NHS
Lancashire and South Cumbria
Integrated Care Board

Performance Report (PR)

Integrated Care Board

5 November 2026



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Integrated Care Board

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Introduction

NHS Lancashire and South Cumbria Integrated Care Board

The ICB aspires to move from reporting performance to actively assuring and improving population outcomes.

A group has been established to develop the Performance Report, and a transition plan is in place with clear actions an timescales for delivery. Actions and progress made is detailed on the following slide.

The ambition is to get to a position where the ICB Board receives a report that articulates whether:

- Outcomes are improving for our population
- Services are safe, effective, accessible and equitable
- The ICB is delivering the priorities it has committed to
- Resources are used productively and sustainably
- There are risks and what actions are being taken

This is particularly important in the 2026/27 environment: NHS England's new Oversight Framework explicitly combines delivery segmentation, organisational capability and an oversight response, rather than treating performance as simply a collection of key performance indicators.

Within this version of the Performance Report we have included:

- Population Commissioning Footprints for our four 'Places' to provide a high-level view of demographic and socioeconomic indicators. These profiles are the first iteration and are being developed with Commissioning leads.
- A spotlight on employment indicators to introduce a new dimension on the wider determinants that impact on the health of our population. We will change the focus area within each report and use this information within our commissioning teams to understand the factors that contribute to health outcomes.

Performance Report (PR) Transition Plan

Developing PR – Phase 1&2 Progress

Lancashire and South Cumbria Integrated Care Board

	Task	Update	Progress	Quarter 2			Quarter 3		
				July	August	September	October	November	December
Governance	Establish development group	Group meets weekly	100% on track						
	Q&O Committee updates	Next update due at October Committee	100% on track						
	Board updates	PR and update at November Board	100% on track						
Phase 1	Continue with current IPR	PR and update at October Committee / November Board	100% on track						
	Review areas of good practice	Initial review undertaken. Keep watching brief	100% on track						
	Scope new areas for inclusion	Strawman in progress - October deadline	85% progress						
	Assess availability of HI data	HI data reported. Reivew of frequency underway	75% progress						
	Consider broader metrics	Outcomes, Finance and Workforce review	75% progress						
	Collate list of national data sources	All existing metrics data sourced. Linked to strawman	75% progress						
	Develop new visulisations	PR at September Board includes new visuals	75% progress						
	Undertake a RACI	RACI to be completed in October	25% progress						
	Map out new geographies	Mapping of data commenced	50% progress						
Phase 2	Biuld in predictive modelling	To commence in Q3	10% progress						
	Explore dynamic reporting	To commence in Q3	5% progress						
Phase 3	Introduce advanced analytics	To commence in Q4							
	Consider use of AI	To commence in Q4							
	Develop portal view	To commence in Q4							
	Awareness raising / training	To commence in Q4							
	Utilisation of IPR	To commence in Q4							

All Governance actions are 100% on track, including development group meeting regularly and updates at both Committee and Board meetings.

Phase 1:
Actions to be completed by end of October:
- 2 x 100% complete
- 1 x 85% complete
- 4 x 75% complete
- 1 x 50% complete
- 1 x 25% complete

High confidence level for completion with progress monitored weekly

Phase 2:
Actions commenced in Q3

Phase 3:
Actions to commence in Q4 (earlier if possible)

Executive Summary

Elective / Planned Care

At the end of August 2026, 231,851 patients were waiting for treatment across the ICB. The August position has deteriorated away from plan. Delivering the waiting list recovery trajectory to March 2027 will be challenging, particularly in relation to overall waiting list size and 18-week performance. The longest waits of 52 weeks or more remain a particular pressure, especially in Gynaecology, Trauma and Orthopaedics, Gastroenterology and Cardiology.

Diagnostics

Performance for patients to receive their diagnostic test within 6 weeks deteriorated in August 2026 and was below plan. There were 51,586 patients waiting for a diagnostic test across the ICB, approximately 1,800 less than the previous month, and a reduction of 6,500 from the beginning of the financial year. Community diagnostic centre (CDC) activity was 99.9% against plan.

Cancer

The ICB exceeded plan for the Faster Diagnosis Standard in August 2026. The 31-day treatment target was below planned performance at 92.83%. The 62-day target (85%) has been challenged for some time with none for the local providers achieving their planned target in August 2026.

Urgent and Emergency Care

For the month of September 2026, 75.57% of patients were seen within 4 hours in A&E. There were 77,635 attendances during the month, approximately 2,000 compared with the same period in 2025. Hospital@Home (Virtual ward) capacity across Lancashire and South Cumbria was 399 beds with an occupancy of 64.16%, below planned achievement.

All Age Continuing Care

The ICB remains a national outlier for eligibility of standard CHC per 50k population, although this continues to reduce. The number of patients eligible for Fast Track per 50k population has risen slightly, from 20.2 to 23.7. The ICB continues to be higher than the national average of 17.7 per 50k.

Mental Health

The ICB met the Dementia diagnosis rate in August 2026. The performance for Talking Therapies Reliable Recovery remains challenged and there was a reduction in the number of inappropriate out of area placements in August which was in line with provisional data reported previously.

Community

There continues to be improved performance in 18 weeks RTT for CYP community services and is ahead of plan. The number of 52 weeks waits for Adult services fell significantly in August 2026 to 24 from 28 in the previous month, whereas the number for Children and Young people remained at 51.

Children and Young People

The performance for Elective 18 weeks performance in under 18's across the 4 main providers has remained static. 3 of the 4 main providers are meeting the target for the proportion of the waiting list waiting over 52 weeks, as is the ICB.

Primary Care

The August 2026 appointment data was significantly below our original planning submission by -65k appointments. This as meant that we are now below our cumulative year to date plan for the first month this year. The ICB appointment rate continues to be similar to North-West averages though remains well below the national average. In the first 6 months of 2026-27, 105.94% of all Planned UDAs have been delivered.

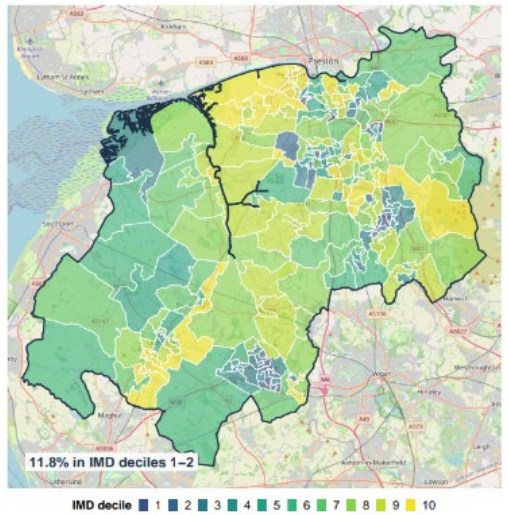
POPULATION COMMISSIONING FOOTPRINT

South Lancashire

Population and place profile

Total Population: 346,138 – 5.7% Increase in last decade

Deprivation



Population structure



Map: MHCLG IMD 2025, ONS geography and OpenStreetMap.
Population pyramid: ONS Census 2001 RM200.
Indicator periods are shown in the spine.

Population and place indicators

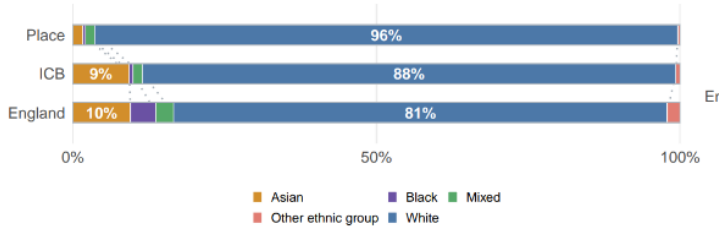
Indicator	Period	Place	England	National range
Population and support				
One–person households occupied by someone aged 66+	2021	13.6%	12.8%	
Providing 50+ hours of unpaid care per week	2021	2.9%	2.6%	
Housing, living conditions and access				
Households with no car or van	2021	15.6%	23.5%	
Modelled fuel–poor households	2024	8.6%	9.9%	
Overcrowded households (bedroom standard)	2021	1.5%	4.4%	
Rented households	2021	26.2%	37.6%	
Socioeconomic conditions				
Children aged 0–15 in relative low–income families (before housing costs)	FYE 2025	17.7%	19.8%	
No qualifications	2021	16.5%	18.1%	
Children and young people				
Year 6 obesity, including severe obesity	2022/23 – 24/25	20.7%	22.4%	
Health and disability				
Activity–limiting disability	2021	18.7%	17.3%	
Bad or very bad self–reported health	2021	5.3%	5.2%	
Emergency hospital admissions: all causes	2016/17 – 20/21	102.7	100.0	
Heart attack (myocardial infarction): emergency hospital admissions	2016/17 – 20/21	105.9	100.0	
Stroke: emergency hospital admissions	2016/17 – 20/21	95.8	100.0	
Chronic obstructive pulmonary disease (COPD): emergency hospital admissions	2016/17 – 20/21	98.4	100.0	
Intentional self–harm: emergency hospital admissions	2016/17 – 20/21	101.9	100.0	

Key: 10th–90th | 25th–75th | Median | England

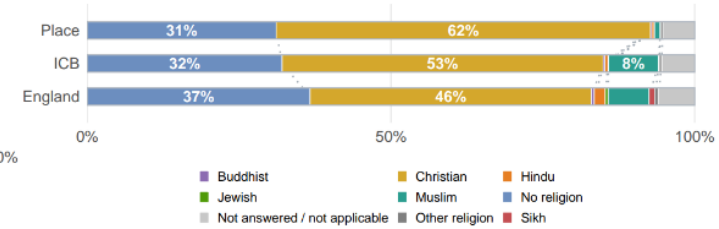
Sig Worse | Sig Better | Sig High | Sig Low | No Sig Difference | Sig Not Calculated

Population diversity | Census 2021

Ethnic group



Religion



Significance compares each Place with the rest of England using 95% confidence intervals. Statistical significance does not necessarily indicate a large or practically important difference. Child-low-income and Year 6 obesity intervals are approximate count-based estimates. Significance is not calculated for modelled fuel-poverty estimates.

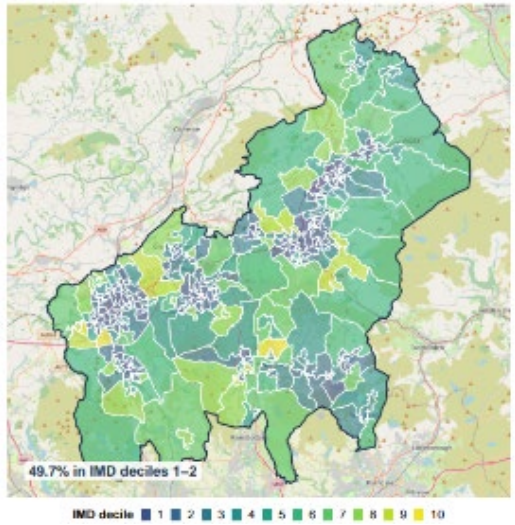
POPULATION COMMISSIONING FOOTPRINT

Pennine Lancashire

Population and place profile

Total Population: 498,036 – 5.3% increase in last decade

Deprivation



Population structure



Map: MHCLG IMD 2025, ONS geography and OpenStreetMap.
Population pyramid: ONS Census 2001 RM200.
Indicator periods are shown in the spine.

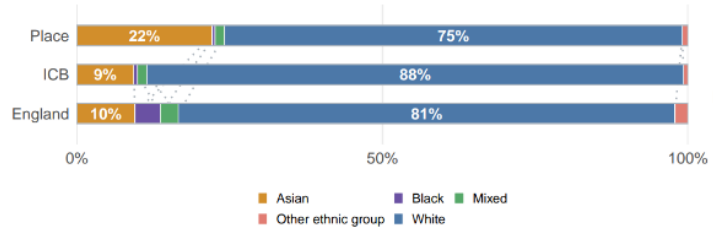
Population and place indicators

Indicator	Period	Place	England	National range
Population and support				
One–person households occupied by someone aged 66+	2021	12.8%	12.8%	
Providing 50+ hours of unpaid care per week	2021	3.0%	2.6%	
Housing, living conditions and access				
Households with no car or van	2021	25.1%	23.5%	
Modelled fuel–poor households	2024	12.3%	9.9%	
Overcrowded households (bedroom standard)	2021	5.1%	4.4%	
Rented households	2021	36.9%	37.6%	
Socioeconomic conditions				
Children aged 0–15 in relative low–income families (before housing costs)	FYE 2025	35.8%	19.8%	
No qualifications	2021	23.3%	18.1%	
Children and young people				
Year 6 obesity, including severe obesity	2022/23 – 24/25	24.5%	22.4%	
Health and disability				
Activity–limiting disability	2021	19.3%	17.3%	
Bad or very bad self–reported health	2021	6.5%	5.2%	
Emergency hospital admissions: all causes	2016/17 – 20/21	121.9	100.0	
Heart attack (myocardial infarction): emergency hospital admissions	2016/17 – 20/21	129.4	100.0	
Stroke: emergency hospital admissions	2016/17 – 20/21	108.4	100.0	
Chronic obstructive pulmonary disease (COPD): emergency hospital admissions	2016/17 – 20/21	177.1	100.0	
Intentional self–harm: emergency hospital admissions	2016/17 – 20/21	121.3	100.0	



Population diversity | Census 2021

Ethnic group



Religion

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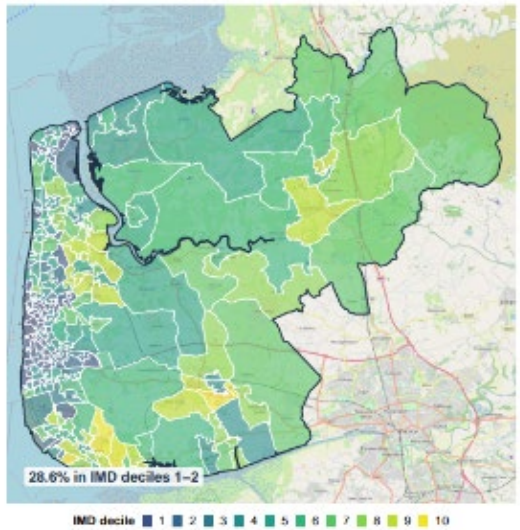
POPULATION COMMISSIONING FOOTPRINT

Fylde Coast Lancashire

Population and place profile

Total Population: 334,243 – 2.6% increase in last decade

Deprivation



Population structure



Map: MHCLG IMD 2025, ONS geography and OpenStreetMap.
Population pyramid: ONS Census 2001 RM200.
Indicator periods are shown in the spine.

Population and place indicators

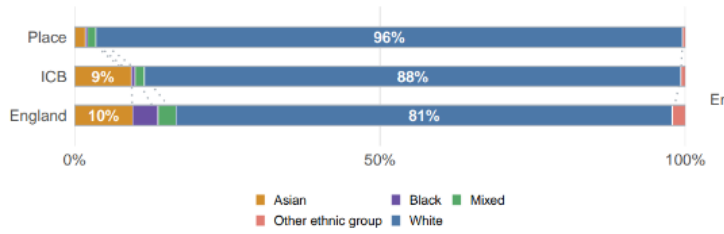
Indicator	Period	Place	England	National range
Population and support				
One–person households occupied by someone aged 66+	2021	16.4%	12.8%	
Providing 50+ hours of unpaid care per week	2021	3.7%	2.6%	
Housing, living conditions and access				
Households with no car or van	2021	24.6%	23.5%	
Modelled fuel–poor households	2024	11.3%	9.9%	
Overcrowded households (bedroom standard)	2021	1.7%	4.4%	
Rented households	2021	33.1%	37.6%	
Socioeconomic conditions				
Children aged 0–15 in relative low–income families (before housing costs)	FYE 2025	23.8%	19.8%	
No qualifications	2021	20.9%	18.1%	
Children and young people				
Year 6 obesity, including severe obesity	2022/23 – 24/25	22.5%	22.4%	
Health and disability				
Activity–limiting disability	2021	23.0%	17.3%	
Bad or very bad self–reported health	2021	7.6%	5.2%	
Emergency hospital admissions: all causes	2016/17 – 20/21	106.6	100.0	
Heart attack (myocardial infarction): emergency hospital admissions	2016/17 – 20/21	122.4	100.0	
Stroke: emergency hospital admissions	2016/17 – 20/21	103.5	100.0	
Chronic obstructive pulmonary disease (COPD): emergency hospital admissions	2016/17 – 20/21	127.4	100.0	
Intentional self–harm: emergency hospital admissions	2016/17 – 20/21	149.7	100.0	

Key: 10th–90th | 25th–75th | Median | England

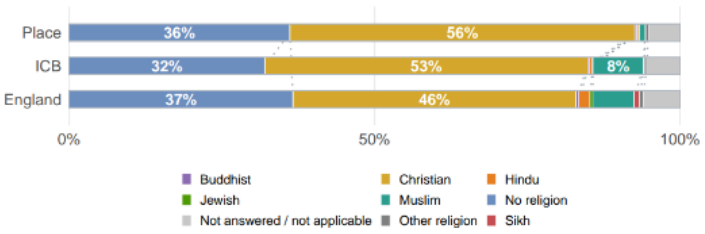
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Population diversity | Census 2021

Ethnic group



Religion



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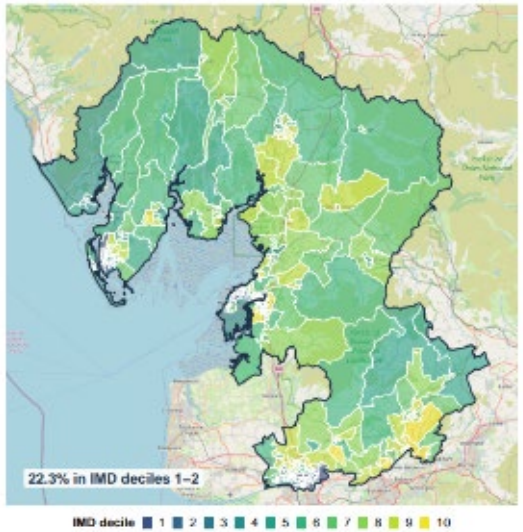
POPULATION COMMISSIONING FOOTPRINT

North Lancashire and South Cumbria

Population and place profile

Total Population: 538,891 – 3.0% increase in last decade

Deprivation



Population structure



Map: MHCLG IMD 2025, ONS geography and OpenStreetMap.
Population pyramid: ONS Census 2001 RM200.
Indicator periods are shown in the spine.

Population and place indicators

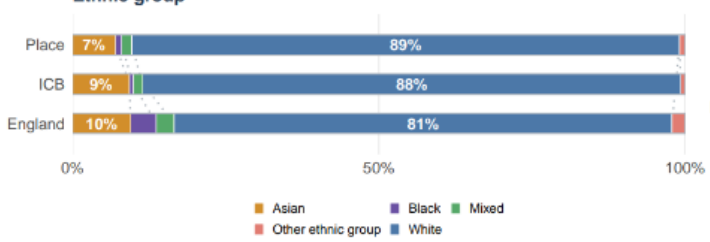
Indicator	Period	Place	England	National range
Population and support				
One–person households occupied by someone aged 66+	2021	14.5%	12.8%	
Providing 50+ hours of unpaid care per week	2021	2.6%	2.6%	
Housing, living conditions and access				
Households with no car or van	2021	21.4%	23.5%	
Modelled fuel–poor households	2024	10.6%	9.9%	
Overcrowded households (bedroom standard)	2021	2.2%	4.4%	
Rented households	2021	31.6%	37.6%	
Socioeconomic conditions				
Children aged 0–15 in relative low–income families (before housing costs)	FYE 2025	20.8%	19.8%	
No qualifications	2021	16.5%	18.1%	
Children and young people				
Year 6 obesity, including severe obesity	2022/23 – 24/25	21.0%	22.4%	
Health and disability				
Activity–limiting disability	2021	18.8%	17.3%	
Bad or very bad self–reported health	2021	5.4%	5.2%	
Emergency hospital admissions: all causes	2016/17 – 20/21	101.0	100.0	
Heart attack (myocardial infarction): emergency hospital admissions	2016/17 – 20/21	126.4	100.0	
Stroke: emergency hospital admissions	2016/17 – 20/21	103.9	100.0	
Chronic obstructive pulmonary disease (COPD): emergency hospital admissions	2016/17 – 20/21	92.9	100.0	
Intentional self–harm: emergency hospital admissions	2016/17 – 20/21	102.8	100.0	

Key: 10th–90th | 25th–75th | Median | England

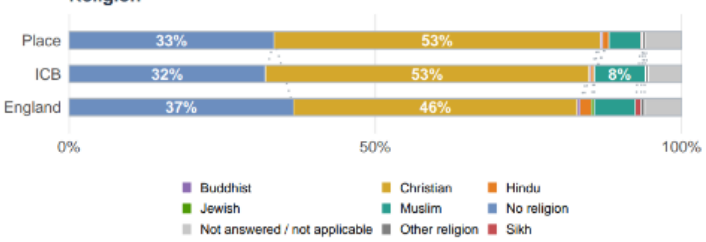
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Population diversity | Census 2021

Ethnic group



Religion



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ICB Metric Summary

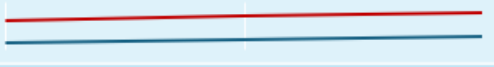
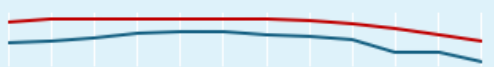
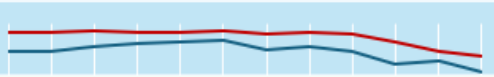
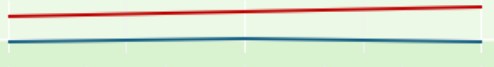
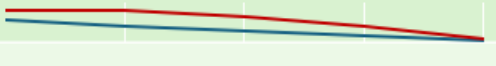
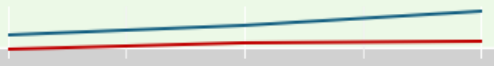
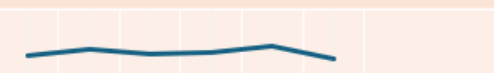
Metric Code	Key Performance Indicator	OF	Date	Plan	Actual	In Month Position
EC001	18 week RTT Performance %	*	Aug-26	67.42%	65.79%	✖
EC002	52 week RTT Performance %	*	Aug-26	0.97%	1.16%	✖
EC003	TOTAL Incomplete RTT Pathways		Aug-26	227,873	231,851	✖
EC004	3) New RTT periods - YTD		Aug-26	285,609	295,709	✖
EC005	1a) Completed pathways for admitted patients (unadjusted) - YTD		Aug-26	53,014	50,405	✖
EC006	1b) Completed pathways for non-admitted patients (unadjusted) - YTD		Aug-26	187,517	186,860	✖
EC007	Specialist Advice - Pre-Referral (Rate per 100 OP)		Jul-26	-	7.34	
EC007	Specialist Advice - Pre-Referral (% DIVERTED)		Jul-26	-	34.1%	
CO001	Number of adults waiting over 52 weeks on community waiting lists	*	Aug-26	44	24	✓
CO002	Number of children waiting over 52 weeks on community waiting lists	*	Aug-26	40	51	✖
CO003	18 weeks performance - children	*	Aug-26	54.73%	64.32%	✓
CYP001	WLMDS – RTT 18 weeks performance (under 18)	*	Sep-26	70.00%	60.60%	✖
CYP002	52+ Weeks RTT % performance	*	Sep-26	<1%	0.80%	✓
D001	% of patients that receive a diagnostic test within six weeks (National ambition of 95%)	*	Aug-26	83.1%	82.8%	✖
CA001	% meeting faster diagnosis standard	*	Aug-26	78.64%	78.88%	✓
CA002	31 Day First Treatment (94% Standard)		Aug-26	94.57%	92.83%	✖
CA003	62 Day referral to treatment (80% Standard)	*	Aug-26	76.91%	70.53%	✖
UEC001	A&E 4 Hour Standard (82% Target)	*	Sep-26	82%	75.57%	✖

Metric Code	Key Performance Indicator	OF	Date	Plan	Actual	In Month Position
UEC002	A&E 4 Hour Standard - Type 1 Only	*	Sep-26	-	61.16%	
UEC003	% of patients spending more than 12 hours in an emergency department (prov)	*	Sep-26	-	14.08%	
UEC004	Average ambulance response time: Category 2	*	Sep-26	00:30:00	00:24:20	✓
UEC005	Virtual ward occupancy		Sep-26	80.16%	64.16%	✖
UEC006	2 Hour urgent community response (UCR) - % in 2 hours		Aug-26	70.00%	89.56%	✓
UEC007	Ambulance handover delays over 30 minutes as a proportion of ambulance arrivals.		Sep-26	-	28.13%	
MH001	Estimated diagnosis rate for people with dementia		Jun-26	66.7%	68.38%	✓
MH002	Inappropriate out of area placements		Aug-26	0	4	✖
MH003	Talking therapies - % of patients achieving reliable recovery	*	Jul-26	45.2%	45.10%	✖
PC001	Number of general practice appointments per 10,000 weighted patients		Aug-26	4,233	3,911	✖
PC002	% Same Day General Consultation Acute		Aug-26	81.1%	79.9%	✖
PC003	Workforce – FTE doctors in General Practice per 10,000 weighted patients		Aug-26	-	5.79	
PC004	Recover Dental Activity - Increase in Units of Dental Activity (UDA)		Sep-26	96%	105.94%	✓
PC005	Percentage of resident population seen by an NHS dentist - ADULT		Aug-26	40.70%	41.60%	✓
PC005	Percentage of resident population seen by an NHS dentist - CHILD		Aug-26	66.20%	68.88%	✓
AAC001	Eligible for Standard CHC per 50k		Q1 26/27	-	57.05	
AAC002	Eligible for Fast Track per 50K		Q1 26/28	-	23.75	
AAC003	Eligible for Funded Nursing Care per 50K		Q1 26/29	-	83.18	

Lancashire & South Cumbria ICB - Population Health Outcomes and Unifying Goals

Population health outcome metrics show that Lancashire and South Cumbria continues to perform below the England average for life expectancy, healthy life expectancy, wider determinants of health and key preventable risk factors.

There has been some improvement in the measures supporting the ICB's Unifying Goals, however more formal assessment of progress requires agreement on the reporting timeframes and baseline position.

Category	What we want to achieve	How we will measure it	L&SC	England	Timeframe	L&SC Trend	Trend over time vs England (as per date range) L&SC England
High level outcomes	**Longer Life**	Life Expectancy at birth (Female)	81.9 years	83.3 years	2020-2024	Improving	
		Life Expectancy at birth (Male)	77.9 years	79.5 year	2020-2024	Improving	
	Healthier Life	Healthy Life Expectancy at birth (Female)	59.5 years	61.3 years	2011-2024	Worsening	
		Healthy Life Expectancy at birth (Male)	58.5 years	60.9 years	2011-2024	Worsening	
Improving the health of the population	**Monitor wider determinants of health**	School readiness (%)	64.4%	68.3%	2022-2025	Worsening	
		Children in relative low-income families (%)	25.8%	19.8%	2021-2025	Worsening	
		Economic Inactivity Rate (%)	21.9%	20.5%	2025	n/a	No time series data available
	Shift to prevention and reducing risk factors	Adult Smoking Prevalence (%)	10.6%	10.4%	2020-2024	Improving	
		Adults classified as overweight or obese (%)	67.5%	64.6%	2022-2025	Worsening	
Category	**What we want to achieve**	**How we will measure it**	**Target**	**L&SC** Gap in DSR IMD1&2 vs IMD9&10	**Timeframe**	**L&SC Trend**	**Trend over time** (as per date range)
Lancashire and South Cumbria ICB's Unifying Goals for health inequalities (Note: data is provisional and needs further review)	**Reduce the gap in HLE by 50% between most and least deprived**	Deprivation gap in under 75 mortality per 100,000 people	50% reduction in gap	401.53	2018-2025	Improving	
	Decrease non-elective admissions by 20% for people from IMD 1 & 2	Deprivation gap in emergency admissions IMD 1 & 2 per 100,000 people	20% reduction in gap	8,034.74	2018-2025	Improving	
	Optimise the health of children with a long-term condition in IMD 1 & 2	Deprivation gap in paediatric non-elective admissions per 100,000 people	20% reduction in gap	3,494.87	2018-2023	Improving	

Note: This data is unchanged because its sources have not been updated.

Lancashire & South Cumbria ICB – Population Health Outcomes and Inequalities

The ICB has a statutory duty to report against a nationally recommended set of health inequality metrics. The detailed assessment is published annually alongside the annual report. The latest report can be found at Health Inequality Metrics 2025/26. The measures presented below focus on a few key metrics to provide a headline position on changes in inequalities. Further detail is included in relevant sections for the report. We use the most recent available data. Not every measure has new data for each report because data release schedules vary. The current position is mixed, with inequalities narrowing for some measures and widening for others. These changes have not been tested for statistical significance and should therefore be interpreted with caution.

	Metric	12 Month Trend	Time Period
Improved	Deprivation gap in percentage of patients who are managed to target for atrial fibrillation (AF)	↓	March 2026
	Deprivation gap in pre-term births	↓	July 2026
	Percentage of patients aged 14+ on GP learning disability registers who have had an annual health check	↑	2025/26
	Deprivation gap in non-elective admissions per 100,000 (directly standardised rate)	↓	2025
	Non-Elective Respiratory Admissions per 100,000 Persons (used as proxy for Deprivation gap in non-elective bed days (per 100,000) occupied by asthma, chronic obstructive pulmonary disease and community-acquired pneumonia)	↓	2025
Worsened	Deprivation gap in percentage of s diagnosed at stage 1 and 2	↑	May 2026
	Deprivation gap in percentage of patients who are managed to target for cholesterol	↑	March 2026
	Deprivation gap in percentage of hypertension (HTN) patients treated to target	↑*	March 2026
	Rates of eligible patients with severe mental illness (SMI) receiving an annual physical health check and action plan	↓	2025/26
Not available	Number of people in a mental health inpatient setting who have a learning disability or are autistic	Not available	
	Deprivation gap in gestational age at booking	Not available	
	Deprivation gap in elective admissions in adults per 100,000 (directly standardised rate)	Not available	
	Deprivation gap in percentage of patients with type 1 diabetes receiving all 8 care processes	Not available	
	Deprivation gap in percentage of patients with type 2 diabetes receiving all 8 care processes	Not available	

* Gap has increased through 2025/26 with early signs of possible downturn in last quarter

Wider Determinants – Spotlight on Employment in Lancashire

The Skills, Employment and Socio-Economic Evidence Base Dashboard is an open-source data pack to provide the latest available data covering many skills, employment and socio-economic themes. It brings together labour market, skills, health, claimant and participation datasets in a way that allows better insight and more informed decision-making.

The scorecard indicates that the labour market has remained relatively resilient but there are clear areas of concern, for example health-related inactivity remains elevated and youth and caring-related measures continue to require attention. When we compare ourselves with similar combined authorities, Lancashire continues to perform relatively well across a range of measures. The challenge now is to increase participation.

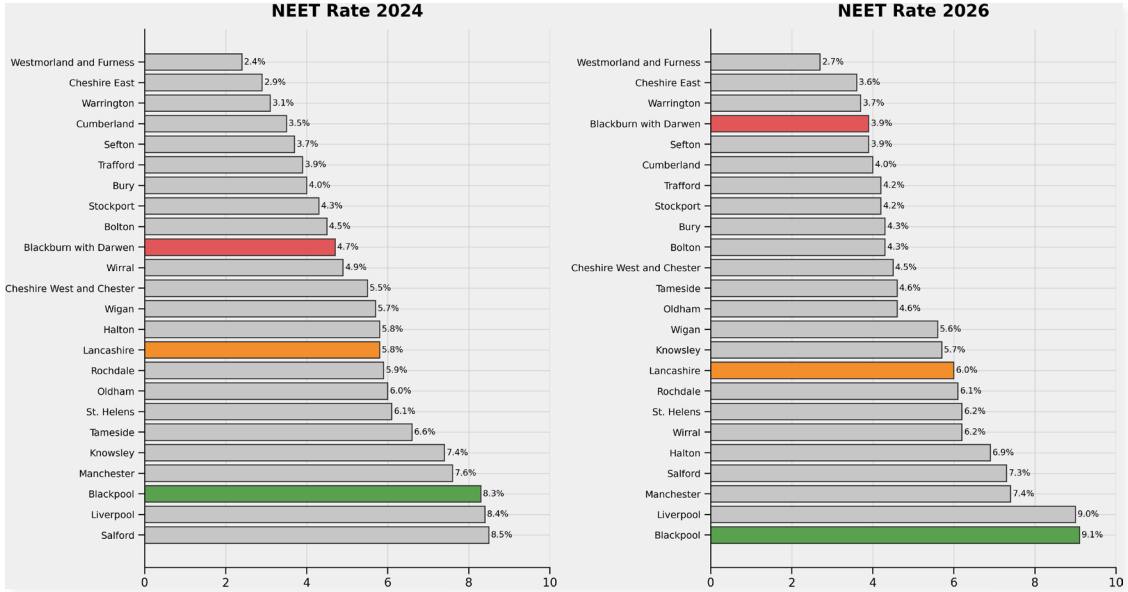
Section	Measure	June 2024	Latest Data	Desired Direction	RAG	Commentary
Cohort specific outcomes	% economic inactivity	23.3	23.3	Lower		Back at the June 2024 baseline, with increases in Wyre, Burnley and Hyndburn offsetting earlier gains elsewhere.
	% claimants	4.5	4.3	Lower		Approaching June 2024 baseline across all districts
	% no working requirements	40.5	53	Lower		53% of claimants are now outside work-related conditionality, with the largest % increases in Blackpool, Pendle and Wyre
	% 16 to 17 year olds not in employment, education or training	5.9	6	Lower		NEET numbers have fallen slightly between 2025 and 2026, although the rate has edged up slightly.
	% claimants aged 18 to 24	5	6.4	Lower		Youth claimant rates remain elevated across all districts.
	% employed with long term health condition	44.9	44.1	Higher		Strong growth in Fylde, Ribble Valley and Pendle has been more than offset by declines in Chorley and Hyndburn.
	% inactive females with caring responsibilities	15.7	22.5	Lower		Caring responsibilities continue to constrain labour market participation.
	Fit notes issued	33,609	34,755	Lower		Rising fit note volumes and limited use of "may be fit for work" suggest missed intervention opportunities. Doctors are the dominant profession issuing fit notes.
Place level labour market outcomes	Employment rate	74.1	73.8	Higher		PAYE data indicates broad-based weakening across every Lancashire district.
	% health related economic inactivity	35.5	40.4	Lower		Long-term sickness inactivity continues to rise, particularly in Preston, Burnley and Wyre.
	% workless households	20.1	-	Lower		Lancashire is now above both the regional and national average for workless households.

Source - Lancashire Skills and Employment Hub

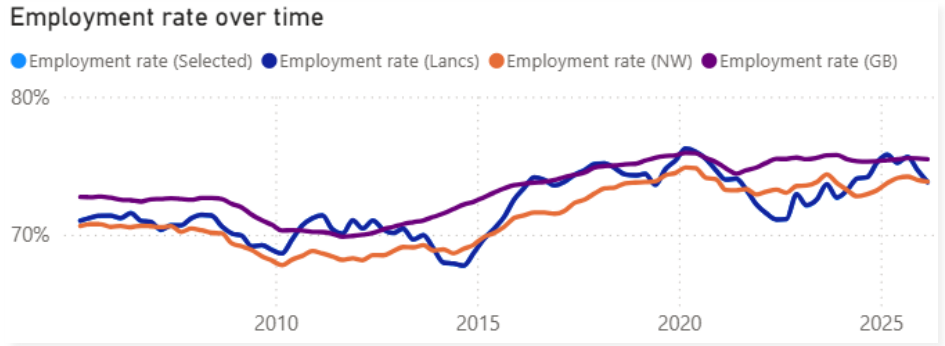
Wider Determinants – Spotlight on Employment in Lancashire

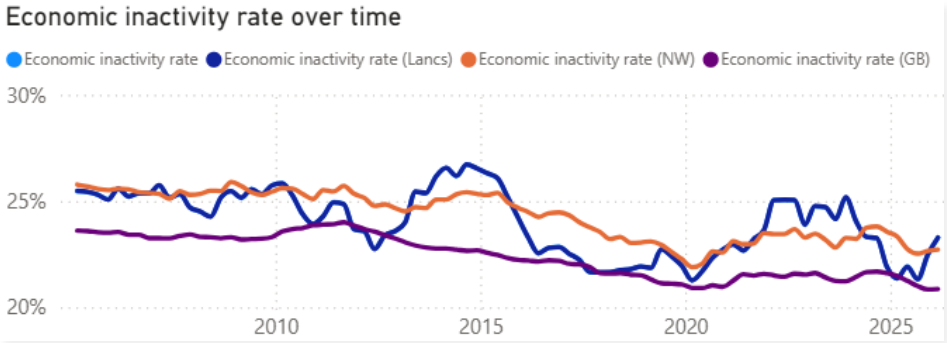
Economic inactivity varies from 32.2% in Hyndburn to 15.4% in West Lancashire. Hyndburn's rate of economic inactivity is 12.3% higher than the national rate and 10.5% higher than the North-West. Blackburn with Darwen, Blackpool and Burnley also have high rates of economic inactivity. The greatest increases in economic inactivity since June 2024 have been in Wyre (15%) and Burnley (12%).

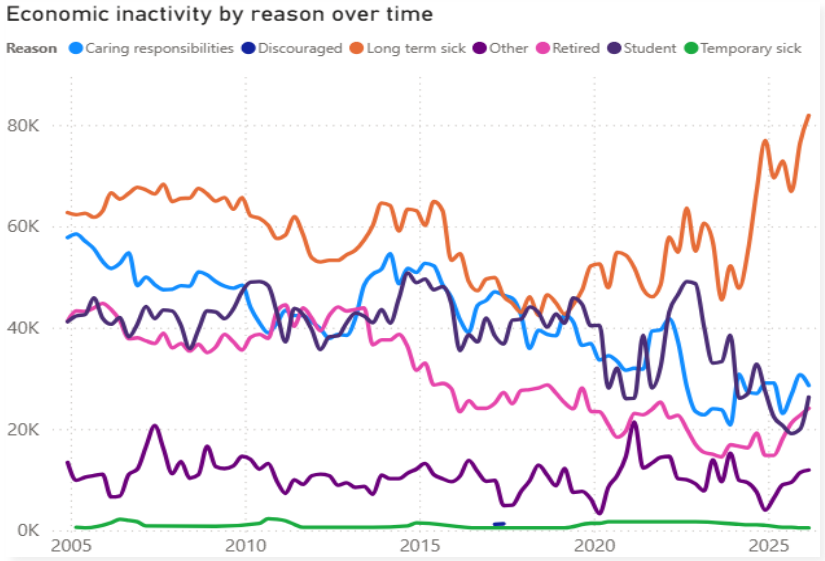
It is notable in the graph below that the greatest reason for the increase in economic inactivity is long term sickness. By comparison, temporary sickness has remained static over the period.



The headline Lancashire NEET position remains relatively positive, but it masks significant local variation across the footprint. It is notable that Blackburn with Darwen has improved its NEET rate between 2024-2026, whilst Lancashire and Blackpool's rates have deteriorated.

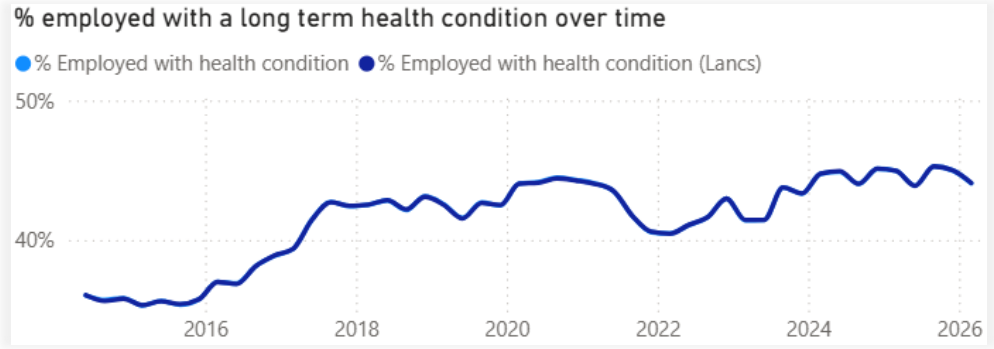






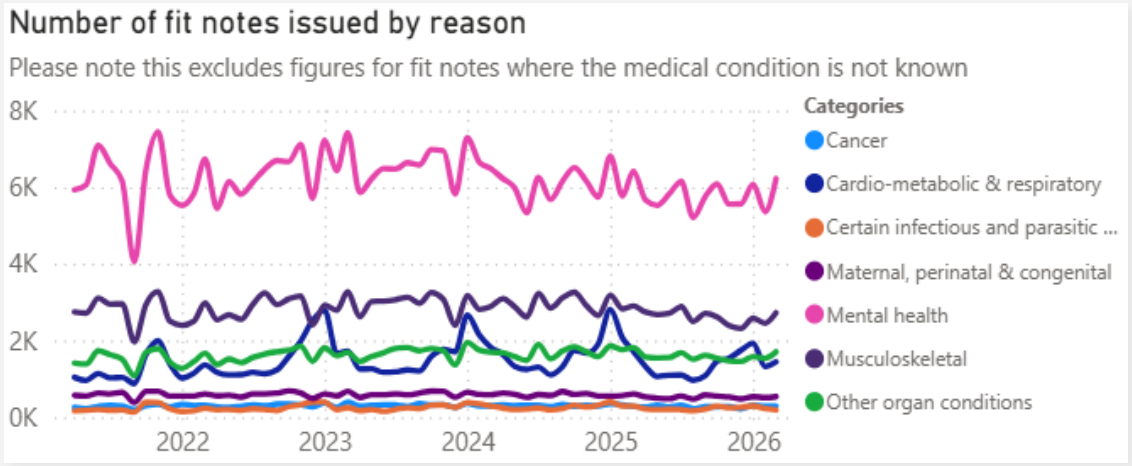
Source- Lancashire Skills and Employment Hub

Wider Determinants – Spotlight on Employment in Lancashire



The % of people employed with a long-term health condition has increased over the last decade to the current rate of 44%. The table below shows this at district level and highlights the significant variation in the change between the districts from June 2024 to March 2026 (15.5% increase in Fylde, as compared to a 17.9% decrease in Chorley).

Local authority district	% employed with health condition as at March 2026	% difference (June 2024)
Fylde	42.1%	15.5%
Ribble Valley	50.5%	13.6%
Pendle	48.2%	13.0%
West Lancashire	38.8%	6.4%
Lancaster	48.5%	2.4%
Rossendale	47.6%	0.5%
Preston	47.1%	-0.7%
Blackpool	42.6%	-0.8%
South Ribble	47.6%	-2.9%
Wyre	39.8%	-3.7%
Blackburn with Darwen	42.8%	-7.0%
Burnley	42.2%	-8.5%
Hyndburn	44.2%	-10.3%
Chorley	39.3%	-17.9%



It is no surprise that the largest category of fit notes issued is for mental health, followed by musculoskeletal. The dashboard enables us to drill down to see the % difference in fit notes issued for each category of condition by district:-

- The % difference in fit notes issued for mental health between June 2024 and March 2025 ranges from 30.9% in East Lancashire to 0.4% in Morecambe Bay.
- The % difference in fit notes issued for musculoskeletal conditions between June 2024 and March 2025 ranges from 25.8% in Fylde and Wyre to -12% in Morecambe Bay.

There are differences in the % of fit notes issued by GPs. In Chorley and South Ribble the % of fit notes issued by GPs is 5% less than in June 2024, whereas the % issued by GPs in Blackburn with Darwen has grown by 2.5%.

Across LSC, only around 5% of fit notes identify people as “maybe fit for work and there has been little change in this trend since July 2023.

Source - Lancashire Skills and Employment Hub

New Report Format – Metric Descriptor

Metric descriptor:-
Brief description of the indicator with inclusion of target details if known.

This data reports performance for each of the 4 main acute providers within the ICB (if applicable) against the plan figure.
(BTH – Blackpool Teaching Hospital, **ELHT** – East Lancashire Hospitals**, LTHT –** Lancashire Teaching Hospitals**, UHMB –** University Hospitals of Morecambe Bay**)**

North-West and England data is provided if available, which can provide a benchmark for the ICB data.

The sub-ICB data shows a breakdown at the previous CCG footprint (if available) to give more granularity to the information.

BwD - Blackburn with Darwen
BLK - Blackpool
EL - East Lancashire
CSR - Chorley & South Ribble
GP - Greater Preston
WL- West Lancashire
FW - Fylde & Wyre
MB - Morecambe Bay

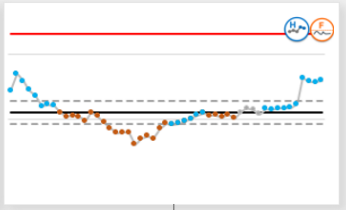
18-Week wait referral to treatment, %

2026/27 the NHS interim operational target for Referral to Treatment (RTT) expects **70%** of patients to begin consultant-led elective treatment within 18 weeks of referral by Mar-27.

L&SC ICB Jun-26

Actual: 65.91%
Plan: 66.58%

Jun-26	NW.	Eng.		BTH	ELHT	LTHT	UHMB	
Actual:	64.81%	65.83%		59.16%	71.99%	58.71%	70.73%	
Plan:				62.61%	65.25%	59.10%	72.14%	
Sub-ICB:	BwD	BLK	EL	CSR	GP	WL	FW	MB
	70.65%	59.41%	69.69%	65.14%	65.08%	67.50%	60.61%	68.36%



Actual :- latest data reported for the indicator
Plan :- forecast submitted as part of the NHS Medium Term Plan (MTP) for the month for that indicator.

This is the **SPC chart** for the actual data for the indicator. The red line is the target. The left of the 2 circles shows the special cause variation for the indicator (in this instance that shows improving variation). The right circle shows Assurance (in this instance the indicator is consistently failing target). For more info, see following slide.

Statistical Process Control Charts – Notes

Within this report there are a number of Statistical Process Control (SPC) charts used to visualise reported metrics.
Below is a 'Key' to the KPI Variation and Assurance icons:-

Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Special Cause Concern: This indicates that special cause variation is occurring in a metric, with the variation being in an adverse direction**. Low (L)** special cause concern indicates that variation is downward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance. **High (H)** is where the variance is upwards for a metric that requires performance to be below a target or threshold e.g. Pressure Ulcers or Falls.

Special Cause Concern: This indicates that special cause variation is occurring in a metric, with the variation being in a favourable direction**. Low (L)** special cause concern indicates that variation is upward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance. **High (H)** is where the variance is downwards for a metric that requires performance to be below a target or threshold e.g. Pressure Ulcers or Falls.

Targets:
Within the SPC tools the 'TARGET' has been set either to the March 2027 ambition based on the 2026-27 operational planning submission (where this metric was required to be submitted) or the national constitutional target / expectation.

Escalation Rules:
1. There is special cause variation of concern
2. Where there are targets and these are not consistently being met or there is a change in assurance rating

Charts Key:

- Upper / Lower process limits
- Mean
- Target

ELECTIVE / PLANNED CARE

Data Source: NHSE RTT Statistics, https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/

EC001: 18-Week wait referral to treatment, %

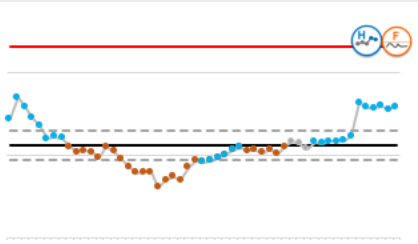
2026/27 the NHS interim operational target for Referral to Treatment (RTT) expects **70%** of patients to begin consultant-led elective treatment within 18 weeks of referral by Mar-27.

L&SC ICB Aug-26

Actual: 65.79%
Plan: 67.42%

Aug-26	NW.	Eng.		BTH	ELHT	LTHT	UHMB	
Actual:	64.67%	65.21%		58.63%	72.10%	59.99%	68.51%	
Plan:				63.29%	66.65%	62.00%	74.05%	

Sub-ICB:	BwD	BLK	EL	CSR	GP	WL	FW	MB
	71.63%	59.00%	69.72%	65.73%	65.43%	66.47%	61.87%	66.82%



EC002: Total waiting over 52 weeks, %

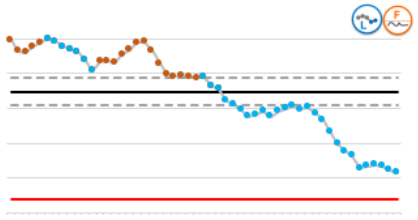
Reduce the proportion of people waiting over 52 weeks for treatment. The ICB current year target is to achieve 0.38% by March 2027.

L&SC ICB Aug-26

Actual: 1.16%
Plan: 0.97%

Aug-26	NW.	Eng.		BTH	ELHT	LTHT	UHMB	
Actual:	1.35%	1.54%		2.70%	0.37%	0.58%	1.60%	
Plan:				0.24%	0.86%	1.48%	1.50%	

Sub-ICB:	BwD	BLK	EL	CSR	GP	WL	FW	MB
	0.44%	2.25%	0.53%	0.64%	0.49%	1.20%	1.74%	1.69%



EC003: Total Incomplete RTT Pathways

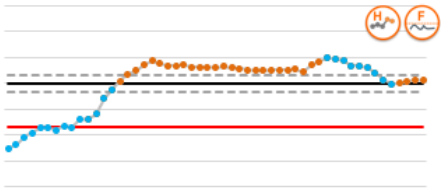
The total number of incomplete Referral to Treatment (RTT) pathway where patients are still waiting to start treatment at the end of the reporting period.

L&SC ICB Aug-26

Actual: 231,851
Plan: 227,873

Aug-26	NW.	Eng.		BTH	ELHT	LTHT	UHMB	
Actual:	974,369	7,147,562		41,103	46,339	62,308	36,391	
Plan:				35,658	46,688	63,459	34,011	

Sub-ICB:	BwD	BLK	EL	CSR	GP	WL	FW	MB
	18,634	32,440	42,148	25,179	29,085	16,987	24,867	42,511



Timeframe: 2022 to 2026

ELECTIVE / PLANNED CARE

Data Source: NHSE RTT Statistics, https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/

EC004: Clock starts, new RTT periods

The clock starts on the exact date the hospital or trust receives the referral from a GP or other authorised healthcare professional.

L&SC ICB Aug-26

Actual: 55,832
Plan: 54,853

Aug-26	NW.	Eng.		BTH	ELHT	LTHT	UHMB	
Actual:				8,064	13,227	12,034	9,233	
Plan:				8,050	12,978	11,582	7,783	
Sub-ICB:	BwD	BLK	EL	CSR	GP	WL	FW	MB
	5,939	6,790	13,172	6,569	8,416	4,752	5,611	12,276



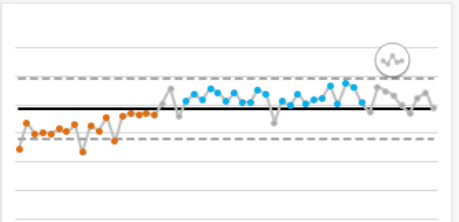
EC005: Clock stops, completed pathways for admitted patients

An RTT clock stop (admitted) refers to the exact moment a patient's waiting time record ends because they have been admitted to a hospital as an inpatient or day case to start their first definitive treatment.

L&SC ICB Aug-26

Actual: 9,728
Plan: 10,191

Aug-26	NW.	Eng.		BTH	ELHT	LTHT	UHMB	
Actual:				1,251	2,146	1,904	1,173	
Plan:				1,323	2,023	2,242	1,045	
Sub-ICB:	BwD	BLK	EL	CSR	GP	WL	FW	MB
	954	1,202	2,120	1,084	1,022	653	1,065	1,628



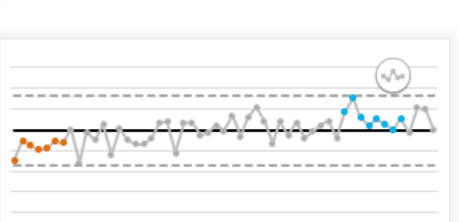
EC006: Clock stops, completed pathways for non-admitted patients

A non-admitted RTT clock stop occurs when a patient's Referral to Treatment (RTT) waiting time clock stops for care that does not involve a hospital admission as an inpatient or day case.

L&SC ICB Aug-26

Actual: 34,810
Plan: 36,511

Aug-26	NW.	Eng.		BTH	ELHT	LTHT	UHMB	
Actual:				4,737	8,064	6,467	5,930	
Plan:				4,362	8,763	6,910	6,486	
Sub-ICB:	BwD	BLK	EL	CSR	GP	WL	FW	MB
	3,109	3,599	5,271	4,065	5,271	2,572	3,432	7,612



ELECTIVE / PLANNED CARE

Data Source: North West System EROC Dashboard - North West Outpatient Transformation Programme - Futures

EC007: Pre-Referral Specialist Advice

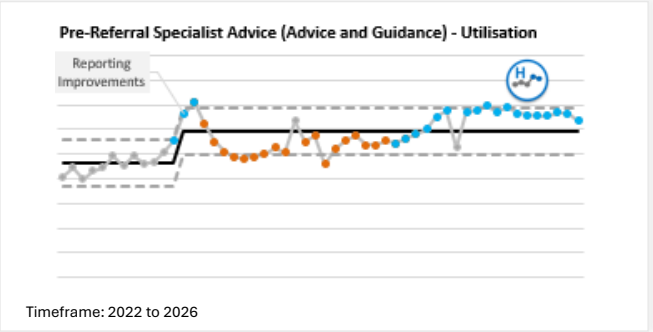
A&G provides primary care with continued access to specialist clinical **advice**, enabling a patient's care to be managed in the most appropriate setting

L&SC ICB Jul-26

Utilisation: 7.3

Diversion: 34.1%

Jul-26	NW.	Eng.		BTH	ELHT	LTHT	UHMB
Utilisation:	6.4	10.1		7.3	6.5	8.6	7.4
Diversion:	39.6%	39.4%		27.7%	19.6%	25.8%	44.7%



Timeframe: 2022 to 2026



Timeframe: 2022 to 2026

ELECTIVE / PLANNED CARE

Commentary:

18-Week wait referral to treatment (RTT)
The August 2026 RTT data reports that at ICB level we running below our planning trajectory : August Actual = 65.79% / Plan = 67.42%. The ICB is still aiming to deliver its18-week performance target of 73.13% by the end of March 2027.

There is specialty level variation underneath this with Neurology, Oral Surgery and Cardiothoracic Surgery all reporting <=55% of patients waiting under 18 weeks. At Provider level, East Lancashire Hospitals is reporting the strongest performance against this metric. The remaining three 3 acute providers are all currently below their 2627 planning trajectory. There is a national focus on recovering elective 18 week performance back to planned levels from December 2026 onwards as part of their 'H2 recovery' programme. Regional projections currently indicate that providers are intending to move to delivering their March 2027 position with 2 of our 4 LSC providers aiming to recover back to their original plan from December.

Total waiting over 52 weeks
The August 2026 RTT data reports that at ICB level we are currently off track with our planning trajectory that aims to deliver 52+ week performance of 0.38% by the end of March 2027. Gynaecology (669 patients) and Trauma & Orthopaedics (442 patients) have the highest number of patients currently waiting in excess of 52 weeks. The significant reductions in long waiters during 2025-26 appears to have stalled over the past couple of months. Of the 2,694 x 52+ week waiters at ICB level at the end of August 2026, 1097 (40.7%) patients were waiting at Blackpool Teaching Hospital while 523 patients (19.4%) were waiting at IS providers or at NHS providers outside of the LSC area.

Clock Starts and Stops
Clock starts are running above planned levels for the ICB both in month and in the year to date and there has been no significant reduction in demand presenting into Acute systems. Providers have been aiming to keep up with the demand through increased clock stops to support improving performance and reducing waiting lists. However, this is a dynamic relationship and variation in patterns and trends occurs between specialties and providers.

Pre-Referral Specialist Advice [Advice & Guidance (A&G)]
There was no requirement to submit a trajectory for Specialist Advice within the 2026-27 operational planning round. Pre-referral specialist advice utilisation has remained relatively consistent since April 2025 while the actual volume of diverted requests has also remained at elevated levels. There is variation by specialty and provider across these metrics. The ICB has a significant proportion of specialist advice that takes place post-referral which has a contribution to the overall system diversion activity.

Actions:

Referral to treatment (RTT)
There are a number of programmes of work being progressed which aim to improve pathways in key priority areas which should help manage demand and support the organisational 'shift left'. Specific schemes include - aiming to increase utilisation for A&G requests, move to more alignment with the national strategies and plans relating to the e-RS system [electronic Referral Service] and clinical triage opportunities through Single Points of Access (SPOA).

Tier 2 developments for 2026/27 with a Gynaecology Tier 2 community service procurement is underway (to be mobilised by Q4) and Ophthalmology Care Navigation Hub commenced in June 2026 which is yielding positive results in terms of deflections and market share shifts. Further work on Headache Pathway will take place in-year directly impacting Neurology demand.

As part of the Outpatient Transformation programme, the PBC are working on a range of efficiency and productivity metrics (DNAs; Cancellations; Theatre utilisation; PIFU) and to manage patients in communities where possible. In addition, the primary care Local Enhanced Service (LES) scheme for 2026-27 is also intended to support reductions in acute activity.

System wide forums , such as the Referral optimisation and Demand Management Group, are supporting the progression of elective referral demand management schemes and the delivery of the national single point of access programme.

Advice & Guidance (A&G)
There are plans to increase utilisation rates for pre-referral specialist advice (A&G) to support addressing waiting list challenges. There is a requirement to implement Single Point of Access (SPOA) across targeted specialties by October 2026, and this has been implemented on a phased approach. Work is ongoing with NHSE on the developments with e-RS and the implications of this in terms of impact on A&G and the transition from locally commissioned bespoke A&G digital platform service. Move to e-RS A&G system has been delayed due to complications with national service developments. Our local system to continue with current 3rd party system for A&G.

Metric	Patient Safety and Experience
Glaucoma (ELHT)	A comprehensive clinical harm review of the Trust's glaucoma waiting list identified significant patient harm associated with delays in receiving definitive glaucoma surgery. For several patients, delayed intervention resulted in progression of glaucoma and irreversible visual field loss, with some patients left with advanced visual impairment despite subsequent treatment. All affected patients have now undergone clinical review, Duty of Candour has been completed, and most have received surgical intervention resulting in improved intraocular pressure control. Further assurance is provided through improved capacity and waiting-list management, with no significant outpatient or material follow-up backlog reported, the surgical backlog forecast to clear in early November, and alternative provision through CHEC available during the temporary referral closure. Continued ICB oversight remains appropriate while surgical recovery, consultant recruitment and safe reopening to new referrals are completed.
Gastroenterology (BTH)	The total backlog has reduced and stands at 3,984 letters with the oldest dating back to May 2026. The Trust has received 8x complaints relating to backlog and there have been 11x incidents (7x no harm and 4x low harm).
Harm Reviews (BTH)	Current assurance regarding elective waiting list harm remains limited, the Trust's July 2026 report did not sufficiently triangulate harm review findings with incident reporting, patient safety processes and organisational learning, and harm reviews continue to be undertaken at pathway closure for waits over 65 weeks rather than over 52 weeks as set out in the standard operating procedure, due to the volume of patients waiting. A decision on moving to a 10% sample of waits over 52 weeks has been deferred pending a more comprehensive report, while the Trust-wide actions arising from the May 2026 urogynaecology review remain outstanding.

2025 NHS Adult Inpatient Survey: Acute Provider Performance Overview

Inpatient experience varies across the acute footprint. University Hospitals of Morecambe Bay NHS Foundation Trust is the strongest performer; Lancashire Teaching Hospitals NHS Foundation Trust is the principal system concern, with positive experience falling from 81% to 76% against an 83% national baseline.

Provider	Standing	Strength	Priority risk
University Hospitals Morecambe Bay	**Better than most trusts** 26th of 64 peers	Virtual ward integration; personal care; mental health and religious needs	Sustaining workforce capacity as acute complexity rises
Blackpool Teaching Hospitals	**About the same** as national average	Respect, dignity and frontline interactions	Admission bottlenecks and emergency-to-ward delays
East Lancashire Hospitals	**About the same** as national average	Stable inpatient experience and elective recovery pathways	Family involvement and post-discharge communication
Lancashire Teaching Hospitals	**Worse than average** 76% positive	Staff kindness and compassion remain high at 96–97%	Declining overall experience and delayed treatment-plan communication

System position: Patient feedback remains positive on dignity, respect and staff kindness (96–99%); the main performance gaps relate to flow, discharge management, family involvement and communication.

Key performance messages	Assurance and corrective action
• Discharge and post-discharge support are the main cross-system drivers of poorer experience. • Variation appears operational rather than cultural, with consistently strong staff kindness scores.	• Scale UHMBT virtual ward communication and self-administration practice through provider collaboration. • Strengthen family-inclusive discharge checks and acute-to-community transition assurance. • Maintain focused recovery oversight at Lancashire Teaching Hospitals, supported by real-time ward feedback.

COMMUNITY

Data Source: https://future.nhs.uk/system/login?nextURL=%2Fconnect%2Eti%2FCommunityHealthServices%2Fview%3FobjectId%3D202353573

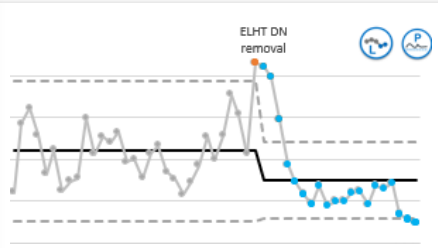
CO001: Number of adults waiting over 52 weeks on community waiting lists

The NHS Medium Term Plan (MTP) has set a target of zero 52 weeks waiters by the end of the financial year 2026-27.

L&SC ICB Aug-26

Actual: 24
Plan: 44

Aug-26	NW.	Eng.	BTH	ELHT	LCFT	UHMB
Actual:	294	5,892	24	0	0	0



Timeframe: 2022 to 2026

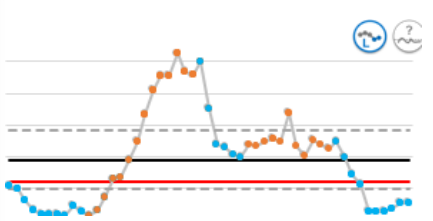
CO002: Number of children waiting over 52 weeks on community waiting lists

The NHS Medium Term Plan (MTP) has set a target of zero 52 weeks waiters by the end of the financial year 2026-27.

L&SC ICB Aug-26

Actual: 51
Plan: 40

Aug-26	NW.	Eng.	BTH	ELHT	LCFT	UHMB
Actual:	7,280	84,048	48	3	0	0


Timeframe: 2022 to 2026

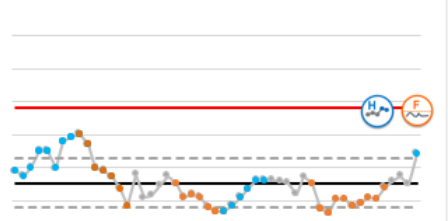
CO003: 18 weeks performance - children

The ICB recognises that meeting the 78% performance target looks challenged at this stage. As part of the NHS medium term plan, the ICB submitted a realistic plan, which was accepted, setting a year end performance for 2026-27 at 66.5%.

L&SC ICB Aug-26

Actual: 64.32%
Plan: 54.73%

Aug-26	NW.	Eng.	BTH	ELHT	LSCFT	UHMB
Actual:	58.92%	46.85%	47.22%	75.92%	no data	93.25%


Timeframe: 2022 to 2026

COMMUNITY

Commentary:

CYP 18 weeks performance and over 52 weeks waits

- The number of 52 weeks waits for CYP community services has remained at 51 in August, significantly above plan. Most of these waits (48) are at Blackpool Teaching Hospitals for Speech & Language Therapy (36) and the community paediatric service (8). The other 52 weeks waits are at East Lancashire Hospitals (3) for the community paediatric service. The number of 52 weeks waits in Aug is currently above plan.
- The 18 weeks performance for CYP has improved in the month to 64.32% from 54.87% in the previous month mainly due an increase in the reporting of services in East Lancashire Hospitals which more accurately reflects the services they deliver. The performance is significantly above plan (40).
- This data excludes services for Lancashire and South Cumbria Foundation Trust, who have not reported against their Children's community services since November 2025.

Adult over 52 weeks waits

- The number of Adult over 52-week waits continue to fall in August 26 to 24 from 28 in the previous month. All the 52 weeks waiters are in Blackpool Teaching Hospitals, the majority of those in MSK (17) and continence services (5).

- There continues to be one patient who has been reported as waiting over 104 weeks in BTH for Neurorehabilitation services.

- There has been a significant increase in the waiting list for Adult community services in LSCICB. This is due to ELHT expanding reporting through the CHS sitrep for all applicable services.

Actions:

CYP over 52 weeks waits

- Providers are submitting monthly waiting times and recovery plans which is demonstrating a reduction in those CYP waiting over 52-weeks. Assurance has been sought on the communication, signposting and waiting well information through the vulnerable services meetings. These will now be done through the Contract and Commissioning Assurance meetings.
- Harm reviews have been requested on all long waits, with no harms identified to date.
- The vulnerable services meetings for all providers has significantly reduced the number of 52 weeks waits for children's community services and have now brought them back in plan. These meetings are being stepped down, and management of the waits will continue through the Contract and Commissioning Assurance meetings with the providers.
- Work is continuing with LTHT to ensure they are reporting their long waits through the appropriate reporting mechanisms.
- Work continues with NCIC through their community contract meeting to manage the long waiters.
- The ICB has raised concern over no data reported for CYP service through the contract meeting. LSCFT have provided activity data for these services but have yet to provide waiting list data.

Adult over 52 weeks waits

- The long waits position and recovery continue to be worked through the community operational meetings with providers.
- The Head of Performance and Assurance presents and discusses performance with operational leads for the providers at the monthly provider collaborative meeting.
- UHMB have an action plan for the recovery of Speech and Language Therapy Services which has been shared with the ICB through the operational group meeting. There are now no 52 weeks waits for this service.
- The community performance lead has met with BTH regarding the long waits across their services. BTH are checking the accuracy of the reporting for these services, particularly a 104 weeks wait for Neurorehabilitation and continuing with their action plans for the recovery of the long waiters' position.

CHILDREN, YOUNG PEOPLE and MATERNITY

Data Source: https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/wlmds/

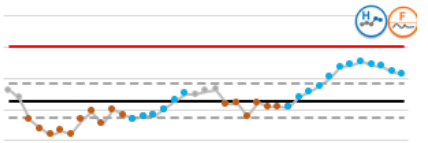
CYP001: WLMDS – RTT 18 weeks performance (under 18)

2026/27 the NHS interim operational target for Referral to Treatment (RTT) expects **70%** of patients to begin consultant-led elective treatment within 18 weeks of referral by Mar-27.

L&SC ICB Sep-26

Actual: 60.6%
Plan: 70.0%

Sep-26	4 Main Providers		BTH	ELHT	LTHT	UHMB
Actual:	60.84%		56.60%	68.95%	53.40%	68.54%



Timeframe: 2023 to 2026

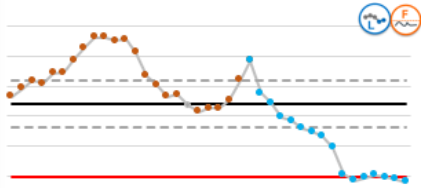
CYP002: 52+ Weeks RTT % performance

The NHS Medium Term Plan (MTP) has set a target of zero 52 weeks waiters by the end of the financial year 2026-27.

L&SC ICB Sep-26

Actual: 0.8%
Plan: <1.0%

Sep-26	4 Main Providers		BTH	ELHT	LTHT	UHMB
Actual:	0.67%		0.91%	0.13%	0.39%	1.68%



Timeframe: 2023 to 2026

Commentary:

18 weeks Performance

- The 18 weeks performance for under 18s continues to be static across the 4 main providers.
- UHMB and ELHT have relatively strong performance with particular improvement seen at ELHT in the last 12 months. ELHT is the only provider meeting their plan for 18 weeks performance.

52 weeks RTT Performance

- The ICB is meeting this target in Sept 26 for under 18s both across the 4 main providers and as a commissioner.
- There is only UHMB not meeting the target in Sept 26. The 1.68% figure represents 57 children, the majority waiting in Paediatric Trauma and Orthopaedics , ENT and Oral and Maxillofacial Surgery.

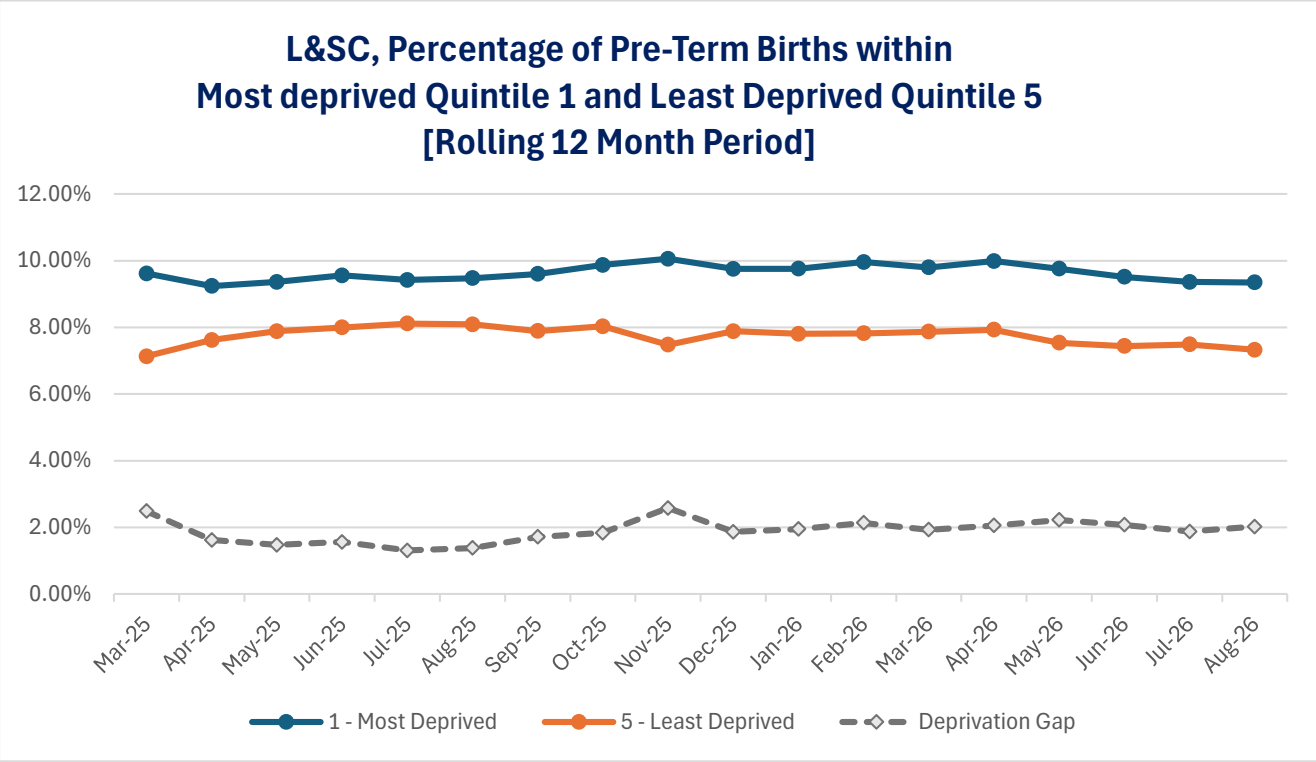
Actions:

- In line with the Medium-term planning framework the CYP quality team have drafted metrics for schedule 4 and 6 to be included in the 26/27 contract. This is so their dedicated oversight on CYP waits and the clear expectation on the review process to take place for any child waiting over 52 weeks.
- The ICB continues to work with the provider collaborative to understand the reasons and solutions for 18 weeks performance being under plan.
- Performance issues are raised through the Contract and Commissioning Assurance Meetings with the providers.
- The quality lead is looking for assurance that no harms have come to these children due to their long waits.

Metric	Patient Safety and Experience
Children & Young People- ASD/ADHD Pathway	Q2 review of complaints includes a total of 13 , with 9 (69%) relating to ASD/ADHD pathway waits and 'right to choose. The ICB in August published a co-produced position statement and FAQs for Right to Choose (RTC) and private autism and ADHD assessments. This has been uploaded on to the ICB Intranet page and shared with all providers in the system including GP's and carer and parent forums. The NEU Way support service that went live in July 2026 across 5 hubs covering Lancashire & South Cumbria has provided early feedback and reporting for the first 2- months. A total of 416 referral received. The top 3 reasons for accessing the service related to support for Autism, issues faced with education including EHCP's and advice and guidance on emotional dysregulation. 100% of parents strongly agreed that they felt listened to and they are clear on their next steps. With a 100% strongly agreeing that they were satisfied with the service. The Service continues to be promoted via system partners and healthcare professionals and local authorities.
Auditory Processing Disorder (APD)	15% (2) of complaints in Q2 were associated with the APD pathway. In Lancashire & South Cumbria there is only one provider who is commissioned to deliver this service. Due to the levels of demand and the current waits, the service in January 2026 closed to new referrals, this was communicated to system partners. An updated position statement has been drafted by the ICB and the provider, with input from parent & carers forum. The plan is for this to be shared with the local communities and system partners.
Paediatric Services Hearing Improvement Program	Potential harm identified through the review and recall process, and the Paediatric Child Hearing Improvement Audit (PCHI), triggers a formal case review. Cases follow the agreed governance route, including regional harm review panel and national moderation. Reviews consider and grade harm using the national framework from low to severe. Providers are notified when a harm has been identified, enabling its internal Duty of Candour and Governance processes to be followed. The ICB continues to track the number and status of cases, including harm gradings and progress through to moderation.

Inequalities in maternity

The number of pre-term births fluctuates on a monthly basis and as such a longer term rolling 12 month period has been used (for example the March 2025 position relates to all births and pre-term births reported from April 2024 to March 2025 inclusive). A higher percentage of pre-term births occur in the most deprived quintile though the trends do suggest some evidence of a reduction in the proportion of pre-term births in both the most and least deprived groups (comparing the 12 months to August 2026 against the 12 months to August 2025). The deprivation gap has remained relatively consistent over the past 9 months at around 2 percentage points (1.87pp – 2.22pp). However, the gap has widened from the August 2025 position (1.38 pp) to August 2026 (2.02 pp).



DIAGNOSTICS

Data Source: https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/

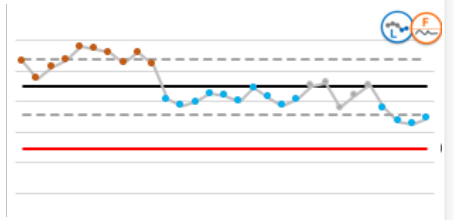
D001: Percentage of Patients that receive a diagnostic test within 6 weeks

The monthly diagnostics waiting times and activity return collects data on waiting times and activity for 15 key diagnostic tests and procedures. The ICB current aim is 99% by 2028/29

L&SC ICB Aug-26

Actual: 82.8%
Plan: 83.1%

Aug-26	NW.	Eng.		BTH	ELHT	LTHT	UHMB	
Actual:	85.1%	75.3%		69.0%	96.3%	75.5%	88.2%	
Plan:				73.9%	98.0%	72.5%	97.0%	
Sub-ICB:	BwD	BLK	EL	CSR	GP	WL	FW	MB
	94.9%	70.8%	94.8%	80.0%	71.8%	76.7%	72.8%	86.9%



Timeframe: 2022 to 2026

Commentary:

Percentage of Patients that receive a diagnostic test within 6 weeks
The national ambition is for 99% of patients to receive their diagnostic test within 6 weeks by March 2029. The latest data for August 2026 reports that the ICB marginally below our medium-term planning submission.

Although ELHT and UHMB are not at planned trajectory levels, they are performing above regional and national averages. LTHT is running above plan while BTH is also not performing in line with its planning trajectory. Community diagnostic centre (CDC) activity was at 99.9% against plan in August 2026.

Total waiting list size continues to reduce month-on-month, since the start of the financial year.

Percentage waiting 6+ weeks increased in August, but the YTD trend continues to improve.

Activity fell in month; however, +3,172 more test were delivered in 2026, compared to August 2025.

Actions:

Diagnostic Collaborative Support
- NOUS modality leads group established to support with local/system issues. Review of NOUS recovery guidance -10 high impact actions.
- Demand Optimisation – Right Test, Right Time Campaign.
- Productivity Improvements – DNA reduction, throughput and utilisation projects in progress.
- Operational Planning – Development of bespoke tools to support planning submissions. Attending system planning meetings and offering support to service managers.

Blackpool Teaching Hospital - Non-Obstetric Ultrasound (NOUS) / Sleep Studies
- NOUS Activity levels remain consistent. Good utilisation of CDCs. Ongoing engagement with ISP for provision of sonographers.
- Sleep Studies: Increased demand on service. Activity increasing and achieving well above plan. CDCYTD 92% against plan

University Hospitals Morecambe Bay – Neurophysiology / Cystoscopy
- Recovery actions submitted to NSHE w/c 5 October 2026.

East Lancashire Hospitals – Urodynamics
- Operational variation due to high volumes of annual leave. Data comparative with August 2025 and will keep under review.

Lancashire Teaching Hospitals – Neurophysiology / Cystoscopy
- Neurophysiology activity increasing and exceeding operational plan. Waiting list and 6ww position better than planned and will continue to monitor long waits.
- Activity comparative with August 2025. Activity has fluctuated across the year. Waiting list and 6ww position better than planned and will continue to monitor long waits.

DIAGNOSTICS

Metric	Patient Safety and Experience
Pathology	Pathology disruption at East Lancashire Hospitals Trust due to industrial action is ongoing, with primary care operating at approximately half of usual activity. Although no significant harm has been formally reported, this cannot be taken as assurance because impacts may emerge over time across multiple pathways. A Quality Impact Assessment, executive briefing and corporate risk assessment have been completed, and recovery planning is under development. Histopathology does remain a network-wide quality and operational risk. Providers continue to face workforce pressures, backlogs, difficulty meeting national turnaround standards and concerns about accreditation and reporting consistency. Urgent and cases are being prioritised, but recovery remains dependent on delivery of the network improvement plans. Work to look at samples that are downgraded, variance across providers, network are working on standards. At this point, the ICB have agreed that a rapid quality review is not appropriate and that the service should have time to work through the complexities of multiple service alignment.
UKAS Accreditation - Histopathology Service (UHMBT-RLI)	Recovery actions remain in progress following the temporary suspension of UKAS accreditation within the RLI Histopathology Service. An Incident Management Team with NHS England oversight continues to monitor recovery, with actions including laboratory automation, outsourcing, mutual aid support, recruitment to consultant vacancies and strengthened governance processes. Assurance has been provided that the suspension relates to process compliance and capacity pressures rather than diagnostic accuracy, with urgent and cases continuing to be prioritised through established escalation arrangements. Backlog reduction remains on track and progress towards regaining UKAS accreditation continues to be closely monitored through enhanced governance and performance oversight.

CANCER

Data Source: Network Contract DES (MI) - NHS England Digital

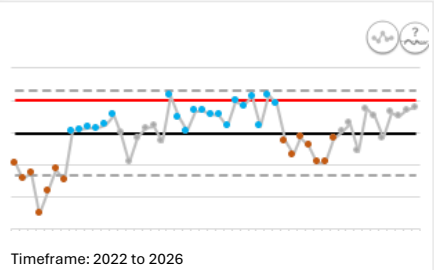
CA001: Faster diagnosis standard, FDS

The NHS Operational Plan has set a target of 80% of patients to be diagnosed or have ruled out within 28 days of being referred urgently by their GP for suspected .

L&SC ICB Aug-26

Actual: 78.88%
Plan: 78.64%

Aug-26	NW.	Eng.		BTH	ELHT	LTHT	UHMB	
Actual:	76.89%	78.60%		72.36%	85.16%	81.85%	79.19%	
Plan:				79.00%	80.00%	80.00%	78.60%	
Sub-ICB:	BwD	BLK	EL	CSR	GP	WL	FW	MB
	82.80%	72.72%	84.64%	80.80%	81.14%	66.71%	76.08%	79.45%



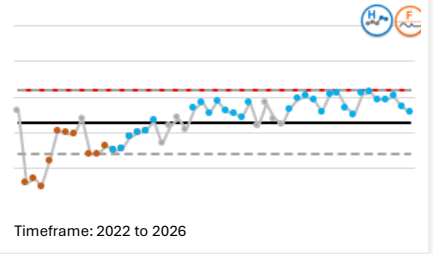
CA002: 31-day first treatment, 94% standard

Requirement that a patient starts their first or subsequent treatment within 31 days of a formal "decision to treat“.

L&SC ICB Aug-26

Actual: 92.83%
Plan: 94.57%

Aug-26	NW.	Eng.		BTH	ELHT	LTHT	UHMB	
Actual:	96.02%	92.10%		96.20%	99.27%	86.05%	98.23%	
Plan:				94.88%	94.20%	94.09%	94.50%	
Sub-ICB:	BwD	BLK	EL	CSR	GP	WL	FW	MB
	95.33%	93.48%	95.31%	89.13%	92.20%	92.64%	90.38%	92.76%



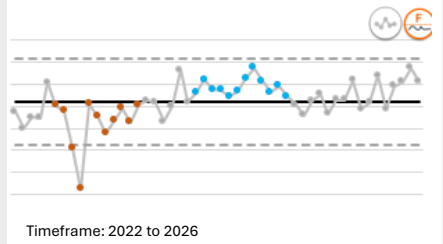
CA003: 62-day referral to treatment, 80% standard

Requirement that patients should start their first definitive treatment within 62 days (roughly two months) of an urgent suspected referral, an urgent screening referral, or a consultant upgrade.

L&SC ICB Aug-26

Actual: 70.53%
Plan: 76.91%

Aug-26	NW.	Eng.		BTH	ELHT	LTHT	UHMB	
Actual:	74.88%	71.90%		52.79%	75.36%	73.03%	72.83%	
Plan:				78.18%	75.86%	80.17%	74.26%	
Sub-ICB:	BwD	BLK	EL	CSR	GP	WL	FW	MB
	66.67%	55.17%	76.04%	82.11%	72.45%	73.49%	56.35%	73.12%



CANCER

Commentary:

Faster Diagnosis Standard
The NHS Operational Plan has set a target of 80% of patients to be diagnosed or have cancer ruled out within 28 days of being referred urgently by their GP for suspected cancer. The ICB did not achieve the FDS standard, however Lancashire Teaching Hospitals Trust achieved their plan.
For achievement, L&SC was ranked 18th out of 36 ICBs and 9th out of 20 Cancer Alliances.

31 Day - The "31-day (COMBINED) Decision to Treat to Treatment" standard in England refers to the NHS target that 94% of cancer patients should begin their first definitive treatment within 31 days of a decision to treat. This standard applies to all cancer patients, regardless of how they were referred for treatment. Performance for the ICB in aggregate across the 4 providers was above the standard at 95.2% in June 2026, as was the total ICB position at 95.0%. For achievement, L&SC was ranked 10th out of 36 ICBs and 8th out of 20 Cancer Alliances.

Actions:

Cancer Alliance Support:
- Continued IOTA expansion to improve ovarian cancer diagnostic accuracy and pathway efficiency.
- Adult teledermatology procurement launched for the L&SC-wide SkinHub, image capture and Centralised Virtual Triage model.
- Continued Centralised Virtual Triage, with 100% of teledermatology images triaged through the L&SC service and 59% of patients discharged or redirected from USC pathways.
- Seasonal skin capacity investment to support biopsy, pathology, triage and treatment activity across providers.
- Revised provider improvement plans and enhanced monthly KLOE oversight, supported by pathway milestone and breach analysis
- Continued implementation of revised NG12 gynaecology pathways, HRT USS optimisation and development of standardised referral, triage and step-down processes.
- Bladder pathway analysis completed at ELHT, with actions progressing on TURBT capacity and pathology and radiology turnaround times
- Kidney pathway analysis progressing for BTH and ELHT, with recommendations to inform provider improvement plans in Q3.

Support from the Cancer Alliance includes:
- Oncology pathway improvement work continues to increase treatment capacity and reduce delays.
- Centralised pre-SACT assessment service and ePROMs pilot progressing, with implementation planned during Q3.
- Oncology transformation progressing, including pharmacy approval streamlining, chair utilisation, integrated capacity dashboards and ePROM interoperability.
- Development of a non-surgical oncology hub-and-spoke model progressing, alongside additional oncology clinic capacity requirements.
- Treatment in the Community SACT model remains subject to resolution of national funding arrangements.
- Additional skin treatment capacity introduced, including 50 outsourced surgical slots at BTH and plastics mutual aid from LTHTR.
- Aseptic transformation programme progressing to increase pharmacy capacity and support future SACT demand.

CANCER

Commentary Continued:

62 Day - The "62-day referral to treatment standard" is a key performance target in the UK's National Health Service (NHS) for care. It mandates that patients referred for suspected should begin their first definitive treatment within 62 days of the referral date. Performance has been challenged for some time with none of the Lancashire & South Cumbria providers achieving the target and all remain below plan. Workforce issues and capacity constraints across a several providers is contributing to poorer 62-day performance. For achievement, L&SC was ranked 17th out of 36 ICBs and 10th out of 20 Alliances.

Early-Stage Proportion – All Sites
Lancashire and South Cumbria saw an improved early-stage diagnosis proportion from 53.9% in June 2025 to 56.6% in June 2026 an increase of 2.6% points. Over the same period the national average increased from 58.3% to 59.4% a 0.9%-point improvement. Although we are improving at a faster rate than the national average we remain below the national position.
A key ambition of the national cancer plan is to significantly increase the proportion of cancers diagnosed at Stage 1 and Stage 2 to 75% by 2035. In the context of other Cancer Alliances, Lancashire and South Cumbria is making positive improvement. The actions underway locally are working when we benchmark ourselves across the wider system. The latest figures show that Lancashire and South Cumbria has moved from 20th to 19th out of England's 20 Cancer Alliances for early-stage diagnosis.

Actions:

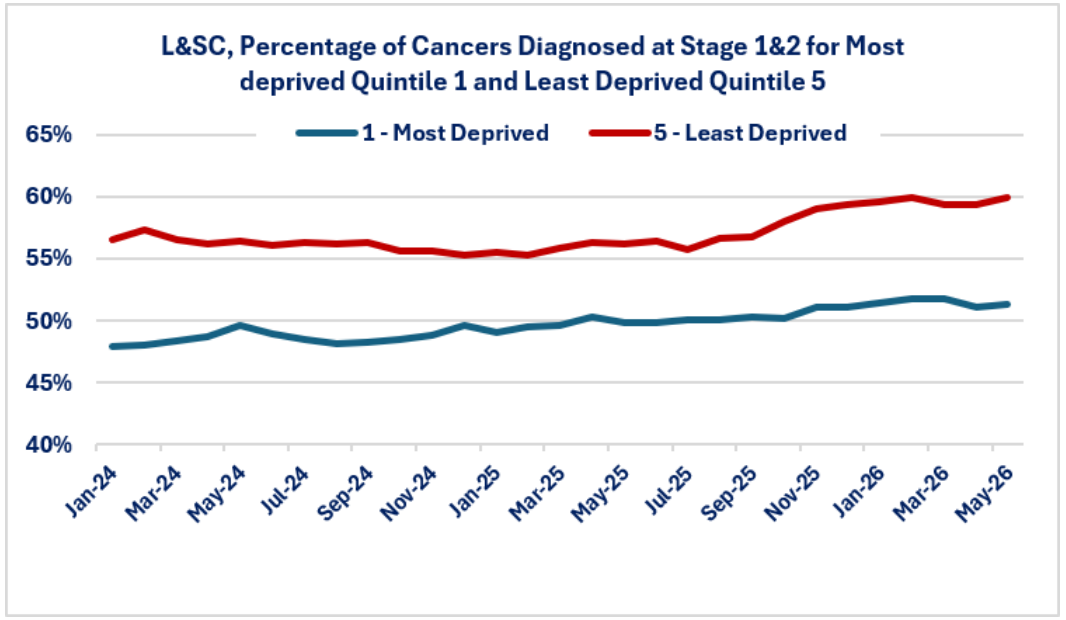
Support from the Alliance includes:

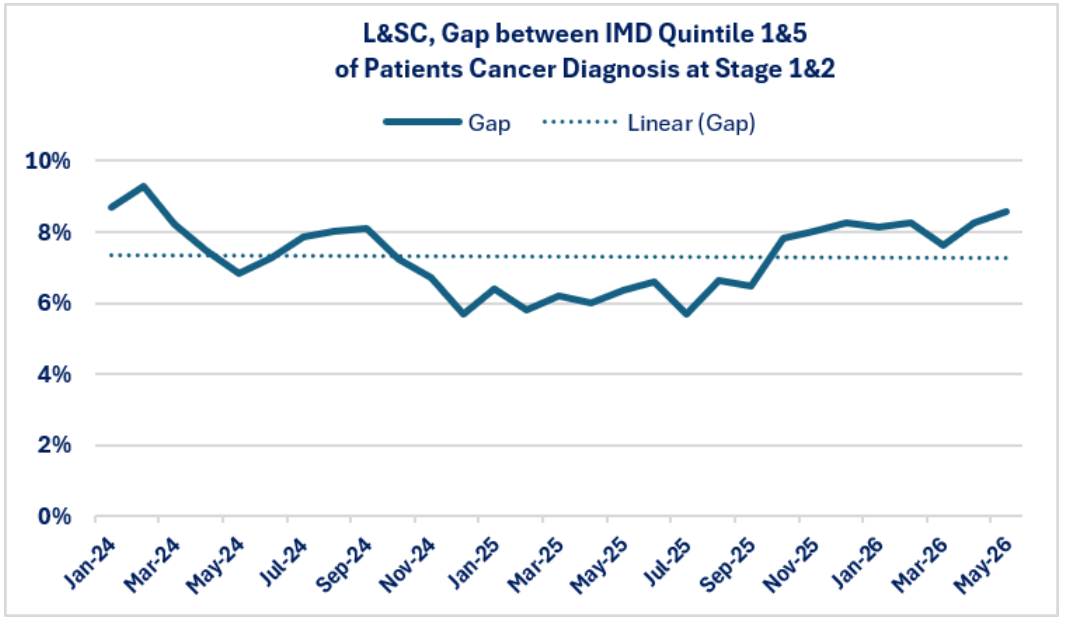
- Improvement work within FDS and 31-day standards continues to support sustained 62-day recovery across pathways.
- MDT optimisation programme progressing following audits, observations and stakeholder interviews across four priority MDTs, with recommendations due in Q3.
- EBUS demand and capacity modelling identified capacity deficits at three providers, with additional capacity implemented at one and further expansion progressing.
- Further tissue sampling capacity work progressing, including CT-guided biopsy and opportunities for shared diagnostic capacity.
- Non-surgical oncology transformation and hub-and-spoke model development progressing to improve treatment capacity and reduce delays.
- Teledermatology, Centralised Virtual Triage and additional seasonal skin capacity continue to support FDS and 62-day performance.
- Bladder and kidney pathway analysis progressing targeted actions on diagnostic, pathology, radiology and treatment delays.
- 12-week rapid improvement programme commenced at BTH, supported by a revised improvement plan and increased focus on delivery and escalation.

CANCER

Inequalities

Whilst early diagnosis is increasing across LSC, it is increasing fastest in the least deprived quintile. Whereas there had been a reduction of the gap between January 2024 and up to summary 2025, the gap has widened since September 2025 to the present. This has been noted and further work is needed to understand what is behind this change.





URGENT and EMERGENCY CARE

Data Source: https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/ae-attendances-and-emergency-admissions-2026-27/, https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/

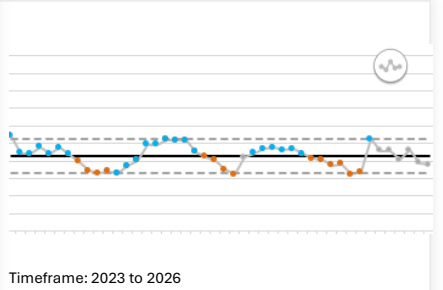
UEC001: A&E 4-hour standard (ALL TYPE)

Four-hour A&E standard requires that at least 95% of patients attending Accident and Emergency are admitted, transferred, or discharged within four hours. Interim operational standards set specific recovery milestones, aim for provider organisations to maintain or improve to 82% by Mar-27.

L&SC ICB Sep-26

Actual: 75.57%
Plan: 82%

Sep-26	NW.	Eng.	BTH	ELHT	LTHT	UHMB
Actual:	71.82%	74.36%	75.98%	75.62%	72.95%	73.46%
Plan:			78.52%	80.65%	74.10%	74.00%



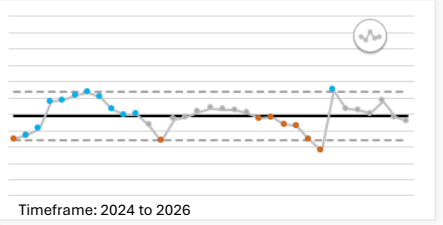
UEC002: A&E 4-hour standard (Type1)

Type 1 ONLY

L&SC ICB Sep-26

Actual: 61.16%
Plan: N/A

Sep-26	NW.	Eng.	BTH	ELHT	LTHT	UHMB
Actual:	57.45%	60.58%	50.57%	62.53%	67.74%	60.25%
Plan:			57.33%	68.34%	69.60%	62.30%



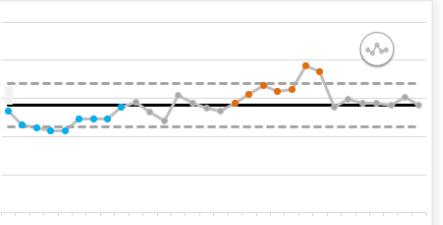
UEC003: % of patients spending more than 12 hours in an emergency department (prov)

The NHS goal for 12-hour A&E waits is to ensure that no patient waits longer than 12 hours from their time of arrival to be admitted, transferred, or discharged.

L&SC ICB Sep-26

Actual: 14.08%
Plan: N/A

Sep-26	NW.	Eng.	BTH	ELHT	LTHT	UHMB
Actual:	13.43%	10.09%	26.32%	14.18%	10.94%	9.74%
Plan:			17.02%	14.29%	14.00%	7.49%



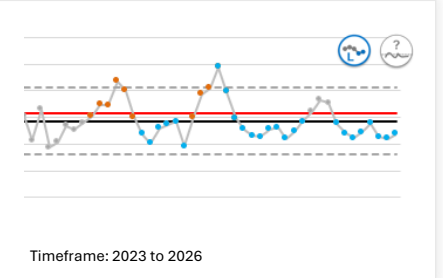
UEC004: Mean ambulance response time – category 2

All ambulance trusts should respond to Category 2 calls in 18 minutes on average. This has been temporarily adjusted to a recovery target of an average of 30 minutes.

L&SC ICB Sep-26

Actual: 00:24:20
Plan: N/A

Sep-26	NW.	Eng.
Actual:	00:24:20	00:31:18



URGENT and EMERGENCY CARE

Data Source: https://future.nhs.uk/system/login?nextURL=%2Fconnect%2Eti%2FNorthWestUECTransformation%2Fview%3FobjectId%3D54564880, https://www.england.nhs.uk/statistics/statistical-work-areas/2-hour-urgent-community-response/, https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/

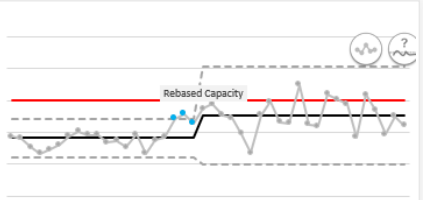
UEC005: Virtual ward occupancy

In line with priorities and operational planning guidance 2025/26, virtual ward utilisation should be consistently above 80%.

L&SC ICB Sep-26

Actual: 64.16%
Plan: 80.16%

Sep-26	NW.	Eng.		BTH	ELHT	LTHT	UHMB
Actual:	67.78%	69.48%		85.92%	72.50%	55.00%	42.47%



Timeframe: 2023 to 2026

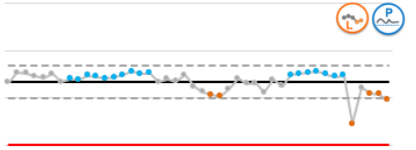
UEC006: 2 Hour urgent community response (UCR) - % in 2 hours

The national target is to assess and begin treatment for people in their homes within 2 hours of a referral, with a national performance standard to reach 70% of appropriate referrals within this timeframe.

L&SC ICB Aug-26

Actual: 89.56%
Plan: 70.0%

Aug-26	NW.	Eng.		BTH	UHMB	LSCFT
Actual:	91%	85%		95%	98%	84%



Timeframe: 2023 to 2026

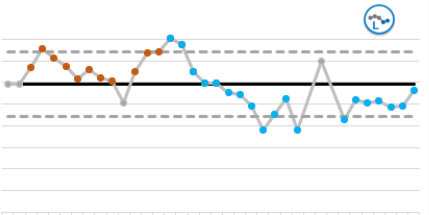
UEC007: Ambulance handover delays over 30 minutes as a proportion of ambulance arrivals

All patient transfers from an ambulance to an emergency department to aim for 15 minutes, with a strict maximum standard of 45 minutes.

L&SC ICB Sep-26

Actual: 28.13%
Plan: N/A

Sep-26	NW.	Eng.		BTH	ELHT	LTHT	UHMB
Actual:	26.93%	26.59%		34.45%	21.89%	30.26%	27.20%



Timeframe: 2023 to 2026

URGENT and EMERGENCY CARE

Commentary:

A&E 4-hour standard
The target for 2026-27 is aimed at provider organisations where every Trust is to maintain or improve to 82% by March 2027. A provider level planning trajectory was submitted targeting delivery of the standard. For the month of September 2026, the ICB aggregate performance deteriorated from the previous month. As a system, Lancashire and South Cumbria was equal 13th best performing ICB during September 2026, outperforming northwest and national averages for All Type performance.

For 'All Type' attendances, 77,635 patients were seen throughout the month, over 2,000 more than the same period in 2025. For 'Type 1' performance, Lancashire and South Cumbria was the 16th best performing ICB during September 2026, outperforming the northwest average. In terms of numbers, over 45,166 Type 1 patients were seen throughout the month, equating to approximately 1,500 per day on average.

Patients spending more than 12 hours in an emergency department
The 12hr target is measured from the point of arrival at the A&E department, unlike the previous 12hr target which was measured from the decision to admit. While the 4hr target focuses on the time to initial assessment and treatment, the 12hr target addresses the overall time a patient spends in the A&E department before being moved to a suitable location.

There is some variation across providers with University Hospitals Morecambe Bay having the lowest level of patients spending over 12 hours in A&E. Trusts have been asked to provider recovery trajectories to get back to plan by December 2026.

Ambulance response time – Category 2
The target refers to the Northwest Ambulance Service (NWAS) response time for ambulance calls which are for serious but non-life-threatening medical emergencies like a stroke or major burns. The standard target is a mean average response time of 18 minutes. This was adjusted to a mean average of 30 minutes in 2023/24 as part of the urgent and emergency care recovery plan. The original 18-minute mean target for Category 2 response times has not been achieved for a significant period both regionally and nationally. Lancashire & South Cumbria performance in September 2026 was 00:22:52, better than the NWAS position of 00:24:20 and significantly better than the national average.

Actions:

UEC Metrics
Local Urgent and Emergency improvement plans were refreshed for 2026/27. Key focus of plans continues to be prevention, admission avoidance, flow and discharge. Further implementation of Care Coordination/Single Point of Access will enable clinical triage and navigate patients to the most appropriate place to receive the care required.

Hear & Treat, See & Treat and See & Convey are well established across L&SC maximising existing services e.g. Hospital@Home, Urgent community response (UCR), Same day emergency care (SDEC).

Integrated Urgent Care (IUC) providers work closely with Trusts to support appropriate management of patients ensuring services are maximised. Where appropriate, the IUC providers in reach during pressured periods.

The is continued on-site GIRFT UEC support at each acute provider to ensure implementation of GIRFT ED Operational standards.

Supporting ELHT and BTH with development of Care Coordination (single point of access for UEC).

Extended opening hours of SCC Dec - Feb to support operational delivery and tracking of winter plan actions.

Demand management review for unscheduled care with a Task and Finish group established to focus on Unscheduled Care Demand management Plan.

Ambulance response time – Category 2
As there is a strong correlation between improvements in hospital handover times and Category 2 ambulance performance then there is a robust focus on ambulance handover across LSC. Establishment of the Strategic Ambulance Improvement group (SAIG) led to the development of local ambulance improvement groups on each hospital footprint bringing together Acute staff, UEC commissioners and NWAS locally. 24-hour Clinical Assessment Services (CAS) are operated by IUC providers 24/7/365 across L&SC supporting NWAS with assessment and treatment where appropriate. All deliver high deflection rates away from ambulance call outs and A&E attendance.

Metric	Patient Safety and Experience
Winter Assurance Quality Visits	The Quality and Safety Team are in the process of planning winter assurance visits, which will take place in Q4 2026/27. The focus of the visits will be on patient safety and will consider corridor care and patient boarding. Key lines of enquiry are being produced for each visit and will include triangulated intelligence from incidents, patient experience and soft intelligence. Where possible this year's visits will be conducted out of hours.
Patient Experience	Across all trusts, patient experience in emergency settings remains mixed. Improvements in patient flow, reduced long waits and targeted frailty pathways are beginning to deliver benefits, however, feedback continues to highlight overcrowding, corridor care, pain management, communication and discharge delays. Providers are responding through pathway redesign, targeted patient experience rounds, senior review of feedback and measures to strengthen patient engagement and feedback collection. Trust specific actions include: **BTH**: Reviewing Emergency Department feedback with senior teams; addressing concerns about pain management, communication and information while waiting; checking SMS feedback mapping; and introducing new posters, QR codes and volunteer-led paper-form collections to increase responses. **ELHT**: Undertaking targeted patient experience rounds within the Emergency Department to gather feedback and identify improvement opportunities in response to concerns about long waits, overcrowding and corridor care. **LTH**: Strengthening urgent and emergency care pathways through the Extended Emergency Medicine Ambulatory Care unit, Medical Decisions Unit, revised pathways for long-waiting patients and continued frailty improvement work. **UHMBT**: Improvement plans are in place to address communication, discharge delays and delays in take-home medication.

MENTAL HEALTH and LEARNING DISABILITIES

Data Source: https://digital.nhs.uk/data-and-information/publications/statistical/primary-care-dementia-data, https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-services-monthly-statistics, https://app.powerbi.com/view?r=eyJrIjoiZDI5NTliNGItNjY3My00Y2MxLWI1YjMtOGYyYWE4ZjZiNjFkIiwidCI6IjM3YzM1NGIyLTg1YjAtNDdmNS1iMjIyLTA3YjQ4ZDc3NGVlMyJ9

MH001: Estimated diagnosis rate for people with dementia

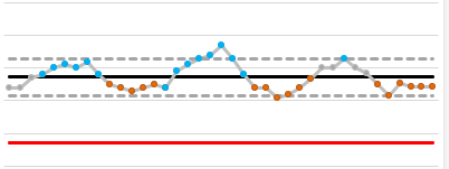
The national dementia diagnosis target in England has aimed for 66.7% of people aged 65+ estimated to be living with dementia to have a formal diagnosis, this metric was removed from the NHS operating planning guidance.

L&SC ICB Jun-26

Actual: 68.4%
Plan: 66.7%

Jun-26	NW.	Eng.
Actual:	70.07%	66.23%

Sub-ICB:	BwD	BLK	EL	CSR	GP	WL	FW	MB
	64.6%	69.7%	65.7%	68.8%	73.3%	66.4%	65.5%	71.4%



Timeframe: 2023 to 2026

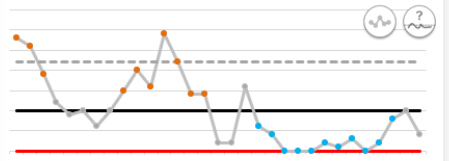
MH002: Inappropriate out of area placements

Adult acute mental health inpatient admissions sent to units outside their local service.

L&SC ICB Aug-26

Actual: 4
Plan: 0

Aug-26	LSCFT
Actual:	4
Plan:	0



Timeframe: 2024 to 2026

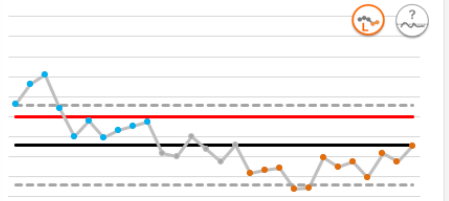
MH003: Talking therapies - % of patients achieving reliable recovery

NHS Talking Therapies is 48% for standard periods, moving up to 51% for the 2026/27 period.

L&SC ICB Jul-26

Actual: 45.1%
Plan: 45.2%

Jul-26	NW.	Eng.	BTH	LSCFT	Lancashire Womens Centre	Village Practice
Actual:	45.9%	46.9%	46.7%	43.8%	58.6%	45.5%



Timeframe: 2024 to 2026

MENTAL HEALTH and LEARNING DISABILITIES

Commentary :

Taking Therapies Reliable Recovery

- The reliable recovery for Talking Therapy at ICB level increased in July 26 to 45.06%, an improvement of 1.43% from the previous month. It is currently only 0.11% under plan, with 3 of the 4 providers meeting their target.
- Blackpool Teaching Hospitals NHS Foundation Trust achieved its July and year-to-date reliable recovery position and is strengthening engagement, readiness-for-therapy communications, therapeutic alliance, treatment review and treatment dose.
- Lancashire and South Cumbria NHS Foundation Trust reported national reliable recovery of 43.68%, compared with 46.8% locally. The Trust is investigating the national and local data discrepancy

Out of Area Placements

- The number of out of area placements has fallen to 4 in August 2026 from 10 in the previous month.

Actions :

Talking Therapies Reliable Recovery

Four LSCFT task-and-finish groups are delivering a service-wide improvement plan across the full patient journey, from referral to discharge. Priorities include appropriate referrals, engagement and early drop-out, treatment delivery and dose, timely step-up, pathway waits, supervision, clinical recording and discharge.

The ICB has agreed SDF Fair Share investment in additional therapist posts, a perinatal clinical lead and a further engagement lead. This will increase capacity to improve treatment dose, engagement, adherence and completion, while supporting reduced pathway waits.

The ICB Reliable Recovery and Improvement Guide, maturity assessment and outcome dashboards will support consistent implementation, targeted improvement and shared learning across providers.

Delivery and impact will be monitored through existing ICB and provider governance, including recovery, treatment completion, drop-out, treatment dose, waiting times, workforce growth and recruitment to the newly funded posts.

Out of Area Placements

LSCFT continues to work through the 5-point recovery plan which has been previously been reported. The Trust is reporting that the plan is ahead of schedule for reducing the number of OAPs and the number of patients clinically ready for discharge.

Metric	Patient Safety and Experience
Absent without leave (AWOL) thematic review	Following a Trust-wide AWOL thematic review, LSCFT has continued to strengthen leave governance, risk assessment and documentation processes. The review identified opportunities to improve pre-leave assessments, AWOL-specific risk management, communication and Section 17 leave recording. A programme of improvement has subsequently been implemented, including mandatory leave-plan reviews, enhanced multidisciplinary oversight and targeted ward-level actions, with learning embedded through wider patient safety and quality improvement arrangements.
Ligature Incidents LSCFT Trust wide	LSCFT continues to report a sustained reduction in ligature incidents, supported by environmental safety improvements including door-top alarms. The Trust maintains oversight of prohibited items, fire-setting risks and other emerging safety concerns through the Early Warning Signs initiative, with ongoing safety reviews informing further improvements to monitoring, assurance and risk management processes.
Fylde Safer Staffing Review (HBTT)	The Fylde Network continues to progress a safer staffing review of Home-Based Treatment Teams (HBTTs) to ensure staffing levels, skill mix and workforce deployment remain aligned to demand, clinical risk and service expectations. Whilst no patient access incidents with harm were reported in August, the Trust continues to report capacity and demand pressures within HBTT services. Wider reviews of urgent care pathways, including the Initial Response Service (IRS), remain ongoing, with findings intended to inform future service development and quality improvement.
Incident at an ICB Commissioned Crisis & Recovery House provided by 'Waythrough' prompting a review of the Crisis houses in L&SC	Following the cessation of Recovery House overnight placements for 16–17-year-olds, the existing Waythrough Outreach Service has been expanded to provide recovery-focused and psychosocial support for this cohort. This operates alongside RAIS, which remains the primary specialist CYP crisis pathway, ensuring young people receive safe, age-appropriate support through a jointly agreed pathway with appropriate safeguarding and clinical oversight.

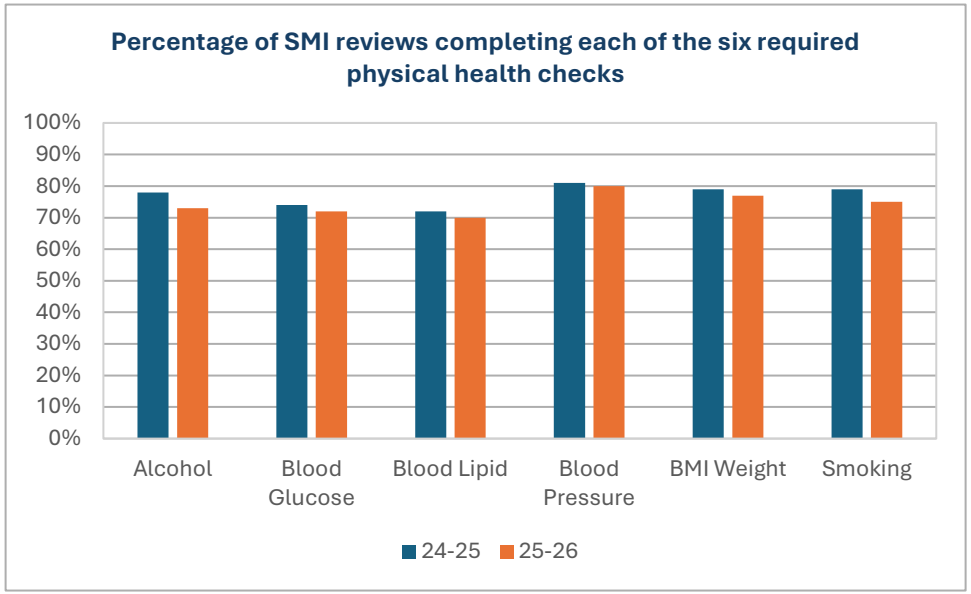
MENTAL HEALTH and LEARNING DISABILITIES

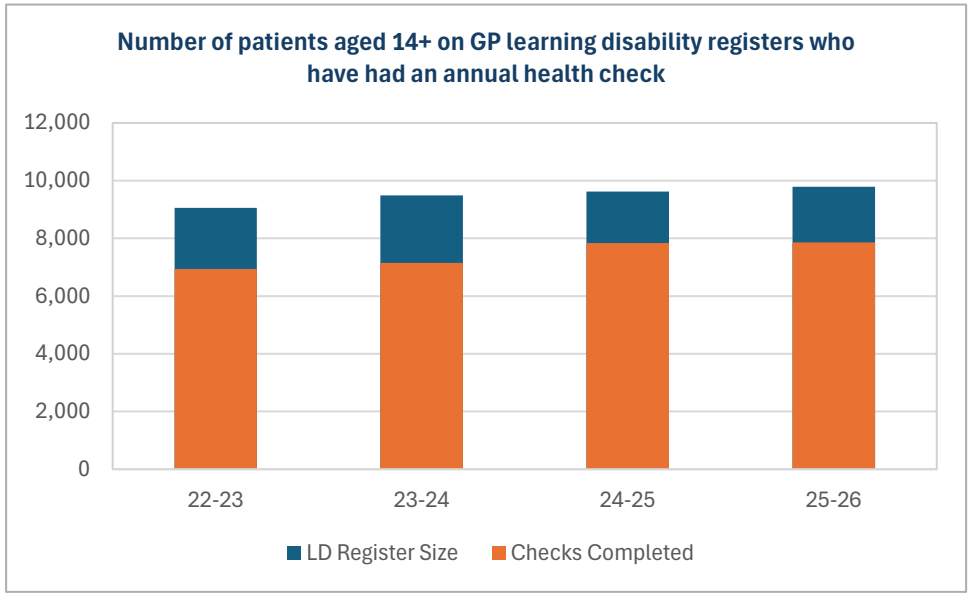
Inequalities

People with SMI have a life expectancy 15–20 years shorter than the general population, largely due to preventable physical illness. People with a learning disability also experience poorer physical and mental health and premature mortality. Annual checks enable health conditions to be identified and managed earlier, ensure treatments and medicines are reviewed, and provide fairer access to preventive care.

The percentage of SMI reviews covering each of the six required physical health checks has fallen between 24/25 and 25/26.
The number of patients aged 14+ on GP learning disability registers has increased each year since 22/23 and the numbers of them have had an annual health check has also increased each year.

The data for Talking Therapies shows that 44% of the patients accessing the service fall under the 3 most deprived groups (by deprivation decile). This proportion is matched by those achieving reliable improvement, but the number achieving reliable recovery is slightly lower at 41%.





PRIMARY CARE

Data Source: Appointments in General Practice - NHS England Digital, General Practice Workforce - NHS England Digital

PC001: No. of general practice appointments per 10,000 weighted patients

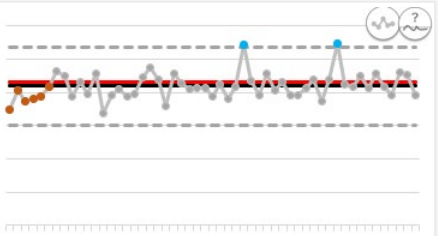
Despite no national target in place local targets have been put in place for numbers of GP appointments per 10,000 weighted population.

L&SC ICB Aug-26

Actual: 3,911
Plan: 4,233

Aug-26	NW.	Eng.
Actual:	3,941.2	4,660.2

Sub-ICB:	BwD	BLK	EL	CSR	GP	WL	FW	MB
	3,565.0	3,132.0	4,020.0	4,129.0	4,251.0	4,373.0	4,294.0	3,780.0



Timeframe: 2022 to 2026

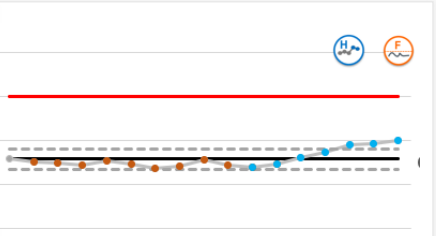
PC002: % Same day consultation appointments

There is a requirement for GP practices to provide same-day consultations for all patients with clinically urgent needs.

L&SC ICB Aug-26

Actual: 79.93%
Plan: 81.06%

Sub-ICB:	BwD	BLK	EL	CSR	GP	WL	FW	MB
	78.10%	81.70%	75.10%	76.30%	83.90%	74.50%	81.80%	83.80%



Timeframe: 2025 to 2026

PC003: Workforce – FTE doctors in General Practice per 10,000 weighted patients

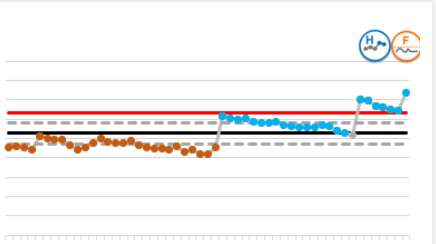
Number of full-time equivalent doctors per 10,000 weighted patients.

L&SC ICB Aug-26

Actual: 5.79
Plan: no plan

Aug-26	NW.	Eng.
Actual:	6.59	6.54

Sub-ICB:	BwD	BLK	EL	CSR	GP	WL	FW	MB
	5.69	4.93	5.41	5.78	7.21	6.06	5.01	6.33



Timeframe: 2022 to 2026

PRIMARY CARE

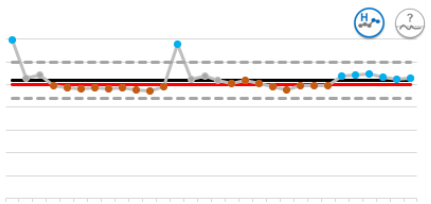
Data Source: Dental Data - Themes - Open Data Portal

PC004: Units of dental activity delivered (UDA) (Cumulative)

UDAs are like tokens that NHS England give to local dentists. When a dentist sees a patient at their practice the dentist uses up a number of these Units. The dentist must use up between 96 and 102 per cent of the UDAs allocated each year.

L&SC ICB Sep-26

Actual: 105.9%
Plan: 96.0%



Timeframe: 2025 to 2026

PC005: Dental, Unique Patients

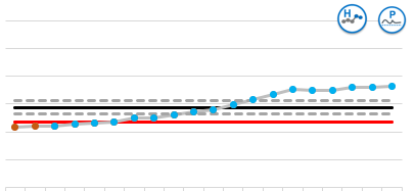
ADULTS : Percentage of resident adults seen by an NHS dentist in the previous 24 months.

CHILDREN : Percentage of resident children seen by an NHS dentist in the previous 12 months.

L&SC ICB Aug-26

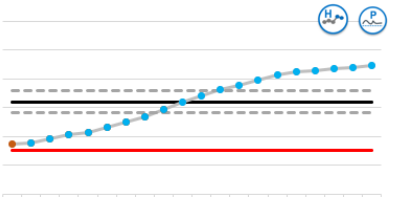
Aug-26	ADULT	CHILD
Actual:	41.60%	68.88%
Plan:	40.70%	66.20%

Adult:



Timeframe: 2025 to 2026

Child:



Timeframe: 2025 to 2026

PRIMARY CARE

Commentary:

GP Appointments
The August 2026 appointment data was significantly below our original planning submission by -65k appointments. The has also meant that we are now below our cumulative year to date plan for the first month this year.

Although the appointment rate is below our planned levels, L&SC practices did provide more appointments in Aug 2026 than the preceding two years; 5.0% more than last year for the month and 5.2% more than last year ytd. The dip in appointments seen in August is in line with the seasonal variation patterns seen national.

The ICB appointment rate per 10,000 weighted population continues to be similar to North-West rates though remains well below the national average. There are variations in appointment rates at sub-ICB level. Due to workforce and recruitment pressures, L&SC continues to have fewer FTE doctors per 10,000 weighted population than national averages.

Same Day Consultation Appointments
Although there have been further improvements in the proportion of same day General Consultation (Acute) appointments seen on the same day, we have deviated away from our planning trajectory that is targeting 90% by March 2027. There are variations between sub-ICB areas and at practice level, with 32% of LSC practices currently achieving ≥ 90% same-day clinically urgent rate.

August's performance may have been affected by seasonal changes in GP tasks and appointment mix not having been reflected in the planning trajectory. Monitoring continues. Overall, it is recognised that practice variation in appointment mapping and data quality remains a key factor influencing reported performance.

Units of Dental Activity (UDA)
In the first 6 months of 2026-27, 105.94% of all Planned UDAs have been delivered.

Dental, Unique Patients - The percentage of unique patients seen within the specified period (24 months for adults / 12 months for children) are running above planned levels this year. Submitted plans for the next 3 years target additional improvements in performance.

Actions:

GP Appointments
Access: The ICB continues to work with practices to maintain and improve patient access, including through our proactive and reactive practice visits which includes a focus on access data. A self-assessment checklist was developed and shared with practices in October to support review of national requirements and identify improvement actions.
Workforce: The ICB's ongoing work to strengthen the general practice workforce will positively impact on access, this includes maximising multidisciplinary teams through ARRS roles, workforce development and improving NWRS data quality. Practices are also being encouraged and supported to access the new national GP reimbursement scheme, which provides additional funding for salaried GP, locum and/or posts previously supported by PCN schemes with the aim of increasing capacity and supporting clinically urgent same-day access.
Clinically Urgent Same-Day Access: The Big Primary Care Conversation webinars on 8 July and 2 September reinforced key access messages, with the latter focusing on Clinically Urgent Same-Day appointment coding, requirements and data quality. Following engagement with the LMC and clinical and commissioning leads, relevant aspects of the ICB's Primary Care Action Plan have been updated. Implementation will be taken forward by a Task and Finish Group in October.
A simplified Clinically Urgent Same-Day dataset has also been developed for practices, supporting greater understanding, comparison and facilitate conversations with practices.

Dental Activity
The ICB's local Dental Access and Oral Health Improvement Programme was developed to enhance its understanding and management of oral health for L&SC and includes local and national initiatives :
Children :
- Child Access and Oral Health Improvement
- Additional access to routine care is also offered through a specific pathway to patients in prioritised groups to ensure their oral health does not impact or prevent treatment for other conditions.

Adults :
- Care Homes support to increase the numbers of elderly patients accessing dental services.
- Urgent Dental Care pathway to increase access for patients.
- Integrated Dental Access Programme to support patient with additional treatment needs following Urgent Care, patients who are not urgent but require treatment within 7 days, and specific patients who are within prioritised groups to ensure their oral health does not impact or prevent treatment for other conditions.
- A review of the data set adopted has been undertaken to ensure consistency and accuracy of data.

PRIMARY CARE

Metric	Patient Safety and Experience
MedChart Electronic Prescribing (Royal Oldham Hospital, Fairfield Hospital and Rochdale Infirmary)	On 25 September 2026, primary care colleagues were advised of an IT failure affecting the MedChart electronic prescribing and medicines administration system at Royal Oldham Hospital, Fairfield General Hospital and Rochdale Infirmary. Paper prescribing arrangements were introduced for inpatient and discharge medicines; however, electronic Handover of Care documents may not contain a complete discharge medication list. Medication changes are being recorded in the Handover of Care document, with full details provided on a paper discharge prescription given to the patient or their representative for presentation to their GP practice. The Greater Manchester Integrated Care Board and Northern Care Alliance leadership teams are working to resolve the issue and strengthen communication across the primary–secondary care interface. GP practices have been asked to direct discharge queries to the electronic prescribing outage Single Point of Access and report related patient safety concerns through the Learn from Patient Safety Events service.

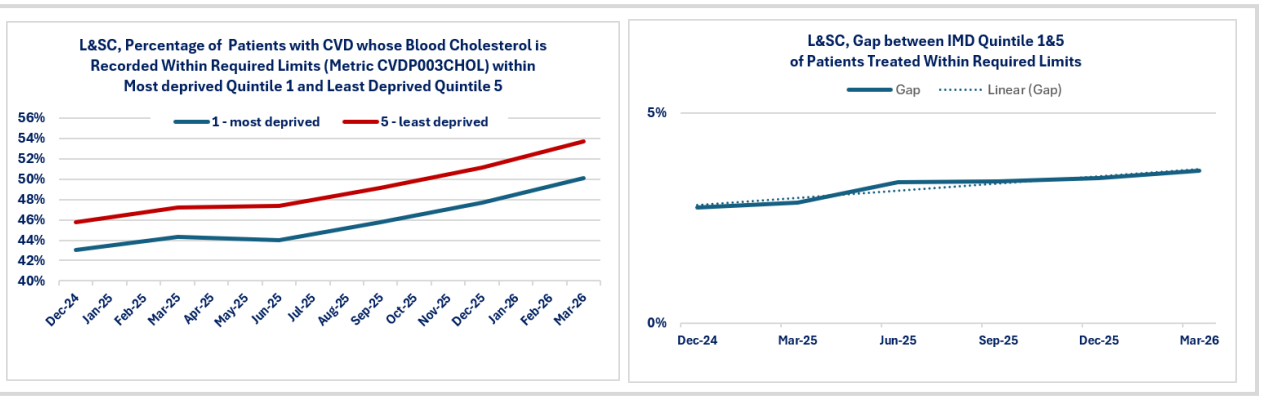
PRIMARY CARE

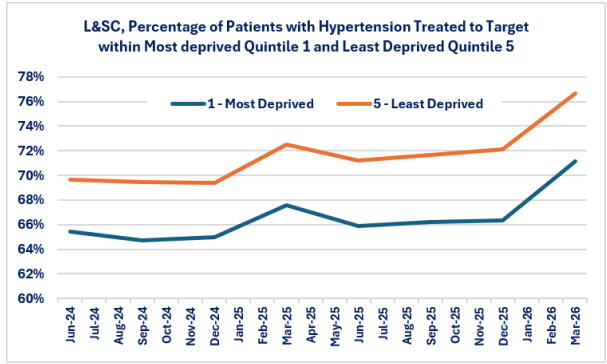
Inequalities

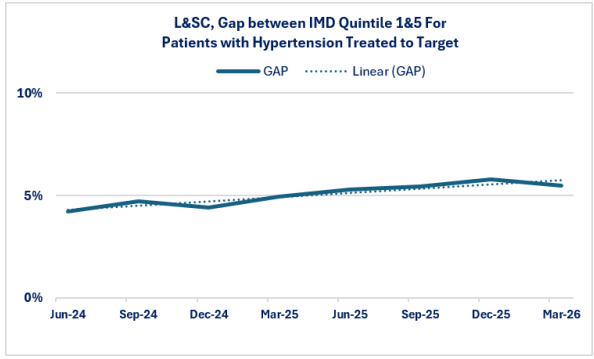
The following charts illustrate a mixed picture in terms of our aims of reducing the gap in cardiovascular disease prevention.

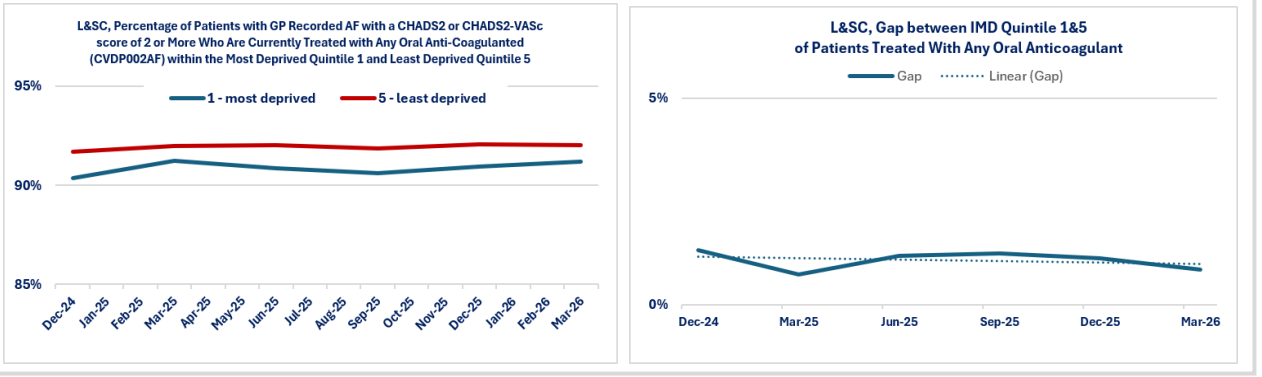
- Gap is increasing for patients with cholesterol recorded being within required limits.
- Gap is reduced for patients with Atrial fibrillation who are treated to target.
- Trend is for an increasing gap in patients with hypertension treated to target, but with signs of a downturn evident in the last quarter of 25/26.

The main contract levers for this work are through the Long -Term Conditions LES. Plans are in place for some targeted work to address unwarranted variation in hypertension, via the Medicines Optimisation Team. The CVDKM Prevention Steering Group will be considering what additional actions could be taken to address the unwarranted variation.









ALL AGE CONTINUING CARE

Data Source: Statistics » Continuing Healthcare and NHS-funded Nursing Care (england.nhs.uk)

AAC001: Eligible for Standard CHC per 50k

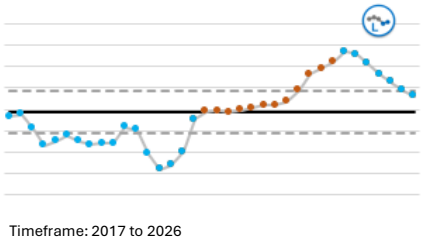
The statistical metric used by NHS England and healthcare analysts to measure how many people receive NHS Continuing Healthcare (CHC) funding relative to the local population size.

L&SC ICB Q1-26/27

Actual: 57.05
Plan: no plan

Q1-26/27	NW.	Eng.
Actual:	68.34	50.78

Sub-ICB:	BwD	BLK	EL	CSR	GP	WL	FW	MB
	53.84	117.63	58.26	77.97	74.35	64.91	106.13	97.87



Timeframe: 2017 to 2026

AAC002: Eligible for Fast Track per 50K

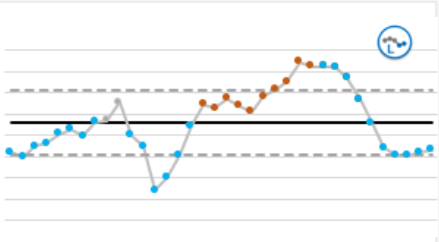
To be eligible for the Fast Track CHC pathway, an individual must meet a strict clinical threshold. An "appropriate clinician" completes the Fast Track Pathway Tool.

L&SC ICB Q1-26/27

Actual: 23.75
Plan: no plan

Q1-26/27	NW.	Eng.
Actual:	25.42	17.70

Sub-ICB:	BwD	BLK	EL	CSR	GP	WL	FW	MB
	14.59	24.91	20.97	26.94	27.59	23.70	27.96	24.25



Timeframe: 2017 to 2026

AAC003: Eligible for Funded Nursing Care per 50K

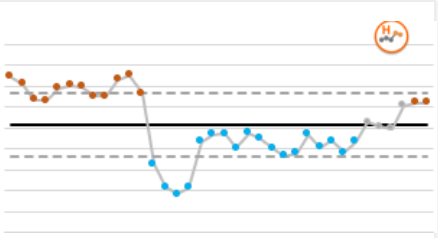
The number of patients eligible for Funded Nursing Care per 50k population

L&SC ICB Q1-26/27

Actual: 83.18
Plan: no plan

Q1-26/27	NW.	Eng.
Actual:	76.08	76.92

Sub-ICB:	BwD	BLK	EL	CSR	GP	WL	FW	MB
	39.25	88.22	45.98	55.79	81.71	82.95	128.69	134.16



Timeframe: 2017 to 2026

ALL AGE CONTINUING CARE

Commentary:

Eligibility for Standard CHC per 50k
'NHS Continuing Healthcare' (NHS CHC) means a package of ongoing care that is arranged and funded solely by the NHS where the individual has been assessed and found to have a 'primary health need' as set out in the National framework for NHS Continuing Healthcare and NHS-funded nursing care. The ICB remains a national outlier for eligibility per 50 thousand population, although this continues to reduce. The rate has reduced for the last seven quarters (57.0 from 68.7) but remains outside of the confidence intervals.

Eligible for Fast Track per 50k
The number of Fast Track patients within L&SC has reduced by 41% since March 2024. This has led to a reduction in the number of patients eligible for Fast Track per 50k population, dropping from 41.1 in Q4 2023-24 to 23.7 at the end of Q4 2025-26. However, for three consecutive periods, the number of patients eligible for Fast Track per 50k population has risen slightly, from 20.2 to 23.7. The ICB continues to be higher than the national average of 17.7 per 50k.

Eligible for Funded Nursing Care per 50k
As the previous backlog of CHC and Fast Track reviews has been cleared this has resulted in an increase in patients on the Funded Nursing Care Pathway. For four consecutive periods, the number of patients eligible for Funded Nursing Care per 50k population has returned to being higher the national average, rising from 74.8 to 83.2

Work underway across the programme includes:
· Optimised triage processes in place.
· Implementation of dual ratification process.
· Weekly meetings in place with external capacity providers to support with CHC reviews.
· Audits of 3 and 12-month reviews in progress with actions/themes being presented to AACC & IPA Senior Leadership Team.
· Weekly assurance meetings with clinical leads.
· Rolling training within clinical staff on DSTs "what good looks like" to identify work to ensure a patient centred approach.
· Implementation of nursing homes completing nursing assessments is in train.
· Audits of nursing assessments completed (with actions/themes) are presented to AACC & IPA Senior Leadership Team.

Actions:

Eligibility for Standard CHC per 50k
· Development of operating procedures and data inputting quality across all teams.
· Development of Dual Ratification Process for review of eligibility decisions following DST to ensure good quality triage is being undertaken.
· Clinical Audit rolling programme in place.
· DST training module implemented.
· Agency staff supporting with CHC 3 month and 12-month reviews.

Eligible for Fast Track per 50k
In addition to above:
· 6-month support from external agency completing 300 reviews and subsequent DSTs.

Eligible for Funded Nursing Care per 50k

· Addition to NHS contract with nursing homes for them to complete nursing assessments Annually.
· Clinical audit rolling programme in place.
· Training with nursing homes as needed.
· Provider event to be held with nursing home providers.

PATIENT EXPERIENCE / SAFETY / INFECTION, PREVENTION, CONTROL (IPC)

Metric	Patient Safety and Experience
Prevention of future deaths (PFD)	A Prevention of Future Deaths report and trust response from BTH was published on the 25th September 2026. The central learning from the report is that patients on the Acute Coronary Syndrome (ACS) pathway may deteriorate despite a less concerning initial presentation, therefore, reliable escalation, communication, oversight and transfer arrangements are required to reduce the risk of avoidable delay and future deaths.
Never Events	5x Never Events (1 wrong-site surgery) (1 Falls from Poorly Restricted Windows) (1 Administration of incorrect medicine dosage) (1 Overdose of insulin due to abbreviations or incorrect device) (1 Wrong implant / Prosthesis) have been reported since the previous report. Learning responses are underway to understand contributory factors and prevent recurrence.
Patient Safety Incident Response Framework (PSRIF) Provider Policy & Plan Update	14x provider policies and plans have been submitted to the Quality and Outcome Committee. 3x have been externally signed off by other ICBs, and 11x revised policies and plans have been reviewed against national guidance. A further three policies and plans are currently under review, with 18-month revisions being actively followed up as they approach their due dates. The LSC ICB Policy is under review and will be presented to the December Quality and Outcomes Committee.
System-wide transfer and handover learning	• A transfer incident identified incomplete communication of swallowing risks. • This reflects a wider issue: key information may be missing when patients move between providers, causing delays and fragmented care. • The ICB is setting up a clinically led group to agree a minimum dataset, standard transfer form, information-governance requirements and an urgent process for obtaining missing information. • Regional patient-safety and coronial intelligence has been requested to identify similar learning and inform the approach.

PATIENT EXPERIENCE / SAFETY / INFECTION, PREVENTION, CONTROL (IPC)

Metric	Patient Safety and Experience
Health Care Associated Infections (HCAI)	• The annual UKHSA HCAI Report 2025/26 demonstrates a reduction in both community-onset and hospital-onset *Clostridioides difficile* infections (CDI); however, increasing trends continue to be observed across other healthcare-associated infections. • A notable increase in cases of meticillin-sensitive *Staphylococcus aureus* (MSSA) and *Pseudomonas aeruginosa* has been identified. Quality improvement activity is ongoing across provider organisations, supported by IPC teams throughout the ICB. • Both Lancashire Teaching Hospitals and Blackpool Teaching Hospitals continue to operate without a Decontamination Lead. This statutory requirement has been highlighted and appropriately escalated through relevant governance processes. • Acute respiratory infections continue to increase. Provider organisations have implemented appropriate IPC measures, supported by winter preparedness initiatives and efforts to improve vaccination uptake. • Close collaboration with Medicines Optimisation teams continues to support delivery of the three antimicrobial resistance (AMR) priorities, with strategic oversight to be provided through the newly established IPC and AMR Board commencing in December 2026. • The newly established system-wide IPC Improvement Group has strengthened collaborative working across organisations, with several quality improvement initiatives identified and agreed for progression.

MORTALITY – SUMMARY HOSPITAL MORTALITY INDICATOR (SHMI)

Data Source: Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation - NHS England Digital

Trust	SHMI Value	Banding Description	Trend
Blackpool Teaching Hospitals	1.3004	Higher than expected	↓
East Lancashire Hospitals Trust	1.2724	Higher than expected	↑
Lancashire Teaching Hospitals	1.0063	As expected	↑
University Hospitals of Morecambe Bay	1.0163	As expected	↓

Time period June 2025-May 2026

Actions :

- **ELHT** - June 2026 monthly HSMR and the rolling HSMR for July 2025–June 2026 are reported as within expected levels. HSMR+ has also been introduced, with changes to the methodology contributing to an improved HSMR position. However, several diagnosis groups remain alerting within HSMR, including pneumonia, alcohol-related liver disease, other lower respiratory disease, colon , COPD/bronchiectasis and peripheral/visceral atherosclerosis.
- The latest published SHMI (June 2025–May 2026) remains higher than expected, with urinary tract infection, lung , pneumonia and acute bronchitis identified as alerting groups. The Trust continues to report that SHMI is affected by historical data quality issues and the exclusion of SDEC activity.

- **BTH** – Coding performance has improved during April – June 26, however, 33% of episodes (4,274) were not coded in July 26. Medical Examiner scrutiny continues across acute and community deaths, SJR processes provide structured clinical review and learning, 86.9% of reviewed Coroner referral cases were scored as inevitable with no learning attributed. The Trust has invested in additional substantive/agency capacity, recruited trainee clinical coders, strengthened training and quality assurance, progressed the Digitised Clinical Records (DCR) programme, and approved investment in AI-supported coding technology.

Assurance:

- **ELHT** - SJR throughput is improving, supported by additional reviewers, administrative support and increased review time, with completed SJRs identifying no concerns regarding the quality of care. The previous diagnostic coding issue affecting SHMI has resolved; however, SDEC data continues to affect interpretation of mortality indicators. Continued oversight is required of SHMI, diagnosis-specific alerts, SJR compliance and associated learning and improvement actions.
- All alerting groups are reviewed by both the Medical Examiners and the Mortality Reviewers. Medical Examiners continue to scrutinise all hospital deaths and mortality reviews are maintaining 100% reviews in some diagnostic groups.

- **BTH -** SHMI and HSMR values continue to be significantly influenced by historical coding delays and reduced co-morbidity capture. Crude mortality and observed deaths remain stable and do not demonstrate evidence of worsening mortality outcomes, or avoidable mortality. Divisional Mortality Reports continue to be received and considered at the Trust's Mortality Governance Committee.