NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

COUNCIL OF GOVERNORS MEETING

COUNCIL OF GOVERNORS MEETING

23 July 2026

10:00 GMT+1 Europe/London

Lecture Room 1, Education Centre 1, Royal Preston Hospital

AGENDA

AGENDA

REFERENCES

Only PDFs are attached

0.0 Agenda (PI) - Council of Governors - 23 July 2026 (1).pdf

Council of Governors

23 July 2026 | 10.00am
Lecture Room 1, Education Centre 1, Royal Preston Hospital

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	10.00am	Verbal	Information	Chair
2.	Apologies for absence	10.01am	Verbal	Information	Chair
3.	Declaration of interests	10.02am	Verbal	Information	Chair
4.	Minutes of the previous meetings held on 23 April 2026	10.03am	✓	Decision	Chair
5.	Matters arising and action log	10.04am	✓	Information	Chair
6.	Chair's opening remarks	10.05am	Verbal	Information	Chair
7. PRODUCTIVITY AND PERFORMANCE					
7.1	Board Committee Chairs' Reports, including Integrated Performance Report Summary	10.15am	✓	Assurance	Non-Executive Directors
7.2	Update from Care and Safety Subgroup	10:55am	Verbal	Information	G Bailey
7.3	Update from Membership Subgroup	11:05am	Verbal	Information	S Brennan
8. SAFETY, QUALITY, WORKFORCE AND PERFORMANCE					
8.1	Patient Experience and Involvement Annual Report	11.15am	✓	Information	J Howles
8.2	Left-shift & neighbourhoods - what does this mean for us?	11.45am	✓	Information	C Granato / L Dickinson
9. GOVERNANCE AND COMPLIANCE					
9.1	Annual Members Meeting	12.15pm	✓	Information	J Foote
10. ITEMS FOR INFORMATION (taken as read)					
10.1	Governor opportunities & activities report		✓		
10.2	Governor issues report		✓		
10.3	Single Improvement Plan		✓		

№	Item	Time	Encl.	Purpose	Presenter
10.4	Minutes of Governor Subgroups: (a) Care and Safety Subgroup – 11 May 2026 (b) Membership Subgroup – 12 May 2026		✓		
10.5	Review of meeting performance	12.20pm	Verbal		Chair
10.6	Date, time and venue of next meeting: *22 October 2026, 1:00pm, Lecture Room 1, Education Centre 1, Royal Preston Hospital*	12.25pm	Verbal	Information	Chair
11. **RESOLUTION TO REMOVE PRESS AND PUBLIC**					
11.1	Resolution to exclude members of the press and public	12.26pm	Verbal	Decision	Chair

1. CHAIR AND QUORUM

Information Item | Chair | 10:00am

2. APOLOGIES FOR ABSENCE

Information Item | Chair | 10:01am

3. DECLARATION OF INTERESTS

Information Item | Chair | 10:02am

4. MINUTES OF THE PREVIOUS MEETING HELD ON 23 APRIL 2026

Decision Item | Chair | 10:03am

REFERENCES

Only PDFs are attached

4.0 Minutes 23 April 2026 Council of Governors (part I).pdf

Council of Governors Public Meeting

23 April 2026 | 1.00pm

Seminar Room A, Education Centre 3, Chorley District Hospital

Present:

Mike Thomas	Chair
Pav Akhtar	Public Governor *(via MS Teams)*
Takhsin Akhtar	Public Governor *(via MS Teams)*
George Bailey	Public Governor (via MS Teams)
Susan Bailey	Public Governor
Linda Bracewell	Public Governor
Sheila Brennan	Public Governor
Darrell Brooks	Public Governor
Sonia Connell	Staff Governor
Ian Facer	Public Governor
Graham Fullarton	Public Governor
Angela Kos	Public Governor
Terry Lindsey	Public Governor
Daniel Matchett	Appointed Governor (via MS Teams)
Zulekha Mushtaq	Public Governor (via MS Teams)
Ian Linacre	Public Governor (via MS Teams)
Carole Oldcorn	Public Governor (via MS Teams)
Enid Povey	Public Governor
Graham Robinson	Public Governor
Suleman Sarwar	Public Governor (via MS Teams)
Christine Turner	Public Governor
Tim Young	Public Governor

Apologies: Philip Curwen, Lou Jackson, Adrian Rata, Tom Ramsey, Sheila Beale, Michelle Brown

In attendance:

Tim Ballard	Non-Executive Director
Nicola Compton	Corporate Affairs Officer
Jennifer Foote MBE	Director of Corporate Affairs
Adrian Leather	Non-Executive Director *(via MS Teams)*
Sarah Morrison	Deputy Chief Executive Officer, Chief Nursing Officer
John Schorah	Non-Executive Director
Katie Stanton	Business Manager, Corporate Affairs *(Minutes)*
Tim Wheeler	Non-Executive Director *(via MS Teams)*

Apologies: Steve Canty, Craig Carter, StJohn Crean, Karen Deeny, Katie Foster-Greenwood, Silas Nicholls

15/26 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.

16/26 Declaration of interests

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

It was noted that Dr Tim Ballard was a subject of item 8.1 Outcome of Non-Executive Director Appraisals and Re-Appointment of Dr Tim Ballard for Second Term *(minute no. 24/26)* and would be asked to leave the room for that point of business.

17/26 Minutes of the previous meeting

It was agreed that the minutes of the meeting held on 20 January 2026 were approved as a true and accurate record subject to an amendment to minute no 5/26 regarding the title of the item which was delivered by the Chief Executive who provided a verbal update and not an update on a report.

18/26 Matters arising and action log

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

19/26 Chair and Deputy Chief Executive's opening remarks

The Chair welcomed Council and welcomed several new members following recent elections. It was noted that this was an opportunity to build new and positive relationships across members and the Board of Directors. Council was informed that the Chair would be available for any individual questions or conversations over the coming year.

Council received an update on the proposals for the NHS Amendment Act 2026 which were expected to include changes in delegation of powers and oversight across all levels of the NHS including the potential dissolution of Council of Governor and membership requirements. It was acknowledged that the Trust should continue to have direct engagement with the community.

Council was also informed of the new regulation ratings and tiers of Trust performance that came into effect 1 April 2026, what level of scrutiny applied to each level and what would trigger movement between the tiers. The Trust expected to be placed in Tier 4 in this new model due to the ongoing financial challenges faced.

An overview of the future of systems level working was provided with notice that structures such as an Integrated Health Organisation (IHO) model were being explored nationally.

Council heard that upcoming local government reform would influence how neighbourhoods could work collaboratively in the future. It was acknowledged that changes could provide opportunities for community offers to be better aligned to local community needs.

The Deputy Chief Executive provided an update beginning with an acknowledgement of the high level of scrutiny the Trust had received during 2025/26 and the opportunity this

had provided for positive reflection, which would be further captured in the 2025/26 Quality Account. The Council was informed that the most recent NHS England review of performance recognised the efforts and capabilities of Trust leaders.

It was reported that the highest level of recurring financial savings in the last decade had been delivered in 2025/26 through significant service change, supported by clinical and operational leadership, and a commitment to improvement alongside financial recovery. It was noted that corporate objectives and the single improvement plan for 2026/27 had been agreed by the Board and would provide the operational framework for delivery for the year ahead. The Trust had now taken the role as lead pathology provider for Lancashire and South Cumbria. It was confirmed that monthly safety visits would continue and an open invitation was extended to Governors to attend. Key priorities were outlined as performance, safety and quality, and it was reported that progress had been made in reducing long waits and improving cancer standards, with further focus planned on referral-to-treatment times and urgent and emergency care performance, including improvements for frail patients through strengthened pathway and system working. It was further reported that the Maternity Incentive Scheme standards had been achieved. Planned capital developments were highlighted, including a mental health assessment facility adjacent to Royal Preston Emergency Department, investment to expand same-day emergency care for frail patients and reduce emergency department congestion, funding for improvements to the Broad Oak Child Development, and ongoing work with Lancashire and South Cumbria Foundation Trust regarding their Longridge Community Hospital closure (currently being accommodated by the Trust at Chorley District Hospital).

During discussion, assurance was sought by the Council regarding whether the Trust's financial targets could be delivered without compromising public and patient safety. Assurance was provided that the financial target had been set centrally and that delivery would be pursued through wholescale transformation rather than reductions that would undermine safe staffing. It was confirmed that safe staffing assessments would continue to be applied. The importance of Safety and Quality Committee scrutiny, including rigorous equality and quality impact assessments and ongoing monitoring, was reiterated, and it was stated that patient safety would remain the red line in decision-making.

20/26 Board Committee Chairs' Reports, including Integrated Performance Report Summary

The Chair invited the newly appointed Lead Governor to share a few remarks of introduction.

It was acknowledged that relationships between Governors and the executive team had not always been strong and that a reset in approach was sought. It was suggested that the Governors' role should be exercised through influence and constructive challenge, with a focus on supporting effective decision-making. The importance of broad Governor engagement was emphasised, with a request that involvement should be widened to avoid reliance on a small group, and it was clarified that the Lead Governor intended to act as a conduit rather than a leadership position over other Governors. Concern was expressed regarding national proposals to remove membership and governance arrangements without consultation, and it was reported that engagement with the National Association of Lead Governors had been undertaken to inform discussion on future models to retain meaningful public and member involvement.

The Non-Executive Directors provided an overview of the areas of focus for their respective assurance committee, focussing updates on three key areas: Alert, Advise and Assure.

a) Safety and Quality Committee:

An update was provided by the Safety and Quality Committee Chair. It was emphasised that rigorous scrutiny had been applied to performance information, with focus placed on underlying detail rather than solely reported figures. It was reported that improvements in cleaning standards and executive focus had contributed to a marked reduction in Clostridium difficile (C. Diff.) and that this issue had been removed from the Trust's main priority list for the first time in three years.

Assurance was provided that safe staffing remained a key determinant of quality of care, underpinned by national guidance, and that particular rigour had been applied in maternity services. It was confirmed that the maternity team had achieved the required standards under the Clinical Negligence Scheme for Trusts and that external review of staffing through Birthrate Plus had been completed, with the findings progressing through internal governance processes. It was noted that multiple external assurance visits and mandatory reporting requirements continued to provide additional oversight, including in relation to maternity, and that further assurance had been gained through participation in neonatal review activity via the Working Together Committee. The adoption of "Always Safety First" was reiterated as a guiding principle for decision-making, including in the context of financial challenge, aligned to equality and quality impact assessments and the organisation's stated red lines. It was also reported that a wider Board development session had been held with the National Patient Safety Lead, and that suggestions from this session continued to be explored for potential embedding where beneficial.

During discussion, clarity was sought by the Council on the urgent and emergency care improvement plan. It was reported that an experienced Improvement Director had been appointed to provide additional capacity to plan development, and that the programme had been structured into defined workstreams with lead ownership, alongside separate medical model redesign. It was reported that tests of change would commence on 1 June, with early outputs expected within six months and measurable improvement anticipated by the end of quarter two, and that further action would be taken if progress had not been realised. It was further reported that plans and savings had been triangulated with operational and financial plans, and assurance was provided that key variances, including workforce-related pressures, had been identifiable at divisional level through routine review processes.

During discussion, clarification was sought on the Trust's C. difficile position against the national target. It was confirmed that the national measure had been set as a tolerance rather than a strict target and that performance had been maintained below tolerance for the previous two years, supported by a multifactorial approach including antimicrobial stewardship and adherence to best practice. It was also reported that capital funding of approximately £31m had been secured for estates improvements, with drainage and sewage infrastructure works planned and expected to support further infection prevention and control.

b) Finance and Performance Committee:

An update was provided on the Finance and Performance Committee's review of the recovery plan, and it was reported that principal risks relating to quality of care, planned care, diagnostics and overall financial sustainability had remained broadly unchanged, with the pace of improvement having been less than desired. Continued operational pressures were noted, including high bed occupancy, ambulance handover delays and the use of overflow capacity, although improvements in elective activity, diagnostics and cancer performance were reported. It was stated that early indicators for the new year had been viewed as positive, with building blocks having been put in place to support further improvement.

The financial position for the previous year was reflected upon, and it was reported that the Trust achieved a deficit reduction of £46.3m against a £60m target. It was also reported that delivery against the waste reduction programme had fallen short, with pay costs, including fixed and variable pay, having been highlighted as a continuing and significant risk requiring further action. Context was provided that in-year savings achieved had exceeded the prior year by approximately £22.5m, but that recurrent efficiency requirements reset annually and continued to create a baseline pressure. The need for realism in planning was emphasised, and it was reported that stronger governance, enhanced programme management and increased investment in project management had been put in place, alongside a request for greater scrutiny at divisional level and clearer accountability for delivery.

c) Workforce Committee:

An update was provided on the Workforce Committee's discussions, and it was reported that the primary focus had been placed on workforce capacity and staff experience, including the impact of workforce actions required to support delivery of the financial recovery plan, which had been viewed as off trajectory. Higher-than-expected levels of staff absence were noted, and it was reported that this had been influenced in part by the sickness absence system not having been fully operational; increased assurance was sought that the required improvements would be delivered as soon as possible.

It was reported that the vacancy restraint methodology had reduced headcount and variable pay, contributing to an improved financial position; however, concerns were expressed that these actions had been associated with stress and reduced morale in some areas, and that staff experience would continue to be monitored. It was further reported that workforce plans for the next three years had been reviewed in more detail and stress-tested, and that mechanisms for a more proactive approach to headcount reduction had been considered, with emphasis placed on ensuring that staff be appropriately communicated with and supported through any transition. The significant challenge for managers and teams was acknowledged, and assurance was sought that the workforce team would have been supporting them effectively.

d) Education, Training and Research Committee:

An update was received from the Education, Training and Research Committee's priorities, and it was reported that progress towards university hospital status continued to be made.

The Committee continued to monitor compliance with core skills and mandatory training which was reported as having remained above 90%. However, organisational

inconsistency was acknowledged with deep-dive reviews having identified medicine and dental services as requiring further focus and assurance. It was noted that assurance had been sought that local leaders would drive the necessary conversations and actions to ensure minimum mandatory training requirements were met.

Improvements in learner experience were reported, and the importance of research and innovation to achieving university status, supporting recruitment and retention, and maintaining high-quality practice was reiterated. It was also reported that resources to support research activity had improved and that further medium to long-term plans had been developed to strengthen this position.

e) Audit Committee:

Audit Committee activity was provided, reporting that one meeting had been held at the end of January. It was noted that procurement derogations from financial procedures had remained an area of focus and that a significant reduction had been achieved in both the number of incidents and the value of associated costs, with continued work aimed at aligning practice to sector best practice. Internal audit reports were summarised, and it was reported that substantial assurance had been received on resuscitation and conflicts of interest, and that moderate assurance had been received on grip and control and renal IT. As a result, strengthening of training assurance and monitoring of declarations had been progressed, and assurance had been sought that the coordinated pay control action plan would be implemented with the least injurious impact on patient safety, quality and outcomes.

The perpetual risk of fraud was acknowledged, and it was reported that vigilance continued, with no major material frauds having been identified. Known risks elsewhere, including false overtime claims and secondary employment whilst receiving sickness pay, were noted as areas requiring continued monitoring. It was further reported that comparative benchmarking data had been requested from auditors to support assessment against best practice, and it was stated that no untoward matters had been expected in the Audit Committee's annual report, which was being finalised.

f) Charitable Funds Committee

An update was provided on the Charitable Funds Committee, and it was explained to Council that the Committee provided overarching oversight of the Trust's charitable functions, with the Rosemere Charity Committee operating as a subcommittee and representing the larger of the Trust's charities. It was reported that assurance work had been focused on ensuring appropriate governance, accurate accounting and audit scrutiny, and vigilance over how charitable funds were spent. It was noted that the positive aspect of the Committee's work had been the consideration of investments in equipment, services and initiatives to benefit patients, and that fundraising activity had continued to have been celebrated through a number of positive examples. It was reported that both charities had remained in strong financial positions and that plans were in place to invest funds effectively for patient benefit. It was further reported that exploration had been underway to better align charitable objectives with workforce and team activities, including staff-led fundraising events, with the dual aim of raising funds for the Trust and supporting morale and team cohesion.

During discussion, a suggestion was made that the Governors' charity fund collection associated with donations at the Costa Coffee outlet at Chorley District Hospital should be closed, with any future donations directed into the main charitable funds arrangements. The suggestion was supported, and it was confirmed that this would be progressed through the next Charitable Funds Committee meeting to simplify governance and administration.

21/26 Update from Care and Safety Subgroup

An update was provided on the Care and Safety Subgroup, and it was confirmed that the minutes from the January and March meetings had been made available. Governors were encouraged to join the Subgroup as a means of increasing understanding of Trust services, and it was noted that discussions had been strengthened when relevant staff had attended and contributed. It was further reported that continued staff attendance from an external representative was not expected to create any constitutional or legal concerns, subject to ongoing willingness and availability to participate.

The need for wider Governor involvement in Subgroup activity was emphasised, and it was reported that succession arrangements for Chair and Deputy Chair roles had been encouraged.

22/26 Update from Membership Subgroup

A Membership Subgroup update was given, and it was reported that one meeting had been held since the previous Council meeting. It was noted that membership numbers had reduced within the 60–74 age group, while an increase had been observed in the 75+ cohort. It was reported that new members had been recruited through recent engagement activity at recent events. Forthcoming opportunities to promote membership were highlighted, including an event at Penwortham in June and planned Health Mela events in coming months, and it was confirmed that applications to participate had been submitted.

23/26 Membership Subgroup Terms of Reference

The Council received the revised Terms of Reference for the Membership Subgroup, which had undergone a full review by subgroup members and was endorsed by the Sub-Group Chair.

The Council RESOLVED to approve the Membership Subgroup Terms of Reference.

24/26 Outcome of Non-Executive Director Appraisals and Re-appointment of Dr T Ballard for Second Term – Report of the Nominations Committee

Dr Tim Ballard left the meeting for this item

The Council acknowledged receipt of the Nomination Committee's report providing assurance of satisfactory appraisals for all Non-Executive Directors and the Chair. The Council also received the recommendation of the committee to re-appoint Dr Tim Ballard for his second term of appointment as a Non-Executive Director.

The Council RESOLVED to:

1. Approve the re-appointment Dr Tim Ballard for a second term of office for three years from 1 October 2026;
2. Note the satisfactory completion of the Non-Executive Director appraisals for 2025/2026.

25/26 Quality Account 2026/27: Engagement on Safety Priorities

An overview of the Quality Account was presented to Council, setting out the Trust's quality activity for the year, including reflection on achievements and areas for improvement, and noting that alignment had been made with the Always Safety First strategy. Progress against the Trust's 2025/26 quality priorities was summarised, including strengthening understanding of patient experience through listening to multiple sources (particularly seldom-heard voices) and improving the experience of patients, families and carers following incidents, complaints and concerns through meaningful and compassionate engagement. Headline feedback indicators were noted, including a small increase in formal complaints and an increase in Friends and Family Test response rates, alongside continued focus on local resolution. It was reported that engagement and involvement activity had been broadened, including through volunteering initiatives, development of a more diverse group of patient safety partners, and strengthened links with community groups, and that opportunities for Governor involvement in staff quality assurance visits were available. Improvements in duty of candour compliance were reported. Continued emphasis was placed on reducing health inequalities, informed by the Core20PLUS5 framework, and it was recommended that the Council's quality priorities for 2026/27 should remain focused on listening to patient experience and compassionate engagement following incidents. Support for the recommended priorities was sought.

The Council highlighted concerns raised regarding the responsiveness of the Patient Advice and Liaison Service (PALS), with acknowledgement times cited as variable. It was accepted that this variability was not acceptable and that greater assurance was required. An action was agreed for feedback on PALS responsiveness to be provided via the relevant quality committee as part of the Trust's patient experience work, recognising that further improvement work was needed.

26/26 Council Effectiveness Self -Assessment

A 2025/26 year end report of Council Effectiveness Key Performance Indicators was provided noting measures were only adopted mid-year. Revised metrics created at an April 2026 Governor Workshop for 2026/27 were presented for adoption, noting that 2026/27 would be the first full year of measurement.

The Council RESOLVED to accept the KPI's set to measure their effectiveness during 2026/27.

27/26 Governor Elections 2026

The Council received the statutory report on the Governor Elections 2026, providing an account of the elections held in March 2026. Newly elected Governors were welcomed and congratulated, and the report was received.

28/26 Items for information

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

(i) Governor Opportunities Summary
(ii) Governor Issues Report
(iii) Appointment of Lead Governor
(iv) Register of Interests
(v) Single Improvement Plan
(vi) Corporate Objectives 2026/27
(vii) Minutes of Governor Subgroups:
- Care and Safety Subgroup – 12 Jan & 19 Mar 2026
- Membership Subgroup – 3 Feb 2026

29/26 Date, time and venue of next meeting

The next meeting of the Council of Governors will be held on 23 July 2026, 10.00am, Lecture Room 1, Education Centre 1, Royal Preston Hospital

30/26 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.

The meeting concluded at 2.44pm

5. MATTERS ARISING AND ACTION LOG

Information Item | Chair | 10:04am

REFERENCES

Only PDFs are attached

5.0 Action log (part I) - Council of Governors - 23.07.26.pdf

Action log: Council of Governors (part I) – 23 July 2026

№	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update
1.	25/26	23.4.26	**Quality Account 25/26:** Feedback on PALS responsiveness to be provided via the safety and quality committee as part of the Trust's patient experience work.	DCEO	23 July 26	**Complete** **Update 23 July 2026:** Point referred to colleagues for consideration in the Patient Experience and Involvement Annual report for SQC review.

6. CHAIR'S OPENING REMARKS

Information Item | Chair | 10:05am

Verbal update

7. PRODUCTIVITY AND PERFORMANCE

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

Other | Non-Executive Directors | 10:15am

Item for assurance

REFERENCES

Only PDFs are attached

7.1 Board Committee Chairs' Reports inc. IPR 23 July 26.pdf

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Council of Governors Report

Meeting of the	**Council of Governors**		**23 July 2026**
	Part I ☒		**Part II** ☐
Title of Report	**Board Committee Chairs' Reports**		
Report Author	Non-Executive Directors of Lancashire Teaching Hospitals NHS Trust		
Recommendation/ Actions required	The Council is asked to receive the report and consider the assurance available from this performance assurance report.		
	Decision ☐	**Assurance** ☒	**Information** ☐
Executive Summary	The Council of Governors has a statutory responsibility to hold the Board of Directors to account, through the Non-Executive Directors (NEDs), for the performance of the Trust. The NEDs provide independent oversight, challenge and assurance across the Trust's governance framework. This report summarises the work undertaken by the Board's assurance committees and highlights the key issues, risks and areas of assurance considered during the reporting period. It does not provide a comprehensive account of all matters discussed, but instead reflects the principal areas of focus and assurance identified by Committee Chairs on behalf of the Board The report provides the Council of Governors with assurance that the Board of Directors is exercising effective oversight and supporting the delivery of safe, high-quality and sustainable services for patients.		
Link to Strategic Objectives 2026/27	**Patients – deliver excellent care:** Improve outcomes, reduce harm and deliver a positive patient experience.		☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.		☒
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.		☒
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.		☒
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.		☒
Due Diligence	To give the Council assurance, please complete the following:		
Committee Approval:	N/A	Date:	
Operational Group Review:	N/A	Date:	
Link to Board Assurance Framework:	N/A - Not aligned to a Principle Risk. 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.		
Appendices	None		

1. Introduction

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

The Board assurance committee structure has been refreshed to align with the Trust's strategic priorities. The new People and Partnerships Committee, chaired by StJohn Crean, NED, has replaced the former Education, Training and Research Committee and Workforce Committee. The revised arrangements support clearer accountability and more integrated oversight across the five domains of the Single Improvement Plan: Patients, Performance, Productivity, Partnerships and People.

2. Update from Committee Chairs

This report will continue to ensure that governors are provided with updates from any assurance committee 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 can provide to the Council of Governors.

People & Partnerships Committee

Chair: StJohn Crean

The newly formed People and Partnerships Committee first met on 15th July and a report will be prepared for the Council of Governors' meeting in October.

Charitable Funds Committee

Chair: Tim Ballard

NED Analysis:

The Charitable Funds Committee met on 16 June 2026 and continued to oversee the governance, financial stewardship and strategic direction of the Trust's charitable funds, including the Hospitals Charity and Rosemere Charity. The Committee reviewed investment performance, charitable income and expenditure, fundraising activity, governance arrangements and the allocation of charitable funding to support patient care, staff wellbeing, research and improvements to the patient environment.

The Committee provided challenge regarding the long-term sustainability of the investment strategy, seeking assurance that the level of investment risk remained appropriate and proportionate to the charities' objectives. The relationship between risk and return was explored and it was questioned whether increasing portfolio risk would deliver meaningful additional benefit and the governance arrangements required for any future changes to investment risk appetite was considered. The Committee also scrutinised the charities' approach to environmental, social and governance (ESG) considerations and requested further information regarding any direct or indirect exposure to fossil fuel investments. In relation to charitable fundraising, the impact of reduced grant funding opportunities was challenged and the Committee explored how alternative funding streams could be developed to maintain future income levels.

The Committee received assurance that both Trust charities remained financially strong and well governed, with income exceeding expectations and fundraising activity continuing to perform well despite a more challenging external funding environment. Assurance was received that investment performance remained strong, outperforming benchmarks whilst remaining aligned to agreed risk and ESG requirements. The Committee was also assured that charitable funding was delivering measurable benefits to patients, staff and research through a wide range of initiatives and that appropriate governance arrangements were in place to ensure effective stewardship and management of charitable resources.

Safety and Quality Committee

Chair: Karen Deeny

NED Analysis:

The Safety and Quality Committee met in April, May and June 2026 and continued to oversee patient safety, quality, clinical effectiveness and regulatory compliance. The Committee reviewed assurance relating to patient safety, infection prevention and control, maternity and neonatal services, mortality, patient experience, health inequalities, Urgent and Emergency Care (UEC) performance and delivery of the Patient Safety Incident Response Framework (PSIRF). Particular focus was given to Principal Risk 1 (Patient Safety and Experience within the UEC Pathway) and Principal Risk 2 (People Experiencing Health Inequalities), both of which remained above tolerance.

The Committee provided significant challenge regarding the continued pressures within Urgent and Emergency Care, including corridor care, patient flow, ambulance handover delays, boarding, pressure ulcers and workforce capacity. Clarity was sought regarding UEC improvement plans and the anticipated delivery of measurable improvements in patient outcomes. It was agreed that future reporting would include clearer metrics, trajectories and evidence of impact, emphasising the need to demonstrate how operational changes would improve patient safety.

Detailed assurance was sought regarding increasing pressure ulcer rates, healthcare assistant vacancies, infection control performance, delayed outpatient appointments and the availability of data to support effective monitoring of health inequalities.

The Committee also scrutinised maternity and neonatal outcomes, children's services, pathology risks, mortality reporting, patient experience feedback and medicines governance. Assurance was sought regarding workforce pressures, audit compliance, consultant review standards in children's services and the effectiveness of learning from incidents and investigations. The Committee emphasised the importance of demonstrating the impact of improvement actions, strengthening organisational learning and ensuring that risks were appropriately reflected within governance and assurance processes.

The Committee received assurance that robust governance arrangements remained in place across patient safety, quality and regulatory compliance. Assurance was received regarding nursing and midwifery staffing, implementation of PSIRF, mortality oversight, medicines governance, maternity safety, children's services and progress against infection prevention and control objectives. The Committee recognised significant improvements in Clostridioides difficile performance, progress in cancer pathways, strengthened oversight of patient safety risks and continued development of the UEC Improvement Programme. Whilst acknowledging that significant challenges remain, particularly within Urgent and Emergency Care pathways, the Committee was assured that comprehensive improvement plans, strengthened governance processes and targeted mitigations were in place to support continued improvement in patient safety, quality and patient experience.

Finance and Performance Committee

Chair: John Schorah

NED Analysis:

The Committee met on three occasions during April, May and June 2026, maintaining oversight of the Trust's financial position, operational performance, and progress against the 2026/27 Financial Recovery Programme. Reports considered covered activity and performance data up to 31 May 2026 only.

Although governance, reporting and oversight arrangements had strengthened, the Committee remained concerned and had limited assurance regarding delivery of the £60m Waste Reduction Programme (WRP), workforce reduction targets and the pace of transformational change required to achieve the Trust's financial plan. The Committee challenged whether sufficient progress was being made to deliver the scale of recurrent savings required and expressed concern regarding the reliance on workforce reductions, service redesign and reductions in temporary staffing expenditure to achieve planned savings.

Financial performance was broadly in line with what was a relatively modest plan for the first two months and the Committee challenged whether this represented sustainable progress; stronger performance would be required to provide assurance on the overall trajectory. The continuing reliance on non-recurrent measures, divisional overspends and the level of accountability for delivery across the organisation was scrutinised. A need for clearer ownership of financial recovery actions and stronger evidence that corrective action was being taken where delivery was behind plan, was emphasised.

The Committee also reviewed operational performance across Urgent and Emergency Care, elective recovery, diagnostics and cancer services. There has been encouraging improvements in several areas. Whilst recognising ongoing challenges, particularly in relation to patient flow, diagnostics and urgent care performance, the Committee challenged the sustainability of current recovery trajectories and sought assurance regarding ongoing delivery of improvement plans. Assurance was received that strengthened performance governance arrangements, divisional accountability processes and programme-level oversight were supporting incremental improvement across several priority areas, including the sustained elimination of 65-week waits, continued reductions in long waiters and improvements in cancer performance.

Assurance was received regarding procurement performance, programme management and the quality of financial and performance reporting, which has improved significantly and is supporting more effective scrutiny and oversight. The Committee also reviewed progress relating to workforce productivity, digital transformation, the Single Improvement Plan and the Medium-Term Plan and received assurance that governance arrangements supporting procurement, programme delivery and performance recovery had strengthened. Whilst acknowledging these improvements, it was recognised that continued focus, pace of delivery and organisational accountability will be critical to achieving workforce, financial and operational recovery objectives during 2026/27.

Workforce Committee

Chair: Adrian Leather

NED Analysis:

The final Workforce Committee met on 12 May 2026 and continued to oversee workforce sustainability, staff experience, equality, leadership development and organisational culture. The Committee reviewed workforce risks, staff survey outcomes, Freedom to Speak Up activity, equality standards, appraisal performance, sickness absence and delivery of the Trust's Social Value Strategy. Focus was given to staff experience, workforce inequalities and the organisational impact of transformation and productivity requirements.

The Committee scrutinised the detail of both the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports prior to their submission to Board for approval and publication.

The Committee further challenged the effectiveness of internal communications, particularly in the context of significant organisational change and productivity expectations, emphasising the importance of consistent, compassionate and evidence-based communication. The Committee also reviewed workforce sustainability risks, including sickness absence management, workforce planning and the implementation of digital workforce solutions, seeking assurance that appropriate actions were in place to support long-term workforce resilience.

Assurance was received that sickness absence rates had improved, appraisal compliance remained above the Trust target and progress was being made in embedding the Social Value Strategy and NHS Management and Leadership Standards within existing leadership frameworks. Assurance was also received regarding action plans arising from staff survey findings and Freedom to Speak Up themes, with targeted interventions and strengthened use of workforce intelligence supporting organisational development and improvement. While recognising ongoing challenges, particularly in relation to workforce equality and staff experience, the Committee was assured that robust governance arrangements and improvement plans were in place to support continued progress and workforce sustainability.

Audit Committee

Chair: Tim Wheeler

NED Analysis:

The Audit Committee met on 16 April and 18 June 2026 and continued to oversee the Trust's governance, risk management, internal control and assurance framework. The Committee reviewed internal and external audit reports, counter-fraud activity, information governance, risk management arrangements, the Annual Report and Accounts and compliance with the NHS Foundation Trust Code of Governance. Focus was given to the effectiveness of the Trust's assurance processes and the robustness of arrangements supporting financial stewardship and organisational governance.

The Committee approved the submission of the Trust's Data Security and Protection Toolkit (DSPT) and associated improvement plan. Also scrutinised was increases in losses and special payments, particularly drug stock losses within the Trust's subsidiary company, and assurance was sought that effective stock management controls were in place and that avoidable losses were being minimised. The Committee further challenged the effectiveness of audit recommendations, governance arrangements supporting hosted services, and the need to strengthen understanding of emerging risks, including Artificial Intelligence governance and digital assurance.

The Committee also sought assurance that audit activity was focused not only on compliance with processes and controls, but also on whether these arrangements were delivering measurable organisational benefit. The Committee challenged the sustainability of improvements in procurement

controls; reviewed assurance relating to fraud prevention and risk management arrangements; and scrutinised the implementation of recommendations arising from internal audit activity.

The Committee received substantial assurance regarding the effectiveness of the Trust's governance, risk management and internal control framework. Internal Audit concluded that the Trust continued to maintain a robust system of internal control, supported by a *Substantial Assurance* opinion, while External Audit reported that the 2025/26 audit was substantially complete with an unmodified audit opinion anticipated.

Assurance was also received regarding counter-fraud arrangements, compliance with the Code of Governance, delivery of the Risk Management Strategy, procurement controls and the preparation of the Trust's Annual Report and Accounts. Whilst ongoing improvement was required in several areas, the Committee was assured that appropriate governance, assurance and oversight arrangements remained in place across the organisation.

3. Financial implications

None

4. Legal implications

Within the authority of the Board to decide

5. Risks

The discharge of assurance via the re-alignment will be monitored to ensure that any gaps in assurance or unintended consequences will be addressed.

6. Impact on stakeholders

The revised committee structure is not expected to have any adverse impact on stakeholders. Relevant Board members, Executive Directors and supporting officers have been informed of the changes through the Trust's governance processes. Governors are being advised of the new arrangements through this report.

The Best Version of Us
Our Culture Counts @LTH

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Integrated Performance Report

June 2026 Trust Board meeting with performance to April 2026


Patients


Performance


People


Productivity


Partnerships

Excellent care with compassion

Always Safety First

@LancsHospitals

Contents

Key to Metric Variation, Assurance Icons & Dashboard Headers

Lancashire Teaching Hospitals NHS Foundation Trust

Key to Metric Variance and Assurance Icons

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

Key to Metric SPC Chart and Variance and Assurance Icons

Mean
Process Limit
Improving special cause
Measure
Concerning special cause
Target

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

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

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

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

Report heading explanation

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

A flag is generated for metrics that are calculated as requring

The latest month target or threshold.

Data to the end of.

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

The name of the Metric

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

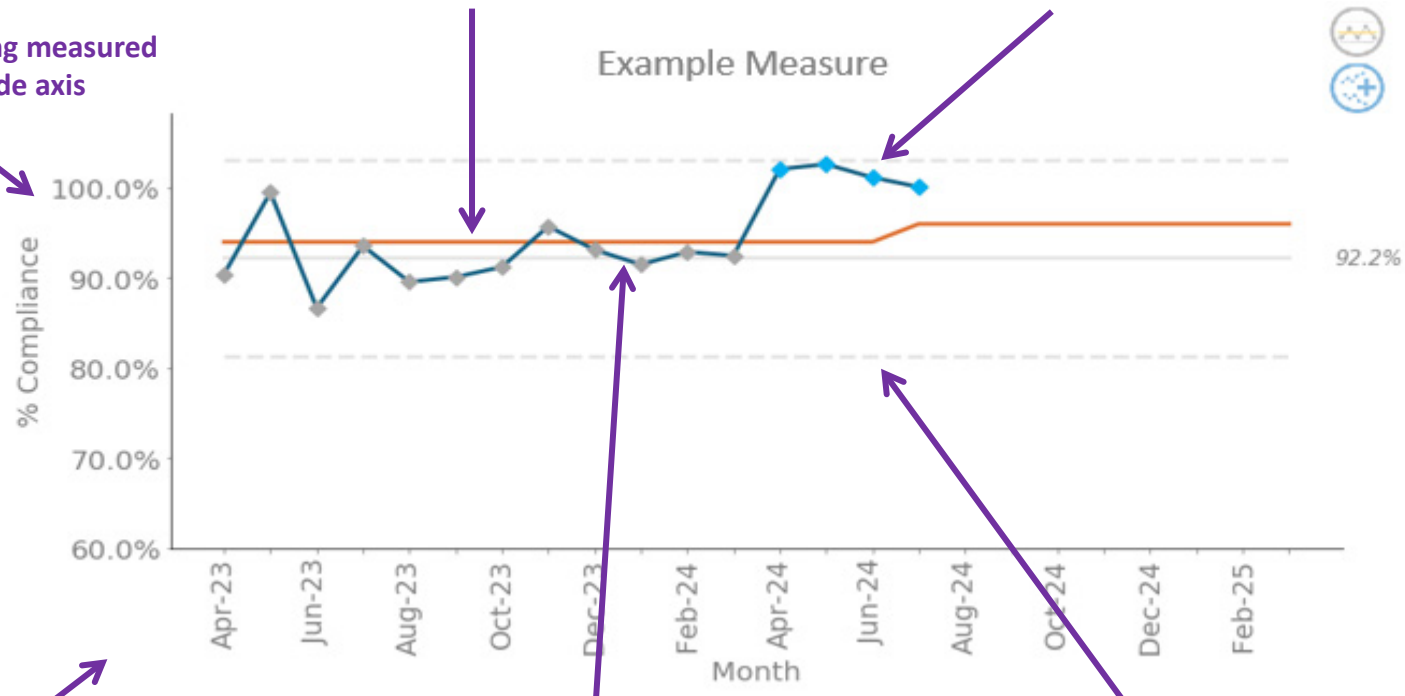
This March 2025 target

The current month actual performance.

How to read Statistical Process Control charts (SPC)

Lancashire Teaching Hospitals NHS Foundation Trust

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



The thing being measured goes up the side axis

The trust target is shown as an orange line

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

Time period goes along the bottom axis

The actual is shown as a blue line.

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

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

SPC KPI Metric Grid

Lancashire Teaching Hospitals NHS Foundation Trust

Variation \ Assurance	Will consistently fail target within expected variation	Could both pass or fail target within expected variation	Will consistently pass target within expected variation
Recent concerning pattern in the data	- Vacancies (% FTE) - Staff Survey: Recommend Trust as place to work	- Pressure Ulcers per 1000 beds days (Category 2 and above) actions - 31 Day Cancer Standard	- Staffing Fill Rate - Registered Nurse - Staffing Fill Rate - Health Care Assistant
Normal variation - no recent change	- Compliance with 15 minute ambulance turnaround time target - Compliance with 45 minute ambulance turnaround time target - Percentage of UEC (Type 1 & 3) patients seen within 4 hours - Average Number of boarded patients - Reduce not meeting criteria to reside - Percentage of patients that receive a diagnostic test within six weeks - Cancer 62-day performance - Staffing Fill Rate - Maternity Support Worker	- Staffing Fill Rate - Registered Midwife - Complaints per 1000 bed days - Perinatal - Number of Stillbirths - Maximum wait of 12 hours as Total Time in Department - Bed occupancy % - 85% theatre utilisation - aggregate - Capped - Cancer Faster Diagnosis Performance - Number of violence and aggression incidents toward staff	- STAR Accreditation all trust (Silver and Above)
Recent positive pattern in the data	- Percentage of patients waiting less than 18 weeks - RTT - 52 week Waiters	- C. difficile performance against national trajectory - no more than 167 Hospital Acquired cases - Sickness Absence (%FTE) - Turnover (%FTE)	

Non SPC Metrics flagged as a concern

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

The Best Version of Us
Our Culture Counts @LTH

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Patients

Excellent care with compassion

Always Safety First

@LancsHospitals

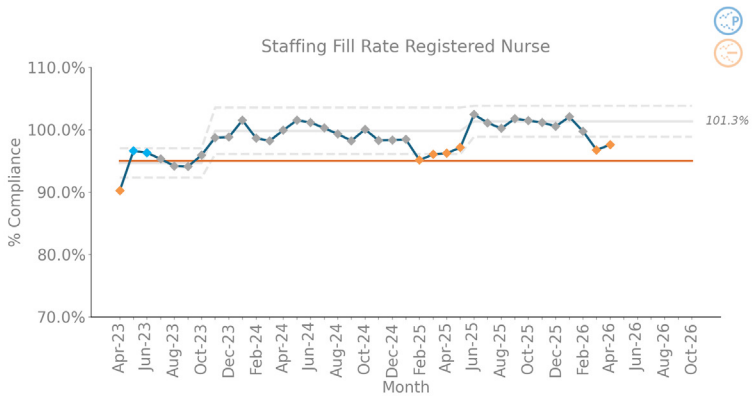
Executive Summary – Alert, Advise, Assure Report

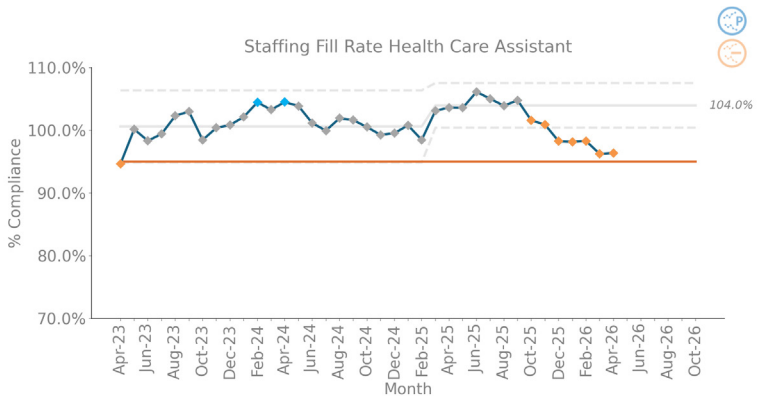
	Issue	Action
Alert Areas of concern or matters that need addressing urgently	**1. Pressure Ulcers per 1000 bed days (Category 2 and above) -** recent concerning pattern over the last 4 months. This is linked to the long waiting times in the UEC pathway, increased use of waiting areas in assessment units and the effectiveness of pressure relieving interventions.	1. A refreshed comprehensive pressure ulcer improvement programme is in place based on the thematic findings from the weekly Pressure Ulcer Review Panel, which was established in November 2025. Learning is being shared across divisions and enhanced oversight of the action plan is in place. Monthly Always Safety First meetings and quarterly thematic reviews further strengthen cross divisional learning and ensure timely action in high incidence areas. 2. Proactive safety walk arounds by the Tissue Viability Team, commenced in April 2026, which enhances real time assurance and support early identification of risks, ensuring sustained improvement in pressure ulcer prevention and patient outcomes. 3. A review of the seating provision in waiting areas has resulted in improved specification seating in the Emergency Department at Royal Preston Hospital and further scoping is underway in all other assessment areas. Replacement mattresses are being purchased, where required, for ED trolleys. 4. Continued focus on quality of the interventions focused on reducing pressure damage through STAR and matron assurance processes.
Advise Areas of ongoing monitoring and any new developments	**1.Maternity Support Worker/ Maternity Care Assistant fill rates** - The overall maternity support worker fill rate is below the Trust target of 95% at 87.1%.	1. A successful recruitment campaign has concluded with new Maternity Support Workers (MSW) progressing through the Care Certificate and supernumerary period. Seven staff joined the numbers in January, with further starters scheduled through to May. This pipeline strengthens the establishment and will improve fill rates as onboarding completes. 2. Sickness continues to impact availability and is being managed in line with policy. 3. Recruitment and onboarding have taken longer than expected following changes within the recruitment team, and temporary bank staffing continues to be used to maintain safe staffing levels, a focus on decreasing reliance on temporary staff has commenced with recruitment team. 4. Shifts where increased risk is present are prioritised for the staffing that are available.
	2. Complaints - consistent stable 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 and improving communication with patients remain the key priority areas of focus.	1. Continue to deliver the actions outlined in the Single Improvement Plan. 2. Increase access to information regarding experience from patients with protected characteristics. 3. Development and delivery of preparing to be in hospital and preparing to go home to help manage expectations and work with families to be prepared to be cared for at home as soon as possible. 4. Continued focus on early resolution with departments and PALS. 5. Focus on use of PALS as early indictors to address concerns in areas and identify themes. 6. Estates and clinical partnership Board focused on improving the estate impact of experience.
Assure Areas of Assurance	**1. Compliance with National Standards of Cleanliness -** point of inspection audits for Very High- and High-Risk Areas are fully compliant at point of inspection where the cleaning standards have been implemented, confirming robust infection prevention and control measures.	1. Fully compliant at point of inspection, confirming robust infection prevention and control measures.
	2. Registered Nurse, Registered Midwife and Health Care Assistant fill rates - are achieving safe staffing levels.	2. Staffing levels consistently meet thresholds, supporting effective care delivery.
	3. STAR accreditation for all Trust.	3. Remains above target across the Trust, reflecting stabilisation following the introduction of critical standards. Continued focus on inpatient area and fundamental standards is critical in ensuring high quality outcomes are achieved for patients.
	4. CQC Must do: By the end of October 2025, the "Must Do's" included in the 2023/2024 CQC Quality Improvement Plan were delivered. **5. Mortality** **Adult HSMR** - Lower than expected, **Adult SMR Adult** - Lower than expected **SMR Child <1 day to 17 years** - As expected **SMR - Neonatal <1-28 days** - As expected **Still Birth rate** - The updated local stillbirth rate between March 2025 and February 2026 was 1.9 per 1000 births which is below the national average of 3.9 per 1000. **6. C.difficile rates -** New tolerance for 2026/2027 has not yet been received but based on 2025/2026 cases remain within trajectory.	4. CQC Quality Improvement Plan has been delivered. 5. Mortality actions continue as outlined in the biannual mortality plan. 6. The IPC Board Assurance Framework actions continue alongside the Infection Prevention and Control (IPC) improvement plan continue, the implementation of the cleaning standards is now in line with plan and appears to be underpinning improved performance.

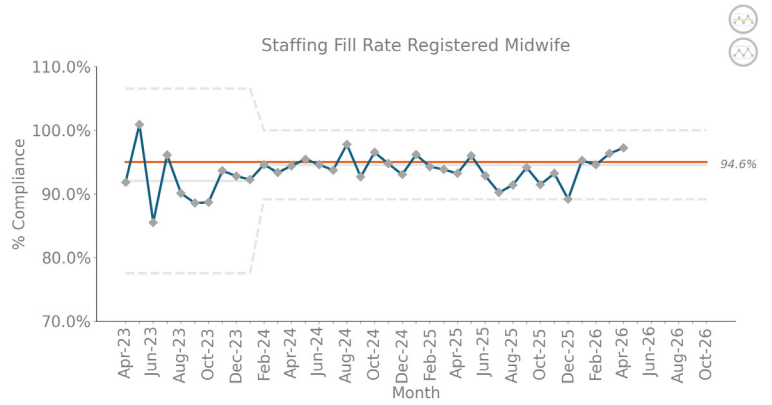
Patients

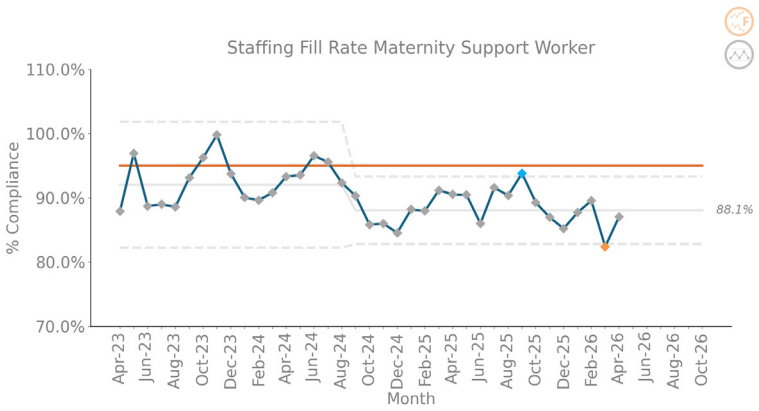
Metric Description		Assurance @ Mar-27	Variation to Latest Actual	Target			Latest Month Actual	Latest Month
				Concern	Mar-27	Latest Month Target		
Deliver Annual Safe Staffing Requirements	Staffing Fill Rate - Registered Nurse	P			95%	95.0%	97.6%	Apr-26
	Staffing Fill Rate - Health Care Assistant	P			95%	95.0%	96.4%	Apr-26
	Staffing Fill Rate - Registered Midwife				95%	95.0%	97.2%	Apr-26
	Staffing Fill Rate Maternity Support Worker/Maternity Care Assistant	F			95%	95.0%	87.1%	Apr-26
Patient Experience and Involvement	Complaints per 1000 bed days				1.40	1.40	1.82	Apr-26
	STAR Accreditation all trust (Silver and Above)	P			75%	75.0%	89.0%	Apr-26
C Difficile Improvement	C. difficile performance against national trajectory - no more than 167 Hospital Acquired cases				14	14	5	Apr-26
Always Safety First	Hospital Standardised Mortality Ratio - Adult	Lower Than Expected					73.9	Dec-25
	Standardised Mortality Ratio - Relative Risk - All Diagnoses Adult	Lower Than Expected					69.3	Dec-25
	Standardised Mortality Ratio - Relative Risk - All Diagnoses Child (<1 day – 17 yrs)	As Expected					291.2	Dec-25
	Standardised Mortality Ratio - Relative Risk - All Diagnoses Neonates (<1-28 Days) *The updated TELSTRA model from November 2024 does not include still births*	As Expected					364.9	Dec-25
	Pressure Ulcers per 1000 bed days (Category 2 and above)				3.30	3.30	5.08	Apr-26
Maternity	Perinatal - Number of Stillbirths				0	0	1	Apr-26

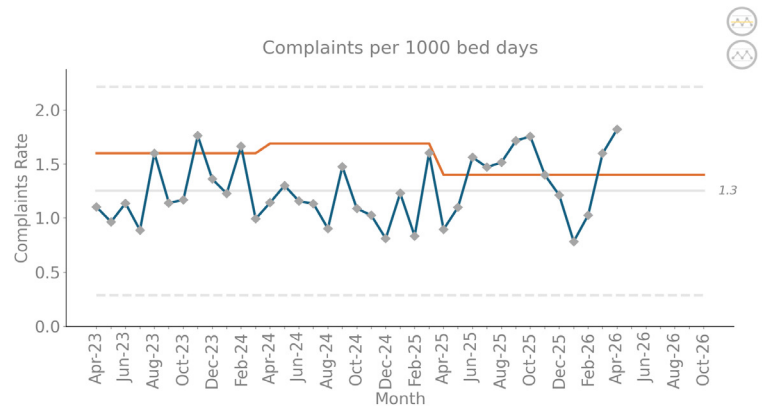
Patients

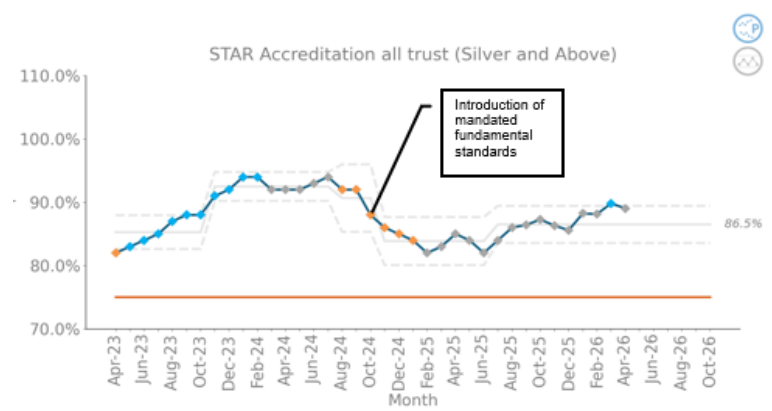

Staffing Fill Rate Registered Nurse
% Compliance
110.0%
100.0%
90.0%
80.0%
70.0%
101.3%
Apr-23 Jun-23 Aug-23 Oct-23 Dec-23 Feb-24 Apr-24 Jun-24 Aug-24 Oct-24 Dec-24 Feb-25 Apr-25 Jun-25 Aug-25 Oct-25 Dec-25 Feb-26 Apr-26 Jun-26 Aug-26 Oct-26
Month

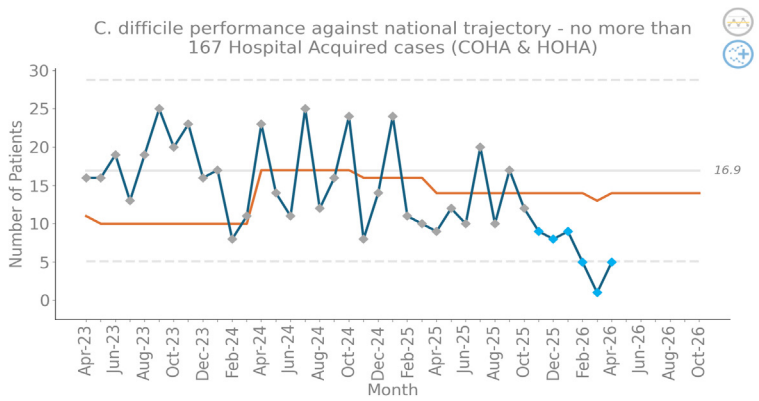

Staffing Fill Rate Health Care Assistant
% Compliance
110.0%
100.0%
90.0%
80.0%
70.0%
104.0%
Apr-23 Jun-23 Aug-23 Oct-23 Dec-23 Feb-24 Apr-24 Jun-24 Aug-24 Oct-24 Dec-24 Feb-25 Apr-25 Jun-25 Aug-25 Oct-25 Dec-25 Feb-26 Apr-26 Jun-26 Aug-26 Oct-26
Month

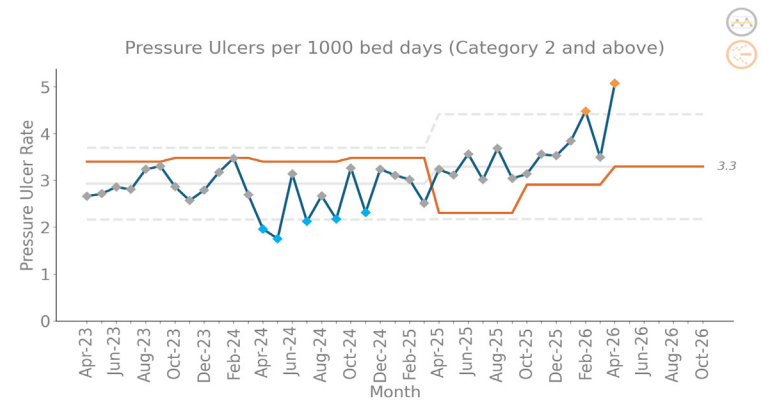

Staffing Fill Rate Registered Midwife
% Compliance
110.0%
100.0%
90.0%
80.0%
70.0%
94.6%
Apr-23 Jun-23 Aug-23 Oct-23 Dec-23 Feb-24 Apr-24 Jun-24 Aug-24 Oct-24 Dec-24 Feb-25 Apr-25 Jun-25 Aug-25 Oct-25 Dec-25 Feb-26 Apr-26 Jun-26 Aug-26 Oct-26
Month

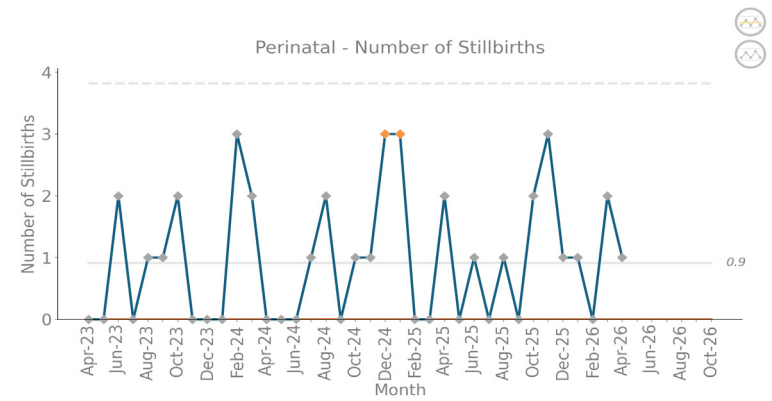

Staffing Fill Rate Maternity Support Worker
% Compliance
110.0%
100.0%
90.0%
80.0%
70.0%
88.1%
Apr-23 Jun-23 Aug-23 Oct-23 Dec-23 Feb-24 Apr-24 Jun-24 Aug-24 Oct-24 Dec-24 Feb-25 Apr-25 Jun-25 Aug-25 Oct-25 Dec-25 Feb-26 Apr-26 Jun-26 Aug-26 Oct-26
Month


Complaints per 1000 bed days
Complaints Rate
2.0
1.5
1.0
0.5
0.0
1.3
Apr-23 Jun-23 Aug-23 Oct-23 Dec-23 Feb-24 Apr-24 Jun-24 Aug-24 Oct-24 Dec-24 Feb-25 Apr-25 Jun-25 Aug-25 Oct-25 Dec-25 Feb-26 Apr-26 Jun-26 Aug-26 Oct-26
Month


STAR Accreditation all trust (Silver and Above)
Introduction of mandated fundamental standards
110.0%
100.0%
90.0%
80.0%
70.0%
86.5%
Apr-23 Jun-23 Aug-23 Oct-23 Dec-23 Feb-24 Apr-24 Jun-24 Aug-24 Oct-24 Dec-24 Feb-25 Apr-25 Jun-25 Aug-25 Oct-25 Dec-25 Feb-26 Apr-26 Jun-26 Aug-26 Oct-26
Month


C. difficile performance against national trajectory - no more than 167 Hospital Acquired cases (COHA & HOHA)
Number of Patients
30
25
20
15
10
5
0
16.9
Apr-23 Jun-23 Aug-23 Oct-23 Dec-23 Feb-24 Apr-24 Jun-24 Aug-24 Oct-24 Dec-24 Feb-25 Apr-25 Jun-25 Aug-25 Oct-25 Dec-25 Feb-26 Apr-26 Jun-26 Aug-26 Oct-26
Month


Pressure Ulcers per 1000 bed days (Category 2 and above)
Pressure Ulcer Rate
5
4
3
2
1
0
3.3
Apr-23 Jun-23 Aug-23 Oct-23 Dec-23 Feb-24 Apr-24 Jun-24 Aug-24 Oct-24 Dec-24 Feb-25 Apr-25 Jun-25 Aug-25 Oct-25 Dec-25 Feb-26 Apr-26 Jun-26 Aug-26 Oct-26
Month


Perinatal - Number of Stillbirths
Number of Stillbirths
4
3
2
1
0
0.9
Apr-23 Jun-23 Aug-23 Oct-23 Dec-23 Feb-24 Apr-24 Jun-24 Aug-24 Oct-24 Dec-24 Feb-25 Apr-25 Jun-25 Aug-25 Oct-25 Dec-25 Feb-26 Apr-26 Jun-26 Aug-26 Oct-26
Month

The Best Version of Us
Our Culture Counts @LTH

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Performance

Excellent care with compassion

Always Safety First

@LancsHospitals

Alert, Advise, Assure Report

Alert Areas of concern or matters that need addressing urgently	• **RTT performance** - The number of follow ups >25% overdue has increased month on month since Oct 24. Capacity constraints are driving these increases however there is an opportunity to significantly demand manage via PIFU despite being close to rates. • **Days Kept Away from Home** - (%) has decreased slightly in Apr 26. The current position is slightly below the revised operational plan target but is consistent with the same period in Apr 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. • **Escalation Beds** - slight decreases were noted in Apr 26 following a period of continued increases month on month since July 25	• **RTT** - There is ongoing work with digital partners to ensure that there is sufficient capacity to support the ambitious rollout of PIFU required to achieve the constitutional performance standards and outpatient transformation aligned to the 26/27 objectives. Additional activity is being mobilised to support the delivery of all planned care performance standards via the use of the Independent sector and via WLI's. An internal business case is undergoing Executive Check and Challenge ahead of formal consideration for approval. • **Boarding/Escalation Bed utilisation/DKAFH** - Work continues within the DKAFH programme with a MADE event taking place in early May and learning is informing changes into routine practice to drive reduced bed days. A development of a multi-agency Transfer of Care hub commenced on 18th May 26 with trusted assessor practices established which support step up admission into IMC. The anticipated impact from the establishment of the Transfer of Care hub is a 1 day LOS reduction for DKAFH patients in pathways 1-3. This alongside continued work on Ward and Board round processes and continued DKAFH improvement roll out will aim to see lost bed days for optimised patients reduced to within target by end March 27.
Advise Areas of ongoing monitoring and any new developments	• **RTT performance -** 18 week RTT performance April 26 performance is 57.4%, this is slight drop in position versus Mar 26 = 59.4% and is marginally below the M01 target. Following a period of sustained reduction DNA rates have continued to fall in Apr 26. This continues the overall downward trend in DNA rates, which remain above target. PIFU rates have increased versus Mar 26 but remain below target. • **DM01 -** Performance has deteriorated in April 26 to 59.73% and is below the operations plan target of 66.1%. This is due to underperformance in NOUS linked to high volumes of urgent scans, increased DNA rates linked to the IS capacity and a shortfall in capacity due to continued workforce gaps. • **UEC -** 4 hour performance deteriorated slightly by -0.9% in Apr compared to Mar 26 with the finalised performance = 71.28% but is above the Apr 26 operational plan target of 68%**.** • **12 hour + ED LOS** - performance deteriorated marginally by 0.04% compared to Mar 26 and remains slightly above the revised Operational Improvement plan. •**Virtual Ward** - occupancy remains just below target but has improved slightly compared to Mar 26.	• **RTT** - Maximisation of productivity actions (DNA rates have reduced by 0.6% and theatre utilisation has increased by 2.5% versus March 26) and the mobilisation of additional capacity remains in progress to support delivery of the performance improvement plans. • **DM01** - Additional capacity has been sourced via an IS provider and has been mobilised mid Feb 26. Additional capacity has been mobilised via internal colleagues undertaking additional work however there remains a shortfall. Following completion of the capacity and demand modelling a resource case is in development and all alternative provisions are being explored in the interim. • **UEC** - Key actions being taken to improve ambulance handover performance include increasing 'Fit to Sit' practices, improve data capture with NWAS, increased flow out of ED via continuous flow 'cycles' every 30 mins to AMU. Workforce total modelling has been undertaken with plans in place to better align rotas with demand from July 26. Scoping is underway to implement the Extended Emergency Medicine Ambulatory Care facility (as per the National model) with ambitions to implement from Q2. •**VW** - A Medical lead has been recruited into the service to support an expanded utilisation - await start date post pre-employment checks.
Assure Areas of Assurance	• **52 Week RTT** - significant improvement in both the actual and % over 52 weeks. April 26 position shows 840 over 52 week breaches = 1.4% vs the M01 target of 2.3%. 52 weeks + breaches has reduced from a high in Aug 25 of 2158. • **Cancer Performance** - has exceeded target for 62 day and FDS for March 26 with a 2% improvements notes in FDS performance versus a year ago and the Trust being ranked in the top quartile nationally and an 18% improvement versus April 25 in 62 days cancer performance. The Trust has seen the 5th largest year on year improvement nationally.	

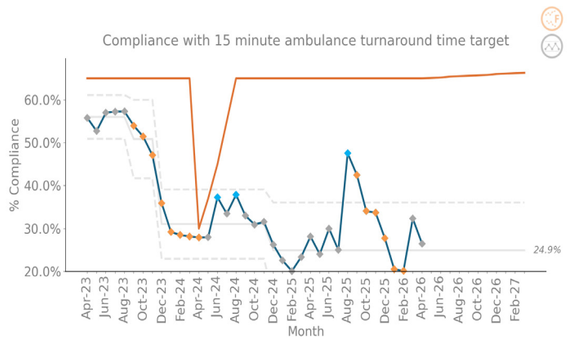
Performance

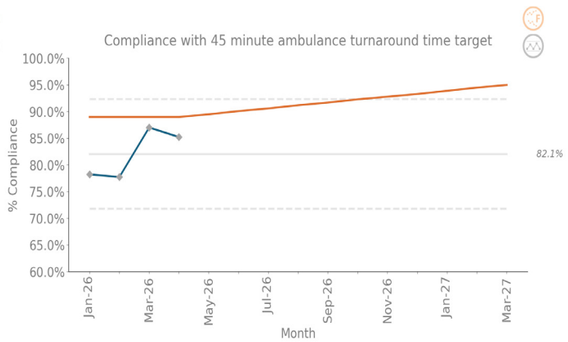
Metric Description		Assurance @ Mar-27	Variation to Latest Actual	Target Concern	Target Mar-27	Target Latest Month Target	Latest Month Actual	Latest Month
UEC In Flow	Compliance with 15 minute ambulance turnaround time target				66.30%	65.00%	26.49%	Apr-26
	Compliance with 45 minute ambulance turnaround time target				95.00%	89.00%	85.23%	Apr-26
	Percentage of UEC (Type 1 & 3) patients seen within 4 hours				82.00%	68.00%	71.28%	Apr-26
	Maximum wait of 12 hours as Total Time in Department (Type 1 and 2)				10.50%	12.50%	12.75%	Apr-26
UEC Flow	Bed occupancy %				94.00%	94.00%	95.72%	Apr-26
	Average Number of boarded patients				0	0	31	Apr-26
UEC Outflow	Reduce not meeting criteria to reside				5.00%	10.10%	9.92%	Apr-26
Elective (long waits)	Percentage of patients waiting less than 18 weeks				70.00%	57.80%	57.40%	Apr-26
	RTT - 52 week Waiters				0	1513	840	Apr-26
Elective (diagnostics)	Percentage of patients that receive a diagnostic test within six weeks				80.00%	66.10%	59.73%	Apr-26
Elective (theatre utilisation)	85% theatre utilisation - aggregate - Capped				85.00%	85.00%	84.76%	Apr-26
Elective (Cancer) (unvalidated position, subject to change)	Cancer 62-day performance				80.30%	65.10%	64.20%	Apr-26
	Cancer Faster Diagnosis Performance				80.00%	80.00%	78.70%	Apr-26
	31 Day Cancer Standard				94.00%	94.10%	87.90%	Apr-26

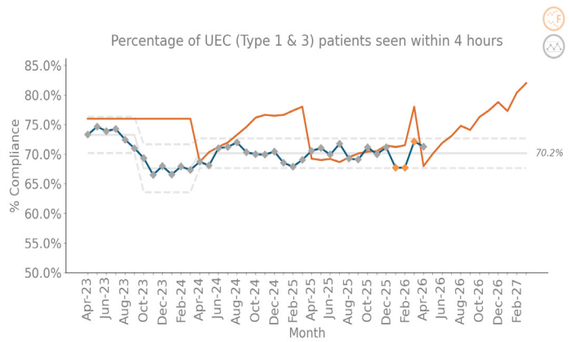
Single Improvement Plan | Patients | Performance | People | Productivity | Partnerships

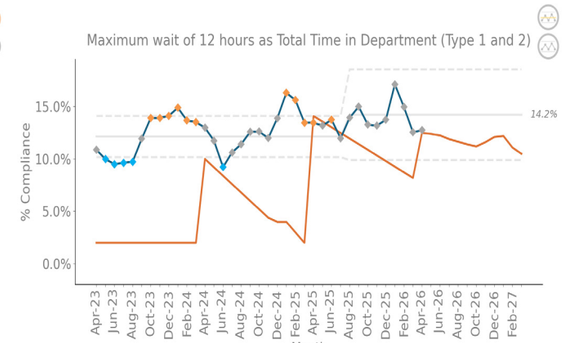
Performance

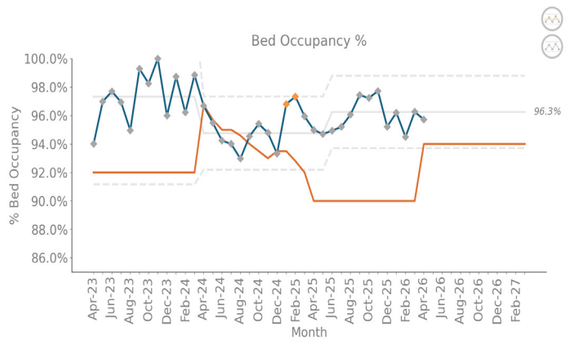
NHS Lancashire Teaching Hospitals NHS Foundation Trust

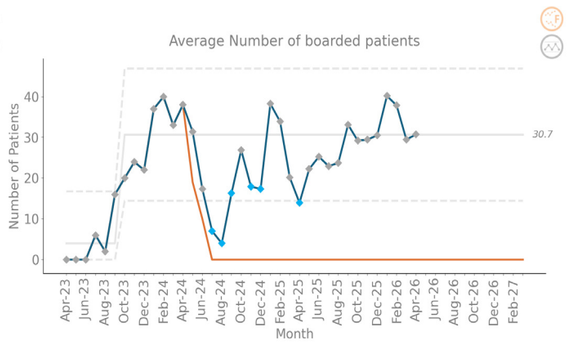


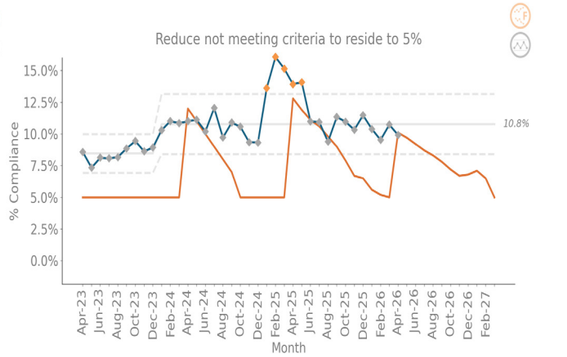


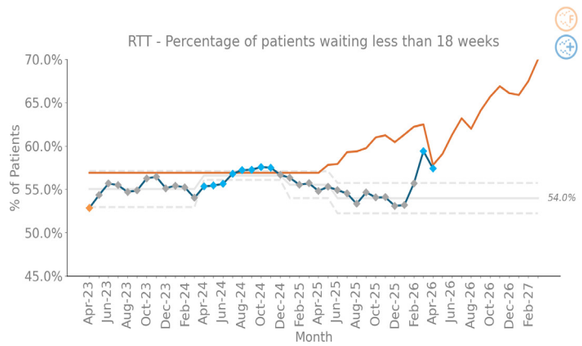


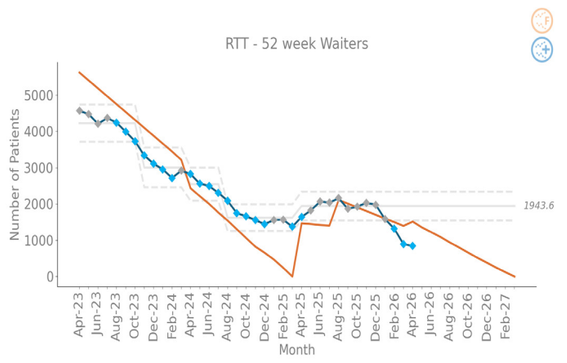


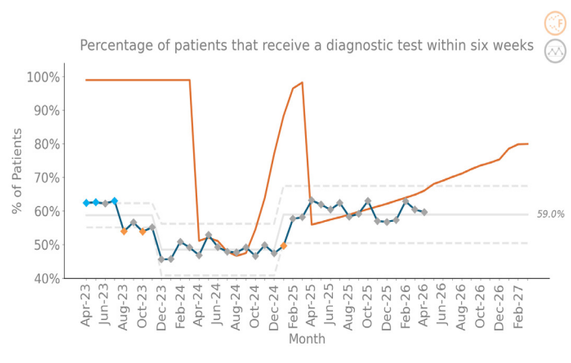


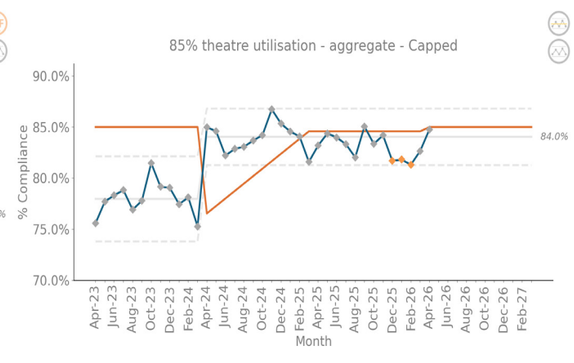


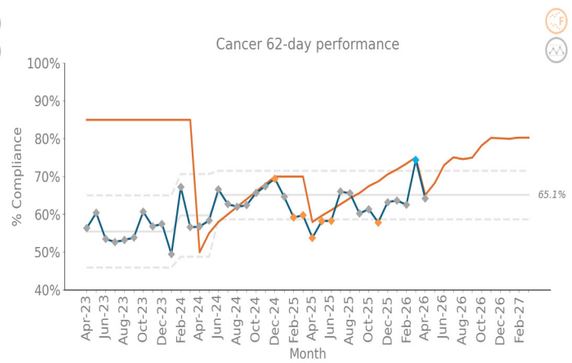


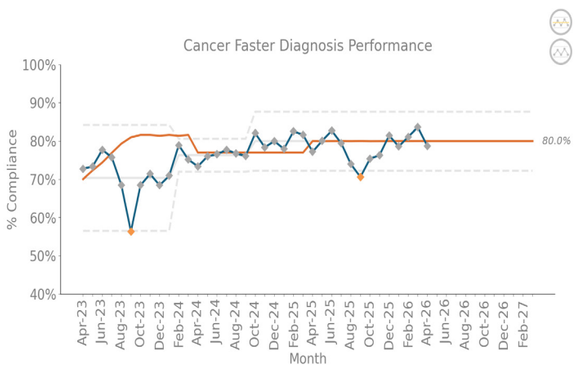


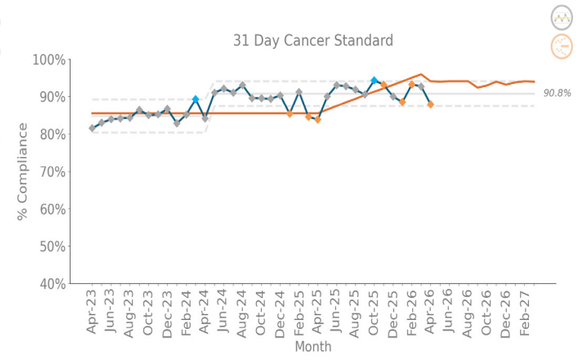






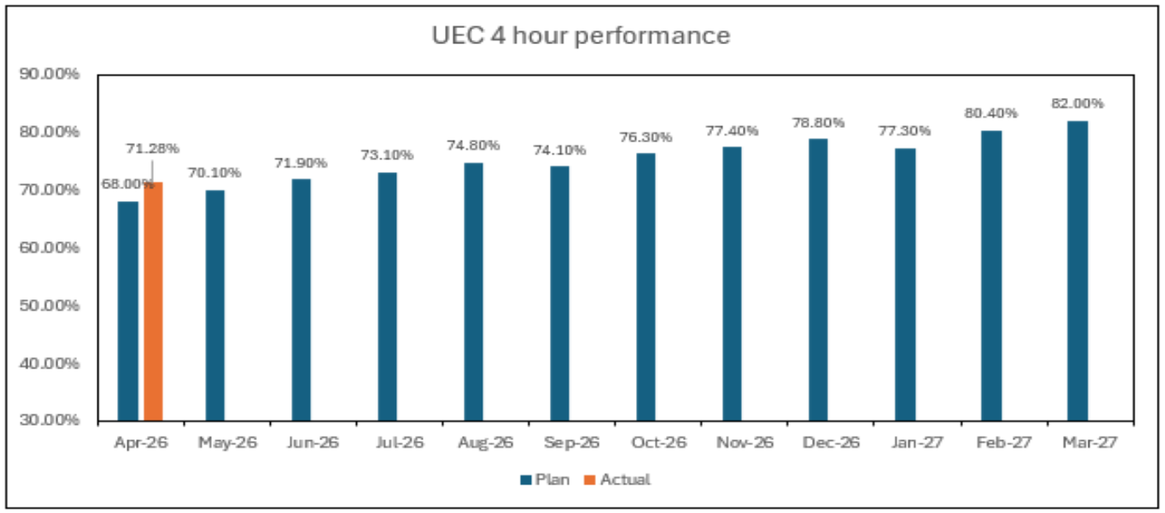


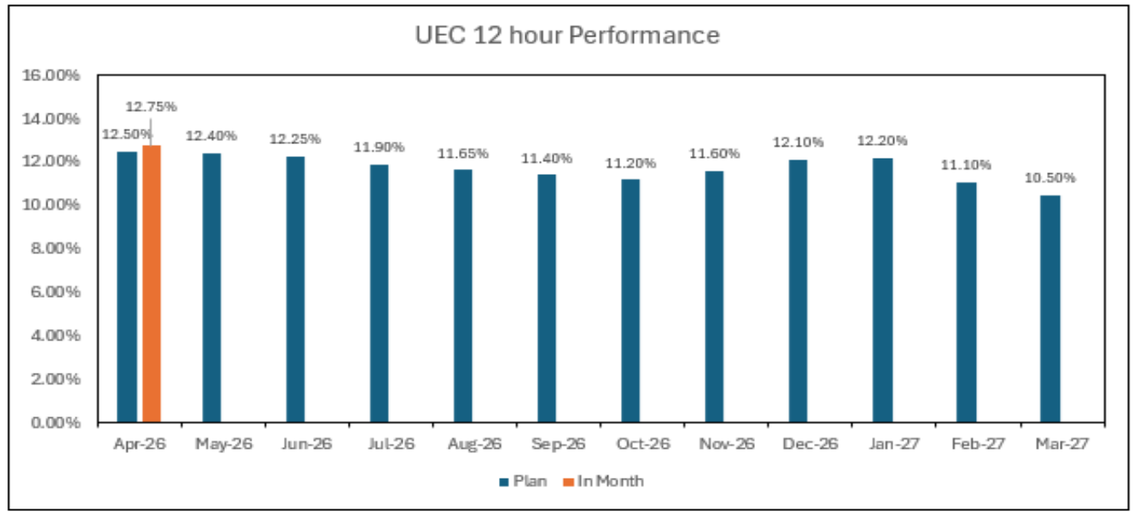


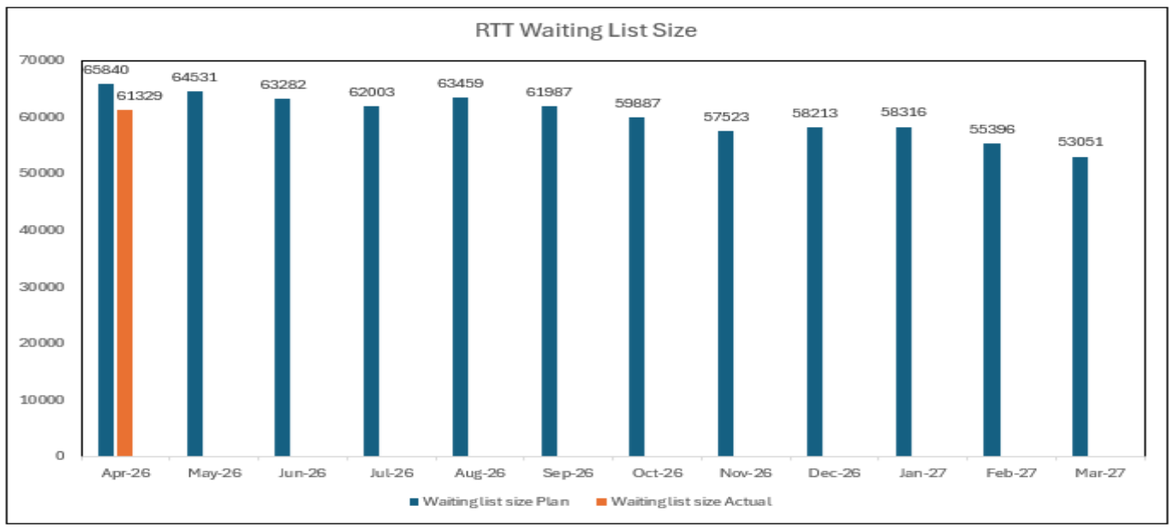


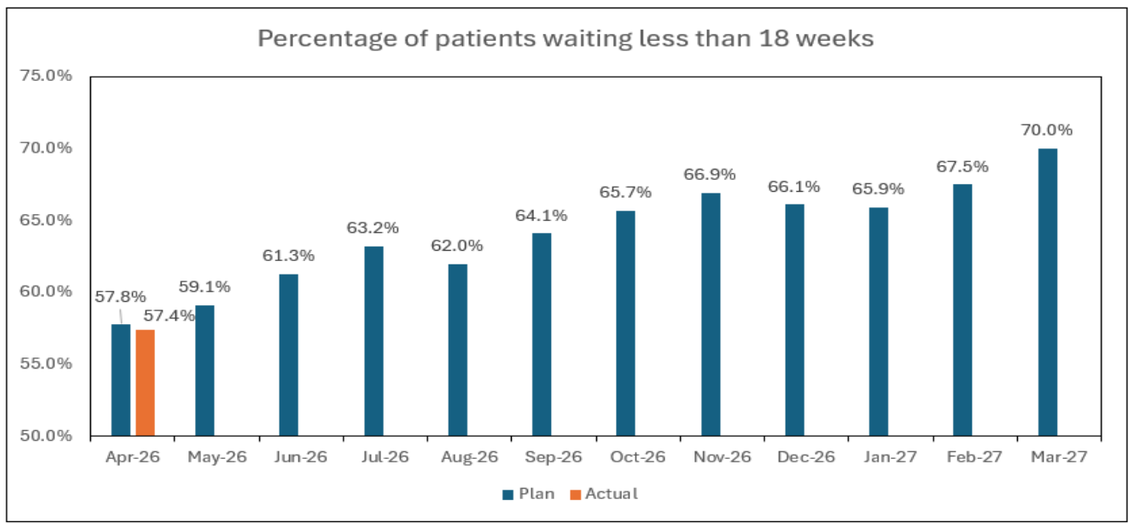
Performance - Tier 1 Charts

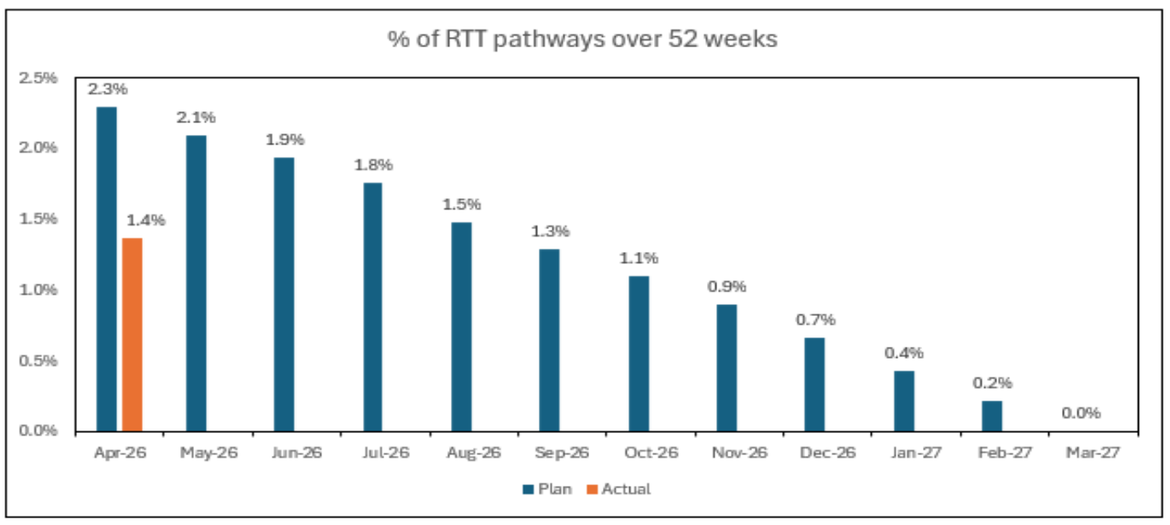
Lancashire Teaching Hospitals NHS Foundation Trust

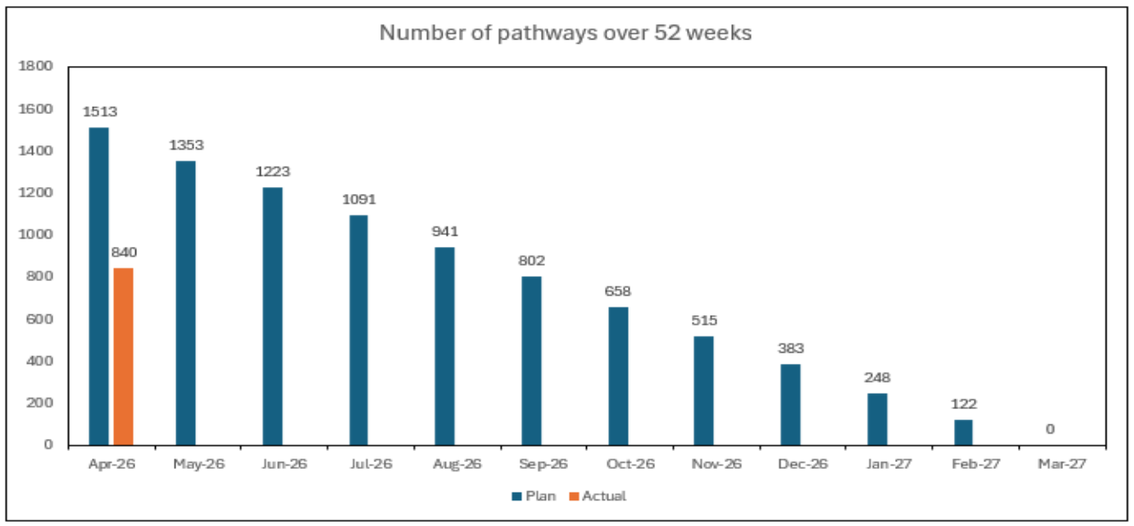


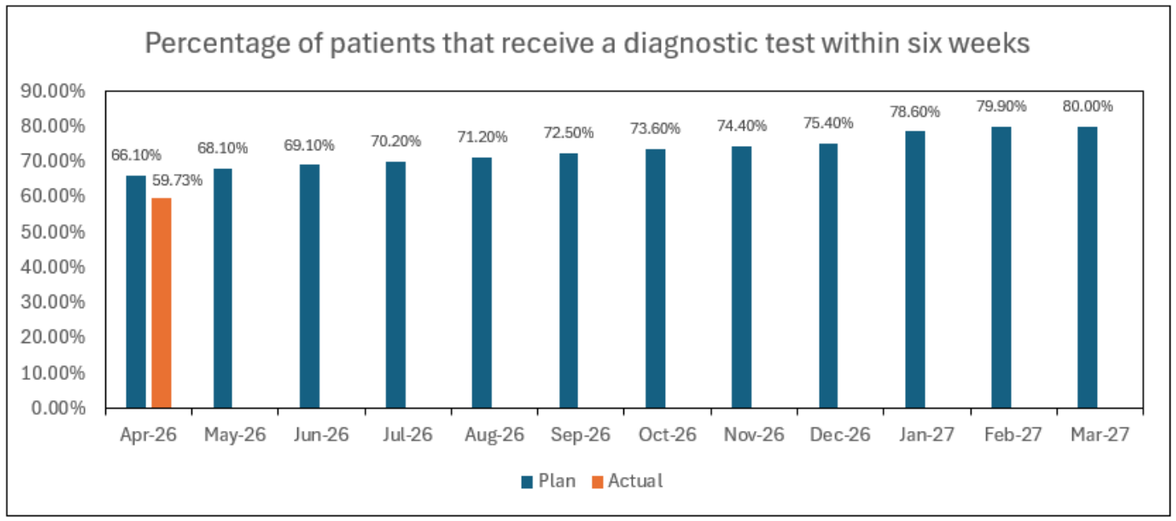


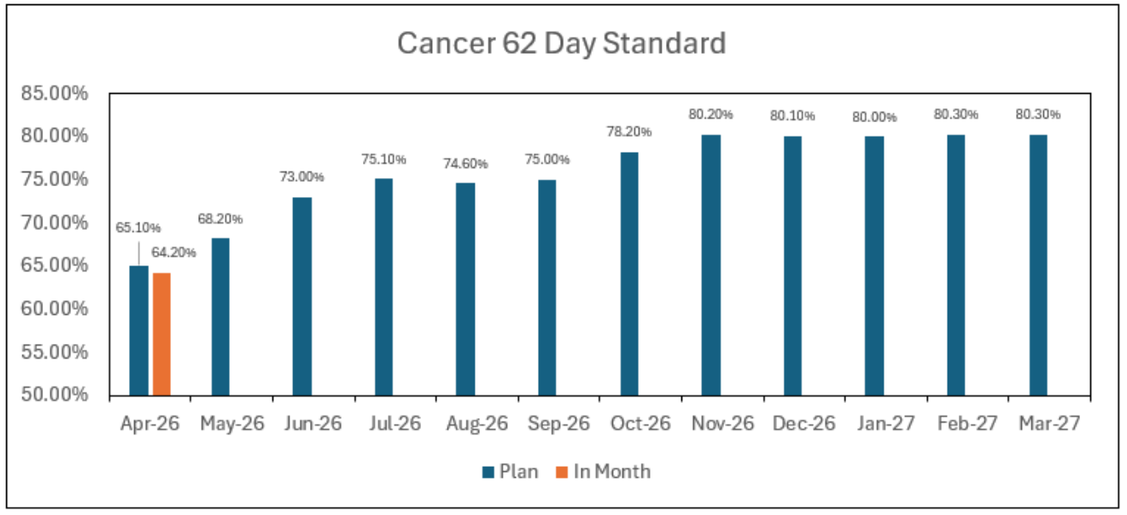


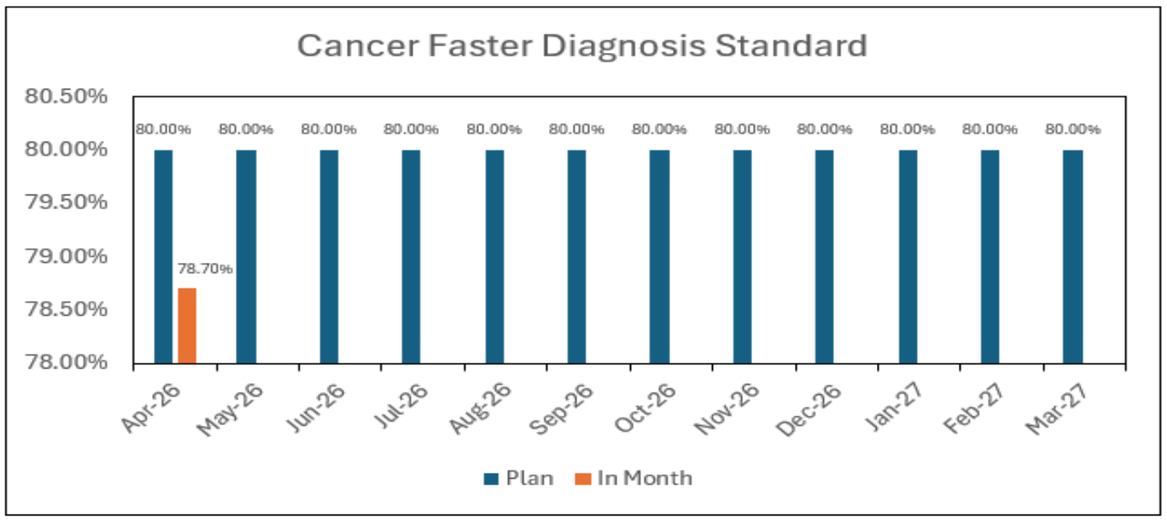


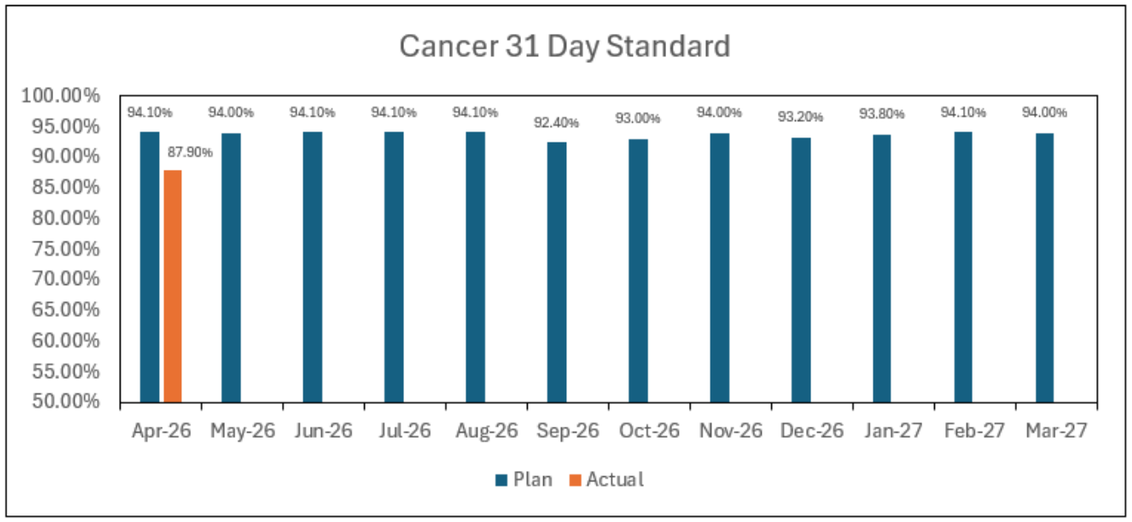





Percentage of patients that receive a diagnostic test within six weeks
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
66.10%
59.73%
68.10%
69.10%
70.20%
71.20%
72.50%
73.60%
74.40%
75.40%
78.60%
79.90%
80.00%
Apr-26
May-26
Jun-26
Jul-26
Aug-26
Sep-26
Oct-26
Nov-26
Dec-26
Jan-27
Feb-27
Mar-27
Plan
Actual


Cancer 62 Day Standard
85.00%
80.00%
75.00%
70.00%
65.00%
60.00%
55.00%
50.00%
65.10%
64.20%
68.20%
73.00%
75.10%
74.60%
75.00%
78.20%
80.20%
80.10%
80.00%
80.30%
80.30%
Apr-26
May-26
Jun-26
Jul-26
Aug-26
Sep-26
Oct-26
Nov-26
Dec-26
Jan-27
Feb-27
Mar-27
Plan
In Month


Cancer Faster Diagnosis Standard
80.50%
80.00%
79.50%
79.00%
78.50%
78.00%
80.00%
78.70%
80.00%
80.00%
80.00%
80.00%
80.00%
80.00%
80.00%
80.00%
80.00%
80.00%
80.00%
Apr-26
May-26
Jun-26
Jul-26
Aug-26
Sep-26
Oct-26
Nov-26
Dec-26
Jan-27
Feb-27
Mar-27
Plan
In Month


Cancer 31 Day Standard
100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
70.00%
65.00%
60.00%
55.00%
50.00%
94.10%
87.90%
94.00%
94.10%
94.10%
94.10%
92.40%
93.00%
94.00%
93.20%
93.80%
94.10%
94.00%
Apr-26
May-26
Jun-26
Jul-26
Aug-26
Sep-26
Oct-26
Nov-26
Dec-26
Jan-27
Feb-27
Mar-27
Plan
Actual

The Best Version of Us
Our Culture Counts @LTH

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

People

Excellent care with compassion

Always Safety First

@LancsHospitals

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

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Alert, Advise, Assure Report: People

	Issue	Action
Alert Areas of concern or matters that need addressing urgently	**Staff Engagement** - levels of advocacy with regards to recommending the organisation as a place to work and be cared for has further declined. This is a quarterly metric - therefore position remains unchanged. **Sickness -** the pilot of a digital sickness absence system is not progressing well. All pilot areas are live with the first module which covers the pathway from absence reporting through to return to work interview. End user feedback is mixed and there are challenges with the functionality that we have not been able to overcome. Implementation of the second module (case management) will take approximately 6 months and there are associated contract issues. The recommendation is not to proceed any further with the system. This is a risk to delivery of the Waste Reduction Programme scheme, although there are other programmes of work ongoing to support sickness absence reduction.	**Staff Engagement** - further implement and embed Staff Engagement Proposal and demonstrate / communicate visible action taken in response to colleague voice. Organisation wide and divisional level action plans have been developed and presented to Workforce Committee in May 2026. **Sickness** - due to the scale of the sickness absence caseload within the organisation and the challenges of ensuring grip and control around policy compliance, alternative digital systems are being scoped. A business case will be required. - the Sickness Absence Reduction Plan has been refreshed for 2026/27, focusing on key actions in the domains of Data, Education, Policy and Process and Wellbeing. Following a reduction in the annualised sickness absence rate of 0.54% for 2025/26, the focus is now on the interventions that will support a further reduction of 0.5% for 2026/27.
Advise Areas of ongoing monitoring and any new developments	**Vacancy** - Vacancy rate remains high due to vacancy control measures, and current cap on 20 WTE approvals per month at Vacancy Control Panel. Vacancy rates have increased following the exit of F&E to One LSC due to the associated change in our WTE denominator.	**Vacancy**- The Finance team are undertaking an establishment cleanse vacancy review within Divisions. This exercise is ongoing and not yet transacted. 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. HCSW vacancies remain high however we have now our to advert for all B2 and B3 vacancies.
Assure Areas of Assurance	**Appraisal** compliance remains above the 90% target. **Core Skills and Mandatory Training** remains above the 90% compliance target for each metric at Trustwide level. **Turnover** remains consistently low for month 1 at 0.62%.	**Appraisal** - actions will focus on increasing use of objectives and personal development planning in appraisal, guidance is being developed to support appraisers to tailor their conversation based at the career and lifestage of appraisees. **Core Skills and Mandatory Training** - actions focus on targeted support to increase compliance by professional group **Turnover** - to refresh strategic actions relating to turnover, which will include a focus on turnover in HCAs, understanding workplace motivators and retention needs based on generational and career point stages.

People

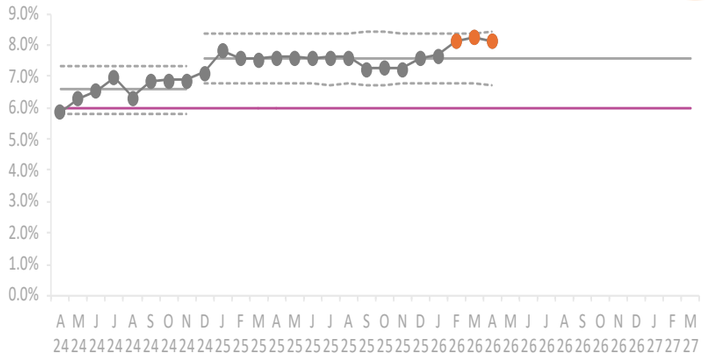
Metric Description		FY2526 Target Assurance	Latest Actual Variation	Target			Latest Actual	Latest Period
				Concern	FY2526	Latest Month Target		
People	Vacancies (% FTE) (source: General Ledger)				≤ 6%		8.13%	M01
	Turnover (% FTE) (annual assessment; ESR in-month reported)				≤ 10%		0.62%	M01
	Sickness Absence (% FTE) (annual assessment; in-month reported)				≤ 5.5%		5.57%	M01
	Number of violence and aggression incidents toward staff (annual assessment; in-month reported)				996		85	M01
	Core Skills Mandatory Training compliance (% modules) (module compliance reported)				100% of metrics at 90%		95.45%	M01
	Appraisal compliance (% HC)				≥ 90%		90.92%	M01
	Staff Survey: Recommend Trust as place to work (quarterly metric)				≥ 60%		42.54%	Q4

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

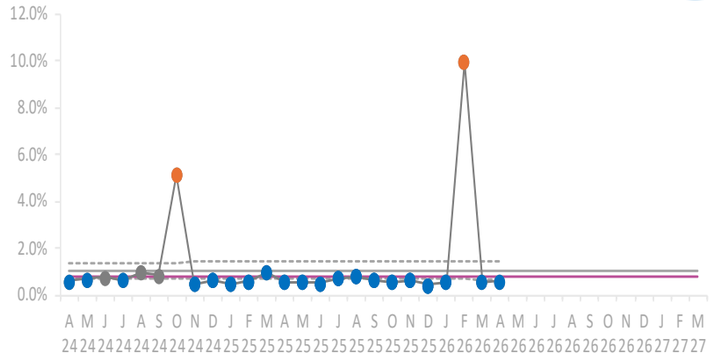
People

NHS Lancashire Teaching Hospitals NHS Foundation Trust

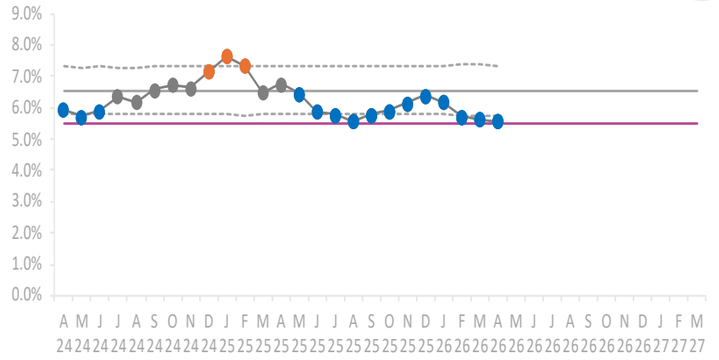
GL Vacancy Rate (% FTE)



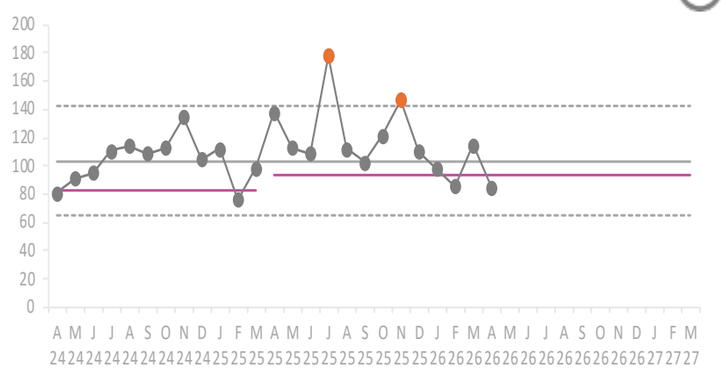
ESR Turnover (% FTE)



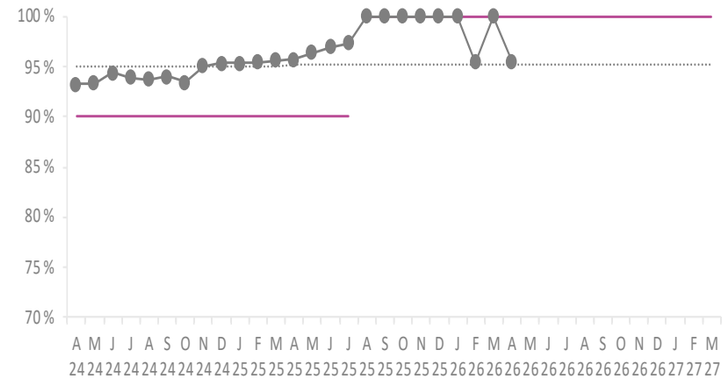
Overall Sickness (% FTE)



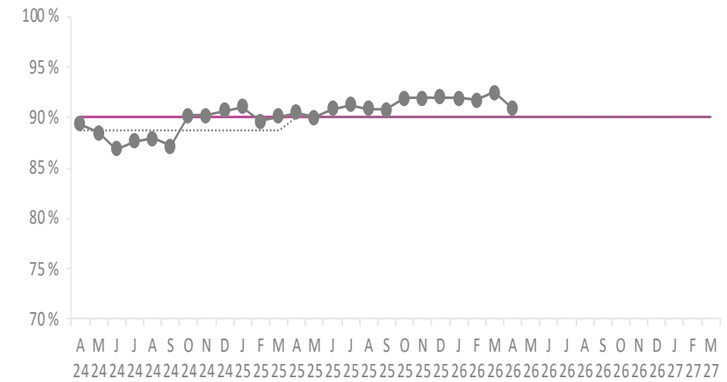
No. of Violence & Aggression Incidents Reported



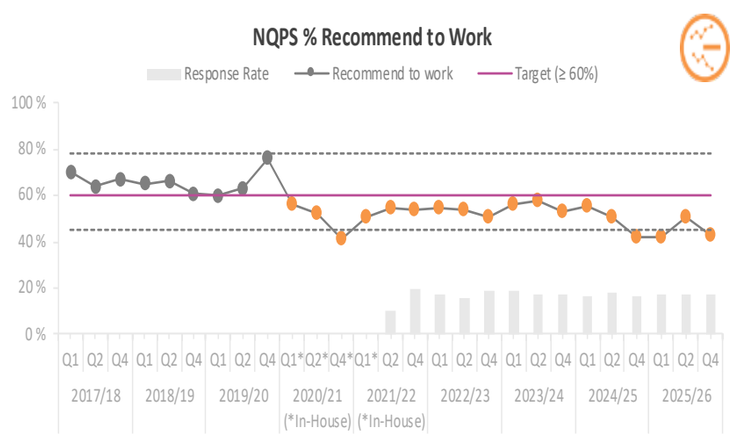
CSTF Compliance (% modules)



Appraisal Compliance (% HC)



NQPS % Recommend to Work



The Best Version of Us
Our Culture Counts @LTH

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Productivity

Alert, Advise, Assure Report

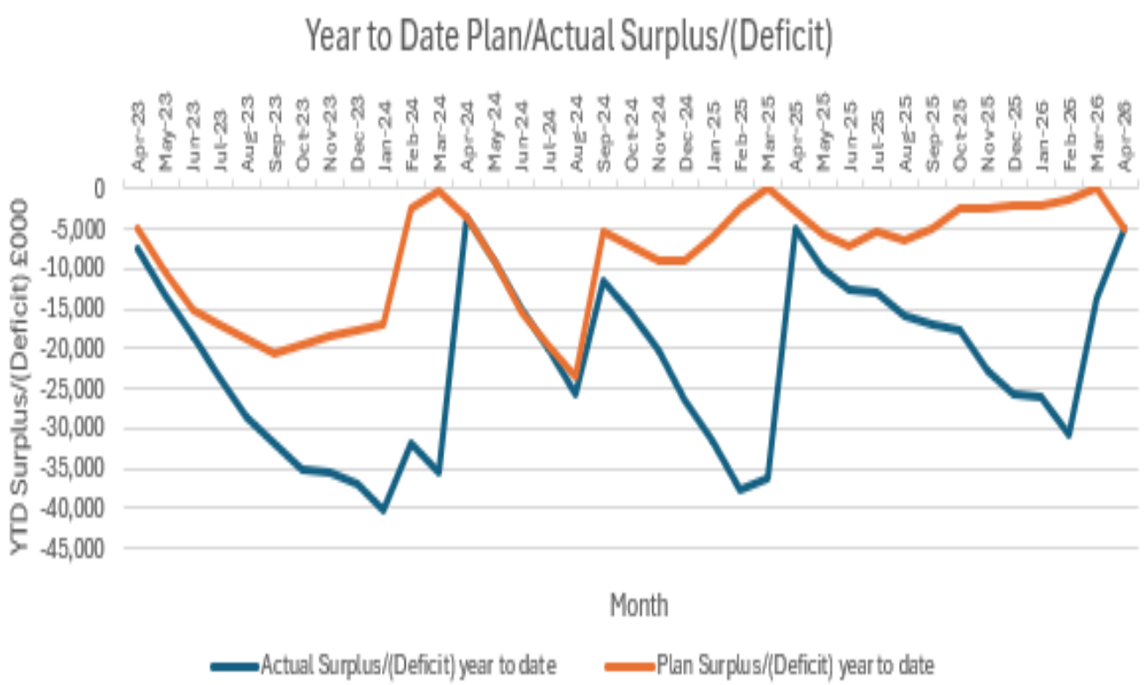
Lancas
NI

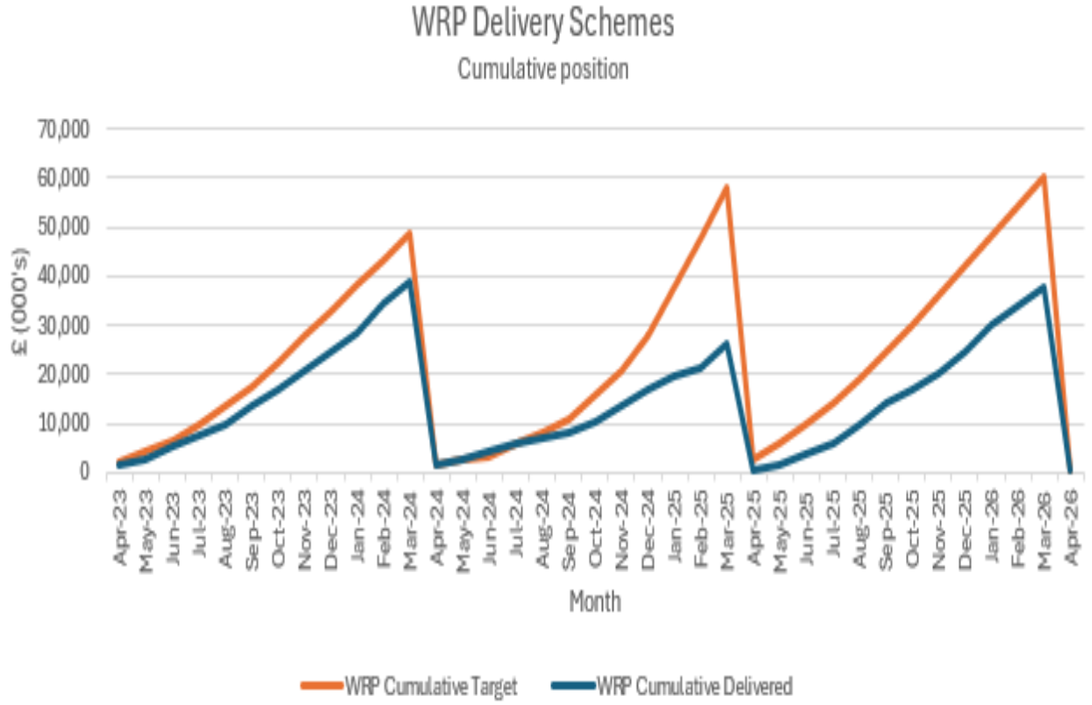
Executive Summary as at 30th April 2026

	Issue	Action	Assurance
Alert Areas of concern or matters that need addressing urgently	**Cash Position**		
	The capital plan for 2026/27 requires £4m of capital cash support as a result of the Trust receiving a delegated capital limit which exceeds the internally generated capital cash. The revenue plan for 2026/27 requires the receipt of £9m of DSF and the delivery of the WRP plan in full in terms of value and timing. Any slippage on either DSF or WRP will mean revenue cash support will be required.	Application for capital cash support will be submitted to DHSC/NHSE as appropriate. Management of WRP to ensure where possible cash releasing efficiencies are implemented. Restriction of supplier payments in accordance with the priority list of suppliers. Utilisation of internal capital cash for revenue purposes as a short-term measure.	
Advise Areas of ongoing monitoring and any new developments	**Oversight Framework**		
	The Trust is in Segment 5 of the 2026/27 oversight framework. Segment 5 is where the organisation is one of the most challenged providers in the country, with low performance across a range of domains and low capability to improve or where the organisation is a challenged provider where NHS England has identified significant concerns. Segment 5 means the Trust will be subject to NHSE's most intensive support - the Provider Improvement Programme (PIP) - to ensure it meets improvement goals. Sustained improvement is required to leave the PIP.	The Trust is receiving support as part of the Provider Improvement Programme (previously Recovery Support Programme), including continued support from PWC.	Enhanced Grip & Control including completion of associate actions, both internal audit and Trust actions, and associat reporting to FPC and Audit Committee. Engagement with and response to any regulatory requirements.
	Waste Reduction Programme		
	The Trust's 2026/27 waste reduction target is £60m, 5.7% of operating expenditure. M1 WRP delivery was £0.5m which is in line with the NHSE Financial Plan of £0.5m. However, the full WRP Plan of £60m has not yet been fully developed and if not developed and delivered will present a risk to the delivery of the 2026/27 financial plan.	Have a fully developed WRP Plan by the end of May 2026 in line with the commitment made to the regulator. Good progress is being made towards achieving this. The Trust is now embedding its own project management office structure to have a sustainable solution moving forward. The Trust has enhanced grip and control activities to mitigate slippage in schemes. For 2026/27 the Trust has implemented its Financial Sustainability Plan with areas aligned to Executive Leads, earlier planning and a focus on sustainable expenditure reduction rather than short term benefits.	Productivity board chaired by CFO External support for specific workstreams. Implementation of Divisional Delivery Groups Embedding of PMO Revised governance arrangements for DDGs
Assure Areas of Assurance	**Capital Position**		
	Capital expenditure for April was £0.9m below plan. The Trust is awaiting outcomes for capital bids that were submitted to NHSE against the national allocations. The Trust spent £823k less that the capital PDC that was received for the NHP land transaction in March 2026.	Plans are being worked up to deliver expenditure to the delegated capital limit. Dialogue is ongoing with the regional NHSE team. The surplus funds (£823k) from the NHP capital allocation in 25/26 are being repaid to DHSC in May.	There is no risk of slippage for the year. The capital plan will be updated as approvals are received.
	Cash Position		
	Current cash forecasts show that the Trust will not require revenue cash support from DHSC until September. However, that is contingent upon WRP delivering cash releasing efficiencies as per the plan targets.	Management of WRP to ensure where possible cash releasing efficiencies are implemented. Restriction of supplier payments in accordance with the priority list of suppliers. Utilisation of internal capital cash for revenue purposes as a short-term measure.	The cashflow forecast is updated daily and any emerging issu are escalated to the CFO. Monthly cashflow review by the CFO.
	Income and Expenditure		
	The M1 income and expenditure actual was a £4.9m deficit which is in line with the NHSE Financial Plan. WRP delivery was on plan at £0.5m delivered. The underlying position improvement as at M1 was £2.1m. The financial impact of industrial action in M1 has been assessed at £0.8m, which has been fully mitigated by the transfer of vacancies within the Pathology Single service and a reduction in pay run rate across clinical divisions.	A re-set of the programme structure, governance and reporting for 2026/27 has taken place, including the introduction of the Productivity Board. The system is receiving enhanced support from NHSE as part of the provider improvement programme (formerly recovery support programme). A focus on grip and control activities continues. The Trust commissioned further external support for specific financial recovery plan workstreams and 2026/27 waste recovery programme development.	Grip and control Interventions and control measures Mandated national support from PWC and the Provider Improvement Programme (formerly Recovery Support Programme)

Productivity

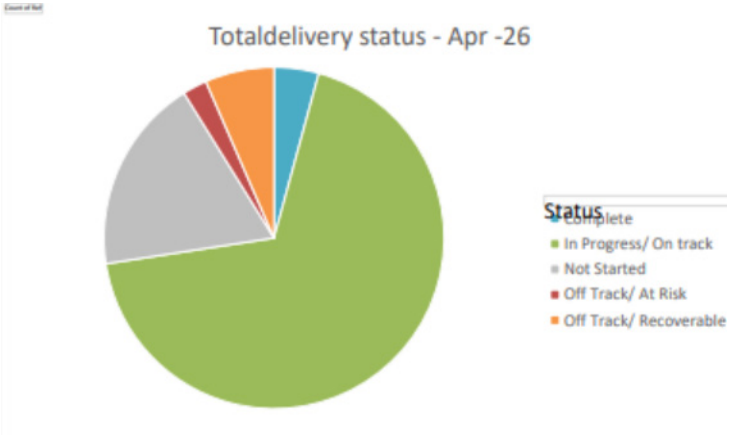
Metric Description		Assurance @ Mar-27	Variation to Latest Actual	Concern	Target (£ 000's) Mar-27	Latest YTD Target	Latest YTD Actual (£ 000's)	Latest Month
Productivity	I&E - Plan v Actual variance					-4938	-4941	Apr-26
	WRP schemes delivery				60000	450	446	Apr-26

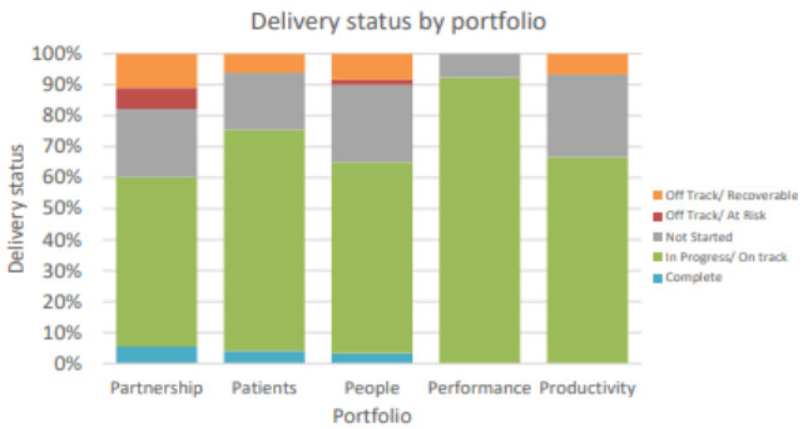




The Lancashire Teaching Hospitals **Single Improvement Plan** aims to improve patient care together.
The plan is based on what matters most to our patients, our colleagues, and our regulators, and it supports our overall goals. The SIP sets out a clear and simple way to improve how the Organisation works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

April-26 | Single Improvement Plan delivery position





Status	Portfolio	Escalation	Key actions
Alert	PATIENTS	• Restraint incidents remain high overall with majority occurring at Levels 1 and 2.	• Task & Finish group established
	PERFORMANCE	• Performance against 62 day cancer waiting time continues to be below target as a result of capacity shortfalls.	• Focus on workforce gaps to recover capacity
	PEOPLE	• Sickness absence management Empactis remains challenging with numerous delays. • Report of racism and discrimination remain persistent with little movement in metrics.	• Consideration of alternate solutions and mitigating actions to sickness management. • Current capacity in EDI constrained, consider capacity and priorities across OD team to support.
Advise	PATIENTS	• Opening date for 4th SGU theatre unconfirmed	• Task & Finish group established to work through staffing, equipment and specialty issues.
	PRODUCTIVITY	• On plan for NHSE Target WRP delivery M1	• Focus on high risk, high value scheme deliver to ensure this continues into M2
	PARTNERSHIPS	• Community partnership agreement delayed.	• Shift to April-26 but being broadened to cover all interfaces.
Assure	PATIENTS	• Funding secured for 24/7 maternity telephone triage and maternity day unit uplift	• Recruitment underway
	PERFORMANCE	• Zero 65 week wait maintained. • Endoscopy performance improved in all modalities.	

The Best Version of Us
Our Culture Counts @LTH

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Integrated Performance Report
Appendix 1 – Assurance Reports

June 2026 Trust Board meeting with performance to April 2026


Patients


Performance


People


Productivity

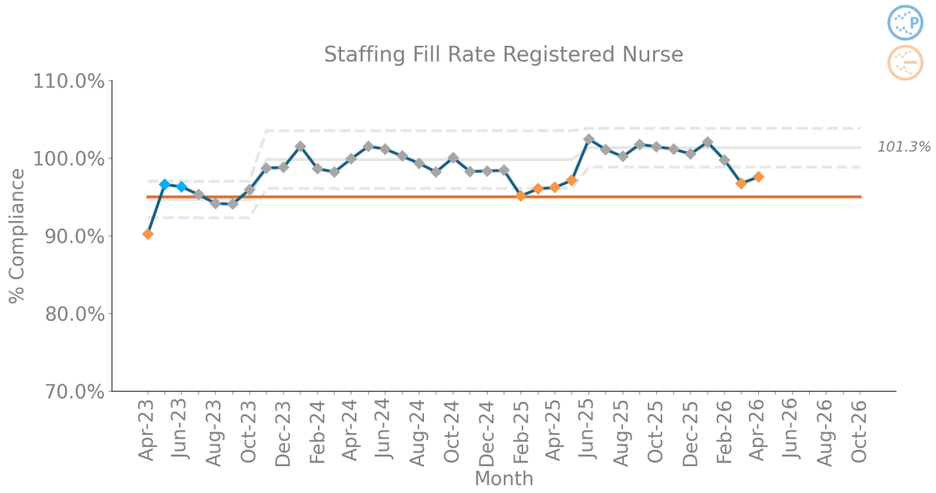

Partnerships

Excellent care with compassion

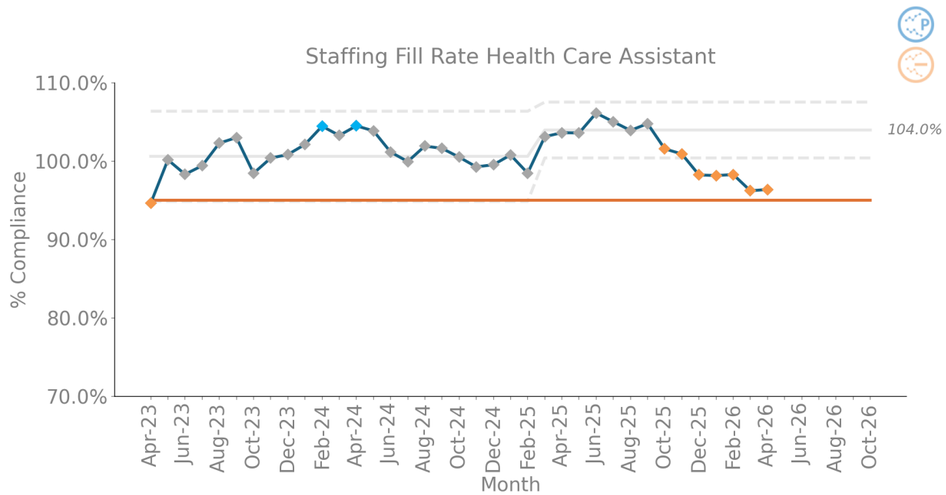
Always Safety First

@LancsHospitals

Patients - Deliver Annual Safe Staffing Requirements Assurance



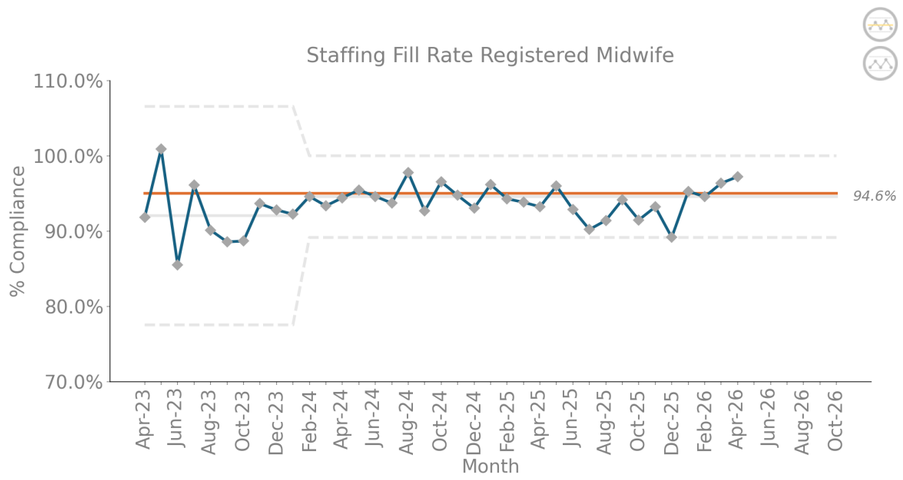
Latest
97.59%
Variance Type
Recent concerning pattern in the data
Mar-27 Target
95%
Target Achievement
Will consistently pass target within expected variation



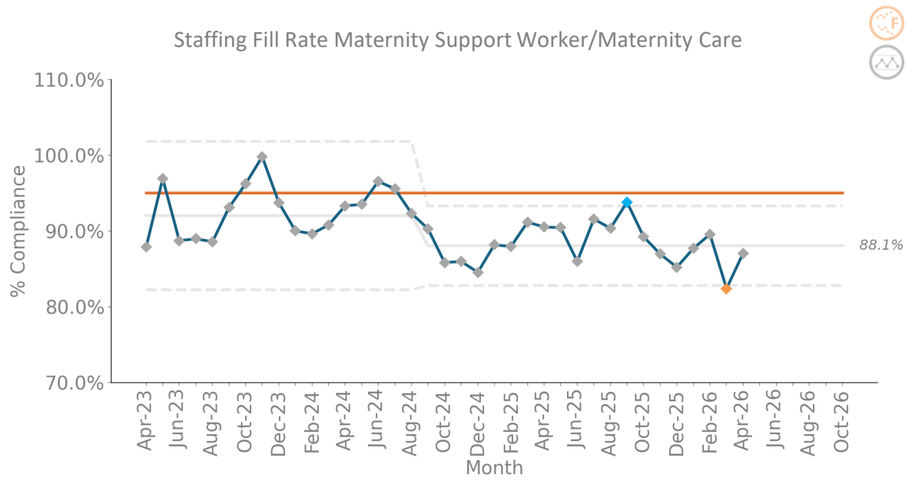
Latest
96.39%
Variance Type
Recent concerning pattern in the data
Mar-27 Target
95%
Target Achievement
Will consistently pass target within expected variation

Metric	Summary	Action	Assurance
Staffing Fill Rate Registered Nurse	The Registered Nurse (RN) staffing fill rate remains stable at 97%, with Chorley District Hospital (CDH) achieving 98% and Royal Preston Hospital (RPH) 97%. This demonstrates sustained performance above the 95% target and reflects effective workforce controls and oversight. Daily staffing reviews, strengthened governance around bank and agency usage, and proactive redeployment of staff continue to support safe staffing levels across all clinical areas.	1. Twice daily nurse staffing meetings are in place 7 days a week for oversight of safe staffing. 2. Roster sign off processes are in place and this has increased to weekly roster efficiency reviews which have commenced by the Divisional Nurse Leaders in October 25. 3. There is a full review of all areas where fill rate is greater than 100% and actions being taken including redeployment of staff where overestablishment is in place on a shift by shift basis . 4. Redeployment of staff into vacancies through organisational change and ward closures, ongoing into February 2026.	1. All clinical areas are showing a stable fill rate position. 2. Daily operational staffing meetings are in place, led by matrons to assess and respond to changes in pressure and demand based on acuity and dependency, red flags and professional judgement. 3. Approval and sign off of all agency shifts by Chief Nursing Officer 4. Biannual safe staffing procedures are in place in line with National Quality Board guidance. 5. Weekly PSIRF oversight panel reviews incident harm levels, this is triangulated through a quarterly serious incident/PSIRF report. 6. Involvement in National Enhanced Theraputic Observation and Care (ETOC) improvement work. 7. Additional duties follow a clear governance process for request and approval by Deputy/ Divisional Nursing Director to maintain safety and efficacies.
Staffing Fill Rate Health Care Assistant	Health Care Assistant (HCA) fill rates have also been maintained at 96% overall (CDH 94%, RPH 97%), despite a high vacancy rate of 22% across inpatient wards. This indicates that mitigating actions, including use of bank staff and enhanced operational oversight, are effective in maintaining safe care delivery in the short term. However, reliance on temporary staffing remains a residual risk.	1. Twice daily nurse staffing meetings are in place 7 days a week for oversight of safe staffing. 2. Internal Band 2–Band 3 progression route is defined and advertised, with the first cohort scheduled to begin in April 2026. 3. Centralised external recruitment campaign advertised in March 2026. 4. Band 3 apprenticeship programme out to recruitment with interviews planned 2nd June 2026.	

Patients - Deliver Annual Safe Staffing Requirements Assurance



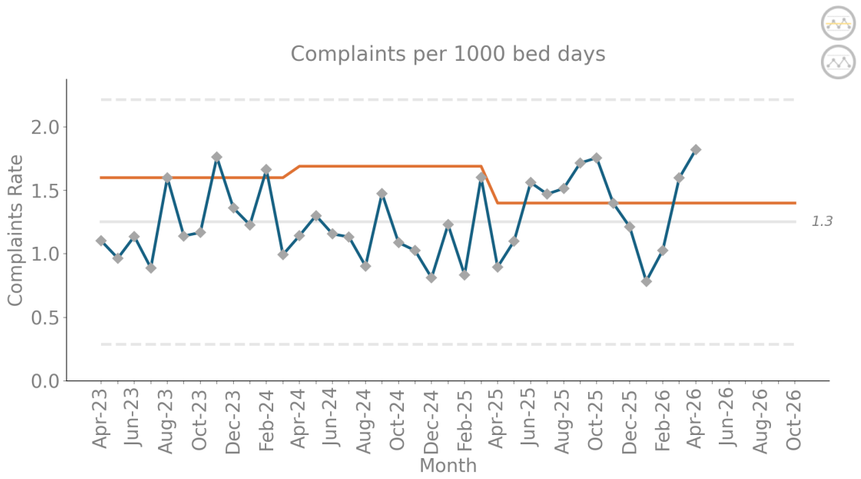
Latest
97.23%
Variance Type
Normal variation - no recent change
Mar-27 Target
95%
Target Achievement
Could both pass or fail target within expected variation



Latest
87.06%
Variance Type
Normal variation - no recent change
Mar-27 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 97.3% which is just above the Trust target of 95% for April 2026. This demonstrates a stablising position and improvement is reflective of theongoing oversight of the midwifery establishment and over offer. Unfilled shifts continue to be sent to bank and agency as required to maintain safety as required. The 2025 Birth Rate Plus has been endorsed and approved by Board of Directors (April 2026) and a 2 year phased approach to funding has been agreed. Phase 1 of targeted recruitment has commenced.	1. Weekly roster efficiency reviews as required to ensure appropriate use of bank and agency. 2. Monthly roster efficency meetings overseen by the deputy Divisonal Midwifery and Nursing Director 3. The service continues to recruit to turnover using over offer of 5 WTE. 4. Annual staffing paper including Birth Rate Plus approved by the Safety and Quality Committee (February 2026) and Board of Directors (April 2026)	1. Registered Midwife fill rates remain stable across day and night shifts. 2. The Safety and Quality Committee reviews fill rates and minimum RM levels for each area monthly. 3. Work is underway with the Safe Staffing Matron to report fill rates by area rather than cumulatively, enabling clearer identification of pressure points and targeted action. 4. All agency shifts require approval from the Deputy/Divisional Midwifery and Nursing Director. 5. Biannual safe-staffing reviews are completed in line with National Quality Board guidance. 6. A weekly PSIRF oversight panel reviews harm levels, supported by quarterly serious-incident/PSIRF reporting. 7. Red-flag reporting is monitored to identify areas requiring additional support to mitigate risk.
Staffing Fill Rate Maternity Support Worker/Maternity Care Assistant	The overall Midwifery Support Worker fill rate remains below the Trust target of 95% , but has improved in month from 85.57% for March 2026 to 87.06% in April 2026. The vacancy rate continues to be closely monitored. VCP oversight processes have affected timely recruitment and delays have been escalated where appropate. Under funded establishment on maternity A has been included in the Birth Rate plus requirments and this has been approved at part of phase 1 . Once substantive posts are filled this will improve overall fill rate performance. To maintain safe staffing levels, there continues to be a requirement to use bank to fill shifts.	1. Weekly roster efficiency reviews are ongoing to ensure appropriate use of temporary staff. 2. Ongoing recruitment to fill all vacancies which are tracked using a local trajectory plan. 3. Sickness management procedures are reviewed by Workforce Business Partner to ensure appropriate management. 4. Band 2 MSW vacancies in maternity A,B and Delivery suite are being progressed through VCP or onboarding process.	1. The Safety and Quality Committee reviews fill rates and minimum safe-staffing levels by area each month. 2. Work with the Matron for Safe Staffing is underway to report area-specific fill rates to better identify pressure points and target actions. 3. Rosters and agency shifts are overseen and approved by the Deputy/Divisional Midwifery and Nursing Director. 4. Biannual safe-staffing reviews are completed in line with National Quality Board guidance. 5. A weekly PSIRF oversight panel reviews harm levels, supported by quarterly serious-incident/PSIRF reporting. 6. Red-flag reports are monitored to highlight areas requiring additional support to manage risk.

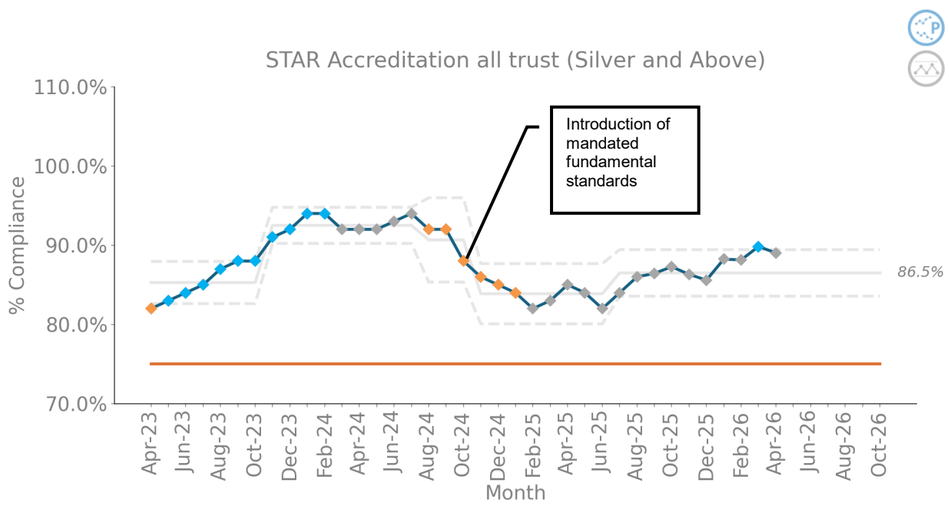
Patients - Complaints



Latest
1.82
Variance Type
Normal variation - no recent change
Mar-27 Target
1.40
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
Complaints per 1000 bed days	Complaints per 1,000 bed days from April 2023 to early 2026, with performance fluctuating around a central baseline and a stepped trajectory line indicating expected or target levels.Overall, complaint rates remain relatively stable, typically ranging between approximately 0.8 and 1.8, with no sustained upward trend over time. The Trust's Single Improvement Plan is guiding both immediate service improvements and longer-term system change to support sustained reduction.	1. Continue to deliver the Single Improvement plan - Patients 2. Continue to deliver the Patient Safety Incident Response Framework with a focus on family liaison roles 3. Monitor actions in relation to National picker Surveys . 4. To deliver the PALS and local early resolution training. 5. Continue to progress the complaints review group using patient safety partners and governors 6. Where concerns have not been responded to locally escalatre to managers.	1. Annual patient experience reports to Safety and Quality committee. 2. Friends and family monthly reporting in place for all departments. 3. Inclusion of patient experience in STAR. 4. Chief Nursing Officer reviews all complaints and signs off responses. 5. Monitor picker survey action plans through Patient, Carer, Experience and Involvement Group.

Patients - Quality Assurance STAR Accreditation



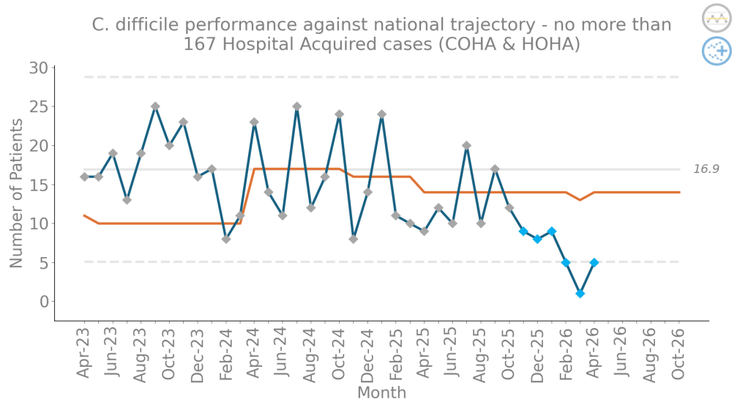
Latest
89.03%
Variance Type
Recent positive pattern in the data
Mar-27 Target
75.00%
Target Achievement
Will consistently pass target within expected variation

Metric	Summary	Action	Assurance
STAR Accreditation all trust (Silver and Above)	There are 119 clinical areas registered for the STAR Quality Assurance Framework. There are 2 clinical area with a red star rating, 11 areas with an amber rating and 106 areas rated green. This results in 13 bronze stars, 32 silver stars and 74 gold stars. Of those 32 areas with silver stars, there are 4 areas who have achieved 3 consecutive silver stars and are awaiting approval at the Gold Star Panel. There are 89% of areas rated silver or above. During April, there were 2 areas with a reduced STAR rating, 1 area had their first visit (rated red), 1 area had an increase to silver and others maintained their star rating. There is one area rated C for the 15 steps. Themes for improvement include the mandated 'critical' standards of the essentials of care, infection prevention and control, risk assessments in particular MUST and weights, 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 escalation areas, provision of meals and drinks in some areas, fluid balance management, assessment and delivery of enhanced therapeutic observations and care (ETOC). A bespoke assurance assessment of the boarding standards was presented to the NMAHP Board during February. There are 78 % of wards, ED and theatres scoring silver and above for STAR accreditation visits.	1. Any standards which are not achieved require an improvement action which is monitored within division through divisional assurance processes and via STAR monthly reviews and STAR accreditation visits. 2. The monthly STAR report includes trustwide and divisional STAR data and highlights good practice, areas for improvement, themes for learning and an overarching STAR improvement action plan, which is cascaded and discussed through the divisional always safety first meetings. The STAR report includes CQC (2023) learning and standards which continue to require improvement. 3. The STAR action plan has been updated to include recurrent themes and now included learning and actions from the Safety Visits undertaken by the senior leadership teams. 4. STAR monthly report updated to highlight those areas who are rated red or amber for STAR visits of less then 90% for STAR monthly. 5. The STAR enhanced oversight panel involves 5 areas to drive action and support with STAR safety and quality actions. Learning and actions are included within the STAR report shared via NMAHP Board.	1. The STAR report is shared with the divisional leadership teams, good practice is shared and celebrated and that actions are developed where improvement is required. 2. Ward/department managers, matrons and professional leads provide assurance that actions are completed and monitored for effectiveness through the 1:1 with matrons and Divisional Nurse Directors. 3. The AMaT system supports with STAR audit data management and oversight and management of improvement actions. 4. There is a BI STAR page available to enable data triangulation. 5. STAR accreditation visits are scheduled depending on star rating, areas with a bronze star rating are reassessed within 2-3 months. (red every 2 months, amber every 3 months). Any area with a 15 steps result of C or below will receive a reassessment within one month. 6. Any immediate risks or serious concerns identified are addressed at the time and followed up to seek assurance that actions are in place.

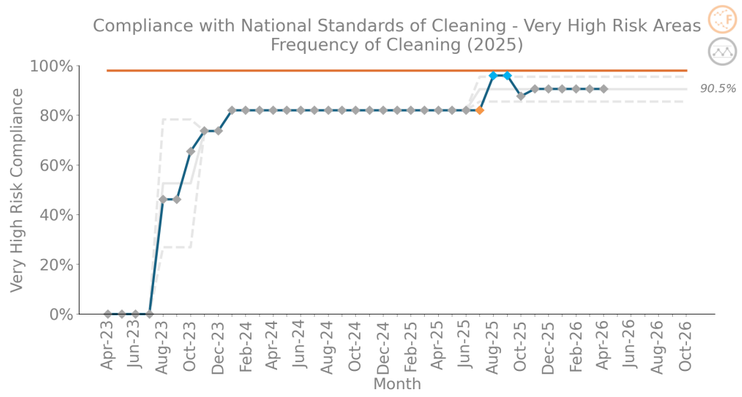
Patients - C Difficile Improvement Programme Assurance

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

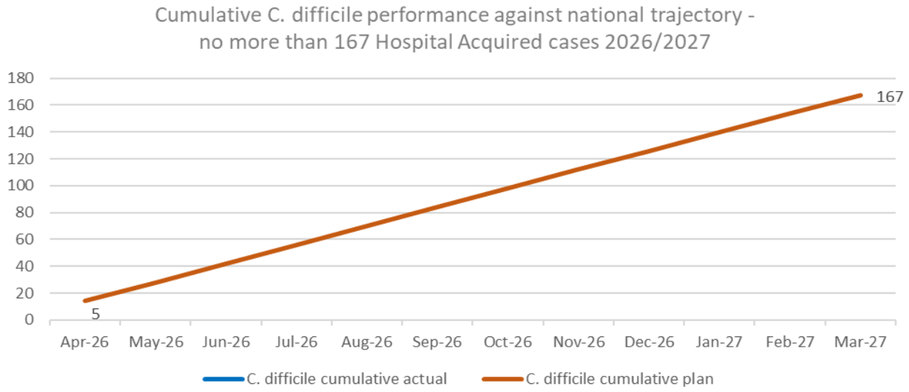
NHS Lancashire Teaching Hospitals NHS Foundation Trust

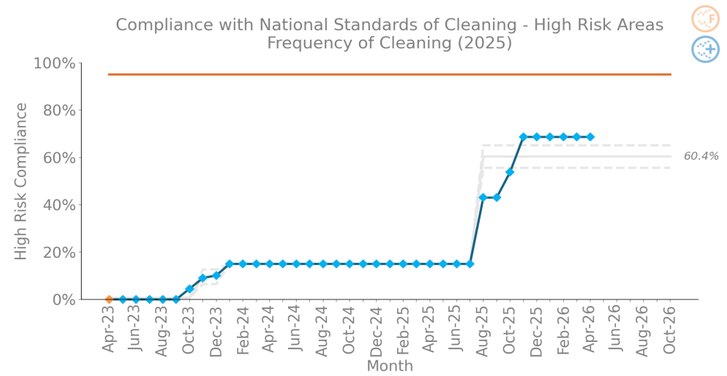


Latest
5
Variance Type
Recent positive pattern in the data
Mar-27 Target
14
Target Achievement
Could both pass or fail target within expected variation



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

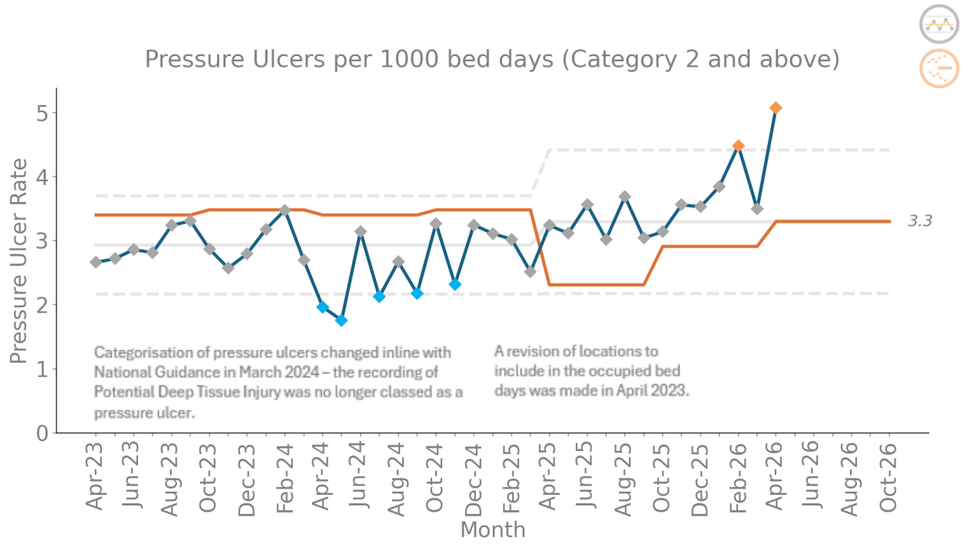




Latest
68.64%
Variance Type
Recent positive pattern in the data
Mar-27 Target
95.00%
Target Achievement
Will consistently fail target within expected variation

Metric	Summary	Action	Assurance
C. difficile performance against national trajectory - no more than 167 Hospital Acquired cases	During April 2026 there was a total of 5 cases for the month, with a total of 5 cases for 2026 / 2027 to date. The Trust's National objective for 2026/2027 has not been set, therefore the previous year's objective will be used until it is released (167 cases) The focused work on CDI reduction and the improvement plan continues to be monitored through the Infection Prevention and Control Committee each month and also the Estates and Clinical Partnership Board. The National Standards of Healthcare Cleanliness (2025) for frequency of cleaning is now visible and monitored through the dashboard alongside the quality checks of those areas not yet achieving the frequency of cleaning standards. Current compliance 90.60% for frequency 1 areas, 68.65% for FR 2 area. Due to ongoing vacancy pressures and associated process delays affecting release and recruitment the service cannot deliver further roll out until resources are aligned to the agreed staffing model.	1.Implementation of the approved business case to be compliant in high risk areas with National Standards of Healthcare Cleanliness (2025) - vacency imacting full roll out acros the Trust, escalated and progressing. 2. Continued focus on IPC practice through STAR monthly and accreditation processes each month. 3. Continue to monitor key performance assurance indicators through Infection Prevention and Control committee each month.	1. IPC BAF report reviewed and shared at IPCC for assurance. 2. IPC Dashboard. 3. IPC monthly revalidation audits such as Hand Hygiene, Commodes, Environmental checks and Mattress checks. 4. Monthly reporting into S&Q, IPCC and Divisional IPC meetings, along with bi-monthly reporting into H&S Committee. 5. STAR encompasses IPC audits and cleaning checklist compliance, with all audit information available within AMAT. 6. NHS England review of IPC assurances. 7. Antimicrobial stewardship oversight and assurance reporting.

Patients - Pressure Ulcers Assurance



Latest
5.08
Variance Type
Recent concerning pattern in the data
Mar-27 Target
3.30
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
Pressure Ulcers per 1000 bed days (Category 2 and above)	Pressure ulcers remain a key indicator of care quality and performance continues above the revised Trust threshold. A comprehensive improvement plan is in place focusing on prevention, consistent standards and strengthened review processes. Oversight has been enhanced through the Pressure Ulcer Panel, supporting cross-divisional learning, alongside pressure ulcer risk reduction rounds led by the Tissue Viability Team, which provide proactive intervention, real-time feedback and education to ward teams. A data quality issue has also been identified relating to the inclusion of incidents that have subsequently been rejected. This is currently under review, with work underway to implement a solution and ensure accuracy of reporting. These measures strengthen oversight and support early intervention while performance remains above target.	1. Monthly sharing of cross-divisional learning, key themes and trends through Always Safety-First (ASF) meetings (from January 2026). 2.Quarterly thematic review of high-incidence pressure-ulcer areas, with findings fed back into monthly ASF meetings to ensure responsive action. 3.Pressure Ulcer Review Panel to review harms, identify themes and trends, and generate actions to improve practice (commenced November 2025). 4. Pressure ulcer risk reduction rounds lead by the tissue viability team, shifting to a proactive assurance model (commenced March 2026). 5. Review and strengthen data quality processes to address the inclusion of rejected incidents within reporting, system/process improvements to ensure accuracy and reliability of pressure ulcer data.	1. Divisional Always Safety First Committees provide oversight of the pressure ulcer improvement plan and monitor progress against key actions. 2. Monthly monitoring of pressure ulcer incidence continues as a priority quality metric, with trends reviewed at divisional and Trust level. 3. STAR compliance for key questions 8d and 9c is monitored monthly as leading indicators of prevention practice. 4. Weekly Pressure Ulcer Panel, with a consolidated monthly learning report submitted to PSIRF Oversight. 5.Monthly oversight group for review and monitoring of actions from Pressure ulcer panel with division leadership representative.

Patients - Always Safety First Assurance - Mortality

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

NHS Lancashire Teaching Hospitals NHS Foundation Trust

	Achievement	Position	Month
Hospital Standardised Mortality Ratio - Adult	Lower Than Expected	73.9	December 2025
Standardised Mortality Ratio - Relative Risk - All Diagnoses Adult	Lower Than Expected	69.3	December 2025
Standardised Mortality Ratio - Relative Risk - All Diagnoses Child (<1 day – 17 yrs)	As Expected	291.2	December 2025
Standardised Mortality Ratio - Relative Risk - All Diagnoses Neonates (<1-28 Days) *The updated TELSTRA model from November 2024 does not include still births*	As Expected	364.9	December 2025

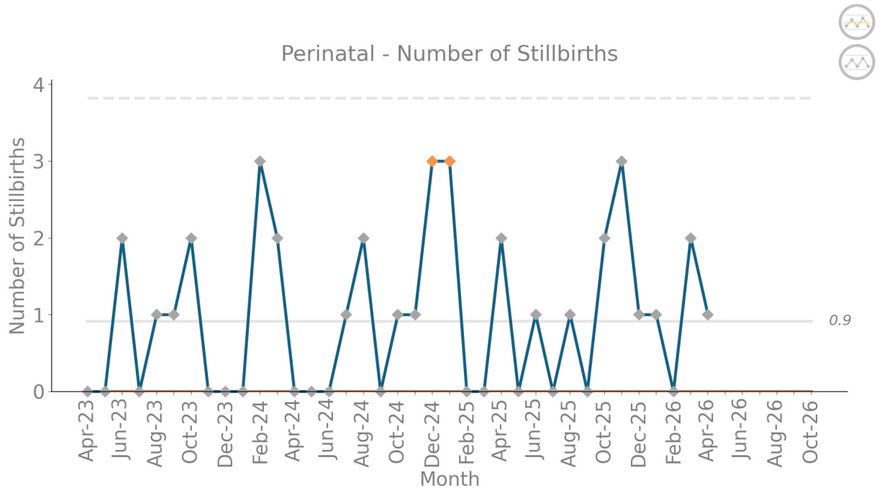
Source Data: Telstra (Dr Foster)

Metric	Summary	Action	Assurance
Hospital Standardised Mortality Ratio - Adult	HSMR is within Upper and Lower Control Limits and lower than expected when compared to peers.	1. Continue with structured judgement review process. 2. Use mortality reviews to establish themes where care or experience could be improved. 3. Continue to work with the medical examiners office to review deaths in line with guidance. 4. Continue to use incident reporting processes where an incident occurs under Patient safety Incident Response Framework (PSIRF). 5. Continue to implement the 10 CNST safety actions for maternity and neonatal 6. Marthas rule (Call for Concern)implementation is underway.	1. Mortality and End of Life committee chaired by Deputy Chief Medical Officer with responsibility for mortality. 2. Twice annual reports to safety and Quality committee. 3. Telstra system utilised to generate mortality data ensuring objective peer data is used to establish reported key performance indicator. 4. Speak Up arrangements are well established in the organisation. 5. Maternity Neonatal report provides assurance of compliance with Maternity neonate Safety Investigation branch for appropriate cases. 6. The Child Death Overview process ensures peer review takes place of all child deaths and is reported through the annual safeguarding report and the mortality reporting arrangements. 7. ED and maternity and neonatal safety forums in place with executive leads identified to encourage speak up in high risk areas. 8. Dr Foster (reverted back from TELSTRA) data will be used to review individual conditions which alert on the HSMR SHMI data. A narrative will be included in Mortality Reports to Safety and Quality Committee. 9.The Trust has been validated against all 10 CNST maternity and neonatal safety actions and is now progressing through the formal sign-off process. 10.Further Dr Foster training sessions will be provided for LTHTR in 2026 -2027.
Standardised Mortality Ratio - Relative Risk - All Diagnoses Adult	SMR is within Upper and Lower Control Limits and lower than expected when compared to peers.		
Standardised Mortality Ratio - Relative Risk - All Diagnoses Child (<1 day – 17 yrs)	SMR (Child <1 day -17 Years) (All Diagnoses) is within Upper and Lower Control Limits and within expected range compared to peer.		
Standardised Mortality Ratio - Relative Risk - All Diagnoses Neonates (<1-28 Days)	SMR (Neonatal <1 day -28 days) (All Diagnoses) is within Upper and Lower Control Limits and within expected range compared to peer.		

Patients - Stillbirths Assurance

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

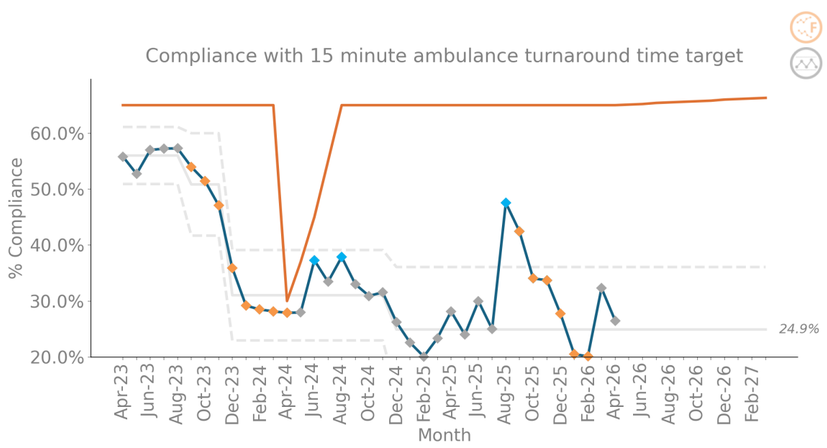
NHS Lancashire Teaching Hospitals NHS Foundation Trust



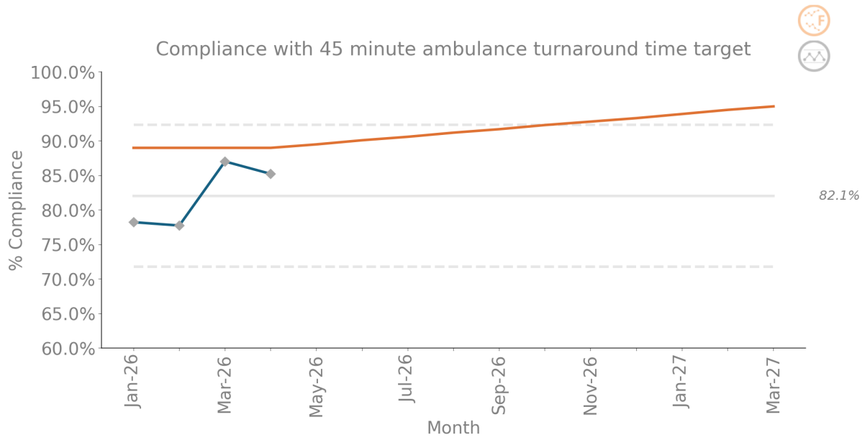
Latest
1
Variance Type
Normal variation - no recent change
Mar-27 Target
0
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
Perinatal - Number of Stillbirths	The service continues to track the rates of stillbirth and review each case in line with national guidelines and reporting requirements. In April 2026 there was one case. The 12-month local average mean still birth rate is 2.1 per 1000 (May 2025 to April 2026 excluding TOPFA) which remains below the national average of 3.9 per 1000 births.	1. Implementation of the Maternity Incentive Scheme (MIS Year 8) safety standards. 2. Implementation of Single Improvement Plan (SIP) actions to improve outcomes for mothers, babies and families. 3. Report all cases via Submit a Perinatal Event Notification (SPEN) 4. Use National Maternity Dashboard analysis to review to provde peer comparsion data for continious improvement	1. Perinatal Quality Surveillance dashboard analysis shared via the maternity and neonatal safety report (to Trust Safety and Quality Committee). 2. Peer comparison data included within the reporting for oversight 3. National MBRRACE reporting provides overview of national themes to ensure learning is understood. 4. The Maternity Outcomes Signal System (MOSS) is now in place which provides real-time monitoring of key maternity outcome—such as term stillbirths, to detect early warning signals and prompt rapid intervention

Performance - UEC Assurance



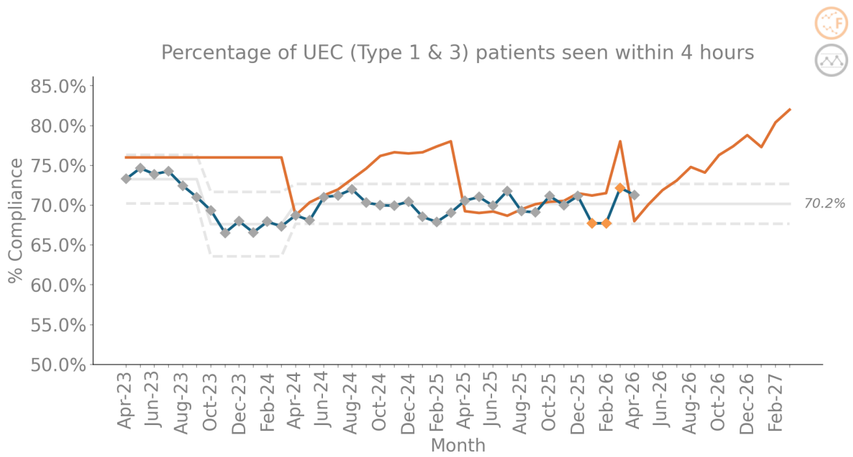
Latest
26.49%
Variance Type
Normal variation - no recent change
Mar 27 Target
66.3%
Target Achievement
Will consistently fail target within expected variation



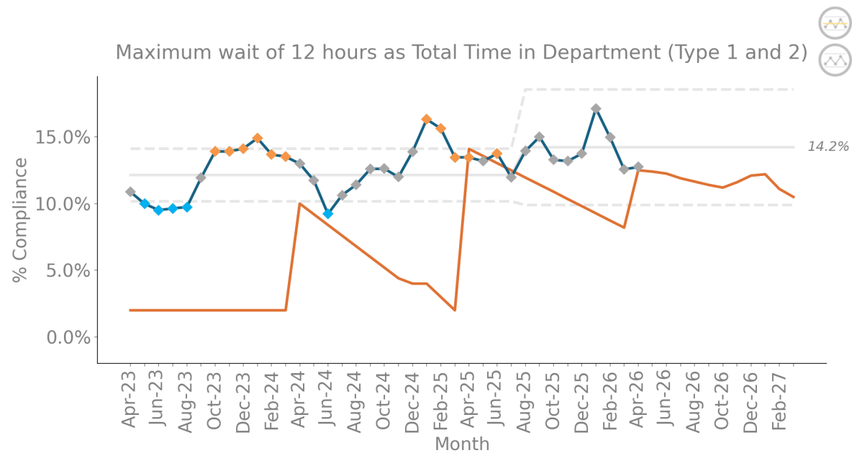
Latest
85.23%
Variance Type
Normal variation - no recent change
Mar 27 Target
95%
Target Achievement
Will consistently fail target within expected variation

Metric	Summary	Action	Assurance
Percentage of Ambulance Handovers within 15 minutes - Trust	In April 26.49% of patients were handed over from NWAS within 15 minutes, a deterioration of -5.81%, after a significant improvement the previous month. However the current position shows normal variation and could either pass or fail the target within expected variation.	Ambulance handover delays remain a high priority, linked with SDEC and EEMAC actions these will see improved flow from the ED and reduce handover delays. Additionally work continues within the DKAFH programmed with a MADE event taking place in early May and learning informing changes into routine practice to drive reduced bed days. Development of a multi agency Transfer of Care hub commenced on 18th May 26 with trusted assessor practices established which support step up admission into IMC. The anticipated impact from the establishment of the Transfer of Care hub is a 1 day LOS reduction for DKAFH patients in pathways 1-3. This alongside continued work on Ward and Board round processes and continued DKAFH improvement roll out will aim to see lost bed days for optimised patients reduced to within target by end March 27.	Monitoring of ambulance demand is undertaken via the weekly Ambulance handover group. Comparison to both the national and regional performance positions for April 26 indicates that the Trust is below the national performance of 36.9% for 15 minute handovers and above the NW performance position of 29.9% of handovers within 15 minutes.
Percentage of Ambulance Handovers within 30 and 45 and 60 minutes - Trust	In April 382 patients waited between 30-60 minutes to be handed over from NWAS to the Trust, a slight increase of 23 from last month. 230 patients waited over 60 minute to be handed over from NWAS to the Trust in April, an increase of 39 compared to the previous month. In April 85.2% of patients were handed over within 45 minutes, a 1.8% deterioration compared to the previous month.		Monitoring of ambulance demand is undertaken via the weekly Ambulance handover group. Comparison to both the national and regional performance positions for April 26 indicates that the Trust is below the national performance position of 77% for 30 minute handovers and slightly below the NW performance position of 74%.

Performance - UEC Assurance



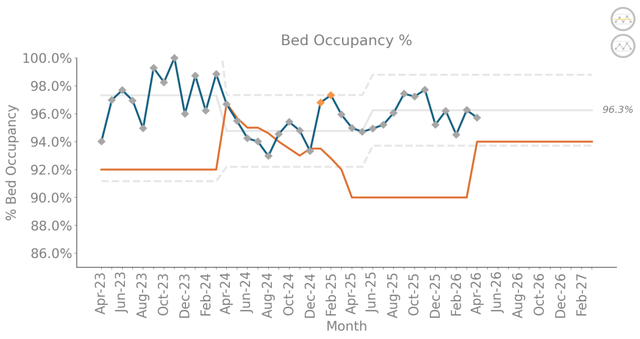
Latest
71.28%
Variance Type
Normal variation - no recent change
Mar 27 Target
82.00%
Target Achievement
Will consistently fail target within expected variation



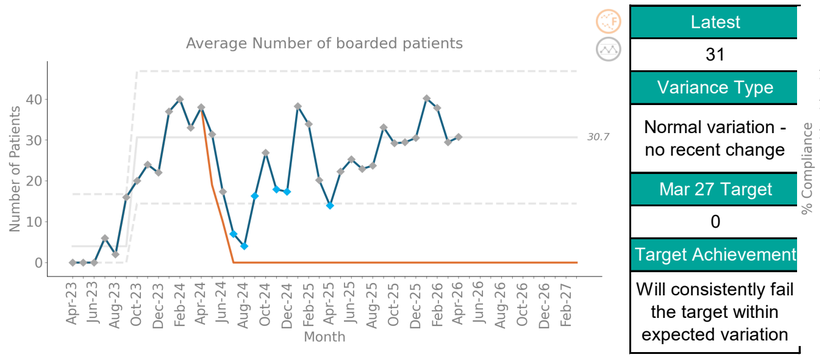
Latest
12.75%
Variance Type
Normal variation - no recent change
Mar 27 Target
10.50%
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
ED 4 Hour Performance - Trust	Performance against the national 4 hour access standard deteriorated slightly in April 2026. The performance improvement was -0.9% compared to March. Performance is above the Operational Plan target for Apr 26. April 26 experienced a higher daily attend than March 26 of approximately 17 per day.	Key actions include increasing 'Fit to Sit' practices, improving data capture with NWAS, and increasing flow out of ED via continuous flow 'cycles' every 30 mins to AMU. Workforce modelling undertaken with plans to better align rotas with demand from July 26. Scoping underway to implement Extended Emergency Medicine Ambulatory Care facility (national model) with Q2 implementation ambitions	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 April 26 of 76.9% and was ranked 90 out of 118 trusts nationally.
Maximum wait of 12 hours as Total Time in Department (Type 1 and 2)	The number of patients waiting over 12 hours (admitted and non-admitted Type 1 only) in ED increased in April to 12.75%, an increase of 0.04% compared to March. The position remains slightly above the revised Operational Improvement plan.	Work continues within the DKAFH programme. MADE event held in May 26 - learning informing changes to routine practice. Multi-agency Transfer of Care hub commenced 18th May 26 with trusted assessor practices supporting step-up admission into IMC. Anticipated 1 days LOS reduction for DKAFH patients in pathways 1-3. Target: lost bed days for optimised patients reduced to target by end March 27.	Overall Bed Occupancy was at 95.7% with a range between 92% - 97% over the last 12 months. The level of boarded patients increased in April with an average of 31 patients per day. The volume of Days Kept Away from Home patients is slightly below the revised operational plan target but is consistent with the same period in Apr 25 Comparison within Model Health System indicates the Trust is above the provider median and within Quartile 3.

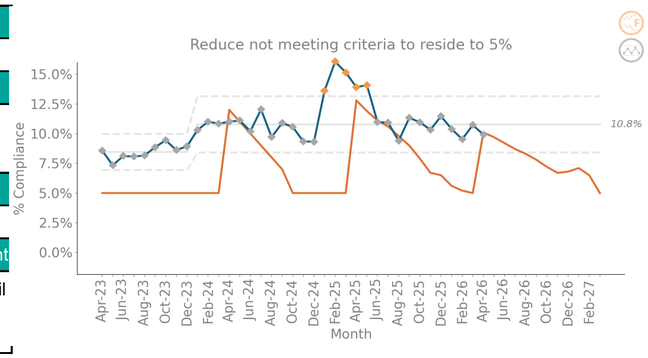
Performance - UEC Assurance



Latest
95.7%
Variance Type
Normal variation - no recent change
Mar 27 Target
94.0%
Target Achievement
Could both pass or fail target within expected variation



Latest
31
Variance Type
Normal variation - no recent change
Mar 27 Target
0
Target Achievement
Will consistently fail the target within expected variation

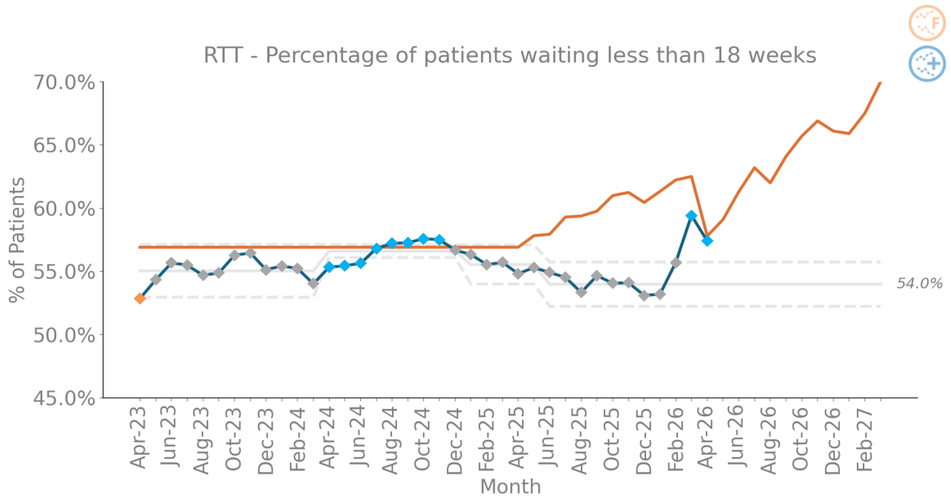


Latest
9.9%
Variance Type
Normal variation - no recent change
Mar 27 Target
5%
Target Achievement
Will consistently fail the target within expected variation

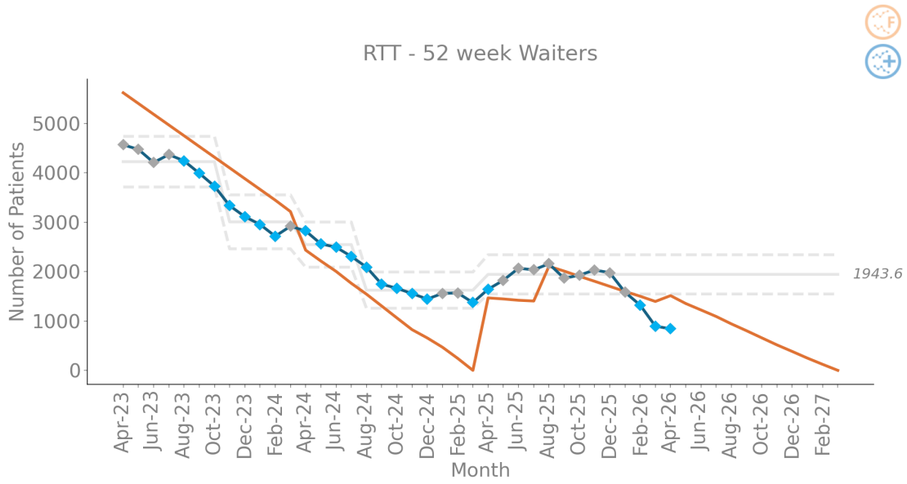
Metric	Summary	Action	Assurance
Bed occupancy %	The position shows an occupancy rate for April 26 of 95.7%, a drop of 0.6% compared to March 26. The data shows normal variation and will consistently fail the target.	Bed occupancy remains significant above target. Work continues linked to the DKAFH programme. A MADE event which took place in early May provided learning and is informing changes into routine practice to drive reduced bed days. A multi-agency Transfer of Care hub commenced on 18th May 26 with trusted assessor practices established to support step up admission into IMC. The anticipated impact is a 1 day LOS reduction for DKAFH patients in pathways 1-3. Continued work on Ward and Board round processes alongside DKAFH improvement roll out will aim to see lost bed days for optimised patients reduced to within target by end March 27.	Assurance via the Urgent Care Improvement Board and Urgent Care Improvement Plan
Average Number of Boarded Patients	On average 31 patients were boarded each day across both sites during April 26 with 922 associated bed days. This is a slight increase compared with the March 26 position. These are predominantly medical patients requiring admission to an acute medical ward. The position shows normal variance and will consistently fail the target within expected variation.	Work continues within the DKAFH programme with a MADE event taking place in early May and learning informing changes into routine practice to drive reduced bed days. A development of a multi-agency Transfer of Care hub commenced on 18th May 26 with trusted assessor practices established to support step up admission into IMC. The anticipated impact from the establishment of the Transfer of Care hub is a 1 day LOS reduction for DKAFH patients in pathways 1-3. This alongside continued work on Ward and Board round processes and continued DKAFH improvement roll out will aim to see lost bed days for optimised patients reduced to within target by end March 27.	Incident levels of harm are monitored on a monthly basis alongside patient feedback. UEC and In-patient survey feedback does reflect patient concerns regarding the practice of boarding. This is also reflected within the staff survey.
Reduce NMC2R to 5%	The number of patients in our hospitals that do not meet the nationally defined clinical criteria to reside for inpatient care in acute hospitals (NMCTR) decreased in April (9.9% = daily average of 85 patients). Compared to the March position this is a decrease of 0.8%. 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.		Monitoring of NMC2R data is undertaken via the Central Lancs Urgent Care Delivery Board

Performance - Elective Care Assurance

Lancashire Teaching Hospitals NHS Foundation Trust



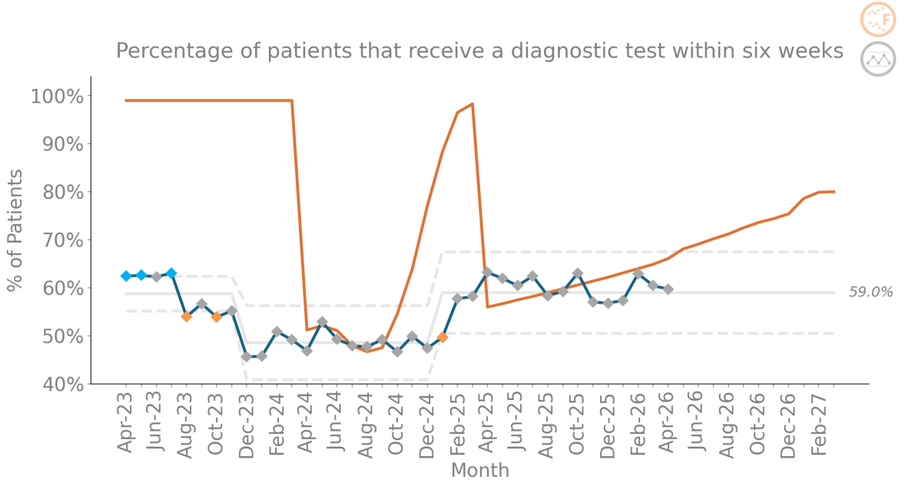
Latest
57.40%
Variance Type
Recent positive pattern in the data
Mar 27 Target
70.00%
Target Achievement
Will consistently fail target within expected variation



Latest
840
Variance Type
Recent positive pattern in the data
Mar 27 Target
0
Target Achievement
Will consistently fail target within expected variation

Metric	Summary	Action	Assurance
Percentage of patients waiting less than 18 weeks	The April 26 position of 57.4% is a 2% deterioration compared to March 26 %. Analysis suggests a recent positive pattern in the data and that the target will be consistently failed. The Operational Plan 2026/27 year end target has been set at 70%.	Ongoing work with digital partners to ensure capacity for ambitious PIFU rollout for constitutional standards and outpatient transformation. Additional activity mobilising via Independent Sector and WLIs. Internal business case undergoing Executive Check and Challenge. DNA rates reduced by 0.6% and theatre utilisation increased by 2.5% versus March 26.	Comparison to the latest national performance position (Mar 26) indicates that the Trust is below the national position of 65.3% waiting under 18 weeks. The Trust is ranked 107 out of 118 trusts nationally for Mar 26 performance.
RTT - 52 week Waiters	The over 52 week waiter position in April was 840, a further decrease of -56 compared to the March position. Analysis suggests a recent positive pattern in the data and that the target may be consistently failed.	Weekly 52 week breach reduction targets are in place for all specialties and is monitored at the weekly COO led Operations Board. Close monitoring of breach risks and capacity shortfalls are in place.	Local monitoring of all speciality RTT clock stop/performance is undertaken via the weekly Operational Board Comparison to the latest national performance position (Feb 26) indicates that the Trust at 1.4% is above the national picture which is 1.3% waiting over 52 weeks. The Trust was ranked 79 out of 118 trusts that submitted data for Mar 26 performance.

Performance - Elective Care Assurance

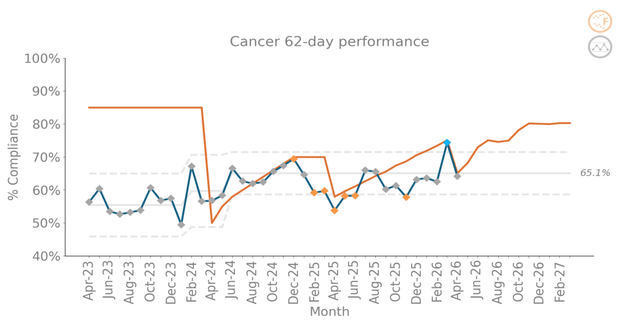


Latest
59.73%
Variance Type
Normal variation - no recent change
Mar 27 Target
80.00%
Target Achievement
Will consistently fail target within expected variation

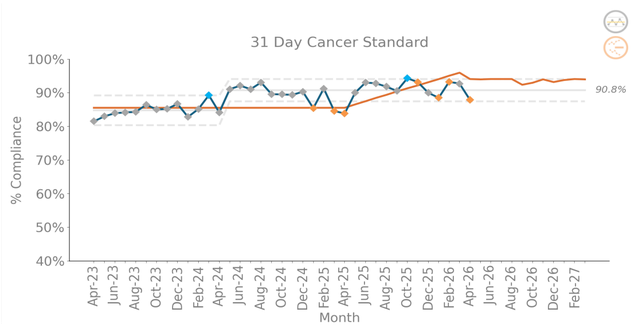
Metric	Summary	Action	Assurance
Percentage of patients that receive a diagnostic test within six weeks	Diagnostic under 6 week performance was 59.73% in April compared to 60.45% in March, a 0.7% deterioration on the March position and below trajectory. The performance has been driven by a deterioration in Audiology, NOUS, Sleep Studies. Urgent and cancer patients are prioritised and seen within 2 weeks. Performance shows normal variation but may consistently fail the target.	NOUS is the main driver of performance deficit. Additional capacity sourced via IS provider, mobilised mid-Feb 26. Internal colleagues undertaking additional work but shortfall remains. Capacity and demand modelling completed: resource case in development with alternative provisions being explored.	The areas of focus are capacity optimisation, productivity, transformation and system working. Review of the latest published data (Mar 26) indicates that LTH is 109th out of 117 trusts that submitted data, the worst performing Trust in the ICB and significantly below the national average of 78.8%.

Performance - Elective Care Assurance

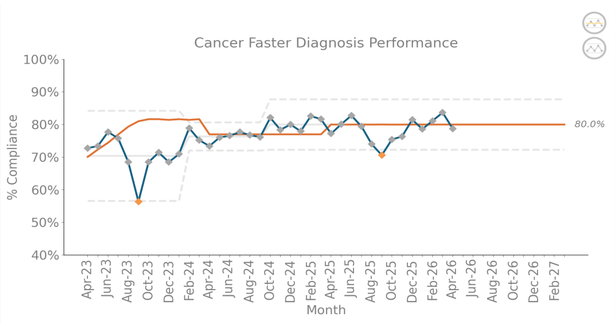
Lancashire Teaching Hospitals NHS Foundation Trust



Latest
64.20%
Variance Type
Normal variation - no recent change
Mar 27 Target
80.3%
Target Achievement
Will consistently fail target within expected variation



Latest
87.90%
Variance Type
Recent concerning pattern in the data
Mar 27 Target
94.0%
Target Achievement
Could both pass or fail target within expected variation

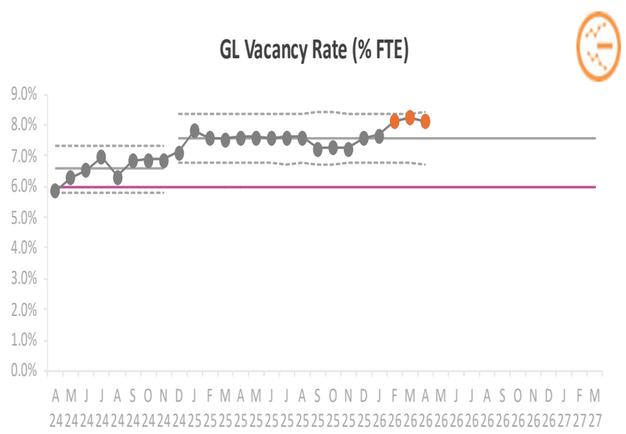


Latest
78.70%
Variance Type
Normal variation - no recent change
Mar 27 Target
80.0%
Target Achievement
Could both pass or fail target within expected variation

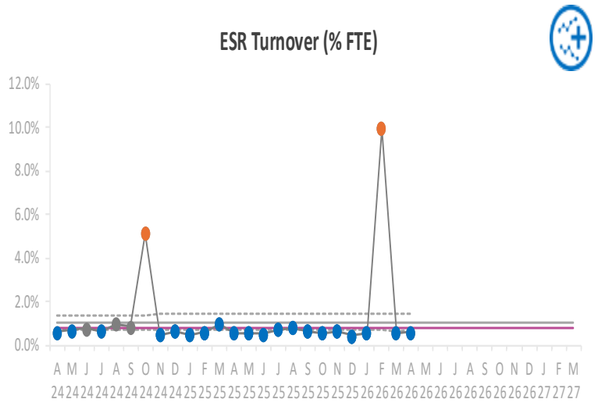
Metric	Summary	Action	Assurance
62 Day Cancer Standard	Performance to the end of April 26 (**currently unvalidated**) has deteriorated compared to last month, and is slightly below the revised monthly operational plan target of 65.1%. Analysis shows normal variation in the data and will consistently fail the target.	Whilst Cancer performance is improving there remains a close focus on individual tumour group improvement plans. Capacity and demand modelling has been completed for the majority of specialties. A Cancer dashboard is in development with the first specialty now live and plans are in place to roll out for all tumour groups by the end of September which will provide live information to inform improvement plans. A Trust wild PTL weekly review has been implemented to track patient pathways. A Reducing Sleepless Nights campaign to provide a core focus on the waits patients experience whilst on a cancer pathway has been launched.	March 26 performance exceeded target for 62-day ad FDS. Trust ranked in top quartile nationally. 18% improvement versus Apr 25 in 62-day performance. 5th largest year-on-year improvement nationally.
31 Day Cancer Standard	Performance to the end of April 26 (**currently unvalidated**) is below last months position, and below the monthly operational plan target of 94.1%, however is expected to improve once validation is complete. Analysis shows a recent concerning pattern in the data and could both pass or fail the target within expected variation.		31 day Decision to Treat performance a focus this year, with the requirement to reach 94% by the end of this year and then achieve 96% Operational standard in the following year. The Trust's latest position for this standard is 93.3%, having made a 7.5% points year on year improvement over the last year, putting the Trust in a strong position to achieve this years 94% target.
Cancer Faster Diagnosis Performance	Performance to the end of April 26 (**currently unvalidated**) is below last months position, and just below 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.		Faster Diagnosis Standard performance is 83.5% with the year end target of 80% achieved, and performance nearly 2% points higher than a year ago. The Trust is in the top quartile nationally ranking 28th/118.

People - Workforce Assurance 1

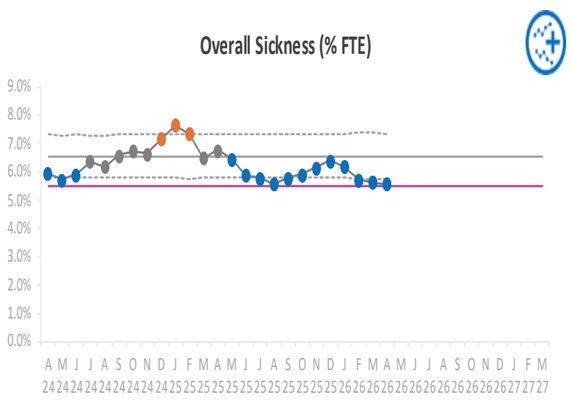
Lancashire Teaching Hospitals NHS Foundation Trust



Latest
8.13%
Variance Type
Recent concerning pattern in the data
Mar 27 Target
≤ 6%
Target Achievement
Will consistently fail target within expected variation



Latest
0.62%
Variance Type
Recent positive pattern in the data
Mar 27 Target
≤ 10%
Target Achievement
Could both pass or fail target within expected variation



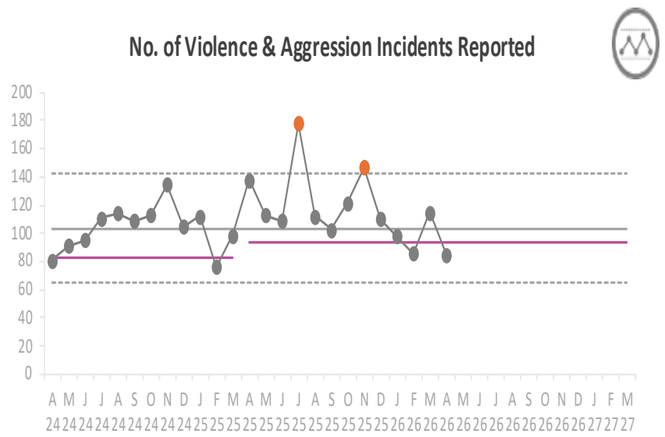
Latest
5.57%
Variance Type
Recent positive pattern in the data
Mar 27 Target
≤ 5.5%
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
Vacancies (% FTE)	Vacancy rate remains high due to vacancy control measures and is not currently scored from a Divisional Improvement Forum perspective.	Divisional management teams reviewing all long-standing vacancies enabling cleansing of establishments Strategies to address Band 3 Healthcare Support Worker gaps being jointly developed by nursing, education and workforce teams Vacancy control process updated to include defined times for holding posts for redeployment and internal/external advertising. Internal first approach to advertising vacancies.	Vacancy rate monitored through Board reporting, Workforce Committee and Divisional Improvement Forums Safe staffing levels monitored daily in clinical areas New People Operations Group to include a focus on resourcing EQIA process utilised to support vacancy control decision-making
Turnover (% FTE)	Turnover remains stable and below tolerance level at 0.62%. Spike in turnover in M11 was due to F&E TUPE.	To refresh strategic actions relating to turnover, which will include a focus on turnover in HCAs, understanding workplace motivators and retention needs based on generational and career point stages. To increase scrutiny of probationary process.	Annual retention strategy update report provided to Workforce Committee. Delivery of retention strategic action plan at corporate level, working with Divisions, Departments and Teams to support improvement in hot spot areas.
Sickness Absence (% FTE)	Sickness absence has reduced in M1 to 5.57% just slightly over our 5.5% target.	The Sickness Absence Reduction Plan has been refreshed for 2026/27, focusing on key actions in the domains of Data, Education, Policy and Process and Wellbeing. Following a reduction in the annualised sickness absence rate of 0.54% for 2025/26, the focus is now on the interventions that will support a further reduction of 0.5% for 2026/27.	Twice yearly assurance reports to Workforce Committee Actions resulting from the MIAA Sickness Absence Management audit monitored through Audit Committee 'Failure to manage sickness absence management effectively' is a Principal Risk and subject to monthly risk management review Fortnightly sickness absence task and finish group in place to monitor actions of the sickness absence reduction plan Paper to May TMB outlined actions completed, ongoing or newly developed.

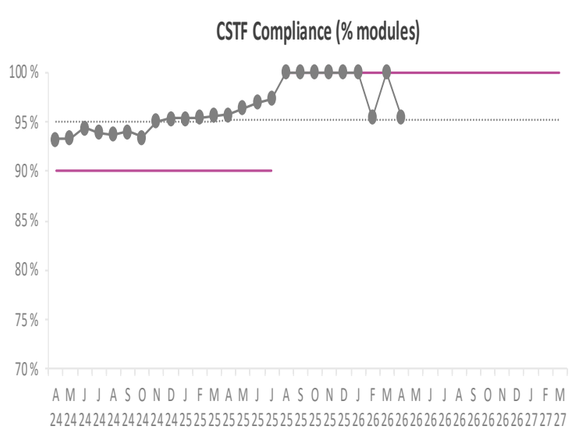
People - Workforce Assurance 2

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

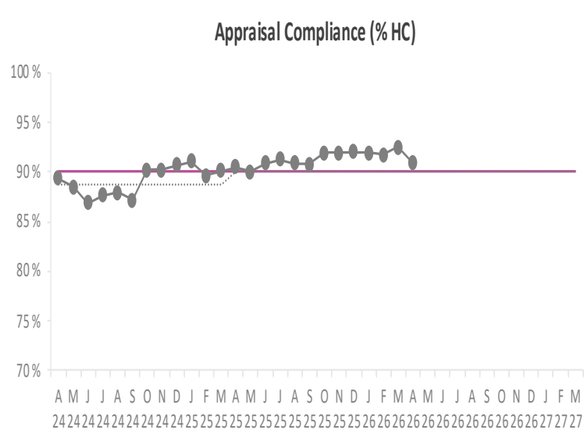
NHS Lancashire Teaching Hospitals NHS Foundation Trust



Latest
85
Variance Type
Normal variation - no recent change
Mar 27 Target
NA
Target Achievement
Could both pass or fail target within expected variation



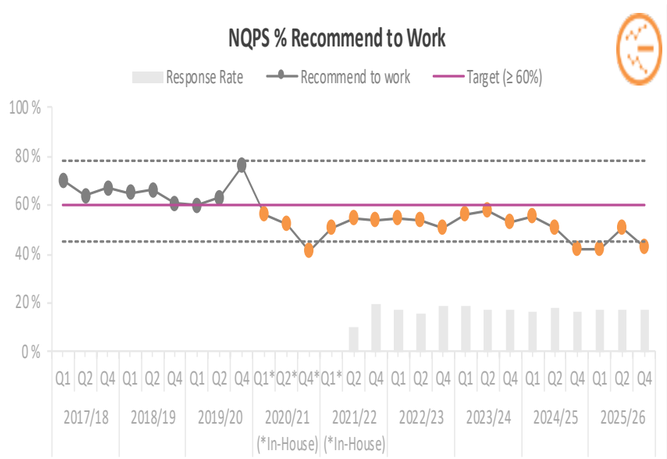
Latest
95.45%
Variance Type
Mar 27 Target
100% of metrics at 90%
Target Achievement



Latest
90.92%
Variance Type
Mar 27 Target
≥ 90%
Target Achievement

Metric	Summary	Action	Assurance
Number of violence and aggression incidents toward staff	Violence and aggression incidents have reduced in month.		Twice-yearly deep dive reports around incidents and actions to Workforce Committee Incident data reviewed through Health & Safety Governance Group
Core Skills Mandatory Training compliance (% modules)	Overall Trustwide Core Skills and Mandatory training compliance is 95.45%	Bi-weekly weekly grip and control meetings are supporting targeted work to ensure those areas of non-compliance are supported to achieve the requirements. Non-compliant staff receive weekly email reminders. Divisional performance is presented by professional group in divisional workforce committees.	Trustwide compliance is meeting the 90% threshold in all core skills and nationally mandated metrics.
Appraisal compliance (% HC)	Appraisal compliance was 90.92% in April which is above the target of 90%.	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 2026. Divisional Performance metrics shared in Divisional Workforce Committees and Divisional Improvement Forums.

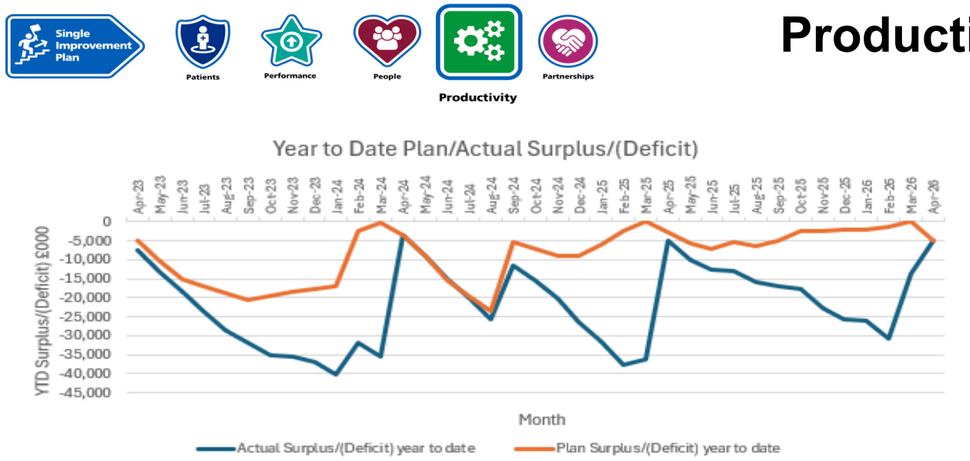
People - Workforce Assurance 3



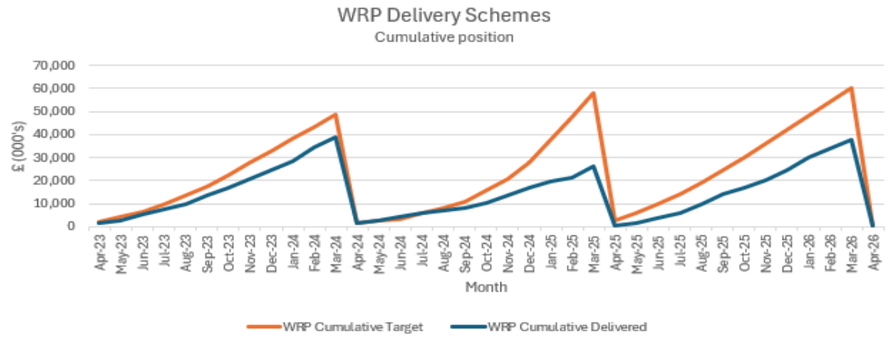
Latest
42.5%
Variance Type
Recent concerning pattern in the data
Mar 27 Target
≥ 60%
Target Achievement
Will consistently fail target within expected variation

Metric	Summary	Action	Assurance
Staff Survey: Recommend Trust as place to work	**Please note: This is a quarterly metric; therefore, there is no update this month.** Levels of advocacy with regards to recommending the organisation as a place to work and be cared for has further declined.	To further implement and embed Staff Engagement Proposal and demonstrate / communicate visible action taken in response to colleague voice. Organisation wide and divisional level action plans have been developed and presented to Workforce Committee in May 2026.	Workforce Committee reports detailing the programme of work in response to NHS Staff Survey data and national benchmarking. Delivery of the corporate action plan progressed through collaboration with relevant teams and leads addressing priorities/themes. Divisional action plans are scheduled for monthly review through Divisional Workforce Committees - frequency and depth of reporting varies across Divisions. Enhanced team support activity is ongoing in targeted areas of concern, with progress tracked and reviewed through Organisational Development operational meetings.

Productivity - Assurance



Latest YTD Actual (,000s)
-4,941
Latest YTD Target (,000s)
-4,938
April 26 YTD Target (,000s)
-



Latest YTD Actual (,000s)
446
Latest YTD Target (,000s)
450
April 26 YTD Target (,000s)
60,000

Metric	Summary	Action	Assurance
I&E - Plan v Actual variance	The M1 income and expenditure actual was a £4.9m deficit which is in line with the NHSE Financial Plan. WRP delivery was on plan at £0.5m delivered. The underlying position improvement as at M1 was £2.1m. The financial impact of industrial action in M1 has been assessed at £0.8m, which has been fully mitigated by the transfer of vacancies within the Pathology Single service and a reduction in pay run rate across clinical divisions.	A re-set of the programme structure, governance and reporting for 2026/27 has taken place, including the introduction of the Productivity Board. The system is receiving enhanced support from NHSE as part of the provider improvement programme (formerly recovery support programme). A focus on grip and control activities continues. The Trust commissioned further external support for specific financial recovery plan workstreams and 2026/27 waste recovery programme development.	Grip and control Interventions and control measures Mandated national support from PWC and the Provider Improvement Programme (formerly Recovery Support Programme)
WRP schemes delivery	The Trust's 2026/27 waste reduction target is £60m, 5.7% of operating expenditure. M1 WRP delivery was £0.5m which is in line with the NHSE Financial Plan of £0.5m. However, the full WRP Plan of £60m has not yet been fully developed and if not developed and delivered will present a risk to the delivery of the 2026/27 financial plan.	Have a fully developed WRP Plan by the end of May 2026 in line with the commitment made to the regulator. Good progress is being made towards achieving this. The Trust is now embedding its own project management office structure to have a sustainable solution moving forward. The Trust has enhanced grip and control activities to mitigate slippage in schemes. For 2026/27 the Trust has implemented its Financial Sustainability Plan with areas aligned to Executive Leads, earlier planning and a focus on sustainable expenditure reduction rather than short term benefits.	Productivity board chaired by CFO External support for specific workstreams. Implementation of Divisional Delivery Groups Embedding of PMO Revised governance arrangements for DDGs

7.2 UPDATE FROM CARE AND SAFETY SUBGROUP

Information Item | G Bailey | 10:55am

Verbal update

7.3 UPDATE FROM MEMBERSHIP SUBGROUP

Information Item | S Brennan | 11:05am

Verbal update

8. SAFETY, QUALITY, WORKFORCE AND PERFORMANCE?

8.1 PATIENT EXPERIENCE AND INVOLVEMENT ANNUAL REPORT?

Information Item | J Howles | 11:15am

REFERENCES

Only PDFs are attached

8.1 Annual Patient Experience Report - COG 23 July 2026.pdf

Council of Governors Report

Meeting of the	**Council of Governors**		**23 July 2026**
	Part I ☒		**Part II** ☐
Title of Report	**Patient Experience, Involvement and Engagement annual report**		
Report Author	John Howles – Associate Director Quality, Experience and Engagement		
Lead Executive Director	Sarah Morrison, Chief Nursing Officer		
Recommendation/ Actions required	The Council is asked to: I. Receive the report and take assurance that robust arrangements are in place to capture, triangulate and act on patient experience intelligence, and that patient voice is effectively embedded within governance, quality improvement and risk management processes across the Trust II. Endorse the continued focus within the Single Improvement Plan on strengthening communication reliability at key points of the patient journey (including delays, discharge and transitions of care), recognising communication as the primary driver of patient experience, complaint escalation and emotional wellbeing.		
	Decision ☐	**Assurance** ☐	**Information** ☒
Executive Summary	This report provides Board assurance that the Trust's arrangements for capturing, triangulating and acting on patient experience intelligence are effective and are delivering measurable improvement in several priority areas during 2025/26. Quantitative outcomes show a mixed but overall improving picture. • The Trust received 329 formal complaints in 2025/26, four more than in 2024/25, but the complaints rate improved against rising activity, with the ratio of complaints to patient contacts improving from 1:2,825 to 1:2,896. • Complaint responsiveness also improved, with 81% of complainants receiving a response within the agreed 35- or 60-day timescale and 94% of complaints acknowledged within three working days. In addition, the Patient Experience and PALS Team managed 1,654 concerns and 4,739 enquiries, demonstrating sustained demand for responsive patient support. • The volume of patient feedback increased materially during the year. Friends and Family Test responses rose from 65,480 to 69,035, an increase of 3,555 responses (5.43%), providing a broader evidence base for improvement. • Compliments increased by 20% to 8,230, and Care Opinion recorded 39 reviews, of which 29 were positive. Together, these indicators show both high engagement and continued recognition of compassionate care despite sustained operational pressure. • National survey outcomes provide further assurance. ○ In the 2025 Maternity Survey, the Trust improved significantly in four areas, with no areas significantly worse, and rose to 13th of 55 Trusts, from 15th of 56 in 2024. Positive ratings were high,		

	including 98% for overall care, 97% for dignity and respect during labour and birth, and 98% for confidence and trust in staff. ○ In the 2025 National Cancer Patient Experience Survey, the Trust sustained an overall score of 9.0/10, above the national average, with a 53% response rate and feedback from 796 patients, the largest sample in the region. ○ The 2024 Inpatient Survey showed no significant improvement areas and three domains somewhat worse than expected, confirming that inpatient environment, involvement in decisions and overall experience remain priorities. ○ The 2024 Children and Young People's Survey showed most ratings were reported as about the same as other Trusts, indicating a broadly average position with clear scope for further improvement. • The report also evidences progress in involvement and inclusive improvement. Volunteer Services deployed 316 active volunteers who recorded 9,846 hours, with over 150 new volunteers recruited during the year. The Patient Information Group produced 63 new leaflets and reviewed 120 existing leaflets. • However, the report also confirms that assurance is weaker for some underserved groups: FFT demographic data shows women accounted for 60% of respondents compared with 34% men, while 85% of respondents identified as White and only 8% came from minority ethnic groups, highlighting the need for more targeted engagement and equity-focused improvement. Overall, the report demonstrates measurable progress in responsiveness, feedback reach, maternity experience, cancer experience and co-produced service improvement. It also confirms that communication, waiting pressures, care environment and health inequalities remain the principal drivers of patient experience risk and therefore the main focus of the Single Improvement Plan for 2026/27.	
Link to Strategic Objectives 2026/27	**Patients – deliver excellent care:** Improve outcomes, reduce harm and deliver a positive patient experience.	☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.	☒
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.	☒
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.	☐
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.	☐
Due Diligence	To give the Council assurance, please complete the following:	
Committee Approval:	Safety and Quality Committee	Date: 29 May 2026
Operational Group Review:	Patient and Carer Experience and Involvement Group	Date: 28 April 2026
Link to Board Assurance Framework:	Principal Risk 1 (26/27) - Patient safety and experience within the urgent and emergency care pathway	
Appendices	Appendix 1: Complaints data Appendix 2: Friends and Family Test data Appendix 3: Care Opinion feedback Appendix 4: Age, sex and ethnicity data Appendix 5: Divisional thematic review of complaints and feedback	

1. Background

This report provides assurance on the Trust's arrangements for capturing, triangulating and acting on patient experience intelligence during 2025/26, and highlights the key areas of progress, risk and priority action.

Evidence from complaints, FFT, surveys, patient stories and involvement activity shows improvement in several areas, while confirming that communication, waiting pressures and equity of access remain the main drivers of risk.

The report therefore focuses on the outcomes achieved, the areas where assurance is strongest, and the targeted actions being taken through the Single Improvement Plan where improvement remains required.

The annual report also provides assurance on the Trust's performance against key patient experience and involvement indicators, including complaints, response quality, Friends and Family Test results, patient surveys and compliments. Delivering care for and with patients strengthens outcomes and supports a model of care that is more efficient, productive and cost-effective.

Oversight of the strategy and its associated performance measures is maintained through the Patient, Carer Experience and Involvement Group (PCEIG), which provides a monthly Chair's Escalation Report to the Safety and Quality Committee. This ensures strong governance, transparency and continued scrutiny of progress.

2. Discussion

Together, this evidence provides a clear line of sight from feedback to action, supported by governance through the Patient, Carer Experience and Involvement Group and escalation to the Safety and Quality Committee.

The Patient Experience and Involvement approach has set a clear expectation across the Trust to listen more deeply and act on what patients and families tell us, whether their experiences are positive or reflect areas needing improvement. In shaping the strategy, we engaged patients, relatives, carers, colleagues, governors and partner organisations. We also actively sought feedback from groups representing people with protected characteristics and recognised the importance of intersectionality in interpreting and responding to their experiences.

Patient Experience and Involvement is strongly aligned with other key Trust strategies, including Equality, Diversity and Inclusion, Mental Health, Learning Disability, Dementia and Autism. This work will now be embedded within the developing Single Improvement Plan, further strengthening the role of patient voice in driving improvement across all aspects of care.

2.1. Assurances

Quantitative feedback

Complaints and Concerns (Appendix 1)

During 2025/26, the Trust received 329 formal complaints, an increase of four complaints (1.23%) compared with 2024/25. Although volume rose slightly, the overall complaints rate continued to improve when considered against patient activity, indicating that complaint growth has not kept pace with rising demand. Response timeliness also improved, with 81% of complainants receiving a response within the locally agreed 35- or 60-day timescale by year end. This represents important

progress in responsiveness and supports a better patient experience, even though further improvement is still required.

Complaints received during the year were noted to be increasingly complex. The ratio of complaints to patient contacts over the past three years is detailed in the table below. Of the 329 complaints received between April 2025 and March 2026, 289 (88%) related to care or services provided at Royal Preston Hospital and 40 (12%) related to Chorley and South Ribble Hospital. All complaints were received within the 12-month timescale set out in the NHS Complaints Procedure.

During the financial year, 253 complaints were closed. Of these, 14 (5.5%) were upheld, 154 (60%) were partly upheld, and 72 (28%) were not upheld. A further 15 cases (6.5%) were rejected as they were more appropriately managed through alternative processes rather than the formal complaints route. In addition, nine second letters were received during the year, reflecting ongoing dissatisfaction or requests for further clarification following the initial response.

In line with NHS Complaints Regulations, complaints should be acknowledged within three working days of receipt. During the reporting period, 94% of complaints received by the Patient Experience and PALS Team were formally acknowledged within this timeframe. All complainants received either verbal or email acknowledgement, with the 94% figure reflecting the point at which cases were opened on the Ulysses Governance system and the case manager made direct contact. Alongside complaint handling, the Patient Experience and PALS Team managed 1,654 concerns and responded to 4,739 enquiries during the year, demonstrating continued high levels of demand across patient experience services.

Top 3 themes from complaints by division:

- **Diagnostic and Clinical Support**
  Feedback relating to Diagnostic and Clinical Support focuses on treatment and procedures, clinical assessments, and diagnostic processes.
- **Women and Children**
  For Women and Children's services, feedback centres on treatment and procedures, communication, and staff behaviour, including diagnosis and clinical assessment.
- **Medicine**
  Within Medicine, key themes include appointments, communication, and treatment or procedures.
- **Surgery**
  In Surgical services, feedback most commonly relates to treatment and procedures, communication, and appointments.

Friends and Family (Appendix 2)

The Friends and Family Test (FFT) is used as a national measure to assess whether patients would recommend Trust services to their friends and family. National reporting requirements cover Maternity, Day Case, Outpatients, Inpatients, and the Emergency Department. The Trust target is for 90% of respondents to recommend services across all areas, with the exception of the Emergency Department where a target of 85% applies. During 2025/26, Day Case and Outpatient services consistently exceeded the 90% target in all four quarters. Maternity services did not meet the target throughout the year, while Inpatients and the Emergency Department remained below target across all quarters, although inpatient performance showed sustained improvement quarter on quarter.

Although not a national requirement, the Trust also undertakes Friends and Family surveys within Children and Young People's Services to ensure an equitable approach to measuring patient experience. Feedback indicates that children and young people accessing urgent and emergency pathways reported less favourable experiences, while Day Case and Outpatient services demonstrated more positive performance, with inpatient services showing signs of improvement. The Neonatal Service maintained a consistently high level of performance, achieving a sustained recommendation rate of 100% throughout the year.

Overall, the data demonstrates both improved reach and stronger engagement with feedback processes. During 2025/26, the Trust received 69,035 FFT responses, an increase of 3,555 compared with 2024/25, representing year-on-year growth of 5.43%. This increase provides a broader evidence base for understanding patient experience and suggests that efforts to widen access to feedback through paper, online and SMS methods are having a positive effect.

Staff continue to actively encourage patients to complete FFT feedback prior to leaving hospital, which has supported increased completion of paper surveys. Ongoing staff training ensures effective use of the FFT system, and patient experience boards are regularly updated with "You said, we did" information and relevant reports generated through CIVICA. FFT performance and resulting improvement actions are monitored through the Safety and Quality Committee, with monthly reports shared with governance and divisional leads to ensure feedback is reviewed, acted upon, and communicated consistently across the Trust.

The Parliamentary Health Service Ombudsman (PHSO)

Complainants have the right to request that the Parliamentary and Health Services Ombudsman (PHSO) undertakes an independent review into their complaint in instances where local resolution has not been achieved. Between the period 1st April 2025 to 31st March 2026 there were 4 cases referred to the PHSO; 2 are ongoing, and 1 was partly upheld, and 1 was not upheld.

During this period, the PHSO sent final reports for 4 cases which were opened prior to April 2025 and the outcome of these were that all 4 were partially upheld.

Compliments

The Trust receives formal and informal compliments from patients and their families in relation to their experience of care. During 2025/26 a total of 8,230 compliments and thank you cards were received by wards, departments and through the Chief Executive's Office. There has been a 20% increase in the number of compliments received this year. Departments are being encouraged to actively log compliments on the Ulysses system which has its own module for this purpose. This provides teams with the opportunity to celebrate success locally and as part of their wider teams and divisions. The results from divisional compliments are now published monthly in the Trust Communications and discussed as part of divisional meetings.

Care Opinion Website (Appendix 3)

During the past financial year there have been a total of 39 reviews posted on the Care Opinion website relating to care and treatment at Lancashire Teaching Hospitals NHS Foundation Trust. These have consisted of 29 compliments and 9 concerns and 1 that has provided both concerns and compliments.

National Patient Survey Result
Maternity Survey 2025
The survey invited responses from mothers who received care during April and July 2025. Compared with the 2024 survey, Lancashire Teaching Hospitals improved significantly in four areas, with no areas identified as significantly worse. The service is now ranked 13th out of 55 Trusts surveyed by Picker, improving from 15th out of 56 in 2024. This demonstrates sustained progress in maternity experience and provides strong assurance that targeted improvement work is translating into better reported care.

A total of 89 questions were included in the 2025 survey, of which 58 were comparable with the previous 2024 survey. Overall, Lancashire Teaching Hospitals has improved its position. Mothers reported very positive experiences, with 98% rating their overall care positively, 97% feeling treated with respect and dignity during labour and birth, 98% expressing confidence and trust in staff, and 98% feeling involved in decisions about their care during labour and birth.

Based on the Care Quality Commission (CQC) published data the Trust showed substantial positive movement across several core patient experience indicators when compared with the 2024 CQC Maternity Survey and show year on year improvements.

Inpatient Survey 2024 (Published September 2025)
The survey is based on a sample of inpatients during January and April 2024. A total of 1250 patients from Lancashire Teaching Hospitals were randomly selected to take part in the survey. 1200 patients were eligible for the survey, of which 450 returned a completed questionnaire, giving a response rate of 38%. This is a 2% decrease on the 2023 survey. The average response rate for the 64 'Picker' trusts in 2024 was 41%.

A total of 63 questions were used in the 2024 survey, of these 45 questions were asked in the 2023 survey. Compared to the 2023 survey, Lancashire Teaching Hospitals has significantly improved in 0 areas, with 1 area identified as significantly worse in 2023, 40 areas show no significant difference. Overall comparison of the 131 Trusts surveyed shows that 8 areas were 'about the same as other NHS Trusts including: admission to hospital; basic needs; doctors; nurses; virtual wards; leaving hospital; kindness and compassion and respect and dignity. 3 areas were (1) 'somewhat worse than expected including: the hospital and ward, specifically room temperature and sleep at night. (2) Care and treatment, specifically involvement in decisions. (3) Overall experience, specifically feeling that they had a very good experience.

Based on the Care Quality Commission (CQC) published data the Trust shows measurable improvements in several areas between the 2023 and 2024 inpatient surveys. The improvement is not uniform, some areas remain unchanged or still below the national averages. The CQC's benchmarking report explicitly includes change over time analysis, confirming that the Trust's scores have moved positively in multiple domains.

National Cancer Survey 2025
The 2025 National Cancer Patient Experience Survey shows that Lancashire Teaching Hospitals continues to deliver strong, patient-centred cancer care. The Trust sustained an overall rating of 9.0/10, above the national average, and with a 53% response rate received feedback from 796 patients, the largest sample in the region. This provides a robust evidence base and demonstrates consistently strong performance across personalised care, care planning, radiotherapy information, teamworking and the availability of a reliable main point of contact.

Several tumour groups, particularly Brain, Colorectal, Head & Neck and Prostate, scored above expected national ranges. Areas requiring focused improvement include discharge information, immunotherapy information, clarity about chemotherapy response, primary care support, and inpatient experience in Breast, Colorectal and Lung pathways.

Engagement from minority ethnic groups remains low, with targeted community outreach under way. Workforce pressures in areas such as Lung services continue to pose risks, alongside rising patient demand. A comprehensive action plan is in place covering communication, personalised care, tumour-specific improvements, health inequalities and GP engagement and will be monitored through established governance groups to ensure continued improvement and assurance in patient experience.

Children and Young People's Survey 2024 (Published May 2025)
The survey is based on a sample of inpatients during March and May 2024. A total of 1250 patients from Lancashire Teaching Hospitals were randomly selected to take part in the survey. 1239 patients were eligible for the survey, of which 239 returned a completed questionnaire, giving a response rate of 19%. The average response rate for the 54 'Picker' trusts in 2024 was 22%.

The last survey was carried out in 2020 and since then the Care Quality Commission (CQC) have implemented several changes:

- Timing of the survey - to reflect variations in people's feelings, situations and the healthcare environment throughout the year.
- Methodology – The 2020 survey collected responses only on paper. In 2024, patients could respond via paper or online, with SMS text reminders introduced.
- Survey content – The CQC has reassessed the survey and made a number of changes to the content to reflect changing priorities in children and young people's healthcare.

Lancashire Teaching Hospitals is ranked 43rd out of the 54 Trusts surveyed by Picker. Due to the change in sample period, data collection period, methodology and content the survey is not comparable to previous years.

Based on the Care Quality Commission (CQC) we cannot compare the 2020 survey with the information in the 2024 survey due to the significant changes, most ratings were 'About the Same' compared to other Trusts.

Qualitative patient feedback

Board Patient Stories
Board patient stories continued to show that compassionate, timely communication and coordinated care improve confidence and reduce anxiety, while delays, poor transitions and pressured environments weaken experience. In response, the Trust has strengthened escalation, discharge and personalised-care arrangements, demonstrating that patient stories are informing service change as well as assurance.

Person-centred approaches focused on what matters most to individuals consistently improved confidence and reduced anxiety. A strong theme across all stories was the role of families as partners in care, whether advocating, supporting decision-making or helping staff understand patient needs. In response to the issues raised, the Trust has strengthened escalation pathways, increased senior oversight of care environments, advanced work on discharge processes, and

continued to embed personalised and coordinated care. These changes demonstrate how patient stories are being translated into practical improvements rather than being used for reflection alone.

Complaints Learning Overview

The complaints review confirms that communication remains the main cause of dissatisfaction, particularly around delays, discharge, expectations and cross-agency coordination. Improvement activity has therefore focused on clearer written responses, better expectation setting, proactive updates and stronger organisational learning so that themes are translated into measurable service change.

Timeliness also remains a recurring theme in formal complaints. While internal teams generally meet response standards, significant delays occur when complaints require joint input from partner agencies such as the ICB or social care. These delays can extend the investigation period by several months, during which patients may feel forgotten or ignored despite work progressing behind the scenes. A key learning point this year has been the importance of offering proactive updates, even when no new developments are available, as the absence of communication is often interpreted as a lack of care. The review also shows that early clinical engagement, or local resolution, is highly effective in resolving concerns informally; however, this early contact must be followed by a timely and structured written response to ensure closure and clearly articulate the learning achieved.

Expectation management is another significant area for improvement. Complaints often arise when patients or families feel unprepared for waiting times, theatre cancellations, emergency department pressures or the complexity of discharge processes involving social care. Many patients do not fully understand the wider system pressures influencing their experience, which can lead to frustration and dissatisfaction. Providing more comprehensive explanations up front, ensuring consistent messaging across different teams and offering written summaries following key discussions would help patients feel more informed and reduce avoidable concerns.

The review also shows that inter-agency coordination has a substantial impact on both the timeliness and quality of complaint handling, particularly where discharge is involved. Patients often describe confusion caused by unclear roles, inconsistent information or delays linked to communication between hospital teams and social care partners. Strengthening relationships, clarifying escalation pathways and improving shared communication tools would support a more seamless approach and reduce complaints that arise from cross-boundary working.

Another important learning theme relates to how the organisation captures and shares learning from complaints. While specialties frequently take corrective action, this learning is not always shared consistently across the Trust. Some complaint responses refer to reflection or insight gained without describing the tangible changes made as a result. The Trust's New Always Safety First Plan reinforces the need for a robust, systematic process to capture learning, disseminate it effectively and evidence resulting improvements, ensuring that these changes are embedded and sustained in practice.

Several improvements have already been implemented to strengthen complaint learning and assurance. Enhancing communication has been a central priority, supported by the development of a clear Trust-wide template for complaint performa that promotes empathy, clarity and a consistent approach to ensuring we capture what patients and families require. Standardised scripts have been introduced to support staff during challenging conversations, especially when discussing delays, cancellations or discharge arrangements, helping to reduce variation in the

information patients receive. The Trust has also strengthened its expectation setting tools through written leaflets and short videos that explain what patients can expect during a hospital stay, helping them better understand their journey and reducing uncertainty. Additional work has focused on improving inter-agency discharge pathways, clarifying named contacts, reinforcing accurate documentation and embedding organisational learning more effectively.

Across all reporting periods, patients consistently praised the compassion, professionalism and dedication of staff. Many described staff as kind, caring and attentive, emphasising that they felt listened to, respected and reassured during vulnerable moments. Named staff and teams appeared regularly in feedback, demonstrating the powerful personal impact of compassionate interactions. This positive feedback remained consistent throughout the year, even during periods of heightened operational pressure.

Despite these strengths, patient accounts also highlighted several persistent challenges that shaped their experiences. Prolonged waiting times were a dominant theme, especially in emergency care, while waiting for a ward bed and during diagnostic and discharge processes. Some patients reported spending long periods in chairs or corridors, including overnight stays, which contributed to discomfort and anxiety. These waits were often compounded by inconsistent communication or a lack of updates, leaving patients uncertain about what was happening and what to expect next. Communication gaps whether related to treatment plans, test results or discharge arrangements regularly influenced how safe, supported and informed patients felt.

Environmental conditions also played a major role in patient experience. Many patients described excessive heat on wards and in waiting areas, lack of air flow, noise, overcrowding and limited seating, all of which were particularly difficult for those waiting for extended periods. Feedback on food quality was mixed: while some patients were satisfied, others reported cold food, missed meals and difficulties related to dietary, cultural or religious requirements. Several patients from the Asian Elders community highlighted instances of inappropriate or non-halal food being provided, indicating a need to improve catering practices and cultural sensitivity.

The ongoing challenges relating to health inequalities and inclusion with Feedback from the Deaf community highlighted barriers to communication, particularly the inconsistent availability of qualified BSL interpreters. Deaf patients stressed the importance of having interpreters available throughout their care journey, not only at key moments, and described the distress caused when these needs were not met. These findings align with broader system work across the Trust to strengthen Deaf awareness, improve interpreter access and explore the introduction of mandatory Deaf awareness training. Engagement with culturally diverse groups, including the Preston Muslim Forum and the Grannies Support Group, also reinforced the importance of meeting cultural and religious needs consistently. Some patients emphasised the importance of halal food, prayer spaces with qibla signs on the ceiling, and the update in policy for female clinicians for intimate care. Several patients described experiences that compromised their privacy or dignity, including being treated in crowded environments or being examined by clinicians of the opposite sex despite expressing discomfort.

Feedback from children and young people showed high levels of emotional safety and satisfaction, with 97% reporting a positive experience and all respondents agreeing that staff were caring and supportive. Children frequently commented on staff friendliness and the reassurance they received. However, the feedback also suggests opportunities to improve support during stressful events, provide clearer explanations using age-appropriate language and strengthen discharge communication, particularly for young people with mental health or emotional needs. Long waits

and overstimulating environments, such as noisy emergency departments, contributed to distress for some children, particularly those with autism, sensory needs or dysregulated behaviour.

Across both adult and paediatric services, psychological wellbeing emerged as a critical component of the overall patient experience. Many individuals reported feeling anxious or overwhelmed during long waits or periods of uncertainty. In some cases, poor communication or dismissive interactions amplified emotional distress. Conversely, small acts of empathy such as clear explanations, a calm tone, eye contact or acknowledging feelings were repeatedly highlighted as helping to reduce anxiety and build trust. These insights reinforce the importance of trauma-informed and psychologically aware care, particularly in high-pressure environments such as ED and surgical assessment unit.

While compassionate interpersonal care remains a core strength across the Trust, systemic pressures linked to capacity, flow, communication and environment continue to shape patient experience. Continuing to Strengthen communication reliability, improving waiting environments, embedding trauma informed practice and ensuring equitable, culturally sensitive care will all be essential to improving patient outcomes, satisfaction and wellbeing. These insights are the essentials of the Single Improvement Plan for patients and reinforce the importance of placing patient voices at the heart of service design and delivery.

2.2. Involvement and Co-Production

The Trust's involvement and co-production work has expanded its reach into local communities and strengthened assurance that service change is being informed by a broader range of lived experience, particularly from groups whose voices are often less visible in routine datasets.

The Patient Voice

These forums provide structured routes for patient and carer voice to influence improvement, policy development and service design across the Trust.
Forums include:

- The Cancer Patient and Carer Forum
- Endometriosis UK Lancashire Forum
- The Patient Information Group
- Specialist Mobility Rehabilitation Centre (SMRC) Mobility Matters Forum
- The Patient Research Group
- Preston Dystonia and Migraine Group
- The Sepsis Patient Support Group
- The Cancer Patient Information Group
- The Carers Forum
- The SMRC Joint User Forum
- The Youth Forum
- Maternity Voices Partnership
- The Critical Care Ex Patients & Relatives Support Group
- The Lancashire Learning Disability and Autism Partnership
- The V. I. (Visual Impairment) Forum
- The Patient and Carers Experience and Involvement Group
- The Preston and District Carers Forum
- The Preston and District over 50's Forum
- Lancashire British Sign Language Forum
- The Preston Muslim Forum – Hamara Centre (Mums and Mini's Group)
- Muslim Grannies Group – Quwwat Education Centre Preston

Muslim Elders (The Grannies)

The Grannies Muslim Group at the Quwwat Education Centre in Preston is made up of older Muslim women who are long-standing users of Trust services. Their insight has directly shaped service improvements, particularly in relation to dignity, accessibility, culturally responsive care and communication support for patients with limited English proficiency.

Throughout the year, they shared several themes:

1. Language & Interpretation: Many members speak little or no English, making interpretation essential for safe care. They highlighted inconsistent access to interpreters, particularly at the point of discharge.
2. Comfort & Dignity: Concerns were raised about long waits on trolleys, limited privacy, and a lack of pillows in A&E and SDEC.
3. Cultural & Religious Needs: Requests included clearer Qibla signage and better support for emotional and spiritual wellbeing.
4. Dietary Needs: Members reported limited staff awareness of Halal requirements
5. Accessibility of Menus: They suggested using photographs on menus to support patients who struggle with written English.

6. Policy: Shared thoughts on Intentional rounding and enhanced care

In response, the Trust implemented a series of practical changes to improve experience and address the issues raised. These actions demonstrate clear evidence of co-production leading to service change.

- increased pillows across ED areas to improve comfort and dignity.
- Developed photographic inpatient menus to improve accessibility for patients with limited English proficiency.
- Updated and circulated a list of female Muslim volunteers to all wards and switchboard to support female Muslim patients more effectively.
- Established plans for ongoing dialogue and follow-up visits to maintain transparency, monitor progress, and ensure accountability for the improvements implemented.
- Contributed in development of new updated intentional rounding policy and development of Enhanced therapeutic Observation d of care policy (ETOC)

Mums and Minis' Group

Based at the Hamara Centre, Preston, the Involvement Services attend the Mums and Minis Group, which also maintains strong links with the Trust's Gynaecology and Maternity Departments and contributes regularly to Maternity Voices Partnership meetings.

Over the year feedback and actions have included:

- Providing Support for the Friends and Family questionnaires
- Supported in that Qurans are available for inpatients, with the group offering to donate additional copies

The Carers Forum

The forum is run in collaboration with the Lancashire Carers Services and continues to involve carers and help provide them with information about support available to them in our communities and within our hospital settings. To mark 'Carers Day' the Trust's Forum updated their 'Carers Charter' and 'The Essential Carers' leaflets, which supports carers by providing information on what support is available when they visit our hospitals. The leaflets are available to read on our

Trust website. Carers have played an active role in shaping Trust services for many years through the long established forum. Their feedback and involvement have contributed to a wide range of developments, including:

- LTHTR Carers Charter
- Improvements to discharge processes, with feedback shared directly with professional leads
- Enhancements to Occupational Therapy and Physiotherapy inpatient services
- DNACPR policy for staff
- The Dementia 'Forget Me Not' document
- Lancashire Carers Service Charter
- Virtual Ward Programme
- Chaperone Policy
- Prioritised Mealtimes Policy

These contributions reflect the Trust's commitment to ensuring carers' voices remain central to service design, policy development, and continuous improvement.

Age UK Lancashire
The trust supports The Living Well Support Service supports adults aged 18+ in Lancashire who require assistance following a hospital stay, illness, or major life event. This service is a great support with our patient and carers and provides:

- Transport home from hospital and help settling in
- Support to remain safely at home
- Prevention of avoidable hospital readmissions
- Practical and emotional support
- Connections to community groups and local health services
- Help with shopping, prescription collection, and other essential tasks post discharge

Saheliyaan Asian Women's Forum
The Asian Ladies Forum at the Community Centre in Chorley, are visited regularly with the goal of gathering feedback from the community and ensuring that our services remain accessible and user-friendly.

In the past the Trust experienced a lack of engagement and insufficient feedback from the community, during conversation the group identified several key factors contributing to these issues:

- The Friends and Family survey was available only in English
- Many members are uncomfortable with digital formats, and paper versions can be difficult to read without proficiency in English. They expressed a preference for translations in Urdu, Arabic, or Gujarati
- Some attendees admitted that, even if paper surveys were provided in their language, they might hesitate to complete them or voice concerns during treatment for fear of being treated differently if their feedback was negative, especially if they were still using the service
- They praised the iPad and DA Video calling services in maternity and gynaecology, which have significantly improved their understanding of procedures and expectations

- The group also commended the availability of halal food for inpatients but noted challenges in understanding menus, which are exclusively in English. Many rely on family members or staff for assistance but feel reluctant to ask due to the demands on staff. They expressed a desire for translated menus to help them make informed choices

Actions have been put in place to address all these points:

- Demonstrations given from the Involvement Services on how to use the Trust website and change the website into different languages, so information is accessible to all the community.
- Breast Care nurse attending the centre and providing education in breast screening services, which has since seen an increase in the number of screenings from the community.
- Provided with friends and family in there own language

Lancashire V.I (Visual Impairment) Forum / Pukar Disability Centre

While the Trust continue to have a great working relationship with the VI Forum, who in the past have contributed to provide direction and feedback on Trust policies, such as the Assistance Dog Policy. Provision of guidance for hospital guides, with the assistance of Guide Dogs UK. Assistance in the provision of information for visual impairment patients and support with guidance on Trust signage and poster creation.

The Trust was proud to support the collaboration between the Visual Impairment Forum Lancashire and the Pukar Disability Resource Centre in Preston for Sight Loss Day, which is a significant event aimed at fostering inclusion and providing essential resources for individuals with visual impairments. The brought together professionals, charities, and community members to share knowledge and support services. The event focused on breaking down barriers and ensuring accessibility, with specialist services offering guidance on available assistance, technology solutions, and general support for sight loss. Some of the key organisations involved included Al-Qalam Vision Institute, Galloways, Glaucoma UK, RNIB, Disability Equality Northwest, Healthwatch, Lancashire Teaching Hospitals NHS Trust Involvement Services, Lancashire Carers Services, Lancashire County Council Sensory Rehabilitation Team and Sight Line.

Our Deaf Community-Strengthening Long Standing Partnerships

Our Deaf community has maintained a close and collaborative relationship with the Trust for many years. This year, members generously shared their personal experiences of accessing our services. Working in partnership with Deafway, these stories were captured on film, supported throughout by British Sign Language (BSL) interpreters to ensure full and accurate understanding. These filmed accounts provide powerful insights into the barriers faced by Deaf patients, highlight examples of good practice, and identify opportunities to further enhance accessibility and service quality. To maximise their impact, the videos have been added to the staff intranet, where they continue to inform, educate, and inspire colleagues across the Trust. This work builds on our involvement in Healthwatch's project One Voice in Health and Social Care in BSL, reinforcing our commitment to inclusive communication and equitable access.

Lancashire BSL Forum Event

The Lancashire British Sign Language Forum Event took place at Preston County Hall in March 2025 and January 2026. The recent event was chaired by Mark Heaton, who provided an overview of the history and achievements of Deaf rights campaigns and outlined future priorities to

strengthen accessibility and equality of opportunity for the Deaf community. Key contributions and updates:

- Presentations highlighted service improvements made over the past year
- Lancashire County Council shared updates on the newly appointed BSL social worker, funded through social services.
- LTHTR Involvement Services presented actions taken in response to the Healthwatch project, including ongoing discussions about introducing mandatory Deaf Culture Awareness e learning for all staff.
- Deafway engagement leads introduced their services and explained how they support the local Deaf community.
- Lancashire County Council also outlined available home adaptations to support independent living, including specialist baby monitors, alarms, and lifeline equipment designed for Deaf users.

BSL interpreters were present throughout the event, ensuring full accessibility. Attendees were encouraged to ask questions and engage directly with presenters. Feedback has been overwhelmingly positive, describing the event as informative, welcoming, and impactful. LTHTR received thanks for its strong commitment and active participation.

Children's Services

Over the past year, Ward 8 and paediatric services have delivered a comprehensive programme of improvements designed to enhance the experience, comfort, and wellbeing of children, young people, and their families. Working closely with clinical teams, families, volunteers, youth forum and external partners, a wide range of initiatives have been implemented to strengthen care quality, improve environments, increase accessibility, and ensure that the voices of CYP meaningfully shape service development.

- Food and nutrition, including expanding the menu with more child-friendly options, establishing fortnightly monitoring meetings with Catering, trialling baby food (with a new supplier now being sourced), introducing gluten-free sandwiches, and launching a meal survey with CYP.
- Feedback through FFT and "tops" is now consistently positive. Child-friendly bed boards were designed, audited, commercially produced, and fully implemented. To support clinical and emotional needs, DigiBete app leaflets were distributed to newly diagnosed diabetes patients, a new parent and carer information leaflet was introduced, and a Children's Emotional Wellbeing and Mental Health Survey was implemented for CYP experiencing poor mental health or dysregulation.
- Enhancements to Cubicle 32 were co-designed with the Youth Forum, resulting in a new "anchor bag" of safe resources and CYP-selected wall art funded through donations. Volunteers were successfully reintroduced to the ward, and an entrance/exit audit with families led to updated signage and a simplified flow.
- A comprehensive programme of environmental enhancements was completed, including sea-themed corridors, a child-friendly "find your way" navigation game, the introduction of the "Otto the Octopus" mascot, a multilingual sea-life welcome display, CYP-painted "Meet the Staff" artwork, QR-code information boards, a new baby-changing unit, and additional sanitary bins.
- A new SEND display board now supports neurodiverse, hearing-impaired, EAL, and complex-needs CYP with visual aids and procedural explanation cards. Hospital passports have been refreshed and are being prepared for rollout across Broadoaks, Fulwood, Ashton Clinics and ED.

- A dual-language book project with LCC was introduced for children aged 3–5, providing books in six community languages to promote home reading.
- .An ISystems audit across all RPH children's areas has been completed, with an action plan to follow focusing on reducing procedural trauma. Work has also begun on establishing a parent/carer peer support group for families of CYP with long-term conditions.
- FFT with QR codes has been introduced for specialist nursing areas at Broadoaks, and Fulwood Clinic has benefitted from new waiting-room toys, including a play kitchen and toy hoovers.
- At the Rawcliffe fortnightly clinic, FFT has been rolled out for the Play Team remit.
- A rich programme of activities and events has been delivered throughout the year, including cultural celebrations (Easter, Eid toy donations, Holi, Chinese New Year, Halloween, Christmas), themed engagement events (World Book Day, National Storytelling Week, National Superhero Day), and educational or enrichment activities delivered by UCLan's Teddy Bear Hospital, Mascots Delights, North West Brick Community CIC, and the Box4Kids programme.

Quality improvement projects

Stoma Accessible Public Toilets: the introduction of stoma friendly public toilets across Royal Preston Hospital and Chorley and District Hospital sites, which was linked to a campaign ran by Colostomy UK making accessible toilets 'stoma friendly'.

Following a successful application to LTHTR Charities for funding this resulted in 27 accessible toilets over the Preston and Chorley sites, which now have hooks to hang personal belongings, shelves to provide a sanitary surface, a full-length mirror to make changing stoma bags easier, a sanitary bin for the disposal of used stoma bags positioned, and signage for doors – "Not all disabilities are visible" as the British Standard recommends. This has been a welcomed introduction by both patients and staff at the Trust.

Family Rooms: LTHTR Charities we also saw the introduction of a family room based in SAU. This has enabled a personal space for patients, allowing conversations to take place in a private comfortable environment and a space for patients and families to have a quiet space. The room has been furnished with a bookcase, sofa, armchair and religious and cultural artefacts which can be used by patients if required.

Volunteers

During 2025/26, Volunteer Services continued to make a significant contribution to patient, visitor and staff experience across the Trust. A total of 316 active volunteers supported services across both hospital sites, delivering a wide range of roles including ward support, hospital guides, meet and greet services, neonatal baby cuddling, chaplaincy support, hospital radio and volunteer dog visits. Recorded volunteer activity totalled 9,846 hours, although this reflects only around 30% of the active volunteer workforce, indicating a substantially wider impact.

Volunteer recruitment remained strong, with over 150 new volunteers welcomed during the year, supported by a revised recruitment model focused on information sessions to ensure role suitability. Improvements to volunteer-specific mandatory training, engagement through newsletters and networks, and enhanced recognition initiatives have strengthened volunteer experience and retention. The service continues to expand its reach through partnerships with third-sector organisations and plans to further develop community-based volunteering opportunities in the coming year.

Patient Information Group

The Patient Information Group has continued to play a vital role in ensuring that Trust leaflets and patient communications remain clear, accurate, evidence based, and accessible. High quality patient information is essential in supporting individuals to understand their care pathway, make informed decisions, and feel confident in planning the next steps of their treatment. Key achievements this year include:

- Production of 63 new leaflets and booklets, with review of 120 existing leaflets, all transposed onto the current Trust template to ensure consistency, clarity, and uniformity across patient information materials
- A full review of all existing patient information resources.
- Delivery of the Annual General Meeting, presenting progress and achievements from the previous year.

Support for Staff

During the reporting period, the trust strengthened organisational capability through a new partnership with the apprenticeship programme. As part of this collaboration, the trust now contributes to the Level 3 Senior Healthcare Support Worker apprenticeship curriculum. This work ensures that new staff receive structured, early exposure to key principles of inclusive, patient-centred care. Training content covers core areas including the use of interpretation services, carer engagement, Deaf culture and BSL awareness, patient communication standards, the Accessible Information Standard, patient involvement mechanisms, ward-based engagement approaches, disability awareness (including hidden disabilities), and the delivery of reasonable adjustments. Embedding these components within apprenticeship teaching supports the development of a confident, informed workforce capable of meeting the diverse needs of the Trust's population.

2.3. Equity, Equality and Health Inequalities (appendix 4)

Demographic analysis of FFT responses shows that while feedback volumes are strong overall, assurance is uneven because younger people, men and minority ethnic communities remain underrepresented. This limits confidence in how fully the Trust understands experience for some groups and reinforces the need for targeted, equity-focused engagement.

Women are over-represented compared to men, which may reflect the mix of services captured in the data, such as outpatient and maternity activity, as well as a higher likelihood of survey completion among women. Female respondents comprise 60% of the sample compared with 34% male respondents, resulting in an approximate 2:1 female-to-male ratio, with a further 6% either preferring not to say or not stating their sex.

In terms of ethnicity, the dataset is not representative of the local population, participation from minority ethnic groups is very low and is further affected by high levels of non-response. This significantly limits confidence in drawing robust conclusions about health inequalities from the data. Ethnically, 85% of respondents identify as White, with minority ethnic groups combined representing only 8% of responses; Asian / Asian British respondents form the largest minority group at 4%. A further 7% did not state their ethnicity, representing a notable data quality limitation. Taken together, these patterns show that while the Trust has a strong overall volume of feedback, assurance is weaker for younger people, men and minority ethnic communities because their voices remain underrepresented in the dataset. This is a significant improvement issue rather than only a data-quality issue, and it reinforces the need for targeted engagement, more inclusive feedback mechanisms and clearer equity-focused measures within the Single Improvement Plan.

Health Inequalities / Partnership working
The Trust continues to contribute to Preston's Suicide and Self Harm Group, coordinated by Preston City Council. As part of the citywide Suicide and Self Harm Action Plan, there is a strong focus on promoting key awareness campaigns throughout the year to ensure important messages reach residents and communities across Preston.

The Communications Team supported delivery of awareness days and campaigns that was over the year. Alongside this, the Digital Team will continue to amplify national and regional NHSE public health campaigns through Trust social media channels, including those relating to flu, mental health, and appropriate use of NHS services with the 'Your Health Campaign'.

To strengthen collaboration across local public services, a shared Padlet is being developed. This will act as a central hub for partners to upload campaign materials, ensuring consistent messaging and improving public access to information.

Addressing Health Inequalities Across Preston
The trust is participating in a series of new initiatives aimed at addressing health inequalities across local communities. Initial meetings focused on the St Matthews Ward, followed by discussions centred on the Ribbleton Ward. These sessions, chaired by Preston City Council, brought together representatives from a wide range of organisations

Community Engagement and Initiatives The group emphasised the importance of building a robust communication network to share community events and ensure stakeholders and residents have timely access to relevant information. Several initiatives were discussed, including:

- City wide Food Access Leaflet: A resource in development to improve awareness of food support services across Preston
- Winter Support Packs: Plans to distribute packs containing coats, essential items, and information on local services
- Art Based Community Project: A funding opportunity with St Catherine's Hospice to facilitate open conversations around death and dying
- Men's Mental Health Event: Westview Leisure Centre, focusing on mental wellbeing and encouraging open dialogue
- Winter Campaign Collaboration: LTHTR shared its winter campaign materials to support wider public health messaging

Other Local Public and Patient Engagement
The trust also visits local GP practices to participate in their Patient Participation Groups. This provides an opportunity to share continued improvement work by the Trust, news and updates and also allows the GP Services to share their developments and request any support needed.

Healthwatch
The trust supported Healthwatch with a number of visits and conducted surveys to feedback vital information from our patients. Along with this, work alongside the trust in projects that support the community and strengthen the voice of the patient and carer from all backgrounds, projects this year include:

The trust alongside Healthwatch Lancashire started an engagement project to understand the experiences of Deaf individuals who use BSL when accessing health and social care services. Two key themes emerged:

- Access Barriers to Booking Appointments: Many participants struggled with phone only booking systems and limited alternatives for arranging appointments.
- Communication Barriers During Appointments: Participants frequently reported a lack of qualified interpreters and unreliable video interpretation services, resulting in distressing and inaccessible care experiences.

Building on the recommendations the trust is part of a group to monitor progress against commitments made by organisations while promoting the active involvement of Deaf individuals who use British Sign Language (BSL) in relevant projects and initiatives.

Women's Health Engagement

The trust attended a Healthwatch organised event focused on women's health issues across Lancashire. The event aimed to highlight service provision within the Trust's catchment area and share key findings relating to access, quality, and gaps in women's health support. The event provided insight into the availability and accessibility of services relating to:

- Menstruation and menstrual health
- Reproductive screening programmes
- Menopause support pathways
- Gynaecological care
- Mental health concerns linked to inadequate service access

Following feedback received, an action plan was developed focusing on improvements to the environment, communication processes, and staff wellbeing. Within the environment, signage at the reception desk was reviewed to ensure clarity, information boards were updated, and the nurse call system was assessed after it was identified that the disabled toilet had no pull cord. A new system has since been installed in SGU, ensuring the disabled WC is now equipped with an appropriate plastic pull cord. In relation to bookings and communication, we addressed concerns regarding cancellations made via the patient portal by establishing with the administration team that confirmation and cancellation calls are now consistently undertaken to prevent patients attending cancelled appointments.

A suggestion to offer bookings a year in advance was escalated to operational management, and the trust tested a move to a six-week booking model. Staff have also been provided with updates on supporting patients with additional needs, with a focus on translation and interpreting services. To support staff wellbeing, information has been shared on access to clinical supervision and emotional support, and clinic templates continue to be reviewed regularly to minimise late-running sessions.

Vulnerable Patient Groups Feedback

Qualitative feedback shows continued inequities for several underserved groups, particularly where communication, accessibility, environment and reasonable adjustments are inconsistent. This supports the need for sustained work on inclusive communication, culturally responsive care and psychologically safer care environments.

Patients with sensory, cognitive or emotional vulnerabilities experience disproportionate distress linked to overcrowded, noisy environments, long waits and inconsistent communication, all of which undermine psychological safety and contribute to unequal experiences of care. Engagement with Black and minority ethnic communities shows reduced confidence in navigating healthcare

services and a need for more sustained Trust visibility and culturally responsive engagement. Although staff were consistently praised, some children reported uncertainty about care plans and discharge, especially when environments were unsuitable or communication was not adapted to their developmental needs.

Cross-Cutting Health Inequalities Themes
Across all groups, several systemic inequalities recur:

- Communication gaps particularly during extended waits, at discharge, or when interpreter or accessible formats are required.
- Environmental discomfort and overstimulation, including heat, noise, overcrowding and lack of quiet spaces disproportionately affecting vulnerable patients.
- Cultural competence gaps, especially around religious practices, dietary requirements, gender-concordant care and inclusive facilities.
- Access barriers, particularly for communities with limited English proficiency, lower health literacy or reduced confidence in NHS systems.
- Inconsistent application of reasonable adjustments, including interpreter use, sensory adaptations, and support for cognitive or emotional needs.

Alignment with Core20PLUS5
The Core20PLUS5 priorities highlight several targeted actions to reduce health inequalities across the Trust. For maternity, strengthening relationships with community groups such as the Mums & Minis group will support continuity of care, culturally safe maternity information, and trusted engagement with women from diverse backgrounds.

In relation to severe mental illness, continued education on trauma-informed practice across all services is essential to reducing distress caused by long waits, overstimulation and uncertainty during care processes, particularly for patients with neurodivergence, cognitive impairment or emotional vulnerability with Charity support in improving the environment and sensory pack sin the Emergency Department.

To improve early cancer diagnosis, the Trust will continue its well established community outreach routes such as mosques, Black community centres and Deaf community organisations to promote screening, improve early symptom recognition and create trusted referral pathways that reduce diagnostic delay in underserved groups.

2.4. Learning and Improvement

Three cross-cutting themes continue to shape patient experience across the Trust and now provide the main focus for improvement action and assurance oversight.

Communication is the biggest driver of patient experience:
Patients need clearer, more consistent information especially about delays, discharge and next steps.

Actions Taken:

- Intentional Rounding has been fully developed and commenced within the Emergency Departments, with ongoing monitoring incorporated into the STAR programme.
- Volunteer capacity has increased by 10%, with a more representative group now supporting wards and departments across the Trust.

- New patient-facing screen messages have been introduced across UEC pathways, providing clear waiting-time information and directing patients to appropriate alternative services.
- Post-discharge experience audits are now routinely undertaken each quarter, capturing feedback from at least ten patients, families and carers.
- Engagement with VCSFE partners has been completed, providing valuable insight into discharge challenges and identifying further community support options.
- The Virtual Ward has been added to the ward-round proforma to strengthen continuity of care, and focused DKAFH work on discharge, admissions and Length of Stay has been delivered and integrated into ongoing improvement activity.

Long waits and system pressures affect dignity and wellbeing

Extended waits in ED, diagnostics and for beds cause anxiety, discomfort and loss of confidence, particularly where communication is limited.

Actions Taken:

- Stronger partnerships have been established with local voluntary and community sector organisations, enabling co-delivery of services and extending reach to underrepresented groups.
- In-patient experience has improved through consistent completion of new intentional rounding, enhanced care practices and full implementation of “About Me” boards across wards.
- The rollout of a new patient-focused “What to Expect in Hospital” video on all Trust iPads, with viewing activity now routinely monitored.
- Pain-score audits within the Medical Division completed, alongside the implementation of noise-reduction measures and a strengthened temperature-management solution for the Acute Medical Unit.
- Food provision has been improved within the Emergency Department and ward areas, with he introduction of a snack trolley, although this remains a concern and will be carried over to next year

Person-centred care and empathy significantly improve experience

Simple actions clear explanations, checking understanding and acknowledging feelings reduce anxiety and increase trust.

Actions Taken:

- Compliance with training has improved, although the target of 90% completion has not yet been achieved for the PALS e-learning module for all staff or for complaints and local-resolution training for Band 6 and above clinical staff. This work will continue through the 2026/27 Single Improvement Plan.
- Further rollout of Martha’s Rule has taken place, alongside the addition of a wellbeing question within Flex to strengthen personalised care and escalation.
- The diversity of the Patient Safety Partner role has been strengthened, ensuring broader representation and lived-experience insight.
- Divisions have also addressed the Trust’s top three cross-cutting themes by focusing attention on emerging trends and delivering targeted actions.
- Qualitative patient-experience feedback for individuals with a learning disability, mental-health needs or dysregulated behaviour is now completed quarterly, with case findings presented to PCEIG to inform learning and ongoing improvement.

2.5. Forward plan and priorities

The 2026/27 Patient Experience Plan sets a clearer Trust-wide approach to improving communication, fundamentals of care, inclusion, responsiveness and the use of patient voice in decision-making.

Delivery will be supported by clearer standards, stronger ward-level leadership, improved access to patient experience intelligence and continued Board oversight through triangulated reporting.

Robust governance arrangements provide Board-level assurance through triangulation of qualitative and quantitative data, including FFT, complaints, PALS, patient stories and safety metrics, with clear divisional accountability. Successful delivery will be evidenced by improved patient feedback, fewer experience-related complaints, stronger communication at key transition points, more equitable insight from seldom-heard groups, and demonstrable learning from patient voice leading to sustained service improvement.

3. Financial implications

While no specific financial costs are associated with producing this annual report, it is recognised that patient experience has a direct impact on clinical outcomes, operational efficiency and overall productivity. By prioritising and improving patient experience, the organisation strengthens its ability to deliver care more effectively and make best use of resources

4. Legal implications

The Trust has a range of legal, regulatory and statutory obligations relating to patient experience, involvement and engagement. Failure to meet these requirements could lead to regulatory intervention, legal challenge, reputational damage and a loss of public confidence.

5. Risks

ED exit block (risk id 25) remains a key operational pressure. A comprehensive UEC Improvement Plan is in place, focusing on admission avoidance initiatives including the new See and Sort Stream Team alongside strengthened hospital flow processes and actions to reduce the number of days patients spend away from home.

Patients cared for in inappropriate area due to the impact of exit block (risk 1427) and reduced capacity within the main department, there is an increased risk of patients not being cared for in the most appropriate setting. This includes patients within the Emergency Department who require monitoring or treatment in a cubicle being managed in waiting rooms or on trolleys in corridors for extended periods of time, which can adversely affect safety, dignity and overall patient experience.

6. Impact on stakeholders

6.2. Trust Board

The continued presence of Trust Executives and Non-Executive Directors during patient safety visits across both hospital sites has created valuable opportunities for staff and patients to share real-time feedback on emerging safety, quality and experience issues affecting care across the organisation.

Staff Themes

Across all areas visited, staff consistently reported working under significant and sustained pressure, driven by high levels of boarding, space constraints, delayed discharges and prolonged escalation.

These pressures contributed to low morale, feelings of being unable to deliver the standard of care they are trained for, and in some teams, experiences of moral injury and Datix fatigue. Despite this, a strong theme of commitment, professionalism and teamwork was evident, with many areas demonstrating visible leadership, open communication channels and supportive team cultures. Staff described exhaustion in some units, particularly where vacancies, redeployment uncertainty or continuous over-capacity were impacting day-to-day functioning.

Nevertheless, teams valued leadership visibility, the opportunity to be heard and the recognition offered during the visits. Concerns around the safety and sustainability of escalation areas especially overnight were repeatedly raised, alongside challenges linked to environmental issues, equipment availability, and the impact on their ability to maintain dignity, privacy and timely care..

Patient Themes

Patient feedback was mixed but highlighted clear, recurring themes. Where staffing was stable and environments were calm, patients expressed high levels of confidence, feeling safe, well-cared for and able to ask questions, with many praising communication and nursing care particularly on wards such as 14, 17, 19 and 20.

Conversely, in escalation areas and the Emergency Department, patients described prolonged waits, boarding in corridors or unsuitable spaces, and challenges affecting privacy, dignity, sleep, comfort and hygiene. Some patients experienced delays in pain relief, food provision and medical review, although many remained understanding of pressures and expressed gratitude towards staff.

Patients consistently emphasised the importance of clear communication about delays, discharge, bed moves and what to expect next. In areas with improved leadership visibility and proactive environment enhancements (e.g., MAU CDH), patients' experiences were notably more positive.

6.3. Council of Governors

The Trust continues to support patient experience through the active involvement of Governors in a range of assurance and engagement activities. Governors regularly participate in Golden STAR walkabouts, providing feedback on the first 15 steps of care and gathering patient experience insight to ensure services meet the standards required to achieve and sustain Gold accreditation. As part of complaints assurance, Governors are members of the Complaints Review Group, where they review complaint responses, analyse themes and discuss learning from complaints received each month. This process supports transparency, honesty and meaningful learning, ensuring patients feel listened to and that appropriate action is taken in response to their feedback.

Additional feedback is provided through the Quality and Safety Subgroup, chaired by a Governor, which enables Governors to raise patient-led questions following walkabouts and direct feedback from patients. This forum allows the Patient Experience Lead to provide assurance that actions have been taken and improvements implemented. Governors are also supported as part of their induction through dedicated training sessions delivered by the Patient Experience Team, covering complaints and concerns, safety and quality, and the effective use of patient experience data to inform improvement across the Trust.

Recommendations

This report provides assurance that robust systems are in place to capture and act on patient experience intelligence, and that patient voice is informing governance, improvement and risk management across the Trust.

It also confirms that communication, waiting pressures, environment and health inequalities remain the principal drivers of experience risk, with targeted action in place through the Single Improvement Plan. Overall, the paper provides appropriate assurance while identifying clear priorities for continued improvement.

It is recommended that:

iii. The Committee is asked to note and take assurance that robust arrangements are in place to capture, triangulate and act on patient experience intelligence, and that patient voice is effectively embedded within governance, quality improvement and risk management processes across the Trust

iv. The Committee is asked to endorse the continued focus within the Single Improvement Plan on strengthening communication reliability at key points of the patient journey (including delays, discharge and transitions of care), recognising communication as the primary driver of patient experience, complaint escalation and emotional wellbeing.

Appendix 1

Complaints data

All information from Ulysses

Comparator data for Complaints 2023 to 2026

Year	Complaints received	Increase/reduction
2023-24	355	-132
2024-25	325	-30
2025-26	329	+4

Number of Complaints by Division – April 2025 to March 2026

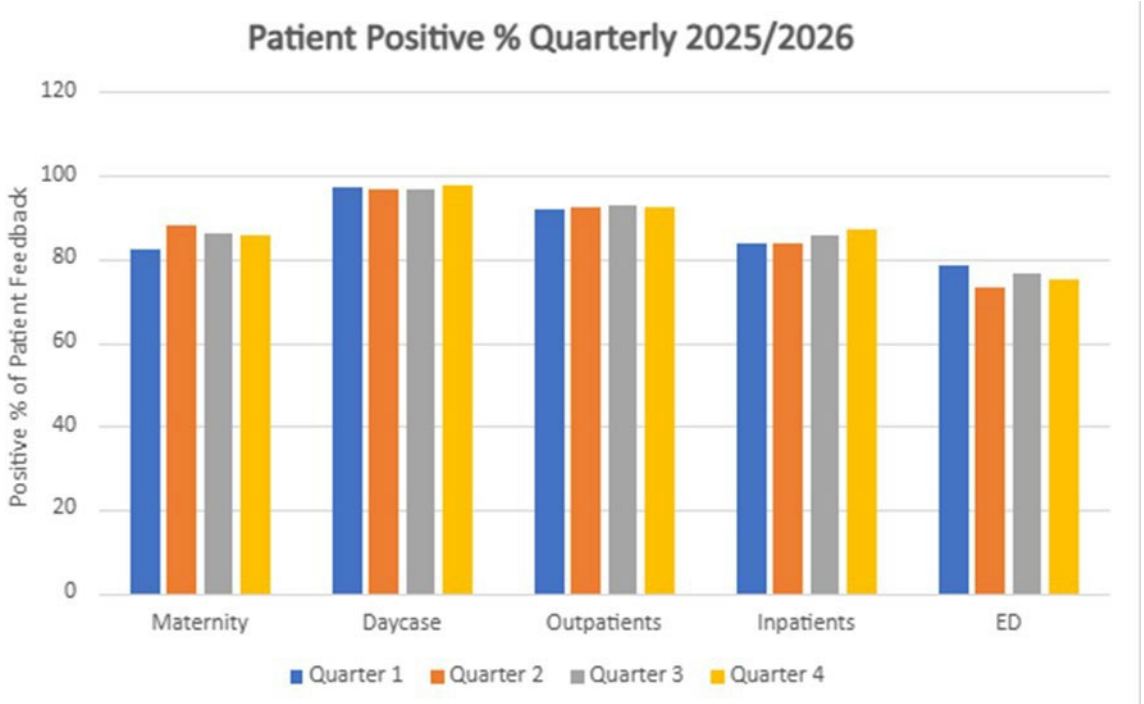
Division	Number (%)	Division	Number (%)
Medicine	120 (36%)	Women and Children's Services	54 (16%)
Surgery	127 (39%)	Diagnostics and Clinical Support	21 (6%)
Estates and Facilities	3 (0.5%)	Corporate Services	4 (1.5%)

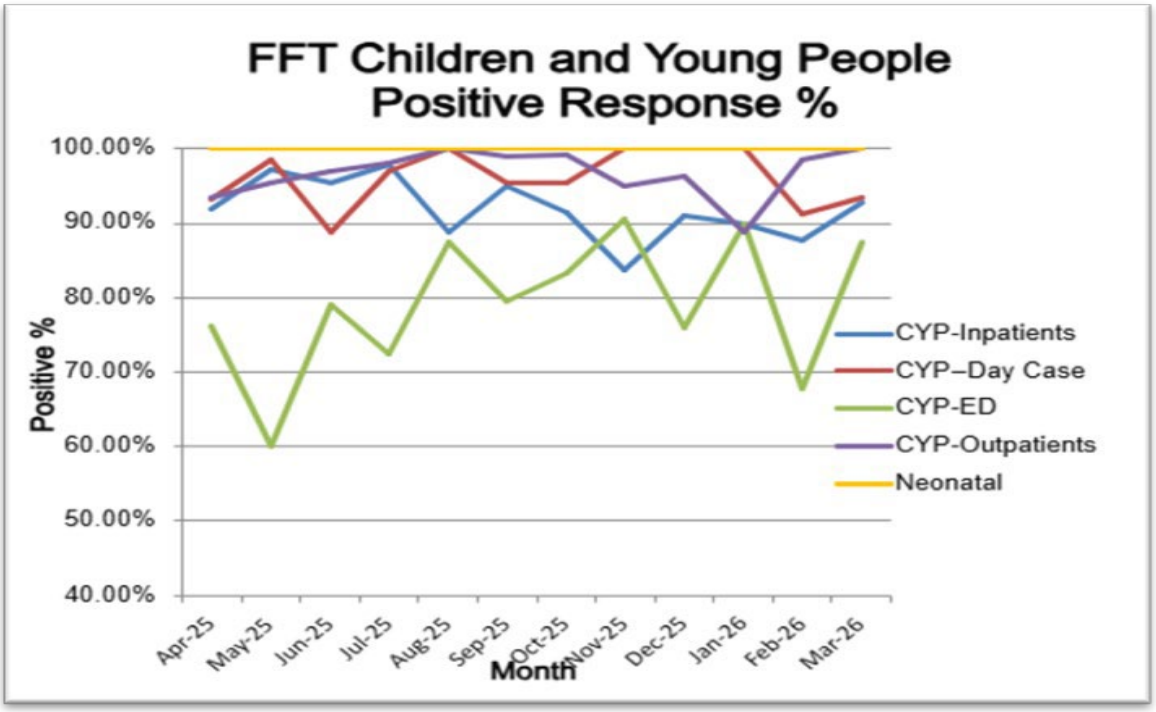
Trend of ratio of complaints per patient contact 2022 to 2026

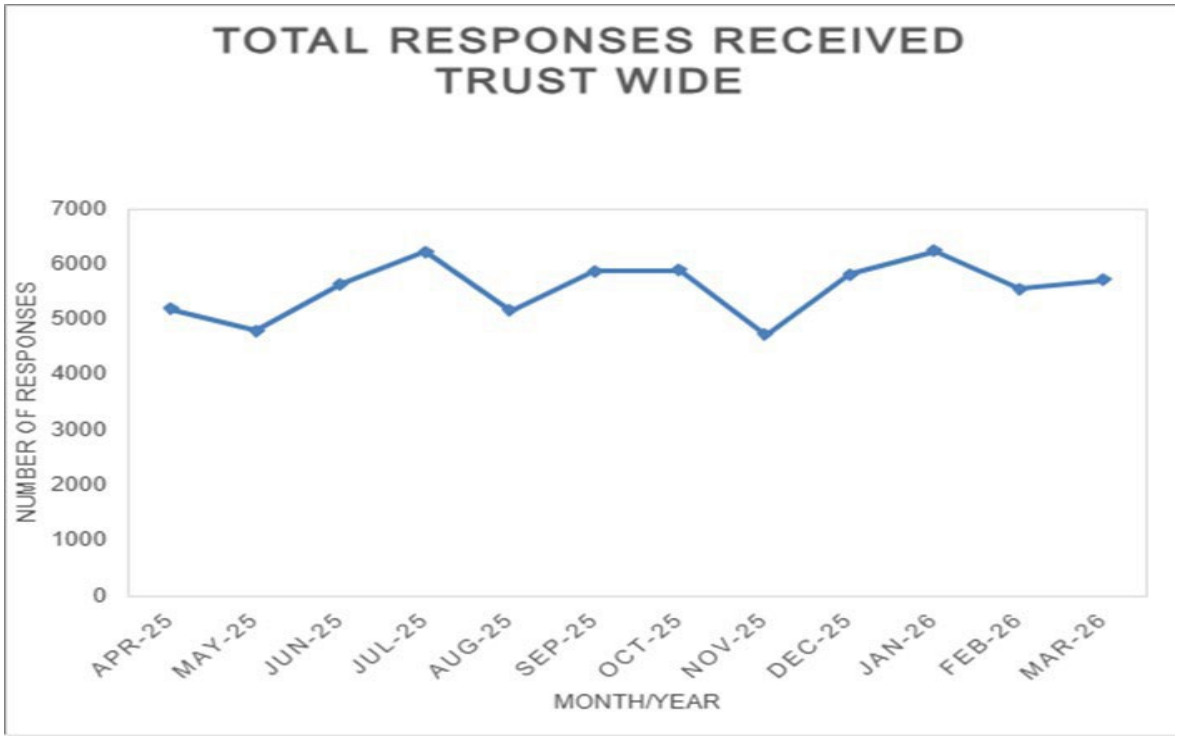
Year	No of complaints	Total episodes (inpatient/outpatient)	Ratio of complaints to patient contacts
2022-23	487	849,328	1:1,744
2023-24	355	882,589	1:2,486
2024-25	325	917,962	1:2,825
2025-26	329	952,167	1:2,896

Appendix 2

Friends and Family data (FFT data from Civica)





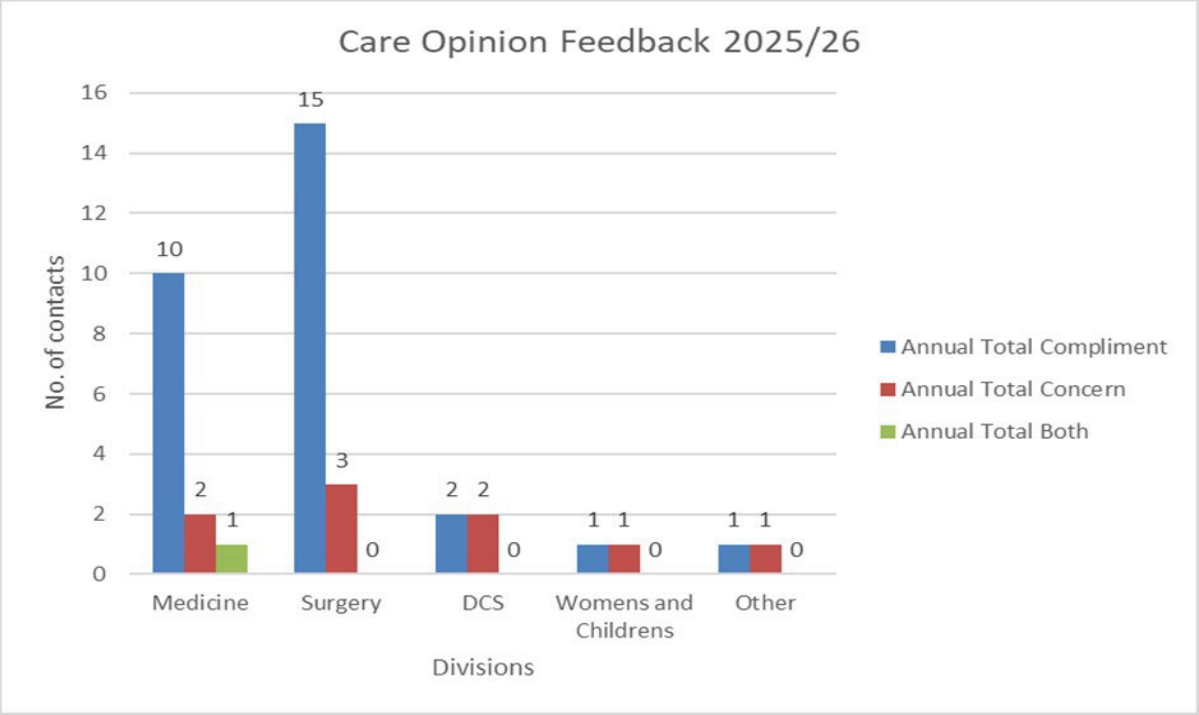


Friends and Family – response rate

Year	QR codes/online surveys	Paper surveys	Telephone surveys	SMS text surveys	Total
2023-2024	3,016	10,944	2,112	46,471	62,543
2024-2025	973	13,661	910	49,936	65,480
2025-2026	1,217	15,587	404	51,827	69,035

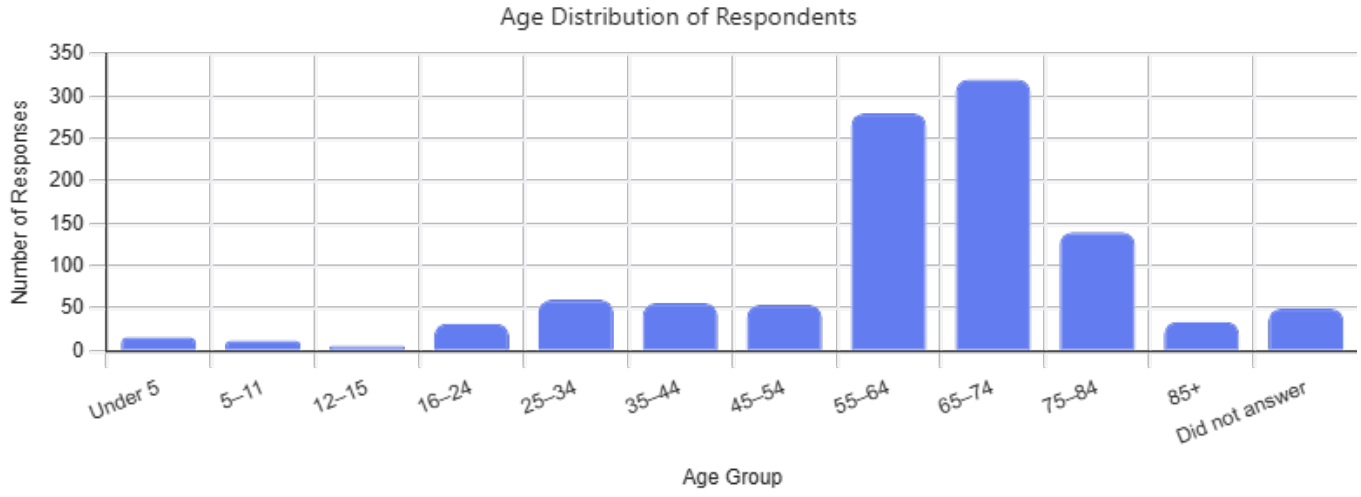
Appendix 3

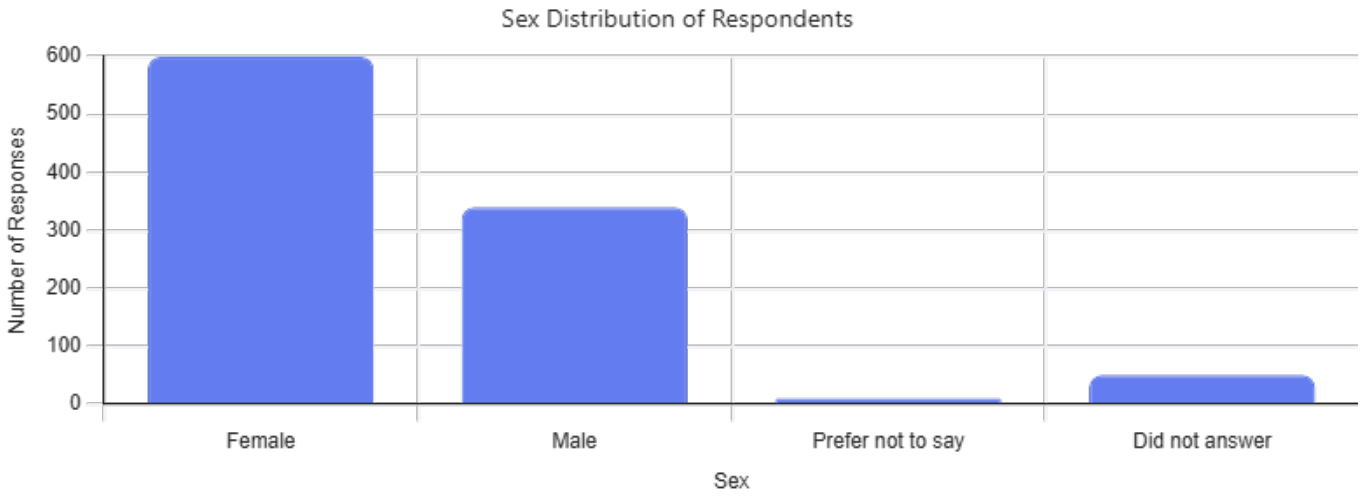
Care opinion Feedback

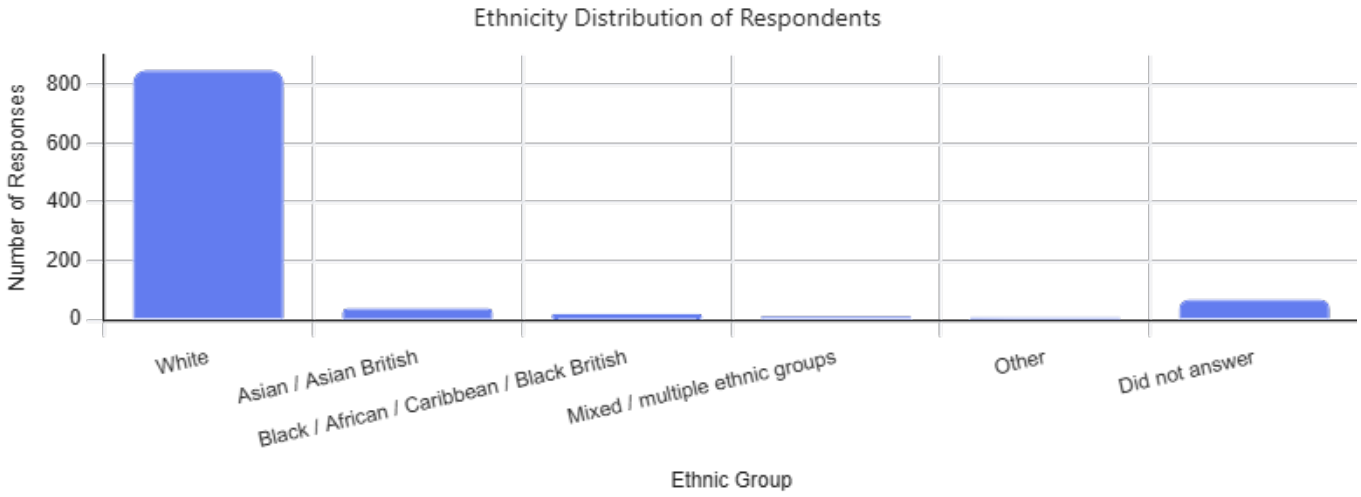


Appendix 4 (data from civica)

Age, Sex and Ethnicity data







Appendix 5 – Divisional deep dive on themes and learning from complaints and feedback

Women and Children's Divisional Complaints Review

The complaints across Women and Children's Services reveal a clear and consistent pattern, with communication failures emerging as the most prominent theme. Patients frequently reported unclear explanations, inconsistent information and feeling insufficiently prepared for critical aspects of their care, particularly highlighted in maternity where families described poor preparation around induction of labour and limited explanation of delays. Similarly, Gynaecology and Breast services identified communication breakdowns as the single largest sub-theme, with patients experiencing avoidable anxiety due to insufficient updates or abrupt staff interactions.

A second theme relates to delays in care, including postponed appointments, extended waiting times and procedural delays, which had a marked emotional impact on service users. Maternity complaints describe delays in triage and time critical observations, while women undergoing induction often felt distressed by prolonged waits compounded by a lack of timely information. Staff attitude and behaviour also feature strongly, with some patients in gynaecology describing dismissive interactions and children and young people reporting that staff appeared too busy, unresponsive or reliant on security rather than trauma-informed approaches to de-escalation.

A range of targeted improvements have been implemented to enhance patient experience, including clearer reception signage, updated information boards, and accessibility improvements through the upgrade of the nurse call system. Booking and communication processes have been strengthened to ensure appointment cancellations are clearly communicated, alongside ongoing review of booking timeframes and enhanced staff guidance on supporting patients with additional needs. Staff wellbeing continues to be supported through access to clinical supervision and reviews of clinic templates to address delays. Quality improvement work has also focused on improving pain management during gynaecology procedures through environmental enhancements, staff education, and revised clinical practices. In addition, relocating Bulkamid procedures to the outpatient setting has improved patient experience, supported continuity of care, and released theatre capacity.

Diagnostic and Care Service Divisional Complaints Review

Analysis of complaints across the Division of Diagnostics and Clinical Support reveals several consistent and interconnected themes, most notably delays in appointments and results, communication shortcomings, and concerns around staff attitude. Delays particularly within Radiology and Pain Services were the predominant issue and often acted as the trigger for wider dissatisfaction, with long waits for imaging, reporting and follow-up appointments creating uncertainty for patients. These operational pressures directly fuelled communication complaints, as patients frequently reported a lack of timely updates, unclear information pathways, and difficulty contacting services.

Additional issues, such as administrative errors, and pathway inefficiencies, highlighted pressure points in high volume diagnostic environments. The learning from these themes emphasises the continued importance of proactive communication, redesigning and improving capacity such as within Fracture Clinic who have improved their phone line and patient contact to improve experience. Alongside this, the presence of high volumes of compliments signals a strong foundation of positive staff behaviours that can be built upon to embed consistent, division-wide improvements in patient experience.

Surgical Divisional Complaints Review

The complaints data highlights three consistent and recurring themes: failures in communication, dissatisfaction with treatment outcomes, and inefficiencies or delays within the treatment pathways, including appointment cancellations. Communication issues were the most dominant, with patients and relatives frequently reporting a lack of updates, unclear explanations, and poor information during delays. Concerns around treatment outcomes often related to unmet expectations or unclear post-operative information. Flow-related complaints particularly in high-pressure areas such as SAU reflected ongoing operational strain.

The learning arising from these themes emphasises the need for stronger, more structured communication practices, including clearer expectation setting and proactive updates; the division has focused on embedding of proactive patient contact methods such as the “5 Ps” intentional rounding model. Additional learning includes the continued work on the importance of accessible, personalised communication through reasonable adjustments, and scaling up successful local improvements such as environment changes and enhanced patient support tools across the division to create more consistent, patient-centred care.

Medicine Division Complaints Review

Patient experience feedback within the Division of Medicine demonstrates a consistent pattern of complaints centred on three core themes: appointments, communication, and treatment/procedures. These themes remain unchanged across all reporting periods and indicate long-standing systemic challenges that continue to affect patient satisfaction and confidence. The most prominent area of concern relates to appointments, with patients repeatedly reporting cancelled appointments, unclear arrangements for follow-up after discharge, and delays in receiving key diagnostic results, such as CT scans, X-rays and echocardiograms. These issues contributed to confusion and anxiety for patients awaiting ongoing care and reflect the need for more robust, predictable pathways

Communication concerns were similarly widespread, highlighting gaps in how information is conveyed between staff and to patients. Patients frequently reported conflicting information from staff on the same ward, insufficient detail in discharge communications, and inadequate handovers between departments particularly between the emergency departments and inpatient wards. Communication challenges in both emergency departments were also noted during periods of high operational pressure. These findings underscore the importance of improving communication practices across the division as a core element of patient safety and experience

Treatment and procedure-related complaints persisted throughout all quarters, often linked to delays in care caused by capacity pressures or variation in how treatment information was explained to patients. Patients expressed uncertainty about expected timeframes and experienced frustration when delays were not clearly communicated. Capacity and environmental issues especially corridor care, overcrowding, and lengthy waits for inpatient beds further contributed to dissatisfaction. Patients described discomfort, lack of dignity, and limited access to facilities while waiting, particularly within the Royal Preston Hospital Emergency Department. These issues highlight the direct impact of hospital flow pressures on patient experience and dignity.

Despite these challenges, the division demonstrated meaningful learning and improvement activity. Several initiatives have been implemented to address communication issues, improve patient flow, and enhance the care environment. These include communication improvement projects, the introduction of dignity spaces within emergency departments, enhanced cleaning programmes, and increased volunteer involvement supporting patient comfort. Additionally, a renewed emphasis on positive patient feedback including improved capture of compliments and a divisional compliments award has helped boost morale and reinforce good practice.

8.2 LEFT-SHIFT & NEIGHBOURHOODS - WHAT DOES THIS MEAN FOR US?

Information Item | C Granato / L Dickinson | 11:45am

REFERENCES

Only PDFs are attached

8.2 Left Shift and Neighbourhoods CoG - July 26.pdf

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Council of Governors Report

Meeting of the	**Council of Governors**		**23rd July 2026**
	Part I ☒		**Part II** ☐
Title of Report	**Left Shift and Neighbourhoods – What does this mean for us?**		
Report Author	Claire Granato – Chief Allied Health Professional Lindsey Dickinson – Deputy Chief Medical Officer		
Lead Executive Director	Sarah Morrison – Chief Nursing Officer and Deputy Chief Executive		
Recommendation/ Actions required	The Council is asked to review and note the contents of this Presentation.		
	Decision ☐	**Assurance** ☐	**Information** ☒
Executive Summary	This presentation outlines the strategic direction of "Left Shift" and Neighbourhood working, highlighting how Lancashire Teaching Hospitals and partners are responding to growing demand, ageing population, rising frailty, increasing emergency care pressures, and challenges across health and social care. The core message is that future sustainability depends on moving from a predominantly hospital-centred model of care to one that focuses on prevention, early intervention, proactive management, and community-based support, with hospital care reserved for those who genuinely require specialist acute services. Frailty is presented as a practical example of this approach, with greater emphasis on earlier identification, multidisciplinary neighbourhood teams, rapid response services, virtual wards, care home support, and advanced care planning to reduce avoidable admissions and help people maintain independence. The presentation also explains the emerging Neighbourhood Model, whereby services across primary care, community services, mental health, social care, voluntary sector organisations and acute providers work together around local populations of approximately 30,000–50,000 residents. This aims to deliver more coordinated, person-centred care closer to home and reduce fragmentation for patients and carers. For Central Lancashire, work is currently focused on neighbourhood design, understanding local populations, testing frailty-focused schemes, participating in the Frailty national collaborative, and strengthening system-wide collaboration, particularly with Lancashire and South Cumbria Foundation Trust (LSCFT)		
Link to Strategic Objectives 2026/27	**Patients – deliver excellent care:** Improve outcomes, reduce harm and deliver a positive patient experience.		☒

	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.	☐
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.	☐
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.	☐
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.	☒
Link to Board Assurance Framework:	Principal Risk 1 (26/27) - Patient safety and experience within the urgent and emergency care pathway	
Appendices	None	

Single Improvement Plan

Patients | Performance | People | Productivity | Partnerships

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Left Shift and Neighbourhoods – What does this mean for us?

Lindsey Dickinson – Deputy Chief Medical Officer

Claire Granato – Chief Allied Health Professional

Excellent care with compassion

Always Safety First

What Does "Left Shift" Mean?

"Left shift" describes the strategic movement of care from hospitals into community, primary care, neighbourhood and home-based settings.

It focuses on preventing deterioration, early intervention, and proactive management rather than reacting to acute illness once hospital admission is required.

The Model of Left shift

Frailty as an Example of Left Shift

"Move from episodic, hospital-centred care to proactive, person-centred care delivered in the community whenever clinically appropriate."

Earlier identification of frailty using primary care registers and risk stratification.

Comprehensive Geriatric Assessment (CGA) delivered closer to home.

Multidisciplinary neighbourhood teams working across GP practices, community services, mental health and social care.

Rapid response and virtual ward models preventing unnecessary admissions.

Better support for care homes and unpaid carers.

Anticipatory care planning and end-of-life planning.

Prevent avoidable crises, reduce unnecessary admissions, and support people to remain independent within their communities.

Why Is Left Shift Important for Lancashire Teaching Hospitals?

Aim: Creating a Sustainable Health and Care System

The Challenge for LTH

- Increasing demand from an ageing population
- Rising numbers of people living with multiple long-term conditions and frailty
- Growing emergency admissions and occupancy pressures
- Delays in discharge linked to community and social care capacity

Why Left Shift Matters: Outcomes Focus

- Reduce avoidable emergency attendances and admissions
- Enable earlier intervention before conditions escalate
- Improve patient outcomes and experience by providing care closer to home
- Reduce length of stay and hospital-associated deconditioning
- Release acute capacity for patients requiring specialist hospital care
- Support delivery of neighbourhood health and integrated care models

The Primary–Community–Acute Interface

What Do We Mean by “Neighbourhoods”?

A ‘neighbourhood’ is a local population of around 30,000–50,000 people where health, social care, community, voluntary and hospital services work together as one team to support local residents.

They are an enabler for the ‘left shift’

More than a geographical area… a way of organising services around people who live there

Coordinated, proactive care closer to home

Built around the needs, strengths and aspirations of the local community

A multidisciplinary team with a shared purpose

What Does a Neighbourhood Team Include?

Local people. Local services. Working together.

GENERAL PRACTICE

GPs and practice teams who know you and your health history, helping you stay well and managing your care.

COMMUNITY NURSING AND THERAPY SERVICES

Nurses, therapists and health professionals who provide care, treatment and rehabilitation in your home or community.

MENTAL HEALTH SERVICES

Support for your emotional wellbeing and mental health, alongside your physical health care.

ADULT SOCIAL CARE

Helping you maintain your independence, stay safe and access practical support when you need it.

VOLUNTARY AND COMMUNITY ORGANISATIONS

Local charities and community groups offering support, advice, social connections and activities that improve wellbeing.

LANCASHIRE TEACHING HOSPITALS SPECIALISTS

Hospital specialists providing expert advice, diagnostics and specialist support closer to home, working with local teams to give you the right care at the right time.

ONE PERSON. ONE TEAM. ONE PLAN.

Working together around you to deliver joined-up, compassionate care closer to home.

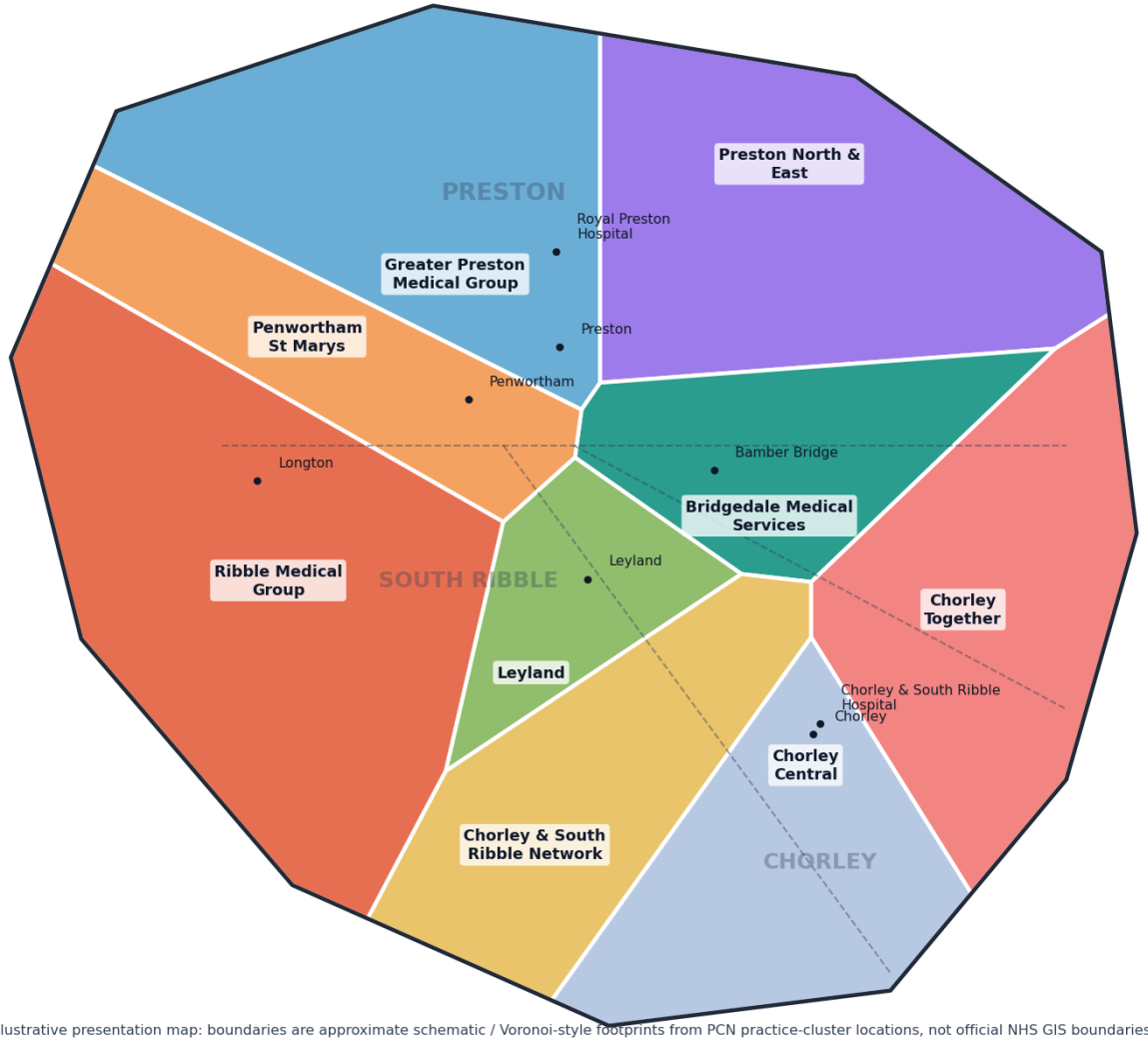
What Does This Look Like/Mean for People?

Earlier support and intervention	Prevention and wellbeing services	More care delivered locally or at home
Reduced need to attend the hospital	Reduced health inequalities	Better health outcomes
Fewer appointments in different locations	Being seen/treated as a whole person	Tailored service offer

How Could Neighbourhoods be Split in Central Lancashire?

Central Lancashire PCN Footprints

Preston | South Ribble | Chorley



Illustrative presentation map: boundaries are approximate schematic / Voronoi-style footprints from PCN practice-cluster locations, not official NHS GIS boundaries.

What's Happening in Central Lancashire?

Neighbourhoods

- Design phase
- Understanding our communities
- Identifying early opportunities to move care closer to home (primary care and VCFSE)

National Frailty Collaborative

- System participation
- Admission avoidance and home first focus
- Frailty Hub testing
- Making best use of resources

Collaborative working with LSCFT

- Joint Committee – focus on transformation
- Priorities:
  - Single Point of Access
  - Frailty
  - Admission/attendance avoidance

Left Shift

9. GOVERNANCE AND COMPLIANCE

9.1 ANNUAL MEMBERS MEETING

Information Item | J Foote | 12:15pm

REFERENCES

Only PDFs are attached

9.1 Annual Members Meeting Report Council July 26.pdf

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Council of Governors Report

Meeting of the	**Council of Governors**		**23 July 2026**
	Part I ☒		**Part II** ☐
Title of Report	**Annual Members Meeting Report**		
Report Author	Katie Stanton, Business Manager, Corporate Affairs		
Lead Executive Director	Jennifer Foote, Director of Corporate Affairs		
Recommendation/ Actions required	**Council is requested to note the arrangements for 2026 and identify appropriate volunteers for Council to present on its behalf at the event.**		
	Decision ☐	**Assurance** ☐	**Information** ☒
Executive Summary	The Trust is required to hold a public Annual Meeting open to its members. At this meeting the annual accounts from prior year are presented, together with an overview of the work of the Trust during that same period. The Annual Members Meeting (AMM) should also be the platform at which elected governors are held to account by their electorate for the work they have undertaken as Council. The meeting must be held within nine months of the end of the financial year and this year the AMM is scheduled for Monday 5 October from 2pm. The Trust is heavily financially constrained this year. However, the Chair and CEO, having listened to previous feedback, have agreed to a prudent commitment of funds to enable an external venue to be used for the event. Lancashire FAs premises at Thurston Road, Leyland have been booked as the venue. The Trust is exploring suitable engagement opportunities available at no additional cost for attendees to enjoy. The convening of the AMM is a matter for the Director of Corporate Affairs in the capacity of Company Secretary.		
Link to Strategic Objectives 2026/27	**Patients – deliver excellent care:** Improve outcomes, reduce harm and deliver a positive patient experience.		☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.		☒
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.		☒
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.		☒
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.		☒
Link to Board Assurance Framework:	N/A - No aligned to a Principle Risk		
Appendices	None		

10. ITEMS FOR INFORMATION (TAKEN AS READ)

10.1 GOVERNOR OPPORTUNITIES SUMMARY

Information Item

REFERENCES

Only PDFs are attached

10.1 Governor Opportunities & Activities 1 Apr-1 July Full Report 23.7.26.pdf

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Council of Governors Report

Meeting of the	**Council of Governors**		**23 July 2026**
	Part I ☒		**Part II** ☐
Title of Report	**Governor Opportunities and Activities – 1 April 2026 to 1 July 2026**		
Report Author	Jennifer Foote, Director of Corporate Affairs		
Recommendation/ Actions required	The Council is asked to receive the report and note the contents for information.		
	Decision ☐	**Assurance** ☐	**Information** ☒
Executive Summary	The purpose of this report is to update the Council of Governors on the opportunities, events and activities governors have been involved in during April to July 2026. 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 are detailed below. It should also be noted that several governors also undertake voluntary roles across both our hospital sites.		
Link to Strategic Objectives 2026/27	**Patients – deliver excellent care:** Improve outcomes, reduce harm and deliver a positive patient experience.		☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.		☒
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.		☒
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.		☒
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.		☒

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.

EVENT: excluding scheduled meetings and workshops	**DATE: 1 April 2026 to 1 July 2026**
Board of Directors Meeting	2 April 2026
Patient and Carers Experience and Involvement Group (P&CEIG)	28 April 2026
Carers Forum	29 April 2026
Chorley Hospital Tour	14 May 2026
Cardio-Respiratory STAR visit at Chorley Hospital	May 2026
Joint Board and Governor Development Session	21 May 2026
Patient and Carers Experience and Involvement Group (P&CEIG)	26 May 2026
Carers Forum	27 May 2026
Joint Governor and NED Visit to Lancashire Eye Centre, Chorley	28 May 2026
Board of Directors Meeting	4 June 2026
Carers Forum	24 June 2026
Brindle Ward visit, Chorley Hospital	24 June 2026
Patient and Carers Experience and Involvement Group (P&CEIG)	30 June 2026

10.2 GOVERNOR ISSUES REPORT

Information Item

REFERENCES

Only PDFs are attached

10.2 Governor Issues - Full Report 23.7.26.pdf

Council of Governors Report

Meeting of the	**Council of Governors**		**23 July 2026**
	Part I ☒		**Part II** ☐
Title of Report	**Governor Issues Report**		
Report Author	Jennifer Foote, Director of Corporate Affairs		
Recommendation/ Actions required	The Council is asked to receive the report and note the contents for information.		
	Decision ☐	**Assurance** ☐	**Information** ☒
Executive Summary	The purpose of this report is to provide visibility of the issues and concerns raised by Governors for information. 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. During the period April 2026 to June 2026, two issues had been raised. The first related to damaged chairs located at the PALS office and on the Red Corridor at Royal Preston Hospital, which presented a potential health and safety risk. Action was taken promptly and both sets of chairs were removed. The second concern related to subcontractors working on the roof at Royal Preston Hospital who appeared not to be wearing appropriate personal protective equipment. Following investigation by Estates and Facilities, assurance was provided that all operatives had been fully inducted and had signed the relevant risk assessments and method statements. A lapse in visible PPE compliance was identified during movement between internal and external work areas. Immediate corrective action was taken, including a toolbox talk, re-induction of operatives, reinforcement of PPE requirements, and enhanced site management monitoring. The issue was resolved and additional controls were implemented to strengthen compliance.		
Link to Strategic Objectives 2026/27	**Patients – deliver excellent care:** Improve outcomes, reduce harm and deliver a positive patient experience.		☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.		☒
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.		☒

	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.	☒
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.	☒

10.3 SINGLE IMPROVEMENT PLAN

Information Item

REFERENCES

Only PDFs are attached

10.3 SIP CoG June 2026.pdf

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Council of Governors Report

Meeting of the	**Council of Governors**		**23/07/26**
	Part I ☒		**Part II** ☐
Title of Report	**SIP June-26 Position**		
Report Author	Katie Marshall, Head of Programme Management Office		
Lead Executive Director	Ailsa Brotherton, Chief Strategy and Improvement Officer		
Recommendation/ Actions required	The Council is asked to: - Note the delivery plan status for June - Note the metric position for June		
	Decision ☐	**Assurance** ☐	**Information** ☒
Executive Summary	The purpose of this report is provide an overview of June delivery position including key risks and high level metric status across each of the 5 portfolios of the Single Improvement Portfolio (SIP) Key areas of delivery risk include -Implementation of the sickness absence management system -Delivery of WRP schemes and savings -Delivery of digital systems included PEP, Self-Check-in and AVT the resulting impact on headcount reduction and savings		
Link to Strategic Objectives 2026/27	**Patients – deliver excellent care:** Improve outcomes, reduce harm and deliver a positive patient experience.		☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.		☒
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.		☒
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.		☒
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.		☒
Due Diligence	To give the Council assurance, please complete the following:		
Committee Approval:	Trust Management Board	Date: 15/07/26	
Operational Group Review:	5 P portfolio boards	Date: June-26	
Link to Board Assurance Framework:	The SIP scope is cross-organisational aiming to deliver the strategic objectives of the Trust strategy. This is directly linked to mitigating and controlling all risks		
Appendices	State whether there are any appendices and list them. For example: Appendix 1: SIP Delivery pack June-26 Appendix 2: SIP Data pack June-26		

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Single Improvement Plan - Delivery Pack

July 2026 meeting

Excellent care with compassion

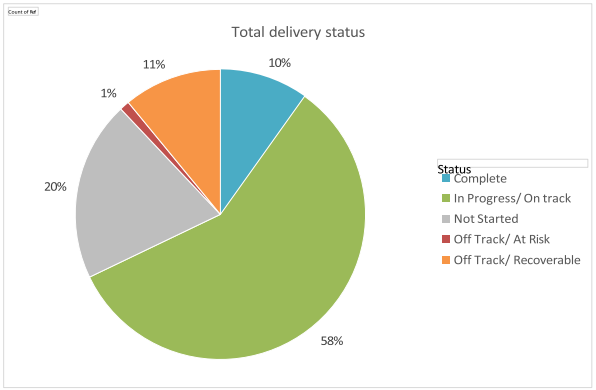
Always Safety First

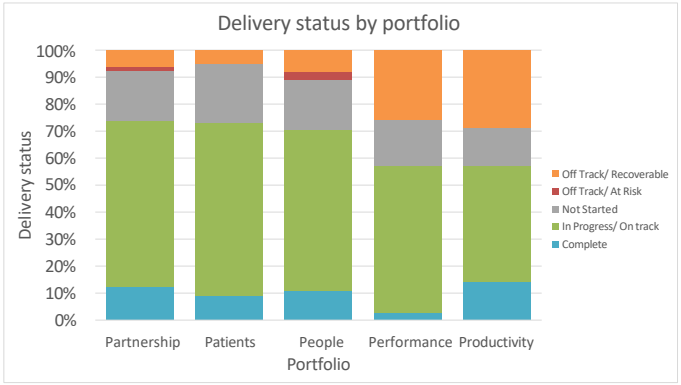
@LancsHospitals

Single Improvement Plan Dashboard 2026-2027

Lancashire Teaching Hospitals Single Improvement Plan (SIP) 2024-2027 has been designed to simplify our approach to what we need to improve across the organisation. Our priorities have been chosen through a combination of feedback from patients, colleagues and our regulators, and alignment to our corporate objectives.

Delivery position | Reporting Period June-26





June 2026 - Overall positive momentum with more work starting and completing, and fewer items at critical risk. However, there has been an increase in 'Off Track / Recoverable' highlighting slippage against planned delivery dates.

Positive Movement:
- Completion rate increased from 7% to 10% (+3 percentage points) — 27 items now complete
- Not Started items reduced from 23% to 19% (-4 percentage points)
- At Risk items reduced from 3% to 1% (-2 percentage points) — only 3 items are at risk overall

Areas of Concern:
- Off Track / Recoverable increased from 8% to 11% (+3 percentage points) — 30 items slipped from in progress to off track against planned date

Key areas of risk:
- Sickness absence management system rollout
- WRP delivery
- Digitall delivery - PEP phase 2, self check in, AVT

Metric position | Reporting Period June-26

Variation \ Assurance	Will consistently fail target within expected variation	Could both pass or fail target within expected variation	Will consistently pass target within expected variation
Recent concerning pattern in the data	- Staff Survey: Recommend Trust as place to work - Vacancies (% FTE)	- Pressure Ulcers per 1000 beds days (Category 2 and above)	- Staffing Fill Rate Registered Nurse - Staffing Fill Rate Health Care Assistant - PIFU Rate
Normal variation - no recent change	- Compliance with 15 minute ambulance turnaround time target - Compliance with 45 minute ambulance turnaround time target - Average Number of boarded patients - Reduce not meeting criteria to reside (DKAFH) - Percentage of patients that receive a diagnostic test within six weeks - Cancer 62-day performance - Staffing Fill Rate Maternity Support Worker/Maternity Care Assistant	- Staffing Fill Rate Registered Midwife - Complaints per 1000 bed days - Perinatal - Number of Stillbirths - Maximum wait of 12 hours as Total Time in Dept - Bed occupancy % - 85% theatre utilisation - aggregate - Capped - Cancer Faster Diagnosis Performance - 31 Day Cancer Standard - Number of violence and aggression incidents toward staff	
Recent positive pattern in the data	- Percentage of UEC (Type 1 & 3) patients seen within 4 hours - Percentage of Patients waiting less that 18 weeks - RTT - 52 week Waiters	- C. diff perf against national trajectory - no more than 199 Hospital Acquired cases - Turnover (% FTE) - Sickness Absence (% FTE)	- STAR Accreditation all trust (Silver and Above)

June 2026 -
Overall positive: Workforce stability, infection control, and training compliance remain strong. STAR Accreditation and appraisal compliance are notable achievements.
Overall negative: Emergency care metrics, patient flow, and elective/cancer pathways have deteriorated. Vacancy rates and staff morale are concerning.

Positive Movement:

Registered Nurse Fill Rate: Remained strong at 97.6% (target: ≥95%), indicating sustained staffing levels.
Registered Midwife Fill Rate: Maintained at 97.2% (target: ≥95%).
STAR Accreditation (Silver and Above): Improved to 89% (target: 75%), showing positive recognition and compliance.
Turnover (% FTE): Exceptionally low at 0.62% (target: ≤10%), suggesting workforce stability.
Appraisal Compliance: Achieved 90.92% (target: ≥90%), meeting appraisal targets.
Core Skills Mandatory Training Compliance: 95.45% (target: 90%), above target
C. difficile Cases: Only 5 cases in April (target: ≤14), well below national trajectory.

Areas of concern:

Ambulance Turnaround (15 min): Dropped sharply to 27.65% in May (previous: 66.3%), well below target.
Ambulance Turnaround (45 min): Fell to 81.5% (previous: 95%), below target.
UEC (Type 1 & 3) Seen Within 4 Hours: Slight improvement to 70.45% in May, but still below target (previous: 82%).
Maximum Wait (12 hours): Increased to 12.15% (previous: 10.5%), indicating longer waits.
Average Number of Boarded Patients: Rose from 0 to 32 in May, a significant negative shift.
Bed Occupancy: Increased to 95.46% (previous: 94%), above optimal levels.
Days Kept Away from Home: Jumped to 2304 lost bed days (previous: 1178), indicating more delayed discharges.
Diagnostic Test Within 6 Weeks: Dropped to 59.73% (previous: 66.1%), below target.
Cancer 62-Day Performance: Declined to 59.09% (previous: 68.2%), below target.
31 -Day Cancer Standard: Fell to 87.52% (previous: 94%), below target.
Vacancy Rate (% FTE): Increased to 8.13% (target: ≤6%), indicating more vacancies.
Sickness Absence (% FTE): Slightly above target at 5.57% (target: ≤5.5%).
Staff Survey (Recommend Trust): Only 42.54% (target: ≥60%), indicating low staff morale.

Patients Portfolio

Programme Aim	To provide better care, faster access and safer services		
SRO	**Sarah Morrison and Steve Canty**	**Milestone tracker**	*% (from plan)*
Programme Director	Catherine Gregory/Rachel Sansbury	Not Started	22%
		In Progress/ On track	64%
Reporting Period	Jun-26	Complete	9%
Report Date		Off Track/ Recoverable	5%
Overall programme rating		Off Track/ At Risk	0%

Escalation Report

Alert (escalations - Tasks at risk)

Patient Experience- ED Friends & Family Test performance remains below target (85%), despite a slight improvement in May. Ward volunteers to routinely collect patient feedback via Friends & Family Test to strengthen data capture (including rollout to ED).

Safeguarding- Dip in rapid tranquilisation audit compliance in Medicine, requiring targeted action. Targeted training and increased oversight being implemented to address compliance issues in Medicine.

Children and Young People- UEC improvement plan for CYP not yet fully developed, representing a key gap in delivery, however Lindsey Dickinson will be working with CYP team to develop a robust UEC improvement plan.

Maternity and Neonatal- Commissioning challenges regarding substantive funding for the Maternal Medicine Centre remains unresolved with the ICB, requiring continued escalation.

Estates and Facilities- Risk to funding for the ward block drainage scheme, with NHS England requesting further detail and no confirmed capital approval. Outline business case submitted for drainage scheme; additional information provided to strengthen funding case.

Advise (challenges - Tasks off track/recoverable)

Patient Experience- Mandatory e-learning (PALS & complaints) launching from June for Band 6+ staff.

Maternity and Neonatal- Potential impact from forthcoming Ockenden and Amos reports, which may require changes to delivery plans.

Always Safety First- Refreshed Always Safety First improvement plan introduced, structured around three pillars: Safer Culture - Safer Systems - Safer Patients

Estates and Facilities- Engagement and planning underway for large-scale estate works, including phasing and decant considerations.

Health and Safety- Actions underway to address HSE findings, particularly around staff medical surveillance compliance.

Specialist Services- Programme in early mobilisation phase with: Initial meetings completed and structure and actions defined

Long Terms Conditions- Initial scoping underway, focusing on: redesign of pathways at system level and identification of best practice models to inform future service design with strong emphasis on integrating health inequalities and safeguarding into pathway redesign

Assure (successes - Tasks complete)

Patient Experience- Commissioned Annie Laverty (Northumbria model) for a 12-week programme to implement experience-based design and real-time feedback approaches.

Safeguarding- Improved Ulysses reporting, enabling better visibility of: Physical restraint incidents and Breakdown by gender, ethnicity, Learning Disability, and mental illness

Maternity and Neonatal- All Tier 2 posts initially recruited, demonstrating strong progress toward rota stability (despite one vacancy emerging). Infant feeding midwife (Band 6) now in post, enabling support to neonatal services to be reviewed.

Medication Safety- Safe staffing SOP completed, providing a formal framework for pharmacy workforce standards. Insulin leads confirmed and initial DSN job plan assessments completed, strengthening governance and oversight.

Estates and Facilities- Six-facet survey launched across the estate, supporting improved space utilisation planning. National Cleaning Standards on track for full compliance before September, nearing full staffing establishment.

Health and Safety- HSE inspection overall positive, with: Strong staff engagement and timely actions acknowledged by inspectors. New senior leadership appointments secured; Band 8A Health & Safety Manager, Band 5 Officer and Recruitment underway for Band 7

Specialist Services- Strong alignment with Always Safety-First programme with a focus on improving patient pathways and communication

Risks

Risk	Score	Mitigation
Insufficient resident Medical staff Rota for paediatrics	20	Business case in progress aiming to address the acute Rota and outpatient capacity short-fall
Maternal Medicine Centre lacking consultant Physician and specialist input from medical specialties	20	Business case for maternal medicine Centre now with ICB.
ED exit block	20	Re-start of the "continuous flow" model DKAFH cultural change programme mobilised

Key decisions	Key enablers
	1. Organisational capacity and engagement with the subject matter expertise to deliver significant organisational change□

Delivery assurance overview	
Delivery tracking	26/27 milestones updated and cycle in place with leads to maintain.
Governance	Patients SIP Board to monitor delivery and escalations to exec
Metrics	Key metrics and outcomes identified. Core patients metrics tracked via main SIP data pack.
Risks	Delivery risk scored and tracked

Performance Portfolio

Programme Aim	To meet and exceed national performance standards		
SRO	**Katie Foster-Greenwood**	**Milestone tracker**	*% (from plan)*
Programme Director	Laura Walsh	Not Due	17%
Clinical Lead	Michael Stewart/ Arnie Bhowmick	In Progress/ On track	52%
Report Date	07/07/2026	Complete	3%
Reporting Period	Jun-26	Off Track/ Recoverable	28%
Overall programme rating		Off Track/ At Risk	0%

Escalation Report

Alert (escalations - Tasks at risk)

UEC	**Days Kept Away from Home** - The % beds occupied via DKAfH patients and lost bed days is higher than target for May 26. Work continues re embedding a strengths based approach to reduce deconditioning, ensure more timely ward actions to promote optimal flow and increased use of the discharge lounge. Additionally work continues with system partners to increase the acuity of patients supported within the 24/7 IMC unit and to prevent avoidable non health related admissio **Boarded Beds** - slight decreases were noted in May 26 however further actions to drive LOS reductions are underway to support the erradication of boarding at the earliest opportunity.
Planned Care	**RTT performance** - The number of follow ups >25% overdue has increased month on month since Oct 24. Capacity constraints are driving these increases however there is an opportunity to significantly demand manage via PIFU and the development of agentic models are in design in Cardiology as a pilot. Additional resource has been requested via an NHSE bid - await outcome, which will support a wider roll out at pace. Target is to increase PIFU rates by +15% by March 27. **RTT 18 weeks** : Performance was static in May 26 with the unvalidated June position showing marginal improvements but performance remains below the operational target. Additional capacity is being mobilised internally and via IS providers, validation is ongoing and productivity improvements to drive DNA reductions and increased theatre and clinic utilisation are underway. Work has commenced with GIRFT to establish a forecasting model linked to capacity and demand modelling and measureable improvement plans and will allow a more accurate forecast to be shared at the end of July.

Advise (challenges - Tasks off track/recoverable)

Diagnostics	**DM01** - Performance in May imprived by +6% however remained below target. The unvalidated performance for June is presently above target at 70.59% with forecasting suggesting compliance against the operational plan will be sustained by Sept 26.
Planned Care	**RTT:** The number of follow ups >25% overdue has increased month on month since Oct 24. Capacity constraints are driving these increases however there is an opportunity to significantly demand manage via PIFU and the development of agentic models are in design in Cardiology as a pilot. Additional resource has been requested via an NHSE bid - await outcome, which will support a wider roll out at pace. Target is to increase PIFU rates by +15% by March 27.
UEC	**Virtual Ward - June 26** occupancy remains just below target but has slightly improved versus May 26. VW Medical staff have been recruited to and commence in post mid July 26. A re-design workshop is planned for September. **Ambulance Handover:** 45-minute+ handover performance improved in June however remains below target. Key actions to drive optimal flow within the ED continue with the launch of EEMAC on 1st July and plans to launch a MAC at the end of July. **SDEC:** % NEL was below the 40% target in May due to the very high levels of bed occupancy and occasional overnight boarding of the department. Plans to protect the space are linked to the EEMAC development and further changes to SDEC will take place aligned to the MAC launch where SDEC will open to 24/7.

Assure (successes - Tasks complete)

Planned Care	**Waiting List size** has continued to reduce with May 26 performance being ahead of plan for the second month. **Long waits:** Zero 65 week breaches (RTT) have been maintained since Nov 25. 52 Week RTT - significant improvement in both the actual and % over 52 weeks with a 5th month of performance above operational plan in May where the number of over 52 week waits = 815 = 1.3% of the waiting list. Work is underway to erradicate 52 week waits by end of Q2 (ahead of the March 27 operational target).
Cancer	**Cancer performance** has exceeded target for 62 day and FDS in May 26 with a 2.4% improvements noted in FDS performance versus April and a 5% improvement in 62 day performance versus April 26.
UEC	**UEC:** 4 Hour performance is above the Trusts operational performance plan for the 3rd consecutive month. **12 hour + ED LOS -** performance is above the Trusts operational performance plan for the 2nd consecutive month.

Risks

Risk	Score	Mitigation
Clinical concerns re follow up backlog and conversaiton of follow up capacity to new resulting from PIFU increases	15	A decision matrix is being developed to ensure safe parameters to support changes in clinical capacity Regular monitoring of PIFU rates Regular monitoring of harms/near misses Scoping options to increase PIFU following waiting list review in the absence of F2F appointments.
Risk re failure to recruit to key medical posts	20	Recruitment plans in place for all medical specialties
ED exit block (escalated to Trust Board)	20	Re-start of the "continuous flow" model DKAFH cultural change programme mobilised
Funding and contract processes for additional capacity - impact on RTT and DM01	20	No funding source in place for 25/26 for DM01 and RTT additional capacity given reduced ERF Cap. Work is underway to assess the impact of transferring ERF funds from RTT areas into other priorities.
Barriers to performance imporvement re lack of data visibility	16	4 productivity dashboards to be developed at pace. Options to ensure data visibility to support the roll out of the Diagnostic Control Room are being scoped

Key decisions	Key enablers
	1. Outpatient Coding to improve income position□ 2. RPA to improve data quality□ 3. Changeology template review to improve standardisation□ 4. Implementation of PEP+ to improve access for patients□ 5. Demand and capacity modelling to make best use of resources□ 6. Population Health data focus to find areas of unwarranted variation and focus improvement, specific focus on DNA and barriers to access□ 7. Shared care pathways to support reduction in follow ups and strengthen the PIFU and PSFU pathway□ 8. Support from ECIST for streaming at the front door□ 9. Support from ECIST for acute medical pathway development□ 10. Scale up of the continuous flow programme□ 11. Support from NHSE regional Diagnostics team to progress diagnostic improvement□ 12. Collaboration with LSCFT which includes;□ Increase 'step up' activity into VW□ Increased utilisation of 2UCR to avoid admission□ Test of change – Community ACP to work with Respiratory ward to support early discharge into the community and/or VW to reduce LoS□ SDEC streaming 13. ICB review of the discharge function/team through a lens of improvement□ 14. Outsourced provider to clear backlog for diagnostics and reach DM01 target□

Delivery assurance overview

Milestone tracking	Improvement plans refreshed for 2627, feeding from detailed specialty level improvement plans into overarching plan
Governance	Improvement plan detailed action delivery monitored via Ops board business cycle
Metrics	Agreed and monitored
Risks	Tracked and reported

People Portfolio

Programme Aim	To support and develop our staff		
SRO	**Neil Pease**	**Milestone tracker**	*% (from plan)*
Programme Director	Louisa Graham	Not Started	19%
		In Progress/ On track	59%
Reporting Period	Jun-26	Complete	11%
Report Date	03/06/2026	Off Track/ Recoverable	8%
Overall programme rating		Off Track/ At Risk	3%

Escalation Report

Alert (escalations - Tasks at risk)

Sickness management: Workforce Advice team capacity extremely constrained - limited capacity for short-term absence cases causing manager frustration. Driven by staffing gaps (1 maternity, 1 long-term sickness, 2 vacancies) plus influx of employee relations cases. Significant employment law risks from failure to support disciplinary/tribunal cases.

Workforce planning, recruitment, resourcing & reporting: WRP WTE removal plan escalated to risk score 20 (Board level, Finance & Performance Committee). 0 WTE transacted against plan in M2. High volume of transformation programmes and data requests challenging to deliver at pace.

Strengthening leadership capability: Capacity and capability to deliver profession-specific leadership programmes constrained. Bespoke OD support required for teams with cultural risks (Pathology Senior Leadership, TUPEd OneLSC). Band 6 recruitment moving to external after internal applicant did not meet criteria.

Improve EDI colleague experience: Government guidance on biological sex released (May 26). Urgent action needed on gender neutral/single occupancy spaces. EDI team capacity impacted 50% (sickness). Initial meetings held re: racism/discrimination experienced by International Midwives. Low engagement from Inclusion forums on key issues.

Advise (challenges - Tasks off track/recoverable)

Sickness Management: Due diligence underway on alternative digital sickness absence management system. Awaiting supplier confirmation on Health Roster interface issue (solution anticipated).

Strenthening retention: HCSW leavers increased from 8 (April) to 13 (May) vs only 6 new starters. Probationary processes being updated for employment law changes. Limited access to turnover data prevents targeted retention interventions at department/team level.

Colleague experience: Your Voice sessions generated significant feedback on physical environment, facilities and estates. Scale and complexity of follow-up work more resource-intensive than scoped. Working with Estates on feasibility, resourcing and timescales but challenges with financing.

Strengthening leadership: Healthskills Programme delayed due to procurement. Ward & Departmental Managers programme design not yet commenced (Oct 2026 start). Senior Leaders Programme viability to be reviewed given scale of other programmes.

Improve EDI colleague experience: New action required following Mann review publication - paper to be shared with Execs noting position, gaps and proposed plan. Requires input from wider OD/Workforce and Patient Experience teams.

Workforce Planning: HCSW B3 gaps remain high with associated bank usage - key risk to WTE mitigation. Challenges with data automation, manual reports still required. L2P data quality issues delaying dashboard development. Workforce analyst capacity challenged pending new recruit start.

Assure (successes - Tasks complete)

Supporting health & wellbeing: Month 2 sickness absence rate of 5.38% - further reduction and >1% lower than same period last year.

Strengthening retention: Overall turnover under target (0.69% May). 60 leavers in May, 123 YTD (vs 139 same point last year). Of 55 voluntary leavers: 20% Promotion, 20% Work-Life Balance, 16% Relocation. New Starters Hub design underway. First redesigned Welcome events delivered with Exec attendance.

Workforce planning: Digital Assistant programme (Phase 1) scoping commenced. 81 WTE HCSW in offer (June 26). Divisional Workforce plans in development (O&G, Oncology completed). Senior Workforce Analyst due to start July 26. Speciality level SIF dashboards in progress on Qlik.

Strengthening leadership capability: Matrons & Professional Leads programme commenced - 2 cohorts inducted, 27 registered. Leadership in Lancs and What Good Looks Like Guides drafted. 87 completed objective setting masterclass. 33 Pathology colleagues trained on Appraisals. Ward & Dept Managers: 102 registered.

Colleague Experience & Culture: Divisional Staff Survey Action Planning completed and reported to Workforce Committee. Trust Corporate Action Plan completed. Strong FY start with 30 TED completions (vs 23 last year). Your Voice events 4&5 underway. Values relaunch plans progressing.

Colleague experience - EDI: Options appraisal paper completed on toilet spaces. Initial review of Lord Mann publication completed with actions noted and gaps identified.

Risk	Score	Mitigation
Continuing risk of lack of oversight around sickness policy compliance. This was a gap in assurance identified by MIAA audit.	16	Procurement engaged to support resolution of issues with contract deliverables Alternative systems being scoped
Lack of national guidance and clear direction from national bodies regarding the Supreme Court Judgement with regards to biological sex, leading to trans colleagues feeling vulnerable and not safe at work, with potential for increased discrimination claims whilst practical arrangements are thought through. Risk in colleague/patient complaints if/when trans colleagues utilise the bathroom spaces which align with their biological sex. Risk in variation of policy and practice with colleagues TUPEing in/out of the organisation, folllowing LTH policy and guidance yet working on a site which is part of another Trust.	15	Estates to provide solutions in respect of the 'art of the possible'. Raised with NW NHSE team and local EDI colleagues. Provision of regular communications to protected groups, signpost H&WB support and Lancs LGBTQ charity, LGBTQ+ Inclusion forum, participation in national workshops to influence and understand national direction and legal implications where possible.
Declining advocacy scores linked to patient care concerns and growing apathy	15	The 2024 Staff Survey highlighted a continued decline in advocacy scores, with free text comments linking concerns to patient care pressures and wider financial challenges. Alongside this, an increasing culture of apathy is emerging, much of which sits outside OD's direct influence. To mitigate this we have strengthened communications to reinforce purpose and pride in patient care, recognising both effort and outcomes. Support managers to lead local improvements that positively influence team culture and experience. Executive engagement sessions themed around advocacy will be rescheduled, focusing on listening to concerns, addressing barriers, and promoting visible leadership.
Capacity within the workforce data team to support delivery actions in line with identified milestones	12	Associate Director covering where possible. Manual reports/extracts being scheduled for storage on server. Data cleanse underway of L2P data, processes and system controls. Interviews arranged for Senior Workforce Analyst 18/19 May. Internal BI support in place to assist in development of job planning and vacancy dashboards.
Psychological wellbeing capacity is leading to significant delays in staff being able to access appropriate support - waiting times in excess of 10 months for high intensity therapies□	12	The skill mix review reported is with the aim of mitigating risk to waiting times. Job plans are being reviewed to maximise clinical capacity New KPIs for each waiting list will be introduced to help quantity the cap between capacity, demand and
Management time and capacity to engage and take forward team level actions which make the difference.	12	Provide leaders with ready-made resources (e.g. 'Conversation Priorities' and 'Change One Thing' tools) to reduce preparation time. The new Managers' Hub, now live on the intranet, gives managers quick and easy access to all tools, resources and training to support colleague experience. Progress is being reinforced through Leadership Forums, Managers' Updates, and divisional reporting to track and share team-level actions. Managers Update session Feb simplfied the approach leaders can take to Staff Survey with the new dashboard new features to support understanding of results. Drop in sessions will be available to support managers too.
Commitment and capacity of departments and services to action feedback at corporate level following staff survey analysis.	12	We will engage with internal departments and services (e.g. IT, Catering, car parking) to share free text comments and triangulate findings with new starter feedback. Where the 2025 survey identifies concerns, relevant departments will be required to analyse themed comments, evidence their response, and develop tangible actions. These will be communicated to colleagues to ensure transparency and close the feedback loop.
Limited vacancies (when vacancy freeze active) for at risk staff members to be redeployed into leading to potential redundancy costs.	8	Redeployment process in place captures all organisational changes to services, potential headcount reductions and vacancies which create opportunities of displaced staff to move into. Full vacancy freeze now lifted. Internal first approach to recruitment as part of VCP processes. To date no escalated redundancy risk associated with redundancy cost.
Limited vacancies (when vacancy freeze active) for at risk staff members to be redeyployed into leading to potential redundancy costs.	8	To develop effective workforce plan which details the changes to services, potential headcount reductions and vacancies which create opportunities of displaced staff to move into.

Key decisions	Key enablers
	Clarity on One LSC strategic direction, target operating model and resourcing to support this programme of work and future direction across IT/BI and Workforce data teams. Workforce information capacity. Capacity within the wider Workforce and Organisational Development Team due to long standing vacancies to enable core workstreams to progress at pace and have reach across the organisation to deliver impact. Leaders and managers ensuring compliance with core skills and appraisal, alongside ensuring all colleagues have a high quality appraisal conversation, with clear objectives set and personal development needs documented. Leaders and managers positively applying people management policies e.g. sickness absence management, probation as tools to ensure good performance. Leaders and managers aware of their responsibilities to take action to improve levels of staff satisfaction.

Delivery assurance overview

Delivery tracking	26/27 milestones updated and cycle in place with leads to maintain.
Governance	People SIP group to monitor delivery and escalations to exec
Metrics	Key metrics and outcomes identified. Core people metrics tracked via main SIP datapack. Discussion on trajectory and outcome metrics in-year
Risks	Delivery risk scored and tracked

Productivity Portfolio

Programme Aim	To use our resources wisely and reduce waste		
SRO	**Craig Carter**	**Milestone tracker**	*% (from plan)*
Programme Director	Mina Patel	Not Started	14%
		In Progress/ On track	43%
Reporting Period	Jun-26	Complete	14%
Report Date	07/07/2026	Off Track/ Recoverable	29%
Overall programme rating		Off Track/ At Risk	0%

Escalation Report

Alert (escalations - Tasks at risk)

Waste Reduction Programme: Significant scheme delivery risk as we move into Q2. Schemes such as Nursing Oversight Framework, Medicine reconfiguration schemes and Model Service all at risk of slipped delivery.

Financial Sustainability: WRP target of £60m (5.7% of operating expenditure) - full plan not yet developed. If not developed and delivered, presents risk to 2026/27 financial plan and cash availability. Capital plan requires £4m cash support; revenue plan requires £9m DSF.

Model Service Programme: Lack of dedicated BI support through recruitment delays limiting progress of wave 1 reviews

Advise (challenges - Tasks off track/recoverable)

Waste Reduction Programme: Key transformational/Productivity programmes at risk of full delivery in year - includes Clinical Admin redesign and NEL Model Service

Financial Sustainability: Cash forecast shows Trust will not require revenue cash support until September - contingent on WRP delivering cash releasing efficiencies. Any slippage on DSF or WRP will mean revenue cash support required.

OneLSC: Ongoing reconciliation process to be established. One LSC Accounting Treatment awaiting final governance arrangements. Procurement Board ToR at final draft stage.

Grip & Control: Two MIAA audits have ToR drafted - awaiting CFO sign-off. PWC G&C action plans require updating prior to quarterly TMB/FPC update.

Model Service Programme: Wave 1 off track - risk to overall programme delivery

Assure (successes - Tasks complete)

Waste Reduction Programme: £60m green plan now achieved

Financial Sustainability: Capital expenditure YTD £2.26m below plan. Positive response from NHSE on capital bids. I&E £0.05m favourable to plan. M2 WRP delivery £1.2m vs £1.1m plan (+£0.1m).

OneLSC: Reconciliation of One LSC tracker to LTH tracker completed. Procurement plans developed for all WRP target (£4.5m), majority fully developed.

Grip & Control: 2025/26 MIAA audit recommendations completed and approved. 2026/27 audit plan approved. Quarterly G&C update reported May 2026. Enhanced G&C measures in place for headcount WRP slippage.

Model Service Programme: 10 reviews completed, 7 output reports awaiting sign-off. Communication plan launched - Wave 2 mobilised for Q2.

Risks

Risk	Score	Mitigation
Deliver 2627 financial plan including fully developed WRP plan	20	Development of a fully developed and signed off WRP plan by the end of May. This deadline has not been met, current green plan at £42.9m with remaining gap being worked through by PWC and PMO with divisional teams.
Cash consequences of financial deficit	16	Committee approved cash management policy, annual cash plan in place monitored and reported monthly to committee including BPPC. Continuous review of capital programme. Engaging with affected suppliers and internal escalation of urgent issues. Efficiency programme progessing with focus on cash out. Applications for cash support where appropriate
Capital programme is not developed with associated governance	12	Review of capital planning and mobilisation underway

Key decisions	Key enablers
	1. Organisational capacity and engagement with the subject matter expertise to deliver significant organisational change 2. Strong and robust finance function to support the annual business cycle and financial performance framework enabled by One LSC 3. Strong and robust procurement function to support non pay delivery 4. Strong system engagement to optimise care in the right setting

Delivery assurance overview

Milestone tracking	Improvement plans reviewed, minor amends to ensure OneLSC objectives are clear.
Governance	Productivity portfolio board held in June, TOR and membership agreed
Metrics	In process of being refreshed for 2627 with new DCFO

Partnerships Portfolio

Portfolio Aim	Work closely with other health care and partner organisations		
SRO	**Silas Nicholls**	**Milestone tracker**	*% (from plan)*
Programme Director	Sarah Morrison	Not Started	18%
		In Progress/ On track	62%
Report Date	07/07/2026	Complete	12%
Reporting Period	Jun-26	Off Track/ Recoverable	6%
Overall programme rating		Off Track/ At Risk	2%

Escalation Report

Alert (escalations - Tasks at risk)

Health Inequalities: The Reasonable Adjustment Digital Flag requirement is at risk of missing the September 2026 national deadline, as Harris has advised that the shared care record solution cannot be delivered until January 2027.

Digital: Several digital schemes remain off track and require clearer revised delivery dates, dependency management with divisional teams, and alignment across digital governance routes.

Research: The dormant innovation / Edovation vehicle requires a strategic decision on whether to reactivate, formally progress through executive governance, or pause while the organisation focuses on University Hospital Status and commercial research priorities.

Advise (challenges - Tasks off track/recoverable)

Education: NHS England restructuring continues to create uncertainty for some education portfolios, although existing communication channels remain open and work is progressing.

Digital: Digital governance is being revised so that the operational digital partnership route, the new digital oversight committee and this board receive aligned reporting without duplication.

Health Inequalities: Health inequalities and population health content will need to be embedded through routine training review processes, as the revised EDI mandatory training package is expected to be nationally provided with limited ability to add local content.

One LSC: The OneLSC delivery plan and aims are still being developed, with Richard Beeken identified as the new lead and a further update requested for August.

Assure (successes - Tasks complete)

Community Services: The LTHTR and LSCFT joint committee terms of reference and memorandum of understanding have been signed off by both boards, with implementation planning due to commence in September 2026. The Community Services Single Point of Access review is underway, with both trusts having completed self-assessment and a system-wide workshop being planned for September.

Education: The University of Lancashire and LTHTR memorandum of understanding has been signed, with two fully funded education fellow posts confirmed to support medical student delivery. Education, improvement, research and innovation collaboration continues to strengthen, including national recognition through conference presentation, a national SAS doctor education award, and apprenticeship direct claim status.

Research and University Hospital Status: UHS work is progressing through the business case, self-assessment and supporting evidence work, with a clear ambition to apply within the current financial year and sooner if possible.

Health Inequalities: The Health Inequalities BI self-serve guide has been developed and will be uploaded to the intranet and training materials to support wider use of population health data

Risks

Risk	Score	Mitigation
The community contract value is not sufficent to deliver the services to specification (LTH then can't meet demand)	16	1. Ensure open and transparent channels of information sharing between LSCFT and LTH 2. Gain full financial oversight before making final decisions 3. Manage expectations on spec delivery ahead of any transfer 3. Influence future commissioning arrangements
Infrastructure at LTH is not robust enough to support integration of community services, with limited opportunity to change due to financial restrictions	12	1. Consider vertical and horizontal integration options 2. Understand LSCFT's clinical/operational leadership structure associated with physical health community services that would transfer to LTH and improve infrastructure
Risk to new 150 day target for trial set-up from staffing response time and aseptic capacity delaying decisions.	9	Funding has been invested from R&I and NIHR in both additional management and the aseptic unit - PB had intial discssions with E Barr - re WRP and aseptic provision and additional staffing is coming. Also discussed potential capital provision with E Barr and Craig C. Still problematic re delays etc but only minor protocol deviations
1. National requirement to have up to date travel plan by December 2026 2. National guidance may not be met within specified timescales - quarterly data reporting 3. Year 1 actions overdue - outlier within LSC and quarterly data submission 4. Unable to provide assurance meeting national supplier roadmap 5. Unable to progress national requirements / Adaptation Plan 6. Unable to provide assurance for all areas of focus	9	Escalate through FPC / SIP

Key Enablers	Key Decisions/ change control

Delivery assurance overview

Milestone tracking	26/27 milestones updated and cycle in place with leads to maintain.
Governance	Partnership SIP Board to monitor delivery and escalations to exec
Metrics	Key outcomes identified and tracked by leads.
Risks	Delivery risk scored and tracked

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Single Improvement Plan - Data Pack

July 2026 meeting

Excellent care with compassion

Always Safety First

SPC KPI Metric Grid

Lancashire Teaching Hospitals NHS Foundation Trust

Variation \ Assurance	Will consistently fail target within expected variation	Could both pass or fail target within expected variation	Will consistently pass target within expected variation
Recent concerning pattern in the data	- Staff Survey: Recommend Trust as place to work - Vacancies (% FTE)	- Pressure Ulcers per 1000 beds days (Category 2 and above)	- Staffing Fill Rate Registered Nurse - Staffing Fill Rate Health Care Assistant - PIFU Rate
Normal variation - no recent change	- Compliance with 15 minute ambulance turnaround time target - Compliance with 45 minute ambulance turnaround time target - Average Number of boarded patients - Reduce not meeting criteria to reside (DKAFH) - Percentage of patients that receive a diagnostic test within six weeks - Cancer 62-day performance - Staffing Fill Rate Maternity Support Worker/Maternity Care Assistant	- Staffing Fill Rate Registered Midwife - Complaints per 1000 bed days - Perinatal - Number of Stillbirths - Maximum wait of 12 hours as Total Time in Dept - Bed occupancy % - 85% theatre utilisation - aggregate - Capped - Cancer Faster Diagnosis Performance - 31 Day Cancer Standard - Number of violence and aggression incidents toward staff	
Recent positive pattern in the data	- Percentage of UEC (Type 1 & 3) patients seen within 4 hours - Percentage of Patients waiting less that 18 weeks - RTT - 52 week Waiters	- C. diff perf against national trajectory - no more than 199 Hospital Acquired cases - Turnover (% FTE) - Sickness Absence (% FTE)	- STAR Accreditation all trust (Silver and Above)

Non SPC Metrics flagged as a concern

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

Patients

Metric Description		Assurance @ Mar-27	Variation to Latest Actual	Target			Latest Month Actual	Latest Month
				Concern	Mar-27	Latest Month Target		
Deliver Annual Safe Staffing Requirements	Staffing Fill Rate Registered Nurse	P			95%	95.0%	98.6%	May-26
	Staffing Fill Rate Health Care Assistant	P			95%	95.0%	95.0%	May-26
	Staffing Fill Rate Registered Midwife				95%	0.95	97.2%	May-26
	Staffing Fill Rate Maternity Support Worker/Maternity Care Assistant	F		⚑	95%	95.0%	92.6%	May-26
Patient Experience and Involvement	Complaints per 1000 bed days				1.40	1.40	1.95	May-26
	STAR Accreditation all trust (Silver and Above)	P			75%	75.0%	88.8%	May-26
C Difficile Improvement	C. difficile performance against national trajectory - no more than 167 Hospital Acquired cases				14	14	15	May-26
Always Safety First	Hospital Standardised Mortality Ratio - Adult	Lower Than Expected					70.1	Jan-26
	Standardised Mortality Ratio - Relative Risk - All Diagnoses Adult	Lower Than Expected					67.6	Jan-26
	Standardised Mortality Ratio - Relative Risk - All Diagnoses Child (<1 day – 17 yrs)	As Expected					280.3	Jan-26
	Standardised Mortality Ratio - Relative Risk - All Diagnoses Neonates (<1-28 Days) *The updated TELSTRA model from November 2024 does not include still births*	As Expected					409.3	Jan-26
	Pressure Ulcers per 1000 bed days (Category 2 and above)			⚑	3.30	3.30	4.40	May-26
Maternity	Perinatal - Number of Stillbirths				0	0	2	May-26

Performance

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Metric Description		Assurance @ Mar-26 / 27	Variation to Latest Actual	Target			Latest Month Actual	Latest Month
				Concern	Mar 26 / 27	Latest Month Target		
UEC In Flow	Compliance with 15 minute ambulance turnaround time target				66.30%	65.20%	24.86%	Jun-26
	Compliance with 45 minute ambulance turnaround time target				95.00%	90.10%	83.94%	Jun-26
	Percentage of UEC (Type 1 & 3) patients seen within 4 hours				82.00%	71.90%	73.22%	Jun-26
	Percentage of UEC (Type 1) patients seen within 4 hours				77.90%	66.30%	67.80%	Jun-26
	Percentage of UEC (Type 3) patients seen within 4 hours				98.00%	94.20%	94.20%	May-26
	Maximum wait of 12 hours as Total Time in Department				10.50%	12.25%	11.00%	Jun-26
	Corridor Care Actual in ED						568	Jun-26
	Corridor Care as a % of total ED attends (Type 1)						4.35%	Jun-26
UEC Flow	Bed occupancy %				94.00%	94.00%	95.52%	Jun-26
	Average Number of boarded patients				0	0	28	Jun-26
UEC Outflow	Reduce not meeting criteria to reside (Days Kep Away From Home)				5.00%	9.20%	11.34%	Jun-26
	Days Kept Away from Home - Lost Bed Days				1178	1178	2304	May-26
	% Patients Discharged on their Discharge Ready Date (DRD)				95.00%	86.90%	82.90%	May-26
	Non Elective Averge LOS (Excl 0 LOS)				7.5	7.5	6.6	May-26
Elective (Diagnostics)	Percentage of patients that receive a diagnostic test within six weeks				80.00%	68.10%	66.02%	May-26
Elective (Long waits)	1st Attendance within 18 Weeks				70.00%	61.10%	60.40%	May-26
	RTT - Percentage of patients waiting less than 18 weeks				70.00%	59.10%	57.44%	May-26
	RTT - 52 week Waiters				0	1353	815	May-26
Elective (Theatre Utilisation)	85% theatre utilisation - aggregate - Capped				85.00%	85.00%	85.87%	May-26
Elective (Cancer) (unvalidated position, subject to change)	Cancer 62-day performance				80.30%	73.00%	68.49%	Jun-26
	Cancer Faster Diagnosis Performance				80.00%	80.00%	83.26%	Jun-26
	31 Day Cancer Standard				94.00%	94.10%	88.83%	Jun-26
Elective (Out-Patients)	PIFU Rate				7.50%	5.20%	4.24%	May-26

People

Metric Description		FY2627 Target Assurance	Latest Actual Variation	Target			Latest Actual	Latest Period
				Concern	FY2627	Latest Month Target		
People	Vacancies (% FTE) (source: General Ledger)				≤ 6%		9.06%	M02
	Turnover (% FTE) (annual assessment; ESR in-month reported)				≤ 10%		0.44%	M02
	Sickness Absence (% FTE) (annual assessment; in-month reported)				≤ 5.5%		5.38%	M02
	Number of violence and agression incidents toward staff (annual assessment; in-month reported)				996		85	M02
	Core Skills Mandatory Training compliance (% modules) (module compliance reported)				100% of metrics at 90%		100.00%	M02
	Appraisal compliance (% HC)				≥ 90%		90.24%	M02
	Staff Survey: Recommend Trust as place to work (quarterly metric)				≥ 60%		40.97%	Q1

Productivity

Metric Description		Assurance @ Mar-27	Variation to Latest Actual	Target (£ 000's)			Latest YTD Actual (£ 000's)	Latest Month
				Concern	Mar-27	Latest YTD Target		
Productivity	I&E - Plan v Actual variance					-11004	-10955	May-26
	WRP schemes delivery				60000	1520	1614	May-26

10.4 MINUTES OF GOVERNOR SUBGROUPS

Information Item

a). Care and Safety Subgroup ? 11 May 2026
b). Membership Subgroup ? 12 May 2026

REFERENCES

Only PDFs are attached

10.4a Minutes CaSS Subgroup 11 May 2026.pdf

10.4b Minutes Membership Subgroup 12 May 2026.pdf

Care and Safety Subgroup

11 May 2026 | 10am| Hybrid meeting, Gordon Hesling Conference Room, RPH

Members:

George Bailey	Public Governor (Chair)
Sonia Connell	Staff Governor *(MS Teams)*
Ian Facer	Public Governor *(MS Teams)*
Graham Fullarton	Public Governor *(MS Teams)*
Lou Jackson	Appointed Governor
Angela Kos	Public Governor *(MS Teams)*
Ian Linacre	Staff Governor *(MS Teams)*
Carole Oldcorn	Public Governor
Graham Robinson	Public Governor
Tim Young	Public Governor *(MS Teams)*
Apologies:	Enid Povey, Christine Turner, Susan Bailey, Linda Bracewell

In Attendance:

David Thompson	Assistant Director of Resilience *(MS Teams)*
Dr Karen Deeny	Non-Executive Director *(MS Teams)*
Nicola Compton	Corporate Affairs Officer *(minutes)*
Alison McCrudden	Patient Experience & Involvement Lead *(MS Teams)*
Apologies:	John Howles

20/26 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.

21/26 Declarations of interest

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

22/26 Minutes of the previous meeting

The minutes of the meeting held on 19 March 2026 were approved as an accurate record subject to a specific point regarding the recording of thanks to outgoing members, where it was agreed that this should be amended to appropriately recognise those individuals by name, and the minutes would be updated accordingly to reflect this change.

23/26 Matters arising and action log

The action log was reviewed and updated.

24/26 Estates and Facilities Update

An update was provided on the actions arising from the previous meeting, confirming that all actions had been progressed, with works either completed or scheduled, and necessary parts ordered and contractors appointed with agreed completion dates. It was

noted that one outstanding action relating to a longstanding issue with a narrow pathway at Chorley required planning permission and would therefore take longer to resolve, with a further update to be provided in due course. The subgroup acknowledged the prompt response to a recent operational issue involving obstructions in hospital corridors, noting that swift intervention had improved accessibility for patient movement and expressing appreciation for the timely resolution of the matter.

The subgroup requested an update on planned electrical and drainage works at the site. It was confirmed that the electrical infrastructure improvements had received executive approval and were progressing, with assurance provided that there would be no disruption to patient services due to the availability of backup systems. In relation to the drainage works, it was noted that plans were still being developed in conjunction with contractors and design engineers, and that due to the complexity of the works, the nature of the building, and the requirement for multiple regulatory approvals, this would be a longer-term programme extending over a number of years.

Concerns were raised regarding wayfinding and signage following recent ward relocations, with acknowledgement that this required improvement, and it was agreed that this would be followed up to ensure appropriate updates were in place. A request was made for an update at the next meeting regarding the condition of flooring within the elective care unit, noting previous concerns that the floor gradient had affected the safe movement of equipment and had generated complaints from staff and patients..

25/26 Patient Quality, Experience and Engagement Update

No representative available.

26/26 Patient Experience and Involvement Update

A report was presented outlining key areas of activity, including work undertaken by the Patient Information Group, which had progressed a significant volume of new and revised patient information materials, including detailed illustrated resources and a number of newly developed leaflets subject to review and refinement to improve clarity and accessibility. Ongoing work to enhance digital access to information was noted, alongside the continued provision of paper copies where required. An update was provided on the Carers Forum, which continued to offer a supportive environment for engagement and discussion, with positive feedback received. Policy oversight activity was highlighted, particularly in relation to patient property and valuables, where ongoing work to strengthen processes and staff awareness had contributed to a reduction in related claims. Update was also provided on volunteer services and associated initiatives to enhance recognition and engagement, as well as the hospital guide scheme, which continued to support patients through improved wayfinding and accessibility, receiving positive feedback. Progress was noted in relation to health inequalities work and partnership activity, including engagement with local stakeholders and community groups. Developments relating to language and interpretation services were reported, including concerns regarding service quality from one provider and plans to review and test an alternative platform to improve reliability and user experience while maintaining a range of interpretation options. Further engagement activity was outlined, including participation in community forums and partnerships with external organisations supporting accessibility, particularly in relation to visual impairment and the deaf community, with future plans to strengthen staff training and awareness in these areas.

The discussion focused on volunteer services, where it was acknowledged that there was limited visibility of the scope and impact of volunteer roles within clinical areas, particularly

in emergency care, and that further work was required to better understand, define and communicate volunteer contributions to both staff and management.

A query was raised regarding the extent to which patient experience and involvement were being embedded within the development of the new urgent and emergency care operating model, particularly in ensuring that patient input informed the programme from the outset rather than following implementation. It was acknowledged that responsibility for this programme sat elsewhere and an action was agreed to seek an update and obtain assurance on this point. It was confirmed that the transformation of urgent and emergency care formed a key component of the wider assurance programme and that Safety and Quality Committee oversight would be established from an early stage to ensure that patient experience was integral to the design and delivery of the programme. Concern was expressed regarding the ambitious timeline associated with the urgent and emergency care improvement programme, specifically the expectation to achieve compliance with the four-hour standard within a six-month period, which was perceived as challenging and that patient experience and involvement functions did not appear to have been engaged at an early stage of the programme, leading to a lack of assurance that patient input was being embedded from the outset. It was acknowledged that the four-hour improvement trajectory formed part of a shorter-term delivery programme, while the broader transformation of urgent and emergency care was a more extensive, longer-term piece of work.

The meeting also considered wider patient experience issues, including examples of extended waiting times and communication concerns, which were highlighted as impacting patient confidence.

Significant concerns were raised regarding the prevalence of inappropriate and discriminatory behaviour directed towards staff by patients and visitors, including instances of racial abuse observed across clinical environments. It was recognised that this behaviour was reflected in staff survey feedback and represented a growing trend, with discrimination between staff reported to be declining but abuse from patients and the public increasing. The importance of reinforcing a zero-tolerance approach was emphasised, with discussion highlighting the need for clear messaging, visible support mechanisms, and staff training to ensure individuals felt confident to challenge unacceptable behaviour. It was acknowledged that failing to act risked normalising such conduct, whereas an immediate and consistent response could help deter further incidents and support affected staff. It was confirmed that this issue would be escalated to the appropriate governance route for workforce oversight, and to provide assurance on the actions being taken to address staff safety and wellbeing.

Positive feedback was also shared recognising areas of good practice, including staff responsiveness and compassionate care, alongside established work to improve accessibility and inclusivity for diverse patient groups, with appreciation noted for ongoing engagement and service development.

27/26 Non-Executive Director Update

An update was provided on the Safety and Quality Committee meeting held in April. It was reported that one of the previously assigned principal risks relating to C. difficile had been successfully mitigated and stood down following sustained improvement, with performance reaching a historically low level of incidents, although ongoing monitoring through established governance arrangements would continue. The remaining principal

risks, relating to patient safety and experience within the urgent and emergency care pathway and reducing health inequalities, had been refreshed to ensure that mitigating actions were clearly defined and within the Trust's control, with a strengthened focus on deliverable actions rather than wider system factors.

The urgent and emergency care transformation programme was highlighted as a significant area of focus, particularly in relation to patient flow and the national priority to eliminate corridor care, with a clear requirement for defined metrics, structured reporting and time-bound milestones. This included work to re-model the medical staffing model to better align with peak demand, alongside the development of new service models such as same day emergency care for frailty patients and enhanced multidisciplinary input, all of which would be subject to regular scrutiny by the Committee. It was emphasised that while system pressures remained a factor, there was a clear shift towards accountability for actions within organisational control.

Further updates confirmed continued progress across a range of quality areas, including the successful implementation of improvements in specialised services, ongoing monitoring of children's services performance, and actions taken in response to increased patient liaison contacts linked to administrative capacity pressures, which had been addressed through reinstatement of resource. Assurance was also provided that all actions arising from the most recent regulatory inspection had been completed, with mechanisms in place to sustain improvements despite external challenges such as changes within regulatory bodies.

The subgroup was also made aware of ongoing workforce challenges affecting service delivery, particularly difficulties in recruiting to certain roles, and the reliance on temporary measures to maintain safe staffing levels. In addition, future areas of focus were highlighted, including oversight of newly consolidated regional services and continued assurance on urgent and emergency care performance and patient experience, reflecting the scale and complexity of the quality agenda being managed.

The subgroup noted assurance that Clostridioides difficile infection rates had improved and were being actively maintained through a comprehensive assurance framework, including ongoing monitoring of cleaning compliance and associated infection prevention processes, with any deterioration in compliance triggering early intervention rather than reliance on infection rates alone.

Concern was raised regarding the potential for unintended consequences arising from financial and workforce decisions, particularly where reductions in administrative capacity had led to service delivery issues. It was confirmed that such incidents had been identified, promptly addressed and were being used to inform wider review and learning, with enhanced monitoring across multiple data sources, including quality dashboards, staffing metrics and clinical audits, to identify emerging risks and understand root causes. The Committee was advised that changes to workforce or service models were undertaken alongside redesign to improve efficiency and quality, supported by robust quality impact assessments and executive scrutiny, although it was acknowledged that full assurance could not be absolute and that a degree of managed risk was inherent. Emphasis was placed on maintaining openness, ensuring rapid learning from both financial and workforce decisions, and being prepared to reverse decisions where necessary.

Further discussion highlighted concerns regarding the impact of operational pressures on patient safety, including boarding, corridor care and rising pressure sores incidents,

alongside challenges associated with service reconfiguration and communication with staff. Assurance was provided that elimination of corridor care and improvement of urgent and emergency care pathways remained key priorities within a wider transformation programme, recognising that significant change would be required and may carry risk. The subgroup acknowledged the importance of balancing innovation and financial sustainability with patient safety, noting that risk could not be eliminated but must be effectively assessed, monitored and mitigated through established governance processes. It was proposed that further development on the risk assessment and assurance framework be provided through a future session to support understanding and oversight.

28/26 Reflections of the meeting and Visits

Constructive feedback highlighted enhancements in attendance and engagement, with acknowledgment of increased participation. The discussion underscored the significance of sustained inclusivity, ongoing member involvement, and contributions to uphold strong governance.

29/26 Request for future meeting topics, visits and any other business

Future Visits

A programme of governor visits was in place, including arrangements across Preston and Chorley, with additional visits being facilitated where specific areas of interest had been identified.

Future Meeting Topics

It was agreed that more time should be allocated within future agendas for interaction during assurance discussions, recognising their value and depth.

Any Other Business

The Committee agreed to confirm the appointment of Enid Povey as Vice Chair of the subgroup.

Date, time, and venue of next meeting
16 July 2026 at 12.30pm – Hybrid Meeting, Gordon Hesling Conference Room, RPH

Membership Subgroup

12 May 2026 | 10.00am | Microsoft Teams Meeting

Members:

Sheila Brennan	Chair
George Bailey	Deputy Chair
Ian Linacre	Public Governor
Graham Robinson	Public Governor
Tim Young	Public Governor

Apologies: L Bracewell, I Facer, E Povey

In attendance:

Karen Deeny	Non-Executive Director
Nicola Compton	Corporate Affairs Officer *(minutes)*

9/26 Chair and quorum

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

10/26 Declaration of interests

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

11/26 Minutes of the previous meeting held on 3 February 2026

The minutes were accepted as a true and accurate record.

12/26 Action Log

The action log would be updated accordingly.

Matters Arising

Events Diary: Thanks to Tim Young, Governors had secured a stand at the Penwortham Gala. A stand had also been reserved at the Leyland Health Mela. Unfortunately, there would be no Governors in attendance at the Burnley Health Mela.

Communications: The Subgroup discussed the current approach to communications and promotion of Trust membership, noting several missed opportunities. It was highlighted that the Subgroup had not been consulted on the most recent *Trust Matters* publication, and concerns were raised that governors should not be waiting to be asked for input. The Subgroup agreed that proactive content should be developed by governors and shared with the Communications Team for inclusion in future publications, particularly in the lead-up to the Annual Members' Meeting.

Members expressed concern that current communications materials did not clearly explain what being a Trust member involved, what benefits membership offered, or why individuals should become members. The Trust website and existing promotional materials were described as unclear and a missed opportunity to engage the local community. Specific concerns were raised regarding existing on-site posters at Royal Preston Hospital and Chorley and South Ribble Hospital; while the design quality was acknowledged, it was noted that the posters did not reference membership or clearly convey their purpose, reducing their effectiveness as engagement tools.

The Subgroup recognised that this point in time presented an opportunity to "reset" the Trust's approach to membership engagement, particularly given the appointment of a new Lead Governor and the arrival of new governors. There was strong support for taking a more inclusive and collaborative approach moving forward.

The potential value of closer working with the Communications Team was discussed. It was suggested that inviting a senior member of the team to engage with the Subgroup could help improve mutual understanding and support the development of clearer, more effective membership messaging. Members noted that this should be approached carefully, acknowledging previous challenging interactions and positioning any engagement firmly as a constructive reset. It was agreed that an informal discussion, rather than a formal Subgroup meeting, may be the most effective way to re-establish the relationship. Emphasis was placed on ensuring that any invitation was positively framed and non-confrontational.

The group also noted opportunities to make better use of Trust digital screens, particularly those now operational at RPH reception and within the Emergency Department, to promote membership and governance awareness. It was suggested that short captions or slides relating to membership could be displayed.

13/26 Discussion on improving communicating with members.

The Subgroup discussed whether current membership engagement activities were successfully reaching all parts of the Trust's communities. Reference was made to dashboard data and recent community engagement activity, including the Gujarat Centre, where there had been positive interest and new member sign-ups. Members questioned whether similar levels of engagement were being achieved across other localities, including areas such as Penwortham and Garstang and noted the importance of ensuring equitable reach across the Trust's population.

It was acknowledged that community events, such as the Penwortham Gala, offered valuable opportunities for engagement due to high footfall. However, members recognised that a consistent challenge remained converting interest into completed membership sign-ups. This was linked to ongoing difficulties in clearly articulating what Trust membership involves and the tangible benefits of becoming a member.

The Sup-group reflected that positioning membership primarily as a route to becoming a governor was not an effective or compelling message for the wider public. It was agreed that clearer and more cohesive messaging around the purpose and value of membership was required.

The potential impact of forthcoming national legislative changes was briefly acknowledged, with members noting that proposed reforms might affect the future role and structure of membership. It was reported that further clarity was expected following the Bill being laid before Parliament later in May, subject to subsequent amendments.

The Subgroup reflected positively on the introduction of KPIs and welcomed the opportunity to monitor trends in membership growth and engagement over time. There was strong agreement that meaningful progress will only be achieved through sustained community presence rather than committee-based discussion alone.

Concerns were noted regarding limited participation from some new governors in the Subgroup. However, it was acknowledged that many had significant external commitments, and that contribution through community engagement was equally valuable.

14/26 Discussion on how to improve membership diversity.

The Subgroup discussed the importance of inclusivity and whether governors' existing skills and experiences outside their Trust roles could be better utilised. It was suggested that some governors might have professional or voluntary experience relevant to inclusive working and community engagement, which could support membership activity if identified and shared.

Members recalled previous discussions at Council of Governors meetings regarding the development of a governor skills matrix, noting that this work had not been progressed. There was agreement that revisiting this idea could help identify skills, expertise and capacity across the Council, including experience in inclusivity and engagement. It was suggested that governor development or training workshops could provide an appropriate forum to explore skills mapping and collective responsibilities.

15/26 Reflections on the meeting

There were no reflections on the meeting.

Date, time, and venue of next meeting:

14 August 2026, 10am, Hybrid Meeting, Gordon Hesling Conference Room, RPH

The meeting concluded at 10.35am

10.5 REVIEW OF MEETING PERFORMANCE

Chair 12:20pm

10.6 DATE, TIME AND VENUE OF NEXT MEETING

Information Item | Chair | 12:25pm

22 October 2026, 1:00pm, Lecture Room 1, Education Centre 1, Royal Preston Hospital

11. ?RESOLUTION TO REMOVE PRESS AND PUBLIC?

Decision Item | Chair | 12:26pm

Verbal

CLOSE

12:27pm