seen in a reduction of *c.difficile* cases and 65 week waiters in line with trajectory.



### SPC KPI Metric Grid



| Variation                                 | Assurance<br>Will consistently fail target within expected variation   | Could both pass or fail target within expected variation   | Will consistently pass target within expected variation  |
|---|--|--|--|
| <br>Recent concerning pattern in the data | <ul style="list-style-type: none"> <li>- Staff Survey: Recommend Trust as place to work</li> <li>- Vacancies (% FTE)</li> <li>- % Percentage of Patients waiting less than 18 weeks</li> <li>- Maximum wait of 12 hours as Total Time in Dept</li> <li>- Percentage of UEC (Type 1 &amp; 3) patients seen within 4 hours</li> <li>- Cancer 62-day performance</li> </ul> | <ul style="list-style-type: none"> <li>- Number of violence and aggression incidents toward staff</li> <li>- 85% theatre utilisation - aggregate - Capped</li> </ul>   | <ul style="list-style-type: none"> <li>- Staffing Fill Rate Health Care Assistant</li> <li>- PIFU Rate</li> </ul>                                  |
| <br>Normal variation - no recent change   | <ul style="list-style-type: none"> <li>- Reduce not meeting criteria to reside (DKAFH)</li> <li>- Number of boarded patients</li> <li>- Bed occupancy to 90%</li> <li>- RTT - 52 week Waiters</li> <li>- 31 Day Cancer Standard</li> <li>- Staffing Fill Rate Maternity Support Worker</li> </ul>  | <ul style="list-style-type: none"> <li>- Staffing Fill Rate Registered Midwife</li> <li>- Complaints per 1000 bed days</li> <li>- Pressure Ulcers per 1000 beds days (Category 2 and above)</li> <li>- Perinatal - Number of Stillbirths</li> <li>- Compliance with 60 minute ambulance turnaround time target</li> <li>- Percentage of patients that receive a diagnostic test within six weeks</li> <li>- Cancer Faster Diagnosis Performance</li> <li>- Turnover (% FTE)</li> </ul> |  |
| <br>Recent positive pattern in the data   | <ul style="list-style-type: none"> <li>- RTT - 65 Week Waiters</li> </ul>  | <ul style="list-style-type: none"> <li>- C. diff perf against national trajectory - no more than 199 Hospital Acquired cases</li> <li>- Sickness Absence (% FTE)</li> </ul>  | <ul style="list-style-type: none"> <li>- Staffing Fill Rate Registered Nurse</li> <li>- STAR Accreditation all trust (Silver and Above)</li> </ul> |

Table 2. SIP Key Performance Indicator grid – February-26

## 2.3 SIP development 2026-2027

The planning process for the Single Improvement Plan 2026-2027 commenced in January. The process outlined in the flowchart below shows the required inputs and connections across the organisation’s strategic framework. The outline plan for SIP 2026-2027 has been reviewed and agreed by the Trust Management Board (TMB) in February including priority areas for improvement and transformation aligned to Trust strategic objectives and areas requiring compliance to baseline national standards.

There is considerable work to be undertaken to fully work up the WRP plan for 2026/27 which is the organisational priority during February and March. The SIP will then be finalised during April and shared to committee.

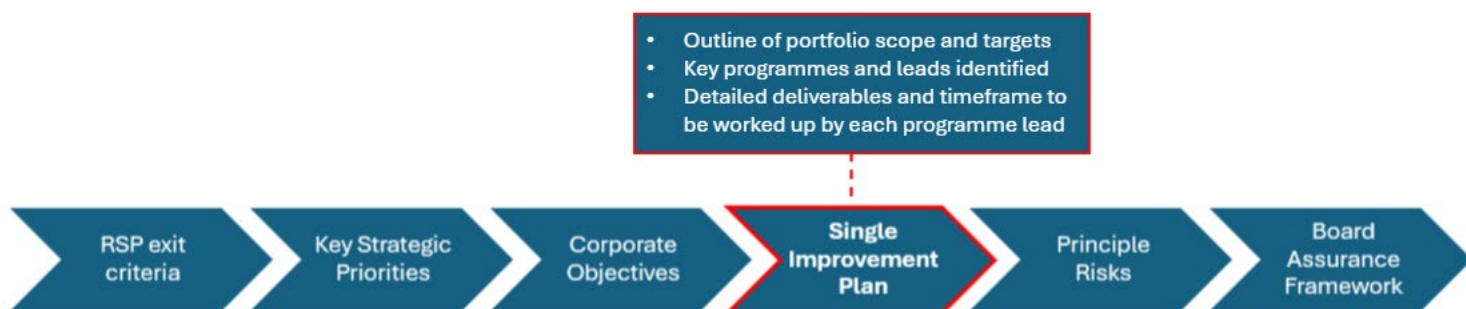


Figure 2. SIP 2026-2027 planning process

## 2.4 SIP Oversight Board escalation

Escalations, areas of challenge and areas of success are reported by each portfolio into the SIP Oversight Board to ensure visibility together under one plan. Key escalations from each portfolio are shown below in table 3.

| Portfolio escalations   | Alert   | Advise  | Assure  |
|-------------------------|---|---|---|
| Single Improvement Plan | <ul style="list-style-type: none"> <li>Challenge to progress Children’s urgent care pathway review due to medical leadership resource required, included in corporate objectives 2026-2027 to ensure prioritisation.</li> <li>Capacity within OD teams is significantly constrained, while reports of racism and discrimination remain persistent with little movement in key metrics. This presents a risk to delivery pace and organisational culture</li> <li>Digital absence management system (Empactis) implementation has been extremely challenging, with poor supplier engagement and delays</li> <li>Further slippage against financial waste reduction programme target</li> <li>Performance against 4 hour (all), 4 hour Type 1 &amp; Type 3 UEC target deteriorated in Jan 26 and were below the operational plans. The deterioration has been driven by increased acuity of attendances, increased LOS and reduced workforce</li> </ul> | <ul style="list-style-type: none"> <li>62 day performance in Dec 25 has improved however remains below the 75% standard and our improvement target</li> <li>Despite improved leaver numbers, vacancy rates—particularly in medicine—remain high. Targeted development routes (Band 2–3, apprenticeships) are progressing but require closer divisional alignment</li> <li>Finalisation of the Financial Sustainability Plan (FSP) has not yet been achieved but deliverable by end-March</li> </ul> | <ul style="list-style-type: none"> <li>Zero 65 week breaches (RTT) have been maintained.</li> <li>Winter absence levels were significantly lower than the same period last year, with no usual seasonal peak observed. This is expected to positively impact the year-end average</li> <li>Trust-wide core skills training compliance is being achieved, with only small pockets of non-compliance remaining. The overall risk is now considered controlled, and this area will move to BAU reporting in 2026/27</li> </ul> |

Table 3. SIP Oversight escalation report

## 2.5 Conclusion

The Single Improvement Plan supported by the Accountability Framework remains the vehicle for delivery and oversight within the organisation. The criteria remain challenging to deliver within current resources and with the operational and financial pressures facing the Trust and the wider system however some positive shifts can be seen in key metrics. Oversight of delivery and outcomes are closely monitored through the SIP governance structure with broadened visibility across senior leaders in the Organisation. The NHSE Recovery Support Programme (RSP) team have made recommendations from observations of the SIP and organisational governance. Several areas were highlighted to need improvement as we mature the SIP and embed across the organisation which is in progress with Executive and Senior Leaders. The PMO and executive team regularly meet with the RSP to discuss progress.

## 3 Financial implications

Non-delivery of the plan will directly impact the Trust's ability to deliver its waste reduction and financial improvement plan in 2025/26. Given the importance of the SIP to the Trust's recovery programme, the CEO continues to chair the monthly SIP Oversight Board and the progress is reported monthly to the Finance and Performance committee and bi-monthly to the Trust Board.

## 4 Legal implications

None

## 5 Risks

The criteria remain challenging to deliver within current resources and with the operational and financial pressures facing the Trust and the wider system. Delivery and management of the SIP is reliant on resources and expertise within the organisation which is at risk due to current level of vacancies across the organisation. Interim PMO resource is in place to focus on supporting delivery of the Waste Reduction Programme (WRP), this resource does not currently provide support across the broader scope of the SIP to allow more delivery support from PMO into divisions. Please refer to the WRP and PMO update paper as reported to committee for specific details on PMO resourcing plan and WRP development.

## 6 Impact on stakeholders

The impact and outcome of delivering the improvement work is to achieve stability of the organisation in year 2 as outlined in our ambition. Several of the metrics are dependent upon collaborative working with key stakeholders and this is a key focus in 2025/26.

## 7. It is recommended that the Council of Governors:

- I. Note the delivery position of the SIP for February 2026 and key areas at risk of non-delivery in-year.



# Council of Governors Report

|  |   |  |   |
|--|---|--|---|
| <b>Meeting of the</b>                    | Council of Governors  | 23 <sup>rd</sup> April 2026                  |   |
| <b>Title of Report</b>                   | Corporate Objectives 2026/27  |  |   |
| <b>Report Author</b>                     | Kate Hudson, Deputy Director of Strategy & Transformation.  |  |   |
| <b>Lead Executive Director</b>           | Ailsa Brotherton  |  |   |
| <b>Recommendation / Actions required</b> | <p>The purpose of this paper is to present to the Council of Governors the finalised corporate objectives 2026/27 which have been set by the Board of Directors in February 2026.</p> <p>Recommendations<br/>The Council of Governors is asked to;</p> <p>i. Note the corporate objectives set by the Board of Directors and the plan to cascade and implement within the organisation</p>  |  |   |
|  | <b>Decision</b><br><input type="checkbox"/>   | <b>Assurance</b><br><input type="checkbox"/> | <b>Information</b><br><input checked="" type="checkbox"/> |
| <b>Executive Summary</b>                 | <p>The purpose of this paper is to present to the Council of Governors the finalised corporate objectives 2026/27 which have been set by the Board of Directors in February 2026. Each year the Trust develops annual corporate objectives which define the strategic priorities of the Trust.</p> <p>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 1.</p> <p>The Board will review the progress made against these objectives through the Single Improvement Plan. The metrics of the single improvement plan are present within the divisional improvement forums and committees of the Board. All major decisions should align with corporate objectives. The Board Assurance Framework identifies principles risks that could impact the achievement of the corporate objectives and provides a structured approach to ensuring these risks are managed effectively.</p> <p>The Trust five-year strategy was updated in Q3 of 2025/26 and approved by the Board of Directors in October 2025. The draft strategy is focused on 5Ps; Patients; Performance; People; Productivity and Partnership, with agreed enabling strategies in development following the same structure.</p> <p>The corporate objectives for 2026/27 have therefore also been aligned to the 5Ps. This paper sets out the high level corporate objectives and the detail that sits within each of these. These will be set as personal objectives for members of the Executive team and used to inform the objective setting in appraisals for the senior leadership team and will be cascaded throughout the organisation.</p> |  |   |

|   |  |   |   |
|---|--|---|---|
| <b>Link to Strategic Objectives 2025/26</b> | <b>Patients – deliver excellent care:</b> Improve outcomes, reduce harm and deliver a positive patient experience.   |   | ☒ |
|   | <b>Performance – deliver timely, effective care:</b> Deliver agreed trajectories in clinical performance.  |   | ☒ |
|   | <b>People – be a great place to work:</b> Create an inclusive culture with leaders at every level leading colleague engagement.  |   | ☒ |
|   | <b>Productivity – deliver value for money:</b> Deliver the agreed financial plan including waste reduction programme, maximising use of resources.   |   | ☒ |
|   | <b>Partnership – be fit for the future:</b> 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. |   | ☒ |
| <b>Committee Approval:</b>                  | Committees of the Board  | <b>Date:</b> February and March 2026    |   |
| <b>Operational Group Review:</b>            | Board Workshop   | <b>Date:</b> 3 <sup>rd</sup> March 2026 |   |
| <b>Link to Board Assurance Framework:</b>   | All Principal Risks within the BAF   |   |   |
| <b>Appendices</b>                           | Appendix 1 – 2026/27 Corporate Objectives – Final.   |   |   |

## 1. Background

The Trust five-year strategy was updated in Q3 of 2025/26 and approved by the Board of Directors in October 2025. The strategy is focused on 5Ps; Patients; Performance; People; Productivity and Partnership, with agreed enabling strategies in development following the same structure.

Each year the Trust develops annual corporate objectives which define the strategic priorities of the Trust. These have been set by the Board of Directors in April February 2026.

The Board will review the progress made against these objectives through the Single Improvement Plan. The metrics of the single improvement plan are present within the divisional improvement forums and committees of the Board. All major decisions should align with corporate objectives.

The Board Assurance Framework identifies principles risks that could impact the achievement of the corporate objectives and provides a structured approach to ensuring these risks are managed effectively.

## 2. Discussion

The purpose of this paper is to present the corporate objectives agreed by Board in February 2026. The Trust five-year strategy was updated in Q3 of 2025/26 and approved by the Board of Directors in October 2025. The strategy is focused on 5Ps; Patients; Performance; People; Productivity and Partnership, with agreed enabling strategies in development following the same structure.

The collective corporate objectives for the Board in 2026/27 have been aligned to the 5Ps and are presented in Table 1.

| Domain       | Board Objective  |
|--------------|--|
| Patients     | Improve outcomes, reduce harm and deliver a positive patient experience.   |
| Performance  | Deliver agreed trajectories in clinical performance  |
| People       | Create an inclusive culture with leaders at every level leading colleague engagement.  |
| Productivity | Deliver the agreed financial plan including waste reduction programme, maximising use of resources.  |
| Partnership  | Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions. |

The detailed corporate objectives have been developed based on the high level objectives set out in Table 1 and are contained within appendix 1. These will be set as personal objectives for members of the Executive team and used to inform the objective setting in appraisals for the senior leadership team and will be cascaded throughout the organisation. The objectives are included within year 3 of the Single Improvement Plan.

## 3. Financial implications

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

## 4. Legal implications

None

## **5. Risks**

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

## **6. Recommendations**

The Council of Governors is asked to;

- i. Note the corporate objectives set by the Board of Directors and the plan to cascade and implement within the organisation..

# Corporate Objectives

2026/27

# Our values and culture

We recognise that the programme of work needed in 2026/27 will be challenging so we must continue to hold firm to our values:



## Compassionate

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



## Collaborative

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



## Respectful

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



## Performance Focused

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



## Empowered

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

# Corporate Objectives

## 1. High Level Objectives

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

(Patients, Performance, People, Productivity, Partnerships)

## 2. Executive Objective

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

## 3. Cascade

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

# Corporate Objectives

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



# Corporate Objectives

| Domain       | Board Objective  |
|--------------|--|
| Patients     | Improve outcomes, reduce harm and deliver a positive patient experience.   |
| Performance  | Deliver agreed trajectories in clinical and financial performance  |
| People       | Create an inclusive culture with leaders at every level leading colleague engagement.  |
| Productivity | Deliver the agreed financial plan including waste reduction programme, maximising use of resources.  |
| Partnership  | Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions. |

# Patients



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

# Patients

| Theme   | Corporate Objective   | Scope and Focus of the Objective   | How will we know if it has been achieved?  | Exec Lead                                   | Assurance Committee          |
|---|---|--|--|---|------------------------------|
| 1.1<br>Women's health/<br>maternity/<br>Neonatal  | Implement the national Maternity and Neonatal Improvement Plan and the Maternity Incentive Scheme   | <p>Deliver the national Maternity and Neonatal Improvement Plan, which sets out a comprehensive framework for enhancing the safety, quality, and equity of care for mothers and babies. This includes</p> <ul style="list-style-type: none"> <li>strengthening clinical leadership,</li> <li>improving workforce capacity</li> <li>embedding evidence-based practices across maternity and neonatal services.</li> </ul> <p>Implementation will be supported by robust governance, continuous learning, and collaboration across the Integrated Care System.</p> | <ul style="list-style-type: none"> <li>Reduction in sepsis, improved thermal stability</li> <li>MEWS/NEWTT2 implementation &amp; compliance</li> <li>Adoption of evidence-based interventions</li> <li>Sustained reduction in term admissions to NICU</li> <li>Sustained improvements in application of Sepsis 6, smoking cessation, diabetes management</li> <li>Improved staffing metrics &amp; safety culture survey scores</li> </ul>                      | Chief Nursing Officer                       | Safety and Quality Committee |
| 1.2<br>Long Term<br>Conditions/<br>local services | <p>Undertake a fundamental specialty redesign adopting the principles of the ten-year health plan. Priority areas year 1</p> <ul style="list-style-type: none"> <li>Frailty</li> <li>COPD</li> <li>Heart Failure</li> </ul> | <ul style="list-style-type: none"> <li>Redesign of those specialties involved in long term care, guided by the principles of the ten-year health plan.</li> <li>Rethink how services are delivered, integrating care across settings, and aligning clinical pathways with population health priorities</li> <li>Focus on prevention, early intervention, and multidisciplinary collaboration, ensuring that specialty services are more accessible and efficient.</li> </ul>   | <ul style="list-style-type: none"> <li>Reduction in emergency admissions for key LTC groups (e.g., COPD, heart failure, diabetes)</li> <li>Reduction in avoidable 30-day readmissions</li> <li>Improved LTC outcome metrics (e.g., HbA1c, spirometry stability, heart failure optimisation)</li> <li>Reduced variation in outcomes between sites/services</li> <li>% of LTC pathways aligned to evidence-based guidance and 10-year plan principles</li> </ul> | Chief Nursing Officer/Chief Medical Officer | Safety and Quality Committee |
| 1.3<br>Specialist<br>Services                     | Recognise the asset specialist services are to the organisation and the important role they play at LTH, delivering cutting edge care and being a catalyst for innovation and pioneering clinical practice                  | <ul style="list-style-type: none"> <li>Foster clinical excellence.</li> <li>Invest in specialist expertise</li> <li>Ensure that services are designed and delivered in a way that meets the diverse needs of the population.</li> <li>Champion innovation and collaboration.</li> </ul>  | <ul style="list-style-type: none"> <li>We can reduce unwarranted variation in both access to care and patient outcomes, ensuring that every individual receives equitable, timely, and effective treatment regardless of geography or circumstance.</li> </ul>   | Chief Medical Officer                       | Safety and Quality Committee |

# Patients

| Theme                            | Corporate Objective  | Scope and Focus of the Objective   | How will we know if it has been achieved?   | Exec Lead  | Assurance Committee          |
|----------------------------------|--|--|---|--|------------------------------|
| 1.4<br>Children and Young People | Design and deliver a children's and young people's plan to improve access to urgent and emergency care | <ul style="list-style-type: none"> <li>Design and implement a comprehensive Children's and Young People's Plan. This plan will be developed in collaboration with healthcare professionals, education providers, local authorities, and most importantly children, young people, and their families</li> </ul>   | <ul style="list-style-type: none"> <li>Identifying and addressing barriers to care</li> <li>Streamlined referral pathways</li> <li>Enhancing the capacity and responsiveness of urgent care services.</li> <li>Creation of a more accessible, responsive, and inclusive urgent care system.</li> </ul>                    | Chief Nursing Officer                              | Safety and Quality Committee |
| 1.5<br>Core Standards            | Improve outcomes and prevent harm  | <ul style="list-style-type: none"> <li>Implement the Always Safety-First strategy 2026-2029</li> <li>Deliver medicines safety and optimisation programme</li> <li>Continued implementation of PSIRF &amp; demonstrate maturity in the approach to learning.</li> <li>Deliver within the agreed <i>C.difficile trajectory</i></li> <li>Deliver annual safe staffing requirements</li> </ul> | <ul style="list-style-type: none"> <li>Improved verification and reconciliation compliance</li> <li>Delivery of Always Safety First and learning strategy</li> <li>Deliver agreed <i>C.difficile trajectory</i></li> <li>Deliver Maternity Incentive Scheme</li> <li>Deliver annual safe staffing requirements</li> </ul> | Chief Medical Officer<br><br>Chief Nursing Officer | Safety and Quality Committee |
| 1.6<br>Core Standards            | Reduce occupancy across UEC pathways   | <ul style="list-style-type: none"> <li>Reduce routine boarding on ward areas</li> <li>Eliminate corridor care in the Emergency Department</li> <li>Reduce ambulance delays</li> </ul>  | <ul style="list-style-type: none"> <li>Reduction in the daily boarded patient metrics</li> <li>Cessation of corridor care outside of critical/major incidents</li> <li>Ambulance handover metrics</li> </ul>  | Chief Nursing Officer                              | Safety and Quality Committee |
| 1.7<br>Core Standards            | Reduction in Health Inequalities across core20plus5 for adults and children and frailty pathways       | <ul style="list-style-type: none"> <li>Work across all pathways to implement agreed actions to further reduce health inequalities</li> </ul>   | <ul style="list-style-type: none"> <li>CORE20PLUS5 metrics for adults and children</li> </ul>   | Chief Nursing Officer                              | Safety and Quality Committee |

## Performance



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

# Performance

| Theme                            | Corporate Objective  | Scope and Focus of the Objective   | How will we know if it has been achieved?  | Exec Lead               | Assurance Committee               |
|----------------------------------|--|--|--|-------------------------|-----------------------------------|
| 2.1<br>Cancer                    | Improve patient experience through a focus on valuing patients' time by developing streamlined pathways and better communication, leading to the delivery of national standards for cancer | Redesign care pathways to be more efficient, reducing unnecessary delays and handoffs. Improved communication, both between healthcare professionals and with patients, will ensure that individuals are well-informed, supported, and actively involved in their care journey.  | <ul style="list-style-type: none"> <li>• Meet and exceed national cancer standards.</li> <li>• Achievement of percentage compliance for Faster Diagnosis Standards, 62 day referral to treatment and 31 days for treatment following a decision to treat as agreed in the annual plan.</li> <li>• Ensuring timely diagnosis, treatment, and follow-up</li> <li>• Fostering trust and confidence in our services.</li> </ul>  | Chief Operating Officer | Finance and Performance Committee |
| 2.2<br>Urgent and Emergency Care | Improve patient experience and performance in Urgent and Emergency Care through the delivery of the 4 hour, 12 hour and ambulance handover standards                                       | <ul style="list-style-type: none"> <li>• Co-design and standardise UEC pathways across providers to reduce duplication and improve consistency, working through the ICS urgent care networks</li> <li>• Streamline handoffs, improve communication, and reduce waiting</li> <li>• Explicitly targeting below-average UEC experience and long length of stay (LoS) for people presenting with mental health needs</li> <li>• Reduce urgent and emergency care waiting times in line with agreed plan               <ul style="list-style-type: none"> <li>- Adults 82%</li> <li>- Children 95%</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li>• Achieve and sustain performance at or better than national average</li> <li>• Same Day Emergency Care (SDEC) utilisation: % of eligible patients managed via SDEC pathways</li> <li>• Reduction in serious incidents related to deterioration/escalation delays; timely delivery of sepsis bundles in urgent pathways</li> <li>• ED Friends &amp; Family Test (FFT) positive score: Sustained improvement quarter-on-quarter</li> </ul> | Chief Operating Officer | Finance and Performance Committee |
| 2.3<br>Urgent and Emergency Care | Implement the strengths-based approach Days Kept Away from Home across all services  | <ul style="list-style-type: none"> <li>• Embedding a culture that values independence, supports recovery, and reduces unnecessary hospital admissions.</li> <li>• Fostering of multidisciplinary collaboration, enabling teams to work together to create care plans that are proactive, preventative, and tailored to each person's strengths and circumstances.</li> </ul>   | <ul style="list-style-type: none"> <li>• Reduction in days kept away from home</li> <li>• Improvement in length of stay</li> </ul>   | Chief Operating Officer | Finance and Performance Committee |

# Performance

| Theme                 | Corporate Objective  | Scope and Focus of the Objective   | How will we know if it has been achieved?   | Exec Lead               | Assurance Committee               |
|-----------------------|--|--|---|-------------------------|-----------------------------------|
| 2.4<br>Core Standards | RTT<br>Eliminate breaches and achieve compliance trajectories as agreed in the annual plan | 52-week and compliance<br>Reduce elective care waiting times in line with agreed and funded plan | <ul style="list-style-type: none"> <li>Eliminate all instances of a patient waiting longer than 52 weeks for treatment</li> <li>Meet and exceed locally agreed compliance trajectories</li> </ul> | Chief Operating Officer | Finance and Performance Committee |
| 2.5<br>Core Standards | Diagnostics<br>Achievement of the 6 week diagnostic waiting times performance trajectories | Reduce diagnostic waiting times  | <ul style="list-style-type: none"> <li>Meet and exceed locally agreed compliance percentages</li> </ul>   | Chief Operating Officer | Finance and Performance Committee |

## People



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

# People

| Theme   | Corporate Objective  | Scope and Focus of the Objective  | How will we know if it has been achieved?  | Exec Lead            | Assurance Committee                      |
|---|--|---|--|----------------------|--|
| 3.1<br>Continuous Improvement, Education, Research and Innovation | Equip all our colleagues, including the Board, with the improvement skills, knowledge and confidence to drive improvements within their teams and services | <ul style="list-style-type: none"> <li>Expand the current programme to include giving teams an understanding of the population health position</li> </ul>   | <ul style="list-style-type: none"> <li>Increased % workforce training in improvement skills and methodology</li> </ul>   | Chief People Officer | Education, Training & Research Committee |
| 3.2<br>Confidence and capability of leaders                       | Strengthen the confidence and capability of leaders  | <ul style="list-style-type: none"> <li>Roll out a range of profession specific leadership and management development programmes.</li> <li>Invest in the develop of the senior leadership team in the organisation.</li> <li>Create a senior leadership development talent map and succession plan.</li> <li>Increase the performance of teams through clear cascaded objective setting process and enhanced personal development planning.</li> </ul> | <ul style="list-style-type: none"> <li>Delivery and strong attendance at leadership development programmes.</li> <li>Positive evaluation feedback and improved leadership capability as measured through appraisal.</li> <li>Improved staff survey outcomes linked to leadership behaviours, increased use of TED at team level, appraisal compliance and increased number of colleagues with objectives and development plans.</li> </ul> | Chief People Officer | Workforce Committee                      |
| 3.3<br>Equality, Diversity & Inclusion                            | Improve the experience of work of colleagues with protected characteristics  | <ul style="list-style-type: none"> <li>Complete process for Antiracist framework.</li> <li>Deliver a talent programme for colleagues with protected characteristics.</li> <li>Increase confidence in disclosing disability and social economic background.</li> </ul>   | <ul style="list-style-type: none"> <li>To achieve bronze level of Antiracist framework.</li> <li>Reduced levels of discrimination reported by Black, Asian and Minority Ethnic colleagues.</li> <li>Reduced levels of bullying and harassment reported by Disabled colleagues.</li> <li>Increased, proportional representation at more senior levels of colleagues with protected characteristics.</li> </ul>                              | Chief People Officer | Workforce Committee                      |

# People

| Theme  | Corporate Objective   | Scope and Focus of the Objective  | How will we know if it has been achieved?   | Exec Lead            | Assurance Committee |
|--|---|---|---|----------------------|---------------------|
| 3.4<br>Health, well being, safety and attendance | Support the health, wellbeing, safety and attendance of our workforce | <ul style="list-style-type: none"> <li>To implement a digital sickness absence management tool.</li> <li>Providing targeted health and wellbeing to support colleagues with protected characteristics or from disadvantaged social economic backgrounds to remain well at work.</li> <li>Taking action to reduce levels of violence and aggression shown towards colleagues from patients, visitors and other colleagues</li> </ul> | <ul style="list-style-type: none"> <li>Reduction in levels of sickness absence.</li> <li>Reduction in the overall incidents of violence and aggression in the workplace.</li> <li>Improved staff survey outcomes in relation to wellbeing support and colleagues feeling well at work.</li> </ul> | Chief People Officer | Workforce           |
| 3.5<br>Colleague experience and culture          | Enhance colleague experience and levels of staff satisfaction         | <ul style="list-style-type: none"> <li>Embed the colleague engagement approach, to ensure colleagues have a voice and involved in sharing ideas for improvement.</li> <li>Increase levels of team effectiveness and engagement through greater utilisation of the TED tool.</li> <li>Support cultural transformation through relaunching our values, leadership behaviours and development of a cultural dashboard.</li> </ul>      | <ul style="list-style-type: none"> <li>Improved levels of colleague engagement and staff satisfaction across all of the NHS People Promise Indicators.</li> <li>Increase NHS Staff Survey response rate.</li> </ul>   | Chief People Officer | Workforce           |

# Productivity



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

# Productivity

| Theme                   | Corporate Objective   | Scope and Focus of the Objective   | How will we know if it has been achieved?  | Exec Lead                              | Assurance Committee               |
|-------------------------|---|--|--|--|-----------------------------------|
| 4.1<br>Finance          | Deliver the waste reduction programme without compromising quality or safety, including clinical pathway redesign, workforce optimisation, and digital innovation | <ul style="list-style-type: none"> <li>• Delivery of agreed Waste Reduction Plan</li> <li>• Consistent compliance with EQIA associated governance to ensure patient care is maintained</li> </ul>                        | <ul style="list-style-type: none"> <li>• Teams delivering to the forecasted plans</li> <li>• Progress in the Improvement and Assurance group (IAG) exit criteria to progress towards exiting National Oversight Framework (NOF) 5</li> </ul> | Chief Finance Officer                  | Finance and Performance Committee |
| 4.2<br>Anchor Institute | Increase Local Procurement  | <ul style="list-style-type: none"> <li>• Prioritise sourcing goods and services from local suppliers, contributing to the economic stability, wealth and growth of the region</li> </ul>                                 | <ul style="list-style-type: none"> <li>• Number of active local suppliers used</li> <li>• Spend through collaborative arrangements (e.g., LPC) that includes explicit local social value or supplier development commitments</li> </ul>      | Chief Finance Officer                  | Finance and Performance Committee |
| 4.3<br>Tech and Digital | Expand use of telemedicine and Remote Monitoring  | <ul style="list-style-type: none"> <li>• Expansion of telemedicine services to provide remote consultations and monitoring, ensuring patients have access to care regardless of their location</li> </ul>                | <ul style="list-style-type: none"> <li>• Increased ability to manage chronic conditions and reducing hospital admissions</li> </ul>  | Chief Strategy and Improvement Officer | Finance and Performance Committee |
| 4.4<br>Tech and Digital | Implement digital Patient Engagement Tools  | <ul style="list-style-type: none"> <li>• Development of digital tools and platforms to enhance patient engagement, such as mobile apps for appointment scheduling, medication reminders, and health education</li> </ul> | <ul style="list-style-type: none"> <li>• Outpatient efficient metrics</li> <li>• Outpatient friends and family feedback metrics</li> </ul>   | Chief Strategy and Improvement Officer | Finance and Performance Committee |
| 4.5<br>Tech and Digital | Expand the use of AI and Machine Learning   | <ul style="list-style-type: none"> <li>• Implementing AI and machine learning algorithms to enhance diagnostics, predict patient outcomes, and optimise treatment plans</li> </ul>                                       | <ul style="list-style-type: none"> <li>• More accurate and timely care, reducing the burden on healthcare professionals and improving patient experiences</li> </ul>   | Chief Strategy and Improvement Officer | Finance and Performance Committee |

## Partnerships



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

# Partnerships

| Theme                        | Corporate Objective   | Scope and Focus of the Objective   | How will we know if it has been achieved?  | Exec Lead                              | Assurance Committee               |
|------------------------------|---|--|--|--|-----------------------------------|
| 5.1<br>Overarching Objective | Be a collaborative system partner   | <ul style="list-style-type: none"> <li>Working with partners across Lancashire and South Cumbria to prevent ill-health, reduce health inequalities and work across organisational boundaries to develop integrated services across primary, community, and secondary care</li> </ul>                         | <ul style="list-style-type: none"> <li>Delivery of provider collaborative priority clinical transformation schemes</li> <li>Delivery of phase two Pathology single service objectives</li> </ul> | Chief Medical Officer                  | Trust Board                       |
| 5.2<br>Diagnostics           | Implement the Integrated Care System-wide diagnostics strategy, including unified PACS/RIS and cardiology systems | <ul style="list-style-type: none"> <li>Standardising Picture Archiving and Communication Systems (PACS), Radiology Information Systems (RIS), and cardiology platforms across organisations to ensure interoperability, reduce duplication, and improve the flow of information between providers</li> </ul> | <ul style="list-style-type: none"> <li>More coordinated care pathways</li> <li>Improved access to diagnostic results</li> <li>Enhanced the ability to share expertise across sites</li> </ul>    | Chief Strategy and Improvement Officer | Finance and Performance Committee |
| 5.3<br>Pathology             | Implement a unified Laboratory Information System across the ICS  | <ul style="list-style-type: none"> <li>To enhance diagnostic efficiency, data sharing, and clinical decision-making</li> <li>Streamlining of laboratory workflows, reduced duplication, and enable real-time access to test results across multiple care settings</li> </ul>                                 | <ul style="list-style-type: none"> <li>Faster turnaround times</li> <li>Improved accuracy</li> <li>Better co-ordination between primary, secondary and community care providers</li> </ul>       | Chief Strategy and Improvement Officer | Finance and Performance Committee |

# Partnerships

| Theme  | Corporate Objective  | Scope and Focus of the Objective   | How will we know if it has been achieved?  | Exec Lead                                   | Assurance Committee                       |
|--|--|--|--|---|---|
| 5.4 Continuous Improvement, Education, Research and Innovation | Further develop our partnerships in Education  | <ul style="list-style-type: none"> <li>Enhance the learning and development of our people and future healthcare professionals</li> <li>Collaboration with leading universities, colleges, and training institutions placements, and research opportunities, ensuring that our people and students are equipped with the knowledge and skills needed to excel in their roles</li> </ul> | <ul style="list-style-type: none"> <li>Provision of comprehensive educational opportunities fit for future healthcare education</li> <li>Further development of a culture of continuous learning and innovation, ultimately improving patient care and outcomes</li> </ul>                                       | Chief People Officer                        | Education Training and Research Committee |
| 5.5 Continuous Improvement, Education, Research and Innovation | Improve research and innovation  | <ul style="list-style-type: none"> <li>Investment in research initiatives and partnerships with leading academic institutions ensures that we stay at the forefront of advances in research</li> <li>We will further build our partnerships with industry to optimise supporting commercial research</li> </ul>  | <ul style="list-style-type: none"> <li>Improvement in the offers our patients receive to access to the latest clinical trials and treatment.</li> </ul>  | Chief Medical Officer                       | Education Training and Research Committee |
| 5.6 Community & Local Services                                 | Vertical integration with community services, providing comprehensive pathways for Central Lancashire working with primary and social care | <ul style="list-style-type: none"> <li>Develop comprehensive, joined-up pathways that span prevention, diagnosis, treatment, and ongoing support</li> <li>Vertical integration to ensure that patients experience continuity across different levels of care, from community to hospital</li> <li>Strengthened collaboration between services operating at the same level</li> </ul>   | <ul style="list-style-type: none"> <li>Reduction in health inequalities, through a reduction in gaps in access, outcomes and experience</li> <li>Improved management of long-term conditions (reduced emergency attendance and unpanned admissions)</li> <li>Shift from reactive to preventative care</li> </ul> | Chief Nursing Officer/Chief Medical Officer | Safety and Quality Committee              |

# Care and Safety Subgroup

12 January 2026 | 10.00am | Hybrid

## Members:

|                  |                              |
|------------------|------------------------------|
| Janet Miller     | Public Governor (Chair)      |
| George Bailey    | Public Governor              |
| Darrell Brooks   | Public Governor (online)     |
| Margaret France  | Public Governor              |
| Graham Fullarton | Public Governor (online)     |
| Lou Jackson      | Appointed Governor (online)  |
| Angela Kos       | Public Governor (online)     |
| Carole Oldcorn   | Public Governor              |
| Enid Povey       | Public Governor (online)     |
| Frank Robinson   | Public Governor (online)     |
| Graham Robinson  | Public Governor (Vice Chair) |
| Tim Young        | Public Governor (online)     |

## In Attendance:

|                  |  |
|------------------|--|
| Alison McCrudden | Patient Experience & Involvement Lead (online) |
| Jo Wiseman       | Interim Business Manager ( <i>minutes</i> )    |

**Apologies:** J Howles, D Thompson

### 1/26 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.

### 2/26 Declarations of interest

There were no declarations made by Subgroup members in respect of the business to be transacted during the meeting.

### 3/26 Minutes of the previous meeting

The minutes of the meeting held on 13 November 2025 were approved as an accurate record.

### 4/26 Matters arising and action log

The action log was reviewed and updated.

A query was raised regarding action 49/25 around the outdated signage displayed on an upper floor. It was confirmed that the matter would be escalated for removal as the fixture appeared to be adhered to the wall and required Estates support.

An update was sought on action 62/25 for the revisions to the Trust website. It was confirmed that improvements had been made to access information on car parking and mental health support. It was noted that further changes to the front page required

discussion with the relevant digital teams. Questions were brought up about how visible crisis support was, and it was emphasised that urgent mental health resources could be found through the designated helpline. There was a concern that patients seeking mental health care who don't check the website before visiting the emergency department might struggle to access important information, so making these details available on the main page would be more beneficial.

A query was raised regarding the accuracy of the car parking information online. It was confirmed that this would be raised at the next car parking meeting to ensure the published guidance reflected the approved flow chart.

## **5/26 Estates and Facilities Update**

Due of ongoing operational pressures, there was no Estates and Facilities representative available to provide an update.

## **6/26 Patient Experience and Involvement Update**

An update was provided outlining activity undertaken during December. A short operational month had been noted due to the holiday period. It was confirmed that a number of patient information leaflets had been renewed or withdrawn in line with updated clinical guidance, and ongoing work continued to ensure materials were aligned to the Trust-standard template. A presentation was being prepared summarising annual leaflet activity, including volumes, renewals and associated printing costs. Updates were provided on the Carers Forum, including the review of the carers charter and essential carers leaflet. Discussions had taken place regarding British Sign Language (BSL) resources, and links to external BSL video libraries had been added to the website to avoid duplication of provision. It was confirmed that health inequality work continued, with a current focus on engagement with the deaf community following a recent report identifying key accessibility issues.

Training needs relating to deaf cultural awareness had been identified and discussions were ongoing to explore inclusion within mandatory training. Clarification was given on support available for the deaf community, including contracted interpreting services and arrangements for video support where appropriate.

The subgroup noted that Healthwatch had produced a substantial report in July, focused on the experiences of British Sign Language (BSL) users across health and social care services. It was reported that several meetings had already taken place at County Hall, with a further session planned on 28 January. The meeting details would be shared on email. Attendees had been provided with a list of key priorities identified by the BSL and wider Deaf community, outlining what they wished to see improved within services. One of the main themes highlighted was the need to ensure that staff working across public sector organisations, including councils and service providers, were appropriately equipped to meet the communication and accessibility needs of BSL users.

A query was raised regarding previous discussions on BSL and whether volunteers had been involved in supporting BSL awareness. It was confirmed that volunteers had already received basic BSL awareness training, now overseen within the wider volunteering remit. Additional training sessions had also been delivered, including Guide Dog and assistance-dog awareness, with further training arranged in partnership with a national organisation. Volunteers were being invited to participate based on interest and suitability.

It was noted that the former hospital guide role had been incorporated into front-of-house functions due to staff changes, allowing individuals to undertake guiding duties to the extent they felt comfortable. While some volunteers preferred not to support wheelchair users, others were willing to escort and direct patients as needed. The hospital continued to offer a pre-booked guiding service, enabling patients to arrange support in advance. Under this arrangement, volunteers met patients at the entrance, accompanied them throughout their visit and ensured they were escorted back to the exit. Only a small number of patients had used the service recently despite being shown on the website. A discussion was held around the video that was recently launched to advise the public of the Opel 4 status as this was not supported with visual aids or script.

Further clarification was sought in relation to accessibility of outpatient appointment letters. It was confirmed that contract discussions were underway to ensure alternative formats could be provided, including large print, audio and translated versions. It was agreed that the letters issued for Dermatology patients and potentially other clinics would have the content checked to see if they asked carers not to wait in the waiting room.

It was confirmed that visiting times were still under review. Both positive and negative feedback had been received around moving to open-visiting hours.

**7/26 Non-Executive Director Update**

No update was available for this meeting.

**8/26 Reflections of the meeting and Lancashire Elective Surgery Hub & ED Visits**

Feedback was provided on the visit to the Lancashire Elective Surgery Hub. It was observed that the dedicated elective environment had enabled planned procedures to continue without disruption from emergency pressures. Staff feedback was noted as positive, though snagging issues typical of a new build had been identified and were understood to be subject to contractor rectification. It was suggested that a visit later in the year would be helpful to check if the repairs had been undertaken and this had been a great opportunity for a joint visit with Non-Executives.

Feedback was also provided on the visit to the Emergency Department. The department had been observed operating under significant pressure, with high attendance levels and extended waiting times. The challenges relating to corridor care, mental health presentations and staff safety were noted. Observations highlighted the impact of capacity constraints on patient experience. Consideration was given to potential mitigations such as improved signage, availability of refreshments and enhanced privacy. Concerns were raised regarding the availability of equipment including remote controls for TVs and consumables. It was suggested that having screens between patients to allow for private seating would be a good option.

**9/26 Request for future meeting topics, visits and any other business**

**Future Visits** – none requested.

**Future Topics**

- The Director of Estates to be asked to attend again to be able to raise some concerns around the estate improvements and cleaning standards. Other issues could be raised referencing the governor process map filed in Team Engine and other governors had the option to ask the subgroup to raise any hot topics.
- Exploration of inpatient flow challenges, including liaison with discharge and social care pathways, given the wider system pressures associated with limited community and care home capacity.

The Director of Estates and Non-Executive Director's absence from the meeting was noted with disappointment.

**Date, time, and venue of next meeting**

19 March 2026 at 12.30pm - Hybrid.

# Care and Safety Subgroup

19 March 2026 | 12.30pm | Hybrid

## Members:

|                  |                              |
|------------------|------------------------------|
| Janet Miller     | Public Governor (Chair)      |
| George Bailey    | Public Governor              |
| Margaret France  | Public Governor              |
| Graham Fullarton | Public Governor (online)     |
| Lou Jackson      | Appointed Governor           |
| Angela Kos       | Public Governor (online)     |
| Carole Oldcorn   | Public Governor              |
| Enid Povey       | Public Governor (online)     |
| Frank Robinson   | Public Governor              |
| Graham Robinson  | Public Governor (Vice Chair) |
| Tim Young        | Public Governor (online)     |

## In Attendance:

|                  |   |
|------------------|---|
| Shaun Ashworth   | Director of Estates and Facilities (online)                               |
| Dr Karen Deeny   | Non-Executive Director (online)   |
| John Howles      | Associate Director of Patient Quality, Experience and Engagement (online) |
| Alison McCrudden | Patient Experience & Involvement Lead (online)                            |
| Katie Stanton    | Business Manager, Corporate Affairs                                       |
| Jo Wiseman       | Corporate Affairs Officer ( <i>minutes</i> )                              |

### 10/26 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.

### 11/26 Declarations of interest

There were no declarations made by Subgroup members in respect of the business to be transacted during the meeting.

### 12/26 Minutes of the previous meeting

The minutes of the meeting held on 12 January 2026 were approved as an accurate record.

### 13/26 Matters arising and action log

The action log was reviewed and updated.

### 14/26 Estates and Facilities Update

An update was provided on Estates and Facilities. It was reported that the recent transition of Estates and Facilities services had been completed smoothly and that operational delivery continued on a business-as-usual basis. Significant progress had been made

during the financial year in delivering capital and backlog maintenance works, supported by multidisciplinary working with clinical teams despite logistical challenges associated with decanting patient areas.

Key highlights included the completion of two new interventional radiology rooms with upgraded nurse call and call bell systems. It was also reported that a new helipad at the Royal Preston Hospital had opened recently, enhancing major trauma provision and supported through charitable funding.

Looking ahead, essential maintenance was required to electrical infrastructure at the Royal Preston Hospital, including transformer works across multiple substations. This would necessitate the site operating on generators for a limited period to enable the works to be undertaken safely. A detailed plan was being developed, with a paper to be submitted to the Trust Management Board for executive approval once finalised.

A major programme of works was outlined for the main ward block, including replacement of drainage infrastructure alongside wider consequential improvements. These would include window replacements, lighting upgrades, ceiling renewals, selective rewiring and enhanced fire safety and compartmentation. Subject to funding approval, the programme was planned over the next four to five years and was expected to significantly reduce the critical infrastructure backlog and improve the environment for patients and staff. It was noted that this programme formed part of a longer-term investment approach and was intended to maintain the existing estate to an appropriate standard pending delivery of a new hospital, which was not anticipated for a considerable period. Indicative funding of approximately £40m over four years was reported, subject to approval through the business case process, with funding expected to be phased and supplemented by internally generated capital. It was advised that the meeting with stakeholders was taking place soon and the invite was shared so the recording could be viewed.

Further updates were provided on car parking and site infrastructure across both hospital sites. It was reported that the upgraded camera system had been installed at both sites and was expected to be fully operational by the end of March.

A number of estate-related issues were raised, including damage to safety fencing near the helipad, faded pedestrian crossings at the rear of the estate, signage deterioration at main entrance at RPH and Gordon Hesling entrance, enforcement of red route restrictions, road markings within car parks and accessibility challenges for patients using walking aids. Concerns were also raised regarding lighting at specific sites in relation to staff safety and energy efficiency. Assurance was provided that these matters would be addressed through routine maintenance programmes, existing contracts and further review by the Estates and Facilities team. Actions were agreed to review signage, road markings, lighting and seating provision, including consideration of repurposing existing benches to support staff wellbeing.

## **15/26 Patient Quality, Experience and Engagement Update**

It was reported that ongoing challenges remained within urgent and emergency care pathways, with feedback from families indicating that experience was not consistently at the desired standard, particularly at the Preston site. Attention was being focused on environmental improvements, including the replacement of seating and furniture in key areas to improve comfort for patients and families.

It was noted that funding had been identified to replace benches within the maternity department, including adult and children's areas, as well as corridor seating. Work was also underway to explore charitable support for the provision of refreshments within waiting areas. Ongoing challenges related to inpatient flow were acknowledged, with recognition that these pressures continued to affect patient experience.

An update was provided on workforce development initiatives. New role-specific patient experience training modules had been introduced within staff training and appraisal processes, with a focus on local resolution and improved handling of complaints. In addition, food-related issues affecting patient experience were discussed, including delays and suitability of meals. It was reported that a specific food action plan was being developed in collaboration with Estates colleagues to address these concerns.

Positive progress was highlighted in relation to volunteer recruitment, with an increase of over 10% compared to the previous year. Plans were in place to further develop and expand volunteer roles to support wards and patient-facing areas, including work aligned to smart ward initiatives. Further work to improve discharge experience was outlined. A discharge audit had been completed, identifying key learning around communication with patients, families and carers, particularly in relation to medicines and pharmacy at the point of discharge. Actions had been implemented and were reported to be well received. A patient information video outlining what to expect during a hospital admission had also been developed, promoting patient and carer empowerment through clear messaging and key questions.

It was reported that information videos had been deployed across inpatient areas via ward iPads and were being piloted within selected frailty wards. Plans were in place to extend use to emergency department waiting areas, supported by the installation of operational television screens. Additional equipment had been secured to enable consistent use of screens across multiple sites, allowing the display of waiting times and patient information. An update was provided on the review of visiting arrangements. A consultation was underway on the visiting policy and essential carers policy, recognising the distinction between visitors and carers. Public feedback was reported to be mixed, with further work planned to determine whether to update the visiting policy or strengthen guidance for essential carers. It was confirmed that outcomes would be communicated clearly to support consistent messaging at reception and ward level.

A recent patient safety walkaround was reported, during which feedback was gathered on how safe patients felt within hospital environments and how concerns would be escalated. This work had been positively received, with plans to test a short safety feedback tool within outpatient settings and selected wards. It was anticipated that this would generate regular patient feedback to inform safety surveillance and improvement work.

It was advised that work was underway to develop a single patient experience improvement plan for 2026–27. Key themes included strengthening feedback and insight from complaints and the Friends and Family Test, improving communication and information, reinforcing fundamentals of care, promoting inclusion and equity, developing a central patient experience hub, enhancing workforce and volunteer development, improving real-time learning and responsiveness, reintroducing always events and strengthening assurance, governance and measurement arrangements.

## 16/26 Patient Experience and Involvement Update

An update was provided on patient information, involvement and community engagement. It was reported that an annual general meeting had taken place in January, providing an overview of activity and achievements over the previous year, including expenditure on printing and the use of website accessibility tools such as translation and text-to-speech functions. The annual general meeting had also been discussed at the carers forum held later in January.

It was noted that the annual review process provided an opportunity to reflect on progress and to shape future priorities, informed by feedback and suggestions raised by carers. A carers' forum held in February had focused on access to additional support and services, reflecting requests from carers for clearer information. It was reported that some partner organisations had been unable to attend but were expected to participate in a future forum scheduled for later in March.

An update was provided on work addressing health inequalities, with a particular focus on collaborative activity with local authorities, voluntary organisations and community services. This work aimed to improve the accessibility and visibility of information available to the public, enabling individuals to better understand and access support within their local area. Attendance at a county-level engagement event earlier in the year was also reported, which had brought together a range of organisations to share learning and promote independent living support, including assistive technologies.

It was further reported that a digital engagement platform was in development to act as a central repository for community engagement activity, campaigns and communications, accessible to internal teams and partners. This was intended to support coordinated working and improve visibility of engagement initiatives once launched.

Progress was reported on an initiative to introduce mandatory deaf awareness training. This work had been informed by feedback from community engagement activity and was being developed in partnership with specialist organisations. The proposed training would include experiential elements to improve understanding of communication barriers, supported by British Sign Language interpretation, and would be delivered primarily through an e-learning format with an assessment component.

It was noted that discussions had taken place with learning and development teams to explore how the training could be embedded within existing equality, diversity and inclusion resources. Consideration was being given to identifying staff groups for whom the training would be most relevant, alongside inclusion of volunteers. Subject to development timelines and partner input, it was anticipated that the training would be implemented within the current year.

During discussion, concerns were raised regarding the accuracy of contact information on patient-facing materials. It was confirmed that a mobile contact number displayed on some posters was no longer operational and that this would be corrected. Further concerns were noted regarding outdated or unobtainable telephone numbers on patient letters, with agreement that examples would be shared to enable review and correction through the appropriate governance route.

It was reported that volunteers had now transferred into Patient Experience and Involvement Services. Going forward, brief update reports would be provided to highlight key activity, recruitment updates, mandatory training, news and events, alongside sharing of relevant newsletters to support assurance and oversight.

## **17/26 Non-Executive Director Update**

An update was provided on quality, safety and patient experience, summarising key matters arising from recent Safety and Quality Committee discussions. It was reported that a peer review of the paediatric trauma unit had taken place. While this was not a regulatory inspection, it had identified areas for improvement, including the absence of a dedicated paediatric resuscitation room. An initial update had been provided to committee, with a fuller report and action plan expected following receipt of the final written feedback.

It was reported that a Never Event had occurred within Interventional Radiology, relating to graft sizing. It was confirmed that there had been no harm to the patient, who had been fully informed and that no changes were required to clinical follow-up or treatment. Further learning was ongoing, including environmental walkthroughs with patient safety partners, and continued scrutiny through the Patient Safety Incident Response Framework oversight arrangements.

An update was provided on maternity services. It was reported that Birthrate Plus modelling had identified a requirement for enhanced staffing to reflect increasing acuity and complexity within the service. A two-year phased investment plan had been developed, focused on nursing and maternity support worker roles and was subject to the Trust's financial approval processes. Assurance was provided that the plan was being implemented on a mitigated risk basis, with progress monitored through regular Safety and Quality reporting. It was noted that the maternity and neonatal safe staffing report had been approved, with forward planning aligned to the Birthrate Plus findings. Positive assurance was also provided in relation to compliance with the Clinical Negligence Scheme for Trusts, with all required standards met and externally validated, reflecting strong performance within maternity services. During discussion, clarification was provided on maternity staffing requirements, confirming that the Birthrate Plus modelling identified a need for approximately 15 whole-time equivalent midwives. It was confirmed that the two-year plan had been approved by the Safety and Quality Committee and would progress through the required financial approvals, with updates to be included in Board papers.

An inspection by the Human Tissue Authority was reported, which had provided very positive feedback. However, it was noted that capital investment was required to replace a post-mortem table. Assurance was sought and provided that funding was being progressed and that this issue would be closed once the replacement had been completed.

The Committee had noted the three principal risks under its oversight: urgent and emergency care pathways, Clostridium Difficile infection, and health inequalities in experience of care. It was reported that the Clostridium Difficile risk score had reduced from 12 to 8, reflecting sustained improvement and performance consistently below trajectory. In contrast, progress in reducing the urgent and emergency care and health inequalities risks remained challenging, largely due to factors outside the Trust's direct control. Work was underway to reframe these risks to clearly distinguish what sat within organisational control while continuing to influence wider system factors.

Positive assurance was reported regarding thrombectomy services, with the 24/7 service now operational following earlier regulatory correspondence. Ongoing work remained in relation to mutual aid arrangements between centres, which would continue to be monitored through committee oversight.

Further assurance was provided following an internal audit review of the Patient Safety Incident Response Framework, which benchmarked the Trust within the top 10% nationally for incident reporting culture. This was noted to reflect strong reporting, investigation and learning processes. In addition, a recent Care Quality Commission visit focusing on Mental Health Act implementation had provided strong assurance, with no concerns identified regarding compliance. It was noted that delays in access to inpatient mental health services remained a system-wide challenge and would continue to be influenced through partnership working.

Discussion also focused on patient experience within urgent and emergency care pathways. It was acknowledged that while some improvements had been demonstrated in parts of the pathway outside the emergency department, progress remained challenging within emergency care itself. The importance of communication was highlighted as a key factor influencing patient experience, with work underway to improve information sharing and manage expectations while patients waited. It was agreed that future focus would remain on actions within the Trust's control, alongside continued system-level collaboration.

Concerns were raised regarding clarity of roles and responsibilities within contracted urgent care services and the interface with emergency department teams. Assurance was provided that professional standards, training and qualifications were in place, and that further work would be undertaken to strengthen understanding of contractual arrangements and communication across services.

## **18/26 Reflections of the meeting and MAU Visit**

An update was provided on reflections from recent visits to the Medical Assessment Unit (MAU). It was reported that two separate visits had taken place. During the first visit, attendance was lower than anticipated due to late changes, which had not been communicated to ward staff in advance. Despite this, staff were welcoming, provided a comprehensive overview of the unit and demonstrated pride in their work. It was reported that the unit was operating under pressure but continued to deliver care effectively, with strong compliance against standards and evidence of sustained performance.

During the visit, several areas for improvement were highlighted. These included reliance on temporary staffing arrangements, with feedback suggesting that greater continuity would be beneficial. Concerns were also raised regarding the discharge lounge, which was reported to be used overnight for patient safety purposes but did not function effectively as a discharge environment. This resulted in additional work for staff each morning to identify appropriate patient placement, leading to frustration despite overall positive morale. Further feedback related to communication about planned changes within MAU. It was noted that staff were aware of proposals to relocate a clinical area but had not received timely updates, contributing to uncertainty. This was recognised as a wider communication issue, with agreement that clearer and more consistent messaging would be beneficial.

Positive feedback was provided regarding leadership and culture within the unit. It was reported that strong leadership, collaborative working and a positive culture had contributed to the unit's journey to achieving high performance standards. Good practice had been shared more widely to support learning across other wards, and the unit was described as a safe and well-led environment.

The second visit was reported to have taken place shortly afterwards and echoed many of the same positive observations. Staff were described as proactive and welcoming, and patient feedback was largely positive, with patients expressing satisfaction with the care received. While the area was noted to be extremely busy, it was reported that staff remained organised and in control.

Some environmental concerns were raised during the second visit. It was noted that seating arrangements in the Williamson Suite were cramped, with chairs positioned closely together, raising issues around privacy and infection control. It was suggested that an improved discharge lounge could help alleviate pressure in this area, particularly for patients who were ready for discharge but awaiting arrangements. Additional concerns were raised regarding patient dignity and the environment of care, including noise levels and the management of patients at end of life within shared spaces. These issues were noted as having been raised separately following the visit.

It was agreed that practical reminders would be issued in advance of future visits to support infection prevention and control, including guidance on personal belongings, attire and storage limitations. Practical arrangements to support governors during site visits were also noted.

## **19/26 Request for future meeting topics, visits and any other business**

### **Future Visits**

Suggestions focused on locally relevant priorities, including national developments in acute medicine and the 72-hour model of care, with particular emphasis on the patient journey through medical wards from admission to discharge. It was agreed that future visits could usefully explore how patients who no longer met criteria to reside were supported to return home. Ward 23 at RPH and Brindle Ward at CDH were suggested as relevant areas and to contact the Divisional Director for Medicine. The Lancashire Eye Clinic at CDH was also suggested as an interesting area to visit.

Further suggestions for visits included Audiology at RPH outpatient services, particularly areas managing high levels of frailty and diverse patient needs, where there were examples of strong performance under challenging conditions.

### **Future Meeting Topics**

It was suggested that a future agenda item could include an update from regional smoking cessation and addiction services, to understand current priorities, service focus and how the transition from previous arrangements had affected benefits for patients and staff.

Members also proposed a future session focused on discharge and flow, reflecting the exceptionally high levels of emergency department demand experienced over the winter period. It was agreed that exploring lessons learned, improvement actions and forward planning would be particularly helpful for new governors and for wider understanding of system pressures.

Concerns were raised regarding health and safety arrangements during major estate works. It was suggested that a future topic or visit should focus on health and safety assurance, particularly in relation to construction activity and contractor compliance, to ensure risks were being appropriately managed.

### **Any Other Business**

It was noted that this meeting marked the final attendance for several long-standing members of the subgroup including the chair. Members formally recorded its thanks for their sustained commitment, valuable contributions and service over many years and extended best wishes for the future.

### **Date, time, and venue of next meeting**

11 May 2026 at 10.00am - Hybrid.

# Membership Subgroup

3 January 2026 | 2.00pm | Microsoft Teams Meeting

## Members:

|                |                 |
|----------------|-----------------|
| Sheila Brennan | Chair           |
| George Bailey  | Deputy Chair    |
| Janet Miller   | Public Governor |
| Enid Povey     | Public Governor |
| Frank Robinson | Public Governor |
| Tim Young      | Public Governor |

## Apologies:

Graham Robinson, Margaret France

## In attendance:

|                 |  |
|-----------------|--|
| Karen Deeny     | Non-Executive Director                       |
| Karen Lawrenson | Corporate Affairs Officer ( <i>minutes</i> ) |

### 1/26 Chair and quorum

The Chair noted that due notice of the meeting had been given to each member and a quorum was present.

### 2/26 Declaration of interests

There were no declarations made in respect of the business to be transacted during the meeting.

### 3/26 Minutes of the previous meeting held on 5 December 2025

The minutes were accepted as a true and accurate record.

### 4/26 Action Log

The action log would be updated accordingly.

## Matters Arising

An update was provided on membership data analysis. It was noted that the official dashboard could not be amended and therefore a quarterly update would instead be produced and incorporated into the membership report for the Council of Governors. It was explained that the current dashboard followed the structure of the Integrated Performance Report, which limited scope for re-design, and that capacity constraints meant a standalone Governor dashboard could not be produced at present. It was suggested that key highlights could be extracted to form a concise summary for Governors. Concerns were raised that the existing dashboard was overly lengthy, difficult to read, and not easily accessible on iPads and issues regarding accessibility standards, colours, and readability were also raised. It was agreed that the accessibility of the current dashboard needed further attention and that a review of key highlights would be undertaken for discussion at the next meeting.

With regards to the Governor Support Role, clarification was provided that the post had been advertised three times, including internal and external rounds during 2024 and 2025, but had not progressed to interview or appointment. It was confirmed that the minutes of 5 December 2025 reflected the most recent recruitment activity, and that the vacancy remained under consideration by the vacancy control panel.

## **5/26 Why be a member?**

The sub-group discussed options for increasing visibility of membership, including placing information tables in public areas across both sites. It was acknowledged that staff automatically became members unless they opted out, and examples of previous practice were shared, including the use of pop-up stalls to engage staff and gather views. It was noted that information on the Trust website was not widely accessed and public-facing communication needed improvement. The discussion broadened to wider communication challenges within the Trust, including inconsistent engagement with members and the limited visibility of positive news stories. Concerns were raised about the absence of a clear social media policy and the implications for Governors using personal accounts. A recurring issue regarding Governors not receiving global Trust communications was discussed, and an action was agreed to investigate the omission of Governor email addresses from the global distribution list with IT. The sub-group reflected on their own reasons for becoming members, which included a desire to contribute, prior involvement in Trust activities, and exposure to membership materials historically available in public areas. It was noted that certain methods previously used to promote membership, such as printed postcards and physical copies of Trust Matters, were no longer routinely available, likely due to financial pressures. The need for clearer and more consistent communication with both staff and public members was emphasised throughout.

## **6/26 Draft Membership Dashboard**

The sub-group reviewed the approach to developing a statistics dashboard and agreed to maintain consistency by using the same quarterly membership data source. It was noted that additional metrics could be incorporated, particularly those frequently queried by Governors, such as staff sickness rates and relevant operational indicators already available within existing performance reports. The potential value of including local population ethnicity comparisons to support understanding of inequalities across the Trust's catchment area was discussed. Reference was made to recent equality, diversity and inclusion activity reported to the Board, and it was highlighted that Governors had not been informed of the associated engagement events, which might have offered opportunities for participation. Members emphasised the need for improved communication about forthcoming engagement activities and clearer identification of where Governors could add value. The discussion reiterated concerns about wider communication challenges within the Trust and the importance of ensuring positive work was visible to staff, stakeholders and the community.

## **7/26 Events Diary**

It was noted there were no known activities in the near future in the Chorley area. It was highlighted that the Preston Health Mela had been the only event attended last year and should not be missed this year; however, a new point of contact was required. It was recalled that a Health Mela in Leyland had also previously taken place. Persistent communication gaps were noted, with concern about unclear ownership within the Trust

for coordinating such events. It was agreed that effort would be made to identify the responsible department, confirm event plans and commence preparations early to secure participation.

**8/26 Reflections on the meeting**

Thanks were formally recorded for two members who were attending their final meeting, recognising their contributions and dedicated service over many years.

**Date, time, and venue of next meeting:**

12 May 2026, 10am, Hybrid Meeting, Gordon Hesling Conference Room, RPH

*The meeting concluded at 3.31pm*

## DATE, TIME AND VENUE OF NEXT MEETING

● Information Item

👤 M Thomas

🕒 2:45 pm

23 July 2026, 10:00am, Lecture Room 1, Education Centre 1, Royal Preston Hospital