East Lancashire Hospitals
NHS Trust
A University Teaching Trust

QUALITY ACCOUNT

2024 - 25

Part 1 Introduction to our Quality Account

1.1 Our Trust 4
1.2 Our Vision and Values....5
1.3 Our Future 6
1.4 Our Approach to Quality Improvement....7
1.5 Our Quality Account 16
1.6 Our Regulator's View of the Quality of our Services 16
1.7 Our Chief Executive's Statement on Quality 18

Part 2 Quality Improvement

2.1 Our Strategic Approach to Quality 21
2.2 Quality Monitoring and Assurance....28
2.3 Priorities for Quality Improvement 2024-25 29
2.4 Mandated Statement on the Quality of our Services
2.4.1 Clinical Audit and Confidential Enquiries....31
2.4.2 Research and Development 35
2.4.3 National Tariff Payment System and CQUIN 35
2.4.4 Care Quality Commission Compliance....35
2.4.5 Data Quality Assurance....36
2.4.6 Information Quality and Records Management....37
2.4.7 Clinical Coding Audit 37
2.5 Complaints Management....37
2.6 Duty of Candour....38
2.7 NHS Staff Survey Results....38
2.8 Medical and Dental Staffing....39

Part 3 Quality Achievements, Statutory Statements and Auditor's Report

3.1 Achievements against Trust Quality Priorities 40
3.2 Harms Reduction Programmes 62
3.3 Achievements against National Quality Indicators
3.3.1 Summary Hospital Level Mortality Indicator (SHMI)....62
3.3.2 Percentage of Patient Deaths with Palliative Care Coding 63
3.3.3 Patient Recorded Outcome Measures (PROMs) 64
3.3.4 Readmissions within 28 Days of Discharge 65
3.3.5 Responsiveness to Personal Needs of Patients 66
3.3.6 Recommendation from Colleagues as a Provider of Care....67
3.3.7 Friends and Family Test Results (Inpatients and Emergency Department) 68
3.3.8 Venous Thromboembolism (VTE) Assessments....69
3.3.9 Clostridium Difficile Rates....71
3.3.10 Patient Safety Incidents....72

3.3.11 Never Events 74
3.3.12 Learning from Deaths 75
3.3.13 Seven Day Service Meeting with Clinical Standards 79
3.3.14 Colleagues Can Speak Up 80
3.3.15 NHS England National Improvement Standards for Learning Disability....80
3.4 Other Quality Achievements
3.4.1 Local 4-hour performance 81
3.4.2 65 week wait target reached....81
3.4.3 Maternity Services rated amongst the best in England 81
3.4.4 Community Services helping more patients than ever be cared in their own home 82
3.4.5 Theatres lead the way for utilisation 82
3.4.6 Transfer of physical and Mental Health Services in Blackburn with Darwen and East Lancs ...83
3.4.7 Moving services out of Accrington Victoria....83
3.4.8 New Heart Care Unit at Royal Blackburn Hospital 83
3.4.9 State of the art Chemotherapy Unit opens at Blackburn Hospital 84
3.4.10 Major milestone in aortic aneurysm treatment 84
3.4.11 Martha's Rule....85
3.4.12 Improvements and upgrades in Data and Digital....85
3.4.13 Further Faster 20 Initiative to reduce waiting lists....86
3.4.14 Keeping patients steady on their feet....86
3.4.15 Patient Experience Strategy launched....86
3.4.16 Maternity discharge videos will transform new patients' experiences....87
3.4.17 Joint Advisory Group (JAG) Accreditation....87
3.4.18 Care Quality Commission (CQC) Adult Inpatient Survey....88
3.5 Statement from Stakeholders
3.5.1 Healthwatch Blackburn with Darwen and Healthwatch Lancashire....88
3.5.2 Lancashire and South Cumbria Integrated Care Board (LSCICB)....90
3.5.3 Lancashire County Council....94
3.6 Statement of Directors' Responsibilities 94
3.7 Glossary....95

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

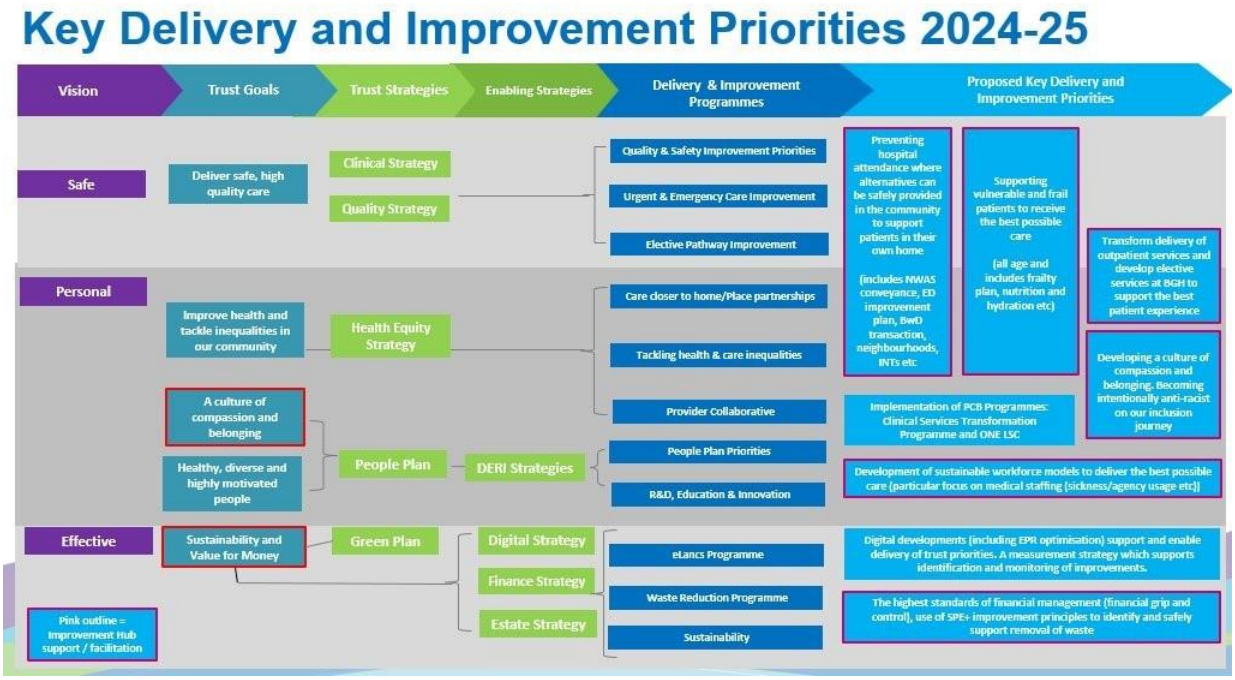
At ELHT, delivering the highest quality healthcare to our local communities is at the heart of everything we do. We have fantastic teams delivering safe effective care and every day we hear stories about how they go above and beyond. Quality is embedded in our culture, and we are committed to continually improving and, in so doing, achieving our organisational vision ‘to be widely recognised for providing Safe, Personal and Effective care.

The Trust has implemented a robust approach to continuous learning and improvement. ‘Improving Safe, Personal and Effective Care’ (SPE+) is our Improvement Practice of understanding, designing, testing, and implementing changes that lead to improvement across the Trust. We work with our patients and carers, our colleagues, our organisation and senior leaders and wider partners across Pennine Lancashire to provide better care and outcomes for our patients, colleagues, and communities and to develop and embed a culture of continuous improvement, learning and innovation.

To ensure that we are delivering Safe, Personal and Effective care we have an embedded process for the identification and agreement of key improvement priorities. The Trust has an agreed set of 11 Key Delivery and Improvement Programmes (see Figure 1). Our improvement priorities are directly informed by our patient safety priorities identified from patient safety investigations and identification of themes, as well as by key operational and pathway improvement priorities from across the organisation and wider system, which align with national requirements.

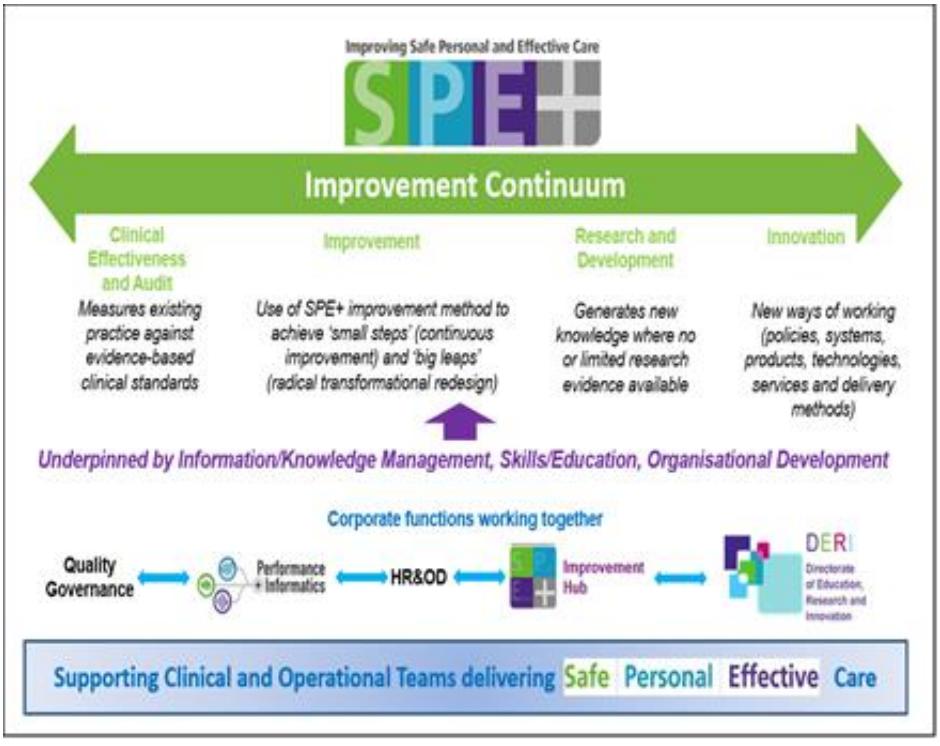
ELHT annually review and refresh key Trust and Enabling Strategies (see Figure 1). The SPE+ Improvement Practice is underpinning to support the delivery of improved outcomes and ELHT being recognised as a learning and improvement organisation (see Figure 2).

Figure 1



There is a Trust-wide approach that spans our Improvement Continuum, and any idea for better care and outcomes for our patients, colleagues and communities will receive the appropriate support the first time.

Figure 2



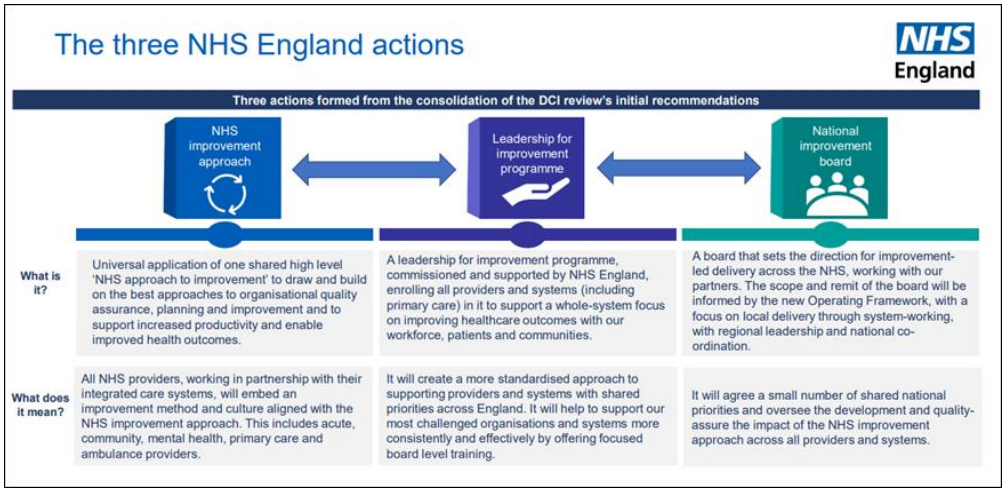
We continue to develop relationships with colleagues, across the organisation and wider system to bring together colleagues involved in improvement (Clinical Audit and Effectiveness, Improvement, Research and Development, Transformation, and Innovation) to support shared learning and spread and celebration of success (see Figure 3).

Figure 3

An NHS Approach to improvement

NHS England have set the expectation that all NHS providers, working in partnership through integrated care systems, will embed a quality improvement method aligned with the NHS improvement approach (Figure 4). This framework support's our ways of working across services at every level of place: primary care networks, local care networks, provider collaboratives and integrated care systems.

Figure 4



NHS Impact

NHS Impact (Improving Patient Care Together) (Figure 5) is the single shared NHS Improvement approach, providing key concepts and principles to create the right conditions for continuous improvement. As an organisation, we are working to embed these principles in all that we do.

Figure 5

The SPE+ Improvement Practice element of the Improvement Continuum is comprised of three key elements which are encapsulated into an Improvement Practice Development Plan. They map to the five components of the recommended NHS improvement approach, and this is depicted below (Figure 6) and within the Practice Development Plan and Commitments 2022/25: Year 2 (Figure 7).

Figure 6

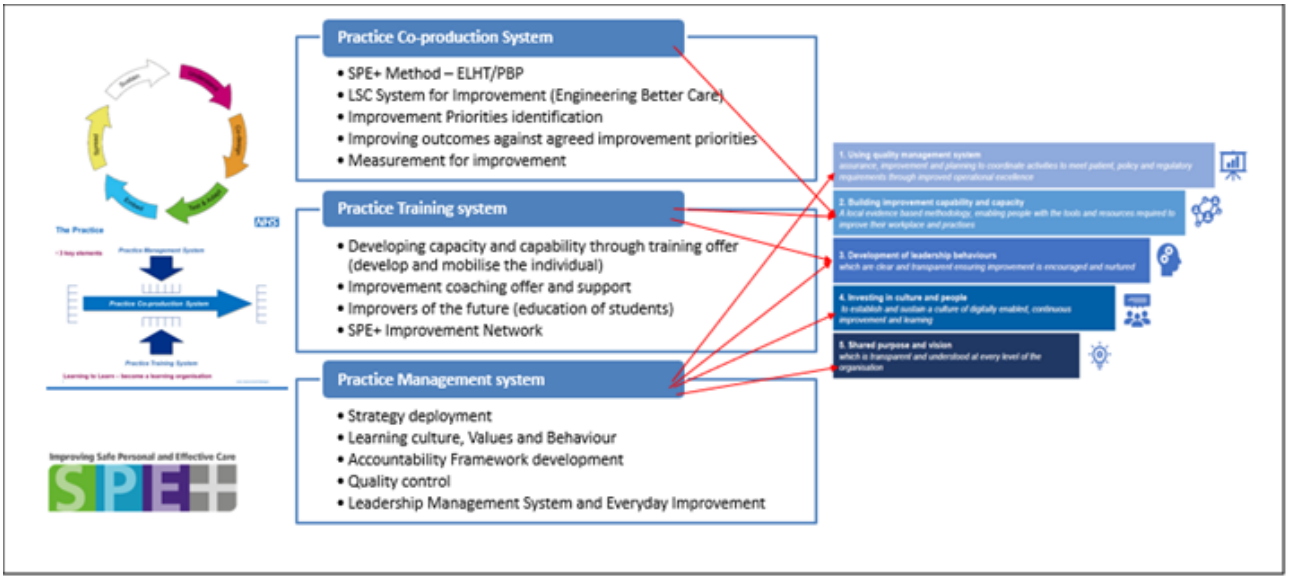


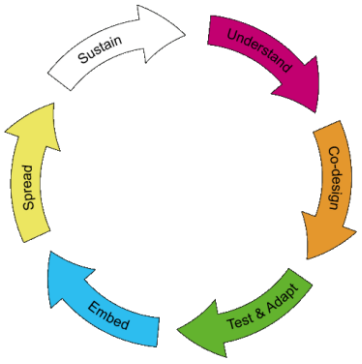
Figure 7: Practice Development Plan and Commitments 2022/25: Year 3

Practice Component	Aim	Objectives
Practice Management System	To embed improvement in all that we do.	1. To implement the Improvement Strategy. 2. To contribute to the learning culture where all colleagues strive for continuous improvement and innovation. 3. To celebrate success and share learning.
Practice Training System	To empower colleagues to make improvements.	1. To continue to develop capacity and capability of colleagues through the SPE+ Improvement Practice training offer. 2. To support colleagues on their improvement journey through high quality Improvement Coaching. 3. To create a SPE+ Improvement Network to support colleagues in sharing best practice.
Practice Co –	To lead change for better care and	1. Working with partners across Lancashire and South

production System	outcomes for our patients, colleagues and community.	Cumbria to develop a consistent system-level method of improvement (Thinking, Method, Delivery). 2. Ensuring a robust approach to the identification of Improvement priorities. 3. Utilising the SPE+ Improvement Practice to support improved outcomes against agreed improvement priorities. 4. Ensuring robust systems for measurement for improvement.

Improvement Practice

We deliver a 6-phase approach to improvement which brings together the improvement principles of the Institute for Healthcare Improvement (IHI) Model for Improvement and Lean. We measure improvements by Delivery, Quality, Cost and People. The six phases of SPE+ are: Understand, Co-Design, Test and Adapt, Embed, Spread and Sustain. This approach is summarised below:



The development of our Improvement Practice has been supported through our involvement in the national NHS Improvement and NHS England Vital Signs Programme. Although this programme has now formally ceased, we continue to develop our Improvement Practice by continually reviewing national and internal best practice and through the development of local, regional, and national Improvement Networks. In 2023/2024, we further developed our improvement practice training offer to include Kata Coaching, the Institute for Healthcare Improvement Breakthrough Series Collaborative and Engineering for Better Care frameworks.

Beyond the Improvement Practice methodology and improvement priority workstreams is the fundamental principle of building improvement into our management system so that it becomes a part of everything we do, bringing together planning, improvement and quality contract and assurance and creating a culture of improvement and learning across the organisation.

SPE+ Improvement Practice Training Framework

To support colleagues in the development of skills and confidence in the application of the SPE+ Improvement Practice we have developed a comprehensive training offer which is summarised in our SPE+ Improvement Practice Training Framework. This is summarised below:

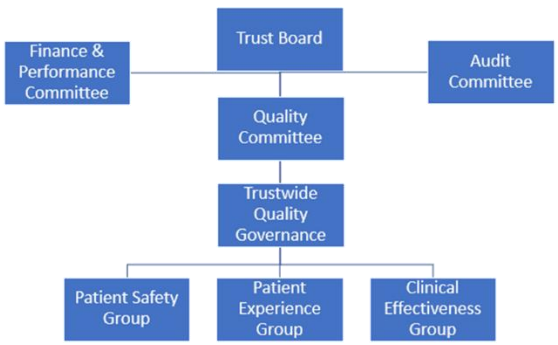
The Improvement Hub Team supports the organisation by coaching and facilitating on defined improvement programmes and projects linked to Trust and Divisional priorities. Colleagues in training, that is 'future improvers,' are supported to develop, contribute and lead quality improvement projects - Multi-professional Preceptorship, Foundation Year 1 (FY1) Doctors, Foundation Year 2 Doctors (FY2), Junior Clinical Fellows (JCF), Internal Medicine Trainees (IMT), UCLan Year 4 Medical Students (SSC4) and UCLan Trainee Advanced Clinical Practitioners (TACPs).

During 2024/2025 the Improvement hub have supported over 190 events**.**

Monitoring and Assurance

Quality monitoring occurs through our corporate and clinical governance structure, reporting to the Trust board via the Quality Committee. Divisional Directors or their deputies attend and provide assurance at these committees.

Mr Jawad Husain remained the Executive Medical Director and the Lead for Clinical Quality and in April 2025 we welcomed Mr Shahid Islam, as the Interim Medical Director, following Mr Husain's retirement.



Board of Directors
The Board of Directors has responsibility for the services that we deliver and is accountable for operational performance as well as the implementation of strategy and policy. During 2024/25, the Integrated Performance Report (IPR) has undergone a full review, and a new Trust IPR has been implemented in line with national best practice. A quality dashboard is reported monthly to the Board of Directors as part of the IPR. Where possible we include performance indicators to measure and benchmark our progress against each quality improvement priority and local quality indicators.

Finance and Performance Committee
The Finance and Performance Committee provide assurance about the delivery of the financial and operational plans approved by the Board for the current year and for the longer-term future, develop forward plans for subsequent fiscal years for consideration by the Board and examine in detail risks to the achievement of national and local performance and activity standards.

Quality Committee
The Quality Committee provides assurance to the Trust Board of Directors in respect of clinical quality and patient safety, effectiveness and experience through robust reporting and performance monitoring.

Audit Committee
The Audit Committee is the high-level risk committee operating on behalf of the Board and concerns itself with the function and effectiveness of all committees. It is the Committee that brings all aspects of governance risk management together. The Audit Committee is charged with ensuring that the Board and Accounting Officer of the organisation gain the assurance they need on governance, risk management, the control environment and on the integrity of the financial statements, as well as other elements of the Annual Report and Accounts.

Trust Wide Quality Governance (TWQG)
The progress of each priority is reported on a quarterly basis to the Trust Wide Quality Governance Group which reports monthly into the Quality Committee. Operational implementation of the commitments will be monitored routinely through the Patient Safety, Patient Experience and Clinical Effectiveness Groups which report monthly to TWQG. Divisional representation and Heads of Corporate services are standing members on the TWQG. Other groups, such as Mortality Steering Group, Hospital Transfusion Committee and Safeguarding Committee, report directly to the Quality Committee through the Trust Wide Quality Governance Group.

Clinical Divisions Quality meetings
There are five Clinical Divisions within the Trust, who report into the Executive Directors and provide assurance on Strategy and risk management performance. Each Division holds a monthly Quality/Performance meeting to receive assurance or escalation from the various Directorates. This is then presented to the Executive Team in quarterly Performance Review Meetings. Similarly, the Directorate meetings are attended by and receive escalation from their respective teams. These meetings are supported by allocated Quality and Safety teams who work closely with the respective Senior Leadership Teams.

Patient Safety Group
Established as a sub-group of the Trust Wide Quality Governance this is the group responsible for providing assurance that there is effective monitoring and oversight of patient safety across all spheres of Trust activity and that improvement of patient safety is

at the heart of the work of the Trust. Chaired by the Assistant Director of Patient Safety and Effectiveness, it is the Trust wide operational focus for accountability for patient safety for quality governance within corporate and the Divisions.
It brings together the business of the corporate clinical leaders within the Trust, who with senior members of the Divisional teams supported by members of the Quality and Safety Unit, have day-to-day responsibility for patient safety driving improvement initiatives in this area.

Patient Experience Group
Established as a sub-group of the Trust Wide Quality Governance this is the group responsible for providing assurance that there is effective monitoring and oversight of patient experience across all spheres of Trust activity and that improvement of patient experience is at the heart of the work of the Trust. Chaired by the Assistant Director of Patient Experience, it is the Trust wide operational focus for accountability for patient experience for quality governance within corporate and the Divisions.
This group combines an overview focus on complaints management with feedback from patients and their carers/families. This group monitors the Friends and Family Test results, Annual Patient Survey feedback themes and links with key partners such as Healthwatch to maintain direct links with community groups.

Clinical Effectiveness Group
Established as a formal sub-group of the Quality Committee this is the engine room for ensuring that there are appropriate arrangements to monitor, assure and improve clinical effectiveness across the range of the Trust's services. Chaired by the Deputy Medical Director, it is the Trust wide operational focus for assurance and accountability for clinical effectiveness and improvement for the Divisions. It brings together the business of clinical leaders and senior members of the divisional teams, supported by the corporate clinical effectiveness functions, with a day-to-day responsibility for clinical effectiveness and quality improvement.

Quality Improvements Triage
The Improvement hub provide a central register for all divisions to register their improvement projects. Each division is responsible to provide updates on project implementation for all the projects within their division via the automated Project Update Form reminders. Divisions are able to see live data based on the progress of each improvement project registered at any time.

Partnership Working
The Trust continues to build on its relationships and communication with the Lancashire & South Cumbria Integrated Care Board (LSC ICB) and the place-based partnership with Lancashire Place. Regular Quality Review meetings are held with quality leads from all organisations. The focus of these meetings is around clinical effectiveness, risk and safety, quality improvement and the patient, family, and carer experience.

The escalation process for incidents, risks and events of concern are triaged daily to ensure timely and appropriate communication to all relevant parties. This allows the Trust to identify and nominate appropriate colleagues to investigate incidents and where appropriate a family liaison officer to support, provide information and feedback to the patient, family and/or carer. Evidence is collated from Divisional Serious Incident Reporting Groups (DSIRG) and presented at a monthly Trust Serious Incident Requiring Investigation (SIRI) Panel. Quality and Safety reports are submitted to one of the bi-monthly subcommittees of the Quality Committee and then to the Trust Board. Following these meetings, validated reports and data are shared with the ICB to provide assurance and to support health economy decision making. Reports include:

- Complaints
- Healthcare Associated Infections (HCAI)
- Exception reports against key performance standards
- Patient Safety Incident Report

The quality scorecard continues to be used this year to facilitate monitoring against a range of quality indicators.

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

On behalf of the Trust Board and colleagues at East Lancashire Hospitals NHS Trust (ELHT), I am pleased to present our Quality Account for 2024/25.

This year has brought continued pressure for everyone across all settings and services, in hospital and in the community. We have seen high levels of demand coupled not just with a need to significantly reduce costs, whilst ensuring we continue to deliver high-quality safe, personal and effective care.

Despite these pressures, teams have continued to demonstrate an unwavering commitment to patients and their families, huge levels of personal resilience, hard work and dedications and a commitment to improvement and innovation.

We owe enormous thanks to colleagues across all services for their efforts each and every day which was especially evident during periods of industrial action, escalating and unprecedented winter pressures and building work to remove crumbling concrete from our hospitals.

Even under such operational challenge, it is brilliant that substantial progress has been made in improving quality and safety. We're proud of the milestones we've reached this year:

- We successfully met our target to eliminate 65-week waits for treatment, with the exception of certain specialist eye procedures subject to national exemptions
- We exceeded national targets for timely diagnoses, including cancer pathways
- Our Emergency Department achieved the national four-hour standard, with nearly 78% of patients seen within this timeframe—2% above the target—placing us among just 38 of 119 acute Trusts in England to do so
- More patients than ever before are receiving care at home, further highlighting the evolving and effective reach of our services.

Our financial challenges were well documented through 2024-25 and the Trust was open and transparent about the need to reduce costs with patients, colleagues and partners.

In February, NHS England downgraded ELHT to segment four of the national NHS Oversight Framework (NOF) and the Trust was enrolled into the Recovery Support Programme (RSP),

alongside the Integrated Care Board (ICB), Lancashire Teaching Hospitals (LTH) and Blackpool Teaching Hospitals (BTH.

In the last few months, the Trust has benefited from a range of intensive and additional scrutiny and support to help reduce costs and ended the financial year with a significant deficit but a notable improvement from earlier projections.

I want to provide some assurance that there is no indication from NHSE that moving to NOF4 is any reflection of the quality of our care or concerns around patient safety.

This report shows we continue to perform well against a number of targets for both urgent and emergency care and elective procedures, despite huge volumes of attendances and demand for our services. We have pockets of very good practice indeed, including one of the best maternity teams in the country and excellent community services which are caring for people in their own homes.

We also celebrated several key achievements in service quality:

- Our Endoscopy team once again secured Joint Advisory Group (JAG) accreditation, recognising their commitment to clinical quality, training, patient experience, and workforce development
- Patient experience remains a central priority, with Friends and Family Test scores and other surveys consistently above 90% across inpatient, outpatient, and community services
- We opened new facilities, including a modern Chemotherapy Unit, a Bereavement Suite, and a dedicated Heart Care Unit—clear examples of our investment in service innovation and patient care.

This report also outlines progress on our seven Key Delivery and Improvement Programmes (KDIPs), which are supported by our Improvement Hub. These programmes reflect our Trust-wide priorities and cover areas such as quality and safety, emergency and elective care, provider collaboration, research and innovation, and digital transformation.

Performance Against 2024/25 Improvement Priorities:

1. **Avoiding unnecessary hospital attendance:**
   While overall attendance rates have not decreased, there has been a rise in 2-hour Urgent Community Response (UCR) referrals and thanks to our continued work in this area, care homes were making more referrals to the service than they were sending residents to ED. Time to be seen in the ED has improved significantly—from 158 minutes in January 2025 to 90 minutes in March 2025. Our Hospital at Home model is also going from strength to strength, significantly 19 admissions were avoided using IV Fluid Bolus treatment which was a new aspect for 2025.
2. **Supporting vulnerable and frail patients:**
   A new Discharge Dashboard has been implemented across ELHT, increasing visibility of patients to monitor and audit discharges more effectively.
3. **Transforming outpatient and elective services:**
   Outpatient Transformation scoping has been completed with a rollout plan for the PEP+

programme, an online platform that gives patients more control of their hospital care experience. Initial specialties have gone live, with further implementation planned into 2025. The platform will help reduce missed appointments and enhance experience.

4. **Fostering a compassionate, inclusive culture:**
   The Trust was awarded Bronze Certification by the NHS Northwest BAME Assembly, Th award recognised proactive efforts to tackle racism, encourage reporting of incidents, and foster a more inclusive environment.
5. **Delivering Provider Collaboration Board programmes:**
   On 1 November 2024, ELHT became the host organisation for *One Lancashire and South Cumbria (One LSC)*. This brought together 1,375 ELHT colleagues with 2,083 colleagues from neighbouring Trusts to run central services jointly in order to deliver the best service possible and avoid duplication.
6. **Driving digital transformation:**
   Our Electronic Patient Record (EPR) continues to evolve, alongside other digital tools including AI applications and PEP+. This is all aimed at improving the patient experience through harnessing technology to streamline process, avoid duplication, save time and enable choice.
7. **Enhancing financial stewardship:**
   Through our SPE+ (Safe, Personal and Effective Plus) improvement methodology, potential cost savings of £1.85 million have been identified, with £1.82 million attributable to pay schemes and £34,821 to non-pay initiatives.

Further detail on these achievements can be found in Section 3.1 of this report.

Throughout the year, I have taken great pride in the dedication our teams have shown—both in delivering care and in supporting each other. Our Improvement Hub continues to build capability across the Trust, with 402 live quality improvement projects, including many of which were launched in 2024/25. Over 3,900 colleagues have received improvement practice training—laying a strong foundation for the future and helping embed a culture of continuous improvement.

Our commitment to partnership working remains firm. The launch of *One LSC and the continued development of a single vascular network and a new single service for pathology are* key steps in our collaborative journey, working with Blackpool Teaching Hospitals, Lancashire Teaching Hospitals, and University Hospitals of Morecambe Bay to strengthen care and performance regionally.

As we move forward, we also remain focused on supporting our workforce's health and wellbeing, ensuring help is available for physical and mental health needs.

I would like to extend my heartfelt thanks to our colleagues, volunteers, and partners for their dedication and compassion throughout the year. I am confident that together we will continue to go above and beyond for our patients and communities.

Looking ahead, our priorities for 2025/26 are to:

- Fully embed the SPE+ improvement approach

- Deliver safe, high-quality care
- Enhance sustainability and value for money
- Foster a compassionate, inclusive culture
- Build a healthy, diverse, and motivated workforce

The Trust Board has reviewed and confirmed that this Quality Account provides a fair and accurate reflection of our performance over the past year. It highlights our unwavering focus on patient safety, experience, and continuous improvement in delivering safe, personal and effective care at ELHT.

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.

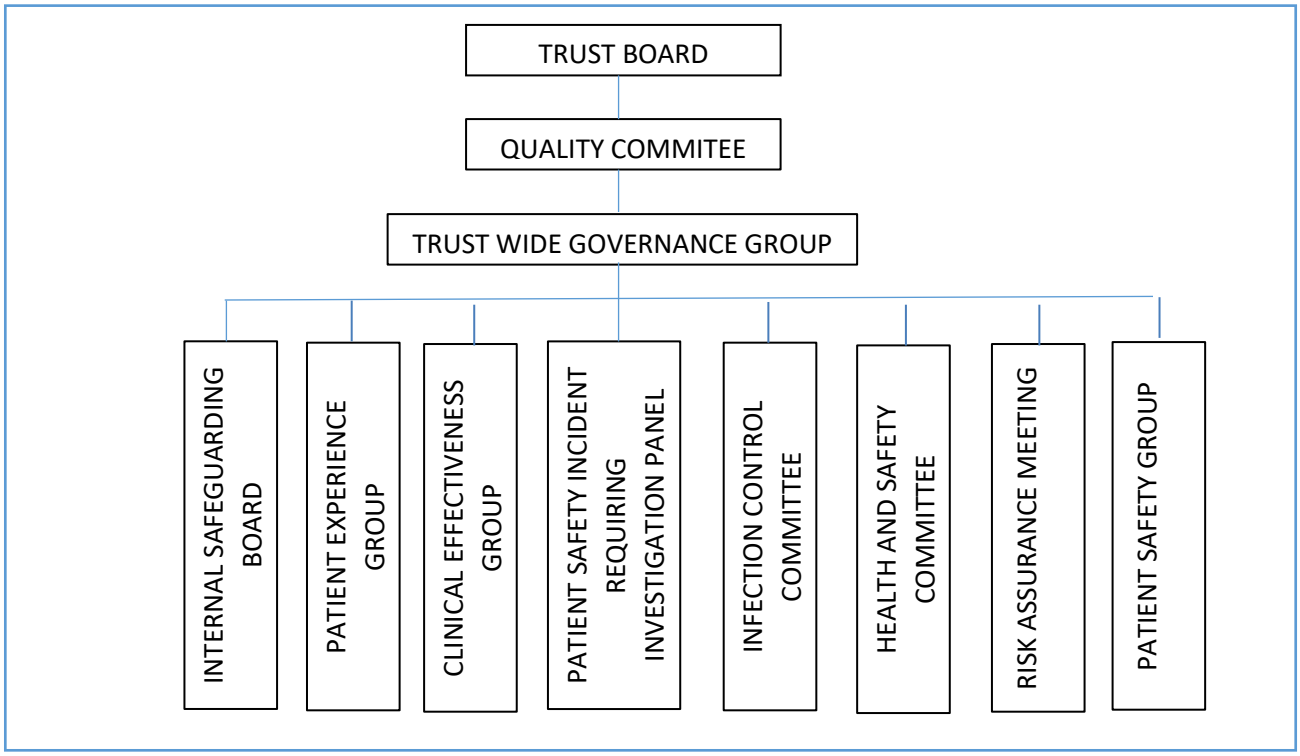
4. The Trust conducts the CQC-required national surveys to gather feedback from patients who have used our adult and children's inpatient services, Emergency Department, and Maternity services. This feedback informs the development and enhancement of our service improvement initiatives.

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).

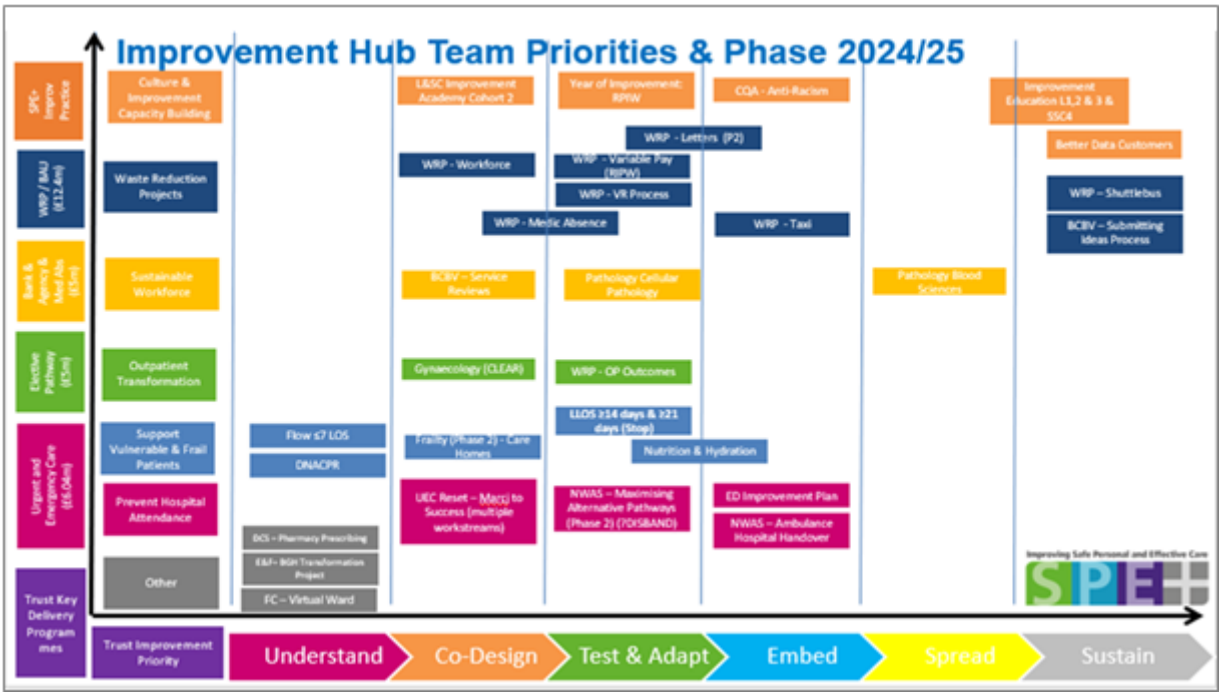
The Trust has identified a number of Key Delivery and Improvement Programmes to support the achievement of Trust goals. The Improvement Hub team will be deployed each year to directly support delivery of a sub-set of these priorities through application of the SPE+ improvement approach. This will be 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

The table below gives an overview of progress against the quality improvement priorities outlined in Section 2.3:

Please note that where data and metrics have been provided sample size will vary.

Key Delivery Programme:	**Improvement Project Title, Goal / Aim:**	**Achievements:**
SPE+ Improvement Practice Culture & Improvement Capacity Building Total numbers trained may also include Bespoke Improvement Practice Training	**Level 1 Improvement Practice – Awareness (Classroom via Trust Corporate Induction)** To provide awareness to new staff commencing employment within	• 63 x Corporate Level 1 Improvement Practice Training Induction Sessions completed = 915 new staff in post trained

delivered in addition to scheduled training by both the Improvement Hub and Improvement Colleagues within Divisions / Workshops and Colleagues in Training / External Colleagues Classroom sessions temporarily ceased on 09/12/24 as per Trust guidance in order to support operational delivery.	ELHT to the SPE+ approach and Improvement practice within the Trust.	
	Level 2 Improvement Practice – Contributor (Classroom) To allow staff to develop a foundation knowledge of SPE+ Improvement Practice within ELHT	• 14 x Level 2 Improvement Practice Training Sessions = 122 staff trained
	Level 2 Improvement Practice Bitesize – (In-person / Virtual) 1. TIMWOODS 2. 5Whys 3. PDSA To provide bitesize training of the 4 core tools covered within Level 2 Contributor classroom session. This allows staff to develop a foundation knowledge of core improvement tools within a 15-minute session.	Number of staff trained in each tool: • TIM WOODS = 779 • 5 Why's = 448 • 6S = 345 • PDSA = 167 This covers multiple sessions completed both face to face and virtually via MS Teams. Number of specific requests sent to IH from teams within the Trust via SharePoint site = 22
	Level 3 Improvement Practice – Lead (Classroom) To allow staff to develop a deeper understanding of SPE+ Improvement Practice within ELHT.	• 2 x Level 3 Improvement Practice Training Sessions = 7 staff trained
	Level 4 – Coach KATA	• 1 x Level 4 Kata Improvement Practice Training Cohorts = 20 staff trained. Joint delivery between Central IH Team and DCS Division (Therapies)
	Level 4 – Coach Clinical Quality Academy	• 4 Teams • 22 Cross-Divisional & MDT Members • 9 Virtual & Face to Face CQA Sessions held

	The Learning Tree – bringing Learning Home To increase active engagement in the outcomes of Patient Safety Incident Investigations (PSII's) by the MfOP MDT (C1, C3, C5, C9 & C11) by September 2024.	• 96 x response from Patient/Services users returned as part of this project • Began testing the first test of change idea on 02.09.24. This was a 7-minute brief to cascade learning following a patient fall • A 7-minute brief is an evidenced based tool and is used in organisations as a quick and simple way to share learning on a range of topics • The foundations of the work that the group did as part of the CQA, is continuing to be built upon and is now embedded as part of the Quality Governance improvement plans moving forwards.
	Team Arushi - Anti-racism & Inclusion To become an intentionally Anti-Racist organisation.	• NHS Northwest BAME assembly bronze certification accomplished • Being an intentionally anti-racist organisation charter approved by Executive and communicated to Trust. • Anti-Racism staff survey designed and deployed. Survey data collected and analysed over 3 periods, • Anti-Racism training programme designed and deployed including "train the trainer" workstream.
	The Healers - Pain Management in the Emergency Department To reduce complaints related to pain management in ED, timely and safe pain management. Developing knowledge and confidence	• Initial assessment of pain and documentation of the patient pain score has increased from 70% to 100% • No statistical change in reduction of complaints (slight downward trend).
	Hospital at Home – Developing the Hospital at Home Service Hospital at Home allow patients to receive the care they need at home, safely and conveniently rather than in hospital. They also provide systems with a significant opportunity to narrow the gap	• The project has achieved the aim to develop an intravenous fluid bolus pathway and embed this into everyday practice. From inception of the initial idea, through working groups, governance boards, piloting to ratification and feedback. • Whilst the scope of this project was intentionally small, it will facilitate rapid of other intravenous pathways which will allow more patients to remain at home and receive an equivalent level of care. • 19 potential admissions have been avoided by administering IV Fluid Bolus and utilising the wrap around model of Hospital at Home

	between demand and capacity for secondary care beds, by providing an alternative to admission and/or early discharge.	• 22 patients have been assessed for IV Fluid Bolus, 5 Patients did not meet the criteria for IV Fluid Bolus, 19 Patients met the criteria as per SOP to receive IV Fluid Bolus, of which all 19 remained safely in their own home and fully recovered. • Cost savings based on ED episode, Ambulance conveyance and 1 night AMU stay £19,912 • The Hospital at Home Team have had a GIRFT review, and as part of this have received recommendations to implement and are using these to develop a framework. Therefore, this CQA Project will be monitored via GIRFT and no longer the Improvement Hub.	
Colleagues in Training The Improvement Hub team, work in conjunction with the Department of Education, Research and Innovation (DERI) and UCLAN to support a range of trainees and newly qualified colleagues to develop their improvement skills and undertake improvement projects – '*Our Improvers of the Future'*		Multi-Professional Preceptorship Level 2 Improvement Practice Training – Contributor sessions	• 4 x Preceptorship sessions delivered virtually via MS Teams • 191 x newly qualified multi-professional colleagues trained.
		Junior Clinical Fellow (JCF): Introduction to Level 3	• 1 x session delivered via MS Teams • 140 x Junior Clinical Fellows in attendance
		Foundation Year 1 Dr training. Improvement Practice Training – Contributor sessions	• 1 x session delivered face to face • 57 x FY1's in attendance
		SSC4 Medical Students (UCLan) 2023/24 cohort – Level 3 Improvement Practice Training – Lead Workshops	• 8 x number of QI workshops delivered (2 x within FY 2024/25) • 175 x SSC4 Medical students (supported across the Burnley and Westlakes Campuses) • 13 / 28 SSC4 QI case studies submitted by the ELHT Central IH Team to UCLan • 42% of SSC4 cohort chose ELHT / Secondary Care QI case studies (75/175)

		• 2023/24 SSC4 cohort grades: 34 x Merits, 84 x Good Pass, and 52 x Passes
	SSC4 Medical Students (UCLan) 2024/25 – Level 3 Improvement Practice Training – Lead Workshops	• 10 x number of QI workshops delivered (2 x within 2025/26) • 8 x number of face-to-face QI Drop-in sessions • 199 x SSC4 Medical students (supported across the Burnley and Westlakes Campuses) • 9 / 21 SSC4 QI case studies submitted by the ELHT Central IH Team to UCLan • 42% of SSC4 cohort chose ELHT / Secondary Care QI case studies (83/199)
Improving the SSC4 experience undertaking QI in Secondary Care To improve the overall feedback from the SSC4 Medical Students that undertake their QI Projects within Secondary Care (ELHT)	• Increase in number of SSC4 Workshops due to size of 2024/25 cohort • Following on from the introduction of Eventbrite QI case study selection in 2023/24, we have utilised the University Blackboard to create a groups function to allow selection of the QI case studies • ELHT Secondary Care QI case studies continue to link to 'live' programmes of work and identified key improvement priorities • Introduction of workshop proforma's to support completion of formative and summative reports for scheduled deadlines • Further specified and condensed improvement tools for students • Introduction of bi-weekly drop-in sessions throughout the year.	
Year Of Improvement (YOI) For >3000 members of staff to have engaged in improvement practice core activity by 30th April 2025 (as per YOI Proposal Briefing Paper) RBH = Royal Blackburn Hospital BGH = Burnley General Hospital CCH = Clitheroe Community Hospital NHSE = NHS England	• YOI launched on Monday 29th April 2024 • 3 x Rapid Process Improvement Weeks completed with a focus on: 1) Level 2 Contributor Training offer. 2) Marketing and Communication of Improvement Hub and Training 3) Visual Management • Delivery and design of L2 Contributor reviewed, and standard work created to incorporate an offer of bitesize training. Cost per head for L2 training significantly reduced	

	by creating bitesize sessions. Cost per head reduced from £10.72 - £00.10p • Level 1 Awareness delivered within ELHT Corporate Induction commenced in July 2024, slides/ content revised Jan 2025 • Comms created and shared with Trust to increase awareness and engagement • IH (Improvement Hub) SharePoint page revised to include button for teams to request training from IH team • 6 x 'pop up' engagement days completed over RBH, BGH, CCH and Accrington Pals sites engaging with 279 x staff • SPE+ training offer revised – plans in progress to develop and commence new Level 4 from May 2025 • Training / coaching pack being developed re: RPIW aiming to increase capability within workforce to run RPIW's independently within own teams / areas • PNA (Professional Nurse Advocates) improvement training in development as per instruction from NHSE • Multiple PDSA's completed re: report out, induction, sign- up sheets for induction, staff engagement.
Creating Better Data Customers 1. Engaging with others 2. Having the right data skills and knowledge 3. Having the right systems 4. Knowing the data, you have 5. Making decisions with data 6. Managing and using data ethically 7. Managing your data 8. Protecting your data 9. Setting your data direction 10. Taking responsibility for data	• 5 x sessions • 34 x multi-professional colleagues attended.
Total number of substantive and staff in training engaged in SPE+ Improvement Practice Training = 3900	

Key Delivery Programme:	**Improvement Project Title, Goal / Aim:**	**Achievements:**
Waste Reduction and Cost Improvement To identify waste reduction opportunities that contributes to the Trust WRP target	**Waste Reduction & Cost Improvement Ideas Submission Process** To identify waste reduction opportunities that contributes to the	The previous process for staff to submit Waste Reduction and Cost Improvement ideas has been reviewed and is currently under further development to ensure that all staff receive a response and feedback on progress following submission of an idea and that all submitted ideas are reviewed in the right place in a timely manner.

	Trust WR and CIP target	• New ideas form created and launched (January 2024) • 1000 ideas submitted
	ELHT Shuttlebus To support the Tender of the ELHT Shuttlebus Service Provider in order to reduce the anticipated total costs of the Shuttlebus Service by ≥50% by the 1st of April 2025	• 8 x Shuttlebus Improvement meetings were facilitated by the Improvement Hub to provide assurance to the Executive Board members, that a joint review had been undertaken by the Trust and ELHT Staff Side Union representatives, in order to mitigate the potential impact of reducing the current shuttlebus service on staff and public users. • A joint aim and shared vision for the On the 1st of April 2025, the new commercial service was introduced and transferred over to Moving People. A new timetable (Monday-Friday) has been developed to meet the needs of the majority of customers and will be continually reviewed to provide the best possible services.
	Taxi's To reduce avoidable Taxi usage (Letters, Medication, Staff and Patient Transfers) Trust wide by £30,000, capping spend at £250,000 by the 31st of March 2025.	• We have seen a downward trend month on month in the last financial year (2024/25) with cost reducing by over £35,000 • In order to further reduce this cost to the Trust a number of key interventions have been implemented: 1. Immediate stop on the use of taxis for TTO's – To Take Out (August 2024) 2. Launch of an electronic Taxi Booking Form to provide additional controls for in hours and out of hours and to limit the number of staff with authority to approve taxi booking requests (September 2024) 3. Promotion of Comms via Trust ELHT website and Poster (September 2024) • **Next Steps:** 1. Revise the ELHT Taxi Usage SOP (Standard Operating Procedure) 2. Develop Divisional Reporting – Usage, Reason and Cost 3. Display Patient Comms Poster in all ward areas and departments 4. Further revise and automate electronic Taxi Booking Form
	Assign Outpatient Letter to the most appropriate form of postal delivery (Phase II) To reduce the number of patient letters being	• A 125,715 reduction in letters being sent by the Trust on the previous year leading to 16.3% reduction (2024/25) • There has been a 16.5% reduction in use of Taxi's to deliver patient letters in months 7-12 (Oct 24- Mar 25) • In months 1-11 we had a reduction in the number of bank shifts to deliver patient

	sent via the ELHT post room* by 50% by the 31st of March 2025 (*includes via 1st & 2nd Class and via Taxi)	letters, however in month 12 (March 2025) we had an increase due to demand on the service and sickness within the department • A 22.9% reduction in the number of scheduled runs to deliver letters from transport in months 7-12 (Oct 24- Mar 25) • A £214,726 reduction in spend on the previous year (2023/2024) • Better understanding of the current methods of postal delivery, the digital format when sending patient information and available data around the internal/external postal processes • SMART Aim revised to incorporate the patient experience and accessibility needs.
	Medics Absence (Phase II) To ensure a fair and consistent approach to the management of all medical and dental absence and unavailability's, that contributes to a reduction in the medical and dental variable pay spend by 10% (£2.4m) by September 2025. WTE = Whole Time Equivalents	• Phase II initiated in October 2024, more focus placed on the rollout and implementation of eRoster and improving all absence management as a cost benefit of this • Core eRoster Project team and Improvement Hub support identified • Review of current state completed, and baseline metrics identified • Standardised four-page reporting tool co-designed between Improvement and eRoster Project team, as per reporting timetable • Divisional Medical eRoster key stakeholders identified and Medical Roster Steering Group relaunched • IT settings in eRoster checked, in preparedness for the roll out of the eRoster project • Roll out plan created (6 Steps) with supporting implementation pack and commenced • SMART Aim reset and finalised • SharePoint site designed by eRoster Project team to provide additional support for implementation and information for the rollout • eRoster Project team supported the Trustwide "LOOP" implementation • Additional 2 x WTE staff joined eRoster Project team and Admin support to help accelerate the project • Communication Plan developed and in place • Contingency plan agreed with RL Datix if system outage • Regular engagement with Divisional Directors of Operations to identify Directorate Teams priority order

		• 'Live' data report created to support reporting and engagement (i.e. Divisional Workforce Assurance Meetings) • Rostering Policy updated • Initial review of MEC Division commenced, as follow-up from the original pilot • New Bank booking process for medical and dental staff being trailed in the General Medicine Directorate • Annual Leave options reviewed, and paper submitted for review and agreement • 6 / 43 (13.9%) of Directorate Teams Fully Rostered electronically (baseline 10%) • 285* / 1136 Fully Rostered *please note that some Directorates were fully rostered electronically prior to Phase II commencing • **6 Step Implementation Plan:** 1. Initial Meeting = 19 x completed 2. Complete Implementation Pack = 17 x completed 3. Set-up = 13 x completed 4. Training = 24 x staff completed 5. Agree 'Go Live' date = 12 x agreed 6. Post Implementation Support = 1 x Team
	Reducing the Spend on Variable Pay To design and deliver 6 x Variable Pay Rapid Process Improvement Weeks (RPIW's) based on the successful work carried out by Leeds and Lancashire Teaching Hospitals to solely focus on reducing variable pay spend across all teams that are reliant on the use of bank and agency, across all of the Divisions within the 2024/25 Financial Year	• ELHT RPIW approach designed underpinned by the SPE+ Improvement Practice Training approach • 5 x RPIW's to reduce Variable Pay Spend delivered January – March 2025 (months 10-12) • 35 x Directorate Teams attended from across the Divisions (Agenda for Change and Medical & Dental) • 57 x ELHT staff members have attended that • Over 88 x schemes have been identified to reduce spend across the Pay (x 74) and Non-pay (x 14) expenditure • 58 x ELHT staff members have been trained on 3 x Bitesize Improvement Tools – TIMWOODS, 5 Whys and PDSA's (Level 2 Contributor) as part of the RPIW's • In-week creation of Bank & Agency and Shift Rate calculator and Reducing the Pay spend SharePoint site • Approximately £1,854,864.74* potential cost savings identified as part of the RPIW's *please note that these will require cross-checking with the 2024/25 and 2025/26 Waste Reduction and Cost Improvement Tracker and split into Pay and Non-Pay schemes, however early calculations predict

		£1.820,043.75 attributable to Pay schemes and £34,821 to Non-Pay schemes • 2025/26 Aim agreed: To reduce the variable pay spend (bank, agency and overtime) across all teams that are reliant on the use of bank, agency and overtime, across all of the Divisions within the 2025/26 Financial Year by £13m by the 31st of March 2026 • Based on the success of the 2024/25 RPIW's, a further 26 x RPIW's have been scheduled to take place across the 2025/26 Financial Year
	Workforce: Improving Trustwide Sickness Absence The primary objectives are: 1. To reduce sickness absence rates across all departments to align with or improve upon national NHS benchmarks 2. To promote physical & mental wellbeing among staff through targeted interventions and supportive policies 3. To enhance employee experience, engagement and satisfaction.	• The top 10 departments/teams with the highest sickness absence rates (by cost/days) identified bi-monthly. • 7/10 department/teams identified in both Months 10 & 12 (bi-monthly), 50% (5/10) have reduced sickness absence (by cost/days), 20% (2/10) have increased sickness absence (by cost/days) since the previous month (10). • Four e-Learning Sickness Absence training programmes have been developed and/or promoted in order to support sickness management from an individual and line manager perspective. A total of 315 staff have accessed these in 2024/25: 1. HR Best Practice 2. HR Bitesize – Long Term Absence 3. HR Bitesize Short-term Absence 4. Managing Sickness and Absence • Targeted intervention and support from Business Partners & Occupational Health has identified three focus areas for improvement: 1. Sickness Prevention 2. RTW processes (Return To Work) 3. Reporting & Supporting individuals returning to work • Trustwide Project M bespoke Workforce Data session held for aspiring leaders and managers to improve sickness absence knowledge, monitoring and reporting • Change to the management of Long-Term Sickness (LTS) for Medical and Dental Staff – this is now being reviewed and managed by the Human Resources Team • Infection Control session held to increase staff knowledge and compliance with infection control processes, in order to reduce gastric/flu related sickness absence Check & Stay conversations (monthly check in with all staff) piloted. Outcomes included: increased staff

		morale, increased staff belonging and reflected a positive effect on sickness absence.

Key Delivery Programme:	Improvement Project Title, Goal / Aim:	Achievements:
Sustainable Workforce	**Trustwide Service Reviews**	• Service review engagement initiated with 17/40 directorates (42%) • Central database of ~ 300 improvement opportunities identified • More than 40 ideas completed – this included the handing off of ideas to other workstreams • Formal processes being developed to hand-off ideas to other workstreams including WRP / CIP, Procurement, Variable Pay and Income.
	Pathology Cellular 1. Increase productivity in Cellular Pathology 2. Reduce number of 2WW & Urgent samples in backlog waiting more than 10 days 3. Reduce dependency on bank & agency staff and processing off-site. 4. Reduce sample rejection rates.	• Value Stream Map developed to support workforce (demand & capacity model) planning. Each significant step mapped including volume and lead-time leading to calculation of WTE required • Identified opportunities to improve productivity including reducing time to locate one-off requests • Kata Training (Improvement Practice Training Level 4 – Coach) delivered to 3 x staff members.
	Pathology Blood Sciences 1. Reduce the volume of samples arriving for processing between 16:00hrs and 20:00hrs 2. Reduce current over-spend in department	• Improvement workshops completed with staff and management across 3 main areas (Specimen Reception, Blood Transfusion & Haematology) • Improvement wall and huddles re-established • 10 areas / quick wins identified for improvement including Urine samples, out-bound calls, equipment utilisation and management of stores • Recruitment ongoing to substantive posts and on-track as per sustainable workforce plan • Bank and Agency spend decreased as established vacancies filled.

	(associated with over-time, bank, transportation and equipment) 3. Implement a sustainable workforce plan by the 31st of March 2024	

Key Delivery Programme:	Improvement Project Title, Goal / Aim:	Achievements:
Elective Pathway Outpatient Transformation	**Elective Outpatients Improvement Programme** All outpatient booking, New, Follow Up, waiting list, holding list, Advice and Guidance, Patient Initiated Follow-Up, and Video Consultations.	• Development of an Outpatient Transformation Programme for 2024/25 • Outpatient Transformation Programme scoping complete for launch in 2024/25 • Advice and Guidance available across all specialties • PEP+ roll out plan in place and first specialties live with plans to complete in 2025 to reduce missed appointments • Outpatient procedure recording levels back to pre-ePR go live levels and outpatient Mpage successfully implemented • Outpatient utilisation review completed • GIRFT further faster assessments completed across all specialties and improvement plans in place • Improvement plan developed to increase the number of patients placed in Patient Initiated Follow-up pathways for implementation in 2025.
	Gynae Outpatients (CLEAR) The intention is to improve the gynaecology outpatient pathway to reduce waiting times and improve quality.	• Workshop completed on the 4th of July 2024 including clinical consultants, nursing, and members from system including General Practitioners • Decision made to continue as a service wide transformation piece with support from CLEAR.

Key Delivery Programme:	Improvement Project Title, Goal / Aim:	Achievements:
Quality Support vulnerable and frail patients	**ELHT Nutrition & Hydration (N&H) Collaborative**	• The ELHT N&H Collaborative has been running for 342/464 days • 11/12 of the original teams are still participating (due to a ward closure)

	For 100% of N&H Project Teams (x 11) to go back to basics for nutrition and hydration, for all inpatients with a decision to admit by 31st July 2025 1. **Delivery:** Speed of Meal Service – from the food trolley arriving to last patient receiving their meal 2. **Quality:** Overall MUST Compliance for all 11 x N&H Collaborative Teams within 24hrs of Admission (Excludes Emergency Department, Maternity & COAU) 3. **People:** 100% patient satisfaction with lunchtime meal service 4. **Cost:** 0% food waste left on plates	• N&H Planning and Guiding Team still established and meeting weekly • Learning Sessions 1 & 2 Workshops (4days in total) have now taken place, with Learning Session 3 scheduled to take place in April 2025 (2days in total). These sessions actively encourage "collaborating" with colleagues • 10 x Executive Sponsor visits have taken place by the Chief Nurse and/or Medical Director and Improvement Hub Team members – excellent feedback received • 3 x Project Team engagement and coaching in-reach ward visits undertaken by the Improvement Hub Programme Lead, Project Support Officer and the AHP Consultant for Nutrition & Hydration across February 2025 • Development and roll-out of an electronic audit and reporting system (November 2024 – April 2025). MUST PowerBi Report already in place prior to this, as it pulls directly from the ePR. Across all 4 x metrics approximately 33,638 submissions have been recorded As of March 2025, please find the current compliance for the lunchtime meal service: 1. **Delivery:** Speed of Meal Service – from the food trolley arriving to last patient receiving their meal is ≤5mins 40secs = 1 / 11 Project Teams, however 10 / 21 wards and departments (107 x submissions) 2. **Quality:** Overall MUST Compliance for all 8 / 11* x N&H Collaborative Teams within 24hrs of Admission is ≥95% = 55.7%. This is slightly higher than the Trustwide compliance of 51.1%. *Please note that the Emergency Department, COAU and Maternity areas are excluded from MUST (32,868 x submissions) 3. **People:** 100% patient satisfaction with lunchtime meal service = 50% of patients surveyed rated their meal as good (341 x submissions) 4. **Cost:** 0% food waste left on plates = 44% of food has been left on plates (322 x submissions)

		• 3/8 Monthly Collaborative Touchpoint Calls taken place • Original Change Package of evidenced based / best practice further reduced. 4 x standardised elements have now been agreed to be implemented across the 11 x participating teams, with a view to scale-up and spread Trustwide (where applicable) • The standard work designed and agreed at Learning Session 3 (April 2025) for Meal Service Delivery (Colour Coded Bays) and MUST (Weighing Patients) will be finalised and rolled out with the next 30-60days • Food Waste Project Group launched in February 2025. Planned Gemba Walk / Go See to be undertaken by the Improvement Hub in April/May 2025 to observe current plate food waste processes (RBH Main Restaurant) • Discussions and planning to spread beyond pilot commenced • ELHT N&H Collaborative Celebration Event to take place in June/July 2025.
	LLOS >14days and >21days LLOS = Longer Length Of Stay 1. To reduce LLOS from >14days to 9 days by March 2025 . 2. To reduce patients who do not meet criteria 2 reside from 6.5% to 5% by March 2025 3. To roll out the Discharge Dashboard across ELHT ward, this is to support flow through the hospital and help reduce LLOS. To reduce waste within the system and for 100% of staff trained in the use and compliance of the dashboard by September 2024.	• The Discharge Dashboard is now embedded and is being used across ELHT. Training has been delivered by the MEC Improvement Matrons and being continuously monitored • Auditing of the MDT Board Rounds is underway, and compliance is currently being analysed • The dashboard is being used to form part of reporting to NHS England • A policy for Discharges was co-designed by the MEC Improvement Matrons, Pharmacy & the Discharge Matrons.

	Flow <7days LOS LOS = Longer Length Of Stay Wouldn't it be good if we could if reduce the length it takes for patients once ready for discharge home from AMU (pending baseline data) by the 31st of July 2025	• A KATA board has been set up and is on the Improvement Wall in AMU • A couple of PDSA's have been undertaken however it has been agreed to disregard them • A further PDSA is now underway to improve the time from decision to discharge to the actual time a patient leaves the ward for home. The baseline data is currently being collated and finalised; However initial analysis has identified that the Average LOS on AMU was 2.45 days (24/03/25-29/03/25).
	DNACPR Improvement Collaborative	• Launched project with a Stakeholder event on 10/12/2024 involving 20 staff members from ELHT & Hospice services • Set up Expert Faculty and have established a monthly meeting from April 2025 • Established 4 key areas of focus • Planned launch of project with applications for from May 2025 • Planned Learning Sessions / action periods & a celebration event over the next 18 months.
	Frailty – (Phase I) L&SC System for Improvement – Engineering Better Care (EBC) To train all staff in Primary Care Network's across Pennine Lancashire on Frailty	• 1181 staff trained at PCN level in Frailty Identification • 12 / 14 PCN's across Pennine Lancashire have had frailty training. 2 x PCN's still remain but there are no further dates planned with Burnley East & Ribble Valley.
	Frailty – Care Homes (Phase II) Wouldn't it be great if we can provide valuable education & information to all our care homes and the identification, prevention & mitigation including reduced attendances to ED and admissions by the 31st of March 2026.	• Observations undertaken in 5 x care homes with the Care home Nurses, ICAT and NWAS to understand what they deliver and what this requires • Established links with the teams that are currently delivery training into care homes • Kick-off meeting held in February 2024 with key members to discuss what the training package would look like. The ask was to collate all the information on what they are doing and look at current data.

	ED = Emergency Department ICAT = Intermediate Care Allocation Team NWAS = Nort West Ambulance Service	• Road Map of the services is currently in co-design • Launch of the 'Never say No' initiative in June 2024 • Launch of the 'Call before convoy' initiative in August 2024 • There has been a drop in ED attendances (approximately 1146 less attends) from care homes since the first iteration of the education package was rolled out back in August 2024 by the Care home Nurses and NWAS and an increase in the number of referrals to the Care Home Nursing team.
	Public Participation Panel (PPP) To improve the role & effectiveness of the ELHT Public Participation by March 2025	Core Planning and Guiding Group continuing to meet to review progress against 4 x Root Causes identified. Progress below: **Root Cause 1 – Data and Metrics** • Meeting with Director of IT and/or Senior Management • Identified metrics/KPI's added as a standing item on the PPP Agenda • PPP meeting materials to be given 7days in advance to allow PPP members to arrive prepared to meetings ready to actively participate and contribute – the pilot period highlighted that out of 9 x meetings 56% of meeting materials were circulated within 7days, 33% within 6days and 11% within 5days. Further PDSA's identified. **Root Cause 2 – Involvement in QI and Service Development Projects** • Meeting with Director of Service Development and/or Improvement Senior Management – ongoing support from a member of Improvement Hub Team. Support and visibility at an Executive Level – attendance at PPP quarterly • Ensuring that the right PPP member and expertise is aligned with the right project. Requests for PPP support added as a standing item on the PPP Agenda • New Request Form for PPP involvement developed, and tracker updated monthly • Promote PPP role via PPP intranet page across 3 core pages: 1. PPP Volunteer Role Profile – Total views = 199, Individual views = 135,

		Engagement time = 80seconds and Clicks on page = 527 2. Get Involved PPP page – Total views = 127, Individual views = 77, Engagement time = 41seconds and Clicks on page = 101 3. PPP page – Total views = 42, Individual views = 26, Engagement time = 49seconds and Clicks on page = 101 **Root Cause 3 – Recruitment Plan** • PPP role profile to added website page • PPP role profile advertised via Lancashire Volunteering Partnership website • Gap analysis tool matching PPP membership skills to projects in development • Training Programme for new starters developed • Wider engagement with community groups – primarily to discuss patient stories but also to publicise the PPP. **Root Cause 4 – Marketing and Comms** • PPP role profile to added website page – 3 x new recruits in the last 12months • PPP activity publicised via Trustwide Comms - Trust Teams Brief (April 2024) • PPP role, function, stories and activity advertised on Trust Intranet page • PPP pop-up banner designed and displayed to promote and publicise the PPP
	CQA Well-Led Self-Assessment	Improvement evidence uploaded and submitted for: • QS1 – Shared Direction and Culture • QS2 – Capable, Compassionate, Inclusive Leaders • QS3 – Freedom to Speak-Up • QS4 – Workforce Equality, Diversity and Inclusion • QS5 – Governance, Management and Sustainability • QS6 – Partnership and Communities • QS7 – Learning Improvement and Innovation • QS8 – Environmental Sustainability

Key Delivery Programme:	Improvement Project Title, Goal / Aim:	Achievements:
Urgent & Emergency Care Pathways Prevent Hospital Attendances	**Emergency Department (ED) Improvement Plan** For ED to achieve a Green NAPF status by the 30th of September 2024 (or the next assessment) NAPF = Nursing Assessment Performance Framework ICB = Integrated Care Board	• Development of the ED Improvement Wall and continuous improvement approach in ED • Establish ED Wall improvement huddle – x 33 • Visits from various colleagues and partners from across the system (including NWAS; Primary Care; ICB).
	NWAS Collaborative – maximising alternative pathways To reduce the number of ambulance conveyances to the ELHT Emergency Department by 30% by the 30th of September 2024 IHSS = Intensive Home Support Services TIA = Transient Ischaemic Attack UCR = Urgent Care Response	• Dedicated phone line for NWAS crews to ICAT • ICE referrals combined with Introduction to Service • IHSS refresher for patients known to IHSS who self-present to ED • NWAS crews on scene referring direct to IHSS • District Nurses escalating to IHSS before ringing 999 • Never Say No Campaign • Head injuries pathways • TIA Pathway • Increase number of referrals for 2hr UCR response • More referrals from Care Homes to 2hr UCR than ED attends • Ambulance conveyance remained static over the year.
	Ambulance Handovers to the Emergency Department (ED) For 90% of ambulance handovers to ED to occur within 30 minutes of arrival by the 31st of December 2024.	• Improvement on performance – baseline 40% to 71% by 30th November 2024 • HAS compliance at 95% and maintaining this performance (baseline 90%) • Embedded improvement approach to the weekly ambulance liaison group (ICB; NWAS; ELHT colleagues) • Consistently good feedback from NWAS re co-working to improve hospital handover.
	MEC Division – Focused	• ED Productivity – time to be seen – at RBH ED overall time reduced from 158 minutes

	improvement priorities Key priorities have been identified by the Divisional Triad including Variable Pay Emergency Pathway; ED Productivity; MOFD National coding; LOS <7days. All have project structure and are underpinned with improvement method.	(baseline January 2025) to 90 minutes (March 2025) • Time to be seen between 8pm and 8am reduced from 222 minutes (January 2025) to 111 minutes (March 2025) • National Discharge delay codes accuracy improving, latest spot check audit showed 60% accuracy. The delay codes are now being utilised in the MEC Daily Discharge huddle; and the Longer length of stay meeting • ED Variable Pay focused on ED Practitioners and ED Nursing has seen a reduction in bank hours filled.
	UEC Reset – March to Success Whole team effort from across the Divisions and our Partners to improve our patient's experience throughout their UEC journey. March is the start of direct focus from pre-hospital to discharge recognising the key stages of the patient's journey to inform our programme of work.	• Engagement with key stakeholders • Focused pieces of work to deep dive to gain understanding • Scope clearly defined ensuring the patient journey is at the heart of the improvement work • 41x ideas/pieces of work suggested A selection of work is underway: • Deep dive decision to admit from ED for learning and focused improvement • Utilisation of inpatient rehab beds and alternatives to inpatient rehab • IHSS on AMU test of change • Introduction of MEC Daily discharge huddle focusing on daily problem solving.

Key Delivery Programme:	**Improvement Project Title, Goal / Aim:**	**Achievements:**
Other Improvement Priorities / Adhoc Requests	**Hidden Disabilities** Increase declaration rates for staff with disabilities	• Increased declaration rate of disability status from a baseline of 5.15% to 6.20% • Reduction in unspecified declaration category from 31.81% to 30.91% • Utilisation of special leave has varied throughout the year but remains the same as the previous year with no significant shift or change • Supported the development of the Neurodiversity Toolkit • Ad hoc requests for support and guidance from both staff & managers • Established Neurodiversity Network which now has over 60 members, meeting quarterly with a supportive SharePoint site.

		• Over 80 posts on the Staff Facebook page have maintained the momentum of the project and kept staff informed and engaged.
	Serum Potassium Reduce the number of tests exceeding 10 hours at each GP practice	• Collection times and number of collections from GP practices reviewed and modelling for 2025/26 commenced • Immediate action that any sample over 10 hours is now identified and no longer rejected • Number of samples with high potassium over 10hours remains variable and no significant improvement has been identified at this point. Focus for 2025/26 will be to reduce the number of hours the samples take to be retrieved from the GP surgeries.
	Complaints Mapping Workshops To improve the timeliness and quality of open complaints, across all Divisions by the 31st of July 2024	• Two face to face and two virtual workshops were delivered (April – June 2024) to: 1. Understand divisional processes and work towards standardised processes – what does good look like? Achieved in Workshop 1 2. To understand each other's roles and responsibilities – Achieved in Workshop 1 3. To understand the data and to have one version of the truth Achieved in Workshop 2 4. Identify areas for improvement / change ideas – 38 x change ideas identified in Workshop 1 5. Identify opportunities to work smarter – Test of Change / PDSA's agreed in Workshop 2
	Falls Workshop Summit	• One face to face workshop (11 x attendees in total) delivered (September 2024) to: 1. To understand the current state and divisional processes - Achieved 2. Review the existing Falls Change Package – Achieved 3. Work towards standardised processes – what does good look like? Wrap around care and Inpatient Journey with no fall future states completed 4. Identify opportunities to work smarter – 21 x change ideas identified 5. To reinvigorate, scale up and spread an agreed Falls Change Package - Ongoing

	Quality Governance Improvement Workshop To co-deliver a stakeholder engagement session in response to concerns raised by the Coroner. 1. To improve the standard of information shared for inquests 2. To improve the response to concerns raised via the Coroner's Office, Medical Examiners (ME) and Complaints Team 3. To improve the triangulation of Quality Governance information between all teams 4. To improve the Trusts reputation with key stakeholders (Patients, Families, Coroner, ICB, CQC) 5. To minimise any further psychological harm to those effected by care and treatment issues	• Facilitation of discussion (18 attendees) and mapping of current and future state – Achieved • To provide assurance of good systems and processes in place – Achieved • Identify waste within the current system and processes for managing concerns using TIMWOODS Tool - Achieved • Support the Identification and agree session outcomes, actions and timescales to complete improvement work – Achieved Initial Key Areas for further improvement are: • Improve training offer for clinical staff in handling incidents • Closer working / communication between the ELHT ME and Legal services • Explore opportunities in Datix to theme incidents to inform learning and improvements.

Improvement Hub Activity

There are currently **402** Improvement Projects registered as 'live' from 2018 to April 2025 – 'live' projects are classified as those in one of the first 5 of the SPE+ 6 phases of improvement (Understand to Spread).

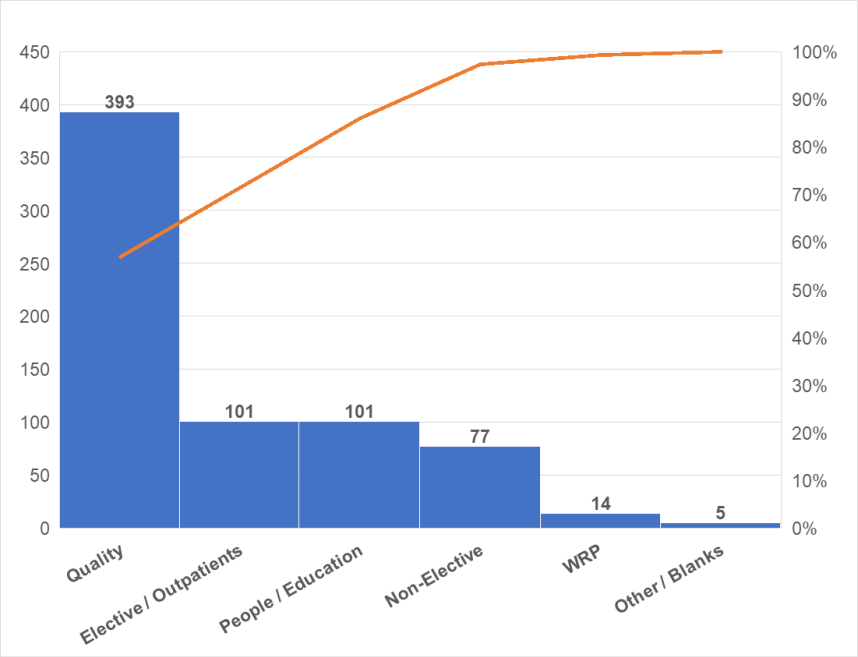
Improvement Projects Registered by Key Word Condition (2018 – April 2025)

Improvement Projects Registered by Key Word Process (2018 – April 2025)

Total number and % of Improvement Projects Registered per Phase (2018 – April 2025)

Understand	Co-design	Test and Adapt	Embed	Spread	Sustain
331	38	96	38	17	173
48%	5%	14%	5%	2%	25%

Total number and % of Improvement Projects Registered per Key Delivery Improvement Programme (2018 – April 2025)



3.2 Harm Reduction Programme

Following the submission of the Harms Reduction Summary Closure Report in March 2024 to the ELHT Quality Committee. Quality Committee Members confirmed that they were content to support and approve the full transition of HRPs to local priorities and for improvement resources to be redirected to supporting other improvement priorities for 2024-25.

Therefore, any current PSIRP and/or Quality priorities supported by either the Quality Governance or Improvement Hub Teams are captured under sections 2.1 and 3.1.

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.

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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 of 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

	VTE RISK Assessments 22-23	1st April 2024- 31stMarch 2025				
		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:

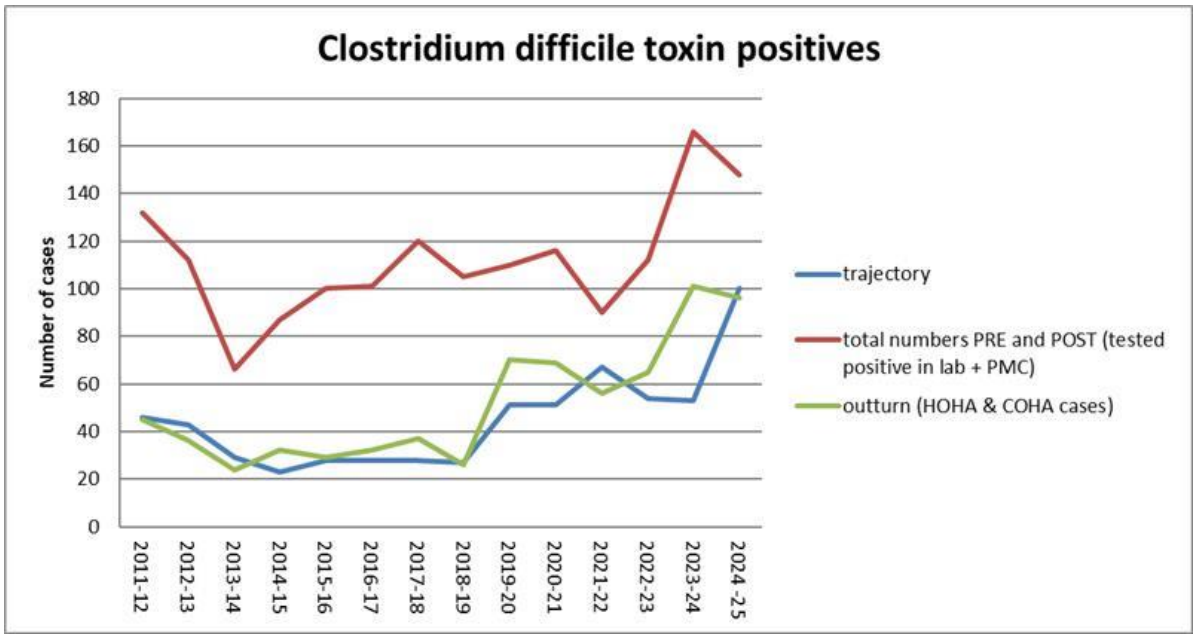
- VTE committee that was reinstated after a period of pause for nearly 18 months from November 2023 continues to be supported with an appropriate level of administrative support through Trust Quality and Safety/Governance team.

- 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.

	Completed	2024-2025
Total number of inpatient deaths 2024/25	**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**

	Completed	PMR 1	PMR 2
Number of Stage 1 and 2 PMR's completed during by quarter 2024/25 (May contain deaths from current and prior years)	**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 behaviour 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 Northwest 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 reduces 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

JAG Joint Advisory Group on GI Endoscopy

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

3.5.1 Healthwatch Blackburn with Darwen and Healthwatch Lancashire

Introduction:

Healthwatch Blackburn with Darwen and Healthwatch Lancashire are pleased to be able to submit the following considered response to East Lancashire Hospitals NHS Trust's Quality Account for 2024-25.

Part 1 including Statement on Quality from the Chief Executive:

This section of the Quality Account provides a clear description of the Trust, the range of services and the Trust's commitment to quality improvement practice, including capacity building within the staff team and links to educational establishments and clear governance structures and partnership working. We know through our work as part of Place Based Partnerships that the Trust is committed to working in collaboration with partners to improve care both in the hospital and community.

The tenor of the whole document is summarised in the approach to Quality Improvement, namely the commitment to providing Safe, Personal and Effective care by empowering staff to drive improvement, to improve care and outcomes for patients and stakeholders whilst maintaining strong governance and driving financial improvements.

Part 2: Quality Improvement:

We are pleased to see the direct link to the NHS National Patient Safety key aims. We actively support the engagement of the Public and Patient Panel as part of the quality improvement work of the Trust and recognise the Trust's commitment to the National Patient Safety Incident Response Framework.

We are very happy to support the ongoing development of the Public Participation Panel and know from our own involvement that members of the Panel are involved in a number of quality improvement initiatives.

We recognise the need to continue to focus on the same 3 local priorities for this work as areas of complaints to Healthwatch and appreciate the Trust's focus on addressing these - namely medication errors, discharge planning and safeguarding patients with learning difficulties.

We appreciate the new methods and approaches of sharing learning across the Trust to support learning and improving the safety culture and from our own experience are aware of these taking place across the year. We are also aware of the work underway for the mortality reduction programme and the new role of Medical Examiners within the Trust.

Improvement Hub Priorities for 2025/26

We note the initiatives listed as part of the Improvement Hub Team priorities for 2025/26 as key areas for improvement both within the Trust and the local health and care system.

Mandated Statements

In accordance with the current NHS reporting requirements, mandatory quality indicators requiring inclusion in the Quality Account we believe the Trust has fulfilled this requirement. The Quality Indicators, results and supporting narrative are clear and well laid out.

We note the excellent participation rate in the National Clinical Audits and National Confidential enquiries and the implementation of actions described to improve the quality of healthcare provided and similar rigour continues in respect of the local clinical audits.

We very much appreciate the continuous open working relationship with ourselves as a local Healthwatch as a valuable source of patient feedback and involves us as a partner in reviewing the Trust's complaints handling process.

Part 3 Quality Achievements and Statutory Statements

We would single out the key actions which have already been taken in i) respect of nutrition and hydration, supporting vulnerable and frail patients; ii) aims to reduce longer lengths of stay in hospital; iii) DNACPR improvements and continuing work around frailty.

We also note the continued focus on the urgent and emergency pathway. We recognise the other quality achievements, and from our own work have seen the quality of maternity services provided by the Trust and the efforts to increase care at home.

Summary

Overall, this is a fair and well-balanced document which acknowledges areas for improvement and details comprehensive actions being taken to further improve patient treatment, care and safety. We welcome these and as Healthwatch we are committed to supporting the Trust to achieve its aims.

Sarah Johns

Chief Officer
Healthwatch Blackburn with Darwen

Jodie Carney

Manager
Healthwatch Lancashire

3.5.2 Lancashire and South Cumbria Integrated Care Board (LSCICB)

Lancashire and South Cumbria Integrated Care Board (LSCICB) appreciates the opportunity to review and comment on the East Lancashire Hospitals Trust (ELHT) Quality Account 2024/25. LSCICB would like to extend thanks to the trust for preparing this Quality Account, including reflection on progress made over the past year and quality priorities for the coming year. We acknowledge the importance of maintaining quality at a time when Providers continue to experience challenges with demand and patient flow under increasingly pressured finances.

Commentary provided in this response letter relates to services commissioned by LSCICB as well as recognising key programmes of work that the trust has undertaken during 2024/25. We have a continued commitment to commissioning high quality services from ELHT and take seriously their responsibility to ensure that patients' needs are met by consistent and high standards of safe care, provision of effective services and that the views and expectations of patients and the public are listened to and acted upon.

The Quality Account provided by ELHT demonstrates a strong commitment to continuous quality improvement, patient safety, and clinical effectiveness. It is commendable that the trust continues to improve communication with patients and families, reviews safer staffing and workforce development and advancing care for people with learning disabilities and autism.

These areas of focus are well aligned with NHS Long Term Plan ambitions, particularly around personalisation, workforce capability, and improving equity of outcomes for vulnerable groups.

In 2023/24, the trust implemented a new Electronic Patient Record (EPR) system. Despite improving access to decision-making tools, the EPR system has limitations. In 2045/25, risks emerged, including a clinical coding backlog affecting the Summary Hospital Mortality Index (SHMI) robustness and accuracy. The trust has acknowledged capacity challenges due to this EPR, with expected activity losses impacting booking management, monitoring, and reporting processes.

The trust has demonstrated a proactive commitment to understanding and addressing significant challenges with their mortality data through regular monitoring of crude death rates and diagnosis-specific trends. The trust continues to review data between July 2023 to June 2024 providing essential insight into the patterns and underlying causes of mortality across the service.

Over the review period, the trust reported crude mortality figures fluctuated with a visible increase in early 2024. Although these figures are not risk-adjusted and hence not directly comparable to national benchmarks, internal trend monitoring has provided some assurance that the mortality levels reflect expected seasonal variations and demographic pressures.

LSCICB acknowledges the persistent challenges identified over the last year when reporting on mortality. Issues relating to the collection of crude mortality figures have not yet been corrected and as a result, while trends are monitored internally over time, the data lacks the necessary granularity to distinguish between expected and potentially avoidable deaths. Additionally, we note the absence of benchmarking against national or regional data, and without external comparators, it is not possible to assess how the trust performance aligns with other trusts of a similar size.

LSCICB notes that the trust completed 120 Structured Judgement Reviews, a decrease from the previous year due to staffing issues. We note, efforts are being made to address these shortfalls, with hopes to increase the number of SRJs completed next year.

It has been recognised that the Emergency Departments are conducting their own mortality reviews, with stroke and intensive care deaths also under review. We note deaths of patients with Learning Disabilities (LD), or Autism are also subject to Structured Judgement Reviews (SJR) in addition to the trust's learning disability reviews.

Over the last 12 months LSCICB has noted the trust has seen significant operational challenges in their cancer performance affecting national cancer standards, particularly in diagnostic timelines and treatment pathways.

In the latest Exception Report (Q4 2024-25), the 62-day backlog has increased due to delays in Endoscopy and Pathology, exacerbated by rising referrals in Lower Gastrointestinal (LGI) and Upper Gastrointestinal (UGI) tumour sites. The 28-day Faster Diagnosis Standard showed variable performance, with breaches primarily in Colorectal and Gynaecology, driven by Endoscopy and Pathology delays. Similarly, the 31-day Decision to Treat to First Treatment pathway has faced setbacks due to surgical capacity limitations, affecting compliance with the performance standard.

Whilst the trust has put in several measures to improve performance, limited progress has been made. Collaboration between histology laboratories within the alliance is ongoing to accelerate histology reporting times. However, the pathology back log remains high and not on trajectory.

Overall, while the trust achieved significant progress in audit completion and assurance reporting, key challenges remain in ensuring engagement across all divisions, improving timely response to national guidance, and closing assurance gaps identified in limited or very limited audits. These issues are being addressed through forward planning, enhanced clinical engagement, and more robust governance processes.

We note there were 62 national audits and 12 national confidential enquiries that covered the services at ELHT in 2024/25 of which ELHT participated in 87% of national audits compared to 88% last year and 12 (100%) National Confidential Enquiries. The remaining 13% of the national audits were not applicable.

The trust reported outcomes on 35 national audits and 9 Confidential Enquiry Reports. These audits spanned all Divisions: Community & Integrated Care, Diagnostics & Clinical Support, Family Care, Medicine & Emergency Care, Surgery & Anaesthetic Services, and trust-wide initiatives.

The trust completed 239 local audits in 2024/25, fewer than last year's 255. Discussions at Clinical Effectiveness Group meetings allowed LSCICB to review assurance levels, noting both good practices and areas for improvement. Significant progress was made in audit completion and assurance reporting, but challenges remain in ensuring engagement across all divisions and improving timely responses to national guidance. LSCICB notes these are being addressed through forward planning, enhanced clinical engagement, and robust governance.

The trust reported 0.1% reduction in compliance submissions than last year to the NHS Digital Secondary Uses Services, this is a repository for healthcare data, enabling analysis to support the delivery of NHS healthcare services. Records reported 99.7% admitted

patient care, 99.7% Outpatient Care and 99.5% Accident and Emergency Care included a patient's valid NHS number and over 98% included the General Practice code.

It is positive to see that the patient voice is continuously ascertained through surveys, complaints feedback, and community engagement, this upholding the trust's principles of getting it right, transparency, fairness, and accountability. We note, the overall Friends and Family Test (FFT) positive response rate remained at 88% in March 2025, which, while stable, is slightly below the trust's target of 90% and 6% lower than last year.

We saw Emergency Care, FFT ratings fluctuate throughout 2024/25 improving from 66% in January 2025 to 76% in March 2025. Positive themes cited included professionalism and compassionate care, though pain management, waiting times and communication around results remained areas of concern. The ICB still awaits an update on the work the department is undertaking to address comments relating to pain management.

In maternity services, the positive response rate decreased from 94% in January 2025 to 84% in March. Negative feedback rose to 9% and highlighted issues with pain management and staff attitude. LSCICB has been sighted on the ongoing action plan within the Family Care Division to address care, quality and patient communication and will monitor the actions through ongoing engagement.

We recognise the work done so far to address the quality of discharge summaries. We were informed by primary care colleagues and other care providers that poor discharge summaries increased workload and led to discrepancies relating to medicines. The introduction of an enquiry mailbox in March 2025 aims to clarify summary related queries. However, timeliness in reviewing and responding to these queries and the quality of discharge summaries must be improved. The ICB will continue to monitor the progress of this work.

We recognise that workforce challenges at ELHT are indicative of broader NHS-wide issues, such as national staffing shortages, high service demand, and financial pressures. It is noted that the trust is actively implementing strategies to enhance recruitment, retention, and employee support. Concerns remain regarding elevated sickness and absence rates. However, the trust has significantly expanded its workforce establishment, increasing from 9,973 to 13,000 as of 31 October 2024. This growth is largely attributed to the Transfer of Undertakings (Protection of Employment) (TUPE) of staff from services under the One Lancashire and South Cumbria (One LSC) arrangements.

Additional challenges include a healthcare support worker vacancy rate despite a decrease in establishment for this group. On a positive note, the trust met its internal safe staffing target of 90%, surpassing the national benchmark of 85%.

The Trust reported a decrease in Clostridium difficile cases, with 92 cases compared to a projected 100 and a reduction from 101 cases last year. We recognise, infection control efforts are ongoing, and all related deaths undergo a patient safety review. Additionally, we note the trust's efforts to improve staff education and electronic patient records management to improve compliance with stool documentation and C. difficile management.

During 2024/25, there has been an observed increase in reported severe harm incidents compared to 2023/24. However, LSCICB acknowledges this is due to the trust transitioning to the Learning from Patient Safety Events (LFPSE) reporting system in July 2024.

We appreciate the trust's continued focus on identifying lessons learned and implementing actions based on patient safety incident investigations through Patient Safety Incident

Requiring Investigation (PSIRI) Panels and we understand this work forms part of the trust's wider harm reduction programme. Furthermore, we recognise the work done by the trust to educate staff, making available Patient Safety Learning Podcasts via the trust's SharePoint site to support staff education and engagement.

The trust reported three Never Events in 2024/25; this is no changed since last year. LSCICB Patient Safety team has been informed of developing improvement plans. However, two Never Events are still under investigation.

During 2024/25 (2555) the trust received a higher number of enquires compared to last year (2483). Of the 2555 received this year, 311 were logged as formal complaints. LSCICB recognises the number of complaints continues to rise, placing pressures on the customer relations team and we thank the trust for inviting LSCICB to the Patient Experience Group, where improvements to address key themes such as clinical treatment in the Emergency Department and obstetrics, discharge processes, and staff attitude are discussed.

There were 12 active Parliamentary and Health Service Ombudsman (PHSO) cases, with 8 pending investigation decisions as of March 2025. LSC ICB recognises the trust's efforts to improve complaint response timeliness, particularly for Level 2 complaints, which are often escalated to Level 4 due to delays or complexity.

We note in 2024/25 the CQC registered the trust for a range of primary care services and a restrictive provision to care for patients subject to the Mental Health Act as a way to support the wider system. Additionally, the trust was visited by the CQC and the ICB during 2024/25, all visits were positive with some reported areas of improvement.

LSCICB would like to take the opportunity to congratulate the trust on the opening of the new Heart Care Unit at Royal Blackburn Teaching Hospital. We understand this purpose-built facility consolidates the Coronary Care Unit and Cardiology Ward into a single, modern space, improving the coordination and delivery of cardiac services.

We also acknowledge the outstanding community driven initiative behind the new "Bluebell Unit," a state-of-the-art chemotherapy and cancer treatment centre at Royal Blackburn Teaching Hospital. With over £120,000 raised through local fundraising efforts, the unit houses both the acute oncology team and the systemic anti-cancer therapy team for the first time. We look forward to understanding more about the impact on collocating this service in the coming year.

In conclusion, ELHT has demonstrated a strong commitment to quality throughout 2024/25, delivering safe, effective, and personalised care. The LSCICB will continue to support the trust's staff, processes, and strategic priorities for 2025/26, ensuring that patient needs remain the central focus.

Yours sincerely

Kathryn Lord
Kathryn Lord

Director of Nursing, Quality Assurance and Safety
Lancashire and South Cumbria Integrated Care Board

3.5.3 Lancashire County Council

Many thanks for sight of the ELHT quality account report for 2024/25. As you will be aware, as of May 2025, the county council have just held their elections and as such are currently in the process of setting up committees etc.

As a result, the Health and Adult Services Scrutiny Committee would be unable to comment on this year's Quality Account. However, the committee will remain engaged and keen to maintain ongoing dialogue throughout 2025/26.

Samantha Parker

Senior Democratic Services Officer

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: M. Sm.

Chief Executive: Martin D. Halyson

Date: 25th June 2025

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 regard 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