



Lancashire Teaching Hospitals
NHS Foundation Trust

COUNCIL OF GOVERNORS MEETING



COUNCIL OF GOVERNORS MEETING



22 October 2026



13:00 GMT+1 Europe/London



Lecture Room 1, Education Centre 1, Royal Preston Hospital



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AGENDA

REFERENCES

Only PDFs are attached



0.0 Agenda (PI) - Council of Governors - 22 October 2026.pdf

Council of Governors

22 October 2026 | 1.00 pm

Lecture Room 1, Education Centre 1, Royal Preston Hospital

Agenda

No	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	1.00 pm	Verbal	Procedural	Chair
2.	Apologies for absence	1.01 pm	Verbal	Procedural	Chair
3.	Declaration of interests	1.02 pm	Verbal	Procedural	Chair
4.	Minutes of the previous meetings held on 23 July 2026	1.03 pm	✓	Procedural	Chair
5.	Matters arising and action log	1.04 pm	✓	Procedural	Chair
6.	Chair's opening remarks	1.05 pm	Verbal	Discussion	Chair
7. PRODUCTIVITY AND PERFORMANCE					
7.1	Board Committee Chairs' Reports, including Integrated Performance Report Summary	1.15 pm	✓	Assurance	Non-Executive Directors
7.2	Update from Care and Safety Subgroup	1:55 pm	Verbal	Discussion	G Bailey
7.3	Update from Membership Subgroup	2:05 pm	Verbal	Discussion	S Brennan
8. PATIENTS (SAFETY AND QUALITY)					
8.1	Winter Planning	2.15 pm	✓	Assurance	K Foster-Greenwood
9. GOVERNANCE AND COMPLIANCE					
9.1	Implications of Health Bill for Council	2.30 pm	✓	Decision	J Foote
9.2	Annual Members Meeting Analysis	2.40 pm	✓	Information	J Foote
10. ITEMS FOR INFORMATION (taken as read)					
10.1	Governor opportunities & activities report		✓		
10.2	Governor issues report		✓		
10.3	Corporate and Governor Calendar		✓		

No	Item	Time	Encl.	Purpose	Presenter
10.4	Strategic Forward Plan		✓		
10.5	Single Improvement Plan		✓		
10.6	Minutes of Governor Subgroups: (a) Care and Safety Subgroup – 16 July and 9 September 2026 (b) Membership Subgroup – 14 August 2026		✓		
10.7	Review of meeting performance	2.50 pm	Verbal		Chair
10.8	Date, time and venue of next meeting: <i>21 January 2027, 1:00pm, Lecture Room 1, Education Centre 1, Royal Preston Hospital</i>	2.55 pm	Verbal	Information	Chair
	Close meeting	2.55 pm			

1. CHAIR AND QUORUM

 Other

 Chair

 1.00 pm

Procedural Item

2. APOLOGIES FOR ABSENCE

● Other

● Chair

● 1.01 pm

Procedural Item

3. DECLARATION OF INTERESTS

 Other

 Chair

 1.02 pm

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

 Other

 Chair

 1.03 pm

Procedural Item

REFERENCES

Only PDFs are attached

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

Council of Governors

Public Meeting

23 July 2026 | 10.00am

Lecture Room 1, Education Centre 1, Royal Preston Hospital

Present:

Tim Ballard	Chair
Pav Akhtar	Public Governor (<i>via MS Teams</i>)
Takhsin Akhtar	Public Governor (<i>via MS Teams</i>)
George Bailey	Public Governor (<i>via MS Teams</i>)
Linda Bracewell	Public Governor
Sheila Brennan	Public Governor
Darrell Brooks	Public Governor
Michelle Brown	Appointed Governor (<i>via MS Teams</i>)
Sonia Connell	Staff Governor
Philip Curwen	Public Governor
Ian Facer	Public Governor
Graham Fullarton	Public Governor
Angela Kos	Public Governor
Terry Lindsay	Public Governor
Daniel Matchett	Appointed Governor (<i>via MS Teams</i>)
Zulekha Mushtaq	Public Governor (<i>via MS Teams</i>)
Ian Linacre	Staff Governor (<i>via MS Teams</i>)
Enid Povey	Public Governor
Tom Ramsay	Staff Governor
Adrian Rata	Staff Governor
Graham Robinson	Public Governor
Suleman Sarwar	Public Governor (<i>via MS Teams</i>)
Tim Young	Public Governor

Apologies: Susan Bailey, Lou Jackson, Carole Oldcorn, Mike Thomas, Christine Turner

In attendance:

Jennifer Foote MBE	Director of Corporate Affairs
Adrian Leather	Non-Executive Director
Karen Lawrenson	Corporate Affairs Officer
John Schorah	Non-Executive Director
Joanne Wiseman	Corporate Affairs Officer

Apologies: StJohn Crean, Karen Deeny, Uzair Patel, Silas Nicholls, Tim Wheeler

Presenters:

John Howles	Divisional Nursing Director for Surgery (<i>minute no. 39/26</i>)
Sarah Welsh	Interim Associate Director for Patient Experience Involvement and Quality (<i>minute no. 39/26</i>)
Claire Granato	Associate Director of AHPs (<i>minute no. 40/26</i>)
Lindsey Dickinson	Deputy Chief Medical Officer (<i>minute no. 40/26</i>)

31/26 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.

32/26 Declaration of interests

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

33/26 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 further clarification in minute reference 20/26 that the measurable improvements anticipated in relation to the Urgent and Emergency Care four-hour wait standard referred to the position from October 2026

34/26 Matters arising and action log

A copy of the action log had been circulated, and no outstanding actions remained.

A request was made and confirmation provided that Council would be informed of the final amount transferred into the Trust's main Charitable Funds account, as approved at the previous meeting (Council of Governors Minute No. 20/26 refers).

35/26 Deputy Chair's opening remarks

An overview of key achievements of the Trust in the year to date was provided. Both clinical and non-clinical staff across the organisation were thanked for their continued dedication, professionalism and commitment to improvement. The Single Improvement Plan was highlighted as a central mechanism for aligning improvement activity, supporting financial sustainability while maintaining a clear focus on patient safety and effective care.

Progress was recognised in a number of services, including improved endoscopy performance, the launch of an extended emergency ambulatory care service, the establishment of a 24-hour thrombectomy service and strong outcomes within the major trauma centre. Investment in infrastructure and service development was also referenced, including the purchase of land in South Preston for a future hospital, refurbishment of the Broadoaks Child Development Centre in Leyland, helipad improvements, a significant research grant for stroke care and investment in radiotherapy equipment at Rosemere Cancer Centre.

It was acknowledged that, while challenges remained, particularly in relation to reducing corridor care, there was evidence of positive momentum across the Trust. Governors and Foundation Trust members were thanked for their continued contribution to the organisation's improvement journey. Special dispensation had been granted to a Governor to enable continued contribution despite being unable to attend meetings in person due to ongoing health issues.

36/26 Board Committee Chairs' Reports, including Integrated Performance Report Summary

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

a) Finance and Performance Committee:

The Finance and Performance Committee update was received. Performance was reported to have improved, with assurance provided that trajectories were being scrutinised through the Finance and Performance Committee and that the Trust had been on track for the four-hour and 12-hour urgent and emergency care standards in May and June. It was acknowledged that further work remained in relation to 18-week referral to treatment, 62-day cancer performance and waiting list reduction, although these areas were reported to be moving in the right direction.

Limited assurance was reported in relation to the Trust's Waste Reduction Programme (WRP) which required delivery of £60 million savings over the year in order to secure additional regional deficit support. The full £60m savings plan had now been identified, although still required full risk-adjustment for deliverability. Whilst delivery was reported to be on plan at quarter one, the target to date had been modest and delivery would need to accelerate significantly, particularly with workforce reduction plans.

In response to questions, it was confirmed that further work was required on workforce planning, workforce deployment, risk appetite and divisional accountability, and that schemes would be subject to quality and patient safety review. It was also acknowledged that under-delivery in year would increase the challenge of achieving the Trust's three-year financial recovery plan.

In response to a question regarding staff communication, it was recognised that internal communication about the financial challenge and associated improvement opportunities was essential to the success of the WRP. As an operational matter, staff communication would continue to receive focus from the Trust Executive.

In response to a question about the scope and clarity of productivity in the context of financial pressures, examples were cited across activity, workforce, digital solutions and prevention-focused work, with further assurance required on delivery, governance and impact. Additional fortnightly meetings had commenced outside the Finance and Performance Committee cycle to monitor progress and actions. It was emphasised that productivity-related improvement and financial recovery should be considered alongside patient safety and outcome measures, with assurance provided that financial improvement must not compromise safe and effective care.

In response to further questions, the modest phasing of the first quarter savings target was explained as reflecting the profile of activity from the previous year and the need to build momentum. It was acknowledged that later-year targets would be significantly more challenging. Some increased confidence was reported that actions were beginning to emerge which could support improvement in the second half of the year; however, full assurance over delivery could not yet be provided.

b) Charitable Funds Committee

The Charitable Funds Committee update was received, and the relationship between the overarching Charitable Funds Committee and the Rosemere charity subcommittee was explained. Rosemere continued to perform strongly, supported by the generosity of staff and the wider community. Income was reported to be slightly below projection, although it was recognised that legacy income remained inherently difficult to forecast and was now required to be recorded once notification had been received, rather than on receipt of funds.

Assurance was provided that charitable funds continued to be applied only to items above and beyond what should ordinarily be funded by the NHS. It was acknowledged that this boundary had become more challenging in the context of wider financial pressures, and that some bids had been received for items which would ordinarily be centrally funded. The Committee had maintained a robust approach in line with Charity Commission expectations and its responsibilities as steward of the charitable funds

Council was informed of a planned fundraising event in support of Rosemere, linked to the charity's 30th anniversary activity. In response to a question regarding charitable funding for improvements which could later be affected by estate or infrastructure works, the need for careful consideration was acknowledged, with appropriate reinstatement or equivalent benefit expected to be considered where relevant.

c) Safety and Quality Committee

An update was provided on the Safety and Quality Committee, with assurance provided that patient safety remained a central focus in the context of significant financial pressures. It was reported that the Committee continued to apply robust but constructive challenge, with a revised approach to meetings enabling greater time for scrutiny, discussion and assurance rather than presentation of reports.

Urgent and emergency care, including corridor care, was identified as a key area of focus due to its wider impact on patient safety and related harms, including pressure ulcers. The Committee had sought more granular assurance on delivery plans, trajectories and timescales, although assurance remained partly judgement-based and would be strengthened once sustained improvement was evidenced through performance data.

Maternity services had been considered in the context of national reports and recommendations, including Ockenden-related learning. Assurance was provided that relevant findings were being reviewed and that feedback had been requested on the Trust's position and improvement actions. It was reported that key maternity and neonatal outcome measures remained within expected tolerances, although implementation of Birthrate Plus recommendations would need to be phased due to financial constraints.

In response to a question regarding rising caesarean section rates, it was confirmed that communication and education for service users remained work in progress, with further

discussion held with clinical leadership. Operational changes, including all-day theatre lists, had been introduced to support increased demand.

In response to questions regarding pressure ulcers, it was acknowledged that prolonged waits in urgent and emergency care, use of bank staff, communication issues and access to appropriate equipment were contributing factors requiring further assurance.

In response to questions regarding delivery of urgent and emergency care improvement trajectories, it was confirmed that further granular assurance had been sought from clinical leadership. It was acknowledged that the position remained challenging and partly assured, with delivery dependent on evidence of sustained improvement in the data.

The importance of maintaining patient safety while delivering financial recovery was emphasised. Quality impact assessment processes were in place to identify potential unintended consequences of savings schemes, with senior clinical input and the ability to veto proposals where patient safety risks were identified. The Committee also discussed the “safety first” strategic approach, with assurance provided that patient safety was monitored through a range of outcome measures, safety metrics, incident review processes and direct non-executive observation of clinical governance arrangements.

d) Workforce Committee

An update was provided on the Workforce Committee, which had met for the final time on 12 May, with its functions transferred across the Finance and Performance Committee and the People and Partnerships Committee.

Assurance was provided that triangulation of core skills, staff experience, appraisals and sickness had enabled greater scrutiny of high-performing and underperforming teams, and that targeted work was being undertaken to address areas of shortfall. Improvements in sickness absence were reported, with associated productivity benefits and reduced reliance on bank staff contributing to more stable teams. An alert was noted in relation to inequitable staff experience, particularly for disabled staff, as identified through workforce race and disability equality data. Further engagement with staff and targeted improvement activity were identified as required.

In response to a question regarding the potential link between bank staff use and poorer patient outcomes, it was noted that this remained a focus of the Committee. In response to a further question regarding the impact of workforce reductions on patient safety and patient experience, it was reported that digital solutions and ambient technology were being explored to support administrative capacity, although implementation had been variable and further assurance had been sought. In response to a question regarding anti-racism and behaviour standards, it was reported that further assurance had been requested on the effectiveness and consistency of implementation plans, with targeted action required in areas where behaviours and staff experience did not meet expected standards.

e) Education, Training and Research Committee

No further meeting had taken place since the last Council meeting.

f) Audit Committee

An update was provided on the Audit Committee, and assurance was provided that the drugs loss position was not material and was controlled.

37/26 Update from Care and Safety Subgroup

An update was provided on the Care and Safety Subgroup. Support from the subgroup was acknowledged, and efforts were being made to encourage continued attendance and pro-active engagement. Ward visit reports were being introduced to capture structured feedback from Governor visits and to ensure these were reported through the Committee. Detailed reports had been received at the latest meeting, with themed discussion areas including anti-racism and communications. The group's focus was being developed to better reflect patient experience, while maintaining its role in supporting effective challenge and collective contribution to improving patient experience.

38/26 Update from Membership Subgroup

An update was provided on the Membership Subgroup. There had been limited interest from members in attending forthcoming engagement events, which was considered to have been a missed opportunity to meet with the public. The focus had therefore shifted to the Annual Members' Meeting, with improved communication and use of social media planned to support wider awareness and attendance. Updated membership data was expected to be available for the next membership meeting in August.

39/26 Patient Experience and Involvement Annual Report

J Howles and S Welsh attended for this item

The Patient Experience Annual Report was received, with assurance provided that systems were in place to listen to patients, carers and communities, and to use feedback to inform improvement. Improved patient feedback was noted, including increased Friends and Family Test responses, a rise in compliments, improved complaints handling timescales and strong national survey results in maternity and cancer services. The contribution of volunteers and Governors to patient experience activity was also recognised.

It was acknowledged that communication remained the most significant factor affecting patient experience, particularly in relation to delays, discharge processes, waiting times and periods of operational pressure. The need for further targeted engagement with underrepresented groups, including men, younger people and some ethnic communities, was also noted. Priorities for 2026/27 included improving communication, reducing the impact of long waits, maintaining privacy and dignity in challenging environments, and strengthening equitable, patient-centred care.

In response to a question regarding PALS activity, it was confirmed that concerns and enquiries were monitored against a local response standard and reviewed with divisions. Appointment delays were identified as the largest theme, with related improvement work being considered through patient experience governance routes. Assurance was provided that concerns were shared with relevant clinical and divisional leads and reported through performance improvement forums to support identification of themes and learning.

In response to a further question regarding the Complaints Review Group, it was stated that complaint outcome categories, including upheld, partially upheld and not upheld, were established as part of national reporting requirements.

40/26 Left shift and Neighbourhoods

C Granato and L Dickinson attended for this item

The left shift and neighbourhoods update was received. The approach reflected the strategic movement of care from hospital into community, primary care, neighbourhood and home-based settings, in line with the NHS 10-year plan. The approach was described as transformational, with a focus on prevention, early identification, proactive management, specialist support in the community and primary care, and hospital care only where clinically required.

Frailty was highlighted as an example of the approach, with work underway on early identification, stratification and participation in the National Frailty Collaborative. Further development was required in relation to community-based comprehensive geriatric assessment, multidisciplinary working, rapid response and virtual ward services to support admission avoidance and home-first care.

The importance of the model was noted in the context of increasing demand, long-term conditions, emergency admissions, bed pressures and delayed discharges. Integrated neighbourhood working in Central Lancashire remained at an early stage, with further work required to develop neighbourhood models, make better use of population health data and identify services which could be shifted closer to home.

Digital interoperability and shared care plans were identified as key challenges to effective delivery. Collaborative work with Lancashire and South Cumbria NHS Foundation Trust was being formalised through a joint committee, expected to commence in September, to support transformation and accountability. The outcomes-based focus of the approach was welcomed, and the importance of effective communication and information continuity across services was emphasised.

41/26 Annual Members Meeting

The Annual Members' Meeting details were received. It was reported that the meeting had been scheduled for Monday 5 October at the same venue as the previous year, following positive feedback. The change of day was intended to test whether an alternative date would support attendance, and the venue booking had also been influenced by availability constraints.

42/26 Items for information

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

- (i) Governor Opportunities Summary
- (ii) Governor Issues Report
- (iii) Single Improvement Plan
- (iv) Strategic Forward Plan
- (v) Minutes of Governor Subgroups:
 - Care and Safety Subgroup – 11 May 2026

- Membership Subgroup – 12 May 2026

43/26 Review of meeting performance

The Chairing of the meeting was acknowledged positively, with appreciation expressed for allowing the questioning of Non-Executive Directors to take place as part of the Council's role in holding them to account. The attendance and responses of the Non-Executive Directors were also recognised, and a number of challenging questions had been addressed across several areas. It was acknowledged that the level of challenge had been appropriate and in line with the intended purpose of the meeting.

44/26 Date, time and venue of next meeting

The next meeting of the Council of Governors was confirmed as 22 October 2026, 1.00pm, Lecture Room 1, Education Centre 1, Royal Preston Hospital

45/26 Resolution to remove press and public

No members of the press or public were in attendance and no resolution to exclude was therefore required.

The meeting concluded at 12.09pm

5. MATTERS ARISING AND ACTION LOG

 Other

 Chair

 1.04 pm

Procedural Item

REFERENCES

Only PDFs are attached

 5.0 Action log (part I) - Council of Governors - 23 July 2026.pdf

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

No	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update
1.	33/26	23.7.26	Matters arising: Governor charity fund - Council to be informed of the final amount transferred into the Trust's main Charitable Funds account	Head of Charities	22.10.26	Completed Update 22 October 2026: Communication emailed to Governors by CAT on behalf of Head of Charities.

6. CHAIR'S OPENING REMARKS

● Discussion Item

● Chair

● 1.05 pm

Verbal update

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

 Other

 Non-Executive Directors

 1.15 pm

Item for Assurance

REFERENCES

Only PDFs are attached



7.1 Board Committee Chairs' Reports inc. IPR CoG October 2026.pdf



Council of Governors Report

Meeting of the	Council of Governors		22 October 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.	☒	
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 structures align with the Trust's strategic priorities 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 People and Partnerships Committee met on 15 July and 8 September 2026. Oversight was maintained of the strategic risks within the Committee's remit, with particular scrutiny applied to whether mitigating actions were translating into measurable reductions in risk. Positive assurance was received in relation to workforce compliance, health and wellbeing, medical job planning and progress against the Education and Research and Innovation Single Improvement Plans. Improvements in sickness absence and mandatory training compliance were reported, while continued attention was considered necessary in relation to workforce capacity, employee relations pressures and the demonstration of measurable benefits from improvement activity.

At the September meeting, concern was raised regarding persistent OneLSC risks, where evidence of operational improvement remained limited despite mitigating activity and established escalation arrangements. Further assurance was therefore required regarding the effectiveness of these mitigations. Assurance was received regarding progress against the Education and Research and Innovation Single Improvement Plans, including strengthened governance and academic partnership arrangements and continued progress towards University Hospital Status. A strong foundation for implementation of the NHS Staff Standards was reported, although improvements were required in workforce intelligence to support understanding of inequalities and the drivers of the gender and disability pay gaps. Positive assurance was also received regarding overall turnover, onboarding and first-year retention, with the principal retention challenge identified amongst colleagues in the earlier years of employment.

Assurance was received that patient safety, quality and service performance within the Neonatal Unit had been maintained despite high sickness absence, although continued scrutiny was required because earlier improvements in absence had not been sustained. Workforce compliance and mandatory training performance were also reported to be improving, with further development required to strengthen the relationship between training compliance and patient safety and to ensure that failing workforce indicators were accompanied by clear actions, ownership and assurance. Assurance was additionally received regarding medical appraisal, revalidation and governance arrangements, although a resilience risk arising from limited capacity within the central appraisal and revalidation function required further attention.

Charitable Funds Committee

Chair: Tim Ballard

NED Analysis:

The Charitable Funds Committee met on 15 September 2026. Positive performance was reported across both the Hospital's Charity, Baby Beat and Rosemere Charity, with income ahead of target and expenditure remaining controlled. Strong fundraising activity and continued demand for charitable funding were reported, alongside progress with key initiatives including the Baby Beat-supported garden at the Sharoe Green Unit and funding to enhance patient involvement and diversity within cancer research. The Committee was assured that recent workforce changes within the Hospital's Charity would not affect service delivery.

A Rosemere Charity funding application of £32,454 for a Patient and Public Involvement, Engagement and Inclusion Coordinator within the cancer research service was approved, with the role intended to enhance patient experience, engagement and diversity in research activity. A minor amendment to the Rosemere Management Committee Terms of Reference was also reported to align the approval threshold with Standing Financial Instructions.

The overall charitable funds financial position remained positive, with income ahead of target and expenditure broadly in line with plan. A subsequent investment update had confirmed a first-quarter gain of £95,000, providing further assurance regarding the overall financial position. The Annual Reports and Accounts and Letters of Representation for both charities were approved, subject to completion of minor non-material amendments following external audit. Assurance was provided that the amendments would not affect the financial position, key messages or overall understanding of the accounts.

Safety and Quality Committee

Chair: Karen Deeny

NED Analysis:

The Safety and Quality Committee met on 31 July, 28 August and 25 September 2026. Across the period, oversight was maintained regarding the principal risks within the Committee's remit, with continued focus applied to Urgent and Emergency Care, workforce pressures, maternity and neonatal services, pathology, infection prevention, patient safety and regulatory compliance. In July, significant obstetric workforce pressures and the fragility of pathology services were escalated, with inherited histopathology backlogs and industrial action requiring enhanced oversight and recovery arrangements. Assurance was received regarding nursing and midwifery safe staffing, maternity and neonatal safety arrangements, safeguarding, the STAR quality assurance framework, and mortuary and care after death services.

At the August meeting, Urgent and Emergency Care remained outside risk tolerance, although early improvement in corridor care was reported following implementation of new services. Pathology remained under enhanced regulatory and organisational oversight, with strengthened governance, performance reporting and quality monitoring arrangements established during service transition and industrial action. Significant improvement in pressure ulcer performance was reported, while continued attention was required in relation to *Clostridioides difficile*, workforce pressures and the timeliness of assurance arising from national clinical audits. Assurance was received that Patient Safety Incident Response Framework arrangements continued to mature, Allied Health Professional staffing remained safe and significant improvements had been achieved within Endoscopy. The Committee escalated the learning arising from

a Coroner's finding of neglect, for which organisational, workforce, leadership and governance actions had been implemented.

At the September meeting, the pathology industrial action risk had increased and remained a significant operational and patient safety concern requiring continued Board oversight, although no moderate or severe patient harm incidents had been identified. Particular attention was also given to increasing Healthcare Assistant vacancies and the extent to which existing mitigations addressed the consequences rather than the underlying workforce pressures. A cross-committee referral to the People and Partnerships Committee remained in place to support coordinated oversight of recruitment and retention.

Detailed scrutiny was undertaken of maternity and neonatal services. The Maternity Outcomes Signalling System safety drill had provided assurance in accordance with required standards and had identified no systemic safety failures. However, the overall assessment was self-assessed as Amber/Red due to known issues requiring further action, including workforce pressures, induction pathways and caesarean section timeliness. The national 10-point plan baseline assessment demonstrated established governance and assurance arrangements but identified further improvement requirements, including workforce capacity, maternity experience and health inequalities reporting, Martha's Rule and triage performance. The assessment was recommended to the Board for approval and submission to NHS England.

Early benefits from the Urgent and Emergency Care Improvement Programme were reported, including improvements in patient flow and corridor occupancy. However, definitive assurance could not yet be provided that the March 2027 corridor care elimination target would be achieved, with further evidence required regarding the impact and sustainability of transformation initiatives. Positive assurance was received regarding overall sepsis outcomes, medical staffing safety, claims management and improvements in health and safety governance. External review through the Recovery Support Programme had provided positive assurance regarding the quality of care and reliability of the STAR assurance process, while identifying opportunities to strengthen sustainable improvement and organisational learning.

Finance and Performance Committee

Chair: John Schorah

NED Analysis:

The Finance and Performance Committee met on 28 July, 25 August and 22 September 2026. Across the period, continued improvement was reported across a number of operational performance measures, including urgent and emergency care, diagnostics, cancer and elective pathways. However, significant financial and workforce risks remained, particularly in relation to delivery of the Waste Reduction Programme (WRP), workforce reduction, cash, digital dependencies and the sustainability of improvement. Although the full £60m WRP had been identified, forecast delivery remained materially below target and workforce reduction remained significantly behind trajectory.

Financial assurance reduced during the period. At Month 4, a £14.5m deficit was reported, £1.04m adverse to plan, with performance supported by non-recurrent measures. Further work was required for a credible route from forecast WRP delivery of approximately £41m to the £60m target. By September, an emerging cash-flow risk indicated that emergency cash support could be required from December 2026, while uncertainty remained regarding deficit support funding, full-year WRP delivery and future contract income. Limited assurance was consequently provided regarding the overall financial position.

Operational performance continued to improve, with diagnostic performance reaching 75.54% in August and remaining above trajectory. Improvements were also reported across urgent and emergency care, cancer and elective pathways. However, continued concern was raised regarding patients remaining in hospital despite no longer meeting the criteria to reside and the dependency on system partners to provide sufficient community and domiciliary care capacity. The trajectory for improvement therefore remained partly dependent upon factors outside the Trust's direct control. Improvements in Endoscopy were sustained, with all three modalities having achieved 100% performance during July and the work being shared nationally as an exemplar of good practice.

Workforce reduction remained behind plan, with continued reliance on temporary staffing, digital enablement and larger transformation schemes. Increasing attention was given to fragile specialist services, where workforce shortages and operational risks required continued recruitment, transformation and, in some cases, system-level solutions. Digital dependencies, particularly delays to the Patient Engagement Portal, continued to affect workforce reduction, clinical administration and productivity schemes.

Audit Committee

Chair: Tim Wheeler

NED Analysis:

The Audit Committee met on 17 September 2026. Assurance was received that delivery of the Internal Audit Plan remained on track, with no concerns identified that were expected to affect the future Head of Internal Audit Opinion. However, continued scrutiny was required in relation to four outstanding recommendations from 2024/25 concerning sickness absence, health and safety governance and mandatory training, where implementation dates had been revised as actions formed part of wider improvement programmes.

Substantial Assurance was received from the Sepsis Data Quality and C. difficile reviews. The clinical systems downtime policy was also considered to provide a reasonable overall framework, although improvements were required in relation to training, assurance reporting and learning arrangements. Payroll controls relating to salary overpayments were considered effective, with recovery processes in place and no significant issues identified through audit testing. Counter-fraud arrangements continued to provide assurance, with existing controls maintained while a strengthened thematic fraud risk assessment was being developed.

Cyber security assurance was received through comparative benchmarking and independent testing, with positive results reported from external attack simulation activity. Partial assurance was provided in relation to clinical audit reporting. Although action plans were in place and several areas demonstrated good performance, clearer risk-based trajectories, trend analysis and triangulation between reporting cycles were required to strengthen assurance regarding improvement over time.

Concern was raised regarding procedural document compliance, which had reduced from 90% to approximately 85%, reflecting an increased backlog of overdue reviews. Strengthened governance and recovery arrangements had been introduced; however, the Committee considered that extending the standard review period would not address the underlying causes. The three-year review standard was therefore retained and the revised procedural document template was approved.

Integrated Performance Report

October 2026 Council of Governors meeting with performance to
August 2026



Patients



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SPC KPI Metric Grid

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Appendix 1 – Assurance Reports

Key to Metric Variation, Assurance Icons & Dashboard Headers

Key to Metric Variance and Assurance Icons

Assurance Icon			
Variation Icon	Will consistently fail target within expected variation	Could both pass or fail target within expected variation	Will consistently pass target within expected variation
	Failing Target and Getting Worse 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
	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
	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
<i>Recent concerning pattern in the data</i>			
<i>Normal variation – no recent change</i>			
<i>Recent positive pattern in the data</i>			

Key to Metric SPC Chart and Variance and Assurance Icons

Mean
 Process Limit
 Improving special cause

Measure
 Concerning special cause
 Target

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

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

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

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

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

No signs of change over time evident in recent data

An example of concerning change is evident in the recent data

An example of positive change is evident in the recent data

Report heading explanation

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

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

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

The latest month target or threshold.

Data to the end of.

The name of the Metric

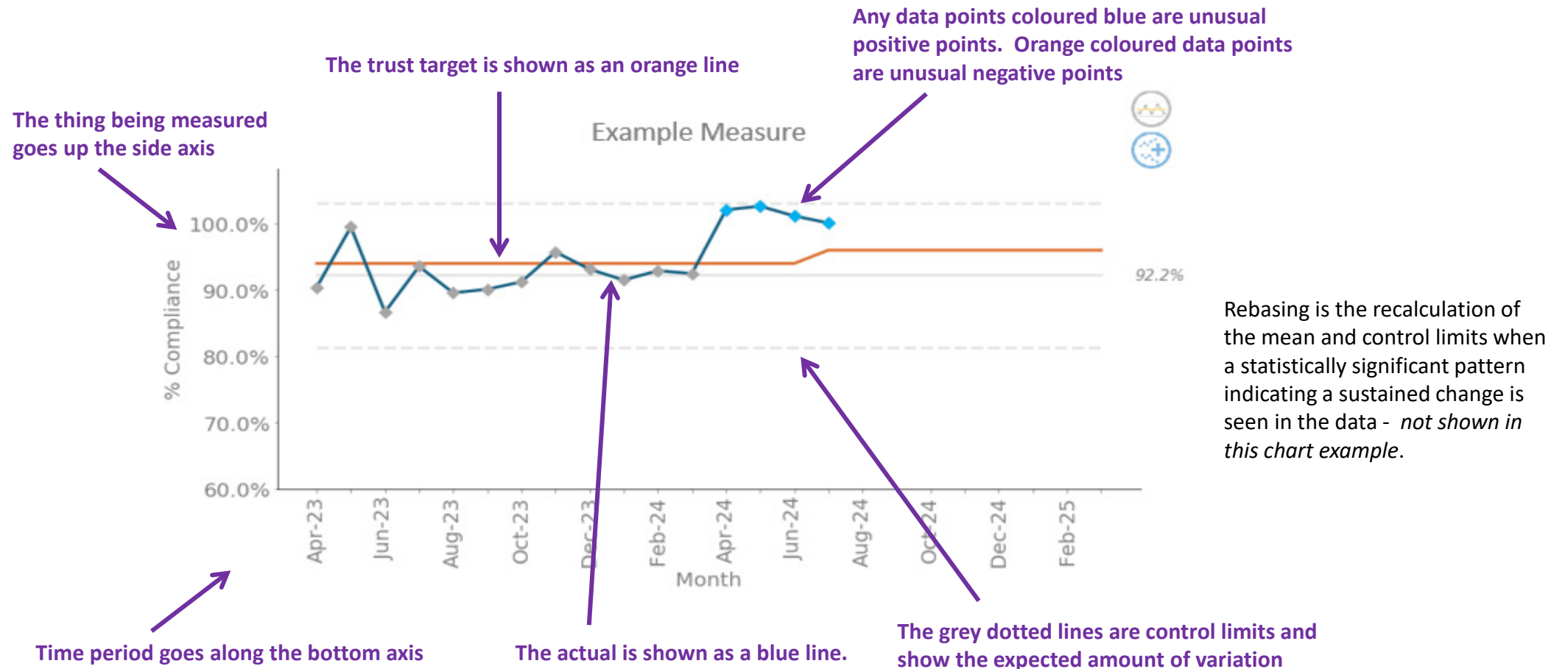
This shows whether there is a special or common cause variation of the metrics.

This March 2025 target

The current month actual performance.

How to read Statistical Process Control charts (SPC)

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





SPC KPI Metric Grid

Assurance Variation	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		- 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 - Staffing Fill Rate - Maternity Support Worker	- Staffing Fill Rate - Registered Midwife - Complaints per 1000 bed days - Perinatal - Number of Stillbirths - C. difficile performance against national trajectory Hospital Acquired cases (COHA & HOHA) - Bed occupancy % - 85% theatre utilisation - aggregate - Capped - Cancer Faster Diagnosis Performance - 31 Day Cancer Standard - Merged - 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 - Percentage of patients that receive a diagnostic test within six weeks - Cancer 62-day performance - Merged - Vacancies (% FTE) - Sickness Absence (%FTE)	- Pressure Ulcers per 1000 beds days (Category 2 and above) actions - Maximum wait of 12 hours as Total Time in Department - Turnover (%FTE)	

Non SPC Metrics flagged as a concern

Non SPC Metrics

Hospital Standardised Mortality Ratio	Lower Than Expected
Standardised Mortality Rate (All Diag	Lower Than Expected
Standardised Mortality Rate (Child <1	As Expected
Standardised Mortality Rate (Neonate	As Expected

Patients



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	Issue	Action
Alert Areas of concern or matters that need addressing urgently	1.a) Corridor Care remains high with 542 patients affected this in month in the Emergency Department. The improvement in 12 hour waits positively impacts the number of patients expereincing corridor care and a plan to eliminate by 31 March 2026 is in place. 1.b) Boarded Patients The average number of patients boarded patients per day has remained broadly unchanged with 27 patients per day affected by this.	1. Urgent & Emergency Care (UEC) pathway productivity: Continued focus on admission avoidance, length-of-stay reduction and improving frailty pathways. 2. Strengthened governance and oversight arrangements remain in place, including executive-led workstreams, weekly performance reporting and monitoring through the strategic oversight group and UEC improvement Board. 3. System-wide collaboration through the single improvement plan and Place-based UEC delivery structures continues to support coordinated action and address capacity constraints across the pathway. 4. The introduction of Extended Emergency Medicine Ambulatory Care (EEMAC) in July has successfully reduced patient numbers in corridors and waiting areas, supporting improved flow and patient experience. 5. The Medical Decisions Unit (MDU) opened in August 2026 to improve pathways of care. 6. A review of patient pathways across acute services is being undertaken to reduce duplication, streamline processes and support the delivery of more effective and efficient patient pathways. 7. System Single point of access event held 24.9.26 with the intention of improving accessiblity and avoiding hospital admissions. 8. Frailty ED, Community and Adult Social care huddles including post discharge frailty follow up and admission avoidance improvement programmes are currently demonstrating sustained week on week improvements in the length of time in ED for over 65 years.
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 89.3%.	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 - These remain within normal variation, however there has been a recent pattern of elocated activity for three data points, the most recent month demonstrates a return closer to the mean. Complaints continue to be predominantly driven by communication failures, delays in care and discharge processes. Patients consistently report frustration when expectations are not managed, information is inconsistent, or updates are not provided. Operational pressures, particularly waiting times, discharge complexity, corridor care and environmental challenges, remain significant contributors to dissatisfaction. Accessibility, cultural responsiveness and equitable communication also remain important themes for improvement.	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. 7. Invited review from a patient experience specialist to support the development of a strengthened patient experience programme, draft report now received and will be shared in Safety and Quality committee in October 26 and reported to Board December 2026.
	3. Pressure Ulcers per 1000 bed days (Category 2 and above) - performance has remained above target since March 2025 until the last 3 months data points where there has been a significant improvement below the mean and below target. As this metric this has been an alert to Safety and Quality Committee in previous months this has now moved to advise until there is evidence that the improvement has been sustained.	1. Continued weekly harm review panel to focus on learning and improvements chaired by Deputy Chief Nursing Officer. 2. Ten-point improvement plan is in place and is being actively overseen for improvements. 3. Proactive Reduction of pressure ulcer rounds carried out by Tissue Viability Nurses are identifying early actions to take preventative actions whilst teaching and training colleagues in real time. 4. Equipment audit has been completed and minimum stock levels identified for each clinical area. Assurance of this is being monitored via Matrons daily checks and the plan is to become embedded within STAR assurance. 5. Divisional governance arrangements for review and validation of pressure ulcers have been reviewed and implemented 6. Refocus on fundamentals of care in ward and departments to reinforce good practice 7. All Matrons have received a letter to outline standards, expectations and to set their objective to reduce pressure ulcers 8. Pressure Ulcer Prevention training added to critical standards for STAR accreditation from October.
	4. Compliance with National Standards of Cleanliness - compliance with mandated cleaning frequencies remains at 90.6% for very high risk areas and at 68.65% compliance for high risk areas. Point of care inspection audits remain above target.	1.Recruitment to remaining 13.91WTE domestics is essential to be compliant with the national standards of cleanliness. This is a risk for delivery as recruitment is taking longer than turnover of staff in post. This continues to be escalated and tracked. 2.Following full service capacity appraisal, the service will step down NSoC across FR3, with resource redirected to FR1 and FR2 areas only. 3.The joint audit process is robust and focussing on the specific areas that need attention. 4.Positive working arrangements between clinical, estates and facilities staff are collaboratively overseeing this risk via partnership board.
	1. . Registered Nurse, Registered Midwife and Health Care Assistant fill rates - are achieving safe staffing levels.	1. Staffing levels consistently meet thresholds, supporting effective care delivery.
	2. STAR accreditation for all Trust.	1. 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.
	3. Mortality - April data (Data is always a quater behind) Adult HSMR - Lower than expected, Adult SMR Adult - As expected SMR Child <1 day to 17 years - As expected SMR - Neonatal <1-28 days - As expected Still Birth rate - The 12-month local average mean still birth rate is 2.1 per 1000 (May 2025 to April 2026 excluding TOPFA) remains below the national average of 3.9 per 1000 births. 4. C.difficile rates - New tolerance for 2026/2027 has been agreed at 109 cases. Currently within trajectory.	1. Mortality actions continue as outlined in the biannual mortality plan. 1. 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.



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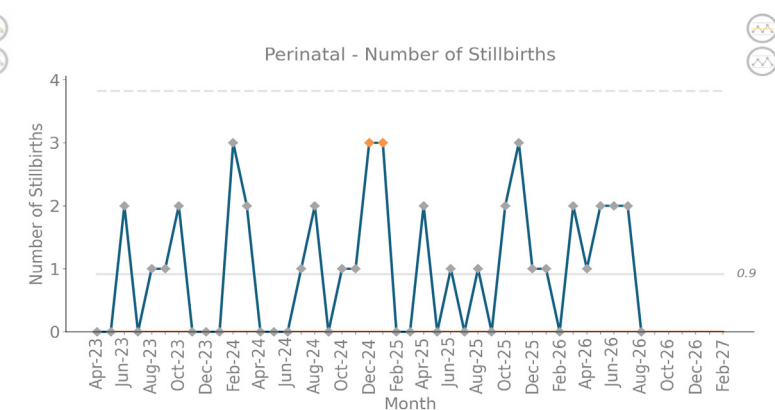
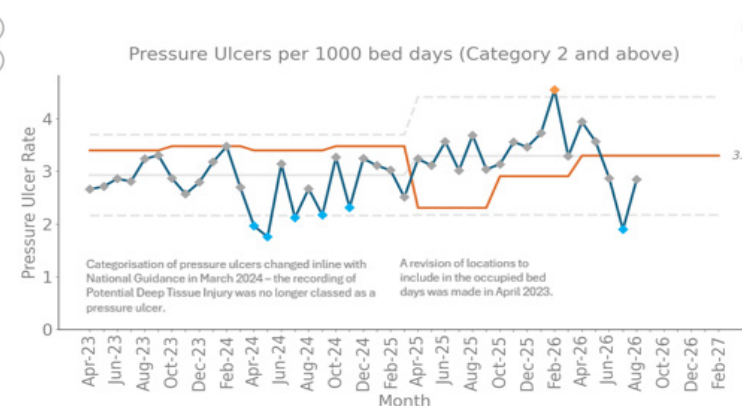
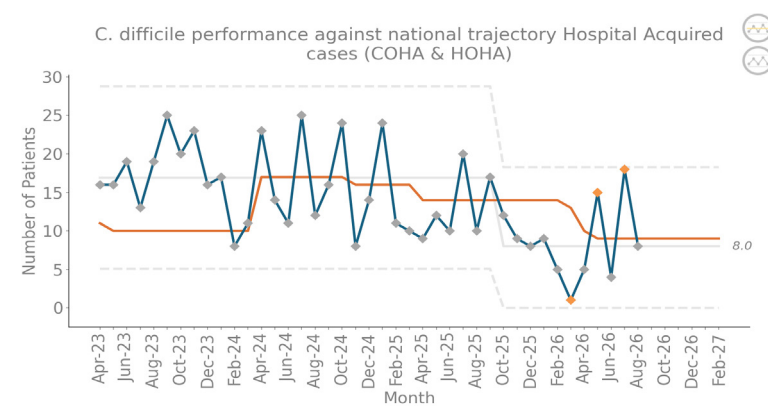
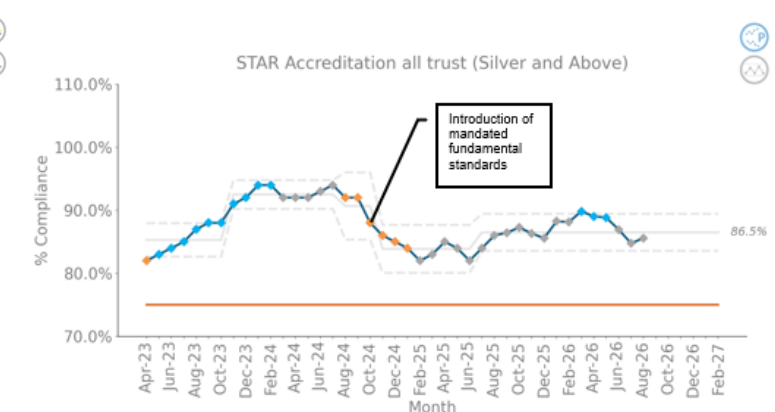
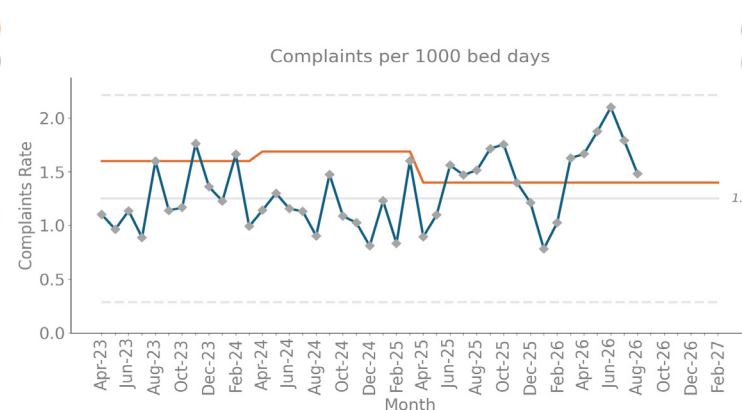
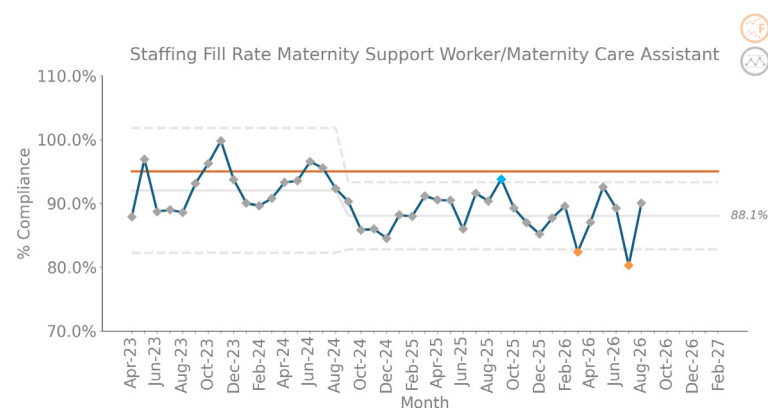
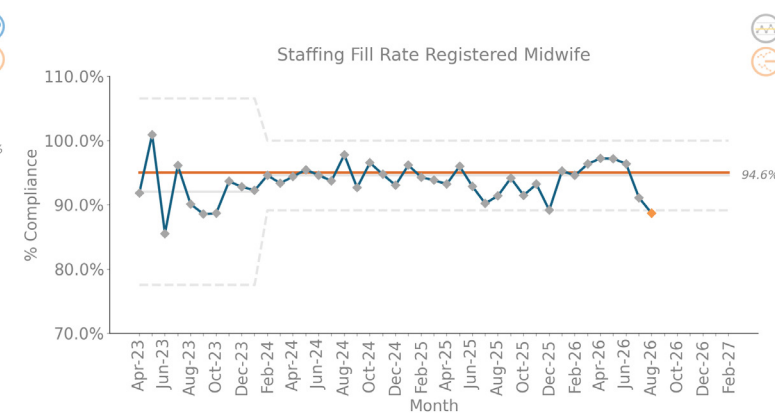
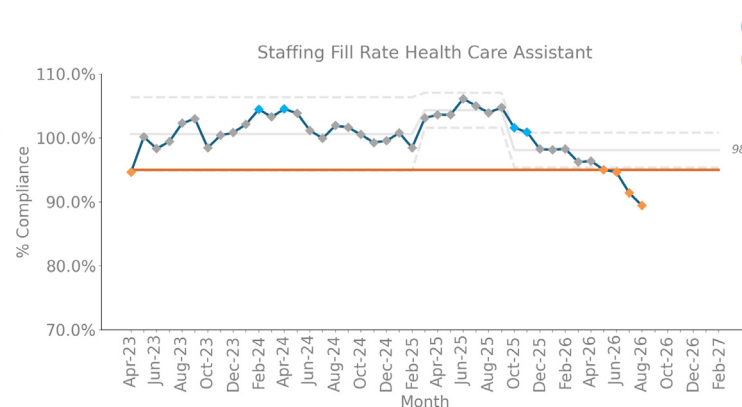
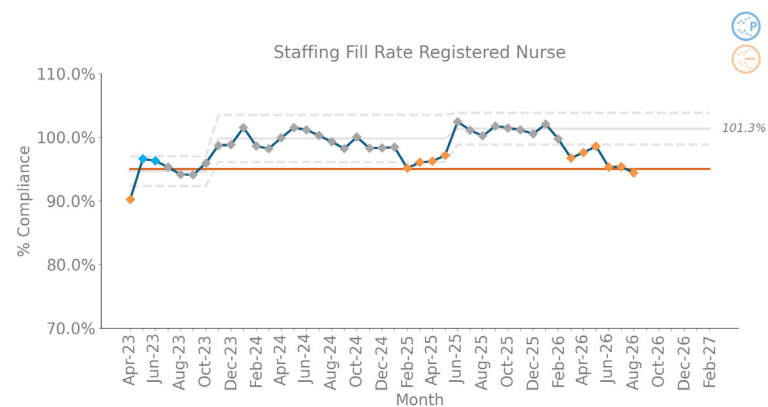
Patients

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				95%	95%	94.41%	Aug-26
	Staffing Fill Rate - Health Care Assistant				95%	95%	89.46%	Aug-26
	Staffing Fill Rate - Registered Midwife				95%	95%	88.67%	Aug-26
	Staffing Fill Rate Maternity Support Worker/Maternity Care Assistant				95%	95%	90.04%	Aug-26
Patient Experience and Involvement	Complaints per 1000 bed days				1.40	1.40	1.48	Aug-26
	STAR Accreditation all trust (Silver and Above)				75.0%	75.0%	85.6%	Aug-26
C Difficile Improvement	C. difficile performance against national trajectory Hospital Acquired cases (COHA & HOHA)				9	9	8	Aug-26
Always Safety First	Hospital Standardised Mortality Ratio - Adult	Lower Than Expected					75.0	Apr-26
	Standardised Mortality Ratio - Relative Risk - All Diagnoses Adult	As Expected					88.4	Apr-26
	Standardised Mortality Ratio - Relative Risk - All Diagnoses Child (<1 day – 17 yrs)	As Expected					174.6	Apr-26
	Standardised Mortality Ratio - Relative Risk - All Diagnoses Neonates (<1-28 Days) <i>The updated TELSTRA model from November 2024 does not include still births</i>	As Expected					123.2	Apr-26
	Pressure Ulcers per 1000 bed days (Category 2 and above)				3.30	3.30	2.85	Aug-26
Maternity	Perinatal - Number of Stillbirths				0	0	0	Aug-26



Patients

Patients



Performance



Patients



Performance



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Performance

Alert, Advise, Assure Report

Category	Performance Driver	High Impact Actions	Performance Recovery
ALERT ⚠ Areas requiring urgent attention	• RTT 18 week performance - * Due to a National extension to the August 26 validation of performance the performance remains unvalidated. July 26 performance at 58.88% was a 0.16% improvement compared to June 26. However performance remains under the Operational Performance target. 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. • Boarding & Days Kept Away from Home - DKAFH (%) has decreased by 0.4% in August 26.The position remains significantly above the operational plan target and is higher than August 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. The numbers of patients cared for in boarder beds decreased in August 26 and escalation bed occupancy has significantly reduced since June.	• RTT - Additional capacity internal and external is being mobilised.A Super September initiative has commenced and early indications show increased booked activity. The Cardiology AI PIFU pilot is in development with clinical protocol testing underway with further scoping in Max Fax and Dermatology. • Boarding/DKAFH - Board and Ward round improvement work continues to progress and run alongside the EEMAC and MDU model of care improvements.	• RTT: An RTT forecasting methodology is being developed in conjunction with GIRFT. High level assessments project a return to operational standard performance for 18 weeks by the end of Q3. • UEC/Boarding: The anticipated 4 hour performance benefit of MDU is forecast to be between 1.2-1.4%. The anticipated 4 hour performance benefit of Frailty SDEC is forecast to be ~1.2%. Modelling of the impact on ED overcrowding and boarding will be reviewed at the end of Q2.
ADVISE 📅 Areas of ongoing monitoring	• UEC 4 Hour performance - The LTH operational performance target for August 26 re 4 hour performance was not achieved. Performance showed a decrease of -1.3% in August compared to July 26. August 26 performance decreased by 8 national ranking places. • UEC 12 hour + ED LOS - Aug 26 performance decreased slightly compared with July 26 at 11.29% and is below the Operational Improvement plan target of 11.7% for the fourth consecutive month. •Virtual Ward - occupancy remains below target and remains consistent with July performance (60.4% occupancy). •Cancer Performance (July) - 31 day performance is below target by 0.7%, this is being driver by high volumes of Dermatology referrals and delays within the pathology part of the pathway.	• UEC - Key actions being taken to improve the UEC model of care with a further embedding of EEMAC and MDU pathways. Further plans are in development to support NWS direct pathways to EEMAC/MDU from early Oct 26. •VW - Medical posts have been recruited into the service to support an expanded utilisation - pre employment checks are underway. A review of wider VW staffing is underway to scope an increase in out of hospital capacity. •Cancer Performance - Key actions relating to the mobilisation of increased treatment and diagnostic capacity in July and August for Skin is being mobilised.	• UEC 12 Hour : The Trust is on trajectory to meet the operational performance targets. • Cancer: Performance forecasting suggests 62 Day cancer performance will meet operational standards by Nov 26, with 31 day performance achieving standard from July 26 onwards.
ASSURE ✓ Areas of positive assurance	• RTT Waiting List Reduction & 52 week performance - * Due to a National extension to the August 26 validation of performance, the performance remains unvalidated. The final position for July 26 shows that waiting list size is ahead of target. Finalised performance for August is not yet available due to an extended national deadline however the latest position re 52 week+ waits shows 365 patients on the waiting lists (ahead of target). Waiting list size in August is presently higher than July 26 however remains ahead of the operational target with further validation pending. • DM01 - Performance improved further in July 26 to 73.35% and is above the operations plan target of 70.2%. Significant improvement in over 6 week waiters in NOUS and Echo. July 26 performance is the highest performance noted at LTH for the past 4 years. • Cancer Performance (July) - FDS 62 day performance shows a further improved position (+1.3% versus June 26), and is only 0.1% under the July Trust operational performance plan. Trust performance is ranked 41st out of 117 providers for 62 day.		



Performance

Performance

Metric Description		Assurance @ Mar-27	Variation to Latest Actual	Target			Latest Month Actual	Latest Month
				Concern	Mar-27	Latest Month Target		
UEC In Flow	Compliance with 15 minute ambulance turnaround time target				66.30%	65.50%	28.86%	Aug-26
	Compliance with 45 minute ambulance turnaround time target				95.00%	91.20%	85.70%	Aug-26
	Percentage of UEC (Type 1 & 3) patients seen within 4 hours				82.00%	74.80%	72.56%	Aug-26
	Maximum wait of 12 hours as Total Time in Department (Type 1 and 2)				10.50%	11.65%	11.29%	Aug-26
UEC Flow	Bed occupancy %				94.00%	94.00%	93.77%	Aug-26
	Average Number of boarded patients				0	0	27	Aug-26
UEC Outflow	Reduce not meeting criteria to reside				5.00%	8.30%	11.49%	Aug-26
Elective (long waits)	Percentage of patients waiting less than 18 weeks				70.00%	63.20%	58.88%	Jul-26
	RTT - 52 week Waiters				0	1091	362	Jul-26
Elective (diagnostics)	Percentage of patients that receive a diagnostic test within six weeks				80.00%	70.20%	73.35%	Jul-26
Elective (theatre utilisation)	85% theatre utilisation - aggregate - Capped				85.00%	85.00%	83.71%	Aug-26
Elective (Cancer)	Cancer 62-day performance - Merged				80.30%	74.60%	75.00%	Jul-26
	Cancer Faster Diagnosis Performance				80.00%	80.00%	82.90%	Jul-26
	31 Day Cancer Standard - Merged				94.00%	94.10%	89.40%	Jul-26



Performance

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People



Patients



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People



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**Always
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Alert, Advise, Assure Report: People

	Issue	Action
Alert Areas of concern or matters that need addressing urgently	Staff Engagement - Quarter 2 data set for the question "I would recommend my organisation as a place to work" has marginally increased since Q1 from 41% in Q1 to 43.7% in Q2. This remains below the target score of 60%. Whilst there is a marginal improvement, year on year trends typically see Q2 having slightly higher levels of engagement, this tends to correlate with moving out of winter and different patient pressures. We have in this quater seen a 2% increase in the item "I am enthusiastic about my job" and a similar 2% increase in "I look forward to going to work" when compared with Q1. Sickness - sickness absence remained high in M5. Although there was a small improvement in the long-term absence rate (4.43% compared to 4.62% in M4), this was offset by an increase in the short-term absence rate (1.88% compared to 1.75% in M4).	Staff Engagement - further implement and embed Staff Engagement Proposal and demonstrate / communicate visible action taken in response to colleague voice. To rescope the metrics used in Divisional Improvement Forums and accountability oversight frameworks to also include the item "Patient care is my organisations top priority", this would better align with the strategic programme of work we are taking around improving patient experience and real time reporting. Sickness - The business case for a Digital Sickness Absence system has been developed and is in the review and approval process. This is essential to provide full organisational oversight of sickness absence management, with the additional benefit of it being a tool to push out wellbeing advice and information to colleagues. The scale of the sickness absence caseload means that it is impractical to monitor policy compliance and maintain grip and control around absence management without a digital solution.
Advise Areas of ongoing monitoring and any new developments	Vacancy - Following the establishment review and vacancy removal exercise, the Trust vacancy rate has reduced to 5.46%, moving within target tolerance. Violence and Aggression - The number of reported violence and aggression incidents continues to fluctuate monthly, and increased in M5 (135 incidents, compared to 99 in M4). The highest number of incidents consistently occur in Emergency Department and other areas where the nature of the patient's condition makes them more prone to violent and aggressive behaviour.	Vacancy - Health Care Support Worker (HCSW) recruitment continues to address high level of vacancy in this area with Support to Nursing staff group as a whole carrying c 300 vacancies and HCSW being 230 WTE of these. We are starting to see HCSW commencing in post in M5 with 13 WTE new starters. However this is offset by a comparable number of leavers in month for M5. Despite this reported growth is up 10 WTE on M4 levels in part to due associated internal movements. We would expect c 60-70% of the pipeline offers converting to starts. Violence and Aggression - a Rapid Improvement Workshop was held in M4 with good multi-disciplinary engagement, and this generated new test of change ideas to supplement existing improvement work. A further workshop will be held in M6, which will focus mainly on the Zero Tolerance letter process.
Assure Areas of Assurance	Appraisal - Compliance remains above the 90% target for month 5. Core Skills and Mandatory Training - remains above the 90% compliance target for each metric at Trustwide level. Turnover remains consistently low for month 5 at 0.5%, of the voluntary leavers the reasons for leaving were promotion, improved work life balance, for health reasons or retirement. Vacancy - HCSW vacancies have reduced by c 50 WTE since M2 due to focused work on recruitment.	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, this now needs to be emedded in training and made available via the managers hub. Actions and communications to be developed to embed a positive performance management culture, with greater emphasis on giving and receiving feedback, having regular 1-1 conversations and regular review of objectives alongside day to day management of operational issues. Core Skills and Mandatory Training - actions focus on targeted support to increase compliance by professional group Turnover - The first draft of the New Starter Hub has also been completed, informed by feedback from the July Managers Update. The next stage will be to make necessary changes to induction and probation processes to be incorporated the purpose of this is to reduce turnover in colleagues with less than 1 years service.



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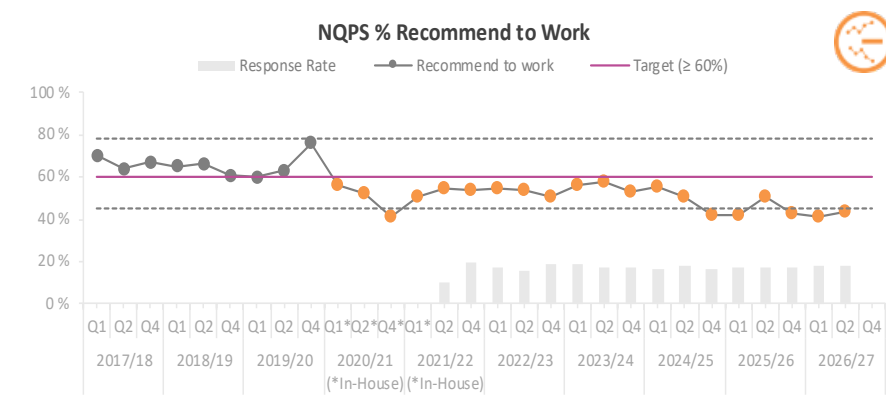
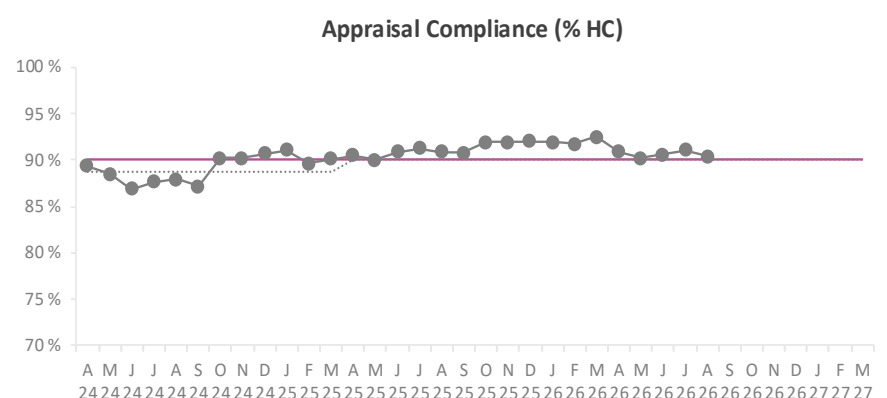
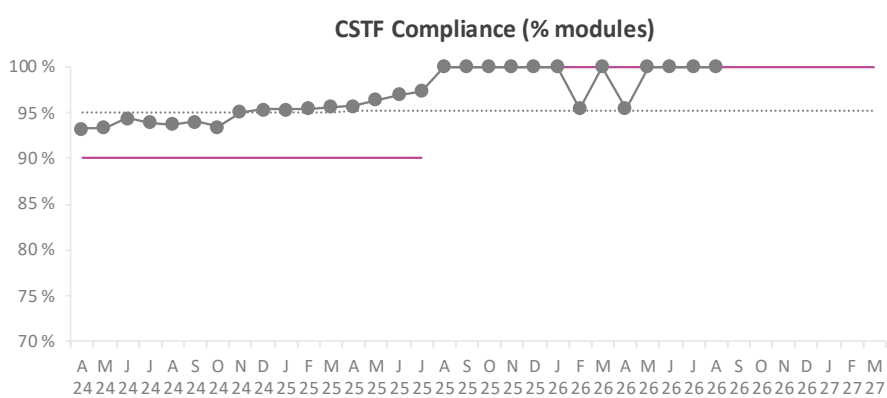
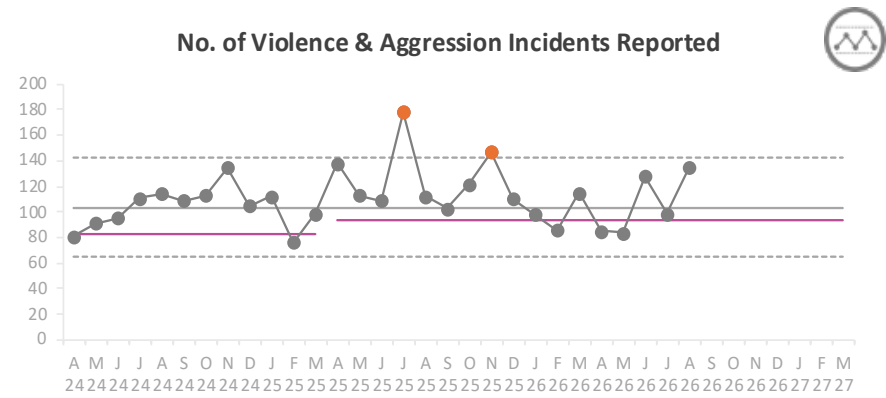
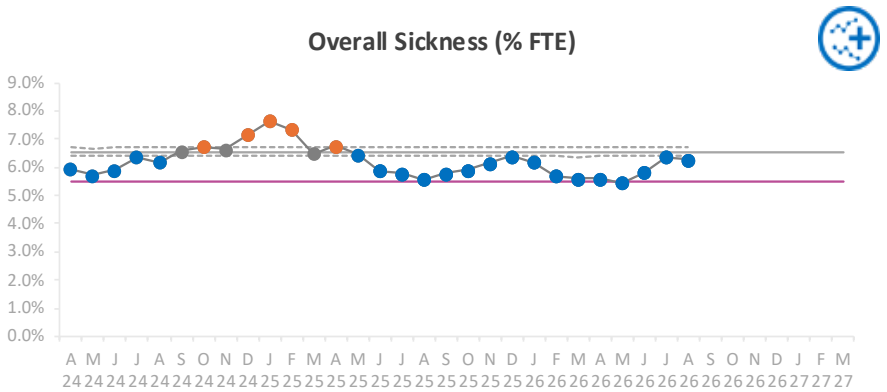
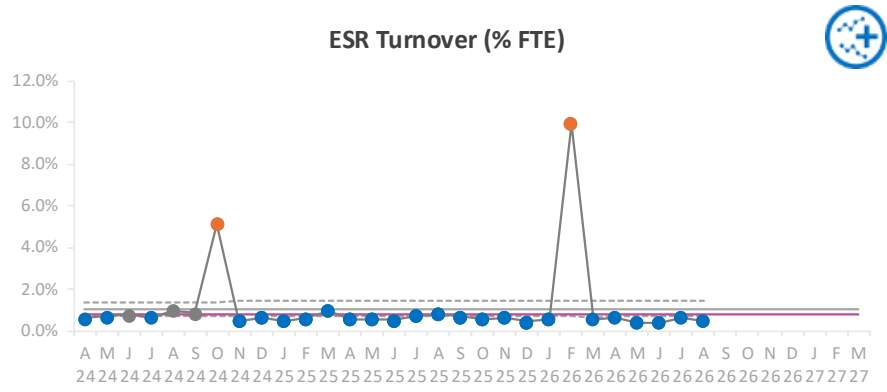
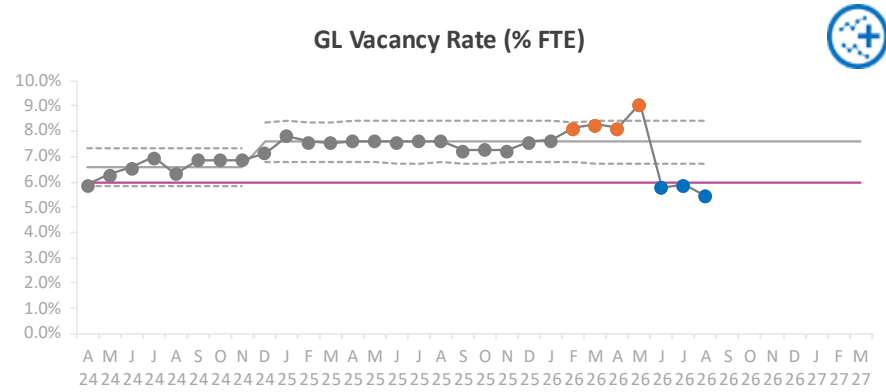
NHS Foundation Trust

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%		5.46%	M05
	Turnover (% FTE) (annual assessment; ESR in-month reported)				≤ 10%		0.50%	M05
	Sickness Absence (% FTE) (annual assessment; in-month reported)				≤ 5.5%		6.29%	M05
	Number of violence and aggression incidents toward staff (annual assessment; in-month reported)				996		135	M05
	Core Skills Mandatory Training compliance (% modules) (module compliance reported)				100% of metrics at 90%		100.00%	M05
	Appraisal compliance (% HC)				≥ 90%		92.32%	M05
	Staff Survey: Recommend Trust as place to work (quarterly metric)				≥ 60%		43.70%	Q2



People

People



Productivity



Patients



Performance



People



Productivity



Partnerships

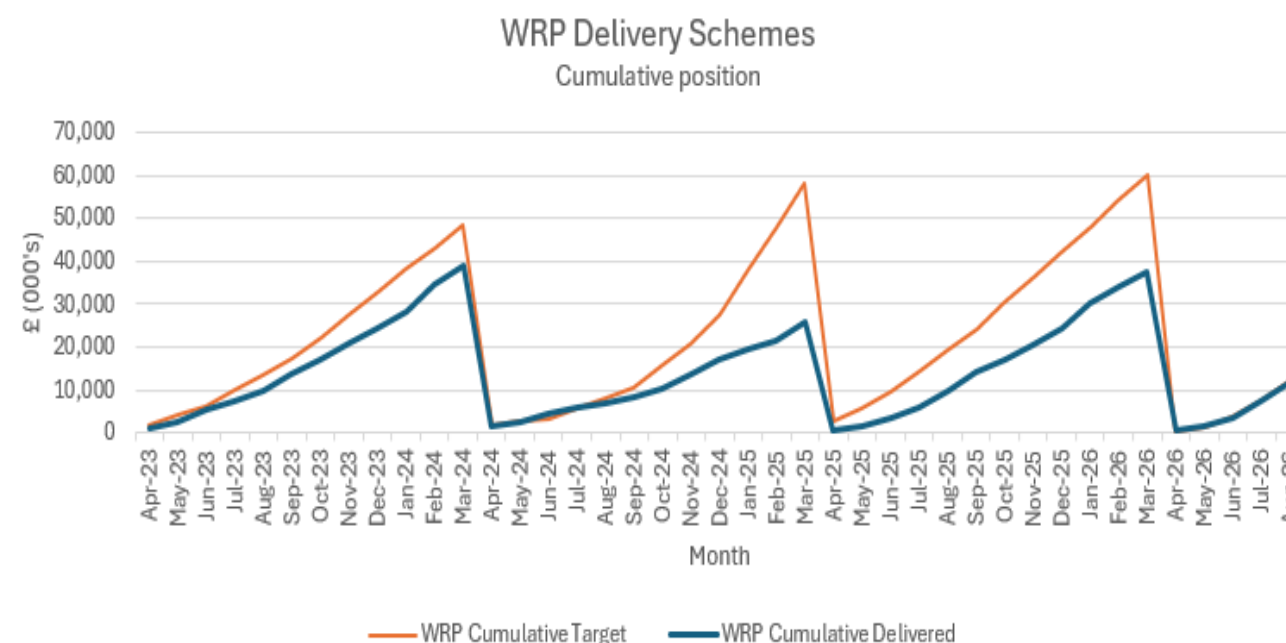
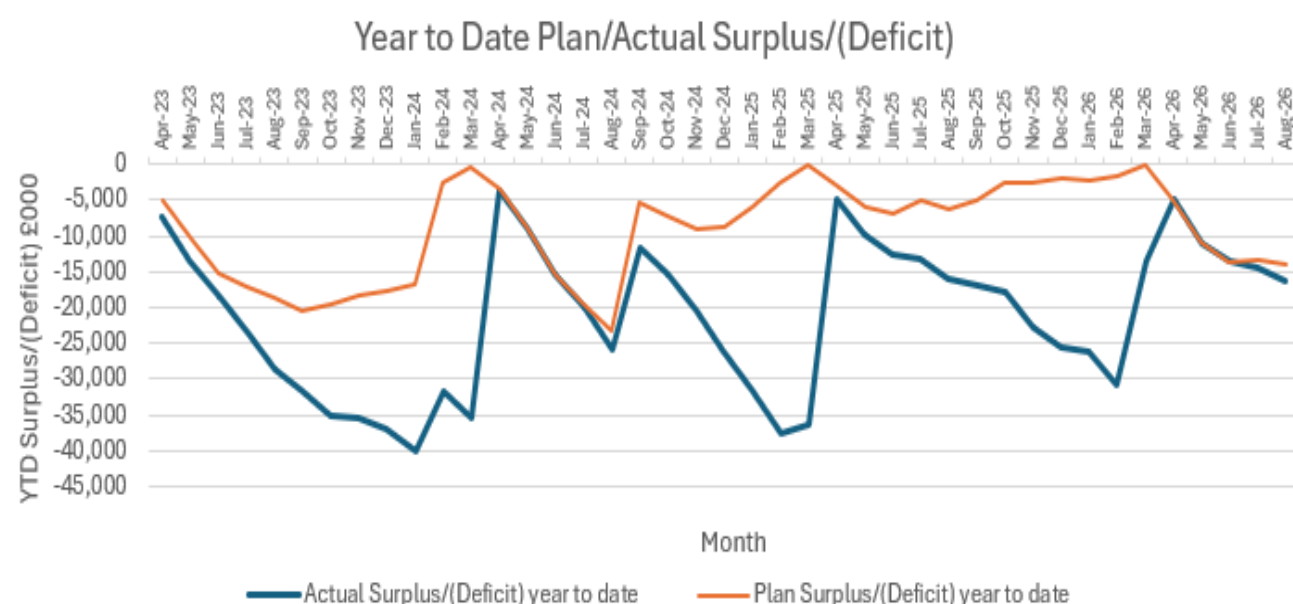
Executive Summary as at 31st August 2026			
	Issue	Action	Assurance
Alert Areas of concern or matters that need addressing urgently	Waste Reduction Programme		
	The Trust's 2026/27 waste reduction target is £60m, 5.7% of operating expenditure. Month 5 YTD WRP delivery is under-performing by £0.42m, however the NHSE Submitted Plan phasing is heavily weighted to later in the year. The in year Waste Reduction Programme has fully been identified at £60.0m with fully developed schemes to this value. Forecasting of WRP is assumed to be £60.0m best case, £41m likely case and £37m worst case. Confidence levels will continue to be reviewed at DDGs. Scheme development is continuing to ensure that any WRP plan slippage is mitigating.	The Trust has introduced a process to help mitigate the gap on WRP plan. This requests that Divisions review their recruitment pipeline to see what posts can be held to enable realignment to the expected WRP headcount reduction. 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. In September 2026 the Trust has implemented enhanced WRP assurance through the Financial Recovery Board.	Productivity board chaired by CFO External support for specific workstreams. Implementation of Financial Recovery Board, Divisional Delivery Groups and WRP Review meetings Embedding of PMO
	Cash Position		
	The Trust has been advised that Q2 DSF will be withheld by NHSE. Mitigations had been approved by the Trust Board, however the cash position was managed through working capital management which avoided the need to defer the September PDC dividend payment. Any slippage on WRP will mean revenue cash support may be required if the slippage exceeds the amounts that can be reasonably achieved through working capital management.	Application for capital cash support will be submitted to DHSC/NHSE as appropriate, after the mitigating actions have been implemented. 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 issues are escalated to the CFO. Monthly cashflow review by the CFO/ CEO
Advise Areas of ongoing monitoring and any new developments	Income and Expenditure		
	The Trust is reporting a £2.20m adverse position to plan to the end of August 2026. The Trust has a YTD £16.18m deficit against a £13.99m planned deficit (including DSF funding of £3.85m). DSF has not been received for M4 and M5 (£1.5m). Month 5 YTD WRP delivery is under-performing by £0.42m, however the NHSE Submitted Plan phasing is heavily weighted to later in the year. The forecast for 2026/27 has been developed based on non-receipt of DSF (best and likely cases include Q2-4 non-receipt, worst case includes further clawback of Q1), unmitigated Pathology industrial action costs as at month 5, further unmitigated Pathology industrial action costs (best and likely case includes £0.10m for M6, worst case includes a further £0.80m for M7-12) and a range associated with WRP delivery risk.	A re-set of the programme structure, governance and reporting for 2026/27 has taken place, including the introduction of the Productivity Board, Financial Recovery Board, DDGs and WRP Review meetings. Headcount reduction continues to be of significant focus with an additional 31.72WTE WRP delivered in M5 (106.29WTE YTD).	Grip and control Interventions and control measures are constantly being reviewed
Assure Areas of Assurance	Capital		
	Capital expenditure YTD is £4.04m below plan, with the slippage being mainly due to unforeseen site complications on the decarbonisation scheme. The contractor is confident the project will still deliver as per plan by the year-end. A positive response has been received from NHSE regarding capital bids against national allocations. To date we have received confirmation for £20.550m from NHSE. However work continues to ensure the remaining funding available to the trust is approved by NHSE.	The Trust is producing business cases for capital bids that have received approval to proceed to the next stage against the national allocations. Dialogue is ongoing with the regional NHSE team.	The capital plan will be updated as NHSE approvals are received. A system wide approach is being developed to support optimal use of national allocations.



Productivity

Productivity

Metric Description		Assurance @ Mar-27	Variation to Latest Actual	Concern	Target (£ 000's)		Latest YTD Actual (£ 000's)	Latest Month
					Mar-27	Latest YTD Target		
Productivity	I&E - Plan v Actual variance				0.0%	-13987	-16181	Aug-24
	WRP schemes delivery				60000	12025	11607	Aug-24

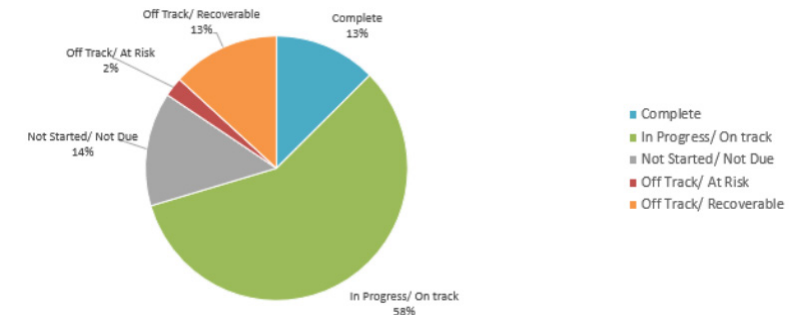


August-26 | Single Improvement Plan delivery position

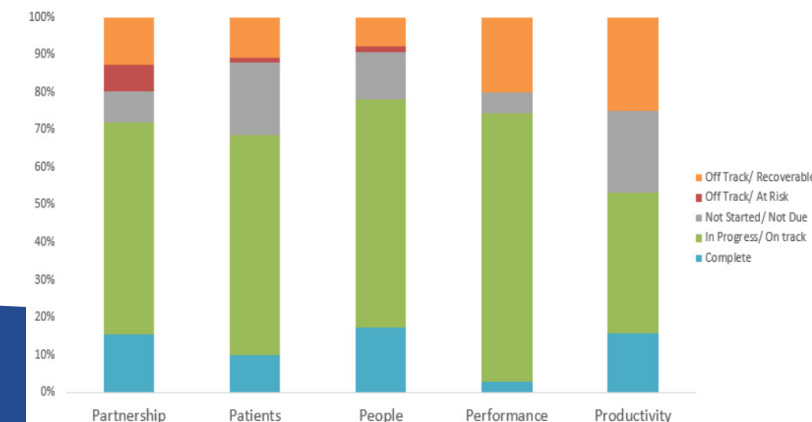
AAA	Issue	Action
Alert	Productivity: There are continued challenges in delivering the £60m plan but the Board is committed to achieving the plan and is proactively managing the risk. Performance: 18 week RTT performance remains off track however has seen improvement in July (Aug performance remains unvalidated). Days Kept Away from Home lost bed days remain high and above target. Partnerships: Digital and infrastructure outstanding funding, system and data sharing decisions are slowing delivery of several improvement programmes.	- CFO leading work to improve delivery forecast with CSIO driving delivery recovery actions. CEO mobilised Financial Recovery Board for fortnightly oversight of delivery focus and drive pace. Sprint approach being planned for joined up working across divisions to deliver against challenging transformational work. - COO leading work to increase capacity via a Super September initiative with ~30% increased activity identified to date. Actions underway to strengthen discharge and flow actions. - CSIO has implemented the Digital Oversight Committee for increased assurance on digital timeline and delivery. Ongoing work to recover digital delivery.
Advise	People: Sickness at 6.3%, support role vacancies and high temporary staffing continue to stretch teams. Performance: Diagnostic performance (DM01) has improved in Aug and is above target for the 3rd month – showing highest levels of performance since March 2020. 62 day cancer performance has improved in July 26. Patients: Experience and estates - emergency department feedback remains below target, and some safety, estates and staffing actions are receiving continued oversight.	- CPO plans in place to support the workforce pipeline, reduce sickness and progress the outstanding people and inclusion actions. - COO supporting close monitoring of productivity and performance re diagnostics and 31 day cancer at tumour group level. - CNO focus on patient feedback and resolve the outstanding estates funding and staffing decisions.
Assure	Performance: Reduction in long waits (52 week+) is showing a continued improvement and is ahead of target for the 7th month, similarly waiting lists size has continued to be ahead of plan for the 4th month and is ahead of target. Cancer performance re FDS is ahead of target for the 3rd month	Continued mobilization of additional capacity (internal and outsourcing), recruitment is ongoing into critical clinical roles.

Delivery movement is positive overall, with more milestones completed and fewer not yet started but a slight increase in delivery timeframe slippage although this is recoverable. Risks are actively discussed in each portfolio board to mitigate and control.

Overall delivery status – August-26



Delivery status by Portfolio – August-26



Integrated Performance Report

Appendix 1 – Assurance Reports

October 2026 Trust Board meeting with performance to August 2026



Patients



Performance



People

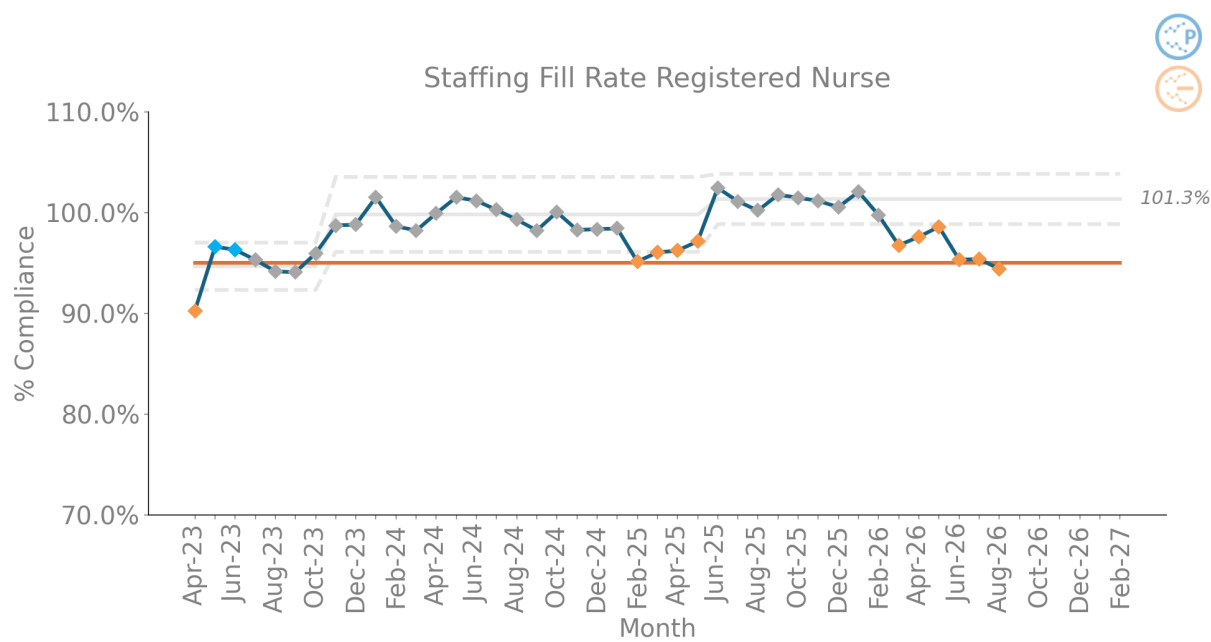


Productivity

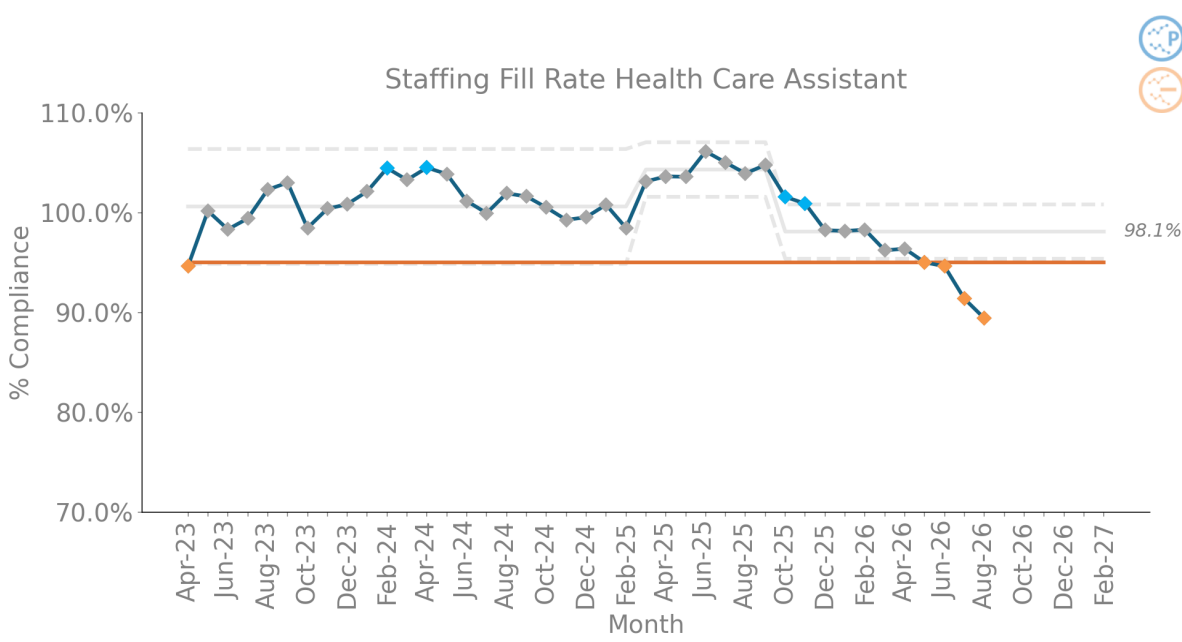


Partnerships

Patients - Deliver Annual Safe Staffing Requirements Assurance



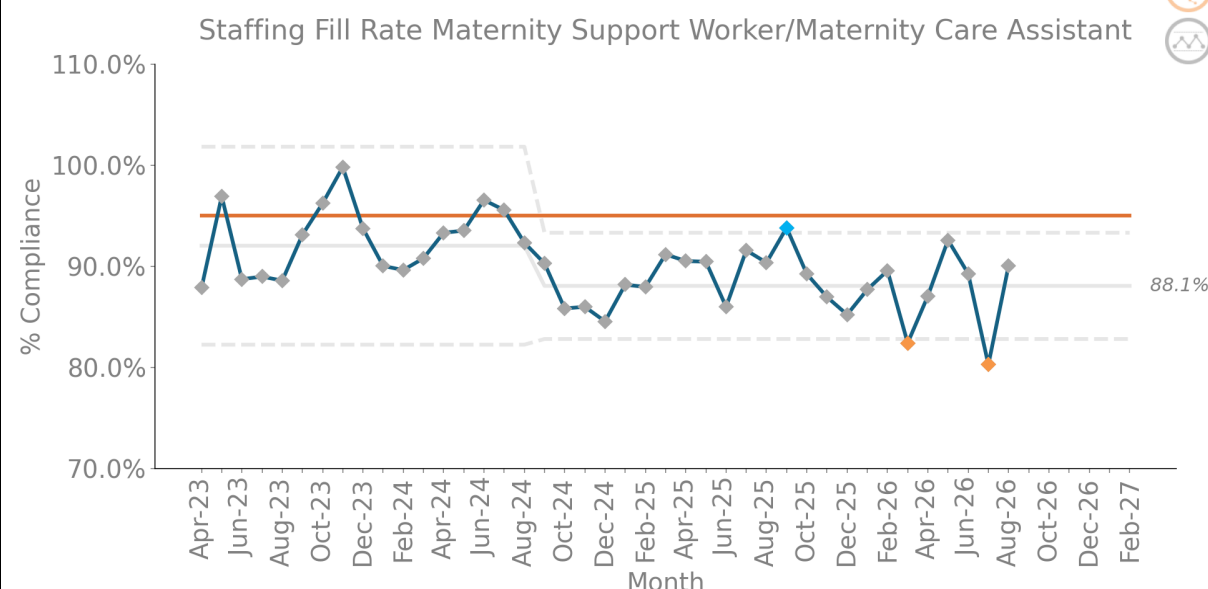
Latest
94.41%
Variance Type
Recent concerning pattern in the data
Mar-27 Target
95%
Target Achievement
Will consistently pass target within expected variation



Latest
89.46%
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	In August 2026, the Registered Nurse staffing fill rate was 94.41%, outside the Trust target range of 95–100%. CDH achieved 97.89%, RPH reported 93.91%, below target. Overall, safe staffing assurance is maintained through daily reviews, proactive deployment and established escalation processes. Performance continues to be monitored alongside patient acuity, quality indicators and red flag events, with targeted oversight at RPH to identify and mitigate emerging risks.	1. Twice daily nurse staffing meetings operate seven days a week, providing consistent oversight and timely management of safe staffing risks. 2. Established roster sign off processes are strengthened by weekly roster efficiency reviews, led by the Divisional Nurse Leaders since October 25, supporting effective workforce deployment and accountability.	1. All clinical areas continue to demonstrate stable staffing fill rates supporting assurance that safe staffing levels are being maintained. 2. Matron-led daily operational staffing meetings assess and respond to changes in pressure and demand, informed by patient acuity and dependency, red flags and professional judgement. 3. All agency shifts require approval and sign-off by the Chief Nursing Officer, providing senior oversight and control. 4. Biannual safe staffing reviews are undertaken in line with National Quality Board guidance, supporting evidence-based establishment planning.
Staffing Fill Rate Health Care Assistant	The Healthcare Assistant (HCA) fill rate continues to show a downward trend, reflecting high vacancy levels across inpatient wards. In August 2026, the overall fill rate was 89.46%—CDH 88.46% and RPH 89.66%—below the Trust target range of 95–100%. Temporary staffing and proactive workforce deployment continue to mitigate immediate risks and support safe care delivery. However, sustained vacancies and reliance on bank staffing remain workforce risks requiring close monitoring, targeted recruitment and continued oversight through established staffing escalation processes.	1. Twice-daily nurse staffing meetings operate seven days a week, providing consistent oversight and timely escalation of safe staffing risks. 2. A defined and advertised internal Band 2-to-Band 3 progression pathway supports workforce development and retention. 3. The centralised external recruitment campaign has recruited 102.59 WTE Band 2 and 68.91 WTE Band 3 Healthcare Assistants since May 2026, supporting vacancy reduction and workforce stability. The impact of this recruitment is not yet felt due to the time taken to progress through recruitment and induction, which can take circa 5-6 months. 4. Level 3 apprenticeship scheduled to commence September 26, level 2 apprenticeship interviewed with a planned commencement for October 26.	5. The weekly PSIRF Oversight Panel reviews incident harm levels, with findings triangulated through the quarterly serious incident and PSIRF report to identify trends and emerging risks. 6. Participation in the national Enhanced Therapeutic Observation and Care programme supports continuous improvement and the adoption of evidence-based practice 7. Additional duties follow a defined governance process, requiring approval from the Deputy or Divisional Nursing Director to maintain safety, effectiveness and appropriate oversight. 8. Delegated authority for bank approvals supports budget holders to secure timely staffing while operating within clear standards, targets and monitoring arrangements.

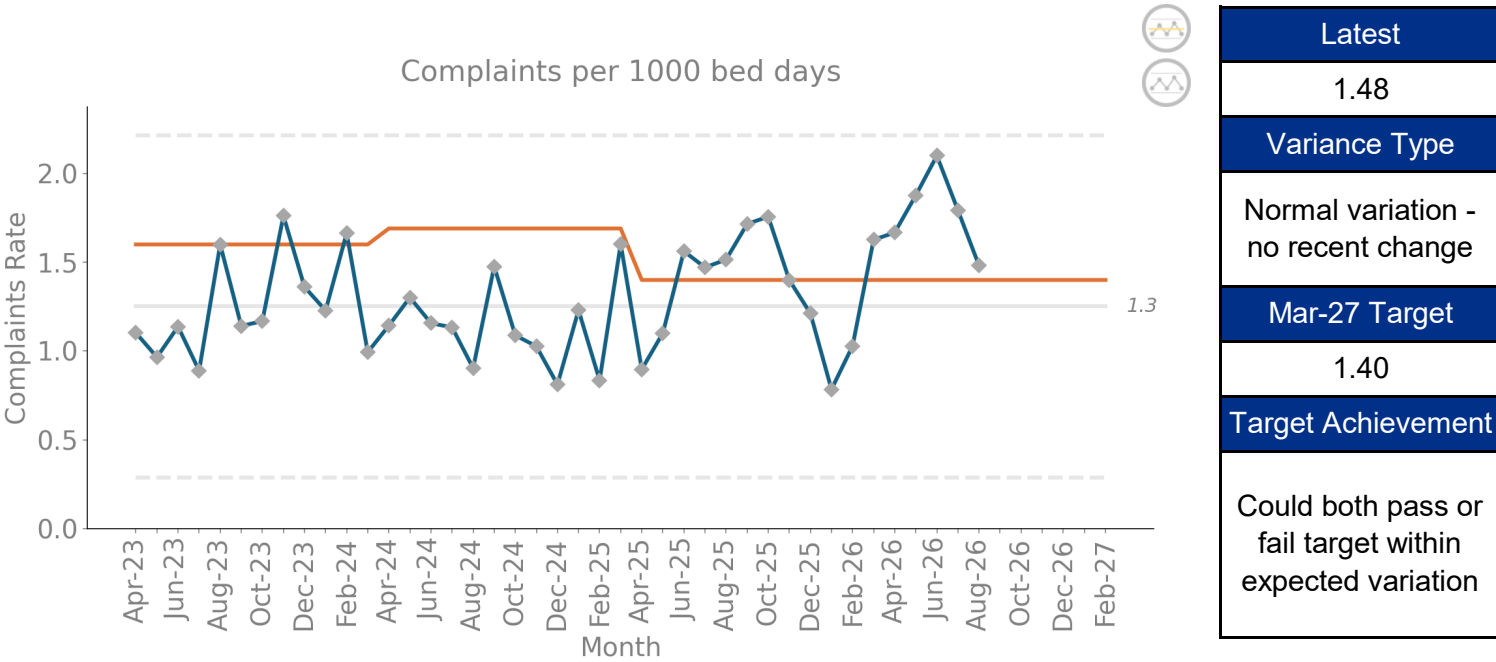
Latest
88.67%
Variance Type
Recent concerning pattern in the data
Mar-27 Target
95%
Target Achievement
Could both pass or fail target within expected variation



Latest
90.04%
Variance Type
Normal variation - no recent change
Mar-27 Target
95%
Target Achievement
Will consistently fail target within expected variation

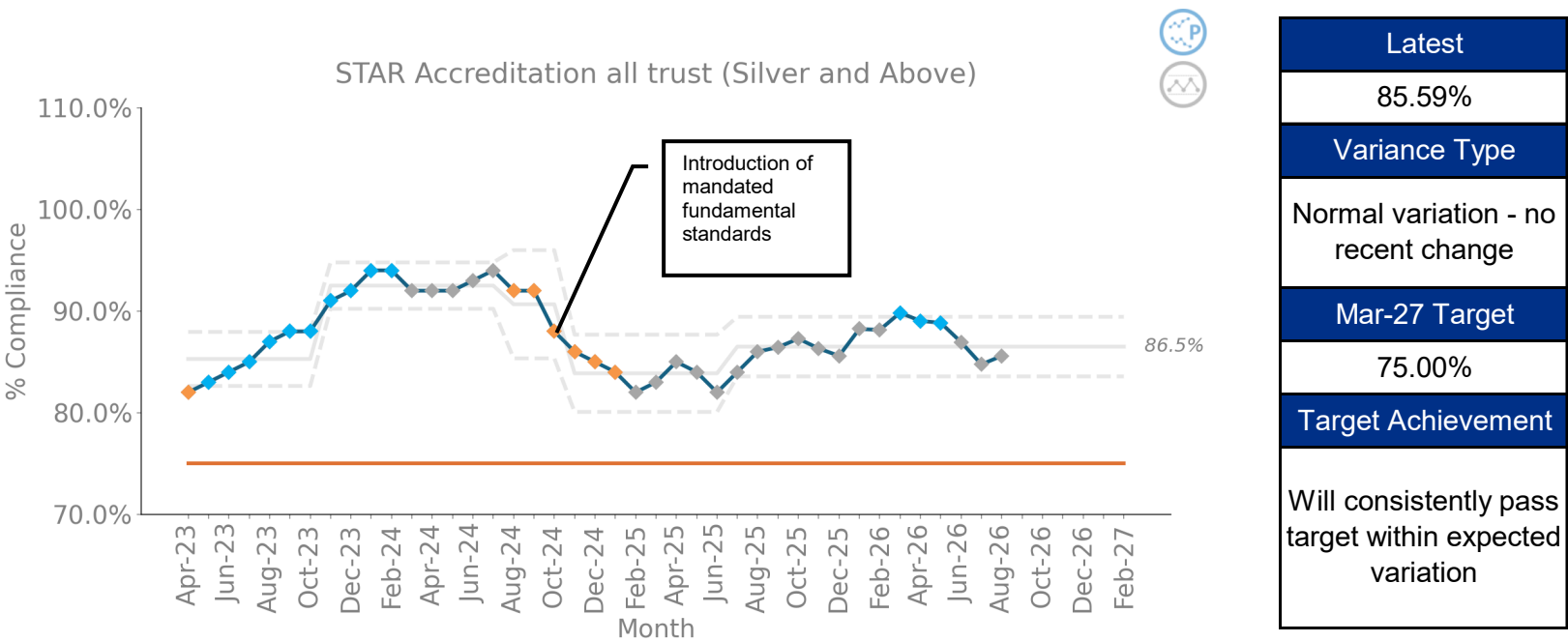
Overall page 49 of 141

Patients - Complaints



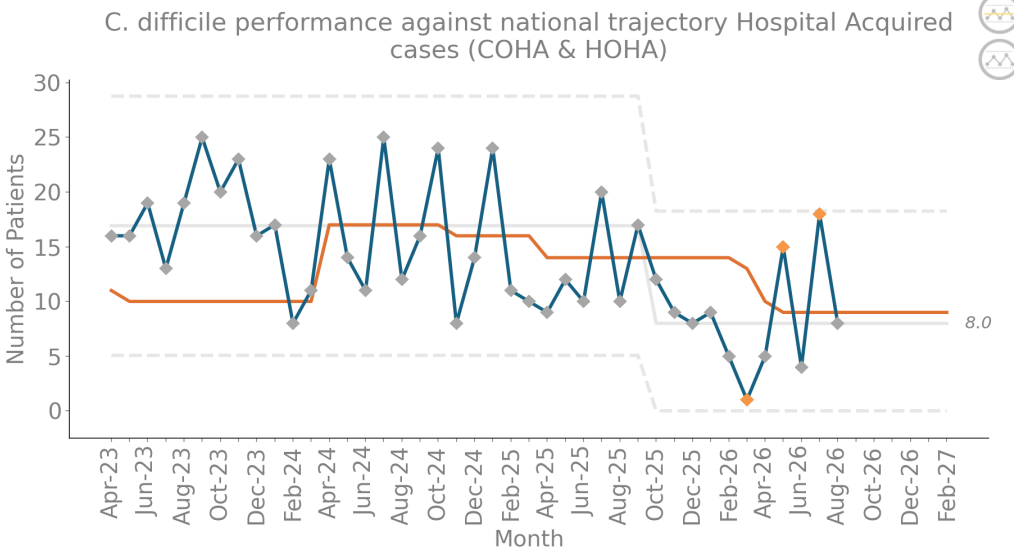
Metric	Summary	Action	Assurance
Complaints per 1000 bed days	Complaints per 1,000 bed days from April 2023 to early 2026, with performance fluctuating around a central baseline and a stepped trajectory line indicating expected or target levels.Overall, complaint rates have reduced this month from 1.79 in July to 1.48 in August. The Trust’s Single Improvement Plan is guiding both immediate service improvements and longer-term system change to support sustained reduction.	- Continue to deliver the Single Improvement plan - Patients - Continue to deliver the Patient Safety Incident Response Framework with a focus on family liaison roles - Monitor actions in relation to National picker Surveys . - To deliver the PALS and local early resolution training. - Continue to progress the complaints review group using patient safety partners and governors - Where concerns have not been responded to locally escalatre to managers. - ELeaning training for PALS concerns and a seperate package for Complaints Handling will be on training records within the next month.	- Annual patient experience reports to Safety and Quality committee. - Friends and family monthly reporting in place for all departments. - Inclusion of patient experience in STAR. - Chief Nursing Officer reviews all complaints and signs off responses. - Monitor picker survey action plans through Patient, Carer, Experience and Involvement Group. - Weekly meetings with the divisions to monitor progress and response times for concerns and complaints.

Patients - Quality Assurance STAR Accreditation

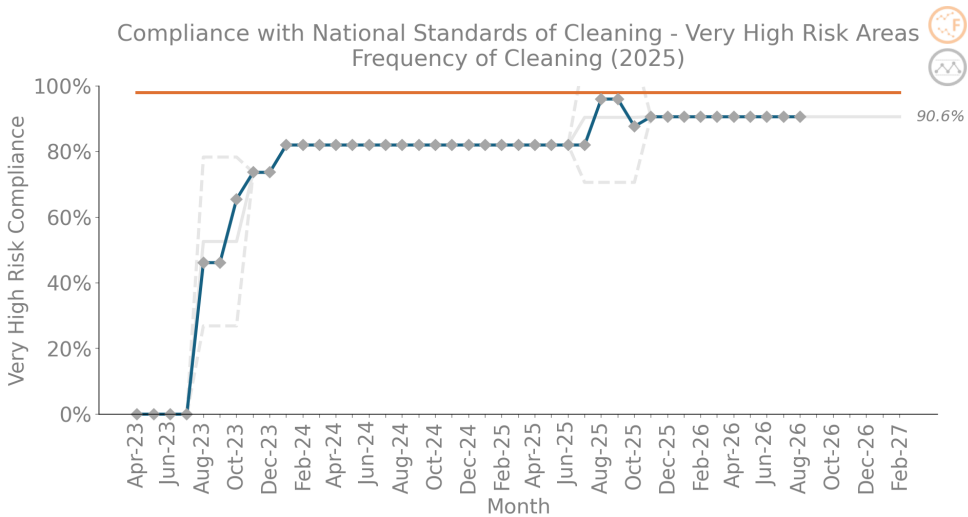


Metric	Summary	Action	Assurance
STAR Accreditation all trust (Silver and Above)	There are 118 clinical areas registered for the STAR Quality Assurance Framework. There are 101 areas rated green, 15 areas rated amber and 2 areas rated red. This results in 73 gold stars, 28 silver stars and 17 bronze stars. Of those 28 areas with silver stars, there are 6 who have achieved 3 consecutive silver stars and are awaiting gold panel approval. The Trust achieved 86% of areas rated silver and above and 62% of areas are rated gold for STAR accreditation visits. During August, there was 1 area who maintained a bronze star rating, 1 area reduced from silver to bronze, 2 areas reduced from gold to bronze, 1 area achieved their 3rd silver star and 2 areas achieved their first silver star, 1 area acheived a 2nd silver star and 5 areas maintained their gold star rating. Themes for improvement include recurring gaps in safety checks and equipment assurance, gaps in intentional rounding and incomplete skin assessment, risk assessments in particular weights and MUST as well as inconsistencies with fluid and food dietary charts. The Trust achieved 75% of Wards, ED and Theatres rated silver and above for the STAR accreditation visits.	- Standards which are not achieved require an improvement action which is monitored within the division through divisional assurance processes and via STAR monthly reviews and STAR accreditation visits. - The monthly STAR report includes trust wide and divisional STAR data and highlights good practice, areas for improvement and themes for learning, 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. - STAR monthly reports highlight those areas who are rated red or amber for STAR visits of less than 90% for STAR monthly. - There is clear direction that all bronze-rated areas have an action plan which is overseen by the Matron/Professional Lead, and divisional leads, all areas are required to be buddied with a gold-rated area and teams discuss their STAR improvement actions within team meetings.	- 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. - 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. - The AMaT system supports with STAR audit data management and oversight and management of improvement actions. - There is a BI STAR page available to enable data triangulation. - 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. - Any immediate risks or serious concerns identified are addressed at the time and followed up to seek assurance that actions are in place.

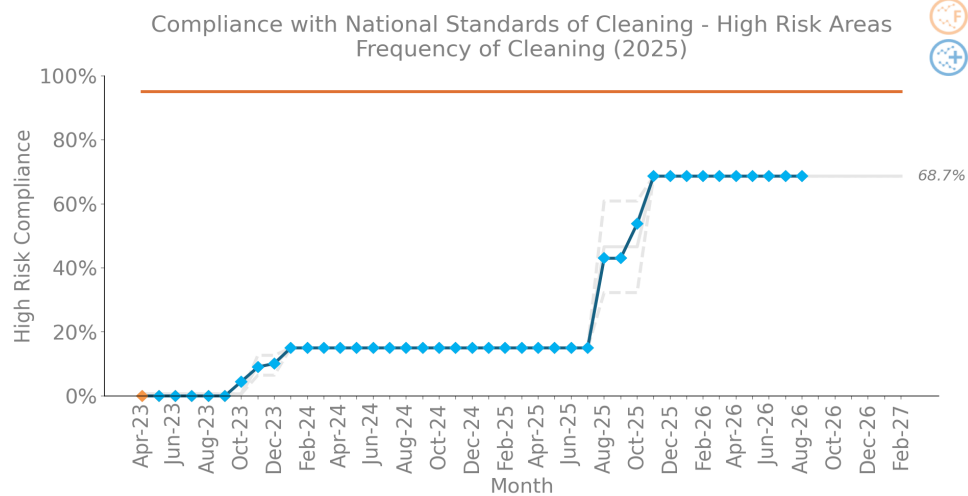
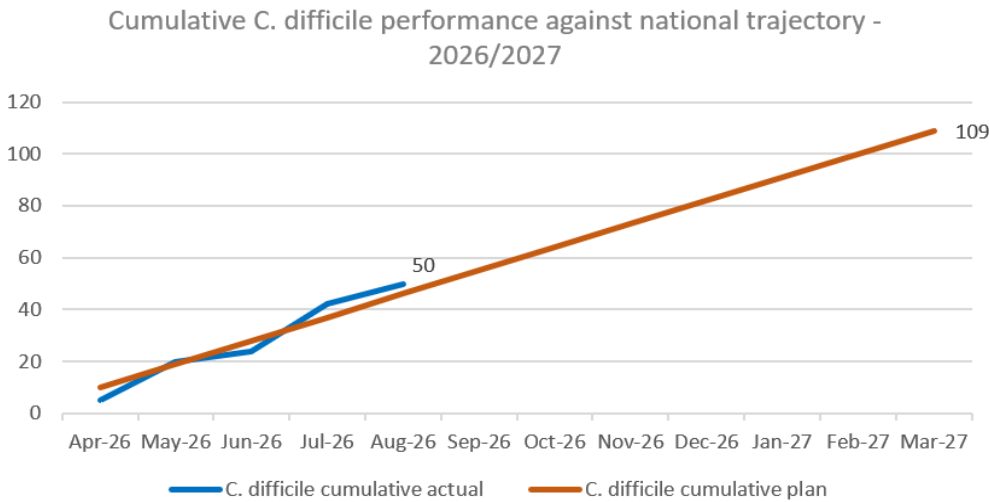
Patients - C Difficile Improvement Programme Assurance



Latest
8
Variance Type
Normal variation - no recent change
Mar-27 Target
9
Target Achievement
Could both pass or fail target within expected variation

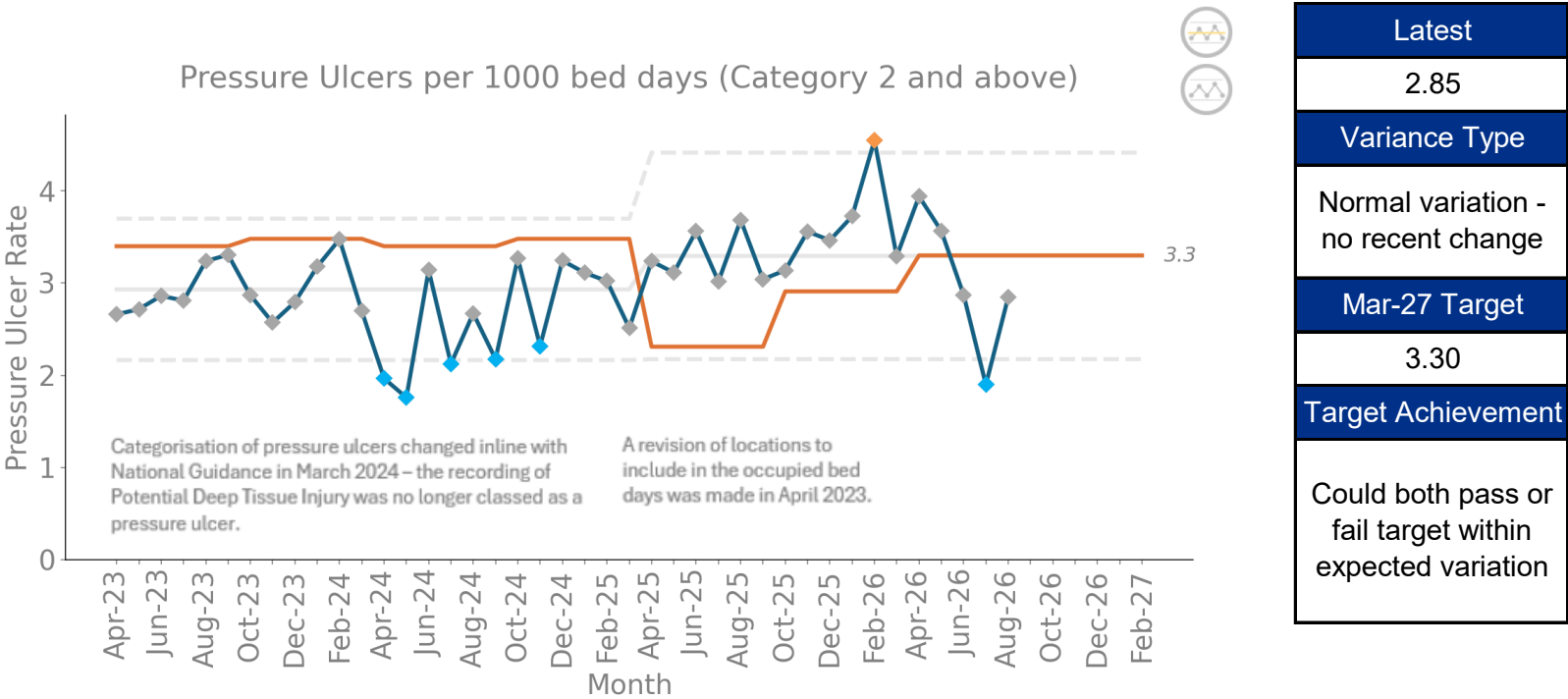


Latest
90.60%
Variance Type
Normal variation - no recent change
Mar-27 Target
98.00%
Target Achievement
Will consistently fail target within expected variation



Latest
68.65%
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 Hospital acquired cases (COHA & HOHA)	During August 2026, 8 CDI cases were reported, bringing the 2026/27 year-to-date total to 50 against the Trust’s national objective of no more than 109 cases. . The CDI reduction programme and improvement plan remain subject to monthly oversight through the Infection Prevention and Control Committee and the Estates and Clinical Partnership Board. Compliance with the National Standards of Healthcare Cleanliness (2025) is monitored through the dashboard, alongside quality checks in areas not yet meeting required cleaning frequencies. Current cleaning-frequency compliance is 90.60% in Frequency 1 areas and 68.65% in Frequency 2 areas. Vacant domestic posts pose a risk to full compliance by the target date of September 2026 as vacancies have increased and recruitment is not keeping up with turnover of staff. Vacancies in month have increased to 13.91 WTE. This is being escalated through appropriate governance routes. The rise in CDI cases in Frequency 2 clinical areas require continued scrutiny and timely delivery of planned improvements.	1.Implementation of the approved business case to be compliant in high risk areas with National Standards of Healthcare Cleanliness (2025) - Trust vacancy sweep and subsequent vacancy freeze has led to a review of domestic capacity. Following full service capacity appraisal, the service will step down NSoC across FR3 - 6 categories, with resource redirected to FR1 and FR2 areas only. 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 Board Assurance Framework reviewed through the Infection Prevention and Control Committee. 2. MIAA audit provides substantial assurance. 3. IPC dashboard and revalidation audits provide oversight of performance, compliance and emerging risks. 4. IPC risks and performance are reviewed through established Trust governance committees. 5. STAR incorporates IPC audits and cleaning-checklist compliance, 6. NHS England’s review provides external scrutiny and assurance regarding the Trust’s IPC arrangements and controls. 7. Antimicrobial stewardship is subject to established oversight and assurance reporting.



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, to provided proactive intervention, real-time feedback and education to ward teams. These measures strengthen oversight and support early intervention with a Trust focus on pressure ulcer prevention in line with the Trsut improvement plan.	- Monthly divisional review of pressure ulcer incidents, themes and trends through ASF meetings, translating learning into targeted actions to reduce harms. - Weekly Pressure Ulcer Review Panel to review harm, identify factors, and drive actions to prevent recurrence, with learning escalated through governance (from Nov 2025). - Proactive risk reduction rounds led by the tissue viability team, providing real-time support and challenge to improve prevention and reduce avoidable harm (from Mar 2026). - Delivery of an evidence-based improvement plan addressing key incident themes, with impact measured through reduced pressure ulcer incidence. - Strengthened data quality through housekeeping and reporting processes to ensure consistent, reliable data for monitoring trends and providing credible assurance.	- Divisional Always Safety First Committees provide oversight of the pressure ulcer improvement plan and monitor progress against key actions. - Monthly monitoring of pressure ulcer incidence continues as a priority quality metric, with trends reviewed at divisional and Trust level. - STAR compliance for key questions 8d and 9c is monitored monthly as leading indicators of prevention practice. - Weekly Pressure Ulcer Panel, with a consolidated monthly learning report submitted to PSIRF Oversight. - Monthly oversight group for review and monitoring of actions from Pressure ulcer panel with division leadership representative.

Patients - Always Safety First Assurance - Mortality

Achievement	Position	Month
Lower Than Expected	75.0	April 2026
As Expected	88.4	April 2026
As Expected	174.6	April 2026
As Expected	123.2	April 2026

Hospital Standardised Mortality Ratio - Adult
Standardised Mortality Ratio - Relative Risk - All Diagnoses Adult
Standardised Mortality Ratio - Relative Risk - All Diagnoses Child (<1 day – 17 yrs)
Standardised Mortality Ratio - Relative Risk - All Diagnoses Neonates (<1-28 Days) <i>The updated TELSTRA model from November 2024 does not include still births</i>

Source Data: Telstra (Dr Foster)

Metric	Summary	Action	Assurance
Hospital Standar dised Mortality Ratio - Adult	HSMR is within Upper and Lower Control Limits and lower than expected when compared to peers.	- Continue with structured judgement review process. - Use mortality reviews to establish themes where care or experience could be improved. - Continue to work with the medical examiners office to review deaths in line with guidance. - Continue to use incident reporting processes where an incident occurs under Patient safety Incident Response Framework (PSIRF). - Continue to implement the 10 CNST safety actions for maternity and neonatal - Marthas rule (Call for Concern)implementation is underway. - Review the interface of Medical Examiner Reviews, Incident Reporting and Structured Judgement Reviews to ensure timely identification of harm level associated with patient deaths. - Identify top themes of learning from deaths and family feedback, identify existing relevant workstreams and develop maturity of learning framework including each theme. Project to be overseen by Mortality and End of Life Committee	- Mortality and End of Life committee chaired by Deputy Chief Medical Officer with responsibility for mortality. - Twice annual reports to safety and Quality committee. - Telstra system utilised to generate mortality data ensuring objective peer data is used to establish reported key performance indicator. - Speak Up arrangements are well established in the organisation. - Maternity Neonatal report provides assurance of compliance with Maternity neonate Safety Investigation branch for appropriate cases. - 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. - ED and maternity and neonatal safety forums in place with executive leads identified to encourage speak up in high risk areas. - 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. - The Trust has been validated against all 10 CNST maternity and neonatal safety actions and is now progressing through the formal sign-off process. - Further Dr Foster training sessions will be provided for LTHTR in 2026 -2027.
Standardised Mo rtality Ratio - Relative Risk - All Diagnoses Adult	SMR is within Upper and Lower Control Limits and lower than expected when compared to peers.		
Standardised Mo rtality 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 Mo rtality 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

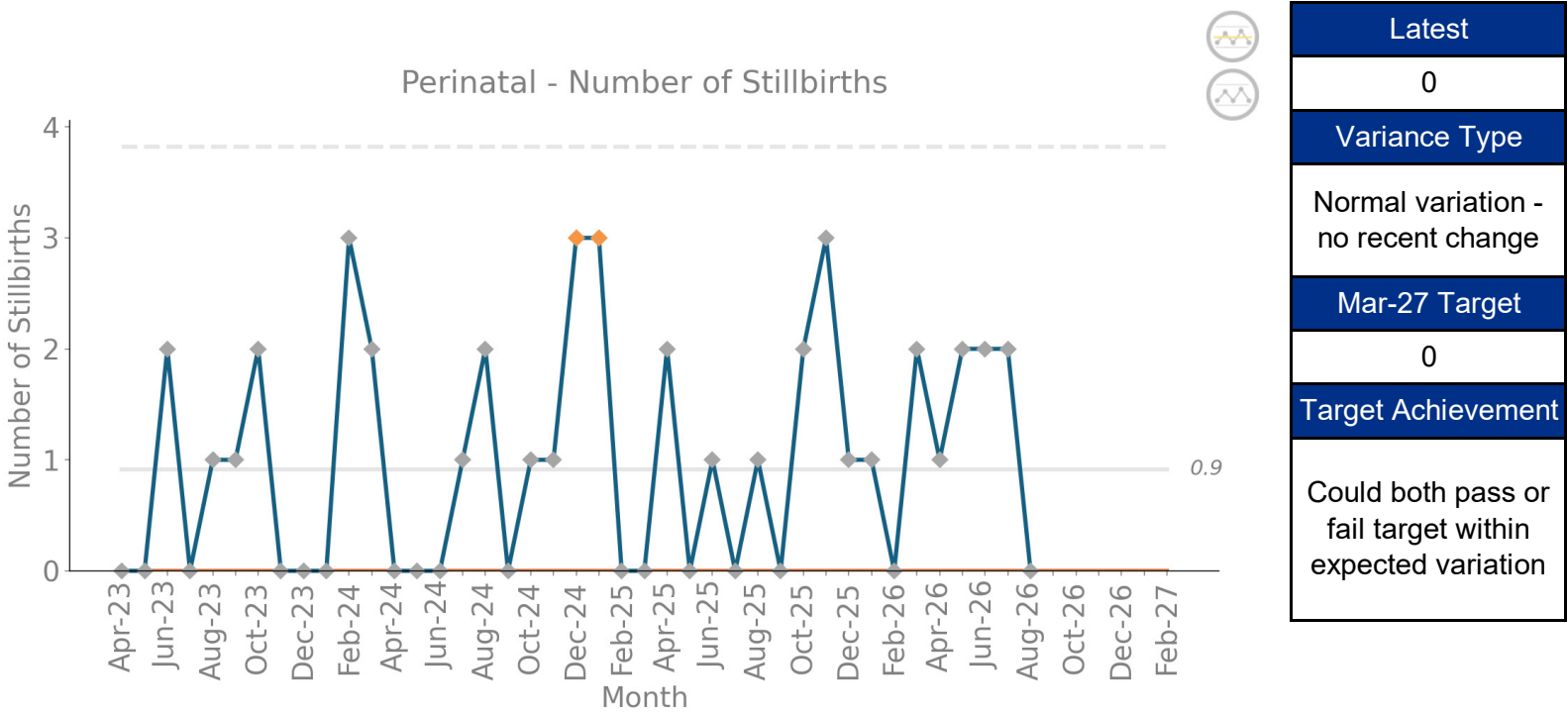
Performance

People

Productivity

Partnerships

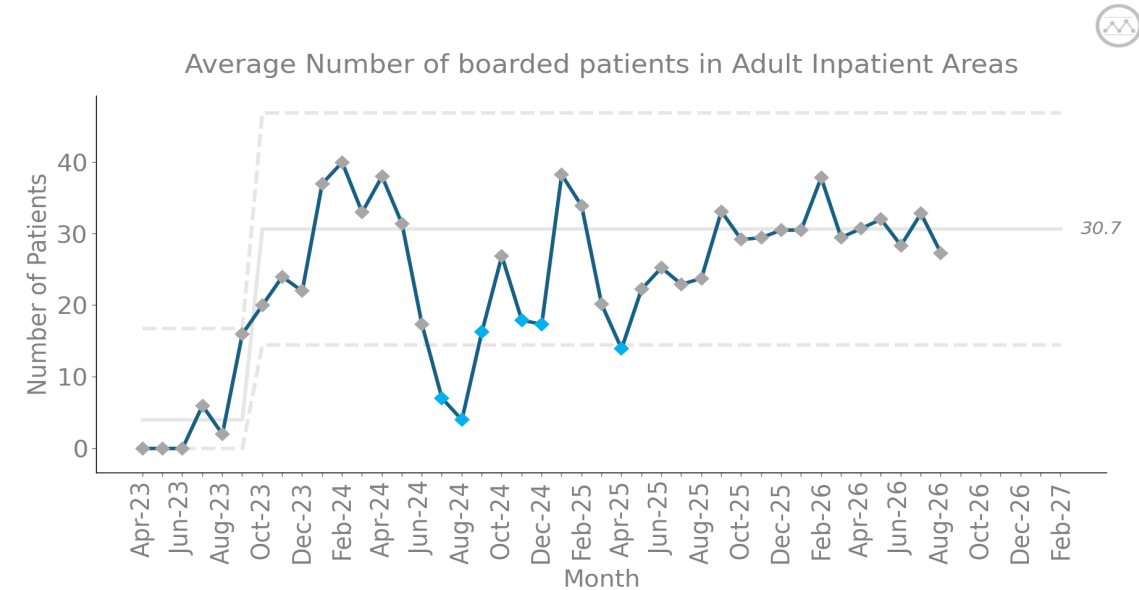
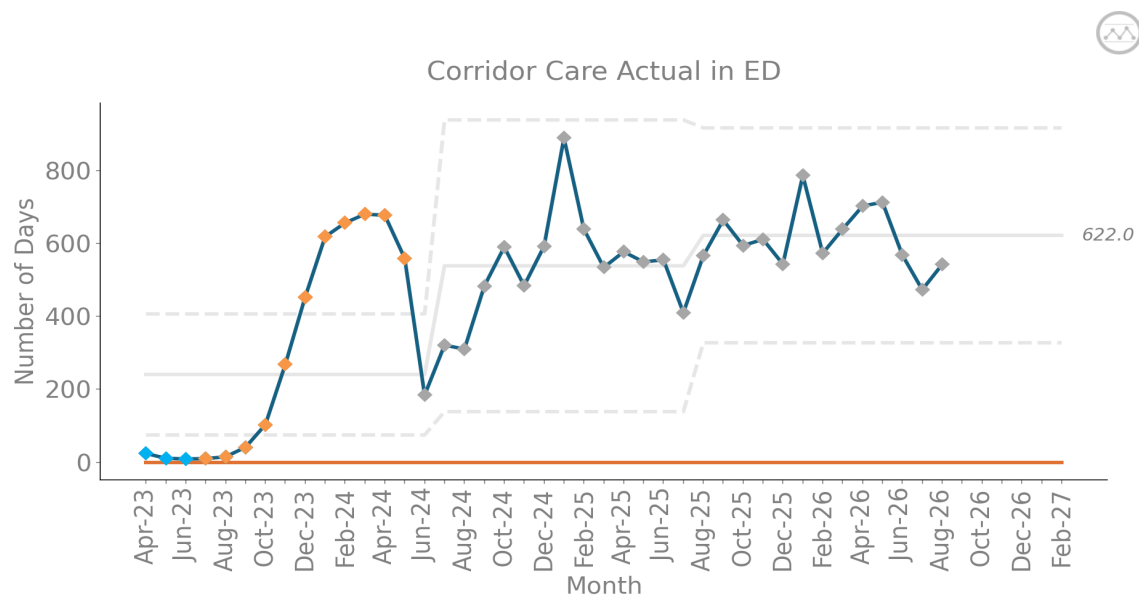
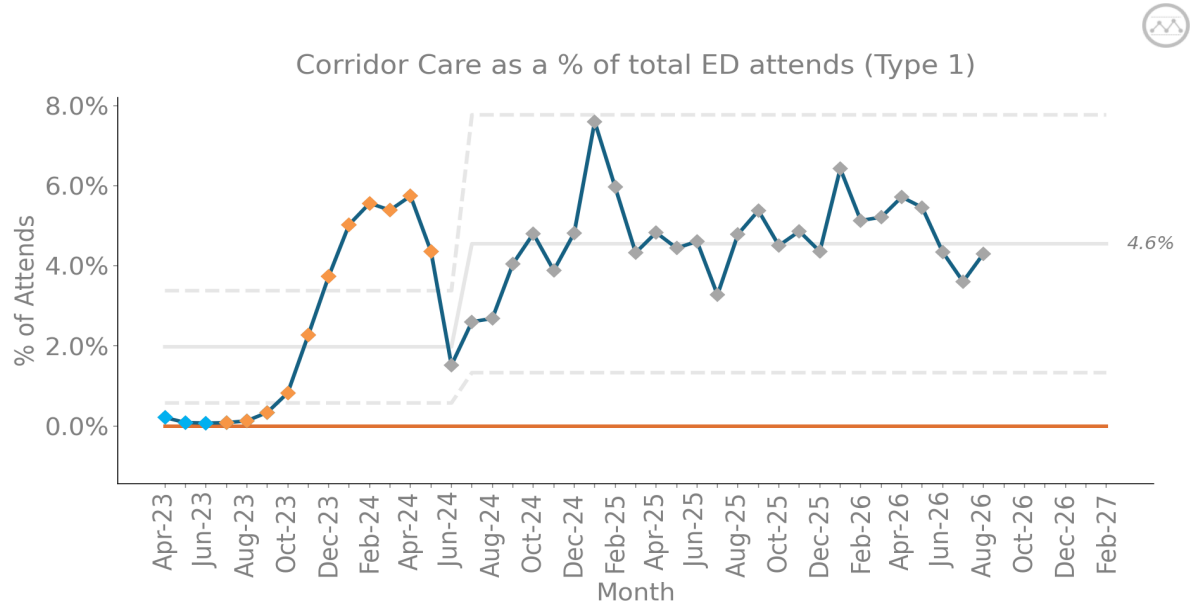
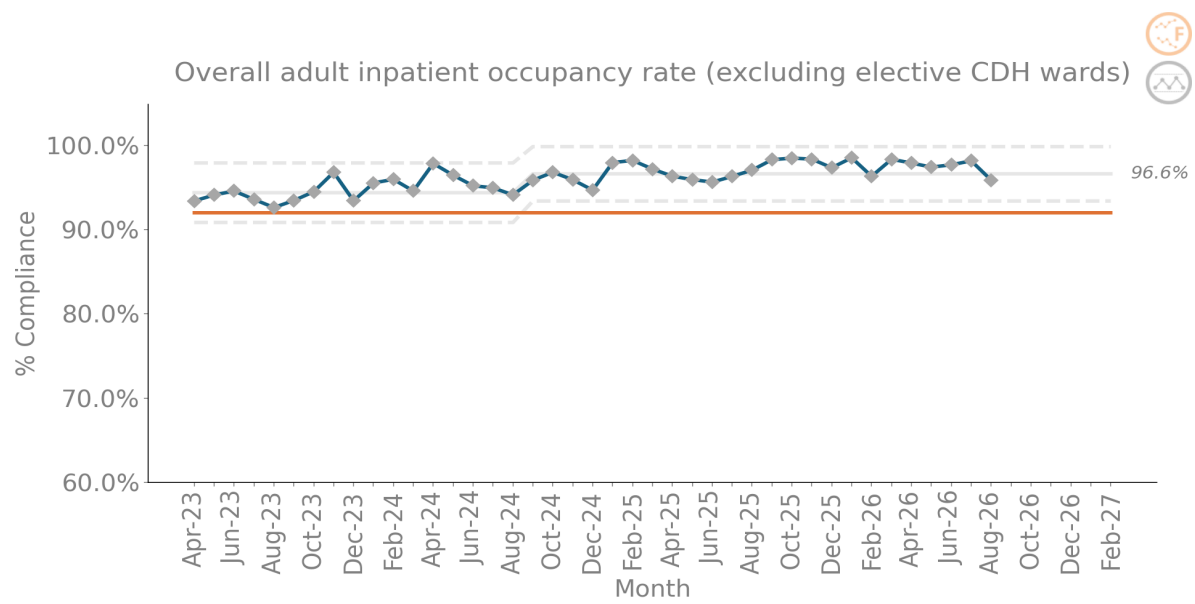
Patients - Stillbirths Assurance



Metric	Summary	Action	Assurance
Perinatal - Number of Stillbirths	There were no stillbirths reported in August. The service continues to track the rates of stillbirth and review each case in line with national guidelines and reporting requirements. The 12-month local average mean still birth rate is 2.1 per 1000 (May 2025 to April 2026 excluding TOPFA) 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 provide peer comparison data for continuous improvement.	1. Perinatal Quality Surveillance dashboard analysis shared via the maternity and neonatal safety report (to Safety and Quality Committee). 2. Peer comparison data included within the reporting for oversight 3. National MBRRACE reporting provides overview of national themes to ensure learning is understood. 4. 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., there are no live signals at this time.



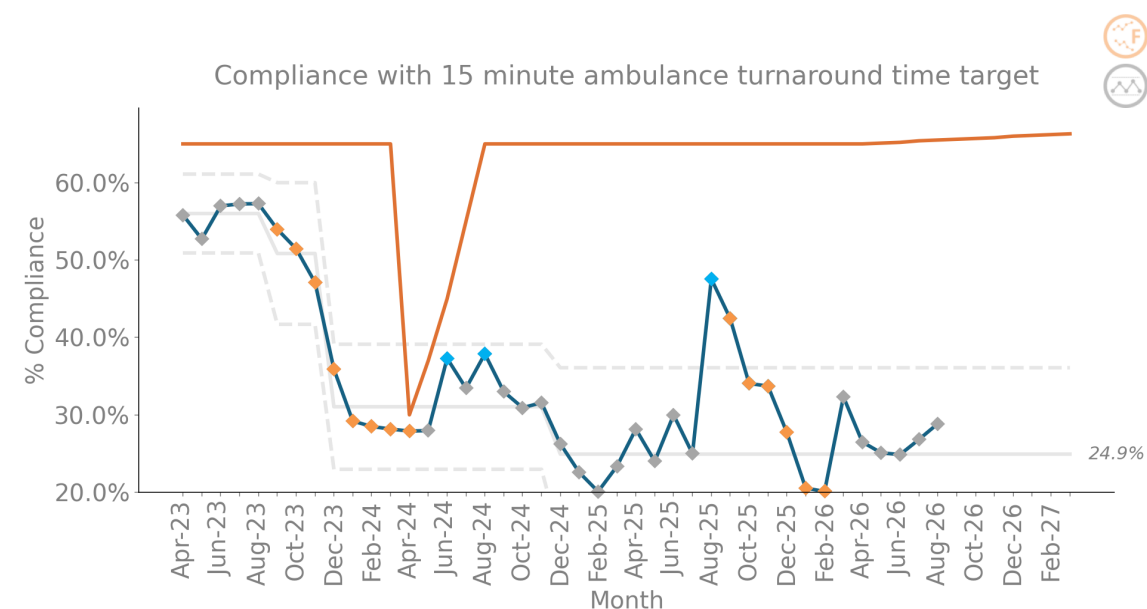
Patients - Corridor Care



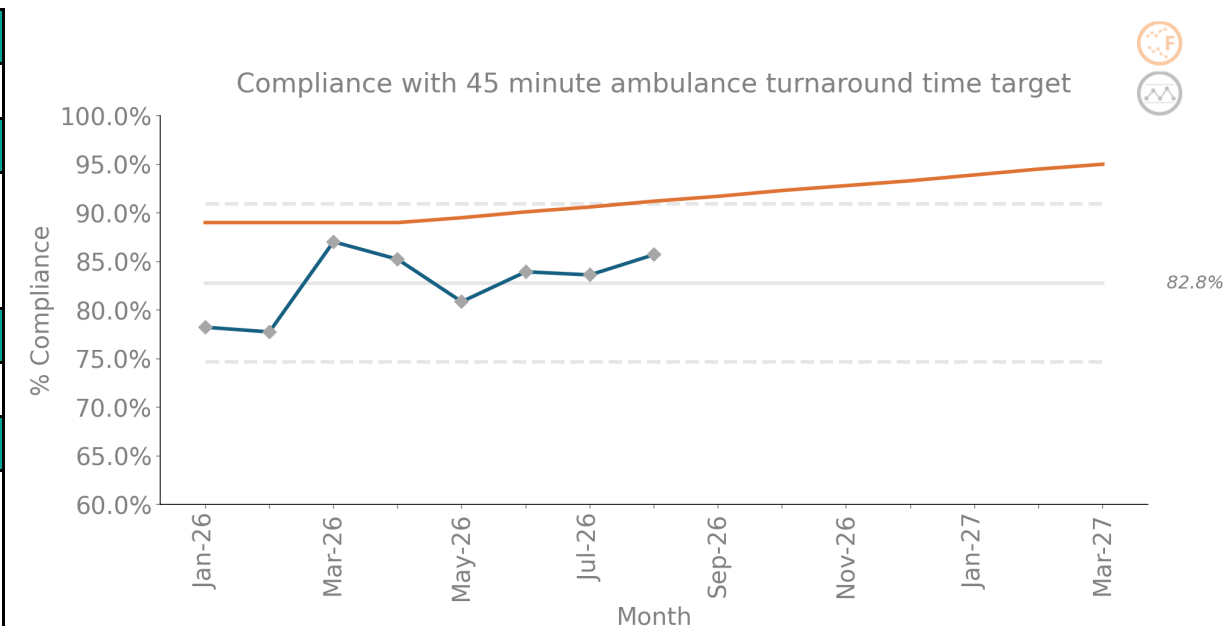
Metric	Summary	Action	Assurance
Overall adult inpatient occupancy rate (excluding elective CDH wards)	Adult inpatient occupancy remains above the Trust target at 95.9% against a target of 92%. SPC analysis demonstrates sustained common-cause variation with no recent improvement, indicating the Trust continues to operate at consistently high occupancy levels rather than experiencing a temporary increase in demand. Whilst occupancy has reduced from previous months, capacity pressures remain significant and continue to impact patient flow across the organisation. Ongoing work through the Urgent and Emergency Care Improvement Programme, including pathway redesign, admission avoidance initiatives and flow improvement schemes, continues to support reductions in avoidable occupancy and improve patient movement through the hospital. Occupancy, patient flow and discharge performance remain subject to enhanced operational oversight and system-wide monitoring through established governance arrangements.	1. Urgent & Emergency Care (UEC) pathway productivity: Continued focus on admission avoidance and length-of-stay reduction to release capacity and de-pressure occupancy. 2. Strengthened governance and oversight arrangements remain in place, including executive-led workstreams, weekly performance reporting, and monitoring through the Strategic Oversight Group and UEC Improvement Board. 3. System-wide collaboration through the Single Improvement Plan and Place-based UEC delivery structures continues to support coordinated action and address capacity constraints across the pathway. 4. The introduction of Extended Emergency Medicine Ambulatory Care (EEMAC) in July has successfully reduced patient numbers in corridors and waiting areas, supporting improved flow and patient experience. 5. The Medical Decisions Unit is planned to open in August 2026 to improve pathways of care. 6. A review of patient pathways across acute services is being undertaken to reduce duplication, streamline processes and support the delivery of more effective and efficient patient pathways.	1. The Improvement Plan is overseen by the Chief Operating Officer, providing executive sponsorship and alignment to the Trust's Single Improvement Plan 2. Fortnightly, executive-led workstream meetings review progress against agreed actions and unblock risks and issues. 3. Weekly performance reporting flows into the Strategic Oversight Group, with monthly reporting to the UEC Improvement Board. 4. Additional assurance is provided through the Single Improvement Plan Portfolio Board and the Place UEC Delivery Board (Lancashire & South Cumbria).



Performance - UEC Assurance



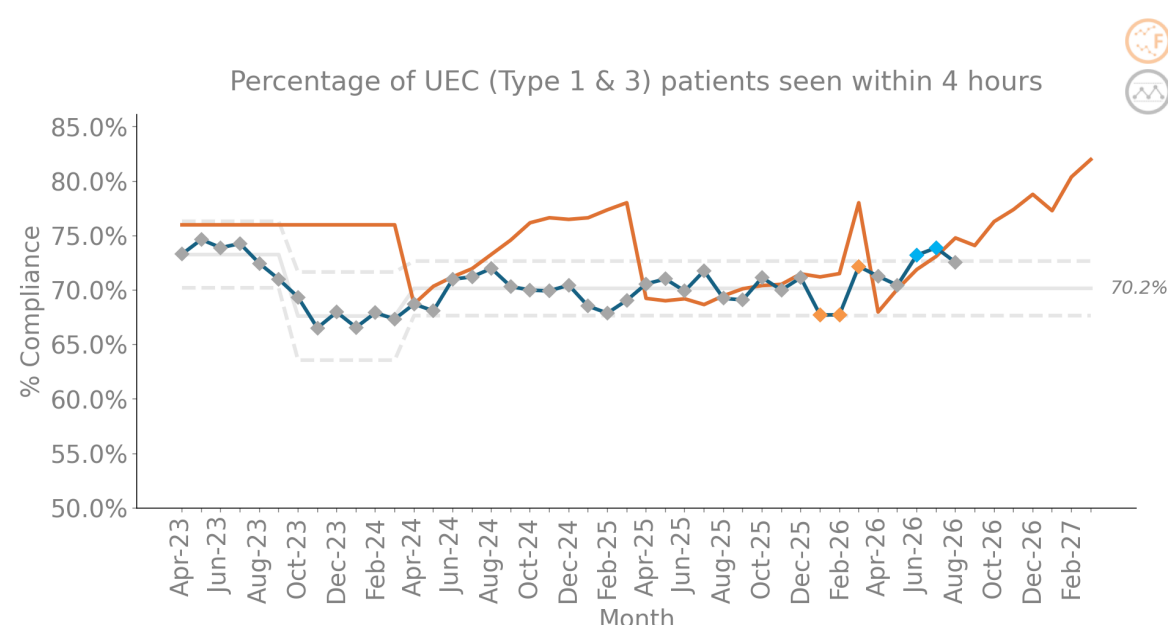
Latest
28.86%
Variance Type
Normal variation - no recent change
Mar 27 Target
66.3%
Target Achievement
Will consistently fail target within expected variation



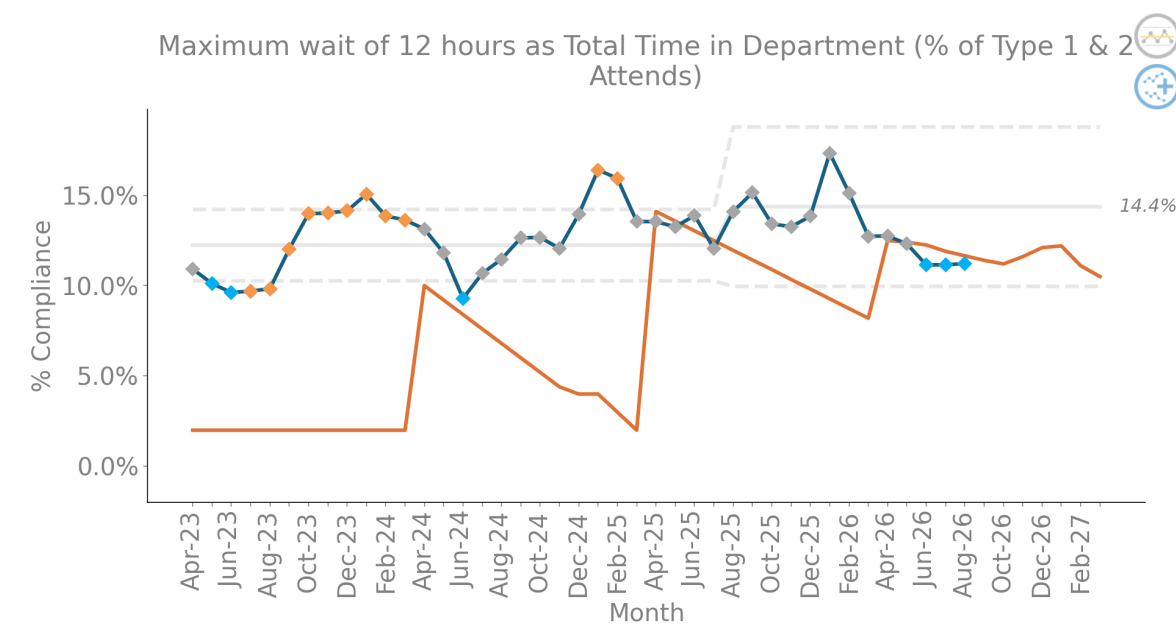
Latest
85.70%
Variance Type
Normal variation - no recent change
Mar 27 Target
95%
Target Achievement
Will consistently fail target within expected variation

Metric	Summary	Action	Assurance
Percentage of Ambulance Handovers within 15 minutes - Trust	In August 28.86% of patients were handed over from NWS within 15 minutes, an improvement of 2.04% compared to July. However the current position shows normal variation and will consistently fail the target within expected variation.	Improvement actions to support timely ambulance handover will be supported via the launch of the EEMAC, re-designed Acute Medical model and 24/7 SDEC which will commence at the end of July 26. 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 will support delivery of a 1 day LOS reduction for DKAFH patients in pathways 1-3, thus reducing bed occupancy and aiding timely flow from ED. 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.	Comparison to both the national and regional performance positions for August 26 indicates that the Trust is below the national performance of 35.2% for 15 minute handovers and below the NW performance position of 31.7% of handovers within 15 minutes.
Percentage of Ambulance Handovers within 30 and 45 and 60 minutes - Trust	In August 74.25% of patients were handed over from NWS within 30 minutes, an improvement of 2.93% compared to July 26. Over 85.7% were handed over within 45 minutes, an improvement of 2.09% compared to July 26.		Comparison to both the national and regional performance positions for August 26 indicates that the Trust is below the national performance position of 75.2% for 30 minute handovers and below the NW performance position of 75.4%.

Performance - UEC Assurance



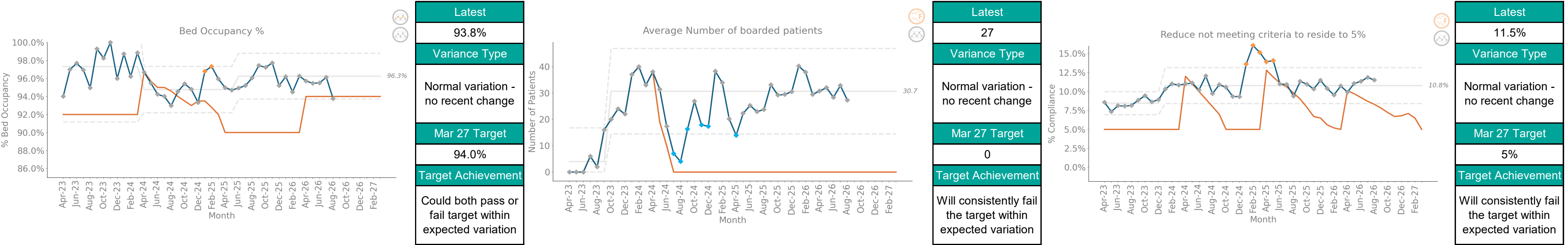
Latest
72.56%
Variance Type
Normal variation - no recent change
Mar 27 Target
82.00%
Target Achievement
Will consistently fail target within expected variation



Latest
11.29%
Variance Type
Recent positive pattern in the data
Mar 27 Target
8.20%
Target Achievement
Could both pass or fail target within expected variation

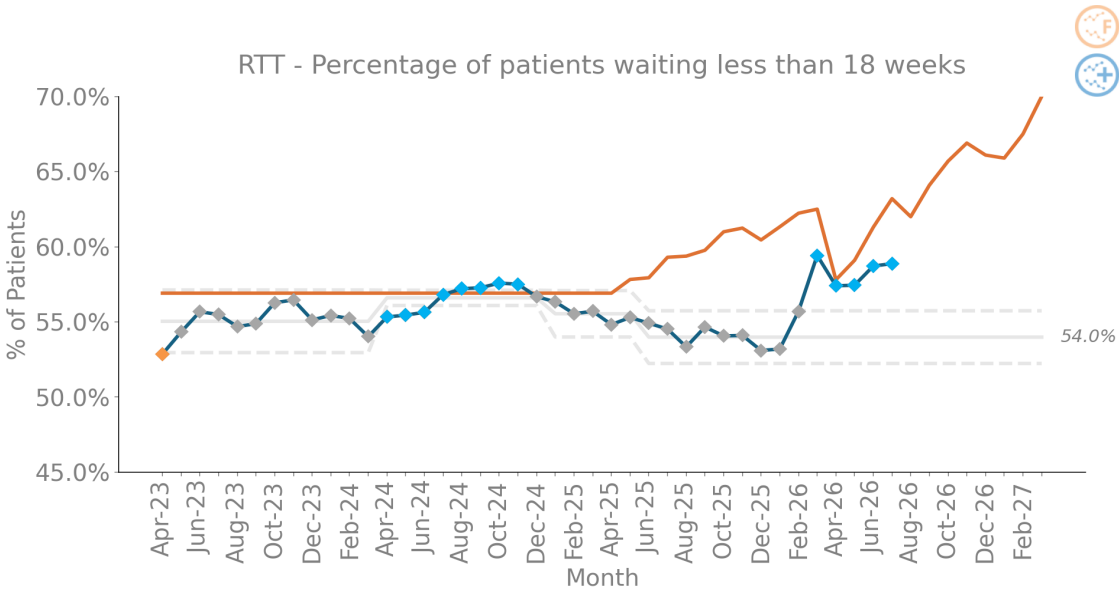
Metric	Summary	Action	Assurance
ED 4 Hour Performance - Trust	Performance against the national 4 hour access standard decreased in August 2026. Performance was 1.3% lower than July 26, and is lower than the Operational Plan target for July 26. August 26 experienced a lower daily attend level that July 26 of approximately 27 lower per day.	Progress continues with the Trusts UEC Transformation programme with key themes focusing on re-designed pathways Pre and Post hospital, the acute medical model of care, SDEC, Frailty and site escalation. An Extended Emergency Medicine Ambulatory Care facility was launched in July. Ther re-designed Acute Medical Model (MAC) will commence at the end of August 26 providing 24/7 SDEC provision and a Frailty SDEC service will be launched in Q2.	Comparison of 4 hour performance to the latest published national benchmarks indicates that the Trust is below the national average for August 26 of 75.0% and was ranked 73 out of 117 trusts nationally, a slight decrease of 8 places compared to July 26.
Maximum wait of 12 hours as Total Time in Department (% of Type 1 and 2 Attends)	The number of patients waiting over 12 hours (admitted and non-admitted Type 1 only) in ED for August 2026 increased slightly on July at 11.29%. The position shows normal variation and could both pass the year end target.	Work continues within the DKAFH programme. Multi-agency Transfer of Care hub commenced in 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.	The level of boarded patients decreased in August with an average of 27 patients per day. The volume of Days Kept Away from Home patients is far in excess of the target and above the August 25 position.

Performance - UEC Assurance

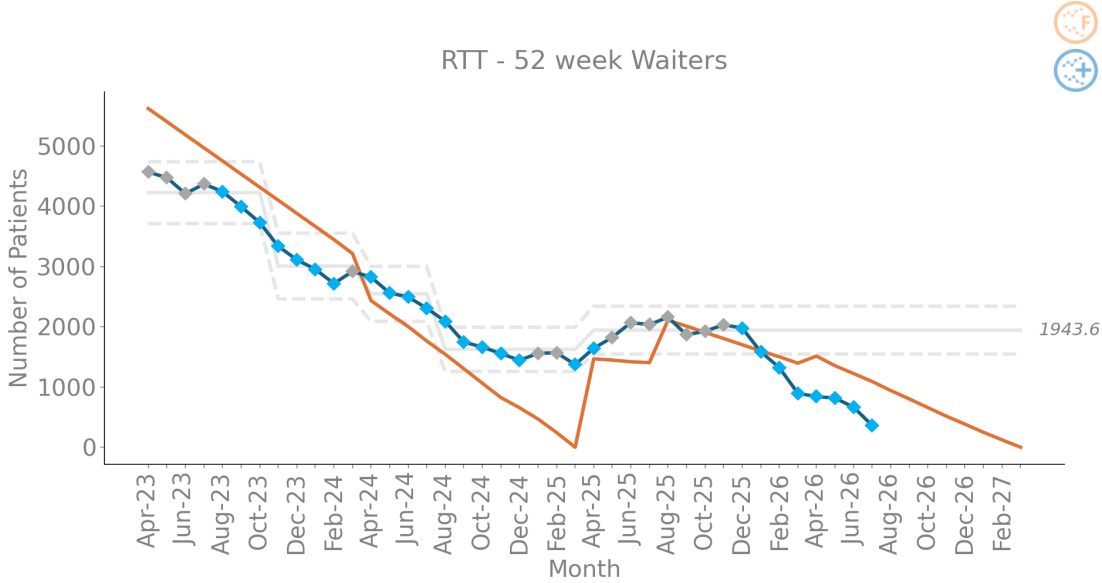


Metric	Summary	Action	Assurance
Bed occupancy %	The position shows an occupancy rate for August 26 of 93.8%, a decrease of 2.3% compared to July 26. The data shows normal variation and could both pass or fail the target within expected variation.	Bed occupancy remains significantly above target. Work continues linked to the DKAFH programme. 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 27 patients were boarded each day across both sites during August 26 with 837 associated bed days. This is a decrease compared with the July 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.	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 (NMC2R) decreased marginally in August (11.5% = daily average of 88 patients). Compared to the July position this is a decrease of 0.4%. The data shows normal variation and will consistently fail the target within expected variation.		Monitoring of NMC2R data is undertaken via the Central Lancs Urgent Care Delivery Board

Performance - Elective Care Assurance



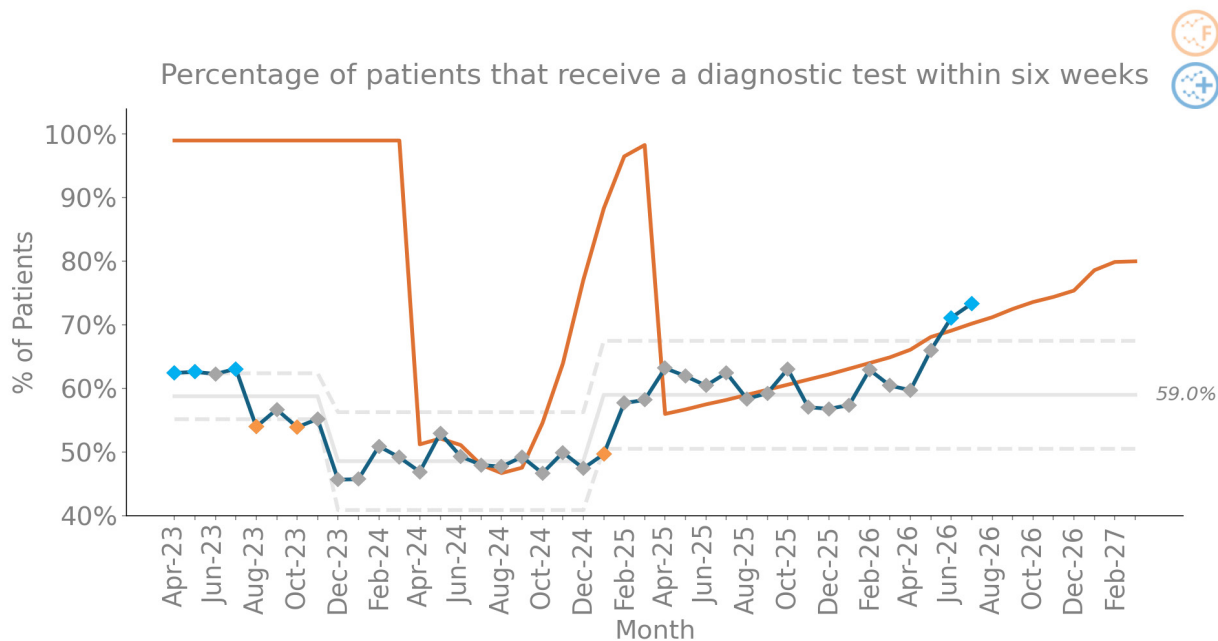
Latest
58.88%
Variance Type
Recent positive pattern in the data
Mar 27 Target
70.00%
Target Achievement
Will consistently fail target within expected variation



Latest
362
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 July 26 position of 58.88% is a 0.16% improvement compared to June 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%. NATIONAL DEADLINES FOR AUGUST 26 HAVE BEEN EXTENDED. FINALISED DATA WILL NOT BE AVAILABLE UNTIL 23RD SEPTEMBER 2026	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 a further 0.4%.	Comparison to the latest national performance position (June 26) indicates that the Trust is below the national position of 65.8% waiting under 18 weeks. The Trust is ranked 111 out of 118 trusts nationally for June 26 performance. July national performance is unavailable for this KPI at this time.
RTT - 52 week Waiters	The over 52 week waiter position in July was 362, a further decrease of -304 compared to the June position. Analysis suggests a recent positive pattern in the data and that the target may be consistently failed. NATIONAL DEADLINES FOR AUGUST 26 HAVE BEEN EXTENDED. FINALISED DATA WILL NOT BE AVAILABLE UNTIL 23RD SEPTEMBER 2026	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 (July 26) indicates that the Trust at 0.6% in July was below the national picture of 1.5% waiting over 52 weeks. The Trust was ranked 34 out of 117 trusts that submitted data for July 26 performance.

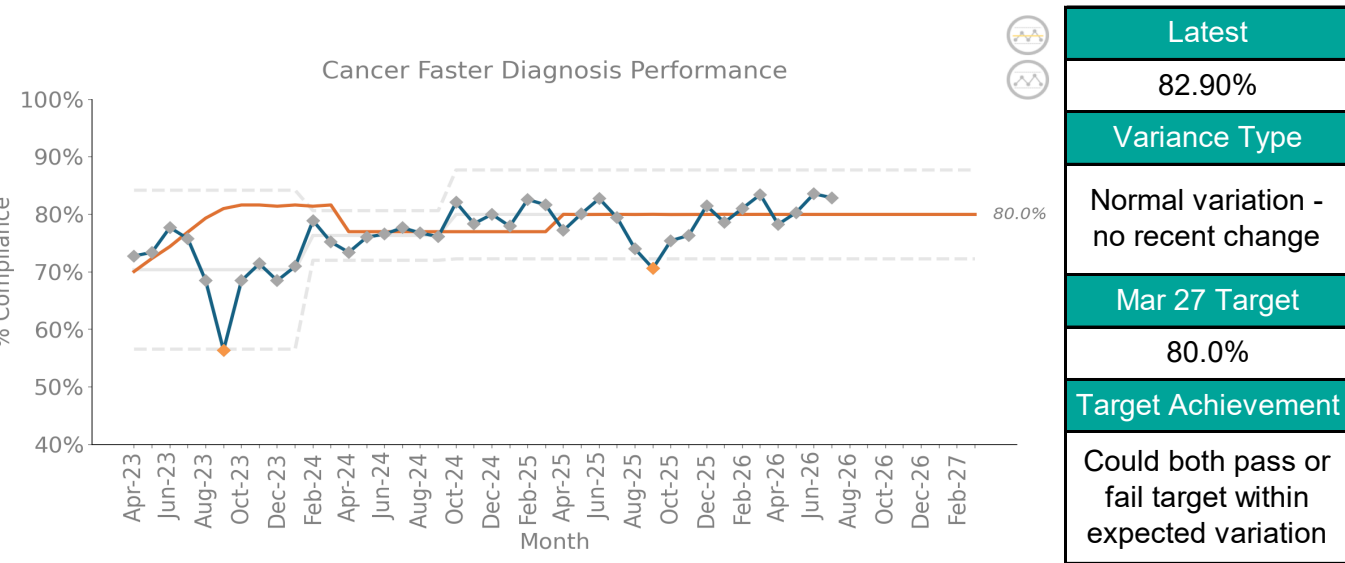
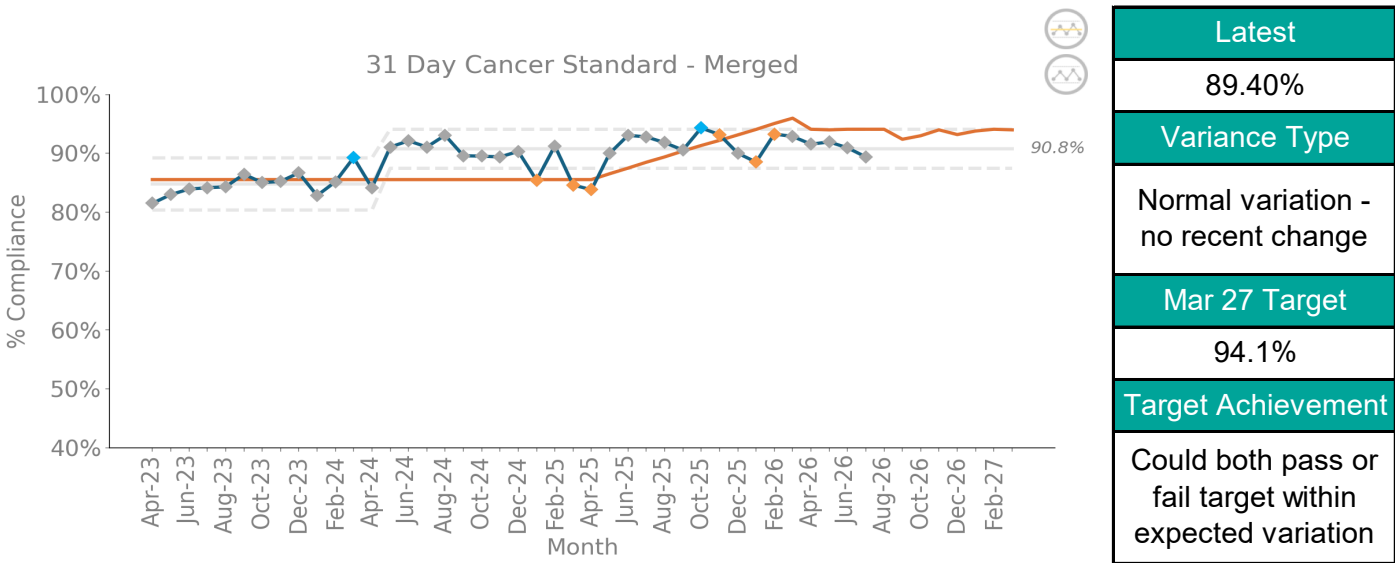
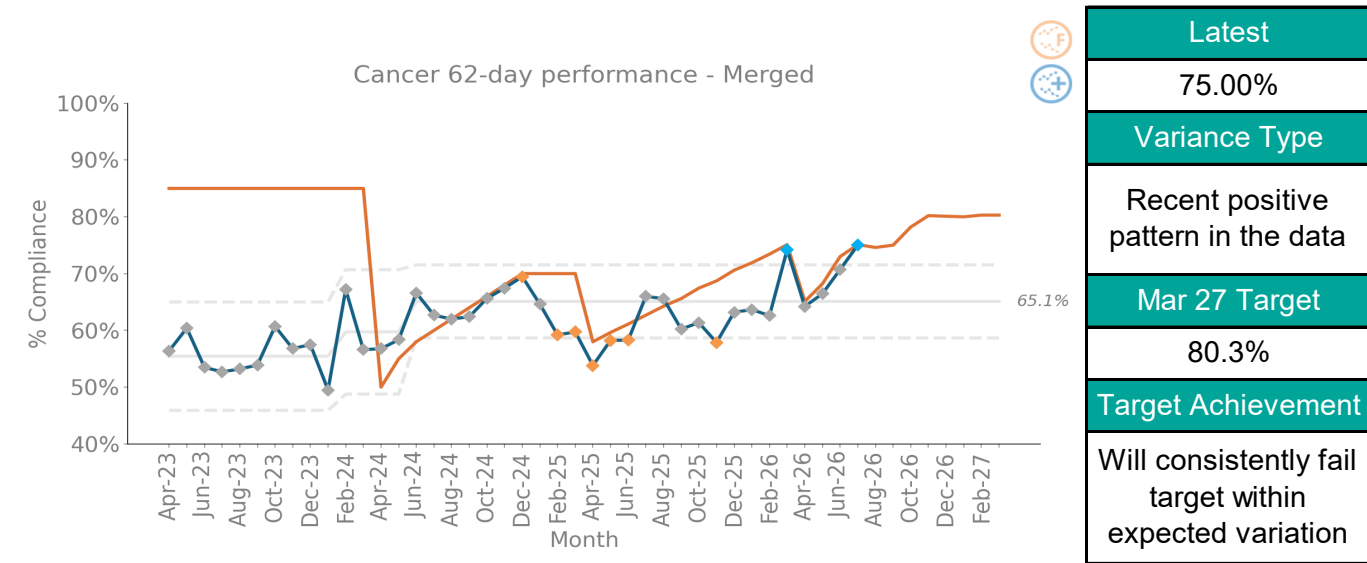
Performance - Elective Care Assurance



Latest
73.35%
Variance Type
Recent positive pattern in the data
Mar 27 Target
80.0%
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 73.35% in July compared to 71.13% in June, a further 2.22% improvement on the June position and above the trajectory for July of 70.2%. The July 26 DM01 performance is the highest reported since March 2020. The performance has been driven by further improvements in NOUS and Echo over 6 week waiters. Urgent and cancer patients are prioritised and seen within 2 weeks. Presently 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 is impacting on the improved position. Internal colleagues undertaking additional work but shortfall remains. Capacity and demand modelling completed and recruitment and increased IS capacity are being mobilised.	The areas of focus are capacity optimisation, productivity, transformation and system working. Review of the latest published data (July 26) indicates that LTH is 86th out of 117 trusts that submitted data, a further improvement of 7 places compared to June but significantly below the national average of 76.9%.

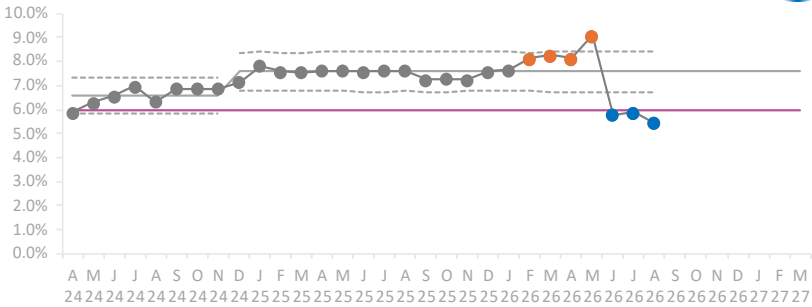
Performance - Elective Care Assurance



Metric	Summary	Action	Assurance
62 Day Cancer Standard - Merged	Performance to the end of July shows a further improved position (+1.3% versus June 26), and is only 0.1% under the July Trust operational performance plan. Analysis shows normal variation in the data and will consistently fail the target within expected variation.		July 26 performance is above the latest national performance of 75% (July 26). The trust was ranked 41 out of 117 trusts for July performance, an improvement of 3 places.
31 Day Cancer Standard - Merged	Performance to the end of July 26 has fallen from June to 89.4% and is also below the monthly operational plan target of 94.1%. The performance is driven by high volumes of referrals within the Dermatology service and capacity constraints within pathology. Analysis shows a normal variation in the data and could both pass or fail the target within expected variation.	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 10 specialties 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. Recruitment into key clinical vacancies has commenced with postholders due to commence in role starting 03/08/26.	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. July 26 performance is below the latest national performance of 92.5% (July 26). The trust was ranked 100 out of 117 trusts for July performance, a drop of 28 places.
Cancer Faster Diagnosis Performance	Performance to the end of July 26 decreased by 0.8% versus June 26 but was above the monthly operational plan target of 80%. Analysis shows a recent concerning pattern in the data and could both pass or fail the target within expected variation.		Faster Diagnosis Standard July performance is 82.9% with the month on month target of 80% achieved. The Trust is currently ranked 36th out of 117 trusts.

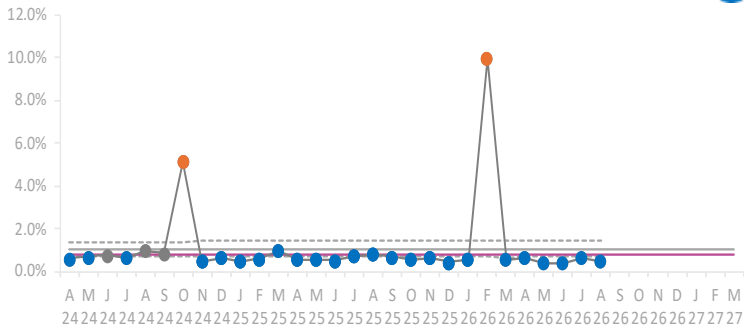
People - Workforce Assurance 1

GL Vacancy Rate (% FTE)



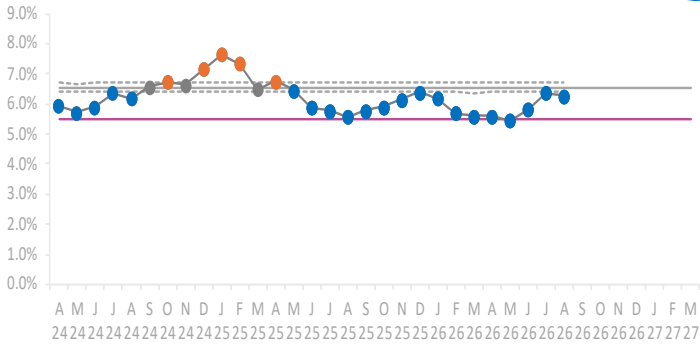
Latest
5.46%
Variance Type
Recent concerning pattern in the data
Mar 27 Target
≤ 6%
Target Achievement
Could both pass or fail target within expected variation

ESR Turnover (% FTE)



Latest
0.50%
Variance Type
Normal variation - no recent change
Mar 27 Target
≤ 10%
Target Achievement
Could both pass or fail target within expected variation

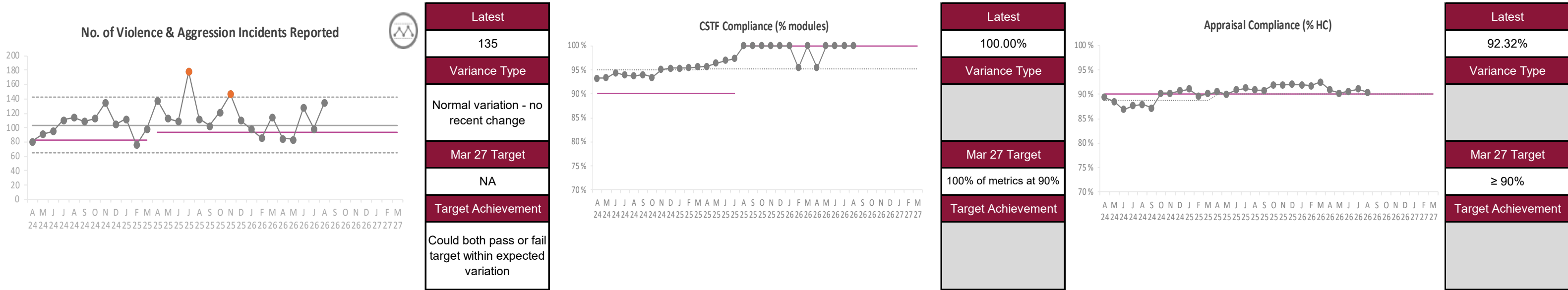
Overall Sickness (% FTE)



Latest
6.29%
Variance Type
Normal variation - no recent change
Mar 27 Target
≤ 5.5%
Target Achievement
Will consistently fail the target within expected variation

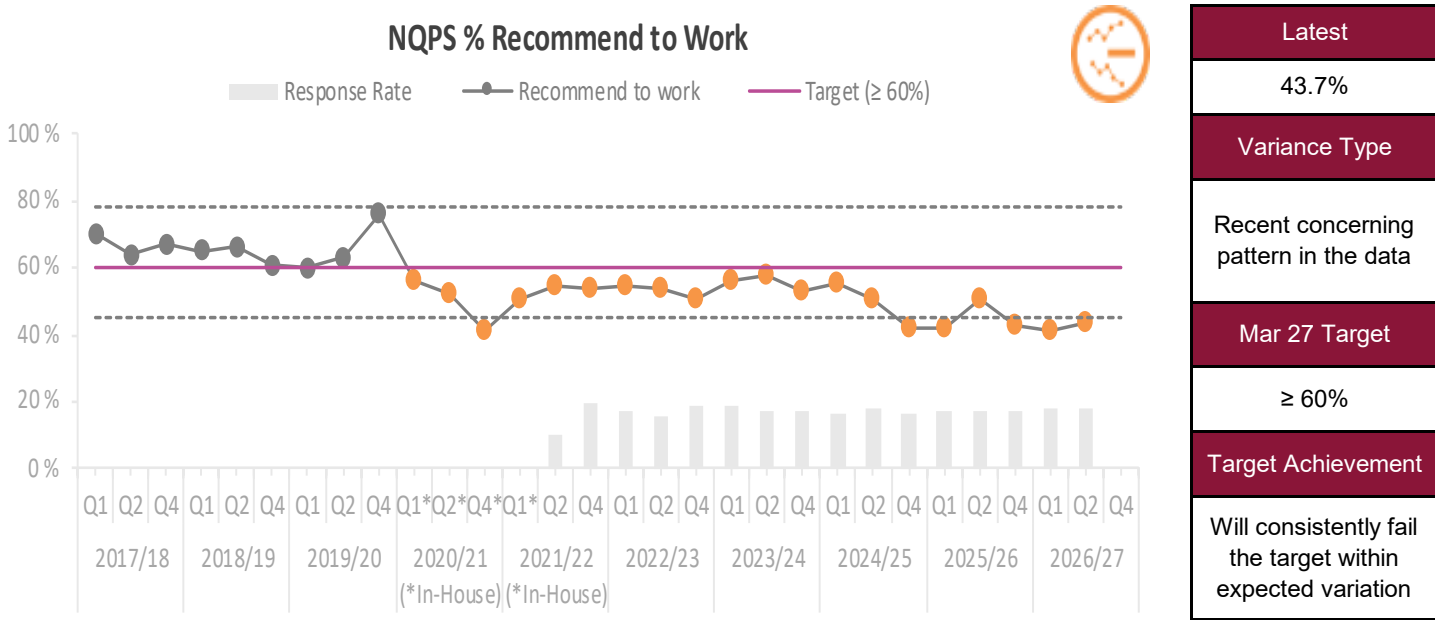
Metric	Summary	Action	Assurance
Vacancies (% FTE)	Following the establishment review and vacancy removal exercise, the Trust vacancy rate has reduced to 5.46% moving within target tolerance. However workforce supply challenges remain, particularly within Healthcare Support Worker and selected Medical and Dental groups. A significant recruitment pipeline remains in progress, including over 230 WTE HCSW vacancies currently under active recruitment.	Strategies to address Band 2/3 Healthcare Support Worker gaps have been developed jointly developed by nursing, education and workforce teams. Divisional Workforce Business Partners developing resourcing plans for hard to fill roles. Centralised recruitment underway.	Vacancy rate monitored through Board reporting, People and Performance Committee and Divisional Improvement Forums Safe staffing levels monitored daily in clinical areas. People Operations Group to include a focus on resourcing. EQIA process utilised to support vacancy control decision-making.
Turnover (% FTE)	M5 data for turnover is at 0.5% which is a further decrease than M4 at 0.64%, this remains below target.	The Annual Retention Report was recently presented at the People and Partnership Committee, it outlined the strategic programmes of work to tackle areas where turnover is higher. This includes focussing on what would support colleagues in early career to stay with us, identifying reasons for leaving by HCA colleagues and the fact that a significant proportion stay with us but as a bank worker and increasing our understanding of wider reasons for leaving by improving our data collection methodology.	Annual retention strategy update report provided to Workforce Committee in September 2026. 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 remained high in M5. Although there was a small improvement in the long-term absence rate (4.43% compared to 4.62% in M4), this was offset by an increase in the short-term absence rate (1.88% compared to 1.75% in M4).	The Workforce Business Partners are supporting managers to develop targeted action plans in 10 ward areas, although this work is currently behind plan due to gaps in the Workforce team. The business case for a Digital Sickness Absence system has been developed and is in the review and approval process. This is essential to provide full organisational oversight of sickness absence management, with the additional benefit of it being a tool to push out wellbeing advice and information to colleagues. All long-term sickness absence cases >6 months have recently been reviewed due to increasing numbers. There is evidence of slippage in policy milestones and management plans have therefore been refreshed.	'Failure to manage sickness absence management effectively' is a Principal Risk and subject to risk management review Annual Health and Wellbeing report, including a deep dive around sickness absence was presented to the July 2026 People & Partnerships Committee Waste Recovery Scheme around sickness absence reduction devolved to divisions and monitored through Divisional Delivery Group and Divisional Improvement Forums.

People - Workforce Assurance 2



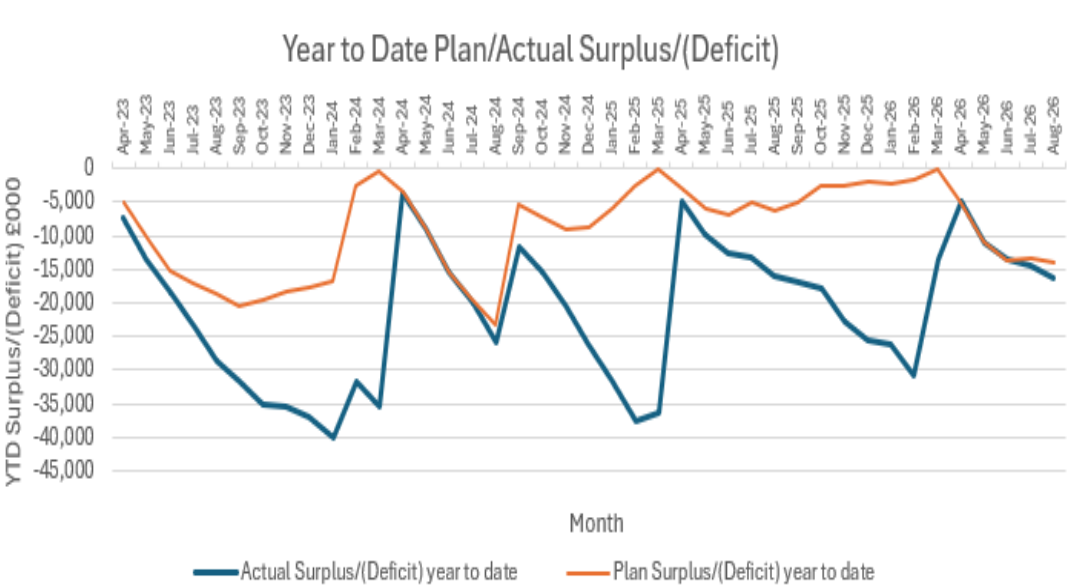
Metric	Summary	Action	Assurance
Number of violence and aggression incidents toward staff	The number of reported violence and aggression incidents continues to fluctuate monthly, and increased in M5 (135 incidents, compared to 99 in M4). The highest number of incidents consistently occur in Emergency Department and other areas where the nature of the patient's condition makes them more prone to violent and aggressive behaviour.	A Rapid Improvement Workshop was held in M4 with good multi-disciplinary engagement, and this generated new test of change ideas to supplement existing improvement work. A further workshop will be held in M6, which will focus mainly on the Zero Tolerance letter process. Targeted improvement work continues in Emergency Department including planned Estates developments to improve security.	Annual deep dive reports around incidents and actions to People and Partnerships Committee Incident data and reviewed through Health & Safety Governance Group
Core Skills Mandatory Training compliance (% modules)	Trust-wide compliance meets or exceeds the 90% threshold across all Core Skills and nationally mandated metrics, supported by established governance, reporting and escalation arrangements.	Divisional management teams are provided with both percentage compliance data and non-compliant staff numbers to support local accountability, prioritisation and escalation in accordance with the Mandatory Training Policy. For practical training requirements, session and assessment capacity is routinely reviewed, with targeted support implemented where additional capacity or improvement action is identified.	People and Partnerships Committee receives assurance on the Trust's governance, monitoring and escalation arrangements for statutory and mandatory training.
Appraisal compliance (% HC)	Appraisal compliance was 92.32% for M5, this has slightly increased from 91.1% in M4 and remains above the target of 90%.	To further progress the strategic actions in relation to appraisal, these include delivery of Objective Setting Masterclass training to teams with lowest scores on NHS Staff Survey items relating to appraisal. Embedding career based discussions in appraisal and publishing resources online. Refreshing templates based on NHS Managers Code and Standards and updated organisational values. The appraisal process has recently been audited, with final outcomes to be presented back to the Trust.	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

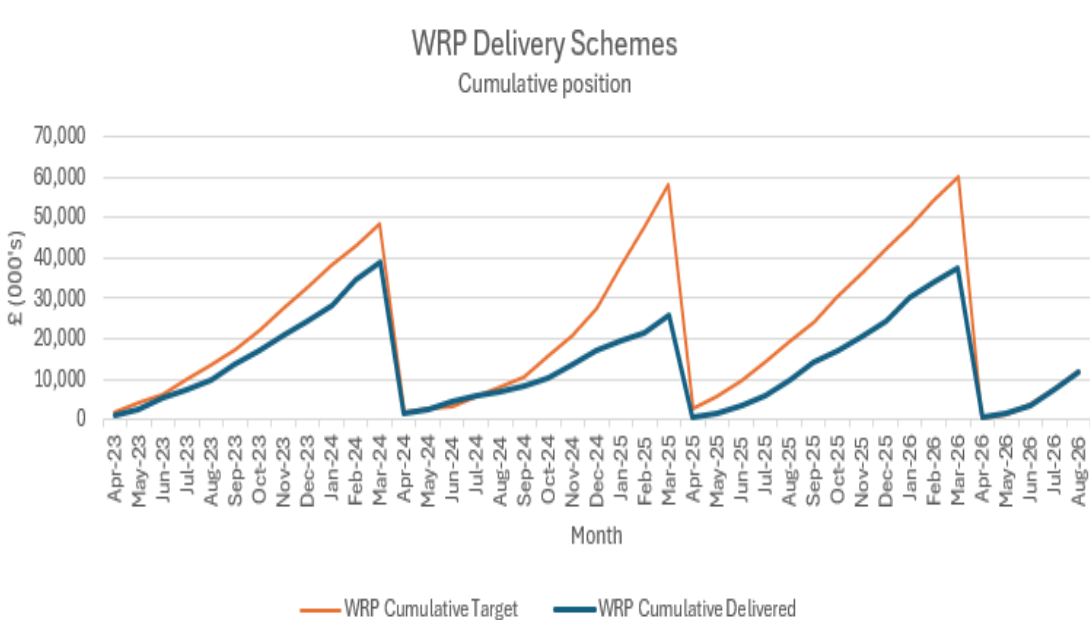


Metric	Summary	Action	Assurance
Staff Survey: Recommend Trust as place to work	There have been no further changes to this metric, as it is a quarterly metric. Feedback from last report still stands which is - Quarter 2 data set for the question "I would recommend my organisation as a place to work" has marginally increased since Q1 from 41% in Q1 to 43.7% in Q2. This remains below the target score of 60%. Whilst there is a marginal improvement, year on year trends typically see Q2 having slightly higher levels of engagement, this tends to correlate with moving out of winter and different patient pressures. We have in this quarter seen a 2% increase in the item "I am enthusiastic about my job" and a similar 2% increase in "I look forward to going to work" when compared with Q1.	A corporate-level action plan is being progressed and all Divisions have a staff survey action plan in place, with Divisions reviewing progress with the Staff Engagement Lead. Teams who are lower scoring have been contacted with the offer of targeted support. Work is now focussing on the next NHS Staff Survey round which will commence in October 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)
-16,181
Latest YTD Target (,000s)
-13,987
Aug-26 Annual Target (,000s)
0



Latest YTD Actual (,000s)
11,607
Latest YTD Target (,000s)
12,025
Aug-26 Annual Target (,000s)
60,000

Metric	Summary	Action	Assurance
I&E - Plan v Actual variance	The Trust is reporting a £2.20m adverse position to plan to the end of August 2026. The Trust has a YTD £16.18m deficit against a £13.99m planned deficit (including DSF funding of £3.85m). DSF has not been received for M4 and M5 (£1.5m). Month 5 YTD WRP delivery is under-performing by £0.42m, however the NHSE Submitted Plan phasing is heavily weighted to later in the year. The forecast for 2026/27 has been developed based on non-receipt of DSF (best and likely cases include Q2-4 non-receipt, worst case includes further clawback of Q1), unmitigated Pathology industrial action costs as at month 5, further unmitigated Pathology industrial action costs (best and likely case includes £0.10m for M6, worst case includes a further £0.80m for M7-12) and a range associated with WRP delivery risk.	A re-set of the programme structure, governance and reporting for 2026/27 has taken place, including the introduction of the Productivity Board, Financial Recovery Board, DDGs and WRP Review meetings. Headcount reduction continues to be of significant focus with an additional 31.72WTE WRP delivered in M5 (106.29WTE YTD).	Grip and control Interventions and control measures are constantly being reviewed
WRP schemes delivery	The Trust's 2026/27 waste reduction target is £60m, 5.7% of operating expenditure. Month 5 YTD WRP delivery is under-performing by £0.42m, however the NHSE Submitted Plan phasing is heavily weighted to later in the year. The in year Waste Reduction Programme has fully been identified at £60.0m with fully developed schemes to this value. Forecasting of WRP is assumed to be £60.0m best case, £41m likely case and £37m worst case. Confidence levels will continue to be reviewed at DDGs. Scheme development is continuing to ensure that any WRP plan slippage is mitigating.	The Trust has introduced a process to help mitigate the gap on WRP plan. This requests that Divisions review their recruitment pipeline to see what posts can be held to enable realignment to the expected WRP headcount reduction. 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. In September 2026 the Trust has implemented enhanced WRP assurance through the Financial Recovery Board.	Productivity board chaired by CFO External support for specific workstreams. Implementation of Financial Recovery Board, Divisional Delivery Groups and WRP Review meetings Embedding of PMO

7.2 UPDATE FROM CARE AND SAFETY SUBGROUP

● Discussion Item

● G Bailey

🕒 1.55 pm

Verbal update

7.3 UPDATE FROM MEMBERSHIP SUBGROUP

● Discussion Item

● S Brennan

● 2.05 pm

Verbal update

8. PATIENTS (SAFETY AND QUALITY)

8.1 WINTER PLANNING

● Other

● K Foster-Greenwood

● 2.15 pm

Item for Assurance

REFERENCES

Only PDFs are attached



8.1 Winter Planning Paper 26-27 CoG October 2026.pdf

Winter Surge Plan 2026/27

Winter Surge Planning Report 2026/27							
Report to:	Council of Governors			Date:	27/08/2026		
Report of:	Chief Operating Officer			Prepared by:	L Walsh – Deputy COO		
Purpose of Report							
For assurance	☒	For approval	☒	For discussion	☐	For information	☐
Executive Summary:							
This paper sets out the 2026/27 Winter Surge Plan for Lancashire Teaching Hospitals NHS Foundation Trust, describing the forecast increase in urgent and emergency care demand, the associated bed-capacity gap, the expected impact on emergency and elective performance if left unmitigated, and the proposed schemes to support delivery through winter. The modelling forecast is based on H1 2026/27 non-elective activity variances, an average length of stay of between 4.1 and 4.4 days, and a planning assumption of 95% occupancy. It indicates a monthly bed gap of between 10 and 73 beds across October 2026 to March 2027, with the greatest pressure in November. This level of occupancy remains above the NHSE ambition of 92%, but reflects the need to balance winter resilience with delivery of the Financial Recovery Plan. If unmitigated, the forecast bed deficit would lead to an estimated deterioration in four-hour emergency performance of between 0.7% and 5.0% during winter. Increased non-elective demand would also reduce inpatient capacity available for elective care, creating a further risk to RTT recovery and wider planned care delivery. A total winter surge reserve of £800k has been identified. Phase 1 schemes have been prioritised for mobilisation based on impact and ease of implementation. These schemes focus on reducing ED attendances, avoiding admissions, improving ambulance and ED flow, reducing length of stay, increasing discharge capacity and strengthening infection-related flow resilience. All schemes will be monitored monthly and any scheme which fails to mobilise or deliver the required outcomes will be considered for cessation and investment will be directed to alternative schemes. The Phase 1 schemes recommended for approval are: ➤ Additional paediatric medical capacity to reduce waits in ED and PAU, prevent four-hour breaches and support timely discharge. ➤ Increased discharge lounge capacity to improve AMU access, reduce ED overcrowding and reduce 12-hour length of stay delays. ➤ An ED transfer team to reduce ED overcrowding and ambulance handover breaches.							

- Mental health weekend support to enable timely assessment, support hospital avoidance and reduce long waits in ED for mental health transfers.
- A high intensity user practitioner to increase capacity for frequent attenders, support admission avoidance and improve ED performance.
- Increased point-of-care flu testing to support timely discharge and transfer, reduce delayed discharge and improve infection-related flow.
- Electronic prescribing for discharge medication to reduce length of stay and release bed capacity.

Phase 2 schemes are being developed with system partners, with approval expected through the Central Lancashire Operational Delivery Group in September 2026. These schemes are intended to strengthen hospital avoidance and community-based support and will be funded from the remaining winter surge allocation, subject to approval.

The paper also recognises key delivery risks, including the reduced winter funding envelope compared with 2024/25, uncertainty around seasonal infections, potential constraints in securing temporary staffing, residual risk of boarding if demand cannot be fully mitigated, and possible cost implications if ward moves or reconfigurations are required. The 2026/27 staff vaccination campaign is included as a supporting mitigation to protect workforce capacity and reduce infection-related disruption.

All schemes will be monitored monthly against mobilisation milestones and projected outcomes. Where schemes do not mobilise or under-deliver, the Central Lancashire Urgent Care Delivery Board will recommend disinvestment with one month's notice and reinvestment into alternative schemes.

It is recommended that:

- I. Council of Governors note the contents of the report and the risks associated with winter surge demand.

Trust Strategic Aims and Ambitions supported by this Paper:			
Aims	Ambitions		
To offer excellent health care and treatment to our local communities	☒	Consistently Deliver Excellent Care	☒
To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☐
To drive innovation through world-class education, teaching and research	☐	Deliver Value for Money	☒
		Fit For The Future	☐
Previous consideration			
N/A			

1. Background

Lancashire Teaching Hospitals NHS Foundation Trust (LTH) has been working with Divisional and corporate colleagues to develop options to ensure the effective management of surge demand over the winter months.

LTH budget setting identified £800K to be held in reserves to support winter demand. System wide, Divisional and corporate teams have identified schemes to address the identified bed and capacity deficits with initiatives supporting the following key areas:

- 1) ED attendance avoidance
- 2) Timely discharge home or to appropriate place of care
- 3) Length of Stay (LOS) reduction
- 4) Admission avoidance

2. Assessment – Bed deficit and impact on 4 hour performance

The data in table 1 has considered the Non-Elective (NEL) admission plan and calculated a forecast for H2 based upon the variance to plan within H1 26/27. An associated bed day demand has been identified assuming an average length of stay (ALOS) of between 4.1 and 4.4 days.

A bed gap analysis has been undertaken based on an assumed bed occupancy of 95%. It is acknowledged that this is higher than the NHSE ambition of 92% and whilst all UEC improvement ambitions continue to aim to achieve 92% bed occupancy, it will not be possible to deliver this in Q4 26/27 due to the requirement to deliver the Financial Recovery Plan (FRP).

Table 1 – Non Elective Operational Plan

NEL Operational Plan Delivery Oct-Mar 2026/27
Bed Requirements Oct-Mar 2026/27

	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Total NEL Operational Plan	5,013	5,051	4,837	4,882	4,740	5,004
NEL ALOS 2025/26 (specific PODs)	4.3	4.3	4.4	4.4	4.2	4.1
Bed Day Requirement	21,711	21,636	21,509	21,431	19,702	20,495
Bed Requirement	700	721	694	691	704	661
Current NEL bed stock	686	686	686	686	686	686
% Occupancy (based on plan v available beds)	102%	105%	101%	101%	103%	96%
Target % Occupancy	95%	95%	95%	95%	95%	95%
Var	7%	10%	6%	6%	8%	1%
Bed requirement to deliver 95% occupancy	737	759	730	728	741	696
95% Variance to Current Beds	51	73	44	42	55	10
Current A&E Plan	76.33%	77.40%	78.80%	77.32%	80.40%	82.00%
% Unmitigated Performance Deterioration	-3.55%	-5.07%	-3.07%	-2.89%	-3.79%	-0.69%

The table above shows the current and unmitigated bed deficit. It suggests that the bed gap, assuming a 95% bed occupancy is between 10 and 73 beds, based on variations in demand month on month.

Based on this bed gap, an assessment of ED performance has been included in the data set linked to performance year to date and deteriorations in bed occupancy per 0.5%. The unmitigated bed deficit would result in a performance deterioration of between -0.7% to -5% over the course of winter.

To address this gap and the associated risks to patient safety and organisational performance, the following mitigating schemes have been developed.

3. Mitigations to address the identified bed gap

Scheme Detail	Duration	Outcome
Additional Paediatric medical capacity	5 months	Reduced waiting times within ED and PAU 4 hour breach prevention Increased timeliness of discharge/reduced LOS
Increased discharge lounge capacity	5 months	Earlier admission to AMU ED overcrowding reduction Reduced 12 hour+ LOS
ED transfer Team	6 months	Reduced ED overcrowding Reduce ambulance handover breaches
Mental Health Weekend Support	6 months	Reduced admissions Reduced ED overcrowding Reduced ED attendances Reduced long waits in ED for MH transfer
High Intensity User Practitioner	6 months	Increased capacity to reduce ED attendance Reduced LOS Increased admission avoidance Improved 4 hour ED performance
Increased Flu Testing using POC	6 Months	Increased weekend discharge rate Reduction in delayed discharge ED Reduced LOS. Reduction in Flu transmission rates Increased flow across site
Electronic Prescribing	6 Months	Reduced LOS Increased bed capacity

Phase 1 schemes have been developed to provide surge demand mitigation and will be funded from the identified winter surge budget. To complement the winter surge provision, schemes supported via system partners have been scoped and are considered as Phase 2.

Phase 2 scheme approval will be supported via the Central Lancs Operational Delivery Group (CLOGD) in Sept 2026 and following approval, mobilization will commence asap.

All schemes are approved based on projected outcomes which will be monitored monthly, alongside

mobilization milestones. In the event of any scheme failing to be mobilised or under delivering on outcomes, the Central Lancashire Urgent Care Delivery Board will recommend that scheme funding is dis-invested with a 1 month notice period and monies re-invested in alternative schemes.

4. Seasonal Influences

In addition to seasonal increases in unplanned care demand, the risk of winter respiratory infections on staffing capacity is also a key consideration.

Winter Vaccination Campaign 2026/27

- There is a focus to significantly improve the vaccination rates achieved in 2025/26. Seasonal training for vaccinators is already live and a staffing plan to support vaccination capacity is underway.
- Vaccination delivery will be through a combination of planned pop up stands/sessions and roving teams throughout all areas of the Trust over an extended day.
- Promotion of sessions will be focused in high footfall areas to increase awareness of sessions.
- Specific departmental visits will be scheduled for larger departments.

5. Risks to the delivery of the winter surge plan

Financial Recovery Plan (FRP) associated risk: Whilst a budget of £800K was set aside to support the management of surge winter demand on the organisation, this is a reduced allocation versus 2024/25 and maintains the allocation identified in 2025/26.

Seasonal Infections: The data utilised in the modelling has not considered any exceptional impacts of a significant seasonal infection.

Mobilisation risks: Availability of temporary staffing to support surge schemes may be constrained and given the current financial constraints, approval to recruit to additional temporary staff may not be reached. Any additional staffing secured would result in increases in variable pay spend during the winter period.

Boarding: Whilst surge demand mitigation schemes have been outlined above, there remains a risk that demand is not able to be fully mitigated and this may, for patient safety reasons, result in the need to board patients into non core bed spaces. To prevent this, the implementation of EEMAC & MDU has seen success in streaming people out of the ED department and treat/discharge patients in a reduced length of time. Further embedding of the Continuous Flow Model at weekends is planned, along with a new approach to managing patient flow by the Hospital site team.

Further ward moves: The additional winter bed capacity scheme described above is costed on the use of a current shared space. Should there be any further ward reconfigurations, this may impact on the associated costs outlined.

6. Recommendations

It is recommended that:

- I. Council of Governors note the contents of the report and the risks associated with winter surge demand.

9.1 IMPLICATIONS OF HEALTH BILL FOR COUNCIL

● Decision Item

● J Foote

● 2.30 pm

REFERENCES

Only PDFs are attached



9.1 Implications for Council - Health Bill 2026 CoG October 2026.pdf



Council of Governors

Meeting of the	Council of Governors	22 October 2026	
	Part I ☒	Part II ☐	
Title of Report	Implications of the Health Bill 2026 for Council of Governors		
Report Author	Jennifer Foote, Director of Corporate Affairs		
Lead Executive Director	Jennifer Foote, Director of Corporate Affairs		
Recommendation/ Actions required	Council is asked to consider the report. In particular, in the absence of a definitive position on the date for implementation, the immediate implications for elections to Council for 2027. In undertaking this consideration, Council is requested to: 1. Recognise that a pause is placed on the election process for 2027; 2. Determine the management of the term of office of the four governors eligible for re-election in March.		
	Decision ☒	Assurance ☐	Information ☐
Executive Summary	The Health Bill 2026 proposes the most significant change to NHS Foundation Trust governance since Foundation Trusts were established. The Bill removes the statutory requirement for councils of governors and membership arrangements and transfers a number of governance functions to the Secretary of State. It is expected that Royal assent will be received early in 2027, with implementation from 1 April 2027. This timeline would mean that no new appointments will need to be made in 2027 but as the lead up to the election process starts in January, Council will need to consider the options available to manage the uncertainty around process next year.		
Link to Strategic Objectives 2025/26	Patients – deliver excellent care: Improve outcomes, reduce harm and deliver a positive patient experience.	☐	
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.	☐	
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.	☐	
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.	☐	
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.	☒	

Current Understanding of Implications of the Health Bill (Health Act 2026)

At a workshop on 21 May 2026, Council was presented with the outline proposals for the Health Bill, including the expectation of changes to the constitutions of Foundation Trusts to remove both Council and membership. The Bill is currently progressing through the House of Lords (Committee Stage) and is expected to receive Royal Assent early in 2027, in line with implementation of the measures contained within it from 1 April.

Current authority of Council compared to future state (this has remained unchanged from the initial proposals discussed in May)

Current	Post Health Act 2026
Council appoints Chair and other NEDs	Secretary of State (probably via NHS Region) appoints
Council holds NEDs to account for the performance of the Board	Replaced by national provider assurance arrangements, departmental oversight and regulatory review.
Membership Register	No membership register. The Trust will continue in its engagement with communities and stakeholders as it does presently through a range of different mechanisms.
Approval of significant transactions by Council	Undertaken by Secretary of State
Approval of amendments to the Constitution by Council	Undertaken by Secretary of State (probably via NHS Region)
Provide the views of membership and the 'public at large' on matters affecting the Trust	Opportunities for more flexible engagement approaches, broader representation beyond election-based models, reduced administrative burden and stronger integration with place-based partnerships

The Trust already operates or engages with a number of patient, volunteer and community groups. The Council workshop planned for December 2026 will be an opportunity to understand the many and varied options to continue to engage with the Trust in a voluntary capacity post April 2027.

Council Elections 2027

The timeline would ordinarily be confirmed as:

- Notice of Election/Nominations open – Tuesday, 5 January 2027
- Nominations deadline – 5pm on Tuesday, 2 February 2027
- Voting packs despatched to members – Wednesday, 24 February 2027
- Close of election – Friday, 19 March 2027
- Declaration of results – Monday, 22 March 2027

Governors who have come to the end of their current term of office are:

Pav Akhtar. Pav will have served 3 terms (9 years) by 31/3/27 and so will not be eligible to stand for re-election in any event.

The following will have served one or two terms and would be eligible for a further term:

Graham Robinson
Tom Ramsay
Angela Kos
Philip Curwen

The expectation that any candidate putting themselves forward for election in 2027 would have no position to occupy on appointment questions the validity of running a timetable for the election on the usual timescale. It is therefore proposed that a pause be placed on the election timetable, with a commitment to commence should the need for appointments to be made from 1 April 2027 (or as soon as possible thereafter) become necessary.

Options to manage the position pending certainty on timetable:

1. The four governors who would be eligible to stand for a further term are recognised by Council to continue with their current term for the potential short period of time to bridge any gap between 1 April 2027 and when the recommenced election could deliver newly elected members for appointment.
2. Current arrangements are adhered to, and Council potentially carries five vacancies until such time as an election could deliver new appointments.

With both options it is recommended that the nine year maximum tenure rule is applied and that Council carries a vacancy following Pav Akhtar's end of term of office (should this situation arise post April 2027).

Risks

Option 1 carries a risk that it could be challenged legally through judicial review. However, this is a theoretical risk with a very low probability of crystallisation in that, it is both highly likely that no governor will be required to serve beyond 1 April 2027 and in any event the likelihood of legal challenge if option 1 was implemented for a short period of time is extremely low.

If the risk associated with option 1 is to be mitigated completely, option 2 should be followed.

Financial Implications

The Council elections for 2026 cost c. £20k.

Recommendation

Council is asked to consider the report. In particular, in the absence of a definitive position on the date for implementation, the immediate implications for elections to Council for 2027. In undertaking this consideration, Council is requested to:

1. Recognise that a pause is placed on the election process for 2027;
2. Determine the management of the term of office of the four governors eligible for re-election in March.

9.2 ANNUAL MEMBERS MEETING ANALYSIS

● Information Item

● J Foote

● 2.40 pm

REFERENCES

Only PDFs are attached



9.2 Annual Members Meeting 2026 ? Analysis Report CoG October 2026.pdf

Council of Governors Report

Meeting of the	Council of Governors		22 October 2026
	Part I	☒	Part II
Title of Report	Annual Members Meeting 2026 – Analysis Report		
Report Author	Katie Stanton, Business Manager Corporate Affairs		
Lead Executive Director	Jennifer Foote, Director of Corporate Affairs		
Recommendation/ Actions required	The Council is asked to receive the update as confirmation that Governors have discharged their duties in representing the interests of Trust members and the public.		
	Decision	Assurance	Information
	☐	☐	☒
Executive Summary	In line with the requirements set out in the Constitution, the Annual Members Meeting (AMM) was held on Monday, 5 October 2026 at Lancashire FA, The County Ground, Leyland. The event provided a platform for Governors to discharge their statutory duties in representing the interests of Trust members and the public. The report provides an analysis of the 2026 AMM and is presented to Council for information.		
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	State whether there are any appendices and list them. For example: Appendix 1: 2026 Annual Members Meeting agenda		

1. Introduction

In line with the requirements set out in the Constitution, the Annual Members' Meeting (AMM) was held on Monday, 5 October 2026 from 2.00pm to 4.00pm in the Sir Tom Finney Room, The County Ground, Thurston Road, Leyland, PR25 2LF. The event provided a platform for Governors to

discharge their statutory duties in representing the interests of Trust members and the public. The agenda for the AMM has been included as appendix 1 for information.

The 2026 AMM was a live face-to-face event. Data is provided below on attendance at the event. Conscious of efficiencies and environmental advantages, the event was paper-lite to support the Trust's Green Plan and on arrival members were passed a limited delegate pack containing the agenda and a question card. Accessible information standard versions were available to attendees and the event was supported by British Sign Language interpreters.

2. **Format**

The AMM was hosted by the Vice-Chair, Adrian Leather, who presented an overview of the Trust's achievements and performance during 2025–26. Prof Sarah Morrison, Chief Nursing Officer and Deputy Chief Executive Officer, presented a summary of the Trust's key achievements, and Craig Carter, Chief Finance Officer, presented a summary of the Annual Accounts. Lead governor, Graham Robinson, also outlined the work undertaken by the Council of Governors during the previous 12 months and how together with the Non-Executive Directors and Board, Governors had worked together in the interests of the local population. A question-and-answer session followed, with responses provided by Professor Silas Nicholls, Chief Executive Officer.

The AMM received keynote presentations from Claire Granato, Chief Allied Health Professional, and Leasa Fish, Associate Director of AHPs and Consultant Physiotherapist. The presentations outlined the Trust's work to move care closer to home and the continued development of partnership working.

Katie Foster-Greenwood, Chief Operating Officer, presented an update on improving patient waiting times and the Trust's performance in key areas.

Partners from Lancashire Teaching Hospitals Charities, Age UK, Sepsis Awareness and Heartbeat attended the event. Attendees were encouraged to engage with the organisations and were offered blood pressure checks.

3. **Attendance**

In total 46 people attended the AMM. Disaggregating 25 attending as members of the Board, presenters, exhibitors, and support staff, this meant that 21 members of the public joined in person. Of the 21 members of the public joining in person, there were 7 Governors, 3 Staff Members, and 7 Public Members. 4 non-members also attended the event.

Category	Number
Public Members	7
Staff Members	3
Governors	7
Board of Directors	9
Exhibitors	4
Support	12
Non-Members	4
Total	46

For comparison, the following table shows the breakdown of those joining the 2025 AMM:

Category	Number
Public Members	16
Staff Members	1

Governors	9
Board of Directors	8
Exhibitors	6
Support	6
Non-Members	3
Total	49

4. **Publication of the Event**

The Annual Members' Meeting (AMM) 2026 was promoted through various external and internal communication channels from mid-September to early October, including a dedicated website page, digital advertisements, social media posts, intranet graphics, weekly bulletins, leader and colleague briefings, and executive video messages to encourage attendance.

5. **Evaluation of the event**

Whilst members had been invited to register any comments regarding the event by emailing the Corporate Affairs Team, there have been no responses received to date.

Appendix 1: 2026 Annual Members Meeting agenda

Item	Time	Encl.	Presenter
Welcome and Introduction	2.30pm	Verbal	Adrian Leather, Vice-Chair
Annual Review 2025/26	2.35pm	Presentation	Katie Foster-Greenwood, Chief Operating Officer
Annual Accounts 2025/26	2.45pm	Presentation	Craig Carter, Chief Finance Officer
Council Overview - Governors	3.00pm	Verbal	Graham Robinson, Lead Governor
Q&A Session	3.15pm	Verbal	Silas Nicholls, Chief Executive Officer
The theme for this year's Annual Members Meeting is 'The NHS Left Shift: Moving Care Closer to Home and Reducing Time Spent Waiting'			
Keynote Speakers – Moving Care Closer to Home	3.30pm	Presentation	Claire Granato, Chief Allied Health Professional Leasa Fish, Associate Director of AHPs/Consultant Physiotherapist
Keynote Speaker – Improving Waiting Times for Patients	3.45pm	Presentation	Katie Foster-Greenwood, Chief Operating Officer Vicky Hughes, Specialty Business Manager, Diagnostics and Diagnostics and Clinical Support Service
Session Close	4pm	Verbal	Silas Nicholls, Chief Executive Officer Adrian Leather, Vice-Chair

10. ITEMS FOR INFORMATION (TAKEN AS READ)

10.1 GOVERNOR OPPORTUNITIES & ACTIVITIES REPORT

● Information Item

REFERENCES

Only PDFs are attached

 10.1 Governor Opportunities and Activities Report 1 July - 1 Sept.pdf



Council of Governors Report

Meeting of the	Council of Governors		22 October 2026
	Part I	☒	Part II ☐
Title of Report	Governor Opportunities and Activities – 1 July 2026 to 1 September 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 July to September 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 July 2026 to 1 October 2026
Joint Governor and Non-Executive Director Visit to Audiology, RPH	6 July 2026
Patient Safety Visit	8 July 2026
Patient and Carers Experience and Involvement Group (P&CEIG)	28 July 2026
Board of Directors Meeting	6 August 2026
Patient Safety Visit	12 August 2026
Patient and Carers Experience and Involvement Group (P&CEIG)	25 August 2026
Joint Governor and Non-Executive Director Visit to Healthport (Community Diagnostic Centre)	10 September 2026
Patient and Carers Experience and Involvement Group (P&CEIG)	29 September 2026

10.2 GOVERNOR ISSUES REPORT

● Information Item

REFERENCES

Only PDFs are attached



10.2 Governor Issues Report CoG Sept 2026.pdf



Council of Governors Report

Meeting of the	Council of Governors		22 October 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 1 July 2026 to 1 September 2026, three issues had been raised relating to estates, facilities and health and safety concerns. These included outdated COVID-19 signage and public-facing displays, lapses in contractor PPE compliance during roof works, concerns regarding the location and signage for an evacuation chair on Level 3 at Royal Preston Hospital, and a defective flashing emergency escape light. Investigations were undertaken and corrective actions implemented, reinforcement of PPE requirements and site safety controls, re-induction of contractors, and rectification of evacuation chair signage. All issues raised during this period had been resolved by September 2026.		
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 CORPORATE AND GOVERNOR CALENDAR

● Information Item

REFERENCES

Only PDFs are attached



10.3 Corporate and Governor Calendar 2027-28 CoG Oct 2026.pdf

Please do not print!



Corporate and Governors' Calendar 2027-28

This calendar contains the dates of all meetings for the following:

BOARD OF DIRECTORS AND COMMITTEES OF THE BOARD:

- Audit Committee
- Board of Directors
- Board Workshops
- Charitable Funds Committee
- Finance and Performance Committee
- Non-Executive Directors' meetings
- People and Partnerships Committee
- Remuneration Committee
- Safety and Quality Committee
- Board Strategy Away Day

COUNCIL OF GOVERNORS, SUBGROUPS, AND MISCELLANEOUS MEETINGS:

- Care and Safety Subgroup
- Council Training Sessions
- Council of Governors
- Membership Subgroup
- Nominations Committee
- Joint Board and Council Development Sessions
- Annual Members' Meeting

If you have any queries, please contact Corporate Affairs by email:
company.secretary@lthtr.nhs.uk



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2027-28 Overview *(The venues in the Calendar will be kept under constant review and a revised version published on the Trust's website on a regular basis)*

APRIL 2027		
06	1.00pm – 3.00pm	Council Training Session
08	9.15am – 3.00pm	Board of Directors
15	10.00am – 11.30am	Nominations Committee
15	10.30am – 1.00pm	Audit Committee
22	1.00pm – 4.00pm	Council of Governors
27	1.00pm – 4.00pm	Finance and Performance Committee
29	2.00pm – 3.30pm	Remuneration Committee
30	11.00am – 1.30pm	Safety and Quality Committee

MAY 2027		
04	1.00pm – 3.30pm	Board Workshop
10	10.00am – 12.30pm	Care and Safety Subgroup
11	10.00am – 11.30am	Membership Subgroup
11	1.00pm – 4.00pm	People and Partnerships Committee
13	1.00pm – 3.00pm	Council Training Session
20	1.00pm – 3.00pm	Joint Board and Governor Development Session
25	1.00pm – 4.00pm	Finance and Performance Committee
28	11.00am – 1.30pm	Safety and Quality Committee

JUNE 2027		
03	9.15am – 3.00pm	Board of Directors
15	1.00pm – 2.30pm	Charitable Funds Committee
17	10.30am – 1.00pm	Audit Committee
22	1.00pm – 4.00pm	Finance and Performance Committee
25	11.00am – 1.30pm	Safety and Quality Committee

JULY 2027		
13	1.00pm – 4.00pm	People and Partnerships Committee
15	12.30pm – 3.00pm	Care and Safety Subgroup
22	10.00am – 1.00pm	Council of Governors
27	1.00pm – 4.00pm	Finance and Performance Committee
29	1.00pm – 3.30pm	Board Workshop
30	11.00am – 1.30pm	Safety and Quality Committee

AUGUST 2027		
05	9.15am – 3.00pm	Board of Directors
13	10.00am – 11.30am	Membership Subgroup
19	1.00pm – 3.00pm	Council Training Session
24	1.00pm – 4.00pm	Finance and Performance Committee
27	11.00am – 1.30pm	Safety and Quality Committee

SEPTEMBER 2027		
07	1.00pm – 3.30pm	Board Workshop
08	10.00am – 12.30pm	Care and Safety Subgroup
09	11.00am – 12.30pm	Remuneration Committee
14	1.00pm – 4.00pm	People and Partnerships Committee
14	9.30am – 11.00am	Charitable Funds Committee
16	10.30am – 1.00pm	Audit Committee
23	1.00pm – 3.00pm	Joint Board and Council Development Session
24	11.00am – 1.30pm	Safety and Quality Committee
28	1.00pm – 4.00pm	Finance and Performance Committee

OCTOBER 2027		
07	9.15am – 3.00pm	Board of Directors
14	10.00am – 12.00pm	Council Training Session
21	1.00pm – 4.00pm	Council of Governors
26	1.00pm – 4.00pm	Finance and Performance Committee
29	11.00am – 1.30pm	Safety and Quality Committee

NOVEMBER 2027		
09	1.00pm – 4.00pm	People and Partnerships Committee
11	1.00pm – 3.30pm	Board Workshop
15	12.30pm – 3.00pm	Care and Safety Subgroup
16	11.30am – 1.00pm	Membership Subgroup
23	1.00pm – 4.00pm	Finance and Performance Committee
26	11.00am – 1.30pm	Safety and Quality Committee

DECEMBER 2027		
02	9.15am – 3.00pm	Board of Directors
14	1.00pm – 2.30pm	Charitable Funds Committee
16	1.00pm – 3.00pm	Council Training Session
21	1.00pm – 4.00pm	Finance and Performance Committee

JANUARY 2028		
07	11.00am – 1.30pm	Safety and Quality Committee
11	1.00pm – 4.00pm	People and Partnerships Committee
13	10.30am – 1.00pm	Audit Committee
17	10.00am – 12.30pm	Care and Safety Subgroup
20	10.00am – 1.00pm	Council of Governors
25	1.00pm – 4.00pm	Finance and Performance Committee
27	1.00pm – 3.30pm	Board Workshop
28	11.00am – 1.30pm	Safety and Quality Committee

FEBRUARY 2028		
03	9.15am – 3.00pm	Board of Directors
10	10.00am – 12.00pm	Council Training Session
11	10.00am – 11.30am	Membership Subgroup
22	1.00pm – 4.00pm	Finance and Performance Committee
25	11.00am – 1.30pm	Safety and Quality Committee

MARCH 2028		
02	1.00pm – 3.30pm	Board Workshop
09	12.30pm – 3.00pm	Care and Safety Subgroup
14	1.00pm – 4.00pm	People and Partnerships Committee
14	9.30am – 11.00am	Charitable Funds Committee
28	1.00pm – 4.00pm	Finance and Performance Committee
31	11.00am – 1.30pm	Safety and Quality Committee

Audit Committee

Date	Time	Venue	Final date for receipt of reports:
15/04/2027	10.30am – 1.00pm	Virtually using Microsoft Teams	08/04/2027
17/06/2027	10.30am – 1.00pm	Virtually using Microsoft Teams	10/06/2027
16/09/2027	10.30am – 1.00pm	Virtually using Microsoft Teams	09/09/2027
13/01/2028	10.30am – 1.00pm	Virtually using Microsoft Teams	06/01/2028

Members	In attendance
Four Non-Executive Directors: - Audit Committee Chair - Finance and Performance Committee Chair - Safety and Quality Committee Chair	Chief Executive Officer (as required) Chief Finance Officer Internal and External Audit representatives Associate Director of Risk and Assurance Assistant Director of Financial Services Director of Corporate Affairs Corporate Affairs Officer (minutes)

Board of Directors

Date	Time	Venue	Final date for receipt of reports:
08/04/2027	9.15am – 3.00pm	Lecture Hall, Education Centre 3, Chorley and South Ribble Hospital	31/03/2027
03/06/2027	9.15am – 3.00pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	26/05/2027
05/08/2027	9.15am – 3.00pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	28/07/2027
07/10/2027	9.15am – 3.00pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	29/09/2027
02/12/2027	9.15am – 3.00pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	24/11/2027
03/02/2028	9.15am – 3.00pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	26/01/2028

Members	In attendance
Chair Non-Executive Directors Chief Officers	Chief People Officer Chief Strategy and Improvement Officer Director of Communications and Engagement Director of Corporate Affairs Business Manager (minutes)

Board Strategy Away Day

Date	Time	Venue	Final date for receipt of reports:
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To Be Confirmed

Attendees
Chair Non-Executive Directors Chief Officers Chief People Officer Chief Strategy and Improvement Officer Director of Communications and Engagement Director of Corporate Affairs

Board Workshop

Date	Time	Venue	Final date for receipt of reports:
04/05/2027	1.00pm – 3.30pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	27/04/2027
29/07/2027	1.00pm – 3.30pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	22/07/2027
07/09/2027	1.00pm – 3.30pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	31/08/2027
11/11/2027	1.00pm – 3.30pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	04/11/2027
27/01/2028	1.00pm – 3.30pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	20/01/2028
02/03/2028	1.00pm – 3.30pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	24/02/2028

Members	In attendance
Chair Non-Executive Directors Chief Officers	Chief People Officer Chief Strategy and Improvement Officer Director of Communications and Engagement Director of Corporate Affairs Corporate Affairs Officer (notes and actions)

Charitable Funds Committee

Date	Time	Venue	Final date for receipt of reports:
15/06/2027	1.00pm - 2.30pm	Virtually using Microsoft Teams	08/06/2027
14/09/2027	9.30am – 11.00am	Virtually using Microsoft Teams	07/09/2027
14/12/2027	1.00pm - 2.30pm	Virtually using Microsoft Teams	07/12/2027
14/03/2028	9.30am – 11.00am	Virtually using Microsoft Teams	07/03/2028

Members	In attendance
Three Non-Executive Directors comprising: - Committee Chair - Two Non-Executive Directors Chief Nursing Officer Chief Finance Officer	Head of Charities Assistant Finance Director Director of Corporate Affairs Corporate Affairs Officer (minutes)

Finance and Performance Committee

Date	Time	Venue	Final date for receipt of reports:
27/04/2027	1.00pm - 4.00pm	Virtually using Microsoft Teams	20/04/2027
25/05/2027	1.00pm - 4.00pm	Virtually using Microsoft Teams	18/05/2027
22/06/2027	1.00pm - 4.00pm	Virtually using Microsoft Teams	15/06/2027
27/07/2027	1.00pm - 4.00pm	Virtually using Microsoft Teams	20/07/2027
24/08/2027	1.00pm - 4.00pm	Virtually using Microsoft Teams	17/08/2027
28/09/2027	1.00pm - 4.00pm	Virtually using Microsoft Teams	21/09/2027
26/10/2027	1.00pm - 4.00pm	Virtually using Microsoft Teams	19/10/2027
23/11/2027	1.00pm - 4.00pm	Virtually using Microsoft Teams	16/11/2027
21/12/2027	1.00pm - 4.00pm	Virtually using Microsoft Teams	14/12/2027
25/01/2028	1.00pm - 4.00pm	Virtually using Microsoft Teams	18/01/2028
22/02/2028	1.00pm - 4.00pm	Virtually using Microsoft Teams	15/02/2028
28/03/2028	1.00pm - 4.00pm	Virtually using Microsoft Teams	21/03/2028

Members	In attendance
Four Non-Executive Directors comprising: - Committee Chair - Three Non-Executive Directors Chief Operating Officer Chief Finance Officer Chief Strategy and Improvement Officer	Chief Medical Officer Chief People Officer Chief Nursing Officer Deputy Chief Operating Officer Deputy Director of Finance Associate Director of Workforce Resourcing Transformation Deputy Medical Director for Professional Standards Associate Director of Risk and Assurance Director of Corporate Affairs Corporate Affairs Officer (minutes)

Non-Executive Directors’ meetings

Date	Time	Venue
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The Non-Executive Directors are scheduled to meet informally on a monthly basis and will review the frequency as required.

Members	In attendance
Chair Non-Executive Directors	Chief Executive Officer or Deputy Chief Executive Officer (as required) Director of Corporate Affairs

People and Partnerships Committee

Date	Time	Venue	Final date for receipt of reports:
11/05/2027	1.00pm – 4.00pm	Virtually using Microsoft Teams	04/05/2027
13/07/2027	1.00pm – 4.00pm	Virtually using Microsoft Teams	06/07/2027
14/09/2027	1.00pm - 4.00pm	Virtually using Microsoft Teams	07/09/2027
09/11/2027	1.00pm - 4.00pm	Virtually using Microsoft Teams	02/11/2027
11/01/2028	1.00pm - 4.00pm	Virtually using Microsoft Teams	04/01/2028
14/03/2028	1.00pm - 4.00pm	Virtually using Microsoft Teams	07/03/2028

Members	In attendance
Four Non-Executive Directors comprising: - Committee Chair - Three Non-Executive Directors Chief People Officer Chief Medical Officer Director of Communications and Engagement	Deputy Chief People Officer Associate Director of Workforce Deputy Director of Education Deputy Director of Research and Innovation Associate Director of Risk and Assurance Director of Corporate Affairs Corporate Affairs Officer (minutes)

Remuneration Committee

Date	Time	Venue	Final date for receipt of reports:
29/04/2027	2.00pm – 3.30pm	Virtually using Microsoft Teams	22/04/2027
09/09/2027	11.00am – 12.30pm	Virtually using Microsoft Teams	02/09/2027

Members	In attendance
Chair Non-Executive Directors	Chief Executive Officer Chief People Officer Director of Corporate Affairs Business Manager (minutes)

Safety and Quality Committee

Date	Time	Venue	Final date for receipt of reports:
30/04/2027	11.00am – 1.30pm	Virtually using Microsoft Teams	23/04/2027
28/05/2027	11.00am – 1.30pm	Virtually using Microsoft Teams	21/05/2027
25/06/2027	11.00am – 1.30pm	Virtually using Microsoft Teams	18/06/2027
30/07/2027	11.00am – 1.30pm	Virtually using Microsoft Teams	23/07/2027
27/08/2027	11.00am – 1.30pm	Virtually using Microsoft Teams	20/08/2027
24/09/2027	11.00am – 1.30pm	Virtually using Microsoft Teams	17/09/2027
29/10/2027	11.00am – 1.30pm	Virtually using Microsoft Teams	22/10/2027
26/11/2027	11.00am – 1.30pm	Virtually using Microsoft Teams	19/11/2027
07/01/2028	11.00am – 1.30pm	Virtually using Microsoft Teams	31/12/2027
28/01/2028	11.00am – 1.30pm	Virtually using Microsoft Teams	21/01/2028
25/02/2028	11.00am – 1.30pm	Virtually using Microsoft Teams	18/02/2028
31/03/2028	11.00am – 1.30pm	Virtually using Microsoft Teams	24/03/2028

Members	In attendance
Four Non-Executive Directors comprising: - Committee Chair - Three Non-Executive Directors Chief Operating Officer Chief Medical Officer Chief Nursing Officer	Associate Director of Safety and Learning Associate Director of Risk and Assurance Divisional Nursing and Midwifery Director Senior Associate Director of Continuous Improvement and Research Deputy Chief Nursing Officer Director of Corporate Affairs Corporate Affairs Officer (minutes)

Care and Safety Subgroup *To be confirmed, subject to any future statutory requirements*

Date	Time	Venue	Final date for receipt of reports:
10/05/2027	10.00am - 12.30pm	Hybrid Meeting – Gordon Hesling Conference Room, Royal Preston Hospital	03/05/2027
15/07/2027	12.30pm - 3:00pm	Hybrid Meeting – Gordon Hesling Conference Room, Royal Preston Hospital	08/07/2027
08/09/2027	10.00am - 12.30pm	Hybrid Meeting – Gordon Hesling Conference Room, Royal Preston Hospital	01/09/2027
15/11/2027	12.30pm - 3:00pm	Hybrid Meeting – Gordon Hesling Conference Room, Royal Preston Hospital	08/11/2027
17/01/2028	10.00am - 12.30pm	Hybrid Meeting – Gordon Hesling Conference Room, Royal Preston Hospital	10/01/2028
09/03/2028	12.30pm - 3:00pm	Hybrid Meeting – Gordon Hesling Conference Room, Royal Preston Hospital	02/03/2028

Members	In attendance
Governors	Non-Executive Director (Safety and Quality Committee Chair) Director of Facilities and Services Associate Director of Patient Quality, Experience and Engagement Patient Experience Lead Director of Corporate Affairs Corporate Affairs Officer (minutes)

Council Training Sessions *To be confirmed, subject to any future statutory requirements*

Date	Time	Venue	Final date for receipt of reports:
06/04/2027	1.00pm – 3.00pm	Lecture Room 3, Education Centre 1, Royal Preston Hospital	30/03/2027
13/05/2027	1.00pm - 3.00pm	Lecture Room 3, Education Centre 1, Royal Preston Hospital	06/05/2027
19/08/2027	1.00pm - 3.00pm	Lecture Room 3, Education Centre 1, Royal Preston Hospital	12/08/2027
14/10/2027	10.00am - 12.00pm	Lecture Room 3, Education Centre 1, Royal Preston Hospital	07/10/2027
16/12/2027	1.00pm - 3.00pm	Seminar Room A, Education Centre 3, Chorley & South Ribble Hospital	09/12/2027
10/02/2028	10.00am - 12.00pm	Lecture Room 3, Education Centre 1, Royal Preston Hospital	03/02/2028

Members	In attendance
Chair Governors	Executive Directors – <i>to be confirmed</i> Director of Corporate Affairs Corporate Affairs Officer (notes and actions)

Council of Governors *To be confirmed, subject to any future statutory requirements*

Date	Time	Venue	Final date for receipt of reports:
22/04/2027	1:00pm - 4:00pm	Seminar Room A, Education Centre 3, Chorley & South Ribble Hospital	15/04/2027
22/07/2027	10.00am - 1.00pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	15/07/2027
21/10/2027	1:00pm - 4:00pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	14/10/2027
20/01/2028	10.00am - 1.00pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	13/01/2028

Members	In attendance
Chair Governors	Chief Executive Officer Non-Executive Directors Director of Corporate Affairs Business Manager (minutes)

Membership Subgroup *To be confirmed, subject to any future statutory requirements*

Date	Time	Venue	Final date for receipt of reports:
11/05/2027	10.00am – 11.30am	Hybrid Meeting – Gordon Hesling Conference Room, Royal Preston Hospital	04/05/2027
13/08/2027	10.00am – 11.30am	Hybrid Meeting – Gordon Hesling Conference Room, Royal Preston Hospital	06/08/2027
16/11/2027	11.30am – 1.00pm	Hybrid Meeting – Gordon Hesling Conference Room, Royal Preston Hospital	09/11/2027
11/02/2028	10.00am – 11.30am	Hybrid Meeting – Gordon Hesling Conference Room, Royal Preston Hospital	04/02/2028

Members	In attendance
Governors	Widening Partnership Manager Director of Corporate Affairs Corporate Affairs Officer (minutes)

Nominations Committee *To be confirmed, subject to any future statutory requirements*

Date	Time	Venue	Final date for receipt of reports:
15/04/2027	10.00am – 11.30am	Virtually using Microsoft Teams	08/04/2027

Members	In attendance
Chair One Staff Governor <i>(or Substitute)</i> Two Public Governors <i>(or Substitute)</i> One Appointed Governor <i>(or Substitute)</i>	Chief Executive Officer Chief People Officer Director of Corporate Affairs Corporate Affairs Officer (minutes)

Joint Board and Council Development Session *To be confirmed, subject to any future statutory requirements*

Date	Time	Venue	Final date for receipt of reports:
20/05/2027	1.00pm - 3.00pm	Lecture Room 3, Education Centre 1, Royal Preston Hospital	13/05/2027
23/09/2027	1.00pm - 3.00pm	Lecture Room 3, Education Centre 1, Royal Preston Hospital	16/09/2027

Members	In attendance
Chair Non-Executive Directors Chief Officers Chief Strategy and Improvement Officer Director of Communications and Engagement Governors	Director of Corporate Affairs Corporate Affairs Officer (notes and actions)

Annual Members’ Meeting *To be confirmed, subject to any future statutory requirements*

Date	Time	Venue
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To Be Confirmed

Members	In attendance
Chair Non-Executive Directors Chief Officers Chief Strategy and Improvement Officer Director of Communications and Engagement	Communications Team Director of Corporate Affairs Business Manager Corporate Affairs Officers
<i>All other staff welcome to attend</i>	

10.4 STRATEGIC FORWARD PLAN

● Information Item

REFERENCES

Only PDFs are attached



10.4 Strategic Foward Plan CoG October 2026.pdf



Council of Governors Report

Meeting of the	Council of Governors		22 October 2026
	Part I	☒	Part II ☐
Title of Report	Strategic Forward Plan: Operational Planning 2027/28 and Delivery of Year Two of the Trust Strategy		
Report Author	Anna Ryan/Ian Ward/Kate Hudson		
Lead Executive Director	Ailsa Brotherton, Chief Strategy and Improvement Officer		
Recommendation/ Actions required	I. The Council is asked to receive assurance from this Strategic Forward Plan paper that the 2027/28 planning process provides a clear bridge from the Trust Strategy to delivery of its second year.		
	Decision ☐	Assurance ☒	Information ☐
Executive Summary	This Strategic Forward Plan paper describes how the Trust Strategy remains the organising framework for the Trust’s ambition to become a leading accountable healthcare organisation in Lancashire and South Cumbria. The 2027/28 operational planning round is the mechanism for translating that long-term direction into the second year of delivery. It will not create a new strategic direction; it will refresh the approved Medium Term Plan against the latest forecast, national requirements and system assumptions, and convert the five strategic domains of Patients, Performance, People, Productivity and Partnerships into an integrated and affordable delivery plan. Planning will be bottom up, specialty led and divisionally owned. Activity, capacity, workforce, finance, quality, productivity and transformation will be tested together, with clinical leadership, functional challenge, executive triangulation and staged Board oversight. This will establish a credible route to the Trust Strategy’s year two commitments, including improved access and outcomes, care closer to home, digitally enabled services, workforce capability, financial breakeven by the end of 2027/28 and stronger partnership delivery.		
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:	Not applicable at this stage; this report sets out the planning and assurance process.	Date: Not applicable	
Operational Group Review:	Trust integrated planning arrangements, including specialty, divisional and functional review	Date: October 2026 onwards	
Link to Board Assurance Framework:	Relevant to principal risks concerning patient safety and experience, delivery of performance trajectories, workforce capacity, financial sustainability and system dependencies.		
Appendices	No appendices		

1. Background and strategic context

The Trust Strategy establishes the Trust's ambition to become a leading accountable healthcare organisation, delivering an affordable and sustainable model of care for local and specialist populations. Its direction remains valid and is organised through five interdependent domains: Patients, Performance, People, Productivity and Partnerships. The second year must move from strategic intent into measurable delivery, while retaining the national shifts from hospital to community, analogue to digital and sickness to prevention.

The approved Medium Term Plan already provides the delivery baseline for 2027/28. It commits the Trust to financial breakeven by the end of 2027/28, improvement in elective, cancer, diagnostic and urgent care standards, and a reduction in the elective waiting list. The planning round will refresh the remaining two years of that plan and add a further year to maintain a rolling three year view through to 2029/30.

2. How planning will deliver year two of the Trust Strategy

The 2027/28 operational plan will be the principal bridge between the Trust Strategy and year two delivery. Specialty and Clinical Business Unit plans will start from the latest forecast and set out demand, activity, capacity, performance, workforce, finance, quality, productivity, transformation and key risks. This will allow the Trust to test whether the commitments in the Trust Strategy remain credible and to make any evidence based changes through the appropriate governance route. The plan will connect to the Single Improvement Plan, which will translate the five domains into programmes, milestones, outcomes, benefits and named accountability.

Patients

Year two planning will set out how services will improve safety, experience, outcomes and equity, with a stronger emphasis on personalised, preventative and digitally enabled care. Specialty plans will identify the actions required to sustain maternity and neonatal improvement, redesign pathways for frailty, COPD and heart failure, strengthen specialist services, improve urgent and emergency access for children and young people, reduce avoidable harm and address inequalities through Core20PLUS5. Plans will also show how urgent and emergency care flow will improve by reducing boarding, corridor care, ambulance handover delays and avoidable hospital use.

Commissioning intentions support this domain through prevention, neighbourhood health, earlier intervention and care closer to home. Benefits will be included only where patient impact, clinical assurance and alternative capacity are clear.

Performance

Planning will convert the Trust Strategy's commitment to timely and effective care into specialty-level trajectories supported by credible operational actions. Current Medium Term Plan commitments for

2027/28 include 81% 18-week referral-to-treatment performance, 82.5% for the 62 day cancer standard, 90% diagnostic performance, 86.6% against the four hour standard and an elective waiting list of 44,329. Each trajectory will be tested against demand, core capacity, seasonality, workforce availability, productivity and delivery milestones, with no planned deterioration in constitutional standards.

Commissioning intentions reinforce referral to treatment recovery, outpatient transformation, urgent and emergency care, intermediate care and community diagnostics. Changes will affect trajectories only when their timing, impact and partner delivery are sufficiently certain.

People

The workforce plan will identify the capacity, capability, leadership and culture required to deliver year two of the strategy safely. Specialty and divisional plans will align workforce numbers, skill mix, job plans, recruitment, retention, temporary staffing and productivity with the activity and service model proposed. They will also support improvement capability, leadership development, succession planning, inclusion, colleague wellbeing, attendance and cultural transformation so that teams are equipped to lead and sustain change.

Commissioning intentions may require new roles, skill mixes, training, workforce transfer or joint working across organisational boundaries. These impacts must be agreed before workforce reductions or benefits are assumed.

Productivity

Year-two planning will support the Trust Strategy's commitment to better value, recurrent sustainability and financial breakeven by the end of 2027/28. Unmitigated elective and outpatient activity rises from 658,530 in 2026/27 to 691,840 in 2027/28. Specialty plans will therefore establish job planned core capacity, quantify the remaining gap and reduce the requirement first through evidenced demand management, pathway redesign, left shift and productivity before additional capacity is considered. Waste reduction, workforce optimisation, digital patient engagement, telemedicine, remote monitoring, artificial intelligence and improved utilisation of estates and diagnostics will be translated into quantified actions, milestones and recurrent benefits.

Commissioning intentions may create productivity opportunities but must identify recurrent funding, transition costs, stranded costs, contractual treatment and deliverable benefits. Reduced acute activity will not automatically be treated as a cost reduction.

Partnerships

The operational plan will give practical effect to the Trust Strategy's commitment to act as a collaborative system partner and to develop integrated local and specialist pathways. This includes system diagnostics and digital infrastructure, pathology and laboratory information systems, community integration, education partnerships, research and innovation, University Hospital ambitions and the Trust's anchor institution role. Organisational assumptions will be aligned with commissioners and providers so that decisions on pathways, capacity, funding, data and accountability are coherent across Lancashire and South Cumbria.

Commissioning intentions support joint delivery of neighbourhood health, prevention, community alternatives, outpatient redesign and digital enablement. Where pathways, impacts, ownership, funding and contractual arrangements are not agreed, proposals will remain assumptions or risks rather than core benefits.

Taken together, the commissioning intentions broadly support the Trust Strategy by advancing the three national shifts from hospital to community, analogue to digital and sickness to prevention. The planning process will ensure that this strategic alignment is matched by operational deliverability and that the combined impact across Patients, Performance, People, Productivity and Partnerships is understood. Assurance will be built through specialty ownership, divisional sign off, cross functional check and challenge, functional assurance, executive triangulation and staged Board oversight before the final plan is approved.

3. Financial implications

The detailed 2027/28 financial plan will be developed through this process and must support the existing commitment to financial breakeven by the end of 2027/28. Planned activity, workforce and additional capacity will be tested against the available financial envelope. Recurrent and non recurrent costs, income, productivity, transition funding, stranded costs and double running will be explicit, and the final financial, operational and workforce positions must reconcile.

4. Legal implications

There are no direct legal implications from the planning approach. Individual service changes may require separate consideration of statutory duties, consultation, equality, workforce, procurement, contracting and regulatory requirements through the relevant approval routes.

5. Risks

Principal risks are an inaccurate or changing baseline; misalignment between activity, workforce, finance and contracts; insufficiently evidenced productivity or transformation; affordability constraints; a compressed timetable; incomplete national guidance; limited clinical and planning capacity; and dependencies on commissioners or partners. Controls include an agreed forecast baseline, documented assumptions, specialty and divisional ownership, clinical and functional sign off, regular triangulation, risk based challenge, early escalation and clear contingencies where delivery depends on external action.

6. Impact on stakeholders

Clinical and operational teams will own detailed plan development, supported by Finance, Workforce, Strategy, Transformation, Digital, Estates and Quality. Governors and Non-Executive Directors will receive staged assurance rather than seeing the plan only at final approval. Commissioners and partners will be engaged where delivery depends on pathway changes or shared capacity. Material service changes will require proportionate engagement with patients, colleagues and partners, with clear communication about what is proposed, agreed or still subject to confirmation.

7. Recommendations

It is recommended that the Council of Governors:

- II. receives assurance from this Strategic Forward Plan paper that the 2027/28 planning process provides a clear bridge from the Trust Strategy to delivery of its second year.

10.5 SINGLE IMPROVEMENT PLAN

● Information Item

REFERENCES

Only PDFs are attached

 10.5 Single Improvement Plan CoG October 2026.pdf

Council of Governors

Meeting of the	Council of Governors	22/10/26
	Part I ☒	Part II ☐
Title of Report	SIP August 2026 Position	
Report Author	Katie Marshall, Head of Programme Management Office	
Lead Executive Director	Ailsa Brotherton, Chief Strategy and Improvement Officer	
Recommendation/ Actions required	The committee is asked to - Note the delivery position and impact of the Single Improvement Plan for August-26. - Note key areas of success, risk and interdependence within the Single Improvement Plan for August-26.	
	Decision ☐	Assurance ☐
		Information ☒
Executive Summary	The purpose of this report is to provide an overview of August delivery position including key risks and high-level metric status across each of the 5 portfolios of the Single Improvement Plan (SIP). Delivery movement is positive overall, with more milestones completed and fewer not yet started. However, the improvement is partly offset by a small increase in off-track delivery. Key areas of delivery risk continue to be – - Implementation of sickness absence management system - Delivery of WRP savings with forecast at £42m - Digital delivery slippage including PEP, Self Check-in and AVT and impact on headcount reduction and WRP savings Additional areas of risk identified in this period include - - Boarding and delayed discharge remain significant despite reduced ED corridor care and the opening of EEMAC and the Medicines Decisions Unit. - Workforce Advice capacity and sickness absence have deteriorated, weakening sickness-management grip and creating WRP and employment-law risk. Delivery dependencies relating to workforce capacity, BI resource, digital delivery and system funding are affecting progress across several portfolios. Mixed position seen in metrics, with positive improvements in elective performance and workforce indicators, offset by continuing deterioration	

	across urgent and emergency care flow measures and key cancer standards. Financial recovery and patient flow remain the two most significant whole-plan risks. The CI workplan has now been embedded into each portfolio of the SIP with a CI lead joining each portfolio board to support delivery of the identified priority work. This will continue to develop to provide the support required with a focus on Patients and Productivity portfolios.	
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 Committee assurance, please complete the following:	
Operational Group Review:	SIP Portfolio Board(s)	Date: Aug-26
Link to Board Assurance Framework:	The SIP scope is across the organisation, it's delivery it directly linked to mitigating and controlling principle risks.	
Appendices		

1. Background

In April 2024, Lancashire Teaching Hospitals developed and implemented a Single Improvement Plan (SIP) with the aim to align and focus improvement efforts across the Organisation in a 3-year strategic plan. Detailed delivery reports and metric pack are include as appendices to this paper.

2. Discussion

2.1 SIP AAA Report

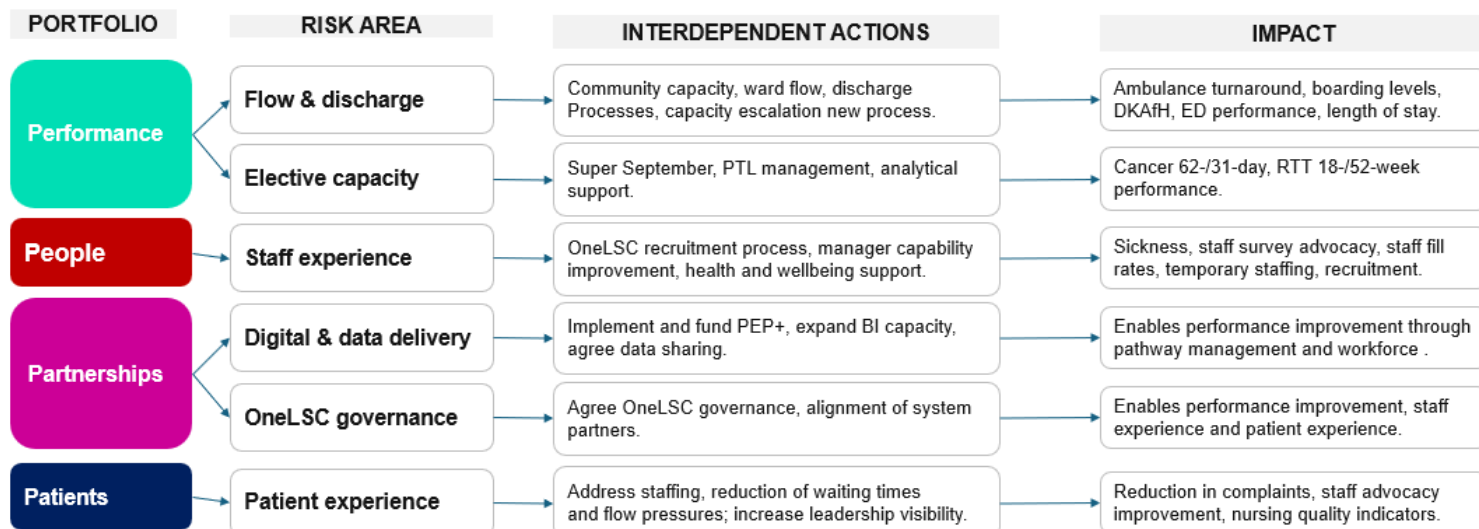
Key areas of success, risk and upcoming concern within the SIP delivery plan and impact on key metrics are shown within table below includes areas to Alert, Advise and Assure committee.

Table 1. SIP AAA

AAA	Escalation	ACTION
Alert	• Productivity: There are continued challenges in delivering the £60m plan but the Board is committed to achieving the plan and is proactively managing the risk. • Performance: 18 week RTT performance remains off track however has seen improvement in July (Aug performance remains unvalidated). Days Kept Away from Home lost bed days remain high and above target. • Partnerships: Digital and infrastructure outstanding funding, system and data sharing decisions are slowing delivery of several improvement programmes.	• CFO leading work to improve delivery forecast with CSIO driving delivery recovery actions. CEO mobilised Financial Recovery Board for fortnightly oversight of delivery focus and drive pace. Sprint approach being planned for joined up working across divisions to deliver against challenging transformational work. • COO leading work to increase capacity via a Super September initiative with ~30% increased activity identified to date. Actions underway to strengthen discharge and flow actions. • CSIO has implemented the Digital Oversight Committee for increased assurance on digital timeline and delivery. Ongoing work to recover digital delivery.
Advise	• People: Sickness at 6.3%, support role vacancies and high temporary staffing continue to stretch teams. • Performance: Diagnostic performance (DM01) has improved in July and is above target for the 2nd month – showing highest levels of performance since March 2020. 62 day cancer performance has improved in July 26. • Patients: Experience and estates - emergency department feedback remains below target, and some safety, estates and staffing actions need continued oversight.	• CPO plans in place to support the workforce pipeline, reduce sickness and progress the outstanding people and inclusion actions. • COO supporting close monitoring of productivity and performance re diagnostics and 31 day cancer at tumour group level. • CNO focus on patient feedback and resolve the outstanding estates funding and staffing decisions.
Assure	• Performance: Reduction in long waits (52 week+) is showing a continued improvement and is ahead of target for the 7th month, similarly waiting lists size has continued to be ahead of plan for the 4th month and is ahead of target. Cancer performance re FDS is ahead of target for the 3rd month	• Continued mobilisation of additional capacity (internal and outsourcing), recruitment is ongoing into critical clinical roles.

2.2 Focus for second half of 2026/27

During the second half of 2026/27 key areas require focus to ensure that intended improvement within the targeted metrics are achieved. There are several areas of interdependence and risk across the SIP that connect operational recovery, workforce management, financial recovery and improved patient experience.



All areas shown are directly linked to WRP delivery.

2.3 Detailed delivery overview August 2026

Delivery movement is positive overall, with more milestones completed and fewer not yet started. However, the improvement is partly offset by a small increase in off-track delivery.

2.3.1 Positive Movement

Milestones completed increased to 37 actions (+5) in month increasing to 13%,
In Progress / On track increased by (+2) to 58%

Table 2. Key milestones completed

Portfolio	Programme	Deliverable completed	Impact	Metric
People	Leadership capability	Leadership in Lancs behaviours reviewed and updated for the Managers Code, inclusive behaviours, civility and professionalism.	Improved lens on inclusion in Leadership in Lancs guidance – impacting all staff groups	Indirect – enabling action for staff experience. Impact via Staff Survey advocacy score.
	Colleague experience with EDI	Trust Values behaviours reviewed and updated for the Managers Code, inclusive behaviours, civility and professionalism.	Improved lens on inclusion in managers guidance	Indirect – enabling action for staff experience. Impact via Staff Survey advocacy score.
	Colleagues experience with EDI	Equity/Equality Representative training developed and delivered into workforce-management processes.	Improved lens on inclusion in managers guidance	Indirect – enabling action for staff experience. Impact via Staff Survey advocacy score.
Patients	Safeguarding	Restraint reporting: Ulysees reporting now captures key protected characteristics and vulnerability indicators.	Improved visibility for personalised patient care and shared learning.	Indirect – enabling action reduction in restraints.
	Specialised Service	Specialised Services scope baseline agreed following receipt of service specifications.	To allow focus on any areas where the population have a differential access to other systems in the region.	Indirect – enabling action

2.3.2 Areas on plan and stable

The majority of the SIP programmes are progressing to scheduled timeline plan and the impact of steady progress can be seen in key areas of sustained stability and continuing improvement across People and Patients portfolios.

Table 3. Key areas progressing and sustaining improved metrics

Portfolio	Metric position
Patients	Registered Nurse Fill Rate: 95.4% against a 95.0% target. Maintaining performance above target. STAR Accreditation: 84.8% against a 75% target. Continues to perform significantly above target Pressure Ulcers (Cat 2+): 2 per 1,000 bed days against a target of 3.30.
People	Turnover (% FTE): 0.64% against a target of ≤10%. Appraisal Compliance: 91.10% against a target of ≥90%. Core Skills Mandatory Training Compliance: 100% of modules above the required 90% threshold.
Performance	Cancer Faster Diagnosis Standard: 82.04% against an 80% target. Non-Elective Average Length of Stay: Slight improvement to 6.9 days against a target of 7.5 days. RTT - % of patients waiting less than 18 week is at 58.88% positively increased since last month UEC – 12 hr wait under target at 11.01% against target of 11.90%

2.3.3 Areas of Concern/Risk

Off Track / Recoverable increased from 37 to 39 actions (+2), at 13%.

Off Track / At Risk doubled from 6 to 7 actions (+1), at 2%.

Table 4. Key milestones off track

Portfolio	Programme	Deliverable off track	Mitigation action	Impact	Aligned metric
Patients	Patient Experience	Central Patient Experience Hub	New owner aligned due to change in personnel. Knowledge and resources focus and targeting increase in hub usage	Key enabler to improve patient experience across the organisation learning from existing best practice	Indirect enabling action – impact visible in FFT scores
Performance	Urgent & Emergency Care	Increase utilisation of Virtual Ward to a minimum of 80% by Jun-26	Clinical model workshop planned for September 2026 with new medic in post.	Key enabler to improve flow for inpatient admissions and enabler move toward reduce bed base in medicine wards.	Overall bed occupancy decreased from 96.13% to 93.77%, under target levels.
Performance	Urgent & Emergency Care	Improve processes - booking, triage, streaming pre-admission.	Lack of domiciliary care capacity aligned to 2hr Urgent Care Response (UCR) - escalated to LCC.	Delay to timeline will delay bed base and workforce reduction schemes and reduce in-year financial benefit.	Days Kept Away from Home increased from 2494 to 2511 lost bed days.
Productivity	OneLSC Finance & Procurement	Establish reporting oversight and assurance for OneLSC.	OneLSC lead Richard Beeken priority action to implement governance and deliver OneLSC intelligent client model.	Creates delays in timeline and risk to visibility associated to the WRP.	Indirect – enabling action to provide robust support services to clinical divisions
Partnership	Digital	Phase 3 PEP: Implement electronic clinical patients letters	Technical system issues, testing in development system underway. Interim measures of departments manually printing any non-digital patient letters.	Enabler to planned workforce reduction via WRP scheme. Delay to timeline will delay workforce reduction schemes and reduce in-year financial benefit.	Indirect enabling action to support alternate operational delivery model with impact in WRP and WTE delivery.

Table 5. Key milestones at risk

Portfolio	Programme	Deliverable at risk	Mitigating action	Impact	Aligned metric
People	Colleague Health & Wellbeing	Progress implementation plan for digital sickness absence management system	Empactis pilot terminated. Alternative system identified and at late stage of due diligence.	System to support managers with managing sickness. This may delay expected reduction of sickness rate and reduce an in-year financial benefit.	Current sickness rate increased from last month 5.81 and above target at 6.31%.
Partnership	Digital	Phase 2 PEP: Implement patient self-booking and management of electronic patient correspondence through the NHS App	Behind scheduled to rollout PEP due to continued system issues. Working with digital and specialty teams to re-set timeline.	Enabler to planned workforce reduction via WRP scheme for PEP. Delay to timeline will delay workforce reduction schemes and reduce in-year financial benefit.	Indirect enabling action to support alternate operational delivery model with impact in WRP and WTE delivery a

3 Financial implications

The delivery of the Waste Reduction Programme target 2026/27 is the key financial risk within the Single Improvement Plan with many programmes within the SIP directly linked to WRP delivery. The WRP plan is monitored via the Productivity Portfolio Board. Oversight of this is within the Trust Management Board chaired by the CEO with progress reported monthly to the Finance and Performance committee and bi-monthly to the Trust Board. A detailed update is provided to committee via separate WRP report.

4 Legal implications

None

5 Risks

The criteria remain challenging to deliver into 2026/27 within current resources and with the operational and financial pressures facing the Trust and the wider system. Delivery and management of the SIP is reliant on resources and expertise within the organisation, which is at risk due to the current level of vacancies and posts being held in the recruitment process across the organisation.

6 Impact on stakeholders

The impact and outcome of delivering the improvement work is to see an improvement in key metrics for both patients and staff and to see transformational change emerge to meet ambitions set out in the Trust strategy.

7. It is recommended that the committee:

- I. Note the delivery position and impact of the Single Improvement Plan for August-26.
- II. Note key areas of success, risk and interdependence within the Single Improvement Plan for August-26.

10.6 MINUTES OF GOVERNOR SUBGROUPS:

● Information Item

- a) Care and Safety Subgroup ? 16 July and 9 September 2026
- b) Membership Subgroup ? 14 August 2026

REFERENCES

Only PDFs are attached

 10.6a CaSS minutes 16 July 9 Sept 2026.pdf

 10.6b Minutes - Membership Subgroup minutes 14 August 2026.pdf

Care and Safety Subgroup

16 July 2026 | 12.30pm | Hybrid meeting, Gordon Hesling Conference Room, RPH

Members:

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

In Attendance:

Prof. Karen Deeny	Non-Executive Director (MS Teams)
Karen Lawrenson	Corporate Affairs Officer (minutes)
Alison McCrudden	Patient Experience & Involvement Lead (MS Teams) (<i>minute 34/26</i>)
Apologies:	Shaun Ashworth

30/26 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.

31/26 Declarations of interest

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

32/26 Minutes of the previous meeting

It was agreed that the minutes of the meeting held on 11 May 2026 were approved subject to the inclusion of apologies of a public governor.

33/26 Matters arising and action log

The action log was reviewed and updated.

34/26 Estates and Facilities Update

Item was not discussed due to non-attendance of the required attendee.

35/26 Patient Experience and Involvement Update

Alison McCrudden attended for this item

The report outlined continued progress in patient experience and involvement activities across the Trust during May to July 2026. Significant work had been undertaken to

develop, review and update patient information leaflets, including the completion of a new Urology information booklet. Efforts continued to ensure information remained accessible through a range of formats and languages, supported by the Patient Information Group, which provided feedback to improve clarity and accessibility of patient resources. The Carers Forum concluded its current programme following several years of partnership working with carers and external organisations, during which carers had influenced a range of Trust policies, services and patient care initiatives. Volunteer services continued to expand, with ongoing recruitment, the introduction of new Pets as Therapy teams, enhanced training opportunities and recognition activities during Volunteers' Week. Plans were also progressed to align the volunteer service with the Patient Experience and PALS team to strengthen patient engagement across the Trust. Work also progressed to improve accessibility and inclusion through the planned implementation of a new interpretation platform, which was expected to deliver enhanced functionality and future cost savings. Engagement with the Deaf community supported the development of accessible training resources, while the Trust's Health Day showcased a wide range of internal and external support services, promoting patient engagement and community involvement.

The Subgroup expressed its appreciation for the contribution and value of the written report provided, and conveyed their gratitude for the effort invested in supporting the work of the Subgroup.

36/26 Non-Executive Director Update

The Subgroup received assurance from the Chair of the Safety and Quality Committee on progress across a range of quality and safety priorities. The Subgroup commended the rapid progress made in developing an accessible easy-read Quality Account ahead of schedule in a particularly challenging timeframe. Cancer performance remained strong in several pathways, with improvements in breast and urology services, although challenges continued within colorectal, gynaecology and head and neck services. Robust arrangements were in place to assess and mitigate risk for patients awaiting treatment. Assurance was also provided through the Safety and Quality Dashboard, which demonstrated safe staffing arrangements, strong cleaning standards and *Clostridioides difficile* performance below target levels. Concern remained regarding an increase in pressure ulcers, with further investigation underway into potential contributing factors, including prolonged Emergency Department waits, specialist equipment issues and workforce challenges. Improvements in workforce stability within children's services were noted, with outstanding consultant capacity issues expected to be resolved through recruitment. The Committee had also reviewed progress within the Urgent and Emergency Care transformation programme, noting positive developments but emphasising the need for clearer measures of impact on patient outcomes and flow. Further work was required to meet all elements of a new NHS England framework for the first 72 hours of non-elective care. The Annual Mortality report provided assurance that mortality indicators remained within expected ranges, while medicines governance demonstrated strong compliance and progress in improving medicines-related patient experience. Assurance was also received regarding the safe management of medical devices and equipment despite capital replacement pressures, although further analysis had been requested to improve visibility of future replacement requirements, risks and funding constraints.

The Subgroup received assurance that delivery of the Urgent and Emergency Care transformation programme remained on track, with no identified risks to achieving the

four-hour waiting time target by October. Members emphasised the importance of patient involvement in shaping service changes and noted that engagement activity would continue as priorities became more clearly defined. Assurance was also provided regarding the extensive governance and oversight of Urgent and Emergency Care performance through regular reporting to Board, Committees and the Single Improvement Plan.

The Subgroup discussed the increase in pressure ulcers and the potential impact of temporary staffing levels on continuity of care, team cohesion and communication. Ongoing challenges in recruiting healthcare support workers were attributed to wider labour market pressures rather than recruitment processes. Concerns arising from ward visit feedback regarding the use of personal cooling and heating devices were noted, with the issue to be explored further through existing governance arrangements. The Subgroup also received an update on national maternity service improvement requirements and noted that a review of recommendations and communications planning was underway. Positive external feedback on the effectiveness of the Safety and Quality Committee was welcomed, particularly recognition of constructive challenge, strong triangulation of information and consideration of workforce, financial and quality impacts in decision-making.

37/26 Topic of the meeting: Communications

The Subgroup discussed communication as a recurring theme emerging from governor visits and wider staff engagement, recognising it as a significant organisational challenge with implications for staff experience, operational effectiveness and patient care. Concerns related to communication within and between departments, clarity of organisational decisions, information sharing across health and care systems, and the impact of communication failures on patient flow, discharge processes and medicines management. The Subgroup also highlighted concerns regarding outdated information displayed across Trust sites, missed opportunities to communicate achievements and improve awareness of leadership roles, and reports of a high volume of unanswered telephone calls, which were viewed as evidence of the scale of the challenge. Members noted that communication issues were consistently reflected in complaints, patient feedback, incident investigations and workforce discussions.

38/26 Reflections of the meeting and recent visits

The Subgroup reflected on the developing approach to governor visits and the reporting arrangements arising from them. It was suggested that a standard report template should be used to capture observations from visits, with reports being shared through the Subgroup and Council. Members proposed that some visits were better suited to detailed reporting than others, particularly where visits focused on specific safety or assurance questions rather than general observation. The Subgroup emphasised the value of visit reports in identifying themes and ensuring the patient voice was represented, while recognising the need for clear processes and careful consideration of boundaries. The Subgroup agreed that further work was required to develop the reporting process and ensure key themes and concerns were effectively summarised, escalated and used to support assurance on care and safety matters.

39/26 Request for future meeting topics and visits

The Subgroup suggested that the Healthport should be considered for a future visit, particularly following the significant investment made in the service. It was noted that the area continued to experience considerable operational pressure, with high levels of demand from walk-in X-ray activity and blood tests. It was felt that a visit would provide an opportunity to better understand the impact of the investment, the current challenges being experienced by staff, and how increasing demand was affecting patient flow and service capacity.

40/26 Positive Impact Story

Not discussed at the meeting.

Date, time, and venue of next meeting

9 September 2026 at 10.00am – Hybrid Meeting, Gordon Hesling Conference Room, RPH

Care and Safety Subgroup

16 July 2026 | 12.30pm | Hybrid meeting, Gordon Hesling Conference Room, RPH

Members:

George Bailey	Public Governor (Chair)
Susan Bailey	Public Governor
Linda Bracewell	Public Governor (MS Teams)
Graham Fullarton	Public Governor (MS Teams)
Angela Kos	Public Governor (MS Teams)
Ian Linacre	Staff Governor
Enid Povey	Public Governor (MS Teams)
Graham Robinson	Public Governor

Apologies: Sonia Connell, Ian Facer, Lou Jackson, Ian Linacre, Christine Turner

In Attendance:

Prof. Karen Deeny	Non-Executive Director (MS Teams)
Karen Lawrenson	Corporate Affairs Officer (minutes)
Davd Thompson	Assistant Director of Resilience (<i>minute 45/26</i>)
Sarah Welsh	Interim Associate Director of Patient Experience, Involvement and Quality (<i>minute 46/26</i>)

Apologies: Shaun Ashworth, Karen Deeny, Alison McCrudden

Observers:

Liana Clamor	Admin Support Officer
Chris Boden	Communications Officer

41/26 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.

42/26 Declarations of interest

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

43/26 Minutes of the previous meeting

It was agreed that the minutes of the meeting held on 16 July 2026 were approved as a true and accurate record.

44/26 Matters arising and action log

The action log was reviewed and updated.

45/26 Estates and Facilities Update

David Thompson attended for this item

The Subgroup noted the appointment of an interim Head of Capital and congratulated the Security Team on its nomination for the Trust's Team of the Year award. An update was provided on the Trust's security and safeguarding system, including the use of facial recognition technology to support patient safety. Members noted that the system was used only for identified high-risk patients and enabled security teams to respond quickly when vulnerable individuals attempted to leave clinical areas. The system had supported the prevention of serious incidents and the location of missing patients. It was reported that the upgraded security infrastructure had significantly improved surveillance and incident response capabilities across hospital sites. Assurance was provided that facial recognition alerts were subject to human verification and had not resulted in any known misidentifications.

Further updates were requested regarding the sloping floors within two cubicles in the RPH Elective Care Centre, compliance with national cleaning standards, and proposed electrical and drainage works. The Subgroup were advised that efforts were continuing to recruit to vacant cleaning posts in order to maintain required standards. An update was also provided on priority infrastructure schemes, including electrical and drainage works. Members noted that a risk-based submission had been prepared for Board consideration and that plans for drainage improvements were progressing through the design phase. The drainage programme was expected to be a long-term project, with delivery anticipated over the next two to three years. It was also agreed that concerns regarding the condition of the audiology carpets would be investigated and a cost estimate obtained for repair of the soundproof rooms so that the audiology team can consider a charity funding request. An offer was made for the group to observe the safeguarding system.

46/26 Patient Quality, Experience and Engagement Update

Sarah Welsh attended for this item

The Subgroup received an update on work to strengthen patient experience and involvement, including handheld translation devices, health inequalities monitoring, improvements to the maternity afterbirth service and patient experience training. Plans were outlined to pilot near real-time patient feedback across selected inpatient wards, maternity and emergency departments, alongside a refresh of the patient and carer engagement forum to strengthen co-design, community representation and divisional accountability. The Subgroup welcomed the proposals and requested clarity on the reporting of inpatient survey results and assurance regarding patient involvement in emergency care transformation. Concerns regarding access to services and unresolved enquiries through the patient liaison service were acknowledged as areas requiring further review.

47/26 Common themes arising from Governor visits

The Subgroup discussed observations from recent visits, including staff pressures, variable availability of appropriately skilled support staff, constrained clinical environments and the importance of timely communication with patients and families. Positive feedback regarding staff commitment, care and professionalism was also recognised. It was agreed that the governor visit reporting format would be revised to record factual observations without assumption of causation, and consideration could then be given for clear governance route for reporting observations and escalations through to the Council of Governors.

48/26 Topic of the meeting: Boarding and Pressure Sores Connection

Not discussed in the meeting.

49/26 Reflections of the meeting and recent visits

Not discussed as this was raised as part of minute reference 47/26.

50/26 Request for future meeting topics and visits

An offer had been made for the group to observe the safeguarding system.

51/26 Positive Impact Story

Not discussed at the meeting.

Date, time, and venue of next meeting

9 November 2026 at 12.30pm – Hybrid Meeting, Gordon Hesling Conference Room, RPH

Membership Subgroup

14 August 2026 | 10.00am | Microsoft Teams Meeting

Members:

Sheila Brennan	Chair
George Bailey	Deputy Chair
Ian Facer	Public Governor
Ian Linacre	Public Governor
Enid Povey	Public Governor
Graham Robinson	Public Governor

Apologies:

L Bracewell, K Deeny, A Sharples, T Young

In attendance:

Katie Stanton Corporate Affairs Officer (*administrating*)

16/26 Chair and quorum

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

17/26 Declaration of interests

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

18/26 Minutes of the previous meeting held on 12 May 2026

The minutes were accepted as a true and accurate record.

19/26 Action Log

The action log would be updated accordingly.

20/26 Preparation for the Annual Members' Meeting in relation to advertising, publicity

The Subgroup received an update on arrangements for the forthcoming Annual Members' Meeting (AMM). Members sought clarification regarding the requirement to continue holding an Annual Members' Meeting in light of anticipated NHS reforms. It was confirmed that the Trust remained legally required to hold an annual membership meeting for as long as current Foundation Trust arrangements remained in place.

The Subgroup reflected on the 2025 AMM and considered that opportunities to promote the event more widely had been missed. Concerns were raised regarding the limited

visibility of advertising and the low level of engagement generated through social media activity. Members commented that publicity for the event had been minimal and agreed that a stronger promotional approach should be adopted for the 2026 meeting.

The importance of governors proactively supporting promotion of the AMM through their own networks and social media channels was discussed. It was recognised that this would be most effective if supported by professionally branded communications materials produced through the Trust's Communications Team. An update was provided that planning for the AMM was progressing and that a communications plan was already being developed in partnership with the Communications Team. It was confirmed that promotion would include social media, website content, Trust publications and local press coverage. Members were advised that publicity materials would be made available approximately four weeks before the event, although an exact publication date was not yet confirmed. Members suggested that, in addition to sharing Trust social media posts, it would be beneficial to have downloadable promotional materials, such as a PDF or image file, which governors could distribute through email and wider community networks.

The possibility of radio advertising was discussed. It was recognised that detailed promotional arrangements sat within operational responsibilities, and it was agreed that suggestions raised by the Subgroup would be shared with the Communications Team for consideration.

21/26 Improvement in General Communication

This agenda item was stood down due to lack of content.

Date, time, and venue of next meeting:

17 November 2026, 11.30am, Hybrid Meeting, Gordon Hesling Conference Room, RPH

The meeting concluded at 10.20am

10.7 REVIEW OF MEETING PERFORMANCE

● Information Item

● Chair

● 2.50 pm

Verbal

10.8 DATE, TIME AND VENUE OF NEXT MEETING

● Information Item

● Chair

● 2:55 pm

21 January 2027, 1:00pm, Lecture Room 1, Education Centre 1, Royal Preston Hospital

CLOSE

🕒 2.55 pm