East Lancashire Hospitals
NHS Trust
A University Teaching Trust

East Lancashire Hospitals NHS Trust Board Meeting

Safe | Personal | Effective

TRUST BOARD (OPEN SESSION)

AGENDA

9 July 2025 at 9.30am

Activity Room, Dovestone Gardens, Briercliffe Road, Burnley

✓ = document attached
v = verbal

Time	Ref	Item	Lead		Purpose
OPENING BUSINESS					
09.30	TB/2025/083	**Chairs Welcome and Apologies**	Chair	v	Information
	TB/2025/084	**Declarations of Interests**	Chair	v	Information
	TB/2025/085	**Minutes of the Previous Meeting** To approve the minutes of the Board meeting (open session) that was held on 14 May 2025.	Chair	✓	Approval
	TB/2025/086	**Matters Arising** To discuss any matters arising from the minutes.	Chair	v	Discussion
	TB/2025/087	**Action Matrix** To note progress against outstanding actions.	Chair	✓	Discussion
	TB/2025/088	**Chair's Report**	Chair	✓	Information
	TB/2025/089	**Chief Executive's Report**	Chief Executive	✓	Information
	TB/2025/090	**Patient Story**	Chief Nurse	v	Information
FORMULATING STRATEGY					
	TB/2025/091	**Green Plan**	Executive Dir. of Integrated Care, Partnerships and Resilience	✓	Assurance
	TB/2025/092	**Health & Safety Strategy and Policy**	Assistant Dir. of Health, Safety & Risk	✓	Assurance/ Endorsement
ENSURING ACCOUNTABILITY					
	TB/2025/093	**Financial Report**	Executive Director of Finance	✓	Assurance
	TB/2025/094	**Integrated Performance Report** To note performance against key indicators and to receive assurance about the actions being taken to recover areas of exception to expected performance. The following specific areas will be discussed, with items being raised by exception: a) Introduction (Chief Executive) b) Safe (Interim Medical Director and Chief Nurse) c) Caring (Chief Nurse) d) Effective (Interim Medical Director) e) Responsive (Chief Operating Officer)	Executive Directors	✓	Assurance

		f) Well-Led (Chief People Officer and Executive Director of Finance)			
	TB/2025/095	**Patient Safety Incident Response Assurance Report**	Interim Executive Medical Director	✓	Assurance
	TB/2025/096	**Maternity and Neonatal Services Update**	Chief Nurse	✓	Assurance
SHAPING CULTURE					
	TB/2025/097	**Aarushi Project Update**	Joint Chief People Officer	v	Assurance
COMMITTEE REPORTS					
	TB/2025/098	**Triple A Reports from Quality Committee** To note the matters considered by the committee in discharging its duties. a) May 2025 b) June 2025	Committee Chair	 ✓ ✓	Assurance
	TB/2025/099	**Triple A Reports from Finance & Performance Committee** To note the matters considered by the committee in discharging its duties. a) May 2025 b) June 2025	Committee Chair	 ✓ ✓	Assurance
	TB/2025/100	**Triple A Reports from People & Culture Committee** To note the matters considered by the committee in discharging its duties. a) May 2025 b) June 2025	Committee Chair	 ✓ ✓	Assurance
	TB/2025/101	**Remuneration Committee Information Report** To note the matters considered by the committee in discharging its duties. a) May 2025 b) June 2025	Committee Chair	✓	Assurance
	TB/2025/102	**Trust Board (Closed Session) Information Report** To note the matters considered by the board in discharging its duties.	Chair	✓	Information
CLOSING MATTERS					
	TB/2025/103	**Any Other Business**	Chair	v	Information
	TB/2025/104	**Open Forum** To consider pre-submitted questions from the public.	Chair	v	Information
	TB/2025/105	**Board Performance & Reflection** To consider the performance of the Trust Board, including asking:	Chair	v	Discussion

		1. Have we, as the Board, via the agenda and our discussions fulfilled our objective of supporting our: a. Communities b. Staff c. Stakeholders 2. Have we, as the Board fulfilled our statutory obligations.			
	TB/2025/107	**Message from the Board** To identify any key messages the Board wishes to send out to all staff.	Chair	v	
	TB/2025/108	**Date and Time of Next Meeting** 10 September 2025 at 9.30am, Venue TBC	Chair	v	Information

EAST LANCASHIRE HOSPITALS NHS TRUST

TRUST BOARD MEETING, 13:00, 14 May 2025

MINUTES

PRESENT

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

BOARD MEMBERS IN ATTENDANCE (NON-VOTING)

Mrs K Atkinson	Executive Director of Service Development and Improvement	
Mrs M Hatch	Associate Non-Executive Director	
Mr M Ireland	Interim Director of People and Culture	
Miss S Wright	Executive Director of Communications and Engagement	

IN ATTENDANCE

Dr A Brown	Intensive Improvement Director, National Recovery Support Team – Chief Operating Officer's Directorate	Observer
Mr D Byrne	Corporate Governance Officer	Minutes
Mrs S Giles	Interim Director of Corporate Governance/ Company Secretary	
Mr A Patel	Deputy Director of Integrated Care, Partnerships and Resilience	
Miss T Thompson	Divisional Director of Midwifery and Nursing	Item: TB/2025/062

APOLOGIES

Professor G Baldwin	Non-Executive Director
Mrs A Bosnjak-Szekeres	Director of Corporate Governance / Company Secretary
Mr T McDonald	Executive Director of Integrated Care, Partnerships and Resilience

	23 Apr 2025	14 May 2025	3 Jun 2025	11 Jun 2025	9 Jul 2025	10 Sept 2025	12 Nov 2025	14 Jan 2025	11 Mar 2025
Mr S Sawar	✓	✓							
Mrs S Bridgen	✓	✓							
Mrs T Anderson	A	✓							
Prof G Baldwin	A	✓							
Mrs C Randall	A	✓							
Mr K Rehman	✓	✓							
Mrs L Sedgley	✓	✓							
Mrs M Hatch	✓	✓							
Mr M Hodgson	✓	✓							
Mrs S Simpson	✓	✓							
Mrs S Gilligan	✓	✓							
Mr P Murphy	✓	✓							
Mrs K Quinn	A	A							
Mr M Ireland	✓	✓							
Mrs K Atkinson	✓	✓							
Mr T McDonald	✓	D							
Miss S Wright	✓	✓							
Mr S Islam	✓	✓							

✓ Attended A apologies D Deputy attended

TB/2025/053 CHAIRMAN'S WELCOME

Directors were welcomed to the meeting. It was noted that Dr Brown, NHSE Improvement Director, was in attendance to observe the meeting as part of the Recovery Support Programme (RSP).

TB/2025/054 APOLOGIES

Apologies were received as recorded above.

TB/2025/055 MINUTES OF THE PREVIOUS MEETING

Mr Islam requested that his attendance was formally recorded in the minutes from the previous meeting. Mr Hodgson requested a minor amendment be made to the patient safety section of the minutes relating to a query raised by Mrs Sedgley which related to patients who did 'not' have family members or others to advocate for them.

Subject to these changes the minutes were otherwise approved as a true and accurate record.

RESOLVED: **The minutes of the meeting held on 12 March 2025 were approved as a true and accurate record, subject to the aforementioned revisions.**

TB/2025/056 MATTERS ARISING

Directors noted that, following the confirmation that the Trust had met nine of 10 safety actions of the Maternity Incentive Scheme (MIS) Clinical Negligence Scheme for Trusts (CNST) Year Six at the previous meeting, it had subsequently successfully met the remaining action in the intervening period and had therefore attained full compliance.

TB/2025/057 ACTION MATRIX

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

TB/2023/040: Maternity and Neonatal Service Update – Directors were advised that a full update on this item would be provided at the meeting in July and that updates would be provided at the Quality Committee and Trust Wide Quality Group (TWQG) in the interim.

TB/2025/042: Integrated Performance Report – Well-led – It was noted that a deep dive on sickness absence would be presented to the June meeting of the People & Culture Committee.

RESOLVED: **Directors noted the position of the action matrix.**

TB/2025/058 CHAIR'S REPORT

Directors confirmed that they were content to approve the recommendations outlined in the report to appoint Mrs Bridgen and Mr Rehman as vice chairs and to appoint Professor Baldwin as senior independent director. It was reiterated that Mr Featherstone would be joining the board from the following month, as would two associate non-executive directors, and that this would help the strengthen the board from a quality and financial perspective. Directors noted the changes to the chairing and membership of the board committees.

Directors went on to receive an overview of Mr Sarwar's activities since the previous meeting, including his participation in the recent visit to Rossendale Health Centre by the prime minister. It was also noted that Mr Sarwar continued to participate in meetings of the Lancashire Place Partnership and other system-based meetings.

Mr Sarwar highlighted that the relationships between the chairs and chief executive officers (CEOs) of each trust in Lancashire and South Cumbria (LSC) had continued to strengthen over recent months and that there was a much stronger sense of ownership of the challenges currently facing the system.

RESOLVED: **Directors received and noted the report provided by the chair.**

TB/2025/059 **CHIEF EXECUTIVE'S REPORT**

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

At a national level, updates were provided on the recent changes in leadership at NHS England (NHSE), including the implementation of an NHS transformation executive team led by Sir James Mackey, the publication of a model Integrated Care Board (ICB) blueprint, the ongoing development of the NHS 10-year plan, significant reductions in test and check wait times and the recruitment of over 1,500 additional GPs.

At a regional level, updates were provided on the recent announcement by the LSC ICB CEO, Kevin Lavery, of his intention to step down from the role later in the year, the announcement of a new ICB interim medical director, the closure of long COVID services and system wide collaboration successes around data and digital.

At a Trust level, updates were provided on the successful appointment of a new executive medical director, the Trust successfully meeting its financial targets for 2024-25, a recent visit to the Trust's community inpatient facilities by the Care Quality Commission (CQC), improvements to a number of the Trust's key performance metrics, including ambulance handover times.

Directors received a brief overview summary of other recent positive developments at the Trust. It was highlighted that the Trust's endoscopy services had received accreditation from the Joint Advisory Group for Endoscopy (JAG) for the eighth time in a row, it had received £2,000,000 in funding for solar panel installation and that its armed forces veteran team had received a Lord-Lieutenants' Award.

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

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

TB/2025/060 **PATIENT STORY**

Directors were informed that the story being presented had been provided by the wife of a patient and related to a delayed diagnosis that had ultimately led to a poorer outcome for them.

Mr Murphy emphasised that the story made clear the power of reconciliation and the importance of the duty of candour process, particularly in the healthcare sector where things could occasionally go wrong despite the best efforts of colleagues.

This patient story can be viewed by clicking the link here.

Mr Sarwar commented that the circumstances that the patient had found themselves in did not reflect the values of the Trust. It was noted that the same story had been presented at the most recent meeting of the Quality Committee and that a 'deep dive' into the assurance and lessons learned had taken place. In addition positive feedback on investigations was provided at meetings of the Patient Safety Incidents Requiring Investigation (PSIRI) panel and Mrs Anderson reflected that the importance of the duty of candour and honesty in the investigation process was clear at these meetings.

Directors acknowledged that it was often difficult to take part in the duty of candour process and ensure that it was done well, as it required absolute honesty on behalf of the Trust and taking on things that were often difficult to hear.

Mr Hodgson emphasised the importance of team dynamics in ensuring the best outcomes for patients and confirmed that the importance of a patient centred approach was pushed by senior leaders across the organisation on a regular basis.

Mr Sarwar suggested that the Board have a patient attend in person at a future meeting to discuss their experiences first hand. He added that more consideration was also needed around the diversity of the stories presented to the board and its committees, particularly given the importance of health equity to the organisation.

ACTION: Consideration be given to having a patient or relative attend Board in person for the Patient Story.

Lead: Chief Nurse By: September 2025

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

TB/2025/61 **ANNUAL PLAN AND ANNUAL BUDGET 2025-26**

Directors were referred to the previously circulated reports and were advised that they summarised the Trust's strategic and operational planning for the coming 12-month period. It was noted that the Trust had maintained its strategic framework from 2024-25 and that work had been undertaken to ensure that all individual strategies were in date, with a plan on a page, through relevant sub-committees. It was also confirmed that clear monitoring arrangements would be in place via the strengthening of strategic dashboards and that this would feed into sub-committees throughout the year.

Directors went on to receive a brief overview of the Trust's key programmes and priorities for 2025-26. It was noted that there eight key priorities, with nine associated key improvement measures that would be incorporated into the organisations integrated performance reporting mechanisms.

Directors were advised that the final national planning submission had taken place on the 13 April and that a substantial amount of work had been done to strengthen the processes around this, particularly in relation to workforce metrics. It was highlighted that the Trust had confirmed its intention to meet all of its operational requirements for 2025-26 and that a range of productivity assumptions had been made as part of this to ensure that more patients could be treated within the same income envelope.

Discussions had been held through sub-committees and meetings of the board to get to the Trust's final position with regard to its financial plan. Mrs Simpson explained that one change relating to final contract offers was highlighted in the report but stressed that did not change the organisation's bottom-line position or its waste reduction programme (WRP) goal of £60,800,000. Directors noted that there would be a greater focus on actual run rates in 2025-26 so promote a better understanding of the Trust's overall financial position and that a substantial amount of work had gone into facilitating this.

The Board recognised the risks in the Trust's financial position, particularly in relation to the requirement for its cost improvement programme to be largely based on recurrent savings. It was acknowledged that there would be significant challenges around workforce and there would be significant pressure placed on colleagues to deliver. It was recognised that the

annual plan had been developed with colleagues across the Trust and there was clear commitment from all areas to ensure that it was a success.

RESOLVED: **Directors confirmed that they were content to approve the Trust's priorities, annual plan and annual budget for 2025-26.**

TB/2025/062 MATERNITY AND NEONATAL SERVICES UPDATE

Miss Thompson joined the meeting at this time.

Directors received a summary overview of the Trust's progress against the 10 maternity safety actions included in the MIS CNST Year Seven. It was noted that the Trust was on schedule to achieve compliance with all of the safety actions with the following exceptions:

Safety Action 4 - Clinical Workforce: Directors noted that the Trust was currently non-compliant against this action as sufficient time had not yet passed for the first quarterly audit of the year to be completed. It was also noted that there two identified risks relating to the Trust's neonatal nursing workforce action plan and its neonatal workforce and their compliance with British Association of Perinatal Medicine (BAPM) standards.

Safety Action 5 - Midwifery Workforce: It was confirmed that the Trust was currently non-compliant against this action due to the ongoing issues with its midwifery staffing establishments not aligning with Birthrate+ findings. Mr Murphy reiterated that a full update in this area would be provided to the board at its next meeting in July.

Safety Action 8 – Training: It was confirmed that the Trust was currently non-compliant against this action

Directors went on to receive a summary overview of other recent maternity activity, including a recent annual North West regional site visit on the 30 April, the outcome letter from which was still pending as of the meeting and a planned move to begin using the Birmingham symptom- Specific obstetric triage system (BSOTS) at the Trust in the future. It was confirmed that a full paper on the latter would be presented to the board at a later date.

The Board congratulated Miss Thompson for having successfully achieved compliance against all ten safety actions in the MIS CNST for Year Six.

Mr Rehman advised that the challenges around data and digital were significant in some maternity areas, specifically in relation to both infrastructure and a general lack of equipment. Miss Thompson indicated that these issues were being actively worked through and that more detail was provided in the report.

Miss Thompson left the meeting at this time.

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

TB/2025/063 BOARD ASSURANCE FRAMEWORK (BAF)

Directors were informed that the BAF had been refreshed for 2025-26 as part of its annual review process and was being presented alongside an updated risk appetite statement for the Trust. It was noted that the risk appetite was fully aligned to the Trust's risk matrix and had been revised to better reflect the challenges around financial recovery whilst also maintain safe personal and effective care. Directors were informed that further reviews of the BAF would take place on a quarterly basis going forward as part of a broader goal for it to serve as more of a live document.

The format of the BAF would be considered at a future board strategy session.

RESOLVED: **Directors confirmed that they were assured that the BAF was being actively reviewed and steps taken to improve its effectiveness as a source of assurance for the board.**
Directors confirmed that they were content to approve the updated BAF risks and the Trust's revised draft risk appetite statement.

TB/2025/064 CORPORATE RISK REGISTER (CRR) AND RISK PERFORMANCE REPORT

Directors received the latest iteration of the CRR and were provided with a summary of key highlights. It was noted that there were currently 23 risks on the CRR, a number of which had had their scores increased or reduced since the previous meeting, these were:

- 10065: Pharmacy Technical Service refurbishment programme – score increased to 20.
- 10062: Risk of harm and poor experience for patients with mental health concerns – score increased to 20.
- 9545: Potential interruption to surgical procedures due to equipment failure – score reduced to 16.
- 6190: Insufficient capacity to deliver national targets for RTT and cancer – score reduced to 12.

It was noted that action was underway to encourage risk handlers to regularly review their risks and mitigations and to update relevant executive leads.

Directors noted that the highest risk categories remained financial sustainability, digital storage, device management and clinical capacity issues. It was highlighted that the volume of open risks had continued to reduce down to 613 and that the number of significant and moderate risks had also fallen to 312. Directors were advised that this had been offset to a degree by the number of overdue risks increasing slightly to 180.

Mr Islam expressed some concern over the numbers of risk scoring 15 or above that were still sitting at divisional level and indicated that this would be closely monitored over the coming months.

Directors discussed the length of time that a number of risks had remained on the CRR for, Mr Hodgson stressed that a significant amount of progress had been made in the overall management of risks over recent years. He acknowledged that more work was still needed around the embedding of risk between risk and executive leads and indicated that the new risk management framework currently in development would help to facilitate this through additional training and other mechanisms.

It was noted that the Audit Committee would consider and approve the revised risk management framework.

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

TB/2025/065 FINANCIAL REPORT

Directors received an overview of the Trust's financial performance as of month 12 of 2024-25. It was highlighted that it had successfully met its deficit position target of £46,600,000, including the Deficit Support Funding (DSF) amount of £21,900,000, and recognised that a significant amount of work had gone into achieving this. It was noted that the Trust had come slightly under its capital target and had not fully delivered the full value of its WRP.

Directors recognised that the cost improvement asks being placed on the Trust for 2025-26 were significant and that the associated service reviews would likely require difficult decisions to be made.

Mr Hodgson noted the need for the Trust to move to a more sustainable rhythm around the delivery and planning asks for 2025-26 and explained that this would require additional investment and infrastructure to be put in place. He added that it had been made clear that this additional investment would have to provide the necessary financial returns.

RESOLVED: **Directors noted the financial report.**

TB/2025/066 **NURSING PROFESSIONAL JUDGEMENT REVIEW**

Directors were referred to the previously circulated report and received an overview of its key highlights. It was reported that there had been a confirmed uplift of 22% across all in patient establishments and that this was in line with national recommendations. It was also noted that there were currently no registered nurse vacancies. and that the Trust remained an outlier on supernumerary status which may also be play a role in its high sickness and absence rates.

The findings in the report emphasised the importance of having the right conversations with commissioners around the level of resource required for commissioned services. It was agreed that financial analysis against the recommendations outlined in the report would take place through the board's sub-committees.

RESOLVED: **Directors confirmed that they were content to approve the professional judgement recommendations outlined in the report.**

TB/2025/067 **INTEGRATED PERFORMANCE REPORT (IPR)**

a) Introduction

Directors were referred to the previously circulated report and were informed that it covered the period up to the end of March 2025.

b) Safe

Directors were informed that there had been no cases of flu or COVID-19 reported on any ward areas over the last week. It was highlighted that Clostridium difficile (C. diff) cases remained within tolerance levels and that there had been no confirmed cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) since October 2024. It was also reported that the volume of pressure ulcer incidents developed under the Trust's care had continued to fall, as had any associated lapses in care. In addition, staff fill rates had been at 90% or above in all areas.

c) Caring

A sub amount of work was taking place in the emergency department (ED) around friends and family test feedback. The main reasons for complaints were noted to be related to length of stay but the feedback from patients was often very positive regarding the compassionate and high-quality care that they had received.

d) Effective

Directors were informed that early improvements were being seen in the Trust's Hospital Standardised Mortality Ratio (HSMR) data, but it would likely be some time before full accurate data was being reported. It was also noted that improvements to the Summary-hospital Level Mortality Indicator (SHMI) were likely to take longer to manifest.

e) Responsive

Directors received a summary of the Trust's most recently updated performance figures, including its performance against the four-hour A&E standard, ambulance handover times, 65-week waiters and cancer and faster diagnosis standards. It was noted that significant improvements had been seen in relation to ambulance handover times in particular and that the Trust would be hosting a visit by colleagues from another trust in the Mersey and Cheshire Integrated Care System (ICS) to share best practice.

Mrs Gilligan highlighted that the Trust's performance in relation to Referral to Treatment (RTT) targets continued to move in the right direction and that the organisation continued to perform well against outpatient and 65-week targets.

f) Well-led

It was reported that the Trust's sickness and absence rates had fallen slightly but was still higher than at the same period the previous year. Mr Hodgson informed the Board that Lancashire Teaching Hospitals were sharing the steps they had taken to reduce their sickness absence rates, with a view to the Trust learning from their actions.

Deterioration in medical appraisal and information governance training compliance were also highlighted.

RESOLVED: **Directors noted the Integrated Performance Report and received assurance about the activity being taken to improve and maintain performance.**

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

Directors were informed that any out-of-date Standard Operating Procedures (SOPs) were being actively picked up and reviewed by colleagues. It was highlighted that recently published patient safety learning event data had shown the Trust had a higher reporting rate, but a lower harm rate compared to other organisations nationally, and that there had been no breaches of duty of candour since the previous meeting. Directors noted that a total of 18 incidents had been reported, all of which had been allocated to lead investigators.

In response to concerns over the length of time that some SOPs had been overdue for review, Mr Islam confirmed that a full update would be provided at the next meeting of the Trust Wide Quality Group (TWQG).

RESOLVED: Directors noted the report.

TB/2025/069 QUALITY ACCOUNT 2024-25

Directors were referred to the previously circulated Quality Account for 2024-25 and were advised that it had been considered and reviewed by the Quality Committee the previous month, with no requests made for amendments. It was noted that, subject to any amendments agreed by the Board, the Quality Account would be submitted to key stakeholders for their comments, which would be included in the final version of the Quality Account.

ACTION: It was agreed that the Quality Account would be presented to an extraordinary meeting of the board for final approval.

Lead: Chief Nurse By 30th June 2025

TB/2025/070 BOARD CODE OF CONDUCT

Mrs Giles reminded members that a draft form of the board code of conduct had been considered by the board at its last strategy.

RESOLVED: Directors confirmed that they were content to approve and adopt the board code of conduct.

TB/2025/071 COMMITTEE TERMS OF REFERENCE

Directors were referred to the previously circulated terms of reference, which had been updated and approved by each of their respective board sub-committees. It was noted that the Trust Charitable Funds Committee had not met to consider their revised terms of reference and that these would be presented to the board at a later date once this had taken place.

RESOLVED: **Directors confirmed that they were content to approve the revised terms of reference for the board's sub-committees.**

TB/2025/072 **TRIPLE A REPORT FROM QUALITY COMMITTEE**

The report was presented to the Board for information.

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

TB/2025/073 **TRIPLE A REPORT FROM FINANCE AND PERFORMANCE COMMITTEE**

The report was presented to the Board for information.

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

TB/2025/074 **TRIPLE A REPORT FROM PEOPLE AND CULTURE COMMITTEE**

The report was presented to the Board for information.

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

TB/2025/075 **TRIPLE A REPORT FROM AUDIT COMMITTEE**

The report was presented to the Board for information.

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

TB/2025/076 **REMUNERATION COMMITTEE INFORMATION REPORT**

The report was presented to the Board for information.

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

TB/2025/077 **TRUST BOARD (CLOSED SESSION) INFORMATION REPORT**

The report was presented to the Board for information.

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

TB/2025/078 **ANY OTHER BUSINESS**

No additional items were raised for discussion.

TB/2025/079 **OPEN FORUM**

The Board had received a question from an individual with Chronic Fatigue (CF). Their query was in relation to lack of provision of a CF service in East Lancashire. They had already complained to the Integrated Care Board directly who have advised them that there is a service provided by Harrogate NHS Foundation Trust. Their questions to the Trust Board

were how decisions about procurement of such external services are determined? Which agencies are involved? How much discretion does the Trust have? How much input do end users have in the decision process?

The following answer was provided and read out in the meeting:

"The Integrated Care Board (ICB) undertakes an annual commissioning and contracting process with the Trust. The commissioners set out to the Trust what services they would like the Trust to provide and/or stop. The Trust then has the opportunity to assess whether or not it is able to provide the service within the financial envelope proposed and, if necessary, may enter into negotiations around this with the commissioners, but ultimately it is a commissioning decision which services are provided and it is for the ICB to consult with service users if they are intending to significantly change or stop a service. With regards to a Chronic Fatigue Service in particular the Trust has not been asked by the ICB to provide this."

TB/2025/080 BOARD PERFORMANCE AND REFLECTION

Directors stated that they felt that the meeting had appropriately addressed and fulfilled its objectives in relation to its communities, staff, and stakeholders.

Mr Hodgson commented that due to the nature of the many conflicting priorities currently facing the Trust, the board had successfully addressed all relevant areas through agenda items.

RESOLVED: Directors noted the feedback provided.

TB/2025/081 MESSAGE FROM THE BOARD

Mr Sarwar reiterated his earlier praise for the colleagues in the Trust who had received a range of prestigious awards over recent weeks.

Mr Sarwar went on to note that the meeting would be Mrs Anderson's last in her role as a non-executive director (NED) and extended his gratitude to her on behalf of the board for her many contributions during her tenure at the Trust. He added that her support and guidance had been invaluable to him personally in his role as chair.

TB/2025/082 DATE AND TIME OF NEXT MEETING

Wednesday, 9 July 2025 at 13:00 in the Trust HQ Boardroom.

Trust Board Action Tracker

Key:

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

No	Meeting Date	Agenda Item	Action	Lead	Date for completion	RAG	Comments / Update
1	March 2023	TB/2023/040: Maternity and Neonatal Service Update	A full business case regarding the additional funding required to satisfy the Birth Rate+ nursing and midwifery staffing recommendations will be developed and presented to the Board for approval at a later date.	Chief Nurse/ Head of Midwifery	July 2025	B	The reporting of Birth Rate+ will be to the Board via the Quality Committee and Trust Wide Quality Group. On agenda for July 2025.
2	May 2025	TB/2025/060: Patient Story	Consideration be given to having a patient or relative attend Board in person for the Patient Story.	Chief Nurse	September 2025	Y	Action not due yet.
3	May 2025	TB/2025/69: Quality Account 2024-25	It was agreed that the Quality Account would be presented to an extraordinary meeting of the board for final approval.	Interim Executive Medical Director/ Chief Nurse	June 2025	B	The Quality Account 2024-25 was considered and approved by the board at the extraordinary meeting on the 11 June 2025.

TRUST BOARD REPORT

Meeting Date:	9 July 2025	**Agenda Item:**	TB/2025/088
Report Title:	Chair's Report		
Author:	Mr S Sarwar, Chair		
Lead Director:	Mr S Sarwar, Chair		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Approval**	**For Information**
			✓	
Executive Summary:	The Chair's Report provides an update on the activity of the Chair during June and July.			
Key Issues/Areas of Concern:	The Board is asked to note: • National response to maternity & neonatal issues • LSC System Board to Board with NHSE			
Action Required:	The board is asked to note the contents of the report.			

Previously Considered by:	N/A
Date:	
Outcome:	

Chair's Report

External Meeting/Events

1. Engagement with East Lancashire MP's

Along with the Trust's CEO and Director of Communications, I continue to meet our local MP's. The meetings offer an opportunity to provide update on performance and challenges. I am grateful to all the MP's for giving us their time. Their support and guidance have been invaluable, especially as the Board is making some difficult decisions in reference to the financial challenge it faces.

In particular, I had the opportunity, along with CEO and executive colleagues, to meet with Jonathan Hinder MP for Pendle. It was good to discuss current operational and strategic aspects with Jonathan and later he was able to visit the Emergency Department at Blackburn Royal Hospital.

2. Northwest System Leaders event at Bolton Arena.

An outline of the current NHS northwest operational performance was provided by the Northwest Regional Director and the challenges that remain in terms of finance and operational performance. Sir James Mackey (interim CEO of NHS England) outlined the need to do the basics right; focus on managing financial resources better; challenges of poor performance still existing in RTT, 4 hours waiting and 12 hours waiting; plan early for winter and focus on collaboration and partnership working. He outlined the 10-year plan that is forthcoming and opportunities it offers for better planning. He further outlined the growth in workforce but not the requisite increase in performance and standards.

A presentation from GM ICB regarding neighbourhood hub working showed the future direction of shaping services around people within their homes and local settings and not always necessarily hospitals. ELHT has a proud history of delivering high quality community services and welcomes the Government policy of a shift from hospital to home. ELHT is part of a national pilot for frailty and community health model and further information on these will be coming to the Board.

3. Lancashire & South Cumbria system RSP Board to Board Meeting with NHSE

Along with Chairs and CEO of all the providers in Lancashire and South Cumbria who are currently within segment four of the NHS Oversight Framework (NOF4), I attended the Board to Board with NHS England colleagues. The meeting provided an opportunity to update on progress against our legal undertakings that pertain to

governance, leadership and finance. A formal response from NHS England has been shared with the Board.

4. Maternity and Neonatal System Call

Sir James Mackey (interim CEO of NHS England) and Duncan Barton (Chief Nursing Officer NHS England) have outlined major concerns regarding maternity and neonatal services nationally. They gave an update on the national taskforce being established and its likely expertise, composition and potential timelines around its work. They highlighted areas of sight for Boards that included:

- Looking at behaviours, leadership and cultures in Maternity and Neonatal teams. They highlighted the poor outcomes for BAME women nationally and that this was unacceptable and further information will follow on this.
- The focus on closing the inequality gap in maternity and neonatal was the responsibility of all boards.
- There was recognition that Boards were being overburdened with data with consideration being given to a single data set and oversight system for the future.

At ELHT we deliver maternity and neonatal services rated good by CQC and the Board receives regular assurance on compliance and performance. What is clear is that the Board needs to hear more lived experience from service users to better triangulate assurance.

5. Update on Appointment of Associate Non-Executive Directors

To inform the Board that Bill Dixon who was appointed as Associate Non-Executive Director has decided not to take up the role. The Board has no plan to recruit another Associate Non-Executive Director currently.

6. Other Duties

Throughout May and June, I have carried out several other duties including:

- Attended the LSC Provider Collaborative Board, where the focus continues to be on financial challenge, clinical configuration and 1LSC
- Attended monthly Improvement & Assurance Group (IAG) meetings together with Board colleagues. The Chief Executive and Chief Finance Officer will provide greater detail but in summary the Trust is in the process of developing a fully worked up Waste Reduction Plan by the end of June and to be discussed at the next IAG meeting on 3rd July;

- Chaired the Board Strategy and Extraordinary Board meetings in May and June
- Chaired the ELHT Inclusion Group.
- Informally met with the CEO and Chair of LCS ICB, Chairs of other Provider Trusts and the System Turnaround Director;
- Continue to meet with RSP Improvement Director regarding progress in response to our legal undertaking.

TRUST BOARD REPORT

Meeting Date:	9 July 2025	**Agenda Item:**	TB/2025/089
Report Title:	Chief Executive's Report		
Author:	Shelley Wright, Executive Director of Communications		
Lead Director:	Martin Hodgson, Chief Executive		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
				✓
Executive Summary:	This report provides national, regional and Trust-specific updates across the NHS and wider health and social care system which are material to the delivery of organisational aims and the provision of safe, personal and effective care to patients. It includes information about ongoing initatives, high level performance data, updates on the use of the Trust Seal, the most recent SPEC panel awards and seeks to celebrate good practice and success in teams and for individual colleagues.			
Key Issues/Areas of Concern:	None			
Action Required by the Committee:	None			

Previously Considered by:	N/A
Date:	
Outcome:	

1. **Background**

This report is divided into sections covering the following:

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

2. **National Updates**

NHS delivers over 100,000 more treatments for patients in March, despite rise in demand

The NHS delivered over 100,000 more treatments in March compared to the same month last year, with a quarter of a million fewer waiting longer than 18 weeks for care.

New data published shows that NHS colleagues carried out over 1.5 million treatments in just one month and 3.6 million additional appointments since July 2024.

Despite increased demand, the NHS is continuing to make progress in reducing the longest waits, cutting the number of waits over 18, 52 and 65 weeks respectively.

The growth is in addition to almost 1.8 million new referrals to the waiting list in March – an increase of 124,000 compared to the same month last year – showing that despite greater demand typical of this time of year, the NHS is delivering activity at a greater rate than last year.

Urgent and emergency care plan

The NHS Urgent and Emergency Care (UEC) Plan 2025/26 has been published, outlining the approach for transforming urgent and emergency care services this winter. It sets out how these services can be improved and maintained over the next 12 months following successive winters where performance dropped.

It recognises the problems that UEC faces in the NHS and aims to move more patient care into more appropriate care settings.

Amongst its objectives, the plan commits to:

- Eradicating lengthy ambulance handover delays by meeting the maximum 45-minute ambulance handover time standard
- Cutting A&E waits of more than four hours to no more than 22 per cent of the total
- Faster discharge for patients who are medically fit to leave hospital
- £370 million in capital investment for same-day emergency care (SDEC) centres, as well as dedicated mental health crisis assessment centres
- A focus on prevention, including increasing uptake of vaccination

Money pledged for NHS in spending review

Chancellor Rachel Reeves pledged £29 billion of additional funding for the NHS by 2028/29 in the Government spending review announced in June and said the money should be used for the day-to-day running of services. In addition, the capital budget for the Department of Health and Social Care (DHSC) will increase by £2.3 billion in real terms by 2029-30, compared to 2023-24.

The Government also announced it will:

- Invest up to £10 billion in NHS technology and digital transformation by 2028-29, an increase of almost 50% from 2025-26
- Improve health and reduce demand, for example, by investing at least £80 million per year for tobacco cessation programmes and enforcement to support delivery of the Tobacco & Vapes bill
- Move money and care closer to where people live. This includes additional funding by 2028-29 to support the training of thousands more GPs.

Review of maternity and neonatal services

A rapid national investigation into NHS maternity and neonatal services has been announced by the Department of Health and Social Care. It follows a series of meetings between Health and Social Care Secretary Wes Streeting and bereaved families.

The investigation will focus on up to 10 Trusts with the worst-performing maternity services in England, but aims to consider the wider maternity system, bringing together the findings of past reviews into one clear national set of actions to ensure every woman and baby receives safe, high-quality and compassionate care. It will begin immediately and be co-produced with clinicians, experts and parents with an aim to publish findings by December 2025.

UKHSA publishes new analysis of health inequalities in England

The UK Health Security Agency has published a report with a high-level summary of the current state of health inequalities in England. Key findings include:

- People living in the 20% most deprived areas in England are almost twice as likely to be admitted to hospital due to infectious diseases than the least deprived
- Those living in the North-West are 30% more likely to be hospitalised for an infectious disease (3,600 per 100,000 admissions for Sept 23-Aug 24), compared to the England average (2,800 per 100,000)
- Areas of high levels of deprivation typically experience higher levels of air pollution than less deprived and less ethnically diverse areas.

As well as the costs to the social, physical and mental health of our communities, it was estimated that inequalities in emergency infectious disease hospital admissions cost the NHS between £970 million and £1.5 billion in 2022-23.

Boost for clinical trials

Millions of people are now able to search for and sign up to life-changing clinical trials, via the Be Part of Research service on the NHS App. Managed by the National Institute for Health and Care Research (NIHR) this will allow patients to browse and find the trials best suited to their interests and needs.

Eventually the plan will see the NHS App automatically match patients with studies based on their own health data and interests, sending push notifications to their phone about relevant new trials to sign up to. It comes as NIHR launches a UK-wide recruitment drive for clinical trials - the biggest ever health research campaign - to get as many people involved in research as possible.

Tens of thousands more patients receiving crucial scans quicker

Latest data shows 44,000 fewer people were waiting more than six weeks for procedures like endoscopies, ultrasounds and MRIs compared to February last year (2024).

It means some patients being referred for suspected illnesses including heart conditions, spinal cord injuries and various cancers could be diagnosed faster, helping save lives.

The Government is continuing to expand community diagnostic centres (CDCs) nationwide, offering 12-hour, 7-day access to vital tests and appointments.

The expansion is funded from the extra £26 billion investment in the health service delivered at the Autumn Budget, bringing care closer to communities who need it.

Millions receive help from NHS high street pharmacies

More than five million patients have received help from high street pharmacies for minor illnesses, as the NHS brings care closer to people's homes.

Around 2.4 million people received help without booking an appointment at their local pharmacy for seven common conditions including sore throat, earache or shingles.

Pharmacies delivered the most consultations for acute sore throats (835,679) followed by uncomplicated urinary tract infections (UTIs) (665,409).

High street pharmacists have also delivered 1.5 million consultations for minor illness referrals and 1.4 million consultations for urgent medicine supplies.

The move means people do not have to contact their GP to receive help, freeing up appointments for those who need them most.

'Amazon-style' prescription tracking goes live in NHS App for millions of patients

Millions of patients can now track their prescriptions thanks to a new feature in the NHS App helping to reduce unnecessary calls and visits to pharmacies.

NHS England announced that nearly 1,500 high street chemists are now offering the service, which enables patients to check on their prescriptions through real-time “Amazon-style” updates.

Almost half (45%) of phone calls to community pharmacies are estimated to be from patients asking if their prescription is ready, with the new service helping to free up time for pharmacists to provide advice to patients. Instead of phoning up, patients can instead track their prescriptions by logging in to the app to see if their medicines are “ready to collect” or “dispatched by pharmacy” if they are being delivered.

The service is expected to be made available to nearly 5,000 more pharmacies over the next 12 months – covering 60% of those in England.

5-minute ‘super-jab’ for 15 cancers

The NHS is rolling out an injectable form of immunotherapy, Nivolumab, benefitting an estimated 1,200 patients a month who will be able to receive their fortnightly or monthly treatment in five minutes instead of up to an hour via an IV drip.

The roll-out will save over a year’s worth of treatment time for patients and NHS teams annually – enabling patients to spend less time in hospital while freeing up capacity to deliver more appointments and treatments.

The new jab can be used to treat 15 cancer types, including skin cancer, bladder and oesophagus.

Volunteers support the NHS for 6 million hours this year

NHS England figures published during national Volunteers Week shows that 71,828 people volunteered in NHS trusts in the last year donating over 6.4 million hours of their time (an average of a fortnight each). From people in their late teens to those in their late eighties, volunteers have helped with tasks such as directing loved ones around hospitals, collecting medication or basic admin tasks.

3. **Regional Updates**

Review of the Shared Collaborative Agreement

One Lancashire and South Cumbria (One LSC) was set up last year, bringing together many central services from all five trusts across the Provider Collaborative. Hosted by ELHT, it is a formal partnership agreement between all Trusts in the Lancashire and South Cumbria system. The One LSC Shared Collaborative Agreement was reviewed by the Provider Collaborative Board when they met in May. No changes to the agreement were proposed.

Changes to Lancashire and South Cumbria Integrated Care Board (ICB)

The ICB Board has appointed two new members. Stephen Igoe has joined as a Non-executive Director and Stephen Spill as Associate Non-executive.

Both roles will support the ICB to be effective in providing the best health and care services for local people, ensuring that decisions are always taken in the interest of patients and populations across Lancashire and South Cumbria.

Lancashire Teaching Hospitals confirmed as host trust for pathology services

Lancashire Teaching Hospitals has been confirmed as the host trust for a new pathology single service in Lancashire and South Cumbria (LSC).

A decision was taken by the LSC Provider Collaborative and Integrated Care Board earlier this year to form a single, unified pathology service across LSC. Since then, the Pathology Network team has made significant progress in developing plans to form a single service.

In partnership with all Trusts across the network, they will take on responsibility for the delivery of pathology services, with the aim of forming a single team providing a unified service by autumn 2025.

Plans being put together for single vascular network

Vascular services across England are being reconfigured to ensure all patients receive consistent care across provider trusts.

A proposal has been put together to establish a Lancashire, South Cumbria, and Wigan (LSC&W) Vascular Network hosted by Lancashire Teaching Hospitals NHS Foundation Trust.

This would mean that there would be a single dedicated specialist Arterial Centre hosted by Royal Preston Hospital with networked hospital sites at the other partner Trust hospitals including Royal Blackburn Hospital and all staff would work together jointly.

All patients would continue to go to their local hospital for vascular outpatient, day case, and diagnostic services. All patients who need vascular inpatient services would go to Royal Preston Hospital.

This model would aim to create a sustainable specialist network that focuses expertise on a single centre of excellence for Lancashire and South Cumbria while ensuring that everything that can be done safely locally remains at each individual Trust for the convenience of patients.

Patient and staff engagement about this proposal is currently taking place.

Digital platform helps Lancashire and South Cumbria residents make end-of-life plans

A free-to-use digital end-of-life planning platform has been rolled out in Lancashire and South Cumbria. The website empowers residents to make plans for their future health and social care and supports them to communicate these with those important to them. It facilitates will writing and documentation of their wishes for their possessions and digital

accounts when they die. It can also be used to document and share advance care decisions and end-of-life choices.

ICB hears how partnership work is reducing health inequalities

Members of the ICB's board had an insightful visit to various locations around Lancashire to see the fantastic work being done to reduce health inequalities.

Non-executive members Jim Birrell and Sheena Cumiskey met with communities in Burnley, Morecambe and Heysham, where some impactful partnership work is taking place.

The session included a visit Burnley General Hospital and the Down Town community shop to meet members of Burnley Together Partnership, Calico Housing and our Primary Care Network (PCN) and Integrated Neighbourhood Team leads to discuss how support is offered to residents.

Specialist weight management support in Lancashire and South Cumbria

The new weight management medication, Tirzepatide (brand name Mounjaro®), is now available to NHS patients nationally.

It may not be available in Lancashire and South Cumbria yet, even as some people qualify for the medication based on national eligibility criteria. The ICB is currently looking at the options for a new specialist weight management service to cover Lancashire and South Cumbria. This service is being designed in response to feedback from local people about what matters most to them:

- Choice: Both face-to-face and online support and access to a range of treatment options.
- Accessibility: A service that is easy to access and inclusive.
- Timely: Access to services when they are needed most without long waiting lists.
- Holistic: A service that helps people change their relationship with food for the better.

4. **Local and Trust specific updates**

Use of the Trust Seal

The Trust seal has been applied to the following documents since the last report to the Board:

On 19 June 2025 the seal was applied to an Equipment Contractors Collateral Warranty for the supply, maintenance and replacement of equipment at the Royal Blackburn Teaching Hospital between the Trust, Siemens Healthcare Ltd and Consort Healthcare Ltd. This was signed by Martin Hodgson, Chief Executive, and Samantha Simpson, Executive Director of Finance.

On 19 June 2025 the seal was applied to a Deed of Variation to Project for the removal of PACS equipment services at the Royal Blackburn Teaching Hospital between the Trust, Siemens Healthcare Ltd and Consort Healthcare Ltd. This was signed by Martin Hodgson, Chief Executive, and Samantha Simpson, Executive Director of Finance.

On 1 July 2025 the seal was applied to a revised PACS Deed of Termination between the Trust and Siemens Healthcare Ltd. This was signed by Martin Hodgson, Chief Executive, and Samantha Simpson, Executive Director of Finance.

Changes to Trust Board

The Trust has appointed Dr Julian Hobbs as Executive Medical Director and part of the Executive Team and Trust Board – a statutory post that is essential for the safe and efficient running of medical services.

This appointment follows a robust and thorough recruitment and assessment process, which included an impressive field of candidates vying to join the Trust in what is a critical role.

Julian will commence in post on 1 August 2025 and in the meantime, Mr Shahid Islam will continue to support the Executive Team, Trust Board and medical colleagues across ELHT in the role of Interim Executive Medical Director.

The Non-Executive team has said farewell to Non-Executive Director Trish Anderson and welcomed Simon Featherstone and Shahedal Bari who join as Non-Executive Director and Associate Non-Executive Director respectively.

SPECtacular nursing results for Trust teams

A number of teams have been awarded the silver and gold standard as part of the Trust's Safe Personal and Effective Care (SPEC) award. To earn these award, each team had to achieve positive ratings during a series of unannounced inspections as part of the Nursing Assessment and Performance Framework (NAPF). The NAPF framework is based on the Chief Inspector of Hospitals '5 Key Lines of Enquiry', which asks the question: Is the service safe, effective, caring, responsive and well-led? The teams celebrating awards are:

- Ward C14B at Royal Blackburn Teaching Hospital (1st gold award)
- Endoscopy at Royal Blackburn Teaching Hospital (1st silver award)
- Ward C14A at Royal Blackburn Teaching Hospital (4th silver award)
- Ward B24 at Royal Blackburn Teaching Hospital (4th silver award)
- Discharge Lounge at Royal Blackburn Teaching Hospital (4th silver award)

Finance Headlines

The Trust continues to implement its financial recovery plan and colleagues across the Trust are working hard to reduce costs by more than £60million. This continues to be reported in more detail separately to the Board, but a number of related initiatives are included below.

- **Rapid improvement weeks identify nearly £2m of potential savings** Rapid Process Improvement Weeks (RPIW) are taking place to help teams and departments reduce the overall variable pay spend (bank & agency) for the Trust.

  During each week colleagues come together and receive intensive support to review and improve processes. Since launching in January this year, over £1,854,864.74 of potential savings have been identified by 40 teams and departments who have attended.

  The success relies on the fact that the people who do the job everyday are best placed to identify process improvements. They take time to understand their data using a series of tools to support staffing, planning and decision making, and then develop ideas that are rapidly tested and put into action.

  Those participating are being supported by a multi-disciplinary team made up of a good mix of specialist expertise and experience from corporate teams. Further weeks are planned throughout 2025/26.

- **Contract review** Following feedback from colleagues about value for money opportunities, a review of contracts is being carried out.

  It will look at whether what the Trust has paid is in line with the contracts held. It will initially look at:

  - Medical service
  - Clinical service
  - Linin and laundry
  - Radiology reporting
  - Renal
  - Pharmacy

  The aim of this work will be to maximise value, recover any over payments, enhance procurement insight, and inform future decision-making.

- **Working together to save costs** The Improvement team is visiting departments across Royal Blackburn Hospital to talk with colleagues about ways to improve efficiency and reduce waste in processes and systems.

  The sessions aim to support teams to find practical ideas to help save money, all while making work easier and safer for everyone.

It is one of a number of initiatives taking place at the Trust to reduce spend, while finding ways to improve quality of service delivery.

Royal Blackburn Hospital gets £2m A&E improvement cash

The Trust has been given a £2 million bonus for its success in cutting the number of 12 hours waits in the accident and emergency department at Royal Blackburn Teaching Hospital.

It is among 11 NHS organisations in the region to be given a share of £150m capital spend in recognition of having some of the best-performing or most improved A&E wait times and Category 2 ambulance response times in the country.

New Senior Clinical Fellow role will improve patient safety in ED

A new Senior Clinical Fellow role has been introduced in the Emergency Department (ED) to improve patient care, department flow and reduce the need for bank shifts.

This offers a clear career pathway for locally employed doctors, enabling them to progress from Junior Clinical Fellows to Senior Clinical Fellows, then onto Specialty Doctors and, ultimately, Consultants.

By reducing reliance on bank and agency staff, the initiative is expected to generate long-term savings for the Trust—freeing up resources that can be reinvested in patient care and service improvements.

Relocation of Urgent Treatment Centre (UTC) at Blackburn

There have been some changes to the locations of departments to enable essential improvement work to take place.

- The Adult Urgent Treatment Centre (UTC) at RBTH has relocated to the General Outpatients Department, which is accessed through the main entrance of the hospital.
- Children and young people under the age of 16 will continue to access urgent care via the Emergency Department.
- The Ambulatory Emergency Care Unit (AECU) has also successfully moved to Ward B3 at RBTH.

Colleagues were praised for their responsiveness, teamwork and commitment which ensured minimal disruption and a safe, efficient transition during the moves.

Estates funding secured for Burnley General Teaching Hospital

The Trust has secured over £750,000 of national funding to support critical infrastructure work at Burnley General Hospital. The money, part of the Estates Safety Fund, will support fire protection improvements, a lift replacement and an upgrade to infrastructure to heating and water in patient areas.

Over 400 hospitals, mental health units and ambulance sites across the country have secured a total of £750 million towards essential maintenance fixes. The work will be completed by the end of March 2026.

Public engagement about the future of Accrington Victoria

Colleagues and communities across Accrington and Hyndburn have been given the opportunity to have their say on the future of Accrington Victoria Community Hospital.

The building, in Haywood Road, Accrington, was closed in December 2024 when East Lancashire Hospitals NHS Trust was forced to relocate services due to the poor condition of the site.

As part of the closure programme, the Trust made commitments to local people that it would retain clinical services in the town, ensure the rich history of Accy Vic was remembered and celebrated and, when the time came, engage the community in what would happen next to the site.

To kick this off, a survey was published both online and via paper copies in community hotspots to gather initial views and ideas. It was widely promoted and the Trust joined the local MP at the popular Accrington Carnival event to talk to people and capture their views.

Nearly 1,500 people completed the survey and their feedback will be considered by a project team, which includes Hyndburn and Haslingden MP Sarah Smith and Hyndburn Councillor Melissa Fisher, as part of decision making about the next steps for the regeneration of the site.

Lowest ever figures for mums smoking at the time of delivery

The Trust has been part of a team effort across Blackburn with Darwen to reduce the number of pregnant women who still smoke at the time of delivery. In the latest national data for January to March 2025, the rate was 4.4 per cent and the lowest annual figure ever recorded in the area. The national target is 6 per cent and the latest figure of 4.4 per cent is lower than the Lancashire and South Cumbria average of 7.2 per cent and the national average for England, which is 5.6 per cent for the year.

Interventions which have been implemented across the area have included a financial incentive scheme, having maternity support workers in maternity, a pharmacy support scheme and a new stop smoking service is planned. This is clearly a great result which will impact on the health and well being of both mother and baby now and into the future.

Ongoing Stakeholder Engagement Activity

The Trust continues to build upon already effective stakeholder relationships across Lancashire and South Cumbria, the North West region and wider nationally as appropriate.

This has become more important as financial constraints required an agreed waste reduction programme (WRP) far in advance of anything the Trust has ever delivered before.

Our aim in meeting with colleagues, including East Lancashire MPs and representatives of our Local Authorities, is to ensure they are sighted on and able to input into any service changes that affect constituents in their geographical area.

Activity that has taken place recently includes:

- Two regular and well attended monthly meetings for our local MPs
- Two regular and well attended monthly meetings with Local Authority CEOs
- An extended workshop between the Trust, Local Authority CEOs and PLACE colleagues
- Support to the MP for Hyndburn and Haslingden at Accrington Carnival
- A visit to Royal Blackburn Hospital by the MP for Pendle
- A range of responses to correspondence from constituents across a range of issues and concerns

Service improvements to commercial hospital bus

On March 31, 2025, the Trust stopped running a shuttle bus between Royal Blackburn Teaching Hospital, Burnley General Teaching Hospital and Pendle Community Hospital, which was free to use and would have cost £780,000 this year.

Following conversations with patients, colleagues and stakeholders across the area, a commercial bus company Moving People began to operate a similar route on April 1, 2025, including extra stops in Blackburn and Burnley town centres. The initial timetable was offered on week days and made use of the £3 fare cap in place.

Following feedback from colleagues, patients and visitors, changes are now being made to the timetable between Blackburn and Burnley Hospitals. This includes moving the timetable to better accommodate start and finish times and expanded to run on Saturdays and Sundays.

The recent announcement that the fare cap will remain in place until 2027 will continue to limit the cost for passengers to £3 and this can be reclaimed for those who meet eligible criteria to ensure access to healthcare is supported.

Patient wellness questionnaire pilot goes trust wide

A patient wellness questionnaire piloted earlier this year has now been extended across all wards. The questionnaire requires ward nurses to ask each patient or their advocates two simple daily questions - 'how are you feeling today?' and 'how are you feeling compared to last time we asked you?'

The aim is to ensure that when a patient states they don't feel 'well' or 'right', that their concern is taken seriously and any required action by the ward nurses, doctors and Acute

Care Team is initiated. This may include increasing the frequency of observations, or a review by the medical team.

The new questionnaire is part of the Trust's Call for Concern programme, which is the local name for Martha's Rule, a national patient safety initiative providing patients and families with a way to seek an urgent review if their or their loved one's condition deteriorates and they are concerned this is not being responded to. It was introduced at the Trust last year, shortly before it as launched nationally.

AI and Automation at the centre of digital workshop by EPR provider team

Colleagues from the company that provide the Trust's electronic patient record visited Royal Blackburn Teaching Hospital to meet with a range of colleagues about the future of the system including use of artificial intelligence and automation.

Whilst the commercial element of the some of the development work underway would prevent the content of the afternoon from being fully reported, it is clear that new functionality being tested would enhance the experience of the EPR for clinicians and patients.

This includes things such as ambient and direct voice technology as well as digitised processes for day to day nursing activity.

In addition, the Trust is utilising specialist experience at the moment to map systems, understand what data can be provided that isn't and automate processes and use AI to benefit patients and colleagues.

This is in line with the Government's published pledge for the NHS to become more digitally enabled, enhancing patient experience, supporting clinicians to focus on patients and reducing costs and waiting times where possible.

Marathon day for gynaecology robotic surgical team

The gynaecology robotic surgical team undertook a high intensity theatre day, with successful robotic hysterectomy surgery carried out on five patients. The usual maximum on an all day theatre would be three.

The aim of the session was to help reduce waiting lists, drive productivity, improve outcomes for patients and allow greater access to surgery via the da Vinci robot. In the future the team hopes to scale best practice from these lists to standard weekday lists to increase the number and complexity of patients operated on daily.

This level of high intensity theatre lists have only been undertaken by a few Trusts across the country.

Dementia Delivery Plan for 2025-2029

The Trust launched its Dementia Delivery Plan for 2025-2029 at an event that coincided with Dementia Action Week.

The plan outlines a commitment by the Trust to those living with dementia and their carers across East Lancashire, as well as professionals who interact with those living with dementia and their carers. The full document is available on the Trust website www.elht.nhs.uk.

New room provides hope to mums

A new room has opened in the post-natal ward at Burnley to support mums whose babies are at risk of going into care.

The Hope Room has been designed in conjunction with mums with lived experience who shared what might have made their traumatic experience a little better. It provides a private space for meetings or video links with professionals regarding the future of their baby, and has comfortable reclining seats, mood lighting and colourful wall art.

It is the first room of its kind in the country in an acute hospital Trust and been made possible thanks to funding from our charity ELHT&Me and a lot of hard work by a number of people.

Befriending service pilot launched

A befriending service offering emotional support and friendly conversation to identified vulnerable individuals has been launched by the Trust's community teams.

The initiative, which involves colleague volunteers checking in once a week by phone, video call or in person, provides continuity, builds trust and helps to understand the broader issues impacting patients and vulnerable individuals such as housing conditions (like damp affecting respiratory health) and then work with partner charities, with consent, to intervene early.

It's not a clinical or therapeutic service, but a way for that person to have someone to talk to and help reduce feelings of loneliness and make them feel more connected.

The service is offered for up to 12 weeks and will bring lots of benefits include strengthening patient relationships outside crisis situations, identifying and addressing social determinants of health, reducing avoidable GP and ED attendances and enhancing our reputation as an innovative and community-focused service.

The idea was inspired by the CHEWW initiative in Westminster, which focuses on holistic, preventative community support.

Apprentices complete training

A total of 19 apprentices completed their training at the Trust in April and May. Apprentices at ELHT are an integral part of the team, often learning on the job in both clinical and non-clinical settings. From those gaining hands-on experience in clinical areas, to colleagues

studying professional qualifications and senior leaders pursuing Masters-level qualifications, these colleagues are shaping the future of healthcare at the Trust.

ELHT offer employment to 150 young people through King's Trust

ELHT and The King's Trust are celebrating marking a milestone in the 'Get into Hospital' programme. Employment has now been offered to 150 young people who have taken part in scheme which provides training, mentoring, and support to young people wanting to work in the health and social care sector.

Shannon became the 150th young person to be offered employment at ELHT. She attended a taster session which led to a placement and training to become a Healthcare Assistant.

Award shortlist for Sister on Cardiac Care ward

An ELHT colleague described as 'the epitome of an exceptional nurse, embodying patience, compassion and professionalism' was shortlisted for a Student Nursing Times Award.

Zoe Shorrock, Ward Sister on Cardiac Care at Royal Blackburn Teaching Hospital, was one of the finalists in the Practice Supervisor of the Year award at this year's prestigious event.

The awards took place on Friday, 2 May and whilst Zoe did not win, being shortlisted for the awards, which highlight excellence in all specialities of student nursing is an outstanding achievement.

Zoe, who has worked at the Trust since 2018 and works within a team of 30 to 40 colleagues, was nominated because she consistently goes above and beyond to support patients and colleagues, offering thoughtful guidance and excellent bedside manner.

Keelie Barrett is the first maternity support worker to receive honorary fellowship by RCM

Keelie Barrett, an ELHT maternity support worker educator has been awarded an Honorary Fellowship by the Royal College of Midwives (RCM), making her the first MSW to receive such esteemed recognition.

The award was presented to Keelie during the RCM's National Conference in Birmingham in May. The Honorary Fellowship was awarded to Keelie to recognise her contribution to maternity care and the positive impact her work has had on the MSW profession.

Professor Georgina Robertson

Georgina Robertson, the Trust's Clinical Director and Consultant in Emergency Medicine based in the Urgent and Emergency Care team has been awarded an honorary clinical

professor title by Lancaster University in recognition of the work she has done to improve training for medical students in the Trust.

The 2025 Star Awards

More than 500 colleagues have been put forward for the annual Star Awards which recognise the extraordinary people who work at the Trust.

This year there were 10 categories open to applications, all spotlighting teams and individuals who are making a difference to the Trust and our patients.

Entries closed on Monday, 30 June and the judging process is now underway and details of the nominations and finalists will be released in due course.

The usual event is expected to take place in September as long as sponsorship funding can be secured to deliver it without using money from the Trust's main budget.

ENDS

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Meeting Date:	9 July 2025	**Agenda Item:**	TB/2025/091
Report Title:	2023-24 Trust Green Plan		
Author:	R Sethi		
Lead Director:	T McDonald, Executive Director of Integrated Care, Partnerships and Resilience		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓	✓	✓	✓
Executive Summary:	This paper sets out the Trust activities associated with reducing their carbon emissions. There are nine (9) Areas of Focus that are used to determine the Trust position. The Trust Green Plan is based on the 2023/24 activities. The NHS requires every NHS organisation to produce a Board approved Green Plan, aligning with national goals for carbon reduction and sustainability.			
Key Issues/Areas of Concern:	1. Trust Board requested a plan on a page as opposed to reviewing the full Trust Green Plan. 2. The Trust Green Plan paper including the full Trust Green Plan was submitted to the Trust Finance and Performance (F&P) Committee for approval on June 30, 2025. This was deferred due to other matters to the next F&P meeting on July 28, 2025, see paragraph 7.1.1, .			
Action Required by the Committee:	1. Approve the notes / recommendations listed in paragraph 7.			

Previously Considered by:	See paragraph 7.1.1
Date:	
Outcome:	

1. EXECUTIVE SUMMARY

1.1 This paper provides a local and national overview of the Green Plan, the attachments provided are:

1.1.1 Appendix 1 - Trust Board Plan on a Page based on Emission Projection.

1.1.2 Appendix 2 - Potential savings.

1.2 The Trust was reliant on two releases from NHS England before the 2023/24 Trust Green Plan could begin to be drafted, that is:

1.2.1 The finalised ERIC data which was released by the NHS Estates team on the December 19, 2024: https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection/summary-page-and-dataset-for-eric-2023-24 and

1.2.2 The updated Green Plan guidance from NHS England, was released on the February 4, 2025: https://www.england.nhs.uk/long-read/green-plan-guidance/

1.3 The Trust Green Plan for 2022/23 was the final iteration of the previous Green Plan cycle. As per NHS England guidance set out below, an annual update should be published:(Green Plan Guidance 2021). The length of the 2022/23 update was kept consistent with the previous iterations to ensure:

1.3.1 Drastically changing the report structure could jeopardise the consistency and comparability to the original Green Plan.

1.3.2 The report, in its current form, does meet the guidance from NHS England.

1.4 While approved Green Plans cover a three-year period, each NHS Trust and ICS should formally review and update their plans annually to consider:

1.4.1 The progress made and the ability to increase or accelerate agreed actions.

1.4.2 New initiatives generated by staff or partner organisations .

1.4.3 Advancements in technology and other enablers.

1.4.4 The increase in ambition and breadth of national carbon reduction initiatives and targets.

1.5 Wording for the new Trust Green Plan 2023/24 fully complies with the new requirements set out below and is condensed to 39 pages: https://www.england.nhs.uk/long-read/green-plan-guidance/

2. NHSE NET ZERO - NATIONAL POSITION

2.1 In October 2020, the NHS became the world's first health service to commit to reaching carbon net zero, in response to the growing threat to health posed by climate change. On July 1, 2022, the NHS became the first health system to embed net zero into legislation, through the Health and Care Act 2022: https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted

2.2 The NHSE net zero objectives are:

2.2.1 For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032; and

2.2.2 For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

3. TRUST NET ZERO - BACKGROUND

3.1 The Trust in 2021 partnered with Inspired Energy to provide a service that is:

3.1.1 wholly advisory in nature associated with the net zero NHS Agenda. Inspired Energy is assisting the Trust in developing our Green Plan agenda and are providing the information to the Trust to use / implement as we see fit.

3.2 On January 14, 2022, the first Trust Green Plan was submitted to Lancashire & South Cumbria Integrated Care Board (L&SC ICB). It set out the Trust three-year strategy for progressing towards net zero by actioning the nine (9) areas of focus. The Trust Green Plan forms part of the Trust objectives to deliver the NHSE objectives set out in paragraph 2.2.

3.3 A Trust-wide carbon footprint was produced covering financial years 2018/19 through to 2020/21 for a comprehensive overview of emissions over three years. Consumption data has been taken from the Trust annual Estates Returns Information Collection (ERIC), in order to maintain consistency in our publicly available reporting. A detailed action plan

covering the nine (9) areas of focus in the Trust Green Plan, aligned with the Trust's existing clinical, quality, financial and estates strategies, was produced alongside the carbon footprint.

4. TRUST NET ZERO EMISSIONS AS AT MARCH 31, 2024

4.1 Inspired undertake emissions reporting in accordance with guidance published by the Greenhouse Gas Protocol (GHGP) and have contextualised these calculations to align with NHSE guidance on Green Plan structure and national NHS net-zero targets.

4.2 In 2021, the Trust set their baseline year for reporting to align with their financial year 2020/21, this was the Trust's most complete year for data collection, and at the time the pandemic was expected to last several years. 2020/21 therefore was the closest we had to what we expected to be a "normal" reporting year going forward. It has remained our baseline.

4.3 Table 1 shows a summary of the carbon emissions.

Table 1 - 2023/24 Carbon Emission Summary:

Target	Base Line 2020/21 tCO2e	2023/24 tCO2e	Variance tCO2e
2040 "Carbon Footprint"	37,579	27,540	-10,038
2045 (Carbon Footprint Plus"	67,577	75,920	+8,344

1. ***A 26.7% reduction from the baseline has been seen due to the phasing out of desflurane use as an anaesthetic gas, and its replacement by less carbon intensive alternatives. Going forward from FY2024, An annual average reduction of 4.6% compared to the baseline is required to meet the target.***

2. ***A 12.3% increase from the baseline has been seen due to increased expenditure on operational goods and services in FY2024. Going forward from FY2024, an annual average reduction of 5.3% compared to the baseline is required to meet the target.***

5 TRUST NET ZERO - CURRENT RISKS

5.1 Some immediate risks are listed in Table 2, which need to be managed by each of the nine (9) Trust Responsible Leads:

Table 2 - Immediate Risks

Risk	Details
High	The quality of the Trust Green Plan may be compromised due to competing priorities within the Trust, for example, the time taken by the Trust to provide Inspired with the data required for the Green Plan refresh.
High	No or partial responses from the Trust to Inspired on the proposed action plan may compromise the content included in the Trust Green Plan. For example: • Workforce and System Leadership no response, • Sustainable Models of Care partial response.
Medium	The Trust has reduced its 'Carbon Footprint' emissions by over 10,000tCO_2e since the baseline year of FY2021. Although this means emissions from the 'Carbon Footprint' are currently ahead of the trajectory towards net-zero by 2040, many of these reductions are due to the phasing out of desflurane. Future reductions will need to come from more challenging areas, such as the decarbonisation of heating.
High	The 'Carbon Footprint Plus' emissions are not on track to meet the 2045 net-zero target and have in fact increased compared to the baseline. The primary driver for this is the activity associated with Supply Chain and Procurement, and requires a formal rectification plan, such as a supplier engagement plan and updating of procurement contracts. This should also be shown on the Trust risk register.

3. ***High risks have a high probability of occurrence and severe potential impact, requiring immediate attention and strong mitigation strategies.***
4. ***Medium risks are moderately likely and may have moderate impact, needing monitoring and management.***
5. ***Low risks are unlikely and have minimal impact, requiring minimal resources.***

6 TRUST COMMUNICATION TEAM AND INSPIRED

6.1 Inspired continue to provide the Trust with excellent support. The Trust Communications team (Richard Miller) has undertaken outstanding work on the corporate design of the Trust Green Plan.

7 NOTES / RECOMMENDATIONS

7.1 The Trust Board is asked to note / approve the following:

7.1.1 The Trust F&P Committee was asked to approve the Green Plan on June 30, 2025. Due to other matters, the Trust Green Plan had to be deferred to the next F&P meeting, on July 28, 2025. If the Trust Green Plan is deferred again or not approved, then the Trust will not achieve the NHSE requirements, that is, ensure their Board approved Green Plan is published on the internet site by the NHSE date of July 31, 2025.

7.1.2 For completeness, the Trust Board should note NHSE definition below:

- *"Refreshed green plans should be approved by the organisation's board or governing body, published in an accessible location on the organisation's website and shared with NHS England by 31 July 2025."*

If the Trust F&P Committee approve the full Trust Green Plan paper on July 28, 2025, then they will be acting as the Trust governing body.

7.1.3 The Executive lead for sustainability has transferred from the Trust Executive Director of Finance to the Executive Director of Integrated Care, Partnerships and Resilience.

7.1.4 The Trust Executive Director of Integrated Care, Partnerships and Resilience has also agreed to take over chairing the Trust Sustainability Group from the Deputy Director of Finance and will be refreshing the membership and work programme of the Group going forward.

7.1.5 Trust Board is asked to approve Appendix 1, Plan on a Page, as requested.

7.1.6 Trust Executive Director(s) responsible for Sustainable Models of Care and Workforce and Systems Leadership may wish to ensure updates are provided to Inspired. This is important if the Trust Green Plan is not to be compromised.

7.1.7 Trust Executive Director of Finance and Executive Director of Integrated Care, Partnerships and Resilience to consider some on the following:

- Assurances if all "green plan" initiatives are being actioned on the Trust WRP Action Tracker as "green plan" contributions, see Appendix 2.

- Seek formal assurances from One LSC regards an immediate rectification plan associated with Supply Chain and Procurement as listed in Table 2. This may require dialogue with Inspired Energy too.
- Discuss with One LSC if there is a more effective way of delivering the Lancashire and South Cumbria system green plan requirements / opportunities.

Rajan Sethi
Associate Director of Commercial Services
July 1, 2025

Appendix 1 - Trust Board (Closed Session) July 9, 2025 - Plan on a Page based on Emission Projection.

Appendix 1 - Plan on a Page.pdf

Appendix 2 - Potential Savings

Appendix 2 - Potential Savings.xlsx

Emission projections

East Lancashire Hospitals NHS Trust's GHG emissions projections based on the Carbon Footprint and Carbon Footprint Plus trajectories and FY2021 baseline

Green Plan Area of	GHGP	GHGP	NHS Target	Emissions Source	Recorded emissions data						Projected emissions data			
					FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028
Estates and Facilities	Scope 1		Carbon footprint	Pipe-supplied natural gas consumption	11,029	12,221	12,696	10,605	13,384	11,741	10,024	9,355	8,687	8,019
				On-site fuels consumption	61	87	27	1,234	11	12	21	20	18	17
				On-site non-medical gases consumption	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
Medicines				On-site medical gases consumption	0	9,418 *	11,277 *	3,220 *	2,218 *	3,827	8,903	8,309	7,716	7,122
Travel and Transport				Company-owned fuelled vehicles travel	0	199	189	220	211	184	149	139	129	119
				Company-leased fuelled vehicles travel	0	71	54	41	34	123	43	40	37	34
Estates and Facilities	Scope 2		Carbon footprint	Grid-supplied electricity consumption (Location-based)	7,533 *	6,821 *	7,810 *	5,939 *	5,249 *	5,648	6,166	5,755	5,344	4,932
				Grid-supplied electricity consumption (Market-based)	7,533	6,821	0	0	5,620	0	0	0	0	0
Travel and Transport				Company-owned electric vehicles travel	0	0	0	5	21	5	0	0	0	0
				Company-leased electric vehicles travel	0	2	2	2	3	0	1	1	1	1
Estates and Facilities	Scope 1	Category 1	Carbon	Water consumption	105	109	209	104	57	54	165	154	143	132
Supply Chain and Procurement			Carbon footprint plus	Purchased operational goods and services	70,837 **	64,146 **	52,962 **	69,490 **	62,153 **	65,543	44,135	41,929	39,722	37,515
		Category 2		Purchased capital goods	N/C	N/C	N/C	N/C	N/C	42	0	0	0	0
Estates and Facilities		Category 3	Carbon	Upstream fuel and energy losses	3,400	3,285	3,739	4,304	3,805	3,868	2,952	2,755	2,558	2,361
Travel and Transport		Category 4	Carbon footprint	Upstream goods transportation and distribution	N/C	N/C	N/C	N/C	N/C	49	0	0	0	0
Estates and Facilities		Category 5	Carbon footprint	On-site generated waste	648	624	985	860	616	1,139	777	726	674	622
Travel and Transport		Category 6		Business travel	N/C	416	308	474	490	649	243	227	211	195
		Category 7	Carbon footprint plus	Staff commuting travel	9,037 *	9,420 *	9,151 *	9,223 *	10,040 *	9,037 *	9,420 *	9,151 *	9,223 *	10,040 *
Estates and Facilities		Category 8		Upstream leased assets	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Travel and Transport		Category 9		Downstream goods transportation and distribution	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Supply Chain and		Category 10		Downstream processing of goods	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Medicines		Category 11	Carbon	Downstream use of inhalers	N/C	371	283	487	362	280	224	209	194	179
Supply Chain and Procurement			Carbon footprint plus	Downstream use of goods	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		Category 12		Downstream generated waste	N/C	N/C	N/C	N/C	N/C	0	0	0	0	0
Estates and Facilities		Category 13		Downstream leased assets	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		Category 14		Franchises	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		Category 15		Investments	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Travel and Transport	Outside of scope		Carbon footprint	Patient travel	3,533	3,392	3,265	3,187	3,059	N/C	2,720	2,584	2,448	2,312
				Visitor travel	2,379	2,284	2,199	2,146	2,060	N/C	1,832	1,740	1,649	1,557
Total Emissions (location-based)					108,564	112,867	105,155	111,542	103,775	103,461	85,981	81,188	76,394	71,601
Total Emissions (market-based)					108,564	112,867	97,345	105,603	104,146	97,812	79,816	75,433	71,051	66,668
Total Emissions (Carbon Footprint)					22,777	33,625	37,579	27,496	26,462	27,540	29,667	27,689	25,712	23,734
Total Emissions (Carbon Footprint Plus)					85,787	79,242	67,577	84,046	77,313	75,920	56,314	53,498	50,683	47,867

**Historic emissions have been restated to align with improved methodologies
*Historic emissions have been restated due to updated DEFRA emissions factors for respective years

Area of focus	Description	Yearly Emission Savings (tCO_2e)	Assumptions
Travel and transport	All fleet vehicles to be of the latest emissions standards: (1)From 2023, 50% of all fleet vehicles to be of the latest emissions standards, Ultra-low Emission Vehicles (ULEVs, such as plug-in electric hybrid), or Zero Emission Vehicles (ZEVs, such as electric cars) (2) From 2025, 75% of all fleet vehicles to be of the latest emissions standards, ULEVs or ZEVs. (3) From 2030, 100% of all fleet vehicles to be ULEVs or ZEVs, including a minimum of 20% ZEVs.	350–530	Based on a static fleet size and consistent mileage relative to FY24. No change in operational logistics assumed. Emissions savings result from phased vehicle replacement to meet ULEV/ZEV targets (50% by 2023, 75% by 2025, 100% by 2030 with 20% ZEV minimum).
Estates and facilities	REGO - Market based electricity	5,600–5,700	Savings have already been achieved as REGO-backed electricity tariffs were procured once again in FY24 location-based emissions and not the actual tarrifs. Ensure this continues to keep market-based electricity emissions minimal.
Estates and facilities	LED Lights	850- 1000	Based on benchmarking from a comparable NHS facility. Assumes complete replacement of lighting infrastructure with LEDs. Lifetime savings accrued across asset duration (typically 8–10 years). Savings are based on the average lifetime savings of 9500 tCO_2e. Will impact location-based emissions only, assuming REGO-backed electricity tariffs continue to be procured.
Estates and facilities	Optimise energy use by embedding networked Automatic Meter Readers (AMRs) across the Estate with appropriate controls to reduce energy consumption.	2,000–2,100	Based on projected 15% gas consumption reduction across the estate. Assumes FY24 activity levels and no major infrastructure expansion.
Estates and facilities	Utilise the most water efficient technologies, such as low flow taps throughout our estate, when replacing equipment and developing new sites	45–50	Based on potential 40% water efficiency improvements through modern fixtures. Estimates derived from FY24 water use, with deployment across new and replacement installations.
Estates and facilities	Waste paper recyled	70–75	Assumes proper segregation and routing of paper waste into recycling streams. Based on FY24 waste volumes. More accurate estimates possible with detailed plastic/paper purchase data in kg.
Medicine	Set a goal to reduce MDIs to 25% of all non-salbutamol inhalers by prescribing DPIs and soft mist inhalers, where clinically appropriate	125–130	Based on FY24 inhaler prescription data. Clinical appropriateness considered, with stable demand profile into FY25.

Medicine	Switch to methoxyflurane (Penthrox™) in preference to nitrous oxide analgesia/anaesthesia where clinically appropriate.	0.02-0.03	Based on like-for-like substitution of analgesics, assuming constant clinical activity year-on-year.

TRUST BOARD REPORT

Meeting Date:	9 July 2024	**Agenda Item:**	TB/2025/092
Report Title:	Health and Safety Strategy and Policy		
Author:	Mr J Houlihan, Assistant Director of Health, Safety and Risk		
Lead Director:	Mr T McDonald, Executive Director of Integrated Care, Partnerships and Resilience Mrs A Brown, Associate Director of Quality and Safety		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
			✓	
Executive Summary:	The Mersey Internal Audit Agency (MIAA) conducted an evaluation of the Trust's health and safety management system and corporate responsibilities. The review benchmarked current arrangements against applicable health and safety legislation, regulatory standards and established key lines of enquiry (KLOE). The audit concluded with a 'moderate' assurance rating indicating an adequate system of internal controls. However, it identified weaknesses in the design and or inconsistent application of these controls, which could compromise the achievement of certain objectives.			
Key Issues/Areas of Concern:	Key areas for improvement included the need for a more formalised board level process for approving and reviewing the organisational health and safety strategy and policy. Additionally, enhanced oversight and assurance mechanisms for monitoring newly developed workplace health and safety standards were recommended to strengthen compliance, accountability and performance.			
Action Required by the Committee:	Members are requested to: 1. Note the contents of this report 2. Review and approve the health and safety strategy and policy 3. Seek regular assurances from its nominated Committees and or Groups regarding its progress			

Previously Considered by:	Quality Committee
Date:	September 2024
Outcome:	Approval of the Health and Safety Strategy and Policy

The Health and Safety Management System

1. The Trust's Health and Safety Framework is underpinned by the Health and Safety Executive (HSE) Guidance HSG65 '*Managing for Health and Safety*'. This provides a recognised, structured model to ensure a consistent, high-quality approach to health and safety governance.
2. At its core is the Plan-Do-Check-Act (PDCA) cycle which promotes a balanced focus on both system processes and staff behaviours. This model positions health and safety as an integral part of overall organisational governance, rather than a standalone function.

Figure 1 HSG 65 Plan, Do Check, Act Model Diagram

Plan	Establish board level commitment, define strategy and policy and set objectives
Do	Organise systems and people, assess and manage risks, and implement plans
Check	Monitor and measure performance, both proactively and reactively
Act	Review outcomes, learn lessons, and drive continuous improvement

3. The PDCA model is widely endorsed by regulators including the HSE and Care Quality Commission (CQC) and informs regulatory enforcement frameworks and inspection criteria, including CQC's Key Lines of Enquiry (KLOE).
4. An important part of the model in achieving good health and safety planning outcomes is having a strategy and a clear plan. The Trust's health and safety at work policy (the policy) sets clear direction outlining the legal framework for the effective management of health and safety, how this is to be delivered, achieved and performance managed, whilst health and safety strategic planning (the strategy) enables the successful implementation of objectives.

Key Health and Safety Legislation

5. The criteria used to determine policy and planning for implementation are firmly aligned with key legislative and regulatory frameworks, including the Health and Safety at Work etc. Act 1974, the Corporate Manslaughter and Corporate Homicide Act 2007, the Management of Health and Safety at Work Regulations 1999. They are also guided by nationally recognised best practice frameworks, including the HSE and Institute of Directors Guidance (INDG417) and NHS Staff Council Standards. This ensures the Trust's approach is legally sound, strategically informed and underpinned by strong leadership principles.
6. A detailed summary of applicable legislative, regulatory and best practice frameworks is provided in the appendices.

Board Level Health and Safety Governance

7. The table below outlines the criteria used within the PDCA model to determine policy and planning for implementation, alongside the supporting sources of evidence.

Criteria	Evidence
The organisation has securing compliance with health and safety legislation as a core requirement of their strategy, led by the board	Strategy document
There is a health and safety at work policy which is discussed and ratified by the board	Policy document
The board sets priorities and develops performance standards to comply with legislation and improve standards	Internal and external audit reports | Annual reports | Incident statistics and analysis data
The board can provide evidence that priorities and performance standards are based on risk assessment, audit findings and appropriate data	Risk registers | Internal and external audit reports | Annual reports | Incident statistics and analysis data
Board level responsibility for health and safety is defined and organisational accountabilities are clear	Strategy document | Policy document | Job descriptions | Performance agreements | Board minutes | Scheme of delegation
The board has appointed an executive director as the board champion for health and safety. A non-executive director is appointed to scrutinise health and safety performance	Policy document | Job descriptions | Performance agreements | Board minutes
Health and safety are a standing agenda item at board meetings	Board minutes | Health and Safety Committee minutes and updates
The board receives, discussed and scrutinises regular reports and updates on the management of health and safety risks	Board minutes | Annual reports | Health and Safety Committee minutes and updates | Incident statistics and analysis data

The board ensures health and safety issues are integrated into the business planning processes and appropriately actioned	Board minutes | Annual reports | Health and Safety Committee minutes and updates | Incident statistics and analysis data

Internal Audit Findings and Recommendations

8. An internal audit conducted by the Mersey Internal Audit Agency (MIAA) assessed the Trust's health and safety management system and corporate responsibilities, benchmarking against statutory duties and CQC Key Lines of Enquiry (KLOE). The review concluded with *moderate assurance*, recognising an adequate system but identifying inconsistencies in control application and design, which may affect overall effectiveness.
9. Key recommendations included strengthening board oversight through more formal ratification of the policy and strategy. Furthermore, enhanced monitoring of recently developed workplace standards was advised to support legislative compliance, improve audit outcomes, and drive delivery of key safety programmes, with the ultimate goal of achieving 'outstanding' 'safe' and 'well led' safety excellence, culture and high performance.

The impact of not taking action

10. The failure to meet health and safety obligations may:
    a. Result in the injury, infection and or ill health of staff, patients and or others.
    b. Have a detrimental impact on the health, safety and wellbeing of staff, increased sickness absence rates, recruitment and retention, patient safety and effective service provision.
    c. Damage safety culture, organisational values and performance.
    d. Negatively influence staff and patient safety risk reduction strategies and levels of harm i.e. moderate or severe injury or death.
    e. Result in the issue of fines and or enforcement action.
    f. Lead to organisational and individual prosecution.
    g. Adversely affect registration and licence to operate requirements.
    h. Have undesired consequence for claims management and the ability to defend employee, public and third-party liability claims.
    i. Damage credibility, organisational reputation and commercial viability.
    j. Increase adverse publicity.

Regulatory Activity

11. The Health and Safety Committee has conducted a review of recent prosecutions and key enforcement trends, highlighting growing regulatory emphasis on health and social care organisations demonstrating a robust health and safety management system and operating framework. This includes the expectation of strong leadership, effective oversight, and visible senior management commitment and leadership to robust health and safety governance.

Mitigations for risks and timelines

12. The policy has been enhanced to incorporate a more detailed reference to the health and safety management system model and strategy. It clearly outlines the specific arrangements, responsibilities, and accountabilities for all staff and key staff groups. In addition, monitoring mechanisms and key performance indicators have been extended to enable more effective measurement and review, supporting a unified and consistent approach to safety management.
13. The introduction of workplace health and safety standards forms a key component of the Health and Safety Committee's workplan. This initiative is designed to provide stronger assurance to the Quality Committee and Board regarding compliance with statutory health and safety legislation and adherence to regulatory standards.

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

14. Ensuring the health, safety, and wellbeing of patients and staff, alongside the consistent and reliable delivery of services, is essential to avoiding regulatory enforcement and financial penalties. It also underpins the provision of high-quality, safe, personal, and effective care, while safeguarding the organisation’s credibility, reputation, and long-term success at both national and local levels.

Resource implications and how they will be met

15. The policy and supporting standards clearly identify responsible individuals tasked with evaluating the effectiveness of the organisation’s safety management systems and controls. Their role includes addressing non-conformances, ensuring timely corrective action, and applying risk management principles to assess resource utilisation and establish priorities. This approach supports ongoing compliance and promotes a safe, well-led, and healthy environment for staff, patients, and third parties.

Benchmarking Intelligence

16. The Health and Safety Committee's diverse programme of work is now subject to more rigorous measurement, with a focus on proactively shaping and promoting a positive safety culture. This approach is informed by both:
    a. External drivers including existing and emerging legislation, case law developments, key consultation outcomes, professional guidance, and regulatory expectations.
    b. Internal drivers such as evolving organisational strategy and objectives, changes to workforce structures and service delivery models, as well as job design, required competencies, behavioural insights, audit findings, performance data, and statistical analysis.

Conclusion of Report

17. Health and safety management must be forward-looking, continuously evolving beyond past achievements. Ongoing, progressive efforts remain essential to ensure the organisation not only meets but exceeds its statutory and regulatory obligations. Sustaining high standards of safety culture and performance is critical to driving improvement, advancing towards excellence, and achieving external recognition and accreditation. This commitment also supports broader organisational resilience, enhances reputation, and delivers commercial value.

Recommendations

18. Board-level approval and oversight of the health and safety policy and strategy, supported by the Health and Safety Committee's performance management of the standards and the Quality Committee's assurance monitoring will strengthen compliance with statutory requirements. This coordinated governance approach will also drive progress in key safety initiatives and programmes, enhance audit outcomes, and foster the desired safety behaviours, culture, and performance across the organisation.

Next Actions

19. The Board is asked to:
    a. Acknowledge the content and findings outlined in this report.
    b. Review and formally approve the Health and Safety Strategy and Policy
    c. Request ongoing assurance and progress updates from the designated Committees and Groups responsible for overseeing implementation and outcomes.

How the decision will be communicated internally and externally

20. Decisions relating to the review and approval of the Health and Safety Policy, Strategy, and Standards are made through a structured governance framework, including the Health and Safety Committee, Trust-wide Quality Governance Meetings, the Quality Committee, and ultimately the Board.

How progress will be monitored

21. The health and safety policy and strategy have been formally approved by the Health and Safety Committee and are underpinned by a legally required Statement of Intent. This statement, signed by the Chief Executive and the Executive Director of Integrated Care, Partnerships and Resilience, affirms the organisation's commitment to delivering its objectives and upholding its health and safety responsibilities.

Appendices

Appendix A - Legislative, Regulatory and Best Practice Frameworks
Health and Safety Strategy (Attachment)
Health and Safety at Work Policy (Attachment)

Mr J Houlihan, Assistant Director of Health, Safety and Risk
24 June 2025

Appendix A - Legislative, Regulatory and Best Practice Frameworks

Legal Foundations of Accountability

Under ***Section 37 of the Health and Safety at Work etc. Act 1974***, directors and senior leaders are personally accountable when organisational health and safety breaches occur through their consent, connivance, or neglect. This provision reinforces that health and safety obligations are not merely corporate responsibilities, they are personal legal duties that demand active leadership, governance, and vigilance from the top.

Complementing this, ***the Management of Health and Safety at Work Regulations 1999*** requires employers to implement robust arrangements for planning, organisation, control, monitoring, and review of health and safety measures. This regulation ensures health and safety is embedded into both strategic intent and operational execution, adapting to organisational scale, complexity, and change.

Together, they constitute the cornerstone of corporate health and safety governance, promoting a culture of proactive leadership, structured risk management, and ongoing performance improvement.

Corporate Criminal Liability

The ***Corporate Manslaughter and Corporate Homicide Act 2007*** introduces criminal liability for fatal incidents resulting from serious management failures. This heightens the necessity for executive-level scrutiny and reinforces the role of non-executive directors in challenging organisational resilience and risk controls.

Leadership Standards: INDG417

The HSE's guidance, ***INDG417 – Leading Health and Safety at Work***, co-authored with the Institute of Directors, articulates four principles for effective board health and safety leadership:

1. **Active leadership from the top –** visible commitment, clear responsibilities, and integration of health and safety into business decisions.
2. **Worker engagement –** empowering employees to participate in identifying risks and shaping solutions.
3. **Assessment and review –** using audits, incident data, and risk assessments to drive improvement.
4. **Board accountability –** ensuring directors understand and discharge their legal and moral obligations.

This guidance supports a structured *Plan, Do, Check, Act* approach, aligning safety management with broader organisational governance frameworks.

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Health and Safety Strategy and Framework

Achieving 'outstanding' safety excellence

Safe | Personal | Effective

Executive Summary

This is a strategic plan that supports our vision and journey in achieving safety excellence and 'outstanding' accreditation. It describes the legal framework in which we operate, the challenges we expect to face and our ongoing commitment to continuously improve the health, safety and wellbeing of our staff, our patients and others, and of developing and maintaining a proactive health and safety culture that achieves high standards of performance.

Now is the right time to introduce our health and safety strategic plan and operating framework.

It follows a period of uncertainty that has seen the impact of the coronavirus pandemic, regulatory intervention, concerns of governance, safety and risk management performance as well as adapting to new technology and ways of working.

This strategic plan supports our strategic framework and supporting enablers. Our organisation has delivered some inspiring improvement work led by colleagues across our services.

Our vision is to build on this success.

Our refreshed approach to the service we provide and the way we work and behave will support keeping our staff, our patients and others protected from the risk of occupational injury or ill health.

Delivery of this strategic plan will support our ambition and journey in achieving a Care Quality Commission (CQC) rating of being 'outstanding' in well led and safety excellence.

That journey includes significant and exciting change by way of:

- Developing strong senior management health and safety leadership.
- Adopting a more integrated health and safety framework and service delivery model.
- Enhancing the skills, competence and behaviours that enable staff to make the safe way the only way.
- Identifying and reducing key workplace hazards and of looking after each others physical and mental health, safety and wellbeing.

It is also designed to keep us focused on tackling both new and traditional risks, at the right time, in the right way.

By setting out clear objectives and themes we can guide future **insight** that will create the space to **involve** and **improve** what we do, embracing different ways of working against a refreshed set of priorities that will enable us to proactively adapt and respond to changing landscapes as continuous quality and safety improvement becomes our business as usual.

John Houlihan
Assistant Director
Health, Safety and Risk

Health and Safety Strategy and Framework on a Page

Our Strategic Aims

Strong Senior Management Health and Safety Leadership

Integrated Health and Safety Service Delivery Model

Strategy and Performance

Priority Objectives and Delivery

Our Primary Drivers

Leadership Behaviours of Managers and Staff

Health and Safety Management System

Maintaining Skills and Competence

Physical Health and Wellbeing

Our Vision and Mission

Prevent people from having an injury or illness at work or through work
Provide excellence in quality and safety by making the safe way, the only way

Our Enablers

- Health and Safety Policy and Procedures
- Risk Profiling
- Roles and Responsibilities
- Challenging Safety Goals and Objectives
- High Standards of Performance
- Supportive Safety Staff
- Managing Contractors
- Progressive Motivation
- Effective Communication
- Continuous Professional Development
- Health and Safety Training
- Better Use of Technology
- Proactive Safety Monitoring and Audit
- Comprehensive Accident and Incident Reporting and Investigation
- Organisational Learning
- External Accreditation
- Stakeholder Influence

Our Purpose, Our Vision and Our Values

Our collective **purpose** and **vision** is to improve the health, wellbeing and experience of the population we serve by being widely recognised for delivering high quality **safe**, **personal** and **effective** care. This includes more traditional forms of healthcare service provision and of improving the physical and mental wellbeing of our service users and our staff

Our **vision** is underpinned by our **core values** and our **strategic framework** is our commitment to how our **vision** and **values** are delivered throughout the Trust.

Our **behaviours** are an important foundation of providing high quality **safe**, **personal** and **effective** care and are fundamental in the way in which our values are achieved

We have **six goals** that are the '*golden threads*' that weave through all that we do as individuals, teams and collectively as a Trust

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

Our **supporting strategies** are the cornerstone of our **strategic framework**, providing the plan and the what i.e., the details of how we will collectively support delivery of our **vision** and **goals**

Safe | Personal | Effective

Our Quality Strategy

Our **Quality Strategy** has been developed with our colleagues, by listening to our community, receiving feedback from our key stakeholders and reviewing insight, involvement and improvement indicators and data intelligence.

It is supported by several underpinning frameworks that detail the implementation plan that builds upon our previous commitments and achievements.

Our **Quality Strategy** aims to:

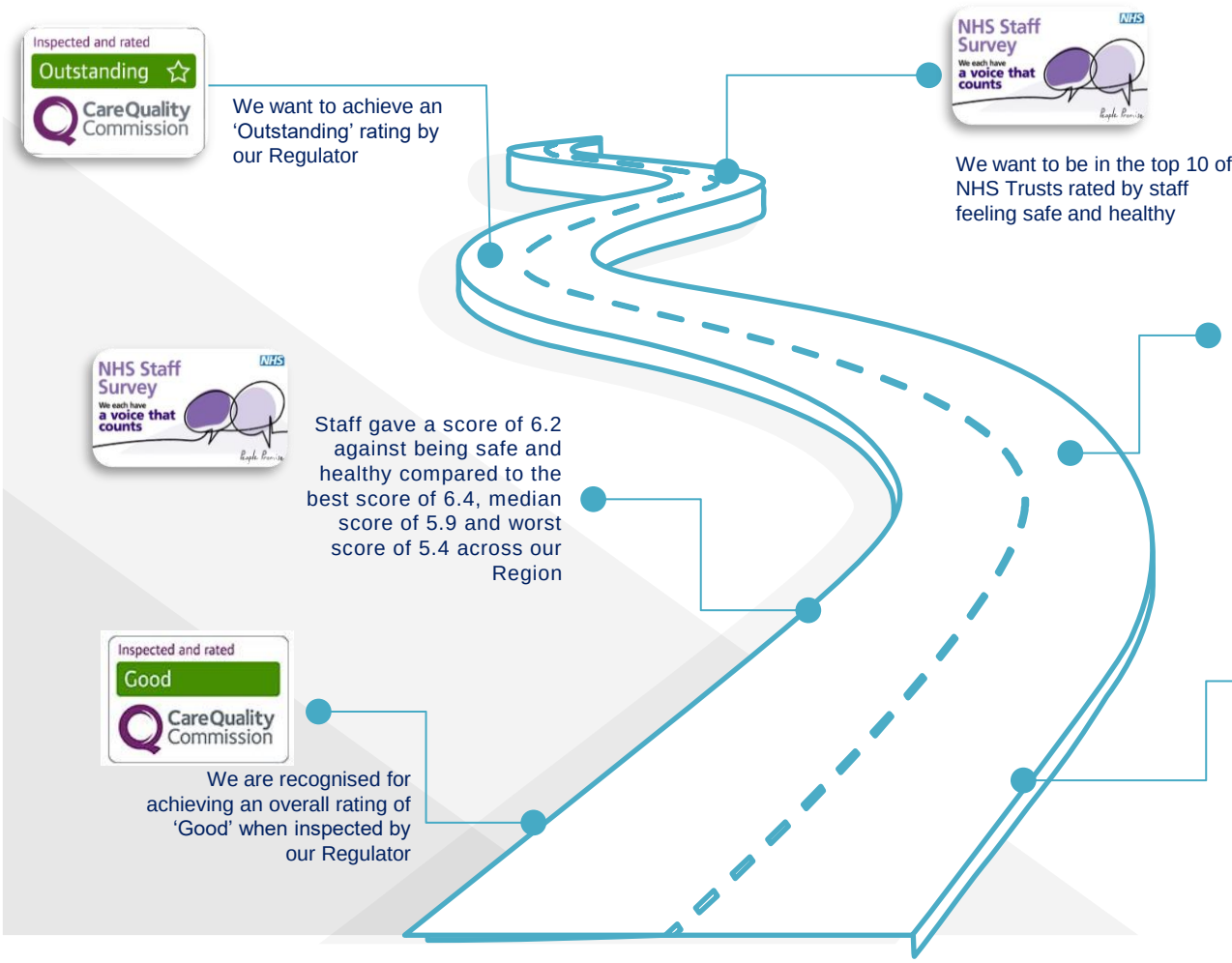
Safe / Insight
Reduce harm, prevent errors and deliver consistently safe care

Personal / Involvement
Influence, challenge, strengthen and promote consistently safe, quality, reliable, accessible, equitable care outcomes

Effective / Improvement
Deliver consistently effective, reliable care and develop and embed a culture of continuous improvement, learning and innovation

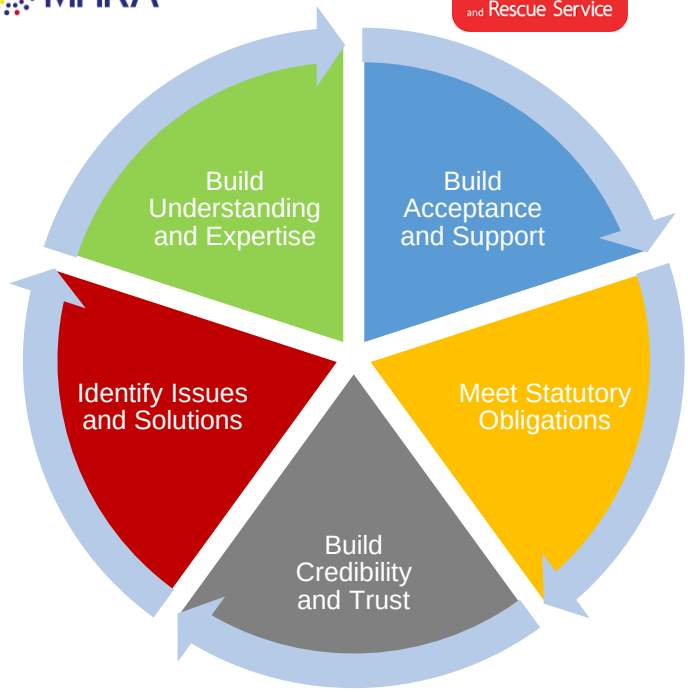
Safe | Personal | Effective

Where we are and where we want to be



Key Stakeholders

HSE Health & Safety Executive
Lancashire and South Cumbria Provider Collaborative
Environment Agency
MHRA
CareQuality Commission
Lancashire Fire and Rescue Service



Patient Safety	Falls	Manual Handling	Fire Safety	Health and Safety
Wellbeing	Security Management	Medical Devices	Quality and Safety Leads	Legal
Occupational Health	Human Resources	Emergency Planning	IT	Estates and Facilities
Datix / Radar Manager	Clinical Leads	Learning and Development	Safety Reps	PFI / Contractors
	Infection Control	Radiation Protection		

Our SWOT Analysis

We have made some significant progress despite some very challenging circumstances and take confidence as we move towards the implementation of our strategic plan

Strengths

Increased value and organisational commitment placed on occupational staff safety and wellbeing

Access to and competent health and safety advice

Weaknesses

Unable to provide quality assurances regarding regulatory framework

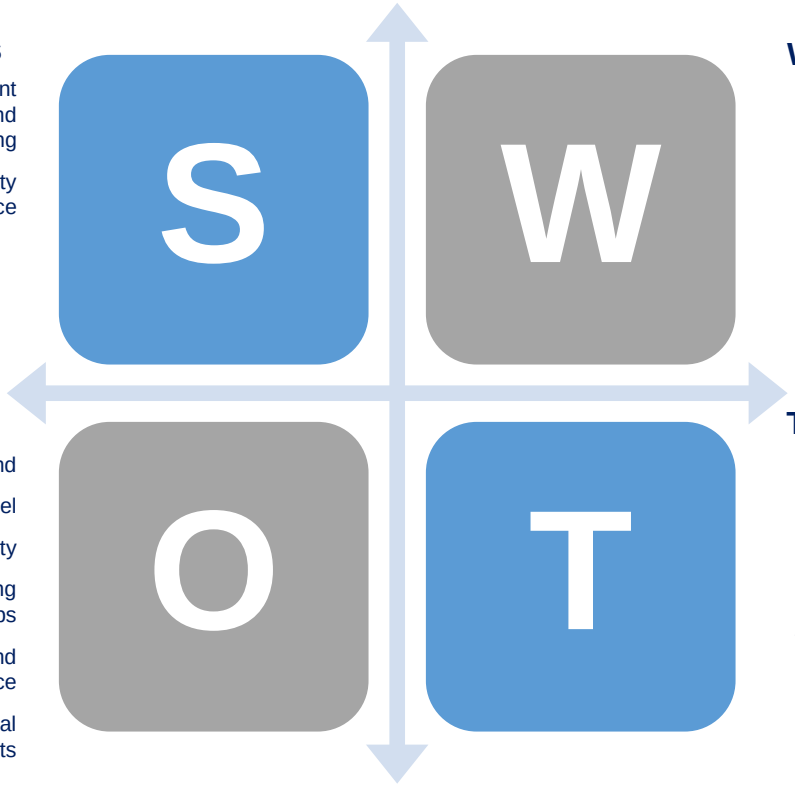
Limited resources. Past, missed opportunities for investment

Reduced senior management insight and overview

No strategic uniformity

Difficulties providing proactive or practical support

Inability to focus on major work projects due to conflicting priorities



Opportunities

Increasing, continuous service demand

One service delivery model

Strategic uniformity

Specialist roles clearly defined with closer working relationships

Consistency in goals, objective setting and performance

Minimised financial risk and increased organisational benefits

Threats

Increasing regulatory activity and enforcement

Guilty knowledge of gaps in the regulatory framework

Fragmented health and safety management system and approach

Disjointed lines of communication, joined up thinking, flexibility and decision making

Manifestation of health and safety issues, increased risk of fines and litigation

Reduced organisational benefit

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Our Vision and Mission

Our vision is to prevent people from having an injury or illness at work or through work

Our mission is to provide excellence in quality and safety by making the safe way, the only way

Delivery will be through this strategic plan, its aims and supporting drivers and enablers

Safe | Personal | Effective

East Lancashire Hospitals NHS Trust
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Our Strategic Aims

Strong Senior Management Health and Safety Leadership

Integrated Health and Safety Service Delivery Model

Strategy and Performance

Priority Objectives and Delivery

Our Primary Drivers

Leadership Behaviours of Managers and Staff

Health and Safety Management System

Maintaining Skills and Competence

Physical Health and Wellbeing

Safe | Personal | Effective

Our Enablers

Strong Senior Management Health and Safety Leadership

There is a genuine desire to continuously improve our safety culture and performance and recognition that safety, and the consistency and reliability in which our services operate, remain crucial if we are to deliver safe, personal and effective care that enhances our organisational credibility, reputation and future

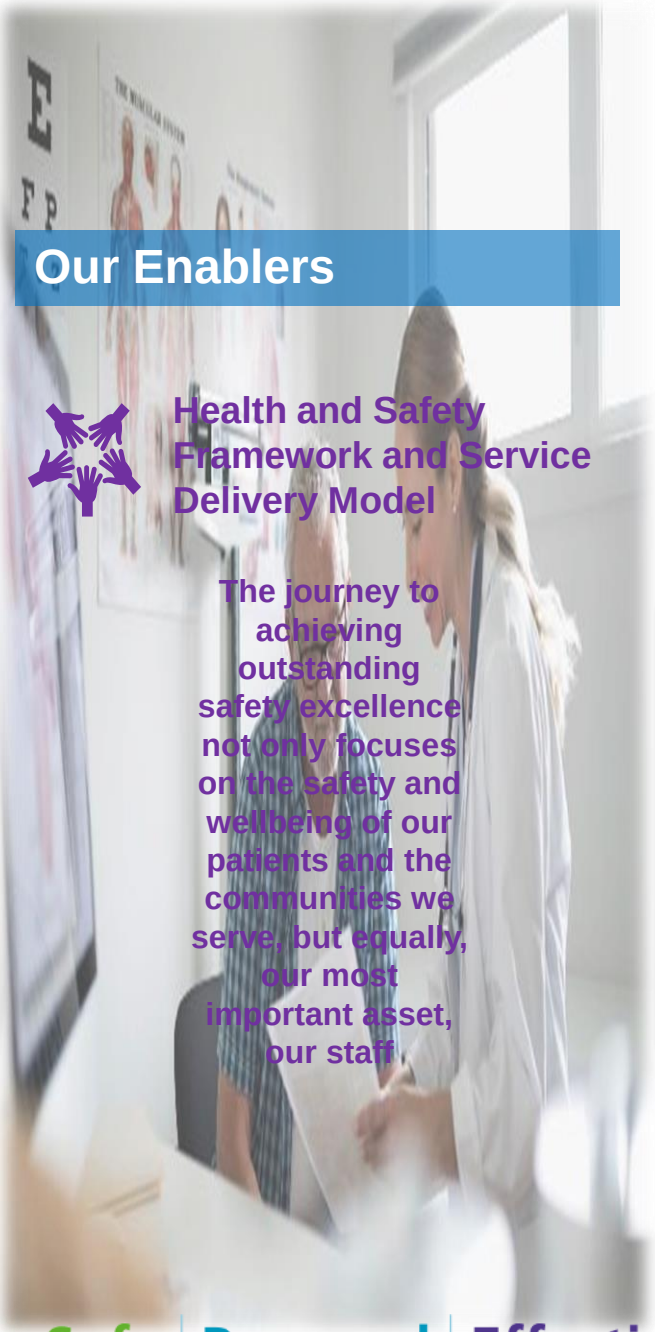
We will support the organisation to achieve outstanding 'safe' and 'well led' excellence by:

Senior management having oversight and integrating INDG417 'leading health and safety at work' guidance as an important senior management toolkit in promoting and driving safety culture and behaviours.

Strengthening senior management health and safety leadership competencies by keeping them well informed of their legal responsibilities, the current safety landscape and what is driving change.

Successful completion of an externally accredited safety qualification i.e., IOSH 'leading' safely course.

Our Enablers



Health and Safety Framework and Service Delivery Model

The journey to achieving outstanding safety excellence not only focuses on the safety and wellbeing of our patients and the communities we serve, but equally, our most important asset, our staff

We will empower the organisation to achieve outstanding 'safe' and 'well led' excellence by:

Adopting a more holistic, integrated organisational approach to health and safety management.

Making sure we have the right resources and competencies to enable our organisation to deliver, and where appropriate, exceed its obligations under health and safety legislation and practice.

Our Enablers

Health and Safety Management System

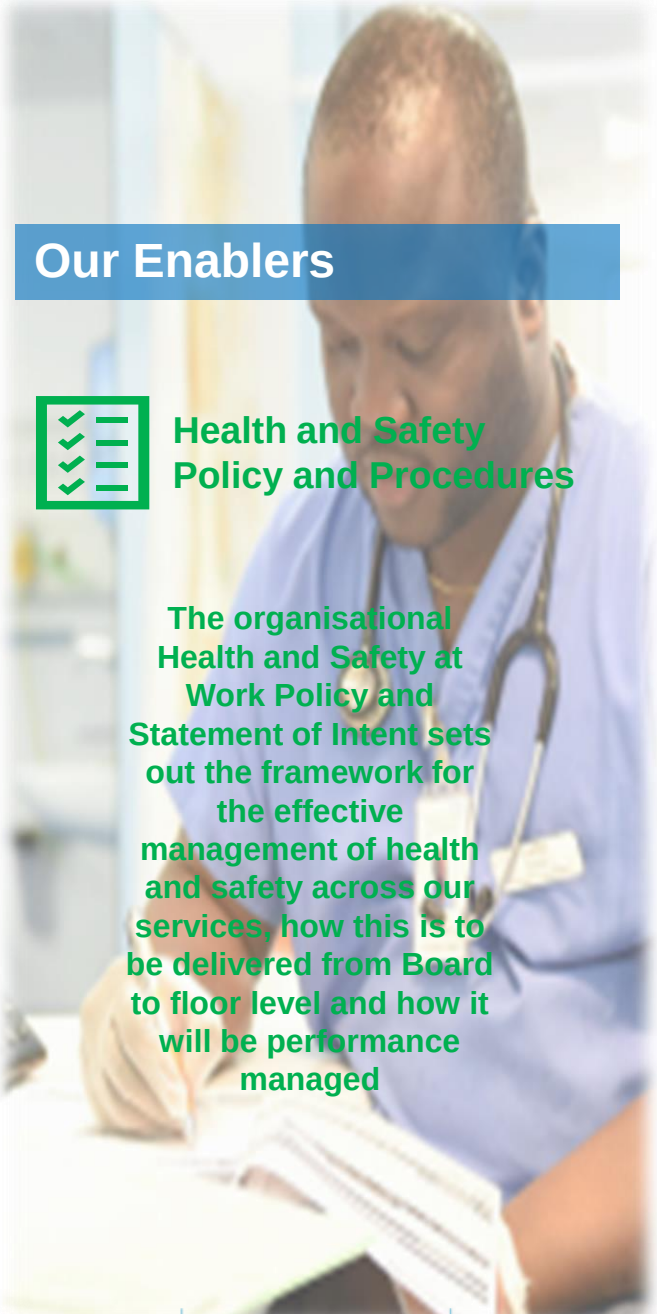
The framework in which our health and safety management system operates will support the delivery of our organisational Health and Safety at Work Policy for the effective planning, organisation, control, monitoring and review of preventative and protective measures that ensures compliance with statutory legislation

We will support the organisation to achieve outstanding 'safe' and 'well led' excellence by:

Revitalising our health and safety management system based on the principles of Health and Safety Executive Guidance HSG 65 'managing for health and safety' providing a clear, recognised model for our organisation to follow.

Evaluating our existing systems and processes, ensuring non-conformances are addressed and enacted upon in a timely manner, and through the process of good governance and risk management, identifying and setting priorities for future action.

Our Enablers



Health and Safety Policy and Procedures

The organisational Health and Safety at Work Policy and Statement of Intent sets out the framework for the effective management of health and safety across our services, how this is to be delivered from Board to floor level and how it will be performance managed

We will support the organisation to achieve outstanding 'safe' and 'well led' excellence by:

Strengthening our policy arrangements to place more emphasis on visible leadership and staff safety behaviours and that its effectiveness is used as supporting evidence that is measured against our strategies, values, and the domains and key lines of enquiry of the Care Quality Commission.

Developing a more comprehensive, robust suite of health and safety procedures and guidance that better supports our policy so as to create a more unified, collective approach to managing health and safety.

Our Enablers

Risk Profiling

Effective leaders and managers know the risks their organisations face, prioritises them in order of importance and take action to control them

We will empower the organisation to achieve outstanding 'safe' and 'well led' excellence by:

Avoiding risk management oversight and using our risk register more proficiently.

Building an organisational profile of the nature and level of our strategic and operational risks and of measuring the effectiveness of controls and assurances in place to manage those risks that will best support our board assurance framework.

Identifying key areas of health and safety risk and, through risk reduction and the use of generic risk assessments, empowering line managers to take action to prevent, reduce or control them to an acceptable level, reducing the potential for accidents and incidents.

Our Enablers

Roles and Responsibilities

Strong senior management health and safety leadership influences managers and staff, who become increasingly receptive of the focus and commitment placed upon it

All staff are required to consider their attitudes, values and behaviours in demonstrating good health and safety principles

We will support the organisation to achieve outstanding 'safe' and 'well led' excellence by:

Clearly defining management and staff responsibilities for health and safety within contracts of employment, codes of conduct and service level agreements, with more specific responsibilities outlined within policy and procedures.

Making sure all staff are made aware of the health and safety risks that may affect them as individuals and teams, as well as those that may affect other persons using or working within our services.

Supporting managers and staff in relation to their ownership of health and safety by providing them with the necessary tools to 'lead by example' and of continuous safety improvements, of not delegating the responsibility to others and challenging unsafe behaviours in a timely way.

Re-emphasising and extending the value and importance placed on staff health, safety and wellbeing against patient outcomes and experience.

Our Enablers

Challenging Safety Goals and Objectives

Having challenging safety goals and objectives supports the delivery of our Quality Strategy and the systematic implementation of key safety drivers and principles

We will support the organisation to achieve outstanding 'safe' and 'well led' excellence by:

Introducing a programme of work and objectives that deliver step changes to include health and safety performance and competency as a major consideration to reducing our sickness absence levels, lost time injury, occupational health surveillance and case management, and compliance with policy or procedures.

Improving safety behaviours and competency through system wide learning that moves our culture of occupational health and safety accidents and injury being inevitable towards being avoidable.

Our Enablers

High Standards of Performance

Clear expectations for delivering and maintaining a culture that seeks to achieve the highest standards of occupational health, safety and wellbeing that are supported with fit for purpose, well communicated systems and processes to implement, monitor and review performance

We will help our organisation to achieve outstanding 'safe' and 'well led' excellence by:

Reviewing our health and safety performance proactively and transparently, enhancing the quality of our accident and incident reporting and investigations, risk analysis, thematic reviews and application of management controls.

Using our Committees or Groups more productively to support the delivery of goals, objectives and key performance indicators used to measure performance.

Transforming health and safety culture from being legislative driven and subsequent compliance to one that focuses on staff behaviours in achieving compliance.

Our Enablers

Supportive Safety Staff

Good leaders should expect to receive professional, competent advice from those in safety critical roles but the management of health and safety must clearly rest with line management so they can improve physical and mental health, safety and wellbeing needs of our staff, and ultimately, those using our services

We will help the organisation achieve outstanding 'safe' and 'well led' excellence by;

Clearly defining the roles, expectations, and competencies of those in safety-critical roles.

Adopting a more integrated way of working that strengthens and improves strategic uniformity, with clear lines of communication, joined up thinking and decision making, flexibility, consistently in goals, objective settings and performance that places us in a better position of supporting our services in responding to future challenges that minimise financial risk and maximise opportunity.

Utilising the commitment, skills and enthusiasm of staff safety representatives, preserving them as a consultative and catalysing asset in developing a more integrated and proactive safety culture.

Moving away from past cultural norms of health and safety leading the safety effort with management in support to one that is reverse.

Our Enablers

Managing Contractors

Working collaboratively with contractors will ensure that their capability and competency needs are met in accordance with our expectations and those of our contractors' work activities which will aim to eliminate or reduce injury or ill health to its lowest level while minimising the environmental impact

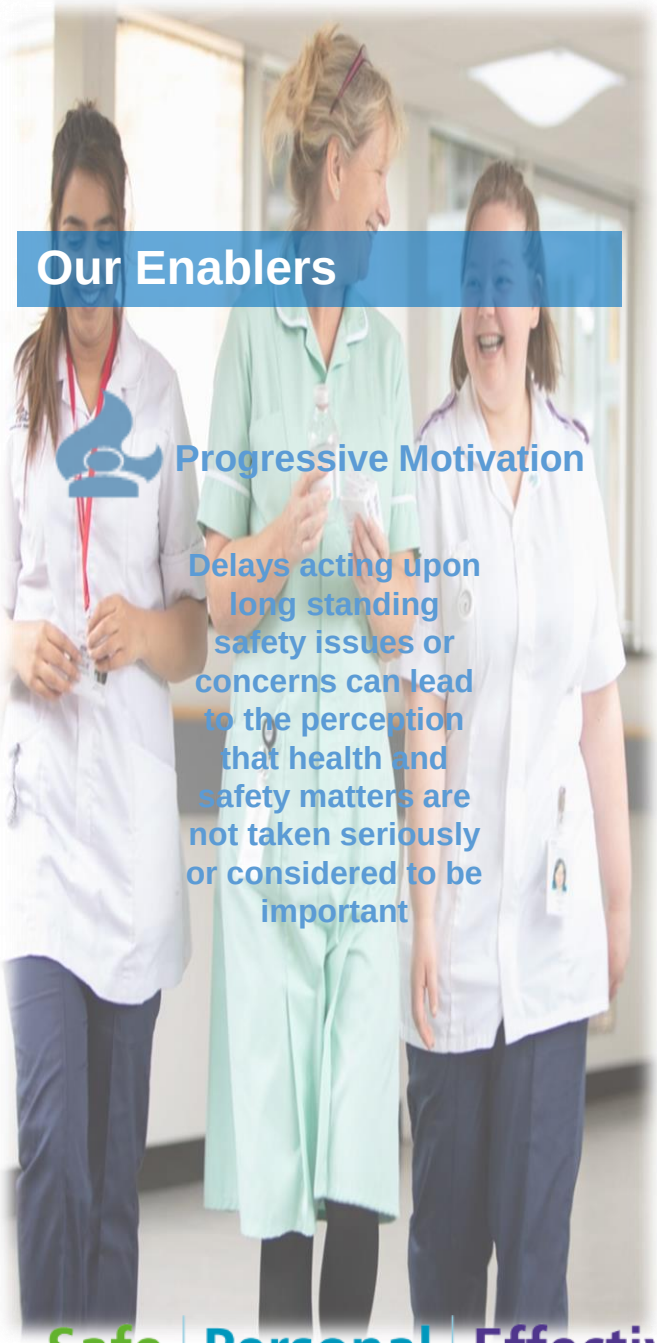
We will support the organisation in achieving 'safe' and 'well led' excellence by:

Improving our tendering procedures and the use of contractor 'passport schemes'.

Establishing a more detailed framework whereby contractor safety performance is measured to the same degree and high standards as we would do our own services.

Creating a culture where unsafe acts or behaviours of contractors are positively and constructively challenged.

Our Enablers



Progressive Motivation

Delays acting upon long standing safety issues or concerns can lead to the perception that health and safety matters are not taken seriously or considered to be important

We will support the organisation to achieve outstanding 'safe' and 'well led' excellence by:

Making safety improvements by staff part of our award initiatives to afford greater opportunity for peer to peer, manager and staff interaction that will influence staff behaviours and promote safety from a positive reinforcement position.

Seeking new ways of engaging with staff to maintain perpetual awareness of proactive safety measures and their active participation through use of safety campaigns, safety climate surveys and quality improvement programmes

Using our appraisal system and staff surveys more effectively to advance desired safety behaviours and competency levels of managers and staff to best enable them to perform their roles safely, effectively and to a high standard.

Our Enablers

Effective Communication

Consulting and involving staff on health and safety matters is paramount in creating and maintaining a safe, healthy workplace.

This not only helps improve health and safety culture and performance across services but positively impacts on the delivery of high quality safe, personal and effective care and patient experience outcomes

We will support the organisation to achieve outstanding 'safe' and 'well led' excellence by:

Revisiting how we maximise engagement with staff and recognised trade unions to form a more unified approach in driving health and safety expectations and standards.

Making better use of communication systems and modern technology available to promote learning and share best practice.

Improving the visibility of our Health and Safety Committee as an important driver and endorsement of organisational accountability and responsibility.

Using service or departmental meetings more effectively to drive key safety management initiatives, solve local issues, define programmes and review performance.

Our Enablers

Continuous Professional Development

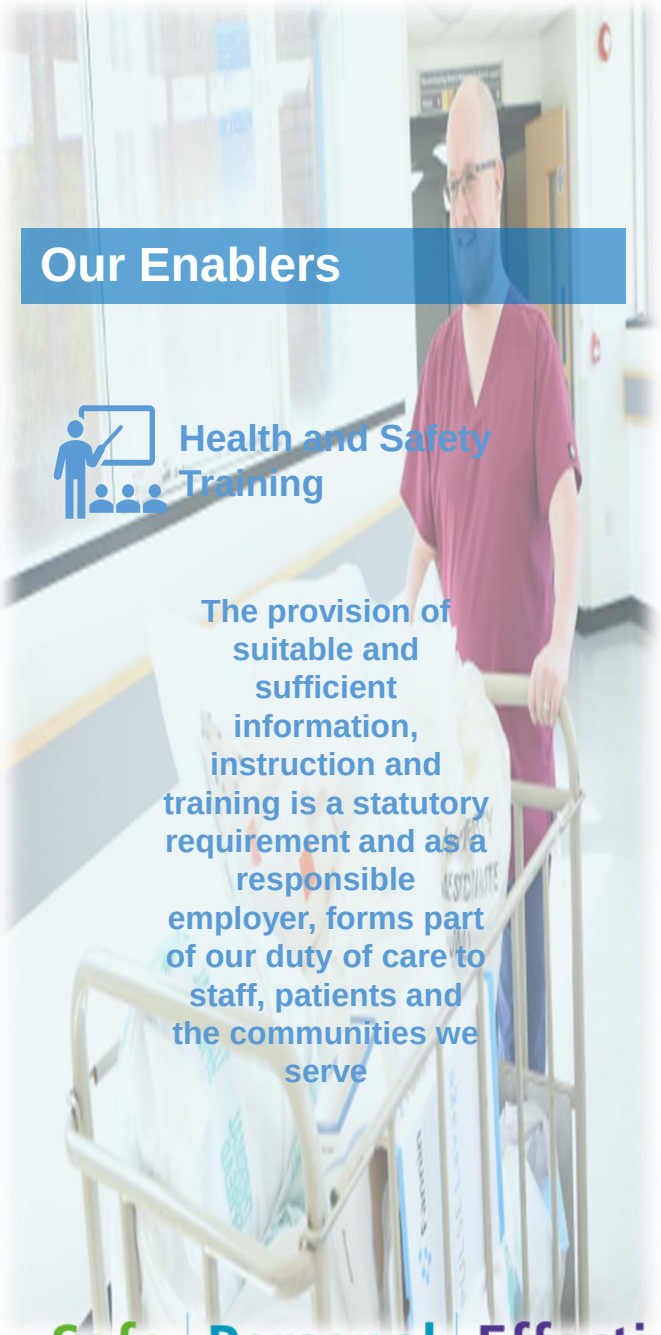
A highly skilled and competent workforce is one of the key drivers of our People Strategy

We will support the organisation to achieve outstanding 'safe' and 'well led' excellence by:

Ensuring everyone, in particular, those performing safety critical roles, has the right level of competence and are equipped to best perform their roles safely and effectively.

Maximising opportunities to improve competency levels by revisiting the use and delivery of externally accredited safety qualifications.

Our Enablers



Health and Safety Training

The provision of suitable and sufficient information, instruction and training is a statutory requirement and as a responsible employer, forms part of our duty of care to staff, patients and the communities we serve

We will support the organisation to achieve outstanding 'safe' and 'well led' excellence by:

Introducing a framework that identifies our health and safety training and competency needs

Making sure the effectiveness of that framework forms part of our accident and incident investigation, proactive monitoring and auditing processes.

Our Enablers

Better Use of Technology

Whilst a 'hands on' approach may still be unavoidable for certain types of hazardous work activity, the use of technology and artificial intelligence will increasingly support and steer the safety effort and help our organisation better discharge its duty of care

We will support our organisation to achieve outstanding 'safe' and 'well led' excellence by:

Making the most of using communication systems and modern technology to drive safety excellence forward, support safer working practices, aid physical risk prevention, convey safety performance and encourage staff feedback mechanisms.

Continuing to embed health and safety into our software systems, developing our health and safety webpage and share point sites along with the use of podcasts and other forms of technology and artificial intelligence to create a more user friendly and interactive approach to deliver important safety initiatives.

Our Enablers

Proactive Safety Monitoring and Audit

Proactive safety monitoring and audit is an essential element of a health and safety management system

We will support the organisation to achieve outstanding 'safe' and 'well led' excellence by:

Avoiding the failure of board oversight, ensuring health and safety is included as a standing agenda item of senior management meetings, with meaningful discussions held.

Providing a more detailed framework of assurances of legislative compliance based upon the outcome of a regulatory gap analysis, to be used as an important driver whereby safety compliance can be continuously measured against statutory legislation and set regulatory standards.

Ensuring our managers and staff understand the benefits of their active engagement and that observations, inspections and a more robust health and safety audit structure and programme is in place that monitors our health and safety management system continuously and not one moment or time of the year.

Our Enablers

Comprehensive Accident and Incident Reporting and Investigation

The reporting, investigation and analysis of work related accidents and incidents forms an essential part of managing health and safety. However, it is learning the lessons of what is uncovered that is at the heart of accident and incident prevention.

This is an important toolkit in developing and refining our understanding of risks associated with our work activities and formation of plans to prevent reoccurrence

We will support the organisation to achieve outstanding 'safe' and 'well led' accreditation by:

Seeking to improve lost time injury performance, and through line management, reduce staff incapacitation as a result of workplace injury.

Making better use of our systems and processes to assess days lost off work due to injury, financial and organisational loss.

Empowering key staff with safety critical roles to develop techniques and competencies to investigate accidents and incidents within their areas of responsibility and control and ensure they are being benchmarked against the safety management systems and processes introduced.

Our Enablers

Organisational Learning

Organisational learning is a key element of a health and safety management system and adopting a systematic approach optimises staff and patient safety outcomes without compromising the delivery of safe, personal and effective care

We will support the organisation to achieve outstanding 'safe' and 'well led' excellence by:

Taking steps to avoid the loss of organisational memory.

Creating a centrally coordinated process of organisational impact assessments against internal and external safety drivers, enhancing learning from liability claims.

Empowering leaders and managers to be aware and enact upon behavioural, cultural and organisational barriers, management system failures and issues that may prevent lessons from being learned and of ensuring outcomes and recommendations are effectively communicated across our organisation.

Our Enablers

External Accreditation

External accreditation provides our staff, our patients, the communities we serve and our external stakeholders with the added confidence safety excellence remains an organisational priority.

It provides a robust framework that supports a healthy, safer workforce and environment that improves productivity, assists legislative compliance and maintains safety excellence and commercial benefits

We will support the organisation to achieve outstanding 'safe' and 'well led' excellence by:

Using the successful delivery of our strategic plan as a springboard to obtaining international accreditation through ISO 450001 certification.

Gaining recognition from our national and professional bodies in achieving and maintaining safety excellence that will enhance our organisational profile, credibility and reputation.

Our Enablers

Physical and Mental Health, Safety and Wellbeing

Many healthcare organisations are feeling the impact of workforce physical and mental health, safety and wellbeing.

A positive health and safety culture enhances physical and mental wellbeing, lowers absenteeism, and boosts employee engagement and output

We will support the organisation to achieve outstanding 'safe' and 'well led' excellence by:

Strengthening our working relationships to ensure a more proactive, critical analysis of workforce physical and mental health and wellbeing risks and their organisational impact remains essential when developing effective risk reduction strategies.

Creating a safety climate that ensures good standards of health, safety and wellbeing, together with a progressive safety culture at work, has a positive impact on staff behaviours outside of work.

Our Enablers

Stakeholder Influence

Inclusive and meaningful stakeholder engagement is the cornerstone of the design, development and delivery of our services

We will support the organisation to achieve outstanding 'safe' and 'well led' excellence by:

Actively engaging with our key internal and external stakeholders to ensure that health, safety and wellbeing needs and outcomes are being met and, in leading by example, work collaboratively with them to drive health and safety improvements and expectations.

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TRUST WIDE DOCUMENT

Delete as appropriate	Policy
DOCUMENT TITLE	Health and Safety at Work Policy
DOCUMENT NUMBER:	ELHT C052 V6.3
DOCUMENT REPLACES Which Version	Version 6.2
LEAD EXECUTIVE DIRECTOR DGM	Executive Director of Integrated Care, Partnerships and Resilience
AUTHOR(S):Note should not include names	Assistant Director of Health, Safety and Risk Management
TARGET AUDIENCE:	Trust Wide
DOCUMENT PURPOSE:	This policy describes the process for implementing the requirements of the Corporate Manslaughter and Corporate Homicide Act 2007, the Health and Safety at Work etc. Act 1974 and of all associated Regulations, Approved Codes of Practice and Guidance relating to the safeguard and protection of all staff, and others, from the undertaking of work activities and the use of assets.
To be read in conjunction with (identify which internal documents)	Health and Safety Strategy and Framework C002 Risk Management Strategy and Framework C003 Incident Reporting Policy C009 Policy for the Reporting, Management and Investigation of Claims C012 Investigation Policy for Incidents, Claims and Complaints C017 Medical Devices Management Policy C029 Safer Handling Policy C037 Fire Safety Policy C040 Management of Asbestos at Work Policy C041 Medical Gas Pipeline Systems Management Policy C051 Control of Substances Hazardous to Health Procedure C054 First Aid Provision Procedure C059 Laser Safety Policy

To be read in conjunction with (identify which internal documents)	C063 Equipment Management Policy C065 Communication of Safety Alerts (Central Alerting System) Policy C068a Security Management Policy C068b Security Management – Personal Safety Policy C068c Security Management – Operational Security Policy C068d Security Management – Missing Absconded Patients Policy C069 Resilience and Escalation Policy and Procedure C070 Water Safety Policy C071 Waste Management Policy C074 Guidance for the Safe Transfer of Patients Policy C078 Slips, Trips and Falls Prevention for Inpatients Policy C089 Latex Policy C090 Energy and Carbon Management Policy C106 Management of Contractors Policy C123 Management of External Visits and Accreditations Policy C125 Use of Bed Rails for Adults Policy C128 Ionising Radiation Safety Policy C129 Ligature Risk Assessment Policy C133 Space Management Policy C144 Sustainability Policy C147 New and Expectant Mothers Procedure C153 Lone Working Policy C158 Electrical Safety Policy C159 Emergency Preparedness, Resilience and Response Policy C160 Evacuation and Shelter Policy C165 Falls Prevention (Staff) including Work at Heights Procedure C166 Zero Tolerance Policy C169 Ventilation Safety Policy C170 Built Environment Operation and Maintenance Policy C171 Display Screen Equipment Procedure C175 Patient Safety Incident Response Plan CP02 Policy and Code of Practice for the Prevention and Management of Inoculation and Sharps Injuries CP44 Cytotoxic and BCG Spillage and Contamination Procedure HR02 Policy and Procedure for the Management of Trust Induction Programme HR06 Attendance at Work Policy HR09 Disciplinary Policy and Procedure

To be read in conjunction with (identify which internal documents)	HR11 Supporting Staff with Disabilities Policy HR15 Facilities and Time off for Recognised Representatives of Staff Organisations HR23 Work Life Balance Policy HR42 Core and Essential Skills Mandatory Training Policy HR69 Work Experience Policy HR73 Fit and Proper Persons Policy HR77 Uniform Dress Code Policy HR80 Agile Working Policy IC00 Infection Control Policy and Procedures IC02 Spillage Policy
Supporting References	• The Corporate Manslaughter and Corporate Homicide Act 2007 • The Health and Safety at Work etc. Act 1974 • Regulatory Reform (Fire Safety) Order 2005 • Health and Safety Executive Guidance HSG65 '*managing for health and safety*' • Institute of Directors Guidance INDG 417 '*leading health and safety at work - leadership actions for directors and board members*' • Sentencing Council - Health and Safety Offences, • Corporate Manslaughter and Food Safety and • Hygiene Offences Definitive Guidelines • Personal Protective Equipment (Enforcement) Regulations 2018 • The Ionising Radiation Regulations 2017 • Control of Electromagnetic Fields at Work Regulations 2016 • Control of Major Accident Hazards Regulations 2015 • Classification, Labelling and Packaging of Chemicals (Amendments to Secondary Legislation) Regulations 2015 • Construction (Design and Management) Regulations 2015 • Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 • Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 • Control of Asbestos Regulations 2012 • Control of Artificial Optical Radiation at Work Regulations 2010 • Control of Noise at Work Regulations 2005 • Control of Vibration at Work Regulations 2005 • Work at Height Regulations 2005 • Control of Substances Hazardous to Health Regulations 2002 • Control of Lead at Work Regulations 2002

Supporting References	• Dangerous Substances and Explosive Atmospheres Regulations 2002 • Health and Safety (Display Screen Equipment) Regulations 1992 as amended by the Health and Safety (Miscellaneous Amendments) Regulations 2002 • Pressure Systems Safety Regulations 2000 • Management of Health and Safety at Work Regulations 1999 • Provision and Use of Work Equipment Regulations 1998 • Lifting Operations and Lifting Equipment Regulations 1998 • Confined Spaces Regulations 1997 • Gas Safety (Management) Regulations 1996 • Health and Safety (Consultation with Employees) Regulations 1996 • Health and Safety (Safety Signs and Signals) Regulations 1996 • Manual Handling Operations Regulations 1992 • Personal Protective Equipment at Work Regulations 1992 • Workplace (Health, Safety and Welfare) Regulations 1992 • Health and Safety (Training for Employment) Regulations 1990 • Electricity at Work Regulations 1989 • Health and Safety Information for Employees Regulations 1989 • Health and Safety (First Aid at Work) Regulations 1981 • Safety Representatives and Safety Committees Regulations 1977

CONSULTATION		
	Committee/Group	**Date**
Consultation	Health and Safety Committee Quality Committee	July 2024 September 2024
Approval Committee	Health and Safety Committee	July 2024
Board Ratification:	July 2025	
NEXT REVIEW DATE:	March 2026	
AMENDMENTS:	This policy has been reviewed and amended to include more specific arrangements, responsibilities and accountabilities of staff and key staff groups, as well as identifying and extending monitoring arrangements and key performance indicators to measure and review its effectiveness so as to form a more unified approach to managing safety. Minor administrative amendments have also been made to director lead roles, job titles and name changes to associated policies and procedures. 18/03/2025 The current version 6.2 of the document remains fit for purpose i.e.it maintains the safety of patients and staff without any amendments and is being reissued as version 6.3 for a period of 6 months.	

CONTENTS

CONTENTS

1. Introduction

1.1. East Lancashire Hospitals NHS Trust, referred to hereafter as 'the Trust', provides a range of services that are guided by statutory duty and legislative requirements. These services are delivered within a framework of policy and procedures to ensure compliance with these requirements.

2. Rationale

2.1. This policy describes the process for implementing the requirements of the Corporate Manslaughter and Corporate Homicide Act 2007, the Health and Safety at Work etc. Act 1974 and of all associated Regulations, Approved Codes of Practice and Guidance relating to the safeguard and protection of all staff, and others, from the undertaking of work activities and the use of assets.

3. Scope

3.1. All staff, and others, employed by, or working within, the Trust are expected to cooperate with the requirements of this policy and any associated procedures.

4. Principles

4.1. The Trust acknowledges its legal and moral responsibilities and is fully committed to achieving the highest standards of health, safety and wellbeing, working to eliminate injury or ill health, as well as minimising the impact upon the environment.

4.2. Consideration of Equality and Diversity, NHS Resolution and Care Quality Commission standards have been made when implementing the requirements of this policy.

5. Procedures

5.1. A list of associated documents that should be read in conjunction with this policy is included within the document control page.

6. Development

6.1. Members of the Health and Safety Committee have been consulted on the requirements of this policy.

7. Health and Safety Management System

7.1. The Health and Safety Management System adopted by the Trust is based upon Health and Safety Executive (HSE) Guidance HSG 65 '*managing for health and safety*' which provides a clear and recognised model to follow. This is illustrated in the diagram below.

Plan Commitment at Board level, determining policy and planning for implementation

Do Organising for health and safety, profiling of risks and implementation of plans

Check Measuring performance, monitoring before events and investigating post events

Act Reviewing performance and acting on lessons learned to continuously improve the health and safety management system

8. Roles, Responsibilities and Duties of Staff

8.1. Generic Statement

a) Staff identified as having a key role within this policy, and any associated procedures, will be asked to provide evidence to support their specific role through one to one, appraisal and or behavioural frameworks.

8.2. The Chief Executive is responsible for:

a) Having overarching accountability for ensuring compliance with health and safety legislation and practice.

b) Nominating an Executive Director with lead responsibility for ensuring compliance with health and safety legislation and practice.

c) Seeking assurance the existing health and safety framework and service delivery model remains fit for purpose.

8.3. **The Executive Director of Integrated Care, Partnerships and Resilience has delegated responsibility for:**

a) Providing the necessary health and safety framework and service delivery model to enable the Trust to fulfil its obligations under health and safety legislation and practice.

b) Delivering and maintaining a culture that seeks to achieve the highest levels of safety performance and occupational health, safety and wellbeing.

c) Maintaining overview and keeping the Board fully appraised of compliance with health and safety legislation and practice and or gaps in assurance, including, but not limited to, proposed or changes to legislation, set standards, guidance and or developments within the field of health and safety.

d) Ensuring Board decisions take health and safety considerations fully into account that support the underlying principles of this policy.

8.4. **The Associate Director of Quality and Safety is responsible for:**

a) Ensuring policies and procedures are developed in accordance with the Policy Standard and are fit for purpose.

b) Ensuring mechanisms are in place to monitor the effectiveness of the health and safety management system and wider risk management process.

8.5. **The Assistant Director of Health, Safety and Risk Management is responsible for:**

a) Acting as the named health and safety 'competent' lead person for the Trust, as required, and in accordance with, statutory legislation.

b) Providing strategic and operational direction in relation to occupational health, safety and wellbeing and the wider risk management process and setting priorities for future action.

c) Ensuring the effectiveness and integrity of the health and safety management system and that risk exemptions in policy and procedural development, risk management and assessment, implementation and monitoring are reported and escalated through relevant governance functions.

8.6. **All Directors are responsible for:**

a) Safeguarding and protecting the health, safety and wellbeing of all staff, and others, employed by, or using the assets of, the Trust.

b) Ensuring they understand, and are aware of, their legal and lawful responsibilities relating to health, safety and wellbeing.

c) Demonstrating visible leadership, by example, of practising safe risk prevention methods and of promoting and influencing a positive health and safety culture.

d) Ensuring all staff, and others, within their areas of responsibility, comply with the arrangements contained within this policy, and any associated procedures.

e) Putting in place adequate resources and arrangements to deliver and maintain the requirements of this policy, and any associated procedures.

8.7. **Heads of Service, Managers, Matrons and Divisional Quality and Safety Leads are responsible for:**

a) Ensuring that they, and staff whom they are responsible for, understand, are aware of, and adhere to the requirements of this policy, and any associated procedures.

b) The onward cascade of this policy, and any associated procedures, guidance or amendments, to such staff, via approved communication and consultation methods, and that this is documented.

c) Demonstrating visible leadership, by example, of practising safe risk prevention methods and of promoting and influencing a positive health and safety culture.

d) Providing, where appropriate, the resources and support for staff to fulfil those responsibilities contained within their role.

This includes the release of those staff engaged in a safety representative role to undergo training and enable them to carry out their functions.

e) Identifying and reducing risks of injury and ill health for staff, and others, within their areas of responsibility, to its lowest level practicable.

f) Ensuring risk assessments are carried out, at regular intervals, with the joint cooperation of staff, and others, where necessary, either through approved documentation, a recognised e-learning and training package or where this is not possible, a trained assessor, seeking assistance from competent persons, where required.

g) Seeking advice, where necessary, from competent persons, should a significant risk be identified, with such risks either removed or exposure avoided.

h) Communicating the findings of risk assessments to all relevant staff and others who may be affected by such work activities.

i) Making sure staff and others, within their areas of responsibility, comply with any safe systems or suitable control measures introduced so as to eliminate or reduce risks to their lowest level practicable.

j) Identifying when an assessment review or further action is required.

This could include, and is not limited to, new starters, job design and task changes, individual capability, introduction of new technology, materials or equipment, changes to any procedures or processes or procedures, results of audits or inspections, changes to an individual's health and wellbeing, reported symptoms of sickness or ill health or when the current assessment is no longer valid.

k) Monitoring and keeping records of all risk assessments performed and of all relevant documentation and that they are made readily available.

l) Seeking assurance that appropriate actions are taken for agency, contractor, service level agreement providers and or others, and that measures following the outcome of risk assessments are shared with their employers and reviewed and enacted upon in a timely manner.

m) Ensuring staff, and others, within their areas of responsibility, report all incidents and risks that compromise workplace health, safety and wellbeing.

n) Investigating, where appropriate, all incidents and near misses relating to workplace health, safety and wellbeing, using an approved and recognised incident reporting system to identify contributory factors and causation, taking steps to avoid reoccurrence and sharing any lessons learned with all relevant staff, Committees or Groups.

o) Ensuring staff, and others, within their areas of responsibility, receive suitable and sufficient information, instruction, training and or supervision in relation to any mitigating risks that may compromise workplace health, safety and wellbeing.

p) Liaising with Occupational Health Services immediately upon receiving written notification from staff of any health effects, where health surveillance screening or environmental monitoring is required or following staff injury or exposure to any symptoms associated with workplace health, safety and wellbeing.

q) Ensuring staff, and others, within their areas of responsibility, attend any health surveillance or monitoring programmes, where required.

r) Acknowledging agreement of any recommendations following the outcome of investigations, assessments, audits and or inspections and ensuring they are enacted upon in a timely manner.

s) Ensuring budgetary requirements allow for the implementation of any safe systems, measures, improvements or changes following the outcome of investigations, assessments, audits or inspections.

Where special precautions or arrangements are required, that these are provided.

t) Undertaking periodic spot checks of work environments and documentation to ensure compliance with legislation and set regulatory standards.

u) Engaging and providing timely feedback to individuals, Committees or Groups to ensure the effectiveness of this policy, and any associated procedures.

v) Maintaining the confidentiality of personal and or medical information unless explicit written consent is given by an individual.

w) Being aware of and enacting upon those staff, and others, within their areas of responsibility, who do not adhere to the requirements of this policy, and any associated procedures, using appropriate human resources intervention and staff behavioural frameworks, as required.

8.8. **Estates, Facilities and Operational Service Leads are responsible for:**

a) Assisting in fulfilling the requirements of this policy and any associated procedures.

b) Demonstrating visible leadership, by example, of practicing safe risk prevention methods and of promoting and influencing a positive health and safety culture.

c) Ensuring all plant, machinery, furniture, medical devices and equipment is suitably controlled and purchased from designated suppliers, in line with approved procurement arrangements, is in good working order and regularly maintained and tested in accordance with legislation, approved guidance or instructions.

d) Making adequate provision and arrangements for safe access and egress and sufficient welfare facilities across all of its assets.

e) Seeking advice, where necessary, from competent persons, should a significant risk be identified, with such risks either removed or exposure avoided.

f) Acknowledging agreement of any recommendations following the outcome of investigations, assessments, audits and or inspections and ensuring they are enacted upon in a timely manner.

g) Ensuring budgetary requirements allow for the implementation of any safe systems, measures, improvements or changes following the outcome of investigations, assessments, audits or inspections.

Where special precautions or arrangements are required, that these are provided.

h) Engaging and providing timely feedback to individuals, Committees or Groups to ensure the effectiveness of this policy and any associated procedures.

8.9. **Human Resources, Infection Control and Occupational Health Leads are responsible for:**

a) Assisting in fulfilling the requirements of this policy and any associated procedures.

b) Demonstrating visible leadership, by example, of practising safe risk prevention methods and of promoting and influencing a positive health and safety culture.

c) Providing advice, support and guidance, where appropriate, to all relevant staff of any adjustments, modifications or restrictions to any work activities and that all relevant documentation is completed.

d) Acknowledging agreement of any recommendations following the outcome of investigations, assessments, audits and or inspections and ensuring they are enacted upon in a timely manner.

e) Undertaking relevant health screening and surveillance programmes, where appropriate, following the outcome of any assessments of risk and ensuring the health, safety and wellbeing needs of identified staff are met.

f) Engaging and providing timely feedback to individuals, Committees or Groups to ensure the effectiveness of this policy and any associated procedures.

g) Maintaining the confidentiality of personal and or medical information unless explicit written consent has been given by an individual.

8.10. **Health and Safety Lead Specialisms and Subject Matter Experts are responsible for:**

a) Providing professional, specialist advice, support and guidance to all levels of staff on matters of health and safety legislation and practice.

b) Demonstrating visible leadership, by example, of practising safe risk prevention methods and of promoting and influencing a positive health and safety culture.

c) Ensuring the integrity and appropriateness of this policy, and any associated procedures, and of any methodologies used.

d) Producing regular reports to relevant Committees or Groups.

e) Monitoring, reviewing and auditing the application and effectiveness of this policy, and any associated procedures.

f) Maintaining the confidentiality of personal and or medical information unless explicit written consent has been given by an individual.

8.11. **Appointed Safety Representatives are responsible for:**

a) Ensuring that they understand, are aware of, and adhere to the requirements of this policy, and any associated procedures.

b) Demonstrating visible leadership, by example, of practising safe risk prevention methods and of promoting and influencing a positive health and safety culture.

c) Representing the interests of staff groups or services and being consulted on matters affecting the health, safety and wellbeing of staff and others.

d) Engaging with Managers to ensure suitable and sufficient arrangements are in place for them to carry out their role safely, competently and have undergone relevant training, where required.

e) Maintaining the knowledge and competency acquired and understanding the limits of their competency, seeking assistance from competent persons, where required.

f) Identifying and reducing risks of injury and ill health for staff, and others, within their areas of responsibility, to its lowest level practicable.

g) Investigating, where appropriate, all incidents and near misses relating to workplace health, safety and wellbeing, using an approved and recognised incident reporting system to identify contributory factors and causation, taking steps to avoid reoccurrence and sharing any lessons learned with all relevant staff, Committees or Groups.

h) Completing and reviewing, where appropriate, risk assessments, seeking advice where necessary from competent persons should a significant risk be identified, with such risks either removed or exposure avoided.

i) Acknowledging agreement of any recommendations following the outcome of investigations, assessments, audits and or inspections and ensuring they are enacted upon in a timely manner.

j) Undertaking periodic spot checks of work environments and documentation to ensure compliance with legislation and set regulatory standards.

k) Engaging and providing timely feedback to individuals, Committees or Groups to ensure the effectiveness of this policy, and any associated procedures.

l) Maintaining the confidentiality of personal and or medical information unless explicit written consent is given by an individual.

8.12. **All Staff are responsible for:**

a) Ensuring that they understand, are aware of, and adhere to the requirements of this policy, and any associated procedures.

b) Being accountable for their own health, safety and wellbeing, and that of others, affected by their acts or work undertakings.

c) Observing, understanding and carrying out guidance in relation to any mitigating risks that may compromise workplace health, safety and wellbeing, where this is provided.

d) Not using any substances or equipment in the workplace that has been brought from home or purchased outside of work unless explicit consent has been received by a senior manager.

e) Not interfering with, misusing or wilfully damaging anything provided in the interests of health, safety and wellbeing.

f) Maintaining a safe and healthy working environment when conducting their work activities by identifying and reporting all incidents and near misses that compromise workplace health, safety and wellbeing as well as any failures, digressions or defects with existing control measures, using an approved and recognised incident reporting system.

g) Cooperating with their Manager when completing risk assessments, acknowledging agreement and compliance with any special arrangements, safe systems, measures, improvements or changes introduced, following their outcome, so as to eliminate or reduce any mitigating risks to their lowest level practicable.

h) Immediately notifying their Manager and or Occupational Health Service of any changes to their condition or health which may impact upon their health, safety and wellbeing and the ability to maintain a safe working environment.

i) Attending any health surveillance or monitoring programmes, where required to do so by a competently trained medical professional.

j) Discussing with their Manager any health or safety concerns they have in relation to their work activities.

8.13. **All Agency, Contractor, Service Level Agreement Providers and Others are responsible for:**

a) Ensuring they understand, and are aware of, their legal and moral responsibilities relating to the health, safety and wellbeing of all staff, and of others, and are fully committed to working to eliminate injury or ill health within their areas of responsibility, to its lowest level practicable, as well as minimising the impact upon the environment.

b) To assist in fulfilling the requirements of this policy, and any other associated procedures.

9. Roles, Responsibilities and Duties of Committees

9.1. **The Health and Safety Committee, as the nominated, responsible Committee, through its Terms of Reference, is responsible for:**

a) Providing assurances of legislative compliance on the systems and processes by which the Trust leads, directs and controls its core corporate and clinical functions for the effective management of health and safety across all services.

b) Developing action plans where deficiencies have been identified and making recommendations to relevant Committees, Groups and or the Board of Directors through Trust approved governance and communication and consultation mechanisms.

c) Liaising with other Committees and or Groups, Divisions and Services to ensure all matters relating to health, safety and wellbeing are considered in a holistic and integrated way.

10. Risk Assessment Process

10.1. The Trust recognises the benefits of managing and controlling risks and of ensuring that the health, safety and wellbeing of all staff, and others, remains of paramount importance.

10.2. To ensure the safeguard and protection of all staff, and others, who are, or could be in the future, exposed to any mitigating risks that may compromise occupational health, safety and wellbeing, a series of risk control measures have been developed to be used for this purpose which are contained within associated policies and or procedures.

10.3. The types of occupational health and safety risks that may present themselves within the workplace may include, but are not limited to, the physical, biological, chemical, mechanical, working or environmental hazards encountered.

10.4. When assessing the risks, consideration must always be given to the following hierarchy of control:

a) **Eliminating** the risk (or substitution to a safer alternative).

b) **Reducing** the risk of exposure e.g. by process change.

c) **Isolating and segregating** the risk to its lowest level practicable.

d) **Controlling** the risk of exposure.

e) The use of **Personal Protective Equipment and Discipline**.

10.5. Risk assessments **must**.

a) Be undertaken for all identified hazardous workplace risks and activities.

b) Be completed, at regular intervals, through approved documentation, a recognised e-learning and training package or where this is not possible, by managers and or a trained assessor, with the joint cooperation of staff, and others, where appropriate.

c) Take into account the advice or instructions provided by competently trained persons, medical or otherwise, that may impact upon its effectiveness.

d) Result in the implementation of suitable control measures or interventions to eliminate or reduce risks to their lowest level practicable.

e) Be communicated to all relevant staff and others, where necessary, who may be affected by such work activities.

f) Be continuously reviewed, especially where there is reason to suspect its validity. This may include, and not be limited to:

- Changes in job design, tasks and individual capability.
- Hazardous substances or equipment being or to be used.
- Introduction of staff and new technology, systems or processes.
- Changes to any procedures or work processes which may need to be followed.
- The health effects to individuals of any identified risks.
- The findings of risk assessments, precautions, interventions and control measures to be taken.
- Reported symptoms of sickness or ill health or changes in personal circumstances.
- Results of any health surveillance, environmental surveys or workplace monitoring schemes.
- When an appropriate timescale has passed, normally two or three years since the last risk assessment.

10.6. Special consideration should be given to staff that are expected to work at night. If a medical certificate stating that night work could affect their health, safety or wellbeing then, where practicable, suitable, alternative daytime work should be offered on similar terms and conditions of employment.

Such instances should be discussed with Human Resources and Occupational Health Service Directorates, with assistance from the Health, Safety and Risk Team, where appropriate.

11. Policy Dissemination

11.1. This policy, and any associated procedures, will be disseminated via Trust approved communication and consultation mechanisms.

12. Implementation

12.1. It is anticipated good health, safety and wellbeing practices, along with a proactive safety culture at work, will have a positive enabling effect in improving the working lives of all staff through collaborative, compassionate and inclusive leadership and reduced likelihood of risk (NHS Long Term Plan and NHS People Plan).

13. Monitoring Compliance

13.1. The Health and Safety Committee, as the approving Committee, will regularly monitor compliance with this policy.

13.2. Where deficiencies in compliance with this policy, and any associated procedures, have been identified, action plans will be developed and monitored by the Health and Safety Committee.

13.3. Risk exceptions will be reported to the Trust Wide Quality Governance Group and Quality Committee on a regular basis.

13.4. The following additional key performance indicators have been identified by the approving Committee to measure the effectiveness of this policy:

a) Percentage reduction of lost time and no lost time injuries to staff whilst at work.

b) Percentage reduction in the number of gap actions identified within the health and safety management system.

c) Agreed outcomes from assessments of risk remain adequate and are the most appropriate method of control.

13.5. The following table, shown overleaf, outlines the minimum requirements for monitoring compliance:

Aspect of compliance being measured or monitored	Individual responsible for the monitoring	Tool and method of monitoring	Frequency of monitoring	Responsible Committee or Group for monitoring
Strategy and Workplace Health and Safety Standards	Assistant Director of Health, Safety and Risk	Regular review and report	Six monthly or where there is reason to suspect its validity	Quality Committee
Policy or Procedural Arrangements	Health, Safety and Risk Manager	Regular review and report	Annually or where there is reason to suspect its validity	Health and Safety Committee
Policy or Procedural Dissemination	Health, Safety and Risk Manager	Regular review and report	Annually or where there is reason to suspect its validity	Health and Safety Committee
Risk Assessment Systems and Processes	Health, Safety and Risk Manager	Regular review and report	Quarterly or where there is reason to suspect its validity	Health and Safety Committee
Information, Instruction and Training	Health, Safety and Risk Manager	Regular review and report	Annually or where there is reason to suspect its validity	Health and Safety Committee

14. Information, Instruction and Training

14.1. Further advice and guidance regarding the requirements of this policy, and any associated procedures, can be obtained from the policy author**.**

14.2. Suitable information, instruction and or training is provided to staff who are, or could be in the future, exposed to any mitigating health, safety and wellbeing risks arising from the undertaking of work activities and the use of assets. This is in addition to the information, instruction, training and or supervision received to undertake the work itself.

14.3. Additional training is in accordance with staff training needs analysis and the outcome of any assessments of risk and will be continuously reviewed, and, where necessary, updated when major changes or activities occur.

14.4. Instructions on the requirements of this policy, and any associated procedures, are contained within corporate induction and or core and statutory training programmes.

14.5. Arrangements are to be made with the policy author should staff require additional risk management and or assessment training.

15. Archiving Arrangements

15.1. All policies and or procedures are archived in compliance with the Trust Records Retention Policy.

16. References

16.1. This policy should be read in conjunction with health and safety and or risk management strategies, policies, procedures and guidance.

17. Associated Documents

17.1. A list of primary and secondary health and safety legislation and further guidance can be found within the document control page.

APPENDIX A

DEFINITIONS

The following terms are used within this policy:

Term	Definition
Act(s)	Enacted piece of primary legislation, commonly called law, which are general in nature and issued by Parliament.
Approved Codes of Practice and Guidance	Guidance on the best practical means of compliance with the requirements of an Act or Regulation.
Approving / Ratifying Committee	Committee responsible for approving and or ratifying policies. All policies need to be approved and sent for ratification. This information is listed in the Policy Standard and or Policy Schedule and is available from the Chair of the Policy Council.
Care Quality Commission	Independent regulator of health and social care services in England, whether provided by the NHS, local authority, private companies or voluntary organisations.
Committee	For the purpose of this policy, the term 'Committee' refers to the East Lancashire Hospitals NHS Trust Board, its Committees, Sub Committees and Groups.
Committee Annual Work Programme	This programme sets out the work of a Committee and the reports required to be on the agenda for each meeting held over the financial year. If agenda items are missed, the reasons why must be recorded in the minutes, alongside the actions required to ensure it is followed.
Document	For the purpose of this policy, a document refers to a policy, procedure or guidance note.
East Lancashire Hospitals NHS Trust	A large integrated healthcare organisation providing acute secondary healthcare for the people of East Lancashire and Blackburn with Darwen, in the heart of the North West of England.
Equality Impact Assessment Tool	A legal requirement under race, disability and gender equality legislation, it is a systematic and evidence based tool that considers the likely impact of implementation on different groups of people.
Guidance	Issued by regulatory agencies or bodies with the aim of providing supportive information on what is considered to be good practice. It does not contain any specific reference to legislation as with an Approved Code of Practice.

Term	Definition
Hazard	Anything that has the potential to cause harm.
Health and Safety Executive	Government agency responsible for the encouragement, regulation and enforcement of workplace health, safety and wellbeing and for research into occupational risks in England, Wales and Scotland.
NHS Resolution	An organisation that handles liability and negligence claims and works to improve risk management practices within the NHS.
Office for Public Management	An independent centre for the development of public services to enable an organisation to improve social outcomes, meet the needs of their communities and respond to change.
Policy	Plan of action adopted and a principle by which all staff are guided and directed in pursuit of corporate objectives. It is a formal document which must be followed by relevant staff. Non-compliance may leave the organisation and staff open to unacceptable risk. A policy formally documents an approved standard or process and may be relied upon for legal purposes.
Policy Checklist	A checklist used by a nominated Committee or Group to approve and ratify policies and procedures. It can also be used by an author as a checklist when developing policy.
Policy Library	The Policy Library is a password protected area on the electronic shared drive where master word and portable document format (PDF) versions of policies and procedures are held.
Policy Schedule	An organisational register of all policies and procedures that is held by the Chair of the Policy Council.
Policy Standard	This is the standard that all policies and procedures are required to follow as set out in the Management of Procedural Documents Policy.
Policy Template	A template that must be used for the development of all policies and procedures.
Procedural Document	Within the context of this policy, a procedural document is a procedure that is laid down in writing that supports the implementation of a policy.
Procedure(s)	A particular way to accomplish an objective by a sequence of activities or course of action (with definite start and end points) that must be followed correctly to perform a task.

Term	Definition
Regulation(s)	An enacted piece(s) of secondary legislation, also referred to as a statutory instrument, enforced by the Health and Safety Executive that are more specific in nature and support the ethos of Acts.
Risk Exception(s)	Those risks that are highlighted and reported in meeting minutes or any risk that is identified and escalated through the governance framework within East Lancashire Hospitals NHS Trust.
Risk(s)	The likelihood and severity of harm arising from a hazard.
Scheme of Reservation and Delegation	The Scheme of Reservation and Delegation can be found on the East Lancashire Hospitals NHS Trust public facing website within the Publication Scheme under Standing Orders and Standing Financial Instructions. The Scheme of Reservation and Delegation sets out the detail of how powers are reserved to the Board of Directors and those that the Board have delegated. It forms part of the corporate governance and regulatory frameworks for business conduct by which all Directors and Officers are expected to comply including the detailed application of policies and procedures. The Board of Directors remain accountable for all of its functions', even those delegated to Committees, Sub Committees, Groups, Individual Directors or Officers, and therefore, expect to receive information about the exercise of delegated functions to enable it to maintain overview and a key monitoring role.

APPENDIX B

EAST LANCASHIRE HOSPITALS NHS TRUST

HEALTH AND SAFETY STATEMENT OF PURPOSE

We will continuously develop, influence, maintain and promote a positive health and safety culture across all our services by adopting the principles outlined within Health and Safety Executive Publication HSG 65 '*Managing for Health and Safety*' and the Institute of Directors Publication INDG 417 '*Leadership of Health and Safety at Work*'.

These principles provide the necessary framework to enable us to deliver and maintain a culture that achieves the highest levels of safety performance and occupational health and wellbeing.

As a responsible healthcare organisation and employer, we are fully committed towards:

Seeking to achieve the highest standards of health, safety and wellbeing.

Working towards an injury free and healthy workplace whilst safeguarding and protecting the safety of our staff, patients and others, as well as minimising the impact upon the environment.

Exceeding our health and safety legal obligations and driving the expectations of others.

Ensuring all our staff, and those employed using our assets, are competent and accountable for achieving the highest standards of health, safety and wellbeing.

Assessing the risks that may arise from our work activities to people, property and the environment and ensuring they are eliminated, reduced, isolated or controlled, so far as is reasonably practicable.

Providing and maintaining safe and healthy workplaces, medical devices and equipment and ensuring the safe use, handling, storage and transportation of any articles and substances.

Continuously monitoring, auditing and reviewing the health, safety and wellbeing performance of our services.

Actively engaging with key stakeholders and our patients to ensure health, safety and wellbeing needs and outcomes are being met.

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Chief Executive	Executive Director of Integrated Care, Partnerships and Resilience

APPENDIX C

HEALTH AND SAFETY STRATEGY ON A PAGE

Our Strategic Aims

Strong Senior Management Health and Safety Leadership

Integrated Health and Safety Service Delivery Model

Strategy and Performance

Priority Objectives and Delivery

Our Primary Drivers

Leadership Behaviours of Managers and Staff

Health and Safety Management System

Maintaining Skills and Competence

Physical Health and Wellbeing

Our Vision and Mission

Prevent people from having an injury or illness at work or through work

Provide excellence in quality and safety by making the safe way, the only way

Our Enablers

- Health and Safety Policy and Procedures
- Managing Contractors
- Proactive Safety Monitoring and Audit
- Risk Profiling
- Progressive Motivation
- Comprehensive Accident and Incident Reporting and Investigation
- Roles and Responsibilities
- Effective Communication
- Organisational Learning
- Challenging Safety Goals and Objectives
- Continuous Professional Development
- External Accreditation
- High Standards of Performance
- Health and Safety Training
- Stakeholder Influence
- Supportive Safety Staff
- Better Use of Technology

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Meeting Date:	9 July 2025	**Agenda Item:**	TB/2025/093
Report Title:	Financial Performance Report Month 2 2025-26		
Author:	Miss C Henson, Deputy Director of Finance		
Lead Director:	Mrs S Simpson, Executive Director of Finance		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
				✓
Executive Summary:	1. The Trust has agreed a break-even annual financial plan for 2025/26, inclusive of £43.324m Deficit Support Funding (DSF). To deliver this plan, the Trust has a Waste Reduction Programme (WRP) of £60.8m. 2. The Trust is reporting a deficit of £7.6m, against a M2 plan of £5.6m deficit; £2m behind the plan. This is the deficit excluding the £3.6m of deficit support funding. The net reported deficit is £4m. 3. The Year-to-date position reported is a £14.1m deficit against a plan of £12.0m; £2m behind plan. 4. The WRP delivered £2.312m in month against a plan of £3.131m, a variance of £0.819m. 5. Year to date, the WRP delivered is £4.335m against a plan of £5.397m, a variance of £1.062m. This reflects the phasing of the £15.4m unidentified at the time of submission to NHSE, which is in equal 12ths in line with NHSE guidance. The YTD unidentified WRP is £2.578m. As the WRP is fully developed, the position will be reported against the planned delivery timeframe. 6. Agency spend at M2 is £432k, 0.9% of gross pay costs against a 1.2% target. 7. The annual 2025/26 capital plan is £33.0m, For M2, year to date spend is £5.9m, £4.1m ahead of plan but still forecasting not to exceed the annual plan. 8. The cash balance on 31st May was £4.9m, a reduction of £5.8m compared to M1.			
Key Issues/Areas of Concern:	Risks to delivery of the financial plan			

Action Required by the Board:	To note the content.

Previously Considered by:	Finance & Performance Committee
Date:	30 June 2025
Outcome:	

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M02 Financial Performance Trust Board

Sam Simpson, Executive Director of Finance

9th July 2025

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Month 2 Financial Position

Month 2 Key Headlines

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Revenue

- The Trust has agreed a break-even annual financial plan for 2025/26, inclusive of £43.324m Deficit Support Funding (DSF). To deliver this plan, the Trust has a Waste Reduction Programme (WRP) of £60.8m.
- The Trust is reporting a deficit of £7.592m, against a M2 plan of £5.581m deficit; £2.011m behind the plan. This is the deficit excluding the £3.610m of deficit support funding. The net reported deficit is £3.982m.
- The Year-to-date position reported is a £14.1m deficit against a plan of £12.0m; £2m behind plan.

Waste Reduction

- The WRP delivered £2.312m in month against a plan of £3.131m, a variance of £0.819m
- Year to date, the WRP delivered is £4.335m against a plan of £5.397m, a variance of £1.062m. This reflects the phasing of the £15.4m unidentified at the time of submission to NHSE, which is in equal 12ths in line with NHSE guidance.
- The YTD unidentified WRP is £2.578m. As the WRP is fully developed, the position will be reported against the planned delivery timeframe.

Cash

- The cash balance on 31st May was £4.9m, a reduction of £5.8m compared to M1.

Capital

- The annual 2025-26 capital plan is £33.0m, For M2, year to date spend is £5.9m, £4.1m ahead of plan but still forecasting not to exceed the annual plan.

Statement of Comprehensive Income

Month 2 – Plan v Actual

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Monthly Actuals	M02 Plan	M02	Variance to Plan
	£000	£000	£000
Operating Income: Patient Care	63,519	64,238	719
Other Operating Income	3,821	3,678	(143)
Total Income	**67,340**	**67,916**	**576**
Substantive	(42,196)	(44,355)	(2,159)
Variable Pay: Overtime	(43)	(32)	11
Variable Pay: WLI / Extras	(481)	(576)	(95)
Variable Pay: Bank	(3,689)	(3,617)	72
Variable Pay: Agency	(542)	(432)	110
Other Staff Costs	(198)	(177)	21
Total Pay	**(47,149)**	**(49,190)**	**(2,041)**
Supplies & Services	(4,169)	(4,906)	(737)
Drugs	(4,921)	(5,416)	(495)
Other Non Pay	(11,456)	(10,692)	764
Total Non Pay	**(20,546)**	**(21,014)**	**(468)**
Total Expenditure	**(67,695)**	**(70,204)**	**(2,509)**
Net Expenditure	**(355)**	**(2,288)**	**(1,933)**
Non Operating Movements			
Non Operating Movements	(536)	(529)	7
Operating Surplus (Deficit)	**(891)**	**(2,817)**	**(1,926)**
Other Non Operating Movements	(1,080)	(1,165)	(85)
Adjusted Financial Performance Surplus (Deficit)	**(1,971)**	**(3,982)**	**(2,011)**
Deficit support Funding	(3,610)	(3,610)	-
Adjusted Financial Performance Surplus (Deficit) Excluding DSF	**(5,581)**	**(7,592)**	**(2,011)**

The variance to plan at M2 is driven predominantly by Substantive pay costs, and the non-delivery of WRP.

Income:
The main variance to plan relates to pass through income for high-cost drugs offsetting the additional expenditure in non-pay.

Pay:

- Overall pay is £2m above plan at M2
- Bank and agency were both favourable to plan but overall, the shortfall in delivery of the pay WRP was £1.454m
- Within the substantive M2 spend there is £517k relating to organisational change costs, this will have a 2025/26 benefit of £467k, and a FYE of £1m

Non-Pay:
£469k adverse variance, of which £519k relates to the High-cost drugs (offset by income) .

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Cash

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Cash position

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- The cash balance on 31st May 2025 was **£4.9m,** a reduction of £5.8m compared to the previous month, largely due to the £2.8m deficit in month (this is the operating deficit as per the SOCI).
- Nevertheless, the Trust was able to pay invoices as they become due in May but its ability to continue to pay suppliers on time is dependent on the delivery of the 2025/26 financial plan.
- The cash flow forecast is predicated on the delivery of cash-releasing WRP, it is therefore imperative that the Trust continues to deliver WRP and run-rate reductions.

Statement of Cash Flows

As at 31st May 2025

Cash remains high risk.

The cash balance on 31st May 2025 was £4.9m, a reduction of £5.8m compared to the previous month.

The Liquidity metric at the 31st May 2025 was 29 days.

This measures the ability to pay off short term debt.
Taking the working capital balance
(Current assets less current liabilities) and divides it by the number of days in the month

The higher the ratio the healthier the cash position.

The plan is 21 days
The average in 2024-25 was 21 days
At the lowest position in February 2025 the Trust was at 2 days.

Cash Flow Statement	As at 31st March 2025 £000	As at 31st May 2025 £000	Prior month £000
Operating Activities			
Operating Surplus/(Deficit)	(33,629)	(3,610)	(1,321)
Depreciation and amortisation	24,129	4,002	2,008
Impairments and reversals	14,568	0	0
Donated assets received credited to revenue but non cash	(434)	0	0
(Increase)/decrease in trade and other receivables	(402)	(5,902)	(2,845)
(Increase)/decrease in inventories	(1,341)	207	47
Increase/(decrease) in trade and other payables	9,972	(690)	(2,334)
Increase/(decrease) in other liabilities: deferred income	12,171	(647)	916
Increase/(decrease) in provisions	(144)	(38)	(24)
Net cash inflow from Operating Activities	24,890	(6,678)	(3,553)
Cash Flows from Investing Activities			
Interest received	1,947	331	119
(Payments) for property, plant and equipment and intangible assets	(24,858)	(1,948)	(815)
Proceeds from disposal of property, plant and equipment	545	90	0
Receipt of cash donations to purchase capital assets	52	0	0
Net cash outflow from Investing Activities	(22,314)	(1,527)	(696)
Net cash inflow before Financing	2,576	(8,205)	(4,249)
Cash Flows from Financing Activities			
Public dividend capital received	23,043	0	0
Loans from Department of Health - repaid	(200)	0	0
Capital element of lease payments	(7,474)	(1,237)	(629)
Capital element of PFI payments	(11,123)	(1,234)	(617)
Interest paid	(698)	(283)	(100)
Interest element of PFI obligations	(5,979)	(958)	(479)
PDC dividend (paid)/refunded	5,066	0	0
Net cash outflow from Financing Activites	2,635	(3,712)	(1,825)
Decrease in cash	5,211	(11,917)	(6,074)
Cash at the beginning of the year	11,575	16,786	16,786
Cash at the end of the financial period	16,786	4,869	10,712

Statement of Financial Position

East Lancashire Hospitals NHS Trust
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	As at 31st March 2025 £000	As at 31st May 2025 £000	Year to date movement £000	Prior month £000	In-month movement £000
Assets:					
Intangible assets	19,168	18,546	(622)	18,856	(310)
Property, plant and equipment	266,094	265,111	(983)	265,570	(459)
Right of use assets	31,946	35,362	3,416	31,822	3,540
Inventories	11,310	11,104	(206)	11,264	(160)
Receivables (NHS)	17,592	21,465	3,873	20,613	852
Receivables (non-NHS)	19,605	21,602	1,997	19,322	2,280
Cash and cash equivalents	16,786	4,869	(11,917)	10,712	(5,843)
Total assets	382,501	378,059	(4,442)	378,159	(100)
Liabilities:					
Trade and other payables (capital)	(6,418)	(5,658)	760	(6,121)	463
Trade and other payables (non-capital)	(70,990)	(70,300)	690	(68,513)	(1,787)
Lease related liabilities	(32,433)	(35,924)	(3,491)	(32,342)	(3,582)
PFI related liabilities	(228,045)	(228,601)	(556)	(229,218)	617
Provisions for liabilities and charges	(3,439)	(3,409)	30	(3,418)	9
Other liabilities: deferred income	(13,693)	(13,046)	647	(14,609)	1,563
Total liabilities	(355,018)	(356,938)	(1,920)	(354,221)	(2,717)
Total assets employed	27,483	21,121	(6,362)	23,938	(2,817)
Financed by taxpayers equity					
Public dividend capital	332,933	332,933	0	332,933	0
Revaluation reserve	21,711	21,712	1	21,712	0
Income and expenditure reserve	(327,161)	(333,524)	(6,363)	(330,707)	(2,817)
Total taxpayers equity	27,483	21,121	(6,362)	23,938	(2,817)

The operating deficit in month 2, as shown on the Statement of Comprehensive Income (SOCI) of £2.817m, is the in-month movement shown in the income and expenditure reserve.

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Capital

Capital

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Capital Scheme													
	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	25/26
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Donated assets	42	42	42	42	42	42	42	42	42	42	42	38	500
PFI lifecycle costs	300	300	300	300	300	300	300	300	300	300	300	304	3,604
CHP ROU assets				4,656								-	4,656
Other ROU assets (intra-DHSC group)				12								-	12
Other ROU assets												6,332	6,332
Other internally funded schemes	572	572	572	572	572	572	572	572	572	572	572	597	6,889
Net Zero												1,980	1,980
Diagnostics												828	828
Electiive Recovery												1,634	1,634
UEC												5,766	5,766
Estates Safety												757	757
Planned Spend	**914**	**914**	**914**	**5,582**	**914**	**914**	**914**	**914**	**914**	**914**	**914**	**18,236**	**32,958**

Actual Spend	1,045	4,861											5,906
Forecast spend			1,504	914	914	914	914	914	914	914	914	18,236	27,052
Actual Spend	**1,045**	**4,861**	**1,504**	**914**	**914**	**914**	**914**	**914**	**914**	**914**	**914**	**18,236**	**32,958**

- The Trust 2025-26 Capital plan is £33.0m and the phasing is shown above by month for 2025/26.
- This excludes the RAAC work, where the Trust is expecting a further £4.5m to be awarded in year.
- An MOU has been received at this stage for the Net Zero solar panel work only at £2.0m.
- Of the £11.0m of right of use asset (ROU) related spend, an additional £4.4m has been added to Trust plan. There may be an opportunity that this could be used towards the ROU impact of the Radiology Equipment Contract. Work is ongoing on this and will be finalised by August 2025.

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TRUST BOARD REPORT

Meeting Date:	9 July 2025	**Agenda Item:**	TB/2025/094
Report Title:	Integrated Performance Report		
Author:	Mr S Dobson, Chief Information Officer, One LSC		
Lead Director:	Mrs S Gilligan, Chief Operating Officer		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓	✓		✓
Executive Summary:	This paper presents the corporate performance data as of June 2025.			
Key Issues/Areas of Concern:				
Action Required by the Committee:	Members are requested to note the attached report for assurance.			

Previously Considered by:	Quality Committee (25 June 2025) Finance and Performance Committee (30 June 2025)
Date:	
Outcome:	

Integrated Performance Report

Published: June 2025

Contents

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How to read an SPC Chart

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

A statistical process control (SPC) chart shows data over time. Process limits show how much variability there is in the data to the chart and patterns are highlighted to show where a change is statistically significant. If there is a target, this variability can be used to provide assurance on whether the target is likely to be met in future.

XmR chart
The most common SPC chart type is the XmR chart. Each data point is shown as a grey dot on a grey line. From this data, the mean is calculated and added between the dots as a solid line, and process limits are added as grey dashed lines. If there is a target, it is shown as a red dashed line.

Process limits
In a stable process, over 99% of data points are expected to lie between the process limits. For reporting, the upper and lower process limit values are usually given as the range of expected values going forward.

Special cause variation & common cause variation
Data naturally varies but if this variation is statistically significant, this is called special cause variation and the grey dots are instead shown as blue or orange, depending on whether a higher value is better or worse – blue is used for improving performance, orange for concerning performance. If not significant, the dots stay grey and this is called common cause variation.
The four rules used to trigger special cause variation on the chart, as advised by the Making Data Count team at NHS England, are:
• a point beyond the process limits
• a run of points all above or all below the mean
• a run of points all increasing or all decreasing
• two out of three points close to a process limit as an early warning indicator

Summary

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The matrix provides a summary of performance metrics included in this report. It highlights where metrics are showing assurance and variation.
21.7% of our metrics are consistently achieving target
31.7% of our metrics are inconsistently achieving target
13.3% of our metrics are not achieving target, however 2 of these are showing special cause improvement.
33.3% of our metrics do not have a target currently set.

Variation	Assurance: Achieving target	Assurance: Inconsistently achieving target	Assurance: Not achieving target	Assurance: No target set
Special cause improvement	RN day fill, VTE	A&E 4hr, Vacancy	RTT % > 52 wks, RTT % < 18 wks, Appraisal (AFC), Agency spend	RN agency spend, RN bank spend, Ops cancelled on day, Avg arrival to handover, Cancer backlog >62 days (GP ref)
Common cause	Care staff day fill, Community F&F, Complaints, Inpatient and Outpatient F&F, Appraisal (Consultant and Other & Medical), Safeguarding children L1	MRSA, CHPPD, Maternity F&F, Cancer (28d, 31d, 62d), Handovers >60mins, BPPC NHS No, BPPC Non NHS No, Variance to planned fin performance, WRP, variance to capital programme	Wards <90% fill, A&E F&F, IG training, Sickness	C diff, E.coli, Klebsiella, Pseuedomonas, Crude deaths and rate, Handovers >30mins, Emergency avg LOS, Over 12 hr TiD, Income run rate, Other operating expenses
Special cause concern	RN night fill, Care staff night fill, Turnover	Red flags, Not treated in 28d of cancellation, BPPC NHS Value, BPPC Non NHS Value, Liquidity days		SHMI, A&E attends, Bed occupancy, Employee expenses run rate

SAFE - Summary Scorecard

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METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
AVERAGE FILL RATE REGISTERED CARE STAFF (DAY)	MAY 25	97.85	90.00		P
AVERAGE FILL RATE REGISTERED CARE STAFF (NIGHT)	MAY 25	107.89	90.00	L	P
AVERAGE FILL RATE REGISTERED NURSES (DAY)	MAY 25	93.65	90.00	H	?
AVERAGE FILL RATE REGISTERED NURSES (NIGHT)	MAY 25	98.22	90.00	L	P
MRSA	MAY 25	0.00	0.00		?
PATIENTS RISK ASSESSED FOR VENOUS THROMBOEMBOLISM	MAY 25	90.79	95.00	H	F
NATIONAL NURSING RED FLAGS	MAY 25	5.00	0.00	H	?
WARDS <90% REGISTERED NURSE (DAY) FILL RATE	MAY 25	14.00	0.00		F
CARE HOURS PER PATIENT DAY (CHPPD)	MAY 25	8.02	8.00		?

METRIC	LATEST DATE	VALUE	VARIATION
C DIFF PER 100000 RATE	MAY 25	17.04	
ECOLI PER 100000 RATE	MAY 25	44.31	
KLEBSIELLA PER 100000 RATE	MAY 25	13.64	
PSUEDOMONAS PER 100000 RATE	MAY 25	6.82	
REGISTERED NURSE AGENCY SPEND	MAY 25	78992.00	L
REGISTERED NURSE BANK SPEND	MAY 25	922288.00	L

Alert

During May 2025 overall Nurse staffing was achieved at trajectory for RN and Care Support workers.
14 clinical areas were below the fill rate of 90% for the month of May 2025 during day shifts. Of which 1 ward fell below 80% fill rate. 2 clinical areas were below the fill rate of 90% for the month of May 2025 during night shifts. These were all due to unexpected unavailability and lack of coordinators on a shift.
Nursing red flags for May 2025 was 5 due to delays in intentional rounding and delays in administering medications. There were no patient harm as a result for this but could result in poor patient experience.
Midwifery NICE red flags for May 2025 was 9 due to delays of 2 hours or more between admission for induction and beginning of the process.
There has been an increased number of Carbapenamase Producing Organisms (CPO) contacts due to previously positive patients not being isolated on admission. This has resulted in one outbreak and a number of patient contacts. Letters have been sent to these patients and their GP's, the Infection Prevention and Control team will monitor contacts. An alert has been added to ICNET and EPR to ensure any contacts will be detected on admissions. Contacts will be isolated and screened following admissions.
There has been a notable increase in reported pressure ulcer incidents during May, rising from 41 in April to 56 in May. Moisture associated skin damage incidents have shown a slight decrease, from 75 in April to 72 in May

Advise

Nurse staffing continues to be monitored twice daily in a trust wide staffing meetings chaired by Divisional Directors of Nursing.
Midwifery staffing continues to be monitored four times a day. Where pressure are increased, the calls are then attended by each Divisional Director of Nursing and 1 Deputy Chief Nurse.
Two members of staff contacted scabies which resulted in a number of patient contacts, letters have been sent to the patients and their GP's, the Infection Control team will monitor contacts. An alert has been added to ICNET to ensure any contacts will be been detected on admissions.
Compliance with uploading clinical photography to Datix remains below expected standards, with an overall compliance rate of 84%. This issue is being addressed through divisional action plans, all of which now include specific improvement actions. A new Inpatient Continence Formulary is scheduled to launch in May 2025, aiming to support improved skin integrity and reduce associated harm.
The Trust achieved 55% compliance in April for the audit on the Assessment and Documentation of Pressure Ulcers, falling short of the target range (70–85%). Staff have been reminded of the importance of completing all relevant risk assessments within four hours of patient admission to the ward.

Assurance

The overall percentage fill rate for RNs for days was 93.95% and nights was 98.22%. The overall percentage fill rate for CSW for days was 97.85% and nights was 107.89%.
Electronic care plans for the Management of Clostridium difficile and CPO screening are now live on EPR.
Compliance with the Pressure Ulcer and Moisture-Associated Damage e-learning improved in May, reaching 91.92% and 92.21% respectively. Ongoing oversight and further actions will be coordinated by the Pressure Ulcer Steering Group.

SAFE - Infection Control

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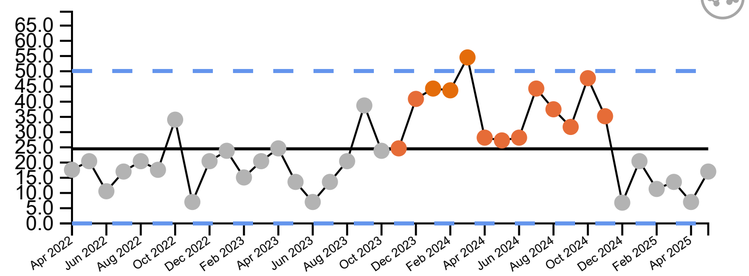
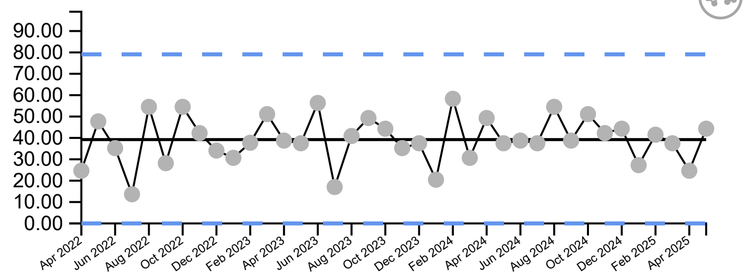
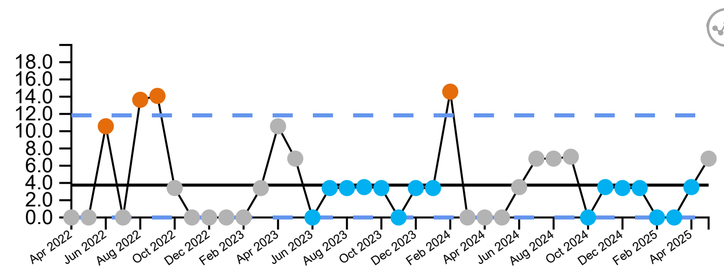
Clostriduim difficile per 100,000 bed days (HOHA & COHA)



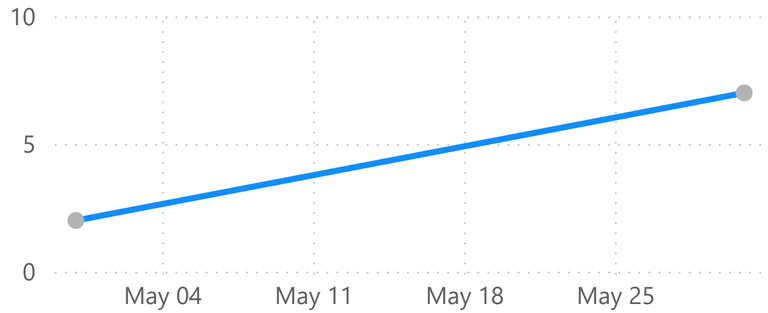
E.coli per 100,000 bed days (HOHA & COHA)



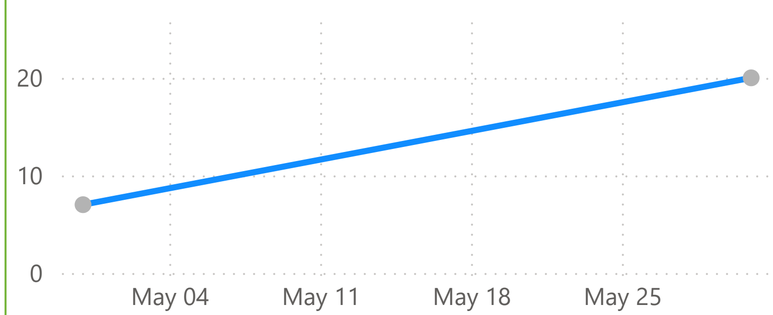
P.aeruginosa bacteraemia per 100,000 bed days (HOHA & COHA)



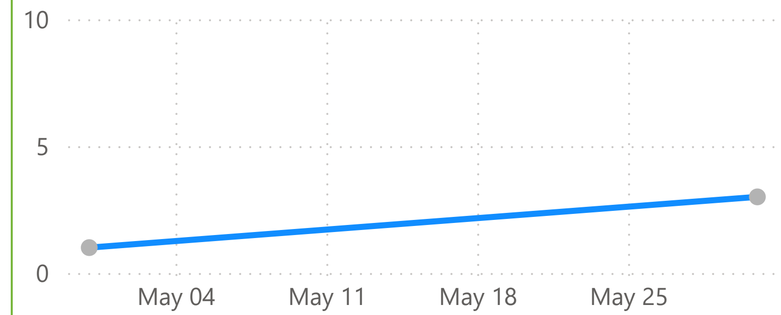
Clostriduim difficile (C.diff) cumulative 25/26



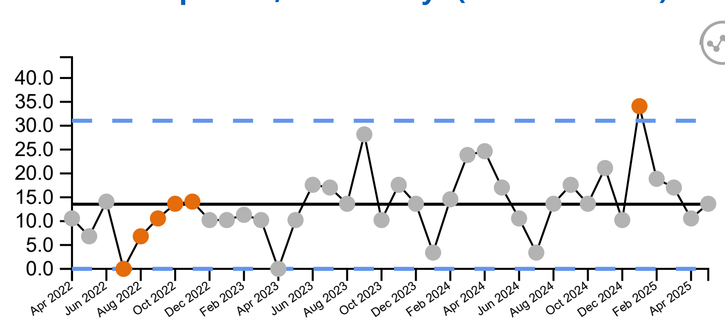
E.coli cumulative 25/26



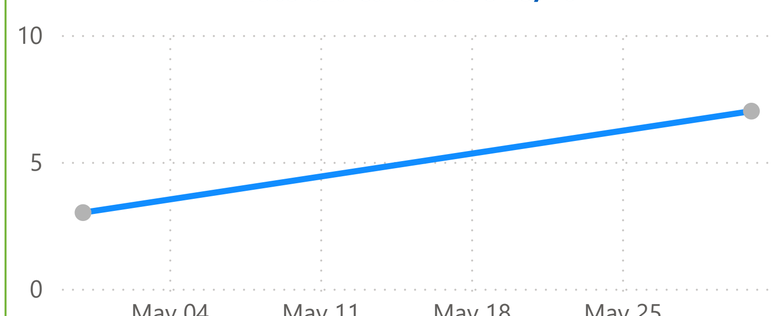
P.aeruginosa bacteraemia cumulative 25/26



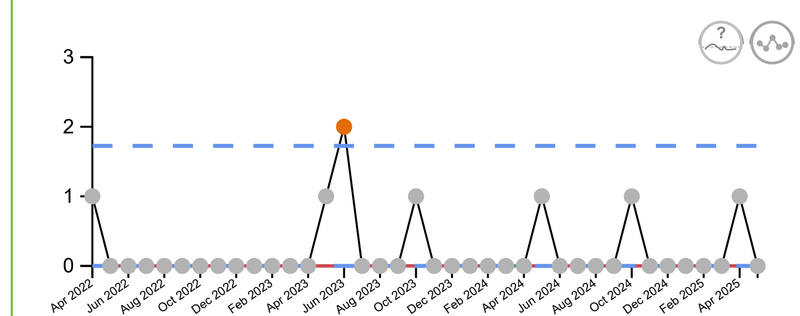
Klebsiella per 100,000 bed days (HOHA & COHA)



Klebsiella cumulative 25/26



MRSA



SAFE - Staffing

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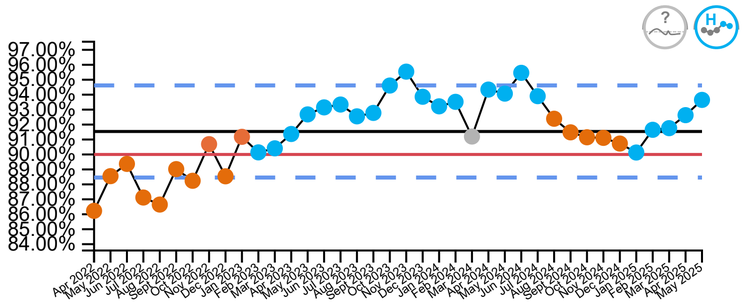
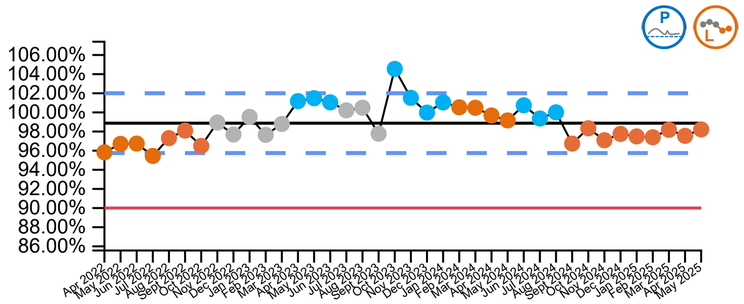
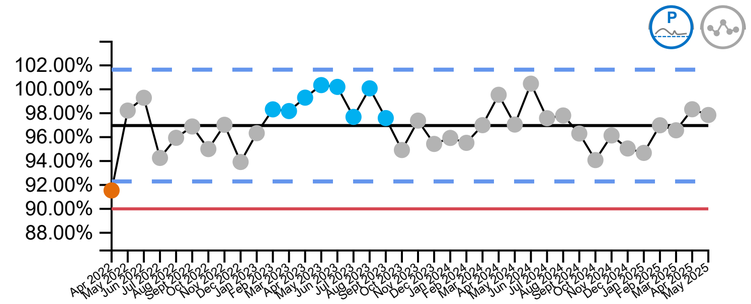
Average fill rate - registered nurses/midwives (day)



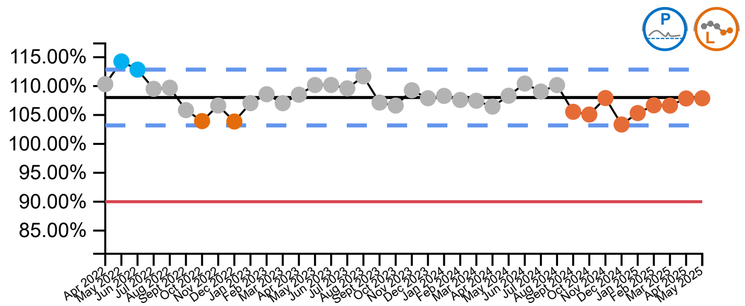
Average fill rate - registered nurses/midwives (night)



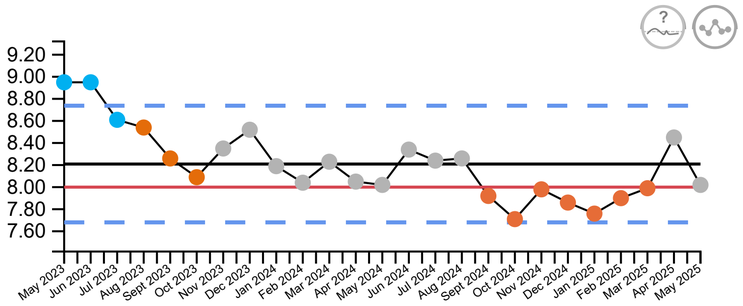
Average fill rate - care staff (day)



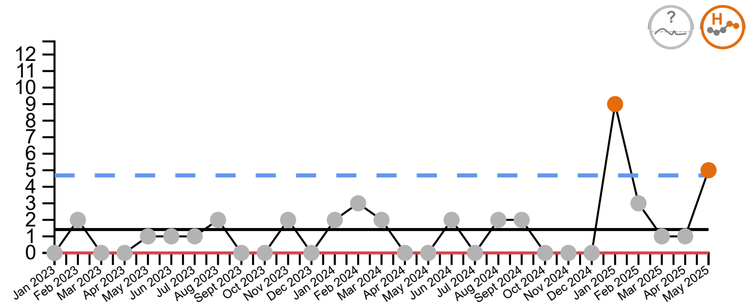
Average fill rate - care staff (night)



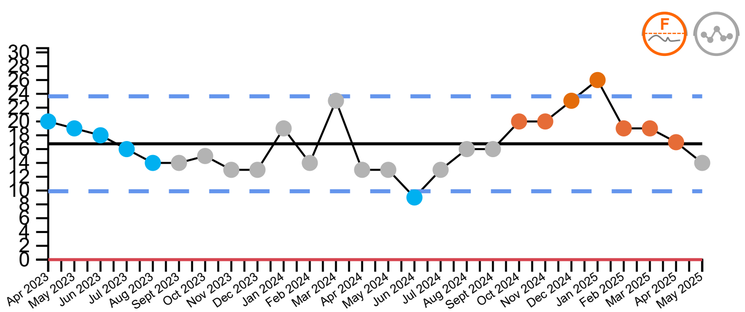
Care hours per patient day (CHPPD)



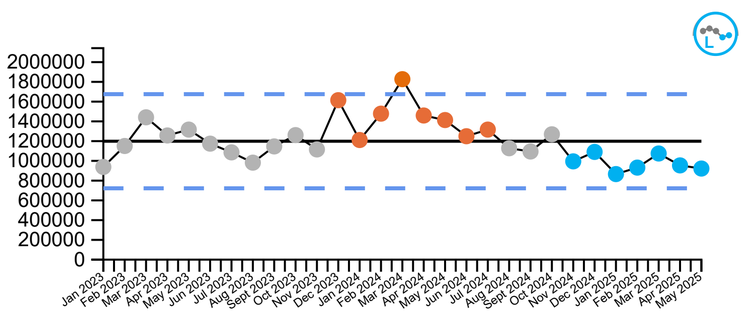
National nursing and midwifery red flags



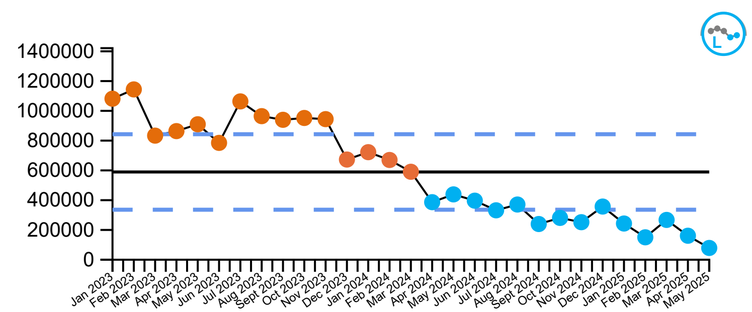
Wards <90% registered nurse (day) fill rate



Registered nurse and midwifery bank spend



Registered nurse and midwifery agency spend

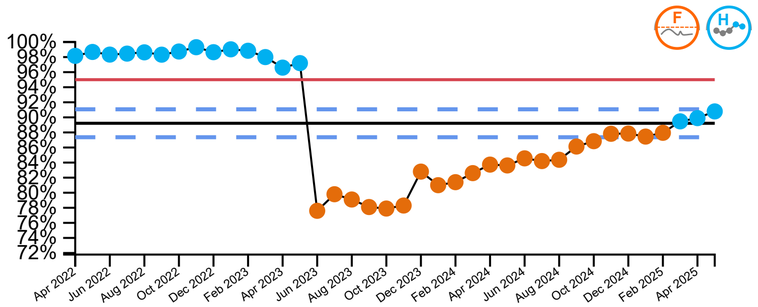


SAFE - Incidents and Pressure Ulcers

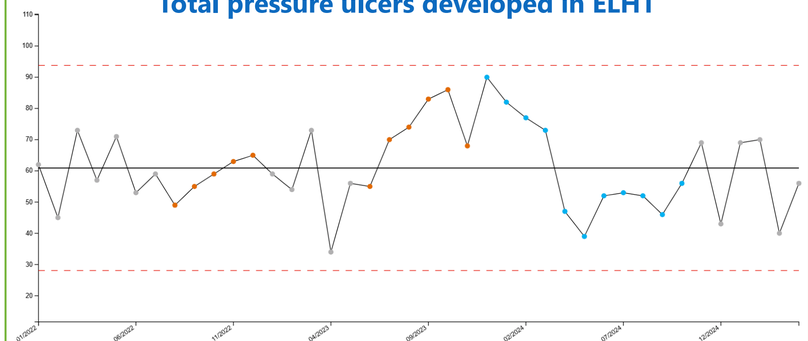
East Lancashire Hospitals NHS Trust
A University Teaching Trust

	Never events	Serious incidents reported to PSIRF	Medication errors serious/fatal harm	Slips trips falls causing moderate or above harm	
In month >	(Blank)	(Blank)	(Blank)	(Blank)	
YTD >	0	3	0	2	CAS alerts - Non-compliance: (Blank)

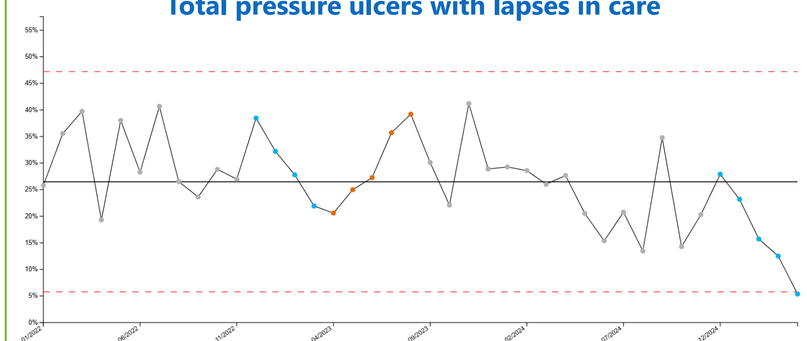
Patients risk assessed for venous thromboembolism



Total pressure ulcers developed in ELHT



Total pressure ulcers with lapses in care



A number of pressure ulcers in recent months remain currently under investigation. New reporting definitions were also introduced from April 2024.

CARING - Summary Scorecard

East Lancashire Hospitals NHS Trust
A University Teaching Trust

METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
A&E FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	MAY 25	75.57	90.00		F
COMMUNITY FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	MAY 25	91.91	90.00		P
COMPLAINTS RATE PER 1000 CONTACTS	MAY 25	0.18	0.40		P
INPATIENT FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	MAY 25	95.05	90.00		P
MATERNITY FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	MAY 25	94.31	90.00		?
OUTPATIENT FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	MAY 25	95.12	90.00		P

Alert

A&E is presenting greater assurance in their Friends & Family Test (FFT) rating, with a positive score currently at 76% (77% last month). For the last four consecutive months A&E have maintained this commendable high performance.

Advise

Positively, Maternity services FFT assurance rating has experienced another upwards jump. Overall satisfaction score now stands at 94% (a rise from 90% in May). The percentage of negative responses decreased from 9% in March to 5% in April. The negative rate further decreased in May to 3%. Oversight of these metrics and their supporting action plans occurs at the Trust's Patient Experience Group and through other internal monitoring forums for maternity care.

At the time of producing this narrative the Trust had 107 active complaints, down from 113 in May 2025. Reflecting the challenging workload faced by Trust staff, the average complaint closure time has increased to 74 days (up from 68 days last month). Encouragingly, however, dedicated efforts between the Divisions and Customer Relations Team are leading to a consistent decrease in cases outstanding for over 40 days.

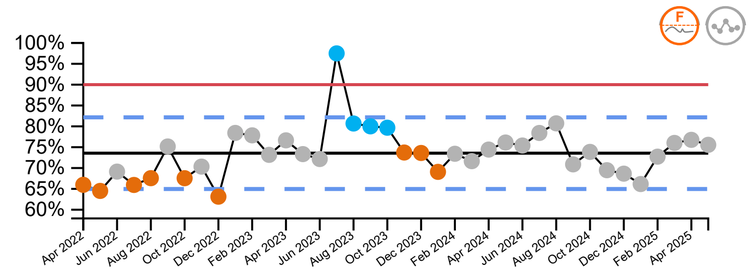
Assurance

Friends and Family Test positive recommendation rates for the Trust's inpatient, outpatient, and community services all remain at or above the national average.

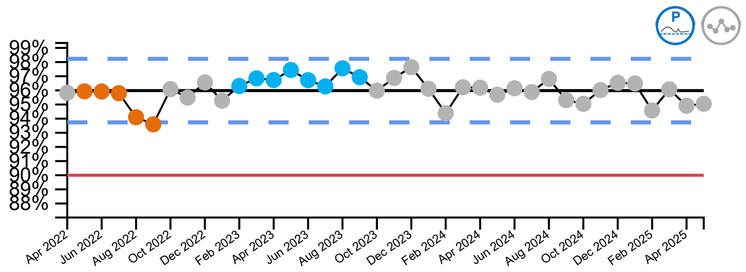
CARING - Feedback

East Lancashire Hospitals NHS Trust
A University Teaching Trust

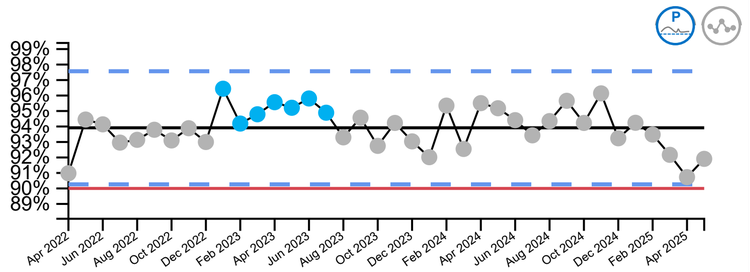
A&E FFT - % describing their experience as good or very good



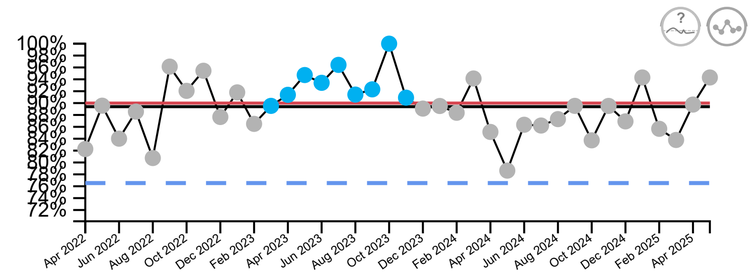
Inpatient FFT - % describing their experience as good or very good



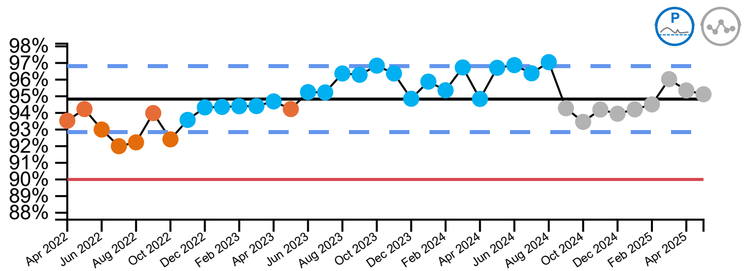
Community FFT - % describing their experience as good or very good



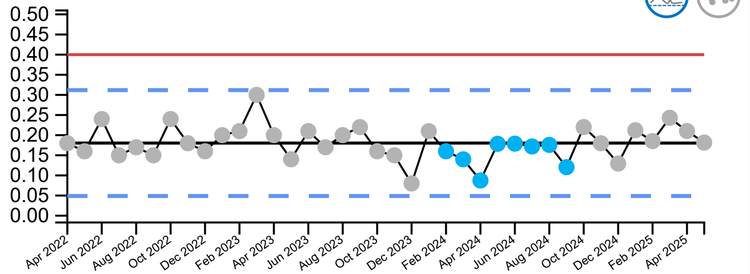
Maternity FFT - % describing their experience as good or very good



Outpatient FFT - % describing their experience as good or very good



Complaints rate per 1000 contacts



EFFECTIVE - Summary Scorecard

East Lancashire Hospitals NHS Trust
A University Teaching Trust

METRIC	LATEST DATE	VALUE	VARIATION
CRUDE DEATHS	MAY 25	130.00	
CRUDE MORTALITY RATE	MAY 25	2.72	
SHMI	MAY 25	1.28	

Alert

The Trust remains unable to provide full assurance in relation to the HSMR and SHMI mortality indicators due to issues with data submission. Data submission is now occurring within necessary timescales, but given the intrinsic delay in availability of secondary data from NHSE, and the effect of the rolling 12 month period used for mortality indicators, accurate HSMR and SHMI are not expected until late summer. The standard HSMR calculation (based on a rolling one year data set) is still unavailable, although see 'Advise' below. SHMI is published and remains very high, although appears to be beginning to reduce, but confidence remains low. The data published nationally does contain a caveat that our data contains a high percentage of invalid diagnosis codes and also notes that the trusts that have removed SDEC activity are reporting higher SHMI. Crude mortality is static at present, and remains within process limits, and is not seasonally adjusted.

The post responsible for managing Doctors revalidation reports and the SJR process has been vacant since 30 June 24 and remains so. It is currently being reviewed as part of a general review of governance staffing. This has impacted both on SJRs and revalidation.

Advise

The Trust has now begun to receive monthly HSMR+ figures, which are within expected range. The month-by-month figures show greater variation than the 12 month rolling figure, but the figure is within expected. The rolling figure is progressively incorporating additional months.

Assurance

Some assurance with respect to trust mortality is provided by close monitoring of the crude mortality rate, which does not exceed control limits.

EFFECTIVE - Mortality

East Lancashire Hospitals NHS Trust
A University Teaching Trust

There are issues impacting the SHMI including:
- Backlog in coding
- Removal of Same day emergency care (SDEC) from Admitted Patient Care (APC) dataset
- Data quality issues with SUS submission impacting spell counts

The Trust has an established mortality steering group which meets monthly to review performance and develop specific action plans for alerting groups.

Latest month SHMI banding

Higher than expected

Stage 1 SJR Reviews

Completed in most recent month

Reviews	Total
Number complete	10
Backlog	>100
5 - Excellent Care	1
4 - Good Care	5
3 - Adequate Care	2
2 - Poor Care	1
1 - Very Poor Care	1

Stage 2 SJR Reviews

Completed in most recent month

Reviews	Total
1 - Very Poor Care	0
2 - Poor Care	2
3 - Adequate Care	0
4 - Good Care	0
5 - Excellent Care	0
Backlog	0
Number complete	2

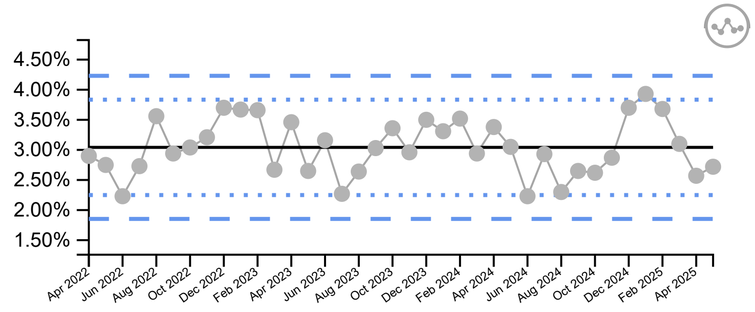
Learning Disability Mortality Reviews

3 deaths reported to LeDeR in May 2025

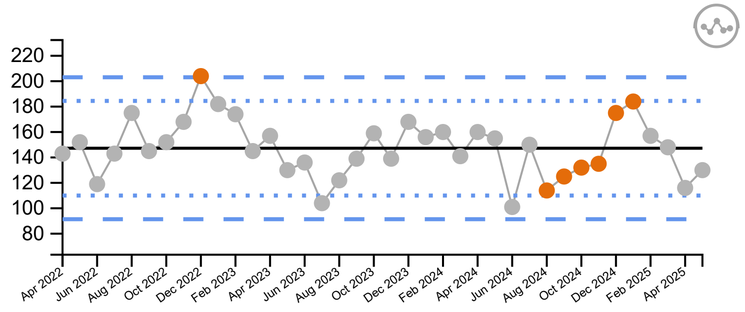
4 learning disability & autism mortality reviews completed in May 2025. All actions monitored and reported to Safeguarding Committee.

9 reviews remain for completion

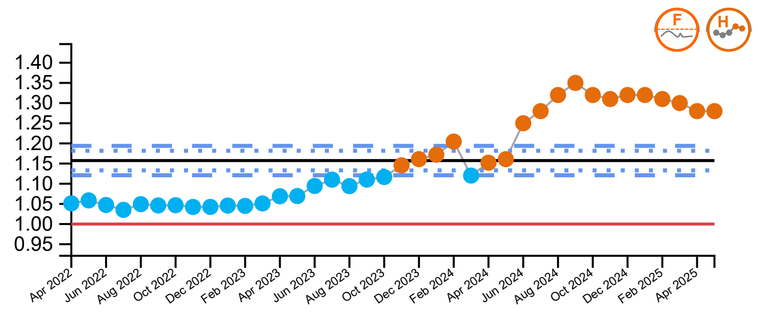
Crude Mortality Rate



In Hospital Deaths



Summary Hospital-level Mortality Indicator (SHMI)



Stillbirths

(Blank)

Year to date stillbirths

36

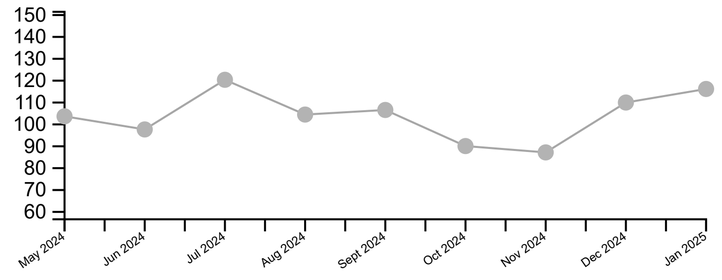
Maternal deaths

(Blank)

Year to date maternal deaths

1

Hospital Standardised Mortality Ratio (monthly)



Safe | Personal | Effective

RESPONSIVE - Summary Scorecard

East Lancashire Hospitals NHS Trust
A University Teaching Trust

METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
28D GENERAL FDS	APR 2025	77.10	75.00		
62D GENERAL STANDARD	APR 2025	78.70	70.00		
A&E 4HR PERFORMANCE (TRUST)	MAY 2025	79.67	78.00	H	
DM01 % OVER 6 WEEKS	MAY 2025	1.92	5.00	L	F
NOT TREATED WITHIN 28 DAYS OF LAST MINUTE CANC	MAY 2025	12.00	0.00	H	
RTT ONGOING % OVER 52 WEEKS	MAY 2025	3.93	1.00	L	F
RTT ONGOING % UNDER 18 WEEKS	MAY 2025	58.43	65.00	H	F

METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
OVER 12 HOURS IN DEPARTMENT %	MAY 25	15.67	15.20		

METRIC	LATEST DATE	VALUE	VARIATION
A&E ATTENDANCES	MAY 25	24955.00	H
BED OCCUPANCY G&A	MAY 25	94.60	H
CANCELLED ON DAY OPERATIONS	MAY 25	49.00	L
EMERGENCY AVERAGE LENGTH OF STAY (EXCL 0 AND 1 DAYS)	MAY 25	10.45	
PATIENTS OVER 62 DAYS (URGENT GP REFERRAL)	APR 25	218.00	L
% HANDOVERS > 30 MINUTES	MAY 25	19.68	
AMBULANCE HANDOVERS >45 MINUTES	MAY 25	195.00	

METRIC	LATEST DATE	VALUE	VARIATION
AVERAGE ARRIVAL TO HANDOVER	MAY 25	24	
MAX ARRIVAL TO HANDOVER TIME	APR 25	250	

METRIC	LATEST DATE	VALUE
RTT ONGOING	MAY 25	57660.00
RTT OVER 52 WEEKS	MAY 25	2264.00
RTT OVER 65 WEEKS	MAY 25	3.00

Alert

12 Patients were cancelled on the day and not rebooked within 28 days of last-minute cancellations; these were due to complexity and capacity

3 Patients waited over 65 weeks in May, all these patients were Ophthalmology patients due to the availability of tissue, and this is a national issue

12 Hours' Time in the Department – 2128 patients waited over 12 hours in our ED Department and increase from April (ED activity for May was 1271 attends higher than April) There is a UEC Improvement Programme working on all aspects of the UEC pathway including reducing length of stay (LoS) and this programme of work and performance will be monitored through the Emergency Care Improvement Group.

Ambulance Handovers : Ambulance Attendances rose from 3,020 in April to 3,170 in May. Handovers >30 minutes increased to 19.68% in May (up from 14.52%). 195 patients experienced handovers over 45 minutes in May.

Average Handover Times: ELHT: 24 minutes 25 seconds, NWAS: 27 minutes 13 seconds. NOTE: That the ambulance handover data provided by NWAS (North West Ambulance Service) for this report measures the time from vehicle to handover, rather than the previous methodology which measured patient handover time. This change in reporting methodology could impact the interpretation of handover times and related performance metrics, we are currently working with the Commissioning Support Unit to ensure the correct reporting is made available to ELHT. There continues to be a joint working group with ELHT and NWAS to support improvements within the handover pathway.

Advise

Same day cancellations were further reduced from previous months to 49 in May.

RTT – 52 Weeks – 3.93% of patients waited over 52 weeks, and work continues to reduce this to 1% by March 2026, this remains challenging especially within Maxillofacial Surgery, Orthopaedics and Gastroenterology. Each specialty has plans in place to reduce waiting times and these are monitored through weekly performance meetings and monthly Elective Productivity and Improvement Group

Assurance

ED – 4-hour performance for May was 79.76% above the required minimum standard of 78%

Diagnostic Performance was 1.92% meaning that 98.8% of patients received their diagnostic tests within 6 weeks, this is no longer a national target but will continue to be monitored as it supports other access targets

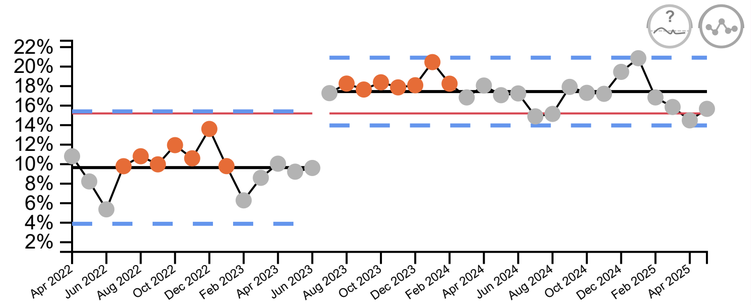
FDS and 62 Cancer standards were achieved in April

Theatre utilisation continues to be in the top quartile nationally

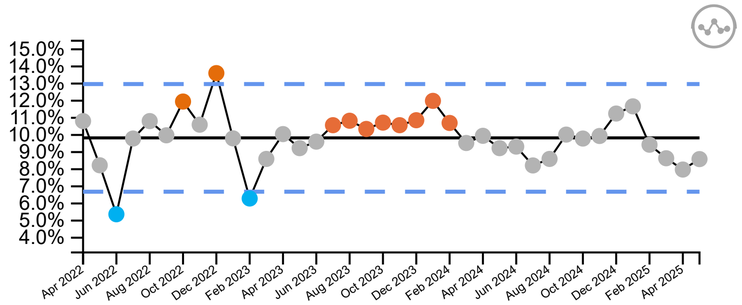
RESPONSIVE - A&E

East Lancashire Hospitals NHS Trust
A University Teaching Trust

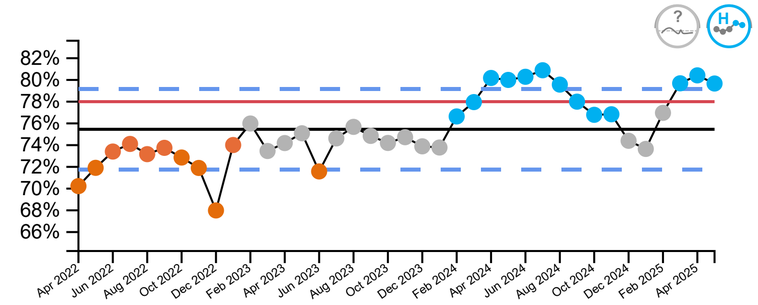
% Over 12 hours in department (type 1)



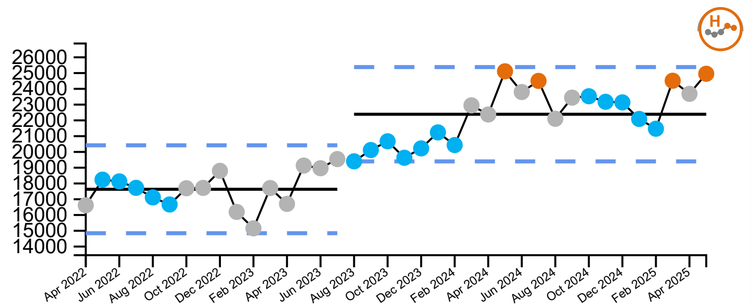
% Over 12 hours in department (all types)



A&E 4hr performance (Trust)



A&E attendances



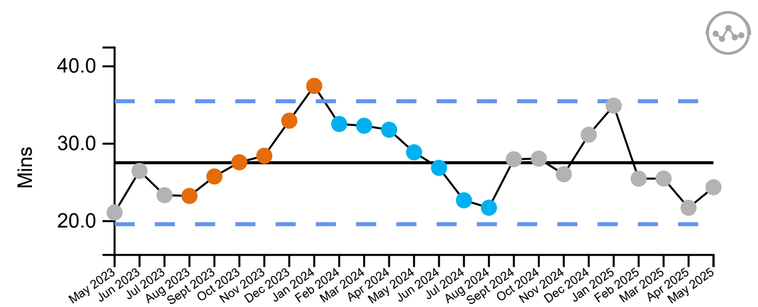
Average arrival to handover time (mins) (latest month)

24

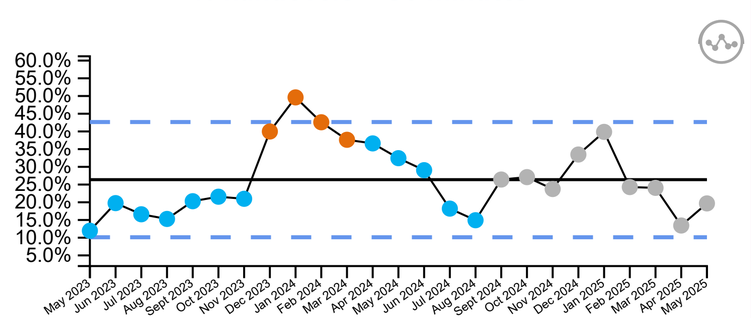
Maximum arrival to handover time (mins) (latest month)

(Blank)

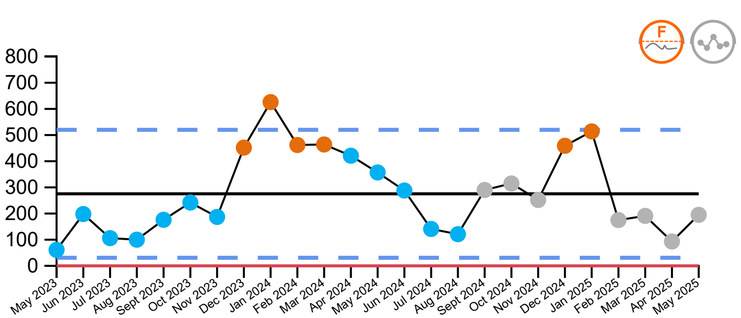
Average arrival to handover time



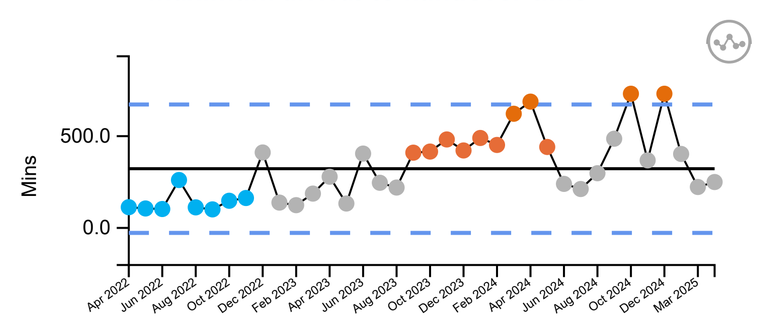
% handovers > 30 minutes



Ambulance handovers >45 minutes



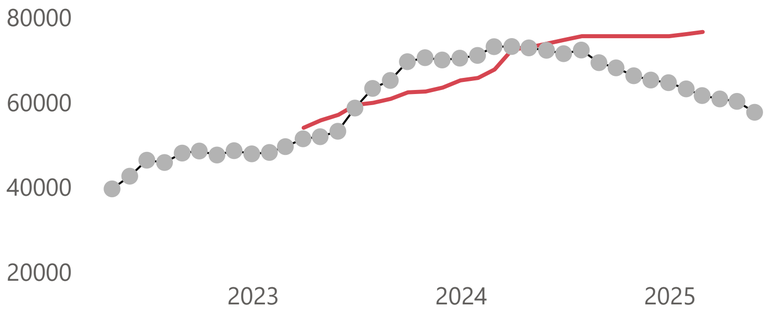
Maximum arrival to handover time



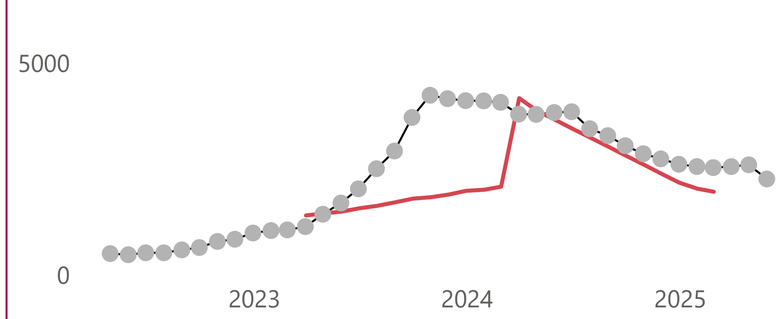
RESPONSIVE - RTT and Diagnostics

East Lancashire Hospitals NHS Trust
A University Teaching Trust

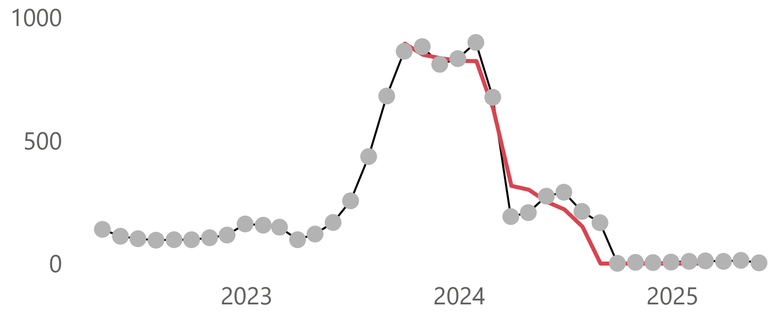
RTT Ongoing



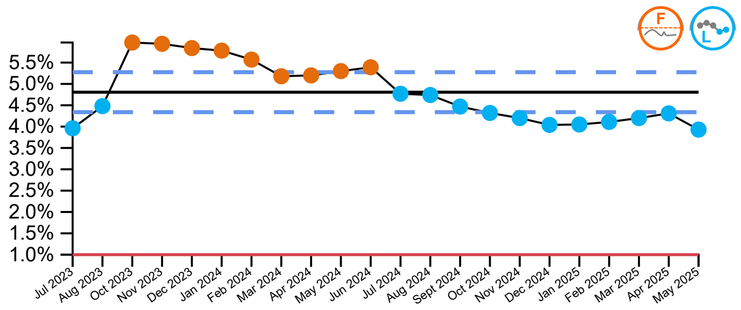
RTT over 52 weeks



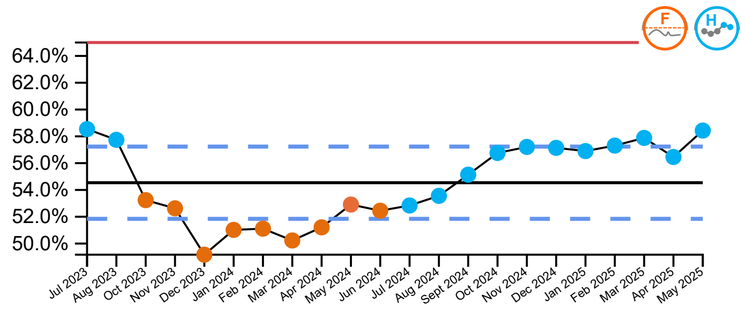
RTT over 65 weeks



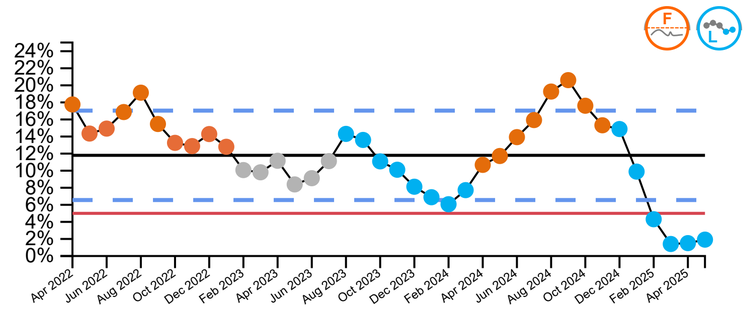
Proportion waiting over 52 weeks for treatment



Proportion waiting no longer than 18 weeks for treatment



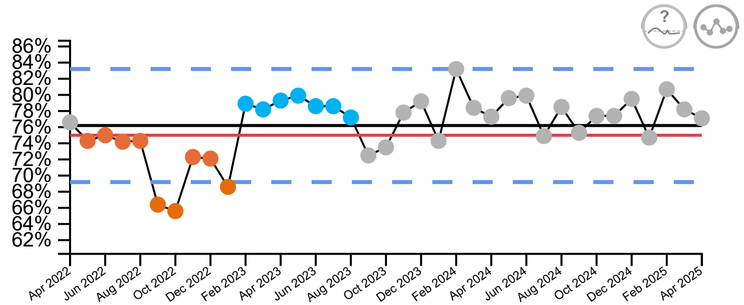
Patients waiting over 6 weeks for a diagnostic test



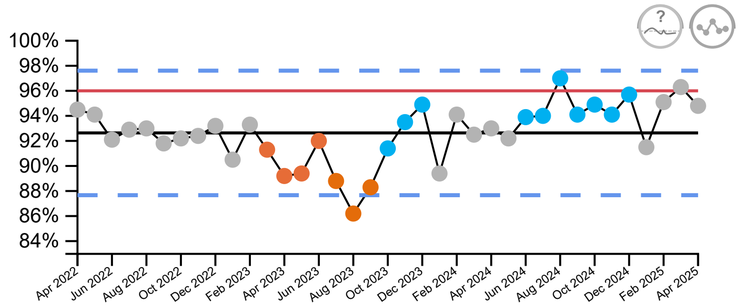
RESPONSIVE - Cancer

East Lancashire Hospitals NHS Trust
A University Teaching Trust

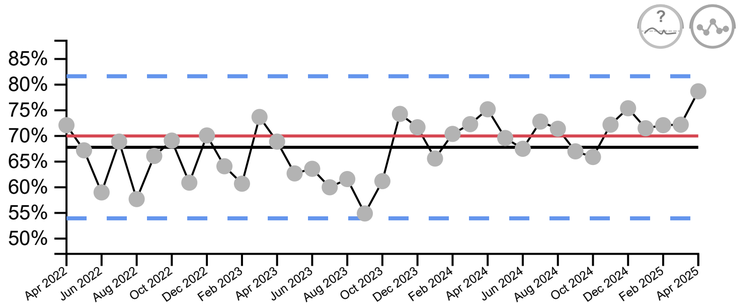
Cancer 28d general FDS



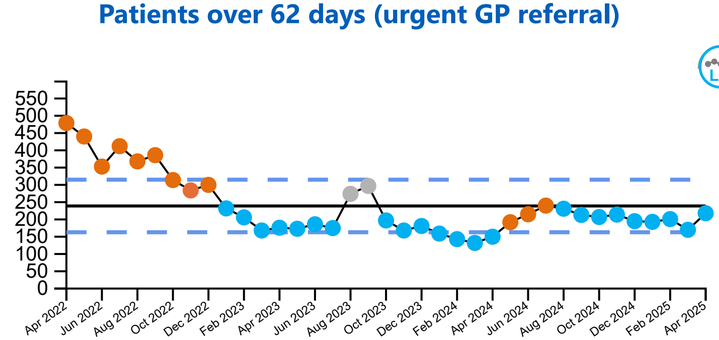
Cancer 31 day general treatment standard



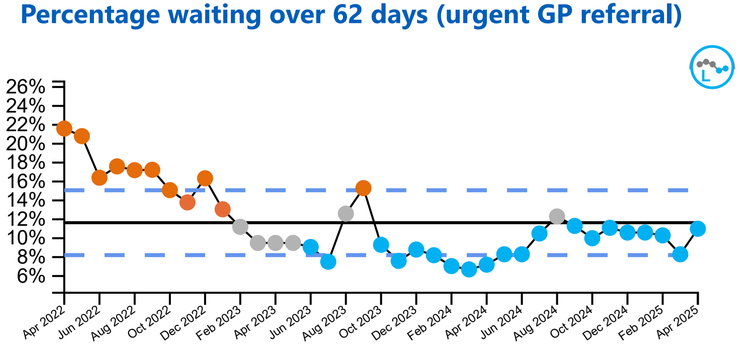
Cancer 62 day general standard



Patients over 62 days (urgent GP referral)



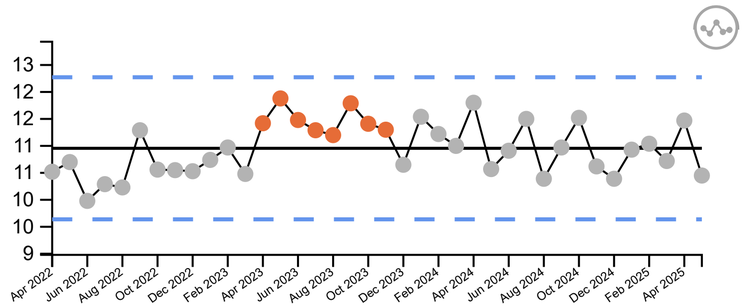
Percentage waiting over 62 days (urgent GP referral)



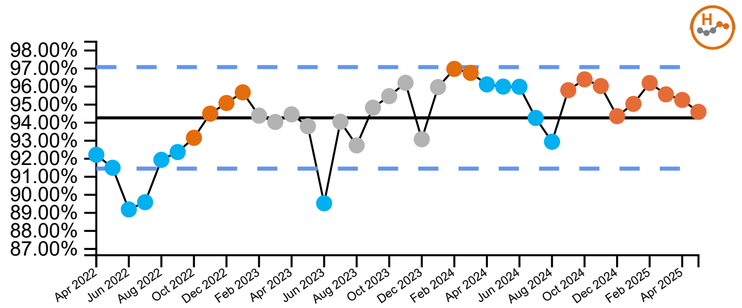
RESPONSIVE - Length of Stay and Bed Occupancy

East Lancashire Hospitals NHS Trust
A University Teaching Trust

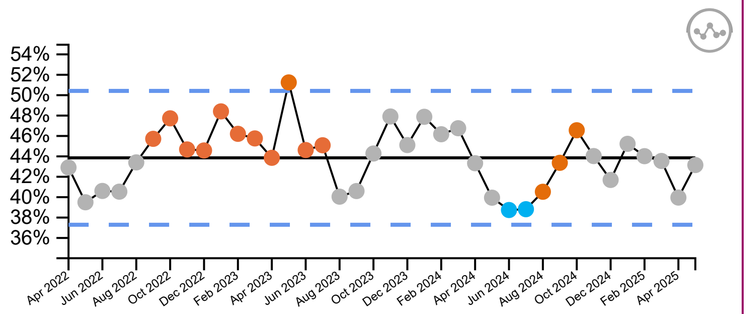
Emergency average length of stay (excluding 0 and 1 days)



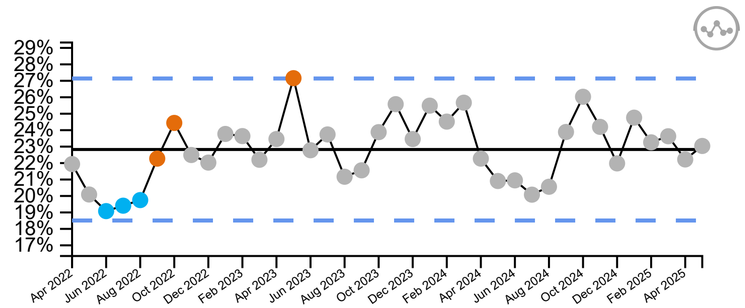
Bed occupancy G&A



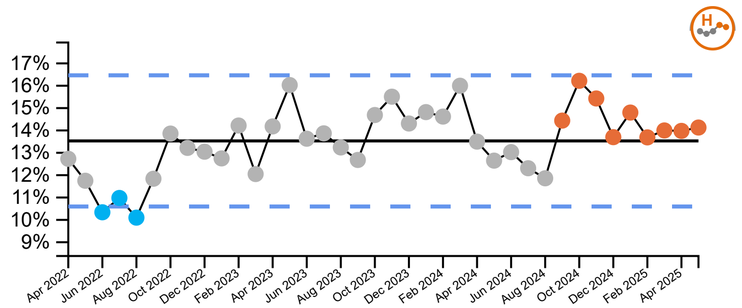
% Beds occupied by Long-Stay Patients 7+ days



% Beds occupied by Long-stay patients: 14+ days



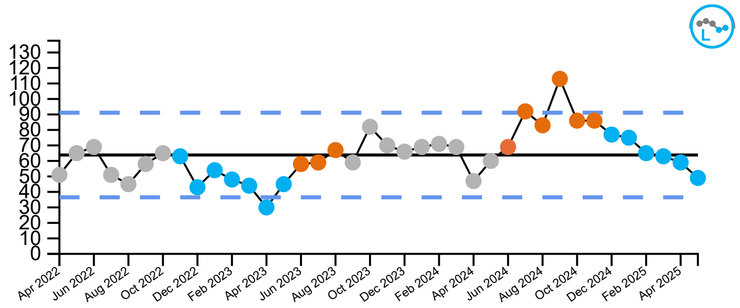
% Beds occupied by Long-stay patients 21+ days



RESPONSIVE - Cancellations and Utilisation

East Lancashire Hospitals NHS Trust
A University Teaching Trust

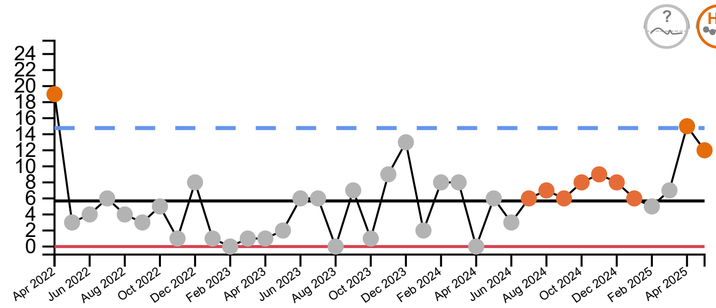
Number of operations cancelled on the day



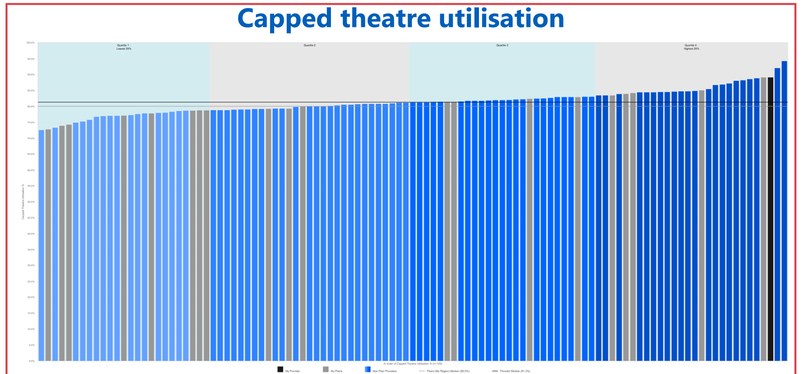
Urgent operations cancelled for 2nd time

(Blank)

On the day cancelled operations not rebooked in 28 days



Capped theatre utilisation



Safe | Personal | Effective

WELL LED - Summary Scorecard

East Lancashire Hospitals NHS Trust
A University Teaching Trust

METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
APPRAISAL (AGENDA FOR CHANGE)	MAY 25	82.00	90.00	H	F
APPRAISAL (CONSULTANT)	MAY 25	95.00	90.00		P
APPRIASAL (OTHER MEDICAL)	MAY 25	98.00	90.00		P
INFORMATION GOVERNANCE TRAINING	MAY 25	93.00	95.00		F
SAFEGUARDING CHILDREN L1	MAY 25	95.00	90.00		P
SICKNESS	MAY 25	6.34	4.50		F
TURNOVER	MAY 25	7.75	12.00	H	P
VACANCY	MAY 25	2.90	5.00	L	?

Alert

Non-Medical appraisal remains below the 90% target, but has improved by 1%, to 82%.
Information Governance has improved by 1% in month, to 93% - below the target of 95%.

Advise

Sickness absence increased in month, 6.34%, compared with 6.11% in April. May 2024 was 5.70%.
Removing the services hosted on behalf of the system (OneLSC), the sickness absence rate is 6.11%. Mental health issues accounted for 34.47% of all absence, with MSK at 20.05%. 69% of absence is long-term (over 28 days).
73.6% of Consultants have a job plan either live or at the sign-off stage, an increase on 71% in April. 68% of Non-Consultant grades have a live job plan or awaiting signature (58% last month).

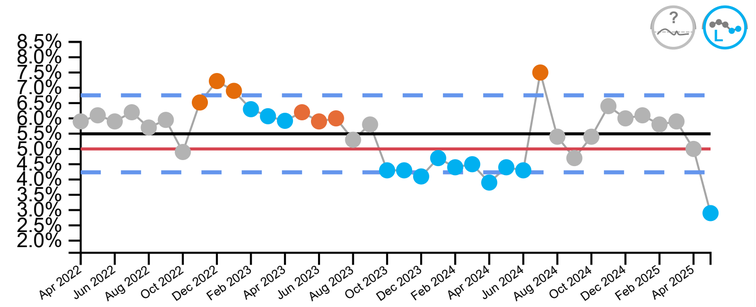
Assurance

Vacancies have reduced, due to budget setting at the beginning of 2025/26. Turnover remains consistent.
Medical appraisals remain above target – 95% for Consultants (91% in April) and 98% for other grades.
Safeguarding Children training compliance remains above 90% target at 95%.

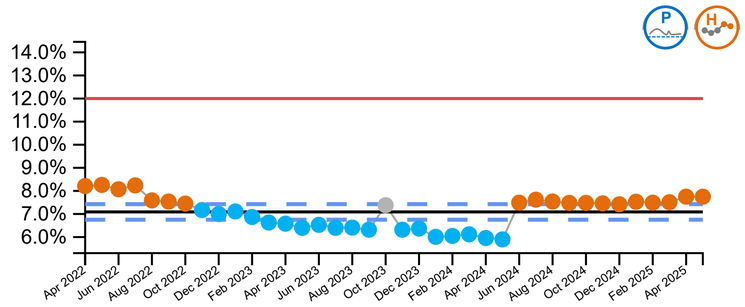
WELL LED - HR

East Lancashire Hospitals NHS Trust
A University Teaching Trust

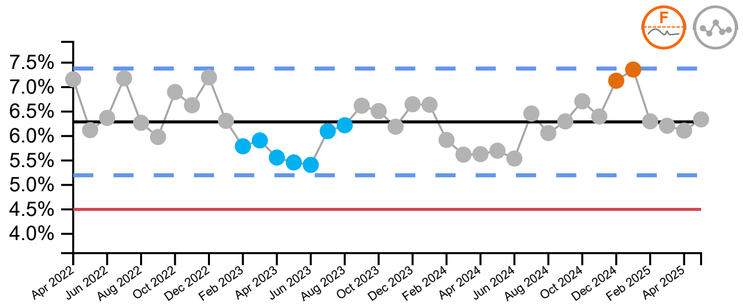
Vacancy rate



Turnover rate



Sickness rate



Freedom to Speak Up Cases by Elements

Reporting Period	Cases	Patient safety	Behaviour & attitudes	Bullying & harassment	Worker safety
Q1 24/25	40	3	21	11	18
Q2 24/25	61	0	35	16	34
Q3 24/25	115	4	29	7	22
Q4 24/25	97	2	32	12	32
Total	**313**	**9**	**117**	**46**	**106**

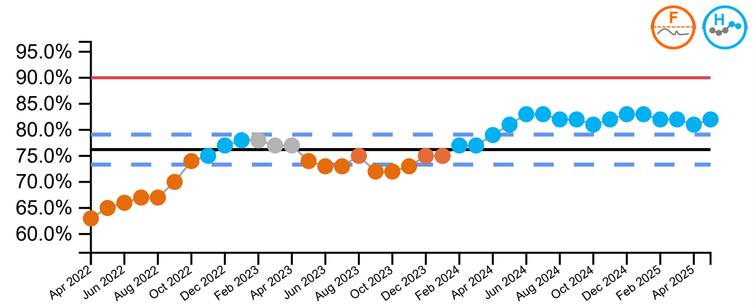
Job Plans

Stage	Consultants	Non consultants grades
Awaiting Signatures	100	11
Complete	168	66
Due Soon	12	2
In Progress	32	9
No Current Job Plan	15	10
Not Started	53	17
Referred Back	1	2
Uploaded	1	2
Total	**382**	**119**

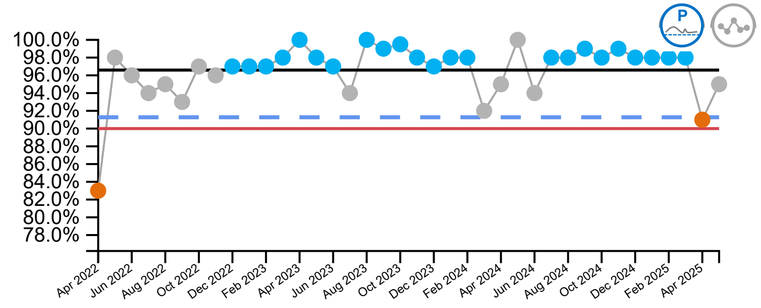
WELL LED - Learning and Development

East Lancashire Hospitals NHS Trust
A University Teaching Trust

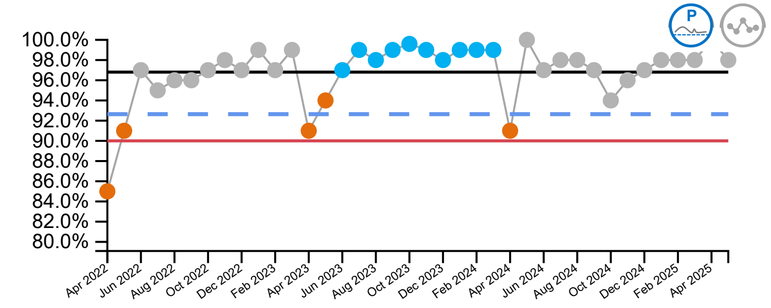
Appraisal rate (agenda for change)



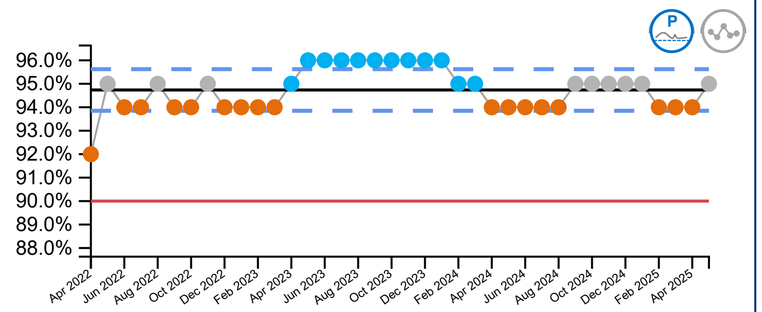
Appraisal rate (consultant)



Appraisal rate (other medical)

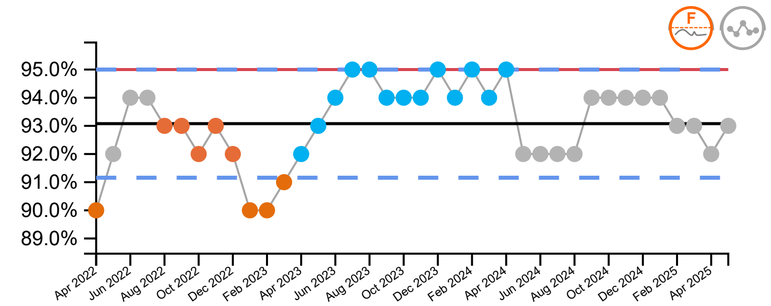


Safeguarding children training



Module	Target	Compliance

Information governance training



WELL LED FINANCE - Summary Scorecard

East Lancashire Hospitals NHS Trust
A University Teaching Trust

METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
BETTER PAYMENT PRACTICE CODE (BPPC) NHS NO OF INVOICES	MAY 25	85.10	95.00		
BETTER PAYMENT PRACTICE CODE (BPPC) NHS VALUE OF INVOICES	MAY 25	85.40	95.00	L	
BETTER PAYMENT PRACTICE CODE (BPPC) NON NHS NO OF INVOICES	MAY 25	92.30	95.00		
BETTER PAYMENT PRACTICE CODE (BPPC) NON NHS VALUE OF INVOICES	MAY 25	94.70	95.00	L	
LIQUIDITY DAYS	MAY 25	-29.20	-21.50	L	
VARIANCE TO PLANNED FINANCIAL PERFORMANCE (DEFICIT) (£M)	MAY 25	-2.10	0.00		
WRP ACHIEVED - VARIANCE TO PLAN (£M)	MAY 25	-0.80	0.00		
AGENCY SPEND AS PROPORTION PAY BILL (£M)	MAY 25	0.90	1.20	L	F
VARIANCE TO CAPITAL PROGRAMME (£M)	MAY 25	4.00	0.00		

METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION
EMPLOYEE EXPENSES RUN RATE (£M)	MAY 25	49.20	0.00	H
INCOME RUN RATE (£M)	MAY 25	67.90	0.00	
OTHER OPERATING EXPENSES RUN RATE (£M)	MAY 25	21.00	0.00	

Alert

Cash Risk and DSF Conditions: The Trust faces a critical cash risk if DSF is withheld due to underperformance. Immediate focus on cost reduction and delivery of WRP is essential to support the cash position.
Unidentified CIPs and Back-Loaded Delivery: A significant portion of savings remains unidentified or backloaded, increasing delivery risk later in the year.
Workforce Spend: Pay spend increased in M02 v M01 by £989k, substantive staff spend increased; bank spend reduced, but there remained an increase in spend overall of £989k when compared to M1.
Contracting and Activity Planning: Lack of formal contracting meetings and unclear activity plans pose a risk to financial and operational planning, in 2025-26.

Advise

WRP Reporting Alignment: There is a need to streamline and align reporting between PMO, finance, and improvement teams at Divisional and Trust level, to avoid duplication and ensure clarity.
Cash Flow Management: The cash balance reduced by £5.8m to £4.9m in May. Significant risks remain and this is being monitored closely.
System Collaboration: Continued engagement with ICB and system partners is essential, particularly around shared savings schemes and commissioning intentions.

Assurance

The Trust has agreed a break-even annual financial plan for 2025/26, inclusive of £43.324m Deficit Support Funding (DSF). To deliver this plan, the Trust has a Waste Reduction Programme (WRP) of £60.8m.
The Trust is reporting a deficit of £7.6m, against a M2 plan of £5.6m deficit; £2m behind the plan. This is the deficit excluding the £3.6m of deficit support funding. The net reported deficit is £4m.
The Year-to-date position reported is a £14.1m deficit against a plan of £12.0m; £2m behind plan.
The WRP delivered £2.312m in month against a plan of £3.131m, a variance of £0.819m.
Year to date, the WRP delivered is £4.335m against a plan of £5.397m, a variance of £1.062m. This reflects the phasing of the £15.4m unidentified at the time of submission to NHSE, which is in equal 12ths in line with NHSE guidance. The YTD unidentified WRP is £2.578m. As the WRP is fully developed, the position will be reported against the planned delivery timeframe.
Agency spend at M2 is £432k, 0.9% of gross pay costs against a 1.2% target.
The annual 2025/26 capital plan is £33.0m, For M2, year to date spend is £5.9m, £4.1m ahead of plan but still forecasting not to exceed the annual plan.
The cash balance on 31st May was £4.9m, a reduction of £5.8m compared to M1.

WELL LED - Finance

East Lancashire Hospitals NHS Trust
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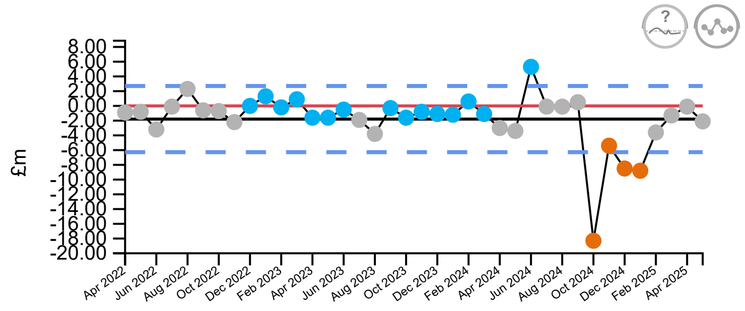
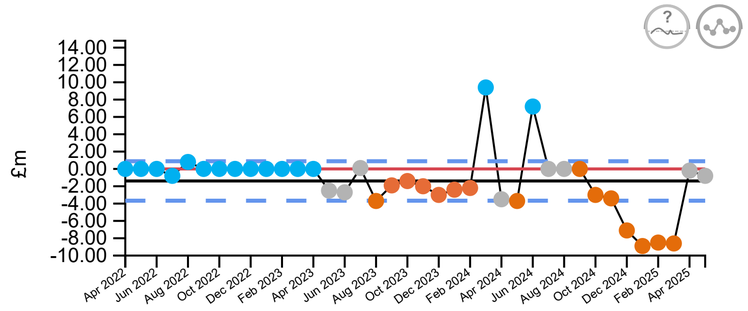
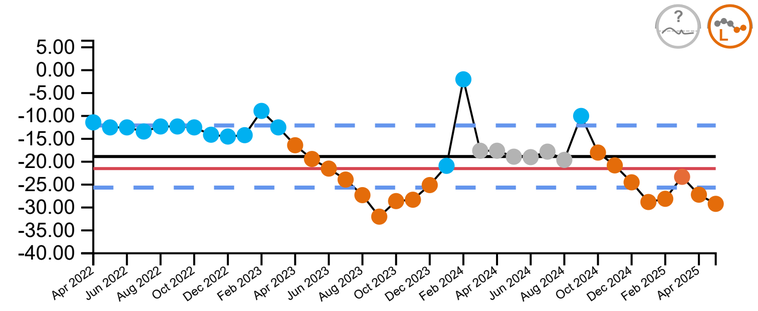
F1 - Variance to planned financial performance (deficit) (£m)



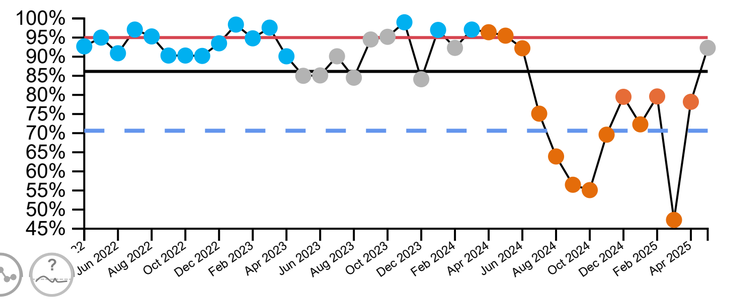
F2 - WRP achieved - variance to plan (£m)



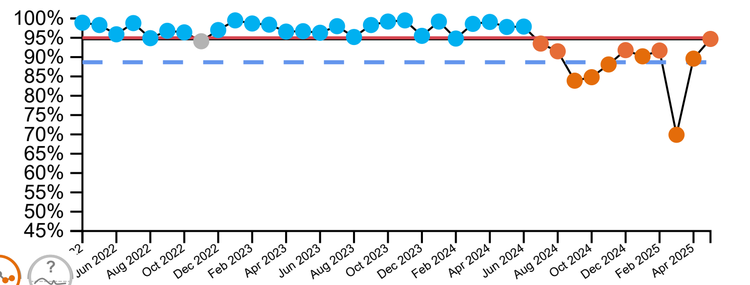
F3 - Liquidity days



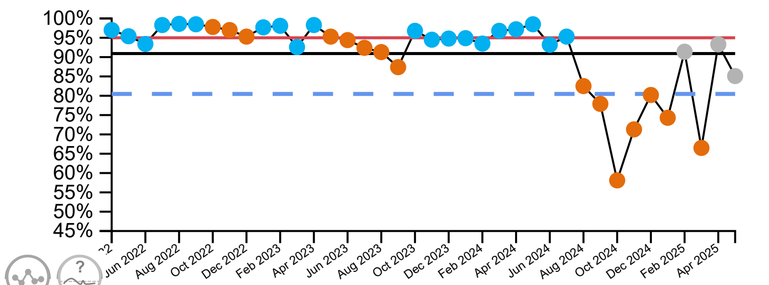
F12 - BPPC Non NHS no of invoices



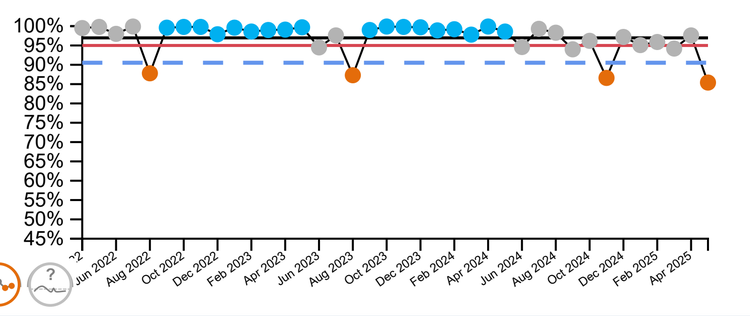
F13 - BPPC Non NHS value of invoices



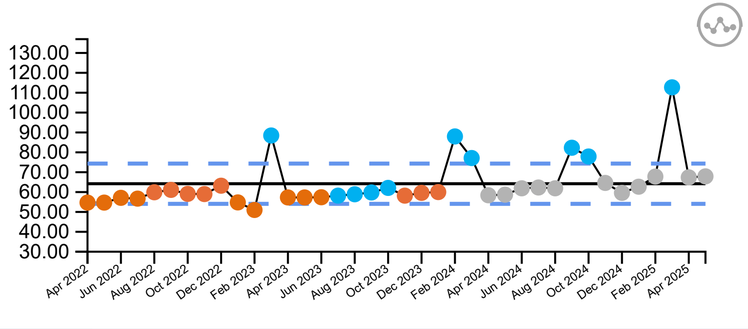
F14 - BPPC NHS no of invoices



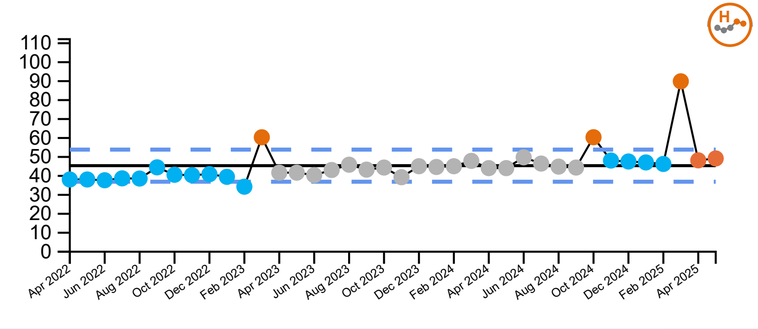
F15 - BPPC NHS value of invoices



Income run rate (£m)



Employee expenses run rate (£m)



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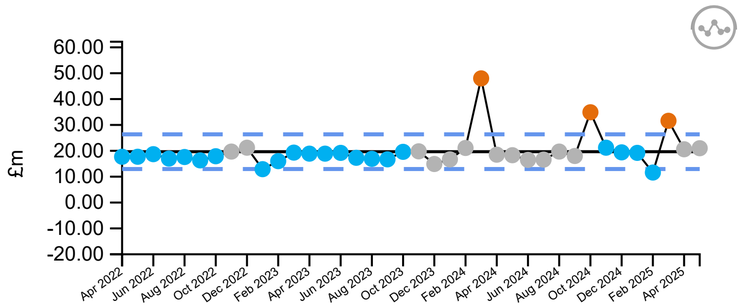
Employer contributions to NHS pensions paid by NHS E on behalf of the trust are removed from March figures.

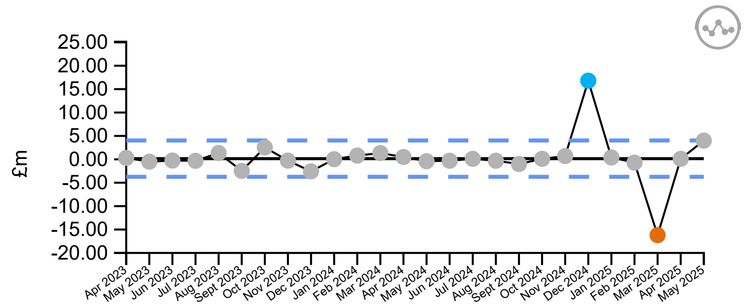
WELL LED - Finance

East Lancashire Hospitals NHS Trust
A University Teaching Trust

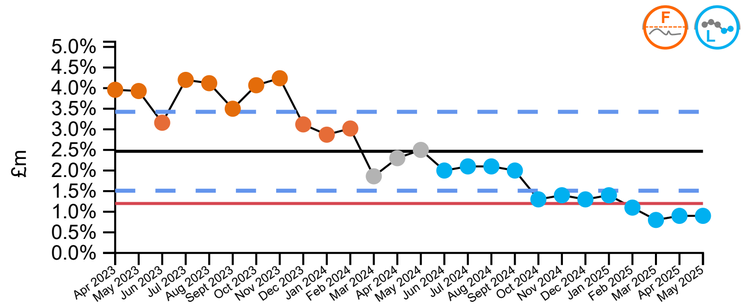
Other operating expenses run rate (£m)



Variance to capital programme (£m)



Agency spend as proportion of total pay bill (£m)



TRUST BOARD REPORT

Meeting Date:	9 July 2025	**Agenda Item:**	TB/2025/095
Report Title:	Patient Safety Incident Response Assurance Report		
Author:	Mr L Wilkinson, Incident and Policy Manager Mrs J Hardacre, Assistant Director of Patient Safety and Effectiveness		
Lead Director:	Mr S Islam, Interim Executive Medical Director		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓			✓
Executive Summary:	The Trust reports and manages incidents in line with the New National Patient Safety Incident Response Framework. Over the last year, there continues to be expected variation in the number of incidents reported per month. However, reporting levels remain with control limits, this is common cause variation which we would expect with the nature of incident occurrence and reporting.			
Key Issues/Areas of Concern:				
Action Required by the Committee:	The Trust Board is asked to receive the paper as a summary update on the incidents reported under the new Patient Safety Incident Response Plan (PSIRP) and the outcome of the Patient Safety Incidents Requiring Investigation (PSIRI) Panel decision-making process on high level investigation reports.			

Previously Considered by:	N/A
Date:	
Outcome:	

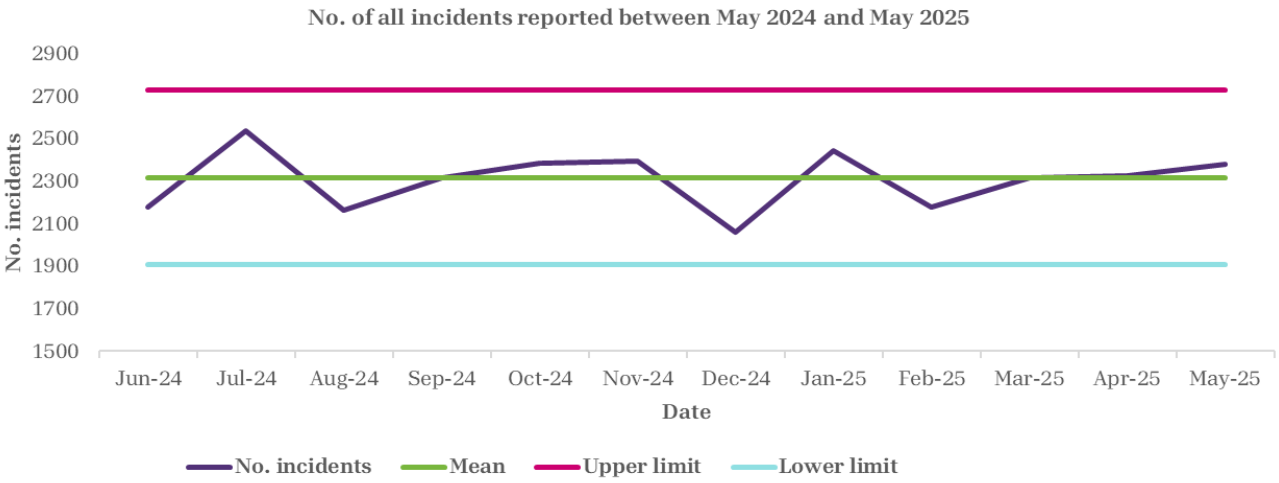
Patient Safety Incident Response Framework Report

Reporting period		April 2025-May 2025
Date and name of meeting:		Information within this report forms part of the Patient Safety Incident monitoring dashboard and PSIRF which is discussed and reviewed at the bi-monthly Patient Safety Group and discussed at the Trust Wide Quality Governance Part B meeting in June 2025.
1a.	**Alert**	There continues to be a deterioration in the number of Trust wide policies and SOPs that are overdue their review date. The position remains unchanged from last months report, with Pharmacy having 16 (76%) of the 21 SOPs that overdue and HR having 19 (48%) of the 39 Policies overdue. This will continue to be escalated to TWQG B and the service leads responsible.
1b.	**Advise**	Now that national data is available via the LFPSE system, we have been able to review our reporting rates in terms of level of physical harm and compare to the national rates and our previous year reporting rates. From the comparative period 12 months ago, the Trust has decreased reporting of no physical harm incidents and increased the number of low and moderate harm incidents. The Trust is currently also reporting higher levels of low physical harm incidents, and lower levels of moderate harm incidents compared to national rates. Levels of both severe physical harm and fatal incidents are below national rates, however, are somewhat like the previous year's rates. The shift from no physical harm to low and moderate is likely due to a change in guidance to report impact to patients regardless of how much the incident contributed (reported separately). A more in-depth analysis is required to understand if this is the case and a review of the accuracy of harm reporting is being undertaken and will be reported on next month.
1c.	**Assure**	

1. Incident Reporting

1.1 The Trust reports and manages incidents in line with the New National Patient Safety Incident Response Framework. Over the last year, there continues to be expected variation in the number of incidents reported per month. However, reporting levels remain with control limits, this is common cause variation which we would expect with the nature of incident occurrence and reporting.

Figure 1: Incidents reported over last 12 months.



1.2 **4705** reported incidents were triaged within 2 working days of being reported in **April and May 2025**, which equates to **99.94%** of all incidents reported within this period.

1.3 At the end of **May 2025** there were **1295** incidents awaiting final approval. Of these **145** cannot be finally approved due to open S42 incidents awaiting Local Authority outcome, incidents awaiting information from Divisions, and outstanding Infection Control reviews included within cluster reviews. This left **1150** incidents awaiting final approval that could potentially be closed. There has been an increase in the number of incidents awaiting final approval due to some long-term sickness in the team and annual leave. The team needs to prioritise other day to day tasks when staffing resource becomes limited.

1.4 Moderate harms remain at a consistent level in May 2025. (appendix A)

1.5 There has been a downward trend in severe harms reported following a spike in September 2024, with 0 severe harm incidents reported in May 2025. (appendix A)

1.6 Four fatal incidents were reported in April and May 2025:

1.7 One related to a child death, where a child attended a A&E in cardiac arrest and was transferred to another hospital where they unfortunately died. This was reported via the Child Death Overview Panel Process and is following that process.

1.8 One related to a patient who received anticoagulants although these were contraindicated following a head injury. This incident is being investigated as a PSII under the Patient Safety Incident Response Plan (PSIRP).

1.9 One related to a death related to a possible delay in administration of antibiotics. This incident is being investigated as a PSII under the PSIRP.

1.10 One related to potential deficiencies in care that may have contributed to a myocardial infarction. This incident is being investigated as a PSII under the PSIRP.

1.11 Now that national data is available via the LFPSE system, we have been able to review our reporting rates in terms of level of physical harm and compare to the national rates and our previous year reporting rates.

From the comparative period 12 months ago, the Trust has decreased reporting of no physical harm incidents and increased the number of low and moderate harm incidents. The Trust is currently also reporting higher levels of low physical harm incidents, and lower levels of moderate harm incidents compared to national rates. Levels of both severe physical harm and fatal incidents are below national rates, however, are somewhat like the previous year's rates.

The shift from no physical harm to low and moderate is likely due to a change in guidance to report impact to patients regardless of how much the incident contributed (reported separately).

A more in-depth analysis is required to understand if this is the case and a review of the accuracy of harm reporting is being undertaken and will be reported on next month.

2. Duty of Candour

2.1 There have been **0** breaches, of Duty of Candour, as set out in CQC Regulation 20.

3. Safety Incident Responses (IR2s)

3.1 In line with the New Patient Safety Incident Response Framework all incidents not being investigated as a Patient Safety Response, or a Patient Safety Incident Investigation the Trust has set a target that these should be reviewed and actioned within 30 days of reporting. A KPI of 90% has been set and appendix C provides an overview by division.

3.2 Overall, the number of IR2s completed investigated within 30 calendar days has improved in all Divisions apart from MEC. The number of IR2s open more than 30 calendar days has also decreased across most divisions. The KPIs are shared and

discussed with Divisions monthly, the main reason given by divisions for the delays is due to clinical pressures.

4. Patient Safety Responses (PSR)

4.1 All incidents that are of moderate or above harm and/or have key safety issues identified, and do not meet the national or local reporting priorities for a PSII are required to have a Patient Safety Response (PSR) completed and are managed within Division. Appendix D provides a breakdown of the number of open PSRs by division and number of any open more than 3 months.

4.2 There has been an overall decrease in the number of open PSRs and the number of those that have been open more than 90 calendar days.

5. Patient Safety Incident Investigations (PSII) National and Local Priorities

5.1 In **April and May 2025**, the Complex Case meeting reviewed **1** new incident and reported **1** incident meeting the PSIRF Priorities and require either a PSII or MNSI investigation, the PSII has been allocated to lead investigators within the Patient Safety Team.

5.2 A KPI dashboard of PSIIs is provided is appendix E. At the end of **May 2025**, the Trust had **20** open PSII incidents of which **10** were being investigated by MNSI.

5.3 At the end of **May 2025** there was **1** PSII which had been open longer than 6 months and **5** MNSI reports.

5.3.1 The **5** MNSI reports that are overdue are outside of the control of trust. The reason1 for the **1** PSII being overdue are as follows:

- The report had been approved at PSIRI but was awaiting confirmation that the actions are being picked up by the AKI/Sepsis task group. An update was expected at the next PSIRI.

5.4 In **April** and **May 2025**, **2** PSII reports were approved by PSIRI with learning and closed.

6 PSIRI Panel Approval and Learning from Reports

6.1 During **April** and **May 2025, 15** reports were reviewed, of these there were **11** were new PSII reports. See appendix F for the detail of these reports and the review outcome.

7 Mandatory National Patient Safety Syllabus Training Modules

7.1 At the end of **April 2025**, the Trust has achieved **96.2%** Level 1a, **90%** Level 1b and **93.6%** Level 2 for National Patient Safety Training since making it mandatory for all staff to complete within the Trust. All Divisions have been sent a list of staff who require to complete the training for each level.

7.2 Due to the update to the Trust's ELHT Learning Hub, now Education Hub there is currently no reports available to provide figures for May 2025, these are currently under development by DERI.

7.3 Table 1: Patient Safety Syllabus Training (as of end of **May 2025**)

National Patient Safety Training	Target	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
Level 1a	95%	93. 80%	93.30%	94.10%	94.30%	94.90%	94.80%	95.20%	95.40%	95.60%	95.80%	96.20%	Unable to obtain
Level 1b		83.50%	84.20%	84.70%	85.10%	85.90%	85.60%	86.00%	87.30%	87.90%	89.60%	90.00%	Unable to obtain
Level 2		89.90%	90.10%	90.90%	91.10%	92.10%	92.00%	92.10%	92.70%	92.90%	93.30%	93.60%	Unable to obtain

8 Trust Wide Policies and SOPs

8.1 At the end of **May 2025**, there were **21** Trust wide SOPs out of **152** overdue their review date, and **39** out of **299** policies are currently overdue their review date.

8.2 The report provides a breakdown of overdue policies and SOPs as requested by Trust Board and a full list is provided in appendix G.

8.3 Pharmacy has a high number of SOPs overdue but confirmed that the SOPs were planned to be reviewed in MSOC in May 25 and following that their position should start to recover.

8.4 HR have the highest number of Polices overdue; assurances have been sought as to how this position will be recovered.

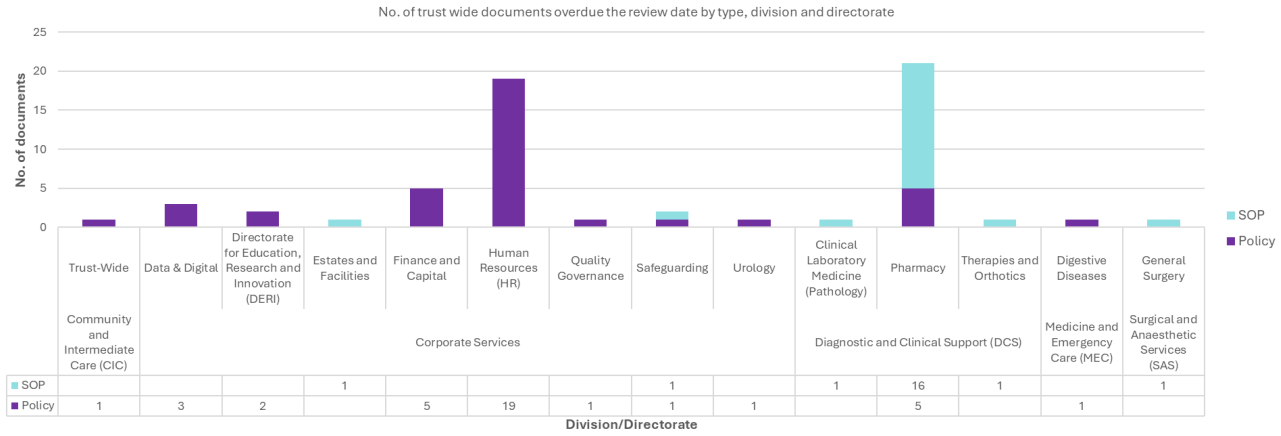


Table 2: Trust wide polices and SOPs within review date:

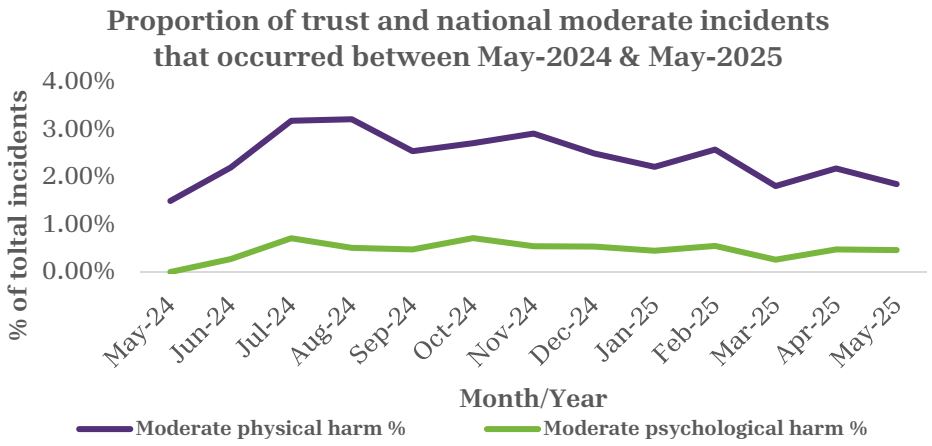
Policies / SOPs	Target	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Trend
Trust wide Policies	90%	83.10%	88.97%	88.70%	93.20%	94.56%	95.56%	95.58%	94.28%	94.30%	90.91%	88.14%	86.96%	↓
Trust wide SOPs		93.75%	88.37%	86.90%	100%	98.63%	100%	97.92%	94.44%	90.21%	88.03%	85.14%	86.18%	↑

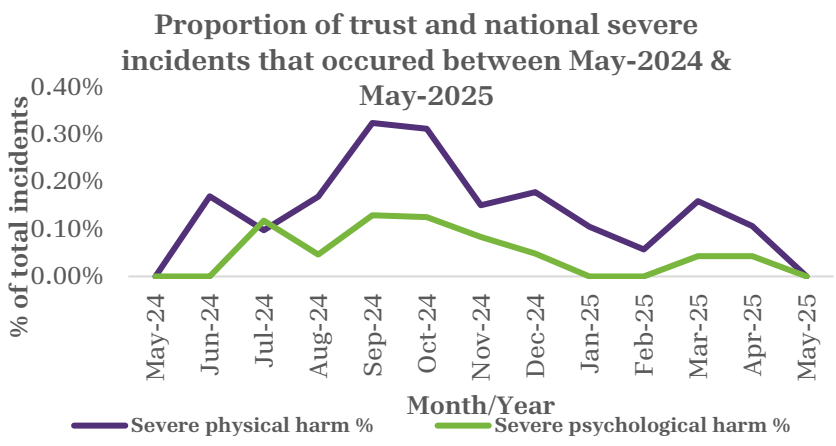
9 Maternity specific serious incident reporting in line with Ockenden recommendations

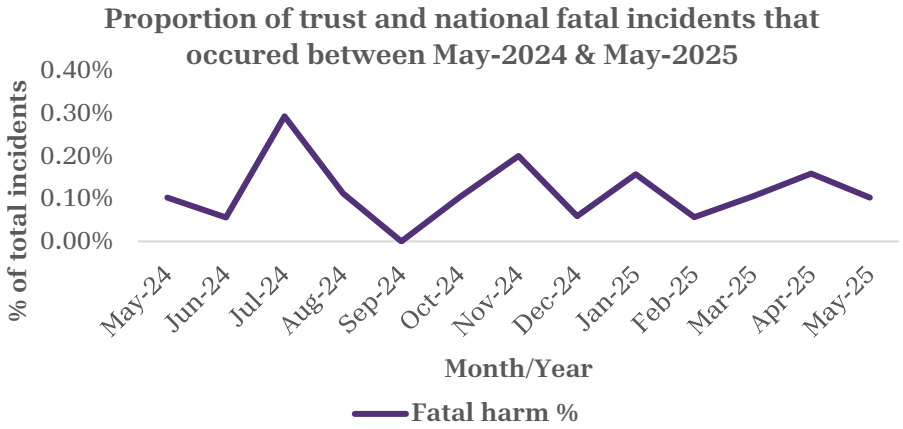
9.1 Following recommendations from the Ockenden review, the Trust is required to report on the number of Maternity specific serious incidents reported on StEIS and the status of the open investigations. Since March 2020 **79** maternity related incidents have been reported on StEIS of which:

- **48** have been approved and closed
- **15** have been agreed for de-escalation from StEIS
- **4** have had closure on StEIS requested
- **9** are currently being investigated by MNSI
- **2** have been reviewed at PSIRI and are awaiting amendments prior to approval.
- **1** is a Never Event which is currently under investigation by the PSII team.

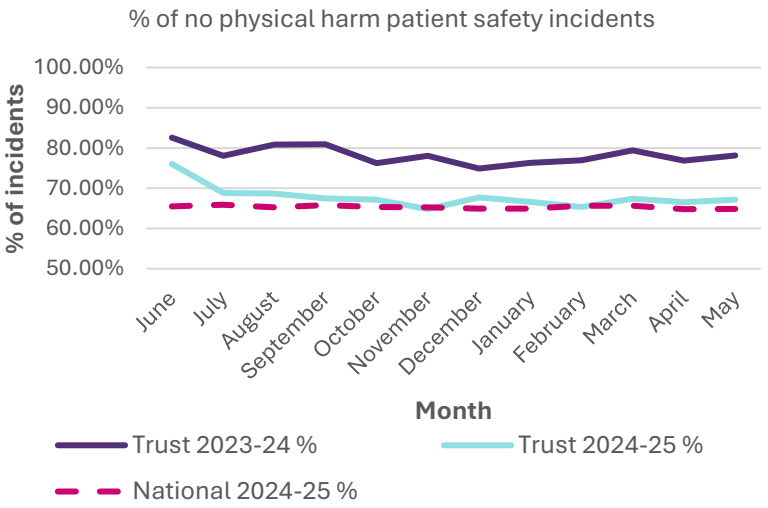
Appendix A: ELHT Incidents by Moderate harm and above

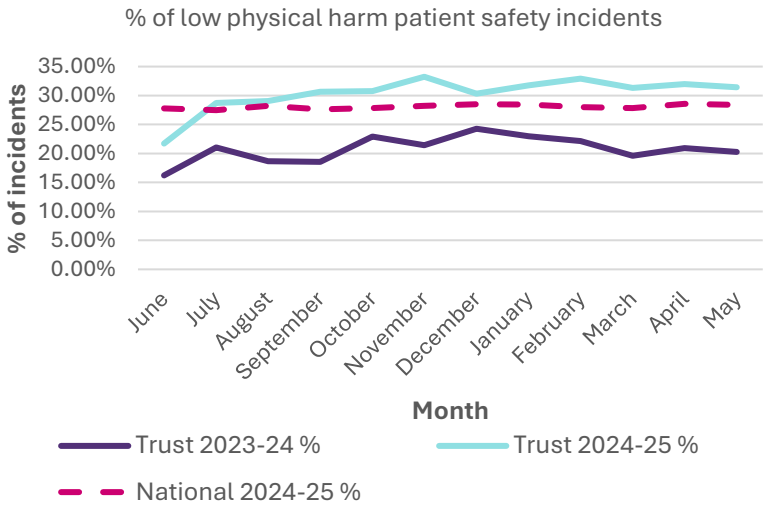


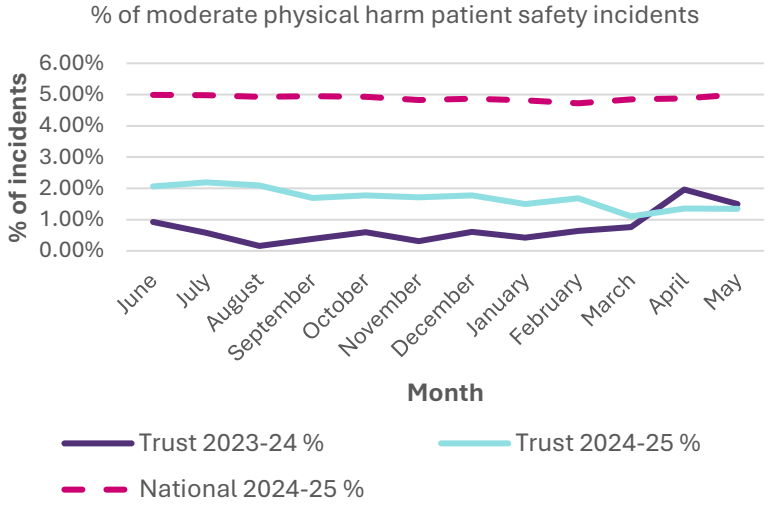


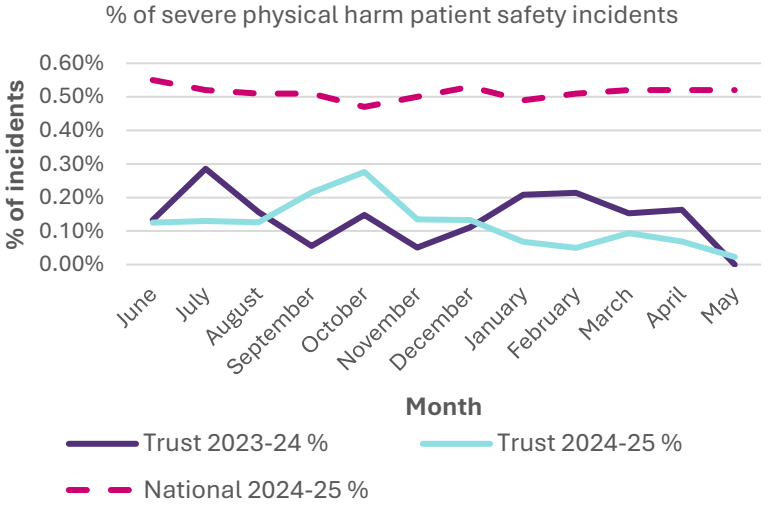


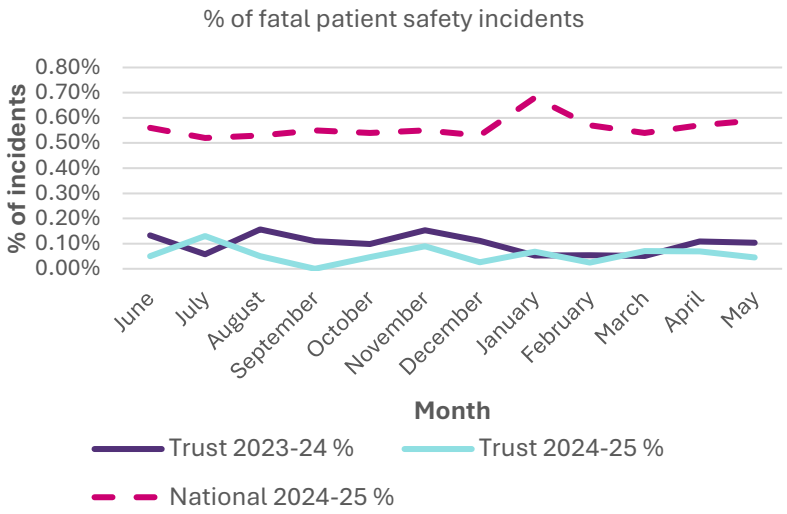
Appendix B: All Incidents compared to National Reporting Figures










% of fatal patient safety incidents
% of incidents
0.80%
0.70%
0.60%
0.50%
0.40%
0.30%
0.20%
0.10%
0.00%
June
July
August
September
October
November
December
January
February
March
April
May
Month
Trust 2023-24 %
Trust 2024-25 %
National 2024-25 %

Appendix C: KPI Dashboard for IR2s

Division	Number of SIRs (IR2s) by Month Trust Target 90%	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	Trend
CIC	Total IR2 reported	360	344	471	375	398	444	405	405	524	423	403	484	↑
	(total number investigated) % complete within 30 calendar days	(323) 89.72%	(289) 84.01%	(424) 90.02%	(316) 84.27%	(344) 86.43%	(388) 87.39%	(373) 92.10%	(356) 87.90%	(479) 91.41%	(387) 91.49%	(362) 89.83%	(458) 94.63%	
DCS	Total IR2 reported	136	103	149	125	116	164	189	118	103	97	100	91	↑
	(total number investigated) % complete within 30 calendar days	(91) 66.91%	(75) 72.82%	(103) 69.13%	(77) 61.60%	(82) 70.69%	(124) 75.61%	(154) 81.48%	(85) 72.03%	(69) 66.99%	(61) 62.89%	(78) 78.00%	(71) 78.02%	
FC	Total IR2 reported	314	239	272	232	259	235	268	210	245	259	227	245	↑
	(total number investigated) % complete within 30 calendar days	(240) 76.43%	(189) 79.08%	(198) 72.79%	(169) 72.84%	(228) 88.03%	(179) 76.17%	(224) 83.58%	(187) 89.05%	(224) 91.43%	(212) 81.85%	(177) 77.97%	(212) 86.53%	
MEC	Total IR2 reported	899	873	936	849	945	936	921	778	908	815	962	903	↓
	(total number investigated) % complete within 30 calendar days	(752) 83.65%	(742) 84.99%	(804) 85.90%	(694) 81.74%	(768) 81.27%	(758) 80.98%	(707) 76.76%	(495) 63.62%	(730) 80.40%	(630) 77.30%	(752) 78.17%	(679) 75.19%	
SAS	Total IR2 reported	426	371	393	346	347	341	357	326	372	314	377	344	↑
	(total number investigated) % complete within 30 calendar days	(362) 84.98%	(291) 78.44%	(315) 80.15%	(304) 87.86%	(312) 89.91%	(298) 87.39%	(310) 86.83%	(248) 76.07%	(313) 84.14%	(253) 80.57%	(282) 74.80%	(260) 75.58%	
Corp	Total IR2 reported	97	85	82	52	67	74	76	32	66	43	39	42	↑
	(total number investigated) % complete within 30 calendar days	(63) 64.95%	(33) 38.82%	(45) 54.88%	(24) 46.15%	(35) 52.24%	(30) 40.54%	(22) 28.95%	(20) 62.50%	(41) 62.12%	(24) 55.81%	(18) 46.15%	(20) 47.62%	
Trust Total	Total IR2 reported	**2232**	**2015**	**2303**	**1979**	**2132**	**2194**	**2216**	**1869**	**2218**	**1951**	**2108**	**2109**	↑
	(total number investigated) % complete within 30 calendar days	**(1831) 64.95%**	**(1619) 80.35%**	**(1889) 82.02%**	**(1584) 80.04%**	**(1769) 82.97%**	**(1777) 80.99%**	**(1790) 80.78%**	**(1391) 74.72%**	**(1856) 83.68%**	**(1567) 80.32%**	**(1669) 79.17%**	**(1700) 80.61%**	

Appendix D: KPI Dashboards for PSRs

Division	Number of PSRs open	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	April 25	May 25	Trend >90
CIC	No. open	44	61	56	51	52	72	83	52	49	38	38	34	↑
	No. open more than 90 calendar days	9	8	2	1	3	5	5	2	4	2	2	3	
DCS	No. open	9	22	14	24	12	13	9	9	10	6	6	7	→
	No. open more than 90 calendar days	1	2	1	2	0	0	0	0	0	1	1	1	
FC	No. open	51	55	54	37	39	39	38	45	44	19	53	48	↑
	No. open more than 90 calendar days	14	11	14	7	6	4	5	5	3	2	3	6	
MEC	No. open	88	102	96	93	60	61	71	82	80	66	73	71	↓
	No. open more than 90 calendar days	25	28	27	32	13	7	9	15	19	15	15	12	
SAS	No. open	31	47	34	37	35	41	28	48	34	27	17	14	↓
	No. open more than 90 calendar days	17	16	12	10	5	6	7	7	7	6	6	2	
Trust	No. open	**223**	**287**	**254**	**242**	**198**	**226**	**232**	**236**	**217**	**188**	**187**	**174**	↓
	No. open more than 90 calendar days	**66**	**65**	**56**	**52**	**27**	**22**	**26**	**29**	**33**	**26**	**27**	**24**	

Appendix E: KPI Dashboards for PSIIs

PSII reports (including HSIB/PMRT)	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Trend
No. new incidents at Complex case	5	2	2	7	2	3	3	2	5	3	0	1	
No. incidents agreed as PSII including (MNSI was HSIB)	5	2	4	3	2	3	4	2	5	3	0	1	
No. over 6 months	3(3)	2(1)	3(1)	5(2)	7(3)	10(4)	11(4)	8(4)	10(4)	7(4)	6(4)	6(5)	→
Total No. of PSIIs Open including (MNSI was HSIB)	27(10)	23(8)	26(7)	27(5)	24(7)	23(10)	24(8)	23(9)	27(9)	27(12)	22(10)	20(10)	↓
No. approved/closed by PSIRI including (MNSI was HSIB)	3	5	1	2	4	4	3	3	2	2	5	2	

Appendix F: Summary of PSII reports reviewed by PSIRI and the outcome

During April 2025 **five** new PSII reports were presented at the Trusts PSIRI panel.

- Incident resulting in death (eIR1299219) – The report was approved with no amendments other than one of the actions to be marked as completed. Below is a summary of safety recommendations identified in the report:
    - The Emergency Department to include the case in their Newsletter to highlight the need to consider abdominal aortic aneurysm as a possible diagnosis for patients aged over 55 with a sudden onset of abdomen, back or flank pain and to undertake an aorta scan where appropriate.

- Each baby counts (eIR1286111) – This was an investigation undertaken by MNSI; the report was approved. Below is a summary of safety recommendations identified in the report:
    - Mothers be provided with information about the risks of sudden unexpected postnatal collapse and how to reduce this in line with national BAPM guidance. This should include individual care planning, risk assessment and guidance for the mother.
    - Staff be supported to undertake regular and meaningful checks of all emergency equipment on the resuscitaire. Best practice would be for a supraglottic airway device to be included in the equipment as per national guidance.
    - Support staff to accurately assess a mother's ability to understand and communicate in English in line with local guidance where English is not a first language. If communication needs are identified, then to produce an individualised care plan.
    - Ensure that there is a robust system in place to support staff to follow up abnormal investigation results and that necessary action is undertaken.

- Each baby counts (eIR1283639) – This was an investigation undertaken by MNSI; the report was not approved as the it needed to return with the action plan. Below is a summary of safety recommendations identified in the report:
    - Ensure that the additional needs of a mother are effectively and appropriately communicated throughout pregnancy to ensure individualised care and ongoing risk assessment.
    - MNSI recommends a holistic risk assessment is undertaken for every mother attending maternity services to identify all risk factors to facilitate a robust management plan.

- Incident resulting in death (eIR1297854) – The report was approved with some amendments required to the harm level and the action plan to return for review. Below is a summary of safety recommendations identified in the report:
    - To improve Emergency Department and medical staff's understanding of the importance of taking blood cultures in a patient's pathway for those with suspected sepsis.
    - Review systems and processes in the Emergency Department and medical wards, to improve blood cultures being taken at the appropriate times in a patient's pathway for those with suspected sepsis, including before antibiotic administration, and in certain circumstances after antibiotic administration.

- Maternal death (eIR1286101) – This was an investigation undertaken by MNSI; the report was approved. There were no safety recommendations identified by MNSI.

Two reports that were previously reviewed by the panel were returned for approval, all were approved with no amendments, however three required some minor amendments to the improvement plan and one required correction to a spelling error.

During May 2025 **six** new PSII reports were presented at the Trusts PSIRI panel**.**

- Incident resulting in death (eIR1302894) – The report was approved with some minor amendments to correct some wording in the report and a review of the action completion dates. Below is a summary of safety recommendations identified in the report:
    - A clear process for babies going through the mortuary is required including regular audits/checks of the mortuary to take place 1-2 times a week
    - A clear tracking process/ register of patients is required to establish where patients are including the transfer to external mortuaries such as MFT to include consideration of a confirmation process of receipt of a patient at an external site.
    - Deceased babies must be stored on an individual shelf in the mortuary. Any foetal remains/products of conception must be placed in a separate fridge. A SOP is required to clearly identify this process and should shared with the porters. A meeting with the porters should take place to identify any barriers in this process and any training requirements.

- Incident resulting in death (eIR1298370) – The report was approved with some amendments to be made to a safety recommendation. Below is a summary of safety recommendations identified in the report:
    - Division to remind all Emergency Department staff that specialities can be contacted directly via the bleep system to ask for a patient review.

- Each baby counts (eIR1286647) – This was an investigation undertaken by MNSI; the report was approved with some updates on completion required to the action plan. Below is a summary of safety recommendations identified in the report:
    - The Trust should ensure that training emphasises the importance of starting chest compressions once a clear airway has been obtained, evidenced by chest wall movement and 30 seconds of ventilation breaths have been given, and prior to securing a definitive airway.

- Incident resulting in death (eIR1279580) – The report was approved with some minor additional information to included in the report. Below is a summary of safety recommendations identified in the report:
    - Division to ensure that if a patient consents to their information being shared that this is communicated to the family and documented in the patients notes.
    - Division to ensure that when patients are repeatedly and consistently making unwise decisions that are impacting on their health then detailed discussion are taking place with the MDT and Safeguarding advice sought if required. Formal Mental Capacity Assessment to be recorded in the patient record. Discussions take place with the family to understand the patient's baseline.
    - Division to share the findings of the investigation with wider teams and approach the Diabetic Specialist Nursing Team to arrange some bespoke educational sessions with he nursing team, to support them with the management of diabetic patients when they are non-compliant.

- Each baby counts (eIR1295796) – This was an investigation undertaken by MNSI; the report was approved with minor amendment to the action plan. No safety recommendations were made by MNSI.

- Each baby counts (eIR1295036) – This was an investigation undertaken by MNSI; the report was not and required resubmission to PSIRI following a review of the action plan to strengthen the actions. Below is a summary of safety recommendations identified in the report:
    - The Trust should review the process and training that exist so that clinicians are equipped with the information and skillset to perform intermittent auscultation in line with local and national guidance.
    - The Trust should review the process and training that exist so that clinicians are equipped with the information and skillset to perform maternal observations in line with local and national guidance.

Three reports that were previously reviewed by the panel were returned for approval, two were not approved, and one required some minor amendments.

Appendix G: Overdue Trust wide Policies/SOPs

Division/Directorate	Ref	Title	Review Date
Community and Intermediate Care			
Trust-Wide	C066	Policy for Care After Death and Support of the Bereaved in Adult Deaths	30/05/2025
Corporate Services			
Data & Digital	C031	Freedom of Information Policy	30/05/2025
	C045	Information Security Policy	30/04/2025
	C134	Subject Access Request Policy	31/05/2025
Finance and Capital	F02	Losses and Special Payments Procedure	31/03/2025
	F19	Anti-Fraud, Bribery and Corruption Policy	31/01/2025
	F22	Standards of Conduct Policy	31/03/2025
	F24	Standing Orders	31/03/2025
	F25	Standing Financial Instructions	31/03/2025
Human Resources (HR)	Agreement	ELHT Local Oncall Agreement	30/04/2025
	C099	Clinical Attachment Policy	31/03/2025
	HR03	Procedure for Recruitment and Retention Premia	30/05/2025
	HR07	Early Resolution Policy	31/03/2025
	HR11	Supporting Staff with Disabilities Policy	28/02/2025
	HR15	Facilities and Time Off for Recognised Representatives of Trade Unions and Staff Organisations	30/05/2025
	HR17	Managing Performance Policy	30/05/2025
	HR31	Alcohol, Drugs and Substance Misuse	30/08/2024
	HR43	Managing Organisational Change Policy & Procedure	30/05/2025
	HR50	Adoption and Adoption Support (Paternity) Pay and Leave Regulations	30/05/2025
	HR51	Guidelines for Consultant Job Planning	31/03/2025
	HR56	Returning to work and breastfeeding policy	30/05/2025
	HR58	Policy on the Development of Professional Roles	31/12/2024
	HR62	Staff Bank and Agency Worker Policy	31/07/2024
	HR64	Pay protection	30/05/2025
	HR65	Compensatory Rest for Doctors (non resident on call)	30/04/2025
	HR68	Undertaking Private Practice	30/04/2025
	HR76	Armed Forces Reserves and Cadets Policy	30/04/2025
	HR77	Uniform/Dress code	30/05/2025
Quality Governance	C157	Chaperones Accompanying Patients During an Intimate Procedure / Treatment	30/04/2024
Safeguarding	C113	Safeguarding Children Supervision Policy	30/05/2025
	SOP020	Referral Pathway for Alcohol and/or Substance Use in Children/Young People under 18 years old	30/05/2025
Urology	CP34	Assessment and management of urinary and faecal incontinence in adults (in-patients)	31/03/2025

Division/Directorate	Ref	Title	Review Date
Diagnostic and Clinical Support			
Clinical Laboratory Medicine (Pathology)	SOP015	Administering Injectable Medicines	31/03/2025
Pharmacy	CP24	Intravenous Therapy Policy (Adult and Paediatrics (not neonates))	30/04/2025
	MM01	Guidelines for the Prescribing, Supply and Use of Unlicensed Medicines	31/03/2025
	MM02	Policy for Supply and / or Administration Of Prescription Only Medicines Under Patient Group Directive	31/12/2024
	MM03	Medicines Reconciliation Policy	30/05/2025
	MM06	Prescribing for Clinical Need Policy	31/03/2025
	SOP014	Preparing Injectable Medicines	31/03/2025
	SOP042	Destruction of Controlled Drugs on Wards and Clinical Areas	18/04/2025
	SOP044	Dealing with suspected Drug Misuse by Staff	28/02/2025
	SOP046	Exceptional Medicines that may be stored in Controlled Drug cabinet	28/02/2025
	SOP049	Supply of over-labelled medicines in clinical areas	28/02/2025
	SOP050	Procedure for use of patients' own drugs on admission	28/02/2025
	SOP051	Short stay medicines discharge procedure	31/01/2025
	SOP053	Handover of medicines to patients-carers at hospital discharge	31/01/2025
	SOP054	Management of medicines-related errors and near misses	31/01/2025
	SOP055	Pharmacist supply of Nicotine Replacement Therapy for inpatients in hospital by Pharmacists	18/04/2025
	SOP058	Covert administration of medicines or disguising medicine	28/02/2025
	SOP059	Procedure for general administration of medication	31/01/2025
	SOP060	Procedure for supply of medicines in Monitored Dose Systems	28/02/2025
	SOP061	Prescription ordering and security	31/12/2024
	SOP069	Procedure for Vaccination of At-Risk Inpatients with Influenza Vaccine	31/12/2024
	SOP113	Procedure for the Management of Oxygen During Periods of High Demand	31/03/2025
Therapies and Orthotics	SOP141	Allied Health Professionals: Return to Practice	30/05/2025
Medicine and Emergency Care			
Digestive Diseases	CP50	Acute Upper GI Bleeding (AUGIB) Guidelines	31/03/2025
Surgical and Anaesthetic Services			
General Surgery	SOP085	Risk Stratifying Process for Follow Up Patients	30/04/2025

TRUST BOARD REPORT

Meeting Date:	9 July 2025	**Agenda Item:**	TB/2025/096
Report Title:	Maternity and Neonatal Services Update		
Author:	Tracy Thompson, Divisional Director of Midwifery and Nursing (Maternity Safety Champion) supported by Maternity & Neonatal (Perinatal transformation team)		
Lead Director:	Peter Murphy – Chief Nurse (Executive Maternity & Neonatal champion)		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓			✓
Executive Summary:	The purpose of this report is to provide: 1. An overview of the safety and quality programmes of work within the maternity and neonatal services resulting from the National Perinatal Safety Ambitions, specific to the ten CNST (Clinical Negligence Scheme for Trusts) maternity safety actions included in year six of the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme. (Appendix 1 - CNST Year 6 criteria) 2. Updates regarding ELHT (East Lancashire Hospitals Trust) maternity services response to the NHS England/Improvement (NHS E/I) – Ockenden recommendations and maternity/ Neonatal Three-year delivery plan. 3. Safety intelligence within maternity or neonatology care pathways and programmes that pose any potential risk in the delivery of safe care to be escalated to the trust board. 4. Continuous Quality and Service improvements, progress (Bimonthly report presented at trust wide quality committee) with celebrations noted.			
Key Issues/Areas of Concern:				
Action Required:	The Board of Directors are asked to. • Receive and discuss the CNST-MIS update, all compliance reports, and recommendations for year 6 quarter four – final submissions and outcome • Provide bimonthly reporting to ELHT trust board with any barriers that may impact on the implementation and longer-term sustainability plans and deliverables aligned with the maternity and neonatology safety • Discuss any safety concerns with Trust board members aided by floor to board agendas further guided by the Executive and non- executive board safety champions.			

Previously Considered by:	
Date:	
Outcome:	

1. INTRODUCTION

The purpose of this report is to provide:

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

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

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

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

2. CNST - MATERNITY INCENTIVE SCHEME

2.1 Summary overview

Blue indicates complete

Green indicates progressing without concern

Orange indicates barriers/ risk to compliance identified

Red indicates non-compliance identified

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

Safety Action	Progress	Assurance/Exceptions
1. Perinatal Mortality Review Tool (PMRT)		● Compliance with Safety Action 1 was achieved for CNST Year 6 and all targets for Year 7 remain on track. ● Year 7 guidance requires that 75% of reports must be published within 6 months, up from a target of 60% previously. ● Year 7 guidance requires that for 50% of the deaths reviewed an external member should be present at the MDT review panel. ● These new targets take effect from April 2025 and will be monitored with assurance provided through quarterly PMRT reports. Q1 PMRT report will be submitted to September Trust Board.
2. Maternity Services Data Set (MSDS)		● July will again be the reporting month for this Safety Action. Compliance will be evidenced at September Trust Board. ● All metrics remain on track.
3. Transitional Care (TC)		● Annual TC audit will be submitted to January 2026 Trust Board. ● The Jaundice Quality Improvement (QI) will be monitored as the QI for this Safety Action.
4. Clinical Workforce		● Year 7 guidance requires that one consultant attendance audit is completed covering a 3-month period in the CNST Year. A quarter 1 audit will be completed and submitted to September Trust Board. ● Audits for employing long and short-term locums will be submitted to September Trust Board. ● **Identified risk** - The Neonatal Nursing Workforce action plan will continue to be monitored as part of this Safety Action if non-compliant with British Association of Perinatal Medicine (BAPM). Annual workforce paper will demonstrate workforce analysis against activity including qualified in speciality (QIS) trained nurse if compliance is at risk <70%.

		● Correction to previous report: The neonatal medical workforce is compliant with BAPM standards and a report to evidence this will be submitted to September Trust Board.
5. Midwifery Workforce		● Midwifery Safe staffing January-July report will be submitted to September Trust Board. ● Birthrate+ exercise is due for renewal this CNST year to maintain compliance. A meeting has taken place to initiate the process with oversight from the Directorate Manager and Assistant Director of Midwifery. ● **Identified risk** - Current funded midwifery establishment does not reflect Birthrate + findings and recommendations. Plan/mitigations reflected in Biannual reports trust board for year 6. Additional paper to present in June 2025 at TWQGA & Quality committee and 9th July Trust board. ● Safe Midwifery Staffing paper included as Appendix 4.
6. Saving Babies Lives v3 Care Bundle (SBLv3)		● ELHT are currently at 91% overall implementation following the LMNS assurance visit on 8th of January 2025. ● Further progress and sustainability of current implementation plan with associated actions continues with close oversight from Obstetrics Clinical Director/Perinatal Quadrumvirate.
7.User Feedback		● The Transformation Team and Deputy Director of Midwifery are working with the Engagement Lead and Maternity and Neonatal Voices Partnership (MNVP) Lead and Engagement Lead to plan the schedule of works to meet and deliver the asks of SA7.
8. Training		● No changes to guidance for Safety Action 8 in CNST Year 7. Compliance will continue to be monitored to ensure 90% targets are met by the cut-off date on 30th of November 2025. ● Anaesthetist compliance with PROMPT training has increased to 98%. ● **Identified risk –** Neonatal medical team NLS compliance is currently 67%. This is being managed by the Neonatal lead consultant to schedule additional sessions in July & August 2025 to both meet the expected training compliance and meet CNST requirement by the 30th of November reporting period.
9. Board Assurance		● An update on progress with the Culture Improvement Plan will be brought to September Trust Board. Culture coach sessions to be completed by the 1st of July 2025 ● Triangulation of claims, incidents, and complaints will now be monitored at Floor to Board meetings, with updates to be brought to Trust Board.
10. MNSI (Maternity and Newborn Safety Investigation) / NHS Resolution		● Quarter 1 MNSI report will be submitted to Trust Board in September. ● Year 7 guidance requires that MNSI information be provided to patients in a format that is accessible to them. Any exceptions to this are to be reported to Trust Board. This will be included in quarterly reports brought to Trust Board.

2.2 Key updates and exceptions per Safety Action

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

CNST - PMRT

(All measures reported against month of death)

* = Data not relevant for month
n/a = Data not available at time of report

	Reporting Measure	Threshold	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Monthly Trend
PMRT02a	a) i Number of cases reported to MBRRACE within 7 days		3	5	1	2	4	2	4	5	1	5	4	1	
		100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
PMRT06a	c) i Number PMRT tool started 2 months		3	5	1	2	4	2	4	5	1	5	4	1	
		95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

	Reporting Measure	Threshold	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Monthly Trend
PMRT05a	c) ii Number PMRT published reports by 6 months		3	4	1	2	3	1	2	1	0	0	0	0	
		75%	100.0%	80.0%	100.0%	100.0%	75.0%	50.0%	50.0%	20.0%	0.0%	0.0%	0.0%	0.0%	
PMRT05c	Number PMRT published reports not due		0	0	0	0	0	0	1	4	1	5	4	1	
			n/a	n/a	n/a	n/a	n/a	n/a	n/a	1	0	0	0	0	
PMRT05d	Number PMRT with External Member Present	50%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	20.0%	0.0%	0.0%	0.0%	0.0%	

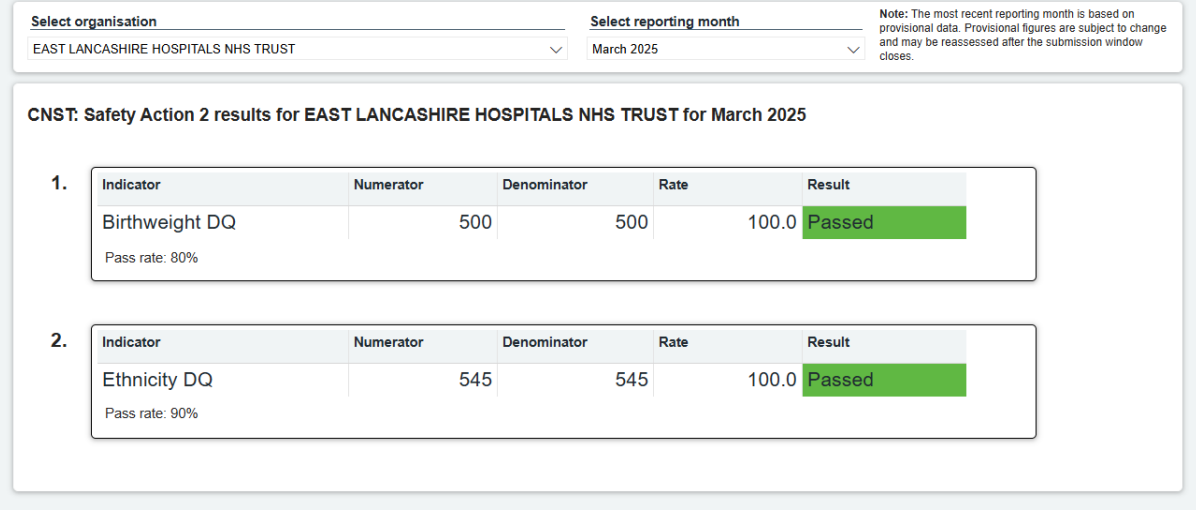
The Perinatal Mortality Review Tool (PMRT) dashboard above evidence that all metrics are currently on track for CNST Year 7.

The below new requirement is now included in the dashboard:

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

As this requirement is new it will be measured on deaths occurring following the 2nd of April 2025. There is therefore a delay in reporting as PMRT meetings have not yet taken place for deaths within this period. An external member rota has been produced for the region to cover the requirements for this ask.

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



Select organisation: EAST LANCASHIRE HOSPITALS NHS TRUST

Select reporting month: March 2025

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

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

1.

Indicator	Numerator	Denominator	Rate	Result
Birthweight DQ	500	500	100.0	Passed

Pass rate: 80%

2.

Indicator	Numerator	Denominator	Rate	Result
Ethnicity DQ	545	545	100.0	Passed

Pass rate: 90%

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

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

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

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

The service has been conducting a quality improvement (QI) to reduce jaundice readmissions (Appendix 3). This QI will be used as evidence for Safety Action 3. An update will be provided on progress with this QI to the LMNS at the Quality Assurance Panel, and to safety champions at Floor to Board on the 13th of June 2025.

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

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

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

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

As the service is non-compliant with BAPM standards for neonatal nursing staffing, an updated version of the action plan as submitted in previous CNST years will be submitted to September Trust Board. A report evidencing compliance with BAPM standards for the neonatal medical workforce will also be submitted to September Trust Board.

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

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

The Birthrate+ exercise was completed in 2022 and must be repeated every 3 years as per MIS requirements, meaning this is due for renewal in 2025. A meeting has taken place with Birthrate+ to initiate the reassessment, and the process will be led by the Directorate Manager and the Assistant Head of Midwifery.

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

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

2.2.6 Safety action 6: Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three (SBLv3)?

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

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

SBL Element	Current Implementation (as assured by LMNS)
Element 1 - Reducing Smoking in Pregnancy	8/10 interventions implemented and evidenced **(80%)**
Element 2 - Fetal Growth Restriction	19/20 interventions implemented and evidenced **(95%)**
Element 3 - Reduced Fetal Movement	2/2 interventions implemented and evidenced **(100%)** [1 intervention contains 4 asks]
Element 4 - Effective fetal monitoring during labour	5/5 interventions implemented and evidenced **(100%)**
Element 5 - Reducing preterm births and optimising perinatal care	24/27 interventions implemented and evidenced **(89%)**
Element 6 - Management of Diabetes in Pregnancy	6/6 interventions implemented and evidenced **(100%)**

Meetings with the LMNS have been diarised throughout the CNST Y7 reporting period as below, this provides the forum to meet the ask *'Trusts should be able to demonstrate that at*

least two (and up to three) quarterly quality improvement discussions have been held between the ICB (as the commissioner) and the Trust.':

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

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

The Perinatal Transformation team, the Assistant Director of Midwifery, and the Consultant Midwife are working with the Maternity and Neonatal Voices Partnership (MNVP) Engagement Led to plan a schedule of projects for the MIS Year, covering the below requirements:

Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.
The Transformation Team and Prevention Lead Midwife are conducting a Translation Quality Improvement (QI), aiming to improve access to interpreter services for service users whose first language is not English. As part of this work, the Prevention Lead Midwife and Improvement Support Officer attended a Home Start community group to seek feedback from service users to inform changes. Feedback centred around the need to continuously offer interpreters at all appointments, and the need to improve access to translated patient information resources. The MNVP Lead is a member of the QI working group and is involved in work to understand this feedback and create an action plan in response.

Evidence of an action plan coproduced following joint review of the annual Care Quality Commission (CQC) Maternity Survey free text data which CQC have confirmed is available to all trusts free of charge.
An action plan based on CQC survey results and free text data has been drafted by the Transformation Team, Quality and Safety Team, and Midwifery Leaders. This draft will be discussed with the MNVP Lead and Engagement Lead to request support with gathering further feedback on the themes identified.

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

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

- **Fetal monitoring and surveillance (in the antenatal and intrapartum period) training**. 90% attendance required for midwives, obstetric consultants and all other obstetric doctors who contribute to the obstetric rota.
  All relevant staff groups are currently over 90%.
- **Maternity emergencies and multi-professional training (PROMPT)**. 90% attendance for obstetric consultants and doctors, midwives, maternity support workers, and anaesthetic consultants.
  All relevant staff groups are currently over 90%.
- **Neonatal basic life support (NLS)**. 90% attendance required for neonatal consultants, junior doctors (who attend any births unsupervised), neonatal nurses (who attend any births unsupervised), advanced neonatal nurse practitioners, and midwives.
  All relevant staff groups are currently over 90% aside from the neonatal nursing team, which since the previous report has increased to 87%, through management by the Neonatal Training Lead.

A meeting took place on the 29th of May 2025 with all leads for this safety action to review the new guidance and put in place processes to reach or maintain compliance by the 30th of November 2025, the date at which this safety action is measured. A follow up meeting with all leads will be held to monitor progress in September.

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

Safety Champions are continuing to meet with the perinatal leadership team at a minimum of bi-monthly at Floor to Board meetings. The last meeting took place on the 16th of June 2025.

Perinatal Quality Surveillance Model (PQSM) Minimum Data Set April 2025 data:

Perinatal Quality Surveillance Dataset

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

	Metric	Standard	Jan 25	Feb 25	March 25	April 25
Perinatal Data	1:1 care in labour	100%	100%	100%	100%	100%
	Stillbirth rate	<4.4/1000	10.25	2.48	7.62	8.71
	Term admissions to NICU	<7%	6.98	7.23%	5.78	6.54%
	Obstetric haemorrhage >1.5 litre (within 24hrs)	<10%	3.33%	5.59%	3.07	5.45
	3rd/4th degree perineal tear	<5%	4.41%	5.67%	3.31	3.66

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

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

Stillbirth rate:
There has been in increase in the rate of stillbirths for March and April –in both March there were 3 stillbirths and 1 Late MTOP and in April there were 3 stillbirths and 1 MTOP. 1 Of the March stillbirths was an intrapartum stillbirth and is being investigated by MNSI. The other stillbirths are being reviewed by the PMRT process.

Term admission to NICU:
The Term admission rate has reduced in March and April. All of these are reviewed by the ATAIN process. So far, none of these admissions have been identified as avoidable and incidental learning only has been identified.

3rd/4th degree perineal tears
The number of 3rd/4th degree tears has reduced since February – all these continue to be reviewed.

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

	Metric	Standard	Jan 25	Feb 25	March 25	April 25
Feedback	Service user feedback (MNVP)		3 sessions attended	4 session attended	3 session attended	1 session attended
	FFT satisfaction rated as good	>90%	92.63	85.56%	84.31%	87.09
	Number of level 4 complaints	-	4	1	5	1
	Executive safety walkaround	Bi-Monthly	0	0	0	1
	Maternity/ Neonatal Safety Champion walkaround	Bi-Monthly	1	0	1	1

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

	Metric	Jan 25	Feb 25	March 25	April 25
CNST	Progress with CNST 10 safety action compliance	●	●	●	●

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

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MNVP Service User Feedback:

FFT satisfaction rated as good:
There has been an increase in the number of FFT responses rating care as poor/very poor. These continue to be monitored at monthly Patient experience group and an action plan agreed, this will be shared at the next Trust PEG meeting.

Level 4 Complaints
There have been level 4 complaints in April. These are monitored and any themes identified. These include staff attitudes, delays in analgesia.

Executive Safety Walkarounds:
Executive Safety Champions meetings have taken place in both birth centres and the antenatal ward.

Moderate or above incidents:
There has been 1reported incident in April – this is a possible avoidable VTE. There have been 3 new PMRT cases reported.

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

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

CNST:
Year 7 standards were published on April 2nd, currently on track with meeting these.

'Is the Trust's claims scorecard reviewed alongside incident and complaint data.'

An update on the actions taken after the implementation of a triangulation task and finish group was provided at Floor to Board on the 16th of June 2025 (**Appendix 1**). Next steps from this work include using data and Statistical Process Control (SPC) charts to further triangulate results and identify trends, and to commence improvement work based on the findings.

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

Following on from previous updates, ELHT maternity and neonatal services were offered the opportunity to train Culture Coaches to hold regular culture conversations with staff and support the delivery of local culture improvements. The culture coaches have now held culture conversations in all areas. Feedback from these sessions will come via the Culture Coaches for discussion at the July Quad meeting, to inform the culture improvement plan.

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

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

A detailed overview of cases within the reporting period to present are provided in the quarterly reports produced by the Quality and Safety Lead. The quarter 1 report will be submitted in September.

Updated MIS Year 7 guidance now states that Trust Board must have sight of *'evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme. This needs to include reporting where families required a format to make the information accessible to them and should include any occasions where this has not been possible, with*

a SMART plan to address any challenges for the future.'. This is already standard procedure within the service and as such will be added to the quarterly report submitted to Trust Board.

3. MATERNITY AND NEONATAL PERFORMANCE DATA – EXCEPTIONS AND IMPROVEMENT PRACTICE

The Family Care Divisional Analyst has developed performance data in the Statistical Process Control (SPC) chart format (**Appendix 2**). These charts will be aligned with the perinatal quality assurance dashboard as part of Safety action 9. Divisional process already in place to review at the monthly Perinatal Dashboard meetings in order to identify any exceptions and themes, to then be reported into Perinatal Governance Board for oversight, monitoring and assurance. The Transformation Team will undertake any improvement work identified as necessary through this process, to ensure QI projects are data informed, responsive to unwarranted variation with the appropriate rationale for normal variation.
The first exception report is attached as an appendix, outlining areas of normal and unwarranted variation (**Appendix 3**).

4. CONCLUSION

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

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

Perinatal Quadrumvirate:
Tracy Thompson, Divisional Director of Midwifery and Nursing
Martin Maher, Clinical Director Obstetrics/Gynaecology
Rajasri Seethamraju, Clinical Director Neonatology
Charlotte Aspden, Directorate Manager of Maternity and Neonatology
July 2025

Appendix 1 – Triangulation Claims Complaints and Incidents

CNST SA9 scorecard triangulation May 2(

Appendix 2 – Maternity Performance Report

Maternity Performance Report

Appendix 3 – Maternity Performance Data Exception Report

Exceptions and Improvement Practic

Appendix 4 – Safe Midwifery Staffing Paper

ELHT Board paper for safe midwifery st

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ELHT CNST Claims/Complaints/Incidents Triangulation May 2025 update

CNST SA 9 – Review of the Trust's claims scorecard alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level.

Safe | Personal | Effective

May 2025 Update

The Scorecard that was published in September 2024 highlighted that the leading reason for claims in obstetrics as;

- Delay in treatment or diagnosis
- Failure to recognise complications in labour
- Monitoring in second stage of labour
- Lack of antenatal screening

Within NICU these are;

- HIE/Cerebal Palsy/Brain injury
- Medication incidents

The scorecard is updated annually, with the next update due in September/October 2025.

This update will focus on the actions from the last presentation, and update of themes and trends in the period September 2024- March 2025

CNST Scorecard 2014-2024 – Maternity

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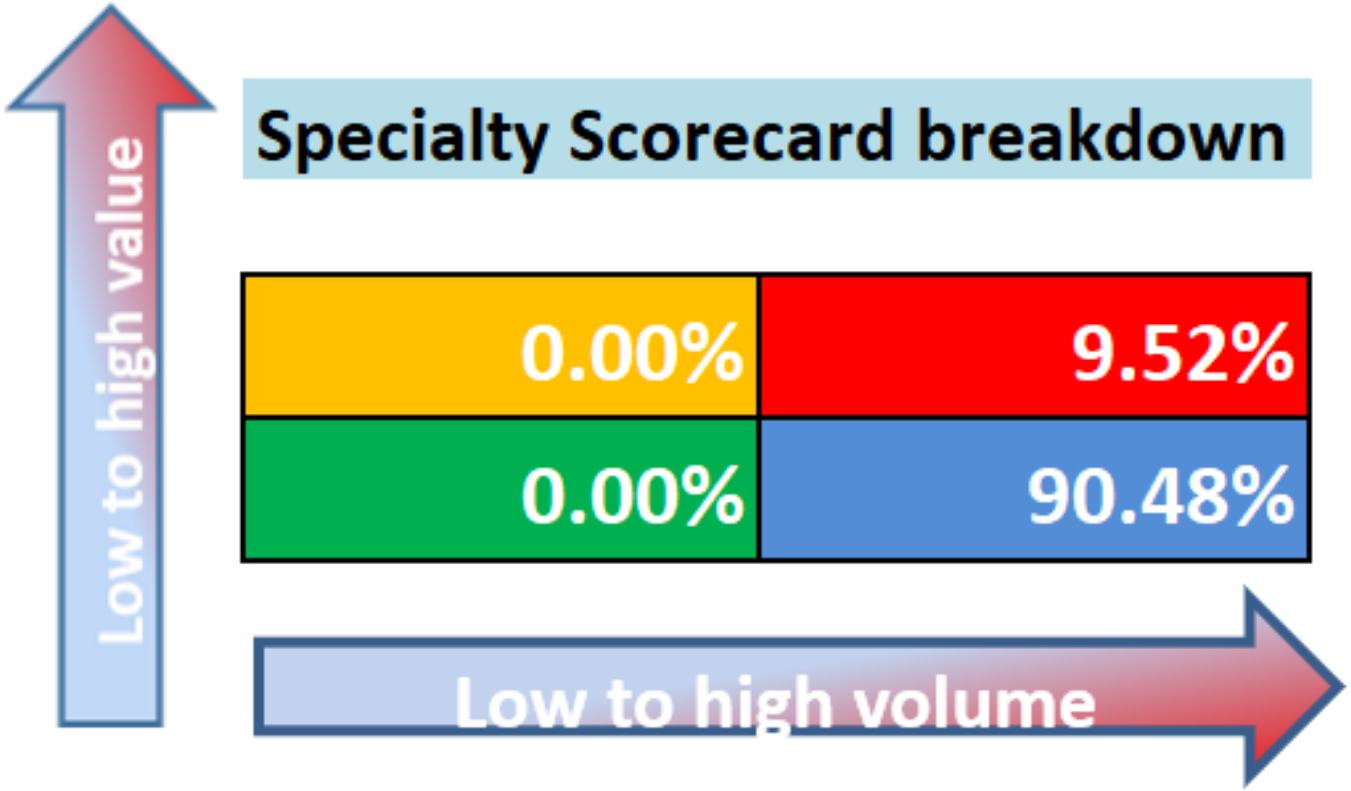
Specialty - Value of claims (£)	% of Trust Clinical Claims - Value	Specialty - Volume of Claims
77,713,629	34%	84



Top 5 **injuries** for Obstetrics

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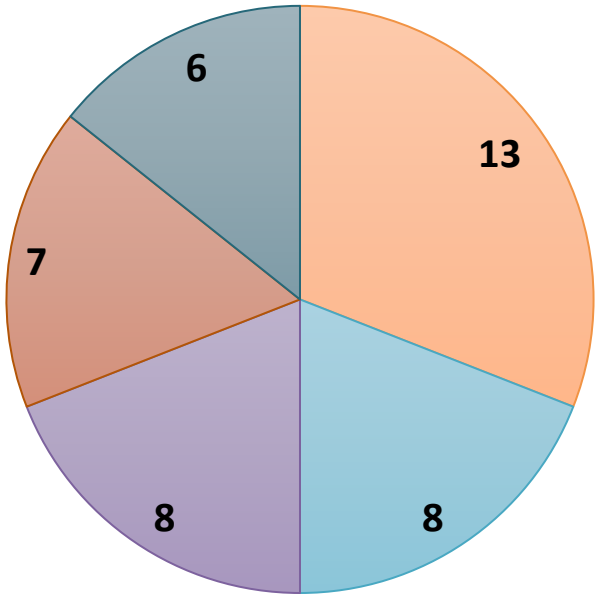
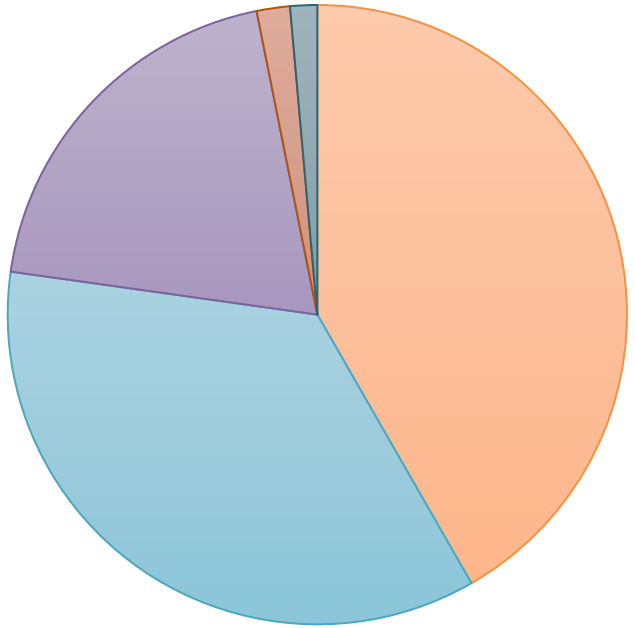
Volume



Stillborn
Fatality
Unnecessary Pain
Cerebral Palsy
Adtnl/unnecessary Operation(s)

Value £



Brain Damage
Cerebral Palsy
Developmental Delay
Cardiovascular Condition
Stillborn

Top 5 **causes** for Obstetrics

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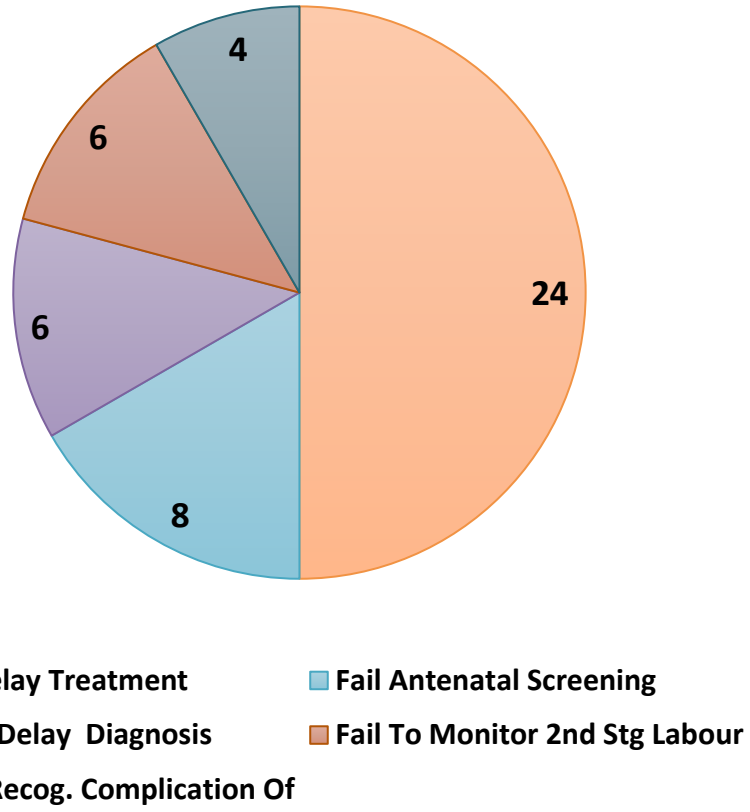
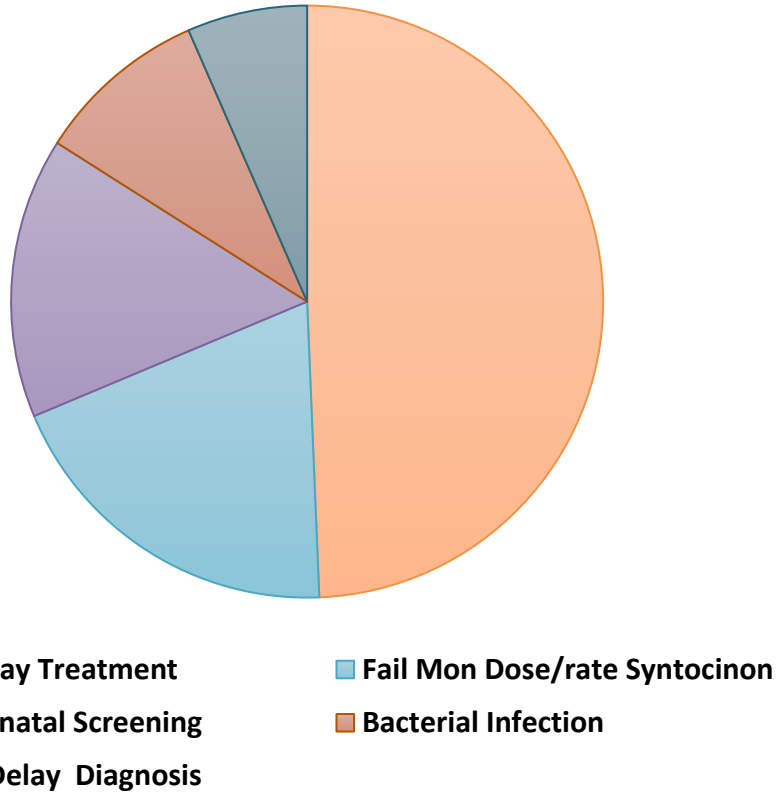
Volume



Value £



CNST Scorecard 2014-2024 – Neonatology

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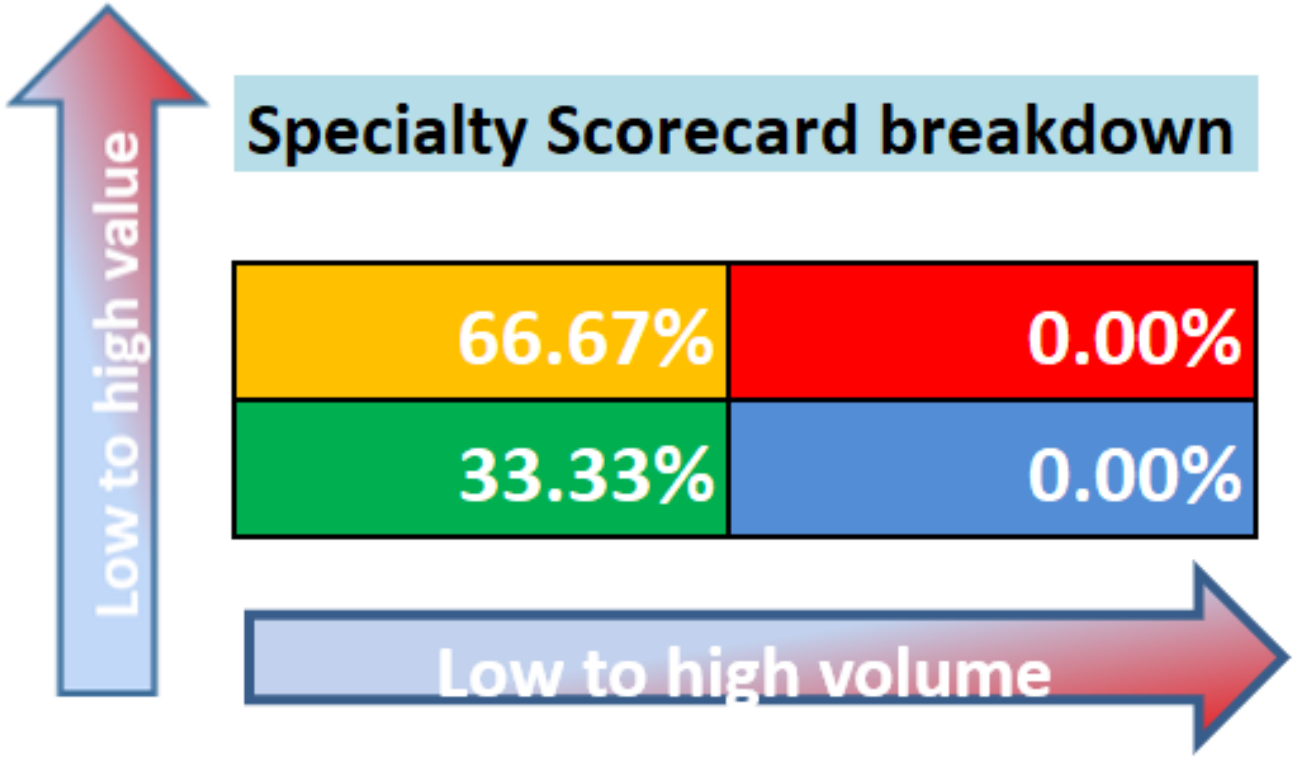
Specialty - Value of claims (£)	% of Trust Clinical Claims - Value	Specialty - Volume of Claims
19,187,190	8%	3



Top **causes** by **value** for Neonatology

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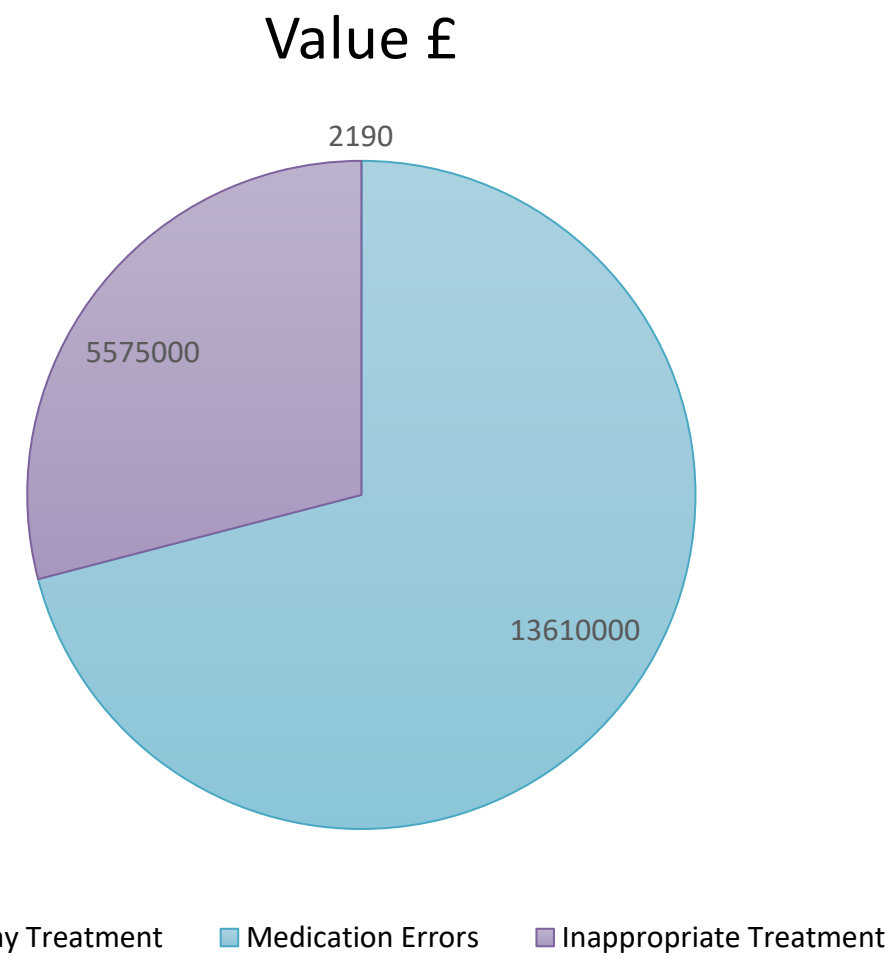

Top **injuries** by **value** for Neonatology

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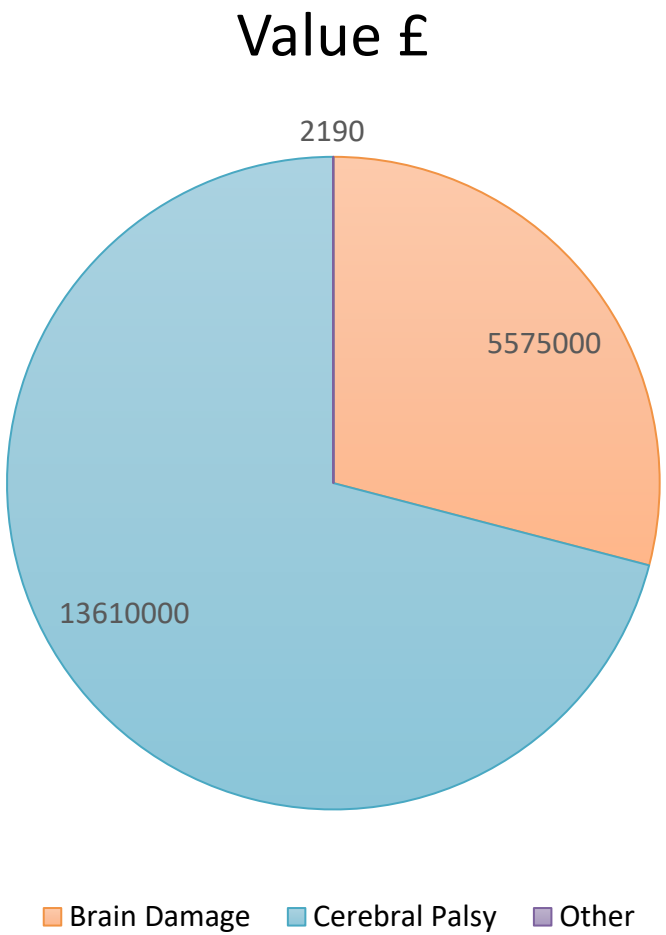
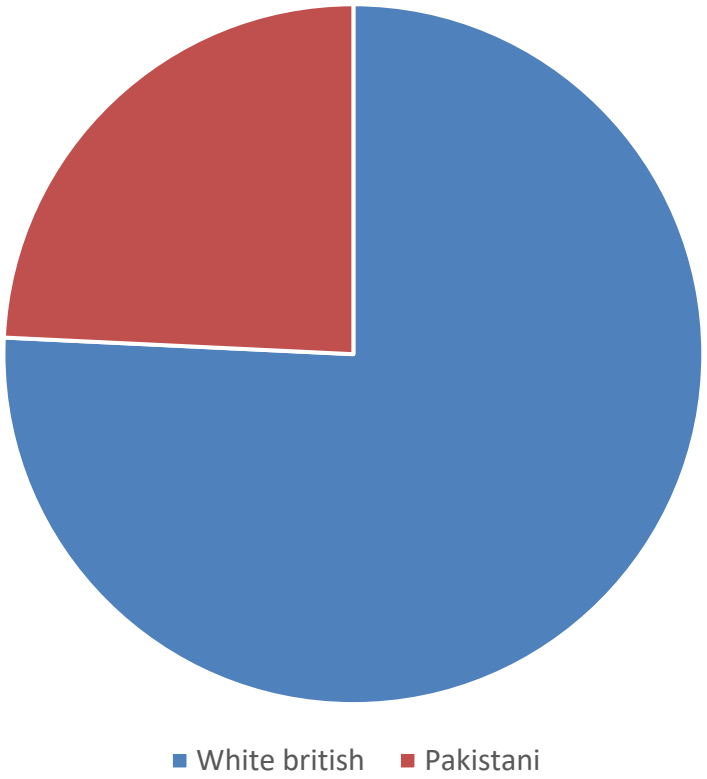
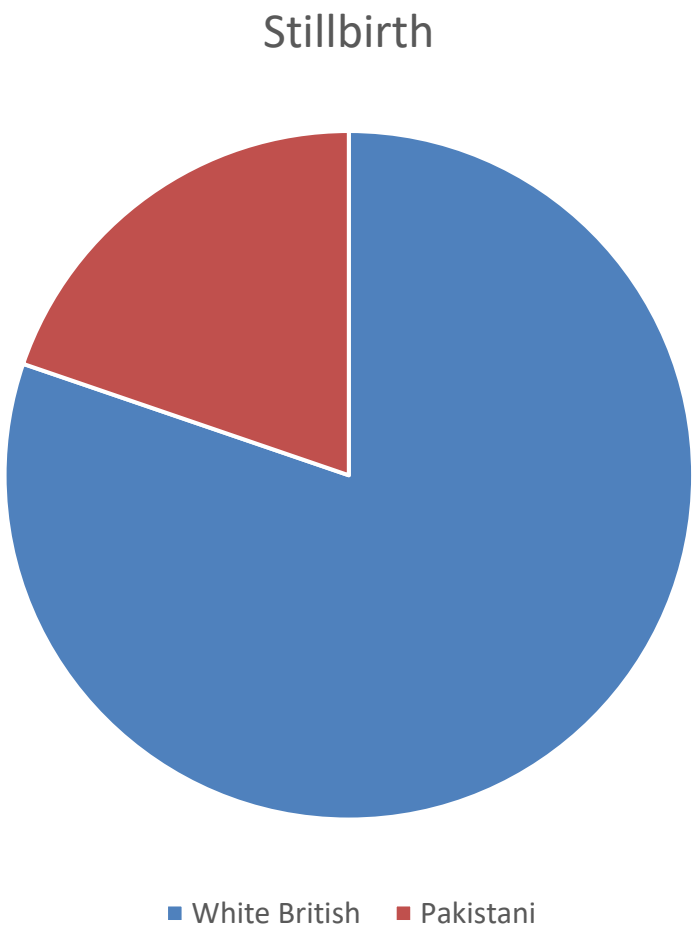
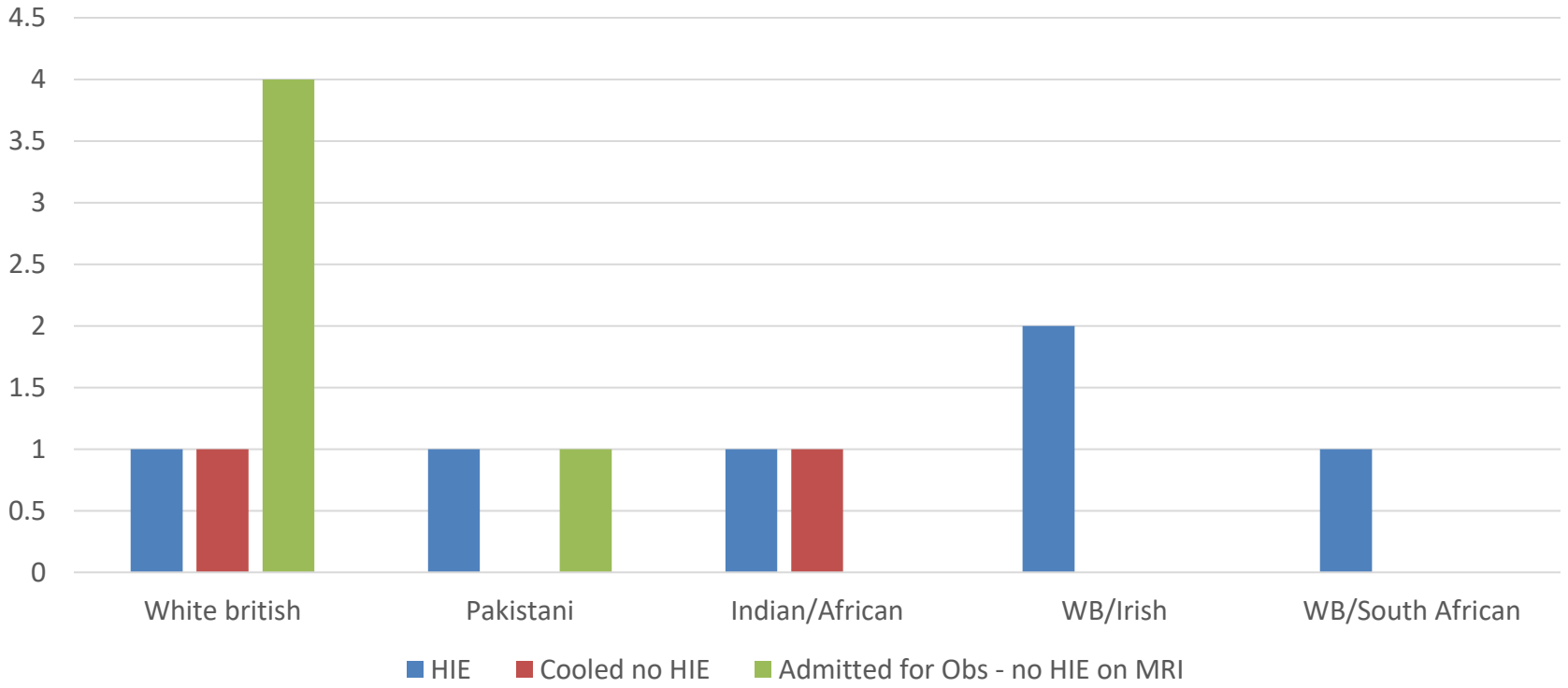


Ethnicity from Claims in the 2024 Scorecard

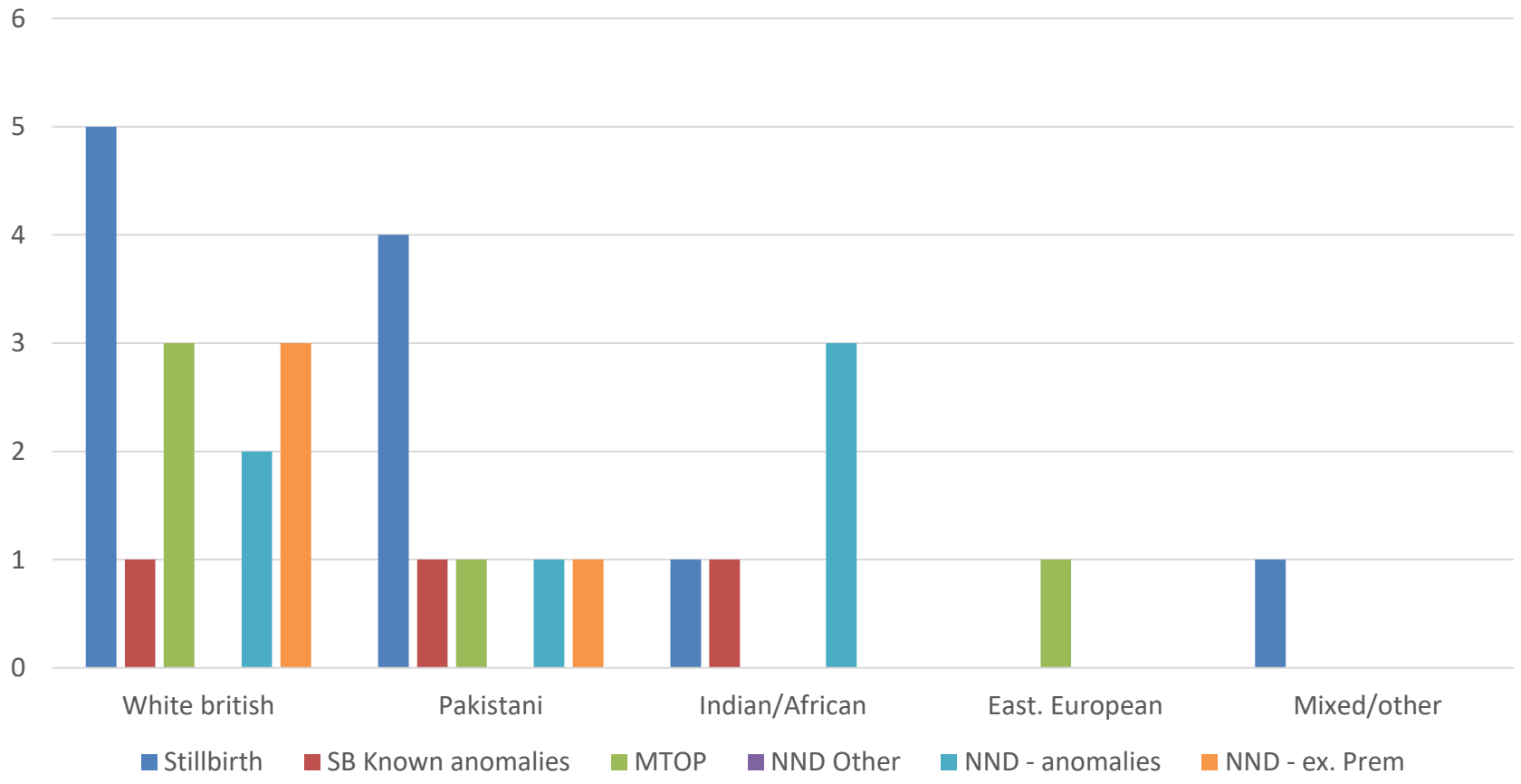




Ethnicity of babies admitted with potential or actual HIE September-March 2025



Ethnicity of fetal losses September 2024 – March 2025



Triangulation of stillbirths and HIE with claims by ethnicity

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- The majority of claims for HIE are by white British families
- The majority of babies admitted with suspected HIE are white British
- The number of babies diagnosed with HIE in NICU falls evenly across all ethnicities
- The number of claims for stillbirths are made by white British families
- The total number of fetal losses is highest in white British families
- The number of stillbirths without fetal anomalies falls evenly across white British, Pakistani and Indian/African women.

Top 5 Maternity **Incidents** in the last 6 months (September – March)

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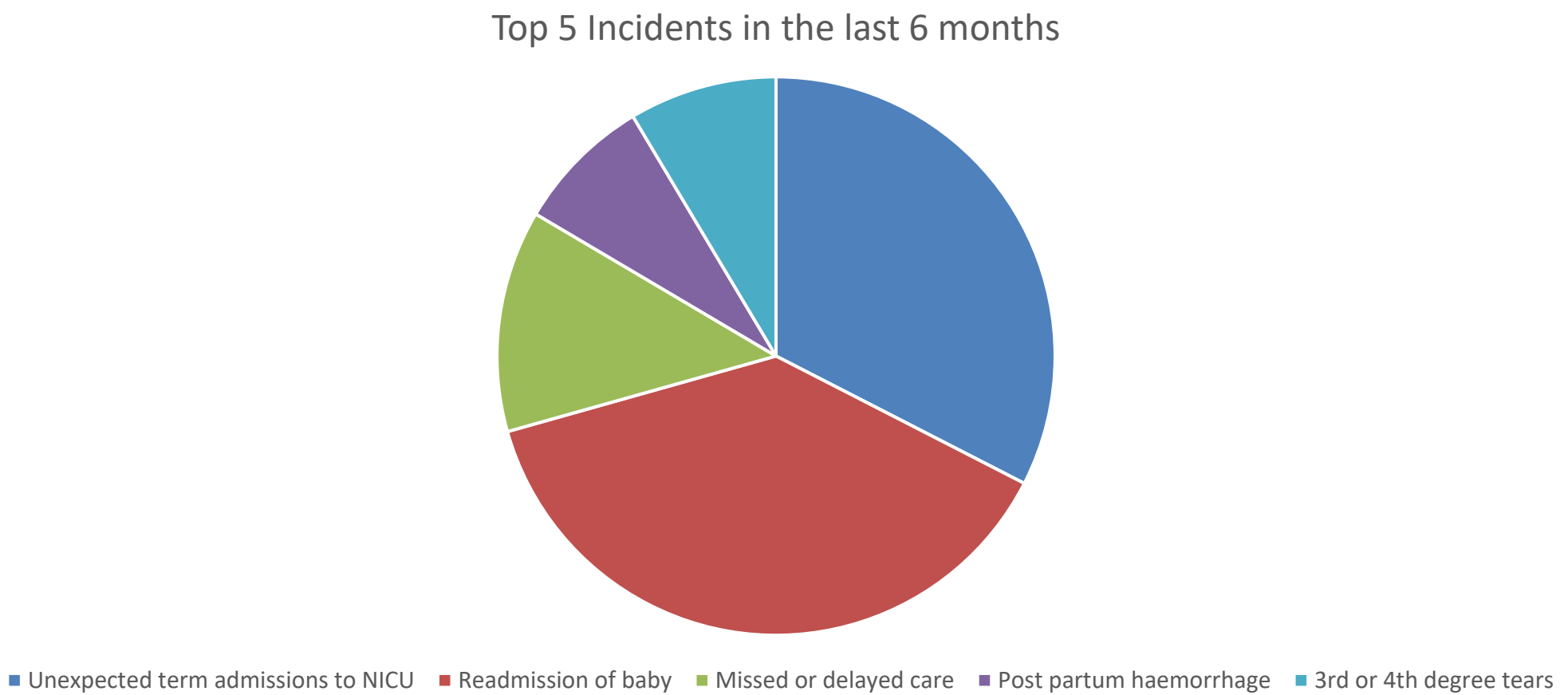
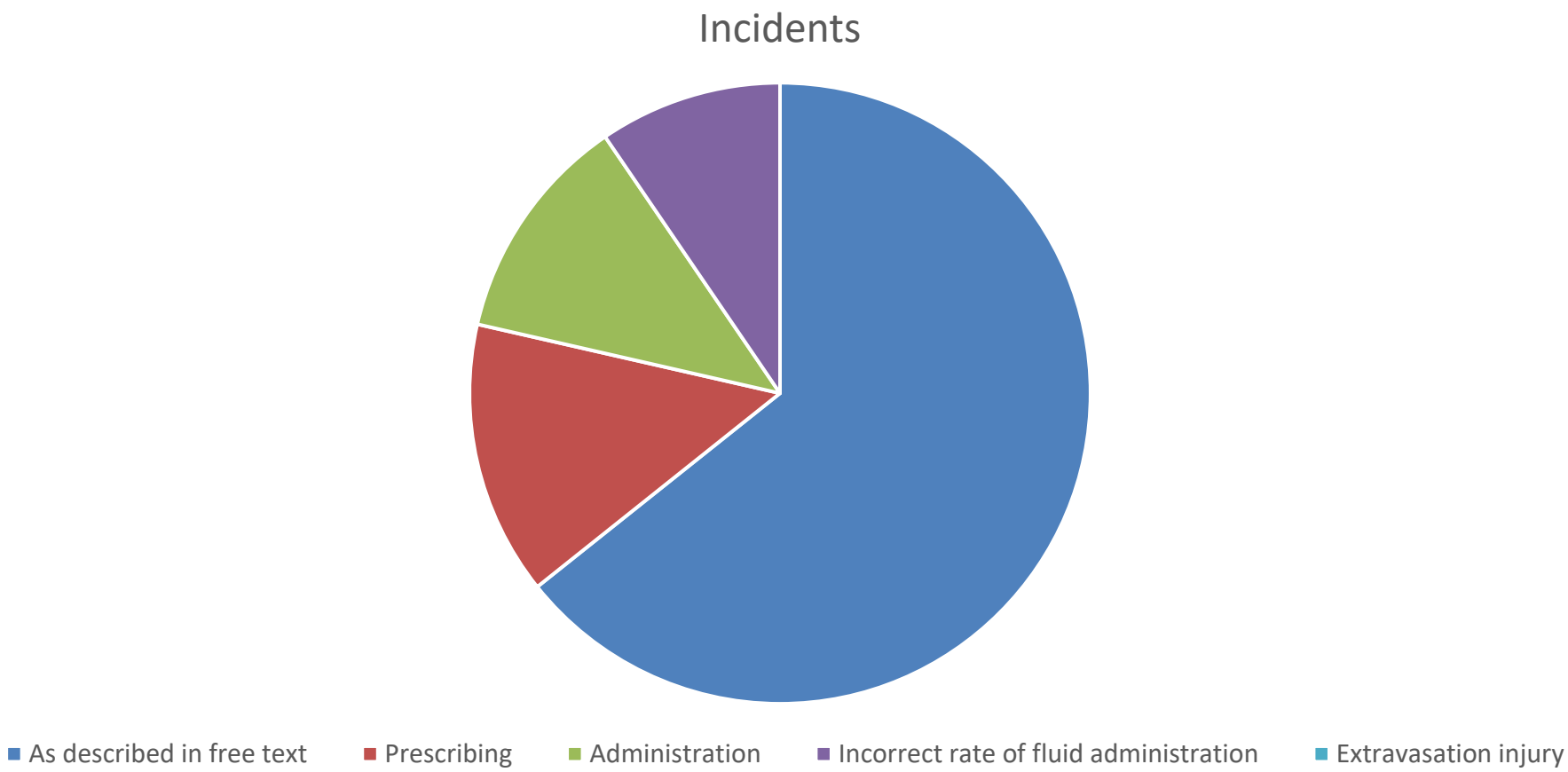


Top 5 Neonatology **Incidents** in the last 6 months (September-March)



Incidents reported as ‘As described in free text)

Description	Number
Baby desaturation/ self-extubation	9 (these have been reported as part of an audit for service improvement)
Neonatal unit closed due to acuity	3
Unable to accept in-utero transfer	1
Feed related incident	3
Documentation issue	5
Mediation issue	1
Review of results	1
Discharge plan	1
Supply issue	2
Thermoregulation	1

Complaint themes September-March (Maternity and Neonatology)

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- **Delays in care**
- **Birth experience**
- **Communication (regarding care and treatment and staff attitudes)**
- **Issues with care in general**
- **Failure to recognise and respond to abnormal fetal heartbeat (1)**

Incidents September to March

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Readmission of babies

- Readmission of baby due to neonatal jaundice is the highest category of incidents in this period. This is an increase from previous reporting periods. This may be due to an ongoing QI project and closer monitoring of readmissions ensuring that all of these are reported.
- A QI project is in place to address this.
- This increase is not reflected in the complaints or historic claims.
- Babies admitted to NICU due to Jaundice are reviewed by ATAIN, and are followed up to monitor for signs of kernicterus. There have been previous claims for this reason.

Incidents September to March

East Lancashire Hospitals NHS Trust
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Term admissions to NICU

- Term admission to NICU remains in the top 5 incidents – this includes babies admitted with actual or suspected HIE. All these admissions are reviewed by ATAIN or MNSI.
- Within this reporting period there have to date been 0 avoidable admissions to NICU
- Of the babies admitted with suspected or actual HIE, 6 met MNSI criteria and 5 of these had normal MRIs.
- 1 baby had mild HIE on MRI.
- There have been 2 pre-term babies who received cooling therapy who have HIE on MRI scan.
- Investigations are ongoing for these babies. These may be future claims.

Incidents September to March

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Missed or delayed care

- This is a subject for claims in the scorecard reporting period and a source of complaints and is in the top 5 of incidents.
- Incidents relate to;

❑Delays in specialist referrals

❑Delays in scans following growth concerns

❑Delays in Induction of labour process/ C sections

❑Missed postnatal visits

❑Missed care or observations

These have not resulted in poor outcomes or been factors in serious incident reviews

This is also a factor in complaints

Incidents September to March

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- Post partum haemorrhages are reported to ensure care is given in line with guidance. Incidental learning only has been identified.
- 3rd and 4th degree tears remain a top 5 incident. These are also reported to ensure care is given in line with guidance and identify any training needs.
- There has been some incidental learning identified, but no factors what would have prevented these tears.
- Claims have been made historically for trauma caused by these tears.

Incidents September to March; ethnicity of 3rd and 4th degree tears

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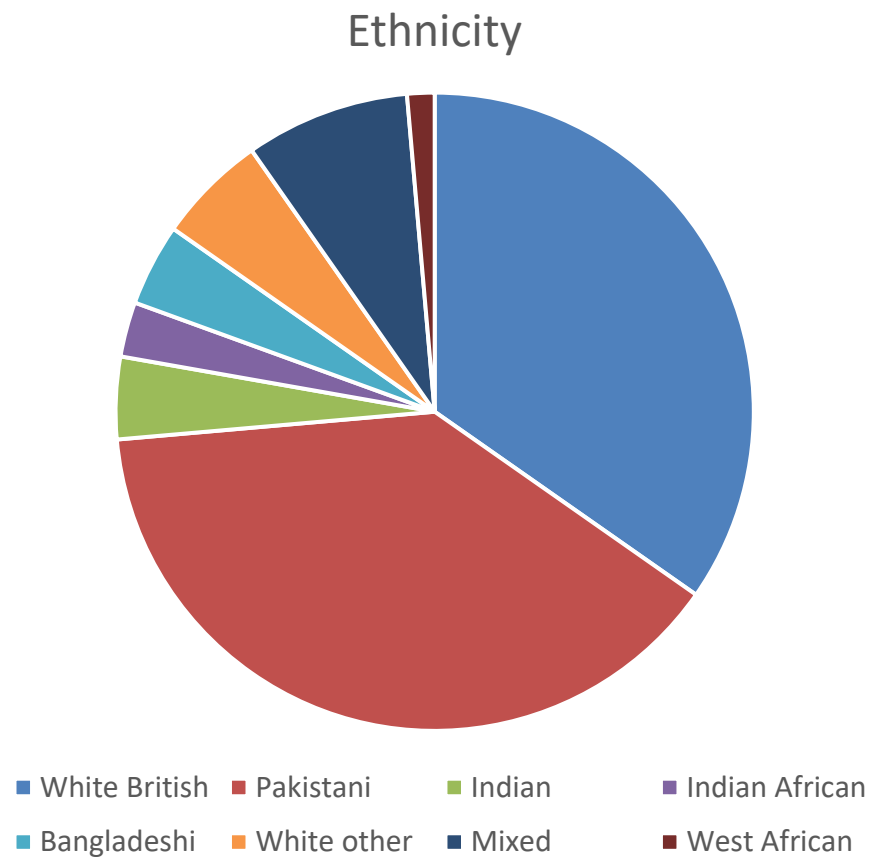

- The number of women from a BAME background is proportionally higher than the number of white British Women
- Further exploration of this issue is required
- 3rd and 4th degree tears are audited annually and learning identifed

Incidents September to March

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NICU incidents;

- The majority of incidents in NICU relate to prescribing or drug administration errors.
- These are reported and discussed each quarter at directorate meetings and learning identified
- Prescribing errors are most commonly reported and these are linked to a risk relating to lack of EPMA in NICU – this is an ongoing project
- Issues with gentamicin administration and blood level results have been a theme – there has been ongoing training with this
- There have been no adverse outcomes following these

Triangulation

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Stillbirth/fatality;

Leading cause and value for claims.

Linked to delays in careand failure to recognise abnormal fetal hearbeat.

All deaths are reviewed by PMRT or MNSI and learning identified.

Within this reporting period, 2 stillbirths have had their reviews completed that are avoidable stillbirths due to issues in care pertaining to delays in care and not following guidance.

Triangulation

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HIE/Brain injury;

This is a high value and high volume source of claims and a top 5 incident.

Within this reporting period there have been 3 babies with HIE identified on MRI in NICU.

All other babies admitted for cooling therapy with suspected HIE will continue to be monitored for 2 years.

Joint reviews of the care of all these babies are held and an annual review reports on the 2 year outcome for these babies. The 2023/2024 review is planned later this year.

Triangulation

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Medication errors;

Although these have been one of the top sources of claims for neonatal care, in this reporting period there have been no advers outcomes from medication incidents.

Any staff involved in these incidents undertake a medicines management course and reflection.

Learning for the whole team is identified.

Actions – update from last report;

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1. Delays in the induction of labour process and caesarean sections are reported regularly. There is a QI project with a business case and corporate risk registered with a plan to increase capacity to reduce delays. The induction of labout process is also being reviewed, and a rag rating system has been implemented to ensure there are no adverse outcomes.

2. Fetal monitoring – The fetal monitoring team provide mandatory training for all staff. This training is updated to reflect any learning as it arises. The team give individual support to staff and are involved in the review, feedback and safety action planning following any incidents involving fetal monitoring. Intermittent auscultation has been a recent focus and monthly audit of compliance occurs.

3. Medication errors are reported and monitored. Medicines management is mandatory training each year. Individual feedback is given to staff. Ongoing training and SIMS including electronic prescribing.

4. OASI injuries continue to be monitored and audited to ensure that care is given in line withguidance. Individual feedback, support and training is given when any concerns are raised.

5. Stillbirths and Neonatal deaths are reviewed and reported locally and nationally. Any issues in care are identified and actions taken.

Ongoing areas for action

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1. Delays in Induction of labour are reported and monitored. There is an ongoing QI project to improve the patient experience.

2. Ongoing QI project for C sections to ensure adequate capacity, reduce delays and prevent harm.

3. 3rd and 4th degree tears – continued monitoring and education for all staff.

4. Fetal monitoring training is updated to reflect issues identified in reviewing incidents.

5. Medication – mandatory training for medicines management. Training around electronic prescribing and recording of administration.

6. Perinatal Mortality review process and learning, reporting to MBRRACE.

Maternity Performance Report

Published: June 2025

How to read an SPC Chart

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

A statistical process control (SPC) chart shows data over time. Process limits show how much variability there is in the data to the chart and patterns are highlighted to show where a change is statistically significant. If there is a target, this variability can be used to provide assurance on whether the target is likely to be met in future.

XmR chart
The most common SPC chart type is the XmR chart. Each data point is shown as a grey dot on a grey line. From this data, the mean is calculated and added between the dots as a solid line, and process limits are added as grey dashed lines. If there is a target, it is shown as a red dashed line.

Process limits
In a stable process, over 99% of data points are expected to lie between the process limits. For reporting, the upper and lower process limit values are usually given as the range of expected values going forward.

Special cause variation & common cause variation
Data naturally varies but if this variation is statistically significant, this is called special cause variation and the grey dots are instead shown as blue or orange, depending on whether a higher value is better or worse – blue is used for improving performance, orange for concerning performance. If not significant, the dots stay grey and this is called common cause variation.

The four rules used to trigger special cause variation on the chart, as advised by the Making Data Count team at NHS England, are:
- a point beyond the process limits
- a run of points all above or all below the mean
- a run of points all increasing or all decreasing
- two out of three points close to a process limit as an early warning indicator

Bookings & Antenatal

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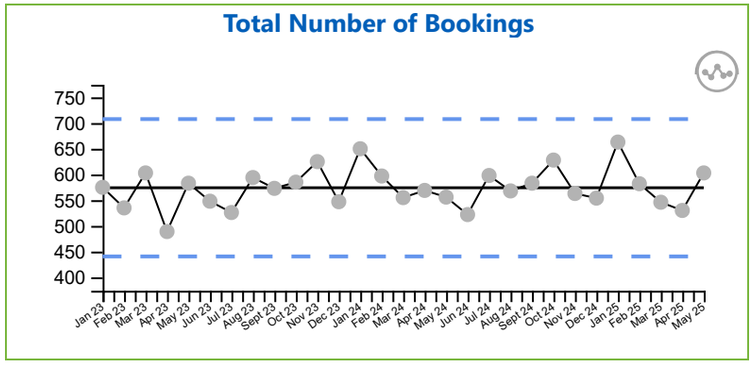

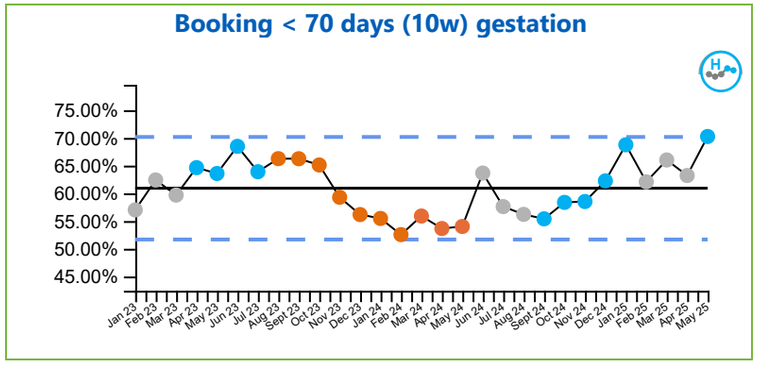

Deliveries

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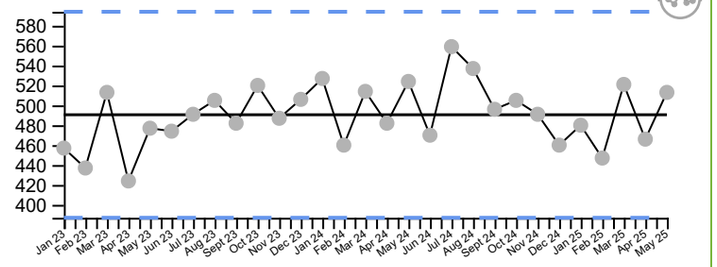
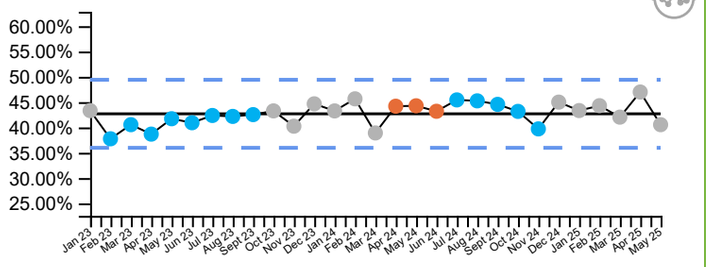
A University Teaching Trust

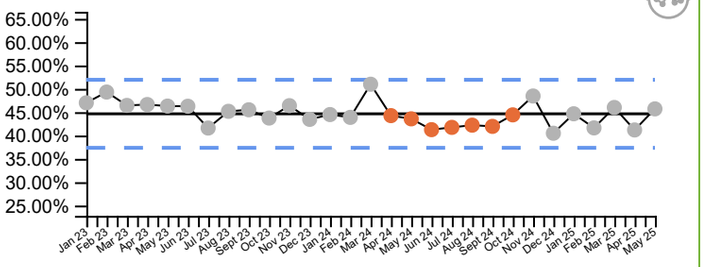
Number of Woman giving birth



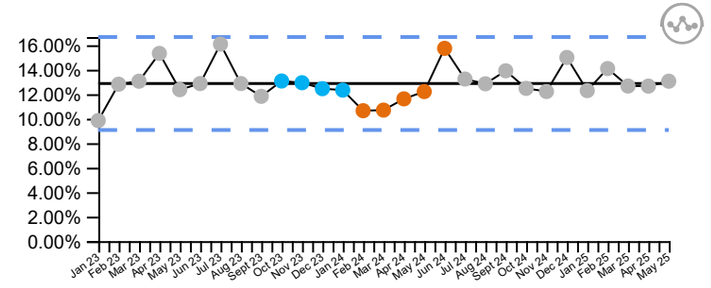
Total Number of Women experiencing a Caesarean Section



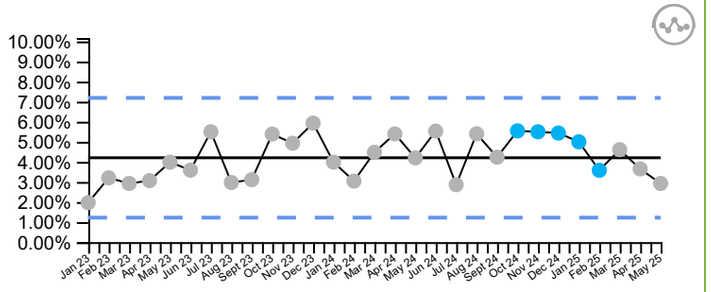
Spontaneous Delivery Rate



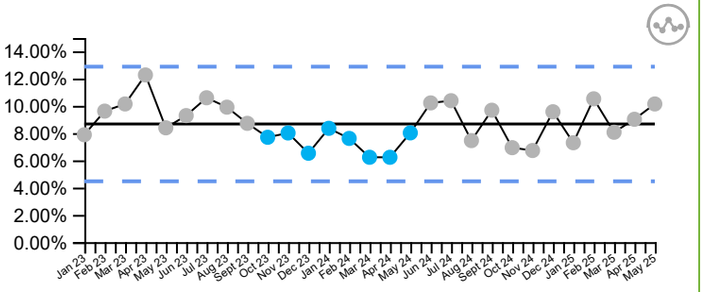
Number of Women Instrumental Births



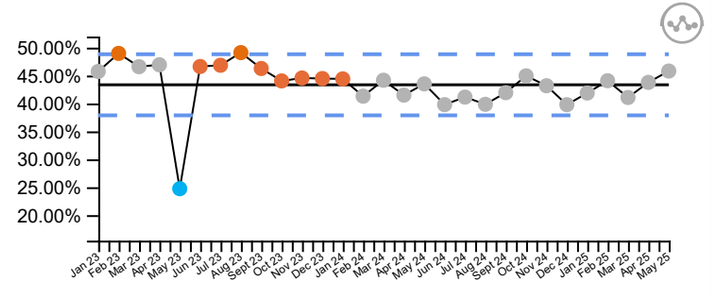
Number of Women Ventouse Births



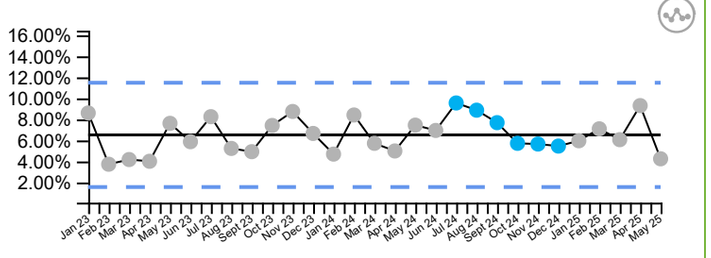
Number of Women Forceps Births



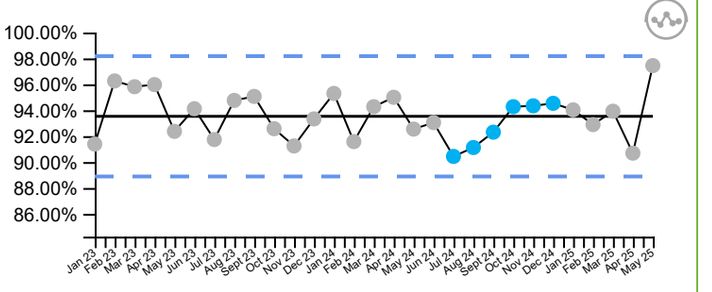
Total Number of Women Induced



Total Number of Women Unsuccessfully Induced requiring Caesarean Section



Total Number of Women Successfully Induced



Deliveries

East Lancashire Hospitals NHS Trust
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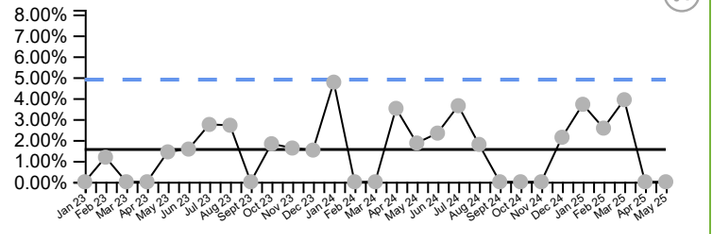
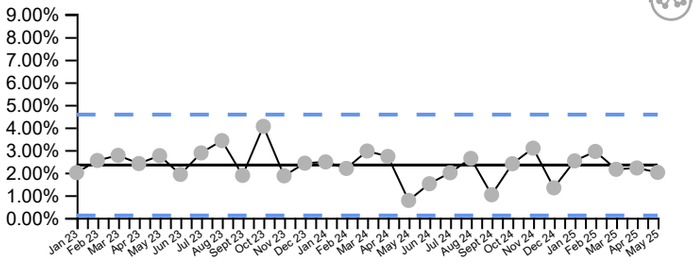
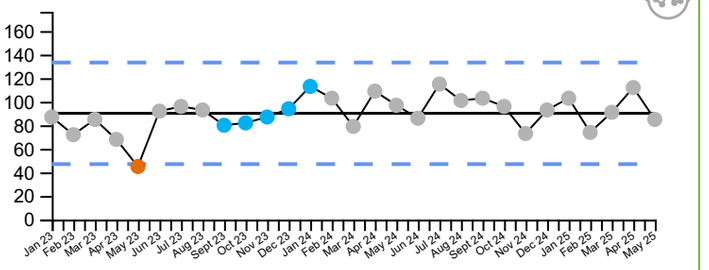
Women induced for reduced fetal movements <39 weeks gestation



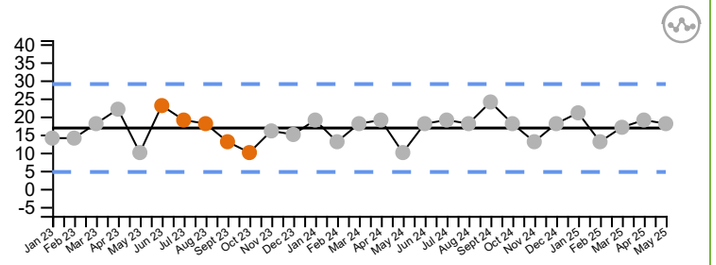
LSCS at full dilatation



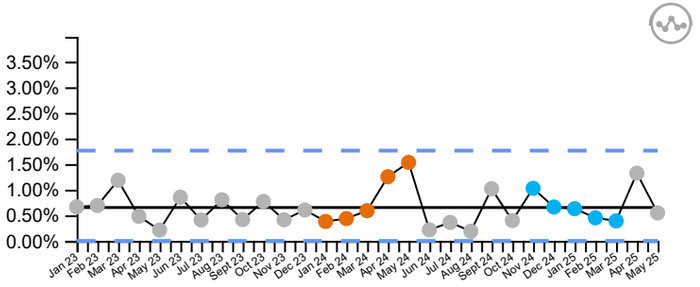
Number of Women with a previous caesarean section



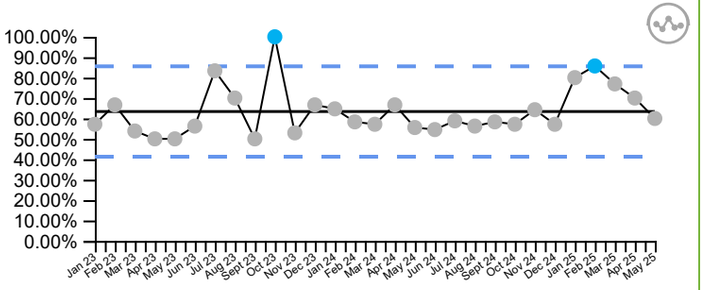
Number of women having a vaginal birth, after a previous caesarean section



Total number of deliveries before 27 weeks gestation



Live births less than 3rd centile delivered > 37+6 weeks



Neonates & Mortality

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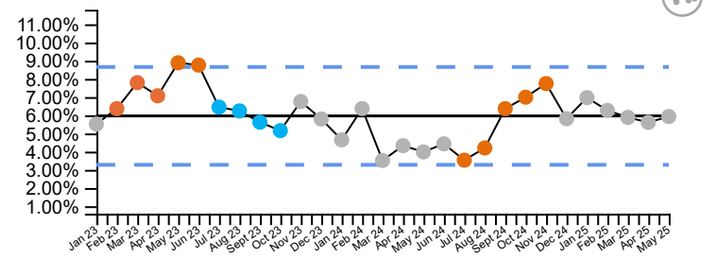
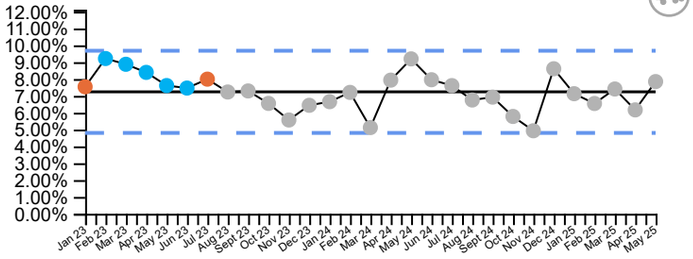
A University Teaching Trust

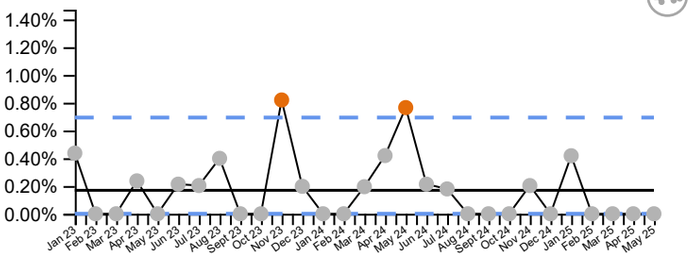
Admissions to Neonatal Unit >37 weeks



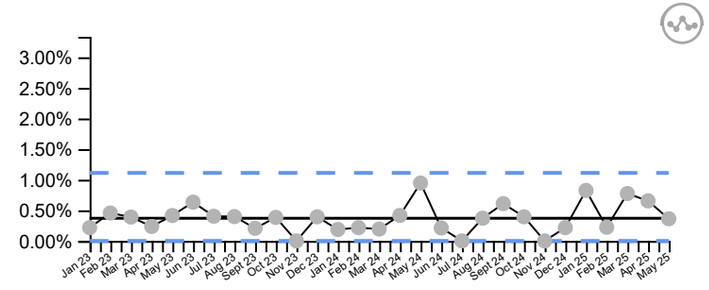
Pre-term births (Under 37 weeks)



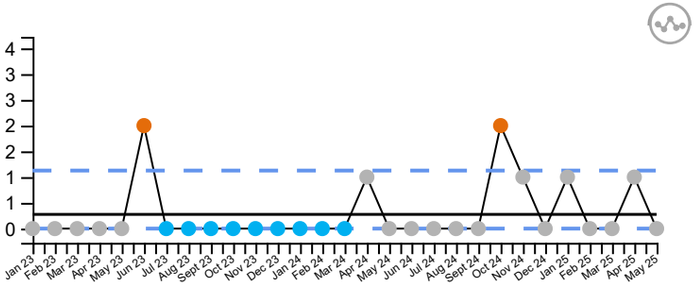
Neonatal Deaths



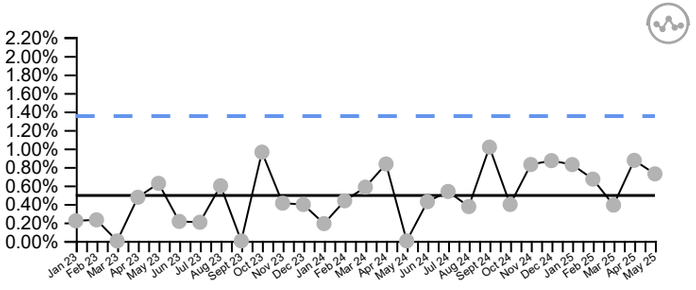
Stillbirth



Rate of intrapartum stillbirth



HIE (Hypoxic-Ischemic Encephalopathy)



Incidents

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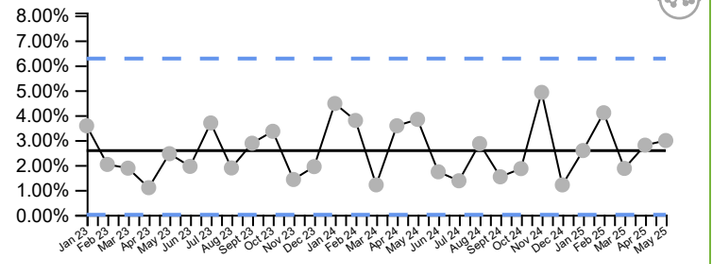
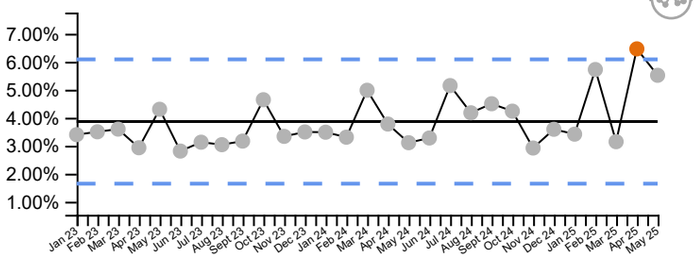
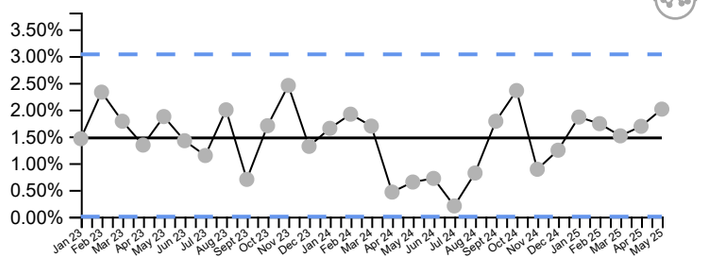
3rd/4th degree tears



PPH >= 1500ml



Apgar score <7



Smoking

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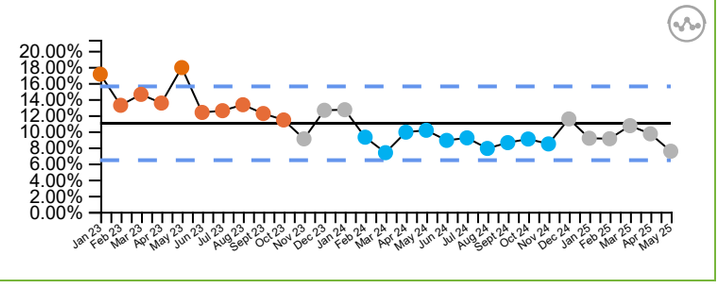
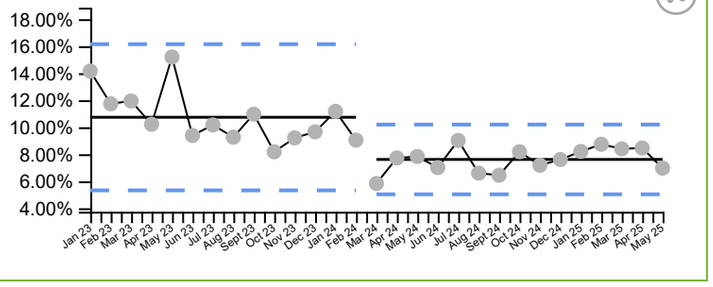
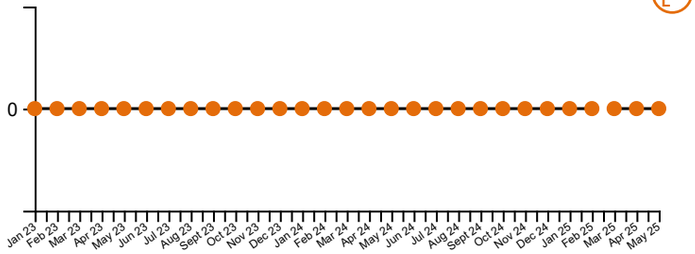
Proportion of women who were current smokers at booking appointment



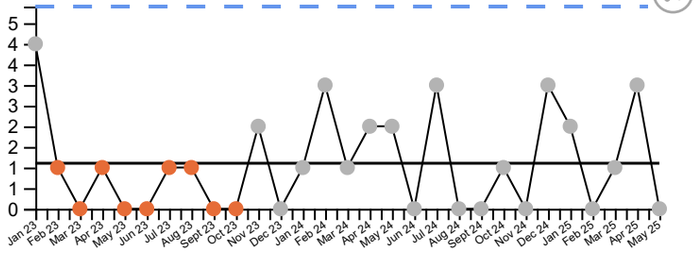
Smoking at delivery



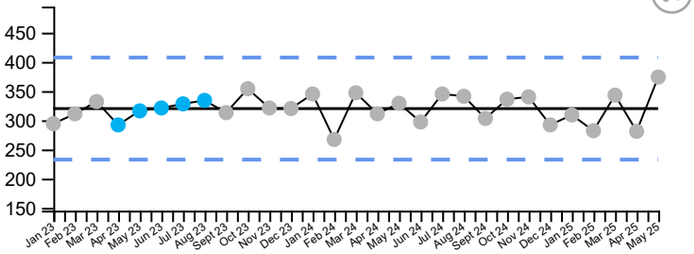
Placement on Continuity – Black/Asian Women



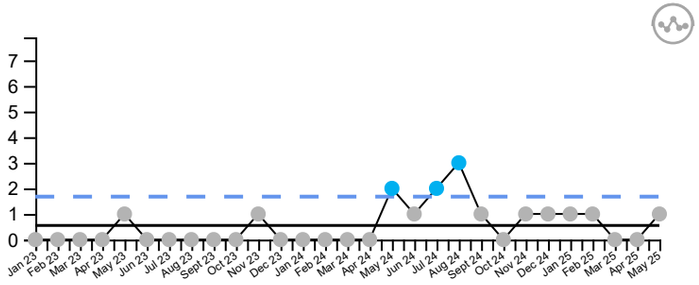
Placement on Continuity – Women in most deprived areas



Women receiving 121 care



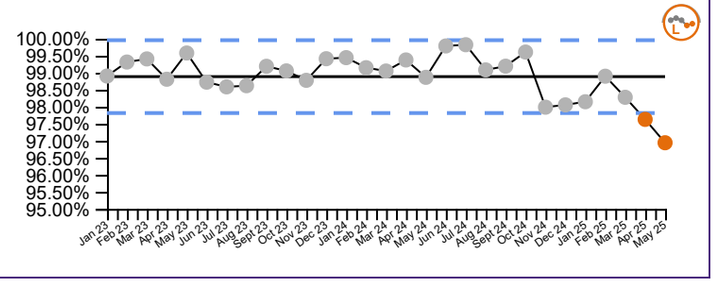
Rate total babies born midwife not present



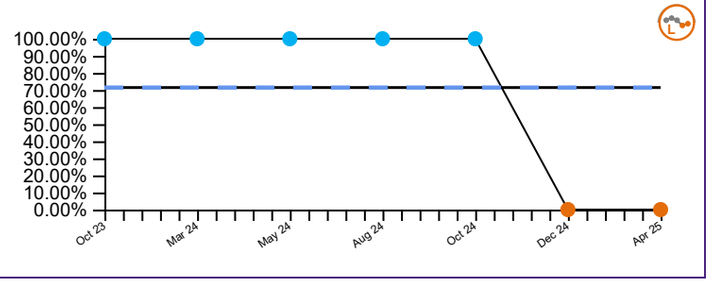
Screening KPIs

East Lancashire Hospitals NHS Trust
A University Teaching Trust

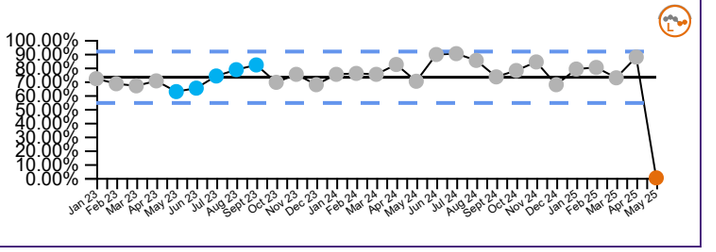
Babies that have achieved NP1 (screening complete within 72 hours of birth)



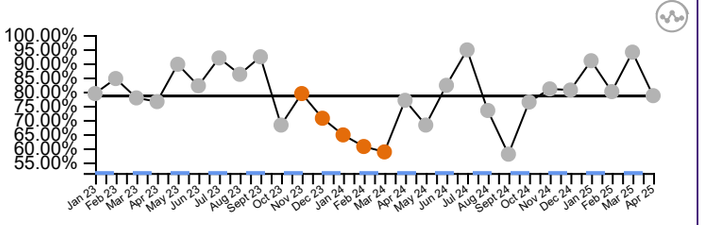
All babies born that have had Ophthalmology appointment less than or equal to 14 days of newborn eyes examination



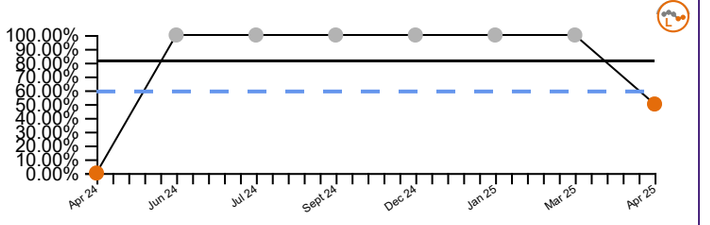
All babies born that have had USS within 4-6 weeks of birth or 38-40 weeks corrected age if born <34 weeks gestational age



All babies born that have attended orthopaedic specialist assessment or discharged following US by 6 weeks of birth or 40 weeks corrected age if born <34 weeks gestational age



All babies with screen positive testes results requiring urgent review and seen by a consultant paediatrician/associate specialist within 24 hours of newborn testes examination



Exceptions and Improvement Practice

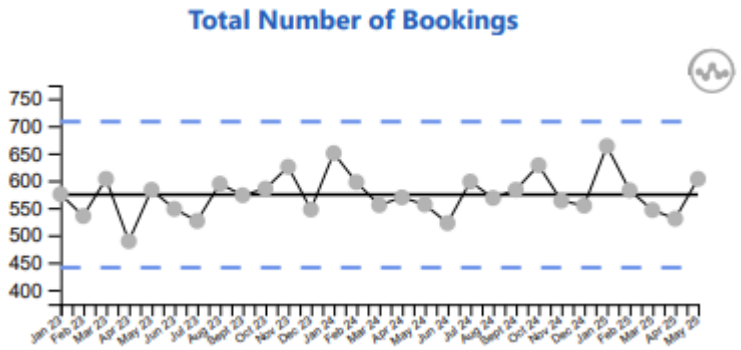
This documented is intended to be viewed alongside the Maternity Performance report dated June 2025.

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

Data naturally varies but if this variation is statistically significant, this is called special cause variation and the grey dots are instead shown as blue or orange, depending on whether a higher value is better or worse – blue is used for improving performance, orange for concerning performance. If not significant, the dots stay grey, and this is called common cause variation. However, in some metrics the acceptable range may be reversed based on maternity's strategy or vision. This is complex due to the nature of maternity services and the individual's perception of birth choices.

Bookings and Antenatal

Total Number of Bookings



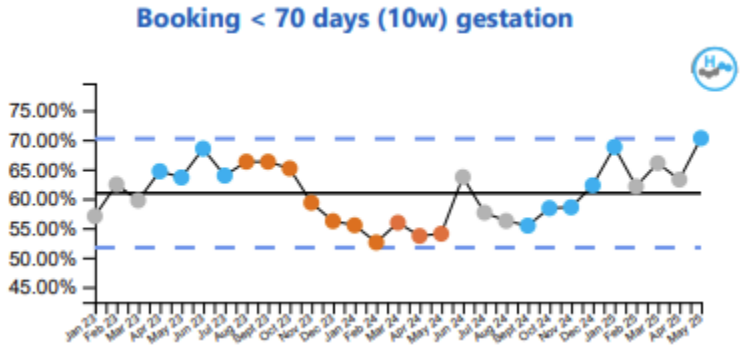
Normal Variation

The number of bookings remains within normal variation from January 2023. January appears to be a month that bookings increase to over 650 in the period.

Unwarranted Variation

N/A

Bookings < 10 weeks gestation



Normal Variation

From the period August 2023 to May 2024 the number of Bookings under 10 weeks gestation improved.

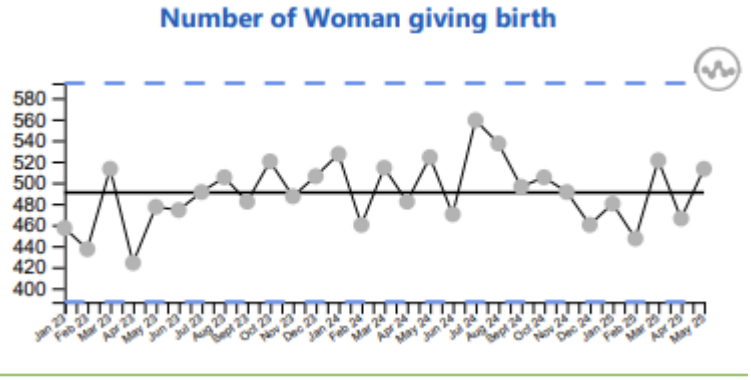
Unwarranted Variation

From June 2024 the number of bookings after 10 weeks appears. There is ongoing work to improve the awareness of accessing maternity services in early pregnancy. Comparing the number of

bookings in January 2025 to the 10 weeks target the increase may be attributed to acuity. However, the decrease in bookings is not replicated in the first to second quarter of the year 2025.

Deliveries

Number of women giving birth



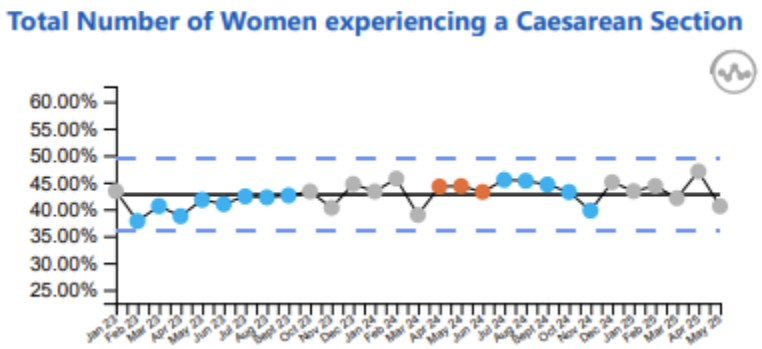
Normal Variation

The number of women giving birth is within normal variance. The number increased in July 2024 to 559. The first quarter of 2025 follows a similar trend so similar figures may be anticipated in quarter 2 and 3.

Unwarranted Variation

N/A

Total number of women experiencing a caesarean section



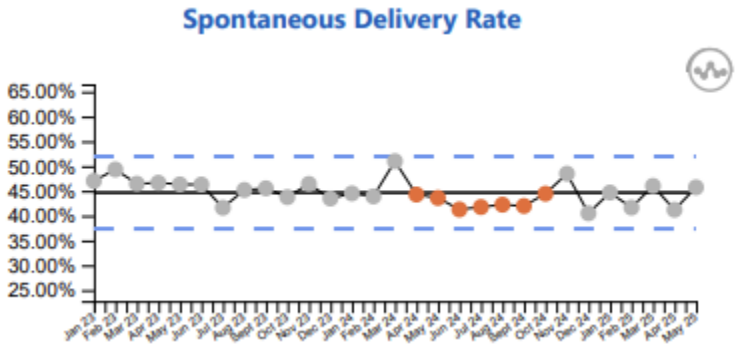
Normal Variation

The overall rate of women experiencing a caesarean section is steadily increasing. In 2022, NHS England removed the requirement to keep caesarean section rates at around 20%. Since the beginning of 2023 the caesarean section rate has risen from 35% to 47% in April. In November 23, March 2024, November 2024 the caesarean section decreases but this correlates with the spontaneous delivery rate increasing in correlation for the same month.

Unwarranted Variation

N/A

Spontaneous Delivery Rate



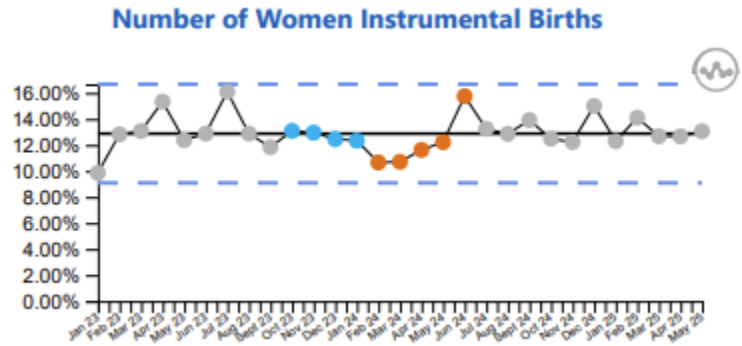
Normal Variation

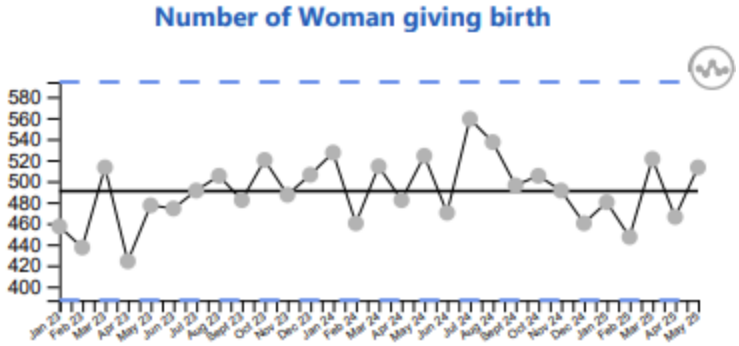
The spontaneous delivery rate is within a normal variation. Spontaneous commencement of labour is a data point that can sometimes be subject to incorrect data input.

Unwarranted Variation

The decline in spontaneous deliveries from April 2024 to October 204 correlates with the rise in total number of women experiencing a section for a similar period. This data point may reflect a select group of women that opt for caesarean section that may have laboured spontaneously that did not wish for induction of labour.

Number of women experiencing an instrumental birth





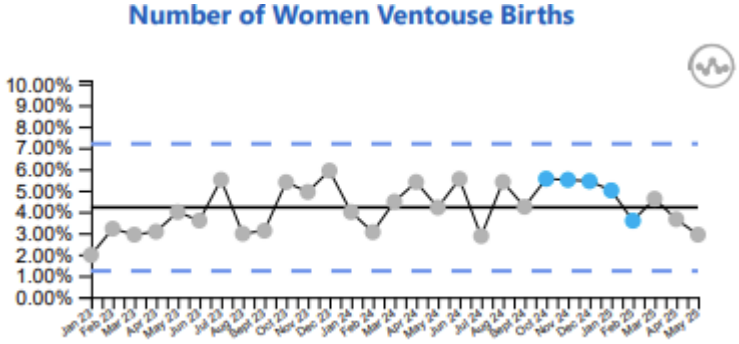
Normal Variation

The number of women experiencing an instrumental birth falls within normal variation. The highlighted cause for concern data points map to the number of women giving birth. Therefore, the instrumental births rise and fall with the number of births within the trust.

Unwarranted Variation

N/A

Number of women experiencing a ventouse birth



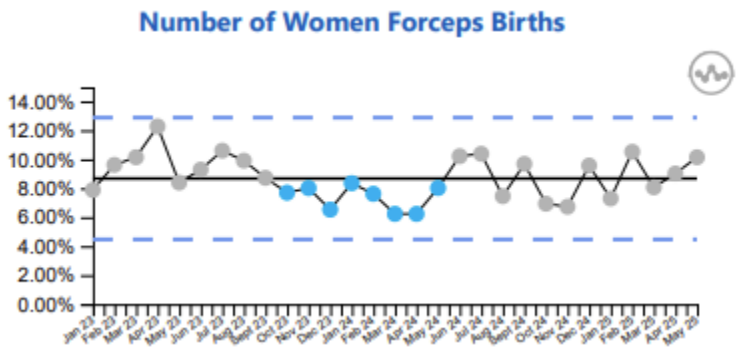
Normal Variation

The number of women experiencing a ventouse birth is within normal variation.

Unwarranted Variation

N/A

Number of women experiencing a forceps birth



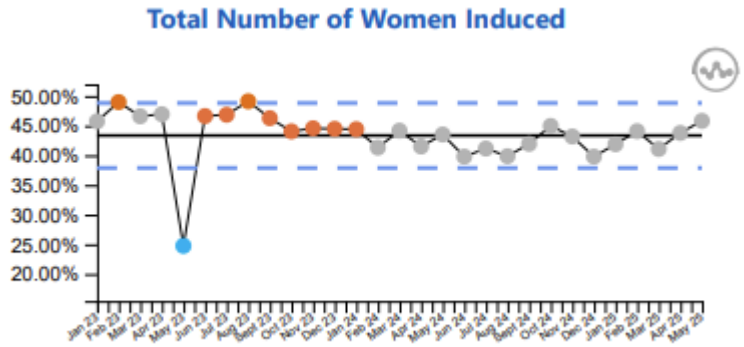
Normal Variation

The number of women experiencing a forceps birth is within a normal variation.

Unwarranted Variation

N/A

Total number of women induced



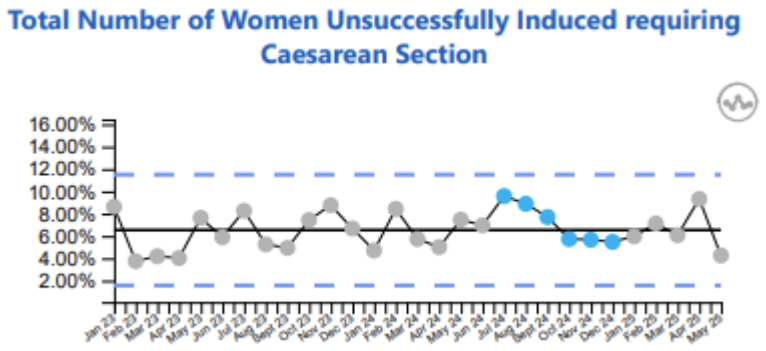
Normal Variation

The total number of number women induced is declining. The rate varies between 50% to 39%. This is reflected in the increased number of caesarean sections. The number of inductions remains elevated. These figures will be impacted by Reduced Fetal Movements Regional Guideline G74 v3.1, for example. In addition, the Term Pre- Labour Rupture of the Membranes Guideline G7a v7. As well as women choosing to opt for induction of labour as their individual birth choice.

Unwarranted Variation

In May 2023 the number of women induced decreased sharply and then increased. This may be indicative of input errors by users on the maternity EPR.

Total number of Women Unsuccessfully Induced requiring Caesarean Section



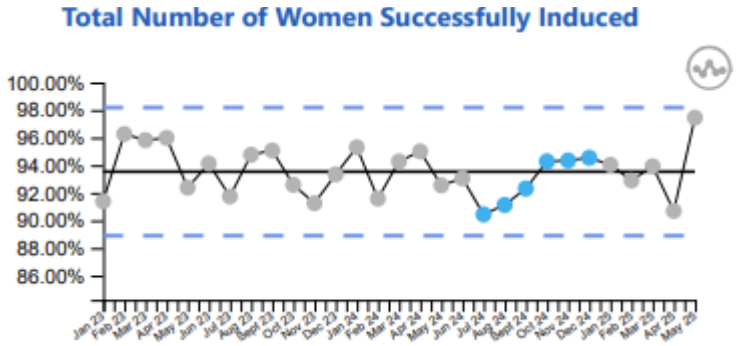
Normal Variation

When compared to the number of women giving birth the unsuccessful inductions trend similarly. Thus, the rate is a normal rate of variation.

Unwarranted Variation

N/A

Total Number of Women Successfully Induced



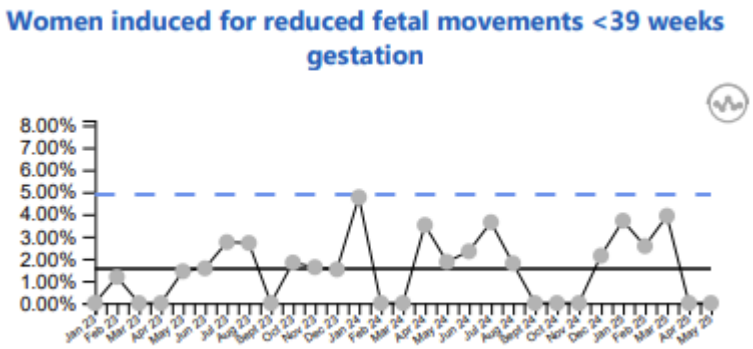
Normal Variation

When compared to the number of women giving birth the successful inductions trend similarly. Thus, the rate is a normal rate of variation. In May 2025 the rate of successful inductions was 97%. Increased birth choices regarding caesarean section may account for this rate.

Unwarranted Variation

N/A

Women induced for reduced fetal movements <39 weeks gestation



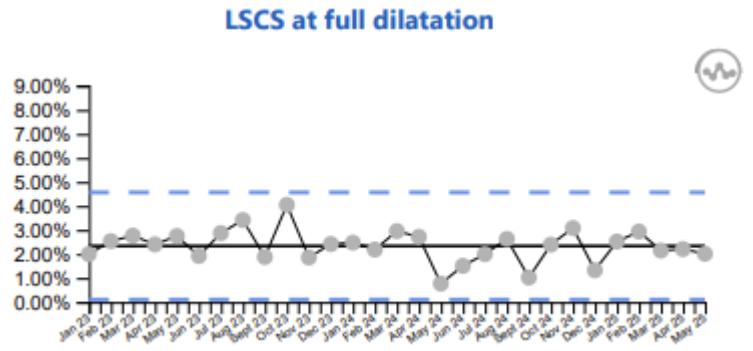
Normal Variation

Women induced for reduced fetal movements remains within a normal variance. The numerical value each month range from 0- a peak of 4 in January 2024.

Unwarranted Variation

N/A

LSCS at full dilatation



Normal Variation

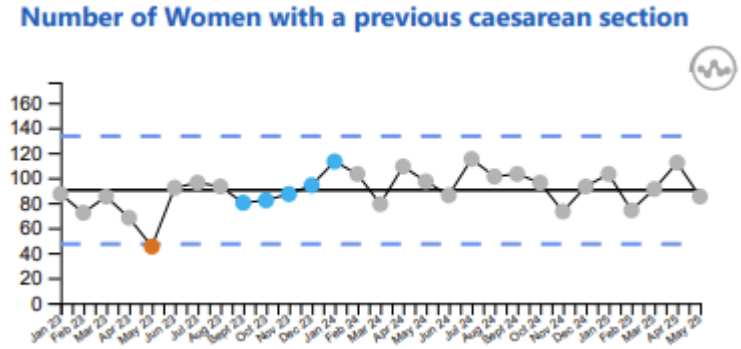
Women experiencing a caesarean section at full dilatation remains with a normal variance. The numerical value each month ranges from 21 women in October 2023 to 4 women in May 2024.

Year to date 2% of caesareans performed are on women at full dilatation

Unwarranted Variation

N/A

Number of women with a previous caesarean section



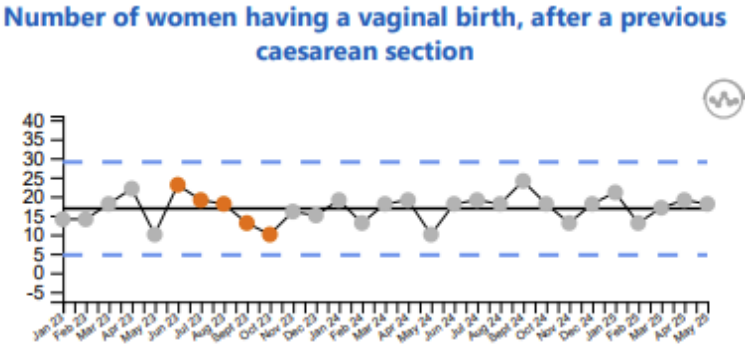
Normal Variation

The rate of women experiencing a previous c-section steadily increasing. This would reflect the changes to practice national and locally.

Unwarranted Variation

N/A

Number of women having a vaginal birth, after a previous caesarean section



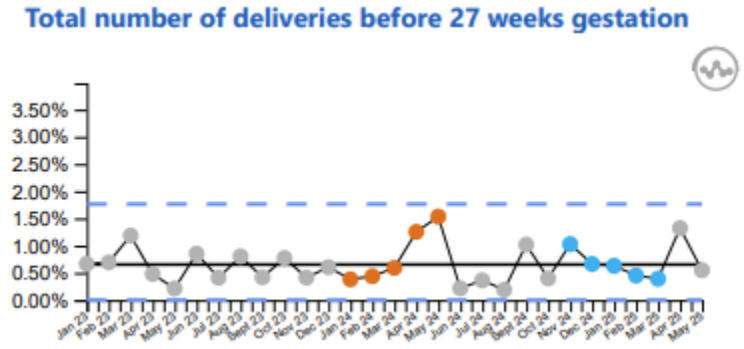
Normal Variation

The number of women having a vaginal birth after a previous caesarean section remains in a normal rate of variance.

Unwarranted Variation

N/A

Total number of deliveries before 27 weeks gestation



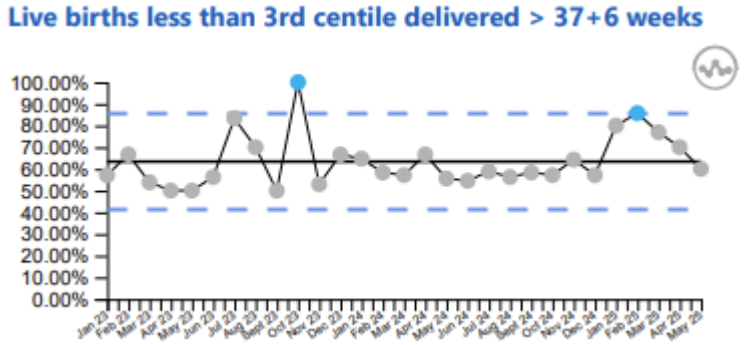
Normal Variation

The total number of deliveries before 27 weeks gestation remains in a normal rate of variance.

Unwarranted Variation

The figures for preterm birth before 27 weeks gestation averages around 3 a month. There are some statistical anomalies seen in March 2023, April 2024 and May 2024 where the number increased to 6, 6 and 8 for those months.

Live births less than the 3rd centile delivered > 37+6 weeks



Normal Variation

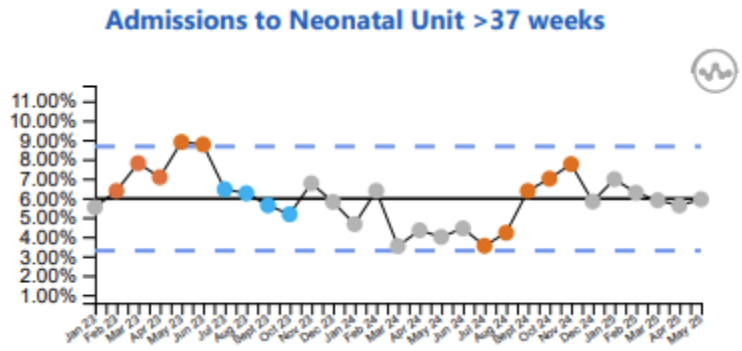
The number of babies born on less than the 3rd centile delivered over 37+6 weeks is within a normal rate of variance.

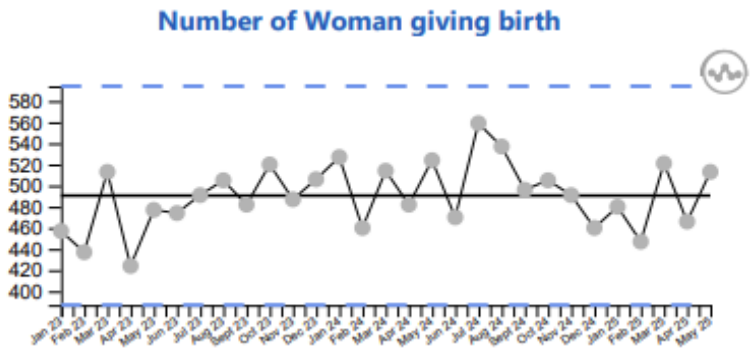
Unwarranted Variation

N/A

Neonates & Mortality

Admissions to Neonatal Unit > 37 weeks





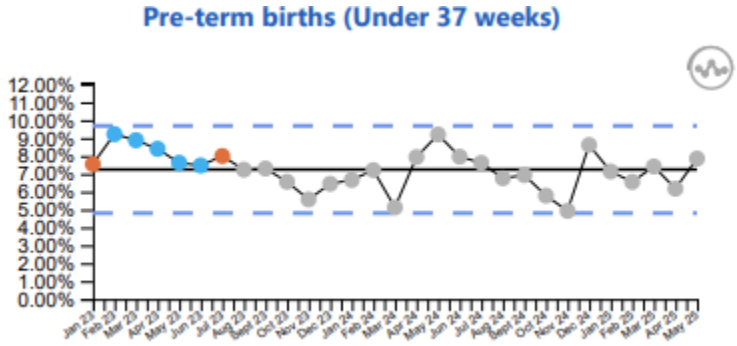
Normal Variation

N/A

Unwarranted Variation

The trend for admissions to the neonatal unit over 37 weeks is declining gradually. Around six percent of cases after 37 weeks result in an admission to NICU. Although there is an increase seen from July 2024 and the following months until December 2024. As previously detailed the number of births for July 2024 peaks at its highest.

Pre- term births (Under 37 weeks)



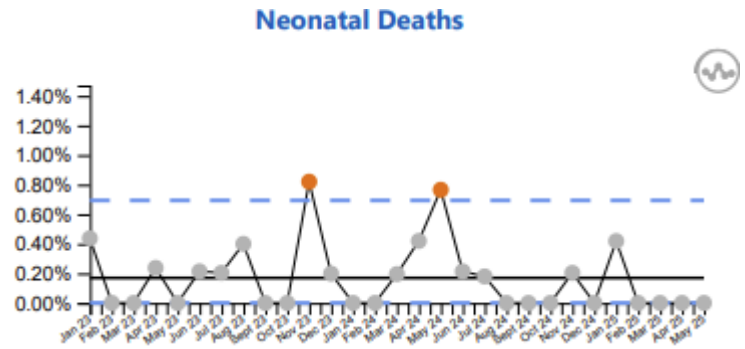
Normal Variation

The preterm birth rate remains with a normal rate of variance from August 2023.

Unwarranted Variation

Prior to August 2023 the rate was decreasing as expressed on the chart.

Neonatal Deaths



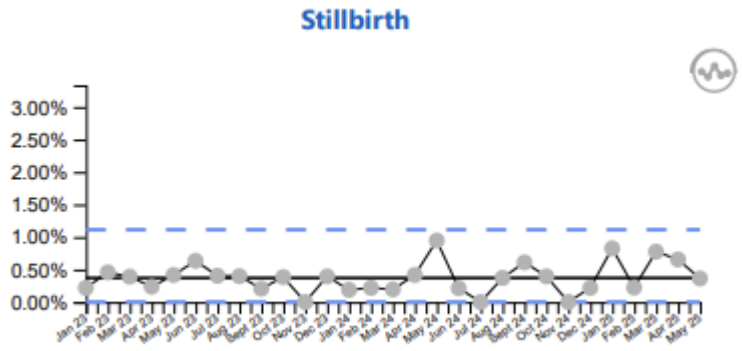
Normal Variation

The incidence of neonatal death is usually zero or one.

Unwarranted Variation

In November 2023 and May 2024, the incidence rises to four cases. Although appearing as significant on the chart this is a statistical anomaly.

Stillbirth



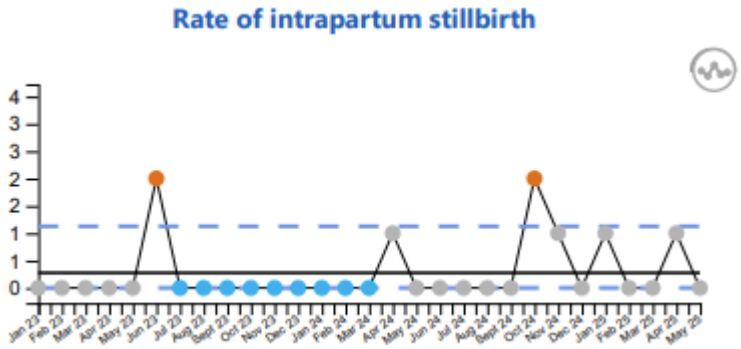
Normal Variation

The incidence of still birth is within a normal variation. The figures average at once a month but peak at 4 incidences in January 2025.

Unwarranted Variation

N/A

Rate of intrapartum stillbirth



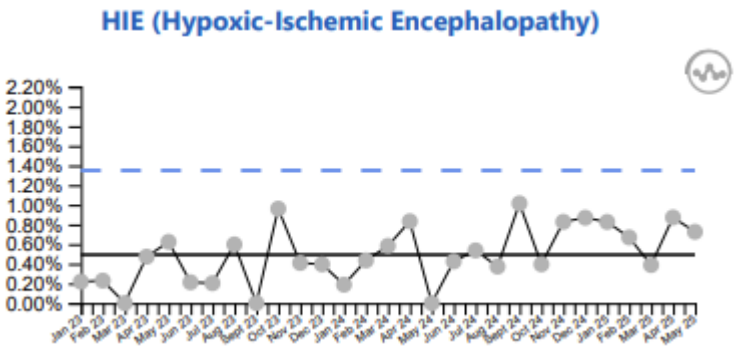
Normal Variation

The rate of intrapartum stillbirth is usually less than one.

Unwarranted Variation

There are significant increases represented on the chart in June 2023 and November 2024. The figures for these months peak at 2 incidences of intrapartum stillbirth.

HIE (Hypoxic-Ischemic Enceophalopathy)



Normal Variation

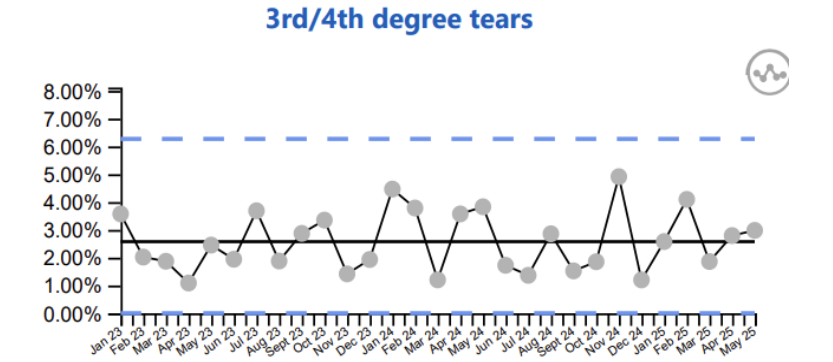
The incidence of HIE is within a normal rate of variance.

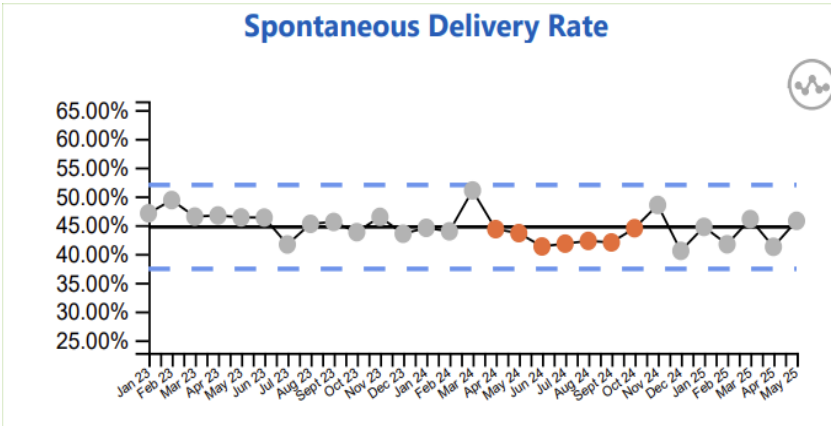
Unwarranted Variation

N/A

Incidents

Third/ Fourth Degree Tears





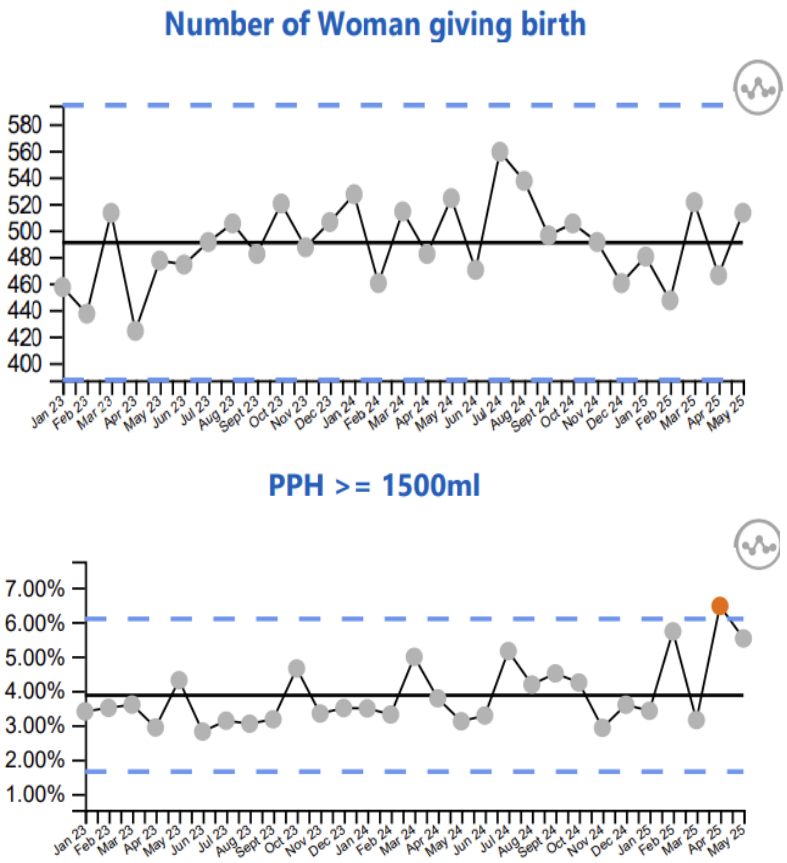
Normal Variation

The rate of 3rd/4th degree tear when compared to spontaneous delivery rate follows a similar trend line. The peak of 5% in the month November 2024 correlates with the rise in the number of spontaneous births. Both data points decline similarly in December 2024.

Unwarranted Variation

N/A

PPH>=1500ml



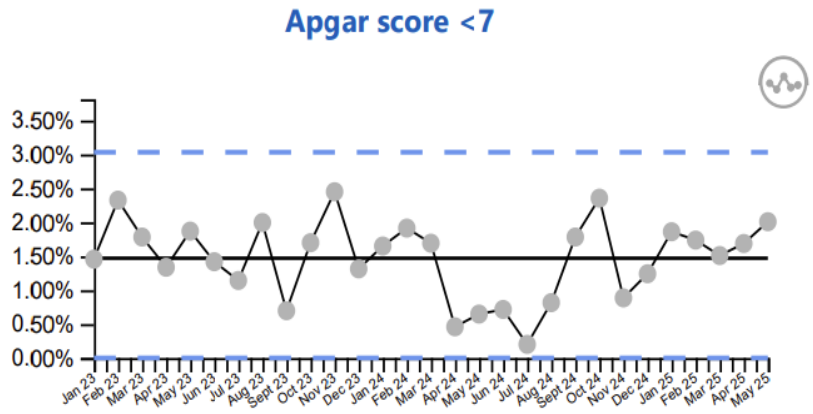
Normal Variation

The rate of PPH >=1000mls is within normal variance. When compared to the overall delivery rate the incidences are comparable. For example, July 2024 there is a peak in birth rate vs the number of incidences of PPH equal or over 1500mls.

Unwarranted Variation

The OBS UK study commenced in November 2024 and has become more embedded in the first quarter of 2025. This would account for the steady incline in the incident rate. This peaks at 6% in February 2025.

Apgar Score <7



Normal Variation

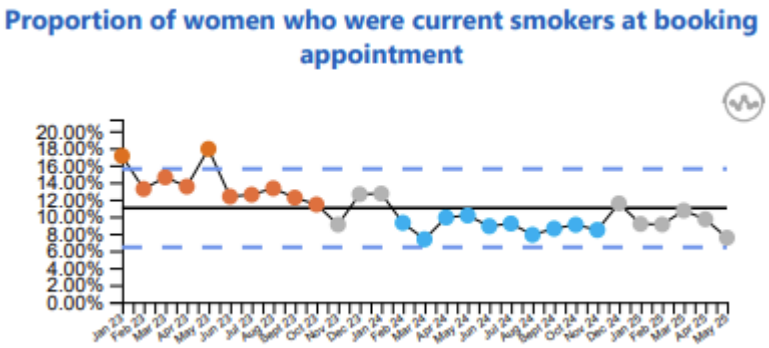
Apgar score <7 for all neonates remains in the rate of normal variance.

Unwarranted Variation

N/A

Smoking

Proportion of women who were current smokers at booking



Normal Variation

In January 2023 the percentage of women who reporting smoking at booking was 20%. This has decreased to 7.5% in the month of May 2025. In real terms this is numbers of 70-80 women smoking at booking in 2023 to 35-50 in the year 2025.

Unwarranted Variation

N/A

Smoking at delivery

Normal Variation

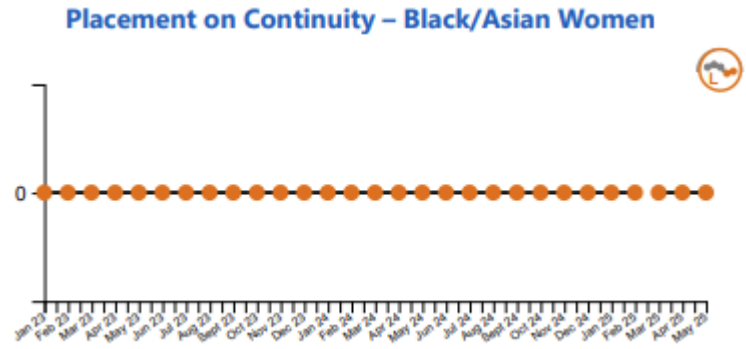
In the year 2025 it would not be unusual for 15%- 17% of women to be smoking at delivery. In May 2025 this was figure was 6.97%. Although not visualised on the chart as this is considered common cause variation the number of women smoking at delivery is on the continual decline. The smoking cessation team began in January 2024.

Unwarranted Variation

N/A

121 Care

Placement on continuity – Black/Asian Women



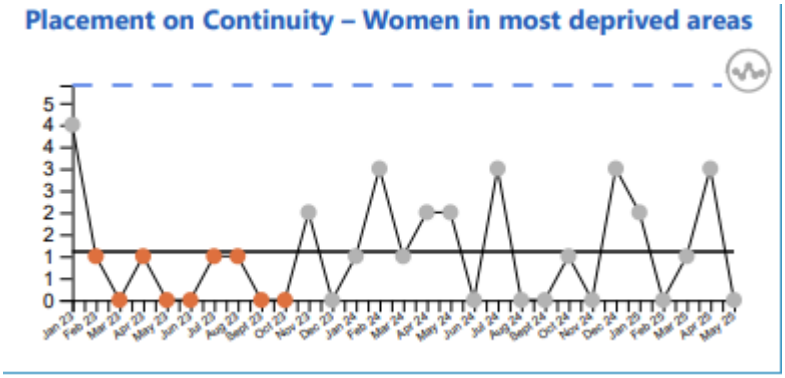
Normal Variation

This chart was historical thus the data doesn't appear to reflect community services correctly. The establishment of the willow team will support the reintroduction and relevance of this chart.

Unwarranted Variation

N/A

Placement on continuity – Women in most deprived areas



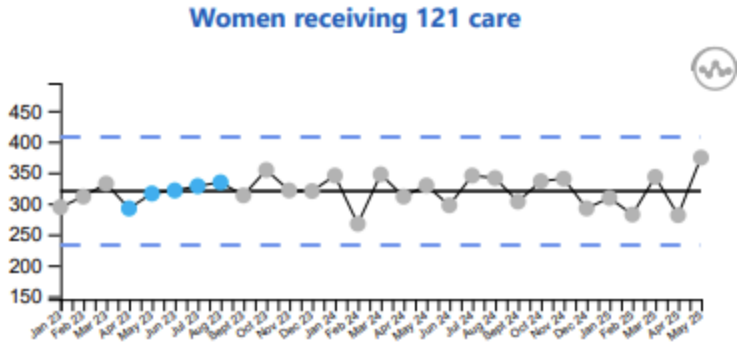
Normal Variation

This chart was historical thus the data doesn't appear to reflect community services correctly. The establishment of the willow team will support the reintroduction and relevance of this chart.

Unwarranted Variation

N/A

Women receiving 1-2-1 care



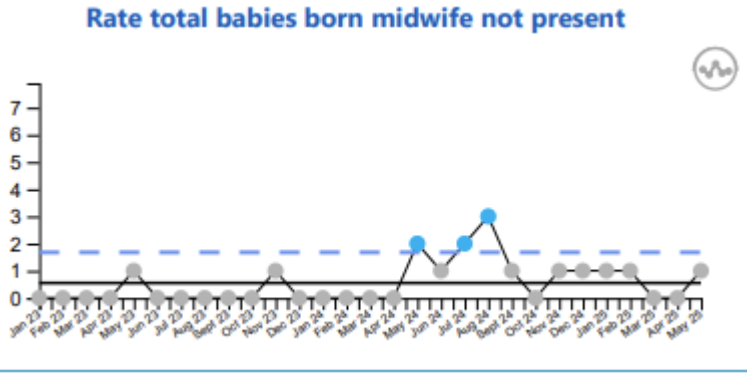
Normal Variation

N/A

Unwarranted Variation

Women not receiving 1-2-1 care in labour is incident reportable. The levels of women represented on this chart not receiving 1-2-1 care would be unwarranted and not reflected in the Datix reports or Birth Rate Plus data. The digital midwife has identified that midwives may be incorrectly selecting the 'patient had 1-2-1 care in labour'. Unfortunately, the number of incorrect data inputs is many and would be laborious to edit the records and would require the midwife confirming the data inputted is incorrectly. Datix reports would provide a more accurate representation of midwives being unable to care for a patient 1-2-1 in labour.

Rate total babies born midwife not present



Normal Variation

The incidence rate for 2023-till 2025 is 16 cases. However, the incidence rate of Born before arrival is 99.

Unwarranted Variation

In August 2023 the rate of babies born with midwife not present increased however this was the maximum of three occasions.

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Meeting Date:	9 July 2025	**Agenda Item:**	TB/2025/098a
Report Title:	Triple A Report from Quality Committee		
Author:	Mrs C Randall, Non-Executive Director/Committee Chair		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓			✓
Executive Summary:	This report sets out the summary of the items discussed at the Quality Committee meeting held on 28 May 2025. The triple A format of this report sets out items for alert, action or assurance form the Committee to the board.			
Key Issues/Areas of Concern:				
Action Required:	The board is asked to note the report.			

Previously Considered by:	
Date:	
Outcome:	

Committee Name:	Quality Committee
Date of Meeting:	28 May 2025
Committee Chair:	Catherine Randall
Attendance:	Quorate
Key Items Discussed:	Urgent and Emergency Care Update Demo of Waiting List Tool Quality Impact Risk Assessments Thematic Overview Nurse Staffing Exception Report Trust Wide Quality Group AAA Reports Patient Safety Incident Response Framework Report Integrated Performance Report (Exception Reporting)

ALERT

Please include items that have been discussed at the Committee which the Board need to be alerted to. Items such as areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter.

- The committee was advised that there had been a rise in the number of assaults on Trust staff and that this was closely linked to the increased waiting times being seen for mental health patients in the emergency department and elsewhere in the organisation. It was suggested that a summit should be arranged with colleagues from the ICB and from other trusts in the region to discuss these issues further and potential solutions.
- Members were advised that the Trust's mortuary had recently received an unannounced visit by Human tissue Authority which had raised a number of serious concerns. It was confirmed that immediate changes had been made following this inspection and indicated that a full and comprehensive action plan was currently being developed which the committee would receive an update on at a future meeting

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- The committee received an overview of the outcomes of the urgent and emergency care reset improvement programme that had taken place earlier in the year. It was noted that significant improvements had been made.
- Members received the latest iteration of the nurse staffing exception report. It was highlighted that the Trust's staffing establishments were correct and that only a small number of minor recommendations had been put forward. It was also noted that the Trust's threshold for safe staffing had recently been raised to 90% and that 17 wards had fallen below this rate in April due to a combination of factors. including ward moves.

ADVISE

Please include items that have been discussed at the Committee which the Board need to be advised about, such as matters that have on-going monitoring or any new developments which need sharing.

- Members were presented with a patient story from a young stroke survivor. A discussion was held on the importance the patient experience and on the importance of ensuring that primary care colleagues referred such patients to correct sites to ensure they received appropriate treatment.
- The committee received an early demo of a new waiting list tool, intended to empower colleagues to take ownership of their data.
- A thematic overview of the Trust's Quality Impact Risk Assessments (QIRAs) was presented to the committee. It was noted that a total of 347 separate QIRAs had been submitted, 333 of which had ultimately been approved.

East Lancashire Hospitals NHS Trust
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TRUST BOARD REPORT

Meeting Date:	9 July 2025	**Agenda Item:**	TB/2025/098b
Report Title:	Triple A Report from Quality Committee – June 2025		
Author:	Mrs C Randall, Non-Executive Director/Committee Chair		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓			✓
Executive Summary:	This report sets out the summary of the items discussed at the Quality Committee meeting held on 25 June 2025. The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.			
Key Issues/Areas of Concern:				
Action Required:	The board is asked to note the report.			

Previously Considered by:	
Date:	
Outcome:	

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Committee Name:	Quality Committee
Date of Meeting:	25 June 2025
Committee Chair:	Catherine Randall
Attendance:	Quorate
Key Items Discussed:	Urgent and Emergency Care Update - March Reset Improvement Programme Update Long Mental Health Waits in ELHT (ED and Inpatients) Update on Paediatric Services Histopathology Update Floor to Board Report for Maternity and Neonatology Services - Midwifery Safe Staffing- Joint ELHT/ LMNS Round table Report following Birth Rate Plus (BR+) Recommendations Quality Impact Risk Assessment (QIRA) Summary Report Nurse Staffing Exception Report AAA Report Trust Wide Quality Group AAA Reports Patient Safety Incident Response Framework Report Integrated Performance Report (Exception Reporting) Strategic Dashboards – Clinical Strategy / Quality Strategy / Health Equity Strategy

ALERT

Please include items that have been discussed at the Committee which the Board need to be alerted to. Items such as areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter.

- Members were informed that that the wait times being experienced by mental health patients in urgent and emergency care settings continued to be significant and that no progress had been made in relation to arranging a regional summit to discuss the matter further. The committee received an overview of the work taking place at Lancashire and South Cumbria NHS Foundation Trust around long mental health waits.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- The committee received a patient story from the mother of a paediatric patient who was from a BAME heritage background. The story was largely positive, with a number of positive aspects of the patients care highlighted. This prompted a discussion among members around the need for stories from patients with other protected characteristics at future meetings.
- Members were advised that a number of appointments had been made to the Trust's histopathology department which would help to continue in the reduction of its routine sample backlog.

ADVISE

Please include items that have been discussed at the Committee which the Board need to be advised about, such as matters that have on-going monitoring or any new developments which need sharing.

- The committee discussed the need for a NED to be appointed as champion for children and younger people's services going forward.
- Members discussed the difficulties arising from non-commissioned services that the Trust provided, particularly in relation to paediatric care.
- Members noted that the Trust's QIRA process would be revised to promote an additional focus on quality aspects and that the Datix reporting system had been updated to indicate whether any incidents were linked to any QIRA related changes.

East Lancashire Hospitals NHS Trust
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TRUST BOARD REPORT

Meeting Date:	9 July 2025	**Agenda Item:**	TB/2025/099a
Report Title:	Triple A Report from Finance and Performance Committee – 2 June 2025		
Author:	Mrs S Bridgen, Non-Executive Director		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓			✓
Executive Summary:	This report sets out the summary of the items discussed at the Finance and Performance Committee meeting held on 02.06.2025 The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.			
Key Issues/Areas of Concern:				
Action Required:	The board is asked to note the report.			

Previously Considered by:	N/A
Date:	
Outcome:	

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Committee Name:
Finance and Performance
Date of Meeting:
02.06.25
Committee Chair:
Sallie Bridgen
Attendance: Quorate
Key Items Discussed:

ALERT

The Committee were informed that the **final plan for 2025/26** had been submitted with an increased waste reduction programme (WRP) target of £60.8 million.

The Trust's **financial position for month 1** was reported as a deficit position of £6.525 million against a planned deficit of £6.44 million. The cash position was £10.7 million. The capital plan had been allocated £30 million for the 2025/26 financial year, and in month 1 £1 million had been spent. The committee recognised good performance in month 1 while acknowledging the ongoing (and growing) challenge of developing and delivering the full waste reduction plan.

The Committee received an **Update from the Recovery Director**. The Committee supported a proposal for a 12 week extension of the Price Waterhouse Cooper (PwC) contract in order to allow support to be provided whilst the Trust's own Programme Management Office (PMO) was established. The committee recommended the Trust Board approve the extension.
The Committee received a verbal update on the **Waste Reduction Programme** – the expectation from the last IAG meeting was that £60.8m should be fully developed by now. This had not been achieved. £42.13 million of WRP was fully developed, along with £7.75 million of opportunity, and pre-pipeline values of £15 million. The Committee recognised that part of the £60.8 had included assumptions about the Commissioning Intentions removing cost – which has not happened. It noted the considerable work that has taken place, and recognised that in light of our Legal Undertaking under NOF 4, our ability to achieve a Quarter on Quarter improvement, and deliver

the Plan the priority must now be to develop a full WRP Plan in excess of £60.8m and continue to focus on delivery of the plan.

Members noted that work would shortly need to commence on the **2026/27 plan** to ensure all targets had been fully developed before submitting the plan to NHSE.

ASSURE

The Committee received the **Grip and Control report** and noted that there were only 3 ambers left on the report. With regards to the PwC report it was noted that all aspects had improved. Members were advised that job planning, and the medical e-roster would require time to implement, with job planning needing to ensure that the right level of productivity and performance was allocated within the resources available.

The Committee was presented with a presentation on the **UEC improvement plan**. With regards to WRP, it was explained that £1.6 million had been implemented, with a full year effect of £9.4 million, with a headcount reduction of 136.4 whole time equivalents (WTE). Performance has also improved eg ambulance hand over time had increased substantially from 43% in January 2025 to 80% in April, against a target of 90%

The Committee received a report on the **Investment Case Review**. Over 100 cases had been identified for review, with the intention to either maintain investment, continue investment but improve, or to disinvest. All cases reviewed so far demonstrated that benefits had been achieved demonstrating that a return on investment was being achieved and that there was the potential for cost avoidance. A further update will be provided in July.

The Committee received an update on Costing, Costing Transformation and **patient level costing** and recommended to Board Delegated Authority for submission.

ADVISE

The Committee noted the importance to work with Place partners on demand management to reduce the number of people attending the hospital. It was raised that East Lancashire had the lowest number of GPs in the country and although there would be a significant uplift in funding, it was unknown how GP numbers would be affected.

An update on the Integrated Performance Report (IPR) was provided.

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Meeting Date:	9 July 2025	**Agenda Item:**	TB/2025/099b
Report Title:	Triple A Report from Finance and Performance Committee - 30 June 2025		
Author:	Mrs S Bridgen, Non-Executive Director		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓			✓
Executive Summary:	This report sets out the summary of the items discussed at the Finance and Performance Committee meeting held on 30.06.2025 The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.			
Key Issues/Areas of Concern:				
Action Required:	The board is asked to note the report.			

Previously Considered by:	
Date:	
Outcome:	

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Committee Name:
Finance and Performance
Date of Meeting:
02.06.25
Committee Chair:
Sallie Bridgen
Attendance: Quorate
Key Items Discussed:

ALERT

The Trust has agreed a break-even annual financial plan for 2025/26, inclusive of £43.324m Deficit Support Funding (DSF). To deliver this plan, the Trust has a Waste Reduction Programme (WRP) of £60.8m.
The Trust is reporting a deficit of £7.592m, against a M2 plan of £5.581m deficit; £2.011m behind the plan. This is the deficit excluding the £3.610m of deficit support funding. The net reported deficit is £3.982m.
The Year-to-date position reported is a £14.1m deficit against a plan of £12.0m; £2m behind plan.
The WRP delivered £2.312m in month against a plan of £3.131m, a variance of £0.819m Year to date, the WRP delivered is £4.335m against a plan of £5.397m, a variance of £1.062m. This reflects the phasing of the £15.4m unidentified at the time of submission to NHSE, which is in equal 12ths in line with NHSE guidance.
The YTD unidentified WRP is £2.578m. As the WRP is fully developed, the position will be reported against the planned delivery timeframe.
The cash balance on 31st May was £4.9m, a reduction of £5.8m compared to M1.
The annual 2025-26 capital plan is £33.0m, For M2, year to date spend is £5.9m, £4.1m ahead of plan but still forecasting not to exceed the annual plan.

The Committee noted that the £2m adverse plan is made up of the MARS costs of £534k (including legal) and the shortfall on the pay WRP. This underperformance will make the challenge in future months greater, and Month 3 will be critical to delivering a Quarter on Quarter improvement, and the Plan.

The Committee noted the significant risks around full delivery of the financial plan including the WRP programme, management of cash, managing the capital risks, the financial impact of the HCA review of banding, the financial impact of the MARS schemes and any potential redundancies and that the LSC ICB contract has not yet been signed.

The Committee recognised that the normalised run rate information and positive progress on Agency, Bank and Grip and Control gives good assurance that our WRP is working, and that now we have a fully developed plan, this can be tracked closely in future meetings.

The Committee received an **Update from the Recovery Director**.

The WRP now includes £60.8 fully developed with further opportunity this is now £77m. The WRP plan has delivered 7% of the overall target YTD, although there is slippage. The emphasis now shifts to implementation of the approximately 400 schemes on the tracker. PMO development continues with some posts now filled with internal appointments ahead of training and wider commissioning. A PMO Head of finance has been identified and commences 1st week July. The business case for the SME team has been sent to NHSE and a decision is expected imminently.

The Grip and Control process has been agreed and will require three to four weeks to introduce as soon as the PMO roles are filled and trained. The Committee requested that this is revisited at Board to ensure we have the skills and capacity required.

ASSURE

The Committee received an **Improvement Update** on 2 key programmes of work supported by the Improvement Hub team.

The Service Review Programme. As a result of Wave 1 and 2 a total of £4.5m WRP schemes have been identified. This has enabled the Trust to further agree a stretch for 2025/26 on a further £4m FYE (£2m PYE). Work is also underway to embed the service review process into the Trust planning cycle so that it becomes embedded into business as usual.

The Variable Pay Programme has agreed a further stretch target, increasing the Trust target for 2025/26 to £16.1m with £3.3m implemented to date.

As the PMO develops, reporting on the outcomes of Improvement work will be streamlined into the WRP reporting process. The Committee agreed that it would be helpful to introduce a ‘deep dive’ approach, bringing colleagues into the Committee to share their

improvement work, using the opportunity for constructive challenge and to celebrate success.

ADVISE

The Committee received a summary of the work ongoing of the **L&SC Provider Collaborative's** key programmes of work. Work continues on key programmes of work whilst further review of the overall programme is undertaken by an independent Clinical Advisor in conjunction with the Integrated care Board (ICB) and PCB.
Dr Hugo Mascie-Taylor is working with the ICB and PCB to do a review of plans related to the clinical configuration blueprint to propose next steps, including a review of the current programmes underway relating to reconfiguration / new operating models.
The Committee recognised the need for Board level discussion on this, and suggested inviting Dr Hugo Mascie-Taylor to this.

The Committee received an update on the **National Cost Collection exercise**. Scores over 100 indicate higher costs than average and scores under 100 indicate lower costs than average. The current position predicts a score of 98.7, although the final score will be based on what other Trusts have submitted and this will not be published for several months. The National Cost Collection submission date is 3rd July 2025 and will be approved and submitted by the Director of Finance. The final output will be brought back to a future committee meeting.

The Committee received an update on the **Radiology Service Contract**, which will be brought to a future Committee for Approval.

The Committee received an update on the **Corporate Risk Register**. A new risk management strategy and framework are under governance review, with a training package prepared for implementation upon ratification. The Committee will then ensure all risks allocated to F&P will be addressed through the Workplan.

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Meeting Date:	9 July 2025	**Agenda Item:**	TB/2025/100a
Report Title:	Triple A Report from People and Culture Committee – May 2025		
Author:	Mrs L Sedgley, Non-Executive Director/Committee Chair		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓			✓
Executive Summary:	This report sets out the summary of the items discussed at the Quality Committee meeting held on 12 May 2025. The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.			
Key Issues/Areas of Concern:				
Action Required:	The board is asked to note the report.			

Previously Considered by:	N/A
Date:	
Outcome:	

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Committee Name:	People and Culture Committee
Date of Meeting:	25 June 2025
Committee Chair:	Liz Sedgley
Attendance:	Quorate
Key Items Discussed:	PWC Grip and Control Action Plan Staff Story HCA Recruitment and Retention Inclusion Chair Report Mutually Agreed Resignation Scheme (MARS) Update Staff Side Update

ALERT

Please include items that have been discussed at the Committee which the Board need to be alerted to. Items such as areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter.

- The committee was informed that there has been an increase in the number of IR1 Forms relating to staff wellbeing. An amendment to the QIRA forms for CIP schemes is now available to specifically assess the impact of potential schemes on staff wellbeing and this will be monitored by the committee going forward.
- The update on HCA retention and recruitment highlighted a growing issue in relation to the lack of respect shown towards band 2 &3 HCAs in some clinical areas. Work is being undertaken to share good practice in relation to retention and continued pastoral support and training.
- The Inclusion report highlighted that colleagues are not getting timely support with reasonable adjustments, the committee discussed some of the issues causing delays and noted that the Trust has a statutory duty to provide reasonable adjustments to staff where applicable. This will be monitored closely as it was an area where there was a decline in the staff survey results.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- The committee received an update on the PWC Grip and Control checklist and noted the areas where work is still ongoing namely on e-rostering for medics and

job planning and it is expected that these projects will be completed by the end of August

- An update on the Improvement work linked to the WRP Plan was given highlighting the work to reduce variable pay leading to a recurrent saving of £13M per annum. The committee was pleased to note that the Trust is liaising with colleagues in LTH and Blackpool to share learning and ideas from internal RPIW'S to reduce variable pay.
- The assurance gained from these presentations and reports is somewhat limited as the IPR for People & Culture is still being developed and colleagues were invited to meet outside the meeting to discuss the metrics and KPI 's needed to provide assurance.
- The P& C chairs within the ICS are looking to establish a forum to meet on a regular basis to discuss issues and share learning and good practice.

ADVISE

Please include items that have been discussed at the Committee which the Board need to be advised about, such as matters that have on-going monitoring or any new developments which need sharing.

- The update on the recent MARS scheme was received and it was noted that the Trust is on track to complete the process within agreed timescales and provide a leave date of 31 May for those employees who accepted the offer. A lessons learnt exercise will be carried out to inform any future MARS schemes and this will incorporate learning from both within ELHT and the ICS. A further update will be given next month to confirm the final data and cost savings once all the outcomes are known.
- The staff story from an internationally recruited midwife and her mentor highlighted the value of effective mentorship and support for our internationally recruited staff to help them settle into the new working environments and communities.

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Meeting Date:	9 July 2025	**Agenda Item:**	TB/2025/100b
Report Title:	Triple A Report from People and Culture Committee – June 2025		
Author:	Mrs L Sedgley, Non-Executive Director/Committee Chair		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓			✓
Executive Summary:	This report sets out the summary of the items discussed at the Quality Committee meeting held on 2 June 2025. The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.			
Key Issues/Areas of Concern:				
Action Required:	The board is asked to note the report.			

Previously Considered by:	N/A
Date:	
Outcome:	

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Committee Name:	People and Culture Committee
Date of Meeting:	25 June 2025
Committee Chair:	Liz Sedgley
Attendance:	Quorate
Key Items Discussed:	Sickness and Absence Report Staff Health and Wellbeing Update Report - Mental Health Review Workforce Grip and Control Update Variable Pay Improvement Programme Update Staff Side Update Integrated Performance Report

ALERT

Please include items that have been discussed at the Committee which the Board need to be alerted to. Items such as areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter.

- Job planning rates have deteriorated in month 1 together with non-medical appraisal rates which dropped to 81% compared to the Trust target of 90%. Plans are in place to address both of these areas but teams are reporting issues with capacity to complete these on time as staff are prioritising the ongoing work to identify WIP and the financial pressures.
- Both HR and staff side colleagues are concerned about Union capacity to deal with the number of consultations which are currently being requested both for ELHT and One LSC.
- Whilst sickness absence fell this month to 6.11% it is considerably higher that May 24 which was 5.64%. A discussion about the reporting and recording mechanisms and the limitations of both were had and help is being requested from PWC to build on the systems that the Trust has in place whilst a long-term solution is implemented. HR colleagues will work with LTH to look at implementing their case management system.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- An update was received on the MARS scheme with 24 staff accepting and leaving the organisation and a further 24 from One LSC. A lessons learnt exercise with be carried out both within ELHT and the ICS to ensure that we can use a more automated, streamlined approach to applications and approvals which will reduce the administrative burden but also help manage staff expectations
- The committee was updated on the e rostering programme for medics is on target for completion in August
- The review of long-term locums has shown some progress in areas such as elderly medicine, diabetes and other traditionally hard to recruit to areas
- Month 1 has shown a reduction in headcount of 72.33 WTE, together with a significant reduction in enhanced rates of pay and zero non-clinical agency spend in the month.

ADVISE

Please include items that have been discussed at the Committee which the Board need to be advised about, such as matters that have on-going monitoring or any new developments which need sharing.

- The divisions are looking at all vacancies and where possible looking at whether role re banding can be applied or alternative working practices be used.
- The committee was advised that conversations are taking place across the system and will be taken to a regional level if needed to address enhanced rates of pay and shortage occupations.

TRUST BOARD REPORT

Meeting Date:	9 July 2025	**Agenda Item:**	TB/2025/101
Report Title:	Remuneration Committee Summary Report		
Author:	Mr D Byrne, Corporate Governance Officer		
Lead Director:	Professor G Baldwin, Non-Executive Director		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
				✓
Executive Summary:	The list of matters discussed at the Remuneration Committee meetings held on 14 May 2025 and 11 June 2025.			
Key Issues/Areas of Concern:				
Action Required:	The board is asked to note the report.			

Previously Considered by:	
Date:	
Outcome:	

Meeting: **Remuneration Committee**
Date of Meeting: **14 May 2025**
Committee Chair: **Graham Baldwin, Non-Executive Director**

ITEMS DISCUSSED

At the meeting of the Remuneration Committee on 14 May 2025, the following matter was discussed in private:

a) Appointment of the Interim Chief People Officer
b) Acting Up Chief People Officer Arrangements

Meeting: **Remuneration Committee**
Date of Meeting: **11 June 2025**
Committee Chair: **Graham Baldwin, Non-Executive Director**

ITEMS DISCUSSED

At the meeting of the Remuneration Committee on 11 June 2025, the following matter was discussed in private:

a) Director of People and Culture Options and Recommendations
b) Confirmation of Interim Chief People Officer Arrangements

TRUST BOARD REPORT

Meeting Date:	9 July 2025	**Agenda Item:**	TB/2025/102
Report Title:	Trust Board (Closed Session) Summary Report		
Author:	Mr D Byrne, Corporate Governance Officer		
Lead Director:	Mr S Sarwar, Chairman		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
				✓
Executive Summary:	The report details the agenda items discussed in closed session of the board meetings held on 14 May 2025. As requested by the board it can be confirmed that, in preparing this report the external context has been taken into account, such as regulatory requirements placed on NHS providers. Other elements such as local needs, trends and engagement with stakeholders would not be applicable in this instance.			
Key Issues/Areas of Concern:				
Action Required:	The board is asked to note the contents of the report.			

Previously Considered by:	N/A
Date:	
Outcome:	

Meeting: **Trust Board (Closed Session)**
Date of Meeting: **14 May 2025**
Committee Chair: **Shazad Sarwar, Chairman**

ITEMS APPROVED

The minutes of the previous meeting held on the 12 March 2025 were approved as a true and accurate record.

The minutes of the extraordinary board meetings held on the 19 March 2025 and 23 April 2025 were also approved as true and accurate records.

ITEMS DISCUSSED

At the meeting of the Trust Board on 14 March 2025, the following matters were discussed in private:

a) Round Table Discussion: National ICB / PCB and Pennine Lancashire Update.
b) Round Table Discussion: Trust Improvement Plan
c) Horizon Scanning and Communications Update
d) Board Assurance Framework Private Report – Risk 7 Cyber Security
e) One LSC Update
f) Proposed Board Development Programme 2025-26

ITEMS RECEIVED FOR INFORMATION

None.