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East Lancashire Hospitals NHS Trust Board Meeting

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East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD (OPEN SESSION) AGENDA

12 November 2025 at 09.30

Boardroom, Trust Headquarters, Royal Blackburn Teaching Hospital

✓ = document attached
v = verbal

Time	Ref	Item	Lead		Purpose
OPENING BUSINESS					
09.30	TB/2025/138	**Chairs Welcome and Apologies for Absence**	Chair	v	Information
09.32	TB/2025/139	**Declarations of Interests**	Chair	v	Information
09.35	TB/2025/140	**Minutes of the Previous Meeting held on:** a) 10 September 2025 b) 29 September 2025 c) 13 October 2025	Chair	✓ ✓ ✓	Approve
09.40	TB/2025/141	**Action Tracker and Matters Arising**	Chair	✓	Discussion
09.50	TB/2025/142	**Patient Story**	Chief Nurse	v	Information
10.00	TB/2025/143	**Chair's Report**	Chair	✓	Information
10.05	TB/2025/144	**Chief Executive's Report**	Chief Executive	✓	Information
FORMULATING STRATEGY					
10.25	TB/2025/145	**Provider Collaboration Board Strategic Update**	Chief Executive	✓	Information
10.30	TB/2025/146	**Trust Strategy Refresh – Progress & Next Steps**	Executive Director of Service Development & Improvement	✓	Information
ENSURING ACCOUNTABILITY					
10.40	TB/2025/147	**Financial Report**	Executive Director of Finance	✓	Assurance
11.10	TB/2025/148	**Integrated Performance Report**	Executive Directors	✓	Assurance
COMFORT BREAK 11.30 – 11.40					
11.40	TB/2025/149	**East Lancashire Hospitals NHS Trust Improvement Plan (RSP Exit Criteria)**	Executive Director of Service Development & Improvement	✓	Assurance
11.50	TB/2025/150	**Provider Capability Self-Assessment**	Interim Director of Corporate Governance	✓	Approval
12.00	TB/2025/151	**Freedom to Speak Up Report**	Interim Chief People Officer	✓	Assurance
12.05	TB/2025/152	**Patient Safety Incident Response Assurance Report**	Executive Medical Director	✓	Assurance

12.10	TB/2025/153	**Maternity and Neonatal Services Update**	Chief Nurse/ Executive Medical Director	✓	Assurance
SHAPING CULTURE					
12.20	TB/2025/154	**Strategic Response to NHS England and NW BAME Assembly Anti-Racism Requirements**	Interim Chief People Officer	✓	Assurance
12.30	TB/2025/155	**Staff Survey Progress Update**	Interim Chief People Officer	✓	Assurance
ITEMS FOR NOTING					
---	TB/2025/156	**East Lancashire Hospitals NHS Trust Annual Provider Self-Assessment 2025**	Interim Chief People Officer	✓	Approval
---	TB/2025/157	**Triple A Reports from Quality Committee** a) September 2025	Committee Chair	 ✓	Assurance
---	TB/2025/158	**Triple A Reports from Finance & Performance Committee** a) September 2025 b) October 2025	Committee Chair	 ✓ ✓	Assurance
---	TB/2025/159	**Triple A Reports from People & Culture Committee** a) October 2025 b) November 2025	Committee Chair	 ✓ ✓	Assurance
---	TB/2025/160	**Triple A Report from Audit and Risk Committee** a) October 2025	Committee Chair	 ✓	Assurance
---	TB/2025/161	**Triple A Report from Trust Charitable Funds Committee** a) October 2025	Committee Chair	 ✓	Assurance
CLOSING MATTERS					
12.35	TB/2025/162	**Message from the Board**	Chair	v	Information
12.40	TB/2025/163	**Any Other Business**	Chair	v	Information
12.45	TB/2025/164	**Date and Time of Next Meeting** 14 January 2026 at 9.30am, Boardroom, Trust HQ	Chair	v	Information

BOARD MEETING (PUBLIC SESSION)
10 SEPTEMBER 2025 9.30AM
BOARDROOM, TRUST HQ
MINUTES

PRESENT

Mr S Sarwar	Chairman
Mr S Featherstone	Non-Executive Director
Dr J Hobbs	Executive Medical Director
Mr M Hodgson	Chief Executive
Mrs S Gilligan	Chief Operating Officer / Deputy Chief Executive
Mr P Murphy	Chief Nurse
Mrs C Randall	Non-Executive Director
Mr K Rehman	Non-Executive Director
Mrs L Sedgley	Non-Executive Director

BOARD MEMBERS IN ATTENDANCE (NON-VOTING)

Mrs K Atkinson	Executive Director of Service Development and Improvement
Professor S Bari	Associate Non-Executive Director
Mrs M Hatch	Associate Non-Executive Director
Mr N Pease	Interim Chief People Officer
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 E Dawkins	Associate Director of Organisational Development	Item: TB/2025/127
Mrs S Giles	Interim Director of Corporate Governance / Company Secretary	
Mr M Greatrex	Interim Deputy Director of Finance	
Mrs D Jaines	Senior Consultant, ValueCircle	Observer
Dr U Krishnamoorthy	Deputy Medical Director, Professional Standards and Systems Improvement	Item: TB/2025/127
Mr G Lorimer	Sales Director, EMR Solutions	Observer
Mr A Patel	Deputy Chief Integration Officer	

Miss T Thompson	Divisional Director of Midwifery and Nursing	Item: TB/2025/121

APOLOGIES

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

	23 Apr 2025	14 May 2025	9 Jul 2025	10 Sept 2025	12 Nov 2025	14 Jan 2026	11 Mar 2026
Mr S Sawar	✓	✓	✓	✓			
Mrs S Bridgen	✓	✓	✓	A			
Mrs T Anderson	A	✓					
Prof G Baldwin	A	✓	A	A			
Mrs C Randall	A	✓	A	✓			
Mr K Rehman	✓	✓	✓	✓			
Mrs L Sedgley	✓	✓	✓	✓			
Mrs M Hatch	✓	✓	✓	✓			
Dr S Bari			✓	✓			
Mr S Featherston			✓	✓			
Dr J Hobbs				✓			
Mr M Hodgson	✓	✓	✓	✓			
Mrs S Simpson	✓	✓	✓	D			
Mrs S Gilligan	✓	✓	✓	✓			
Mr P Murphy	✓	✓	✓	✓			
Mrs K Quinn	A	A					
Mr M Ireland	✓	✓					
Mrs K Atkinson	✓	✓	D	✓			
Mr T McDonald	✓	D	✓	D			
Miss S Wright	✓	✓	✓	✓			
Mr S Islam	✓	✓	✓				
Mr N Pease			✓	✓			

✓ Attended **A apologies** **D Deputy attended**

TB/2025/109 CHAIRMAN'S WELCOME AND APOLOGIES

Directors and observers were welcomed to the meeting. Apologies were recorded as above.

Directors were advised that Mr Rehman would be chairing the meeting in place of Mr Sarwar until he arrived at the meeting. Dr Hobbs was welcomed to his first Board meeting at the Trust as Executive Medical Director.

TB/2025/110 DECLARATIONS OF INTEREST

There were no additional declarations of interest raised.

TB/2025/111 MINUTES OF THE PREVIOUS MEETING

Mr Featherstone requested that the attendance list in the minutes from the previous meeting be amended to reflect the fact that he had been present. Directors otherwise approved the minutes as a true and accurate record.

Subject to the aforementioned amendment the minutes of the meeting held on 9 July 2025 were approved as a true and accurate record.

TB/2025/112 ACTION TRACKER AND MATTERS ARISING

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.

It was confirmed that the Trust's green plan had been published on its website.

Mr Hodgson confirmed that full preparation efforts were underway for the winter period and that a winter assurance template had recently been submitted to the Integrated Care Board (ICB) and colleagues in the NHS England (NHSE) regional team. He added that the Board would be required to sign off the Trust's planning templates by the end of the month.

Directors noted the position of the action matrix.

TB/2025/113 PATIENT STORY

Directors were referred to the patient story detailed the experiences of a patient's family with the Trust's end of life and bereavement service during and following the death of their mother earlier in the year. The patient story can be viewed here.

It was agreed that it was good to have been provided with another story by a patient from a Black, Asian and Minority Ethnic (BAME) background.

Mr Murphy emphasised the importance of getting end-of-life care right for patients and their families, and that every effort would continue to be made to ensure that such care was delivered in a personalised manner.

Mr Rehman requested that the formal thanks of the board was passed onto the colleagues involved in the story.

Directors received the Patient Story and noted its content.

TB/2025/114 CHAIR'S REPORT

Directors received an overview of Mr Sarwar's activities since the previous meeting.

Directors received and noted the report provided by the chair.

TB/2025/115 CHIEF EXECUTIVE'S REPORT

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

It was highlighted that the first publication of NHS trust performance rankings had taken place the previous day and that the Trust had been ranked at 89 out of 134 acute trusts. It was explained that the Trust had automatically been placed into segment five due to being in the Recovery Support Programme (RSP) and that clear communication had taken place with staff to explain the reasons for this.

With regards to industrial action, Mr Hodgson stressed that while the Trust would always recognise the right of colleagues to take such action it would always come at a cost, adding that the most recent bout of industrial action taken by resident doctors had resulted in additional £800k of costs to the organisation.

Directors were referred to the information in the report regarding data recently published by the NHS that showed that patients in the most deprived areas were more likely to wait for planned procedures. It was noted that work done by Mr Patel and public health colleagues had provided clear statistical evidence that there were no disparities regarding access to the care provided by the Trust to its local population.

Mr Hodgson highlighted that the substantial amount of work being done by Trust colleagues to improve its financial situation had been recognised at the last meeting of the IAG and that there have been clear reductions in the organisation's run rate and normalised pay position. He acknowledged that the rating given to community inpatient services by the CQC was disappointing but pointed out that the Trust had only been a single percentage point from a rating of 'good' and advised that a subsequent visit to the organisation by the CQC earlier in the week had been extremely positive.

Directors went on to receive a brief overview summary of other recent positive developments at the Trust. It was highlighted that eight apprentices had successfully completed their training at the Trust in June and July and that the shortlist for the annual Star Awards ceremony had been announced following the receipt of 500 separate nominations across 12 categories.

Directors approved ward B22 for Safe, Personal and Effective Care (SPEC) status.

It was noted that the Care Quality Commission (CQC) had visited to assess mental health pathways. This visit was not limited to the Emergency Department (ED) but also included wards and that the purpose of the visit was to gain a better understanding of the scale of the issue, rather than to assess services directly. It was confirmed that no concerns had been raised and that the Trust continued to work closely with colleagues at Lancashire and South Cumbria NHS Foundation Trust (LSCFT) on a daily basis.

In addition, following discussions with the Chief Executive of LSCFT and colleagues from the ICB, it had been agreed to pursue a 'mental health ED' pilot scheme. It was confirmed that further feedback would also be provided at a future meeting of the Quality Committee.

Mr Rehman emphasised the importance of the board continuing to receive updates on the neighbourhood pilot scheme and on the need for the Trust to proactively provide assurance and reassurance to patients regarding the 'league table' figures and what this may mean for their care. He noted that the progress made in addressing inequalities was a particularly positive development and suggested that further efforts should be made to bring these improvements to life at future board meetings. Mr Rehman referred to the updates provided on the national staff survey and commended the ongoing work to engage staff and foster a positive organisational culture in the Trust.

Directors received the report and noted its contents.

TB/2025/116 ANNUAL PLANNING 2026-27

Directors received a report outlining the draft planning framework for the 2026-27 financial year. It was noted that the planning process was moving towards a five-year timeframe which represented a significant challenge, particularly in terms of completing the initial planning work by quarter three of the current year during what was typically an extremely busy period.

The efforts to align strategic and operational planning were acknowledged by the board and the additional clarity on the role of providers, the ICB and place-based partners that this provided. It was confirmed that initial work had already commenced, including the organisation of kick-off workshops in June and July and that collaboration was ongoing with commissioning colleagues to clarify intentions. Directors noted that capacity remained an issue and that further updates on the planning process would follow as they became available.

Mr Hodgson highlighted that improved engagement with commissioners and a clearer focus from ICBs on strategic commissioning had been beneficial but stressed that challenging discussions would be required in 2026-27 regarding the continuation of services that were either unfunded or insufficiently funded, as the Trust could not continue to sustain the financial losses that it had in previous years.

Referring to integration, particularly in relation to risks associated with imaging storage and clinical services, Mrs Atkinson confirmed that the Trust's digital strategy would be refreshed as part of the wider strategic refresh to better reflect the ambitions of the ten-year plan and outline subsequent steps. She added that digital enablement had been identified as a key component of other strategic initiatives and highlighted the importance of evaluating returns on investment and ensuring that digital transformation remained central to the planning process going forward.

Mr Hodgson emphasised that the appointment of Mr McDonald as executive lead for digital and data would provide additional capacity, senior oversight and help to support the advancement of digital capabilities to improve patient care. He added that collaborative work with service leads was also taking place to enhance these efforts.

Directors received the report and noted its contents.

TB/2025/117 FINANCIAL REPORT

Directors received an overview of the Trust's financial performance as of month four (M4). It was reported that the Trust had reported a deficit of £5.8m, just over £2m behind the planned position, with a number of key drivers that contributing to this including over £800k of costs associated with recent industrial action and a shortfall of the Trust's Waste Reduction Programme (WRP) of just over £900k. It was explained that this shortfall amounted to less than £200k against the Trust's reprofiled WRP plan and that this should be considered reasonable performance at the current time.

Directors were informed that year-to-date (YTD), the Trust was reporting a deficit of £26.2 m, £5.5 million behind its initial plan and £3.5m behind its reprofiled plan. It was noted that improvements continued to be seen with agency spend and bank spend once the impact of industrial action was factored out. Cash was identified as a growing risk, although it was explained that following an improvement of £2.5 million in cash during the month, the Trust was not yet in a position where additional cash support was required. It was confirmed that a further review would be undertaken once month five (M5) figures had been finalised. It was highlighted that a number of new ideas were being developed and added to the project pipeline to get WRP savings back on track, with several initiatives already implemented.

It was agreed that there were several positive signs that the Trust's run rate was reducing, including reductions in its normalised pay bill, and indicated that further strengthening of its grip and control mechanisms were ongoing. Mr Hodgson emphasised the importance of the Trust ensuring that it received Deficit Support Funding (DSF) and indicated that good progress was being made with many of the associated requirements.

Responding to a query from Mrs Randall regarding the mitigations in place for further potential industrial action, Mrs Gilligan explained that while appropriate actions were always taken in the event of such action, it was impossible to be able to prepare for it fully in advance. She clarified that when patient appointments were cancelled this was only done the day before action was due to take place to allow for resolution being achieved.

Mr Rehman reflected that the board session with divisional and other senior leadership teams in August had been a productive one and that future sessions would both allow better socialisation of the challenges facing the Trust and easier triangulation for himself and his fellow non-executive directors.

Directors noted the financial report.

TB/2025/118 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 August 2025. It was noted that the Trust continued to perform well in several key metrics including ambulance handover times, four-hour A&E performance and theatre usage but faced challenges in others, particularly in relation to patients waiting over 52-weeks for treatment and the volume of patients waiting for 12 hours more to be seen in the ED.

b) Safe

Mr Sarwar Joined the meeting at this time (10:52)

Responding to a query from Mr Featherstone regarding the issues with ant and fly infestations referred to in the report, Mr Murphy indicated that robust monitoring processes were in place and that dedicated strategies had been developed to address these issues.

Addressing a query from Professor Bari as to whether any plans were in place to improve the Trust's Venous Thromboembolism (VTE) assessment performance, Dr Hobbs explained that the drop in this area was related in part to the implementation of its EPR system and confirmed that it was expected to improve following the deployment of additional functions.

It was noted that the Trust triangulated episodes of harm with legal claims made against the Trust. Dr Hobbs suggested that this intelligence could be presented to the board at a later date to provide a broader view on what the Trust's issues were.

Dr Hobbs went on to inform directors that the Trust's job planning process had been refreshed, including the associated policy, and that there would be better alignment between demand and capacity to business planning cycles going forward.

c) Caring

Directors were referred to the nursing fill rate information in the report and were advised that there were no areas of concern. It was also highlighted that significant reductions had been made in the volume of lapses in case relating to pressure ulcers.

d) Effective

Directors were informed that a full mortality update would be provided later in the meeting.

e) Responsive

Directors received a summary of the Trust's most recently updated performance figures, including its performance against the four-hour A&E standard, ambulance handover times, 65-week waiters and cancer and faster diagnosis standards. It was highlighted that the Trust's ambulance handover times continued to be better than the North West Ambulance Service (NWAS) average, despite receiving the highest number of patient attendances in the North West, and that it remained ahead of trajectory for its Referral to Treatment (RTT) performance.

Directors were advised that there were some areas of ongoing concern, including the proportion of patients waiting 12 hours or more in the ED remaining high, despite recent improvements, and the Trust being off trajectory for its 52-week position. It was confirmed that plans were being progressed to address these.

Addressing queries from Mr Sarwar regarding the impact of the work being done to address 12 hour waits and the measures being taken to address recent spikes in longer length of stay and bed occupancy, Mrs Gilligan explained that the recent changes put in around 12 hour stays would undoubtedly have an impact going forward and that combining discharge teams in community and acute settings would help to promote better alignment between the two going forward.

In response to a further query from Mr Sarwar regarding the Trust's strong performance in relation to ambulance handover time and whether there was any possibility that it may be receiving more ambulance conveyances as a result, Mrs Gilligan stated that there was no statistical evidence that this was the case.

Mr Rehman commented that length of stay remained a critical area of consideration for the Trust and requested that regular updates continued to be provided at committee and board level going forward, including quantification of the associated financial elements.

ACTION: Updates will continue to be provided to the Quality Committee and Finance and Performance Committee on the costs associated with length of stay and bed occupancy.
BY WHO: Chief Operating Officer
BY WHEN: Ongoing

Responding to a request for clarification as to whether clinical validation system was in place for RTT metrics, Mrs Gilligan explained clinically based algorithms were in place to facilitate

this but indicated that the capacity of clinicians to carry out the actual validation work remained a challenge. She added that a pilot was currently being tested in some areas to determine if greater clinician involvement in the assessment side of the process would have a noticeable beneficial impact.

In response to additional concerns from Professor Bari regarding the increased use of the Same Day Emergency Care (SDEC) unit potentially being used as another A&E area, Mrs Gilligan clarified that while the SDEC function was currently being utilised on a 24/7 basis, it was not being used as a bedded Acute Medical Unit (AMU) and was only being used for appropriate patients.

Mrs Gilligan confirmed that there was clear statistical evidence that there were no disparities in relation to ethnicity and geographical base for patients waiting longer to access care. She indicated that addition relating to health equity would be factored into future iterations of the IPR.

f) Well-led

It was reported that sickness absence rates continued to be areas of challenge for the Trust but that some signs of recovery had been seen over recent weeks following the implementation of a number of changes to the process and related governance arrangements. Directors were informed that the Mersey Internal Audit Agency (MIAA) had been asked to carry out an audit of sickness and absence compliance and that work continued, incorporating learning from Lancashire Teaching Hospitals (LTH) NHS Foundation Trust, to further improve the situation. It was noted that appraisals also remained an area of concern, and that compliance stood at around 80% as of the meeting.

Mr Sarwar emphasised the need for clear reduction trajectories to be provided at future meetings and for the organisation to benchmark itself against its peer organisations in the region with lower levels of sickness to determine what further action the Trust might be able to take. Mr Sarwar added that he would like for more information on the costs associated with sickness and absence to be discussed at the People and Culture Committee going forward.

ACTION: Additional information regarding the costs associated with increased sickness and absence levels to be provided to the People and Culture Committee going forward.

BY WHO: Executive Director of Finance / Chief People Officer

BY WHEN: Ongoing

Mr Pease confirmed that there was no clear link between the rise in mental health related sickness absence figures and known incidences of bullying or other concerns raised to the Trust's Freedom to Speak Up (FTSU) service.

Mr Sarwar went on to refer to the discussions earlier in the meeting regarding the importance of the Trust successfully securing DSF for the year and requested that an in-depth analysis of the associated worst- and best-case scenarios was presented to and discussed at the next meeting of the Finance and Performance Committee.

ACTION: Additional analysis and options regarding deficit support funding will be brought to the Finance and Performance Committee and to the board at a later date.
BY WHO: Executive Director of Finance
BY WHEN: October 2025

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

TB/2025/119 MORTALITY DEEP DIVE

The board was presented with a report detailing the Trust's ongoing issues with its mortality performance and the range of factors that continued to contribute to them. It was noted that shifts in the Summary Hospital-level Mortality Indicator (SHMI) were almost always attributable to coding changes and that while many of the coding issues previously identified had been resolved, other recent changes to exclude SDEC data from the Trust's data sets had resulted in a significant shift in the underlying SHMI calculations. Directors were also informed that many other organisations had not implemented this change, leading to inaccurate national comparisons. It was highlighted that there had been no notable change to the Trust's crude mortality rate over the same period, further suggesting that the rise in SHMI performance was being driven by the changes to SDEC recording rather than any issues relating to quality of care.

The report outlined several treatments for this issue, including actions to addressing ongoing coding issues, normalise mortality and improve the quality of care being provided to deteriorating patients and it was anticipated that there would be a noticeable shift in the Trust's mortality baseline over the coming 12-month period. It was noted that the potential restoration of SDEC data to the Trust's submitted data was also being considered if the July 2025 deadline for other organisations was not met to achieve comparable figures. Directors were referred to

the comparative data provided in the report from other trusts around quality of care for a range of conditions and were advised that these showed that the Trust was performing at an above average level for the majority of initial care measures, sepsis and front-door elements of care. It was highlighted that an agreement had also been reached with the Advancing Quality Alliance (AQuA) to carry out an external piece of assurance in relation to the matter that would be progressed at pace.

Mr Featherstone expressed his gratitude for the report and for the deeper understanding of the Trust's mortality issues that it had provided. He noted that the Trust was currently carrying out a relatively low number of Structured Judgement Reviews (SJRs) and stated that it would be beneficial for a clear trajectory around this to be provided in a future update.

Dr Hobbs explained that the issues with coding outlined in the report could not be resolved in any less time due to the need to have a full rolling average over this period. He agreed that any actions implemented elsewhere would need to be intelligently targeted and timely and indicated that further updates would be provided to the Quality Committee on the progress being made on a regular basis.

It was noted that further optimisation of the clinical uses of the Trust's EPR would play a key role in the improvements needed to the coding issues discussed and stated that it would be beneficial for an update on the progress being made with this to be provided either to the board or to one of its sub-committees at a future meeting.

ACTION: An update on the ongoing implementation and development of the Trust's electronic patient record system will be presented to the board or one of its sub-committees at a future meeting
BY WHO: Executive Medical Director
BY WHEN: To be confirmed.

Mr Hodgson praised the proactive action taken by Dr Hobbs and his colleagues in reaching out to AQuA for an external assessment.

Directors received the report and noted its contents.

TB/2025/120 PATIENT SAFETY INCIDENT RESPONSE ASSURANCE (PSIRA) REPORT

Mr Sarwar took over as chair of the meeting from this point.

Directors were referred to the previously circulated report and agreed to take it as read. It was highlighted that an alert had been raised following a breach of duty of candour and that a new Never Event had been declared relating to a small fragment of medical equipment being retained in a patient's jaw following an Oral and Maxillofacial Surgery (OMFS) procedure. It was confirmed that immediate action had been taken to remove the specific piece of equipment from use and to ask the ICB to review the incident.

The board noted that although low levels of harm were being reported, there was suspected a risk of underreporting and were advised that a review of the reporting criteria had been initiated to ensure that all incidents were being captured appropriately. Assurance was provided regarding medicines management through the introduction of daily reviews, thematic analyses and the strengthening of processes to ensure that all reports referenced national guidance appropriately and that audits were carried out when required.

Dr Hobbs confirmed that a number of actions had been initiated in relation to falls. In relation to the rigor applied to child death pathways, Mr Murphy confirmed that that all trusts were required to follow a strict process and that the Trust followed all of the requirements associated with this.

Directors noted the report.

TB/2025/121 MATERNITY AND NEONATAL SERVICES UPDATE

Miss Thompson joined the meeting for this item.

Directors received a summary overview of the Trust's progress against the 10 maternity safety actions included in the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) 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 not yet fully compliant with this action and that a further update would be provided to the board in November 2025.

Safety Action 5 - Midwifery Workforce: Directors were advised that following the ratification of the birth rate+ staffing case by the Finance and Performance Committee the Trust would be moving forward with Junior Clinical Fellow (JCF) vacancy reviews and clinical posts. It was noted that a decision was still awaited on specialist midwifery posts before any vacancy reviews would be progressed.

Safety Action 8 – Training: It was confirmed that compliance would continue to be monitored to ensure that the 90% compliance target was met by the submission date of the 30 November 2025.

It was acknowledged that there would likely be a greater focus on potential inequity in maternity treatments going forward as part of the wider national scrutiny being placed on maternity and stated that the board would need a level of assurance that this was not the case at the Trust.

Mr Hodgson reiterated the need to balance the asks around financial savings against additional staffing requirements and emphasised that this was something that the Trust would have to continue to manage. He noted that the report made mention of a potential risk to the Trust's neonatal nursing workforce that would be expounded upon at the next meeting of the board in November.

Miss Thompson clarified that this risk was related to British Association of Perinatal Medicine (BAPM) standards and indicated that this was unlikely to be a significant area of concern for the Trust based on its activity and datasets. She confirmed that an update would be provided at the next meeting once the necessary calculations and alignment work had been carried out. **Directors were assured by the activity taking place to deliver safe, personal, and effective care in the Trust's maternity and neonatal services.**

TB/2025/122 ACCOUNTABILITY AND OVERSIGHT FRAMEWORK

The revised Accountability Framework was presented to directors, outlining the accountability delegated from the board throughout the Trust. It was explained that the document comprised two main elements. The first element addressed accountability, setting out roles and responsibilities across the organisation, with a key change being the implementation of a recommendation from the NHSE to establish a single person accountable for finance within each division. The second element detailed arrangements for mortality and patient experience, specifying responsibilities for each area. Directors were referred to the revised Performance and Improvement Oversight Framework and were advised that this was now clearly set out across six key domains.

In response to comments from Mr Featherstone regarding the lack of clarity around domain scores within the proposed balanced scorecard and what the board would have direct visibility over, Mrs Atkinson indicated that this would be further developed as a next step.

Mr Hodgson confirmed that the revised Accountability Framewore had been supported by divisional colleagues, with feedback from them indicating that there was a clear sense of the joint responsibility in addressing the many challenges facing the Trust.

Directors approved the revised Performance Accountability Framework.

TB/2025/123 MEDICAL APPRAISAL AND REVALIDATION

Directors were referred to the most recent iteration of the annual Medical Appraisal and Revalidation report. Dr Hobbs explained that the report was being presented to approve for submission to NHSE within the stipulated timeframe.

Directors approved the Appraisal and Revalidation Report.

TB/2025/124 EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) ANNUAL STATEMENT

The board was presented with the latest EPRR Annual Statement and was advised that it summarised the work undertaken to ensure EPRR functionality and that suitable mechanisms were in place to fulfil the organisation's statutory obligations.

Directors approved the EPRR Annual Statement.

TB/2025/125 BOARD ASSURANCE FRAMEWORK (BAF)

The updated BAF was presented to the board for consideration. It was confirmed that all risks had been reviewed and their actions updated following review by directors. Following review by the Finance and Performance Committee there had been a request to ensure that risk five (financial sustainability) captured the risks associated with DSF and the Trust's cash position. Directors were informed that a substantial amount of work was being led by the Trust's Assistant Director of Health, Safety & Risk to revise the Risk Management Strategy and that a finalised version would be presented at the Audit Committee meeting in October for ratification.

Mr Sarwar reported that a number of financial risks had been pointed out at the most recent meeting of the IAG and emphasised the need for these to be properly reflected in the BAF, particularly those relating to Cost Improvement Programmes (CIPs), DSF and commissioning intentions.

Directors noted the report.

TB/2025/126 CORPORATE RISK REGISTER

Directors were referred to the previously circulated report. There was recognition of the need for a full review of the Trust's risk register, specifically to assess whether the high volume of longstanding risks with high scores were still scored appropriately, and of the need for more timely review of risks going forward.

It was noted that Executive Risk Assurance Group (ERAG) reviewed high scoring risks and the adequacy of controls, including whether the level of mitigations was insufficient or if the severity of risks was being overstated.

Mr Sarwar suggested that more consideration was needed as to how risks could be monitored through internal audit mechanisms.

ACTION: Consideration to be given as to how risks could be monitored through internal audit mechanisms.

BY WHO: Audit Committee Chair

BY WHEN: October 2025

Directors noted the report.

TB/2025/127 AARUSHI PROJECT UPDATE

Dr Krishnamoorthy and Mrs Dawkins joined the meeting for this item.

The board received an update on the progress of the Trust's Aarushi Project, as well as the actions needed, and the support required to complete them. The initiative was reaffirmed as a high strategic priority for the Trust due to its alignment with other organisational commitments, including the Health Equity (HE) agenda and Equality, Diversity and Inclusion (EDI) objectives. It was noted that the BAME Assembly and Anti-Racism Framework remained integral components of this work and the importance of the initiative for the delivery of Safe, Personal and Effective Care (SPEC) care was emphasised, given its significant impact on both physical and mental health outcomes for both patients and staff.

Updates were provided on key areas of work aimed at reducing inequalities in staff recruitment and progression and patient experience, as well as strengthening organisational culture to be more compassionate. It was confirmed that while good progress had been made by the relevant teams, it had become clear that efforts had not been equitable across all sites, and that further support would be required to address this disparity. The development and launch of an inclusive recruitment toolkit were highlighted as a significant achievement and emphasis

was put on the need for ongoing support to ensure the sustainability and embedding of the toolkit and its principles within the organisation.

Progress in staff progression was discussed, with maternity services identified as a focus area. It was highlighted the Trust had appointed two senior midwives during the year, marking a milestone after a period without representation at this level. These metrics were noted to have a direct impact on the ethnicity pay gap, which remained considerable. Efforts to reduce inequalities in patient experience were reviewed, with improvements observed in the Friends and Family Test (FFT) across several domains. It was reported that positive outcomes were now seen eleven domains out of 23, up from seven, with further improvements anticipated.

Directors went on to receive an overview of more challenging areas, including the need for further improvements to the equitable lived experience of staff through measurable outcomes. It was noted that several opportunities had been identified to enhance the robustness of the processes used to manage accusations of racism within the Trust, with a view to extending these improvements to other areas, such as issues of sexual safety in the future.

Directors were advised that collaborative work with external partners continued, with the next sponsor for the initiative was identified University of Lancashire. It was confirmed that discussions were underway, with the aim of finalising a Memorandum of Understanding for joint working in the coming months. Engagement with the most deprived communities, particularly pregnant mothers, was also highlighted, as well as the importance of listening to the experiences of black mothers to inform future work due to the recognised increased risk of mortality among this group.

Mr Sarwar expressed the gratitude of the board to Dr Krishnamoorthy and Mrs Dawkins for the work that they had, and continued to do, around anti-racism. He reiterated the commitment of the board to the Trust's anti-racism pledge to ensure that its culture was absolutely inclusive and that ongoing issues with discrimination were addressed.

It was agreed that People and Culture Committee would continue to focus on the Aarushi Project. Board members also requested that inequality data be embedded across the papers and reports presented to Board and Committees.

ACTION: Discussions to take place at the People and Culture Committee on how to further develop and shape the work of the Aarushi Project.

BY WHO: People and Culture Committee

BY WHEN: November 2025

Directors noted the report.

TB/2025/128 NURSING PROFESSIONAL JUDGEMENT REVIEW

The outcomes of the latest round of Nursing Professional Judgement Reviews were received and noted by the board.

Directors noted the report.

TB/2025/129 TRIPLE A REPORTS FROM QUALITY COMMITTEE

The reports were presented to the board for information.

Directors noted the report.

TB/2025/130 TRIPLE A REPORTS FROM FINANCE AND PERFORMANCE COMMITTEE

The reports were presented to the board for information.

Directors noted the report.

TB/2025/131 TRIPLE A REPORTS FROM PEOPLE AND CULTURE COMMITTEE

The reports were presented to the board for information.

Directors noted the report.

TB/2025/132 TRIPLE A REPORT FROM AUDIT AND RISK COMMITTEE

The report was presented to the board for information.

Directors noted the report.

TB/2025/133 DATA, DIGITAL AND TECHNOLOGY COMMITTEE TERMS OF REFERENCE

Directors received the terms of reference for the proposed Data, Digital and Technology Committee.

Directors approved the terms of reference for the Data, Digital and Technology Committee.

TB/2025/134 AUDIT COMMITTEE TERMS OF REFERENCE

Directors received the updated terms of reference for the Audit Committee and noted the proposed changes.

Directors approved the updated terms of reference for the Audit Committee.

TB/2025/135 MESSAGE FROM THE BOARD

It was agreed that the message from the board was one of recognition of the complex environment that the Trust was working in and the challenges that it was facing, but also of the positive progress being made across a range of crucial areas. It was recognised that a substantial amount of work taking place at a divisional level had been clear in the items discussed by the board.

TB/2025/136 ANY OTHER BUSINESS

No additional items of business were raised for discussion.

TB/2025/137 DATE AND TIME OF NEXT MEETING

Wednesday, 12 November 2025 at 09:30. Venue to be confirmed.

East Lancashire Hospitals NHS Trust
A University Teaching Trust

EXTRAORDINARY BOARD MEETING
29 SEPTEMBER 2025, 5.00pm
MS TEAMS

PRESENT

Mr S Sarwar	Chairman
Mr M Hodgson	Chief Executive/Accountable Officer
Professor G Baldwin	Non-Executive Director
Mrs S Bridgen	Non-Executive Director
Mr S Featherstone	Non-Executive Director
Mrs S Gilligan	Chief Operating Officer
Dr J Hobbs	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)

Dr S Bari	Associate Non-Executive Director
Mrs M Hatch	Associate Non-Executive Director
Dr N Pease	Interim Chief People Officer
Miss S Wright	Executive Director of Communications and Engagement

IN ATTENDANCE

Mrs S Giles	Interim Director of Corporate Governance	
Miss K Ingham	Corporate Governance Manager	Minutes
Mr A Patel	Deputy Chief Integration Officer	For Mr T McDonald

APOLOGIES

Mrs K Atkinson	Executive Director of Service Development and Improvement
Mrs A Bosnjak-Szekeres	Director of Corporate Governance
Mr T McDonald	Chief Integration Officer

ETB/2025/040 CHAIRMAN'S WELCOME AND APOLOGIES

Mr Sarwar welcomed Directors to the meeting. Apologies were received as recorded above.

ETB/2025/041 DECLARATIONS OF INTEREST

There were no declarations of interest made in relation to the agenda items being discussed.

ETB/2025/042 2025-26 WINTER PLANNING

Mr Patel presented the proposed winter plan for 2025-26, and confirmed that it had undergone extensive discussion at the Finance and Performance Committee earlier in the day, but that there was a requirement for the plan to be approved by the Board.

Directors were informed of the process for developing the plan, which was noted to be significantly more detailed than in previous years, involving collaboration with local authority and place-based colleagues.

Mr Patel stated that the initial submission had been made in July 2025, with subsequent revisions and further detail added following a recent stress-testing session. Directors were assured that the plan had been reviewed through multiple perspectives, and that additional winter planning activities had been included for information.

Directors noted and discussed the key strengths, limitations, risks, and mitigations set out within the plan. Mr Patel provided additional information around the operational escalation levels that were in place and that an internal exercise was scheduled for 13 October 2025 to test the plan. The Board was informed that, in addition to existing staffing measures, further efforts were underway to address identified gaps.

It was noted that paediatric services had been identified as a potential gap, though this was not considered a significant concern at present. Further engagement with local authority partners was ongoing, and assurance was sought regarding senior decision-making forums.

The importance of executive support for frontline staff was emphasised, with recent actions already being taken during periods of increased demand.

Directors discussed the work that was taking place to maximise vaccination rates, which was highlighted as a priority. Efforts were also being made to reduce bed occupancy ahead of the Christmas period.

During discussion, it was recognised that the plan differed from previous years, with a greater focus on internal controls and accountability for external factors. The integration of divisions and the movement of the discharge team into a new structure were noted as steps towards a more integrated approach.

Directors discussed the need for regular review points over the coming months to monitor progress and adapt the plan as necessary. Financial challenges and the need for robust community infrastructure were acknowledged, with concerns raised about the mechanisms for holding partners to account given the reduction in available beds.

ACTION: It was agreed that the Quality Committee would receive regular updates on the deployment and monitoring of the plan.

BY WHO: Chief Integration Officer

By WHEN: monthly reporting to the Quality Committee from November 2025.

Directors received an overview of the communications plan, which was noted to include links to both local and national messaging regarding prevention, vaccination, and appropriate service use.

Directors agreed to approve the winter plan, recognising its alignment with national direction and the thorough stress-testing undertaken. It was agreed that oversight would be maintained through the relevant committees, with a focus on finances, staffing, and quality.

RESOLVED: **Directors approved the 2025-26 winter plan and the proposed monitoring through the Quality Committee.**

ETB/2025/043 ANY OTHER BUSINESS

There were no further matters of business raised.

ETB/2025/044 Date and Time of Next Meeting

The next meeting of the Trust Board will take place on 12 November 2025, 9.00am, Boardroom, Trust HQ, Royal Blackburn Teaching Hospital.

East Lancashire Hospitals NHS Trust
A University Teaching Trust

EXTRAORDINARY BOARD MEETING
13 OCTOBER 2025, 5.00pm
MS TEAMS

PRESENT

Mr S Sarwar	Chairman
Mr M Hodgson	Chief Executive/Accountable Officer
Professor G Baldwin	Non-Executive Director
Mr S Featherstone	Non-Executive Director
Mr T McDonald	Chief Integration Officer
Mr P Murphy	Chief Nurse
Mrs C Randall	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
Dr N Pease	Interim Chief People Officer
Miss S Wright	Executive Director of Communications and Engagement

IN ATTENDANCE

Mrs S Giles	Interim Director of Corporate Governance	
Miss K Ingham	Corporate Governance Manager	Minutes
Mrs M Montague	Deputy Chief Operating Officer	For Mrs S Gilligan

APOLOGIES

Dr S Bari	Associate Non-Executive Director
Mrs S Bridgen	Non-Executive Director
Mrs A Bosnjak-Szekeres	Director of Corporate Governance
Mrs S Gilligan	Chief Operating Officer
Mrs M Hatch	Associate Non-Executive Director
Dr J Hobbs	Executive Medical Director
Mr K Rehman	Non-Executive Director

ETB/2025/045 CHAIRMAN'S WELCOME AND APOLOGIES

Mr Sarwar welcomed Directors to the meeting. Apologies were received as recorded above.

ETB/2025/046 DECLARATIONS OF INTEREST

There were no declarations of interest made in relation to the agenda items being discussed.

ETB/2025/047 ELECTIVE & UEC RECOVERY TRAJECTORIES

Directors received a detailed update on the elective and urgent and emergency care (UEC) recovery trajectories. Mrs Atkinson presented the context, highlighting the rapidly evolving operational landscape and the recent refocusing of NHS England (NHSE) regarding delivery expectations.

Directors recognised the focus on delivering previously agreed commitments, with a half-year review scheduled for 23 October 2025. It was emphasised that a credible financial plan, alongside an operational plan, was required for this review. The Board also noted the importance of addressing cancer waits, particularly the 62-day and diagnosis targets, and acknowledged the scrutiny these areas would face.

Directors discussed the Trust's position within the North West and Lancashire and South Cumbria (LSC) systems, noting operational strength but recognising ongoing risks and challenges, particularly regarding 52-week waits and 12-hour targets. It was noted that revised trajectories had been submitted to NHSE, subject to approval at this meeting.

It was agreed that while the Trust was operationally strong and capable of delivering the required outcomes, financial implications remained, and delivery was predicated on securing additional income and potentially insourcing services.

Directors noted that the Trust was largely comfortable with the UEC trajectory, as performance was broadly good with there having been no changes made to the requirements for the four- and twelve-hour targets. it was noted that a conservative approach had originally been adopted when submitting the original plan for 12-hour waits. Directors agreed to maintain the current plan, with ambitions to improve further if possible, noting potential cost benefits.

With regard to the elective care trajectory, it was noted to have been based on the affordability of the Elective Recovery Fund (ERF), with assumptions baked into the plan. Directors noted

that the Trust had seen the highest increase in referrals within the system and acknowledged vacancies and pressures in key areas, resulting in deviation from the planned trajectory.

Directors noted that the Trust's current validated position was 96.8% with an aim to treat the remaining cases, with a specific focus on reducing 52-week waits by the end of the year. The most cost-effective solution identified was to bring forward insourcing in digestive diseases, already factored into the plan.

The Trust had raised the option of overperformance to the Integrated Care Board (ICB) and the NHSE regional team, who had been supportive, but it was noted that this may have an impact on the half-year review.

The risks for quarter four were noted, with the need to adjust plans to fit original expectations. Directors agreed to approve both the advancement of spend and the final submission of trajectories, with regular reporting to both the Executive Team and Finance and Performance Committee.

Directors went on to discuss the impact of health inequalities on the communities served by the Trust, and it was confirmed that no unintended consequences were anticipated. It was agreed that ongoing reviews would take place through the Quality Committee to monitor any health inequalities.

Directors reviewed and discussed the financial risks, particularly regarding income and the ERF cap contract. It was noted that overperformance could trigger activity management plans by the ICB to align with their financial plans.

Directors also recognised the need for clear communication with NHSE at the half-year review and agreed that tactical flexibility was required to avoid being constrained by external expectations.

RESOLVED: **Directors received the information presented and approved the recovery trajectories, subject to receiving assurance that the Trust will receive funding to match additional activity.**

ETB/2025/048 ANY OTHER BUSINESS

There were no further matters of business raised.

ETB/2025/049 Date and Time of Next Meeting

The next meeting of the Trust Board will take place on 12 November 2025, 9.00am, Boardroom, Trust HQ, Royal Blackburn Teaching Hospital.

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Board of Directors (Open Session) Action Tracker

Key:

B	Action complete
G	Action on track for deadline
A	Action not likely to meet deadline
R	Action passed deadline

No	Meeting Date	Agenda Item	Action	Lead	Date for completion	RAG	Comments / Update
1.	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	A	Work is progressing to identify patients/family members who would be willing to share their experience in person.
2.	September 2025	TB/2025/118: Integrated Performance Report	Dr Hobbs to liaise with NHS Resolution regarding the presentation of updated LTPS scorecard information to the Quality Committee and to the board.	Executive Medical Director	October 2025	G	
			Updates will continue to be provided to the Quality Committee and Finance and Performance Committee on the costs associated with length of stay and bed occupancy.	Chief Operating Officer	Ongoing	B	Action for Finance and Performance Committee and Quality Committee. Marked as complete for Board
			Additional information regarding the costs associated with increased sickness and absence levels will be provided to the People and Culture Committee going forward.	Executive Director of Finance	Ongoing	B	Action for People and Culture Committee. Marked as complete for Board
			Additional analysis and options regarding deficit support funding will be brought to the Finance and		October 2025	B	Action for Finance and Performance Committee, Marked as complete for Board

			Performance Committee and to the board at a later date.				
3.	September 2025	TB/2025/119: Mortality Deep Dive	An update on the ongoing implementation and development of the Trust's electronic patient record system will be presented to the board or one of its sub-committees at a future meeting.	Executive Medical Director	TBC	**A**	
4.	September 2025	TB/2025/126: Corporate Risk Register	Consideration to be given as to how risks could be monitored through internal audit mechanisms.	Audit Committee Chair	October 2025	**B**	Review of the Board Assurance Framework is a mandated audit undertaken annually. An additional Risk Management Core Controls review was undertaken in May 2025, all recommendations from this have been implemented. The Internal Audit Plan for the year is developed with consideration to the risks on the BAF and CRR and can be flexed mid-year if this risks change.
5.	September 2025	TB/2025;127: Aarushi Project Update	Discussions to take place at the People and Culture Committee on how to further develop and shape the work of the Aarushi Project.	People and Culture Committee	November 2025	**B**	Action for People and Culture Committee. Marked as complete for Board

East Lancashire Hospitals NHS Trust
A University Teaching Trust

BOARD OF DIRECTORS

Meeting Date:	12th November 2025	**Agenda Item:**	TB/2025/143
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 the months of September and October 2025.			
Key Issues/Areas of Concern:				
Action Required by the Board:	The Board asked to note the contents of the report.			

Previously Considered by:	
Date:	
Outcome:	

Chair's Report

Application for University Hospital Status

The Chief Executive and I were pleased to sign our application to the Department of Education to formally request University Hospital Status, in recognition of our strong commitment to education, training and research and close relationship with University of Central Lancashire and Lancaster University. The new name being proposed is 'East Lancashire University Hospitals NHS Trust'. Achieving such status would not only elevate the Trust's profile but also strengthen our ability to attract top talent and contribute to the future of healthcare education.

Remembrance Day and Veterans Support Service

As Chair, I take this moment to honour Remembrance Day and pay tribute to the bravery and sacrifice of all who have served in the Armed Forces. I would also like to commend the outstanding work of our Veterans Support Service, whose work exemplifies the values of our Trust and reaffirms our commitment to those who have given much in service to the nation.

Anti-Racism and Anti-Semitism Review

The Trust continues to demonstrate its ongoing commitment to anti-racism and antisemitism. I shared with colleagues the letter from NHSE requesting support for the work being led by Lord Mann. There is a report on the Board agenda today providing greater detail on the work in this area. As the Trust refreshes its strategies, we will ensure that this work is intrinsic to our people strategies. The recent meeting looking at ethnicity pay gap outlined some of the drivers and the work that is being done to close the gap.

Failure to Prevent Fraud – Board Training

New 'failure to prevent fraud' legislation came into effect from 1st September 2025. I was pleased to see such strong Board attendance at recent training sessions facilitated by our internal audit provider. This demonstrates our ongoing commitment to ensuring high standards of integrity and probity across the Trust, thereby protecting the public purse.

Changes to the Board

On behalf of the Board I would like to thank Melissa, whose term comes to an end later this month, for her commitment and valuable contributions during her time with the Trust and wish her all the best for the future.

As colleagues are aware this is also my last Board meeting with the Trust as my own term comes to an end. I would like to thank the Board and wider colleagues their support during

my time as Chair. I have no doubt the Trust will continue to provide the excellent safe, personal and effective care that has been evident during my tenure. We have faced demanding times — as the NHS always does — but we've also seen remarkable progress: in patient care, innovation, and collaboration. What has always stood out to me is our shared determination to do the right thing by our patients, staff and communities that we serve. I leave confident that the Trust is in strong hands. The values and commitment in this room give me great reassurance about the future. I know you will continue to drive improvement and uphold the highest standards of care.

It has been an honour to serve as your Chair and to serve the communities of East Lancashire with integrity, honesty and gratitude. Thank you for the trust you've placed in me, and for the difference you continue to make every day. I wish you and the Trust every success for the years ahead.

Meetings attended

- Mid-year review meeting with NHSE
- Improvement & Assurance Group
- Chaired October's Lancashire & South Cumbria Provider Collaborative Board
- ELHT Finance & Performance Committee
- ELHT Quality Committee
- ELHT Inclusion Group
- Meeting with Chair of LSC ICB Chair and Meetings with Chairs of Providers

TRUST BOARD

Meeting Date:	12 November 2025	**Agenda Item:**	TB/2025/144
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**
				X
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 initiatives, high level performance data, updates on the use of the Trust Seal 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:	None
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**

Joint executive team set up across DHSC and NHS England
From the beginning of November, a new single joint executive team for the Department of Health and Social Care (DHSC) and NHS England will be formed, bringing policy and delivery together as part of the transition to one organisation.

In March, the Prime Minister announced NHS England would be brought back into DHSC to end duplication. There will remain a layer of regional leadership.

Medium term planning framework
The medium-term planning framework has been published by the NHS, setting out how it is moving to a new operating model, resetting the financial framework and creating much greater opportunity for local autonomy through the new neighbourhood health approach, a new foundation trust model and the creation of integrated health organisations.

The three strategic shifts and wider transformation areas of the 10 Year Health Plan offer a blueprint for reimagining services, unlocking productivity and redirecting resources to where they can deliver the greatest impact.

The medium term planning framework provides a road-map to achieving this - it sets out the priority deliverables and the reform opportunities that ICBs and providers need to deliver for the next three years and the broader strategic aims that will need to be reflected in 5-year plans developed by each organisation.

National NHS league tables published
The Department for Health and Social Care has published national NHS league tables, rating NHS organisations from the highest to the lowest according to their performance.

Each trust is scored against metrics in the National Oversight Framework (NOF), including performance against targets like reducing wait times for elective procedures, emergency care and improving ambulance response times.

Publication of this information in this way is going to happen every three months or ‘quarter’ and is designed to make it easier for local communities to assess their local NHS Trust, highlighting where performance is good and where things need to improve.

ELHT is ranked 89th in the table our of 134 trusts. League table positions for other trusts in Lancashire and South Cumbria are:

- University Hospitals of Morecambe Bay: 83
- Blackpool Teaching Hospitals: 125
- Lancashire Teaching Hospitals: 127
- Lancashire and South Cumbria Foundation Trust is 53rd out of 61 non-acute trusts.

National maternity investigation
The Government has announced a rapid, independent, national investigation into maternity and neonatal services at 14 trusts.

The 14 trusts do not include ELHT, but the investigation will look at a range of services across the entire maternity system, following independent reviews across multiple trusts that have revealed a pattern of similar failings: women's voices ignored, safety concerns overlooked and poor leadership.

It will be led by Baroness Valerie Amos who will put families at the heart of the work and affected families were asked to provide input to the draft terms of reference of the investigation.

Following its conclusion, she will deliver one clear set of national recommendations to achieve consistently high-quality, safe maternity and neonatal care, with interim recommendations delivered in December 2025.

Government to tackle antisemitism and other racism in the NHS
An urgent review of antisemitism and all forms of racism in the NHS is to take place. Led by Lord John Mann, it will look at how to protect patients and staff from racism and hold perpetrators to account.

It will examine how the regulatory system for healthcare professionals tackles antisemitism and other forms of racism at every stage, from employment through to professional oversight. It will also look at regulatory processes, transparency in investigations, reporting mechanisms, and how zero-tolerance policies can be more effectively implemented across the health service.

At the same time, the government has announced the immediate rollout of strengthened mandatory antisemitism and anti-racism training across the health service, and NHS England will review its uniform guidance so patients and staff always feel respected in NHS settings.

Industrial action
Resident doctors in England will be taking industrial action from 14-19 November in a dispute with the Government over pay.

The British Medical Association (BMA) has advised that the national industrial action involving resident doctors will impact shifts that start from 7am on Friday, 14 November until 7am on Wednesday, 19 November.

Plans will be put in place by the Trust and an incident co-ordination centre will manage the situation to support any emerging issues for the duration of the strike.

Patients with appointments booked on strike days will be contacted if their appointment needs to be rescheduled due to industrial action. Any appointments that need to be rescheduled will be done so as a priority.

Record summer of NHS activity

A record summer of demand in urgent and emergency care shows every sign of continuing into the autumn, with this September being the busiest on record for A&E and ambulance services across the country.

There were 2.31 million A&E attendances in September, a 4% rise on last September (2.21 million). Despite this, a greater proportion of patients were seen within four hours compared to last year (75% vs 74.2%).

A record 4.60 million elective cases were managed by the NHS between June and August - up 138,000 on last year (4.46m), while 210,946 more cases joined the waiting list in the same period.

The NHS also delivered almost 7.5 million tests and checks - over a quarter of a million more than in summer 2024 (7.48m vs 7.21m) - and a record 654,640 patients received a cancer diagnosis or had the disease ruled out within the target 28 days.

Between April and August more than half a million patients (589,336) have avoided an unnecessary hospital referral through Advice and Guidance, where GPs access advice directly from consultants for their patients.

'Stress tests' and pre winter check-ins as NHS ramps up winter prep

Local NHS leaders have been testing the robustness of their winter plans by participating in scenario exercises such as staff shortages, rapid increase in demand and multiple virus outbreaks.

Local teams have also been asked to identify patients who are most vulnerable to winter viruses and at risk of a hospital admission, to provide targeted care and ensure they have the appropriate vaccinations.

At ELHT, winter planning exercises have taken place in line with this to ensure teams have robust plans for what is expected to be another busy period.

New NHS online hospital to give patients more control over their care
The NHS has announced it is setting up NHS Online - an 'online hospital' that will reform the way healthcare is delivered. The new model of care will not have a physical site, instead digitally connecting patients to expert clinicians anywhere in England. The first patients will be able to use the service from 2027.

The intention is that when a patient has an appointment with their GP, they will have the option of being referred to the online hospital for their specialist care. They will then be able to book directly through the NHS App and have the ability to see specialists from around the country, online and without leaving their home or having to wait longer for a face-to-face appointment. If they need a scan, test or procedure, they'll be able to book this in at a time that suits them at Community Diagnostic Centres closer to home.

Online GP appointment requests available everywhere
All GP practices in England are now required to keep online consultation tools open from 8am to 6.30pm, Monday to Friday. From 1 October, patients can now request appointments, ask questions and describe symptoms online throughout the day rather than calling their surgery or visiting in person. This will help free up practice phone lines for those who need them most and make it more convenient to access appointments.

GPs across England to take '3 strikes and rethink approach'
Patients with a potentially deadly illness will be diagnosed sooner through a new life-saving patient safety initiative called Jess's Rule that is being rolled out across the NHS.

Jess's Rule is named in memory of Jessica Brady, who died of cancer in December 2020 at the age of 27, and aims to help avoid tragic, preventable deaths as GPs are supported to catch potentially deadly illnesses sooner.

The new initiative will ask GPs to think again if, after three appointments, they have been unable to offer a substantiated diagnosis, or the patient's symptoms have escalated - encouraging them to review patient records comprehensively, seek second opinions from colleagues and consider specialist referrals when appropriate.

3. **Regional Updates**

ICB staffing update
Aaron Cummins joined the Lancashire and South Cumbria Integrated Care Board (ICB) as Chief Executive Officer on 1 November, moving from his role as Chief Executive Officer for University Hospitals of Morecambe Bay NHS Foundation Trust. Scott McLean has been appointed as interim chief executive until UHMB appoint a replacement.

Sam Proffitt, who had deferred her retirement to become Acting CEO at the ICB as an interim measure, retired on 31 October.

At the end of November, Acting Chief Finance Officer Stephen Downs will be leaving the ICB to take up the role of Deputy Chief Finance Officer at NHS Greater Manchester Integrated Care Board (ICB).

The ICB has been joined by Mark Bakewell, from the Cheshire and Mersey region, who will be Acting Chief Finance Officer on an interim basis until a substantive appointment to the CFO role is made.

Jane Scattergood is now Acting Chief Nurse for the ICB. Following an internal process, Jane has been seconded from her role as Director of Health and Care Integration (South Cumbria) into the Acting Chief Nurse role until 31 March 2025.

Blackburn with Darwen selected to pioneer national Neighbourhood Health Implementation Programme

Blackburn with Darwen and Morecambe Bay are among 43 places across England that will receive support from national and regional teams to pioneer neighbourhood health services.

The Neighbourhood Health Implementation Programme is a major NHS initiative designed to establish and accelerate the development of neighbourhood health models, shifting care from hospital to communities.

Under the Neighbourhood Health Implementation Programme, each place will draw together a range of professions and organisations to develop 'neighbourhood health teams' consisting of community nurses, hospital doctors, social care workers, pharmacists, dentists, optometrists, paramedics, social prescribers, local government organisations and the voluntary sector – giving people easier and more joined up access to the right care and support closer to their own homes.

Burnley NHS initiative bridging gaps in local healthcare access

A collaborative project in Burnley is helping to bridge gaps in healthcare access for underserved populations. More than 500 health checks have been caried out by Burnley East and West Primary Care Networks (PCNs), as well as voluntary, community, faith and social enterprise sector (VCFSE) partners. They have provided clinics to groups of vulnerable people, including those affected by homelessness, refugees, asylum seekers and veterans. The project targeted areas with a higher-than-expected rate of urgent and emergency care hospital admissions and high levels of deprivation.

Hospital patients gain more control and faster access

A groundbreaking online service is giving hospital patients greater control over their appointments and quicker access to important documents and resources.

PEP+ (Patient Experience Portal) is a mobile-friendly platform designed to make healthcare more accessible and efficient.

It allows patients to choose their own appointment times from available slots, appointment letters are delivered digitally, and digital questionnaires are improving preparation for appointments.

Since its launch, PEP+ has expanded to serve patients across multiple NHS trusts within the Lancashire and South Cumbria Integrated Care Board (ICB) area, including ELHT, Lancashire Teaching Hospitals, University Hospitals of Morecambe Bay and Blackpool Teaching Hospitals.

Currently, the portal handles more than 5,000 patient interactions every day.

New grants scheme to boost cancer awareness and early diagnosis
Lancashire and South Cumbria Cancer Alliance is offering up to £10,000 to local voluntary sector organisations to deliver projects that will improve cancer awareness and support early diagnosis.

The initiative aims to empower communities through impactful projects that will raise awareness of cancer signs and symptoms, encourage participation in screening and vaccination programmes, address barriers to care and support people to seek early help.

Spring North will oversee the grants process on behalf of the Cancer Alliance and the scheme will specifically target communities facing the poorest cancer outcomes and those experiencing barriers to accessing care.

Winter flu and COVID vaccine campaign in Lancashire and South Cumbria
Winter flu and COVID-19 jabs were made available to the most at-risk residents of Lancashire and South Cumbria from 1 October.

The new campaign starts as data shows early signs of an increase in flu cases, and COVID-19 cases have been steadily increasing for weeks, with hospitalisations increasing by 60 per cent.

Vaccine teams across the region are working to make it as easy as possible for people to receive their vaccines – including using mobile vaccination buses to deliver vaccines closer to home, running family drop-in sessions in the community, and for the first time delivering flu vaccines to two and three-year-olds in some community pharmacies.

New services introduced to improve the lives of those with dementia
With increasing numbers of people being diagnosed with dementia, a new five-year dementia strategy has been published, setting out how the NHS in Lancashire and South Cumbria will improve the lives of all those affected.

The first phase focuses on a service that supports the patient and their loved ones directly after diagnosis, including the Dementia Navigator Service, Cognitive Stimulation Therapy sessions and Dementia Hubs.

The service will be delivered by the Alzheimer's Society and Age UK Lancashire.

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:

- Lease between Global Enterprises Ltd and East Lancashire Hospitals NHS Trust relating to the Globe Centre in Accrington.

Changes to the Trust Board

As previously advised, the Trust's Chair Shazad Sarwar will conclude his term as Chairman on November 28, after serving on the Trust Board for three years.

Associate Non-Executive Director (NED) Melissa Hatch will also complete her term and leave the Board this month.

The Trust would like to put on record its thanks to both colleagues for their effort and commitment during their time with ELHT and wish them every success in the future.

The Trust is now actively seeking new colleagues to join the Board in specific Non-Executive Director (NED) roles. The appointment of a Chair is within the bailiwick of NHS England, who will manage arrangements for a successor and are expected to make announcement in due course.

Medical Directorate Update

The Board should be advised on two updates within the Executive Medical Director's portfolio.

The first is that Julian Hobbs as Executive Medical Director himself will be the lead and contact for the Trust with with the national Infected Blood Compensation Authority (IBCA), which is a role requested by Government.

Secondly, the Board is asked to approve the appointment of two lead colleagues supporting issues within our resident doctor team. The recommendation is for Anna Sibly, Consultant Paediatrician, and Adam Proudly, Chief Registrar, to take up these roles.

Finance Headlines

The Trust continues to implement its financial recovery plan and colleagues across all services and settings are working hard to reduce costs by £60.8million by the end of March 2026, in line with the budget plans. This continues to be reported in more detail separately to the Board, but a number of related initiatives are included below.

- **Reducing variable pay:** Further adjustments have made to pay controls through the introduction of panels that will provide additional scrutiny around non-clinical variable pay. Any request for a non-clinical bank / agency is subject to review by this panel.

- **Hospital home delivery service for prescriptions:** The outpatient pharmacies at Blackburn and Burnley hospitals have stopped a prescription delivery service. Prescriptions were originally delivered to a small number of patients across East Lancashire but increased significantly during COVID to reduce the need for patients to come in to collect their medication. Around 200 prescriptions were being delivered each week, costing around £130,000 a year. Alterative arrangements are being put in place for patients who cannot attend the pharmacy.

- **Reducing the cost of translation services:** Reduced rates have been secured for translation and video interpreting services, creating not only cost savings but also a more efficient service for patients, with video options reducing the need for travel for translators. In March an app was introduced to enable more video interpretation and now has over 600 subscribers.

- **Colleague ideas scheme** Over 1,400 ideas have been put forward by colleagues about how to reduce spend or work more efficiently. The suggestions are now being reviewed on a weekly with over £228,000 of potential savings identified by ideas submitted so far.

  Key themes so far have been:
  - Recycling uniforms
  - Digitisation of patient communication
  - Reducing unnecessary stationery and consumables

The work has helped deliver a further £4.7m of savings by the end of August.

Mid-year review

NHS England has carried out a mid-year review of the Trust, scrutinising finance, quality and performance.

The Trust set out its financial position for the remainder of this year as well as expectations around operational performance targets during the meeting on October 23.

NHSE noted a strong grip on elective performance and Urgent and Emergency Care (UEC) pathways, including in the Accident and Emergency (A&E) department at Royal Blackburn Teaching Hospital, Urgent Care Centre at Burnley General and the Minor Injuries Unit at Accrington Acorn.

It welcomed positive performance on seeing patients in A&E within four hours and the commitment to continue to reduce the number of people who wait 12 hours to be admitted and may be cared for on the corridor when demand for care is high.

Increased productivity and improvements in elective pathways were also recognised as helping the Trust to reduce the number of patients waiting over 52 weeks, supporting a national target of eliminating this by the end of March.

One LSC Lead Host Arrangements

Chief Executives from all Lancashire and South Cumbria Integrated Care System (ICS) providers met in October to discuss the future of One LSC which resulted in agreement on a number of key improvements to governance and other underpinning principles.

The conclusions of a review into the effectiveness of arrangements surrounding One LSC carried out by Price Waterhouse Cooper (PWC) and the actions from One LSC's Improvement and Assurance Group (IAG) meetings informed options and next steps.

These include a key change to governance arrangements, which has been approved by the Joint Committee of the Lancashire and South Cumbria Provider Collaborative (JCPCB) for ELHT to move from Hosting One LSC to being the Lead Provider. This means the Trust remains the employer for One LSC colleagues across the system but will take over overall responsibility, regulatory accountability and contract management for all services on behalf of all the other Trusts.

Whilst the exact internal operating model for ELHT becoming the Lead Provider has yet to be agreed, it is clear that One LSC will become a material part of the Trust under these new arrangements, albeit the existing Strategic Collaboration Agreement (SCA) remains in place as the underpinning partnership agreement between Trusts and all services set out in Schedule 3 remain valid, with no descoping or removing of services or parts of services at this point.

Immediate next steps are to:

- Undertake a stocktake of the provision of services within the current sphere of One LSC.
- Determine the underpinning operating models of these services
- Develop and agree the associate management structures and supporting governance arrangements

Accrington Victoria Community Hospital (AVCH) Site

The Trust announced it would move services out of Accrington Victoria Community Hospital (AVCH) in September 2024 due to the poor fabric of the building, which was no longer fit for purpose as a modern and effective health care facility.

Underpinning the operational and tactical plan to withdraw from the site was a comprehensive approach to service modelling, audit and utilisation of local sites with capacity to amalgamate services nearby and a commitment to engaging with local people to understand their views on the future of the site in Haywood Road, Accrington.

These plans were delivered as envisaged and a Strategic Group, chaired by Hyndburn and Haslingden MP Sarah Smith and including representatives of Hyndburn Council, the Lancashire and South Cumbria Integrated Care Board and patients, was set up to oversee regeneration plans.

Members of the group agreed at their meeting in October to start to identify a suitable partner to help regenerate the site in line with the outcomes of the recent engagement exercise. This will involve ELHT transferring ownership of the site and the ultimate provision of at least 60 Supported Living Accommodation units as well as additional Health and Community space and services, including a GP.

New strategy planned for Trust

The Trust is currently refreshing its overarching strategy with the aim of bringing together various other existing strategies into one single plan.

It will also incorporate the key three shifts outlined in the NHS 10 year heath plan - moving care from hospitals to the community, changing the focus from sickness to prevention and transforming analogue systems to digital.

To support this activity, a workshop was recently held with senior leaders in the organisation, featuring presentations from the Integrated Care Board, public health and voluntary sector who provided valuable insights into their activity, which overlaps with the work of the Trust.

Over the next few months a series of engagement sessions will take place to help co-design the strategy with colleagues and key stakeholders.

Trust leading the way for productivity

The Trust has been ranked 2nd nationally in a league table for productivity growth, published in the HSJ last month.

The table compares cost weighted activity growth (such as outpatients, non-electives and A&E attendances) against real terms resource growth (pay and non-pay spend).

ELHT has an overall productivity growth estimate of 13.4%, just 1% behind the leader of the table, University Hospitals Birmingham.

Celebrating 10 years of robotic surgery

Patients and colleagues came together at the end of September for a special event to mark 10 years of robotic surgery at the Trust.

Since the installation of the £1.3 million Da Vinci surgical robot in 2015, ELHT has carried out over 3,000 procedures, making us a leader in robotic-assisted surgery in Lancashire.

Starting with robotic prostatectomies, the service has evolved into a comprehensive programme which now encompasses hepatobiliary, colorectal, head and neck cancer procedures, urology, and gynaecology surgeries. This also gives us one of the best theatre utilisation figures across the UK with shorter hospital stays and significantly fewer post operative complications.

Among the 50 guests was Frank Steele, who made history as the first patient in East Lancashire to undergo robotic colorectal surgery. Frank, a former professional footballer and Royal Mail worker, thanked the surgical team for what he calls “the gift of life.”

Leading the way for Martha’s Rule

The Trust's Call for Concern initiative is already demonstrating how it is providing additional support for patients.

Part of the national Martha's Rule campaign, the dedicated phoneline to identify early signs of deterioration was launched in April for people who are concerned about a patient's condition and who want an independent medical review.

The hotline has since received 80 calls, of which, 49 (61%) were categorised as possible clinical deteriorations.

Following review by the Acute Care Team 12 (24%) of those referred were confirmed to be genuine deteriorations and potentially lifesaving interventions were given to those patients.

New health campaign launches ahead of winter

With winter fast approaching, the Trust is expecting an increase in patients needing support with their health, with the season traditionally triggering an increase in respiratory conditions, flu and COVID.

ELHT has been working with Trusts across Lancashire and South Cumbria to create a campaign focused on prevention, signposting and self-care to help and direct communities to find the right help at the right time and prevent illness - and ultimately, a hospital attendance.

Entitled 'Good heath starts…' the messaging reminds people of the steps they can take to look after themselves and their families, including vaccinations,

The campaign is being shared across the Trust's communications channels, in family hubs, stakeholder newsletters and other avenues.

Free flu vaccinations made available to colleagues

Colleagues are being offered a free flu vaccination as part of ongoing support for health and wellbeing.

Vaccinators are visiting sites across the Trust as well as offering drop-in sessions and pre-booked appointments to ensure the vaccine is as accessible as possible.

The team administered more than 2,200 vaccines in the first few weeks of the campaign. The flu vaccination helps to provide important protection, prevent serious illness and minimise hospitalisations during busy winter months.

National Staff Survey launched

The National NHS Staff Survey launched at the Trust on 15 September and closes on November 28. It is completely anonymous and managed by a third party on behalf of the Trust. So far, more than 36 per cent of colleagues have already responded, which is better than the same point last year and the national average.

This reflects excellent early momentum and an encouraging indicator of engagement, particularly given the operational pressures staff continue to face.

This year the Trust has worked hard on a creative and well-coordinated campaign, using an innovative and disruptive campaign entitled ‘Unmute yourself’ and harnessing the power of local champions, visible leadership support from managers and a renewed focus on divisional ownership to encourage participation.

Our ambition this year is not just to improve response rates but to deepen the quality of

engagement in what is the biggest workplace survey of its kind across the NHS — ensuring staff feel their views matter and see evidence of change connected to their experience. The survey results will be vital in shaping our cultural priorities and in identifying where continued investment in leadership and wellbeing support is most needed.

The results are expected to be published in Spring 2026.

Listening labs for colleagues

A series of listening labs are being hosted by the Executive Team to provide dedicated space for colleagues to share what’s working, what’s not and what could make their day-to-day working life better.

The sessions use a 'just one thing' approach, which means colleagues are asked just one question – “What’s the one thing that would make the biggest difference to your role?”

To ensure the sessions are focussed and remain relevant to all attendees, they are categorised into work areas such as nursing or admin and clerical with the option to take part in an open discussion as well as join anonymous interactive activity.

Action plans are being developed on the back of feedback raised in the session as part of ongoing work to listen and improve colleague experience.

Safe space sessions

Safe space sessions have been organised for all Black, Asian and Minority Ethnic (BAME) and Muslim colleagues in response to the recent rise in community tensions across the UK.

These sessions provide a confidential and supportive environment for colleagues to share their experiences, reflections and concerns, and to be heard without fear or inhibition.

The key themes will be shared with the Executive Team, followed by a feedback session where leaders will outline the actions they will take in response.

Cancer drop-in sessions for South Asian community

Cancer support drop-in sessions have been arranged at Royal Blackburn Teaching Hospital for anyone from the South Asian community who is or has been affected by cancer.

They provide opportunity for people to share experiences, find out what support is available and meet Cancer Champions Nazia and Sophia, who were appointed by Spring North to raise awareness of cancer and improve early diagnosis across Blackburn with Darwen.

The organisation is training local people to become Cancer Champions, equipping them to have open and culturally sensitive conversations about cancer and help others feel more confident accessing support.

Many people from South Asian backgrounds face barriers to early diagnosis, including stigma, language, and myths about cancer. As a result, they are less likely to attend screening appointments and more likely to be diagnosed at a later stage. This project is designed to change that by building trust and starting important conversations within communities.

Barcoding to support pathology lab

A new barcoding at source process to support the Pathology Lab has been rolled out across GP practices and is now being implemented across all wards.

This new process will significantly improve lab efficiency and assist with reducing sample rejection rates, ultimately enhancing patient experience by avoiding unnecessary repeat blood draws.

New snack menu available to support patients needing extra nutrition

A new snack menu designed to provide extra nutrition for patients who are nutritionally at risk, need additional energy or are struggling to finish full meals has been introduced.

Patients are encouraged to choose one to two of their favourite snacks to enjoy alongside their usual meals, offering additional calories to support recovery and wellbeing in a way that suits them.

Baby friendly accreditation for Paediatric Services and NICU

The Trust is one of the first in the country to achieve UNICEF Baby Friendly Initiative (BFI) Stage One accreditation for Paediatric Services.

The services were highly commended for their thorough planning and dedication to implementing the baby friendly standards.

The Neonatal Intensive Care Unit (NICU) at Lancashire Women's and Newborn Centre at Burnley General Teaching Hospital has successfully completed its UNICEF BFI accreditation – a mandatory reassessment for all services two years after their initial accreditation.

The reassessment took place over two visits in June and highlights the unit's continued commitment to delivering safe, personal and effective care for babies, mothers and their families. The assessment team praised the unit's well-educated colleagues, positive outcomes for families and the warm, supportive atmosphere created by colleagues.

The BFI is a global programme to support breastfeeding and parent-infant relationships by improving standards of care.

Star Awards winners announced

The Trust announced the winners of the Star Awards 2025 during a virtual event in September.

Colleagues were shortlisted from more than 500 nominations by a range of judges from across the Trust Board and teams in a range of settings and services in 12 categories. Each was then invited to celebrate their success and shared inspiring stories that reminded everyone why ELHT truly shines on the night.

Thousands of colleagues tuned in as part of the live event and commented on celebration posts on social media, with more watching the ceremony on catch up and commenting since then.

Colleagues from the Executive Team are currently visiting winners to present their trophies and certificates in person and have been joined by a number of special guests, including the family who nominated the winner of the patient-focused Health Hero Award.

This year's Star Awards were sponsored by Equans, Consort and Burnley General Hospital Phase V SPC Ltd.

Alfie's top dog

The Trust's therapy dog Alfie has been named overall national winner in the BBC Countryfile Magazine Dog of the Year 2025 competition.

Alfie, an apricot Cockerpoo who joined the Trust in January 2022 thanks to funding from the hospital charity ELHT&Me, beat hundreds of other beloved pups to take the lead in the national competition consider the ultimate celebration of people's much-loved pets.

Proud owners were asked to submit photos of their beloved pups across four canine categories and Alfie's handler and member of the Trust's Chaplaincy team Rachel Fielding was keen to showcase the incredible work he does with patients and colleagues across all sites.

The judging panel reviewed the entries and shortlisted five dogs in each category and the public voted for their favourite one. Alfie not only came top in his own category of Working Wonder but took overall winner too.

Blackburn Birth Centre celebrates 15 years of supporting local families

Blackburn Birth Centre marked 15 years of providing safe, personal and effective care to families across East Lancashire with a special community event.

Since opening its doors in September 2010, the centre has welcomed thousands of babies into the world in its calm, home-from-home environment.

The anniversary event included guided tours of the centre and fun activities such as garden yoga and face painting.

Kicking off landmark health research project with Blackburn Rovers

Blackburn Rovers Community Trust (BRCT) has launched a groundbreaking project to make it easier for people to be part of health and care research.

The National Institute for Health and Care Research (NIHR) has funded BRCT to deliver the scheme, titled ‘Rovers Reach’, in partnership with East Lancashire Hospitals NHS Trust (ELHT).

It will give people opportunities to take part in vital research studies at the club’s Ewood Park stadium, which will host accessible, inclusive and welcoming research opportunities throughout the week, including matchdays.

Veterans team scoops award

The Armed Forces Veteran Team were named winners at the English Veteran Awards.

The awards recognise the outstanding contributions of veterans in various fields, including business, fitness and sport, and the organisations that support the military community.

The Trust's Armed Forces Veteran Team came top in the health and wellbeing category which recognises organisations that promotes and encourages others to maintain a good heath and well-being.

So far this year the team has identified and seen over 4,000 veterans.

TODIEE Team recognised with staff development award

The Transformation, OD, Inclusion and Staff Experience and Engagement (TODIEE) Team has been recognised with a staff development award by Talogy, the organisation behind the HLM 360 leadership tool.

The team was nominated by the North West Leadership Academy for their ongoing and innovative use of the HLM 360 tool in developing colleagues and embedding it across leadership and coaching programmes.

Academic First for Midwifery and Prestigious Title for Emergency Medicine Leader

Rebecca Sessions, Consultant Midwife at ELHT, has become the first midwife in the Trust to earn a Professional Doctorate in Health.

She graduated from the University of Central Lancashire this July and her achievement marks a proud moment for maternity services across the organisation.

Her research explored how informed consent is discussed and understood during induction of labour - an area she's passionate about improving and she is already bringing the insights gleaned from her 65,000-word thesis into her work at the Trust.

Long-serving Consultant in Emergency Medicine, Dr Georgina Robertson, has also been awarded an honorary clinical professor title following 30 years of dedicated service.

Professor Robertson, Clinical Director of the Emergency Department at Royal Blackburn Teaching Hospital, was presented with the honour by Lancaster University in recognition of her remarkable career, which has included mentoring many colleagues and junior doctors over more than three decades.

ENDS

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TRUST BOARD

Meeting Date:	12 November 2025	**Agenda Item:**	TB/2025/146
Report Title:	Trust Strategy Refresh – Progress and Next Steps		
Author:	Mrs Catherine Vozzolo, Associate Director – Service Development		
Lead Director:	Mrs Kate Atkinson – Director of Service Development & Improvement		

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

Executive Summary:

The new Trust strategy is currently under development.

The first phase of engagement is to flesh out the content within each of our strategy segments with our stakeholders.

A standardised slide deck has been produced to facilitate discussions across the Trust and with external stakeholders.

The key points of our engagement -

1. We start our coproduction of our strategy with patient views and engagement, to ensure that patients are at the heart of our strategy.
2. That a number of people engage with stakeholders simultaneously in the next few weeks to seek views to input into our strategy.
3. We have deliberately kept our 'questions' to stakeholders simple and broad – at this point we want to capture as much as possible and harness some of the ambition within teams.

The next steps, after this initial engagement are

- Collate all ideas and theme these within one of the five segments of our new Trust Strategy
- Socialisation of themes for further iteration by stakeholders.
- First cut strategy drafted by December and shared for further iteration and engagement, before final sign off.

The strategy development is closely aligned to Trust planning this year, and divisional and directorate plans on a page now mirror the document segments – this will ensure we are 'well led' in terms of having clear 'true norths and board to floor strategic intent.

Once we have a final strategy signed off – a detailed launch and communications plan will be developed for the new year.

Key Issues/Areas of Concern:

- 'Headspace' - staff are managing financial recovery and operational pressures. However, this process will help

	drive some of the ambition and forward thinking back into our teams. • Capacity and pace – the timescale is very challenging and hence why we are engaging in parallel with many stakeholders. • Alignment to wider system strategies and plans, 5-year strategic commissioning plans, a system clinical strategy and neighbourhood health plans will be developed in parallel. This will require ongoing work to review and align the Trust strategy as a system partner.
Action Required by the Committee:	1. To review the proposed segments of the new strategy and 'ambition page' to confirm this captures the Board's direction of travel. 2. To provide any further feedback on the strategy engagement and plan. 3. To note progress against strategy development.

Previously Considered by:	Trust Strategy Group
Date:	Weekly meetings
Outcome:	NA

Improving health in East Lancashire

NHS
East Lancashire Hospitals
NHS Trust
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Our ELHT Strategy 2026- 2031

Safe | Personal | Effective

ELHT. *Because that's who we are*

Developing our strategy together

East Lancashire Hospitals NHS Trust
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- We are currently engaging with staff, patients and partners to co-produce our strategy for the next 5 years
- All suggestions will be themed into key priorities
- Our priorities will be aligned to national, system, regional and local priorities and policy
- This will be set out in a new single Trust strategy, supported by a smaller number of enabling plans
- Our draft strategy will be circulated for final views in January 2026 and signed off at Trust Board in February/March

Where we are in 2025.....

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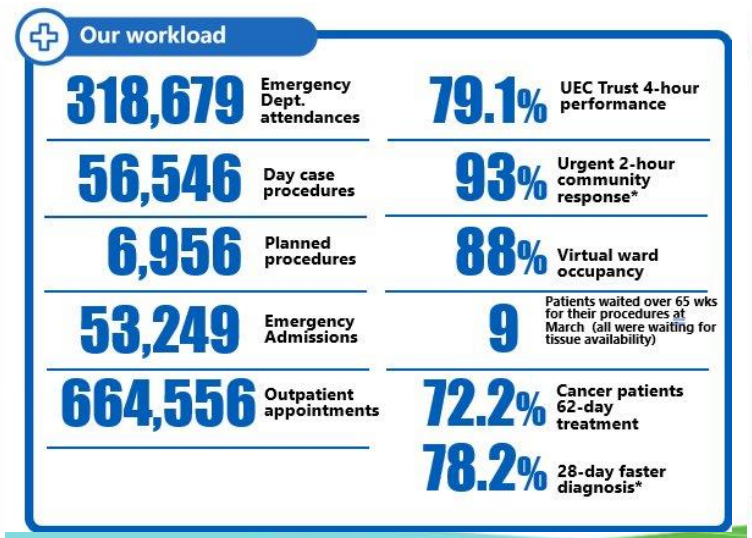
- The population we serve has increasing needs that we must respond to, resulting in increasing demand across all of our services, and we still have considerable backlogs in elective care
- We must redesign services around patient needs and continue to improve and transform using our Improvement Practice to harness staff ideas and scale up and spread improvements
- There are new national deliverables that we are required to meet set out in a new 10 Year Health Plan
- There is system change and configuration (across health and local authorities) that we need to align to
- We face a reducing budget to deliver services and there is a national drive to increase efficiency and productivity
- We have pockets within the Trust where our workforce continues to be fragile
- There are technical and digital advances that we should seize as opportunities for the future
- We should develop a compelling future within ELHT to recruit, retain and look after our staff



A Recap - ELHT's Strategic Framework

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

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

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

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

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

Our supporting strategy is the cornerstone of our Trust Strategic Framework, providing the plan and the **WHAT** – this strategy provides the details of how we will collectively support delivery of our vision and goals through a series of strategies and enabling strategies.

Our ambition for the future

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We've made real progress since launching our Trust strategy five years ago, which was focussed on the recovery and restoration of services after the Covid-19 pandemic. Every day we work together to provide safe, personal and effective care. Services have improved, teams have grown stronger, and we've made a real difference to the lives of the people we care for. But we're not stopping here. Now's the time to build on that success with a bold strategy for the next five years.

Our aim is simple: to deliver outstanding care that's clinically excellent, digitally smart and built around the real needs of our communities. Whether it's at home, in the community or in hospital, we want every person to get the right care, in the right place, at the right time. Getting this right will also ensure we get the most value out of each pound that we spend, securing our future sustainability.

We'll keep pushing boundaries through innovation, collaboration and a relentless focus on quality and safety. We'll strengthen the specialist services we're known for — while transforming care to focus more on prevention, early help and long-term health.

This strategy isn't just about systems. It's about people. It's about supporting our brilliant staff, listening to patients and working side-by-side with partners and communities to create something better — together.

Our new strategy format……

East Lancashire Hospitals NHS Trust
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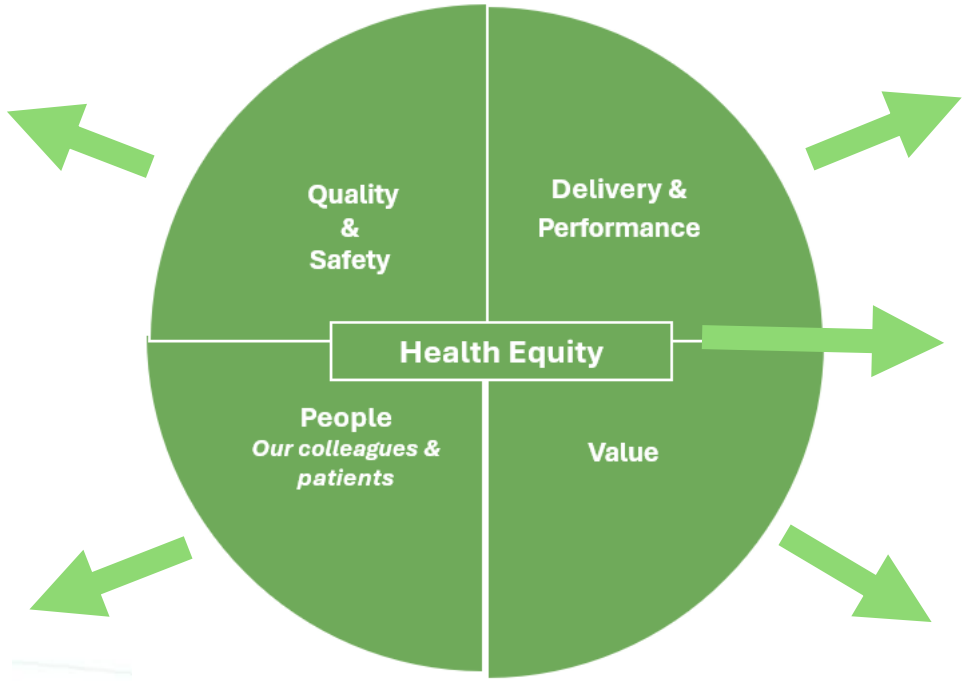
Improving Health in East Lancashire
ELHT's Strategy 2026- 2031

Our new strategy will be built around five themes and will inform a new set of Trust goals. We will describe our key aims and ambitions for each theme for the next five years, alongside a clear vision for developing our clinical and essential support services. Working with the Patient Participation Panel and stakeholders, including colleagues, we'll turn these ambitions into meaningful pledges that reflect what matters most to the people we serve.

In this section we outline what it means to achieve the highest standards of quality and safety in how we organise and deliver our services.



In this section we outline what delivering outstanding services really means and the high standards of performance we've committed to achieving for our patients.

Health Equity will run through all sections so that we put health equity at the heart of what we do to better support our local population.

In this section we will set out what it means to ensure the best possible experience for our colleagues and patients

In this section we will set out what it means to ensure that we maximise the value we get from every pound that we spend

The strategy will describe 'what' we want to achieve, and the delivery of the strategy will be described and underpinned by 5 enabling plans – one for each section.

Our ELHT strategy will also be aligned to national policy:

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Moving more care from hospitals to communities

Moving care from hospitals into homes, closer to the places people live and their community.

For ELHT this is

- **Hospital Only When Necessary**: Closer collaboration with primary care to ensure hospital visits happen only when essential.
- **Fewer Appointments, Faster Care**: Patients will need fewer outpatient visits, with more "see and treat" options for quicker diagnosis and treatment.

Making better use of technology

Using digital technology promises faster, higher-quality, more connected care.

For ELHT this is

- **Smarter Digital Access**: Enhanced digital tools to make managing healthcare and accessing information easier for patients.
- **Adopting Advanced Tech**: Adoption of frontier technologies, including AI, to streamline care and enhance safety.

Preventing sickness, not just treating it

Preventing rather than simply treating sickness will keep people healthier for longer.

For ELHT this is

- **Supporting system partners** in delivering our key prevention priorities together
- **From anchor to action**: transforming patient contact into lasting health – ensuring all patient interaction makes a difference to the long term and not just immediate care

Our Engagement Plan

The key points of our engagement plan are

1. To meet initially with public participation panel and key patient user groups - so that patients are at the heart of our strategy.
2. A number of people will engage with teams simultaneously in the next few weeks to get their input to help coproduce our strategy. *We have developed a standardised slide deck that people can take and use.
3. The slide deck includes an introduction to our current position and strategy development and then asks questions to prompt discussion and views about what should be included in the different segments of our strategy.
4. We have deliberately kept our questions simple and broad – at this point we want to capture as much as possible and harness some of the ambition within our teams.

Our identified stakeholders

- Local schools
- Other health providers
- Education – colleges etc
- Private sector
- Registered bodies – GMC etc.

- PLACE partners
- NHSE
- CQC
- Provider Collaborative
- Regulators
- GPs
- Suppliers
- Social Care – adult and children
- NWAS

- Our colleagues / staff (all groups)
- Unions
- MPs
- Our patients
- Patient user groups / PPP / MNUP etc
- ICB / commissioning colleagues
- PCB
- Clinical networks
- Government
- NOF RSP team
- Coroner

- The general public
- Schools and education
- Voluntary agencies
- Councillors
- Press/journalists/media
- Local authorities
- Carers and Carer voices
- UKAS

Progress to Date

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- Trust Board / Senior Leadership Group joint strategy sessions held on 13th August and 8th October 2025
- A detailed engagement plan has been designed to ensure that all stakeholders are involved in developing our strategy so that it is truly coproduced.
- To date, a meeting has taken place with our Patient Participation Panel – to ensure that patient's voices are at the heart of our strategy. In addition, executive 121s and sharing of a standardised slide deck/workshop questions for discussion with meetings across and external to the Trust.
- Key priorities are beginning to be identified by stakeholders – these will be collected through the engagement phase and grouped/themed for further socialisation and review.
- A joint council/ICB/Trust alignment session is planned for week of 3rd November to join key priorities with our partners.
- A draft 'skeleton' document has been designed by the Trust Strategy Group – awaiting the content and details to be added in once engagement is completed.

Next steps

- Engagement will continue during November – with all stakeholders, groups, patients and our staff
- All suggestions and comments will be themed and placed within one of the five segments of the Strategy
- An initial draft of themes and proposed objectives will be socialised with stakeholders again for further iteration
- A first draft strategy will be prepared by December – which can then be socialised across stakeholders and with the Trust Board
- A final strategy will be presented to Trust Board January/February for sign off
- Launch of the new strategy will take place February/March ready for the new financial year from 2026/7 onwards.

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TRUST BOARD

Meeting Date:	12 November 2025	**Agenda Item:**	TB/2025/147
Report Title:	Financial Performance Report Month 6 2025-26		
Author:	Mr M Greatrex, Interim 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:	At month 6, the Trust is reporting an in-month deficit of £5.34m, against a planned deficit of £3.54m; £1.8m behind the plan. The year-to-date (YTD) position is a £35.2m deficit against a planned deficit of £28m; £7.3m behind plan (includes the original WRP plan and excludes the DSF). The WRP delivered £2.9m in month which is £1.8m behind the revised plan. (£2.2m adverse to the original PFR plan). The WRP has delivered £18.4m YTD which is £3m behind the revised plan; however, this is £5.9m adverse to the original PFR YTD plan. **Key Metrics** Agency spend of £0.5m, is £0.2m better than plan and represents a 59% reduction on 2024/25 run rate. Bank spend of £3.5m is £0.1m favourable to plan, this represents a 21% reduction on 2024/25 run rate. The cash balance at the end of September was £13.0m, an increase of £2.4m compared to M5. The annual 2025-26 capital plan is £40.6m at M6, YTD spend is £12.7m, £2.5m ahead of plan. Worked/Paid WTE have reduced 2 WTE from Month 5 to 9,685.
Key Issues/Areas of Concern:	The Trust's financial plan for 2025/26 is break-even, including £43.3m deficit support funding (DSF) that is subject to delivery of the plan. The key risks associated with delivery of the plan include: Full delivery of the Waste Reduction Programme of £60.8m on a recurrent basis. Cash flow forecasting indicates a significant challenge by M10 2025. Divisional pressures to be contained within the agreed budgets/ plan. The finalised impact of the HCA review of banding inclusive of the associated timescales for both cash and revenue.

	The financial impact of any further industrial action. The impact of Deficit Support Funding being withheld (cash and delivery of plan).
Action Required by the Committee:	Note the content of the report.

Previously Considered by:	Finance and Performance Committee
Date:	27 October 2025
Outcome:	Noted

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M06 Financial Performance Trust Board

12th November 2025

Month 6 Key Headlines

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Summary of Financial Position

- In month **deficit of £5.34m**, against **deficit plan of £3.54m** therefore **£1.8m behind the plan**.
- YTD **deficit of £35.2m** against the PFR deficit plan of £28m therefore **£7.3m behind plan** (includes the original WRP plan and excludes DSF).
- In month **WRP delivered £2.9m** against the WRP Delivery plan, therefore **£1.8m adverse to the reprofiled plan** (£2.2m adverse to PFR plan)
- YTD **WRP delivered £18.4m** against the WRP Delivery plan, therefore **£3m behind the reprofiled plan** (£5.9m adverse to PFR YTD plan of £24.3m) **note 30% of annual plan delivered in H1 leaving 70% to be delivered in H2**
- **Cash balance** at the end of September was **£13.0m**, an increase of £2.4m compared to M5 cash position of £10.6m.
- **Capital** Plan 2025-26 is £40.6m. At M6, spend is **£12.7m**, £2.5m ahead of plan.
- Paid/worked WTE have reduced 2 WTE from Month 5 to **9,685**

M6 Plan vs Actual

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Monthly Actuals	Current Month Plan	Current Month Actual	Variance to Plan
	£000	£000	£000
Operating Income: Patient Care	63,870	64,922	1,052
Other Operating Income	3,890	4,951	1,061
Total Income	**67,760**	**69,873**	**2,113**
Substantive	(41,901)	(43,334)	(1,433)
Variable Pay: Overtime	(43)	(32)	10
Variable Pay: WLI / Extras	(355)	(776)	(421)
Variable Pay: Bank	(3,547)	(3,468)	79
Variable Pay: Agency	(511)	(323)	188
Other Staff Costs	(195)	(162)	33
Total Pay	**(46,552)**	**(48,096)**	**(1,544)**
Supplies & Services Clinical	(3,700)	(4,991)	(1,291)
Drugs	(4,493)	(4,499)	(6)
Other Non Pay	(11,325)	(12,505)	(1,180)
Total Non Pay	**(19,518)**	**(21,995)**	**(2,477)**
Total Expenditure	**(66,070)**	**(70,090)**	**(4,020)**
Net Expenditure	**1,690**	**(218)**	**(1,908)**
Non Operating Movements	(436)	(407)	(29)
Operating Surplus (Deficit)	**1,254**	**(625)**	**(1,879)**
Other Non Operating Movements	(1,179)	(1,108)	(71)
Adjusted Financial Performance Surplus (Deficit)	**75**	**(1,733)**	**(1,808)**
Deficit support Funding	(3,610)	(3,610)	0
Adjusted Financial Performance Surplus (Deficit) Excluding DS	**(3,535)**	**(5,343)**	**(1,808)**

	£m	Recurrent	Non-Recurrent
Income Plan	67.8		
Offset (HCD/Clear)	0.7	x	
ERF	0.8		x
CPD	0.6		x
Income Actual	69.9		

	£m	Recurrent	Non-Recurrent
Pay Plan	46.6		
Bank Holiday Benefit	-0.15	x	
Pay Pressures/Pension	0.24	x	
Underdelivery WRP	1.45	x	
Pay Actual	48.10		

	£m	Recurrent	Non-Recurrent
Non-Pay Plan	19.5		
Offset by Income	0.72	x	
Consultancy Pressure	0.27	x	
PFI Pressure	0.22	x	
Theatres	0.11	x	
Utilities	0.16	x	
Other	0.10	x	
Underdelivery WRP	0.90	x	
Non-Pay Actual	22.00		

Drivers of variance YTD

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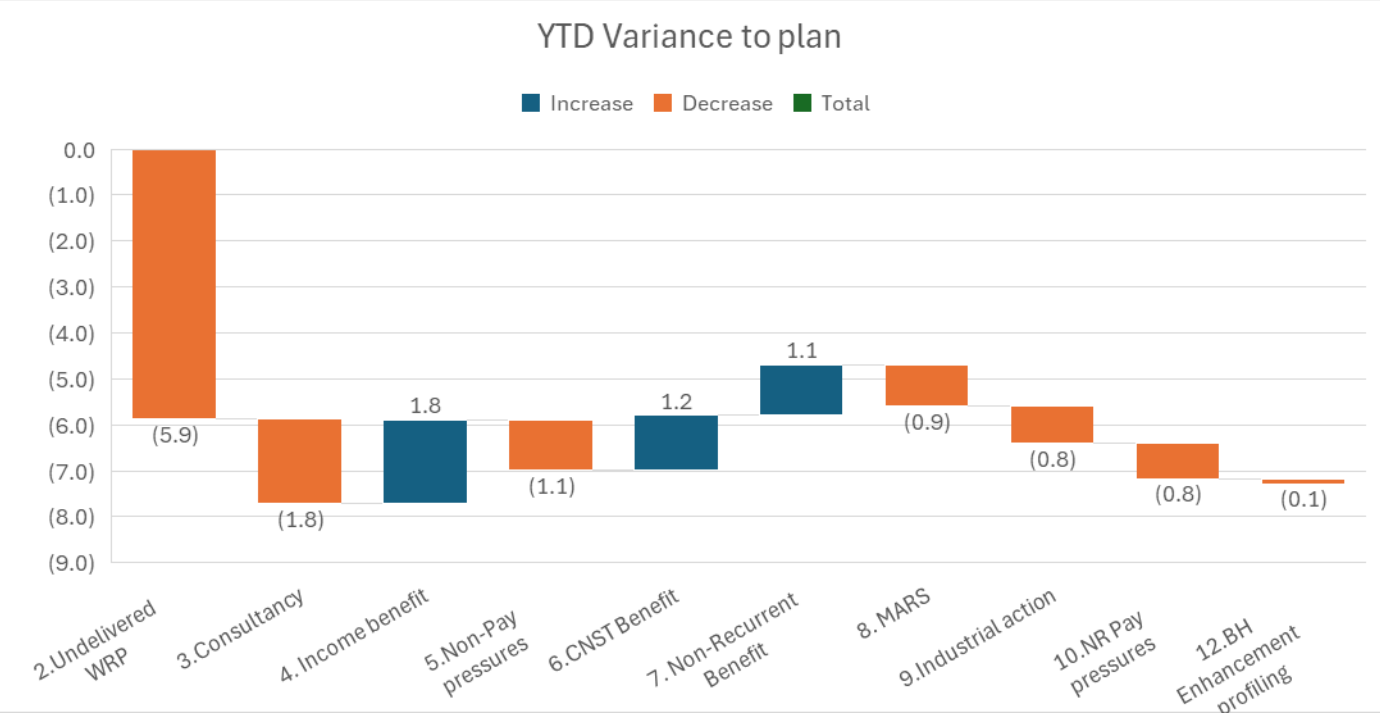

1. **YTD Plan** £28m Deficit
2. **Undelivered WRP** pressure £5.9m
3. **Consultancy** pressure £1.8m
4. **Income** benefit £1.8m (ERF, CPD and Variable income)
5. **Non-pay** pressures £1.1m (PFI, Stocks, Utilities)
6. **CNST** one-off benefit £1.2m
7. **NR HCA Income** benefit £1.1m
8. **MARS** pressure £0.9m
9. **Industrial Action** pressure £0.8m M04
10. **NR Pay** Pressures £0.8m, backdated pay and pension opt-in
11. **Bank Holiday profiling** pressure £0.1m
12. **M6 Actual** £5.3m Deficit

WRP – Performance

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	M6 Performance				WR & FIP Annual Target 2526	YTD Performance					
Division	Actual	Plan	Variance	% Var		YTD Delivered	YTD Target Plan	Variance	% Varr.	Recurrent YTD Act.	Non-Recurrent YTD Act.
MEC	1,140	1,277	-137	-11%	13,870	£5,758	£5,638	£120	2%	£5,025	£733
SAS	1,508	1,263	245	19%	13,420	£3,209	£4,425	-£1,215	-27%	£1,909	£1,300
FCD	-93	737	-830	-113%	7,600	£547	£3,151	-£2,604	-83%	£544	£3
DCS	634	814	-180	-22%	9,710	£2,779	£4,174	-£1,395	-33%	£2,475	£304
CIC	-370	250	-620	-206%	4,920	£360	£1,529	-£1,169	-76%	£334	£26
CORP	28	38	-10	-173%	3,060	£1,104	£1,008	£96	10%	£1,104	£0
Est.	64	120	-56	-54%	3,290	£814	£683	£131	19%	£814	£0
DERI	5	5	0	-3%	1,070	£6	£7	£0	-3%	£6	£0
Onelsc	34	200	-166	-89%	3,850	£436	£910	-£474	-52%	£436	£0
ALL	-62	0	-62	13617491%	0	£3,370	£0	£3,370	-190384269%	£0	£3,370
ELHT Total	**2,888**	**4,705**	**-1,817**	**-39%**	**60,790**	**£18,384**	**£21,523**	**-£3,140**	**-15%**	**£12,648**	**£5,736**

Note: YTD 30% of the full year WRP plan has been delivered leaving 70% to be delivered in H2

Key Risks

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Key Risks

The Trust's financial plan for 2025/26 is **break-even,** including £43.3m deficit support funding (DSF) which is **subject to achievement of the plan**. The key risks associated with delivery of the plan will be monitored and reported monthly, they are:

- Full delivery of the **Waste Reduction Programme of £60.8m** is required.
- The impact of the **withholding of Deficit Support Funding** if the system/ Trusts are not delivering the financial plan. This will impact income and cash as well as delivery of the financial plan. M7 DSF has been agreed, however there is no confirmation for **Months 8-12.**
- Cash flow forecasting is signalling cash will become a significant challenge by **Month 10 2025 and will be heavily impacted by the receipt or withholding of DSF**.
- **Divisional positions to be within budget**, and all pressures contained within the funding available in the plan.
- The financial impact of the **HCA review of banding** inclusive of the associated timescales for both cash and revenue. The impact of the prospective position is currently under review.
- The financial impact of any **further industrial action**
- The risk of an **Activity management plan (APM**) impacting ERF assumptions and overperformance of activity.

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2025-26 Cashflow Forecast

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Cash Flow Forecast	M07	M08	M09	M10	M11	M12	M1	M2	M3	M4	M05	M06
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Opening Cash Balance	**12,954**	**14,955**	**9,972**	**2,949**	**3,029**	**2,842**	**3,077**	**3,077**	**3,077**	**3,077**	**3,077**	**3,077**
Cash Inflows												
Capital PDC funding	-	1,080	1,731	3,754	3,754	4,287	-	-	-	-	-	-
Other capital funding	2,032	2,032	2,032	2,032	2,032	2,765	2,000	2,000	2,000	2,000	2,000	2,000
ICB and NHSE income	75,418	68,178	68,165	68,163	71,779	67,454	72,500	72,500	72,500	72,500	72,500	72,500
Other NHS and non-NHS income	4,383	3,068	3,070	3,118	3,118	4,933	3,500	3,500	3,500	3,500	3,500	3,500
VAT	2,137	1,500	1,500	1,500	1,500	1,500	1,750	1,750	1,750	1,750	1,750	1,750
PDC revenue support	-	-	-	-	-	15,300	-	-	-	-	-	-
Interest	167	167	167	167	167	167	150	150	150	150	150	150
Total Inflows	**84,137**	**76,024**	**76,665**	**78,733**	**82,349**	**96,406**	**79,900**	**79,900**	**79,900**	**79,900**	**79,900**	**79,900**
Cash Outflows												
Capital Expenditure	(4,875)	(3,615)	(3,779)	(5,802)	(5,802)	(6,546)	(2,000)	(2,000)	(2,000)	(2,000)	(2,000)	(2,000)
Salaries	(32,902)	(32,983)	(32,959)	(32,370)	(30,784)	(30,746)	(31,000)	(31,000)	(31,000)	(31,000)	(31,000)	(31,000)
PAYE/NIC/Pension Benefits	(21,682)	(21,737)	(21,721)	(21,248)	(21,257)	(21,232)	(21,500)	(21,500)	(21,500)	(21,500)	(21,500)	(21,500)
NHS Litigation Authority Contributions	(2,625)	(2,625)	(2,625)	(2,625)	(100)	(100)	(2,400)	(2,400)	(2,400)	(2,400)	(2,400)	(2,400)
Other NHS Purchase Ledger Payments	(3,296)	(3,296)	(3,296)	(3,296)	(3,296)	(3,296)	(3,000)	(3,000)	(3,000)	(3,000)	(3,000)	(3,000)
Non-NHS Purchase Ledger Payments	(16,755)	(16,751)	(19,307)	(13,310)	(21,296)	(34,250)	(20,000)	(20,000)	(20,000)	(20,000)	(20,000)	(20,000)
Total Outflows	**(82,135)**	**(81,008)**	**(83,688)**	**(78,652)**	**(82,536)**	**(96,172)**	**(79,900)**	**(79,900)**	**(79,900)**	**(79,900)**	**(79,900)**	**(79,900)**
Net Cash Flow	**2,001**	**(4,984)**	**(7,023)**	**81**	**(187)**	**235**	**-**	**-**	**-**	**-**	**-**	**-**
Closing Cash Balance	**14,955**	**9,972**	**2,949**	**3,029**	**2,842**	**3,077**	**3,077**	**3,077**	**3,077**	**3,077**	**3,077**	**3,077**

Key points and cash forecasting assumptions

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- The Trust received DSF in M7 but awaits confirmation for the remainder of Q3. However, with the risk adjustment forecast deficit position increasing, the Trust is forecasting to require Provider Revenue Support PDC from January 2026.
- With the YTD deficit position, robust treasury management is required and as a result the management of payments to suppliers is becoming more challenging.
- The total value of approved invoices being withheld has increased in month and is likely to increase further during the remainder of Q3 and significantly so, should DSF not be received in months 8 and 9.
- Any applications to receive temporary Provider Revenue Support PDC as working capital to support liquidity will require approval from the Trust Board of Directors together with evidence of demonstrable action taken by the Board to delivery the 2025/26 plan.
- A significant proportion of the Trust's Capital Programme is supported by Public Dividend Capital, which is capital related cash that can only be spent on capital items/projects and must be spent by the end of the financial year but not drawn down in advance of need. It is therefore important that the capital programme is managed effectively including accurately forecasting what can be spent in year.

Statement of Financial Position

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	As at 31st March 2025 £000	As at 30th September 2025 £000	Year to date movement £000	Prior month £000	In-month movement £000
Assets:					
Intangible assets	19,168	17,736	(1,432)	18,107	(371)
Property, plant and equipment	266,094	265,084	(1,010)	265,024	60
Right of use assets	31,946	34,781	2,835	36,415	(1,634)
Inventories	11,310	11,182	(128)	11,121	61
Receivables (NHS)	17,592	21,400	3,808	21,265	135
Receivables (non-NHS)	19,605	24,255	4,650	24,638	(383)
Cash and cash equivalents	16,786	12,954	(3,832)	10,569	2,385
Total assets	382,501	387,392	4,891	387,139	253
Liabilities:					
Trade and other payables (capital)	(6,418)	(4,044)	2,374	(4,482)	438
Trade and other payables (non-capital)	(71,452)	(85,868)	(14,416)	(83,028)	(2,840)
Lease related liabilities	(32,433)	(35,510)	(3,077)	(37,111)	1,601
PFI related liabilities	(228,045)	(221,433)	6,612	(222,109)	676
Provisions for liabilities and charges	(3,439)	(3,481)	(42)	(3,444)	(37)
Other liabilities: deferred income	(13,693)	(10,273)	3,420	(12,708)	2,435
Total liabilities	(355,480)	(360,609)	(5,129)	(362,882)	2,273
Total assets employed	27,021	26,783	(238)	24,257	2,526
Financed by taxpayers equity					
Public dividend capital	332,933	337,073	4,140	333,923	3,150
Revaluation reserve	21,711	21,712	1	21,712	0
Income and expenditure reserve	(327,623)	(332,002)	(4,379)	(331,378)	(624)
Total taxpayers equity	27,021	26,783	(238)	24,257	2,526

The cash balance on **30th September** was £13.0m, an increase of £2.4m compared to the previous month.

The main reason for this movement is the receipt of **£3.2m** of capital PDC funding which is expected to be utilised in M7 with a £2.8m increase in payables offset by a £2.4m reduction in deferred income.

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Capital forecast	2025-26	M06 YTD			M07	M08	M09	M10	M11	M12	2025-26
	Plan	Plan	Actual	Variance	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Internally funded											
Donated assets	500	252	-	(252)	42	42	42	42	42	1,599	1,809
PFI lifecycle costs	3,604	1,800	2,845	1,045	474	474	474	474	474	475	5,690
CHP ROU assets	4,656	4,656	5,849	1,193	-	-	-	-	-	-	5,849
Other ROU assets (intra-DHSC group)	12	12	-	(12)	-	-	-	-	-	12	12
Other ROU assets	6,332	-	1,379	1,379	-	-	-	-	-	3,760	5,139
Other internally funded schemes	6,889	3,432	1,787	(1,645)	260	260	260	260	260	258	3,345
Externally funded											
UEC #2	-	-	-	-	-	-	-	700	700	825	2,225
Net Zero	1,980	-	826	826	330	330	494	-	-	-	1,980
Diagnostics	1,435	-	-	-	-	-	-	480	480	475	1,435
Electiive Recovery	1,044	-	-	-	-	-	-	348	348	348	1,044
UEC	5,749	-	-	-	-	-	-	989	989	988	2,966
Estates Safety	757	-	-	-	-	150	150	150	150	157	757
RAAC	-	-	-	-	2,497	357	357	357	357	354	4,279
IT		-	-	-	-	-	-	-	-	410	410
Funding to replace use of cash reserves	-	-	-	-	-	730	730	730	730	730	3,650
Total	**32,958**	**10,152**	**12,686**	**2,534**	**3,603**	**2,343**	**2,507**	**4,530**	**4,530**	**10,391**	**40,590**

Capital

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- The Trust's **Capital Programme for 2025-26 has reduced by £1.7m to £40.6m** due to the expected deferral of £2.8m of PDC funding for the Emergency Village reconfiguration scheme into 2026-27.
- The impact of this change is partially offset by the addition for £0.4m of PDC funding for IT related capital schemes and an expected £0.6m increase in donated assets.
- We have yet to receive confirmation of funding for the £7.9m of other PDC funded schemes.
- Of the £11.0m included for right of use asset (ROU) related spend which matches the allocation from the ICB, £9.6m has been identified for specific schemes year to date, the Trust has recognised **£12.7m** of capital expenditure, consisting of **£6.9m of right of use assets related spend and £2.9m of PFI lifecycle related** spend with most of the remaining balance spent on Estates related schemes.
- This represents an overspend of **£2.5m against plan with the £2.6m of ROU asset and £1.0m of PFI lifecycle spend recognised ahead of plan** offsetting slippage elsewhere. The Trust is forecasting that it will meet the Capital Plan and will refine its capital forecast over the coming months as plans for PDC funded spend are confirmed.

Glossary

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Better Payment Practice Code (BPPC) - *The requirement of the BPPC is to pay 95% of undisputed, valid invoices within 30 days of receipt. The 95% is in terms of value and volume of invoices.*

Deficit Support Funding (DSF) - *Non recurrent funding to allow trusts to deliver a breakeven position in 2024-25*

Elective Recovery Fund (ERF) – *Additional funding received by the trust to deliver 107% of pre-pandemic elective activity (elective activity being outpatient new, outpatient procedures, day cases and electives).*

Goods Received Not Invoiced (GRNI) - *refers to a situation where the trust has received goods but hasn't yet received the corresponding invoice from the supplier, necessitating a temporary accounting entry to track the liability until the invoice arrives.*

IFRS – *International Financial Reporting Standards constitute a standardised way of describing Trusts/company's financial performance and position so that company financial statements are understandable and comparable across international boundaries.*

IFRS16 Right of Use Assets – *Following the change in accounting standards, the trust must recognise and capitalise the appropriate leases through the balance sheet, where previously is was recognised through revenue only.*

Glossary

PDC Public Dividend Capital *represents the Department of Health's (DH's) form of funding to NHS Providers. The DH is expected to make a return on its net assets, including the assets of NHS trusts, of 3.5%.*

PDC Provider Revenue Support *- Revenue Support PDC is available to support revenue expenditure for cash-distressed providers for necessary and essential expenditure to protect continuity of patient services* **Waste Reduction & Finance Improvement Programme** (WR & FIP) – this is the terminology for the efficiencies required by the trust. (previously referred to as CIP / WRP) Waste Reduction is achieved when the actual run rate is reduced

Run Rate – Refers to the income and expenditure trend for an organisation at the end of a defined financial period. In this case we use the NHS financial year (24/25 Inflated for 25/26 prices)

Normalised Run rate - The Normalised Run rate removes any non-recurrent pressures/benefits , any technical gains and any rephasing of income or expenditure such as pay awards to the month it relates to.

Exit Run Rate - Recurrent run rate income and expenditure trend for an organisation at the end of a defined financial period. In this case we use the NHS financial year, and the exit run rate is defined by the position on 31 March 2025 excluding non-recurrent income/expenditure and the full year effect of income/expenditure.

Provider Financial Return (PFR) – Monthly financial monitoring NHSE return

Financial Planning Return (FPR) – The yearly financial plan template set out by NHSE.

Waste Reduction Programme (WRP) – The Trusts efficiency programme

High-Cost Drugs (HCD) – High-cost drugs are pass through in nature

TRUST BOARD

Meeting Date:	12 November 2025	**Agenda Item:**	TB/2025/148
Report Title:	Integrated Performance Report		
Author:	Stephen Dobson		
Lead Director:	Sharon Gilligan		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	x	x		x
Executive Summary:	The Board are directed towards the following sections: • **Safe** – Infection Control, Staffing, Harm Free • **Caring** – Feedback • **Effective** – Mortality • **Responsive** – A&E, RTT, Cancer, Length of Stay, Cancellations • **Well Led** – Finance, Workforce			
Key Issues/Areas of Concern:	The Board are directed towards the following issues of concern: **Safe:** **Staffing** - Overall RN fill rates: Days 92.01%, Nights 96.17%. 20 clinical areas below 90%. **Infection Prevention** - There has been an increase in the number of COVID +ve patients and COVID outbreaks on in-patient wards. These outbreaks are being monitored daily. Communication around COVID testing, frequently asked questions and correct isolation guidance has been reviewed and published on OLI. **Caring:** **Patient Experience –** Whilst the Trust has seen a reduction in complaints rates per 1000 patient contacts remain low. However, at the time of producing the report the Trust had 128 active complaints. **Friends and Family Test (FFT):** A&E remains at 75%, in line with national average but below other services. **Responsive:** **FDS Performance** – Performance was challenged following the impact of staff leave in August. There are several improvements initiatives planned, with targeted actions to strengthen the FDS element of the cancer pathway. These will help recovery of performance **RTT >52 Weeks** – Performance continues to be below trajectory; however, delivery of the agreed recovery plan remains on track to return to plan by December 2025, with all 65-week breaches forecast to be cleared.			

	UEC – 12-hour Waits – The number of patients waiting over 12 hours remains a concern, although improvement has been observed. There is a dedicated improvement plan in place for UEC and the implementation of the pathway redesign, this is expected to deliver a sustained reduction in long waits and improve patient experience**.** **<u>Finance</u>:** **Month 6 position** reports a **£1.7m deficit**, £1.8m behind plan (excluding DSF). The **Waste Reduction Programme (WRP)** has delivered **£18.4m** YTD, £5.9m behind plan, with mitigating actions being implemented. **Cash** remains stable at **£13.0m**, though system and winter pressures pose ongoing risk. **<u>Workforce</u>:** **Sickness absence:** Absence remains high, but has reduced in M6: - 6.63% inc. OneLSC (6.70% in M5) - 6.20% excl. OneLSC (6.24% in M5) - **Appraisal**: Agenda For Change – 79%, behind target of 90% **Information Governance** is behind the required 95% compliance rate, at 91%.
Action Required by the Committee:	Directors are requested to note the attached report for assurance

Previously Considered by:	Finance and Performance Committee People and Culture Committee
Date:	27 October 2025 3 November 2025
Outcome:	

Integrated Performance Report

Published: October 2025

Safe | Personal | Effective

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

Contents

East Lancashire Hospitals NHS Trust
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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

East Lancashire Hospitals NHS Trust
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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.
17% of our metrics are consistently achieving target
31% of our metrics are inconsistently achieving target
17% of our metrics are not achieving target, however 6 of these are showing special cause improvement.
35% of our metrics do not have a target currently set.

Variation \ Assurance	Achieving target	Inconsistently achieving target	Not achieving target	No target set
Special cause improvement	Safeguarding children training, Turnover	Avg fill RN (day), A&E 4hr, Over 12hr TiD % (type 1), 31d cancer	VTE, RTT % >52wks, RTT < 18wks treatment, <18wks for 1st appt, Appraisal (AFC), Agency spend	Crude Mortality rate, In hospital deaths, Cancelled on day ops, % handovers >30 mins, Avg arrival to handover, Maximum arrival to handover, Income run rate, Handovers > 45 mins
Common cause	Avg fill care staff (day & night), Inpatient, Community, Outpatient F&F, Appraisal (consultant & other medical)	MRSA, CHPPD, Maternity F&F, 28d cancer, 62d cancer, Variance to planned performance, WRP, BPPC x 2, Variance to capital programme	Wards <90% RN day fill, A&E F&F, IG training, Sickness	C diff, E coli, Pseudomonas, Klebsiella, Stillbirths, 62d urgent cancer GP, Emg avg LOS, % occupied 7+, 14+ & 21+
Special cause concern	Avg fill RN (night), Complaints	Nursing red flags, Cancelled on day not rebooked in 28d, Vacancy, BPPC x 2, Liquidity days		A&E Attendances, Bed occupancy, Employee expenses run rate, Other operating run rate

SAFE - Summary Scorecard

East Lancashire Hospitals NHS Trust
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METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
AVERAGE FILL RATE REGISTERED CARE STAFF (DAY)	SEPT 25	98.59	90.00		P
AVERAGE FILL RATE REGISTERED CARE STAFF (NIGHT)	SEPT 25	110.00	90.00		P
AVERAGE FILL RATE REGISTERED NURSES (DAY)	SEPT 25	92.01	90.00	H	?
AVERAGE FILL RATE REGISTERED NURSES (NIGHT)	SEPT 25	95.59	90.00	L	P
MRSA	SEPT 25	0.00	0.00		?
PATIENTS RISK ASSESSED FOR VENOUS THROMBOEMBOLISM	SEPT 25	90.70	95.00	H	F
NATIONAL NURSING RED FLAGS	SEPT 25	10.00	0.00	H	?
WARDS <90% REGISTERED NURSE (DAY) FILL RATE	SEPT 25	16.00	0.00		F
CARE HOURS PER PATIENT DAY (CHPPD)	SEPT 25	7.91	8.00		?

METRIC	LATEST DATE	VALUE	VARIATION
REGISTERED NURSE AGENCY SPEND	SEPT 25	20106.18	L
REGISTERED NURSE BANK SPEND	SEPT 25	1020742.07	L
MEDICATION ERRORS CAUSING LOW HARM AND ABOVE	SEPT 25	40.00	
SLIPS TRIPS AND FALLS CAUSING LOW HARM AND ABOVE	SEPT 25	76.00	

Alert

During September 2025 overall Nurse staffing was achieved at trajectory for RN and Care Support workers.
16 clinical areas were below the fill rate of 90% for the month of September 2025 during day shifts. Of which 2 ward fell below 80% fill rate, this relates to unexpected unavailability and movement of co-ordinators.
4 clinical areas were below the fill rate of 90% for the month of September 2025 during night shifts in the Family Care Division. These were all due to unexpected unavailability and services are diverted to the Burnley Birth Centre or Birth Suite- which does not reflect in the fill rate %, and a reduction in activity on the children's unit.
Nursing red flags for September 2025 was 3, due to delays in intentional rounding and delay of more than 30 mins in providing pain relief.. There were no patient harm as a result for this but could result in poor patient experience. Midwifery National NICE red flags for September 2025 was 12.
There has been an increase in the number if Covid positive in-patients and Covid outbreaks, there are currently 6 outbreaks. The IPC team visit the ward/department when the outbreak is declared giving advice on PPE & a PPE station is available at the entrance of the ward/department, correct isolation in place, appropriate signage is displayed and staff are following the correct guidance. The outbreaks and number of positive cases are monitored daily and the information
cascaded internally. Communication around Covid testing guidance and frequently asked questions have been drafted and are due to be published on OLI.
Reported pressure ulcer incidents decreased from 65 in August to 45 in September, and moisture-associated skin damage incidents reduced from 74 to 65 over the same period. From 15 September 2025, the uploading of clinical photography alongside incident reports became a mandatory requirement. While this reduction in numbers is positive, it may be influenced by the new reporting process, and therefore ongoing scrutiny will be maintained to ensure data accuracy and continued quality monitoring.

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.
An infestation of flies was observed on ward B2, the patients were transferred to ward C2 and the ward closed. Pest control carried out fogging on the 14th October, the external site was inspected and work is being undertaken to remove foliage.
The ward will be monitored for 72 hrs, If there is no further evidence of flies the ward will re-open on Monday 20th October.
The Trust's assessment and documentation of Pressure Ulcer audits is ongoing, with current compliance remaining below the target range of 70-85%. Staff have been reminded of the importance of completing all relevant risk assessments within four hours of patient admission.

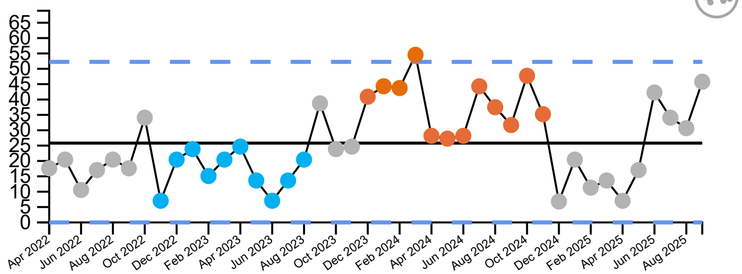
Assurance

The overall percentage fill rate for RNs for days was 92.01% and nights was 95.59%. The overall percentage fill rate for CSW for days was 98.59% and nights was 110%.
Compliance with Pressure Ulcer (90.6%) and Moisture-Associated Damage (90.8%) e-learning remains moderately high. This is continually by the Pressure Ulcer Steering Group to support sustained improvement and ongoing staff education.
There have been no further cases of CPO detected following the outbreak on Critical Care side A. An outbreak meeting was held on the 26th September with external partners, no further meetings are required unless we have further positive patients identified from contact tracing, this is monitored daily.

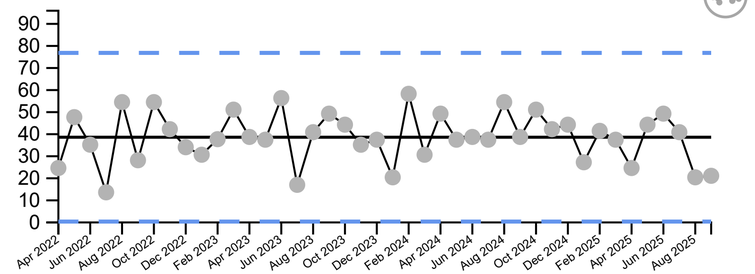
SAFE - Infection Control

East Lancashire Hospitals NHS Trust
A University Teaching Trust

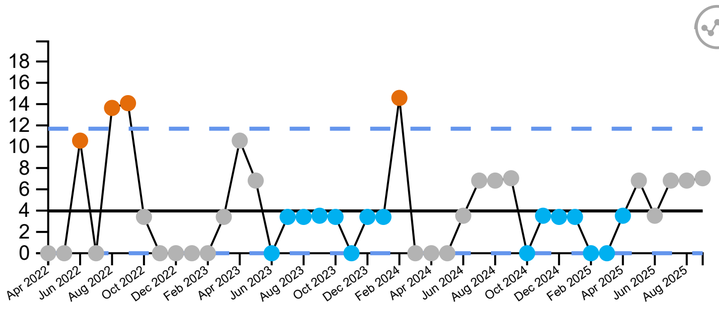
C diff per 100000 bed days rate



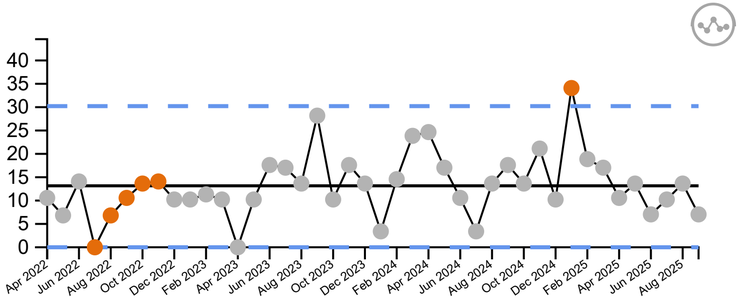
Ecoli per 100000 bed days rate



Pseudomonas per 100000 bed days rate



Klebsiella per 100000 bed days rate



C diff

In month	YTD	Same time last year
13	51	48

E coli

In month	YTD	Same time last year
6	58	63

Klebsiella

In month	YTD	Same time last year
2	18	20

Pseudomonas

In month	YTD	Same time last year
2	10	5

MRSA

In month	YTD	Same time last year
0	2	1

SAFE - Staffing

East Lancashire Hospitals NHS Trust
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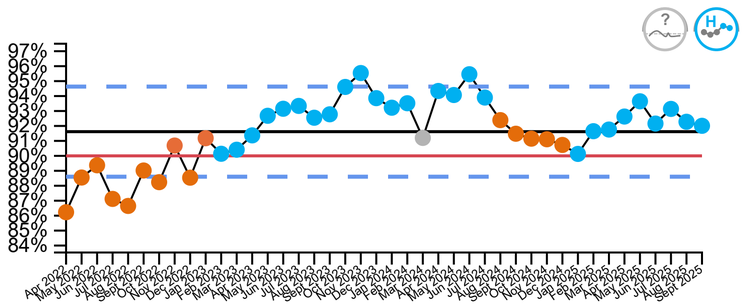
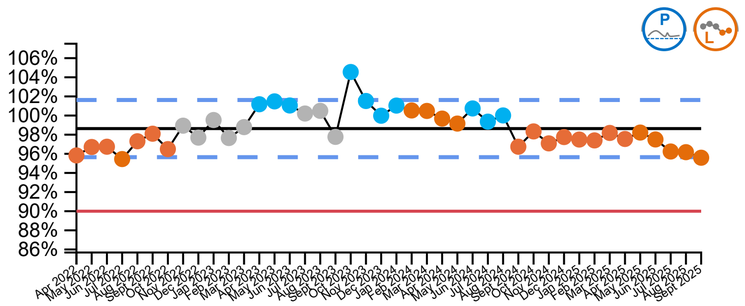
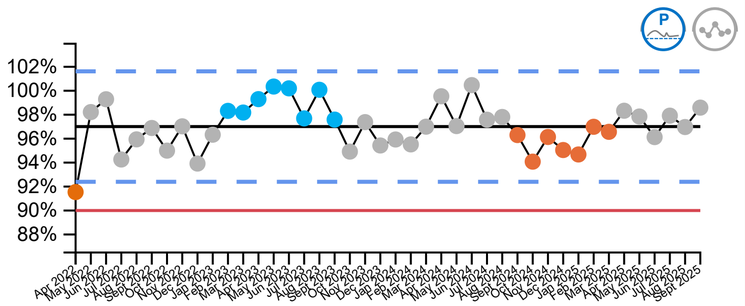
Average fill rate registered nurses (day)



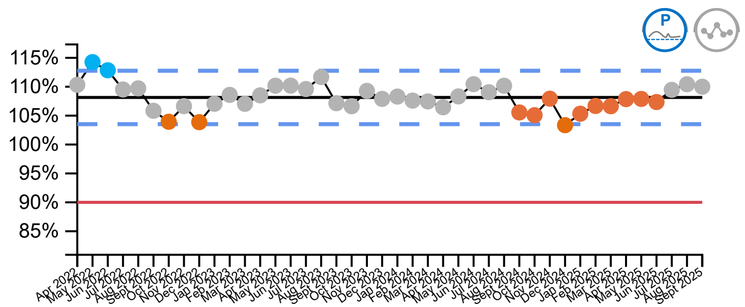
Average fill rate registered nurses (night)



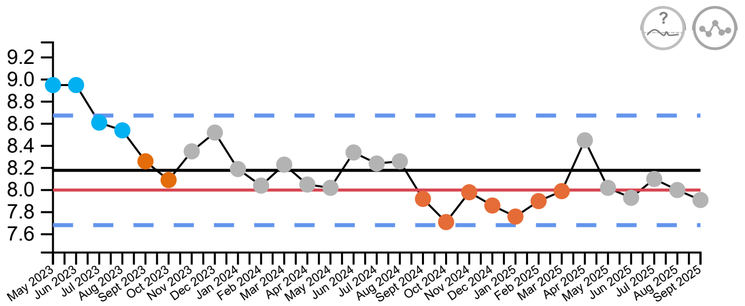
Average fill rate registered care staff (day)



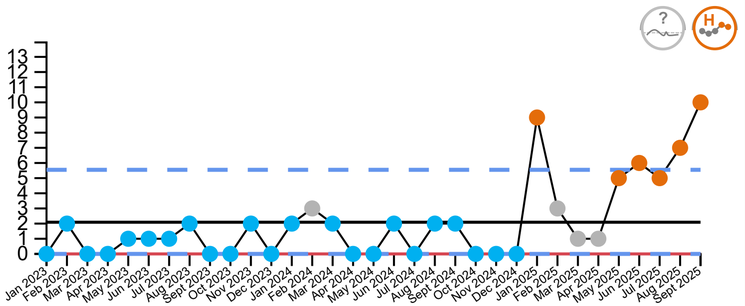
Average fill rate registered care staff (night)



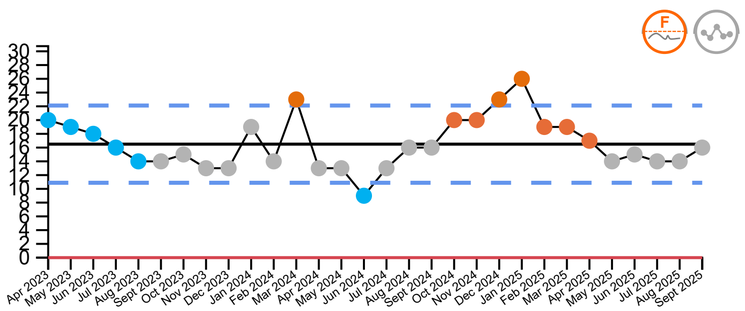
Care hours per patient day (CHPPD)



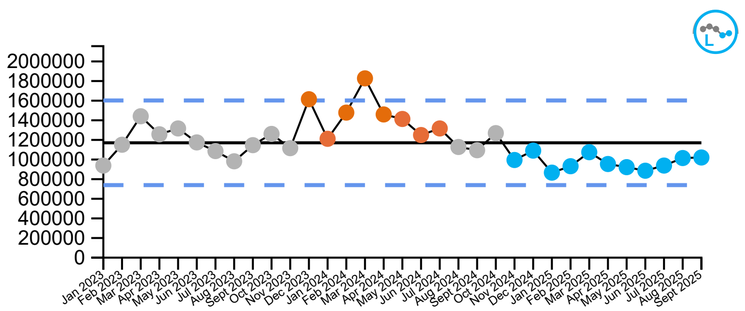
National nursing red flags



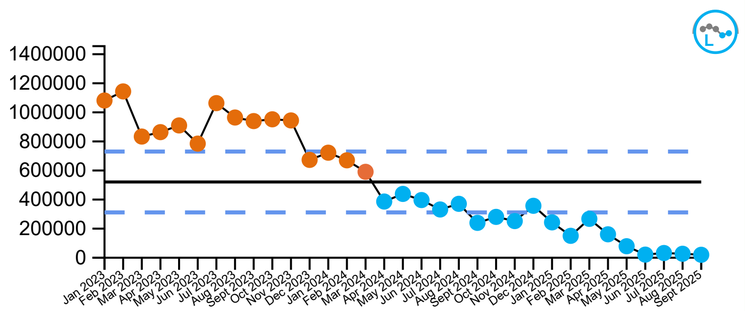
Wards <90% registered nurse (day) fill rate



Registered nurse bank spend



Registered nurse agency spend

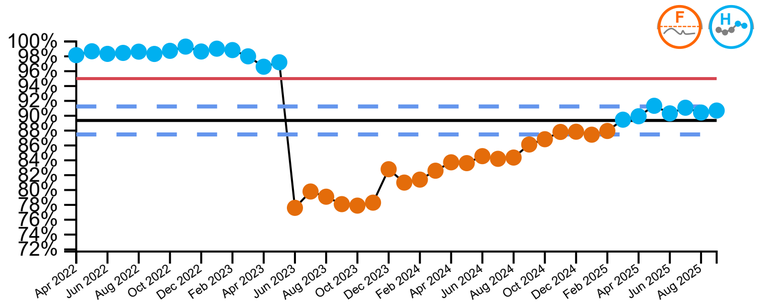


SAFE - Incidents and Pressure Ulcers

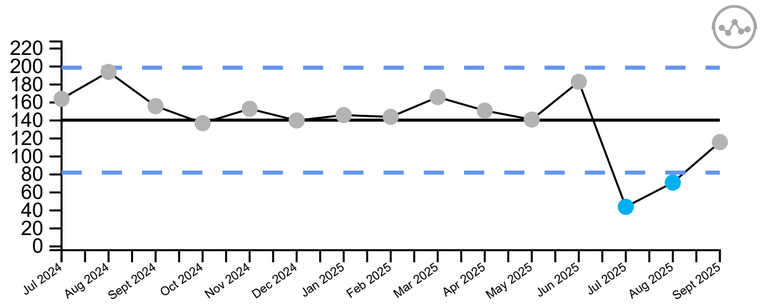
East Lancashire Hospitals NHS Trust
A University Teaching Trust

	Never events	Serious incidents reported to PSIRF	Medication errors moderate harm and above	Slips trips falls moderate harm or above	
In month >	0	2	2	4	
YTD >	1	15	11	16	CAS alerts - Non-compliance: 1

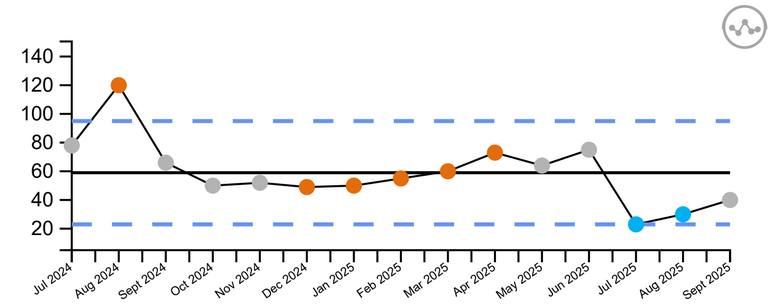
Patients risk assessed for Venous Thromboembolism



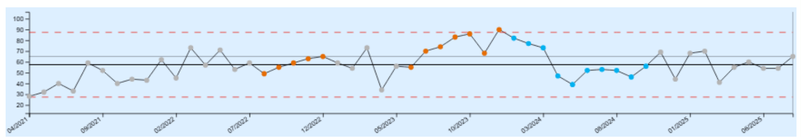
Medication errors causing low harm and above



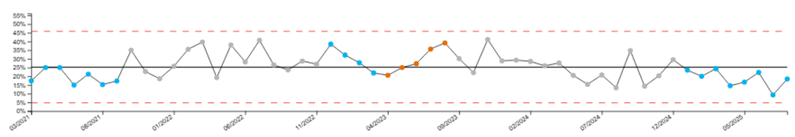
Medication errors causing low harm and above



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	SEPT 25	70.96	90.00		
COMMUNITY FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	SEPT 25	96.18	90.00		
COMPLAINTS RATE PER 1000 CONTACTS	SEPT 25	0.27	0.40		
INPATIENT FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	SEPT 25	95.08	90.00		
MATERNITY FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	SEPT 25	92.50	90.00		
OUTPATIENT FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	SEPT 25	94.15	90.00		

Alert

The A&E Friends & Family Test (FFT) positive score has seen a concerning slow but steady decline over the past three months, dropping from the mid-70s to the current 70%. National average 81% (August 2025). Analysis of the FFT narrative feedback highlights consistent issues that directly correlate with this drop: excessive waiting times, the use of corridor care, and concerns regarding the attitude of some staff.

To effectively address this decline and drive improvement, the A&E management team has access to the FFT data to analyse the issues and inform targeted action plans.

Advise

The Trust receives a significantly low volume of complaints, registering only 0.27 complaints per 1,000 patient contacts. The Trust breaches its timeframes on 68% of complaints. The numbers of days to complete a response have increased slightly from 53 days to 60 days.

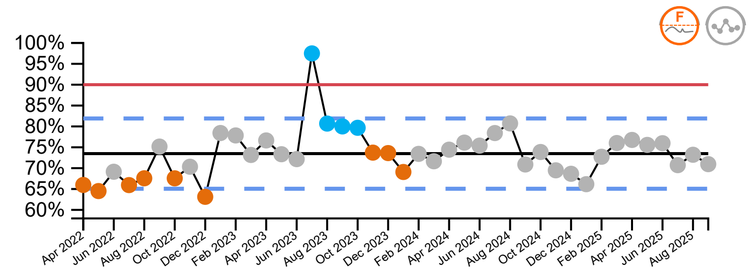
Assurance

The positive patient endorsement remains high: our core services, including inpatient, maternity, outpatient, and community care, have maintained positive Friends and Family Test (FFT) recommendation rates that are at or above the national average (NHS England FFT data, August 2025).

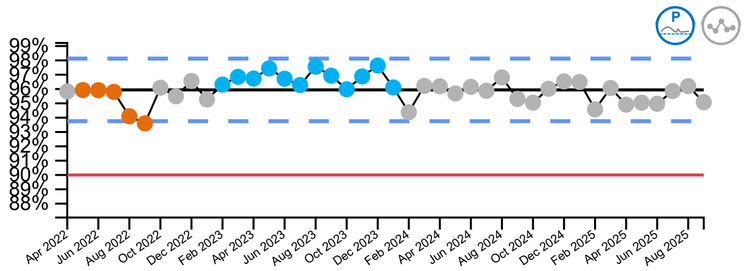
CARING - Feedback

East Lancashire Hospitals NHS Trust
A University Teaching Trust

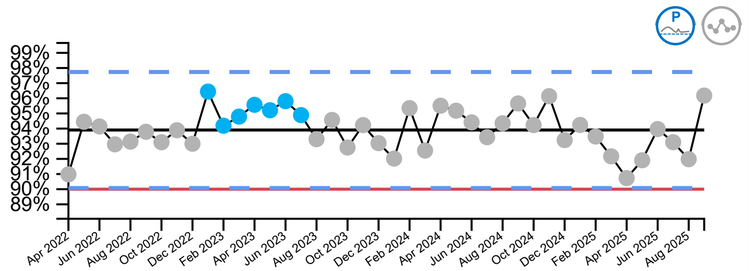
A&E Friends and Family % describing their experience as good or very good



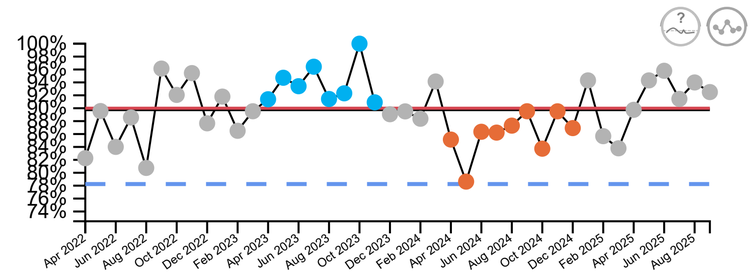
Inpatient Friends and Family % describing their experience as good or very good



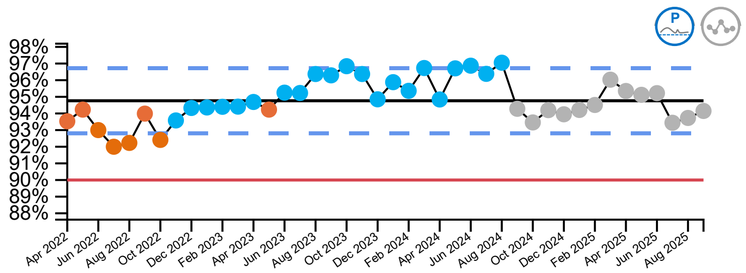
Community Friends and Family % describing their experience as good or very good



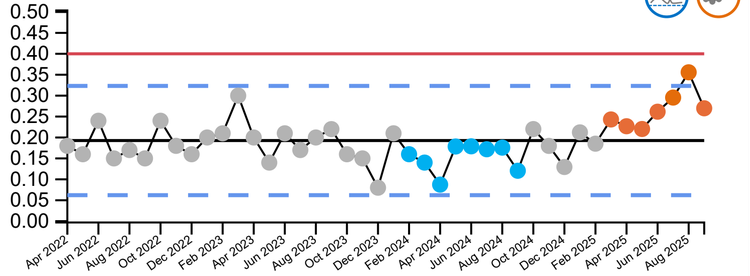
Maternity Friends and Family % describing their experience as good or very good



Outpatient Friends and Family % 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	SEPT 25	95.00	
CRUDE MORTALITY RATE	SEPT 25	2.07	
STILLBIRTHS	SEPT 25	2.00	

METRIC	LATEST DATE	VALUE
MATERNAL DEATHS	SEPT 25	0.00
SHMI	MAY 25	1.19
HOSPITAL STANDARDISED MORTALITY RATIO	JUN 25	104.90

Alert

The Trust remains unable to provide full assurance in relation to the HSMR and SHMI mortality indicators due to issues with data submission and the impact of inconsistent removal of SDEC activity across NHS Trusts.
Current SHMI is 1.19, which is above expected although continues to improve. Current HSMR+ is 104.9, which is within expected, as it also was for the previous month.

Advise

The most recent HSMR+ and SHMI figures now include a full 12 months of coded data, and therefore the issue relating to incomplete diagnostic codes impacting our SHMI has resolved, and the HSMR+ figure which has previously only included the coded months will now represent a 12 month rolling period.
Work is ongoing to improve the throughput of SJR reviews. The administration post has been filled, and additional reviewers have been trained, although there have been retirements of experienced reviewers. Throughput does remain below target.

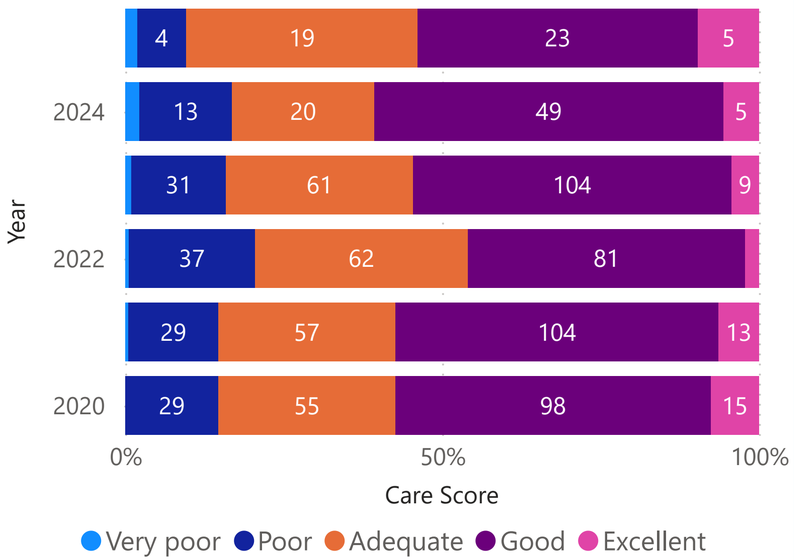
Assurance

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

SJR Stage 1 Completed by Year and Overall Score



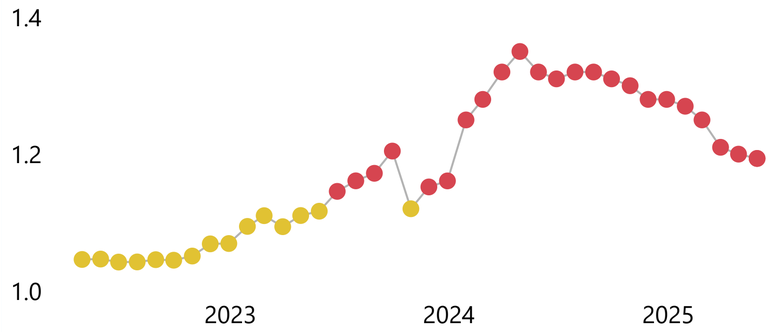
SHMI and HSMR Series

Below expected levels
Within expected levels
Higher than expected levels

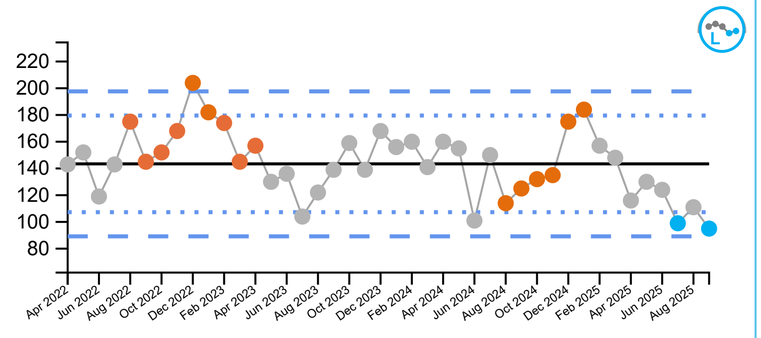
Learning Disability Mortality Reviews

4 deaths reviewed and completed, 0 deaths recorded in September, 0 remaining deaths to report

SHMI



In Hospital Deaths



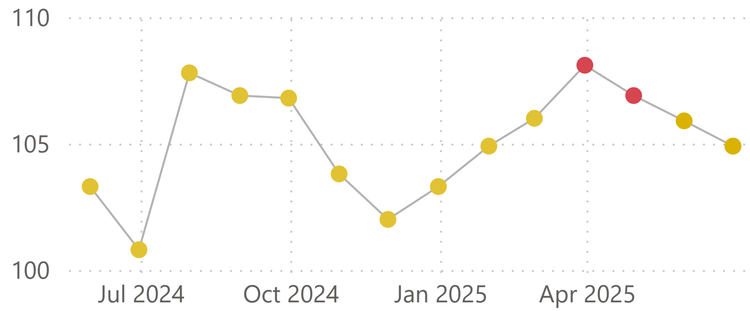
Stillbirths

In month	YTD	Same time last year
2	16	11

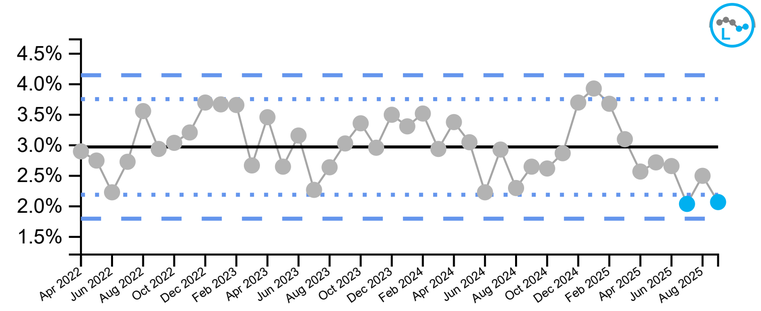
Maternal deaths

In month	YTD	Same time last year
0	1	1

Hospital Standardised Mortality Ratio (rolling monthly)



Crude mortality rate



RESPONSIVE - Summary Scorecard

East Lancashire Hospitals NHS Trust
A University Teaching Trust

METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
28D GENERAL FDS	AUG 2025	70.10	80.00		
62D GENERAL STANDARD	AUG 2025	74.90	75.00		
A&E 4HR PERFORMANCE (TRUST)	SEPT 2025	79.47	78.00		
DM01 % OVER 6 WEEKS	SEPT 2025	1.43	5.00		
NOT TREATED WITHIN 28 DAYS OF LAST MINUTE CANC	SEPT 2025	10.00	0.00		
RTT ONGOING % OVER 52 WEEKS	SEPT 2025	3.55	1.00		
RTT ONGOING % UNDER 18 WEEKS	SEPT 2025	60.36	62.00		

METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
OVER 12 HOURS IN DEPARTMENT %	SEPT 25	14.06	15.20		

METRIC	LATEST DATE	VALUE	VARIATION
A&E ATTENDANCES	SEPT 25	24194.00	
BED OCCUPANCY G&A	SEPT 25	95.25	
CANCELLED ON DAY OPERATIONS	SEPT 25	28.00	
EMERGENCY AVERAGE LENGTH OF STAY (EXCL 0 AND 1 DAYS)	SEPT 25	11.29	
PATIENTS OVER 62 DAYS (URGENT GP REFERRAL)	SEPT 25	212.00	
% HANDOVERS > 30 MINUTES	SEPT 25	15.28	
AMBULANCE HANDOVERS >45 MINUTES	SEPT 25	121.00	

METRIC	LATEST DATE	VALUE	VARIATION
MAX ARRIVAL TO HANDOVER TIME	SEPT 25	85	
AVERAGE ARRIVAL TO HANDOVER	SEPT 25	21	

METRIC	LATEST DATE	VALUE
RTT ONGOING	SEPT 25	55629.00
RTT OVER 52 WEEKS	SEPT 25	1977.00
RTT OVER 65 WEEKS	SEPT 25	0.00

Alert

Faster Diagnosis Standard (FDS) – *Target 80% by March 2026* - Performance in August was 70.1% (national 74.6%). This position was primarily affected by annual and sickness leave across several clinical teams. Improvement actions are underway, including:

- Implementation of Cancer 360 to enhance patient tracking and pathway visibility.
- Colorectal triage improvements to reduce time to first appointment.
- Direct-to-treatment model for skin tele-triage patients.
- Introduction of standardised communication templates in Urology and Dermatology to improve pathway consistency and patient experience.

Referral to Treatment (RTT) >52 Weeks – *3.6% (Target 1% by March 2026)* - The Board-approved recovery plan is now in delivery, with significant improvement expected in Q3. All 65-week breaches are on track to be cleared by December 2025, bringing 52-week performance back on trajectory. Key specialties under pressure remain Gynaecology, Dermatology, and Oral & Maxillofacial Surgery (OMFS).

Urgent & Emergency Care – 12-hour waits - There was a 1.5% improvement from August with performance at 14.06%, reflecting the early impact of pathway redesign work. A plan has been approved to introduce a Medical Decision Unit at the front door to improve patient flow and experience.

Advise

Ambulance Handovers – The Trust received 3,083 ambulance attendances in September, with 121 handovers >45 minutes, a reduction from 169 in August and the lowest level since April 2025. 15.28% of handovers exceeded 30 minutes, continuing a positive trend. The Trust remains in active collaboration with NWAS to further improve performance.

Cancelled on-the-day Operations – 28 cases, reduced from 48 in August, largely attributable to sickness absence.

Bed Occupancy – Remains high at 95.25%, reflecting ongoing inpatient demand and flow pressures.

Assurance

Referral to Treatment (RTT) - Total ongoing: 55,629 (554 below trajectory). 1st Appointment <18 weeks: 63.9% (trajectory 62.5%). Ongoing <18 weeks: 60.4% (trajectory 59.4%). 65-week breaches: *Zero reported*

Cancer 62-Day Standard – *Target 75% by March 2026* - Performance at 74.9% remains above the national average (69.1%)

DM01 Diagnostics – Performance remains strong at 1.43%, with 98.57% of patients receiving their diagnostic test within 6 weeks.

Emergency Care (4-hour Standard) – 79.47%, above national performance (75%)

Ambulance Handover – Average handover time 00:21 minutes, better than the NWAS regional average of 23:43 minutes.

RESPONSIVE - A&E

East Lancashire Hospitals NHS Trust
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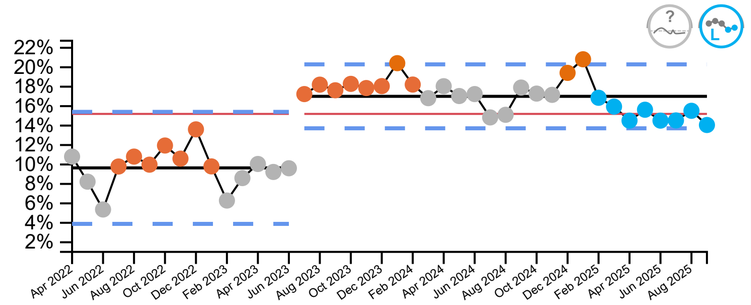
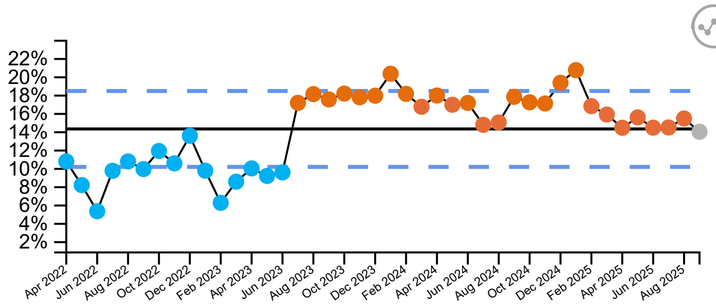
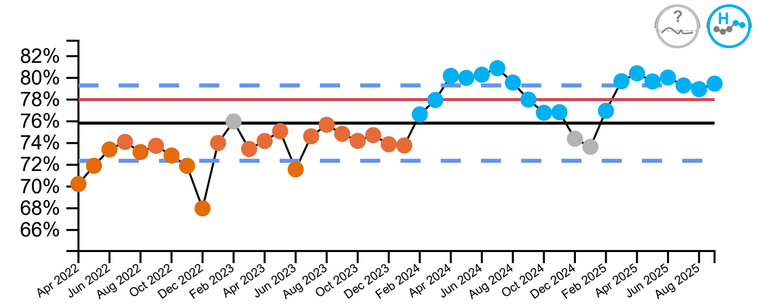
Over 12 hours in department % (type 1)



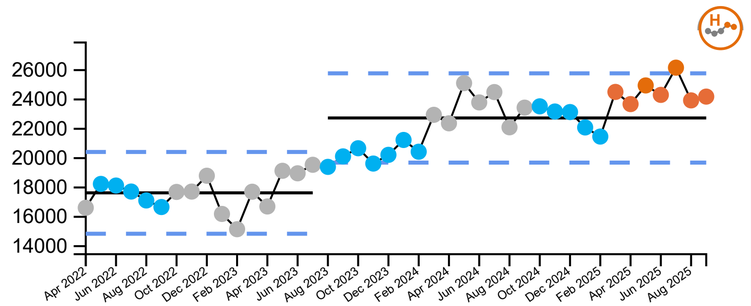
Over 12 hours in department %



A&E 4hr Performance (Trust)



A&E Attendances



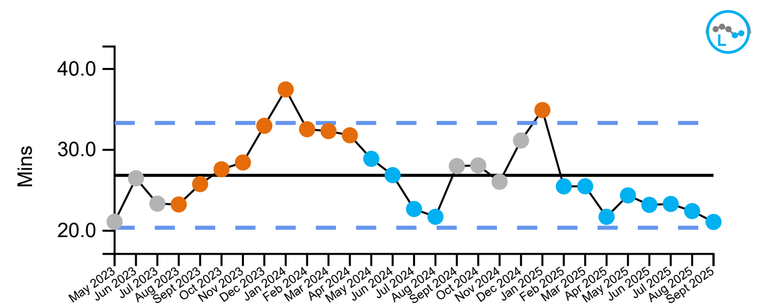
Average arrival to handover time (mins) (latest month)

21

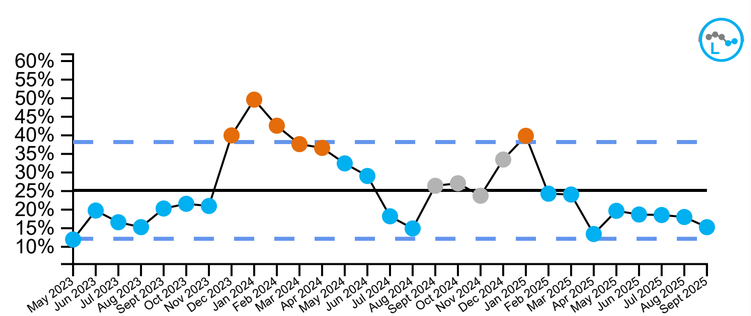
Maximum arrival to handover time (mins) (latest month)

85

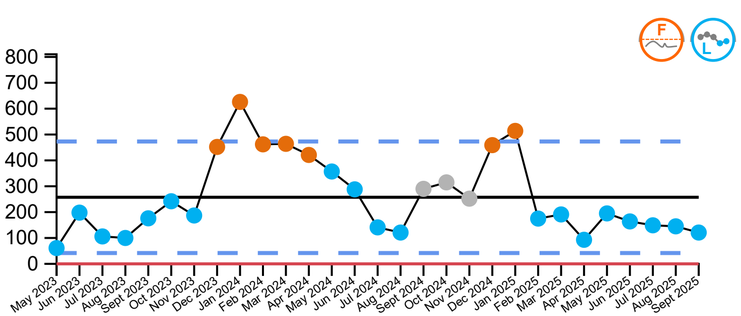
Average arrival to handover



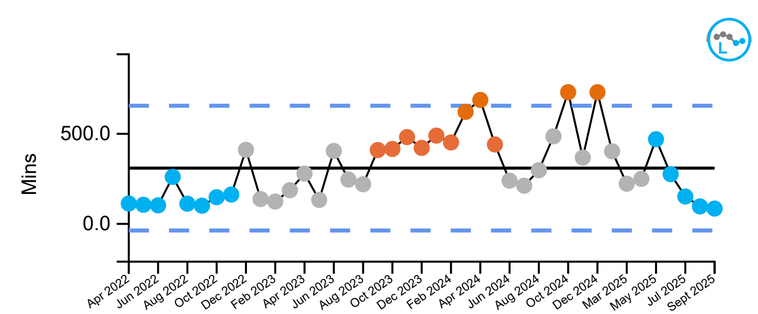
% handovers > 30 minutes



Ambulance Handovers >45 minutes



Max arrival to handover time



RESPONSIVE - RTT and Diagnostics

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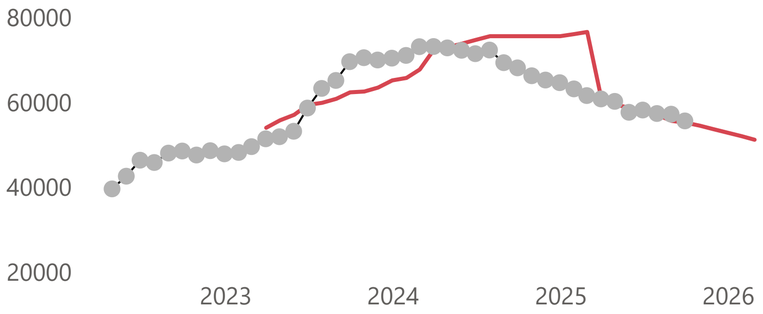
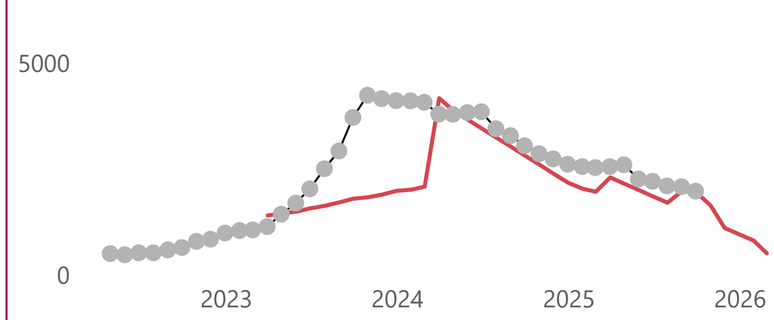
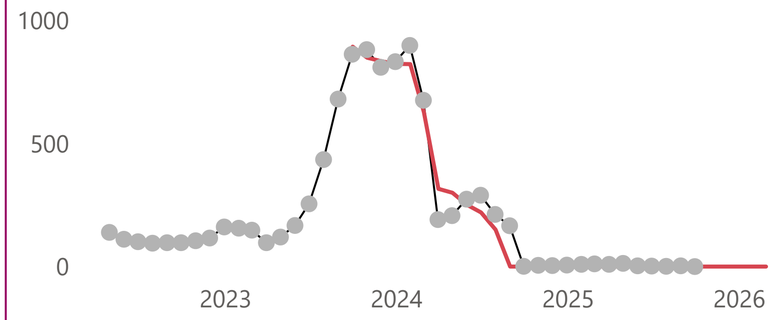
RTT Ongoing



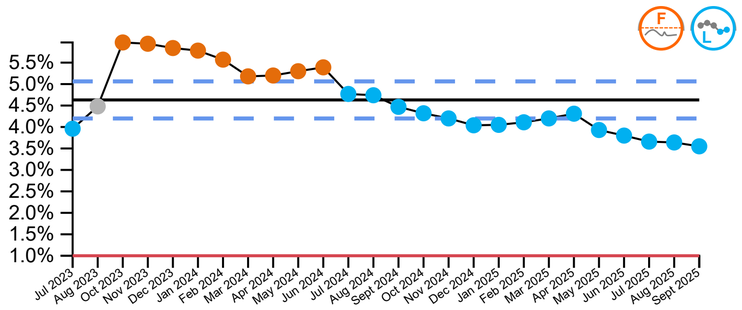
RTT Over 52 Weeks



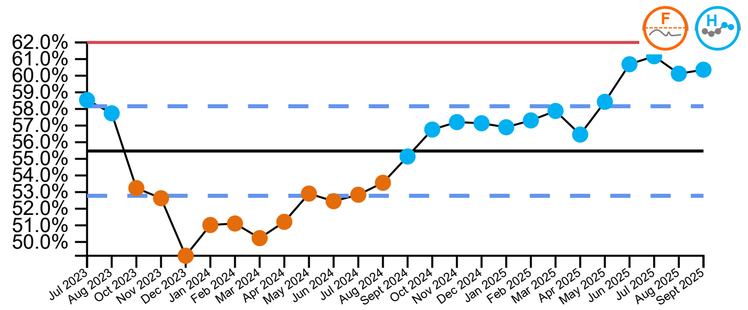
RTT Over 65 Weeks



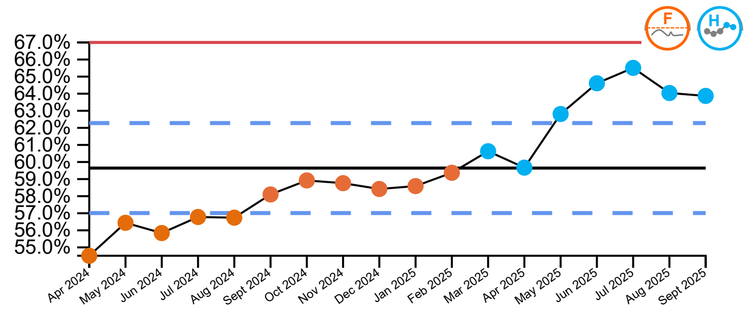
RTT Ongoing % Over 52 weeks



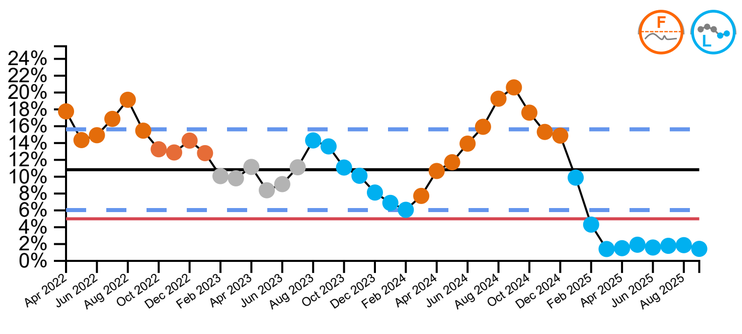
Proportion waiting < 18 weeks for treatment



Proportion waiting < 18 weeks for 1st appointment



DM01 % over 6 weeks



RESPONSIVE - Cancer

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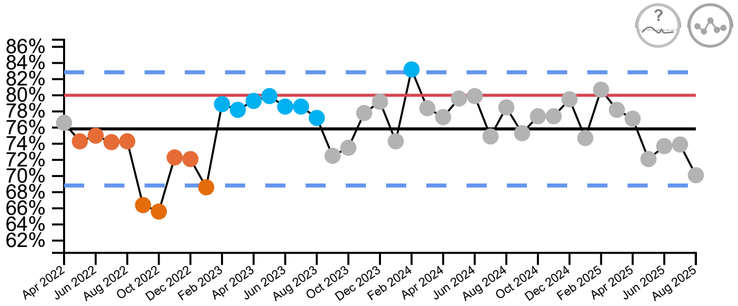
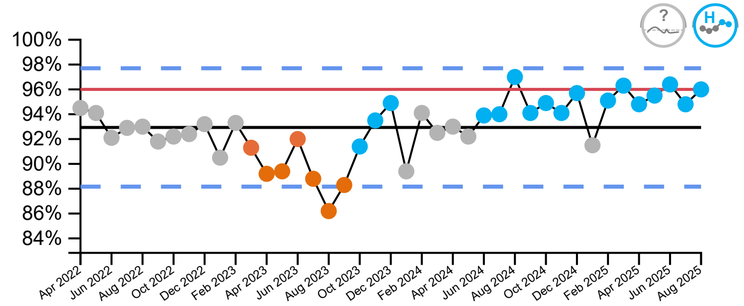
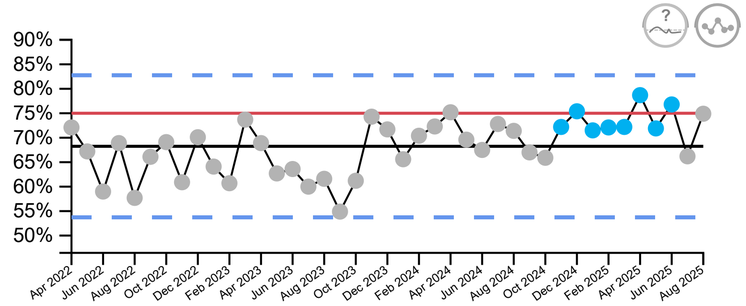
28d General FDS



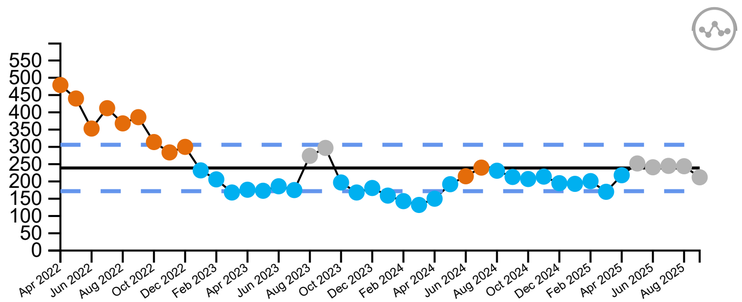
31d General treatment standard



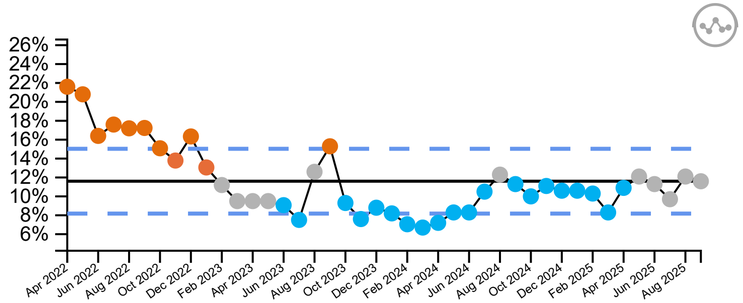
62d General Standard



Patients over 62 days (urgent GP referral)



Waiting over 62 days (urgent GP referral)



RESPONSIVE - Length of Stay and Bed Occupancy

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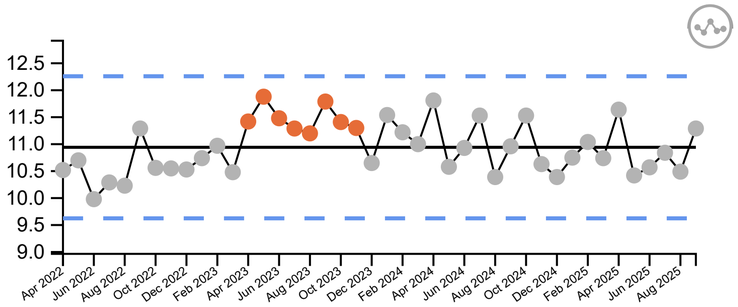
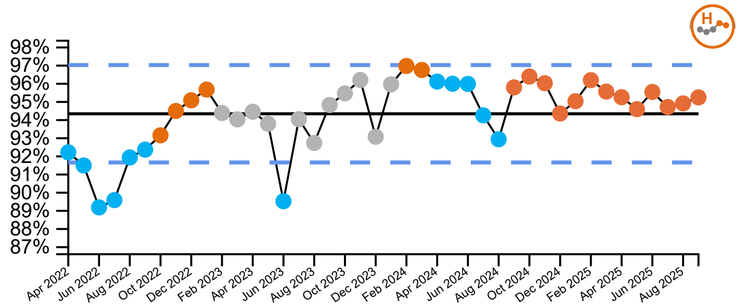
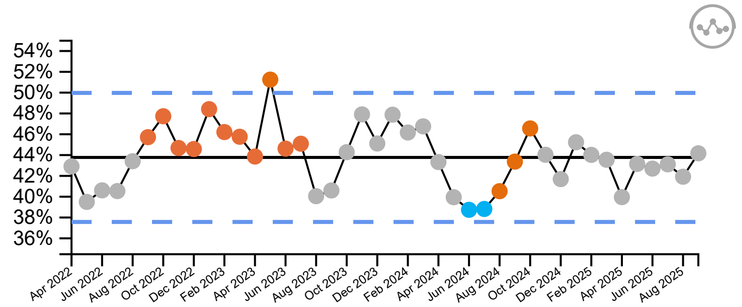
Emergency average length of stay (excl 0 and 1 days)



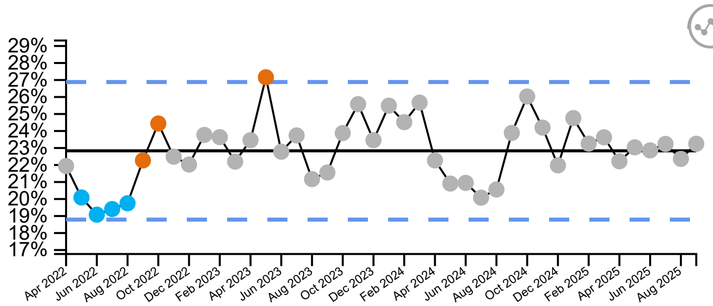
Bed occupancy G&A



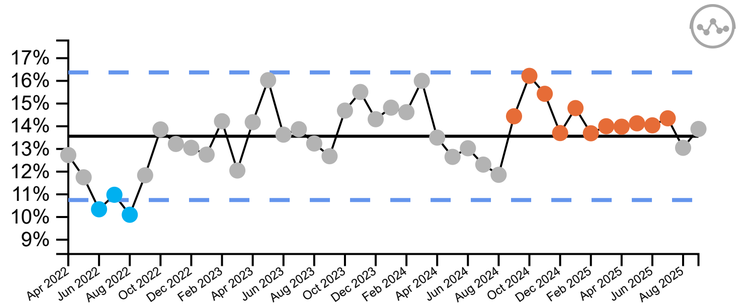
% Beds occupied by Long-Stay Patients 7+ days



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



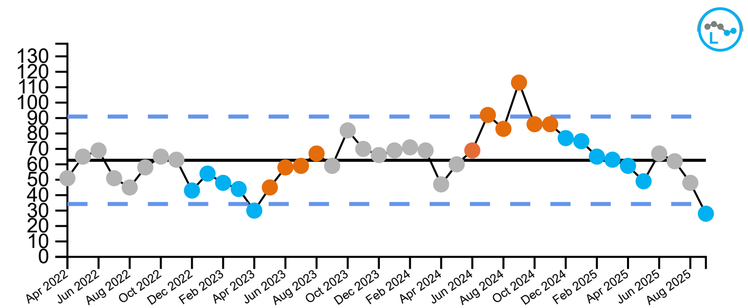
% Beds occupied by Long-stay patients 21+ days



RESPONSIVE - Cancellations and Utilisation

East Lancashire Hospitals NHS Trust
A University Teaching Trust

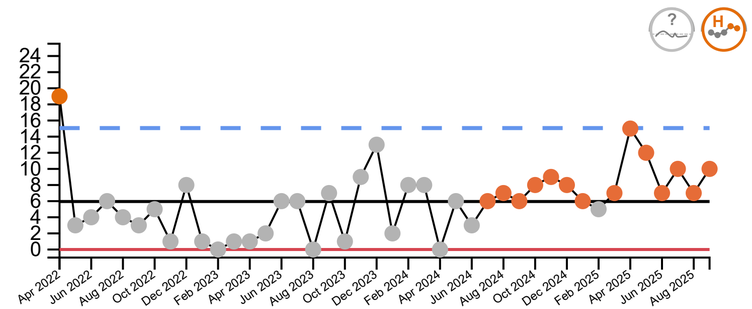
Cancelled on day operations



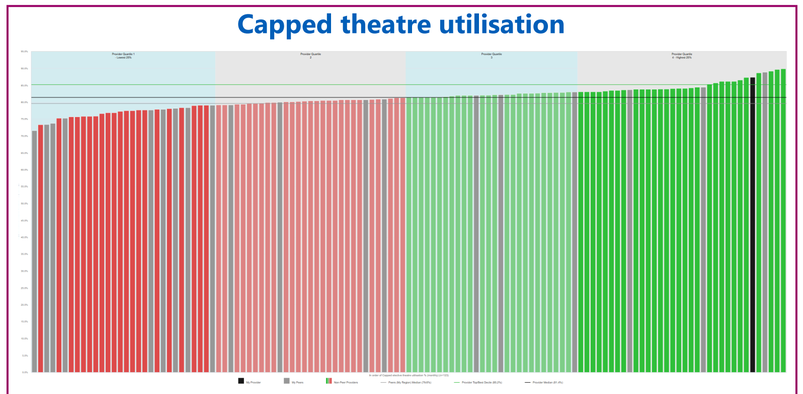
Urgent operations cancelled for 2nd time

0

On the day cancelled operations not rebooked in 28 days



Capped theatre utilisation



WELL LED - Summary Scorecard

East Lancashire Hospitals NHS Trust
A University Teaching Trust

METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
APPRAISAL (AGENDA FOR CHANGE)	SEPT 25	79.00	90.00	H	F
APPRAISAL (CONSULTANT)	SEPT 25	98.00	90.00		P
APPRIASAL (OTHER MEDICAL)	SEPT 25	98.00	90.00		P
INFORMATION GOVERNANCE TRAINING	SEPT 25	91.00	95.00		F
SAFEGUARDING CHILDREN L1	SEPT 25	96.00	90.00	H	P
SICKNESS	SEPT 25	6.30	4.50		F
TURNOVER	SEPT 25	6.72	12.00	L	P
VACANCY	SEPT 25	5.00	5.00	H	?

Alert

Information Governance compliance remains behind the required level of 95%, declining slightly to 91%.
Non-medical appraisal has declined by 1% to 79%, remaining behind Trust target of 90%.

Advise

Sickness absence has reduced slightly to 6.63% (6.70% in August).
If we remove the impact of OneLSC, the ELHT Divisional figure for September is 6.22%, down from 6.28% the previous month.
74% of Consultants have a job plan either live or at sign-off stage, up from 72% in August. 76% of non-Consultant grades have a live job plan or awaiting signature (75% in August)

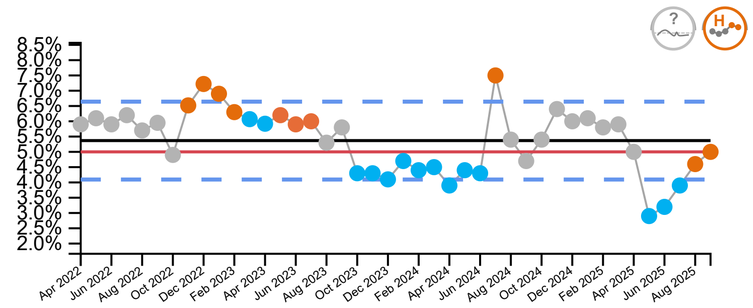
Assurance

Medical appraisal compliance remains strong – Consultant 98% and Other Medical 98%.
Safeguarding Children L1 further improved to 96% (target of 90%).
Vacancy levels have increased to 5.00%, due to ongoing vacancy control, but remain within accepted levels.
Turnover have reduced to 6.72% (6.85% in August).

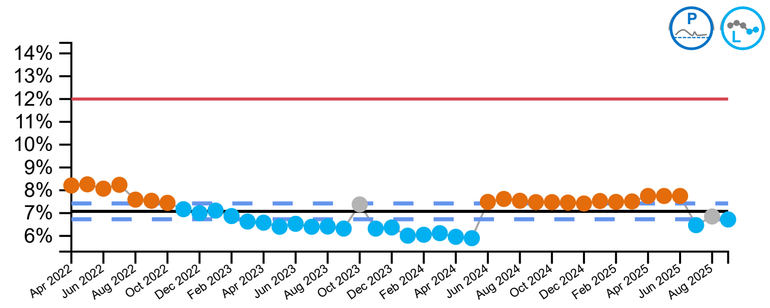
WELL LED - HR

East Lancashire Hospitals NHS Trust
A University Teaching Trust

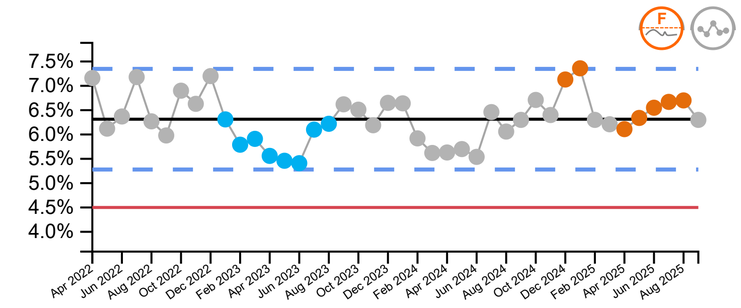
Vacancy



Turnover



Sickness



Freedom to Speak Up Cases by Elements

Concerns with elements of...

Reporting Period	Patient safety	Behaviour & attitudes	Bullying & harassment	Worker safety & wellbeing	Overall number of cases
24/25 Q1	3	21	11	18	40
24/25 Q2	0	35	16	34	61
24/25 Q3	4	29	7	22	115
24/25 Q4	2	32	12	32	97
25/26 Q1	6	25	8	34	76

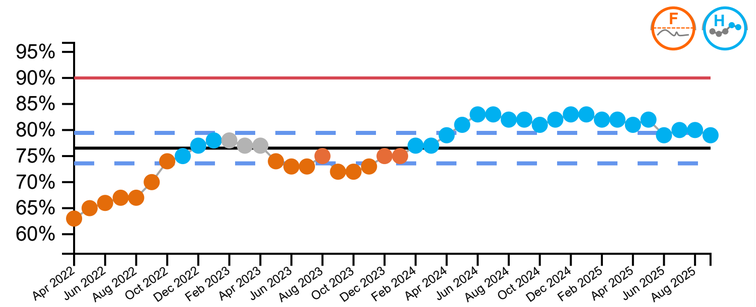
Job Plans

Stage	Consultants	Non consultants grades
Awaiting Signatures	124	22
Complete	102	54
Due Soon	7	0
In Progress	49	18
No Current Job Plan	7	6
Not Started	91	22
Referred Back	2	2
Uploaded	0	0
Total	**382**	**124**

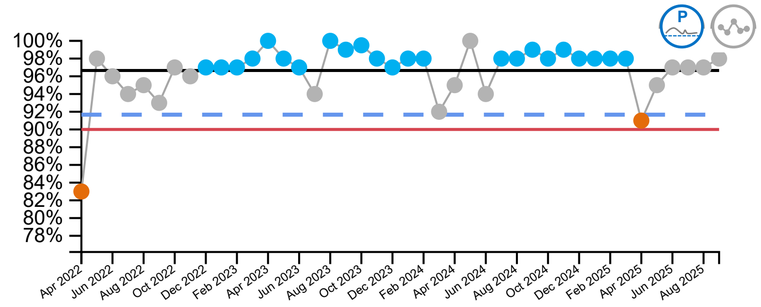
WELL LED - Learning and Development

East Lancashire Hospitals NHS Trust
A University Teaching Trust

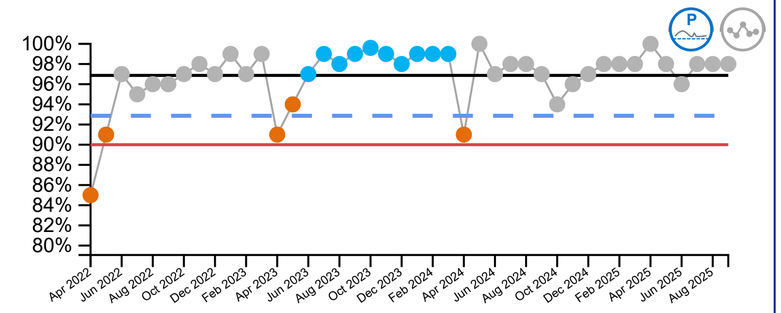
Appraisal (agenda for change)



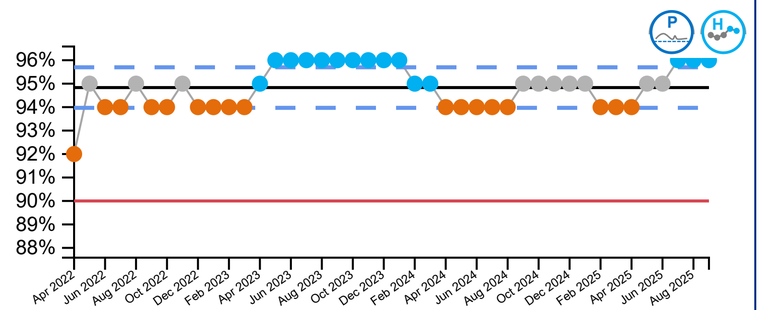
Appraisal (consultant)



Appriasal (other medical)

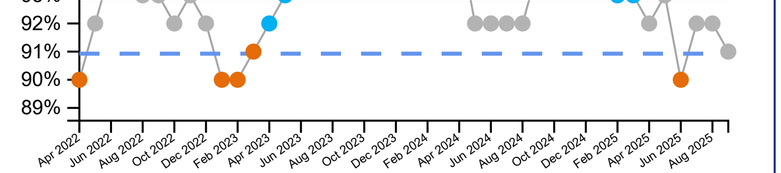


Safeguarding Children L1



Module	Target	Compliance
Basic Life Support	90.00	0.86
Conflict Resolution L1	90.00	0.97
Equality, Diversity and Human Rights	90.00	0.96
Health, Safety and Welfare	90.00	0.95
Infection Prevention L1	90.00	0.98
Infection Prevention L2	90.00	0.91
Prevent	90.00	0.96
Safeguarding Adults L1	90.00	0.95
Safeguarding Adults L2	90.00	0.95
Safeguarding Adults L3	90.00	0.87
Safeguarding Children L1	90.00	0.96
Safeguarding Children L2	90.00	0.95
Safeguarding Children L3	90.00	0.88
Safeguarding Children L4	90.00	1.00
Fire Safety	95.00	0.95
Freedom to Speak Up	95.00	0.95
Information governance training	95.00	0.91
Safer Handling L1	95.00	0.96
Safer Handling L2 (Patient Handling)	95.00	0.92

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	SEPT 25	72.80	95.00		
BETTER PAYMENT PRACTICE CODE (BPPC) NHS VALUE OF INVOICES	SEPT 25	94.10	95.00		
BETTER PAYMENT PRACTICE CODE (BPPC) NON NHS NO OF INVOICES	SEPT 25	64.00	95.00		
BETTER PAYMENT PRACTICE CODE (BPPC) NON NHS VALUE OF INVOICES	SEPT 25	91.10	95.00		
LIQUIDITY DAYS	SEPT 25	-29.73	-21.50		
VARIANCE TO PLANNED FINANCIAL PERFORMANCE (DEFICIT) (£M)	SEPT 25	-1.81	0.00		
WRP ACHIEVED - VARIANCE TO PLAN (£M)	SEPT 25	-2.29	0.00		
AGENCY SPEND AS PROPORTION PAY BILL (£M)	SEPT 25	0.67	1.20		F
VARIANCE TO CAPITAL PROGRAMME (£M)	SEPT 25	-0.81	0.00		

METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION
EMPLOYEE EXPENSES RUN RATE (£M)	SEPT 25	48.10	0.00	H
INCOME RUN RATE (£M)	SEPT 25	69.87	0.00	H
OTHER OPERATING EXPENSES RUN RATE (£M)	SEPT 25	21.99	0.00	H

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 will maintain our cash balance without the need to request borrowing from NHSE.
WRP Delivery: The Trust achieved £2.9m WRP in Month 6 against a reprofiled plan of £4.7m. Cumulatively the Trust had delivered £18.4m of savings which is £3m adverse to the reprofiled plan. The risk adjusted forecast is £58.6m (excluding DSF). This is a £10.4m deterioration since M6.
Workforce Spend: Pay spend increased in M06 v M05 by £2.2m, linked primarily to the release of a £1.9m pay related accrual in M5.
Contracting and Activity Planning: Activity and finances have been agreed for 2025-26 contract and the contract has been signed.
Contract does not reflect activity being delivered through the NEL pathways or in Maternity. Deconstruction of the block contract guidance has been issued for 2026-27 Formal contract meetings have commenced for 2025-26.

Advise

WRP Reporting Alignment: There is good progress to streamline and align reporting between PMO, finance, and improvement teams at Divisional and Trust level. An in-house team has been developed with fully automated reporting for WRP using Power Bi.
Cash Flow Management: The monthly cash flow forecast based on the risk adjusted revenue position. While the cash balance increases by £1.0m to £9.6m in September, the cash position is being monitored closely with significant risks remaining.
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 £43.3m Deficit Support Funding (DSF). To deliver this plan, the Trust has a aste Reduction Programme (WRP) of £60.8m.
The Trust is reporting a deficit of £1.7m for M6, £1.8m behind the planned position. This is the deficit excluding £3.6m of DSF. The net reported deficit is £5.3m.
The year-to-date position, excluding £21.7m of DSF, is a £35.2m deficit, £7.3m behind the planned position of £27.9m.
The WRP delivered £2.9m in month against, a variance of £2.3m to the original plan of £5.2m. Year to date, the WRP delivered is £18.4m against the original plan of £24.3m, a variance of £5.9m. 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. Plans have been made to mitigate this underperformance in the latter end of the year.
Cash - The cash balance on 30th September was £13.0m, an increase of £2.4m compared to £10.6m on 31st August.
Capital - The 2025-26 capital plan is £40.6m. While the year to date spend at M6 of £12.7m is £2.5m ahead of plan, the Trust is still forecasting not to exceed the annual plan.

WELL LED - Finance

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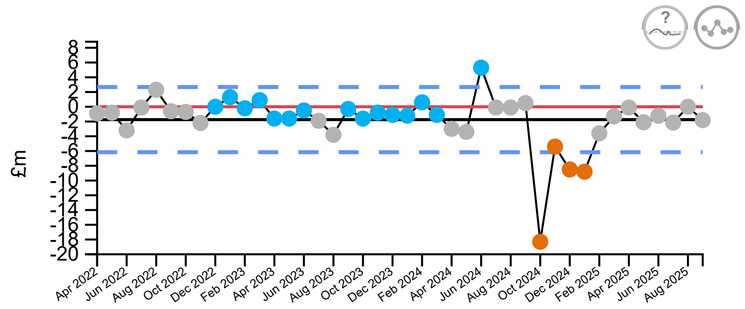
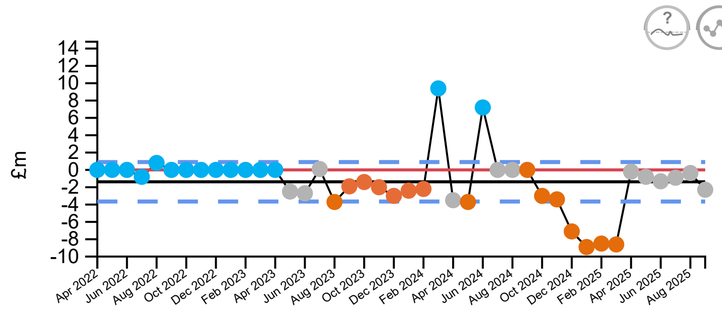
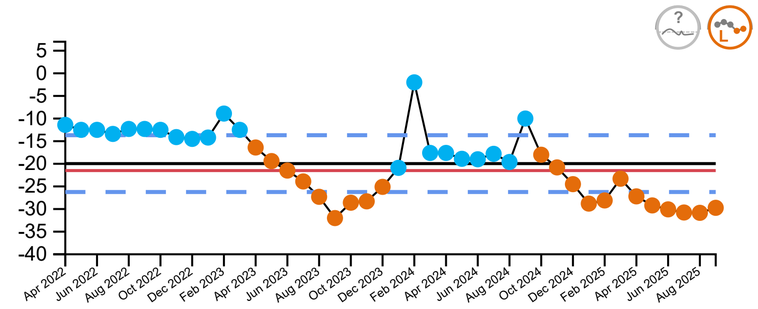
Variance to planned financial performance (deficit) (£m)



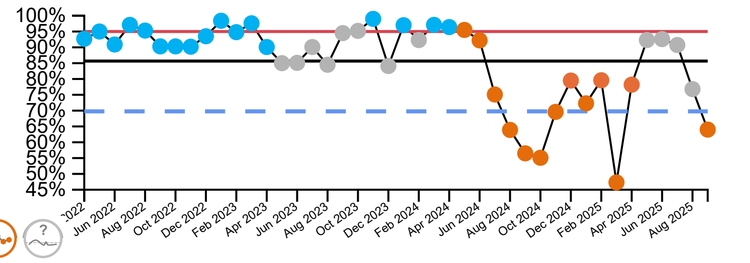
WRP achieved - variance to plan (£m)



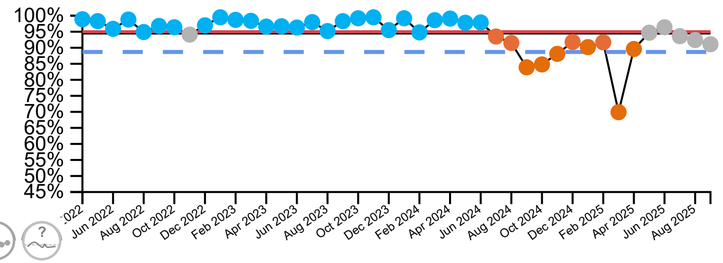
Liquidity days



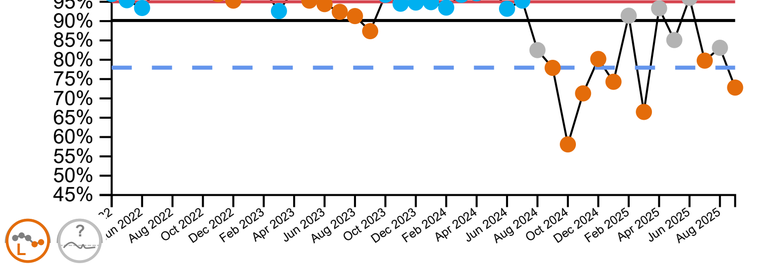
Better Payment Practice Code (BPPC) Non NHS No of Invoices



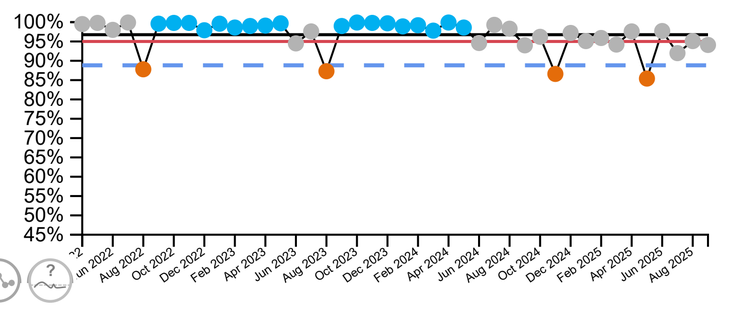
Better Payment Practice Code (BPPC) Non NHS Value of Invoices



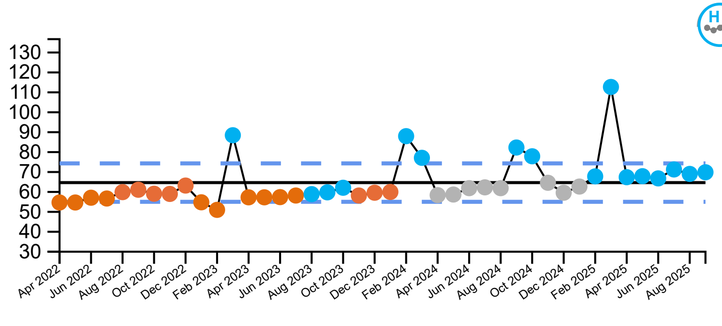
Better Payment Practice Code (BPPC) NHS No of Invoices



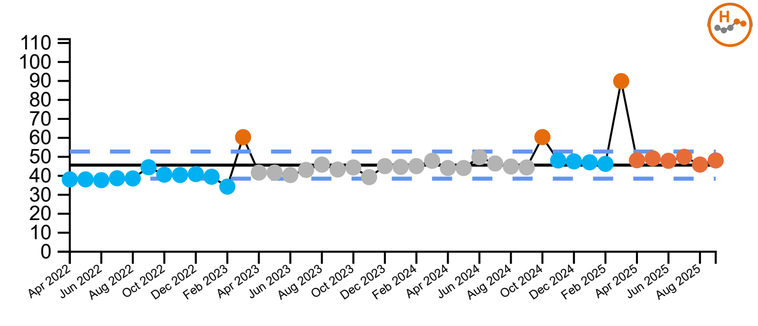
Better Payment Practice Code (BPPC) NHS Value of Invoices



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

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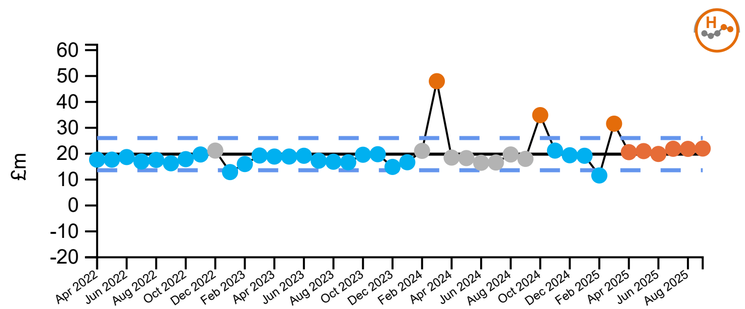
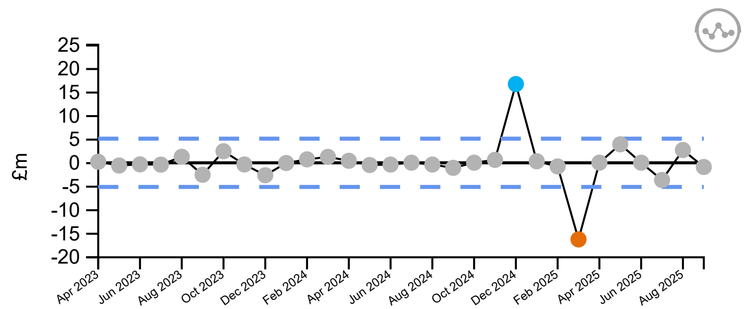
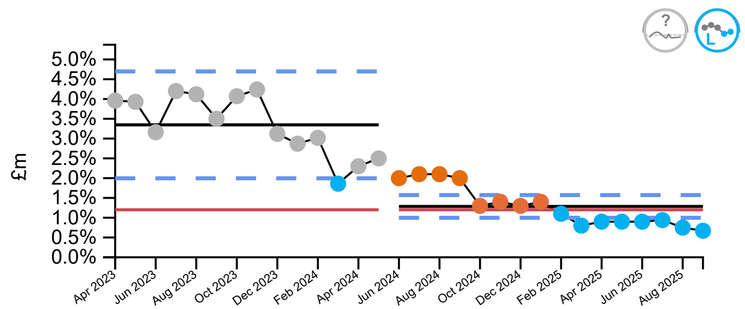
Other operating expenses run rate (£m)



Variance to capital programme (£m)



Agency spend as proportion pay bill (£m)



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TRUST BOARD

Meeting Date:	12 November 2025	**Agenda Item:**	TB/2025/149
Report Title:	East Lancashire Hospitals NHS Trust Improvement Plan (RSP Exit Criteria)		
Author:	Catherine Vozzolo, Associate Director of Service Development		
Lead Director:	Kate Atkinson, Director of Service Development & Improvement		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
			✓	
Executive Summary:	The East Lancashire Hospitals NHS Trust (ELHT) Improvement Plan has been developed to support the Trust to evidence the improvement actions underway and associated impact in response to meeting the Recovery Support Programme (RSP) Exit Criteria and associated Legal Regulatory Undertakings. The Improvement plan was first presented to Trust Board in July 2025 in draft format and following feedback from Board members and NHSE improvement leads has now been updated to its current form. For months 4 and 5 the Improvement Plan has been reported internally. From month 6 (November 2025) it will also be reported through to the Trust Board, the ELHT Improvement and Assurance Group (IAG) with the ICB and then to NHSE for review and sign off. The Improvement Plan is supported by a detailed delivery plan to ensure completion of all exit criteria. It is monitored through the Finance Improvement Group (FIG), which will ensure clear oversight of the plan's delivery. The FIG reports to the Trust Board and the Improvement and Assurance Group (IAG). The Improvement Plan is also monitored at Trust Board subcommittees (People & Culture Committee, Finance & Performance Committee and Audit Committee). Progress has been made in compiling relevant evidence and cross reference in all aspects of the improvement plan. In the last month, further actions on the governance and leadership action plan have turned from green to blue (completed). Further evidence has been collated in support of the RSP recommendations.			

	The improvement plan has been updated, with the arrows for each criteria indicating progress in the last month.
Key Issues/Areas of Concern:	None
Action Required by the Committee:	Members are asked • to note the updated improvement plan and provide further comments or feedback on the content of the plan. • to confirm whether the self-assessment is accurate and therefore approved, or whether further recommendations can be made.

Previously Considered by:	Executive Team Meeting
Date:	4th November
Outcome:	Improvement Plan feedback noted and is now included in the report to Trust Board.

NHS
East Lancashire Hospitals
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East Lancashire Hospitals NHS Trust Improvement Plan

Update Report Month 6

Safe | Personal | Effective

ELHT. *Because that's who we are*

Improvement Plan Contents

East Lancashire Hospitals NHS Trust
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Introduction to the Improvement Plan

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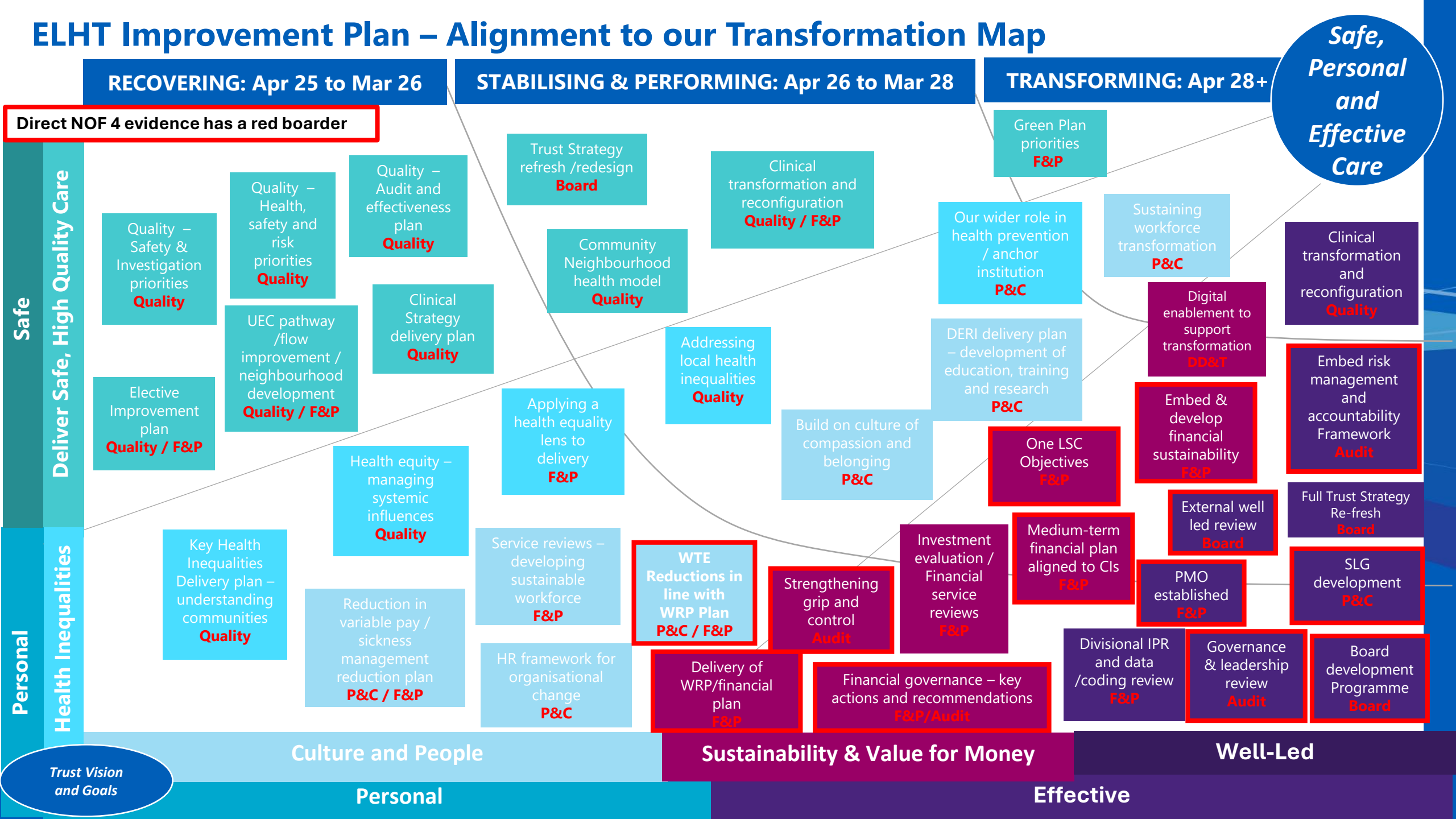
- The East Lancashire Hospitals NHS Trust (ELHT) Improvement Plan has been developed to support the Trust to evidence the improvement actions underway and associated impact in response to meeting the Recovery Support Programme (RSP) Exit Criteria and associated Legal Regulatory Undertakings.

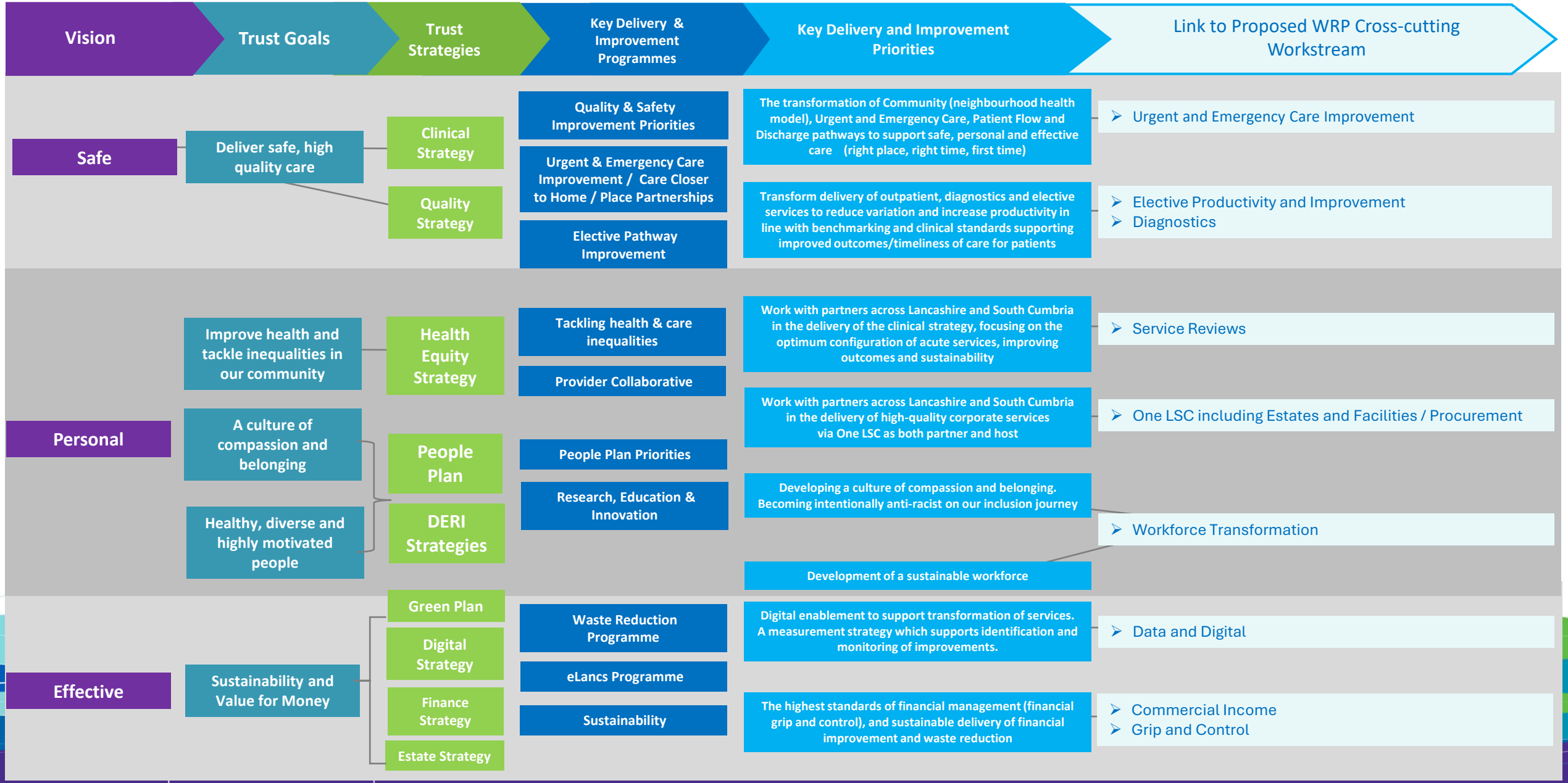
- The Improvement Plan is rooted in our operational performance and outcomes, recognising the contributions our colleagues make every day, whilst acknowledging the impact of a deteriorating financial outlook and the requirement to strengthen our leadership and governance, which must now be improved. This is what Safe, Personal and Effective care means for ELHT.

- It is vital that the Improvement Plan does not become a means by which to oversee all Trust operations and is focussed on the key RSP Exit Criteria. However, there is a clear link between these improvement actions and the daily running of the Trust and delivery of its wider ambitions and improvement plans which is shown on our Transformation Map; an outline of the supporting governance by which the actions in the plan will be scrutinised is set on out page 7.

ELHT Improvement Plan – Alignment to our Transformation Map



ELHT Strategic Framework - WRP cross-cutting workstreams and alignment



Multi-Year Recovery Plan

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One-year plans and priorities have been agreed for 2025026. Over 2025-26 the Trust Strategy will be refreshed (and all associated strategies/plans) to support greater alignment to the wider system and reflective of a multi-year recovery plan.

AIM	Recovering	Stabilising	Performing	Transforming
	Urgent recovery and steadying the ship…		**Getting into the pack and leading the field**	
	2025/26 – 2026/27		2027/28 – 2028/29 & beyond..	
OBJECTIVES	• NOF 4 Improvement plan and Transformation Map is defined and mobilised • Review and re-fresh of Trust Strategy to align to Trust and System Improvement Plan		• Improvement plan is delivered, long-term vision designed and delivering • Improvement Plan is delivered to ensure ongoing delivery of Safe, Personal and Effective Care • System leader, collaborating for Lancashire and South Cumbria to thrive	
OUTCOMES	• **Improvement plan defined and resourced** • **Programme Management Office mobilised and aligned to SPE+ Improvement Practice**	• **Improvement plan and programmes delivering to plan** • **Evidence and confidence that Legal Undertakings / Exit Criteria are met** • **Exit from NOF4 of Recovery Support Programme**	• **Outstanding provision of care and financially stable** • **Place of choice to work, train and thrive** • **Upper quartile performance nationally**	

Full alignment to NOF4 Exit Criteria required alongside key system strategies/plans

Improvement Plan Governance and Reporting

East Lancashire Hospitals NHS Trust
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Supporting Delivery – Our Programme Management Office, SPE+ Improvement Practice and Communications Approach

The Improvement Hub Team:

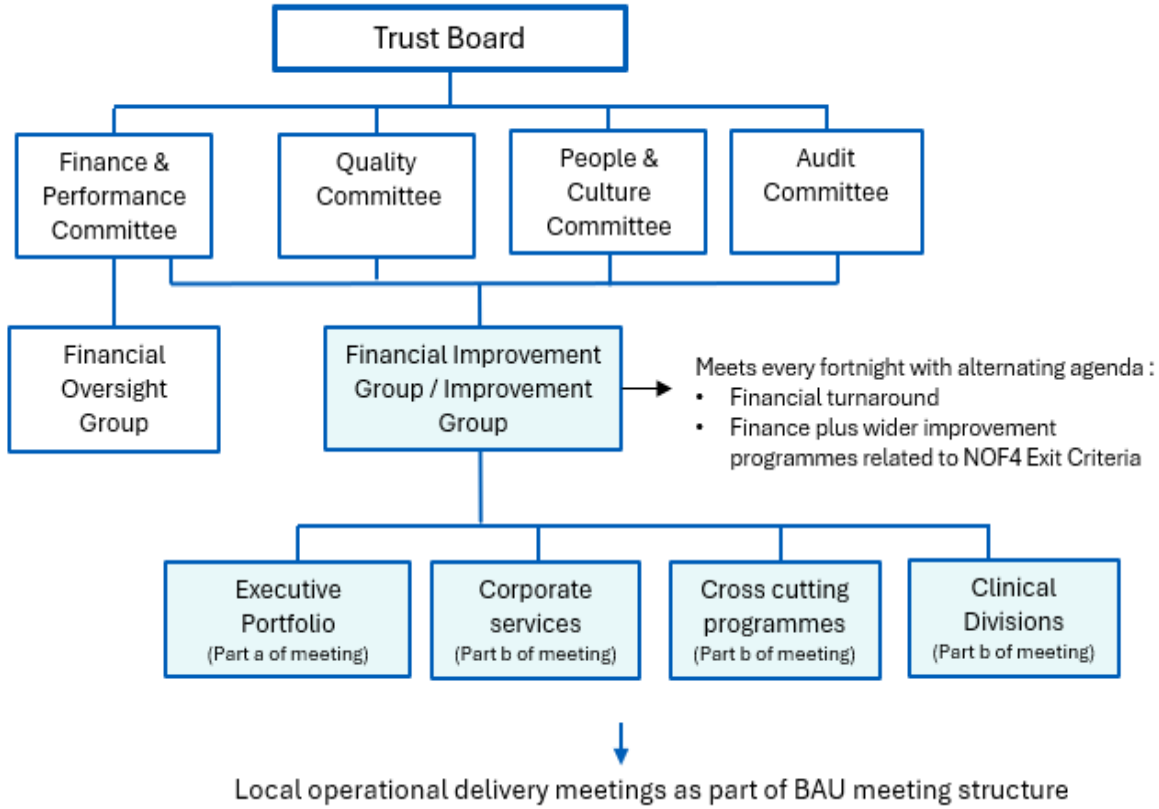
- Develop 'Daily Management' principles based on continuous improvement
- Continue to build Improvement capability and capacity
- Create a wider network of sharing good practice through ELHT and wider system partners
- Support measurement of all work to strengthen a data-based approach
- Support wider improvement beyond financial recovery to support delivery of our vision for Safe, Personal and Effective Care

The PMO:

- Provide a systematic approach to support delivery of financial recovery
- Develop standardisation of project management practices
- Provide governance of processes strengthening assurance
- Support risk management of overall delivery

Our communication and engagement plan will:

- Support our colleagues in understanding the challenge, put forward their ideas and celebrate success



Cross-Cutting Workstreams

9 Cross-cutting workstreams have been identified and aligned to the Trust's framework of Key Delivery and Improvement Programmes and Priorities for 2025/26.

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Trust Strategy	Delivery & Improvement Programmes 25/26	Cross Cutting Workstream	Task and Finish Groups	Executive Sponsor	Assurance Committee	Total £ Value	Total WTE	Total PIDs
People Plan	People Plan Priorities	Workforce Transformation	MARS, E-Rostering, Job Planning, Sickness & Absence, Bank/ Agency/Volume, Spans & Layers	Chief People Officer	People & Culture			
Clinical & Quality Strategy	Elective Pathway Improvement	Elective Productivity Improvement	Theatres, Outpatients, Elective Flow.	Chief Operating Officer / Director of Service Development & Improvement	Finance & Performance			
		Diagnostics	Pathology, Meds Management, Pharmacy*, Diagnostic Imaging	Medical Director	Quality			
	Urgent & Emergency Care Improvement	UEC Improvement Plan	UEC/ NEL incl. Los.	Chief Nurse / Chief Integration Officer	Quality			
Health Equity Strategy	Tackling Health & Care Inequalities	Service Reviews	Specialty / CI Reviews, Service Reviews, Post Investment Reviews	Director of Service Development & Improvement	People & Culture			
Finance Strategy	Sustainability	Commercial Income	Non-NHS, Philanthropy, R&D, Coding.	Director of Communications	People & Culture			
		OneLSC	Procurement*, Contracts, SLAs, PFI, E&F.	Director of Finance / Chief Integration Officer	Finance & Performance			
		Grip & Control	Pay/ Non-Pay Panels, Investigations.	Director of Finance	Finance & Performance			
Digital Strategy	WRP	Data & Digital	Data & Digital, Cerna AI, OneLSC Digital.	Chief Integration Officer	Data, Digital & Technology			

PMO review has been completed to assign all PIDs to cross-cutting workstreams.

SRO's to sign off at next cross-cutting workstream meetings.

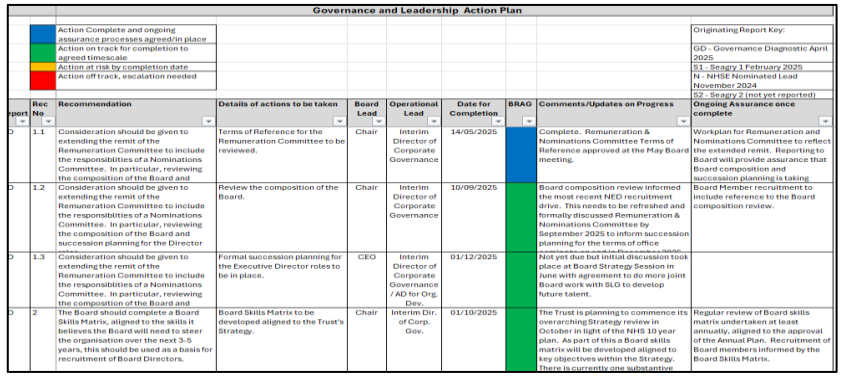
Leadership and Governance Reviews

East Lancashire Hospitals NHS Trust
A University Teaching Trust

4 key leadership and governance reviews have been completed or are in progress. All key recommendations from each review have now been combined into an overall Governance and Leadership Action Plan, which was approved at Trust Board in July and endorsed through IAG on 29th July 2025.

L&G Review	Key Actions Required
NHSE Nominated Lead Report (November 2024)	The final report identified 16 recommendations for action.
Financial Governance Review (initial review)	The Finance Governance Review was commissioned and undertaken by Seagry Consultancy Ltd. The final report identified 13 recommendations for action.
Governance Diagnostic Report	The report provides an assessment of the corporate governance arrangements within the Trust. The report includes 18 recommendations to address the identified areas for improvement
Financial Governance Review (wider review)	Phase 2 Financial Governance Review commissioned and underway with Seagry Consultancy (expected to complete by end of August)

Governance & Leadership Action Plan :



Governance and Leadership Action Plan

Rec No	Recommendation	Details of actions to be taken	Board Lead	Operational Lead	Date for Completion	BRAG	Comments/Updates on Progress	Ongoing Assurance once complete
1.1	Consideration should be given to extending the remit of the Remuneration Committee to include the responsibilities of a Nominations Committee. In particular, reviewing the composition of the Board and	Terms of Reference for the Remuneration Committee to be reviewed.	Chair	Interim Director of Corporate Governance	14/05/2025		Complete. Remuneration & Nominations Committee Terms of Reference approved at the May Board meeting.	Workplan for Remuneration and Nominations Committee to reflect the extended remit. Reporting to Board will provide assurance that Board composition and succession planning is taking
1.2	Consideration should be given to extending the remit of the Remuneration Committee to include the responsibilities of a Nominations Committee. In particular, reviewing the composition of the Board and succession planning for the Director	Review the composition of the Board.	Chair	Interim Director of Corporate Governance	10/09/2025		Board composition review informed the most recent NED recruitment drive. This needs to be refreshed and formally discussed Remuneration & Nominations Committee by September 2025 to inform succession planning for the terms of office	Board Member recruitment to include reference to the Board composition review.
1.3	Consideration should be given to extending the remit of the Remuneration Committee to include the responsibilities of a Nominations Committee. In particular, reviewing the composition of the Board and	Formal succession planning for the Executive Director roles to be in place.	CEO	Interim Director of Corporate Governance / AD for Org. Dev	01/12/2025		Not yet due but initial discussion took place at Board Strategy Session in June with agreement to do more joint Board work with SLG to develop future talent.	
2	The Board should complete a Board Skills Matrix, aligned to the skills it believes the Board will need to steer the organisation over the next 3-5 years, this should be used as a basis for recruitment of Board Directors.	Board Skills Matrix to be developed aligned to the Trust's Strategy.	Chair	Interim Dir. of Corp. Gov.	01/10/2025		The Trust is planning to commence its overarching Strategy review in October in light of the NHS 10 year plan. As part of this a Board skills matrix will be developed aligned to key objectives within the Strategy. There is currently one substantive	Regular review of Board skills matrix undertaken at least annually, aligned to the approval of the Annual Plan. Recruitment of Board members informed by the Board Skills Matrix.

Progress against the action plan will be monitored operationally on a monthly basis by the Trust Improvement Group with assurance of delivery reported to the Audit Committee and Trust Board.

RSP NOF 4 Exit Criteria and Evidence Required

East Lancashire Hospitals NHS Trust
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1	2	3	4	5
Delivery of financial plan and Waste Reduction Programme	Deliver quarter-on-quarter run rate improvement throughout 2025/26	Develop a medium-term financial recovery plan covering the period post 2025/26	Demonstrate effective financial and organisational governance structures and mechanisms	Full participation in the Recovery Support Programme
2025/26 break-even position and deficit no more than the £43.3m planned	Quarter-on-quarter improvement in underlying run rate throughout 2025/26	A Board and IAG approved plan for financial recovery and maintenance beyond 2025/6 by the end of Q3	Development of an improvement plan to ensure timely response, evidence and completion of recommendations in the Governance Review of April 2025	Executive Board attendance at monthly IAG meetings
Achievement of £60.8m WRP and plans in excess of £61m to offset any under delivery	Robust expenditure controls in line with PwC recommendations		A Board/Improvement & Assurance Group agreed governance and leadership action plan in response to the recommendations for the Governance Review of April 2025,and following publication of the Seagry review outcomes	Engagement with Turnaround Director and team and response to requested actions
Delivery against key expenditure categories as outlined in the financial plan and WRP			Evidence of full board engagement in an externally commissioned (Value Circle) Board development programme which addresses the recommendations of the leadership review undertaken by the interim Director of Governance, fostering unitary behaviours	Timely and accurate reporting of finance data
A reduction in who time equivalent (WTE) staffing as agreed in the WRP			Identification of finance and org risks and effective controls in BAF, Risk Management Processes, AAA reports at Board and subcommittee level	Establishment of a Programme Management Office (PMO) and appointment of Senior Responsible Officers (SRO) to manage delivery of financial and organisational plans
Finalisation of Commissioning Intentions with the ICB along with associated costs and in-year and medium-term impact assessment			Management of executive vacancies in line with ICB change programme mandates and through notification to and involvement with the NHSE regional team	
			Demonstrable assurance that any risk to quality and patient safety through WRP is mitigated	

Regulatory Undertakings - ELHT

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Undertaking Focus	Key Actions
Financial Planning	1.1 Within a timeframe set by NHS England, the Licensee will agree a 2025/26 Financial Plan with NHS England.
	1.2 The Licensee will deliver a quarter-on-quarter run rate improvement from Quarter 4 2024/25 and throughout 2025/26.
	1.3 The Licensee will comply with all documented actions required by the System Financial Turnaround Director through the IAG.
Recovery Support Programme	2.1 The Licensee will evidence all reasonable steps have been taken to meet the Recovery Support Programme (RSP) Exit Criteria as set out and agreed by the IAG, in accordance with the timescales agreed by the IAG.
	2.2 The Licensee will carry out a review of progress against the RSP Exit Criteria and report to the IAG, in accordance with the timescales agreed by the IAG.
	2.3 In line with the IAG Terms of Reference and the requirements of the NHS Oversight Framework segmentation, the Licensee will cooperate fully with NHS England, health sector stakeholders and any external agencies or individuals appointed to work with or support the Licensee to address the concerns which these undertakings seek to address.
Leadership and Governance	3.1 The Licensee will co-operate and engage as required with the "Governance and Leadership Review" initiated by NHS England and led by an NHS England appointed Improvement Director.
	3.2 The Licensee will ensure that it has in place sufficient and effective Board and management leadership capacity and capability, as well appropriate governance systems and processes to enable it to: 3.2.1 comply with the undertakings at paragraphs 1 and 2 effectively; and 3.2.2 address any other issues relating to governance or operations that have caused or contributed to, or are causing or contributing to, or will cause or contribute to, the breach of the conditions of the Licensee's licence
	3.3 The Licensee will inform NHS England prior to recruitment to executive board level posts and will (a) share the relevant person specifications with NHS England in draft for NHS England's comment. (b) provide a timetable for the appointment, and (c) ensure that there is NHS England representation on the interview panel.
Meetings and Reports	5.1 The Licensee will provide regular reports to NHS England through the IAG on its progress in meeting the undertakings set out above.
	5.2 The Licensee will attend monthly IAG meetings, or, if NHS England stipulates, conference calls, as required, to discuss its progress in meeting those undertakings. IAG meetings will be led by the System Financial Turnaround Director, with attendees specified by NHS England.
	5.3 The Licensee will provide NHS England with the assurance relied on by its Board in relation to its progress in delivering these undertakings, upon request.
	5.4 The Licensee will comply with any additional reporting or information requests made by NHS England.
Funding Conditions and Spending Approvals	4.1 Where interim support financing or planned term support financing is provided by the Secretary of State for Health to the Licensee under Schedule 5 to the National Health Service Act 2006, the Licensee will comply with any terms and conditions which attach to the financing.
	4.2 The Licensee will comply with any reporting requests made by NHS England in relation to any financing to be provided to the Licensee by the Secretary of State for Health pursuant to schedule 5 to the NHS Act 2006.
	4.3 The Licensee will comply with any spending approvals processes that are deemed necessary by NHS England.

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

Improvement Plan Delivery Update

October 2025 Month 6 Report

Safe | Personal | Effective

ELHT. *Because that's who we are*

Key messages this month

East Lancashire Hospitals NHS Trust
A University Teaching Trust

- We continue to see an improvement on the quarter on quarter normalised run rate but recognise that there needs to be increased focus on reducing costs recurrently to ensure delivery of the in-year financial plan
- We have delivered £18.4m Year to Date (YTD) of our Waste Reduction Programme against a plan of £21.5m. However this is only 30% of the total plan for the year and so the focus is on the actions required to deliver the remaining 70% plus mitigate operational pressures being identified.
- Our headcount reduction year to date is 409.06 WTE (contracted for substantive, worked for bank and agency) which represents 63% of plan and YTD reductions in bank and agency £1.2m favourable to plan (£6.1m reduction YTD from M12).
- Our revised forecast most likely case is £15.3m (£9.9m WRP and £5.4m operational pressures).
- Mitigation planning work continues to develop the detail of this including impact on WTE plan. Senior Leadership engagement very positive to build the plan.
- We continue to review and improve our approach to financial recovery. Further grip and control measures being identified as we embed the actions from PwC review and work to increase pace of impact.
- All actions on our leadership and governance plan are on track and our operational performance remains generally strong.

Financial Metrics – Month 6 – October 2025

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Summary of Financial Position

- In month **deficit of £5.34m**, against **deficit plan of £3.54m** therefore **£1.8m behind the plan**.
- YTD **deficit of £35.2m** against; deficit plan of £28m therefore **£7.3m behind plan** (excluding the DSF).
- In month **WRP delivered £2.9m** against the WRP Delivery plan, therefore **£2m adverse to plan** (£2.2m adverse to PFR plan)
- YTD **WRP delivered £18.4m** against the WRP Delivery plan, therefore **£3.1m behind plan**. (£5.9m adverse to PFR YTD plan)
- **Cash balance** at the end of September was **£13.0m**, an increase of £2.4m compared to M5 cash position of £10.6m.
- **Capital** Plan 2025-26 is £40.6m. At M6, spend is **£12.7m**, £2.5m ahead of plan.
- Paid/worked WTE have reduced 2 WTE from Month 5 to **9,685**

A full financial summary is provided in the evidence folder

RSP NOF 4 Exit Criteria- Progress Summary October 2025

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Exit Criteria	Delivery	Risk	Update/Escalations at Month 4	Overall Outcome
1. Deliver the financial plan submitted as agreed in April 2025 and the Waste Reduction Programme savings agreed in June 2025.	↓	↓	Trust Board has approved a financial plan for 2025/26. The WRP plan is in place with £60.8m fully developed. Workforce plan agreed with plan of 650 reduction in year. A grip and control action plan is in place with monitoring through the F&P Committee. A new Financial improvement group is now in place to oversee delivery of the financial recovery plan. A daily non-pay grip and control panel is now in place to further scrutinise non pay spend. M6 saw an in month deficit of £5.34m, against deficit plan of £3.54m therefore £1.8m behind the plan. YTD deficit of £35.2m against; deficit plan of £28m therefore £7.3m behind plan (excluding the DSF). Month 6 WRP delivered £2.9m against the WRP Delivery plan, therefore £2m adverse to plan (£2.2m adverse to PFR plan) YTD WRP delivered £18.4m against the WRP Delivery plan, therefore £3.1m behind plan. (£5.9m adverse to PFR YTD plan)	Outstanding
2. Deliver quarter-on-quarter run rate improvement throughout 2025/26.	↔	↔	There has been a quarter-on-quarter run-rate reduction since Q3 24/25. The Q1 normalised position has reduced from £23.2m in Q4, down to £21.8m in Q1, a £1.4m improvement, and a further improvement of £0.6m to £21.2m at Q2. The focus for the Trust needs to be to reduce costs recurrently and in turn reduce the underlying deficit into 2026/27.	Outstanding
3. Develop a medium-term financial recovery plan covering the period post 2025/26.	↓	↓	ELHT Director of Strategy and Improvement has led a system planning improvement event to review and revise the 2025/26 planning activities to ensure agreement of plans by end of Q3 2025/26. Work ongoing with commissioners to early identification and co-design of commissioning intentions to enable identification of risk and agreement of mitigation plans to inform plans for 2025/26. Commissioning intentions work is complete with intentions for 2026 onwards now recieved. A joint workshop with the ICB to develop the detail of commissioning intentions was held on 29th October. Planning groups have been stood up and work is ongoing for delivery of plans in anticipation of planning guidance. National planning guidance has been published but technical guidance has not yet been published. 1st draft submissions due December and final plans in January which is out of aligment with the exit criteria and will cause a risk to delivery.	Outstanding
4. Demonstrate effective financial and organisational governance structures and mechanisms.	↔	↔	Leadership and governance review completed and endorsed by RSP Improvement Director. Leadership and Governance Action Plan in place encompassing recommendations of financial governance reviews, NHSE nominated lead findings and governance review. A detailed Board development programme has been initiated, phase 1 is complete and phase 2 has commenced. The WRP process has been improved and monitoring process tightened. Progress against recommendations is evidenced in the action plan. Good progress is being made against the	Outstanding
5. Full participation in the Recovery Support Programme	↔	↔	The Trust continues to engage positively with the IAG, System Turnaround Director and national RSP leads in developing our programme. A financial recovery programme is in place, a PMO has been appointed and executive SROs identified for all programmes of work.	Outstanding

Regulatory Undertakings	Delivery	Risk	Update/Escalations at Month 4	Overall Outcome
Financial planning	↔	↔	The financial plan has been agreed with Trust Board and with NHS England All documented actions through IAG have been completed on a monthly basis. There has been a quarter-on-quarter run-rate reduction since Q3 24/25. The Q1 normalised position has reduced from £23.2m in Q4, down to £21.8m in Q1, a £1.4m improvement, and a further improvement of £0.6m to £21.2m at Q2. The focus for the Trust needs to be to reduce costs recurrently and in turn reduce the underlying deficit into 2026/27.	Outstanding
Recovery Support Programme	↑	↔	A detailed improvement plan has been developed, including supporting delivery plan outlining key actions with Exec SRO accountabilities. Further work has taken place this month on delivery against the cross cutting workstreams by Exec SROs with their teams.	Outstanding
Leadership & governance	↔	↔	Our governance and leadership action plan combines recommendations from all reviews completed. Recommendations are well in progress with more completed this month. The Board development plan is in place with initial sessions completed.	Outstanding
Funding conditions and spending approvals	↔	↔	The Trust has complied with all requirements in respect of approvals for external consultancy support for financial recovery activites.	Outstanding
Meetings and reports	↑	↑	Further work has been completed on the governance process underpinning to delivery of exit criteria and financial recovery including the establishment of the Financial Oversight Group and the Financial Improvement Group. Financial reporting to F&P Committee and oher groups has been significantly improved.	Outstanding

KEY:

The arrows represent the change from last month:
↑ Improvement from last month:
↔ No change from last month:
↓ Deteriorating position from last month:

Criteria Outcome: Outstanding | Evidence completed

Assurance Status
- Completed successfully for embeddedness/ sustainability
- On track to deliver to plan
- Some elements not on track, mitigations to deliver to plan
- Off track, with insufficient mitigation

Exit Criteria 1 – Progress Update

KEY:

The arrows represent the change from last month:
- ↑ Improvement from last month:
- ↔ No change from last month:
- ↓ Deteriorating position from last month:

Criteria Outcome: Outstanding | Evidence completed

Assurance Status
- Completed successfully for embeddedness/ sustainability
- On track to deliver to plan
- Some elements not on track, mitigations to deliver to plan
- Off track, with insufficient mitigation

Exit Criteria (1):

Deliver the financial plan submitted and agreed in April 2025 and the Waste Reduction Programme savings agreed in June 2025.

Reporting Mechanisms:

- Monthly financial reporting including income and outcome, and run rate, deficit support position and staffing expenditure. Reporting actual and position against plan.
- Monthly IAG reports and meeting letters to identify CIP identification and delivery against plan and progress against key expenditure categories and service re-design changes.

Recommended Outcome: Outstanding / In progress

Criteria	Evidence required	Delivery	Risk	Deadline Date	Exec SRO	Key update/escalations	Supporting Evidence
A 2025/26 financial outturn break-even position and overall financial deficit of no more than the £43.3m planned.							
	1. Financial plan for 25/26 agreed and signed off			01-Jun-25	Executive Director of Finance	Financial plan agreed in April 2025 and WRP agreed in June 2025.	**1.1 Trust Board paper** **1.2 F&P paper** **1.3 IAG slides**
	2. Monthly financial reporting including income and outcome, and run rate, deficit support position and staffing expenditure. Reporting actual and position against plan.	↓	↔	31-Mar-26	Executive Director of Finance	A monthly financial report including income and outcome, run rate, deficit support position and staffing expenditure is now in place. This is reported actual and position against plan as required. This is reported through FOG (Finance Oversight Group) and to Finance & Performance Committee . It is also reported at IAG on a monthly basis. The summary financial report is also shared at our Senior Leadership Group with all senior leaders.	**1.4 FOG report - latest month. F&P financial report.** **1.5 F&P Committee financial report - monthly reports** **1.6 IAG slides/report - monthly reports**
Achievement of the planned Waste Reduction Programme (WRP) £60.8m savings with fully developed Cost Improvement Plans (i.e. Board signed PIDs) in excess of £61m to offset any under delivery.							
	1. Full WRP plan for 25/26 - CIP tracker	↓	↓	01-Jun-25	Chief Executive / Exec SROs	A full WRP plan for 25/26 is in place and was signed off in June 2025. All schemes are fully developed and delivery is being tracked through the PMO. QIRAs have been signed off by the Medical Director and Chief Nurse. The schemes have also been aligned with the cross cutting workstreams that have accountable officers. This is monitored operationally through Finance Improvement Group and Finance Oversight Group and through the Finance and Performance Committee. It is also reported through IAG on a monthly basis. There is some slippage against WRP schemes and a risk to delivery has been identified of £9.9m against a plan of £60.8m. Work is now underway to identify mitigations to support the delivery of the WRP plan in full.	**1.7 Full WRP plan signed off by Trust Board** **1.8 QIRA Process and SOP** **1.9 Updated CIP Tracker process issued 21/08/2025** **1.10 Summary of schemes against each cross cutting workstream** **1.11 TOR - Cross cutting workstreams** **1.12 TOR - Financial Improvement Group** **1.13 TOR - Financial Oversight Group**
	2. F&P WRP progress update report	↓	↓	31-Dec-25	Executive Director of Finance	A detailed F&P progress report continues to be developed and refined to support approriate reporting through FIG and the financial recovery report to F&P. The Financial Oversight Group also supports/tightens reporting governance through F&P. Work is ongoing to refine this based on implementation of a revised WRP trakcer and development of new reporting capabilities.	FOG month as noted in 1.4 above Finance and Performance Committee finance report as noted above in 1.5
	3. Monthly IAG reports and meeting letters to identify CIP identification and delivery against plan and progress against key expenditure categories and service re-design changes.	↓	↔	31-Mar-26	All Executive SROs	CIP identification and delivery against plan is managed through a refreshed governance process. Cross cutting workstreams with Executive SROs are in place to drive delivery through the year. This is supported by the Financial Improvement Group which meets fortnightly, chaired by the Trust CEO. Work is underway to identify risks to delivery to support FOT reporting and the development of mitigation plans to ensure delivery of the plan in full.	IAG report - August and September 2025 as noted in 1.6 above
Delivery against key expenditure categories as outlined in the financial plan and WRP							
	Monthly reporting	↔	↔	31-Mar-26	All Executive SROs	Monthly financial reports to FOG, FIG and F&P.	Monthly report for FOG, F&P and IAG As above.
A reduction in whole time equivalent (WTE) staffing as agreed in the WRP.							
	Detailed WTE staffing plan aligned to the WRP plan.	↓	↓	01-Jun-25	Chief People Offider	There is a detailed WTE plan aligned to our WRP plan for 2526. A total of 650 WTE reduction is planned by month 12. A phased reduction plan is in place. The WTE plan is in the process of being fully reviewed in light of FOT analysis and re-profiling will take place in accordance with mitigation plans agreed.	**1.15 WTE reduction plan signed off by Trust Board** **1.16 Update to People & Culture Committee -August 2025**
	Reduction in WTE as per the agreed profiled plan	↔	↔	31-Mar-26	Exec SROs	Headcount reduction YTD (M6) is 409.06 WTE (contracted for substantive, worked for bank and agency). This is 106.47 WTE behind plan which has improved by 22.76 WTE compared to M5. (The wte reduction on a worked/paid basis for all staff is 445 to month 6). Year to date reductions in bank and agency is £1.2m favourable to plan (£6.1m YTD). Work is ongoing to re-profile the WTE plan including mitigation plans.	as noted in evidence 1.5 above
Finalisation of commissioning intentions with the ICB along with associated costs and in-year and medium- term impact assessment.							
	Commissioning intentions summary including costs and in year/ medium term	↓	↔	31-Dec-25	Director of Service	A plan for 2025-26 has been agreed. Finalisation of segment 0/1 commissioning intentions planned completed by end August 2025 but the final outcome needs finalising to feed into contracting discussions	**1.17 Minutes of meetings, letters.** **1.18 Summary of CI work in 2025/6 - report to Board**
	Commissioning intentions for 2627 - summarised plan including income and cost	↔	↔	31-Dec-25	Director of Service	Work ongoing in 2025 will feed into commissioning intentions for 2627 and the ICB has a clear timeline for delivery in place. Details and assessments are still to be completed - which will be completed by end Q3.	**1.19 - letters from ICB** **1.20 - Workshop papers and agenda and outputs - 29th October**

Exit Criteria 2 – Progress Update

Exit Criteria (2):	**Reporting Mechanisms:**	**Recommended Outcome:**
Deliver quarter-on-quarter run rate improvement throughout 2025/26	- Quarterly regional reporting as part of Regional Support Group oversight - Monthly IAG reports and meeting letters	**Outstanding / In Progress**

Criteria	Evidence required	Delivery	Risk	Deadline Date	Lead Exec SRO	Key update/escalations	Supporting Evidence
The organisation with deliver a quarter on quarter run rate throughout 2025/26.							
	Quarterly regional reporting as part of Regional Support Group oversight.	↔	↔	Quarterly reports to end of 25/26	Executive Director of Finance	There has been a quarter-on-quarter run-rate reduction since Q3 24/25. The Q1 normalised position has reduced from £23.2m in Q4, down to £21.2m in Q2, a £2m improvement, and a further improvement of £0.6m to £21.2m at Q2.. Workstreams have all been assigned Executive SROs with accountability through the FIG. Grip and control processes in place and are currently being refreshed through the PMO and Executive SROs. Mitigaiton plans being developed to support WRP delivery.	F&P Report as per evidence number 1.1 IAG report - as per evidence number 1.3 **2.1 Grip and control SOP and associated papers**
	Monthly IAG reports and meeting letters	↔	↔	Monthly updates to end of 25/26	Executive Director of Finance		
Robust expenditure controls in line with PwC recommendations.							
	Grip and Control cross-cutting workstream establishment	↔	↔	Monthly updates to end of 25/26	Executive Director of Finance	The Trust received the updated assessment of Grip and Control from PwC on 14th July 2025 It contained 112 recommendations – of which 88 were rated as red and amber (62 pay) The PMO co-ordinates updates against the plan and these are reported to F&P, People and Culture Committeee and Audit Committee. Pay – a full update on the new PWC actions has been provided to People and Culture Committee as part of the Workforce Update Paper. In addition, there is enhanced control processes established including a daily variable pay control panel and weekly vacancy control panel. Non-pay – key actions underway as part of a new enhanced non-pay grip and control process are: Establishment of non-pay working group to oversee implementation of enhanced grip and control measures inclusive of One LSC/Procurement. Establishment of daily MDT non-pay panels to scrutinise all agreed aspects of non-pay based on requsition value PMO roles identified to focus on non-pay grip and control and support of panels preparation summaries and output capture. Ongoing management and ownership of grip and control processes Agreement of a non-pay exemption list for certain categories, alternatively NHSSC spend ceiling imposition based on historic ordering patterns to reduce run rate impact promptly to avoid these coming to panel e.g. items to avoid clinically urgent delays and optimise use of resources Communications – Trust-wide road shows and all relevant information on OLI sharepoint site and available trust-wide communication channels, followed by dry-runs Further measures are being developed which are reflected in the IAG M6 Grip and Control update.	**2.2 G&C workstream reports** **2.3 Response to PwC recommendations** **2.4 Sharepoint / OLI information** **2.5 Pay and Non-Pay panel records** Finance reports - as per 1.1 and 1.3 evidence
	Enhanced Grip and Control measures	↔	↔	Monthly updates to end of 25/26	Executive Director of Finance		
	Response to PwC Grip and Control Recommendations	↔	↔	Monthly updates to end of 25/26	Executive Director of Finance		

KEY:

The arrows represent the change from last month:
- ↑ Improvement from last month:
- ↔ No change from last month:
- ↓ Deteriorating position from last month:

Criteria Outcome: Outstanding | Evidence completed

Assurance Status
- Completed successfully for embeddedness/ sustainability
- On track to deliver to plan
- Some elements not on track, mitigations to deliver to plan
- Off track, with insufficient mitigation

Exit Criteria 3 – Progress Update

Exit Criteria (3):	Reporting Mechanisms:	Recommended Outcome:
Develop a medium-term financial recovery plan covering the period post 2025/26	- Monthly IAG reports and meeting letters	Outstanding / In Progress

Criteria	Evidence required	Delivery	Risk	Deadline Date	Exec SRO	Key update/escalations	Supporting Evidence
A Board and IAG approved plan for financial recovery and maintenance beyond 2025/26 by the end of Q3							
	Clear planning process, timetable and assumptions in place to support agreement of medium-term plan	↓	↓	End Dec 25	Exec Director of Finance	Planning for phase 1 of planning (following national planning guidance) now in progress. Planning meeting stood up from September 2025. System planning meetings stood up. Planning updates monitored through PCB executive group. Alignment with commissioning intentions into the planning timeline- now received with a joint workshop with the ICB on 29th October. National planning guidance has been published but technical guidance has not yet been published. 1st draft submissions due December and final plans in January which is out of aligment with the exit criteria and will cause a risk to delivery.	**3.1 Exco planning updates - July and August and Sept 2025** **3.2 System planning timeline** **3.3 System Planning minutes** **3.4 System meeting notes**
	Engagement and robsut review of commissioning intentions	↓	↓	End Dec 25	Director of Service Development & Improvement	Commisioning intentions review during 2025/6 complete. Commissioning intentions for 2026 onwards received and joint workshop held on October. The PSC commissioned by the ICB to support quantification of commissioning intetions. This will not be available until late November.	summary of commissioning intentions work in 2025 when published by ICB - as per evidence 1.17 and 1.18 Letters for 2026 onwards - 1.18
	Financial plan including WRP plan for 26/27 by end of Q3, signed off by Board	↓	↓	End Dec 25	Exec Director of Finance	Planning timeline in progress to match national planning guidance. Significant work ongoing to develop WRP schemes for 2026-7 as part of the ongoing WRP meetings. Schemes are being added to the pipeline on a weekly basis. The Service reviews are supporting the process of speciality financial planning for nex year.	**3.5 F&P and Trust Board reports**
	Monthly IAG reports and meeting letters	↔	↔	Monthly	All Exec SROs	This will document discussions held at IAG by way of updates	Monthly IAG reports and meeting letters - as per 1.6

KEY:

The arrows represent the change from last month:
↑ Improvement from last month:
↔ No change from last month:
↓ Deteriorating position from last month:

Criteria Outcome: Outstanding | Evidence completed

Assurance Status
- Completed successfully for embeddedness/ sustainability
- On track to deliver to plan
- Some elements not on track, mitigations to deliver to plan
- Off track, with insufficient mitigation

Exit Criteria 4 – Progress Update

KEY:

The arrows represent the change from last month:
↑ Improvement from last month:
↔ No change from last month:
↓ Deteriorating position from last month:

Criteria Outcome: Outstanding | Evidence completed

Assurance Status
- Completed successfully for embeddedness/ sustainability
- On track to deliver to plan
- Some elements not on track, mitigations to deliver to plan
- Off track, with insufficient mitigation

Exit Criteria (4):
Demonstrate effective financial and organisational governance structures and mechanisms

Reporting Mechanisms:
Monthly IAG reports which identify participation in governance and leadership activity.
By end of July presentation of a governance and leadership actions plan to the IAG and monthly review of progress.

Recommended Outcome:
Outstanding / In progress

Criteria	Evidence required	Delivery	Risk	Deadline Date	Exec SRO	Key update/escalations	Supporting Evidence
Development of an improvement plan to ensure timely response, evidence and completion of recommendations in the Governance Review of April 2025.							
	Monthly IAG reports which identify participation in governance and leadership activity.	↔	↔	Monthly	Director of Service Development & Improvement	Updates provided to IAG on a monthly basis.	**4.1 IAG minutes**
	Full improvement plan signed off by Board	↔	↔	01-Sep-25	Director of Service Development & Improvement	First draft of improvement plan reviewed at July Trust Board. Final draft of improvement plan to be presented at FIG end August and September IAG/Board meetings	**4.2 copy of improvement plan and Trust Board minutes - July 2025** **updated improvement plan and delivery plan - August and sept 2025**
A Board/Improvement and Assurance Group agreed governance and leadership action plan in response to the recommendations of the Governance Review of April 2025, and following publication of the Seagry review outcomes							
	By end of July presentation of a governance and leadership action plan to the IAG and monthly review of progress.	↔	↔	end July 2025	Director of Corporate Governance	Governance and leadership action plan completed combining all previous reviews. Signed off at Trust Board on 28th July and submitted to IAG on 30th July. Draft Seagry 2 Report received and action plan updated to reflect the new recommendations and progress against Seagry 1 recommendations.	**4.3 Governance and leadership action plan** IAG minutes as]er 4.1
	Completion of recommendations in the Governance Reivew of April 2025	↔	↔	31-Mar-26	Director of Corporate Governance	All governance review actions are complete or underway and are incorporated into the governance and leadership action plan. The only red area is in relation to timeliness of Board and Committee papers. Several actions	Governance and leadership action plan as per 4.3
	Commission Wider Financial Governance Stage 2 review	↔	↔	end August 2025	Director of Corporate Governance	The second Seagry review is in progress and a draft report has been recevied. Seagry 2 draft report presented to the Board on 10 September. All recommendations accepted and incorporated into overarching G&I	**4.4 - all documents in relation to Seagry**
	Incorporate fiindings of wider financial governance review into the governance and leadershop action plan once recevied	↔	↔	end September 2025	Director of Corporate Governance	The Trust leadership and governance action plan now incorporates recommendations from all reviews including the wider Governance Review from the Stage 2 Seagry review.	**4.5 Revised Leadership and goverance action plan** **4.6 minutes of sign off at Board of updated action plan**
Identification of financial and organisational risks and effective controls as evidenced in Board Assurance Framework and Risk Management processes and triangulation via Triple A reporting at subcommittee and Board level.							
	Board Assurance Framework reviewed and updated	↔	↔	30/09/2025	Director of Corporate Governance	BAF risks for 2025/26 reviewed and updated and risk appetite strameents agreed by Trust Board in April 25. Work ongoing to improve updates/reporting. New format agreed at October Audit Committee to be implemented from Quarter 4.	**4.8 Traingulation to Tripe A reporting - checking assurance is True, actions underneath - consider need for a workstream review to stand back and reflect on improvements**
	Risk Management Strategy reviewed and updated	↔	↔	31/10/2025	Medical Director	Risk Management Framework and Strategy and approved at Audit Committee in October.	**4.9 Evidence at ERAG as a specific agenda item for financial recovery** QIRA process and SOP as per evidence as per evidence 1.8
	Corporate Risk Register reviewed and updated	↑	↔	30/09/2025	Medical DIrector	Initial review completed and risk register and CRR completely overhauled. Ongoing meetings with Risk owners to review and update CRR risks. Executive Risk Assurance Group where the CRR is considered now formally reports to Audit Committee.	**4.10 Corporate Risk Register review session notes.outcomes, ERAG notes**
Management of executive team vacancies in line with agreed ICB change programme mandates and through notification to and involvement with the NHS England regional team.							
	Evidence of due process as required for any recrtuiment	↔	↔	Ongoing	Director of Corporate Governance	Medical Director appointment completed in line with process. Interim Chief People Officer completed in line with process.	**4.11 Recruitment information**
Demonstrable assurance that any risk to quality and patient safety through the delivery of CIP's is mitigated.							
	Review of QIRA process	↑	↔	31/10/2025	Chief Nurse	Review of QIRA process underway.	Evidence of QIRA review process as per evidence 1.8
	Evidence of QIRA reviews via Quality Committee	↑	↔	31/10/2025	Chief Nurse	QIRAs are reported to Quality Committee. Review of role of Quiality Committee to strengthen oversight to be undertaken on back of QIRA process review	**4.12 Quality Committee papers**

Exit Criteria 5 – Progress Update

Exit Criteria (5):	Reporting Mechanisms:	Recommended Outcome:
Full participation in the financial recovery support programme	- Monthly IAG reports which identify participation in the RSP	Outstanding / in progress

Criteria	Evidence required	Delivery	Risk	Deadline Date	Exec SRO	Key update/escalations	Supporting Evidence
Executive Board attendance at monthly Improvement and Assurance Group meetings.							
	Attendance at IAG	↔	↔	31-Mar-26	Full Board	All Executive Board including Non-Executive Directors now attend IAG meetings	IAG minutes as per evidence 4.1
Engagement with the Turnaround Director and associated support executive team and response to requested actions including monthly reporting, financial planning and specific project deliverables.							
	Proactive engagement with PwC Central team	↔	↔	31-Mar-26	Full Board	IAG pre-meets, ongoing PID reviews, ongoing developing of reporting	**5.1 - evidence of correspondence and meetings**
	Regular meetings with System Turnaround Director	↔	↔	31-Mar-26	Full Board	Meetings through IAG	IAG minutes as per evidence 4.1
Timely and accurate reporting of financial data.							
	Detailed financial data available at Finance and Performance Committee and Trust Board. Detailed financial review through improved governance meetings.	↔	↔	31-Mar-26	Exec Director of Finance	Financial data reporting has been improved at both IAG and F&P and Trust Board. Detailed review of data is completed at the newly established Financial Oversight Group and Financial Improvement Group. Work is ongoing to improve the timeliness of papers to be circulated for F&P.	**5.2 - FOG TOR and all minutes** **5.3 - FIG TOR and all minutes**
Establishment of a trust wide Project Management Office (PMO) function and appointment of Senior Responsible Officers (SROs) to manage delivery of financial and organisational plans.							
	Establishment of PMO funcion	↓	↓	31-Mar-26	Director of Service Development & Improvement	PwC instructed to support PMO function from April to August 2025. PMO now staffed from internal resources in support of financial recovery in the Trust. Establishment of PMO is progressing but a full review has been undertaken in October. New support for the PMO has been identified and commenced from 3/11/25 with support from the NHS Transformation Unit.	**5.4 PMO updates to F&P**
	Appointment of SROs to manage delivery of financial and organisational plans	↓	↓	31-Mar-26	Director of Service Development & Improvement	Cross cutting workstreams established including ToR and alignment to financial delivery and WRP delivery. Each workstream has an identified Executive SRO, PMO link, clinical link and operational leads. The Finance Improvement Group, chaired by the CEO, will hold executive SROs to account for delivery - this meets fortnightly. Further work ongoing to mature the cross-cutting workstreams and associated reporting.	FIG minutes as per evidence 5.3 above **5.5 Workstream Highlight Reports - examples** **5.6 F&P updates - example reports**

KEY:

The arrows represent the change from last month:
- ↑ Improvement from last month:
- ↔ No change from last month:
- ↓ Deteriorating position from last month:

Criteria Outcome: Outstanding | Evidence completed

Assurance Status
- Completed successfully for embeddedness/ sustainability
- On track to deliver to plan
- Some elements not on track, mitigations to deliver to plan
- Off track, with insufficient mitigation

Regulatory Undertakings - Progress Summary October 2025

East Lancashire Hospitals NHS Trust

All Exit Criteria link to the Regulatory Undertakings. The table below provides a summary of updates at Month 6. There is a detailed breakdown of updates against each sub-section of the undertakings with cross referencing of relevant evidence and exit criteria as part of the RSP Exit Criteria Supporting Plan.

Undertaking Focus	Key Actions	Delivery	Risk	LEAD Exec SRO	Key Update/Escalations	Supporting Evidence
Financial Planning		↓	↔			
	1. Within a timeframe set by NHS England, the Licensee will agree a 2025/26 Financial Plan with NHS England.			Chief Executive	The financial plan has been agreed with Trust Board and with NHS England	Full financial plan
	1.2 The Licensee will deliver a quarter-on-quarter run rate improvement from Quarter 4 2024/25 and throughout 2025/26.	↔	↔	Exec Director of Finance	There has been a quarter-on-quarter run-rate reduction since Q3 24/25. The Q1 normalised position has reduced from £23.2m in Q4, down to £21.2m in Q2, a £2m improvement. The focus for the Trust needs to be to reduce costs recurrently and in turn reduce the underlying deficit into 26/27.	F&P monthly finance report IAG reports
	1.3 The Licensee will comply with all documented actions required by the System Financial Turnaround Director through the IAG.	↑	↔	Chief Executive	All documented actions through IAG have been completed on a monthly basis.	IAG action plans and evidence of completion
Recovery Support Programme		↑	↔			
	2.1 The Licensee will evidence all reasonable steps have been taken to meet the Recovery Support Programme (RSP) Exit Criteria as set out and agreed by the IAG, in accordance with the timescales agreed by the IAG.	↑	↔	Director of Service Development & Improvement	An improvement plan has been presented to Trust Board in July 2025 and further iterated with support of the national RST lead. This is now monitored monthly and updated with progress. Formal reporting to IAG and NHSE will start from November.	Improvement plan and supporting delivery plan
	2.2 The Licensee will carry out a review of progress against the RSP Exit Criteria and report to the IAG, in accordance with the timescales agreed by the IAG.	↑	↔	Director of Service Development & Improvement	The updated Improvement Plan is being presented at the October Financial Improvement Group and IAG in November 2025.	IAG minutes
	2.3 In line with the IAG Terms of Reference and the requirements of the NHS Oversight Framework segmentation, the Licensee will cooperate fully with NHS England, health sector stakeholders and any external agencies or individuals appointed to work with or support the Licensee to address the concerns which these undertakings seek to address.	↔	↔	Chief Executive	There has been significant engagement with NHSE leads as we develop our exit criteria plan and improvements required. The Trust works collaboratively with partners including the ICB and through the IAG to provide assurance on	IAG minutes, meeting summaries with NHSE leads,
Leadership & Governance		↔	↔			
	3.1 The Licensee will co-operate and engage as required with the "Governance and Leadership Review" initiated by NHS England and led by an NHS England appointed Improvement Director.	↔	↔	Director of Corporate Governance	Goverenance Review completed April 2025. Findings and recommendations endorsed by NHSE Improvement Director and accepted by the Board. Our governance and leadership action plan combines recommendations from all reviews completed. Recommendations are well in progress with more	**R1 - Governance Diagnostic Report April 2025.Leadership and governance action plan** **R2 - Minutes of Board sign off**
	3.2 The Licensee will ensure that it has in place sufficient and effective Board and management leadership capacity and capability, as well appropriate governance systems and processes to enable it to: 3.2.1 comply with the undertakings at paragraphs 1 and 2 effectively; and 3.2.2 address any other issues relating to governance or operations that have caused or contributed to, or are causing or contributing to, or will cause or contribute to, the breach of the conditions of the Licensee's licence	↔	↔	Director of Corporate Governance	A Board leadership and governance action plan is in place incorporating the second Seagry review. Phase 1 Board development completed. Phase 2 Board developed agreed and commissioned to commence Dec 2025 (once new Chair joins) - June 2026. Additional RSP funding secured to support the delivery of the G&L Action Plan. Succession planning underway with NHSE for new Chair.	Summary of Board development as per evidence 4.7 Attendance, programmes for the days -as per evidence 4.7 Value circle baseline - request value circle re-observation in coming months -as per evidence 4.7 **R3 - Request a Board reflection and review as evidence of progress**

Regulatory Undertakings - Progress Summary October 2025

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Undertaking Focus	Key Actions	Delivery	Risk	LEAD Exec SRO	Key Update/Escalations	Supporting Evidence
	3.3 The Licensee will inform NHS England prior to recruitment to executive board level posts and will (a) share the relevant person specifications with NHS England in draft for NHS England's comment. (b) provide a timetable for the appointment, and (c) ensure that there is NHS England representation on the interview panel.	↓↔	↔	Director of Corporate Governance	There has been appropriate involvement of the ICB and NHSE in the appointment of the Executive Medical Director and Interim Director of People and Culture (shared arrangement with Lancashire Teaching Hospitals NHS Trust). Board succession planning paper to Sept Rem Comm. There are no foreseen Executive appointments in the next 6-12 months.	Evidence of engagement during appointment as per evidence 4.11
Funding Conditions and Spending Approvals		↔	↔			
	4.1 Where interim support financing or planned term support financing is provided by the Secretary of State for Health to the Licensee under Schedule 5 to the National Health Service Act 2006, the Licensee will comply with any terms and conditions which attach to the financing.	↔	↔	Exec Director of Finance	The Trust has complied with all requirements in respect of approvals for external consultancy support for financial recovery activites.	**R4 - Evidence of completion of NHS approval paperwork for external consultancy support and relevant emails.**
	4.2 The Licensee will comply with any reporting requests made by NHS England in relation to any financing to be provided to the Licensee by the Secretary of State for Health pursuant to schedule 5 to the NHS Act 2006.	↕↔	↔	Exec Director of Finance	The Trust has complied with all requirements in respect of approvals for external consultancy support for financial recovery activites.	Evidence of completion of NHS approval paperwork for external consultancy support and relevant emails as per R4 above.
	4.3 The Licensee will comply with any spending approvals processes that are deemed necessary by NHS England.	↑↔↑	↔	Exec Director of Finance	The Trust has complied with all requirements in respect of approvals for external consultancy support for financial recovery activites.	Evidence of completion of NHS approval paperwork for external consultancy support and relevant emails as per R4 above.
Meetings & Reports		↑	↑			
	5.1 The Licensee will provide regular reports to NHS England through the IAG on its progress in meeting the undertakings set out above.	↔↑	↔	Director of Service Development & Improvement	A detailed improvement plan will be presented to Nov 25 IAG and will be uploaded to NHSE.	IAG minutes and actions as per evidence 4.1
	5.2 The Licensee will attend monthly IAG meetings, or, if NHS England stipulates, conference calls, as required, to discuss its progress in meeting those undertakings. IAG meetings will be led by the System Financial Turnaround Director, with attendees specified by NHS England.	↔	↔	Chief Executive / all Exec	IAGs have been attended by the Executive team or appropriate deputy. They are chaired by the System Financial Turnaround Director.	IAG minutes and attendance lists as per evidence 4.1
	5.3 The Licensee will provide NHS England with the assurance relied on by its Board in relation to its progress in delivering these undertakings, upon request.	↑	↑	Director of Service Development & Improvement	A detailed improvement plan and progress reports are provided through IAG and as requested. A joint Sharepoint has been established in August 2025 to share evidence and provide assurance to NHSE leads.	Improvement plan Sharepoint site
	5.4 The Licensee will comply with any additional reporting or information requests made by NHS England.	↔	↔	Director of Service	No additional requests at this time	**R5 - Evidenbce of reponse to requests as approriate.**

KEY:

The arrows represent the change from last month:
↑ Improvement from last month:
↔ No change from last month:
↓ Deteriorating position from last month:

Criteria Outcome: Outstanding | Evidence completed

Assurance Status
- Completed successfully for embeddedness/ sustainability
- On track to deliver to plan
- Some elements not on track, mitigations to deliver to plan
- Off track, with insufficient mitigation

EVIDENCE & ASSURANCE

East Lancashire Hospitals NHS Trust
A University Teaching Trust

➢ Finance update to F&P – Month 6	Appendix 1
➢ Leadership and Governance Action Plan	Appendix 2
➢ RSP Exit Criteria Supporting Plan	Appendix 3

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD

Meeting Date:	12 November 2025	**Agenda Item:**	TB/2025/150
Report Title:	Board Capability Self-Assessment		
Author:	Susan Giles Interim Director of Corporate Governance/Company Secretary		
Lead Directors:	Board of Directors		

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

Executive Summary:

As part of the NHS Oversight Framework (NOF) NHSE will be assessing, and publishing, a rating of provider capability alongside their NOF segmentation ranking.

A Trust's capability rating will be based on an annual Board self-assessment against the six domains of NHSE's 'The Insightful Provider Board'.

The proposed certifications are against the domains are as follows:

Strategy	Partially confirmed
Quality	Confirmed
People & Culture	Confirmed
Access & Delivery	Partially confirmed
Productivity & VFM	Confirmed
Finance	Partially confirmed

The Trust is required to submit the high-level self-certification against the six domains (appended to this paper), together with the supporting paper to Board.

Key Issues/Areas of Concern:	
Action Required by the Executive:	The Board is asked to review the self-assessment and, subject to any changes, approve it for submission to NHSE.

Previously Considered by:	Executive Team
Date:	28th October 2025
Outcome:	Draft self-certification approved for submission to the Board.

1 Introduction

As part of the NHS Oversight Framework (NOF) NHSE will be assessing, and publishing, Trust's capability alongside their NOF segmentation ranking.

A Trust's capability rating will be based on an annual Board self-assessment. This approach is designed to:

- Promote **board-level self-awareness** and transparency (an underpinning principle of the framework is that of 'no surprises' between Trusts and oversight teams).
- Enable NHSE to assess a provider's **capacity for improvement**.
- Determine NHSE's improvement response.
- Align with existing governance reviews and reporting mechanisms.

2 Self-Assessment Framework

Boards must self-assess against the six domains outlined in NHSE's The Insightful Provider Board:

- Strategy, leadership and planning
- Quality of Care
- People and culture
- Access and delivery of services
- Productivity and value for money
- Financial performance and oversight

Boards must identify if they are 'compliant', 'partially compliant' or 'not met'. The self-assessment is not designed to be a tick box exercise in compliance but rather to encourage Boards to demonstrate a grip on governance and leadership and be candid about gaps in compliance and risks together with remedial action being taken.

NHS England recognise that the board may not be able to make a positive self-assessment either because it considers the risks in a specific area are too great or its organisation is already manifestly failing in a specific area (for example, delivering on access targets). In these situations, boards are asked to explain:

- the reasons why a positive self-assessment cannot be made against specific criteria and the extent to which these have been outside the trust's control to address (for example, industrial action, system-wide factors)
- how long the reasons have persisted
- a summary of any mitigating actions the trust has taken or is taking
- if not already shared with oversight teams, a high-level description of trust plans to address the issue, how long this is likely to take and KPIs or other information the trust will use to assess progress

The self-assessment process must align with the Annual Governance Statement and Board Assurance Framework.

3 NHSE Review

A review of the returns will then be conducted by NHS England within 4 weeks of receiving the self-assessment. Regional oversight teams will consider the Board's self-assessment against their own intelligence and third-party evidence from other regulators and information such as the staff survey to rate the Trust's capability as follows:

- Green – high confidence in management
- Amber-green – some concerns or areas that need addressing
- Amber-red – material issue needs addressing or failure to address major issues over time
- Red – significant concerns arising from poor delivery, governance and other issues.

The capability rating will be discussed with the Board and used to inform the level of scrutiny and support a Trust receives. The finalised capability ratings should be published in December 2025. Trusts that are going to be allocated to the Provider Improvement Programme will be informed at this time.

4 Process for completion of the self-assessment

A self-assessment against the criteria and underpinning key lines of enquiry (appendix 1) has been completed by the Executive Team and relevant operational leads.

The Trust has also consulted with Dr April Brown, RSP Improvement Director, and her helpful observations as someone who has been supporting the Trust for some months, have been incorporated into the self-assessment.

5 Assessment against the domains

Strategy, leadership and planning – Partially confirmed

Whilst the Trust has a current strategic framework and supporting strategies in place, it is conducting a full strategy refresh, which will be aligned to the NHS 10 year plan and system priorities and aligned to the medium term plan to be developed as part of the new Planning Framework for the NHS in England. As part of this work the Trust has received notification of the commissioning intentions for 26/27 and is working through these to understand the impact upon the Trust.

The Trust chair finishes his first term on 28 November 2025 and the Trust is awaiting confirmation from NHSE regarding the process for appointing the Chair's successor. A Non Executive Director (NED) recruitment campaign for 3 substantive NED posts is on hold pending the appointment of the new Chair.

Quality of care – Confirmed

The Trust has a comprehensive governance framework to ensure high standards in clinical effectiveness, patient safety, and quality improvement. Central to this is the Annual Audit Forward Plan, which aligns national and local audit participation. The Clinical Effectiveness and Audit Team, reporting to the Executive Medical Director, oversees compliance with NICE guidance and GIRFT reviews, while the Clinical Effectiveness Group escalates concerns to senior governance forums. Risks are assessed for immediate action or inclusion on the Corporate Risk Register (CRR), with incidents tracked via Datix and reviewed through daily triage and weekly Complex Case Meetings.

Quality oversight is embedded at all levels, with monthly reviews at Trust-wide Quality Governance Groups and the Executive Risk Assurance Group (ERAG), chaired by the Chief

Executive. The Board receives regular updates on the Quality Strategy, PSIRF, CRR, and patient experience data, including FFT and national surveys. Staff and patient engagement is fostered through initiatives like Listening Labs, Quality Walkrounds, and Senior Support and Share visits. The Trust also ensures learning from legal claims, inquests, and national reviews, while external assurance is provided to the ICB via the Quality Scorecard. The Quality Committee, supported by a skilled executive and non-executive team, operates under a defined workplan and monitors progress against the Clinical Strategy using live dashboards and narrative reports.

People and culture – Confirmed
The People & Culture Committee review diversity and staff experience reports. Staff survey results and action plans are reviewed by the board. There are numerous staff networks in place with lead NEDs for them all. Staff side is a key partner at the People & Culture Committee.

Compliance with mandatory training is monitored by the Board via the Integrated Performance Report.

The Freedom to Speak Up (FTSU) Guardian is another key partner at People & Culture Committee and provides an annual report to the Board. Every concern raised is treated as serious, the more complex concerns will receive oversight and attention as and when required with the Guardians having access to senior managers and direct executive directors who will intervene when required to do so. There is a lead NED for FTSU. In 24/25 there was an increase of 33% in concerns raised, including an increase in reporting from BAME colleagues. Indicative of a culture of reporting and raised awareness of processes. In the last staff survey the Trust was not an outlier for raising concerns and was 6.68 above the average of 6.39.

Access and delivery of services – Partially confirmed
The Trust is in tier 3 for RTT and A&E performance targets. There are Board approved recovery plans in place to achieve compliance however the Trust is awaiting confirmation that overperformance to deliver RTT will be funded. In addition, if winter pressures exceed the Trust's mitigation plans this will put the achievement of these targets at risk.

Productivity and value for money – Confirmed
The Trust participates in the GIRFTFF20 programme. There are directorate level productivity plans in place utilising GIRFT and Model Hospital data. Productivity opportunities have been identified and built into operational plans for 2025/26. In addition, the Trust performs well on theatre productivity, consistently in the top 3 Trusts in the country. The 2024/25 external audit found no significant weaknesses in the Trust's arrangements for improving economy, efficiency and effectiveness.

Financial performance and oversight – Partially confirmed
The Trust is in NOF5 for finance, governance and leadership. As a result of external reviews of financial governance, support from PwC and the establishment of a Programme Management Office (PMO), the Trust has a strengthened financial governance framework. At month 6 the Trust is behind plan, there is a need to increase grip and control to ensure that the Trust recovers its WRP plan during months 7-12. Internal audit will be conducting reviews of the Cost Improvement Programme, Non-Pay controls and bank and agency staffing in Quarter 3 and 4.

6 Next steps

Subsequent to Board approval the self-assessment will be submitted to NHSE by 5pm on 12th November 2025.

The self-assessment will also be shared with ValueCircle to inform our Board Development Programme.

Any material in-year changes to compliance must be reported to the regional oversight team and therefore the annual self-assessment cannot be a one off annual exercise but Board's must give consideration to compliance on an ongoing basis.

7 Recommendation

The Board is asked to review the self-assessment and, subject to any changes, approve it for submission to NHSE.

Appendix 1

I. Strategy, leadership and planning

Self-assessment criteria	Indicative evidence or lines of enquiry
1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners.	• Are the trust's financial plans linked to and consistent with those of its commissioning integrated care board (ICB) or ICBs, in particular regarding capital expenditure? • Are the trust's digital plans linked to and consistent with those of local and national partners as necessary? • Do plans reflect and leverage the trust's distinct strengths and position in its local healthcare economy? • Are plans for transformation aligned to wider system strategy and responsive to key strategic priorities agreed at system level?
2. The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHS England.	• Is the trust currently complying with the conditions of its licence? • Is the trust meeting requirements placed on it by regulatory instruments – for example, discretionary requirements and statutory undertakings – or is it co-operating with the requirements of the national Performance Improvement Programme (PIP)?
3. The board has the skills, capacity and experience to lead the organisation.	• Are all board positions filled and, if not, are there plans in place to address vacancies? • What proportion of board members are in interim/acting roles? • Is an appropriate board succession plan in place? • Are there clear accountabilities and responsibilities for all areas of operations including quality, delivering access standards, operational planning and finance?
4. The trust is working effectively and collaboratively with its system partners and NHS trust collaborative for the overall good of the system(s) and population served.	• Is the trust contributing to and benefiting from its NHS trust collaborative? • Does the board regularly meet system partners, and does it consider there is an open and transparent review of challenges across the system? • Can the board evidence that it is making a positive impact on the wider system, not just the organisation itself – for example, in terms of sharing resources and supporting wider service reconfiguration and shifts to community care where appropriate and agreed?

II. Quality of care

Self-assessment criteria	Indicative evidence or lines of enquiry
5. Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own	• The trust can demonstrate and assure itself that internal procedures:

information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	○ ensure required standards are achieved (internal and external) ○ investigate and develop strategies to address substandard performance ○ plan and manage continuous improvement ○ identify, share and ensure delivery of best practice ○ identify and manage risks to quality of care • There is board-level engagement on improving quality of care across the organisation. • Board considers both quantitative and qualitative information, and directors regularly visit points of care to get views of staff and patients. • Board assesses whether resources are being channelled effectively to provide care and whether packages of care can be better provided in the community. • Board looks at learning and insight from quality issues elsewhere in the NHS and can in good faith assure that its trust's internal governance arrangements are robust. • Board is satisfied that current staff training and appraisals regarding patient safety and quality foster a culture of continuous improvement.
6. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board.	• Does the board triangulate qualitative and quantitative information, including comparative benchmarks, to assure itself that it has a comprehensive picture of patient experience? • Does the board consider variation in experience for those with protected characteristics and patterns of actual and expected access from the trust's communities? • Is the board satisfied that it receives timely information on quality that is focused on the right matters? • Does the board consider volume and patterns of patient feedback, such as the Friends and Family Test or other real-time measures, and explore whether staff effectively respond to this? • How does the organisation involve service users in quality assessment and improvement and how is this reflected in governance? • Is the board satisfied it is equipped with the right skills and experience to oversee all elements of quality and address any concerns? • Is the board satisfied that the trust has a clear system to both receive complaints from patients and escalate serious and/or re-occurring complaints to the relevant executive decision-makers?

III. People and culture

Self-assessment criteria	**Indicative evidence or lines of enquiry**

7. Staff feedback is used to improve the quality of care provided by the trust.	• Does the board look at the diversity of its staff and staff experience survey data across different teams (including trainees) to identify where there is scope for improvement? • Does the board engage with staff forums to continually consider how care can be improved? • Can the board evidence action taken in response to staff feedback?
8. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels.	• Does the trust regularly review skills at all levels across the organisation? • Does the board see and, if necessary, act on levels of compliance with mandatory training?
9. Staff can express concerns in an open and constructive environment.	• Does the board engage effectively with information received via Freedom To Speak Up (FTSU) channels, using it to improve quality of care and staff experience? • Are all complaints treated as serious and do complex complaints receive senior oversight and attention, including executive level intervention when required? • Is there a clear and streamlined FTSU process for staff and are FTSU concerns visibly addressed, providing assurance to any others with similar concerns? • Is there a safe reporting culture throughout the organisation? How does the board know? • Is the trust an outlier on staff surveys across peers?

IV. Access and delivery of services

Self-assessment criteria	**Indicative evidence or lines of enquiry**
10. Plans are in place to improve performance against the relevant access and waiting times standards.	• Is the trust meeting those national standards in the NHS planning guidance that are relevant to it? If not, is the trust taking all possible steps towards meeting them, involving system partners as necessary? • Where waiting time standards are not being met or will not be met in the financial year, is the board aware of the factors behind this? Is there a plan to deliver improvement?
11. The trust can identify and address inequalities in access/waiting times to NHS services across its patients.	• The board can track and minimise any unwarranted variations in access to and delivery of services across the trust's patients/population and plans to address variation are in place.
12. Appropriate population health targets have been agreed with the integrated care board.	• Is there a clear link between specific population health measures and the internal operations of the trust? • Do teams across the trust understand how their work is improving the wider health and wellbeing of people across the system?

V. Productivity and value for money

Self-assessment criteria	Indicative evidence or lines of enquiry

13. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant.	• Board uses all available and relevant benchmarking data, as updated from time to time by NHS England, to:
	  ○ review its performance against peers
	  ○ identify and understand any unwarranted variations
	  ○ put programmes in place to reduce unwarranted negative variation.
	• The trust's track record of delivery of planned productivity rates.

VI. Financial performance and oversight

Self-assessment criteria	Indicative evidence or lines of enquiry
14. The trust has a robust financial governance framework and appropriate contract management arrangements.	• Trust has a work programme of sufficient breadth and depth for internal audit in relation to financial systems and processes, and to ensure the reliability of performance data. • Have there been any contract disputes over the past 12 months and, if so, have these been addressed? • [Potentially more appropriate for acute trusts] Are the trust's staffing and financial systems aligned and show a consistent story regarding operational costs and activity carried out? Has the trust had to rely on more agency/bank staff than planned?
15. Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes.	• Does the board stress-test the impact of financial efficiency plans on resources available to underpin quality of care? • Are there sufficient safeguards in place to monitor the impact of financial efficiency plans on, for example, quality of care, access and staff wellbeing? • Does the board track performance against planned surplus/deficit and where performance is lagging it understands the underlying drivers?
16. The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn.	• Is the board contributing to system-wide discussions on allocation of resources? • Does the trust's financial plan align with those of its partner organisations and the joint forward plan for the system? • Would system partners agree the trust is doing all it can to balance its local/organisational priorities with system priorities for the overall benefit of the wider population and the local NHS?

Provider Capability - Self-Assessment Template East Lancashire Hospitals NHS Trust

	The Board is satisfied that…		*(Mitigating/contextual factors where boards cannot confirm or where further information is helpful)*
Strategy, leadership and planning	• The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners • The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE • The board has the skills, capacity and experience to lead the organisation • The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served	**Partially confirmed**	*Whilst the Trust has a current strategic framework and supporting strategies in place, it is conducting a full strategy refresh, which will be aligned to the NHS 10 year plan and system priorities and aligned to the medium term plan to be developed as part of the new Planning Framework for the NHS in England. As part of this work the Trust has received notification of the commissioning intentions for 26/27 and is working through these to understand the impact upon the Trust.* *The Trust chair finishes his first term on 28 November 2025 and the Trust is awaiting confirmation from NHSE regarding the process for appointing the Chair's successor. A NED recruitment campaign for 3 substantive NED posts is on hold pending the appointment of the new Chair.*
Quality of care	• Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients • Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	**Confirmed**	
People and Culture	• Staff feedback is used to improve the quality of care provided by the trust • Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels • Staff can express concerns in an open and constructive environment	**Confirmed**	
Access and delivery of services	• Plans are in place to improve performance against the relevant access and waiting times standards • The trust can identify and address inequalities in access/waiting times to NHS services across its patients • Appropriate population health targets have been agreed with the ICB	**Partially confirmed**	*The Trust is in tier 3 for RTT and A&E performance targets. There are Board approved recovery plans in place to achieve compliance however the Trust is awaiting confirmation that overperformance to deliver RTT will be funded. In addition, if winter pressures exceed the Trust's mitigation plans this will put the achievement of these targets at risk.*
Productivity and value for money	• Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	**Confirmed**	
Financial performance and oversight	• The trust has a robust financial governance framework and appropriate contract management arrangements • Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes • The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	**Partially confirmed**	*The Trust is in NOF5 for finance, governance and leadership. As a result of external reviews of financial governance, support from PwC and the establishment of a Programme Management Office (PMO), the Trust has a strengthened financial governance framework. At month 6 the Trust is behind plan, there is a need to increase grip and control to ensure that the Trust recovers its WRP plan during months 7-12. Internal audit will be conducting reviews of the Cost Improvement Programme, Non-Pay controls and bank and agency staffing in Quarter 3 and 4.*
	In addition, the board confirms that it has not received any relevant third-party information contradicting or undermining the information underpinning the disclosures above.	**Confirmed**	

Signed on behalf of the board of directors

Signature

Name

Date

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD

Meeting Date:	12 November 2025	**Agenda Item:**	TB/2025/151
Report Title:	Freedom to Speak Up Report		
Author:	N Bamber, Freedom to Speak Up Guardian J Butcher, Head of Freedom to Speak Up		
Lead Director:	N Pease, Interim Chief People Officer		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
				✓
Executive Summary:	This report outlines key developments in the Freedom to Speak Up (FTSU) service at ELHT from 2024/25 and the first half of 2025/26.			
Key Issues/Areas of Concern:	A record 313 concerns were raised last year, with a further 138 in Quarters 1 and 2—reflecting rising staff engagement. Concerns raised mainly relate to support with HR processes, behaviours, and perceived discrimination. Nationally, the FTSU function will transfer to NHS England, but the Guardian role remains protected in future contracts. EDI data shows growing confidence among BAME and disabled staff to speak up, supported by diverse ambassadors and mandatory training. However, training compliance remains below target and requires attention.			
Action Required by the Committee:	Continued Trust support is essential during this transition period and to maintain momentum in creating a safe, inclusive culture.			

Previously Considered by:	People and Culture Committee
Date:	6th October 2025
Outcome:	Approved

Background

1. The importance of listening to staff cannot be overemphasised. When staff raise concerns, they want to know that they are encouraged and supported to do so and can do it safely in a protected environment. Following on from the Sir Robert Francis Review, it is a requirement of the NHS Standard Contract that Trusts appoint a Freedom To Speak Up (FTSU) Guardian.

Introduction

2. This report has been prepared to advise the Committee of progress made since the last bi-annual report in December 2024. It provides data for the full year 2024/25 and bi-annual data for Quarters 1 and 2 of 2025/26 (April to September 25). This report is also being shared with Trust Board.

National Updates

3. It has been widely publicised that following the publication of the *Patient Safety Landscape Review*, the functions of The National Guardian Office will transfer to NHS England and the National Guardian Office will close.
4. Whilst this represents a major shift in the governance of Freedom to Speak Up Guardians, a letter was sent to all providers, confirming that Freedom to Speak Up, and the role of Guardians remains essential and will be included in the NHS Standard Contract for 2026/27. (Appendix 1)

Number of cases, themes and actions taken

5. In 2024/25, 313 concerns were raised. An increase of 33% from last year.
6. In 2025/26 Quarter 1 saw 76 concerns raised, an increase of 90% on the same quarter last year. Quarter 2 saw 64 concerns raised, a 5% increase from the same quarter last year.
7. Last year, quarter 3 saw the highest number of concerns raised ever seen (115), (Appendix 2)
8. We continue to see anonymous cases being raised, having 7 last year and 17 this year so far (Appendix 3).14 of these in Q2 are due to a concern raised in ED for which anonymity was protected for individuals. Whilst these are difficult to feed back on, we continue to take the concerns seriously and provide assurance at a divisional level.

9. Administrative and clerical remain the staff group who raise the most concerns at 153 during this period. 21 concerns in 24/25 Q4 from Healthcare Scientists were due to a dedicated cultural review in the area. We have seen a positive increase in Medics raising concerns in 2025/26. (Appendix 4)
10. Appendix 5 shows a summary of themes of concerns raised through FTSU.
11. The 31 concerns raised in Q3 regarding culture are due to a cultural review which took place in Histopathology. A full report and action plan is now sat with the Division for action and is being monitored for completion with the Divisional Director, HR Business Partner and FTSU Guardian. So far the action plan is meeting the current times for implementation of actions.
12. Support through HR process has increased to the top concern raised. This is mainly in relation to service changes, a large number IG breaches identified, support through disciplinary / investigations, annual leave carry over and concerns over employment rights – reflective of current climate and service changes taking place. We are working extremely closely with our HR teams and Senior Managers in relation to time taken to address HR investigation and matters. We understand that there is an issue with the allocation of investigating managers and understand that this is something that HR are working towards increasing.
13. It remains that through concerns raised, we are hearing that staff of all grades are feeling the recent system and financial pressures evident throughout the Trust. This is manifesting in staff feeling a lack of support, burnout, increased inappropriate behaviours and low morale. Managers are struggling to find the time to support staff as they usually would, meaning traditional routes of speaking up are becoming impaired or not addressed. Many staff comment they are currently part of the sickness absence process or are thinking about leaving due to current morale. Again, we are feeding this information back to our HR colleagues for additional support were required for managers and also ensuring that Managers are aware of assistance that is available for our colleagues via Occupational Health department and Wellbeing Teams etc.

EDI data / Perceived detriment

14. Of the 445 concerns that were raised during this period, 20% of colleagues identified as BAME. This is a close representation of the Trust which has 17% of colleagues from a BAME background.

15. For the one concern received regarding perceived detriment this was from someone of BAME background. They are currently considering whether to pursue a formal route or not. We are supporting them currently and encouraging them to pursue the formal route.
16. During this reporting period, 28 concerns were raised relating to perceived racial discrimination. Of these, 9 progressed to formal investigation, 2 were addressed through informal routes, 2 received no response from the individuals involved, and 1 was referred to the Equality, Diversity, and Inclusion (EDI) team. The remaining 14 concerns were submitted anonymously during Q2, in response to online discussions about the Emergency Department. These individuals felt racially targeted. As a result, an external independent review is currently underway in the Emergency Department to examine the issues raised.
17. We received 3 concerns for alleged sexual misconduct, all from women. One has proceeded to formal investigation; one has left the Trust and the other is not willing to come forward at this time but is being supported.
18. There have been 12 concerns raised regarding perceived detriment of disabled colleagues. 6 were around inappropriate behaviours and attitudes, usually from managers dealing with their case, and 6 were around difficulties implementing reasonable adjustments.
19. We are encouraged that more and more colleagues are speaking up about concerns of this nature now and we would expect that the mandatory training that is now in place is being used as a tool to give them the confidence to speak up. The next part of this encouragement would be to share with our colleagues widely some of these concerns raised and the outcomes to show that their concerns are heard and dealt with in line with Trust Policies and Procedures.
20. We are also encouraged that a more reflective number of colleagues from the BAME background feel brave and supported enough to raise concerns that they may have not felt able to do so in the past. We would think that the fact that we now have 22 ambassadors from various backgrounds has assisted in this increase.

Freedom to Speak Up Mandatory training

21. FTSU training Levels 1 and 2 became mandatory for all staff on 18 October 2023. FTSU training Level 3 became mandatory for Band 9 and above on 26 February 2024.

22. We'd like to highlight the risk that compliance for Level 1, 2 and 3 training is below the 90% target. (Appendix 6)
23. Automatic reminders are sent to all staff who are non-compliant but this hasn't yet helped to increase compliance. We will aim to encourage staff to complete during Freedom to Speak Up week also.

Freedom to Speak Up Week

24. FTSU week is taking place on 13-17 October 2025 and the theme is 'Follow Up in Action', focusing on how important action is in speaking up to provide reassurance that colleagues voices translate into meaningful change. We ask that senior leaders engage with the communications during this week to show that the Trust supports making speaking up business as usual which leads to real improvements for our colleagues and patients.

Conclusion / Recommendation

25. To approve to note and approve the content of the report. Once approved the report will be made available to managers and staff.
26. To commit to completion of the Level 3 FTSU Follow Up training for staff members Band 9 and above as there has been no increase since the last report.
27. We appreciate, as do many colleagues, the continuing support from the Trust towards the Freedom to Speak up service and ask for this support to continue during this potentially unsettling time of transition to NHS England.

Appendix 1

NHS England

To: • Freedom To Speak Up Guardians

cc. • Chief People Officers

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

13 August 2025

Dear Guardians

Update Following the Publication of the Patient Safety Landscape Review

Following the publication of the *Patient Safety Landscape Review*, we would like to take this opportunity to reaffirm the vital role that Freedom to Speak Up Guardians continue to play across the NHS. Guardians are instrumental in ensuring that staff voices are heard, that patients are protected from harm, and in supporting the development of safer, fairer, and more transparent healthcare systems.

As outlined in the recommendations of the review, the functions of the National Guardian's Office will be transferred to NHS England. Until such time, the National Guardian's Office will remain the primary support and main point of contact for Guardians.

We can confirm that Freedom to Speak Up, and the role of Guardians, will be incorporated into the NHS Standard Contract for 2026/27. We wish to provide assurance of our ongoing commitment to the national support and guidance of Guardians. NHS England will assume responsibility for leading this work from 2026/27 onwards.

We will continue to provide updates regarding the closure of the National Guardian's Office and the transition of its functions, as further details become available.

Thank you for your continued dedication and invaluable contribution to fostering a culture of speaking up across the healthcare system.

Yours sincerely,

Navina Evans
Chief Workforce Officer
NHS England

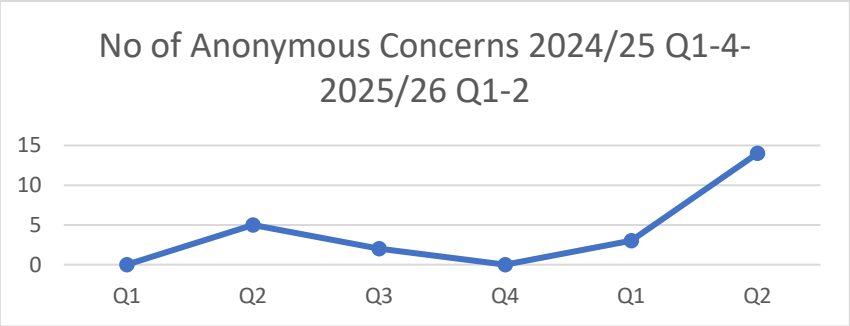
William Vineall
Director, NHS Quality, Safety, Investigations
DHSC

Bethany Carter
Interim Director of Operations and Strategy
National Guardians' Office

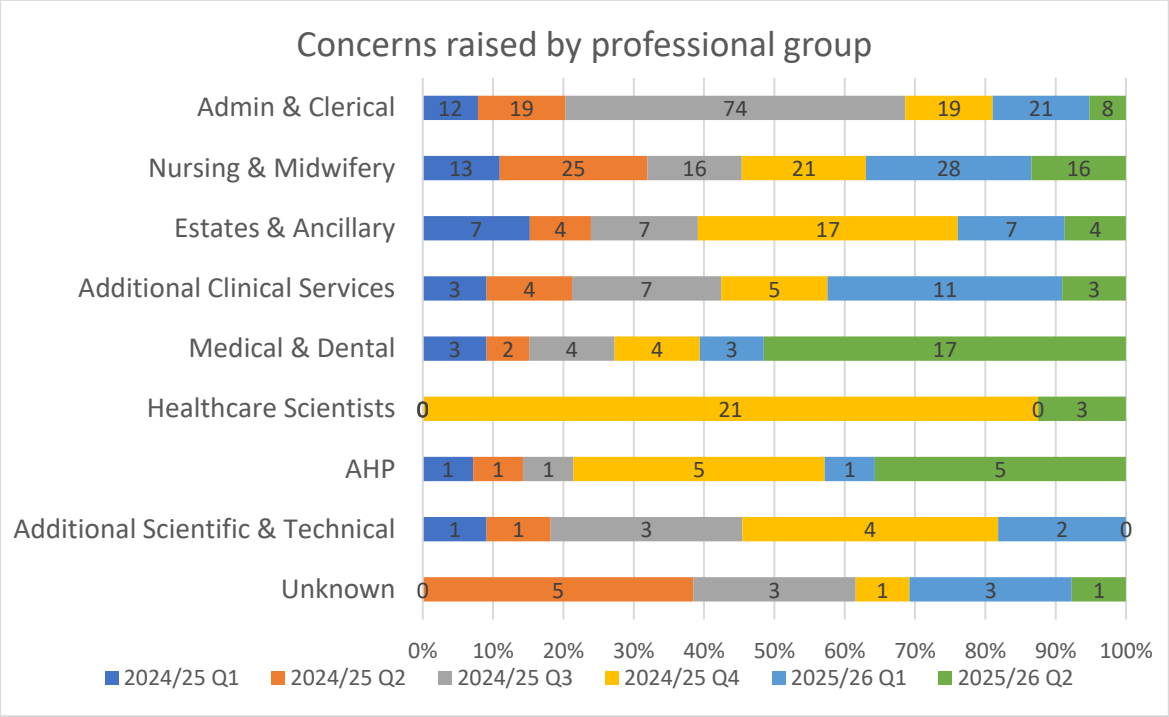
Appendix 2 – Summary of number of concerns by quarter and year.

No of concerns	Q1	Q2	Q3	Q4	Total
2022/23	41	59	49	56	**205**
2023/24	55	62	70	49	**236**
2024/25	40	61	115	97	**313**
2025/26	76	64			

Appendix 3 - Number of anonymous concerns from Q1 24/25 - Q2 25/26



Appendix 4 – Number of concerns raised by professional group from Q1 24/25 - Q2 25/26



Appendix 5 – Summary of concerns by theme from Q1 24/25 - Q2 25/26

Theme	2024/25				2025/26	
	Q1	Q2	Q3	Q4	Q1	Q2
Total Cases	40	61	115	97	76	56
Support through HR Process	9	9	10	25	30	10
Perceived Inappropriate Attitudes and Behaviours	9	15	8	20	11	10
Culture	5	4	31	21	0	1
Perceived lack of support from manager	3	8	12	16	12	5
Working Environment	0	0	0	1	2	0
Perceived Racial Discrimination	1	7	3	0	1	16
Perceived bullying by manager	2	6	4	6	4	3
Perceived bullying by colleague	4	2	6	3	2	1
Wellbeing	0	4	0	4	3	2
Patient Care	3	0	3	0	4	2
Perceived Disability Discrimination	1	2	3	0	3	2
Safety Risk Staff	2	0	3	0	3	1
Lack of communication	1	3	1	0	1	0
Recruitment Practices	0	1	2	0	0	0
Perceived Sexual Misconduct	0	0	1	1	0	1
Perceived maternity discrimination	0	0	0	0	0	1
Perceived detriment	0	0	0	0	0	1

Appendix 6 – Summary of mandatory training compliance by level as of 16/09/25.

Level	Name	Audience	Compliance rate (as of 16/09/25)
Level 1	Speak Up	All staff	89%
Level 2	Listen Up	All staff	87%
Level 3	Follow Up	Band 9 and above	60%

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD

Meeting Date:	12 November 2025	**Agenda Item:**	TB/2025/153
Report Title:	Maternity and Neonatal Services Update		
Author:	Tracy Thompson, Divisional Director of Midwifery and Nursing (Maternity Safety Champion) collectively informed by Perinatal Transformation Team & Perinatal quadrumvirate team.		
Lead Director:	Peter Murphy, Executive Director of Nursing. Board Level Maternity/Neonatal Safety Champion.		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓	✓	✓	✓
Executive Summary:	The purpose of this report is to provide: 1. An overview of the quality and safety programmes of work within the maternity and neonatal services resulting from the National Perinatal Safety Ambitions, specific to the ten maternity and neonatal safety actions included in year 7 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS). 2. Updates regarding East Lancashire Hospitals Trust (ELHT) maternity and neonatal services response to the Maternity and Neonatal 3 Year Delivery Plan are detailed in the bi-monthly Quality Committee Floor to Board reports – by escalation to Trust Board only. 3. Escalation to Trust Board of any safety intelligence as outline in the NHSE Perinatal Quality Oversight Model, within maternity or neonatal care pathways and programmes that poses a potential risk in the delivery of safe care. 4. Information and assurance of progress with continuous service improvements ensuring a “what good looks like approach”.			
Key Issues/Areas of Concern:				
Action Required by the Committee:	The Board of Directors are asked to: • Receive and discuss the CNST-MIS update, all compliance reports, with any recommendations for year MIS 7. • Discuss any safety concerns and programme delivery barriers with Trust Board members, aided by floor to board agendas further guided by the Executive and Non-Executive board safety champions. • Advise and guide on any maternity or Neonatology safety concerns, to evidence any actions , timleines and mitigations.			

Previously Considered by:	
Date:	
Outcome:	

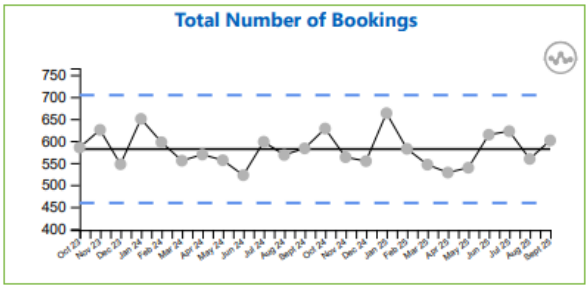
1. MATERNITY AND NEONATAL PERFORMANCE DATA – EXCEPTIONS

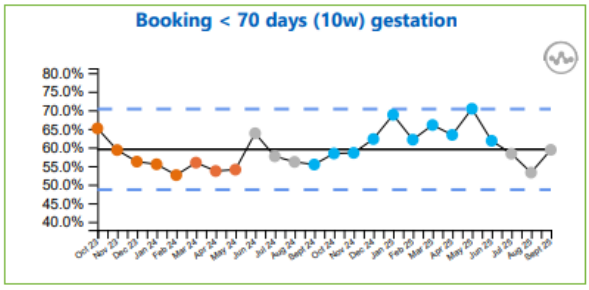
1.1 Maternity SPC Report

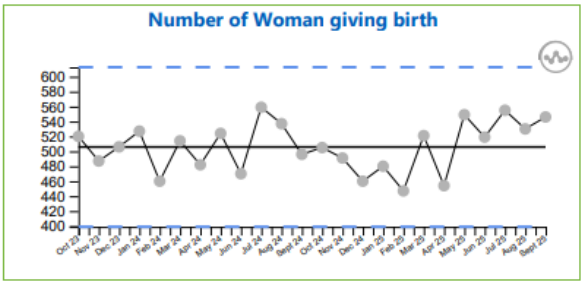
1. The Family Care Information & Performance Manager has developed a dashboard demonstrating data in Statistical Process Control (SPC) chart format (**Full report - Appendix 1**). The data is refreshed on the first week of every month, providing data for the month previous. This is analysed for emerging trends and outliers initially by the Information & Performance Manager and Transformation Programme Manager. An exceptions report is produced. Following this the report is a standard agenda item at the FC Maternity and Neonatal Data & Digital Group and further to Divisional Management Board.

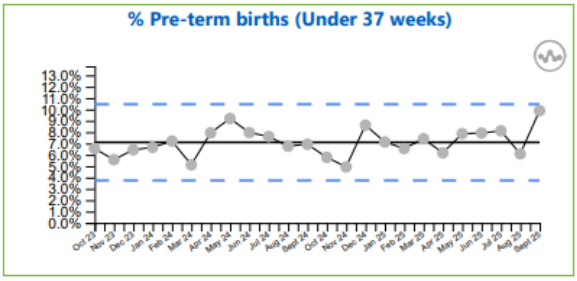
1. The September 2025 exception report (Appendix 2) highlights data findings regarding c-sections, due to a 21% increase in the c-section rate when comparing September 2024 to September 2025, 3rd/4th degree tears due to a spike in occurrence for September 2025, and gives assurances regarding PPH >= 1500ml and Admissions to Neonatal Unit >37 weeks.

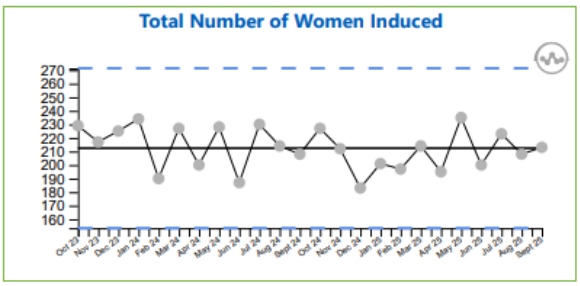
2. Key data charts are demonstrated below:

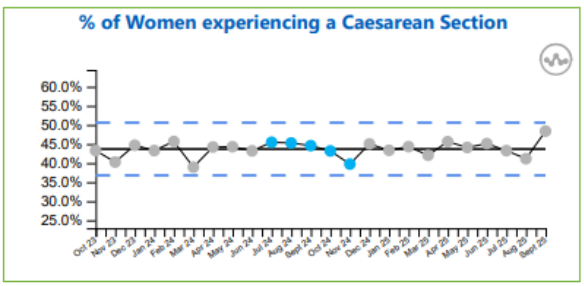


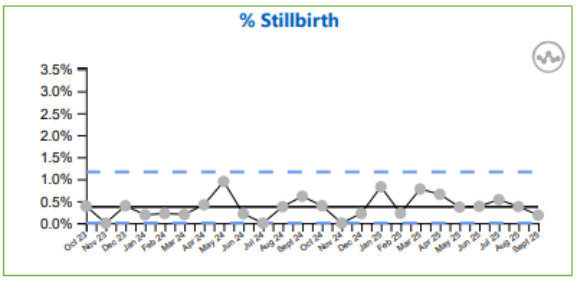


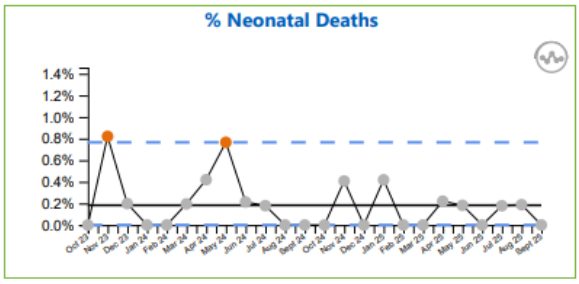












1.2 NW ODN - Neonatal Quarterly Dashboard

The Northwest Operational Delivery Network (NW ODN) has developed the Neonatal Quarterly Dashboard which looks at activity and transfer information in the NW ODN, unit closures and a range of clinical and outcome measures to allow comparison of activity with national benchmarks, many of which are National Neonatal Audit Programme (NNAP) measures. A guide of the measures and flags of the dashboard has been provided (appendix 3).

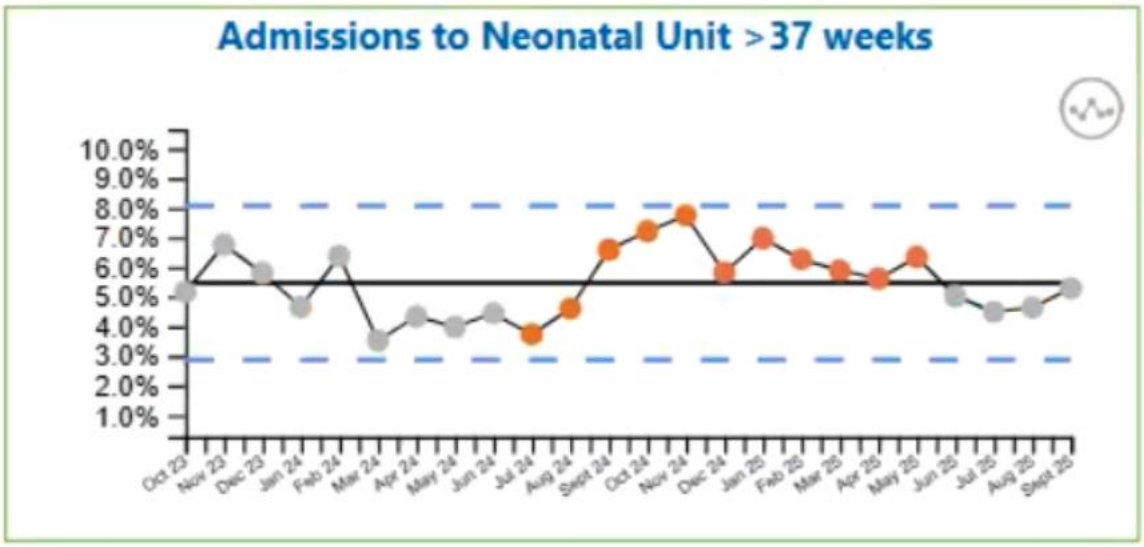
The dashboard updates currently available shows data up until June 2025. Please note this when reviewing alongside any data measures also provided in the above locally created SPC report as this is updated to September 2025.

The NW ODN dashboard shows that Q1 (Apr-Jun 2025) Term Admissions to NICU >37weeks as a % of live births was flagging as Amber at 5.8%:

Network Name	Unit Level	Location Name
LSC	NICU	Burnley

		25/26 Q1
Term admissions - percentage of NNU first admissions	ATAIN Visual	56.4%
Term admissions - percentage of term births (37wk+)	ATAIN Visual	6.2%
Term admissions - percentage of live births	ATAIN Visual	5.8%

This is reflected in the local SPC dashboard, as stated within the exception report above and reflected in the SPC chart below, Jul 2024 – May 2025 saw an increase in admission to NICU >37 weeks and a sustained trend above the 24-month average, from June 2025 this has now dropped below the 24-month average and has been sustained over 4 months. This is not yet an identified trend but will continue to be monitored. Over 24-months the rate has always remained within expected variation. The next iteration of the quarterly NW ODN dashboard will reflect these local findings.



The data below is provided on the NW ODN quarterly dashboard and demonstrates the instances where the Neonatal Unit has been closed to external admissions:

Closed to External Admissions
Rolling 4 Quarters

	24/25 Q2	24/25 Q3	24/25 Q4	25/26 Q1	Mean
APH	0	10	0	4	4
COC	0	0	0	0	0
ECH	1	2	0	1	1
LNP - LWH	5	6	3	0	4
MCHT	0	0	1	1	1
MWL - ODGH	5	2	4	17	7
MWL - STHK	11	11	1	8	8
WHH	2	5	1	2	3
MFT - NMGH	0	1	0	0	0
MFT - SMH	13	6	20	6	11
MFT - WYTH	2	0	2	0	1
RBH	0	0	6	38	11
ROH	0	10	8	2	5
SHH	0	0	0	0	0
TGH	0	0	1	0	0
WWL	0	1	8	6	4
BTH	0	1	2	11	4
ELHT	0	5	2	2	2
LTHTR	2	1	3	0	2
MBHT - FGH	0	2	0	7	2
MBHT - RLI	0	3	0	3	2

1.3 Data Management Processes

Divisional data management processes have been streamlined as described in the October 2025 Quality Committee Report (Appendix 4) to ensure data quality issues are highlighted and rectified prior to exceptions and themes being reported through the divisional via Bimonthly Perinatal Governance Board and Divisional Management Board.

The Transformation Team work alongside Maternity and Neonatal clinical teams to implement any improvement work identified through this data management process. This process ensures QI projects are data informed, and clinician time and resource is directed to priority pieces of work.

2.CNST – MATERNITY INCENTIVE SCHEME

2.1 Summary overview

Blue indicates sign-off for the CNST period by LMNS received
Green indicates progressing without concern
Orange indicates barriers/ risk to compliance identified
Red indicates non-compliance identified

Safety Action	Progress	Assurance/Exceptions
1. Perinatal Mortality Review Tool (PMRT)		● We are within required timeframes for all metrics for deaths of babies within the Y7 period as per guidance.
2. Maternity Services Data Set (MSDS)		● The July scorecard has been published and shows compliance.
3. Transitional Care (TC)		● Annual Transitional care (TC) audit will be submitted to January 2026 Trust Board. ● The Jaundice Quality improvement will be monitored as the response for this Safety Action and has been presented to the Board Level Safety Champions in October 2025.
4. Clinical Workforce		● Consultant attendance audit complete and shows compliance, no escalation required. ● Employing long and short-term locums audit complete and shows compliance, no escalation required. ● **Identified risk** - The Neonatal Nursing Workforce action plan remains in place. The annual workforce paper demonstrates workforce analysis v activity including qualified in speciality (QIS) trained nurse and finds that there will be a period of non-compliance with QIS below the 70 % target. This is detailed in the report with actions. ● Following further review, the Neonatal Medical Workforce is now compliant with BAPM standards for tiers 1, 2 and 3.
5. Midwifery Workforce		● Birthrate+ exercise is due for renewal this CNST year to maintain compliance. Submission of all required data has been made. Awaiting the final report. ● **Identified risk** - Current funded midwifery establishment does not reflect the 2022 Birthrate + findings and recommendations. Plan/mitigations are

		reflected in biannual midwifery staffing reports which ensures SA5 compliance.
6. Saving Babies Lives v3 Care Bundle (SBLv3)		● ELHT are currently at 94% overall implementation following the LMNS assurance visit in September 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		● Escalations regarding MNVP lead capacity and the extended requirements of the MNVP role were included within the September 2025 Trust Board reporting and discussed within the September LMNS CNST visit. Whilst there is an MNVP infrastructure in place for which there is evidence to support, LMNS have acknowledged that this infrastructure is no longer fit for purpose. ELHT will therefore be responding to the asks of this safety action via ongoing escalation of these issues and an action plan to meet these needs, this will be informed by the LMNS gap analysis exercise due to be complete in November 2025 and the completion of the collaborative self-assessment tool which is underway. These actions ensure we remain compliant for CNST Y7.
8. Training		● Compliance for Neonatal Resuscitation Training previously escalated as below the required compliance is now 92% and compliant. ● **Identified risk** – The medical emergencies training (PROMPT) compliance for obstetrician is currently 86%. This is being managed by the Maternity Education Team and Consultant Midwife to ensure non-compliant staff members are all booked onto the training.
9. Board Assurance		● Triangulation of claims, incidents, and complaints was presented to the Floor to Board meeting in October 2025
10. MNSI (Maternity and Newborn Safety Investigation) / NHS Resolution		● Quarterly MNSI reports are submitted to Trust Board. ● Year 7 guidance requires that MNSI information be provided to patients in a format that is accessible to them. Any exceptions to this are to be reported to Trust Board.

2.2 Key updates and exceptions per Safety Action

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

The Perinatal Mortality Review Tool (PMRT) dashboard below demonstrates that all metrics are currently on track for CNST Year 7. [Correct at the time of authoring this report – 28/10/2025]

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	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
SAFETY ACTION 1	PMRT01a	Total Number of Stillbirths (= 24 weeks)		4	3	1	1	2	2	3	2
	PMRT01	Number of Neonatal Deaths		0	1	0	0	1	1	1	0
	PMRT01c	Number of late fetal loss between 22+0 and 23+6 weeks		1	0	0	0	0	0	0	0
		Total Eligible Cases		5	4	1	1	3	3	4	2
	PMRT02a	a) i Number of cases reported to MBRRACE within 7 days		5	4	1	1	3	3	4	2
			100%	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		5	4	1	1	3	3	4	2
			95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	PMRT05a	c) ii Number PMRT published reports by 6 months		4	4	0	0	0	0	0	0
			75%	80.0%	100.0%	*	*	*	*	*	*
	PMRT05c	Number PMRT published reports not due		0	0	1	1	3	3	4	2
	PMRT05d	Number PMRT with External Member Present *monitored from Apr-25 deaths onward		5	3	1	1	0	0	0	0
			50%	100.0%	75.0%	100.0%	100.0%	*	*	*	*

The PMRT Q2 report including the action tracker, identified themes and related improvement work is included as per Appendix 5, this has been shared with the Maternity and Neonatal Safety Champions on the 2nd of October 2025 Floor to Board meeting (minutes in Appendix 6).

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

EAST LANCASHIRE HOSPITALS NHS TRUST | July 2025 | and may be reassessed after the submission window closes.

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

1.

Indicator	Numerator	Denominator	Rate	Result
Birthweight DQ	575	580	99.1	Passed

Pass rate: 80%

2.

Indicator	Numerator	Denominator	Rate	Result
Ethnicity DQ	615	630	97.6	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 to evidence MIS Year 7 compliance. July results as above show compliance and therefore sign-off of this safety action.

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, as registered and monitored via the Trust Clinical Audit & Effectiveness team.

The service is conducting a quality improvement (QI) to reduce jaundice readmissions, indicated through local data as a key theme for postnatal readmission. A progress update (appendix 7) has been provided to the Maternity and Neonatal Safety Champions at Floor to Board on the 2nd of October 2025 and will be shared further to the LMNS Quality Assurance Panel reporting in November 2025. Key items to note:

- Readmissions due to jaundice as a % of births have reduced from Q1 2025 [6.3%] to Q2 2025 [5.7%].
- A jaundice video to educate parents has been developed and made available alongside the postnatal discharge digital videos suite.
- The pilot to test all babies jaundice levels over 24 hours old prior to discharge from postnatal ward [transcutaneous bilirubin TCB test] has been ratified into the jaundice guidance and is now standard practice following successful trial.

- Further improvements could be trialled where midwives perform TCB testing on day 2/3 in community, allowing identification and intervention to place prior to the need for readmission to NICU. The Directorate Manager has submitted a bid for the funds required to purchase TCB monitors and will report back to Maternity and Neonatal Safety Champions when response is received.

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. An audit of compliance covering February to August 2025 as per technical guidance requirements is complete and Trust Board is asked to acknowledge that the audit shows full compliance. Evidence is held within the CNST SharePoint.

The MIS Year 7 guidance requires that the quarterly consultant attendance audit be replaced by one audit covering any 3-month period in the reporting year. A quarter 1 audit is complete, and Trust Board is asked to acknowledge that the audit shows full compliance. 2 cases are identified in the audit as non-attendance however LMNS have advised this does not affect compliance as the consultant was stood down appropriately.

The Trust are asked to record if the neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standard of nursing staffing. The Neonatal Nursing Workforce Paper (appendix 8) provides assurance of Neonatal Nurse Safe Staffing levels from the period of October 2025 – October 2026. The report highlights non-compliance with BAPM recommendation for 70% of nursing staff to be Qualified in Speciality (QIS) trained – current figures for September 2025 show 66% compliance due to several staff who are QIS trained who have left the organisation. This has been recognised by the Neonatal team and escalated to the Maternity and Neonatal Safety Champions via Floor to Board meeting as well as the LMNS and the NW ODN. This should only impact for a short period of time whilst newly qualified nurses complete the required training, due for qualification early 2026. Other mitigations for the shortfall in QIS include mobilising the Specialist Educator roles, and Band 7 managerial roles into the clinical care numbers to support during periods of escalation. This is reflected in the Neonatal Workforce Action Plan, (5 objectives) included within the workforce paper (appendix 8.1).

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

ELHT midwifery staffing funded establishment with the application of professional judgment as reflected in the biannual paper (direct ask of CNST SA5) is compliant with the outcomes of the Clinical posts of – 7.50 deficit with a 6.80 specialists 2022 Birthrate+ calculations. This is not in funded establishments for month 7.

Midwifery staffing oversight reports to cover the remaining CNST requirements are provided as part of the monthly reports presented at trust wide quality governance A and Quality committee were planned versus actual staffing levels and red flags with rationale and mitigation to cover shortfalls is reviewed. Maternity and Neonatology services manage their safe nurse staffing levels daily via the birth rate plus acuity app, (Maternity) Northwest connect tool based on BAPAM requirements (Neonatology) to inform the joint safety huddles and be reflected in the daily staffing templates to reflect any redeployment, safe skill mix and risk assessments to mitigate shortfalls. All templates are available on SharePoint
The midwife to birth ratios remains static 1 :26/27, 100% compliance with supernumerary labour ward co-ordinator & the provision of 121 care in labour at 100% compliance.

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. Relevant meetings have taken place with Birthrate+ colleagues to initiate the 2025 reassessment; data analysis is underway with a timeline for the final midwifery workforce report to be completed in Q4 2025.

2.2.6 Safety action 6: Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three (SBLv3)?

3. A quarterly review of the 6 elements of Saving Babies' Lives (SBL) was conducted on the 23rd of September 2025. Compliance increased to 65/69 interventions implemented overall, which equates to 94%. A breakdown of elements is provided below.

SBL Element	Current Implementation (as assured by LMNS)
Element 1 - Reducing Smoking in Pregnancy	9/10 interventions implemented and evidenced **(90%)**
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	24/26 interventions implemented and evidenced **(92%)**
Element 6 - Management of Diabetes in Pregnancy	6/6 interventions implemented and evidenced **(100%)**

4. Further review meetings are scheduled throughout the CNST Y7 reporting period as follows:
    a) 4th November 2025 (Quarter 2)
    b) 13th January 2026 (Quarter 3, sign off)

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

5. *'Evidence of MNVP infrastructure being in place from your LMNS, if evidence of an MNVP commissioned and functioning as per national guidance is unobtainable there should be evidence that this has been escalated via Trust, ICB and Regional Level.'*
   As per detail within the September 2025 Maternity and Neonatal Update Report to Trust Board, ELHT MNVP have escalated issues with capacity to meet the asks of the CNST guidance. This has been escalated to LMNS who advise that whilst evidence remains in place to show that MNVP infrastructure is in place, as per previous years, this infrastructure is acknowledged as no longer fit for purpose. LMNS are performing a gap analysis of the MNVP infrastructure against guidance / requirements which will inform a risk assessment and action plan.

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

6. *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%.

7. *Maternity emergencies and multi-professional training (PROMPT): 90% attendance for obstetric consultants and doctors, midwives, maternity support workers, and anaesthetic consultants*. Obstetric consultant and doctors are currently at 86% compliance, which is a risk to CNST compliance. Plans are in place for doctors to attend sessions within October and

November which will raise compliance above 90% prior to the 30th of November 2025 deadline. This has been escalated to the Perinatal Leadership Team.

8. *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%.

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?

9. 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 2nd October 2025. Minutes attached as (appendix 6.) Please refer to these meeting minutes to view the discussion and findings regarding the triangulation of the Trust claims scorecard with incidents and complaints.

10. Perinatal Quality Surveillance Model (PQSM) Minimum Data Set August 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	May 25	June 25	July 25	August 25
Perinatal Data	1:1 care in labour	100%	100%	100%	100%	100%
	Stillbirth rate	<4.4/1000	3.61	5.73	5.32	3.72
	Term admissions to NICU	<7%	6.11%	5.42%	4.10%	4.59%
	Obstetric haemorrhage >1.5 litre (within 24hrs)	<10%	5.46%	6.93%	3.97%	4.15
	3rd/4th degree perineal tear	<5%	3.90%	3.53	3.20	4.16

	Metric	Standard	May 25	June 25	July 25	August 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: August 2025

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 have been 2 stillbirths in this period – 1 was a baby with known early onset severe fetal growth restriction with poor prognosis; 1 presented with reduced fetal movements at 31 weeks – IUD confirmed . These are being reviewed by the PMRT process.

Term admission to NICU:

The Term admission rate has remained stable. All of these are reviewed by the ATAIN process. So far, none of the cases this year have been identified as potentially avoidable.

3rd/4th degree perineal tears

The number of 3rd/4th degree tears has remained stable since February – however there has been a slight increase in August. These will continue to be closely monitored.

Training Compliance:

The average for training compliance across all staff groups remains >90% attendance.

	Metric	Standard	May 25	June 25	July 25	August 25
Feedback	Service user feedback (MNVP)		1 session attended	1 session attended	0 session attended	1 session attended
	FFT satisfaction rated as good	>90%	93.51%	95.87%	91.46%	94%
	Number of level 4 complaints	-	3	3	4	2
	Executive safety walkaround	Bi-Monthly	0	0	1	2
	Maternity/ Neonatal Safety Champion walkaround	Bi-Monthly	1	1	2	0

	Metric	May 25	June 25	July 25	August 25
External Reporting	Maternity incidents graded moderate or above	1	3	3	1
	Cases referred to MNSI	2	0	1	1
	Cases referred to coroner	0	0	1	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	May 25	June 25	July 25	August 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%

MNVP Service User Feedback:
MNVP engagement lead attended a session at Baby zone Blackburn and has shared feedback with the trust. This will be taken to the next patient experience group for discussion.

FFT satisfaction rated as good:
There has been an increase in the number of FFT responses rating care as good. There is an action plan in progress to address the themes identified from poor feedback.

Level 4 Complaints
There have been level 2 complaints in August. These are monitored and any themes identified. These include experiences in care and communication.

Executive Safety Walkarounds: Executive walk rounds took place in CBS/COU and antenatal clinic at RBH. Feedback has been received and shared for ANC.

Moderate or above incidents:
eIR1319179 – an extravasation injury during ferratin infusion undergoing review.

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

MNSI referral:
1 case was referred to MNSI in August – this was a cooled baby but it cases were not accepted as they did not meet the criteria for investigation.

CNST:
Year 7 standards were published on April 2nd, currently on track with meeting these.

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.

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 2 report is submitted as per appendix 9

2. 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 for wider discussions and escalation as and when required.

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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

November 2025

Appendix 1 – September 2025 Maternity SPC Report

Appendix 2 – September 2025 Maternity SPC Exceptions Report

Appendix 3 – NW ODN Dashboard Guide

Appendix 4 – October 2025 Quality Committee Report

Appendix 5 – PMRT Q2 Report and Action Plan

Appendix 6 – October 2025 Floor to Board Minutes (not included in the paper to Board due to them containing patient identifiable information)

Appendix 7 – Jaundice QI Update Presentation

Appendix 8 – Neonatal Workforce Paper

Appendix 8.1 Workforce action plan 2025-26 (included in Neonatal workforce paper)

Appendix 9 – MNSI Report

Maternity Performance Report

Latest Month: September 2025

Updated: 10th October 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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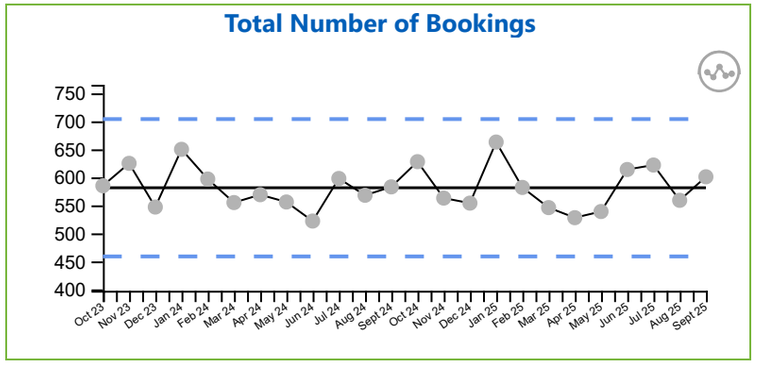

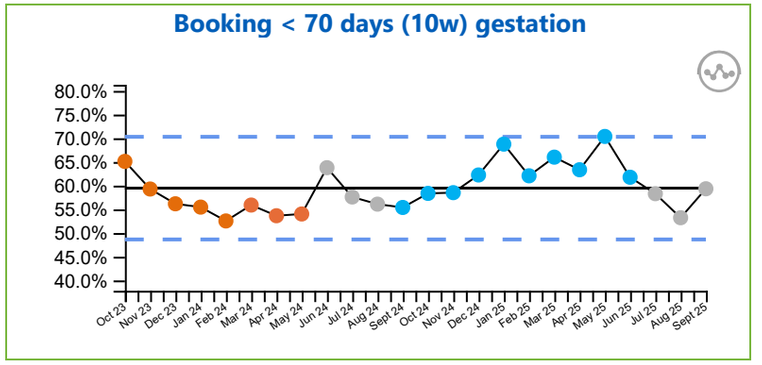

Inductions

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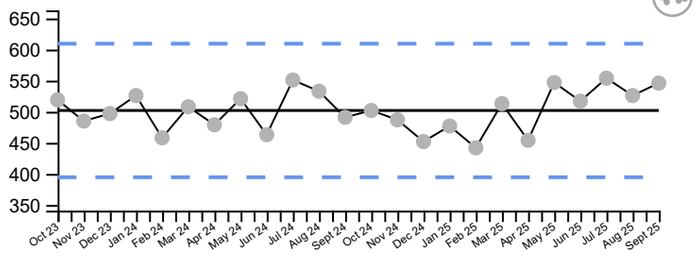
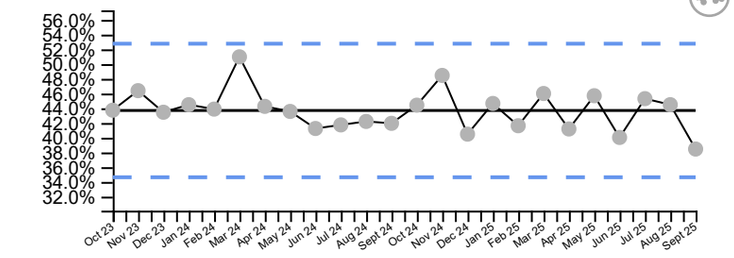
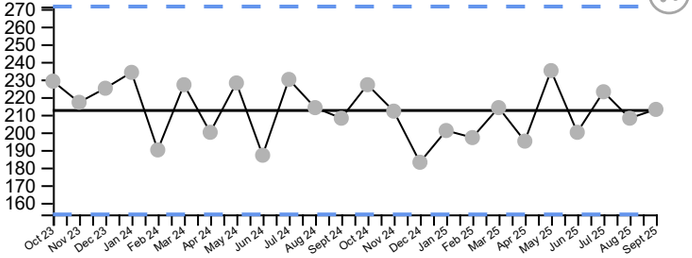
Spontaneous Delivery Rate



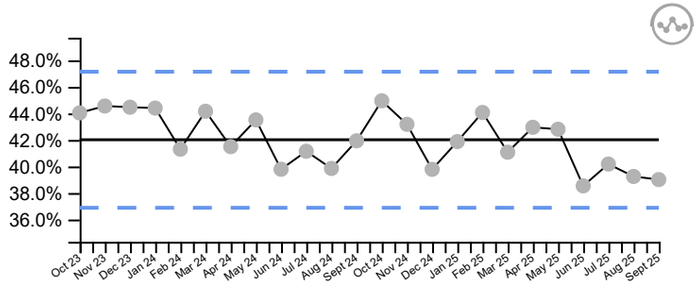
Spontaneous Delivery Rate



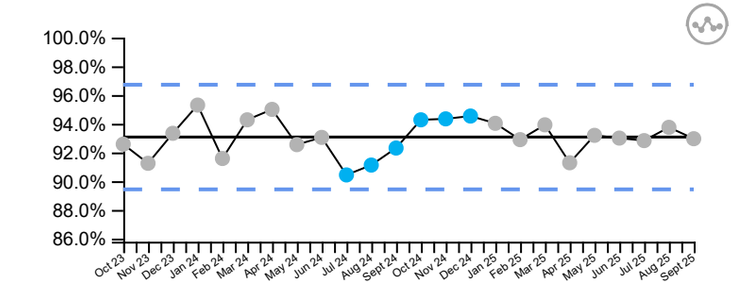
Total Number of Women Induced



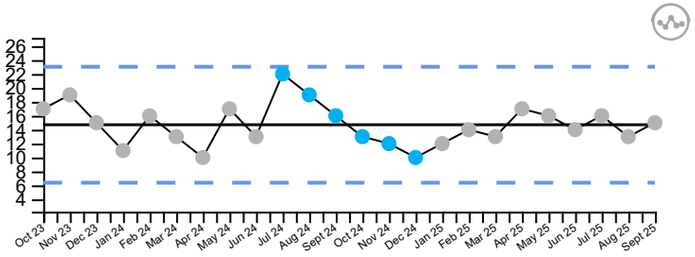
% of Women Induced



% of Women Successfully Induced



Total Number of Women Unsuccessfully Induced requiring Caesarean Section



Mode of Deliveries

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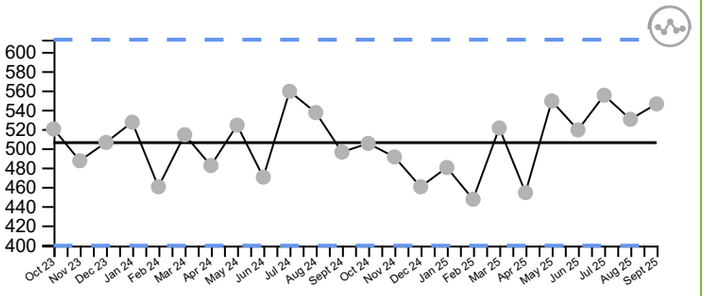
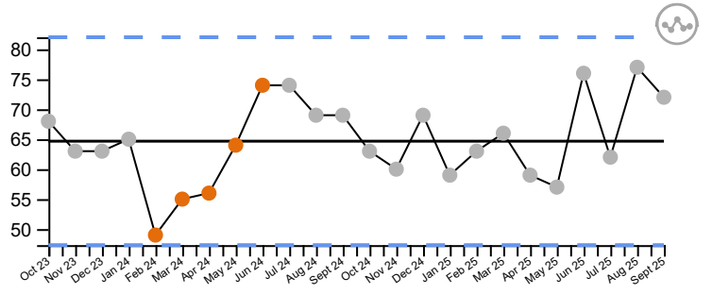
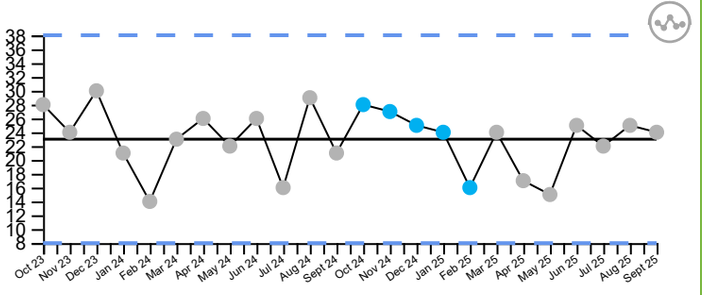
Number of Woman giving birth



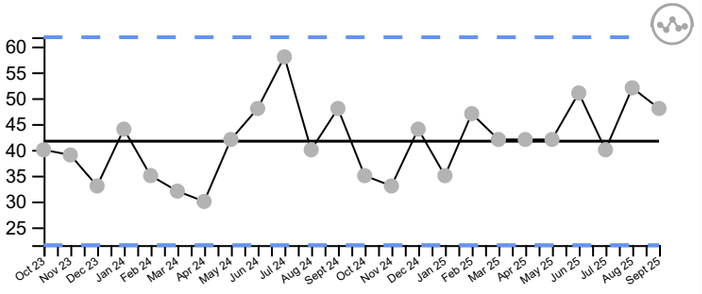
Number of Women Instrumental Births



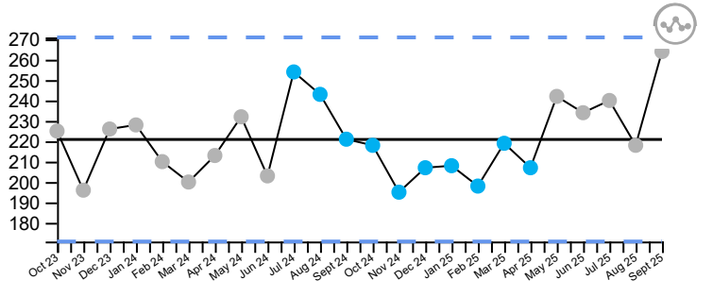
Number of Women Ventouse Births



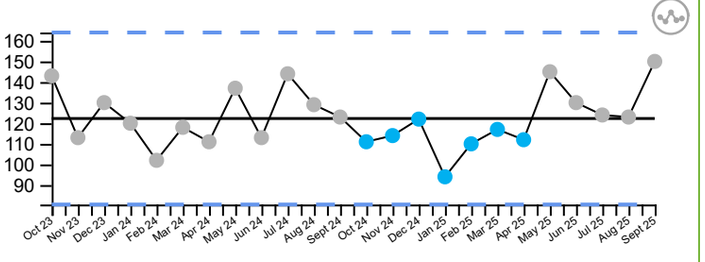
Number of Women Forceps Births



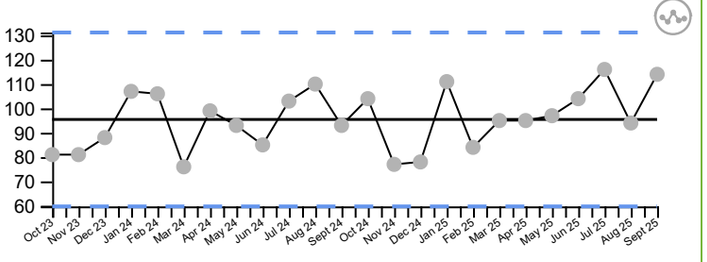
Total Number of Women experiencing a Caesarean Section



Total Number of Women experiencing Emergency Caesarean Section



Total Number of Women experiencing Elective Caesarean Section (Cat 4)



C-Section Deliveries

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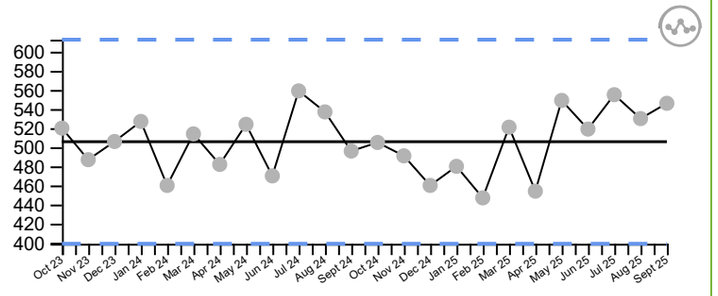
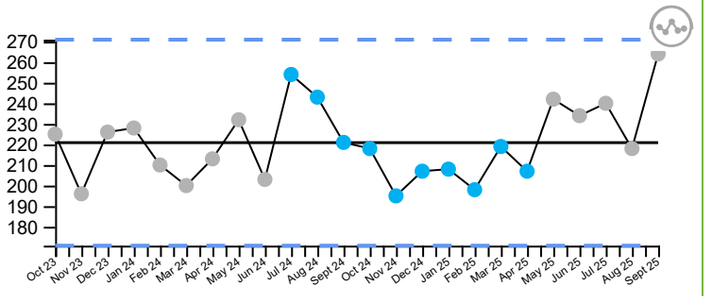
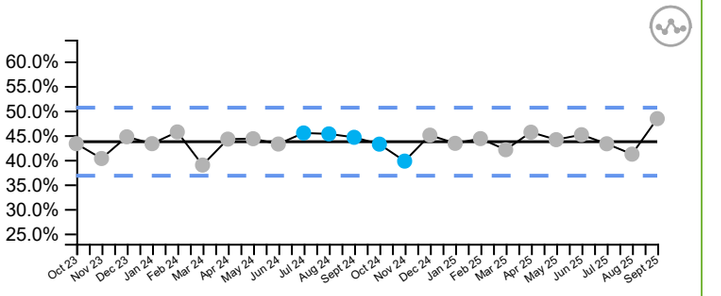
Number of Woman giving birth



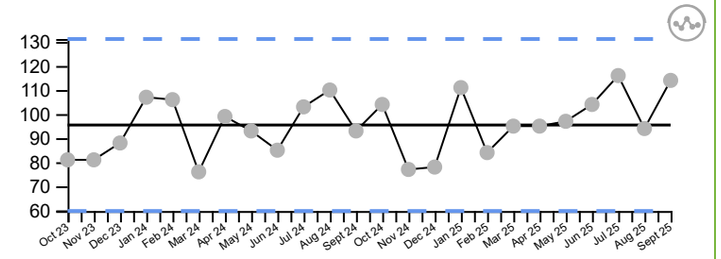
Total Number of Women experiencing a Caesarean Section



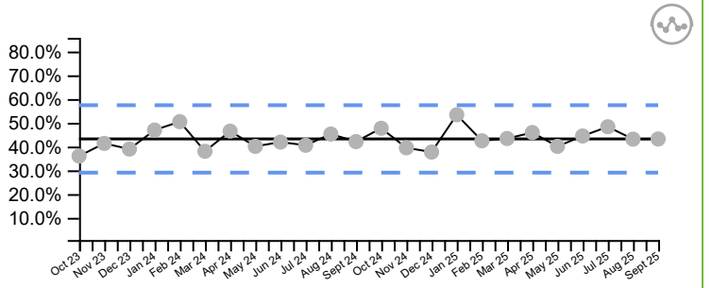
% of Women experiencing a Caesarean Section



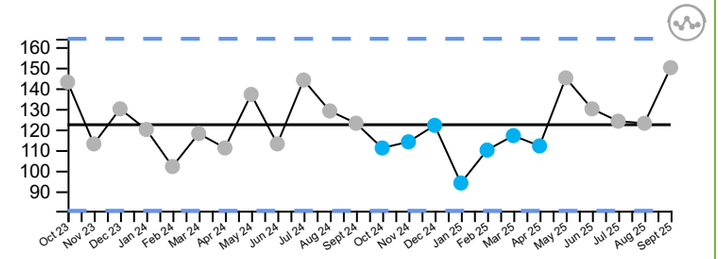
Total Number of Women experiencing Elective Caesarean Section (Cat 4)



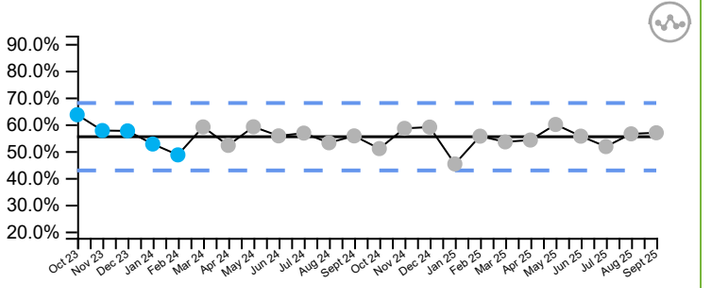
% of Women experiencing Elective Caesarean Section (Cat 4)



Total Number of Women experiencing Emergency Caesarean Section



% of Women experiencing Emergency Caesarean Section



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C-Section Measures

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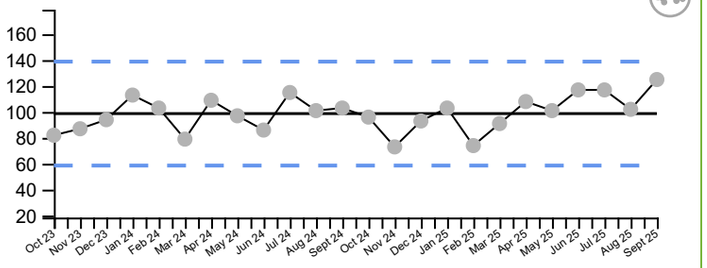
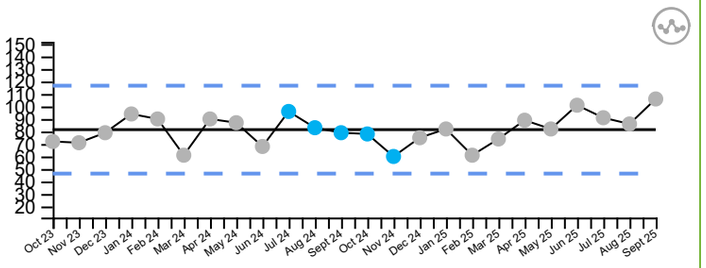
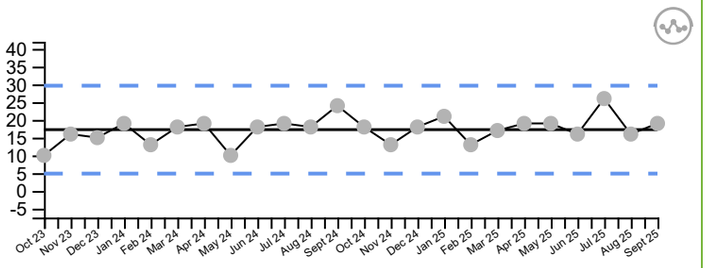
Number of Women with a previous caesarean section



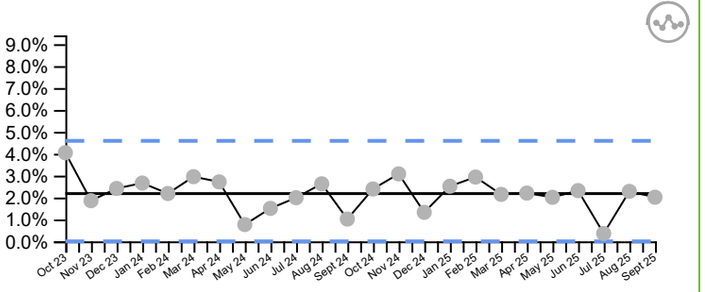
Number of women having a caesarean section birth, after a previous caesarean section



Number of women having a vaginal birth, after a previous caesarean section



% LSCS at full dilatation



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Incidents

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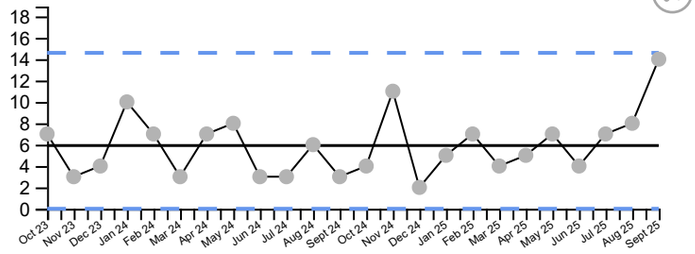
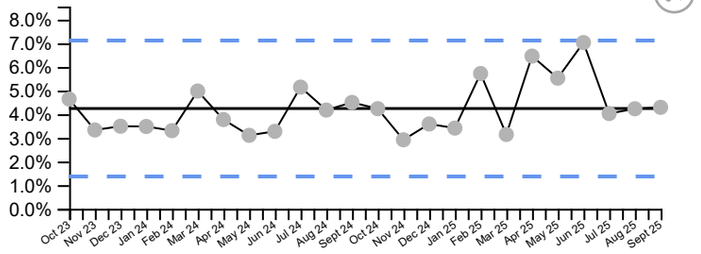
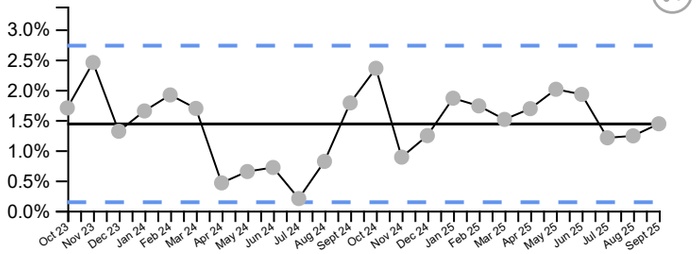
3rd/4th degree tears



% PPH >= 1500ml



% Apgar score <7



Pre-Term & Neonates

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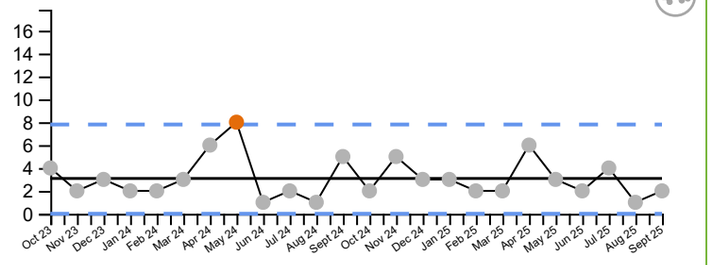
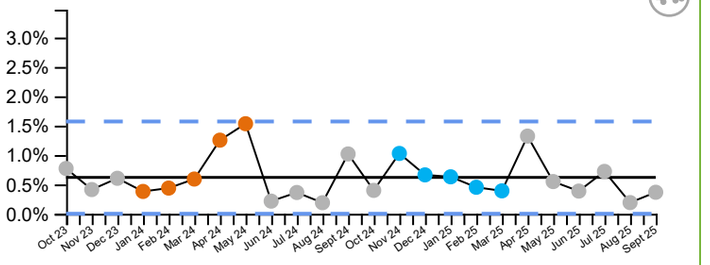
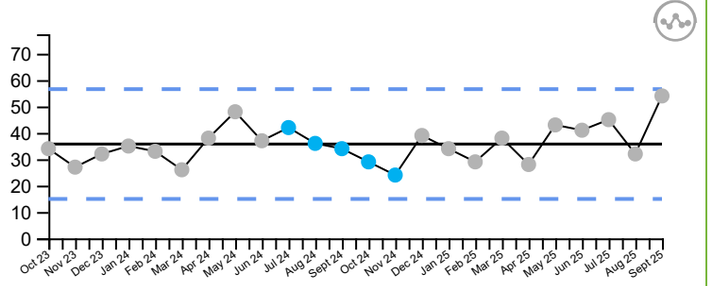
Total number of deliveries before 27 weeks gestation



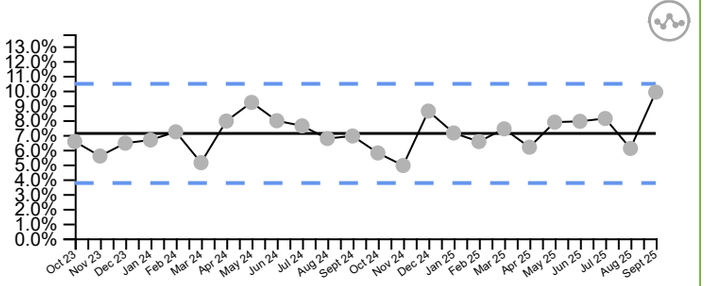
% of deliveries before 27 weeks gestation



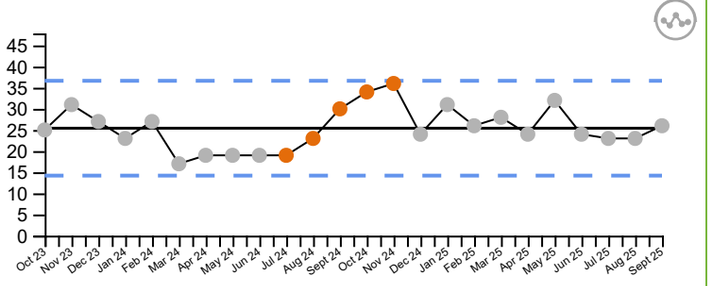
Pre-term births (Under 37 weeks)



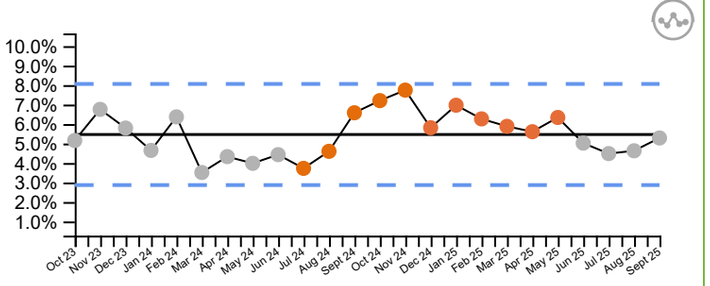
% Pre-term births (Under 37 weeks)



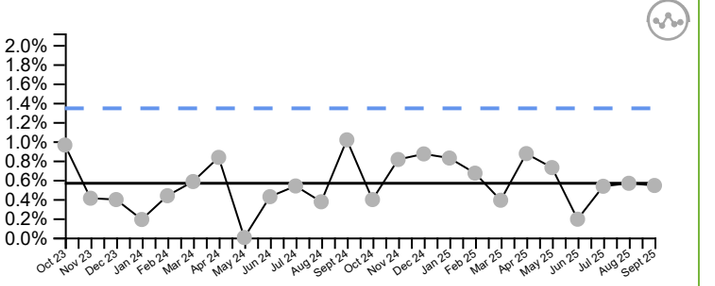
Admissions to Neonatal Unit >37 weeks



% Admissions to Neonatal Unit >37 weeks



% HIE (Hypoxic-Ischemic Encephalopathy)



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Mortality

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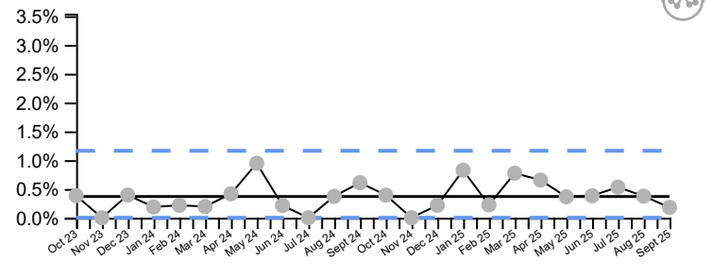
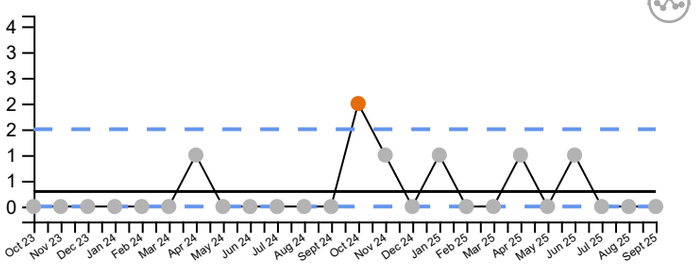
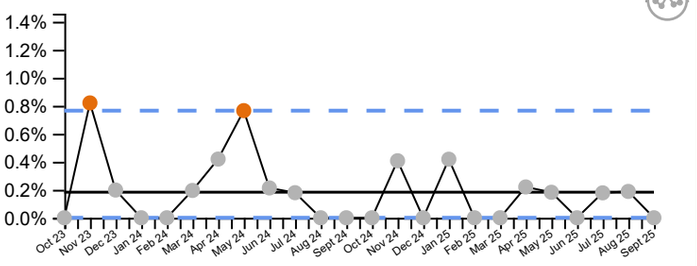
% Stillbirth



Rate of intrapartum stillbirth



% Neonatal Deaths



Smoking

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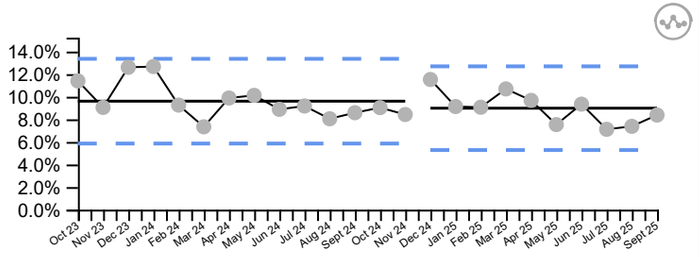
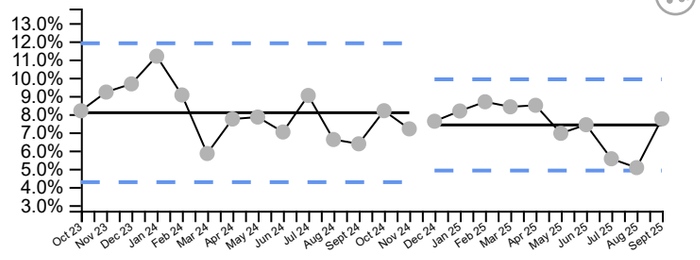
Proportion of women who were current smokers at booking appointment



Smoking at delivery



121 Care

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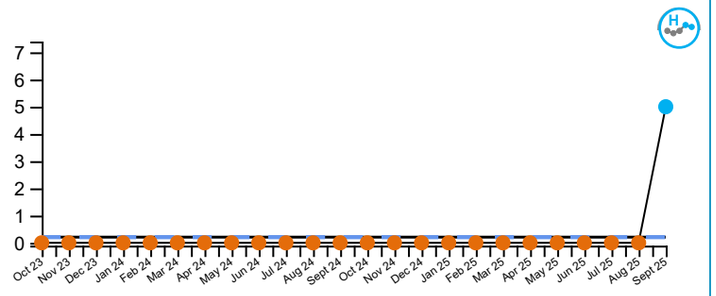
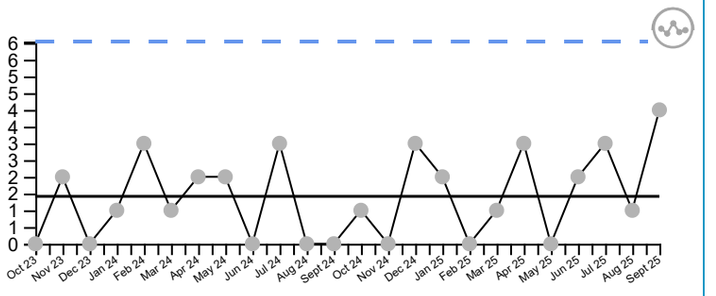
A University Teaching Trust

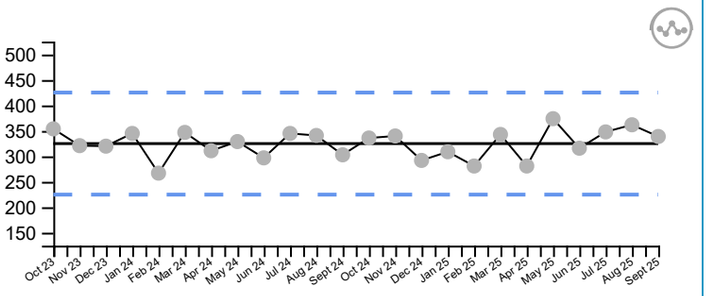
Placement on Continuity – Black/Asian Women



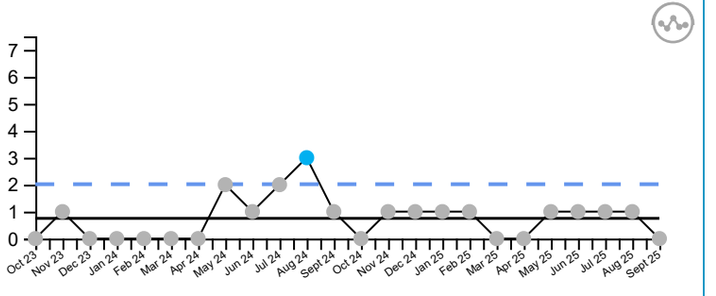
Placement on Continuity – Women in most deprived areas



Women receiving 121 care



Rate total babies born midwife not present



Screening NIPE KPIs

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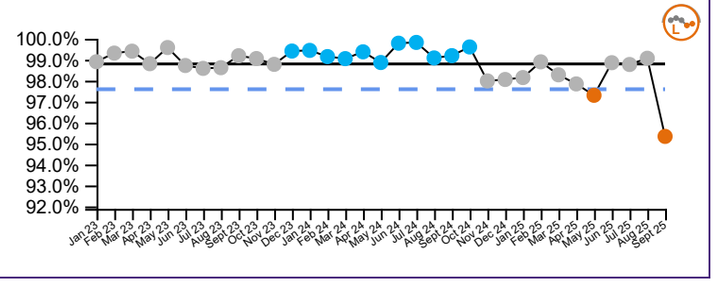
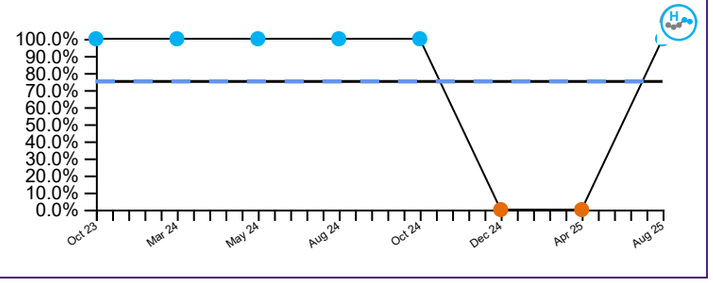
A University Teaching Trust

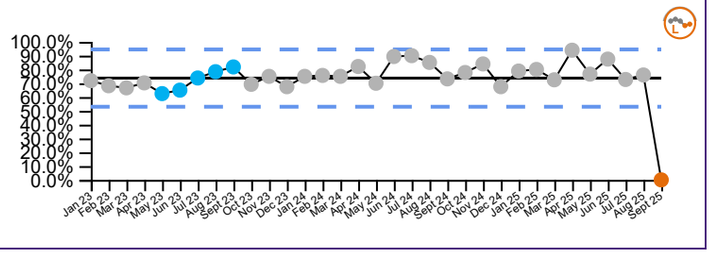
Babies that have achieved NP1 (screening complete within 72 hours of birth)



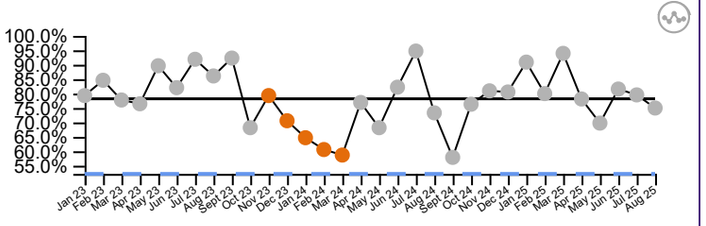
All babies born that have had Ophthalmology appointment less than or equal to 14 days of newborn eyes examination



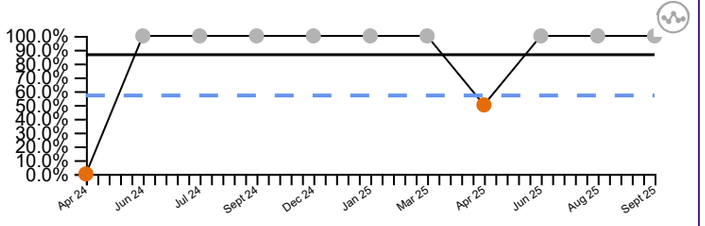
All babies born that have had USS within 4-6 weeks of birth or 38-40 weeks corrected age if born <34 weeks gestational age



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



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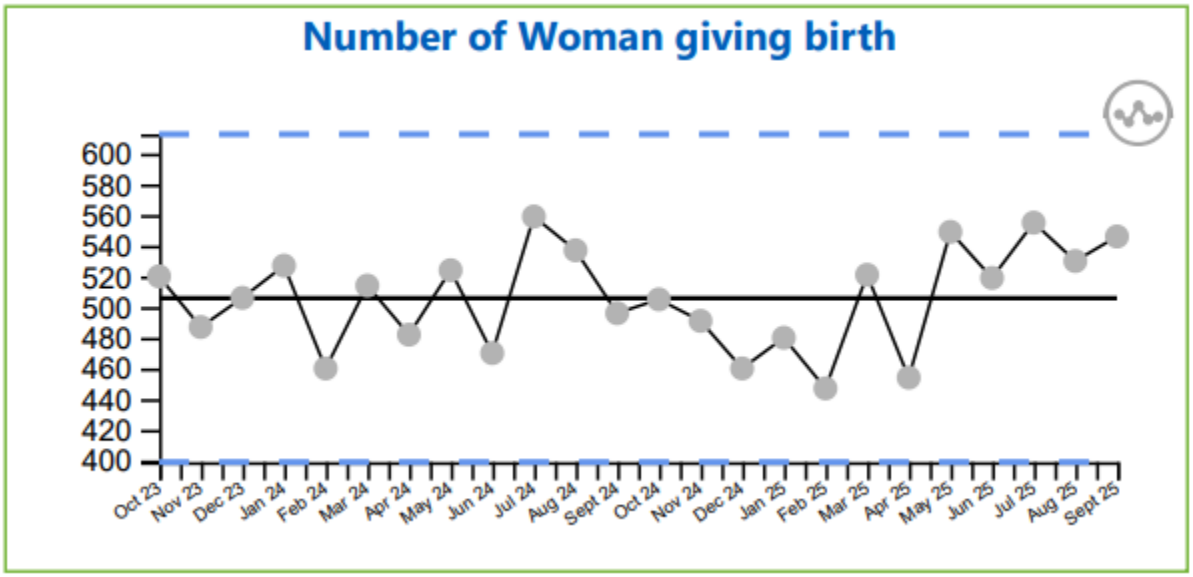
Maternity Data Dashboard - Exceptions

This document is intended to be viewed alongside the Maternity Performance report September 2025.

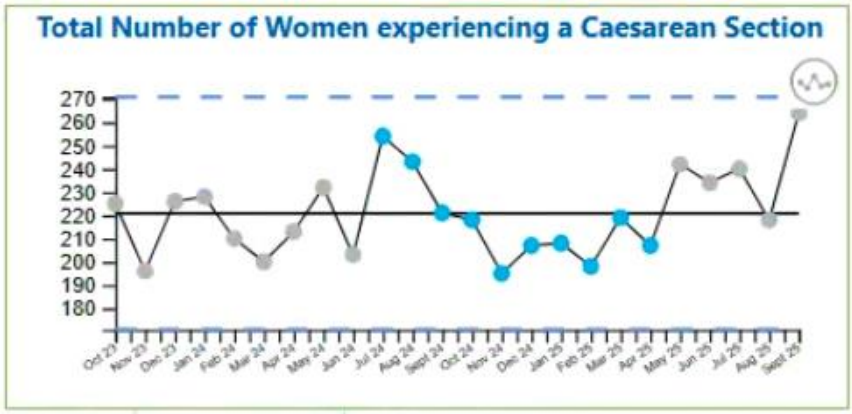
Data naturally varies but if this variation is statistically significant, this is called special cause variation and the grey dots are instead shown as blue or orange, depending on whether a higher value is better or worse – **blue is used for improving performance**, **orange for concerning performance.**

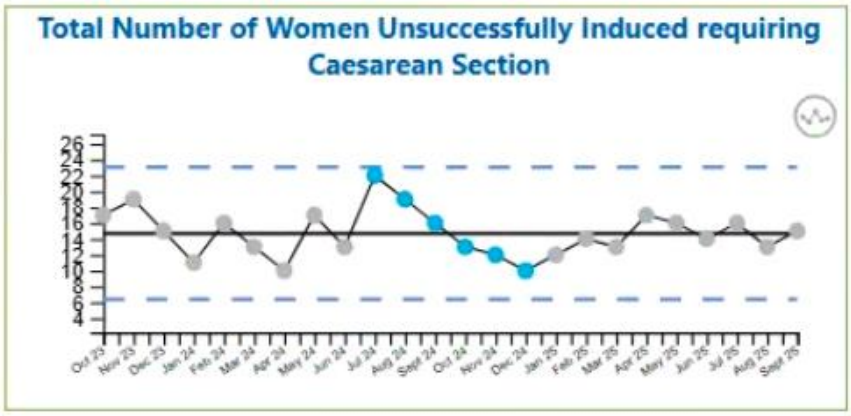
If not significant, the dots stay grey, and this is called common cause variation.

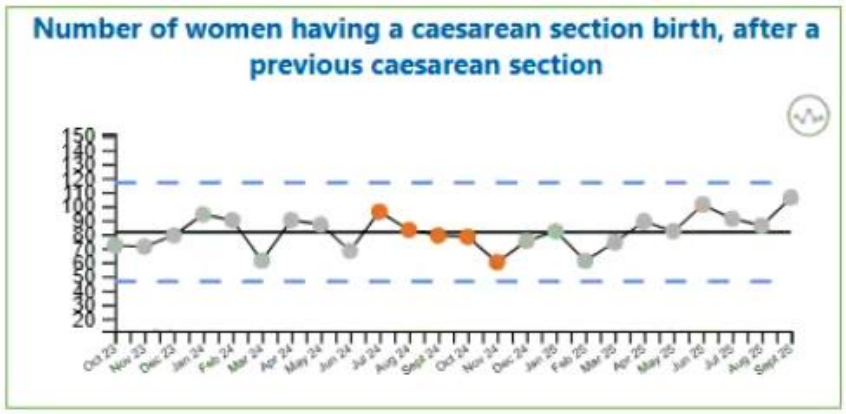


The average number of women giving birth per month over the previous 24 months is 510. May 2025 – September 2025 shows a sustained increase in births above average; all months remain well within the expected variation limits.

1. Caesarean Section







Type of Birth (Count of Women)

	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Total
Women Giving Birth	502	487	453	477	443	513	454	547	519	554	526	546	**6021**
Vaginal Birth	287	296	252	272	247	302	247	307	285	313	309	282	**3399**
CS Elective	89	75	73	99	74	91	84	80	98	99	83	96	**1041**
CS Emergency	126	113	127	105	120	116	118	152	130	139	129	166	**1541**
CS Grad Not Recorded	0	0	1	0	0	0	0	0	0	0	0	0	**1**
CS Total	215	188	201	204	194	207	202	232	228	238	212	262	**2583**

September 2025 is the highest number of C-Sections (both emergency and elective) in the previous 24 months. September 2024 saw 216 C-sections, September 2025 saw 262 C-sections, this is an increase rate of 21.3%. For comparison, the number of women giving birth in September 2024 is 498 and September 2025 is 546 – this is an increase rate of 9.64%

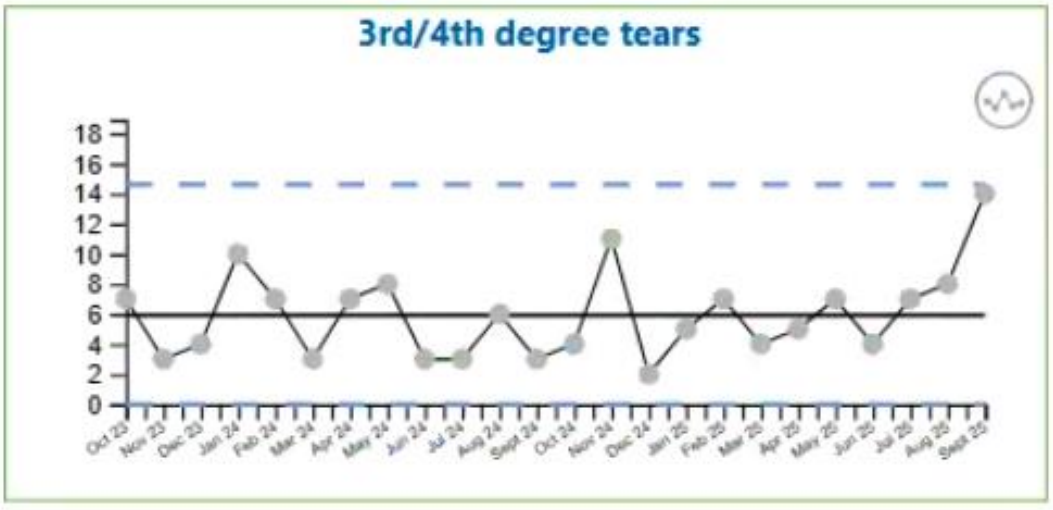
The total number of C-sections in month remained within expected variation.

106/ 262 had a c-section after a previous c-section (40%).

In September 2025, 37% were Elective C-Section and 63% Emergency C-Section.

Data Quality Highlight - The current data for unsuccessful induction requiring c-section shows for September 2025, 15/166 emergency c-sections were as a result of unsuccessful induction (9%). This has been highlighted as a possible data quality issue via the data & digital group which is being reviewed by the Informatics & Performance Manager and Transformation Lead.

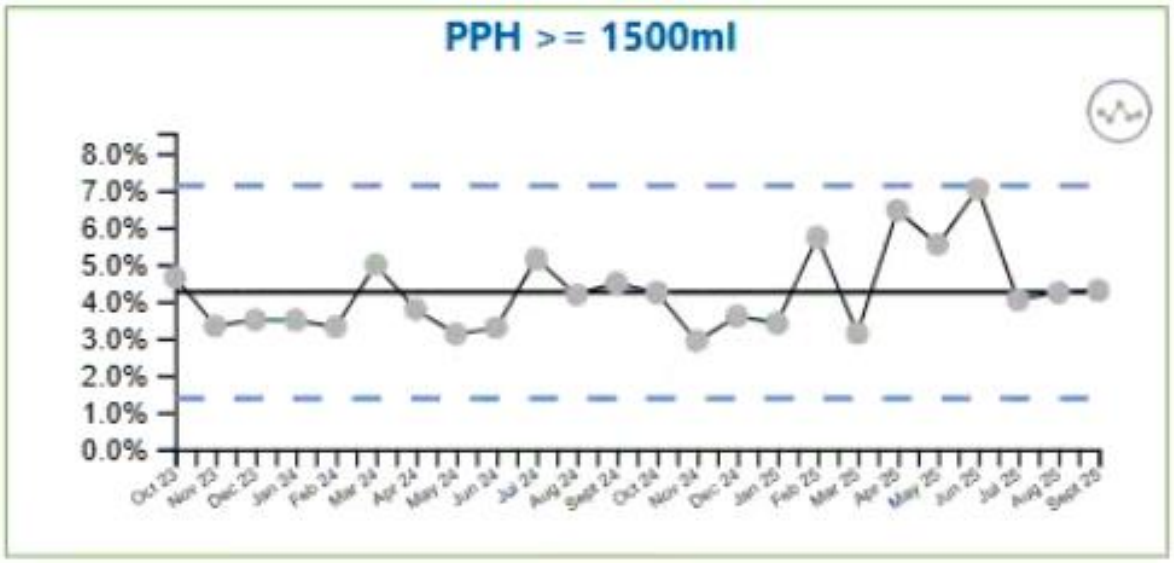
2. 3rd/ 4th degree tears



September 2025 has seen an increase in 3rd & 4th degree tear to 14, the average over the previous 24 months is 6. This is an increase rate above the average of 133% where the increase rate above average for women giving birth in September 2025 is 7%.

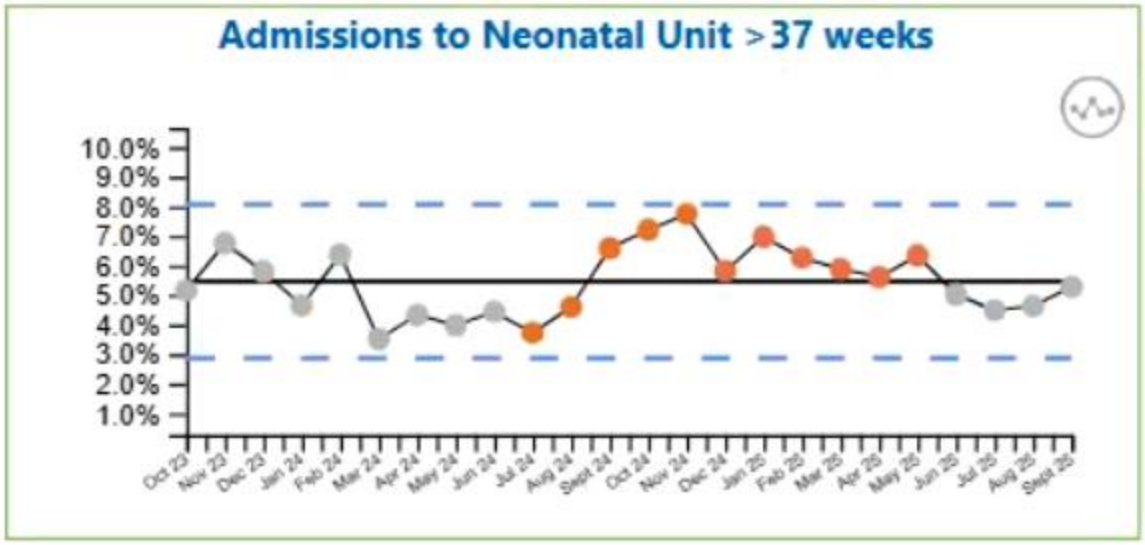
There is no trend to report, and this is within the upper limit of the accepted variation. This has been raised by the Perinatal Pelvic Health Specialist Midwife who is reviewing each of the cases and liaising with the Quality & Safety Lead to report findings.

3. PPH >= 1500ml



The PPH >=1500ml rate saw an increase over the months of Apr, May, June 2025. This did not progress to a trend, Jul, Aug, Sep 25 saw a return to the average rate of 4%. Maternity is taking part in a research study called OBS UK, which involves using measured blood loss (MBL) instead of estimated blood loss (EBL). Measured blood loss is more accurate than estimated blood loss because it relies on objective, quantifiable methods, such as weighing swabs and collecting blood in calibrated containers. In contrast, estimated blood loss depends on subjective visual assessment, which is often inaccurate and can lead to underestimation, particularly in cases of significant haemorrhage.

4. Admissions to Neonatal Unit >37 weeks



Jul 2024 – May 2025 saw an increase in admission to NICU >37 weeks and a sustained trend above the average, from June 2025 this has now dropped below the 24month average and this has currently been sustained over 4 months. This is not yet an identified trend but will be monitored. Over 24months the rate has been within expected variation. A 3-monthly audit of ATAIN continues.

NHS North West Neonatal Operational Delivery Network

NORTH WEST NEONATAL OPERATIONAL DELIVERY NETWORK

A Guide to the NWNODN Dashboard 2024/2025, including flags (V1 2025)

NORTH WEST OPERATIONAL DELIVERY NETWORK:
A Guide to the NWNODN Dashboard (2025/26)

This document sets out the details of the NWNODN Dashboard measures, excluding further analysis.

Sources of standard

This document has been designed to match the standards set out in the National Neonatal Audit Programme (NNAP): A guide to the 2024 audit measures. (RCPCH, January 2024 v1.2). This will be updated once the 2025 guide is available. It is recommended that you refer to the NNAP document if you require further information or clarification of the audit measure.

Term Admission information has been collated in-line with the national ATAIN data collection standards – Reducing Harm Leading to Avoidable Admissions of Full-term Babies into Neonatal Units: Findings & resources for improvement. (NHS England, February 2017). NWNODN standards are additional measures agreed by the NWNODN Data Group and ratified by the NWNODN Senior Management Team (SMT).

The following documents have also been referred to in this document:

NHS England. Neonatal Critical Care Service Specification. 2016. Available at: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/01/e08-serv-spec-neonatalcritical.pdf.

British Association for Perinatal Medicine (2011) Service Standards for Hospitals Providing Neonatal Care (3rd edition). Available at: https://www.bapm.org/resources/service-standards-hospitals-providing-neonatal-care-3rd-edition-2010.

Department of Health. Toolkit for high quality neonatal services. 2009. Available at: http://webarchive.nationalarchives.gov.uk/20130123200735/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107845.

Notes

Numerators and denominators stated in this document are for the unit dashboards. For locality and NWNODN dashboards, data from individual units will be combined and the appropriate numerators and denominators for the wider groups applied.

Activity and Transfers

TERM ADMISSIONS

Admissions to NNU for babies born ≥37weeks' gestation, by first admission only, shown as a percentage of total births

Source of Standard: ATAIN

Numerator: The number of babies born ≥37 weeks gestation admitted to a neonatal unit.

Denominator: Total number of live births (all gestations)

Inclusion Criteria : Term Admission data from Badgernet download, based on admission date where episode 1, any day location of care NNU (not PNW, OBS, or TC) and gestation weeks ≥37 weeks.

MINIMISING INAPPROPRIATE SEPARATION OF MOTHER AND LATE PRETERM & TERM BABIES

Average number of special care or normal care days, when oxygen was not administered, for babies born at term or late pre-term (34 to 36weeks' gestational age) who did not have any surgery or a transfer during any admission

Source of Standard: NWNODN Measure

Numerator: Number of NNU SC and NC days, when oxygen, CPAP, ventilation or respiratory support was not administered.

Denominator: Measure 1 = Number of NNU admissions episode 1, with at least 12 hours of care and without major surgery and without any transfer of care location and gestation ≥34 weeks and <37weeks.
Measure 2 = Number of NNU admissions episode 1, with at least 12 hours of care and without major surgery and without any transfer of care location and gestation ≥37weeks.

Inclusion Criteria: NNU admission episode 1s lasting at least 12 hours, with all babies' care at that unit, excluding babies who did not have any major surgery (Excludes PNW, TC).

PERCENTAGE OF NETWORK IC ACTIVITY IN NICUs

Percentage of IC activity taking place in a NICU

Source of Standard: NWNODN

Numerator: The number of IC care days in a NICU.

Denominator: The number of IC care days within locality.

Inclusion Criteria:
IC Care days at a NICU as a percentage of total IC care days, IC care day based upon BAPM 2011 (level 1), reported by care day date

INAPPROPRIATE TRANSFERS OUT OF LOCALITY (WITHIN NWNODN)

Number of postnatal transfers out of locality but within the NWNODN, shown by locality.

Source of Standard: NWNODN

Numerator: The number of inappropriate transfers out of locality (Within NWNODN)

Denominator: N/A

Inclusion Criteria:
Based upon discharge date from locality during reporting period.

CLOSED TO EXTERNAL ADMISSIONS

The number of whole days (i.e. 24 hrs +) when closed to external admissions.

Source of Standard: NWNODN

Numerator: The number of whole days (i.e. 24 hrs +) when unit was closed to external admissions.

Denominator: N/A

Inclusion Criteria: Unit Closures for 24 hours as per the ConnectNW - daily ring round data

PERCENTAGE OF PRETERM DELIVERIES

Pre-term births as a percentage of live births 22 to 36 weeks

Source of Standard: NWNODN

Numerator: Maternity return live birth data filtered for gestation ≥ 22 weeks and <37 weeks

Denominator: Maternity return live birth data filtered for gestation ≥ 22 weeks

Inclusion Criteria:
All live births by episode 1 of care

Optimal perinatal care

BIRTH IN A CENTRE WITH A NICU

The number of deliveries below 27 weeks gestational age (<28 if multiple delivery) or with birthweight < 800g delivered in a maternity service on same site as a NICU.

Source of Standard: NNAP, NWNODN

Numerator: Total number of mothers who delivered at gestation < 27weeks', or for multiples gestation <28 weeks, or baby's birth weight is < 800g and unit level is NICU, by locality

Denominator: Total number of mothers who delivered at gestation <27weeks' OR for multiples gestation <28 weeks OR baby's birth weight is < 800g, by locality

Inclusion Criteria:
Deliveries admitted to a LNU or SCU, with a gestation <27weeks' or <28weeks' multiple delivery or birthweight <800g. Multi births count as 1 delivery, as per NHSE quarterly submission.

<32 WEEKS IN SCU

The number of first episodes below 32 weeks gestation born in Special Care Unit (SCU).

Source of Standard: NWNODN

Numerator: The number of first episodes below 32 weeks gestation born in SCU.

Denominator: N/A

Inclusion Criteria: First episodes admitted to SCU where gestation is <32 weeks.

ANTENATAL STEROIDS

Proportion of mothers who deliver a baby at less than 34 weeks' gestational age who receive a full course of antenatal corticosteroids within 1 week prior to delivery

Source of Standard: NNAP Measure

Numerator: Number of mothers who delivered at less than 34weeks' gestation who were given a full course of steroids and first or last dose is within 7 days of birth.

Denominator: Total number of mothers who delivered at less than 34 weeks gestation.

Inclusion Criteria: Count of deliveries grouped by mother's anonymised NHS code**,** based upon admission date**,** episode 1**,** gestation <34weeks'**,** day one location of care NNU, mothers given antenatal steroids (multiple births- best outcome)

ANTENATAL MAGNESIUM SULPHATE

Proportion of mothers of babies born less than 30weeks' gestational age who were given magnesium sulphate

Source of Standard: NNAP Measure

Numerator: Number of mothers who delivered <30weeks' gestation and were given magnesium sulphate.

Denominator: Number of mothers who delivered at <30weeks' gestation.

Inclusion Criteria: Count of deliveries grouped by mother's anonymised NHS code, based upon admission date, episode 1, gestation weeks <30, day one location of care NNU, mothers given Magnesium Sulphate (multiple births - best outcome used).

ANTENATAL ANTIBIOTICS

Proportion of mothers who deliver a baby at less than 34 weeks' gestational age who receive a course of antenatal antibiotics

Source of Standard: Measure 1: MatNeo SIP & SBL Element 5

Numerator: Number of mothers who delivered at less than 34 weeks gestation who were given a course of antibiotics more than 4 hours before delivery.

Denominator: Total number of mothers who delivered at less than 34 weeks gestation.

Inclusion Criteria: Count of deliveries grouped by mother's anonymised NHS code**,** based upon admission date**,** episode 1**, <**34weeks' gestation**,** day one location of care NNU, mothers given antenatal antibiotics (multiple births- best outcome)

DEFERRED CORD CLAMPING FOR VERY PRETERM BABIES

Percentage of babies born <34 weeks' gestational age who had their cord clamped at or after 1 minute of age

Source of Standard: NNAP Measure

Numerator: The number of babies admitted to NNU whose cord was clamped at or after one minute.

Denominator: The denominator is the number of babies born <34 weeks & admitted to NNU.

Inclusion Criteria:
All babies born at <34weeks gestation who were admitted to an NNU. Babies whose place of birth is listed as Home or Transit will have their network of birth updated to the provider network of their earliest episode.

PROMOTING NORMAL TEMPERATURE ON ADMISSION FOR PRETERM BABIES

Percentage of babies <34 weeks gestation age admitted to a NNU who have their temperature recorded within one hour of birth & the measurement is within the range of 36.5 °C – 37.5 °C

Source of Standard: NNAP Measure

Numerator: The numerator is the number of babies <34 weeks who had their temperature taken within one hour of birth and where the measurement was in the specified range.

Denominator: The denominator is number of babies <34 weeks admitted who were admitted to the NNU within one hour of birth.

Inclusion Criteria:
Count of babies based upon admission date**,** episode 1**,** day one location of care NNU

BREASTMILK FEEDING IN THE FIRST 2 DAYS OF LIFE

The proportion of babies born at <34 weeks' gestational age who receive their own mother's milk in the first 2 days of life

Source of Standard: NNAP

Numerator: The number of babies born <34weeks' gestation who were receiving their mother's own in the first 2 days of life.

Denominator: The number of babies born <34weeks' gestation who survived to age 48 hours

- **Inclusion Criteria:** Episode 1 of care and gestation <34weeks. Babies who received their own mother's breast milk on day 1 or day 2 of life. Babies will be classified as meeting the standard if they receive any of the following on Day 1 or day 2 of life: Mother's fresh expressed breast milk. Suckling at the breast, Mother's frozen expressed breastmilk, Colostrum.

TYPE AND DURATION OF RESPIRATORY SUPPORT

Proportion of babies born <32 weeks' gestation who only receive non-invasive respiratory support during the first week of life

Source of Standard: NNAP

Numerator: Number of babies born <32weeks' gestation who did not have any invasive respiratory support for all first 7 days of admission without any surgery on these days and still admitted at day 8 of life.

Denominator: Number of babies admitted to NNU at <32weeks' gestation (without any surgery within first week of life who survived to day 8 on a neonatal unit).

Inclusion Criteria:
Based upon admission date, babies <32weeks' gestation, attributed to episode 1 and survive and on a unit at day 8 of life with no surgery in first 7 days of life.

CAFFEINE

Percentage of babies born at <30 weeks' gestational age given caffeine within the 1st 2 days of life

Source of Standard: MatNeo SIP measure

Numerator: Number of babies born <30weeks gestation who were given caffeine in the first 2 days of life.

Denominator: Number of babies admitted to NNU at <30 weeks gestation who survived to 48 hours of life.

Inclusion Criteria:
Attributed to episode 1 and gestation <30weeks. Babies who received caffeine on day 1 or day 2 of life on an NNU ward, having a NWNODN location of care at 48 hrs of life.

Parental Partnership

PARENTAL CONSULTATION WITHIN 24 HOURS OF ADMISSION

Percentage of documented consultation between a senior member of the NNU team and a parent within 24 hours of the admission, excluding babies receiving TC care

Source of Standard: NNAP Measure

Numerator: Number of NNU admissions where there is a documented parental consultation with a senior team member within 24 hours of admission.

Denominator: Number of NNU admissions admitted for more that 12 hours where baby is receiving intensive, high dependency or special care. Babies admitted to more than one unit will count as multiple admissions.

Inclusion Criteria: admissions lasting at least 12 hours, receiving SC HD or IC, on an NNU Ward (Excludes PNW, TC). Babies admitted to more than one unit will count as multiple admissions.

PARENTAL PRESCENCE AT CONSULTANT WARD ROUNDS

Percentage of ward rounds (care days) that include a parent, excluding babies receiving TC

Source of Standard: NNAP Measure (measure 1)

Numerator: The number of NNU care days during entire stay where a parent was present on ward round.

Denominator: The number of NNU care days for NNU admissions that are at least 24 hours in length where parents on ward round field has been populated.

Inclusion Criteria: Admissions lasting at least 24 hours**,** total episodes of care where baby was on NNU,

Care processes

EARLY BREASTMILK FEEDING

The proportion of babies <34weeks' gestation at birth receiving any of their mother's milk at day 14 of life.

Source of Standard: NNAP

Numerator: Number of babies born <34weeks' gestation who were receiving their mother's own milk at day 14

Denominator: Number of babies with a gestation of less than 34 weeks who have survived to day 14 of life

Inclusion Criteria: Count of episodes based upon care data at day 14 of life and gestation< 34weeks. Babies who received their own mother's breast milk at day 14 of life (if missing data then best result from day 13 or 15) on an NNU ward, having a NWNODN location of care at 48 hrs of life.

Babies will be classified as meeting the standard if they receive any of the following on Day 14 of life, or the best of day 13 or 15 when day 14 feeding data has not been completed: mother's fresh expressed breast milk, suckling at the breast or mother's frozen expressed breastmilk.

BREAST MILK AT DISCHARGE

Proportion of babies <34 weeks' gestation at birth receiving any of their mother's milk when discharged from the NNU and the proportion of babies, any gestation at birth, receiving any of their mother's milk when discharged from the NNU

Source of Standard: NNAP measure and NWNODN additional standard

Numerator: The number of babies born <34weeks' / any gestation who were receiving any of their mother's own milk at discharge or penultimate day of care.

Denominator: Number of NNU admissions where the discharge destination is Home, feeding data is available on final or penultimate day of care and gestation at birth <34 weeks' / any gestation

Inclusion Criteria: Count of episodes based upon discharge date**.**
Discharge Destination = Home. Daily record on last day or penultimate day
Enteral feeds = breast milk, breast milk & formula or formula only.

ROP SCREENING

Percentage of babies with a gestational age of <31weeks gestational age or <1501g at birth undergoing first Retinopathy of Prematurity (ROP) within the specified time window

Source of Standard: NNAP Measure

Numerator: The number of eligible babies who have had ROP screening in-line with the national guideline.

Gestational age at birth (completed weeks)	National guideline ROP screening window
Less than 31 weeks' gestational age	31+0 and 31+6weeks' postmenstrual age, or at 4 completed weeks' postnatal age (28-34 days), whichever is later.
At or after 31 weeks' gestational age, with birthweight less than 1501g	36 weeks' postmenstrual age or 4 completed weeks' postnatal age (28–34 days), whichever is sooner.

Denominator: All babies eligible for ROP screening.

Inclusion Criteria: Eligible babies: gestation <31 weeks or birth weight < 1501g; alive at start of ROP window**,** Count of episodes of eligible babies
Reporting period based on eligible babies' final discharge
Reported at NNU where discharged before screening window closed.
Reported at NNU where first screening took place during screening window.
Reported at NNU where admitted when screening window closed but not screened

FOLLOW UP AT TWO YEARS OF AGE

Percentage of babies born at <30weeks' gestational age who have a follow-up appointment at 2 yrs gestationally corrected age (18-30 months' gestationally corrected acceptable range)

Source of Standard: NNAP Measure

Numerator: Number of babies born <30weeks' gestation who have had a medical follow-up at 2 years of age (appointment between 547 days & 913 days after corrected gestational age).

Denominator: Number of babies born at <30 weeks gestation that have been discharged home or to foster care this excludes babies who died prior to discharge.

Inclusion Criteria:
Based upon birth date, babies with gestation <30 weeks, only babies with final discharge alive, attributed to & reported at NWNODN final discharge unit.

NURSE STAFFING – numerically staffed

Proportion of shifts numerically staffed according to guidelines & service specification

Source of Standard: NNAP Measure

Numerator: The number of shifts where nurse staffing met or exceeded recommended staffing levels as per service specification rules (NHS England, 2016)

Denominator: The number of shifts per period (2 per day)

Inclusion Criteria:
Count of shifts (based on a two-shift model of each calendar day), Service specification rules: 1:1 intensive care; 1:2 high dependency care; 1:4 special care; additional shift coordinator

Clinical Outcomes

Preterm brain injury – IVH 3 or 4 or death

Proportion of babies born at less than 32weeks' who experience intraventricular haemorrhage (IVH) grade 3 or 4 or died.

Source of Standard: NNAP Measure

Numerator: Number of babies born <32 weeks gestational age with IVH3/4 or die before discharge.

Denominator: Number of babies < 32 weeks gestational age with a complete scan in first 28 days of life or died within 7 days of birth.

Inclusion Criteria: Based on date that baby reached 44 weeks PMA and attributed to the unit and network of birth. When babies are born at home or in transit they are assigned to Other.

Preterm brain injury – cPVL or death

Proportion of babies born at less than 32 weeks who experience cystic periventricular leukomalacia (cPVL) or died.

Source of Standard: NNAP Measure

Numerator: Number of babies born <32 weeks gestational age with cPVL or died before discharge.

Denominator: Number of babies < 32 weeks gestational age with a complete cPVL scan or died before discharge.

Inclusion Criteria: Based on date that baby reached 44 weeks PMA and attributed to the unit and network of birth. When babies are born at home or in transit they are assigned to Other.

Preterm brain injury – cPVL

Proportion of babies born at less than 32 weeks who experience cystic periventricular leukomalacia (cPVL)

Source of Standard: NNAP measure

Numerator: Number of babies born <32 weeks gestational age with cPVL .

Denominator: Number of babies born <32 weeks gestational age.

Inclusion Criteria: Based on date that baby reached 44 weeks PMA and attributed to the unit and network of birth. When babies are born at home or in transit they are assigned to Other.

Preterm brain injury – cPVL or IVH

Proportion of babies born at less than 32 weeks who experience cystic periventricular leukomalacia (cPVL) or intraventricular haemorrhage (IVH) grade 3 or 4.

Source of Standard: NNAP measure

Numerator: Number of babies born <32 weeks gestational age with IVH grade 3 or 4.

Denominator: Number of babies born <32 weeks gestational age.

Inclusion Criteria: Based on date that baby reached 44 weeks PMA and attributed to the unit and network of birth. When babies are born at home or in transit they are assigned to Other.

Preterm brain injury – Missing data

Percentage of babies born at less than 32 weeks with missing head scan data for intraventricular haemorrhage (IVH) grade 3 or 4.

Source of Standard: NWNODN measure (To support Saving Babies Lives)

Numerator: Number of babies born <32weeks gestational age with no head scan for IVH

Denominator: Number of babies born <32 weeks gestational age.

Inclusion Criteria: Based on date that baby reached 44 weeks PMA and attributed to the unit and network of birth. When babies are born at home or in transit they are assigned to Other.

BLOODSTREAM INFECTION

Percentage of babies <32weeks' gestation at birth who have one or more episodes of bloodstream infection, characterised by one or more positive blood cultures taken, after 72 hours of age

Source of Standard: NNAP Measure

Numerator: The number of admitted babies born <32 weeks' gestation with clear pathogenic infections & remain on the unit at 72hrs of age.

Denominator: Number of Admissions babies <32weeks' gestation discharged in reporting period who are present on neonatal unit at 72 hours of age.

Inclusion Criteria: Babies who experience their final discharge in the reporting quarter and where present on the neonatal unit at 72 hours of age.

BRONCHOPULMONARY DYSPLASIA

Percentage of babies born at <32weeks' gestational age who develop significant Bronchopulmonary Dysplasia or die

Source of Standard: NNAP Measure

Numerator: The number of babies born <32 weeks' gestation inclusive, who developed BPD or died.

Denominator: Number of babies born <32 weeks' gestation who were still an inpatient in neonatal unit at 36 weeks' postmenstrual age, had been discharge alive from neonatal care at less than 36 weeks' postmenstrual age, or had died before 36 weeks postmenstrual age, and who have complete respiratory data at 36 weeks of life.

Inclusion Criteria: BPD will be defined by the level of respiratory support at 36 weeks postmenstrual age or if baby died by 36 weeks postmenstrual age**,** BPD defined by receiving any ventilation, CPAP, Non-invasive ventilation, hi flow nasal cannula or oxygen treatment. If missing data, then 1 day subsequently/prior to this date will be used, will also include babies who died pre 36 weeks postmenstrual age.

NEC

Percentage of babies born at <32weeks' gestational age who meet the NNAP surveillance definition for necrotising enterocolitis

Source of Standard: NNAP Measure

Numerator: The number of babies born <32weeks' gestation who survived to at least 48 hours after birth who are defined as having NEC.

Denominator: All babies born <32weeks' gestation who survived to at least 48 hours after birth and have a complete NEC diagnosis field.

Inclusion Criteria: Count of babies born <32 weeks, with final discharge from care, who are diagnosed as having NEC at Surgery, post-mortem or based upon the following clinical and radiographic signs. At least one clinical feature from:

- Bilious gastric aspirate or emesis
- Abdominal distension
- Occult or gross blood in stool (no fissure)

  and at least one radiographic feature from:
- Pneumatosis
- Hepato-biliary gas
- Pneumoperitoneum

Babies who are found to have 'Focal Intestinal Perforation' at surgery or post-mortem should not be recoded as having NEC. Data will be collated by month of discharge and attributed to the hospital where baby was resident at 48 hours of life.

COOLING PER 1,000 LIVE BIRTHS

The rate of babies cooled per 1,000 live births (recorded for all gestations & 37 wks and above

Source of Standard: NWNODN

Numerator: Number of babies actively cooled (all gestations) / 37 weeks & above only

Denominator: Total number of live births divided by 1000

Inclusion Criteria: Based upon admission date of episode 1, for babies actively cooled in any episode. Attributed to place of birth, not location of cooling.

HIE PER 1,000 LIVE BIRTHS

The number of babies born ≥35weeks' (and ≥37weeks) gestation, having a diagnosis of HIE grade 2 or 3, per 1,000 live births

Source of Standard: NWNODN

Numerator: Measure 1: Number of babies born ≥35 weeks who have a diagnosis of HIE grade 2 or 3 as per inclusion criteria.
Measure 2: Number of babies born ≥37 weeks who have a diagnosis of HIE grade 2 or 3 as per inclusion criteria

Denominator: Total number of live births divided by 1000

Inclusion Criteria: Attributed to episode 1 with gestation ≥35 (or ≥37) weeks, for babies diagnosed with HIE grade 2 or 3 on any daily care day or at discharge, during any episode of care, including babies who died.

MORTALITY

All Deaths occurring in neonatal units per 1,000 live births
Gestation group deaths as percentages of babies born 22to23weeks gestation, 24to31 weeks' gestation and all gestations (NNU admissions only) who die pre 44 weeks post-menstrual age.

Source of Standard: NNAP Measure & additional NWNODN standards

Numerator: Rate per 1000 - number of babies who die on an NNU any gestation
Gestational group percentages - number of deaths for babies born at the specified gestations, pre 44 weeks post-menstrual age.

Denominator: Rate - number of live births divided by 1,000.
Gestational Group percentages - Number of episode 1 admissions for the specified gestations.

Inclusion Criteria:
Attributed to episode 1, for babies with discharge destination = 3 (died)
All deaths are attributed to place of birth, not the unit where baby died or was transferred to including hospice.

Data quality

Ethnicity of Mother and Baby Data Quality

Percentages of babies where mother's ethnicity and baby's ethnicity are recorded.

Source of Standard: NWNODN standards

Numerator: Measure 1: Number of babies with 'mother's ethnicity' recorded.
Measure 2: Number of babies with 'baby's ethnicity' recorded.

Denominator: Number of episode 1 admissions.

Displayed as: Measure 1: Percentage of babies with mother's ethnicity recorded.
Measure 2: Percentage of babies with baby's ethnicity is recorded.

Inclusion Criteria:
Episodes 1 (babies) all gestations.

Flagging of Dashboards Outliers

Quarterly dashboard data which fall below the agreed target for units, localities or across the NWNODN are flagged as detailed below. Amber flags highlight where units have achieved in-line with the national average but have not yet achieved the national target or the ODN mean for the previous year.

1. Dashboard data is presented in full quarters (i.e. April – June Q1, July – Sept Q2, Oct-Dec Q3 & Jan to March Q4).

2. Where data is outside the mean or target for a measure for a quarter, it will be flagged on the dashboard in a red or amber box, as detailed in the summary below.

3. If the unit data is incorrect due to missing data this should be amended and will be updated when the dashboard is refreshed.

4. The NNAP mean for all neonatal units will be used as the red flag for measures, as taken from the NNAP report published in November 2024.

5. If an ODN only measure, the flag is set by the NWNODN data group, and where appropriate calculated using the previous years' mean across the NWNODN.

6. Some measures have an amber flag. This is where the outcome does not meet the NNAP development standard or where a unit performs better than the NNAP national average, as taken from the latest report (2023 data published in November 2024) but below the 2024 ODN mean.

7. For the ATAIN measure units will flag red if below the national target of 6% and amber if they are above the ODN target based on the previous year's mean.

8. If there are two consecutive quarters flagging red, then the unit or locality will become an outlier. Depending upon the measure, the NWNODN Director and Clinical Lead may contact units individually to request further information or offer support.

9. Flags for mortality will be escalated via NSG to the provider. A local review and report back to NSG will then be requested to understand any learning or local requirement for further investigation. A guide for reporting back local review will be shared with a provider with local data when identified as an outlier

10. The locality dashboards will continue to be presented at NSG and give an overall view of outliers across the locality for each measure. Discussions at locality level, if necessary, will be escalated to the Senior Management Team (SMT) for review.

11. The NWNODN dashboards will continue to be presented at the quarterly SMT meetings with locality outlier flags being highlighted.

Flags Summary 2025

Activity and Transfers:	Flag	Old flag	National standard
Term admissions - percentage of live births	>6% red >4.9% to 6% amber	>6% red >4.9% to 6% amber	ATAIN national target ODN standard based on 2024 mean
Minimising separation late preterm (34-36wk)	>5.9% red	>5.7%	ODN measure based on 2024 mean rate
Minimising separation term (37wk+)	>2.8% red	>2.8%	ODN measure based on 2024 mean rate
Percentage of network IC activity in NICUs	<90% red	<90%	ODN measure agreed by data group
Inappropriate transfers out of locality (within NWNODN)	No Flag	No flag	ODN measure
Closed to external admissions Unit	>10 days	>10 days	ODN Measure agreed by data group
Percentage of preterm deliveries 24-<37	No Flag	No flag	New dashboard tab in 2025/24 Q3 for maternity purposes only
Optimal perinatal care:	Flag	Old flag	National standard
>27 weeks in LNU No. of deliveries <27 weeks gestation (or <28wks if multi) or 800g at an LNU	>1 red 85% born at a NICU for locality	>1 red	ODN Measure NHSE standard
Birth in a centre with a NICU <27wks – still in LNU after 24hrs	>1 red	>1 red	ODN Measure Neonatal Service Specification
The number of deliveries below 32 weeks gestation born in a Special Care Unit (SCU)	>1 red	>1 red	ODN measure
Antenatal steroids (<34 wks) **Full course given & last dose <7 days**	<53% red >53% to <55% amber	<52%	NNAP National Average red. SBL mean 2024 55%
Antenatal magnesium sulphate (<30 wks) **Within 24hrs prior to birth**	<85% red >85% to 90% amber	<87% red >87% to 90% amber	NNAP National Average NNAP development standard 90%

Antenatal antibiotics (<34wks) **>4hrs prior to delivery**	36% red No amber	No flag	ODN Mean for 2024
Deferred cord clamping (<34 wks) **1 min or longer**	<68% red >68% to < 80% amber	<60% red 60-<75% amber	NNAP National Average ODN Mean for 2024
Promoting normal temperature on admission for preterm babies (<34wks) **36.5-37.5 on NNU within 1 hour of birth**	<80% red >80% to 90% amber	<77% red 77% to 90% amber	NNAP national average NNAP development standard 90%
Breastmilk feeding in first 2 days of life (< 34wks) **Mothers milk to include suckling, tube feed, mouth care or buccal administration**	<62% red >62% to 70% amber	<49% 49-69% amber	NNAP National Average ODN mean for 2024
Type and duration of respiratory support (<32 wks, non-invasive)	<49% red		NNAP National Average No amber flag as NW below national mean
Caffeine (<30 wks) **Commenced by end of day 2 of life**	<96% red	<94% red	ODN measure based on 2024 percentage
Parental Partnership:	Flag	Old flag	National standard
Parent consultation within 24hrs of admission	<95% red	<96% red	NNAP National Average No amber as high red flag
Consultant ward rounds when parent present	<39% red	>96	NNAP National Average No amber as ODN below NNAP mean
Care processes:	Flag	Old flag	National standard
Early breastmilk feeding Day 14 (<34wks)	<80% red	<79% red	NNAP National Average No amber as ODN mean the same
Breastmilk at discharge (<34wks)	<63% red	<63%	NNAP National average No amber as ODN mean the same
Breastmilk at discharge (All)	<59% red		ODN mean for 2024
ROP screening	<78% red >78% to 100% amber	<69% red >78% to 100% amber	NNAP National Average NNAP development standard 100%
Follow-up at two years of age	<77% red >77% to 90% amber	<73% red >73% to 90% amber	NNAP National Average NNAP development standard 90%
Nurse staffing - numerically staffed	<79% red >79% to 100% amber	<74% red >74% to 100% amber	NNAP National Average red NNAP development standard 100%

Clinical outcomes	Flag	Old flag	National standard
Bloodstream infections (<32wks) – Unit	>4.6% red	>5.4%	NNAP National average No amber as ODN mean the same
Bronchopulmonary dysplasia and death (<32wks)	>40% red	>39%	NNAP National average No amber as ODN mean the same
NEC (<32wks)	>5.5% red <5.5% to >4.1% amber	>6.2%	NNAP National average ODN mean for 2024
Cooling per 1000 live births	>1.8	>1.6	ODN measure > 2 SD's outside 2024 ODN Mean
HIE grade 2 or 3 per 1000 live births (>= 35wks)	>1.1	>1.2	ODN measure > 2 SD's outside 2024 ODN Mean
HIE grade 2 or 3 per 1000 live births (>= 37wks)	>1.3	New measure	ODN measure > 2 SD's outside 2024 ODN Mean
Mortality per 1000 live births – NICU / Non- NICU	No flag	No flag	No agreed flag. Will continue to develop a way to flag rates
Mortality as per NNAP definition			
Mortality gestation 22-23 weeks	No flag	No flag	For monitoring only
Mortality gestation 24-27 weeks	No flag	No flag	For monitoring only
Mortality gestation 28-31 weeks	No flag	No flag	For monitoring only
Mortality gestation 24-31 weeks **(Reported at 44wks)**	>4.2% NON-NICU >7.4% NICU >6.4% overall mean	>4.2% NON-NICU >7.8% NICU >6.4% locality – check	Taken from NNAP restricted dashboard Dec 2024 (as split by level of unit)
Mortality gestation 32+ weeks	No flag	No flag	For monitoring only
Mortality gestation all weeks	No flag	No flag	For monitoring only
Preterm brain injury as per NNAP definition (note only IVH missing data flagged as cPVL missing data is a very low %)			
Preterm brain injury: IVH missing data **(Brain Injury data is reported at 44 wks)**	<10%	New flag	ODN flag. National missing data is 13% but ODN is considerably lower
Preterm brain injury: IVH3/4 only	>7%	New flag	NNAP mean 2023 data No amber flag this year as only recently added to DB
Preterm brain injury: IVH3/4 or death	>14%	New flag	NNAP mean 2023 data No amber flag this year as only recently added to DB

Preterm brain injury: cPVL only	>3%	New flag	NNAP mean 2023 data No amber flag this year as only recently added to DB
Preterm brain injury: cPVL or death	>10%	New flag	NNAP mean 2023 data No amber flag this year as only recently added to DB
Data quality:			
Ethnicity baby % of babies with ethnicity entered	<90% red	<90% red	NNAP requirement to enter ethnicity data but not reported. Currently an ODN measure
Ethnicity mother % of mothers with ethnicity entered	<90% red	<90% red	NNAP requirement to enter ethnicity data but not reported. Currently an ODN measure

All NNAP National averages are taken from the 2023 data (NNAP Report, Published November 2024)

QUALITY COMMITTEE

Meeting Date:	**29th Otober 2025**	**Agenda Item:**	**QC/2025/264**
Report Title:	**Floor to Board report for Maternity & Neonatology services**		
Author:	Tracy Thompson (Divisional Director of Nursing & Midwifery) informed by Perinatal Transformation Programme Manager		
Lead Director:	Peter Murphy, Executive Director of Nursing. (Board Level Maternity/Neonatal Safety Champion)		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
				ü
Executive Summary:	To provide Bimonthly updates to ELHT (East Lancashire Hospitals NHS Trust) Quality committee through the maternity and Neonatal safety champions, perinatal transformation team, perinatal quadrumvirate. 'Floor-to-board' meetings, executive and non-executive walk arounds with other trust wide patient, quality, and governance forums. Updates for quality committee will include matters in relation to wider improvements related to maternity and neonatal safety assurance. Improvements relative to the National directives include the maternity incentive schemes (MIS ten safety actions), LMNS (Local Maternity and Neonatal System) deliverables aligned with funding streams, Ockenden immediate and essential actions and the three-year delivery plan for maternity and neonatology.			
Key Issues/Areas of Concern:				

Action Required by the Committee:	Quality committee members are asked to receive the report, note the contents acknowledge Maternity/Neonatology services progress with any exceptions aligned to quality and service improvements, adding any recommendations. Related to key delivery programmes - Clinical Negligence Scheme for Trust – Maternity Incentive Scheme (CNST-MIS) Maternity & Neonatal 3-year delivery plan

Previously Considered by:	
Date:	
Outcome:	

1. Maternity and Neonatology 3-year delivery plan – An introduction

The three-year delivery plan published by NHS England in March 2023 (**Appendix 1**) aims to make care safer, more personalised, and more equitable. The plan continues and aligns to the recommendations set out in the independent reports by Donna Ockenden on maternity services in Shrewsbury and Telford (Ockenden Report, 2022), by Dr Bill Kirkup on maternity and neonatal services in East Kent (Reading the Signals Report, 2022), and previously Morecambe Bay (Kirkup Report, 2015)

The plan sets out the responsibilities specific to the Trusts, to the ICB's (integrated care boards) as a partner within an ICS (integrated care system) - the Local Maternity and Neonatal System (LMNS) is the maternity and neonatal arm of the ICS who provides assurance to the regional teams who further are responsible for the relationship between ICB's and NHS England.

The plan asks services to concentrate on four high level themes:

- Listening to and working with women and families with compassion
- Growing, retaining, and supporting our workforce

- Developing and sustaining a culture of safety, learning, and support
- Standards and structures that underpin safer, more personalised, and more equitable care

Maternity and Neonatal services aim is to reflect the four themes within the three-year plan as the structure for Floor to Board reports presented at ELHT Quality Committee, further informing staff teams and service users with a mirrored approach. One example being the Maternity and Neonatal Newsletter to staff and service user friendly infographics as updates to be shared through the MNVP (Maternity and Neonatal Voice Partnerships) agendas alongside updates via the trust website. Standardised communication with all colleagues and service users working towards the shared goals and ambitions of the 3-year delivery plan is an essential part of the perinatal culture.

2. Theme 1 - Listening to and working with women and families with compassion

This theme is further defined by 3 objectives;

1. Care that is personalised
2. To improve equity for mothers and babies
3. To work with service users to improve care.

2.1 Perinatal Pelvic Health Services (PPHS)

The NHS Long Term Plan committed to improve access to pelvic health physiotherapy and other specialists for all women and pregnant people with pelvic health conditions during their pregnancy and the year after giving birth and that all women and pregnant people have access to multidisciplinary pelvic health services and pathways across England. Further to this the 2023 Maternity and Neonatal 3-year plan stated a key commitment for ensuring access to these services in all areas of England by 2024.

In 2021 Lancashire and South Cumbria (LSC) were one of the 14 areas in the country to pilot the new Perinatal Pelvic Health Services (PPHS) which were developed collaboratively to meet the above asks and commitments. Following the success of this pilot the services were embedded into routine care; the service at ELHT currently is funded for a PPHS Specialist Midwife Lead for 18.75hr/w and a further 5hr/w of a second specialist midwife to support perineal clinic. The service receives 784 referrals per year, and 184 patient contacts are made per month alongside the Perineal Acute Assessment and MDT Perineal OASI Clinics. The service is supported by an Obstetric Consultant on an ad hoc basis however this is not formally job planned. Escalations have been made to the perinatal leadership team regarding the demand and capacity for this service, in response the Clinical Director for Obstetrics and Directorate Manager are reviewing the consultant role for the service to review and formalise the resource required. In addition, ELHT consultant midwife is reviewing the job plan for the PPHS midwife to align with the

current capacity and demand together with a plan for when annual leave is taken, the patients' referrals into this service do require a timely approach within the system.

The 2024 All Party Parliamentary Group Birth (APPG) Trauma Report (**Appendix 2**) addresses the topic of birth injuries and specifically perineal tearing, the report explains 'During vaginal birth, many women experience perineal tearing. In most cases, these tears are minor and heal quickly. Some women, however, experience third- or fourth-degree tears, also known as obstetric anal sphincter injuries (OASI). These can cause lasting problems, including urinary and bowel incontinence, chronic pain and pelvic organ prolapse, when an organ such as the uterus or bladder descends into the vagina.' The report highlights the below information regarding the financial costs of OASI to the NHS:

'There has been little research on the financial cost to the NHS of anal sphincter injuries sustained during childbirth, though it can be partly measured through litigation costs. NHS figures show:
• The highest rate of litigation in clinical practice is for childbirth injuries.
• The value of maternity claims doubled between 2016/17 and 2022/23.38 In 2022/2023 the total cost of maternity payouts was £1.1bn.

The value of the average damages awarded for these claims has increased significantly. 2006/2007 the average maternal injury claim was worth approximately £82,011 and in 2022/2023 it averages at £301,492.'

At ELHT, there was 131 incidents of OASI injury during 2024 which accounts for 3.8% of all vaginal births. In a data triangulation exercise presented to the Maternity and Neonatal Safety Champions in October 2025 it was demonstrated that within the previous 6 months (72 reported incidents from April to September 2025) OASI injuries are the fourth most prevalent reported incident. These incidents are reported via the Perinatal Quality Oversight Model (PQOM) dashboard to board level safety champions in the bi-monthly Floor to Board meeting and the Maternity Performance Report which reviews the data as Statistically Process Control (SPC) charts and exceptions are reported through the directorate to division and Trust Board. ELHT are not an outlier in comparison with peers or National statistics with the metric, although the continued prevention via the key improvement practice and maternity multidisciplinary education forums is essential. The PPHS Specialist Midwife and Trust DATIX Manager are currently making improvements to the OASI incident reporting and investigating template to enhance the key information provided to inform any themes for quality improvement.
All OASI incidents are continually reviewed via prospective audit to ensure care was given in line with guidance and findings are reported annually through the Clinical Effectiveness meetings. The 2024 audit finds that although some incidental learning has been identified and acted upon, no factors would have prevented the ¾ tears.

A key recommendation from the APPG Birth Trauma report is to 'Roll out and implement, bespoke training, for the OASI (obstetric and anal sphincter injury) care bundle.' It is reported that implementation of full bundle reduces a woman's risk of sustaining of OASI injuries by 20%. Currently, the theoretical elements of OASI care bundle have been delivered to all midwives, alongside APPEAL training in pelvic floor exercises and to all doctors with 98% attendance compliance across these staff groups.

However, ELHT are not an official subscriber of the OASI care bundle as this requires further training hours to provide simulation-based training, the training team are exploring the possibility of providing the theoretical training via e-learning however whilst the Royal College of Obstetrics and Gynaecology do provide resources for this, it is not on a platform that would track staff access and completion and therefore unable to record compliance and provide assurances. The recommendation of the APPG report also is that the theoretical and simulation training is delivered together to provide maximum benefit. The Divisional Director of midwifery and consultant midwife are currently reviewing the maternity training schedules to risk assess which will be provided to the Trust. (Action to update progress via TWQGA)

3. Theme 2 – Growing, retaining, and supporting our workforce

The three-year plan states that 'The ambition of safer, more personalised, and more equitable maternity and neonatal services in this plan can only be delivered by skilled teams with sufficient capacity and capability.' This theme is further defined by:

Objective 4. Growing the workforce,

Objective 5. Value and retain the workforce, and

Objective 6. Invest in skills.

3.1 Recruitment and Retention Plan

Progress with the R& R plan continues as led by the Recruitment and Retention Specialist Midwife, demonstrated in detail in the previous Quality Committee report, August 2025. A further update to this will be provided to the December 2025 Quality Committee. Given the uplift in funding to meet the recommended midwife clinical hours of 7.50wte aligned with birth rate plus, following the agenda item at trust board in July 2025 followed by agenda item in July 2025 at financial and performance committee, this will now meet the clinical requirements aligned with CNST safety action 5, to be reflected in the Bi-annual midwifery staffing paper due in December 2025 to present to board in January 2026.

ELHT having received NHSE/ ICB fixed term funding for a newly appointed maternity support worker to work, alongside the MCOC willow team and a preceptorship midwife to deliver on all the expected quality standards for the March 2023 midwifery preceptorship framework.

Neonatology has seen a recent drive-in nurse recruitment given an increase in maternity leave and to fulfil requirements for Neonatology nurses to attend the cohort of training to be qualified in speciality (QIS) trusts are measured on the compliance rates of QIS trained neonatology nurse aligned with CNST – safety action 4.

4. Theme 3 - Developing and sustaining a culture of safety, learning, and support

The three-year plan states that 'An organisation's culture is shaped by the behaviour of everyone in it. In maternity and neonatal services, a safety culture improves the experience of care and outcomes for women and babies and supports staff to thrive.' This theme is further defined by:

Objective 7. Develop a positive safety culture,

Objective 8. Learning and improving

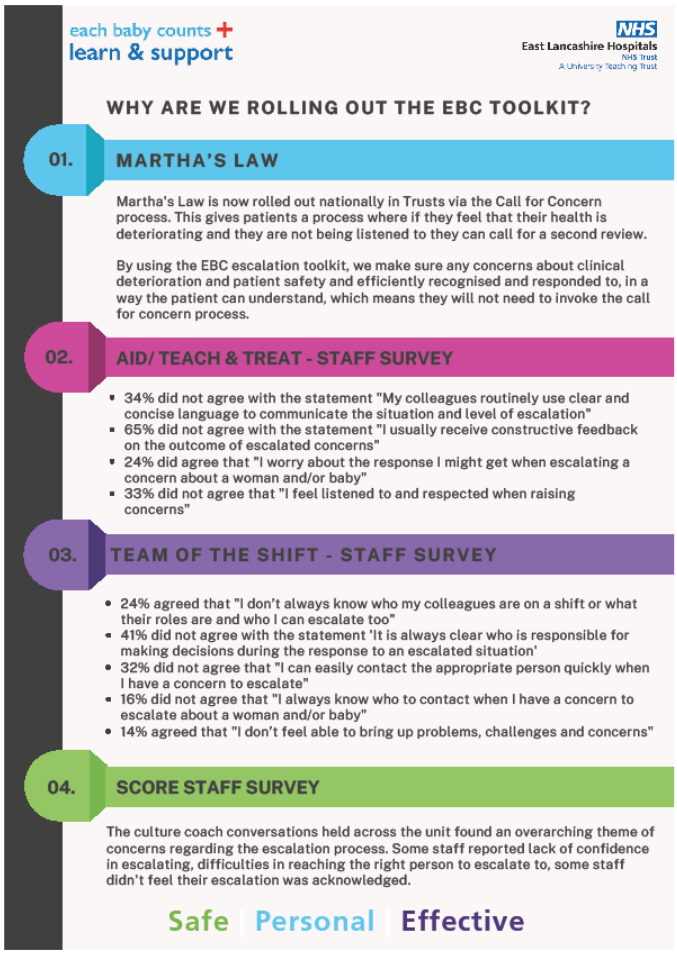
Objective 9. Support and oversight.

4.1 Escalation: Each Baby Counts (EBC) Toolkit

The EBC toolkit has been developed within the Royal College of Obstetrics and Gynaecology (RCOG) escalation campaign with the aim to help maternity units to build the right culture, behaviours and conditions that enable effective clinical escalation. This will:

- Reduce delays in escalation by improving the response escalation and action taken.
- Standardise the use of safety critical language.
- Reduce feelings of hierarchy, creating a supportive environment which empowers staff of all levels to speak up when they identify deterioration or a potential mistake.
- Promote a culture of respect, kindness, and civility amongst staff members, normalising positive feedback and saying thank you to each other.
- Improve the ways in which we listen to women.

A project group consisting of Obstetric Consultant Lead, Maternity Matrons, Band 7 area leads, consultant midwife, Digital Specialist Midwife, Fetal Monitoring Specialist Midwives, Maternity Education Team the Perinatal Transformation Team reviewed learning from incidents, Maternity and Neonatal Safety Investigation (MNSI) cases, national cases and improvements such as Martha's Law, staff surveys and staff culture coach conversations to provide a baseline for the project. This is collated and provided back to staff in the below infographic:



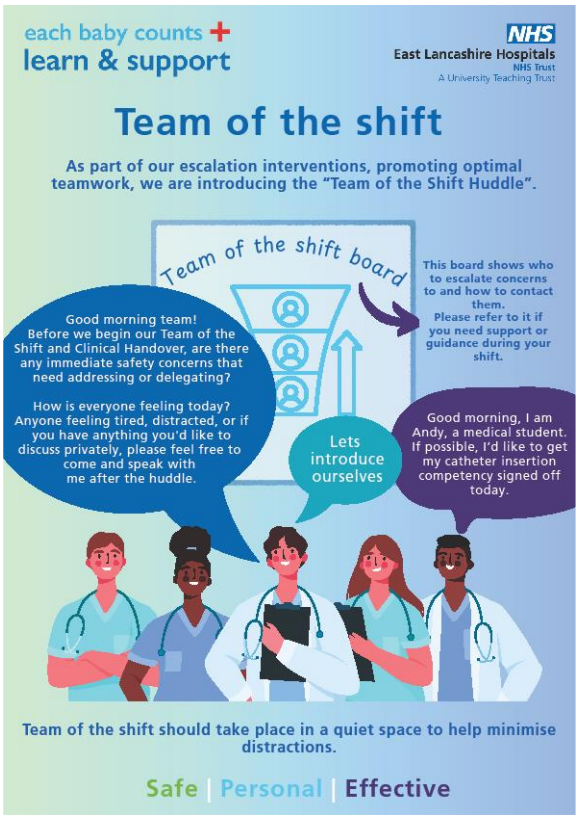
The toolkit has been launched via 'Escalation October' with members of the project group conducting daily walk rounds to promote the tools, raise awareness, and provide information to all staff. Training on the EBC escalation toolkit will be incorporated into the PROMPT programme by the maternity training and fetal monitoring team.

The toolkit includes 3 key elements;

Team of the Shift aims to build a psychologically safe, inclusive, and collaborative working environment by identifying all staff on shift, their roles, and support needs, while flattening hierarchies and encouraging open communication. It fosters a positive workplace culture through kindness, mutual respect, and shared understanding of priorities, challenges, and learning opportunities. Team of the Shift boards have been standardised in each maternity area, the project team collected photos of all Obstetric doctors from trainee to consultant to create a board in each area which identifies each team member with their photo, name, and grade.

On 6th October 2025, the obstetric consultant lead for the project led the first Team of the Shift on Central Birth Suite. The below poster was created by the Maternity & Neonatal

Project Support Officer to share to staff prior to this launch what this entails in an engaging format:



- **Advice, Inform, Do (AID)** aims to streamline clinical escalation by clearly signalling when escalation is occurring, prompting timely responses, and helping clinicians prioritise effectively during busy shifts. It also empowers junior staff to escalate confidently, reducing delays and improving patient safety.

- **Teach or Treat** aims to foster respectful, open conversations among clinical staff, empowering junior team members to speak up, ask questions, and escalate concerns without fear. It promotes shared understanding, flattened hierarchies, and a culture of learning and kindness, while keeping the woman at the centre of decision-making.

The below handout card, which is double-sided to include AID on one side and Teach or Treat on the other, was developed and distributed during the October walk rounds to support staff with these initiatives as below:

Progress with this project has been provided in a project poster (**appendix 3**) to be provided to the Local Maternity and Neonatal System as shared learning via the Patient Safety Group.

5. Theme 4 - Standards and structures that underpin safer, more personalised, and more equitable care

The three-year plan states that 'To deliver the ambition set out in this plan, maternity and neonatal teams need to be supported by clear standards and structures. This includes being enabled to implement best clinical practice for all families, having high quality data to inform the decisions of clinicians and leaders, and having digital tools that enable information to flow.' This theme is further defined by:

Objective 10. Standards to ensure best practice
Objective 11. Data to inform learning
Objective 12. Making better use of digital technology.

5.1 Perinatal Data & Digital Group

A Perinatal Data & Digital Group has been established in October 2025, which streamlines into one effective group the previous aims of the Digital Operations Group and the Maternity Dashboard Meeting. This group is established to oversee, track, monitor and escalate any issues and risks associated with the use of the electronic patient record systems – Badger net and Millennium. The group will work to achieve system optimisation therefore ensuring data accuracy and accessibility to inform service performance. The Maternity and Neonatal dashboard and exceptions will be reviewed at this meeting in the first instance each month, this allows the attendees to ascertain if any data trends and outliers are attributed to data quality/ system issues which can be rectified, where the data is true clinical variation this will then be discussed at the Perinatal Governance Board. This group therefore adds extra scrutiny and understanding of our service data prior to escalation of issues through the division and Trust. (Terms of Reference – **Appendix 4**)

5.2 Five-year review of still births, mortality, and neonatal deaths at ELHT led by the perinatal leadership team.

Presentations attached, agenda items for October quality committee- exceptions to shared and discussed at Trust board on the 12th of November 2025.

6. National Programmes & Investigation Report Responses – Key updates

6.1 Clinical Negligence Scheme for Trust – Maternity Incentive Scheme (CNST-MIS)

The guidance for CNST Year 7 was published on the 2nd of April (**Appendix 5**) and the position against the guidance is as follows:

***Blue indicates this safety action is complete and signed off via the LMNS visits.**

Safety Action	Progress	Assurance/Exceptions

1. Perinatal Mortality Review Tool (PMRT)		● We are within required time limits for all metrics for deaths of babies within the Y7 period as per guidance.
2. Maternity Services Data Set (MSDS)		● The July scorecard has been published and shows compliance.
3. Transitional Care (TC)		● Annual Transitional care (TC) audit will be submitted to January 2026 Trust Board. ● The Jaundice Quality improvement will be monitored as the response for this Safety Action and has been presented to the Board Level Safety Champions in October 2025.
4. Clinical Workforce		● Year 7 guidance requires one consultant attendance audit to be completed covering a 3-month period in the CNST Year. A quarter 1 audit has been completed which shows compliance, this will be submitted to November Trust Board. ● Audits for employing long and short-term locums also show compliance and will be submitted to November Trust Board. ● **Identified risk** - The Neonatal Nursing Workforce action plan remains in place. The annual workforce paper will demonstrate workforce analysis v activity including qualified in speciality (QIS) trained nurse and re-evaluate if compliance is at risk <70%. Confirmation of if this remains at risk following the annual review with be brought to November Trust Board, the action plan will be revised if the risk remains. ● Following further review, the Neonatal Medical Workforce is now compliant with BAPM standards for tiers 1, 2 and 3.
5. Midwifery Workforce		● Birthrate+ exercise is due for renewal this CNST year to maintain compliance. Submission of all required data has been made. Awaiting the final report. ● **Identified risk** - Current funded midwifery establishment does not reflect the 2022 Birthrate + findings and recommendations. Plan/mitigations are reflected in biannual midwifery staffing reports which ensures SA5 compliance.
6. Saving Babies Lives v3 Care Bundle (SBLv3)		● ELHT are currently at 94% overall implementation following the LMNS assurance visit in September 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		● Escalations regarding MNVP lead capacity and the extended requirements of the MNVP role were included within the September 2025 Trust Board reporting and discussed within the September LMNS CNST visit. Whilst there is an MNVP infrastructure in place for which there is evidence to support, LMNS have acknowledged that this infrastructure is no longer fit for purpose. ELHT will therefore be responding to the asks of this safety action via ongoing escalation of these issues and an action plan to meet these needs, this will be informed by the LMNS gap analysis exercise due to be complete in November 2025 and the completion of the collaborative self-assessment tool which is underway. These actions ensure we remain compliant for CNST Y7.

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 submission date on 30th of November 2025. ● Compliance for Neonatal Resuscitation Training previously escalated as below the required compliance is now 92% and compliant. ● **Identified risk –** The medical emergencies training (PROMPT) compliance for obstetrician is currently 86%. This is being managed by the Maternity Education Team and Consultant Midwife to ensure non-compliant staff members are booked onto the training.
9. Board Assurance		● An update on progress with the Culture Improvement Plan was included in September Trust Board report. Culture coach session feedback has been reviewed for themes as continues to be discussed by the quadrumvirate. ● Triangulation of claims, incidents, and complaints was presented to the Floor to Board meeting in October 2025
10. MNSI (Maternity and Newborn Safety Investigation) / NHS Resolution		● Quarterly MNSI reports are submitted to Trust Board. ● 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.

7. Recommendations

7.1 The committee is asked to acknowledge this summary paper under the four themes of the three-year plan with any exceptions and updates as an assurance that the National Maternity and Neonatology agenda is being implemented as a step wise approach with both divisional and trust board assurances. This is in collaboration with the Local maternity & Neonatal system (LMNS), NW (Northwest) regional teams, and integrated care system (ICS).

8. Conclusion

8.1 Quality, Safety, and performance within Maternity and Neonatology services here at ELHT remain a direct focus to be aligned with the relevant QI projects relative to any overarching themes directed by MNSI, PMRT, PSIRI actions and Clinical audit for areas improvement. Any immediate areas of concerns are reflected in the agendas to ensure quality and safety for mothers and families in collaboration with the maternity and neonatal safety champions is discussed to support any actions through scheduled bi – monthly floor to board meetings.

8.2 The committee is asked to receive and acknowledge this maternity/ Neonatology quality floor to board report together with the additional maternity staffing paper (Joint Round table exercise with ICB colleagues) requesting any further information if required on behalf of ELHT maternity & Neonatology services to the perinataltransformationteam@elht.nhs.uk or contact any of the ELHT maternity and Neonatology safety champions.

Executive Maternity Safety Champion – Peter Murphy

Non- Executive safety champion – Khalil Rehman

Midwifery Safety Champion – Tracy Thompson

Obstetric Safety Champion – Mr Martin Maher

Neonatology Safety Champions – Dr Raja Seethamraju and Ruth Dawson

Appendices

Appendix 1- Maternity and Neonatology 3-year delivery plan

2023 - 3 year mat neo plan (2).pdf

Appendix 2 – APPG Birth Trauma Report

2024 - Birth Trauma Inquiry Report for Put

Appendix 3 – Escalation EBC Toolkit Project Poster

Escalation Project October 2025.pdf

Appendix 4 – Maternity & Neonatal Data & Digital Group

ToR_MatNeo_Data_Digital_Group_October

Appendix 5 - CNST Year 7 Guidance

MIS year 7 Final.pdf

Quarterly PMRT report

Q2|July -September 2025

Title	**Family Care Division Quarterly PMRT Report (Jul-Sept 2025)**
Author	Helen Collier, Consultant Obstetrician & Perinatal Lead
Executive sponsor	Peter Murphy, Executive Director of Nursing & Midwifery
Summary	This report aims to enable the division to demonstrate actions taken in response to mortality within the division and to share learning from mortality reviews. This report is a mechanism for sharing improvements and changes in practice made as a result of investigations into mortality. The report enables the sharing of good practice across directorates and wider within the organisation where appropriate.
Recommendations	

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits, and improvements (safe, efficient, and sustainable care and services) and the organisation's corporate objectives Alignment of partnership organisations and collaborative strategies/collaborative working (Pennine Lancashire local delivery plan and Lancashire and South Cumbria STP) are not sufficient to support the delivery of sustainable, safe, and effective care through clinical pathways The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact (delete yes or no as appropriate and give reasons if yes)

Legal	Yes/~~No~~	Financial	Yes/~~No~~
Equality	Yes/~~No~~	Confidentiality	~~Yes~~/No

Contents

PMRT process

The PMRT has been designed to support the review of the following perinatal deaths:

- Late fetal losses where the baby is born between 22^{+0} and 23^{+6} weeks of pregnancy showing no signs of life, irrespective of when the death occurred, or if the gestation is not known, where the baby is over 500g;
- All stillbirths where the baby is born from 24+0 weeks gestation showing no signs of life, or if the gestation is not known, where the baby is over 500g;
- All neonatal deaths where the baby is born alive from 22^{+0} but dies up to 28 days after birth, or if the gestation is not known, where the baby is over 500g;
- Post-neonatal deaths where the baby is born alive from 22^{+0} but dies after 28 days following neonatal care; the baby may be receiving planned palliative care elsewhere (including at home) when they die.

Maternity Incentive Scheme Year 7 criteria

As of April 2025 the MIS Year 7 criteria have been published. The criteria relating to safety action 1 (*"Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard?"*) have been changed from the previous iteration. The new standards are:

Safety action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths that occurred from 1 December 2024 to 30 November 2025 to the required standard?

Required Standard
a) **Notify all death:** All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days. (See technical notes 1 to 5).
b) **Seek parents' views of care**: For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 1 December 2024 onwards. (See technical notes 6 to 8)
c) **Review the death and complete the review:** For deaths of babies who were born and died in your Trust from 1st December 2024 onwards multi-disciplinary reviews using the PMRT should be carried out; 95% of reviews should be started within two months of the death, and a minimum of 75% of multi-disciplinary reviews should be completed and published within six months. 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. (See technical notes 9 to 18)
d) **Report to the Trust Executive:** Quarterly reports of reviews of all deaths should be discussed with the Trust Maternity and Board Level Safety Champions and submitted to the Trust Executive Board on an ongoing basis from 1 December 2024. (See technical notes 19 to 20)

CNST Safety Action 1 targets (as per MIS year 7 criteria)

Performance against new MIS Year 7 criteria for deadlines due within Q2

1. Deaths notified to MBRRACE within 7 working days (target 100%)
    a. **100% (n=8) notified within target time**
2. Parents given opportunities to provide feedback or raise questions/concerns (target 95%)
    a. **100% (n=8) of parents had their input sought**
3. A review of the death should be commenced within 2 months (target 95%)
    a. **100% (n=11) had a PMRT review commenced within target time**
4. A multi-disciplinary review should be completed and published by 6 months (target 60%)
    a. **93.3% (n=14) had a MDT PMRT review report published by 6 months**
5. External representation should be present at PMRT review (target 50%)
    a. **60% (n=3) had an external representative at their PMRT review***

*CNST Maternity Incentive Scheme have confirmed that metric 5. will be monitored for deaths of babies from April 2025 onwards only, as this was a new ask in the guidance published this year. PMRT meetings which will be monitored for CNST compliance have been included in September's data.

PMRT Meeting Grading

Criteria for Care Graded for Antenatal, Intrapartum, Postnatal Care (if applicable)

- Grade A
    - No issues with care identified from birth up to the point the baby died.
- Grade B
    - Care issues identified which would have made no difference to the outcome for the baby.
- Grade C
    - Care issues identified which may have made a difference to the outcome
- Grade D
    - Care issues identified which would have made a difference to the outcome

Grading of care – Stillbirths

	Meeting Month (Q2)			
	July	**August**	**September**	**Total**
Number of cases discussed	**3**	**0**	**4**	**7**
Grading (up to birth of baby)				
A	**1**	**0**	**2**	**3**
B	**2**	**0**	**1**	**3**
C	**0**	**0**	**1**	**1**
D	**0**	**0**	**0**	**0**
Grading (following death of baby)				
A	**2**	**0**	**1**	**3**
B	**1**	**0**	**3**	**4**
C	**0**	**0**	**0**	**0**
D	**0**	**0**	**0**	**0**

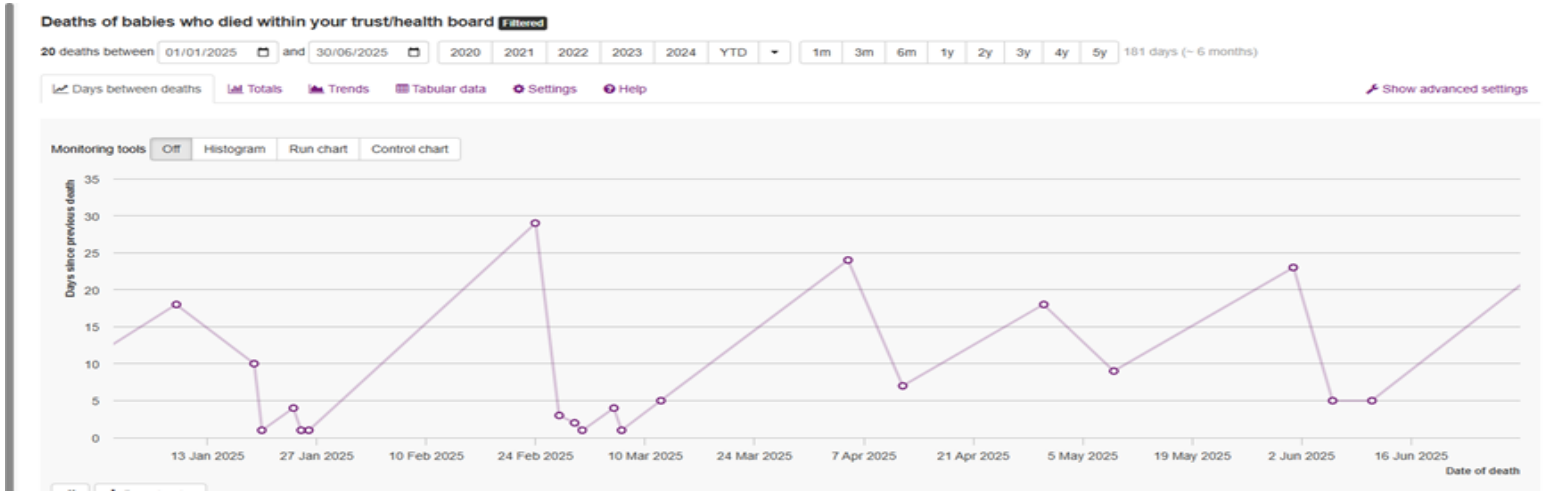
Grading of care – Neonatal deaths & Late fetal losses

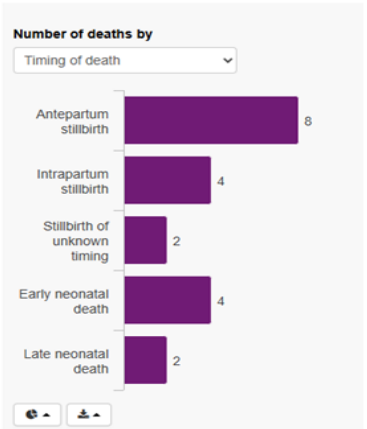
	Meeting Month (Q2)			
	July	August	September	Total
Number of cases discussed	0	0	1	1
Grading (up to birth of baby)				
A	0	0	1	1
B	0	0	0	0
C	0	0	0	0
D	0	0	0	0
Grading (from birth of baby until death)				
A	0	0	1	1
B	0	0	0	0
C	0	0	0	0
D	0	0	0	0
Grading (following death of baby)				
A	0	0	1	1
B	0	0	0	0
C	0	0	0	0
D	0	0	0	0

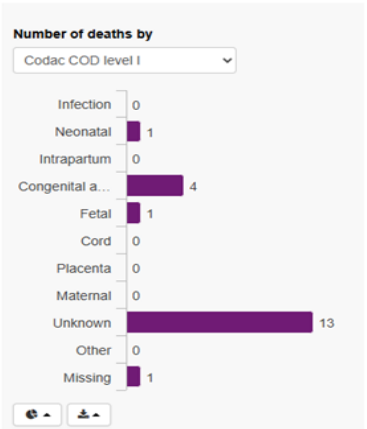
Clinical summary of new cases eligible for PMRT review occurring during Q2

MBBRACE ID	Type of case	Gestation at birth	Date of death	Clinical summary
99343	stillbirth	32+5	09/07/25	Known anencephaly under FMU
98946	stillbirth	24+6	11/07/25	ePPROM from 20/40, admitted with pain at 24+, no FH on ausculatation whilst inpatient
99640	NND	39+0	31/07/25	APH on ward during IOL for IVF and LGA. ? velamentous cord insertion
99914	NND	33+5	20/8/25	ePPROM from 19/40, EMCS for malpresentation and meconium liquor.
100077	stillbirth	31+6	31/08/25	Late booker, attended with no FMs. Birthweight 4th centile.
100073	stillbirth	24+5	31/08/25	Attended preterm birth antenatal clinic – no FH on scan
1001541	NND	39+6	05/09/25	EMCS at MBHT – NN transfer for level 3 care – NND
100375	stillbirth	31+5	21/09/25	Gestational diabetes, severe fetal growth restriction
100376	Late fetal loss	23+5	20/09/25	Known cystic hygroma under FMU
100463	stillbirth	38+1	26/09/25	Low-risk pregnancy, attended in labour – intrapartum stillbirth, suspected abruption

MBRRACE Real time data 1st January – 30th June 2025







PMRT Action Tracker (as of 29th October 2025 – previously completed actions excluded)

ISSUE	AGREED ACTION	PROGRESS	LEAD	DEADLINE	STATUS
FMU guideline to be updated to include uterine artery Dopplers to be done at FMU appointments as clinically appropriate	Guideline update	Completed	HC	31/7/2025	Completed
All women with learning difficulties must have appropriate service provisions put in place to ensure adequate support available including referral to Enhanced Midwifery Team (EMT)	EMT Guideline update	Lead changed to reflect change to EMT lead role, EMT sop taken to Octobers QSB but amendments needed- returning to November QSB	AB	31/12/2025	In Progress
Referral pathway from EPAU to maternity to be created	SOP for referrals	To be reassigned to EPAU lead colleague	TBD	31/12/2025	Lead Re-assignment
Previous pregnancy records must be accessed for all women especially those with a history of stillbirth to include review of previous investigations that may be relevant for future pregnancies	Pathway of care for women who have had a previous pregnancy loss to be reviewed	Process mapped, Risk registered, ongoing work requiring business plan	HC	31/12/2025	In Progress
Assurances required that postnatal bereavement care is being provided in line with NBCP	Audit	Audit of postnatal care to be performed 6 months post guideline introduction	NG	30/12/2025	In Progress
Previous bariatric surgery SOP/guideline required	SOP/ Guideline	Development of new bariatric guidance underway, due to competing pressures and other projects ongoing (e.g. IOL guidance review) this requires more time- deadline amended.	SJD	01/02/2026	In Progress

Themes emerging from PMRT

Issue	Action/Improvement plan	Impact measure	Review date
Kleihauer samples are not being taken from women on CBS who have had a fetal loss.	• Learning shared at CBS Bereavement meeting • Reminder to all CBS staff via Share to Care	• Ongoing review by PMRT process • 3 monthly audit of compliance with individual feedback	January 31st 2026
Interpreters/Translation services not being used for all women who do not speak English or it is not a competent 1st language Documents not readily available in all languages	Linked to QI project to improve availability and use of translation services; • Increased awareness of translation services • Translation resource pack • Education for staff • Audit of use of translation services • Feedback of any issues in accessing translating services to Trust lead • Exploration of other resources for translating documents/leaflets such as AI • Process for documents to be translated as needed when not available in required language	• Repeat audit of use of translation services • Patient feedback via Friends and Family • Feedback from Trust Lead	28/02/26
Maternity triage process at ELHT is not in line with national guidance as it does not follow a BSOTS methodology. This has been associated with delays in being seen in triage, lack of completion of telephone assessment sheet,	Linked to QI project for maternity triage at ELHT to align service provision with national guidance	Current implementation date is February 2026	

inappropriate action taken following telephone assessment, women not seen in the right place at the right time. The incidents linked with this include stillbirths.			
Service provision for women requiring Enhance Midwifery Care has not been adequate to meet the needs of this cohort and provide safe care. This has contributed to poor outcomes in women with learning difficulties and complex social situations where individualised enhanced midwifery care may have made a difference to the outcome.	QI project to review the EMT has been ongoing; • Review of the demand and capacity of the EMT • Review the SOP for the EMT • Review the criteria for referral to the EMT	Audit of EMT caseloads	31/01/26

ELHT Maternity & Neonatology

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Jaundice readmissions - Quality improvement

Louise Bardon | Alex Brooks Moizer | Ruth Dawson | Becky White | Steph Davy | Kathryn Sansby | Charlotte Aspden | Katie Rodwell

Safe | Personal | Effective

Background

- Identified a significant number of babies readmitted to NICU with jaundice levels (SBR) above exchange level.

Audit data

- The audit carried out showed out of the 244 babies, 162 had a TCB test (transcutaneous bilirubin) prior to discharge, 83 babies did not have a TCB.

- Compliance with undertaking TCB monitoring on eligible babies prior to discharge in October 2024 was 66%.

UNDERSTAND – The Aim of the Project

Aim Reduce the number of babies being readmitted to NICU due to jaundice by 10% by April 2026.

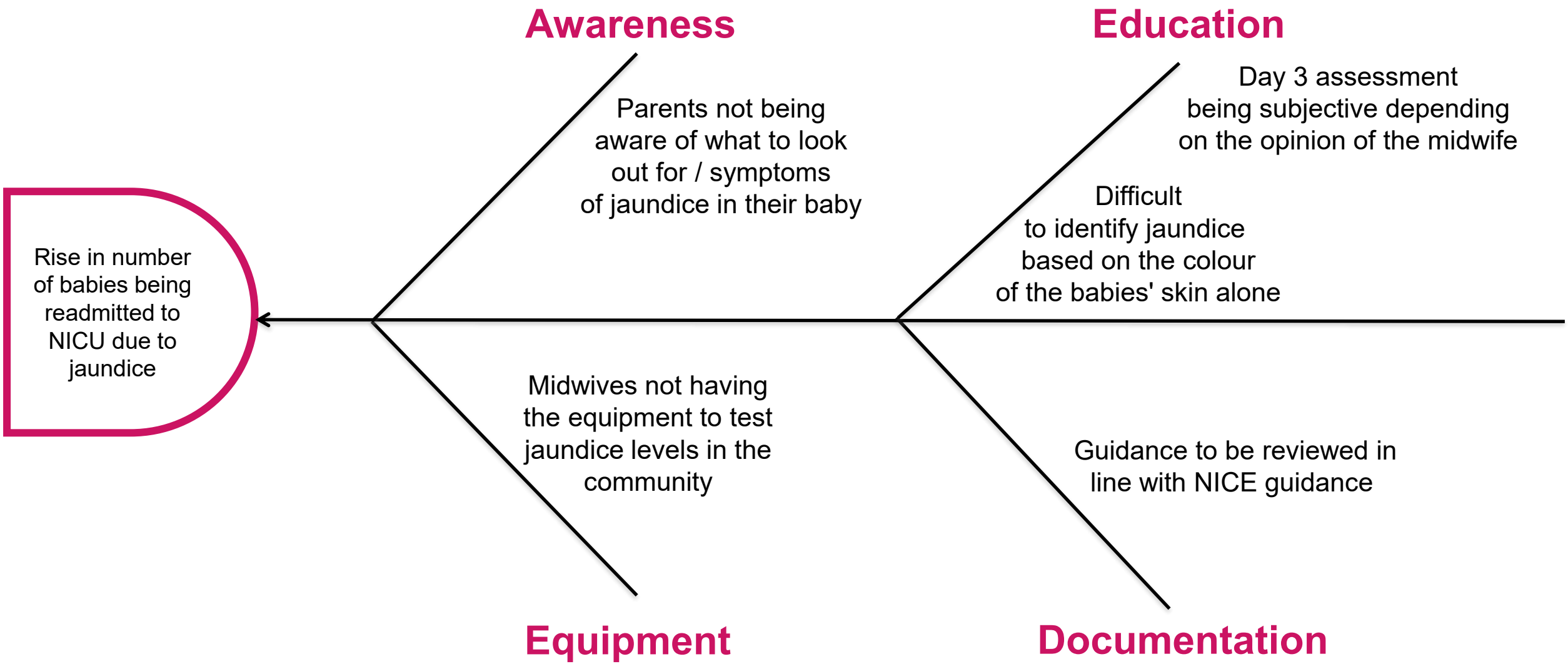
Change ideas

- Testing all babies SBR levels over 24 hours old before they are discharged from the postnatal ward.
- Educating staff and parents to prevent babies being readmitted.
- Community midwives being given the equipment (TCB monitors) to check jaundice levels at community visits after birth.

Scope

- **In Scope:** Test babies on postnatal ward prior to discharge as we already have the TCB monitors available on the ward.
- **Out of scope:** Currently do not have enough TCB monitors for community midwives to test jaundice levels in community however resource to be explored.

ROOT CAUSE



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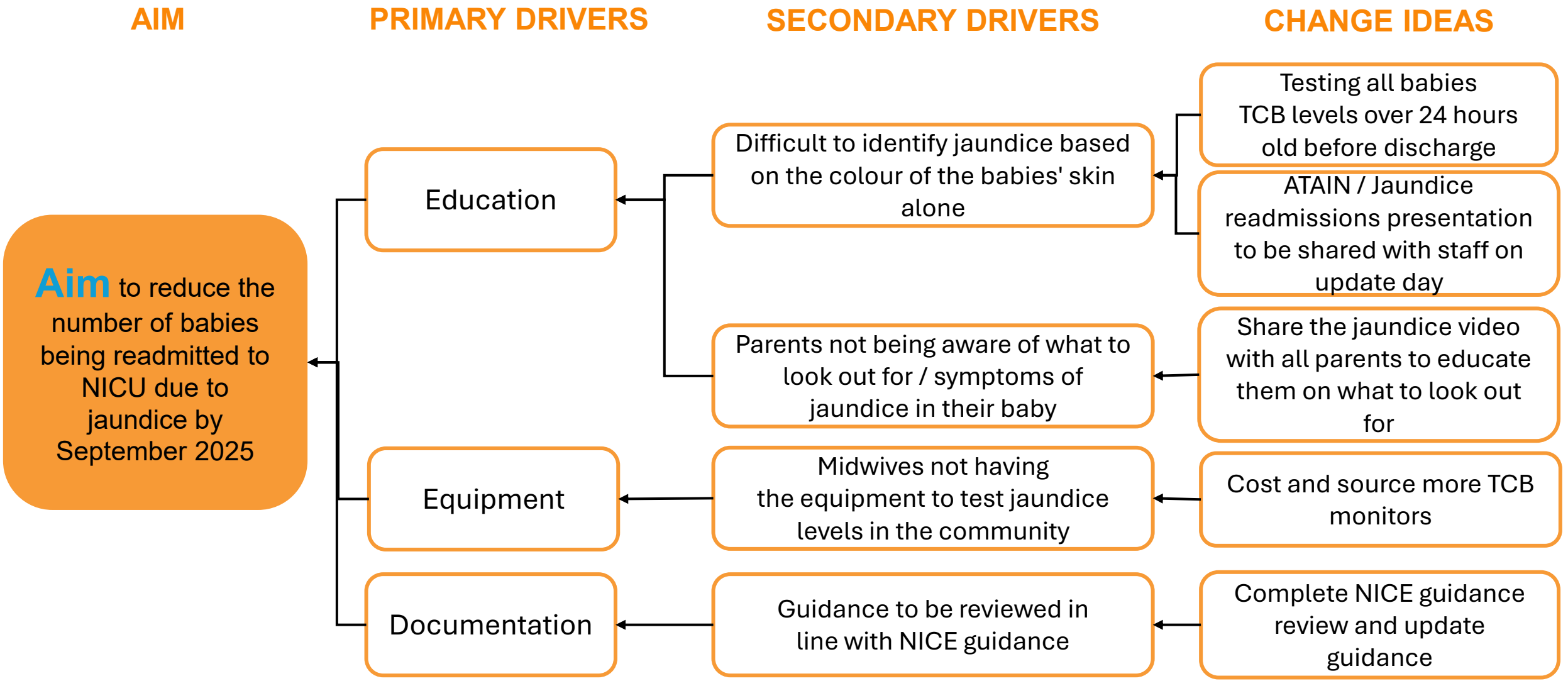
CO-DESIGN – Driver Diagram



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TEST AND ADAPT – PDSA cycle

Plan:

Implement a pilot to test all babies jaundice levels over 24 hours old on the unit before being discharged from the postnatal ward.

Do:

Create guidance for staff to follow including risk factors and criteria for testing babies before discharge

Study:

Review data and number of incidents after implementation

Act:

Update the jaundice guideline to include any changes made

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Data measures

East Lancashire Hospitals NHS Trust
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Incidents

2024 – 17 admissions from home with jaundice on day 5

2025 – 8 admissions (2 from the ward & 6 from home) – 1 was a day 2 so picked up appropriately.

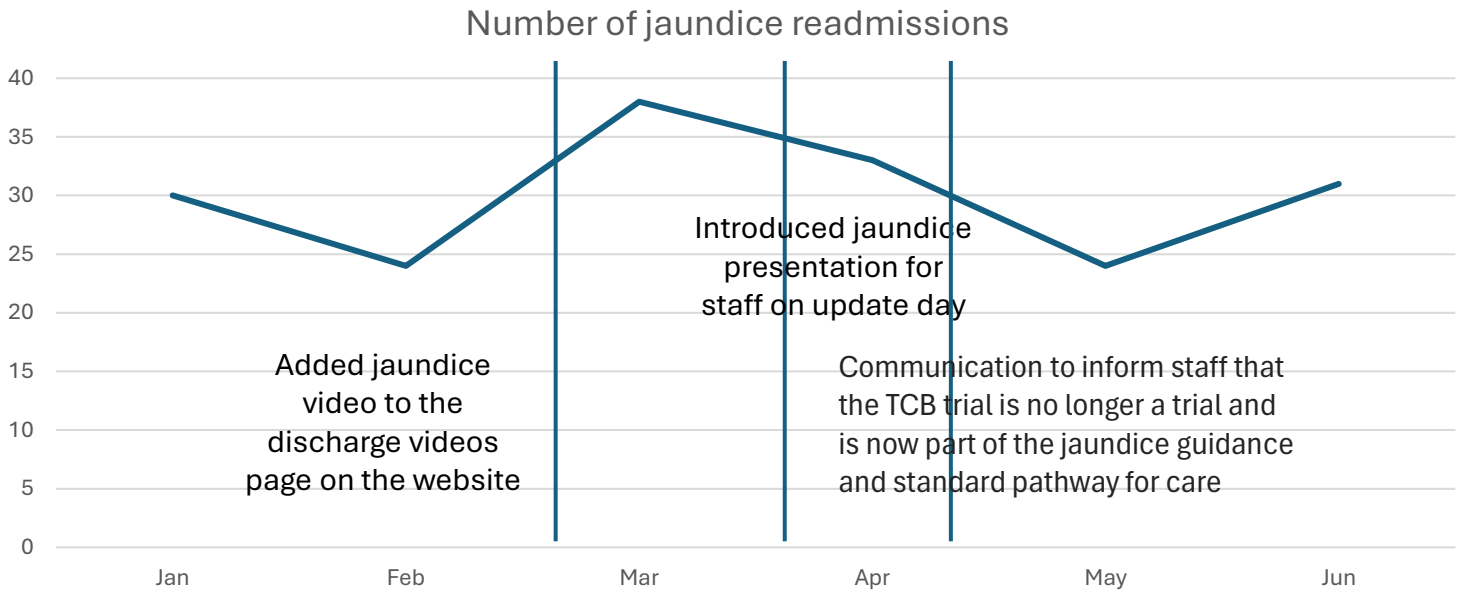
Review of Jaundice Readmissions

The data collected by the BFI team shows readmissions due to jaundice have slightly reduced from Q1 to Q2.

Q1 - Total live births at ELHT (Jan – Mar 2025) = 1459 | Total No. Jaundice readmissions (Jan-Mar 2025) = 92 | Readmissions as a % of births = 6.3%

Q2 - Total live births at ELHT (Apr - Jun 2025) = 1535 | Total No. Jaundice readmissions (Apr - Jun 2025) = 88 | Readmissions as a % of births = 5.7%

Introduced pilot to test all babies jaundice levels over 24 hours old on the unit before discharge



Next steps: The SBR re-audit looking at compliance with TCB and impact has commenced. We have seen a noticeable reduction in babies being admitted from home to NICU on day 5 with jaundice above exchange transfusion since introducing TCB monitoring. This will be presented at the next Jaundice QI meeting.

TEST AND ADAPT – Ongoing actions

Action	Lead	Status
Complete baseline assessment following NICE guidance and update the NICU guidance and assessment tool	PNW matron and consultant lead	Ongoing
Complete SBR audit for the month of August 2025	PNW matron and consultant lead	Ongoing
Look into making TCB a mandatory field on Badgernet discharge tasks. Add feeding assessment as a mandatory field. Add TCB line to Badger Net (currently on paper).	Digital midwife	Ongoing
Create a how to guide for staff to streamline recording feeding assessments on Badger and share with staff as lesson of the week.	Baby Friendly Specialist Midwife	Ongoing
Submit capital bid business case to fund TCB machines for community midwives. (Including the savings that will be made by testing jaundice levels on day 2/3 in community compared to babies being readmitted to NICU)	Business Manager	Awaiting outcome

EMBED	SPREAD	SUSTAIN
Communicate changes to the guideline to all staff effectively. Guideline shared at QSB and with staff at their ward meetings	Share QI with the LMNS and other units at the Quality assurance panel meeting	Continue to monitor incidents and audit through business as usual processes

MATERNITY INCENTIVE SCHEME (MIS) YEAR 7: Neonatology Nursing annual workforce staffing review.

Item **MIS: SAFETY ACTION 4**

Purpose Information
Monitoring

October 2025

Title	Neonatal Nursing Annual Workforce Staffing review/ Paper 2025
Author	Louise Bardon, Assistant Director of Midwifery and Neonatology Ruth Dawson, Matron for Neonatology& Transitional care
Executive sponsor	Tracy Thompson, Divisional Director of Midwifery and Nursing Peter Murphy, Chief Nurse / Executive Maternity/Neonatology safety champion

Summary: This annual Neonatology staffing report provides assurance of Neonatal Nurse Safe Staffing levels from the period of October 2025 – October 2026.

These assurances are also aligned with the national requirements of the Maternity Incentive Scheme for Trusts (MIS) Year 7.

For information – Safety action 4 (part D) is to ensure that the Neonatal Nursing workforce in each Neonatal Unit meets the service specification for BAPM Neonatal Nursing standards.

or

the standards are not met but there is an action plan with progress against any previously developed action plans and monitored via a risk register. Any action plans should be shared with the Local Maternity and Neonatal System (LMNS) and Neonatal Operational Delivery Network (ODN).

If the requirements had not been met in the previous year of the maternity incentive scheme (MIS), Trust Board should evidence progress against the action plan previously developed including the new relevant actions to address any deficiencies and share this with the LMNS and ODN Leads.

Maternity Incentive Scheme Year 7, SA4, Neonatal Nursing Workforce Paper.

The final Ockenden report reflects in Neonatal Care/Chapter 12 that the number of neonatal nurses in all trusts who are 'qualified in speciality' (QIS) must be increased to the BAPM recommended level, of 70 % also ensuring funding and access to the appropriate training courses are in place. Progress must be subject to annual review.

This report provides further information in respect of the following:
a) A systematic, evidence-based process to calculate Neonatal nurse staffing establishment using the Neonatal workforce assessment tool in collaboration with the Northwest operational delivery network (NWODN).
b) As a consequence of undertaking the workforce tool, evidence must be provided that any shortfalls in establishment form part of the action plan for safety action 4 of the MIS.
c) As of October 2022, the Neonatal Band 7 Coordinator overseeing the NICU unit at ELHT has supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all acuity/activity throughout each duty.
d) There is a monthly report covering neonatal nurse staffing exceptions and any red flag reports which is submitted to the Trust board.
e) ELHT can provide assurances of BAPM request to achieve 70% staff trained in QIS.
f) A Clinical specialist Nurse/Non- clinical support professional review has taken place in line with the National Neonatal Critical Care Review (NNCCR) part two. Funding has been secured for a Clinical Educator post.
Nationally it is recognised that a triangulated approach is taken when reviewing Nurse staffing.
This report will detail a professional judgment review, alongside the neonatal workforce calculations of neonatal nurse staffing in line with MIS and Ockenden workforce planning.
ELHT in collaboration with the NWODN complete a Neonatal workforce tool quarterly to review workforce position and planning. The recent quarterly review was completed in April 2025 and is representative of the first quarter of the calendar year.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Failure to deliver essential standards of quality and safety. Failure to deliver and deploy an effective information and intelligence strategy

Impact

Legal	No	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by:

1. Purpose

The aim of this report is to provide assurances to ELHT Quality Committee and Trust Board that there is an effective system of Neonatal Nurse workforce planning and monitoring of safe staffing levels for the period of October 2025 – October 2026. This is a requirement of the Maternity Incentive Scheme year 7 (MIS) Safety Action 4. Following the national neonatal critical care transformation review (NCRR) in 2021 part one funding was allocated to all trusts to support cot side care. This has enabled ELHT to increase nursing funded establishments. Part 2 of this funding has secured the Nonclinical Neonatal Specialist Educator role.

2. Background

The Neonatal Intensive Care Unit at East Lancashire Hospitals Trust (ELHT) provides level 3 neonatal care. The service includes a total of 34 available cots, of which 6 support Intensive Care, 8 support High Dependency care, and there are 20 Special Care cots.

The Neonatal nursing workforce also includes staffing to support an additional ten transitional care (TC) cots which are co-located on the postnatal and transitional care ward, seven days a week 8am – 8pm.

The level 3 service also includes a Neonatal Community Outreach team providing on-going care and support to babies and families following discharge from hospital. This community model utilises a multi-disciplinary approach to individualised care and care planning.

Level 3 status is allocated and reviewed by the Northwest Operational Delivery Network (NWODN). This status means that additional specialist modalities are available. These include High Frequency Oscillatory Ventilation, Nitric Oxide Therapy and Therapeutic Cooling. These specialised treatments enable babies from other local hospitals to be referred via the Lancashire and South Cumbria system, and cot bureau, to be transferred and treated at ELHT NICU, based in the Lancashire women and new-born centre, to support the demand for access to level 3 care for these babies and families.

Review of the nursing workforce tool should include:

- Activity data for a full year (365 days) should be used and can be for either a calendar or financial year. (This data is provided by the Neonatal ODN and can be viewed at the end of this report).
- Data for Transitional Care activity should be excluded as the calculations are for the neonatal unit only.
- The calculator can be used to model workforce requirements for service developments or changes. For example, use activity data which includes ‘lost’ activity to model cot-base requirements.

- Nurse staffing WTE funded establishment and WTE in post by qualification i.e., Nurse/Midwife with QIS, Nurse/Midwife without QIS, and Nursing Associates/Non-registered staff.
- The WTE numbers should be for nursing workforce providing direct patient care only. Any time allocated for additional roles, such as management, education, outreach etc. should be excluded.
- A supernumerary nurse in charge will be included in the calculations for all units.
- Transitional Care (TC) staffing numbers are not included. (TC staffing/ analysis will be completed as a briefing paper in 2026/2027 scheduling)
- In line with the recommendations in the Department for Health (DH) Toolkit for Neonatal Care (2009) the multiplier includes an uplift of 25% for annual leave, study leave, maternity/paternity leave and sick leave.
- The multiplier is based on a 26-hour day to include two hours per day for shift handover and supervision (such as appraisals).
- Nursing workforce requirements are calculated to meet BAPM Service and Quality Standards for Provision of Neonatal Care in the UK (2022).
  Recommended Nurse: Infant ratios are – Intensive Care 1 nurse: 1 baby, High Dependency Care 1 nurse: 2 babies, Special Care/Transitional Care 1 nurse: 4 babies.
- Where Trusts are non-compliant with a funded establishment based on the neonatal workforce tool or equivalent calculations, an action plan must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.

3. Supporting references

- Service and Quality Standards for Provision of Neonatal Care in the UK (2022)
  BAPM document
  Service and Quality Standards for Provision of Neonatal Care in the UK | British Association of Perinatal Medicine
- Department of Health (2009) Toolkit for High-Quality Neonatal Services. Available at: https://webarchive.nationalarchives.gov.uk/20130123200735/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107845
- National Institute for Health and Care Excellence (2010). Specialist Neonatal Care Quality Standard. https://www.nice.org.uk/guidance/qs4
- NHS Improvement (2018) Safe, Sustainable and Productive Staffing: An Improvement Resource for Neonatal Care
  https://improvement.nhs.uk/documents/2978/Safe_Staffing_Neonatal_FINAL_PROOF_27_June_2018.pdf
- NHS England Neonatal Service specification [e08] (2015).

https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/01/e08-

4. Operational assurance

ELHT Maternity/Neonatal services hold a collaborative safety huddle four times daily within a 24-hour period. Additional staffing huddles are arranged in addition to the safety huddles if neonatal nurse staffing is risk assessed with unpredicted shortfalls to enable protected time to allow for escalation and address any shortfalls with timely planning. Any potential red flags are reflected at the safety huddles to mitigate and resolve. (Local and regional policies, Safety huddles, staffing numbers, shortfalls, mitigation, and plans are evidenced and accessible on Maternity SharePoint.)

Such planning in times of escalation include a risk assessment of QIS/RN duties being placed out to bank and agency via escalation/ executive sign off. Cross divisional redeployment of paediatric nurse's, midwives and maternity support workers who have the appropriate skills and competencies to work in shortfall areas in special care to allow for QIS/RN nurses to cover care required in IC, HD, SC, and IPC isolation care requirements.

ELHT trust wide document/local policy Safe Nursing and Midwifery Staffing Escalation policy supports addressing daily staffing shortfalls. (ELHT/C135 version 3.2, 2024)

Local Neonatal unit Nurse staffing escalation SOP clearly reflects the local actions and risks assessments to be undertaken to ensure safety based on acuity activity and staffing levels.

ELHT complete a bespoke risk assessment for all babies requiring isolation with an IR1/ proforma uploaded to Datix to ensure safe staffing is reviewed as part of the risk assessment

In addition, following the national neonatal critical care review national funding is available for all trusts, ELHT received wave 1 funding in April 2021 and wave 2 in July 2023

5. Current position neonatal nurse staffing -

Currently funded posts are:

Band 7 – 8.82
Band 6 – 28.28
Band 5 – 46.97

Based on current funded establishment we are almost recruited to funded establishment. The service aims to backfill up to 5 WTE to cover maternity leave at a pressure. Currently there is 0.96 WTE RNs on Maternity leave and due to current pressures across the Trust this backfill is awaiting approval. 9. In conclusion –1.91 wte below budget to meet BAPM compliance.

Qualified in speciality (QIS)

The data within this report provided by the ODN shows 54.38 WTE RNs Qualified in Speciality (QIS) which equates to 70.6% nurse staff trained in QIS, which meets BAPM recommendations of 70%. However, there have been several staff who are QIS trained which have recently 'moved on' in their careers, and whilst the latest data provided for the report suggests that the number of QIS trained staff on NICU is compliant with the BAPM recommendations, the current figures for September are 66% reflecting a slight fall below the required BAPM standard of 70% . This will impact for a brief period whilst newly qualified nurses complete the required training, this has been recognised by the Neonatal team and shared with the LMNS and the ODN.
There are currently a cohort of newly qualified nurses undertaking the QIS course (4.52 WTEs) and a cohort of neonatal nurses undertaking the Foundation in Neonates Program (FIN) (4.52 WTE) due to qualify early in 2026. Other mitigations for the shortfall in QIS include mobilising the Specialist Educator roles, and Band 7 managerial roles into the clinical care numbers to support during periods of escalation.

Specialist roles include:

Baby Friendly Infant Feeding Specialist Nurse 0.64 WTE- Band 6
Clinical Educator 1.7 WTE- Band 7
Clinical Educator 0.85 WTE- Band 6
Digital Nurse 0.64 WTE - Band 6
Retinopathy nurse 0.32 WTE – Band 6
Close Relative Marriage Nurse – 0.80 WTE Band 6 in post (1.00 WTE Funded)

Transitional care cover currently covers 12 hours per day 7 days a week on the Post-natal Ward. There has been a request through professional judgement to increase this support to include cover 24 hours per day 7 days a week. The TC nurse baseline establishment is funded to cover 12 hours a day. Overnight where acuity and dependency permit a TC nurse will support the postnatal ward as an outreach model approach, given the care delivery for TC infants overnight, maternity support workers are trained and equipped to perform newborn

observations and escalate any deviations from the normal to the midwife caring for the mother and infant.

The NICU band 7 supernumerary coordinator maintains surveillance and oversight of any infants requiring escalation for admission to the neonatal unit should it be required.

Current transitional care (TC cover)

This is funded through the Band 5 establishment and nurses are rostered to cover TC daily. BAPM recommendation for TC cover is a ratio of 1:4, there are currently a maximum of 10 TC cots on the Post-natal Ward.

Allied Health Professionals

Funding has been secured for bespoke Allied Health Professionals (AHPs) to join the Neonatal Workforce from previous Ockenden monies:

Physiotherapist – 1 WTE
Speech and Language Therapist – 0.6 WTE
Specialist Pharmacist – 0.8 WTE
Psychologist – 0.4 WTE

6. Conclusion

In conclusion the neonatal workforce is currently fully established, staff trained that are QIS is 70.6% with staff currently on the course, specialist nurses are moving out of the cot side budget and TC cover is not provided 24 hours a day and this has been requested through Professional Judgement. BAPM nurse staffing compliance meets the HRG activity requirements for the period April 2024 – April 2025 data.

7. Recommendations

ELHT Trust board, with the Executive and Non-Executive maternity safety champion is asked to receive and acknowledge this Neonatal Nursing Workforce paper as a review of neonatal staffing to support the ask of MIS safety action 4, neonatal nursing workforce requirements. The action plan to support these findings is available at: -

Workforce Action Plan 25-26.xlsx

ELHT - Neonatal Nursing workforce calculator

Completed 29.07.2025 by Ruth Dawson (Matron).

Neonatal Nursing Workforce Tool (2020): Burnley

Unit details						
Trust	East Lancashire Hospitals NHS Trust					
Unit	Burnley					
Designation	NICU					
Completed by	Ruth Dawson					
Date completed	29.7.25					
Activity period	01/04/24	to	31/03/25		365	days

Activity (HRG 2016)			Staffing numbers (WTE) DIRECT PATIENT CARE ONLY		
	Activity	Commissioned cots		Budget	In post
HRG 1 (IC)	1,514	6	Total QIS	76.74	54.38
HRG 2 (HD)	2,230	8	Total Non QIS	0.00	22.60
HRG 3 - 5 (SC)	4,399	20	Total Non Reg	4.93	4.48
Total	**8,143**	**34**	**Total**	**81.67**	**81.46**

Activity calculations (HRG 2016)							
	Activity	*For calculations*		Commissioned cots	Occupancy for period	Cots required to meet activity at average 80% occupancy	Variance: declared cots against required
		80% of daily activity	*WTE (6.07 / BAPM)*				
HRG 1	1,514	*5.2*	*6.07*	6	69.13%	6	0
HRG 2	2,230	*7.6*	*3.04*	8	76.37%	7	1
HRG 3	4,399	*15.1*	*1.52*	20	60.26%	15	5
Total	**8,143**			**34**	**65.62%**	**28**	**6**

Nursing workforce calculations (WTE) DIRECT PATIENT CARE ONLY					
NB total nurse staffing required to staff declared cots = 97.12, of which 67.98 (70%) should be QIS					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	81.67	81.46	83.58	-1.91	-2.12
Total reg nurses	76.74	76.98	76.72	0.02	0.26
Total QIS	76.74	54.38	60.72	16.02	-6.34
Total non-QIS	0.00	22.60	16.00	-16.00	6.60
Total non-reg	4.93	4.48	6.86	-1.93	-2.38
Reg nurses as % nursing staff	94.0%	94.5%	91.8%		
QIS as % reg nurses	100.0%	70.6%	79.1%		

Our Vision is for neonatal care to be delivered by an integrated, multi-disciplinary team which makes the best use of the skills available and is focussed on care by parents and families

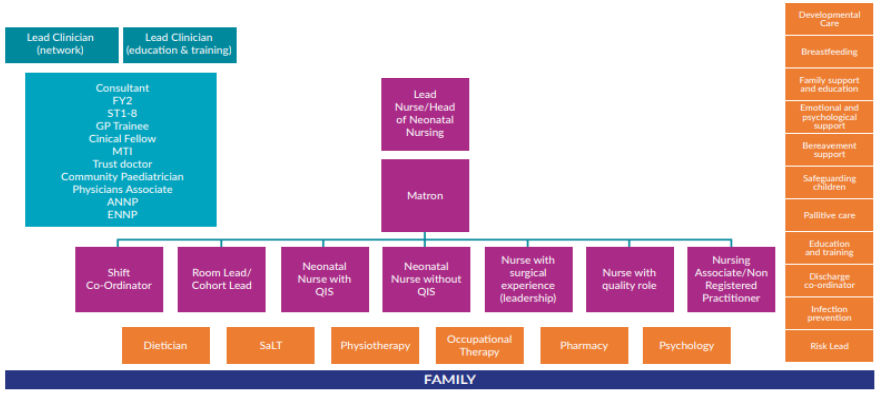
The NWNODN Workforce Strategy introduces the concept of the Ideal Team - it is not proposing a 'one size fits all' approach but recognizes that, while there are issues which affect everyone, each unit across the North West will have its own specific issues in providing care through multi-disciplinary teams. These issues will look different dependent on a number of factors including unit designation, estate, staffing and activity levels.
What the strategy offers to neonatal care providers is options to support you in building the most appropriately skilled multi-disciplinary team for your unit, going through the following stages:
Quantify • Build • Generate • Move forward

Where you are now
Quantify – you can use the "Ideal Team" tab to describe what you currently have across the MDT.
Include/describe any current mitigation for gaps – e.g. supernummary shift co. doing enhanced roles - you can use the "Comments column in the Ideal Team tab for this.

Describe your Vision, your Ideal Team - you can use the "Ideal Team" tab to describe what Ideal Team looks like across the MDT**.**
Where do you want to be in 5 years?
Think about this in terms of the constraints of today and how you could mitigate them by introducing different roles into the team, using the conversations had in the NWNODN workforce meeting and what you know about your service,

Build your Ideal Team: continued on the "Ideal Team" tab and once you have described your gaps you can use the "Filling the Gaps tab" identify high level plans/priorities for these gaps/roles. .
Building the right workforce mix for your neonatal unit (NNU) is not solely a matter of identifying the gap in WTE against national standards for nursing, medical, AHP and administrative functions.
Your action plan will require reflection and consideration of the mix of staffing roles which you believe are the most appropriate for your service.
This should include consideration of roles which may not currently exist within your (NNU) as well as those which you have not yet integrated from the ideal team.
Another aspect to consider when building your ideal team is not just the roles, but the potential for flexible use of those roles.
Your action plan will also need to consider how you will fill the gaps - some of those considerations are referenced here

The Workforce Strategy gives an overview of some of the different roles which may not be included in your team today
NWNODN-Workforce-Strategy-Sept-2021.pdf (neonatalnetwork.co.uk)
NWNODN-Workforce-Strategy-Toolkit-Sept-2021.pdf (neonatalnetwork.co.uk)
Below is a diagram from the NWNODN Strategy of how the Ideal Team can come together:



Moving Forward - Generate the change : You can use the "example action plan" tab which has more deatil to support this
You now know what your "Ideal Team" looks like.
Create an action plan around how you are going to get them into post. (see example action plan)
The Workforce Toolkit sets out a number of area you will need to consider in recruiting and developing your team
The Education Toolkit has information to support career and succession planning
https://www.neonatalnetwork.co.uk/nwnodn/wp-content/uploads/2022/01/Education-Toolkit-v1-January-2022.pdf

		WTE			Comments
		Now	**Ideal**	**Gap**	
Nursing workforce: **Quantify the nursing WTE needed for your unit, based on cot base and the National Neonatal Workforce Tool for direct patient care roles** **Use the ideal core team to quantify individual roles such as leadership, quality/link roles and AHP roles.**					
	Shift CoOrdinator	7.62	7.62	0	
	Room Lead	0	1	1	
	Neonatal Nurse with QIS	60.18	62.53	2.35	
	Neonatal Nurse non QIS	24.67	24.67	0	
	Neonatal Nurse with surgical experience	0	0	0	
	Nurse with quality role - developmental care	0	0.8	0.8	
	Nurse with quality role - infant feeding	0.64	1	0.36	
	Nurse with quality role - family support and education	0.32	0.8	0.48	
	Nurse with quality role -emotional and psychology support	0.64	0.8	0.4	
	Nurse with quality role - bereavement support	0.16	0.8	0.64	
	Nurse with quality role - safeguarding children	0	0.8	0.8	
	Nurse with quality role - palliative care	0.16	0.8	0.64	
	Nurse with quality role - education and training	1	2.2	1.2	
	Nurse with quality role - Discharge Co-Ordinator	0	0.8	0.8	
	Nurse with quality role - Infection Prevention	0.64	1	0.36	
	Nurse with quality role - Risk Lead	0.32	1	0.68	
	ENNP	0	1	1	
Medical workforce: **Quantify the medical workforce PAs/WTE needed for your unit, based on the BAPM standards:– Optimal Arrangements for Neonatal Intensive Care Units in the UK (2021) | British Association of Perinatal Medicine (bapm.org) Optimal arrangements for Local Neonatal Units and Special Care Units in the UK (2018) | British Association of Perinatal Medicine (bapm.org)** **Identify the gap between the current and required medical workforce after allocation of trainees**		**PAs now**	**Ideal PAs**	**PA GAP**	**Comments**
	Lead Clinician - (Protected PAs for being neonatal lead)				
	Lead Clinician for Education and Training (protected PAs for neonatal)				
		BAPM Compliant Y/N	**WTE needed to be compliant**		
	Tier 1	Y			
	Tier 2	Y			
	Tier 3	N	2		
	ANNP	Y			
	Physician's Associate	N			
	MTIs	N			
	Other - please describe	Y(Mmed inetrnational fellows)			
Allied Health Professional workforce: **Use the ideal core team to quantify the need relevant to your unit.** **Considerhow to use the NWNODN AHP Team when understanding your gaps - the NWNODN will; work collaboratively with neonatal based AHPs, unit leads and senior management teams to agree both Network-wide and unit based clinical priorities for enhancing and maximising care.**		**WTE Now**	**WTE Ideal**	**WTE Gap**	
	Dietitian	0.6	1	0.4	
	Speech & Language Therapist	0	1.8	1.8	
	Physiotherapy	0.4	1	0.6	
	Occupational Therapy	0	1	1	
	Psychology	0	1	1	
	Pharmacy	0.5	2.1	1.6	
Administrative support team: **Use the ideal core team to quantify the need relevant to your unit**					
	Housekeeping	3.65	5	1.35	
	Data Entry	0	1	1	
	Administration	2.63	2.63	0	
	Business management				
	Technical support	0	1	1	

	Having described your Ideal Team and identified your gaps use this page this page to identify high level plans/priorities for these gaps/roles.						
		WTE Gap	**Priority Low/Medium/High**	**Is budget/funding available?**	**Action Lead**	**Timescale for action within 6mths, 1 year, 2 years, 5years**	**Considerations**
Nursing workforce:							
	Shift CoOrdinator	0					
	Room Lead	1	low	N	Ruth Dawson	5 years	Not a priorty for our NICU as we have a supernumary shift coordinator.
	Neonatal Nurse with QIS	2.35	medium	N	Ruth Dawson	2 years	Numbers increased due to NCCR review, we will be able to increase or QIS numbers as new staff take on the course over the next couple of years.
	Neonatal Nurse non QIS	0					
	Neonatal Nurse with surgical experience	0					
	Nurse with quality role - developmental care	0.8	medium	N	Ruth Dawson	1 year	Plan to increase our phsio contraced hours from the Ockenden monies to support with developmental care
	Nurse with quality role - infant feeding	0.36	medium	N	Ruth Dawson	1 year	Having achieved stage 3 BFI standards we are keen to maintain this award and improve our breastfeeding rates in onjunction with a well established Infant Feeding team within the Trust.
	Nurse with quality role - family support and education	0.48	medium	N	Ruth Dawson	1 year	This role can fall under other roles, we currently use a B7 ith some management time to suport this role, with a small team of nurses and HCAs.
	Nurse with quality role -emotional and psychology support	0.4	medium	N	Ruth Dawson	1 year	Currently have a counsellour in post but some more hours would be beneficial.
	Nurse with quality role - bereavement support	0.64	medium	N	Ruth Dawson	1 year	This is mostly supported by a bereavement midwife however for our NICU babies and more specialised approach would be gold standard.
	Nurse with quality role - safeguarding children	0.8	medium	N	Ruth Dawson	1 year	Currently work closely with our safeguarding team within the Trust, we have a Band 7 sho leqads on Safeguarding and support from our Community outreach Team
	Nurse with quality role - palliative care	0.64	medium	N	Ruth Dawson	1 year	This is now being achieved through a B7 role with support from community team and interestd staff nurses. Peadiatrics have recruited a palliative care nurse in the Trust who will be working with NICU also.
	Nurse with quality role - education and training	1.2	high	N	Ruth Dawson	6 mths	High priority for level 3 unit and currently lots of recruitment but also for retenetion of QIS and B6 nurses to receive robust education in their role development.
	Nurse with quality role - Discharge Co-Ordinator	0.8	medium	N	Ruth Dawson	1 year	
	Nurse with quality role - Infection Prevention	0.36	high	N	Ruth Dawson	6 mths	high priority due ingoing infection control action plans on the back of previous infection control outbreaks.
	Nurse with quality role - Risk Lead	0.68	high	N	Ruth Dawson	6 mths	High priority for a leve 3 unit to have appropriate risk lead manager to work on incidents, ATAIN reviews, CNST related subjects, liaise with maternity risk lead for collaborative working.
	ENNP	1	low	N	Ruth Dawson	5 years	not a priority at the moment with our ANNP programme, although we are keen to send staff on the course for their development.
Medical workforce:							
	Tier 1	0					
	Tier 2	0					
	Tier 3	2	high	no	Savi Sivashankar	2 years	BAPM compliance is high priority but lack of funds has prevented from progressing
	ANNP	0					
	Lead Clinician - with Protected PAs for being neonatal lead						
	Lead Clinician for Education and Training (protected PAs for neonatal)						
Allied Health Professional workforce:							
	Dietitian	0.4	high	N	Ruth Dawson	1 year	Some funding for AHP support coming through from Ockenden monies which is an excellent start. This will support some of the quality roles above.
	Speech & Language Therapist	1.8	high	Y	Ruth Dawson	6 mths	
	Physiotherapy	0.6	high	N	Ruth Dawson	6 mths	
	Occupational Therapy	1	high	Y	Ruth Dawson	6 mths	
	Psychology	1	high	Y for 0.4	Ruth Dawson	6 mths	

	Pharmacy	1.6	high	N	Ruth Dawson	6 mths	
Administrative support team:							
	Housekeeping	1.35	high	N	Ruth Dawson	6 mths	More HKs needed to keep up witht the requirements from infection comtrol and NAPF team.
	Data Entry	1	high	N	Ruth Dawson	6 mths	This role is much needed for unit with full Badger EPR and is being funded for 06.wte from curretn nursing budget as it was not successful at business case level.
	Administration	0					
	Business management						
	Technical suport	1	high	N	Ruth Dawson	1 year	Dedicated support required for a level 3 unit with multiple equipment needs.

NWNODN Sample Workforce Action Plan 2025 - 26

	Aims/ Targets/ Objectives	How this will be achieved	What expected outcome will be	What evidence will support this	Lead/s	Timescales	Monitoring/ Update
1	Reach required 70% compliance for nurse staff trained in QIS	a) Cohort of newly qualified nurses undertaking the QIS course due to qualify early 2026	a) Compliance by Q1 2026	**a) Record of qualifications?** Logged on e-roster	a) Ruth Dawson - Matron for NICU	**Mar-26**	
1	Recruitment of registered nurses in line with BAPM recommendations with regards to safe staffing levels against patient ratios	a)Current on-going recruitment campaign to recruit to establishments b)Ensuring applications shortlisted in timely way and assessment panels and interview panels setup in advance and to keep to weekly timetable schedule	a) Staffing levels to reflect funded establishment until BAPM funding available. b) To complete a business case to fulfil and address deficiences in nurse staffing aligned with BAPM recommendations. c) Continue with bids via the neonatal critical care process as an enabler for income to be received to support BAPM recommendations.	a) Business case to complete. b) Neonatal Critical Care bids.	Ruth Dawson/ Matron for NICU with Divisional Director of midwifery/ Nursing and Assistant Director of midwifery at ELHT.	**Jan-26**	
2	Monthly PWR Data for neonatal nurse staffing.	a) Monthly validation	a) to identify any emerging gaps in BAPM and QIS compliance in real time	a) PWR dashboard b) Attendance at monthly meetings with ELHT workforce analyst c) Annual Staffing Paper	Tracy Thompson / Louise Bardon / Perinatal Support Officer	**Jan-26**	
3	Review of roles to manage skill mix and encourage innovative roles.	a) Introduction of New roles b) Review of AHP services and how these support the nursing workforce.	a) Implementation of new roles and associated competencies. b) Funding to be received via additional bid through neonatal critical care monies	a) Role diversity, recruit AHP's as agreed in the plan following neonatal critical care bid. b) Recruit to roles	Ruth Dawson/ Matron for NICU with Divisional Director of midwifery/ Nursing and Assistant Director of midwifery at ELHT.	**Jan-26**	
4	Training and development opportunities are taken up and positively evaluated by all staff	a)To promote ascending and aspiring Talent b) Review funding for continuing education. c) Ensure all staff are facilitated to maintain mandatory competencies and monitor compliance.	a) Yearly Training Needs anaysis completed and training delivered.	Compliance maintained across all areas of mandatory training	Neonatal education team leads	**Feb-26**	
5	Introduce the professional nursing advocate model	a) cross trust wide working with ELHT PNA lead b) Establish objectives for neonatology nurses	Set up a PNA staff resources area on Sharepoint to mirror Maternity PMA programme of works	Sharepoint Resource Area Minutes of meetings Neonataology PNA lead attendance in Trust-wide groups	a) Ruth Dawson - Matron for NICU & Louise Bardon with NICU Band 7 leads	**May-26**	

References

1	**Department of Health (2009)** Toolkit for High-Quality Neonatal Services. Available at:	https://webarchive.nationalarchives.gov.uk/20130123200735/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107845
2	**National Institute for Health and Care Excellence (2010).** Specialist Neonatal Care Quality Standard. Available at	http://publications.nice.org.uk/specialist-neonatal-care-quality-standard-qs4
3	**NHS Improvement (2018)** Safe, Sustainable and Productive Staffing. An Improvement Resource for Neonatal Care. Available at:	https://improvement.nhs.uk/documents/2978/Safe_Staffing_Neonatal_FINAL_PROOF_27_June_2018.pdf
4	**NHS England Neonatal Service specification [e08] (2015).** Available at:	https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/01/e08-serv-spec-neonatal-critical.pdf
5	**Implementing the Recommendations of the Neonatal Critical Care Transformation Review. (2019)** Available at:	https://www.england.nhs.uk/publication/implementing-the-recommendations-of-the-neonatal-critical-care-transformation-review/
6	**NWNODN Workforce Strategy**	NWNODN-Workforce-Strategy-Sept-2021.pdf (neonatalnetwork.co.uk)
7	**NWNODN Workforce Strategy Toolkit**	NWNODN-Workforce-Strategy-Toolkit-Sept-2021.pdf (neonatalnetwork.co.uk)

CNST Year 7 SA 10 update /Oct 25

Name	Incident	MNSI consent	MNSI DOC letter sent	Accessible format requested	NHSR leaflet given	Referred to MNSI	Case accepted	Reported to NHSR	Claims Reporting Wizard	Date ref. NHSR
MI038665	Intrapartum Stillbirth	Yes	Yes		n/a	n/a	n/a	n/a	n/a	n/a
MI038734	Cooled Baby	No	Yes		Yes	No *MNSI informed of cooled baby but no consent from family	n/a	n/a	n/a	No consent
MI 038811	Intrapartum stillbirth	Yes	Yes		n/a	Yes	N/A	n/a	n/a	n/a
MI 039077	Intrapartum stillbirth	Yes	Yes		n/a	Yes	Yes	n/a	n/a	n/a
MI 039154	Cooled Baby	Yes	Yes		Yes	Yes	No -Normal MRI results, no family/ trust concerns	n/a	n/a	n/a
MI039170	Cooled Baby	Yes	Yes		Yes	Yes	No -Normal MRI results, no family/ trust concerns	n/a	n/a	n/a
MI039194	Cooled Baby	Yes	Yes		Yes	Yes	No -Normal MRI results, no family/ trust concerns	n/a	n/a	n/a
MI039263	Cooled Baby	Yes	Yes		Yes	Yes	Yes	Yes	M24CT645/093.	17.02.25
MI040230	Cooled Baby	Yes	Yes		Yes	Yes	Yes	Yes	M25CT645/001	01.04.25 (delay as rejected on first referral and re referred)
MI039555	Cooled Baby	Yes	Yes		Yes	Yes	Yes	Yes	M24CT645/094	5.3.25
MI040242	Intrapartum stillbirth	Yes	Yes		n/a	Yes	Yes	n/a	n/a	n/a
MI 040824	Cooled Baby	Yes	Yes		Yes	Yes	Yes	Yes	M25CT645/005.	22.4.25
MI041660	Cooled Baby	Yes	Yes		Yes	Yes	Yes	Yes	M25CT645/011	19.5.25
MI041980	Cooled Baby	Yes	Yes	No	Yes	Yes	No – did not meet criteria	n/a	n/a	n/a
MI042700	Cooled Baby	Yes	Yes	No	Yes	Yes	No – Known fetal abnormalities	n/a	n/a	n/a
MI 044834	NND	Yes	Yes	No	Yes	Yes	Yes	n/a	n/a	n/a
MI 045009	Mat Death	No								
MI 045769	Cooled baby	Yes	Yes	No	Yes	Yes	Yes	Yes		05/09/25

Name	Incident	MNSI consent	MNSI DOC letter sent	Accessible format requested	NHSR leaflet given	Referred to MNSI	Case accepted	Reported to NHSR	Claims Reporting Wizard	Date ref. NHSR
MI 046229	Neonatal death	Yes	Yes	No	N/A	Yes	Yes	N/A	N/A	N/A
MI 047170	Intrapartum stillbirth	Yes	Yes	No	N/A	Yes	Awaiting consent	N/A	N/A	N/A

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD

Meeting Date:	12 November 2025	**Agenda Item:**	TB/2025/154
Report Title:	Strategic Response to NHS England and NW BAME Assembly Anti-Racism Requirements		
Author:	Emma Dawkins, Associate Director of Organisational Development		
Lead Director:	Dr Neil Pease, Interim Joint Chief People Officer		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓	✓		✓
Executive Summary:	This paper provides a strategic response to the NHS England and NW BAME Assembly letters (September and October 20259) requesting action on racism, Islamophobia, and antisemitism. It aligns national directives with ELHT's current initiatives, including the Aarushi Project and themes from the recent Safe Space Conversations. The report outlines progress, planned actions, and identifies gaps requiring further attention, ensuring ELHT's approach is proactive, evidence-informed, and embedded in governance.			
Key Issues/Areas of Concern:	The Trust has made good progress with its anti-racism efforts, and efforts need to be maintained by leaders to support the actions, treating anti-racism work as a complex / wicked problem. Safe space discussion provoked honest discussions, raising specifics concerns and important issues to be addressed in respect of current context as well as systemic racism. There is a need to build trust in processes and to develop psychological safety and work to strengthen HR processes with anti-racism lens. Staff Networks support this activity, and work continues to strengthen and realign executive sponsorship, support for plans, and to close feedback loop. Updated definition of antisemitism to be included in the updated EDI policy and anti-racism policy when drafted, and mandatory training to be adopted when launched. Continued roll out of anti-racism and allyship training needed to support updated mandatory training, for this to be effective. Embed anti-racism priorities and progress updates through divisional performance frameworks, with disaggregated data to increase ownership, needs data analytics support. Need to ensure risks are captured, scored and recorded with sufficient oversight. Governance will be through the People and Culture Committee.			
Action Required:	The People and Culture Committee is asked to note the requirements, the progress to date, risks and actions required to fully develop our anti-racist practice to ensure we tackle rising threats of racism, islamophobia and antisemitism. They are asked to approve, endorse the next steps and lend voice to the cause.			

Previously Considered by:	People and Culture Committee

East Lancashire Hospitals
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Date:	03/11/2025
Outcome:	Progress was noted however, the discussion was around the systemic nature of racism, Islamophobia and Antisemitism, and the need for the Committee to do some soul searching about the experiences and the action needed. It was noted that Martin Hodgson as Chief Executive has met with the Staff Network Chairs and members of the inclusion team to receive the feedback report. The group have been asked to make recommendations of between 3 and 5 priority actions that network members believe would have most impact, and for these to be put forward so that they could be driven throughout the organisation, with leaders being accountable. The Committee noted the lack of diversity on the meeting and that diversity was a real imperative to address the issues and meet needs of population. Discussion took place about the development of a single strategy and that the anti-racism strategic priorities would need to be a work plan rather than an additional strategy. A paper will come back to the Committee with the safe space and roundtable themes for review with clear actions, resources, governance and accountability. The data, stories and action plans to be shared with Senior Leadership Group to ensure divisional accountability.

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Introduction

1. This paper provides a strategic response to the NHS England and NW BAME Assembly letters (September and October 2025) requesting action on racism, Islamophobia, and antisemitism.

Background

2. In September 2025, NHS England North West's leadership has issued a call to action in response to the rise in nationalist sentiment and Islamophobic hostility across the UK, which is deeply affecting Black, Asian, Minority Ethnic (BAME) and Muslim staff. These external pressures are impacting staff wellbeing, safety, and sense of belonging within NHS organisations.
3. This was followed in October 2025 by the NHS England publication titled "Request for action on racism including antisemitism" outlining a formal call to action for NHS organisations to strengthen their stance against all forms of hatred, including antisemitism, Islamophobia, and racism.
4. The Trust has an ongoing and public commitment to becoming an actively, visibly and proactively anti-racist organisation. In support of this, the Aarushi Project was formed to participate in the Clinical Quality Academy programme, to develop the anti-racist strategy for the Trust, aligned to the NW BAME Assembly's Anti Racism Framework (ARF). The project has used improvement methodologies to support a programme of change.
5. The Board provided renewed commitment to this programme in September 2025.
6. The Aarushi project team, staff network chairs and members of the wider people and culture team, have undertaken recent listening exercises with minoritised groups to further inform the plans of action, and this feedback is currently being shared with Executives and Senior Leaders. Listening events are planned more regularly for professional groups and staff networks and a paper will be coming to the committee in December, outlining the governance around that.
7. This strategic approach, backed up by data and continually informed by lived experience ensures that the project follows evidence-based practice. It is imperative that the actions taken address the inequality or inequity that is experienced, and therefore, whilst responding to national and regional requests is important, we will continue to work with those groups experiencing the inequities to formulate the plans.
8. This paper therefore sets out the requirements in the letters, the evidence base, the lived experience of colleagues and the Trust's progress and gaps. It also sets out the risks to implementation and mitigations as resources and time continue to be tight.

Executive Summary

9. A review of the requirements contained in the letters as carried out to inform this report and future actions. (Appendix 1.)
10. Strengths of the current approach and actions include:
    a. Aarushi Project: intentional anti-racism strategy with QI methodology.
    b. Safe Space Conversations: rich qualitative data and staff voice. Sessions offered in response to wider events and have included for different staff groups including faith based and for BAME and internationally educated colleagues, supported by chaplaincy, EDI and senior leaders.
    c. Bronze accreditation under NW BAME Framework and silver action plan in place.
    d. Inclusive recruitment toolkit piloted with training developed ready for Trust roll out supported by updated Policy, will form part of the future Anti-Racism Policy.
    e. Ethnicity pay gap analysis completed; roundtable planned to further inform action planning.
11. Analysis of the gaps demonstrates the following to form future actions, including:
    a. Antisemitism not yet fully integrated into policies and frameworks.
    b. Anti-racism training rollout was paused due to financial pressures but resumed. Cultural competence training is being targeted to PNAs. Pace, scale and sustainability is an issue within current resources. Supervision and CPD for trainers needed.
    c. Disciplinary disparities (WRES Metric 3) require urgent review and anti-racism lens to HR policies and processes including the development of a senior review and triage and ability for case reviews and sharing of learning.
    d. Reporting confidence remains low; staff fear reprisals, actions outlined in the safe space paper in draft to be taken to execs for review, and to work with HR, Staff Guardian and Staff Networks to develop Trust.
12. Several risks were identified during the process of the review with potential impacts and mitigations. (Appendix 2.)
13. Actions primarily sit within the EDI Integrated Action Plan, and are taking forward by the Aarushi Project team, and wider leadership teams with people and culture teams.
14. Oversight is through Inclusion Group and People and Culture Committee.

Next Steps and recommendations

15. In response to the letters from NHS England this report demonstrates that the Trust is in a strong position to respond to this call to action in respect of racism, islamophobia and

antisemitism. Actions need to be informed by evidence, and respond to the feedback of our people, patients and communities about their lived experience. (Appendix 3.)

16. Actions to support further development of our aim to be anti-racist and address this in its many forms exist and will be strengthened through:
    a. Anti-Racism and trauma informed response from leaders in response to the safe space issues, validating the experiences and not minimising them.
    b. Sharing safe space themes, stories, EDI performance data, and the EDI improvement plan with SLG and DMBs to grow engagement and develop actions that decisively respond to Safe Space themes.
    c. Embed in cultural element of divisional performance reviews.
    d. Maintain the rollout of the Introduction to Anti-Racism and Allyship training with protected resources and supporting trainers with CPD and supervision.
    e. Embed antisemitism awareness into current review and update of EDI policy, Anti-Racism Policy and future strategy refresh.
    f. Review and strengthen HR processes with anti-racist and trauma-informed lens, to better manage cases, ensure case reviews enabling lessons learnt, effective triage processes and investigation protocols, with increased supervision and reflective practice for HR, staff side and investigators. (Appendix 3).
    g. Ensure risks are fully captured on risk register and scored accordingly.
    h. Monitor progress via People and Culture Committee and Trust Board, linking lived experience with data.
    i. Further review of any actions following the prime ministers request for review into antisemitism, in respect of workforce equalities or health inequalities.

Conclusion

17. The People and Culture Committee is asked to note the requirements, the progress to date, risks and actions required to fully develop our anti-racist practice to ensure we tackle rising threats of racism, islamophobia and antisemitism. They are asked to approve, endorse the next steps and lend voice to the cause.

Emma Dawkins, Associate Director of OD, 24 October 2025

THE APPENDIX

Appendix1: Summary and response including evidence-based appraisal of actions

Requirement	Summary of Action	Due Date	Evidence-Based Appraisal	ELHT Progress & Gaps
Adopt IHRA definition of antisemitism	Formally adopt and communicate definition	Q4 2025	Must be backed by cultural change	Action planned: will be included in the update to the EDI policy and Anti-Racism Policy.
Update EDI training incl. antisemitism & Islamophobia	Refresh mandatory modules	Q1 2026	Online training alone is ineffective	Trust requires annual EDI mandatory training using eLearning for Health so will adopt updated resources in year. Supporting Anti-Racism and Allyship Training needs protected rollout and resourcing: update Allyship Framework to specifically reference antisemitism.
Refresh EDI training early	Encourage early completion	Q2 2026	Reflective sessions more effective	Will be updated in year due to existing requirements: embedded into appraisal and as part of leadership development
Update uniform/workwear guidance	Inclusive policies for religious expression	Q2 2026	Co-design essential	New workwear policy in place, co-designed with networks to be more inclusive.
Support BAME staff networks	Resource and empower networks	Immediate & ongoing	Improves staff experience	Active network, new chairs; CEO sponsorship: paper with execs to review and strengthen sponsorship across all networks. Safe space listening paper going to execs and PCC. Faith networks in place where they are stainable, supported by chaplaincy. Interfaith network was considered but not taken forward. Signposting to regional groups where gaps exist and smaller listening groups offered.
Promote visible leadership	Senior leaders to model allyship	Immediate & ongoing	Accountability is key	Board commitment reaffirmed; EDI objectives in appraisals (needs auditing); leaders to give voice to AR and Allyship priorities across Trust and in own areas.
Embed anti-racism in education	Active bystander &	Q1 2026	Must be integrated with reform	Anti-Racism and Allyship training underway after pause; reciprocal mentoring planned;

Requirement	Summary of Action	Due Date	Evidence-Based Appraisal	ELHT Progress & Gaps
	inclusive leadership			supervision being developed for trainers;Embedded in leadership and management training; models such as Khan's framework for anti-oppressive practice being considered to address differential attainment.
Strengthen WRES implementation	Improve recruitment & reduce harassment	Q1 2026	Requires transparency	Some WRES metrics improving; disciplinary disparity remains; need to address career progression; ethnicity pay gap reporting. Development and reflective practice to be embedded in people and culture teams aligned to Too Hot to Handle. (Appendix 3)
Share anti-racist actions	Report initiatives & celebrate diversity	Q4 2025	Builds morale & consistency	Bronze accreditation achieved; silver plan in progress; work with University of Lancashire; GMC highlighted as best practice; NW Public Health Conference
Publicly reaffirm anti-racism	Communicate stance to staff & communities	Immediate	Must be backed by action	Charter launched; visible commitment made mural in RBH; Teams Brief commitments made; further communications to be developed with specific messaging on how to raise a concern and commitment visible at BGH site; sensitive comms and response to what is happening more broadly in society with marches, flags when brought into workplace.

Appendix 2: Risks, potential impacts and mitigations

Risk	Impact	Likelihood	Mitigation
Training delays due to financial constraints	Reduced staff awareness and cultural competence	High	Prioritise protected funding/ resource for anti-racism and allyship training
Underreporting of racism and Islamophobia	Inaccurate data, unresolved harm, reputational risk	High	Strengthen trauma-informed reporting systems and staff confidence
Lack of integration of antisemitism actions	Incomplete compliance with NHS England directive	Medium	Embed antisemitism into divisional reviews and training modules
Disciplinary disparities (WRES Metric 3)	Perceived injustice, reduced trust in HR processes	High	Review and reform disciplinary protocols with independent oversight
Inconsistent leadership response	Erosion of psychological safety and staff morale	High	Mandating of inclusive leadership development and accountability frameworks; use of performance reviews to highlight risks and importance of actions in this area. Greater diversity of leaders, need to develop positive action plans.
Cultural exclusion and ignorance	Staff disengagement, reduced retention	Medium	Roll out cultural intelligence and religious literacy training
Failure to act on Safe Space feedback	Loss of trust, reputational damage	High	Translate feedback into divisional action plans with SLG oversight
Lack of disaggregated data on EDI due to lack of EDI data analytics capacity	Lack of ownership at local level; seen as Trust problem; lack of accountability	High	Work with digital and data teams and local governance teams to develop disaggregated data
Current external campaigns and political pressure	Breach trust values and behaviours; damage psychological safety and patient safety	High	Clear standards, policies in place, decisive action, support for minoritised groups.

Appendix 3: Further reading

- NW BAME Assembly and NHS England Letter - call to action (September, 2025)
- Sir Jim Mackey Letter - "Request for action on racism including antisemitism (October, 2025)
- Starmer's plan to combat NHS racism will not work | Comment | Health Service Journal, Roger Kline, October 2025
- Too Hot to Handle?, Brap, March 2024
- Moving from not racist to anti-racist | The King's Fund Prof Joy Warmington MBE, Simon Newitt, March 2024
- 'Be the change: how to lead with accountability and anti-racism', Kings Fund, July 2025 Prof Joy Warmington MBE, CEO of Brap and Anne-Marie Archard, Senior Consultant.

East Lancashire Hospitals NHS Trust
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TRUST BOARD

Meeting Date:	12 November 2025	**Agenda Item:**	TB/2025/155
Report Title:	Staff Survey Weekly Update		
Author:	Rachael Rogers, OD Practitioner		
Lead Director:	Dr Neil Pease ,Chief People Officer		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	X	X		
Executive Summary:	Staff survey is still live until the 28 November 2025. The Trust is still tracking slightly above average response rate against the national average and this point last year. The team on the ground are continuing to target areas of lower response and attend Divisional Management Boards to share team level data.			
Key Issues/Areas of Concern:	Bank worker response rate remains low. There are some professional groups below average including medical and dental and estates and facilities. BAME response is lower than for white colleagues. Responses slowed down during half term. Campaign will ramp up to include a countdown.			
Action Required by the Committee:	Note the progress so far and the activities to increase the response rates.			

Previously Considered by:	People and Culture Committee
Date:	03 November 2025
Outcome:	Noted the response rates and supported the future actions, Requested that this remains on the agenda during the fieldwork period.

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Staff Survey 2025: Exec Weekly Update (Week 7)

3rd November 2025

Author: Rachael Rogers – OD Practitioner (People Experience)
Lead Director: Neil Pease – Interim Joint People Officer

Weekly executive summary

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Response rates – benchmark comparison (Week 7)

The current overall response rate for substantive staff is **36%.** This is marginally above the national response rate of **35.39%** and tracking the IQVIA average of 36%. Our response rate is **slightly higher than at the same point last year** (34.8%).
Bank Staff responses at **5.8%** remain lower than the national response rate of 10.87%.

Divisional weekly narrative

- Response rates have slowed across divisions with the exception of the weekly increase of One LSC (People – 7.2%, Digital and Procurement – 5.3%).
- DERI remains the highest Divisional total response rate at 69%
- FCD greatest increase in ELHT weekly response rate at 3.8%; of particular note Post Natal ward increased by 16.67%, the team are now nearly 7% above ELHT average (last week the team were 5% below ELHT average)
- MEC still an area of concern at only 26% total response rate with the largest staff groups (add. clinical servs, AHPs, nursing, medical & dental all significantly below Trust response rate)*
- One LSC E&F continue to have low total response rate of 21% and weekly response rate slowed to 1.5% this week, against 2.2% the previous week.

Staff group weekly narrative

- Medical and dental weekly response slowed to 1.1% against previous weeks response rate of 7.2%. Total response rate is still below Trust response rate at 22.8%.
- Consistent weekly increase for AHPs, nursing and admin and clerical, although ACS still lower than Trust response rate.
- Admin and Clerical are the highest total response staff group.
- BAME staff total response rate still well below Trust response and that of white staff, weekly response rate slowed from 3.4% the previous week to 2.26% this week.

Note: Both national and local slowing of response rates in line with half term break.

Response rates

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Staff group	ELHT 2025	ELHT 2024	National	IQVIA avg.
Substantive staff	36%	34.8%	35.39%	36%
Bank staff	5.8%	NA	10.87%	11%

Division	Eligible	Overall completed	Previous week response rate	Current response rate	Increase
CIC	1186	480	**37.90%**	**40.50%**	2.60%
Corporate	291	170	**55.30%**	**58.40%**	3.10%
DCS	1766	766	**40.80%**	**43.40%**	2.60%
DERI	142	98	**69.00%**	**69.00%**	0.00%
FCD	1258	475	**34.00%**	**37.80%**	3.80%
MEC	2207	574	**23.70%**	**26.00%**	2.30%
SAS	2057	699	**31.60%**	**34.00%**	2.40%
One LSC People	166	93	**48.80%**	**56.00%**	7.20%
One LSC Digital	1047	539	**47.50%**	**51.50%**	4.00%
One LSC E&F	1769	371	**19.50%**	**21.00%**	1.50%
One LSC Finance	243	122	**44.90%**	**50.20%**	5.30%
One LSC Procurement	117	44	**35.90%**	**37.60%**	1.70%

Staff group	Eligible	Overall completed	Previous week response rate	Current response rate	Increase
Bank	1591	92	**5.20%**	**5.80%**	0.60%
Add clinical Serv	1933	582	**28.10%**	**30.10%**	2.00%
Admin & clerical	3329	1726	**48.10%**	**51.80%**	3.70%
AHPs	809	331	**37.90%**	**40.90%**	3.00%
Estates & facilities	1648	302	**17.40%**	**18.30%**	0.90%
Medical & dental	856	195	**21.70%**	**22.80%**	1.10%
Nursing & midwifery	3293	1147	**31.50%**	**34.80%**	3.30%
White	9091	3715	**37.98%**	**40.86%**	2.88%
BAME	2877	646	**20.19%**	**22.45%**	2.26%

Week 7 response rates by team 03.11.25.xlsx

Week 7 response rates by Division & Staff Group 03.11.25.xlsx

Ongoing support activity

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- Continued promotion via: Teams Brief, Corporate meetings, Posters and flyers at training events, Trust Newsletter, ELHT People Facebook page.
- Weekly reminders on Trust brief.
- Monday weekly update report to full stakeholder group, including JLNC and JNCC.
- Monday 'Unmute' meeting with key stakeholders (low attendance – now stood down).
- Drop-in support sessions (primarily) for Estates & Facilities staff at RBH and BGH.
- Volunteer visit to Theatres BGH and LWNB Theatres to promote survey using additional flyers.
- Regular promotion by Temporary Staffing team to bank colleagues via email and Bank staff Facebook page.
- Reminders on Bank staff payslips to complete survey.
- Chocolates presented to a randomly selected high-performing team by member of Execs every Wednesday.
- Reminders sent out to targeted Professional Groups by Exec sponsor.
- Call for support from Clinical Directors and other senior medics to encourage medical and dental uptake.
- Fortnightly reminders and live data sent to Staff Network chairs & co-chairs.
- Weekly Comms "Shout Outs" to teams with highest engagement.
- Regular OneLSC data shared with Comms lead.
- Increased to weekly targeted comms and data sent to lowest responding teams (with 30 or more staff).
- Increased to weekly targeted comms and team level data sent to Divisional triumvirates and HR Ops senior team.
- Staff survey team attendance for focused spot at Divisional DMBs in October / November.
- "Intel" or concerns from staff groups or teams fed back to Divisional triumvirates for targeted support.

New support highlighted

? **Any other suggestions?**

Key messages and reminders

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- Focus and prompts to teams who are not currently meeting the 10 completions threshold, as these teams will be "invisible" when final results are published. Pushing the message to teams that **"10 is the magic number"**
- Now past halfway mark will focus on a countdown to the survey close date of 28th Nov and highlight **blocks** and **unblocks** to competing the survey.
- Local ownership and line manager support is a vital factor in driving up responses.
- Continued focus and working with senior colleagues to reach and engage:
  - medical and dental colleagues
  - BAME colleagues
  - E&F colleagues
  - MEC patient facing colleagues
- Myths around confidentiality and repercussions need to be quashed regularly and at all levels.
- Reinforcement that “all feedback is welcome” needed.
- Ongoing communications and actions needed to dispel beliefs that “nothing changes” when staff provide feedback.
- On-going and clear message that **all** staff can have protected time to complete the survey.
- More chocolate donations would be greatly received to increase rewards and promotion.

New messages and reminders highlighted

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TRUST BOARD

Meeting Date:	12 November 2025	**Agenda Item:**	TB/2025/156
Report Title:	East Lancashire Hospitals NHS Trust Annual Provider Self-Assessment (SA) 2025		
Author:	Julia Owen: Deputy Director Education, Research & Innovation and relevant subject leads as are documented		
Lead Director:	Neil Pease: Interim Chief People Officer		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
				✓
Executive Summary:	NHSE require all placement providers to submit an annual Self-Assessment (SA). The SA relates to the standards within the Quality Framework that organisations are expected to have in place to provide a quality learning environment for the learners they have responsibility for. The reporting period for this SA is April 2024-March 2025.			
Key Issues/Areas of Concern:	In summary it is clearly evidenced that ELHT provides a high-quality experience for all of our learners, but the ongoing capacity/demand and resource challenges have impacted on this. Any sections that need addressing have related action plans in place and we have evidence of many areas where our offer has been enhanced and developed.			
Action Required:	In order for the SA to be submitted to NHSE Board approval is required.			

Previously Considered by:	
Date:	
Outcome:	

EAST LANCASHIRE HOSPITALS NHS TRUST

ANNUAL SELF-ASSESSMENT (SA) 2024-2025

EXECUTIVE SUMMARY

NHS England (NHSE) require all placement providers to submit an annual Self-Assessment (SA). The SA relates to the standards within the Quality Framework that organisations are expected to have in place to provide a quality learning environment for the learners they have responsibility for aligned to NHSE's Education Quality Strategy, Education Quality Framework, and Education Funding Agreement.

It is based on the philosophy of continuous quality improvement, the identification of quality improvement potential, the development of action plans, implementation and subsequent evaluation.

Placement providers are asked to complete an online form indicating where they have or have not met the standards as set out in the SA. There is the opportunity under most of the questions for placement providers to provide comments to support their answers.

The SA covers the time period from April 2024-March 2025.

In summary it is clearly evidenced that ELHT provides a high-quality experience for all of our learners, but the ongoing capacity/demand and resource challenges have impacted on this. Any sections that need addressing have related action plans in place and we have evidence of many areas where our offer has been enhanced and developed.

The top three achievements/good practice areas and challenges identified for the reporting period are as follows:

Achievements and Good Practice:
- Collaboration/Partnerships
- Placement Capacity/Expansion
- CPD

Challenges:
- Placement Management/Capacity (all areas)
- Training Space and Facilities
- Curricula/Training Standards

BACKGROUND INFORMATION, REPORT AND KEY POINTS

In accordance with the Care Act 2014, NHSE is responsible for the leadership of all healthcare education and training for those employed by the NHS and for those seeking NHS employment. NHSE also has the statutory obligations for the quality of the services delivered that it funds, as well as for the safety and protection of students and patients.

The NHSE Education Quality Framework identifies the standards that organisations are expected to meet to provide high quality learning environments. The NHS Education Funding Agreement 2024-27 requests all providers to fulfil the obligations of its roles and responsibilities set out in the NHSE Education Quality Framework and to submit a return to

NHSE on their compliance with the contract. There is the requirement, via the NHS Education Funding Agreement that organisations will undertake this annually.

The Self-Assessment (SA) for placement providers is a process by which placement providers carry out their own quality evaluation against a set of standards. It is based on the philosophy of continuous quality improvement, identification of quality improvement potential, development of action plans, implementation, and subsequent evaluation. Providers are asked to complete their SA online indicating where they have or have not met the standards as set out in the SA. The SA is divided into 12 sections:

- Section 1: Challenges within education and training.
- Section 2: Achievements within education and training.
- Section 3: Compliance with the obligations and key performance indicators of the NHS Education Funding Agreement.
- Section 4: Compliance with Quality, Library, Reporting Concerns and Patient Safety training obligations, and KPIs of the NHS Education Funding Agreement.
- Section 5: Policies and processes in relation to Equality, Diversity and Inclusion.
- Sections 6-11: NHS England's Education Quality domains/standards and declare any areas, by exception, where standards are not met for each main professional group.
- Section 12: Sign off and submission.

Analysis and feedback to placement providers

The data will form the basis of an internal national NHSE report outlining national themes and national compliance across England against the NHS Education Funding Agreement key performance indicators and the Education Quality Framework standards. Highlights from national findings will be published on NHSE's website.

Information from the SA will be triangulated with other evidence gathered through existing quality processes. This combined picture is used to determine how well an organisation is fulfilling the requirements of the Education Funding Agreement. The SA is also an opportunity to identify and confirm best practice which could be shared within and across organisations.

Regional and local education quality teams will use the data contained within the SA and provide feedback to placement providers, if required, via local quality assurance processes. The threshold for follow-up review meetings will be determined by regional teams as part of their ongoing quality management processes.

How NHSE will share the Self-Assessment

The SA itself will not be a public document and as such will not be published on NHS England's website.

The information contained within the SA (either whole or in part) may be shared with:

- Higher Education Institutes
- Undergraduate Medical and Dental Schools
- Healthcare Regulators
- NHS England Internal Teams
- Other Arms-length Bodies
- Integrated care boards

The SA could also be shared under a Freedom of Information Request

NHS ENGLAND SELF-ASSESSMENT FOR PLACEMENT PROVIDERS 2025

TRAINING PROFESSION SELECTION

Q2. Please select from the list below those professional groups your organisation currently train, please select all those which apply:

	Yes, we train in this professional group	No, we do NOT train in this professional group
Advanced Practice	x	
Allied Health Professionals	x	
Dental	x	
Dental Undergraduate	x	
Healthcare Science	x	
Medical Associate Professions	x	
Medicine Postgraduate	x	
Medicine Undergraduate	x	
Midwifery	x	
Nursing	x	
Paramedicine	x	
Pharmacy	x	
Psychological Professions		x
Social Workers		x

SECTION 1 - PROVIDER CHALLENGES

Q3. This section asks you to provide details of up to three challenges related to education and training within training within your organisation. Please consider whether any of the challenges affect your ability to meet the education quality framework standards. For each challenge:

- Select the category that best describes the challenge.
- Provide a brief description of the challenge.
- If you cannot find a suitable category, please select "Other" and begin your narrative by stating the appropriate category.

Categories:
Apprenticeships / Burnout/Wellbeing / Culture / Curricula/Training Standards / Education Governance & Strategy / Equality, Diversity and Inclusion (EDI) / Funding - Requirements/Unpredictability/Timeliness / Increase in LTFT/Reasonable Adjustment Requests / IT Systems / NHS England Issues/Processes / Placement Management/Capacity / Supervisors/Educators (investment) / Supervisors/educators (recruitment/retention) / Supervisors/educators (training) / Training affected by service pressures (cannot release staff) / Training Equipment/Systems / Training Space/Facilities / Trust Merger or Reconfiguration / Workforce Challenges (recruitment/retention) / Other

1	Placement Management/Capacity (all areas)

	All multi-professional student, trainee and learner numbers across the organisation remain high due to the ongoing national and local drivers for increase, with the current service pressures this has the potential to adversely affect quality and experience of placement provision. We are working with our HEI's and system partners to explore how simulation, skills sessions, enhanced teaching activity and regional placement mapping can alleviate capacity pressures and how coordination in terms of placement structure can maximise clinical opportunities. OMFS continues to provide expanding capacity for dental and surgical training. We have expanded capacity for residents in both, however there is a shortage in national recruitment for some of the posts we have. We fill these locally with JCFs if necessary.
2	Training Space/Facilities Delivering a high-quality education offer within available resources and finances, both Trust wide and as part of the ICS/B, is an ongoing challenge. The financial position within LSC and the NHS nationally has exacerbated some issues including the education and training facilities across ELHT. This is on the Trust's corporate risk register, scored at 16 with mitigations and an action plan in place; there is a task and finish group meeting monthly chaired by Tony McDonald, Chief Integration Officer, whose role includes executive leadership for estates and facilities.
3	Curricula/Training Standards Multiple curriculums are being delivered from undergraduate and postgraduate perspectives; we are utilising structured approaches including quality assurance processes to mitigate the impact of this.

SECTION 2 - PROVIDER ACHIEVEMENTS AND GOOD PRACTICE

Q6. This section asks you to provide details of up to three achievements related to education and training within your organisation. Please consider how the achievements enable your ability to meet the education quality framework standards. For each achievement:

- Select the category that best describes the achievement.
- Provide a brief description of the achievement.
- If you cannot find a suitable category, please select "Other" and begin your narrative by stating the appropriate category.

Categories:
Collaboration/Partnerships / CPD / Culture / Development of TEL Provision / Equality, Diversity and Inclusion (EDI) / Increased SIM for Training / Innovative Training/Course Development / Learner/Trainee Support or Wellbeing / Multi-professional Initiatives / New/Improved Strategy or Governance / Placement Capacity/Expansion / Quality – Improvement Initiatives, response to data, positive feedback / Recruitment/Retention Initiatives / Supervisors/Educators (investment) / Supervisors/Educators (training) / Other

1	Collaboration/Partnerships

	ELHT continues to work in partnership with local education providers, HEI's and councils to ensure that education and training meet the requirements of the workforce, enabling them to deliver the best possible care for our population. This strong collaboration expands across partner organisations within the ICS, sharing thoughts, ideas and processes creating a wider equal offer for development of the workforce and a support pipeline for the community and those seeking careers within the NHS. Close working relationships exist between the Trust and NHSE-NW, medical specialty schools and national bodies such as the Royal Colleges and GIRFT. We are recognised for our long-standing collaboration with the Kings Trust to support individuals in the local community into entry level roles, through a strong placement to recruitment programme.
2	Placement Capacity/Expansion We have worked closely with HEI partners to restructure the medical degree curriculum to maximise placement capacity where possible, whilst focussing on improving student experience. Expansion of placement capacity has also been achieved through use of simulation and support from the wider MDT. We have expanded capacity for dental postgraduate placements and are also linking with primary care. The offer of placements for medical postgraduate placements and work experience students continues. Local and national survey data informs further areas for development in addition to areas of excellence.
3	CPD We have fully reviewed our Training Needs Analysis process which has led to a full co-ordination of CPD and streamlining of approvals for staff. Robust governance is in place to ensure that we are supporting development of all staff, teams and services within the available resources.

SECTION 3 - CONTRACTING AND THE NHS EDUCATION FUNDING AGREEMENT

Q9. Please confirm your compliance with the obligations and key performance indicators set out in Schedule 3 of the NHS Education Funding Agreement (EFA).	**Yes**	**No**
There is board level engagement for education and training at this organisation.	x	
The funding provided via the NHS Education Funding Agreement (EFA) to support and deliver education, and training is used explicitly for this purpose.	x	

We undertake activity in the NHS Education Funding Agreement which is being delivered through a third-party provider.	x	
We or our sub-contractor(s) did not have any breaches to report in relation to the requirement of the NHS Education Funding Agreement (EFA)	x	
We are compliant with all applicable requirements of the Data Protection Legislation and with the requirements of Schedule 5 of the NHE Education Funding Agreement	x	
We did not have any health and safety breaches that involve a learner to report in the last 12 months. (Please note that this question pertains exclusively to breaches that have been, or would be, investigated by the Health and Safety Executive.)	x	
We facilitate a cross-system and collaborative approach, engaging the ICS for system learning.	x	
We have collaborative relationships with our stakeholders (e.g. education providers) which provide robust mechanisms to deliver agreed services.	x	

If 'yes' please add comments to support your answer, if 'no' please provide further detail:

The Directorate of Education, Research & Innovation (DERI) is fully supported by the Trust Board and Executive team. We have a DERI Strategy and Education Plan in place which underpins the ELHT Strategic Framework and Clinical Strategy. We report bi-monthly through DERI governance processes and also report into the People and Culture Committee. The Directorate has developed systems and processes to ensure the correct attribution of education income across the Trust.

The palliative care aspect of the Cancer Care/End of Life module for medical students is provided by local hospices (Pendleside and East Lancashire Hospices), these are the only Learning Objectives which cannot be achieved within ELHT. The timetables for these students are co-ordinated by the undergraduate team at ELHT.

Postgraduate Foundation Psychiatry placements are provided by LCSFT.

We have attracted dental foundation programme residents who add to our workforce, and as funded from the regional foundation programme relieves the financial burden on the Trust.

We work in partnership across the system and have core membership in all education meetings, this includes for example LSC Strategic Education & Training Collaborative

We are working closely with ICS colleagues to ensure an equal offer to support widening participation.

We are also working collaboratively with local colleges to provide high quality placements for learners on both clinical and non-clinical programmes.

SECTION 4 - EDUCATION QUALITY

This section asks you to confirm your compliance with the quality, library, reporting concerns and patient safety training obligations and key performance indicators of the NHS Education Funding Agreement (EFA).

Q12. Can you confirm as a provider that you…	**Yes**	**No**
Are aware of the requirements and process for an education quality intervention, including who is required to attend.	x	
Are reporting and engaging with the requirements and process to escalate issues, in line with NHS England's education concerns process.	x	
Have developed and implemented a service improvement plan to ensure progression through the Quality and Improvement Outcomes Framework for NHS Funded Knowledge and Library Services.	x	
Actively promote, to all learners, use of the national clinical decision support tool funded by NHS England (https://access.bmjgroup.com/nhse/)?	x	
Have a Freedom to Speak Up Guardian who actively promotes the process for raising concerns through them to their learners.	x	
Have a Guardian of Safe Working (if postgraduate doctors in training are being trained) who actively promotes the process for raising concerns through them to their learners.	x	

If you selected 'yes' for any of the above, please add comments to support your answer; if you selected 'no' for any of the above, please provide further detail:

The library service improvement plan is aligned to the forthcoming 2026 QIOF return following a meeting with NHSE in June this year.

The national clinical decision support tool is promoted within the Trust, and we are currently reviewing how this could be enhanced.

Freedom to Speak Up Guardian promotional materials are displayed throughout the Trust and referred to in all Trust inductions. There is a dedicated page on the Trust Intranet for the Guardian Services. Mandatory training is available on the Trust's Education Hub which is available for all staff and learners.

The Guardian of Safe Working (GOSW) works closely with the Director of Medical Education and all stakeholders and participates in induction of various resident doctors. A

Resident Doctors' Forum is held bi-monthly for those in formal training posts and Locally Employed Doctors. Feedback is given to this group surrounding exception report patterns and outcomes. The GOSW also reports regularly to the Trust's Leadership Team.

Q13. In the last 12 months, has your organisation been referred to a regulator for concerns relating to education and training (GMC, GDC, HCPC, NMC, or other relevant regulatory bodies, with or without conditions imposed)?	
No - we have not been referred to a regulator	x
Yes - we have been referred to a regulator	
I am not aware whether the organisation has been referred to a regulator	

Q14. Please rate your organisation's status on actively implementing and embedding the Safe Learning Environment Charter (SLEC) multi-professionally. https://www.england.nhs.uk/long-read/safe-learning-environment-charter/	
Fully implemented	
Partially implemented	x
Not yet started to implement	

Q15. Have you reviewed, at Board Level, and where appropriate, taken action on the outcome of the results of 2024's National Education and Training Survey (NETS).	
Yes	x
No	

Please provide a brief description of the action you have taken as a result, if 'no' please provide further details including your plans to use the NETS data for quality improvement activity in the future:

NETS outcomes are discussed at Divisional Education meetings, the Pre-Registration Education Quality Group and at the Trust's Education Operational Delivery Board. NETS results are also triangulated against other sources of student feedback e.g. P@RE evaluations for non-medical learners, HEI placement feedback for medical students and at ELHT end of placement and end of course reviews.

NETS feedback is provided to the Medical Education Quality Assurance Group and the Medical Directors Group and then relevant outcomes escalated to Board Level.

Q16. 2025's NETS will be open between 7 October 2025 and 2 December 2025. How will your organisation increase their NETS response rate for 2025?

All students and employees will be contacted by both ELHT and HEI's regarding the completion of NETS (with links) and follow up emails. Students are also encouraged to complete the NETS at the end of on-site teaching sessions and following inductions. PEF, LBE and JCEF teams highlight the NETS QR code at the end of each student teaching session. Postgraduate - use of What's App groups, forums and Foundation Year reps to encourage engagement. Foundation Team will send reminder e-mails out to both cohorts for completion. This is carried out throughout the period where the survey is open.

Q17. Patient Safety and the promotion of a Patient Safety culture is integral to the Education Quality Framework. Please provide the following information:	
Name and email address of your Board representative for Patient Safety.	Dr Julian Hobbs, Executive Medical Director Julian.hobbs@elht.nhs.uk
Name and email address of your Non-Executive Director representative for Patient Safety.	Catherine Randall, Non-Executive Director, who Chairs Trust Patient Safety Incident Requiring Investigation Panel (PSIRI) Catherine.randall@elht.nhs.uk
Name and email address of your Patient Safety Specialist/s.	Jacquetta Hardacre, Assistant Director of Patient Safety Jacquetta.hardacre@elht.nhs.uk
What percentage of your staff have completed the patient safety training for level 1 within the organisation (%).	Level 1a 96% (All Staff) – at 17/09/25

SECTION 5 - EQUALITY, DIVERSITY AND INCLUSION

Q19. Does your organisation have an Equality, Diversity and Inclusion Lead (or equivalent):	
Yes	x
No	
If 'yes' please provide the name and email address of your EDI Lead for education and training, if 'no' please provide further detail: Nazir Makda, Inclusion & Belonging Lead, Nazir.makda@elht.nhs.uk	

Q20. Does your organisation:	**Yes**	**No**

Ensure reporting mechanisms and data collection take learners into account?	x	
Implement reasonable adjustments for learners with a disability?	x	
Ensure policies and procedures do not negatively impact learners who may have a protected characteristic(s)?	x	
Ensure International Graduates (including International Medical Graduates) receive a specific induction into your organisation?	x	
Ensure policies and processes are in place to manage with discriminatory behaviour from patients?	x	
Ensure a policy is in place to manage Sexual Harassment in the Workplace?	x	
Have initiatives to support reporting of sexual harassment?	x	
Confirm it has signed up to the NHS England Sexual Safety in Healthcare - Organisational Charter?	x	
Have a designated sexual safety lead, such as a Domestic Abuse and Sexual Violence (DASV) lead?	x	

If 'yes' please add comments to support your answer, if 'no' please provide further detail:

Reporting mechanisms and data collection take learners into account, with divisional EDI dashboards capturing WRES, WDES and EDS metrics and shared with education leads to identify patterns affecting trainees. Reasonable adjustments are provided for learners with disabilities through the Wellbeing and Adjustment Passport and support from Occupational Health, ensuring equity in placement experiences.

All policies and procedures are equality impact assessed to minimise risk of negatively affecting colleagues or learners with protected characteristics. International graduates, including IMGs are identified prior to starting with the Trust, they receive a structured induction covering clinical practice, cultural orientation, and pastoral support. A checklist is administered with adjustments to initial starting working pattern arrangements.

We have clear policies to manage discriminatory behaviour from patients, ensuring staff and learners are supported and incidents are acted upon. A Sexual Safety Policy is in place and supported by campaigns and initiatives to encourage reporting, including the Freedom to Speak Up Guardian and HR routes. ELHT has signed up to the NHS England Sexual Safety in Healthcare Charter, underlining our commitment to a safe learning and working environment.

In addition, we have a designated Domestic Abuse and Sexual Violence (DASV) Lead, who acts as the Trust's Sexual Safety Lead, providing oversight and ensuring alignment with national standards.

Collectively, these actions demonstrate a clear commitment to ensuring learners are supported, protected, and able to thrive in an inclusive and safe environment at ELHT.

Q21. How does your organisation manage sexual harassment reports?

ELHT manages sexual harassment reports through a clear, confidential, and supportive process. Staff and learners are encouraged to raise concerns via multiple routes, including their line manager, HR, the Freedom to Speak Up Guardian, or directly through the Trust's dedicated reporting mechanisms. All reports are treated seriously and sensitively, with assurance that individuals will be listened to and protected from victimisation.

The Trust has a Behavioural Standards and Sexual Safety Policy which sets out expectations of behaviour, reporting procedures, and the process for investigation and resolution. Sexual safety is also a specific category within the incident reporting system, ensuring concerns are tracked, monitored, and escalated appropriately. In addition, the Trust has a Safer Environment Policy for tackling abuse from patients and the public towards staff, and an Early Resolution Policy for staff-to-staff concerns, providing structured approaches depending on the source of the behaviour.

Cases are reviewed promptly, with oversight from HR and the employee relations review group where appropriate. Where required, disciplinary procedures are followed, and support is provided to the colleague through Occupational Health, counselling, or pastoral support via Chaplaincy and Staff Networks.

To build confidence in reporting, awareness campaigns and training emphasise zero tolerance for harassment, highlight reporting routes, and reinforce that colleagues will be supported. ELHT has also signed the NHS England Sexual Safety in Healthcare Charter and has a designated Domestic Abuse and Sexual Violence (DASV) Lead to ensure oversight, accountability, and continuous improvement in how reports are managed.

Our approach ensures that sexual harassment is addressed robustly, staff and learners feel safe to speak up, and a culture of respect and dignity is actively promoted across the organisation.

Q22. Postgraduate Deans and their teams are keen to consider responses and initiatives and share good practice. Please share details of EDI initiatives or successes that are specific to or have an impact on education and training in your organisation and the email address for someone we can contact to discuss this further.

At ELHT we have embedded Equality, Diversity and Inclusion (EDI) within our education and training programmes to ensure equitable access and improved experiences for learners and educators. Several initiatives and successes have had a measurable impact:

- **Bronze Award:** ELHT has committed to becoming anti-racist and completed a 12-month Clinical Quality Academy project on anti-racism, sponsored by the Chief Executive, and led clinically and operationally by the co-chairs of the Black, Asian and Minority Ethnic (BAME) Network and allies. In May 2024 the Trust was awarded the Bronze Award by the North-West BAME Assembly for progress against the Anti-Racism Framework.

- **Inclusive Recruitment and Development**: We have rolled out an Inclusive Recruitment Toolkit and bite-sized e-learning for all recruiting managers, ensuring fair and transparent recruitment into training and development opportunities. This supports widening participation in education and progression pathways.
- **Mentoring, Career Clinics and Coaching**: Targeted programmes are now in place for colleagues from under-represented groups, including BAME, IMG staff, to support access to career conversations, coaching, and mentoring. This has directly benefitted postgraduate trainees and staff in clinical education roles.
- **EDI Dashboards**: We have developed divisional EDI dashboards that provide insight into WRES and WDES metrics relevant to training and progression. These are used to monitor trends, highlight disparities, and inform targeted interventions.
- **Anti-Racism and Inclusive Leadership Training**: We are scaling up our anti-racism, Allyship and inclusive leadership training for clinical supervisors and managers to create psychologically safe learning environments for trainees.
- **Partnerships**: We are aligning with the Anti-Racism Framework and working with our system partners to ensure education governance structures are inclusive and accountable.

Collectively, these initiatives have strengthened awareness of disparities, improved access to development opportunities, and supported a more inclusive training culture across ELHT.

Contact for further discussion: Nazir Makda – EDI Lead,
Email: nazir.makda@elht.nhs.uk

Q23. Please select the most appropriate categories for the examples of EDI good practice or initiatives you shared above. Please select all that apply:	
Awards	x
Awareness raising	x
Data (Equality monitoring, increasing disclosure, improving data sets, data for decision making)	x
Development programmes (Career development, comprehensive programs, mentoring, coaching)	x
Employer engagement, outreach and partnership (Partnerships with HEIs and community groups, provider events for staff, community events)	
Funding	
Improving staff experience (Staff networks, affinity groups, listening sessions, facilities)	x
Learning resources or tools	
Organisational review or assessment of EDI	

Recruitment	x
Strategies, policies or processes	x
Training (Mandatory, non-mandatory, skills development)	x

Q24. For education and training, what are the main challenges for EDI in your organisation?

Although progress has been made, challenges remain in embedding EDI into education and training at ELHT. One of the most pressing challenges is addressing differential attainment, where attainment gaps between different ethnic groups persist, particularly for international medical graduates and BME staff in postgraduate training. Closing this gap requires sustained cultural change, stronger mentorship, and targeted interventions.

Increasing the confidence of all employees to speak out when discrimination or unwanted behaviours are encountered or witnessed is a big challenge. While policies and reporting mechanisms exist, many colleagues including learners still feel uncertain or fearful about raising concerns. This may stem from a lack of trust in how reports will be handled, worry about being labelled a “troublemaker,” or concerns about confidentiality and potential repercussions on career progression. Witnesses to discrimination can also feel unsure whether it is their place to intervene or report, leading to bystander silence. This lack of confidence undermines a culture of openness and can allow poor behaviours to persist unchallenged. We are addressing this challenge by developing our visible leadership commitment, consistent responses to concerns, psychological safety within teams, and ongoing training and communication to reinforce zero tolerance for discrimination.

BME staff and colleagues with disabilities are underrepresented in some senior education and supervisory roles, limiting diverse role models for learners and perpetuating barriers to progression. At the same time, some learners from underrepresented groups report experiencing microaggressions, bias, or exclusion within clinical placements. While efforts are being made to create psychologically safe learning environments, ensuring this consistently across all settings remains a challenge.

Another barrier lies in the availability and quality of data. While divisional EDI dashboards have improved reporting on WRES and WDES, gaps remain in the timeliness and granularity of data relating to education and training outcomes. Without robust data, it is more difficult to identify patterns of inequity and respond with evidence-based interventions.

Embedding anti-racism and EDI into everyday practice also requires constant attention. The Trust has made a strategic commitment through the Anti-Racism Framework and national standards, but competing operational pressures can dilute focus. Sustaining progress requires visible leadership commitment, adequate resourcing, and strong governance and we are continuing to develop in all these areas.

In summary, the main challenges for ELHT lie in ensuring that EDI principles are fully embedded in every aspect of education and training. Sustained collaboration with regional and national partners is essential to share good practice and maintain momentum.

SECTION 6 - ASSURANCE REPORTING: LEARNING ENVIRONMENT AND CULTURE

Q26. Quality Framework Domain 1 - Learning environment and culture	**We meet the standard** for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
The learning environment is one in which education and training is valued and championed.	x	
The learning environment is inclusive and supportive for learners of all backgrounds and from all professional groups.	x	
The organisational culture is one in which all staff, including learners, are treated fairly, with equity, consistency, dignity and respect.	x	
There is a culture of continuous learning, where giving and receiving constructive feedback is encouraged and routine.	x	
Learners are in an environment that delivers safe, effective, compassionate care and prioritises a positive experience for patients and service users.	x	
The environment is one that ensures the safety of all staff, including learners on placement.	x	
All staff, including learners, are able to speak up if they have any concerns, without fear of negative consequences.	x	
The environment is sensitive to both the diversity of learners and the population the organisation serves.	x	
There are opportunities for learners to take an active role in quality improvement initiatives, including participation in improving evidence led practice activities and research and innovation.	x	
There are opportunities to learn constructively from the experience and outcomes of patients and service users, whether positive or negative.	x	
The learning environment provides suitable educational facilities for both learners and supervisors, including space and IT facilities, and access to knowledge and library specialists.	x	

The learning environment in my organisation promotes human-centred and dynamic multi-professional learning opportunities.	x	
The learning environment encourages learners to be proactive and take a lead in accessing learning opportunities and take responsibility for their own learning.	x	
The learning environment provides opportunities for learners to apply for flexibility within their placements.	x	
It is Trust policy for Learners to apply for flexibility within their placements.	x	

Q27. For the exceptions selected in the previous question, please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box.
If required, you can add the details of the sub professions / specific specialties in the comments box.

All standards met.

Q28. For the exceptions listed above, please provide further details including a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from NHS England Workforce, Training and Education.

All standards met. No listed exceptions. However, as we are always striving for excellence any opportunities to enhance our offer would be explored and we would be keen to discuss this with NHSE.

Q29. We are keen to hear about initiatives and good practice related to the learning environment and culture of your organisation, that are specific to or have an impact on education and training. If you would like to share any examples, please provide:

- **A brief description of the initiative/good practice**
- **The professional group(s) this relates**
- **The email address for someone we can contact to discuss this example further**

There are a broad range and style of learning opportunities within the organisation. The proactive support from departments within DERI assists in colleagues being able to access training and education. Innovative approaches are used by multi-professional teams for example increased usage of simulation in MDT. Significant innovation has been seen with new courses and structures. The SONIC course (Dr Rajasri Seethamraju) and POCUS course (Dr Shanthi Siva) are now nationally recognised.

To help ensure that Year 5 medical students at ELHT are prepared for their role as a resident doctor our students shadow some of our foundation doctors. To support this

initiative, we offer an Introduction to Medical Education Train the Trainer course to our FY1s and FY2s. We have also worked with Dr Shanthi Siva, Consultant in Emergency Medicine, to deliver a further programme for Junior Clinical Fellows at ELHT.

SECTION 7 - ASSURANCE REPORTING: EDUCATIONAL GOVERNANCE AND COMMITMENT TO QUALITY

Q31. Quality Framework Domain 2 – Education governance and commitment to quality	**We meet the standard** for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
There is clear, visible and inclusive senior educational leadership, with responsibility for all relevant learner groups, which is joined up and promotes team-working and both a multi-professional and, where appropriate, inter-professional approach to education and training.	x	
There is active engagement and ownership of equality, diversity and inclusion in education and training at a senior level.	x	
The governance arrangements promote fairness in education and training and challenge discrimination.	x	
Education and training issues are fed into, considered and represented at the most senior level of decision making.	x	
The provider can demonstrate how educational resources (including financial) are allocated and used.	x	
Educational governance arrangements enable organisational self-assessment of performance against the quality standards, an active response when standards are not being met, as well as continuous quality improvement of education and training.	x	
There is proactive and collaborative working with other partner and stakeholder organisations to support effective delivery of healthcare education and training and spread good practice.	x	
Consideration is given to the potential impact on education and training of service changes (i.e. service re-design / service reconfiguration), taking into account the views of learners, supervisors and key stakeholders (including WT&E and Education Providers).	x	

Q32. For the exceptions selected in the previous question, please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

All standards met.

Q33. For the exceptions listed above, please provide further details including a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

All standards met. No listed exceptions. However, as we are always striving for excellence any opportunities to enhance our offer would be explored and we would be keen to discuss this with NHSE.

Q34. We are keen to hear about initiatives and good practice related to the educational governance and commitment to quality in your organisation, that are specific to or have an impact on education and training. If you would like to share any examples, please provide:

- **A brief description of the initiative/good practice**
- **The professional group(s) this relates**
- **The email address for someone we can contact to discuss this example further**

Regular forums are in place to obtain feedback from resident doctors. Additional meetings are undertaken within divisions and directorates to obtain additional feedback e.g. Share to Care meetings. Education leaders are required to provide information to the Medical Education Quality Assurance Group and provide feedback and action plans surrounding any concerns raised. Areas of good practice are also shared by this group. Regional teaching delivered locally such as Internal Medicine Northwest Simulation Programme receives local and regional feedback allowing benchmarking across the northwest.

ELHT has governance and quality visits from all HEI partners in relation to undergraduate medical students. In 2025, the GMC attended our visit from the University of Lancashire (contact Kiel.Shoja@elht.nhs.uk for further discussion).

DERI has a training request process for all staff. All requests are reviewed and where require funding follow an internal governance process ensuring appropriate use of funding and equal opportunities for all staff.

SECTION 8 - ASSURANCE REPORTING: DEVELOPING AND SUPPORTING LEARNERS

Q36. Quality Framework Domain 3 – Developing and supporting learners	**We meet the standard** for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
There is parity of access to learning opportunities for all learners, with providers making reasonable adjustments where required.	x	
The potential for differences in educational attainment is recognised and learners are supported to ensure that any differences do not relate to protected characteristics.	x	
Supervision arrangements enable learners in difficulty to be identified and supported at the earliest opportunity.	x	
Learners receive clinical supervision appropriate to their level of experience, competence and confidence, and according to their scope of practice.	x	
Learners receive the educational supervision and support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.	x	
Learners are supported to complete appropriate summative and/or formative assessments to evidence that they are meeting their curriculum, professional and regulatory standards, and learning outcomes.	x	
Learners are valued members of the healthcare teams within which they are placed and enabled to contribute to the work of those teams.	x	
Learners receive an appropriate, effective and timely induction and introduction into the clinical learning environment.	x	
Learners understand their role and the context of their placement in relation to care pathways, journeys and expected outcomes of patients and service users.	x	
Learners are supported, and developed, to undertake supervision responsibilities with more junior staff as appropriate.	x	
Learners are encouraged to access resources to support their physical and mental health and wellbeing as a critical foundation for effective learning.	x	

Q37. For the exceptions selected in the previous question, please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

All standards met.

Q38. For the exceptions listed above, please provide further details including a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

All standards met. No exceptions to report. However, as we are always striving for excellence any opportunities to enhance our offer would be explored and we would be keen to discuss this with NHSE.

Q39. We are keen to hear about initiatives and good practice related to how you develop and support learners within your organisation, that are specific to or have an impact on education and training. If you would like to share any examples, please provide:

- **A brief description of the initiative/good practice**
- **The professional group(s) this relates**
- **The email address for someone we can contact to discuss this example further**

A greater structure in the approach to IMGs starting in the organisation as their first NHS job is now in place with collaboration with NHSE-NW and other hospital Trusts in Lancashire. Enhanced educator training and departmental rota support forms part of a package of enhanced initial support to allow a smooth transition to independent working.

For medical postgraduate resident doctors structures are in place to identify and support those with additional training requirements or health and wellbeing needs. Department training leads and the education leadership team are proactive in the approach to maximising opportunities for support and development in these groups. There is a close working relationship with NHSE-NW Heads of Schools and professional and welfare structures, in additional to regional occupational health professionals.

ELHT works closely with HEIs/colleges to support our student learner needs. Regular meetings and visits from HEI's/colleges ensure good practice.

We have also set up a placement capacity working group across the region with our local NHS Trusts to map placement capacity within the ICS as a whole.

SECTION 9 - ASSURANCE REPORTING: DEVELOPING AND SUPPORTING SUPERVISORS

Q41. Quality Framework Domain 4 – Developing and supporting supervisors	**We meet the standard** for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
Formally recognised supervisors are appropriately supported, with protected time in job plans/job descriptions, to undertake their roles.	x	
Those undertaking formal supervision roles are appropriately trained as defined by the relevant regulator and/or professional body and in line with any other standards and expectations of partner organisations (e.g. Education Provider, WT&E).	x	
Clinical Supervisors understand the scope of practice and expected competence of those they are supervising.	x	
Educational Supervisors are familiar with, understand and are up-to-date with the curricula of the learners they are supporting. They also understand their role in the context of learners' programmes and career pathways, enhancing their ability to support learners' progression.	x	
Clinical supervisors and Educators are supported to understand the education, training and any other support needs of their learners.	x	
Supervisor and Educator performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for continued professional development and role progression and/or when they may be experiencing difficulties and challenges.	x	
Supervisors can easily access resources to support their physical and mental health and wellbeing.	x	

Q42. For the exceptions selected in the previous question, please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

All standards met.

Q43. For the exceptions listed above, please provide further details including a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

All standards met. No exceptions listed. However, as we are always striving for excellence any opportunities to enhance our offer would be explored and we would be keen to discuss this with NHSE.

Q44. Please confirm your organisation ensures educators/supervisors have formal development to undertake this role.

Educational and clinical supervisor workshops are undertaken within the Trust. Other programmes which are accredited by the AOME are recognised by the Trust. Educator Updates are aligned to GMC frameworks.

Q45. Which of the following statements best describes how distributed funds are allocated for defined educator and education activities in your organisation:	
All funding is tracked and reported (to the accountable officer) as being directly spent on educators and education activities.	
Over 75% of the funding is tracked and reported as being directly spent on educators and education activities.	x
Between 50-75% of the funding is tracked and reported as being directly spent on educators and education activities.	
Less than 50% of the funding is tracked and reported as being directly spent on educators and education activities.	
The funding for educators is not currently tracked and reported.	

Q46. What approaches are used to ensure educators across all professions consistently use protected time set aside for their educational duties?	
We have a formal scheduling system and leadership to support and prioritise protected educator time.	
Educators manage their own schedules without formal oversight.	x
Protected time is offered but often redirected to clinical or administrative duties.	
There is no consistent approach to supporting access to protected educator time across all professions.	

Q47. Do you hold a record of educators in your organisation?

Yes, for all professions	x
Yes, for some professions	
No	

Q48. Please provide the name and e-mail address(es) of Senior Educator(s) or Educator Leaders responsible or accountable for education and training for professions below as appropriate.

We would like to use the data to:

- **Share region-specific data with the Educator Workforce**
- **Programme regional leads, to enable them to build their networks of educator leaders**
- **Share profession-specific data with the national professional leads, to enable them to build their networks of educator leaders, anticipated by cascade to regional leads**
- **Enable the cascade of communication on the educator workforce programme via these key stakeholders**

	Name	Email Address(es)
Allied Health Professionals	Alison Turner	Alison.turner@elht.nhs.uk
Dental	Jeet Rao	Jeethendra.rao@elht.nhs.uk
Healthcare Science	Alison Turner	Alison.turner@elht.nhs.uk
Medical	Anna Sibley	Anna.sibley@elht.nhs.uk
Non-clinical roles	Julia Owen	Julia.owen@elht.nhs.uk
Nursing and Midwifery	Julia Owen Jed Walton-Pollard Jane Pemberton	Julia.owen@elht.nhs.uk Jarrod.Walton-Pollard@elht.nhs.uk Jane.pemberton@elht.nhs.uk
Pharmacy	Edward Mensforth	Edward.mensforth@elht.nhs.uk
Psychological Professions	Shameem Zia	Shameem.Zia@elht.nhs.uk

Q49. We are keen to hear about initiatives and good practice related to how you develop and support supervisors within your organisation, that are specific to or have an impact on education and training. If you would like to share any examples, please provide:

- **A brief description of the initiative/good practice**
- **The professional group(s) this relates**
- **The email address of someone we can contact to discuss this example further**

Education Updates are provided for medical educators and are structured to respond to national and any local concerns arising.

Staff who support and train students are encouraged to apply for 'honorary lecturer' status from corresponding HEI's.

Our PEF team deliver education updates and educator development programmes to all of our non-medical staff. These programmes have been developed in partnership with our local HEI's and meet the regulatory standards of both the NMC and HCPC.

We have introduced an Introduction to Medical Education Programme, which is aimed at improving the understanding of medical education for our resident doctors.

Members of our LBE, JCEF and PEF team will again complete a Postgraduate Diploma in Clinical Education.

SECTION 10 - ASSURANCE REPORTING: DEVELOPING PROGRAMMES AND CURRICULA

Q51. Quality Framework Domain 5 – Developing programmes and curricula	**We meet the standard** for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
Practice placements must enable the delivery of relevant parts of curricula and contribute as expected to training programmes.	x	
Placement providers work in partnership with programme leads in planning and delivery of curricula and assessments.	x	
Placement providers collaborate with professional bodies, curriculum/programme leads and key stakeholders to help to shape curricula, assessments and programmes to ensure their content is responsive to changes in treatments, technologies and care delivery models, as well as a focus on health promotion and disease prevention.	x	
Placement providers proactively seek to develop new and innovative methods of education delivery, including multi-professional approaches.	x	
The involvement of patients and service users, and also learners, in the development of education delivery is encouraged.	x	

Timetables, rotas and workload enable learners to attend planned/timetabled education sessions needed to meet curriculum requirements.	x	

Q52. For the exceptions selected in the previous question, please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

All standards met.

Q53. For the exceptions listed above, please provide further details including a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

All standards met. No exceptions listed. However, as we are always striving for excellence any opportunities to enhance our offer would be explored and we would be keen to discuss this with NHSE.

Q54. We are keen to hear about initiatives and good practice related to the delivery of programmes and curricula in your organisation, that are specific to or have an impact on education and training. If you would like to share any examples, please provide:

- **A brief description of the initiative/good practice**
- **The professional group(s) this relates**
- **The email address for someone we can contact to discuss this example further**

The organisation is proactive in collecting feedback and responding to all of our trainees and learners.

We have developed and enhanced simulation-based education for our multi-professional learners, including the use of an immersive suite for training.

Members of ELHT staff and the education team continuously support the review and development of curricula at all of our partner HEI's. In addition, ELHT is currently working with one of our local colleges to develop a new Nursing Associate direct entry programme.

There is a regular peer review of training facilitators.

SECTION 11 - ASSURANCE REPORTING: DEVELOPING A SUSTAINABLE WORKFORCE

Q56. Quality Framework Domain 6 – Developing a sustainable workforce	**We meet the standard** for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.	x	
Learners in my organisation are well supported to learn using modern methods and technologies	x	
Does the provider provide opportunities for learners to receive appropriate careers advice from colleagues.	x	
The provider engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.	x	
Transition from a healthcare education programme to employment and/or, where appropriate, career progression, is underpinned by a clear process of support developed and delivered in partnership with the learner.	x	

Q57. For the exceptions selected in the previous question, please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

All standards met.

Q58. For the exceptions listed above, please provide further details including a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

All standards met. No exceptions listed. However, as we are always striving for excellence any opportunities to enhance our offer would be explored and we would be keen to discuss this with NHSE

Q59. How would you rate your organisation's awareness of evidence-based principles for modernising healthcare education?

- **Modern evidence-based education ensures that healthcare learning is effective, inclusive, and aligned with real-world impact.**

- **Modern healthcare demands collaborative, person-centred care that is supported by equally collaborative and inclusive education environments.**

These questions ask you to reflect on how well your organisation enables learners to engage with contemporary educational approaches, such as hybrid, digital, immersive and AI-assisted tools. It considers whether learners feel equipped and supported to navigate these methods in ways that enhance their practice and professional growth.

Highly aware and actively applying them	
Aware but not consistently applying them	x
Somewhat aware	
Minimally aware	
Not aware at all	

Please add comments to support your answer:

An organisations engagement with contemporary education approaches depends on its ability to adopt new pedagogies, integrate technology, support employee professional development and foster an inclusive student-centred environment. At ELHT we are using technology such as AI, simulation and virtual reality to develop critical thinking and clinical skills. We use a blended approach to learning and teaching delivery. Learners are equipped to navigate a range of methods, but we do have some challenges due to the IT infrastructure and skills of the workforce.

Q60. To what extent do you agree or disagreed with this statement:
My organisation actively addresses barriers to modernising healthcare education (e.g, technological, cultural, structural).

Strongly agree	
Agree	x
Neutral	
Disagree	
Strongly Disagree	

Please add comments to support your answer:

ELHT does actively address barriers through effective partnerships and collaboration, however the challenges of the financial position within LSC and the NHS does impact on this.

We are working on our education facilities as has been previously documented

We are currently exploring with our IT team how we can expand the use of Simulation and VR in the delivery of clinical learning within finite resources and the challenging capacity demands.

Q61. We are keen to hear about initiatives and good practice related to developing a sustainable workforce within your organisation, that are specific to or have an impact on education and training. If you would like to share any examples, please provide:

- **A brief description of the initiative/good practice**
- **The professional group(s) this relates**
- **The email address for someone we can contact to discuss this example further**

We have a career development pathway in place for nursing. The starting point of this is our work with:

- Local HEI's: supporting placements of cadets and T-Level students leading to employment as HCA's or Nursing Associates (NA) within the organisation.
- Kings Trust and Job Centre Plus to enable work placements with guarantee of an interview for a bank or substantive post. We have focussed on HCA vacancies and are placing the applicants in areas with vacancies with a plan to offer the post on completion of their programme.

Once in an HCA post we provide support and offer of training as an NA, once they have been qualified as an NA for a year, we then offer the 2-year Nursing Degree Apprenticeship with employment as a registered nurse on qualification.

Julia.owen@elht.nhs.uk

SECTION 12 – FINAL SUBMISSION

Q63. Board level sign-off (Premises, Learning Environment, Facilities and Equipment)	
I confirm that our premises, learning environments, facilities and equipment are: suitable for the performance of the Services; accessible, safe and secure; comply with any applicable Health and Safety Legislation, any other Applicable Law, Guidance, appropriate risk management clinical guidance, good healthcare practice and the requirements of any relevant Regulator; and are sufficient to enable the Services to be provided at all times and, in all respects, in accordance with the NHS Education Funding Agreement.	

Q64. Board level sign-off	
I confirm that the responses in the SA have been signed off at Board level	
Name, email address and role of Board representative for education and training: Dr Neil Pease: Interim Chief People Officer neil.pease@elht.nhs.uk	

Julia Owen
Deputy Director Education, Research & innovation
22nd October 2025

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Meeting Date:	12 November 2025	**Agenda Item:**	TB/2025/157 to TB/2025/161
Report Title:	Triple A Reports from Board Sub-Committees: • 157: Quality Committee (September 2025) • 158a: Finance and Performance Committee (September 2025) • 158b: Finance and Performance Committee (October 2025) • 159a: People and Culture Committee (October 2025) • 159b: People and Culture Committee (November 2025) • 160: Audit and Risk Committee (October 2025) • 161: Trust Charitable Funds Committee (October 2025)		
Author:	Non-Executive Director Committee Chairs		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓	✓		
Executive Summary:	The reports deliver a summary of the items discussed at the Board sub-Committees held since the Board meeting on 10 September 2025. The triple A format of these reports set out items for Alert, Action or Assurance from the Committees to the Board.			
Key Issues/Areas of Concern:	This report raises concerns around the availability of some committee papers and therefore the effective functioning of the committees.			
Action Required:	The Board is asked to note the reports.			

Previously Considered by:	
Date:	
Outcome:	

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Committee Name:	Quality Committee
Date of Meeting:	24 September 2025
Committee Chair:	Simon Featherstone
Attendance:	Quorate
Key Items Discussed:	Nurse Staffing Exception Report
	Staffing Inequalities
	MIAA Clinical Coding Internal Audit Report
	Quality Assurance Assessment Framework Operational Policy

ALERT

- Trust Board should be aware that a number of the papers for the September Quality Committee were submitted late or not received. Notable was non-submission of the Integrated Performance Report and late submission of the Corporate Risk Register Dashboard and the Patient Participation Panel Report.
    - It was recognised by the Chair of the Quality Committee that pressures in the Trust are high, however for the committee to function correctly and provide assurance to Trust Board, papers need to be submitted in a timely manner and with a focus on assurance.
    - The Interim Director of Corporate Governance has taken a paper to the Executive Director team which sets out the action being taken to improve the timely distribution of papers, clarify responsibilities, and reinforce accountability for the timely submission of papers.

ASSURE

- The Committee received assurance that arrangements are in place to safely staff the inpatient wards with the correct number of staff with the right skills and at the right time, as set out in line with the National Quality Board (NQB) Standards and Expectations for safe staffing. (BAF 2).
- The Committee received a paper which provided an update on the MIAA audit of clinical coding. The Committee were advised that the audit report provided substantial assurance in relation to clinical coding.
    - The MIAA report identified 6 areas for further improvement.
    - All improvement recommendations have deadlines for action, and a follow-up report will be presented at October Quality Committee to provide assurance that all actions have been completed. (BAF 3).

ADVISE

- Following a request at August Quality Committee, the Committee received a paper as part of the Safer Staffing update which provided information on the ethnic breakdown of nurse staffing on the inpatient wards. The report highlighted significant disparities in terms of ethnicity at Divisional and ward level and in the distribution of staff working weekend and night shifts. The Committee accepted the report but recognised that the paper, whilst highlighting a skewed distribution of staffing ethnicity, did not provide a deep enough understanding of the reasons for the current distribution of staff. The Committee agreed that a more in-depth review of the current position was needed, and the Chief Nurse has agreed to undertake this. (BAF 3).

- The Committee approved the Operational Policy for the Quality Assurance Assessment Framework (QAAF) and advised that a discussion at Part 2 of Trust Board should take place to ensure the Board are fully sighted on the potential impacts of the QAAF process. (BAF 2).

Committee Escalation Report

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Name of Committee:	Finance and Performance Committee	**Report to:**	Trust Board
Date of Meeting:	29 September 2025	**Date of next meeting:**	27 October 2025
Chair:	Liz Sedgley, Non-Executive Director	**Quorate: (Y/N)**	Y

Introduction

Alert

What	So What	What Next
1. Whilst the Trust hit its target deficit of £3.7m for month 5, it is still £5.5m away from the YTD target of £24.4m. This is principally due to the WRP delivered being £15.5m which is £3.6m behind the original plan of £19.1m. The reprofiled WRP plan (the original plan included 1/12th of the unidentified WRP per month) YTD is £16.7m and the committee noted that the WRP plan for H2 is significantly higher with a target of an additional £2m WRP pm from Month 7 onwards. 2. The Trust is still facing considerable challenges managing its cash reserves as WRP projects are not driving cash savings at the required rate. An updated cashflow was presented showing that Month 8 will be challenging without additional cash support. 3. The committee received the winter plan and noted the significant risk to finances, performance and patient experience if	•	•

demand for emergency care spikes due to shortages of GPs and access to primary care across Pennine Lancashire 4. A report was presented showing the cost implications and pressures on staffing for caring for the increasing number of mental health patients being admitted. 5. The Trust is currently off trajectory for 52 week waits, with 3.6% of patients waiting against a target of 1%. The most challenged areas are subject to speciality level productivity and improvement plans. 12 hour plus waits in ED continues to be challenging, however a change in process to bring senior clinical reviews into ED earlier in the patient pathway is now underway and is expected to reduce waiting times.		
Assurance		
What	**So What**	**What Next**
1. The 25/26 contract with the LSC ICB has now been signed 2. Non pay grip and control weekly meetings are now in place and will be refined over the coming weeks. 3. The Trust achieved its WRP plan for August as the PMO is now established with all key roles recruited. PwC has completed its contract with the Trust, and the 3 SME consultants are working on specific workforce, data and investigation work to further support the cross cutting WRP schemes and identification of WRP for 26/27. This is further	•	

supported by the RSP funded data analyst who is in post to support the PMO and workforce colleagues. 4. Performance continues to improve across a number of metrics with the Trust achieving the 4hr ED standard, DMO1 and RT less than 18 weeks. Theatre utilisation continues to be strong helping to support elective recovery. 5.		
Advise		
What	**So What**	**What Next**
1. Winter planning simulation exercises have been held bringing together all key stakeholders across the North West region in order to test the robustness of the Trust's winter plans and ensure there is consistency, transparency and shared accountability for delivery of the 25/26 Winter Plan. 2. The committee received an interim update on the extended test of change for delivery of intermediate care services at Albion Mill . The final report will be received by the committee in December. 3. The committee recommended that a review of the VFM OF external support being given to the Trust is carried out and will be received by the Audit Committee. 4. An update was given on the ongoing review of the revenue investment cases	•	1.

Committee Escalation Report

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Name of Committee:	Finance and Performance Committee	**Report to:**	Trust Board
Date of Meeting:	27 October 2025	**Date of next meeting:**	24 November 2025
Chair:	Liz Sedgley, Non-Executive Director	**Quorate: (Y/N)**	Y

Introduction

Alert

What	So What	What Next
1. The financial plan was missed in month with a deficit of £5.34m (£1.8m off plan). This means that the Trust has a YTD deficit of £35.2m which is now £7.3m over the agreed plan. 2. The committee received a revised forecast outturn position which showed a most likely risk to the breakeven financial plan of £15.3m due to under delivery of WRP and operational pressures. 3. The Trust is still facing considerable challenges managing its cash position as WRP projects are not driving cash savings at the required rate. 4. The committee was informed that a review will be carried out into the external support received and the lessons learnt in working	• The WRP delivered in month was £2.9m which is £2.2m below the original month 6 target and has meant that the WRP delivered YTD of £18.4m is now £5.9m behind the original plan; £3.1m behind the reprofiled WRP delivery plan. • The continuing under delivery of the financial plan may also put at risk receipt of some of the deficit support funding for H2 together with the fact that 70% of the whole WRP programme is forecast to be delivered in H2. • An updated cashflow was presented showing that Month 10 will be challenging without additional cash support.	• A rapid review is being carried out of mitigations to recover the financial position and deliver the financial plan for 25/26 and this will be presented to the Board at the earliest opportunity. •

with external organisations to develop the financial recovery plan. 5. There is a risk to achieving the delivery targets for 25/26 if extra income is not available to support the additional costs associated with the increased activity required to meet the targets. 6. The committee requested that the Quality committee review the increase in still births in the year compared to 2024.		
Assurance		
What	**So What**	**What Next**
1. The Trust was number one in the country for theatre utilisation. 2. Operational performance and efficiency was acknowledged by NHSE at the mid-year review, especially given the continuing pressure on services due to the demand for unscheduled care which has not reduced over the summer months.	•	
Advise		
What	**So What**	**What Next**
1. The committee was updated on the ongoing improvement project within UEC and ED in particular about the reduction in the numbers of patients spending over 12 hours in ED by extending the opening hours of the AEC unit and so improving	•	1.

patient experience as evidenced by patient feedback. 2. A detailed options paper for the Accrington Victoria site was presented and the committee and support was given for Option 2 to progress. 3. An update on the progress on planning for 26/27 was received and the risks noted around the continuing financial pressures and efficiency and productivity targets. The Trust was number one in the country for theatre utilisation. 4. Operational performance and efficiency was acknowledged by NHSE at the mid-year review, especially given the continuing pressure on services due to the demand for unscheduled care which has not reduced over the summer months. 3.		

Committee Escalation Report

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Name of Committee:	People and Culture Committee	**Report to:**	Trust Board
Date of Meeting:	6 October 2025	**Date of next meeting:**	3 November 2025
Chair:	Liz Sedgley	**Quorate: (Y/N)**	Y

Introduction

Alert

What	So What	What Next
1. The level of organisational change being carried out across all areas of the Trust is putting significant demands on both the HR teams and staff side in supporting staff whose roles are under review and staff side in particular is struggling to accommodate the number of staff requiring support through the support and the number of alternative roles available to offer staff is now quite limited. 2. The staff story around physiological support available to staff who have experienced a traumatic experience highlighted the gaps in the Trust's offer and how the Trust's own systems of hot debriefs after a serious incident caused this individual's PTSD. Work is ongoing to build the business case for additional resource for physiological support although there would be additional financial pressures associated with this the committee acknowledged the need to implement this. 3. The committee were briefed on the investment required to implement the mandated Oliver Mc	•	1

Gowan training to support patients with learning difficulties 4. The Trust missed the target reduction of WTE and currently 129WTE off plan and this is a significant driver in the under performance of the financial plan 5. The Freedom to Speak Up report showed that there has been a significant increase in concerns raised – 33% higher than last year. The main themes included inappropriate behaviours and issues related to HR processes particularly regarding service reviews and organisational change. 20% of concerns raised were from BAME colleagues with complaints made around racial discrimination, sexual misconduct and disability discrimination		
Assurance		
What	**So What**	**What Next**
1. The committee received the attending awards policy which sets out the Trust's approach and will address historic discrepancies in how staff have been supported to attend awards ceremonies. 2. The committee was briefed on the process to carry out the job planning cycle 3. The grip and control report highlighted the reductions in bank and agency spend and salary overpayments compared to the previous year. 4. The winter plan was presented, and the committee noted the significant workforce challenges and that leadership and visibility of	•	

senior leaders would be improved through daily meetings and matron led visits		
Advise		
What	**So What**	**What Next**
1. The Freedom to Speak Up report was received and a paper is expected to be brought to the committee later in the year to discuss how we can triangulate the feedback from all the various listening groups across the organisation. The committee also noted that the levels of compliance with the mandatory training for FTSU is below the target. 2. There has been a strong start to the launch of the staff survey with a return rate of 23% which is above the national average and there is a communications campaign to continue to promote the staff survey over the next 2 months	•	1.

Committee Escalation Report

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Name of Committee:	People and Culture Committee	**Report to:**	Trust Board
Date of Meeting:	3 November 2025	**Date of next meeting:**	1 December 2025
Chair:	Liz Sedgley	**Quorate: (Y/N)**	Y

Introduction

Alert

What	So What	What Next
1. The committee was updated on the impact of the decision for ELHT to become the lead provider for OneLSC. The immediate focus for the HR team is on stabilisation of the service as staff are dealing with high attrition rates leading to workload imbalance and leadership gaps together with the uncertainty surrounding the future of the service has led to low morale and anxiety amongst the staff. 2. The WTE reduction target although the gap has been reduced to 109WTE in month 6, a review of all the WRP projects on the tracker is being carried out with a reprofiled WTE reduction attached to this work. 3. The committee received a report on the increase of violent and abusive incidents against staff, it was noted that the current trend is showing significant increase in such incidents and at current rates would indicate an increase of 45% year on year. It was also noted that the Staff Safety Group is currently without a chair and this	• A rapid audit of all the roles and requirements of the service is currently being carried out to help develop a new operating model.	1

has been escalated to the Trust Executive to ensure that a chair is appointed immediately.		
Assurance		
What	**So What**	**What Next**
1. The annual Fire Safety report for 24/25 was presented. 2. The Committee heard the Trust's response to the NHSE and NW BAME Assembly letters requesting action on racism, Islamophobia and Antisemitism. The committee noted the work carried out to date but acknowledged that the pace and focus needs to increase to improve the experience of staff with protected characteristics within ELHT. 3. A report on the progress made in implementing the NHSE Sexual Safety Charter. 4. The plan to improve the performance appraisal experience and completion rate at ELHT was heard which will include a rapid improvement week planned for December.	• The committee supported this work and the plan to address the remaining gaps to fully implement and then embed the Charter.	
Advise		
What	**So What**	**What Next**
1. The committee was advised that work is ongoing to agree a methodology across the ICS for the reconciliation of WTE worked and contracted 2. An update on the staff survey was received with the response rate standing at 33.4% which was slightly higher than last year. However response rates for BAME staff, OneLSC E&F and MEC are still below the Trust response rates.	•	1.

Triple AAA Report

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Name of Group:	Audit Committee	**Report to:**	Board of Directors
Date of Meeting:	13th Oct 2025	**Date of next meeting:**	19th November 2025
Chair:	Khalil Rehman	**Parent Committee:**	Board of Directors

Alert

What	So What	What Next
Internal Audit	Due to a number of factors including absences of executive leads, the IA plan for 25/26 is **significantly off trajectory.**	IA (MIAA) and DoF have been reminded that the AC had requested in June 25, that the bulk of the FY25/26 IA plan was to be completed by the end of Jan 2026. MIAA advised resources & priorities are to be realigned accordingly.
Internal Audit (FY25/26) FY24/25 - IA reports	Consultant Job Planning - **Limited assurance** – this Is the only piece of work completed as part of the FY25/26 IA plan in the past 6 month period. • Clinical Coding – substantial assurance • IT Critical application EPR system – **Limited Assurance** • Data Security & Protection Toolkit (DSPT) – Overall Assurance Rating – **Very High Risk**; Veracity of the organisation's self-assessment - High Confidence	Further discussion with MD & OD to provide assurance and integrate alongside WRP & PMO work. To be also discussed at P&C. To be discussed at Data & Digital committee.
Request to amend FY25/26 IA plan	Management requested delaying QIA and EIA iA reviews until Q4. AC declined. AC requested removal of ONELSC IA due to structural hosting/provider model changes.	These are important so as to be able to triangulate with WRP plan and ensure safety and quality and should not be delayed.

Grip & Control Plan	Unfortunately no substantive progress or evidencing of impact since IAG. **Limited Assurance.**	Former Turnaround director was advised of the need to provide evidencing and impact. AC now to review G&C at every meeting and will have additional meetings in Nov and possibly Dec to track progress on G&C.
Backlog and Tracking of IA recommendations	This Impacts on our HOIA opinion (already limited) and **no clear assurance or evidence of progress on previous year recommendations.** Some going back to FY22/23. An updated executive process on implementing recommendations was presented and noted.	Exec/PMO to review approach and priorities and link with ERAG – to be reviewed at NOV AC.
Assurance		
What	**So What**	**What Next**
Financial Governance Action Plans	Actions on track.	To be monitored by exception at F&P.
BAF Risk 7 Cyber Security	Significant risks highlighted. Noted good progress on regulatory asks re: cyber risks raised by NHS National digital team in early 2025.	Now to be covered at new Data &. Digital Committee.
Waivers & Tenders	New format and better information provided	Next meeting – further actions that could be undertaken to align with PMO and procurement savings.
Compliance with NHS Code of Governance for Provider Trusts	Report received.	
Advise		
What	**So What**	**What Next**
Counter Fraud update	Noted.	Follow up reports at future committees.

Committee Escalation Report

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Name of Committee:	Trust Charitable Funds Committee	**Report to:**	Trust Board
Date of Meeting:	20 October 2025	**Date of next meeting:**	19 January 2026
Chair:	Melissa Hatch	**Quorate: (Y/N)**	Yes

Introduction

The Trust Charitable Funds Committee met on 20 October 2025 to review financial performance for the first half of 2025-26 (April-September), consider funding applications, and provide governance oversight of the charity's operations. This report highlights positive developments in fundraising and operational performance, key strategic decisions requiring Board input, and emerging sustainability challenges that require management action. The Committee continues to exercise robust oversight of charitable funds on behalf of the Board as Corporate Trustee, ensuring all funds are deployed in accordance with donor intentions and regulatory requirements.

Alert

What	So What	What Next
Charity Team Capacity: Ongoing staffing challenges continue to impact fundraising capacity and operational effectiveness, limiting the charity's ability to maximise income generation and develop new initiatives.	Understaffed charity teams limit growth potential and create dependency on large donations rather than sustainable, recurring fundraising income, creating long-term financial vulnerability.	Conduct workforce planning review to identify optimal staffing model; undertake comprehensive charity strategy review in early 2026 (January-March) to align resource allocation with strategic priorities; and report progress to Committee at April meeting with focus on impact on fundraising performance and project delivery.
Financial Value-for-Money Concerns: Analysis of financial information presented at October's Committee suggests questions about whether administrative costs and investment management fees are proportionate to regular fundraising income (excluding the one-off £2m donation). The Committee has requested verification of the data to determine if action is required.	Disproportionate overheads such as administrative costs and investment management fees, relative to recurring income could create structural sustainability concerns, limiting the charity's capacity to deploy funds for patient benefit.	Finance to provide verified financial data and clarification on administrative cost allocation and investment management fee basis to Committee by January 2026 meeting to determine whether further action is required.

Assurance

What	So What	What Next

Committee Escalation Report

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Significant High-Value Donation Received: The Committee received confirmation that the charity has successfully banked a £2 million donation from a high-net-worth donor for the purchase of medical equipment. Procurement of equipment has commenced in accordance with the donor's intentions, with appropriate governance arrangements in place for equipment selection and donor engagement. This represents exceptional generosity and demonstrates strong community support for our services.	The £2m donation significantly enhances the charity's capacity to invest in equipment benefiting patient care and staff experience, demonstrating community trust and confidence in the Trust's charitable work	Equipment procurement to continue in accordance with governance framework, with progress updates to be provided to the Committee at future meetings
Retail Hub Performance: The retail hub at Royal Blackburn Teaching Hospital continues to perform well, managed via a Trading Subsidiary, with a profit of £65,000 for 2024-25 available to purchase equipment. There is scope for expansion of the retail element of the charity across other sites.	The retail hub's consistent profitability provides an additional reliable income stream to supplement fundraising activities, with potential for revenue growth through planned expansion.	Retail expansion business case to be developed, including site assessment and investment requirements, for Committee consideration in early 2026.
Strengthened Governance Framework: The Committee has reviewed and endorsed revised Terms of Reference, which strengthen governance arrangements through increased quorum requirements and explicit alignment with the UK Charity Governance Code.	Enhanced governance arrangements strengthen the Committee's oversight capability and demonstrate alignment with sector best practice, supporting the Board's assurance that charitable funds are managed appropriately.	Revised Terms of Reference to be formally approved by the Board as Corporate Trustee in April 2026.
Advise		
What	**So What**	**What Next**
Capital Funding Request: The Committee has reviewed a capital funding request of approximately £208,000 for automated prescription collection stations at Royal Blackburn and Burnley General hospitals. This investment aims to address	• The proposal aligns with the charity's patient benefit objectives by directly addressing service performance failures and improving patient satisfaction.	For the January Committee: • Pharmacy team to provide detailed quotations for collection stations and operating cost analysis

poor KPI performance (only 44.5% of prescriptions dispensed within 30 minutes at Blackburn) and reduce patient complaints. The Committee approved gathering further information before approval in principle is sought, including quotations for stations, understanding economies of scale around having two sites rather than one, and clarity on associated oncosts.	• The investment represents significant capital deployment (£208k) and warrants robust due diligence before commitment to ensure value for money and sustainable revenue models. • A two-site approach may offer operational benefits and efficiency gains but requires detailed financial modelling to justify the additional capital investment compared to a single-site pilot.	• Financial analysis of two-site versus single-site models, including revenue projections and payback periods, to be completed. • Committee to review full business case and grant approval in principle (or otherwise) at January 2026 meeting, with final approval subject to satisfactory completion of due diligence on quotations, economies of scale analysis, and revenue sustainability
Other agenda items		