East Lancashire Hospitals
NHS Trust
A University Teaching Trust

East Lancashire Hospitals NHS Trust Board Meeting

Safe | Personal | Effective

TRUST BOARD (OPEN SESSION)

AGENDA

14 May 2025 at 12.30am

Boardroom, Trust HQ, Birch House

✓ = document attached
v = verbal

Time	Ref	Item	Lead		Purpose
OPENING BUSINESS					
12.30pm	TB/2025/053	**Chairs Welcome and Apologies**	Chair	v	Information
12.35pm	TB/2025/054	**Declarations of Interests**	Chair	v	Information
12.40pm	TB/2025/055	**Minutes of the Previous Meeting** To approve the minutes of the Board meeting (open session) that was held on 12 March 2025.	Chair	✓	Approval
12.45pm	TB/2025/056	**Matters Arising** To discuss any matters arising from the minutes.	Chair	v	Discussion
12.50pm	TB/2025/057	**Action Matrix** To note progress against outstanding actions.	Chair	✓	Discussion
1.00pm	TB/2025/058	**Chair's Report**	Chair	✓	Information
1.10pm	TB/2025/059	**Chief Executive's Report**	Chief Executive	✓	Information
1.30pm	TB/2025/060	**Patient Story**	Chief Nurse	v	Information
FORMULATING STRATEGY					
1.45pm	TB/2025/061	**Annual Plan and Annual Budget 2025-26**	Executive Director of Finance/ Executive Director of Service Improvement & Development	✓	Approve Assurance
2.00pm	TB/2025/062	**Maternity and Neonatal Services Update**	Chief Nurse/ Divisional Director of Nursing & Midwifery	✓	Assurance
2.15pm	TB/2025/063	**Board Assurance Framework and Risk Appetite Statement 2025-26**	Executive Director of Service Development & Improvement / Interim Director of Corporate Governance	✓	Assurance
2.35pm	TB/2025/064	**Corporate Risk Register**	Interim Executive Medical Director	✓	Assurance
ENSURING ACCOUNTABILITY					
2.45pm	TB/2025/065	**Financial Report**	Executive Director of Finance	✓	Assurance
2.50pm	TB/2025/066	**Nursing Professional Judgement Review**	Chief Nurse	✓	Assurance
3.00pm	TB/2025/067	**Integrated Performance Report** To note performance against key indicators and to receive assurance about the actions being taken to recover areas of exception to expected	Executive Directors	✓	Assurance

		performance. The following specific areas will be discussed, with items being raised by exception: a) Introduction (Chief Executive) b) Safe (Interim Medical Director and Chief Nurse) c) Caring (Chief Nurse) d) Effective (Interim Medical Director) e) Responsive (Chief Operating Officer) f) Well-Led (Director of People and Culture and Executive Director of Finance)			
3.20pm	TB/2025/068	**Patient Safety Incident Response Assurance Report**	Interim Executive Medical Director	✓	Assurance
3.30pm	TB/2025/069	**Quality Account 2024-25**	Interim Executive Medical Director	✓	Approval
SHAPING CULTURE					
3.40pm	TB/2025/070	**Board Code of Conduct**	Interim Director of Corporate Governance	✓	Approve
COMMITTEE REPORTS					
3.50pm	TB/2025/071	**Committee Terms of Reference**	Interim Director of Corporate Governance	✓	Approve
3.55pm	TB/2025/072	**Triple A Reports from Quality Committee** To note the matters considered by the committee in discharging its duties. a) March 2025 b) April 2025	Committee Chair	 ✓ ✓	Assurance
4.00pm	TB/2025/073	**Triple A Reports from Finance & Performance Committee** To note the matters considered by the committee in discharging its duties. a) March 2025 b) April 2025	Committee Chair	 ✓ ✓	Assurance
4.05pm	TB/2025/074	**Triple A Reports from People & Culture Committee** To note the matters considered by the committee in discharging its duties. a) March 2025 b) April 2025	Committee Chair	 ✓ ✓	Assurance
4.10pm	TB/2025/075	**Triple A Report from Audit Committee** To note the matters considered by the committee in discharging its duties. a) April 2025	Committee Chair	 ✓	Assurance
4.12pm	TB/2025/076	**Remuneration Committee Information Report** To note the matters considered by the committee in discharging its duties.	Committee Chair	✓	Assurance

4.15pm	TB/2025/077	**Trust Board (Closed Session) Information Report** To note the matters considered by the board in discharging its duties.	Chair	✓	Information
CLOSING MATTERS					
4.20pm	TB/2025/078	**Any Other Business**	Chair	v	Information
4.25pm	TB/2025/079	**Open Forum** To consider pre-submitted questions from the public.	Chair	v	Information
4.30pm	TB/2025/080	**Board Performance & Reflection** To consider the performance of the Trust Board, including asking: 1. Have we, as the Board, via the agenda and our discussions fulfilled our objective of supporting our: a. Communities b. Staff c. Stakeholders 2. Have we, as the Board fulfilled our statutory obligations.	Chair	v	Discussion
4.35pm	TB/2025/081	**Message from the Board** To identify any key messages the Board wishes to send out to all staff.	Chair	v	
4.40pm	TB/2025/082	**Date and Time of Next Meeting** 9 July 2025 at 12.30pm, Trust HQ Boardroom, Birch House	Chair	v	Information

EAST LANCASHIRE HOSPITALS NHS TRUST

TRUST BOARD MEETING, 13:00, 12 March 2025

MINUTES

PRESENT

Mr S Sarwar	Chairman	Chair
Mr M Hodgson	Chief Executive / Accountable Officer	
Professor G Baldwin	Non-Executive Director	
Mrs S Bridgen	Non-Executive Director	
Mrs S Gilligan	Chief Operating Officer / Deputy Chief Executive	
Mr P Murphy	Chief Nurse	
Mrs C Randall	Non-Executive Director	
Mr K Rehman	Non-Executive Director	
Mrs L Sedgley	Non-Executive Director	
Mrs S Simpson	Executive Director of Finance	

BOARD MEMBERS IN ATTENDANCE (NON-VOTING)

Mrs K Atkinson	Executive Director of Service Development and Improvement
Mr M Ireland	Interim Director of People and Culture
Mr T McDonald	Executive Director of Integrated Care, Partnerships and Resilience
Miss S Wright	Executive Director of Communications and Engagement

IN ATTENDANCE

Mr D Byrne	Corporate Governance Officer	Minutes
Mrs S Giles	Interim Director of Corporate Governance/ Company Secretary	
Miss T Thompson	Divisional Director of Midwifery and Nursing	Item: TB/2024/155

APOLOGIES

Mrs P Anderson	Non-Executive Director
Mrs A Bosnjak-Szekeres	Director of Corporate Governance / Company Secretary
Mrs M Hatch	Associate Non-Executive Director
Mr J Husain	Executive Medical Director / Deputy Chief Executive

Mr A Razaq	Director of Public Health, Blackburn with Darwen Borough Council
Mrs K Quinn	Executive Director of People and Culture

TB/2025/028 CHAIRMAN'S WELCOME

Directors were welcomed to the meeting. It was noted that a number of observers were in attendance, some of which had been shortlisted for the Non-Executive and Associate Non-Executive Director roles currently being recruited to at the Trust.

TB/2025/029 APOLOGIES

Apologies were received as recorded above.

TB/2025/030 DECLARATIONS OF INTEREST

The Directors Register of Interests was presented for approval. It was noted that the Register had been updated but due to a technical error some entries were showing as 'awaiting confirmation'. This will be corrected prior to being published on the Trust website.

RESOLVED: Directors approved the position of the Directors' Register of Interests, pending the requested amendment.

TB/2025/031 MINUTES OF THE PREVIOUS MEETING

Directors, having had the opportunity to review the minutes of the previous meeting, approved them as a true and accurate record.

RESOLVED: The minutes of the meeting held on 15 January 2025 were approved as a true and accurate record.

TB/2025/032 MATTERS ARISING

There were no matters arising.

TB/2025/033 ACTION MATRIX

Directors noted that all items on the action matrix were reported as complete, had been updated via the action matrix report or were to be presented as agenda items at this, or at subsequent meetings. The following updates were provided:

TB/2023/040: Maternity and Neonatal Service Update – Mr Murphy confirmed that a full overview on the Birth Rate+ findings would be provided under the maternity and neonatal update item at the next meeting of the Board. Directors noted that this would include a

summary of the associated staffing asks, and how these compared with the findings of recent professional judgement reviews, and any staffing gaps, as well as how these were being mitigated or resolved.

TB/2024/150: Chief Executive's Report – It was confirmed that there had been some impact on local care home facilities due to the changes made to national insurance payments, with a number either ceasing to operate or merging with others. Directors noted that there had been no significant impacts on patient flow as a result and that there were clear links between these developments the system ambition for more elder patients to be cared for at home where possible.

RESOLVED: Directors noted the position of the action matrix.

TB/2025/034 CHAIRMAN'S REPORT

Mr Sarwar began his update by extending his thanks to Trust staff for continuing to manage the levels of demand being placed on them, and by recognising the negative impact that the system's financial situation was having on them.

Directors received an overview of Mr Sarwar's activities since the previous meeting, including his ongoing participation in the monthly Improvement and Assurance Group (IAG) meetings, at which the Trust's finances and plans for 2024-25 and 2025-26 continued to be closely scrutinised by NHS England (NHSE) colleagues. It was noted that the Trust had now been formally placed into NHS Oversight Framework (NOF) Recovery Support Programme (RSP) arrangements and was being provided with additional governance and leadership support as a consequence.

Mr Sarwar advised Directors that he had met with a range of stakeholders since the previous meeting, including his fellow chairs across Lancashire and South Cumbria, the chair of the Integrated Care Board (ICB) and local Members of Parliament (MPs). The importance of engaging with stakeholders was emphasised, both to update them on the status of the organisation and the challenges that it was facing and to recognise the impact that some if its recent decisions, including the closure of Accrington Victoria Hospital (AVH), were having on local communities. Mr Sarwar extended his thanks to the local MP for Pendle and Clitheroe in particular for recently taking the time to visit the urgent treatment centre at Burnley General Teaching Hospital (BGTH), interact with staff and see how the Trust's services continued to change and evolve to meet the demands being place upon them.

RESOLVED: Directors received and noted the update provided.

TB/2025/035 CHIEF EXECUTIVE'S REPORT

Directors received a summary of national, regional and Trust specific headlines since the previous meeting.

At a national level, updates were provided on the significant pressures that continued to be placed on NHS services, the recent announcements regarding changes to the leadership of NHSE, and the subsummation of NHSE into the Department of Health and Social Care and the planning process for 2025-26.

At a regional level, updates were provided on the placing of organisations in LSC into NOF RSP arrangements, the announcement of a new timetable for the New Hospitals Programme (NHP) developments at the Royal Preston Hospital and Royal Lancashire Infirmary sites and the planned move to a single collaborative pathology service across LSC.

At a Trust level, updates were provided on the recent decision to close services at the AVH site on the basis on building compliance sand safety concerns, the provision of a replacement shuttle bus service by a local provider from the start of the new financial year, a range of changes to services, the ongoing work to identify potential financial savings, a recent visit from Care Quality Commission (CQC) colleagues to community inpatient services and a recent visit from ICB colleagues to the A&E department at Royal Blackburn Teaching Hospital (RBTH).

Mr Hodgson went on to inform Directors of a range of other positive developments at a Trust level, including the achievement of Joint Advisory Group (JAG) accreditation by endoscopy services, the award of a humanitarian medal to one of its consultant colleagues for their work in Gaza and achievement of specialist endometriosis accreditation by the organisation for the 10th year in a row.

Directors received a list of the wards and departments put forward to receive Safe, Personal and Effective Care (SPEC) status and confirmed that they were content to these to be awarded.

Responding to a request for clarification from Mrs Sedgley regarding the involvement of one of the Trust's clinician's in raising awareness around ketamine abuse, Miss Wright explained that this was not an active component of the organisation's communication strategy and that the colleague in question had been approached by a journalist to help get the message out in this way. She added that the Trust would strive to ensure that colleagues would be available to participate in any future healthcare communications campaigns if they were approached in a similar manner.

Professor Baldwin made reference to the information in the report around the use of artificial intelligence (AI) to detect breast cancer cases earlier and enquired if the Trust had given any consideration to developing its own strategy around the implementation of AI going forward. Mr Hodgson indicated that the Trust was currently using AI in some specific areas, including stroke scans, but acknowledged that there was more to be done in this area. He added that the organisation had also not yet developed a formal strategy around this area.

RESOLVED: **Directors received the report and noted its contents.**

TB/2025/036 **STAFF / PATIENT STORY**

Directors were reminded that, due to the length of the patient story, it had been circulated for viewing in advance of the meeting. They were informed that it related to a patient who had died in the Trust's care, whose family had subsequently complained to the organisation around various aspects of their care. It was noted that following an initial meeting with the family to discuss their complaints, Trust colleagues had continued to engage with them and that they had ultimately chosen to work with the organisation as volunteers on a series of improvement programmes, including some of those highlighted in the patient story. It was confirmed that the family continued to work with the Trust and had provided an addendum to the initial story detailing the positive developments that had taken place since.

Addressing a request from Mr Rehman for assurance that the right lessons had been learned from the experiences detailed in the patient story and how long it would take this to be reflected across the areas referenced, Mr Murphy emphasised that the involvement of the family had been invaluable in addressing the issues raised. He confirmed that the associated learning had been disseminated across the organisation and advised that the family had also met with relevant colleagues where less compassionate care had been identified, adding that this had been a positive experience for both parties.

In response to a query from Mrs Sedgley regarding the mechanisms in place to protect patients who did have family members or others to advocate for them, Mr Murphy advised that a range of processes were in place to advocate for patients, including its 'call for concern' service, incident reporting mechanisms to generate additional learning and its ongoing improvement work.

Responding to an observation from Professor Baldwin regarding the leadership and accountability aspects of the issues identified in the story, Mr Murphy indicated that a substantial amount of work was taking place around this.

RESOLVED: **Directors received the Patient Story and noted its content.**

TB/2025/037 **CORPORATE RISK REGISTER (CRR) AND RISK PERFORMANCE REPORT**

Directors received the latest iteration of the CRR and were provided with a summary of key highlights. It was noted that there were currently 23 risks on the CRR, three of which had been added since the previous meeting, these were:

- **9755: Delays undertaking elective caesarean sections.**
- **9777: Loss of education, research and innovation accommodation and facilities.**
- **10095: PAC issues impacting on efficiency and ability to meet targets and obstructive workflow.**

Directors were also informed that two risks had been downgraded since the previous meeting, these were:

- **9545: Potential interruption to surgical procedures due to equipment failure – score reduced to 16.**
- **6190: Insufficient capacity to accommodate patients in clinic within timescales – score reduced to 12.**

It was confirmed that there had been no movement in any other risks on the CRR and that the highest risk areas remained financial sustainability, digital systems and storage of data, the management of medical devices, insufficient capacity to meet demand and sub optimisation of the electronic patient record (EPR) system. It was highlighted that good progress was being made around the general management of risks and that there had been further reductions made in the numbers of open and overdue risks.

Addressing a request for clarification from Mr Rehman, Mr Murphy confirmed that some of the issues and controls detailed in the information for risk **8033 (increased requirement for nutrition and hydration intervention in patients resulting in delays)** were linked to the patient story presented earlier in the meeting. He added that some of the specific issues raised in the patient story had also been incorporated not the collaborative work currently being done around nutrition and hydration.

Mr Sarwar raised concerns around the number of actions in the report that did not have firm timescales in place and requested that Mr Islam discussed this with colleagues after the meeting to facilitate these being implemented.

RESOLVED: **Directors received the update and assurance about the work being undertaken in relation to the management of risks.**

ACTION: **Mr Islam to discuss the provision of clearer timescales around risk actions with colleagues. By: May 2025**

TB/2025/038 BOARD ASSURANCE FRAMEWORK (BAF)

Directors were informed that the six risks currently on the BAF were being reviewed and refreshed as part of the annual review process and would be presented to the Board at its meeting in May for consideration and approval. It was confirmed that the Trust's risk appetite statement would be reviewed and presented as part of this process. Directors noted that consideration was also being given to the development of an additional dedicated BAF risk around cyber security.

RESOLVED: **Directors noted the update provided.**

TB/2025/039 PATIENT SAFETY INCIDENT RESPONSE ASSURANCE (PSIRA) REPORT

Directors were informed that a Never Event had occurred since the previous meeting, involving the incorrect placement of a nasogastric (NG) tube. It was confirmed that no harm had come to the patient involved and that a full patient safety incident investigation (PSII) was taking place to look at the circumstances behind the incident.

Directors received a summary of the other key highlights of the report, including a rise in incident reports related to staffing issues, a total of 64 incidents waiting approval as of the end of January 2025 and the reporting of three fatal incidents since the previous meeting. It was confirmed that all three of these incidents were undergoing PSIIs.

Mr Murphy clarified that the issues around staffing were related, in the main, to short term sickness and indicated that staff continued to be moved between areas as required to maintain required safe staffing levels.

RESOLVED: **Directors noted the report and received assurances about the reporting of incidents via the PSIRF.**

TB/2025/040 MATERNITY AND NEONATAL SERVICES UPDATE

Directors received a summary overview of the Trust's progress against the 10 maternity safety actions included in the Maternity Incentive Scheme (MIS) Clinical Negligence Scheme for Trusts (CNST) Year Six.

Safety Action 1 - Perinatal Mortality Review Tool (PMRT): It was explained that the Trust was non-compliant with this action and that a series of steps were being taken to mitigate the associated risks for CNST Year Seven.

Safety Action 2 - Maternity Services Data Set (MSDS): It was confirmed that the Trust was fully compliant against this action.

Safety Action 3 - Transitional Care (TC): It was confirmed that the Trust was fully compliant against this action.

Safety Action 4 - Clinical Workforce: It was confirmed that the Trust had met all requirements for this action bar the aforementioned Birth Rate+ staffing recommendations which were still being worked through.

Mr Murphy reiterated that an update would be provided at the next meeting regarding any staffing gaps relating to the Birth Rate+ recommendations.

Safety Action 5 - Midwifery Workforce: It was confirmed that the Trust was fully compliant against this action.

Safety Action 6 - Saving Babies Lives v3 Care Bundle (SBLv3): It was confirmed that the Trust was fully compliant against this action. It was also highlighted that the Trust had achieved 91% compliance for SBL care bundle implementation.

Safety Action 7 – Maternity Neonatal Voice Partnership (MNVP) User Feedback: It was confirmed that the Trust was fully compliant against this action.

Safety Action 8 – Training: It was confirmed that the Trust was fully compliant against this action, with all training thresholds met by the end of the reporting period.

Safety Action 9 - Board Assurance: It was confirmed that the Trust was fully compliant against this action and that additional support was being provided by Mr Murphy and Mr Rehman to further develop the Perinatal Quality Surveillance Model (PQSM) and facilitate better triangulation of associated data.

Safety Action 10 - Maternity and Newborn Safety investigation Programme (MNSI) / NHS Resolution: It was confirmed that the Trust was fully compliant against this action and was compliant with qualifying cases.

Mr Rehman referred to the mitigations listed in relation to SA1 and stated that this met the Trust's aspirations to remain an open and transparent with regard to any areas that it was falling short of.

Mr Sarwar extended his thanks to Miss Thompson and her colleagues for the significant amounts of work that continued to go into maintaining the high quality of the Trust's maternity and neonatal services.

RESOLVED: **Directors received the report and were assured by the activity taking place to deliver safe, personal, and effective care in the Trust's maternity and neonatal services.**

TB/2025/041 FINANCIAL PERFORMANCE REPORT MONTH 10 2024-25

Directors received an overview of the Trust's financial performance as of month 10 of 2024-25. It was noted that the Trust's deficit position currently stood at £47,300,000 and that there had been significant improvements from the position reported at month 9 following the significant amount of work done by colleagues in this area. Emphasis was put on the fact that this was still a significant deficit figure and that it would bring a number of additional challenges, particularly in relation to the Trust's cash reserves. Directors were advised that several of the Trust's suppliers had not been paid due to cash shortages and that this would need to be worked through the end of 2024-25 and into 2025-26.

Directors were presented with a breakdown of the varying types of income and expenditure for 2024-25 to date and noted that there had been further reductions in bank and agency spend and increases in income. It was confirmed that there was a strong focus on securing additional savings up to year end, particularly in relation to workforce costs, and on cost improvement programmes for 2025-26 to put the Trust's cash position in as strong a place as possible at the start of the year.

Mr Hodgson emphasised that it was incumbent on the Trust to live within its financial means when using taxpayer money. He also emphasised the importance of proper triangulation of the Trust's finances and to be as productive and efficient as possible.

Responding to a request from Mr Sarwar, Mr Islam stated that some areas of the Trust were likely overstaffed and that reductions in workforce numbers would not necessarily equate to a loss in quality. He also stressed the need to streamline services and be realistic around what the Trust would be able to provide with the resources available to it going forward.

Mrs Gilligan advised that the current approach being taken through service reviews was to ensure that the same level of quality and care could be delivered in more efficient ways.

Mr Sarwar noted that it would be crucial for the Trust to have robust clinical leadership in place to drive improvements and take costs out. He also agreed on the need for the organisation to be clear on which services it would be able to continue to provide and facilitating appropriate conversations with commissioning colleagues around those that it would no longer be able to.

TB/2025/042 INTEGRATED PERFORMANCE REPORT (IPR)

a) Introduction

Directors were referred to the previously circulated report and were informed that it covered the period up to the end of January 2025. It was noted that the report was being presented in a revised format and that this was based on national best practice.

Mrs Atkinson invited comments and feedback on the new format of the report and indicated that further changes would be implemented from April onwards due to the implementation of new operating targets.

b) Safe

Directors were informed that the levels of flu and COVID-19 infections in the Trust had continued to decrease. It was also highlighted that the Trust remained well below tolerance levels for Clostridium difficile (C. diff) infections and that there had been no cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) reported since the previous meeting.

Mr Murphy reported that there continued to be very high demand on the Trust's UEC pathways and explained that a 'reset' exercise was being carried out to decongest the Emergency Department (ED) and take patients off corridors.

RESOLVED: Directors noted the information and assurance provided within the Safe section of the Integrated Performance Report.

c) Caring

Mr Murphy informed Directors that there had been deterioration in friends and family test feedback from the ED and improvements seen in maternity areas.

RESOLVED: Directors noted the information and assurance provided under the Caring section of the Integrated Performance Report.

d) Effective

Directors were informed that the issues with the Trust's mortality data raised at previous meetings were ongoing and that its Hospital Standardised Mortality Ratio (HSMR) and

Summary Hospital-level Mortality Indicator (SHMI) figures could not be trusted to be reliable as a result. It was highlighted that there had been a slight improvement in the Trust's crude mortality rates from December to January.

Mrs Bridgen confirmed that mortality had been discussed at length at the most recent meeting of the Quality Committee and that assurance had been provided not just from the Trust's crude mortality levels but also the range of processes in place to monitor it.

Responding to a query from Mrs Sedgley regarding the lack of information around Learning Disability Mortality Reviews in the report, Mr Islam indicated that this was likely because none were due but stated that he would confirm this after the meeting.

RESOLVED: **Directors received assurance and noted the information provided under the Effective section of the Integrated Performance Report.**

ACTION: **Mr Islam to confirm if Learning Disability Mortality Review information was not included in the IPR due to none being due. By: May 2025**

e) Responsive

Directors received a summary of the Trust's most recently updated performance figures, including its performance against the four-hour A&E standard, ambulance handover times, 65-week waiters and cancer and faster diagnosis standards. It was highlighted that significant improvements had been made in relation to Diagnostic Waiting Times and Activity (DM01) performance throughout December and January and that further improvements were expected in February once validation had taken place. Directors also noted that the Trust was currently ranked at second best in the country in terms of theatre productivity.

RESOLVED: **Directors noted the information provided under the Responsive section of the Integrated Performance Report and received assurance about the work being undertaken to improve patient care and experience.**

f) Well-led

It was reported that the Trust's sickness and absence rates stood at 7.63% for January and that the final figure for February was still being awaited. Directors were informed that improvements were expected in March, as better figures were already being seen.

Responding to a query from Mr Sarwar as what plans were underway to address the Trust's ongoing high sickness and absence rates, Mr Ireland explained that specific interventions

were being carried out around any long-term sicknesses. He acknowledged that more work was needed in this area. Addressing a further query from Mr Sarwar as to how the Trust was performing against other organisations in this area, Mr Ireland confirmed that all other acute organisations were seeing similar increases.

Mr Sarwar requested that the matter was discussed in more detail at the People and Culture Committee prior to an update being provided to the board at a later date.

In response to a request from Mrs Bridgen, Mr Islam reported that consultant job planning compliance currently stood at over 80% and indicated that it was unlikely that this would reach the 95% target by the end of the year. He confirmed that similar issues were being seen at other organisations and that a further report on the situation was due to be provided to the executive team by the end of the week.

Mr Ireland added that this was closely monitored through and addressed through the Trust's Workforce Assurance Meetings which fed into the People and Culture Committee.

RESOLVED: **Directors noted the information provided under the Well-Led section of the Integrated Performance Report and received assurance about the activity being taken to improve and maintain performance.**

ACTION: **A 'deep dive' into sickness and absence levels in the Trust will take place at a future meeting of the People and Culture Committee.**

TB/2025/043 **TRIPLE A REPORT FROM PEOPLE AND CULTURE COMMITTEE**

The report was presented to the Board for information.

RESOLVED: **Directors received the report and noted its content.**

TB/2025/044 **TRIPLE A REPORT FROM FINANCE AND PERFORMANCE COMMITTEE**

The report was presented to the Board for information.

RESOLVED: **Directors received the report and noted its content.**

TB/2025/045 **TRIPLE A REPORT FROM QUALITY COMMITTEE**

The report was presented to the Board for information.

RESOLVED: **Directors received the report and noted its contents.**

TB/2025/046 **REMUNERATION COMMITTEE INFORMATION REPORT**

The report was presented to the Board for information.

RESOLVED: **Directors received the report and noted its contents.**

TB/2025/047 **TRUST BOARD (CLOSED SESSION) INFORMATION REPORT**

The report was presented to the Board for information.

RESOLVED: **Directors received the report and noted its contents.**

TB/2025/048 **ANY OTHER BUSINESS**

No additional items were raised for discussion.

TB/2025/049 **OPEN FORUM**

Directors were informed that no questions had been raised by members of the public prior to the meeting.

TB/2025/050 **BOARD PERFORMANCE AND REFLECTION**

Directors stated that they felt that the meeting had appropriately addressed and fulfilled its objectives in relation to its communities, staff, and stakeholders. It was felt that the patient story had been particularly relevant and had helped to focus minds on the fact that the main duty of the Trust was to deliver safe care to patients and to learn from this when it fell short.

RESOLVED: **Directors noted the feedback provided.**

TB/2025/051 **MESSAGE FROM THE BOARD**

Mr Sarwar stated that the previous four months had demonstrated the ability of the Trust to move and become agile as an organisation, both to deliver the significant financial savings expected of it whilst also maintain the quality of care that patients received. He noted that a substantial amount of energy had gone into getting this balance right and that this would need to continue to ensure that the Trust did right by its patients.

TB/2025/052 **DATE AND TIME OF NEXT MEETING**

Mr Sarwar informed Directors that the next Trust Board meeting would be taking place on Wednesday, 14 May 2025 at 13:00 in the Trust HQ Boardroom.

Trust Board Action Tracker

Key:

	Action complete
	Action on track for deadline
	Action not likely to meet deadline
	Action passed deadline

No	Meeting Date	Agenda Item	Action	Lead	Date for completion	RAG	Comments / Update
1	March 2023	TB/2023/040: Maternity and Neonatal Service Update	A full business case regarding the additional funding required to satisfy the Birth Rate+ nursing and midwifery staffing recommendations will be developed and presented to the Board for approval at a later date.	Chief Nurse/ Head of Midwifery	May 2025	R	The reporting of Birth Rate+ will be to the Board via the Quality Committee and Trust Wide Quality Group. It is proposed that there is a report to the Board at the meeting in July 2025.
2	March 2025	TB/2024/159: Ratification of Board Sub-Committee Terms of Reference	The revised terms of reference for the Finance and Performance and Trust Charitable Funds Committees will be presented at a future meeting for ratification.	Corporate Governance Manager	March 2025	B	Agenda item: May 2025
3	April 2025	TB/2025/037: Corporate Risk Register Report (CRR)	Mr Islam to discuss the provision of clearer timescales around risk actions with colleagues.	Interim Executive Medical Director	May 2025	B	Revised terms of reference have been developed for the review of risks on the CRR, including the setting of clear timescales for updating actions/providing updates.
4	April 2025	TB/2025/042: Integrated Performance Report - Effective	Mr Islam to confirm if Learning Disability Mortality Review information was not included in the IPR due to none being due.	Interim Executive Medical Director	May 2025	B	The Interim Executive Medical Director provided the required information to Mrs Sedgley on 19 March 2025.

5	April 2025	TB/2025/042: Integrated Performance Report – Well-led	A 'deep dive' into sickness and absence levels in the Trust will take place at a future meeting of the People and Culture Committee	Interim Director of People and Culture	June 2025	B	This action will be transferred to the People and Culture Action Matrix.

TRUST BOARD REPORT

Meeting Date:	14 May 2025	**Agenda Item:**	TB/2025/058
Report Title:	Chair's Report		
Author:	Mr S Sarwar, Chair		
Lead Director:	Mr S Sarwar, Chair		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Approval**	**For Information**
			✓	
Executive Summary:	The Chair's Report provides an update on the activity of the Chair during April and May. I have reviewed the specific responsibilities of the Non-Executive Directors and made a number of proposed changes and appointments as set out within the paper. In addition, the Interim Director of Corporate Governance, on my behalf, has developed a Board Code of Conduct and proposed Board Development Programme for 2025-26 both of which are on the agenda for approval.			
Key Issues/Areas of Concern:	N/A			
Action Required by the Board:	The Board is asked to: • Approve the appointment of Sallie Brigden and Khalil Rehman as Vice-Chairs; • Approve the appointment of Graham Baldwin as Senior Independent Director; • Note the appointment of new Non-Executive Directors; • Note the changes in Non-Executive Director chairing and membership of Board Committees; and • Note the division of responsibilities between the Chair and Chief Executive.			

Previously Considered by:	N/A
Date:	
Outcome:	

Chair's Report

Visit from the Prime Minister

The Trust had a 'VIP' visit on 28th April 2025 when the Prime Minister visited Rossendale Health Centre to meet with Trust colleagues and patients. Rossendale Health Centre is an excellent example of integrated care, which is greatly appreciated by local people using its services. The Chief Executive and I were very proud to be able to share with the Prime Minister a number of examples where the Trust has achieved excellent operational and clinical performance in 2024/25. The Chief Executive shall provide further detail of this visit within his report.

Appointment of Vice-Chairs

In preparation for the current Vice-Chair, Trish Anderson, coming to the end of her term in June 2025, I have considered the arrangements for the Vice-Chair. In recognition of the challenging year that lies ahead I would like to propose to the Board that Sallie Brigden and Khalil Rehman are appointed as Vice-Chairs.

For clarity Sallie would act as Chair in my absence and take a portfolio lead around finance and Khalil would take a portfolio lead around governance, which fits with his role as Chair of Audit Committee. The role description for the Vice-Chair is appended to this paper for information (Appendix 1).

I would like to thank Trish, on behalf of the Board, for her valuable contribution and commitment during her time with the Trust and wish her all the best for the future.

Appointment of Senior Independent Director

Having reviewed the governance arrangements supporting the Board I would like to propose the appointment of Graham Baldwin as Senior Independent Director. Whilst not a requirement for NHS Trusts, this is in line with best practice and can prove to be a valuable role in supporting Board governance. The role description for the Vice-Chair is appended to this paper for information (Appendix 2).

Appointment of new Non-Executive Directors

After an open and competitive recruitment process the Trust has appointed the following Non-Executive Directors:

Simon Featherstone Non-Executive Director

Bill Dixon – Associate Non-Executive Director

Dr Shahedal Bari – Associate Non-Executive Director

It is anticipated that they will join the Trust in June. Their appointments strengthen the Board skill set and collective knowledge, particularly in the areas of quality of care, clinical governance, clinical reconfiguration and financial sustainability and efficiency. I'm sure colleagues will join me in welcoming them to the Board.

Changes to Non-Executive Director Membership of Committees

It is expected that our new Non-Executive Director and Associate Non-Executive Directors will be joining us in June. In anticipation of this, and in line with the principles of good governance, I have taken the opportunity to review the Non-Executive Director chairing and membership of the Board Committees and Non-Executive Director lead roles. This has

resulted in a number of changes which I have appended to this paper (Appendix 3) for information.

The Terms of Reference for all of the Board Committees have been reviewed and are on the agenda for approval.

Division of Responsibilities between the Chair and Chief Executive

In line with the provisions of the NHS Code of Governance for Provider Trusts the Chief Executive and I have met to clearly identify our responsibilities and in particular the division of leadership of the Board and executive leadership of the Trust's operations. For transparency this has been set out in the attached Division of Responsibilities (Appendix 4).

Other Duties

Throughout April and May I have carried out a number of other duties including:

- Attended the Lancashire Place Partnership as a representative of the Lancashire Provider Collaborative Board;
- Attended the LSC Provider Collaborative Board, where the focus continues to be on financial challenge, areas of collaboration and closer working on service improvement;
- Panel member for the recruitment of the Trust's Executive Medical Director;
- Attended monthly Improvement & Assurance Group(IAG) meetings together with Board colleagues. The Chief Executive will provide greater detail but in summary the Trust is making good progress in getting back to financial balance over the next two years but recognises there is still a lot to do. A fully worked up waste reduction plan is expected to be developed by the end of May for presentation at the next IAG;
- Chaired the Board Strategy and Extraordinary Board meetings in April and May;
- Chaired the ELHT Inclusion Group;
- And informally met with the CEO and Chair of LCS ICB, Chairs of other Provider Trusts and the System Turnaround Director.

Appendix 1

Role of the Vice Chair

The Vice Chair is a Non-Executive Director appointed by the Board of Directors. The Vice Chair has all the general duties of a Non-Executive Director but with the enhanced duties of the Vice Chair as set out below. The Vice Chair appointment will not attract any extra remuneration.

In summary the purpose of the Vice Chair is to deputise for and support the Chair.

Qualifying Criteria:

The Vice-Chair must be considered to fulfil the criteria of 'independent' as set out in NHS England's Code of Governance for Provider Trusts Provision 2.6.

Circumstances that are likely to impair, or could appear to impair, a Non-Executive Director's independent include, but are not limited to, whether a Director:

- Has been an employee of the Trust within the last two years;
- Has, or has had within the last two years, a material business relationship with the Trust either directly or as a partner, material shareholder, Director or senior employee of a body that has such a relationship with the Trust;
- Has received or receives remuneration from the Trust apart from a Director's fee; participates in the Trust's performance-related pay scheme or is a member of the Trust's pension scheme;
- Has close family ties with any of the Trust's advisors, Directors or senior employees;
- Holds cross-directorships or has significant links with other Directors through involvement with other companies or bodies;
- Has served on the Trust Board for more than six years from the date of their first appointment (subject to provision where Chairs and NEDs can serve beyond six years subject to rigorous review and NHS England approval); or
- Is an appointed representative of the Trust's university medical or dental school.

The SID, whilst eligible to be the Vice-Chair, cannot carry out the SID role when acting as Chair of the Trust.

The Board will review the appointment of the Vice-Chair every three years or when the incumbent Vice-Chair's term of office as Non-Executive Director comes to an end, whichever is sooner.

Key Duties:

The Vice-Chair will normally preside at meetings of the Board of Directors in the following circumstances:

- When the Chair is unavailable to chair the meeting due to ill health or annual leave; and
- On occasions when the Chair has declared a pecuniary interest that prevents them from taking part in the consideration of a matter being discussed by the Board.

The Vice-Chair may be asked to stand in for the Chair at public events or stakeholder meetings.

The Vice-Chair may assist the Chair in their leadership responsibilities, acting as a sounding board and advisor.

The Vice-Chair may be asked to take on lead portfolio roles assigned by the Chair or Board.

The Vice-chair will have access to the support and advice of the Company Secretary in fulfilling their duties.

Appendix 2

Role of the Senior Independent Director

The Senior Independent Director (SID) is a Non-Executive Director appointed by the Board of Directors. The SID has all the general duties of a Non-Executive Director but with the enhanced duties of the SID as set out below. The SID appointment will not attract any extra remuneration.

In summary the purpose of the SID is to provide a sounding board for the Chair and to serve as an intermediary for the other Directors when necessary.

Qualifying Criteria:

The SID must be considered to fulfil the criteria of 'independent' as set out in NHS England's Code of Governance for Provider Trusts Provision 2.6.

Circumstances that are likely to impair, or could appear to impair, a Non-Executive Director's independent include, but are not limited to, whether a Director:

- Has been an employee of the Trust within the last two years;
- Has, or has had within the last two years, a material business relationship with the Trust either directly or as a partner, material shareholder, Director or senior employee of a body that has such a relationship with the Trust;
- Has received or receives remuneration from the Trust apart from a Director's fee; participates in the Trust's performance-related pay scheme or is a member of the Trust's pension scheme;
- Has close family ties with any of the Trust's advisors, Directors or senior employees;
- Holds cross-directorships or has significant links with other Directors through involvement with other companies or bodies;
- Has served on the Trust Board for more than six years from the date of their first appointment (subject to provision where Chairs and NEDs can serve beyond six years subject to rigorous review and NHS England approval); or
- Is an appointed representative of the Trust's university medical or dental school.

The Chair is not eligible to be the SID. The Vice-Chair, whilst eligible to be the SID, cannot carry out this role when acting as Chair of the Trust.

The Board will review the appointment of the SID every three years or when the incumbent SID's term of office as Non-Executive Director comes to an end, whichever is sooner.

Key Duties:

The SID will be available to Directors and staff if they have concerns which contact through the usual channels of Chair, Chief Executive and Company Secretary has failed to resolve or where it would be inappropriate to use such channels.

The SID has a key role in supporting the Chair in leading the Board, acting as a sounding board and source of advice for the Chair.

The SID will determine the process for, and conduct, the Chair's annual appraisal and should hold a meeting with other Non-Executive Directors at least annually as part of the Chair's appraisal process.

The SID will also support the Remuneration & Nominations Committee in ensuring that there is an orderly succession process for the Chair role when reappointment or new appointment is necessary.

In the event that there are concerns about the performance of the Chair, the SID should provide support and guidance to the Board in seeking to resolve concerns, or in the absence of a resolution, in liaising with NHS England to take formal action.

In circumstances where the Board is undergoing a period of stress the SID has a vital role in intervening to resolve issues of concern. For example, where the relationship between the Chair and Chief Executive is too close or insufficiently harmonious or where key decisions are being made without reference to the Board. In such circumstances the SID will work with the Chair, other Directors and Company Secretary to resolve significant issues.

The SID will have access to the support and advice of the Company Secretary in fulfilling their duties.

Appendix 3

NED Committee Membership / Chairing Arrangements and Other Duties

Committee Membership from June 2025

	Chair	Members
Audit Committee	Khalil Rehman	Graham Baldwin Liz Sedgley Sallie Brigden Simon Featherstone
Remuneration Committee	Graham Baldwin	All NEDs
Quality Committee	Simon Featherstone	Catherine Randall Sallie Brigden Shahedal Bari
Finance & Performance Committee	Sallie Brigden	Liz Sedgley Simon Featherstone Bill Dixon
People & Culture Committee	Liz Sedgley	Khalil Rehman Catherine Randall Melissa Hatch
Charitable Funds Committee	Melissa Hatch (Catherine Randall from November 2025)	Bill Dixon Khalil Rehman

Other NED Roles

Non-Executive Director	Role
Sallie Brigden	NED for Diversity & Equality
Graham Baldwin	NED for BAME Staff Network NED for Veterans Network
Khalil Rehman	NED for Data & Digital NED Maternity Champion NED for International & Overseas Staff Network (shared role)
Simon Featherstone	NED for Doctors in Difficulty NED for Freedom to Speak Up NED for DAWN Network
Catherine Randall	NED for Safeguarding NED for PSIRI Panels NED for LGBTQ+ Network
Liz Sedgley	NED for Health, Safety & Security (shared role)

	NED Wellbeing Guardian NED for Mental Health & Wellbeing Employee Network
Melissa Hatch	NED for Health, Safety & Security (shared role) NED for Women's Employee Network NED for Families and Carers Staff Network
Bill Dixon	NED for Business Continuity NED for International & Overseas Staff Network (shared role)
Shahedal Bari	NED for End-of-Life Care NED for Muslim Employee Network

Appendix 4

Division of Responsibilities between the Chair and Chief Executive

This Memorandum of Understanding between the Chair and Chief Executive of East Lancashire Hospitals NHS Trust sets out the differing and complementary leadership roles of the Chair and Chief Executive.

In accordance with NHS England's Code of governance for provider trusts [the Code] it is essential that as Chair and Chief Executive we are clear about our respective roles.

Section B Provision 1.2 of the Code states that responsibilities should be clearly divided between the leadership of the Board and the executive leadership of the Trust's operations. No individual should have unfettered powers of decision.

Whilst there is a detailed division of responsibility appended to this Memorandum, we agree that at the broadest level the Chair's role is to lead the Board of Directors to ensure that the organisation has the vision, strategy and resource in place to deliver the objectives of the Trust and to create the conditions for good governance. The Chief Executive's role is to lead the executive team and ultimately ensure that the Board's vision and strategy is achieved and that all risks are effectively managed.

We acknowledge that the Chair's role is not an executive one and does not require becoming involved in the day-to-day operational management of the Trust but rather the Chair provides strategic challenge and oversight, ensuring that operational decisions align with the Trust's objectives.

We both respect the authority of the Board of Directors as the ultimate decision-making body in the Trust, whilst at the same time recognising that the Chief Executive in their capacity as Accounting Officer has a personal responsibility to Parliament for the overall performance and conduct of the Trust.

We recognise that we both have a role in communicating with external stakeholders but agree that the Chair leads in representing the Board in high-level stakeholder engagement whilst the Chief Executive will take the lead in communicating with external stakeholders about operational matters.

We recognise that the way we conduct ourselves individually and together has a significant impact on the effectiveness of the Board of Directors and on the culture of the Trust. We will therefore strive to behave consistently with this Memorandum, the Board Code of Conduct and to always reflect the values of the Trust; and we will commit to regularly reflecting on the extent to which we are operating consistently with the role specifications outlined in this Memorandum.

Shazad Sawar	**Martin Hodgson**
Chair	**Chief Executive**
Date:	**Date:**

Annex 1

Division of responsibilities

Chair	Chief Executive
Reports to the Board of Directors and is accountable to NHS England for the performance of the Board of Directors.	Reports to the Chair and Board of Directors
The Chief Executive, and the Company Secretary via a dotted line, report directly to the Chair.	All members of the Executive Team and wider management structure report directly or indirectly to the Chief Executive.
Leads and ensures effective operation of the Board of Directors.	Leads the Trust's operations.
Ensures that the Board of Directors determines the Trust's strategy and overall objectives. Holds the Chief Executive to account for the effective delivery of the Trust's strategy and objectives.	Responsible for proposing and developing, in consultation with the Board, the Trust's strategy and overall objectives. Once agreed, responsible for their implementation with the appropriate allocation of resources and management of risk.
Guardian of the Board's decision-making processes.	Ensures the provision of support and information to the Board to enable effective decision-making, and implements the decisions of the Board and its Committees.
Sets the Board agenda, ensuring that it captures all of the important issues facing the Trust.	Provides input into the Board agenda, ensuring the Chair is aware of important issues facing the Trust. Escalates urgent or significant operational issues requiring Board attention outside of formal Board meetings.
Leads by example the Board's values and behaviours, including setting the style and tone of discussions at Board meetings.	Communicates the Board agreed values and behaviours to all employees, ensuring that the values are embedded in everyday operations.
Ensures the Board receive accurate, timely and clear information.	Ensures that reports to the Board contain accurate, timely and clear information.
Ensures effective flows of information between the Board and its Committees, Non-Executive Directors and Executive Directors.	Provides effective information and communication systems.
Ensures compliance with Board procedures.	Ensures that the Executive Team comply with Board procedures.
Facilitates effective contribution of all Board members. Ensures that constructive	Supports the Chair in facilitating and sustaining constructive relationships

relations existed between Executive and Non-Executive Directors.	between the Executive and Non-Executive Directors.
Proposes the membership and chairs of Board Committees.	If appointed by the Board, serves as a member on any Board Committee.
Leads the induction of new Non-Executive Directors and the Board induction of new Executive Directors.	Leads the Trust induction of new Executive Directors and contributes to the induction of new Non-Executive Directors.
Leads on the appraisals of Non-Executive Directors, and the appraisals of Executive Directors in relation to their Board Director roles.	Leads the appraisals of Executive Directors in relation to their Executive roles.
Ensures there is an effective Board development programme in place.	Supports the chair with the commissioning of any external board development support.
Promotes the highest standards of integrity, probity and corporate governance throughout the Trust, particularly at Board level.	Conducts the affairs of the Trust in compliance with the highest standards of integrity, probity and corporate governance.
Takes the lead representing the Board in high-level stakeholder engagement.	Takes the lead in representing the Trust and communicating on operational matters with external stakeholders.

TRUST BOARD REPORT

Meeting Date:	14 May 2025	**Agenda Item:**	TB/2025/059
Report Title:	Chief Executive's Report		
Author:	Ms S Wright, Executive Director of Communications		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
				✓
Executive Summary:	A summary of relevant national, regional and local updates is provided to the board for context and information.			
Key Issues/Areas of Concern:				
Action Required:	Members are requested to receive the report and note the information provided.			

Previously Considered by:	
Date:	
Outcome:	

1. Background

This report is divided into sections covering the following:

- National headlines relevant to the NHS and wider health and social care economy
- News and information from across the North West and Lancashire and South Cumbria system area, including details from the Integrated Care Board (ICB) and Provider Collaborative Board (PCB)
- Local and Trust specific updates

2. National Updates

Significant changes announced for NHS England

The Government announced in March that NHS England will be abolished and brought into the Department of Health and Social Care, in order to reduce duplication. The transformation will take place over the next two years.

It follows the resignation of Amanda Pritchard who formally notified the NHS England Board in February of her decision to stand down as Chief Executive. Sir James Mackey will take over as interim Transition CEO of NHS England. In March, three other members of the Board announced they would stand down in Chief Financial Officer Julian Kelly, NHS Chief Operating Officer Emily Lawson and Chief Delivery Officer and National Director for Vaccination and Screening Steve Russell.

A new NHS Transformation Executive Team will support ongoing business priorities, statutory functions and day to day delivery.

NHS 10-year plan

Over 220,000 contributions were made by the public and health and care colleagues towards the national NHS 10-year plan.

A range of opportunities were provided for people to share their views, including a dedicated portal, Change NHS, and face to face events. In East Lancashire, the Trust attended a workshop organised by Hyndburn MP, Sarah Smith, where local residents were able to provide feedback.

The surveys on Change NHS are now closed and the plan is being finalised. Change NHS was launched in October 2024 to hear views, experiences, and ideas to help shape the new NHS health plan for England.

The plan is expected to focus on three shifts for the NHS which are:

- Moving care from hospitals to communities
- Making better use of technology
- Focussing on preventing sickness, not just treating it

Foundations for NHS reform

Plans have been set out nationally to reduce the collective deficit of the NHS in England.

Sir James Mackey, Chief Executive of NHS England, has outlined the foundations for reform, with a promise of more detail when the outcome of the Government's overarching Spending Review is known. They are:

- Integrated Care Boards (ICBs) are expected to reduce running costs by 50% and will have a critical role to play in the future as strategic commissioners
- All NHS providers will reduce their corporate cost growth, with savings reinvested locally to enhance frontline services

The NHS faces a significant finance challenge across the country.

The ICB in Lancashire and South Cumbria, along with Blackpool Teaching Hospitals, Lancashire Teaching Hospitals and ELHT remain in NHS Oversight Framework Segment 4 (NOF4) and are being supported through the National Recovery Support Programme (RSP).

The system remains one of the most financially challenged in the country and continues to spend beyond its allocated budgets, with a significant deficit expected in 2025-26. Robust and detailed plans are being put together to reduce costs, whilst ensuring patient safety is not compromised.

NHS slashes tests and checks waits to five year low

The average wait for tests and checks since the height of the pandemic has more than halved according to new national data.

Patients were waiting an average of 17 days for tests and checks in January – 43 days less than at the height of the pandemic (May 2020). Average waits for tests are now the lowest since February 2020.

NHS teams delivered more than 2.5 million checks in January, up almost a quarter (23%) on 2.05 million in January 2019 and 5% higher than the same month last year (2.4 million in January 2024). The total waiting list in January fell for the fifth month in a row by 35,000 from 7.46 million to 7.43 million, meaning it has now fallen by 193,000 since July 2024. The estimated number of patients waiting in January was 6.25 million.

Over 1,500 extra GPs recruited

New figures show an extra 1,503 GPs have been recruited since 1 October. The recruitment boost should enable more patients to see a doctor – easing pressure on GPs and cutting waiting lists. Alongside changes to the GP contract for 2025-26, these additional GPs will help end the '8am scramble' for appointments which so many patients currently endure every day – reducing the number of people attending same day emergency care (SDEC) pathways.

New services for patients under pharmacy funding deal

Patients will receive more services through community pharmacies. The Department of Health and Social Care has agreed funding with Community Pharmacy England worth an extra £617 million over two years following a 6-week consultation with the organisation.

The investment comes alongside reforms to deliver a raft of patient benefits, as part of the government's agenda to shift the focus of care from hospitals into the community, so that people can more easily access care and support on their high streets.

Beds lost to seasonal viruses this winter greater than population of Malta

The number of hospital beds taken up by seasonal viruses this winter was more than the equivalent of the population of Malta, according to NHS data.

Almost 600,000 beds were taken up by patients with Covid, flu, RSV or norovirus this winter (594,937 from 25 November 2024 – 30 March 2025), as NHS services experienced a 'quad-demic' of viruses.

The number of inpatients with norovirus reached record highs in February with cases up as much as 150% on the same month last year**.** The number of cases surged by up to 40% week on week and over 40,000 bed days were lost to the vomiting bug in February alone.

Throughout March, cases have dropped week on week but winter illness pressures still remain high.

Review to make postgraduate medical training 'best in the world'

Two of England's leading doctors are to oversee a significant review into postgraduate training for newly qualified medics.

National Medical Director Professor Sir Stephen Powis and Chief Medical Officer Professor Sir Chris Whitty will lead the review as part of work to address concerns raised by resident doctors (previously known as junior doctors).

The review will be based on feedback from current resident doctors and students, locally employed doctors and medical educators, with a series of engagement events around the country starting from March 2025.

The review will cover placement options, the flexibility of training, difficulties with rotas, control and autonomy in training, and the balance between developing specialist knowledge and gaining a broad range of skills.

NHS spring Covid vaccine rollout kicks off with more than half a million appointments already booked

NHS colleagues began delivering spring Covid vaccines on Tuesday, 1 April, with more than half a million appointments booked in the week the booking system opened.

Individuals that need extra protection this year include those aged 75 and over (including those by 17 June 2025), older adult care home residents and immunosuppressed individuals aged six months and over.

Local NHS teams have been working to make it as easy as possible for people to get jabbed close to home and around 7.5 million people will be invited to get their jabs. Invites will be sent via email, NHS App messages, texts, or letters.

Tens of thousands seek NHS advice on breast cancer screening following launch of first-ever NHS campaign

Tens of thousands of people have accessed NHS advice on attending mammograms since the launch of the first-ever NHS breast cancer screening campaign.

The NHS in England launched its first-ever awareness campaign on Monday, 17 February to highlight the benefits of screening and encourage more women to make the most of regular mammograms, as figures showed more than four in ten (46.3%) invited for the first time don't act on their invitation.

There was a 97% increase in clicks to the breast-screening-services finder, where women, aged between 50 and 71, can see where they can get screened in their local area.

Nationwide roll out of artificial intelligence tool that predicts falls and viruses

A new artificial intelligence (AI) tool is being rolled out across the NHS that can predict a patient's risk of falling with 97% accuracy, preventing as many as 2,000 falls and hospital admissions each day.

The predictive tool, developed by health tech provider Cera, is now being used in more than two million patient home care visits a month, monitoring vital health signs to predict worrying signs of deterioration in advance. It can then alert healthcare staff so they can step in and reduce the risk of hospitalisation.

The software is in use across more than two thirds of NHS integrated care systems across the country and helps to provide care at home by flagging as many as 5,000 high-risk alerts a day, reducing hospitalisations by up to 70%.

Frontline NHS workers facing rise in physical violence

One in seven NHS workers (14.38%) experienced physical violence from patients, their relatives or other members of the public in 2024, according to the latest annual NHS staff survey.

The report reveals attacks on staff have increased since 2023 (13.88%) – though numbers are below the record levels seen between 2020 to 2022 during and following the pandemic.

Employees experiencing discrimination at work reached its highest level in five years (9.25%), with more than half (54.09%) saying the discrimination they received from patients and the public was based on their ethnic background.

One in 12 (8.82%) NHS workers experienced unwanted sexual behaviour – including offensive comments, touching and assault. The proportion of employees affected remains similar to the level reported in 2023 (8.79%) when the question was first asked.

3. Regional Updates

ICB Chief Executive to step down

NHS Lancashire and South Cumbria Integrated Care Board (ICB) Chief Executive, Kevin Lavery, has announced that he will step down after three years in the role.

Mr Lavery wrote to colleagues to share the news, saying that he was proud of the work that has taken place to address major challenges that the ICB has faced since it was established in 2022.

The ICB's Chief Finance Officer, Sam Proffitt, will now take on the role on an interim basis.

New interim medical director announced for ICB

Dr David Levy stepped down from his role as Medical Director for Lancashire and South Cumbria Integrated Care Board (ICB) at the end of February.

Following an internal selection process, Dr Andy Knox has been announced as the interim medical director.

Dr Knox will undertake the role on a six-month basis whilst the process to secure a permanent medical director takes place. He will work closely with the executive team during this time to ensure that the ICB maintains strong clinical leadership throughout this period of change.

Long Covid service no longer accepting referrals

From Thursday, 1 May 2025, the long Covid services in Lancashire and South Cumbria will no longer be commissioned as standalone services.

The service is made up of different healthcare professionals and was launched to support people who were suffering ongoing effects of the virus months after being infected.

Between January 2021 and January 2025, there were 1,720 referrals to the Pennine service and the team have done a fantastic job helping improve the lives of all those affected.

The decision to stop the service was taken by NHS Lancashire and South Cumbria Integrated Care Board (ICB) due to a significant drop in referrals, and a change to the national funding from 1 April.

Anyone who was accessing the services has been contacted directly by their provider to ensure they are supported appropriately based on their individual needs.

Data and Digital system-wide collaboration successes

Over the last four months, Data and Digital teams across Lancashire and South Cumbria have started to collaborate in a more effective way and are currently exploring how to standardise many systems/processes across Lancashire and South Cumbria to begin to deliver value across the five provider Trusts, reducing duplication and significantly improving patient experience.

Some examples of this activity are:

- A Patient Engagement Portal with benefits demonstrated in the self-booking of appointments through the portal, reducing ‘did not attend’ rates from 7% down to 2%
- Improving capturing outpatient activity and identifying additional activity on clinical systems which the Trust has not been paid for. This process and exercise is likely to generate over £6million of additional income across the system
- A single programme management tool
- Sharing Database Administrators between Trusts has prevented at least two high severity outages and is supporting the upskilling of people across our organisations.

‘Feedback Fortnight’ gains insights from children, young people, parents and carers

Children and young people, as well as their parents and carers, were invited to share their experiences of the local NHS during a two-week period in March.

Labelled 'Feedback Fortnight', the pilot project was led by the children and young people team at Lancashire and South Cumbria Integrated Care Board (ICB), alongside partners from across the region.

Engagement took place with children, young people and their families and carers to help the ICB understand their experiences of health services and ways in which services and programmes can be improved.

Some of the topics the ICB were looking for feedback on included attendees experiences of accessing services and their satisfaction levels with care, waiting times and information provided, with a final report to be made available on the ICB website in due course.

Male suicide prevention campaign

The NHS in Lancashire and South Cumbria launched a new campaign in March to tackle the issue of male suicide.

Suicide rates in the North West are now the highest the UK and it is the single biggest killer of men under 49.

The latest Let's Keep Talking campaign aims to help males in the region understand that reaching out and seeking help isn't a weakness and that help and support is available.

4. Local and Trust specific updates

Changes to the Trust Board

Since the last meeting, there have been some changes to the Trust Board.

Executive Medical Director, Jawad Husain, retired from his role on 31 March. Jawad joined the Trust in February 2020 and was immediately handling the Covid pandemic which reached our doors just days afterwards. Mr Shahid Islam is currently acting as Interim Executive Medical Director.

Finance Headlines

Whilst the details of the Trust's progress on recovering its overall budget position is reported in more detail separately to the Board, it is important to recognise that the financial control total for 2024-25 was delivered as agreed. This was a deficit position of circa £40million and whilst it remains incumbent upon all colleagues to manage budgets responsibility and to live within established financial parameters as set, it is right to recognise the amount of effort expended by teams across all services and settings to achieve it.

The requirement for this financial year is to half that deficit by the end of March 2026 which requires the Trust to reduce costs by more than £60million in year. The Trust currently has around £30million of savings approved for implementation, with another £15million worth of detailed plans in place and an organisation wide programme ongoing to find another £15million to achieve the total amount. This work is being supported by colleagues in the national Recovery Support

Programme (RSP) and other specialist financial consultants following the Trust's move into segment four of the NHS Oversight Framework (NOF) in February.

Performance Headlines

Whilst the details of the Trust's overall performance will be reported in more detail separately, it is important to share the headlines as part of this overview which demonstrate that colleagues continue to perform well both clinically and operationally. For the year 2024/25 just ended this includes:

- Waiting lists reduced for elective procedures by almost 17 per cent – with no one waiting more than 65 weeks for care
- Just under 80 per cent of people seen in urgent and emergency within four hours – despite huge and record breaking numbers of people turning up for care
- Patients handed over from ambulance colleagues in less than 30 minutes on average
- Consistently high standards in cancer pathways
- Consistently strong productivity in operating theatres which are amongst the best in England and often in the top three Trusts nationally
- 99 per cent of all patients waiting less than six weeks for a diagnostic test
- Continued improvement in already effective maternity services which are recognised as some of the best in the country

These are just a few highlights aligned to key performance metrics and do not reflect the totality of activity, hard work and compassion delivered by colleagues in all services, across all settings and in the community, each and every day.

Recent Visits from the Care Quality Commission (CQC)

The Care Quality Commission (CQC) recently carried out two planned visits to the Trust. They spent time in a number of community services settings as part of a formal inspection and in the emergency department informally at Royal Blackburn Teaching Hospital.

As part of both of these visits the inspection teams spoke to patients, colleagues and partners about their experiences as well as considering performance data to inform their feedback and views.

Whilst we are waiting for formal feedback, the CQC does provide immediate input as part of all visits and the feedback from both of these recent interactions was very positive indeed.

We are grateful to the CQC for their time and findings which are always an opportunity for colleagues to learn and share information about the delivery of our services and improvements being made.

The Trust's current rating is good overall, with pockets of outstanding practice.

March to Success' initiative paves the way for improvement

Throughout March, intensive activity was carried out to reduce pressure within the urgent and emergency care pathways – which was internally named 'March to Success'.

The objective was to encourage colleagues to think differently and identify new opportunities to optimise resources and processes to provide safe, personal and effective care to enable the Trust to make immediate improvements and create a longer-term, sustainable improvement on long waits to be seen and lengths of stay in the department and hospital settings as a whole.

The results were positive and the Trust has seen an overall improved performance during March 2025 across a number of key measures. To keep this momentum going into April and beyond, the team will pull together what they have seen, done, heard and collected throughout the month to inform the specific work streams to take the UEC improvement programme of work forward.

Improved ambulance hospital handover time helps reduces delays in ED

The Emergency Department team at RBTH, recognised as the busiest in the North West for emergency ambulance arrivals, has seen an improved performance in their ambulance hospital handover time – showing a real shift in timeliness and reducing delays.

The team have been working in collaboration with NWAS colleagues to make patient experience the best it can be during the transition of care.

Multiple changes have been developed, including the way a patient is triaged at initial assessment, and improved visual management in the department and the introduction of a one way in and out system for NWAS crews to alleviate congestion.

Thanks to an enormous team effort and hard work ambulance hospital handover turnaround times (arrival to ambulance crew leaving the hospital) have seen a vast improvement. For the first three months of 2025 the average time was 36 minutes 19 seconds compared to 45 minutes 41 seconds for the same period in 2024.

And since the start of April 2025 the Trust has been recognised as the best performing hospital in the Northwest, with Monday, 7 April seeing 90% of our patients handed over within 30 minutes.

Rapid improvement weeks identify over £900,000 of potential savings

The Trust held a series of Rapid Process Improvement Weeks (RPIW) to help teams and departments reduce the overall variable pay spend (bank and agency) for the Trust.

Following similar initiatives at Leeds Teaching Hospitals and Lancashire Teaching Hospitals, during each week colleagues come together and receive intensive support to review and improve processes.

So far, three RPIWs involving 13 teams and departments from all areas of the Trust have taken place, identifying approximately £906,000 of annual savings simply by changing the way they work.

The Trust has received over 1,000 other cost-saving ideas from colleagues ranging from small but impactful measures such as streamlining how we send patient appointment letters to larger projects that require more planning to implement for the 2025/26 financial year.

Endoscopy services receive eighth consecutive accreditation

Endoscopy services have received accreditation from the Joint Advisory Group for Endoscopy (JAG) for the eighth time in a row.

The Trust's endoscopy services were first JAG accredited in 2017 and are required to submit evidence annually to demonstrate that they are continuing to meet the required standards.

JAG accreditation means that patients can have increased confidence in their endoscopy service, being assured of a high quality of care and colleagues can feel a sense of pride in being able to show that they offer a high quality and safe service.

Changes to endoscopy services

The endoscopy suite, based at Rawtenstall Health Centre, has been consolidated into provision at Burnley General Teaching Hospital and Royal Blackburn Teaching Hospital.

The Trust had 10 endoscopy rooms – six in Burnley, three in Blackburn and one in Rossendale. The team across them carry out around 22,000 procedures each year including colonoscopy, gastroscopy and flexible sigmoidoscopy. However therapeutic treatments for patients is only delivered at Burnley and Blackburn, so some patients were having to attend a second appointment to access this.

Consolidating endoscopy activity on the two main sites will improve service to patients and the times they are waiting to be seen and by becoming more effective in our delivery the Trust will save more than £650,000 a year.

New solar panel funding for Burnley and Pendle hospitals

Nearly £2 million has been awarded to the Trust by the Department for Energy Security and Net Zero to install solar panels.

The panels will be installed this year at Burnley and Pendle hospitals where they are expected to generate over 1 million kilowatt hours of energy over the course of a year. This will potentially save the Trust over £250,000 a year.

The money is part of £180 million that has been awarded across the country to deliver community clean energy projects, including new rooftop solar power on schools, and measures to help hospitals reduce energy bills.

Community services helping more patients than ever be cared for in their own home

Latest figures released from The Intensive Home Support Service (IHSS) shows that its performance over the past year is helping prevent hospital admissions.

Throughout 2024:

- IHSS had 19,563 referrals, 5,107 new patients, 3,558 care home referrals, 40,649 face-to-face visits, 10,059 telephone consultations and 133,944 calls to ICAT
- The Front Door model, based at RBTH's emergency department, assessed 1,426 patients with 1,083 being discharged home
- The team responded to 10,035 urgent community responses (UCR) – and are currently well about the above the national target of 70%, consistently achieving 95% compliance with the two-hour target
- More requests are being made by care homes to IHSS than ever before and this has exceeded ED attends for three months in a row

- The Trust's virtual ward programme, Hospital at Home, has seen a 79.4% virtual ward utilisation. The service, which has accepted 32,010 referrals since its start in October 2022 and allowed for 90.4% of patients remaining in their usual place of residence helps to reduce the pressure on the Trust's inpatient wards and services and freeing up space for others to receive care quicker.

By providing care for people in the community, the team is helping reduce time spent in hospital and avoiding admissions in the first place.

Prime Minister visits Rossendale

Prime Minister Sir Keir Starmer visited Rossendale Primary Health Care Centre in April.

Whilst at the centre he met with a number of colleagues from the Trust and the wider health and social care team, as well holding a patient focus group.

The Prime Minster used the visit to announce the first freeze of prescription charges in England for three years and to learn more about the successful work taking place at Rossendale Community Diagnostics Centre.

Trust features in Channel 4 documentary series

Emergency Theatre colleagues featured in a new three-part documentary series that aired on Channel 4.

The programme, called 999: The Critical List, followed colleagues as they juggled urgent life-or-death cases and how they decide how they prioritise patients going into Theatre Six - the operating room dedicated to unplanned emergency procedures.

The series was filmed in January 2024 and has received positive feedback from colleagues and viewers who have been given the opportunity to see behind the scenes of a busy department.

NHS staff survey results revealed

Results of the 2024 NHS National Staff Survey have been published for all Trusts in England.

It is one of the largest workforce surveys in the world and is carried out every year to improve colleague experiences across the NHS. Over 4,200 colleagues (42%) completed it.

A total of 119 questions were asked and of these 113 can be compared with last year's results in that scores for six questions were significantly better, 79 had no significant difference and 15 were notably worse. Whilst it is disappointing to see a deterioration in some results, the Trust is committed to using the results of the survey to identify areas for improvement.

The information will help departments and the organisation to track where things are improving or declining and identify areas for improvement.

Moving from protected meal times to supported meal times

Family, friends and carers are now able to stay and support their relatives and friends during mealtimes.

The Trust has moved away from the traditional concept of protected meal times and embraced a more flexible, person-centred approach called supported meal times.

Protected meal times were introduced to reduce interruptions during meals, aiming to give patients a calm environment to eat. While the intention was good, in practice, this sometimes meant that patients didn't always get the help they needed.

Supported meal times, on the other hand, prioritise active assistance and engagement. This approach recognises that many patients need support to eat—whether that's physical help, encouragement, or simply having someone to sit with.

Patient wellness questionnaire pilot a success

A patient wellness questionnaire that was piloted as part of Trust's Call for Concern initiative has been expanded to another four pilot sites across the Trust.

Ward nurses ask patients or their advocates two simple daily questions - 'how are you feeling today?' and 'how are you feeling compared to last time we asked you?'. The aim is to identify potential deterioration in conditions as early as possible.

Since starting the project, over 700 patients have been asked the wellness questions. From those identified as requiring intervention, 75% have been resolved through nurses using their clinical judgment to put interventions in place and the other 25% have been reviewed by a doctor.

Feedback has been extremely positive, with patients stating their experience has improved as they feel listened to. The questionnaire will be implemented Trust-wide in May.

Trio of community nurses awarded prestigious Queen's Nurse title

Three community nurses have been given the prestigious title of Queen's Nurse.

Louise Canovan, Helen Davis and Julia Higginson were handed the accolade by nursing charity The Queen's Nursing Institute (QNI) for their commitment to high standards of patient care, learning and leadership.

It follows a rigorous application process which required detailed evidence of professional practice and feedback from colleagues, patients and families.

The QNI is dedicated to improving the nursing care of people at home or in the community and the Nurse's Award is a way of highlighting nurses who are delivering high quality services.

Community hospital's memories displayed in local exhibition

Precious memories of Accrington Victoria Community Hospital were exhibited at Accrington Library throughout March and April.

Services were moved out of Accrington Victoria in December because it was no longer fit for purpose for colleagues or patients. The Trust has stayed true to its promise to keep key services local and discussions with local leaders and Hyndburn MP Sarah Smith have commenced as to how we engage local residents and ascertain the future of the site so that it continues to serve the local community.

As services moved, care was taken to preserve artefacts, images and historical plaques from the site and many of them form part of the exhibition, along with personal stories of past patients and colleagues.

The exhibition was well received with the library and the Trust both receiving positive feedback from people who visited it. Artefacts are now being kept safe so they can be displayed in an appropriate way in the future.

A programme of engagement events will now begin with the local community and stakeholders to agree next steps to regenerate the building for the town.

Burnley Endometriosis Centre celebrates 10th consecutive year of BSGE accreditation

The Gynaecology Endometriosis Centre at Burnley has retained its accreditation from the British Society for Gynaecological Endometriosis (BSGE) for the 10th consecutive year — a significant milestone that highlights the team's ongoing commitment to excellence in patient care.

The Centre, led by consultant gynaecologists Mr Abdel-Aty and Mr Elsherbiny, has continued to build on its strong foundations, working closely with our Colorectal Surgery Consultants to offer comprehensive, multidisciplinary care. Notably, this year’s submission to the BSGE demonstrated an increase in the number of procedures performed.

The BSGE plays a vital role in advancing gynaecological care across the UK, aiming to improve surgical standards, foster training, and support the exchange of knowledge in minimal access techniques for patients with gynaecological issues.

NROL team to expand digital rehabilitation programme

The Neuro Rehabilitation Online team (NROL), hosted at ELHT, has been awarded 12 months of funding to continue its work to support stroke survivors and people living with neurological conditions.

The NROL programme was originally developed during the pandemic by SameYou in partnership with University College Hospital London, providing online therapy across Lancashire and South Cumbria. It delivers cognitive, communication and physical therapy via video calls, enabling more therapy to be delivered and therefore better outcomes for patients.

Armed Forces Veteran Team receive Lord-Lieutenants’ Award

The ELHT Armed Forces Veteran Team has received a Lord-Lieutenants’ Award.

The team, made up of Armed Forces Veteran Team Manager Sid Sadiq and Clinical Site Manager and Armed Forces Veteran Senior Lead Fiona Lamb, received a Lord-Lieutenants’ Certificate of Meritorious Service for veterans and service charities at a ceremony held on Wednesday, 12 March.

HM Lord-Lieutenants are appointed by The King to represent him in each county of the United Kingdom and the honours they present are among the highest an individual can receive.

Emergency Department celebrates HSJ Partnership Awards nomination

Colleagues from the Emergency Department were finalists in the HSJ Digital Awards 2025 in the improving urgent and emergency care through digital category.

It is in recognition of the streaming and redirection tool which helps direct patients to the most appropriate care for their condition. It is currently being used at the front door of the Trust's emergency and urgent departments at Blackburn, Burnley and Accrington.

The project has been a massive success at all three Trust sites with patients able to walk in the door, complete triage and get an appointment within five minutes.

Done in partnership with the Strata booking system and by using the Booking and Referral Standard (BaRS) it's resulted in up to 75% of patients who complete the triage being eligible to return later for an appointment. Despite attendances continuing to rise at the Royal Blackburn Hospital, the four-hour targets have improved from 87.71% in August 2021 to 94.94% in August 2024. The average time spent in the department for patients has gone down from 178 minutes to 94 minutes in the same time period.

The team were also recently shortlisted for the HSJ Partnership Awards for Best Contribution to the Improvement of Urgent and Emergency Care for the same tool and although they were not the overall winner, they were thrilled to be nominated.

Winners of the HSJ Digital Awards will be announced on 26 June.

Consultant Anaesthetist awarded humanitarian medal by King Charles

Consultant in Anaesthetics and Prehospital Emergency Medicine, Dr Matthew Newport has been awarded a Humanitarian Medal by King Charles.

Dr Newport, who works at the Royal Blackburn Hospital has deployed to Gaza five times over the past 12 months as part of the Government's humanitarian response to the Israel/Gaza crisis.

Funded by UK-Med, he worked alongside multinational health professionals to build and operate a tented field hospital on the Southern coast of Gaza that sees upwards of 500 patients a day. The field hospital received regular mass casualty events alongside a constant stream of trauma and medical cases, including many children.

ENDS

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD

Meeting Date:	14 May 2025	**Agenda Item:**	TB/2025/061
Report Title:	Annual Plan and Annual Budget 2025-26		
Author:	Mrs C Vozzolo, Associate Director of Service Development Ms C Henson, Deputy Director of Finance		
Lead Director:	Mrs K Atkinson, Director of Service Development and Improvement Mrs S Simpson, Director of Finance		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
			✓	
Executive Summary:	The Trust has a full Strategic Framework / overarching Trust Strategy which has been developed over the last 3 years which was signed off at Trust Board in September 2023. This is reviewed and updated annually as part of the Trust operational planning process. The Trust Planning update provides a summary of the Trust's planning priorities for 2025-26 including our updated Trust priorities, strategies priorities (Strategy plans on a page) and a summary of our national planning submission covering our key plans for 2025-26. The Trust's overall Strategic Framework has remained the same. There has been a review of the Key Delivery and Improvement Priorities for 2025-26 with 8 key priorities identified and include 19 key measures of improvement which will be reported as part of the Trust's Integrated Performance Report. All supporting strategies have been reviewed to agree key priority plans on pages for each for 2025-26 and will be monitored through strategic dashboards to relevant sub-committees on a bi-annual basis. In line with National operational planning requirements there has been a resubmission of Trust and System plans at the end of April 2025 and a summary of these plans is presented. In line with the Trust's Standing Financial Instructions and Scheme of Delegation, it is the responsibility of the Trust Board to approve the financial plan and associated budgets. Budget holders are then delegated the authority by the Board to spend up to the value outlined within the approved budget. The 2025/-6 financial plan that the Trust Board approved was submitted on the 30 April 2025 and the Annual Budget will reflect the financial plan.			
Key Issues/Areas of Concern:	The operational plan submitted is both ambitious and challenging as the Trust aims to meet its financial recovery requirements and continue to meet core national standards and ensure delivery of Safe, Personal and Effective Care. This is			

	reflected in the resetting of the Trust risk appetite statements as referenced in the Board Assurance Framework. Relevant Trust Board Sub-Committees will monitor progress and risks to delivery and any resulting recovery and improvement plans as the year progresses. The Trust will be monitored and held to account on the run rate improvements, as set out in the legal undertakings signed by the Board.
Action Required by the Committee:	The Trust Board are asked to: • Approve Trust Priorities for 2025-26 • Note the updated position against the national planning requirements for 2025-26 • Approve the Annual Budget for 2025-26

Previously Considered by:	Trust Board Subcommittees have reviewed and approved the relevant Strategy plan on a page for 2025/6. The Senior Leadership Group and Executive Team meeting have reviewed our key priorities and plans on a page.
Date:	April 2025 meetings
Outcome:	Support and approval for our plans and priorities.

East Lancashire Hospitals
NHS Trust
A University Teaching Trust

Trust Planning Update
Trust Board – 14th May 2025

Safe | Personal | Effective

ELHT. Because that's who we are

Executive Summary

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Introduction

- This paper provides a summary of:
  - Trust Strategies and Priorities for 2025/26 aligned to the Trust being placed in the Recovery Sup0portProgramme (National Oversight Framework Segment 4) due to its financial position and how we will measure performance against our priorities during 2025/26
  - Final version 'Strategy Plans on a Page' for the next 12 months against our key Trust Strategies and enabling Strategies (our key 12-month objectives against each of our 5-year Trust Strategies)
  - Summary of our NHSE planning submission for 25/26 plans (April submission)

Next steps

- The key next steps are:
  - May onwards – delivery of priorities tracked weekly through the Executive Improvement Wall, and updates to key sub committees of Trust Board and key measures included in Integrated Performance Report
  - During 2025 we will conduct a full-scale review of our Trust strategic priorities with a view to setting new plans from 2026/27 onwards

Recommendation

- **The Trust Board are asked to approve Trust Priorities for 2025/26 and note the updated position against the national planning requirements for 2025/26**

Contents

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

Trust Strategy and Priorities Update

Safe | Personal | Effective

ELHT. Because that's who we are

Trust Strategy and Priority Update

East Lancashire Hospitals NHS Trust
A University Teaching Trust

- The Trust has a full Strategic Framework / overarching Trust Strategy which has been developed over the last 3 years which was signed off at Trust Board in September 2023.
- The Trust's financial position has deteriorated over the last couple of years and significantly in 2024/25 culminating in recent downgrading to NHS Oversight Framework segment 4 (NOF4) and entry into the Recovery Support Programme on 4th February 2025. This is likely to result in a multi-year recovery programme.
- NHS Operational Planning Guidance for 2025/26 was published on 30th January 2025 and the Trust has developed and submitted a plan for 2025-2026 aligned to this guidance, with final submission on 30th April 2025.
- In Spring 2025 the Government will publish a new 10 Year Health Plan setting out 3 big shifts for the future NHS: from hospital to community, from analogue to digital, and from sickness to prevention. Whilst some of the priorities for this are set out in the 2025/26 planning guidance the full extent of the 10-year vision is yet to be detailed which could have a significant impact on the Trust's overarching strategies and plans.
- A number of key Trust Strategies require renewal in 2025 and some/all will now require a significant re-fresh and will need to take account of the current financial position and NOF4 status, the publication of the new 10 Year Health Plan, maturing of the ICB and Place (e.g. the Trust's Clinical Strategy was written just before the ICB was formally constituted and Place boundaries changed) including the recent work commissioned on the Clinical Strategy for Lancashire and South Cumbria, and recent changes to the way we deliver corporate services after the implementation of One LSC.
- This presents an opportunity to undertake a co-ordinated piece of work across all strategies to retain the best of what ELHT already has in place but to further enhance/bring these together to ensure alignment to support the ongoing delivery of Safe, Personal and Effective Care in the current context and need for a multi-year recovery plan. It may also represent an opportunity to consolidate and reduce the overall number of strategies and support creation of one key Trust Strategy with supporting delivery plans. A revised Strategy, as part of a Multi-Year Recovery Plan) would present a significant opportunity for co-design with patients, colleagues and partners.

Trust Strategy and Priority Plans for 25/26

East Lancashire Hospitals NHS Trust
A University Teaching Trust

- As previously agreed, the following updates have been undertaken to the Trust's Strategic Framework for 2025-26:
  - Trust Strategic Framework:
    - Current Strategic Framework Goals retained but measurement to be enhanced through stronger links to the refreshed Integrated Performance Report
    - Key delivery and improvement programmes reviewed and updated (with further alignment to the new Programme Management Office (PMO) to be undertaken in year as the PMO develops) including clear measures of success (Delivery, Quality, Cost, People)
  - Trust supporting and enabling strategies:
    - In line with previous years a plan on a page for each existing strategy has been produced to detail in-year priorities for existing in date strategies or to act as a bridge plan for any strategy which was due for renewal in 2025/26
  - Divisions have completed their Divisional and Directorate Business plans as per normal arrangements for sign off and review through Quarterly Performance Meetings (as per 2024/25)
- Key actions completed so far to support development of this plan:
  - Board Strategy Session (February 2025) – overview and proposed approach discussed and agreed
  - Executive Team/Senior Leadership Group (March 2025) – review and revision of goals, programme, priorities for 2025/26
  - Trust Sub-Committees (April 2025) – review of Annual Planning Submission / Strategy Plans on Pages 2025/26 as per relevant Sub-Committee
  - **Board sign off – May 2025**
- Next Steps:
  - Further work is undertaken to develop and agree a strategy refresh process during 2025/26 in line with the Recovery Support Programme and when further details of requirements for exit from NOF4 are known – to commence in Quarter 2

ELHT Strategy Status

Strategy	Strategy Status	24/25 Plan on Page	Work undertaken for 2025/26
ELHT Strategic Framework	Refreshed 2024/25	Yes	Reviewed and updated for 25/26 to incorporate latest plans for 25/26. Strengthened Key Performance Indicators and reviewed/refreshed Key Delivery and Improvement Programmes/Priorities for next 12 months
Clinical Strategy	2022-27	Yes	25/26 Plan on a page development for existing strategy completed. A full refresh/redevelopment of new strategy to be agreed when new Medical Director starts
Quality Strategy	2022-25	Yes	Discussed at Trust-Wide Quality Governance in January 2025 with a view to extension of current strategy for 1 further year to support ongoing completion of key objectives and allow time for refresh in line with a revised clinical strategy. 25/26 Plan on a page completed.
Health Equity Strategy	Full strategy in development Plan on page for 23/24 and 24/25	Yes	Draft strategy developed. Requires final review and sign off. Plan on a page for 25/26 completed.
People Strategy	Strategy 2019 – 2024 with plan on page for 24/25	Yes	25/26 Plan on a Page completed. A proposal to be developed to write a multi-year strategy thereafter. Will need to align to future Clinical Strategy and One LSC.
Green Strategy	2022-25	Yes	Current strategy remains relevant so can be extended forwards. Plan on a page for 25/26 completed.
Estates	2024-2030 with plan on page for 24/25	Yes	Revised strategy signed off in March 2024. Normal process of annual development of plans. Plan on a page for 25/26 completed.
Digital	Plan on page 23/24 and 24/25	Yes	Interim plan on page agreed for 24/25 to allow implementation of EPR and Creation of One LSC. 25/26 a further Plan on Page completed and full digital strategy refresh to be planned in line with Clinical Strategy refresh and further development of One LSC
Finance	2023-2027	Yes	Consideration of review requirements since entry into NOF4 and financial recovery plan. 25/26 Plan on page completed.
Department of Education, Research & Innovation	2022-2027	Yes	25/26 Plan on a page completed. Plan in place to review overall strategy during 2026.

Supporting and Enabling Strategies – Plan on Page 25/26

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Strategy	Lead Executive	Lead Deputy to Support	Committee to Sign Off	Committee Sign Off Date
Clinical Strategy	Medical Director, Chief Nurse	Associate Director of Service Development	Quality	30/04/25
Quality Strategy	Medical Director, Chief Nurse	Associate Director of Quality & Safety	Quality	30/04/25
Health Equity Strategy	Chief Nurse	Deputy Director of Integrated Care, Partnerships and Resilience	Quality	30/04/25
People Strategy	Executive Director of People & Culture	Deputy Director of People & Culture	People and Culture	7/4/25
Green Strategy	Executive Director of Integrated Care, Partnerships and Resilience	Head of Service - SRM	F&P	28/4/25
Estates	Executive Director of Integrated Care, Partnerships and Resilience	Divisional Director of Estates & Facilities	F&P	28/4/25
Digital	Executive Director of Finance/Director of Service Development & Improvement	Head of Digital & Data	F&P	28/4/25
Finance	Executive Director of Finance	Deputy Director of Finance	F&P	28/4/25
DERI	Executive Director of People & Culture	Deputy Director of Education, Research & Innovation	People and Culture	7/4/25

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

Trust Priorities 2025/26

Safe | Personal | Effective

ELHT. *Because that's who we are*

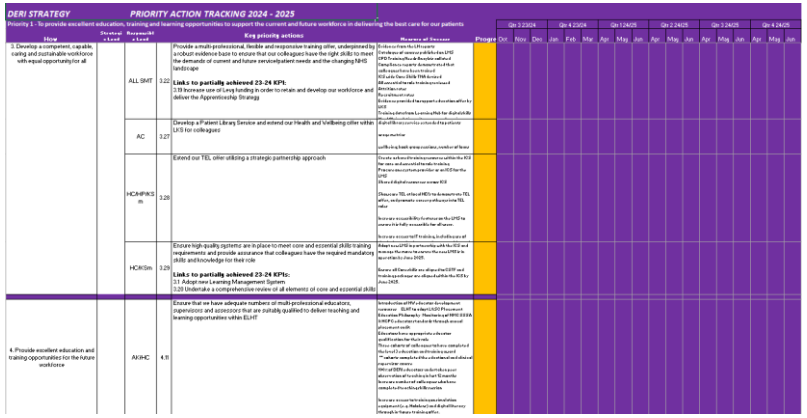
ELHT Key Delivery and Improvement Priorities 2025-26

Vision	Trust Goals	Trust Strategies	Key Delivery & Improvement Programmes	Key Delivery and Improvement Priorities	Measures of Improvement
Safe	Deliver safe, high quality care	Clinical Strategy	Quality & Safety Improvement Priorities	The transformation of Community (neighbourhood health model), Urgent and Emergency Care, Patient Flow and Discharge pathways to support safe, personal and effective care (right place, right time, first time)	➢ ED Over 12 hours in the department - reduction 17% to 15% ➢ Discharge at least 2% more patients (84% to 86%) on their discharge ready date ➢ Improve our average delay in discharge from 5 days to a maximum of 4.5 days ➢ Improve the number of patients discharged within 7 days by at least 1%
			Urgent & Emergency Care Improvement / Care Closer to Home / Place Partnerships		
		Quality Strategy	Elective Pathway Improvement	Transform delivery of outpatient, diagnostics and elective services to reduce variation and increase productivity in line with benchmarking and clinical standards supporting improved outcomes/timeliness of care for patients	➢ Improvement in patients waiting for treatment – 62.2 % of all patients will be seen and treated within 18 weeks ➢ Improvement in patients awaiting cancer diagnosis – 80 % of patients will have a diagnosis within 28 days and 75 % of all patients to have a diagnosis and treatment initiated within 62 days ➢ We will see more patients than last year (ERF activity plan) by improving productivity within outpatients and theatres
Personal	Improve health and tackle inequalities in our community	Health Equity Strategy	Tackling health & care inequalities	Work with partners across Lancashire and South Cumbria in the delivery of the clinical strategy, focusing on the optimum configuration of acute services, improving outcomes and sustainability	➢ Delivery of at least two significant service configurations within 2025/26 ➢ Development of a clear 'blue print' for service transformation and reconfiguration on which to build future service changes
			Provider Collaborative		
	A culture of compassion and belonging	People Plan	People Plan Priorities	Work with partners across Lancashire and South Cumbria in the delivery of high-quality corporate services via One LSC as both partner and host	➢ Delivery of 5% Efficiency saving on current run rate through service redesign and transformation across One LSC ➢ Establishment of One LSC post transfer governance arrangements (new way of system working)
	Healthy, diverse and highly motivated people	DERI Strategies	Research, Education & Innovation	Developing a culture of compassion and belonging. Becoming intentionally anti-racist on our inclusion journey	➢ Improvement in staff experience - we are compassionate and inclusive theme by 2% ➢ Reduction in disparity ratio by ethnicity from shortlisting to appointment to bring current ratio of 4.69 to the national average of 1.65. (WRES Metric 2) ➢ Reduction in the percentage of staff experiencing discrimination at work from manager/team leader /colleagues by 2% with further improvements to close the gap (**Staff Survey 2024**: 15% BAME and 7% white staff)
				Development of a sustainable workforce	➢ Reduction in variable pay spend by £13m
Effective	Sustainability and Value for Money	Green Plan	Waste Reduction Programme	Digital enablement to support transformation of services. A measurement strategy which supports identification and monitoring of improvements.	➢ Cyber assurance framework compliance ➢ Uptake of AI based digital tools
		Digital Strategy	eLancs Programme		
		Finance Strategy	Sustainability	The highest standards of financial management (financial grip and control), and sustainable delivery of financial improvement and waste reduction	➢ Delivery of breakeven financial plan (including the receipt of Deficit Support Funding) ➢ Delivery of CIP - £60.8m
		Estate Strategy			

ELHT Priorities – 2025/26
How we will measure delivery

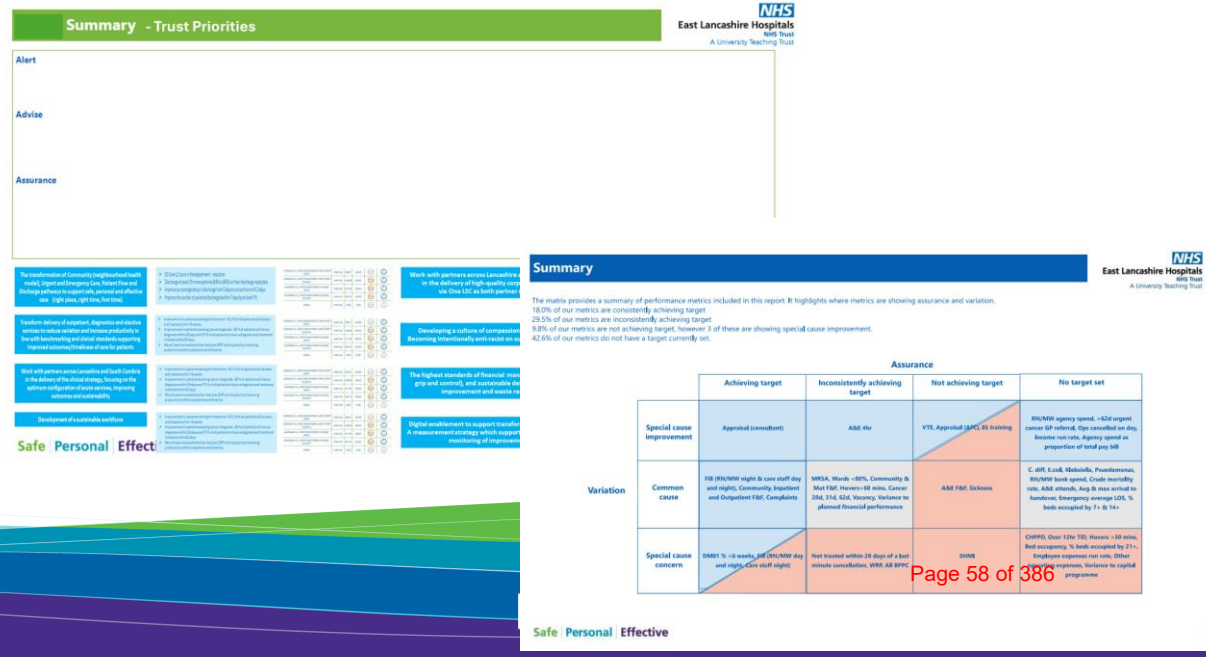
East Lancashire Hospitals NHS Trust
A University Teaching Trust

- Divisional Plans will be monitored through quarterly performance meetings to ensure that Divisions have strong grip and control of plans



- Strategic priorities – each Trust Strategy will have a 'strategic dashboard' monitored through the relevant subcommittee of Trust Board on a bi-annual basis

- Our key Trust priorities will be monitored through our Trust IPR on a monthly basis with key outcomes per priority identified so that we can see the pace of improvement through the year.
  An additional page will be added to the Trust IPR summary for progress against Trust priorities



Safe | Personal | Effective

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

Trust Strategy Overview

Safe | Personal | Effective

ELHT. *Because that's who we are*

ELHT Trust Strategy Overview

East Lancashire Hospitals NHS Trust
A University Teaching Trust

In September 2023 the Trust Board signed off the overarching Trust Strategy.

This sets out the Trust's:

- Strategic Framework
- Key Strategies
- Key Delivery and Improvement Programmes
- Trust Business Planning Cycle
- Trust approach to Improvement (SPE+ Improvement Practice)
- Accountability Framework
- Links to Board Assurance Framework
- Monitoring Framework including Strategy refresh timetable

ELHT Strategic Framework

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Our collective organisational vision is to be widely recognised for **providing safe, personal and effective care.** Our Trust vision is underpinned by our core values. We have committed in all our activities and interactions to put patients first, respect the individual, act with integrity and to serve the community and promote positive change.

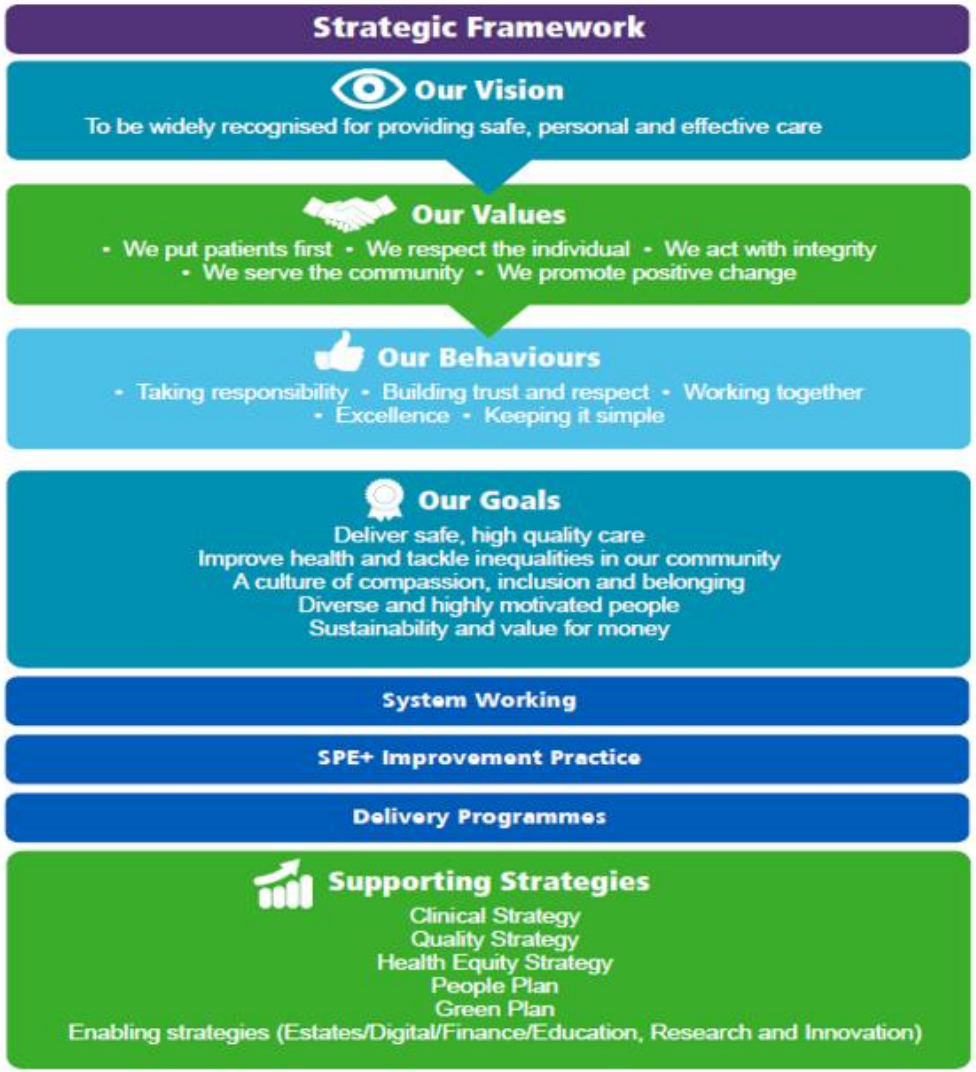
Our Strategic Framework (right) summarises how our vision and values are delivered throughout the organisation.

OUR BEHAVIOURS are an important foundation of providing safe, personal and effective care. These are fundamental to ensuring that our values can be achieved.

We have **FIVE GOALS**. These are the *golden threads* that weave through all that we do; as individuals, teams and collectively as an organisation.

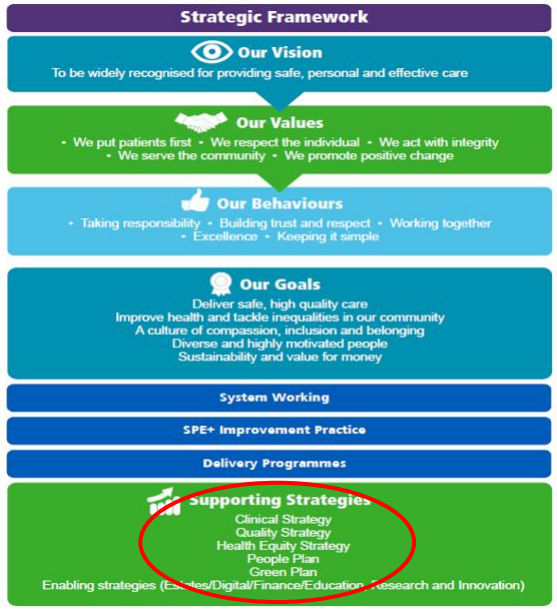
HOW we deliver our strategies, goals and vision is through our system working, our business structure and key delivery programmes. All our work is underpinned by our improvement practice. We have **11 delivery programmes**, **SPE+ improvement practice** and **business planning** to support delivery.

Our supporting strategies are the cornerstones of our Trust Strategic Framework, providing the plan and the **WHAT** – these strategies provide the details of how we will collectively support delivery of our vision and goals.



Supporting Strategies

East Lancashire Hospitals NHS Trust
A University Teaching Trust



There are 4 main Trust Strategies that form the cornerstones of our Trust plans. These are approved, with designated timelines and monitored regularly at Trust Board. The strategies are aligned together so that they fit the pieces of the 'Trust jigsaw' in terms of delivering our plans and ambitions as an organisation.

➢ Clinical Strategy

Our 5-year Clinical Strategy expresses our collective purpose to improve safe, personal and effective care together and our plans to continue to develop the services we provide for our patients.
Our future is defined as a 'hospital without walls', networking as partners in local partnerships and within the bigger integrated system of care across Lancashire and South Cumbria.
We have identified key 5-year improvement priorities across urgent and community care, elective medical and surgical care, diagnostics and population health.

➢ Quality Strategy

Quality commitments are set out in the Strategy to deliver Safe, Personal and Effective Care.
The Strategy incorporates 6 Trust Frameworks : Legal framework, Risk Management Framework, Clinical Effectiveness Framework, Patient Experience Framework, Patient Incident Safety Response Framework and the Health and Safety Framework.
14 Key priorities are identified split under overarching goals of Insight/Safe, Involvement/Personal, Improve/ Effective and Improve+.

➢ People Plan

Our People Plan enables ELHT to recruit the best people, with the right skills and values to an organisation that supports staff to be the best they can be in a culture of community, compassion, inclusion, innovation and improvement to deliver Safe, Personal and Effective Care to the population itserves.
Our key people plan focus :

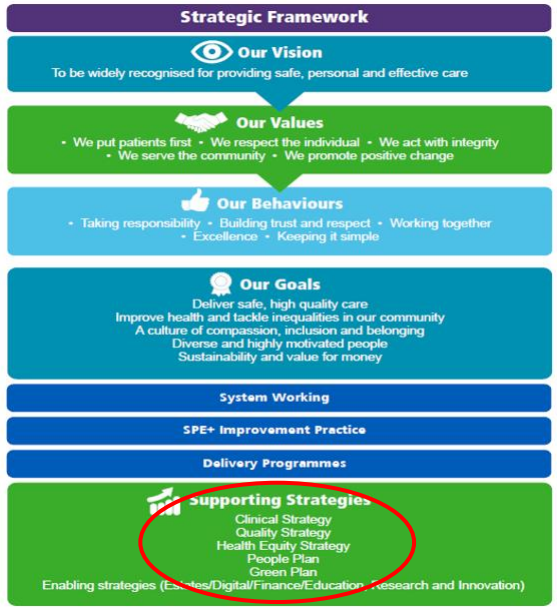
- Looking after our people
- Belonging in the NHS
- Growing for the Future
- Developing new roles and ways of working

➢ Green Plan

ELHT is committed to achieving the Net Zero goal of 2040 for controllable emissions and 2045 for emissions as well as to supporting its staff, its patients and the wider community in reducing their own emissions, fulfilling its role as an anchor institution. The Green Plan sets out our road map to Net Zero through a detailed action plan covering nine areas of focus. These include workforce and systems leadership, sustainable models of care, digital transformation, travel and transport, estates and facilities, medicines, supply chain and procurement, food and nutrition and adaptation.

Enabling Strategies

East Lancashire Hospitals NHS Trust
A University Teaching Trust



There are 4 enabling strategies within the Trust.

These enable and support all our plans and delivery within the organisation.

These are also approved and monitored through our Trust Board.

➢ **Estate Strategy**

The key principles of the Estates Strategy are

- System First Clinical Strategy (L&SC system)
- Using Infrastructure to create a healthy population
- Delivering a Net Zero National Health Service

Key Estates objectives are outlined by site in the Strategy (RBH/BGH/Other sites) and these are triangulated with other strategies and plans so that estates and facilities support the wider clinical objectives of the Trust.

➢ **Digital Strategy**

The Trust Digital Strategy supports and underpins our service planning and delivery and is a key enabler across all our delivery plans, strategies and improvement practice.

Our strategy is part of the wider ICB Digital Strategy across Lancashire and South Cumbria. We are part of a digital journey to achieve joined up system access and use ensuring that digital solutions are a full part of our future clinical provision.

➢ **Finance Strategy**

The key principles of the Strategy are :

- Ensuring the limited resources are spent on improving the quality of patient care in East Lancashire and the wider Lancashire and South Cumbria footprint
- Meet all statutory financial responsibilities
- Financial Sustainability
- Financial Recovery

These are achieved through sound financial governance arrangements and accurate planning triangulated with activity and workforce plans.

➢ **DERI Strategy**
(DERI- *Education, Research and Innovation*)

The DERI Strategy is split into 3 parts – Education Strategy, Research Strategy and Innovation Strategy.

- There are 7 key priorities of the Education Strategy.
- There are 3 key priorities for Innovation.
- There are 6 key priorities within the Research Strategy.

The priorities are aligned to our wider framework, including our People Plan and are focused on improving and supporting education, research and innovation in the workforce and Trust as key enablers with an underpinning role in providing and improving safe, personal and effective care.

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

Trust Strategies:

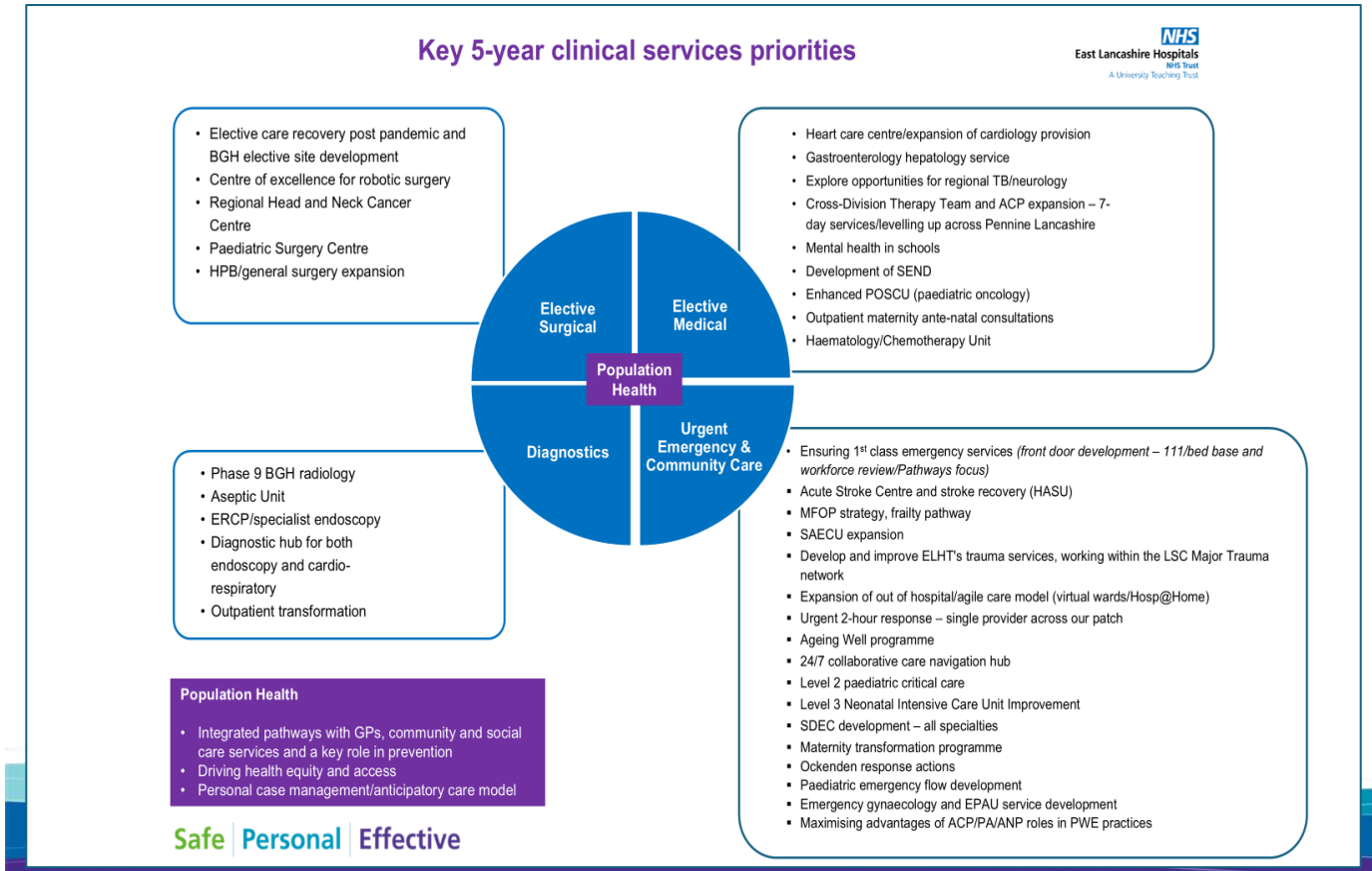
‘Plans on a Page’ Priorities for 2025-2026

Safe | Personal | Effective

ELHT. *Because that’s who we are*

Clinical Strategy

Key Priorities for 2025/2026:



Elective Surgical:

- Continue to drive productivity and efficiency in elective care in order to reduce our overall waiting list
- Review of our fragile and vulnerable services with clear plan to stabilise and improve services
- Work with the wider system clinical transformation workstreams in transforming clinical services across L&SC
- Build a centre of excellence for Cancer Services making further improvements to care
- Increase robotic capacity utilisation at BGH and invest in further robotic capacity within the Trust

Elective Medical:

- Haemo/Chemo Unit (planning work)
- Cardiology BGH outpatient review

Diagnostics:

- Optimise the role of healthcare scientists and therapies, maximising skills as part of blended workforce, maximising capacity and efficiency
- Phase 9 Radiology BGH (planning and case build up)
- Outpatient Improvement & Transformation

UEC / Community:

- Frailty Improvement - improving care of the elderly surgical patients-across orthopaedics, General Surgery and Vascular services
- Consider a joint ambulatory care unit for MEC and SAS to support pathways
- Emergency surgery expansion with additional theatre list
- Improving management of emergency surgery with reduction in LOS for emergency surgery
- Ockenden – continue to improve Maternity care within ELHT
- Paediatric L2 Critical Care – working within wider PCB planning

- **Population Health:**
- Driving health equity and access
- Personalised Care –further work and improvement
- Improvement in Palliative and End of Life care
- Further integration of acute and community healthcare through key service reviews and improvement work

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Extended QUALITY STRATEGY 2025-26

Strategy Leads:

- Alison Brown - Associate Director Quality & Safety
- Jacquetta Hardacre – Assistant Director **Safety** & **Effectiveness**
- John Houlihan – Assistant Director **Health, Safety & Risk**
- Alison Brown – Associate Director of Quality & Safety – Legal Services

Commitments	Aims
SAFETY & INVESTIGATION • ***To reduce harm, prevent errors, and deliver consistently safe care*** *through increased visibility and insight from multiple sources of patient safety information.*	We will complete the early adoption of the Patient Safety Incident Response Framework We will review the data system (Datix) currently used to manage incidents and risk Strengthen the Patient Safety culture through links to a Just Culture approach
HEALTH, SAFETY & RISK • ***To provide excellence in Quality and Safety by making the Safe Way the Only Way. To prevent people from having an injury at or through work.***	Implement and monitor the Health and Safety strategy Develop strong senior management health and safety leadership in line with *INDG417 'Leadership of Health and Safety'* Improve training and competency needs for the identification, assessment and management of risks Improve risk appetite statements that support the Board in effective risk management decision making
AUDIT & EFFECTIVENESS • ***To deliver consistently effective and reliable care,*** *based on best practice which is delivered in a culture that encourages and enables innovation to Improve outcomes.*	Building audit capability across the organisation through skills development To increase engagement with audit and effectiveness work To ensure coordinated access and monitoring of clinical and governance skills training through DERI Develop and embed GIRFT processes to drive improvement from learning
LEGAL SERVICES • ***To deliver standardised, risk-based management of inquests claims and access to legal advice.***	To embed learning from GIRFT Litigation processes Implement and monitor Inquest management pathway Raise awareness of claims themes and NHSR dashboard across the Trust.

PEOPLE PLAN ON A PAGE 2025 / 2026

Key focus of the plan: Using the People Promise Themes, to support the delivery of Safe, Personal and Effective care; balancing the health, wellbeing and experience of our workforce with our financial and operational recovery priorities.

Supporting financial recovery

Reduce sickness absence

- Revised sickness absence training
- Bespoke, detailed sickness absence reporting
- Increased support to line managers
- Improved absence recording for medics
- EASE early interventions
- Roll out of new approach & support for reasonable adjustments

Reduce variable pay

- B&A usage calculator & other variable pay management tools developed
- Updated & bespoke e-roster training
- Rapid improvement in-reach activity with teams
- Centralised management of annual leave on roster
- Roll out of health roster for all medics
- Central pay control group

Service & Workforce Reviews

- Facilitated workshops to support workforce reduction / transformation.
- Improved workforce data access & training for managers

HR Framework for organisational change

- Fit for purpose approach to large scale consultations
- Statutory compliance & risk management
- Redeployment
- Change readiness program
- Well-being support
- Outplacement / job fair / clearing house support

People Promise

- EDI Improvement priorities including expansion of pay gap reporting
- Sexual safety policy & preventative approach
- Further embed Anti-racism & Allyship to improve experience and close the gap

- Focused TED support to improve staff experience
- MDT approach to staff survey action planning with Divisions
- Healthy team behaviours

- Succession planning program
- Managers induction & support program
- Bitesize development for staff & managers to support org change and improvement

- Project M supporting manager wellbeing to support that of their teams
- Women's health strategy
- Support to reduce burnout and mental health related absence

- Increased collaboration with teams and FTSU service for targeted intervention
- Listening events for professional groups and staff networks to support staff survey action planning to improve staff experience
- Enabling staff to make improvements and share learning

- Promote flexible working practices to support workforce reduction & transformation
- Improve understanding of and approach to reasonable workplace adjustments
- Increase understanding of flexible retirement options

Health Equity Priorities 2025 -2026

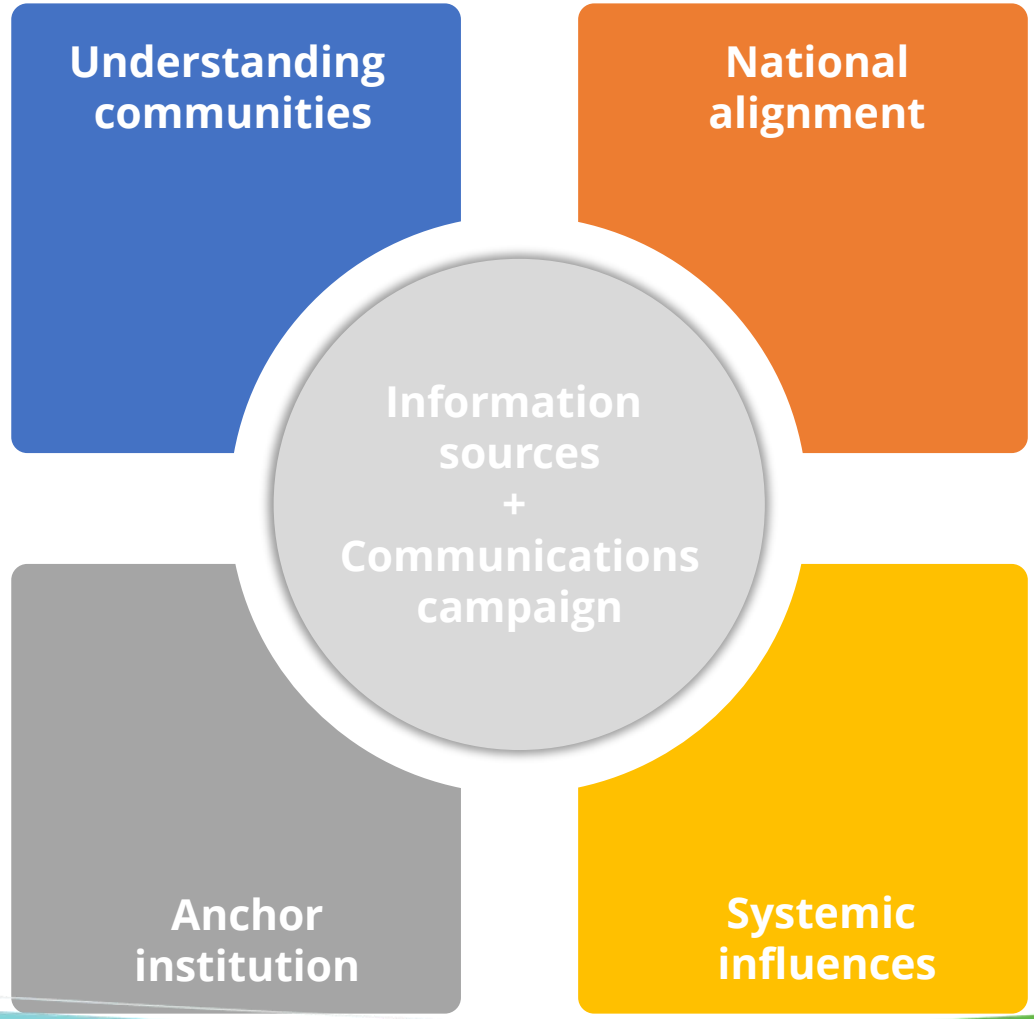
East Lancashire Hospitals NHS Trust
A University Teaching Trust

Addressing local inequalities:

- Priority Wards
- High intensity users in ED
- Patient public engagement programme and leadership development
- Technology-enabled care programmes

A role beyond healthcare:

- Improving housing partnerships
- Local workforce development
- Prince's Trust work and Project scope for young adults
- Anchor people development



Applying a health equity lens:

- Adult Core20Plus5
- Children/young people Core20Plus5
- National planning/ICB guidance
- Missed appointments and RTT
- EDS2022 annual submission

Encompassing components:

- Anti racism campaign
- Enhancing data quality and richness
- Inclusive recruitment and leadership
- Accessible information standards
- ACE's / Trauma informed Trust

Green Plan

East Lancashire Hospitals NHS Trust
A University Teaching Trust

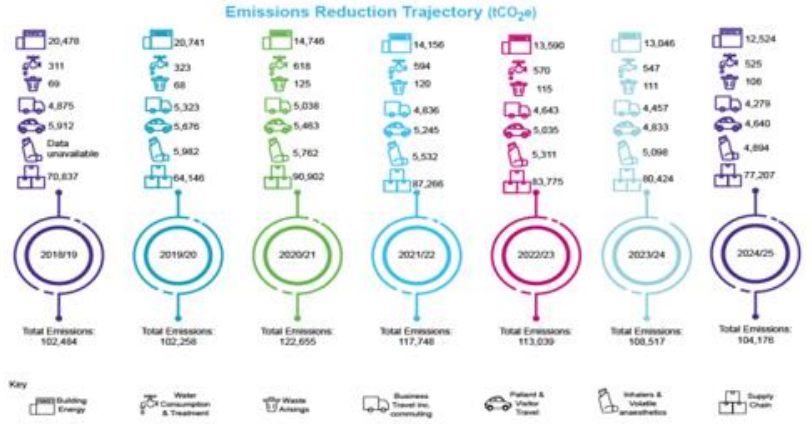
ELHT GREEN PLAN 2022-2025: summary

Our Green Plan Vision

Net Zero: resource consumption and Greenhouse Gas (GHG) emission reductions that align with NHS net zero targets

Climate Resilience: reducing the environmental impact of our activities and provide a basis for us to become a climate change-resilient organisation

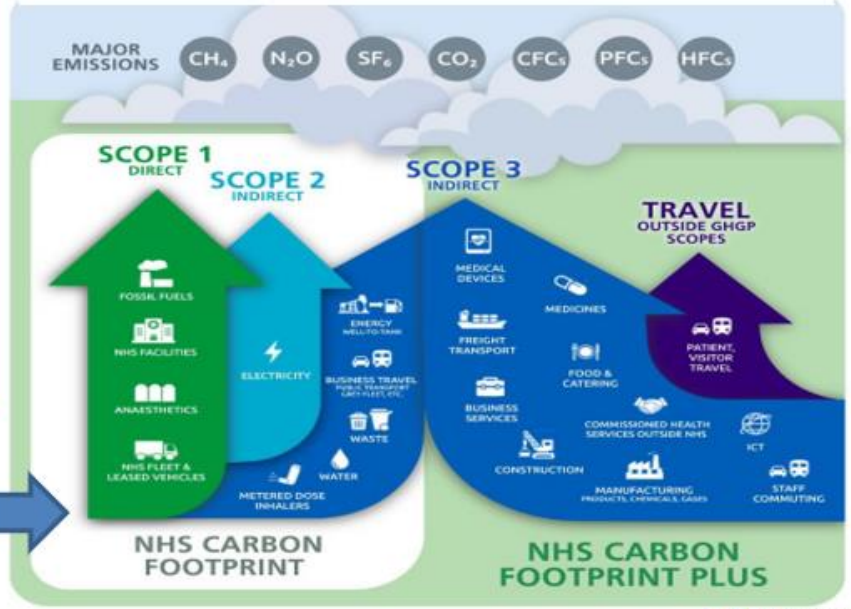
Social Value: actions that leverage our role as a place-based anchor institution to accomplish social value



3-Year Improvement Priorities

Our Green Plan has nine Areas of Focus that appraise our status and set actions to be achieved within the next three years:

1. Workforce and Systems Leadership
2. Sustainable Models of Care
3. Digital Transformation
4. Travel and Transport
5. Estates and Facilities
6. Medicines
7. Supply Chain and Procurement
8. Food and Nutrition
9. Adaptation



Scope 1 and 2 emissions are those that we can control and directly influence. Some scope 3 emissions such as waste and business travel can also be directly influenced

Green Plan Priorities 2025/2026

The Trust has a detailed set of objectives against our key 3-year improvement priorities and will continue to work in 25/26 on this plan. It focuses on the key priorities:

- Workforce & Systems Leadership
- Sustainable Models of Care
- Digital Transformation
- Travel and Transport
- Estates and Facilities
- Medicines
- Supply Chain and Procurement
- Food and Nutrition
- Climate Adaptation

Financial Strategy 2025-26

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Financial Recovery

The 2025-26 Financial plan includes a challenging Waste Reduction and Financial Improvement Programme. This sets out the ambition to bring the Trust back into financial balance. The Trust is committed to ensure expenditure does not exceed the income that the Trust receives. In line with the NHS England 2025-26 Planning Guidance – To live within the budget allocated, reduce waste and improve productivity. ICBs, trusts and primary care providers must work together to plan and deliver a balanced net system financial position in collaboration with other integrated care system (ICS) partners.

Grip and Control

To enhance and focus on ensuring there is robust grip and control throughout the Trust. The Trust will work with partners to collaborate and adopt best practice wherever possible.

Value for Money

Ensure that the Trust carries out its business of providing healthcare within sound financial governance arrangements that are controlled and monitored through robust audit and accounting mechanisms that are open to public scrutiny The annual audit will include the auditor's commentary on use of resources (value for money) arrangements, auditing both financial and non-financial governance arrangements within the Trust.

Collaboration and Transformation

2025-26 is a pivotal year to see the outcomes of the One LSC Collaboration that was entered in 2024-25 for corporate and estate and facilities staff. The Trust is committed to the success of One LSC. The Trust will actively participate and influence decision making in respect of the Trusts services, ensuring decisions improve quality, delivery of patient care and the have a positive impact on our staff and patients

Meet Financial Statutory Duties

The Trusts ambition and regulatory duty is to meet a breakeven position. The Trust must ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings. This is known as the breakeven duty. NHS trusts should normally plan to meet this duty by achieving a balanced position on their income and expenditure account each and every year.

Staff Development

Engage with all finance staff in improving NHS Finance to support the delivery of quality services for patients, supported by the vision of One NHS Finance.

Enabling Strategies : Data & Digital

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Data&Digital

Key priorities 2025/2026

- **Prioritise actions that support the delivery of Trust and System priorities to improve patient outcomes or have been shown to reduce costs or release staff time**

National Priorities – Planning Guidance

- Proactively offer NHS App-first communications to patients (with due regard to digital inclusion), by default through the NHS Notify service
- Adhere to the 'Federated Data Platform (FDP) First' policy, connecting their own digital and data infrastructure to the FDP. NHS England will support adoption of the FDP to 85% of all secondary care trusts by March 2026
- Shift to the national collaboration service NHS.Net Connect where feasible (NHS mail)
- Complete planned electronic patient record (EPR) system procurements and upgrades, and all trusts without an EPR continue to work to procure and implement one as quickly as is safely possible
- Deploy the Electronic Prescription Service wherever possible
- Integrate systems with the NHS e-Referral Service
- Achieve and maintain compliance with the NHS Multi-Factor Authentication Policy and act to strengthen their cyber security
- Mitigate against digital exclusion, including by implementing the framework for NHS action on digital inclusion

System Working

- **Collaboration in Lancashire & South Cumbria**: Seek opportunities to improve user experience and data capabilities, including performance reporting, supporting single data environments and FDP data sharing.
- **Technology and Cyber Security**: Work with OneLSC to enhance cyber security and database management, implementing data centre and network strategies.
- **System convergence and system interoperability** to support data flow across primary, secondary and third sectors to generate efficiencies and support patients.
- **Spread projects** where cost reductions and patient benefits in existing workflows have been identified, PEP+

ELHT Specific

- **Cyber Assurance Framework Compliance**: Upgrade infrastructure to meet national guidelines and regulations.
- **Data Analytics Expansion**: Create reporting tools to enhance operational and clinical activities and research, improving data capture and record quality for clinical coding.
- **System Interoperability**: Enhance information sharing, including health records and medications.
- **Data & Digital Team Resilience**: Build resilience within the current Data & Digital team.
- **Innovation and Digital Growth**: Explore digital expansion opportunities while addressing financial challenges, supporting the organisation's clinical and operational strategies.
- **Digital Developments**: Advance projects like EPR, Flow Ambient AI, and various integrations, including AI trials and upgrades.
- **Digital Competency Framework**: Implement the framework and ISDN accreditation; develop the Federated Data Platform and Secure Data Environment.
- **Clinical Coding Tools**: Assess clinical coding tools to lessen dependence on external staffing.
- **Oracle Analytics Cloud**: Launch the new business intelligence solution for operational and data quality reporting.
- **Business Intelligence Plan**: Execute the plan and establish a unified solution for report management.
- **Data Management**: Enhance data management practices, focusing on security, quality, and migration to Microsoft Azure.

Education, Research and Innovation Strategy 2022-27

DERI Strategy 2022-2027 Summary

(Directorate of Education, Research & Innovation)

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

Our Mission is to work in partnership to improve people's health and wellbeing through innovative healthcare that is supported by excellence in education and research

Our vision is to be nationally recognised as an outstanding provider of innovative high-quality education and research in support of safe, personal and effective care for all

- In education we want to be renowned for providing excellent education, training and learning opportunities to support the current and future workforce in delivering the best care for our patients
- In research we want to work with system partners to integrate research activity into all areas of ELHT for the benefit of our patients and colleagues
- In Innovation we want to become recognised across the region as an exemplar site for the development and adoption of innovative practice within healthcare through greater collaboration with local and regional partners

Education Plan Priorities

- Develop a competent, capable and sustainable workforce with equal opportunity for all
- Provide excellent education and training opportunities for the future workforce
- Support and empower educators, trainers, mentors and supervisors
- Provide high quality learning environments with a culture for lifelong learning
- Develop excellence in patient safety training through simulation
- Ensure effective governance for all education and maximise the use of resources and funding to support delivery of the Education Plan
- Work in partnership to lead the education agenda forwards utilising a system wide approach

Research Plan Priorities

- Increase patient, carer and wider stakeholder involvement in our research activity, to identify needed interventions and support effective implementation
- Support the development of our workforce to actively seek out the best evidence to help improve outcomes and experiences for people, including patients and carers
- Raise research awareness and further a culture of enquiry and critical thinking to engage colleagues in the Trust's research agenda
- Enable effective leadership and create a supportive infrastructure with good collaboration which will provide access to resources, training and research opportunities for all
- Strengthen our existing and develop new partnerships to further enhance and develop our areas of clinical research for patient benefit
- Develop our organisational systems

Innovation Plan Priorities

- Investment in colleagues, patients and carers to develop and foster an innovation culture
- Investment in infrastructure to support innovative practices
- Greater collaboration with innovation agencies and organisations and as a result increased work with local and regional business partners

Safe Personal Effective

SPEH

DERI Strategy Priorities 25/26

To provide excellent education, training and learning opportunities to support the current and future workforce in delivering the best care for our patients

- Enable ACPs to work across patient pathways and new care models.
- Increase Levy funding use for workforce retention and the Apprenticeship Strategy.
- Create career pathways supported by education programmes
- Expand patient Library Service and improve compliance with Library Quality Improvement and Outcome Framework (QIOF).
- Lead TEL agenda and coordinate clinical placements using technology.
- Deliver end point assessments and apprenticeship programs with system partners.
- Provide high-quality education and simulation facilities at our main sites.
- Achieve ASPiH accreditation and evaluate education investment impact.

To work with system partners to integrate research activity into all areas of ELHT for the benefit of our patients and colleagues in the NHS

- Engage ELHT researchers in PPI for diverse and inclusive research.
- Increase NIHR Patient Research Experience Survey (PRES) responses annually.
- Ensure staff complete Good Clinical Practice Training bi-annually.
- Boost workforce research involvement and develop commercial research partnerships.
- Ensure timely delivery of contract commercial research per NIHR CRN KPIs.
- Increase annual research income, focusing on commercial research.
- Develop professional research support services with HEI partners.
- Utilise data assets for a data-enabled clinical research environment.

To be recognised across the region as an exemplar site for the development and adoption of innovative practice within healthcare through greater collaboration with local and regional partners

- Develop closer relationships with local, regional and national innovation partners

Estate Infrastructure Priorities for 2025 - 2026

Our Future is digital Our Future is Green
Our Future is Sustainable We have the right Accommodation
We shape Healthier Places

Burnley General Hospital

- Gynaecology Theatre 1 and 2 –equipment replacement
- LED lighting replacement
- Breast Care replacement of 3 breast screen machines
- CT Scanner replacement
- Dermatology refurbishment
- Fire Remediation Programme
- 25/26 Lifecycle works various
- Theatre and Elective Centre
- Phase 1 Calico development 90 extra care facilities
- Multistorey Car Park including EV charging
- Site Electrical Infrastructure
- Lift Replacement
- Fire Damper replacement
- BMS System replacement LWNC

System First Clinical Strategy

Safe | Personal | Effective

- ICB Clinical Estates Health Infrastructure Strategy
- NHS Long Term Plan
- Greener NHS
- Backlog maintenance reduction
- Flexible use of healthcare estate usership not ownership

Community Hospitals and Healthcare Facilities

- Repurposing of Accrington Victoria site
- Repurposing of Pendle Community Hospital Site
- Clitheroe review of service provision ground floor and bed reduction second floor
- Fire Stopping and Life Cycle Programme
- Step down facilities reconfiguration
- Community services occupation survey
- Blackburn Birth Centre Review

Using Infrastructure to create a healthy population

Safe | Personal | Effective

- Staying Well
- Preventative Services
- Integrated Care
- Environmental Sustainability

Royal Blackburn Hospital

- Chemotherapy upgrade
- Emergency Care Village
- Electrical Infrastructure Upgrade
- Theatre Lifecycle
- Park View Upgrade
- Tower view RAAC removal
- MES Gamma Camera replacement
- Blue Line Fire Alarm System
- Lift Replacement staff accommodation
- Chemo Pod Replacement
- LED lighting replacement Trust owned Estate
- 25/26 Life cycle Programme various wards and Departments
- Key Worker Accommodation refurbishment
- Fire Stopping and Life Cycle Programme

Delivering a Net Zero National Health Service

Safe | Personal | Effective

Health Infrastructure is an enabling ecosystem for a sustainable health system and Healthier population

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

Update on NHSE Planning Submission – 2025/2026 Plans

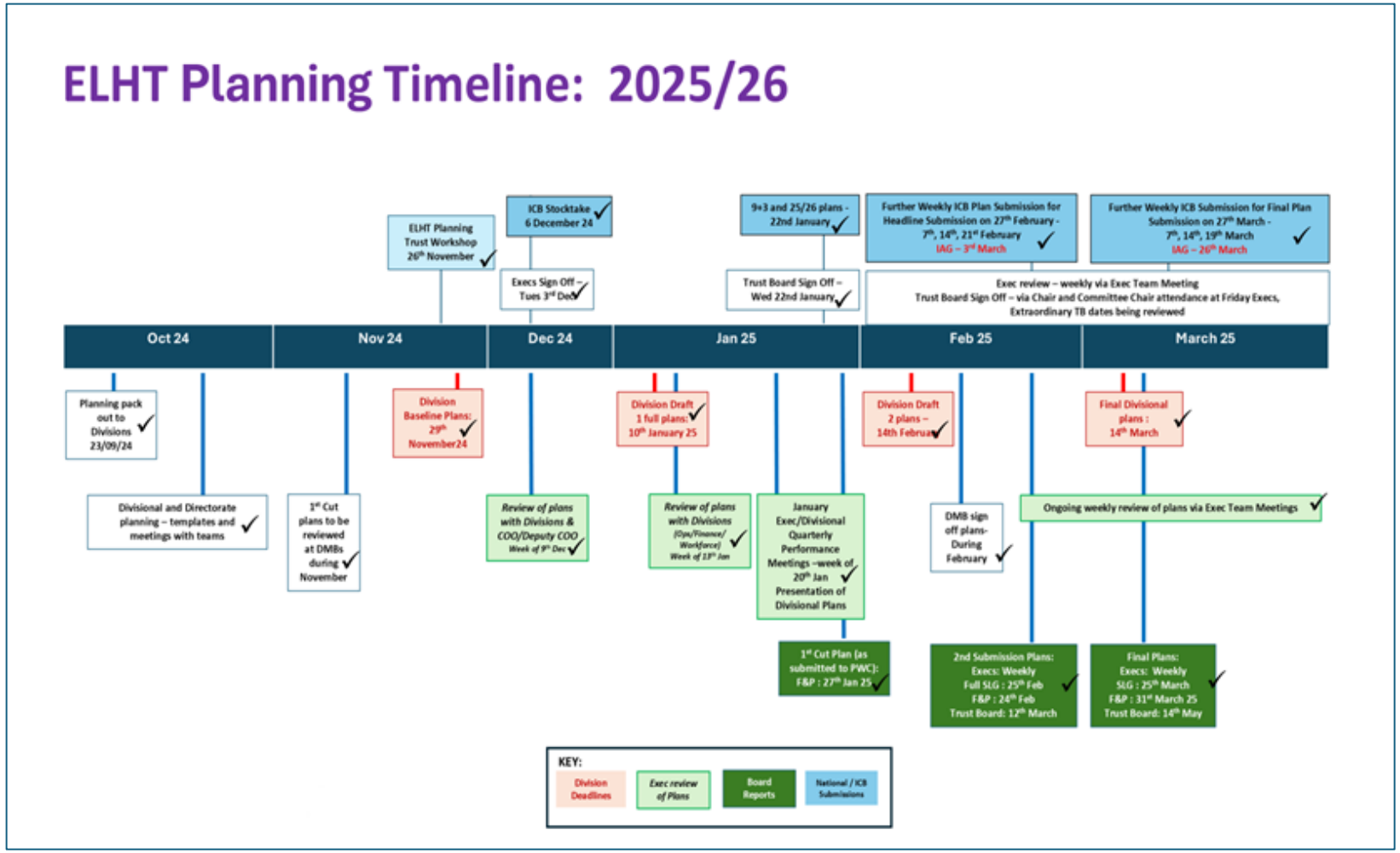
Safe | Personal | Effective

ELHT. Because that's who we are

Planning Update: System Submission

East Lancashire Hospitals NHS Trust
A University Teaching Trust

- The Trust submitted a full and Trust Board approved workforce, finance and activity plan on 31st March 2025 to the ICB and NHSE. A further amended submission was made on 30th April 2025
- Detailed divisional plans to support our submission are now in place and tracking reports have been developed to start from April 2025
- Our plans meet local, system and national priorities, including key planning guidance



Safe | Personal | Effective

ELHT. Because that's who we are

Elective Care

**April submission*

- Our plans achieve our required ERF contract income value (equivalent to 112 % of 19/20 levels)
- Our plans are based on ambitious productivity plans rather than increased investment (doing more for less)
- Plans do not yet include any commissioning intentions as discussions are ongoing, but are aligned with our internal finance and workforce plans
- Through validation and improvement in pathway management we are aiming to reduce our ongoing RTT by 10,000 pathways
- Our PIFU is currently 1.63 % in the FOT benchmark and we will increase to at least 3% by March 26
- We aim to deliver on all key planning guidance asks as noted below.

	Variance FOT 24/25 to 25/26 Plan **ERF acute*	Comments
New Outpatients	Increase of 1,009	The FOT for 24/25 incorporates a 21 % increase in outpatient activity above plan and we aim to maintain this level of improvement in 2025/26.
Follow up Outpatients	Increase of 12, 518	Increase linked to increase in outpatient procedures planned for 2025/26. The plan for follow up *without* procedure (our true follow up) drops from FOT of 202,306 to our plan 185,462
Day case	Increase of 3,428	Increase reflects improved productivity on last year's plan
Elective Ins	Increase of 558	Increase reflects improved productivity on last year's plan
Outpatient Procedures	Increase of 32,616	Improved productivity plus data capture

April 25 submission	RTT – Incomplete pathways <18 weeks			RTT – Incomplete pathways <52 weeks			Time to 1st appointment			Cancer 62-day pathway			Cancer – Faster Diagnosis Standard			A&E within 4 hours			A&E +12 hours		
	Target	March 26	Rating	Target	March 26	Rating	Target	March 26	Rating	Target	March 26	Rating	Target	March 26	Rating	Target	March 26	Rating	Target	March 26	Rating
ELHT	62.2 %	62.2 %	2	1.0 %	1.0 %	2	67 %	67 %	2	75 %	75 %	2	80 %	80 %	2	78 %	78 %	2	17.8 %	15.2 %	2

Urgent and Emergency Care

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Our overall ambition is to significantly improve our UEC pathways during 2025-26, with a number of key projects aimed at eliminating corridor care, reducing cost and improving quality of care that our patients receive

In 2025/26 we will:

- Achieve the 78% ED 4-hour target
- Reduce corridor care
- Reduce the number of patients who spend more than 12 hours in the emergency department
- Continue to focus on ambulance handover times dropping the average by at least 1 minute over the year from our current performance of 25 minutes and we will aim to be better than the NWAS average month on month despite being the busiest blue light emergency department
- Discharge at least 2% more patients (84% to 86%) on their discharge ready date
- Improve our average delay in discharge from 5 days to a maximum of 4.5 days
- Improve the number of patients discharged within 7 days by at least 1%

East Lancashire Hospitals
NHS Trust
A University Teaching Trust

2025/26 Annual Plan and Annual Budget

Trust Board – Public

14th May 2025

Safe | Personal | Effective

ELHT. Because that's who we are

Introduction

East Lancashire Hospitals NHS Trust
A University Teaching Trust

- In line with the Trust's Standing Financial Instructions and Scheme of Delegation, it is the responsibility of the Trust Board to approve the financial plan and associated budgets. Budget holders are then delegated the authority by the Board to spend up to the value outlined within the approved budget.

- Work has been taking place across Lancashire and South Cumbria to standardise financial planning, whereas the planning process has been standardised, the annual budget setting process work continues. Some of the work is reflected in 2025/26, with the aim to fully standardise by 2026/27.

- It is important that the budgets set are an accurate representation of what the Trust is expecting to happen in terms of both income and expenditure. The usefulness of the budget as a tool for both monitoring and performance management purposes is quickly undermined if budgets do not accurately reflect realistic and anticipated spending plans.

- The 2025/26 financial plan that the Trust Board approved was submitted on the 30th April 2025 and the Annual Budget will reflect the financial plan. The latest contract offer from the ICB set out the impact of changes resulting in a reduction in contract income, offset by an additional allocation of Deficit Support Funding (DSF). Consequently, the DSF increases to £43.324m, with a net neutral impact on the plan. Work continues with the commissioner to review the full scope of the commissioning intentions.

- The Trust will be monitored and held to account on the run rate improvements, as set out in the legal undertakings signed by the Board.

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

2025/26 Revenue Plan

Safe | Personal | Effective

ELHT. *Because that's who we are*

2025/26 Annual Plan

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Annual Plan	£000's
Operating income from patient care activities	762,469
Other operating income	45,853
Employee expenses	(552,412)
Operating expenses excluding employee expenses	(236,520)
Operating Surplus	**19,390**
Net Finance Costs	(7,010)
Surplus for the period/year	**12,380**
Remove capital donations/grants/peppercorn lease I&E impact	(27)
Remove PFI revenue costs on an IFRS 16 basis	18,189
Add back PFI revenue costs on a UK GAAP basis	(30,542)
Adjusted financial peformance surplus (deficit)	**0**

Adjusted financial performance surplus/(deficit)	0
Less Non-Recurrent Deficit Funding	(43,324)
Adjusted financial peformance surplus (deficit) excluding Non-Rec	**(43,324)**

The 2025-26 Annual Plan is made up as follows :-

£ 808.3m of Operating Income

£(788.9)m of Operating Expenses of which £552.4m relates to Employee Expenses (72.5%)

The Trust plans to incur £(7.0) m of Finance costs made up of £2.0m Investment Income and £(9.0) m of Finance costs.

After adjusting for the PFI revenue costs of £(12.4)m, the Trust is reporting a breakeven plan.

Excluding the £43.3m deficit support funding this would result in a £43.3m deficit.

As approved by the Board, the WRP target is £60.8m.

Introduction

East Lancashire Hospitals NHS Trust
A University Teaching Trust

- The Trust's revenue financial plan and annual budget is made up of the following steps:

- Budget holders will be provided with a budget that is fair and reasonable. Budgets will be developed in conjunction with budget managers and will be signed off by divisional and corporate leadership teams as part of the Trust's financial planning process.
- The annual budget in 2025/26 will reflect the annual plan and will be based on the steps shown above.
- The Budget Setting principles have been discussed and the approach agreed at the Finance Assurance Board on the 14th April 2025, with the Trust Senior Leadership Team at the Senior Leadership Group on the 15th April 2025 and at Finance and Performance Committee on the 28th May 2025.

Key Principles

- **The Trusts 2025-26 Financial Plan and Annual Budget is based on the 2024-25 Exit Run Rate with a small number of agreed exceptions***

- Starting with FOT at M10 2024-25
- Adjusted for agreed exceptions*
- Less, any non-recurrent identified income or expenditure gains / losses
- Plus, the Full year impact of any in year gains / losses
- Less, any Non recurrent WR & FIP
- Plus, the Full Year Impact of all WR & FIP schemes
- **= 2024-25 Exit Run Rate**

- Plus, inflation in line with national guidance /agreed with the system
- Plus, any identified new financial pressures in 2025-26
- Plus, any improvement cases approved in 2024-25 that have not yet begun
- Reflection of the L&SC ICB Contract and any commissioning intentions agreed
- **= 2025-26 Financial Plan**

* next slide

Key Principles

*** The following exceptions have been reflected in the 2025-26 Annual Budget**

- Hosted Services budgets are excluded and has nil impact
- Research and Development Budgets are realigned for the expenditure budget to be funded within the available income in year and c/f
- Resident Doctor budgets to be protected and reconciled in line with the Education contract
- Ward Budgeted Establishment will be protected in line with the safe staffing levels agreed
- Vacant posts that have been agreed since M10 and are not in post and not covered by bank or agency
- Vacant posts that are acknowledged will be appointed due to national /local recruitment shortages

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

2025/26 Capital Plan

Safe | Personal | Effective

ELHT. *Because that's who we are*

2025/26 Capital Annual Plan (1 of 2)

East Lancashire Hospitals NHS Trust
A University Teaching Trust

2025-26 Capital Plan Expenditure Plan	Committed £000's	Available £000's	Total £000's	Externally Funded	Internally Funded
Estates & Facilities					
Emergency village - Electrical Infrastructure	200		200		✓
CDC -Rossendale CT Scanner- Now BGH	405		405		✓
Tower view Raac *	0		0	✓	
Theatres electrical upgrade	960		960		✓
Lift - Accommodation	20		20		✓
Catering roof contribution	13		13		✓
E&F Capital	320		320		✓
24-25 MES CT/Gamma Scanner	125		125		✓
Blueline fire Alarm	60		60		✓
B2 & B4 lifecycle works	239		239		✓
Fire remedial works	72		72		✓
MES Vascular Digital Fluoroscop	151		151		✓
Other Maintenance/ replacement budget		465	465		✓
2025-26 Capital Bids to be confirmed	8,985		8,985	✓	
Net Zero	1,980		1,980	✓	
Total Estates	13,530	465	13,995		
Digital					
ePR upgrade	792		792		✓
ePR -Cerner	1,428		1428		✓
Refer to Pharmacy	103		103		✓
Digital operability	187		187		✓
IM&T Capital	420		420		✓
Other Digital		465	465		✓
Total Digital	2,930	465	3,395		
Medical Devices / EBME					
Medical equipment contingency	96	368	464		✓
Total EBME	96	368	464		

The 2025/26 capital plan is £28.566m

This includes £8.985m of capital bids that are awaiting external funding approval from NHSE.

It excludes £4.531m of RAAC funding that will be allocated in year.

It includes £1.980m of Net Zero funding on the back of a successful bid for solar energy projects £1.7m for Burnley General Hospital and £0.3m for Pendle Community Hospital.

The plan may change in year if the Trust receives any additional external funding or donations.

2025/26 Capital Annual Plan (2 of 2)

East Lancashire Hospitals NHS Trust
A University Teaching Trust

2025-26 Capital Plan Expenditure Plan	Committed £000's	Available £000's	Total £000's	Externally Funded	Internally Funded
Right of Use Assets					
CHP lease additions	4,656		4656		✓
Other ROU assets (intra-DHSC group)	12		12		✓
Other new leases and lease liability remeasure	1,940		1940		✓
Total Right of Use Assets	6,608	-	6,608		
Other					
Donated Assets	500		500	✓	
PFI Lifecycle Costs	3,604		3604		✓
Total	4,104	-	4,104		
GRAND TOTAL	27,268	1,298	28,566		

FUNDING STREAM	Committed £000's	Available £000's	Total £000's	Externally Funded	Internally Funded
Internally generated resources					
Use of cash reserves	9,037		9,037		✓
Depreciation	24,785		24,785		✓
PFI lifecycle prepayments	-2,173		-2,173		✓
Less: capital element of payments relating to PF	-12,205		-12,205		✓
Less: IFRS16 adjustments	-2,343		-2,343		✓
Less: annual loan repayments	0		0		✓
Donations & Grants	500		500		✓
Net book value of non-current assets disposed	0		0		✓
Public Dividend Capital	10,965		10,965	✓	
GRAND TOTAL	28,566	-	28,566		

The Trust's Capital plan is overseen through the Trust Capital Planning Board.

The Estates & Facilities risks and priorities are overseen through the E&F Strategy & Delivery Group.

The Digital and Data risks and priorities are overseen through the D&D Senate.

The Medical Devices risks and priorities are overseen though the Medical Devices Steering Group.

The right of use assets/leases and the PFI are commitments against the Capital Programme.

TRUST BOARD REPORT

Meeting Date:	14 May 2025	**Agenda Item:**	TB/2025/062
Report Title:	Maternity and Neonatal Services Update		
Author:	Miss T Thompson, Divisional Director of Midwifery and Nursing (Maternity Safety Champion) supported by Maternity & Neonatal transformation lead		
Lead Director:	Peter Murphy, Executive Director of Nursing. (Board Level Maternity/Neonatal Safety Champion)		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓	✓		✓
Executive Summary:	The purpose of this report is to provide: • An overview of the safety and quality programmes of work within the maternity and neonatal services resulting from the National Perinatal Safety Ambitions, specific to the ten CNST (Clinical Negligence Scheme for Trusts) maternity safety actions included in year six of the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme. (Appendix 1 - CNST Year 6 criteria) • Updates regarding ELHT (East Lancashire Hospitals Trust) maternity services response to the NHS England/Improvement (NHS E/I) – Ockenden recommendations and maternity/ Neonatal Three-year delivery plan. • Safety intelligence within maternity or neonatology care pathways and programmes that pose any potential risk in the delivery of safe care to be escalated to the trust board. • Continuous Quality and Service improvements, progress (Bimonthly report presented at trust wide quality committee) with celebrations noted.			
Key Issues/Areas of Concern:				
Action Required:	The Board of Directors are asked to. • Receive and discuss the CNST-MIS update, all compliance reports, and recommendations for year 6 quarter four – final submissions and outcome • Provide bimonthly reporting to ELHT trust board with any barriers that may impact on the implementation and longer-term sustainability plans and deliverables aligned with the maternity and neonatology safety • Discuss any safety concerns with Trust board members aided by floor to board agendas further guided by the Executive and non- executive board safety champions.			

Previously Considered by:	
Date:	

Outcome:	

1. INTRODUCTION

The purpose of this report is to provide:

1. An overview of ELHT maternity and neonatal quality and safety programmes resulting from national policy and Maternity and Neonatology safety ambitions. The Secretary of State's ambition to halve the number of stillbirths, neonatal deaths, maternal deaths, and brain injuries by 2025 is a key focus. This will also include a reduction of the pre-term birth rate from 8%-6% by 2025.

2. A monthly progress summary with any exceptions will be evidenced at ELHT trust boards with clear plans specifically relating to the ten CNST maternity safety actions included in year seven of the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme. **(Appendix 1)**

3. Regular updates with schedules regarding ELHT maternity and neonatology services in response to the NHS England/Improvement (NHSE) Ockenden review- immediate and essential actions, Three Year maternity and neonatology Delivery Plan, all party parliamentary group (APPG) birth trauma report are submitted to sub-group Quality Committee to inform Trust Board.

   This bi-monthly assurance report will be submitted to the ELHT Board of Directors for appropriate assurance, oversight, monitoring and escalation within the maternity and neonatology services.

2. CNST - MATERNITY INCENTIVE SCHEME

2.1 Summary overview

Blue indicates complete

Green indicates progressing without concern

Orange indicates barriers/ risk to compliance identified

Red indicates non-compliance identified

The Trust received feedback from the Maternity Incentive Scheme that the criteria for CNST Year 6 was met in full and the Trust will receive the incentive bonus for the year. The guidance for CNST Year 7 was published on the 2nd of April and the position against the guidance is as follows:

Safety Action	Progress	Assurance/Exceptions
1. Perinatal Mortality Review Tool (PMRT)		● Compliance with Safety Action 1 was achieved for CNST Year 6 and all targets for Year 7 remain on track. ● Year 7 guidance requires that 75% of reports must be published within 6 months, up from a target of 60% previously. ● Year 7 guidance requires that for 50% of the deaths reviewed an external member should be present at the MDT review panel. ● All changes to guidance will be reviewed at the PMRT away day and implemented by the Quality and Safety Lead. ● Q4 PMRT report is attached for submission (Appendix 2).
2. Maternity Services Data Set (MSDS)		● Year 7 guidance requires that only 2 metrics are now monitored for this Safety Action: Valid birthweight information is inputted for at least 80% of babies born in the month. Valid ethnic category for at least 90% of women booked in the month. ● July will again be the reporting month for this Safety Action. Compliance will be evidenced at September Trust Board.
3. Transitional Care (TC)		● Annual TC audit will be submitted to January 2026 Trust Board. ● The Jaundice Quality Improvement (QI) outlined in the report below will be monitored as the QI for this Safety Action.
4. Clinical Workforce		● Year 7 guidance requires that one consultant attendance audit is completed covering a 3-month period in the CNST Year. A quarter 1 audit will be completed and submitted to September Trust Board. ● Audits for employing long and short-term locums will be submitted to September Trust Board.

		● **Identified risk** - The Neonatal Nursing Workforce action plan will continue to be monitored as part of this Safety Action, as it remains non-compliant with British Association of Perinatal Medicine (BAPM) standards. ● **Identified risk** - The Neonatal Medical Workforce is now non-compliant with BAPM standards for tiers 1 and 2, meaning this will be added to the risk register as per CNST guidance and monitored via an action plan.
5. Midwifery Workforce		● Midwifery Safe staffing January-July report will be submitted to September Trust Board. ● Birthrate+ exercise is due for renewal this CNST year to maintain compliance. A meeting has taken place to initiate the process. ● **Identified risk** - Current funded midwifery establishment does not reflect Birthrate + findings and recommendations. Steps taken to mitigate this risk were detailed in the November Trust board report.
6. Saving Babies Lives v3 Care Bundle (SBLv3)		● ELHT are currently at 91% overall implementation following the LMNS assurance visit on 8th of January 2025. ● Further progress and sustainability of current implementation plan with associated actions continues with close oversight from Obstetrics Clinical Director/Perinatal Quadrumvirate.
7.User Feedback		● The Transformation Team and Assistant Head of Midwifery are working with the Engagement Lead and MNVP Lead to plan the schedule of works to meet and deliver the asks of SA7.
8. Training		● No changes to guidance for Safety Action 8 in CNST Year 7. Compliance will continue to be monitored to ensure 90% targets are met by the cut off date on 30th of November 2025. ● **Identified risk –** Anaesthetist compliance with PROMPT training is currently 88% (target 90% by 30th November 2025). ● **Identified risk –** Neonatal nursing compliance with NLS training is currently 85% (target 90% by 30th November 2025),
9. Board Assurance		● An update on progress with the Culture Improvement Plan will be brought to July Trust Board. ● Triangulation of claims, incidents, and complaints will now be monitored at Floor to Board meetings, with updates to be brought to Trust Board.
10. MNSI (Maternity and Newborn Safety Investigation) / NHS Resolution		● Quarterly MNSI report will be submitted to Trust Board in May. ● Year 7 guidance requires that MNSI information be provided to patients in a format that is accessible to them. Any exceptions to this are to be reported to Trust Board.

2.2 Key updates and exceptions per Safety Action

2.2.1 Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

The Perinatal Mortality Review Tool (PMRT) dashboard is currently being reconfigured to reflect changes to MIS requirements for Year 7 as detailed below. The quarterly PMRT report for quarter 4 is attached (Appendix 2) to provide assurances that all metrics have passed for the quarter.

Feedback from the Maternity Incentive Scheme regarding Safety Action one for MIS Year 6 stated that as for the 4 cases that missed the Factual Questions (FQ) deadline, the team had still been able to publish 3 of the reports within the 6 month timeframe, they were satisfied that the standard had been met. ELHT therefore passed MIS Year 6 and will receive the full incentive bonus. All failsafe checks remain in place as per previous Trust Board updates to ensure standards are met for MIS Year 7.

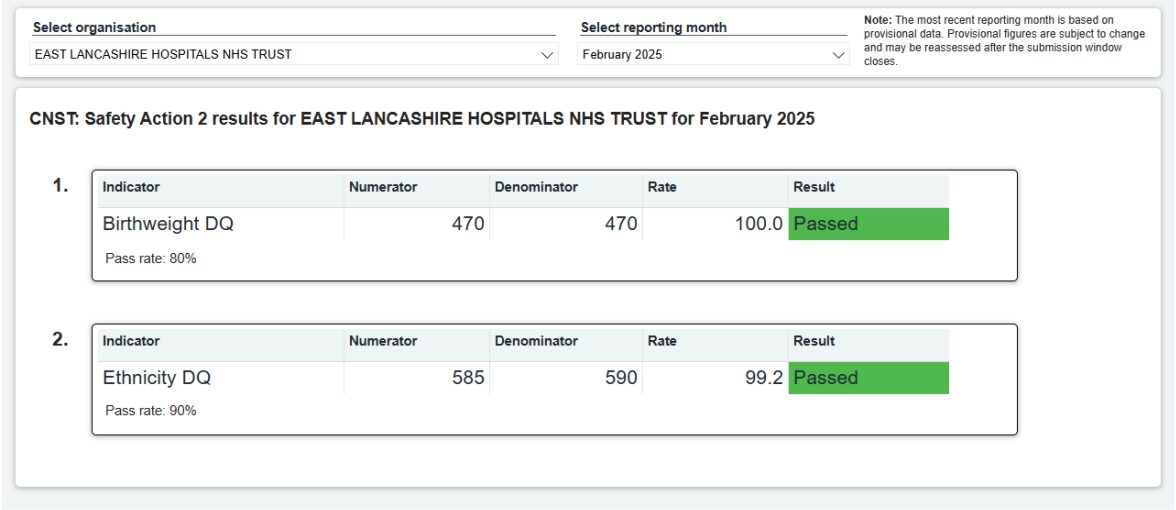
'A minimum of 75% of multi-disciplinary reviews should be completed and published within six months'.

The guidance for MIS Year 7 includes changes for Safety Action 1 standard c) which now requires that 75% of reports are published within 6 months, up from 60% in MIS Year 6. The PMRT report for quarter 4 (Appendix 2) shows this was compliant at 88% for the quarter.

'For a minimum of 50% of the deaths reviewed an external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT.'

A further change in the MIS Year 7 guidance for standard c) is the above requirement. As this requirement is new it will be measured from the 2nd of April 2025 and will therefore be reported on in the July Trust Board report. An external member rota has been produced for the region to cover the requirements for this ask.

2.2.2 Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?



Select organisation: EAST LANCASHIRE HOSPITALS NHS TRUST

Select reporting month: February 2025

Note: The most recent reporting month is based on provisional data. Provisional figures are subject to change and may be reassessed after the submission window closes.

CNST: Safety Action 2 results for EAST LANCASHIRE HOSPITALS NHS TRUST for February 2025

1.

Indicator	Numerator	Denominator	Rate	Result
Birthweight DQ	470	470	100.0	Passed

Pass rate: 80%

2.

Indicator	Numerator	Denominator	Rate	Result
Ethnicity DQ	585	590	99.2	Passed

Pass rate: 90%

The “Clinical Negligence Scheme for Trusts: Scorecard” in the Maternity Services Monthly Statistics publication series, as above, publishes each month and this is used to evidence sustained compliance to the data quality measures required for this safety action.

‘July 2025 data contains valid birthweight information for at least 80% of babies born in the month. This requires the recorded weight to be accompanied by a valid unit entry.’
In MIS Year 7 the above requirement has been added to the guidance. As shown on the scorecard above, this metric was at 100% in February 2025. This metric and the ethnicity data quality measures are now the only metrics monitored for Safety Action 2.

July 2025 is the month submitted into MIS Year 7 evidence to evidence compliance for this reporting year. July results will be brought to Trust Board in September.

2.2.3 Safety action 3: Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?

The service has now moved towards an annual TC audit, meaning that the next audit covering the MIS Year 7 reporting period will be submitted to Trust Board in January 2026.

The service has been conducting a quality improvement (QI) to reduce jaundice readmissions (Appendix 3). This QI will be used as evidence for Safety Action 3. An update will be provided on progress with this QI to the LMNS at the Quality Assurance Panel, and to safety champions at Floor to Board on the 5th of June 2025.

2.2.4 Safety action 4 – Can you demonstrate an effective system of clinical workforce planning to the required standard?

The MIS Year 7 guidance sets out criteria for employing long and short-term locums as per previous MIS year. Audits of compliance with these criteria will be submitted to the September Trust Board.

Implementation of RCOG guidance on compensatory rest for Consultants and Senior Speciality, Associate Specialist and Specialist (SAS) doctors will continue to be monitored via MIS, however it will not be measured in Year 7.

Updated MIS Year 7 guidance requires that the quarterly consultant attendance audit is replaced by one audit covering any 3-month period in the reporting year. A quarter 1 audit will be completed and submitted to September Trust Board. Any exceptions will be discussed prior at Perinatal Governance Board and Floor to Board.

Evidence that a duty anaesthetist is immediately available for the obstetric unit 24 hours a day will be provided in the form of a duty anaesthetist one month rota, as in MIS Year 6. This will be submitted to July Trust Board.

2.2.5 Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

The bi-annual midwifery staffing report for the period 1st of January to 30th June 2025 will be submitted to the September 2025 Trust Board, covering the reporting elements of this safety action.

The Birthrate+ exercise was completed in 2022 and must be repeated every 3 years as per MIS requirements, meaning this is due for renewal in 2025. A meeting has taken place with

Birthrate+ to initiate the reassessment, and the process will be led by the Directorate Manager and the Assistant Head of Midwifery.

A business case was completed in March 2023 following the Birthrate+ assessment in September 2022 for the deficit in funding to meet the midwifery staffing establishment as set out in the Birthrate+ report. This will be reviewed following the Birthrate+ reassessment.

In addition to the Birthrate+ reports that demonstrate the supernumerary status of the ward coordinator on Birth Suite and one-to-one care for women in active labour, which are included in the bi-annual staffing report, monthly staffing red-flag reports will now be produced. From May 2025, each area lead will produce a report using Birthrate+ and present this at the Perinatal Quality and Safety Board.

A standalone midwifery/ staffing paper has been completed to include cover for the maternity triage model to present at TWQGA in June 2025.

.

2.2.6 Safety action 6: Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

'Provide assurance to the Trust Board and ICB that you are on track to achieve compliance with all six elements of SBLv3 through quarterly quality improvement discussions with the ICB.'

A quarterly review (July-September) of the 6 elements of Saving Babies' Lives (SBL) was conducted on the 8th of January 2024. Compliance increased to 64/70 interventions implemented overall, which equates to 91%. A breakdown of elements is provided below.

SBL Element	Current Implementation (as assured by LMNS)
Element 1 - Reducing Smoking in Pregnancy	8/10 interventions implemented and evidenced **(80%)**
Element 2 - Fetal Growth Restriction	19/20 interventions implemented and evidenced **(95%)**

Element 3 - Reduced Fetal Movement	2/2 interventions implemented and evidenced **(100%)** [1 intervention contains 4 asks]
Element 4 - Effective fetal monitoring during labour	5/5 interventions implemented and evidenced **(100%)**
Element 5 - Reducing preterm births and optimising perinatal care	24/27 interventions implemented and evidenced **(89%)**
Element 6 - Management of Diabetes in Pregnancy	6/6 interventions implemented and evidenced **(100%)**

Meetings with the LMNS have been diarised throughout the CNST Y7 reporting period as below, this provides the forum to meet the ask *'Trusts should be able to demonstrate that at least two (and up to three) quarterly quality improvement discussions have been held between the ICB (as the commissioner) and the Trust.':*

- 19th June 2025
- 23rd September 2025 – CNST Y7 Q1
- 4th November 2025 – CNST Y7 Q2
- 13th January 2025 – CNST Y7 Q3 (sign off)

2.2.7 Safety action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

The Perinatal Transformation team, the Assistant Director of Midwifery, and the Consultant Midwife are working with the MNVP Engagement Lead to plan a schedule of projects for the MIS Year. This will include coproduction of the CQC survey action plan and the collection of further feedback to support improvements, as per MIS Year 7 requirements.

The MNVP Lead and Engagement Lead have been working with the Transformation Team and Digital Midwife to improve communications with service users. A service user focus group took place in the community in February 2025, and a working group including the MNVP Lead was set up on the 23rd of April to redesign the Maternity website based on this feedback. Patient feedback will be sought on the redesign. A particular focus has been on updating the contacts page to make the service more accessible and to reduce the number of calls being received by the incorrect areas.

The Transformation Team and Prevention Lead Midwife are conducting a Translation QI, aiming to improve access to interpreter services for service users whose first language is not English. As part of this work, the Prevention Lead Midwife and Improvement Support Officer attended a Home Start community group to seek feedback from service users to inform changes. Feedback centred around the need to continuously offer interpreters at all appointments, and the need to improve access to translated patient information resources. This work further contributes to the MIS Year 7 requirement to engage with those service users at risk of experiencing the worst outcomes.

2.2.8 Safety action 8: Can you evidence the 3 elements of local training plans and 'in-house', one day multi professional training?

There have been no changes to the metrics and target thresholds for training monitored for Safety Action 8 in MIS Year 7. The 3 elements remain:

- **Fetal monitoring and surveillance (in the antenatal and intrapartum period) training**. 90% attendance required for midwives, obstetric consultants and all other obstetric doctors who contribute to the obstetric rota.
  All relevant staff groups are currently over 90%.
- **Maternity emergencies and multi-professional training (PROMPT)**. 90% attendance for obstetric consultants and doctors, midwives, maternity support workers, and anaesthetic consultants.
  All relevant staff groups are currently over 90% aside from anaesthetists, currently at 88%.
- **Neonatal basic life support (NLS)**. 90% attendance required for neonatal consultants, junior doctors (who attend any births unsupervised), neonatal nurses (who attend any births unsupervised), advanced neonatal nurse practitioners, and midwives.
  All relevant staff groups are currently over 90% aside from the neonatal nursing team, at 85%.

A meeting has been arranged on the 21st of May 2025 with all leads for this safety action to review the new guidance and put in place processes to reach or maintain compliance by the 30th of November 2025, the date at which this safety action is measured.

2.2.9 Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

Safety Champions are continuing to meet with the perinatal leadership team at a minimum of bi-monthly at Floor to Board meetings. The next meeting is scheduled for the 29th of April 2025.

Perinatal Quality Surveillance Model (PQSM) Minimum Data Set February 2024 data:

Perinatal Quality Surveillance Dataset

East Lancashire Hospitals NHS Trust
A University Teaching Trust

CQC Metric Ratings	Overall	Safe	Effective	Caring	Well led	Responsive
	Good	Good	Good	Good	Good	Good
On the maternity improvement programme?		No				

	Metric	Standard	Nov 24	Dec 24	Jan 25	Feb 25
Perinatal Data	1:1 care in labour	100%	100%	100%	100%	100%
	Stillbirth rate	<4.4/1000	2.01	2.14	10.25	2.48
	Term admissions to NICU	<7%	7.93%	6.69%	6.98	7.23%
	Obstetric haemorrhage >1.5 litre (within 24hrs)	<10%	2.85%	3.70%	3.33%	5.28%
	3rd/4th degree perineal tear	<5%	4.39%	2.38%	4.41%	6.42%

	Metric	Standard	Nov 24	Dec 24	Jan 25	Feb 25
Staffing/Training	Maternity NICE red flags		0	0	0	0
	Dedicated obstetric consultant presence on labour ward	90hrs/week	90	90	90	90
	Midwife to birth ratio (establishment)	<1.28	<1.28	<1.28	<1.28	<1.28
	Midwife to birth ratio (in post)	<1.28	<1.28	<1.28	<1.28	<1.28
	Training compliance for all staff groups (CNST)	>90%	>90%	>90%	>90%	>90%

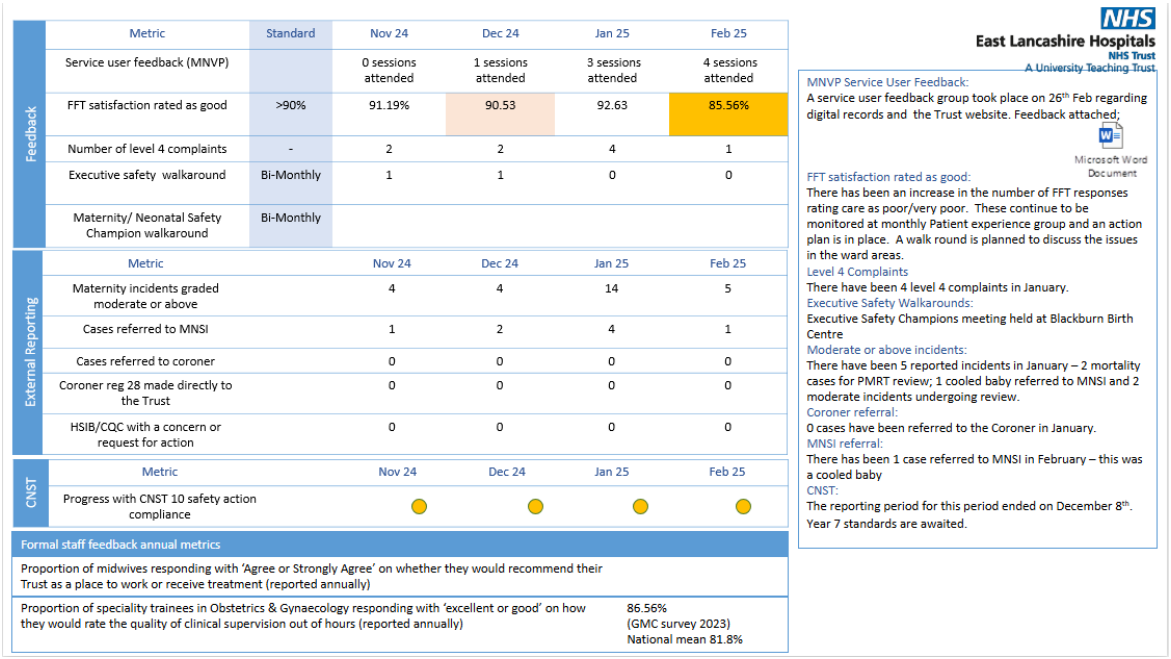
Perinatal Data:
All metrics within the perinatal data has been specifically reviewed against the Maternity Scorecard Data, ensuring all data is collated in the same way and enhancing data quality.

Stillbirth rate:
There has been 1 stillbirth in February, this was an intrapartum stillbirth – the intrauterine death was confirmed on arrival in the unit. This is being investigated by MNSI.

Term admission to NICU:
The Term admission rate has remained at the same level as. All these admissions have been reviewed and none have been avoidable. Any incidental learning is identified and shared with the teams.

3rd/4th degree perineal tears
The number of 3rd/4th degree tears has increased in February – all these are being reviewed.

Training Compliance:
The average for training compliance across all staff groups remains >90% attendance. MIS CNST standards for year 6 suggest that all aneasthetists who may occasionally work in the birth suite must attend PROMPT. This may be difficult to achieve.



	Metric	Standard	Nov 24	Dec 24	Jan 25	Feb 25
Feedback	Service user feedback (MNVP)		0 sessions attended	1 sessions attended	3 sessions attended	4 sessions attended
	FFT satisfaction rated as good	>90%	91.19%	90.53	92.63	85.56%
	Number of level 4 complaints	-	2	2	4	1
	Executive safety walkaround	Bi-Monthly	1	1	0	0
	Maternity/ Neonatal Safety Champion walkaround	Bi-Monthly				

	Metric	Nov 24	Dec 24	Jan 25	Feb 25
External Reporting	Maternity incidents graded moderate or above	4	4	14	5
	Cases referred to MNSI	1	2	4	1
	Cases referred to coroner	0	0	0	0
	Coroner reg 28 made directly to the Trust	0	0	0	0
	HSIB/CQC with a concern or request for action	0	0	0	0

	Metric	Nov 24	Dec 24	Jan 25	Feb 25
CNST	Progress with CNST 10 safety action compliance				

Formal staff feedback annual metrics	
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their Trust as a place to work or receive treatment (reported annually)	
Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (reported annually)	86.56% (GMC survey 2023) National mean 81.8%

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

MNVP Service User Feedback:
A service user feedback group took place on 26th Feb regarding digital records and the Trust website. Feedback attached;

Microsoft Word Document

FFT satisfaction rated as good:
There has been an increase in the number of FFT responses rating care as poor/very poor. These continue to be monitored at monthly Patient experience group and an action plan is in place. A walk round is planned to discuss the issues in the ward areas.

Level 4 Complaints
There have been 4 level 4 complaints in January.

Executive Safety Walkarounds:
Executive Safety Champions meeting held at Blackburn Birth Centre

Moderate or above incidents:
There have been 5 reported incidents in January – 2 mortality cases for PMRT review; 1 cooled baby referred to MNSI and 2 moderate incidents undergoing review.

Coroner referral:
0 cases have been referred to the Coroner in January.

MNSI referral:
There has been 1 case referred to MNSI in February – this was a cooled baby

CNST:
The reporting period for this period ended on December 8th. Year 7 standards are awaited.

'Is the Trust's claims scorecard reviewed alongside incident and complaint data.'
An update on the actions taken after the implementation of a triangulation task and finish group will be provided at Floor to Board on the 5th of June 2025. Feedback from this will be provided in the July Trust Board report.

'Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.'
The culture improvement plan as informed by the results of the Safety, Communication, Operational, Reliability and Engagement (SCORE) culture survey is monitored and lead by the Maternity and Neonatal Quadrumvirate (Quad), who meet monthly with a direct focus on safety and culture listed within the agenda.

Following on from previous updates, ELHT maternity and neonatal services were offered the opportunity to train Culture Coaches to hold regular culture conversations and support the delivery of local culture improvements. The Culture Coaches have completed initial training and have attended follow up session on the 28th of February 2025. The culture coaches have also held initial culture conversations with Neonatal Doctors, Advanced Neonatal Nurse Practitioners, the Obstetric / midwifery individual department and theatre team. Feedback from these sessions will come via the Culture Coaches for discussion at Quad meetings, to

inform the culture improvement plan. Further sessions with midwifery teams and MSWs are planned throughout April and May to add to the valuable feedback that has already been collected. The culture conversations include Maternity, Neonatology and theatre teams.

2.2.10 Safety action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations Special Health Authority (MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025?

The Perinatal Quality Surveillance Model – Minimum Data Set as above contains monthly data of the number of HSIB/MNSI cases reported and accepted or rejected. The rationale and further detail are also included within the data set for assurance and/or discussion where required.

A detailed overview of cases within the reporting period to present are provided in the quarterly reports produced by the Quality and Safety Lead. The quarter 4 report is attached as an appendix for submission (**Appendix 3**).

Updated MIS Year 7 guidance now states that Trust Board must have sight of *'evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme. This needs to include reporting where families required a format to make the information accessible to them and should include any occasions where this has not been possible, with a SMART plan to address any challenges for the future.'.* As such, this has been added to the quarterly report submitted to Trust Board. Please note use of translation services highlighted to be included as part of the Quality improvement to measure compliance and documentation aligned with such sensitive conversations (**Appendix 3**)

Other Update

April Quality committee (QC) subcommittee report (**Appendix 4)** for reference trust board members. QC papers and contents are prescheduled aligned with position updates on the deliverables of the maternity and neonatology three-year delivery plan.

Annual Northwest regional site visit took place on Wednesday 30th April, outcome letter pending. Agenda included presentations on maternity & neonatology services improvements, Consultant midwife portfolio, ELHT Midwifery continuity of care (MCOC), ELHT maternity triage risk assessment with plan working towards go live with Birmingham symptom- Specific obstetric triage system (BSOTS) A standard initial triage system to assess mothers and help prioritise women for care based on clinical urgency. BSOTS is the recommended triage system in England and widely adopted supported by the December 2023 Royal college of obstetricians and Gynaecologists (RCOG) maternity triage good practice paper. Other presentations and workshops included ELHT Perinatal mortality review tool (PMRT)cases with outcomes, Caesarean section risk assessment and progress, quality improvement projects including translation services, debrief consultation pathways, Ante natal community clinic consultations. Medical, midwifery and neonatal workforce with improvements. Engagement/ listening sessions took place with student midwives, international recruited midwives and Maternity support workers and the post-natal and transitional care team. A tour of the unit also took place with a feedback session including the Executive and non-executive safety champions, deputy chief nurse and deputy COO for ELHT.

The site visit was a great opportunity for ELHT maternity and Neonatal services to celebrate and showcase the great work, commitment and coproduction with women and families taking place, reflecting on the continuous improvement journey with opportunities to share plans for the next phases. The team received some wonderful and balanced feedback.

4. CONCLUSION

On behalf of ELHT maternity and neonatology services this bimonthly assurance report to ELHT trust board serves to inform progress of the ten CNST maternity safety actions throughout the year 7 reporting period.

Any other matters of patient safety concerns will continue to be reported through the bimonthly maternity and neonatology safety champions floor to board agendas and reflected within trust board papers for wider discussions and escalation as and when required.

Perinatal Quadrumvirate:

Tracy Thompson, Divisional Director of Midwifery and Nursing

Martin Maher, Clinical Director Obstetrics/Gynaecology

Rajasri Seethamraju, Clinical Director Neonatology

Charlotte Aspden, Directorate Manager of Maternity and Neonatology

May 2025

Appendix 1 – CNST-MIS Y7 Guidance

20250401 - MIS year 7 Final (1).pdf

Appendix 2 – PMRT Quarter 4 Report

Quarterly PMRT report Q4 2025.docx

Appendix 3 – MNSI quarterly update

CNST SA 10 Year 6 April 25 Update.doc

Appendix 4 – Quality Committee Report April 2025

01. Floor to Board Report Quality Comm

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Meeting Date:	14 May 2025	**Agenda Item:**	TB/2025/063
Report Title:	Review of the Board Assurance Framework		
Author:	Executive Directors Interim Director of Corporate Governance		
Lead Director:	Mrs K Atkinson, Executive Director of Service Development & Improvement		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓			

Executive Summary:

The Executive Directors have refreshed the Board Assurance Framework against the strategic priorities and annual plan for 2025/26. This has resulted in the rewording of the risks and the inclusion of a new strategic risk in relation to cyber security. It should be noted that the BAF is a dynamic document which will continue to be regularly reviewed and developed during the course of the year.

At the April Board Strategy Session, the Board spent time reviewing the Risk Appetite Statement for 2025/26 and this is attached for formal Board approval. Due to the rapidly changing external environment the Board has committed to conduct a mid-year review of the Risk Appetite Statement in addition to its usual annual review.

The Board also discussed how it, and the Committees, can best utilise the BAF to inform their discussions. The following actions were agreed:

- Quarterly review of the BAF in its entirety at the Board;
- Quarterly review of the BAF through the lens of quality, workforce, finance and productivity at the various Board Committees, with the Audit Committee overseeing the effectiveness of this;
- Simplified narrative to accompany the BAF, which clearly sets out what has changed, the rationale for the change or if there have been no changes;
- The BAF format will be reviewed with a view to making the document more user-friendly;
- Consideration to the addition of a strategic risk reflecting the challenge of addressing health inequalities;
- Expanding the description of the new cyber-security risk to include resilience; and
- The Board to consider how it measures progress against delivery of strategy and integrates this with the quarterly review of the BAF.

	These actions will be taken forward, together with the actions from the MIAA review of the BAF, and progress reported with the next quarterly review of the BAF.
Key Issues/Areas of Concern:	The seven BAF risks have been agreed as areas of strategic risk by the Board.
Action Required by the Board:	The Board is asked to: • Be assured that the Board Assurance Framework is being actively reviewed and steps taken to improve its effectiveness as a source of assurance for the Board; • Note that the cyber-security risk will be discussed within the private section of the Board meeting; • Approve the draft Risk Appetite Statement; and • Note the actions agreed at the Board Strategy session which will be actioned within the Quarter 1 review of the BAF.

Previously Considered by:	Board Strategy Session (and subsequent Committee meetings)
Date:	9th April 2025
Outcome:	Draft Risk Appetite Statement developed; and Actions to improve the BAF discussed and agreed.

DRAFT 2025/26 Risk Appetite Statement

1 Introduction

Risk appetite is defined as the amount of risk, on a board level, that an organisation is willing to accept in pursuit of its strategic objectives. The Board of Directors has considered and documented its risk appetite statement in order to assist decision-makers across the Trust in understanding the degree of risk to which they are permitted to expose the Trust to, whilst encouraging enterprise and innovation.

The statement of risk appetite is dynamic and will be reviewed at least annually by the Board to ensure that it reflects the rapidly changing external environment within which the Trust and wider NHS operates.

2 Key context for Risk Appetite Statement 2025-26:

The Trust enters 2025-26 in a difficult period where it seeks to ensure continued delivery of its vision to deliver safe, personal and effective care at a time of national and system change and within a very constrained financial position which has led to regulatory action under the NHS Oversight Framework by being placed into Segment 4/Recovery Support Programme.

.

Key considerations which have informed the identification of our key strategic risks are outlined below:

2.1 Quality

- Quality and safety must not be compromised and needs to continuously improve
- Improving health inequality and equity for the people of East Lancashire and Blackburn with Darwen needs to be central to our decision making
- We need to continue to engage with and involve our patients and local population in our decision making

2.2 Our People

- Improving the lived experience of our patients and staff must continue to be one of our key guiding principles
- The pressure on our workforce must be recognised in providing for patient and service needs at a time of increased demand and unrelenting need to reform how we work
- We must transform and reduce our workforce numbers to support financial recovery and recognise and recognise the impact of this on staff morale

- We must continue to support the health and wellbeing of our colleagues
- We need to develop capacity and skills for delivery of reform/change and support our colleagues to work at pace achieve this

2.3 Finance

- The Trust has a significant financial deficit and has been placed in NHS NOF 4/Recovery Support Programme. The Trust must meet its obligations of delivering the legal undertakings agreed.

2.4 System Leadership

- There are significant national and regional changes underway to NHS England, Lancashire and South Cumbria (L&SC) Integrated Care Board (ICB)
- The role of Place and Neighbourhoods is vital to support effective demand management and care closer to home
- There needs to be an effective/mature system strategy and commissioning – there are ongoing issues in terms of maturity and impact
- The L&SC Provider Collaborative continues to mature it partnership but needs to increase delivery of key programmes supported by strong governance
- The L&SC System is in deficit with other providers and the ICB being placed in NHS NOF 4/Recovery Support Programme
- There is an ongoing need to balance but recognise the tension of the Trust's duty and desire to collaborate for the benefit of our patients, Trust and system whilst ensuring organisational regulatory requirements are met

2.4 National Context

- A New NHS 10 Year plan will be published with 3 shifts at its core:
  - Moving care from hospitals to communities
  - Making better use of technology
  - Focussing on preventing sickness, not just treating it
- The ongoing impact of demand and pressure on services alongside the financial context has the potential to impact on quality at organisational, system and national level
- There continues to be a top-down performance management system approach

3 Use of the Risk Appetite Statement

The statement of risk appetite is a broad one, to be used as a tool enabling better internal control but does not offer definitive answers to any specific risk management issue. When assessing and managing risk, managers should review the risk appetite statement to help them determine an acceptable risk target score and set out the mitigating action required to achieve this.

No statement of risk appetite can encompass every eventuality and there may be exceptions where the Board has valid reasons for setting a level of tolerance outside of the scope of the risk appetite. In these cases the rationale for the Board's decision will be formally documented.

4 Risk Appetite Statement

Quality

Delivering high quality, safe, personal and effective services is the main objective of the Trust. Therefore the Trust has a **cautious** appetite for risks to the quality and safety of patient care. In practice this means that the Trust's preference is for risk avoidance. However, if necessary the Trust will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.

Financial

The Trust's appetite with regards to its finances or use of resources is **cautious.** The Trust is prepared to accept the possibility of limited financial risk. In recognition of the Trust's need to meet its statutory duty of 'living within its means', value for money is a primary concern.

People

The Trust is committed to recruiting and retaining the best staff. It has an appetite to **pursue** workforce innovation. The Trust is willing to take risks which may have implications for the workforce but could improve the skills and capabilities of our staff. The Trust recognises that innovation is likely to be disruptive in the short term but with the possibility of long term gains.

Regulatory

The Trust will have a **minimal** appetite for noncompliance with regulatory requirements. It will avoid any decisions that may result in heightened regulatory challenge unless absolutely necessary.

Reputational

The Trust will **pursue** innovation even if this means taking decisions that are likely to result in the scrutiny of the organisation. It will outwardly promote new ideas and innovations where potential benefits outweigh the risks.

5 Risk Appetite Definitions and Target Scores

The risk appetite definitions have been aligned to the Trust's risk matrix.

Descriptor	Definition	Risk Target Score
None	Avoidance of risk is a key organisational objective.	0
Minimal	Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.	1-3
Cautious	Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.	4-6
Open	Willing to consider all potential delivery options and choose, whilst also providing an acceptable level of reward.	8-12
Pursue	Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).	15-20
Significant	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.	25

Approved by: The Board of Directors
Date Approved:
Date to be Reviewed:

Board Assurance Framework Quarter 1 Review

The Executive Directors and their deputies with BAF risks assigned to them have reviewed and revised the strategic risks. They have been slightly revised for 2025/26 with a new risk relating to cyber-security, due to the sensitive nature of the information contained within this risk it will be considered within the closed session of the Board meeting. An overview of the Strategic risks is included in Appendix 1 to this paper.

The full BAF was presented to the April Audit Committee and the other Board Committees have considered the risks presented to them as follows:

a) **Finance & Performance Committee:** BAF 1, BAF 3, BAF 5, BAF 6 and BAF 7.
b) **Quality Committee**: BAF 2.
c) **People and Culture Committee**: BAF 4 and BAF 6.

For ease of reference, we have produced the following heat map of the BAF risks for 2025-26 below.

2025-26		LIKELIHOOD				
		Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
CONSEQUENCE	Catastrophic 5				BAF 1 BAF 5 BAF 7	
	Major 4			BAF 4	BAF 3 BAF 6b	BAF 2
	Moderate 3				BAF 6a	
	Minor 2					
	Negligible 1					

The Board is asked to review, discuss and approve the revised BAF.

	Key Strategic Risk Area	2024/25 Board Assurance Framework Risk	Risk Score (Jan 25)	2025/26 Board Assurance Framework Risk	Proposed risk score (April 25)
1	Integrated Care, Partnerships, System Working	The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in unimproved health and wellbeing for our communities.	C4 x L4 = 16	The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in unimproved health and wellbeing for our communities and fail to support the financial recovery of both the Trust and System and exit from NHS Oversight Framework Segment 4 (Recovery Support Programme).	C5x L4 = 20
2	Quality and Safety	The Trust may be unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter.	C4 x L4 = 16	The Trust may be unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter.	C5 x L4 = 20
3	Elective Recovery and Emergency Care Pathway	A risk to our ability to deliver the National access standards as set out in the 2024-25 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence.	C4 x L5 = 20	A risk to our ability to deliver the National access standards as set out in the 2025-26 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence.	C4 x L4 = 16
4	Culture, Workforce Planning and Redesign	The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture.	C4 x L4 = 16	The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of its inability to successfully transform the workforce to support recovery underpinned by our compassionate wellbeing, equality, diversity and inclusion and improvement focused culture.	C4 x L3 = 12
5	Financial Sustainability	The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.	C5 x L5 = 25	The Trust is unable to meet its agreed financial targets for 2025-26 as part of a multi-year financial recovery plan for both the Trust and wider Lancashire and South Cumbria (LSC) system.	C5 x L4 = 20

6	One LSC – Host and Partner	As Host: Increased staff transferring into the Trust increases activity across existing ELHT corporate services affects the Trust's ability to provide high quality corporate services to both One LSC and core ELHT services. As Partner: One LSC does not deliver the anticipated benefits of high-quality corporate services across partner organisations.	C4 x L5 = 20 C4 x L5 = 20	As Host: The Trust is unable to meet its hosting obligations, leading to reputational damage and potential financial implications to the Trust and other partners. As Partner: One LSC does not deliver the anticipated benefits of high-quality corporate services across partner organisations.	C3 x L4 = 12 C4 x L4 = 16
7	Cyber Security	N/A	N/A	Redacted for security reasons	Redacted

BAF Risk 1 – Integrated Care / Partnerships / System Working

Risk Description: The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in unimproved health and wellbeing for our communities and fail to support the financial recovery of both the Trust and System including exit from NHS Oversight Framework Segment 4 (Recovery Support Programme)

Executive Director Lead: Chief Executive / Executive Director of Service Development and Improvement

Strategy: ELHT Strategic framework (Partnership Working)

Links to Key Delivery Programmes: Care Closer to Home/Place-based Partnerships, Provider Collaborative, Tackling health and care inequalities

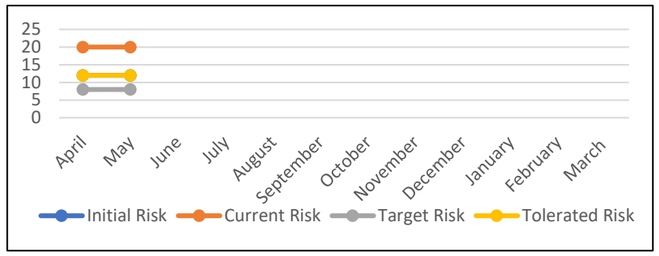
Date of last review: Executive Director: May 2025

Lead Committee: Finance and Performance Committee

Links to Corporate Risk Register (CRR): Currently there are no risks on the CRR that are rated at 15 and above that are related to BAF risk 1.

Risk Rating (Consequence (C) x Likelihood (L)):

Current Risk Rating:	**C5 x L4 = 20**
Initial Risk Rating:	C4 x L3 = 12
Tolerated Risk	C4 x L3 = 12
Target Risk Rating:	C4 x L2 = 8



Effectiveness of controls and assurances:

X	Effective
	Partially Effective
	Insufficient

Risk Appetite: Pursue/High/15-20

Controls: (What mechanisms, systems, rules and procedures do we already have in place that help us to either mitigate the risk from occurring or reduce the potential impact)

Lancashire and South Cumbria Integrated Care System/Board (ICS/ICB):

- The ICB has worked with partners to develop a Joint Forward Plan and to create a clinical strategy blueprint. System clinical reconfiguration leadership support has been commissioned to drive forward the system transformation programme.
- The ICB continues to develop its commissioning approach and has formalised commissioning intentions for 2025/26 alongside a commissioning delivery plan.
- The system Programme Management Office continues to develop to support delivery and monitoring of benefits realisation of system-wide programmes.
- ELHT has strong representation at all levels of system working and oversight groups. This is inclusive of Executive, senior clinical and operational representation at ICS working groups for key programmes, tactical co-ordination groups and planning groups to ensure alignment of plans.
- The ICB will develop and agree an improvement plan as part of the Recovery Support Programme to support exit from NHS Oversight Framework Segment 4 (NOF4)

Provider Collaborative Board (PCB):

- The PCB drives key programmes of work on both Clinical Services and Central Service redesign which feed into PCB Governance Structures
- A Joint Committee has been formed to enable effective decision making for specified Programmes.
- ELHT plays a key role in the PCB including Chief Executive and Chair at PCB Provider Collaborative Board, lead Director Senior Responsible Officer (SRO) roles, representation at all other functional Director co-ordination groups and senior clinical and operational staff represented at clinical and non-clinical programme and working groups.
- The Clinical Services Programme Board, oversees a programme of work focussed on clinical services configuration including fragile services.
- Central Services Programme Board oversees potential savings and other benefits of Central Services programmes opportunities with ELHT as the host of One LSC (refer to separate BAF risk 6).
- 3 of 5 Providers in the PCB are part of the Recovery Support Programme and as such, PCB plans will need to support the requirements of the Recovery Support Programme to support collective exit from NOF4.

Place-Based Partnership (PBP):

- Blackburn with Darwen Place and Lancashire Place including East Lancashire priorities are now agreed with place based delivery structures continuing to develop and be reflected in system commissioning intentions.
- Place + key forums in place to support delivery where needed across East Lancashire and Blackburn with Darwen e.g. Urgent and Emergency Care Delivery Board and delivery programmes being developed to align to NOF4.

ELHT:

- ELHT Strategic framework has been developed to ensure clear alignment of organisational aims to wider system aims.
- Key organisational strategies have been refreshed/developed to clearly outline ELHT priorities for development as a partner in the wider system.

Assurances: (This is the confidence we have in the effectiveness of the controls and action plans in place (e.g. regular risk reports, audits, regular monitoring at the Directorate Quality meetings or Risk Meetings etc.)

Service delivery and day to day management of risk and control:

- ICS/PCB/PBP Updates are a standing agenda item at Executive meeting and Senior Leadership Group.
- PCB Programme Update reports to the PCB Joint Committee.
- Weekly monitoring of Key Delivery and Improvement Programmes via Executive Improvement Wall
- Trust Improvement Register monitored at Divisional Transformation Boards and Clinical Effectiveness Committees.
- Organisational plans for operational planning established and agreed via Trust and System planning processes.
- Accountability Framework implemented from January 2023 (currently being refreshed) including weekly Improvement Wall updates as part of the weekly Executive Team meetings, Senior Leadership Group and quarterly Divisional Performance meetings.

Specialist support, policy and procedure setting, oversight responsibility:

- Standing agenda item at Trust Board where approvals will be established, and permissions are provided by the Board to let Executives progress the generation of ideas and options with external stakeholders.
- Board Chief Executive Officers (CEO) report including updates on system developments and engagement.
- System delivery plans are reflected in updates on Trust Key Delivery and Improvement Programmes. ELHT Key Delivery and Improvement Programmes established with relevant Programme Boards in place which feed into Trust sub-committees to report progress and give assurance.
- Strategic dashboards developed to enable monitoring of key Trust strategies at relevant Trust sub-committees with reporting to Trust Board twice a year.

Independent challenge on levels of assurance, risk and control:

- Provider Collaborative Board Business Plan signed off by all partners. Ongoing assurance on delivery provided via PCB Board and oversight groups.
- Trust, PBP, PCB plans feed into ICS-level plans as part of the national operational planning processes and are scrutinised by NHS Improvement/England.
- Regular communication with NHS England, NHS subsidiaries, Commissioners and Senior/Executive Management between teams.
- Mersey Internal Audit Agency (MIAA) audit of financial sustainability and improvement practice complete with action plan agreed and sign off at Audit Committee with substantial assurance
- MIAA audit of ELHT Business Planning processes complete with action plan agreed and sign off at Audit Committee with substantial assurance

BAF Risk 1 – Integrated Care / Partnerships / System Working

• Strategy deployment framework/process will support development and delivery of organisational plans aligned to wider system, supported by Accountability Framework to monitor delivery. • 10 Key Delivery and Improvement Programmes and associated improvement priorities have been agreed for 2025/26, aalongside 8 key improvement priorities with key measures of success outlined. These will support the delivery of the Trust's Improvement Plan which will be agreed as part of the Recovery Support Programme and requirements to exit NOF4. • The Trust has a dedicated Recovery Director to support financial recovery and is establishing a Programme Management Office (PMO). ELHT Improvement Practice (Improving Safe, Personal and Effective Care (SPE+), has been developed to support delivery and build capacity for Improvement. Improvement Hub Team Properties will be aligned to the PMO supporting delivery of requirements of the Recovery Support Programme.	

Gaps in controls and assurance: Any issues implementing controls or activities which enforce a control that do not go ahead are known as Gap's in Controls. Gaps in assurances show us what we need to improve on to ensure we can deliver assurances that the risk is progressing.
Mitigating actions: actions, which when taken, will either reduce or eliminate the likelihood of the risk occurring or reduce the organisations exposure to that risk.
Progress update/Impact: Update by exception and effectiveness of impact on address gap in control/assurance

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1.	Commissioning intentions need to support delivery of tangible improvements and system transformation and financial recovery.	Work with system partners to agree commissioning intentions and ensure clear plans in place to achieve system transformation and financial recovery	Director of Service Development and Improvement with SRO leads	June 2025	Work ongoing to review and agree impact of commissioning intentions for 2025/26 including Quality Impact and Risk Assessments to support decision making and quantification of financial savings to support financial recovery plans in 20252/6. These will be built into the trust financial recovery and transformation programmes upon agreement. System workshop held on 10th April but work still ongoing to align assumptions and impact for 2025/26.	R
2.	System transformation programmes need to deliver significant system transformation to deliver quality and financial benefits and algin to the Recovery Support Programme (RSP)	Work with partners to develop and implement system transformation programmes via the Clinical Transformation Board.	Executive leads	June 2025	System clinical reconfiguration leadership support commissioned and agreed as part of the Recovery Support programme. Work underway to: • undertake a rapid diagnostic of current clinical transformation and reconfiguration plans. • Identification of programmes where transformation can be accelerated • Develop a clinical reconfiguration proposal	A
3.	Benefits for community services/out of hospital priorities not yet fully realised.	Work with Place + partners to further develop community services in line with the Community Transformation Programme to maximise benefits to support patients to receive care in their own home where possible and reduce demand in the acute setting.	Executive Director of Integrated Care, Partnerships and Resilience	April 2026	Co-production and co-delivery with place partners of service development and transformation including end to end pathway improvement across primary, community and acute settings. Agreement of clear targets and plans to reduce demand in secondary care, support increase care at home and support delivery of agreed Waste reduction Plan across the UEC pathway. Work underway to map the impact of changes to Primary Care Local Enhanced Services for impact on demand management to the hospital and to clarify opportunities from the system-wide review of Community Services as part of the Kingsgate Review.	A
4.	Implement Trust Programme Management Office (PMO) with clear links between Trust key Delivery and Improvement Programmes/Priorities to support financial recovery	Establish PMO and strengthen key delivery and improvement programmes to support realisation of benefits (Delivery, Quality, Cost, People) and delivery of requirements to support exit from NOF 4.	Recovery Director, Director of Service Development and Improvement, Director of Finance	May 2025	Interim PMO arrangements in place and work underway to strengthen key delivery programmes to support identification and delivery of Trust Waste reduction Programme in 2025/26	A
5.	Trust planning process will continue to mature to support floor to board connections of goals and priorities alongside wider system alignment	Ongoing review and improvement of planning processes at organisational and system level to respond to any requirements identified as being part of the recovery Support Programme.	Director of Service Development and Improvement	June 2025	2025/26 planning processes nearing completion following submission of national planning submission in April 2025. Final feedback awaited particularly aligned to financial recovery and development of Waste Reduction Programme. Key Trust Priorities finalised with roll forward of all trust Strategies for 22025/26,signed off at key Trust Committees in April and final approval at Trust Board in May 2025. Trust planning processes will then be re-reviewed in Q1/Q2 in line with system review of planning and feedback as part of recovery Support Programme.	A
6.	Ongoing development of SPE+ improvement Practice to support delivery of key improvement priorities and to build improvement capability across the organisation/system	Ongoing review and development of SPE+ Improvement Practice at organisational and system level to build capability and support delivery and refresh of SPE+ Practice Plan/Strategy in line with NHS Impact	Director of Service Development and Improvement	June 2025	Improvement hub team capacity identified to support key improvement priorities for 2025/26, increased monitoring in place to support realisation of benefits aligned to Trust Waste Reduction Programme. Continue to review the offer from NHS Impact to align organisational and national improvement priorities. Work underway to ensure alignment of Improvement Hub Team to PMO.	A
7.	Trust Accountability Framework can mature further to support and assure delivery of Trust priorities and realisation of benefits.	Review effectiveness of Trust Accountability Framework and further improve to support delivery	Director of Service Development and Improvement	June 2025	Review commenced of Accountability Framework including effectiveness of Divisional Quarterly Performance meetings, measurement and reporting framework. This will now be expanded to consider the requirements of the Recovery Support Programme. Revised Integrated Performance Report implemented from March 2025 and work underway to develop Divisional IPRs and improve other reporting.	A

BAF Risk 2 – Quality and Safety

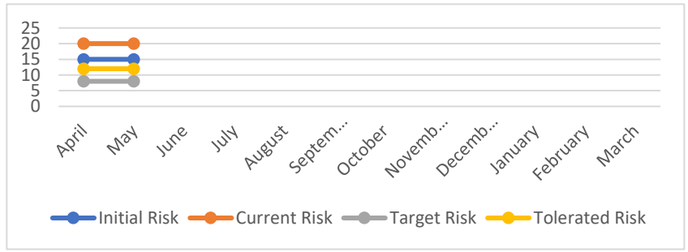
Risk Description: The Trust may be unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter.		**Executive Director Lead:** Executive Medical Director and Chief Nurse	
Strategy: Quality Strategy	**Links to Key Delivery Programmes:** Quality and Safety Improvement Priorities	**Date of last review:** Executive Review: May 2025	**Lead Committee:** Quality Committee

Links to Corporate Risk Register:

Risk ID	Risk Descriptor	Risk Rating
10086	Lack of adequate online storage for images may result in missed or delayed diagnosis	**20**
9545	Potential interruption to surgical procedures due to equipment failure	**20**
9336	Increased demand with a lack of capacity within ED can lead to extreme pressure and delays to patient care	**20**
8126	Poor records management due to sub optimal implementation of new e-PR system	**20**
8941	Increased reporting times in histology due to increased activity outstripping resource	**20**
8061	Patients experiencing delays past their intended clinical review date may experience deterioration	**16**
8033	Increased requirement for nutrition and hydration intervention in patients resulting in delays	**16**
7165	Failure to comply with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).	**16**
6190	Insufficient capacity to accommodate patients in clinic within timescales	**16**
9851	Lack of standardisation of clinical documentation processes and recording in Cerner	**15**
8808	Breaches to fire stopping and compartmentalisation in walls and fire door surrounds – Burnley General Teaching Hospital.	**15**
10065	Pharmacy Technical Service refurbishment programme	**15**
10062	Risk of harm and poor experience for patients with mental health concerns	**15**
9900	Poor identification, management and prevention of delirium	**15**
9653	Increased demand with a lack of capacity within ELHT can lead to extreme pressures and delays to patient care	**15**
9601	Risk of avoidable patient falls with harm	**15**

Risk Rating (Consequence (C) x Likelihood (L)):

Current Risk Rating: C5 x L4 = 20
Initial Risk Rating: C5 x L3 = 15
Tolerated Risk C4 x L3 = 12
Target Risk Rating: C4 x L2 = 8



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite: Cautious/2-6

Controls: (What mechanisms, systems, rules and procedures do we already have in place that help us to either mitigate the risk from occurring or reduce the potential impact).

Strategy and Planning:

- The Quality Strategy contains 14 core priorities which are routinely reported and monitored through the Quality Committee. These will be reviewed and updated annually through workshops with key partners.
- The Quality Strategy priorities for 2025/26 have been confirmed, with associated KPIs. Progress against the 2025/26 priorities is reviewed by the Executive team via the Executive Improvement Wall.
- The current local priorities of the Patient Safety Incident Response Framework are due for review/update in March 2025. However, due to the high number of National Priorities, cases for Coroners Court and operational pressures within the Trust, it has been agreed that the current PSIRF would be extended to September 2025. This will allow adequate time for the local priorities to be completed and to hold workshops to review, discuss and agree new local priorities for commencement in October 2025.
- Learning from the first year of implementing PSIRF has acknowledged priorities for 2022-23 were implemented over 18 months and therefore the 23-24 priorities are anticipated to cover until mid-2025.

Assurances: (This is the confidence we have in the effectiveness of the controls and action plans in place (e.g. regular risk reports, audits, regular monitoring at the Directorate Quality meetings or Risk Meetings etc.)

Service delivery and day to day management of risk and control:

- Monitoring against Model Hospital, Getting it Right First Time (GIRFT), National Institute for Health and Care Excellence (NICE) guidelines, Internal and Clinical Audits (local and national), specialist commissioning, CQC insight data (monthly)
- Quality Walkrounds including Executive and Non-Executives Establishment of 3s visits to all areas of the Trust, to listen to both staff and patients/carers, receive feedback and take action.
- Bespoke improvement walls are regularly reviewed for both ED and AMU by Executive Directors
- Nursing Assessment Performance Framework (NAPF) Process has been reviewed and updated with ongoing reports to Quality Committee. Document has been reviewed to reflect Trust policy's and CQC quality standards.
- Safe, Personal, Effective Care (SPEC) process has been reviewed and updated and the ratings of green/silver/gold wards/areas (mapped to the CQC Key Lines of Enquiry).
- Co-ordination of GIRFT through Audit and Effectiveness Team to identify Trust wide efficiency and effectiveness gains and reported to the Quality Committee regularly.

Floor to Board Reporting and escalation (Risk and Quality):

- The Trust has an established quality assurance process supported through a formal Committee Structure. This provides the golden thread enabling reporting and escalation between the Divisions and the Board.
- The Trust Board, Quality Committee, Finance and Performance Committee, People and Culture Committee and Audit Committee all receive reports on risk/quality as part of their annual workplan, or as escalation where indicated.
- Escalation required outside of standard Committee processes is enabled through Senior Leadership Group, chaired by the Chief Executive or other Executive member to enable timely decision making and trust wide focus where required.
- All Divisions (including Estates and Facilities) have Quality and Safety meetings which coordinate Directorate assurance reports and escalation. Divisional reports are escalated to the Quality Committee via the Trust Wide Quality Governance Group.
- Statutory requirements are monitored specifically through Trust Wide assurance meetings including, but not limited to Mortality Steering Group, Patient Safety Group, Patient Experience Group, Clinical Effectiveness Committee, Infection Prevention and Control Steering Group, Safeguarding Board, Medicines Safety and Optimisation, Hospital Transfusion Committee, Organ Donation Committee, Health and Safety Committee, all of which report directly or indirectly to the Trust's Quality Committee, which is a sub-committee of the Board.
- The Professional Standards Group and Employee Relations Case Review Group monitor professional/staff behaviours and all referrals to professional bodies.
- The Risk Assurance Meeting coordinates and monitors all risks reported as potentially scoring 15 or above and escalates to the Executive Risk Assurance Group (ERAG) before inclusion onto the Corporate Risk Register.
- The Patient Safety Incident Response Plan, Patient Experience Framework, Risk Management Framework and Clinical Effectiveness Framework co-ordinate the operational implementation of the priorities which are reported and monitored through respective assurance groups, and exceptions reported to Quality Committee.
- Implementation of the Extreme Escalation Policy which replaces beds with trolleys in clinical spaces to assist the transfer of patients from ED into AMU/more appropriate environment. This in turn assists the capacity within the ED to see and treat other patients. Every morning at 8am, there is exec lead clinical safety meeting with A&E, divisions and flow team to manage and monitor patient admissions and flow.
- The Trust continues to manage current pressures through an IMT approach.
- A&E Delivery Board lead by an Executive Director ensures processes are in place to help co-ordinate the care of patients between community, primary care, NWAS and ELHT.
- A&E and Acute Medical Unit improvement board, developed with alternative weekly executive review
- Quarterly Divisional performance meetings where all elements of quality and performance are discussed.
- Data and Digital Senate and Data and Digital Board are the forums for implementing and monitoring data and digital strategy.
-

- Initial programme directed at flow commenced in March 2025 with a development of an ongoing plan for the 2025-26 financial year.
- Direct patient referrals into Same Day Emergency Care (SDEC) pathways to help bypass urgent care and ED.
- Admission avoidance through the use of Intensive Home Support Service (IHSS) in ED.
- Acute Care Team supporting resus in ED.
- Acute medical physician in-reach into A&E from 8.30am to 8.30pm
- Patient champions in ED
- Use of 24/7 ambulatory care on an intermittent basis to assist acute care (staffing dependent).
- Work is being undertaken with colleagues in primary care regarding patient pathways.
- Medical Examiners review the care provided to patients who have died in the Trust and can make recommendations or seek further action dependent upon their findings.
- Complex Case meeting weekly to monitor and allocate for investigation any patient/staff safety incidents identified.
- Monthly complaints and inquest drop-in sessions with each division to monitor performance and highlight risk
- Mobilisation of 24/7 IHSS service complementing the 24/7 Intermediate Care Allocation Team (ICAT) service Monday to Friday between 8am – 4pm for the ED front door team.
- New PSIRP priorities have now been identified and included in the update Patient Safety Incident Response Plan approved at Quality Committee on 1st November.
- New model for patient safety culture reflecting the Insight/Involve/Improve model – integrating patient and staff safety data (in line with the National Patient Safety Strategy) has been agreed in principle with the Quality and Safety team.
- Patient safety specialists are working with Deputy Director of HR to integrate staff safety metrics alongside patient safety.
- New Clinical Lead for Retention, Resilience and Experience commenced in post on 1 August 2023 with a focus on nursing and AHP workforce.
- Work is being undertaken with ward managers and team leaders to review and learn from observations of patient care to improve patient care, outcomes and experience.
- Quality Wall walkrounds have commenced (reviews of the quality KPI's in ED)
- Triple S visits which are informal and report to People and Culture committee quarterly
- A new Patient Experience Strategy has been approved by the Board of Directors and launched in September 2024. It has been monitored at Patient Experience Group and is being reported via Trust governance arrangements.
- Back to the floor session by execs attending different clinical and non-clinical areas
- Nursing professional judgment review process completed was presented to the Quality Committee in January 2025 and to the Trust Board in May 2025
- Nurse vacancies remain at minimal number and are monitored through active workforce planning.

Specialist support, policy and procedure setting, oversight responsibility:

- Integrated Care Board (ICB) have confirmed their contract requirements in relation to Quality reporting. Internal systems have been updated to ensure timely data and exception submission. First submission completed at the end of Q2. The Trust has continued to strengthen reporting against the updated Quality contract requirements and is proposing updates to the Quality metrics contained within the IPR to further strengthen internal assurance and visibility of these metrics
- Review and sign off of QIRA by medical director and chief nurse prior to implementation of any initiative
- ICB Improvement and Assurance meetings (IAG), monthly executive to executive assurance meetings
- ICB has split the assurance and safety functions with new leadership and focus.
- Monthly Quality Review Meetings with ICB Quality Team continue.
- Maternity and Newborn Safety Investigations (MNSI) (formerly Health Safety Incident Board) reports – review deaths and Health and Safety incidents.
- Engagement meetings with Care Quality Commission (CQC) in place monitoring performance against the CQC standards. The Trust is preparing for its next Well-Led review,
- Patient Safety Incident Response Framework (PSIRF) supported through regular contact with NHS England Implementation Team. The Trust is supporting the adoption of PSIRF across the system as an active member of the implementation group.
- Early adoption of Parliamentary and Health Service Ombudsman (PHSO) Complaints Standards supported through regular contact with PHSO Local Safeguarding Children's Board (LSCB)/Safeguarding Adults Board (SAB) reporting on Care Act and Children Act Standards.
- Arctic Willow winter specific EPRR exercise undertaken to ensure the NHS is adequately prepared for the winter period. Next ICB wide EPRR exercise planned for January 2025
- Regular Updates on ICB EPRR.
- Regular meeting with Specialist Commissioner for tertiary services (Vascular, HPB, Neonates)
- CB representatives attend Quality Committee, Mortality steering group, PSIRI

BAF Risk 2 – Quality and Safety

	Independent challenge on levels of assurance, risk and control: • Annual organisational appraisal report. • CQC inspections and preparation/evidence gathering ongoing. Internal assurance processes evidencing performance against CQC Quality Standards have been aligned to the updated regulatory framework. • The Internal Audit Plan for 2024-25 has being developed by the Mersey Internal Audit Agency (MIAA) in conjunction with Trust colleagues and improvement actions plan reporting to Audit Committee. • Regular Engagement meetings with General Medical Council (GMC). Coroner reviews of care provided through Inquest Processes. • Public Participation Panel (PPP) involvement in improvement activities and walk rounds. • Patient Safety Partners now participating in a quality governance meetings such as Venous Thromboembolism (VTE) Committee and Accessible Information Standards Task & Finish group. • Customer Relations Team undertaking recommendations from the Mersey Internal Audit Agency (MIAA) report into complaints management at ELHT. • PHSO complaints monitoring and external reports. Elective Care Recovery Board which includes regional and ICS level representation and scrutiny. • Quarterly Guardian of Safe Working report (GOSW) for junior doctors provided to the People and Culture Committee • JAG accreditation in Endoscopy • Regular GIRFT assessment and bench marking • Participating in GIRFT Further Faster 20 project. • Annual organ transplant report to NHSE • Patient Safety Walkrounds • Board sign-off for SPEC recommendations • Review of MHUAC with Stakeholders • ICB Quality reviews of services
Gaps in controls and assurance: Any issues implementing controls or activities which enforce a control that do not go ahead are known as gaps in controls. Gaps in assurances show us what we need to improve on to ensure we can deliver assurances that the risk is progressing. **Mitigating actions:** Actions, which when taken, will either reduce or eliminate the likelihood of the risk occurring or reduce the organisations exposure to that risk. **Progress update/Impact:** Update by exception and effectiveness of impact on address gap in control/assurance	

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	Fragility and availability of the medical workforce Health and Wellbeing of the Workforce	As part of Waste Reduction Programme (WRP) work has commenced to identify opportunities to reduce agency and bank spend on medics. Focus on completed job plans. Service line reviews underway to identify gaps in demand and capacity To strengthen the Patient Safety Culture in line with the Workforce Plan and a Just Culture Approach.	Executive Medical Director/ Executive Nurse Director /Executive Director of People and Culture	Quarterly reviews with projected completion in March 2026..	Long term this has been partially achieved and the Governance Assurance structure review completed and is being consulted on. Job Planning Scrutiny Committee now embedded and focusing on productivity and VFM, recognising the need to increase effectiveness of Medical workforce in support of individual medics achieving their job plans. PCB and ICB are working closely in addressing the fragile services identified across LSC. Compassionate Conversations approach introduced as part of leadership training module to support psychological safety whilst learning from mistakes has been embedded as part of leadership training. . Strengthening of job planning scrutiny panel with support provided to CDs by medical staffing team in job planning. Trust's Q&S Team are providing support to the Staff Safety Group in relation to violence against staff.	A
2.	Provision of pathology services, with specific issues with histopathology within the Trust (medical and healthcare scientists)	Work is taking place across providers via mutual aid, facilitated via the ICB and external outsourcing and open recruitment. Improvement work within Cell Pathology has initiated to identify internal efficiency opportunities.	Executive Medical Director	Review September 2025	Good progress made in blood sciences to address staffing gaps and to support implementation of improvement work. Ongoing reduction of backlogs in histopathology and clear action plan in place to support ongoing improvement woprk via Trust Improvement Team	A

BAF Risk 2 – Quality and Safety

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
		Continued effort to appoint into Biomedical Scientist (BMS) and Medical Laboratory Assistant (MLA) vacancies in the department.			and external support to review processes and team working to further identify improvement opportunities. Working with the pathology collaborative on benchmarking job plans and reporting activity across L&SC.	
3.	Functionality of ePR causing issues with data quality, performance and affecting users capability to maximise the potential of the electronic system.	There is a need for relevant clinical document formats to be standardised and uploaded to Cerner eLancs team best use of resource needed to manage data cleansing and accuracy issues to enable timely reporting and performance monitoring and acting on change and service requests from staff/departments. Within current contract Upgrade of Cerner required to latest version to allow for access to new features and functionality. Data submission to national teams on activity, mortality, coding, audit to ensure that accurate and validated assumptions on income, HSMR/SHMI and activity. Quality of information added to the system remains an issue. Coding and quality and affect mortality indicators too.	Executive Medical Director	September 2025	Issues with ePR and Data Quality continue to be escalated and are being managed through the Data and Digital Senate/Board. Ongoing training is taking place with clinical/admin colleagues on the ePR. The Cerner upgrade has been approved in May 2025 and will be implemented in September 2025. Ongoing workstreams in place to address coding issues and refreshed mortality data now being received. HSMR data now received and part year data shows mortality score at 100 which is within expected levels. Clinical Lead with responsibility for GIRFT and Model Hospital working with Q and S team. Ongoing work with our East Lancs team, coders and the Mortality Steering Group (with deep dives into outliers).	A
3.	Management of Deprivation of Liberty Safeguards processes.	Continuous programme of audit Trust wide and implementation of action plan including: • Strengthened MCA/DoLS training offer • Development of 'heat map' to identify areas in need of greatest support • Development of 7 minute briefings • Development of a 'myth-busting' animation which will be mandatory for all level 3 staff • Strengthened documentation on Cerner • Working with the NAPF team to ensure a consistent approach	Executive Director of Nursing/ Executive Medical Director/ Executive Director of Integrated Care, Partnerships and Resilience	Complete	The number of DoLs applications has now risen to expected levels and has been sustained after a period of close monitoring. All actions are complete and ongoing monitoring processes in place. This action to be removed in next BAF update and controls/assurances updated. Risk 4932 has been re-reviewed and downgraded from a risk score of 15 to 12 and so removed from the corporate risk register.	B
4.	The Quality Impact and Risk Assessment Process (QIRA) has been strengthened in light of the Trust financial recovery process but now requires independent review.	Constraints in finances will result in lack of investment into workforce, development of service, capital investment and revenue. This has the potential to negatively impact on quality and safety. The QIRA process has been strengthened but work is ongoing to fully align to the new Programme Management Office and will be independently audited via internal audit.	Executive Director of Finance / all Executive Directors	September 2025	Recovery director appointed to work with execs and teams in improving financial deficit. PMO office being established with help from PWC to manage delivery of schemes The Trust has re-reviewed and agreed a standardised QIRA process which is fully aligned to the processes of the PMO and the Waste Reduction Programme. The outputs are reported to Quality Committee to ensure sub-committee oversight. As part of the annual internal audit plan this process will be reviewed.	A
5	Lack of capacity to manage increased activity across the Trust	Bed remodelling for managing increased activity Review of services to assess demand and capacity Work with Place based partners in improving patient pathways Implement GIRFT and Model Hospital best practice approaches to care	Executive Director of Finance / Executive Medical Director / Executive Chief Nurse / Chief Operating Officer	September 2025	Established relationships through interface meetings with Place based leadership. ELHT is participating in the GIRFT faster forward programme Working with divisions on ensuring that that we capture activity levels. Working with national teams. Service line reviews taking place to determine demand & capacity, non commissioned services and productivity UEC improvement plan re-reviewed and updated for 2025/26	G

BAF Risk 2 – Quality and Safety

BAF Risk 3 - Elective Recovery and Emergency Care Pathway

Risk Descriptor: A risk to our ability to deliver the National access standards as set out in the 2025 - 2026 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence.

Executive Director Lead: Chief Operating Officer / Executive Director of Integrated Care, Partnerships and Resilience

Strategy: Clinical Strategy & Operational Strategy

Links to Key Delivery Programmes: Elective and Emergency Pathway Improvement

Date of last review: Deputy Director Review: May2025
Executive Director Review: May2025

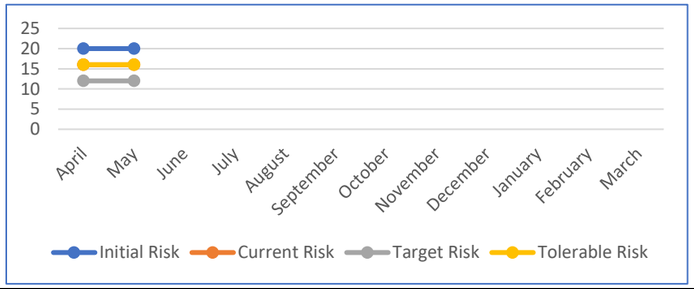
Lead Committee: Finance and Performance Committee

Links to Corporate Risk Register

Risk ID	Risk Descriptor	Risk Rating
9336	Lack of capacity can lead to extreme pressure resulting in a delayed care delivery.	**20**
8126	Poor records management due to sub optimal implementation of new e-PR system	**20**
8941	Increased reporting times in histology due to increased activity outstripping resource	**16**
8061	Management of harm from the holding list	**16**
6190	Insufficient capacity to accommodate patients in clinic within timescales	**16**
9895	Patients not receiving timely emergency procedures in theatre	**15**
9851	Lack of standardisation of clinical documentation processes and recording in Cerner	**15**
9653	Increased demand with a lack of capacity within ELHT can lead to extreme pressures and delays to patient care	**15**

Risk Rating (Consequence (C) x Likelihood (L)

Current Risk Rating: **C4 x L4 = 16**
Initial Risk Rating: C4 x L5 = 20
Tolerable Risk Rating: C4 x L4 = 16
Target Risk Rating: C4 x L3 = 12



Effectiveness of controls and assurances:

X	Effective
	Partially Effective
	Insufficient

Risk Appetite: Open/8-12

Controls: (What mechanisms, systems, rules and procedures do we already have in place that help us to either mitigate the risk from occurring or reduce the potential impact).

Overall planning and delivery processes:

- Trust clinical strategy developed covering a 5-year period to support ongoing delivery and development of elective and emergency care services. Plan on a page agreed for 2025/26 linked to annual planning process.
- Development of systems and processes to support reduction in risk to Health Equity supported by a plan to address health inequalities at place level.
- Development of system and processes to assess and reduce risk of clinical harm potential for patients on both the elective waiting lists and emergency care pathways ensuring safe, personal and effective care.
- Annual business planning and review of progress against delivery in place. This includes performance trajectories for all emergency and elective performance standards.
- A joint place delivery and improvement plan (via the Urgent and Emergency Care Delivery Board (UECDB)) for urgent and emergency care (UEC) in place. Further work around primary care access needs to be confirmed from place leads/ICB, work is being carried out around priority wards and integrated neighbourhood care. Updated the plan on a page for UECDB and this is based on three pillars: a) making it easier to access the right care b) increasing urgent and emergency care capacity c) improving discharge and expanding care outside of hospitals.

Operational Management processes:

- Active implementation and monitoring of elective improvement plans for 2025-26, diagnostic clearance plans and OP booking to ensure effective support for delivering the overall plan.
- Elective Productivity Improvement Group oversees the improvements for Elective Recovery
- Emergency Care Improvement Group (ECIG) oversees UEC improvements in the Trust.
- Robust flow management system and processes in place with flow team and bed meetings for ongoing Situation Reports (SitRep) reporting and agreement of actions over 24/7 period and ongoing plans to strengthen discharge matron and patient flow facilitator role for supporting timely 7-day discharges
- Data collection to identify target themes and services from the high intensity service users' group to inform the system demand management schemes for UEC. Specific focus around Mental Health pathways with Lancashire and South Cumbria Foundation Trust (LSCFT).

Assurances: (This is the confidence we have in the effectiveness of the controls and action plans in place (e.g. regular risk reports, audits, regular monitoring at the Directorate Quality meetings or Risk Meetings etc.)

Service delivery and day to day management of risk and control:

- The Trust achieved agreed trajectories against all performance standard for March 2025s- 2026.
- Clear trajectories for all key targets for Referral to treatment times, 4-hour UEC target, Cancer, Diagnostics and activity levels in place and monitored via reporting to weekly operational team meeting, executive team meeting, senior leadership group.
- Site meetings 7 days a week ensuring timely escalation of delays (potential and actual) with corrective actions.
- Mobilisation of 24/7 IHSS service complementing the 24/7 ICAT service
- Established a Trust Health and Equalities Committee chaired by the Chief Nurse feeding to the Quality Committee and People and Culture Committee
- The Trust has implemented the Elective Improvement Productivity Group (EPIG).
- The Trust has embedded the discharge bundle across all wards with clinical champions who promote best practice. In addition, there had been a release of discharge matron colleagues from community bed management functions to enable a dedicated focus on pathway, discharges and ward support for preparing pathways 1, 2 and 3 patients for the community teams to case manage. An electronic daily discharge dashboard has been developed and embedded across all inpatient areas.
- Capped theatre utilisation has been sustained at a minimum of 85% since September 2024, week ending 20th April ELHT 2024 Capped utilisation was 91.3%% - 3rd highest in the country and has been constantly in the upper decile.

Specialist support, policy and procedure setting, oversight responsibility:

- Executives meet all with all divisions every morning (Monday – Friday) at 8.00am to support delivery manage risks and address any issues for UEC and operational flow.
- Benchmarking data available from Getting It Right First Time (GIRFT), Model Hospital.
- Lancashire and South Cumbria oversight and co-ordination via Elective Activity Co-ordination Team, Elective Care Recovery Group, Lancashire and South Cumbria Chief Operating Officers meetings.
- System level plan monitoring at Pennine Lancashire via UECDB and Integrated Care Board (ICB) level via relevant system forums.

BAF Risk 3 - Elective Recovery and Emergency Care Pathway

• Refreshed support to continue to strengthen internal ED processes to manage maximum time in department to 12-hours from arrival to discharge. This includes activation of enhanced escalation during surge • Improve Multi-disciplinary Team (MDT) compliance against the agreed ward discharge process based on the best practice discharge bundle and board round effectiveness. A clinically led safe discharge MDT steering group in place. • Clinical engagement with the required compliance to agreed standards and change plans ensuring ownership for discharge planning on admission. • Sustaining community response services for both step-up (admission/attendance avoidance) and step down (timely discharge facilitation) care to maximise opportunities for admission avoidance and reduce demand for inpatient beds. • Manage acute beds No Medical Criteria to Reside (NMC2R) to less than 10% of bed base with a stretch target of 5% of bed base in line with national requirements to maximise acute bed capacity for appropriate acute needs. **Oversight arrangements:** • Weekly operational meetings to monitor progress against KPIs, chaired by COO /Deputy COO. • Monthly outpatient improvement group chaired by the Executive Director of Service Development and Improvement plan with Patient and Public Panel representatives. • Theatre Utilisation Improvement Board in place and aligned with GIRFT requirements, targeting over 85% utilisation. • Governance processes have been reviewed around theatre utilisation and introduced support and challenge sessions with the Chief Operating Officer and Deputy Medical Director for Performance for any specialties that do not achieve trajectory as intensive support. • Embedding Elective Productivity and Improvement (EPIG) jointly chaired by Chief Operating Officer/Deputy Chief Executive and Director of Service Development and Improvement to oversee the delivery of all elective care standards. This group monitors productivity plans at specialty level.	• Clear standard operating procedure in place for times when ED is overflowing, and the main hospital corridor needs to be used to accommodate patients. **Independent challenge on levels of assurance, risk and control:** • Delivery of trajectories are monitored at ICB level through • The monthly improvement and assurance meeting with the ICB
Gaps in controls and assurance: Any issues implementing controls or activities which enforce a control that do not go ahead are known as gaps in controls. Gaps in assurances show us what we need to improve on to ensure we can deliver assurances that the risk is progressing. **Mitigating actions:** actions, which when taken, will either reduce or eliminate the likelihood of the risk occurring or reduce the organisations exposure to that risk. **Progress update/Impact:** Update by exception and effectiveness of impact on address gap in control/assurance	

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	Activity levels for 25/26 may not be achieved consistently.	The controls and weekly monitoring taking place to work towards the achievement of the 2025/26 activity plan (112.63% of 19/20 plan levels).	Chief Operating Officer	March 2026	A clear activity plan is in place for 2025-26 with productivity assumptions in place to support increased activity at reduced cost whilst maintaining income levels. This will be monitored through usual performance mechanisms but with an enhanced level of monitoring of associated income to ensure all activity is coded appropriately.	A
2	The national ambition for NHS diagnostics in 2025/26, centres on improving patient access to diagnostic tests, reducing waiting times, and ensuring timely reporting of results. Delays in diagnostic performance could impact on the delivery of RTT and Cancer standards	Implementation of Modality level delivery plans. Monitor performance through weekly operational meetings Monitoring of performance and waiting lists through divisional performance meetings	Chief Operating Officer	March 2026	ICS wide modelling completed, and discussions are ongoing around mutual aid to across the Lancashire and South Cumbria area ensuring patients have equity of access. The Trust continues to perform better than the national average and a trajectory is in place to meet 2025/26 planning guidance requirements. Endoscopy remains the biggest pressure area, but recovery plans are in place and monitored by the Chief Operating Officer.	G

BAF Risk 3 - Elective Recovery and Emergency Care Pathway

<table>
<tr><th>No.</th><th>Gap in controls and/or assurance</th><th>Action Required</th><th>Exec Lead</th><th>Due Date</th><th>Progress Update</th><th>BRAG</th></tr>
<tr><td>3</td><td>Meeting Cancer Standards
National Ambition for the standards
62 day – 75% by March 2026
28 day – 80% by March 2026</td><td>Joint work with the Cancer Alliance on improvement
Continued Tumour site level detail to prevent backlog
Continued transparency of backlog delays at tumour site level for targeted preventative interventions
Weekly patient tracking with divisions for all tumour sites.
Agree trajectories to achieve new targets.</td><td>Chief Operating Officer</td><td>March 2026</td><td>Cancer action plan refreshed for 25/26 and will be monitored through the Cancer Steering Board Current submitted performance, against the National Ambition
<table><tr><td>March 25 Performance (Trust)</td><td>National Ambition by March 2025</td></tr><tr><td>62-day standard 72.2%</td><td>70%</td></tr><tr><td>31-day standard 96.3 %</td><td>96%</td></tr><tr><td>FDS standard 80.6%</td><td>77%</td></tr></table></td><td>A</td></tr>
<tr><td>4</td><td>Continued risk of >65 week RTT breaches and risk of not delivering a maximum of 1% < 52 week maximum wait by March 2026.</td><td>Demand and capacity at specialty review completed with improvement actions
With daily micromanagement.
Each directorate is setting an improvement trajectory which will be monitored through weekly operational meetings.</td><td>Chief Operating Officer</td><td>March 2026</td><td>There are daily meetings with divisional reps on managing all patients at risk of breaching 78 and 65 weeks.
Daily monitoring continues to maintain this position for 65 weeks performance
The Trust achieved the 65-week RTT target for all patients by March 2025 with the exception of patient awaiting specialist surgery. The reason for this is due to a nationally recognised supply issue.
There is now focus on achieving a maximum of 1% of total patients on an RTT pathway waiting no more than 52 weeks.</td><td>A</td></tr>
<tr><td>5</td><td>UEC
Reducing the number of patients waiting over 12 hours time in the ED Department</td><td>Improvement plan in place to support reducing the amount of time patients spend in the ED corridor this includes:
Streaming to alternative pathways
Admission avoidance via SDEC and IHSS
Use of escalation SOP when required in extreme pressures
Monitor the impact of any reduction in bed capacity</td><td>Executive Director of Integrated Care Partnerships and Resilience/ Chief Nurse</td><td>March 2026</td><td>As part of the 2025 – 2026 planning, the Trust is committed to reducing the percentage of patients waiting over 12 in the ED depart from 17.8% to 15.2%
March performance was at 15.95% and April 14.55%
The UEC improvement plan has been reviewed and updated for 2025/26 and work is ongoing with place partners.</td><td>G</td></tr>
<tr><td>6</td><td>Ambulance handover times</td><td>As part of an LSC collaboration the Trust is working with NWAS colleagues to improve ambulance handover times, to an average of 24 mins and to be better than the NWAS average handover time</td><td>Executive Director of Integrated Care Partnerships and Resilience /Chief Operating Officer</td><td>March 2026</td><td>As part of the 2025 – 2026 planning, the Trust is committed to improving average ambulance handover time to 24 mins
Working collaboratively with NWAS colleagues on handover times. There are dedicated meetings with NWAS & ELHT staff on a collaborative approach to improvement.
March 2025 – 26 mins - Percentage of patients with a handover of <30 mins 68.7%
April average handover time was 23.57mins Percentage of patients with a handover of < 30 mins 79.74%</td><td>A</td></tr>
</table>

BAF Risk 3 - Elective Recovery and Emergency Care Pathway

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
7	Discharge 2% more patients on discharge ready date (84% > 86%) Improve average delay in discharge to 4.5 days from 5 days	Embedding of the discharge dashboard to support reduction in longer length of stay and not meeting criteria to reside	Executive Director of Integrated Care Partnerships and Resilience /Chief Nurse	March 2026	Discharge optimisation group established March 2025 under the leadership of the Divisional Medical Director for CIC and Divisional Director of Nursing for MEC	A

BAF Risk 4 – Culture Workforce Planning & Redesign

Risk Description: The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of its inability to successfully transform the workforce to support recovery underpinned by our compassionate wellbeing, equality, diversity and inclusion and improvement focused culture.		**Executive Director Lead:** Interim Executive Director of People and Culture	
Strategy: People Plan	**Links to Key Delivery Programmes:** People Plan Priorities, Financial Recovery Priorities, Improvement Priorities.	**Date of last review:** May 2025	**Lead Committee:** People and Culture Committee

Links to Corporate Risk Register:

Risk Number	Risk Descriptor	Risk Rating
9746	Inadequate funding model for research, development and innovation	**16**

Risk Rating (Consequence (C) x Likelihood (L)):

Current Risk Rating: **C4 x L3 = 12**
Initial Risk Rating: C4 x L4 = 16
Tolerated Risk Rating: C4 x L3 = 12
Target Risk Rating: C3 x L3 = 9

Effectiveness of controls and assurances:

X	Effective
	Partially Effective
	Insufficient

Risk Appetite: Pursue/High

Controls: (What mechanisms, systems, rules, and procedures do we already have in place that help us to either mitigate the risk from occurring or reduce the potential impact)

- Freedom to Speak Up (FTSU) Guardian and Ambassadors – in line with the national FTSU agenda. They report to the Staff Safety Group, People & Culture Committee and Trust Board.
- ICB People Committee has re-established and has developed a revised workforce strategy. PCG has established a number of Professional Working Groups (PWG) that will report through PCB Exec Co. Operational issues from these forums are picked up through the Executive team and reporting on progress is provided through the quarterly workforce report to the People and Culture Committee.
- The Trust People plan is operationally delivered through the Senior Leadership Group (SLG) and Divisional Management Boards (DMBs) and delivery is accountable through People and Culture Committee (PCC) as part of the Trust workforce report. This also forms part of the well led section of the Integrated Performance Report (IPR).
- Grip and Control analysis undertaken by PWC, with a clear action plan developed. Actions put in place across all recommendations and presented to Execs, Trust Board and Improvement and Assurance Group (IAG). Actions being reviewed through relevant Committees – PCC for all workforce metrics.
- Waste Reduction Programme meetings are held with each clinical division each week and each corporate team every fortnight to review the development and delivery of waste reduction plans, progress against workforce plans, agreeing improvement trajectories where required.
- Vacancy control processes reviewed and strengthened. The panel meets twice per month with final sign off of any vacancies to be advertised being completed via the Executive Team
- HR framework has been developed for use to support workforce transformation across the LSC system and has been in place from 1 March 2025.

Assurances: (This is the confidence we have in the effectiveness of the controls and action plans in place (e.g. regular risk reports, audits, regular monitoring at the Directorate Quality meetings or Risk Meetings etc.)

<u>Service delivery and day to day management of risk and control:</u>

- Trust's Staff Safety Group oversees the day-to-day operational risks and interventions to ensure staff safety matters are addressed.
- Workforce Assurance meeting with divisions twice per month and corporate once a month, with robust control measures implemented around variable pay, vacancy control, grip and control, job planning, annual leave, overpayments, managing attendance and wellbeing.
- Eight Staff Networks, each are supported by an Executive Lead and Non-Executive Champion and reporting through the Inclusion Group covering protected characteristic (including BAME, Women's, Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+), Disability and Wellness, Mental Health, Neurodiversity, Muslim, Christian, Overseas and International Staff Support and Armed Forces Veterans & Families. Reports to inclusion group.
- Freedom to Speak-Up (FTSU) – the Trust has FTSU Ambassadors embedded across the organisation to support the FTSU Guardian in enabling staff to raise concerns. The Trust continues to recruit new Ambassadors to increase access and fill gaps caused by turnover, including discussions with our local BMA representative about increasing the number of FTSU Ambassadors within the medical workforce. Freedom to Speak up month – October 2025. FTSU included within the Trust's mandatory training programme.
- Workforce dashboards enable divisions to utilise daily to manage workforce availability, sickness, variable pay and headcount and targets for reduction will be set.
- Reviewing Divisional workforce metrics and support through Divisional Performance Meetings and PCC. Annual reporting to Board on full EDI metrics with tracking in the quarterly workforce report to People and Culture Committee. Divisional EDI data packs shared with divisions with understand data session option with EDI lead.
- Continued expansion of the Team Engagement and Development (TED) Tool across the organisation enabling teams to manage team culture. MDT support for teams and divisions using data such as sickness absence, staff survey, culture data to identify areas for targeted support.

BAF Risk 4 – Culture Workforce Planning & Redesign

- The service review process which is underway across all services includes a workforce redesign support offer to enable teams to identify productivity and transformation opportunities. The Trust is adopting a best practice guide to reducing variable pay, implementing a series of rapid improvement weeks and developing a toolkit for managers to reduce variable pay.
- Partnership working with Unions has been strengthened, with key representation from staff side at People and Culture Delivery and Governance Group, Senior Leadership Group and PCC. JNCC and JLNC mechanisms in place to oversee organisational and workforce transformation and policy ratification.
- Health and Wellbeing – a comprehensive health and wellbeing strategy and offering in place and leading the ICS Enhanced Health and Wellbeing and occupational health workstream. This is monitored through the One LSC governance structures. Regular updates are provided to the Board on wellbeing and a NED wellbeing guardian is in post.
- Directorate of Education, Research, and Innovation (DERI) Strategy clearly articulates the ambition of the Trust to support workforce, research and innovation to make the Trust a more attractive place to work. DERI reporting to the PCC.
- Staff Sponsor Group in place chaired by the Chief Executive supported by the people experience MDT working with divisions to address improvements to culture and staff experience as measured by staff survey. Quarterly meetings with additional input from MDT for divisions and teams. MDT approach taken through the People and Culture Committee for approval. Staff stories come to the Committee to enable triangulation of data with staff experience.
- Inclusion Group which is chaired by the Chair and has membership from Staff Networks, Divisions, professional leads and People and Culture leads oversees inclusion and belonging priorities and progress reporting into the People and Culture Committee.
- Improvement priorities - Anti-Racism project established with support from the improvement team. Reasonable adjustment improvement project – key metrics agreed and are tracked and reported to People and Culture Committee.
- Leadership strategy – SPE+ leadership strategy, leadership framework, core leadership pathway, managers induction in place. This is monitored through the P&CD and the People and Culture Committee.
- Exec led performance meetings oversees delivery of objectives and strategies including workforce metrics at divisional level.

- The Trust's Behaviour Framework continues to be embedded across the organisation and is now integrated into the recruitment and appraisal processes.
- Appraisal and core skills training compliance reporting is tracked and reported on monthly basis and monitored through performance meetings and NAPF assessments. Wellbeing conversations as part of annual appraisal. Managers encouraged to have regular check ins and 121s with staff members to dynamically assess wellbeing and morale.
- Project M is a programme of support for the wellbeing of managers and continues to be delivered virtually for people with line management responsibility. Attendance is monitored. Facilitators provide advice and guidance and pick up themes for ongoing focused intervention.
- Further alignment of leadership and Organisational Development (OD) activities to the Safe, Personal, Effective Plus (SPE+) Improvement Practice as part of Trust Improvement Continuum has been scoped and built into Improvement Practice Development Plan.
- Recruitment, retention, and staff in post data is monitored through IPR and Workforce Report to People and Culture Committee.
- Job planning continues, linked to improved use of eRostering for medical staff to improve transparency. Updates reviewed weekly through Divisional Waste Reduction Programme meetings.
- Variable pay spend reviewed via the Waste Reduction Programme meetings with Divisions each week, with robust control measures now in place for booking bank/agency shifts.
- Exit interviews – system recording exit interviews is established and reports can be generated by the HR Team.

<u>Specialist support, policy and procedure setting, responsibility:</u>

- Human Resources (HR) Directors Group across the ICS inform and monitor delivery of the system level workforce agenda but also direct Trust activity where collaboration has been agreed or where opportunities have been identified.
- Integrated Care System (ICS) Equality, Diversity, and Inclusion (EDI) collaborative is in place to support the development and sharing of best practice.
- Trust Wellbeing Lead chairs system group to establish standardisation.
- ICS Culture and Belonging Strategic Group established.
- Trust Chair and NED EDI lead are members of the regional BAME Assembly.
- Trust was part of People Promise Cohort 2 and attended the regional SRO and national meetings.
- PMO support for Trust wide workforce schemes to support cost reduction and avoidance.

<u>Independent challenge on levels of assurance, risk, and control:</u>

- Workforce Race Equality Standard (WRES) and Workforce Diversity Equality Standard (WDES) results are nationally benchmarked and action plans with timelines in place. Regular reporting to the People and Culture Committee and the Trust Board on progress. Ongoing monitoring of workforce diversity through the re-establishment of the Diversity and Inclusion Steering Group and Trust staff networks.
- EDS 2022 – system level assessment with ICB, patient and community groups, staff side and voluntary sector.
- National Staff Survey reports and benchmarks the Trust's performance against other organisations at a national and regional level.
- The Trust works within the national FTSU framework and is accountable to the National Guardian for delivery.
- Reporting to the People and Culture Committee, Trust Board and the ICB People Board on a regular basis to provide assurance and address areas of challenge.
- Workforce Plan submission – there is an annual workforce plan submission to the national regulator which is triangulated internally with finance and activity data and aligned to our clinical strategy. This is monitored through the Integrated Care Board (ICB). The 2025-26 plan will be submitted on or before 19 March 2025.
- Monitored by NHS England and the ICB on our bank and agency spend, with a requirement to report any breaches of NHSE cap – ELHT has remained within the NHSE cap since October 2023 and zero off-framework since August 2023. The variable pay improvement work is starting to have a positive impact on bank usage.
- Workforce elements of Annual Internal Audit Plan agreed for 2025-26. Action plans in place for audits carried out that are tracked though Audit Committee.
- Bank and Agency Oversight in place across the system via a workstream of the CPO Professional Working Group.
- Internal and ICB vacancy control panels provide oversight on recruitment.
- Monthly IAG meetings with the ICB which scrutinise the workforce KLOE.

Gaps in controls and assurance: Any issues implementing controls or activities which enforce a control that do not go ahead are known as gaps in controls. Gaps in assurances show us what we need to improve on to ensure we can deliver assurances that the risk is progressing.

Mitigating actions: actions, which when taken, will either reduce or eliminate the likelihood of the risk occurring or reduce the organisations exposure to that risk.

Progress update/Impact: Update by exception and effectiveness of impact on address gap in control/assurance

BAF Risk 4 – Culture Workforce Planning & Redesign

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	Financial recovery – development and full delivery of workforce schemes needed to close the gap given NOF 4 status.	Ensure timely development and delivery of workforce schemes to close the gap in meeting financial recovery targets recurrently. Support for those impacted by change and change readiness programme. Review of organisational change policy and support.	Executive Director of People and Culture	May 2025 and monthly review.	• Weekly Waste Reduction Programme (WRP) meetings established. Daily management dashboards produced. • Variable pay – rapid improvement weeks held, weekly initially, now fortnightly – targeting highest users of temp staffing. • HR Framework team stood up - MARS scheme implemented. • Review of organisational change policy in partnership with staff side to tighten up controls around redeployment. • Service reviews continuing with selected areas of Trust.	
2	Risk of staff leaving the NHS due to burnout.	On-going delivery of the ELHT People Plan underpinned by a compassionate and inclusive culture. Continued roll out of Health and Wellbeing Strategy with focus on women's health, developing the mental pathway and on reasonable adjustments. Targeted work through Staff Sponsor Group and People Experience MDT to work with teams and divisions. Attendance Management and Wellbeing Management Scheme. Continue to roll out restorative clinical supervision and train up more professional nurse advocates to meet the target ratio of PNAs to staff members.	Executive Director of People and Culture	A milestone report will be provided to the People and Culture Committee in July 2025	• PID and QIRA produced for management of sickness absence scheme. • Continued development of mental health pathways and interventions as recommended by the external review. • PCB OH and Wellbeing services have carried out a procurement exercise for a common IT platform in readiness for the future model, contract to be signed and plans need to be developed to migrate all Trusts on to the new system. • Project M – a peer support group for line manager wellbeing was launched in January 2024 by the CEO and now well embedded. • Recruitment to central resource to support reasonable adjustments. • Training for managers in attendance management and reasonable adjustments. • MDT on track with divisional feedback of staff survey results and to identify the 3 cultural themes and teams for in-reach support. • Recruiting to further cohorts of PNA training.	A
3	Risk of loss of service due to national industrial action.	Ongoing management of action through Industrial Action Cell as required.	Executive Director of Integrated Care, Partnerships and Resilience	N/A	• There are currently no live mandates for industrial action. • This may change with the pending announcements on recommended pay awards. .	n/a
4	Risk of impact of colleagues experiencing discrimination, abuse and harassment from colleagues, managers and patients	Development of compassionate and inclusive culture. Trust becoming anti-racist. Greater cultural competence of line managers who line manage internationally educated colleagues. Sexual safety project to be fully implemented. Closing the gap of experiences between colleagues who have a protected characteristic and those without. Process for reasonable adjustments to be centralised, greater visibility of those requesting reasonable adjustments and outcomes. Implementation of EDI Improvement Plan.	Executive Director of People and Culture	End of March 2026	• Inclusion Group stepped back up – oversight of network actions however greater divisional representation is needed to broaden out ownership of agenda. • Achievement of Bronze Award. Silver action plan developed for anti-racism. • Training brochure for EDI being finalised with prioritised training offer linked to aspects of improvement. • Allyship and Anti racism training was paused due to the financial challenge to release time and capacity. Capacity for delivery has reduced now and still needs to be stepped back up. • Inclusive recruitment toolkit and training implemented. • TAFG set up for sexual safety, eLearning is available. Policy is still outstanding at this time. • EDS 2022 done, need to write report and finalise the plans and bring through committees. • Financial challenge is creating some barriers to reasonable adjustments and flexible working being agreed. Raised at JNCC, Execs and Inclusion Group. • Staff experience MDT – linking with divisions to identify the cultural themes for improvement.	A

BAF Risk 5 – Financial Sustainability

✓**Risk Descriptor**: The Trust is unable to meet its agreed financial targets for 2025/26 as part of a multi-year financial recovery plan for both the Trust and wider Lancashire and South Cumbria (LSC) system.

Executive Director Lead: Executive Director of Finance

Strategy: Finance Strategy

Links to Key Delivery Programmes: Waste Reduction Programme

Date of last review:

Deputy Director of Finance,

Executive Director of Finance, May 2025

Lead Committee: Finance and Performance Committee

Links to Corporate Risk Register (CRR):

Risk ID	Risk Descriptor	Risk Score
10082	Failure to meet internal and external financial targets	25

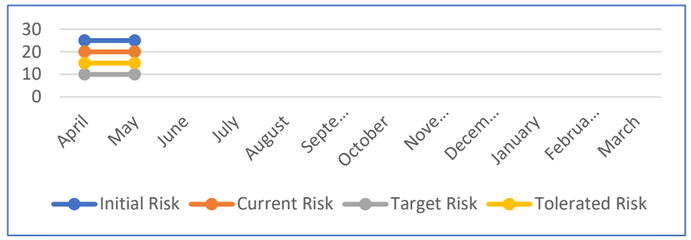
Risk Rating (Consequence (C) x Likelihood (L)):

Current Risk Rating: **C5 x L4 = 20**

Initial Risk Rating: C5 x L5 = 25

Tolerated Risk Rating: C5 x L3 = 15

Target Risk Rating: C5 x L2 = 10



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite: Cautious/4-6

Controls: (What mechanisms, systems, rules and procedures do we already have in place that help us to either mitigate the risk from occurring or reduce the potential impact)

Organisation

- A full review of the financial accountability meeting structure has taken place to make the best of use of time
- A Programme Management Office is being established and each Division and One LSC has a weekly 1 hour meeting to monitor progress of plans and implementation to support financial recovery including grip and control, workforce plan and waste reduction programme.
- A weekly Vacancy Control Panel is in place at divisional and Trust level with Chief Executive sign off for all posts,
- A weekly Non-Pay Control Group is in place reviewing all discretionary spend with an Executive SRO
- A weekly Pay Control Group, chaired by the Deputy DoF, is in place that reviews the oversight and process behind all payments to staff and contractors.
- The Financial plan for 2025/26 has been developed via the annual planning process, and was approved by Trust Board prior to National Submission. This takes account of the Trust's required Control Total and financial improvement.
- The Trust Standing Financial Instructions (SFI's) are reviewed annually and updated for any national guidance and regulations. The last review was completed in April 2025.
- The financial position, forecasting for the year, capital spend against programme and progress towards achievement of the Cost Improvement Programme (CIP) are reported and scrutinised through the monthly Finance Assurance Board with Executive, Capital Planning Board chaired by the Deputy Director of Finance, and the Finance and Performance Committee.
- Service Reviews and rapid improvement weeks for Variable Pay are taking place with the longer-term aim to roll out across the Trust
- A PMO has been established and a Recovery Director appointed to support delivery of the financial recovery.

- Communication about the financial challenge and action to be taken is being led from the Executives, including the regular Team Brief, and through the senior leadership of the Trust.

Assurances: (This is the confidence we have in the effectiveness of the controls and action plans in place (e.g. regular risk reports, audits, regular monitoring at the Directorate Quality meetings or Risk Meetings etc.)

Service delivery and day to day management of risk and control:

- Financial plan and delivery of ongoing performance scrutinised via Finance and Performance Committee with key risks identified.
- Corporate Risk Register updated for latest financial risks facing the organisation with action plans in place to mitigate risks which are regularly reviewed and updated
- Divisional, Trust wide and system Waste Reduction Programmes continue to be developed, savings not fully identified, Quality Impact Risk Assessments (QIRAs) are completed for all schemes and signed off by the Chief Nurse and Medical Director and PMO is strengthening assurance on delivery through robust processes via completion and assessment of Project Initiation Documents
- A Grip and Control Assessment was undertaken by PWC, and the Trust has developed a Grip and Control plan to reduce spend which has been signed off by Audit Committee, Finance and Performance Committee and Trust Board.
- In-depth review of the additional financial pressures identified in year have been determined. Mitigations etc will be reported through Finance and Performance Committee.

Specialist support, policy and procedure setting, oversight responsibility:

- A Recovery Director has been employed to support the Trust in the development and implementation of its Financial Recovery Plan
- Programme Management Office in development which will provide full oversight of and support delivery of the Waste Reduction programme
- Corporate collaboration – full participation in all areas and opportunities identified.
- The Trust and LSC system has a NHSE nominated lead who is working with the LSC System up to summer 2025.
- PwC is working with the Trust and the LSC System as the system entered formal regulatory intervention.

BAF Risk 5 – Financial Sustainability

<u>System</u> • System finances monitored through System Finance Group (includes representation of all providers and Integrated Care Board (ICB)) to facilitate understanding and actions associated with the overall system financial position. • One LSC Central services collaborative programme underway with ELHT as the host. • System financial controls implemented from August 2023 and remain in place. • Assurance and oversight in place with the System Turnaround Director and the supporting team and NHSE.	• A financial governance review took place in January 2025 with an action plan agreed, which is monitored via Audit Committee. <u>Independent challenge on levels of assurance, risk and control:</u> • The Trust is part of the NHS Oversight Framework Segment 4 Recovery Support Programme • Internal and external audit – plan to be agreed at Audit Committee May 2025. Audit of accounts to be presented to Audit Committee in June 2025. • Counter fraud workplan for 2025/26 agreed at Audit Committee April 2025. • One NHS Finance Towards Excellence Accreditation 3-year reaccreditation was awarded in October 2024

Gaps in controls and assurance: Any issues implementing controls or activities which enforce a control that do not go ahead are known as gaps in controls. Gaps in assurances show us what we need to improve on to ensure we can deliver assurances that the risk is progressing.

Mitigating actions: actions, which when taken, will either reduce or eliminate the likelihood of the risk occurring or reduce the organisations exposure to that risk.

Progress update/Impact: Update by exception and effectiveness of impact on address gap in control/assurance.

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	Inadequate funding for the services commissioned	Work with the ICB on the funding for the services commissioned, in line with the NHS Payment Services guidance.	Executive Director of Finance	Q1 2025/26 Monthly updates to be provided	Commissioning workshop 10/4/25 to resolve outstanding issues, as agreed in the IAG meeting with the System Turnaround Director and the ICB. Work still ongoing to review and resolve all outstanding issues. Along with all Trusts in the LSC system, the Trust is modelling the 2025/26 tariff on planned activity levels to inform discussions with the commissioner.	R
2	The LSC system requires all parties to agree to the control totals, to deliver a balanced plan after the £164m Deficit Support Funding for 2025/26.	Continue to develop plans for system, region and national sign off, and documenting all risks of reducing expenditure in line with expectations.	Executive Director of Finance	Monthly updates to be provided	The Board has reviewed and signed off its control total for 2025/26 resulting in agreement of a £60.8m Waste Reduction Programme for 2025/26. Work now underway to implement and monitor delivery of the plan (refer to action 4).	A
3	No signed Contract for 2025/26	To work with the ICB to agree the contract disputes	Executive Director of Finance	End May 2025	The issues in the side letters to the 2024/25 have not been resolved. The Trust will not be in a position to sign the contract until the issues have been resolved or there is a clear action plan and timeline for doing so that will provide assurance to the Board. (Refer to action 1)	R
4	The financial plan will not be met in 2025/26	To work collectively across with the Trust and with external support to help to turnaround the financial position and financial recovery.	Executive Director of Finance	Monthly updates. End March 2026	Additional measures are in place with additional control groups in place. A PMO has been established to support financial recovery. A Recovery Director has been appointed.	A

BAF Risk 6 - One LSC Partner and Host

Risk Descriptor

As Host: The Trust is unable to meet its hosting obligations, leading to reputational damage and potential financial implications to the Trust and other partners.

As Partner: One LSC does not deliver the anticipated benefits of high-quality corporate services across partner organisations

Executive Leads: Executive Director of Finance
Executive Director of Service Development and Improvement
Executive Director of People and Culture

Strategy: Indirectly links to all and overall Trust strategy.

Links to Key Delivery Programmes: Provider Collaborative

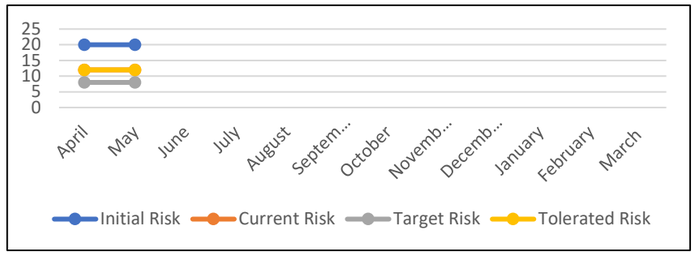
Date of last review: May 2025
Executive Director of Finance,
Director of Service Development and Improvement,
Interim Director of Corporate Governance

Lead Committee:
Finance and Performance Committee
People and Culture Committee

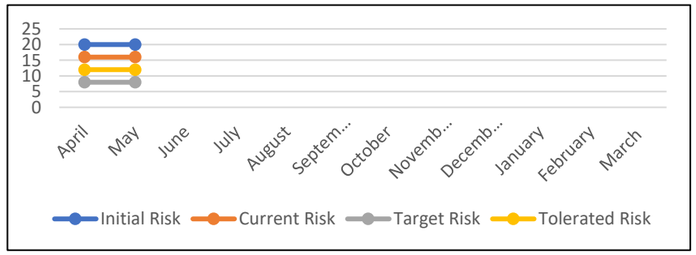
Links to Corporate Risk Register (CRR):

Risk Rating (Consequence (C) x Likelihood (L)):

<u>As Host</u>
Current Risk Rating: C3 x L4 = 12
Initial Risk Rating: C4 x L5 = 20
Tolerated Risk C4 x L4 = 12
Target Risk Rating: C4 x L2 = 8



<u>As Partner</u>
Current Risk Rating: C4 x L4 = 16
Initial Risk Rating: C4 x L5 = 20
Tolerated Risk C4 x L3 = 12
Target Risk Rating: C4 x L2 = 8



Effectiveness of controls and assurances:

As Host

	Effective
x	Partially Effective
	Insufficient

As Partner

	Effective
x	Partially Effective
	Insufficient

Risk Appetite: Pursue/15-20

Controls: (What mechanisms, systems, rules and procedures do we already have in place that help us to either mitigate the risk from occurring or reduce the potential impact)

- The LSC Provider partners and ICB have been working together to identify ways of collaborating (refer to BAF risk 1 for details of collaborative working) on the delivery of central services across the area. This had resulted in delegated powers bestowed by the individual Trust Boards to the PCBJC to deliver on the agreed objectives.
- The process included identifying a host Trust (ELHT) with a comprehensive programme for the planned transfer in November2024. Services successfully transferred on 1 November 2024.
- One LSC Managing Director and senior leadership team in place.

<u>Provider Collaborative Board (PCB):</u>

- Provider Collaborative Board Joint Committee (PCBJC) meeting monthly and regular reporting on progress and decisions sought on delegated items as required.
- Central Services Executive Sub-Committee (CSEC) as a sub-committee of the PCBJC with a remit for the delivery of the collaborative element for central services under the delegated authority for operational matters. Membership made up of 5 provider CEOs or their deputies who are voting Executive Board members of the provider Trusts. CSEC chaired by the Host Trust, ELHT, Chief Executive, as SRO for Corporate Services and from January 2025.
- Strategic Collaborative Agreement sets out the high level legal, commercial and governance principles of collaboration amongst the partners. Trust Boards signed off the Business Transfer Agreements and Supply Agreements prior to

Assurances: (This is the confidence we have in the effectiveness of the controls and action plans in place (e.g. regular risk reports, audits, regular monitoring at the Directorate Quality meetings or Risk Meetings etc.)

<u>Service delivery and day to day management of risk and control:</u>

- ELHT Hosted Services Committee will add an additional layer of governance to ensure seamless service delivery and management and mitigation of risks at host and partnership level
- ELHT Hosted Services Committee is in place and held its first meeting on 8 October 2024
- Formal governance structures are now in place for One LSC via the Central Services Executive Sub-Committee and Professional Working Groups.
- Assurance around the people element of One LSC will be provided through ELHT People and Culture Committee
- ELHT Executives and the Trust Programme Management Office meet weekly with One LSC leadership team to oversee and receive assurance on the One LSC Waste Reduction Programme which is also reported to CSEC.

<u>Specialist support, policy and procedure setting, oversight responsibility:</u>

- Existing PCBJC and CSEC terms of reference form the foundation of policy and procedure for central services collaboration including system oversight

<u>Independent challenge on levels of assurance, risk, and control:</u>

- MIAA as internal auditors for the host and all the partners will agree the appropriate audit arrangements for the governance and management processes of One LSC
- NHSE as the regulatory body will also provide a scrutiny of the collaborative arrangements for central services.
- Legal Due Diligence completed as part of the transfer process, risks identified, and mitigation plans agreed.

transfer on 1st November 2024. The Supply Agreement set out the services to be provided as transferred during the baselining period. • Professional Working Groups in place and continue to develop to oversee performance and planning of all portfolios of One LSC. <u>ELHT</u> • ELHT (as partner and host) has put in place and continues to develop the governance infrastructure to ensure that it delivers on its partner and host obligations. The monitoring of the One LSC and other services hosted by ELHT is through the Hosted Services Committee, which reports to Finance and Performance Committee. Regular monitoring of host and partnership activities and assurance about governance and risk management is through established One LSC governance structures and through to Trust processes as appropriate. • The SCA sets out key hosting obligations and risk share through the partnership arrangements. The due diligence process associated with the completion of key schedules of the SCA (e.g. Business Transfer Agreement) ensured that the Trust as host can fully risk assess its ability to meet Host obligations and standards and work with partners to mitigate these risks accordingly.	• NHSE fully signed off the creation of One LSC in advance of the transfer date and will monitor progress.

Gaps in controls and assurance: Any issues implementing controls or activities which enforce a control that do not go ahead are known as Gaps in Controls. Gaps in assurances show us what we need to improve on to ensure we can deliver assurances that the risk is progressing.
Mitigating actions: actions, which when taken, will either reduce or eliminate the likelihood of the risk occurring or reduce the organisations exposure to that risk.
Progress update/Impact: Update by exception and effectiveness of impact on address gap in control/assurance

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1.	CSEC and Professional Working Groups continue to mature and develop in order to ensure effective oversight and monitoring of performance and development of One LSC.	Ongoing development of oversight and governance arrangements.	Managing Director One LSC CSEC Executive Leads	June 2025	ELHT Chief Executive has taken over chair of One LSC as Host Chief Executive. CSEC has full oversight of One LSC plans including transformation plans. Work ongoing with PwC to review and optimise the operating model for One LSC.	A
2.	Host governance and oversight arrangements in place but will continue to mature.	Ongoing development of oversight and governance arrangements as host.	Director of Finance Director of People and Culture Interim Company Secretary	June 2025	Hosted Service Committee in place. Terms of reference due to be reviewed with clarity of reporting lines to F&P and P&C Committees. Quality governance arrangements agreed with ELHT and partners and undergoing monthly review. Clarity needed with regards to arrangements for internal auditing of OneLSC.	A
3.	ELHT Corporate capacity to support One LSC is still in development and being monitored to determine capacity requirements	Close liaison with Managing Director for One LSC and Directors for confirmation of requirements and agreement with partners for appropriate transfer of resources in line with SCA.	Executive Directors of all corporate functions	June 2025	Initial agreements sought on resource requirements and provision of support through transfer from partners or mutual aid. Ongoing monitoring now underway in order to determine resource requirements for discussion and agreement via CSEC.	A
4.	The benefits of One LSC will be through the transformation of services and these work programmes are in the early stages of development.	Agreement of transformation programmes across all service areas.	Managing Director One LSC Professional Working Groups	June 2025	Work commenced via CSEC and Professional Working Groups to agree priorities and approaches to transformation of services. Opportunities through planning processes to agree immediate priorities and assessment of benefits.	A
5.	Ongoing engagement of staff side and partnership working continues to mature.	Further development of staff side relationships to support transformation of services. Continued development of communications plans	Managing Director One LSC Professional Working Groups	June 2025	The One LSC Engagement and Communications Partnership Group commenced its bi-monthly meeting schedule on 25 November 2024. This group is a partnership with Staff Side colleagues from across the system. It has been established to ensure Staff Side colleagues are engaged with and included in the development of One LSC. Implementation of One LSC communications plan.	A

TRUST BOARD REPORT

Meeting Date:	14 May 2025	**Agenda Item:**	TB/2025/064
Report Title:	Corporate Risk Register		
Author:	Mr J Houlihan, Assistant Director of Health, Safety and Risk		
Lead Director:	Mr S Islam, Interim Executive Medical Director Mrs A Brown, Associate Director of Quality and Safety		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓	✓	✓	✓
Executive Summary:	The corporate risk register lists 23 risks, an increase from the previous report. Five risks have higher scores, one reduced to 16, and another decreased to 12 pending approval for removal. Key risks include financial sustainability, data storage, medical devices management, capacity issues and electronic patient record optimisation. A new risk management strategy and framework are under governance review, with a training package prepared for implementation upon ratification			
Key Issues/Areas of Concern:	There has been a 70% rise in high-risk scores (15 or above) not included in the corporate risk register. Data and digital risks increased by 15%, primarily concerning systems and records management, while human resources risks rose by 8%, with key concerns being safe staffing levels and recruitment challenges. Except for MEC and CIC, all other divisions experienced a notable growth in overdue risks			
Action Required by the Board:	Members are tasked with noting and approving the report contents and of supporting the new risk management strategy and framework by reviewing and agreeing on key risk elements referred to within the appendices that relate to risk sub type categories and risk descriptors, risk governance			

Previously Considered by:	
Date:	02 May 2025
Outcome:	Embedding risk ownership, strengthening governance and performance monitoring, enhancing education and training and addressing historical cultural norms in relation to the use of the risk register will help achieve risk management goals and further solidify the benefits outlined within the report, ensuring a more robust and mature risk management framework and enterprise model

Risk management and the impact of taking / not taking action

1. Risk management is a systematic process to identify, assess, and mitigate risks to minimise harm, enhance safety and improve performance. It is a statutory health and safety requirement and a core principle of an effective organisational safety management system. Regulatory bodies like the Health and Safety Executive and Care Quality Commission prioritise risk management as a key factor during inspections to assess quality, safety and service standards.
2. Effective risk management safeguards patients, staff and the Trust from harm, ensures compliance with legal and regulatory standards and minimises loss. It aids strategic planning, decision making and maintaining operational licenses while enhancing resilience, optimising resources, fostering innovation and improving efficiency. Additionally, good risk management reduces financial, legal and insurance costs, boosts stakeholder confidence, strengthens reputation and supports long term viability.

Corporate Risk Register Performance Activity

3. The corporate risk register (CRR) now includes 23 risks reflecting an increase since the previous report. Among these, five risks have increased risk scores, one risk's score has been reduced to 16 whilst another has decreased to 12 awaiting approval for removal. No other risk scores have changed. Key risks relate to financial sustainability, digital systems and data storage, medical device management, capacity issues and suboptimal use of electronic patient records. Of the 23 risks, 53% are clinical management, 17% data and digital, 13% health and safety, 9% financial and 4% each for medical devices and patient safety. Further details are in the appendices.

Risk Management Performance Activity

4. The risk register has seen notable changes in 2024-25. Open risks have decreased by 40%, from 1015 to 613, significant or moderate risks scoring 9-12 have dropped by 75%, from 862 to 232, long term risks open for over three years were halved, down 50% from 619 to 312 and a 10% reduction in tolerated risks was achieved during the year. However, overdue risks have risen by 10% from 107 to 188 and risks scoring 15 and above not on the CRR increased by 70% from 27 to 46.
5. Clinical management risks dominate (53%) with sub types of capacity / demand (21%) and assessment / diagnosis (9%). Data and digital risks (17%) focus on systems (34%) and records management (21%). Health and safety risks (13%) primarily relate to buildings/infrastructure (31%) and security management (19%).

6. The diagnostic and clinical service (26%) and surgical anaesthetic service (22%) hold the most risks among divisions while Trust wide risks (11%) lead the directorates followed by radiology (10%), pathology (10%) and theatres / day surgery (7%).

Mitigations for risks and timelines

7. A comprehensive risk profiling and mapping exercise has focused on strengthening risk accuracy. This includes the identification of strategic and operational risks benchmarked against strategy, legislation, regulatory standards and best practice. Additionally, a detailed list of new risk type and sub-type categories, along with supporting risk descriptors, now strengthen the risk assurance framework.
8. Risk governance has been refined by mapping risk types and sub-types to specific committees and groups, assigning chairs / executive leads for oversight and utilising subject matter experts to manage risks within their domains. Regular review of risks is conducted through standardised terms of reference and annual performance reporting. Additionally, the effectiveness of divisional quality and safety board (DQSB) meetings in scrutinising risks before escalation to risk assurance meetings (RAM) has been reviewed.
9. Risk management performance has been enhanced through continued reaffirmation of the risk management framework (RMF) and escalation processes along with targeted improvements in managing risks scoring 15+ not on the CRR. Enhanced scrutiny of risk scores, controls and assurances against consequence scoring criteria has been implemented, alongside more detailed divisional reporting and monitoring of KPI metrics. Increased focus from the RAM and Executive Risk Assurance Group (ERAG), targeted reviews of live and tolerated risks for closure, and engagement with subject matter experts have further strengthened risk management. Challenges such as conflicting priorities for risk handlers in presenting risks are being addressed to ensure continued progress.
10. Risk management competencies of managers and key staff have been elevated through coaching, mentoring and issue of new guidance. Additionally, risk management training has been approved for inclusion in the management competency framework, with work in progress with DERI in utilising technology to form a blended approach to learning.
11. System enhancements to the Datix risk management module include review of its upgrade capabilities, profiling risks into new type and sub-type categories and linking high-scoring risks on the CRR to the board assurance framework (BAF). Approval

statuses and nominated committees have been integrated, while a mandatory actions section ensures accountability. Access to the risk register is being restricted to strengthen ownership and prevent misuse, unproductive categories like "other" have been removed and mandatory fields with character limits have been implemented to ensure completeness and clarity in risk records.

Challenges

12. Risk management improvements have encountered numerous challenges including external factors like industrial action, financial pressures, and strategic shifts, alongside internal issues such as system changes, organisational restructuring, staffing limitations and service demands. Cultural resistance and historical norms have further hindered progress, while decisions against adopting a total quality management system, delays in upgrading Datix servers and competing priorities like electronic patient record implementation have slowed advancements.
13. Despite these obstacles, significant efforts have yielded positive outcomes, such as process standardisation to reduce duplication, enhanced risk register quality and the achievement of KPI targets, ensuring ongoing progress in risk oversight and management.

How the action / information relates to achievement of strategic aims and objectives or improvement objectives

14. Effective leaders prioritise and address organisational risks to eliminate or minimise them. A robust governance and RMF is essential for ensuring the quality and integrity of internal management systems, particularly in identifying, classifying and managing strategic and operational risks. Linking these risks to the BAF is critical to the success of a safety management system and prevents misuse of the risk register.

Resource implications and how they will be met

15. The health, safety and risk management team face severe resource and capacity constraints, compounded by growing service demands, competing priorities and reliance from other services. Progress is further hindered by the need to address ingrained historical risk management practices and performance challenges.

Benchmarking Intelligence

16. Risks are identified and measured through diverse methods to foster a proactive risk management culture. These include aligning with legislation, regulatory standards, case law and professional guidance; responding to external regulators; changes in organisational strategy; evaluating workforce structures and competencies; learning from incident reporting and investigations; assessing risk processes; analysing KPI metrics and statistical data; leveraging audits, inspections, surveys, focus groups and external benchmarking.

Conclusion of Report

17. The Trust has made significant progress in risk management and remains dedicated to integrating effective practices as a foundation for delivering safe and sustainable healthcare services. Its approach to risk management is cautious but steadily evolving, with improved leadership driving greater visibility of desired outcomes. Despite advancements, substantial challenges remain, including embedding risk ownership, strengthening governance and performance monitoring, enhancing education and training, and addressing historical cultural norms in risk management. Achieving these goals will further solidify the benefits outlined within this report, ensuring a robust and mature risk management framework.

Recommendations

18. Enhancing risk profiling and mapping, improving risk quality and quantity, utilising lead specialisms and subject matter experts, raising RMF and escalation process awareness and adhering to risk review cycles are crucial priorities. These efforts significantly influence the quality of risks recorded on the risk register.

Next Actions

19. Efforts to improve risk management focus on standardising processes, enhancing the quality and quantity of risks on the register, and reaffirming the RMF and escalation procedures. Reviews of live risks, the implementation of the new risk management strategy and framework and BAF connections are ongoing, alongside developing clearer risk appetite statements and strengthening governance through improved reporting and oversight. Initiatives include better generic risk assessments, software enhancements for tracking and performance, targeted training modules to improve awareness and competence and more effective use of the risk register.

20. Additionally, proactive responses to emerging risks, stakeholder engagement to foster ownership and the use of KPIs remain priorities. A long-term plan aims to unify health and safety and risk management strategy and frameworks for a more cohesive approach.

How the decision will be communicated internally and externally

21. Decisions regarding the review and approval of risks and the validity of risk scores are made via DQSB meetings, at Committees / Groups and escalated through the approved governance framework.

How progress will be monitored

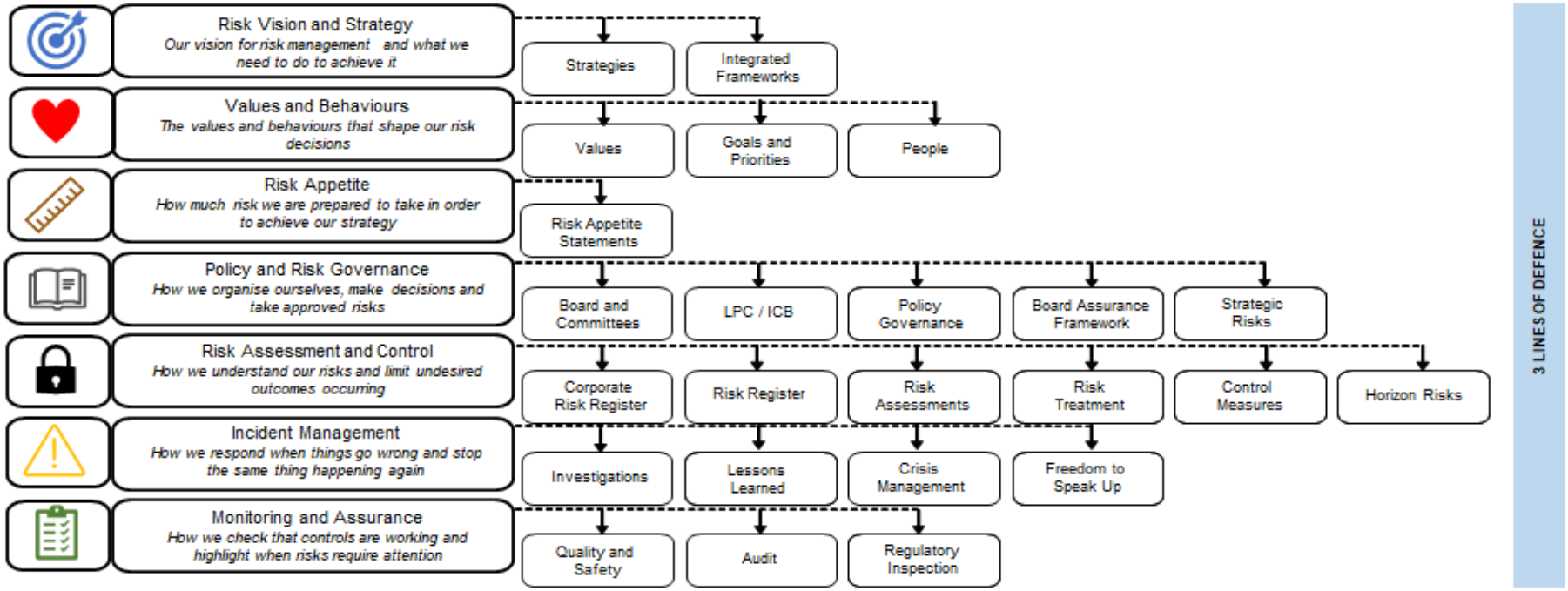
22. The quality and integrity of risks on the risk register, especially those with a score of 15 or higher, are monitored through RAM, Trust Wide Quality Governance (TwQG) and ERAG meetings. A senior executive lead, appointed by ERAG, oversees and ensures that risks on the CRR are effectively managed and mitigated in line with the RMF.

Appendices

23. Risk management strategy and framework on a page
24. Key risk elements - risk sub type categories, risk descriptors and governance
25. Summary of the CRR
26. Detailed CRR

Mr J Houlihan - Assistant Director of Health, Safety and Risk
02 May 2025

Risk Management Strategy and Framework on a Page



Key Risk Elements

Risk Types, Descriptors and Governance Assurance

The Trust has identified its risk types which are the principal risks which arise from the nature of the Trust's operating environment, supported by a comprehensive set of risk sub types aligned to each risk type and determined using risk management identification and methodology.

	Risk Type	Summary Descriptor	Exec Lead	Senior Leadership Support	Management of Risk Sub Types	Oversight by
	Clinical	Potential for harm to patients due to inadequate clinical management systems and errors in diagnosis, treatment or care	Executive Medical Director	Chief / Deputy Chief Nurses	Identified Clinical Leads	Clinical Effectiveness Group
	Data and Digital	Risks associated with the use, storage and transmission of data and reliability of digital systems	Executive Director of Finance	Chief Information Officr	Identified Data and Digital Leads	Data and Digital Senate
	Emergency Planning	Threats in the ability to maintain service provision during, as well as after, significant failures of systems and of responding effectively to emergencies and natural disasters	Executive Director of Integrated Care, Partnerships and Resilience	Associate Director of Integrated Care, Partnerships and Resilience	Emergency Preparedness, Planning and Resilience Manager	Emergency Preparedness, Planning and Resilience Committee
	Financial	Risks of direct or indirect loss in relation to the Trust's financial stability such as budget deficits, financial reporting, fraud and inadequate revenue	Executive Director of Finance	Chief Management Accountant	Identified Finance Leads and Specialisms	Finance and Performance Committee
	Governance	Risks relating to the effectiveness of its registration, leadership, decision making, compliance with regulations and operation of its governance framework	Executive Medical Director	Associate Director of Quality and Safety	Identified Governance Leads and Specialisms	Trust Wide Quality Governance
	Health and Safety	Risks relating to the health and safety of its staff, patients, visitors, contractors, buildings, assets and the environment	Executive Director of Integrated Care, Partnerships and Resilience	Assistant Director of Health, Safety and Risk	Identified Safety Leads and Specialisms	Health and Safety Committee

	Risk Type	Summary Descriptor	Exec Lead	Senior Leadership Support	Management of Risk Sub Types	Oversight by
	Human Resources	Risks relating to workforce supply, recruitment and retention, skills and competency, behaviours and performance, wellbeing and culture	Executive Director of People and Culture	Deputy Director of People and Culture	Identified HR Leads and Specialisms	People and Culture Committee
	Infection Prevention	Risks relating to the management and spread of hospital acquired infection and transmission	Chief Operating Officer	Head of Infection, Prevention and Control	Identified IPC Leads and Specialisms	Infection, Prevention and Control Committee
	Medical Devices	Risks relating to the safe and effective use of medical devices and whole lifecycle management	Executive Director of Integrated Care, Partnerships and Resilience	Associate Director of Integrated Care, Partnerships and Resilience	Medical Devices Safety Officer	Medical Devices Steering Committee
	Medicines Management	Risks relating to the safe and effective prescribing, dispensing and administration of medications	Chief Operating Officer	Chief Pharmacist	Medicines Safety Officer	Medicines Safety and Optimisation Group
	Patient Safety	Risks of harm to patients from any source within the healthcare system	Executive Medical Director	Assistant Director of Patient Safety and Clinical Effectiveness	Identified Patient Safety Leads and Specialisms	Patient Safety Group
	External	Risks originating outside the control of the Trust that have the potential to impact on its operations	Senior Executives	Directors	Assistant Directors	Board and its Committees and Groups

Summary of the Corporate Risk Register

	ID	Risk Type	BAF	Division	Title	Likelihood Score	Consequence Score	Risk Score	Exec Lead	Effectiveness of Controls	Risk Movement	Committee / Group	Committee for assurance
1	10082	Financial	5	Trust wide	Failure to meet internal and external financial targets	5	5	25	S Simpson	Limited	⟷	Finance Assurance Board	Finance & Performance Committee
2	10086	Clinical	2	Trust wide	Lack of adequate online storage for images may result in missed or delayed diagnosis	5	4	20	S Simpson	Inadequate	⟷	Data & Digital Senate	Finance & Performance Committee
3	10065	Clinical	2	DCS	Pharmacy Technical Service refurbishment programme	4	5	20	S Islam	Inadequate	↑	TWQG B	Qualty Committee
4	10062	Clinical	2	Trust wide	Risk of harm and poor experience for patients with mental health concerns	5	4	20	P Murphy	Inadequate	↑	TWQG A	Quality Committee
5	9755	Clinical	2	Family Care	Delays undertaking elective caesarean sections	4	5	20	P Murphy	Limited	↑	Family Care Divisional DQSB	Quality Committee
6	9336	Clinical	2 / 3	MEC	Increased demand with a lack of capacity within ED can lead to extreme pressure and delays to patient care	5	4	20	S Islam	Limited	⟷	MEC DQSB	Finance & Performance Committee
7	8941	Clinical	2	DCS	Increased reporting times in histology due to increased activity outstripping resource	5	4	20	S Islam	Limited	⟷	Elective Productivity & Improvement Group	Finance & Performance Committee
8	8126	DDaT	2	Corporate	Poor records management due to sub optimal implementation of new e-PR system	5	4	20	S Islam	Adequate	⟷	Data & Digital Senate	Finance & Performance Committee
9	9777	Corporate	2	Corporate	Loss of education, research and innovation accommodation and facilities	4	4	16	T McDonald	Limited	↑	DERI Estates meeting	Finance & Performance Committee
10	9746	Financial	5	Corporate	Inadequate funding model for research, development and innovation	4	4	16	M Ireland	Limited	⟷	DERI SLG	Performance & Culture Committee
11	9545	Clinical	2	SAS	Potential interruption to surgical procedures due to equipment failure	4	4	16	S Simpson	Limited	↓	Medical Devices Steering Group	Quality Committee
12	8061	Clinical	2 / 3	Trust wide	Patients experiencing delays past their intended clinical review date may experience deterioration	4	4	16	S Gilligan	Limited	⟷	Elective Productivity & Improvement Group	Quality Committee
13	8033	Clinical	2	Trust wide	Increased requirement for nutrition and hydration intervention in patients resulting in delays	4	4	16	P Murphy	Limited	⟷	Nutrition & Hydration Streeting Group	Quality Committee
14	7165	H&S	2	Corporate	Failure to comply with RIDDOR	4	4	16	T McDonald	Limited	⟷	Health & Safety Committee	Quality Committee
15	10095	MEC	3	Cardiology	PAC issues impacting on efficiency and ability to meet targets and obstructive workflow	5	3	15	S Simpson	Inadequate	↑	Data & Digital Senate	Finance & Performance Committee
16	9900	NICE	2	Trust wide	Poor identification, management and prevention of delirium	5	3	15	S Islam	Limited	⟷	TWQG B	Quality Committee
17	9895	Clinical	3	SAS	Patients not receiving timely emergency procedures in theatres	5	3	15	S Islam	Limited	⟷	SAS DQSB	Quality Committee
18	9851	DDaT	2	Trust wide	Lack of standardisation of clinical documentation processes and recording in Cerner	5	3	15	P Murphy	Limited	⟷	Data & Digital Senate	Quality Committee
19	9653	Clinical	2 / 3	Trust wide	Increased demand with a lack of capacity within ELHT can lead to extreme pressures and delays to patient care	5	3	15	P Murphy	Adequate	⟷	Elective Productivity & Improvement Group	Quality Committee
20	9301	H&S	2	Trust wide	Risk of avoidable patient falls with harm	3	5	15	P Murphy	Limited	⟷	Falls Strategy Group / TWQG A	Quality Committee
21	8808	H&S	2	Corporate	Breaches to fire stopping and compartmentalisation at BGH	3	5	15	T McDonald	Adequate	⟷	Fire Safety Committee / TWQG B	Quality Committee
22	4932	Clinical	2	Trust wide	Patients who lack capacity to consent to hospital placements may be being unlawfully detained	5	3	15	P Murphy	Limited	⟷	Safeguarding Committee / TWQG A	Quality Committee
23	6190	Clinical	3	Trust wide	Insufficient capacity to deliver national targets for RTT and cancer	3	4	12	S Gilligan	Limited	↓	Elective Productivity & Improvement Group	Finance & Performance Committee

Corporate Risk Register Detailed Information

No	ID	Title				
1	10082	**Failure to meet internal and external financial targets**				
Lead		Risk Lead: A Hussain Exec Lead: S Simpson	**Current score**	**25**	**Score Movement**	⇔
Description		There is a risk that the failure to meet the Trust financial plan and obligations together with the failure to meet the wider Lancashire and South Cumbria ICB system financial plan is likely to lead to the imposition of special measures and limit the ability of the Trust to invest in the services it provides. The financial risk is made up of insufficient funds to provide the services to the population of East Lancashire, a lack of control on how funds are allocated across partner organisations, a 7.7% efficiency target of £57.8m for the Trust, a level that has never been achieved previously and a Trust and system wide financial deficit that still needs closing.				
Controls and Assurances in place		**Controls** Robust financial planning arrangements to ensure financial targets are achievable within the Trust. Accurate financial forecasts. Financial performance reports distributed across the Trust to allow service managers and senior managers to monitor financial performance. Enforcement of Standing Financial Instructions through financial controls to ensure expenditure commitments to incur expenditure are made within delegated limits. **Assurances** Frequent, accurate and robust financial reporting and challenge by the way of:- Trust Board Report Finance and Performance Committee Finance Report Audit Committee Reports Integrated Performance reporting Divisional and Directorate Finance reports Budget Statements Staff in Posts Lists Financial risks External Reporting and Challenge		**Gaps and potential actions to further mitigate risk**	**Gaps / weaknesses in controls** A high efficiency target than has ever been achieved in the past to ensure the Trust is fully engaged and playing their part in reducing efficiencies and the cost base. The financial regime is managed at a system level rather than at a Trust level. The financial gap is across the system not just the Trust. **Gaps / weaknesses in assurances** Lack of understanding of full system risks. Lack of airtime for discussion of the full system risks.	
Update since the last report		**Update 23/04/2025** **Risk reviewed. No change in risk score** **Progress Update** The Trust reported a £68.492m deficit for 2024-25, against a breakeven plan. Despite this, a monthly surplus of £1.2m was achieved, reflecting a £1.8m improvement from the previous month. A deficit financial plan of £21.9m was offset by non-recurrent deficit support funding received by month six, revising the annual plan to breakeven. The breakeven plan includes a £59.7m cost improvement programme, though only £20.1m has been delivered so far. Agency spend of £9.8m (1.6% of gross pay) is £5.6m below target, while capital expenditure aligns with forecasts at £45m. The Trust's cash balance rose to £16.8m by March 31, an £11.6m increase from February. **Next Review Date 16/05/2025**		**Date last reviewed**	**23/04/2025**	
			Risk by quarter 2025-26	**Q1**: 25	**Q2**:	**Q3**:	**Q4**:
			8-week score projection	**25**			
			Current issues	System wide external influences			

No	ID	Title
2	10086	**Lack of adequate online storage for images may result in missed or delayed diagnosis**

Lead	Risk Lead: D Hallen Exec Lead: S Simpson	Current score	20	Score Movement	⇔

Description

There is a risk that capacity for the storage and transfer of ECHO images from ultrasound machines used within Chronic Obstructive Pulmonary Disease (COPD) and Neonatal Intensive Care Units (NICU) services may result in missed or delayed diagnosis if no suitable clinical management or digital storage solution can be found.

Controls and Assurances in place

Controls

1. The existing service contract has been extended.
2. Current ultrasound images stored on scanning machines and McKesson software installed on NICU computers.
3. Image transfer via desktop, through the PACS system, out of hours and via MS teams which have prevented transfer of a baby and safe overview of images.
4. Patient transfer to other Hospitals for echocardiology review.
5. Set standards on provision of an ultrasound service issued by the Royal College of Radiologists include key areas essential for delivery of high quality, effective ultrasound imaging services and examinations that services are expected to review and follow.
6. Organisational policy and procedural controls in place for the lifecycle management of medical devices.
7. Integrated Care Board has ownership of the risk and is working on a digital solution.

Assurances

1. Imaging incidents closely reviewed and monitored and linked to the management of risk.
2. Cerner e-PR has an imaging module, cloud storage and PAS patient list connection that capture, store, access and share imaging data and multimedia across the system providing a holistic patient view.
3. Current capacity levels regularly being monitored. Capacity within Childrens Observation and Admissions Unit is 117.2 GB (99.8% full) with 247.9 MB remaining. Capacity within COPD is approx. 250 GB and NICU is approx.. 800 GB with further capacity checks required.
4. The Technical Diagnostics Team within the Integrated Care Board (ICB) is exploring costs and solutions, with Bridgehead identified as a solution, along with cardio imagery. Planning parameters and vendor response in place for viability.
5. Work is underway with software providers for a temporary solution for the storage of images that does not add to current storage capacity. An approach has been considered for Siemens to partition VNA and assist with the holding of data and or for Sectra to provide a fully functional solution until a more permanent solution is found.
6. Regular meetings held between the Executive Medical Director, Chief Nurse, Director of Finance and Director of Operations for the Family Care Division to understand the risk and mitigations required.
7. Divisional Quality and Safety Meetings in place to review and support the management of this risk.
8. Medical Devices Management Group meetings in place to provide assurances of compliance regarding the lifecycle management of medical devices.

Gaps and potential actions to further mitigate risk

Gaps / weaknesses in controls

1. Additional cost implications for contract extension and a software storage solution.
2. Current ultrasound images stored on scanning machines have limited memory capacity.
3. Images transfers to desktop, through PACS and MS teams is ineffective. Attempted input of images onto PACS slows the entire system down, is too big to be sent via image exchange portal and has limited storage availability. Use of MS teams heavily reliant on availability of consultants to attend MS team meetings.
4. Patient transfers to other Hospitals may be unnecessary, unsafe and reliant on bed availability.
5. Limited assurance Royal College of Radiologists standards are being used to benchmark or measure performance or compliance.
6. Additional staff training in system use is required.
7. Development of a virtual private network (VPN) tunnel is under trial and not embedded as clinical management process.
8. Cranial ultrasound scans and echocardiogram images cannot be separated and stored with further exploration of how scans are stored required.
9. A planned strategy and system solution being brought in by the ICB to increase storage capacity is awaiting implementation.
10. Limited assurance policy and procedural controls regarding the lifecycle management of medical devices is robust, is being followed or suitably performance managed.

Gaps / weaknesses in assurances

1. Common incident themes relate to equipment malfunction, delays in diagnosis, clinical symptoms warranting emergency transfer of patient to another Hospital and difficulties transferring images.
2. Cerner e-PR imaging module and set up requires further exploration to determine effectiveness.
3. Limited evidence of assurance current capacity levels are regularly checked and monitored.
4. Bridgehead solution remains fully dependent on the release of funding and approval by the ICB.
5. Solution offered by Siemens does not help image sharing with other Hospitals and effectiveness of direct image transfers still requires exploration.
6. Effectiveness of the Medical Devices Management Group to support management of this risk.

Update since the last report

Update 07/04/2025
Change of risk lead. No change in risk score.
Risk has been reviewed by the Chief X Information Officer. Assurance of compliance against national guidance for the storage of clinical images is being reviewed which will help support mitigation of this risk and a reduced risk score.

Next Review Date 06/05/2025

Date last reviewed	07/04/2025			
Risk by quarter 2025-26	Q1	Q2	Q3	Q4
	20			
8-week score projection	20			
Current issues	System wide external influences			

No	ID	Title				
3	10065	**Pharmacy Technical Service refurbishment programme**				
Lead		Risk Lead: M Randall Exec Lead: S Islam	**Current score**	**20**	**Score Movement**	
Description		The failure to maintain aseptic units to external standards risks equipment malfunction, such as air handling units, pharmaceutical isolators, and HEPA filters. This could cause environmental breaches, product contamination, delays in chemotherapy services, and breaches in cancer targets. It also increases the danger of errors in high-risk product dispensing, endangering staff health and patient safety. Additionally, it compromises the ability to support clinical trials and research, leading to halted projects, financial losses, and reputational damage for the organization.		**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. Failure to comply with HTM guidance and quality assurance standards. 2. Dispersed oil testing and pressure differential failure in clean rooms visible on magnahelic gauges, interlocking doors not working. 3. A chemotherapy port has exceeded its life span with no plans in place regarding lifecycle management. 4. Contract with JLA (formerly Atlas) now expired, reports not being sent through, so having to review maintenance contract which is more expensive. 5. Difficult to manage all reports being recorded on the unit. 6. No environmental control in the old outpatient dispensary so not suitable for storing clinical trials unless upgrade works carried out. 7. Delays of up to forty four weeks ordering isolators adds to existing financial pressures and work programme constraints. 8. Growth restriction of aseptic unit with at least one pharmaceutical isolator not operational in last two years. 9. CIVA service has been stopped. 10. Outsourcing of parenteral nutrition service due to failing equipment. 11. Increased waste due to shelf life of outsourced products. 12. Staff behaviours in ignoring notices 13. No capacity on chemotherapy unit for patient growth so difficult to control service demands **Gaps / weaknesses in assurances** 1. Lack of national pharma support to provide aseptic service provision is putting a strain on services and workforce. 2. Multiple shut downs of units have occurred in the last two years. 3. A 15% increase in aseptic service provision in last two years with capacity and demand intensive. 4. Chemo and clinical trial demand growing and exceeding capacity of unit. 5. Review of capacity data highlighting workforce issues. 6. Environmental monitoring results have a two week response time causing delays in picking up any breaches. 7. Limitations in mutual aid due to age and condition of units across NHS organisations in the LSC area. 8. Workforce issues are leading to increased psychosocial risks. 9. Difficult to assess safety of MABs when in phase 2 of development, as COSHH data not available. 10. Limited backup to support chemotherapy service if aseptic unit fails 11. Heating and cooling system not working and not replaced in timely manner	
Controls and Assurances in place		**Controls** 1. Aseptic unit audits undertaken by external service provider 2. Staff preparations use aseptic non touch technique to reduce contamination risk 3. Old outpatient dispensary identified to store clinical trials 4. Risk assessment of monoclonal antibodies designed to look at new products being accepted on the formulary. 5. FMS/magnahelic panel continuously monitored for pressure change 6. Staff notice to ensure door system is used for single entry only into each room. Staff training put in place around GMP and entry to clean room etiquette 7. Aseptic unit shut and works commenced 8. External quarterly and annual PPM of units – chemo POD PPM compliant 9. Commissioned review undertaken by specialism **Assurances** 1. Aseptic team reviewing system for environmental breaches on a monthly basis via pharmacy quality meetings. 2. Quality exception report excursions are being investigation and error rate reviews undertaken 3. Monthly meetings taking place and urgent response service plans sent through from clean room specialist company. 4. Regular environmental testing undertaken of the unit and the workforce. 5. Transformation plans for aseptic unit in place, with an integrated care systems working group looking at long term service provision. 6. A north west pharmaceutical quality assurance regional audit is undertaken every 18 months. 7. Outsourcing of products is undertaken where possible to meet service demand. 8. Non aseptic medicine trials and other alternatives being explored to prepare aseptic products in clinical areas. 9. Annual service and external PPM by cleanroom projects and JLA-DOP and pressure test compliant. 10. Life cycle works commenced. 11. Monitoring temperature, heaters available for office space but not cleanroom				
Update since the last report		**Update 16/04/2025** **Change of Exec Lead. Increase in risk score.** Still awaiting closure of actions, NICU response, URS for aseptic unit approval, change of maintenance contract, 24 hr support and estates and PFI team review of actions. Aseptic unit closed and works commenced **Next review date 14/05/2025**		**Date last reviewed**	**16/04/2025**	
				Risk by quarter 2025-26	**Q1**: 20	**Q2**:	**Q3**:	**Q4**:
				8-week score projection	**20**			
				Current issues	Systems, capacity and workforce pressures			

No	ID	Title				
4	10062	**Risk of significant harm and poor experience for patients attending with mental health concerns**				
Lead		Risk Lead: M Illingworth Exec Lead: P Murphy	**Current score**	**20**	**Score Movement**	
Description		There is a risk of harm and poor experiences for patients with mental health concerns due to delays in assessment and transfer caused by limited specialist bed availability. The Trust lacks the necessary registration, resources, and standard training to provide adequate care, leading to ongoing incidents of harm to both staff and patients. This situation restricts the Trust's ability to support system-wide care effectively.		**Gaps and Potential actions to further mitigate risk**		
Controls and Assurances in place		**Controls** - Shared care protocol in place with Lancashire and South Cumbria NHS Foundation Trust (LSCFT). - Daily escalation of patients awaiting a mental health bed via gold command. - Multi agency s.136 pathways in place - Newly created Enhanced Care Support Team to support with complex patients with internal staff who are appropriately trained in physical restraint and experienced in the care of patients who present with behaviours that challenge. - Lead Nurse for Mental Health is in post. - Joint working arrangements exist between ELHT and LSCFT. - Development of pathway for the management of mental health patients in Emergency Care. - Management of challenging behaviours training available in DERI, but not mandatory. - Safeguarding Team available for advice regarding the management of patients at risk. - Enhanced care assessments undertaken. - De-escalation Least Restrictive Restraint Policy now in place and available on OLI. - External trainer identified, Training Needs Analysis completed by DERI. Annual training in place for security staff, with the first round completed. - Risk Assessment and guidance for the management of MH patients is currently used within ED. - The CQC are supporting the Trust to register for the provision and treatment under the Mental Health Act. - ELHT has submitted an application to register for MH Status. **Assurances** - Enhanced care lead nurse informally monitors and escalates gaps in completed risk assessments to the mental health liaison team based in the emergency department. The Matrons include this within their reports to the ED Quality meeting. - The mental health liaison meeting reports to the emergency department divisional management board meetings and facilitates joint working between the emergency department and mental health liaison team. - A mental health interface meeting has been set up to provide assurances against established measures. A dashboard is being developed. - Multi agency oversight group, chaired by the ICB, monitors patient mental health activity and is chaired by the Integrated Care Board. - Incidents of harm involving patients with mental health or learning disabilities reported in Datix. - A task and finish group has been set up to review the management of ligatures, first meeting in Jan-24 - Wellbeing reporting and Wellbeing conversations in place - Mental Health Liaison Nurses based within the Emergency Department - All security staff are trained in the use of restraint to RRN standards. - De-escalation Least Restrictive Restraint Policy monitoring and reporting processes in place for the use of physical and chemical restraint. - Newly created MH Interface meeting to be held monthly with LSCFT colleagues to support the implementation of the Treat as One document and to ensure oversight of improvements to the care of patients with MH concerns. The TOR include monthly oversight of incidents/complaints etc. to ensure trends and themes are identified and lessons learnt are implemented. - Visibility of inquest closure forms at TWQG and in Exec slides			**Gaps / weaknesses in controls** - LSCFT are routinely unable to staff the requirements of the Shared Care Protocol for 1:1 etc. - Enhanced Care Team is not fully recruited to at present, including formal lead for the service. - Mental Health risk assessments only provided by MHLT for patients with medical recommendations in place and often provide limited information. - Infrequent availability of resource to address escalated patients via gold command due to mental health bed availability. - Access to specialist advice for mental health concerns can only be accessed externally from LSCFT. Lead professional is now in place and working on a pathway to increase support for complex patients. - Lack of ability for specialised care plans to be written by mental health nurses to support patients within general adult acute ward environments. - Limited control of other patients witnessing distress and deterioration in mental health conditions within ward environments. - Staffing levels not able to manage associated risk when gaps are not covered by specialist teams. - Acute staff often manage mental health risks without adequate training placing themselves and patients at risk. No training plan available. - Incomplete or unsuitable environmental and clinical risk management processes. - Lack of formal agreed shared care model results in inconsistent levels of support and gaps in provision. - No specific Trust policy for the care of mental health patients. **Gaps / weaknesses in assurances** - Assurance processes not embedded or visible against jointly agreed standards. - No specialist input from mental health nurses to ensure appropriate actions are being taken. - The ED mental health liaison meeting is not linked to formal governance arrangements. - Compliance against s.136 pathway requirements not visibly reported across the Trust. - The multi-agency oversight group is not linked into formal governance arrangements. - Limited access to specialist internal support for mental health concerns. - No access for staff to undertake mental health training to support patients and families. - Requirements from treat as one documentation are outstanding. - No formal oversight of ligature risk assessments. Staff safety dashboard not yet in place - Liaison Nurse support to the wider hospital unclear - MH Liaison Team will develop a part 2 RA that is available for staff to utilise in ward areas, however, this is only available for those patients with medical recommendations for transfer to a MH bed. - Inquest closure forms are retrospective - The DoLs aren't authorised formally by the LA as required by the legislation resulting in a lack of independent scrutiny. - The environmental risk assessment process requires standardisation and formally embedding throughout the organisation.	

<table>
<tr><td></td><td>- Trust Board, CQC and ICB aware of current on-going process to risk assess application for registration.
- Daily Gold call escalates concerning cases at system level
- H&S Committee monitors incidents of environmental harm to patients
- MHUAC and linked MH Liaison Team on site with linked systems from February 2021</td><td></td><td colspan="4"></td></tr>
<tr><td rowspan="4">Update since the last report</td><td rowspan="4">Update 22/04/2025
Risk Reviewed. Increase in risk score
A regular review of incidents is taking place to understand causation and address issues. There has been a 44% reduction in numbers of self-harm incidents compared to the previous financial year to date. Increased resistance from local Trusts to support transfers and absence of formalised pathway. A full review of this risk and internal controls and assurances is being undertaken by the newly appointed mental health nurse which will support mitigation of this risk and a reduced risk score.

Next review date 14/05/2025</td><td>Date last reviewed</td><td colspan="4">22/04/2025</td></tr>
<tr><td rowspan="2">Risk by quarter 2025-26</td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr>
<tr><td>20</td><td></td><td></td><td></td></tr>
<tr><td>8-week score projection</td><td colspan="4">20</td></tr>
<tr><td>Current issues</td><td colspan="4">System wide influences</td></tr>
</table>

No	ID	Title				
5	9755	**Delays in undertaking elective caesarean sections**				
Lead		Risk Lead: C Aspden Exec Lead: P Murphy	**Current score**	**20**	**Score Movement**	⇧
Description		There is a deficit in capacity for elective caesarean sections against annual increasing demand. The current delivery model and mitigation to meet the gap have implications for clinical and patient safety risks and compromises emergency operative availability				
Controls and Assurances in place		**Controls** 1 Antenatal inpatient manager and Consultant Obstetric lead undertake daily review of planned elective caesarean sections to monitor and manage planned waiting list. 2 Weekly meeting to pick up any reutilised list. Hoping that where there is an available list that obstetric capacity and midwifery bank will pick up the sessions. Where there isn't a list for reutilisation, a capacity request is submitted. 3 Using on-call obstetric staffing and central Birth Suite Midwifery and maternity support worker staffing to do elective activity in addition to their job planned work. 4 Improvement case drafted and submitted for decision (included in documents) proposal to move back to a 5-day model (Ockenden recommendation is to aspire to a 5-day (10 session model). 5 Established a task & finish group to maximise efficiencies and see improved utilisation of current capacity. **Assurances** 1 The only confidence in controls is that the overspill of elective caesarean sections are managed on the emergency pathway but this is not a sustainable or safe control. 2 Monthly escalation meeting hosted by Divisional Director of Operations and Divisional Director of Midwifery & Nursing. 3 Weekly review of capacity requirements and planned activity.		**Gaps and potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1 Limitations for Antenatal Inpatient Manager and Consultant Obstetric Lead to undertake daily review of elective caesarean section demand. with potential single point of failure in times of sickness or unavailability. Business case seeks approval of elective admissions clerk to support the process and remove burden off clinical team. 2 Additional capacity sessions - unsustainable, costly, unreliable, dependent on availability of theatre/anaesthetic cover and midwifery staffing. There is a decline in staff who pick up bank shifts/capacity. Antenatal Ward Manager often stepping in to cover sections taking her away from substantive duties. 3 Availability of extra sessions further impacted by lifecycle works reducing number of lists available for re-utilisation, with activity moved from Blackburn to Burnley theatres. 4 Programme of theatre lifecycle work commenced that necessitates more elective work to be undertaken in the Lancashire Women & Newborn Centre. As a result maternity services will not have access to Gynae Theatre 4 as a 2nd emergency obstetric theatre during this time. On days elective caesarean section lists are taking place there will only be one available emergency theatre (obstetric theatre 1). 5 Category 3 caesarean sections should be risk assessed by the Obstetric Consultant on call and Band 7 Co-ordinator to be facilitated when safe to do proceed. 6 Additional elective work (category 4) should be conducted on days without concurrent elective lists, housed on gaps in the elective lists or escalated to the Maternity Triad to secure additional capacity if required. 7 Ongoing assessment of risk and work around the demand and capacity for caesarean sections is continuing. 8 Unable to guarantee requests for extra theatre capacity - if additional elective capacity is not available women are often listed from Central Birth Suite into emergency capacity, however given the above availability of gynae 4 due to Lifecycle works this mitigation is now not often an option. 9 Inefficient use of staffing resource which will cause additional hidden tasks for Acute lead consultant, midwifery leaders and ward clerks. 10 A business case was originally submitted in 2022/23 which proposed moving back to a 5-day delivery model, at the time it paused as part of the Trust Business Case Stock take exercise and put on hold due to the 22/23 financial position of the Trust. 11 Revised business case re-submitted in 2024/2025 - no decision taken as yet (17.09.24). In August 2024 current business case has been added to the urgent case review tracker. 12 Increasing elective work impacts availability of emergency theatre. Impact of grade 3s on acute workload, has caused delay to emergency work (increased requirement to break into a second emergency theatre, staffing pressures). 13 Approval of the business case will further exacerbate SAS risk 10139 availability of theatres, due to the fact that it will reduce availability of a second emergency theatre on Mondays and Fridays.	

			14 Gynae 4 the second emergency obstetric theatre has planned elective work listed - where there is need to break into this theatre for an emergency obstetric case, this impacts on productivity of Trust level elective recovery plans and long waiting patients. **Gaps / weaknesses in assurances** 1 Limited assurance due to lack of formalised processes for identified controls and actions, alongside ongoing pressure on emergency team. This creates a risk of delays in emergency cases, potentially resulting in poor maternal and or fetal outcomes
Update since the last report	**Update 11/04/2025** **New Risk** There remains a significant and daily risk whilst the service demand requires using the emergency team to undertake elective work. The controls currently in place do not mitigate these risks. **Next Review Date 12/05/2025**	**Date last reviewed**	**11/04/2025**
		Risk by quarter 2025-26	**Q1**: 20 / **Q2**: / **Q3**: / **Q4**:
		8-week score projection	20
		Current issues	System wide external influences

No	ID	Title				
6	9336	**Increased demand with a lack of capacity within ED can lead to extreme pressure and delays to patient care**				
Lead		Risk Lead: J Dean Exec Lead: S Islam	**Current score**	**20**	**Score Movement**	⟺

Description	A lack of capacity is leading to extreme pressure resulting in delayed delivery of optimal standard of care. At times of extreme pressure, increasing patient numbers across the emergency pathway makes the provision of care difficult, impacts on clinical flow, increases the risk of nosocomial infection spread as a result of overcrowding and poor patient experience leading to complaints.	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls and assurances** 1. Ambulance handover and triage escalation processes only effective if patients are transferred elsewhere and interventions are carried out. 2. OPEL triggers consistently remain at Level 4 with no escalation strategy should triggers be continuously met. 3. Clinical pathways are not being effectively utilised. 4. Patients not always keen to follow 111 / GP direct booking pathways to UCC. 5. Daily staff assessments are completed but there is still not enough staff to send support. 6. Limitations of 'pull through' and what can be achieved are due to challenges regarding patient discharge. 7. Extreme escalation highly dependent on flow. It does not always decrease pressures due to same sex / side room requirements. 8. Zoning of departments is only effective where severe overcrowding does not take place. 9. The corridor care standard operating procedure, hourly rounding by nursing staff and processes across acute and emergency medicine cannot be safely followed at times of severe overcrowding. 10. Workforce redesign undertaken twice yearly and despite a clear recruitment strategy and positive campaign, gaps in vacancies continue to remain high locally and nationally. 11. Safe Care Tool is completed twice yearly and has highlighted gaps between need and decision making. 12. Departmental board and walk rounds can take several hours due to severe overcrowding. 13. Reduced thresholds for support result in pushback from clinical areas vs a pull model. 14. Delays in the HR onboarding process is resulting in slow recruitment of volunteers and not enough to support demand. 15. Bed meeting actions can be person dependent e.g. consultants to discharge patients etc. 16. Further in reach to department support does not always occur due to staffing levels and space constraints, creating further delays. 17. Staff are not always available to redeploy to support at times of increased pressure. 18. Compliance with UK guidance for isolation of infectious patients creates further risks e.g. availability of side rooms etc. 19. Not all patients or staff follow infection prevention control policy requirements. 20. Not enough side rooms to support clinical requirements, in particular, patients identified as being not for corridor when severely overcrowded. 21. Reports not always accessed and meetings can be stood down due to operational pressures meaning data is not always enacted upon. 22. Added demand s coming from other NHS organisations due to better management of risk by ELHT. 23. No additional plan to support patients who require higher levels of care once high observation beds within AMUB are occupied. 24. A patient experience strategy is in place to support patients within ED but is heavily reliant on demand vs capacity so complaints continue to increase yearly despite interventions being put in place. 25. Friends and family results highlighting increasing concerns of waiting times. 26. System partners ability to flex and meet demands of local health population compounded with offer of mutual aid, with support with hospital diverts increasing risk
Controls and Assurances in place	**Controls** 1. Ambulance handover and triage escalation processes to reduce delays 2. Operational Pressure Escalation Level triggers and actions completed for ED and Acute Medical Units. 3. Established 111 / GP direct bookings to Urgent Care Centre. 4. 111 pathways from GP / North West Ambulance Service (NWAS) directly to Ambulatory Emergency Care Unit. 5. Pathways in place from NWAS to Surgical Ambulatory Emergency Care Unit (SAECU), Children's Observation and Assessment Unit (COAU), Mental Health, Gynaecology and Obstetrics and the Community. 6. ED streamer tool in place to redirect patients to an appointment or alternative service where required. 7. Daily staff capacity assessments completed and staff flexed as required. 8. Divisional Flow Facilitators established across all divisions to assist with clear escalation and 'pull through'. 9. Escalation pathway and use of trolleys in place for extreme pressures. 10. Zoning of departments to enable better and clearer oversight, staffing and ownership and isolation of infected patients, in particular, those with influenza and risks of cross contamination. 11. Corridor care standard operating procedure embedded. 12. Workforce redesign aligned to demands in ED. 13. Safe Care Tool designed for ED. 14. Full recruitment of established consultants. 15. Matrons undergone coaching and development on board rounds. 16. Reduced thresholds within critical care to support patient admissions. 17. Patient champions in post to support patients on corridors and volunteers utilised to support with non-clinical tasks. **Assurances** 1. Support provided by IHSS Ltd. in regularly reviewing admission avoidance. 2. Gold command in place to provide support. 3. Bed meetings held x4 daily with Divisional Flow Facilitators. 4. Hourly rounding by nursing staff embedded in ED. 5. Daily consultant ward rounds done at cubicles so review of care plans are undertaken. 6. Daily 'every day matters' meetings held with Head of Clinical Flow and Patient Flow Facilitators. 7. Daily visit by Infection Control Nurse to ED with patients identified as being not for corridor. 8. Increased bed capacity within cardiology. 9. High observation beds in place on AMU to support patients who require high levels of care. 10. Further in reach to departments in place to help decrease admissions. 11. Discussions ongoing with commissioners in providing health economy solutions via A&E delivery board. 12. Continuous review of processes across Acute and Emergency medicine in line with incidents and coronial process.		

Update since the last report	**Update 22/04/2025** **Change of Exec Lead. No change in risk score** ED continue to see increased pressure on pathways and subsequent overcrowding and daily utilisation of corridor spaces. Additional medical wards have been opened whereby all clinical space at this point is in use. There has been an increase in the RN establishment so all ED corridor spaces can be fully recruited to and continuous positive RN recruitment, with minimal vacancies now. SOP for corridor care now live. **Next Review Date 26/05/2025**	**Date last reviewed**	**22/04/2025**			
		Risk by quarter 2025-26	**Q1**	**Q2**	**Q3**	**Q4**
			20			
		8 week score projection	**20**			
		Current Issues	Recovery and restoration pressures, recruitment and retention			

No	ID	Title				
7	8941	**Increased reporting time in histology due to increased activity outstripping resource**				
Lead		Risk Lead: C Rogers Exec Lead: S Islam	**Current score**	**20**	**Score Movement**	⟺
Description		Increased reporting times in histology due to increased workload and reduced staffing numbers can lead to the mismanagement of patient care with long term effects, the non-compliance with national standards with significant risk to patients, poor patient experience if results are delayed, multiple complaints, low performance rating i.e. NHSE cancer performance, uncertain delivery of key objectives or service due to lack of staff and low staff morale	**Gaps and Potential actions to further mitigate risk**		**Gaps / weaknesses in controls** 1. Dissection workload not adequately covered by clinical staff. 2. Activity increase higher than technical staff can complete, despite the issue of overtime and use of locum staff. 3. Failure of medical devices and equipment is adding to delays. 4. Volume of work marked urgent has increased by c.45%. 5. Gaps in recruitment of junior doctor posts remain. **Gaps / weaknesses in assurances** 1. Unexpected cancers found after waiting in backlog. 2. Surges in incidents regarding histology reporting times. 3. Poor monitoring and escalation of issues and meetings often stood down. 4. Some breaches fall outside the control of the Trust e.g. patients breaching targets due to complexity of pathways, comorbidities and patient choice.
Controls and Assurances in place		**Controls** 1. A 5 year workforce plan is in place to support recruitment and retention. 2. Recruitment of locum staff, additional senior BMS 3. MLA posts filled. 4. Triaging of cases to prioritise cancer cases. 5. Increased outsourcing of breast workload, colposcopy screening cases and routine cases to neighbouring NHS Trusts and external providers and reporting services. 6. Additional dissection bench created to increase capacity **Assurances** 1. Consultant staff supporting with dissection. 2. Work being triaged based on clinical urgency given the information provided upon the request form. 3. Weekly cancer performance meetings in place and attended by the histology/performance manager. 4. Escalation process for priority cases is well established. 5. Pathology collaborative exploring support.			
Update since the last report		**Update 11/03/2025** **Change of Exec Lead. No change in risk score.** Position is showing signs of improvement with a reduced backlog of cases from the use of mutual aid, additional bank work and external reporting services. Turnaround times remain above target and recruitment of locums and outsourcing remains challenging due to financial constraints. Increasing numbers of complaints relating to turnaround times and delays. **Next Review Date 11/04/2025** **Reminder issued to risk owner to update risk**	**Date last reviewed**		**11/03/2025**
			Risk by quarter 2025-26	**Q1**	**Q2**	**Q3**	**Q4**
				20			
			8 week score projection	**20**			
			Current issues	System pressures			

No	ID	Title				
8	8126	**Poor records management due to sub optimal implementation of new e-PR system**				
Lead		Risk Lead: D Hallen Exec Lead: S Islam	**Current score**	**20**	**Score Movement**	⇔
Description		A lack of continuous optimisation and investment may lead to frustration and create disillusionment, leading to poor usage and productivity, unsafe workarounds, substandard data and ineffective clinical decision making.				
Controls and Assurances in place		**Controls** General - significant resource in place to support improvement opportunities and deliverables - dedicated senior consultant identified by Cerner to undertake work to review issues identified and support further development and actions required - recruitment of e-PR champions, super users and floor walkers to support system implementation - development of e-PR SharePoint one stop shop site of readily available resources e.g. workflow sheets, 'hot sheets' outlining brief instruction on how to complete tasks on Cerner and FAQ's covering general, clinical, administrative, IT, pharmacy and discharge processes Clinical management - improvement plan in place with identified learning outcomes spread across the Trust - initial focus on outpatient areas i.e. head and neck, cardiology, urology, fracture clinical, gynaecology, respiratory and dermatology - completion of project to identify all policies, procedures and guidance affected by system implementation - prescribing is structured and follows a digital process with appropriate auditing capabilities - replacement of ICE with Order Entry Catalogue and Order Entry Form to place requests and ordering of all surgical procedures and medications Communication - regular updates using a variety of trust wide communication systems, digital and social media platforms - use of roadshows and walkabouts to raise awareness and demonstrate system use - issue of role specific posters, flyers and key contacts - use of displays across inpatient and staff areas Education, training and competency - registration process and extensive roll out of end user training and support - development and issue of staff handbooks - library of quick reference guides developed and available on SharePoint and e-Coach and organised by job role describing how to use particular tools or complete set workflows e.g. admission, transfer, discharge, prescribing etc. - series of patient journey demonstration and training videos have been created and available to view on the learning hub and YouTube channel to help navigate the new system - personalised demonstrations for doctors, nurses and allied health professionals - clinician RTT training - virtual discharge masterclasses held to demonstrate discharge processes for inpatients, outpatients, emergency department and same day emergency care to assist staff to successfully discharge a patient using the e-PR system and create full discharge summaries, with recordings routinely available from the e-PR hub on OLI - power chart and revenue cycle (RPAS) e-learning videos covering a wide range of patient journey demonstrations such as; - ED triage covering patient summary, staff check in to shift and work location, adult triage and assessment forms, Manchester triage, discriminators and dictionary, presenting complaints, nursing notes and observations - ED doctors covering clerking, ordering tests and medication, patient status view, specialty referrals, documentation of decision to admit, bed requests, ED discharge workflow - nursing inpatient admissions covering care compass, patient status overview and activity timeline, tasks to complete, admissions assessments including observations, pain assessments, EWS scoring, medicines administration and drug charts, discharge care plans, day of admission checklist, discharge planning risk assessment - inpatient admission – doctor covering doctors worklist, admission documentation including auto text example, book patient for theatre, admission clerking notes including ability to forward to other recipients and available previous documentation within record - inpatient preoperative checklist and discharge care plan (nursing) covering preoperative checklists, prior to discharge plan and discharge dashboard - discharge (doctors) covering fit for discharge, discharge documentation and summary, discharge medication and discharge letter - discharge (nursing) covering day of discharge checklist, key discharge information and PM conversation discharge of patient				
Gaps and potential actions to further mitigate risk		**Gaps / weaknesses in controls** General - limited capital budget to invest in additional hardware or software as clinical requirements develop - the lack of sufficient administrative resource - lack of effective clinical management to support and maintain implementation may impact on service provision and delivery leading to a secondary impact on patient safety - inability to rapidly flex current system to respond to emerging demands from 'external' NHS bodies for additional information Clinical management - key control issues identified regards elective outpatient and inpatients i.e. clinic set up and bookings; flow and discharge i.e. admission, discharge and transfer processes and discharge workflows; encounters; radiology integration; equipment and prescribing - other issues identified relate to endoscopy booking issues; GP discharge summaries and reporting - clinical management policies, procedures, systems and processes may not be in place or updated to reflect system changes following go live - clinical management policies, procedures, systems and processes may not be followed by clinicians or are being effectively monitored by policy authors, committees and or groups - there is more than one method of recording the same piece of information - pharmacy medicines dispense system requires updating Emergency preparedness, response and resilience - limited assurance policy and or procedural requirements remain effective, are being monitored, reviewed or followed Governance - there is no robust document management solution currently in place e.g. imaging, documentation etc. Digital - local data and digital strategy in development to help drive successful implementation of e-PR system - network instability which may lead to intermittent crashes - extended contracts on existing digital systems that provide current cover causing unexpected, additional financial pressure - no functioning information governance service at present - impact on infrastructure if technology, clinical management and techniques are developed in isolation from main e-PR - not all digital and clinical management systems are registered or known about - current system contracts do not identify specific switch over dates and are being rolled over annually - community services system is not connected to acute setting - scanning solution not consistent across all specialties and case note groups - rolling replacement of hardware and regular audits of IT service desk issues to identify challenges around themes such as reliable Wi-Fi etc. - clinical incidents relating to system implementation and use to identify challenges - integration architecture skills set is not native to the trust Patient and staff safety - limited assurance staff related health and wellbeing support systems are being used, monitored or reviewed for Cerner related issues **Gaps / weaknesses in assurances** Clinical management - staff familiarisation and confidence with the new system to support safe clinical pathways e.g. admission, transfer, discharge and prescribing etc. which in turn may lead to backlogs and delays in patient flow - limited assurance clinical pathways including assessments and workflows remain robust, are the most				

	Emergency preparedness, response and resilience - policy and procedural controls in place relating to emergency preparedness, response and resilience, major incident and business continuity planning - paper based contingencies remain in place to allow and record data capture Governance - e-Lancs managed from one command centre Digital - national data and digital strategy in place to help drive successful implementation of e-PR system - stability of existing systems i.e. clinical and patient flow system (including capture of nursing documentation), digital dictation and scanning - improved digital infrastructure, network upgrades and digital solutions including storage to maintain and manage existing systems in place to help best utilise data sets and information from e-PR system - extended contracts on existing digital systems that provide current cover - register of non-core systems capturing patient information (feral systems) - decommissioning programme of digital systems underway - IT helpdesk and self-service portal in place to help resolve technical and general issues Patient and staff safety - staff access to a wide ranging staff health and wellbeing support mechanisms e.g. occupational health and wellbeing teams, employee assistance programmes, external organisations, staff side, freedom to speak up guardians etc. Task based - improved digital infrastructure and investment in new technology and equipment e.g. connectivity, large screen monitors for status and track boards, bed planning and control centres, use of barcode scanners for medication, patient wristband supply and scanning, workstations on wheels, laptop trolleys and bedside usage, medicine trolleys specifically built for ward medication dispensing, anaesthetic machines within theatres, badge readers for logging within inpatient and theatre areas, use of 24/7 device computers with access viewer software installed in clinical areas etc. - use of personalisation lab to allow customisation of system to suit individual needs e.g. doctor, allied health professional, nurse etc. **Assurances** General - digital solution meets regulatory and data set compliance requirements - system designed around national clinical requirements - back office and application support teams triage, troubleshoot and resolve issues - support with staff familiarisation and confidence on clinical management systems readily available from Cerner e-PR and e-Lancs expertise - business as usual support roles from executive team, directors, on call senior managers, matrons, enhanced service desk and self-service portal - early go live period identified has identified a number of issues relating to the technical design and adoption by staff which is expected due to the size and scale of implementation Clinical management - a stop, start and continue project, led by a clinical lead in improvement practice involving cross divisional engagement, has reviewed working practices across all clinical, operational, administration, human resources and governance processes - key control issues identified are being closely monitored with executive leads and through working groups - clinical document library outlining electronic and paper based systems covering policy and procedures, clinical risk assessments, bundles, care plans etc. - patient and statutory data sets captured in Bedrock Data Warehouse with reports in place - patient flow monitored through Alcidion MiyaFlow - patient care is visible and monitored through e-PR - patient activity is captured leading to accurate income reports - digital medical record capability shared within treatment and support teams Communication - regular webinars and team brief sessions held Education, training and competency - use of access fairs to ensure smooth staff logins - additional 940 hours available to support adoption and optimisation of system provided by Cerner for individual and team coaching Emergency preparedness, response and resilience - the EPRR committee benchmarks performance against national standards and provides assurances of organisational compliance Governance - weekly e-PR Programme Board meetings chaired by Medical Director - weekly incident management meetings chaired by Chief Operating Officer and Director of Service Improvement - weekly e-Lancs Improvement and Optimisation Group - use of specific working task groups as required - e-PR programme included as standing agenda item at Executive and Senior Leadership Group meetings		appropriate method of control, are being followed by staff or are being monitored and reviewed Communication - human factors and behaviours may be as a result of information fatigue and or culture/change acceptance Education, training and competency - accessing e-Coach may not be clearly understood or being utilised effectively by staff Emergency preparedness, response and resilience - limited assurance major incident and business continuity plans covering digital and clinical management systems may not be reviewed, tested, updated or followed to reflect e-PR implementation Governance - work underway to review longer term governance structure and arrangements to support the digital transformation journey - limited assurance monitoring and review of data within e-PR is being assessed to determine how well it is being used and of driving improvements - impact on mandatory national and local audit activity i.e. coding timelines, delays and observed changes in coded diagnosis reducing numbers of expected cases for submission - data behind GIRFT metrics and model hospital data is not being updated in a timely manner Staff safety - limited assurance HR/occupational health systems are being monitored against implementation to determine whether major system change is having a negative impact on staff health and wellbeing

	- progress on those key control issues identified undertaken at weekly Cerner incident management team meetings - monitoring and performance management of incidents reported through DATIX and IT helpdesk following system go live - learning from themes and trends converted into videos or quick reference guides and uploaded onto e-Coach - operational teams monitoring and reviewing clinical pathways - escalations, monitoring and performance discussed at ICB assurance meetings - governance arrangements to be reviewed in Jan-24 - ongoing assessment of staff feedback, incidents and problems raised through operational teams are assessed to look at change requests and training requirements Digital - completion of build work and excessive technical testing - all critical systems directly and indirectly managed by data and digital - 24/7 systems support in place - significant amount of business intelligence system data quality and usage reporting - consistent monitoring of clinical management systems and support via IT helpdesk - service desk e-PR tickets are continuously monitored - robust process in place for change requests Patient and staff safety - no patient or staff harm at present Task based - evaluation of issues undertaken by multi-disciplinary teams e.g. digital, clinical operational teams, learning and development, improvement hub, system support and leadership etc. through in person and observations utilising SPE+ improvement methodology		

Update since the last report	**Update 07/04/2025** **Change in Exec Lead. No change in risk score** Data and digital board is working on addressing the risk by segmenting into various functional components. These will reflect challenges that range from embedding of the system to upgrades required to maintain the functionality of EPR. A number of work stream are currently looking into coding, training, data accuracy and optimising of the pathways to improve the functionality of EPR **Next Review Date 06/05/2025**	**Date last reviewed**	**07/04/2025**			
		Risk by quarter 2025-26	**Q1**	**Q2**	**Q3**	**Q4**
			20			
		8-week score projection	**20**			
		Current issues	System wide external influences			

No	ID	Title				
9	9777	**Loss of Education, Research and Innovation Accommodation and Facilities**				
Lead		Risk Lead: A Appiah Exec Lead: T McDonald	**Current score**	**16**	**Score Movement**	
Description		There is a risk that the buildings at Park View Offices at Royal Blackburn Teaching Hospital and the Training and Development Centre at Burnley General Hospital hosting will be decommissioned due to disrepair and investment that will impact on the teaching hospital accreditation with no other alternative accommodation to enable DERI to meet current and future training needs.		**Gaps and Potential actions to further mitigate risk**		
Controls and Assurances in place		**Controls** 1 Estates and Facilities Premises Assurance Model 2 Business continuity plan in place 3 Relocation of a number of services to alternative accommodation 4 Investment made into maintaining classroom and teaching IT portable equipment should DERI need to move location 5 Ward simulation suite has been built and completed **Assurances** 1. Scoping exercise undertaken to determine type and size of space required and alternative locations in readiness for any potential move of the service 2. Walkaround building environmental assessment completed. Whilst investment was required to fix the external fabric of the building it was safe and fit for purpose for DERI services to remain in situ for the time being. 3. Building issues monitored weekly via DERI SLT meetings and monthly safety meetings. 4. Daily monitoring and observations undertaken by education centre team 5. Discussions taking place between estates and facilities and DERI with Calico developers to explore potential opportunities for relocation. 6. Maintenance issues reported via Equans / Estates and Facilities helpdesk and via Datix where appropriate 7. Steering Group established to review remedial work requirements			**Gaps / weaknesses in controls** 1 Financial constraints and limited access to funding to improve existing centres. 2 Some maintenance and remedial works still required to ensure the building remains fit for purpose. 3 Secondary issues may manifest if remedial work is not carried out e.g. damp, mould, rotting windows etc. further adding to costs. 4 Ward simulation suite cannot host all research, education and innovation activity. **Gaps / weaknesses in assurances** 1. Assessment outcomes have identified deficiencies with building infrastructure and maintenance.
Update since the last report		**New Risk** There is a significant impact on already existing pressures within education and research with no sufficient alternative accommodation to enable DERI to meet current and future training needs, minor works undertaken to improve seminar rooms **Next Review Date** 06/05/2025		**Date last reviewed**	**07/04/2025**	
				Risk by quarter 2025-26	**Q1**: 16	**Q2**:	**Q3**:	**Q4**:
				8 week score projection	**16**			
				Current issues				

No	ID	Title
10	9746	**Inadequate funding model for research, development and innovation**

Lead	Risk Lead: J Owen Exec Lead: M Ireland	Current score	16	Score Movement	⟺

Description	The Research, Development and Innovation Service within DERI is not centrally funded by the Trust. It is financed through complex funding streams such as the National Institute for Health Research (NIHR), Clinical Research Network (CRN) Greater Manchester and from income generated from commercial and non-commercial research activity. This model of funding is no longer sustainable	**Gaps and potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1 Commercial and non-commercial study income subject to change without warning leading to fluctuations in income or performance expected for funding provided and is non recurrent making forecasting extremely challenging. 2 Failure to look at funding model of Research, Development and Innovation could result in significant and rapid loss of highly skilled workforce and infrastructure severely damaging the Trust's ability to deliver vital ground breaking research for patients. These staff groups are specialised and once lost will take a considerable amount of time to re-establish. 3 Income generated from research and innovation rarely provides a within financial year return on investment in staffing resource and can take a few years for a new post to develop the surrounding portfolio within the service and is subject to exterior pressures within clinical and support services. 4 Research support function and SMT does not directly generate income, but is vital to support the research activity, be that developed research or hosted. The skilled expertise and advice given to prospective researchers helps increase potential for successful funding applications. Average success rate for grant applications is 17%, with unsuccessful grant applications still requiring support. 5 Not replacing staff has increased risk of not being able to deliver certain functions of the service, as well as increased pressure and stress on staff remaining, with current pressures unsustainable. **Gaps / weaknesses in assurances** 1 Rebalancing research portfolio to include more income generation from commercial research is happening but takes time to grow and establish. 2 Generated income limited without a dedicated research facility as clinical priority will take precedence for capacity (including support services). 3 Current recruitment freeze to non-clinical roles having an impact on staffing capacity to deliver current and expand research portfolio in line with DERI strategy and Research Plan. 4 Future benefits of investment realised over a longer trajectory such as research capability funding and income generation
Controls and Assurances in place	**Controls** 1. Finance within DERI moved from substantive education posts into research. 2. Investment in additional resources (B6 0.4 WTE and B4 0.2 WTE) for a six month period has allowed for better scrutiny and control of contractual and financial assessment of projects, timely raising of invoices and chasing aged debt. 3. Agreed proposals within business plan will see consistency in approach and alignment with other NHS organisations. 4. Procurement of Edge Research Management System allows for improved efficiency at capturing and costing for research activity and better financial oversight that was previously held. **Assurances** 1. Annual negotiations held with NIHR and CRN to proportionately increase investment to reflect balance and expansion of research portfolio across services allowing for movement of some posts to the CRN funding stream. 2. Fortnightly finance meetings between R&I Accountant, Deputy Divisional Manager for DERI and Head of R&I Department to review income and budgets. 3. Additional funding routes and benchmarking of financial models across other NHS organisations being explored. 4. Engagement with senior finance personnel and good lines of communication with executives to form a collaborative approach to the business plan.		

Update since the last report	**Update 07/04/2025** **Change of Exec Lead. No change in risk score.** Lead of finance project handed over in Jan-25. Work progressing with new delivery teams joining to organise finance. Since Dec-24 project has added £57k of finance activity into the tracking system EDGE. Prioritisation exercise took place to close studies where contractual targets have been met and not accept amendments to studies where targets were met to allow teams to focus on income generating activity **Next Review Date 06/05/2025**	**Date last reviewed**	**07/04/2025**			
		Risk by quarter 2025-26	**Q1**	**Q2**	**Q3**	**Q4**
			16			
		8-week score projection	**16**			
		Current issues	System wide external influences			

No	ID	Title
11	9545	**Potential interruption to surgical procedures due to equipment failure**

Lead	Risk Lead: J Preston Exec Lead: S Simpson	**Current score**	**16**	**Score Movement**	⇩

Description	Theatre items that are out of service or obsolete pose a significant risk of complete failure which will impact on service delivery and patient safety. These items include theatre stack systems and Integrated theatre solutions which are now out of service contract. Additional critical medical devices and items are also due to be without support in the short and medium term	**Gaps and potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1 No spare parts availability internally or with supplier 2 Supplier has confirmed items now obsolete and replacement parts are no longer available 3 Possibility for loan kit to be unavailable 4 Potential for equipment to break and be no longer available 5 Field Safety Notices are not applicable as failure is due to age of equipment 6 Planned preventative maintenance of equipment for obsolete items is not included as part of contractual arrangements 7 A review of the responsibilities and arrangements within the medical devices policy is required **Gaps / weaknesses in assurances** 1 Increasing numbers of incidents identified 2 Meetings of the Medical Devices Management Group have not consistently taken place to allow monitoring and overview of equipment service contracts 3 Potential failure to report incidents of equipment issues or breakages 4 Delays in progress of the task and finish group may be experienced due to financial pressures
Controls and Assurances in place	**Controls** 1 Loan kit ordered when equipment broken if available (parts and items dependent) 2 Theatre staff fully trained and competent to work the equipment 3 Specialty scheduling and theatre oversight in place 4 Service contracts in place jointly managed between EBME and Theatres 5 Policy in place for the lifecycle management of medical devices monitored by the Medical Devices Management Group 6 Managed service in place for some equipment **Assurances** 1 Capital bids process in place 2 Business case to propose moving to a managed service and potential solution to the risk accepted by Board 3 Good relationship with and support from EBME, supplier and company representative 4 Breakages of choledoscopes fully investigated with theatres, EBME and supplier with the outcome of investigations finding no particular trend, with some breakages due to fragility of equipment and increased complexity of cases 5 Task and Finish Group established to progress replacement of equipment and managed service option 6 Monitoring at theatre and divisional meetings 7 Monitoring of incidents linked to risk and likelihood scoring criteria 8 Regular updates provides to Senior Exec Team		
Update since the last report	**Update 08/04/2025** **Change of risk lead. Risk score reduced from 20 to 16** Upgrades to integrated theatres delayed due to lifecycle works at RBH being delayed for delivery. New programme to be confirmed, but likely to be done Apr-May 25 **Next Review Date 07/05/2025**	**Date last reviewed**	**08/04/2025**
		Risk by quarter 2025-26	**Q1**: 16 / **Q2**: / **Q3**: / **Q4**:
		8-week score projection	**16**
		Current issues	Management of Medical Devices

No	ID	Title				
12	8061	**Patients experiencing delays past their intended clinical review date may experience deterioration**				
Lead		Risk Lead: A Marsh Exec Lead: S Gilligan	**Current score**	**16**	**Score Movement**	⟺
Description		Patients are waiting past their intended date for review appointments and subsequently coming to harm due to a deteriorating condition or from suffering complications as a result of delayed decision making or clinical intervention.	**Gaps and Potential actions to further mitigate risk**			
Controls and Assurances in place		**Controls** 1 Red, Amber, Green (RAG) ratings included on all outcome sheets in outpatient clinic. 2 Restoration plan in place to restore activity to pre-covid levels. 3 RAG status for each patient to be added to the comments field on the patient record in Outpatient Welcome Liaison Service (OWLS) to capture current RAG status. This will allow future automated reports to be produced. 4 All patients where harm is indicated or flagged as a red rating to be actioned immediately. Directorates to agree plans to manage these patients depending on numbers. 5 A process has been agreed to ensure all follow up patients in the future are assigned a RAG rating at the time of putting them on the holding list. 6 Process has been rolled out and is monitored daily. 7 Underlying demand and capacity gaps must be quantified and plans put in place to support these specialities in improving the current position and reducing the reliance on holding lists in the future. 8 Administrator appointed to review all unknown and uncoded patients requesting clinical input and micromanagement of red patients in chronological order to find available slots. **Assurances** 1 Updates provided at weekly Patient Transfer List (PTL) meetings. 2 Daily holding list report circulated to all Divisions to show the current and future size of the holding list. 3 Meetings held between Divisional and Ophthalmology Triads to discuss current risk and agree next steps. 4 Requests made to all Directorates that all patients on holding list are initially assessed for potential harm due to delays being seen, with suitable RAG ratings applied to these patients. 5 Specialties continue to review patients waiting over 6 months and those rated as red to ensure they are prioritised. 6 Audit outcomes highlighted no patient harm due to delays. 7 Meetings held with Directorate Managers from all Divisions to understand position of all holding lists. 8 Individual specialities undertaking own review of the holding list to identify if patients can be managed in alternative ways. 9 Updates provided weekly to Executive Team.		**Gaps / weaknesses in controls** 1 Holding list remains high due to backlog from COVID-19. 2 General lack of capacity across specialties impacting on reducing holding list numbers. 3 Not all staff are following standard operating procedures for RAG rating of patients, leaving some patients without a rating. **Gaps / weaknesses in assurances** 1 Automated reporting system in development that will ensure oversight of risk stratified lists by specialty. 2 Current level of patients without a RAG rating classed as uncoded and unknown. 3 Patient appointments not RAG rated will drop onto the holding list if appointments are cancelled. 4 Patients added onto the holding list from other sources such as theatres, wards etc will not have a RAG identified.	
Update since the last report		**Update 07/03/2025** **Risk reviewed. No change in risk score** Continuing increase in volume of patients and time constraints due to competing waiting list demands. Upward trend in the last three months. More accurate reporting now available **Next Review Date 06/05/2025**	**Date last reviewed**	**07/03/2025**		
			Risk by quarter 2025-26	**Q1**	**Q2**	**Q3**	**Q4**
				16			
			8 week score projection	**16**			
			Current issues	Recovery and restoration pressures, recruitment and retention			

No	ID	Title				
13	8033	**Increased requirement for nutrition and hydration intervention in patients resulting in delays**				
Lead		Risk Lead: M Davies Exec Lead: P Murphy	**Current score**	**16**	**Score Movement**	⟺
Description		Failure to meet nutrition and hydration needs of patients as set out within the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which sets out the requirements for healthcare providers to ensure persons have enough to eat and drink to meet nutrition and hydration needs and receive support in doing so.		**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1 Non adherence to policy and procedural controls. 2 Inconsistent, inaccurate assessments and recording of malnutrition risk. 3 Lack of appropriate use of safeguarding processes. 4 Limited capacity of speech and language therapists, dietetics, endoscopy and nursing, including bank and agency, delaying assessments and impacting on feeding routes. 5 Limited capacity of nutrition support team undertaking ward rounds. 6 Lack of available housekeepers at weekends. 7 Training gap regarding nutrition and hydration training identified within doctors curriculum. 8 No process in place for the recording and review of non-mandatory training compliance. **Gaps / weaknesses in assurances** 1 Staff knowledge and confidence questionable in use of safeguarding processes in these cases. 2 No review of nutrition and hydration at ward rounds or timely best interest decisions. 3 Not all patients are weighed, with an over reliance on estimation of weight, not actual. 4 Recording of information in multiple places. 5 Current electronic 'MUST' toolkit insufficiently used to gather compliance reports and prevents healthcare assistants inputting weights. 6 Access to the nutrition support team is limited and instigated by dieticians and nutrition nurses rather than referral from ward. 7 Insufficient information provided in referrals to dieticians and speech and language therapists. 8 Timely review of blood results relating to parenteral feeding. 9 No medical representation at the Nutrition and Hydration Steering Group.	
Controls and Assurances in place		**Controls** 1 Regulatory requirements and guidance written into nutrition and hydration provision to inpatients, parental nutrition, enteral feeding, refeeding, mental capacity and safeguarding adults policies and procedures. 2 Standard operating procedures and tools in place i.e. ward swallow screen, electronic malnutrition screening tool, food record charts and fluid balance, nasogastric tube care bundle, food for fingers and snack menus and nutrition and hydration prompts on ward round sheets. 3 Inclusion within Nursing Assessment and Performance Framework (NAPF) and ward managers audits 4 Training provided to staff that includes malnutrition screening, nasogastric tube replacement, nasogastric x-ray interpretation and nasogastric bridle, mouthcare, malnutrition identification and management, fluid balance, Percutaneous Endoscopic Gastronomy (PEG) management and food hygiene. **Assurances** 1 Nutrition and hydration prompt on ward round sheets 2 Inclusion within ward manager audits. 3 Monitoring of incidents and levels of harm, complaints, patient experience outcomes etc. as part of divisional reports. 4 Outcome results form part of the work plan of the Nutrition and Hydration Steering Group. 5 Inclusion via Nursing Assessment and Performance Framework (NAPF).				
Update since the last report		**Update 07/04/2025** **Risk Reviewed. No change in risk score** Rise in nutrition and hydration related incidents primarily related to SLT and MUST performance. Full risk review required **Next Review Date 06/05/2025**		**Date last reviewed**	**07/04/2025**	
				Risk by quarter 2025-26	**Q1**	**Q2**	**Q3**	**Q4**
					16			
				8 week score projection	**16**			
				Current issues	Recovery and restoration pressures, recruitment and retention			

No	ID	Title
14	7165	**Failure to comply with RIDDOR**

Lead	Risk Lead: J Houlihan Exec Lead: T McDonald	Current score	16	Score Movement	⟺

Description	Failure to provide quality assurance of legislative compliance regarding the reporting of certain types of injuries, diseases and dangerous occurrences to the Health and Safety Executive (HSE) within set regulatory timescales	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. Delays determining RIDDOR due to increasing volume and complexity of accidents and incidents requiring review and investigation 2. Limited assurance managers and staff are following policy or procedural controls regarding reporting of accidents or incidents, of this being highlighted or captured within management systems or processes or it being performance managed 3. No standardised investigation process or quality management system used to capture total numbers of days lost off work (LTI) as a result of workplace accident or injury leading to absence, avoidance or duplication 4. Introduction of patient safety learning response timescales identified as part of the new Patient Safety Incident Response Framework (PSIRF) may delay incident investigations and their subsequent impact on external regulatory reporting requirements 5. Improvements in compliance heavily reliant on major changes to incident management and triage processes and limited capacity and resource within the health and safety team 6. Lead specialisms and or SME's not being utilised effectively regarding review and investigation of incidents within their own areas of responsibility and control and determining external reporting requirements of RIDDOR when undertaking investigations 7. Investigations to determine RIDDOR highlighting gaps in quality safety management systems or processes, policy and procedural controls in particular risk assessments, not being followed or undertaken by managers and staff **Gaps / weaknesses in assurance** 1. RIDDOR performance increasingly attracting the interest of the HSE and CQC 2. No evidence of assurance lead specialisms or SME's in safety critical roles benchmarking or using RIDDOR performance as an important driver in reducing mitigating risks or improving safety management systems, processes or behaviours 3. Numbers of accidents and incidents being reviewed or investigated by the health, safety and risk team to determine RIDDOR status account for 25-30% of all accidents and incidents reported in DATIX. This continues to significantly impact on the work and resources of the team i.e. 6,539 were reviewed or investigated in 2021/22, this increased to 6,713 in 2022/23 and 6.725 in 2023/24. Current FYTD incidents total 5,947 (Jan-25) with numbers projected to exceed previous year figures 4. There has been a 50% increase in RIDDOR reportable incidents compared to the previous FYTD from 38 in 2022/23 to 57 in 2023/24. A total of 37 RIDDOR reportable incidents have occurred this FYTD, 11 of which have been reported outside of timescales 5. The threshold level of achieving 95% compliance continues to remains in place
Controls and Assurances in place	**Controls** 1. Responsibilities of staff to report accidents and incidents in a timely manner using Datix contained as part of the incident management policy 2. RIDDOR reporting requirements contained as part of the incident management policy controls 3. Responsibilities of staff to report any health concerns contained within health and safety at work policy 4. Improved data capture and utilisation of incident management module of DATIX 5. Centralised process firmly established for health and safety team to review and submit RIDDOR reportable incidents externally to the HSE 5. Days lost off work as a result of a workplace accident or injury captured as part of the HR sickness management and return to work processes 6. Increased management and staff awareness and understanding of RIDDOR i.e. what is and what is not reportable, consequences and timescales involved, relevant work examples and the issue of guidance 7. RIDDOR awareness training rolled out to targeted staff groups i.e. members of the health and safety committee, lead specialisms and or subject matter experts, occupational health services, divisional quality and safety leads and teams and patient safety investigation leads. Further ad hoc training across divisional groups available, where necessary 8. Increased senior management awareness of RIDDOR to help drive and reinforce importance of ensuring legislative compliance 9. New Occupational Health Management System OPAS-G2 now being used to capture and inform of the types of medically diagnosed occupational related disease, infections and ill health identified as being RIDDOR reportable 10. New RIDDOR process introduced in Oct-24. Refresher RIDDOR awareness training completed in Sep-24 to support new process **Assurances** 1. Review of legal requirements and compliance regularly undertaken 2. Specialist advice, support and guidance on RIDDOR reporting requirements readily available 3. Continuous monitoring and review of all accidents and incidents to staff, patients, contractors and members of public undertaken by health, safety and risk team 4. Thematic review of RIDDOR performance included as an agenda item of the Health and Safety Committee, with escalation and or exception reporting to the TWQG and Quality Committee, where necessary 5. RIDDOR reportable occupational disease more explicitly included within occupational health performance reporting 6. Collaborative working partnerships strengthened with clinical and non-clinical service specialisms and safety critical roles e.g. matrons, ward managers, patient safety lead investigators, incident and triage team, infection control, occupational health, estates and facilities, human resources, legal services, falls lead, manual handling lead, security management etc. should any significant trends be identified 7. Attendance of health and safety team at weekly complex case review meetings to identify and determine RIDDOR reportable incidents to patients 8. RIDDOR performance included as part of QG KPI metrics for senior management oversight and review 9. A 10% target to reduce numbers of RIDDOR reportable incidents remains in place for 2024-25. A 35% reduction has been achieved this FYTD 10. Steady increase in RIDDOR reporting compliance rates from 56% in 2023-24 to 70% at present (end Jan-25)		
Update since the last report	**Update 07/04/2025** **Risk Reviewed. No change in risk score.** Compliance rates have improved from 56% to 71% at present that will support mitigation of this risk and a reduced risk score. **Next Review Date 06/05/2025**	**Date last reviewed**	07/04/2025
		Risk by quarter 2025-26	Q1: 16 / Q2 / Q3 / Q4
		8 week score projection	16
		Current issues	Systems, capacity and workforce pressures

No	ID	Title				
15	10095	**Cardiology PAC issues impacting on efficiency and ability to meet targets and obstructive workflow**				
Lead		Risk Lead: K Thomson Exec Lead: S Simpson	**Current score**	**15**	**Score Movement**	
Description		The current change cardiology PACS system used is EOL. There is a risk of cardiology PAC issues impacting on efficiency and ability to meet targets.		**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1 Poor functionality of existing system. 2 System supplier unable to resolve issues. 3 Compatibility with existing IT infrastructure in supporting upgrade 4 Potential cyber vulnerability of Change healthcare 5 Business continuity plans for failure revert to paper copy with no image storage availability 6 Impact on existing workforce pressures, clinical time and delayed diagnosis and treatment **Gaps / weaknesses in assurances** 1 Delays in estimated target date for new platform 2 Failure to meet deadline and resulting contract extension and upgrade at financial cost 3 No assurance of upgrade installation 4 Unpredictability of reporting system workflows and demands 5 Numbers of incomplete reports increasing 6 No assurance of upgrade installation	
Controls and Assurances in place		**Controls** 1 Purchase of cardiology PACS system upgrade 2 Change contract with maintenance support 3 IT member trained in change cardiology PACS system solution 4 Local super users for frequent basic troubleshooting 5 Business continuity plans up to date for major incident and failure. **Assurances** 1 Still running on old system 2 Finance directed towards upgrades. 3 Meetings with IT and IBC for future solutions 4 Engagement with system engineers to resolve current system issues 5 Incident reporting system and process in place				
Update since the last report		**New risk** Funding has been released for upgrade of the system but no indication at present when this will take place **Next review date** 06/05/2025		**Date last reviewed**	**07/04/2025**	
				Risk by quarter 2025-26	**Q1**: 15	**Q2**:	**Q3**:	**Q4**:
				8 week score projection	**15**			
				Current issues				

No	ID	Title
16	9900	**Poor identification, management and prevention of delirium**

Lead	Risk Lead: P McManamon Exec Lead: S Islam	**Current score**	**15**	**Score Movement**	⟺

Description	National Institute of Clinical Excellence (NICE) guidance relating to the identification, assessment, management and prevention of delirium in acute hospital settings is partially and or not being met	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. Existing digital flow requires doctors to complete delirium assessment through task list and not through ad hoc to complete task with additional training required 2. Staff awareness of SQID / Digital Delirium Care Plan requires additional awareness and training 3. Compliance with dementia audits and outcomes requires stronger divisional support. Deputy Chief Nurse requested dedicated monthly delirium audit data to be escalated 4. The training module for delirium is not a mandatory training requirement and does not fully mitigate the risks associated with delirium. 5. Published guidance and recommendations (agitated delirium in elderly) are not always followed. **Gaps / weaknesses in assurances** 1. Poor compliance with pilot assurance measures with further monthly audits planned required 2. New delirium workflow not embedded in daily practice with further training devised and planned 3. Work to create an investigation prompt for clinicians as part of the delirium diagnostic work flow and to assist clinical judgement underway.
Controls and Assurances in place	**Controls** 1. Single Question to Identify Delirium (SQID) now live on Cerner. A positive SQID issues a delirium diagnostic assessment task to doctors lists 2. Digital delirium bundle and assessment in place for clinical teams investigating and managing delirium. This utilises 4AT as advised by NICE 3. Digital delirium prevention and management care plan now in place to support patients identified or at risk of delirium which issues a delirium diagnostic assessment is positive or unsure 4. A delirium awareness training module is available to staff with rapid tranquilisation training in support. 5. Available guidance on agitated delirium in elderly persons. 6. Patients with suspected delirium can be referred to relevant specialist nursing teams for support and review where required. **Assurances** 1. Delirium reports and updates produced and shared at dementia strategy meetings and the patient experience group. 2. A dementia champion documentation audit is being piloted monthly that includes seeking assurances of the effectiveness of delirium assessments. 3. Additional monthly delirium data reports for escalation 4. A share point site has been created for signposting and resource identification. 5. A training programme is in place to deliver delirium awareness key points training. 6. Further training packages for nursing and resident doctors will be implemented to ensure new digital delirium flow is embedded 7. A nationally accredited delirium awareness e-learning module has been added to the learning hub.		
Update since the last report	**Update 07/04/2025** **Change of Exec Lead and Risk Handler. No change in risk score.** The initial results from a national audit of dementia has identified limited assurances regarding the effectiveness of delirium assessments on patients that require them with the delirium pathway significantly reducing effectiveness. **Next review date 06/05/2025**	**Date last reviewed**	**07/04/2025**

Risk by quarter 2025-26	Q1	Q2	Q3	Q4
	15			
8-week score projection	15			
Current issues	System wide influences			

No	ID	Title
17	9895	**Patients not receiving timely emergency procedures in theatres**

Lead	Risk Lead: N Tingle Exec Lead: S Islam	**Current score**	**15**	**Score Movement**	⇔

Description	There is a risk that increasing demand on the emergency theatre due to increased hospital acuity may lead to delays in patients not receiving timely emergency procedures.	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. No systematic approach in alerting and reviewing patients once listed. 2. No alert system when emergency patients have breached NCEPOD categorisation and not had timely emergency procedure. 3. Standing down of elective theatres or opening second theatres not always possible due to capacity and clinical priorities of elective patients. 4. Financial impact of cancellations on day of elective patients. 5. No bed capacity for surgical patients. 6. Not all cases are appropriately listed due to MDT requirements, times unknown, case complexity etc. which impacts on oversight at scheduling. 7. Known complex overruns are not always staffed requiring emergency staff to cover. 8. Regular overrun of elective theatres requires staff to relieve others who have to go home. Only six theatre staff available resulting in stopping of theatre six. 9. Limited assurance policy and procedural controls are effective or are being followed. 10. Reliance on voluntary staffing of capacity lists. 11. Weekend capacity stopped due to financial challenges **Gaps / weaknesses in assurances** 1. Potential for inappropriate categorisation when booking emergency patients. 2. Failure to discuss patient safety and risk at theatre triad and at divisional and directorate meetings. 3. Incident reports not always completed or capture severity of harm as unknown if there is a delay to surgery or disease progression. 4. Issues not highlighted if coordinator is not on duty. 5. Actions from meetings may not be enacted upon 6. Failure to manage capacity list due to lack of resource. 7. Additional sessions cancelled due to financial challenges
Controls and Assurances in place	**Controls** 1. All patients listed in accordance with NCEPOD guidance and time to theatre. 2. Patients reviewed by medical team to ensure they remain appropriately categorised and have not deteriorated. 3. Standing down of elective theatre based on clinical urgency and prioritisation. 4. Escalation standard operating procedure in place for patient flow. 5. Scheduling to ensure elective theatres are run in accordance with session time. 6. Senior theatre coordination and duty anaesthetist ensure efficient running of all operating theatres to prevent overrun. 7. Policy arrangements in place for ensuring elective procedures are booked in a timely manner to facilitate correct staffing for the elective capacity. 8. Additional second theatre at weekends to cover capacity. **Assurances** 1. Daily review of acuity of emergency list and capacity to assess availability of opening a second emergency theatre where required. 2. Theatre triad, directorate meetings held to discuss patient safety and risk at divisional and theatre directorate level. 3. Monitoring and review of incidents. 4. Emergency coordinator highlights capacity issues to duty anaesthetist and theatre operational manager. 5. Scheduling and oversight meetings in place for elective lists 6. Business case being made for additional theatre sessions.		
Update since the last report	**Update 18/04/2025** **Change of Exec Lead. No change in risk score** Additional Sunday capacity list for emergency patients stood down due to financial challenges **Next review date 16/05/2025**	**Date last reviewed**	**18/04/2025**

Risk by quarter 2025-26	Q1	Q2	Q3	Q4
	15			

8 week score projection	**15**
Current issues	Recovery and restoration pressures, recruitment and retention

No	ID	Title				
18	9851	**Lack of standardisation of clinical documentation process and recording in Cerner**				
Lead		Risk Lead: C Owen Exec Lead: S Simpson	**Current score**	**16**	**Score Movement**	⟺

Description	The introduction of Cerner e-PR system has created changes in documentation processes with numerous ways to navigate system and document information resulting in a lack of document standardisation requiring coordination, of providing policy and procedural guidance, education and support and effective ways to audit compliance of new systems and processes. This could result in omission of documentation, evidence of care, duplication or contradictory information relating to provision of care and potential that processes no longer align to clinical management policies, standard operating procedures and national guidance, with elements of documentation captured in existing audits no longer available to view.	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. Staff unaware of variation of processes in Cerner at go live so all processes need review and agreement to standardise. 2. Compliance audit reporting for some elements may not be possible or align to Cerner. 3. Unable to set up compliance reports until agreement of standardised process. 4. No electronic document management system or guidance on scanning in place. **Gaps / weakness in assurance** 1. Due to the volume of change requests and system analyst capacity, the alignment of system builds, audit and policy review is taking time to work through and prioritise. 2. Availability of lead experts to review system and advise and update policies is a timely process. 3. Limited assurance of monitoring scanning activity. 4. Limited capacity of reporting team to work on clinical reporting due to pressure for business as usual reports and resolving data quality issues for operational reporting.
Controls and Assurances in place	**Controls** 1. Appointment of Chief Nursing Information Officer (CNIO) in post. 2. New Integration Architect recruited to assist and upskill system analysts to execute change requests. 3. Head of Nursing leading review of effectiveness of clinical management policy and procedural controls, risk assessment processes and care plans. 4. Library of quick reference guides on step by step instructions on common processes available via e-coach. 5. Training videos available on OLI, YouTube and Learning Hub. 6. Review of clinical documentation included as part of Nursing Assessment and Performance Framework (NAPF). 7. Standardisation of clinical information and records management now obtained and can be audited. 8. Ward manager training delivered by CNIO to all ward managers to standardise nursing documentation. 9. EPR Adoption and Optimisation Group established to tackle lack of standardised work through production and ratification of policy and standard operating procedures **Assurance** 1. Key processes lacking in standardisation are being identified. 2. Assurances provided by policy authors of effectiveness of policy, procedure and risk assessment controls being aligned to Cerner. 3. Escalation process for Cerner related issues in place. 4. Engagement groups with staff and subject leads in progress to understand the issues. 5. A clinical records management group has been established to monitor and receive assurance of compliance. 6. Nursing risk assessments now available via systems reporting portal with other reports awaiting development. 7. Mini NAPF and audits of clinical areas undertaken by matrons with outcomes shared and enacted upon. 8. 93% of staff received training on Cerner e-PR before 'go-live' date. All new staff complete training on start of employment. 9. Ongoing updates, including changes or handy tips, issued via trust wide approved communication systems. 10. Creation of One LSC model allows for pooling of resources across the region that will help address capacity. 11. Upskilling of SA by IA ongoing. 2 team members can also now build in system 12. Ward manager training completed and positive		

Update since the last report	**Update 07/04/2025** **Risk reviewed. No change in risk score** Ward manager training has been undertaken and care plan training video is due for release later in the month. Due to a lack of compliance reporting unable to provide assurance training has had the desired impact. ICS wide EDMS task and finish group set up and led by LTH. A separate risk regarding scanning and uploading of documentation is being created to capture clinical management and organisational oversight risk. **Next Review Date 06/05/2025**	**Date last reviewed**	**07/04/2025**			
		Risk by quarter 2025-26	**Q1**	**Q2**	**Q3**	**Q4**
			15			
		8 week score projection	**15**			
		Current Issues	System wide influences			

No	ID	Title
19	9653	**Increased demand with a lack of capacity within ELHT can lead to extreme pressure**

Lead		Current score	16	Score Movement	⟺

Lead: Risk Lead: J Dean; Exec Lead: P Murphy

Description

There is an increased risk extreme escalation to increase capacity within hospital environments will result in patient and staff physical and or mental harm as well as increasing privacy and dignity issues, hospital acquired infection, complaints, poor patient experience and reputational damage.

Controls and Assurances in place

Controls

1. Ward area risk assessments in place and reviewed where escalation bed space is to be opened.
2. Patients assessed by senior nurse on duty to ensure most appropriate patient is identified to be cared for in escalation bed.
3. Portable nurse call systems in place for additional beds to enable patients to alert staff when required.
4. Temporary storage made available as required.
5. Patient medications are stored within ward medication trolleys.
6. Patients placed onto the escalation bed are to be self-caring and able to stand to aid transfer to bathroom where possible.
7. Patients requiring electrical equipment or oxygen therapy are not to be allocated bed space.
8. Emergency equipment available if unexpected deterioration is experienced.
9. All staff to ensure adherence to infection prevention control policy and procedural controls.
10. Standard operating procedure in place to support and strengthen decision making of patient selection and placement when using escalation bed and trolleys.

Assurance

1. When escalation trolley is in use, the ward risk assessment is reviewed each day.
2. Assessment is signed by appropriate staff to confirm required needs are being met each time the area is opened.
3. A signature sheet is kept with the ward assessment and compliance of its use audited as required.
4. Extra equipment in use to support bed space e.g. patient call alarm, bedside table and crate for any belongings are being managed as per policy and procedural controls.
5. When equipment is not in use, it is the wards responsibility to ensure the electronic patient buzzer is kept on charge at the nurses station and checked twice daily as part of safety huddles.
6. Use of extreme escalation trolleys is monitored, incidents are reviewed, linked to the risk and investigated as appropriate, with lessons learned shared with staff.
7. The Electronic Patient Tracking System is updated to ensure the correct ward area is used at all times of extreme escalation.
8. Quarterly review of risk assessments are undertaken by the health and safety team via use of audits and incident review.
9. Monthly meeting are set up to review any incident reports received to identify any ongoing themes or increased risk.
10. When appropriate patients cannot be sourced to fill a surge trolley and the Trust is under extreme pressures and requires this capacity, beds will be utilised in the surge spaces as appropriate to maximise the use of these areas and increase overall capacity on the wards across MEC and SAS

Gaps and Potential actions to further mitigate risk

Gaps / weaknesses in controls

1. Lack of space around bed area affecting personal care and impacting on patent and staff safety.
2. Reduced access to electrical power sockets, oxygen and suction, overhead lighting and trailing wires and cables have increased slips, trips and fall hazards.
3. Reduced space where escalation bed is positioned has increased risk of patient falls due to compromised observation of patients and additional equipment in the area and is impacting on safer handling of patients and infection prevention and control adherence.
4. Privacy and dignity may be compromised due to privacy screens not allowing the same privacy as the curtains.
5. Poor patient experience leading to increased patient and relatives concerns being raised and potential risk of increased formal complaints and potential reputational damage.
6. Reduced space around bed/trolley for staff to safely deliver care. Lack of amenities for patients to enable them to be independent with some aspects of care e.g. no bedside table to provide access to personal belongings and diet and fluids within their reach.
7. Potential staff harm due to inability to safely handle patients and increased equipment in area
8. Increased nurse anxieties due to managing medical staff's expectations.
9. Staff morale and wellbeing may be reduced due to increased workload and managing patients and visitors expectations.
10. Due to the number of nursing vacancies and high agency or bank usage, there may be times, in particular, overnight, when the ward team are very junior and may be under already significant pressures leading to heightened stress and anxiety.

Gaps / weakness in assurance

1. Reduced space between bed spaces not adhering to national guidance and potential to increase risk of hospital associated infections.
2. Capacity and demand cannot be predicted.
3. Patients refusing to move to the trolleys if they are in bed.
4. Inability to find suitable patients to go onto the trolleys due to acuity or dependency.

Update since the last report

Update 07/04/2025
Risk reviewed. No change in risk score.
Difficulties in sourcing appropriate patients at times of extreme pressure to be nursed on trolleys as a surge patient on the ward. SAS have reviewed this position and have sourced beds to allocate patients onto instead of surge trolleys to maximise the use of these areas. This does reduce space between these two bed and has been risk assessed.

Next Review Date 06/05/2025

Date last reviewed	07/04/2025			
Risk by quarter 2025-26	**Q1**	**Q2**	**Q3**	**Q4**
	15			
8 week score projection	15			
Current Issues	System wide influences			

No	ID	Title
20	9301	Risk of avoidable patient falls with harm

Lead	Risk Lead: D Simpson Exec Lead: P Murphy	Current score	15	Score Movement	⇔

Description	Failure to prevent patient slips trips and falls resulting in avoidable harm due to lack of compliance / assurance with Local and National policies / procedures	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. Lack of consistency / compliance with local assurance tools including enhanced care scoring tool and patient risk assessments 2. Lack of consistency in approach following a fall with harm on a ward (currently bespoke input to ward area to assure patient safety for all patients on the ward which is dependent on initial review findings 3. Falls checklist to be built directly into DATIX to reflect other checklists, i.e. pressure ulcers 4. No trust wide falls action plan as patients coming to harm following a fall are reported through DATIX and investigated through divisional processes. This information is presented through a divisional quarterly report which are specific to their areas and provide assurance of actions, themes. trends and wider learning 5. Inconsistencies with staffing in relation to increased level of observation requirements for patients in our care and in accordance with the enhanced care policy 6. Inconsistencies with staff training in relation to understanding and delivery of enhanced levels of patient observation as per SOP004 (Levels of Enhanced care) 7. Inconsistencies in documentation on e-PR for falls prevention and management (change requests made Dec 23) **Gaps / weaknesses in assurances** 1. Increase in fracture neck of femurs as in-patient past 6/12 - 11 since Jan 23 any avoidable harm will be captured through the Falls Checklists completed and presented at divisional DSIRG meetings - learning shared at monthly Falls strategy group meeting and assurance through Divisional quarterly reports uploaded to ACTIONS within this risk 2. Increase in number of falls with avoidable harm to inpatients which have potentially contributed to the patient's death 3. Due to increase in falls contributing to patient death which has not seen previously the risk has been re-scored at 15 (understand that a consequence score should not change however death had not been seen previously so not scored as such but now this is evident this is felt to be a more accurate reflection of the risk 4. Due to this change it is felt that the falls collaborative work undertaken in 2015 should be revisited and reviewed in line with current practice and changes since COVID
Controls and Assurances in place	**Controls** 1. Patient falls included as part of the Trust's Patient Safety Incident Response Framework as a local priority for learning 2. 5 investigations completed on falls leading to #NOF and themed to identify safety improvements 3. Completion of investigations for all inpatient falls resulting in moderate or above harm in line with the ELHT Patient Safety Incident Response Framework 4. Falls investigation reports are carried out by appropriately trained nurses from the clinical areas which are reviewed through the DSIRG process for Patient Safety Response investigations at Divisional level and by PSIRI for STEIS reportable incidents monthly 5. Enhanced care scoring tool in place with appropriate SOP (SOP004 Levels of enhanced care) enhanced care e-learning accessible on the learning hub, enhanced care lead nurse in post and developing a digital solution for staff to undertake a patients enhanced care score (this is currently a paper process) 6. Multifactorial patient falls risk assessments in place monitored through monthly ward audits for assurance (following the implementation of e-PR) it was evident that a change request was urgently required as the information from the falls risk assessment was not being correctly pulled through to request a multi-factorial falls risk assessment which potentially led to lack of risk assessment compliance at patient level - this change request has now been actioned and issue resolved) 7. Falls strategy group meets monthly and represented by all divisions 8. Divisional falls action plans monitored through the falls steering group and uploaded to the risk quarterly. themes and trends following falls investigations are shared for learning across all divisions at the falls strategy group 9. Yellow ID badge introduced to identify staff undertaking enhanced care for patients at high risk of falls 10. Cohort bays are identified through appropriate "C" logo on doors entering the bay to increase staff awareness 11. Patients at risk of falls are identified daily at ward safety huddles 12. Enhanced care lead is recruiting a team of 30 enhanced care support workers who will support the most vulnerable patients in our care with appropriate supervision, interaction and observation 13. Falls checklist now aligned with PSIRF **Assurances** 1. Good monitoring tools in place across the wards and also links into Trust meetings at all levels (Directorate, Divisional sharing of incidents and lessons learned) 2. Falls summit action plan approved 3. Workshop planned with the falls strategy group to use a start stop continue approach to share and spread falls prevention strategies Trust wide		
Update since the last report	**Update 07/04/2025** **Change of risk handler. No change to risk score.** Falls summit undertaken and actions agreed. No falls with lapses in care with catastrophic consequences since Jan-24. Also data showing reduced number of falls generally since Apr-24 which will support a reduced risk score should no further catastrophic harm be seen. **Next Review Date 06/05/2025**	**Date last reviewed**	07/04/2025

Risk by quarter 2025-26	Q1	Q2	Q3	Q4
	15			

8 week score projection	12
Current issues	System wide influences

No	ID	Title				
21	8808	**Breaches to fire stopping and compartmentalisation at BGH**				
Lead		Risk Lead: J Houlihan Exec Lead: T McDonald	**Current score**	**15**	**Score Movement**	⟺
Description		There is a risk that breaches in fire stopping and compartmentalisation works within Phase 5 at BGH, a PFI building not owned by the Trust, may lead to rapid fire and smoke spread, endangering lives and critical healthcare service provision if rigorous fire safety inspection, maintenance and staff training protocols are not followed		**Gaps and Potential actions to further mitigate risk**		
Controls and Assurances in place		**Controls** 1. Fire safety design aligned to health technical memorandum and building requirements 2. Fire safety management policy and procedural controls in place 3. Fire safety risk assessments conducted for occupied (Trust) and non-occupied (Consort) areas to identify breaches 4. Fire stopping maintenance program for walls, doors and service penetrations 5. Project management of fire protection remedial works and find and fix processes established 6. Upgrade of suitable building fire detection systems to provide early warning of fire 7. Fire risers and firefighting equipment in place, tested and maintained 8. Fire safety awareness training forms part of core and statutory training requirement for all staff 9. Relevant staff trained in awareness of alarm and evacuation methods 10.Emergency evacuation procedures and business continuity plans in place across services 11.Random sampling and audit of project works being undertaken 12.Contractual arrangements in place with PFI partners in establishing duty holder responsibilities of building controls, testing and servicing of alarm systems and planned preventative maintenance **Assurances** 1. Independent consultant employed to oversee project 2. Certification of fire safety materials e.g. EN 1366-3 3. Prioritisation of higher risk areas and of addressing remedial works and defect corrections to fire barriers in external cavity walls, doors and frame sealings 4. All before and after photographic evidence of remedial works recorded and appropriately shared 5. Fire wardens in place with additional fire wardens provided by partner organisations where necessary to maintain vigilance, patrol common areas across hospital sites and undertake fire safety checks 6. Provision of on-site fire safety team response where required 7. External monitoring, servicing and maintenance of fire safety alarm system 8. Suitable fire safety signage in place 9. Agreement of external response times and project management overview by Lancashire Fire and Rescue Service and NHS England 10.Incident reporting system in place to track repeat issues 11.Fire safety committee established, chaired by an exec lead, to seek assurances, monitor progress and compliance 12.Target rate of 25% reduction of fire safety incidents remains in place for 2024-25. A 30% reduction has been achieved this FYTD. Highest numbers of incidents relate to fire alarm activations and false alarm electrical defects 13.Sample survey and external intrusive survey completed and results shared with all relevant parties. Further exploratory surveys to determine materiality of any issues raised			**Gaps / weaknesses in controls** 1. Older hospital building areas may not meet modern standards 2. Backlogs in implementing works due to competing priorities 3. Inspections to determine the adequacy of fire stopping and compartmentalisation works may be infrequent, lack detail or integrity e.g. missing hidden voids, integrity of fire door architrave surrounds and general gaps around or underneath fire doors etc. 4. Robustness of fire safety management plan, policy and risk assessment processes and effectiveness of fire wardens 5. Not all locations within occupied areas have updated completed fire safety risk assessments 6. Limited funding for proactive maintenance 7. Contractors or sub-contractors may not be suitably trained on NHS specific fire standards 8. Collaborative working arrangements regarding the completion, review and sharing of fire safety risk assessments for both occupied and non-occupied areas requires strengthening **Gaps / weaknesses in assurances** 1. Materials may be certified but incorrectly installed 2. Lack of cooperation from partner organisations in relation to construction drawings, test evidence and materials in situ slowing down survey and remedial project management works 3. Lack of traceability for materials used in historical works e.g. combustible material identified above ceiling voids with fire detection present omitted from original fire safety documentation 4. Limited independent verification of contractor workmanship 5. Additional issues identified with fascial cavity barrier and external wall survey, with Kingspan render insulation present but no test evidence to show fire resistance properties have been provided by Project Co or Kingspan	
Update since the last report		**Update 07/04/2025** Risk reviewed. No change to risk score. No change to risk score - Fire Safety Committee informed a formal review of risk is to be undertaken by key stakeholders and reported on at the next Committee meeting in Dec-24 for approval. Agreement between stakeholder of no change in risk score **Next Review Date 06/05/2025**		**Date last reviewed**	**07/04/2025**	
				Risk by quarter 2025-26	**Q1**	**Q2**	**Q3**	**Q4**
					15			
				8 week score projection	**12**			
				Current issues	Recovery and restoration pressures, recruitment and retention			

No	ID	Title				
22	4932	**Patients who lack capacity to consent to hospital placements may be being unlawfully detained (Tolerated Risk)**				
Lead		Risk Lead: R Woods Exec Lead: P Murphy	**Current score**	**15**	**Score Movement**	⟺
Description		Patients referred to Lancashire County Council (LCC) and Blackburn with Darwen Council (Supervisory Body) for a Deprivation of Liberty Safeguards (DoLS) authorisation are not being assessed by these agencies within the statutory timescales, or at all, which means the DoLS is in effect unauthorised.	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** Inability of supervisory body to process assessments in line with statutory provision 1. Trust unable to extend urgent authorisation beyond maximum time permitted of 14 days In the absence of assessments patients will not have a DoLS authorised and will not have had relevant checks undertaken to ensure they are legally detained, leading to patients being detained without authorisation as not doing so would present an even greater risk. Plans to change DoLS to Liberty Protection Safeguards (LPS) remains on hold by the Government, with no date set for their implementation or subsequent publication of new National Approved Codes of Practice. **Gaps / weaknesses in assurances** No gaps or weaknesses identified that remain the responsibility of the Trust. Little evidence of assurance received from the supervisory body of it meeting its obligations for the assessment of patients Quarterly audits of MCA and DoLS have been stepped down due to vacancies and LTA within the safeguarding team		
Controls and Assurances in place		**Controls** 1. Policy and procedures relating to the Mental Health Capacity Act (MCA) and DoLS updated to reflect 2014 Supreme Court judgement ruling. 2. Mandatory training on MCA and DoLS available to all clinical professionals. 3. Improvement plan introduced for the management of DoLS applications following internal audit to enable timely and accurate recording of applications made and to demonstrate application of MCA in absence of Local Authority (LA) review. 4. Applications being tracked by the Safeguarding Team 5. Changes in patient status relayed back to the LA acting as the Supervisory Body. 6. Ability to extend urgent authorisations for all patients up to 14 days in total. 7. LCC hospital DoLS process now in place to priorities any urgent DoLS applications where increasing restrictions are being put in place to keep the patient safe. **Assurances** 1. Risk known to both Local Adult Safeguarding Boards for Blackburn with Darwen and Lancashire Local Authority. 2. Quarterly audits of MCA and DoLS being undertaken by the Safeguarding Team and reported to the NMLF and Safeguarding Committee on a quarterly basis. 3. DoLS data monitored via the Safeguarding Committee each month via the dashboard. 4. Additional legal advice obtained via Trust legal Team regarding current DoLS escalation process. 5. Patients not known to suffer any adverse consequence or delays in treatment.				
Update since the last report		**Update 07/04/2025** **Tolerated Risk. Risk reviewed. No change in risk score.** Mitigation of this risk continues to remain outside the control of the Trust. Assurances required from supervisory body it is advancing mitigation of this risk and addressing resource requirements for assessment of patients as part of its statutory obligations that will support a reduced risk score. **Next review date 06/05/2025**	**Date last reviewed**	**07/04/2025**		
			Risk by quarter 2025-26	**Q1**: 15	**Q2**:	**Q3**:	**Q4**:
			8-week score projection	**12**			
			Current issues	External influences regarding mitigation of risk beyond the control of the Trust			

No	ID	Title				
23	6190	**Insufficient clinical capacity to deliver national targets for RTT and cancer**				
Lead		Risk Lead: Michelle Montague Exec Lead: Sharon Gilligan	**Current score**	12	**Score Movement**	⇩
Description		Insufficient clinic capacity for patients to be seen in outpatient clinics resulting in unbooked new patients and very large holding lists of overdue patients, in some cases, there is significant delay and increased risk to patients. The demand far outweighs capacity and waiting lists have increased significantly over the past few years. All patients are risk stratified (red, amber, green rated) but still cannot be seen within timescales with an added risk those patients identified as amber could become red over time.		**Gaps and Potential actions to further mitigate risk**		
Controls and Assurances in place		**Controls** 1. Action plan and ongoing service improvements identified to reduce demand. 2. Expanded non-medical roles e.g. orthoptists, optometrists, specialised nurses etc. 3. Use of clinical virtual pathways where appropriate 4. Additional capacity sessions offered to clinicians when opportunity arises 5. Operational management team in place including administrative support for waiting list validation 6. Teams to micromanage full utilisation of clinics to ensure capacity is maximised 7. Development in ability to extract data from front end of Cerner regards waiting lists. BI teams in process of rebuilding the rev cycle reports that will give accurate information to support validation 8. GOV.UK notify can now be set up for all DPIA and invoice approval. Trial validation taking place within surgical division. **Assurances** 1. Weekly divisional and performance meetings held to discuss current position 2. Weekly operational meetings held with Chief Operating Officer to challenge outpatient activity and recovery. 3. Bi weekly COR meeting to discuss Cerner related issues 4. Regular monitoring of waiting lists at directorate level and escalated to division 5. Incident reporting and review. 6. DCOO, CXIO's and Deputy Medical Director working on a solution to record clinical harm reviews within outpatient setting on MPAGE of Cerner. 7. New reports available that distinguishes which patients have already been seen and duplicated. 8. Reduction in holding list 9. 65 week target achieved except for corneal grafts due to tissue availability 10. Validation month on month increase			**Gaps / weaknesses in controls** 1. Clinical management policy and procedural controls for managing patient lists requires full review in line with implementation of Cerner Millennium. 2. Relaunch of Outpatient Transformation Group to take place, with all services looking at project streams with the support of improvement managers. 3. Insufficient workforce and resource to provide capacity or carry out validation of all waiting lists. 4. Limited outpatient space to provide required clinics. 5. Increasing service demand and improved medical advancements are resulting in increased appointments and complexity of cases. 6. Data quality issues within EPR following migration. **Gaps / weakness in assurance** 1. Limited funding to recruit additional staff and equipment to be able to increase activity e.g. medical, nursing, administration 2. Challenges in extending outpatient estates capacity for additional clinics. 3. Increasing staff burnout and wellbeing due to constant pressures. 4. Data quality reporting issues. 5. Need to test logics built in reports to be able to remove duplicate patients.
Update since the last report		**Update 07/04/2025** **Risk reviewed. Risk score reduced.** **Awaiting approval of risk removal from CRR** Significant improvement in building and replicating worklists within e-PR to support validation of waiting lists and enable automated closure of pathways where patients have been seen, have future appointments or duplication. New reports are now available to allow directorates to manage patients more appropriately however these are showing a number of data errors. A change request has been made for data and digital to test the logics built in order to cleanse the data within the worklists. Teams continue to micromanage waiting lists and create additional capacity where possible and clinical teams are able. A review of gaps in controls and assurances as a result of improvement works is being undertaken to help mitigate this risk. **Next Review Date 06/05/2025**		**Date last reviewed**	07/04/2025	
				Risk by quarter 2025-26	Q1: 12	Q2	Q3	Q4
				8 week score projection	12			
				Current Issues	Recovery and restoration pressures, recruitment and retention			

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD

Meeting Date:	14 May 2025	**Agenda Item:**	TB/2025/065
Report Title:	Financial Performance Report Month 12 2024-25		
Author:	Miss C Henson, Deputy Director of Finance		
Lead Director:	Mrs S Simpson, Executive Director of Finance		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
				✓
Executive Summary:	The Trust's initial plan for 2024-25 was a deficit of £21.9m, so with the non-recurrent allocation of Deficit Support Funding (DSF), the Trust's revised annual financial plan was breakeven. The Trust reported a year end deficit of £68.492m, after receipt of £10.9m surge funding, (excluding DSF); a deficit of £46.6m including the £21.9m DSF, against the planned break-even position for the 2024/25 financial year. The Trust reported a surplus of £1.3m in month 12, an improvement of £1.8m from the previous month. This is in line with the Control total agreed through the Improvement and Assurance Group (IAG) process. The breakeven plan was inclusive of a £59.7m cost improvement programme. Capital expenditure was at £45m at M12, £0.4m below the planned spend of £45.4m. The cash balance on 31st March was £16.8, an increase of £11.6m compared to the previous month. Agency spend for the year was £9.8m, £5.6m under the plan/national target. (1.6% of gross pay costs v a planned 2.8%) The Trust has delivered £20.1m of its WR&FIP target for 2024-25, against a £59.7m plan. The Trust's 2024-25 Draft Annual Accounts were submitted by the deadline of noon on 25th April 2025.			
Key Issues/Areas of Concern:	The level of WR&FIP delivery in 2024/25 impacts on the scale of the challenge for 2025/26.			
Action Required by the Committee:	To note the content.			

Previously Considered by:	Finance & Performance Committee

Date:	28th April 2025
Outcome:	Noted the delivery of the control total for 2024-25, as agreed through the Integrated Assurance Group with the System Turnaround Director.

East Lancashire Hospitals
NHS Trust
A University Teaching Trust

Financial Performance

Trust Board – Public

14th May 2025

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

Month 12 Financial Revenue Position

Safe | Personal | Effective

ELHT. Because that's who we are

Month 12 Key Headlines

East Lancashire Hospitals NHS Trust
A University Teaching Trust

- The Trust's initial plan for 2024/25 was a deficit of £21.9m, so with the non-recurrent allocation of Deficit Support Funding (DSF), the Trust's revised annual financial plan was breakeven.

- The Trust reported a year end deficit of £68.492m, after receipt of £10.9m surge funding, (excluding DSF); a deficit of £46.6m including the £21.9m DSF, against the planned break-even position for the 2024/25 financial year

- At M11, the Trust forecast an outturn position of £68.5m; the actual 2024/25 outturn is an improvement of £8k.

- The Trust reported a surplus of £1.3m in month, an in month improvement of £1.8m from the previous month.

- The outturn position is in line with the Control Total agreed through the Improvement and Assurance Group (IAG) process.

Month 12 Summary Position

East Lancashire Hospitals NHS Trust
A University Teaching Trust

	NHSE Plan	Annual Plan	In month			Cumulative			Forecast outturn
			Plan	Actual	Variance	Plan	Actual	Variance	
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Operating Income									
Operating Income from Patient Care Activities	715,127	721,021	57,884	109,793	51,909	721,021	783,549	62,528	743,638
Other Operating Income	40,800	47,970	4,364	2,918	(1,446)	47,970	47,412	(558)	47,650
Employee expenses	(526,530)	(523,560)	(42,838)	(89,764)	(46,926)	(523,560)	(613,229)	(89,669)	(570,579)
Operating expenses excluding employee expenses	(206,916)	(222,950)	(14,872)	(22,835)	(7,963)	(222,950)	(236,861)	(13,911)	(245,604)
Operating (Deficit)	**22,481**	**22,481**	**4,538**	**112**	**(4,426)**	**22,481**	**(19,129)**	**(41,610)**	**(24,895)**
Net Finance Costs	(34,556)	(34,556)	(527)	21,866.00	22,393	(34,556)	(11,422)	23,134	(33,428)
Gains/(Losses) on disposal of assets	0	0	0	5.00	5	0	67	67	62
(Deficit) for the period/year	**(12,075)**	**(12,075)**	**4,011**	**21,983**	**17,972**	**(12,075)**	**(30,484)**	**(18,409)**	**(58,261)**
Remove impairments	0	0	0	-	0	0	0	0	8,796
Remove impact of PFI liability remeasurement	12,102	12,102	(1,347)	(20,755.00)	(19,408)	12,102	(16,122)	(28,224)	2,969
Remove capital donations/grants I&E impact	(27)	(27)	(2)	5.00	7	(27)	0	27	(118)
Breakeven duty financial performance (deficit)	**0**	**0**	**2,662**	**1,233**	**(1,429)**	**0**	**(46,606)**	**(46,606)**	**(46,614)**
Less Non-Recurrent Deficit Funding	(21,886)	(21,886)	0	0	0	(21,886)	(21,886)	0	(21,886)
Breakeven duty financial performance (deficit) excluding Non-Recurrent Deficit Funding	**(21,886)**	**(21,886)**	**2,662**	**1,233**	**(1,429)**	**(21,886)**	**(68,492)**	**(46,606)**	**(68,500)**

The draft 2024/25 annual accounts are currently with the external auditors.

Annual Income & Expenditure Analysis

East Lancashire Hospitals NHS Trust
A University Teaching Trust

	Expenditure			Percentage
	Budget	Actual	Variance	Variance
Division/Department	**£000**	**£000**	**£000**	**%**
Medicine & Emergency Care	(157,786)	(172,352)	(14,565)	9.23%
Surgery and Anaesthetic Services	(145,479)	(161,850)	(16,371)	11.25%
Community & Intermediate Care	(55,718)	(59,157)	(3,439)	6.17%
Diagnostic and Clinical Support	(108,254)	(114,380)	(6,126)	5.66%
Family Care Division	(84,429)	(92,361)	(7,932)	9.40%
Estates and Facilities	(63,372)	(67,843)	(4,472)	7.06%
Corporate Services	(52,951)	(56,162)	(3,211)	6.06%
Education, Research & Innovation	(16,331)	(13,675)	2,656	-16%
Division/Department	**(684,320)**	**(737,780)**	**(53,461)**	8%
Central Expenditure	(106,019)	(139,787)	(33,768)	32%
Income	790,339	830,961	40,622	5.14%
Total	**0**	**(46,606)**	**(46,607)**	0.00%
Deficit Support funding	0	(21,886)		
Total Excluding DSF		**(68,492)**		

Draft 2024/25 Annual Accounts

East Lancashire Hospitals NHS Trust
A University Teaching Trust

The 2024/25 Draft Annual Accounts were submitted by the deadline of noon on the 25th April 2025.

The Key dates are listed below

Date	Task	Completed
25-04-25 (noon)	Unaudited TACs and accounts submitted to NHSI via portal	☑
25-04-25 (noon)	Unaudited TACs and accounts send to external audit via e-mail with Annual Governance Statement.	☑
09-05-25	NHSI distributes DHSC group mismatch schedules to NHS providers	☐
09-05-25	NHS providers re-submit TACs to provide updated agreement of balances information to the Provider Accounts tean	☐
13-05-25	Limits letters (NHS trusts only)	☐
tbc	Audit Committee	☐
30-06-25	Independent Auditors' Report received and signed	☐
30-06-25	Audited accounts to be submitted by Trust to DHSC by noon 1. Audited Accounts and accounting policies 2. Audited accounts: signed Statement of Financial Position (balance sheet) 3 Audited accounts: signed Statement of Accounting / Accountable Officer's Responsibilities 4 Audited TAC schedules (submission of PFR form) 5 Audited TAC schedules: Print or screenshot of the 'Confirmations' tab and signed at the bottom by the Chief Executive as confirmation that the final audited TAC schedules have been submitted. 6 Full final test of audited annual report 7 Annual report signed pages GAM 3.8 and 3.9 8 Auditor ISA260 report 9 Original signed audit report (audit opinion) on the accounts 10 Original signed CO and FD certificate on the summerarisation schedules (TAC schedules) 11 Auditor report on the summerisation schedules (TAC Schedules)	

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

Waste Reduction and Financial Improvement Performance

Safe | Personal | Effective

ELHT. *Because that's who we are*

WR & FIP – Delivery by Division

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Division	WR & FIP Annual Target 2024/25	YTD Performance					Recurrent Actuals	
		2425 Annual Delivered	YTD Delivered	YTD Target Plan	Variance	% Varr.	Recurrent YTD Act. (2425)	Recurrent YTD Act.
MEC	11,620	£5,711	£5,711	£11,620	-£5,909	-51%	£5,586	£5,586
SAS	11,649	£2,290	£2,290	£11,649	-£9,359	-80%	£1,586	£1,586
FC	6,686	£1,947	£1,947	£6,686	-£4,739	-71%	£1,866	£1,866
DCS	8,485	£2,055	£2,055	£8,485	-£6,430	-76%	£1,304	£1,304
CIC	3,619	£1,594	£1,594	£3,619	-£2,025	-56%	£579	£579
Corp.	2,956	£1,882	£1,882	£2,956	-£1,074	-36%	£1,305	£1,305
Est.	4,498	£1,011	£1,011	£4,498	-£3,487	-78%	£527	£527
DERI	1,175	£1,175	£1,175	£1,175	£0	0%	£1,175	£1,175
Central	8,991	£2,513	£2,513	£8,991	-£6,478	-72%	£2,513	£2,513
ELHT Total	**59,679**	**£20,176**	**£20,176**	**£59,679**	**-£39,503**	**-66%**	**£16,441**	**£16,441**

- **£20.176m** has been delivered in 2024-25, **£39.5m** less than the planned 24/25 WRP. In-month delivery has increased by **£1.4m.**
- £16.4m of the WRP is recurrent , with **£3.7m** as non-recurrent.
- **279 QIRAs** completed for M12, with all schemes transacted having an approved QIRA in place.

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

Cash

Safe | Personal | Effective

ELHT. Because that's who we are

Statement of Cash Flows 31st March 2025

East Lancashire Hospitals NHS Trust
A University Teaching Trust

The cash balance on 31st March was **£16.8m,** an increase of £11.5m compared to the previous month, mainly as a result of the £29.9m received from the ICB on 24th March. This has allowed the Trust to manage more effectively creditor payments. However, the Trust's ability to continue to pay suppliers on time is dependent on the delivery of the 2025/26 financial plan.

Cash Flow Statement	As at 31st March 2024 £000	As at 31st March 2025 £000	Prior month £000
Operating Activities			
Operating Surplus/(Deficit)	(16,883)	(27,934)	(19,242)
Depreciation and amortisation	22,831	24,129	22,156
Impairments and reversals	19,385	8,796	0
Donated assets received credited to revenue but non cash	(173)	(434)	(403)
(Increase)/decrease in trade and other receivables	11,976	(3,436)	(11,113)
(Increase)/decrease in inventories	(759)	(1,341)	401
Increase/(decrease) in trade and other payables	(23,797)	13,085	16,089
Increase/(decrease) in other liabilities: deferred income	(5,875)	12,170	4,956
Increase/(decrease) in provisions	(511)	(145)	(179)
Net cash inflow from Operating Activities	**6,194**	**24,890**	**12,665**
Cash Flows from Investing Activities			
Interest received	2,051	1,947	1,806
(Payments) for property, plant and equipment and intangible assets	(42,483)	(24,855)	(21,443)
Proceeds from disposal of property, plant and equipment	9	531	526
Receipt of cash donations to purchase capital assets	0	52	26
Net cash outflow from Investing Activities	**(40,423)**	**(22,325)**	**(19,085)**
Net cash inflow before Financing	**(34,229)**	**2,565**	**(6,420)**
Cash Flows from Financing Activities			
Public dividend capital received	31,250	23,043	21,372
Loans from Department of Health - repaid	(200)	(200)	(200)
Capital element of lease payments	(5,927)	(7,475)	(6,809)
Capital element of PFI payments	(12,276)	(11,123)	(12,789)
Interest paid	(479)	(696)	(571)
Interest element of PFI obligations	(5,982)	(5,979)	(5,833)
PDC dividend (paid)/refunded	(5,464)	5,066	4,924
Net cash outflow from Financing Activites	**922**	**2,636**	**94**
Decrease in cash	**(33,307)**	**5,201**	**(6,326)**
Cash at the beginning of the year	**44,882**	**11,575**	**11,575**
Cash at the end of the financial period	**11,575**	**16,776**	**5,249**

2024/25 BPPC Performance

East Lancashire Hospitals NHS Trust
A University Teaching Trust

	Number	£000s
Non-NHS payables		
Total non-NHS trade invoices paid in the year	85,889	465,632
Total non-NHS trade invoices paid within target	60,712	413,938
Percentage of non-NHS invoices paid within target	**70.7%**	**88.9%**
NHS payables		
Total NHS trade invoices paid in the year	2,397	43,310
Total NHS trade invoices paid within target	1,919	41,239
Percentage of NHS invoices paid within target	**80.1%**	**95.2%**

Better Payment Practice Code (BPPC) performance was below target in March with the Trust only meeting the target to pay 95% of invoices on time by value for NHS invoices for 2024/25.

Statement of Financial Position

East Lancashire Hospitals NHS Trust
A University Teaching Trust

- The £11.5m increase in cash is largely represented by a £10.7m reduction in debtors, a £7.2m increase in deferred income and a £6.2m reduction in trade payables.
- There has been a £13.8m reduction in the balance on the accounts payable system, although this is offset by an increase in accruals including a £7.7m increase in pay related accruals.
- There is also a £20.1m reduction in the value of PFI liabilities as a result of a technical adjustment which has impacted on the revenue position before technical adjustments.

	As at 31st March 2024 £000	As at 31st March 2025 £000	Year to date movement £000	Prior month £000	In-month movement £000
Non-Current Assets:					
Intangible assets	25,257	19,169	(6,088)	22,021	(2,852)
Property, plant and equipment (PFI)	97,553	96,024	(1,529)	96,834	(810)
Property, plant and equipment (other)	166,079	170,071	3,992	172,521	(2,450)
Right of use assets	19,060	31,947	12,887	31,036	911
Receivables	675	699	24	675	24
Total non-current assets	**308,624**	**317,910**	**9,286**	**323,087**	**(5,177)**
Current assets:					
Inventories	9,969	11,310	1,341	9,569	1,741
Receivables (NHS)	24,031	20,054	(3,977)	27,429	(7,375)
Receivables (non-NHS)	17,109	18,821	1,712	19,770	(949)
Assets held for sale	475	0	(475)	0	0
Cash and cash equivalents (GBS/NLF)	11,562	16,764	5,202	5,231	11,533
Cash and cash equivalents (other)	13	13	0	18	(5)
Total current assets	**63,159**	**66,962**	**3,803**	**62,017**	**4,945**
Total assets	**371,783**	**384,872**	**13,089**	**385,104**	**(232)**
Current liabilities:					
Trade and other payables (capital)	(7,254)	(6,418)	836	(3,088)	(3,330)
Trade and other payables (non-capital)	(60,849)	(73,394)	(12,545)	(77,139)	3,745
Borrowings / DHSC loan	(6,500)	(6,796)	(296)	(11,170)	4,374
Other financial liabilities (PFI)	(12,586)	(7,038)	5,548	(14,161)	7,123
Provisions for liabilities and charges	(609)	(565)	44	(601)	36
Other liabilities: deferred income	(1,522)	(13,693)	(12,171)	(6,478)	(7,215)
Total current liabilities	**(89,320)**	**(107,904)**	**(18,584)**	**(112,637)**	**4,733**
Net current assets/(liabilities)	**(26,161)**	**(40,942)**	**(14,781)**	**(50,620)**	**9,678**
Total assets less current liabilities	**282,463**	**276,968**	**(5,495)**	**272,467**	**4,501**
Non-current liabilities					
Borrowings / DHSC loan	(13,015)	(25,638)	(12,623)	(20,302)	(5,336)
Other financial liabilities (PFI)	(220,032)	(221,007)	(975)	(233,967)	12,960
Provisions for liabilities and charges	(2,912)	(2,872)	40	(2,797)	(75)
Total non-current liabilities	**(235,959)**	**(249,517)**	**(13,558)**	**(257,066)**	**7,549**
Total assets employed	**46,504**	**27,451**	**(19,053)**	**15,401**	**12,050**
Financed by taxpayers equity					
Public dividend capital	309,890	332,933	23,043	331,262	1,671
Revaluation reserve	19,225	21,712	2,487	18,749	2,963
Income and expenditure reserve	(282,611)	(327,194)	(44,583)	(334,608)	7,414
Total taxpayers equity	**46,504**	**27,451**	**(19,053)**	**15,403**	**12,048**

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

Capital

Safe | Personal | Effective

ELHT. Because that's who we are

Capital

East Lancashire Hospitals NHS Trust
A University Teaching Trust

- Funding for the 2024-25 capital programme increased by £0.4m to £45.4m due to a £0.5m increase in PFI lifecycle costs offset by a £0.1m reduction in donated assets.
- Of the £0.4m underspend against available capital funding, £0.1m relates to leased assets, which at £20.6m represents the largest area of expenditure with the £11.5m of PFI lifecycle costs including £8.8m of reclassified expenditure largely charged to the revenue position in previous years.

	2024/25 Actuals	2024/25 Forecast
	£000	£000
Total funding available	**45,400**	**45,000**
IFRS 16 Right of use assets	20,600	20,700
Externally funded schemes	4,600	4,900
Estates	4,800	5,200
Information technology	2,500	2,200
PFI lifecycle	11,500	10,900
Medical equipment	100	100
Donations and capital grants	400	600
Other schemes	500	400
Total capital expenditure	**45,000**	**45,000**
Variance	**(400)**	**0**

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

Workforce

Safe | Personal | Effective

ELHT. *Because that's who we are*

2024/25 Workforce vs Plan

East Lancashire Hospitals NHS Trust
A University Teaching Trust

	YTD Plan	YTD Actuals	
	Mar-25	Mar-25	Movement
Staff Type	**wte**	**wte**	**wte**
Total Substantive	9,270.27	9,652.07	381.80
Total Bank	551.79	712.52	160.73
Total Agency	87.05	61.92	-25.13
Total	**9,909.11**	**10,426.51**	**517.40**

	YTD Plan	YTD Actuals	
	Mar-25	Mar-25	Movement
Staff Group	**wte**	**wte**	**wte**
Regst'D Nurses & Others	3,136.67	3,279.63	142.96
Medics	1,048.12	1,125.03	76.91
Hcare Scients & Others	1,066.59	1,135.74	69.15
Support Clinical Staff	2,004.90	2,205.44	200.54
Nhs Infrastructure Supp	2,652.83	2,679.67	26.84
Other Staff Costs	0.00	1.00	1.00
Total	**9,909.11**	**10,426.51**	**517.40**

- Compared to the submitted workforce plan for 2024-25, the Trust is 517.40 wte above the plan for March.
- This is an increase of 39.46 wte from March 2024 and includes 122 wte related to service transfers so a net reduction of 82 wte.

YTD Workforce Movement M11 to M12

East Lancashire Hospitals NHS Trust
A University Teaching Trust

The actual WTE has increased by **7.84 wte** (*worked for all staff types*) from the previous month across all staff types and staff groups, and the cost of pay has increased by £42k.

	Actuals	Actuals	
	Feb-25	Mar-25	Movement
Staff Type	**wte**	**wte**	**wte**
Total Substantive	9,346.07	9,356.42	10.35
Total Bank	717.20	712.52	-4.68
Total Agency	59.75	61.92	2.17
Total	**10,123.02**	**10,130.86**	**7.84**

Actuals	Actuals	
Feb-25	Mar-25	Movement
£000	**£000**	**£000**
42,222	41,909	-313
3,572	3,798	225
515	645	130
46,310	**46,351**	**42**

	Actuals	Actuals	
	Feb-25	Mar-25	Movement
Staff Group	**wte**	**wte**	**wte**
Regst'D Nurses & Others	3,114.44	3,123.83	9.39
Medics	1,154.67	1,153.84	-0.83
Hcare Scients & Others	1,091.49	1,098.98	7.49
Support Clinical Staff	2,147.74	2,145.62	-2.12
Nhs Infrastructure Supp	2,611.58	2,603.99	-7.59
Other Staff Costs	3.10	4.60	1.50
Total	**10,123.02**	**10,130.86**	**7.84**

Actuals	Actuals	
Feb-25	Mar-25	Movement
£000	**£000**	**£000**
14,082	14,421	339
11,976	12,168	192
5,101	5,161	60
6,261	6,217	-45
7,950	8,168	218
939	217	-722
46,310	**46,351**	**42**

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

Glossary

Safe | Personal | Effective

ELHT. *Because that's who we are*

Glossary

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Better Payment Practice Code (BPPC) - *The requirement of the BPPC is to pay 95% of undisputed, valid invoices within 30 days of receipt. The 95% is in terms of value and volume of invoices.*

Deficit Support Funding (DSF) – *Non-recurrent funding to allow Trusts to deliver a breakeven position in 2024/25*

Elective Recovery Fund (ERF) – *Additional funding received by the trust to deliver 107% of pre-pandemic elective activity (elective activity being outpatient new, outpatient procedures, day cases and electives).*

Goods Received Not Invoiced (GRNI) - *refers to a situation where the trust has received goods but hasn't yet received the corresponding invoice from the supplier, necessitating a temporary accounting entry to track the liability until the invoice arrives.*

Glossary

East Lancashire Hospitals NHS Trust
A University Teaching Trust

IFRS – International Financial Reporting Standards constitute a standardised way of describing Trusts/company's financial performance and position so that company financial statements are understandable and comparable across international boundaries.

IFRS16 Right of Use Assets – *Following the change in accounting standards, the Trust must recognise and capitalise the appropriate leases through the balance sheet, where previously is was recognised through revenue only.*

PDC Public Dividend Capital represents the Department of Health's (DH's) form of funding to NHS Providers. The DH is expected to make a return on its net assets, including the assets of NHS Trusts, of 3.5%.

PDC Provider Revenue Support - *Revenue Support PDC is available to support revenue expenditure for cash-distressed providers for necessary and essential expenditure to protect continuity of patient services.*

Glossary

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Waste Reduction & Finance Improvement Programme (WR & FIP) – this is the terminology for the efficiencies required by the Trust. (previously referred to as CIP / WRP) Waste Reduction is achieved when the actual run rate is reduced.

Run Rate – Refers to the income and expenditure trend for an organisation at the end of a defined financial period.

Exit Run Rate **-** Recurrent run rate income and expenditure trend for an organisation at the end of a defined financial period. In this case we use the NHS financial year, and the exit run rate is defined by the position on 31 March 2025 excluding non-recurrent income/expenditure and the full year effect of income/expenditure.

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Meeting Date:	14 May 2025	**Agenda Item:**	TB/2025/066
Report Title:	Nursing Professional Judgement Review		
Author:	Mr J Walton-Pollard (Deputy Chief Nurse) Mrs J Pemberton (Deputy Chief Nurse) Mrs M Dixon (Corporate Finance)		
Lead Director:	Mr P Murphy (Chief Nurse)		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓			✓
Executive Summary:	This paper will provide the bi-annual Professional Judgement Review which incorporates a formal evaluation of the Trust's ward/unit/department(s) staffing templates using a triangulated approach. This includes an analysis of 30 days census data utilising the Safer Nursing Care Tool (SNCT) (Shelford Model) during August 24, a review of the nurse sensitive indicators (Sept 24 – Dec 24) and the professional judgement of the senior nursing team.			
Key Issues/Areas of Concern:	Risk ID: 3804,4043,9259,9468,9382,9568,5790,5791.			
Action Required by the Committee:	Quality Committee is asked to consider the professional judgement and agree the recommendations and further actions. The committee is asked to note the data in terms of fill rates, vacancy rates, sickness rates, staff turnover and recruitment plans.			

Previously Considered by:	Quality Committee
Date:	29/01/2025
Outcome:	Noted

Introduction

1. In line with national guidance which recommends a professional judgement is carried out every six months. An evaluation exercise was carried out in Nov-Dec 24 against the recommendations of the August 24 (summer census) Safer Nursing Care Tool (SNCT). This paper will provide the six-monthly update as per national guidance.
2. The professional judgement was carried out in the month of August 24 using the nationally recognised acuity tool (Safer Nursing Care Tool (SNCT) Shelford model) as the Trust has a licence to use this tool. A correlation was also made with the relevant nurse sensitive indicators using data from Oct 24 to Dec 24 (see appendix one) along with the professional judgement of the Deputy Directors of Nursing, Divisional Directors of Nursing, Assistant Directors of Nursing, Matrons, and Ward Managers. In line with national guidance, meetings with the above were held between Oct 24 to Dec 24, to review every inpatient template so that a correlation can be made with the SNCT data and nurse sensitive indicators.
3. It is worth noting that the SNCT has changed recently to consider patients receiving 1-1 and 1-2 level of care. This has produced a significant change in the outcome of the SNCT data, compared to the recent winter census (Dec 23) showing an increase in the recommendation of the budgeted templates. However, the staffing required for patients needing a 1-1 is sought from the internal bank which needs to be considered when applying the triangulated approach. Assurance can be given that the divisional and corporate finance teams have been heavily involved, providing accurate and up to date information on establishments. The divisions have also implemented monthly check and challenge meetings which review bank and agency spend along with sickness monitoring to ensure established controls on spend are being adhered to. It is worth noting that due to unprecedented demand on patient flow and challenges with Emergency Department capacity, there are extra escalation beds open (34) across the in-patient wards which were taken into consideration with the August 24 census exercise.

Professional Judgement summer Census 24

General Points

4. The following points should be noted.

5. As a result of this review, with a particular emphasis on the triangulated approach the current in-patient templates were professionally judged as safe. However, senior nurses agreed this is only if the bank shifts for the 1-1's were filled. Bank fill rate for this group of staff is >80%.
6. The compliance against the templates (Actual v Planned) is monitored monthly in the newly formed Trust Wide Governance Committee and the established Quality Committee. Assurance can be provided the Trust does have a Standard Operational Policy (SOP) for the day-to-day management of nurse staffing which will be described in detail in the newly designed monthly safe staffing report. The Trust continues to maintain fill rates for Registered Nurses and Support workers of greater than 90% for both days and nights. The national quality board recommends that fill rates should be between 90% and 105%. There is a minimal nurse patient ratio of 1-8 with an additional shift co-ordinator during the early shift on all acute in-patient wards.

7. It has been confirmed by the Safe Staffing Fellows at NHS England (NHSE) that the SNCT census will potentially show some establishments as 'overstaffed' when comparing the census outcome to the establishment on smaller wards. This is exacerbated if acuity/activity is low. The Royal Blackburn site has several smaller (14 & 17-18 bedded) wards which need a minimum of 3 RNs per shift for clinical safety reasons. One exception to this is Ward C5 which has 2 RNs at night. This is supported using the triangulated approach as described above.
8. The finance team have confirmed there is an uplift of 22% across all in-patient establishments. This is in line with national recommendations and consistent with the integrated care system. Ward budgets include a 22% uplift to both the budget and the establishment. This reflects the amount of time staff may be unavailable. The 22% is made up of 14% annual leave, 5% sickness and 3% study leave. Historical data shows (see below) that sickness is usually above this allocation which can cause cost pressures on budgets.
9. Since the last professional judgement, which was presented to Board of Directors in July 24, the Trust has commissioned an external review of nurse staffing (see appendix three). This has provided the Board of Directors further assurance that the nurse staffing templates and safe and effective. However, there were some recommendations around ward managers supernumerary status and the maturity of the divisional Check and Challenge processes.
10. All Ward Managers and community team leaders have supernumerary status one day per week which is not in line with the recommendations of the Francis (2013) report which states ward managers should have supernumerary status five days per week. It was proposed at the last professional judgement this is increased to five days which BOD agreed in principle provided a funding source could be found. Unfortunately, this source has not been found therefore, the Trust remains an outlier. In comparison with the three other acute providers within the integrated care system, two have their ward managers supernumerary five days and one has them supernumerary three days per week.
11. A separate piece of work is currently underway to re-align the Agenda for Change (AfC) pay scale for the Health Care Support Worker workforce. This has involved working with staff side to re-write Job Descriptions along with a set of tasks the band 3 workforce undertake. An options appraisal is currently being developed for Executive Directors to consider. The professional judgement of the senior team concluded that all HCSW's on the in-patient templates will need to be working at B3 level to meet service needs. However, the full cost of this will need to be agreed at a later date.

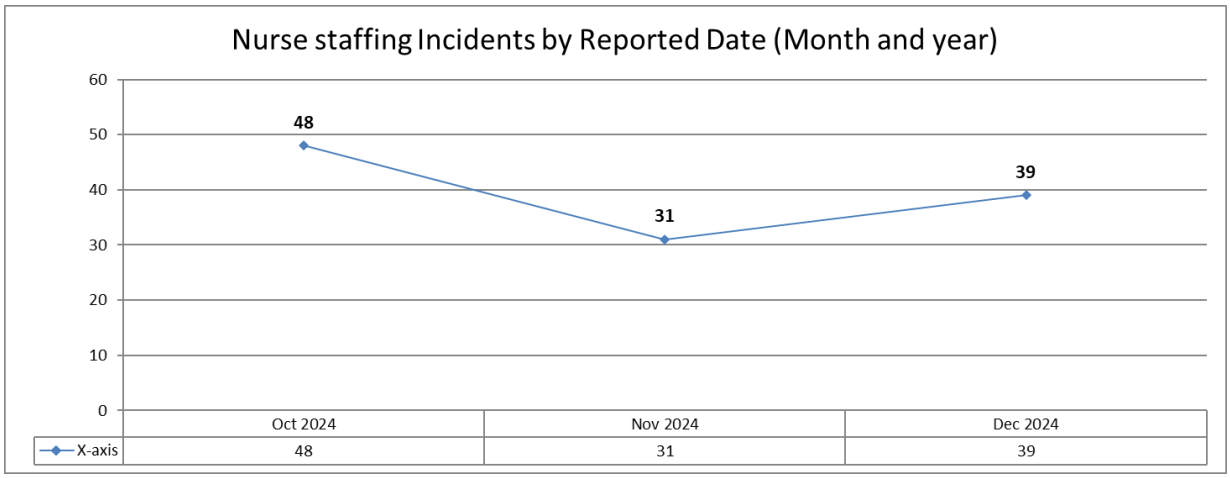
Professional Nurse Advocate Protected Time.

12. The impact of the Covid-19 pandemic, the multifaceted and complex issues the aftermath has brought; with nurses feeling burnt out leading to concerns with nurses' mental health. An urgent call to introduce the availability of supportive measures towards the restoration and recovery for all nurses was required.
13. In response The Professional Nurse Advocate (PNA) Training Programme was launched in March 21 to support the NHS recovery plan following the Covid-19 pandemic.
14. It is a virtual Level 7 accredited programme which is held virtually over 10 days and the academic assessment may include essays, poster presentations and competency portfolios, depending on which Higher Education Institute is used.

15. Monthly data recording is required from the PNA's to enable local, regional and national oversight. Protected time has not been agreed making it difficult for the PNA's to deliver their objectives and therefore, PNA activity monthly reporting to NHSE from the Trust is extremely poor.
16. The request is board support one day per month per PNA to support the delivery of supervision for the current 45. It is worth noting that NHS England guidance suggests that the Trust will need to work 140 PNA's in the future. This is currently being absorbed within established ward budgets.

Nurse Staffing Related Incidents.

17. Along with fill rates, incidents related to nurse staffing are monitored by the Deputy Director of Nursing. The tables below show the number of staffing related incidents per month and their subcategories for the period of Oct 24 to Dec 24. There have been no known staffing related incidents which have caused harm.



Subcategory	Total
Delay of more than 30 minutes in providing pain relief - (Due to Staffing)	1
Less than 2 registered Nurses / Midwives present on a ward during any shift	3
Staff indicated concerns	23
Staff shortage - Midwives	10
Staff shortage - nursing	79
Unable to reliably carry out intentional rounding	2
Total	**113**

Registered Nurse and Clinical Support Worker Sickness (Dec 23 to Feb 24)

18. The Sickness/Absence rates from Oct 24-Dec 24 are displayed in the table below. Although there has been an improvement since the last review, sickness is still over the Trust trajectory of 4%. Whilst the Trust has an absence management policy, it is acknowledged that this could be more robustly applied if ward managers had supernumerary time to support staff who are absent from work.

Average	Count of staff	Number of staff HC	Staff in post FTE	Occurrences	Covid Sickness %	Non Covid Sickness %	Total %
Support	825	1361	1170	398	0.09%	10.05%	10.15%
N&M	1664	3389	3029	783	0.05%	6.98%	7.03%

Nursing Vacancies, Recruitment and Attrition

19. The Trust currently has approx. 0 WTE RN and 40 Support Worker vacancies across the medical division and a further 22 RNs within the ED due to an increase in the budgeted establishment. This is due to 35 newly qualified RN's and Nursing Associates who started in March 25 and recent ward closures.

Divisional Points to note.

Medicine and Emergency Care

20. Ward B4 have been working to 3 RNs on a night shift for the last 2 years but only have funding for 2 RNs. Utilising the triangulated approach, the professional judgement of the senior nursing team supports 3 RNs, and this is in line with other similar wards.
21. Ward C7 have been undertaking a test of change since the last professional judgement where they have put an extra clinical support worker on nights seven days per week. This is supported utilising the Shelford Tool and the triangulated approach.
22. Wards D1, D3 and C11 have used funding for a 4th RN on the later part of the day shift to work a twilight shift. This is agreed using the professional judgement of the senior nursing team and is now embedded into practice. This initiative is cost neutral.
23. The current staffing requirements for the Emergency Department is complex and fluid. In addition, the Trust has purchased the Safer Nursing Care Tool licence specifically for Emergency Care and staff have been fully trained to use this. However, on further discussion with the NHSE safer staffing fellows, it has become apparent that the tool does not consider patients who have been in the department greater than 12 hours. At present, most patients who require admission spend greater than 12 hours within the department due to pressures around flow. Therefore, it is not recommended any decision is made using the ED Safer Nursing Care Tool. The Head of Nursing for Emergency Care has written guidance for the number of staff required in relation to the number of patients at any one time. It is the

professional judgment of the senior nursing team that this guidance meets the needs of the department which is broadly in line with RCN workforce standards which is a nurse ratio of 1-2 in the resus area and 1-5 in majors (see table below).

24. In April 24, the Executive Team agreed recurrent funding to uplift the RN's per shift from 22 to 28 WTE and Health Care Support Workers from 12 to 18 WTE. This has now been put into the budget and recruitment is ongoing. Whist the budget has now been secured nurse staffing in the Emergency Department is often flexed to meet demand. This at times involving moving staff from wards within the Trust and increasing bank and agency at nights. Nurse staffing within the emergency department is discussed in the Trust wide nurse staffing meetings and in the 8am Incident Management Team meeting to ensure executive directors have daily oversight of any risks.

25. It has been confirmed by the NHS England safer staffing team that the SNCT will be amended to capture length of stay in the ED and when rolled out the Trust will utilise again**.**

Reference guide for ED nurse staffing for escalated numbers in the department (this is a guide and professional judgement must be used from the ED matron- all essential areas of ED must be staffed as per professional judgment)

Number of patients in dept	Total RNs needed	Total HCSW's needed
55	22	12
60	23	13
65	24	14
70	25	15
75	26	16
80	27	17
85	28	18
90	29	19
95	30	20
100	31	21
Plus 1 RN and 1 HCSW for every increment of 5 patients in department.		

Plus 6 extra band 2 HCSW to support with 1:1 care.

Surgical and Anaesthetic Division.

26. Wards B22 and B24 are both 23 bedded acute orthopaedic wards which take direct admissions from the emergency department. Using the triangulated approach, the professional judgement of the senior nursing team is asking to increase the RNs on a night shift by 1 however, the SNCT does not support this. The wards are an outlier when comparing them to similar acute wards in the Trust, therefore, it is recommended a further run of the SNCT is completed before any recommendation is made. The wards may wish to trial bringing in the 4 RN on the day shift a little later in the day to increase staffing at the beginning of the night shift.
27. Both theatre complexes on the RBH and BGH site have compared their budgeted establishment using the Association for Perioperative Practice (AfPP) guidance calculator which shows the establishments to be broadly in line with this guidance.

However, both Matrons highlighted an issue with theatre 'overruns' which cause further pressure on staffing therefore, a separate business case has been development to address this. Since the last professional judgment further funding has been secured for five three session days per week. A further business case has been developed to run a further five three session days. There is however, an unfunded session in the CT/Angio rooms which sits outside of the traditional theatre schedule however, these are staffed therefore as far as the professional judgment is concerned this is not a safety issue.

28. Further work is needed to understand the budgeted establishment on the Chemo Unit at RBH and the staffing levels required however, there is no ask for investment at this time. The BGH budgeted establishment is professionally judged as adequate.
29. The Critical Care Unit is staffed to Guidelines for the Provision of Intensive Care Standards (GPEC) standards. This is monitored through the ICS 'Peer Review' process bi-annually. Due to a recent Cost Improvement Program a decision was made to staff the unit to acuity rather than bed base. This has been agreed with the local Critical Care Network and will be reviewed at regular intervals

Paediatrics

30. The Paediatric unit has not used the SNCT tool to determine staffing levels. Therefore, the staffing levels on the unit have been benchmarked using Royal College of Nursing Guidance, which stipulates a 1:4 Ratio for children over 2 years and a 1:3 for children under 2 years. The standard ratio reduces further if a side room is used 1:2. The senior nursing team have reviewed their staffing levels using this guidance and agreed when taking seasonal variance into consideration this is broadly met. The internal bank is used when demand increases, and the ward managers are in a supernumerary capacity and can therefore, flex into the rostered numbers when necessary. The unit does at time provide HDU care when a child deteriorates although the Trust is not commissioned to provide this. When there is a demand for HDU care this is provided on a 1:2 for level two and a 1:1 for level three care. The unit does not keep level three patients' long term, as they are transferred to a tertiary paediatric unit. It is also worth noting a review of the paediatric bed base is under way therefore, there is no ask for resource currently. The senior nursing staff on the review believed the unit was safely staffed and have not reported any harm because of staffing.

Community and Integrated Care Division

Integrated Care Wards

31. Wards identified pressure relating to enhanced care requirements (1-1), particularly relating to falls prevention.
32. Utilising the triangulated approach, it has been identified that wards 22, Ribblesdale, Hartley and Reedyford require additional HCA hours for twilight and daybreak early shifts to support safe care. Use of these shifts has been proven to reduce the use of additional overnight HCA staff at Pendle and Clitheroe hospitals. This will be managed through bank shifts via the enhanced care criteria (1-1 SOP).

33. The Pendle wards (Hartley and Reedyford) have also requested an additional HCA on long days at weekends because they have significant work to do to support meal service including the dishwashing of crockery after every meal. This is captured on an estates held risk register relating to support staff provision to all 3 Pendle wards. Further work needs to be done with the estates division to develop a solution for the weekends.
34. In addition, utilising the triangulated approach Ward 19 have been identified as requiring a 4th night HCA which will give them equivalent to Ward 22 establishment which is an equivalent ward. This has been in the run rate for several years.

Adult Community Nursing

35. The CIC division purchased the SNCT community licence and have now had the opportunity to run two sets of data at approximately six-month intervals over the last 12 months. Whilst the tool showed the WTE head count to be broadly correct, the professional judgment of the senior leadership had identified a cost neutral re alignment of services and skill mix which is currently been operationalised. The SNCT for community is currently suspended by the national team to allow for an evaluation. Once this is re-launched the Trust will continue to base the six-month professional judgement on the SNCT.

Maternity Staffing

36. Maternity staffing has not been reviewed as part of this professional judgement as there is a separate process in line with Ockenden (2222) recommendations which involves bi-monthly Board of Directors oversight.

Neonatal Nurse Staffing

37. ELHT neonatal unit nurse workforce requirements are funded aligned with the Healthcare Resource Group activity calculations for April 2023 to April 2024. British association of perinatal medicine (BAPM) nurse staffing compliance meets the service specification for that period. This is calculated using the relevant national workforce tool and recommendations by (BAPM) standards for nurse staffing.
The National Nurse Workforce Tool (NNWT) for direct Patient/Cot side Care and the Northwest Neonatal Operational Delivery Network (NWODN) Quality Nursing Roles Calculator (QNRC) - For Quality Roles has been completed and submitted to the NWNODN in 2024. This aligns with the plan for CNST safety action 4.
38. Following the National Neonatal critical care review (NCCR). ELHT Trust received some recurrent funding to increase cot side care WTE nurses, this bridged the gap to reduce the deficit in compliance with British Association of Perinatal Medicine (BAPM) standards for nurse staffing. This was based on activity and acuity in the previous 3 years. All posts are recruited to and in post. It is recommended that the unit collates and monitors BAPM compliance monthly in the Divisional Governance Meeting so that assurance can be provided to the Trust Board at the six-monthly professional judgements.

Finance

39. The Professional Judgement Review has identified there will be no increase in cost for the recommended changes due to the changes already being in the run rates for 2024-25.

	Run rate effects:-		
Area	**wte**	**£**	**Comments / Actions**
Ward Manager / Team Leader - supernumerary review	-	-	Improvement case under review
PNAs Time	-	-	Absorbed within current budgets
MEC Ward B4	-	-	Within run rate 23/24 so funded - budget realignment required to fund the establishment.
MEC - Ward C7	-	-	Within run rate 23/24 so funded - budget realignment required to fund the establishment.
MEC - Ward D1, D3 & C11	-	-	Within run rate 23/24 so funded - budget realignment required to fund the establishment.
SAS - Elective Centre	-	-	Improvement case based on anticipated future activity required
FC - COAU	-	-	Budget realignment undertaken to address shortfall from Paediatric ward areas
CIC - Ward 19	-	-	Within run rate 23/24 so funded - budget realignment required to fund the establishment.
CIC - Community Nursing	-	-	Band 6 funding from band 5 actioned
Total	-	-	

Conclusion and Recommendations

The BOD are asked to consider the professional judgement and agree the recommendations.

The BOD are asked to note the data in terms of fill rates, vacancy rates, sickness rates, staff turnover and recruitment plans.

Appendix one

Monthly TREND	Day		Night				Number of wards below 80 %			
							Day		Night	
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Sum of Midnight Counts of Patients	Care Hours Per Patient Day (CHPPD)	Average fill rate - registered nurses/m	Average fill rate - care staff (%)	Average fill rate - registered nurses/m	Average fill rate - care staff (%)
Jun-23	93.2%	100.2%	101.1%	110.2%	28056	8.95	1	1	1	0
Jul-23	93.3%	97.7%	100.2%	109.6%	29766	8.61	0	2	0	0
Aug-23	92.6%	100.1%	100.5%	111.7%	30062	8.54	1	2	0	0
Sep-23	92.8%	97.6%	97.8%	107.2%	29886	8.26	0	2	2	1
Oct-23	94.6%	94.9%	104.5%	106.6%	31679	8.09	0	2	0	1
Nov-23	95.5%	97.4%	101.5%	109.3%	30083	8.35	0	3	0	0
Dec-23	93.4%	95.4%	100.0%	108.0%	30111	8.52	1	2	0	1
Jan-24	93.2%	95.9%	101.0%	108.3%	31392	8.19	0	4	0	1
Feb-24	93.5%	95.5%	100.5%	107.6%	29830	8.04	1	2	1	1
Mar-24	91.2%	97.0%	100.5%	107.5%	30877	8.23	0	2	0	1
Apr-24	94.3%	99.5%	99.7%	106.4%	30852	8.05	0	1	1	1
May-24	94.1%	97.1%	99.2%	108.3%	31886	8.02	0	1	0	0
Jun-24	95.5%	100.5%	100.7%	110.4%	30887	8.34	0	1	0	0
Jul-24	93.9%	97.6%	99.4%	109.1%	31622	8.24	2	1	0	0
Aug-24	92.4%	97.8%	100.0%	110.2%	31181	8.30	4	0	0	0
Sep-24	91.5%	96.3%	96.7%	105.6%	31713	7.92	1	2	1	1
Oct-24	91.1%	94.1%	98.3%	105.1%	33266	7.71	1	3	0	0
Nov-24	91.1%	96.1%	97.1%	107.9%	32370	7.98	0	2	0	0
Dec-24	90.7%	95.0%	97.8%	103.3%	33394	7.86	1	3	0	1

Appendix Two

Ward	Beds	Current Staffing Numbers per shift	WTE Current Uplift of 22%	SNCT Data Dec 23 WTE with uplift.	SNCT Data June 24 with uplift **NEW TOOL**	Proposed Establishment	Falls	Pressure Ulcers	Complaints	Med Errors	NAPF Status
							In the last 3 Months Oct 24 to Dec 24. **Assume falls no/low harm & pressure ulcer cat 2 unless stated**				
Ward 19 BGH	23	Early: 4 + 4 Late: 3 + 4 Night: 2 + 4	34.70	38.4	45.8	No Change	5	0	1	1	Amber
Ward 22 (16) BGH	27	Early: 4 + 4 Late: 3 + 4 Night: 3 + 4	41.54	38.5	43.6	No Change	10	1 CAT 3	0	2	Green
CLI RB	32	Early: 5 + 4 Late: 5 + 4 Night: 3+ 4	43.92	44.6	39.8	No Change	11	1 CAT 3	2	1	SPEC
RH	17	Early: 3 + 5 Late: 2 + 5	34.21	21.4	31.8	No Change	1	0	0	0	SPEC

		Night: 2 + 3									
Hartley	24	Early: 4 + 3 Late: 3 + 3 Night: 2 + 3	31.48	34.7	37.1	No Change	1	3 CAT 3	1	1	AMBER

Pendle RF	24	Early: 4 + 3 Late: 3 + 3 Night: 2 + 3	31.48	33.6	41.6	No Change	1	0	1	0	Green
Marsden		Early: 4 + 6 Late: 4 + 5 Night: 2+Twi + 3	41.31	37.2	45.4	No Change	0	0	0	0	Green
AMU	73	Early: 19 + 13 Late: 19 + 13 Night: 18 + 9	164.42	126.4	154.7	No Change	2	3	6	0	Green
B14	24	Early: 5 + 4 Late: 5 + 4 Night: 3 + 3	41.19	29.9	39.5	No Change	2	1 cat 1 1 cat 3	1	7	SPEC
B2	23 (3)	Early: 5+4 Late: 5 + 4	44.92	38.2		No Change	0	1	0	0	Green

		Night: 3+ 4			44.4						
B22	23	Early: 4 + 6 Late: 4 + 6 Night: 2 + 3	48.02	38.5	41.3	No Change	3	2 cat 2 4 cat 3	1	1	Green
B24	23	Early: 4 + 4 Late: 4 + 4 Night: 2 + 3	37.09	28.8	34.4	No Change	8	2 cat 2 4 cat 3	4	0	Green
B4	24	Early 4 + 6 Late: 3 + 6 Night: 3 + 4	43.93	37.1	52.0	No Change	1	2	2	0	Green
B6	22	Early: 4+ 3 Late: 3 + 3 Night: 3 + 3	32.41	New Ward	33.1	No Change	0	1	0	0	Amber
B8	22	Early: 4+ 3 Late: 4 + 3 Night: 3 + 2	33.12	No data	38.7	No Change	0	1	0	0	Amber
C10	22	Early: 5+ 4 Late: 5 + 4 Night: 3 + 4	43.97	33.5	39.4	No Change	0	0	0	0	Green
C11	22	Early: 4+ 4 Late: 3 + 4	35.74	35.2		No Change	0	3	1	0	Amber

		Night: 2 (TWI) + 3			43.2						
C14a	17	Early: 4+ 2 Late: 3 + 2 Night: 2 + 2	26.5	21.3	28.9	No Change	1	0	1 (ICB)	4	SPEC
C14b	17	Early: 4+ 2 Late: 3 + 2 Night: 2 + 2	26.5	22.1	30	No Change	2	1 cat 3	2	8	SPEC
C18a	18	Early: 4+ 2 Late: 3 + 2 Night: 2 + 2	26.5	23.9	30.4	No Change	5	1 cat 3	1	4	SPEC
C18b	18	Early: 4 + 3 Late: 3 + 3 Night: 2 + 2	29.24	24.2	27.3	No Change	11	1 cat 3	0	5	SPEC
DDU	48	Early: 8 + 6 Late: 8 + 6 Night: 6 + 8	73.96	71.8	Ward Split	No Change	-	-	--		
ESU	35	Early: 8 + 6 Late: 8 + 6 Night: 7 + 4	68.52	39.0	63.7	No Change	10	0	0	12	SPEC

C5	14	Early: 3+ 4 Late: 3 + 4 Night: 2 + 3	33.0	22.0	35.5	No Change	0	0	0	0	SPEC
C7	22	Early: 4 + 3 Late: 4 (-1) + 3 Night: 2+ twi + 2(3)	30.18	33.1	37.2	32.99	0	0	0	0	SPEC
C9	22	Early: 4 + 4 Late: 4+ 4 Night: 2 + 3	35.73	32.4	37.9	No Change	1	2	0	0	SPEC
D1& D3	43	Early: 8 + 6 Late: 8 + 6 Night: 4 + 6	65.99	58.7	80.2	No Change	0	2	1	0	Amber Amber
OPU	46	Early: 10 + 7 Late: 10 + 7 Night: 5 + 7	79.65	71.1	77.2	No Change	0	5	1	0	Ambe r
WD 15	24	Early: 5 (4) + 4 Late: 3 + 3 Night: 2 + 3	34.9	28.4	27.3	No Change	3	1 cat 3	0	2	SPEC

C6	25	Early: 4 + 4 Late: 4 + 4 Night: 3 + 3	38.51	31.6	41.8	No Change	0	0	0	0	SPEC
C8	20	Early: 4 + 4 Late: 4 + 4 Night: 2 + 3	36.85	28.9	31.3	No Change	0	3	2	0	SPEC
CCU	10	Early: 4 + 2 Late: 4 + 2 Night: 3 + 1	27.54	-		No Change	0	0	1	0	SPEC
Card Ward	26	Early: 5 + 3 Late: 5 + 3 Night: 3 + 2	35.73	No Data	41.8	No Change	1	0	1	0	SPEC
C2	24	Early: 4 + 3 Late: 4 + 3 Night: 3 + 4	38.96	36.0	36	No Change	1	1	2	1	Green
B18	26	Early: 4 + 3 Late: 4 + 3 Night: 3 + 4	38.96	36.0	40.7	No Change					-
Gynea	16	Early: 3 + 1 Late: 3 + 1 Night: 2 + 1	No data	No data	No data	-	0	0	0	0	Green

Appendix Three

(067) 1 ELHT Safer Staffing Governance

Bibliography

British Association of Perinatal Medicine, n.d. *About BAPM.* [Online]
Available at: https://www.bapm.org/
[Accessed 27 July 2023].

Francis , R., 2013. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry - excutive summary..* [Online]
Available at:
https://assets.publishing.service.gove.uk/goverment/upload/system/uploads/attachment_dat/file/279124/0947.pdf
[Accessed 26 June 2023].

Joint Agency Commercial Imagery Evaluation Standards, 2023. *EBMT.* [Online]
Available at: https://www.ebmt.org/accreditation/jacie-standards
[Accessed 27 July 2023].

NHS Improvement, 2018. *Developing Workforce Safeguards,* London: NHSI.

Ockenden , D., 2022. *Final report of the Ockenden review.* [Online]
Available at: https://www.gov.uk/government/publications/final-report-of-the-ockenden-review
[Accessed 27 July 2023].

Safe Staffing for Maternity Services, 2022. *birthratePLUS.* [Online]
Available at: https://birthrateplus.co.uk/
[Accessed 24 June 2023].

Shelford Group, 2023. *Safer Nursing Care Tool.* [Online]
Available at: https://shelfordgroup.org/safer-nursing-care-tool/
[Accessed 25 June 2023].

The Faculty of Intensive Care Medicine, 2022. *Guidelines for the Provision of Intensive Care Services.* [Online]
Available at: https://www.ficm.ac.uk/standardssafetyguidelinesstandards/guidelines-for-the-provision-of-intensive-care-services
[Accessed 27 June 2023].

The Royal College of Emergency Medicine/Royal College of Nursing , 2020. *Nursing Workforce Standards for Type 1 Emergency Departments.* [Online]
Available at: file:///C:/Users/RH1188/Downloads/Nursing-workforce-standards-for-Type-1-EDs-Oct-2020.pdf
[Accessed 26 June 2023].

Safer Nurse Staffing Governance Review

East Lancashire Teaching Hospitals NHS Trust

February 2025

Executive Summary

This review was jointly commissioned by the Integrated Care Organisation through the Chief Nurse function and the Trust through the Chief Executive Office. The review was requested for assurance on nurse safer staffing processes and governance arrangements associated with this. This was against a backdrop of financial scrutiny and ensuring services are safely staffed but also efficient.

This report provides an evaluation of safer staffing governance at East Lancashire Teaching Hospitals NHS Trust (ELHT). The review examines compliance with national standards for completion, reporting and monitoring effectiveness, as well as other processes of ensuring that nurse staffing is safe daily.

The review concludes that East Lancashire Teaching Hospitals NHS Trust has established effective safer staffing governance processes with several areas of good practice. Recommendations focus on refining existing systems, enhancing reporting mechanisms, and improving financial controls to ensure continued safe staffing whilst maximising efficiency particularly in variable pay. The Trust had already recognised and implemented a range of supportive measures at conclusion point of this report, and there were examples of good practice on both enhanced roster reporting and the approach to the culture of change using quality improvement and rapid improvement events. Due to recent implementation of schemes at the time of this report it was not possible to evaluate effectiveness of these schemes.

The reviewers would also like to note that there was demonstrable cohesion amongst staff and an ethos of working collectively on improvement objectives.

Background and Context

ELHT has undertaken significant work to strengthen nurse staffing governance since 2023, including:

- Implementation of the Shelford Model Safer Nursing Care Tool (SNCT) with bi-annual census periods and the Community Nursing Safer Staffing Tool (CNSST) tool for Community.
- Development of comprehensive monthly exception reporting to Quality Committee.

- Enhanced Board oversight through Integrated Performance Reporting.
- Recent peer review by NHS England's nursing workforce team.

Methodology of review

This review comprised:

Analysis of Trust documentation including:

- Professional judgement reviews (2023-2025).
- Monthly staffing exception reports.
- Public Board papers 2020-2024 and available relevant committee papers.
- NHS England peer review findings.
- Benchmarking against national workforce metrics (PWR).
- Review of SNCT implementation and data quality.

Insight Interviews

- Chief Executive.
- Chief nurse, Deputy Chief Nurses.
- Trust Chief Operating Officer, Finance Director, Chief People Officer.
- Trust focus group of thirty-eight nurse leaders.
- Roster Management/Temporary Staffing Team.

The review included an on-site sample qualitative review of ward and departments staffing numbers against establishment templates recommended in professional judgement papers. This targeted areas in the Trust within Accident and Emergency, Surgery and Medical wards and included meeting budget holders and those with roster accountability as well as other staff to ascertain their view on staffing ratios.

Key Findings

The Trust use evidence based safer staffing tools and triangulated with professional judgement and care quality metrics to set nursing establishments in line with NQB Guidance.

The Trust has demonstrated appropriate implementation of the SNCT and ED SNCT (specifically for ED):

- Structured bi-annual census periods (Summer/Winter).
- Updated methodology incorporating 1:1 and 2:1 requirements.

- Triangulation with run rate, professional judgement, and quality indicators.
- Clear reporting cycle of business through Quality Committee to Board.
- Focus group discussion highlighted that there is potential that not all red flag incidents were being reported through current processes. It is recommended that this view is tested as part of good practice.

It is recognised that during times of unpredictable pressures and volume of patients attending ED, the Trust may require higher levels of ED nurse staffing which may not be accounted for in the establishment reviews. However, it is noted that there is an appropriate escalation process in place to support this.

While the trust's current use of run rate (as part of the six monthly safer staffing reviews) provides a baseline understanding of staffing patterns and seasonal variations, we recommend enhancing the staffing methodology by prioritising evidence-based tools that incorporate patient acuity and care complexity data. This would not only align with best practices in workforce planning along with more precise allocation of nursing resources and budget setting.

The trust has used the Community Nursing Safer Staffing Tool (CNSST) in the community for approximately 18 months and are now using the updated tool CNSST II. We saw evidence of good practice regarding continual use of this tool during a national pause and review to maintain levels of competency in using the tool and informing decisions and practice.

It is worth noting that at the time of this review there were approximately eighty staff across surgery, maternity and medicine on maternity leave whose posts were not back filled during their leave

Governance, Reporting and Monitoring:

- There are escalation processes for staffing concerns and a standard operating procedure to follow.
- Staff corroborated processes and discussed mitigated actions and escalation against policies and SOPs. What we heard is what would be expected to manage nurse staffing and maintain safety.
- There has been a recent refresh on roster governance arrangements and controls through roster management and check and challenge meetings which had been recognised by the Trust as an area of focus.
- Further analytic reporting on staff availability has recently been developed in the Trust to inform both retrospective decision-making and prospective decision-making related to nurse staffing. The reviewers were not able to evaluate the effectiveness of this as this was an early implementation, however there is an opportunity to share practice across the ICS.

- Enhanced variable pay groups with revised controls have been in place with executive leadership. Through review of papers and discussions, the reviewer concurs that variable pay controls that have recently been introduced will support effective use of resources.
- Rapid improvement events have been recently introduced using Quality Improvement methodology for targeted areas with the ethos of shared accountability and ownership, from which learning and best practice can be shared across the Trust.
- The trust believes there is further opportunity in variable pay with controls for temporary workforce and short notice requirements. The revised governance arrangements and controls should support this.
- Review of availability reporting for the Trust has recently been refreshed. The reviewers agree this will further strengthen assurance.

Areas of Good Practice

- Compliance with NQB recommendations around safer staffing governance.
- Implementation of CNSST II in community settings.
- Bi-annual census periods using SNCT.
- Recent refresh of roster governance.
- Commencement of check and challenge meetings with senior nurses.
- Using QI processes to strengthen governance frameworks and empower staff through rapid improvement events- this supports the culture of autonomy and ownership.
- Newly implemented Business Intelligence reporting around roster availability and temporary workforce use – whist it is too early to report on effectiveness of this, there may be some opportunity for shared learning.
- The Trust has quarterly reconciliation of ledger, ESR and rosters.

Recommendations

- There may be value in re-circulating the Fundamentals of Safer Staffing e-learning package for nurse budget holders and colleagues involved in staffing decisions.
- Ensure continued implementation of financial training for clinical budget holders. The reviewers have not had sight of the training content but recommend that this should include effective forecasting and reporting, and the co-dependencies linked to this e.g. unavailability, supernumerary, unfunded activity.

- There may be some benefit in reviewing the 22% of headroom/uplift applied in establishment setting at ELHT. Headroom in nursing refers to the additional capacity built into rosters above the baseline establishment to account for expected absences such as annual leave, training, and sickness. A review of this would ensure that headroom/uplift is based on emerging patterns and needs. With correct headroom/uplift levels there should be capacity to cover predictable absences in advance.
- Strengthen reporting of red flags ensuring complete visibility of potential staffing issues, this will further support establishment reviews and inform decision making e.g. QIA process.
- Consider implementing a consistent maternity leave backfill strategy to further the work currently being undertaken around unavailability.
- Improve variable pay controls through enhanced governance arrangements and executive oversight to effectively manage costs while ensuring appropriate staffing levels are maintained.
- Continue rapid improvement events using Quality Improvement methodology in high variable pay areas, building on recent successes that have already identified potential cost savings.
- Ensure continued compliance with use of Safe Care for daily safe staffing decisions.
- Link in with National Enhanced Therapeutic Observations of Care (focused on 1:1 care provision) national programme and NHSE Regional Nursing Workforce Lead regarding involvement in regional Community of Practice and joining possible future ETOC programme cohorts for 90 improvement programme.
- A theme which was corroborated in a number of forums, interviews and within clinical areas regarding ward managers/budget holders' availability for non-clinical tasks due to planned clinical activity, which some staff felt may impact on delivery of key objectives. Therefore It is recommended that a review is undertaken by the Trust to test this and ascertain current baseline against delivery of key role functions to establish if the current model is delivering what the Trust needs in terms of outcomes. Key role functions need to include all aspects of running a ward safely, effectively, and efficiently.

Conclusion

The review of safer nurse staffing governance at East Lancashire Teaching Hospitals NHS Trust demonstrates that the organisation has established robust systems for ensuring appropriate nurse staffing levels across its services. The Trust has successfully implemented nationally recognised evidence-based tools, including the Safer Nursing Care Tool for

inpatient areas and ED and the CNSST II for community settings, which represents commendable adherence to best practice.

The Trust's approach to staffing governance demonstrates compliance with National Quality Board recommendations through consistent achievement of fill rates above 90%, twice-daily staffing reviews, established escalation processes, and regular reporting mechanisms. The triangulation of staffing data with professional judgment and quality metrics provides a comprehensive foundation for establishment setting and decision-making.

While the governance structure is sound, the review has identified opportunities for refinement and optimisation. These include strengthening red flag incident reporting, reviewing the 22% headroom allocation to ensure it aligns with current patterns and needs, developing a consistent approach to maternity leave backfill, and enhancing financial controls for variable pay. The Trust's recent initiative to improve analytics for staff availability reporting is promising and should be further developed to strengthen prospective workforce planning.

Financial efficiency remains a challenge in the current NHS climate, but the Trust has demonstrated commitment to addressing this through rapid improvement events that have already identified potential cost savings. Continued focus by the Trust on pay controls, with appropriate oversight and governance, will be essential to balance financial sustainability with safe staffing levels and assure/or advise the Trust Board on future financial decisions, quality impact and workforce planning strategies.

The implementation of the recommendations outlined in this report will further strengthen the Trust's approach to nurse safer staffing governance, ensuring that East Lancashire Teaching Hospitals NHS Trust continues to provide safe, high-quality care while maximising the efficiency of its nursing workforce.

In summary, East Lancashire Teaching Hospitals NHS Trust has established effective safer staffing governance with several areas of good practice identified. The organisation is well-positioned to build on this foundation and address the identified areas for development to further enhance both patient safety and operational efficiency.

Author/s

Claire Harrington

Regional Head of Nursing Workforce – Regional Safer Nurse Staffing Lead

Nursing Directorate NHSE North West

Bridget Lees

Executive Director of Nursing, Midwifery and AHP

Blackpool Teaching Hospitals NHS Foundation Trust

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Meeting Date:	14 May 2025	**Agenda Item:**	TB/2025/067
Report Title:	Integrated Performance Report		
Author:	Mr D Hallen, Director – Data and Digital		
Lead Director:	Mrs S Gilligan, Chief Operating Officer		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓			
Executive Summary:	This paper presents the corporate performance data at March 2025			
Key Issues/Areas of Concern:				
Action Required by the Committee:	Members are requested to note the attached report for assurance.			

Previously Considered by:	
Date:	
Outcome:	

Integrated Performance Report

Published: April 2025

Safe | Personal | Effective

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

Contents

East Lancashire Hospitals NHS Trust
A University Teaching Trust

How to read an SPC Chart

East Lancashire Hospitals NHS Trust
A University Teaching Trust

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

A statistical process control (SPC) chart shows data over time. Process limits show how much variability there is in the data to the chart and patterns are highlighted to show where a change is statistically significant. If there is a target, this variability can be used to provide assurance on whether the target is likely to be met in future.

XmR chart
The most common SPC chart type is the XmR chart. Each data point is shown as a grey dot on a grey line. From this data, the mean is calculated and added between the dots as a solid line, and process limits are added as grey dashed lines. If there is a target, it is shown as a red dashed line.

Process limits
In a stable process, over 99% of data points are expected to lie between the process limits. For reporting, the upper and lower process limit values are usually given as the range of expected values going forward.

Special cause variation & common cause variation
Data naturally varies but if this variation is statistically significant, this is called special cause variation and the grey dots are instead shown as blue or orange, depending on whether a higher value is better or worse – blue is used for improving performance, orange for concerning performance. If not significant, the dots stay grey and this is called common cause variation.
The four rules used to trigger special cause variation on the chart, as advised by the Making Data Count team at NHS England, are:
- a point beyond the process limits
- a run of points all above or all below the mean
- a run of points all increasing or all decreasing
- two out of three points close to a process limit as an early warning indicator

Summary

East Lancashire Hospitals NHS Trust
A University Teaching Trust

The matrix provides a summary of performance metrics included in this report. It highlights where metrics are showing assurance and variation.
18.0% of our metrics are consistently achieving target
29.5% of our metrics are inconsistently achieving target
9.8% of our metrics are not achieving target, however 3 of these are showing special cause improvement.
42.6% of our metrics do not have a target currently set.

Variation \ Assurance	Achieving target	Inconsistently achieving target	Not achieving target	No target set
Special cause improvement	Appraisal (consultant)	A&E 4hr	VTE, Appraisal (AFC), IG training	RN/MW agency spend, >62d urgent cancer GP referral, Ops cancelled on day, Income run rate, Agency spend as proportion of total pay bill
Common cause	Fill (RN/MW night & care staff day and night), Community, Inpatient and Outpatient F&F, Complaints	MRSA, Wards <80%, Community & Mat F&F, Hovers>60 mins, Cancer 28d, 31d, 62d, Vacancy, Variance to planned financial performance	A&E F&F, Sickness	C. diff, E.coli, Klebsiella, Psuedomonas, RN/MW bank spend, Crude mortality rate, A&E attends, Avg & max arrival to handover, Emergency average LOS, % beds occupied by 7+ & 14+
Special cause concern	DM01 % >6 weeks, Fill (RN/MW day and night, Care staff night)	Not treated within 28 days of a last minute cancellation, WRP, All BPPC	SHMI	CHPPD, Over 12hr TiD, Hovers >30 mins, Bed occupancy, % beds occupied by 21+, Employee expenses run rate, Other operating expenses, Variance to capital programme

SAFE - Summary Scorecard

East Lancashire Hospitals NHS Trust
A University Teaching Trust

METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
AVERAGE FILL RATE REGISTERED CARE STAFF (DAY)	MAR 25	96.57	90.00		
AVERAGE FILL RATE REGISTERED CARE STAFF (NIGHT)	MAR 25	106.63	90.00		
AVERAGE FILL RATE REGISTERED NURSES (DAY)	MAR 25	91.76	90.00		
AVERAGE FILL RATE REGISTERED NURSES (NIGHT)	MAR 25	98.18	90.00		
MRSA	MAR 25	0.00	0.00		
PATIENTS RISK ASSESSED FOR VENOUS THROMBOEMBOLISM	MAR 25	89.23	0.00		
NATIONAL NURSING RED FLAGS	FEB 25	0.00	0.00		
WARDS <80% REGISTERED NURSE (DAY) FILL RATE	MAR 25	1.00	0.00		
CARE HOURS PER PATIENT DAY (CHPPD)	MAR 25	7.99	8.00		

METRIC	LATEST DATE	VALUE	VARIATION
C DIFF PER 100000 RATE	MAR 25	13.64	
ECOLI PER 100000 RATE	MAR 25	37.50	
KLEBSIELLA PER 100000 RATE	MAR 25	17.04	
PSUEDOMONAS PER 100000 RATE	MAR 25	0.00	
REGISTERED NURSE AGENCY SPEND	MAR 25	267300.24	
REGISTERED NURSE BANK SPEND	MAR 25	1074718.07	

Alert

During the month of March 2025 we have seen a slight improvement again with nurse staffing for both days and nights, but not enough to see a statistical variation impact. 1 clinical area was below 80% for the month of March 2025, this was due to staff on a medically optimised ward being redeployed to support operational pressures in the Emergency Department. This was a risk based decision, and there were no harms as a result. There was 1 red flag reported in March 2025, there was no harm but delays in service delivery which could result in poor patient experience.
There has been a decrease in the number of reported incidents from 70 in February to 44 in March 2025. Since April 1, 2024, a total of 643 pressure ulcer incidents have been reported under the care of ELHT with 116 confirmed lapses in care (18%). These figures reflect a significant improvement compared to the 2023-2024 position.

Advise

Nurse staffing continues to be monitored twice daily in a trust wide staffing meetings chaired by Divisional Directors of Nursing. Midwifery staffing continues to be monitored four times a day. Where pressure are increased, the calls are then attended by each Divisional Director of Nursing and 1 Deputy Chief Nurse. From April 2025 the trust as agreed to start to monitor performance against less than 90% standard, which will see a probable statistical change in performance.
The new process for the investigation of pressure ulcers in residents within the Regulated Care Sector has gone live within the District Nursing service and monitoring is in place to ensure adherence to agreed pathways, led by the CIC QG team, the TV Matron and the DN Matrons. Compliance with uploading clinical photography on datix is improving (80.25%) for February. The number of Moisture Associated Skin Damage incidents continue to be a concern with 700 reported since April 1, 2024 – all Divisional action plans now have a specific action to ensure that all relevant staff are undertaking the appropriate training module and an impatient continence formulary is due to be launched in Mary 2025.

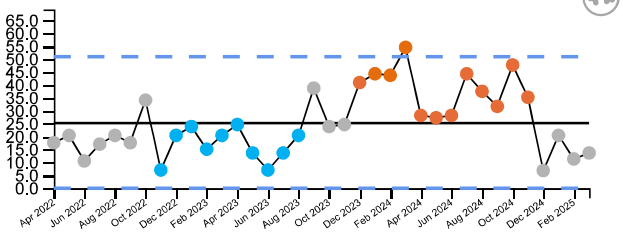
Assurance

The overall percentage fill rate for RNs for days and nights was above 90% and fill rate for CSW for days and nights was above 96%.
Compliance with the Pressure Ulcer and Moisture Associated Damage e-learning increased in March to 91.05% and 91.40% respectively. This issue will be addressed by the Pressure Ulcer Steering Group.

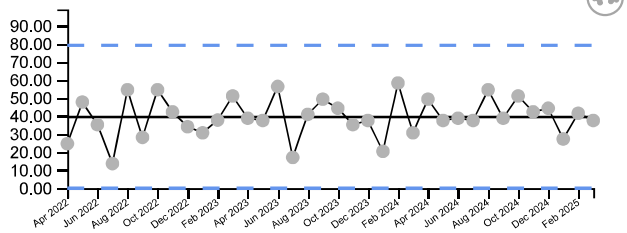
SAFE - Infection Control

East Lancashire Hospitals NHS Trust
A University Teaching Trust

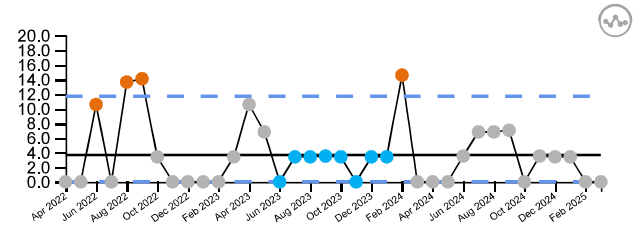
Clostriduim difficile per 100,000 bed days (HOHA & COHA)



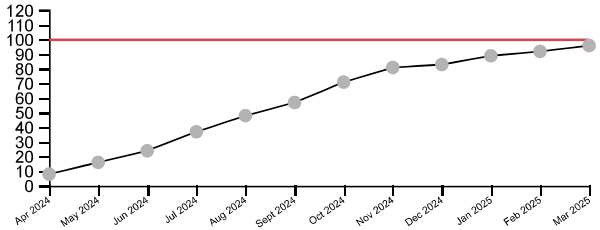
E.coli per 100,000 bed days (HOHA & COHA)



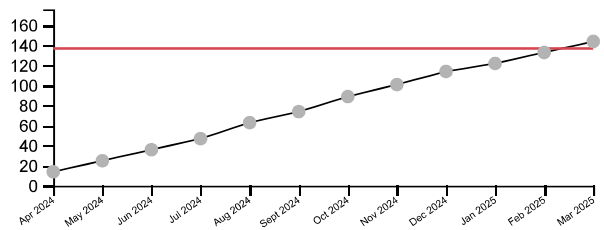
P.aeruginosa bacteraemia per 100,000 bed days (HOHA & COHA)



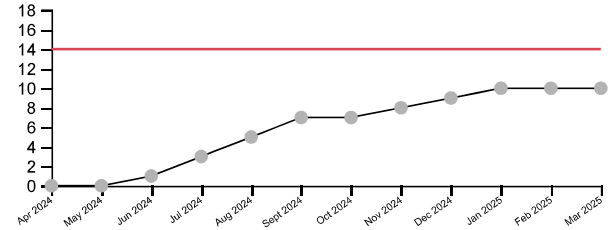
Clostriduim difficile (C.diff) cumulative 24/25



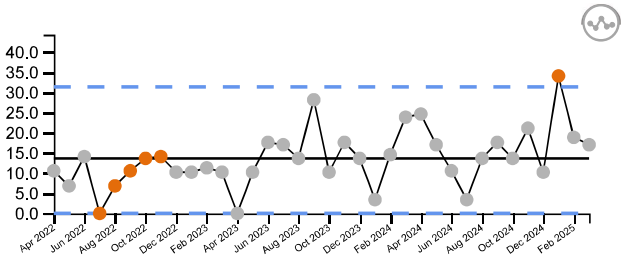
E.coli cumulative 24/25



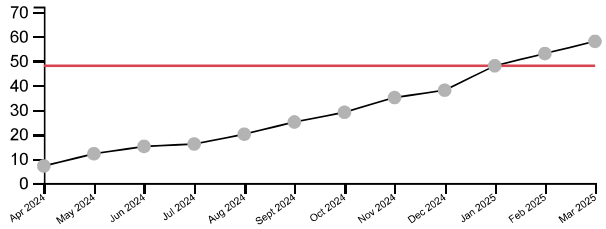
P.aeruginosa bacteraemia cumulative 24/25



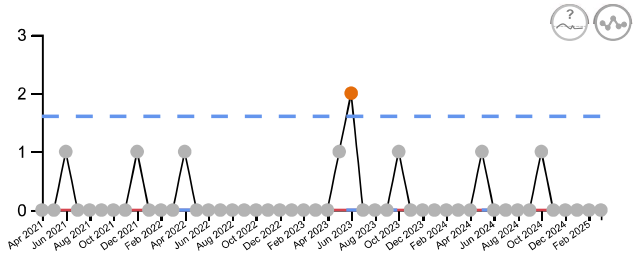
Klebsiella per 100,000 bed days (HOHA & COHA)



Klebsiella cumulative 24/25



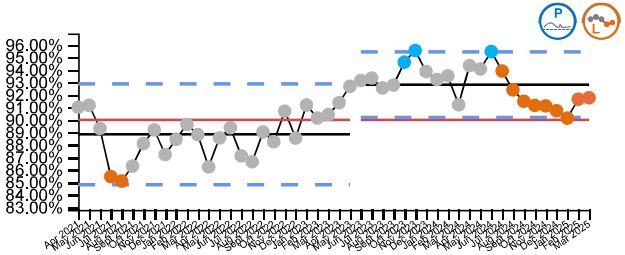
MRSA



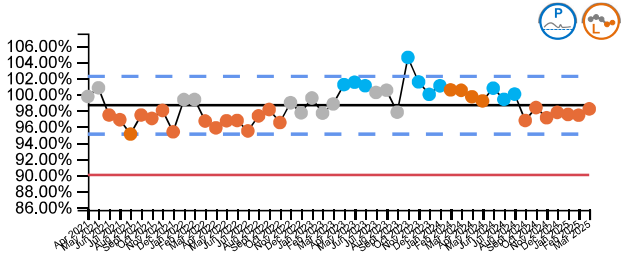
SAFE - Staffing

East Lancashire Hospitals NHS Trust
A University Teaching Trust

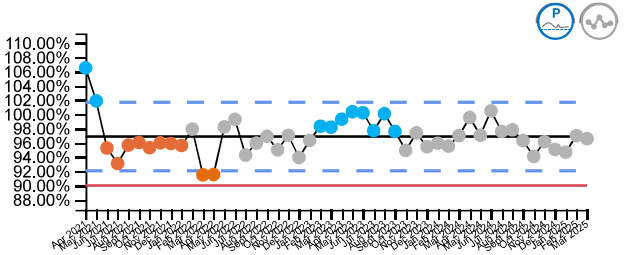
Average fill rate - registered nurses/midwives (day)



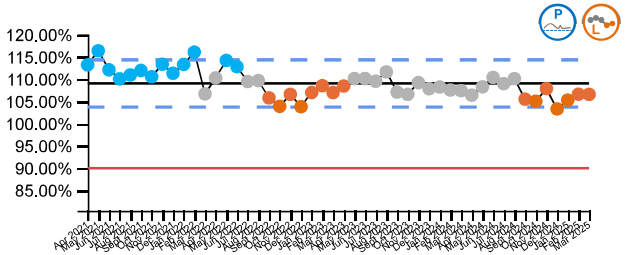
Average fill rate - registered nurses/midwives (night)



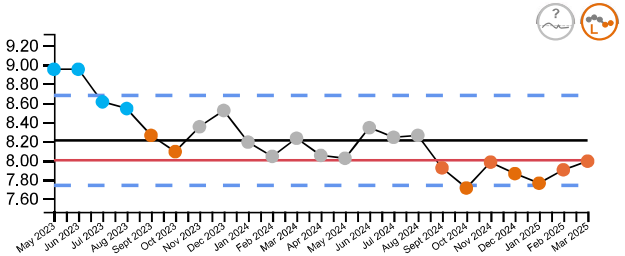
Average fill rate - care staff (day)



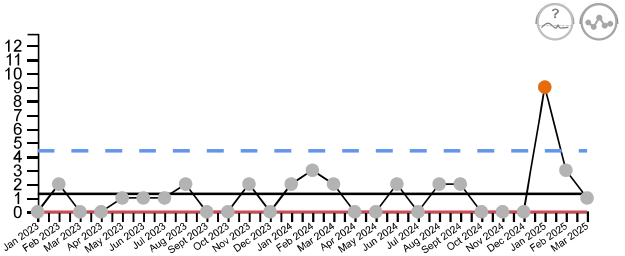
Average fill rate - care staff (night)



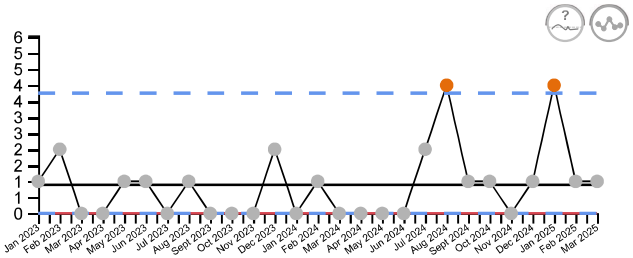
Care hours per patient day (CHPPD)



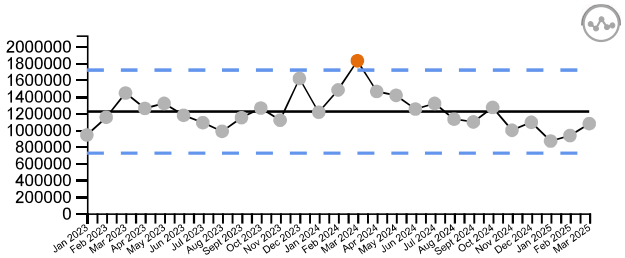
National nursing and midwifery red flags



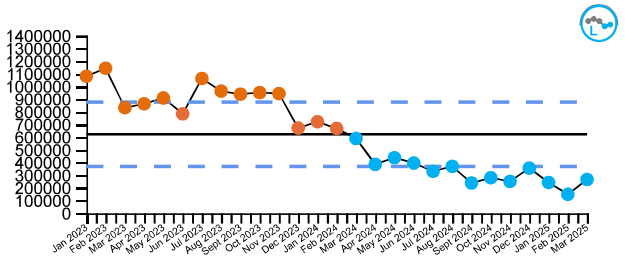
Wards <80% registered nurse (day) fill rate



Registered nurse and midwifery bank spend



Registered nurse and midwifery agency spend



Safe | Personal | Effective

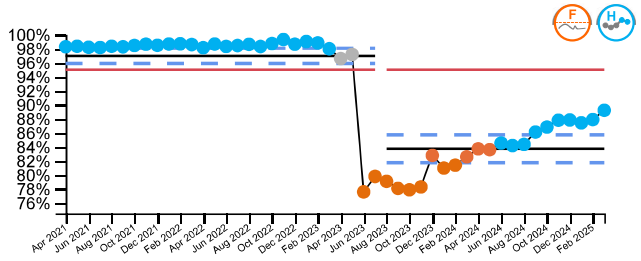
SAFE - Incidents and Pressure Ulcers

East Lancashire Hospitals NHS Trust
A University Teaching Trust

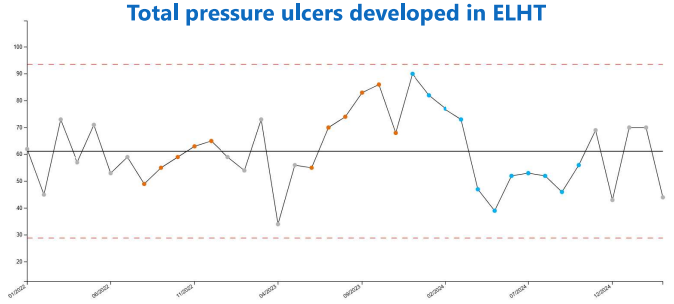
In month Never events	Year to date Never events	In month Medication errors serious/fatal harm	Year to date Medication errors serious/fatal harm	In month CAS alerts - Non-compliance	Year to date CAS alerts - Non-compliance
0	3	0	6	1	12

In month Serious incidents	Year to date Serious incidents	In month Slips trips falls serious/fatal harm	Year to date Slips trips falls serious/fatal harm
3	44	3	12

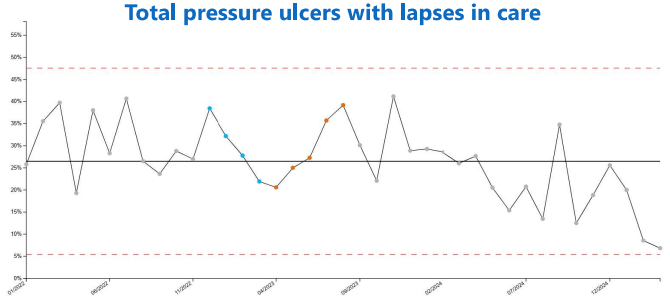
Patients risk assessed for venous thromboembolism



Total pressure ulcers developed in ELHT



Total pressure ulcers with lapses in care



A number of pressure ulcers in recent months remain currently under investigation. New reporting definitions were also introduced from April 2024.

CARING - Summary Scorecard

East Lancashire Hospitals NHS Trust
A University Teaching Trust

METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
A&E FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	MAR 25	76.02	90.00		
COMMUNITY FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	MAR 25	92.17	90.00		
COMPLAINTS RATE PER 1000 CONTACTS	MAR 25	0.24	0.40		
INPATIENT FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	MAR 25	96.07	90.00		
MATERNITY FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	MAR 25	83.79	90.00		
OUTPATIENT FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	MAR 25	96.03	90.00		

Alert

The Friends and Family Test (FFT) recommendation rate for A&E has shown continued improvement, rising by 3 percentage points to 76% – an increase from 73% last month. While still below the national average of 80% (January 2025), this represents a positive trend given the current pressures on the department.

Advise

Maternity services experienced another slight decrease in positive response rates from 86% in February to 84% in March. The negative responses are predominately relating to the postnatal ward concerning midwife consistency, staff attitude, pain management, and discharge procedures. Family Care remains actively engaged in investigating the underlying context of the identified themes to inform the development of targeted solutions. The Trust's Patient Experience Group will monitor the implementation and impact of these solutions.

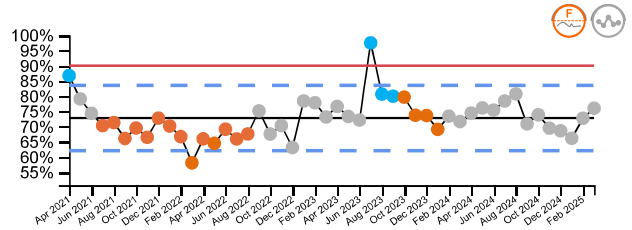
Assurance

Across our inpatient, outpatient, and community services, Friends and Family Test positive recommendation rates consistently meet or exceed the national average.
Currently, the Trust has 106 active complaints. The average time to close a complaint is 64 days. The formal complaint rate per 1,000 contacts has remained stable and in line with expectations.

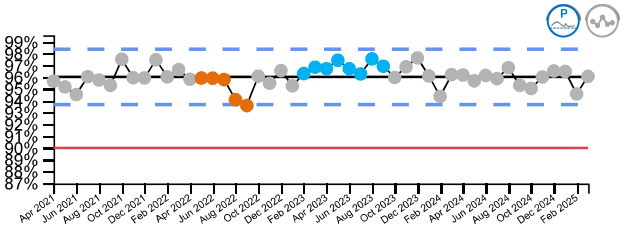
CARING - Feedback

East Lancashire Hospitals NHS Trust
A University Teaching Trust

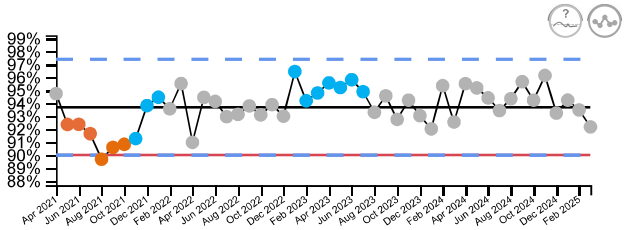
A&E FFT - % describing their experience as good or very good



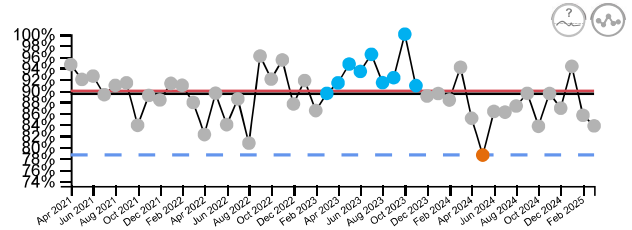
Inpatient FFT - % describing their experience as good or very good



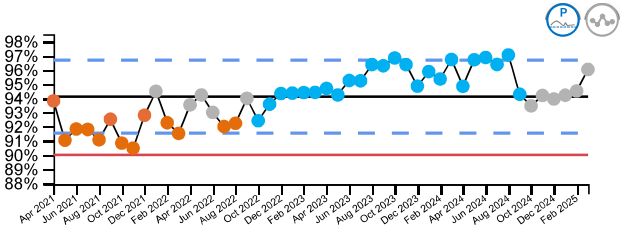
Community FFT - % describing their experience as good or very good



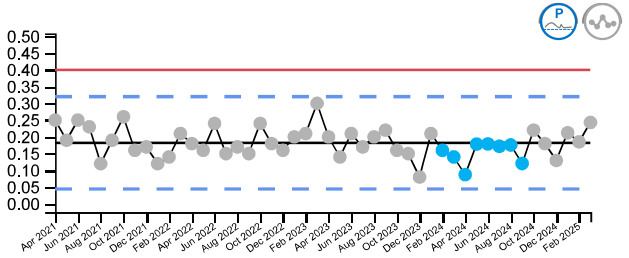
Maternity FFT - % describing their experience as good or very good



Outpatient FFT - % describing their experience as good or very good



Complaints rate per 1000 contacts



EFFECTIVE - Summary Scorecard

East Lancashire Hospitals NHS Trust
A University Teaching Trust

METRIC	LATEST DATE	VALUE	VARIATION
CRUDE DEATHS	MAR 25	148.00	
CRUDE MORTALITY RATE	MAR 25	3.10	
SHMI	MAR 25	1.30	

Alert

The Trust remains unable to provide assurance in relation to the HSMR and SHMI mortality indicators due to issues with data submission. Data submission is now occurring within necessary timescales, but given the intrinsic delay in availability of secondary data from NHSE, and the effect of the rolling 12 month period used for mortality indicators, accurate HSMR and SHMI are not expected for several months. HSMR is not currently calculated but has historically been above expected. Telstra is moving to a new model (HSMR+) and initial indications on a limited data set are that this will substantially improve reported mortality ratio. SHMI is published and remains very high, although has plateaued (1.30), but confidence remains low. The data published nationally does contain a caveat that our data contains a high percentage of invalid diagnosis codes and also notes that the trusts that have removed SDEC activity are reporting higher SHMI. Crude mortality is static at present, and remains within process limits, and is not seasonally adjusted. The post responsible for managing Doctors revalidation reports and the SJR process has been vacant since 30 June 24. The recruit who was expected to commence 4 March will no longer be taking up the post. This has impact both on SJRs and revalidation.

Advise

Stillbirth numbers have returned to expected levels.

Assurance

Some assurance with respect to trust mortality is provided by close monitoring of the crude mortality rate, which does not exceed control limits.

EFFECTIVE - Mortality

East Lancashire Hospitals NHS Trust
A University Teaching Trust

There are issues impacting the SHMI including:
- Backlog in coding
- Removal of Same day emergency care (SDEC) from Admitted Patient Care (APC) dataset
- Data quality issues with SUS submission impacting spell counts

The Trust has an established mortality steering group which meets monthly to review performance and develop specific action plans for alerting groups.

Latest month SHMI banding

Higher than expected

Stage 1 SJR Reviews

Completed in most recent month

Reviews	Total
Number complete	3
Backlog	> 100
5 - Excellent Care	1
4 - Good Care	2
3 - Adequate Care	0
2 - Poor Care	0
1 - Very Poor Care	0

Stage 2 SJR Reviews

Completed in most recent month

Reviews	Total
Number complete	0
Backlog	0
5 - Excellent Care	0
4 - Good Care	0
3 - Adequate Care	0
2 - Poor Care	0
1 - Very Poor Care	0

Learning Disability Mortality Reviews

LeDeR and Mortality Reviews

Number of deaths	Dec 2024	Jan 2025	Feb 2025
Learning Disability	3	4	3
Autism	0	0	0
Completed mortality reviews	7	4	4

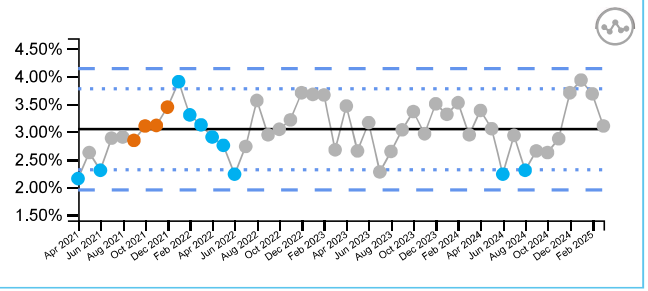
LeDeR and Mortality Reviews

The new process which includes a monthly review and sign off meeting commenced in January 2025.

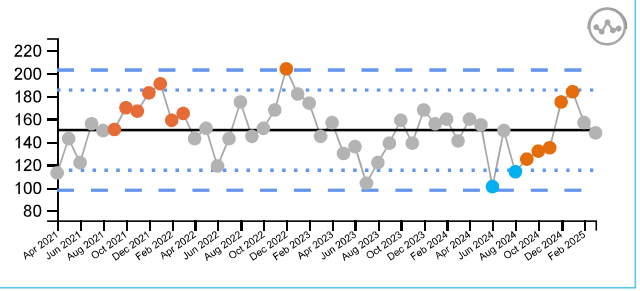
Outcomes from reviews

- Produce a 7 minute briefing re independent Mental Capacity Advocates (IMCA)
  ACTION - Julie Clift and Rachel Jeffries to design for submission to NWF for approval in April 2025
- Request further review from Gastroenterology. Could we have done anything more to review patients' condition as an outpatient?
- ACTION - Professor Lynch agreed to review this case.
- Noted in 3 of the reviews that patients had been moved during the end-of-life period.
  ACTION – Non noted

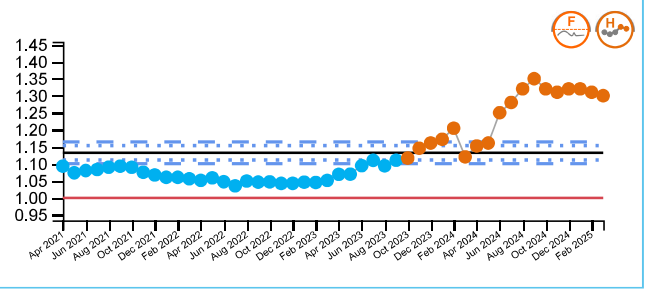
Crude Mortality Rate



In Hospital Deaths



Summary Hospital-level Mortality Indicator (SHMI)



Stillbirths

4

Year to date stillbirths

30

Maternal deaths

0

Year to date maternal deaths

1

Safe | Personal | Effective

RESPONSIVE - Summary Scorecard

East Lancashire Hospitals NHS Trust
A University Teaching Trust

METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
A&E 4HR PERFORMANCE (TRUST)	MAR 25	79.69	78.00	H	?
AMBULANCE HANDOVERS >60 MINUTES	MAR 25	93.00	0.00		?
DM01 % OVER 6 WEEKS	MAR 25	1.41	5.00	L	F
NOT TREATED WITHIN 28 DAYS OF LAST MINUTE CANC	MAR 25	7.00	0.00	H	?
28D GENERAL FDS	FEB 25	80.70	75.00		?
31D GENERAL TREATMENT STANDARD	FEB 25	95.10	96.00		?
62D GENERAL STANDARD	FEB 25	72.10	70.00		?

METRIC	LATEST DATE	VALUE	VARIATION
% HANDOVERS > 30 MINUTES	MAR 25	24.83	H
A&E ATTENDANCES	MAR 25	24513.00	H
BED OCCUPANCY G&A	MAR 25	95.57	H
CANCELLED ON DAY OPERATIONS	MAR 25	63.00	L
EMERGENCY AVERAGE LENGTH OF STAY (EXCL 0 AND 1 DAYS)	MAR 25	10.72	
OVER 12 HOURS IN DEPARTMENT	MAR 25	2132.00	H
AVERAGE ARRIVAL TO HANDOVER	MAR 25	0.44	
MAX ARRIVAL TO HANDOVER TIME	MAR 25	3.72	
PATIENTS OVER 62 DAYS (URGENT GP REFERRAL)	MAR 25	170.00	L

METRIC	LATEST DATE	VALUE
RTT ONGOING	MAR 25	60810.00
RTT OVER 52 WEEKS	MAR 25	2557.00
RTT OVER 65 WEEKS	MAR 25	10.00
RTT OVER 78 WEEKS	MAR 25	0.00

Alert

Cancelled and not rebooked within 28 days

There were 7 patients who had operations cancelled on the day and were rebooked outside the required 28-day timeframe. Contributing factors for this included case complexity, consultant availability, and theatre capacity pressures at Royal Blackburn Hospital (RBH).

ED – 12 Hours: Time in the Department

The Emergency Department (ED) experienced exceptionally high demand in March, with 24,513 attendances recorded. This surge contributed to an increase in the number of patients waiting over 12 hours, rising to 2,132—108 more than in February. However, as a proportion of total attendances, this marks an improvement, from 11.7% in January decreasing to 9.4% in February, and 8.7% in March. To address these ongoing pressures, an improvement programme is currently underway, focusing on urgent and emergency care and discharge pathways, with the aim of sustainably reducing prolonged ED waits.

Advise

Same day Cancellations - There was a further reduction in same day cancelled operations, falling to 63 in March.

In RTT (Referral to Treatment) pathways, over 65 weeks - 10 ophthalmology outpatients were reported as waiting over 65 weeks. This delay was due to national challenges relating to tissue availability.

AmbulanceHandover Performance - Ambulance activity remained high, with 3,141 arrivals in March. Of these, 93 handovers exceeded 60 minutes — a reduction from 127 in February and 438 in January, demonstrating encouraging progress. Handovers over 30 minutes reduced by 1.51%, down to 24.83% from 26.34% in February. The average ambulance handover time improved to 26 minutes and 13 seconds, better than the NWAS average of 26:55 and an improvement from the February average of 29:43. A joint working group between ELHT and NWAS remains in place to drive further improvements in handover efficiency.

Assurance

ED four-hour performance - for March stood at 79.69%, above the national ambition of achieving 78% by March 2025 and reflecting the impact of focused improvement initiatives.

Diagnostic performance (DM01) - in March 1.41%, meaning 95.69% of patients received their diagnostic test within 6 weeks and achieving the national ambition of 5% by March 2025. This is the second month of achieving this standard as February performance was 4.31%

Cancer standards - performance remains on track or above trajectory:

The 28-Day Faster Diagnosis Standard was met at 80.7% (target:77%).

The 31-Day Combined Treatment standard was 95.1%, exceeding the Trust's 94% trajectory and approaching the national ambition of 96% by March 2025

The 62-Day General Standard was achieved at 72.1%,above the national ambition of 70% by March 2025.

The number of patients waiting over 62 days following urgent GP referral has decreased from 201 in February to 170 in March, showing steady improvement in backlog clearance

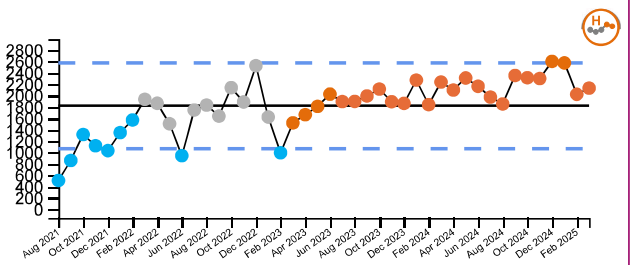
RTT on going continues to reduce

Theatre Utilisation - The Trust continues to remain in the top quartile for performance

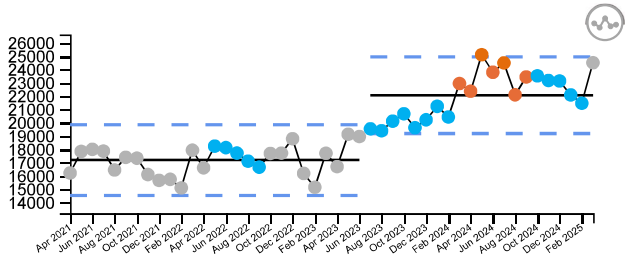
RESPONSIVE - A&E

East Lancashire Hospitals NHS Trust
A University Teaching Trust

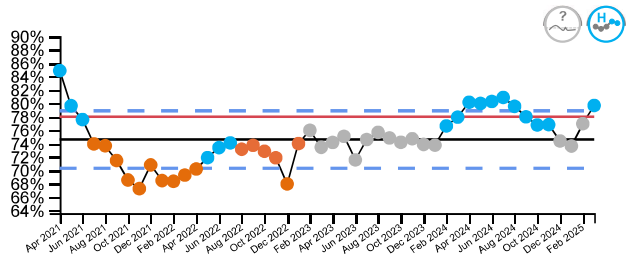
Over 12 hours in department



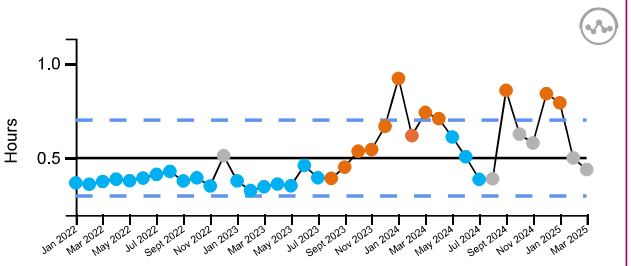
A&E attendances



A&E 4hr performance (Trust)



Average arrival to handover time



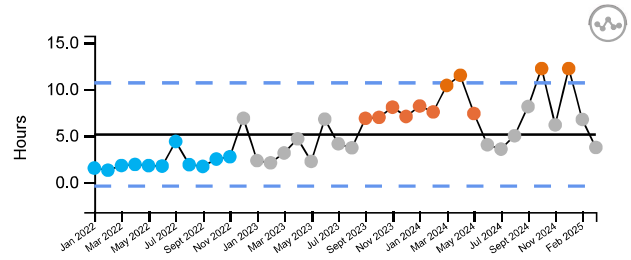
Average arrival to handover time h:mm (latest month)

0:26

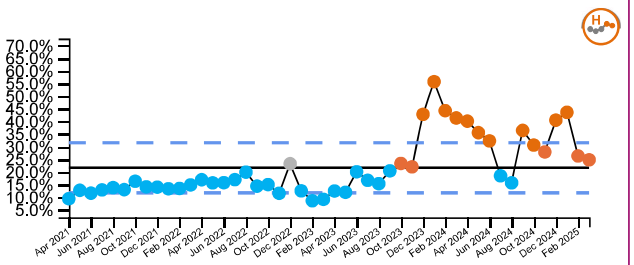
Maximum arrival to handover time h:mm (latest month)

3:43

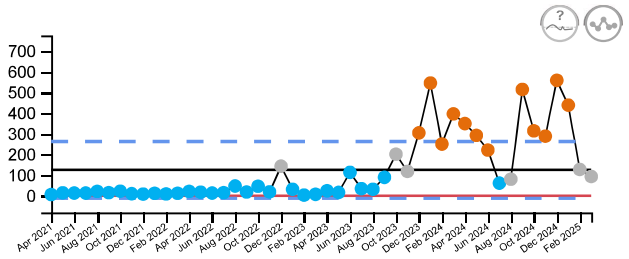
Maximum arrival to handover time



% handovers > 30 minutes



Ambulance handovers >60 minutes

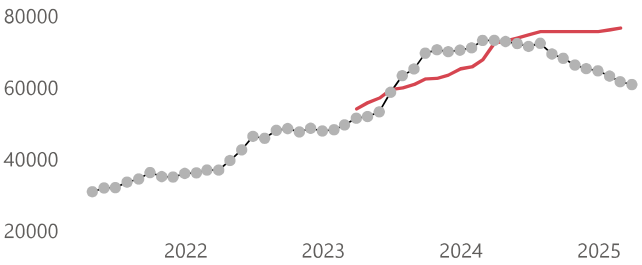


Safe | Personal | Effective

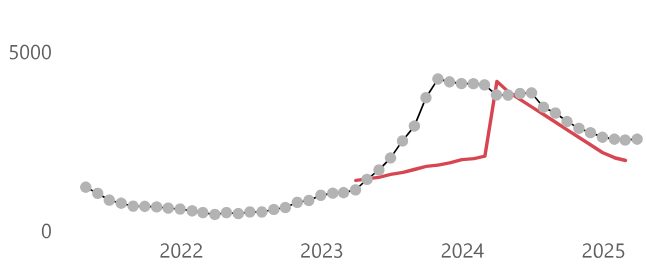
RESPONSIVE - RTT and Diagnostics

East Lancashire Hospitals NHS Trust
A University Teaching Trust

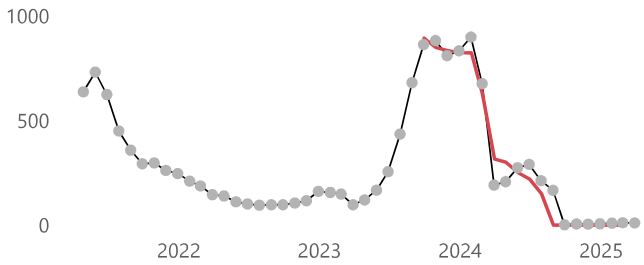
RTT Ongoing



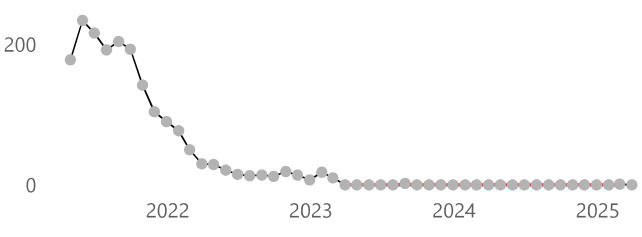
RTT over 52 weeks



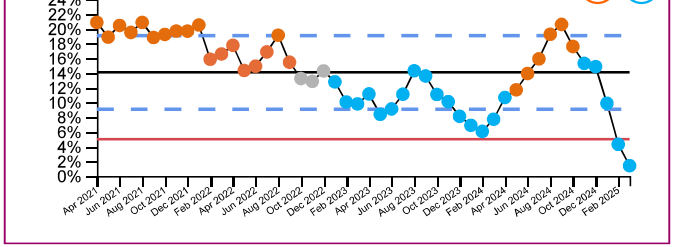
RTT over 65 weeks



RTT over 78 weeks



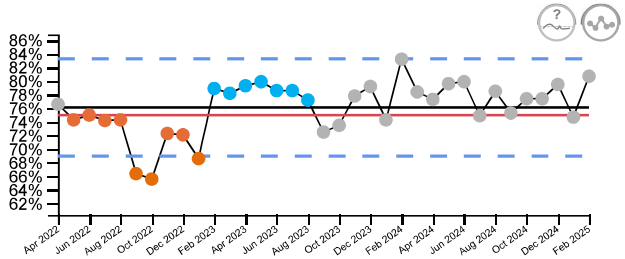
Patients waiting over 6 weeks for a diagnostic test



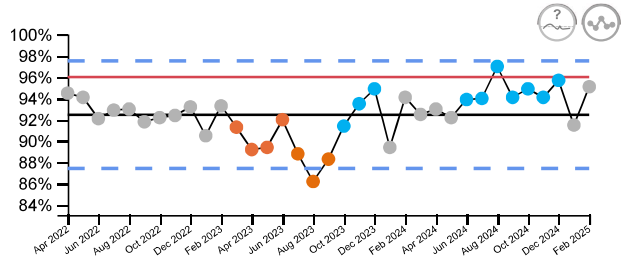
RESPONSIVE - Cancer

East Lancashire Hospitals NHS Trust
A University Teaching Trust

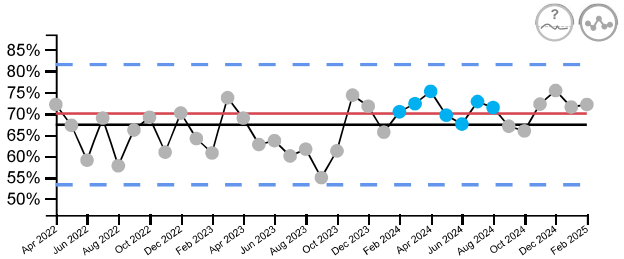
Cancer 28d general FDS



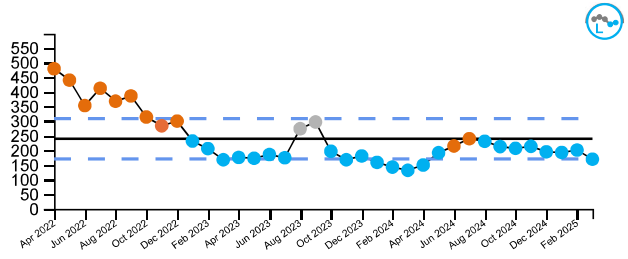
Cancer 31 day general treatment standard



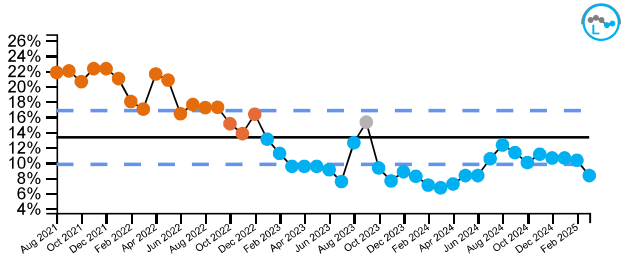
Cancer 62 day general standard



Patients over 62 days (urgent GP referral)



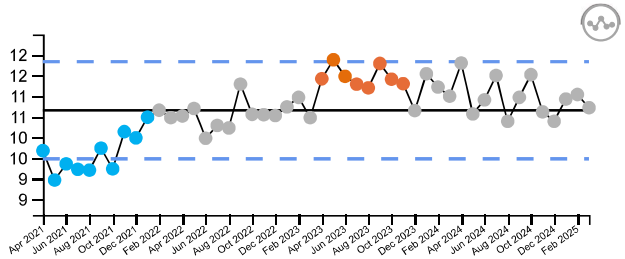
Percentage waiting over 62 days (urgent GP referral)



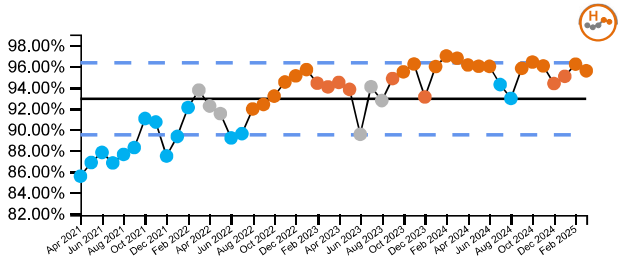
RESPONSIVE - Length of Stay and Bed Occupancy

East Lancashire Hospitals NHS Trust
A University Teaching Trust

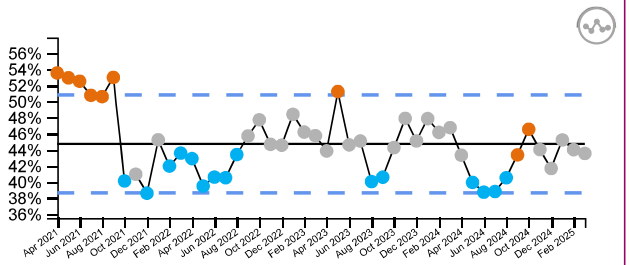
Emergency average length of stay (excluding 0 and 1 days)



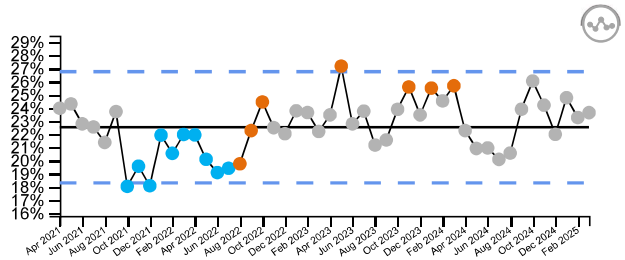
Bed occupancy G&A



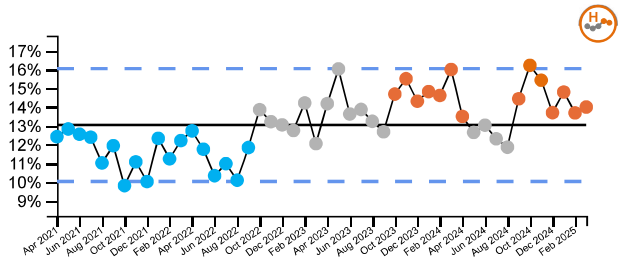
% Beds occupied by Long-Stay Patients 7+ days



% Beds occupied by Long-stay patients: 14+ days



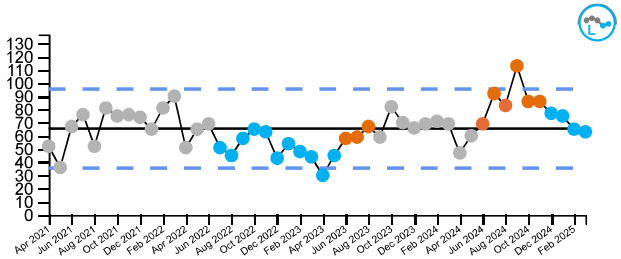
% Beds occupied by Long-stay patients 21+ days



RESPONSIVE - Cancellations and Utilisation

East Lancashire Hospitals NHS Trust
A University Teaching Trust

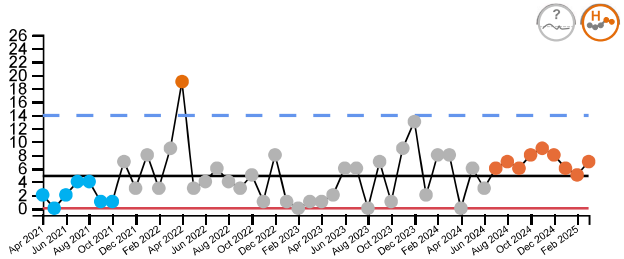
Number of operations cancelled on the day



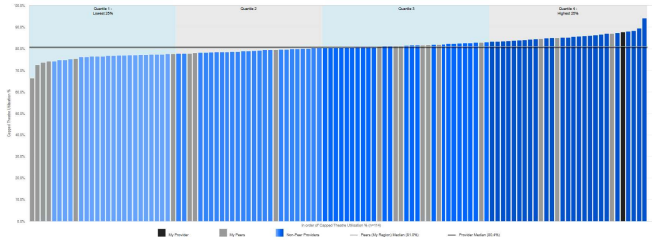
Urgent operations cancelled for 2nd time

0

On the day cancelled operations not rebooked in 28 days



Capped theatre utilisation



WELL LED - Summary Scorecard

East Lancashire Hospitals NHS Trust
A University Teaching Trust

METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
APPRAISAL (AGENDA FOR CHANGE)	MAR 25	82.00	90.00	H	F
APPRAISAL (CONSULTANT)	MAR 25	98.00	90.00	H	P
APPRIASAL (OTHER MEDICAL)	MAR 25	98.00	90.00		P
INFORMATION GOVERNANCE TRAINING	MAR 25	93.00	95.00	H	F
SAFEGUARDING CHILDREN L1	MAR 25	94.00	90.00		P
SICKNESS	MAR 25	6.21	4.50		F
TURNOVER	MAR 25	7.51	12.00		P
VACANCY	MAR 25	5.90	5.00		?

Alert

Non-medical appraisals remain at 82%, 8% below the target of 90% compliance.
Information Governance training compliance remains below the 95% target, with no change in month – 93%.

Advise

Sickness absence fell in March to 6.21%. This is 0.42% lower than February (6.64%), but 0.59% higher than the same point last year (5.63%).
A working group has commenced a piece of improvement work around specific interventions to help colleagues around the main causes of sickness absence, the top two being stress/anxiety/depression and Musculo-skeletal issues.
Specific roles are being recruited to, to assist colleagues with disabilities, providing advice and support around adjustments to the working environment, providing an improved link to Access to Work support.
Freedom to Speak Up figures for Q4 will be available in the next report.

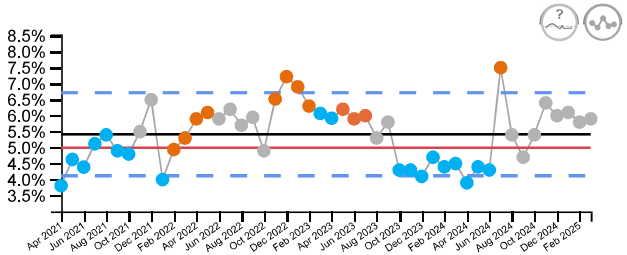
Assurance

Medical appraisals compliance remains high and above target, both Consultant and non-Consultant grades at 98%.
Safeguarding training stands at 94%, consistently above target.
Turnover remains consistent, remaining well within Trust target.
Vacancies have increased slightly, but this is expected, given the ongoing vacancy control measures in place.

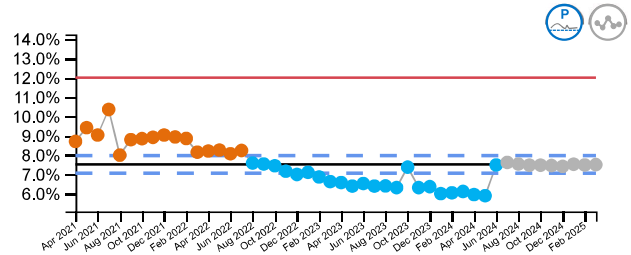
WELL LED - HR

East Lancashire Hospitals NHS Trust
A University Teaching Trust

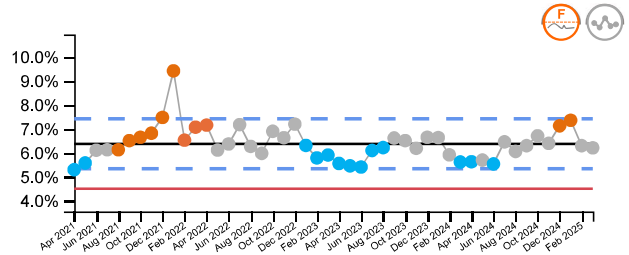
Vacancy rate



Turnover rate



Sickness rate



Freedom to Speak Up Cases by Elements

Reporting Period	Cases	Patient safety	Behaviour & attitudes	Bullying & harassment	Worker safety
Q1 24/25	40	3	21	11	18
Q2 24/25	61	0	35	16	34
Q3 24/25	115	4	29	7	22
Total	**216**	**7**	**85**	**34**	**74**

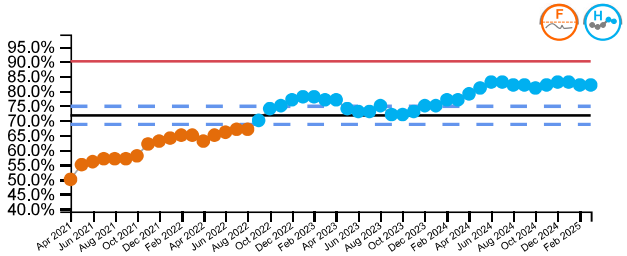
Job Plans

Stage	Consultants	Non consultants grades
Awaiting Signatures	106	24
Complete	146	43
Due Soon	20	11
In Progress	52	10
No Current Job Plan	17	9
Not Started	41	18
Referred Back	2	0
Uploaded	0	0
Total	**384**	**115**

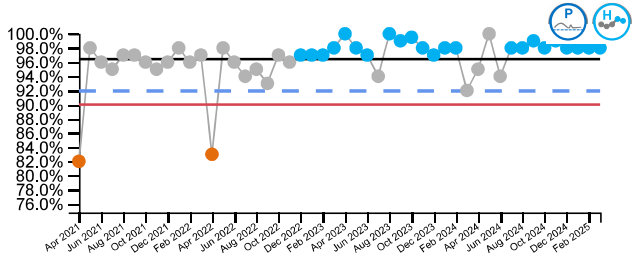
WELL LED - Learning and Development

East Lancashire Hospitals NHS Trust
A University Teaching Trust

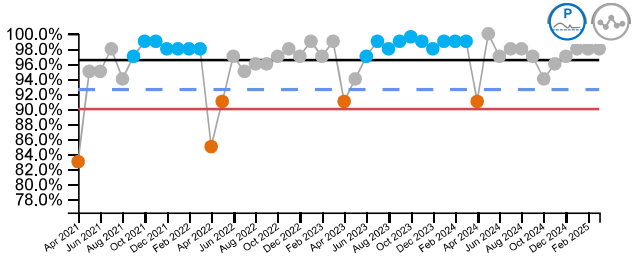
Appraisal rate (agenda for change)



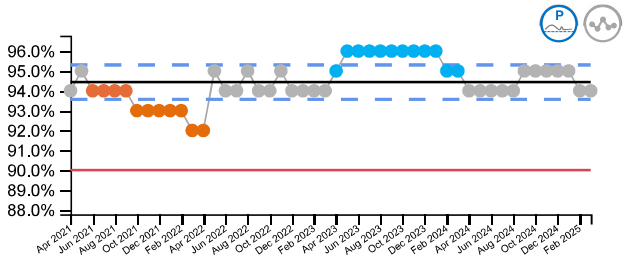
Appraisal rate (consultant)



Appraisal rate (other medical)



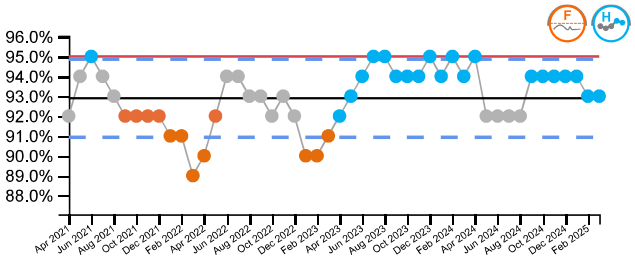
Safeguarding children training



Module	Target	Compliance
Basic Life Support	90.00	0.89
Conflict Resolution L1	90.00	0.97
Equality, Diversity and Human Rights	90.00	0.97
Health, Safety and Welfare	90.00	0.97
Infection Prevention L1	90.00	0.98
Infection Prevention L2	90.00	0.90
Prevent	90.00	0.96
Safeguarding Adults L1	90.00	0.95
Safeguarding Adults L2	90.00	0.96
Safeguarding Adults L3	90.00	0.89
Safeguarding Children L1	90.00	0.94
Safeguarding Children L2	90.00	0.96
Safeguarding Children L3	90.00	0.91
Safeguarding Children L4	90.00	1.00

Fire Safety	95.00	0.95
Freedom to Speak Up	95.00	0.94
Information governance training	95.00	0.93
Safer Handling L1	95.00	0.96
Safer Handling L2 (Patient Handling)	95.00	0.91

Information governance training



Safe | Personal | Effective

WELL LED FINANCE - Summary Scorecard

East Lancashire Hospitals NHS Trust
A University Teaching Trust

METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
BETTER PAYMENT PRACTICE CODE (BPPC) NHS NO OF INVOICES	MAR 25	66.50	95.00		
BETTER PAYMENT PRACTICE CODE (BPPC) NHS VALUE OF INVOICES	MAR 25	94.20	95.00		
BETTER PAYMENT PRACTICE CODE (BPPC) NON NHS NO OF INVOICES	MAR 25	47.30	95.00		
BETTER PAYMENT PRACTICE CODE (BPPC) NON NHS VALUE OF INVOICES	MAR 25	69.90	95.00		
LIQUIDITY DAYS	MAR 25	-23.30	-14.30		
VARIANCE TO PLANNED FINANCIAL PERFORMANCE (DEFICIT) (£M)	MAR 25	-1.30	0.00		
WRP ACHIEVED - VARIANCE TO PLAN (£M)	MAR 25	-8.60	0.00		
VARIANCE TO CAPITAL PROGRAMME (£M)	MAR 25	-16.20	0.00		

METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION
EMPLOYEE EXPENSES RUN RATE (£M)	MAR 25	89.90	0.00	
INCOME RUN RATE (£M)	MAR 25	112.70	0.00	
OTHER OPERATING EXPENSES RUN RATE (£M)	MAR 25	31.60	0.00	

Alert

Better Payment Practice Code (BPPC) performance remained well below target in March with the Trust only meeting the target to pay 95% of invoices on time by value for NHS invoices for 2024-25.
WR & FIP £20.2m has been delivered in 2024-25, £39.5m behind the planned WR & FIP. In-month delivery has increased by £1.4m.
Only £16.4m of the £20.2m is recurrent.

Advise

Both bank and agency spend increased in-month, linked primarily to M11 being a shorter month with M12 also being a month where more annual leave is taken/EID celebrations.
The £4.6m over-performance for ERF has been assumed position in the M12 position
The cash balance on 31st March was £16.8m, an increase of £11.5m compared to the previous month, mainly as a result of the £29.9m received from the ICB on 24 March. This has allowed the Trust to stop with holding payments to suppliers in relation to approved invoices and is currently able to pay invoices as they become due. However, the Trust's ability to continue to pay suppliers on time is dependent on the delivery of the 2025-26 financial plan.
The capital plan underspent by £0.4m.

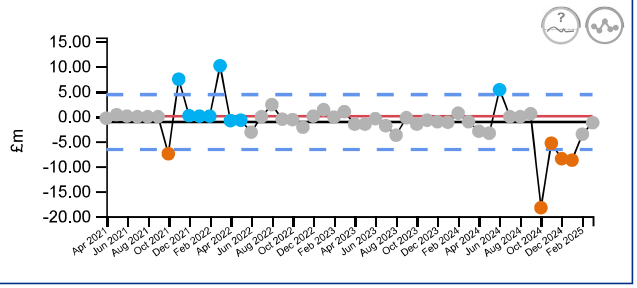
Assurance

The Trust met the agreed revised forecast outturn that was agreed a the IAG.
Excluding the Deficit Support Loan of £21.9m, the Trust is reporting a deficit of £68.492m, against a planned break-even position for the 2024-25 financial year to date. A run rate improvement of £1.8m in month from last month. (M11 £610k).
Including the Deficit Support Loan, the Trust is reporting a deficit of £46.6m, against a planned breakeven position for the 2024-25 financial year, an adverse movement of £1.4m in month against plan, largely due to WRP achieved being £39.5m below plan.
At M11 the Trust forecasted an outturn position of £68.5m, the outturn position is a £8k improvement on the forecast position.
Agency spend as a proportion of the total pay bill remains below the mean, with a performance level for 2024-25 of 1.6% achieved against a target of 2.8%.

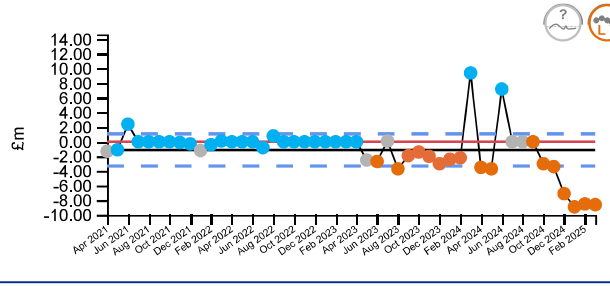
WELL LED - Finance

East Lancashire Hospitals NHS Trust
A University Teaching Trust

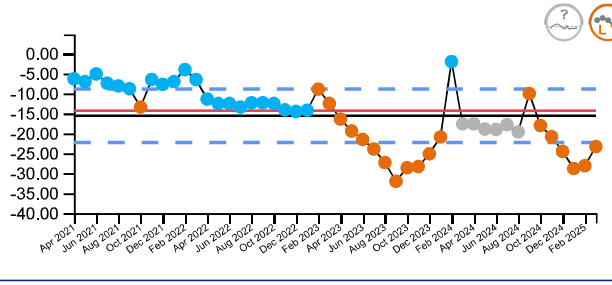
F1 - Variance to planned financial performance (deficit) (£m)



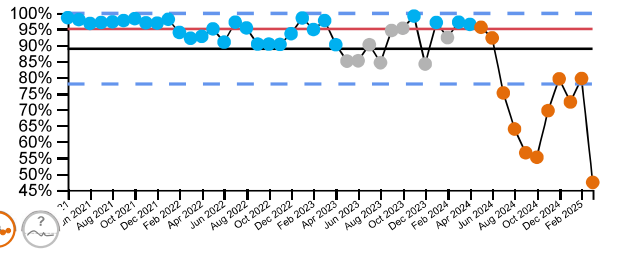
F2 - WRP achieved - variance to plan (£m)



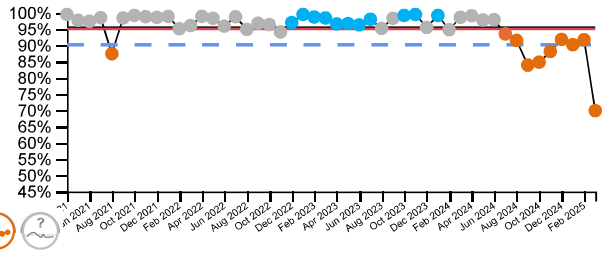
F3 - Liquidity days



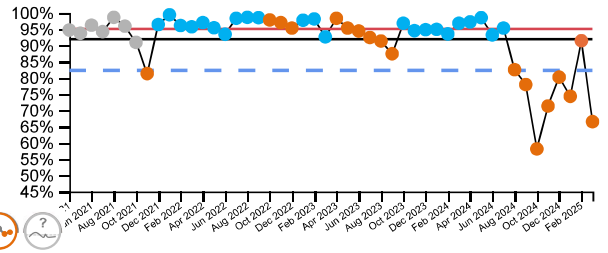
F12 - BPPC Non NHS no of invoices



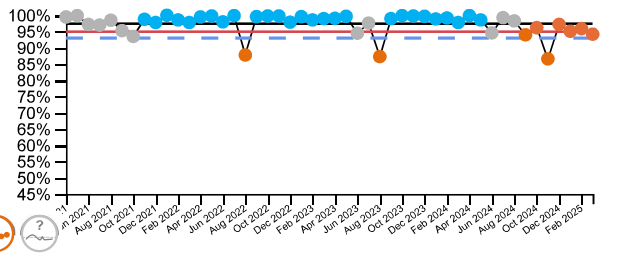
F13 - BPPC Non NHS value of invoices



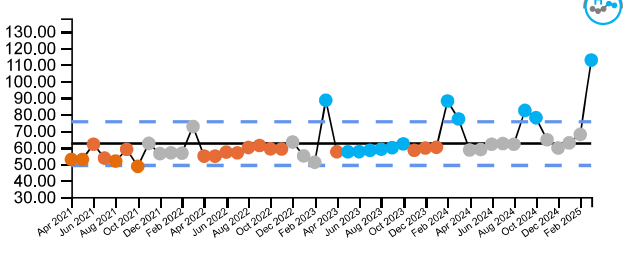
F14 - BPPC NHS no of invoices



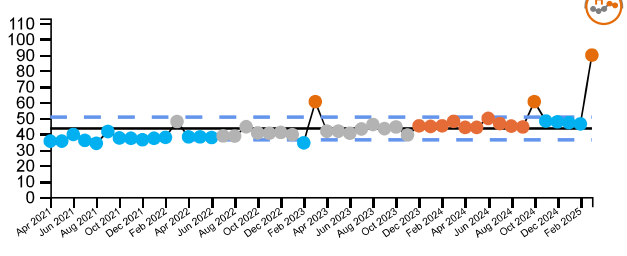
F15 - BPPC NHS value of invoices



Income run rate (£m)



Employee expenses run rate (£m)



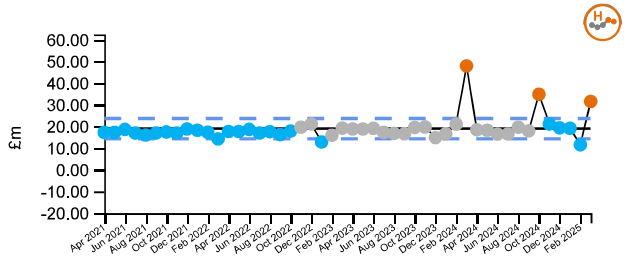
Safe | Personal | Effective

Employer contributions to NHS pensions paid by NHS E on behalf of the trust are removed from March figures.

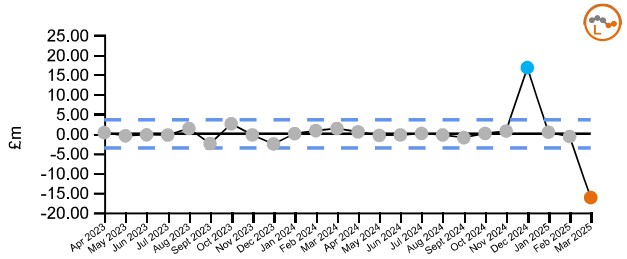
WELL LED - Finance

East Lancashire Hospitals NHS Trust
A University Teaching Trust

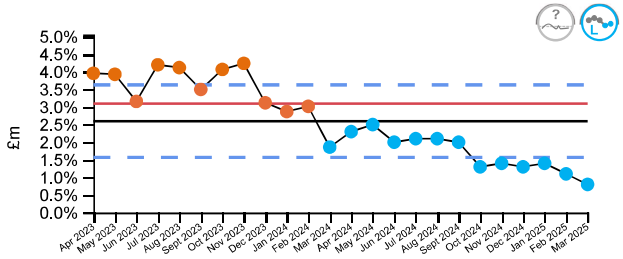
Other operating expenses run rate (£m)



Variance to capital programme (£m)



Agency spend as proportion of total pay bill (£m)



TRUST BOARD REPORT

Meeting Date:	14 May 2025	**Agenda Item:**	TB/2025/068
Report Title:	Patient Safety Incident Response Assurance Report		
Author:	Mr L Wilkinson, Incident and Policy Manager Mrs J Hardacre, Assistant Director of Patient Safety and Effectiveness		
Lead Director:	Mr S Islam, Interim Executive Medical Director		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓			✓
Executive Summary:	The Trust reports and manages incidents in line with the New National Patient Safety Incident Response Framework. Over the last year, there continues to be expected variation in the number of incidents reported per month. However, reporting levels remain with control limits, this is common cause variation which we would expect with the nature of incident occurrence and reporting.			
Key Issues/Areas of Concern:				
Action Required by the Committee:	The Trust Board is asked to receive the paper as a summary update on the incidents reported under the new Patient Safety Incident Response Plan (PSIRP) and the outcome of the Patient Safety Incidents Requiring Investigation (PSIRI) Panel decision-making process on high level investigation reports.			

Previously Considered by:	
Date:	
Outcome:	

Patient Safety Incident Response Framework Report

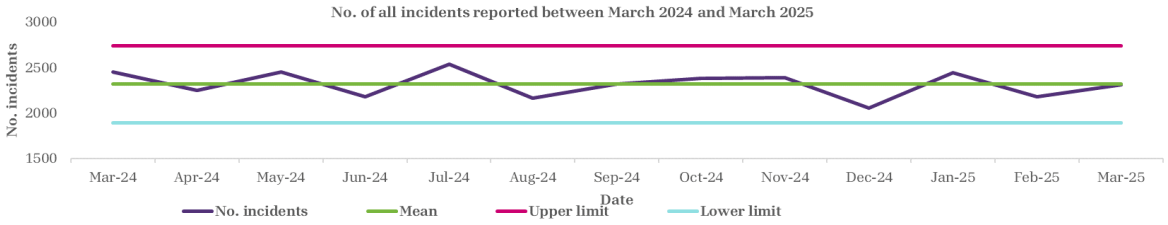
Reporting Period:		February 2025 to March 2025
Date and name of meeting:		Information within this report forms part of the Patient Safety Incident monitoring dashboard and PSIRF which is discussed and reviewed at the bi-monthly Patient Safety Group, however, this was stood down in March but information was shared and discussed at the Trust Wide Quality Governance Part B meeting in March 2025.
1a.	**Alert**	The number of SOPs overdue has increased under the agreed KPI. There were 17 Trust wide SOPs overdue out of 142, which equates to 88% with a target of 90%. The Division with the largest number overdue is DCS, specifically with Pharmacy with 14. Reminders have been sent out to all authors.
1b.	**Advise**	At the beginning of April, the National Learning from Patient Safety Events (LfPSE) published its first reporting data for the whole of NHS England which covered October to December 2024. As such we are now able to compare our reporting data for that period against national rates. ELHT currently has a higher reporting rate for low physical harm, and a lower rate for all other physical harm gradings. NHS England is due to publish in mid-May further data including organisation level data. New Patient Safety Learning Podcasts are now available on the Patient Safety SharePoint site for staff to access and the first session of the new Patient Safety Response training has now taken place for staff who complete PSRs within the Divisions. More sessions are available for staff to book though the learning hub.
1c.	**Assure**	At the end of March 2025 there were 725 incidents awaiting final approval. Of these 113 could not be finally approved as they were open S42 incidents awaiting local authority outcome. The Incident and Policy team continue to work on recovering the position and at the time of reporting reduced the number back under the target of 500. Plans have been put in place to maintain the position going forward.

1. Incident Reporting

1.1 The Trust reports and manages incidents in line with the New National Patient Safety Incident Response Framework. Over the last year, there continues to be expected variation in the number of incidents reported per month. However, reporting levels remain with control limits, this is common cause variation which we would expect with the nature of incident occurrence and reporting.

1.2 The reduction in reporting from December 2024 has been monitored and this has not been sustained over the last 3 months.

Figure 1: Incidents reported over last 12 months.



1.3 **4492** reported incidents were triaged within 2 working days of being reported in **February and March 2025**, which equates to **99.95%** of all incidents reported within this period.

1.4 At the end of **March 2025** there were **725** incidents awaiting final approval. Of these **142** could not be finally approved due to open S42 incidents awaiting Local Authority outcome, incidents awaiting information from Divisions, and outstanding Infection Control reviews included within cluster reviews, leaving 612 against a target of 500.

1.5 There has been a slight reduction in the number of reported moderate physical harm incidents in March 2025, there has however also been an increase in the number of incidents reported as no harm. (appendix A)

1.6 After an increase in September and October 2024, the number of severe harm incidents reported have reduced, in March two incidents were reported. (appendix A)

1.7 The two fatal incidents reported in February and March 2025: (appendix A)

1.7.1 One related to a patient with raised Troponin levels that may not have been communicated appropriately. However, on review it was confirmed this did not contribute to the outcome and level of harm downgraded.

1.7.2 One related to a patient who was positive for Covid being moved to a ward and not isolated. Division have downgraded the harm level to moderate, however, this is awaiting review at complex case.

1.8 At the beginning of April 2025, the National Learning from Patient Safety Events (LfPSE) published its first reporting data for the whole of NHS England which covered

October to December 2024. As such we are now able to compare our reporting data for that period against national rates. (appendix B). ELHT currently has a higher reporting rate for low physical harm, and a lower rate for all other physical harm gradings. NHS England is due to publish in mid-May further data including organisation level data.

2. Duty of Candour

2.1 There have been **0** breaches, of Duty of Candour, as set out in CQC Regulation 20.

3. Safety Incident Responses (IR2s)

3.1 In line with the New Patient Safety Incident Response Framework all incidents not being investigated as a Patient Safety Response, or a Patient Safety Incident Investigation the Trust has set a target that these should be reviewed and actioned within 30 days of reporting. A KPI of 90% has been set and appendix C provides an overview by division.

3.2 There has been an overall decrease in **March 2025** in IR2 completion in all but CIC division who have achieved the 90% KPI target for the second month running. The KPIs are shared and discussed with Divisions monthly, the main reason given by divisions for the delays is due to clinical pressures.

4. Patient Safety Responses (PSR)

4.1 All incidents that are of moderate or above harm and/or have key safety issues identified, and do not meet the national or local reporting priorities for a PSII are required to have a Patient Safety Response (PSR) completed and are managed within Division. Appendix D provides a breakdown of the number of open PSRs by division and number of any open more than 3 months.

4.2 There has been an overall decrease (33 to 26) in the number of open PSRs and the number of those that have been open more than 90 calendar days.

4.3 The first session of the new Patient Safety Response training took place on 7th April which supports staff within Divisions to have the skills and knowledge to complete PSR investigations. Training dates have been allocated for the next 12 months and are available to book via the learning hub.

5. Patient Safety Incident Investigations (PSII) National and Local Priorities

5.1 In **February and March 2025**, the Complex Case meeting reviewed **8** new incidents and reported **8** incidents meeting the PSIRF Priorities and require either a PSII or MNSI investigation, the PSIIs have been allocated to lead investigators within the Patient Safety Team.

5.2 A KPI dashboard of PSIIs is provided is appendix E. At the end of **March 2025**, the Trust had **27** open PSII incidents of which **12** were being investigated by MNSI.

5.3 At the end of **March 2025** there were **3** PSIIs which had been open longer than 6 months and **4** MNSI reports.

5.3.1 The **4** MNSI reports that are overdue are outside of the control of trust. The reasons for the **3** PSIIs being overdue are as follows:

- 1 PSII report has been approved at PSIRI but still awaiting Divisional safety improvement plan before it can be closed.
- 1 PSII completed and approved by Division and due to be presented at PSIRI in April 2025.
- 1 PSII was delayed due to engagement with family and approval of terms of reference, investigation and draft report has been completed and due to be presented for approval at Division at the end of April before going to PSIRI for Trust approval.

5.4 In **February** and **March 2025**, **4** PSII reports have been approved by PSIRI with learning and closed.

6 PSIRI Panel Approval and Learning from Reports

6.1 During **February** and **March 2025, 8** reports were reviewed, of these there were **4** new PSII reports. See appendix F for the detail of these reports and the review outcome.

7 Mandatory National Patient Safety Syllabus Training Modules

7.1 At the end of **March 2025**, the Trust has achieved **95.8%** Level 1a, **89.60%** Level 1b and **93.3%** Level 2 for National Patient Safety Training since making it mandatory for all staff to complete within the Trust. All Divisions have been sent a list of staff who require to complete the training for each level.

7.2 Table 1: Patient Safety Syllabus Training (as of end of **March 2025**)

National Patient Safety Training	Target	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec24	Jan 25	Feb 25	Mar 25
Level 1a	95%	93.30%	93.60%	93. 80%	93.30%	94.10%	94.30%	94.90%	94.80%	95.20%	95.40%	95.60%	95.80%
Level 1b		83.50%	84.40%	83.50%	84.20%	84.70%	85.10%	85.90%	85.60%	86.00%	87.30%	87.90%	89.60%
Level 2		88.30%	88.80%	89.90%	90.10%	90.90%	91.10%	92.10%	92.00%	92.10%	92.70%	92.90%	93.30%

8 Trust Wide Policies and SOPs

8.1 At the end of **March 2025**, there were **17** Trust wide SOPs out of **142** overdue their review date, and **27** out of **297** policies are currently overdue their review date.

8.2 The report provides a breakdown of overdue policies and SOPs as requested by Trust Board and a full list is provided in appendix G.

8.3 Of the 3 overdue policies for Quality Governance

8.3.1 2 policies are under Patient Experience.

8.3.2 The 3rd policy Health & Safety are working with key stakeholders to identify the appropriate author.

Figure 2: Trust wide policies and SOPs overdue by Directorate

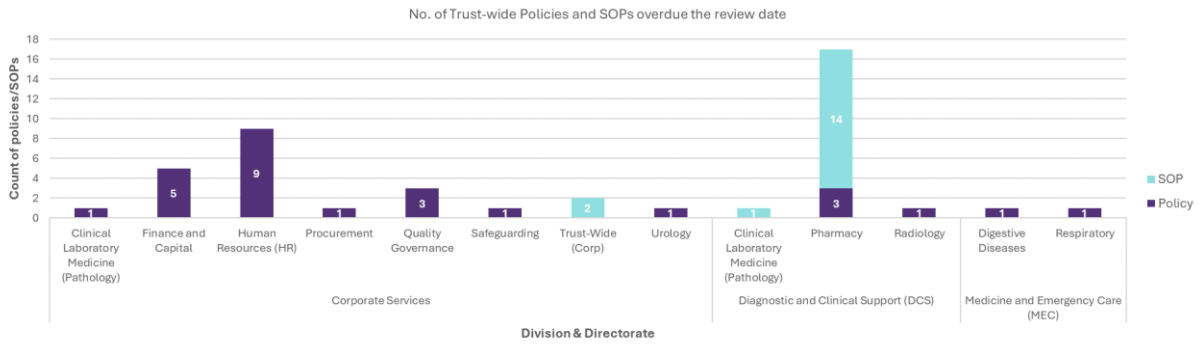


Table 2: Trust wide polices and SOPs within review date:

Policies / SOPs	Target	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Trend
Trust wide Policies	90%	86.11%	84.83%	83.10%	88.97%	88.70%	93.20%	94.56%	95.56%	95.58%	94.28%	94.30%	90.91%	↓
Trust wide SOPs		93.75%	95.86%	93.75%	88.37%	86.90%	100%	98.63%	100%	97.92%	94.44%	90.21%	88.03%	↓

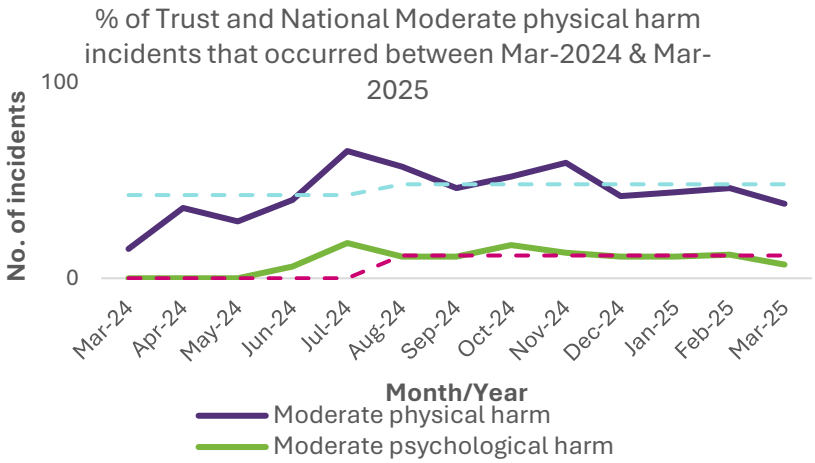
9 Maternity specific serious incident reporting in line with Ockenden recommendations

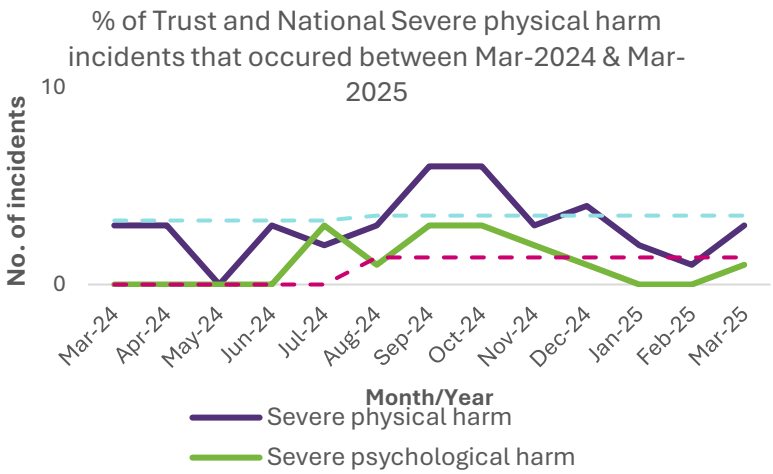
9.1 Following recommendations from the Ockenden review, the Trust is required to report on the number of Maternity specific serious incidents reported on StEIS and

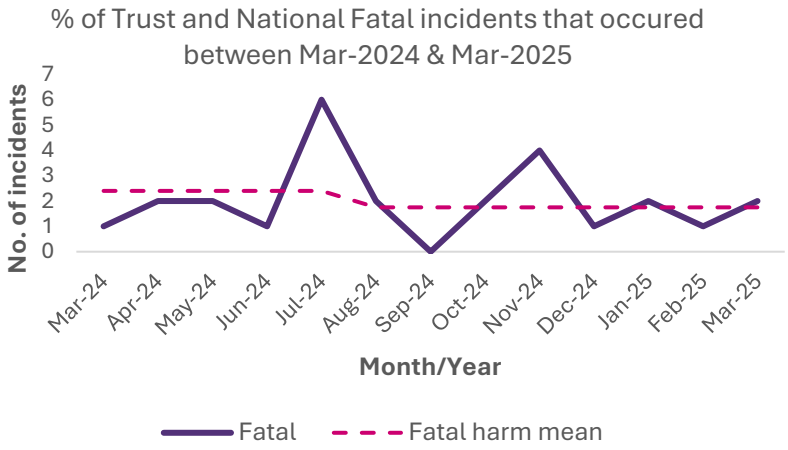
the status of the open investigations. Since March 2020 **78** maternity related incidents have been reported on StEIS of which:

- **46** have been approved and closed
- **15** have been agreed for de-escalation from StEIS
- **4** have had closure on StEIS requested
- **12** are currently being investigated by MNSI
- **1** is being undertaken via the PMRT process

Appendix A: ELHT Incidents by Moderate harm and above

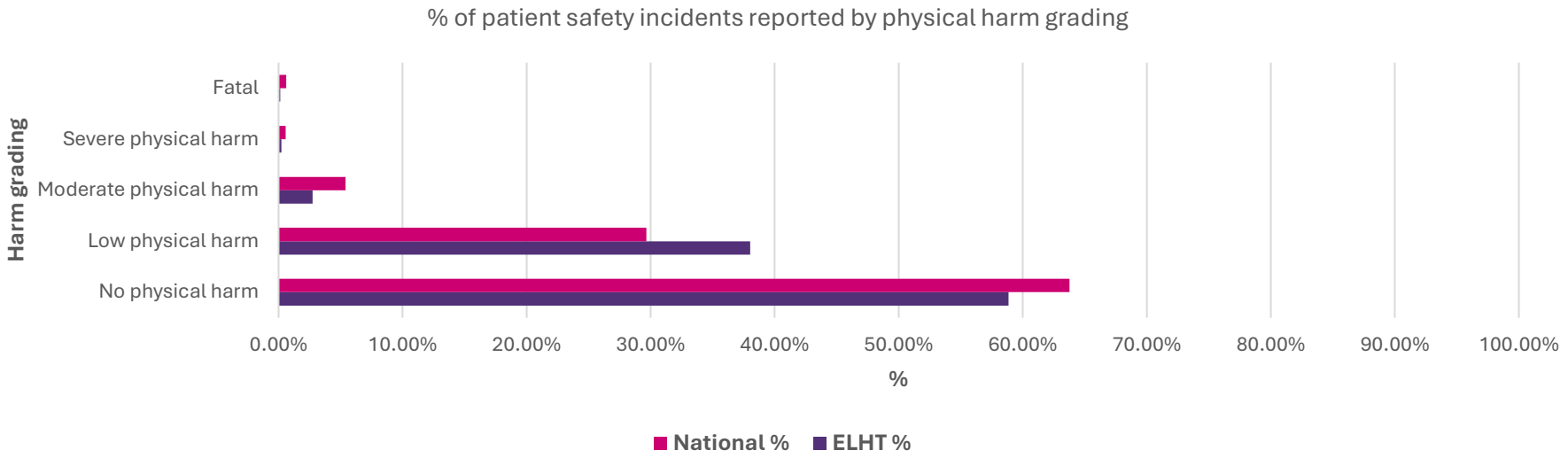






Appendix B: All Incidents compared to National Reporting Figures

Harm grading	ELHT count of reported incidents	ELHT %	National count of reported incidents	National %
No physical harm	3272	58.86%	463629	63.78%
Low physical harm	2114	38.03%	215646	29.66%
Moderate physical harm	153	2.75%	39151	5.39%
Severe physical harm	13	0.23%	4076	0.56%
Fatal	7	0.13%	4449	0.61%
Total	**5559**		**726951**	



Appendix C: KPI Dashboard for IR2s

Division	Number of SIRs (IR2s) by Month Trust Target 90%	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Trend
CIC	Total IR2 reported	341	315	360	344	471	375	398	444	405	405	524	423	
	(total number investigated) % complete within 30 calendar days	(300) 87.98%	(281) 89.21%	(323) 89.72%	(289) 84.01%	(424) 90.02%	(316) 84.27%	(344) 86.43%	(388) 87.39%	(373) 92.10%	(356) 87.90%	(479) 91.41%	(387) 91.49%	
DCS	Total IR2 reported	110	112	136	103	149	125	116	164	189	118	103	97	
	(total number investigated) % complete within 30 calendar days	(85) 77.27%	(93) 83.04%	(91) 66.91%	(75) 72.82%	(103) 69.13%	(77) 61.60%	(82) 70.69%	(124) 75.61%	(154) 81.48%	(85) 72.03%	(69) 66.99%	(61) 62.89%	
FC	Total IR2 reported	284	283	314	239	272	232	259	235	268	210	245	259	
	(total number investigated) % complete within 30 calendar days	(222) 78.17%	(228) 80.57%	(240) 76.43%	(189) 79.08%	(198) 72.79%	(169) 72.84%	(228) 88.03%	(179) 76.17%	(224) 83.58%	(187) 89.05%	(224) 91.43%	(212) 81.85%	
MEC	Total IR2 reported	992	903	899	873	936	849	945	936	921	778	908	815	
	(total number investigated) % complete within 30 calendar days	(863) 87.00%	(762) 84.39%	(752) 83.65%	(742) 84.99%	(804) 85.90%	(694) 81.74%	(768) 81.27%	(758) 80.98%	(707) 76.76%	(495) 63.62%	(730) 80.40%	(630) 77.30%	
SAS	Total IR2 reported	434	344	426	371	393	346	347	341	357	326	372	314	
	(total number investigated) % complete within 30 calendar days	(291) 67.05%	(276) 80.23%	(362) 84.98%	(291) 78.44%	(315) 80.15%	(304) 87.86%	(312) 89.91%	(298) 87.39%	(310) 86.83%	(248) 76.07%	(313) 84.14%	(253) 80.57%	
Corp	Total IR2 reported	83	87	97	85	82	52	67	74	76	32	66	43	
	(total number investigated) % complete within 30 calendar days	(37) 44.58%	(47) 54.02%	(63) 64.95%	(33) 38.82%	(45) 54.88%	(24) 46.15%	(35) 52.24%	(30) 40.54%	(22) 28.95%	(20) 62.50%	(41) 62.12%	(24) 55.81%	
Trust Total	Total IR2 reported	**2244**	**2044**	**2232**	**2015**	**2303**	**1979**	**2132**	**2194**	**2216**	**1869**	**2218**	**1951**	
	(total number investigated) % complete within 30 calendar days	**(1798) 80.12%**	**(1687) 82.53%**	**(1831) 64.95%**	**(1619) 80.35%**	**(1889) 82.02%**	**(1584) 80.04%**	**(1769) 82.97%**	**(1777) 80.99%**	**(1790) 80.78%**	**(1391) 74.72%**	**(1856) 83.68%**	**(1567) 80.32%**	

Appendix D: KPI Dashboards for PSRs

Division	Number of PSRs open	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Trend >90
CIC	No. open	55	40	44	61	56	51	52	72	83	52	49	38	↓
	No. open more than 90 calendar days	5	5	9	8	2	1	3	5	5	2	4	2	
DCS	No. open	9	8	9	22	14	24	12	13	9	9	10	6	↑
	No. open more than 90 calendar days	1	0	1	2	1	2	0	0	0	0	0	1	
FC	No. open	53	54	51	55	54	37	39	39	38	45	44	19	↓
	No. open more than 90 calendar days	11	17	14	11	14	7	6	4	5	5	3	2	
MEC	No. open	124	115	88	102	96	93	60	61	71	82	80	66	↓
	No. open more than 90 calendar days	18	24	25	28	27	32	13	7	9	15	19	15	
SAS	No. open	51	50	31	47	34	37	35	41	28	48	34	27	↓
	No. open more than 90 calendar days	13	17	17	16	12	10	5	6	7	7	7	6	
Trust	No. open	**292**	**277**	**223**	**287**	**254**	**242**	**198**	**226**	**232**	**236**	**217**	**188**	↓
	No. open more than 90 calendar days	**48**	**66**	**66**	**65**	**56**	**52**	**27**	**22**	**26**	**29**	**33**	**26**	

Appendix E: KPI Dashboards for PSIIs

PSII reports (including HSIB/PMRT)	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Trend
No. incidents at Complex case	23	3	5	2	2	7	2	3	3	2	5	3	
No. incidents agreed as PSII including (MNSI was HSIB)	5	2	5	2	4	3	2	3	4	2	5	3	
No. over 6 months	5(3)	3(2)	3(3)	2(1)	3(1)	5(2)	7(3)	10(4)	11(4)	8(4)	10(4)	7(4)	↓
Total No. of PSIIs Open including (MNSI was HSIB)	25(4)	24(4)	27(10)	23(8)	26(7)	27(5)	24(7)	23(10)	24(8)	23(9)	26(9)	27(12)	→
No. approved/closed by PSIRI including (MNSI was HSIB)	5	5	3	5	1	2	4	4	3	3	2	2	

Appendix F: Summary of PSII reports reviewed by PSIRI and the outcome

During February 2025 One new PSII reports were presented at the Trusts PSIRI panel.

- Incident resulting in death (eIR1290496) – The report was approved with amendments but required re submission to the panel with the completed action plan. Below is a summary of safety recommendations identified in the report:
  - Division to implement a safety net process for ERCP MDT referral outcomes.
  - SOP ENDO57 to be updated to clarify who has responsibility for each aspect of the ERCP MDT process, and then to be circulated to staff and ensure that all staff are aware of the responsibilities set out in the SOP.

Three reports that were previously reviewed by the panel were returned for approval, all three were approved, however, one required some minor amendments.

During March 2025 three new PSII reports were presented at the Trusts PSIRI panel.

- Incident resulting in death (eIR1291936) – The report was approved with amendments to include the improvement work that has taken place regarding handovers. Below is a summary of safety recommendations identified in the report:
  - SAS to review how venous thromboembolism prophylaxis is prescribed post operatively if the initial dose needs to be administered later than 6.00pm so that subsequent does are prescribed in accordance with Trust policy. The division to engage with the Pharmacy Department once the process has been agreed to explore if a pre-populated template can be created for the electronic patient record system to support prescribing.
  - Ward C18b to ensure all nursing staff complete the Trusts e-learning package for venous thromboembolism prevention.
- Incident resulting in death (eIR1299918) – The report was approved outside of the PSIRI meeting by the Executive Medical Director due a requirement for submission to an inquest. Below is a summary of safety recommendations identified in the report:
  - Radiology Directorate should consider whether additional actions are required in order to provide assurance that neuroradiology reporting is sufficiently accurate.
  - Stroke, vascular and radiology teams should meet to consider how joint decision-making, case selection and risk assessment could be facilitated, either by neurovascular MDT or similar process.

- Incident resulting in death (eIR1279589) – The report was approved with some minor amendments to highlight the issues that caused the investigation to be delayed but required re submission to the panel with the completed action plan. Below is a summary of safety recommendations identified in the report:
  - Improve EPR communications and EPR training around the use of Sepsis and AKI bundles for Trust staff.

Four reports that were previously reviewed by the panel were returned for approval, all four were approved, however three required some minor amendments to the improvement plan and one required correction to a spelling error.

Appendix G: Overdue Trust wide Policies/SOPs

Division/Directorate	Ref	Title	Review Date
Corporate Services			
Clinical Laboratory Medicine (Pathology)	IC08	Severe Acute Respiratory Illness Policy including MERSSARS Avian Influenza	29/11/2024
Finance and Capital	F02 F19 F22 F24 F25	Losses and Special Payments Procedure Anti-Fraud, Bribery and Corruption Policy Standards of Conduct Policy Standing Orders Standing Financial Instructions	31/03/2025 31/01/2025 31/03/2025 31/03/2025 31/03/2025
Human Resources (HR)	C099 HR07 HR09 HR11 HR29 HR31 HR51 HR58 HR62	Clinical Attachment Policy Early Resolution Policy Disciplinary Policy & Procedure Supporting Staff with Disabilities Policy Positive Mental Health and Well being Alcohol, Drugs and Substance Misuse Guidelines for Consultant Job Planning Policy on the Development of Professional Roles Staff Bank and Agency Worker Policy	31/03/2025 31/03/2025 31/03/2025 28/02/2025 31/03/2025 30/08/2024 31/03/2025 31/12/2024 31/07/2024
Procurement	C110	On Site Management of Suppliers and Supplier Representatives	31/03/2025
Quality Governance	C006 C157 CP02	Complaints / Concerns Policy and Procedure Chaperones Accompanying Patients During an Intimate Procedure / Treatment Prevention and Management of Inoculation/Sharps Injuries	28/06/2024 30/04/2024 28/02/2025
Safeguarding	C112	Supporting Patients and others who are at risk of/are experiencing Domestic Abuse	28/02/2025
Corporate Nursing	SOP081 SOP130	Nursing Bedside Handovers Nursing Assessment Performance Framework (NAPF) Operational Policy	 31/03/2025
Urology	CP34	Assessment and management of urinary and faecal incontinence in adults (in-patients)	31/03/2025

Division/Directorate	Ref	Title	Review Date
Diagnostic and Clinical Support			
Clinical Laboratory Medicine (Pathology)	SOP015	Administering Injectable Medicines	31/03/2025
Pharmacy	MM01	Guidelines for the Prescribing, Supply and Use of Unlicensed Medicines	31/03/2025
	MM02	Policy for Supply and / or Administration Of Prescription Only Medicines Under Patient Group Directive	31/12/2024
	MM06	Prescribing for Clinical Need Policy	31/03/2025
	SOP014	Preparing Injectable Medicines	31/03/2025
	SOP044	Dealing with suspected Drug Misuse by Staff	28/02/2025
	SOP046	Exceptional Medicines that may be stored in Controlled Drug cabinet	28/02/2025
	SOP049	Supply of over-labelled medicines in clinical areas	28/02/2025
	SOP050	Procedure for use of patients' own drugs on admission	28/02/2025
	SOP051	Short stay medicines discharge procedure	31/01/2025
	SOP053	Handover of medicines to patients-carers at hospital discharge	31/01/2025
	SOP054	Management of medicines-related errors and near misses	31/01/2025
	SOP058	Covert administration of medicines or disguising medicine	28/02/2025
	SOP059	Procedure for general administration of medication	31/01/2025
	SOP060	Procedure for supply of medicines in Monitored Dose Systems	28/02/2025
	SOP061	Prescription ordering and security	31/12/2024
	SOP069	Procedure for Vaccination of At-Risk Inpatients with Influenza Vaccine	31/12/2024
	SOP113	Procedure for the Management of Oxygen During Periods of High Demand	31/03/2025
Radiology	CP03	Referral to Radiology by Non-Medical Registered Health Professionals	31/03/2025
Medicine and Emergency Care			
Digestive Diseases	CP50	Acute Upper GI Bleeding (AUGIB) Guidelines	31/03/2025
Respiratory	CP15	Chest Drain Policy	28/02/2025

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Meeting Date:	14 May 2025	**Agenda Item:**	TB/2025/069
Report Title:	Draft Quality Account Report 2024-25		
Author:	Mrs A Brown, Associate Director of Quality & Safety		
Lead Director:	Mr S Islam, Interim Executive Medical Director		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
			✓	
Executive Summary:	It is a National requirement for all NHS Trusts to publish their Quality Account by 30th June each year, a report must be shared with key partner organisations for their comments, which will be included in the final version. The final draft will be re-submitted to the Quality Committee in June 2025.			
Key Issues/Areas of Concern:				
Action Required:	Members are asked to receive the draft Quality Account for approval before sharing with key partner organisations and ICB to enable them to provide their stakeholder statements.			

Previously Considered by:	
Date:	
Outcome:	

1. Introduction

a. Quality Accounts are mandatory annual reports from providers of NHS healthcare and serve to provide information to the public about the quality of the services that they deliver.

2. Background

a. The format and content of the Trust's Quality Account is in the main directed by regulation and for 2024/2025 it includes:
   i. The Trusts priorities for quality improvement 2025/26
   ii. Performance against the quality priorities that the Trust set for 2024/25
   iii. Performance against a range of nationally mandated quality indicators and processes during 2024/25
   iv. Performance against a range of locally determined quality initiative during 2024/25

b. The Trust Chairperson and Chief Executive are responsible for signing off the final version of the Trust's Quality Account, which must include external key stakeholder validation statements.

c. The mandated format of the Quality Account has historically directed the inclusion of:
   i. Outcome data / information against the following pre-determined quality processes:
      1. Clinical Audit and confidential enquiries
      2. Research and development
      3. CQUIN
      4. CQC compliance
      5. Data Quality Assurance
      6. Information quality and records management
      7. Clinical Coding audit
      8. The CQC statements/compliance
      9. Complaints management
      10. Learning from deaths
   ii. Performance data / information against the following pre-determined quality indicators:
      1. Hospital Mortality (SHMI)
      2. Percentage of deaths with palliative care coding

3. Patient Report Outcome Measures (PROMS)
4. Readmissions (28 days discharge)
5. Recommendations from staff as a provider of care
6. Friends and Family Test in emergency department
7. Venous Thromboembolism (VTE) risk assessment *(awaiting information from VTE Lead)*
8. Clostridium Difficile Infection
9. Patient Safety Incidents
10. Never Events

d. The mandated format of the Quality Account has also directed the inclusion of several quality improvement priorities with associated targets for implementation in the forthcoming year.

e. There is no national requirement for NHS trusts or NHS foundation trusts to obtain external auditor assurance on the quality account. Quality account approval from the Trusts own governance procedures is sufficient.

f. All providers are asked to upload their quality Account to an appropriate page on the Trusts website. Ensuring it is clearly visible and easily accessed by members of the public. The link for the webpage most be forwarded to NHS England.

g. There are several sections information/figures (highlighted in yellow within appendix 1) which have not been received or figures may need updating once national data has been published at the time of submitting this draft Quality Account. The following sections/information will be included in the final Quality Account for approval by the committee before external publication.

   i. 1.4 Our Approach to Quality Improvement – awaiting information from the Quality Improvement Team.
   ii. 1.7 Our Chief Executive Statement on Quality – to be added once draft version approved.
   iii. 3.1 Achievements against trust quality priorities – awaiting information from the Quality Improvement Team.
   iv. 3.2 Harm Reduction Programme – awaiting confirmation/information if section still required from the Quality Improvement Team.

v. 3.5 Statements from Stakeholders – draft Quality Account will be submitted to stakeholders for comments on approval from Quality Committee and Trust Board
vi. 3.6 Statement of Directors' Responsibility – to be signed on completion and approval of final version

3. Recommendation

a. The draft Quality Account has been presented at the Quality Committee in April 2025, where no comments or feedback have been received. The Trust Board are requested to agree delegated authority for the sign off of the Quality Account be given to the Quality Committee. Quality Committee have agreed to sign off the final draft on the 25 June 2025, to enable the deadline of the 30 June to be met.
b. Members are asked to receive the draft Quality Account (appendix 1) and approve the content before sharing with key stakeholders. The final version of the Quality Account will be re-submitted at the June Quality Committee for approval before uploading on Trust Website.

Alison Brown, Associate Director for Quality & Safety
7 May 2025

East Lancashire Hospitals
NHS Trust
A University Teaching Trust

QUALITY ACCOUNT

2024 - 25

EAST LANCASHIRE HOSPITALS NHS TRUST – QUALITY ACCOUNT REPORT 2024-25

1.0 PART ONE – INTRODUCTION TO OUR QUALITY ACCOUNT

1.1 Our Trust

Our patients are at the heart of everything we do at East Lancashire Hospitals NHS Trust (ELHT). We pride ourselves in delivering **Safe**, **Personal** and **Effective** care that contributes to improving the health and lives of our communities.

As a leading provider of high quality acute secondary and integrated healthcare services across East Lancashire and Blackburn with Darwen, we deliver a wide range of health services to a population of 566,000 people, many of whom live in some of the most socially deprived areas of England. Our services cover an area of approximately 1,211 square kilometres.

We employ over 9,000 people, working across four hospitals and various community services within our six geographical areas. These areas are Blackburn with Darwen, Burnley, Hyndburn, Pendle, Ribble Valley and Rossendale. In addition, in the last year 1,375 ELHT-based colleagues and an additional 2,083 support services colleagues from across Blackpool Teaching Hospitals, Lancashire and South Cumbria NHS Foundation Trust, Lancashire Teaching Hospitals and University Hospitals of Morecambe Bay were brought together to form One LSC, which is hosted by ELHT.

As well as providing a full range of acute, secondary and community services, the Trust is also a specialist centre. The specialist services provided are for hepatobiliary, head and neck and urological cancer services, as well as cardiology and vascular services. In addition, the Trust is a network provider of Level 3 neonatal intensive care.

The Trust currently has 830 core beds and 38 escalation beds. It also has nearly two million patient contacts a year from the most serious of emergencies to planned operations and procedures, using state-of-the-art facilities.

Our absolute focus on patients as part of our vision “to be widely recognised for providing **Safe**, **Personal** and **Effective** care” has been demonstrated in the Trust’s continued progress and being rated ‘Good with areas of outstanding’ by the Care Quality Commission (CQC).

Over 150 dedicated volunteers working across our services give their time and skills freely to support us. They work alongside Trust colleagues to provide practical support to our patients, their families and carers, and visitors to the Trust. Their enthusiasm and experience make a huge difference to our patients’ experience.

As a teaching organisation, we work closely with our major academic partners, the University of Central Lancashire, Lancaster University and Blackburn College. Together we nurture a workforce of tomorrow's doctors, nurses and allied health professionals.

There are two private finance initiative (PFI) schemes for parts of the buildings at Royal Blackburn Teaching Hospital and Burnley General Teaching Hospital sites. We are committed to improving and investing in our healthcare facilities, predominantly focusing on our on-going commitment to the Burnley General Teaching Hospital site.

1.2 Our Vision and Values

Our vision and objectives are key to our operating principles and improvement priorities which help to guide the way we work and what we strive to achieve.

Our values underpin those, ensuring our services are the very best they can be for our patients and our environments are respectful and supportive for all.

1.3 Our Future

Putting Quality at the heart of everything we do – Delivering Safe, Personal and Effective Care.

As health and care organisations in Blackburn with Darwen and Lancashire we have, for many years, shared a common purpose to integrate our service provision and work together effectively to improve health outcomes for our residents.

As part of Place Based Partnership working across both Blackburn with Darwen and Lancashire, we will continue to work collaboratively to:

- Improve the health and wellbeing of the population and reduce inequalities
- Provide consistent, high-quality services that remove unwarranted variation in outcome
- Consistently achieve national standards/targets across the sectors within the partnership
- Maximise the use of our Pennine Lancashire financial allocation and resource

We will work collaboratively with partner organisations to develop out of hospital health care and a number of specific health priorities locally including a focus on ageing well, mental health, and improvements in elective and emergency care.

With organisations across the wider Lancashire and South Cumbria (LSC) system, we will be an active partner in developing a joint service vision to improve outcomes in population health and healthcare. We will support wider system priorities including tackling inequalities in outcomes, experience, and access, enhancing productivity and value for money and to help support broader social and economic development.

Our quality commitments focus on initiatives that will:

- **Provide Safe care** - Reduce harm, prevent errors, and deliver consistently safe care through increased visibility and insight from multiple sources of patient safety information.
- **Provide care that is Personal** – Deliver patient centred care which involves patients, families, carers, and system partners in the planning delivery of care and opportunities to improve patient safety.
- **Provide Effective care** – Deliver consistent effective and reliable care, based on best practice which is delivered in a culture that encourages and enables innovation to **Improve** outcomes.

Strengthening Our Partnerships

Working in partnership across Place Based Partnerships within Blackburn with Darwen and Lancashire (PBPs), the Lancashire and South Cumbria Provider Collaborative Board (PCB) and wider Lancashire and South Cumbria Integrated Care System/Board (LSC ICS/ICB) has been a fundamental part of our improvement journey so far and will continue to underpin all our work within the coming year.

Our drive to improve the quality of care delivered across our communities will see the Trust work increasingly though partnerships across our localities. We will further develop our role as part of an integrated offer, working more closely with our commissioners and with other local providers, including GPs, Community and Mental Health Trusts, and colleagues in social care.

We will work as part of a joined-up system across Lancashire and South Cumbria ICS contributing to and learning from best practice across the region and working to ensure equity of care for our communities.

As our partners at the ICB and Place develop their new structures, plans and priorities in the coming years, so too will we. By adjusting and developing our plans, we will ensure our priorities and underpinning delivery are aligned. This will ensure maximisation of our combined partnership contribution to improving the health and wellbeing of the population of East Lancashire.

1.4 Our Approach to Quality Improvement

Awaiting update from Quality Improvement Team

1.5 Our Quality Account

Quality Accounts are annual reports from providers of NHS services which provide information about the quality of the services they deliver. Our Quality Account demonstrates our commitment to continuous evidence-based service quality improvement and to explaining our progress in this area to patients, the public and interested parties.

The way in which we report through our Quality Account is set out in legislation and covers:

- The Trust's priorities for quality improvement in 2024-25.
- Performance during the last year against quality priorities set by the Trust.
- Performance during the last year against a range of nationally set quality indicators, initiatives and processes.
- Performance during the last year against a range of other quality indicators, initiatives, and processes.

Our Quality Account has been developed over the course of 2024-25 as we have continually monitored and reported against our quality priorities and indicators both within the organisation and externally to the public, commissioners, and regulators and at a national level. We invite you to provide us with feedback about this report, or about our services.

If you wish to take up this opportunity, please contact:

Associate Director of Quality and Safety
East Lancashire Hospitals NHS Trust
Fusion House
Evolution Park
Haslingden Road
Blackburn
BB1 2FD
Email: qualityandsafetyunit@elht.nhs.uk

1.6 Our Regulator's View of the Quality of our Services

Between the 4th and 6th March 2025, the Care Quality Commission (CQC) carried out an unannounced inspection of Community Hospitals Inpatient Wards. During this visit, the CQC inspected Marsden and Hartley at Pendle Community Hospital, Ribblesdale at Clitheroe, Albion Mill, Ward 19 and Ward 22 and Rakehead at Burnley General Hospital. No patient safety concerns were raised during the inspection. High level feedback has been provided, identifying some areas for improvement which have been integrated into an internal action plan. We await receipt of the draft formal report at the time of writing. The outcome of this inspection could impact on the ratings described below.

Since the 1st of November 2024, the Trust has hosted a number of shared corporate services on behalf of the Lancashire and South Cumbria System. This shared service is called OneLSC and has been added to the Trust registration under the Royal Blackburn Teaching Hospital site as the main base. One LSC oversees all corporate services across Lancashire and South Cumbria and brings together a wealth of expertise in one place ensuring organisations are supported with the right knowledge and skills across its corporate functions.

The last comprehensive Care Quality Commission (CQC) inspection took place from 28 August to 27 September 2018. The CQC visited the Trust to conduct a series of inspections concluding with a 'Well-led' review. Following their review, the report was published on 12 February 2019 and the Trust was rated as being Good overall, with areas of Outstanding.

The CQC scores for each of the combined Trust, main hospital sites and overall are as follows:

Ratings for a Combined Trust	
Acute	Good
Community end of Life	Outstanding
Community health services for adults	Good
Mental Health for children and young people	Outstanding

Royal Blackburn Teaching Hospital Overall - Good	
Safe	Good
Effective	Good
Caring	Good
Responsive	Requires improvement
Well-led	Good

Burnley General Teaching Hospital Overall - Good	
Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

The CQC also awarded the use of Resources rating based on an assessment carried out by NHS Improvement.

The CQC combined rating for Quality and Use of Resources summarises the performance of our Trust, taking into account the quality of services as well as the Trust's productivity and sustainability. This rating combines the five Trust-level quality ratings of Safe, Effective, Caring, Responsive and Well-led with the Use of Resources rating.

East Lancashire Hospitals NHS Trust Overall - Good	
Safe	Good
Effective	Good
Caring	Good
Responsive	Requires Improvement
Well-led	Good
Effective use of Resources	Good

All areas for improvement continue to be monitored through the appropriate assurance committee structure and the Trust and CQC have regular engagement meetings. Our Transfusion and Haematology Services were inspected by the Medicines and Healthcare products Regulatory Agency (MHRA) on 29–30 November 2023. This has resulted in an Improvement Action Plan which is on-going under the leadership of an allocated member of the Executive Team. Compliance has improved significantly and whilst ELHT remains in compliance management the MHRA no longer require monthly updates.

1.7 Our Chief Executive's Statement on Quality

To be included once draft approved

2.0 PART TWO – QUALITY IMPROVEMENT

2.1 Our Strategic Approach to Quality

Introduction

Quality underpins the vision of ELHT which is to be "widely recognised for providing **Safe**, **Personal** and **Effective** care." This has been demonstrated in the Trust's continued progress and being rated 'Good with areas of outstanding' by the Care Quality Commission (CQC).

The Trust is committed to the continuous improvement of the quality of care given to local people and, in so doing, achieving our organisational aim 'to be widely recognised for providing **Safe**, **Personal** and **Effective** care'. All Executive Directors have responsibility for Quality Governance across their particular spheres of activity and the Executive Medical Director is the delegated lead for Quality on the Board overall.

Quality monitoring occurs through our Clinical Governance structure, reporting to the Board via the Quality Committee. The Quality Committee is informed by the Trust Wide Quality Governance Meeting (TWQG), Patient Safety Incidents Requiring Investigation Panel (PSIRI), Clinical Effectiveness Group (CEG), Patient Safety Group (PSG), Patient Experience Group (PEG), Health and Safety Committee (H&SC), Lessons Learnt Group (LLG), Internal Safeguarding Board and Infection Prevention and Control Sub-Committee. Divisional Directors or their agreed deputies attend and report at these committees. Reporting in Divisions replicates this corporate structure to ensure consistent reporting from 'floor to Board'.

The ELHT vision aligns directly with the principles of the NHS National Patient Safety Strategy - NPSS (2019). The National Patient Safety Strategy (NHS England 2019) focuses on three key aims.

1. Improve our understanding of safety by drawing **insight** from multiple sources of patient safety information.
2. **People** have the skills and opportunities to improve patient safety, throughout the entire system.
3. **Improvement** programmes enable effective and sustainable change in the most important areas.

Our Quality Strategy is based on the exact same three aims, with an explicit link to our Quality Improvement programme.

Our commitment to providing high quality care for the people of East Lancashire has seen the embedding of our Public Participation Panel (PPP) as a monthly meeting directly supported by our Chief Nurse. The PPP are actively engaged in the development and review of services, providing a patient/carer perspective to our quality improvement plans.

The system continues to develop across Lancashire and South Cumbria, in line with the national move towards increased integration and we continue to support a system wide approach to quality. As active system partners we continue to support the delivery and improvement of quality at a system level as we continue to plan to develop healthcare services across the region.

Safe Care

The organisations response to safety is being influenced by the new National Patient Safety Incident Response Framework (PSIRF) which replaced the National Serious Incident Framework (SIF).

In December 2021, the Trust implemented the new Patient Safety Incident Response Framework (PSIRF) as an Early Adopter representing the NHS North-West region. The PSIRF model is described within the National Patient Safety Strategy (NPSS) and has underpinned changes to all aspects of Quality Governance and strengthens links to Improvement.

In November 2023, the Trust used a thematic analysis approach to determine new local patient safety priorities. Through our analysis of patient safety insights from data sources from January 2021 to December 2022, safety insights from key stakeholders and using the criteria in the National PSIRF, the Trust has identified three new local priorities it will focus on from November 2023. Due to the number of investigations focused on national priorities, the Trust has made the decision to extend the existing local priorities until September 2025.

- **Medication Errors** – linked to anticoagulant medication.
- **Discharge planning** – discharge between acute hospital beds to IHSS or care homes
- **Safeguarding patients with learning difficulties** – inappropriate use of the mental capacity act.

The Trust will be reviewing its Patient Safety Incident Response Plan and local priorities with a plan to publish the new updated version in October 2025.

Routine patient safety response (PSR) investigation of incidents resulting in harm are conducted using a portfolio of tools, including round tables, clinical reviews, timeline analysis. These are coordinated within the divisions and reported/monitored at the Trust's Patient Safety Group.

Clinical Effectiveness

There is a continued evolution to the approach of ensuring clinical directorates are delivering effective, evidence-based care in a reliable manner. The Clinical Audit & Effectiveness Team's function is to support clinical teams in providing assurance against standards to ensure the organisation is delivering best practice according to national guidance. To ensure that directorates are delivering best practice and are aware of the standards expected of them each directorate has a 'portfolio' of activity against which they monitor their performance.

This portfolio includes:

a. National audits, registries and confidential enquiries as mandated by the national contract i.e. the National Clinical Audit Patient Outcome Programme (NCAPOP)

b. Other national audits, registries and confidential enquiries included in the NHS England Quality Accounts list.

c. Regional and local audits as determined by commissioners or regional bodies i.e. CQUINs or for accreditation.

d. Local quality audits (for example compliance with local care bundles and alignment with other quality governance intelligence - incidents, risk, patient safety and experience etc.)

e. Monitoring and implementation of relevant national clinical guidance (E.g. NICE Guidance and Quality Standards)

f. Monitoring and implementation of relevant National Confidential Enquiry (NCE) recommendations

g. Getting It Right First Time (GIRFT) data and metrics (Including Further Faster and Further Faster 20)

Nationally there is a drive to collect continuous data to support timely reporting on performance to support quality improvement activities delivered by audit providers. This has meant a continued focus on data completeness and data quality delivery within set deadlines to support ongoing learning and assurance from outcomes. With the implementation of the Electronic Patient Record in June 2023, ELHT has identified some initial challenges with deadlines due to continued manual extraction. Further opportunities to establish automated data extraction are being explored to aid the timely submission of data to national audit platforms and national registries as well as local quality audits. This activity continues to be led by the designated responsible Trust, Divisional and Specialty Clinical Leads, responsible for developing a portfolio of evidence and providing assurance of compliance with appropriate standards through designated quality governance forums, supported by the central Clinical Audit & Effectiveness Team.

Monitoring and Improving the Safety Culture

The safety of both patients and colleagues in healthcare is influenced by the extent to which safety is perceived to be important. The Trust has a combination of structures and processes both at and below Trust Board level to ensure and assure the quality of our services, together with systems to monitor our safety culture and systems.

The Trust has developed and introduced several methods of sharing learning across the Trust to support learning and improving the safety culture, which includes:

- Patient Safety Learning events which is a method of sharing learning from incidents to a wide range of colleagues and giving them the opportunity to look at the identified problems and why they happened, review the actions taken to improve safety and identify any further learning that may be required.
- ELHT Patient Safety Alerts used across the Trust to either raise awareness regarding safety concerns and include safety critical actions for immediate implementation either across the Trust, Divisions or Directorates. These are monitored for assurance against actions at either the Patient Safety Group or Lessons Learnt Group.
- Patient Safety Bulletin is produced quarterly by the Patient Safety Incident Investigation Team to highlight and raise awareness of learning and safety improvements from national and local priorities under the Patient Safety Incident Response Framework (PSIRF).
- In 2023 the Trust developed a new Patient Safety Incident Dashboard with key performance indicators for assurance at Patient Safety Group, Trust Wide Quality Governance and Quality Committee, this has been further developed in 2024.
- A new Patient Safety SharePoint site to enable colleagues to have easy access to useful information regarding patient safety and learning.
- New Patient Safety Podcasts which share good practice of engagement within the Patient Safety Incident Investigation process and sharing of learning from investigations which are available to all staff on the Patient Safety SharePoint site.

Mortality Reduction Programme

The Trust monitors mortality statistics, performance and identifies areas for focus or improvement through a monthly Mortality Steering Group, chaired by the Executive Medical Director or Deputy Medical Director (Quality).

The Trust has robust governance arrangements in place to review, report and learn from patient deaths through the analysis of various data sets, including:

- Mortality benchmarking – HSMR, SMR, SHMI, Crude Mortality
- Medical Examiner Service Activity and Learning
- Adult SJR Mortality Reviews and Learning
- PSIRI process, where a death has resulted from an incident
- Perinatal, Neonatal and Child Deaths
- Learning Disability deaths, Reviews and Learning

The standardised mortality ratios (HSMR, SMR, SHMI) have been subject to significant data challenges because of delayed coding arising from vacancies in that team and the introduction of the Electronic Patient Record. More robust data on these is expected to be available with Q1-2 of this year. Coding is now being submitted within timescales. During the year, crude mortality rates have been used to identify variation – this has remained within control limits during the year.

The Trust continues to use the Structured Judgement Review (SJR) methodology via an electronic review process that is part of our patient safety governance software system. The review process is in line with the most recent NHS England guidance: Learning from Deaths and includes an overall score. The Trust completed 120 SJR reviews last year, which has again fallen since previous years because of vacancy in the administrative post supporting this. Additional reviewers have been identified and training sessions have been carried out.

Additionally, some other areas perform their own mortality reviews, including the Emergency Department, which has reviewed 76 deaths in the last year. Stroke and intensive care deaths are also being reviewed, and progress is being made on mechanisms to ensure all deaths of patients with a recognised Learning Disability (LD) or Autism are also subject to SJR's in addition to review by our learning disability reviewers. Following this, information is submitted to the regional Learning from lives and deaths – people with learning disabilities and autistic people (LeDeR) team, for an external review of care to be completed. Such deaths are either highlighted by the input of the LD team during their stay or highlighted by the Medical Examiner Service and submitted for review.

Maternal deaths are reviewed using a primary mortality review and then may be referred to the Coroner or Maternity and Neonatal Safety Investigation (MNSI) programme for further investigation.

All stillbirths and late miscarriages after 22 weeks gestation are reviewed through the perinatal mortality review process (PMRT). This involves a preliminary review, a primary review and a secondary review at the neonatal mortality meeting. All deaths are then further reviewed at multi-disciplinary perinatal mortality meetings.

In addition, any stillbirth of a baby over 37 weeks gestation that occurs during the intrapartum period (during labour) is referred to the Maternity and Neonatal Safety Investigations (MNSI) programme for external review.

All Neonatal Deaths are discussed with the Medical Examiner team and if any care or service delivery issues are identified these are referred to the coroner for further investigation.

Child Deaths are all subject to the Sudden Unexpected Death in Childhood process (SUDC) and co-ordinated through the Trust Safeguarding Team, where appropriate. Any unexpected child death would also be discussed with the coroner.

The Trust continues to review all hospital deaths and has recruited additional Medical Examiners and Medical Examiner Officers to support the service to cover community deaths.

Medical Examiners (ME's)

The Medical Examiner Service became a statutory service from the 9th September 2024 following passing of legislation. All deaths which do meet the criteria for immediate referral to the Coroner must be referred to the local Medical Examiner Service. This includes all deaths in a hospital setting and all deaths in a community setting.

The ME office, although independent of the Trust, is based at the Royal Blackburn Teaching Hospital site and employs Medical Examiner Officers (MEO's) and Medical Examiners (ME's) The Medical Examiner Office utilise medical systems both in hospital (e.g. Cerner, Ice, Sectra) and community (EMIS, NWAS). The MEO's are able to create a complete case for the Medical Examiner, and by performing appropriately delegated tasks they allow the MEs to focus on case scrutiny. Proportionate scrutiny of a death is undertaken by a ME, who is an experienced doctor with additional training (completed through the RC Pathologists) in death certification and the review of documented circumstances of death.

Once a case has been reviewed, there is a discussion with the attending practitioner regarding the proposed cause of death. The ME office can provide support if required in agreeing an accurate and acceptable cause of death. Either the ME or MEO will then speak with the NOK / informant regarding the cause of death and circumstances around the death. The NOK / informant may provide additional information and comment on the care provided to the deceased. Any concerns can be raised to the MEO/ ME. The ME team can see any complaints, incidents, safeguarding alerts that may already be place. Positive feedback regarding care is also received from the NOK / informants.

Any concerns regarding care identified by the ME service, that do not necessitate a Coroners referral, can raised through the Trusts normal governance processes (e.g. IR, SJR's). The ME can work closely with the Coroner / Coroners officers and help facilitate referral in cases where it is felt following ME review a Coroners referral is required.

Data from the Medical Examiner Service has shown that in nearly 20% of cases, recently bereaved families had passed positive comments back to the teams looking after their loved one at the end of their life.

The ME office provides the Trust with a monthly Mortality Report which is presented at the Mortality Steering Group. In this the ME service can report any trends or themes which have been noticed and provide ongoing input into the Trusts Learning from Deaths processes.

In 2023/2024 the ME office reviewed over 3100 deaths including both acute and non-acute deaths, from this review the ME office has raised 61 SJRs, and resolved 109 complaints before they were escalated to the Trust. The expected number of deaths referred to the ME service for 2024 / 2025 will be significantly higher given the change in legislation in September 2024 which means community deaths must be referred alongside acute hospital deaths.

The Lead Medical Examiner works closely with all relevant stakeholders including for example the Senior Coroner, Lead Registrar, Faith leaders and the regional and national Lead ME's. East Lancashire ME office is one on a small number nationally to provide an 'out of hours' weekend service to assist with any fast release deaths - reflecting the requirements of the local population.

Where incidents are raised by the ME office, these are investigated under the Trust's usual LFPSE (Learning from Patient Safety Events) processes. Cases in which poor care is felt to have contributed to death are discussed at a weekly complex case meeting to ensure appropriate investigation is undertaken. Points for learning are fed back within clinical divisions.

The ME office additionally provides a report to the Trust Mortality Steering Group describing their activity, which allows themes and trends to be identified.

Personal Care

The Trust's new Patient Experience Strategy seeks to build upon its engagement with patient, carers and the public, strengthening their influence on how we provide and develop services, support the safety culture and respond to patient and the public's feedback.

Developed in partnership with patients, carers, the public, and staff, the Strategy leveraged a range of patient experience data, including complaints, compliments, incidents, and national/local survey results, to inform and guide the identification of improvement opportunities.

The Strategy's impact and progress are continuously monitored, informed by ongoing patient experience intelligence.

Gathering comments from patients, carers, and the public is a routine practice within the Trust, facilitated by numerous sources such as:

1. The Friends and Family Test (FFT) continues to offer an easily accessible way for all patients receiving inpatient and outpatient care to provide their reviews and opinions on their experience. A key indicator of the survey is patient recommendation. Colleagues across the Trust utilise this feedback to shape both immediate and longer-term service improvements, with overall trends monitored by Divisions and the Executive team.

2. Across the Trust, we utilise patient, carer, and colleague stories to underscore the profound impact our interactions have on the experience and outcomes of patients and their families, whether positive or negative. These narratives are actively encouraged and valued by colleagues, proving to be a rich and influential source of feedback that informs our learning. Patients and their relatives appreciate it to voice their perspective.

3. Complaints, concerns, and compliments are integral to daily interactions within the NHS. They provide valuable insights into the intended and unintended consequences, both positive and negative, of our services and the human interactions within them. The Trust utilises this feedback, in conjunction with other intelligence, to improve patient safety, strengthen customer service, and support best practice.

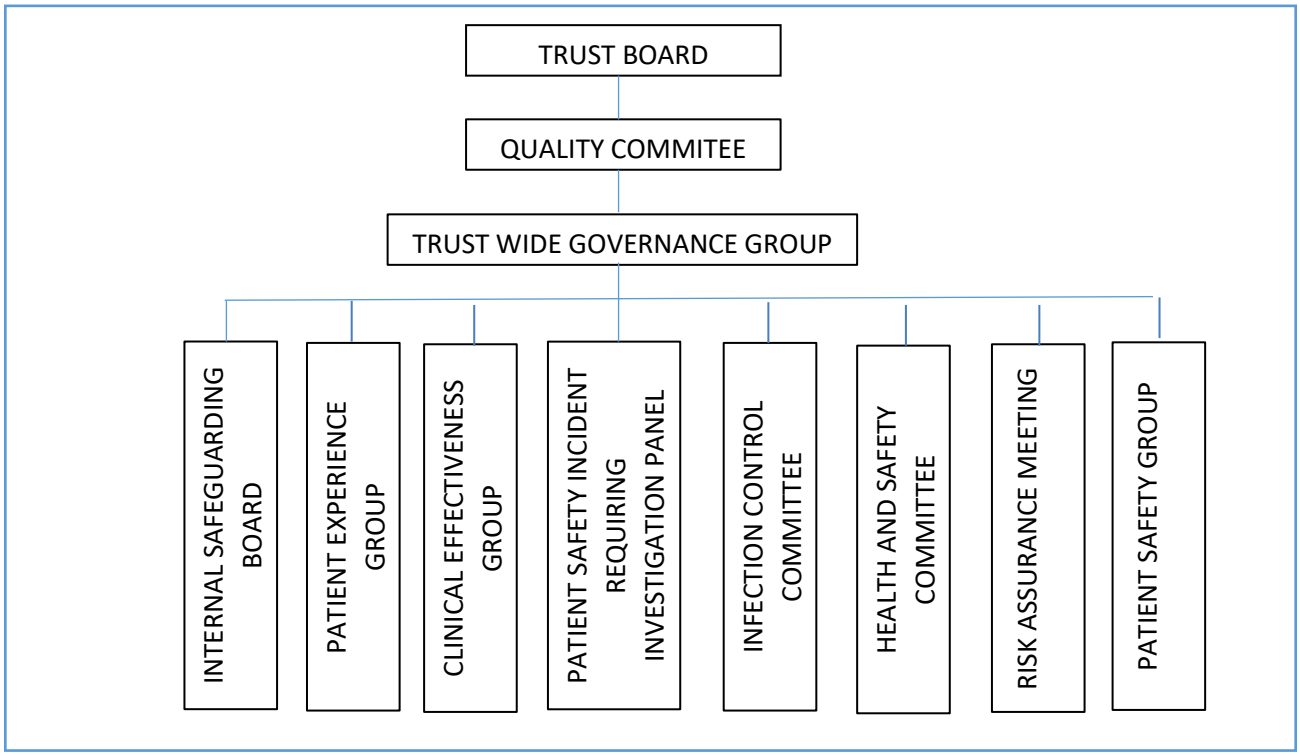
4. The Trust conducts the CQC-required national surveys to gather feedback from patients who have used our adult and children's inpatient services, Emergency Department, and Maternity services. This feedback informs the development and enhancement of our service improvement initiatives.

5. The Public Participation Panel (PPP) members continue to be highly active within the Trust. Demonstrating their proactive engagement, the PPP has initiated its own Quality Improvement (QI) project, supported by the Trust's Improvement Practice Programme Lead and Patient Experience Team. This initiative aims to enhance how they identify areas for scrutiny, through better - structured analysis.

Governance Arrangements for Quality

Improving quality continues to be the Board's top priority. It also represents the single most important aspect of the Trust's vision to be widely recognised for providing **Safe**, **Personal** and **Effective** care. The Trust places quality and safety at the heart of everything we do. Ensuring that our activities offer best quality and high safety levels is becoming our minimum standard rather than an aspiration. This continual drive for quality means our patients; their families and all our stakeholders can have greater confidence in the Trust as we move forward. The Trust has established the governance and committee structure shown in figure 1 to ensure the Board receives assurance in relation to the delivery of the Trust's objectives and that risk to the delivery of **Safe**, **Personal** and **Effective** care is appropriately managed.

Figure 1: Trust Governance Structures for Quality and Safety



2.2 Quality Monitoring and Assurance

To support delivery of our quality improvement work streams, the Trust has defined a meeting structure that supports the flow of information to and from the Trust Board. The corporate meeting structure is reflected within each of the Trust's clinical divisions thereby ensuring the Board has proper oversight of performance at all levels of the Trust, down to ward level. The meeting structure also provides a clear route of escalation for issues that need executive decision. Meetings take place on a regular basis and utilise standardised information to drive and inform the discussion. The data contained within the various performance dashboards showing monitoring of quality improvement areas is a mixture of outcome targets and process milestones that are presented to demonstrate performance at all levels of the Trust.

The Board Assurance Framework (BAF) and the Corporate Risk Register provide assurance to the Board that risks to patient safety, reputation and quality are appropriately managed in a timely way. The risk management process is designed to ensure current and potential future risks to quality are identified and included on the risk register, for example new technologies and changes in policy and funding. There are clear directorate and divisional reporting structures with specific triggers and processes by which risk and mitigating actions are reported and escalated. There is a clear and dynamic process for the management of risk in the organisation and both the BAF and the Corporate Risk Register are regularly reviewed to ensure appropriate, preventative, and corrective actions have been taken.

The Trust Board is ultimately accountable for the delivery of quality outcomes, and they are held to account by our regulators. Oversight of the Quality and Safety Framework is supported by a Quality Governance Unit, comprising three specific portfolios of patient safety/clinical risk, patient experience, and clinical effectiveness. Similarly, Divisional Medical Directors, Divisional Director of Operations and Divisional Director of Nursing are responsible for the delivery of quality outcomes within their divisions and the Trust Board holds Divisional Senior Management Teams to account for delivering quality outcomes within their respective divisions. This principle of accountability and responsibility is reflected from Board to Floor and supports the delivery of our quality objectives.

During 2024-25 the East Lancashire Hospitals NHS Trust continued to provide and / or subcontracted 8 NHS Services. These services have been identified using the CQC's definition of regulated activities. The services provided during the year were:

- Treatment of disease, disorder, or injury
- Diagnostic and screening procedures
- Family planning services
- Maternity and midwifery services
- Nursing care
- Surgical procedures
- Termination of pregnancies
- Management of supply of blood and blood-derived products

The Trust has reviewed all the data available on the quality of care in all these NHS services. The Trust continues to use its integrated quality, safety, and performance scorecard to facilitate this and has begun using a Quality Dashboard to support triangulation. Reports to the Trust Board, the Quality Committee, Trust-wide Quality Governance Group and Senior Leaders Group all include data and information relating to quality of services. Progress against last year's priorities for quality improvement, as set out in our Quality Account 2024-25; have been managed by way of these reporting functions. The income generated by the NHS Services reviewed represents 98% of the total income generated by the East Lancashire Hospitals NHS Trust for 2024-25. (2023-24 98%).

2.3 Priorities for Quality Improvement 2024/25

The Trust co-ordinates a comprehensive rolling programme of Quality Improvement and PSIRP initiatives and the publication of the Quality Account give us the opportunity to highlight some of the initiatives which we will specifically focus on during the coming year(s).

The Trust has identified a number of Key Delivery and Improvement Programmes to support the achievement of Trust goals. The Improvement Hub team will be deployed each year to directly support delivery of a sub-set of these priorities through application of the SPE+ improvement approach. This will be agreed through the annual planning process.

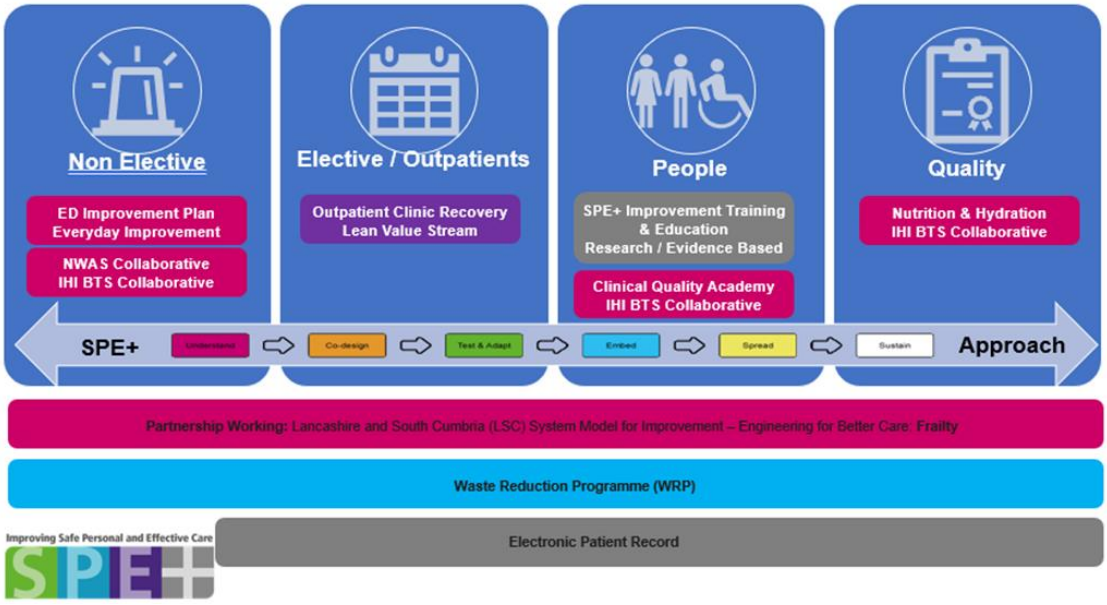
The Improvement Hub team will also support development of skills for improvement through training for others to apply the SPE+ improvement approach. Over time the improvement practice will be used increasingly to support delivery of Trust Goals.

2024-25 Trust Goals and Key Delivery and Improvement Programmes

Key Delivery Programmes:	Deliver Safe, high quality care	Compassionate & Inclusive Culture	Improve health & tackle inequalities in our community	Healthy, diverse & highly motivated people	Drive sustainability
Urgent & Emergency Care improvement	●				
Elective pathway improvement	●				
People plan priorities		●		●	●
Quality & Safety improvement priorities	●		●		
Electronic Patient Record	●			●	●
Care closer to home / Placed-based partnerships	●		●		
Provider Collaborative	●		●		●
Tackling health & care inequalities		●	●		●
R&D, Education & Innovation	●			●	
Waste Reduction Programme	●				●
Sustainability					●

SPE+ Approach & Improvement Hub Team support

Improvement Hub Team Priorities 2024/25



Improvement Hub Team Priorities 2025/26

Improvement Projects for 2025/26 within the organisation will continue across a broad spectrum delivered by local teams. For the Improvement Hub Team the priorities will be focussed within two key Programmes, supporting improvements in both Quality for patients and staff as well as contributing to the organisations Waste Reduction

Programme. Underpinning all programs will be a structured Improvement education and training programme to support developing capability.

Delivery Programme	Trust Goal(s)	Improvement initiatives/programmes
Improvement Capability Building/ NHS Impact	• SPE+ Improvement Practice	The Year of Improvement - Year 2 • Improvement Practice Training Offer – Level 1: Awareness • Continue to deliver Improvement Practice Training Levels 2: Contributor and 3 Lead • Clinical Quality Academy (Project Teams x 4) • Quality improvement (QI) training for Colleagues in Training Groups - Principles of Daily Management • Improvement for the workforce of the future
Urgent and Emergency Care Improvement/ Care Closer to Home/ Place Partnerships	• Deliver safe, high-quality care • Sustainability and Value for Money	• NWAS Ambulance Handovers • Emergency Department Improvement Plan • NWAS Conveyances • Length of Stay
People Plan Priorities	• A culture of compassion and belonging • Healthy, diverse and highly motivated people • Sustainability and Value for Money	• T• Becoming an intentionally Anti-racist Organisation • Medical Absence (sickness and agency usage) • Reduce Variable Pay • Vacancy Review • Organisation sickness
Waste Reduction Programme (WRP)	• Sustainability and Value for Money	• WRP Training (Level 2 Improvement Practice: Contributor) **Agreed WRP Programme projects:** • Postal Delivery – letters • Taxi usage • Pharmacy – Prescribing

Other improvement initiatives as required throughout the year.

2.4 Mandated Statements on the Quality of our Services

2.4.1 Clinical Audit and Confidential Enquiries

Clinical Audit involves improving the quality of patient care by reviewing current practice and modifying it where necessary. The Trust takes part in Regional and National Clinical Audits, and we also carry out local audits. Sometimes there are also National Confidential Enquiries which investigate an area of health care and recommend ways of improving it. The Trust also takes part in these Confidential Enquiries.

During 2024-25, 62 national clinical audits and 12 national confidential enquiries covered services that ELHT provides. During that period East Lancashire Hospitals NHS Trust participated in 54 (87%) national clinical audits and 12 (100%) national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The National Clinical Audits and National Confidential Enquiries that ELHT was eligible for, and subsequently participated in are set out in the table below. The National Clinical Audits and National Confidential Enquiries that ELHT participated in, and for which data collection was initiated or completed during 2024-25 also appears in the table below alongside the percentage of cases required by the terms of that audit or enquiry.

National Audits

Audit Topic	Coordinator	Frequency	Participation	Required / Sample Submission
Adult Asthma Secondary Care (NRAP)	RCP	Continuous	Yes	100%
BAUS Snapshot National Audit of Penile Fracture (SNAP)	BAUS	Intermittent	Yes	100%
BAUS Environmental Lessons Learnt and Applied to the bladder Cancer Care Pathway (ELLA)	BAUS	Intermittent	Yes	100%
Breast and Cosmetic Implant Registry (BCIR)	NHS England	Continuous	Yes	100%
Case Mix Programme (CMP)	ICNARC	Continuous	Yes	100%
Chronic Obstructive Pulmonary Disease (COPD) Secondary Care (NRAP)	RCP	Continuous	Yes	100%
Emergency Medicine QIPs: Care of Older People	RCEM	Intermittent	Yes	100%
Emergency Medicine QIPs: Time Critical Medications (Year 1)	RCEM	Intermittent	Yes	100%
Emergency Medicine QIPs: Mental Health (Self-Harm)	RCEM	Intermittent	Yes	100%
Elective Surgery (National PROMs Programme)	NHS England	Continuous	Yes	100%
Fracture Liaison Service Database (FLSD) (FFFAP)	RCP	Continuous	Yes	100%
Improving Quality in Crohn's and Colitis (IQICC)	IBD Registry	Continuous	No	NA
Learning Disability Benchmarking Audit Year 6	NHS Benchmarking	Intermittent	Yes	100%
Learning Disability and Autism Programme (LeDeR)	NHS England	Continuous	Yes	100%
Myocardial Ischaemia National Audit Project (MINAP) - National Cardiac Audit Programme (NCAP)	NICOR	Continuous	Yes	100%
National Adult Diabetes Audit – Core (NDA)	NHS England	Continuous	Yes	100%
National Audit of Cardiac Rehabilitation	University of York	Continuous	Yes	100%
National Audit of Cardiac Rhythm Management (CRM)	NICOR	Continuous	Yes	100%
National Audit of Care at the End of Life (NACEL)	NHS benchmarking	Intermittent	Yes	100%
National Audit of Inpatient Falls (FFFAP)	RCP	Intermittent	Yes	100%
National Audit of Metastatic Breast Cancer (NAoMe)	NATCAN	Continuous	Yes	100%
National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	RCP	Continuous	Yes	100%
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	RCPCH	Intermittent	Yes	100%
National Bowel Cancer Audit (NBOCA)	NATCAN	Continuous	Yes	100%
National Audit of Primary Breast Cancer NAoPri)	NATCAN	Intermittent	Yes	100%
National Cardiac Arrest Audit (NCAA)	ICNARC	Continuous	Yes	100%
National Child Mortality Database	University of Bristol	Continuous	Yes	100%
National Comparative Audit of Blood Transfusion – Audit of NICE Quality Standards QS138	NHSBT	Intermittent	Yes	100%
National Comparative Audit of Blood Transfusion –Bedside Transfusion Audit	NHSBT	Intermittent	No	NA
National Diabetes Foot Care Audit (NFDA)	NHS Digital	Continuous	Yes	100%
National Diabetes Inpatient Safety Audit (NDISA)	NHS Digital	Continuous	No	NA
National Early Inflammatory Arthritis Audit (NEIAA)	BSR	Continuous	Yes	100%
National Emergency Laparotomy Audit (NELA): Laparotomy (Lap)	RCA	Continuous	Yes	100%
National Emergency Laparotomy Audit (NELA): No Laparotomy (NoLap)	RCA	Continuous	Yes	100%
National Gestational Diabetes Audit	NHS Digital	Continuous	Yes	100%
National Heart Failure Audit	NICOR	Continuous	Yes	100%
National Hip Fracture Database (FFFAP)	RCP	Continuous	Yes	100%
National Invasive Cervical Cancer Audit	RCP	Continuous	Yes	100%

National Joint Registry (NJR)	HQIP	Continuous	Yes	100%
National Kidney Cancer Audit (NKCA)	RCP	Continuous	Yes	100%
National Lung Cancer Audit (NLCA)	NATCAN	Continuous	Yes	100%
National Maternity and Perinatal Audit (NMPA)	RCOG	Continuous	Yes	100%
National Neonatal Audit Programme (NNAP)- Neonatal Intensive and Special Care	RCPCH	Continuous	Yes	100%
National Non-Hodgkin Lymphoma Audit (NNHLA)	NATCAN	Continuous	Yes	100%
National Ophthalmology Database (NOD) National Cataract Audit	RCOphth	Continuous	No	NA
National Paediatric Diabetes Audit (NPDA)	RCPCH	Continuous	Yes	100%
National Pancreatic Cancer Audit (NPaCA)	NATCAN	Continuous	Yes	100%
National Pregnancy in Diabetes Audit - Adults (NPID)	NHS Digital	Continuous	Yes	100%
National Prostate Cancer Audit (NPCA)	NATCAN	Continuous	Yes	100%
National Vascular Registry	RCS	Continuous	Yes	100%
Children and Young Peoples Asthma Secondary Care (NRAP)	RCP	Continuous	Yes	100%
Perioperative Quality Improvement Programme	RCA	Continuous	TBC	NA
Pulmonary Rehabilitation Organisational and Clinical Audit	RCP	Continuous	Yes	100%
Quality Outcomes in Oral & Maxillofacial Surgery (QOMS): Trauma	BOAMS	Continuous	No	NA
Quality Outcomes in Oral & Maxillofacial Surgery (QOMS): Orthognathic Surgery	BOAMS	Continuous	No	NA
Quality Outcomes in Oral & Maxillofacial Surgery (QOMS): Non-Melanoma Skin Cancers	BOAMS	Continuous	No	NA
Quality Outcomes in Oral & Maxillofacial Surgery (QOMS): Oral and Dentoalveolar Surgery	BOAMS	Continuous	No	NA
Sentinel Stroke National Audit Programme (SSNAP)	RCP	Continuous	Yes	100%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	SHOT	Continuous	Yes	100%
Society for Acute Medicine's Benchmarking Audit (SAMBA)	SAMBA	Intermittent	Yes	100%
Transition (Adolescents and Young Adults) and Young Type 2 Audit	NHS Digital	Continuous	Yes	100%
National Major Trauma Registry (NMTR)	NHSE	Continuous	Yes	100%

Key to Audit Coordinator abbreviations	
BAUS	British Association of Urological Surgeons
BCIR	Breast and Cosmetic Implant Registry
BOAMS	British Association of Oral & Maxillofacial Surgeons
BSR	British Society for Rheumatology
FFFAP	Falls and Fragility Fractures Audit Programme
IBD	Inflammatory Bowel Disease
ICNARC	Intensive Care Audit and Research Centre
NATCAN	National Cancer Audit Collaborating Centre
NCAP	National Cardiology Audit Programme
NHSBT	NHS Blood and Transplant
NICOR	National Institute for Cardiovascular Outcomes Research
NRAP	National Respiratory Audit Programme
RCA	Royal College of Anaesthetists
RCEM	Royal College of Emergency Medicine
RCOG	Royal College of Obstetricians and Gynaecologists
RCOphth	Royal College of Ophthalmologists
RCP	Royal College of Physicians
RCPCH	Royal College of Paediatrics and Child Health
RCPsych	Royal College of Psychiatrists
RCS	Royal College of Surgeons
PROMs	Patient Recorded Outcome Measures

National Confidential Enquiries (NCE's)

Audit Title	Coordinator	Frequency	ELHT Participated	Data collection completed 2023 -24	Sample Submission
Medical and Surgical Clinical Outcome Review Programme: Juvenile Idiopathic Arthritis	NCEPOD	Intermittent	Yes	Yes	100%
Medical and Surgical Clinical Outcome Review Programme: Emergency Surgery in Children and Young People	NCEPOD	Intermittent	Yes	Yes	100%
Medical and Surgical Clinical Outcome Review Programme: End of Life Care	NCEPOD	Intermittent	Yes	Yes	100%

Medical and Surgical Clinical Outcome Review Programme: Blood Sodium Study	NCEPOD	Intermittent	Yes	Yes	100%
Medical and Surgical Clinical Outcome Review Programme: Acute Limb Ischaemia	NCEPOD	Intermittent	Yes	Ongoing	Ongoing
Medical and Surgical Clinical Outcome Review Programme: Acute Illness in People with a Learning Disability	NCEPOD	Intermittent	Yes	Ongoing	Ongoing
Medical and Surgical Clinical Outcome Review Programme: Rehabilitation following Critical Illness	NCEPOD	Intermittent	Yes	Ongoing	Ongoing
Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal Mortality Surveillance	MBRRACE-UK, NPEU, University of Oxford	Continuous	Yes	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal Mortality and serious morbidity confidential enquiries	MBRRACE-UK, NPEU, University of Oxford	Continuous	Yes	Yes	100%
Maternal morbidity confidential enquiry - annual topic based serious maternal morbidity	MBRRACE-UK, NPEU, University of Oxford	Intermittent	Yes	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal Mortality surveillance and mortality confidential enquiries	MBRRACE-UK, NPEU, University of Oxford	Continuous	Yes	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal morbidity confidential enquiries	MBRRACE-UK, NPEU, University of Oxford	Continuous	Yes	Yes	100%

Key to Audit Enquiry Coordinator abbreviations	
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
MBRRACE-UK	Mothers and Babies - Reducing Risk through Audits and Confidential Enquiries – United Kingdom
NPEU	National Perinatal Epidemiology Unit

The results of 35 national clinical audit reports and 9 National Confidential Enquiry reports were received and reviewed by the Trust in 2024-25. Following the review of National Clinical Audit reports, East Lancashire Hospitals NHS Trust intends to continue to implement the following actions to improve the quality of healthcare provided:

- National Audit reports will continue to be presented at specialty/ multi-specialty effectiveness meetings or other appropriate forums where lessons learnt, subsequent recommendations and action will be agreed so that practice and quality of care can be improved.
- A list of all National Audit Reports received is collated and shared with the Medical Director, Divisional / Directorate Clinical Effectiveness Leads, and is monitored via Divisional and Trust Clinical Effectiveness Groups to provide assurance that these reports are being reviewed and lessons learnt, and any subsequent recommendations and action captured.
- The Medical Director / Designated Deputy may request clinical leads to present finding at Clinical Leaders Forum or Quality Committee for further assurance.
- National audit activity which highlights the need for improvement will have associated improvement plans developed and monitored at an appropriate forum for assurance.
- The Clinical Audit Annual Report will include a summary on the participation in national audit activity along with learning, assurance or subsequent actions for improvement.

239 local clinical audits were completed by East Lancashire Hospitals NHS Trust in 2024-25. The results of which were presented / scheduled to be presented at specialty/ multi-

specialty audit or other appropriate forums and the Trust intends to take the following actions to improve the quality of healthcare provided:

- All local audit activity will continue to be presented and discussed at specialty/multi-specialty effectiveness meetings and/or appropriate forums where lessons learnt are captured, assurance identified and or recommendations for actions agreed to support improvement.
- Monitoring of action matrices will occur at subsequent clinical effectiveness or designated fora to ensure that actions are implemented to agreed timescales led by the Specialty Clinical Effectiveness Lead or forum chair.
- Meeting minutes and associated action matrices will be available for discussion at Divisional Clinical Effectiveness meetings or appropriate management forums. Outcomes will be included in divisional reporting to the Trust Clinical Effectiveness Group.

All local clinical audit activity will also be included in annual reporting as a record of all activity and lessons learned as a result of audit to provide assurance and support improvement in quality and patient care.

2.4.2 Research and Development

The number of patients receiving relevant health services provided or subcontracted by ELHT in 2024/25 that were recruited during that period to participate in research approved by a research ethics committee is 9867 recruited participants across 83 studies.

2.4.3 National Tariff Payment System and CQUIN

For 2024-25, the mandatory CQUIN scheme has been paused, see statement from NHS England below:

During 2024/25 the mandatory CQUIN scheme will not operate. NHS England has produced a list of optional indicators that can be used by any systems that have agreed to operate a local quality scheme during the pause. Please note that operation of such scheme is entirely optional and a matter for local agreement between providers and commissioners.

Note: There has been no agreement with commissioners to continue this scheme during this reporting period, ELHT have continued to monitor some of the 2023/24 CQUINs requiring improvement as part of our local audit programme.

2.4.4 Care Quality Commission Compliance

East Lancashire Hospitals NHS Trust is required to register with the Care Quality Commission and its current registration status is unconditional.

The Trust is now registered with the CQC as a provider of Acute, Community and Primary Care services, following the transfer of PWE Primary Care services to our provision.

The Trust has additionally updated its Statement of Purpose (SOP) with the CQC to reflect the transfer of Community Diabetes, Lymphoedema and Complex Case Services from Lancashire and South Cumbria Foundation Trust (LSCFT) from March 2024.

An application for the provision of care to patients who are subject to the Mental Health Act has been agreed with restrictions by the CQC, in support of the wider system.

During this financial year, several services have moved and transferred. All changes have been notified to the CQC:

- District nursing
- Treatment room
- Podiatry
- Integrated Neighbourhood Teams – Complex Case Management
- Community rehabilitation
- Home First therapists
- Admin team
- Albion Mill
- Inclusion of Community Diagnostic Centre (CDC) for Rossendale Primary Care Centre and Burnley General Teaching Hospital
- Darwen Health Centre. A number of services have transferred to ELHT from Blackburn with Darwen Local Authority.
- Removal of Accrington Victoria Community Hospital.
- Inclusion of services previously provided at Accrington Victoria Community Hospital into existing locations (Barbara Castle Way & Burnley General Hospital) and new locations: Accrington Pals Health Centre, Acorn Health Centre and Great Harwood Health Centre.

2.4.5 Data Quality Assurance

East Lancashire Hospitals NHS Trust submitted the following records during 2024-25 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

Records submitted from Apr 24 to Jan 25 (most recent figures):

- Admitted Patient Care 136,552
- Outpatient Care 637,804
- Accident and Emergency Care 285,954

The percentage of records in the published data - which included the patient's valid NHS number, was:

Performance for Apr 24 to Jan 25 (most recent figures):

- Admitted Patient Care 99.7%
- Outpatient Care 99.7%
- Accident and Emergency Care 99.5%

The percentage of records in the published data - which included the patient's General Medical Practice Code was:

Performance for Apr 24 to Jan 25 (most recent figures):

- Admitted Care 98.2%
- Outpatient Care 98.9%
- Accident and Emergency Care 98.6%

East Lancashire Hospitals NHS Trust will be taking the following actions to improve data quality:

- Continue to use the Second User Service (SUS) data quality tools and other benchmarking tools to identify areas of improvement.
- Support data quality improvement within the meeting structures
- Continue to embed data quality ownership across the Trust.

2.4.6 Information Quality and Records Management

The Trust aims to deliver a high standard of excellence in Information Governance by ensuring information is collated, stored, used and disposed of securely, efficiently and effectively and that all of our processes adhere to legal requirements. This includes completion of Data Protection Impact Assessments, annual Data Security Awareness Training for all colleagues, contract reviews and a comprehensive information asset management programme. The Trust has also deployed the national training for Information Asset Owners and supporting the owners through this process. The Trust has a suite of Information Governance policies to ensure patient, colleagues and organisational information is managed and processed accordingly.

The Data Security Protection Toolkit for 2024/25 has undergone significant updates to align with the National Cyber Security Centre's Cyber Assessment Framework (CAF). These changes aim to shift the focus from a compliance checklist to a set of broad principles that drive good decision-making and support a culture of continuous improvement.

The Trust is currently working towards the required standards for the 2024/2025 period and the final submission is 30th June 2025. The programme of work is overseen by the Senior Information Risk Owner through the SIRO Meeting as well as the Information Governance Steering Group which the SIRO also chairs.

2.4.7 Clinical Coding Audit

The Data Security and Protection Toolkit (DSPT) is due to take place on 10 February 2025 (200 FCE’s) through the Lancashire Coding Collaborative.

The Trust is also participating in another audit which is part of the internal audit programme post Cerner (200 FCE’s) by the Merseyside Internal Audit Agency (MIAA) in April 2025.

The department no longer has a qualified Accredited Clinical Coding Auditor.

Some audits have been carried out by senior members of the Coding Team and external auditors, but the programme has been limited due to staffing issues.

The Senior Clinical Coder is currently covering the role to minimise risk within the team, whilst a review of the structure and requirements of the Clinical Coding Team takes place.

Band 2 Performance Audits (50 episodes per coder x 2 audits)

All coders have had random spot checks, checking for co-morbidities and standards.

Now that ELHT are part of the Lancashire County Council and One LSC, the Trust are able to use auditors from other Trusts to carry out this role.

2.5 Complaints Management

Feedback is a powerful and useful mechanism for improving the quality of care and the patient experience, individually and for the wider NHS, as well as contributing to a culture of learning from experience. Patients, relatives, and carers are encouraged to communicate any concerns to colleagues with the aim of addressing those concerns immediately. The Trust has adopted the principles of good complaints handling, as set out by the

Parliamentary and Health Service Ombudsman and which reflect the Trust's own vision and values as follows:

Getting it right - Being customer focused - Being open and accountable – Acting fairly and proportionately - Putting things right - Seeking continuous improvement.

These principles are in line with the Trust Vision and Values.
The Trust Board acknowledges the importance of listening to patients' stories directly. As a result, these are now presented at Trust Board meetings.

The Customer Relations Team deals with concerns raised formally and informally, ensuring that individual concerns are addressed effectively, and lessons are learnt from the issues raised. During 2024 - 25, 2555 enquiries were received from a variety of sources (2483 in 2023/24). The team reports key performance indicators to Executive and Divisional leads to closely monitor concerns raised and to ensure a timely response is provided. Within the 2555 enquiries, 311 were logged as formal complaints during this period (304 in previous year). Complainants are contacted as soon as possibly following raising their concerns.

The current policy ensures that complainants are kept informed and updated and that greater compassion is evident within responses. Complaints handling is available to staff to support awareness of complaints requirements and correct procedures to ensure that complaints are dealt with in a timely and appropriately manner, providing assurance that lessons are learned from complaints across the Trust and themes have been identified. This training includes local resolution, complaints policy, colleagues' responsibilities and response writing. Regular reports now include more detail of these.

Complainants have the right to take their complaint to the Parliamentary and Health Service Ombudsman if they remain dissatisfied with the Trust's response. During the financial year 2024-2025, 12 complaints were referred to the Ombudsman, 2 are currently under investigation by the Ombudsman, 6 are being reviewed for possible investigation, 4 are closed (1 was not agreed for investigation, 1 was upheld, 1 was not upheld and one was another organisation).

2.6 Duty of Candour

The Duty of Candour (DOC) requirement (Health and Social Care Act 2008 Regulations 2014: Regulation 20), was established as a statutory duty for provider organisations in 2015 and is a requirement for registration with the Care Quality Commission (CQC).

The Trust has a Being Open and Honest Policy to ensure an apology is given to all patients, families and carers where the Trust has caused moderate harm or above to a patient. The Trust has a Standard Operating Procedure for tracking and monitoring the delivery of Duty of Candour and a report is published twice weekly and made available to Divisional Quality and Safety Leads, to support clinical teams to deliver the regulation requirements in a timely manner. Oversight of the effectiveness of this procedure is vested in the Medical Director and the Associate Director for Quality and Safety with assurance reports to the Trust's Quality committee. The Trust has an e-learning package for Duty of Candour which is available to all colleagues on the Trusts learning hub to access.

In 2024/25, the Trust reported no breaches of Duty of Candour in line with the required Health and Social Care Act 2008 Regulations 2014: Regulation 20.

2.7 NHS Staff Survey Results

The NHS Staff Survey is conducted by the Picker Institute Europe and National data. The Trust is required to publish the results of two elements of the survey as follows:

Indicator	Question	% Result
KF21 (Q15)	Does your organisation act fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age? Workforce Race Equality Standard 1	62%
KF26 (Q14c)	Not experienced harassment, bullying or abuse from other colleagues	17%

For Q15, ELHT has seen a decline on the previous year's percentage (62.0%). ELHT is better than the national average of 57%.

For Q14c, ELHT has seen an increase in the previous year's percentage (83%). ELHT is better than the national average of 82%.

2.8 Medical and Dental Staffing

Medical and Dental staffing has improved significantly in the last 2 years following successful Business cases to improve on Safe, Personal & Effective care, but to also reduce reliance on contingent labour and thus increasing the quality. As a Trust, we continue to proactively monitor and innovate to manage the recruitment and retention of Medical and Dental (M&D) colleagues. The Trusts figures show an increase in M&D WTE establishment in the last 12 months, peaking in November 2024. However, due to increased scrutiny around the Trust vacancies, this dipped for Q4 in the financial calendar. Graph shows the growth in M&D Establishment:

MonthYearShort	Establishment
Aug 2023	792.9
Sep 2023	792.5
Oct 2023	796.1
Nov 2023	794.0
Dec 2023	789.8
Jan 2024	791.5
Feb 2024	794.4
Mar 2024	793.3
Apr 2024	794.9
May 2024	807.5
Jun 2024	810.6
Jul 2024	810.6
Aug 2024	803.8
Sep 2024	845.4
Oct 2024	851.3
Nov 2024	882.2
Dec 2024	858.9
Jan 2025	858.4
Feb 2025	854.5
Mar 2025	856.5

The monitoring of Medical and Dental gaps continues to be done through the Trusts Workforce Efficiencies Group in which each Division on a monthly basis. Each week Medical Staffing presents its M&D vacancies as well as agency usage to one of our Divisions. The purpose of this is to triangulate with our support services to ensure proactive recruitment, rotas are fit for purpose, agency exit plans etc.

Since April 25 this group has evolved to provide wider assurance around Long Term bank/agency workers and also looks at the Top 25 Medical & Dental earners at the Trust.

We continue to develop retention pathways for our oversees doctors, with a new 'Locally Employed Doctor' contract in 2023 providing the same opportunities for Trust doctors as we provide for our Doctors in training. A successful programme for our Junior and Senior Clinical Fellows provides opportunities to retain and develop colleagues into substantive Specialty and Specialist posts. A successful CESR programme, in which we currently have 19 doctors signed up to in ED alone, supports the development pathway into Consultant posts outside of National training programmes.

With the increase in our Staff in Post over the last 2 years, we are now seeing a reduction in our Variable pay spend for M&D staff. As part of our IMT, each Division has worked on schemes to reduce the reliance on contingent labour.

There is currently an ongoing Medical Rostering project to deliver the Healthroster platform for all M&D staff. This will provide us with transparent and consistent operational effectiveness of rosters, Annual leave management and sickness management.

The system will also provide further assurance around capacity/demand and the work to meet our 42-week contractual job plans.

Overall, the Trust continue to proactively manage M&D gaps in an inclusive and innovative way. The main focus for the 25/26 year is optimising our workforce from robust job planning, leave and absence management, as well as output data. All of this will have a positive impact on not just our variable pay spend, but our promise to deliver **Safe**, **Personal** and **Effective** Care.

3.0 PART THREE - QUALITY ACHIEVEMENTS, STATUTORY STATEMENTS AND AUDITOR'S REPORT

3.1 Achievements against Trust Quality Priorities

Awaiting information from Quality Improvement Team

3.2 Harm Reduction Programme

Awaiting confirmation if required or information from Quality Improvement Team

3.3 Achievement against National Quality Indicators

3.3.1 Summary Hospital Level Mortality Indicator (SHMI)

The Summary Hospital Level Mortality Indicator (SHMI) was introduced by the Department of Health and Social Care in 2011-12 and reports on risk adjusted ratios of deaths that occur in hospitals and up to thirty days after discharge, divided by the number of deaths that were expected given the size of the Trust and other factors such as the patient's age, method of admission and underlying medical conditions.

The latest published SHMI trend data up to August 2024 for East Lancashire Hospitals NHS Trust is set out in the following table:

SHMI Outcomes	Latest published rolling 12 months to Aug 24
East Lancashire NHS Trust SHMI Value	1.32
East Lancashire NHS Trust % of deaths with palliative care coding	20
East Lancashire NHS Trust SHMI banding	Higher than expected
National SHMI	1.00
Best performing Trust SHMI	0.70
Worst performing Trust SHMI	1.32

East Lancashire Hospitals NHS Trust considers that this data is insufficiently robust to draw conclusions. Substantial issues with data submission have arisen since the introduction of the Cerner EPR. These issues include:

- Significant delays in clinical coding have arisen, due to vacancies in the team and overheads from working with a new system.
- Considerable and ongoing work has been required to identify the correct areas of the record from which to submit data, and to carry out verification. A submission error means that data from December 23 – March 24 was locked in at an uncoded position.
- The introduction of Cerner was used as an opportunity to move to the future process of classifying same day emergency care (SDEC) as part of the Emergency Care dataset, as opposed to the inpatient dataset on which mortality is calculated. Trusts which are early adopters of this have noted significant changes in standardised mortality ratios as a result of the substantial reduction of low-risk spells included.

An alternative mortality ratio is the HSMR. The Trust has not yet submitted sufficient data since Cerner to receive a calculation of HSMR. A bulk submission of SUS data has been made back to April 2024 which should improve data quality. However, the large backlog in clinical coding and the removal of SDEC will continue to impact mortality figures. This indicator has historically been higher than expected, which is known to be at least partially reflective of low palliative care coding (see 3.3.2). There has been a substantial revision of the HSMR methodology, however the impact of this remains to be determined.

The Trust Crude Mortality statistics - the number of deaths per admission, and the absolute number of deaths - are being closely monitored. There has been an increase in the number of inpatient deaths and crude mortality rate for the past 6 months.

East Lancashire Hospitals NHS Trust is taking the following actions to improve

- Continuing to monitor the crude mortality and identify alerting groups from this data.
- Urgently improving the timeliness and quality of data submission to ensure that more accurate standardised mortality data can be produced.
- Continuing the 'Learning from Deaths' processes and introducing quality improvement work, where necessary, to address alerting groups.
- Building on the introduction of the bereavement team and the seven-day palliative care team to ensure patients receive the optimal care at the end of life.

3.3.2 Percentage of Patient Deaths with Palliative Care Coding

This is an indicator designed to accompany the Summary Hospital-level Mortality Indicator. The SHMI makes no adjustments for palliative care. This is because there is considerable variation between Trusts in the coding of palliative care. Using the same data as the SHMI this indicator presents crude percentage rates of death that are coded with palliative care at either diagnosis or treatment speciality level.

East Lancashire Hospitals NHS Trust percentage of deaths with palliative care coding	20%
National percentage of deaths with palliative care coding	44%
Trust with highest percentage of deaths with palliative care coding	67%
Trust with lowest percentage of deaths with palliative care coding	17%

East Lancashire Hospitals NHS Trust considers that this data is as described for the following reasons:

The Trust has a lower-than-average score for specialist palliative care coding. This is reflected in part by differences in coding palliative care input in some areas of the Trust such as critical care.

East Lancashire Hospitals NHS Trust is taking the following actions to improve this ratio and so the quality of its services by:

- The Trust has introduced seven-day palliative care service.
- The Trust continues to enhance the end of life / bereavement team and in February 2025 opened a new Bereavement Suite.
- The Trust has launched a quality improvement project relating to end of life and advanced care planning.

3.3.3 Patient Recorded Outcome Measures (PROMs)

Patient Recorded Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient's perspective. Currently covering two clinical procedures PROMs calculate health gains after surgical treatment using pre and post-operative surveys.

The two procedures are:

- Hip Replacement
- Knee Replacement

PROMs measure a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires. This health status information is collected pre-op and 6 months after a procedure and provides an indication of the outcomes or quality of care delivered to NHS patients; this data has been collected by all providers of NHS funded care since April 2009.

The following tables set out the percentage of ELHT patients identified as achieving an 'improved post-operative adjusted average health gain' in comparison with the national figures for both of the PROMs procedures using the EQ-5D measure of health gain. The 'EQ-5D Index' scores are a combination of five key criteria concerning patients' self-

reported general health: mobility, self-care, usual activities, pain/discomfort and anxiety/depression.

.

3.3.3.1 Hip Replacement Surgery

Hip Replacement Surgery	2020-21	2021-22	2022-23	2023-24	2024-25
ELHT	No Data	88.4%	91.0%	88.1%**	No Data
National Average	90.0%	88.4%	89.4%	88.8%**	No Data

3.3.3.2 Knee Replacement Surgery

Knee Replacement Surgery	2020-21	2021-22	2022-23	2023-24	2024-25
ELHT	No Data	78.8%	86.1%	78.7%	No Data
National Average	82.0%	82.1%	82.6%	80.9%	No Data

PROMs outcome data covering April 2020 to March 2021 published by NHS Digital Hospital, shows no returns from ELHT during this period for both Pre and Post op questionnaires – ELHT records show that only 5 pre-op questionnaires were completed for this period due to the COVID Pandemic. 2023-24 published figures are finalised for the period. There are no provisional published outcome figures for 2024-25 in NHS Digital

East Lancashire Hospitals NHS Trust considers that this data is as described for the following reasons:

ELHT has a process in place to ensure patients receive a pre-operative questionnaire for completion at their pre-operative assessment.

Patients can decline to complete the questionnaire (optional); in these cases, questionnaires are still collated to monitor ELHT submission rates and inform where education and patient information may be required.

East Lancashire Hospitals NHS Trust is taking the following action to improve performance, and so the quality of its services:

A verbal request sheet has been scripted to ensure standardisation of information given to maintain and improve participation rates.

Random spot checks will be continued to prevent a decline in participation rates, regular feedback will be given on a to the Pre-op assessment coordinator via email.

Patients are encouraged to complete the post operative questionnaire at 6 months via the hip and knee school.

3.3.4 Readmissions within 28 Days of Discharge

The following table sets out the Trust's performance during 2032-24 for emergency admissions within twenty-eight days of discharge. We have used Dr Foster data which provides national benchmarking from the National Hospital Episodes Statistics data. The

Health and Social Care Information Centre (HSCIC) do not provide data on readmissions at the level of detail required. The figures shown below represent internally validated figures as at February 2025:

All ages	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
Readmission Rate	8.33%	8.20%	8.61%	9.07%	9.73%	9.57%	8.83%	6.6%
Age Band	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
0-15	13.12%	11.74%	12.52%	12.02%	11.43%	13.09%	13.87%	8.4%
16+	7.28%	7.45%	7.81%	8.53%	9.46%	8.91%	7.80%	6.3%

East Lancashire Hospitals NHS Trust considers that this data is as described for the following reasons:

The overall ELHT 28-day readmission rate produced by Dr. Foster is 6.6%. The trust is below the national rate of 8.1%.

- For the 0-15 age group, the rate is 8.4% which is below the national rate of 10.0%.
- For the 16+ age group the rate is 6.3% which is below the national rate of 7.8%.

Readmission rates for paediatrics have fallen substantially since last year and are now lower than the national rate. This is primarily the result of reclassification of assessment unit attendances from inpatient to SDEC attendances, which brings the Trust into line with standard practice. However, there has also been contribution from QI measures described in last year's Quality Account.

3.3.5 Responsiveness to Personal Needs of Patients

The Trust values and encourages feedback on how its services perform and uses a variety of methods including patient satisfaction surveys. We also believe that involving and co-producing service developments with patients and the public will help us to continually improve the care, experience, and services we provide and have a well-established Public Participation Panel (PPP) which helps the Trust build on established relationships between health professionals, patients, carers and the public. PPP members ensure we are putting the voice and needs of patients at the forefront of decision making and that the views of patients, carers and families are represented at all levels of the organisation.

The Trust participates in the national programme of patient satisfaction surveys. The Care Quality Commission uses the results from the surveys in the regulation and monitoring and inspection of Trusts in England. Results are shared with the Clinical Divisions to develop action plans to address any issues identified.

The Adult Inpatient Survey sampled 1250 consecutively discharged inpatients, working back from the last day of November 2023 who had at least one night in hospital. There

were 398 usable responses received giving a final response rate of 34%. This compares with a response rate of 37% in the 2022 survey.

Table 1 below details the top 5 scoring questions for the Trust in 2023 with a comparison with the 2022 score if available.

Top 5 Questions	Score	
	2022	2023
During your time in hospital, did you get enough to drink?	9.80	9.23
Were you given enough privacy when being examined or treated?	9.61	9.21
Were you ever prevented from sleeping at night by any of the following? Room temperature.	n/a	9.19
To what extent did you understand the information you were given about what you should or should not do after leaving hospital?	8.87	8.95
Overall, did you feel you were treated with respect and dignity while you were in hospital?	9.16	8.87

Table 1 – ELHT top 5 scoring questions

Table 2 below details the bottom 5 scoring questions for the Trust in 2023 and a comparison with the 2022 score if available.

Bottom 5 Questions	Score	
	2022	2023
During your hospital stay, were you ever asked to give your views on the quality of your care?	1.78	3.81
Were you ever prevented from sleeping at night by any of the following? I was not prevented from sleeping	4.55	3.91
Thinking about any medicine you were to take home, were you given any information?	4.08	3.97
To what extent did hospital staff involve your family or carers in discussions about you leaving hospital?	5.61	5.07
Were you able to get hospital food outside of set mealtimes?	5.43	5.33

Table 2 –ELHT bottom 5 scoring questions

In comparison to other Trusts who took part in the survey, ELHT has performed about the same for most questions. Overall, the 2023 results remain generally consistent with 2022 and 2021 across Trusts taking part. This follows declines in opinions in the 2021 survey in comparison with 2020. There continue to be challenges around the number of patients attending the Emergency Department and requiring admission.

IQVIA, who administer the survey on behalf of the Trust, have recommended areas the Trust may want to consider strengthening. The survey details have been shared with Divisions for integration into their existing service improvement plans, where identified as required. The Trust has also incorporated 6 key questions into our Patient Experience, Engagement and Involvement Strategy 2024 – 2027 to measure improvement.

3.3.6 Recommendation from Colleagues as a Provider of Care

The data made available to the East Lancashire Hospitals NHS Trust by the National Staff Survey Coordination Centre with regard to the percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends. This provides an indication of whether our colleagues feel the Trust provides a positive experience of care for our patients.

- 55.8% of colleagues said – if a friend or relative needed treatment they would be happy with the standard of care provided by the organisation.
- 73.6% of colleagues said – care of patients/services users is the organisations top priority.

The Trust scored 6.8 for the overall colleague engagement score on the 2024 national staff survey which is similar to the NHS national average of 6.85.

3.3.7 Friends and Family Test Results (Inpatients and Emergency Department)

The Friends and Family Test (FFT) is a well-established means to measure the experience of patients that have recently received care within acute hospital Trusts. Based on approaches like Trustpilot or Tripadvisor

Patients are invited to respond to a question, in the context of each service, 'Overall, how was your experience of our service?', by choosing one of six options ranging from very good to very poor. Patients can give their reviews and opinions at any time during their episode of care, which is used by staff to drive improvement.

Patients are able to answer the FFT question via completion of an FFT card, online via the Trust's website or QR code. FFT feedback is also collected from patients via SMS texting across Accident & Emergency, Outpatient attenders, maternity and community services.

The following table sets out the percentage positive rating for the period April 2024 to March 2025 for inpatients and emergency care and how these results compare with other Trusts nationally.

	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024	October 2024	November 2024	December 2024	January 2025	February 2025	March 2025
Inpatient positive % rating												
ELHT	96	96	96	96	97	95	95	96	97	96	95	96
Nat Average *excludes independent sector providers	94	94	94	95	95	94	94	95	94	94	Not yet available	Not yet available
A&E positive % rating												
ELHT	74	76	75	78	81	71	74	69	69	66	73	76
Nat Average	79	78	79	80	83	79	78	77	76	80	Not yet available	Not yet available

The East Lancashire Hospitals NHS Trust considers that this data is as described for the following reasons:

We value the feedback from our patients and ensure it influences how we develop and deliver our services; therefore, staff are supported to collect information from patients.

Over 34,000 inpatients and emergency care attenders have provided feedback during the period April 2024 – March 2025. The Trust has received consistently high scores from inpatients, with an average of 96% of inpatients rating their overall experience as either very good or good.

There are ongoing challenges around the number of patients attending the Emergency Department and Urgent Care Centres which has impacted on the positive response rate across Emergency Care.

Advice and support will continue to be provided to specific areas so that feedback is collected and recorded in a timely manner and used to influence service improvements.

3.3.8 Venous Thromboembolism (VTE) Assessments

		1st April 2024- 31stMarch 2025				
	VTE RISK Assessments 22-23	Q1	Q2	Q3	Q4	Total
ELHT	Number of VTE-risk assessed Admissions	12610 (83.96%)	13666 (84.99%)	13143 (87.43%)	Nil Data	39419 (85.46%) Based on available data
	Total Admissions	15019	16080	15032	Nil Date	46131
National	Number of VTE-risk assessed Admissions Total Admissions Percentage of admitted patients risk-assessed for VTE	ELHT reporting on VTE is still continuing to evolve and progress since the transition to Cerner as it was discontinued since end of June 2023 and resumed only from April 2024 . Nil VTE data is available for the fourth quarter between Jan 2025 and March 2025 National figures revealed National average of 89% overall Northwest regional average was 86.1% None of the Regions overall achieved the National standard of 95% although a small number of Trusts have achieved this across the country https://www.england.nhs.uk/?s=VTE https://www.england.nhs.uk/statistics/statistical-work-areas/vte/vte-risk-assessment-2024-25/q1-revised/				
	Best Performing Trust	99.7%				
	Worst performing Trust	14.9%				

The above partial data for Quarters 1-3 only is available and data is not available for the last quarter of 2024/25 between 1.1.2025 and 31.3.2025 as this is yet to be reported after validation.

Trust Informatics team have developed a VTE reporting system from Cerner data on completed hospital episodes on inpatient admissions that is not reliant as it had been historically on clinical coding. This is continually being reviewed and updated to enhance the reliability of the reporting through system upgrades within Cerner. This is in order to ensure that reporting on behalf of organisation is accurate and robust and reflective of all true in-patient admissions that require a VTE risk assessment on admission as per NICE guidelines.

The annual data over the three quarters is 85.46% and is below the national average which is presently at 89% and very close to the Northwest regional average which is 86.1%. This is a significant drop compared to pre-cerner figures which were 98.3%, 97.90% and 98.45% between 2020/21, 2021/22 and 2022/23. There was paucity of reporting and data in 2023/24 with transition to Cerner preceding this which had a significant impact.

VTE committee was reinstated post-Covid with administrative support from Trust Governance which enables to monitor the Divisional and Directorate VTE risk assessment figures and Trust figures with action plans as part of the VTE Harms reduction program. Live data reporting of VTE figures of real time in-patients in beds was facilitated as part of this updated reporting by Informatics that continues to be tested, evaluated and updated with system upgrades as required by findings of exploration as continuous quality improvement. Examples of recent changes to Cerner implemented through QI project and Task and finish group by Trust VTE committee are as below:

1. All patients with no change in mobility would default to having a mandatory full VTE risk assessment, which would be captured in the reporting.
2. For antenatal and postnatal patients, a data field would be added to state "nil applicable" for bleeding risk when no other factors were present.
3. The VTE prophylaxis “Yes/No” data field would become mandatory.
4. The position of the VTE prophylaxis data field would be moved to follow the clinical workflow.
5. Clinical Informatics would ensure that completed data fields were pulled into the final reports

All the above will positively enhance the Trust capability to enable robust VTE risk assessment data collection and reporting accordingly alongside other QI measures.

East Lancashire Hospitals NHS Trust considers that this data is as described for the following reasons:

- Systems and processes are in place at ELHT for risk assessing all appropriate patients utilizing the national VTE risk assessment tool on admission on Cerner EPR system.
- The current electronic VTE risk assessment system on Cerner EPR since the move from the previous online system of VTE risk assessment on Alcadion or Hospidea system since June 2023 is now well embedded and working well.
- Trust VTE performance metrics is showing a trajectory of improvement over the three quarters from 83.99 to 84.99 to 87.43% over the first three quarters with data pending for Quarter 4.
- Trust VTE risk assessment consistently improved from just above 95% in 2012, to 97% since July 2013, above 97.5% since July 2014 and above 98.3% since July 2016 until April 2020. There was a drop in the VTE risk assessment figures noted by 0.40 % overall during the pandemic times in 2020/21 which resumed Trust trajectory at 98.45% in 2021/22 and 2022/23.Trust VTE risk assessment figures continued to be significantly above National average of above 95% at 98.47% for the two consecutive years prior to Cerner implementation. With ongoing Continuous QI approaches through VTE

committee work Trust figures are consistently improving and will hopefully be back to previous figures as a high performing Trust in this aspect as well towards the end of next year.

East Lancashire Hospitals NHS Trust is taking the following action to improve performance, and so the quality of its services:

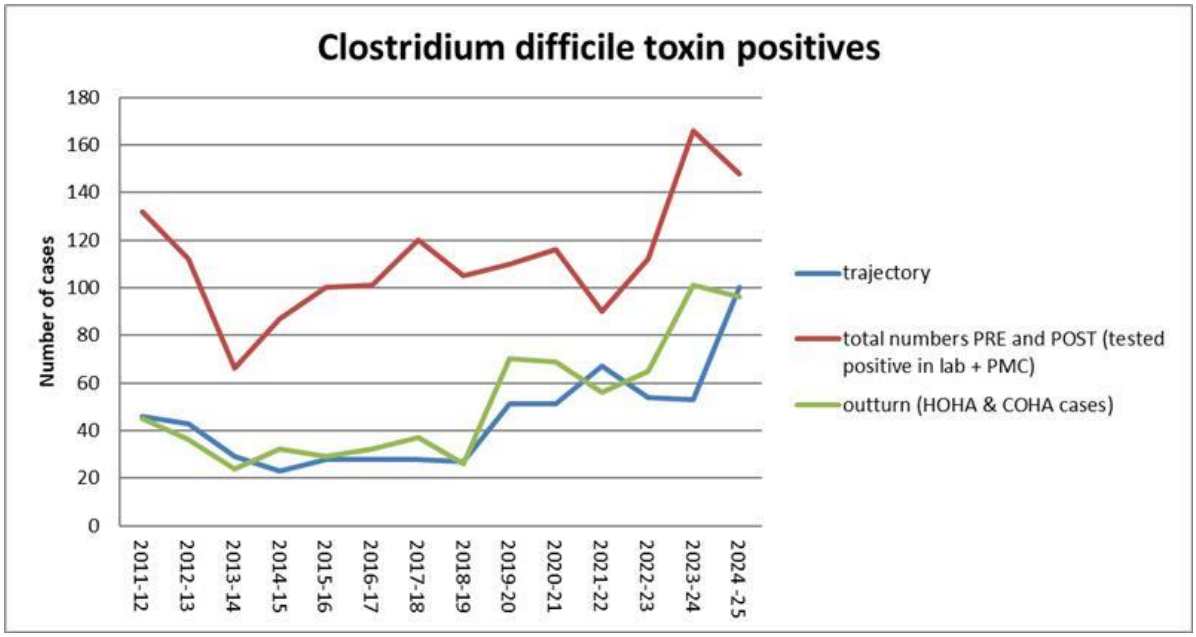
- VTE committee that was reinstated after a period of pause for nearly 18 months from November 2023 continues to be supported with an appropriate level of administrative support through Trust Quality and Safety/Governance team.
- VTE committee terms of reference updated again and continues to be bi-monthly frequency and to reflect the governance reporting arrangements currently in place.
- Monitoring of identification, reporting and management of Hospital acquired VTE through formal reporting by all divisions that resumed was subject to a clinical audit recently with action plans implemented through the Trust VTE committee which functions as a sub-committee of Trust Patient Safety group.
- Trust policy CP17, Part 1 is currently being reviewed and the Part 2 of the policy on Diagnosis and Management of VTE was updated last year.
- VTE committee working group is working closely with the Trust informatics teams and Robust Informatics reporting that is fit for purpose is in place and continues to be improving.
- Educational event was delivered for Foundation year trainees at change of rotation again this year with live Cerner demonstration of VTE work streams and task lists on Cerner to enable better compliance with risk assessment as well as prophylaxis prescribing. Further ongoing training is planned with every rotation change.
- A ward-based spot audit on VTE risk assessments and prescribing was undertaken in AMU A and AMU B as part of QI work planned through VTE champions and QI group.
- Trust wide audit on Hospital acquired VTE reporting and evaluation for lessons learnt that was commissioned by VTE committee through the clinical audit and effectiveness team for 2024/25 year was completed and action plans implemented. The reporting tool has been digitalised and integrated into Datix to enable a Trust wide consistent approach.
- Reaudit of HAVTE, VTE risk assessment and Management of Suspected and confirmed VTE is included in the forward planner for 2025/26 as ongoing QI initiatives enhancing the quality and efficacy of this Trust harms Reduction programme.

3.3.9 Clostridium Difficile Rates

The data made available to the Trust by the Health and Social Care Information Centre with regard to the rate per 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.

The Trust reported 96 clostridium difficile positives 76 HOHA & 20 COHA the trajectory for 2024/25 was 100.

Clostridium difficile toxin positive results from April 2024 – March 2025:



East Lancashire Hospitals NHS Trust considers that this data is as described for the following reasons:

Assertive action on management of hospital acquired infections has been undertaken for a number of years to reduce the rate to the present level. Post infection reviews have now been replaced with patient safety reviews (PSR's) aligning Infection Prevention & Control with the Patient Safety Incident Framework. PSR's are not required for all individual HCAI cases, they will only be completed if the case meets the following criteria. Confirmed transmission from genotyping/ribotyping indicating outbreak (two or more patients where cross contamination has occurred) b) Area's part of a Period of Increased Incidence (two or more cases within 28 days) c) Hospital associated infection on death certificate. Nationally there continues to be an increase in Clostridium difficile more evident in the North of the country.

East Lancashire NHS Trust intends to take actions to improve this rate and so the quality of its services by:

There have been ongoing quality improvement projects around improving the management of Clostridium difficile cases with the introduction of an electronic diarrhoea care plan now live on the electronic patient record system (EPR) a Clostridium difficile care plan is due to go live in May 2025. IPC and the Consultant Microbiologist are working alongside DERI to introduce a Clostridium difficile learning package for the medical staff on the management of cases. The IPC team are working closely with patient services to improve environmental cleanliness and embed the National Cleaning Standards.

3.3.10 Patient Safety Incidents

NHS Trusts are now automatically report all incidents which involve patients to the Learning from Patient Safety Events system (LFPSE) when reported on the Trusts risk management system.

East Lancashire Hospitals NHS Teaching Trust can use this information to understand its reporting culture; higher reporting Trusts usually have a strong safety culture and as such the Trust continues to actively encourage the reporting of incidents and near misses.

LFPSE data does not supply the same information as NRLS which was used to calculate the information usually provided. In the previous Quality Account, the Trust calculated the reporting rate below using the number of patient safety incidents reported on the Trust Governance System (Datix) and the occupied bed days (per 1000); this may translate into a significant increase in the number of rates of reported incidents. As with the previous year's data we are unable to provide the Cluster rates and therefore compare ourselves to other Trusts within the cluster.

Patient safety incidents per 1000 bed days	**Oct 2017 to Mar 2018**	**April 2018 to Sept 2018**	**Oct 2018 to Mar 2019**	**April 2019 to Sept 2019**	**Oct 2019 to Mar 2020**	**Apr 2020 to Mar 2021**	**Apr 2021 to Mar 2022**	**Apr 2022 to Mar 2023**	**Apr 2023 to Mar 2024**	**Apr 2024 to Mar 2025**
ELHT number reported	7401	6426	6398	8128	8269	11142	12887	21241	22550	22367
ELHT reporting rate	46.4	42.0	40.9	52.0	53.2	44.0	43.1	62.5	66.7	66.2
Cluster average number	5449	5583	5841	6276	6502	12502	14368			
Cluster average reporting rate	43	44.5	46	50	51	58	57.5			
Minimum value for cluster	1311	566	1278	1392	1271	3169	3441			
Maximum value for cluster	19897	23692	22048	21685	22340	37572	49603			
Patient safety incidents resulting in severe physical or psychological harm	**Oct 2017 to March 2018**	**April 2018 to Sept 2018**	**Oct 2018 to March 2019**	**April 2019 to Sept 2019**	**Oct 2019 to Mar 20**	**Apr 2020 to Mar 21**	**Apr 2021 to Mar 22**	**Apr 2022 to Mar 2023**	**Apr 2023 to Mar 2024**	**Apr 2024 to Mar 2025**
ELHT number reported	9	6	9	5	6	19	20	22	35	49
ELHT % of incidents	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.1	0.2	0.2
Cluster average number	13.5	13.5	14	15	14.5	31	37.4			
Cluster average reporting rate	0.3	0.3	0.3	0.3	0.2	0.3	0.3			
Minimum value for cluster	0	0	0	0	0	4	2			
Maximum value for cluster	78	74	62	76	91	137	157			
Total incidents across cluster	1810	1771	1780	1896	1870	3,817	4603			
Cluster % of incidents	0.2	0.2	0.2	0.2	0.2	0.2	0.3			
Patient safety incidents resulting in Fatal harm	**Oct 2017 to March 2018**	**April 2018 to Sept 2018**	**Oct 2018 to March 2019**	**April 2019 to Sept 2019**	**Oct 2019 to Mar 20**	**Apr 2020 to Mar 21**	**Apr 2021 to Mar 22**	**Apr 2022 to Mar 2023**	**Apr 2023 to Mar 2024**	**Apr 2024 to Mar 2025**

ELHT number reported	2	1	6	4	6	17	8	7	24	25
ELHT % of incidents	0	0	0.1	0	0.1	0.2	0.1	0.03	0.1	0.1
Cluster average number	5.3	5.1	5.2	4.8	5	24	20.4			
Cluster average reporting rate	0.1	0.1	0.1	0.1	0.1	0.2	0.2			
Minimum value for cluster	0	0	0	0	0	0	1			
Maximum value for cluster	24	22	23	24	22	146	81			
Total incidents across cluster	712	706	678	628	666	3011	2513			
Cluster % of incidents	0.1	0.1	0.1	0.1	0.1	0.2	0.1			

East Lancashire Hospitals NHS Trust considers this data is as described for the following reasons:

The overall number of incidents reported by the Trust in 2024/25 has slightly reduced from 2023/24. Staff are encouraged and understand the importance of reporting all levels of incidents across the Trust so that learning can be shared.

The reported severe harm incidents have increased from 2023/24 this is because from July 2024 the Trust started to report into LFPSE and therefore begun to record both physical and psychological harm. The change is reflected in the above figures.

ELHT Patient Safety Incident Requiring Investigation (PSIRI) Panel has focused on the identification of lessons learned and actions taken following review of patient safety incident investigations to ensure services are improved and harm is reduced.

The Trust has a comprehensive harms reduction programme supported by the Quality Improvement Team and Quality Governance which provides assurance of the reduction in harms to the Trusts Quality Committee.

The Trust continues to make improvements to investigation processes and dissemination of learning, in line with changes made to the Patient Safety Incident Response Framework, following its national rollout, and as other Trusts within the ICB begin working under the framework:

- The Patient Safety Team have been delivering Introduction of Human Factors training since April 2024, and Patient Safety Response (PSR) Investigation training has been introduced with the first session taking place in April 2025. These two training sessions will ensure all investigators who undertake PSR investigations are compliant with the Patient Safety Incident Response Framework (PSIRF) investigation standards.
- The Patient Safety Incident Investigations (PSII) process has been reviewed to improve the timescales to complete the investigations.
- The Patient Safety Team held a Quality Governance Forum in July 2024 with the focus on the requirements of:
    - PSIRF
    - LFPSE
    - Involving Patients and families in incident investigations (being open and honest)

- How learning is shared across the Trust
- New Patient Safety Learning Podcasts produced by the Patient Safety Incident Investigation Team have been developed to support good practice in involving staff, patients and families within the investigation process and learning outcomes from key investigations. These are available to all staff on the Patient Safety SharePoint site for viewing.

3.3.11 Never Events

A Never Event is a serious incident that is recognised as being entirely preventable if all the correct guidance is followed and all our systems work to create a safe situation for patients and colleagues. Over 2024/25 the Trust has reported 3 incidents that meet the criteria of the NHS Never Event Framework:

Type of Never Event	Number
Retained foreign object post procedure	2
Misplaced naso-gastric tube	1

One of the three Never Event incidents has been fully investigated and the Trust found important learning that has been shared with colleagues across the organisation, with our commissioners and the patients. Detailed safety improvement plans for this incident have been developed, updated and assurance on the completion and embedding of learning has been overseen by Patient Safety Group and Patient Safety Incident Requiring Investigation panel. The other two Never Events at the time of the Quality Account being published were still under an investigation.

Learning from Never Event Incidents

On three occasions within 2024-25 the Trust has not met the expectations of **Safe**, **Personal** and **Effective** care regarding Never Events. Currently the Trust identified several key changes in systems and processes from the first retained foreign object post procedure incident and learning was shared within the Trusts Patient Safety Bulletin. The learning included:

Retained foreign object post procedure Never Event 1:

- A review and update of the Trusts protocol for counting swabs, needles, and instruments in the Trusts Maternity now includes clear guidance of the use of Local Safety Standards for Invasive Procedures (LocSSIPs) and whiteboards for counts.
- Introduction of the 'perfect whiteboard' fully implemented across all birth sites and staff provided with training
- Staff induction for Central Birth Suite and Birth Centres now includes local guidance for birth and suturing on the use of LocSSIPs and whiteboard counts
- New 'complete' suture packs for the birth environment introduced

3.3.12 Learning from Deaths

Throughout 2024-2025 East Lancashire Hospitals NHS Trust has been using the Structured Judgement Review (SJR) methodology to review clinical care of patients who have died. This methodology assigns a score to particular elements of care and an overall score for a patient's care. A score of 1 or 2 identifies a concern that care was poor and a secondary review process is triggered to determine whether or not this poor care contributed to the patient's death. If this is felt to be the case a round table discussion is

held with the clinical team involved and where the SJR concerns are validated a patient safety investigation of the case is undertaken and presented to the Divisional Serious Incident Reporting Group or the Trust's Patient Safety Incident Requiring Investigation (PSIRI) Panel.

The identification of cases to be reviewed follows the processes identified within 'Learning from Deaths' and in line with National Guidance.

Not every death is subjected an SJR; the primary reasons for triggering an SJR are listed in the Trusts 'Learning from Deaths' Policy. The triggers for SJR are reviewed and amended in line with alerting groups.

Breakdown of deaths in 2024 - 2025 and number of completed SJR's for this time period.

Total number of inpatient deaths 2024/25	**Completed**	**2024-2025**		
	Q1	515		
	Q2	455		
	Q3	547		
	Q4	597		
Total		**2,114**		
Number of Stage 1 and 2 SJR's completed 2024/25 (May contain deaths from current and prior years)		**SJR 1**	**SJR 2**	**Deficiencies in care which may have contributed to death**
	Q1	29	10	3
	Q2	11	3	0
	Q3	29	2	0
	Q4	5	4	0
Total		**74**	**19**	**3**

The number of SJRs carried out in this financial year has been adversely impacted by a reduction in the number of available reviewers and vacancy in the administrative support to the reviewers.

The learning points from SJR reviews are collated into areas of good practice and areas for improvement which are tied into the Trust improvement priorities. Whilst end of life care remains a significant area for improvement, there has been notable evidence of good practice likely to be a result of the introduction of the end-of-life care and bereavement team and their support to ward based teams.

Themes are collated with learning from other clinical governance functions (claims, complaints, incident reviews) and help to inform Quality Improvement projects. Section 3.1 and 3.2 of the Quality Account describes what achievements have been made against

areas of learning and what future improvement plans the Trust will be focusing on in 2024-25.

In addition to the general SJR process, mortality reviews also take place within individual specialties, including the Emergency Department, stroke services and intensive care. Paediatric, neonatal and maternal deaths have specific review processes.

Furthermore, all deaths are reviewed by the Medical Examiners (MEs), which is a statutory process. The ME service are able to raise issues with care, which can then be investigated through the incident process.

Paediatric Mortality

At East Lancashire Hospitals NHS Trust, all Paediatric deaths including out of hospital deaths are reviewed through a mortality process. In 2019 a strengthened review process more akin to the structured judgement review process used in adults was implemented. All paediatric deaths are subject to a multidisciplinary primary review with a paediatric consultant and senior nurse reviewing the case in a structured way.

Following this all deaths are reviewed at the paediatric mortality group consisting of consultant's senior nurses and doctors in training. Actions for improvements are noted and implementation is monitored through this group. Going forwards this process will also align with the newly implemented child death review meetings.

The table below demonstrates the number of cases reviewed by the process.

		In Hospital	At Home	Another Trust	Out of Area
Total number of Paediatric Deaths by Location and quarter the Death occurred 2024/25	**Q1**	3	0	0	2
	Q2	2	0	0	0
	Q3	2	3	0	0
	Q4	4	0	0	3
Total		**11**	**3**	**0**	**5**
Number of Stage 1 and 2 PMR's completed during by quarter 2024/25 (May contain deaths from current and prior years)	**Completed**	**PMR 1**	**PMR 2**		
	Q1	5	4		
	Q2	2	0		
	Q3	5	3		
	Q4	6	3		
Total		**18**	**10**		

In summary areas of good practice noted through this process are:

- Paediatricians and Children's Community Teams for Children and Young People with life limiting conditions.

- When advance care planning is done well it has an incredibly empowering impact on the family whose voice can be clearly heard in the process
- Resuscitations started by North-West Ambulance Service and continued in the Emergency Department with general paediatric input are extremely systematic and processes for bereavement support and escalation to the Child Death Overview Panel robustly followed

Key issues for which actions have been generated relate to the following:

- End of Life Care and Advance Care Planning should be started at earliest opportunity. This may prevent escalation of care to tertiary centres when a ceiling of care has been reached, if families and professionals agree that this is in the best interest of the individual child or young person.
- Discussion of what the agreed ceiling of care is, and it being clearly documented to prevent invasive interventions should be completed early in the patient journey when it is clear that further escalation would not have a positive outcome
- Advance Care Planning should be considered and evidenced even before End Of Life Care in order to ensure child and families wishes are captured and to support and inform difficult conversations that need to take place when a child or young person's health deteriorates.
- Primary care management of the acutely unwell child needs to be supported to empower GP's and ensure children get the most appropriate and timely review.
- Childhood suicide has been more prevalent nationally and local trends although low are evident in the reviews.
- As part of the review of child mortality it has become evident that there is a gap in service with the need for a Bereavement/Palliative care nurse based locally to empower families and promote Advanced Care Planning. This discussion is currently taking place with commissioners and has been incorporated as part of the community specialist nursing review. There are now two Kentown nurses in place at ELHT who fulfil this role, with one post permanent and the other funded until 2026 with no current agreement for future funding.

Learning Disability Mortality Reviews (LeDeR)

The NHS Long Term Plan made a commitment to continue learning from deaths (LeDeR) and to improve the health and wellbeing of people with a learning disability and autism.

The LeDeR programme was set up as a service improvement programme to look at why people are dying and what we can do to change services locally and nationally to improve the health of people with a learning disability and autism and to reduce health inequalities.

By finding out more about why people died we can understand what needs to be changed to make a difference to people's lives.

ELHT contribute to this process by notifying NHS England of all the deaths of people with a learning disability or autism. Following the notification of death a structured judgement review is completed and recommendation and actions for learning are shared within the organisation at the regional LeDeR lessons learnt group. Thematic cause of death is also reported annually to NHS England's national standards.

In summary areas of good practice noted through this process are:

- Use of flagging of learning disability and autism in electronic care record
- Use of learning disability and autism care plan

Key issues noted and reported via learning disability and autism operations group:

- Documentation errors on DNACPR and incomplete DNACPR documentation.
- Earlier involvement of next of kin
- Carer involved in Best interest decisions rather than NOK
- Issues with MCA, lack of capacity assessments, referrals where required to IMCA for best interest decision making.
- Best interest decisions for NG tubes
- No LD flag on electronic system
- Issues with end-of-life care planning and delays in access to management plans
- Lack of use of hospital passports to inform care
- Movement of patients during end-of-life care.

Reviews are now completed at a monthly learning disability and autism mortality meetings. Where necessary actions are formulated. Outcomes from this meeting is included in a monthly report to mortality steering group. Actions are monitored and reviewed at learning disability and autism operations group and reported to Safeguarding Committee.

Breakdown of Learning Disability deaths in 2043-25 and number of completed LeDeR's for this time period by financial quarter:

Adult inpatient deaths and number of those which had a Learning Disability or Autism Stage 1 and 2 LDA-SJR's completed 2024/2025 (Completed LD-SJR's may contain deaths from prior quarters/years)	**Quarter**	**In-patient Deaths**	**LDA-SJR 1 Completed**	**LDA-SJR 2 Completed**	**LeDeR (New LD review Process)**	**Deficiencies in care which may have contributed to death**
	Q1	515	5	1	N/A	0
	Q2	455	6	1	N/A	0
	Q3	547	7	3	N/A	0
	Q4	597	6	2	3	1
Total		**2,114**	**24**	**7**	**3**	**1**

3.3.13 Seven Day Service Meeting the Clinical Standards

The Trust continues to deliver services in line with the national 7-day standards.

Consultant job plans are designed to enable the review or delegated review of patients by a consultant within 14 hours of acute admission in all specialities 7 days a week. However, delays in the emergency pathway of patients transferring to speciality from emergency medicine has made this very challenging to achieve in Medicine.

Consultant led Board rounds and ward rounds take place on all inpatient units 7 days per week. This enables prioritisation of patient reviews based on severity of need, and delegation of review or need for the review for each patient.

All diagnostic services for acute admissions are available for patients 7 days a week either within ELHT or in an arrangement with a regional provider.

NEWS2, or maternity and paediatric equivalents are used across the Trust to measure patient illness and risk of deterioration, so that assessments can be escalated if the patient deteriorates or is at risk of deterioration 7 days a week, and 24 hours a day. Sepsis Bundles and e-Observations for these cohort patients are also in place. This has been supplemented by the Call for Concern approach for patients and families. The Trust has a 24-hour graded response by a dedicated team who have responsibility for managing and treating acutely unwell and deteriorating patients.

Patient flow facilitators and discharge coordination team works over 7 days per week to ensure timely progress of the patient's care including discharge in collaboration with system partners.

Multidisciplinary team members including pharmacists, therapists and advanced and specialist practitioners work across the 7 days of the week where this is required in acute care.

Shift handovers occur throughout every day of the week in all specialities to ensure continuity of care.

Our electronic patient record was implemented in June 2023. This will enable us to measure and audit against the timed standards in a comprehensive and efficient manner, although these audits are not currently in place.

3.3.14 Colleagues can speak up (Freedom to speak up)

ELHT is committed to ensuring the highest standards of service and the highest ethical standards in delivering this service. The Freedom to Speak up (Whistleblowing) policy (HR20) is in place to support and assist colleagues in raising concerns without fear of discrimination or reprisal. ELHT will deal with all disclosures consistently, fairly and confidentially. Anyone who works (or has worked) in for East Lancashire Hospitals NHS Trust can raise concerns under this policy. This includes agency workers, bank colleagues, temporary workers, students, volunteers and governors.

Anyone raising a concern under this policy is not at risk of losing their job or suffering any form of reprisal as a result. ELHT will not tolerate the harassment or victimisation of anyone raising a concern. Nor will the Trust tolerate any attempt to bully colleagues into not raising any such concern. Any such behavior is a breach of ELHT values as an organisation and, if upheld following investigation, could result in disciplinary action.

Colleagues can raise concerns in a variety of ways and advice is given that in the first instance to raise the concerns with their line manager (or lead clinician or tutor) if colleagues member feels able to do so, however if this is not an option or this step does not resolve matters, the other options are:

- Though the Staff Guardian - identified in the Freedom to Speak Up review to act as an independent and impartial source of advice to colleagues at any stage of raising a concern, with direct access to anyone in the organisation, including the chief executive, or if necessary, outside the organisation.

- If a concern remains, then they can be brought to the attention of our Executive Director or Non-Executive Director with responsibility for whistleblowing or one of the external bodies as listed in the Trust Policy.

Feedback to the person who raised the concern is critical. The sense that nothing happens is a major deterrent to speaking up. There are situations where this is not straightforward due to the need to respect the privacy of others involved in the case. However, there is almost always some feedback that can be given, and the presumption should be that this is provided unless there are overwhelming reasons for not doing so. Feedback is given to those who speak up in a variety of ways, mainly face to face, letter or via email.

ELHT are committed to the principles of the Freedom to Speak Up review and its vision for raising concerns and will respond in line with the model published in Sir Robert Francis's CQ (2015) Freedom to Speak up: an independent report into creating an open and honest reporting culture in the NHS.

The Trust board is provided with regular information in a full board report about all concerns raised by our colleagues and what actions are being taken to address any problems.

3.3.15 NHS England National Improvement Standards for Learning Disability

The NHS England National Improvement Standards for Learning Disability audit 2023/24 is currently ongoing and will be submitted to NHS England in March 2025. The outcome report, which will outline areas for action this coming year, will follow in the next few months.

The delivery plan for learning disability is under development which includes current actions for service improvement based on recommendations from previous NHS standards audit, LeDeR actions from learning and anticipated action recommendations from this year's benchmarking audit. This delivery plan will be submitted to the ELHT safeguarding committee for agreement. The outcomes of the plan's actions will be monitored and reviewed at the learning disability and autism operational group with a quarterly report to safeguarding committee and Patient Experience Group with action progress and completions.

3.4 Other Quality Achievements

3.4.1 Local 4-hour performance

The Trust has been praised for exceeding a national target for at least 76% of patients in the Emergency Department to receive care within four hours.

ELHT was one of 38 out of 119 acute Trusts in England that achieved the standard - and at nearly 78%, the Trust was 2% higher than the target.

A letter of congratulations was received from Sarah-Jane Marsh, National Director of Integrated Urgent and Emergency Care and Deputy Chief Operating Officer at NHS England, who expressed heartfelt gratitude to the Trust, its teams, and partners.

3.4.2 65-week wait target reached

The Trust achieved a national target to eliminate 65-week wait for elective care.

An enormous amount of work was done by teams who put plans in place to meet the NHS England goal by 30 September.

This was done despite the operational pressures remaining consistently high throughout the year.

3.4.3 Maternity services rated amongst best in England

Maternity care at ELHT is considered among the best in England after being rated 'better than expected' in a 2024 Care Quality Commission (CQC) survey.

The national questionnaire gathered responses from mothers across the country who gave birth in the delivery suite at Lancashire Women's and Newborn Centre or midwifery-led units at Rossendale, Blackburn and Burnley in February 2024.

It examined all aspects of maternity services, including antenatal care, care during labour and birth and post-natal care and from almost 19,000 responses nationally, ELHT was highlighted as one of just eight Trusts in England and one of only two in the North West whose results were 'better than expected' overall.

Patients praised the Trust for the ability of partners to stay with them as much as they wanted, taking their concerns seriously, and being able to get help from staff when needed.

3.4.4 Community services helping more patients than ever be cared for in their own home

More patients than ever are being cared for in their own homes by colleagues at the Trust.

The Trust has a range of teams and services who are working hard to avoid unnecessary hospital admissions by helping patients receive the most appropriate care, in the most appropriate place.

Results are going from strength to strength, including:

- Throughout 2024 community services had 19,563 referrals, 5,107 new patients, 3,558 care home referrals, 40,649 face-to-face visits, 10,059 telephone consultations and 133,944 calls to Intermediate Care Allocation Team who provide a single point of access to health and social care professionals
- The front door team, based at the emergency and urgent care departments, assessed 1,426 patients with 1,083 discharged home
- The urgent community response (UCR) team responded to 10,035 patients within two hours – and are currently well about the above the national target of 70% and consistency achieves over 95&% compliances
- The Trust's virtual ward programme has seen a 79.4% virtual ward utilisation. The service, which has accepted 32,010 referrals since its start in October 2022 and allowed for 90.4% of patients remaining in their usual place of residence helps to reduce the pressure on the Trust's inpatient wards and services and freeing up space for others to receive care quicker.

3.4.5 Theatres lead the way for utilisation

Data released in December revealed that the Trust is top of the country for theatre utilisation.

Getting it right first time (GIRFT), a national NHS England programme designed to improve the treatment and care of patients, set a target to achieve 85% theatre utilisation by 2024/25.

This includes measures to capture the time spent giving clinical care, such as administering anaesthetic and undertaking surgical procedures.

Data from the improvement tool Model Hospital, which benchmarks quality and productivity, showed ELHT has a score of 90.4%, which is testimony to the hard-working theatre teams.

3.4.6 Transfer of physical and mental health services in Blackburn with Darwen and East Lancashire

Following an extensive review of how adult community physical health services and children and young people's mental health services are delivered in the area and by whom, proposals were developed, approved and implemented in July to:

- Transfer NHS adult community physical health services in Blackburn with Darwen from LSCft to ELHT – including the transfer of existing colleagues.
- Children and young people's mental health services in Blackburn with Darwen and East Lancashire, known as ELCAS (East Lancashire Child and Adolescent Services), from ELHT to LSCft – including the transfer of existing colleagues.

ELHT worked closely with Lancashire and South Cumbria NHS Foundation Trust (LSCft) and the Integrated Care Board (ICB) to ensure these moves offer patients consistency of service and the same high-quality care, regardless of where they live.

3.4.7 Moving services out of Accrington Victoria

The Trust announced in October 2024 that all services at Accrington Victoria would relocate as the building was in serious decay and no longer fit for purpose as a healthcare facility.

A commitment was made (and delivered) that the critical services within the building would remain within Accrington and a phased and purposeful approach was taken to relocate departments including the Minor Injuries Unit, X-ray, PWE GP team and outpatients' department with minimal disruption to patients or services – providing a more modern and clinically safe environment.

Accrington Victoria is now effectively closed and is being secured and protected by the Trust whilst conversations about its future are finalised.

3.4.8 New Heart Care Unit at Royal Blackburn Teaching Hospital

A new Heart Care Unit opened at Royal Blackburn Teaching Hospital, bringing together the Coronary Care Unit and the Cardiology Ward into a single location on Level 4.

The new cardiology facility is the result of many years of planning and development and includes a 10-bed unit for coronary care and 26 bed cardiac care ward. Patient experience has been further enhanced with the inclusion of a cardiac assessment unit and ambulatory area.

The Unit was officially opened by local comedian Ted Robbins.

3.4.9 State-of-the-art chemotherapy unit opens at Blackburn Hospital

Local communities came together to raise over £120,000 for a state-of-the-art chemotherapy unit at Royal Blackburn Teaching Hospital.

The newly refurbished "Bluebell Unit" which provides chemotherapy, immunotherapy and supportive treatments to cancer patients was officially opened in September.

The unit is now home to the acute oncology team and systemic anti-cancer therapy team, who are based together for the first time, which will improve the support available for patients and team members. It also has dedicated private rooms for patients and their loved ones.

The investment was made possible thanks to the support of a wide number of community organisations and local residents who raised the money through various fundraising events, including cave dives and tea dances.

3.4.10 Major milestone in aortic aneurysm treatment

The radiology team at Royal Blackburn Teaching Hospital reached a significant milestone by completing their 500th endovascular repair of an aortic aneurysm, a procedure that has significantly improved patient outcomes by reinforcing the aorta and reducing rupture risks.

This landmark achievement underscores the Trust's pioneering role in this life-saving technique, which began in October 1999 with Dr Duncan Gavan, Consultant Interventional Radiologist, performing the first procedure. Dr Gavan also carried out the 500th procedure, marking a full- circle moment in this remarkable journey.

The procedure involves minimal incisions and reduced anaesthetic needs, making it suitable for patients who cannot undergo more invasive surgery. The procedure has evolved from taking over three hours to just 70 minutes, allowing for faster patient recovery and discharge.

This milestone reflects the Trust's commitment to advancing treatments and achieving better quality outcomes for patients.

3.4.11 Martha's Rule

The Trust launched Call for Concern, providing a telephone number for anyone to use if they are worried about the deterioration of a patient's condition.

A poster campaign was also developed to raise awareness on wards, with a QR code linking to detailed information on the ELHT website. The campaign was launched as national publicity raised awareness of Martha's Rule which is encouraging Trusts to introduce a process for rapid review.

3.4.12 Improvements and upgrades in Data and Digital

Despite recent challenges, including power outages, global IT outages and cyber-attacks, high-quality data and digital services have been consistently delivered across the organisation.

New features have been enabled on Microsoft Teams, allowing colleagues to record and transcribe meetings. These features offered many benefits, including near real-time subtitles, the ability to rewatch meetings, and assistance with notetaking. A policy was introduced alongside this rollout to ensure safe usage, protecting colleagues, patients, and their families.

Preparations also continued for the replacement of Clinicom with a new system called Careview, accessible to colleagues the intranet and the electronic patient records system. Training guides, videos, and support were made available to ensure a smooth transition, as Clinicom was phased out due to being outdated.

Additionally, the Cisco phone systems were successfully upgraded across all sites.

3.4.13 Further Faster 20 initiative to reduce waiting lists

The Trust is one of a number of Trusts to be part of a national initiative to reduce waiting lists.

Further Faster 20 brings together clinicians and operational teams with the challenge of collectively going 'further and faster' to transform patient pathways and working to reduce unnecessary appointments and improve access and waiting times for patients.

Clinical transformation groups have been established across 19 specialties, involving clinical leads from across the trusts as well as national speciality leads, and other key stakeholders.

The aim is that by learning from each other, harnessing the solutions that already exist in departments across the country, trusts can make a positive impact, for both the NHS workforce and for patients, on a national scale.

3.4.14 Keeping patients steady on their feet

A self-referral service at the Trust is helping to keep patients safe on their feet, live independently and reduce hospital admissions.

Patients who have been admitted or attended hospital due to a fall or unsteadiness can be seen by the Steady On! Falls Prevention Team. The team of two carry out home

assessments to identify what needs to be put in place to support patients with daily living and reduce future hospital admissions.

They look at a range of factors to create a falls prevention plan, including safe, supportive footwear and foot care and helping with medication support.

The team also assess the home environment and lighting, discuss activity and exercise to promote strength and balance and ask the question ‘do you fall?’ to identify any patterns to try and reduce risks.

It is part of a range of community services provided by the Trust to help people avoid unnecessary admissions to hospital and receive support in their usual place of residence.

3.4.15 Patient experience strategy launched

The Trust’s new patient experience, engagement and involvement strategy was launched with two special virtual events.

More than 150 colleagues joined the sessions, where Chief Nurse Pete Murphy detailed the new strategy and its ambitious targets.

The three-year strategy has been designed with colleagues and patients and their representatives, with emphasis put on supporting the needs of our most vulnerable patients, including those with learning disabilities, cognitive impairment (dementia) and children and young people.

Delivering excellent care requires the experience of our patients, carers and families to be considered at every opportunity. The Trust is committed to taking every opportunity to hear from people who use our services, their families, carers and visitors and encouraging them to get involved in shaping the way the Trust provides its services.

The strategy outlines plans to introduce patient safety partners, increase the influence of patients and the public as we develop plans and processes, help the Trust identify and minimise the impact of health inequalities, and widen the engagement of patients and public.

3.4.16 Maternity discharge videos will transform new parents’ experiences

A raft of new videos designed to provide crucial information to new parents in an accessible format has been launched.

The videos are a digital version of the essential information given to parents on discharge, including safe sleeping, taking care of wounds and infant feeding. They are designed to be

watched back at any time of day – or night – when new parents might need the information the most.

They have been translated into the eight most-used languages in the communities that ELHT serves.

The videos were funded by Electricity Northwest, whose free Extra Care Register provides extra support to those who may need it during a power cut, including those with young children.

3.4.17 Joint Advisory Group (JAG) accreditation

The Royal College of Physicians and its official body the Joint Advisory Group (JAG), has re- awarded JAG accreditation to the endoscopy units at the Trust for the eighth consecutive time.

JAG is a voluntary scheme that focuses on standards, identifies areas for development and is based on evidence linked to clinical quality, patient experience, workforce and training.

By participating in the voluntary JAG programme the Trust's Endoscopy Service ensures that patients receive first class care. JAG accreditation verifies that rigorous, high-quality standards, used across the UK and Republic of Ireland, are met to support delivery and improvement of endoscopy services. These standards were developed by a multi-professional group of clinicians, managers, and service users. The accreditation programme is run by the Royal College of Physicians (RCP) and is dedicated to improving care quality standards.

It is the 'Gold Standard' for Endoscopy Departments, and it is testament to the team that the service has met the required JAG accreditation standards.

3.4.18 Care Quality Commission's (CQC) Adult Inpatient Survey

The 2023 Care Quality Commission's (CQC) Adult Inpatient Survey gathered responses from over 63,000 NHS patients nationwide. It focused on those who stayed in hospital for at least one night during November 2023 and were 16 or older at the time of their stay.

At ELHT, 1,250 patients were invited to take part, with around 400 responding. The survey explored various aspects of the patient journey, from admission to discharge, including the hospital environment and overall experience.

While our scores are comparable to other Trusts in many areas, they show a decline in overall experience. On a positive note, we received strong feedback on themes of kindness, compassion, and respect for dignity. This speaks to the ongoing dedication of our colleagues who continue to provide care under challenging circumstances, particularly with record numbers of patients coming through urgent and emergency care pathways.

We're determined to use this feedback as an opportunity to improve and make sure we're providing the best care possible.

3.5 Statements from Stakeholders

To be included in the final version on receipt of Stakeholder statements

3.5.1 Healthwatch Blackburn with Darwen and Healthwatch Lancashire

3.5.2 Lancashire and South Cumbria Integrated Care Board (LSCICB)

3.5.3 Lancashire County Council

3.6 Statement of Directors' Responsibilities

The Directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulations 2011 to prepare Quality Accounts for each financial year. The Department of Health and Social Care has issued guidance on the form and content of annual quality accounts incorporating the above legal requirements.

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the Trust's performance over the period covered
- The performance information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- The Quality Account has been prepared in accordance with Department of Health and Social Care guidance.

The Directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

Signed By Order of the Board:

Chairman:

Chief Executive:

Date:

3.7 GLOSSARY

Term	Explanation
Acute Kidney Injury (AKI)	Acute kidney injury is a sudden episode of kidney failure or kidney damage that happens within a few hours or few days.
Advancing Quality (AQ)	A process to standardise and improve the quality of healthcare provided in NHS hospitals
Advancing Quality Alliance	The Advancing Quality Alliance was established to support health and care organisations in the Northwest to deliver the best health, wellbeing and quality of care for all by being a trusted source of quality improvement expertise for the NHS and wider health and social care systems.
Antimicrobial	An agent that kills microorganisms or inhibits their growth
Board Assurance Framework (BAF)	The BAF is a key framework which supports the Chief Executive in completing the Statement on Internal Control, which forms part of the statutory accounts and annual report, by demonstrating that the Board has been properly informed through assurances about the totality of the risks faced by the Trust.
Care Bundle	A group of interventions which are proven to treat a particular condition
Care Quality Commission (CQC)	The independent regulator for health and social care in England
Clinical Audit	A quality improvement process that seeks to improve patient care and outcomes by measuring the quality of care and services against agreed standards and making improvements where necessary
Clinical Commissioning Group (CCG)	Clinical Commission Groups are clinically led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.
Clostridium Difficile Infection (CDI)	A type of infection
Commissioning for Quality and Innovation (CQUIN)	A payment framework linking a proportion of a Trust's income to the achievement of quality improvement goals
Commissioning Support Unit (CSUICB)	Commissioning Support Units provide Clinical Commissioning Groups with external support, specialist skills and knowledge to support them in their role as commissioners, for example by providing business intelligence services and clinical procurement services.
COPD	Chronic Obstructive Pulmonary disease – This is the name used to describe a number of conditions including emphysema and chronic bronchitis
Datix	An electronic system that supports the management of risk and safety involving patients and colleagues
DNACPR	Do not attempt cardiopulmonary resuscitation – this is a treatment that can be given when you stop breathing (respiratory arrest) or your heart stops beating (cardia arrest)
Dr Foster Guide	A national report that provides data on patient outcomes in hospitals in the UK
Duty of Candour	The Duty of Candour is a legal duty on hospital Trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. Duty of Candour aims to help patients receive accurate, truthful information from health providers.
EQ-5D	Instrument for measuring quality of life
Family Liaison Officer (FLO)	Acts as a single point of contact for the relevant person, patient, next of kin in regards to liaise with on the investigation of a serious incident

Get It Right First Time (GIRFT)	A programme to improve the quality of care within the NHS by reducing unwarranted variations, bringing efficiencies and improvement patient outcomes
GROW	Gestation related Optimal Weight, used to assess fetal size and growth of baby.
Healthwatch	Healthwatch England is the national consumer champion in health and care and has significant statutory powers to ensure the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services.
Health Education England (HEE)	Supports the delivery of excellent healthcare and health improvement to the patients and public of England by ensuring that the workforce of today and tomorrow has the right numbers, skills, values and behaviours, at the right time and in the right place.
HCV	Hepatitis-C virus
Hospital Episode statistics	A data warehouse containing records of all patients admitted to NHS hospitals in England
Hospital Standardised Mortality Ratio (HSMR)	A national indicator that compares the actual number of deaths against the expected number of deaths occurring within hospitals
Indicator	A measure that determines whether a goal or an element of a goal has been achieved
Information Governance Toolkit	An online tool that enables NHS organisations to measure their performance against information governance requirements
ICB/ICS	Integrated Care Board/System are clinically led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.
Lean	Lean is a system of continuous process improvement, which is increasingly being applied to health services in the UK and overseas to: improve the quality of patient care; improve safety; eliminate delays; and reduce length of stay.
LocSSIPs	Local Safety Standards for Invasive Procedures is a document that outlines the specific safety and quality steps required for a particular invasive procedure within a hospital or healthcare facility.
Morbidity	The disease state of an individual, or the incidence of illness in a population
Mortality	The state of being mortal, or the incidence of death (number of deaths) in a population
MBBRACE	Mothers and babies: reducing risk through audits and confidential enquires across the UK
MSOC	Medicines Safety Optimisation Committee
National Confidential Enquiries (NCEs)	A process to detect areas of deficiency in clinical practice and devise recommendations to resolve them
National Early Warning Scores (NEWS)	A tool to standardise the assessment of acute illness severity in the NHS
National Patient Safety Alerts (NPSA)	National patient safety alerts are issued by NHS Improvement to rapidly warn the healthcare system of risks. They provide guidance on preventing potential incidents that may lead to harm or death.
National Reporting and Learning System (NRLS)	A national electronic system to record incidents that occur in NHS Trusts in England
Never Event	Never Event are serious medical errors or adverse events that should never happen to a patient
NHS England (NHSE)	A body that oversees the budget, planning, delivery and day-to-day operation of the NHS in England as set out in the Health and Social Care Act 2012

NHS Improvement (NHSI)	A body that supports foundation Trusts and NHS Trusts to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.
NHS Number	A twelve-digit number that is unique to an individual and can be used to track NHS patients between NHS organisations
National Institute for Health and social Care Excellence (NICE)	A body to improve outcomes for people using the NHS and other public health and social care services by producing evidence-based guidance and advice for health, public health and social care practitioners. NICE develops quality standards and performance metrics for those providing and commissioning health, public health and social care services and provides a range of information services for commissioners, practitioners and managers across the spectrum of health and social care
National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	The purpose is to assist in maintaining and improving standards of care for adults and children for the benefit of the public by reviewing the management of patients, by undertaking confidential survey and research.
Nursing Assessment Performance Framework (NAPF)	Measures the quality of nursing care delivered by individuals and teams and is based on the 6Cs Compassion in Practice values.
Palliative Care	When there is no cure for an illness, palliative care tries to make the end of a person's life as comfortable as possible
Parliamentary and Health Service Ombudsman	A body that investigates complaints where individuals perceive they have been treated unfairly or have received poor service from government departments, other public organisations and the NHS in England
Patient Administration System (PAS)	An electronic system used by acute Trusts to record patient information such as contact details, appointments and admissions
Patient Advice and Liaison Service (PALS)	A service that offers confidential advice, support and information on health-related matters
Patient Safety Incident Response Framework/Plan	New National incident reporting and investigation requirements.
PFI	Private finance initiative a way for the public sector to finance public works projects through the private sector.
Place based partnerships	Place based partnerships are collaborative arrangements between organisations responsible for arranging and delivering health and care services and others with a role in improving health and wellbeing.
Quality and Safety Framework	The means by which quality and safety is managed within the Trust including reporting and assurance mechanisms
Red Flag Drugs	Within ELHT specific drugs/drug classes are identified as those where timeliness of dosing is crucial, and these are known as ***RED Flag*** *drugs*. Healthcare professionals involved in the medication administration process must make every effort to secure the timely availability of these drugs for dosing
Research Ethics Committee	A committee that approves medical research involving people in the UK, whether in the NHS or the private sector
Secondary Uses Service	A national NHS database of activity in Trusts, used for performance monitoring, reconciliation and payments
SIRO	Senior Information Risk Owner, this person takes on overall responsibility for the Trusts information risk policy.

Structured Judgement Review (SJR)	A methodology for reviewing case records of adult patients who have died in acute general hospitals. The primary goal is to improve quality through qualitative analysis of mortality data.
Summary Hospital Mortality Indicator (SHMI)	The ratio between the actual number of patients who die following hospitalisation and the number that would be expected to die
Venous Thromboembolism (VTE)	A blood clot forming within a vein
WHO Checklist	A checklist that identified three phases of an operation, before induction of anaesthesia, time out, sign out that helps minimize the most common and avoidable risks endangering the lives and well-being of surgical patients

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Meeting Date:	14 May 2025	**Agenda Item:**	TB/2025/070
Report Title:	Board Code of Conduct		
Author:	Mrs S Giles, Interim Director of Corporate Governance		
Lead Director:	Mr S Sawar, Chair		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**To Approve**	**For Information**
			✓	
Executive Summary:	A proposed Board Code of Conduct has been developed which sets out the values and behaviours of the Board. The Board shapes the culture of its organisation by how it operates and behaves so having a code of conduct is at the heart of shaping that culture. The code incorporates the Principles of Public Life, Trust values and values promoted within the Insightful Provider Board (NHS England).			
Key Issues/Areas of Concern:				
Action required by the Board:	The Board is asked to approve the Code of Conduct for Board Members.			

Previously Considered by:	Board Strategy Session
Date:	9th April 2025
Outcome:	To present the Code for formal approval at the May Board meeting. The Board will spend a further session exploring how the Board shapes the culture of the Trust using the framework provided within The Insightful Provider Board.

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Board of Directors

Code of Conduct

'The Board shapes the culture of the Trust by how it operates and behaves. Board Members, through their actions and how they govern, should be visible and approachable role models who lead and promote the organisation's values for their staff and patients and service users.'

The Insightful Provider Board – NHS England

1 Introduction

1.1 High standards of corporate and personal conduct are an essential component of public services. As an NHS Trust, East Lancashire Hospitals NHS Trust is required to comply with the principles of best practice applicable to corporate governance in the NHS.

1.2 This Code sets out values underpinning the expected conduct of Directors of the Trust in the performance of their duties. It should be considered alongside The Code of Governance for NHS Provider Trusts (NHS England) and the Trust's Standing Orders and policies.

1.3 The Board expects that this Code will inform and govern the decisions and conduct of all Directors.

2 Directors duties

2.1 Directors have a duty to conduct business with probity, to respond to staff, patients and suppliers impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct. The general duty of the Board and individual Directors is to act in such a way that promotes the success of the Trust so as to maximise the benefits for the Trust and the public, whilst ensuring the delivery of safe, personal and effective care.

3 Principles of Public Life

2.2 The Seven Principles of Public Life (The Nolan Principles) apply to anyone who holds a position of public trust, including Directors of NHS Trusts. These principles should guide the behaviour of Directors. They ensure that such individuals act in the public's best interest and maintain high ethical standards.

2.3 The Nolan Principles are:

Selflessness – in performing their duties Directors will act solely in terms of public interest, they will not act in order to gain financial or other material benefit for themselves, their family or their friends.

Integrity – Directors should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

Objectivity – in performing their duties, including making public appointments, awarding contracts or recommending individuals for reward and benefits, Directors should make choices on merit alone.

Accountability – Directors are accountable for their decisions and must submit themselves to whatever scrutiny is appropriate to their office.

Openness – Directors should be transparent as possible about the decisions and actions that they take, giving reasons for their decisions and only restricting information when the wider public interest clearly demands it.

Honesty – Directors have a duty to declare any relevant and material private interests relating to their public duties and take steps to resolve any conflicts that arise in a way that protects public interest.

Leadership – Directors should promote and support these principles by their leadership and example.

4 Trust Values and Behaviours

4.1 Directors are also expected to uphold and model the Trust's values and behaviours:

Our values:	Our behaviours:
• We put patients first • We respect the individual • We act with integrity • We serve the community • We promote positive change	• Taking responsibility • Building trust and respect • Working together • Excellence • Keeping it simple

5 The Insightful Provider Board

5.1 The Insightful Board identifies values which are integral to positive organisational culture:

Open and Transparent – Directors will behave in a way that develops and fosters a safe reporting culture, so that service users, staff and family members feel able to report incidents or concerns and feel assured that these will be listened to and acted on. They will ensure that the duty of candour is followed.

Compassionate and Inclusive – Directors will actively promote equity, equality, diversity and inclusion.

Fair and Just – Directors will consider wider systemic issues when things go wrong, ensuring that the organisation and individuals learn without fear of retribution. Directors will balance the need to learn from incidents with accountability for their consequences.

Problem-sensing – Directors will proactively seek out and listen to the views of staff, patients, service users and families. They will scrutinise organisational intelligence to proactively identify any system weaknesses.

Continuously Improving – Directors will seek to learn from best practice elsewhere as well as local innovation to identify ways to improve.

6 Personal Conduct

6.1 Directors are expected to conduct themselves in a manner that reflects positively on the Trust and not in a manner which could reasonably be regarded as bring their office or the Trust into disrepute.

6.2 In addition to the other provisions set out in this Code Directors must:

- Contribute effectively to the workings of the Board of Directors to enable it to fulfil its role and functions;
- Raise concerns and provide appropriate scrutiny and challenge regarding the Trust's operations or a proposed Board decision where appropriate;
- Recognise the differing roles of the Chair, Senior Independent Director, Chief Executive, Non-Executive Directors and Executive Directors;
- Make every effort to attend meetings of the Board and its committees;
- Accept responsibility for their own performance, learning and development.

7 Fit and Proper Person

7.1 All Directors are required to comply with the Care Quality Commission Regulation 5: Fit and Proper Persons: Directors. Directors must certify upon appointment, and annually within the Board appraisal process, that they are/remain a fit and proper person.

7.2 If circumstances change whereupon a Director can no longer be considered a fit and proper person, they are suspended from being a Director with immediate effect pending confirmation and any appeal.

7.3 Where it is confirmed that a Director is no longer a fit and proper person, their Board membership is terminated.

8 Compliance

8.1 The Board will satisfy itself that the actions of the Board and Directors fully reflect the values and provisions in this Code and that, as far as is reasonably practicable, any alleged breaches of compliance are fully investigated and acted upon.

8.2 All Directors, upon appointment, will be required to give an undertaking to abide by the provisions of this Code of Conduct.

Approved by: The Board of Directors

Date of Approval:

Date of Review:

TRUST BOARD REPORT

Meeting Date:	14 May 2025	**Agenda Item:**	TB/2025/071
Report Title:	Board Committee Terms of Reference		
Author:	Susan Giles Interim Director of Corporate Governance/Company Secretary		
Lead Director:	Susan Giles Interim Director of Corporate Governance/Company Secretary		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
			✓	
Executive Summary:	The Terms of Reference for the Board Committees have all been reviewed against best practice and the recommendations from the Seagry Report. Each Committee has had chance to comment on the Terms of Reference and have approved them for presentation to the Board for formal approval. As part of the review the Chair has reviewed the Non-Executive Director chairing and membership of the Board Committees, and this is outlined within the Chair's Report to the Board. Each Committee has a draft workplan for 2025/26 to ensure that it has a schedule of reporting which should enable the Committee to fulfil their responsibilities within their respective Terms of Reference. The revised Charitable Funds Committee Terms of Reference have not yet been through that Committee due to the timing of Committee meetings and therefore they will be presented to a future Board meeting for approval. Key points to note are: 1) The Audit Committee Terms of Reference are aligned to the NHS Audit Committee Handbook example terms of reference. 2) The remit of the Remuneration Committee has been extended to include Nominations responsibilities, in particular reviewing the composition and skill set of the Board to inform succession planning. 3) Across all of the assurance committees the terms of reference have been strengthened in relation to: • Explicitly stating the Committee's role in relation to having grip and control; • Ensuring responsibilities reflect the Committee's role in gaining assurance on behalf of Board;			

	• Clarifying the quorum; • Clarifying reporting arrangements to the Board and communication between Board Committees and sub-committees; • Setting out the sub-committee/group structure beneath each Committee. In addition as good practice a Committee Etiquette has been drafted and is included for approval. This will be shared with members and those in regular attendance at Committees.
Key Issues/Areas of Concern:	
Action Required:	The Board is asked to approve the Terms of Reference for the following Committees: • Quality Committee • Finance & Performance Committee • People & Culture Committee • Audit Committee • Remuneration & Nominations Committee To approve the Committee code of etiquette.

Previously Considered by:	All Board Committees
Date:	April 2025
Outcome:	Approved for submission to the Board for final approval.

Board Committee Etiquette and Principles

Purpose

To ensure professional and productive meetings, all participants in Board Committee meetings—whether in person or virtual—are expected to adhere to the following code of etiquette.

1. Preparation and agenda management:

- The Committee Chair is to approve the final agenda with input from the Executive Lead(s).
- Items are not to be added without the Chair's approval once the agenda has been finalised.
- Papers with completed front sheets to be submitted in the prescribed format by the deadline set by the Corporate Governance team.

2. General Conduct (Applies to All Meetings)

- Arrive on time or log in early to ensure meetings start on time.
- Send apologies in advance of the meeting to the Corporate Governance Team who will inform the Chair and check the Committee will be quorate.
- Papers should be read in advance of the meeting.
- When presenting items it should be assumed that papers have been read and only key points or issues should be highlighted.
- Sensitive or confidential information should not be discussed outside of the meeting beyond the membership.
- Hard copies of papers should be disposed of in line with the Trust's information governance policies.
- All those attending should conduct themselves in line with the Trust's values at all times.
- Avoid unnecessarily repeating points already made or interrupting others.

3. In-Person Meetings

- Silence mobile devices; avoid texting, emailing, or unrelated web browsing.
- Avoid side conversations and wait to be recognised by the Chair.

4. Virtual Meetings

- Attend from a quiet, distraction-free location with stable internet.
- Test audio and video functionality ahead of time.

- Keep your camera on and avoid doing other activities during the meeting.
- Keep microphones muted when not speaking to reduce background noise.
- Use your full name and title (if appropriate) for easy identification on screen.
- Use the chat for relevant comments or questions.

5. Meeting Dynamics

- Respect the authority and direction of the Chair in managing the meeting flow.
- Disclose any conflicts proactively and recuse yourself where appropriate.

6. Post-Meeting

- Draft minutes to be with the Chair for approval within 7-10 days after the meeting.
- An updated action tracker to be circulated to all members and those with actions within 7 days of the meeting.
- Complete any assigned actions in a timely and accurate manner.

PEOPLE AND CULTURE COMMITTEE TERMS OF REFERENCE

1 Constitution

1.1 The Board of Directors ("the Board") has established a Committee with delegated authority to act on its behalf in matters relating to workforce, organisational culture, staff safety and governance to be known as the Quality Committee ("the Committee").

1.2 The Committee is a non-executive Committee accountable to the Board and has no executive powers, save any expressly provided within these terms of reference.

2 Authority

2.1 The Committee is authorised by the Board to:

2.1.1 Investigate any activity within its terms of reference;

2.1.2 Seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee;

2.1.3 Obtain independent professional advice and to secure the attendance of external advisors, within the parameters of the Scheme of Delegation, with the support of the Director of Corporate Governance; and

2.1.4 Approve such policies and procedures within the remit of the Committee as may be assigned by the Board.

3 Purpose

3.1 The primary purpose of this Committee is to have grip and control of workforce and organisational development related matters across the Trust to provide assurance or escalate concerns to the Board.

3.2 Specifically the Committee will:

3.2.1 Oversee the development and implementation of the Trust's People Strategy and recommend it to the Board for approval;

3.2.2 Monitor the delivery of any Trust-wide workforce metrics and associated performance measures, identifying and understanding any significant variation and ensuring an appropriate response;

3.2.3 Provide assurance to the Board on the development, implementation and review of the workforce plans in order to support service improvement; and

3.2.4 Monitor workforce aspects of the Annual Plan.

4 Responsibilities

4.1 To fulfil its purpose the Committee will:

4.1.1 Obtain assurances that the Trust's workforce plan supports the annual objectives of the organisation through the identification of an appropriate workforce model and development plan;

4.1.2 Contribute to the development of an effective workforce and organisational development strategy that is aligned to the clinical strategy and financial sustainability of the Trust, and make appropriate recommendations to Board for approval;

4.1.3 Receive assurance on behalf of the Board that the Trust's workforce policies satisfy relevant standards and guidance issued by regulators, Royal Colleges and other professional and national bodies;

4.1.4 Assuring the Board of compliance with key national and statutory workforce requirements, including the National People Plan, People Promise and NHS HR OD Futures;

4.1.5 Monitor performance and data quality of workforce information ensuring action is taken to address underperformance;

4.1.6 Receive assurance reports on the results of the NHS Staff Survey and have oversight of the resulting action plan;

4.1.7 Receive assurance about staffing safeguards from the Guardian of Safe Working and Freedom to Speak Up Guardian;

4.1.8 Promote a culture of open and honest reporting amongst the workforce;

4.1.9 Receive assurance regarding the Trust's Equality, Diversity and Inclusion Strategy;

4.1.10 Receive Chair reports from sub-groups set out below in respect to areas of concern, seeking assurance that robust timely action plans are in place to resolve concerns;

4.1.11 Escalate to the Board any significant concerns about staffing levels or other workforce related aspects within the Trust; and

4.1.12 Oversee the strategic and operational workforce risks aligned to the Committee on the Board Assurance Framework and Corporate Risk Register by:

i) Monitoring the effectiveness of the controls and assurances in place and progress against the agreed risk mitigations ensuring that they address gaps in control and assurance;

ii) Commissioning deep drive reviews for any risk within the Committee's

remit;

iii) Referring appropriate risk matters to the Audit Committee for their consideration.

5 Membership

5.1 The Committee will comprise the following membership:

- Three Non-Executive Directors, one of whom shall be chair
- Executive Director of People & Culture
- Chief Nurse or Executive Medical Director
- Executive Director of Finance
- Executive Director of Service Development and Improvement
- Executive Director Communications & Engagement

5.2 Only voting Board members have the right to vote at meetings.

5.3 Members are expected to attend at least 75% of meetings.

5.4 The Chief Executive has a standing invitation to attend any meeting of the Committee.

5.5 Other Executive Directors may be invited to attend the Committee for specific items.

6 In Attendance

6.1 The following will be in regular attendance at meetings:

- Director of Corporate Governance
- Deputy Director of People and Culture
- Director of Education, Research and Innovation
- Associate Director of Culture and Belonging
- Associate Director of Occupational Health, Wellbeing and Engagement
- Partnership Officer

6.2 Persons in attendance will not have voting rights.

6.3 The Committee Chair may also extend invitations to other individuals with relevant skills, experience, or expertise as necessary. Any such individuals will be in attendance only.

7 Quorum

7.1 A quorum will comprise four members including at least two Non-Executive Directors and two Executive Directors.

7.2 In the event that the Chair is unable to attend one of the other Non-Executive Directors shall chair the meeting.

7.3 In the event that a Non-Executive Director is unable to attend, any other Non-Executive Director can be invited to attend as a substitute voting member.

7.4 Associate Non-Executive Directors and non-voting Executive Directors continue as non-voting members but do count towards the quorum of the Committee.

7.5 Executive Directors who are unable to attend may nominate deputies who are able to contribute and make decisions on their behalf as a substitute voting member. Any such deputies will count towards the quorum.

8 Frequency

8.1 The Committee will meet at least 10 times per year. Additional meetings may be called at the discretion of the Chair of the Committee.

9 Administrative Arrangements

9.1 The Committee will have in place an annual work programme, which will be aligned to the responsibilities set out within the terms of reference and the Trust's annual objectives set by the Board. The Director of Corporate Governance/Company Secretary will ensure that the work programme is regularly updated throughout the year.

9.2 The Committee will receive the papers for meetings a minimum of 5 working days prior to the meeting.

9.3 Administrative support for the Committee will be provided by the Corporate Governance Team.

10 Reporting to the Board

10.1 The Committee will report to the Board via the Committee Chair and the presentation of a 'Triple A' (Assure, Advise, Alert) report.

10.2 Key workforce metrics will also be monitored at every Board meeting as part of the Integrated Performance Report.

10.3 The Committee will provide an annual report to the Board setting out how it has fulfilled its terms of reference throughout the year, providing an overview of the assurances received and making any recommendations to improve the effectiveness of the Committee.

11 Relationship with other Board Committees

11.1 The Committee will communicate with other Board Committees via common membership and the formal escalation of any issues via Committee Chairs and/or the Director of Corporate Governance/Company Secretary.

11.2 The Chair of the People and Culture Committee will be a member of the Audit Committee to ensure that there is a direct link to and from the Audit Committee, particularly in relation to any quality and safety related internal audits.

11.3 Where a matter relating to workforce and culture has a significant financial implication, particularly in relation to workforce planning and any headcount reductions, the Committee will refer that matter to the Finance and Performance Committee for consideration.

11.4 Where a matter relating to workforce and culture has significant quality implications, particularly in relation to professional staffing reviews relating to nursing, allied health professionals and midwifery services, the Committee refer that matter to the Quality Committee for consideration.

12 Reports from Sub-Committees

12.1 The Committee may commission, receive and review advisory and assurance reports and improvement plans from the following groups:

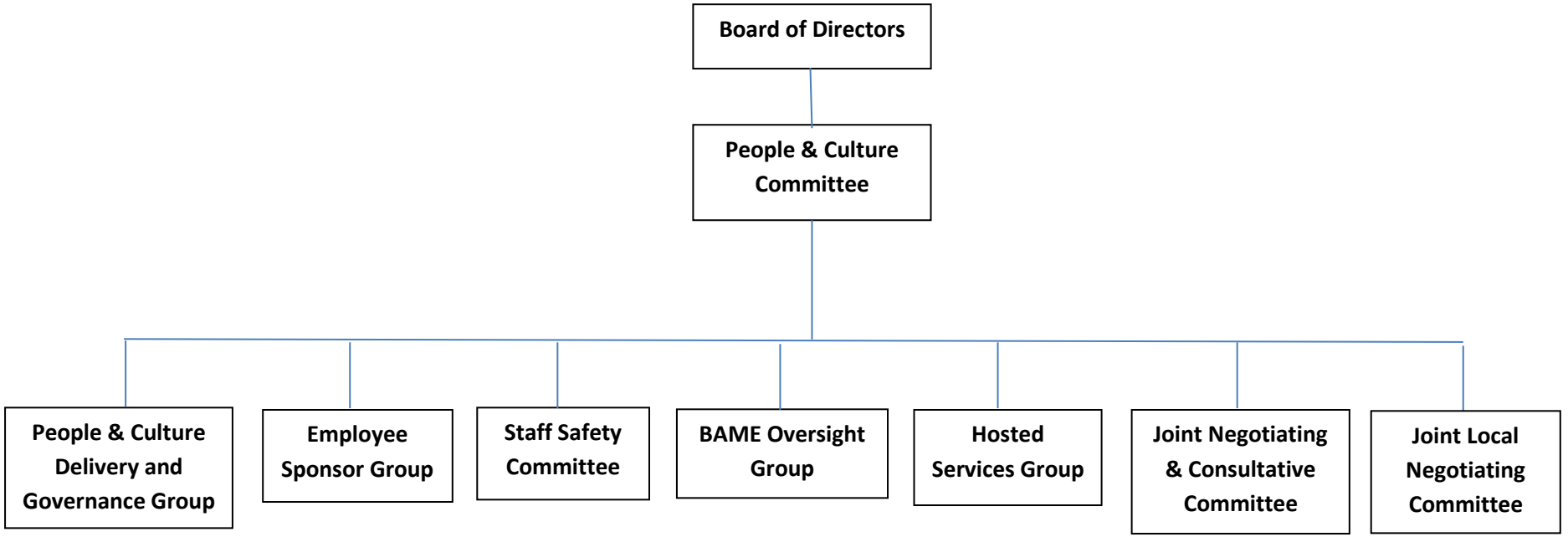
- People and Culture Delivery and Governance Group
- Staff Safety Committee
- Employee Sponsor Group
- BAME Oversight Group
- Joint Negotiating and Consultative Committee
- Joint Local Negotiating Committee
- Hosted Services Group

13 Review

13.1 The Committee shall review its effectiveness on an annual basis, escalating any recommendations for change to the Board.

13.2 The Board will formally review the terms of reference for the Committee at least every two years.

People and Culture Sub-Committee Structure



FINANCE AND PERFORMANCE COMMITTEE TERMS OF REFERENCE

1 Constitution

1.1 The Board of Directors ("the Board") has established a Committee with delegated authority to act on its behalf in matters relating to financial and operational plans to be known as the Finance and Performance Committee ("the Committee").

1.2 The Committee is a non-executive Committee accountable to the Board and has no executive powers, save any expressly provided within these terms of reference.

2 Authority

2.1 The Committee is authorised by the Board to:

2.1.1 Investigate any activity within its terms of reference;

2.1.2 Seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee;

2.1.3 Obtain independent professional advice and to secure the attendance of external advisors with relevant experience and expertise with the support of the Director of Corporate Governance; and

2.1.4 Approve such policies and procedures within the remit of the Committee as may be assigned by the Board.

3 Purpose

3.1 The primary purpose of this Committee is to have grip and control of financial and operational performance to provide assurance or escalate concerns to the Board.

3.2 Specifically the Committee will:

- Provide assurance on the delivery of the financial and operational plans approved by the Board for the current year;
- Examine exceptions to the achievement of those plans and action taken to correct exceptions;
- Develop forward plans for subsequent financial years for consideration by the Board; and
- Examine in detail risks to the achievement of national and local performance and activity standards.

4 Responsibilities

4.1 To fulfil its purpose the Committee will:

4.1.1 Monitor and oversee the effectiveness of the Trust's planning processes and annual business plan supported by:

i) reviewing the effectiveness of the Trust's activity planning methodology;

ii) overseeing the preparation and negotiation of annual contracts with commissioners;

4.1.2 Review the draft annual business plans prior to Board approval and submission to the commissioner/national regulator of the NHS. The Committee has particular responsibility for obtaining assurance on:

- Operational plans
- Financial plans
- Cash balances
- Capital plans
- Estates and facilities plans
- Digital plans

4.1.3 The Committee will work with People & Culture Committee to consider the workforce plans, particularly from the perspective of the financial impact of these.

4.1.4 Review the Trust's annual financial plan and ensure that key assumptions are realistic and explicit;

4.1.5 Monitor and review the Trust's performance against national and local standards and activity plans, seeking corrective action and assurance where activity has deviated from plan;

4.1.6 Monitor and review procurement effectiveness including the supplier net promote scores;

4.1.7 Monitor the Trust's financial performance in relation to use of resources, income and expenditure, and capital expenditure programme seeking corrective action and assurance where performance has deviated from plan;

4.1.8 Monitor delivery of waste reduction and improvement programmes (productivity and efficiency savings) seeking assurance on variances from plan and relevant recovery actions;

4.1.9 Review the cash flow forecasts, liquidity position and aged debt position of the Trust;

4.1.10 Review the PFI contract governance and contract management;

4.1.10 Assess the financial implications of performance against the Trust's principal contracts;

4.1.11 Assess any proposed borrowing arrangements and make appropriate recommendations to the Board;

4.1.12 Provide assurance that operational performance reporting is robust.

4.1.13 Oversee and monitor compliance with national oversight framework;

4.1.14 Oversee the strategic and operational finance and performance risks aligned to the Committee on the Board Assurance Framework and Corporate Risk Register by:

i) Monitoring the effectiveness of the controls and assurances in place and progress against the agreed risk mitigations ensuring that they address gaps in control and assurance;

ii) Commissioning deep drive reviews for any risk within the Committee's remit;

iii) Referring appropriate risk matters to the Audit Committee for their consideration; and/or

iv) Escalating any concerns regarding financial and operational risks to the Board.

4.1.15 Monitor and gain assurance on the Trust's Emergency, Preparedness, Resilience and Response;

4.1.16 Oversee the development and deployment of the IM&T Strategy including issues relating to cyber security and digital security risks.

4.1.17 Receive and review reports on System, Place and Collaborations as pertaining to the Trust to identify potential impacts and delivery upon wider commitments to system partners.

4.1.18 Consider the financial implications of any system wide opportunities and risks and make recommendations to the Board in respect of these.

5 Membership

5.1 The Committee will comprise the following membership:

- Three Non-Executive Directors, one of whom shall be chair
- Chief Executive
- Executive Director of Finance
- Chief Operating Officer
- Executive Director of Service Development and Improvement
- Executive Director Integrated Care, Partnerships and Resilience
- Executive Director of People and Culture

5.2 Only voting Board members have the right to vote at meetings.

5.3 Members are expected to attend at least 75% of meetings.

5.4 Other Executive Directors may be invited to attend the Committee for specific items.

6 In attendance

6.1 The following will be in regular attendance at meetings:

- Director of Corporate Governance/Company Secretary
- Associate Director of Quality and Safety
- Associate Director of Service Development and Improvement

6.2 Persons in attendance will not have voting rights.

6.3 The Committee Chair may also extend invitations to other individuals with relevant skills, experience or expertise as necessary. Any such individuals will be in attendance only.

7 Quorum

7.1 A quorum will comprise four members including at least two Non-Executive Directors and two Executive Directors.

7.2 In the event that the Chair is unable to attend one of the other Non-Executive Directors shall chair the meeting.

7.3 In the event that a Non-Executive Director is unable to attend, any other Non-Executive Director can be invited to attend as a substitute voting member.

7.4 Associate Non-Executive Directors and non-voting Executive Directors continue as non-voting members but do count towards the quorum of the Committee.

7.5 Executive Directors who are unable to attend may nominate deputies who are able to contribute and make decisions on their behalf as a substitute voting member. Any such deputies will count towards the quorum.

8 Frequency

8.1 The committee will meet at least 10 times per year. Additional meetings may be called at the discretion of the Chair of the Committee.

9 Administrative Arrangements

9.1 The Committee will have in place an annual work programme, which will be aligned to the responsibilities set out within the terms of reference and the Trust's annual objectives set by the Board. The Director of Corporate Governance/Company

Secretary will ensure that the work programme is regularly updated throughout the year.

9.2 The Committee will receive the papers for meetings a minimum of 5 working days prior to the meeting.

9.3 Administrative support for the Committee will be provided by the Corporate Governance Team.

10 Reporting to the Board

10.1 The Committee will report to the Board via the Committee Chair and the presentation of a 'Triple A' (Assure, Advise, Alert) report.

10.2 Financial performance will also be monitored by every Board meeting as part of the Integrated Performance Report and the Financial Report.

10.3 The Committee will provide an annual report to the Board setting out how it has fulfilled its terms of reference throughout the year and providing an overview of the assurances received.

11 Relationship with other Board Committees

11.1 The Committee will communicate with other Board Committees via common membership and the formal escalation of any issues via Committee Chairs and/or the Director of Corporate Governance/Company Secretary.

11.2 The Chair of the Finance and Performance Committee will be a member of the Audit Committee, and the Chair of Audit Committee will be a member of the Finance and Performance Committee, to ensure that there is a direct link between Committees, particularly in relation to any financial and operational performance related internal audits.

11.3 Where a financial or operational decision has significant quality or safety implications the Committee will refer that matter to the Quality Committee for consideration.

11.4 Where a matter relating to a financial or operational decision has significant workforce implications the Committee will refer that matter to the People and Culture Committee for consideration.

12 Reports from Sub-Committees

12.1 The Committee may commission, receive and review advisory and assurance reports and improvement plans from the following groups:

- Finance Oversight Group
- Capital Planning Group

- Data and Digital Committee
- Information Governance Steering Group
- Hosted Services Group
- Sustainability Group
- Central Services Executive Committee

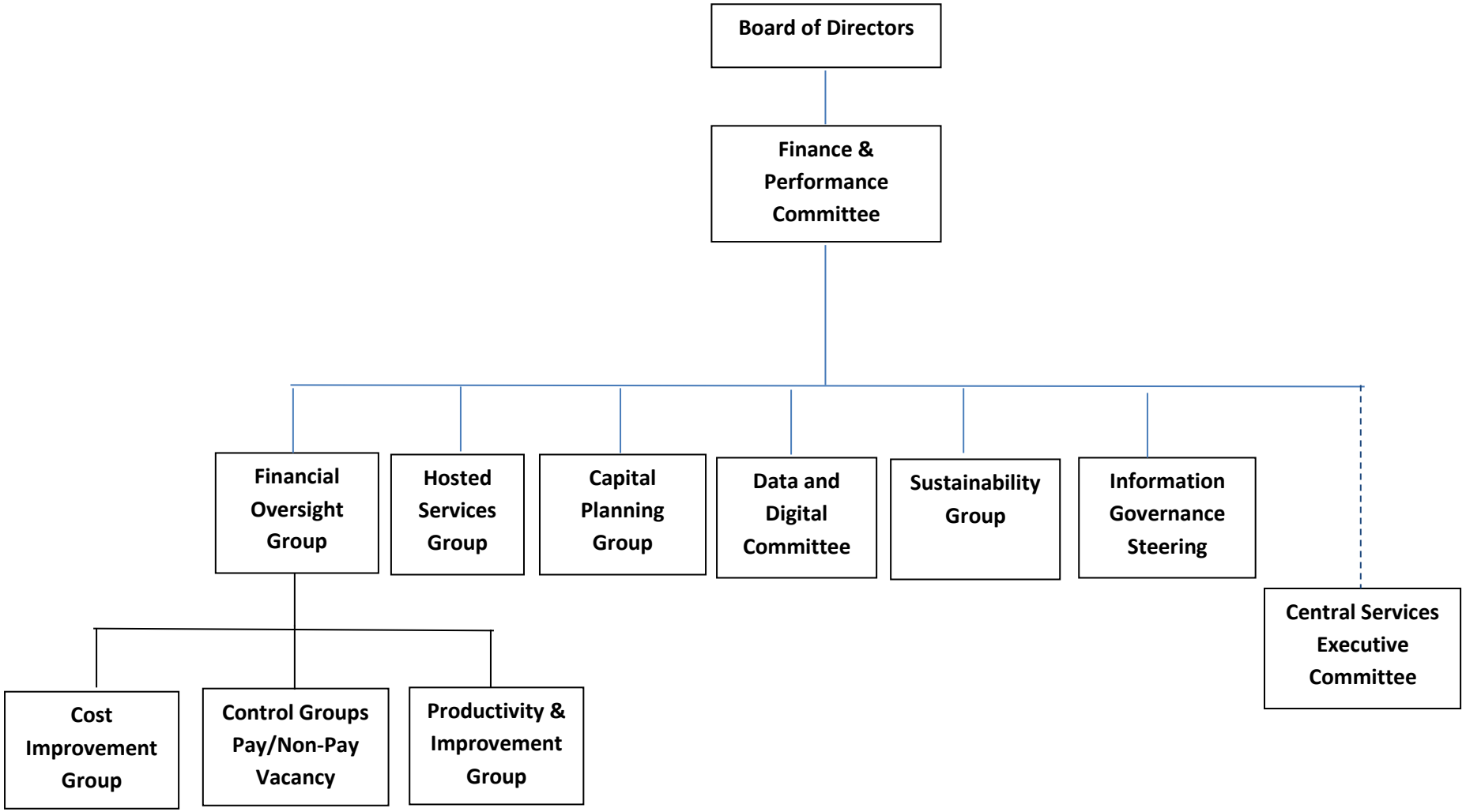
12.2 In addition to the standing sub-committees the Committee may establish time-limited programme boards for strategic programmes being implemented. Any such programme boards will formally report to the Committee until such time as they are formally stood down.

13 Review

13.1 The Committee shall review its membership and effectiveness on an annual basis, escalating any recommendations for change to the Board.

13.2 The Board will formally review the terms of reference for the Committee at least every two years.

Finance and Performance Committee Sub-Committee Structure



QUALITY COMMITTEE TERMS OF REFERENCE

1 Constitution

1.1 The Board of Directors ("the Board") has established a Committee with delegated authority to act on its behalf in matters relating to patient and staff safety and clinical governance to be known as the Quality Committee ("the Committee").

1.2 The Committee is a non-executive Committee accountable to the Board and has no executive powers, save any expressly provided within these terms of reference.

2 Authority

2.1 The Committee is authorised by the Board to:

2.1.1 Investigate any activity within its terms of reference;

2.1.2 Seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee;

2.1.3 Obtain independent professional advice and to secure the attendance of external advisors with relevant experience and expertise with the support of the Director of Corporate Governance; and

2.1.4 Approve such policies and procedures within the remit of the Committee as may be assigned by the Board.

3 Purpose

3.1 The primary purpose of this Committee is to have grip and control of quality across the Trust to provide assurance or escalate concerns to the Board.

3.2 Specifically the Committee will:

3.2.1 Promote and lead the Quality Strategy that strives to ensure delivery of Safe, Effective and Personal care;

3.2.2 Monitor the delivery of any Trust-wide quality and safety metrics and associated performance measures as defined within the Quality Strategy, identifying and understanding any significant variation and ensuring an appropriate response;

3.2.3 Ensure that there are effective structures, processes and controls in place to promote safety and excellent in the standards of care and treatment;

3.2.4 Monitor compliance with CQC standards and other quality related regulatory frameworks; and

3.2.5 Monitor performance in relation to contractual quality schedules including services contracted out to third parties, ensuring compliance with CQC standards

and other quality related regulatory frameworks.

4 Responsibilities

4.1 To fulfil its purpose the Committee will:

4.1.1 Oversee the production of the Trust's Quality Account in line with national guidance and endorse them for approval by the Trust Board;

4.1.2 Ensure that the Trust considers and implements recommendations and guidance from external bodies and national enquiries insofar as they relate to quality and safety;

4.1.3 Ensure that appropriate processes are in place to ensure compliance with all standards and guidance issued by regulators, Royal Colleges and other professional and national bodies;

4.1.4 Oversee the development and implementation of the Trust's Quality Strategy;

4.1.5 Confirm that appropriate action is taken in response to adverse clinical incidents, complaints and litigation, ensuring that lessons are learned across the Trust;

4.1.6 Ensure that examples of good practice are disseminated across the Trust;

4.1.7 Ensure that the clinical audit forward plan is relevant and comprehensive, and to monitor compliance with the plan;

4.1.8 Monitor the Infection Prevention and Control Board Assurance Framework, ensuring robust timely actions are in place to address any areas of weakness;

4.1.9 Oversee any relevant programmes within the Trust's Planning Framework;

4.1.10 Confirm that a robust system is in place to ensure effective quality impact assessments are undertaken in relation to all waste reduction and financial improvement plans;

4.1.11 Receive Chair reports from sub-groups set out below in respect to areas of concern, seeking assurance that robust timely action plans are in place to resolve concerns;

4.1.12 Escalate to the Board any significant concerns about standards of care and treatment within the Trust or where it considers any service to be unsafe;

4.1.13 Review and gain assurance with respect to the Trust's health and safety obligations being met, ensuring robust timely action plans are in place to address any weaknesses; and

4.1.14 Oversee the strategic and operational quality and safety risks aligned to the Committee on the Board Assurance Framework and Corporate Risk Register by:

i) Monitoring the effectiveness of the controls and assurances in place and

progress against the agreed risk mitigations ensuring that they address gaps in control and assurance;

ii) Commissioning deep dive reviews for any risk within the Committee's remit;

iii) Referring appropriate risk matters to the Audit Committee for their consideration.

5 Membership

5.1 The Committee will comprise the following membership:

- Three Non-Executive Directors, one of whom shall be chair
- Chief Nurse
- Executive Medical Director
- Chief Operating Officer
- Executive Director of Integrated Care, Partnerships and Resilience

5.2 Only voting Board members have the right to vote at meetings.

5.3 Members are expected to attend at least 75% of meetings.

5.4 The Chief Executive has a standing invitation to attend any meeting of the Committee.

5.5 Other Executive Directors may be invited to attend the Committee for specific items.

6 In Attendance

6.1 The following will be in regular attendance at meetings:

- Director of Corporate Governance/Company Secretary
- Associate Director of Quality and Safety
- The Senior Quality Assurance Manager of Lancashire & South Cumbria Integrated Care Board.

6.2 Persons in attendance will not have voting rights.

6.3 The Committee Chair may also extend invitations to other individuals with relevant skills, experience, or expertise as necessary. Any such individuals will be in attendance only.

7 Quorum

7.1 A quorum will comprise four members including at least two Non-Executive Directors and two Executive Directors.

7.2 In the event that the Chair is unable to attend one of the other Non-Executive Directors shall chair the meeting.

7.3 In the event that a Non-Executive Director is unable to attend, any other Non-Executive Director can be invited to attend as a substitute voting member.

7.4 Associate Non-Executive Directors and non-voting Executive Directors continue as non-voting members but do count towards the quorum of the Committee.

7.5 Executive Directors who are unable to attend may nominate deputies who are able to contribute and make decisions on their behalf as a substitute voting member. Any such deputies will count towards the quorum.

8 Frequency

8.1 The Committee will meet at least 10 times per year. Additional meetings may be called at the discretion of the Chair of the Committee.

9 Administrative Arrangements

9.1 The Committee will have in place an annual work programme, which will be aligned to the responsibilities set out within the terms of reference and the Trust's annual objectives set by the Board. The Director of Corporate Governance/Company Secretary will ensure that the work programme is regularly updated throughout the year.

9.2 The Committee will receive the papers for meetings a minimum of 5 working days prior to the meeting.

9.3 Administrative support for the Committee will be provided by the Corporate Governance Team.

10 Reporting to the Board

10.1 The Committee will report to the Board via the Committee Chair and the presentation of a 'Triple A' (Assure, Advise, Alert) report.

10.2 The Quality Account will be presented to the Board annually.

10.3 Quality and safety performance will also be monitored at every Board meeting as part of the Integrated Performance Report.

10.4 The Committee will provide an annual report to the Board setting out how it has fulfilled its terms of reference throughout the year and providing an overview of the assurances received.

11 Relationship with other Board Committees

11.1 The Committee will communicate with other Board Committees via common membership and the formal escalation of any issues via Committee Chairs and/or the Director of Corporate Governance/Company Secretary.

11.2 The Chair of the Quality Committee will be a member of the Audit Committee to ensure that there is a direct link to and from the Audit Committee, particularly in relation to any quality and safety related internal audits.

11.3 Where a matter relating to quality or safety has a significant financial implication the Committee will refer that matter to the Finance and Performance Committee for consideration.

11.4 Where a matter relating to quality or safety has significant workforce implications, particularly in relation to professional staffing reviews relating to nursing, allied health professionals and midwifery services, the Committee refer that matter to the People and Culture Committee for consideration.

12 Reports from Sub-Committees

12.1 The Committee may commission, receive and review advisory and assurance reports and improvement plans from the following groups:

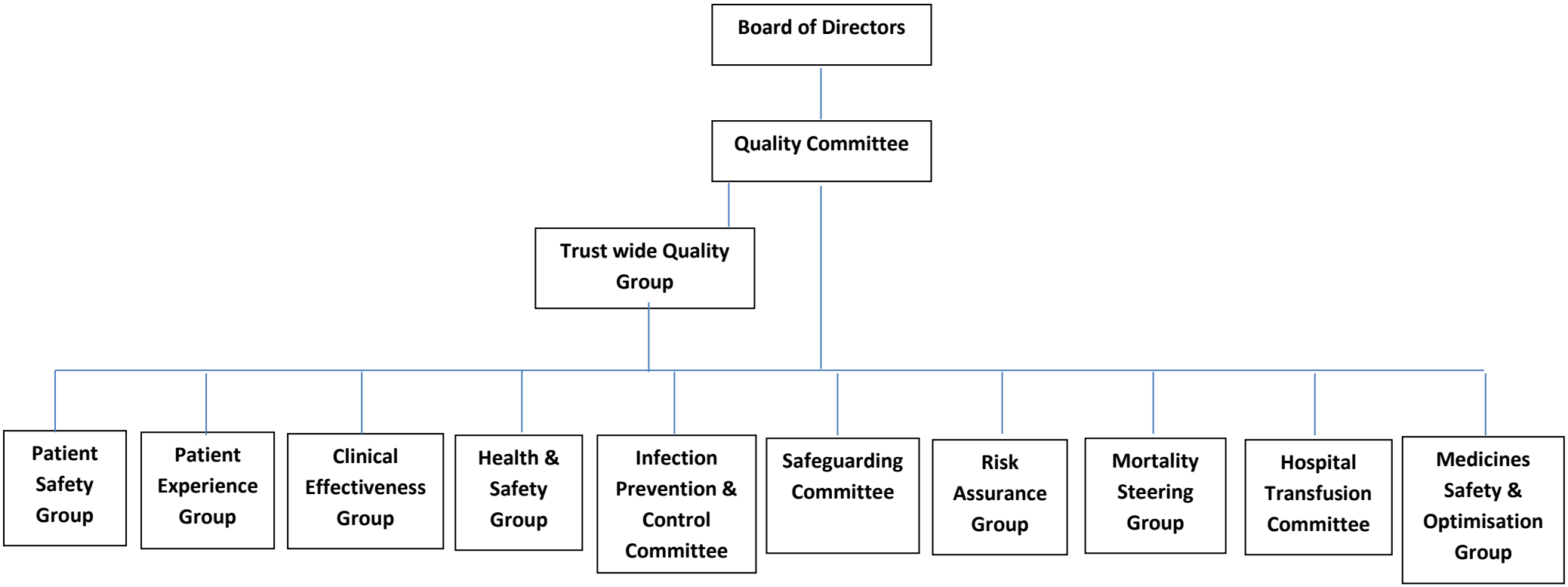
- Trust wide Quality Governance Group
- Patient Safety Group
- Patient Experience Group
- Clinical Effectiveness Group
- Health and Safety Committee
- Executive Risk Assurance Group
- Safeguarding Committee
- Hospital Transfusion Committee
- Mortality Steering Group
- Infection Prevention Committee
- Medicines Safety and Optimisation Group

13 Review

13.1 The Committee shall review its membership and effectiveness on an annual basis, escalating any recommendations for change to the Board.

13.2 The Board will formally review the terms of reference for the Committee at least every two years.

Quality Committee Sub-Committee Structure



Notes:

The Trust Wide Quality Group receives direct reports from the sub-groups for the purpose of improving the assurance and accountability reporting to the Quality Committee.

The Quality Committee may commission reports directly from the sub-groups.

All of the sub-groups may escalate directly to the Quality Committee via Annual Reports and Triple A reporting.

REMUNERATION AND NOMINATION COMMITTEE TERMS OF REFERENCE

1 Constitution

1.1 The Board of Directors ("the Board") has established a Committee with delegated authority to act on its behalf in determining the remuneration, terms of service and allowances for the Chief Executive and Executive Directors to be known as the Remuneration and Nominations Committee ("the Committee").

1.2 The Committee is a non-executive Committee accountable to the Board and has no executive powers, save any expressly provided within these terms of reference.

2 Authority

2.1 The Committee is authorised by the Board to:

2.1.1 Investigate any activity within its terms of reference;

2.1.2 Seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee;

2.1.3 Obtain independent professional advice and to secure the attendance of external advisors, within the parameters of the Scheme of Delegation, with the support of the Director of Corporate Governance; and

2.1.4 Approve such policies and procedures within the remit of the Committee as may be assigned by the Board.

3 Purpose

3.1 The primary purpose of this Committee is to determine the appropriate remuneration, allowances and terms and conditions of Executive Directors and to succession plan for the Board of Directors.

3.2 Specifically the Committee will determine:

3.2.1 all aspects of salary (including performance related elements/bonuses);

3.2.2 provisions for other benefits, including pensions and cars;

3.2.3 arrangements for termination of employment and other contractual terms.

4 Responsibilities

4.1 To fulfil its purpose the Committee will:

(Remuneration responsibilities)

4.1.1 Determine the policy on the remuneration of Executive Directors and Very Senior Managers (VSMs) not on Agenda for Change. Taking into account pay and

employment conditions across the Trust and wider NHS and benchmarking against other Trusts of similar size and complexity;

4.1.2 Appoint and set the terms and conditions for any Associate Non-Executive Directors;

4.1.3 Agree and oversee, on behalf of the Board, performance of the Chief Executive and Executive Directors;

4.1.4 Ensure publication, within the Annual Report, of the total remuneration from NHS sources of all Board Directors;

4.1.5 Recommend and monitor the level and structure of remuneration for Very Senior Managers;

4.1.6 Approve any non-contractual termination payments to staff in-line with the Trust's Special Severance Pay Policy;

(Nomination Responsibilities)

4.1.7 Annually review the structure, size, composition and diversity of the Board and make recommendations for change, where appropriate;

4.1.8 Evaluate the balance of skills, knowledge and experience of the Board, and using this evaluation to inform succession planning for the Board;

4.1.9 Provide assurance to the Board that there is appropriate succession planning in place for Board Directors, taking into account future challenges, risks and opportunities facing the Trust;

4.1.10 Review the description of role and capabilities for any Executive Director appointment;

4.1.11 Ensure that the appointment process is designed to attract the best candidates that fully reflect a wide range of backgrounds and the Trust's commitment to equality, diversity and inclusion, and that recruitment processes will consider candidates on merit and against objective criteria;

4.1.12 Approve any matters relating to the continuation in office of any Executive Director including the suspension or termination of service of an Executive Director as an employee of the Trust, subject to the provisions of law and their service contract;

4.1.13 Approve any temporary or interim arrangements for appointing Executive Directors;

4.1.14 Ensure that the Trust has an appropriate policy in place to check proposed Board appointees and existing Board Directors comply with the requirements under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and

Proper Persons Test.

5 Membership

5.1 The Committee will comprise the following membership:

- Trust Chair
- All Non-Executive Directors (one of whom shall be Committee Chair)
- Associate Non-Executive Directors

5.2 Only voting Board members have the right to vote at meetings.

5.3 Members are expected to attend at least 75% of meetings.

6 In Attendance by invitation:

6.1 The following will be in attendance at meetings by invitation from the Committee Chair:

- Chief Executive
- Chief People Officer
- Director of Corporate Governance

6.2 Persons in attendance may not be present for discussion relating to their own appointment, remuneration, terms of service or other such matters where they have a conflict of interest.

6.3 Persons in attendance will not have voting rights.

6.4 The Committee Chair may also extend invitations to other individuals with relevant skills, experience, or expertise as necessary. Any such individuals will be in attendance only.

7 Quorum

7.1 A quorum will comprise four Non-Executive Directors.

7.2 In the event that the Chair is unable to attend one of the other Non-Executive Directors shall chair the meeting.

7.3 Associate Non-Executive Directors continue as non-voting members but do count towards the quorum of the Committee.

8 Frequency

8.1 The Committee will meet at least four times per year. Additional meetings may be called at the discretion of the Chair of the Committee.

9 Administrative Arrangements

9.1 The Committee will have in place an annual work programme, which will be aligned to the responsibilities set out within the terms of reference. The Director of Corporate Governance/Company Secretary will ensure that the work programme is regularly updated throughout the year.

9.2 The Committee will receive the papers for meetings a minimum of 5 working days prior to the meeting.

9.3 Administrative support for the Committee will be provided by the Corporate Governance Team.

10 Reporting to the Board

10.1 The Committee will report to the Board via the Committee Chair.

10.2 The Committee will provide an annual report to the Board setting out how it has fulfilled its terms of reference throughout the year, providing an overview of the assurances received and making any recommendations to improve the effectiveness of the Committee.

11 Relationship with other Board Committees

11.1 The Chair of the Remuneration & Nominations Committee will be a member of the Audit Committee to ensure that there is a direct link to and from the Audit Committee,.

12 Reports from Sub-Committees

12.1 The Committee does not have any sub-groups.

13 Review

13.1 The Committee shall review its effectiveness on an annual basis, escalating any recommendations for change to the Board.

13.2 The Board will formally review the terms of reference for the Committee at least every two years.

AUDIT AND RISK COMMITTEE TERMS OF REFERENCE

1 Constitution

1.1 The Board of Directors ("the Board") has established a Committee to be known as the Audit and Risk Committee ("the Committee").

1.2 The Committee is a non-executive Committee accountable to the Board and has no executive powers, save any expressly provided within these terms of reference.

2 Authority

2.1 The Committee is authorised by the Board to:

2.1.1 Investigate any activity within its terms of reference;

2.1.2 Seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee;

2.1.3 Obtain independent professional advice and to secure the attendance of external advisors, within the parameters of the Scheme of Delegation, with the support of the Director of Corporate Governance; and

2.1.4 Approve such policies and procedures within the remit of the Committee as may be assigned by the Board.

3 Purpose

3.1 The primary purpose of this Committee is to provide assurance or escalate concerns to the Board and Chief Executive as the Accountable Officer in relation to:

- Governance;
- Risk management;
- The control environment;
- Integrity of the financial statements; and
- Other elements of the Annual Report and Accounts.

3.2 The Committee will ensure that the Trust has robust audit arrangements.

4 Responsibilities

The Committee's responsibilities can be categorised as follows:

4.1 Governance, risk management and internal control

4.1.1 The Committee shall review the adequacy and effectiveness of the system of governance, risk management(including review of the Board Assurance Framework and Corporate Risk Register) and internal control, across the whole of the

organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives;

4.1.2 In particular, the Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the annual governance statement), together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the Board;
- The Trust's risk management and control frameworks;
- The underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications, including the NHS Code of Governance;
- The policies and procedures for all work related to counter-fraud, bribery and corruption as required by the NHSCFA.

4.1.3 In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of governance, risk management and internal control together with indicators of their effectiveness.

4.1.4 This will be evidenced through the Committee's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it.

4.1.5 As part of its integrated approach, the Committee will have effective relationships with other key Board Committees so that it understands processes and linkages. However these other Committees must not usurp the Audit Committee's role.

4.2 Internal Audit

4.2.1 The Committee shall ensure that there is an effective internal audit function that meets the *Public Sector internal audit standards, 2017* and provides independent assurance to the Committee, Chief Executive as the Accountable Officer and Board. This will be achieved by:

- considering the provision of the internal audit service and the costs involved;
- At least once in a five year period the Committee shall point an Auditor Panel to oversee the market-testing of the internal audit provision to ensure value for money and effectiveness;

- reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework;
- considering the major findings of internal audit work (and management's response), and ensuring coordination between the internal and external auditors to optimise the use of audit resources;
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the organization; and
- monitoring the effectiveness of internal audit and carrying out an annual review.

4.3 External Audit

4.3.1 The Committee shall review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit (and make recommendations to the board when appropriate)
- discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan
- discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee
- reviewing all external audit reports, including the report to those charged with governance (before its submission to the board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses
- ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services.

- 4.3.2 At least once in a five year period the Committee shall appointed an Auditor Panel to oversee the market-testing of the external audit contract. The Auditor Panel will advise on the selection, appointment and removal of the external auditors as well as on the maintenance of an independent relationship with that auditor, including dealing with possible conflicts of interest.

4.4 Other Assurance Functions

4.4.1 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, where relevant to the governance, risk management and assurance of the organisation.

4.4.2 These may include, but will not be limited to, any reviews by Department of Health and Social Care arm's length bodies or regulators/inspectors (for example, the Care Quality Commission, NHS Resolution) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies).

4.4.3 In addition, the Committee will review the work of other Committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own areas of responsibility. In particular, this will include the Quality Committee, for which assurance from clinical audit can be assessed.

4.4.4 The Committee will review the Quality Account prior to its presentation to the Board for approval.

4.5 Anti-Fraud

4.5.1 The Committee shall satisfy itself that the organisation has adequate arrangements in place for anti-fraud, bribery and corruption that need NHSCFA's standards and shall review the outcomes of work in these areas.

4.5.2 With regards to the local Anti-Fraud Specialist it will review, approve and monitor anti fraud work plans, receiving regular updates on anti-fraud activity, monitor the implementation of action plans and discuss NHSCFA quality assessment reports.

4.6 Management

4.6.1 The Committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

4.6.2 The Committee may also request specific reports from individual functions within the organisation (for example, compliance reviews and or accreditation reports).

4.6.3 The Committee shall receive the annual report on the declarations of interest and the Trust's registers of gifts and hospitality will be presented twice per year.

4.7 Financial Reporting

4.7.1 The Committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.

4.7.2 The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

4.7.3 The Committee shall review the annual report and financial statements before submission to the Board, or on behalf of the Board where appropriate delegated authority is place, focusing particularly on:

- the wording in the annual governance statement and other disclosures relevant to the terms of reference of the committee

- changes in, and compliance with, accounting policies, practices and estimation techniques
- unadjusted misstatements in the financial statements
- significant judgements in preparation of the financial statements
- significant adjustments resulting from the audit
- letters of representation
- explanations for significant variances.

4.8 System for raising concerns

4.8.1 The Committee shall review the effectiveness of the arrangements in place for allowing staff (and contractors) to raise (in confidence) concerns about possible improprieties in any area of the organisation (financial, clinical, safety or workforce matters) and ensure that any such concerns are investigated proportionately and independently, and in line with the relevant policies.

4.8.2 Review any reported incident of whistleblowing, fraud, corruption or possible breach of ethical standards or legal or statutory requirements that may have a significant impact on the Trust's published financial accounts or reputation.

4.9 Governance regulatory compliance

4.9.1 The Committee shall review the organisation's reporting on compliance with the *NHS Code of Governance* and the fit and proper persons test.

4.9.2 The Committee shall satisfy itself that the organisation's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest.

4.9.3 The Committee shall review, on behalf of the Board, the operation of and proposed changes to the standing orders, standing financial instructions and scheme of delegation.

4.9.4 The Committee shall receive a report on, and review, all instances of waivers to standing orders.

4.9.5 The Committee shall receive any reports on any non-compliance with standing orders and standing financial instructions and any justification for non-compliance and the circumstances around the non-compliance.

4.9.6 Where the Committee considers there is evidence of ultra vires transactions this will be escalated by the Committee Chair to the Board.

4.9.7 The Committee will review the schedule of losses and compensations.

4.9.8 The Committee will receive any reports on reviewing banking arrangements.

4.9.9 The Committee will review schedules of debtors/creditors balances over 6 months old and £5,000 and management plan for these.

4.9.10 The Committee will provide assurance in respect of emergency preparedness.

4.9.11 The Committee will review an update on information governance arrangements within the Trust and the work of the SIRO.

4.9.12 Receive regular cyber security reports, including updates on cyber-related workstreams, risk, controls and other relevant information governance reports.

4.9.13 Review the Data Security and Protection Toolkit prior to submission.

4.9.14 The Committee will collaborate with other Audit Committees to ensure effective systems of control across the provider collaborative.

4.10 Management

4.10.1 The Committee may request and review reports and positive assurances from Directors and Managers on the overall arrangements for governance, risk management and internal control.

4.11 Host Arrangements

4.11.1 Where the Trust hosts services the Committee will ensure that there is an appropriate governance and accountability framework in place to manage any risks to the Trust as host. This will include ensuring that there are appropriate risk management, internal control arrangements and reporting in place to manage any risks to the Trust as host, as well as the internal audit arrangements for the hosted service.

4.11.2 The Committee will receive an annual report from the hosted service setting out the total remuneration packages of the Directors of the hosted service together with assurance that the correct governance and decision making processes have been followed by the Provider Collaborative Board as the decision making bodies in this matter, before any implementation instructions are delivered to payroll.

5 Membership

5.1 The Committee will comprise a membership of four Non-Executive Directors including:

- Audit Committee Chair, who shall have recent and relevant financial experience
- Chair of Remuneration & Nominations Committee
- Chair of Finance & Performance Committee
- Chair of Quality Committee
- Chair of People & Culture Committee

5.2 The Committee should corporately possess knowledge / skills / experience / understanding of:

- Accounting;

- Risk management;
- Internal / external audit;
- Technical or specialist issues pertinent to the organisation's business;
- Experience of managing similar sized organisations;
- The wider relevant environments in which the organisation operates; and
- The accountability structures.

5.3 Only voting Board members have the right to vote at meetings.

5.4 Members are expected to attend at least 75% of meetings.

5.5 The Chair of the Trust shall not be a member of the Committee.

6 In attendance

6.1 The following will be in regular attendance at meetings:

- Executive Director of Finance
- Director of Corporate Governance/Company Secretary
- External Auditors
- Internal Auditors
- Anti-Fraud Specialist

6.2 The Chief Executive shall be invited to attend the meeting where the Annual Accounts, Annual Report and Annual Governance Statement will be presented.

6.3 Other Executive Directors/Managers may be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that director/manager.

6.4 Persons in attendance will not have voting rights.

6.5 The Committee Chair may also extend invitations to other individuals with relevant skills, experience or expertise as necessary. Any such individuals will be in attendance only.

6.6 At least once a year the committee will meet privately with internal auditors, external auditors and the Anti-Fraud Specialist, without management present.

6.7 The Head of Internal Audit, representative of external audit and Anti-Fraud Specialist have a right of direct access to the Committee Chair.

7 Quorum

7.1 A quorum will comprise three members.

7.2 In the event that the Chair is unable to attend one of the other Non-Executive Directors shall chair the meeting.

7.3 In the event that a Non-Executive Director is unable to attend, any other Non-Executive Director can be invited to attend as a substitute voting member.

7.4 Associate Non-Executive Directors continue as non-voting members but do count towards the quorum of the Committee.

8 Frequency

8.1 The committee will meet at least 6 times per year to conduct its regular business as well as an additional meeting to review the Annual Accounts and Annual Report. Additional meetings may be called at the discretion of the Chair of the Committee.

9 Administrative Arrangements

9.1 The Committee will have in place an annual work programme, which will be aligned to the responsibilities set out within the terms of reference. The Director of Corporate Governance/Company Secretary will ensure that the work programme is regularly updated throughout the year.

9.2 The Committee will receive the papers for meetings a minimum of 5 working days prior to the meeting.

9.3 Administrative support for the Committee will be provided by the Corporate Governance Team.

10 Reporting to the Board

10.1 The Committee will report to the Board via the Committee Chair and the presentation of a 'Triple A' (Assure, Advise, Alert) report.

10.2 The Committee will provide an annual report to the Board on its work in support of the Annual Governance Statement, specifically commenting on the:

- Fitness for purpose of the Board Assurance Framework;
- Completeness and 'embeddedness' of risk management in the organisation;
- Effectiveness of governance arrangements;
- Appropriateness of the evidence that shows that the organisation is fulfilling regulatory requirements relating to its existence as a functioning business.

10.3 The annual report will also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

10.4 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board.

11 Relationship with other Board Committees

11.1 The Chairs of the Board Committees will form the membership of the Committee to ensure a direct link to and from the Audit Committee.

11.2 Information will flow between the Board Committees via the common membership and the formal escalation of any issues via Committee Chairs and/or the Director of Corporate Governance/Company Secretary.

11.3 Where an external review has significant financial, quality or workforce implications the Committee will refer that matter to the relevant Committee for consideration.

12 Reports from Sub-Committees

12.1 The Committee does not have any sub-groups.

13 Review

13.1 An annual Committee effectiveness evaluation will be undertaken and reported to the Committee and the Board.

13.2 The Board will formally review the terms of reference for the Committee at least every two years.

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Meeting Date:	14 May 2025	**Agenda Item:**	TB/2025/072a
Report Title:	Triple A Report from Quality Committee – March 2025		
Author:	Mrs C Randall, Non-Executive Director/Committee Chair		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓			✓
Executive Summary:	This report sets out the summary of the items discussed at the Quality Committee meeting held on 26 March 2025. The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.			
Key Issues/Areas of Concern:				
Action Required:	The board is asked to note the report.			

Previously Considered by:	
Date:	
Outcome:	

Committee Name:	Quality Committee
Date of Meeting:	26 March 2025
Committee Chair:	Catherine Randall
Attendance:	Quorate
Key Items Discussed:	Urgent and Emergency Care Update Health Equity Data Update Pressure Ulcer Update Quality Impact Risk Assessments Inquests / Claims Update Nurse Staffing Exception Report Trust Wide Quality Group AAA Reports Patient Safety Incident Response Framework Report Patient Participation Panel Report Integrated Performance Report (Exception Reporting)

ALERT

Please include items that have been discussed at the Committee which the Board need to be alerted to. Items such as areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter.

- The committee was provided with a patient story from the parent of a child with Avoidant/Restrictive Food Intake Disorder (ARFID). It was noted that this was a relatively newly diagnosed eating disorder, and that work was underway to raise awareness of it both across the Trust and the NHS more generally.
- Members were informed that urgent care had recently received a red NAPF assessment due to a combination of environmental and medication issues. It was noted that daily walk rounds were taking place with infection prevention and control colleagues to monitor this and ensure that the quality issues raised were being addressed.
- It was reported that the main hospital corridor had needed to be used for patient care due to a surge in pressures at the front door. It was highlighted that a new SOP was currently being operationalised that was intended to improve the experience of patients receiving corridor care.
- The additional challenges facing staff were recognised.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- The committee was informed that there had been significant improvements in the numbers of timely discharges being made.
- It was reported that hand overs from care homes had improved, as had ambulance handover times in general.
- It was highlighted that there had been reductions in the numbers of incidents involving slips, trips and falls.
- Members were advised that ICB colleagues had recently visited the Trust to carry out a walk round in the emergency department and had provided very positive feedback.

ADVISE

Please include items that have been discussed at the Committee which the Board need to be advised about, such as matters that have on-going monitoring or any new developments which need sharing.

- Members were informed that pressure ulcers continued to be closely monitored and that notable improvements had been made since the previous update provided in September 2024.
- The latest QIRA information was shared with the committee and it was agreed that further 'deep dives' would take place into specific schemes going forward.

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Meeting Date:	14 May 2025	**Agenda Item:**	TB/2025/072b
Report Title:	Triple A Report from Quality Committee – April 2025		
Author:	Mrs C Randall, Non-Executive Director/Committee Chair		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓			✓
Executive Summary:	This report sets out the summary of the items discussed at the Quality Committee meeting held on 30 April 2025. The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.			
Key Issues/Areas of Concern:				
Action Required:	The board is asked to note the report.			

Previously Considered by:	
Date:	
Outcome:	

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Committee Name:	Quality Committee
Date of Meeting:	30 April 2025
Committee Chair:	Catherine Randall
Attendance:	Quorate
Key Items Discussed:	Urgent and Emergency Care Update Equitable Cancer Care Update End of Live / Bereavement Service Update Floor to Board Report for Maternity and Neonatology Services Quality Impact Risk Assessments Nurse Staffing Exception Report Nursing Assessment Performance Framework Update Trust Wide Quality Group AAA Reports Patient Safety Incident Response Framework Report Board Assurance Framework Corporate Risk Register Risk Management Framework 2025-28 Draft Quality Account 2024-25 Clinical Strategy / Quality Strategy / Health Equity Priorities/Plans on a Page 2025-26 Integrated Performance Report CQC Update Committee Terms of Reference Committee Workplan 2025-26

ALERT

Please include items that have been discussed at the Committee which the Board need to be alerted to. Items such as areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter.

- Members were informed that that waits for urgent theatre appointments were increasing, along with an increase in the number of people over 65 on the elective surgery list.
- Issue regarding communication skills for medical staff, with it noted that training could be needed in order to ensure sympathetic delivery when giving bad news.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- The Committee was assured that work to resolve patients receiving corridor care was ongoing.
- An update on the work taking place within Primary Care to resolve Urgent and Emergency care issues was received.
- The Committee were informed about a new tool that had been created, focused on Cancer care, that would look at waiting lists and enable queuing theory to be applied. A demonstration of the tool is to be provided in the next meeting.
- The model ICB operating template for Urgent and Emergency Care to be shared with Quality Committee members.
- Quality Impact Risk Assessments continue to be completed and reviewed prior to service changes to ensure that the quality of service would not be affected.
- The Committee were updated on the Nurse Staffing Exception report, noting that the Staff Staffing threshold had been met for March 2025 and continued to be benchmarked against national standards.
- The Committee were assured that with regards the Patient Safety Incident Response Framework, the Trust was lower than the national average for the number of harms reported, with the exception of low levels of physical harm.

ADVISE

Please include items that have been discussed at the Committee which the Board need to be advised about, such as matters that have on-going monitoring or any new developments which need sharing.

- It was noted that at times, patients were being held on the corridor until suitable areas could be found for them. The standard operating procedure had been updated.
- Members were informed that a visit from the national team had taken place within the Trust's Maternity Unit.

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Meeting Date:	14 May 2025	**Agenda Item:**	TB/2025/073a
Report Title:	Triple A Report from Finance and Performance Committee – March 2025		
Author:	Mrs L Sedgley, Non-Executive Director/Committee Chair		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓			✓
Executive Summary:	This report sets out the summary of the items discussed at the Finance and Performance Committee meeting held on 31 March 2025. The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.			
Key Issues/Areas of Concern:				
Action Required:	The board is asked to note the report.			

Previously Considered by:	
Date:	
Outcome:	

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Committee Name:	Finance and Performance Committee
Date of Meeting:	31 March 2025
Committee Chair:	Liz Sedgley
Attendance:	Quorate
Key Items Discussed:	Finance Reporting Planning 2025/26 Improvement Update Albion Mill Evaluation Report EPR System Update and Finance Implications One LSC Integrated Performance Report Investment Cases Review Contracts over £1,000,000 System Issues

ALERT

Please include items that have been discussed at the Committee which the Board need to be alerted to. Items such as areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter.

- The Committee had a further update on the 25/26 plan which is showing a deficit of £72.5 million after identified WRP & FIP of £30 million. There is a further unidentified WRP &FIP of £28.9 million which is needed to bring the deficit to £43.5 million. The IAG meeting earlier in the month resulted in the request to bring the final deficit figure to £40 million with the intention that breakeven will be achieved in 26/27. There is considerable risk within the plan for 25/26 and support from Place and primary care will be critical to ensure that the Trust can deliver care within the reduced bed base and not have the levels of patients treated on corridors as experienced in 24/25.
- The meeting scheduled for 10 April with commissioners to confirm intentions for 25/26 will be critical to help identify further WRP opportunities for 25/26. Schemes which could generate a £12.7 million opportunity to reduce costs need decisions from the ICB before they can be added into the WRP for 25/26 or future years if consultation processes are required.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- It was noted that agency spend was down to 1.8% of gross pay costs at £9.2 million and is £4.8 million below target.
- Total pay for month 11 has improved by £0.8 million, £0.3 million of this is non recurrent being release of accruals but the balance of £0.5 million is recurrent and as a result of the work on improving controls on variable pay.
- Year to date capital expenditure for 24/25 is at £36.6 million with a forecast year end spend of £45 million and a breakeven position against the plan.
- The Committee had an up-to-date report on performance and was pleased to hear that the 4-hour A&E standard was achieved for March and for the year. The 65-week elective target was achieved for March with the exception of those awaiting specialist surgery due to a national supply issue. The DMO1 target (95% of patients having their diagnostic test within 6 weeks of referral) was achieved in February which was one month ahead of trajectory and the Trust continues to be in the top decile for theatre utilisation.
- The Improvement team's update this month focused on the programme of work – March to Success carried out in the month which focused on improving the UEC patient journey and has identified 41 schemes from staff. The improvement projects have identified £8.5 million of WRP for 25/26. The Trust has committed to meeting all the national performance targets for 25/26 apart from the time to first outpatient appointment, but a commitment has been given to improve this by 5%
- The activity and performance plan for 25/26 shows a commitment to meet all the national performance targets for 25/26 apart from the time to first outpatient appointment. However, the Trust has committed to a 5% improvement on this target compared to 24/25.

ADVISE

Please include items that have been discussed at the Committee which the Board need to be advised about, such as matters that have on-going monitoring or any new developments which need sharing.

- The Committee noted the improvement in the financial results for February, as the deficit for the month reduced by £5.3 million to £0.6 million. This is principally due to the in-month recognition of 11/12ths of the ERF income of £4.6 million. The Trust is

now £45.3 million behind the revised breakeven plan, this is £69.8m YTD excluding the deficit support funding.

- The CIP for 24/25 was £59.7 million of which only £18.8 million has been delivered by month 11 and the FOT is expected to be £19.9 million. This is a shortfall of £39.8 million for the year which will cause significant pressure into 2025/26.
- Forecast Outturn position (FOT) was in Month 9 established at £85.9 million, with the additional elective income of £4.6 million, £10.9 million additional surge funding allocation and a run rate reduction of £1.3 million from grip and control measures the FOT for 24/25 is now expected to be £68.5 million.
- The application for additional deficit support of £20 million was declined however the Trust received £10.9 million in additional surge funding. The ICS also received additional funding which enabled them to pay overdue balances. This has improved the cash position to £5.2 million, however due to the ongoing deficit, cash will continue to be tight and will be carefully monitored.

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Meeting Date:	14 May 2025	**Agenda Item:**	TB/2025/073b
Report Title:	Triple A Report from Finance and Performance Committee – April 2025		
Author:	Mrs S Bridgen, Non-Executive Director/Committee Chair		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓			✓
Executive Summary:	This report sets out the summary of the items discussed at the Finance and Performance Committee meeting held on 28.04.2025 The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.			
Key Issues/Areas of Concern:				
Action Required:	The board is asked to note the report.			

Previously Considered by:	
Date:	
Outcome:	

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Committee Name:	Finance and Performance Committee
Date of Meeting:	28 April 2025
Committee Chair:	Sallie Bridgen
Attendance:	Quorate
Key Items Discussed:	Finance Reporting
	Financial Recovery Update
	Grip and Control Action Plan
	Planning Update
	Budget Setting Principles
	Albion Mill – Proposed Way Forward
	EPR Business Case Update
	Integrated Performance Report
	MIAA CIP Report
	Board Assurance Framework
	Corporate Risk Register
	Finance and Performance Committee Terms of Reference

ALERT

The Committee received an update from the Recovery Director and the Director of Service Development and Improvement on our **financial recovery activity and the Waste Reduction and Financial Improvement Programme 25/26.**

As at 22/4/25 the Waste Reduction Programme (WRP) stands at £38.886m against a target of £60.8m. Work is ongoing to establish the Programme Management Office (PMO) and support is being provided to all Divisions to drive further opportunity identification and commence delivery assurance of the WRP.

The Committee recognised the significant work and progress made.
Further work is required to identify the full £60.8m, and to develop the PMO

The Committee requested that executive colleagues meet outside the meeting to agree an appropriate format for future reports to enable effective oversight and assurance.

ASSURE

The Committee received assurance on **Month 12 financial position**.
The Trust is reporting a deficit of £68.492m, against a break-even plan for the 2024-25 financial year. £68.492m behind the revised breakeven plan. A surplus of £1.2m in month, an improvement of £1.8m in month (M11 £610k).
The Trusts revised annual financial plan is to deliver a breakeven plan inclusive of a £59.7m cost improvement programme.
Other key metrics are:

Agency spend of £9.8 (1.6% of gross pay costs) is £5.6m under target. (Planned 2.8%, £15.5m for 24-25)
The Trust delivered £20.1m of its WR & FIP target for 2024-25, against a £59.6m plan.
Capital expenditure is at £45m at M12, in line with the forecasted spend for the year.
The cash balance on 31st March was £16.8, an increase of £11.6m compared to the previous month.

The Committee will meet to review the Finance Report structure after the May Committee, with a particular focus on how we triangulate with workforce data, and P&C Committee. Also strengthening reporting on Estate Maintenance in the context of Capital Planning. While recognising the scale of the financial challenge, it is also important to note the progress made in the final quarter of the year, with an improved position, and 279 QUIRAS produced to ensure all planned changes maintain safety.

The Committee received a report on the **PWC Grip and Control Action Plan** which provides assurance on progress against the actions agreed. Work is underway in all areas, and while some remain amber – this is indicative of the time required for full implementation and assurance that systems are operating effectively. Work will be ongoing to continue to refine and develop the plan and associated reporting to give full assurance of implementation and impact.

It also received the **MIAA CIP report**. Since then, there has been a significant overhaul of the approach to WRP, linked to the One LSC Finance Programme, and the establishment of a PMO in the Trust, with the enhanced reporting on a weekly basis to PwC. The actions will be considered in the context of the new arrangements to ensure that all are recorded as complete, superseded or still relevant and on track for delivery by the deadlines agreed. This will be monitored through the Audit Committee.

The Committee Approved the continuation of the P**roof of Concept at Albion Mill** until 31st March 2025. This is fully funded and will enable completion of options appraisal for future provision of service. It was agreed that a further report will come to the Committee in December, to ensure sufficient time is available to cease the service at that point if necessary.

The Committee has approved the **ePR upgrade**. This single upgrade will allow ELHT to become compliant with NHS Care Identity Service 2 (CIS2) requirements without entering into a multi-year contract for upgrades which could potentially become unwarranted should a change in ePR system be made.

The Committee received the **Performance Report**. It has requested that P&C Committee seek further assurance on the impacts on colleague morale of the current waste reduction activity. It also noted areas for further assurance for Quality Committee – and will meet with the Chairs of both Committees to agree the most appropriate way of addressing the quality and workforce aspects of this report.

ADVISE

The Committee received reports on Planning Guidance and Budget Setting Principles.
It reviewed the BAF and Corporate Risk register, and requested that the BAF risk re Commissioning Intentions be considered further. It approved the updated Finance and Performance Terms of Reference.

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Meeting Date:	14 May 2025	**Agenda Item:**	TB/2025/074a
Report Title:	Triple A Report from People & Culture Committee – March 2025		
Author:	Mrs T Anderson, Non-Executive Director/Committee Chair		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓			✓
Executive Summary:	This report sets out the summary of the items discussed at the People & Culture Committee meeting held on 3 March 2025. The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.			
Key Issues/Areas of Concern:				
Action Required:	The Board is asked to note the report.			

Previously Considered by:	
Date:	
Outcome:	

Committee Name:	People & Culture Committee
Date of Meeting:	3 March 2025
Committee Chair:	Trish Anderson
Attendance:	Quorate
Key Items Discussed:	Financial Update Corporate Risk Register Staff Story HR Framework Variable Pay Rapid Improvements Planning update People Promise Examplar Progress Health and Well-being Update

ALERT

Please include items that have been discussed at the Committee which the Board need to be alerted to. Items such as areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter.

- It has been confirmed nationally that there will be no funding for a second year of the People Promise Manager role. A deep dive evaluation is in progress to determine whether the People Promise function can be incorporated into the back-office support mechanisms.
- The Trust is experiencing a deteriorating position in relation to staff health and well-being with a significant increase in sickness absence rates over the last 12 months. A heat map culture dashboard is being developed and will be overseen by the Committee.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- The Committee noted progress of the management of operational risk on the Corporate Risk Register.

- The Committee received an overview of the HR Framework to be used across LSC to ensure a consistent approach to workforce reductions. The Committee will receive a further update once the Trust's MARS scheme has closed.
- The Committee reviewed the outputs from the divisional Workforce Assurance Meetings and noted the very positive outputs from the Medicine and Emergency Care Division Workforce Assurance Meeting.
- Two new tools have been developed in-house by the Trust's temporary staffing team to promote better roster management and ultimately reduce bank and agency spend.
- There has been significant work undertaken as part of the Trust's rapid improvement exercises. A substantial piece of work will be taking place around non-pay and procurement.

ADVISE

Please include items that have been discussed at the Committee which the Board need to be advised about, such as matters that have on-going monitoring or any new developments which need sharing.

- Work is ongoing to develop an inclusive uniform proposal. The Uniform Policy is being further developed following consultation with staff side.
- The Committee received a staff story from a Health Care Assistant who shared her experience on joining the Trust and feeling unwelcome in her first role and unsupported during her induction. She had then experienced support from the Trust's work-based education team and moved into a new department. The Committee recognised the work of the Education team and received assurance that every HCA now receives care certificate training and pastoral support upon joining the Trust. A further rapid improvement exercise is being undertaken, including recruitment and retention of HCAs.

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Meeting Date:	14 May 2025	**Agenda Item:**	TB/2025/074b
Report Title:	Triple A Report from People & Culture Committee – April 2025		
Author:	Mrs Trish Anderson, Non-Executive Director/Committee Chair		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓			✓
Executive Summary:	This report sets out the summary of the items discussed at the People & Culture Committee meeting held on 7 April 2025. The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.			
Key Issues/Areas of Concern:				
Action Required:	The Board is asked to note the report.			

Previously Considered by:	
Date:	
Outcome:	

Committee Name:	People & Culture Committee
Date of Meeting:	7 April 2025
Committee Chair:	Trish Anderson
Attendance:	Quorate
Key Items Discussed:	Workforce Assurance Meetings Update Professional Nurse Advocate Programme Update Stay conversations/Staff Check in pilot MARS update Staff Survey Results Planning update DERI Plan on a page People & Culture plan on a page Committee Terms of Reference

ALERT

Please include items that have been discussed at the Committee which the Board need to be alerted to. Items such as areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter.

- The Trust had not met the national ambition for a ratio of 1:20 Professional Nurse Advocates by March 2025, this is captured on the risk register. The Committee discussed how the PNA programme could be delivered despite financial constraints and the need to take a different approach.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- Members received an update on the Trust's planning submission for 2025/26 and the identification of £30,000,000 of waste reduction identified thus far.
- MARS applications are still being worked through. Clinical colleagues are integrated within the process to ensure that no roles critical to patient safety are lost.

- The DERI and People and Culture Plans on a Page were approved for submission to the Board.
- The revised committee Terms of Reference were considered prior to be being presented to the Board for approval. It was agreed that the committee will spend some dedicate time following a meeting to consider the workplan for 25/26 and what good assurance would look like across the range of Committee's responsibilities.

ADVISE

Please include items that have been discussed at the Committee which the Board need to be advised about, such as matters that have on-going monitoring or any new developments which need sharing.

- Workforce Assurance Meetings and CIP meetings will be merged to weekly divisional meetings focussing on financial recovery, grip and control and delivery of waste reduction programmes.
- The committee noted the results of the STAY pilot within the Medicine and Emergency Care Division. There had been notable reductions in absence and vacancy rates. The Committee supported the roll out of the STAY process but noted the challenges in delivering this.
- The Staff Survey results were considered with a particular focus on how this will be taken forward and measured throughout the year using pulse surveys to enable the Trust to be more reactive in real time.

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Meeting Date:	14 May 2025	**Agenda Item:**	TB/2025/075
Report Title:	Triple A Report from Audit and Risk Committee – April 2025		
Author:	Mr K Rehman, Non-Executive Director/Committee Chair		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓			✓
Executive Summary:	This report sets out the summary of the items discussed at the Audit and Risk Committee meeting held on 14 April 2025. The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.			
Key Issues/Areas of Concern:				
Action Required by the Committee:	The Board is asked to note the report.			

Previously Considered by:	
Date:	
Outcome:	

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Committee Name:	Audit and Risk Committee
Date of Meeting:	14 April 2025
Committee Chair:	Khalil Rehman
Attendance:	Quorate
Key Items Discussed:	National Information Security Information Notice on Multi-Factor Authentication Internal Audit Update, including annual report, progress report, Head of Internal Audit Opinion, and 2025/26 workplan External Audit Update PWC Grip and Control – Report and Action Plan Seagry Financial Review – Action Plan Management Response to Medical Staff Annual Leave Management Response to Care for Vulnerable Patients with Dementia Anti-Fraud Update, including 2024/25 annual report and 2025/26 audit plan. Review of 2024/25 Accounting Policies Review of Going Concern for 2024/25 Financial Year 2024/25 Draft Annual Report and Accounts Timetable Draft Response from Those Charged with Governance Draft Annual Governance Statement 2024/25 Waivers Report Board Assurance Framework Corporate Risk Register Recovery Support Programme Funding Audit Committee Terms of Reference

ALERT

Please include items that have been discussed at the Committee which the Board need to be alerted to. Items such as areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter.

- The Committee were informed about the Limited Assurance Head of Internal Audit (HOIA) Opinion. It was noted that there are further Internal Audit (IA) reports to be received and more information would be provided in the Draft Annual Governance

Statement. The Committee has asked for all 2025/26 IA's to be completed by the internal auditors and responses from management by January 2026 to support closing off actions by year end. Committee expressed concern at the number of limited assurance reports in the last quarter and that controls were not being applied or effective. The need for Executive support to drive progress on previous year actions to support HOIA for 25/26 is critical.

- The Committee were updated on work involving the Trust's cyber security arrangements, and multi-factor authentication.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- The Committee was assured that the PWC grip and control action tracker was in place, including key milestones.
- The Committee was assured that actions were om track for the Seagry action plan.
- An update was provided to the Committee on the Board Assurance Framework following the Board Strategy day.

ADVISE

Please include items that have been discussed at the Committee which the Board need to be advised about, such as matters that have on-going monitoring or any new developments which need sharing.

- The Internal Audit Workplan for 2025/26 was presented, with the Committee agreeing that it would be discussed with Committee Chairs prior to sign off.
- It was noted that the Trust Board would delegate authority to the Audit and Risk Committee for final sign off of the Annual Accounts and Annual Report, and completion of the Annual Governance Statement.
- The Committee approved the 2025/26 Anti-Fraud workplan and noted that compliance with Declarations of Interest needed to improve to enable all aspects of the Anti-Fraud Annual Report to be reported as being green.
- The Committee noted that the Risk Management Strategy was being reviewed.
- The Committee noted the terms and funding amounts related to the Recovery Support Programme Funding.

TRUST BOARD REPORT

Meeting Date:	14 May 2025	**Agenda Item:**	TB/2025/076
Report Title:	Remuneration Committee Summary Report		
Author:	Mr D Byrne, Corporate Governance Officer		
Lead Director:	Professor G Baldwin, Non-Executive Director		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
				✓
Executive Summary:	The list of matters discussed at the Remuneration Committee meetings held on 23 January 2025 and 20 February 2025.			
Key Issues/Areas of Concern:				
Action Required:	The board is asked to note the report.			

Previously Considered by:	
Date:	
Outcome:	

Meeting: **Remuneration Committee**

Date of Meeting: **9 April 2025**

Committee Chair: **Graham Baldwin, Non-Executive Director**

ITEMS DISCUSSED

At the meeting of the Remuneration Committee on 9 April 2025, the following matter was discussed in private:

a) Appointment of the Executive Medical Director
b) Deputy Chief Executive Allowance and Arrangements
c) Recruitment and Remuneration for Deputy Chief Operating Officer
d) Terms of Reference

TRUST BOARD REPORT

Meeting Date:	14 May 2025	**Agenda Item:**	TB/2025/077
Report Title:	Trust Board (Closed Session) Summary Report		
Author:	Mr D Byrne, Corporate Governance Officer		
Lead Director:	Mr S Sarwar, Chairman		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
				✓
Executive Summary:	The report details the agenda items discussed in closed session of the Board meetings held on 15 January 2025. As requested by the Board it can be confirmed that, in preparing this report the external context has been taken into account, such as regulatory requirements placed on NHS providers. Other elements such as local needs, trends and engagement with stakeholders would not be applicable in this instance.			
Key Issues/Areas of Concern:				
Action Required:	The board is asked to note the contents of the report.			

Previously Considered by:	
Date:	
Outcome:	

Meeting: **Trust Board (Closed Session)**
Date of Meeting: **14 March 2025**
Committee Chair: **Shazad Sarwar, Chairman**

ITEMS APPROVED

The minutes of the previous meeting held on the 15 January 2025 were approved as a true and accurate record.

ITEMS DISCUSSED

At the meeting of the Trust Board on 14 March 2025, the following matters were discussed in private:

a) Round Table Discussion: National ICB / PCB and Pennine Lancashire Update.
b) Round Table Discussion: Recovery Support Programme
c) Financial Reporting: Financial Performance
d) Financial Governance Review Action Plan – Seagry Action Plan Update
e) Financial Governance Review Action Plan - NHSE Investigation and Intervention Nominated Lead Review Update
f) National Planning Guidance 2025-26
g) Colleague Ideas Scheme
h) One LSC
i) National Staff Survey Feedback Pathology Update
j) Pathology Update
k) Communications Update and Horizon Scanning

ITEMS RECEIVED FOR INFORMATION

None.